COMMUNITY HEALTH NEEDS ASSESSMENT

DEPARTMENT OF HEALTH & SOCIAL SERVICES

STAMFORD HOSPITAL
The Regional Center for Health

affiliate Columbia University College of Physicians and Surgeons
member New York-Presbyterian Healthcare System
A Planetree Hospital

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ACKNOWLEDGEMENTS

The Stamford / Lower Fairfield County Community Health Needs Assessment (CHNA) and strategic planning project was made possible through the generous support of The Stamford Hospital. Stamford Hospital, along with the City of Stamford's Health Department, as well as other public health and community health stakeholders, worked collaboratively for more than a year to conduct this assessment and planning project. The project was guided by a Steering Committee made up of senior representatives from Stamford Hospital and the Stamford Health Department. Additional input was provided by an informal Advisory Group made up of other hospital and local health department officials, as well as representatives from community-based organizations throughout the region. The combined expertise, knowledge, and commitment provided by the members of these committees was vital and this project would not have been possible without their support and guidance.

The Steering Committee, on behalf of Stamford Hospital and the Stamford Health Department, would like to thank all of the people that were involved in this project, particularly those who were interviewed or surveyed, or participated in the community listening sessions and strategic planning work groups. This project would not have been possible without their input and support.

EXECUTIVE SUMMARY

INTRODUCTION

Stamford Hospital is committed to serving the residents of the Lower Fairfield County Region by delivering a comprehensive array of programs and services intended to improve the health and well-being of residents throughout the hospital's service area. In order to ensure the hospital is meeting the needs of the community it serves, in 2011, the hospital collaborated with the Stamford Health Department to begin the process of updating their Community Health Needs Assessment (CHNA). Stamford Hospital engaged John Snow Inc., a national public health research and consulting firm, to conduct the assessment including a quantitative and qualitative analysis of the community's demographics, health behaviors, and overall health status; the availability of health care resources and barriers to access the community faces; priorities for improvements in the community's health; and priorities for improvements to the larger health care system that serves the Lower Fairfield County region. The results of the CHNA have, in turn, been used to develop an action plan that will guide the hospital's strategic direction to meet the community's health related needs.

METHODOLOGY

The assessment and planning process was conducted in three phases and included quantitative analysis of primary and secondary data sources, as well as qualitative analysis of information gathered through key informant / stakeholder interviews. In Phase I – secondary data was compiled from local, State and national sources to assess an array of characteristics – from demographics, to current health status and overall morbidity and mortality. Nearly 100 interviews were also conducted with a broad cross section of stakeholders including, but not limited to, hospital management and staff, public health officers, elected officials, and community residents.

In Phase II – additional secondary data was collected along with primary data gathered through a Community Health Mail Survey targeting 3,400 residents. With a response rate of 36%, 1,228 surveys were analyzed with results broken down by town. Additional analysis was conducted on low income respondents (defined as respondents with annual household income of less than $50,000). Understanding low income, racial/ethnic minority and other vulnerable populations can be hard to reach, a separate convenience survey was administered with the help of research assistants and Stamford Hospital volunteers – gathering input from 271 residents at targeted venues including health fairs, primary care clinics, and community centers.

In Phase III – the Steering Committee guiding the CHNA reviewed the results of Phases I and II and began a strategic planning process to identify four priority health areas: Health and Wellness; Chronic Disease; Mental Health/ Substance Abuse (Behavioral Health); and Access to Services.

Next, two community listening sessions were held to review the CHNA data and gain input / buy in from key stakeholders on the four priority areas identified above. Workgroups were established for each priority area, and recommended goals, objectives and strategies were identified to inform the Stamford Hospital Community Action Plan for Population Health and Prevention.

KEY FINDINGS

Demographics

Population – In 2010, the total population of Lower Fairfield County was 364,519, representing a 3.1% increase since 2000. The eight towns included in the analysis vary by size and growth rate – with Stamford and Norwalk being the largest and second largest towns respectively. Lower Fairfield County had a slightly higher percentage of families in households (68.3%) than the State (66.3%), while the towns of Stamford and Norwalk had slightly higher proportions of non-family households.

Age Distribution – Lower Fairfield County has roughly the same age distribution as the State, though there is variation at the town level. In 2010, Stamford and Norwalk had a slightly younger population in comparison to the State, while the median age in the communities of Greenwich, New Canaan, Weston, Westport and Wilton was higher than the State.

Racial and Ethnic Diversity – The demographic composition with respect to race / ethnicity has changed considerably since 2000 – driven principally by changes in the towns of Stamford and Norwalk which have seen significant growth in the Asian and Hispanic / Latino populations. In Stamford, 46.7% of the population is non-white or Hispanic / Latino, while in Norwalk the proportion is 44.3%.

Educational Attainment – A significantly higher percentage of Lower Fairfield County residents have attained a college or advanced degree (53.1%) compared to the State (35.1%), but again – there is variation at the town level. Stamford and Norwalk have substantially higher proportions of the population with less than a high school diploma (11.9% and 13.5% respectively) when compared to the surrounding towns, but are closer to the State and County rates (11.8% and 11.7% respectively).

Income, Poverty and Employment - Fairfield County is one of the most affluent counties in the United States. Six of the eight towns evaluated had median annual household incomes in excess of $122,000. Stamford and Norwalk, however, had significantly lower median household incomes when compared to surrounding towns – largely attributed to the significantly larger proportions of individuals living in poverty in those communities (10.2% and 8.2% respectively). Lower Fairfield County was impacted by the economic downturn and recession over the past 5 years, but has generally fared better than the rest of the nation and the State as a whole. Stamford, with unemployment rate of 7.9% in 2009, is a notable exception.

Housing – Housing costs throughout Lower Fairfield County are significantly higher than the State with median single family home prices two to six times higher than the State. Monthly mortgages and monthly rental payments are also significantly higher than the State as a whole. The high cost of housing contributes to the overall high cost of living in the region – a challenge that was identified for the region's low income population.

Access to Healthy Foods and Recreation – Fairfield County residents have extensive access to parks and recreational facilities across the County; in fact, the County is in the top 10th percentile of counties nationally when it comes to recreational facility access. In general, Lower Fairfield County residents also have substantial access to healthy foods. However, access is a concern for some residents with four Census tracts having been identified as "food deserts" in the region.

Crime – Overall, Fairfield County exhibits higher violent crime rates than the State – driven almost exclusively by the crime rates of Stamford and Norwalk. In 2009, the violent crime rate in Stamford was 292 per 100,000 population while in Norwalk, it was 507 per 100,000. Violent crime rates in the other six towns in Lower Fairfield County were substantially lower than the State– ranging from 15 to 86 incidents per 100,000 population. Similar trends are seen with property crime – with Stamford and Norwalk each exhibiting substantially higher rates than the other towns in Lower Fairfield County, but still falling below the State's rate.

Health Behaviors

Rates of Obesity / Overweight – Nearly half (46%) of Lower Fairfield County residents were overweight or obese in 2011, compared to 54.4% of the County overall, and 60.6% of the State. The low income population was more likely to be obese or overweight with rates of 55% in the mail survey and 62% in the convenience survey. Obesity / Overweight was ranked as the #1 most significant health problem in the community by survey respondents.

Physical Exercise and Healthy Eating – Nearly one third of those surveyed in Lower Fairfield County reported not getting any physical activity in the past seven days – with higher rates of inactivity seen in Stamford (37%), Norwalk (34%), and in low income populations (46%). Additionally, only 17% of survey respondents in Lower Fairfield County reported eating 5 or more servings of fruits and vegetables per day – significantly lower rates than the State (28.3%) and County overall (30.2%).

Substance Use and Abuse – The rate of current smokers in Lower Fairfield County (8%) is lower than the County overall and the State, but there are high rates (ranging from 10-12%) seen in Stamford, Norwalk, Greenwich and within the low income population. High rates of binge drinking and heavy drinking were reported in Lower Fairfield County when compared to the State – with particularly high rates seen in the region's most affluent communities. Reported rates of illegal drug use were low across all towns surveyed, however – legal drug abuse (e.g. prescription drug abuse) was reported at higher rates in Stamford (11%) and in low income populations (13%) than compared to the State (9%).

Health Outcomes

Perceived Health Status – Low income populations were substantially more likely to report their health status as fair or poor than compared to Lower Fairfield County and the State overall. They were also more likely to report a higher number of days in poor physical health in the last 30 days – with 9% of low income mail survey respondents, and 20% of convenience survey respondents reporting 15 or more days of poor physical health in the past month.

Chronic Disease – Reported rates of Angina or Coronary Heart Disease in Lower Fairfield County (3%) were comparable to the County overall (3.2%) and the State (3.6%) – but it is worth noting the higher rate reported in the low income Population (5%). With the exception of Norwalk and Weston, mortality rates from Cardiovascular disease (CVD) are lower than the State's rate. One contributing factor to this may be that Lower Fairfield County residents diagnosed with hypertension (a major risk factor for CVD) are more likely to manage their disease with medication than the County overall and the State.

The rate of Diabetes diagnoses in Lower Fairfield County (7%) is approximately the same as the State (7.3%) but higher rates (ranging from 9-13%) are seen in Norwalk, Stamford and within the region's low income population.

Reported asthma diagnoses in Lower Fairfield County are higher than the State in all towns except Darien / Rowayton and New Canaan with particularly high rates seen in Norwalk (15%), Westport, Wilton, and Weston (13%) and Stamford (12%). It is worth noting that low income residents are more than twice as likely to visit the emergency room due to asthma as residents of Lower Fairfield County overall.

Cancer - Cancer is a significant concern in the region and was ranked by Lower Fairfield County Community Health Survey respondents as the #2 most significant health issue affecting the area. While cancer screening rates in Lower Fairfield County are generally higher than the County or State, incidence and mortality rates for certain cancers – most notably, breast cancer and prostate cancer – are also much higher in certain Lower Fairfield County towns than the County as a whole or in Connecticut.

Mental Health - Mental health and particularly depression, anxiety, and stress, are a substantial problem in Lower Fairfield County, especially for low income residents. The impacts of mental health disorders alone are dramatic, and these issues are also a clear risk factor – and/or complication factor – for chronic diseases, such as diabetes, heart disease, and stroke. Low income and racial/ethnic minority populations are more likely to be sad/blue or tense/anxious than the overall population in Lower Fairfield County. Qualitative data indicated that mental health issues are a major priority for the region, given the level of morbidity and mortality and the lack of access that was reported, particularly for low income individuals and families.

Health Care Access and Utilization

Resources and Use of Health Care Services- Lower Fairfield County is fortunate to have a strong and vibrant health care system that spans the breadth of the health care continuum from public health and social service providers, to primary care medical, dental, behavioral health, hospital (emergency and inpatient services), rehabilitation and long-term care services. While there are no absolute gaps in services available, this does not mean that everyone receives the type of care that they need, when they need it, and where it is most appropriate.

For instance, while nearly all survey respondents (92%) reported having a primary care provider (PCP) or regular doctor, the low income population was less likely to report such (87% in the mail survey, and 74% in the convenience survey). Low income residents were also less likely to have had a routine dental care visit in the past 12 months – with 60% of low income mail survey respondents and 50% of convenience survey respondents reporting a dental visit compared to 78% of Lower Fairfield County residents overall.

The trend continues with specialty care utilization – with 59% of low income mail survey respondents reporting a specialty visit versus 67% of Lower Fairfield County residents overall. The lack of access to primary and specialty care may be a contributing factor to the higher rates of ED utilization in the low income population (38%) versus the rate of 24% in Lower Fairfield County overall. Further evidence of this is the high percentage of Emergency Room visits – especially in Stamford – that are for non-emergent, emergent but primary care

treatable, or emergent but preventable conditions. The lack of access to health care services was ranked as the second leading health issue among low income survey respondents and the third leading health concern for those in Stamford.

Barriers to Access- The quantitative and qualitative data from the assessment clearly show that large segments of the population, particularly low income and racial/ethnic minority populations, face barriers to care and struggle to access services. Some struggle due to the complexity of their medical, social, financial, and family support situations. Others struggle due to linguistic, cultural, and health literacy barriers. Still others struggle because they are uninsured or Medicaid insured and experience difficulty in finding service providers who are willing to provide care on a discounted basis. While 94% of residents surveyed in Lower Fairfield County reported being insured, the proportion of the low income population with insurance was substantially lower at 76%. This disparity is also seen for dental insurance, with 46% of low income populations reporting coverage, vs. 61% of Lower Fairfield County residents overall. The cost of co-pays, deductibles, and out-of-pocket expenses was identified by survey respondents and participants in key informant interviews as the most significant barrier to access.

COMMUNITY HEALTH PRIORITIES

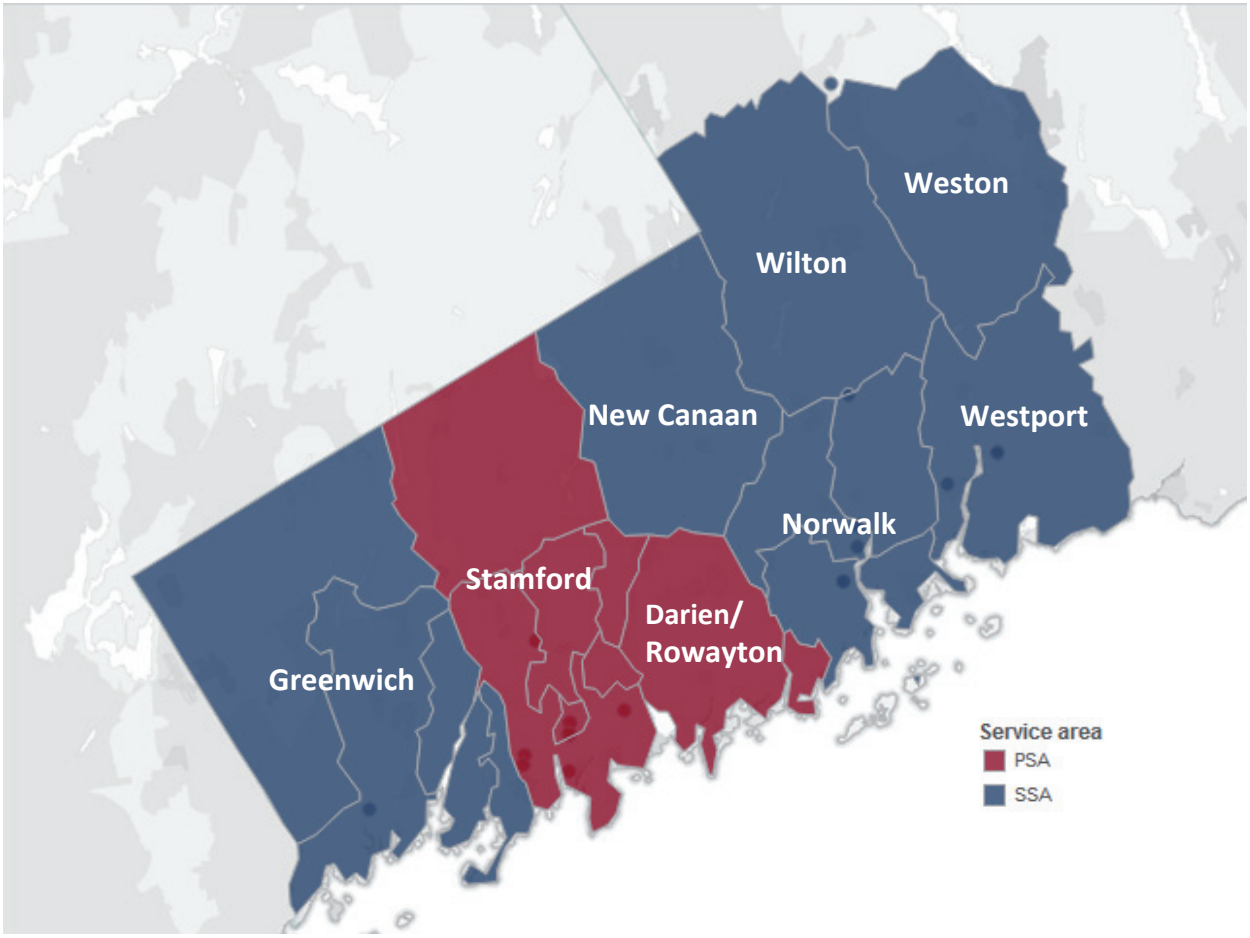
After reviewing the breadth of data that was compiled during this assessment, the Steering Committee identified four community health priority areas: 1) Health and Wellness, 2) Chronic Disease, 3) Mental Health/Substance Abuse (Behavioral Health) and 4) Access to Services. With a focus on health and wellness, it will be important to ensure residents have access to health education, healthy food and fitness opportunities, and prevention and screening services. Residents with chronic diseases such as heart disease, diabetes, asthma, cancer and obesity should be supported with chronic disease management programs that will not only help reduce the burden of the disease to the residents, but also reduce inpatient hospitalizations and emergency room visits. Access to behavioral health services needs to be strengthened for residents with depression, anxiety, and /or stress as well as residents who abuse alcohol and/ or prescription drugs. And finally – access to primary and specialty care, dental services, and mental health / addiction services needs to be strengthened for the low income and racial / ethnic minority populations. Ensuring proper access to these services can lead to better care in the right place and at the right time – again reducing the burden of disease, while also reducing unnecessary emergency room utilization, hospitalizations, and associated costs to the health care system. These priorities will lay the foundation for the Stamford Hospital Community Action Plan for Population Health and Prevention.

INTRODUCTION

In 2011, Stamford Hospital, in collaboration with the Stamford Health Department, made a commitment to update their Community Health Needs Assessment and hired John Snow, Inc. (JSI), a nationally recognized research and consulting firm with expertise in public health, to assist them in conducting this work. JSI has extensive experience working with hospitals, academic medical centers, physician practices/networks, and State and local health departments, among other organizations, to assess community health needs and develop strategic plans to address these needs. JSI staff assisted Stamford Hospital and the Stamford Health Department with primary and secondary data collection, conducting key informant interviews, and writing the preliminary action plan.

Stamford Hospital's desire to conduct this assessment was born largely out of their commitment to the residents of the Lower Fairfield County region and their wish to improve the health and well-being of residents throughout the hospital's Primary and Secondary Service areas.

Figure 1: Map of Stamford Hospital's Primary and Secondary Service Areas.



The region of focus is depicted in Figure 1 and includes the towns and cities that comprise Lower Fairfield County as follows:

Stamford Hospital's Primary Service Area:

- Stamford
- Darien
- Rowayton

Stamford Hospital's Secondary Service Area:

- Greenwich
- Old Greenwich
- Cos Cob
- Riverside
- New Canaan
- Norwalk
- Weston
- Westport
- Wilton

The completion of this assessment also fulfills a new federal Internal Revenue Service (IRS) requirement, built into the new Patient Protection and Affordable Care Act (PPACA), which mandates that all non-profit hospitals conduct a community health needs assessment (CHNA) and strategic planning process every three years. The requirement further stipulates that the CHNA must be done in collaboration with local public health officials and other health and social service providers, and that it involve community residents. Finally, the requirement States that an associated implementation strategy be adopted by the hospital to address the community health needs identified through the CHNA. This strategy will guide the hospital to work in collaboration with other health care, public health, and social service organizations in the targeted area – as well as the community at-large – to address the priorities identified by the assessment.

Accordingly, the purpose and scope of this report is to:

- Assess the demographics, health behaviors, and overall health status of the Stamford / Lower Fairfield County region.
- Assess the availability of health care resources and any barriers to access the community may face.
- Identify priorities for improvements in community health and improvements to the larger health care system that serves the Stamford / Lower Fairfield County region.

The associated Action Plan lays a roadmap for Stamford Hospital and various collaborating partners to address the priorities identified in this report with a specific focus on:

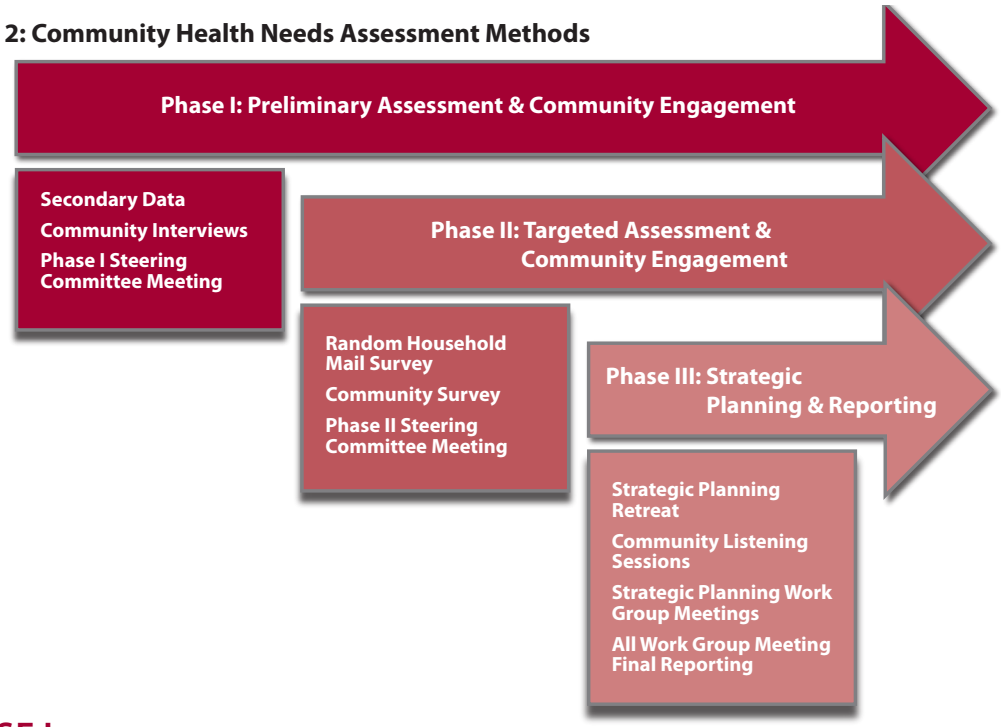
- Improved access for low income and vulnerable populations
- Improved coordination amongst providers
- Reductions in unnecessary emergency room visits and inpatient hospitalizations, and
- Improved health status and health outcomes in the community.

COMMUNITY HEALTH ASSESSMENT METHODS

The assessment and planning process was conducted in three phases, which allowed the Steering Committee to:

1. identify the health care needs and priorities of residents of Stamford and Lower Fairfield County, as well as health disparities across populations;
2. engage community stakeholders, including residents throughout the service area; and
3. facilitate the development of a detailed, action-oriented strategic plan targeting the most pressing community health needs.

Figure 2: Community Health Needs Assessment Methods



PHASE I

In Phase I, a preliminary needs assessment and community engagement effort was conducted that relied heavily on information collected through existing secondary data from local, State and national sources. These sources included (but were not limited to) the U.S. Census Bureau, Connecticut Department of Labor, Connecticut Behavioral Risk Factor Surveillance System (BRFSS), and the Connecticut Hospital Association CHIME database. The data collected from these sources provided important information on the demographic characteristics of the population, as well as social determinants of health, current health status, access to care, health-related risk factors, disease incidence and prevalence, and overall morbidity and mortality.

Figure 3: Phase I Summary

PHASE I: PRELIMINARY ASSESSMENT AND COMMUNITY ENGAGEMENT

KEY INFORMANT INTERVIEWS

- **~ 100 Interviews**
- **Structured interview protocol**
- **Majority, in-person, one-on-on interviews**

- Hospital clinical and administrative staff
- Primary care providers
- Behavioral health providers
- Elder services providers
- Social service providers
- Public health officials
- Public housing staff
- Advocacy organizations
- Faith-based organizations
- Public officials
- Community leaders

SECONDARY DATA

- **200+ data variables**
- **Local data for the cities/towns of Darien, Greenwich, New Canaan, Norwalk, Stamford, Westport, Weston, and Wilton**
- **National, State and County comparison data**

POPULATION CHARACTERISTICS & SOCIAL DETERMINANTS OF HEALTH

- Age and gender
- Family composition
- Race/ethnicity
- Language
- Income and poverty
- Education
- Crime
- Housing
- Employment

HEALTH STATUS, MORBIDITY/MORTALITY, & HEALTH-RELATED RISK FACTORS

Prevalence, incidence, death, and hospitalization rates for:

- Diseases of the heart
- Cancer
- Infectious diseases
- Respiratory diseases
- Mental health
- Substance abuse
- Maternal/child health

Proportions of the population who are impacted by the leading health risk factors:

- Diabetes
- Obesity/overweight
- Lack of physical fitness
- Poor nutrition
- Tobacco use

ACCESS TO CARE & SERVICE UTILIZATION

- Medical and dental insurance status
- Access to a primary care provider
- Access to preventative services
- Access to dental services
- Access to medical specialty services
- Hospital inpatient utilization
- Emergency department utilization

Dozens of interviews were also conducted in Phase I to engage the community in the assessment process. These interviews captured community perceptions on priority health issues, service gaps, and barriers to access, as well as suggested strategic initiatives to address these issues. In all, nearly 100 people were interviewed, including administrative and clinical staff from Stamford Hospital, representatives from local health and social service agencies, public health officers, other public and elected officials, representatives from advocacy organizations and foundations, members of the clergy, and community residents. See Appendix 5 for a full list of Key Informant interviews.

At the end of Phase I, the Steering Committee met with other key community stakeholders to review preliminary findings, discuss emerging ideas from the secondary data and key informant interviews, consider their implications, and finalize plans for Phase II of the assessment.

PHASE II

In Phase II, a targeted community assessment and community engagement process was conducted that collected additional secondary data to fill in gaps and clarify questions that arose during the Phase I Steering Committee meeting. Many Behavioral Risk Factor Surveillance System (BRFSS) and American Community Survey (ACS) data points collected during Phase I could only be broken out to the County or State level; due to our assessment's specific focus on Lower Fairfield County, we wanted to examine results specifically for this region, both in aggregate and by town. As a result, two community surveys were conducted during Phase II to capture this data.

Figure 4: Phase II: Targeted Assessment and Community Engagement

COMMUNITY HEALTH SURVEYS	
COMMUNITY HEALTH MAIL SURVEY	**CONVENIENCE SURVEY**
• 3,000 randomly selected households in Lower Fairfield County • ~1,300 returned surveys • 52% response rate	• Administered by research assistants • Data collected in 8 community venues (e.g., health fairs, community centers, safety net primary care clinics, and faith-based organizations) • ~ 300 surveys collected
• 20-page survey • Questions drawn from validated national surveys • Survey included questions related to: - Respondent demographic and socio economic characteristics - Health behaviors and lifestyle - Access and barriers to care - Perceived health concerns and priorities	- Need, knowledge, and use of services - Self-reported health status - Child health, older adult health, and caregiver issues - Chronic disease and prevention

The household mail survey (going forward, we will refer to this survey as the "2011 Lower Fairfield County Community Health Survey" or "mail survey" in the report) was administered to a randomly selected sample of 3,400 households in Lower Fairfield County. The sample size of 3,400 was based on the goal of producing reliable estimates, especially at the town level. The project team oversampled the City of Stamford, and especially the low income residents (defined as households with annual household income below $50,000) within Stamford; these populations tend to be harder to reach and, as a result, are often excluded from these assessment efforts. In total, 1,228 mail surveys were returned by Lower Fairfield County residents, a response rate of over 36%. Please see Appendix 1 for a copy of the mail survey.

Table 1: Household Mail Survey Response Rate by Town

	Stamford	Darien/ Rowayton	Greenwich*	New Canaan	Norwalk	Weston	Westport	Wilton	Total
Total # of respondents	448	138	97	101	117	101	113	113	**1,228**
Response rate	37%	35%	32%	34%	39%	34%	38%	38%	**36%**

*** Includes towns of Greenwich, Cos Cob, Old Greenwich, and Riverside.**

Source: 2011 Lower Fairfield County Community Health Survey

To ensure input was received from low income, racial/ethnic minority, and other vulnerable populations, an additional community convenience survey (we will refer to this as "convenience survey" going forward in the report) was administered through selected community venues, including community health fairs, primary care clinics, faith-based community organizations, and other community centers. The survey was conducted with the help of research assistants, Stamford Hospital volunteers, and volunteers from community organizations to serve as translators for respondents who did not speak or read English. Overall, 271 community members participated in this survey. The results were then utilized to verify trends identified in the responses received from low income and racial / ethnic minority participants in the mail survey. Throughout the report – any dramatic differences identified in the convenience survey sample will be identified.

The culmination of Phase II was a comprehensive needs assessment analysis that compiled, integrated, and analyzed all of the data collected in Phases I and II. This report became the basis for the strategic planning process conducted in Phase III.

PHASE III

In Phase III, the Steering Committee began a strategic planning and reporting process that vetted the findings from Phases I and II, established community health priorities, and identified a range of strategies that would become the basis of the Community Action Plan.

To kick off Phase III, the Steering Committee participated in a retreat to review the data and identify a proposed set of community health priorities and a set of emerging strategies. After reviewing the data compiled during Phases I and II, as well as input from the community and local health organizations, the Steering Committee members identified four priority health areas to target in the strategic planning process:

- Health and Wellness
- Chronic Disease
- Mental Health/Substance Abuse (Behavioral Health)
- Access to Services

After the retreat, two community listening sessions were held to review the needs assessment data and introduce the priority health areas identified during the retreat: one with key stakeholders, local public health officials, leading health and social service providers, and the community at-large; and another with senior staff from the City of Stamford, including key staff from the City's Health Department.

After the listening sessions, four community health workgroups were coordinated, one for each priority area identified by the assessment. These workgroups were composed of representatives from the Hospital, local health departments, and other key community health stakeholders.

The workgroups met multiple times over the course of three months and were charged with developing a series of goals and objectives, as well as a set of core strategies, geared toward addressing the issues that were part of their priority area. See Appendices 7-14 for all workgroup charges and membership.

At the culmination of Phase III, the input from the four workgroups was combined and analyzed by management of Stamford Hospital who, in turn, prepared the Stamford Hospital Community Action Plan for Population Health and Prevention to be executed in collaboration with an array of community partners.

ANALYSES AND LIMITATIONS

While we attempted to gather a broad picture of community health status in Lower Fairfield County through secondary data collection, key informant interviews and community surveys, there were some gaps in our analysis. The main limitation we faced in our evaluation was the lack of available information (especially from secondary sources) broken out by demographic characteristics such as race, ethnicity, gender, socioeconomic status, and age. Additionally, the community surveys we conducted did not have a large enough sample size to stratify results by most of these factors (with the exception of income). Racial and ethnic health disparities were mentioned frequently in our key informant interviews and during our workgroup meetings, but we have limited data to support these comments.

It should also be noted that setting priorities is not a simple or often straight-forward exercise. Certainly community health priorities must be data-driven and rooted in the existing evidence but they also must take into consideration community resources, gaps in existing programs or services, and community perceptions. It matters little what the data says if there is no will or capacity to address the issue in the community, or if there are numerous programs or institutions already addressing the issues that the data highlights. Additionally, many of the key findings and data elements are interrelated and overlapping across the identified priority areas. In an effort to articulate all of the identified priorities and provide clear evidence illustrating why the area was identified, there is redundancy in some of the data that is reported.

Finally, this report does not address all of the findings drawn from the data that was compiled during the assessment. In particular, it does not highlight many of the most positive aspects related to health status in the region. Lower Fairfield County is a very healthy community overall with strong, vibrant health care programs and public health systems.

FINDINGS

The following is a discussion of the characteristics of Lower Fairfield County's population as well as the socioeconomic factors that impact health status and the ability to maintain a healthy lifestyle. This section is then followed by a discussion of key health indicators that were identified through the assessment process.

SOCIAL DETERMINANTS OF HEALTH FRAMEWORK

"Social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between communities."

Social determinants of health key concepts, World Health Organization (WHO)

Utilizing the social determinants of health framework, we are able to take a broader view of what defines the health of the communities Stamford Hospital serves. Health is not simply determined by individuals taking care of themselves by maintaining a healthy diet, living an active lifestyle, abstaining from smoking, or receiving all preventative health services. Rather, an individual's health is also impacted by access to social and economic opportunities; resources and supports available at home, in the neighborhood, and in the community; the quality of schools; the safety of workplaces; the cleanliness of the environment; and the nature of social interactions and relationships. Resources that can enhance quality of life include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency / health services, and environments free of life-threatening toxins.[1]

Thus, in addition to analyzing health behaviors and outcomes, this CHNA will evaluate the resources and factors contributing to the social determinants of health in Lower Fairfield County.

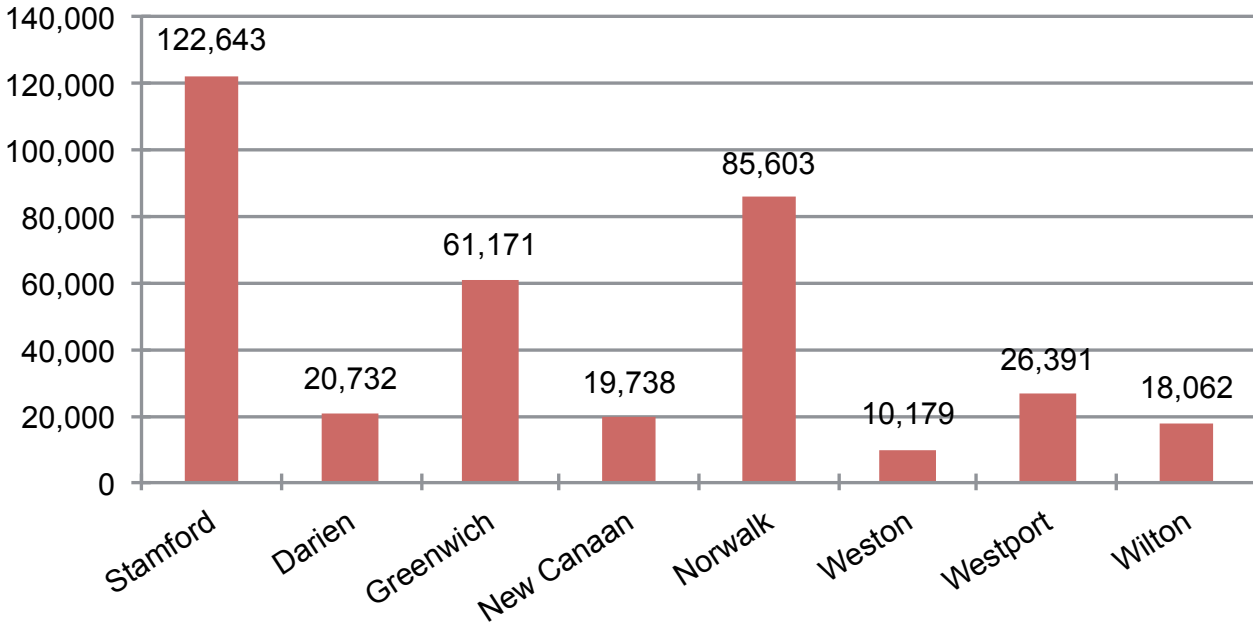
[1]http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=39

DEMOGRAPHICS

An understanding of community need and health status begins with knowledge of the population's characteristics, as well as the underlying economic and environmental factors that impact health. This information is critical to recognizing disease burden, identifying target populations, setting health-related priorities, and targeting strategic responses. The Stamford Hospital / Lower Fairfield County Community Health Needs Assessment (CHNA) compiled a wide range of quantitative data from the US Census Bureau and other federal, State, and local sources related to age, gender, race/ethnicity, ancestry, income, poverty, family composition, education, crime, unemployment, and other determinants of health. The assessment also collected qualitative information through key informant interviews and community listening sessions to capture community perceptions, highlight barriers to access, and gather input regarding other key factors impacting the health of residents.

Population

Figure 5: Total Population by Town in Lower Fairfield County Towns, 2010



Source: 2010 Decennial Census

The overall size of the cities and towns in Lower Fairfield County has remained relatively stable since 2000. The total population of the eight cities and towns that were part of the assessment was 364,519 in 2010, representing a 3.1% increase since 2000.[2]

[2]2000 and 2010 Decennial Census

Population growth rates by town are shown in Table 2, with the majority of the growth in Lower Fairfield County being attributed to Stamford, Norwalk and Darien.

Table 2: Population Change in Connecticut, Lower Fairfield County, and Towns 2000 - 2010

	2000 Population	2010 Population	#Change	% Change
Stamford	117,083	122,643	5,560	4.7%
Darien	19,607	20,732	1,125	5.7%
Greenwich	61,101	61,171	70	0.1%
New Canaan	19,395	19,738	343	1.8%
Norwalk	82,951	85,603	2,652	3.2%
Weston	10,037	10,179	142	1.4%
Westport	25,749	26,391	642	2.5%
Wilton	17,633	18,062	429	2.4%
Lower Fairfield County	353,556	364,519	10,963	3.1%
Fairfield County (Total)	**882,567**	**916,829**	**34,262**	**3.9%**
State of CT	3,405,565	3,574,097	168,532	4.9%

Source: 2000 and 2010 Decennial Census, U.S. Census Bureau

Overall, Lower Fairfield County has a slightly higher percentage of families in households (68.3%) than the State as a whole (66.3%) with all towns except Stamford (63.4%) and Norwalk (63.7%) exceeding the State's proportion (Table 3). Similarly, all towns have a higher percentage of households with children under the age of 18 with the exception of Stamford (29.5%) and Norwalk (29.2%) versus the State at 30.0%. In turn - Norwalk and Stamford have a higher proportion of non-family households (36.3% and 36.6% respectively) than the State (33.7%) and Lower Fairfield County overall (31.7%).

Table 3: Household and Families by Type in Connecticut, Lower Fairfield County, and Towns 2010[3]

	Total households	% Of Families	% With children < 18 years	% Female householder, no husband present with children < 18 years	% Non family households
Darien	6,698	82.2	50.5	4.1	17.8
Greenwich	23,076	69.8	35.3	4.7	30.2
New Canaan	7,010	77.0	43.2	4.1	23.0
Norwalk	33,217	63.7	29.2	6.7	36.3
Stamford	47,357	63.4	29.5	6.1	36.6
Weston	3,379	84.5	48.7	3.7	15.5
Westport	9,573	75.6	41.2	4.4	24.4
Wilton	6,172	79.3	44.8	3.4	20.7
Lower Fairfield County	136,482	68.3	34.1	5.5	31.7
Fairfield County (Total)	335,545	69.4	33.8	6.5	30.6
State of CT	1,371,087	66.3	30.0	7.1	33.7

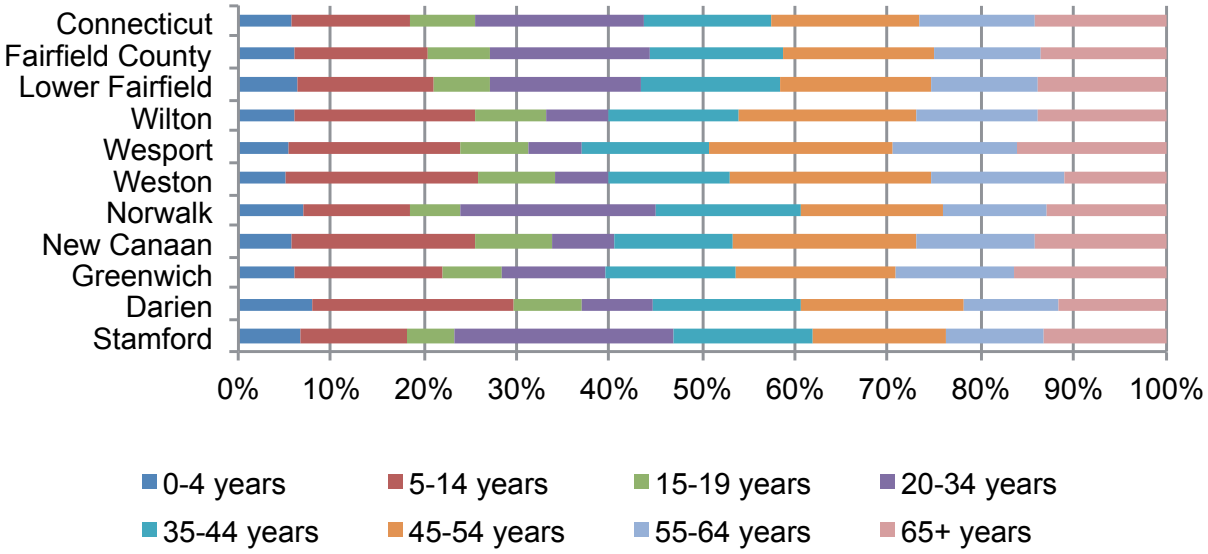
Source: 2010 Decennial Census, U.S. Census Bureau

[3]Percentages are calculated as a percent of all households. Households are broken into families (related) and non-families (singles and unrelated individuals). Families can be married couples with or without children, single parents with children, or groups of related adults. Female-headed families with children is a subset of all families and also a subset of families with children. Not all household types are presented. Therefore, the percentages do not add across the table.

Age Distribution

As seen in Figure 6, Lower Fairfield County's population overall has roughly the same age distribution as the State. However, there is variation seen at the town level – with the communities of Stamford and Norwalk (median ages 37.1 and 38.2 years respectively) having a slightly younger population than the State and County (median ages 40 and 39.5 years respectively). Meanwhile, the communities of Greenwich, New Canaan, Weston, Westport, and Wilton have older populations than the State and County with median ages of 42.8 years or higher[4].

Figure 6: Age Distribution in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2010



Source: 2010 Decennial Census

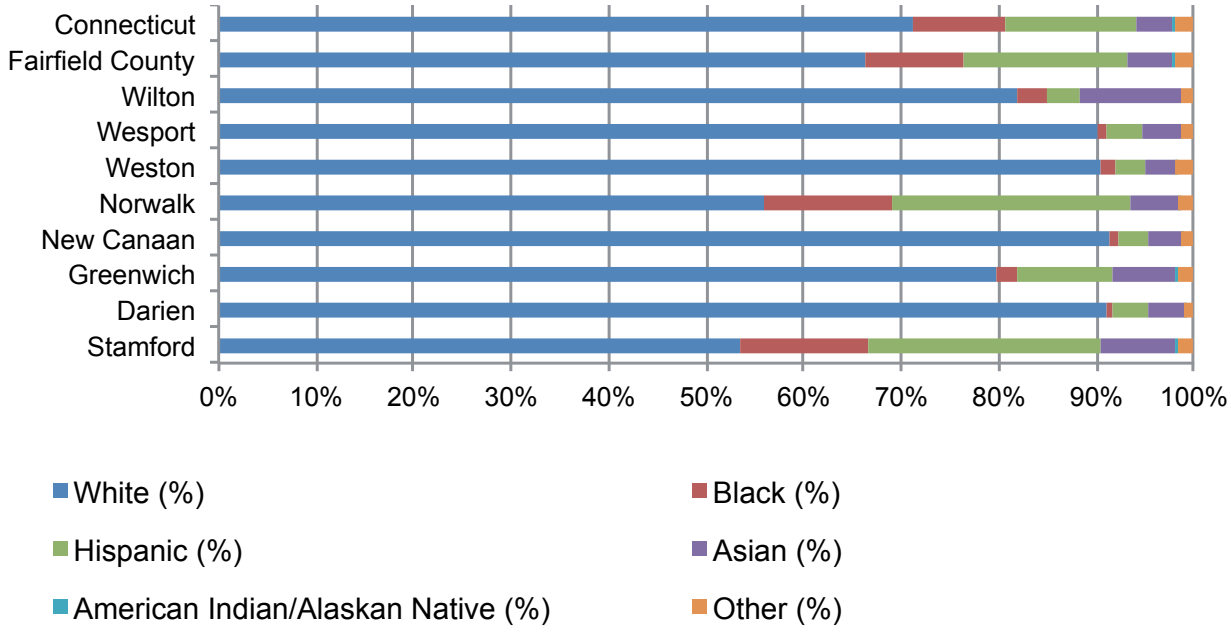
In 2010, 13.7% of Lower Fairfield County's population was age 65 or older compared to 14.2% Statewide, 13.5% for the County overall, and 13.1% for the City of Stamford.[5] In the same year, approximately 1 in 4 households (26.4%) in Lower Fairfield County had at least one older adult over the age of 65 living in it- essentially the same as the percentage Statewide (26.5%).[6]

[4]2010 Decennial Census
[5]ibid
[6]ibid

Racial and Ethnic Diversity

Lower Fairfield County is predominantly comprised of White non-Hispanics, but there are large proportions of foreign-born and racial/ethnic minority populations, many of whom face linguistic and cultural barriers, particularly in Stamford. The demographic composition, of Lower Fairfield County, particularly with respect to race/ethnicity, has changed considerably over the past 10 years, driven almost exclusively by changes in the demographic composition of the Cities of Stamford and Norwalk which have each seen significant growth in the Asian and Hispanic / Latino populations.[7]

Figure 7: Race/Ethnicity of Population in Connecticut, Fairfield County, and Lower Fairfield County Towns, 2010



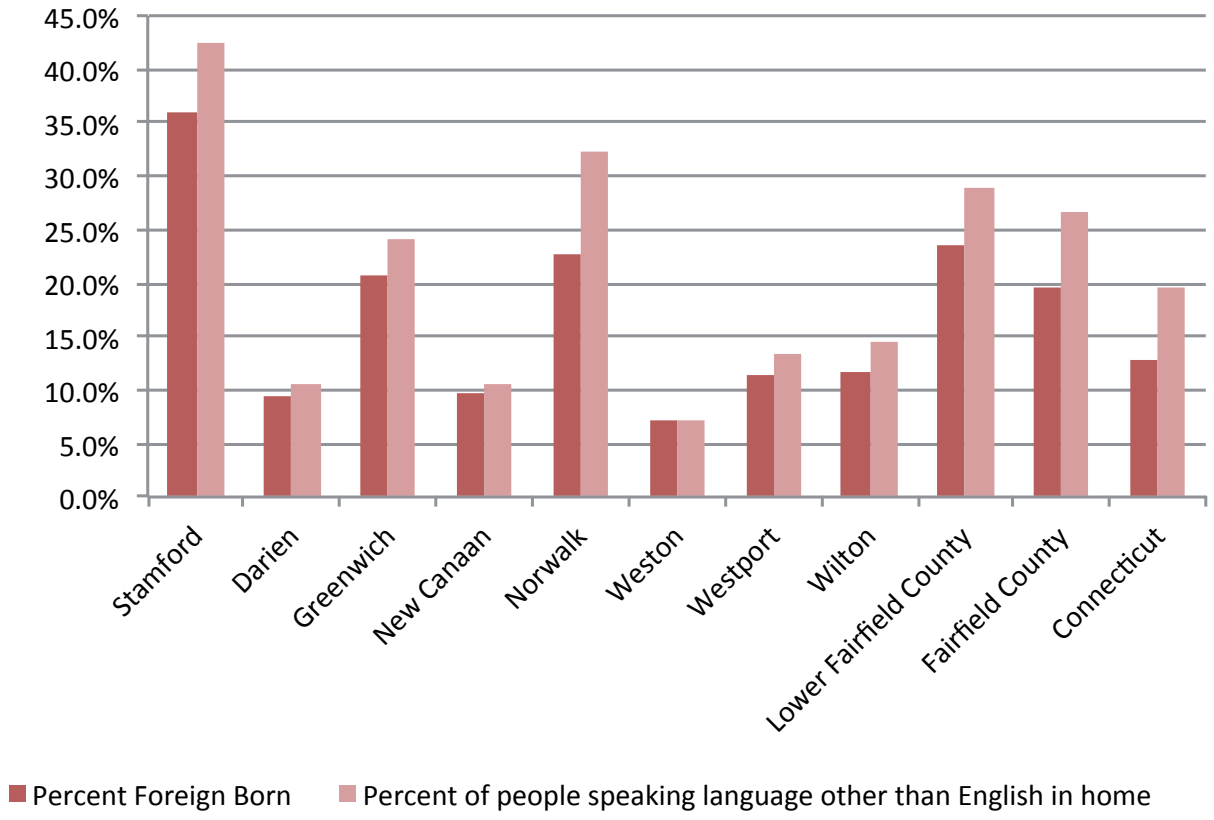
SOURCE: 2010 Decennial Census

The City of Stamford has a large and growing racial and ethnic minority population, with particularly large numbers of Haitians and Hispanics/Latinos. In 2009, 46.7% of Stamford's population was non-White or Hispanic/Latino, up from 38.8% in 2000. The largest racial/ethnic minority population in Stamford is the Hispanic/Latino population, which in 2009 comprised about 23.8% of the population – up from 16.8% in the year 2000.[8] Anecdotally, Stamford is widely thought to have the largest undocumented Hispanic/Latino population in the State.

[7] 2000 and 2010 Decennial Census
ibid

As seen in Figure 8, in 2009, 23.5% of Lower Fairfield County's population was foreign born and 28.8% of the population age 5 years old or older spoke a language other than English at home. In comparison, 12.8% of the State's population and 19.6% of the County's population reported being foreign born. These figures were especially high in Stamford, where 36.0% of the population was foreign born and 42.4% of the population spoke a language other than English at home.[9]

Figure 8: Percent of People Foreign Born and Percent Speaking Language Other than English in Home in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2009



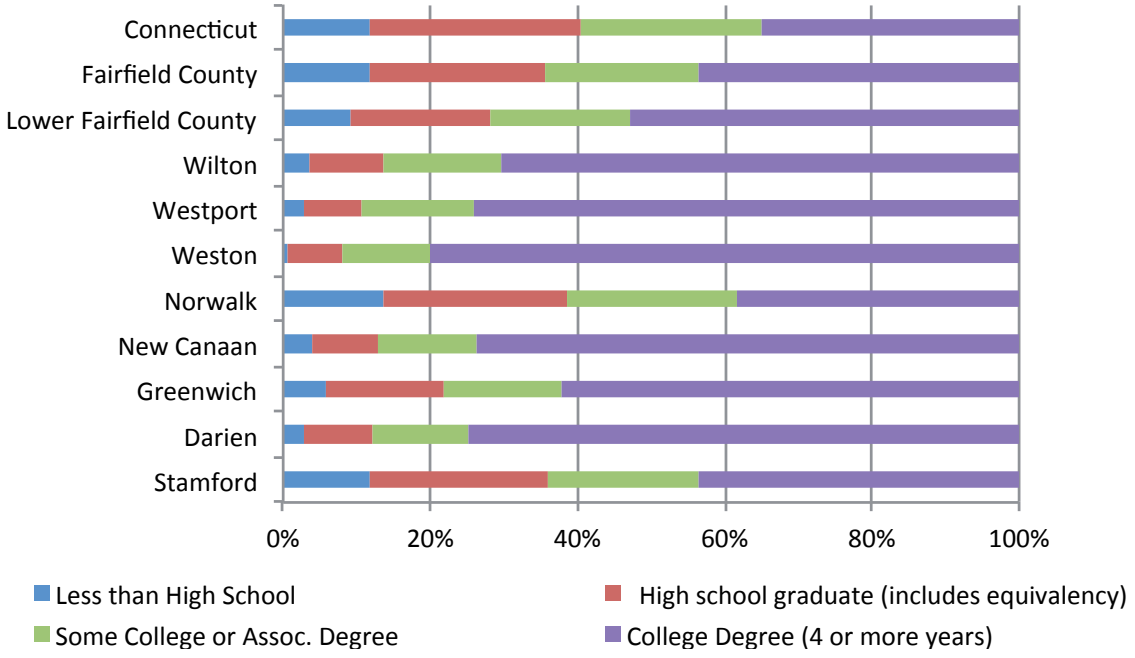
Source: 2005-2009 American Community Survey

[9]2005-2009 American Community Survey

Educational Attainment

Compared to the State, large proportions of Stamford's elementary and secondary school students are racial/ethnic minorities. In 2010, 60% of Stamford's elementary and secondary students were racial/ethnic minorities, compared to 35% for the State of Connecticut overall[10].

Figure 9: Educational Attainment in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2009



Source: 2005-2009 American Community Survey

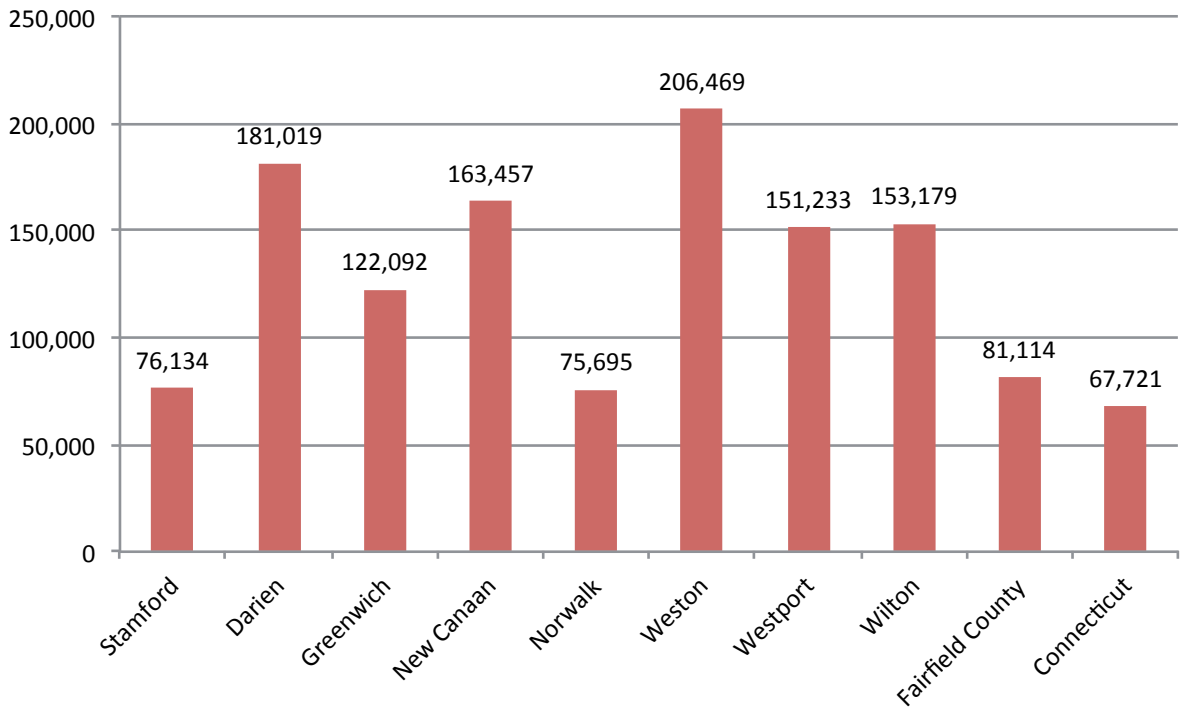
Overall, a significantly higher percentage of the population of Lower Fairfield County has attained a college or advanced degree (53.1%) than compared to the State (35.1%) and Fairfield County as a whole (43.5%). This is largely driven by the Towns of Darien, New Canaan, Weston, Westport and Wilton where a range of 70 - 80% of the towns' populations have a four year degree or more. Meanwhile, the proportion of adults with a four-year degree or more in the towns of Stamford (43.5%) and Norwalk (38.4%) are also higher, but closer to the State level. Stamford and Norwalk also have substantially higher proportions of the population with less than a high school diploma (11.9% and 13.5% respectively) than compared to the rest of the towns in Lower Fairfield County – but again, are closer to the State and County rates (11.8% and 11.7% respectively).[11]

[10]2008-2009 CT State Department of Education School Profile Reports
[11]2005-2009 American Community Survey

Income and Poverty

In 2010, Fairfield County ranked among the top 2% of all US counties based on per capita income.[12] Income and affluence tend to have a very positive impact on overall health status. Median household income in six of the eight towns making up Lower Fairfield County was $122,000 or higher. In Stamford and Norwalk, however, median household income of approximately $76,000 is significantly less than surrounding towns, and falls closer to the State and County levels of $67,721 and $81,114 respectively. This is further evidenced by the percentage of public school students in these towns eligible for free or reduced-price meals. According to the Connecticut State Department of Education School Profile Reports, in the 2008-2009 school year, 43.4% of Stamford public school students and 30.1% of Norwalk public school students were eligible for this benefit, compared to 30.3% of students Statewide. By contrast, less than 2% of students in the five towns with the highest median income in Lower Fairfield County – Weston, Darien, New Canaan, Wilton, and Westport – were eligible for free or reduced-price school meals.

Figure 10: Median Household Income in Connecticut Fairfield County, and Lower Fairfield County Towns, 2009

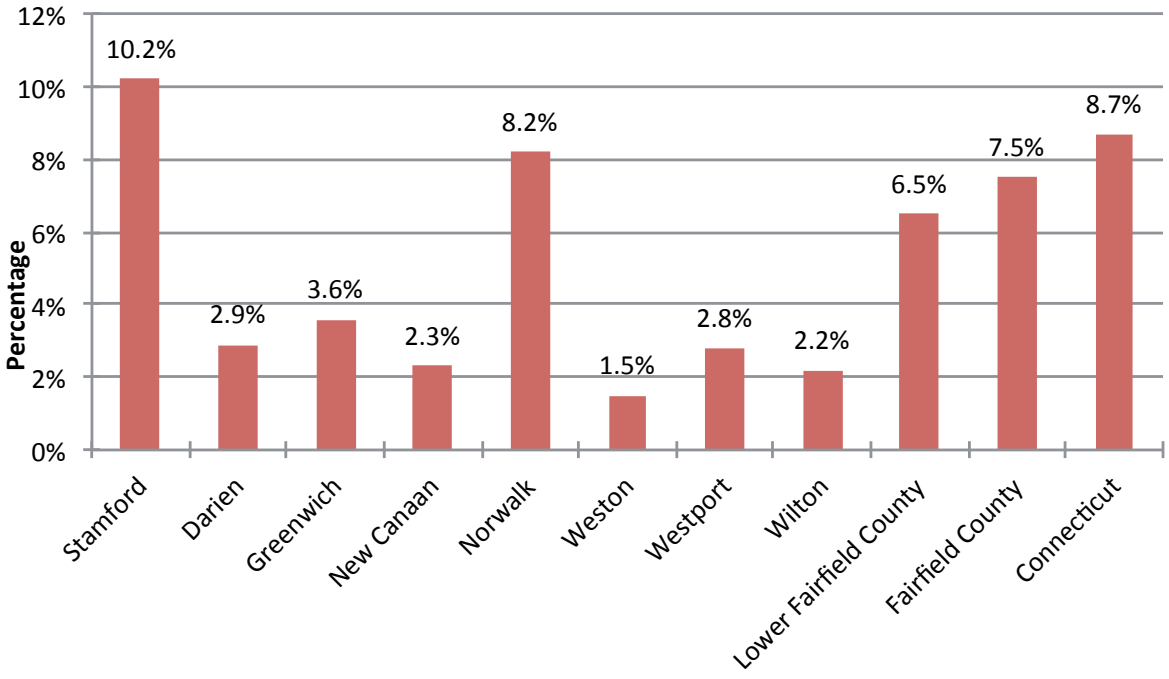


Source: 2005 – 2009 American Community Survey

[12] 2005-2009 American Community Survey

Despite the substantial wealth in the region, there are also significant pockets of poverty in Fairfield County, centered largely in Stamford and Norwalk, and these populations face major health and health care access disparities. As seen in Figure 11, in 2009, 6.5% of Lower Fairfield County's population lived in poverty – with the highest rates seen in Stamford (10.2%) and Norwalk (8.2%).

Figure 11: Persons Living Below Poverty Level in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2009

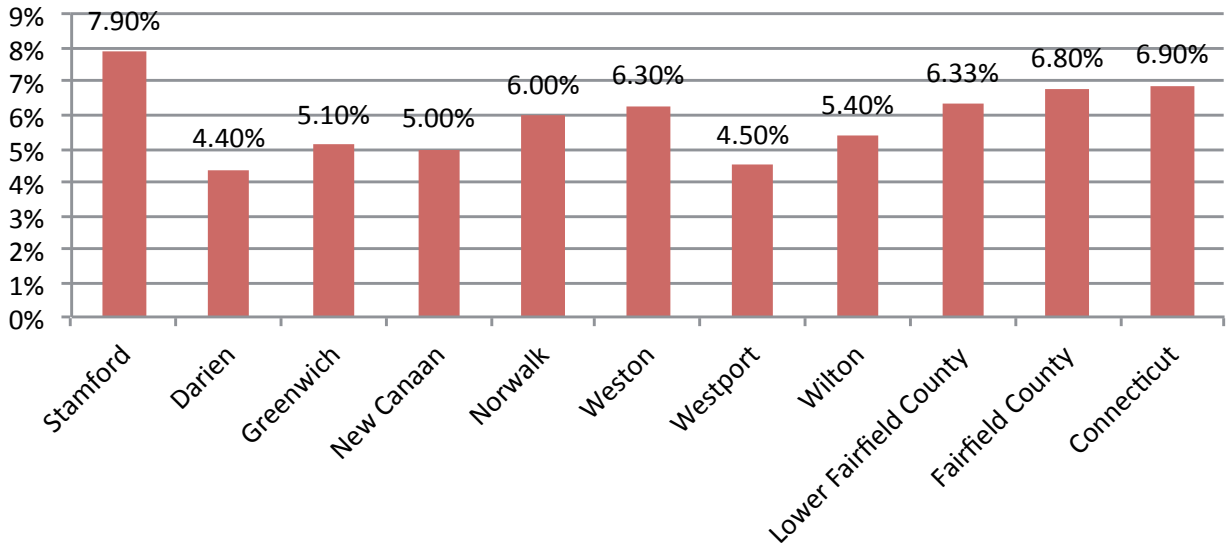


Source: 2005 – 2009 American Community Survey

EMPLOYMENT

Lower Fairfield County was clearly impacted by the economic downturn and recession over the past five years but has generally fared better than the nation overall. Unemployment rates for Fairfield County hovered between 7-8% over the past few years but have been slightly better than the State and national rates. Most of the cities and towns in Lower Fairfield County had unemployment rates between 5-6% during this period, while Stamford's ranged between 7-8%.

Figure 12: Unemployment Rate in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2009



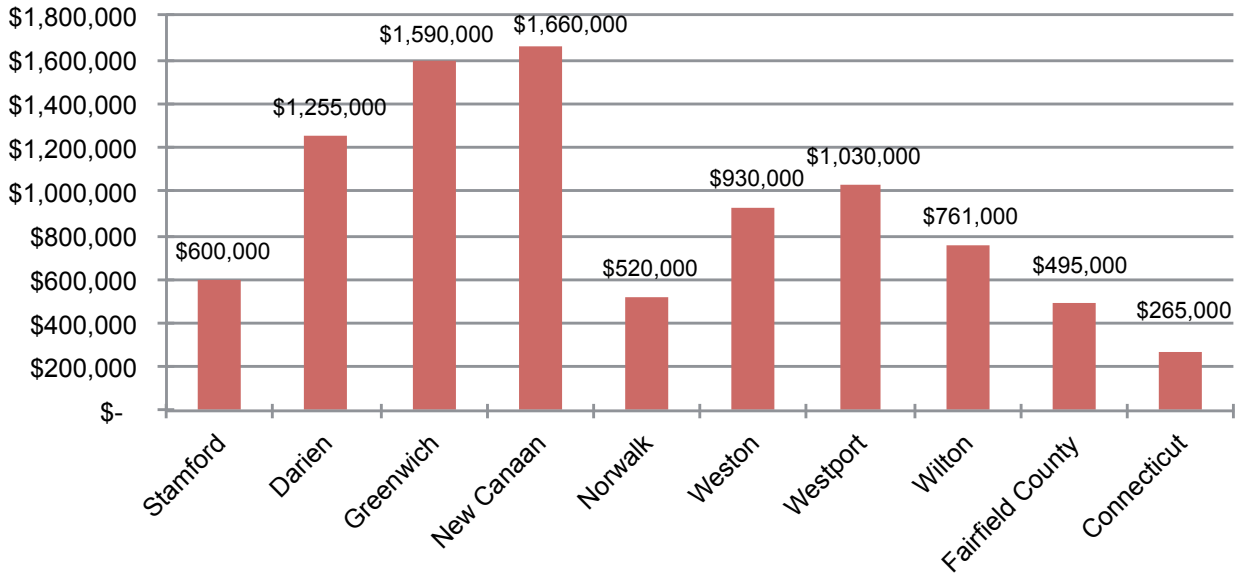
Source: 2005-2009 American Community Survey

SOCIAL ENVIRONMENT

Housing

Housing costs throughout Lower Fairfield County are significantly higher than the State as a whole. These costs contribute to an overall high cost of living that, according to our key informant interviews, is a source of struggle for the region's low income population. As seen in Figure 13, the median single family housing prices in the towns of Stamford and Norwalk are approximately two times higher than the State's; meanwhile the towns of Darien, Greenwich, New Canaan and Westport have median housing prices that are four to six times as high as the State.

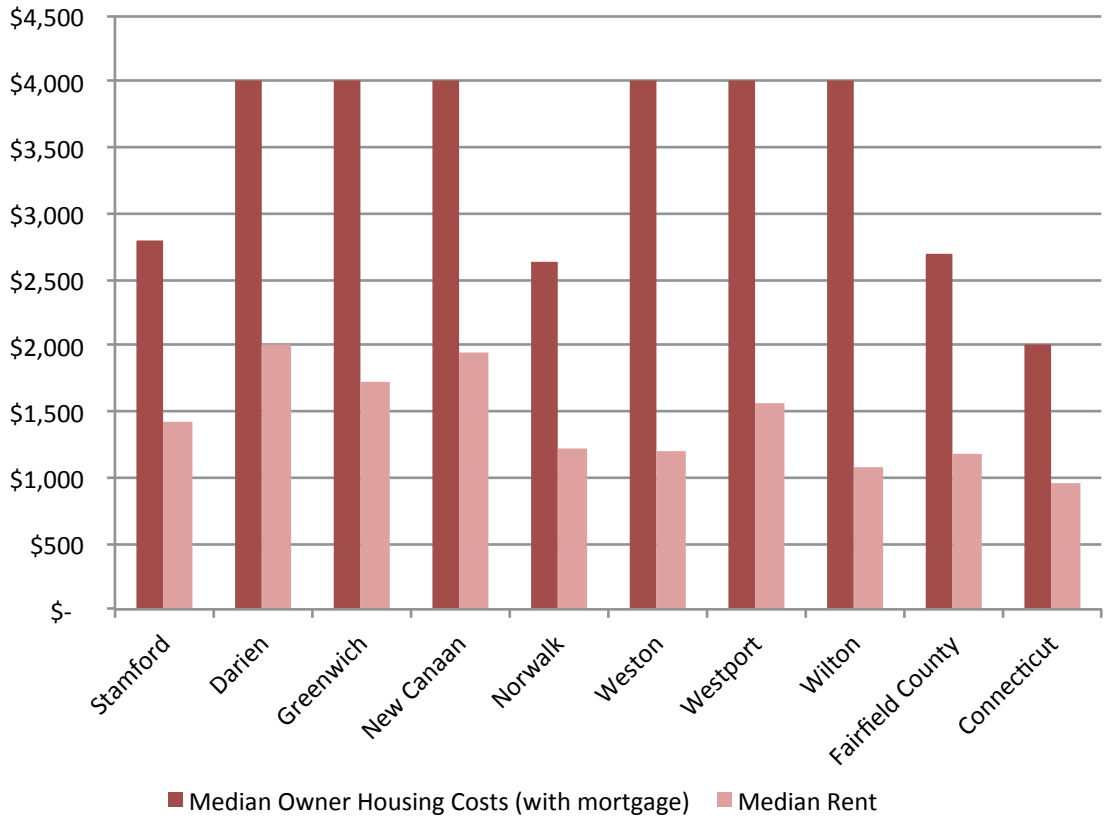
Figure 13: Median Single Family Residential Housing Price in Connecticut, Fairfield County and Lower Fairfield County Towns, 2009



Source: 2009 CT Office of Policy and Management Real Estate Sales Database (Norwalk, New Canaan, Weston and Darien data is from 2008)

The high cost of housing is further exhibited in Figure 14, showing monthly housing costs with a mortgage and monthly rental costs are higher in the towns of Lower Fairfield County than for the State as a whole. Monthly mortgage costs range from $2,600 to $2,800 per month in the towns of Norwalk and Stamford, and exceed $4,000 per month in the towns of Darien, Greenwich, New Canaan, Weston, Westport and Wilton. This compares to $2,016 per month for the State. Likewise, monthly rental expense in the towns of Norwalk and Stamford is 27% - 47% higher than the State's average of $958 / month, while in the towns of Darien, Greenwich, and New Canaan – the rates are 1.8 to two times as high.

Figure 14: Median Monthly Housing Costs in Connecticut, Fairfield County and Lower Fairfield County Towns, 2010



Housing cost for owners includes mortgage, taxes, insurance, and utilities. Rent does not include utilities unless they are included in the rent payment.

Source: 2005 – 2009 American Community Survey

Access to Healthy Foods and Recreation

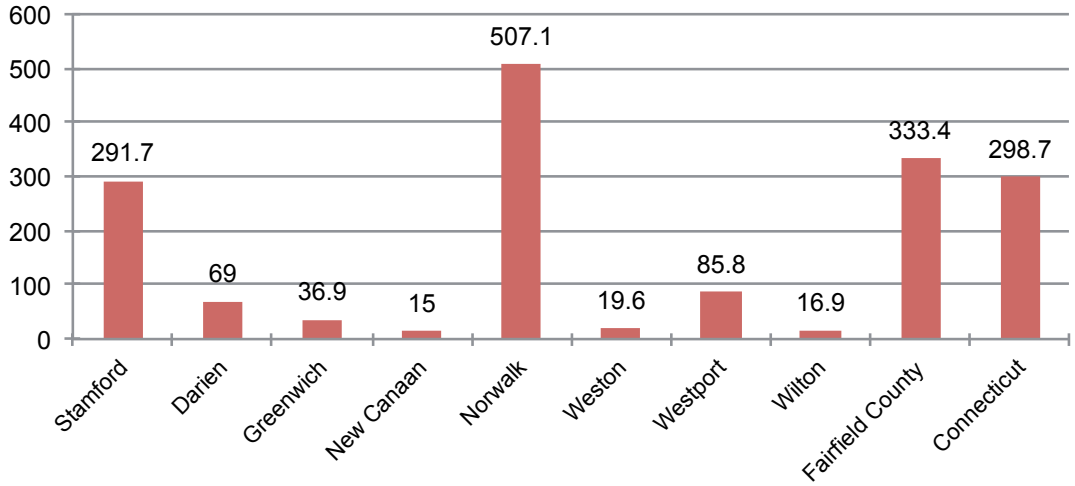
Fairfield County residents have extensive access to parks and recreational facilities across the County. Thirty-nine percent (39%) of the population lives within one half-mile of a park,[13] and Fairfield County is in the top 10th percentile of counties nationally when it comes to recreational facility access – 19 facilities per 100,000 population, compared to 14 facilities per 100,000 across the State.[14] There are well over 20 gyms, YMCAs, and recreational facilities in Stamford Hospital's primary service area alone.

Access to healthy foods is a concern for some residents of Lower Fairfield County; four Census tracts have been identified as "food deserts" in the region. Food deserts are defined by the USDA Food Environment Atlas as low access areas (i.e. areas where at least 100 households are more than ½ mile from a supermarket and have no access to a vehicle) and low income areas (i.e. the census tract has a poverty rate of 20% or greater). Overall, 3% of low income Fairfield County residents live more than one mile from a grocery store.[15] Additionally, 37% of restaurants in Fairfield County are fast food restaurants[16]; research has shown that proximity to fast food establishments is associated with increased BMI, especially among low income populations.[17]

Crime and Safety

While Fairfield County's violent crime rate is higher than the State's, this is driven almost exclusively by the very high crime rates in Stamford and Norwalk. The violent crime rates for most of Lower Fairfield County's towns are dramatically lower than the State and County averages. As seen in Figure 15, in 2009 the violent crime rates for the towns other than Stamford and Norwalk ranged from 15 to 86 incidents per 100,000. In Stamford the rate was 292 per 100,000 and in Norwalk the rate was 507 per 100,000. The majority of the violent crimes in both towns are aggravated assault and robberies.

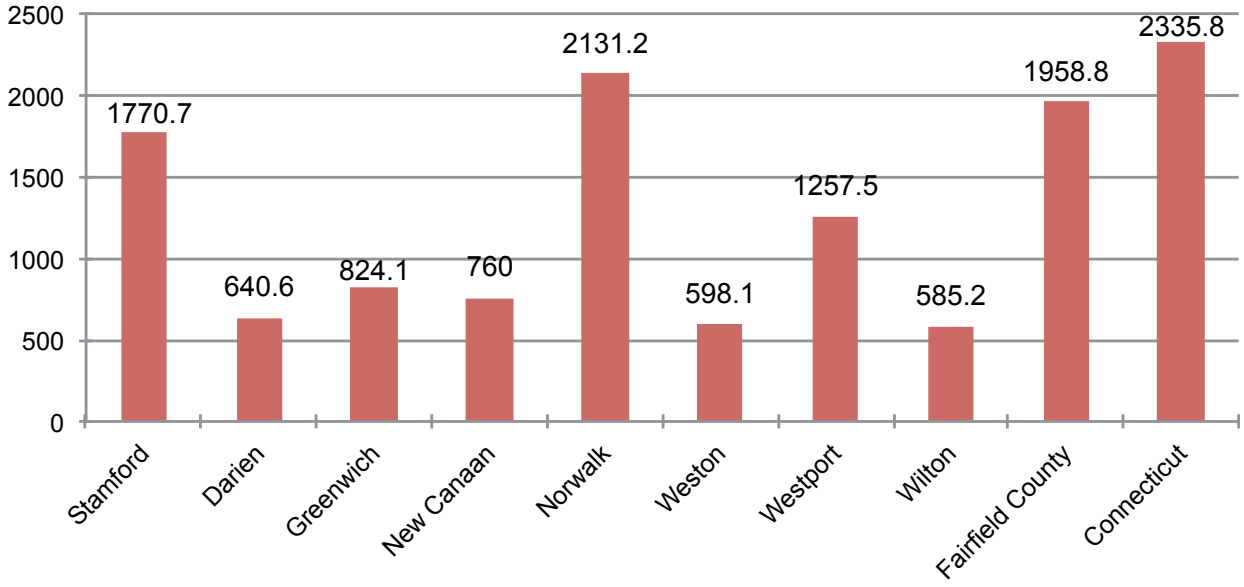
Figure 15: Overall Violent Crime Rate per 100,000 Population in Connecticut, Fairfield County, and Lower Fairfield County Towns, 2009



SOURCE: 2009 FBI's Uniform Crime Reports and 2009 Census annual population count (for rate). Certain towns did not have crime data available: Easton, New Fairfield, Redding, Sherman, and Stafford.

[13]CDC National Environmental Public Health Tracking Network, 2010.
[14]Census County Business Patterns, 2010.
[15]USDA Food Environment Atlas, 2012.
[16]Census County Business Patterns, 2010.
[17]L. Reitzel, et. al. Density and Proximity of Fast Food Restaurants and Body Mass Index Among African Americans. American Journal of Public Health, 2013.

Figure 16: Overall Property Crime Rate per 100,000 Population in Connecticut, Fairfield County, and Lower Fairfield County Towns, 2009



SOURCE: 2009 FBI's Uniform Crime Reports and 2009 Census annual population count (for rate).
Certain towns did not have crime data available: Easton, New Fairfield, Redding, Sherman, and Stafford.

As with violent crimes, property crime rates in Stamford and Norwalk are substantially higher than the other towns in Lower Fairfield County, but still fall lower than the State's rate of 2,336 incidents per 100,000 population.

SUMMARY OF DEMOGRAPHICS AND SOCIAL ENVIRONMENT

Lower Fairfield County is predominantly white, non-Hispanic and is one of the most affluent communities in the country. Residents are generally well educated, less likely to be unemployed and more likely to have access to healthy foods and recreational facilities. Crime rates in much of the region are significantly lower than in the State, with the exception of Stamford and Norwalk. These factors tend to lead to better health status and, not surprisingly, Lower Fairfield County overall is healthier than the State and the nation across many leading health indicators. However, there are substantial pockets of low income and racial/ethnic minority populations, particularly in Stamford and Norwalk, that suffer from health inequities. These populations and communities contend with linguistic and cultural barriers, higher crime rates, more limited access to healthy foods and recreational facilities, and much higher unemployment rates. These factors complicate medical, social, and financial status for these populations and ultimately lead to inaccessible health care services and disparities.

HEALTH BEHAVIORS

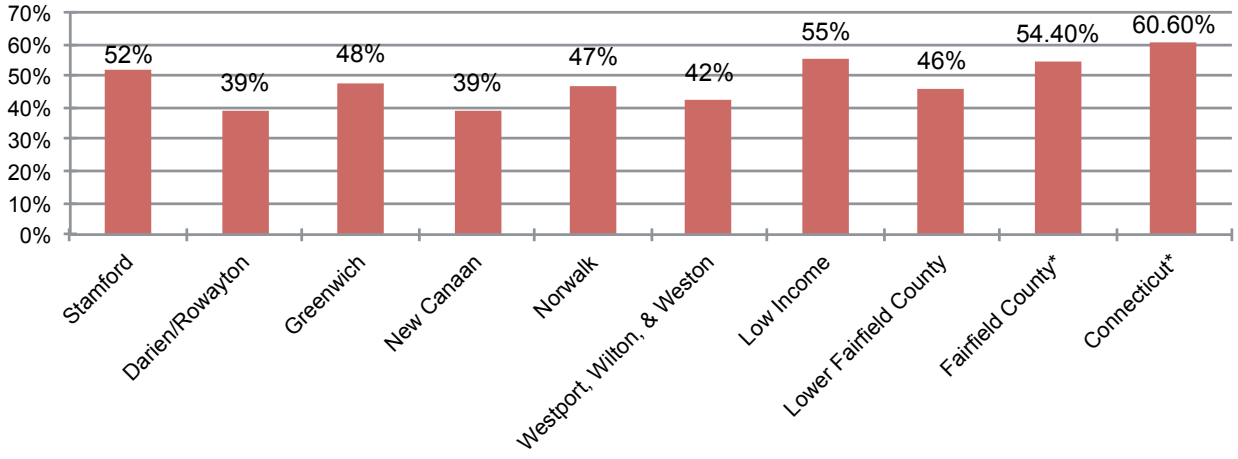
HEALTHY EATING, PHYSICAL ACTIVITY, AND OVERWEIGHT / OBESITY

Obesity is a serious public health problem across the nation and is a leading risk factor for chronic diseases such as heart disease, hypertension, diabetes, cancer, and depression. In the past, obesity prevention efforts have focused on areas such as healthy eating lectures, workshops and classes, as well as exercise classes and walking programs. It is not enough, however, to simply encourage physical activity and healthful eating. People need access to healthy foods and places for safe play and recreation where they live, work and learn. Research suggests that the following six behaviors help to prevent obesity: 1) Being physically active, 2) Eating fruits and vegetables, 3) Breast feeding, 4) Avoiding or limiting sugar-sweetened beverages, 5) Avoiding unhealthy snacks such as chips and candy and 6) Limiting television or computer viewing.[18]

Overweight/Obesity

Overall, in Lower Fairfield County, obesity/overweight was ranked as the #1 most significant health problem in the community by survey respondents. Residents of Stamford and Norwalk in particular agreed with this top priority ranking, as did the low income population.

Figure 17: Percentage of Population That is Overweight or Obese in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011



Source: 2011 Lower Fairfield County Community Health Survey; *2010 Connecticut Behavioral Risk Factor Surveillance System (BRFSS)

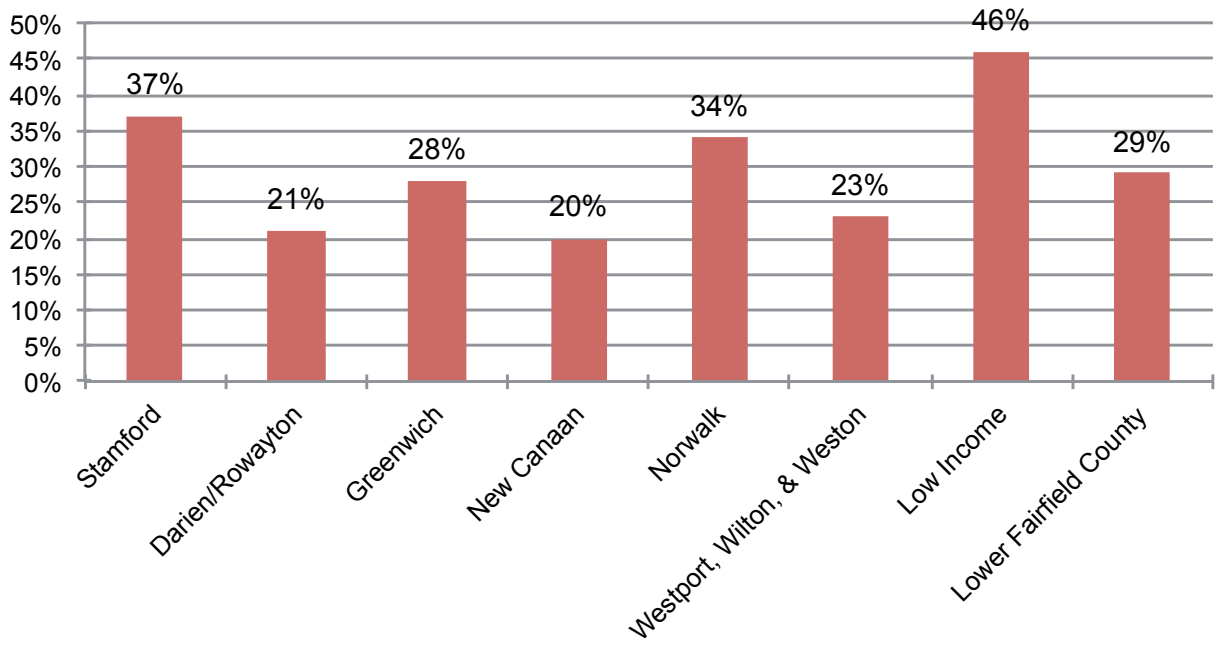
[18]http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=29

According to findings from our community survey, nearly half (46%) of Lower Fairfield County residents were overweight or obese in 2011 (based on Body Mass Index, or BMI, calculated by reported height and weight). While lower than the overall County and State rates (54.4% and 60.6% respectively), the percentage is still high and reflected a range of 39% - 52% across all towns. It is worth noting the higher rates seen in the city of Stamford (52%) and in the region's low income Population (55%). (Note: the low income convenience survey participants reported a rate of obesity / overweight of 62%).

Lack of Physical Exercise

Physical exercise is an important component of maintaining a healthy weight and overall healthy lifestyle. Twenty-nine percent (29%) of those surveyed in Lower Fairfield County reported not getting any physical activity in their leisure time in the past seven (7) days. Among those living in Stamford the percentage was 37%, in Norwalk 34%, and among low income populations 46% reported no leisure time physical activity.

Figure 18: Percentage of Population that Reported No Physical Activity in Lower Fairfield County and Towns, 2011

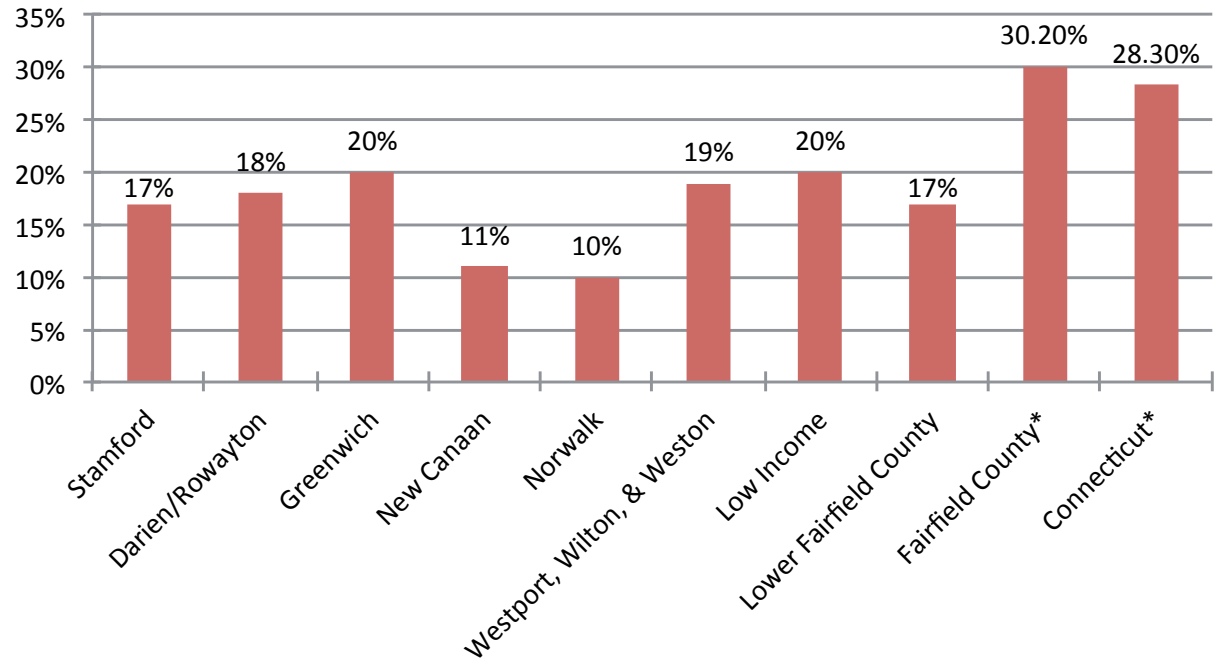


Source: 2011 Lower Fairfield County Community Health Survey

Nutrition

In addition to exercise, maintaining a balanced, nutritional diet is an important component of a healthy lifestyle. Only seventeen percent (17%) of survey respondents across Lower Fairfield County reported eating 5 or more servings of fruits and vegetables per day. The proportions were similar across all towns surveyed, with the biggest variances seen in New Canaan (11%) and Norwalk (10%). Overall, however, the proportions are substantially lower than the State and County rates (28.3% and 30.2% respectively).

Figure 19: People Who Reported Eating 5+ Servings of Fruit and Vegetables Per Day in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011



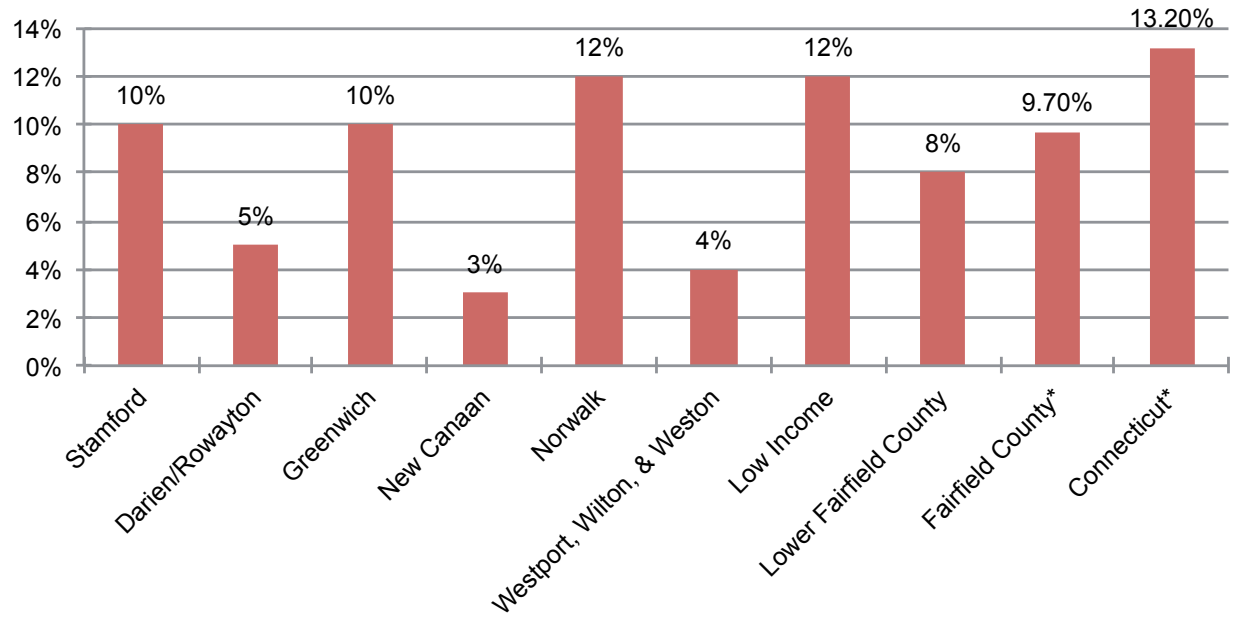
Source: 2011 Lower Fairfield County Community Health Survey; *2009 Behavioral Risk Factor Surveillance System (BRFSS)

SUBSTANCE USE AND ABUSE (TOBACCO, ALCOHOL, AND OTHER DRUGS)

Tobacco Use

Overall, residents of Lower Fairfield County are less likely to smoke cigarettes than residents of the County or the State.

Figure 20: Percentage of Current Smokers in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011



Source: 2011 Lower Fairfield County Community Health Survey; *2010 Connecticut Behavioral Risk Factor Surveillance System (BRFSS)

Eight percent (8%) of survey respondents from Lower Fairfield County reported being current smokers compared to 13.2% of State residents, and 9.7% of County residents. Higher rates are seen at the individual town level, with 10% of residents in Greenwich and Stamford and 12% of residents of Norwalk reporting being current smokers. Higher rates are also seen in the low income population (12%). Sixty percent of respondents reported that they have never smoked, and of the current smokers, 80% reported they are considering quitting within the next six months[19].

[19]2011 Lower Fairfield County Community Health Survey.

Substance Abuse

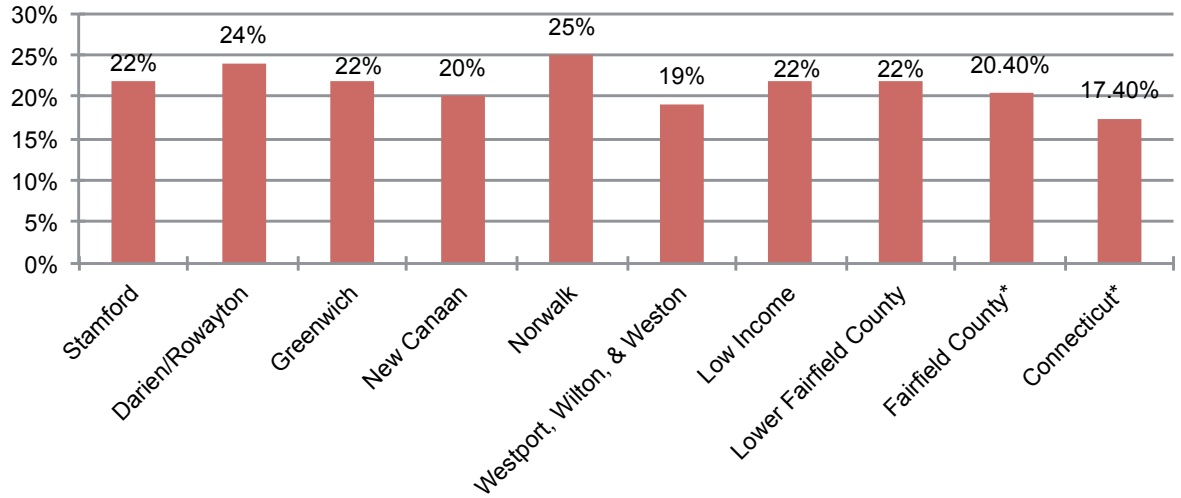
Alcohol is by far the most commonly used drug in the United States and Connecticut. According to data from the 2011 National Survey on Drug Use and Health (NSDUH), slightly more than half (51.8%) of Americans aged 12 or older reported being current alcohol drinkers, which translates to an estimated 133.4 million drinkers in 2011. An estimated 8.7% or 22.5 million Americans aged 12 or older were current (in the past month) illicit drug users. Estimates of the total overall costs of substance abuse in the United States, including productivity and health- and crime-related costs exceed $600 billion annually[20].

Substance abuse and drug addiction are like any other chronic disease, such as diabetes, asthma or heart disease and can be managed successfully. As with other chronic diseases, it is not uncommon for a person to relapse and begin abusing drugs again[21].

Alcohol Use

The proportion of residents reporting being "binge drinkers" per CDC guidelines[22] was substantially higher than the State across all towns surveyed.

Figure 21: Percentage of Population that Reports Binge Drinking in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011



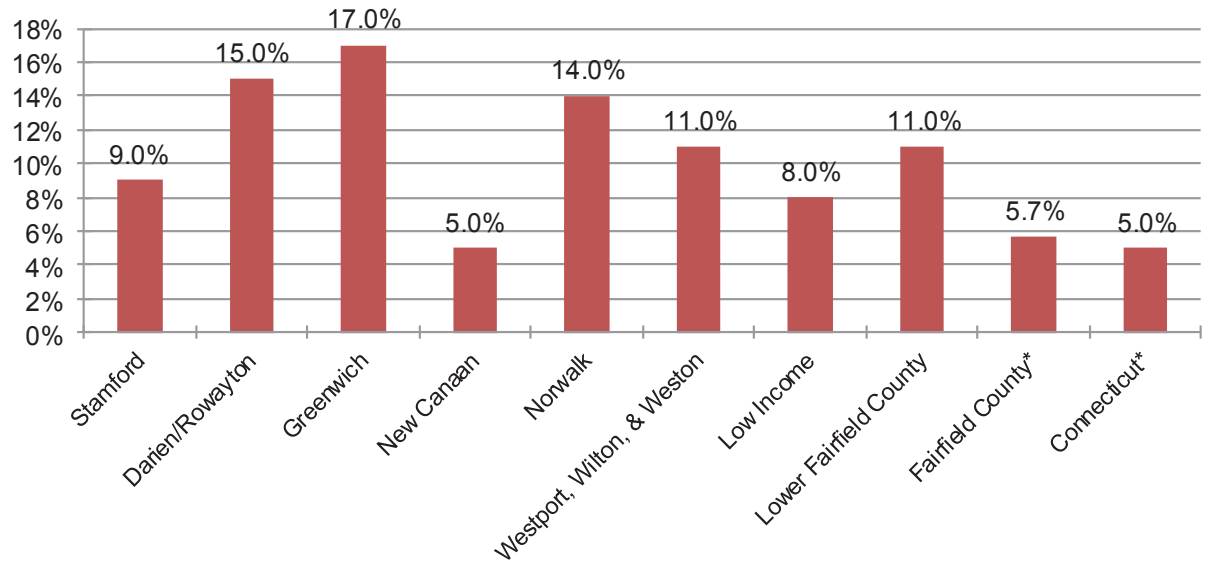
Source: 2011 Lower Fairfield County Community Health Survey; *2010 Connecticut Behavioral Risk Factor Surveillance System (BRFSS)

[20]Results from the 2011National Survey on Drug Use and Health: Summary of National Findings. (http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.htm)
[21]National Institute on Drug Abuse: Understanding Drug Abuse and Addiction, November 2011. (http://www.drugabuse.gov/publications/drugfacts/understanding-drug-abuse-addiction)
[22]Binge drinking means men drinking 5 or more alcoholic drinks within a short period of time or women drinking 4 or more drinks within a short period of time.

Overall, 22% of Lower Fairfield County residents reported being binge drinkers compared to 17.4% for the State. The percentage of residents reporting as binge drinkers ranged from a low of 19% in Westport, Wilton and Weston to a high of 25% in Norwalk.

Likewise, the proportions of residents reporting being "heavy drinkers" per CDC guidelines[23] in Lower Fairfield County was very high, particularly in the region's most affluent communities.

Figure 22: Percentage of Population That Reports Heavy Drinking in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011



Source: 2011 Lower Fairfield County Community Health Survey; *2010 Connecticut Behavioral Risk Factor Surveillance System (BRFSS)

Eleven percent (11%) of residents In Lower Fairfield County reported drinking heavily on a weekly basis, compared to 5% for the State and 5.7% for Fairfield County. Especially high rates of heavy drinking were reported in the towns of Greenwich (17%), Darien / Rowayton (15%) and Norwalk (14%).

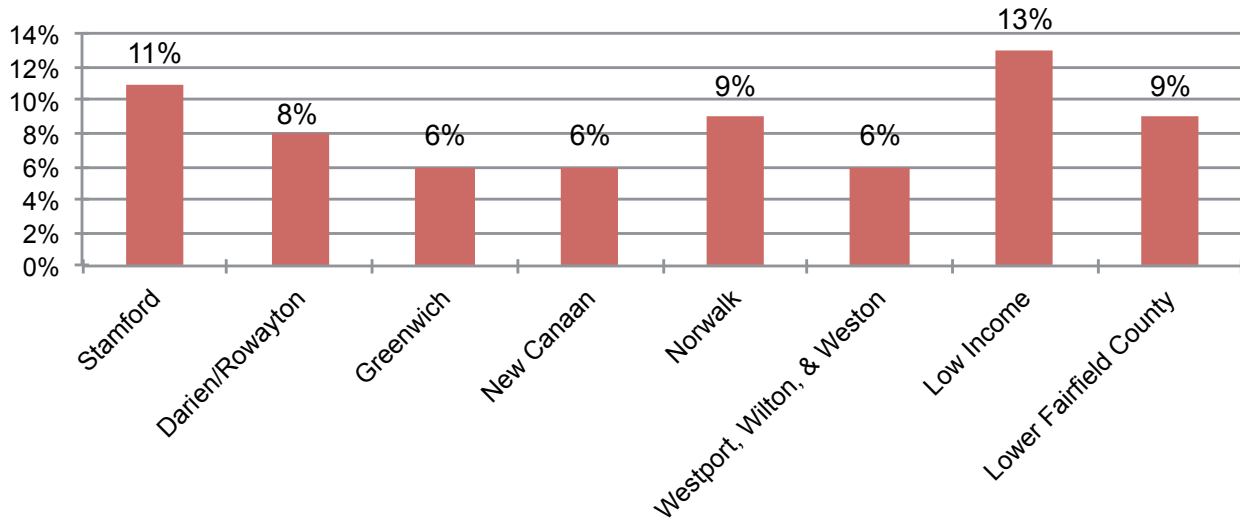
[23]Heavy drinking is typlically defined for men as consuming an average of more than 2 drinks per day, or more than 14 drinks per week. For women, heavy drinking is typically defined as consuming an average of more than 1 drink per day, or more than 7 drinks per week.

Drug Use

The proportion of residents in Lower Fairfield County who reported using marijuana was relatively low (4% overall) and consistent across all towns surveyed (range of 2% - 5%). Reported use of other illegal drugs (cocaine and heroin) was also extremely low – 1% or less across all towns surveyed.

Significant proportions of residents surveyed in Lower Fairfield County reported using prescription drugs inappropriately, with the exception of those in Greenwich, New Canaan, Westport, Wilton and Weston. As seen in Figure 23, the highest rates of prescription drug abuse were seen in Stamford (11%) and among the low income population surveyed (13%).

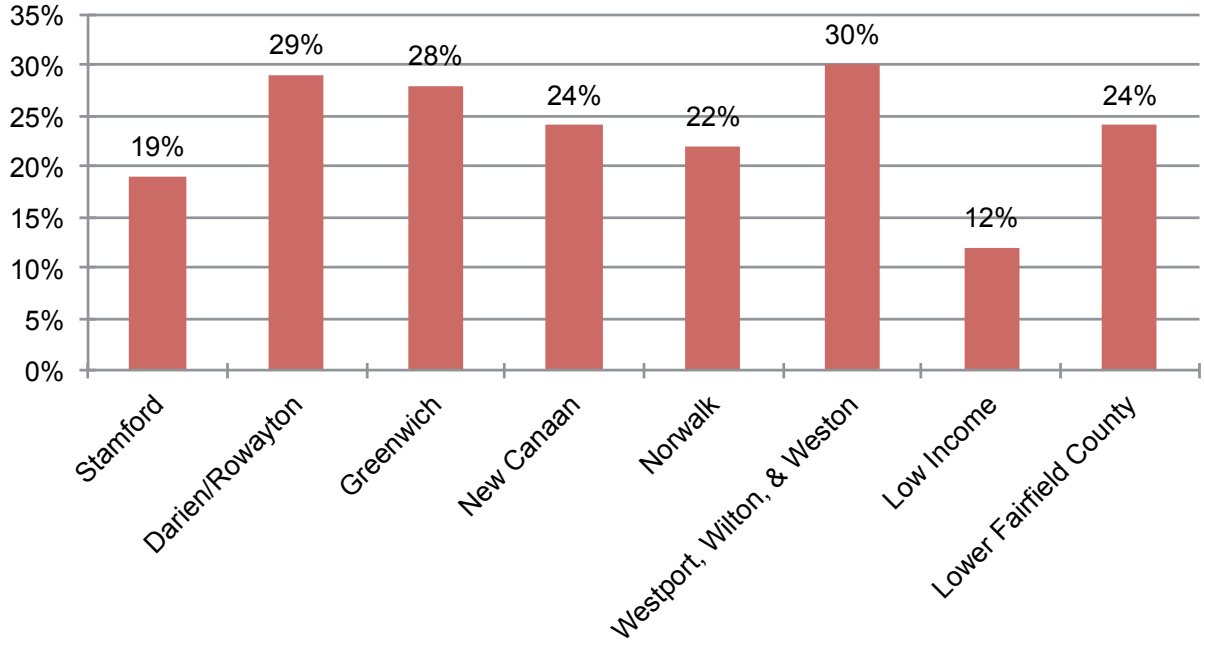
Figure 23: Percentage of Population That Reports Legal Drugs Used on Own* in Past 12 Months in Lower Fairfield County and Towns, 2011



SOURCE: 2011 Lower Fairfield County Community Health Survey

** "On own" means either without a doctor's prescription, in larger amounts than prescribed, or for a longer period than prescribed.*

Figure 24: Percentage of Population That Drove Within 2 Hours of Drinking or Using Illegal Drugs in Past Month in Lower Fairfield County and Towns, 2011



Source: 2011 Lower Fairfield County Community Health Survey

Twenty four percent (24%) of residents in Lower Fairfield County overall reported driving within 2 hours of drinking or using illegal drugs. The rates of residents reporting driving within 2 hours of drinking or using illegal drugs were especially high in the towns of Westport, Wilton, and Weston (30%), Darien / Rowayton (29%), and Greenwich (28%).

SUMMARY OF HEALTH BEHAVIORS

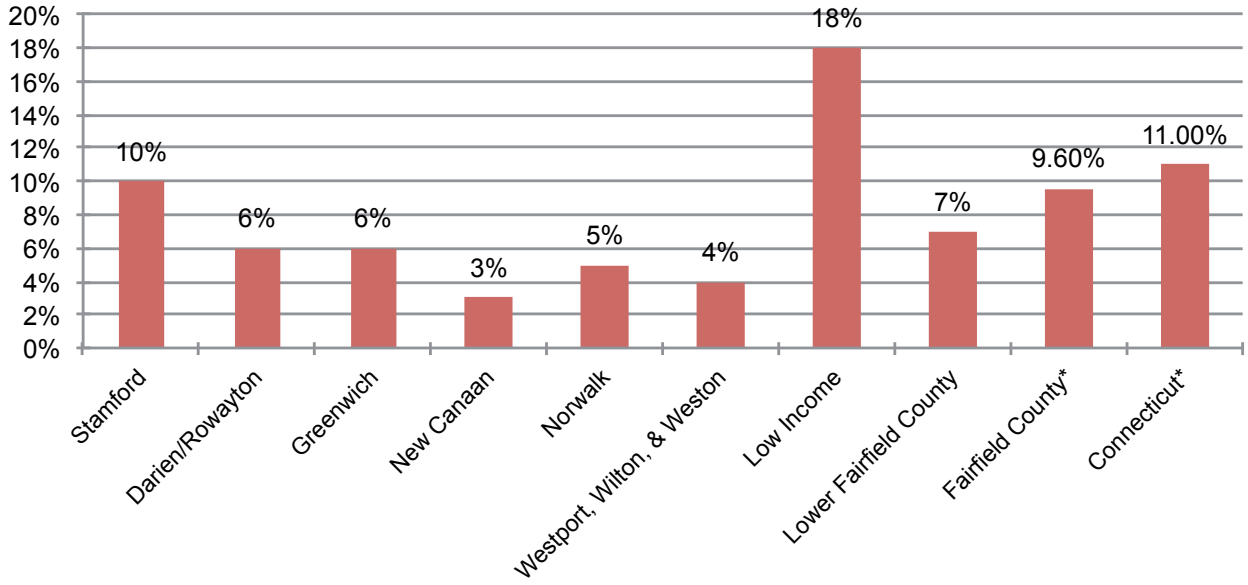
Despite high reported rates of no physical activity and lower rates of fruit and vegetable consumption in comparison to State and County levels, Lower Fairfield County residents are less likely to be obese or overweight in comparison to the rest of the County and State. Lower Fairfield County residents are also less likely to smoke than the rest of the County and State, but the rates of smoking in the towns of Stamford, Greenwich, and Norwalk are still high in their own right. Moreover, there are major disparities among low income, racial/ethnic minority populations that should be addressed as well.

Alcohol abuse and risky alcohol consumption is a major issue in Lower Fairfield County. This is particularly true for heavy drinking, as Lower Fairfield County adults are more than twice as likely to drink heavily as adults Statewide. Alcohol abuse and risky drinking were much more common among affluent, suburban populations than in low income, racial/ethnic minority communities. Prescription drug abuse was also a substantial problem in the affluent communities. Nearly 1 in 10 adults in Lower Fairfield County reported using prescription drugs in a way other than as prescribed. Substance abuse was identified as the third highest health priority by survey respondents, with the towns of Darien / Rowayton, New Canaan, Wilton, Weston, and Westport identifying it as the highest or second highest priority. This is especially noteworthy due to the disparities in outcomes and the unique target population of affluent populations for whom substance abuse was a major issue.

HEALTH OUTCOMES

Eighteen percent (18%) of low income respondents to the mail survey reported their general health status as fair or poor, compared to 7% of Lower Fairfield County residents and 11% of residents across the State. (Note: 33% of the low income convenience survey participants reported their general health status as fair or poor).

Figure 25: Percentage of People Who Reported Fair/Poor Health in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011



Source: 2011 Lower Fairfield County Community Health Survey; *2010 Behavioral Risk Factor Surveillance System (BRFSS).

Additionally, low income survey respondents reported an average of 4 poor physical health days in the past 30 days, double the average number of poor health days reported by all Lower Fairfield County residents. Nine percent (9%) of low income survey respondents reported they spent more than half of the past 30 days in poor physical health. By contrast, only four percent of all Lower Fairfield County residents reported 15 or more days in poor physical health over the last 30 days. (Note: low income convenience survey participants reported an average of 6.5 poor physical health days; and 20% reported 15 or more days in poor physical health).

Table 4: Average Days in Poor Physical Health in Past 30 Days and Percent of Respondents with 15+ days in poor physical health in Lower Fairfield County and Towns, 2011

	Stamford	Darien/ Rowayton	Greenwich	New Canaan	Norwalk	Weston, Westport, Wilton	Low Income	Lower Fairfield County Total
Average days in poor physical health in past 30 days	3	2	3	1	2	2	4	2
% respondents with 15+ days in poor physical health	7%	2%	5%	2%	5%	3%	9%	4%

Source: 2011 Lower Fairfield County Community Health Survey

CHRONIC DISEASE – CARDIOVASCULAR DISEASE

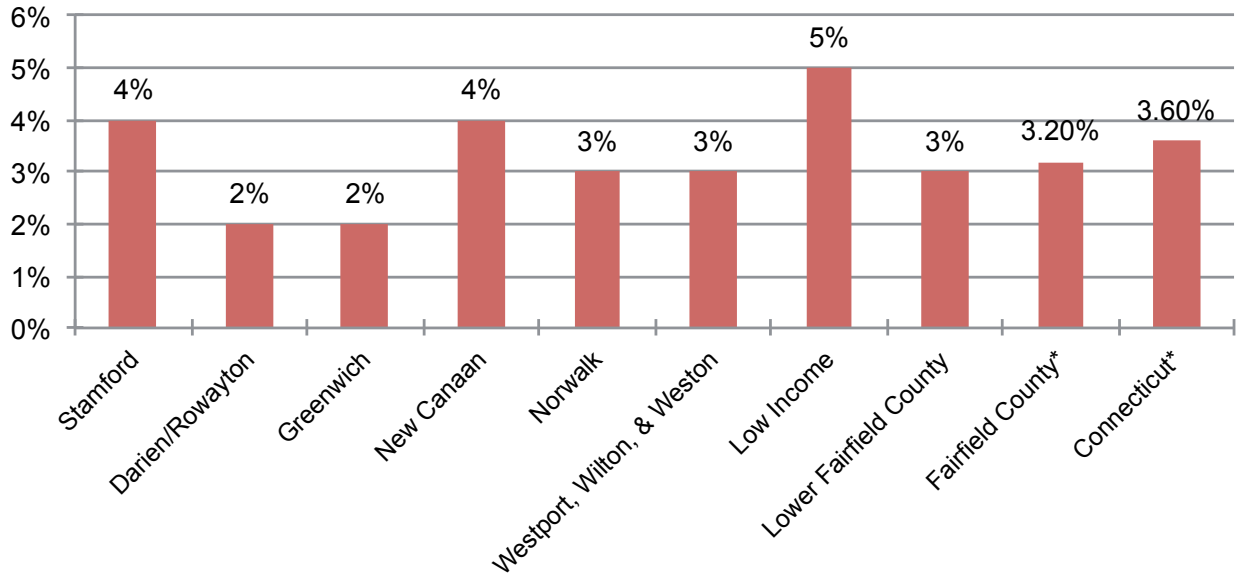
Cardiovascular diseases – including coronary heart disease, cerebrovascular disease/stroke, and hypertension – are some of the leading causes of hospitalization and death in Lower Fairfield County. Nationally, over one-third of adults manage one or more cardiovascular diseases, and often they are managed poorly; less than half of Americans diagnosed with hypertension appropriately manage it with medication[24].

[24] Healthy People 2020 Topics and Objectives: Heart Disease and Stroke. http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=21

Major Cardiovascular Disease (CVD)

According to the 2011 Lower Fairfield County Community Health Survey, 3% of Lower Fairfield County residents reported being diagnosed with angina or coronary heart disease by a health professional. The incidence of coronary heart disease and angina did not vary significantly by town, but was reported at a slightly higher rate in the low income population (5%).

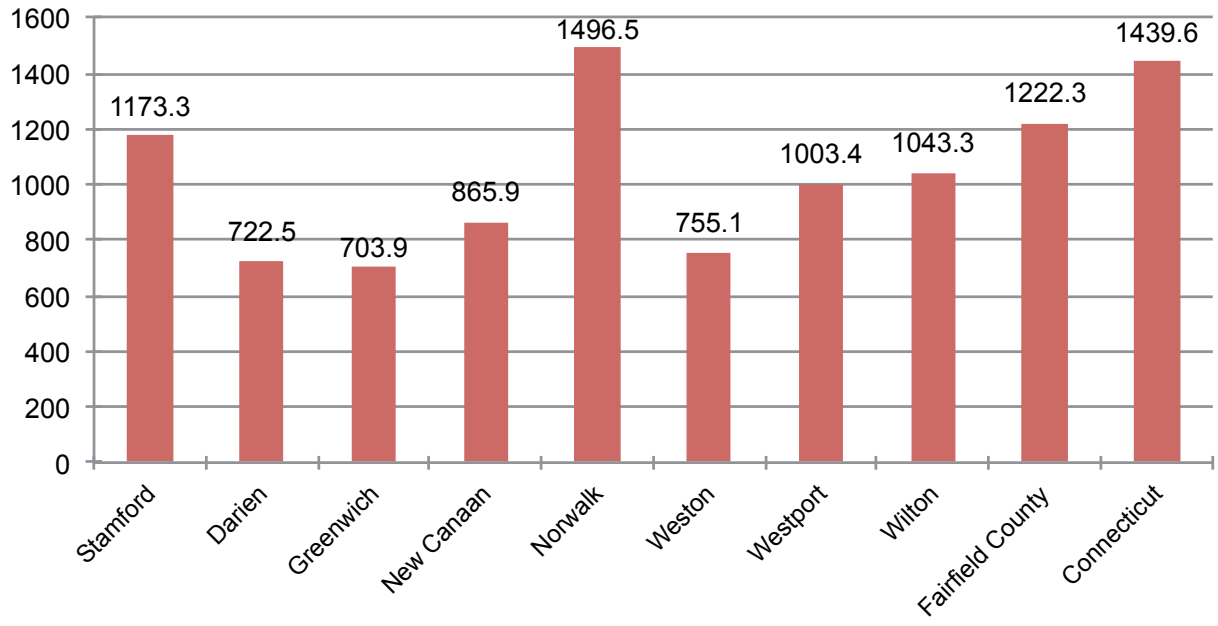
Figure 26: Percentage of People Who Have Ever Been Told They Have Angina or Coronary Heart Disease (CHD) in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011



Source: 2011 Lower Fairfield County Community Health Survey;*2010 Behavioral Risk Factor Surveillance System (BRFSS).

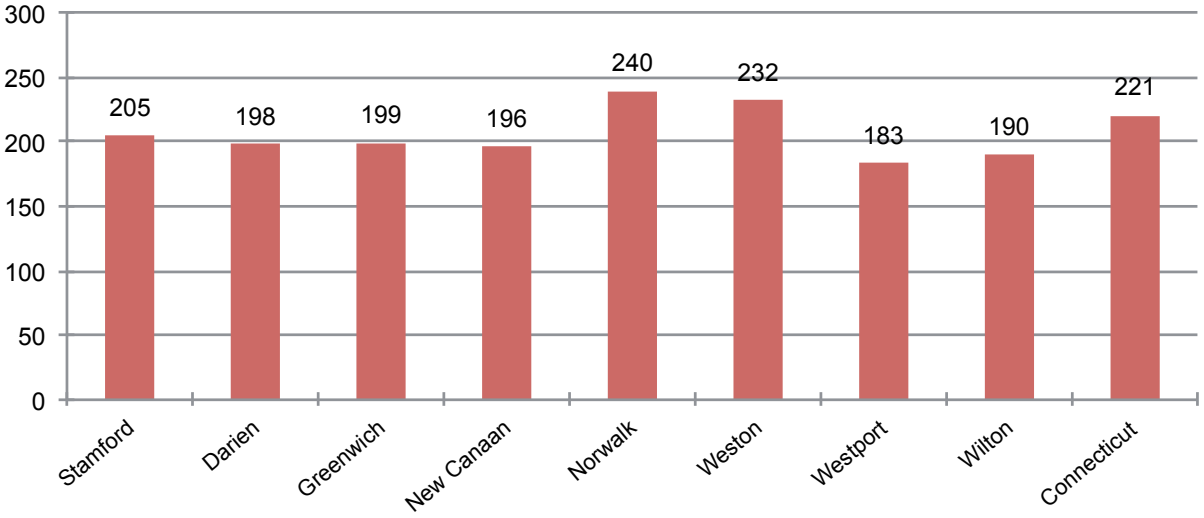
Norwalk has the highest age-adjusted hospitalization rates (1,496.5 per 100,000 residents) for major cardiovascular disease among the towns in Lower Fairfield County, and Norwalk's age-adjusted CVD hospitalization and mortality rates exceed the State rates. Interestingly, while Weston's CVD hospitalization rate is nearly half of Norwalk's – and one of the lowest hospitalization rates in Lower Fairfield County for this measure – the age-adjusted death rate for major cardiovascular disease in Weston (232 per 100,000 residents) is almost as high as Norwalk (240 per 100,000 residents).

Figure 27: Major Cardiovascular Disease (CVD) Hospitalizations- Age Adjusted Rate per 100,000 population in Connecticut, Fairfield County, and Lower Fairfield County Towns, 2010



Source: 2009-2010 CHIME Data (Primary Diagnosis).

Figure 28: Major Cardiovascular Disease (CVD) Deaths- Age Adjusted Rate (per 100,000 population) in Connecticut, Fairfield County, and Lower Fairfield County Towns, 2007



Source: 2005-2007 CT Department of Health, Office of Vital Records – Death Certificate (this data is not available on the County level).

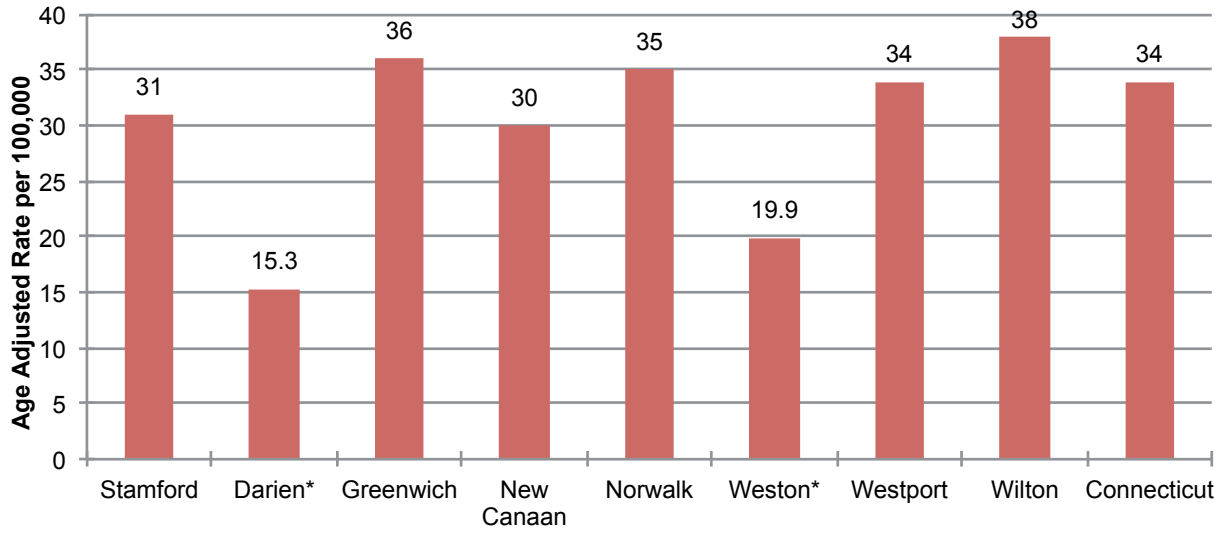
Cerebrovascular Disease and Stroke

Cerebrovascular disease refers to illnesses associated with any dysfunction in the vessels supplying blood to the brain. Stroke (including ischemic and hemorrhagic stroke) is the most common cerebrovascular diagnosis – nearly 1 million Americans suffer a stroke annually. Stroke is also the third leading cause of death in the country[25].

While strokes can occur at any age and have multiple possible causes (including arterial malformation or a traumatic injury), high blood pressure is the primary risk factor for stroke, and there are many ways individuals can manage their stroke risk by improving their health[26].

In Stamford, cerebrovascular disease-related hospitalization rates of 221 per 100,000 residents are slightly higher than the County rate (208.2 per 100,000 residents) and in Norwalk, the rate of 238.3 per 100,000 residents is higher than both the County and the State (231.5 per 100,000)[27]. Cerebrovascular disease mortality rates exceed the age-adjusted State mortality rate in Norwalk, Greenwich, and Wilton, as illustrated by the graph below.

Figure 29: Cerebrovascular Deaths- Age Adjusted Rate per 100,000 Population in Connecticut and Lower Fairfield County Towns, 2007



Source: 2005-2007 CT Department of Health, Office of Vital Records- Death Certificate (not available on County level). *crude rate

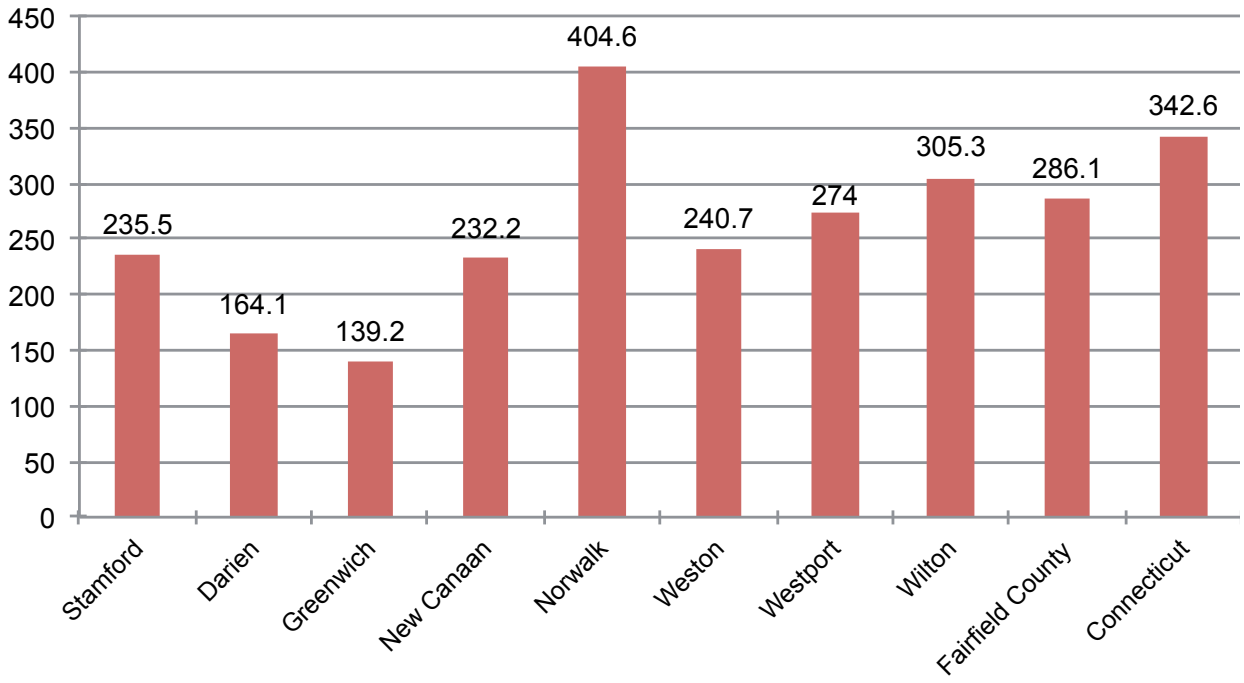
[25]National Library of Medicine: Stroke. http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001740/
[26]Ibid.
[27]Source: 2009-2010 CHIME Data (primary diagnosis).

Coronary Heart Disease (including Myocardial Infarction)

Coronary heart disease is a major cardiovascular disease characterized by decreased blood flow to the heart due to cholesterol and fatty deposits blocking the coronary arteries[28].

Similar to major cardiovascular disease, age-adjusted hospitalization and death rates for coronary heart disease are higher in Norwalk than the rest of Lower Fairfield County and the State as seen in Figures 30 and 31.

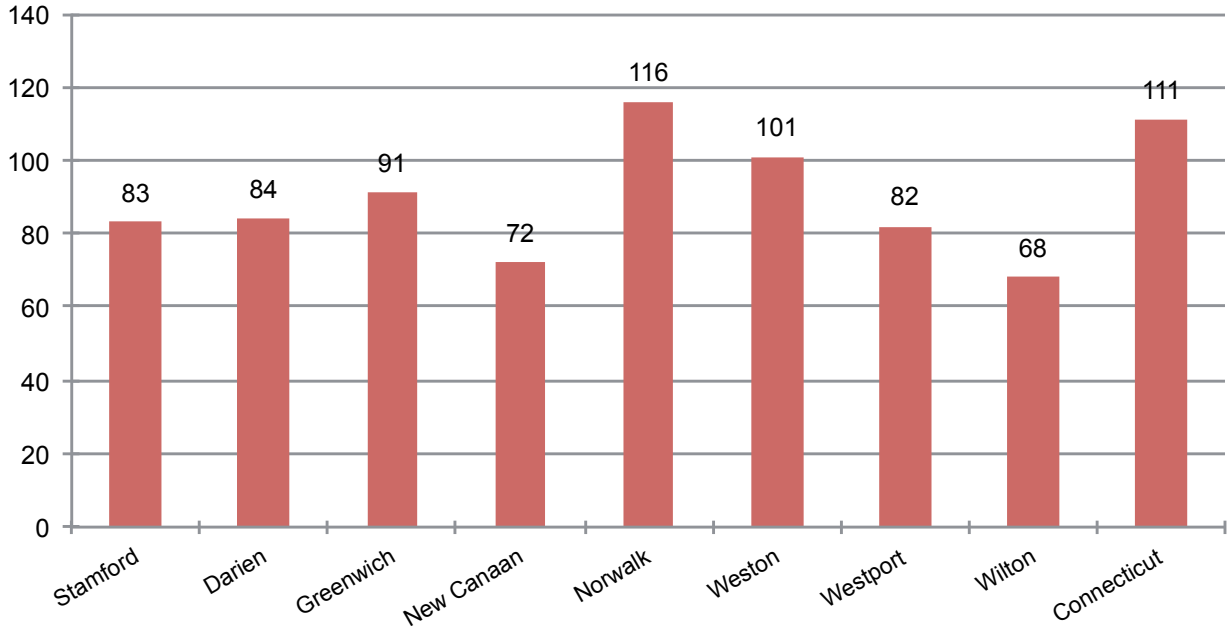
Figure 30: Coronary Heart Disease (Including Myocardial Infarctions) Hospitalizations- Age Adjusted Rate in Connecticut, Fairfield County, and Lower Fairfield County Towns, 2010



Source: 2009-2010 CHIME Data (Primary Diagnosis).

[28]NYSDOH: Cardiovascular Disease. https://www.health.ny.gov/diseases/cardiovascular/heart_disease/

Figure 31: Coronary Heart Disease (Including Myocardial Infarctions) Deaths- Age Adjusted Rate per 100,000 Population in Connecticut and Lower Fairfield County Towns, 2007



Source: 2005-2007 CT Department of Health, Office of Vital Records – Death Certificate (this data is not available on the County level).

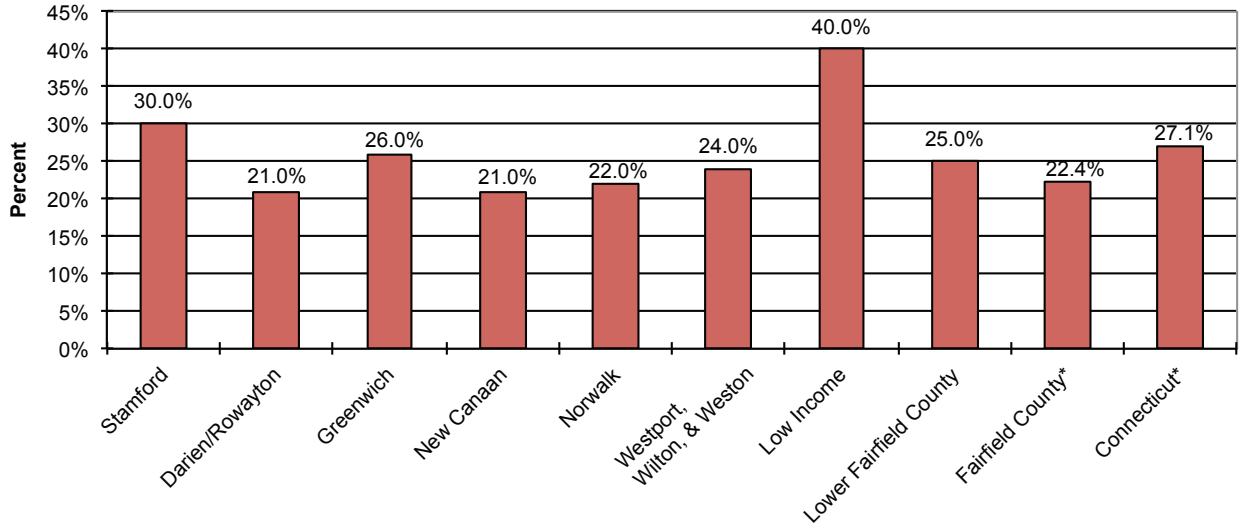
Hypertension

Hypertension is defined as blood pressure exceeding 140/90 mmHg. Hypertension is a primary risk factor for heart attack, stroke, and heart failure, among other diagnoses, and uncontrolled hypertension (e.g. with medication and/or lifestyle and behavior changes) is also associated with decreased life expectancy. 67 million American adults – nearly one-third of the adult population – have high blood pressure[29].

One quarter of mail survey respondents in Lower Fairfield County have ever been told they have high blood pressure. This number varies significantly by income, with 40% of low-income respondents to the mail survey reporting a diagnosis of hypertension.

[29]CDC: High Blood Pressure. http://www.cdc.gov/bloodpressure/index.htm

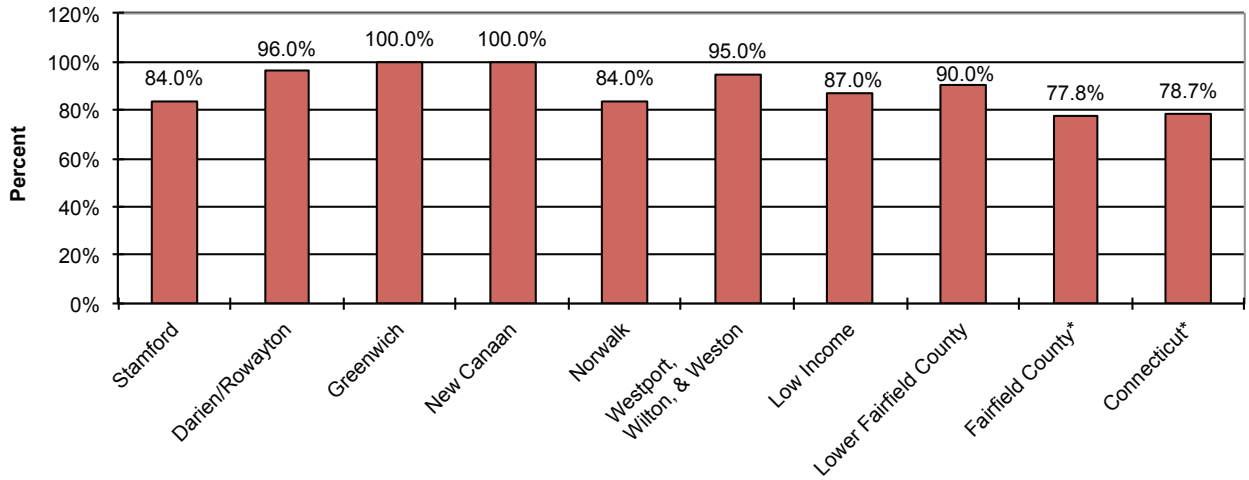
Figure 32: Percentage of People who Have Ever been told they Had High Blood Pressure/Hypertension in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011



Source: 2011 Lower Fairfield County Community Health Survey; *2009 Behavioral Risk Factor Surveillance System (BRFSS).

The overwhelming majority – 90% – of Lower Fairfield County residents diagnosed with hypertension report they are currently taking medication to manage their blood pressure[30]; Statewide, only 79% of residents diagnosed with hypertension are currently on medication[31]. As seen in Figure 33, Stamford and Norwalk residents, as well as low income residents of Lower Fairfield County – reported the lowest rates of medical management of their hypertension.

Figure 33: Percentage of People with Hypertension Currently Taking Blood Pressure Medication in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011



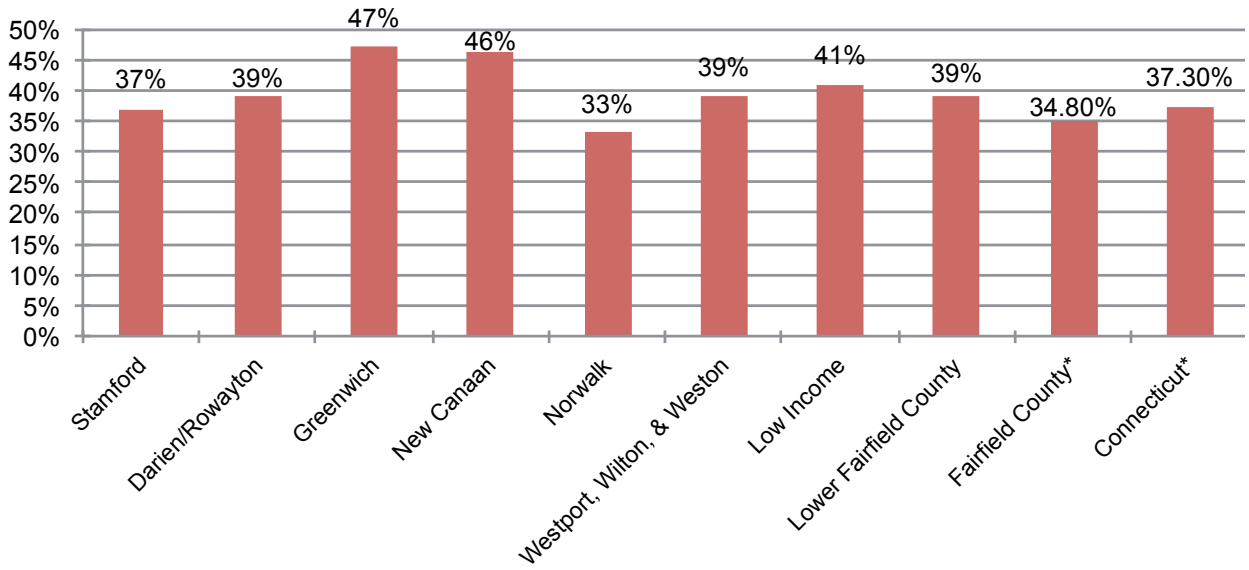
Source: 2011 Lower Fairfield County Community Health Survey; *2009 Behavioral Risk Factor Surveillance System (BRFSS).

[30]2011 Lower Fairfield County Community Health Survey.
[31]2009 Behavioral Risk Factor Surveillance System (BRFSS).

High Cholesterol

Lower Fairfield County residents are slightly more likely to be diagnosed with high blood cholesterol than residents of the rest of the County and State. By town, Greenwich and New Canaan have the highest incidence rates of high cholesterol in the region as seen in Figure 34.

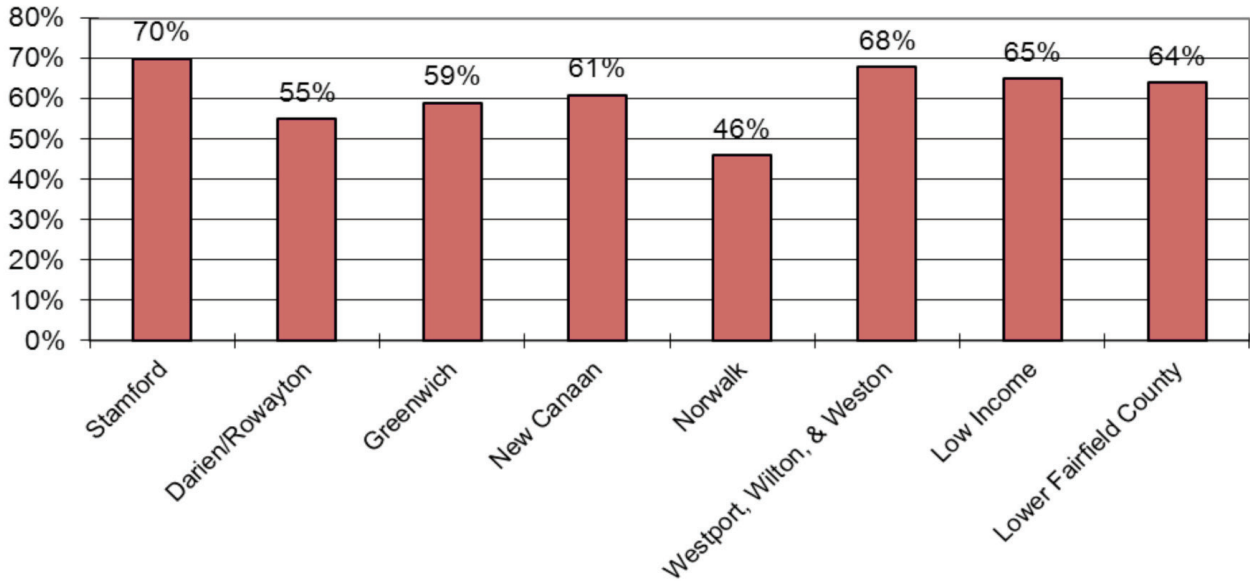
Figure 34: Percentage of People Who Have Had Cholesterol Checked and Told It Was High in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011



Source: 2011 Lower Fairfield County Community Health Survey; *2009 Behavioral Risk Factor Surveillance System (BRFSS).

Lower Fairfield County residents with high blood cholesterol are much less likely to manage their condition with medication than residents with hypertension – 90% of residents with high blood pressure currently take medication to manage their condition, compared to 64% of residents with high cholesterol. The mail survey did not capture, however, whether residents were managing their high cholesterol in alternative ways – such as diet and/or exercise.

Figure 35: Percentage of People with High Cholesterol Taking Medicine to Lower Cholesterol in Lower Fairfield County and Towns, 2011



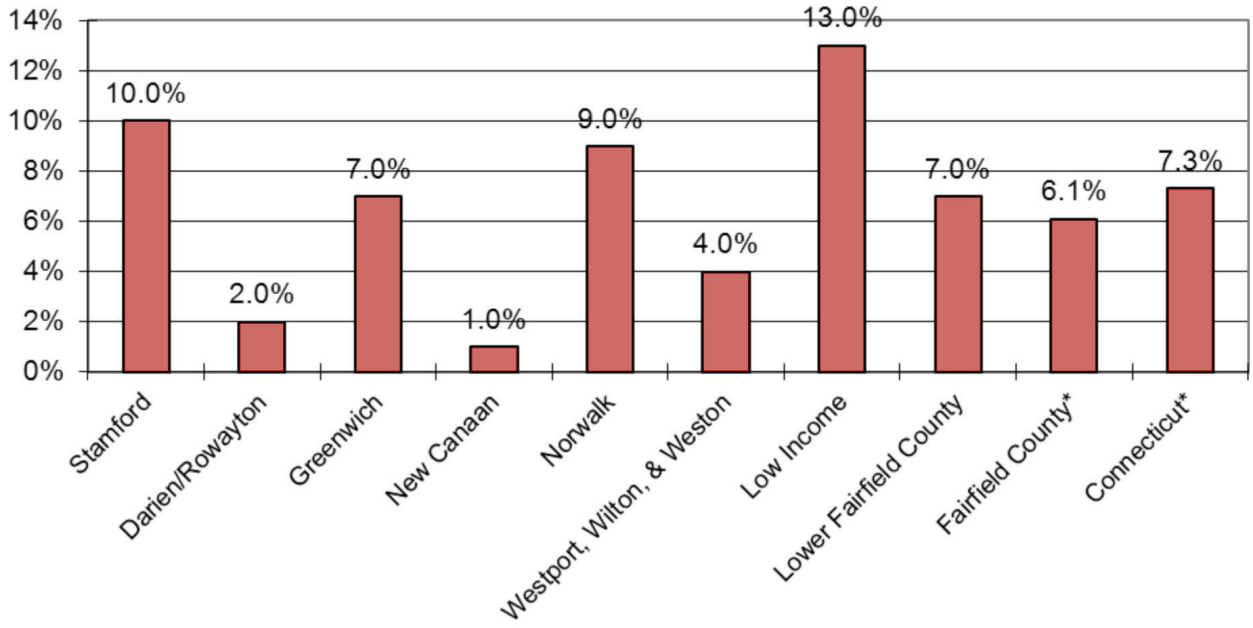
Source: 2011 Lower Fairfield County Community Health Survey.

CHRONIC DISEASE – DIABETES

Nationally, approximately 8.3% of the population (including children and adults) has Type 1 or Type 2 Diabetes, but nearly 7 million diabetics (27% of the diabetic population) are not aware of their condition[32]. Approximately 25.6 million adults (or 11.3% of the population) are diabetic[33].

With the exception of Stamford and Norwalk, virtually all towns in Lower Fairfield County have lower adult diabetes rates than the County or State. The low income population has the highest rates of diabetes (13%), nearly twice the rate of the State. It is important to note that both our mail survey data and Behavioral Risk Factor Surveillance System (BRFSS) data reported below rely on individuals' self-reports of a diabetes diagnosis by a health professional, so the undiagnosed portion of the population with diabetes is excluded from our analysis.

Figure 36: Percentage of Adults Who Were Told They Have Diabetes in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011

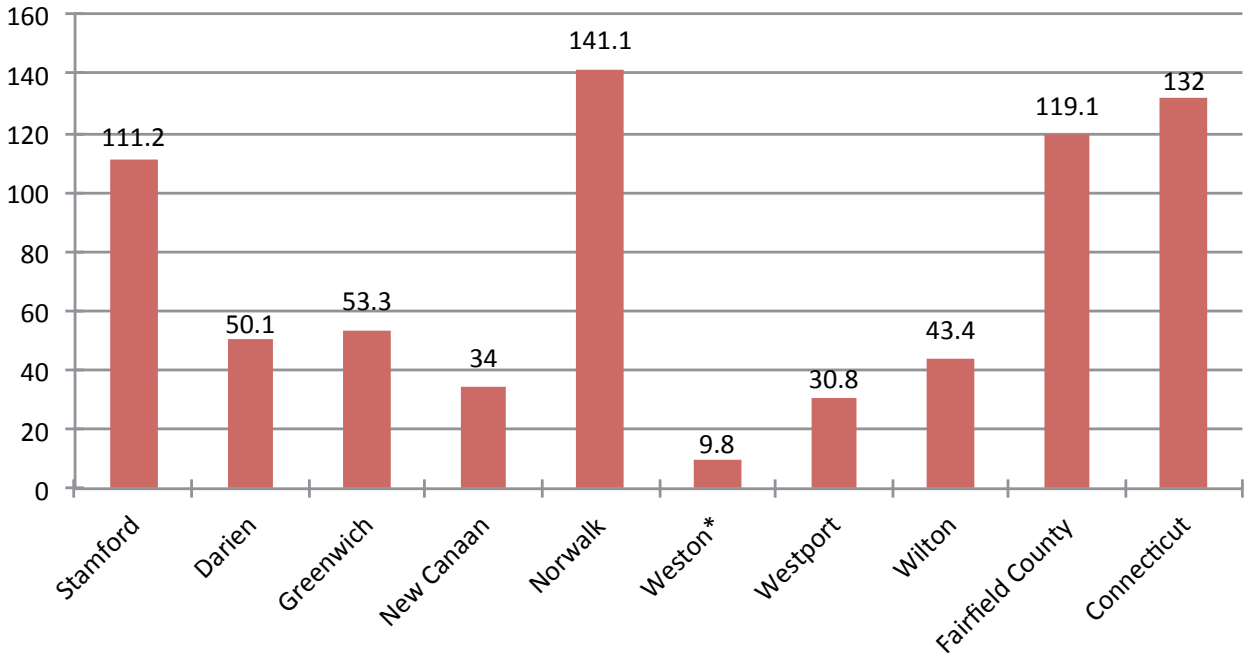


Source: 2011 Lower Fairfield County Community Health Survey; *2010 Behavioral Risk Factor Surveillance System (BRFSS).

Likely as a result of the higher diabetes incidence rates in these towns, Norwalk and Stamford residents are more likely to be hospitalized for diabetes or diabetes-related complications, and also have higher diabetes-related mortality rates than the other towns in Lower Fairfield County.

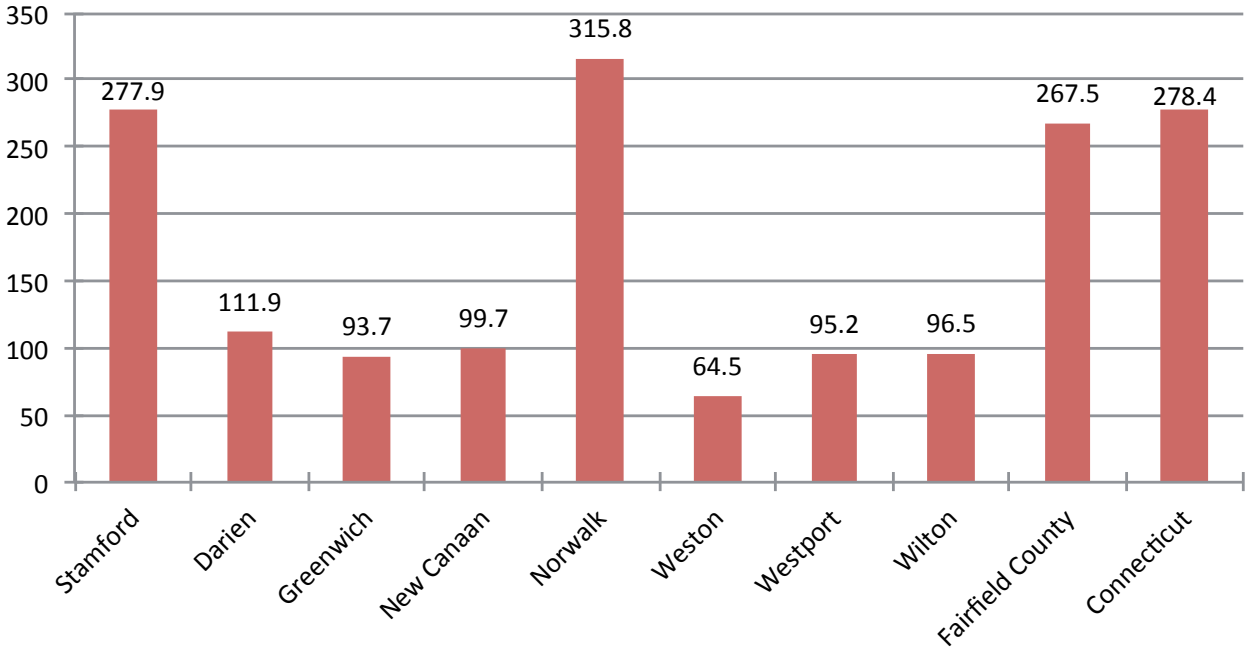
[32]ADA Diabetes Statistics.http://www.diabetes.org/diabetes-basics/diabetes-statistics/
[33]NIH National Diabetes Statistics 2011.http://diabetes.niddk.nih.gov/dm/pubs/statistics/

Figure 37: Diabetes Hospitalizations- Age Adjusted Rate per 100,000 Population in Connecticut, Fairfield County, and Lower Fairfield County Towns, 2010



Source: 2009-2010 CHIME Data (Primary Diagnosis) *crude rate

Figure 38: Diabetes Related Hospitalizations- Age Adjusted Rate per 100,000 Population in Connecticut, Fairfield County, and Lower Fairfield County Towns, 2010

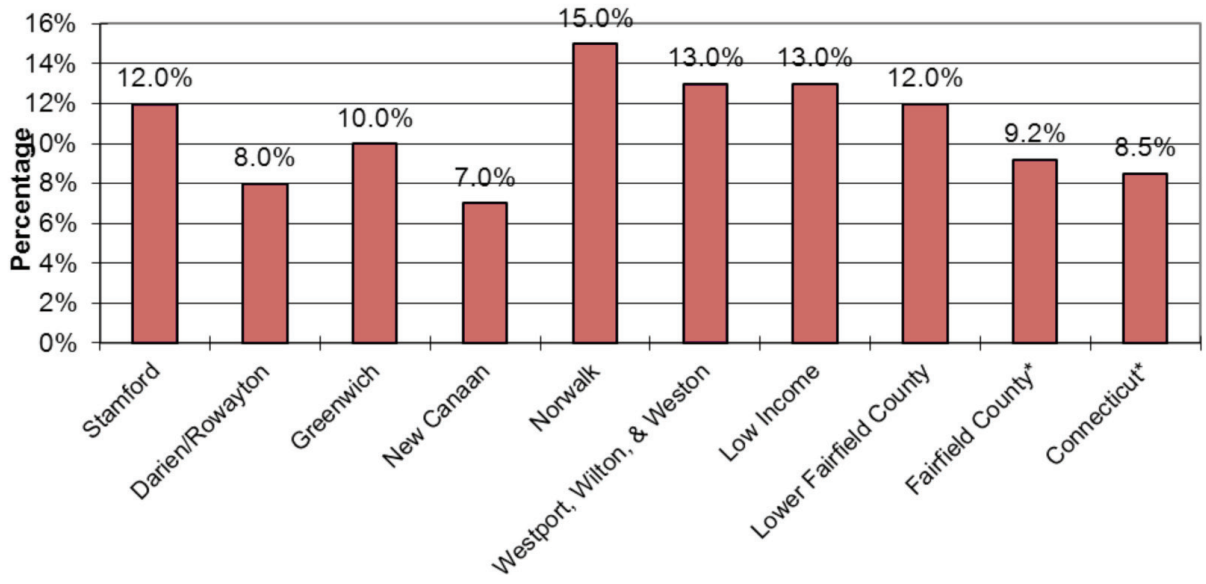


Source: 2009-2010 CHIME Data (Primary Diagnosis).

CHRONIC DISEASE – ASTHMA AND RESPIRATORY HEALTH

Twelve percent of Lower Fairfield County adults have been told by their doctors that they have asthma, which is about 33% higher than the proportion of residents State– and County–wide. Norwalk (15%), Westport/Weston/Wilton (13%), and Stamford (12%) have the highest asthma incidence rates in Lower Fairfield County.

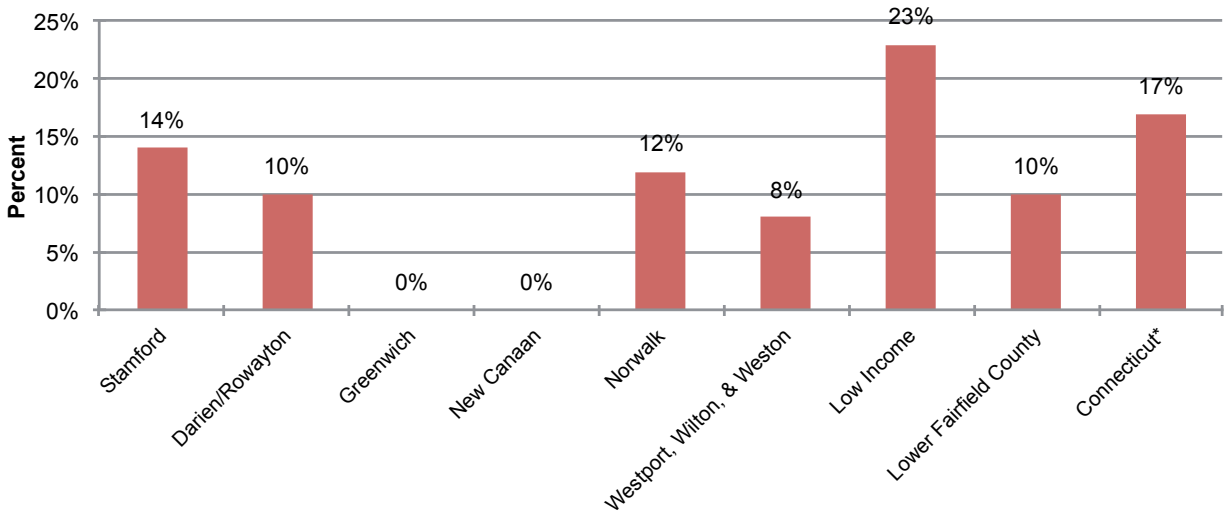
Figure 39: Percentage of Those Who Have Ever Been Told They Have Asthma, or Currently Have Asthma in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011



Source: 2011 Lower Fairfield County Community Health Survey; *2010 Behavioral Risk Factor Surveillance System (BRFSS).

While asthma incidence rates among low income residents in Lower Fairfield County (reported at 13%) are not significantly higher than the rates in the general population, low income residents are much more likely to require emergency asthma treatment. Twenty three percent (23%) of low income residents with asthma have had an ER visit due to their diagnosis in the last 12 months, compared to only 10% of residents in Lower Fairfield County overall and 17% of residents Statewide.

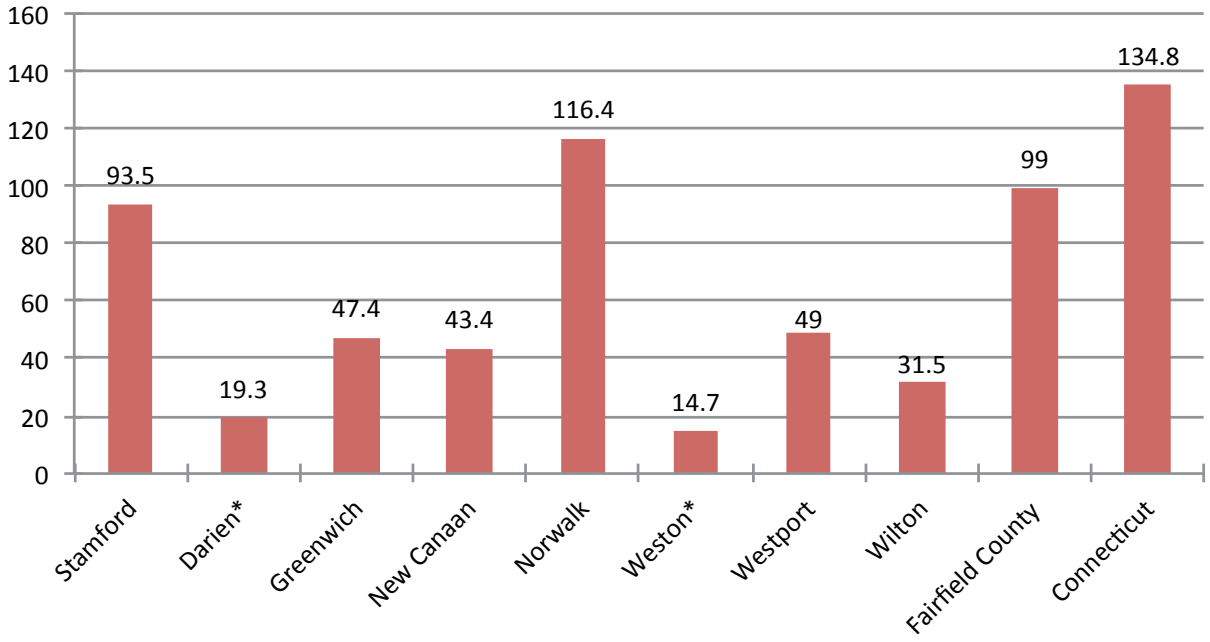
Figure 40: Percentage of People with Asthma Who Visited the ER in the Past 12 Months Due to Asthma in Connecticut, Lower Fairfield County and Towns, 2011



Source: 2011 Lower Fairfield County Community Health Survey; *2003 Behavioral Risk Factor Surveillance System (BRFSS).

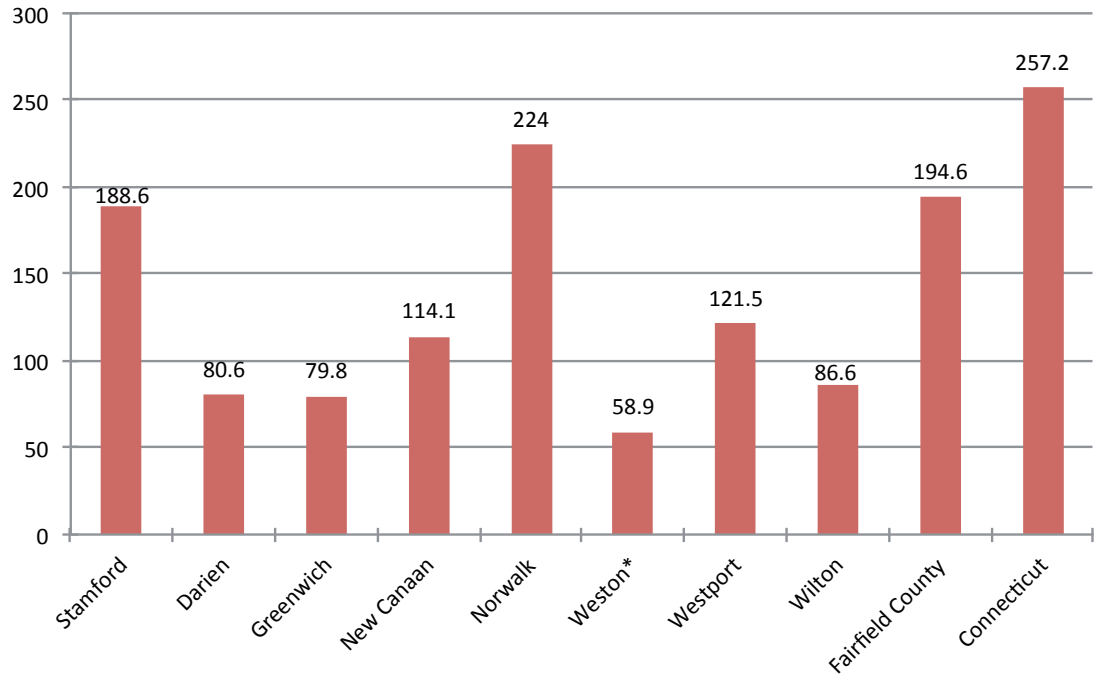
As seen in Figures 41 and 42, age-adjusted hospitalization rates per 100,000 population for asthma and asthma-related diagnoses were not significantly higher than State or County rates in the towns of Lower Fairfield County. The hospitalization rates for those living in Norwalk were higher than the rest of the towns in Lower Fairfield County, but that is likely due to the higher asthma incidence rates reported in Norwalk.

Figure 41: Asthma (Primary Diagnosis) Hospitalizations- Age Adjusted Rate per 100,000 Population in Connecticut, Fairfield County and Lower Fairfield County Towns, 2010



Source: 2009-2010 CHIME Data (Primary Diagnosis). *crude rate

Figure 42: Asthma Related (Primary or Secondary Diagnoses) Hospitalizations- Age Adjusted Rate per 100,000 Population in Connecticut, Fairfield County, and Lower Fairfield County Towns, 2010

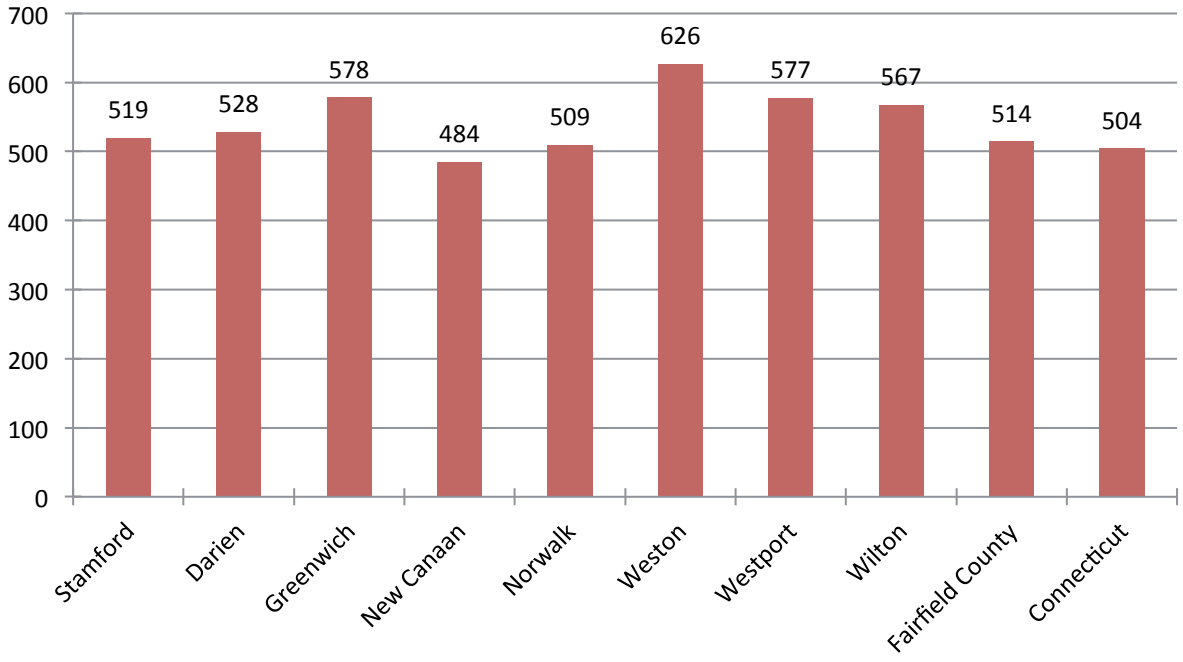


Source: 2009-2010 CHIME Data (Primary Diagnosis). *crude rate

CANCER

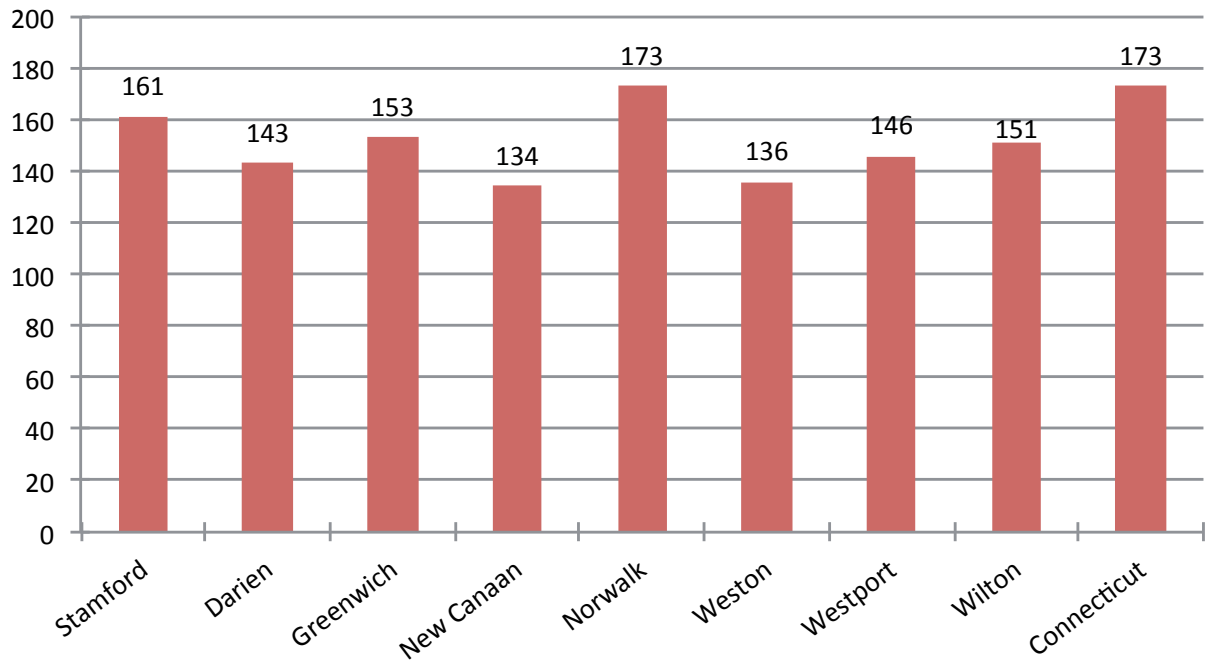
According to Tumor Registry data from the State Department of Public Health, residents of Lower Fairfield County are less likely to die of cancer than residents of the State and Fairfield County overall. However, there is considerable variation with respect to cancer incidence and cancer-related hospitalization rates, and a number of cities and towns have significantly higher incidence and hospitalization rates for cancer than the State and the County.

Figure 43: Cancer (all types) Incidence- Age Adjusted Rate per 100,000 Population in Connecticut, Fairfield County, and Lower Fairfield County Towns, 2007



Source: 2006-2007 CT Department of Health Tumor Registry (available at Health Equity Alliance) for towns; 2003-2007 State Center Profiles from the CDC for State and County (based on CT Tumor Registry Data).

Figure 44: Cancer (all types) Deaths- Age Adjusted Rate (per 100,000 Population) in Connecticut and Lower Fairfield County Towns, 2007



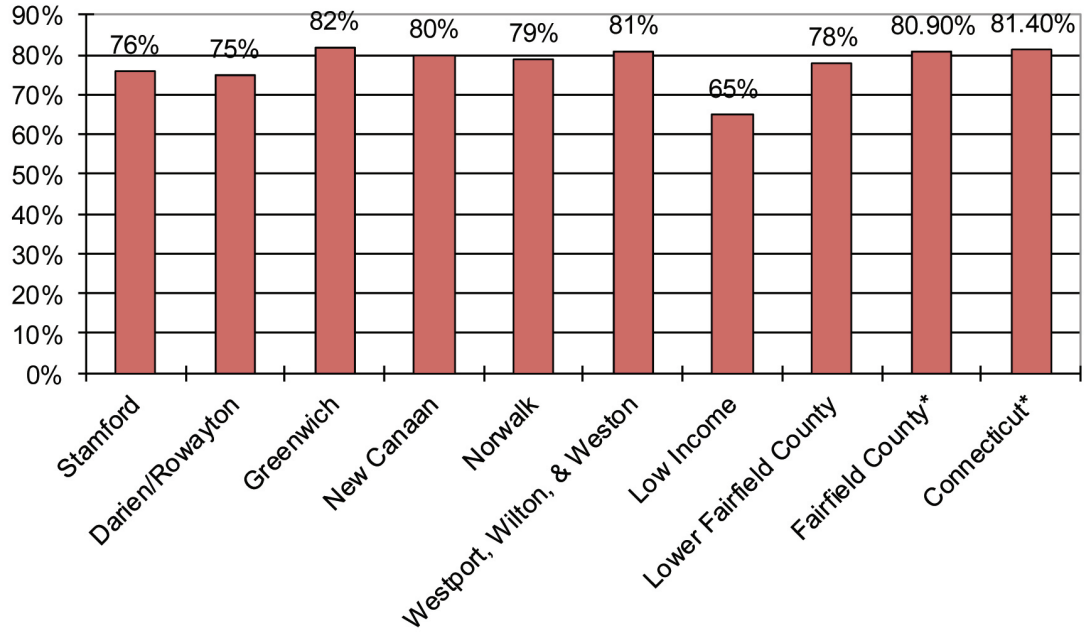
Source: 2005-2007 CT Department of Health, Office of Vital Records- Death Certificate (not available on County level).

Screening Rates

As the following charts indicate, cancer screening rates for all cancer types are very high across Lower Fairfield County, which might provide some explanation for the high cancer incidence rates – and lower age-adjusted cancer death rates – in the area.

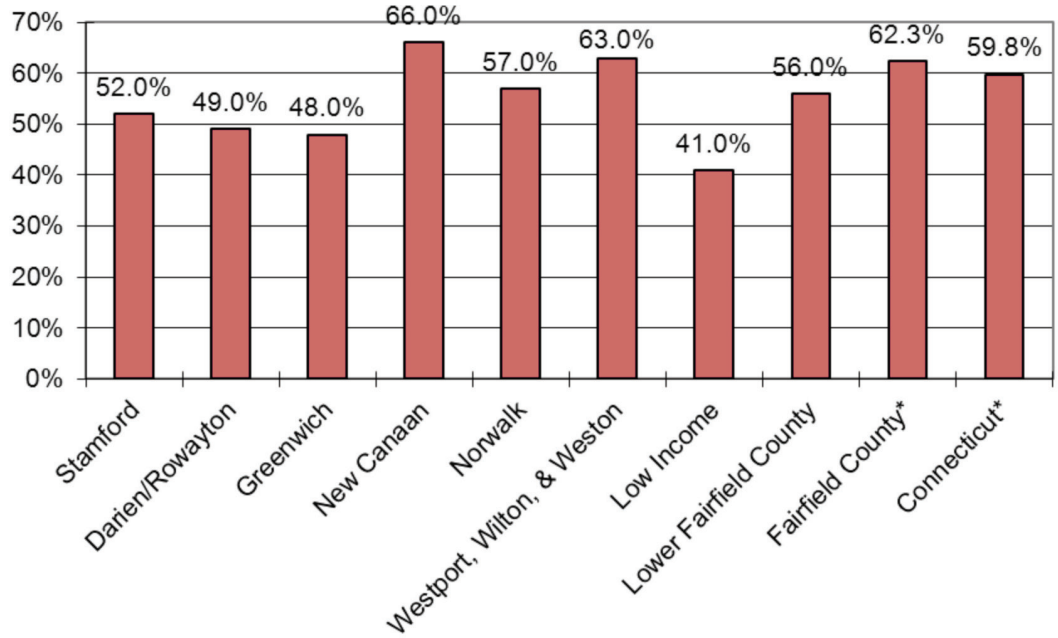
The low income population in Lower Fairfield County is much less likely to get all types of cancer screening; the biggest disparities are seen in mammogram and Prostate Specific Antigen (PSA) screening. As a result, cancer may be detected later in this population, leading to higher health care costs, more invasive treatment and (likely) worse outcomes.

Figure 45: Percentage of Women 40+ Who Have Had a Mammogram in Past 2 Years in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011



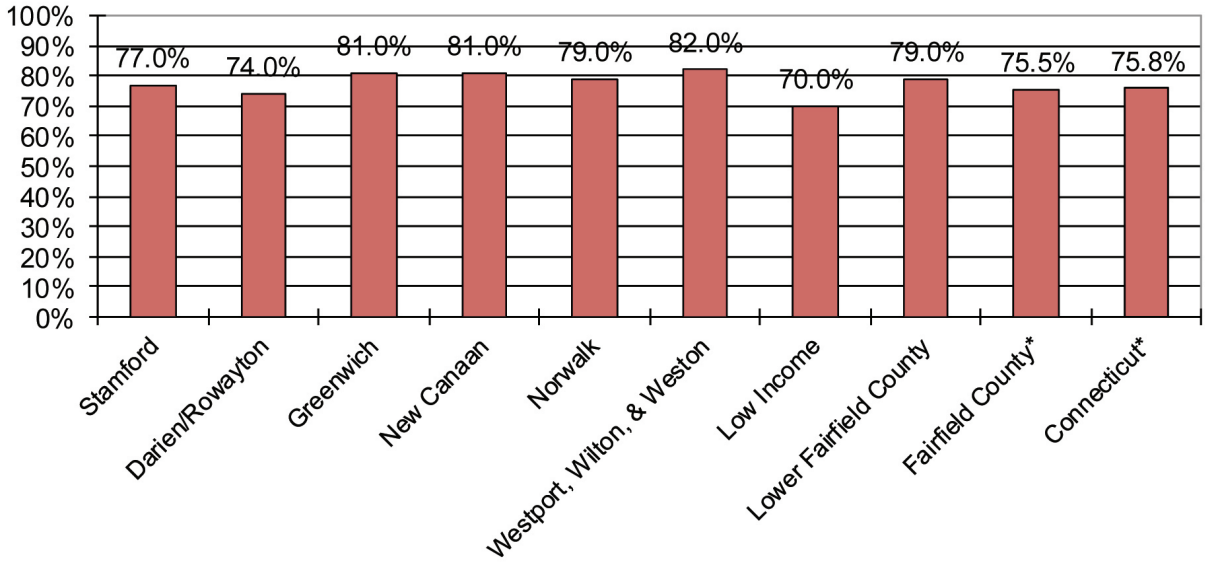
Source: 2011 Lower Fairfield County Community Health Survey; *2010 Behavioral Risk Factor Surveillance System (BRFSS).

Figure 46: Percentage of Men 40+ Who Have Had PSA Test in Past 2 Years in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011



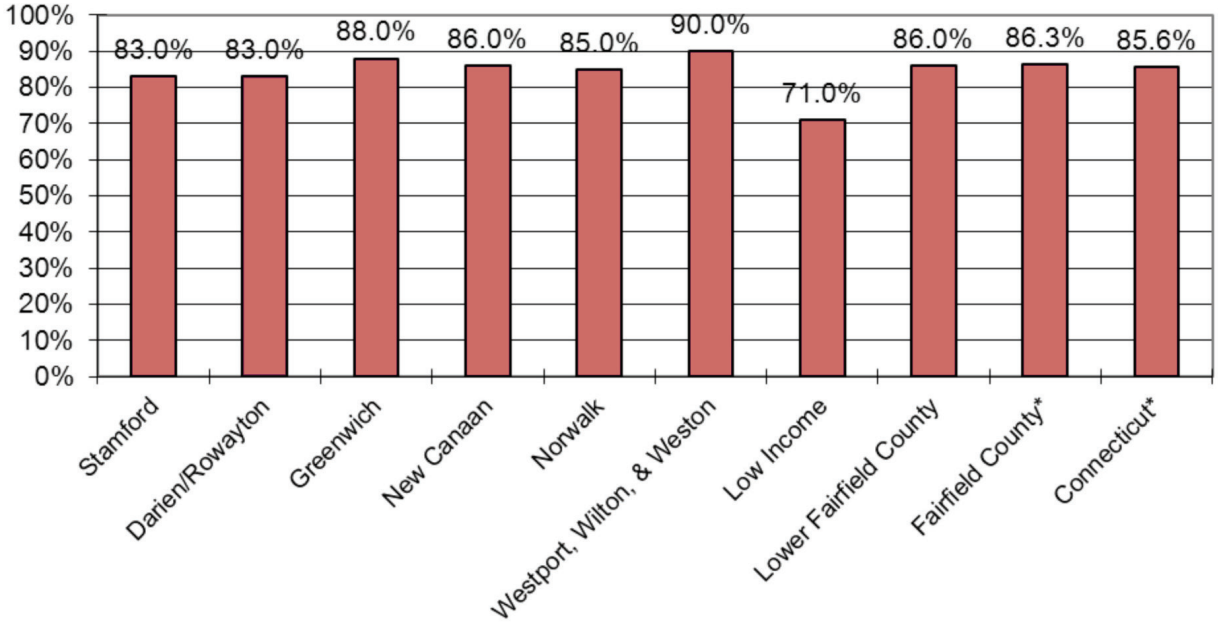
Source: 2011 Lower Fairfield County Community Health Survey; *2010 Behavioral Risk Factor Surveillance System (BRFSS).

Figure 47: Percentage of Men & Women 50+ Who Have Had Sigmoidoscopy/Colonoscopy in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011



Source: 2011 Lower Fairfield County Community Health Survey; *2010 Behavioral Risk Factor Surveillance System (BRFSS).

Figure 48: Women 18+ Who Have Had a Pap in Past 3 Years in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011

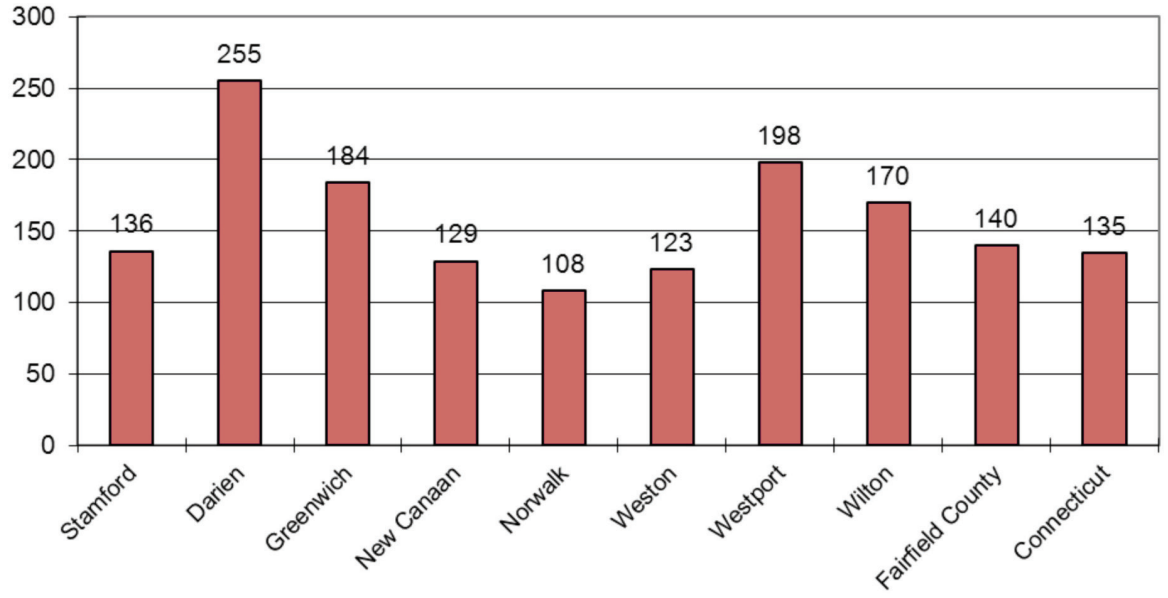


Source: 2011 Lower Fairfield County Community Health Survey; *2010 Behavioral Risk Factor Surveillance System (BRFSS).

Breast Cancer

As indicated in Figure 45, nearly 80% of women age 40 and over in Lower Fairfield County have had a mammogram in the past two years, which may partially explain the high breast cancer incidence rates in the area, especially in Darien, Westport, Greenwich, and Wilton.

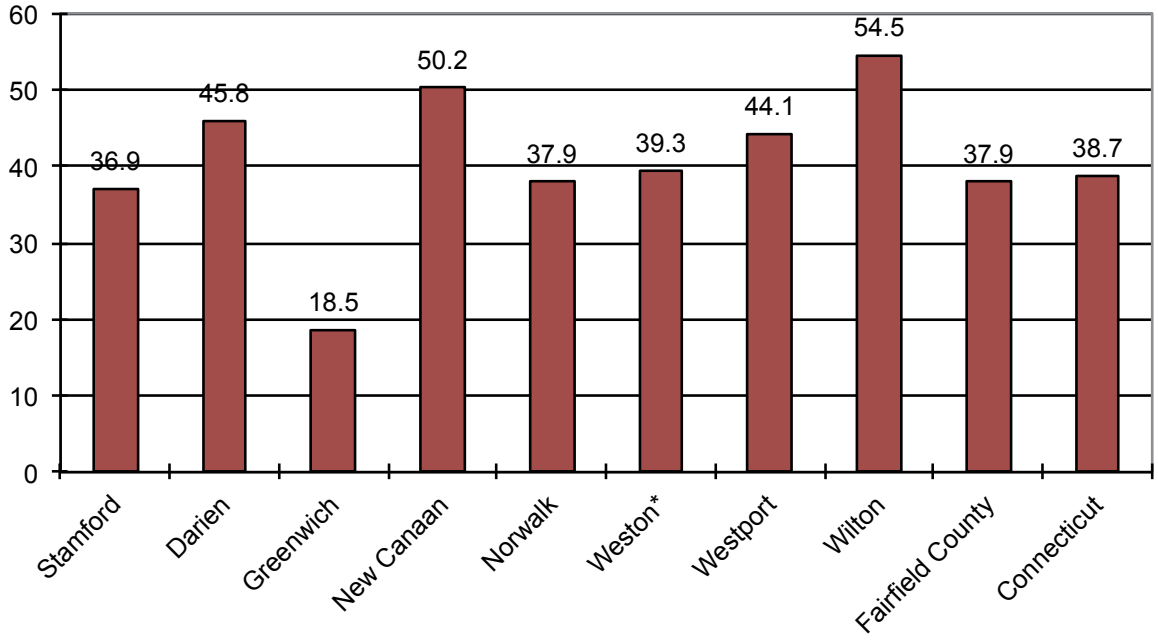
Figure 49: Breast Cancer Incidence- Age Adjusted Rate (per 100,000 Population) in Connecticut, Fairfield County, and Lower Fairfield County Towns, 2007



Source: 2006-2007 CT Department of Health Tumor Registry (available at Health Equity Alliance) for towns; 2003-2007 State Center Profiles from the CDC for State and County (based on CT Tumor Registry Data)

Unfortunately, high rates of mammogram screening do not always mean breast cancer is detected at an earlier stage and is more easily treatable. As seen in Figure 50, five towns in Lower Fairfield County (Wilton, New Canaan, Darien, Westport, and Weston) all have higher breast cancer hospitalization rates than the County or State.

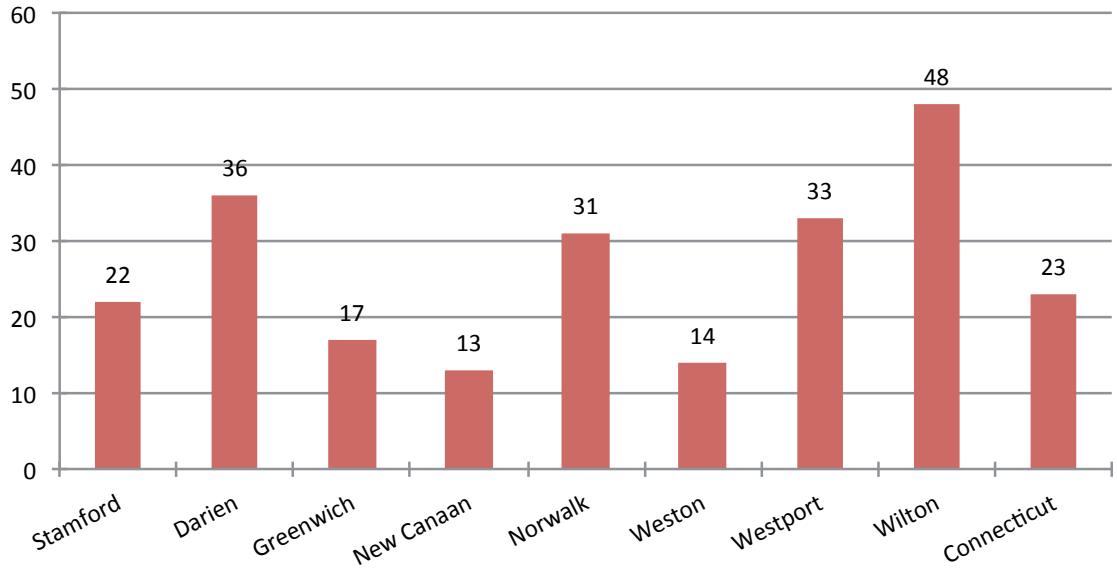
Figure 50: Breast Cancer Hospitalizations- Age Adjusted Rate per 100,000 Population in Connecticut, Fairfield County, and Lower Fairfield County Towns, 2010



Source: 2009-2010 CHIME Data (primary diagnosis) *crude rate

Additionally, Wilton, Darien, Westport, and Norwalk all have age-adjusted breast cancer mortality rates that exceed the State rate.

Figure 51: Breast Cancer Deaths, Age Adjusted Rate per 100,000 Population in Connecticut and Lower Fairfield County Towns, 2007

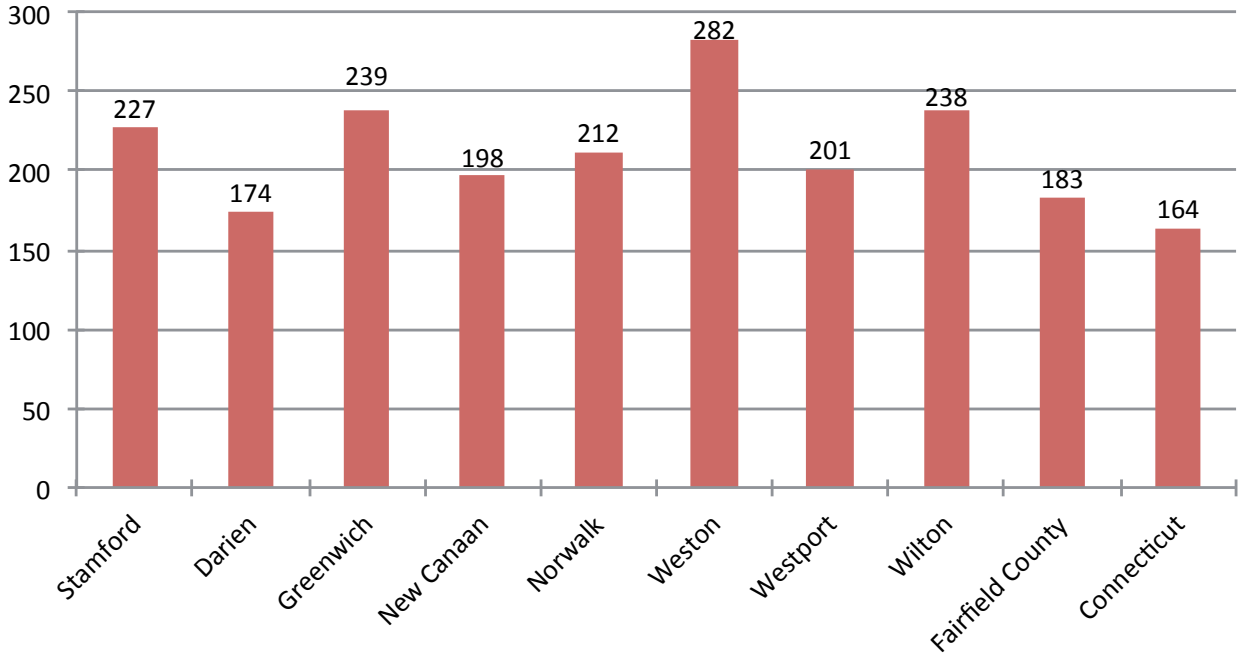


Source: 2005-2007 CT Department of Health, Office of Vital Records- Death Certificate (not available on County level).

Prostate Cancer

As with breast cancer, prostate cancer incidence and mortality rates are higher than the State rates for many cities and towns in the region. Stamford, Greenwich, Weston, and Wilton residents are much more likely to be diagnosed with prostate cancer than residents of the County or State (see Figure 52), and Greenwich (38 deaths per 100,000 population, age-adjusted) and Norwalk (34 deaths per 100,000 population, age-adjusted) have the highest prostate cancer mortality rates in Lower Fairfield County.

Figure 52: Prostate Cancer Incidence- Age Adjusted Rate per 100,000 Population in Connecticut, Fairfield County, and Lower Fairfield County Towns, 2007



Source: 2006-2007 CT Department of Health Tumor Registry (available at Health Equity Alliance) for towns; 2003-2007 State Center Profiles from the CDC for State and County (based on CT Tumor Registry Data)

Colorectal Cancer

Colorectal cancer incidence rates are also higher than State rates in selected towns in Lower Fairfield County. Weston and Wilton have the highest colorectal cancer incidence rates in the region (78 and 63 cases per 100,000 population, respectively)[34] , but colorectal cancer mortality rates in these towns are not significantly higher than the rest of Lower Fairfield County, and are lower than the Statewide mortality rate.

It should be noted, the assessment was not able to compile incidence rates by race/ethnicity or income at the State or County level, but nationally there is strong evidence showing disparities in incidence and death among most racial/ethnic minorities when compared to the majority, non-Hispanic White populations. The 2011 Lower Fairfield County Community Health Survey results demonstrated clear disparities in cancer screening rates among low income populations and racial/ethnic minority populations. Given the disparities in outcomes and the fact that it is the second leading cause of death, cancer was identified as a high priority health issue within the broad category of chronic disease.

MENTAL AND BEHAVIORAL HEALTH

According to a National Institute of Mental Health study published in 2011, mental health disorders affect approximately 44 million adults and 13.7 million children each year. Mental health issues are the leading cause of disability nationally[35] – in terms of lost healthy time measured in disability adjusted life years (DALYs), mental health disorders are as disabling as heart disease or cancer – and are associated with poor physical health, higher utilization of medical services, and premature death[36].

The most common mental health diagnoses are anxiety (which affects approximately 40 million adults in the US) and mood disorders (including major depressive disorder, bipolar disorder, and dysthymic disorder); together these diagnoses affect approximately 20.9 million American adults. Rates of mental health problems are significantly higher for patients with certain chronic conditions such as diabetes, asthma and heart conditions. Patients who do not treat both physical and mental health conditions have poorer health outcomes for both co-occurring conditions, as well as higher health care costs overall[37].

[34] 2006-2007 CT Department of Health Tumor Registry
[35]Healthy People 2020: Mental Health and Mental Disorders. http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28
[36]Mental Health Care Services in Primary Care: Tackling the Issues in the Context of Health Care Reform, October 2011. http://www.americanprogress.org/wp-content/uploads/issues/2010/10/pdf/mentalhealth.pdf
[37]National Institutes of Mental Health (NIMH). The Numbers Count: Mental Disorders in America. http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml

As seen in Table 5, low income populations in Lower Fairfield County were more than twice as likely to report being sad or blue 15 or more of the last 30 days than Lower Fairfield County residents overall. Similarly, low income residents were considerably more likely to report being tense or anxious 15 or more days per month than residents of Lower Fairfield County overall. Residents across Lower Fairfield County were more likely to report feeling worried, tense, or anxious than sad or blue over the previous 30 days.

Table 5: Percent of population reporting 15 or more days (of last 30 days) in poor mental health

	Stamford	Darien/ Rowayton	Greenwich	New Canaan	Norwalk	Westport, Wilton & Weston	Low Income	Total
% of respondents with 15 or more days in poor mental health	6%	1%	4%	3%	9%	4%	9%	5%
% of respondents with 15 or more days feeling sad or blue	6%	3%	3%	2%	6%	3%	10%	4%
% of respondents with 15 or more days feeling tense/anxious	12%	10%	11%	7%	11%	9%	19%	10%

Source: 2011 Lower Fairfield County Community Health Survey

Low income populations were nearly twice as likely to report being limited by their physical, emotional, and mental health as residents County or Statewide. Thirty-one percent (31%) of low income residents reported limitations due to their health[38], compared to just 14% for Fairfield County residents and 17% of residents in the State[39].

Lower Fairfield County residents had significantly lower ED utilization for mental health disorders than County or State residents[40] , as well as lower utilization of Department of Mental Health and Addiction Services (DMHAS) resources than State residents. Norwalk (1273.7 unique residents per 100,000 population receiving services) and Stamford (1141.2 unique residents per 100,000 population receiving services) had the highest unduplicated DMHAS utilization rates in the region, but these rates were still only about half of the rate for the State of Connecticut (2199.3 unique residents per 100,000 population receiving services)[41]

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[38]2001 Lower Fairfield County Community Health Survey
[39]2010 Behavioral Risk Factor Surveillance System (BRFSS)
[40]2009 CHIME Data
[41]2007 Department of Mental Health and Addiction Services (DMHAS) data

INFECTIOUS DISEASE

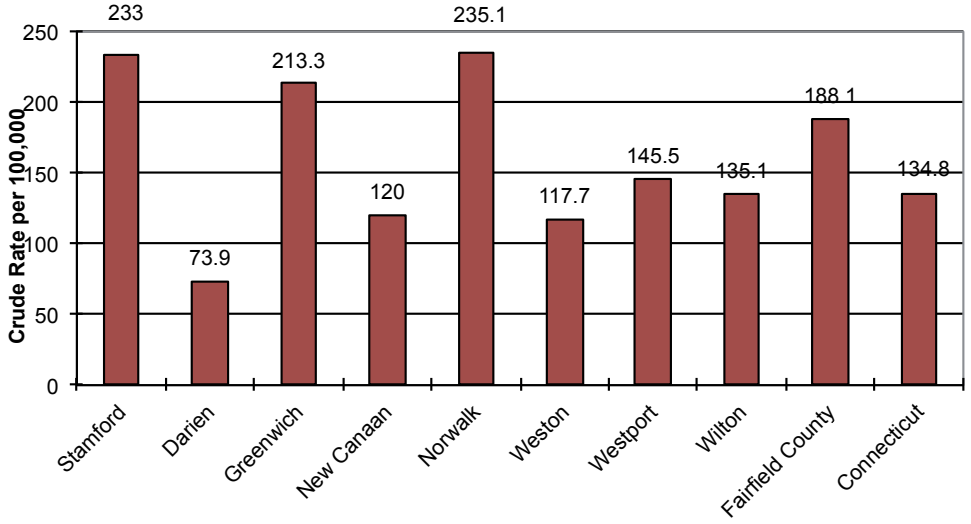
Infectious diseases are disorders caused by organisms and transmitted from an outside source. Some infections are passed person-to-person, while others are transmitted from animal or insect bites. Still others are contacted by ingesting contaminated food, water or other exposures in the environment. The assessment captured infectious disease incidence data in Lower Fairfield County for each of the following infectious diseases: Tuberculosis, Chlamydia, Gonorrhea, Syphilis, HIV/AIDS, and Pneumonia/Influenza. With a few notable exceptions, infectious disease rates for nearly all of the diseases listed were substantially lower across the region when compared to the State and County overall.

Residents of Stamford had a statistically higher incidence rate for tuberculosis than residents Statewide – 7.4 cases per 100,000 population, compared to 2.4 cases per 100,000 population across Connecticut[42]. Stamford and Norwalk also had higher HIV/AIDS incidence (new cases) and prevalence rates (total diagnosed cases) than the State or the County[43].

Norwalk had the highest incidence rates of sexually transmitted diseases (STDs) in the region, and the syphilis incidence rate in Norwalk was more than double the State rate – 4.8 cases per 100,000 population (crude rate), compared to 2.3 cases per 100,00 population (crude rate) in Connecticut[44] .

Finally, as seen in Figure 53, influenza incidence rates were higher than State rates across Lower Fairfield County, with Norwalk, Stamford, and Greenwich reporting the highest incidence rates in the region.

Figure 53: Influenza Incidence (Crude Rate per 100,000) in Connecticut, Fairfield County, and Lower Fairfield County Towns, 2011



Source: 2010-2011 Season- Positive Influenza Tests, CT Department of Public Health Reportable Disease Statistics

[42] 2010 TB Incidence Data – CT Department of Public Health Reportable Disease Statistics.
[43] 2009 CT Department of Public Health HIV/AIDS Surveillance Program – HIV/AIDS cases.
[44] 2009 STD Incidence Data – CT Department of Public Health Reportable Disease Statistics.

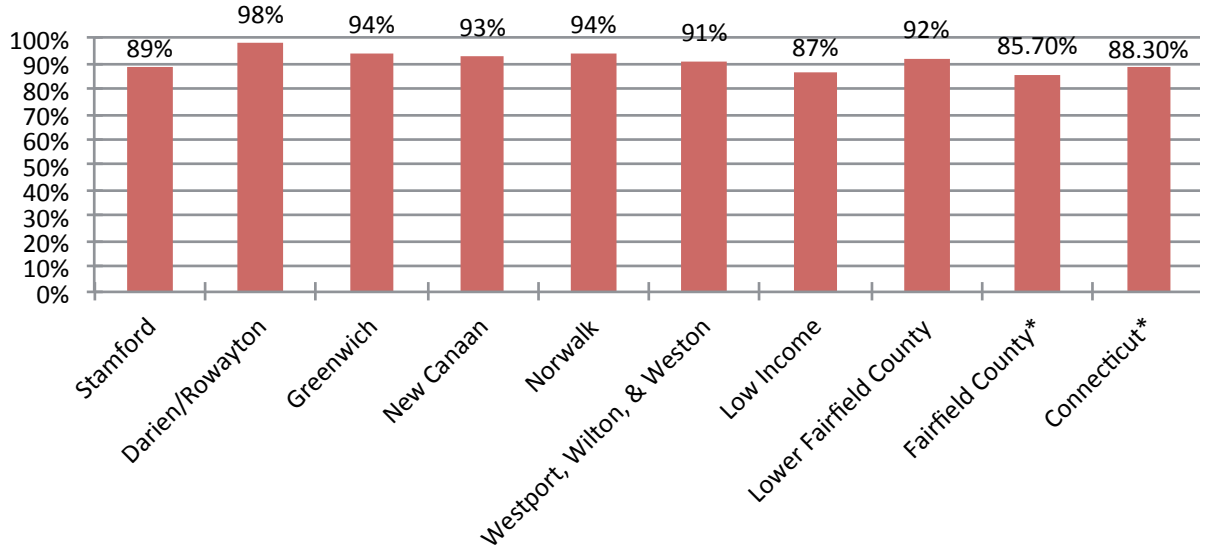
HEALTHCARE ACCESS AND UTILIZATION

The extent to which a full continuum of high quality, timely, accessible care is available is undoubtedly critical to good health. Comprehensive health insurance coverage has also been shown to be a major determinant of good health. This assessment did not include a comprehensive health system inventory and capacity assessment, however, a listing of community health resources compiled with input from a number of key stakeholders can be found in Appendix 6. Additionally, quantitative data from the surveys and secondary sources combined with qualitative data from interviews and the community listening sessions provided a great deal of valuable information related to access. Specifically, these data informed our assessment of service needs and barriers to access in relation to primary medical care, dental, behavioral health, and medical specialty services, as well as hospital emergency department and inpatient care. These sources also provided information related to provider shortages and barriers to access such as transportation, cost, and appointment wait-times, as well as challenges related to culture, language and health literacy. Lack of access to health care services was ranked as the second leading health issue among low income survey respondents and the third leading health concern for those in Stamford.

RESOURCES AND USE OF HEALTHCARE SERVICES

Nearly all survey respondents (92%) in Lower Fairfield County reported having a primary care provider (PCP) or regular doctor, compared to 85.7% for the County as a whole and 88.3% for the State. A disparity exists, however, for the low income and racial/ethnic minority populations of the region who, with reported rates of 87%, were less likely to have a regular doctor or PCP. (Note: only 74% of low income participants in the convenience survey reported having a regular doctor or PCP).

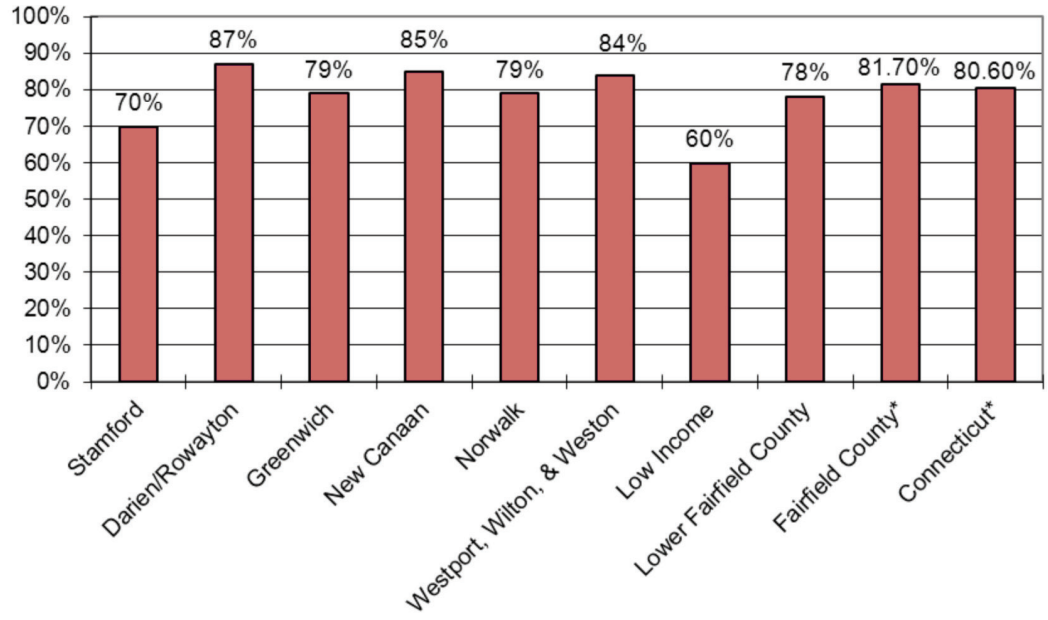
Figure 54: Percentage of People with Regular PCP or Personal Doctor In Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011



SOURCE: 2011 Lower Fairfield County Community Health Survey; *2010 Connecticut Behavioral Risk Factor Surveillance System (BRFSS)

Low income and racial/ethnic minority populations were also much less likely than residents of Lower Fairfield County to have had a routine dental care visit in the past 12 months. As seen in Figure 55, only 60% of the low income population reported a routine dental care visit in the past 12 months, vs. 78% in Lower Fairfield County overall, and 80.6% at the State level. (Note: only 50% of low income participants in the convenience survey reported a routine dental visit in the past 12 months). It is also worth noting the significantly lower rate reported in Stamford (70%).

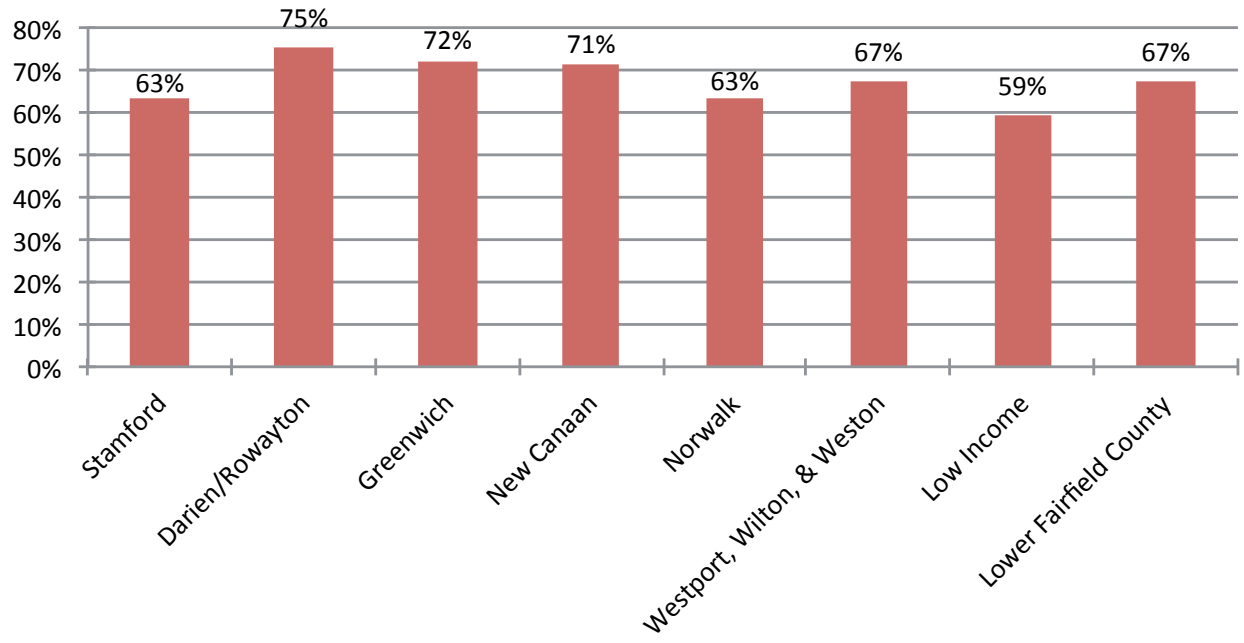
Figure 55: Percentage of Population that Visited a Dentist in the Past 12 Months in Connecticut, Lower Fairfield County, Lower Fairfield County and Towns, 2011



SOURCE: 2011 Lower Fairfield County Community Health Survey; *2010 Connecticut Behavioral Risk Factor Surveillance System (BRFSS)

Low income and racial/ethnic minority populations were also less likely to access medical specialty care services in the past 12 months. Given that the morbidity and mortality rates due to chronic medical conditions are substantially higher in these populations, this finding is particularly noteworthy.

Figure 56: Specialty Care Utilization in Past 12 Months in Lower Fairfield County and Towns, 2011



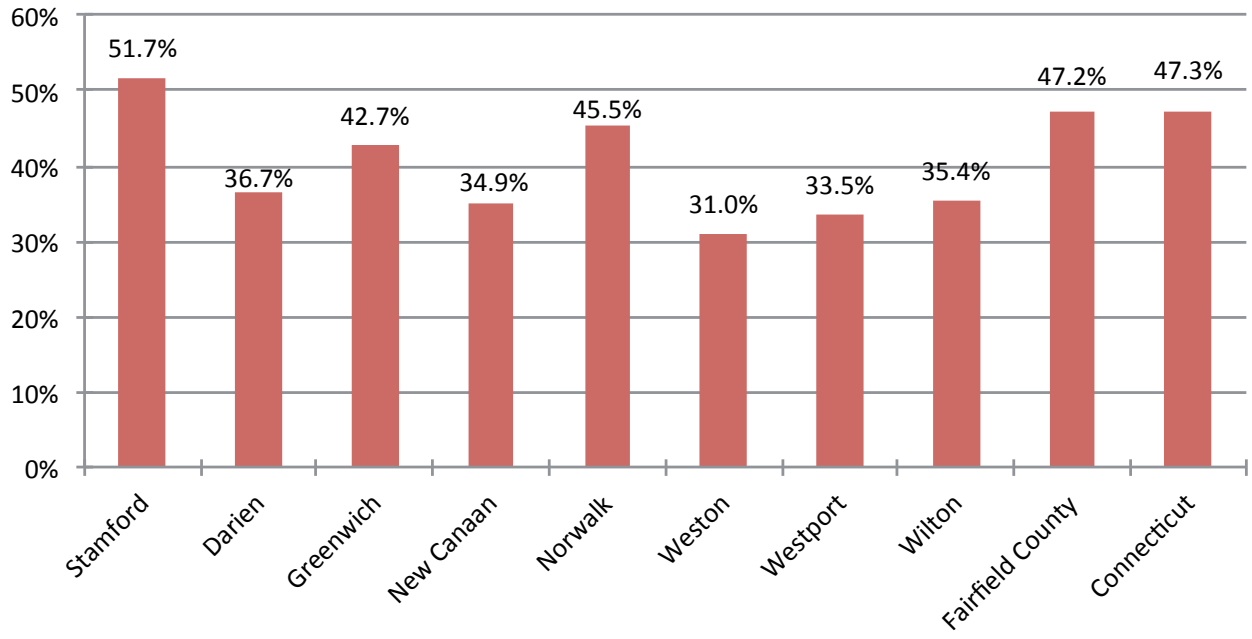
Source: 2011 Lower Fairfield County Community Health Survey

Overall, 67% of residents in Lower Fairfield County had seen a medical specialty care provider in the past 12 months, compared to 59% of low income populations. Lower rates were also seen in Stamford and Norwalk, with 63% of respondents in each town reporting specialty care utilization in the last 12 months.

EMERGENCY ROOM UTILIZATION AND HOSPITALIZATIONS

As seen in Figure 57, 52% of all hospital emergency visits in Stamford were either non-emergent, emergent but primary care treatable, or emergent but preventable. Although this percentage is only slightly higher than the County's and State's rate (47%), it is still relatively high and points to the need to strengthen the primary care system. It is worth noting the substantially lower rates in Darien, New Canaan, Weston, Westport and Wilton – ranging from 31% - 36.7% of ED visits being either non-emergent, emergent but primary care treatable, or emergent but preventable.

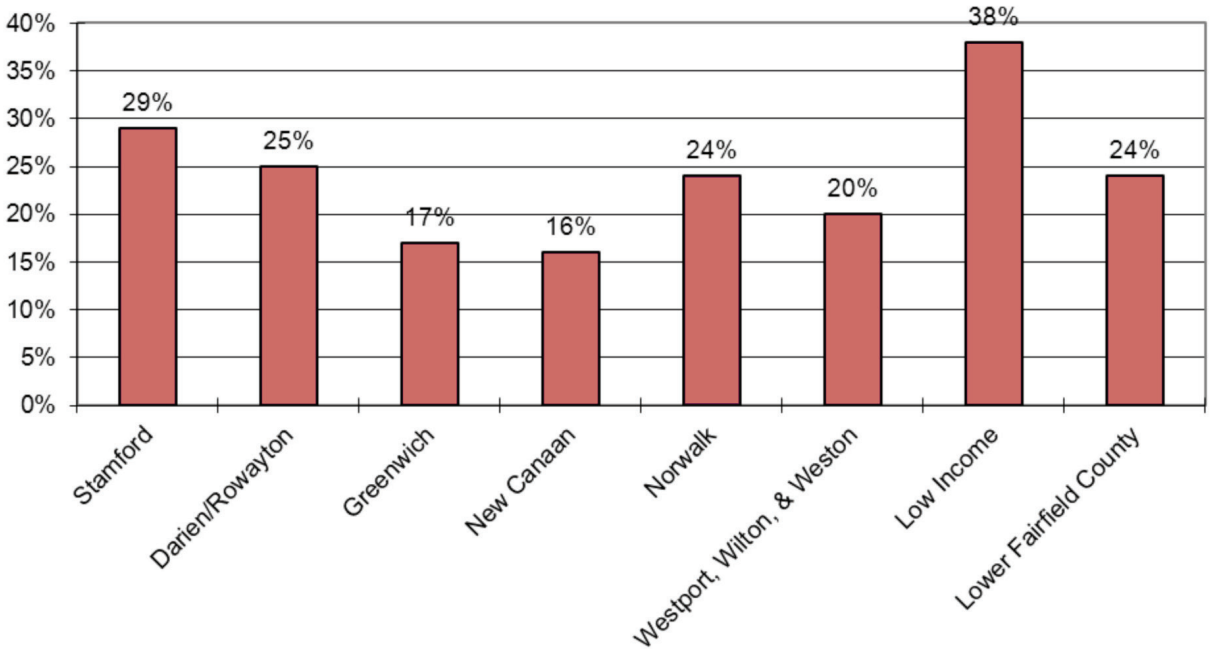
Figure 57: Non-Emergent; Emergent, Primary Care Treatable; and Emergent, ED care needed, preventable (ED discharges) in Connecticut, Fairfield County and Lower Fairfield County Towns, 2009



Source: 2009 CHIME Data

Low income respondents to the survey were more likely to report a hospital emergency department visit in the last 12 months. Nearly 40% of low income residents had been to the emergency room in the past 12 months compared to 24% for the Lower Fairfield County region overall. The higher rates in Stamford (29%) are also worth noting.

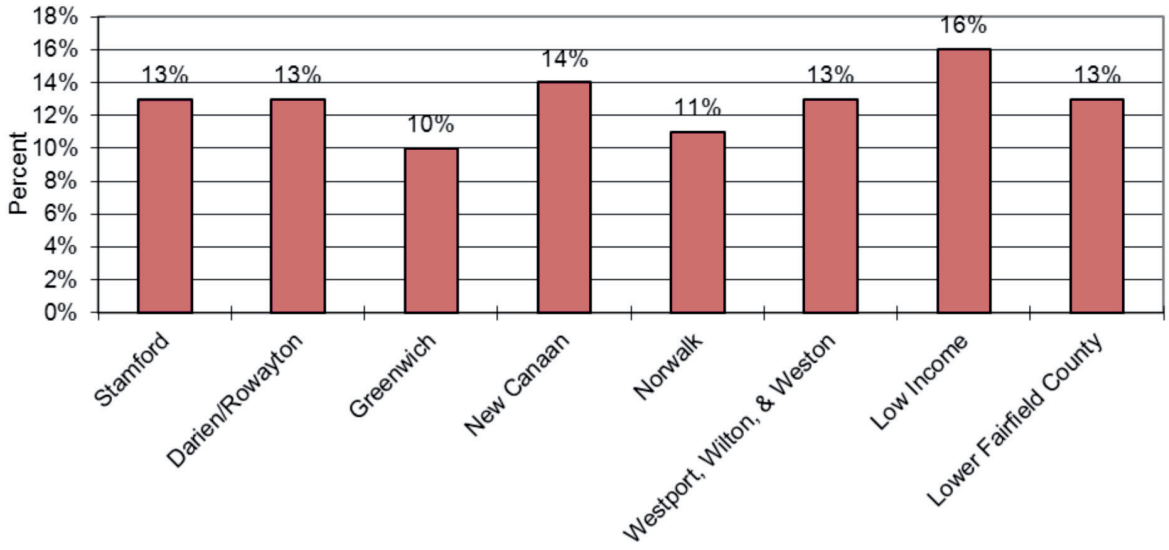
Figure 58: Emergency Room Utilization in Past 12 Months in Lower Fairfield County and Towns, 2011



Source: 2011 Lower Fairfield County Community Health Survey

Low income respondents to the survey were also more likely to report an overnight hospital stay in the past 12 months. Overall, 13% of Lower Fairfield County residents reported a hospital overnight stay, compared to 16% of low income populations. (Note: 30% of low income participants in the convenience survey reported a hospital overnight stay).

Figure 59: People Who Have Stayed Overnight in Hospital in Past 12 Months in Lower Fairfield County and Towns, 2011



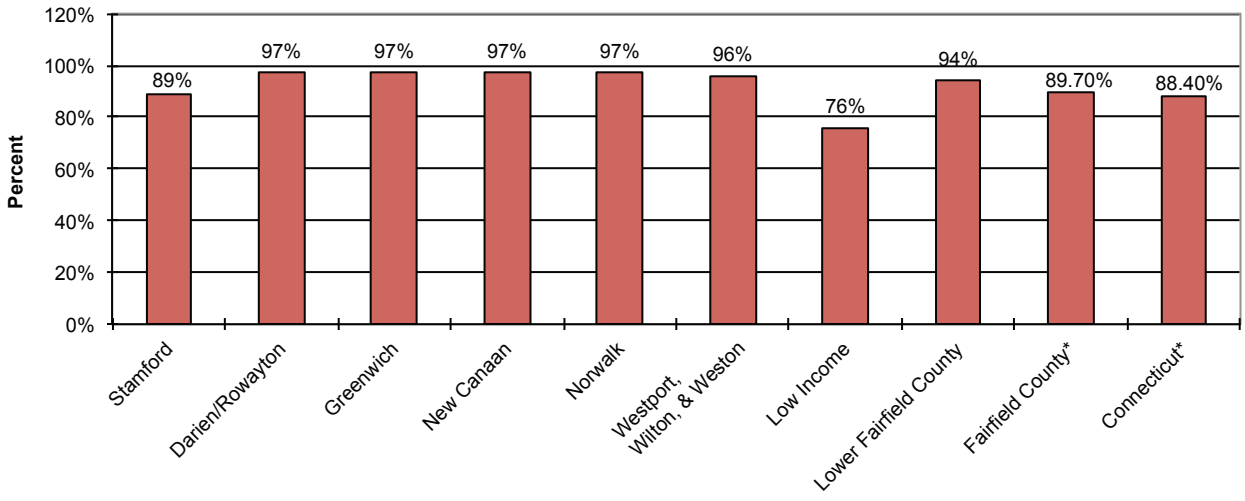
Source: 2011 Lower Fairfield County Community Health Survey

CHALLENGES TO ACCESSING HEALTH CARE SERVICES

Insurance Coverage

Lower Fairfield County residents overall are more likely than residents throughout the State and County to have medical health insurance. However, low income and racial/ethnic minority populations are much less likely to be insured. Ninety-four percent (94%) of residents surveyed in Lower Fairfield County reported being currently insured compared to 89.7% in the County overall, 88.4% for the State, and only 76% of those living in low income households.

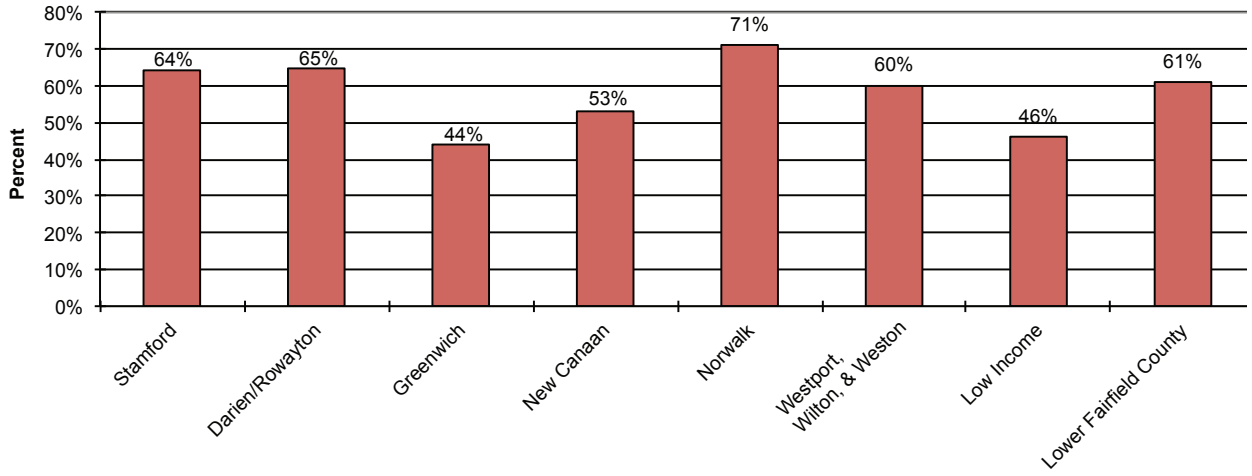
Figure 60: Percentage of Adults 18-64 Currently Insured in Connecticut, Fairfield County, Lower Fairfield County and Towns, 2011



Source: 2011 Lower Fairfield County Community Health Survey; *2010 Connecticut Behavioral Risk Surveillance System (BRFSS)

The disparities among low income and racial and ethnic minority populations exist for dental coverage as well, though a much smaller percentage of residents in Lower Fairfield County have dental insurance. Overall, 61% of survey residents reported having dental insurance coverage, versus only 46% of low income residents. The lower rates of coverage reported in Greenwich (44%) and New Canaan (53%) are also worth noting.

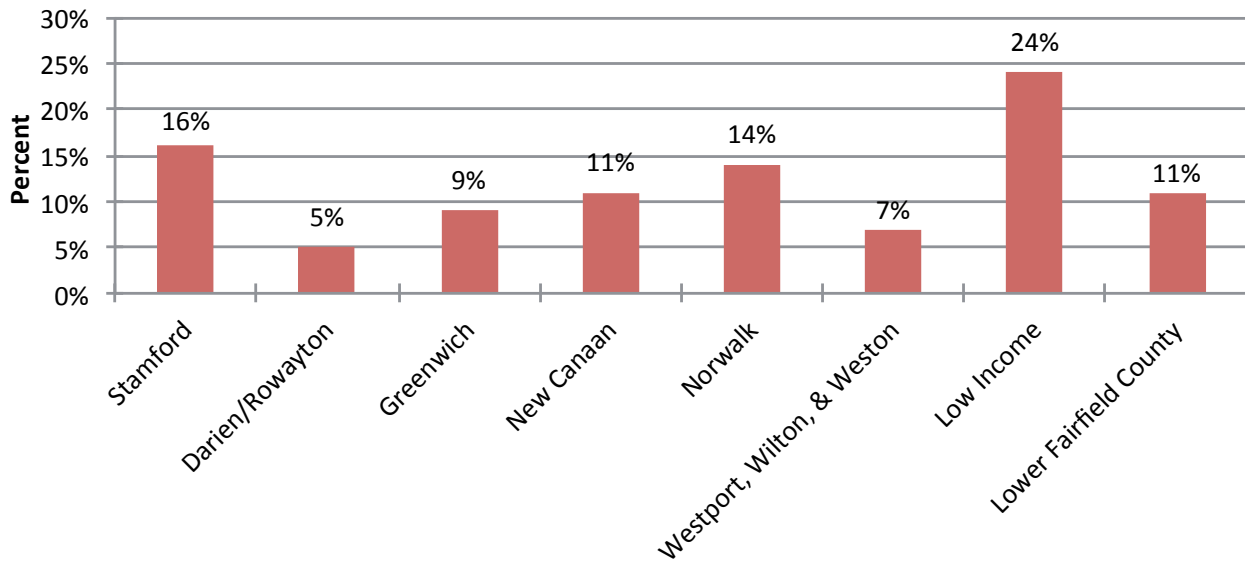
Figure 61: Percentage of Population That Has Dental Insurance in Lower Fairfield County and Towns, 2011



Source: 2011 Lower Fairfield County Community Health Survey

While a high percentage of Lower Fairfield County survey respondents reported having prescription insurance coverage (93%), there were still significant proportions of respondents across the region and across racial/ethnic groups who were unable to get a medication prescription filled due to cost. Overall, 11% of survey respondents were unable to get a prescription filled due to cost, with higher disparities seen in the low income population (24%) and in the city of Stamford (16%).

Figure 62: People Who Could not Get Prescription Filled in Past 12 Months Due to Cost in Lower Fairfield County and Towns, 2011



Source: 2011 Lower Fairfield County Community Health Survey

BARRIERS TO ACCESS

Based on survey responses, key informant interviews, and community listening sessions, the most significant barrier to access is the cost of co-pays, deductibles, and out-of-pocket expenses (both for insured or uninsured residents).

The second most common barrier reported by survey respondents, interviewees and listening session participants was transportation, particularly for older adults and low income residents.

Cultural, linguistic, and health literacy barriers were also cited as major concerns, particularly by health and social service providers and the patient advocacy organizations involved in the assessment.

COMMUNITY HEALTH PRIORITIES

Once all of the assessment's findings were compiled, the Steering Committee participated in a comprehensive strategic planning process. The Steering Committee convened a strategic planning retreat to: 1) agree on a series of County-wide, community health priorities, 2) identify demographic and socio-economic target populations and 3) develop a menu of potential core strategies that would guide their program development efforts over the next three years.

After reviewing the breadth of data that was compiled during this assessment, the Steering Committee identified four community health priority areas: 1) Health and Wellness, 2) Chronic Disease, 3) Mental Health/Substance Abuse (Behavioral Health) and 4) Access to Services. Figure 63 provides additional detail regarding the scope of each of the four priority areas.

Figure 63: Community Health Priorities

After vetting the priorities with key stakeholders for their input during two community listening sessions, four workgroups were created (one for each priority area) to develop a series of goals and objectives, as well as a set of core strategies geared toward addressing the issues identified in the CHNA.

Input from the four workgroups was combined and analyzed by management of Stamford Hospital who, in turn, prepared the Stamford Hospital Community Action Plan for Population Health and Prevention. A copy of which can be found in Appendix 15.

TARGET POPULATIONS

Successful community health interventions are typically targeted at specific communities or segments of the population in order to ensure that the activities are tailored to the specific interests, motivating factors, and cultural or linguistic needs of a particular community or group. Targeting interventions on specific communities or population segments also allows one to focus resources on those most at-risk and those who are most likely to demonstrate an impact. With this in mind, one of the key findings from the assessment was that low income and racial/ethnic minority populations faced major disparities in access and health outcomes, across nearly all of the leading health care indicators.

Stamford Hospital, the local health department, and many of the region's leading health and social service organizations have a broad mission to serve the community as a whole, and certainly many of strategic and programmatic initiatives that arise because of this assessment will be aimed at improving the health and well-being of all residents throughout the Lower Fairfield County region. However, special emphasis will be placed on low income and racial/ethnic minority populations as the Action Plan is implemented.

CONCLUSION

With the completion of the Lower Fairfield County Community Health Needs Assessment, Stamford Hospital analyzed a wide range of data obtained from primary and secondary sources, as well as through key informant interviews, to identify the most pressing health needs in the region. Utilizing the social determinants of health framework, the hospital was able to take a broader view of what defines the health of the communities it serves – analyzing pertinent data on demographics, health behaviors, health outcomes, and access to services.

Lower Fairfield County is one of the most affluent regions in the country, with a rich array of resources to support community health and wellness. Yet, a closer look at the data shows a number of disparities for low income and minority populations – populations that are growing in the towns of Stamford and Norwalk. These disparities range from educational attainment to access to affordable housing, as well as higher rates of chronic disease, and less access to primary, preventative, and specialty care services.

Stamford Hospital's mission is to provide a broad range of high quality health and wellness services focused on the needs of our patients. To have the greatest impact, we also acknowledge the importance of working in collaboration with key partners in the community including other health care providers, community based organizations, and our local health departments to address the priorities identified through the CHNA. With the implementation of the Action Plan, and ongoing assessment of many of the key metrics highlighted in this report, the hospital and its partners will work to ensure that the future delivery of programs and services is having a positive, measurable impact on improving community health.

APPENDICES

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Stamford
Community Health Needs Assessment

Sponsored by Stamford Hospital and the Stamford Department of Health and Social Services

NOTE: It is important that this survey be filled out by the adult (18 years or older) in the household whose birthday is coming up next.

(This is important so we can accurately represent all ages of people in your community)

Si usted habla Español y prefiere tener una copia de esta encuesta en Español, por favor llame gratis a JSI al 877-361-1814, deja un mensaje con tu nombre complete y tu direccion, y una copia de esta encuesta en Español se le enviará por correo.

If you need additional assistance in completing this survey please call Torie Pascoe at JSI: 617-482-9485.

October 2011

JSI

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Stamford Community Health Needs Assessment Survey

INSTRUCTIONS AND INFORMATION FOR COMPLETING THE SURVEY
PLEASE READ CAREFULLY

Thank you for your willingness to complete this important survey. This survey is part of the Stamford Community Health Needs Assessment. Your responses to this survey will be very helpful as Stamford Hospital and the City of Stamford identify primary health concerns and explore ways that the Hospital, health and social service agencies, and the community at-large can work together to improve the health and well-being of the residents.

Your responses are completely confidential and your participation is voluntary. Information will never be presented in a way that could identify individual respondents. Questionnaires will be destroyed after the results have been compiled.

- If there is any question that you would prefer not to answer, you can skip over it. However, your response to each question is important to the project.
- **The adult (18 years or older) in the household whose birthday is coming up next should complete this survey.** This will help us to ensure that we obtain a representative sample of adults living in the City of Stamford. As the adult whose birthday is coming up next, answer questions with respect to yourself, such as your age and your sex.
- There are sections of the survey that will ask questions about different members of your household. In some sections, you will be asked to answer questions about children or older adults in your household. You should feel free to consult with other household members for information when completing the survey.
- If you need assistance filling out the survey due to poor eye sight or difficulty reading, then please ask another person in your household to help you read the survey and respond to each question. However, make sure that you are still answering questions specific to yourself (the adult in the household with the next upcoming birthday).

incorrect marks	correct mark	**Fill in circles darkly and completely.**
		

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Section A: Sociodemographics

First we would like to find out some things about your background so that we can compare needs for people like yourself to other groups in the community.

A1. What is your age? ☐☐ years

A2. What is your sex?

○ Male ○ Female

A3. Do you consider yourself to be:

○ Heterosexual/straight ○ Bisexual
○ Gay/Lesbian ○ Unsure
○ Choose not to answer

A4. Are you Hispanic or Latino?

○ Yes ○ No

A5. Which one or more of the following would you say is your race? Mark all that apply.

○ White
○ Black or African American
○ Asian, specify:
  ○ Chinese
  ○ Japanese
  ○ Korean
  ○ Other Asian, specify: _____
○ Native Hawaiian or Other Pacific Islander
○ American Indian or Alaska Native
○ Other _____

A6. How long have you lived in the Lower Fairfield County region?

○ Less than 6 months
○ 6 months to 1 year
○ Greater than1 year to 5 years
○ Greater than 5 years to 10 years
○ More than 10 years

A7. What language(s) do you speak at home? Mark all that apply.

○ English
○ Haitian Creole
○ Portuguese
○ Spanish
○ Other _____

A8. What is your current marital status?

○ Married
○ Divorced/Separated
○ Widowed
○ Never married
○ A member of an unmarried couple

A9. What is the highest grade or year of school that you have completed?

○ Never attended school or only attended kindergarten
○ Grades 1 through 8 (elementary)
○ Grades 9 through 11 (some high school)
○ Grade 12 or GED (high school graduate)
○ College 1 year to 3 years (some college, Associates degree, or technical)
○ College 4 or more years (Bachelors degree, Masters degree, or beyond)

A10. Check the <u>one</u> answer that best describes your current employment status.

○ Employed for wages
○ Self-employed
○ Out of work for <u>more</u> than 1 year
○ Out of work for <u>less</u> than 1 year
○ A homemaker
○ A student
○ Retired
○ Unable to work

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Section A: Sociodemographics

A11. How many children (younger than 18 years of age) live in your household?

☐☐ number of children

A12. If one or more children live in your household, then what is the age of each child?

- ○ Child #1 ☐☐ years
- ○ Child #2 ☐☐ years
- ○ Child #3 ☐☐ years
- ○ Child #4 ☐☐ years
- ○ Child #5 ☐☐ years

A13. How many members of your household, including yourself, are 18 years or older?

☐☐ number of individuals

A14. Please indicate your total annual household income (before taxes) including all sources and types of income (i.e., wages, public assistance, child support, interest income, social security, stocks, rental income, trust funds) earned by all individuals in your household.

- ○ $0 - $14,999
- ○ $15,000 - $24,999
- ○ $25,000 - $34,999
- ○ $35,000 - $49,999
- ○ $50,000 - $74,999
- ○ $75,000 - $124,999
- ○ $125,000 - $249,999
- ○ $250,000 - $349,999
- ○ $350,000 or more

Section B: Access to Medical Care

B1. During the past 12 months, was there any time that you did <u>not</u> have any health insurance/coverage?

○ Yes ○ No

B2. If you do not currently have health insurance or you have <u>not</u> had insurance at any time in the past 12 months, what are the reasons why? Mark all that apply.

- ○ My employer does not offer it
- ○ I am self-employed
- ○ I am currently unemployed
- ○ I can't afford insurance
- ○ I am healthy and don't think I need it
- ○ Other _____

B3. Do you currently have health insurance/coverage?

- ○ Yes
- ○ No **(go to Question B6 on pg. 3)**

B4. What kind of health insurance do you currently have?

- ○ Medicare
- ○ Medicaid (i.e., Medicaid, Husky A/B, Medicaid for low income adults)
- ○ Other public plan (i.e., Charter Oak Health Plan)
- ○ The military, CHAMPUS, TriCare, or VA
- ○ Managed care plan (HMO, PPO) (e.g., Anthem Blue Cross/Blue Shield, United Healthcare, ConnectiCare)
- ○ Other Private Insurance

B5. With your current health insurance plan, do you have prescription drug coverage, which covers a share of the cost of prescription drugs?

○ Yes ○ No

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Section B: Access to Medical Care

Primary care physicians (also known as family practice or internal medicine doctors) are usually the doctors people go to first if they have health care needs or problems. They manage care for their patients, including referrals to specialist physicians.

B6. Do you have at least one person you think of as your personal doctor or primary care provider?

○ Yes ○ No

B7. If yes, what type of primary care provider do you usually see?

○ Family Practitioner
○ Internist
○ OB/GYN
○ Other

B8. Do you have one place (clinic, hospital, practice) that you usually go to for primary care?

○ Yes ○ No

B9. If yes, where do you usually go for primary care services?

○ Private physician's office
○ Health Clinic
○ Emergency Room
○ Urgent Care/Immediate Care Center
○ Other (please specify: _____)

B10. About how long has it been since you last visited a primary care provider for a routine check-up?

○ Anytime less than 12 months ago
○ Greater than 1 year but less than 2 years ago
○ Greater than 2 years but less than 5 years ago
○ 5 or more years ago
○ Never **(go to Question B12)**

B11. In which community did you usually get primary care services?

○ Cos Cob ○ Riverside
○ Darien ○ Rowayton
○ Greenwich ○ Stamford
○ New Canaan ○ Weston
○ Norwalk ○ Westport
○ Old Greenwich ○ Wilton
○ Other, (please specify: _____)

B12. In the last 12 months, how many times did you go to an emergency room to receive medical care?

○ None ○ 1-2 ○ 3-4 ○ 5 or more

Specialty care physicians are trained in identifying and treating diseases and conditions of particular parts of the body (e.g., a cardiologist treats conditions related to the heart; a dermatologist treats conditions and diseases of the skin). Most times you need a referral from your primary care doctor if you want to see a specialist for a particular problem.

B13. Did you need services from a specialty care physician in the past 12 months?

○ Yes
○ No **(go to Question B16 on pg.4)**

B14. What kind of specialty care did you need?

○ Cardiology (* heart)
○ Dermatology (* skin)
○ Endocrinology (* hormonal system, diabetes, metabolic disorders)
○ Neurology (* nervous system, brain disorders, stroke)
○ OB/GYN (* female reproductive system)
○ Oncology (cancer care)
○ Orthopedics (* bones and muscles)
○ Pain Management
○ Pulmonology (* lungs)
○ Rheumatology (arthritis, * joints)
○ Urology (* urinary system, prostate)
○ Other, (please specify: _____)

*diagnosis and treatment of diseases of the

Section B: Access to Medical Care

B15. In which community did you get specialty services (in the past 12 months)?

- ○ Cos Cob
- ○ Darien
- ○ Greenwich
- ○ New Canaan
- ○ Norwalk
- ○ Old Greenwich
- ○ Riverside
- ○ Rowayton
- ○ Stamford
- ○ Weston
- ○ Westport
- ○ Wilton
- ○ Other, (please specify: _____)

B16. Did you stay in a hospital overnight for care or observation in the past 12 months?

- ○ Yes
- ○ No **(go to Question B18)**

B17. In which hospital did you have your overnight visit (in the past 12 months)?

- ○ Greenwich Hospital
- ○ Norwalk Hospital
- ○ Stamford Hospital
- ○ Yale-New Haven Hospital
- ○ Saint Vincent's Medical Center
- ○ Other, (please specify: _____)

B18. Did you receive all of the health services you needed in the past year, including primary care, specialty care, etc.?

- ○ Yes **(go to Question B20)**
- ○ No

B19. What is the main reason(s) you did not get care that you needed? Mark all that apply.

- ○ Cost of visits, co-payments, deductibles
- ○ Did not have health insurance
- ○ Did not have a doctor or primary care provider
- ○ Could not find a doctor or primary care provider willing to serve me
- ○ Do not feel comfortable with or trust my primary care doctor
- ○ Did not have transportation/could not get to the doctor
- ○ Wait time for an appointment too long
- ○ Afraid of getting bad news
- ○ No reason to go/no health problems
- ○ Other reasons, please specify:

_____

B20. How many, if any, different prescription medications are you currently taking?

☐☐ prescription medications

B21. How many, if any, different non-prescription medications are you currently taking that are doctor-recommended, like aspirin?

☐☐ non-prescription drugs that are doctor-recommended

B22. Was there a time during the past 12 months when you needed to fill a drug prescription or to buy a doctor-recommended non-prescription drug, but could not because of cost?

- ○ Yes ○ No

B23. Do you currently have dental insurance/coverage?

- ○ Yes ○ No

B24. How long has it been since you last visited a dentist or dental clinic for any reason?

- ○ Anytime less than 12 months ago **(go to Question C1 on pg. 5)**
- ○ Greater than 1 year but less than 2 years ago
- ○ Greater than 2 years but less than 5 years ago
- ○ 5 or more years ago
- ○ Never

B25. What was the main reason(s) you did not visit the dentist in the past year? Mark all that apply.

- ○ Cost of visits, co-payments, deductibles
- ○ Did not have dental insurance
- ○ Did not have a dentist or dental provider
- ○ Could not find a dentist or dental provider willing to serve me
- ○ Do not feel comfortable with or trust my dentist or dental provider
- ○ Did not have transportation/could not get to the dentist
- ○ Wait time for an appointment too long
- ○ Afraid of getting bad news
- ○ No reason to go/no oral health problems
- ○ Other reasons, please specify:

_____ ☐

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Section C: Health Behaviors/Lifestyle

C1. How tall are you?

☐ **feet** ☐☐ **inches**

C2. How much do you weigh?

☐☐☐ **pounds**

The next questions are about physical activities or exercise you may do in your free time for 10 minutes or more, other than walking.

C3. During the last 7 days, did you do any moderate physical activities (e.g., mowing the lawn, bicycling on level roads) in your free time for 10 minutes or more, other than walking? Moderate physical activities make you break a sweat and raise your heart rate, but you're still able to carry on a conversation.

○ Yes
○ No **(go to Question C6)**

C4. For how many days did you do this in the last 7 days?

○ 1 day
○ 2 days
○ 3 days
○ 4 days
○ 5 days
○ 6 days
○ 7 days

C5. On average, how many minutes did you spend doing moderate physical activities in your free time on those days?

☐☐☐ **average minutes per day**

Now think about vigorous activities you did in your free time that take hard physical effort, such as aerobics, running, soccer, spinning/fast bicycling, or fast swimming.

C6. During the last 7 days, did you do any vigorous physical activities in your free time for 10 minutes or more, other than walking? Vigorous activities make you breathe much harder than normal and raise your heart rate significantly.

○ Yes
○ No **(go to Question C9 on pg. 6)**

C7. For how many days did you do this in the last 7 days?

○ 1 day
○ 2 days
○ 3 days
○ 4 days
○ 5 days
○ 6 days
○ 7 days

C8. On average, how much time did you spend doing vigorous physical activities in your free time on those days?

☐☐☐ **average minutes per day**

Section C: Health Behaviors/Lifestyle

Now think about all the foods you ate or drank during the past 30 days, including meals and snacks.

C9. How many times a day do you usually eat fruit or drink 100 % fruit juices (such as orange, grapefruit or tomato)?

- ○ 0 times per day
- ○ 1 time per day
- ○ 2 times per day
- ○ 3 times per day
- ○ 4 times per day
- ○ 5 or more times per day

C10. How many times a day do you usually eat green salad, potatoes (not including French fries, fried potatoes or potato chips), carrots, or other vegetables? Do not include rice because it is not a vegetable.

- ○ 0 times per day
- ○ 1 time per day
- ○ 2 times per day
- ○ 3 times per day
- ○ 4 times per day
- ○ 5 or more times per day

The next few questions are about lifestyle and behaviors, such as smoking, drinking alcoholic beverages, and use of illegal substances/drugs. We want to again reassure you that your answers to these questions will be kept completely confidential.

C11. Have you smoked at least 100 cigarettes, or 5 packs, in your entire life?

- ○ Yes
- ○ No **(go to Question C16 on pg. 7)**

C12. Do you currently smoke cigarettes every day, some days or not at all?

- ○ Every day
- ○ Some days
- ○ Not at all **(go to Question C16 on pg. 7)**

C13. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?

○ Yes ○ No

C14. Are you considering quitting smoking within the next 6 months?

- ○ Yes
- ○ No **(go to Question C16 on pg.7)**

C15. Are you seriously planning to quit smoking within the next 30 days?

○ Yes ○ No

Section C: Health Behaviors/Lifestyle

C16. During the past 30 days, have you had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor? One drink is equivalent to a 12 ounce beer, a 5 ounce glass of wine, or a drink with one shot of liquor.

○ Yes
○ No **(go to Question C21)**

C17. During the past 30 days, how many days did you have at least one drink of any alcoholic beverage?

☐☐ **Days in the past 30 days**

C18. On the days when you drank alcohol, during the past 30 days, about how many drinks did you drink on average?

☐☐ **Number of drinks**

C19. Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 or more drinks (if you are a man) or 4 or more drinks (if you are a woman) on any one occasion?

☐☐ **Number of times in the past 30 days**

C20. During the past 30 days, what is the largest number of drinks you had on any occasion?

☐☐ **Number of drinks**

C21. In the past 12 months, have you used marijuana?

○ Yes ○ No

C22. In the past 12 months, have you used cocaine or crack?

○ Yes ○ No

C23. In the past 12 months, have you used heroin?

○ Yes ○ No

C24. In the past 12 months, have you used any other illegal drugs or substances?

○ Yes
○ No
(Please specify): _____

C25. In the past year, have you used any of the below medicines or drugs on your own? "On your own" means either without a doctor's prescription, in larger amounts than prescribed, or for a longer period than prescribed. Mark all that apply.

○ Sedatives (e.q., sleeping pills, barbiturates, Seconal, Quaalude)
○ Tranquilizers or anti-anxiety drugs (e.g., Valium, Librium, muscle relaxants, Xanac)
○ Painkillers (e.g., Codeine, Darvon, Percocet, Dilaudid, Demerol, Morphine, Vicodin, Oxycontin)
○ Stimulants (e.g., Preludin, Benzadrine, Methadrine, uppers, speed, amphetamines, Ritalin)
○ I haven't used any of the above drugs in the past year on my own

Section C: Health Behaviors/Lifestyle

C26. In the past month, have you driven a car within two hours after drinking any alcoholic beverages or using any illegal drugs (e.g., marijuana, cocaine, heroin)?

○ Yes ○ No

C27. In the past month, have you been in the car with a driver who drank any alcoholic beverages or used any illegal drugs (e.g., marijuana, cocaine, heroin) within the previous two hours?

○ Yes ○ No

C28. How often do you use seat belts when you drive or ride in a car?

○ Always ○ Nearly always ○ Sometimes ○ Seldom ○ Never

C29. In the past 12 months, has a doctor, nurse or other health professional treated you for Lyme disease?

○ Yes ○ No

C30. Do you feel that you know how to reduce your risk of becoming infected with Lyme disease?

○ Yes, know a lot about it
○ Yes, know something about it
○ No, know very little about it

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Section D: Chronic Disease and Prevention

This next section asks about several medical conditions you might have.

D1. Have you ever been told by a doctor, nurse or other health professional that you have diabetes?

○ Yes
○ No **(go to Question D8 on pg. 10)**

D2. Are you now taking insulin?

○ Yes ○ No

D3. Are you now taking diabetes pills?

○ Yes ○ No

D4. In the past 30 days, how often did you check your blood level for glucose or sugar? Include times when checked by a family member or friend, but do not include times when checked by a health professional.

☐☐☐ **Times in the past 30 days**

D5. About how many times in the past 12 months have you seen a doctor, nurse, or other health professional for your diabetes?

☐☐ **Number of times**

D6. A test for "A1C" measures the average level of blood sugar over the past three months. About how many times in the past 12 months has a doctor, nurse, or other health professional checked you for hemoglobin A1C?

☐☐ **Number of times**

○ Never heard of hemoglobin A1C test

D7. When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light.

○ Anytime less than 1 month ago
○ Greater than 1 month but less than 1 year ago
○ Greater than 1 year but less than 2 years ago
○ 2 or more years ago
○ Never had an eye exam in which the pupils were dilated

Section D: Chronic Disease and Prevention

D8. Have you ever been told by a doctor, nurse or other health professional that you have asthma?

○ Yes
○ No **(go to Question D11)**

D9. During the past 3 months, have you used prescription inhalers (not including over-the-counter inhalers like Primatene Mist)?

○ Yes ○ No

D10. During the past 12 months, have you had to visit an emergency room or urgent care center / immediate medical care center because of asthma?

○ Yes ○ No

D11. Have you ever been told by a doctor, nurse or other health professional that you have hypertension or high blood pressure?

○ Yes
○ Yes, but only during pregnancy **(go to Question D13)**
○ Told borderline high or pre-hypertensive
○ No **(go to Question D13)**

D12. Are you currently taking medicine for your high blood pressure or hypertension?

○ Yes ○ No

D13. Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse or other health professional that you have high blood cholesterol?

○ Yes
○ No **(go to Question D16 on pg. 11)**

D14. About how long has it been since you last had your blood cholesterol checked?

○ Anytime less than 12 months
○ Greater than 1 year but less than 2 years ago
○ Greater than 2 years but less than 5 years ago
○ 5 or more years ago
○ Never

D15. Are you currently taking medicine to lower your cholesterol, like Lipitor™, Zocor ™, Pravachol™, or Simvastatin™?

○ Yes ○ No

Section D: Chronic Disease and Prevention

D16. Have you ever been told by a doctor, nurse or other health professional that you had a heart attack, also called a myocardial infarction?

○ Yes
○ No **(go to Question D18)**

D17. Were you prescribed a beta-blocker, such as Atenolol or Metoprolol, after you were treated for your heart attack?

○ Yes ○ No

D18. Have you ever been told by a doctor, nurse or other health professional that you have angina or coronary heart disease?

○ Yes ○ No

D19. Have you ever been told by a doctor, nurse or other health professional that you had a stroke?

○ Yes ○ No

D20. A flu shot is an influenza vaccine injected into the arm. During the past 12 months, have you had a flu shot?

○ Yes ○ No ○ Don't know/Not sure

D21. A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the flu shot. Have you ever had a pneumonia shot?

○ Yes ○ No ○ Don't know/Not sure

D22. Have you ever been told by a doctor, nurse or other health professional that you had cancer?

○ Yes
○ No **(go to Question D24 on pg. 12)**

D23. What type of cancer(s) were you diagnosed as having? Mark all that apply.

○ Lung
○ Colorectal
○ Prostate
○ Breast
○ Cervical, ovarian, or uterine
○ Pancreatic
○ Stomach or esophageal
○ Liver/bile duct
○ Urinary/bladder
○ Non-Hodgkin lymphoma
○ Leukemia
○ Thyroid
○ Oral cavity/pharynx
○ Melanoma (skin)
○ Other, please specify:

_____

Section D: Chronic Disease and Prevention

The next few questions are about cancer screening. Cancer screening tests help detect cancer at an early stage when it is still treatable and can help you live longer. Some tests everybody can get (like blood stool tests, sigmoidoscopy and colonoscopy for colorectal cancer), some tests are specific to men (like PSA and DRE tests for prostate cancer) and some tests are specific to women (like mammography for breast cancer and Pap tests for cervical cancer). Please make sure to answer the questions below that are appropriate for you based on your gender.

D24. A blood stool test is a test for colorectal cancer that may use a special kit at home to determine whether the stool contains blood. Have you ever had this test using a home kit?

- ○ Yes
- ○ No **(go to Question D26)**
- ○ Don't know/Not sure **(go to Question D26)**

D25. How long has it been since your last blood stool test using a home kit?

- ○ Anytime less than 12 months ago
- ○ Greater than 1 year but less than 2 years ago
- ○ Greater than 2 years but less than 3 years ago
- ○ Greater than 3 years but less than 5 years ago
- ○ 5 or more years ago

D26. Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of colorectal cancer or other health problems. Have you ever had either of these exams?

- ○ Yes
- ○ No **(if you are a woman go to Question D28 on pg. 13; if you are a man go to Question D33 on pg. 14)**
- ○ Don't know/Not sure **(if you are a woman go to Question D28 on pg. 13; if you are a man go to Question D33 on pg. 14)**

D27. How long has it been since you had your last sigmoidoscopy or colonoscopy?

- ○ Anytime less than 12 months ago
- ○ Greater than 1 year but less than 2 years ago
- ○ Greater than 2 years but less than 5 years ago
- ○ Greater than 5 years but less than 10 years ago
- ○ 10 or more years ago

Section D: Chronic Disease and Prevention

The next few questions are specific to women.
If you are a man, please skip to Question D33 on pg. 14.

D28. A mammogram is a type of x-ray that is taken of each breast to look for breast cancer. Have you ever had a mammogram?

- ○ Yes
- ○ No **(go to Question D30)**
- ○ Don't know/Not sure **(go to Question D30)**

D29. How long has it been since you had your last mammogram?

- ○ Anytime less than 12 months ago
- ○ Greater than 1 year but less than 2 years ago
- ○ Greater than 2 years but less than 3 years ago
- ○ Greater than 3 years but less than 5 years ago
- ○ 5 or more years ago

D30. Have you had a hysterectomy?

- ○ Yes **(go to Question E1 on pg. 15)**
- ○ No

D31. A Pap test is a test for cancer of the cervix. Have you ever had a Pap test?

- ○ Yes
- ○ No **(go to Question E1 on pg. 15)**
- ○ Don't Know/Not sure **(go to Question E1 on pg. 15)**

D32. How long has it been since you had your last Pap test?

- ○ Anytime less than 12 months ago
- ○ Greater than 1 year but less than 2 years ago
- ○ Greater than 2 years but less than 3 years ago
- ○ Greater than 3 years but less than 5 years ago
- ○ 5 or more years ago

Section D: Chronic Disease and Prevention

The next few questions are specific to men.
If you are a woman, please skip to Question E1 on pg. 15.

D33. A Prostate-Specific Antigen test, also called a PSA test, is a blood test used to check men for prostate cancer. Have you ever had a PSA test?

- ○ Yes
- ○ No **(go to Question D35)**
- ○ Don't know/Not sure **(go to Question D35)**

D34. How long has it been since you had your last PSA test?

- ○ Anytime less than 12 months ago
- ○ Greater than 1 year but less than 2 years ago
- ○ Greater than 2 years but less than 3 years ago
- ○ Greater than 3 years but less than 5 years ago
- ○ 5 or more years ago

D35. A digital rectal exam (DRE) is an exam in which a doctor, nurse, or other health professional places a gloved finger into the rectum to feel the size, shape and hardness of the prostate gland. Have you ever had a digital rectal exam?

- ○ Yes
- ○ No **(go to Question E1 on pg. 15)**
- ○ Don't know/Not sure **(go to Question E1 on pg. 15)**

D36. How long has it been since you had your last digital rectal exam?

- ○ Anytime less than 12 months ago
- ○ Greater than 1 year but less than 2 years ago
- ○ Greater than 2 years but less than 3 years ago
- ○ Greater than 3 years but less than 5 years ago
- ○ 5 or more years ago

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Section E: Self-Reported Health Status

E1. Would you say in general your health is:

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

E2. Are you limited in any way in any activities because of physical, mental, or emotional problems?

○ Yes ○ No

E3. Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone? Include occasional use or use in certain circumstances.

○ Yes ○ No

E4. Thinking about your physical health, which includes physical illness or injury, for how many days during the past 30 days was your physical health <u>not good</u>?

☐☐ **days**

E5. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health <u>not good</u>?

☐☐ **days**

E6. During the past 30 days, for about how many days have you felt sad, blue, or depressed?

☐☐ **days**

E7. During the past 30 days, for about how many days have you felt worried, tense, or anxious?

☐☐ **days**

E8. During the past 30 days, for about how many days have you felt you did not get enough rest or sleep?

☐☐ **days**

E9. During the past 30 days, for about how many days have you felt very healthy and full of energy?

☐☐ **days**

E10. Has a doctor or other healthcare provider ever told you that you had an anxiety disorder (including acute stress disorder, anxiety, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, phobia, posttraumatic stress disorder, or social anxiety disorder)?

○ Yes ○ No

E11. Has a doctor or other healthcare provider ever told you that you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?

○ Yes ○ No

Section F: Need, Knowledge and Use of Services

F1. In the past 12 months, have any adults in your household needed any of the following services?

	Didn't need the service	Needed the service and received it	Needed the service, but didn't receive it	Main reason didn't receive services						
				Cost	Transportation	Poor quality	Embarrasment	Confidentiality	Wait time too long	Could not find	Other
a. Alcohol/Drug services (i.e., education, counseling and treatment)	○	○	○	○	○	○	○	○	○	○	○
b. Dental Health Services (i.e., cleaning, assessment and treatment)	○	○	○	○	○	○	○	○	○	○	○
c. Food assistance (i.e., food pantry)	○	○	○	○	○	○	○	○	○	○	○
d. Housing assistance (Assistance in obtaining affordable housing and/or maintaining current residence)	○	○	○	○	○	○	○	○	○	○	○
e. Mental health services (i.e., education, counseling and treatment)	○	○	○	○	○	○	○	○	○	○	○
f. Parenting support	○	○	○	○	○	○	○	○	○	○	○
g. Prenatal care	○	○	○	○	○	○	○	○	○	○	○

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Stamford Hospital currently provides support groups and health education activities in Stamford and Lower Fairfield County. The following questions will help the Hospital identify the needs of the community.

F2. Which of the following support groups would you be interested in participating in? (Choose all that apply).

- ○ ALS (Amyotrophic Lateral Sclerosis or Lou Gehrig's Disease) Support Group
- ○ Alanon (Support for relatives and friends of alcoholics)
- ○ Alcoholics Anonymous
- ○ Alzheimer's Support Group
- ○ Amputee Support Group (For those who have had a limb amputated)
- ○ Bariatric Surgery Support Groups (For those who have had weight loss surgery)
- ○ Cancer Support Group
- ○ Compassionate Friends (Grief support after the death of a child)
- ○ Caring for the Elderly
- ○ Crohn's Disease Support Group
- ○ Depression Support Group
- ○ Caring for the Chronically Ill (Diabetes, COPD, Post Traumatic Brain Injury) Support Group
- ○ Eating Disorders Support Group
- ○ Fibromyalgia Support (For those who suffer from a condition that causes chronic widespread musculoskeletal pain accompanied by fatigue, sleep, memory and mood issues.)
- ○ Grief Support Group
- ○ Happiness Club (Group that helps teens develop and maintain happiness and positivity)
- ○ Muscular Dystrophy Support Group
- ○ Multiple Sclerosis Support Group
- ○ NAMI (National Association for Mentally Ill) Support Group
- ○ Parish Nurse Meetings (Christian ministry community group that works to support the physical, emotional, and spiritual health of its members)
- ○ Parkinson's Disease Support Group
- ○ Pulmonary Arterial Hypertension Support Group (for those who suffer from increased pressure in the pulmonary arteries)
- ○ Rheumatoid Arthritis Support Group
- ○ Scleroderma Foundation Tri-State, Inc
- ○ Weight Loss Support/Education
- ○ Veterans of Foreign Wars
- ○ Other (please specify): _____

F3. Which of the following health education activities would you be interested in participating in? (Choose all that apply)

- ○ Integrative/Alternative Medicine (A holistic approach combining alternative and conventional medical practice that seeks to treat the whole individual)
- ○ Asthma Education
- ○ Cancer Education
- ○ CPR (Cardiopulmonary Resuscitation)
- ○ Elder Health
- ○ Heart Disease Education
- ○ Nutrition and Exercise
- ○ Pain Management
- ○ Prenatal Care
- ○ Smoking Cessation
- ○ Stress Management (Techniques for reducing stress and improving everyday functioning)
- ○ Other (please specify): _____

Section G: Special Subpopulations: Child's Health

The next few questions are for those households with children 17 years old or younger. If your household does not include children, go to Question H1 on pg. 21. Answer these questions for the child in the household with the next upcoming birthday.

G1. Does the child have at least one person you think of as his/her personal doctor or primary care provider?

○ Yes ○ No

G2. If yes, what type of primary care provider does the child usually see?

○ Family Practitioner
○ Pediatrician
○ Other

G3. Does the child have one place (clinic, hospital, practice) where he/she goes for primary care?

○ Yes ○ No

G4. If yes, where does he/she usually go for primary care services?

○ Private physician's office
○ Health Clinic
○ Emergency Room
○ Urgent Care/Immediate Care Center
○ Other (please specify: _____)

G5. About how long has it been since the child last visited a doctor or other provider for a routine check-up, physical examination, or wellness visit?

○ Less than 1 month
○ 1 to 3 months
○ 4 to 6 months
○ 7 to 12 months
○ More than one year

G6. About how long has it been since the child last visited a dentist or other dental provider for any reason?

○ Less than 1 month
○ 1 to 3 months
○ 4 to 6 months
○ 7 to 12 months
○ More than one year

G7. Has the child received all required vaccinations, including MMR (measles, mumps, rubella), DTP (tetanus), Polio, Varicella (chicken pox)?

○ Yes ○ No

G8. Since the child's birth, have you delayed or not gotten him/her immunized because of concerns about the safety of vaccines?

○ Yes ○ No

If the child you are reporting on is 13 years or older (a teenager), please answer the following questions on adolescent mental health. If the child is younger than 13 years, then go to Question G12 on pg. 20.

G9. In the past month, how often was the teen unhappy, sad, or depressed?

○ Never ○ Usually
○ Sometimes ○ Always

G10. In the past month, how often was the teen withdrawn and did not get involved with others?

○ Never ○ Usually
○ Sometimes ○ Always

G11. During the past 12 months, did the teen ever seriously consider attempting suicide or actually attempt suicide (that you know of)?

○ Yes ○ No

Section G: Special Subpopulations: Child's Health

G12. In the past 12 months, have any children (17 years or younger) in your household needed any of the following services? (If there are no children in your household skip to H1, on page 21.)

	Didn't need the service	Needed the service and received it	Needed the service, but didn't receive it	Main reason didn't receive services						
				Cost	Transportation	Poor quality	Embarrasment	Confidentiality	Wait time too long	Could not find	Other
a. Asthma care/services	○	○	○	○	○	○	○	○	○	○	○
b. Autism care/services (i.e., counseling, drug treatment)	○	○	○	○	○	○	○	○	○	○	○
c. ADD/ADHD care/services (i.e., counseling, drug treatment)	○	○	○	○	○	○	○	○	○	○	○
d. Dental Health Services (i.e.,cleaning, assessment, and treatment)	○	○	○	○	○	○	○	○	○	○	○
e. Diabetes health services (i.e., education/counseling, treatment)	○	○	○	○	○	○	○	○	○	○	○
f. Mental health services (i.e., education, counseling and treatment)	○	○	○	○	○	○	○	○	○	○	○

Section H: Special Subpopulations: Older Adult Health

Please answer questions in Section H with respect to the older adult (defined as 65 years or older) in your household with the next upcoming birthday. This may be you (if you're 65 years or older with the next upcoming birthday) or another older adult in your household. If no older adult lives in your household, then skip to Question I1 on pg. 22. This section is only to be answered by those individuals who have an older adult living in the household.

H1. In the past 12 months, have any older adults (65 years or older) in your household needed any of the following services?

	Didn't need the service	Needed the service and received it	Needed the service, but didn't receive it	Main reason didn't receive services						
				Cost	Transportation	Poor quality	Embarrasment	Confidentiality	Wait time too long	Could not find	Other
a. Alzheimer's care/services	○	○	○	○	○	○	○	○	○	○	○
b. Coordination of care after discharge from the hospital, other facility or program	○	○	○	○	○	○	○	○	○	○	○
c. Care for cognitive impairment (i.e., dementia)	○	○	○	○	○	○	○	○	○	○	○
d. Parkinsons care/services	○	○	○	○	○	○	○	○	○	○	○
e. Respite care	○	○	○	○	○	○	○	○	○	○	○
f. Adult day care	○	○	○	○	○	○	○	○	○	○	○
g. Nursing home placement	○	○	○	○	○	○	○	○	○	○	○
h. Assisted living	○	○	○	○	○	○	○	○	○	○	○

H2. If any older adults (65 years or older) in your household have been diagnosed with any of the above health problems, has their care taker had adequate support services?

○ Yes ○ No

H3. In the past 3 months, how many times has the older adult fallen and injured themselves?

☐☐ Times

Section I: Environmental questions

The following questions are about your home.

I1. Have you ever had your house checked for lead?

- ○ Yes
- ○ No
- ○ Don't know/Not sure
- ○ Refused

I2. Have you ever had your house checked for radon?

- ○ Yes
- ○ No
- ○ Don't know/Not sure
- ○ Refused

I3. Do you have a private drinking water well?

- ○ Yes
- ○ No
- ○ Don't know/Not sure
- ○ Refused

I4. When was the last time you had your well water tested for bacteria and/or chemicals?

- ○ Within the past year (1 to 12 months ago)
- ○ Within the past 2 years (1 to 2 years ago)
- ○ Within the past 5 years (2 to 5 years ago)
- ○ 5 or more years ago
- ○ Never
- ○ Don’t know/Not sure
- ○ Refused

I5. How safe do you feel walking in your neighborhood during the day?

- ○ Very safe
- ○ Somewhat safe
- ○ Somewhat unsafe
- ○ Not safe at all
- ○ Don’t know/Not sure
- ○ Refused

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Section J: Perceived Community Health Needs

J1. What do you think are the three (3) most significant health concerns affecting your community?

- ○ Accidental injuries (drowning, choking, home or work-related accidents)
- ○ Asthma
- ○ Birth defects
- ○ Cancer. What type(s)? _____
- ○ Child abuse/neglect
- ○ Diabetes
- ○ Domestic violence
- ○ Gun-related injuries
- ○ Heart disease/heart attacks
- ○ HIV/AIDS
- ○ Infant death
- ○ Infectious/contagious disease (TB, pneumonia, flu, etc.)
- ○ Lack of access to health care (no transportation, cost, not available, etc.)
- ○ Lack of preventive services (cancer screening, vaccines, immunizations, physicals, etc.)
- ○ Lung disease (emphysema, COPD, etc.)
- ○ Mental health issues (depression, schizophrenia, suicide)
- ○ Motor vehicle accidents
- ○ Obesity/overweight
- ○ Poor dental health
- ○ Poor nutrition
- ○ Sexually transmitted diseases (STDs, such as Herpes, Gonorrhea, Chlamydia, etc.)
- ○ Stroke
- ○ Substance abuse issues (alcohol or illicit drug use)
- ○ Teenage pregnancy
- ○ Tobacco use
- ○ Other (please specify):

_____

Thank you for your time and participation in this survey. We want to assure you that your responses are completely confidential and the information from this survey will never be presented in a way that could identify individual respondents.

If you have any questions about this project, please feel free to contact Torie Pascoe at JSI: 617-482-9485.

Please return this survey in the enclosed postage paid envelope or mail to:

John Snow, Inc.
44 Farnsworth Street
Boston, MA 02210

THANK YOU!

Appendix 2: Steering Committee Members

Name	Title	Organization
Cindy Banks	Planning Consultant	Stamford Hospital
Beth Chaty, JD	Director of Planning (through Nov 2012)	Stamford Hospital
Deborah Fedeli	Director of Patient Centered Services	Stamford Hospital
Anne Fountain, MPH	Director of Health and Social Services	City of Stamford
Gregory Kearns, MHA	Director of Planning	Stamford Hospital
Pamela Koprowski	Public Affairs Consultant	Stamford Hospital
Kara Koss, MPH	Planning Analyst	Stamford Hospital
Alec McKinney	Senior Project Director	John Snow, Inc.
David Smith	Senior Vice President, Strategy; Chief Strategy and Network Development Officer	Stamford Hospital
Jeanne Van Lent	Executive Director, Marketing & Corporate Communications	Stamford Hospital

Appendix 3: Advisory Committee Members - Community

Name	Title	Organization
Adele Gordon	Regional Director	Community Health Center, Inc. (FQHC)
Alan Mathis	Executive Director	Liberation Programs
Amy Taylor		Community Health Center, Inc. (FQHC)
Anna Nelson	Executive Director	Stamford Senior Center
Anne Fountain, MPH	Director	Stamford Dept. of Health and Social Services
Bill Callion	Manager, Fairgate Farm	Fairgate Farm
Bob Arnold	Chief Executive Officer	Family Centers, Inc.
Bridget Fox	Executive Director, Volunteer Center	Volunteer Center of SWCT/ United Way
Christina Crain	Deputy Director	SW Area Agency on Aging
Cindy Perjon		DuBois Center
David Knauf, MPH, MS, RS	Director of Health	Town of Darien
David Reed, MD	Medical Director/ Director of Public Health	Town of New Canaan/ Stamford Hospital
Deborah Matthews, PhD	Director, Crisis Service	Child Guidance Center of SW CT
Dennis Torres	Director of Healthcare Programs	Charter Oak Community Family Center Inc.
Donna Spellman	Director of Outreach	Charter Oak Community Family Center Inc.
Emily Goldschmid		Kids in Crisis
Eric Stein	Stamford, Manager	Optimus Health Care, Inc. (FQHC)
Ernest Lamour	Executive Director	YMCA
Eugene Campbell	Executive Director	Yerwood Center
Genalyn Amihan	Clinical Nurse Liaison	Masonicare
Henry Yoon, MD	Medical Advisor	Stamford Dept. of Health and Social Services
Ingrid Gillespie	Director	Lower Fairfield County Regional Action Council (LFCRAC)

Appendix 3: Advisory Committee Members - Community, cont'd

Name	Title	Organization
Jason Shaplen	Chief Executive Officer	St. Luke's Life Works- Inspirica
Jennifer Hallisey	V.P. Education	United Way of Western CT
Johnnie Malloy	Sr. Vice President	Liberation Programs
Juan Medrano	Director of Finance; President, Hispanic Advisory Council	Yerwood Center
Karen Gottlieb	Executive Director	AmeriCares
Kate Heichler		Interfaith Council of SW CT
Kathy Walsh	President	NeighborsLink
Ken Broder	President, Past Board Member	Stamford Dental Society
Kerri Hagan	Public Health Educator	Stamford Dept. of Health and Social Services
Leslie Sexer		Family Centers, Inc.
Linda Autore	President and Chief Executive Officer	Laurel House
Ludwig Spinelli	Chief Executive Officer	Optimus Health Care, Inc. (FQHC)
Madhu Mathur, MD, MPH	Director, KIDS'FANS, Childhood Obesity Force	Chair Obesity Task Force/Stamford Hospital
Marie Allen	Executive Director	SW Area Agency on Aging
Marie Johnson	Executive Director	Partnership in Elderly Services (PIES)
Mike Cotela	Executive Director	Boys and Girls Club
Molly Larson, RN	Public Health Nurse	Town of Darien
Norma Kirwan	Director	Bennett Behavioral Health Center
Olga Brown	Director of Nursing, City of Stamford	Stamford Public Schools
Patricia Gallegos	Stamford Site Director	Optimus Health Care, Inc. (FQHC)
Rona Marotta	WIC Program Coordinator/ Nutritionist	Health Dept., City of Stamford
Shari Shapiro	Executive Director	Kids in Crisis
Sherry Perlstein	Executive Director	Child Guidance Center
Sondra Pryor	Parent/School Liaison	Yerwood Center

Appendix 3: Advisory Committee Members - Community, cont'd

Name	Title	Organization
Stephanie Haen		Charter Oak Community Family Center Inc.
Tanya Court	Director Public Policy & Programs	Business Council of Fairfield County
Terri Drew	Director	City of Stamford - Youth Services Bureau
Thomas Hill		Optimus Health Care, Inc. (FQHC)
Vincent J. Tufo	Executive Director	Charter Oak Community Family Center Inc.
Willard Pinn	Executive Director	DuBois Center

Appendix 4: Advisory Committee Members – Stamford Hospital

Name	Title	Department
Beth Chaty	Director of Planning	Strategy and Market Development
Bill Heist	Executive Director	Ambulatory Services
David Smith	Sr VP, Chief Strategy & Network Development Officer	Administration
Debbie Milne	Dir., Diabetes & Endocrine Center	Diabetes and Endocrine Center
Deborah Fedeli	Director	Patient Centered Services
Dory Ferraro	Dir. Clinical Operations	Center for Surgical Weight Loss
Draupathi Nambudiri, MD	Department Chair	Department of Psychiatry
Eilish Hourihan	Director, Emergency Department, Immediate Care Center, Infusion Center, and Stroke Program	Emergency Department
Elizabeth Manfredo	Director, Cancer Service Line	Bennett Cancer Center
Gerald Rakos, MD	Chair, Dept. of Pediatrics	Pediatrics
Helaine Klein	Case Manager	Case Management
Hossein Sadeghi, MD	Dir. Pediatric Pulmonology	Pediatrics Pulmonology/ Asthma
Irene Oshrin	Dir. Clinical Services	SHIP
Jayson Podber, MD	Medical Director	Emergency Department
Jeanne Van Lent	Director of Marketing	Strategy and Market Development
Jill Sanislo	Senior Social Worker	Case Management
Kara Koss, MPH	Planning Analyst	Strategy and Market Development
Mary Henwood-Klotz, MPH	Director	Center for Integrative Medicine & Mobile Wellness
Mary Judge, RN, MBA	Manager, Community Health & Education	Community and Health Education
Pamela Koprowski	Public Affairs Consultant	Strategy and Market Development

Appendix 4: Advisory Committee Members – Stamford Hospital, cont'd

Name	Title	Department
Peggy Martino	Dir. Heart and Vascular Institute	Heart and Vascular
Rod Acosta, MD	Chair, Medical Staff	Medical Staff Leadership/ SHIP
Rohit Bhalla, MD	VP, Chief Quality Officer	Administration
Sandra Bardsley	Clinical Operations Director, Nursing Admin.	Nursing
Sarah Sanders	Clinical Operations Director, Nursing Admin.	Nursing
Sharon Kiely, MD	Sr. VP Medical Affairs, Chief Medical Officer	Medical Affairs
Steven Horowitz, MD	Chief, Division of Cardiology	Heart and Vascular
Vicki Hoffman	Service Line Director	Orthopedics, Pediatrics, Women's Health and the Breast Center

Appendix 5: Key Informant Interviews

Name	Title	Organization
Adele Gordon	Regional Director	Community Health Center, Inc. (FQHC)
Allan Troy, MD	Chairman-Dept. of Medicine	Stamford Hospital
Andrew Synder, MD	President, SHIP	Stamford Hospital
Angelica Oxford	President	Junior League of Stamford/ Norwalk
Angelo Mallozzi, MD		Stamford Family Practice-Stamford Group
*† Anne Fountain, MPH	Director	Stamford Dept. of Health and Social Services
Barbara Decker	Chair	Stamford Health Commission
Bert Ballin, MD		Stamford Health Commission
Bismruta Misra, MD	Diabetes and Endocrine Center	Stamford Hospital
* Bob Arnold	Chief Executive Officer	Family Centers, Inc.
* Bobby Valentine	Director of Public Safety, Health & Welfare	City of Stamford
Carol Fucigna, MD		Fairfield County OB/GYN
Cathy Catrini		Stamford Health Commission
Cathy Malloy	Executive Director	The Center for Sexual Assault Crisis
Chris Bruhl	President & CEO	Fairfield Business Council
*† David A. Knauf, MPH, MS, RS	Director of Health	Town of Darien
*† David Reed, MD, MPH	Medical Director/ Director of Public Health	Town of New Canaan/Stamford Hospital
Deborah Milne	Director, Diabetes & Endocrine Center	Stamford Hospital
Deborah Namcheck	Director, Rehab Services	Stamford Hospital
Deborah Fedeli	Director, Patient-Centered Services	Stamford Hospital
Denise Pflueger	Executive Vice President	Stamford CTE CAP Agency

Appendix 5: Key Informant Interviews, cont'd

Name	Title	Organization
* Dennis Torres	Director of Healthcare Programs	Charter Oak Community Family Center Inc.
Dominique Srdanovic	Nurse Navigator	Stamford Hospital
Donald Lombino, MD	Director, ED	Stamford Hospital
* Donna Spellman	Director of Outreach	Family Centers, Inc.
Dory Ferraro	Clinical Director, Bariatric Surgery	Stamford Hospital
Draupathi Nambudiri, MD	Dorothy Bennett Behavioral Center	Stamford Hospital
Elizabeth Manfredo	Director, Cancer Service Line	Stamford Hospital
* Elizabeth Paris	Coordinator, Darien Senior Center	Town of Darien
* Eric Koehler	CEO	Jewish Community Center
Eric Stein	Stamford, Manager	Optimus Health Care, Inc.
Ernest Lamour	Executive Director	YMCA
Frank Masino, MD	Medical Director, Bennett Cancer Center	Stamford Hospital
Gerald Rakos, MD	Chair, Dept. of Pediatrics	Stamford Hospital
*† Henry Yoon, MD	Medical Advisor	Stamford Dept. of Health & Social Services
Ingrid Jimenez	CEO	Visiting Nurse & Hospice Care of Southwestern Connecticut
Jack Condlin	President	The Stamford Chamber of Commerce
* James Lisher	Chair, Health & Human Services Commission	Town of New Canaan
* Jeb Walker	First Selectman	Town of New Canaan
John Rodis, MD	SR. VP Medical Affairs	Stamford Hospital
Joseph Larcheveque	EMS Coordinator	Stamford EMS
* Juan Medrano	Director of Finance; President, Hispanic Advisory Council	Yerwood Center
† Karen Gottlieb	Executive Director	AmeriCares

Appendix 5: Key Informant Interviews, cont'd

Name	Title	Organization
Katharine Radziewicz	Nurse Navigator	Stamford Hospital
Kathy Silard, RN	Chief Operating Officer	Stamford Hospital
* Kathy Walsh	President	NeighborsLink
Kerri Ubaldi	ED Nurse Manager	Stamford Hospital
Lance Bruck, MD	Chairman-Dept. OB/GYN	Stamford Hospital
Robert Lindberg, MD		Primary Care and Family Medicine – Town of Darien
Lt. Walter Droz	Officer	Salvation Army
Ludwig Spinelli	CEO	Optimus Health Care, Inc.
† Madhu Mathur MD, MPH	Director, KIDS FANS; Chair, Obesity Task Force	Childhood Obesity Task Force/ Stamford Hospital
* Marie Johnson	Exec. Director, Senior Services	Partnership in Elderly Services
Mary Judge, RN, MBA	Manager, Community Health & Education	Stamford Hospital
Maureen Adams	Director of Case Management and Social Work	Stamford Hospital
Melissa Ronk	Nurse Navigator	Stamford Hospital
Michael Coady, MD	Chief, Cardiac Surgery	Stamford Hospital
Michael Parry, MD	Director, Infectious Diseases	Stamford Hospital
* Michael Pavia	Mayor	City of Stamford
* Mike Cotela	Executive Director	Boys & Girls Club
Noel Robin, MD	Chairman-Dept. Medicine	Stamford Hospital
Norma Kirwan	Director	Bennett Behavioral Health Center
* Olga Brown	Director of Nursing, City of Stamford	Stamford Public Schools
Patricia Gallegos	Stamford Site Director	Optimus Health Care, Inc.
Patricia Parry		Stamford Health Commission
Patricia Squires	Exec Director, SEMS	Stamford EMS
* Peter Tesei	First Selectman	City of Greenwich

Appendix 5: Key Informant Interviews, cont'd

Name	Title	Organization
Philip Corvo, MD		Stamford Health Commission
Rudolph Taddonio, MD	Medical Director, Orthopedics & Spine	Stamford Hospital
Russell Turk, MD	Riverside OB/GYN	OB/GYN
* Samuel E. Deibler	Director, Commission on Aging	City of Greenwich
* Sandra Pryor		Yerwood Center
Sarah Williams		American Cancer Society Representative
Sharon Kiely, MD	Sr. VP Medical Affairs, Chief Medical Officer	Stamford Hospital
* Sherry Perlstein	Executive Director	Child Guidance Center
Stephen Gallousis, MD		Fairfield County OB/GYN
Steven Horowitz, MD	Chief, Division of Cardiology	Stamford Hospital
Susan Delaney	Executive Director	Domestic Violence Center
* Terry Drew	Director	Stamford Youth Services Bureau
*† Timothy J. Callahan, MPH	Director of Health	City of Norwalk
* Vincent J. Tufo	Executive Director	Charter Oak Community Family Centers, Inc.
* Winnie Hamilton	Assistant Superintendent	Stamford Public Schools

*** Denotes representatives of the community served by the hospital facility**
† Denotes individuals with special knowledge of or expertise in public health

Descriptions of Key Informants with special knowledge or expertise in public health:

***† Anne Fountain, MPH** **Director** **Stamford Dept. of Health and Social Services**

Anne Fountain has been the Director of the Stamford Department of Health and Social Services since 2010. As Director, she is responsible for safeguarding and improving the physical and environmental health of all Stamford residents through environmental testing and monitoring, preventive and educational health services, and other services.

Appendix 5: Key Informant Interviews, cont'd

***† David A. Knauf, MPH, MS, RS** **Director of Health** **Town of Darien**

As Director of Health for the Town of Darien, David Knauf is responsible for community health prevention and education services, environmental safety, compliance with local, State, and federal health regulations, and emergency preparedness.

***† David Reed, MD, MPH** **Medical Director/ Director of Public Health** **Town of New Canaan/ Stamford Hospital**

Dr. David Reed has been the Director of Public Health for the Town of New Canaan since 2005. Additionally, he serves as the Director of Case Management and Utilization Review at Stamford Hospital. As Director of Public Health he is responsible for health education and disease prevention, as well as ensuring compliance with all local, State and federal health regulations.

***† Henry Yoon, MD** **Medical Advisor** **Stamford Dept. of Health & Social Services**

As Medical Advisor for the Stamford Department of Health and Social Services, Dr. Yoon is responsible for overseeing all of the city's medical clinics. He has held this position since 2010. Additionally, Dr. Yoon is a member of the Department of Family Medicine at Stamford Hospital.

† Karen Gottlieb **Executive Director** **AmeriCares**

Karen Gottlieb has been the Executive Director of AmeriCares' three free health clinics in Connecticut (in Norwalk, Danbury and Bridgeport) since 1996. A fourth free clinic will be opening in Stamford in late 2013. Ms. Gottlieb is responsible for fundraising, program development, and staff training, and under her leadership AmeriCares has provided health services to over 20,000 uninsured CT residents.

† Madhu Mathur MD, MPH **Director, KIDS FANS; Chair, Obesity Task Force** **Stamford Hospital**

Dr. Mathur directs the KIDS' FANS Program, which promotes healthy eating and physical activity for children through wellness programs, fitness and nutrition education classes in schools and other community venues. Dr. Mathur founded and chairs the Stamford Childhood Obesity Task Force, and is also a Pediatrician and Obesity Medicine Physician at Stamford Hospital. Dr. Mathur has been the Medical Director for the SW Connecticut Regional Medical Home Initiative since 2005 and the Chairperson of the Health and Wellness Committee of the CT Childhood Blueprint Initiative since 2008.

***† Timothy J. Callahan, MPH** **Director of Health** **City of Norwalk**

Timothy Callahan has been the Director of Health for the City of Norwalk since 1992. In his role he is responsible for environmental health and safety, health education, disease prevention and control, as well as emergency preparedness.

Appendix 6: Community Health Resource List

Hospitals
Stamford Hospital, Stamford
Greenwich Hospital, Greenwich
Norwalk Hospital, Norwalk

Health Clinics
AmeriCares Free Clinic, Stamford
Dental Center of Stamford, Stamford
Franklin Street Community Health Center, Stamford
Optimus Health Center, Stamford
Town Center Dental of Stamford, Stamford

AmeriCares Free Clinic, Norwalk
Norwalk Community Health Center, Norwalk
Norwalk Hospital Dental Clinic, Norwalk
Norwalk Smiles Dental Center, Norwalk
SONO Dental Group, Norwalk

Health Departments
Stamford Department of Health and Social Services
- Department of Recreation
- Stamford Community Development Office
- Stamford Health Commission
- Stamford Walks
- Women, Infant & Children's Services, City of Stamford- Dept. of Health

Darien Health Department
Greenwich Department of Health
New Canaan Health Department
Norwalk Health Department
Westport/Weston Health District

Housing Authorities and Housing Resources
Charter Oak Communities (Stamford Housing Authority), Stamford
Urban League of Southern CT, Stamford

Appendix 6: Community Health Resource List, cont'd

Darien Housing Authority, Darien
Greenwich Housing Authority, Greenwich
New Canaan Housing Authority, New Canaan
Norwalk Housing Authority, Norwalk

Housing
Augustus Manor, Stamford
Belltown Manor, Stamford
Bishop Curtis Homes of Glenbrook, Stamford
Clinton Manor, Stamford
Cross Road Residence, Stamford
Czescik Homes, Stamford
Eleanor Roosevelt House, Stamford
Glenbrook Manor, Stamford
Harboursite, Stamford
Mapleview Tower, Stamford
Mutual Housing Association of SW CT, Stamford
Neighborhood Housing Services of Stamford, Stamford
New Neighborhoods, Inc., Stamford
Pilgrim Towers, Stamford
Quintard Manor, Stamford
Rippowam Manor, Stamford
Shelter for the Homeless – Pacific House, Stamford
Shippan Place, Stamford
St. John's Towers, Stamford
St. Luke's Lifeworks – Inspirica, Stamford
Stamford Green, Stamford
The Atlantic, Stamford
Willard Manor, Stamford

Bishop Curtis Homes, Greenwich
McKinney Terrace, Greenwich
Pavilion House, Greenwich
Quarry Knoll Drive I&II, Greenwich

Canaan Parish, New Canaan
Mill Apartments, New Canaan
School House Apartments, New Canaan

Appendix 6: Community Health Resource List, cont'd

Cedar Court, Norwalk
Hilltop Homes, Norwalk
Irving Freese Homes, Norwalk
Kingsway Apartments, Norwalk
Laura Raymond Homes, Norwalk
Leroy Down, Norwalk
Norwalk Emergency Shelter, Norwalk
Senior Court, Norwalk
Shostak Apartments, Norwalk
West Avenue Apartments, Norwalk

Bacharach Community Homeless Shelter, Westport
Gillespie Center Homeless Shelter, Westport

Ogden House, Wilton

Behavioral Health Services
Child Guidance Center of Southern Connecticut, Stamford
NEON - Viewpoint, Stamford
Family Centers, Inc., Stamford
Franklin DuBois Center, Stamford
Jewish Family Services of Stamford, Stamford
Laurel House, Inc., Stamford
Liberation Programs, Inc., Stamford
Optimus Health Care Behavioral Health Center, Stamford
Shelter for the Homeless, Inc., Stamford
St Luke's Community Services, Stamford

Kids in Crisis, Cos Cob

Pathways, Inc., Greenwich

Silver Hill Hospital, New Canaan

Connecticut Renaissance, Inc., Norwalk
Family & Children's Agency, Inc., Norwalk
Human Services Council of Mid-Fairfield, Norwalk
Keystone, Inc., Norwalk
Liberation Programs, Inc., Stamford, Norwalk
Search For Change, Inc., Norwalk

Hall Brooke Behavioral Health Services, Inc., Westport
Interfaith Housing Association, Westport
Positive Directions, Westport

Food and Nutrition Services
Catholic Charities: Senior Nutrition Program, Stamford
Community Tabernacle Outreach Center Food Pantry, Stamford
Food Bank of Lower Fairfield County, Stamford
Haitian American Community Center Food Pantry, Stamford
New Covenant House, Stamford
Salvation Army of Stamford, Stamford
Wilson Memorial Church of God in Christ, Stamford
Zion Lutheran Church Food Pantry, Stamford

Meals-On-Wheels of Greenwich, Greenwich

Meals-On-Wheels of New Canaan, New Canaan

Norwalk Senior Center - Meals on Wheels, Norwalk
The Salvation Army of Norwalk, Norwalk

Weston Social Services, Weston

Westport Group Lunch, Westport

Meals-On-Wheels of Wilton, Wilton

Appendix 6: Community Health Resource List, cont'd

Long Term Care, Hospice and Assisted Living Facilities; Home Care Agencies
Almost Family, Stamford
Atria of Stamford, Stamford
Brighton Gardens, Stamford
ComforCare Home Care, Stamford
Courtland Gardens Health Center Inc., Stamford
Danielcare, Stamford
Edgehill, Stamford
Greenwich Hospital-Hospice Program, Stamford
Long Ridge of Stamford, Stamford
Scofield Manor, Stamford
Senior Helpers, Stamford
Smith House Skilled Nursing Facility, Stamford
St. Camillus Health Center, Stamford
Stellar Home Care, Stamford
Sunrise of Stamford, Stamford
Synergy Homecare, Stamford
Wormser Congregate, Stamford

Atria Darien, Darien
Maplewood at Darien, Darien
Right at Home, Darien

Comfort Keepers, Greenwich
Greens at Greenwich, Greenwich
Greenwich Woods Health Care Center, Greenwich
Greenwich-Laurelton Nursing & Convalescent Home, Greenwich
Hill House, Greenwich
Nathaniel Witherell, Greenwich
Parsonage Cottage, Greenwich
Sterling Care LLC, Greenwich
The Mews Independent Senior Assisted Living, Greenwich

New Canaan Inn, New Canaan
Waveny Care Center, New Canaan

Appendix 6: Community Health Resource List, cont'd

Bright Star, Norwalk
Broad River Homes, Norwalk
Clinical Love and Care, Norwalk
Constellation and Homemakers, Norwalk
Family and Children's Aid, Norwalk
Four Nurses at Work, Norwalk
Haven Care for the Elderly, Norwalk
Home Instead, Norwalk
Honey Hill Care Center, Norwalk
Louise Carlson Senior Residence, Norwalk
Loving Care, Inc., Norwalk
Ludllow Commons, Norwalk
Maplewood at Strawberry Hill, Norwalk
Marathon Health Care Center of Norwalk, Norwalk
Masonicare Home Health and Hospice, Norwalk
Notre Dame Convalescent Home, Inc., Norwalk
Precise Care, Norwalk
Premier Home Health Care Services, Inc., Norwalk
Steps in Home Care, Norwalk
Tender Loving Care, Norwalk
The Marvin, Norwalk

Miss Daisy's Home Care, Weston

Home Care on Call, Westport
Home Choice Senior Care, Westport
Home Helpers, Westport
Keeping Care At Home, Westport
Quality Care Services, Inc., Westport
The Saugatuck (Co-op), Westport
Tutela Services, Westport
Westport Health Care Center, Westport

Brookdale Place of Wilton, Wilton
Greens At Cannondale, Wilton
Lourdes Health Care Center, Inc., Wilton
Visiting Nurse and Hospice of Fairfield County, Wilton
Wilton Meadows Health Center, Inc., Wilton

Appendix 6: Community Health Resource List, cont'd

Senior Services
Adult Protective Services/Dept. of Social Services, Stamford
Catholic Charities - Hispanic Outreach to Seniors, Stamford
City of Stamford Med-Assist Program, Stamford
Over Sixty Club, Stamford
Senior Neighborhood Support, Stamford
Senior Services of Stamford, Stamford
Stamford Senior Center, Stamford

Darien Senior Activities Center, Darien

Greenwich Senior Center, Greenwich

Lapham Center, New Canaan
StayingPut, New Canaan

Norwalk Senior Center, Norwalk
Senior Services Coordinating Council, Norwalk

Weston Senior Center, Weston

Westport Center for Senior Activities, Westport

Wilton Senior Center, Wilton

Southwestern Connecticut Agency on Aging, Bridgeport

Social Services
City of Stamford Department of Social Services, Stamford
City of Stamford Social Service Commission, Stamford

Darien Department of Human Services, Darien
Person to Person, Darien

Greenwich Social Services, Greenwich
Person to Person, Greenwich

Department of Human Services, New Canaan

Family and Children's Services, New Canaan

Dept. of Human Services, Westport

Transportation Services
Fish of Stamford, Stamford
Stamford Share the Fare Program, Stamford
Voluntary Service for the Blind, Stamford

Gallivant Program, Darien

Dial-a-Ride of Greenwich, Greenwich

Getabout, New Canaan

Easy Access (Town to Town), Norwalk
Norwalk Transit District, Norwalk

ITN Coastal Connecticut, Weston

ITN Coastal Connecticut, Westport

Educational Resources
Adult Education – Stamford Public Schools, Stamford
Child Care Learning Centers, Inc., Stamford
Sacred Heart University, Stamford
University of Connecticut, Stamford

Norwalk Community College

Appendix 6: Community Health Resource List, cont'd

Workforce and Immigration Assistance

CT Works Centers, Stamford
Haitian American Community Center, Stamford
Hispanic Advisory Council, Stamford
International Institute, Stamford
Literacy Volunteers, Stamford
NeighborsLink, Stamford
Urban League of SWCT, Stamford
YWCA Greenwich/Stamford

Other Health Resources
American Red Cross
ARI of Connecticut, Inc., Stamford
Catholic Family Services, Stamford
Connecticut Legal Services, Stamford
Domestic Violence Crisis Center, Stamford
Planned Parenthood, Stamford
Sexual Assault Crisis Center, Inc., Stamford
Stamford Cares, Stamford
Stamford Emergency Medical Services (SEMS), Stamford
United Way of Western CT, Stamford
Utility Assistance Programs, Stamford

Center for Hope, Darien
Post 53 Emergency Medical Services, Darien
Tiny Miracles Foundation, Darien

Abilis, Greenwich
Breast Cancer Alliance, Greenwich

Alzheimer's Caregiver Support Group (at Waveny Care Center), New Canaan
New Canaan Cares, New Canaan
New Canaan Volunteer Ambulance Corps., New Canaan

Catholic Family Centers, Norwalk
Fairfield County Community Foundation, Norwalk
Norwalk Economic Opportunity Now (NEON), Norwalk

Appendix 6: Community Health Resource List, cont'd

Al-Anon/Alcoholics Anonymous (Nationwide)
Center for Medicare Advocacy (Nationwide)
Infoline 211 (Statewide)
March of Dimes (Statewide)
Medical Home for Children with Special Needs (Statewide)
Parent Leadership and Training Institute (Statewide)

Appendix 7: Access to Services Workgroup Charge

Access to Services – Community Health Strategic Priority

- **Specialty Care for Low Income**
- **Mental Health/Addiction**
- **Avoidable ED Utilization**
- **Dental Care for Low Income**
- **Housing and Food Assistance**

Work Group Goal:

The Community Health Needs Assessment Steering Committee identified Access to Services as a Community Health Strategic Priority. The Access to Services Work Group will develop an Action Plan to identify the goals, objectives, evaluative metrics, community partners, core strategic activities, and resources required for a targeted series of activities that will allow Stamford Hospital, the Stamford Department of Health and Social Services, and other community partners to make progress towards addressing the key issues/factors (listed in the shaded box above) associated with this priority.

Work Group Objectives:

- Review findings and obtain general agreement on the key issues/factors established by the Steering Committee as central to the Access to Services priority area
- Identify primary target populations (geographically, demographically, and socio-economically)
- Explore and characterize the realm of programmatic or strategic goals related to Access to Services (i.e., service integration, enhanced referral systems, expanded capacity etc.)
- Identify the major community partners that should be involved to achieve these goals and implement appropriate programs or activities
- Outline in as much detail as possible an array of viable activities that could be implemented to achieve the programmatic goals or objectives established by the Work Group, keeping in mind the target populations identified above
- Consider the evaluative metrics that should be used to track impact and the extent to which programmatic or strategic efforts are allowing you to reach your designated goals
- Consider the resources that would be required to implement the identified activities

Agenda Meeting 1:

1) Introductions, Project Background, and Review of Work Group's Goals
2) Review of Community Health Needs Assessment Findings
3) Discuss/Confirm Community Health Strategic Priority
4) Explore/Characterize the Realm of Programmatic or Strategic Goals/Objectives related to Access to Services (i.e., service integration, enhanced referral systems, expanded capacity, etc.)
5) Identify Key Community Partners and Core Strategies

Things to consider between meetings:

- Are there existing programs geared to addressing the identified goals? How would you refine or restructure these existing programs to achieve the identified goals?
- What types of actions or activities are best suited for the key community partners identified?
- What new programs should be developed to meet the goals identified at the first meeting?

Agenda Meeting 2:

1) Review/Confirm the Programmatic or Strategic Goals/Objectives Identified at the Last Meeting
2) Review/Confirm the Range of Key Community Partners Identified at the Last Meeting
3) Outline in as much detail as possible an Array of Viable Activities that Could Be Implemented to Achieve the Programmatic Goals/Objectives Set by the Work Group
   a. Organized by Goal/Objective and Target Population
   b. Ensure a mix of short-term, "doable" activities and more grandiose, medium- or long-term efforts that may take more time to implement

Things to consider between meetings:

- Are there programmatic or strategic ideas or activities that were not addressed in the last meeting?

Agenda Meeting 3:

1) Review the Array of Viable Activities Identified at the Last Meeting (Organized by Goal/ Objective, Target Population, and Perhaps Community Partner)
2) Begin to Frame the Broader Action Plan to Ensure that All of the Key Issues, Goals/ Objectives, and Target Populations are Included (make sure that there is a mix of short-, medium-, and long-term activities)
3) Identify Evaluative Metrics for Each Programmatic or Strategic Idea
4) Consider the Resource Needs for Each of the Programmatic or Strategic Ideas

Appendix 8: Access to Services Workgroup Members

Name	Title	Organization
Adele Gordon	Regional Director	Community Health Center, Inc. (FQHC)
Beth Chaty	Director of Planning	Stamford Hospital
David Smith	Sr VP, Chief Strategy & Network Development Officer	Stamford Hospital
Dennis Torres	Director of Healthcare Programs	Charter Oak Community Family Center Inc.
Donna Spellman	Director of Outreach	Charter Oak Community Family Center Inc.
Eilish Hourihan	Director, Emergency Department, Immediate Care Center, Infusion Center, and Stroke Program	Stamford Hospital
Elizabeth Manfredo	Director, Cancer Service Line	Stamford Hospital
Eric Stein	Stamford, Manager	Optimus Health Care (FQHC)
Henry Yoon, MD	Medical Advisor	Stamford Dept. of Health & Social Services
Jason Shaplen	Chief Executive Officer	St. Luke's Life Works- Inspirica
Jayson Podber, MD	Medical Director	Stamford Hospital
Kara Koss, MPH	Planning Analyst	Stamford Hospital
Karen Gottlieb	Executive Director	Americares
Kathy Walsh	President	NeighborsLink
Kenneth Broder, DMD	President, Past Board Member	Stamford Dental Society
Linda Autore	President and Chief Executive Officer	Laurel House
Ludwig Spinelli	Chief Executive Officer	Optimus Health Care, Inc. (FQHC)
Marie Johnson	Executive Director	Partnership in Elderly Services PIES

Appendix 8: Access to Services Workgroup Members, cont'd

Name	Title	Organization
Pamela Koprowski	Public Affairs Consultant	Stamford Hospital
Patricia Gallegos	Stamford Site Director	Optimus Health Care, Inc. (FQHC)
Peggy Martino	Dir. Heart and Vascular Institute	Stamford Hospital
Rod Acosta, MD	Chair, Medical Staff	Stamford Hospital
Sandra Bardsley	Clinical Operations Director, Nursing Admin.	Stamford Hospital

Appendix 9: Behavioral Health Workgroup Charge

Behavioral Health – Community Health Strategic Priority

- **Depression, anxiety, stress**
- **Alcohol and prescription drug abuse**

Work Group Goal:

The Community Health Needs Assessment Steering Committee identified Behavioral Health as a Community Health Strategic Priority. The Behavioral Health Work Group will develop an Action Plan to identify the goals, objectives, evaluative metrics, community partners, core strategic activities, and resources required for a targeted series of activities that will allow Stamford Hospital, the Stamford Department of Health and Social Services, and other community partners to make progress towards addressing the key issues/factors (listed in the shaded box above) associated with this priority.

Work Group Objectives:

- Review findings and obtain general agreement on the key issues/factors established by the Steering Committee as central to the Behavioral Health priority area
- Identify primary target populations (geographically, demographically, and socio-economically)
- Explore and characterize the realm of programmatic or strategic goals related to Behavioral Health (i.e., prevention, screening/identification, treatment protocols, management of disease, service integration, etc.)
- Identify the major community partners that should be involved to achieve these goals and implement appropriate programs or activities
- Outline in as much detail as possible an array of viable activities that could be implemented to achieve the programmatic goals or objectives established by the Work Group, keeping in mind the target populations identified above
- Consider the evaluative metrics that should be used to track impact and the extent to which programmatic or strategic efforts are allowing you to reach your designated goals
- Consider the resources that would be required to implement the identified activities

Agenda Meeting 1:

1) Introductions, Project Background, and Review of Work Group's Goals
2) Review of Community Health Needs Assessment Findings
3) Discuss/Confirm Community Health Strategic Priority
4) Explore/Characterize the Realm of Programmatic or Strategic Goals/Objectives related to Behavioral Health (i.e., prevention, screening/identification, treatment protocols, management of disease, service integration etc.)
5) Identify Key Community Partners and Core Strategies

Things to consider between meetings:

- Are there existing programs geared to addressing the identified goals? How would you refine or restructure these existing programs to achieve the identified goals?
- What types of actions or activities are best suited for the key community partners identified?
- What new programs should be developed to meet the goals identified at the first meeting?

Agenda Meeting 2:

1) Review/Confirm the Programmatic or Strategic Goals/Objectives Identified at the Last Meeting
2) Review/Confirm the Range of Key Community Partners Identified at the Last Meeting
3) Outline in as much detail as possible an Array of Viable Activities that Could Be Implemented to Achieve the Programmatic Goals/Objectives Established by the Work Group
    a. Organized by Goal/Objective and Target Population
    b. Ensure a mix of short-term, "doable" activities and more grandiose, medium or long-term efforts that may take more time to implement

Things to consider between meetings:

- Are there programmatic or strategic ideas or activities that were not addressed in the last meeting?

Agenda Meeting 3:

1) Review the Array of Viable Activities Identified at the Last Meeting (Organized by Goal/ Objective, Target Population, and Perhaps Community Partner)
2) Begin to Frame the Broader Action Plan to Ensure that All of the Key Issues, Goals/ Objectives, and Target Populations are Included (make sure that there is a mix of short, medium, and long-term activities)
3) Identify Evaluative Metrics for Each Programmatic or Strategic Idea
4) Consider the Resource Needs for Each of the Programmatic or Strategic Ideas

Appendix 10: Behavioral Health Workgroup Members

Name	Title	Organization
Adele Gordon	Regional Director	Community Health Center, Inc. (FQHC)
Alan Mathis	Executive Director	Liberation Programs
Beth Chaty	Director of Planning	Stamford Hospital
Cindy Perjon		DuBois Center
Deborah Matthews, PhD	Director, Crisis Service	Child Guidance Center of SW CT
Dennis Torres	Director of Healthcare Programs	Charter Oak Community Family Center Inc.
Draupathi Nambudiri, MD	Department Chair	Stamford Hospital
Eilish Hourihan	Director, Emergency Department, Immediate Care Center, Infusion Center, and Stroke Program	Stamford Hospital
Eric Stein	Stamford, Manager	Optimus Health Care (FQHC)
Henry Yoon, MD	Medical Advisor	Stamford Dept. of Health & Social Services
Ingrid Gillespie	Director, Lower Fairfield County Regional Action Council (LFCRAC)	Liberation Programs
Jayson Podber, MD	Medical Director	Stamford Hospital
Jeanne Van Lent	Director of Marketing	Stamford Hospital
Johnnie Malloy	Sr. Vice President	Liberation Programs
Kara Koss, MPH	Planning Analyst	Stamford Hospital
Leslie Sexer		Family Centers, Inc.
Ludwig Spinelli	Chief Executive Officer	Optimus Health Care, Inc. (FQHC)
Norma Kirwan	Director	Bennett Behavioral Health Center
Pamela Koprowski	Public Affairs Consultant	Stamford Hospital

Appendix 10: Behavioral Health Workgroup Members, cont'd

Name	Title	Organization
Patricia Gallegos	Stamford Site Director	Optimus Health Care, Inc. (FQHC)
Sarah Sanders	Clinical Operations Director, Nursing Admin.	Stamford Hospital
Shari Shapiro	Executive Director	Kids in Crisis
Sherry Perlstein	Executive Director	Child Guidance Center

Appendix 11: Chronic Disease Workgroup Charge

Chronic Disease – Community Health Strategic Priority

- **Heart disease, diabetes, asthma, cancer**
- **Obesity**
- **Chronic disease management**
- **Avoidable Emergency Department use and Hospital readmission**

Work Group Goal:

The Community Health Needs Assessment Steering Committee identified Chronic Disease as a Community Health Strategic Priority. The Chronic Disease Work Group will develop an Action Plan to identify the goals, objectives, evaluative metrics, community partners, core strategic activities, and resources required for a targeted series of activities that will allow Stamford Hospital, the Stamford Department of Health and Social Services, and other community partners to make progress towards addressing the key issues/factors (listed in the shaded box above) associated with this priority.

Work Group Objectives:

- Review findings and obtain general agreement on the key issues/factors established by the Steering Committee as central to the Chronic Disease priority area
- Identify primary target populations (geographically, demographically, and socio-economically)
- Explore and characterize the realm of programmatic or strategic goals related to Chronic Disease (i.e., prevention, treatment protocols, management of disease, etc.)
- Identify the major community partners that should be involved to achieve these goals and implement appropriate programs or activities
- Outline in as much detail as possible an array of viable activities that could be implemented to achieve the programmatic goals or objectives established by the Work Group, keeping in mind the target populations identified above
- Consider the evaluative metrics that should be used to track impact and the extent to which programmatic or strategic efforts are allowing you to reach your designated goals
- Consider the resources that would be required to implement the identified activities

Agenda Meeting 1:

1) Introductions, Project Background, and Review of Work Group's Goals
2) Review of Community Health Needs Assessment Findings
3) Discuss/Confirm Community Health Strategic Priority
4) Explore/Characterize the Realm of Programmatic or Strategic Goals/Objectives related to Chronic Disease (i.e., prevention, treatment protocols, management of disease, etc.)
5) Identify Key Community Partners and Core Strategies

Things to consider between meetings:

- Are there existing programs geared to addressing the identified goals? How would you refine or restructure these existing programs to achieve the identified goals?
- What types of actions or activities are best suited for the key community partners identified?
- What new programs should be developed to meet the goals identified at the first meeting?

Agenda Meeting 2:

1) Review/Confirm the Programmatic or Strategic Goals/Objectives Identified at the Last Meeting
2) Review/Confirm the Range of Key Community Partners Identified at the Last Meeting
3) Outline in as much detail as possible an Array of Viable Activities that Could Be Implemented to Achieve the Programmatic Goals/Objectives Established by the Work Group
   a. Organized by Goal/Objective and Target Population
   b. Ensure a mix of short-term, "doable" activities and more grandiose, medium or long-term efforts that may take more time to implement

Things to consider between meetings:

- Are there programmatic or strategic ideas or activities that were not addressed in the last meeting?

Agenda Meeting 3:

1) Review the Array of Viable Activities Identified at the Last Meeting (Organized by Goal/ Objective, Target Population, and Perhaps Community Partner)
2) Begin to Frame the Broader Action Plan to Ensure that All of the Key Issues, Goals/ Objectives, and Target Populations are Included (make sure that there is a mix of short, medium, and long-term activities)
3) Identify Evaluative Metrics for Each Programmatic or Strategic Idea
4) Consider the Resource Needs for Each of the Programmatic or Strategic Ideas

Appendix 12: Chronic Disease Workgroup Members

Name	Title	Organization
Adele Gordon	Regional Director	Community Health Center, Inc. (FQHC)
Anna Nelson	Executive Director	Stamford Senior Center
Beth Chaty	Director of Planning	Stamford Hospital
Christina Crain	Deputy Director	SW Area Agency on Aging
David Reed, M.D.	Medical Director/ Public Health Director	Town of New Canaan/ Stamford Hospital
Debbie Milne	Dir., Diabetes & Endocrine Center	Stamford Hospital
Diane Kwan, RN	Clinical Nurse Liaison	Masonicare
Dory Ferraro	Dir. Clinical Operations	Stamford Hospital
Eric Stein	Stamford, Manager	Optimus Health Care (FQHC)
Genalyn Amihan	Clinical Nurse Liaison	Masonicare
Henry Yoon, MD	Medical Advisor	Stamford Dept. of Health & Social Services
Hossein Sadeghi, MD	Dir. Pediatric Pulmonology	Stamford Hospital
Irene Oshrin	Dir. Clinical Services	SHIP
Jill Sanislo	Senior Social Worker	Stamford Hospital
Kara Koss, MPH	Planning Analyst	Stamford Hospital
Ludwig Spinelli	CEO	Optimus Health Care, Inc. (FQHC)
Marie Allen	Executive Director	SW Area Agency on Aging
Molly Larson, RN	Public Health Nurse	Town of Darien
Pamela Koprowski	Public Affairs Consultant	Stamford Hospital
Patricia Gallegos	Stamford Site Director	Optimus Health Care, Inc. (FQHC)
Peggy Martino	Dir. Heart and Vascular Institute	Stamford Hospital
Rohit Bhalla, MD	VP, Chief Quality Officer	Stamford Hospital
Steven Horowitz, MD	Chief, Division of Cardiology	Stamford Hospital

Appendix 13: Health and Wellness Workgroup Charge

Health and Wellness – Community Health Strategic Priority

- **Health education and fitness**
- **Prevention and screening (e.g. Tuberculosis, Sexually Transmitted Infections, Cancer)**
- **Nutrition**
- **Chronic disease management**
- **Self-management support**
- **Health promotion**
- **Support and survivorship**
- **Emotional well-being**

Work Group Goal:

The Community Health Needs Assessment Steering Committee identified Health and Wellness as a Community Health Strategic Priority. The Health and Wellness Work Group will develop an Action Plan to identify the goals, objectives, evaluative metrics, community partners, core strategic activities, and resources required for a targeted series of activities that will allow Stamford Hospital, the Stamford Department of Health and Social Services, and other community partners to make progress towards addressing the key issues/factors (listed in the shaded box above) associated with this priority.

Work Group Objectives:

- Review findings and obtain general agreement on the key issues/factors established by the Steering Committee as central to the Health and Wellness priority area
- Identify primary target populations (geographically, demographically, and socio-economically)
- Explore and characterize the realm of programmatic or strategic goals related to Health and Wellness (i.e., education/awareness; health promotion; screening/identification; disease management)
- Identify the major community partners that should be involved to achieve these goals and implement appropriate programs or activities
- Outline in as much detail as possible an array of viable activities that could be implemented to achieve the programmatic goals or objectives established by the Work Group, keeping in mind the target populations identified above

- Consider the evaluative metrics that should be used to track impact and the extent to which programmatic or strategic efforts are allowing you to reach your designated goals
- Consider the resources that would be required to implement the identified activities

Agenda Meeting 1:

1) Introductions, Project Background, and Review of Work Group's Goals
2) Review of Community Health Needs Assessment Findings
3) Discuss/Confirm Community Health Strategic Priority
4) Explore/Characterize the Realm of Programmatic or Strategic Goals/Objectives related to Health and Wellness (i.e., education/awareness; health promotion; screening/identification; disease management)
5) Identify Key Community Partners and Core Strategies

Things to consider between meetings:

- Are there existing programs geared to addressing the identified goals? How would you refine or restructure these existing programs to achieve the identified goals?
- What types of actions or activities are best suited for the key community partners identified?
- What new programs should be developed to meet the goals identified at the first meeting?

Agenda Meeting 2:

1) Review/Confirm the Programmatic or Strategic Goals/Objectives Identified at the Last Meeting
2) Review/Confirm the Range of Key Community Partners Identified at the Last Meeting
3) Outline in as much detail as possible an Array of Viable Activities that Could Be Implemented to Achieve the Programmatic Goals/Objectives Established by the Work Group
   a. Organized by Goal/Objective and Target Population
   b. Ensure a mix of short-term, "doable" activities and more grandiose, medium or long-term efforts that may take more time to implement

Things to consider between meetings:

- Are there programmatic or strategic ideas or activities that were not addressed in the last meeting?

Agenda Meeting 3:

1) Review the Array of Viable Activities Identified at the Last Meeting (Organized by Goal/ Objective, Target Population, and Perhaps Community Partner)
2) Begin to Frame the Broader Action Plan to Ensure that All of the Key Issues, Goals/ Objectives, and Target Populations are Included (make sure that there is a mix of short, medium, and long-term activities)
3) Identify Evaluative Metrics for Each Programmatic or Strategic Idea
4) Consider the Resource Needs for Each of the Programmatic or Strategic Ideas

Appendix 14: Health and Wellness Workgroup Members

Name	Title	Organization
Anne Fountain, MPH	Director	Stamford Dept. of Health and Social Services
Beth Chaty	Director of Planning	Stamford Hospital
Bridget Fox	Executive Director, Volunteer Center	Volunteer Center of SWCT/ United Way
Bill Callion	Manager, Fairgate Farm	Fairgate Farm
David Knauf, MPH, MS, RS	Director of Health	Town of Darien
David Reed, M.D.	Medical Director/ Director of Public Health	Town of New Canaan/ Stamford Hospital
Deborah Fedeli	Director	Stamford Hospital
Donna Spellman	Director of Outreach	Charter Oak Community Family Center Inc.
Elizabeth Manfredo	Director, Cancer Service Line	Stamford Hospital
Ernest Lamour	Executive Director	YMCA
Eugene Campbell	Executive Director	Yerwood Center
Gerald Rakos, MD	Chair, Dept. of Pediatrics	Stamford Hospital
Jeanne Van Lent	Director of Marketing	Stamford Hospital
Jennifer Hallisey	V.P. Education	United Way of Western CT
Juan Medrano	Director of Finance; President, Hispanic Advisory Council	Yerwood Center
Kara Koss, MPH	Planning Analyst	Stamford Hospital
Katie Heichler		Interfaith Council of Southwestern Connecticut
Kerri Hagan	Public Health Educator	Stamford Dept. of Health and Social Services
Madhu Mathur, MD, MPH	Director, KIDS'FANS, Chair Obesity Task Force	Childhood Obesity Task Force

Appendix 14: Health and Wellness Workgroup Members, cont'd

Name	Title	Organization
Mary Henwood-Klotz, MPH	Director	Stamford Hospital
Mary Judge, RN, MBA	Manager	Stamford Hospital
Mike Cotela	Executive Director	Boys and Girls Club
Olga Brown	Director of Nursing Services	Stamford Hospital
Pamela Koprowski	Public Affairs Consultant	Stamford Hospital
Rona Marotta	WIC Program Coordinator and Nutritionist	Health Dept., City of Stamford
Sondra Pryor	Parent/School Liaison	Yerwood Center
Tanya Court	Director Public Policy & Programs	Business Council of Fairfield County
Terri Drew	Director	City of Stamford - Youth Services Bureau
Vicki Hoffman	Director, Women's Health Service Line	Stamford Hospital
Vincent J. Tufo	Executive Director	Charter Oak Community Family Centers, Inc.
Willard Pinn	Executive Director	Dubois Center

Appendix 15: Stamford Hospital Community Action Plan for Population Health and Prevention

Background:

In response to the Stamford/ Lower Fairfield County Community Health Needs Assessment (CHNA) conducted in 2013, Stamford Hospital is launching a new strategic initiative in Population Health and Prevention as part of its **Action Plan** to optimize the health and well-being of the populations it serves. Based on the results of the CHNA, stakeholders from Stamford Hospital, the City of Stamford Health Department, other public officials, and community members collaborated to establish priorities to improve the health of the community. Four **priority needs** were identified including: 1) Health and Wellness, 2) Chronic Disease, 3) Behavioral/Mental Health, and 4) Access to Services. A significant common finding across the four (4) priority areas was indications of racial/ethnic disparities in needs, resources, and risk.

Approach:

The planned approach to address the priority needs identified in the CHNA is to develop a roadmap for population health based on best practices and evidence-based interventions that are culturally tailored and target multiple leverage points in the pathway to health. Through this roadmap, and in collaboration with key partners, Stamford Hospital will aim to:

A. *Improve* lifestyle and address social/environmental factors that contribute to chronic disease and lead to preventable hospitalizations and unnecessary ER visits;

B. *Improve* access to primary, specialty, and preventive services to all community residents to reduce documented racial and ethnic disparities;

C. *Improve* the coordination of care between the hospital, outpatient providers, the home, and the patient to facilitate a more seamless connection between the hospital system and the community it serves.

Scope:

It is widely recognized that many of the determinants of health fall outside of the traditional healthcare system; therefore Stamford Hospital believes the *engagement of the community in the process of improving health is vital.*

A fundamental aspect of the framework for the Action Plan is that it addresses multiple factors that determine the health of the community including:

- medical care
- lifestyle choices
- social/cultural factors, and
- environmental influences

Appendix 15: Stamford Hospital Community Action Plan for Population Health and Prevention, cont'd

To achieve the overarching goal of improving the health status of the community, Stamford will position itself as the Stamford Health System, emphasizing the roles of medical care and other forces in determining the health of the community. As a strategic approach to reduce disparities, the Action Plan embraces the concept of health equity which emphasizes an equal opportunity for all groups to achieve optimal health. Focus on this concept ensures that priorities and distribution of resources are driven by need and capacity. Another guiding principle is the concept of health as multidimensional, not merely as the absence of disease. The *Population Health and Prevention* strategic initiative will be a driving force to implement the Action Plan in the Stamford/Lower Fairfield County community with the mission to improve the health and quality of life of the populations served by Stamford Hospital.

Theoretical Framework:

The proposed Action Plan is guided by established theories of individual and community behavior change grounded in social learning theory and community activation principles as outlined in Attachment A.

Through its work, and in collaboration with key partners (e.g. Local Departments of Health, Federally Qualified Health Centers, Skilled Nursing Facilities, Behavioral Health Providers, Community Based Organizations, etc.), Stamford Health System will not only develop new programs and initiatives, but also strengthen and integrate existing programs and services that support the three aims of improving lifestyle, access to services, and coordination of care as outlined above. A listing of planned new and existing programs / initiatives to support each of these three aims can be found in Attachment B.

It should be noted that development of the infrastructure to create a sustainable model to improve population health with the ability to adapt to changing community needs is paramount to the framework.

Target Populations:

The community served by Stamford Health System includes the target populations listed below and the Action Plan has been developed in recognition of the importance of providing for the potential flow of individuals from one group to another. Accordingly, the transition and coordination of care is critical to efforts to improve quality, outcomes, and community health. The Action Plan is committed to integrating cross-cutting interventions with quality improvement efforts that impact the various target populations served, which are identified as follows:

- Inpatients
- Outpatients
- Corporations / employees
- Local Community populations

Appendix 15: Stamford Hospital Community Action Plan for Population Health and Prevention, cont'd

Implementation:

The Action Plan will emphasize cross cutting evidence-based interventions and programs aimed at root causes of the most prevalent chronic diseases that lead to health disparities and recurrent hospitalizations, AND are amenable to prevention. Implementation of the Action Plan will be expected to:

- Strengthen and coordinate preventive services
- Facilitate access to care
- Empower populations through knowledge transfer, innovation diffusion, social media and marketing, community activation, and environmental engineering

Objectives:

The Steering Committee of the *Population Health and Prevention* strategic initiative will establish specific objectives to achieve the maximum benefit to the target populations based on their assessment of community needs and multidisciplinary expertise in medicine and public health. *Examples* include:

- Reducing overall rates of and disparities in:
  - obesity, hypertension, and diabetes
  - unnecessary ER visits related to asthma
- Increasing rates of:
  - community engagement
  - screening and referral for behavioral/mental health conditions

Metrics:

Outcome measures related to specific objectives will be established by the Steering Committee based on state-of-the-art reporting tools and tracking of progress will occur through a periodic reassessment of community health indicators. Progress toward achieving the specified goals and overall mission of the *Population Health and Prevention* initiative will be evaluated and communicated to the community on a regular basis via a multimedia campaign and community partners.

Leadership Infrastructure:

The *Population Health and Prevention* strategic initiative will be guided by a Steering Committee that oversees internal workgroups, and also works collaboratively with a Community Advisory Group.

The Steering Committee is composed of key stakeholders with decision making authority from Stamford Health System representing the areas of:

- Operations
- Strategy / Market Development
- Quality and Patient Safety

Appendix 15: Stamford Hospital Community Action Plan for Population Health and Prevention, cont'd

- Information Systems
- Medical Services
- Public Affairs

Internal workgroups will be established and will include leadership from:

- Key service lines
- Nursing
- Ancillary services
- Planetree / customer satisfaction
- Marketing
- Finance
- Stamford Health Integrated Practices (employed physician network)
- The Stamford Hospital Foundation.

Finally, the Community Advisory Group will have broad representation of the community including:

- Leadership of the Local Departments of Health
- Leadership of the VITA project
- Business owners
- Corporate leaders
- Faith-based leaders
- Patient and caretaker representatives
- School system representatives
- Others

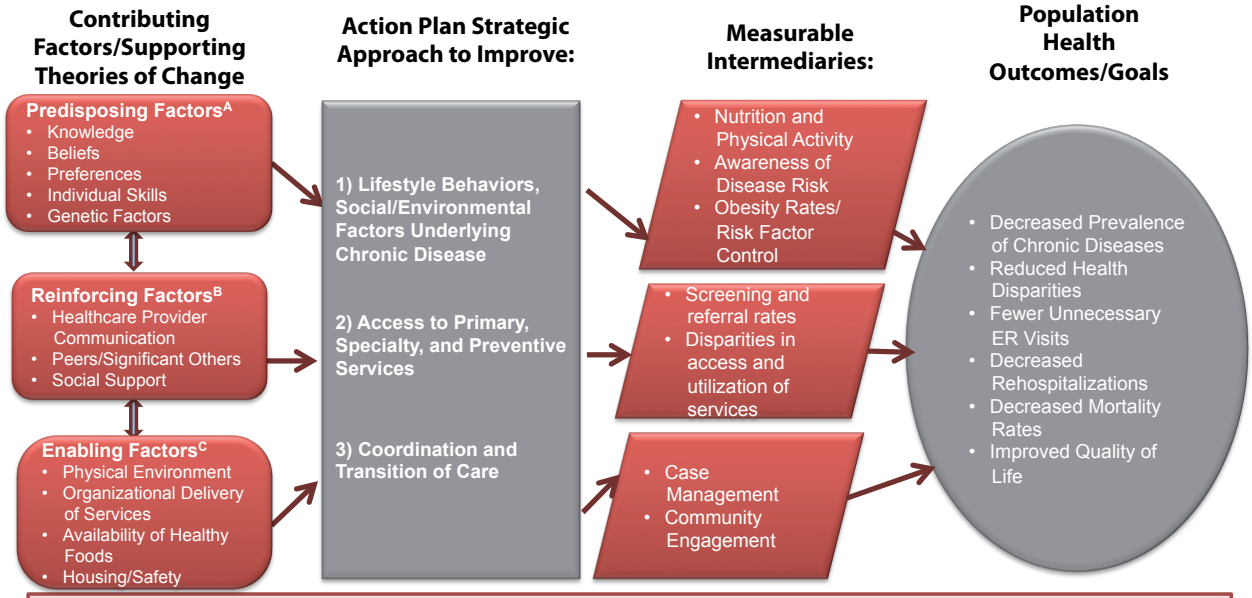
Next Steps:

The Stamford Hospital Board of Directors approved the Action Plan at their meeting on September 25, 2013. In the months that follow, management will proceed with the initial meeting of the Steering Committee where workgroups to oversee the further development and implementation of the Action Plan will be established. During its initial meeting, the Steering Committee will also identify key external partners / stakeholders to be engaged to support the *Population Health and Prevention* initiative – either through formal partnership and/or by participation in the Community Advisory Group.

A first meeting of the Community Advisory Group will be convened in the Fall of 2013 during which the Action Plan will be presented and opportunities for collaboration and partnership will be discussed.

Appendix 15: Stamford Hospital Community Action Plan for Population Health and Prevention, cont'd

Attachment A: Theory-based Action Plan for Stamford Population Health and Prevention



INDIVIDUAL LEVEL OF CHANGE

[A]**Health Belief Model:** behavior is motivated by an individual's perceived susceptibility and/or perceived severity of a disease

Theory of Planned Behavior: a person's behavioral performance is determined by motivation/intention and perceived control over the behavior

INTERPERSONAL LEVEL OF CHANGE

[B]**Social Cognitive Theory:** behavior and other personal factors have a reciprocal relationship with the social environment, continually influencing each other; social support is a key factor in reinforcing behavior

Social Ecological Model: an individual's close peers and family members significantly influence behavior, as do healthcare providers making recommendations; social and cultural norms also affect behavior

COMMUNITY LEVEL OF CHANGE

[C]**Diffusion Theory:** predicts the process by which new ideas are adopted in the community, including how compatible they are with existing customs; support of *program adopters* (i.e., gatekeepers) is critical for implementation

Community Organization Theory: focuses on the key concepts of empowerment, critical consciousness, and community capacity

Appendix 15: Stamford Hospital Community Action Plan for Population Health and Prevention, cont'd

A. *Improve* lifestyle and address social/environmental factors that contribute to chronic disease and lead to preventable hospitalizations and unnecessary ER visits	
New Programs / Initiatives	**Existing Programs / Services to Support**
• Develop preventative cardiology program • Develop preventative medicine program • Develop longevity program • Partner with Charter Oak Communities to continue development of Vita Health and Wellness District and: - Improve access to and quality of Affordable Housing. - Improve access to healthy foods through Fairgate Farm - Improve access to affordable fitness and recreation facilities (new Fitness Center; utilization of Mill River park)	• Health Education Courses focused on Chronic Disease prevention: - Obesity – weight loss, nutrition, fitness - Cardiovascular health - Smoking Cessation - Cancer prevention - Sleep disorders - Stress management - Circulatory problems - Digestive disorders - High cholesterol • Corporate Education / Speaker's Bureau • KIDS' Fitness and Nutrition Services (FANS) • Tully Health and Fitness Institute • Center for Integrative Medicine and Wellness

Appendix 15: Stamford Hospital Community Action Plan for Population Health and Prevention, cont'd

B. *Improve* access to primary, specialty, and preventive services to all community residents to reduce documented racial and ethnic disparities	
New Programs / Initiatives	**Existing Programs / Services to Support**
Primary Care and Preventive Services: • Partner with Americares to develop free clinic; Stamford Hospital to offer diagnostic imaging and lab services free of charge • Strengthen partnership with Optimus (improved communication and coordination) • Partner with Optimus to continue to grow utilization of Vita Health and Wellness Primary Care site; explore implementation of Community Health Workers to conduct outreach • Develop Employee Wellness Program (Livewell) • Develop Corporate and Municipality Wellness Program • Expand biometric and cardiovascular health screening in Mobile Wellness • Develop "Family Passport" program to screen for risk of cardiac illness in family members of cardiac patients	**Primary Care and Preventive Services:** • Health Fairs and Screenings; improve linkages / follow up to primary care • Partnership with Optimus for delivery of Primary Care Services; Primary Care residents and Subsidy • SHIP Primary Care physicians • Tully Immediate Care Center – expanded hours • Mobile Wellness Program – screening for Breast, Cervical, and Colorectal* cancers • Endoscopy Center • Women's Preventative Services (Mammography, Bone Densitometry, etc.) • Influenza Vaccine Campaign w/ Stamford Health Dept. ** Colorectal screening done in partnership with Endoscopy Center*

Appendix 15: Stamford Hospital Community Action Plan for Population Health and Prevention, cont'd

B. *Improve* access to primary, specialty, and preventive services to all community residents to reduce documented racial and ethnic disparities	
New Programs / Initiatives	**Existing Programs / Services to Support**
Specialty Care: • Explore implementation of Project Access with Optimus to offer free specialty care (w/ volunteer physicians) and diagnostic services (from SH) for low income residents. • Evaluate alternative model for Stamford Hospital specialty clinics to improve outcomes and service to underserved **Behavioral Health:** • Conduct Substance Abuse screenings (e.g. SBIRT) in the Emergency Room, ICC, and Primary Care Settings (SHIP Practices, Optimus, Americares) and refer patients to treatment as appropriate. • Explore partnership with Liberation House for patients requiring long term treatment for substance abuse. • Conduct Mental Health screenings for depression (e.g. PHQ-9) in the Emergency Room, ICC, and Primary Care Settings (SHIP Practices, Optimus, Americares) and refer patients to treatment as appropriate **Dental Care:** • Partner with Optimus and CHC to increase access to Dental Care for low income / underserved residents at FQHC sites; explore creation of new dental office in Vita Health and Wellness District.	**Specialty Care:** • SHIP Specialty physicians • Specialty Clinics • Outpatient Rehabilitation Musculoskeletal program **Behavioral Health:** • Inpatient psychiatric services • Partnership with the Domestic Violence Crisis Center **Dental Care:** • N/A

Appendix 15: Stamford Hospital Community Action Plan for Population Health and Prevention, cont'd

C. *Improve* the coordination of care between the hospital, outpatient providers, the home, and the patient to facilitate a more seamless connection between the hospital system and the community it serves.

New Programs / Initiatives	Existing Programs / Services to Support
• Implement Chronic Disease Management programs for: - CHF - COPD - Diabetes • Develop caregiver education program for caregivers of hospitalized patients • Implement CMS bundled payment initiative; develop and enhance partnerships with post-acute providers to enhance the care continuum and better manage patients • Develop and implement infrastructure and systems to support alternative care models (e.g. ACO, Bundled Payment Initiatives, and other models) – - Enhanced information systems, care management systems, partners identified and formal referral relationships / processes established (metrics – savings achieved, readmissions prevented, chronic care management improved) • Explore partnership to allow for delivery of medications to patients at discharge	• Existing resources to manage / treat chronic disease: - Diabetes and Endocrine Center - Support of / participation in Asthma Collaborative - Pulmonary Rehabilitation (Tully) - Anticoagulation and Medication Reconciliation Clinics - Cardiac Rehabilitation (HFI) - Center for Surgical Weight Loss - Bennett Cancer Center - HIV med. case mgmt. (Stamford Cares) w/ Stamford Health Dept. • Planetree Designation- patient centered care engaging patient and family • Hospital Care Management teams and Discharge Program • Nurse Navigators (Cancer focus: Breast, GYN-ONC (new*), Colorectal, prostate and lung) • Telehealth Partnership

STAMFORD HOSPITAL
The Regional Center for Health

affiliate Columbia University College of Physicians and Surgeons
member New York-Presbyterian Healthcare System
A Planetree Hospital

As a Planetree hospital, we are committed to personalizing, humanizing and demystifying the healthcare experience for patients and their families. Our approach is holistic and encourages healing in all dimensions—mind, body and spirit.

Stamford Hospital

30 Shelburne Road
P.O. Box 9317
Stamford, CT 06904-9317
Phone: 203.276.1000

StamfordHospital.org