NAUGATUCK VALLEY
COMMUNITY HEALTH IMPROVEMENT PLAN
2019-2021

GRIFFIN HEALTH

NVHD
NAUGATUCK VALLEY HEALTH DISTRICT
1972

Introduction Letter

Dear Valley Community,

We are pleased to present the 2019-2021 Community Health Improvement Plan (CHIP) for the Naugatuck Valley communities.

The CHIP is part of a regional initiative that supports regulatory and accreditation requirements of both Griffin Hospital and Naugatuck Valley Health District. The overall goal of this Community Health Improvement Plan is to address chronic conditions that affect the health of our community. The CHIP outlines key objectives and strategies that address determinants of health and improve health equity.

This roadmap for improved health results from the consistent dedication of numerous Valley partnerships, working together in a collaborative planning process. More than 75 stakeholders reviewed the top concerning public health issues identified in the 2019 Valley Community Index, resulting in identification of the following key health priorities for the Valley. We invite all residents of the Naugatuck Valley towns to learn about these planned actions to enhance community health.

➢ Behavioral Health
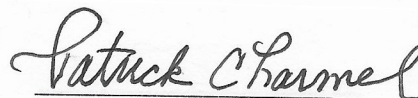➢ Heart Health
➢ Maternal and Infant Health

We would like to extend our thanks to our many committed partners who have contributed their ideas, energy and expertise to develop this Plan.

Together, we look forward to making a difference in the Naugatuck Valley Region.

Yours in health,

Jessica Stelmaszek, MPH
Director of Health
Naugatuck Valley Health District

Patrick A. Charmel
President & CEO
Griffin Health Services

GRIFFIN HEALTH

Table of Contents

Acknowledgements

CHIP STEERING COMMITTEE

Carissa Caserta, Naugatuck Valley Health District
Beth Comerford, Yale-Griffin Prevention Research Center
Kim Doughty, Yale-Griffin Prevention Research Center
Joan Lane, Naugatuck Valley Health District
Todd Liu, Griffin Health Services
Jamie Luckhardt, Naugatuck Valley Health District
Monica Oris, Griffin Health Services
Jessica Stelmaszek, Naugatuck Valley Health District

MEMBER ORGANIZATIONS

Ansonia School Readiness
Alliance for Prevention & Wellness
BHcare
Boys and Girls Club
Catholic Charities
Christian Counseling & Family Life Charities
CT Institute for Refugees and Immigrants
Community Members
Derby Youth Service Bureau
Griffin Health Services
Lower Naugatuck Valley Parent Child Resource Center
Massaro Community Farm
Naugatuck Valley Health District
Naugatuck Valley Medical Reserve Corps
Rape Crisis Center of Milford, Inc.
Shelton Public Schools
TEAM, Inc.
The Umbrella Center for Domestic Violence Services
Valley Community Foundation
Valley Regional Adult Education
Waterbury WIC
Yale-Griffin Prevention Research Center
Zero to Three
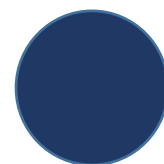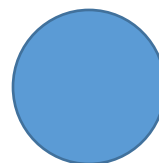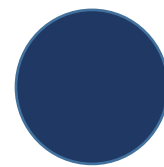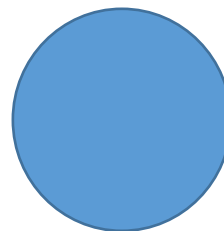
Vision

We strive to be a caring community that nurtures the overall health and quality of life of all its residents by promoting healthy living and equitable access to health services.

Introduction and Background

A Community Health Improvement Plan, or CHIP, is part of an overall process whose objective is to identify strategies to improve the health of a specific community or region. The process begins with a Community Health Assessment, or CHA. "Data obtained through the needs assessment is used to identify priority issues, develop and implement strategies for action, and establish accountability to ensure measurable health improvement"[1]. Simply stated, agencies work together to look at community health needs, select those issues of most concern, and establish a plan to address these issues. This process allows many community based organizations, civic leaders, business owners and community members to understand the types of issues that surround them. It fosters improved coordination to identify and act on community strengths and weaknesses.

This 2019-2021 Community Health Improvement Plan (CHIP) for the Naugatuck Valley is the third such document* for our seven (7) Valley towns: Ansonia, Beacon Falls, Derby, Naugatuck, Oxford, Seymour and Shelton. A key lesson learned from the 2016-2018 CHIP was to identify fewer priority issues and develop new initiatives to support them.

This report relies on data from federal, state, and local government agencies, as well as information collected directly from Valley residents as part of the statewide 2018 DataHaven Community Wellbeing Survey.

Eighty-eight local partners/community members representing 75 different organizations/coalitions attended a community forum in June 2019 to identify the CHIP focus areas based on data from the Valley Community Index. Members of the Valley Community Index Advisory Committee were fully engaged in evaluating the data and directing the local conversations.

The Valley Community Index illustrates the connections between health and other quality of life issues, including economic, educational and cultural elements. The Community Health Improvement Plan incorporates these connections, an acknowledgement of the critical role that social determinants play in the health of the community. The CHIP supports the efforts of the many health and service organizations that strive every day to address the societal inequities that contribute to health disparities within our Valley municipalities.

For prior CHIPS, see www.nvhd.org or griffinhealth.org.

---

[1] National Association of County and Health Officials. "Community Health Assessment and Improvement Planning." www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment.

Key Findings from the Naugatuck Valley Community Health Assessment

Social Determinants of Health

It is well known that the "conditions in which people are born, live, work, and age" [2] substantially influence health. These conditions are called **social determinants of health** and include education, socioeconomic status, neighborhood and physical environment, community factors, stress, and access to healthcare. Social determinants of health tend to disproportionately and adversely affect racial, ethnic, and other minority populations.[3] Therefore, it is important to consider these factors when evaluating the health of a community.

The Valley Community Index reported that the poverty rate in the Valley increased from 5% in 2000 to 8% in 2017 and the low-income rate increased from 15% to 21% over the same period.[4] Another important measure of economic status is the percentage of households that are considered "Asset Limited, Income Constrained, Employed" (ALICE), which represents those above the poverty and low-income lines but still struggling to satisfy their basic needs.[5] In 2016, 34% of the region's households were considered ALICE. Overall, nearly 43% of Valley households were either in poverty or below the ALICE threshold; this figure ranged from 60% in Ansonia, to as low as 21% in Oxford.[6]

Differences in health outcomes that are linked to social or economic disadvantages are called **health disparities**.[7] Examples of health disparities in the Valley include better self-reported health among wealthier residents compared to lower income residents, and racial disparities in fetal and infant mortality. Of adults with annual incomes of $75,000 or more, 67% rate their health as "very good" or "excellent," as compared to just 47% of those with annual incomes below $30,000. Rates of fetal and infant mortality are dramatically higher for Blacks (52.6 per 100,000) as compared to Whites (8.7 per 100,000). [8]

The goal of the current CHIP is to address social determinants of health to reduce health disparities and move closer to achieving **health equity**, a condition in which all residents will have the same opportunities for good health and will not be disadvantaged because of their social or economic circumstances.[9]

---

[2] Artiga, S. & Hinton, E. Kaiser Family Foundation. (2018). Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Retrieved from https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/.

[3] Williams, D. R., & Jackson, P. B. (2005). Social sources of racial disparities in health. *Health Affairs*; *24*(2). Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.24.2.325.

[4] Valley Community Index 2019.

[5] Valley United and United Way of Naugatuck and Beacon Falls (2018). 2016 Point-in-Time Data. Retrieved from http://alice.ctunitedway.org/wp-content/uploads/2018/09/UW-NB-2018-ALICE-Catchment-Page.pdf and http://alice.ctunitedway.org/wp-content/uploads/2018/09/Valley-UW-2018-ALICE-Catchment-Page.pdf

[6] Ibid.

[7] "Disparities." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 17 Aug. 2018, https://www.cdc.gov/healthyyouth/disparities/index.htm.

[8] Connecticut Department of Public Health. 2015 Fetal & Infant Mortality Data.

[9] Definitions | Social Determinants of Health | NCHHSTP | CDC. (2019). Retrieved 18 December 2019, from https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html

Health Indicators

According to the most recent data available, the leading causes of premature death in the Valley, based on years of potential life lost (number of years before age 75) were cancer, heart disease, fetal/infant death, substance abuse, motor vehicle accidents, suicide, and firearm injuries. Importantly, rates of cancer, heart disease, substance abuse, and motor vehicle accidents are higher than those for the state of Connecticut overall; and rates of fetal/infant death, substance abuse, and firearm injuries are increasing. However, mortality data only tell us about people who die; they do not provide a complete picture of the impact of chronic diseases on people's quality of life throughout youth and middle age. Analyses of the records of residents' visits to statewide hospitals and emergency rooms over the past six years and of the data collected through the DataHaven Community Wellbeing Survey presents a clearer picture of the full burden of these conditions.

Years of Potential Life Lost before Age 75 per 100,000 Residents per year due to Leading Causes

Cause	Valley			Trend	Higher or Lower Rate Than CT?
	Rate 2008-12	Rate 2010-14			
Cancer	1556	1507		-	Higher
Lung Cancer	417	407		-	Higher
Breast Cancer	126	116		Decreasing (-8%)	-
Heart Disease	993	913		Decreasing (-8%)	Higher
Fetal/Infant Death	644	765		Increasing (+19%)	-
Substance Abuse	497	511		Increasing (+3%)	Higher
Motor Vehicle Accidents	359	353		-	Higher
Suicide	290	268		Decreasing (-8%)	-
Firearm Injuries	166	176		Increasing (+6%)	-

While cancer causes the most premature death in the Valley, cancers do not all have the same causes and some are less preventable than others. The Hewitt Center for Breast Wellness at Griffin Hospital and The Center for Cancer Care continue to offer several initiatives and programs addressing these important priority areas. On the other hand, heart disease is the second leading cause of death in the Valley and its modifiable risk factors are also associated with some cancers, including lung cancer, which causes the most cancer deaths in the Valley. These risk factors—tobacco use, poor diet, lack of exercise, and substance use—are sometimes referred to as the "actual" causes of death because they contribute to many different causes of death.

Two of the leading causes of premature death—substance abuse and suicide—can be attributed to behavioral health disorders, which include both mental illness and substance use disorders.[10] According to the Substance Abuse and Mental Health Services Administration, behavioral health disorders affect nearly one in five Americans—yet behavioral health care needs often go unmet.[11] In 2016, only 43% of the 44.7 million adults with any mental health disorder received treatment, and less than 11% of adults

---

[10] American Hospital Association (AHA). (2007). TrendWatch: Community Hospitals: Addressing Behavioral Health Care Needs. https://www.aha. org/system/files/2018-02/twfeb2007behavhealth.pdf

[11] https://www.aha.org/system/files/media/file/2019/05/aha-trendwatch-behavioral-health-2019.pdf AND https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf

with a substance use disorder received treatment.[12] Behavioral health is a growing concern both across Connecticut and within the Valley, and data suggests some behavioral health disorders are trending upward. As illustrated in the figure below, drug overdose rates have increased substantially in the past 5 years in both the Valley and the state.

2.13 Overdose death rates have skyrocketed in recent years
Age-adjusted monthly rate of drug overdose deaths per 1 million residents, 6 month moving average, 2012–2018

Connecticut — Valley
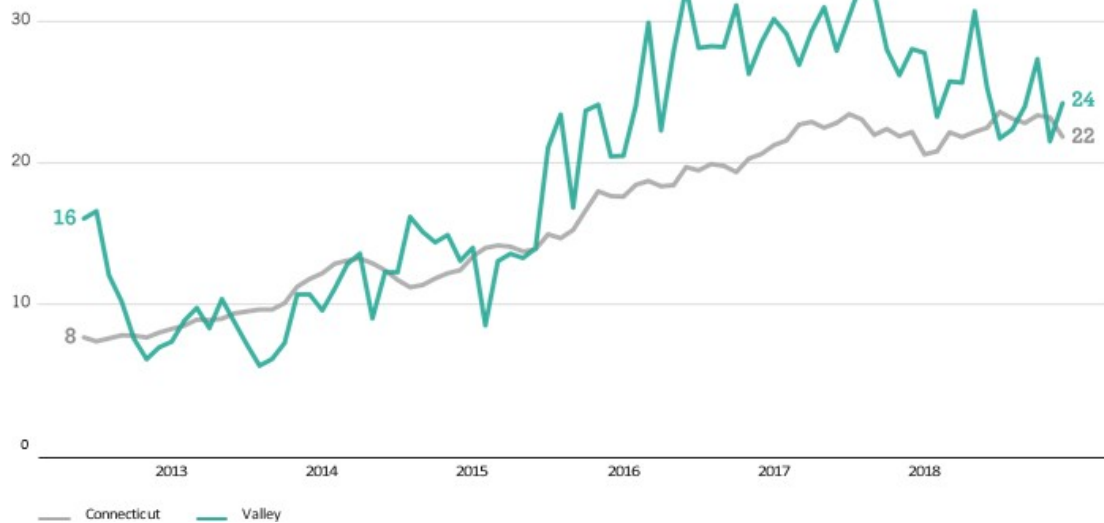
The increasing trend in fetal and infant mortality in the Valley and the stark racial disparities are troubling. The rate of non-adequate prenatal care in the Valley—meaning that the mother went to fewer than 80% of the expected prenatal care visits or did not start the visits until her second trimester—rose from 11.3% of 2006–2010 births (824 infants) to 16.4% of 2011–2015 births (1,076 infants); though the rate is still below the statewide rate, this 45% increase in the Valley was well above the 14% increase experienced across Connecticut.

2.05 Birth outcomes
DataHaven analysis of CTDPH vital statistics data, 2006–2010 and 2011–2015

	2006–2010			2011–2015			Percent change		
	Total births	Low birth weight	Non-adequate care	Total births	Low birth weight	Non-adequate care	Total births	Low birth weight	Non-adequate care
Connecticut	200,357	8%	20%	181,687	8%	23%	−9%	−3%	+14%
Valley	7,292	8%	11%	6,575	8%	16%	−10%	+3%	+45%
Ansonia	1,198	8%	12%	1,039	9%	18%	−13%	+14%	+49%
Beacon Falls	303	7%	7%	206	10%	14%	−32%	+40%	+106%
Derby	748	8%	12%	667	8%	19%	−11%	−3%	+62%
Naugatuck	1,863	8%	11%	1,782	8%	14%	−4%	+3%	+28%
Oxford	595	7%	9%	464	5%	12%	−22%	−22%	+38%
Seymour	821	7%	10%	794	8%	14%	−3%	+18%	+36%
Shelton	1,764	7%	14%	1,623	7%	20%	−8%	−7%	+48%

[12] Ibid.

Development of the Valley Community Health Improvement Plan for 2019-2021

The CHIP Steering Committee met at least bimonthly through the spring of 2019 to review the most recent CHA and determine what the newest priority areas would be. At the June 2019 community meeting the top 7 health issues were presented to the group with data to support the reason they were presented along with current work being done to address the issues. The group voted on the top four areas to focus on, which included: heart health, behavioral issues/substance abuse, maternal and infant care and lung issues (lung cancer and other lung conditions such as asthma and COPD).

The Steering Committee later decided to exclude lung issues as a priority area to limit the number of CHIP priority areas. There are several ongoing and planned programs to address lung health: specifically the lung cancer screening work from the 2016-2018 CHIP, and several new initiatives through Griffin Health Services. Additionally, it was noted that smoking would be addressed in the Heart health working group and vaping will be addressed in the Behavioral Health working group.

The Focus Areas for the 2019-2021 CHIP are:

1. Behavioral Health
2. Heart Health
3. Maternal and Infant Health

Focus areas are mentioned in no particular order of importance

Focus Area 1- Behavioral Health

Why Is This Issue a Priority?

Behavioral health disorders include both mental illness and substance use disorders. Behavioral health is growing concern in the Valley, among all age groups. The need for, and use of, behavioral health services have increased in the Valley region. Ten percent of Valley adults reported being mostly or completely anxious and nine percent reported feeling down, depressed, or hopeless more than half of the days during the two weeks prior to the 2018 DataHaven Community Wellbeing Survey; the respective rates were even higher for younger adults. The Mobile Crisis Intervention Services for children and adolescents experiencing a behavioral or mental health need or crisis, accessed through 2-1-1, received 571 calls from Valley towns in fiscal year 2018. Additionally, the Valley continues to be impacted by the opioids crisis and experiences a high number of non-fatal and fatal overdoses. Improving the emotional and social wellbeing of the Valley residents through access to care and community resources is important to the Valley community.

Workgroup Co-Chairs:

Pamela A. Mautte MS, MCHES, CPS-R
Director, Alliance for Prevention & Wellness
Program of BHcare
pmautte@bhcare.org
203-892-6418

Jessica Stelmaszek, MPH
Director of Health
Naugatuck Valley Health District
jstelmaszek@nvhd.org
203-881-3255

Workgroup Member Organizations:

Ansonia School Readiness; Alliance for Prevention & Wellness; BHcare; Boys & Girls Club; Catholic Charities; The Christian Counseling & Family Life Center; Derby Youth Service Bureau; Naugatuck Valley Health District; Naugatuck Valley Medical Reserve Corps; Rape Crisis Center of Milford, Inc.; Shelton Public Schools; Valley Regional Adult Education; The Umbrella Center for Domestic Violence Services; and Zero To Three

Goals:

Goal 1: To increase behavioral health education and awareness while emphasizing the importance of social and emotional wellness and reducing stigma.

Goal 2: To reduce stress, anxiety, and trauma, especially in young people.

Goal 3: To reduce substance use disorders in the region and promote a recovery community for those with substance use disorders in their families through education and awareness.

Objectives and Strategies:

1. To establish baseline, non-subjective behavioral health data.
    a. Implement and collect data from school screenings and behavioral health agencies.
2. To engage the community stakeholders in addressing capacity concerns.
3. Identify strategies for planning and implementation.

Activities and Actions

1.1 Host behavioral health-related trainings for clinical and non-clinical professional partners and the general public including, but not limited to:
    a. Navigating Resources
    b. Mental Health First Aid
    c. Psychological First Aid
    d. Question, Persuade, Refer (QPR) Suicide Prevention Training
    e. Narcan & Opioids Training

2.1 Host "Call to Action" events

3.1 Resource Development including, but not limited to:
    f. Contribute to the development of a Valley-specific Behavioral Health Resource Guide
    g. Seek funding opportunities
    h. Enhance partnership collaborations

Alignment with the State Health Improvement Plan

This focus is aligned with two sections of *Healthy CT 2020*, the State Health Improvement Plan: Injury and Violence Prevention and Mental Health, Alcohol, and Substance Abuse.

Focus Area 2- Heart Health

Why Is This Issue a Priority?

Data from the 2019 Community Index show that heart disease continues to be a leading cause of premature death in the Valley, as it is nationwide. By addressing heart disease – mainly through lifestyle changes – we can also influence other chronic diseases such as diabetes, obesity, stroke, and some cancers.

Workgroup Co-Chairs:

Beth Comerford, MS
Co-Director
Yale-Griffin Prevention Research Center
beth.comerford@yalegriffinprc.org
203.732.1265, ext. 224

Jamie Luckhardt, BS, CHES®
Health Educator
Naugatuck Valley Health District
jluckhardt@nvhd.org
203-881-3255, ext. 108

Workgroup Member Organizations:

Griffin Health Service, Naugatuck Valley Health District, Yale-Griffin Prevention Research Center, TEAM, Inc., and Massaro Community Farm.

Goals:

Goal 1: To reduce premature death rates due to heart disease in the Naugatuck Valley.

Objectives and Strategies:

1. Develop a social marketing/change plan
2. Identify complementary programming – i.e. policies, interventions and resources
3. Engage key stakeholders (target: business community), primarily Valley Chamber of Commerce and Valley Council of Health and Human Services

Activities and Actions

1.1 Conduct literature search and summary findings
1.2 Hold 3-day training workshop/SME
1.3 Conduct research with target population (business community/adults) (focus groups, interviews, etc.)
1.4 Present findings and develop creative brief
1.5 Develop SM strategy based on above

2.1 Conduct literature review
2.2 Compile inventory of local resources
2.3 Identify programs businesses currently use

3.1 Identify all relevant stakeholders and expand working group
3.2 Engage stakeholder via MOU

4.1 Conduct concept testing and pretesting materials
4.2 Provide resources/support to Valley Chamber and Valley Council and member organizations/businesses
4.3 Develop tracking mechanism

Alignment with the State Health Improvement Plan

The CHIP Heart Disease priority area is aligned with the SHIP's Chronic Disease Prevention and Control section of Healthy CT 2020, which aims to reduce the prevalence and burden of chronic disease through sustainable, evidence-based efforts at risk reduction and early intervention.

Focus Area 3- Maternal and Infant

Why is This Issue a Priority?

The combined fetal and infant mortality rate in Lower Naugatuck Valley (LNV) is trending up, though the trend is decreasing in CT overall – a disturbing comparison for the Valley. Similarly, although the low birthweight trend of 7.8% is comparable to the state, LNV is trending up, while the state is trending down. Additionally, the rate of inadequate prenatal care (care not initiated until after the 1st trimester) is trending up much more quickly in LNV than in the state overall. Maternal and infant health risks also contribute to the incidence of many chronic diseases in childhood and adulthood.

These trend lines triggered a concern to investigate the causes behind the trends, and to identify potential interventions to reverse the trends.

Workgroup Co-Chairs:

Kim Doughty, Research Scientist
Yale-Griffin Prevention Research Center
kim.doughty@yalegriffinprc.org
203.732.1265 ext. 305

Joan Lane, PHAB Coordinator
Naugatuck Valley Health District
jlane@nvhd.org
203.881.3255

Workgroup Member Organizations:

Naugatuck Valley Health District, Yale-Griffin Prevention Research Center, Griffin Hospital, Griffin Faculty Practice, TEAM Inc., Lower Naugatuck Valley Parent Child Resource Center/BHcare, Waterbury WIC, CT Institute for Refugees and Immigrants, at-large community member.

Goals:

Goal 1: To decrease low birth weight and fetal/infant mortality by improving health behaviors among pregnant and non-pregnant women of childbearing age.

Goal 2: To increase adequacy of prenatal care received by pregnant women by empowering women of childbearing age to have planned, healthy pregnancies.

Goal 3: To reduce disparities in adequacy of prenatal care, low birth weight, and fetal/infant mortality experienced by racial, ethnic, and socioeconomic groups.

Objectives and Strategies:

1. Establish baseline, objective data on maternal and infant health outcomes.
2. Increase the accessibility of an enhanced and updated version of the Maternal & Reproductive Health Directory.
3. Develop and implement a social marketing campaign targeting behaviors that influence maternal and infant health.
4. Increase the number of pregnant and postpartum women with HUSKY insurance who are enrolled in the HUSKY Healthy Beginnings program.
5. Increase the number of primary care and Ob/gyn providers who incorporate screening for pregnancy intention into routine visits with women of childbearing age.

Activities and Actions

1.1. Review current Community Health Assessment data and identify gaps
1.2. Explore potential sources of relevant data on maternal and infant health
1.3. Collect and analyze additional data on maternal health and health behaviors during pregnancy

2.1. Include additional services in the existing Maternal & Reproductive Health Directory (e.g., stress reduction, nutrition, physical activity, smoking cessation, substance abuse treatment)
2.2. Ensure distribution of the Maternal & Reproductive Health Directory via social media, agency websites, and publicly accessible physical locations

3.1. Develop marketing strategy (identifying target population and behaviors) and key messages for social marketing campaign
3.2. Pilot test and revise social marketing campaign materials and messages
3.3. Implement social marketing campaign

4.1. Promote the HUSKY Healthy Beginnings program with prenatal care providers
4.2. Promote the HUSKY Healthy Beginning program to pregnant and postpartum women at community events targeting this population

5.1. Assess current practices and interest in pregnancy intention screening among primary care and ob/gyn providers
5.2. Introduce One Key Question® as a resource for pregnancy intention screening
5.3. Work towards incorporating pregnancy intention screening tool into the EHR

Alignment with the State Health Improvement Plan

This focus is aligned with the Maternal Child and Infant section of *Healthy CT 2020*, the State Health Improvement Plan. It relates to the following specific State objectives: MICH-2 (preconception health), MICH-3 (1st trimester care), MICH-4 (adequate prenatal care), MICH-5 (low birthweight), MICH-7 (infant mortality), MICH-8 (infant mortality disparities).