NAUGATUCK VALLEY COMMUNITY HEALTH IMPROVEMENT PLAN

2025-2028

GRIFFIN HEALTH

Public Health
Prevent. Promote. Protect.
Naugatuck Valley Health District

DEAR VALLEY COMMUNITY,

We are pleased to present the 2025 – 2028 Naugatuck Valley Community Health Improvement Plan (CHIP) for the communities of Ansonia, Beacon Falls, Derby, Naugatuck, Oxford, Seymour, and Shelton.

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 CHIP is to serve as a strategic planning tool by which to measure impact and address chronic conditions that affect the health of our community, and to help reduce disparities in the public health and healthcare segments of the Valley population. The CHIP outlines key goals, objectives, strategies, and action steps over the three-year reporting timeframe and is informed by data and community input. The CHIP action plan is a working tool that will be continuously updated and evaluated over time to measure the impact of addressing social drivers of health and improving community health.

This roadmap for improved community health results from the consistent dedication of numerous Valley partnerships, working together in a collaborative planning process. Approximately 100 stakeholders from a wide range of community agencies and the public reviewed the top concerning public health issues identified in the latest community health needs assessment, *The 2025 Valley Community Index*. We invite all residents and individuals connected to the Naugatuck Valley region to learn more about the planned actions to enhance community health in these key priority areas:

Improve Access to Care and Other Social Needs

Enhance Mental and Behavioral Health

Increase Awareness, Access to, and Uptake of Healthy Food and Nutrition Programming and Services

We would like to extend our thanks and gratitude to our many committed partners who have contributed their thoughtful ideas, volunteered their time, and provided expertise to develop this Plan.

Together, we look forward to making a positive difference as we strive to be a caring community that nurtures the overall health and quality of life of all Naugatuck Valley residents by promoting healthy living and equitable access to health services.

Jessica Kristy, MPH
Director of Health
Naugatuck Valley Health District

Patrick A. Charmel
President & CEO
Griffin Health Services

ACKNOWLEDGEMENTS

This Community Health Improvement Plan (CHIP) is the result of the collaboration of individuals from many Naugatuck Valley health and social services organizations, private and public sector agencies, and members of the community. A special thanks to the Valley Community Foundation, Griffin Health Services, Naugatuck Valley Health District, and DataHaven, whose funding and data contributions supported the 2025 Valley Community Index – a local community health needs assessment and foundational document for this CHIP.

CHIP STEERING COMMITTEE

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MEMBER ORGANIZATIONS

Agency on Aging of South Central Connecticut
Ansonia Public Schools
Ansonia Youth Service Bureau
BHcare
BHcare's Alliance for Prevention and Wellness
City of Ansonia
Community Members
Care Connect, LLC
Cornell Scott Hill Health Center
Derby Public Schools
Derby Youth Service Bureau
Haven's Harvest
Housatonic Valley Health District
In-Home Angels, LLC
Naugatuck Public Schools
Naugatuck Valley Council of Governments
Naugatuck Valley Delegation
Naugatuck Valley Health District
Seymour Congregational Church
St. Vincent de Paul of the Valley Inc
TEAM, Inc.
The Boys & Girls Club of the Lower Naugatuck Valley
Town of Seymour
United Way of Naugatuck & Beacon Falls
Valley Community Foundation
Valley Council for Health & Human Services
Yale-Griffin Prevention Research Center

Community members and agencies/organizations/businesses are encouraged to participate! We extend an open invitation and will welcome interested individuals throughout this CHIP cycle.

BACKGROUND

A Community Health Improvement Plan, or CHIP, is part of an overall process intended to identify strategies to improve the health of a specific community or region. The process begins with a Community Health Needs Assessment, or CHNA. “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” (National Association of County and City Health Officials). Simply stated, agencies work together to look at community health needs, select those issues of most concern, and establish a plan to address them. 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.

The 2025-2028 Community Health Improvement Plan (CHIP) for the Naugatuck Valley is the fifth such document* for the 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 so that adequate attention can be given and resources allocated to meaningfully impact them. Further insights drawn from the process of implementing the 2019-2021 and 2022-2024 CHIPs during the COVID-19 pandemic were concerns around setting achievable strategies with measurable outcomes. Emphasis on health disparities among different segments of our community and increasing equity across all population segments remains a priority.

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 2024 DataHaven Community Wellbeing Survey. Eighty-nine local partners and community-members representing 42 different organizations and coalitions attended a community forum on July 18, 2025, for the rollout of the newest community health needs assessment, *The 2025 Valley Community Index*.

The 2025 Valley Community Index illustrates the connections between health and other quality of life issues, including economic, educational, and cultural factors. The CHIP incorporates these connections and acknowledges the critical role that social drivers 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.

Two community workshop sessions were held virtually on August 13, 2025, and August 27, 2025, so that attendees could have a chance to react to the data and help set priority focus areas for the CHIP. These sessions had smaller but still broadly representative groups and came to consensus on 4 selected health concerns as the focus for the 2025-2028 Valley Community Health Improvement Plan: access to care, mental and behavioral health, food and nutrition, and chronic disease. Concerns around transportation and maternal health were also voiced throughout the months long data review process, 2025 Valley Community Index Launch Event, and the two CHIP Workshops.

After breaking into committees by focus area topic to develop the SMART work plan, attached to this document, it became evident that activities related to reducing the burden of chronic disease and maternal and child health would be applicable in all focus area work plans. The Steering Committee made the decision to narrow the scope of this CHIP to three main priority focus areas with the expectation that each committee incorporate chronic disease and maternal health under their work plans.

**For prior CHIPS, see www.nvhd.org/cha-chip or griffinhealth.org.*

State and Federal Health Improvement Alignment

The three priority areas of the 2025–2028 Naugatuck Valley Community Health Improvement Plan (CHIP) — improving access to care, enhancing mental and behavioral health, and increasing awareness and access to healthy food and nutrition — directly align with both the Connecticut State Health Improvement Plan (SHIP) and Healthy People 2030 (HP2030) objectives, reflecting shared goals to improve population health, reduce disparities, and promote equity. Overall, the NVHD CHIP priorities mirror the goals of SHIP and HP2030 by targeting key social determinants of health, addressing chronic and behavioral health conditions, promoting prevention, and ensuring equitable access to resources. By aligning with state and national frameworks, NVHD strengthens opportunities for evidence-based interventions, cross-sector collaboration, and measurable improvements in population health.

Health Connecticut 2025 is the State Health Improvement Plan (SHIP). Connecticut identifies objectives related to:

- Increasing access to preventive, primary, and specialty care, particularly for underserved populations, to reduce disparities in health outcomes.
- Prioritizing behavioral health promotion, early intervention, and access to mental health and substance use services.
- Emphasizes increasing fruit and vegetable consumption, reducing food insecurity, and promoting community-based food access strategies.
- Preventing and managing chronic disease, including obesity, diabetes, heart disease, and cancer, with a focus on early detection, education, and healthy equity.

To read more about Healthy Connecticut 2025, please visit https://portal.ct.gov/-/media/dph/state-health-planning/ct_dph_ship_report_r1-10-6-2021.pdf.

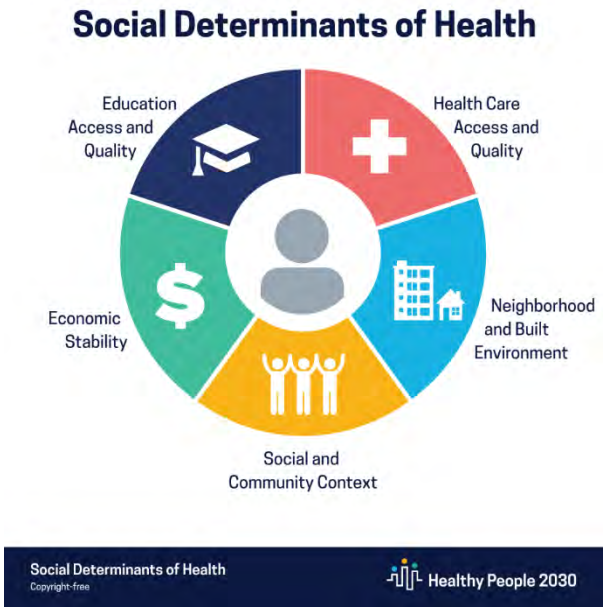
Healthy People 2030 includes 23 Leading Health Indicators (LHIs) with high-priority objectives that address major public health issues. Healthy People 2030 identifies objectives related to:

- Improving access to health services as a key social determinant of health, promoting equitable access to preventive care, screenings, and treatment.
- Reducing the prevalence of mental illness, increasing access to behavioral health services, and improving overall mental well-being in communities.
- Increasing fruit and vegetable intake, improving access to healthy foods, and reducing food insecurity as critical determinants of health.
- Preventing and managing chronic diseases through lifestyle interventions, clinical preventive services, and reducing disparities in disease outcomes.

To read more about Healthy People 2030, please visit https://odphp.health.gov/healthypeople.

Understanding Social Drivers of Health and Health-Related Social Needs

- **Social drivers of Health (SDOH):** The conditions in the environments where people are born, live, learn, work, play, worship, and age affect a wide range of health, functioning, quality-of-life outcomes and risks. SDOH refers to community-level factors. They are sometimes called "social determinants of health." (Adapted from CDC Healthy People 2030)
- **Health-related social needs (HRSN):** Social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They put individuals at risk for worse health outcomes and increased health care use. HRSN refers to individual-level factors such as financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care, and lack of access to transportation. (Adapted from HHS)



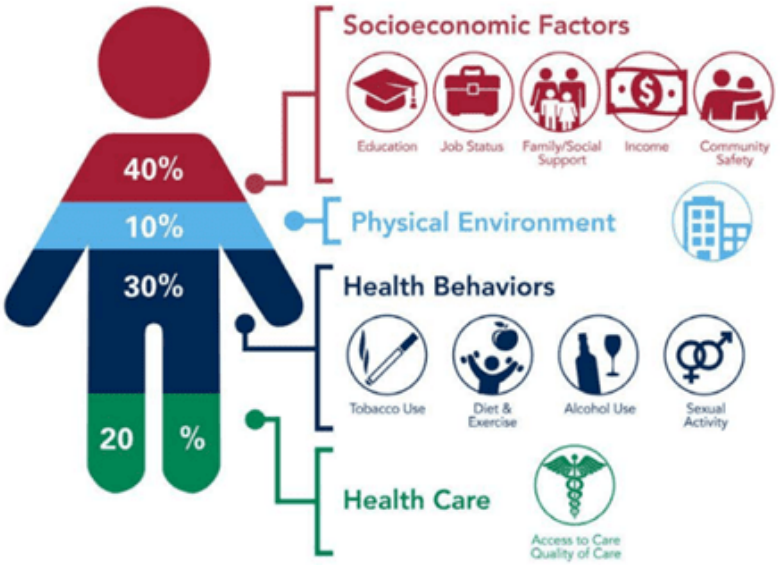


Image Source: American Hospital Association – Addressing Social Determinants of Health, 2018

It is well known that the "conditions in which people are born, live, work, and age" 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. Therefore, it is important to consider these factors when evaluating the health of a community.

KEY FINDINGS FROM THE COMMUNITY HEALTH NEEDS ASSESSMENT: THE 2025 VALLEY INDEX

This section contains the executive summary of the 2025 Valley Community Index report, titled Shining a Spotlight on the Valley Region. This document is available to download from the Valley Community Foundation website https://www.valleyfoundation.org/articles/shining-a-spotlight-on-the-valley-region.

The full 2025 Valley Community Index produced by the Valley Council for Health and Human Services and DataHaven, July 2025 can be accessed at www.nvhd.org/cha-chip or www.griffin.org.

Scan the QR code to be brought to a digital PDF copy of the full report.

The Valley is Growing More Diverse,
Particularly in Ansonia, Derby, and Seymour.

Total Population by Age Group

	Ansonia	Beacon Falls	Derby	Naugatuck	Oxford	Seymour	Shelton	TOTAL AGES
Age 0-19	3,453	1,520	2,542	4,629	2,967	2,786	8,309	**26,206**
Age 20-34	2,926	1,048	2,416	4,838	1,865	2,255	6,681	**22,029**
Age 35-49	4,528	1,498	2,825	8,377	3,360	4,659	10,602	**35,849**
Age 50-64	4,071	962	2,326	6,879	1,680	3,153	7,366	**26,437**
Age 65+	3,973	1,061	2,250	6,911	2,998	3,946	8,444	**29,583**
	18,951	**6,089**	**12,359**	**31,634**	**12,870**	**16,799**	**41,402**	

140,104 people live in the Valley

Latino and Black populations are increasing, while the White population is declining.

Nearly **1 in 5** residents are seniors **aged 65+**

21% of the Valley population is **aged 17** and below.

The Valley population is getting older. The median age in the region is **43.9 yrs,** which is higher than the state average.

Through committee discussions and community feedback, **five themes related to economic security and basic needs consistently rose to the top:**

- Housing Access and Affordability
- Food Insecurity
- Employment and Workforce Development
- Community Connection, and
- Transportation Access.

Educational attainment remains a key driver of economic mobility. Residents with a **bachelor's degree earned an average of $73,000 annually**, compared to **$46,000 for those with a high school diploma** and **$36,000 for those who did not graduate from high school.**

Economic Instability
Affects Nearly Every Aspect of a Person's Life.

The Valley is home to over 50,000 jobs, reflecting a 12% increase since 2003. However, manufacturing jobs have declined by 15% over the last two decades. As of November 2024, unemployment rates across the Valley were below pre-pandemic levels.

Across the region, Valley-wide, the median household income stands at $99,800. Shelton and Oxford report some of the region's highest median household incomes, exceeding $114,000, while Ansonia and Derby report medians under $81,000.

Barriers to employment include limited access to affordable childcare, job training/skillset, and reliable transportation.

Almost One Quarter of Surveyed Residents

Self-report Feeling Financially Insecure.

In Ansonia & Derby **over half the households are ALICE** or living in poverty.

Nearly 1 in 5 Valley residents **reported food insecurity** in the past year, and many experienced housing affordability challenges.

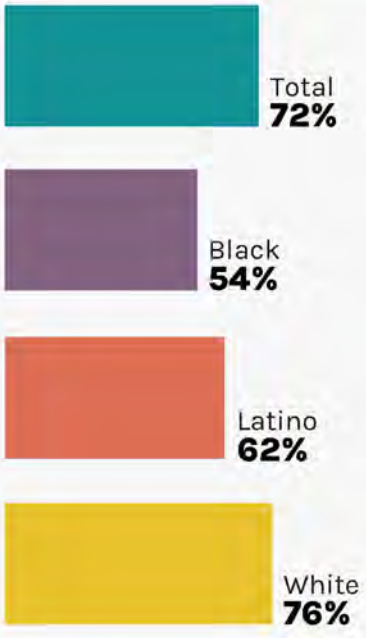
WHAT IS IT?

The **federal poverty rate** for a household of four members in 2025 as defined by the US Department of Health and Human Services **is $32,150.00**

WHAT IS IT?

ALICE (Asset Limited, Income Constrained, Employed) describes a segment of the population that earns above the Federal Poverty Level but still struggles to afford basic necessities. **These households, while employed, lack sufficient income to cover the costs of housing, childcare, food, transportation, healthcare, and technology.**

Homeownership in the Valley by Race/Ethnicity 2023



Housing Affordability Varies Significantly

Across the Valley.

If you live in the Valley, you are less likely to own a home if you are Black (54%) or Latino (62%) than if you are White (76%).

Residents report difficulty finding available units, managing high utility bills and dealing with aging infrastructure. To afford a modest two-bedroom apartment in the Valley, in 2024, a worker must earn between **25.67 and 31.77/hour.**

15% of well-being survey respondents reported being unable to afford adequate shelter in the past year, **up from 9% in 2021.**

In Ansonia and Derby, many households are cost burdened. Within the Valley, the combined cost burdened and severely cost burdened rates range **from 24% in Oxford up to 45% in Derby.** This burden is felt by renters as well as homeowners.

WHAT IS IT?

Cost Burdened:
30.0%-49.9% of income spent on housing.

Severely Cost Burdened:
50% or more of income is spent on housing.

Food Insecurity Continues to Rise in The Valley,
Closely Tied to Wages, Housing Costs, and Family Size.

In 2024 nearly **20%** of respondents have reported **experiencing food insecurity.**

Of those surveyed, food was ranked as the second most important economic issue.

Food pantry use increased more than a third from 2023-2024. with the steepest increases among seniors and families with children.

Despite growing efforts by local organizations to expand food assistance, **the demand continues to exceed available resources.** Some school districts have established weekend food programs to ensure children have access to meals beyond the classroom.

In 2024, There are 26,206 Seniors,
19% of the Valley's Total Population.

Between **2023 and 2024**, food pantry utilization among Valley residents aged 60 and older **increased 31.4%**. Housing for seniors is typically a major expense. The ability to age in place is the second most prominent issue after food security. Senior Centers are a hub and social outlet for many seniors and they need affordable places to live and be connected.

Food Pantry Utilization

	Increase 2023-2024
Age 0-17	51.7%
Age 18-59	29.4%
Age 60+	31.4%
Total	36.7%

Senior friendly communication methods that help close the information gap:

Internet Access | Digital Literacy | Printed Newsletters | Local Radio & Newspapers

Older adults are deeply connected to their communities. Most report satisfaction with their local area. **75% of Seniors 65 and over reported living comfortably/doing alright financially.**

Seniors suffering from elder abuse tend to be female and across all senior age categories. The top three commonly reported allegations are: **exploitation; self-neglect, and neglect by others.**

Understanding the Social Drivers of Health

Plays a Critical Role in Shaping Health and Wellbeing Outcomes in The Region.

Nearly 30% of Valley adults surveyed report delaying medical care in 2024. Such as skipping medications and delaying doctor visits. Poor housing conditions, limited access to nutritious food and environmental exposures, elevate the risk for chronic illnesses

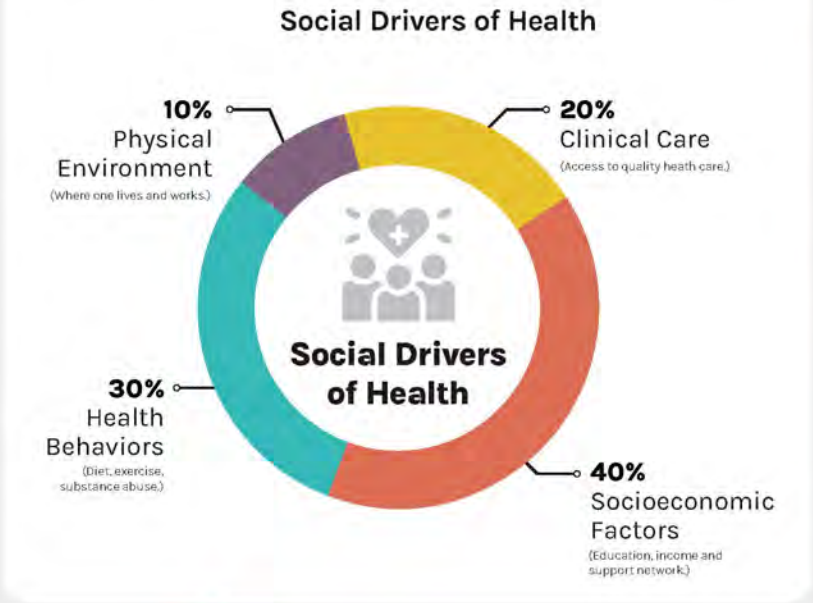
Disparities are not distributed evenly, they are often concentrated in neighborhoods with:

- Higher Poverty Rates
- Aging Housing Stock
- Limited Public Transit

Heart disease in the Valley is 4% higher than the Connecticut State average.

Life expectancy varies significantly, highlighting disparities tied to health, income, and environmental conditions, ranging from 76.4 years to 82.1 years.

In the Valley, falls and violence-related injuries continue to be significant drivers of emergency room visits.



Maternal health outcomes remain an area of concern statewide...practitioners in the Valley note the lasting implications for both maternal and child health, highlighting the need for targeted strategies to improve access and outcomes across diverse populations.

Between 2019 and 2023 the total number of **years-of-life-lost before age 75 per 10,000 residents was 13.7% higher** in the Valley compared to the state average.

Children Make Up 21% of the Valley Population

Nearly **half of all public-school students** in the Valley are eligible for **free or reduced lunch.**

All districts experienced **an increase in English Language Learners since 2021-2022** and make up a significant and growing portion of the student population.

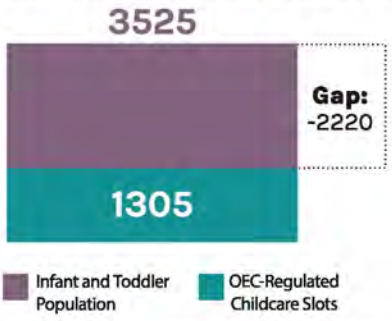
The region's overall **four-year graduation rate was high at 88%** similar to the state's graduation rates 89%, but disparities persist across towns and student populations.

Derby and Ansonia report the lowest graduation rates, reflecting broader systemic challenges. Black (80%) and Latino (83%) students were below the 88% graduation rate for all students.

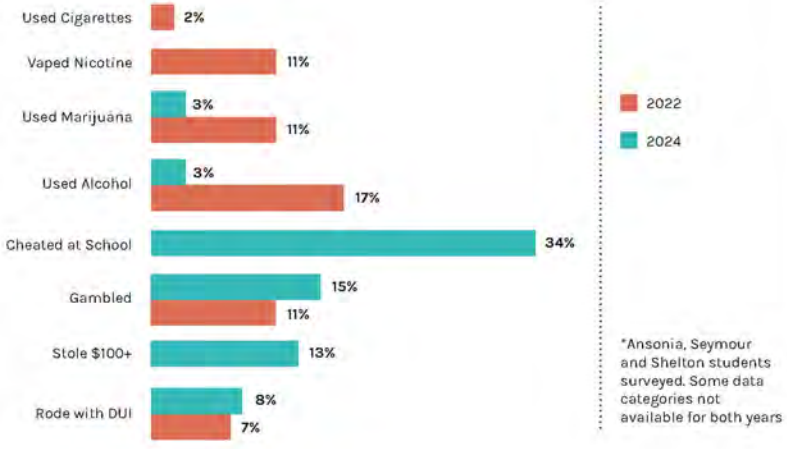
Chronic absenteeism is particularly pronounced in communities with lower income, housing instability and unmet basic needs. Most Valley communities are seeing a decrease in the percentage of students chronically absent.

Access to affordable, high-quality childcare remains a pressing challenge for some families in the Valley with small children.

Child Care Availability: Children 0-2 in 2023 Available Childcare Seats 2024.



Risky Behaviors Reported By *Valley Youth 2022-2024 Comparison



*Ansonia, Seymour and Shelton students surveyed. Some data categories not available for both years

WHAT IS IT?

Chronic absenteeism is when a student misses at least 10% of the school days during a school year.

Conclusion

The 2025 Valley Community Index reflects a detailed picture of life in the region, what is going well and where challenges still stand in the way of health and well-being. Across all seven towns, residents and partners shared their stories, concerns, and hopes, helping to paint a fuller picture of the systems that affect daily life, whether that is access to care, stable housing, education, mental health, or economic stability.

The gaps identified in the Index are not abstract. They impact families, youth, older adults, and working individuals every day. But so do the strengths, dedicated community organizations, resilient residents, and cross-sector partnerships committed to problem-solving and progress. The Valley has a long history of working together, and that collaboration is key to addressing the root causes of health challenges.

To download a full copy of the 2025 Valley Community Index scan the QR code.

Acknowledgments

The Valley Community Index is a collaborative effort that reflects the dedication, insight, and contributions of many individuals and organizations across the region.

A heartfelt thanks to the Valley Council for Health and Human Services and its member organizations for their guidance and support. The Index would not be possible without the commitment of community leaders, nonprofit partners, municipal officials, healthcare providers, educators, and residents who generously shared their expertise, time, and stories.

Special thanks to project collaborators and advisors, including: DataHaven; Griffin Health; local municipal health departments and town governments; members of the Community Index Coordinating Committee; the Naugatuck Valley Health District; and the Valley Community Foundation.

Special recognition goes to the tremendous contributions of community members who participated in listening sessions, responded to surveys, and lent their voices to this project. Their lived experiences are the foundation of the Index.

WHAT CAN YOU DO?

- **Read** the full Community Index report. Utilize the Index data to help **create cross-sector solutions.**
- **Stay informed** about key issues affecting our region. Help instill the importance of community engagement in all our citizens.
- **Become an advocate for change** in your local municipality or school district and with state policymakers.
- Participate in local and regional **community conversations.**
- Focus your resources, time, and talents to have the **greatest impact for those most in need.**
- **Participate** in the Naugatuck Valley Health Improvement Plan.

2025-2028 CHIP FRAMEWORK

This CHIP was designed with Griffin Hospital and Naugatuck Valley Health District's respective regulatory and accreditation requirements. Together, these include:

- The identification of at least two community health priorities (or, focus areas)
- Measurable objectives for each priority
- Strategies that are evidence-based, represent promising practices, or are innovative for each priority
- Each activity or strategy must include a timeframe and a designation of organizations or individuals that have accepted responsibility for implementing it
- At least two policy recommendations, including one aimed at alleviating causes of health inequities
- An emphasis on community engagement in the planning, implementation, and evaluation phases
- Identification of the assets or resources that will be used to address the priority areas
- A process to track the status of the effort or results of the actions taken to implement CHIP strategies or activities

Each priority area will have an overarching goal, specific objectives, and measurable performance strategies. Interrelated themes addressed by strategies include transportation, chronic disease burden, and impact on maternal and child health.

MOVING FROM PLANNING TO ACTION

The subcommittees solicit ongoing input from the community throughout the duration of the CHIP. There are opportunities for the community to join various initiatives and activities under each priority area during the duration of the CHIP as well.

The 2025 Valley Community Index and the 2025-2028 Community Health Improvement Plan are available on both the Griffin Health Services and Naugatuck Valley Health District websites. Printed copies of these documents will be made available to the public (free of charge), as requested.

Additionally, community members and stakeholders expressed their belief about the importance of raising awareness of the CHIP action plan and inviting the community to be involved throughout the year.

The subcommittees solicit ongoing input from the community throughout the duration of the CHIP. There are opportunities for the community to join various initiatives and activities under each priority area during the duration of the CHIP as well.

IMPLEMENTATION AND TRACKING PROGRESS

Each of the CHIP Focus Areas is supported by a workgroup responsible for defining Goals, Objectives/Strategies, Activities/Actions and an implementation plan. A common tracking tool will be utilized, and each priority area working group submits quarterly updates to the CHIP Steering Committee. These reports will be presented to the respective Boards of Griffin Hospital and Naugatuck Valley Health District. The Steering Committee hosts community updates on at least an annual basis. Updated Workplans are appended to the CHIP document at least annually, and are posted to both the Griffin Hospital and Naugatuck Valley Health District websites.

Priority Area A:

INCREASE ACCESS TO CARE AND OTHER SOCIAL NEEDS

GOAL:

Improve equitable access to high-quality healthcare and essential social supports for Valley residents by reducing systemic barriers to care, strengthening coordination across healthcare and community partners, and addressing social drivers of health to improve health outcomes and advance health equity.

WHY IS THIS ISSUE A PRIORITY IN THE VALLEY?

Improving access to care and other social needs is a priority for the 2025–2028 Naugatuck Valley Community Health Improvement Plan because many residents face persistent barriers to obtaining timely, affordable, and culturally appropriate health services which directly influence the health, well-being, and long-term outcomes of the community. Inadequate access leads to missed screenings for conditions like cancer, reducing opportunities for early, effective intervention. Challenges such as limited transportation, lack of insurance, provider shortages, and language or cultural barriers lead to delayed diagnoses, untreated conditions, and higher rates of emergency care use. These issues disproportionately affect low-income families, older adults, and other vulnerable populations, contributing to health disparities across the region.

The 2025 Valley Community Index identifies significant barriers—such as cost, transportation, housing instability, limited behavioral health access, and food insecurity—that prevent many residents from receiving timely, preventive, and coordinated care. These barriers contribute to higher rates of chronic disease, preventable hospitalizations, emergency department overuse, and disparities in health outcomes across the Valley. The Valley's data show that certain groups—low-income families, older adults, people with disabilities, and individuals with limited transportation—face disproportionate barriers.

In the 2024 well-being survey, 14% of adult respondents reported having no medical home, 29% reported delayed medical care due to cost, and 13% stated they were unable to access to care. When people cannot easily access primary care, behavioral health services, specialists, or urgent care, they are more likely to delay preventive services, rely on emergency departments, experience worsening chronic conditions, and have poorer long-term health. Improving access leads to earlier diagnosis, better management of chronic disease, and reduced healthcare costs for families and systems. Health is shaped by the combined systems of healthcare, EMS, public health, social services, housing, transportation, schools, aging services, and other community organizations. The CHIP serves as the shared roadmap that unites these partners under common goals.

Enhancing access to care aligns with Healthy People 2030 and the Connecticut State Health Improvement Plan, Healthy Connecticut 2025. Both emphasize the importance of equitable and comprehensive health services. By prioritizing this area, we aim to strengthen connections between residents and health systems, improve preventive care utilization, and advance health equity throughout the Naugatuck Valley region.

Access to Care Committee Co-Chairs

Myra Odenwaelder, DPT, CEAS, FAB
Griffin Health Services

Aneta Guliuzza, LPN
Griffin Health Services

OBJECTIVE A1. Expand access to primary and specialty care. Reduce the percentage of Valley residents who report not having a regular primary care provider (PCP) by 50% relative to the Valley baseline, through expanded appointment availability, community outreach, and linkage programs.

STRATEGIES

A1.1	Increase the number of available primary and specialty care providers as indicated through Griffin Hospital's Medical Manpower Plan.
A1.2	Enhance chronic disease management and care access by expanding remote patient monitoring capabilities, including increasing eligible patient enrollment and integrating additional clinical conditions or devices as appropriate.
A1.3	Enhance a provider pipeline program in partnership with at least one local university or training institution to support clinical rotations, internships, and other experiential learning opportunities that encourage long-term workforce retention in the community.

OBJECTIVE A2. Partner with at least one Valley EMS agency and three community-based organizations to explore, pilot, and evaluate a Mobile Integrated Healthcare (MIH) model, with the aim of reducing non-emergent EMS transports and ED visits by 10% among enrolled high-utilizer residents and increasing in-home care access across the Valley.

STRATEGIES

A2.1	Conduct a comprehensive feasibility assessment with an EMS agency and 3 community partners to identify community needs, target populations, potential funding sources, reimbursement pathways, EMS capacity, and regulatory requirements for a Mobile Integrated Healthcare program.
A2.2	Develop a pilot program framework in collaboration with EMS, hospital, and community-based organizations including protocols for care coordination, data sharing and patient follow-up.
A2.3	Launch a pilot serving at least 100 high-risk patients with home visits, chronic disease monitoring and social support referrals.
A2.4	Evaluate the pilot's impact on EMS call reduction, hospital readmissions, and patient satisfaction.
A2.5	Secure sustainable funding to expand the pilot to two additional service areas if the pilot outcomes demonstrate improved access, reduced emergency utilization, and positive patient satisfaction. Sustainable funding depends on showing cost avoidance, reduced emergency utilization, and improved outcomes. Create a ROI Report to utilize for funding requests.

OBJECTIVE A3. Reduce transportation barriers and the number of Valley residents reporting transportation as a barrier to medical care by 30% from the 2025 baseline.

STRATEGIES

A3.1	Develop and implement a transportation voucher program in partnership with local transit providers.
A3.2	Develop and implement a community ride share program in partnership with local volunteers.
A3.3	Evaluate impact on reduction in missed medical appointments due to transportation issues as evidenced by improvements in well-being survey responses and internal EMR data collection.
A3.4	Conduct a transportation route analysis by mid-2026 to identify transit gaps near healthcare access points and advocate for alignment of transit routes with peak appointment times (e.g., early morning labs, evening clinics).
A3.5	Conduct an analysis of what types of transportation are offered within each of the 7 towns.

OBJECTIVE A4. Strengthen referral pathways between healthcare and social service providers via VCHHS Community Care Hub & UniteUs participation. Increase the percentage of Valley residents successfully connected to social services (food, housing, transportation, childcare, etc.) by 50% (measured by completed UniteUs referrals) from 2025 baseline throughs systemwide screening and coordinated referrals.

STRATEGIES

A4.1	Increase the number of social services providers participating in the community care hub by 50%.
A4.2	Increase closed-loop referrals between healthcare and social service providers by 50%.

Priority Area B:

ENHANCE MENTAL HEALTH AND BEHAVIORAL HEALTH

GOAL:

Improve the mental and behavioral health and well-being of Valley residents by expanding equitable access to prevention, early intervention, treatment, crisis response, and recovery supports; reducing stigma; strengthening cross-sector coordination; improving data sharing; and addressing social determinants of mental health.

WHY IS THIS ISSUE A PRIORITY IN THE VALLEY?

Mental and behavioral health is a critical component of overall community well-being and is strongly interconnected with physical health, social stability, and quality of life. The 2025 Valley Community Index highlights that a significant proportion of residents experience behavioral health challenges, including anxiety, depression, substance use disorders, and serious mental illness. These conditions affect people across the lifespan and are particularly pronounced in populations facing social and economic inequities, such as low-income households, older adults, and communities of color. Among 2024 Wellbeing Survey respondents, 42% of adults aged 18-34 reported feeling down or depressed multiple days for two weeks, and 21% said they rarely feel emotionally supported. Behavioral health is a cornerstone of Valley community health. By implementing these SMART goals, the Valley CHIP aims to improve access, equity, and outcomes, reduce preventable crises, enhance data transparency, and provide coordinated support for individuals and families affected by mental health challenges. These strategies collectively strengthen community resilience, foster a culture of wellness, and position the Valley to meet its long-term population health goals.

Untreated mental and behavioral health conditions contribute to higher rates of chronic disease complications, emergency department visits, hospitalizations, and premature mortality. They also exacerbate social challenges including housing instability, unemployment, food insecurity, and reduced educational attainment. By prioritizing mental and behavioral health in the Community Health Improvement Plan (CHIP), the Valley aims to improve access to and coordination of care, promote early intervention and prevention, expand access to evidence-based programming, reduce stigma and health disparities, and foster a more resilient and healthy community. Strengthening community resilience will ensure all residents have the resources and support needed to maintain mental and behavioral well-being.

Prioritizing mental and behavioral health aligns with Healthy People 2030 and the Connecticut State Health Improvement Plan, Healthy Connecticut 2025 by emphasizing prevention, early intervention, and equitable access to care. By focusing on this area, we aim to expand access to evidence-based programming, reduce stigma, support prevention efforts, and strengthen community resilience, ensuring that all residents have the resources and support needed to maintain mental and behavioral well-being.

Mental and Behavioral Health Committee Co-Chairs

Lisa Trupp, CCHW
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OBJECTIVE B1. Increase awareness and access to mental and behavioral health programs. Demonstrate a 50% increase in community knowledge of mental and behavioral health access points and programs in comparison to baseline.

STRATEGIES

B1.1.	Perform community asset mapping to identify what programs are currently being offered by local agencies/organizations/providers.
B1.2	Leverage specific access points to increase mental and behavioral health programming.
B1.3	Align with the Access to Care workplan to ensure mental and behavioral health care is included in the buildout of mobile care, remote care, and expanded transportation opportunities for residents to receive mental and behavioral health care.

OBJECTIVE B2. Develop, implement and train all partner agencies on a standardized, culturally responsive Suicide Postvention Plan to support families, schools, workplaces, responders, and the broader community following a suicide death.

STRATEGIES

B2.1.	Conduct a gap analysis of current postvention practices.
B2.2	Develop a standardized Valley suicide postvention protocol detailing: immediate response and coordination, media and communication guidance, support for impacted individuals, families, and schools, responder wellness, and linkage to ongoing behavioral health services.
B2.3	Train community partners in postvention best practices.

OBJECTIVE B3. Improve mental and behavioral health referrals and tracking. Demonstrate a 35% improvement in timeframe from referral to appointment, or closed loop referral in comparison to baseline.

STRATEGIES

B3.1.	Increase the number of mental/behavioral health providers participating in the Valley Community Hub/ UniteUs Referral System annually.
B3.2	Analyze local current referral processes to evaluate efficiency and timeliness of successful referrals.
B3.3	Research a self-screening online utility that empowers residents to self-screen and self-refer for a variety of mental/behavioral health conditions, problematic substance use, work-life stressors, and social determinants of health using brief, validated screening tools and assessments.

OBJECTIVE B4. Improve local mental and behavioral health data sharing. Develop and maintain a public-facing reporting system that shares aggregated behavioral health data from Griffin Hospital, NVHD, EMS, and community-based organizations, providing timely insights into access, utilization, and community mental health trends for residents, policymakers, and stakeholders.

STRATEGIES

B4.1.	Identify data metrics, sources, and frequency of reporting.
B4.2	Develop a public facing mental and behavioral health data dashboard.

Priority Area C:

Improve Awareness, Access to, and Uptake of Healthy Food and Nutrition

GOAL:

Strengthen the Valley's food and nutrition system to ensure residents, particularly those experiencing food insecurity, can easily learn about, access, and consistently obtain nutritious food through coordinated community and state resources. Empower Valley residents with the knowledge, resources, and supports needed to make healthy food choices and reliably access nutrition programs that support long-term health and well-being.

WHY IS THIS ISSUE A PRIORITY IN THE VALLEY?

Access to healthy food and nutrition is a critical priority for the 2025–2028 Naugatuck Valley Community Health Improvement Plan (CHIP) because it directly influences multiple health outcomes and addresses several of the region's most pressing public health challenges. Food insecurity and nutrition have been longstanding concerns in the current and prior Valley community health needs assessments (*The Valley Community Index* reports). Economic disparities also mean that some populations such as low-income families, older adults, and single-parent households are disproportionately affected by food access issues. Many households are "just getting by" or finding it difficult to manage financially. Food is a significant line-item expense; when income is tight, healthier food (fresh fruits/vegetables, lean protein, unprocessed foods, etc.) often becomes less affordable.

Data from the 2025 Valley Community Index show that food insecurity affects a significant portion of households, particularly in communities such as Ansonia, Derby, Naugatuck, and Seymour. Many families face challenges affording fresh produce and other nutritious options, especially in neighborhoods lacking grocery stores or reliable transportation. Nearly 1 in 5 Valley residents report food insecurity. The Naugatuck Ecumenical Food Bank (serving Naugatuck and Beacon Falls) has reported in 2025 to be experiencing its highest demand in 25 years, with many new families seeking assistance, including large households and non-English speaking immigrants.

Prioritizing food and nutrition aligns with Healthy People 2030 and the Connecticut State Health Improvement Plan, Healthy Connecticut 2025.

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Food and Nutrition Committee Co-Chairs

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OBJECTIVE C1. Promote coordination and system-level support for food and nutrition equity. Establish a Valley Food & Nutrition Access Coalition composed of NVHD, Griffin Hospital, school district nutrition services, community-based organizations, faith-based organizations, local government representatives, food retailers, farmers, and resident advocates to facilitate and support a coordinated community approach and infrastructure.

STRATEGIES

C1.1.	Establish the Valley Food & Nutrition Access Coalition.
C1.2	Perform a community mapping exercise to determine the current strengths and existing collaborations.
C1.3	Create a website for Coalition to disseminate information, house resources (toolkits, etc.).

OBJECTIVE C2. Ensure that nutrition assistance eligible households in the Valley are aware of and are participating in state and community-driven nutrition programs to reduce food insecurity. Demonstrate a 30% reduction in the percentage of residents reporting food insecurity.

STRATEGIES

C2.1.	Raise awareness of Federal Nutrition Programs (SNAP, WIC, and Summer EBT) through (multilingual) outreach campaigns among low-income Valley residents, especially in historically underserved neighborhoods to help facilitate enrollment.
C2.2	Assess community resident preferences regarding various approaches to expanded access (e.g. mobile markets, etc.). Share findings of the assessment with and partner with Connecticut Foodshare, local farms, and municipal governments to bring indicated programming/services to neighborhoods identified as food insecure.
C2.3	Assess and expand current use and interest in Valley Community Gardens. Optimize existing sites by raising awareness through promotion and education sessions.

OBJECTIVE C3. Utilize Griffin Hospital's Center for Healthy Living & Teaching Kitchen as well as other community sites to increase community nutrition education programs, events, and offerings. Demonstrate a 30% increase in the number of Valley residents who attend community nutrition education programming.

STRATEGIES

C3.1	Develop, pilot, and disseminate a culturally and linguistically appropriate Food Expiration Education Toolkit— including print materials, digital resources, and workshop guides. Increase community understanding of food date labels ("sell by," "best by," "use by").
C3.2	Use recommendations from YSPH MPH student Capstone project "Utilizing Teaching Kitchens to improve Public Health" to inform specific interventions.
C3.3	Increase the number of nutrition education and cooking workshops, with an emphasis on managing chronic conditions (diabetes, hypertension, etc.), and promote culturally relevant recipes.
C3.4	Increase the number of sites around the community to expand reach with an emphasis on meal planning on a budget, reducing food waste, using seasonal produce, supermarket tours, "MyPlate" workshops
C3.5	Integrate nutrition education into clinical & public health settings - expand culinary medicine training.

OBJECTIVE C4. Reduce food waste in public cafeterias and promote sustainable food habits, achieving a 25% reduction in waste compared to baseline.

STRATEGIES

C4.1	Implement a food waste reduction initiative in collaboration with Griffin Hospital to decrease the amount of food waste and address food insecurity by providing eligible individuals with free healthy excess food from the Griffin Hospital kitchen.
C4.2	Pilot redistributed/recovered food provided as medically tailored food for individuals with chronic conditions. Evaluate for broader community redistribution program.
C4.3	Conduct food waste audits (baseline and annual) in public cafeterias. Disseminate Griffin Hospital Cafeteria Food Waste Reduction Initiative to Valley Public Schools and translate to one pilot school then decide how to measure food waste (ex. measure food donated instead of food waste).
C4.4	Inventory current programming, assess feasibility of implementing "Offer vs. Serve" (OVS) and Healthy Choice Nudges, as appropriate.
C4.5	Explore the possibility of adding a community composting program with one community farm and/or a community organization to reduce food waste in landfills while creating nutrient-rich soil that can be used for farming.

OBJECTIVE C5. Conduct a feasibility study of establishing a food co-op or hub designed to increase access to healthy and affordable foods for all Valley residents while supporting the local agricultural community.

STRATEGIES

C5.1	Conduct a feasibility study on increasing access to healthy, local farm foods through a food cooperative program, including delivery options.
C5.2	Conduct community listening sessions in each participating town to identify barriers to purchasing healthy farm food and shape co-op design.
C5.3	Conduct listening sessions with local farms and municipal leadership to understand logistical concerns to help shape co-op design.
C5.4	Outline parameters for formalizing partnerships with at least one farm for reliable produce supply and seasonal planning.
C5.5	Partner with schools, senior centers, housing authorities, WIC offices, food pantries, and faith-based groups to recruit co-op participants.

Striving 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.