

2012 GREATER NORWALK AREA COMMUNITY HEALTH ASSESSMENT AND IMPROVEMENT INITIATIVE

DECEMBER, 2012



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GREATER NORWALK COMMUNITY HEALTH ASSESSMENT AND COMMUNITY HEALTH IMPROVEMENT PLAN

EXECUTIVE SUMMARY

Introduction

Improving the health of a community is essential to enhancing quality of life of residents in the region and supporting future social and economic well-being. The Greater Norwalk Area collaborative of Norwalk Hospital and Norwalk Health Department is leading a community health planning process to improve the health of residents in the Greater Norwalk Area. The health departments of New Canaan, Westport, Weston, Wilton, Darien, and Fairfield were also involved in this regional effort. This effort includes two phases: (1) a community health assessment (CHA) to identify the health-related needs and strengths of the Greater Norwalk Area and (2) a community health improvement plan (CHIP) to identify major health priorities, develop goals, and implement and coordinate strategies to address these priority issues across the region. This report provides an overview of key findings from the community health assessment and key elements of the community health improvement plan.

PART I: COMMUNITY HEALTH ASSESSMENT

Community Health Assessment Methods

The community health assessment was guided by a participatory, collaborative approach, which examined health in its broadest sense. This process included integrating existing data regarding social, economic, and health indicators in the region with qualitative information from 15 focus groups with community residents and service providers and 17 interviews with community stakeholders. Focus groups and interviews were conducted with individuals from the 7 municipalities that comprise the Greater Norwalk Area, with individuals representing youth; the Hispanic and African American communities; individuals receiving services from a federally-qualified health center; social service, health care, and mental health providers; businesses; housing; law enforcement; and the local government. This qualitative assessment process engaged over 200 individuals.

Key Findings

The following provides a brief overview of key findings that emerged from this assessment.

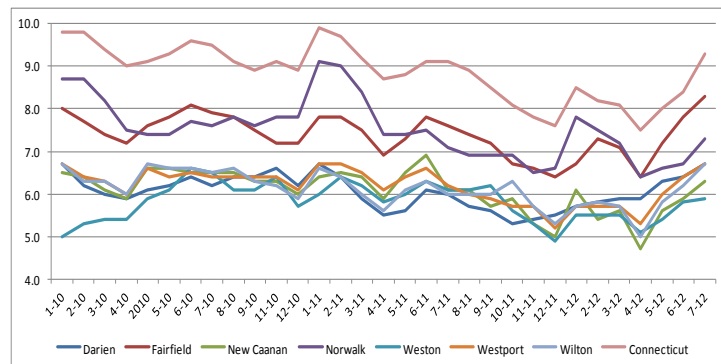
Who Lives in Norwalk?

- **Overall Population:** In 2010, the total population of the Greater Norwalk area was 240,109, an increase of 2.3% from 2000. While the region is located in Fairfield County, the state's largest county, the towns within the region vary by size, growth patterns, wealth, and composition of residents. Norwalk is the most populous town in the area, comprising 36% of the region's population in 2010. Overall, the Greater Norwalk Area has a higher proportion of families (71.5%) than the state as a whole (66.3%), with a greater concentration of families in Darien and Weston. Norwalk and Fairfield have a higher proportion of non-family households.
- **Age Distribution:** The age distribution for the region is similar to that of Connecticut, though the area has a slightly higher proportion of children under age 14 than the state as a whole. Across the 7 municipalities, there is variation in the age distribution and growth rates for each age group.
- **Racial and Ethnic Diversity:** Focus group and interview participants described the region's racial and ethnic diversity as a strength, though the municipalities in the Greater Norwalk Area varied in the levels and type of diversity of their population. While the region as a whole has less racial and ethnic

diversity than the state, Norwalk is 24% Hispanic and 14% African American. In the towns surrounding Norwalk, a greater proportion of racial and ethnic minorities are Asian or Hispanic.

- **Income, Poverty, and Employment:** The Greater Norwalk Area is characterized by substantial variation in income, with both very wealthy and less affluent households across the region and within municipalities. However, residents in the region as a whole struggled during the economic downturn. With the exception of Norwalk, all of the towns in the region have a median household income of greater than \$100,000. The unemployment rate for the region and in all towns in the region was slightly lower than that for the state as a whole (7.6%). Unemployment rates were highest in Fairfield and Norwalk.
- **Educational Attainment:** Interview and focus group participants cited concern regarding educational achievement gaps and school budget cuts resulting from the economic downturn. Others expressed concern regarding educational achievement pressures for youth in the Greater Norwalk Region. While the majority of towns in the region have a highly educated population – approximately twice as many residents have a 4-year degree (70%) compared to the state (35%) – educational levels of adults in Norwalk and Fairfield were generally lower.

Figure 1: Monthly Unemployment, Connecticut Greater Norwalk, and Towns, 2010-2012



DATA SOURCE: Connecticut Department of Labor, Local Area Unemployment Statistics (LAUS)

Social and Physical Environment – What is the Norwalk Community Like?

This section provides an overview of the larger environment around Norwalk to provide a greater context when discussing the community's health.

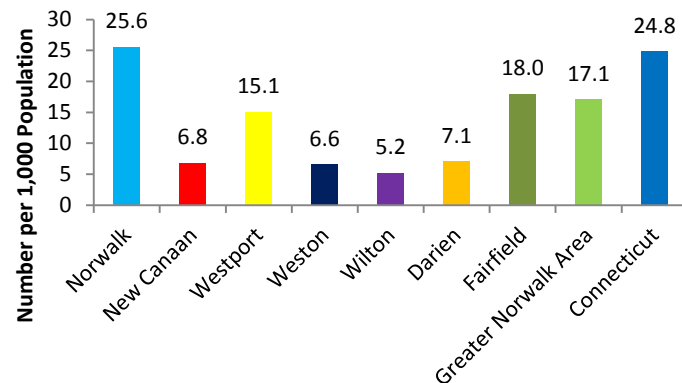
- **Housing:** As a generally affluent region, housing in the Greater Norwalk Area is fairly expensive, with median housing costs for monthly mortgages and rent exceeding that of the state. Focus group and interview participants identified the high cost of living in the region as a concern. Some respondents explained that housing constraints tied to high housing costs are evidenced by increased homelessness, strains on homeless services, and overcrowding in households.
- **Transportation:** Focus group participants described the transit system as a strength in the region. A greater proportion of residents in the region (13.0%) use public transportation to commute to work than the state as a whole (4.4%), perhaps attributable to persons who commute to New York City for work. A smaller percent of households in the region (4.6%) lack access to a vehicle than the state as a whole (8.6%), though there is variation by municipality, with 7.5% of Norwalk households lacking access to a vehicle.
- **Access to Healthy Foods and Recreation:** While the region has greater access to healthy food outlets relative to the state, several pockets of Norwalk have been identified by the U.S. Department of Agriculture as food deserts, with limited access to large supermarkets or grocery stores for low-income residents. While the Greater Norwalk Area (20 per 100,000 population) is also characterized by better access to recreational facilities than the state (14 per 100,000 population), several participants explained that these facilities may be less accessible to low-income residents, who may also have limited access to parks and green spaces.

"Transit system is a big plus as well." – Focus group participant

"They took away the roller skating rink. They took away the ice skating rink. They took away teenage parties for kids that stayed out of the streets ... What is there for our children to do? There's nothing." – Focus group participant

- **Environmental Quality:** Poor air quality is associated with negative health consequences, such as asthma and decreased lung function. While annual number of air quality days for Fairfield County (4 days) was the same as for the state as a whole, Fairfield County (14 days) had more ozone days than the state (6 days).
- **Crime and Violence:** Residents described higher rates of person-to-person violence and domestic violence as major concerns. While the crime rate is lower for the region (17.1 per 1,000 population) compared to the state (24.8 per 1,000 population), the crime rate in Norwalk (25.6 per 1,000) exceeds that of the state. While family violence rates are lower in the region than statewide, family violence has increased in the region since 2008.

Figure 2: Crime rate per 1,000 Population, Connecticut, Greater Norwalk and Towns, 2010



DATA SOURCE: Connecticut Uniform Crime Data, 2010

Risk and Protective Lifestyle Behaviors

This section examines lifestyle behaviors among Norwalk residents that may promote or hinder health.

- **Healthy Eating, Physical Activity, and Overweight/Obesity:** Similar to patterns nationwide, issues around overweight and obesity – particularly healthy eating and physical activity – emerged as key health concerns for focus group and interview participants. In the Greater Norwalk Area, childhood obesity is highest in Norwalk. In 2010, the prevalence of adult obesity in Fairfield County (16.6%) was lower than that of the state (23.0%) and country (27.6%). Diet, busy lifestyles, safety, and sedentary lifestyles were cited as factors contributing to the prevalence of overweight and obesity.
- **Substance Use and Abuse:** Participants described an increase in substance use and abuse as a key health concern for the region. Focus group and interview participants identified smoking, drinking and marijuana as substances that are easily accessible to youth and major issues for the health and well-being of youth. Use of illicit drugs was cited as a concern for residents of Norwalk. Quantitative data show that substance use rates for youth are slightly higher in Connecticut as compared to the nation. Among adults in Fairfield County, binge drinking has increased since 2006 and the percent of adults who binge drink is higher in Fairfield County than the State and nation.

“Gardens at all of the schools – a dynamic effort to introduce fruits and vegetables and influence families.” – Interview Participant

“Folks who are more challenged economically are not going to have physical activity as a priority.” – Focus Group Participant

“Norwalk probably has the most drug activity out of the communities—we have OD’s, illicit drug sales everywhere. It is rampant. We’ve had at least three cases of bath salts. We have meth, heroin, crack, you name it, it’s here.” – Focus group participant

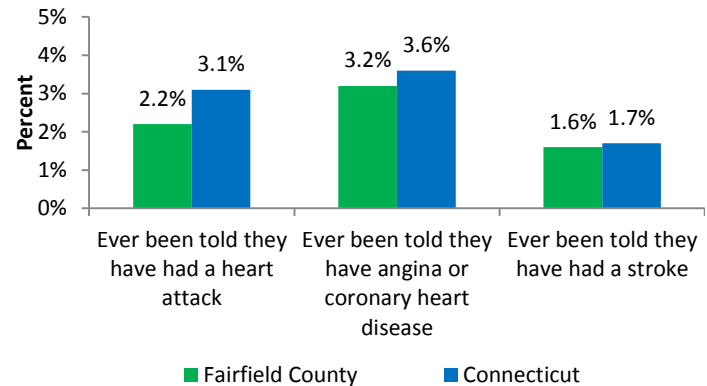
Health Outcomes

This section provides a quantitative overview of the leading health conditions in Norwalk, while also discussing concerns raised among residents and leaders during focus groups and in-depth interviews.

- **Overall Leading Causes of Death:** Quantitative data indicate that the top two causes of mortality in Norwalk, as in Connecticut, are cancer (162 per 100,000 population) and diseases of the heart (149 per 100,000 population).

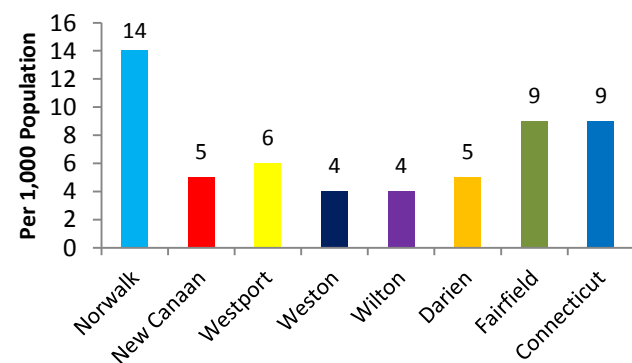
- **Overall Leading Causes of Hospitalization:** The leading causes of hospitalization varied by age group. Among the population under age 65, mental health and digestive issues are the leading causes of hospitalization. For persons aged 65 and over, leading causes of hospitalization are heart and respiratory conditions. Digestive and injury/poisoning issues are leading causes of hospitalization across all age groups.
- **Chronic Disease:** The prevalence of heart disease (3.2%), diabetes (6.0%) and asthma (8.3%) among adults in Fairfield County is lower than the state as a whole. Prevalence statistics for indicators of heart disease are presented in Figure 3.
- **Mental Health:** Mental health, particularly among youth, was a major health concern raised by participants. Focus group and interview participants cited pressures of academic achievement, stigma associated with seeking mental health care, and gaps in mental health services as factors that contribute to the high prevalence of poor mental health in the region. Mental health hospitalization rates are presented in Figure 4.
- **Maternal and Child Health:** While the prevalence of low birth weight (less than 2500 grams) in Fairfield County (7.0%) was below that for the state as a whole (8.1%), the prevalence varied across the Greater Norwalk Region and was highest in Wilton (13.0%). The teenage pregnancy rate was lower for Fairfield County (20.3 per 1,000 females) than for the state as a whole (23.9 per 1,000 females).
- **Oral Health:** In Fairfield County (83.1%), a greater proportion of residents saw a dentist in the past year than statewide (81.6%).
- **Communicable Diseases:** Several focus group and interview participants identified Lyme disease as a major concern. Many towns in the region have seen higher rates of Lyme disease compared to Fairfield County. While the HIV rate is lower in Fairfield County (366.4 per 100,000 population) than the state as a whole (372.6 per 100,000 population), the rate of new HIV cases is higher in Norwalk (15.2 per 100,000 population) than the region and state (11.5 per 100,000 population).

Figure 3: Percent of Adults Who Have Been Told They Have a Heart Related Chronic Condition, Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS),

Figure 4: Mental Health Hospitalizations, Connecticut and Towns, 2005-2010



DATA SOURCE: CT Hospital Association, CHIME Hospital Discharge Data; analysis conducted by CT Association of Directors of Health for years 2005-2010. For CT, DPH hospitalization data 2009; analysis by Norwalk Health Department

Health Care Access and Utilization

The following section provides a quantitative and qualitative overview of health care access and utilization in the region.

- **Resources and Use of Health Care Services:** Participants described health care resources in the region as a major strength, citing comprehensive services at hospitals and other resources throughout the community, including community health centers, school-based health centers, volunteer emergency responders, and food programs as important resources. The ratio of the

population to primary care physicians in Fairfield County (739 population per provider) is lower than that of the state (815 population per provider).

- **Challenges in Accessing Health Care Services:** When asked about access to health care services, participants cited a lack of health insurance, particularly for persons who lost a job during the economic downturn; higher co-pays; and long wait times as major barriers to accessing health care. The proportion of adults in Fairfield County who have health insurance coverage (89.8%) is similar to that of the state (88.4%). Gaps in mental health care and affordability of mental health services in the region emerged as major concerns cited by participants. Gaps in and affordability of dental services was another concern raised by participants. Other challenges to accessing services included transportation, bilingual services, and culturally competent care.

Community Strengths and Resources

When asked to identify assets and resources, participants in the surrounding communities pointed to high quality schools, strong civic mindedness, and philanthropy among residents. Those in Norwalk saw their strong and growing diversity as an asset. Additional assets and resources identified the Greater Norwalk Area included:

- **Health Care Services and Providers:** Participants described health care services and comprehensive care offered by the hospitals in the region as a major strength.
- **Strong Social Service Organizations:** Respondents characterized the region as largely rich in social services. They especially praised food access programs.
- **Facilities Promoting Healthy Behaviors:** According to participants, recreational activities, recreational facilities, parks and green spaces were important and accessible resources for youth and families in the region. This sentiment largely pertained to residents in more affluent communities outside of Norwalk.
- **Geography:** Proximity to New York City and access to the waterfront and recreational facilities were cited as major resources for employment opportunities and recreational activities.

Community Members' Perceptions of What is Needed

Focus group and interview participants were asked about what was needed to address health challenges in the region. The following key themes emerged:

- **Focus on Prevention:** Several participants described a need to change the health infrastructure to emphasize prevention. Providers explained that to reframe the health care focus on prevention, incentive structures would need reform. Additionally, a need for more substance use and mental health services was identified as a need.
- **Health Literacy:** Several focus group and interview participants noted that a lack of understanding of health (health literacy) and health care resources contributed to poor health and health behaviors in the region. While they reported that there were many health education programs in the region, they felt that more programs were needed, particularly around chronic disease prevention and stress management.
- **Centralized Resource Information:** A centralized listing of resources in the region was cited as an important tool needed for providers, medical staff, and discharge planners.
- **Parenting Support:** Additionally, the need to support parents in developing coping and problem-solving skills needed to raise children was a consistent theme throughout interviews.
- **Activities for Youth:** While numerous activities for youth and families were cited, participants noted a need for youth activities in less affluent areas, particularly as some recreational areas are closing.
- **Greater Cultural Competency:** Non-English speaking focus group participants noted the importance of enhanced cultural competency, or recognition of and respect for diverse cultural norms, attitudes, identities, and world views, in the health system. In addition, a need for interpreters and alternative medical practices was also expressed.

- **Enhanced Integration of Information across Health Systems:** The health provider community identified greater integration of health information across systems and incentives for health professionals to practice in the public sector as critical.
- **Greater Collaboration across Agencies:** While close collaboration was cited as a strength among health and social service systems, other participants noted that greater coordination was needed.

Key Overarching Themes and Conclusions:

Several overarching themes emerged from this synthesis of data, including:

- **There is wide variation in the Greater Norwalk Area's population composition and economic levels.** Compared to surrounding towns, Norwalk is more racially and ethnically diverse and has a higher proportion of households with lower median incomes. Participants described civic-minded residents, increasing diversity, a large proportion of highly educated residents, a child-oriented environment and strong business as strengths.
- **Mental health and substance abuse were considered growing, pressing concerns by focus group and interview participants, for which current services were not necessarily meeting community needs.** Stressors associated with the economic downturn and pressures on youth to succeed academically were cited by respondents as major factors contributing to mental health issues in the region. Respondents identified a paucity of mental health providers and services as well as the stigma around seeking mental health services as barriers to accessing mental health care.
- **As with the rest of the state and nation, healthy eating, physical activity and obesity were major issues cited by respondents, particularly as chronic diseases are the leading causes of morbidity and mortality.** A major concern was the substantial prevalence of childhood obesity in Norwalk. While recreational facilities, parks and grocery stores were described as prevalent in the region, participants described variation in access to and affordability of these resources in the region.
- **Currently, numerous services, resources and organizations are working to meet the health and social service needs of residents in the Greater Norwalk Area.** Participants praised the work of community-based organizations, regional organizations, Norwalk Hospital, Norwalk Community Health Center, local health departments and local service organizations in meeting the health needs in the region. However, several respondents described these services as fragmented and shared a vision for a more coordinated approach among these key players in working together to address priority health issues in the region.

PART II: COMMUNITY HEALTH IMPROVEMENT PLAN

Overview of the Community Health Improvement Plan

Norwalk's Community Health Improvement Plan (CHIP) is a long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process. The plan is critical to developing policies and defining actions to target efforts that promote health. Government agencies, including those related to health, human services, and education, as well as hospitals can use the CHIP in collaboration with other partners to set priorities and coordinate and target resources.

Development of the Greater Norwalk Area CHIP

To develop the CHIP, Norwalk Hospital and the Norwalk Health Department partnered to bring together over 100 community residents and leaders in health care, community organizations, education, housing, local government, business, mental and behavioral health, and social services to share the preliminary results of the Community Health Assessment (CHA) and identify priorities for the CHIP. Participants in the community meeting took part in a prioritization activity to identify the most important public health issues for Greater Norwalk from a list of seven major themes identified in the CHA. Based on the results

of the multi-voting exercise, participants agreed upon the following three health priority areas for the CHIP: 1) Mental Health, 2) Obesity, and 3) Substance Abuse.

Following the identification of the priority areas, the Norwalk Core Leadership Team engaged working groups based on interest and expertise that met to develop goals, objectives, strategies, output and outcome indicators, and key partners. Once the draft plan was complete, an online survey was administered to all community members who had been engaged in the assessment and planning process to solicit feedback on the components of the plan. As a result of suggestions made in the survey, the mental health and substance abuse priority areas were combined in to a single priority area.

Strategic Elements of the CHIP

Below are the final priority health issues, goals, and objectives that will be addressed in the CHIP:

Priority Area 1: Mental Health and Substance Abuse

- Goal 1:** Provide education on and access to quality, evidence-based mental health and substance abuse prevention, intervention and treatment services across the life span.
- Objective 1.1:* Increase providers' and community members' awareness and use of evidence-based mental health and substance abuse services and educational resources for prevention, intervention, treatment and recovery.
- Objective 1.2:* Enhance local and regional partnerships to improve access to timely, comprehensive, and coordinated services for diverse populations across the life span by.
- Objective 1.3:* Reduce financial barriers to treatment.

Priority Area 2: Obesity

- Goal 2:** Prevent and reduce obesity in the community by promoting healthy lifestyles
- Objective 2.1:* Increase the number of children and adults who meet physical activity guidelines.
- Objective 2.2:* Increase access to and consumption of healthy and affordable foods throughout the region.

Next Steps

The components included in this report represent the strategic framework for a data-driven, community-enhanced Community Health Improvement Plan. Members of the Core Leadership Team will revise and refine the suggested activities and timelines drafted by workgroup members to complete the action plans for the CHIP. Additionally, partners and resources will be solidified to ensure successful CHIP implementation and coordination of activities and resources among key partners in the Greater Norwalk Area.

INTRODUCTION

Understanding that health is affected by where we live, work, and play, in 2012, Norwalk Hospital and the Norwalk Health Department led a Community Health Assessment and Improvement Plan Initiative with the ultimate goal of creating a healthy community for the Greater Norwalk Area. The health departments of New Canaan, Westport/Weston, Wilton, Darien, and Fairfield, also joined this regional effort. Norwalk Hospital and the Norwalk Health Department contracted with Health Resources in Action (HRiA), a non-profit health consultancy organization in Boston, to assist with research and planning. The purpose and scope of this Initiative was to:

- Assess the health status and broader social, economic, and environmental conditions that impact health
- Recognize community health assets and strengths
- Identify priority issues for action to improve community health
- Develop and implement an improvement plan with performance measures for evaluation
- Guide future community decision-making related to community health improvement

The approach to the CHA and CHIP was guided by the Association for Community Health Improvement (ACHI) framework of 1) establishing an assessment infrastructure, 2) defining the purpose and scope, 3) collecting and analyzing data, 4) selecting priorities, 5) documenting and communicating results, and 6) planning for action and monitoring progress.

The following report is divided into two parts. Part I, the 2012 Community Health Assessment, discusses the methodology and findings of the assessment. Part II, the Community Health Improvement Plan, discusses the methodology, goals, objectives, strategies, and indicators of the improvement plan.

Part I: Community Health Assessment

The following section includes the findings of the community health assessment, which was conducted from March through August 2012, using a collaborative, participatory approach. The 2012 Greater Norwalk Area Community Health Assessment (CHA) was designed to fulfill several overarching goals, specifically to:

- Gain a greater understanding of the health issues of residents of Norwalk, New Canaan, Westport, Weston, Wilton, Darien, and Fairfield
- Identify where and why we are healthy
- Identify where and what we need to do to improve the community's health

I. COMMUNITY HEALTH ASSESSMENT METHODS

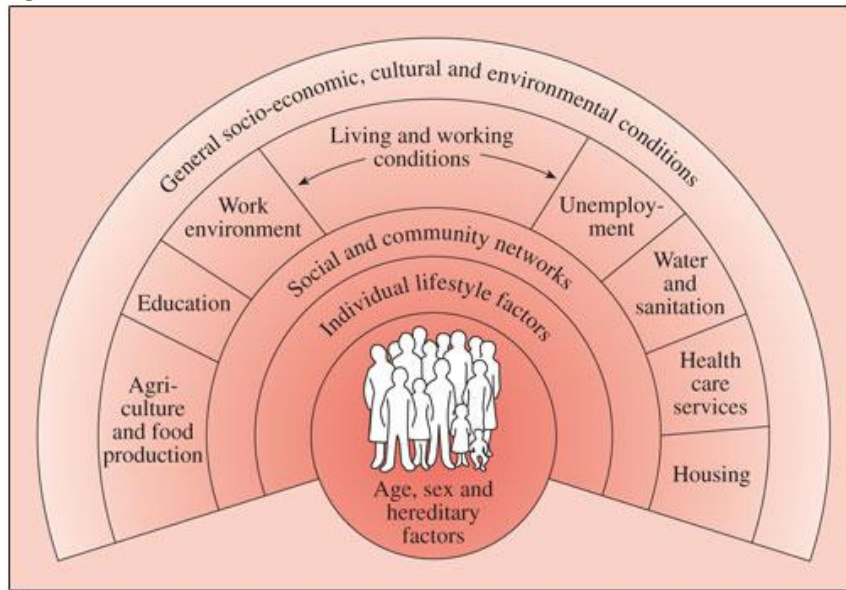
The following section details how the data for the CHA were compiled and analyzed, as well as the broader lens used to guide this process. Specifically, the CHA defines health in the broadest sense and recognizes that numerous factors at multiple levels— from lifestyle behaviors (e.g., diet and exercise), to clinical care (e.g., access to medical services), to social and economic factors (e.g., employment opportunities), to the physical environment (e.g., air quality)—have an impact on the community's health. The beginning discussion of this section describes the larger social determinants of health framework which helped to guide this process.

A. Social Determinants of Health Framework

It is important to recognize that multiple factors affect health, and there is a dynamic relationship between people and their environments. Where and how we live, work, play, and learn are interconnected factors that are critical to consider when assessing a community's health. That is, not only do people's genes and lifestyle behaviors affect their health, but health is also influenced by more upstream factors (i.e., distal factors that influence health) such as employment status and quality of housing. The social determinants of health framework addresses the distribution of wellness and illness among a population— its patterns, origins, and implications. While the data to which we have access is often a snapshot of a population in time, the people represented by that data have lived their lives in ways that are enabled and constrained by economic circumstances, social context, and government policies. Building on this framework, this assessment utilizes data to discuss which populations are healthiest and least healthy in the community as well as to examine the larger social and economic factors associated with good and poor health.

The following diagram in Figure 1 provides a visual representation of how individual lifestyle factors are influenced by more upstream factors.

Figure 1: Social Determinants of Health Framework



DATA SOURCE: World Health Organization, Commission on Social Determinants of Health. (2005)

B. Community Health Improvement Task Force

To provide feedback and guidance on the assessment, an advisory committee, named the Community Health Improvement Task Force, was formed. The group comprised of approximately 40 individuals from 30 key partner agencies and organizations were initially engaged to advise on the process, support data collection, and participate in the development and implementation of programs and policies to address priority issues. Engagement of community members and partners has expanded throughout the project to include over 200 individuals. Members of the Community Health Improvement Task Force included representatives from housing, transportation, education, business, local government, and neighboring health departments. The list of Community Health Improvement Task Force members may be found in Appendix A.

The Task Force met as a whole in March and July. Specifically, the Task Force was asked to provide existing quantitative and qualitative data; identify additional appropriate secondary data sources; provide input on primary data collection; motivate and recruit community members to participate in the assessment process; assist in organizing focus groups; provide technical assistance in their areas of expertise; identify priority issues for health improvement; and develop and implement programs and policies to address priority issues.

Throughout the process, information was provided to all Task Force members through email allowing participants to be informed on the progress of the project and the opportunities to share their expertise.

C. Secondary Data Collection

To provide a salient community health profile of the Greater Norwalk Area (Norwalk, New Canaan, Westport, Weston, Wilton, Darien, and Fairfield¹), existing quantitative data drawn from national, state, and local sources were reviewed. This allowed the development of a portrait of these areas that discusses health, social, and economic characteristics. Data sources included but were not limited to U.S. Census, Centers for Disease Control, the Connecticut Department of Health, Norwalk Hospital, Norwalk Health Department, and County Health Rankings. Types of data included self-report of health behaviors from large, population-based surveys such as the Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey (YRBS), as well as public health disease surveillance data, and vital statistics based on birth and death records. Additionally, data and analyses completed for the Connecticut Health Equity Index² were used to create the portrait and further the discussion of social determinants of health.

D. Qualitative Data Collection

Data collection in the form of focus groups and interviews occurred between June and July 2012. During this time, HRIA conducted qualitative research with hospital and health department staff, community stakeholders, and residents to gauge their perceptions of community strengths, needs, and health concerns, and the programming or services most needed to address these concerns. In total, 177 individuals were engaged across all seven communities through a series of 15 focus groups (with 160 individuals participating) and 17 interviews. For a list of participants, see Appendix B.

Key Informant Interviews

Following the review of secondary data, 17 key informant interviews were conducted with community stakeholders from community-based organizational staff, community leaders, and hospital and health department staff. Interviews explored their perspectives of their communities' health needs and strengths, challenges and successes of working in these communities; gaps in the current programming and servicing environment; and perceived opportunities to address these needs.

Key informant interviews were conducted with both leaders and front-line staff from a wide range of organizations in different sectors, such as education, housing, health care providers, local government, and social services, as well as community residents. Interviews were held either face-to-face or by telephone using a semi-structured interview guide and lasted approximately 30-60 minutes.

Focus Groups

In addition to key informant interviews, 15 focus groups were conducted with a total of 160 community members. The Task Force identified sectors of the community to target for the focus group phase of the data collection. These sectors included: business; housing; law enforcement; local government; education; health care providers; mental health providers;

¹ For this report, all county wide data are labeled as Fairfield County. Data for the Town of Fairfield is labeled as Fairfield.

² The Health Equity Index is a community-based assessment that can be used to identify social, political, economic, and environmental conditions that are most strongly correlated with health outcomes. It is an initiative of the Health Equity Alliance and the Connecticut Association of Directors of Health. (index.healthequityalliance.us)

senior service providers; youth; members of the Hispanic and African American communities; and individuals receiving services from local federally qualified health centers. Focus group discussions examined community members' perceptions of the health assets and needs in their communities, as well as their suggestions on what types of services are needed in the community and how those can be best delivered. Discussions also explored the assets and resources they have identified as working well in their community as well as challenges that many residents currently face in seeking these services.

To engage Task Force members in the qualitative data collection and support the facilitation of the focus groups, a training of facilitators and notetakers was conducted in May for all interested Task Force members. Nine Task Force members were trained during this 90-minute session.

On average, each focus group had 8-13 participants, lasted approximately 60-90 minutes, and was moderated by an experienced HRiA, Norwalk Health Department, Norwalk Hospital, or a Task Force facilitator using a semi-structured guide. In addition to groups in English, two focus groups were conducted in Spanish. Participants in the community resident groups were provided a minimal stipend for their time. It was a priority to recruit participants for the focus groups from all sectors of the population, including traditionally under-served populations. Community Task Force members and community-based organizations served as key partners in recruitment.

Analyses

The collected qualitative information was coded and analyzed thematically by data analysts for main categories and sub-themes. Analysts identified key themes that emerged across all groups and interviews as well as the unique issues that were noted for specific populations. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. While community differences are noted where appropriate, analyses emphasized findings common across the Greater Norwalk Area. Selected paraphrased quotes – without personal identifying information – are presented in the narrative of this report to further illustrate points within topic areas.

E. Analyses and Limitations

The Greater Norwalk Community Health Assessment utilized a participatory, collaborative approach to look at health in its broadest context. As noted earlier, the assessment process included synthesizing existing (secondary) data on social, economic, and health indicators in the region as well as primary qualitative information from focus groups and interviews with community stakeholders from across the seven municipalities to create a health profile for the region. The qualitative data collection sought to elicit the perspectives and opinions of a range of people representing different audiences, including youth, parents, educational leaders, social service and health care providers, police, the faith community, and the general public. The information from these many, varied sources was used to identify priorities and opportunities for action.

As with all research efforts, there are several limitations related to the assessment's research methods that should be acknowledged. It should be noted that for the secondary data analyses, several sources did not provide current data stratified by race/ethnicity, gender, or age – thus, these data could only be analyzed for the total population. It is also important to note that there were geographic limitations to the BRFSS data, which are only available for Fairfield County as a whole and YRBS data, which are only available for the state as a whole.

There are some exceptions to the availability of the local behavioral health data for youth where data exists for the towns of Weston, Wilton, and Fairfield due to their involvement in a grant specific to these communities. Additionally, in many cases across all sources, some data were suppressed and not available because population counts were too small to report.

Likewise, data based on self-reports (i.e., BRFSS, YRBS) should be interpreted with particular caution. In some instances, respondents may over- or underreport behaviors and illnesses based on fear of social stigma or misunderstanding of the question being asked. In addition, respondents may be prone to recall bias—that is, they may attempt to answer accurately but remember incorrectly. In some surveys, reporting and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys here benefit from large sample sizes and repeated administrations, enabling comparison over time.

II. FINDINGS

“People love Norwalk; many were born and raised here. There’s a commitment to help; a lot of foundations. The people are a great strength.” – Interview participant

“We have the waterfront, we have the countryside, we have the amenities.” – Focus group participant

“[There are] \$4 million dollar homes on the water and public housing all in the same community.” – Interview participant

“Norwalk just doesn’t have the [financial] resources that the other communities do.” – Focus group participant

“Each city or town is unique in our community.” – Focus group participant

Located about 50 miles outside of New York City, the region covered by this community health assessment, Greater Norwalk, comprises the communities of Fairfield, Darien, New Canaan, Weston, Westport, and Wilton as well as Norwalk, Connecticut’s sixth largest city. Focus group respondents and interviewees describe their region as one with substantial assets including proximity to New York and to the Long Island Sound; corporate headquarters of several companies; numerous amenities such as restaurants, beaches, parks, walking trails, and theaters; and excellent roads to get to these places. The area’s population was described as a combination of long standing residents and newcomers, including recent immigrants. However, although residents described their region as largely affluent and resource rich, there were differences seen between the city of Norwalk and surrounding towns, and even among the surrounding towns. Furthermore, residents reported that the economic downturn has affected the region’s residents and organizations that provide services to them. These factors have implications for community health and well-being.

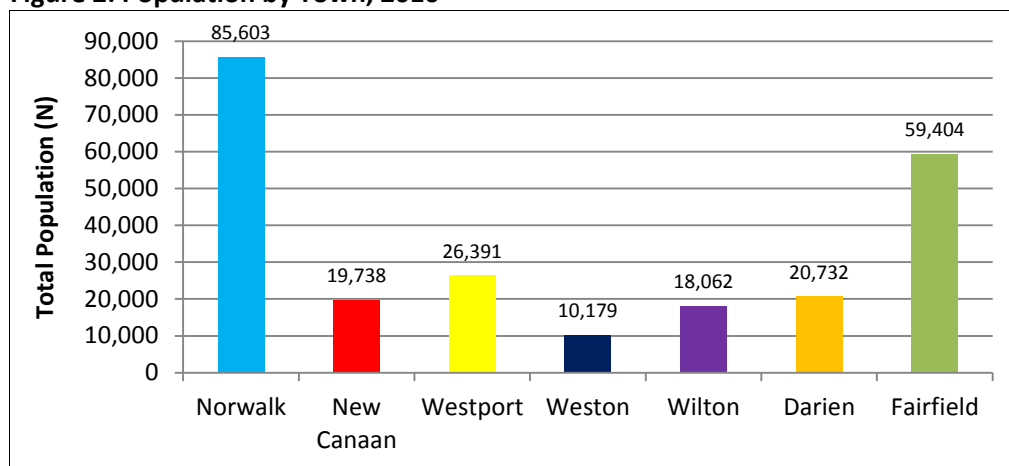
A. DEMOGRAPHICS

The health of a community is associated with numerous factors including the resources and services available (e.g., safe green space, access to healthy foods) as well as who lives in the community. That is to say that, who lives in a community is significantly related to the rates of health outcomes and behaviors of that area. For example, the distribution of age, gender, race, and ethnicity are important characteristics that have an impact on an individual's health by affecting the number and type of services and resources available. The section below provides an overview of the population of Greater Norwalk.

Population

The total population of the Greater Norwalk area was 240,109 in 2010, up 2.3% from 2000 (Figure 2). While the region is located in Fairfield County, the state's largest County, the towns within it vary in terms of size, growth patterns, wealth, and composition of residents. Norwalk, the state's 6th largest city, is the most populous town in the area, comprising 36% of the region's population in 2010. The town of Fairfield comprises another 25% of the defined area's population. The three smallest communities in terms of population size (New Canaan, Weston and Wilton) comprise a total of 20%. The smallest community in the region, Weston, comprises 4% of the region's total population.

Figure 2: Population by Town, 2010



DATA SOURCE: 2010, U.S. Census Bureau, American Community Survey

Greater Norwalk experienced a population increase of 2.3% from 2000 to 2010, a smaller rate of increase than for the state as a whole (4.9%) (Table 1). All towns within the region experienced a population increase between 2000 and 2010, with Darien experiencing that largest increase (5.7%).

Table 1: Population Change in Connecticut, Greater Norwalk, and Towns, 2000 and 2010

	2000 Population	2010 Population	% Change 2000 to 2010
Norwalk	82,951	85,603	3.2
New Canaan	19,395	19,738	1.8
Weston	10,037	10,179	1.4
Westport	25,749	26,391	2.5
Wilton	17,633	18,062	2.4
Darien	19,607	20,732	5.7
Fairfield	57,340	59,404	3.6
Greater Norwalk Area	232,712	240,109	2.3
Connecticut	3,405,565	3,574,097	4.9

DATA SOURCE: 2010, U.S. Census Bureau, American Community Survey

Overall, the region has a higher proportion of families (71.5%) than the state as a whole (66.3%) (Table 2). In the towns of Darien and Weston over 80% of households are families and a high proportion of these are families with children under the age of 18 (50.5% and 48.7%, respectively). Norwalk and Fairfield have a higher proportion of non-family households; slightly over a third of Norwalk households (36.3%) and close to 30% of Fairfield households (27.4%) are non-family households.

Table 2: Household and Families by Type in Connecticut, Greater Norwalk, and Towns, 2010³

	Number of Households	% of Families	% Families with Children <18	% Female householder, no husband present with Children <18	% Nonfamily households (single and unrelated)
Norwalk	33,217	63.7	29.2	6.7	36.3
New Canaan	7,010	77.0	43.2	4.1	23.0
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
Darien	6,698	82.2	50.5	4.1	17.8
Fairfield	20,457	72.6	36.9	4.2	27.4
Greater Norwalk Area	86,506	71.5	37.0	5.1	28.5
Connecticut	1,371,087	66.3	30.0	7.1	33.7

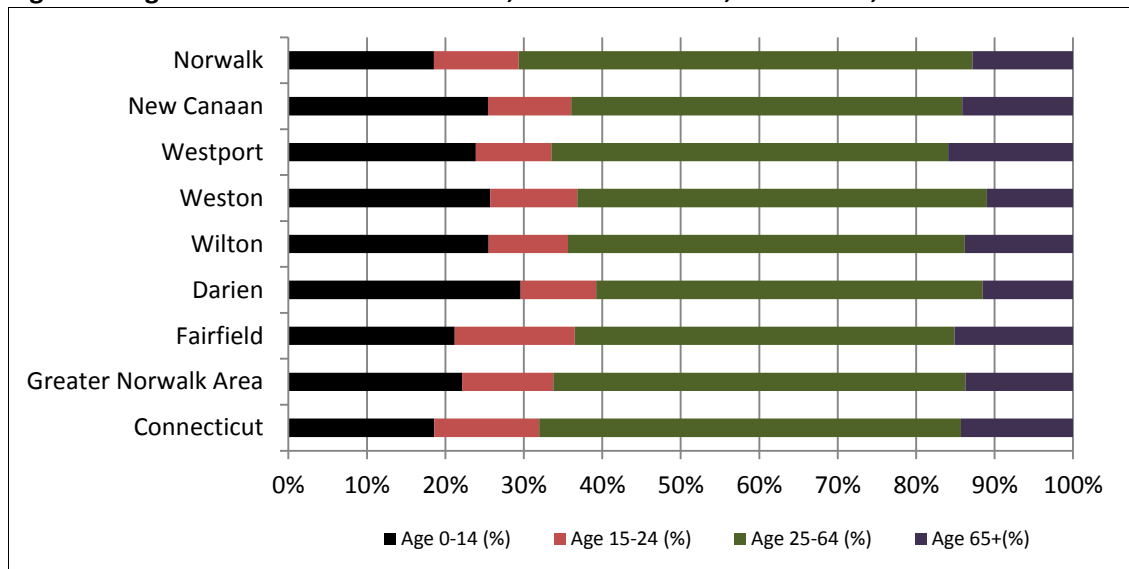
DATA SOURCE: Source: 2010, U.S. Census Bureau, American Community Survey

³ Percentages are calculated as 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

The Greater Norwalk area largely reflects a population age distribution consistent with that of the state: for every ten residents, approximately two residents are under 14 years old while one is 65 or over (see Figure 3). However, the area has a slightly higher proportion of children under age 14 (22.1%) than the state as a whole (18.6%). The age distribution varies somewhat across towns. Nearly 30% of Darien's population is under the age of 14; over 35% of the populations of Darien, Fairfield, Wilton, and Weston are under the age of 24. Norwalk, by contrast, has the smallest proportion of young people—less than 20% under the age of 14 and less than 30% under the age of 24. Norwalk has the largest proportion in the region of the population ages 25-64, however. The senior population comprises a higher proportion of the total population in the communities of Westport and Fairfield, slightly higher than the state average.

Figure 3: Age Distribution in Connecticut, Greater Norwalk, and Towns, 2010

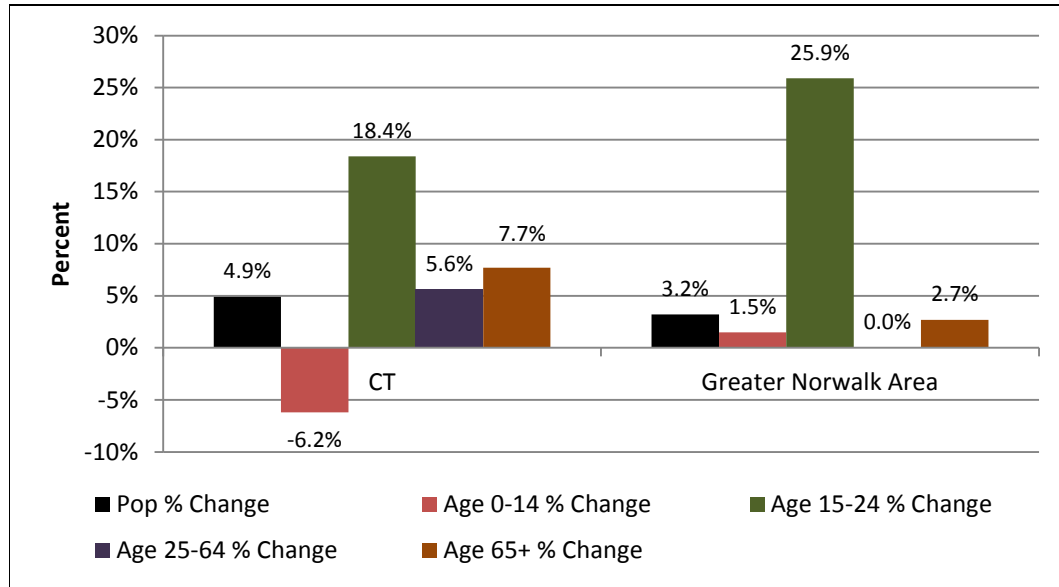


DATA SOURCE: 2010, U.S. Census Bureau, American Community Survey

A comparison of population growth rates between 2000 and 2010 reveals that Greater Norwalk's population of children ages 0-14 experienced an overall increase (1.5%) while the state's youth population in this age group declined substantially (-6.2%) during this decade (Figure 4). The region also experienced a higher rate of growth among those ages 15-24 (25.9%) than the state as a whole (18.4%). Conversely, the state's senior population grew substantially over this same time period (7.7%), while the growth rate of the senior population in the Greater Norwalk Area was lower, although still positive (2.7%).

Within the towns, there was substantial variation in the growth rates of different population groups between 2000 and 2010. Darien and Fairfield experienced the greatest increase across towns in populations under the age of 14 (8.4% and 7.1% growth, respectively) and negative growth in the population over age 65 (-2.4% and -4.6%, respectively). Conversely, the towns of Weston and Wilton experienced negative growth in populations under age 14 (-9.5% and -3.7%, respectively) and substantial growth in the population over age 65 during this ten-year period (15.1% and 16.1%, respectively). [Additional Data in Appendix E]

Figure 4: Population Change by Age Group in Connecticut and Greater Norwalk Area, 2000 and 2010



DATA SOURCE: U.S. Census Bureau, 2000 Decennial Census and 2010 American Community Survey

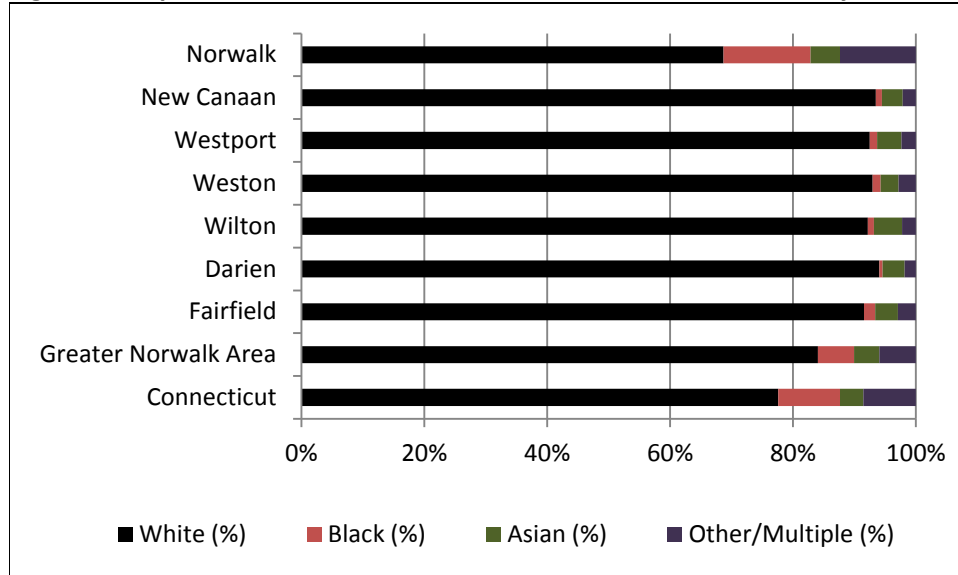
Racial and Ethnic Diversity

“It’s a very, very diverse community which is one of the strong points and one of the more attractive aspects of being and working in Norwalk.” – Focus group participant

The towns surrounding Norwalk were described by residents as largely white, affluent, English-speaking and highly educated. By contrast, respondents described the city of Norwalk as very diverse ethnically and racially as well as economically. Within Norwalk as well, there are differences in population composition according to focus group and interview participants. As one business focus group member explained, *“There are basically two Norwalks—the outer ring which looks and feels like whichever town they are adjacent to and then there’s the inner ring...poverty at a much higher level.”*

Quantitative data confirm the perceptions of focus group members and interviewees. While the city of Norwalk has substantial racial diversity, greater than Connecticut as a whole, the other communities are much less diverse—less than 8% of their populations are non-white (Figure 5). The Black/African American population (14.2%) also comprises a sizeable portion of Norwalk’s population. In surrounding towns, the largest racial minority group is Asian, with a relatively low proportion of Black residents. The region overall has a smaller proportion of Blacks and people of multiple races than the state as a whole but has a slightly higher proportion of Asians (4.1%) than the state (3.8%).

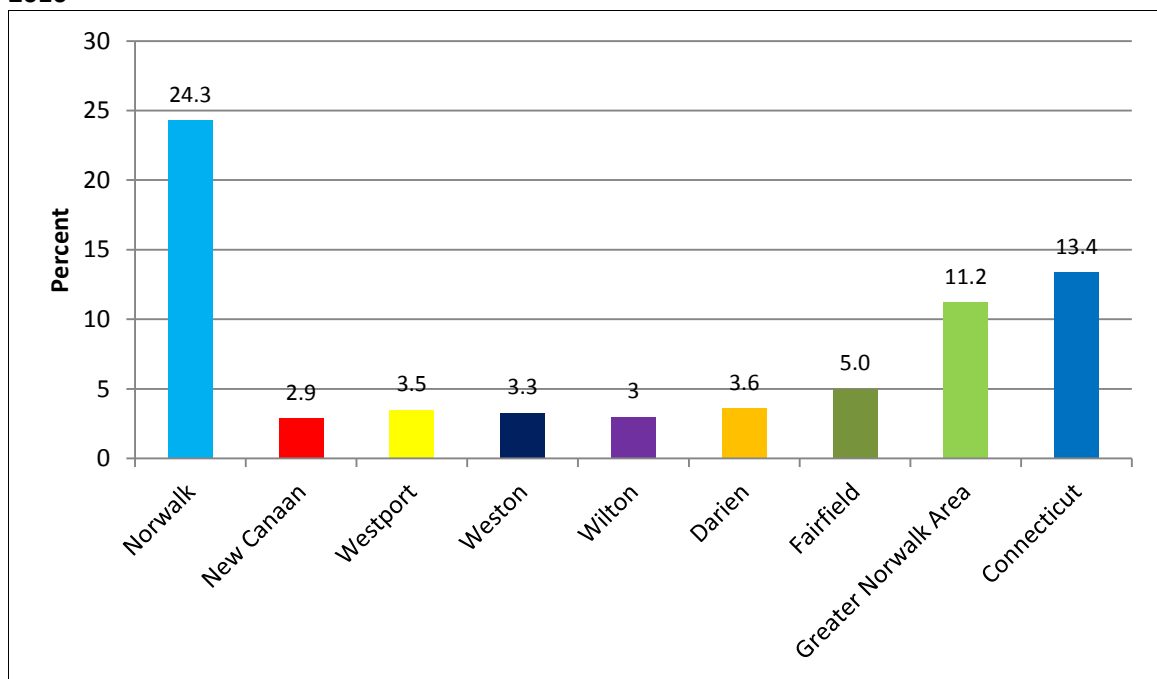
Figure 5: Population of Connecticut, Greater Norwalk, and Towns, by Race, 2010



DATA SOURCE: U.S. Census Bureau, American Community Survey, 2010

When considering the ethnicity, Norwalk has a significantly larger portion of its population who are Hispanic than the neighboring communities and the Connecticut as a whole. As shown in Figure 6, 24.3% of the population in Norwalk is Hispanic, while this population accounts for 13.4% of Connecticut. For other towns in the Greater Norwalk Area this percentage ranges from 2.9% in New Canaan to 5.0% in Fairfield.

Figure 6: Population of Connecticut, Greater Norwalk, and Towns, by Hispanic Ethnicity, 2010



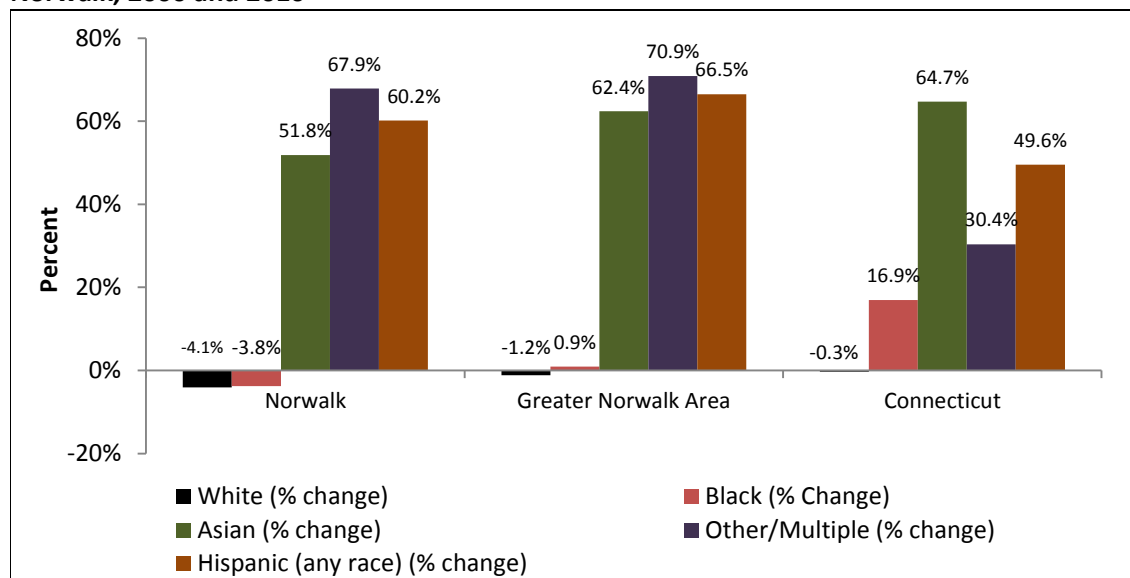
DATA SOURCE: U.S. Census Bureau, American Community Survey, 2010

A comparison of growth rates among diverse populations between 2000 and 2010 reveals a higher rate of growth among those identifying themselves as Hispanic and Other/Multiple Races in the Greater Norwalk Area (66.5% and 70.9%, respectively) than for the state as a

whole (49.6% and 30.4%, respectively) (Figure 7). Both the region and the state experienced a slight decline in the proportion of the White population (-1.2% and -0.3%, respectively). The growth in the Black population was substantially higher for the state (16.9%) than for the region (0.9%) over this time period. Those identifying as Asian grew across the region with a slightly higher rate for the state as a whole (64.7%) than the Greater Norwalk area (62.4%).

Quantitative data about changes in diversity across the towns in the region show that the towns of Fairfield and Wilton have seen the largest increase in those identifying themselves as Black (74.8% and 69.8% increase, respectively) and as Asian (88.1% and 74.5% increase, respectively). The White population decreased in all towns except Darien where it increased by 3.7%. Norwalk experienced the largest decrease in the White population between 2000 and 2010 (-4.1%). [Additional Data in Appendix E]

Figure 7: Population Change by Racial/Ethnic Group in Connecticut, Greater Norwalk, and Norwalk, 2000 and 2010



DATA SOURCE: U.S. Census Bureau, 2000 Decennial Census and 2010 American Community Survey

B. SOCIAL ENVIRONMENT

"It is a safe city There is good control (the police). There are no schools that don't rank well; it seems like a good level of education. Norwalk is a town that I would recommend. There is good work; there is a lot, if they do not work it's because they don't want to." – Focus group participant

"There are great things for the youth here, great for youth development- aquarium, library." – Focus group participant

"People really care about the community." – Interview participant

"There are many opportunities here in Norwalk." – Focus group participant

"It's a big asset to be living in this part of the country...there are opportunities for career choices, medical choices, entertainment. There are a wide range of interesting people." – Focus group participant

"It's a very, very diverse community which is one of the strong points and one of the more attractive aspects of being and working in Norwalk." – Focus group participant

The social environment as discussed in this report includes education, employment, poverty, and crime. These factors have all been shown to affect the health of individuals and groups living in communities. For example, additional years of formal education strongly correlate with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles. Poverty can result in reduced access to health services and negative health consequences, such as increased risk of mortality, increased prevalence of medical conditions and disease incidence, depression, and poor health behaviors.

These social and economic factors were also recognized by community members as an important part of health. For example, jobs and local economic opportunities were mentioned by focus group participants as drivers of good health; they viewed health as the opportunity to earn a living in order to pay for daily essentials like food, medicine, and housing. In addition, residents noted the important relationship between social interaction and cohesion and health; several participants suggested that physical and mental health were improved by neighbors being together and being connected. As one focus group participant shared, *“People choose to be here and when you choose to be here, you’re more invested in the community and its people.”*

Focus group participants and interviewees pointed to substantial strengths and challenges of the region, although these differed by area. When asked about strengths, those in the surrounding communities pointed to high quality schools, strong civic mindedness, and philanthropic tendencies among residents, as well as a very strong “child-orientation,” largely attributable to the large number of stay-at-home moms. Close proximity to shopping and the shore as well as New York City were also cited as assets of the region. Those in Norwalk saw their strong and growing diversity as a strength. Some saw greater opportunity in Norwalk than in other cities. As one focus group participant stated, *“It’s easier to get a job, to be treated better—we are happy here.”*

Educational Attainment

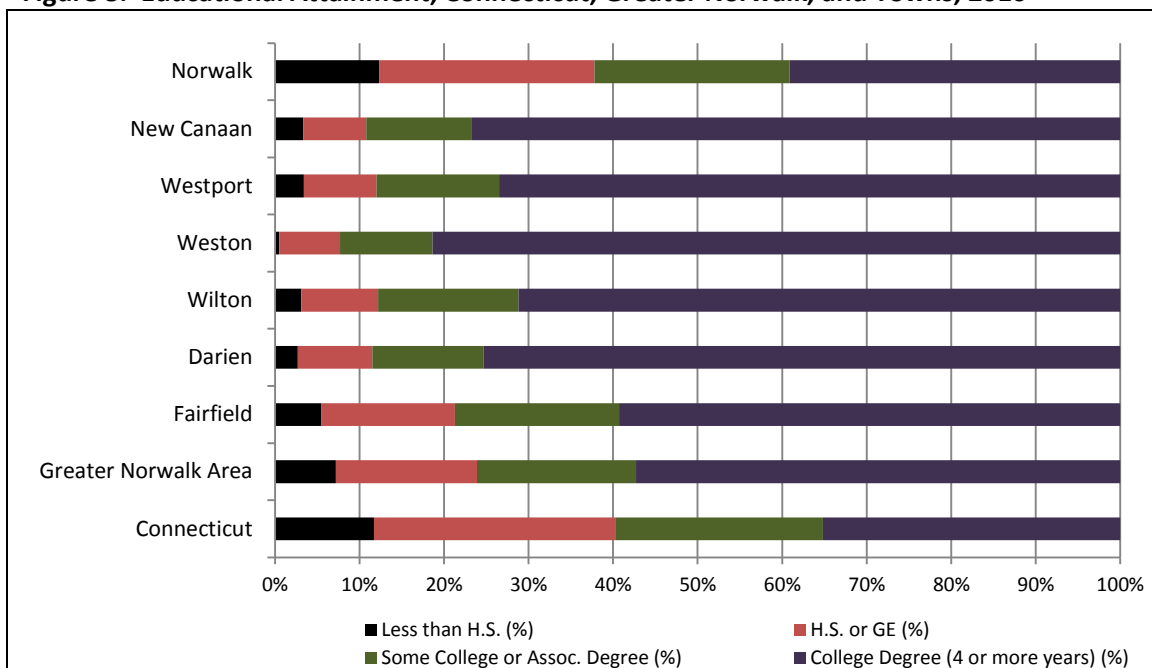
When asked about education in the region, respondents were mixed. Those from Norwalk expressed concern about the quality of education in the city. As one educator noted, *“[there are] dwindling resources and a major achievement gap.”* Student focus group members also expressed concerns about school budget crises that have resulted in the loss of programs such as art, music and vocational classes; these losses make it more difficult for students wishing to pursue those fields or vocations. Those living in the surrounding areas expressed concern about the negative impact of the high achievement culture that characterizes those towns. They reported that there is substantial pressure on families, and especially students, to excel. As one focus group member stated, *“[there is] an expectation for excellence, starring in three sports, going to a big school.”* The consequences of this, according to some, are higher rates of stress and anxiety, which can lead to mental health concerns and substance use.

Adults who complete college are more likely to live healthier lives. Quantitative results show high educational attainment among many of the area’s communities, in general higher than the state average (Figure 8). A review of the literature for the Health Equity Index shows that, with higher education, adults are able to more easily find employment, earn a steady income,

and make better decisions⁴. These factors play a role in health outcomes, and studies have shown that college graduates live longer lives compared to individuals who do not complete high school⁵.

Over 70% of adults in five of the towns (Darien, New Canaan, Weston, Westport, and Wilton) have a four-year degree or more, compared with 35% for the state as a whole. While the proportion of adults with less than a high school diploma is very low in most towns in the area, educational levels of adult residents are generally lower in Norwalk and Fairfield. Fairfield has fewer adults with a college degree or higher (59.3%) than many of the surrounding towns, but it still has a higher proportion than the state. Norwalk, however, has lower levels of educational attainment. The proportion of adults with a 4-year degree or higher (39.1%) is far lower than that of other towns in the area and much closer to the state average of 35.2%. The proportion of Norwalk adults with less than a high school diploma (12.3%) is slightly higher than the statewide average (11.7%) and far above the average for the Greater Norwalk area overall (7.2%).

Figure 8: Educational Attainment, Connecticut, Greater Norwalk, and Towns, 2010



DATA SOURCE: 2010, U.S. Census Bureau, American Community Survey

Income and Poverty

“There are pockets of Norwalk where people feel they have no way out.” – Focus group participant

“Even the affluent are living on the edge.” – Focus group participant

⁴ California Newsreel, Nationality Minority Consortia, Joint Center Health Policy Institute. Unnatural Causes: Is Inequality Making Us Sick? http://www.unnaturalcauses.org/resources.php?topic_id=3

⁵ Robert Wood Johnson Foundation Commission to Build a Healthier America. <http://www.commissiononhealth.org/Education.aspx>

The Health Equity Index points to the connection that income and poverty have to health outcomes. Higher incomes make it easier to buy medical insurance and medical care, nutritious foods, and better child care, and to live in a safe neighborhood with good schools and recreational facilities. Income levels have also been correlated to life expectancy, with lower income earners experiencing lower life expectancies⁶. It has been widely observed that poverty has been linked to ill health and vice versa, creating a cycle between income and health that can continue across lifetimes and generations⁷. Lower income communities have shown higher rates of asthma, obesity, diabetes, heart disease, and child poverty.

Focus group participants and interviewees identified several community concerns. The economic downturn has affected the region's residents and organizations that provide services to them. Poverty within Norwalk has increased. According to one interviewee, the proportion of Norwalk students eligible for free and reduced lunch has risen from 22% to 40%⁸. Other respondents from the city reported that residents are struggling to hold onto employment and sometimes work two or three low-wage jobs while at the same time struggling to pay for things like child care and health care. The economic downturn has affected the more affluent communities as well, as professional jobs have been lost and families struggle with adjusting to new lifestyles. Focus group participants from social service and health organizations reported that increased demand for their services and shrinking resources have challenged their ability to continue to meet needs effectively.

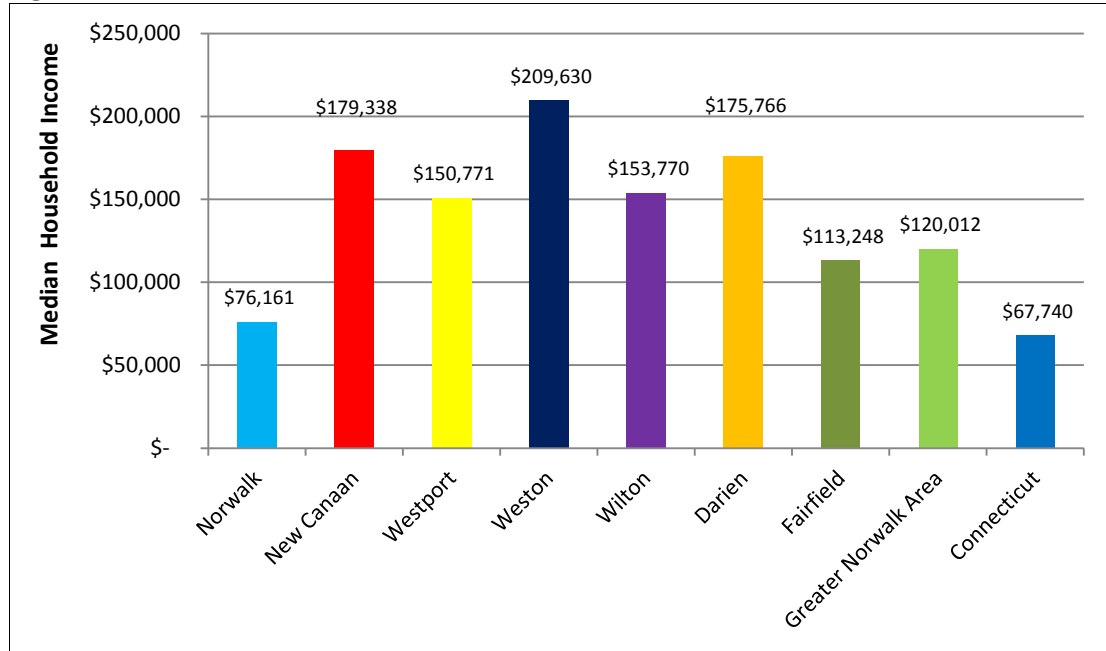
Quantitative data point to a region of substantial wealth. According to the Census Bureau, household median income in the Greater Norwalk area was more than \$50,000 higher than that for Connecticut as a whole (Figure 9). With the exception of Norwalk, all of the towns in the region have a median household income of greater than \$100,000, with the highest in Weston (\$209,630). Norwalk's median household income in 2010 was \$76,161, about \$44,000 lower than that for the Greater Norwalk area as a whole.

⁶ California Newsreel, Nationality Minority Consortia, Joint Center Health Policy Institute. Unnatural Causes: Is Inequality Making Us Sick? http://www.unnaturalcauses.org/resources.php?topic_id=3

⁷ Robert Wood Johnson Foundation Commission to Build a Healthier America. <http://www.commissiononhealth.org/Education.aspx>

⁸ For the Fall semester of 2012, the percentage of students eligible free or reduced lunch in the Norwalk Public Schools was approximately 43%.

Figure 9: Median Household Income, Connecticut, Greater Norwalk Area, and Towns, 2010

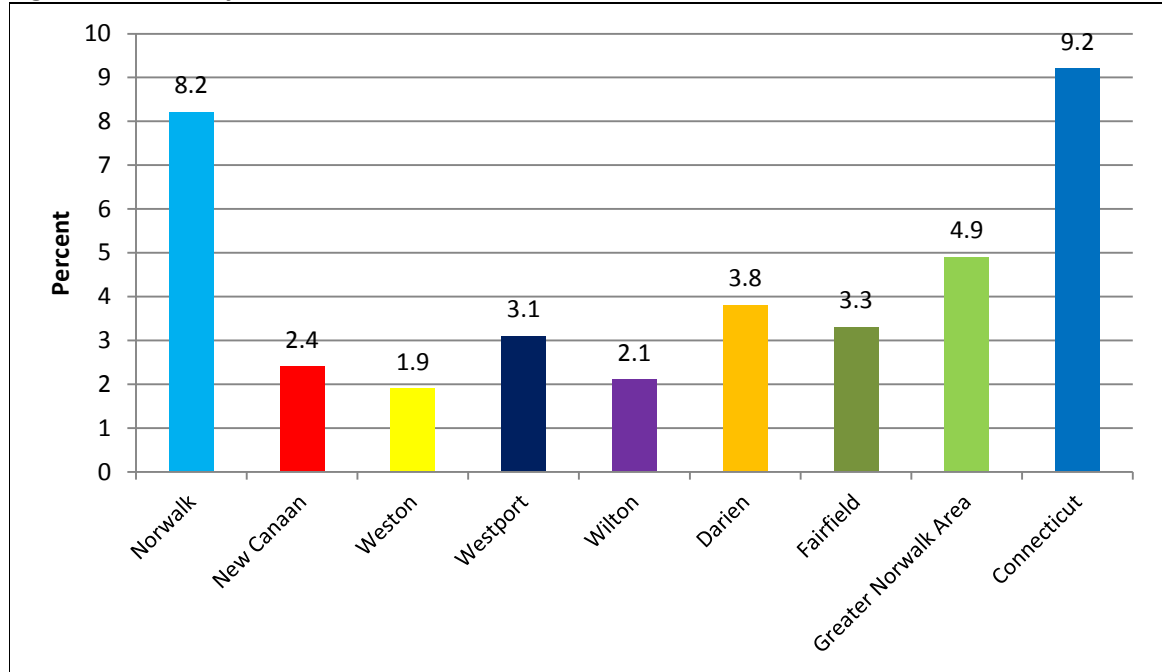


DATA SOURCE: 2010, Census Bureau

Poverty rates across much of the Greater Norwalk area are low. The poverty rate for the region was 4.9% in 2010, almost half the rate for the state (9.2%)

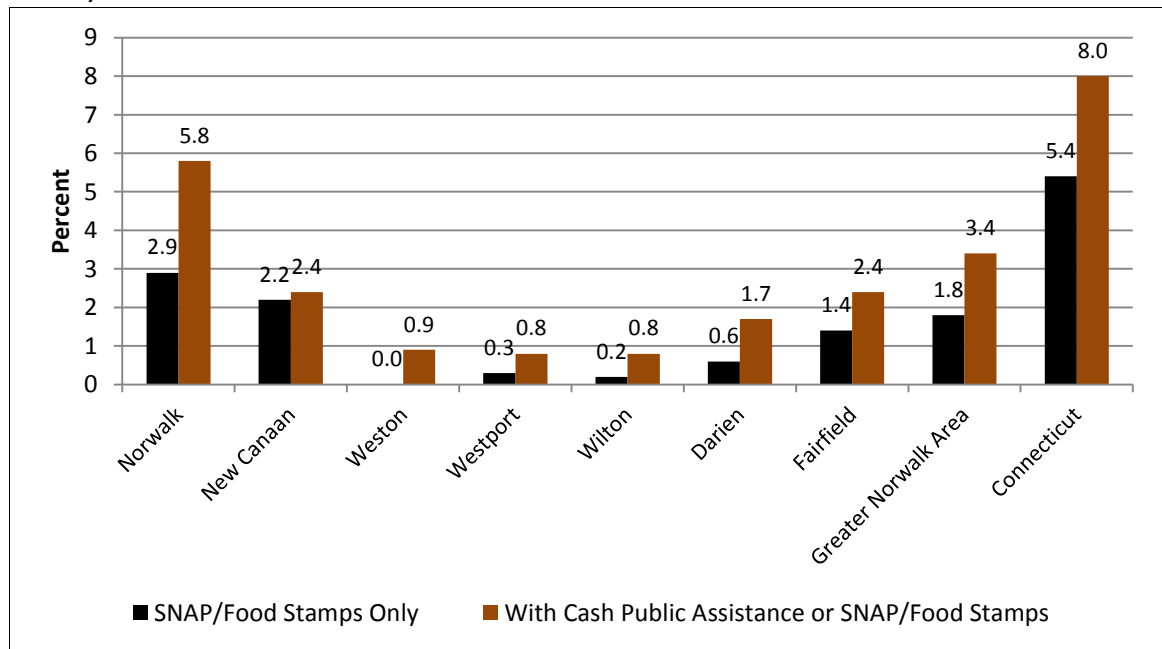
Figure 10 shows the poverty rate was less than 4% in most communities, with the exception of Norwalk where 8.2% of individuals were below poverty level according to the American Community Survey. Because of its larger population size, 61.3% of all persons in poverty (6,868) in the area in 2010 lived in Norwalk. Approximately 3.4% of Greater Norwalk households received cash public assistance or Food Stamps/SNAP in 2010, compared to 8.0% for the state as a whole (Figure 11). Twelve percent of persons in poverty in Norwalk are children under 18.

Figure 10: Poverty Rate, Connecticut, Greater Norwalk Area, and Towns, 2010



DATA SOURCE: U.S. Census Bureau, 2010 American Community Survey. Population for whom poverty has been determined.

Figure 11: Households with public assistance (cash) or food stamps (SNAP), Connecticut and Towns, 2010

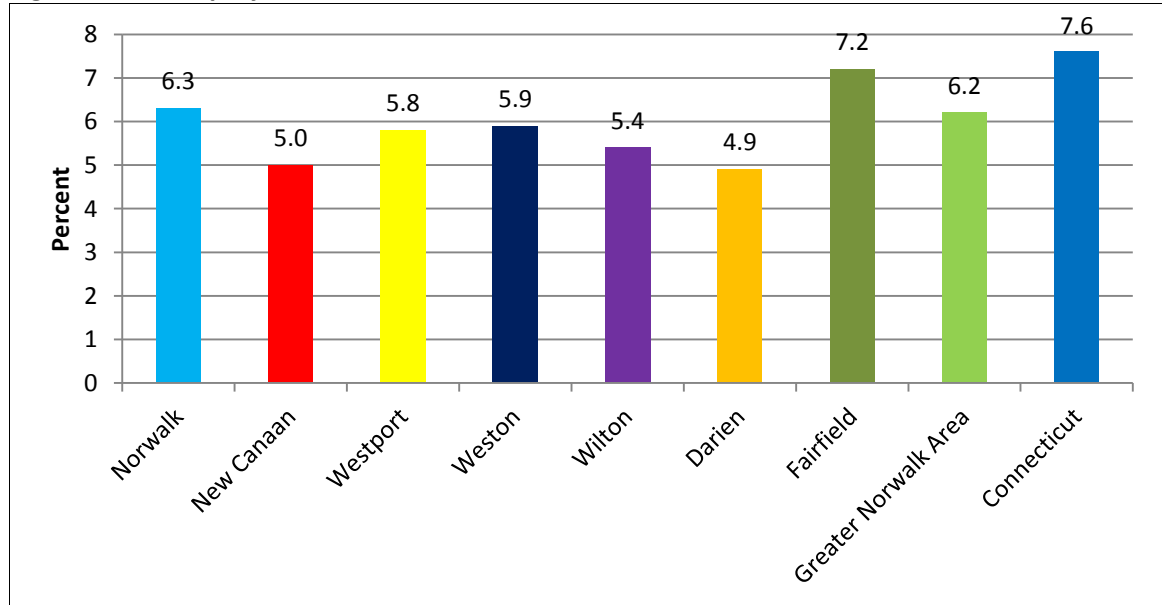


DATA SOURCE: U.S. Census Bureau, American Community Survey, 2010

Employment

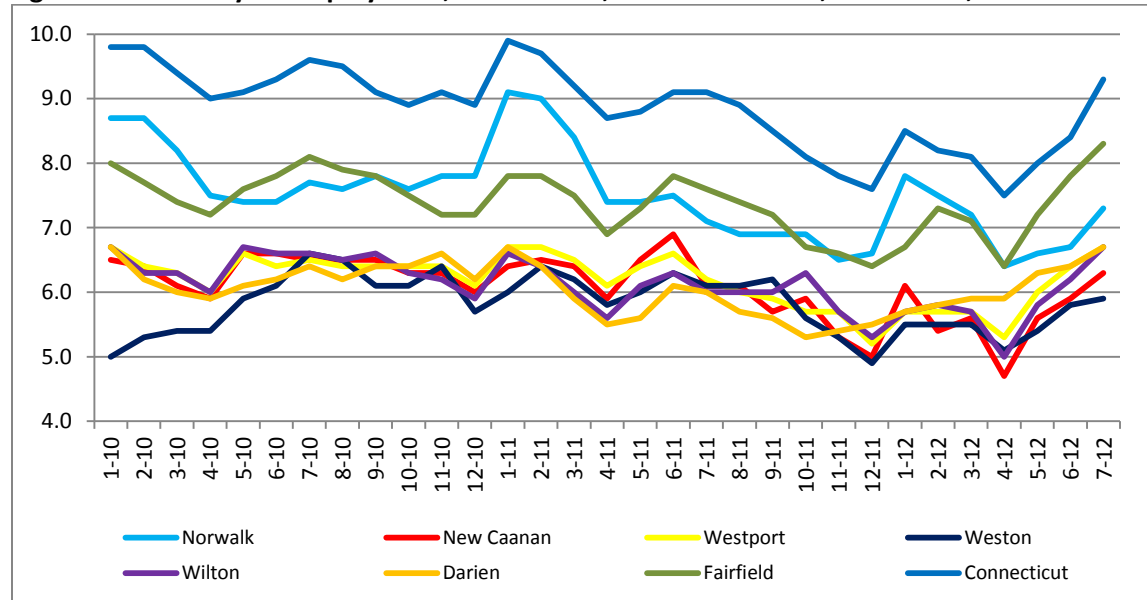
The 2010 unemployment rate for the Greater Norwalk Area was 6.2%, slightly lower than the rate for the state (7.6%) (Figure 12). Across most towns, the rate was between 5-6%. The highest unemployment rate in the area was in Fairfield (7.2%). Darien had the lowest unemployment rate, 4.9%. The unemployment rate in the region has fluctuated monthly since 2010 although over time, the rate for the towns has been less than for the state as a whole (Figure 13).

Figure 12: Unemployment Rate, Connecticut, Greater Norwalk, and Towns, 2010⁹



DATA SOURCE: U.S. Census Bureau, 2010 American Community Survey

Figure 13: Monthly Unemployment, Connecticut, Greater Norwalk, and Towns, 2010-2012

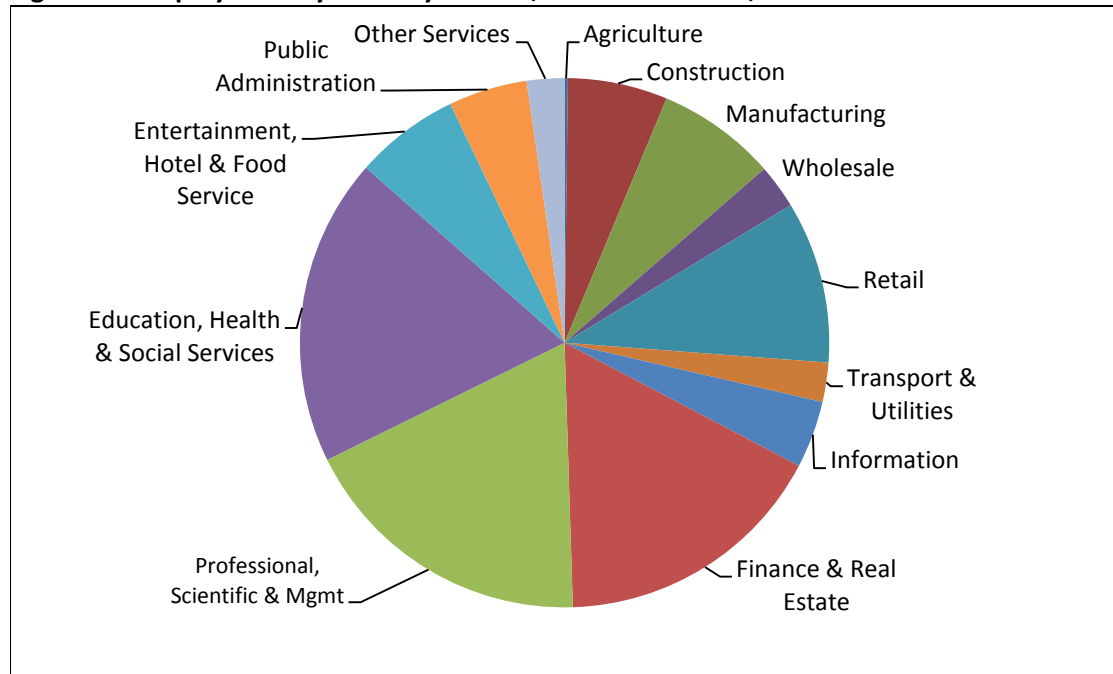


DATA SOURCE: Connecticut Department of Labor, Local Area Unemployment Statistics (LAUS)

⁹ Civilian Labor Force, age 16 and above

As seen in Figure 14, the highest proportion of Greater Norwalk's workers are employed in Education, Health and Social services (18.8%), Professional, Scientific and Management (18.2%), and Finance and Real Estate (16.8%). Compared to the rest of the state, the region has a higher proportion of adults employed in Finance and Real Estate (16.8% compared to 9.5%) and Professional, Scientific, and Management positions (18.2% compared to 10.7%). [Additional Data in Appendix E]

Figure 14: Employment by Industry Sectors, Greater Norwalk, 2010



DATA SOURCE: U.S. Census Bureau, 2010 American Community Survey

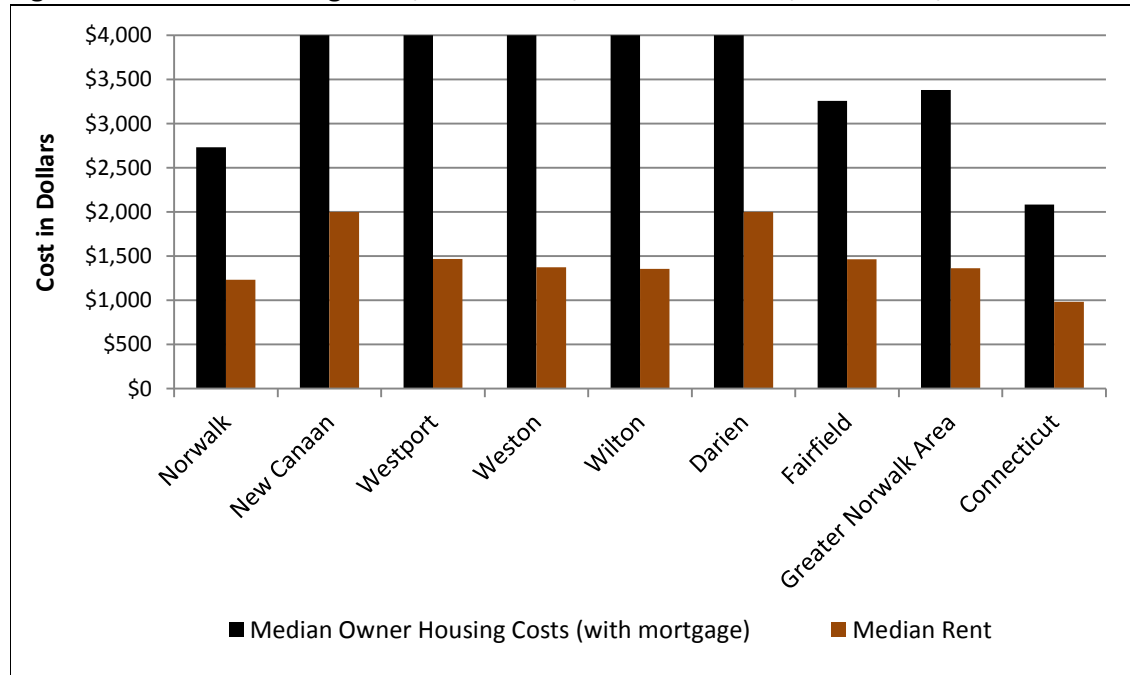
Housing

As a largely prosperous region, housing in the Greater Norwalk Area is expensive and many participants identified the high cost of housing throughout the region as a concern. For some individuals and families, after covering their housing costs, little is left to cover food and other items. Some pointed to rising homeless rates, over-burdened homeless services, and large numbers of people living in one residence/apartment as evidence of growing housing constraints, especially since the economic downturn. Others reported that it has become increasingly difficult for the elderly to afford to stay in their homes. Several focus group members from Norwalk reported that development in some areas of the city (SoNo) is forcing long-time residents out.

As shown in Figure 15, median monthly housing costs with a mortgage or monthly rental costs are higher in this region than for the state as a whole. Monthly mortgage costs range from \$2,731/month in Norwalk to \$4,000/month in the five communities of New Canaan, Westport, Weston, Wilton, and Darien. This compares to \$2,082/month on average for the state. Monthly rental costs are also higher in the region than for the state as a whole. While Norwalk and Fairfield's rentals (\$1,231/month and \$1,464/month, respectively) are slightly higher than for the state as a whole (\$982/month), in New Canaan and Darien, the monthly rental cost is twice as high. Housing in the region is very expensive; the median home sale price in the Greater Norwalk Area is three times higher than for the state as a whole

(\$631,808 versus \$220,000). Data from the Connecticut Housing Finance Authority indicate the median sale price for a single family home in Darien and New Canaan was \$1,250,000 in 2010. [Additional Data in Appendix E] Furthermore, the rate of foreclosure filings for the region (2.75 per 1,000 units) was lower than for the state (4.46 per 1,000 units). [Additional Data in Appendix E]

Figure 15: Median Housing Costs, Connecticut, Greater Norwalk, and Towns, 2010¹⁰



DATA SOURCE: 2010, U.S. Census Bureau, American Community Survey

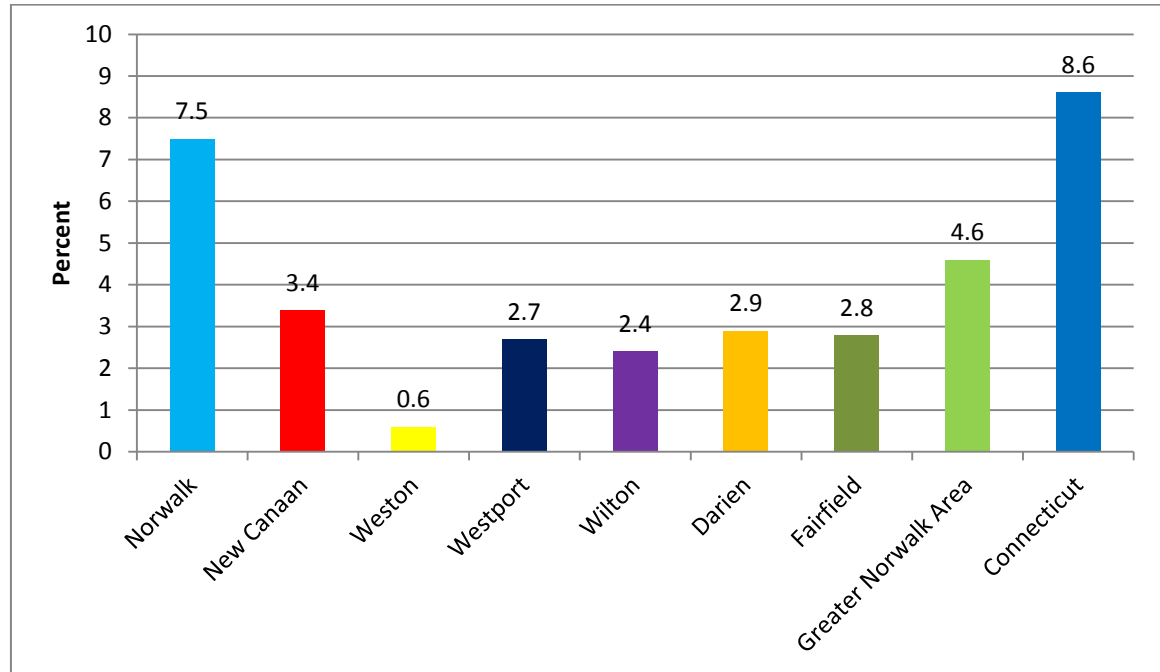
Transportation

“Transit system is a big plus as well.” – Focus group participant

Quantitative data show that fewer Greater Norwalk residents (4.6%) than residents of the state as a whole (8.6%) lack access to a vehicle (Figure 16). While overall, residents in most of the towns have access to a vehicle, 7.5% of Norwalk’s population does not have access to a vehicle. Further, a higher proportion of Greater Norwalk workers (13.0%) use public transportation to get to work than the state as a whole (4.4%) (Figure 17). These findings may be attributable to the proportion of the population that commutes into New York City for work.

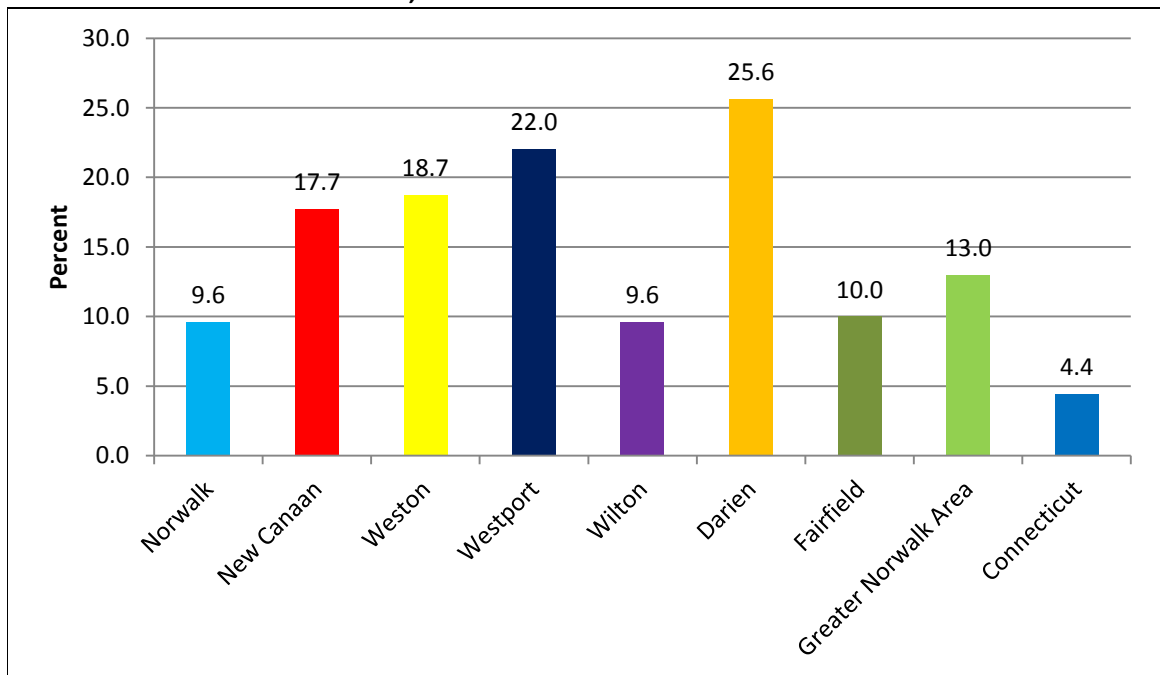
¹⁰ Housing cost for owners includes mortgage (if there is one), taxes, insurance, and utilities. Rent does not include utilities unless they are included in the rent payment.

Figure 16: Households with no Vehicle Available, Connecticut, Greater Norwalk Area towns, 2010



DATA SOURCE: U.S. Census Bureau, 2010 American Community Survey

Figure 17: Proportion of workers using public transportation to get to work, Connecticut and Greater Norwalk Area towns, 2010



DATA SOURCE: U.S. Census Bureau, 2010 American Community Survey

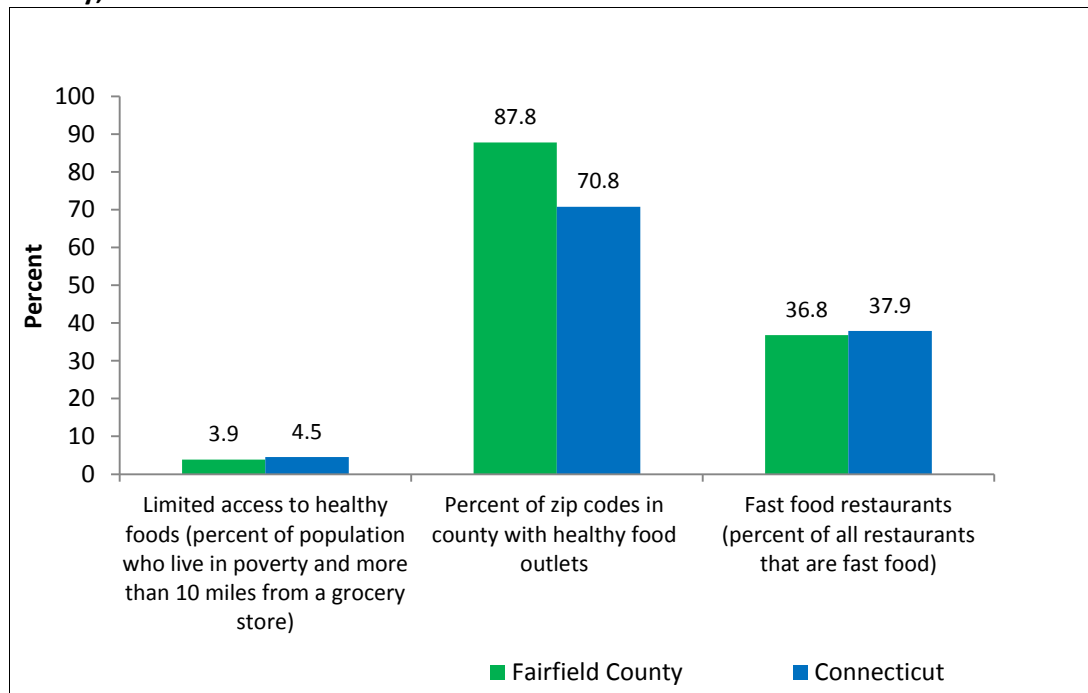
Access to Healthy Foods and Recreation

“Gyms are doing a healthy business – I am seeing full parking lots.” – Focus group participant

“They took away the roller skating rink. They took away the ice skating rink. They took away teenage parties for kids that stayed out of the streets. They took away all of that. What is there for our children to do? There’s nothing.” – Focus group participant

Focus group respondents and interviewees reported concerns about rising obesity levels in the region, particularly among children. Closely related to obesity rates is the availability of healthy foods and opportunities for physical activity and recreation. As Figure 18 below shows, 87.8% of zip codes in Fairfield County have healthy food outlets (i.e., restaurants, grocery stores, convenience stores, farmers’ markets, etc. where healthy foods are sold), higher than the rate for Connecticut as a whole (70.8%).¹¹ However, the proportion of restaurants in Fairfield County that are fast food establishments (36.8%) is similar to that of the state (37.9%). Access to healthy food is a concern in some areas of Norwalk where the U.S. Department of Agriculture has identified three census tracts south of Interstate as food deserts. This means that these areas are low income, and that a substantial number or share of residents has limited access to a supermarket or a large grocery store.

Figure 18: Percent of People with Access to Healthy Foods, Connecticut and Fairfield County, 2009



DATA SOURCE: Census Zipcode Business Patterns, Analysis by County Health Rankings, 2009

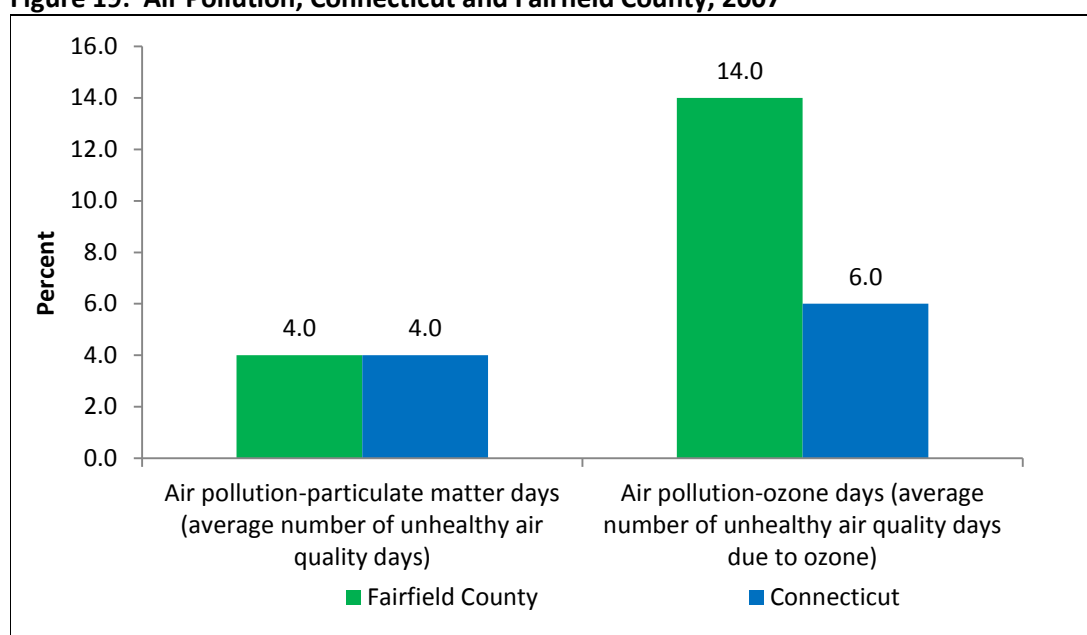
¹¹ Data specific to the Greater Norwalk Area are not available.

Overall, the region has substantial access to recreational facilities, defined by the County Health Rankings as establishments primarily engaged in operating fitness and recreational sports facilities, featuring exercise and other active physical fitness conditioning or recreational sports activities such as swimming, skating, or racquet sports. There are 20 recreational facilities per 100,000 population in Fairfield County, which is higher than the state rate (14 per 100,000)¹². However, the cost of using these facilities can be prohibitive to the less affluent, and some residents have less access to parks and green space than others.

Environmental Quality

The relationship between elevated air pollution—particularly fine particulate matter and ozone—and compromised health has been well documented. A review of the literature by the County Health Rankings indicates that the negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, and asthma, among other adverse pulmonary effects. The annual number of unhealthy air quality days due to fine particulate matter for Fairfield County was 4 in 2007, the same as for the state (Figure 19). However, Fairfield County had far higher (14) ozone days (days when air quality was unhealthy for sensitive populations due to ozone levels) than the state as a whole (6).

Figure 19: Air Pollution, Connecticut and Fairfield County, 2007



DATA SOURCE: U.S. Environmental Protection Agency (EPA), 2007

Crime and Safety

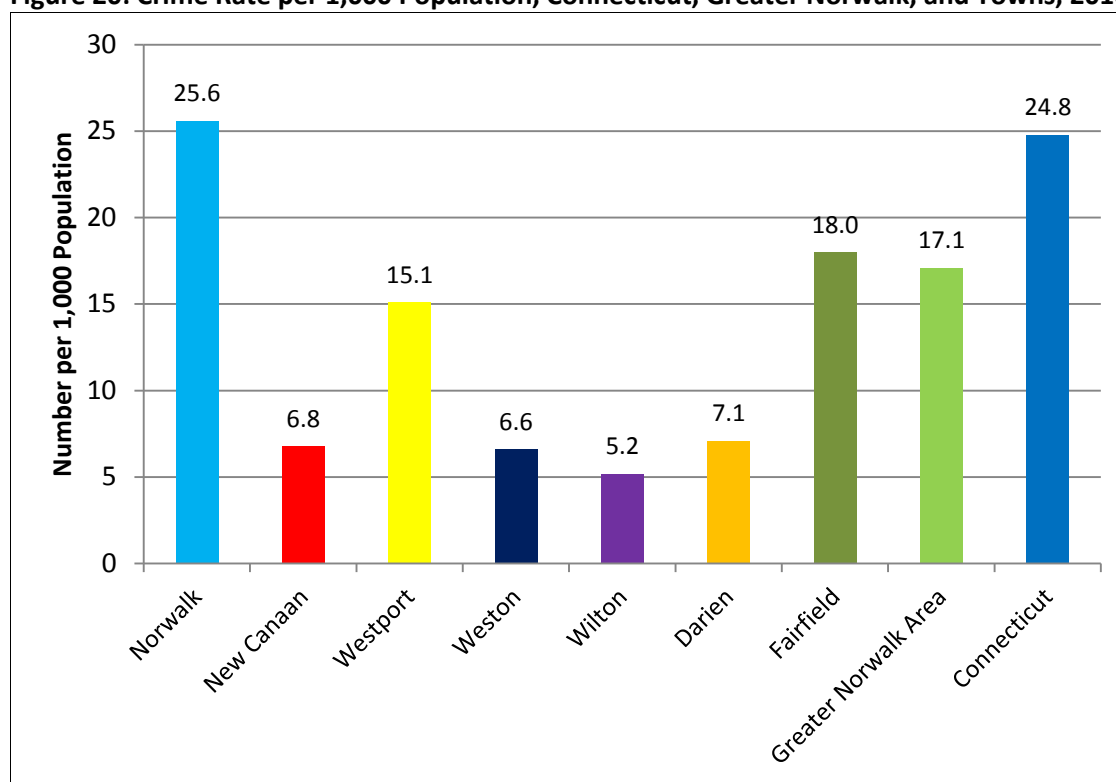
Focus group respondents and interviewees also reported growing rates of person-to-person violence. Within Norwalk, respondents expressed concern about rising crime. Law enforcement focus group members reported a rise in gun violence in the city. As one focus group member stated, *“on my street, in my neighborhood, I feel fine. But not in other places.”*

¹² United States Department of Agriculture (USDA) Food Environment Atlas, analysis by County Health Rankings and Roadmaps, 2009

The crime rate (i.e., calculated below as the sum of crimes against persons and crimes against property per 1,000 population) is a widely used indicator to assess the level of safety in an area. Health Equity Index's literature review links crime rates to poorer health outcomes such as mental illness, drug and alcohol abuse, violence, and mortality rates¹³. High crime rates are also linked to other determinants such as income, education, stress, and race¹⁴. High crime rates contribute to poor physical, economic, and social environments and limits the amount of resources and services available to communities, which lead to poorer health outcomes¹⁵.

Crime data show that, with the exception of Norwalk, the rate of crime is relatively low in the region. While Norwalk (25.6) exceeds the statewide rate of 24.8 crimes per 1,000 population, many of the surrounding communities have rates of less than 10 per 1,000 population. The crime rate in Fairfield and in Westport is also slightly higher than for the rest of the region. See Figure 20.

Figure 20: Crime Rate per 1,000 Population, Connecticut, Greater Norwalk, and Towns, 2010



DATA SOURCE: Connecticut Uniform Crime Data, 2010

Rising rates of domestic violence, within both wealthy and poorer populations, was also cited as a challenge by several respondents. Some attributed this trend to the stress and anxiety resulting from the economic downturn and noted that lack of reporting and/or action by victims is a challenge. As one focus group member noted, *“there are many women that stay*

¹³ Dr Rüdiger Krech (Director, WHO Department of Ethics, Equity, Trade and Human Rights): Social Determinants of Health, May 17, 2010

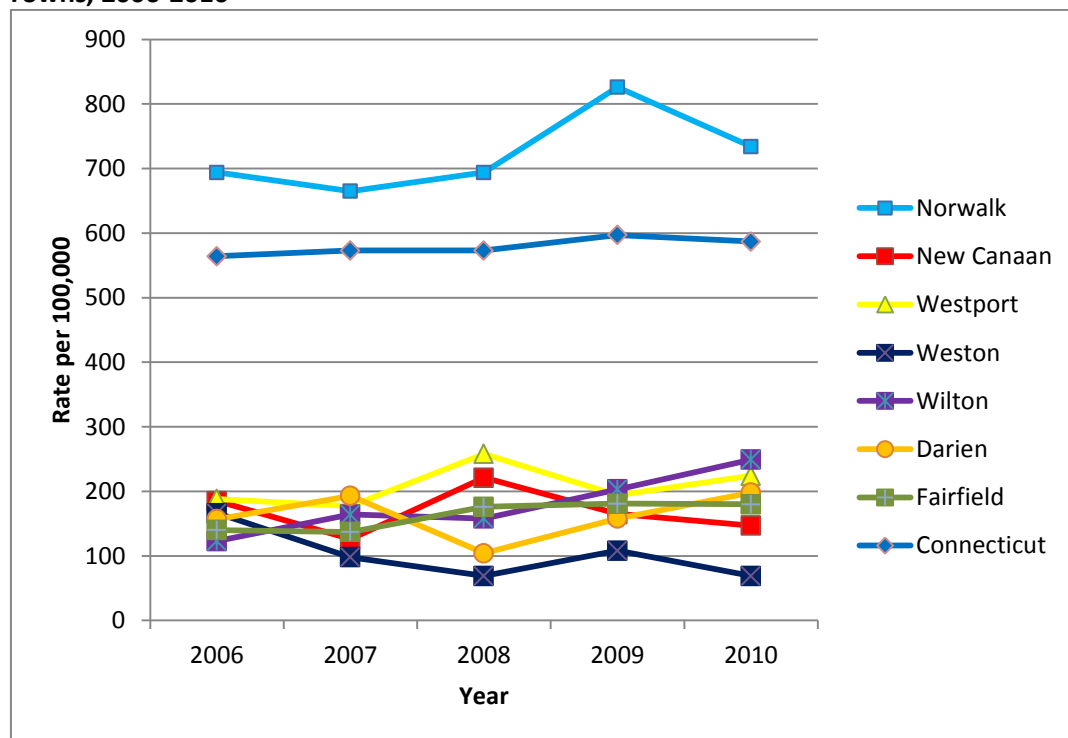
¹⁴ <http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2004/10/03/MNINFANTMO.DTL>

¹⁵ California Newsreel, Nationality Minority Consortia, Joint Center Health Policy Institute. Unnatural Causes: Is Inequality Making Us Sick? <http://www.unnaturalcauses.org/resources.php?>

quiet and don't say anything." A law enforcement focus group member shared the same perspective about more affluent women, *"there are going to be wealthy women who are too embarrassed to follow through with plans we help them put into place. They are dependent on their husbands."*

As focus group and interview participants noted that family and domestic violence are concerns in the region, quantitative data indicate that rates in Norwalk are much higher than what is seen statewide. As shown in Figure 21, while the rate of family violence incidence per 100,000 population has decreased in Norwalk from 2009 to 2010, it still remains much higher than the state (734 incidences per 100,000 population compared to 587 incidences per 100,000 population in 2010). Rates of family violence in the other communities are much less than what is seen statewide, yet the rates have been slightly increasing over time from 2008-2010 in Wilton and Darien.

Figure 21: Rate of Family Violence Incidences per 100,000 Population, Connecticut and Towns, 2006-2010



DATA SOURCE: Connecticut Department of Emergency Services and Public Protection

C. HEALTH BEHAVIORS

This section examines lifestyle behaviors among Greater Norwalk residents that support or hinder health. It examines several aspects of individuals' personal health behaviors and risk factors (including physical activity, nutrition, and alcohol and substance use) that result in the leading causes of morbidity and mortality among area residents. Included in this analysis are some measures that are tracked as part of the Healthy People 2020 (HP2020) Initiative, a 10-year agenda focused on improving the Nation's health. Where appropriate and available, Greater Norwalk area statistics are compared to the state as a whole as well as HP2020 targets. However, due to data constraints, most health behavior measures are available only for Fairfield County as a whole and in some cases, only state-level data are available.

Health was often defined by community residents as practicing healthy behaviors, such as physical activity and healthy eating. Focus group participants noted health as the ability to walk and experience natural spaces like the waterfront. For example, one focus group participant described, *"When we were little, people said, 'go outside and have a good time. I'll see you later.' That was a regular part of every day. Part of it is that there is so much that is organized, there are safety concerns, people feel that they have to keep their kids on a short leash. They are afraid."*

Community residents also recognized the importance of having a healthier food environment to maintain health. Several participants mentioned that school lunch programs have become healthier and that it would be advantageous to implement similar policies for the whole community. Additionally, several young community members noted that health means not using alcohol, tobacco or other drugs, as they have seen the negative consequences of these behaviors. The following section will elucidate further how these lifestyle behaviors affect the health of residents in the Greater Norwalk Area.

Healthy Eating, Physical Activity, and Overweight/Obesity

"There is a new bike path that has been established. Bike riding has become an apparent priority." – Focus group participant

"Gardens at all of the schools – a dynamic effort to introduce fruits and vegetables and influence families." – Interview participant

"There is a lot less physical activity [in schools] than there used to be." – Focus group participant

"Folks who are more challenged economically are not going to have physical activity as a priority." – Focus group participant

"As a culture, we've gotten to thinking these things are going to be quicker and easier than they are. It takes time to go to the farmer's market and cook things. Things you microwave aren't nutritious. It takes time to exercise. As a country, we don't spend time on these fundamental things." – Focus group participant

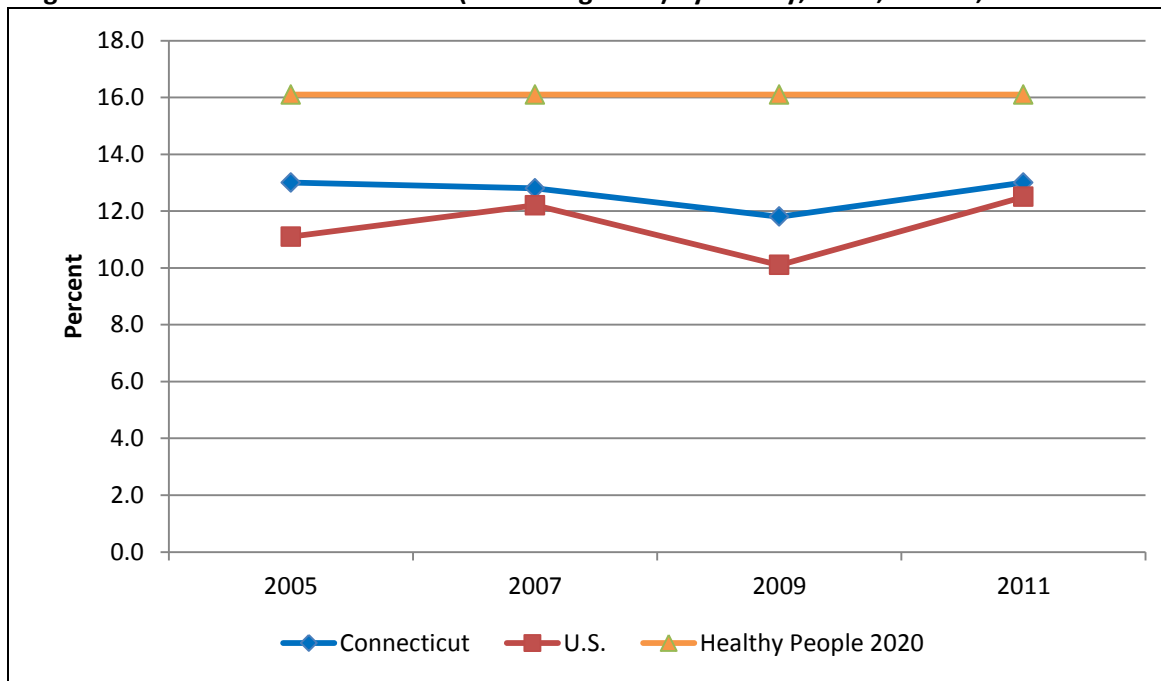
Similar to trends nationwide, issues around obesity—particularly healthy eating and physical activity—emerged as a concern among focus group and interview participants. Obesity was the health issue most frequently named by focus group respondents and interviewees, with a particular concern around childhood obesity. Participants saw that rates of obesity-related conditions such as diabetes and heart disease seemed to be rising.

Respondents offered several reasons for the rise in obesity especially among children, including a fast-paced and busy lifestyle that relies on fast food, concerns about safety, and the attraction of computers and texting that leads children to be more sedentary. Respondents suggested that among less affluent parents, the expense of healthy foods, gym memberships, and physical activity programs creates barriers to healthy eating and physical activity. Teens reported that gym classes in school do little to help or encourage students to stay in shape. Among more affluent parents, a focus on academics and educational activities reduces opportunities for physical activity. As one focus group member noted, *“kids don’t even walk to the bus stop, they get picked up at their own houses.”* Others noted that the old infrastructure in the region has made it difficult to make changes that encourage more physical activity such as adding bike lanes to roads. Several respondents expressed their opinions that the obesity epidemic stems from a lack of motivation among people to engage in healthy behaviors. As one focus group member observed, *“there are a lot of people who do not accept responsibility for taking care of themselves.”*

Child and Youth Obesity

The obesity rate among high school students in Connecticut has changed little since 2005. In 2011, the rate (13.0%) as a whole was similar to that of the nation and lower than the Healthy People 2020 target of 16.1% (Figure 22). While little data are available about obesity rates specifically among Greater Norwalk’s children, there are some data available for Norwalk from the 2011 Norwalk Body Mass Index (BMI) Data Report. Norwalk has youth obesity prevalence rates that are higher than the state average in many cases. For example, for 9th and 10th grade students, the rate is twice as high for Norwalk students than youth in the state of Connecticut overall (20% vs. 10%). Minority children are at higher risk of unhealthy weight than white children, as are children of all races from lower-income families.

Figure 22 : Percent of Obese Youth (9th-12th grades) by County, State, and US, 2005 - 2011



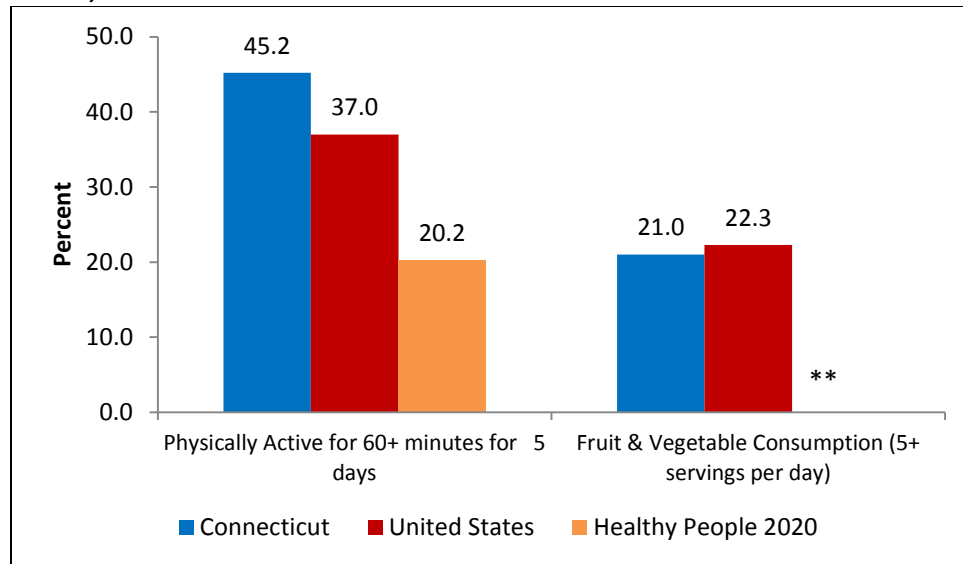
DATA SOURCE: Youth Risk Behavior Survey (YRBS), 2005, 2007, 2009, 2011

**relevant Fairfield County data not available

Data collected through the Youth Risk Behavior Survey indicate that although higher than for the U.S. (37.0%) and the Healthy People 2020 Target (20.2%), less than half 45.2% of youth in

Connecticut are getting the recommended level of exercise per week (Figure 23). Less than one-quarter (21.0%) of youth in Connecticut were eating the recommended number of fruits and vegetables per day, roughly the same proportion for U.S. youth as a whole (22.3%). Town-level data on physical activity collected by the Connecticut Department of Education (Figure 24) indicate that most towns in the Greater Norwalk area exceed the state average for the percent of children meeting physical activity standards (averaging 63-76%). The exception is Norwalk, which had the lowest percentage of children meeting the standards (48.4%) among Greater Norwalk Area towns, and was below the state average (51.0%).

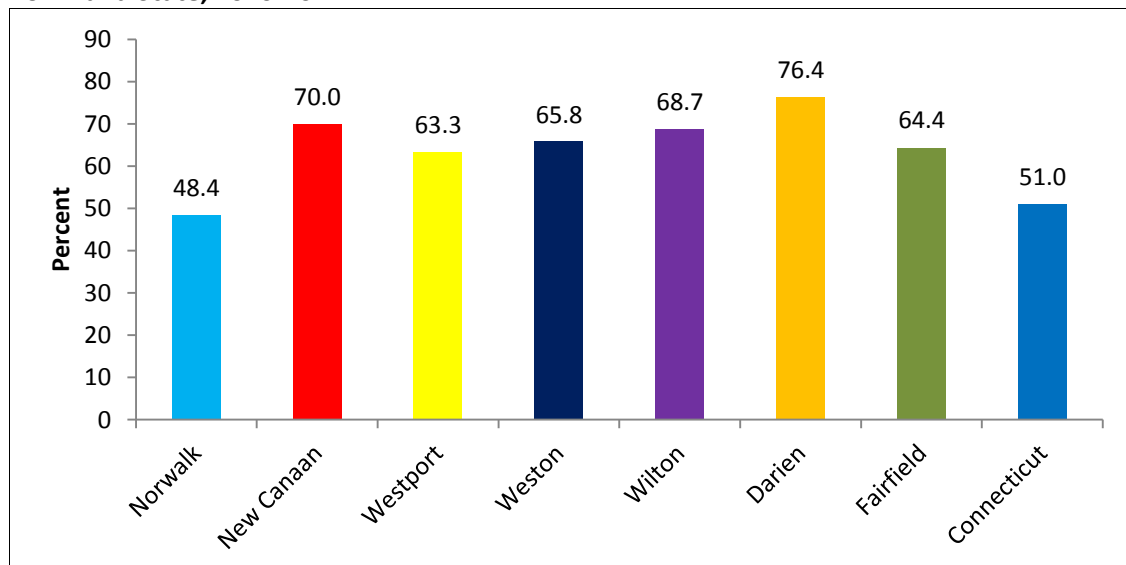
Figure 23: Physical Activity and Fruit and Vegetable Consumption among Youth by State and US, 2009



DATA SOURCE: Youth Risk Behavior Survey (YRBS), 2009

*relevant Healthy People 2020 Target, not available

Figure 24: Percent of Children Meeting the Standard on All Four Physical Activity Tests* by Town and State, 2010-2011



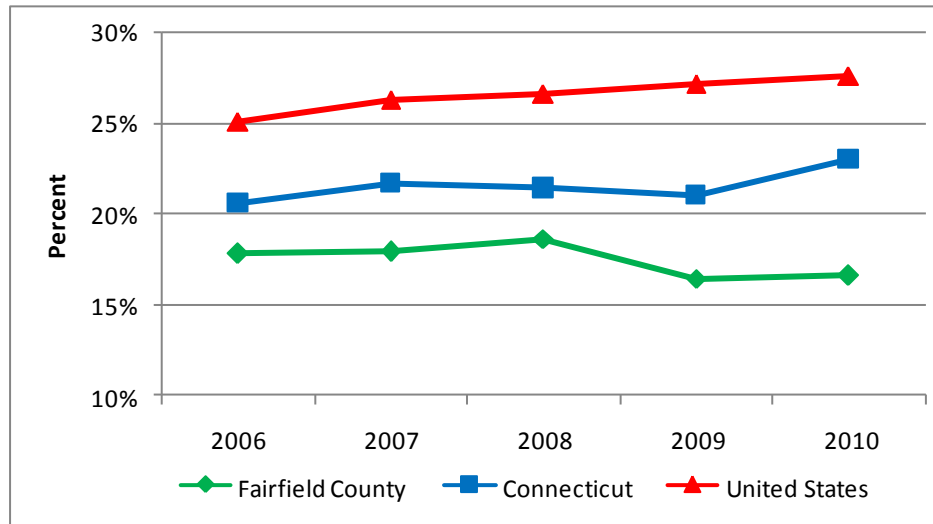
DATA SOURCE: Connecticut State Department of Education, 2010-2011.

*Four tests include: Aerobic endurance, upper body and abdominal strength and endurance and flexibility.

Adult Obesity

As seen in Figure 25, compared to the rest of the state and country, Fairfield County has a smaller prevalence of adult obesity (16.6%) in 2010, compared with the rest of the state (23.0%) and the country (27.6%), and is ranked as having the lowest obesity rate of all Connecticut counties. In addition, obesity in Fairfield County decreased slightly between 2006 and 2010, while rates for Connecticut and the U.S. have increased slightly. There are differences across racial and ethnic groups, however. The rates of adult obesity are highest for Blacks (43.5%), which is almost double the average for Whites (22.1%). [Additional Data in Appendix E]

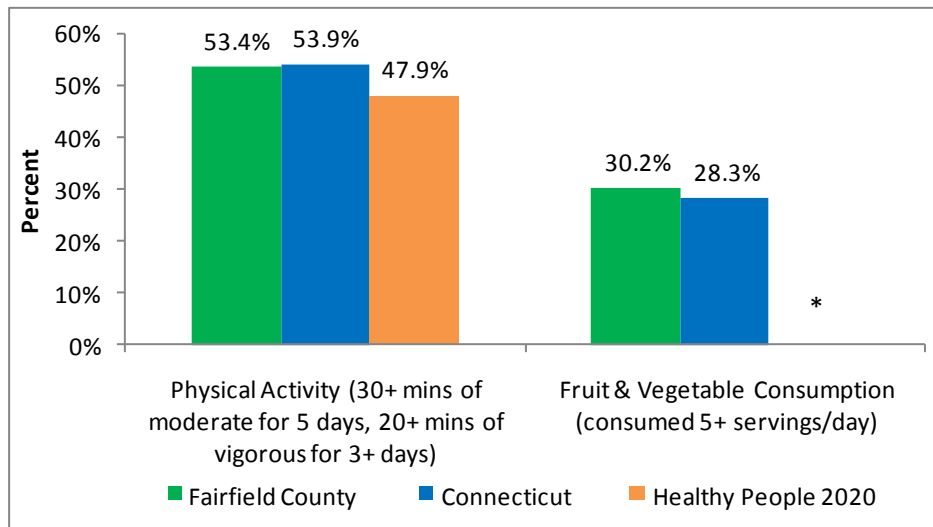
Figure 25: Percent of Obese Adults by County, State, and US, 2006-2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2010

As Figure 26 shows, rates of physical activity and fruit and vegetable consumption among Fairfield County adults are similar to the state as a whole. About one half (53.4%) of adults in Fairfield County are getting the recommended level of exercise per week, a rate similar to Connecticut as a whole (53.9%) and slightly exceeding the Healthy People 2020 goal of 47.9%. Roughly 30% of adults in Fairfield County are consuming the recommended number of fruits and vegetables per day, a rate comparable to that for the state (28.3%).

Figure 26: Physical Activity and Fruit and Vegetable Consumption among Adults in Fairfield County and Connecticut, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2010

*relevant Healthy People 2020 Target, not available

Substance Use and Abuse (Alcohol, Tobacco, and Other Drugs)

"[Police bring on] average a drunk up to the ER every other day. [The ER] has limited resources and they release them after 4-5 hours. Within a week, we're grabbing the same person. [The ER staff should] send them for treatment, not back on the street." – Focus group participant

"[The system] is not always able to work together holistically to get people the longer term help they need." – Interview participant

"Norwalk probably has the most drug activity out of the communities—we have OD's, illicit drug sales everywhere. It is rampant. We've had at least three cases of bath salts. We have meth, heroin, crack, you name it, it's here." – Focus group participant

Substance abuse was the third most-frequently cited health concern in the region, especially in Norwalk, by focus group and interview participants.

Youth Substance Use

"High school kids are dealing with their families' heavy duty problems and this is reflected in their behaviors." – Focus group participant

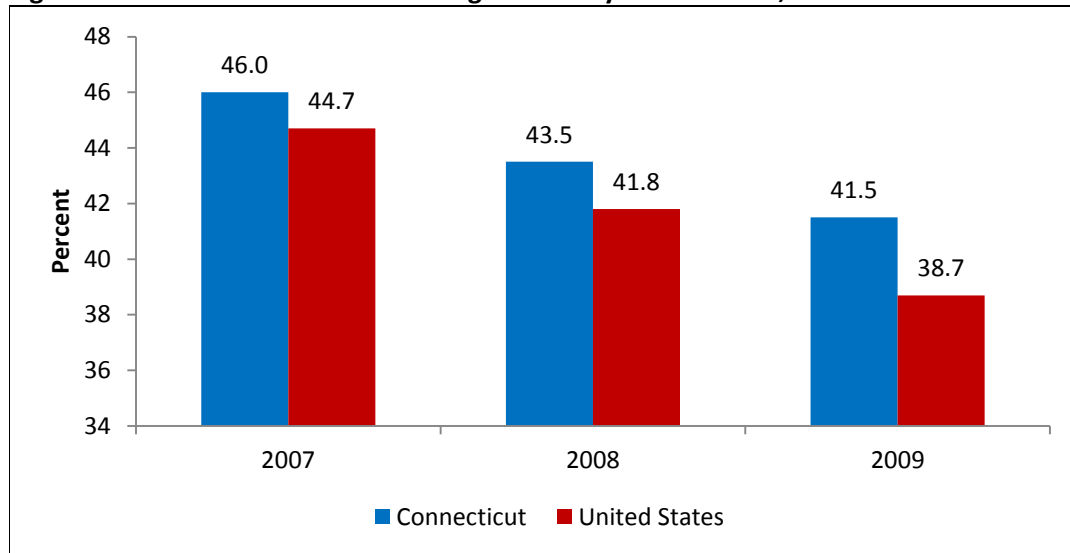
"Alcohol is a very big issue, probably the biggest." – Focus group participant

According to focus group participants and interviewees, among young people, drinking and marijuana is on the rise in both Norwalk and surrounding communities. Teen focus group members identified smoking, drinking, and drug use as a significant concern in their communities and noted that these substances are easily accessible to youth. An educator stated, *"there has been an increase in expulsions and suspensions due to use of marijuana."*

However, quantitative data indicate that drinking rates among youth in the region and the state have declined over time. Data from the Connecticut YRBS indicate that the proportion of youth consuming alcohol declined from 46.0% in 2007 to 41.5% in 2011 (Figure 27). This is similar to rates for the U.S., which had declined from 44.7% in 2007 to 38.7% in 2011.

Data show that the percentage of Connecticut youth consuming alcohol before the age of 13 has decreased from 21.3% in 2005 to 15.6% in 2011, a statistically significant decrease. Data collected by Positive Directions points to the average age of first consumption of alcohol in the region as about 13 years, which is similar to national numbers from the National Institute on Alcohol Abuse and Alcoholism, which identify 11 years old for boys and 13 years old for girls. Similarly, in Connecticut a higher percentage of males (18.2%) than females (12.7%) drank for the first time before 13 years of age. In addition, a higher percentage of Hispanic youth in Connecticut (20.7%) drinks alcohol before the age of 13 years than Black (16.7%) or White (13.8%) youth. These results are consistent with national trends. [Additional Data in Appendix E]

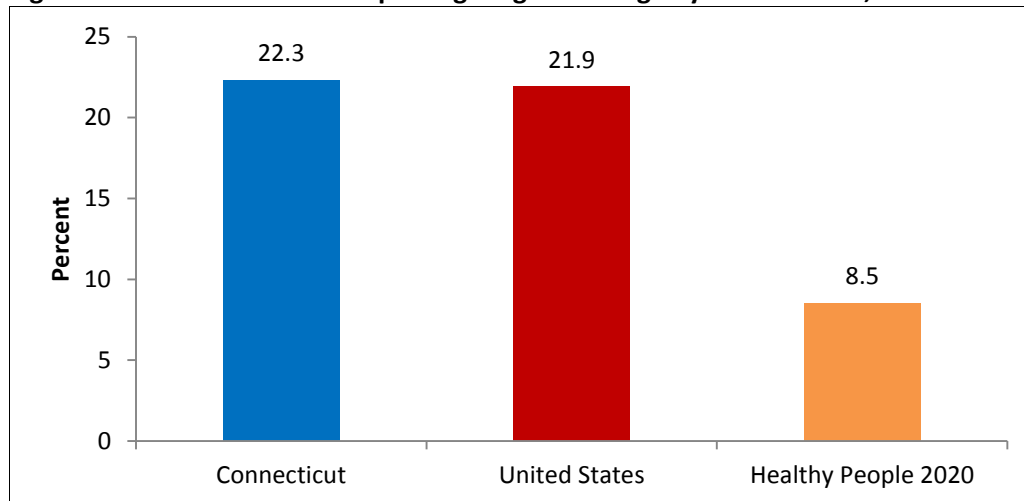
Figure 27: Percent of Youth Consuming Alcohol by State and US, 2007-2011



DATA SOURCE: Youth Risk Behavior System, 2007-2011. Consuming Alcohol= Consumed at least one drink one day in the last 30 days

Binge drinking rates¹⁶ among Connecticut youth (22.3%) are similar to those for the nation as a whole (21.9%) and higher than the Healthy People 2020 target of 8.5% (Figure 28). As with age of first drink, Youth Risk Behavior Survey Data indicate that binge drinking among Connecticut youth has decreased from a rate of 27.8% in 2005 to 22.3% in 2011. This is a statistically significant decrease. The percentage of Connecticut male youth reporting binge drinking (25.4%) is higher than for Connecticut females (19.3%). In addition, a higher percentage of White youth in Connecticut (24.8%) had 5 or more drinks in a row within a couple hours on at least 1 day in the last month than Hispanic (21.1%) or Black (12.3%) youth. This differs from national trends that indicate higher binge drinking rates among Hispanic youth than Black or White youth. [Additional Data in Appendix E]

Figure 28: Percent of Youth Reporting Binge Drinking* by State and US, 2011

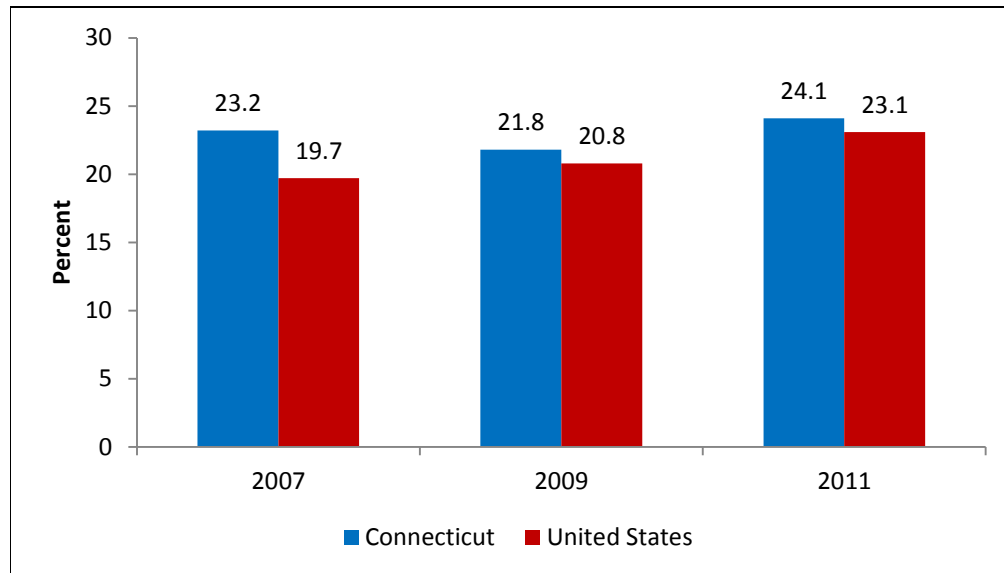


DATA SOURCE: Youth Risk Behavior Survey (YRBS), 2011.
Binge drinking=*5 or more drinks in a row on 1 or more days

¹⁶ Defined as 5+ drinks of alcohol in a row within a couple hours on at least one day in the last month

Marijuana use among Connecticut youth has remained relatively the same (roughly 24%) between 2007 and 2011, although it declined slightly in 2009 (see Figure 29). This rate is slightly higher than that of the U.S. According to 2011 YRBS data, only 6.3% of youth in Connecticut had tried marijuana for the first time before the age of 13, compared to 8.1% for the nation as a whole.

Figure 29: Percent of Youth Using Marijuana* in Previous 30 Days, by State and US, 2007-2011

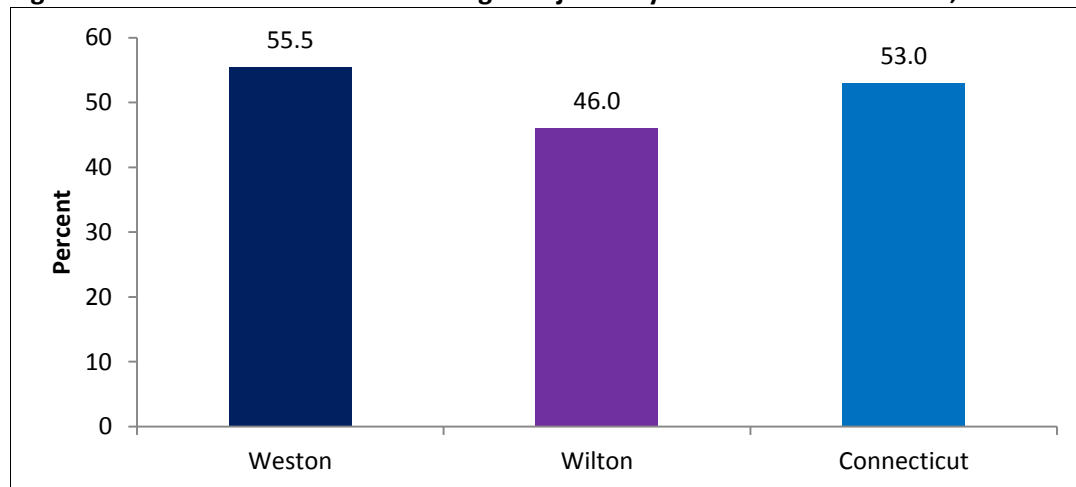


DATA SOURCE: Youth Behavior Risk System, 2007-2011.

* Marijuana Use = Youth using marijuana at least once with the last 30 days

The proportion of 12th graders who have ever used marijuana in selected towns in the region is roughly the same as for the state as a whole (Figure 30). Data collected by Positive Directions points to the average age of first use of marijuana as between 14 and 15 in the region.

Figure 30: Percent of 12th Graders Using Marijuana by Select Towns and State, 2011 & 2012



DATA SOURCE: Positive Directions, 2011 and Youth Risk Behavior System, 2011.

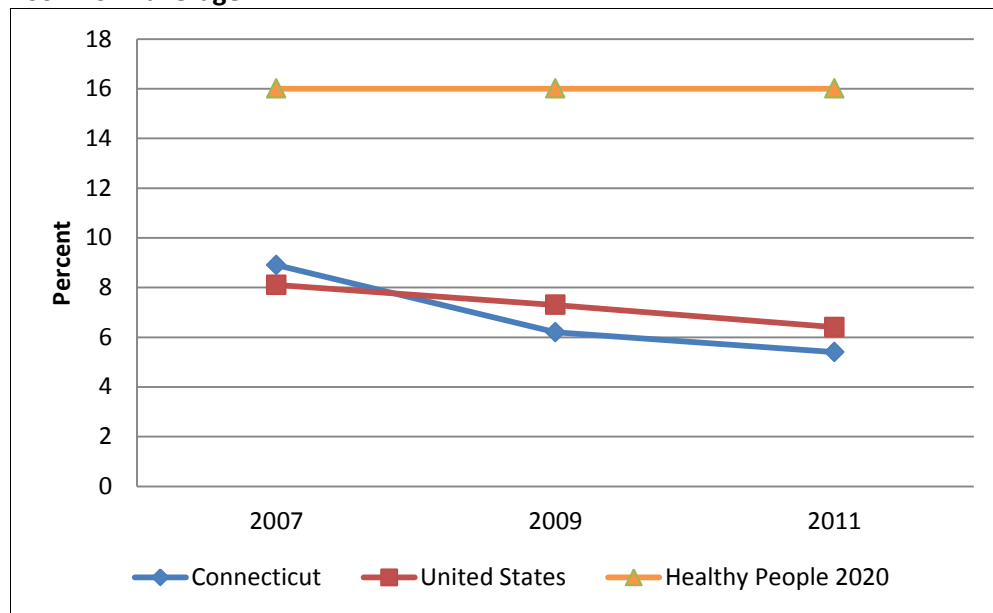
Weston & Wilton: % lifetime users of marijuana users among 12th graders. Source: Positive Directions, 2011.

Connecticut: %12 graders ever used marijuana Source: Youth Risk Behavior System, 2011

Participants in the July 24 Task Force meeting reported concerns about prescription drug abuse. Data collected by Positive Directions in Wilton reveals that 18.6% of senior high school students reported prescription drug abuse, slightly higher than the 16.8% of senior high school students in Connecticut. Nationwide 25.6% of 12th graders report taking prescription drugs without a doctor's prescription.

Quantitative data indicate that smoking rates among youth in the region and the state are low compared to the nation and have declined over time. The proportion of Connecticut youth who smoked heavily (20+ days of the prior month) in 2011 was 5.4% compared to 6.4% for the nation. This is substantially lower than the Healthy People 2020 target of 16% (Figure 31). Furthermore, data indicate that between 2007 and 2011 the proportion of youth smoking heavily decreased both nationally and in the state. In Connecticut, the percentage of youth who smoked heavily decreased from 8.9% in 2007 to 5.4% in 2011.

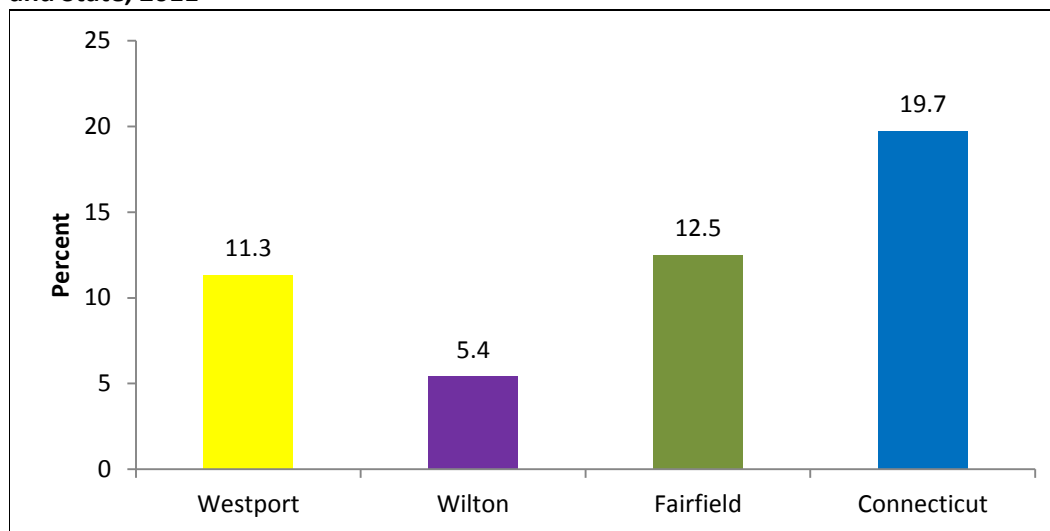
Figure 31: Percent of Youth Smoked Cigarettes on 20+ Days of Last 30 Days by State and US, 2007-2011 average



DATA SOURCE: Youth Risk Behavior System, 2007-2011

Quantitative data reveals that among youth in the three communities for which data are available, rates of youth smoking are lower than for the state as a whole. While 19.7% of 11th graders in Connecticut reported recently using cigarettes in 2011, slightly over 10% of youth in Westport and Fairfield and slightly over 5% of youth in Wilton reported recently using cigarettes (Figure 32).

Figure 32: Percent of 11th Graders Recently Used Cigarettes in Past 30 Days by Select Towns and State, 2011

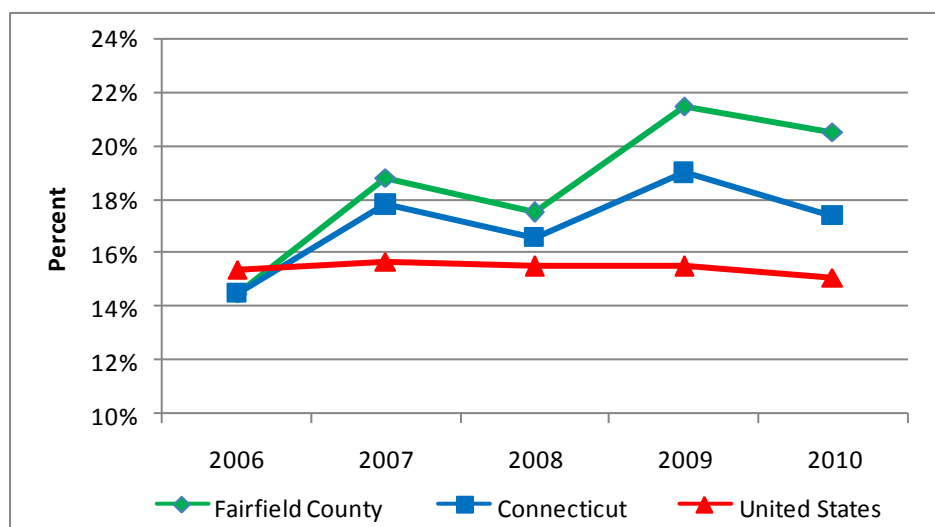


SOURCE: Positive Directions, 2011 & Youth Risk Behavior System, 2011.

Adult Substance Use

Alcohol use among adults is slightly higher among Fairfield County adults (19.7%) than for the state as a whole (18.4%). The percentage of adults who report heavy or binge drinking is higher in Fairfield County (20.5%) than for the Connecticut (17.4%) and the nation (15.1%) (Figure 33). Fairfield County is ranked 8th out of the 8 counties in Connecticut on binge drinking. The rate of binge drinking in Fairfield County and Connecticut has been increasing over the five-year period from 2006-2010, while the rate has been stable for the U.S.

Figure 33: Percentage of Adults Reporting Binge Drinking by County, State, and US, 2006 – 2010



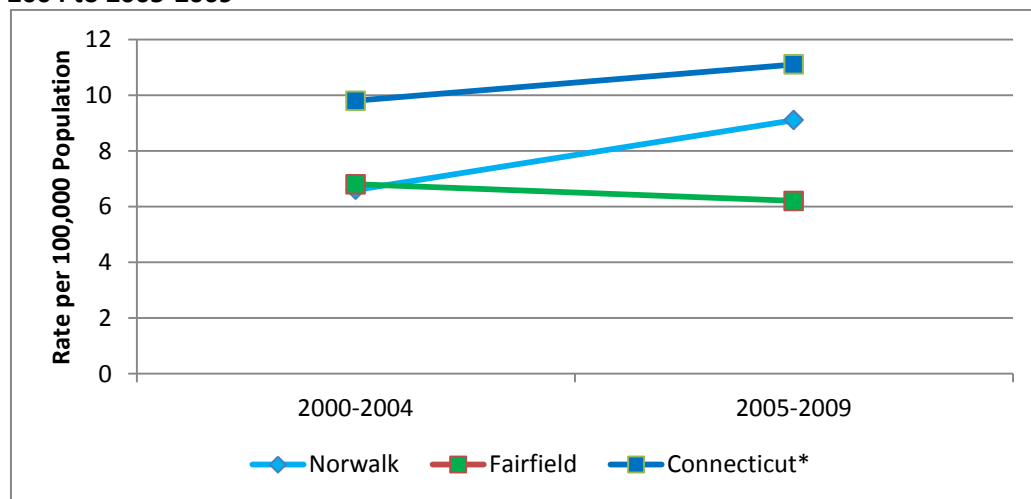
SOURCE: Behavioral Risk Factor Surveillance System (BRFSS).

Young adults age 18-24 (35.4%) had the highest rate of binge drinking (almost double the state average), followed by adults age 25-34 (30.4%). [Additional Data in Appendix E] Binge drinking declines with increasing age until it is only 4.1% for persons over age 65. Males

(23.9%) have a binge drinking rate double that for females (11.5%). Blacks have a lower rate of binge drinking (6.1%) than Hispanics (22.6%) and whites (18.2%).

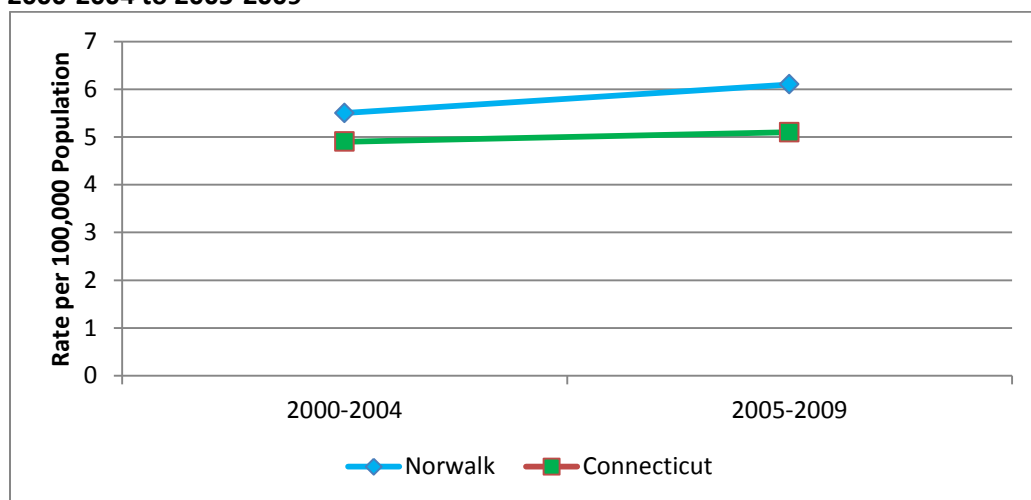
While little reliable data on drug use among adults were available for the region, drug and alcohol-induced deaths are available. In the Greater Norwalk area the highest rate of drug-induced deaths is in Norwalk (9.1 per 100,000 population) and Fairfield (6.1 per 100,000 population) with the other towns having counts that are too low to report. While both Norwalk and Fairfield have rates that are lower than the Connecticut average (11.1 per 100,000 population) (Figure 34), the rates in Norwalk and Connecticut have increased over a five-year period from 2005-2009. Data were also available for alcohol-induced deaths in Norwalk and Connecticut. Over the 2000 to 2009 time frame, the rate in Norwalk increased from 5.5 deaths per 100,000 population to 6.1 per 100,000. This rate was similar to that of Connecticut (5.1 per 100,000 population).

Figure 34: Drug -Induced Deaths per 100,000 Population by Select Towns, and State, 2000-2004 to 2005-2009



DATA SOURCE: Connecticut Department of Public Health Mortality Statistics. * 2005-2009 AAMR is significantly different from 2000-2004 AAMR at $p < 0.05$.

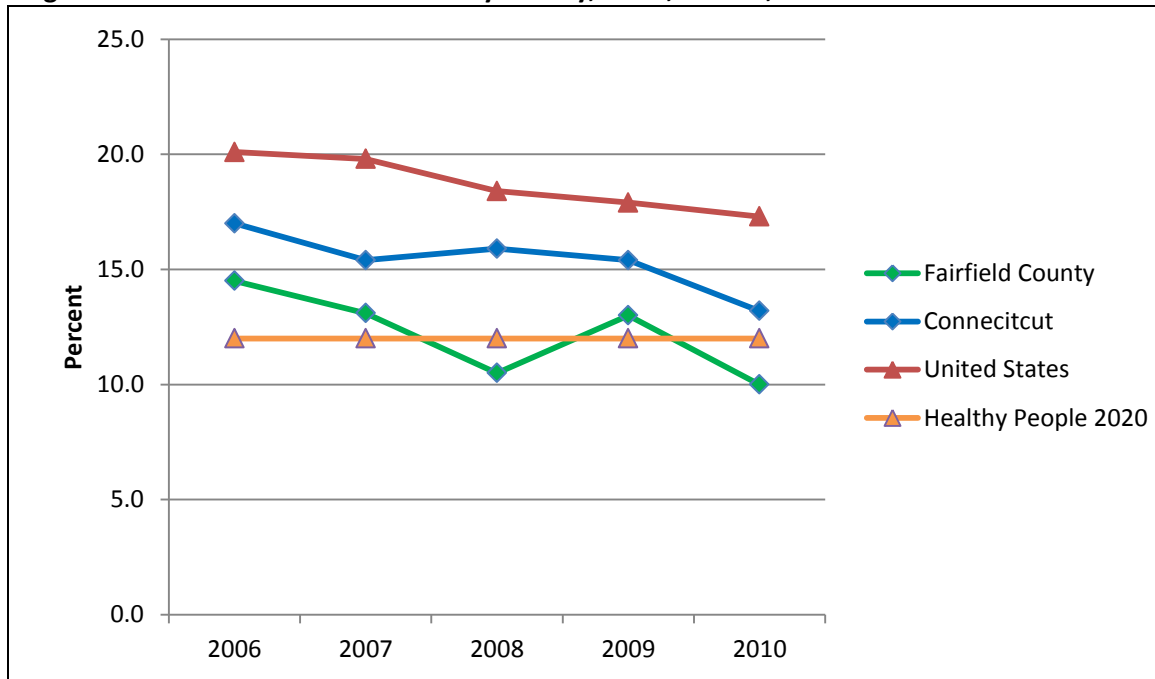
Figure 35: Alcohol-Induced Deaths per 100,000 Populations by Select Town and County, 2000-2004 to 2005-2009



DATA SOURCE: Connecticut Department of Health, Average Annual Mortality Rate (AAMR)

Cigarette use among Fairfield County adults (12.8%) is lower than use among Connecticut adults (15.9%) and below the Healthy People 2020 target (Figure 36). Smoking rates have generally remained steady in Fairfield County over the last several years, but have seen a slight decline from 2009 to 2010.

Figure 36: Percent of Adult Smokers by County, State, and US, 2006-2010



SOURCE: Behavior Risk Surveillance System, 2006-2010

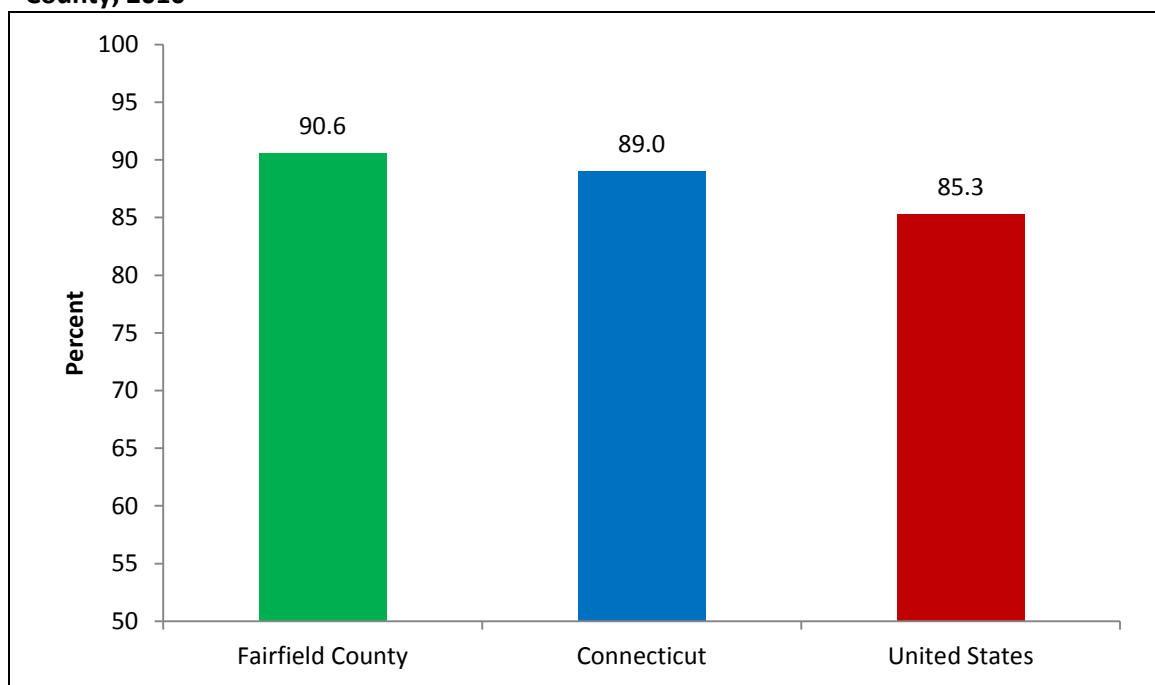
D. HEALTH OUTCOMES

This section of the report provides an overview of leading health conditions in the Greater Norwalk Area from an epidemiological perspective of examining incidence, hospitalization, and mortality data as well as discussing the pressing concerns that residents and leaders identified during in-depth conversations.

Perceived Health Status

As Figure 37 shows below, in Fairfield County, 90.6% of adults perceive their health to be “good” or “excellent,” similar to the state as a whole (89%).¹⁷

Figure 37: Perceived Good or Excellent Health Status, Adults, Connecticut and Fairfield County, 2010



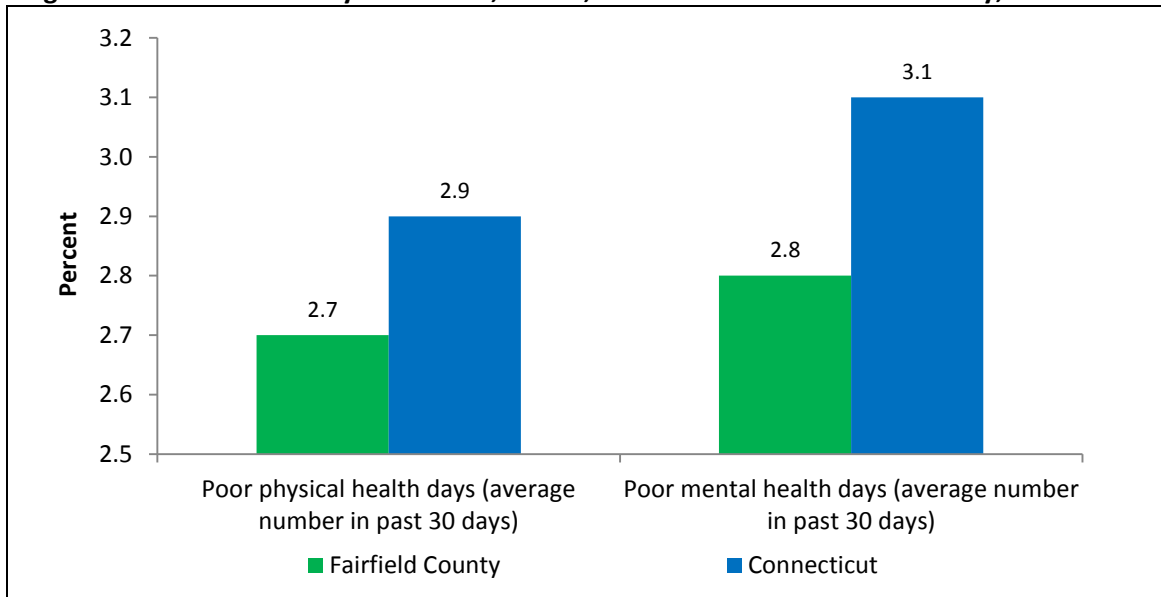
DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS)

A strong association between self-reported health status and mortality has been well documented; thus it is a useful indicator of morbidity within a community¹⁸. Figure 38 shows that a lower proportion of Fairfield County adults than adults in the state as a whole report poor health. A smaller proportion of Fairfield County adult respondents reported poor physical health days (2.7%) and poor mental health days (2.8%) in the 30 days prior to the survey than respondents for the state as a whole (2.9% and 3.1%, respectively).

¹⁷ Data for the Greater Norwalk area and towns not available.

¹⁸ Centers for Disease Control and Prevention. Measuring Healthy Days: Population Assessment of Health-related Quality of Life. Atlanta, GA: Centers for Disease Control and Prevention; 2000.

Figure 38: Poor Health Days in Past 30, Adults, Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS); Analysis conducted by County Health Rankings

Leading Causes of Hospitalization

In general, the Greater Norwalk Area's population is healthy. When considering reasons for going to the hospital when they are not healthy, a few themes are notable. As seen in Table 3, issues related to digestion and injury/poisoning are common across all age groups. Reasons for hospitalization related to mental health are most common in the under 65 population. Reasons related to health disease increase as individuals age.

Table 3: Leading Causes of Hospitalization by Age, 2009

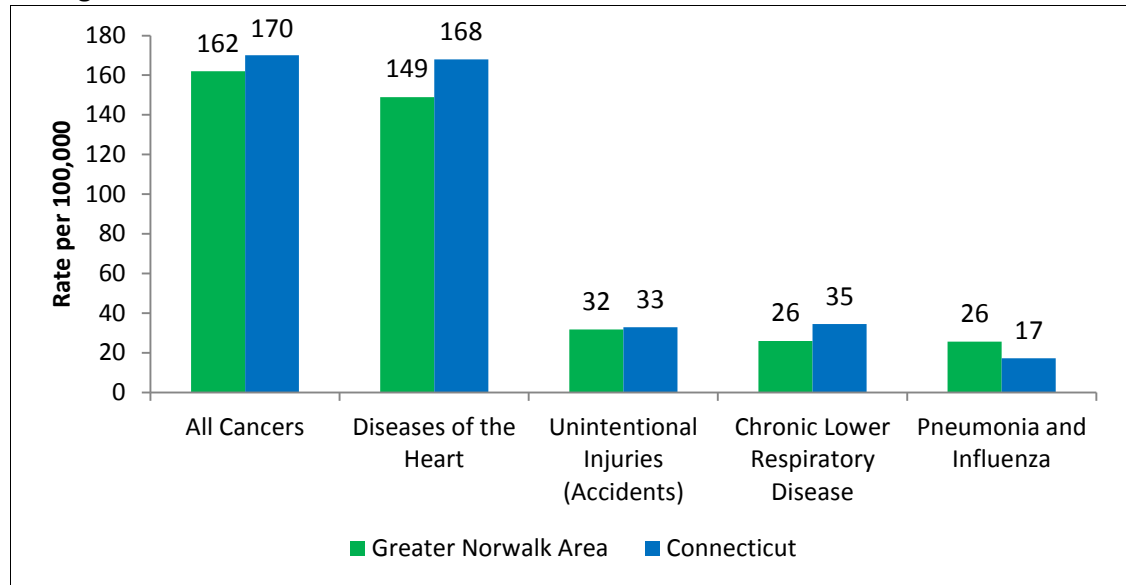
5 to 24 year olds	25 to 64 year olds	65 + year olds
1. Mental	1. Mental	1. Heart
2. Digestive	2. Digestive	2. Respiratory
3. Injury/Poisoning	3. Injury/Poisoning	3. Digestive
4. Respiratory	4. Heart	4. Injury/Poisoning
5. Endocrine	5. Musculoskeletal	5. Genitourinary

DATA SOURCE: Connecticut Office of Health Care Access, 2009

Leading Causes of Death

Quantitative data indicate that residents of the Greater Norwalk area are generally quite healthy. With the exception of pneumonia and influenza, death rates among Greater Norwalk residents from major diseases, illnesses, and injuries are lower than for the state as a whole (Figure 39). Quantitative data indicate that the leading causes of death in the Greater Norwalk area, as in the state, are cancer and heart disease. As seen in Figure 39, mortality rates for the Greater Norwalk area are slightly lower for these diseases (162 and 149 per 100,000 population, respectively) than for the state as a whole (170 and 168 per 100,000 population, respectively). Among the other leading causes of mortality, Greater Norwalk rates for mortality due to unintentional injuries and chronic lower respiratory diseases (i.e., emphysema, chronic bronchitis) are slightly lower than for the state. The death rate due to pneumonia and influenza in the region is higher than for the state (26 versus 17 per 100,000 population).

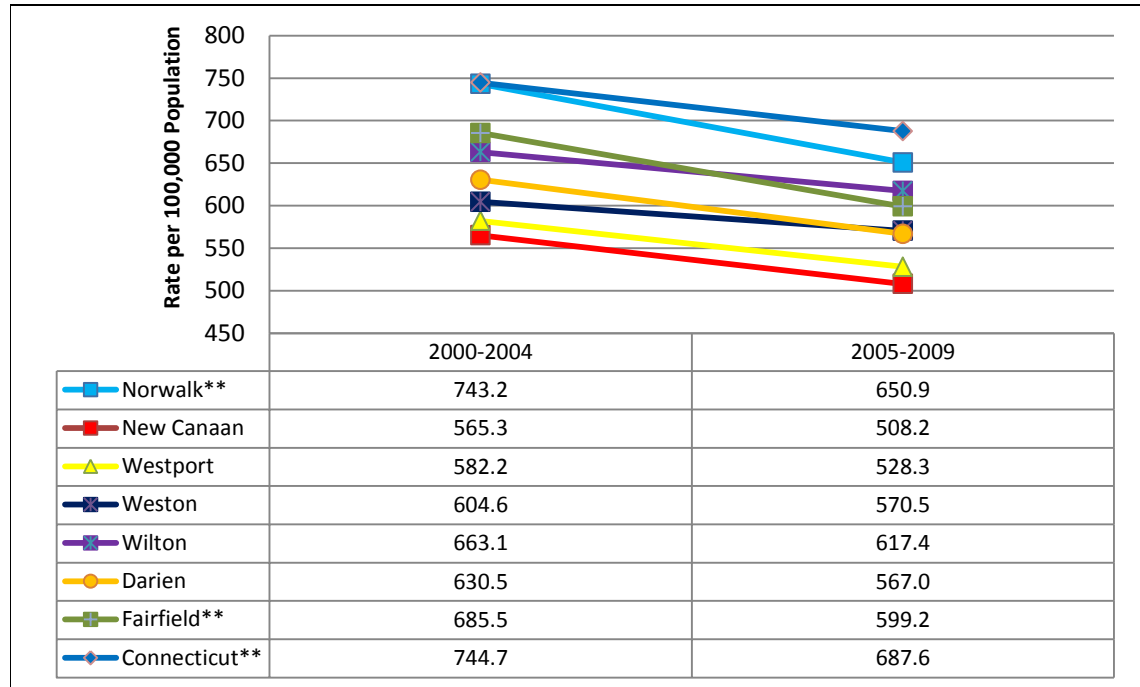
Figure 39: Age Adjusted Mortality Rates, Connecticut and Greater Norwalk, 2005-2009 average



DATA SOURCE: Connecticut Department of Health, Average Annual Mortality Rate, 2005-2009 average

A review of death rate data over time reveals that both the state and the region have had a decline in all causes of death between 2004 and 2009 (Figure 40). The city of Norwalk experienced the greatest decline, from 743.2 deaths per 100,000 population on average for 2000-2004 to 650.9 deaths per 100,000 population in 2005-2009. Norwalk, Darien and Fairfield all experienced a greater decline in their death rates over this time period than the state as a whole. The declines in Fairfield, Norwalk and the state are statistically significant. It should be noted that, per standard procedure by the original data source, mortality rates are aggregated for time periods to increase the sample sizes for comparison. [Additional Data in Appendix E]

Figure 40: Age-Adjusted Death Rates All Causes of Death, Connecticut and Towns, 2000-2004 to 2005-2009

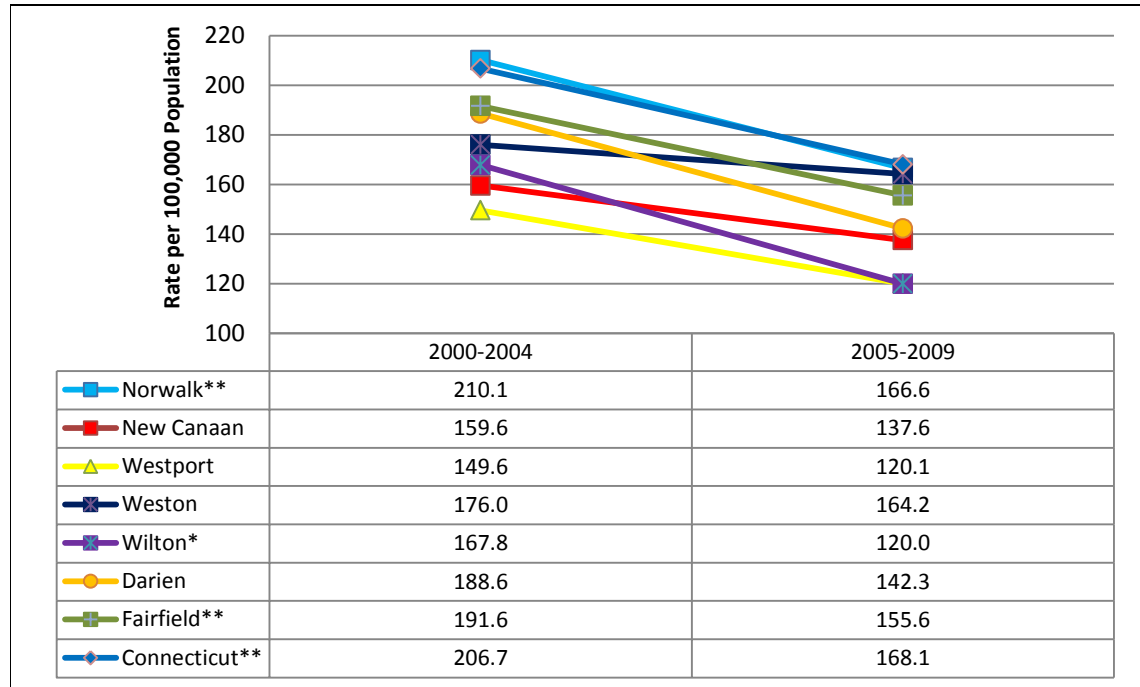


DATA SOURCE: Connecticut Department of Public Health Mortality Statistics.

** 2005-2009 AAMR is significantly different from 2000-2004 AAMR at $p < 0.01$

As Figure 41 shows, age-adjusted death rates due to diseases of the heart have declined in Connecticut and all Greater Norwalk towns between 2000-2004 and 2005-2009. Significant decreases are noted in Fairfield, Norwalk, and Wilton, and the state as a whole. The largest decline, 47.8 deaths per 100,000 population, was seen in Wilton. [Additional data in Appendix E]

Figure 41: Age-Adjusted Death Rates to Diseases of the Heart, Connecticut and Towns, 2000-2004 to 2005-2009



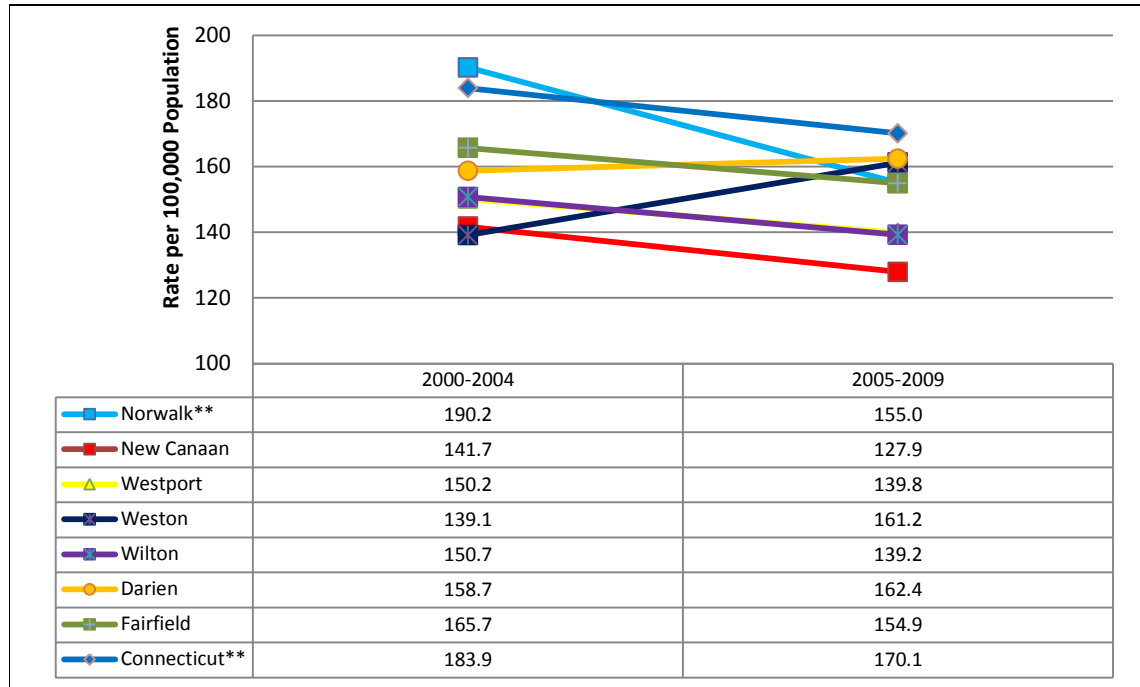
DATA SOURCE: Connecticut Department of Public Health Mortality Statistics.

* 2005-2009 AAMR is significantly different from 2000-2004 AAMR at $p < 0.05$.

** 2005-2009 AAMR is significantly different from 2000-2004 AAMR at $p < 0.01$

Relative to cancer, there is variation across the area. In most Greater Norwalk towns and the state, cancer death rates have declined between 2000-2004 and 2005-2009 (Figure 42). The largest decline was seen in Norwalk (35.2 deaths per 100,000 population). However, Darien and Weston experienced increases in the cancer death rate over this time (by 3.7 and 22.1 deaths per 100,000 population, respectively). Although complete data about specific cancer death rates are not available at the town level, data about cancer deaths for Connecticut as a whole reveals that for many cancer types, death rates have gone down between 2000-2004 and 2005-2009 (Table 4). Exceptions are pancreatic cancer, uterine cancer, and bladder cancer, which have all increased slightly.

Figure 42: Age-Adjusted Death Rates from All Cancers, Connecticut and Towns, 2000-2004 to 2005-2009



DATA SOURCE: Connecticut Department of Public Health Mortality Statistics.

** 2005-2009 AAMR is significantly different from 2000-2004 AAMR at $p < 0.01$

Table 4: Age-Adjusted Death Rates Cancer, Connecticut, 2000-2004 to 2005-2009

	Deaths per 100,000 population	
	2000-2004	2005-2009
Trachea, bronchus & lung cancer	49.3	45.0
Prostate cancer	26.5	23.7
Female Breast cancer	25.1	22.2
Colorectal cancer	18.7	14.6
Pancreatic cancer	10.9	11.9
Ovarian cancer	8.5	8.0
Leukemia	7.1	6.7
Bladder cancer	4.5	4.8
Uterine cancer	4.0	4.5
Brain and central nervous system cancer	4.1	4.1

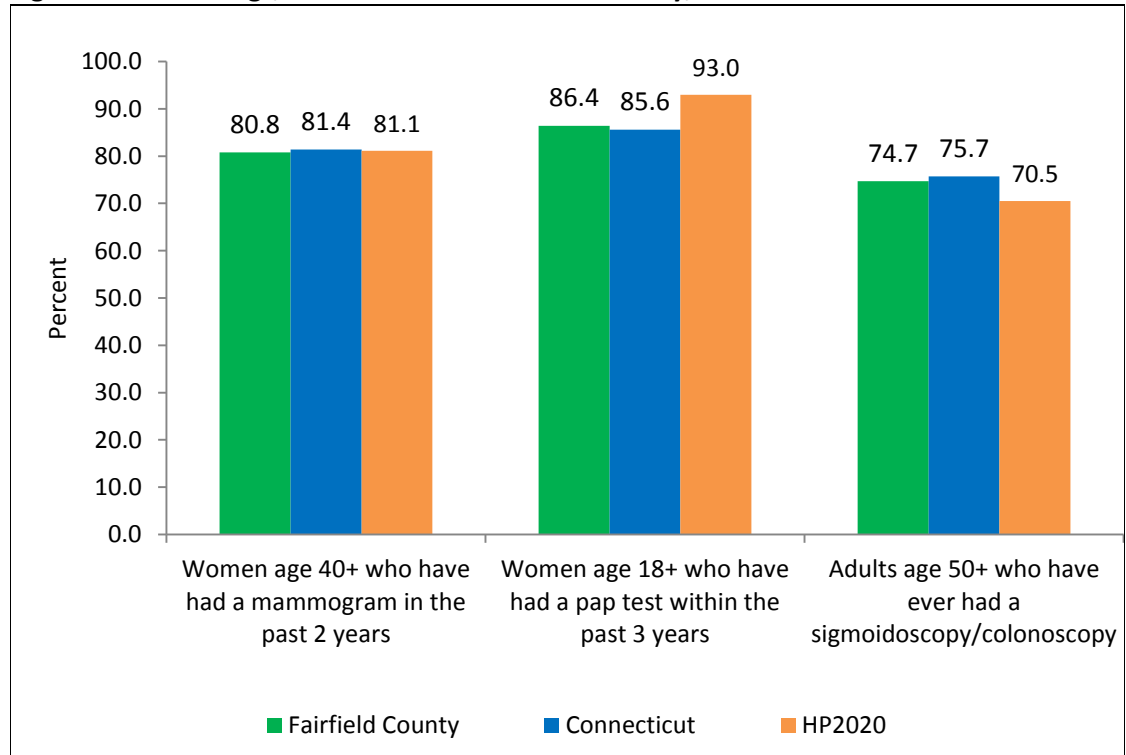
DATA SOURCE: Connecticut Department of Public Health Mortality Statistics.

Quantitative screening data indicate that screening rates among Fairfield County residents are similar to those for the state as a whole (Figure 43 and Figure 44).¹⁹ Approximately 81% of women over the age of 40 in Fairfield County and the state have had a recent mammogram, nearly meeting the HP2020 target of 81.1%. The proportion of women over the age of 18 in

¹⁹ Town-level data are unavailable.

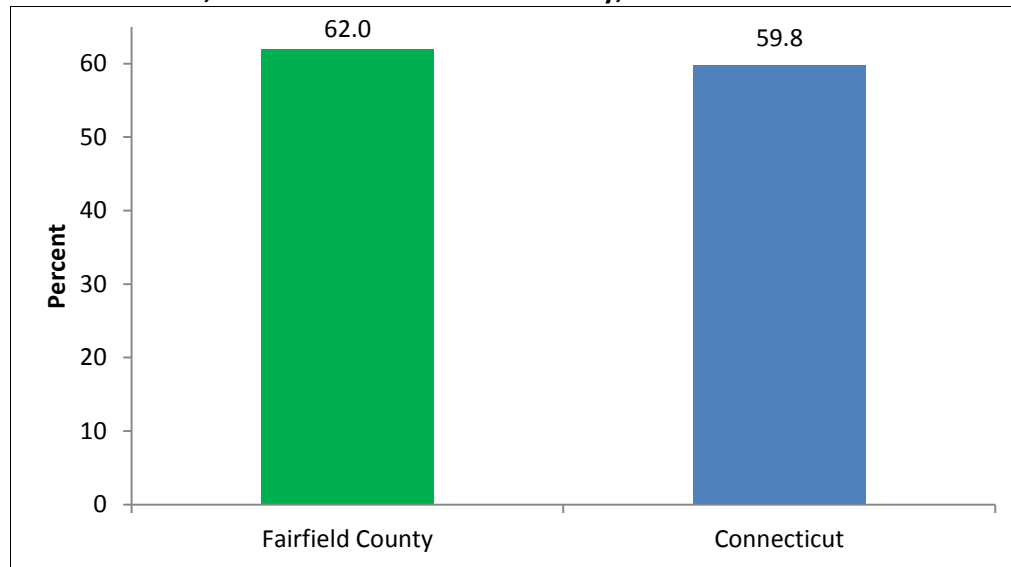
both Fairfield County and the state who have had a pap test is about 86%, lower than the HP2020 target of 93%. Conversely, about 75% of adults over age 50 in Fairfield County and the state have had a sigmoidoscopy/colonoscopy, higher than the HP2020 target of 70.5%. The PSA screening rate for men in Fairfield County (62%) is slightly higher than that for the state as a whole (59.8%).

Figure 43: Screenings, Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2010

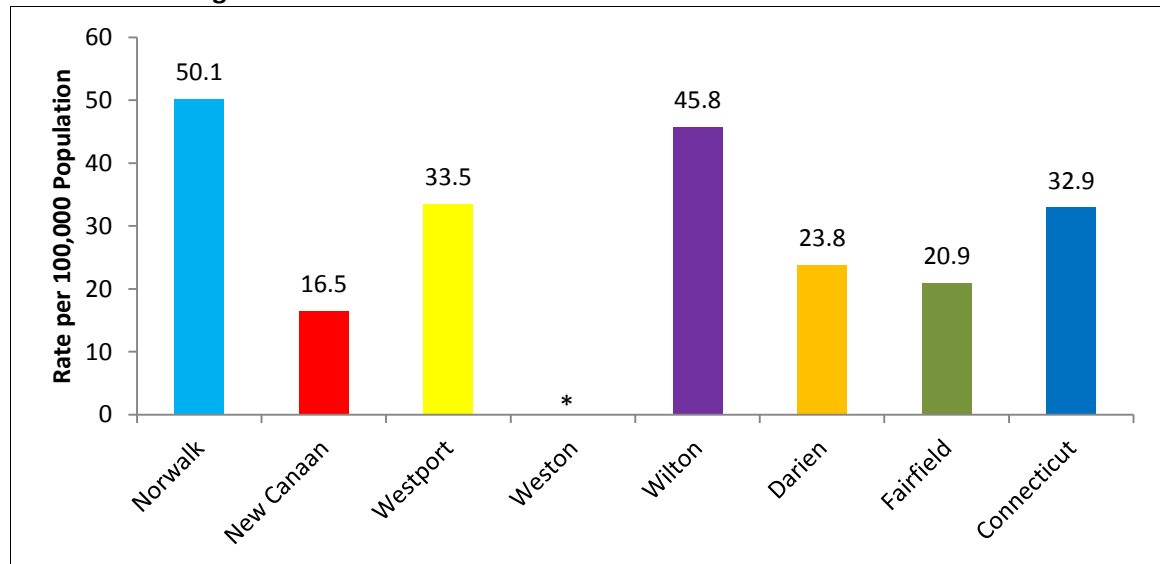
Figure 44: Percent of Men Age 40+ who have screened for Prostate Cancer (via a PSA Test) in the Past 2 Years, Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS)

While not to the extent of heart disease and cancer, accidents (i.e., motor vehicle crashes, falls) are a leading cause of death in the Greater Norwalk Area. On a statewide basis, accidents, on average, take 32.9 lives per 100,000 population (Figure 45). Norwalk and Wilton have rates that are higher than the State of Connecticut at 50.1 and 45.8 per 100,000, respectively. Other towns in the area are similar to or lower than the State's rate.

Figure 45: Age-Adjusted Death Rate due Accidents per 100,000 Population by Town and State, 2005-2009 average

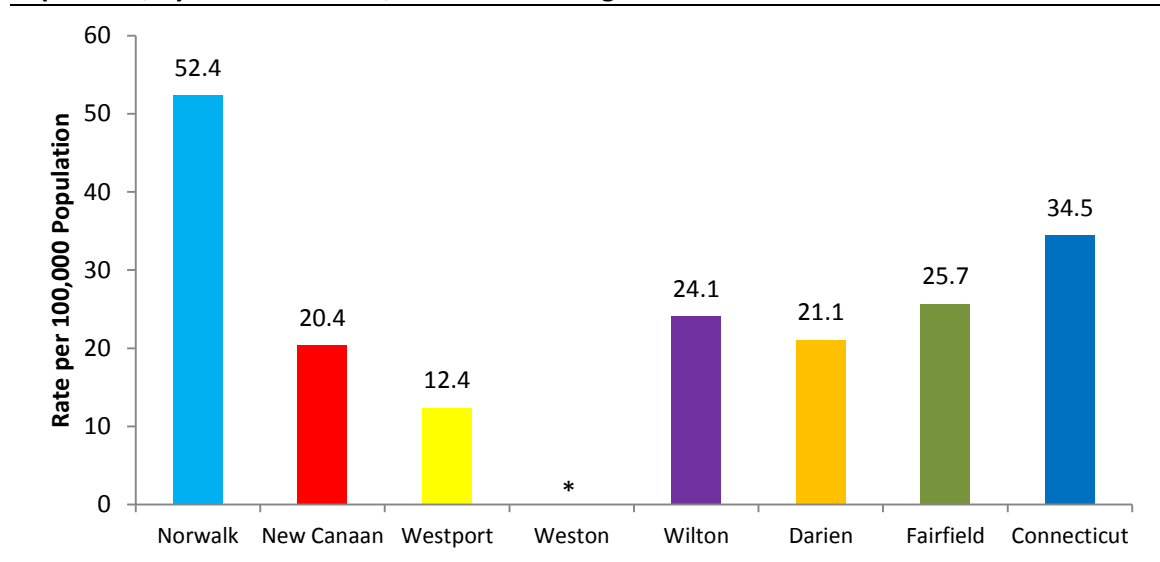


DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432>

*AAMRs are not reported for causes of death with <15 deaths.

Chronic lower respiratory disease is the fourth leading cause of death for the Greater Norwalk Area as a whole. Across the region the rates vary by town (see Figure 46). Norwalk has the highest rate among the towns at 52.4 per 100,000 population. The remaining six towns have rates that are lower than the State of Connecticut (34.5 per 100,000 population).

Figure 46: Age-Adjusted Death Rate due Chronic Lower Respiratory Disease per 100,000 Population, by Town and State, 2005-2009 average

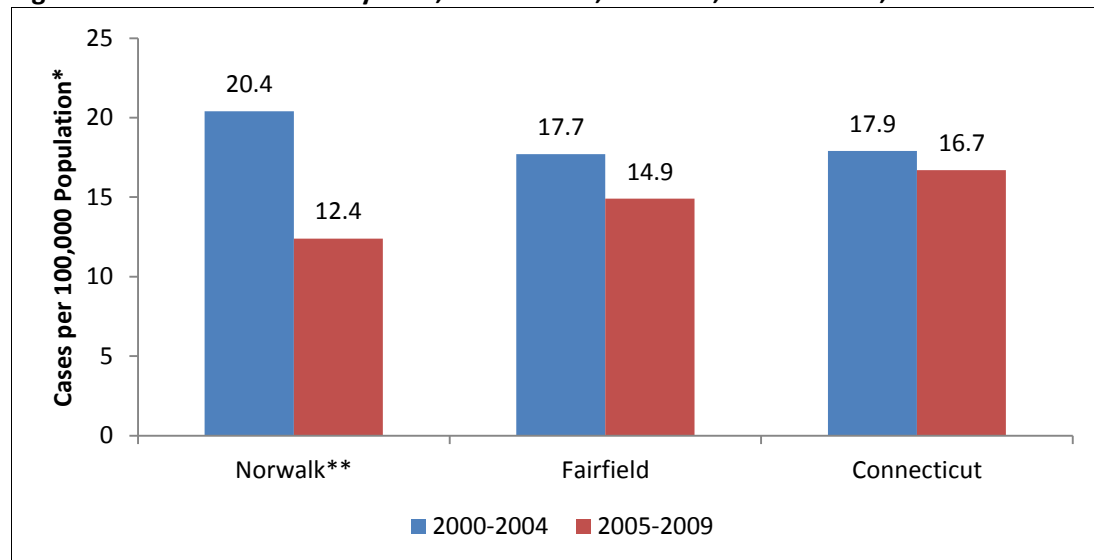


DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432>

*AAMRs are not reported for causes of death with <15 deaths.

The diabetes mortality rate has also declined in both the state and the Greater Norwalk area's two largest cities (Figure 47). The rate of decline from 2000-2004 through 2005-2009 in Norwalk, from 20.4 per 100,000 population to 12.4 per 100,000, was statistically significant. This decline mirrors the trend on a national level. The Centers for Disease Control attributes the decline in the diabetes mortality rate to improved medical care.

Figure 47: Diabetes Mortality Rate, Connecticut, Norwalk, and Fairfield, 2000-2009



DATA SOURCE: Department of Public Health, 2000-2009. * Age-Adjusted Mortality Rate

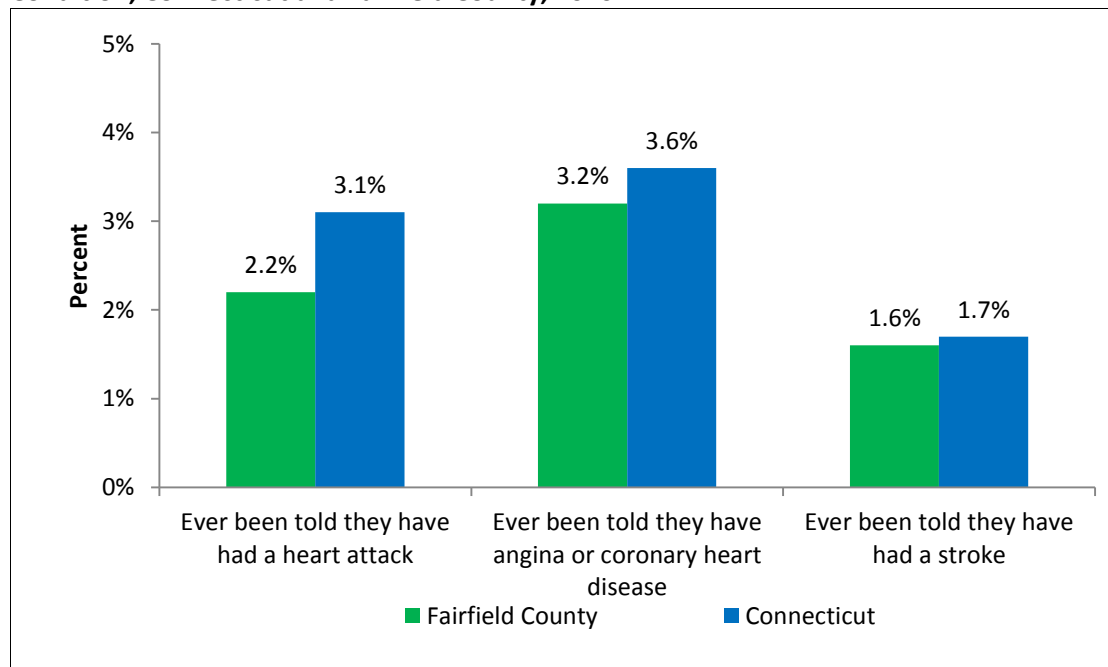
** Change from 2000-2004 to 2005-2009 is significantly different

E. HEALTH AREAS

Chronic Disease – Cardiovascular Disease

The Behavioral Risk Factor Surveillance Survey, a telephone survey of adults, asks respondents whether they ever had or currently have specific chronic conditions. Among survey respondents, heart disease and heart attacks were the most prevalent chronic conditions, with 3.2% and 2.2% of adults in Fairfield County reporting having been currently diagnosed with these diseases, respectively (Figure 48). Less than 2% of adult residents reported ever having a stroke or heart attack. Rates of chronic conditions among adults in Fairfield County are lower than for adults in the state overall.

Figure 48: Percent of Adults Who Have Been Told They Have a Heart Related Chronic Condition, Connecticut and Fairfield County, 2010



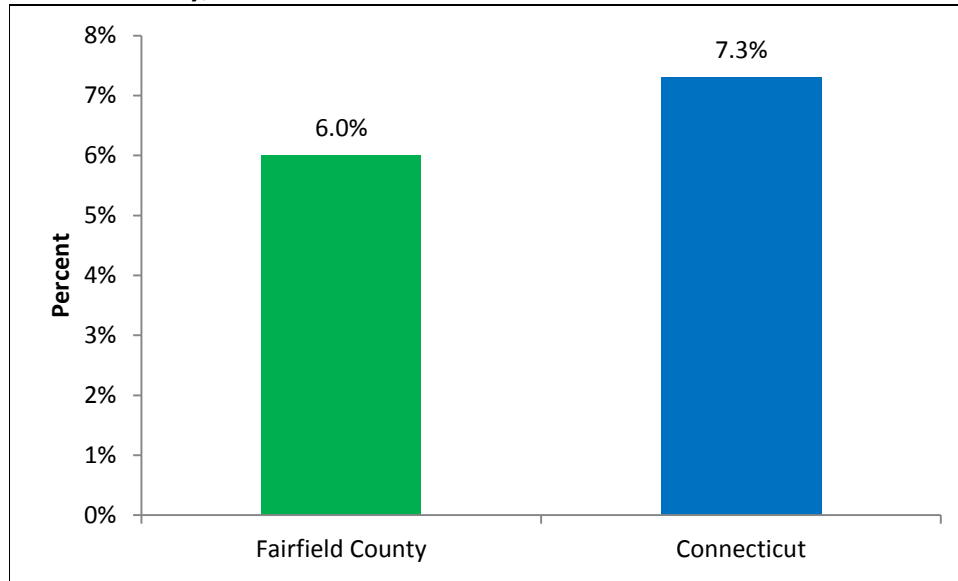
DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2010

Chronic Disease – Diabetes

The diabetes mortality rate has declined in both the state and the Greater Norwalk area's two largest cities, as seen above (Figure 47). The rate of decline from 2000-2004 through in Norwalk, from 20.4 per 100,000 population to 12.4 per 100,000, was statistically significant.

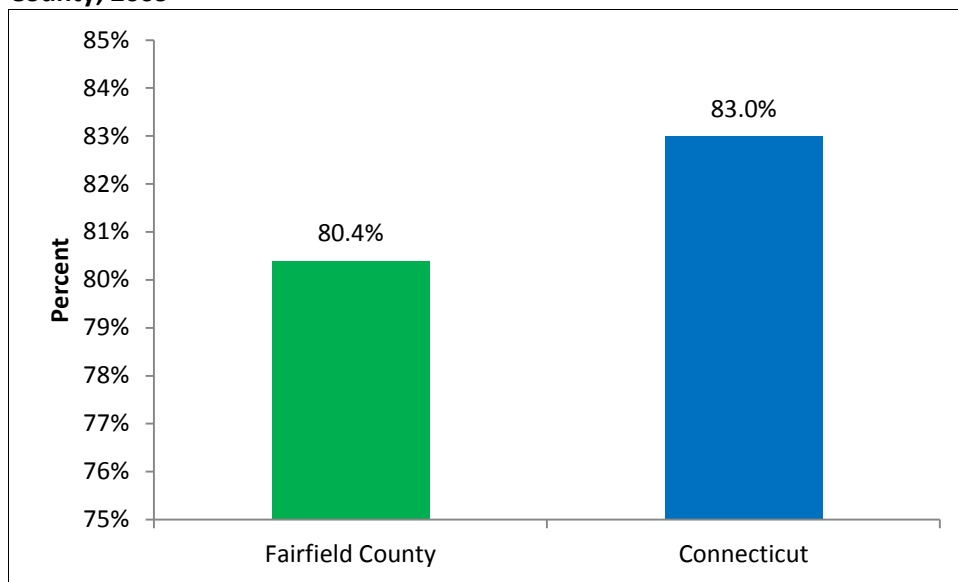
The proportion of adults who have ever been told they have diabetes is lower for Fairfield County (6.0%) than for the state (7.3%) (Figure 49). However, fewer Fairfield County adults with diabetes (80.4%) than Connecticut adults with diabetes (83.0%) received an HbA1c screening in 2009 (Figure 50). HbA1c is a lab test that shows the average level of blood sugar (glucose) over the previous 3 months. It shows how well a person is controlling his or her diabetes.

Figure 49: Percent of Adults who have ever been told they have Diabetes, Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS)

Figure 50: Percent of Diabetics that Receive HbA1c Screening, Connecticut and Fairfield County, 2009

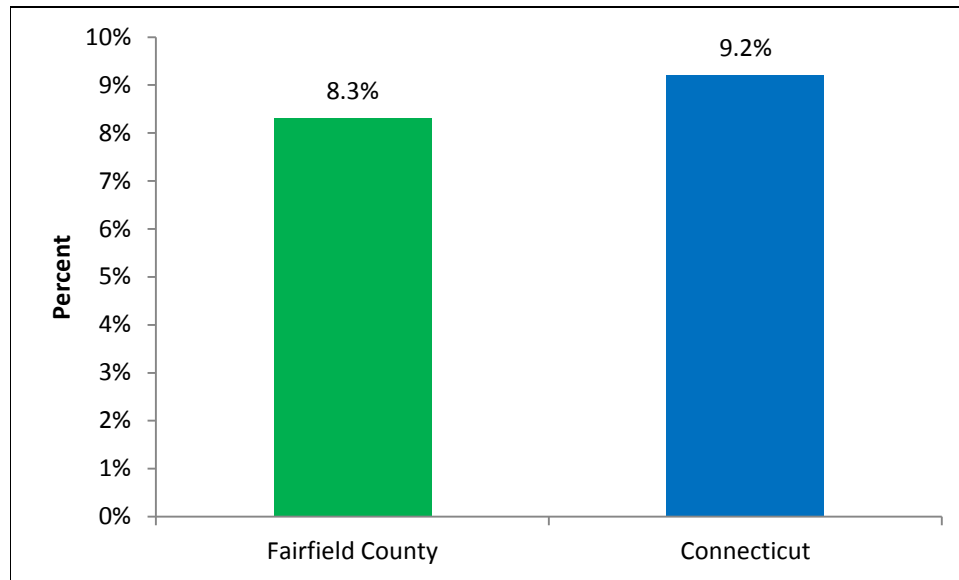


DATA SOURCE: Medicare claims/Dartmouth Atlas, 2009, reported by County Health Rankings

Chronic Disease – Asthma

Asthma rates among Fairfield County adults (8.3%) are slightly lower than for the state as a whole (9.2%) (Figure 51).

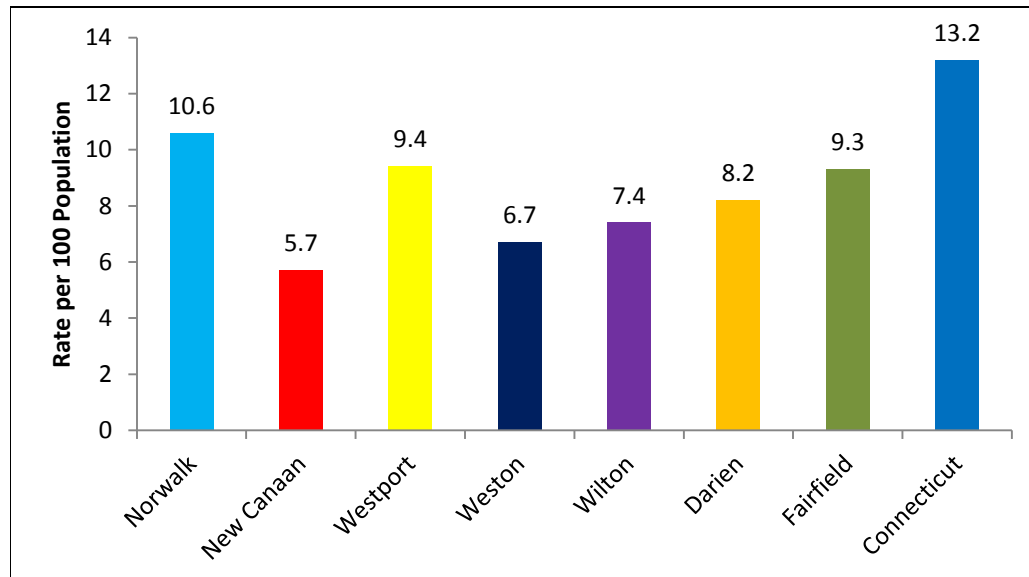
Figure 51: Percent of Adults Who Currently Have Asthma, Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS)

Asthma rates among the region's students are lower overall than for the state (13.2 per 100,000 students) (Figure 52). Among the area's towns, asthma rates among students are highest in Norwalk (10.6 per 100,000 population), Westport (9.4 per 100,000 population) and Fairfield (9.3 per 100,000 population).

Figure 52: Asthma Prevalence Rates by School District for Public Schools, 2006-2009 Combined School Years



DATA SOURCE: Connecticut School-based Asthma Surveillance Report, 2010

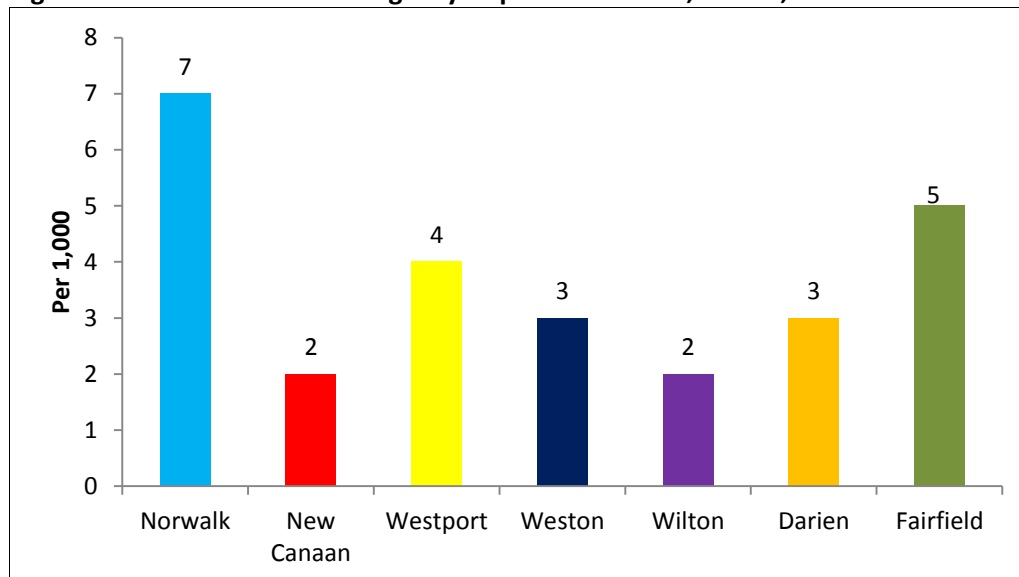
Mental and Behavioral Health

Mental health challenges were also cited as a substantial health concern in the region. Those working in health care, mental health care, and law enforcement in particular noted mental health is a significant concern. In surrounding communities, respondents noted the stress of living in the area and academic pressure felt by students and attributed the high use of alcohol and drugs, eating disorders, and recent suicides to these factors. One focus group respondent shared, *“kids are not allowed to fail. You’re not allowed to try something and not be really good at it.”* One of the teen focus groups observed that social media has affected young peoples’ ability to effectively communicate their emotions leading to abuse of alcohol and drugs. As one teen focus group participant noted, *“people post suicidal tweets or Facebook posts and then you see them the next day and they act like nothing’s wrong.”*

A challenge in more affluent areas, according to participants, is that stigma prevents some from seeking services. Others reported that the rise in mental health issues also has to do with insufficient services to address these needs, especially for lower income individuals. According to focus group members from the hospital, the number of individuals with mental health needs appearing in the Emergency Room (ER) is increasing. Focus group participants from health care, mental health and law enforcement shared the increasing challenges each of these groups faces in meeting mental health needs. A mental health provider focus group member shared, *“there’s a big gap between what in the past was covered by the police and criminal justice system that is now expected to be covered by the mental health system.”* Law enforcement participants noted that they increasingly respond to calls that involve mental health issues.

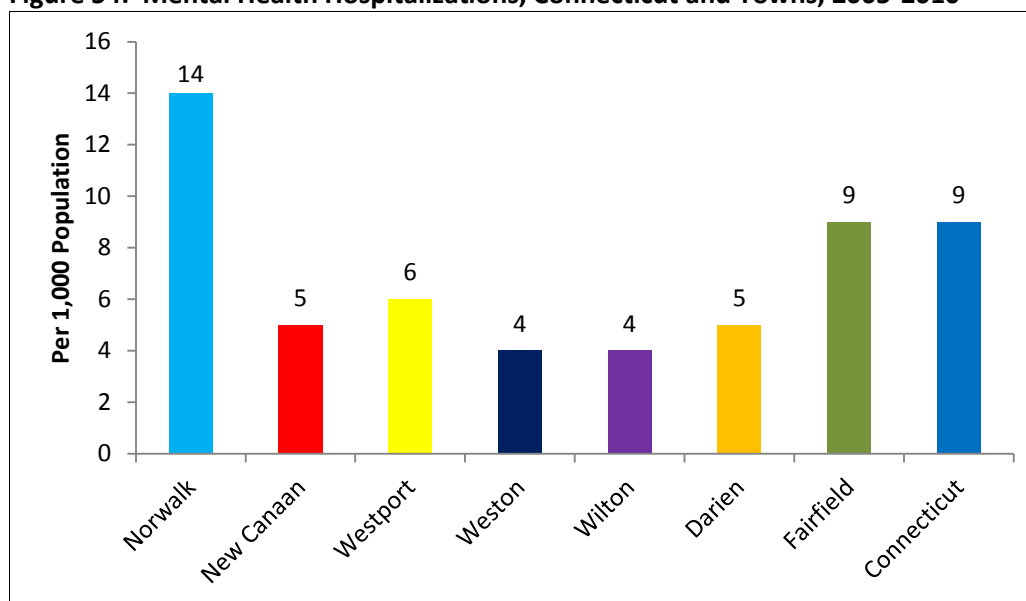
According to the BRFSS, Connecticut (3.1) and Fairfield County (2.8) residents report a higher number of days of poor mental health than the national average (2.3). Quantitative data about hospitalizations for mental health in the Greater Norwalk area show that rates are highest in Norwalk (7 per 1,000 population for emergency room visits and 14 per 1,000 population for hospitalizations). Rates are also relatively high in Fairfield (5 per 1,000 population for emergency room visits and 9 per 1,000 population for hospitalizations) (Figure 53 and Figure 54).

Figure 53: Mental Health Emergency Department Visits, Towns, 2005-2010



DATA SOURCE: Connecticut Hospital Association, CHIME Hospital Discharge Data; analysis conducted by CT Association of Directors of Health for years 2005-2010

Figure 54: Mental Health Hospitalizations, Connecticut and Towns, 2005-2010



DATA SOURCE: Source: Source: CT Hospital Association, CHIME Hospital Discharge Data; analysis conducted by CT Association of Directors of Health for years 2005-2010

Source: For CT, DPH hospitalization data 2009; analysis by Norwalk Health Department

Mental health issues among youth were cited as an area of particular concern in interviews and focus groups. Youth Risk Behavior Surveillance data indicate that 24.4% of Connecticut youth have reported feeling sad or hopeless almost every day for two or more weeks in a row²⁰. Girls were significantly more likely than boys to have felt sad or hopeless (31% vs. 18%) and Hispanic students (33.5%) were more likely to have felt sad or hopeless than White students (22.4%) or Black students (21.2%). Data also indicate that 14.6% of Connecticut youth have seriously considered attempting suicide and 6.7% have attempted suicide one or more times. Girls were more likely than boys to have considered suicide (17.3% vs. 11.9%) and to have attempted suicide (8.2% vs. 5.2%). Hispanic students were more likely to have attempted suicide than White students. [Additional Data in Appendix E]

Bullying was also identified as a concern. According to the Youth Risk Behavior Survey, 21.6% of Connecticut youth reported having been bullied on school property and 16.3% reported having been electronically bullied. Boys were more likely to be bullied on school property than girls (22.3% vs. 20.6%) and girls were significantly more likely than boys to have been electronically bullied (20.1% vs. 12.5%). White and Hispanic students (23.2% and 22.3%) were significantly more likely to be bullied on school property than Black students (13.2%), and White and Hispanic students (17.6% and 17.2%) were significantly more likely to be bullied electronically than Black students (8.8%).

Although YRBS data are not available at a sub-state level, other data point to mental health concerns about youth in the region. For example, 42% of the visits to the Dr. Robert E. Appleby School Based Health Centers, which serve middle and high school students in Norwalk, are for mental health reasons. The top five mental health diagnoses at the centers

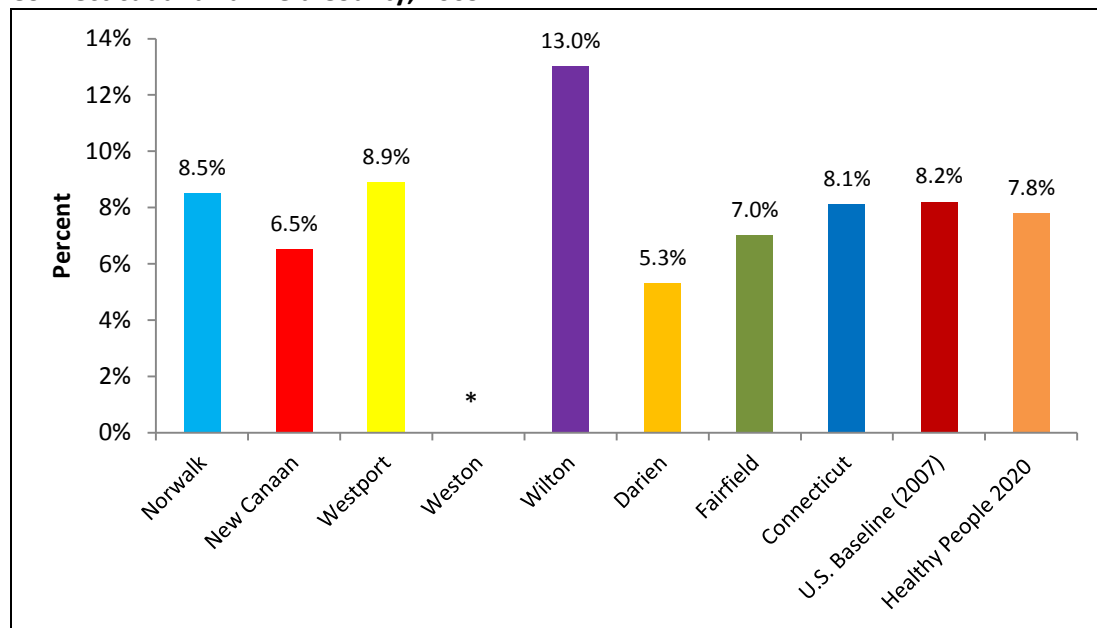
²⁰ YRBS data are not available at the County or town level.

are family circumstance, depression, adjustment disorder with depressed mood, relational problems, and academic maladjustment. The top presenting problems at the Mid-Fairfield Child Guidance Center Outpatient General Clinic were anxiety, disruptive behavior, family conflict, and depression.

Maternal and Child Health

Low birth weight outcomes (less than 2500 grams) in the Greater Norwalk area varied, see Figure 55. Wilton experienced the highest percentage of low birth weight babies in the region (13%), followed by Westport (8.9%). Focus group and interview participants noted that the high percentages of low birth weight babies may be due to multiple births as a result of in vitro fertilization (IVF).

Figure 55: Low Birth Weight (percent of live births with weight < 2500 grams), U.S., Connecticut and Fairfield County, 2009



DATA SOURCE: Connecticut Department of Health, Vital Statistics

*Data suppressed due to too few cases

For teenagers, having a child puts the mother and the child at risk. Research has shown that teenage mothers are less likely to complete high school and college²¹. Children born to teenage mothers are likely to have higher rates of low birth weight, develop chronic health problems, and drop out of school. Quantitative data indicate that the birth rate among Fairfield County teens (20.3 per 1,000 female population) is lower than for the state (23.9)

²¹ Brown, S., & Eisenberg, L. (Eds.). (1995). *The best of intentions: Unintended pregnancy and the well-being of children and families*. Washington, DC: National Academy Press.

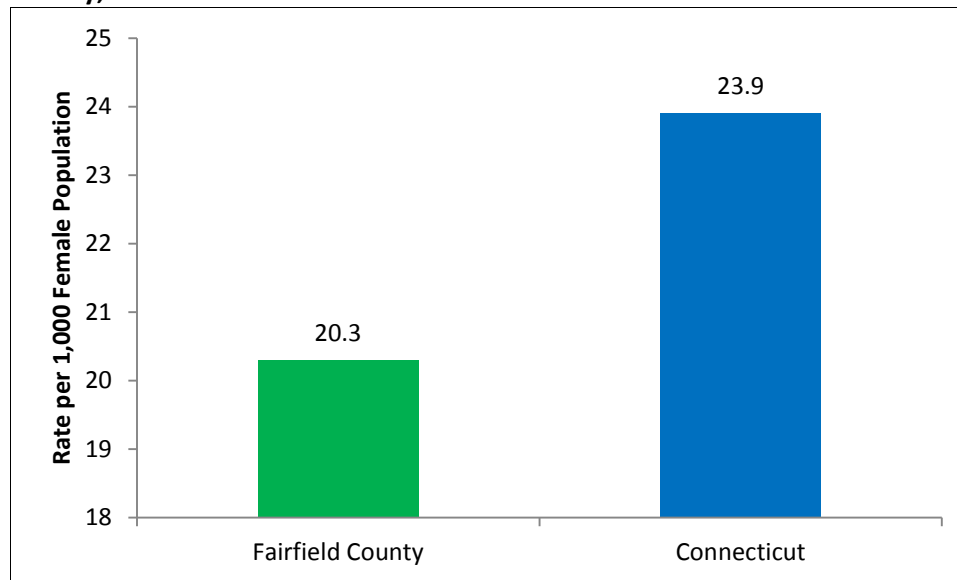
Bustan, M., & Coker, A. (1994). Maternal attitude toward pregnancy and the risk of neonatal death. *American Journal of Public Health*, 84(3), 411-414.

Gipson, J., Koenig, M., & Hindin, M. (2008). The effects of unintended pregnancy on infant, child, and parental health: A review of the literature. *Studies in Family Planning*, 39(1), 18-38.

Moore KA, Myers DE, Morrison DR, et al. Age at first childbirth and later poverty and later poverty. *J Res Adolesc* 1993;3:393-422.

(Figure 56). The proportion of teens giving birth is lower in both Norwalk (4.6%) and Fairfield County (4.9%) than the state (6.8%).

Figure 56: Teenage Birth Rate per 1,000 Females ages 15-19, Connecticut and Fairfield County, 2002-2008

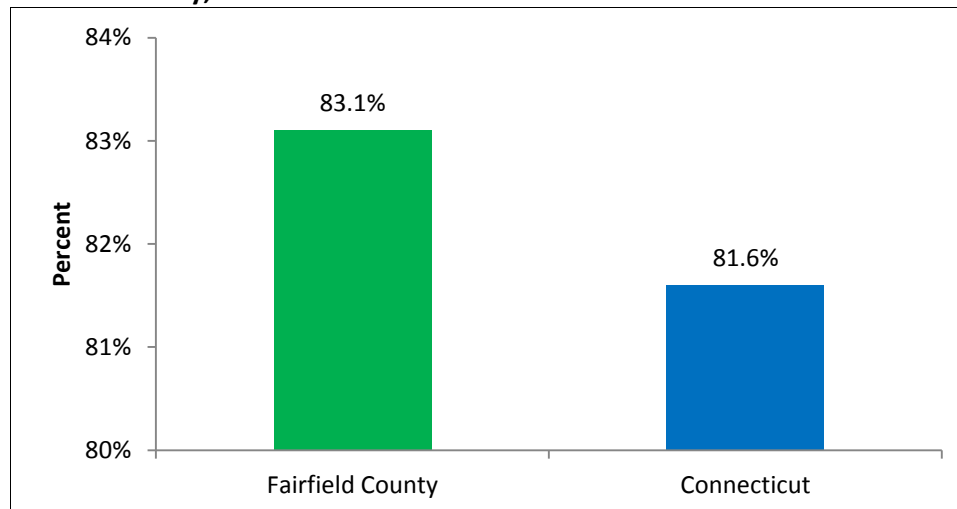


DATA SOURCE: Vital Statistics, National Center for Health Statistics (NCHS)

Oral Health

Quantitative data indicate that the proportion of adults in Fairfield County (83.1%) who have visited the dentist in the past year is higher than for the state (81.6%) (Figure 57).

Figure 57: Percent of Adults who have visited a Dentist in the Past Year, Connecticut and Fairfield County, 2010



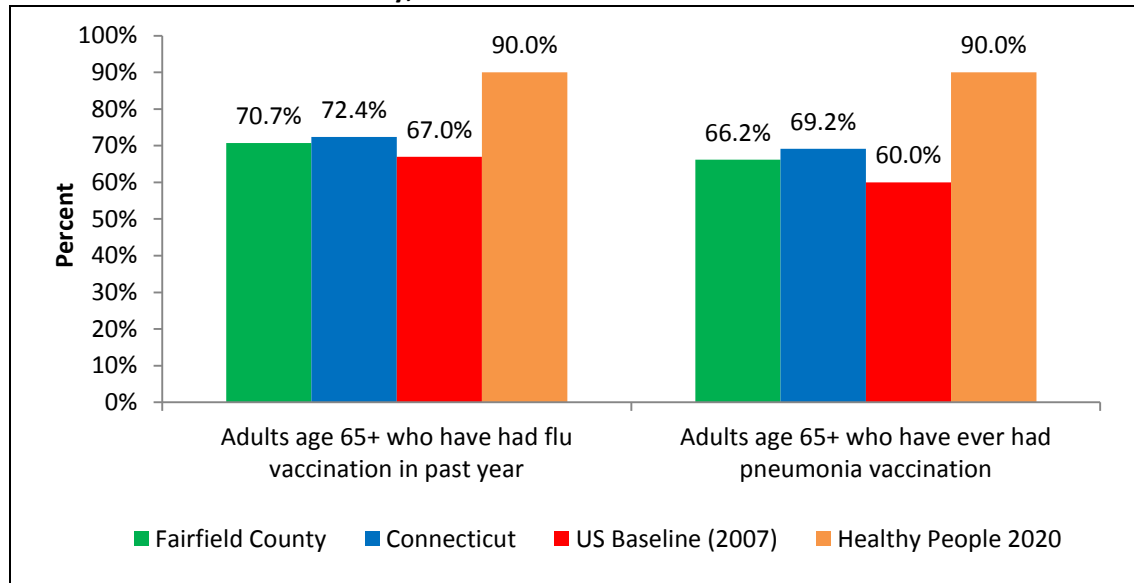
Source: Behavioral Risk Factor Surveillance System (BRFSS)

Communicable Diseases

Vaccine-Preventable Diseases

In 2010, the percentage of adults aged 65 years and older who reported receiving the influenza and pneumococcal vaccines were lower in Fairfield County than for the state as a whole although higher than the nation (Figure 58).

Figure 58: Percent of Adults Age 65+ who have had Flu and Pneumonia Vaccination, U.S., Connecticut and Fairfield County, 2010

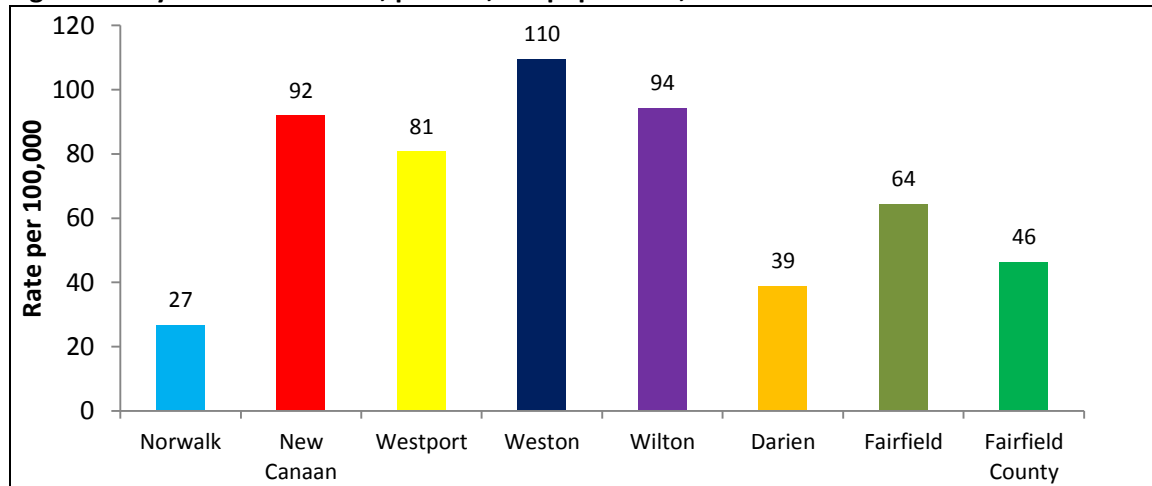


DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS)

Lyme Disease

Several focus group participants and interviewees mentioned Lyme disease as a concern. As one local policymaker noted, “[it] feels like an epidemic proportion.” Lyme disease rates in Connecticut are notably high and in many of the towns of Greater Norwalk, the rate per 100,000 population is higher than the rate for Fairfield County (Figure 59). Weston (110 per 100,000 population), Wilton (94 per 100,000 population), and New Canaan (92 per 100,000 population) experienced the highest rates of Lyme disease in the region.

Figure 59: Lyme Disease Rates, per 100,000 population, 2007-2011

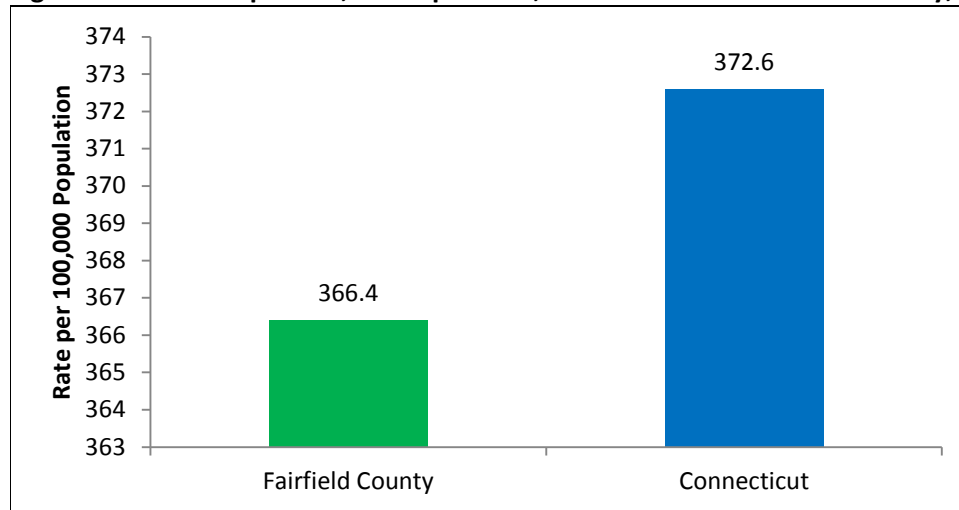


DATA SOURCE: Connecticut Department of Public Health, 2007-2011

HIV/AIDS

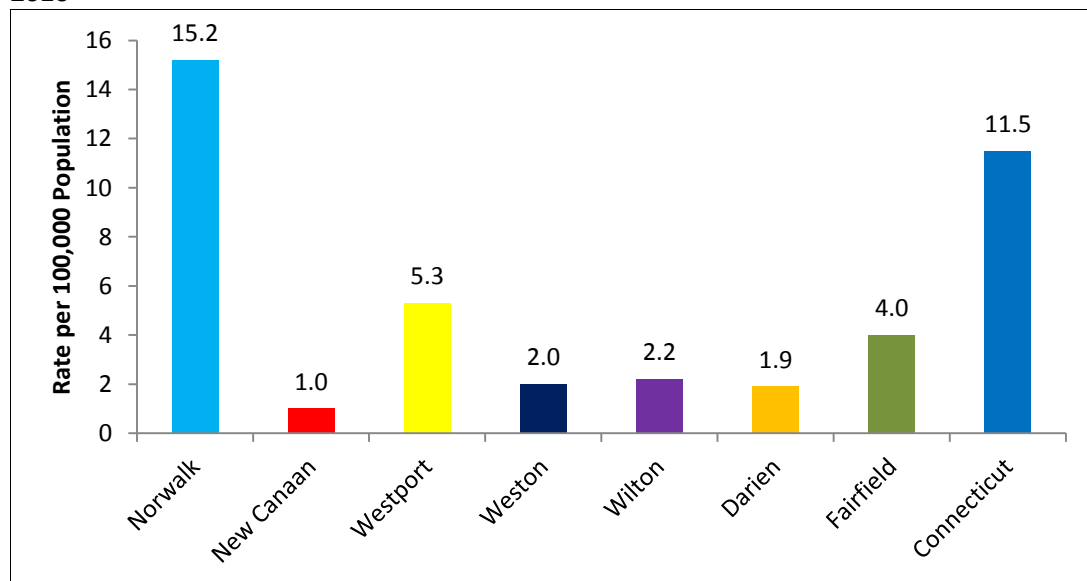
Quantitative data indicate that the rate of HIV is lower in Fairfield County (366.4) than the state (372.6) (Figure 60). The rate of new HIV cases is lower for most towns in the Greater Norwalk area than for the state (Figure 61). The notable exception is Norwalk, where the rate of new HIV cases per 100,000 population (15.2) is higher than for the state (11.5).

Figure 60: HIV Rate per 100,000 Population, Connecticut and Fairfield County, 2006-2010



DATA SOURCE: Connecticut Department of Public Health, HIV Surveillance Program

Figure 61: Rate of New HIV Cases per 100,000 Population, Connecticut and Towns, 2006-2010

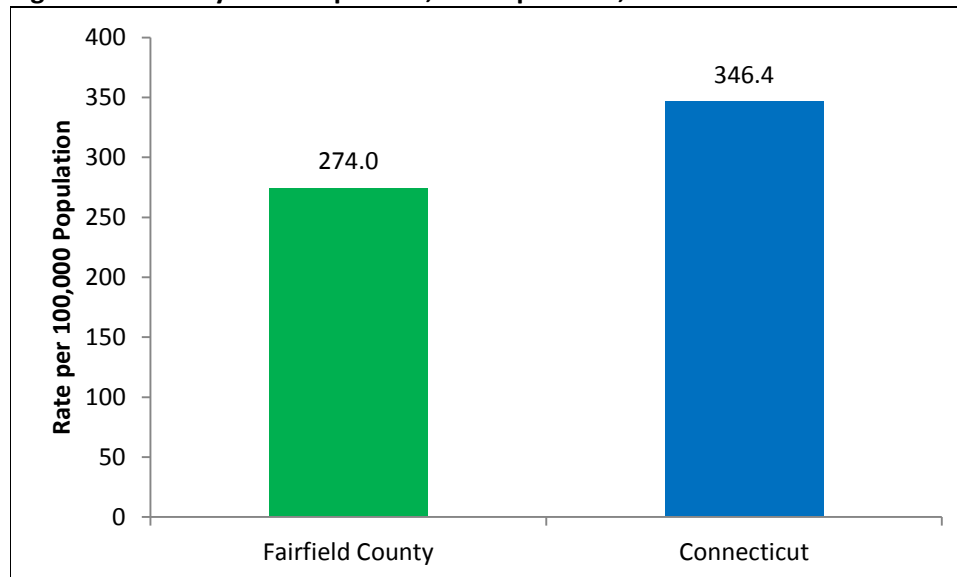


DATA SOURCE: Connecticut Department of Public Health, HIV Surveillance Program

Sexually-Transmitted Diseases

The rate of infection of Chlamydia is used as a proxy for the sexually transmitted diseases. In Fairfield County (274 per 100,000 population) the rate is lower than in the state (346.4 per 100,000 population) (Figure 62).

Figure 62: Chlamydia Rate per 100,000 Population, Connecticut and Fairfield County, 2009



DATA SOURCE: Center for Disease Control (CDC), National Center for Hepatitis, HIV, STD, and TB Prevention, as reported by County Health Rankings

F. HEALTH CARE ACCESS AND UTILIZATION

Resources and Use of Health Care Services

“Overall, I think this is a resource rich area. Just getting to know the other providers in the area, there is a high level of expertise across disciplines and different specialties even within mental health. There are a lot of experts in this county and in this town.” – Focus group participant

“I love the clinic.” –Focus group participant

“The hospital is a great help.” – Focus group participant

“The community health centers are fantastic.” – Focus group participant

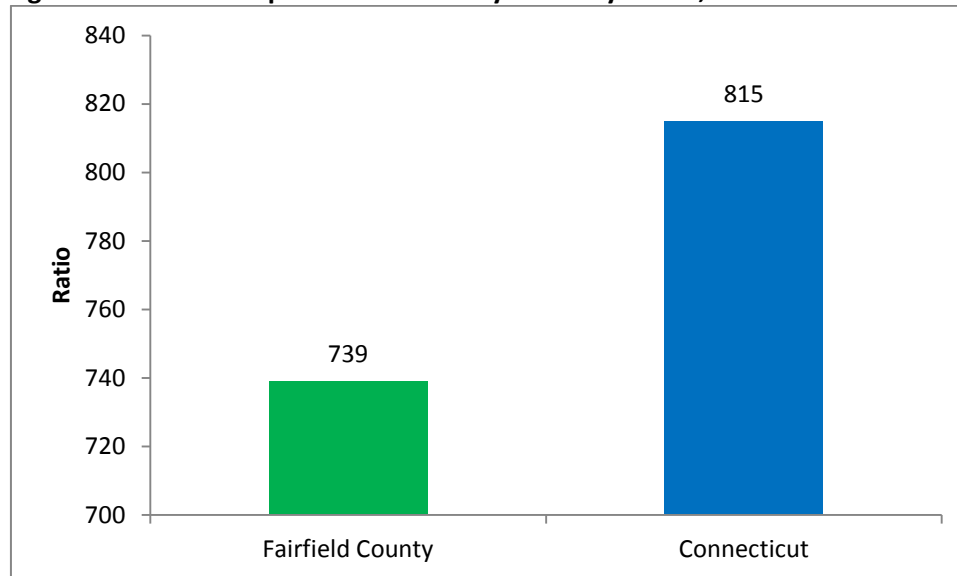
“The people from Norwalk Hospital and the health center follow through.” – Focus group participant

Focus group respondents and interviewees noted that the region has substantial health resources and Norwalk Hospital and the Norwalk Community Health Center in particular were repeatedly cited as important assets. The Hospital was noted for its comprehensive services. Both were described as having excellent outreach, providing valuable community education, and serving a variety of people. As one physician noted, “[we serve] not only poor immigrants who don’t speak the language but we serve some of the wealthiest people in the world and everyone in between.”

Respondents pointed to several other health care assets in the region, including school-based health centers, school nurses, and volunteer emergency medical services in many communities. Local health departments play various roles including conducting screenings and immunizations and providing education in topics such as chronic disease and cooking classes. Respondents shared that there are a number of social service-related programs in the area which provide important services, including Meals on Wheels, Elder House (adult day care), senior centers, libraries and the 211 service line as well as programs such as the Norwalk Healthy Families Collaboration and the Pepperidge Farm initiative to combat childhood obesity.

As shown in Figure 63, the ratio of the population to primary care physicians is smaller in Fairfield County (739 population per primary care physician) than in the state (815). The national benchmark is 631 population per primary care physician.

Figure 63: Ratio of Population to Primary Care Physicians, State and Fairfield County, 2009



DATA SOURCE: Health Resources and Services Administration, Area Resource File (ARF), analysis by County Health Rankings, 2009

Challenges to Accessing Health Care Services

Community members viewed access to care as an essential part of health. One resident stated, *“We’d all like to see everybody have equal access to health care no matter how much money they have.”* When asked about barriers to health care access and good health, focus group and interview participants identified insurance coverage, cost and long wait-times as interfering with receiving care and achieving optimal health. Lack of health insurance was noted as a concern by many and one that has become more challenging as people have lost their jobs in the economic downturn. For those with insurance, higher co-pays were noted as a concern. Providers at both Norwalk Community Health Center and Americares, another clinic, reported an increase in patients over the past few years in response to the decline in the economy and the subsequent loss of health insurance.

Lack of Insurance Coverage and Health Care Cost

“The first question they ask whenever I check in somewhere is whether I have insurance. I’ve walked right in because I’ve had that card when there were other people waiting.” – Focus group participant

“They tell me let’s take it [tooth] out and they gave me a payment plan but each appointment costs something and you have to go to the bank to get a loan.” – Focus group participant

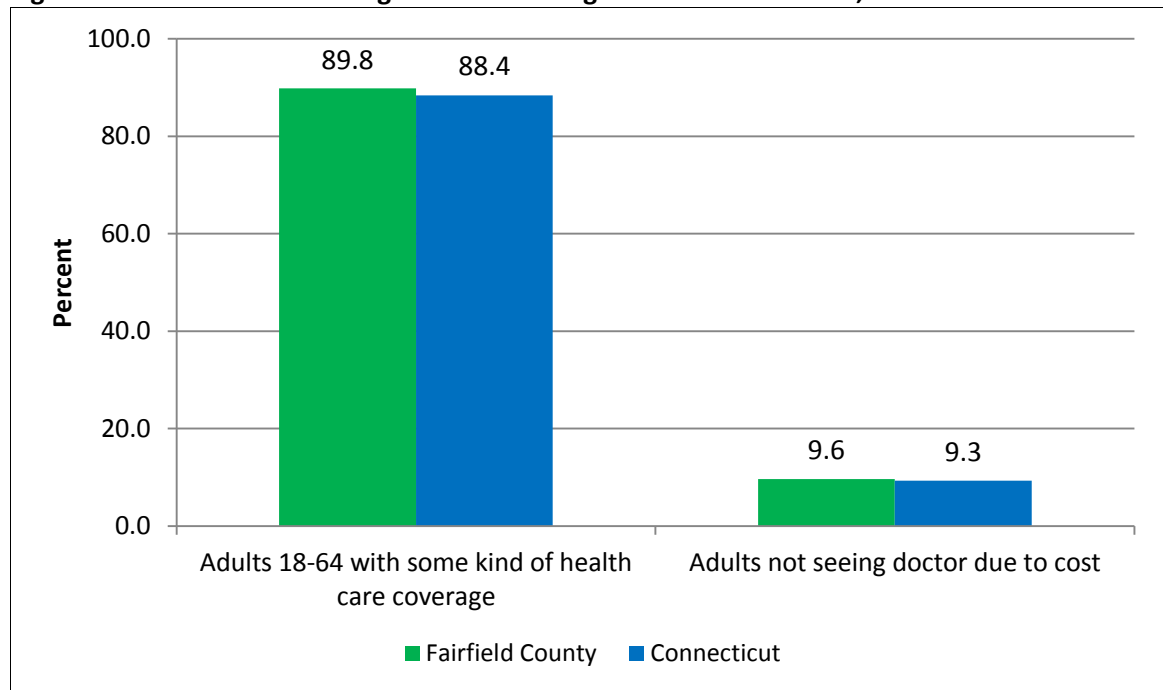
Lack of insurance and underinsurance was the most frequently cited barrier by focus group and interview participants to accessing health care. Focus group members and interviewees also reported that the cost of healthcare creates a barrier to access and often results in delays in seeking services. Several respondents reported a rise in “concierge” (pay ahead) health care. Others shared that they have been billed for services and tests after paying a co-pay. Although the Norwalk Community Health Center was noted as a substantial health asset in the community, some respondents reported surprise that services are discounted but not free.

Access to health care and long wait times for appointments were also named as a concern. Many residents reported that they have waited for long periods to get appointments while

others stated that they were not able to obtain appointments convenient for their work schedules. As one focus group member noted, *“making an appointment is the hardest part of getting health care.”*

Quantitative data indicate that the proportion of Fairfield County adults (89.8%) with some kind of health care coverage is similar to that for the state (88.4%) (Figure 64). Likewise, in both Fairfield County and the state, less than 10% of adults reported not seeing a doctor due to cost.

Figure 64: Health Care Coverage and Not Seeing a Doctor Due to Cost, 2004-2010



DATA SOURCE: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance Survey (BRFSS) Data. Atlanta, Georgia: US department of Health and Human Services, Centers for Disease Control and Prevention

Gaps in Mental Health Delivery System

“There is no incentive for child and adolescent psychiatrists to come into the public sector.” – Focus group participant

“Most people with mental health issues can’t pay for visits and often drop out and are OK for a while and then become acute again.” – Focus group participant

Gaps in the mental health care delivery system were cited as a particular concern for the region. Primary care providers reported treating more patients for depression and other mental health concerns, something they are not all comfortable doing. As one health department focus group member stated, *“this part of the system has so many barriers.”* Among the barriers respondents cited were lack of providers, lack of parity in insurance and insurance coverage, and limited reimbursement. In regards to providers, the ratio of population to mental health providers is smaller in Fairfield County (1469 population per

primary care physician) than in the state (1493).²² While respondents pointed to the success of the ChildFIRST program, they also noted that there is currently a waiting list for families to participate.²³ According to mental health providers, the region lacks skilled mental health providers in the schools, in-patient beds for children, and child psychiatrists, especially those willing to serve Medicaid children. As one focus group member noted, *“not only are they [child psychiatrists] not accessible, some of them aren’t taking new patients because there is so much work.”* Services to help adults transition from acute mental health care to community-based care were also missing, according to respondents.

A 2010 assessment conducted by the Southwest Mental Health Board, Lower Fairfield county Regional Action Council, Mid-Fairfield Substance Abuse Coalition, and RYASAP, identified mental health and substance abuse service needs in the region. On the mental health side, the region has access to counseling services and crisis services, but lacks availability of respite services and inpatient services. In addition, related services such as group homes and supported education services are also less available. Similarly, identified substance abuse service needs included long term and intermediate residential services, intensive outpatient services and detox.

Gaps in Dental Services

Like mental health care, respondents noted gaps in dental services. The ratio of population to dentists in Fairfield County (1174) is slightly better than Connecticut at 1523. Low reimbursement rates by state programs have made it difficult to engage new providers to serve low-income people. In addition, as one dental provider interviewee noted, the state program does not provide for periodontal care and recently changed the frequency of cleanings covered from two per year to one. For patients, especially those with lower incomes, this has often meant forgoing needed treatment or going into debt for dental care. As one focus group member shared, *“I did not remove a molar because I did not have the money. Then it broke and I had to pay the money.”*

Transportation Barriers to Accessing Services

Transportation to health care was also raised as a barrier to access by some participants. One provider focus group member reported that use of 911 for transport to medical care has increased. However, several noted that the Norwalk Community Health Center has recently obtained a medical van that will help to address this need and to ensure greater access to health care for underserved populations.

Cultural Competency

Among non-English speakers, lack of cultural competency of providers and bi-lingual services were noted as concerns and create barriers to access. Immigrants and undocumented people were especially singled out as having difficulty accessing health care and other resources. Several respondents also mentioned concerns about health care for the elderly, noting that there is an insufficient number of physicians (geriatricians) able to care for the unique health needs of the aging population.

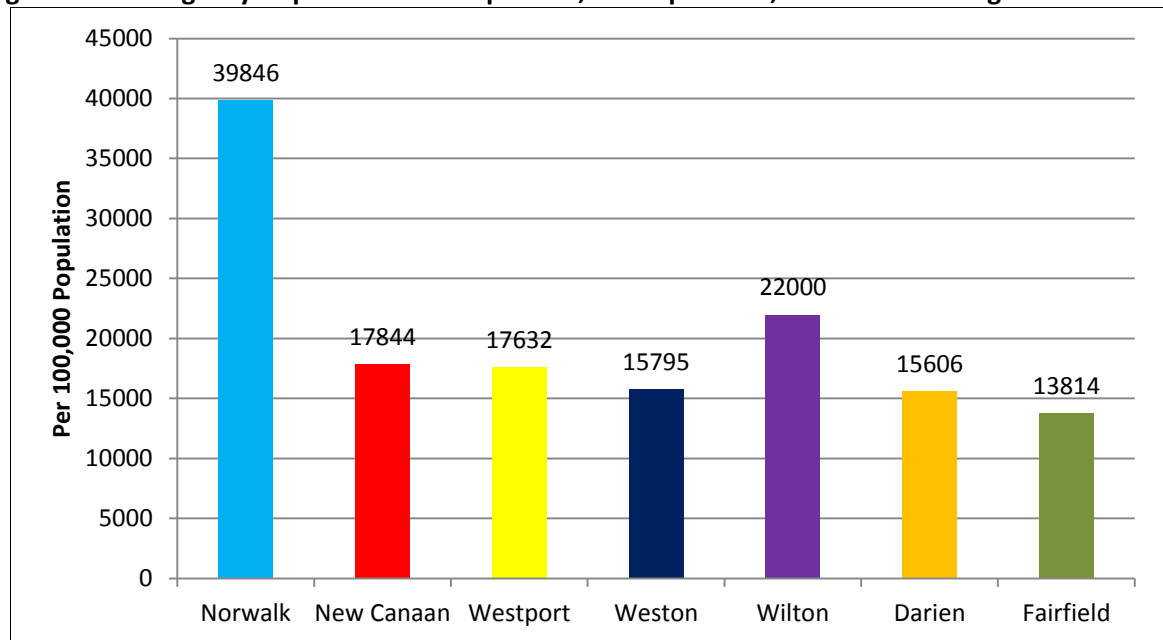
²² United States Department of Agriculture (USDA) Food Environment Atlas, analysis by County Health Rankings and Roadmaps, 2009

²³ Child FIRST is a home-based early childhood intervention program that works to decrease the incidence of serious emotional disturbance, developmental and learning problems, and abuse and neglect among high-risk young children and families.

Emergency Department as Primary Care

One key indicator of challenges in accessing health care is the pattern in the use of hospital emergency department (ED). The Health Equity Index uses the rate of emergency department visits as a proxy for a lack of access to health insurance and primary care services. Norwalk has the highest rate of emergency department visits per 100,000 population at 39,846. The other communities in the Greater Norwalk Area range from 13,814 per 100,000 population in Fairfield to 22,000 per 100,000 population in Wilton (see Figure 65). According to Greater Norwalk area respondents, these barriers to health care access as well as under capacity in some areas have led to greater use of the ED. The consequence, as one focus group member stated, is that “people using the ER for primary care bogs down the system.” Lack of some services such as mental health and access issues for others means increased use of the ED for health services that could be addressed in other facilities. Others reported that problems with transportation and co-pays means that follow-up care after an ED visit does not always take place, resulting in hospital readmission rates and repeat visits to the ED.

Figure 65 : Emergency Department Visits per 100,000 Population, 2005-2009 average



DATA SOURCE: Connecticut Hospital Association, CHIME Hospital Discharge Data; Health Equity Index, analysis conducted by CT Association of Directors of Health, 2005-2009

G. COMMUNITY MEMBERS' PERCEPTIONS OF WHAT IS NEEDED

"How do we bring the community into a space where they are more accountable for themselves and interact differently with the health care system?" – Focus group participant

"Parents need to be better educated and engaged." – Focus group participant

"We tend to try to do too much. It would be great if we could agree on 1 to 2 things that we could collectively do and put our energy behind those things." – Interview participant

"Docs just don't know where to go to find help for their patients." – Interview participant

"You have patients with multiple needs and they can't navigate the system and there isn't anyone who is helping them." – Interview participant

Throughout the focus groups and interviews, participants were asked to identify assets and resources in the community that address the issues and needs they had identified. These programs and services were compiled with additional items from the development of the community health improvement plan into a list. [See Appendix F] Additionally, focus group members and interviewees were asked what was needed to address health challenges in the community. Many reported that they believed more money was needed for services but recognized that this would likely not be forthcoming until the economy improves. Several residents noted that the health centers needed more staff so that patients could *"see the doctor who knows their history"* to receive better personalized care. More staff were also needed to *"reduce wait time"* and *"improve follow-through,"* both viewed by as important for resident respondents.

Those from housing noted the importance of more affordable housing. As one person stated, *"once people have their housing situated, it would free up resources for other things and reduce stress."* Others felt that the region could benefit from more educational support for young people and low wage earners, especially those who do not speak English well.

Focus on Prevention

Several respondents reported that they felt that fundamental change was needed in the health infrastructure to increase emphasis on prevention. As one health department focus group member stated, *"we focus on treating disease...we need a medical home that emphasizes prevention."* Providers talked about changing the incentive structure to emphasize prevention over treatment. More comprehensive substance use and mental health services were also named as a need, as these were two of the top three health concerns raised by community members.

Health Literacy

A number of focus group respondents and interviewees reported that they believed that a lack of awareness/understanding of health (health literacy) and health resources in the community were underlying causes of poor health and unhealthy behaviors in the region. Focus group respondents and interviewees frequently stated that there was a lack of understanding among many about how to take care of themselves. As one person summed up, *"we're reactive, not proactive. Even people with wonderful benefits aren't educated enough about prevention. They react only when there is something serious."* Another concurred, saying *"wellness care is foreign to us. Doing something before it turns into something doesn't happen."*

Although respondents reported that there already are many health education programs in the community, they felt more were needed. They suggested programs that educated about diabetes and other chronic diseases, how to eat better and the importance of physical activity, programs to help people manage stress. They cited the importance of reaching people who are busy, parents, and also those who do not speak English. As one Spanish-speaking focus group member stated, *"we need more groups where we talk about health."* One interviewee suggested that *"there should be a real marketing effort."* Several focus group participants noted that community conversations and events should be held "closer to where the people are" and that personal invitations would encourage them to attend.

Centralized Resource Information

A related need expressed by a number of focus group members and interviewees was a centralized listing of resources offered in the community. Provider focus group members noted that physicians as well as their office staff and discharge planners often do not know about resources offered in the community. Care coordinators are often relied on for such information and connection to services, and focus group members and interviewees who work with care coordinators praised their ability to connect patients to services. Several respondents suggested that a website or some other repository of such information that could be used by physicians and their staff would be helpful.

Support for Parents

The need for parenting support was a consistent theme in interviews and focus groups. Respondents stated that they thought more should be done to help parents model good coping skills for kids and to help them help their children learn about problem solving. As one mental health provider suggested, *"I think looking at how we provide services to families in terms of their ability to raise their children is critical."*

Activities for Youth

Both youth and adult respondents agreed that there were numerous community events and activities, such as family days and community centers, which existed in the area. Among youth, respondents reported a need for more activities, especially in less affluent areas. Several focus group participants mentioned that parks are closing and youth have nowhere to go. *"They took away the roller skating rink. They took away the ice skating rink. They took away teenage parties for kids that stayed out of the streets. They took away all of that. What is there for our children to do? There's nothing,"* stated one respondent. Respondents from these areas also felt that efforts to make healthy food more affordable and physical activity opportunities more accessible were important. Teens mentioned that additional clubs or intramural sports would be helpful for them to stay in shape and interact with each other face to face. As one youth said, *"there is too much social media, texting, tweeting, instead of talking. It's affecting kids' ability to communicate their emotions. Kids act differently in person than they do on social media."*

Despite the perceived lack of youth activities in lower income areas, among more affluent areas there was the perception that more attention was spent on youth activities than was necessary. As one respondent stated, *"this is a very child-oriented area. There is a lot of pressure on young people to excel and achieve- emotionally, physically and academically."* To support the development of youth, these areas were perceived as having many resources and activities. From EMT programs to youth asset building to dozens of sports teams and recreational facilities, the more affluent areas of the region have a wealth of resources

devoted to youth. Respondents in these areas remarked that the challenge was not access to resources and activities, but rather “balancing time, work, stress, exercise and eating healthy.”

Greater Cultural Competency

Cultural competency can be defined many ways, but generally encompasses the ability to recognize and consider the diverse cultural norms, attitudes, identities and world views of all people with whom a person interacts. Organizations and people who strive towards maintaining a culturally competent practice engage in mindful cross-cultural interaction and carefully consider their own biases and expectations before making inferences about the identities and values of others. Enhancing cultural competency within the health system was an identified need by respondents, especially among non-English speaking focus group members. Suggestions included having more interpreters available in places like the ER, providing health information in other languages, offering alternative medicine practices, and ensuring that providers understood other cultures’ health and social beliefs.

Enhanced Integration of Information Across Health Systems

Those in the health provider community reported that they would like to see greater integration of health information across systems and would like to see incentives for physicians, psychiatrists, and dental professionals to come into the public sector.

Greater Collaboration Across Agencies

Finally, although several respondents reported close collaboration across those in the health and social service systems, others felt greater coordination was needed. In Norwalk, an interviewee stated, *“people are stuck in an isolationist attitude.”* As one interviewee noted, *“we have a lot of people working really hard doing a lot of stuff but what we don’t do well is point the resources in the right direction...there is too much jumping in and doing because it just makes people feel better.”*

III. CONCLUSION

Through a review of the secondary social, economic, and epidemiological data in the Greater Norwalk Area as well as discussion with community residents and leaders, this assessment report provides an overview of the social and economic environment of the area, the health conditions and behaviors that most affect the population, and the perceptions of strengths and gaps in the current public health and health care environment. Several overarching themes emerged from synthesizing these data points:

- **There is a variation within the Greater Norwalk Area in population composition and economic levels.** Norwalk differs from the surrounding towns in population size, diversity and number of households with lower median incomes. All of the communities bring strengths and resources to the area to support health improvement. Across the Greater Norwalk Area, focus group and interview participants noted strengths of civic-minded residents, growing diversity, highly educated residents, a child oriented environment, strong businesses, and access to the waterfront and recreational areas.
- **Mental Health and substance abuse were considered growing, pressing concerns by focus group and interview respondents, and one in which the current services were not necessarily addressing community needs.** Focus group and interview participants cited changes in the economy and pressures on adults and youth to succeed as significant reasons for an increased need for mental health and substance abuse services. A lack of accessible providers; a lack of needed services, such as inpatient and educational programs; and stigma around receiving services were expressed as barriers to care. While youth substance use appears to be on the decline, concerns were expressed related to alcohol, marijuana, and prescription drugs, among a range of residents, including parents, those who work with youth, and teens themselves. The social norm was that these substances are easily accessible.
- **As with the rest of the country and state, issues around physical activity, healthy eating, and obesity are issues for residents of the Greater Norwalk Area, especially as chronic conditions are the leading causes of morbidity and mortality.** The Greater Norwalk Area's rates related to physical activity, nutrition, and obesity are similar to or better than what is seen statewide or nationally, yet with heart disease, cancer, and diabetes as top issues in relation to morbidity and mortality, these issues are considered critical to address. Of particular concern was the evidence related to childhood obesity—an issue that will have even more severe health and cost repercussions in the future as the younger generation transitions to adulthood. This issue is more pronounced in the city of Norwalk. In general, although the Greater Norwalk Area residents have access to many grocery stores, parks, and recreational facilities, concerns were related to the accessibility and affordability of these outlets. While several facilities and programs around these issues exist, some interviewees and focus group participants commented that it was critical to address this issue through a comprehensive approach, in that multiple sectors, including health care, education, public works, transportation, local government, and the business community, needed to collaborate together to make an impact on current rates.
- **Numerous services, resources, and organizations are currently working to meet the health and social service needs of area residents.** Throughout the discussions, interview and focus group participants recognized the strong work related to health in which many community-based and regional organizations are involved. Local health departments, Norwalk Hospital and Norwalk Community Health Center, along with dozens of local health and social service organizations, were cited as key players in the community to meet current and future needs.

However, some interviewees commented that services in the area are fragmented, uncoordinated, and under-funded. There was strong interest for these issues to be addressed via a more strategic, coordinated approach with multiple organizations and agencies working together. Overall, participants were hopeful for the future and saw that the discussions occurring in the region would create momentum for moving forward with innovative, collaborative approaches towards health.

Part II: Community Health Improvement Plan

I. OVERVIEW OF THE COMMUNITY HEALTH IMPROVEMENT PLAN

A. What is a Community Health Improvement Plan?

A community health improvement plan is a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources.²⁴

CHIPs are created through a community-wide planning process that engages residents and partners.

B. How to use a CHIP

A CHIP is developed to provide guidance to the health department, its partners, and its stakeholders, on improving the health of the population within the health department's jurisdiction.²⁵ The plan is critical to developing policies and defining actions to target efforts that promote health. Government agencies, including those related to health, human services, and education, as well as hospitals can use the CHIP in collaboration with community partners to set priorities and coordinate and target resources. A CHIP is designed to be a broad, strategic framework for community health that can be modified as conditions change. It is developed in a way that engages multiple perspectives so that any community member or organization can find a role in supporting the plan.

C. Methods

To develop the CHIP, Norwalk Hospital and the Norwalk Health Department partnered to bring together community residents and the area's influential leaders in healthcare, community organizations, education, housing, local government, business, mental and behavioral health, and social services. Following the guidelines of the Association for Community Health Improvement (ACHI), the Public Health Accreditation Board, and National Association of County and City Health Officials (NACCHO), the community health improvement process was designed to integrate and enhance the current community health activities of many organizations in order to leverage existing resources for greater efficiency and impact. The assessment/planning/implementation/evaluation/reassessment process is a continuous cycle of improvement that seeks to "move the needle" on key health priorities over the course of time.

The next phase of the community health improvement process will involve broad implementation of the strategies and action plan developed from the CHIP, and monitoring/evaluation of the CHIP's output and outcome indicators.

²⁴ (Adapted from: United States Department of Health and Human Services, Healthy People 2010. Washington, DC; Centers for Disease Control and Prevention, National Public Health Performance Standards Program, www.cdc.gov/nphpsp/FAQ.pdf).

²⁵ Public Health Accreditation Board (PHAB) Standards and Measures, Version 1.0: Standard 5.2.2. p. 127

II. DEVELOPMENT OF THE GREATER NORWALK AREA CHIP

A. Development of Data-Based Community Identified Health Priorities

After reviewing and discussing the data presented in the Community Health Assessment, members of the Core Leadership Team convened a two-hour community meeting on July 24, 2012 to share the preliminary results of the CHA and identify priorities for the CHIP. Over 100 community members and leaders attended this session, representing diverse perspectives and sectors from the community.

The following themes emerged most frequently from review of the available data and were used in the selection of the CHIP health priorities:

Mental Health

- Depression
- Stress and anxiety
- Stigma
- Access to services

Substance Abuse

- Tobacco
- Alcohol
- Marijuana
- Heroin
- Emerging Substances
(i.e., bath salts)

Chronic Disease

- Cardiovascular Disease
- Cancer
- Diabetes
- Asthma
- HIV/AIDS

Obesity

- Healthy Eating
- Active Living

Health Literacy

After reviewing and discussing the CHA, community members suggested that Long Term Care and Access to Primary and Specialty Care be added to the list of major themes for priority selection.

Facilitators used a quality improvement multi-voting process to identify the three most important public health issues for Greater Norwalk from the list of seven major themes identified from the CHA. Each community participant received three dots to apply to their top three public health priorities, based on the following agreed-upon criteria:

- Political will exists to support change
- Community Values
 - Community cares about it
 - People, power and passion: Likely community mobilization
 - Important to community
- Key area of need (based on data)
 - Size: Many people affected
 - Trend: Getting worse
 - Seriousness: Deaths, hospitalizations, disabilities
 - Causes: Can identify root causes/social determinants
 - Research/evidence-based
- Achievable/doable
 - Feasible and realistic
- Resources available or likely
 - Builds on or enhances current work
- Measurable outcomes
- Can move the needle
 - Proven strategies to address multiple wins/catalytic actions
 - Easy short-term wins
- Population Based Strategies
 - Some groups affected more
 - Can focus on targeted population(s)

The results of the multi-voting process are as follows:

Key Health & Healthcare Themes from the CHA	Total # of Votes
Mental Health	63
Obesity	39
Substance Abuse	36
Access to Primary and Specialty Care	29
Chronic Disease	27
Long Term Care	22
Health Literacy	13

Based on the results of the multi-voting exercise, participants agreed upon the following three health priority areas for the CHIP:

1. Mental Health
2. Obesity
3. Substance Abuse

Task Force members engaged in three small table discussions around the priority areas. They recommended specific areas of focus for the priority areas, identified resources that might be needed and those that are already available to address the issues, and identified organizations and individuals that should be involved in workgroups to develop the CHIP. [See Appendix C for workgroup participants and affiliations]

B. Development of the CHIP Strategic Components

The Core Leadership Team convened two, three-hour work sessions on September 11 and September 25, 2012. Community members and partners were invited to participate in working groups based on interest and expertise in each of the three identified priority areas, as self-indicated on exit surveys from the community planning session. See Appendix C for a list of workgroup participants.

Two-person teams comprised of Core Leadership Team Members and HRiA staff facilitated the working groups on both days to develop draft goals, objectives, strategies, outcome indicators, and potential partners/resources for each of the three priority areas. As preparation for the planning sessions, Data Profiles were prepared for key demographic and social determinant data as well as each of the three priority areas selected from the CHA (Mental Health, Substance Abuse, and Obesity). These profiles were distributed to participants in advance and copies were also made available during the sessions to ensure that plan components were data-driven. Objectives and Outcome Indicators were aligned with Healthy People 2020 targets whenever possible. Finally, participants received samples of evidence-based strategies compiled from various sources, including County Health Rankings and The Community Guide, to inform this part of the planning.

In late October 2012, the Core Leadership Team and HRiA staff reviewed the draft plans developed at the planning sessions and edited the plan components for clarity and consistency. Once the draft plan was complete, an online survey was developed to solicit feedback on the components of the plan. From October 24 through November 7, the online survey was administered to all community members who had been engaged in the assessment and planning process (n=240).

Feedback from survey respondents (n=37) was incorporated into the final Community Health Improvement Plan. In general, the respondents agreed or strongly agreed on the importance of the identified strategies. As a result of suggestions made in the survey, the mental health and substance abuse priority areas were combined in to a single priority area. The CHIP was completed in December 2012.

C. Relationship between the CHIP and other Guiding Documents and Initiatives

The CHIP was designed to complement and build upon other guiding documents, plans, initiatives, and coalitions already in place to improve the public health of the Greater Norwalk community.

At the national level, this CHIP has been aligned with the National Prevention Strategy, Healthy People 2020 and the Center for Disease Control's Winnable Battle-Nutrition, Physical Activity, and Obesity. At the state level, the Connecticut state-wide health improvement plan (SHIP) is currently in development, and the Connecticut Department of Public Health has been engaged in the community health improvement process for Norwalk to increase alignment between both plans. Finally, at the local level, participants in the CHIP development process identified potential partners and resources wherever possible rather than duplicating the recommendations and actions of existing frameworks and coalitions.

III. STRATEGIC ELEMENTS OF THE CHIP

Goals, Objectives, Strategies, Key Partners, and Output/Outcomes Indicators

Real, lasting community change stems from critical assessment of current conditions, an aspirational framing of where you would like to be, and a clear evaluation of whether your efforts are making a difference. The following pages outline the Goals, Objectives, Strategies, Potential Output and Outcomes Indicators, and Potential Partners/Resources for the three health priority areas outlined in the CHIP. See Appendix D for a glossary of terms used in the CHIP.

A. Priority One: Mental Health and Substance Abuse

PRIORITY AREA 1: MENTAL HEALTH AND SUBSTANCE ABUSE	
Goal 1: Provide education on and access to quality, evidence-based mental health and substance abuse prevention, intervention and treatment services across the life span.	
Objective 1.1: Increase providers' and community members' awareness and use of evidence-based mental health and substance abuse services and educational resources for prevention, intervention, treatment and recovery (by date).	
Strategy 1.1.1: Support collaborations among community-based and regional organizations to enhance and deliver training and other educational opportunities for community members on topics related to mental health and substance abuse.	<i>Examples of Partners or Sources of Information</i> <ul style="list-style-type: none"> • Department of Mental Health and Addiction Services (DMHAS 101) • Southwest Regional Mental Health Board (SWRMHB) • Alanon • NAMI • Liberation Programs • Positive Directions • School Nurses • PTOs/PTAs
Strategy 1.1.2: Build upon or expand existing training programs for providers at area educational institutions.	<i>Examples of Partners or Sources of Information</i> <ul style="list-style-type: none"> • Department of Mental Health and Addiction Services (DMHAS 101) • Mid-Fairfield Substance Abuse Coalition • Local prevention councils • Connecticut Renaissance • Family and Children's Agency, Project Reward
Strategy 1.1.3: Establish knowledgeable, well-trained, bi-lingual Patient Navigators and Community Health workers in key community based organizations.	<i>Examples of Partners or Sources of Information</i> <ul style="list-style-type: none"> • Norwalk Community College School of Nursing • Norwalk Community Health Center • Public and private colleges and universities
Strategy 1.1.4: Develop and disseminate a comprehensive, bilingual resource guide for programs and services that support mental health and prevent and treat substance use and abuse.	<i>Examples of Partners or Sources of Information</i> <ul style="list-style-type: none"> • United Way • Connecticut Network of Care • Connecticut Behavioral Health Partnership • Norwalk, CT Resource Directory • Websites and social media as resources for distribution
<i>Sample Output Indicators for 1.1:</i> <ul style="list-style-type: none"> • Bilingual resource guide developed and disseminated • # of hard copies distributed by (DATE) • # of internet downloads • # trainings on adult and youth mental health service • # of educational opportunities related to substance abuse prevention, treatment and recovery • # Bilingual Patient Navigators and Community Health workers trained 	

PRIORITY AREA 1: MENTAL HEALTH AND SUBSTANCE ABUSE

Goal 1: Provide education on and access to quality, evidence-based mental health and substance abuse prevention, intervention and treatment services across the life span.

Sample Outcome Indicators for 1.1:

- Decreased inpatient rate of adolescents admissions
- Decreased emergency department visits for mental illness
- # calls for mental health services (211)
- Increase in the # of referrals or use of programs
- # people calling 211 speaking languages other than English
- Increase in # of patients who stay in treatment
- Increase in # of outpatient services for substance use and abuse
- Increase in # of individuals receiving outpatient services from FQHC
- Decrease in average # of mentally unhealthy days reported in past 30 days
- Increase in # of patient navigators/community health workers who are assisting families with substance abuse services
- Increase in # of culturally and linguistically competent services
- Decrease the proportion of adults aged 18 and older who reported binge drinking during the past month (*NPS Indicator*)
- Decrease the proportion of high school students who reported binge drinking during the past two weeks (*NPS Indicator*)

Objective 1.2: Enhance local and regional partnerships to improve access to timely, comprehensive, and coordinated services for diverse populations across the life span by (date).

<p>Strategy 1.2.1: Conduct a regional assessment of the existing number of mental health care and substance abuse providers/resources currently available for adults and adolescents at each level of care as an initial step in the further development of collaboration and efficient use of resources among providers.</p>	<p>Examples of Partners or Sources of Information</p> <ul style="list-style-type: none"> • (none provided)
<p>Strategy 1.2.2: Identify and/or create 1 or 2 formalized, regional partnerships to address mental health and substance abuse service gaps and inefficiencies through collaborative planning, service delivery, and resource sharing.</p>	<p>Examples of Partners or Sources of Information</p> <ul style="list-style-type: none"> • (none provided)
<p>Strategy 1.2.3: Form an Alliance between local health care providers and community based services to provide accessible and financially viable outpatient services.</p>	<p>Examples of Partners or Sources of Information</p> <ul style="list-style-type: none"> • Norwalk Hospital • Norwalk Community Health Center • Local Providers • Community organizations • Payors

PRIORITY AREA 1: MENTAL HEALTH AND SUBSTANCE ABUSE	
Goal 1: Provide education on and access to quality, evidence-based mental health and substance abuse prevention, intervention and treatment services across the life span.	
Sample Output Indicators for 1.2: <ul style="list-style-type: none"> • Formal structure/local collaboration developed • Local health care providers and community based service providers form Alliance to address access to treatment • Increased representation of service types on regional partnerships • Inpatient, outpatient, early childhood, social service providers, older adults, DCF, DMHAS 	
Sample Outcome Indicators for 1.2: <ul style="list-style-type: none"> • Decreased inpatient rate of adolescents admissions • Decreased ED visits for mental illness • Increase in # people calling 211 speaking languages other than English • Increase in # of clinics • Increase in # of providers • Increase in # of primary care facilities that provide mental health treatment services • Increase in # of outpatient services for substance use and abuse • Increase in # of individuals receiving outpatient services from FQHC • Decrease in average # of mentally unhealthy days reported in past 30 days • Increase in # of culturally and linguistically competent services • Increase in # of patients who stay in treatment 	
Objective 1.3: Reduce financial barriers to treatment (by date).	
Strategy 1.3.1: Convene payers in ACO/PHO (Accountable Care Organization/Physician Hospital Organization) to address reimbursement issues around mental health and substance abuse.	Examples of Partners or Sources of Information <ul style="list-style-type: none"> • Norwalk Hospital • ACO/PHO's • Payors
Strategy 1.3.2: Work with local businesses to promote existing programs that address employees' substance abuse and mental health issues.	Examples of Partners or Sources of Information <ul style="list-style-type: none"> • Federally Qualified Health Centers (FQHC's) • CT Business Partners on Health • Chamber of Commerce • United Way 211 • Employers/Employee Assistance Programs
Sample Output Indicators for 1.3: <ul style="list-style-type: none"> • Payers come to the table 	
Sample Outcome Indicators for 1.3: <ul style="list-style-type: none"> • One payer changes their reimbursement policy • Increased use of existing programs that address employee substance abuse and mental health issues • Decrease in employee absences related to substance abuse and mental health issues 	

B. Priority Two: Obesity

PRIORITY AREA 2: OBESITY	
Goal 2: Prevent and reduce obesity in the community by promoting healthy lifestyles.	
Objective 2.1: Increase the number of children and adults who meet physical activity guidelines by (date).	
Strategy 2.1.1: Increase opportunities for physical activity among school age children (Examples include instituting a walk school bus initiative, developing a physical activity “tool kit” for schools and community-based organizations, establishing or improving organizational policies to promote and support physical activity before, during and after the school day, exploring regional and local joint use agreements)	Examples of Partners or Sources of Information <ul style="list-style-type: none"> • YMCA • Community Centers • Senior Centers • After-School Programs • Food Pantries • Local Supermarkets • Farmers • Parents • Parks and Recreation • ACHIEVE Grant (Norwalk Childhood Obesity Prevention Committee) • Public and private educational institutions – elementary, secondary, colleges and universities
Strategy 2.1.2: Increase opportunities for physical activity among adults. (Examples include promoting “NorWALKER” walking routes, developing community “tool box” for community groups, conduct a community drive to collect exercise equipment and DVDs for distribution to groups with need, conducting a “Biggest Loser”– type community campaign for adults, establishing or improving organizational policies to promote and support physical activity, promote staff wellness programs, host free exercise classes, explore regional and local joint-use agreements.)	Examples of Partners or Sources of Information <ul style="list-style-type: none"> • Parks and Recreation • Senior Centers • Work Sites/Local Businesses • Healthcare Providers • Community Clinics • Faith-based Organizations • Community Organizations • Public Libraries • Local Supermarkets • Community Centers • Transit Authority • Public and private educational institutions – elementary, secondary, colleges and universities

PRIORITY AREA 2: OBESITY	
Goal 2: Prevent and reduce obesity in the community by promoting healthy lifestyles.	
Sample Output Indicators for 2.1: <ul style="list-style-type: none"> • 3-5 evidenced based strategies selected and implemented • New state mandate implemented • #of towns with joint use agreements 	
Sample Outcome Indicators for 2.1: <ul style="list-style-type: none"> • # of minutes of physical activity in the school day • increased enrollment in physical activity in after school settings • increased number of people using walking routes • % of 9th graders at healthy weight • % of adults who meet physical activity guidelines (e.g., HSC survey; KAB survey; QOL survey; Healthy equity index) 	
Objective 2.2: Increase access to and consumption of healthy and affordable foods throughout the region by (date).	
Strategy 2.2.1: Increase access to healthy foods through evidence-based initiatives such as mobile markets, healthy market projects, or healthy restaurant programs.	Examples of Partners or Sources of Information <ul style="list-style-type: none"> • Local Supermarkets • Restaurants • Farmers • CT Department of Agriculture • Chamber of Commerce • Norwalk Health Department • CT Department of Public Health
Strategy 2.2.2: Develop and implement an education campaign (programs, tools, and resources) to increase awareness about healthy eating.	Examples of Partners or Sources of Information <ul style="list-style-type: none"> • ACHIEVE Grant (Norwalk Childhood Obesity Prevention Committee) • Local Media • Local Supermarkets • Worksites/Businesses • Faith-based Organizations • Community Centers • Public and private educational institutions – elementary, secondary, colleges and universities • Restaurants • Local Health Departments • CT Department of Public Health
Sample Output Indicators for 2.2: <ul style="list-style-type: none"> • Evidence-based initiatives to increase access to healthy foods implemented • # of educational programs, tools, and resources available to communities 	
Sample Outcome Indicators for 2.2: <ul style="list-style-type: none"> • % of population with access to outlets selling healthy foods • # of people buying healthy foods • % of students who ate fruits and vegetables less than five times per day during the week before survey • % of high school students who are obese (\geq 95th percentile for BMI by age and sex) • % of adults who are obese/increased proportion of adults at healthy weight 	

IV. NEXT STEPS

The components included in this report represent the strategic framework for a data-driven, community-enhanced Community Health Improvement Plan. Members of the Core Leadership Team will meet with workgroup members to designate lead and supporting roles for partners to implement each strategy, starting in January 2013. They will further develop the strategies and provide more detailed timeframes.

Appendices

APPENDIX A: CORE LEADERSHIP TEAM AND TASK FORCE MEMBERS

One of the great successes of the process to develop the CHA and CHIP was the high level of cross-sector collaboration. This collaboration was led by Norwalk Health Department and Norwalk Hospital who met on a bi-weekly basis to discuss the each step of the process and review progress.

Hosts of CHA/CHIP Process

Norwalk Hospital
Norwalk Health Department

Core Leadership Team

Tim Callahan	Director of Health, Norwalk Health Department
Mary Franco	President, Norwalk Hospital Foundation
	Vice President, Public Affairs, Norwalk Hospital
Deanna D'Amore	Project Coordinator, Norwalk Health Department
Joyce D. Bretherton	Development Associate, Norwalk Hospital Foundation
Theresa Argondezzi	Health Educator, Norwalk Health Department

Consultants

Health Resources in Action, Inc., Boston, MA

Community Health Assessment and Improvement Task Force Members

Inta Adams	Assistant Director, Darien Social Services
Anthony Allison	Program Director, Norwalk Children's Foundation
Dr. Joe Andrews	Medical Director, Connecticut Hospice
Theresa Argondezzi	Health Educator, Norwalk Health Department
Richard Bangs	Norwalk Transit District
Charlene Barlow	Director, Community Outreach -- Home Care Family & Children's Agency
Carol Bauer	Community Advisory Board Member, Norwalk Hospital
Eva Beau	Community Outreach Coordinator, Norwalk Community Health Center
Rowena Bergmans	Consultant, Norwalk Hospital
Debi Boccanfuso	Principal, Darien Public Schools
Maria Borges-Lopez	Board of Trustees, Norwalk Hospital
Toni Boucher	State Senator, Connecticut
Adam Bovilsky	Director, Human Relations and Fair Rent Department, City of Norwalk
Carol Bower	Leading Planning Analyst, Connecticut Department of Public Health
Christine Bradley	Director, Norwalk Public Library
Sharon Bradley	President & CEO, Visiting Nurse and Hospice
Joyce Bretherton	Development Associate, Norwalk Hospital
Michele Bullock	Manager, Patient Access, St. Vincent's Health Services
Barbara Butler	Director, Westport Department of Human Services
Tim Callahan	Director of Health, Norwalk Health Department
Angelica Camacho	Behavioral Health Coordinator, Day Street Community Health Center
Rhonda Capuano	Director, Dr. Robert Appleby School Based Health Centers, Human Services Council
Patricia Carey	APRN, Communicable Disease Coordinator, Norwalk Health Department
Denise Cesareo	Executive Director, ElderHouse
Yohanna Cifuentes	Senior Bilingual Clinician, Mid-Fairfield Child Guidance Center
Sands Cleary	Director of Health, Fairfield Health Department

Tom Closter	Director of Environmental Services, Norwalk Health Department
Mark Cooper	Director of Health, Westport Weston Health District
Christina Crain	Southwestern Connecticut Agency on Aging
Larry Cross	Chief Executive Officer, Norwalk Community Health Center
Deanna D'Amore	Project Coordinator, Norwalk Health Department
Igor Dargery	CEO, Norwalk Medical Group
Dan DeBarba	President & CEO, Norwalk Hospital
Cathy DeCesare	Senior Vice President Strategic Initiatives, United Way of Coastal Fairfield County
Dr. Marvin Den	Norwalk Medical Group
Patricia DiPietro	Business Manager, Norwalk Health Department
Kathleen Dunn	Clinical Manager, Norwalk Hospital Behavioral Health
Izora Ebron	Acting Executive Director, Open Door Shelter
Dr. Marcia Eckerd	Psychologist, Norwalk Hospital Pediatric Development & Therapy Center
Dr. Howard Eison	Internal Medicine
Laura Epstein	Executive Director, Norwalk Senior Services
Mary Franco	President, Norwalk Hospital Foundation
	Vice President, Public Affairs, Norwalk Hospital
Carol Frank	Chair, Norwalk Human Relations Commission, City of Norwalk
Teresa Giegengack	Assistant Director, Client Services, Westport Department of Human Services
Donna Glen	Senior Planning & Business Development Analyst, Norwalk Hospital
Kate Glidden	Senior Supervisory Clinician, Mid-Fairfield Child Guidance Center
Adele Gordon	Director of Fairfield County Sites, Community Health Centers, Inc.
Karen Gottlieb	Executive Director, AmeriCares
Marty Hauhuth	Executive Director, Positive Directions
Hope Hetherington	Chair, Interagency and Partnership Advisory Panel on Lupus
Darleen Hoffler	Supervisor of Clinical Services, Norwalk Health Department
Lauren Hughes	Coordinator Senior Services, Wilton Department of Social Services
Michele Jakob	Outreach Director, Norwalk Senior Center
Betty Karkut	Executive Director, Human Services Council
Dr. Janet Karpia	Pediatrics, Norwalk Hospital, Norwalk Board of Health
David Knauf	Director of Health, Darien Health Department
Tom Kulhawik	Police Chief, Norwalk Police Department
Kimberly Kuta	Director of Research & Evaluation, Stepping Stones Museum
Ken Lalime	Member, Norwalk Board of Health
Molly Larson	Public Health Nurse, Darien Health Department
Dr. David Levinson	President, Norwalk Community College
Sarah Levy	Health Educator, Fairfield Health Department
Ana Lopez	Community Resident
Dr. Susan Marks	Superintendent, Norwalk Public Schools
Patricia Marsden-Kish	Planning Facilitator, Choice Neighborhoods, Norwalk Housing Authority
Allen Mathis	President & CEO, Liberation Programs, Inc.
Candace Mayer	Deputy Director, Norwalk Housing Authority
Dr. Eric Mazur	Vice President & Chief Medical Officer, Norwalk Hospital
Barbara McCabe	Clinic Director, AmeriCares
Barry McGovern	Associate Executive Director, Keystone House
Shaun Mee	Regional Manager, Mutual Security Credit Union
Dr. Katherine Michael	Chair, Department of Psychiatry, Norwalk Hospital
Richard Moccia	Mayor, City of Norwalk
Elayne Mordoff	Community Resident

Ed Musante	President and CEO, Greater Norwalk Chamber of Commerce
Jane Nyce	Executive Director, Staying Put, New Canaan
Kim O’Rielly	Executive Director, Southwest Regional Mental Health Board
Paul Palermo	Executive Director, Norwalk Senior Center
Christy Perone	Sales and Marketing Manager, Brookdale Place, Wilton
Susan Pfister	Director, Department of Human Services, Westport
Heather Porter	Director, Marketing and Business Development, Silver Hill Hospital
Judy Prager	Head Start Nutrition Manager, Norwalk Economic Opportunity Now
Terry Quell	Member, Norwalk Board of Health
Cesar Ramirez	Police Officer, Norwalk Police Department
	Chair, Housing Authority Board of Commissioners, City of Norwalk
Dr. David Reed	Director of Health, New Canaan Health Department
	Medical Advisor, Norwalk Health Department
Dr. Alan Richman	Radiology, Norwalk Hospital
Harry Rilling	Chief of Police, Norwalk Police Department
Milagros Rivera	Community Resident
Nicole Rivard	Community Resident
Maura Romaine	Director, Corporate Communications, Norwalk Hospital
Suzanne Schintzius	Stewardship Manager, Norwalk Hospital, Wilton Human Services, Town of Wilton
Libby Scott	Community Resident
Rose Sellers	Community Resident
Ervin Shames	Board Member, Norwalk Hospital Foundation
Sharon Simon	Community Relations Specialist, Norwalk Hospital
Kristen Sinatra	Director of Marketing, Waveny Care Network
Dr. Vicki Smetak	Chairman, Department of Pediatrics, Norwalk Hospital
Eileen Smith	Executive Director, Soundview Medical Associates
Jane Stickkel	Clinical Supervisor, Connecticut Hospice
Margaret Suib	Fair Housing Officer, City of Norwalk
Amy Taylor	Administrative Assistant to the Director, Day Street Community Health Center
Mary Ann Tessier	Professor and Chair of Nursing, Norwalk Community College
Jeryl Topalian	Executive Director, Planning and Business Development, Norwalk Hospital
Dr. Ed Tracey	Member, Board of Health, Norwalk
Terry Tumpane	Administrator, Waveny Home Health
Sarah Turbert	Director of Youth Development Services, Norwalk YMCA
Grace Vetter	Coordinator of School Health Services, Norwalk Public Schools
Ruthann Walsh	Director, Corporate Citizenship, Pepperidge Farm Corporation
Monica Wheeler	Director of Community Health, Westport Weston Health District
Valerie Williams	Executive Director, Keystone House
David Wrinn	Deputy Chief, Norwalk Police Department

APPENDIX B: FOCUS GROUP AND INTERVIEW PARTICIPANTS

Inta Adams	Assistant Director, Darien Social Services
Marie Allen	Executive Director, Southwestern Connecticut Agency on Aging
Dr. Joe Andrews	Medical Director, Connecticut Hospice
Dilian Aquino	Community Resident
Vicki Ashy	Community Resident
Dr. Tom Ayoub	Obstetrics & Gynecology
Juliana Azor	Community Resident
Melanie Barnard	President, New Canaan Volunteer Ambulance Corp
Dr. Yoni Barnhard,	Chairman, Department of OB GYN, Norwalk Hospital
Katie Banzhaf	Executive Director, STAR
Rose L. Beau	Community Resident
Matt Bernhardt	Community Resident
Debi Boccanfuso	Principal, Middlesex Middle School, Darien Public Schools
Adam Bovilsky	Director, Human Relations and Fair Rent Department, City of Norwalk
Sharon Bradley	President & CEO, Visiting Nurse and Hospice
Bill Brennan	First Selectman, Town of Wilton
Ricky Bretherton	Community Resident
Matthew Brovender	Member, Norwalk Board of Health
Michelle Bullock	Manager of Patient Access, St. Vincent's Behavioral Health Services
Kathy Cahill	Head Teacher, Naramake Elementary School Family Resource Center
John Calka	Captain, Westport Police Department
Tim Callahan	Director of Health, Norwalk Health Department
Elizabeth Canales	Community Resident
Rhonda Capuano	Director, Dr. Robert Appleby School Based Health Centers, Human Services Council
Patricia Carey	APRN, Communicable Disease Coordinator, Norwalk Health Department
Dr. Michael Carius	Chairman, Department of Emergency Medicine, Norwalk Hospital
Nancy Carroll	Deputy Administrator, Norwalk Transit District
Gene Cederbaum	Fair Housing Agent, Town of Westport
Sands Cleary	Director of Health, Fairfield Health Department
Mark Cooper	Director of Health, Westport Weston Health District
Jason Cotaling	Community Resident
Bob Crosby	Deputy Chief, Wilton Police Department
Larry Cross	CEO, Norwalk Community Health Center
Dr. Peter Czuczka	Willows Pediatrics
Igor Dargery	CEO, Norwalk Medical Group
Dan DeBarba	President and CEO, Norwalk Hospital
Cathy DeCesare	Sr. Vice President Strategic Initiatives, United Way of Coastal Fairfield County
Dr. Marvin Den	Norwalk Medical Group
Lori Dominick	Teacher, Fox Run Elementary School, Norwalk Public Schools
Sharaine Dorcinucke	Community Resident
Lloyd Dunbar	Community Resident
Raymond Dunlap	Community Resident
Izora Ebron	Acting Executive Director, Open Door Shelter
Dr. Mark Feigen	Director, Dental Services, Norwalk Hospital

Rita Ferri	Principal, Hindley Elementary School, Darien Public Schools
Peggy Ford	Resident Service Coordinator, Fairfield Housing Authority
Peter Fraboni	Associate Director, Earthplace Harbor Watch Program
Mary Franco	President, Norwalk Hospital Foundation, Vice President, Public Affairs, Norwalk Hospital
Angela Galbo	Community Resident
Mirna Garcia	Community Resident
Joseph J. Giandurco	Teacher, Ponus Ridge Middle School, Norwalk Public Schools
Teresa Giegengack	Assistant Director, Client Services, Westport Department of Human Services
Dr. Katherine Golar	Chief Medical Officer, Norwalk Community Health Center
Ann Goldblatt	Community Resident
Art Goldblatt	Community Resident
Favian Gonzales	Community Resident
Zeronia Gordon	Community Resident
Karen Gottlieb	Executive Director, AmeriCares
Stuart Greenbaum	Executive Director, Mid-Fairfield Child Guidance Center
Kim Guinta	Rewards Manager, Diageo, Inc.
Henner Gutierrez	Community Resident
Sally Harding	Director of Client Services, ElderHouse
Dick Harris	Director of Harbor Watch, Earthplace Harbor Watch Program
Marty Hauhuth	Executive Director, Positive Directions
Hope Hetherington	Chair, Interagency and Partnership Advisory Panel on Lupus
Tyler Hiller	Community Resident
Laura Howell	Community Resident
Lauren Hughes	Coordinator Senior Services, Wilton Department of Social Services
Liz Inca	Community Resident
Michele Jakab	Outreach Director, Norwalk Senior Center
Damaris Jimenez	Community Resident
Giovanni Jimenez	Community Resident
Praveen John	Lieutenant, Norwalk Police Department
Lenore Jordan	Community Resident
Gordon Joseloff	First Selectman, Town of Westport
Bob Kalina	Vice President, Human Resources, Financial Accounting Foundation
Kayla Kessler	Community Resident
David Knauf	Director of Health, Darien Health Department
Anastasia Koskorelos	Community Resident
Tom Kulhawik	Police Chief, Norwalk Police Department
Ken Lalime	Member, Norwalk Board of Health
Janine Lane	Teacher, Fox Run Elementary School, Norwalk Public Schools
Molly Larson	Public Health Nurse, Darien Health Department
Curtis Law	Director, Norwalk Housing Authority
M. Lawson	Community Resident
Jon Lawson	Community Resident
Barbara Lialios	School Nurse, Brien McMahon High School, Norwalk Public Schools
Stephanie Linton	Community Resident
Angelica M. Llanos	Community Resident
Ana P. Lopez	Community Resident

Maria Loya	Community Resident
Robert Mallozzi	First Selectman, Town of New Canaan
Rocio Marcelino	Community Resident
Abel Marcelino	Community Resident
Dr. Susan Marks	Superintendent, Norwalk Public Schools
Patricia Marsden-Kish	Planning Facilitator, Choice Neighborhoods, Norwalk Housing Authority
Graciela Martinez	Community Resident
Elda Mas-Portillo	Community Resident
Candace Mayer	Deputy Director, Norwalk Housing Authority
Dr. Eric Mazur	Vice President and Chief Medical Officer, Norwalk Hospital
Barbara McCabe	APRN, Clinic Director, AmeriCares
Bridget McCallum	Community Resident
David McCarthy	Councilman, Norwalk Common Council
Patricia McCrae	Community Resident
Carol McDonald	Director of Human Services, Town of New Canaan
Shawn Mee	Regional Manager, Mutual Security Credit Union
Dr. Katherine Michael	Chair, Department of Psychiatry, Norwalk Hospital
Richard Moccia	Mayor, City of Norwalk
Elayne Mordoff	Community Resident
Georgina Morgan	Community Resident
Ed Musante	President, Greater Norwalk Chamber of Commerce
Ed Nadriczny	Chief of Police, New Canaan Police Department
Jane Nyce	Executive Director, Staying Put, New Canaan
Brody O'Brien	Community Resident
Dr. Jason Orlinick	Hospitalist, NHPS
Lilian Ortega	Community Resident
Paul Palermo	Executive Director, Norwalk Senior Center/MOW
Mike Parlanti	Community Resident
Ricardo Partida	Community Resident
Veronica Partida	Community Resident
Merlin Perez	Community Resident
Christy Perone	Sales and Marketing Manager, Brookdale Place, Wilton
Tia Perry	Community Resident
Susan Pfister	Director, Department of Human Services, Westport
Catherine Pierce	Municipal Agent, Wilton Department of Social Services
Justin Poruban	Community Resident
Terry Quell	Member, Norwalk Board of Health
Jessica Reardon	Special Education Teacher, Darien Public Schools
David Reed	Director of Health, Town of New Canaan
Joseph Riker	Executive Director, CT Renaissance
Milagros Rivera	Community Resident
Francine Robert	Community Resident
Ramiro Rojo	Community Resident
Ellen Ryan	Director of School Health Services, Darien Public Schools
Juliette Salazar	Community Resident
Angelica Sanchez	Community Resident
Juana Sanchez	Community Resident
Maricela Sanchez	Community Resident

Rachel Satter	Teacher, Holmes Elementary School, Darien Public Schools
Mary Scalise	School Psychologist, Darien Public Schools
Brad Schmidt	Community Resident
Ed Schwartz	Officer, Norwalk Police Department
Libby Scott	Community Resident
Rose Sellers	Community Resident
Kristin Sinatra	Director of Marketing, Waveny Care Network
Yolanda Skinner	NAACP Health Chair
Dr. Vicki Smetak	Pediatric Chairman, Norwalk Hospital
Eileen Smith	Executive Director, Soundview Medical Associates
Yary Solano	Community Resident
Audrey Spellman	Special Educator, Family First Early Intervention Project
Jayne Stevenson	First Selectman, Town of Darien
Jane Stikkel	Clinical Supervisor, Connecticut Hospice
George Taube	Community Resident
Marcha Taube	Community Resident
Mary Ann Tessier	Professor and Chair of Nursing, Norwalk Community College
Rudean Thomas	Community Resident
Tanasia Ticking	Community Resident
Dr. Ed Tracey	Member, Norwalk Board of Health
Terry Tumpane	Administrator, Waveny Home Health
Sarah Turbert	Director of Youth Developmental Services, Norwalk YMCA
Chet Valiante	Publisher/COO, The Hour Publishing Company
Lynn VanDeusen	Community Resident
Aideen Vergara	Occupational Health Nurse Practitioner, GE Capital/Norwalk Hospital
Danielle Waddell	Community Resident
Denise Walsh	Chair, Fairfield Board of Health
Gayle Weinstein	First Selectman, Town of Weston
Ruthann Walsh	Director of Corporate Citizenship, Pepperidge Farm
Monica Wheeler	Director of Community Health, Westport Weston Health District
Valerie Williams	Executive Director, Keystone House
Shawn Wong Won	Community Police Lieutenant, Norwalk Police Department
Darlene Young	Mentoring Program Coordinator, City of Norwalk
Bethany Zaro	Public Health Nurse, New Canaan Health Department
Mariel Zeccola	APRN, Pediatric Development & Therapy Center, Norwalk Hospital

APPENDIX C: CHIP PLANNING SESSION WORKGROUP MEMBERS

Mental Health Work Group

Hollie Bentham-Rice	Disabilities and Mental Health Manager, NEON Child Development Program
Michele Bullock	Manager of Patient Access, St. Vincent's Behavioral Health
Angelica Camacho	Behavioral Health Coordinator, Day Street Community Health Center
Rhonda Capuano	Director, Dr. Robert E. Appleby School Based Health Centers, Human Services Council
Yohanna Cifuentes	Senior Bilingual Clinician, Mid-Fairfield Child Guidance Center
Larry Cross	Chief Executive Officer, Norwalk Community Health Center
Carol Frank	Chair, Norwalk Human Relations Commission
Jim Garland	COO /CFO, Norwalk YMCA
Shaun Mee	Regional Manager, Mutual Security Credit
Kim O'Rielly	Executive Director, Southwest Regional Mental Health Board
Toni Petrucci	Manager Hospitality Services, Norwalk Hospital
Ellen Rogan	Director, Department of Psychiatry, Norwalk Hospital
Valerie Williams	Executive Director, Keystone House
Mariel Zeccola	APRN, Norwalk Hospital, Pediatric Development & Therapy Center

Obesity Work Group

Theresa Argondezzi	Health Educator, Norwalk Health Department
Maria Borges-Lopez	Board of Trustees, Norwalk Hospital
Michael Case	CEO, Norwalk YMCA
Patricia DiPietro	Business Manager, Norwalk Health Department
Karen Gottlieb	Executive Director, AmeriCares
Darleen Hoffer	Clinical Supervisor, Norwalk Health Department
Jim Garland	COO/CFO, Norwalk YMCA
Dr. Janet Karpiak	Pediatrics, Norwalk Hospital & Norwalk Board of Health
Kimberly Kuta	Director of Research & Evaluation, Stepping Stones Museum for Children
Barbara McCabe	APRN, Clinic Director, AmeriCares
Barry McGovern	Associate Executive Director, Keystone House
Peter McKnight	Manager, Clinical Nutrition Services, Norwalk Hospital
Erin Moriarty	NEON Development Center
Judy Prager	Nutrition Consultant, NEON Child Development Program
Amy Taylor	Administrative Assistant to the Director, Day Street Community Health Center
Jeryl Topalian	Director of Planning & Business Development, Norwalk Hospital
Ruthann Walsh	Director, Corporate Citizenship, Pepperidge Farm
Monica Wheeler	Director of Community Health, Westport Weston Health District

CHIP Planning Session Workgroup Members - continued

Substance Abuse Work Group

Eva Beau	Community Outreach Coordinator, Norwalk Community Health Center
Rowena Bergmans	Consultant, Norwalk Hospital
Donna Glen	Senior Analyst, Planning & Business Development, Norwalk Hospital
Lauren Hughes	Coordinator, Senior Services, Wilton Department of Social Services
Alan Mathis	President & CEO, Liberation Programs, Inc.
Dr. Katherine Michael	Chairman, Department of Psychiatry, Norwalk Hospital
Linda Mosel	Chief Operating Officer of Outpatient Services, CT Renaissance
Coral Presti	Interim Director of Nursing and Allied Health, Norwalk Community College

APPENDIX D: GLOSSARY OF CHIP TERMS

Goals - identify in broad terms how the efforts will change things to solve identified problems

Objectives - measurable statements of change that specify an expected result and timeline, objectives build toward achieving the goals

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

Outcome Indicators - the changes that occur at the community level as a result of completion of the strategies and actions taken

Output Indicators - specific deliverables that are the result of the completion of the strategies and actions taken

Priority Areas - broad issues that pose problems for the community

APPENDIX E: ADDITIONAL DATA TABLES

DEMOGRAPHICS AND SOCIAL DETERMINANTS

Table A: Population Change by Age in Connecticut, Greater Norwalk Area, and Towns, 2000 and 2010

	Pop Change Number	Pop % Change	% Change Age 0-14	% Change Age 15-24	% Change Age 25-64	% Change Age 65+
Norwalk	2,652	3.2%	0.3%	11.2%	2.7%	3.3%
New Canaan	343	1.8%	-3.5%	40.9%	-2.5%	6.4%
Westport	642	2.5%	1.1%	52.8%	-4.6%	8.8%
Weston	142	1.4%	-9.5%	59.7%	-2.8%	15.1%
Wilton	429	2.4%	-3.7%	44.1%	-3.2%	16.1%
Darien	1,125	5.7%	8.4%	55.4%	0.0%	-2.4%
Fairfield	2,064	3.6%	7.1%	22.1%	0.0%	-4.6%
Greater Norwalk Area	7,397	3.2%	1.5%	25.9%	0.0%	2.7%
Connecticut	168,532	4.9%	-6.2%	18.4%	5.6%	7.7%

SOURCE: U.S. Census Bureau, 2000 Decennial Census and 2010 American Community Survey

Table B: Population Change by Racial/Ethnic Group in Connecticut, Greater Norwalk Area, and Towns, 2000 and 2010

	Pop Change Number	% Pop Change	White (% change)	Black (% Change)	Asian (% change)	Other/ Multiple (% change)	Hispanic (any race) (% change)
Norwalk	2,652	3.2%	-4.1%	-3.8%	51.8%	67.9%	60.2%
New Canaan	343	1.8%	0.0%	-2.0%	49.0%	46.0%	68.6%
Westport	642	2.5%	-0.3%	4.5%	67.5%	85.4%	54.8%
Weston	142	1.4%	-1.5%	48.9%	51.3%	101.4%	63.1%
Wilton	429	2.4%	-1.1%	69.8%	74.5%	89.8%	99.6%
Darien	1,125	5.7%	3.7%	16.9%	57.0%	64.9%	73.2%
Fairfield	2,064	3.6%	-0.4%	74.8%	88.1%	85.9%	123.8%
Greater Norwalk Area	7,397	3.2%	-1.2%	0.9%	62.4%	70.9%	66.5%
Connecticut	168,532	4.9%	-0.3%	16.9%	64.7%	30.4%	49.6%

SOURCE: U.S. Census Bureau, 2000 Decennial Census and 2010 American Community Survey

Table C: Foreclosures, Connecticut, Greater Norwalk Area, and Towns, 2010

	Housing Units	# Foreclosure Filings	# Foreclosure Filings per 1,000 units
Norwalk	38,025	138	3.63
New Canaan	7,203	12	1.67
Westport	10,243	18	1.76
Weston	3,507	11	3.14
Wilton	6,197	11	1.78
Darien	7,051	14	1.99
Fairfield	20,537	51	2.48
Greater Norwalk Area	92,763	255	2.75
Connecticut	1,475,657	6,582	4.46

SOURCE: Connecticut Housing Finance Agency

Table D: Home Sales, Connecticut, Greater Norwalk Area, and Towns, 2010

	Housing Units	# Single-Family Home Sales	# Home Sales per 1,000 units	Median Sale Price	Town Sale Price as Percent of Connecticut Median
Norwalk	38,025	848	22.30	365,000	166
New Canaan	7,203	290	40.26	1,250,000	568
Westport	10,243	444	43.35	950,000	432
Weston	3,507	141	40.21	800,000	364
Wilton	6,197	221	35.66	729,000	331
Darien	7,051	291	41.27	1,250,000	568
Fairfield	20,537	793	38.61	480,000	518
Greater Norwalk Area	92,763	3,028	32.64	631,808	300
Connecticut	1,475,657	36,798	24.94	220,000	100

SOURCE: Connecticut Housing Finance Agency

Table E: Public Assistance and Food Stamps, Connecticut, Greater Norwalk Area, and Towns, 2010

	Households	With cash public assistance income (and FS if received) (%)	SNAP/Food Stamps Only (%)	With cash public assistance or Food Stamps/SNAP (%)
Norwalk	35,133	2.9	2.9	5.8
New Canaan	6,767	0.2	2.2	2.4
Westport	9,302	0.5	0.3	0.8
Weston	3,270	0.9	0.0	0.9
Wilton	5,994	0.6	0.2	0.8
Darien	6,713	1.1	0.6	1.7
Fairfield	19,220	1.0	1.4	2.4
Greater Norwalk Area	86,399	1.6	1.8	3.4
Connecticut	1,359,218	2.6	5.4	8.0

SOURCE: Source: U.S. Census Bureau, 2010 American Community Survey

Table F: Employment by Occupational Categories, Connecticut, Greater Norwalk Area, and Towns, 2010

	Management, Business, Science and Arts	Services	Sales and Office Occupations	Natural Resources	Production
Norwalk	40.2	16.2	27.0	9.6	7.1
New Canaan	59.7	7.3	28.6	3.0	1.4
Westport	64.7	6.4	24.8	2.7	1.5
Weston	71.0	4.8	18.6	2.8	2.8
Wilton	61.0	7.8	24.3	3.5	3.4
Darien	64.5	3.7	26.1	4.2	1.4
Fairfield	51.5	11.4	28.5	4.9	3.8
Greater Norwalk Area	51.1	11.5	26.7	6.2	4.5
Connecticut	40.0	16.8	25.0	8.0	10.2

SOURCE: U.S. Census Bureau, 2010 American Community Survey

Table G: Employment by Industry Sectors 2010 - Broad Classifications, Connecticut, Greater Norwalk Area, and Towns, 2010

	Norwalk	New Canaan	Westport	Weston	Wilton	Darien	Fairfield	Greater Norwalk Area	Connecticut
Agriculture	0.2	0.2	0	0	0.3	0.1	0.5	0.2	0.4
Construction	7.9	4.4	4	3.6	5	4.2	5.6	6.1	6.4
Manufacturing	8.4	4.5	5.6	3.8	8.2	6.1	7.7	7.3	11.8
Wholesale	2.8	2.7	3.2	3.3	1.7	2.4	2.6	2.7	2.7
Retail	11.9	8.6	8.4	7.4	8	6.1	9.7	9.9	11.1
Transport and Utilities	3.2	2	1	1.8	1.7	1.2	2.5	2.4	3.8
Information	3.7	4.5	3.3	6.5	4.5	4.9	4.1	4.1	2.6
Finance and Real Estate	11.3	25.4	22.8	20.1	21	34.9	14.1	16.8	9.5
Professional, Scientific and Management	16.8	20.7	22.5	22.4	22.9	18.7	15.7	18.2	10.7
Education, Health and Social Services	19.1	16.1	16.6	19	16.7	12.1	22.4	18.8	24.9
Entertainment, Hotel, Food Service	6.9	4.8	6.2	4.7	4.7	4.2	7.4	6.4	8
Public Administration	5.9	3.7	4.4	4	4	3.4	4.2	4.8	4.5
Other Services	1.8	2.4	2	3.3	1.3	1.7	3.4	2.3	3.8

SOURCE: U.S. Census Bureau, 2010 American Community Survey

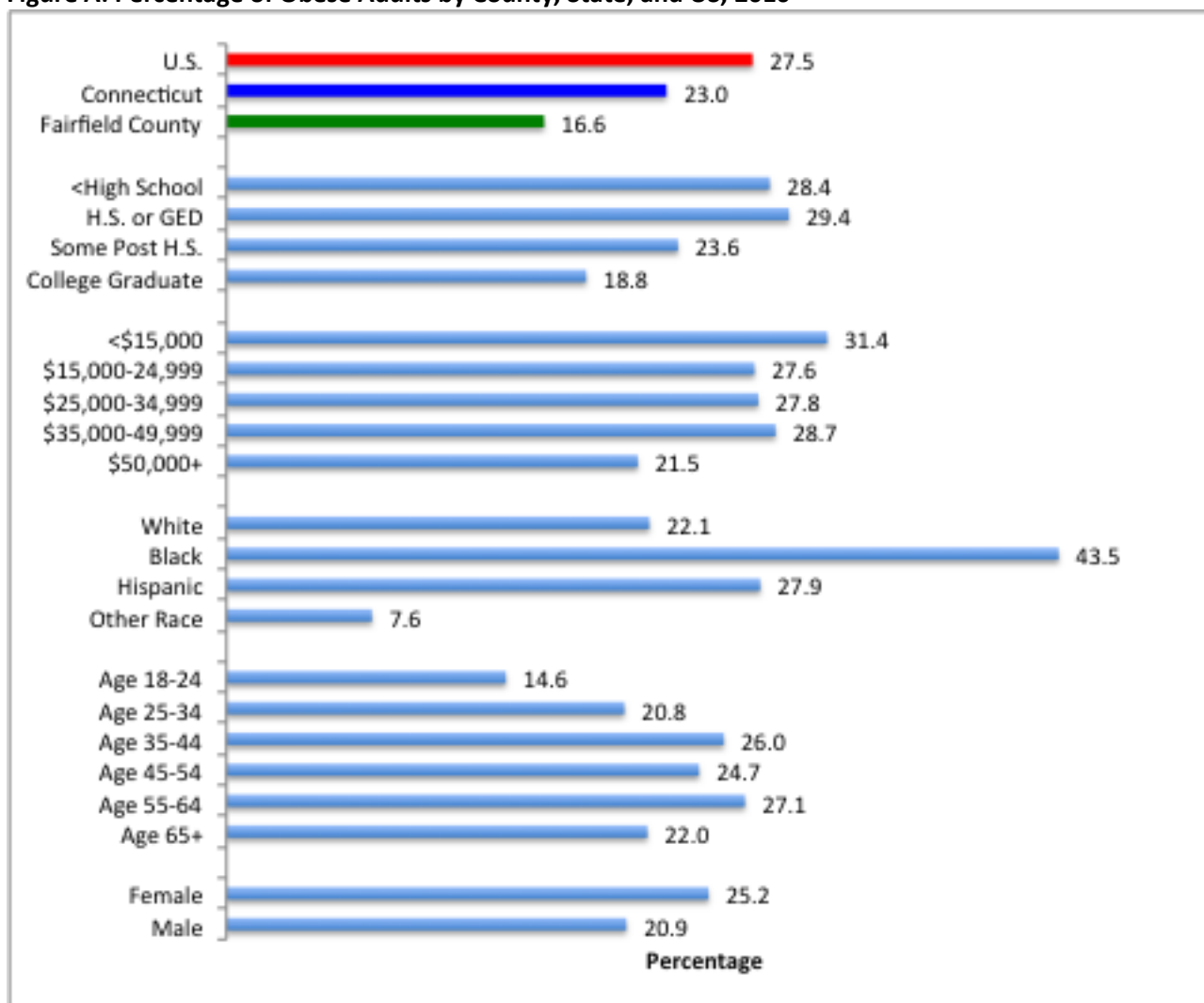
Table H: Crime Rate per 1,000 Population, Connecticut, Greater Norwalk Area, and Towns, 2010

	Crime Rate (# per 1,000)	Crimes Against Persons (# per 1,000)	Crimes Against Property (# per 1,000)
Norwalk	25.62	3.94	21.68
New Canaan	6.78	0.05	6.73
Westport	15.14	0.52	14.62
Weston	6.55	0.09	6.46
Wilton	5.24	0.00	5.24
Darien	7.10	0.05	7.05
Fairfield	18.00	0.60	17.40
Greater Norwalk Area	17.09	1.62	15.47
Connecticut	24.79	2.70	22.09

SOURCE: Source: Connecticut Uniform Crime Data retrieved 5-16-12 from <http://www.dpsdata.ct.gov/dps/ucr/ucr.aspx> Crimes against persons: murder, rape, robbery and aggravated assault. Crimes against property: burglary, larceny, and motor vehicle theft.

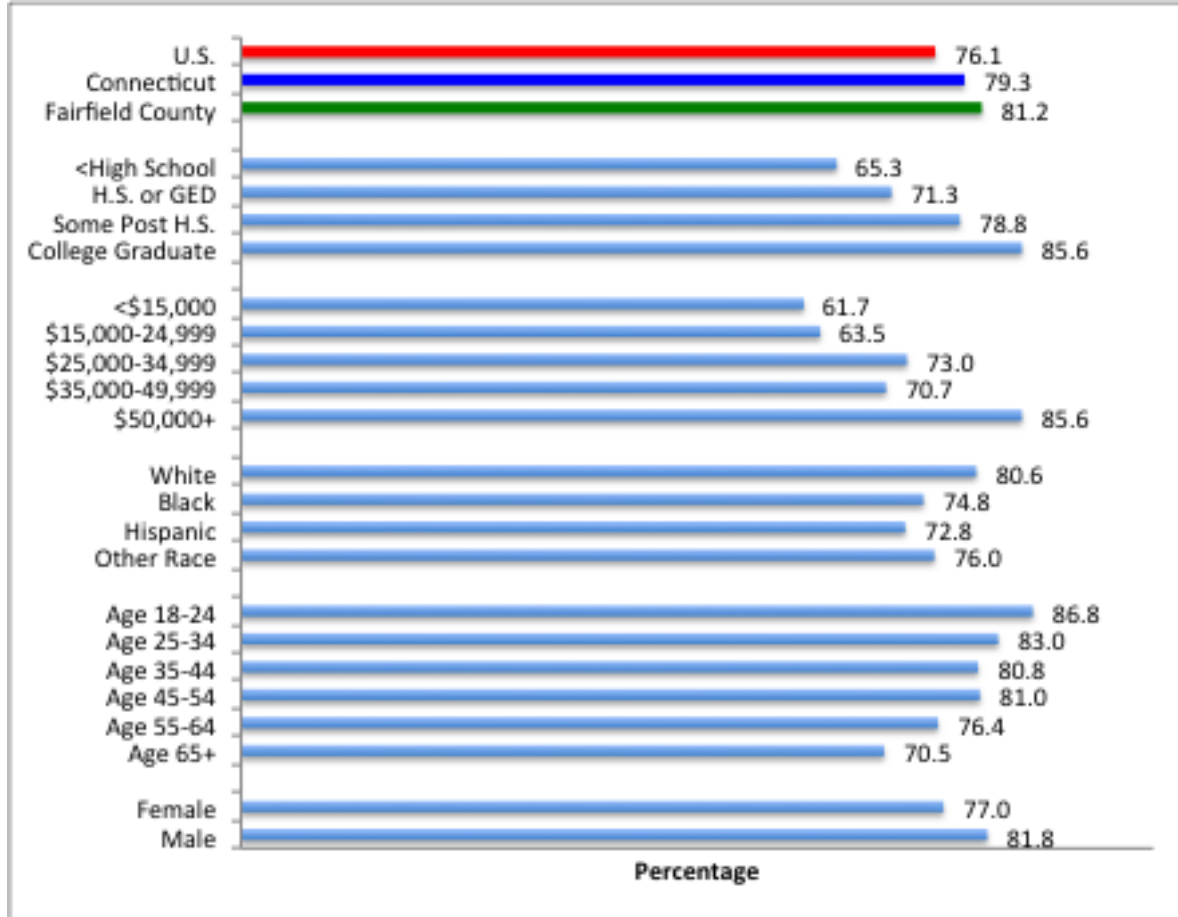
HEALTH BEHAVIORS – ADULTS

Figure A: Percentage of Obese Adults by County, State, and US, 2010



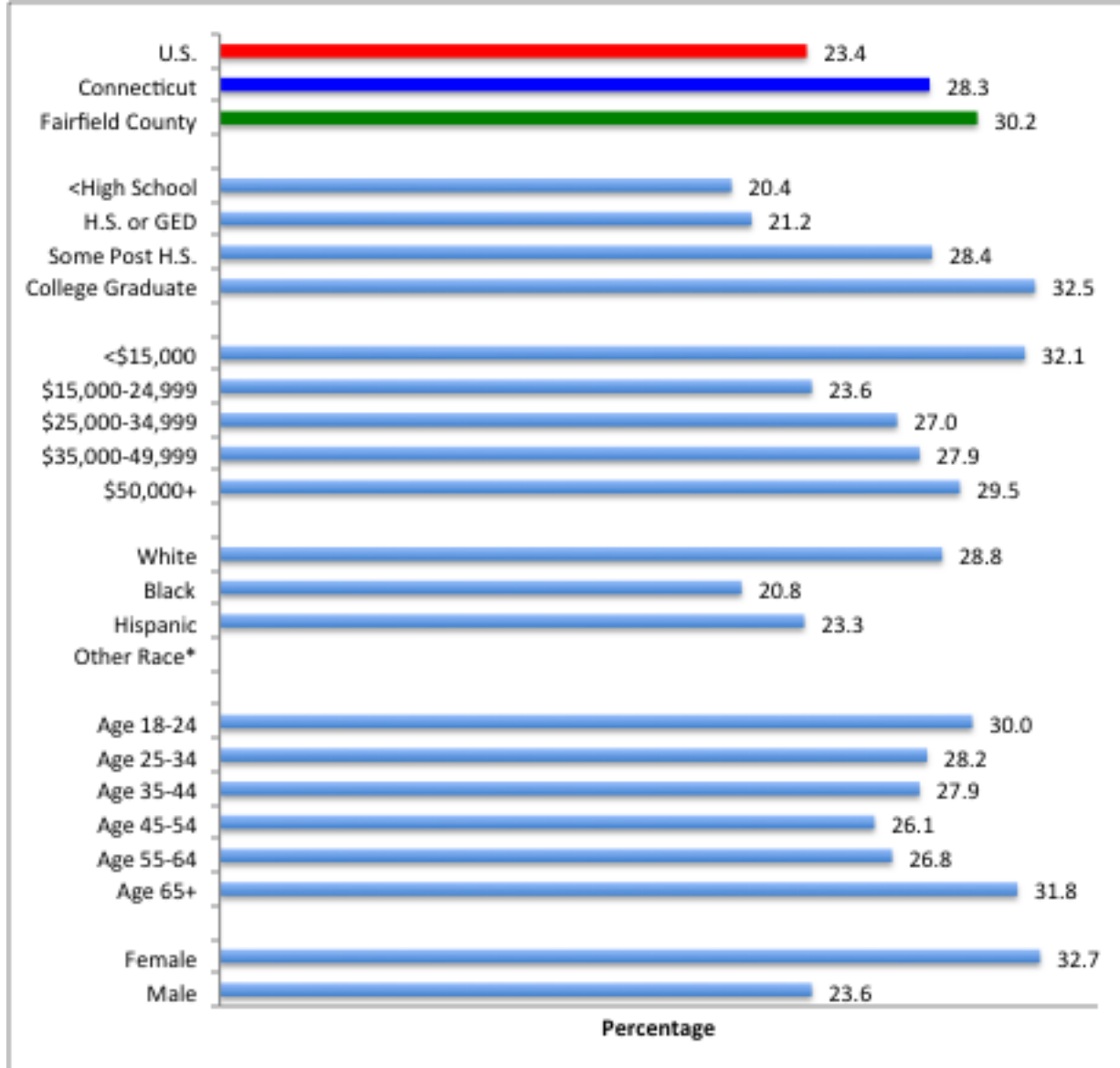
SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Weight classification by Body Mass Index (BMI) – Obese defined as BMI of 30.0 - 99.8. Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

Figure B: Percentage of Adults Reporting Physical Activity in the Past Month by County, State, and US, 2010



SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakdowns for Fairfield County are not available due to small sample size.

Figure C: Percentage of Adults Reporting Recommended Daily Fruit and Vegetable Consumption by County, State, and US, 2009

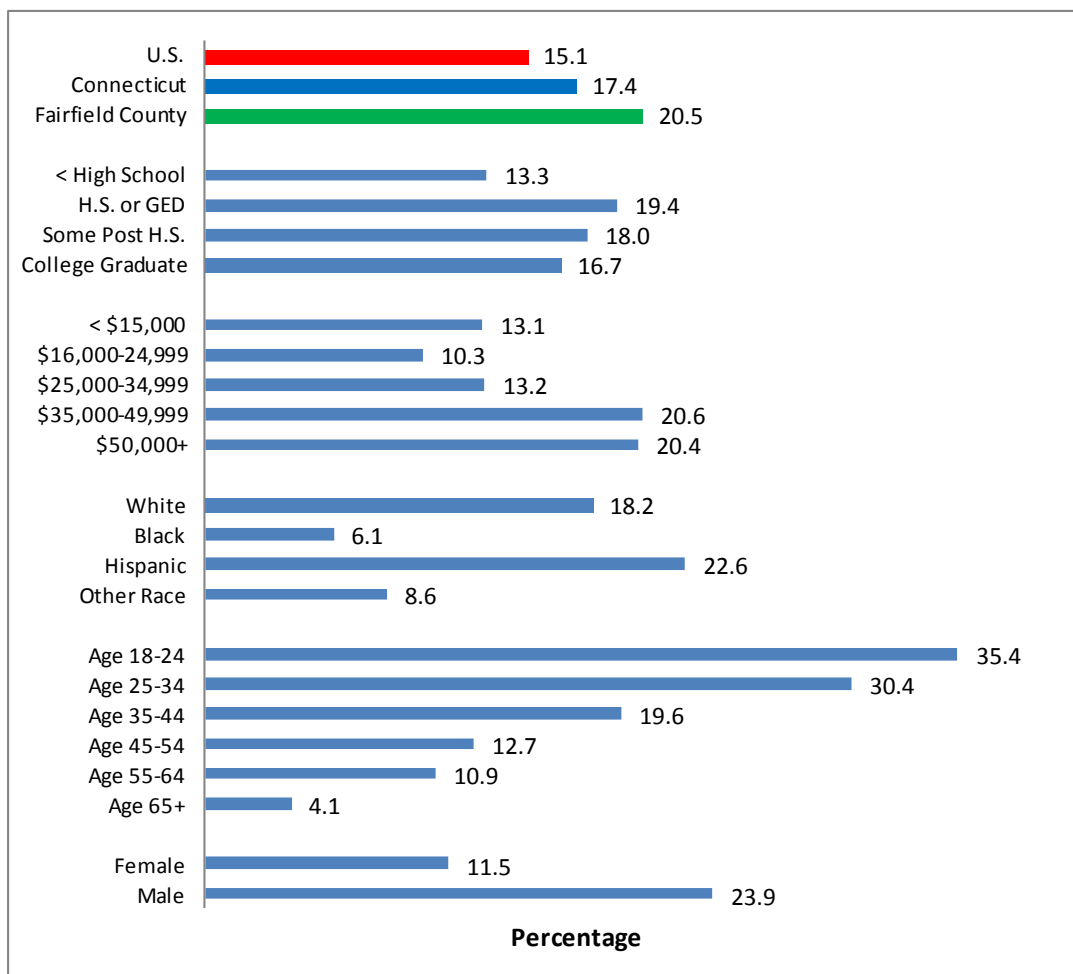


SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Recommended daily fruit and vegetable consumption for adults is defined as consuming fruits and vegetables five or more times per day. Demographic data is for State of Connecticut.

Demographic breakouts for Fairfield County are not available due to small sample size.

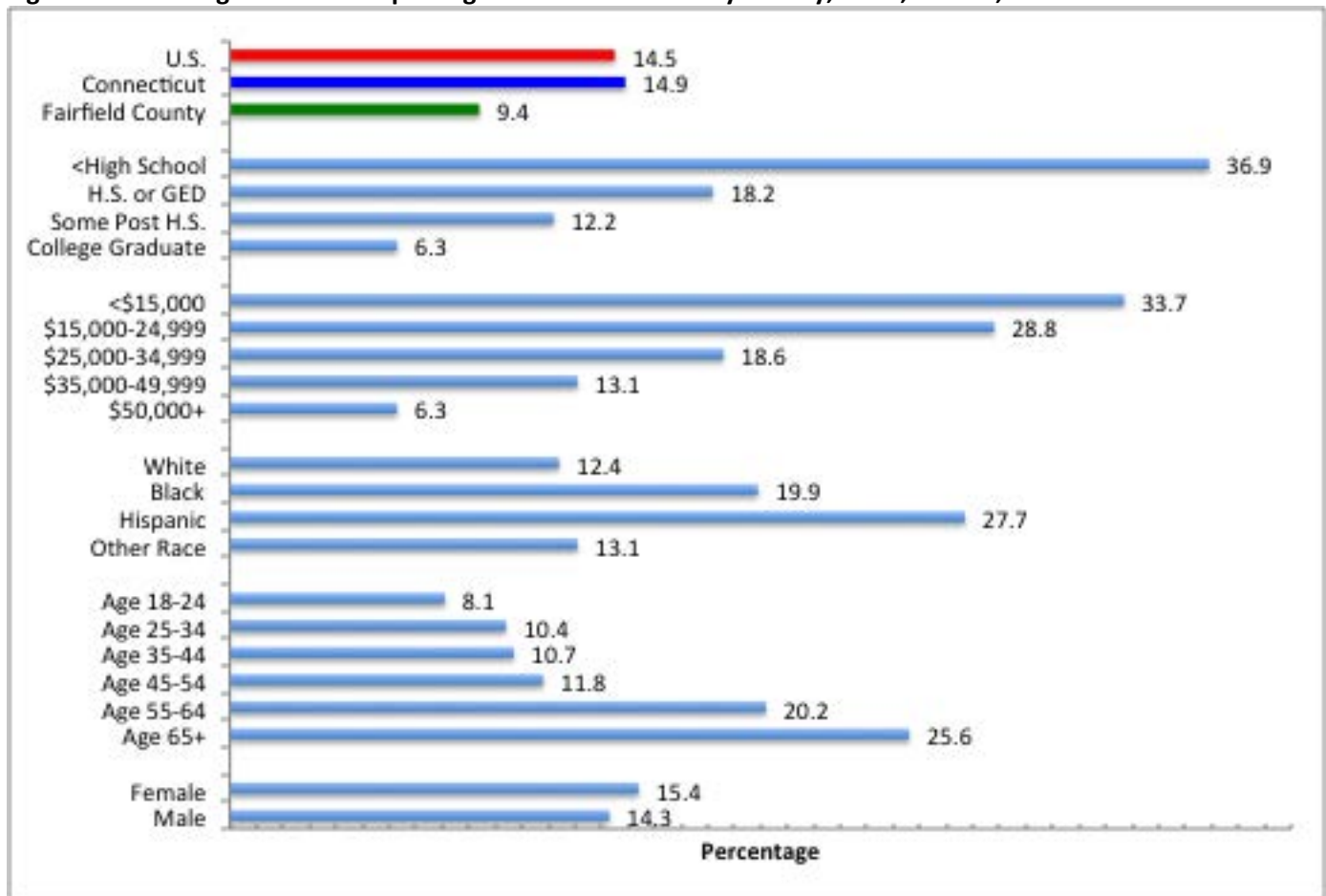
* Not available because the unweighted sample size for the denominator was < 50 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

Figure D: Percentage of Adults Reporting Binge Drinking by County, State, and US, 2010



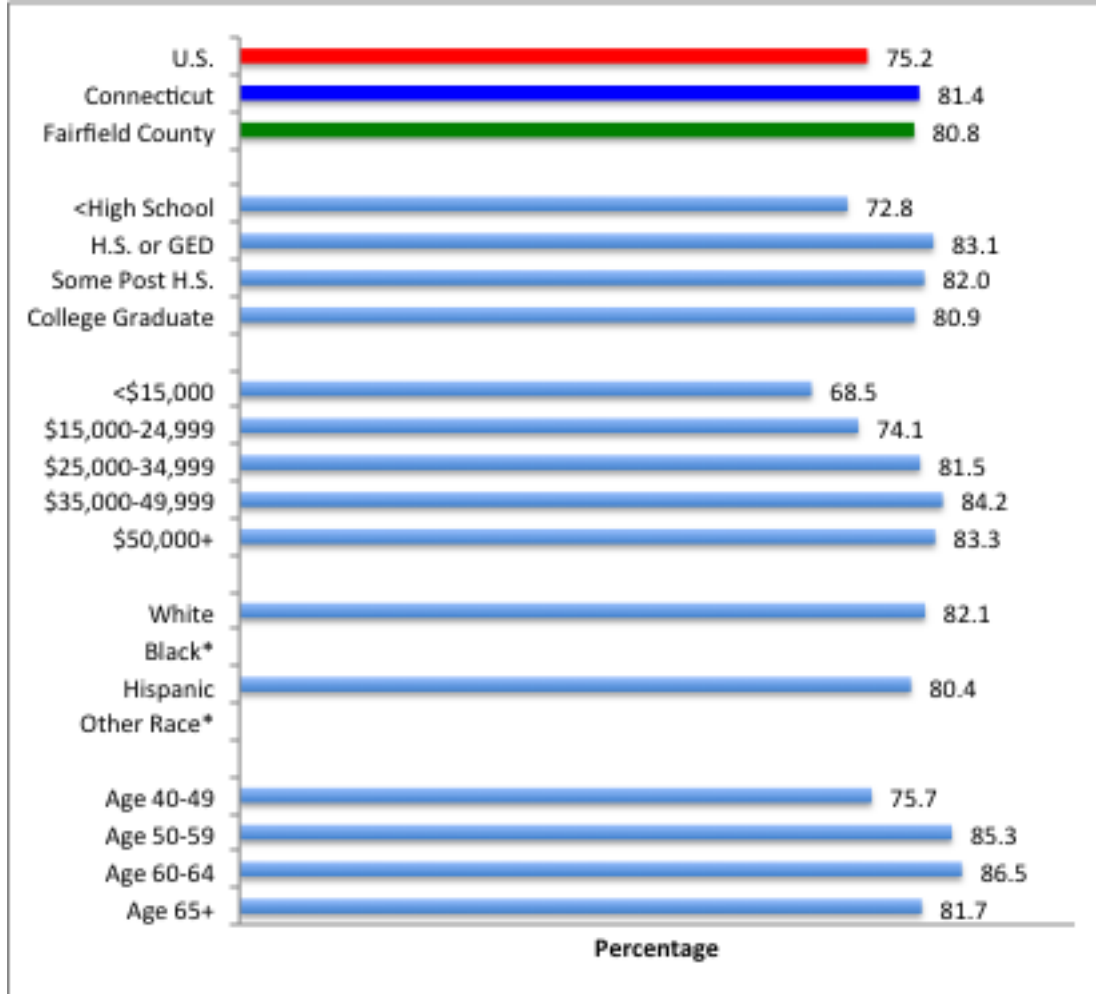
SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Binge drinkers (males having five or more drinks on one occasion, females having four or more drinks on one occasion) Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

Figure E: Percentage of Adults Reporting Fair or Poor Health by County, State, and US, 2010



SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

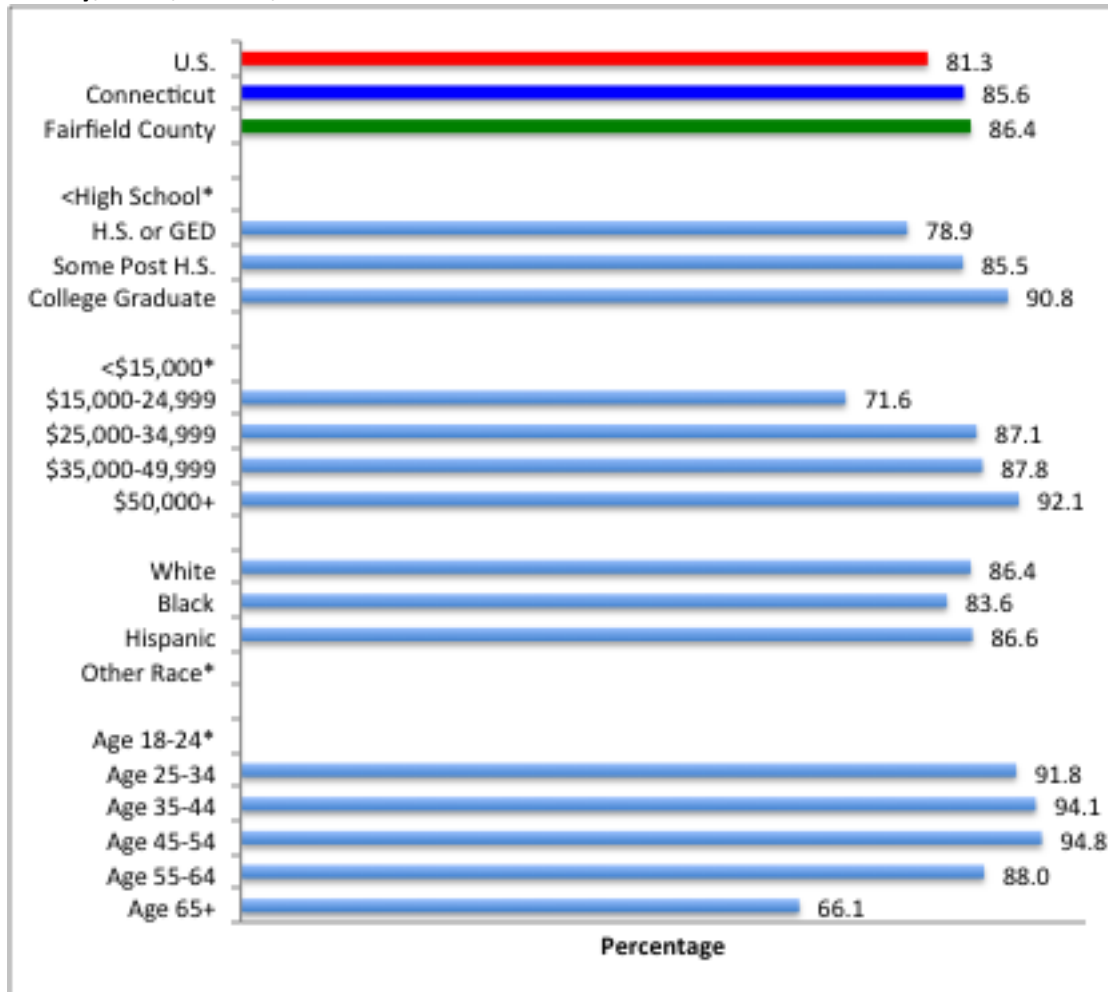
Figure F: Percentage of Women Aged 40+ whom Reported Having a Mammogram in Past 2 Years by County, State, and US, 2010



SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

* Not available because the unweighted sample size for the denominator was < 50 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

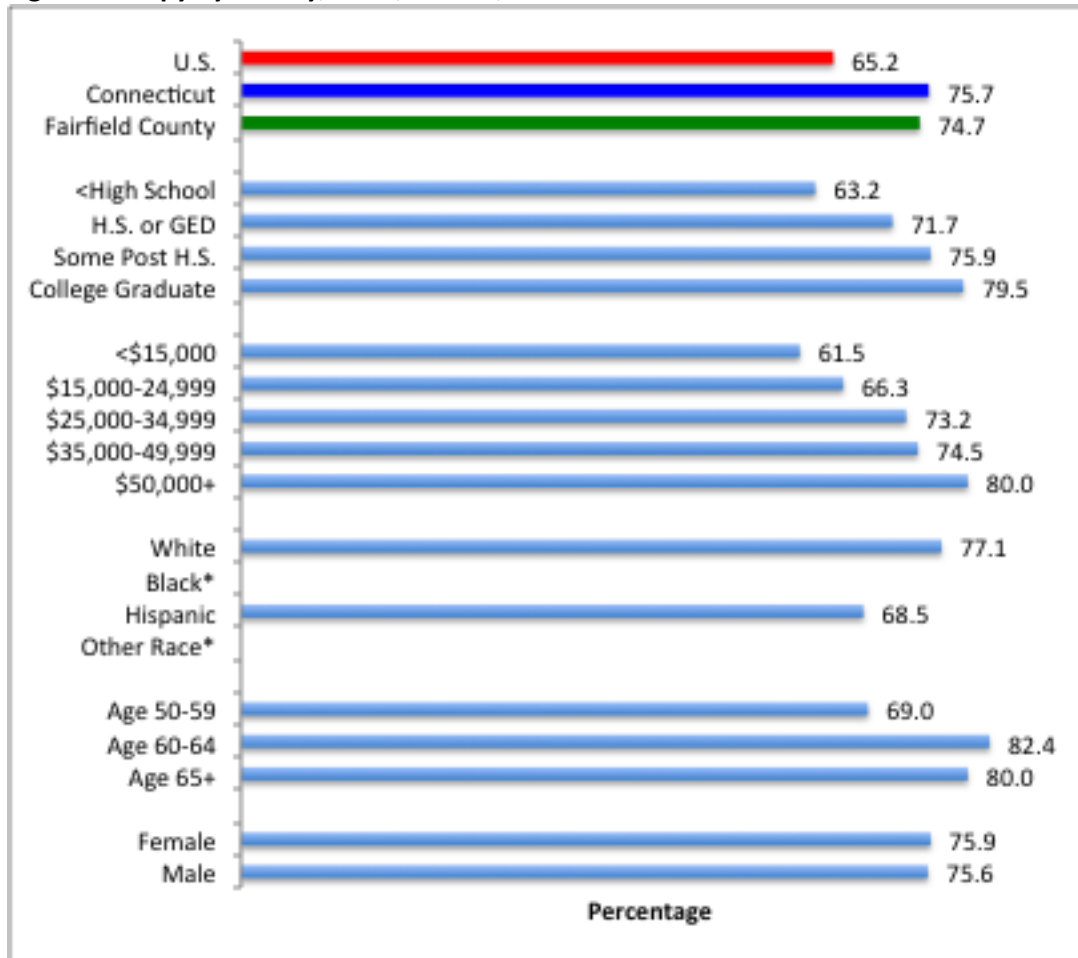
Figure G: Percentage of Women Aged 18+ whom Reported Having a Pap test in Past 3 Years by County, State, and US, 2010



SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakdowns for Fairfield County are not available due to small sample size.

* Not available because the unweighted sample size for the denominator was < 50 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

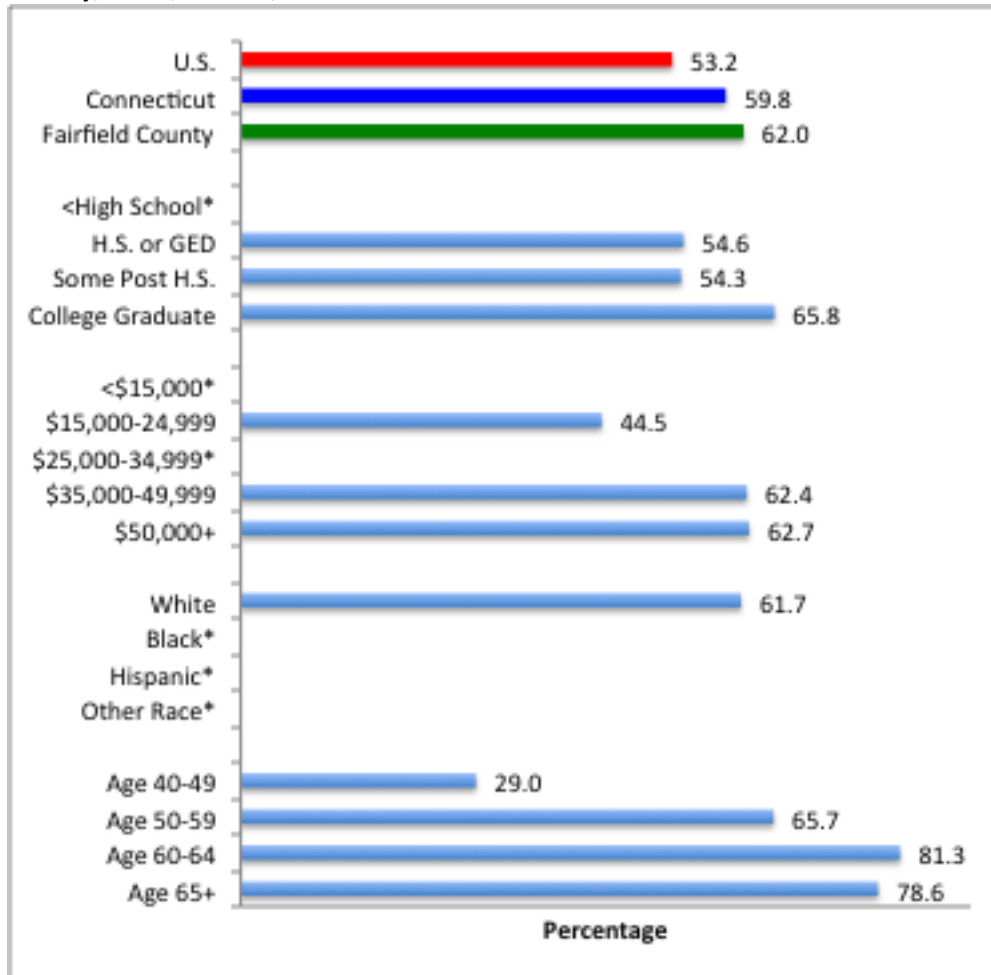
Figure H: Percentage of Adults Aged 50+ whom Reported Having Ever had a Colonoscopy or Sigmoidoscopy by County, State, and US, 2010



SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

* Not available because the unweighted sample size for the denominator was < 50 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

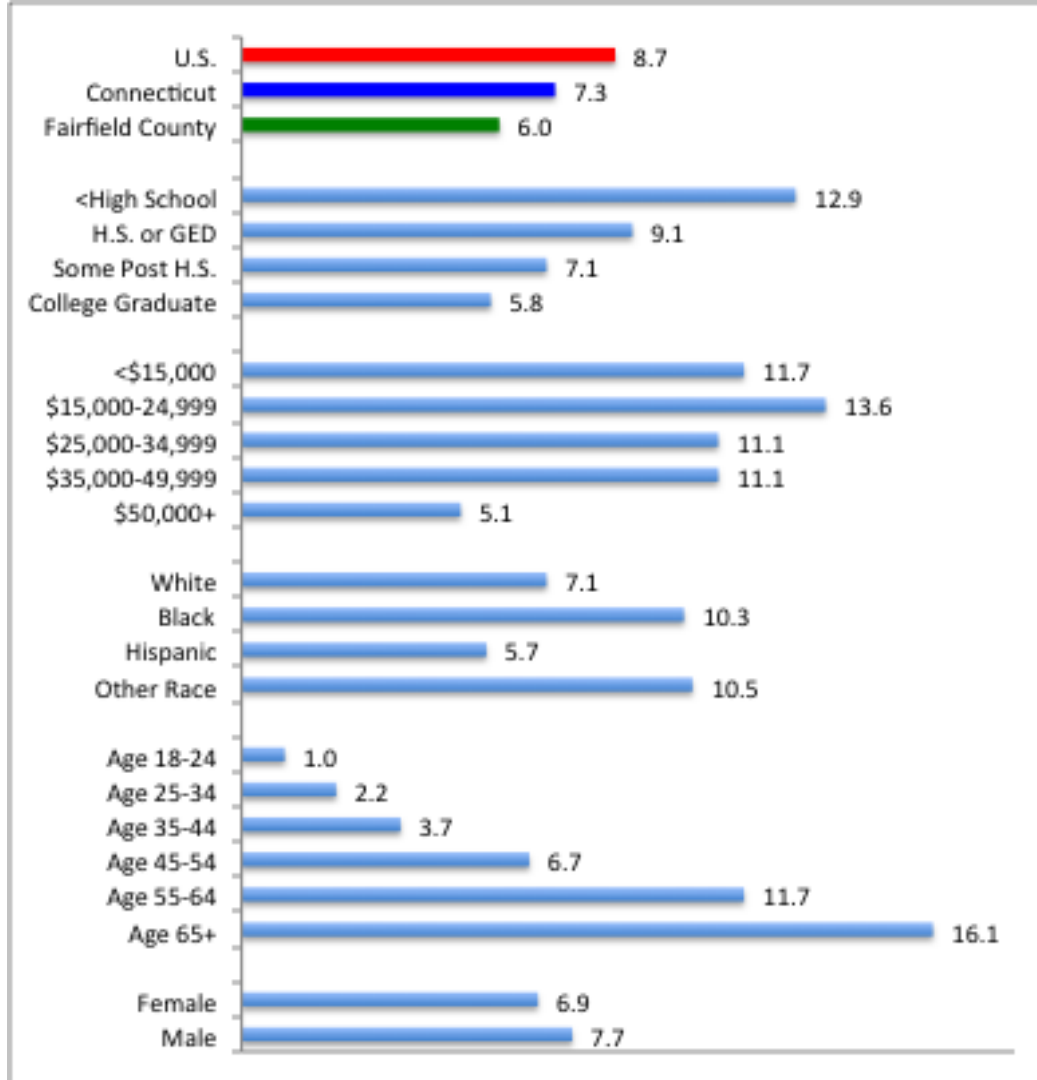
Figure I: Percentage of Men Aged 40+ whom Reported Having a PSA Test in the Past 2 Years by County, State, and US, 2010



SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakdowns for Fairfield County are not available due to small sample size.

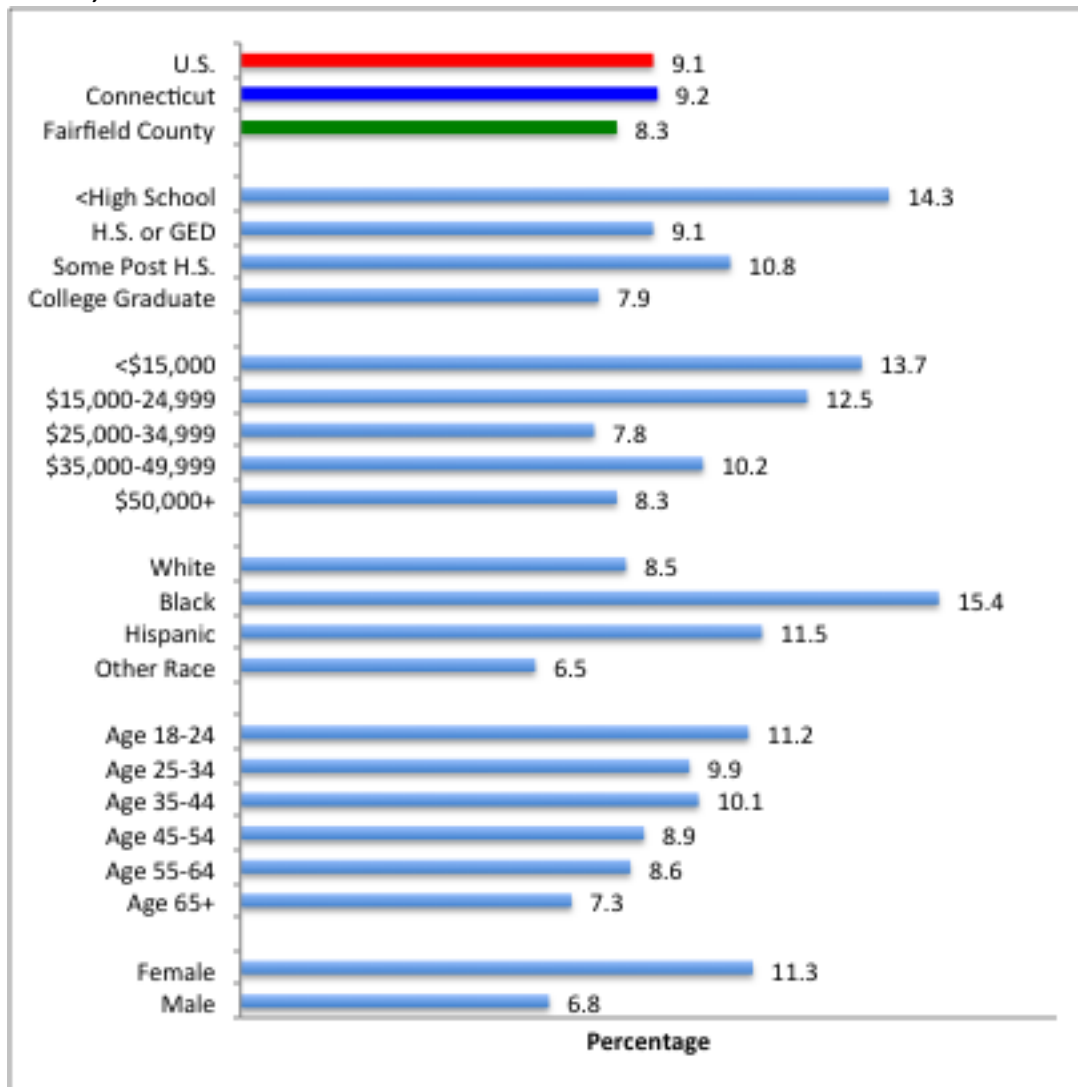
* Not available because the unweighted sample size for the denominator was < 50 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

Figure J: Percentage of Adults Who Have Ever Been Told They Have Diabetes by County, State, and US, 2010



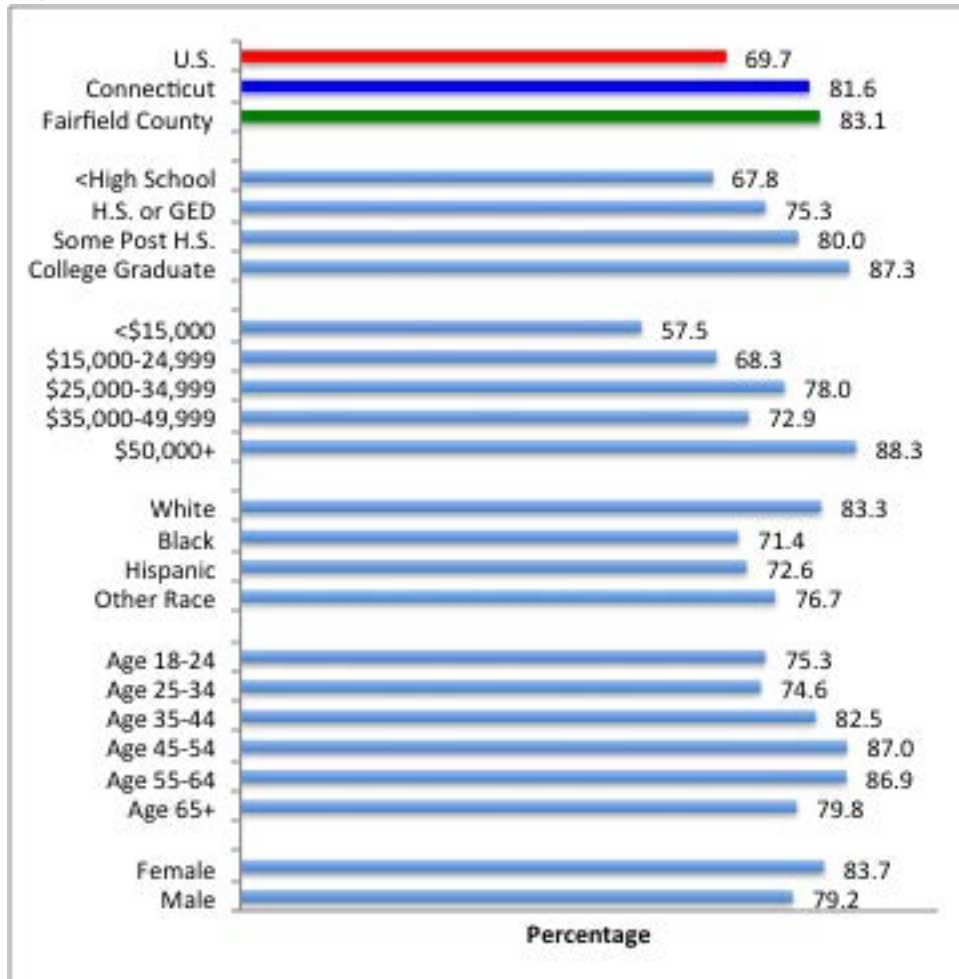
SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

Figure K: Percentage of Adults Who Reported Being told they Currently have Asthma by County, State, and US, 2010



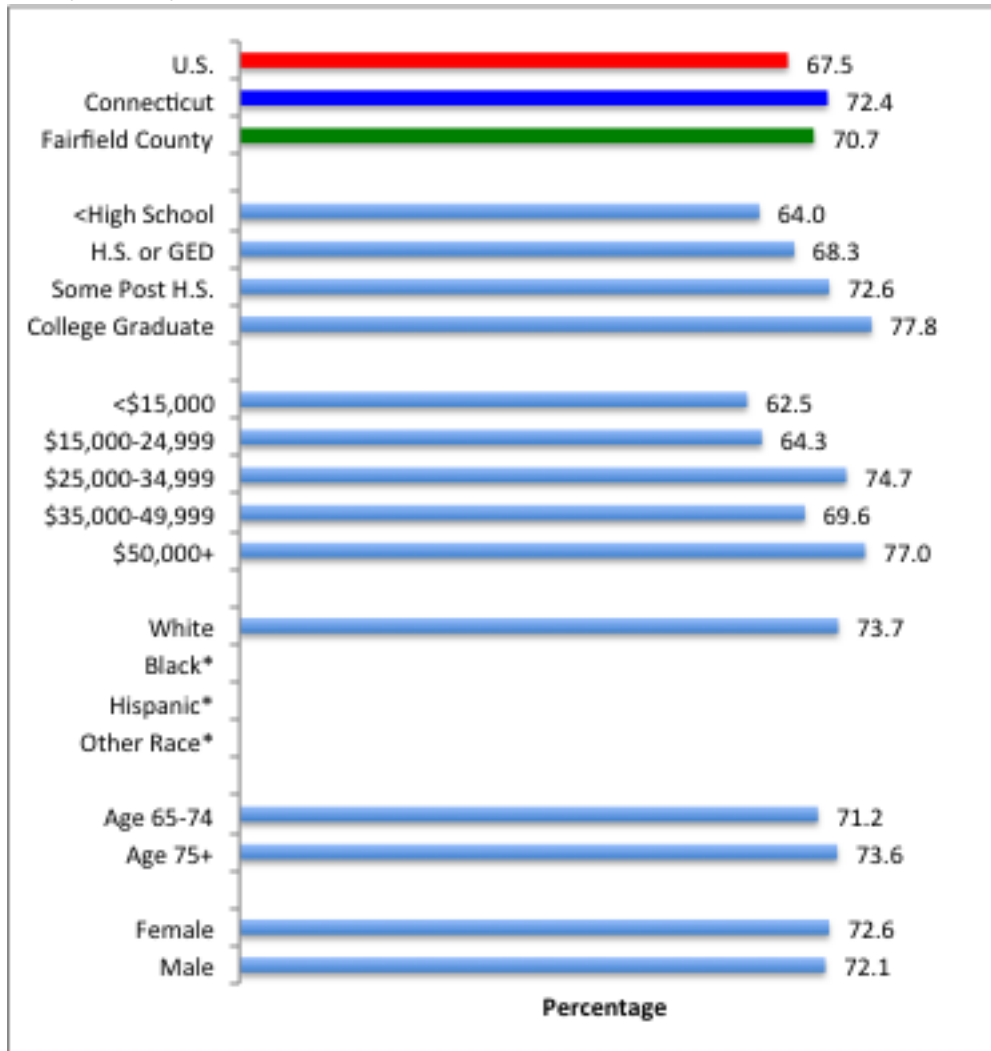
SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakdowns for Fairfield County are not available due to small sample size.

Figure L: Percentage of Adults Who Reported Visiting a Dentist in the Past Year by County, State, and US, 2010



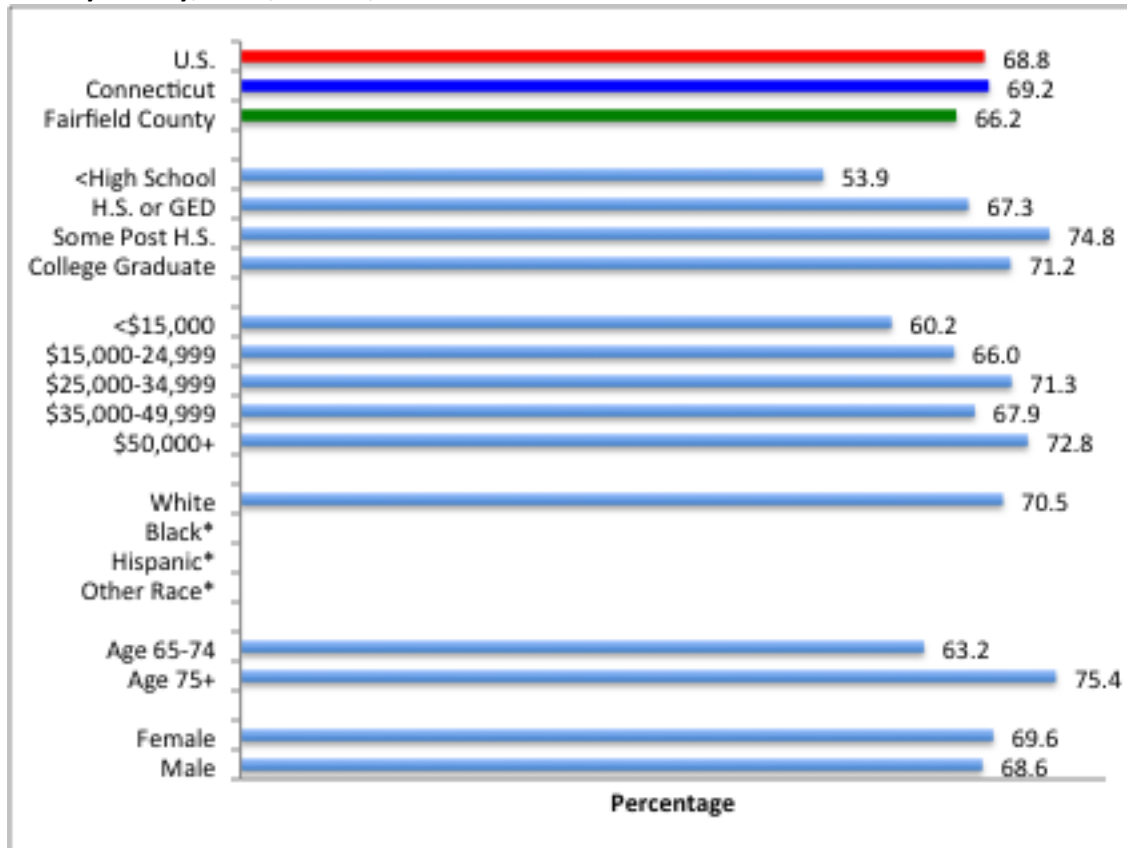
SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

Figure M: Percentage of Adults Aged 65+ Who Reported Having a Flu Shot in the Past Year by County, State, and US, 2010



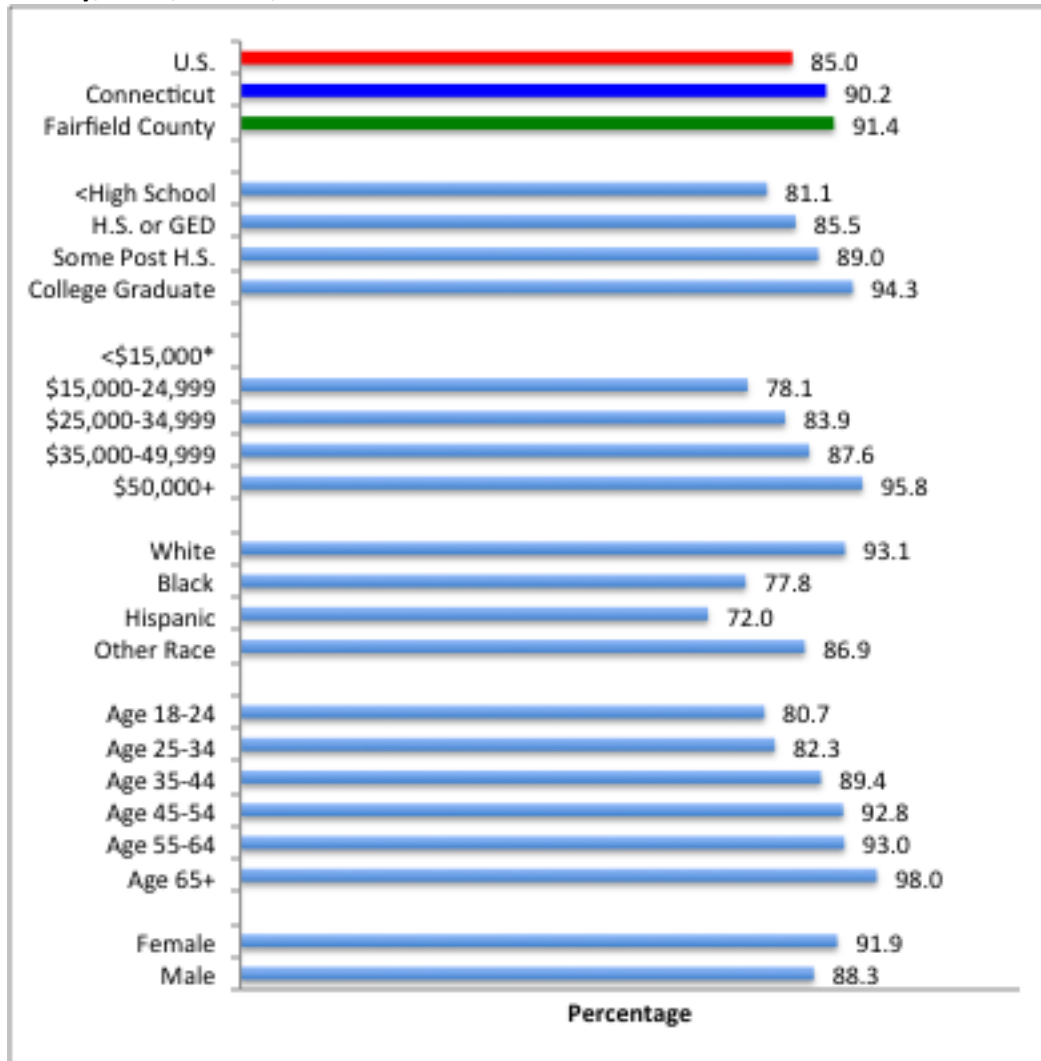
SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

Figure N: Percentage of Adults Aged 65+ Who Reported Having a Pneumonia Vaccination in the Past Year by County, State, and US, 2010



SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakouts for Fairfield County are not available due to small sample size.

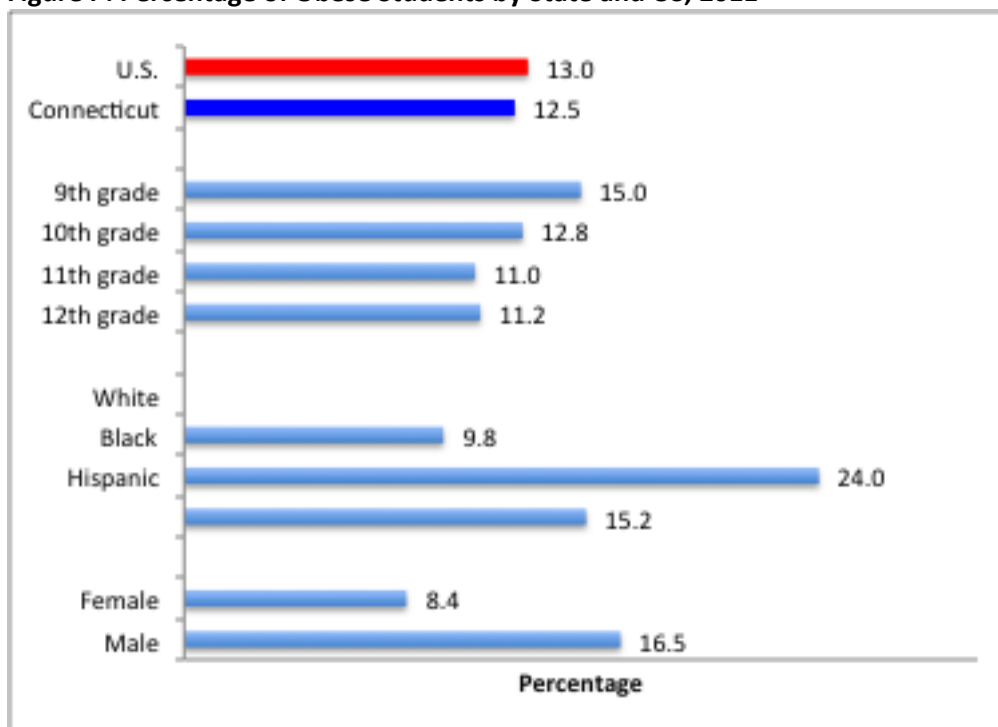
Figure O: Percentage of Adults Who Reported Currently Having Any Kind of Health Care Coverage by County, State, and US, 2010



SOURCE: Behavioral Risk Factor Surveillance System (BRFSS). Demographic data is for State of Connecticut. Demographic breakdowns for Fairfield County are not available due to small sample size.

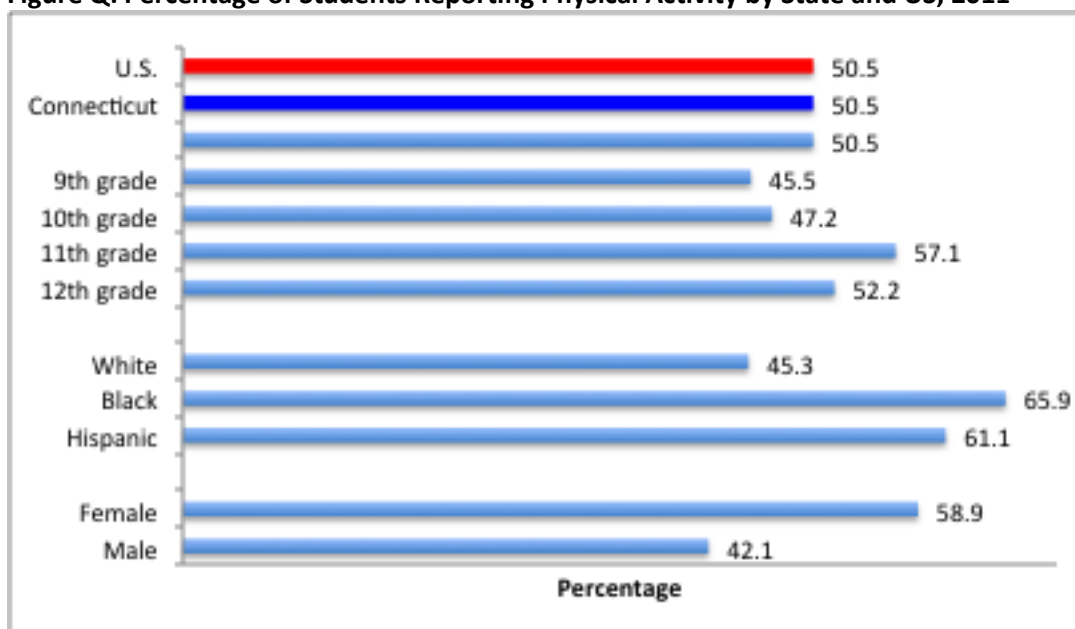
HEALTH BEHAVIORS – YOUTH

Figure P: Percentage of Obese Students by State and US, 2011



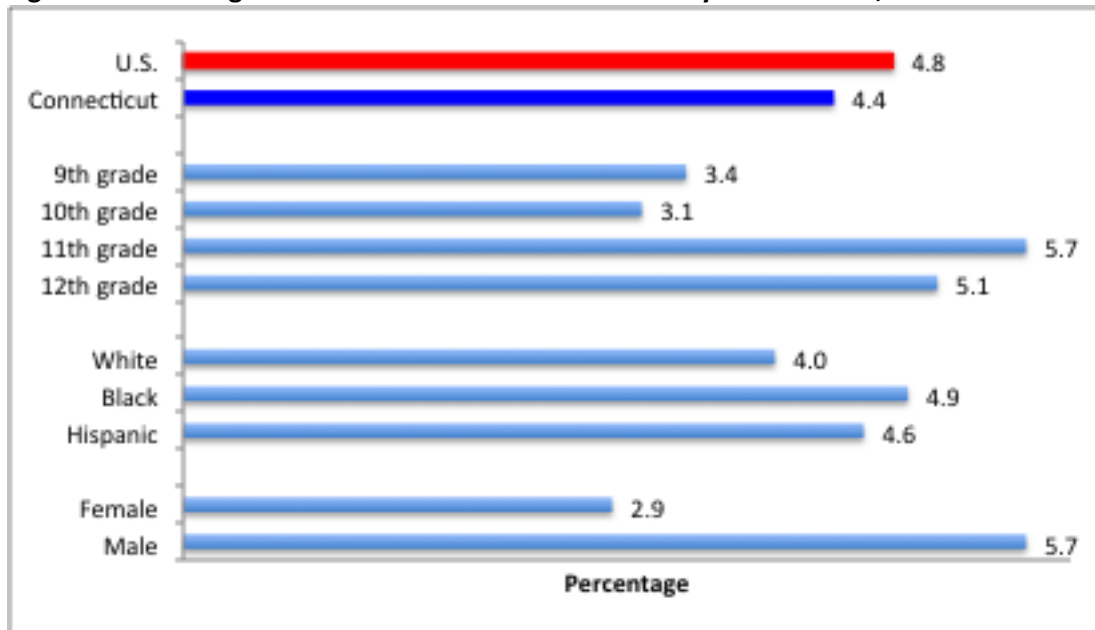
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Demographic data is for State of Connecticut.

Figure Q: Percentage of Students Reporting Physical Activity by State and US, 2011



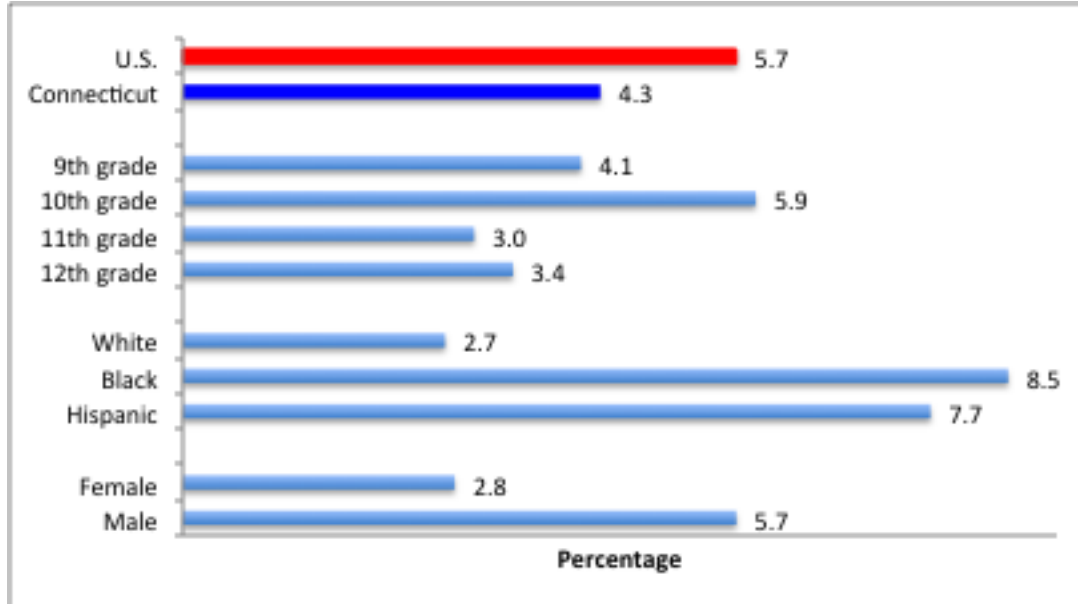
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Physically active defined as at least 60 minutes of physical activity per day for 5 days. Demographic data is for State of Connecticut.

Figure R: Percentage of Students Who Did Not Eat Fruit by State and US, 2011



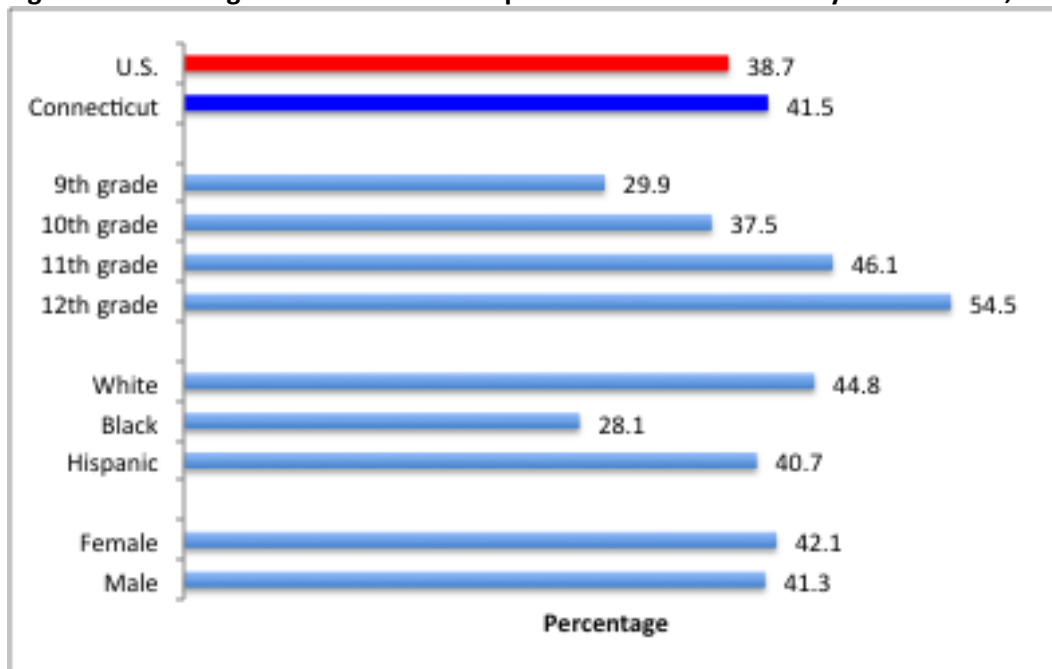
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who did not eat fruit in the seven days prior to the survey. Demographic data is for State of Connecticut.

Figure S: Percentage of Students Who Did Not Eat Vegetables by State and US, 2011



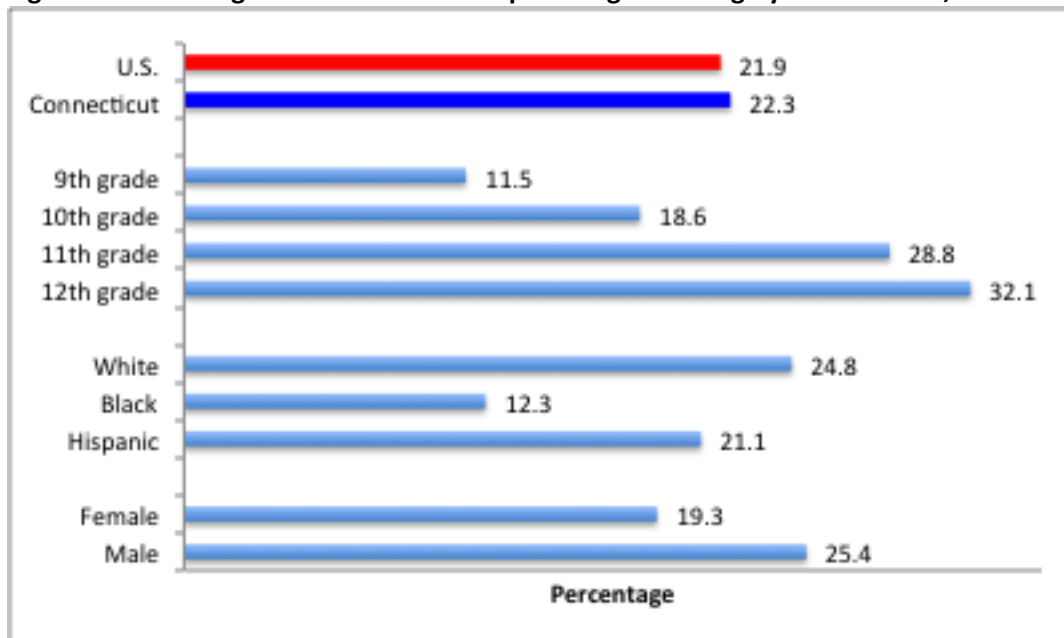
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who did not eat vegetables in the seven days prior to the survey. Demographic data is for State of Connecticut.

Figure T: Percentage of Students Who Report Current Alcohol Use by State and US, 2011



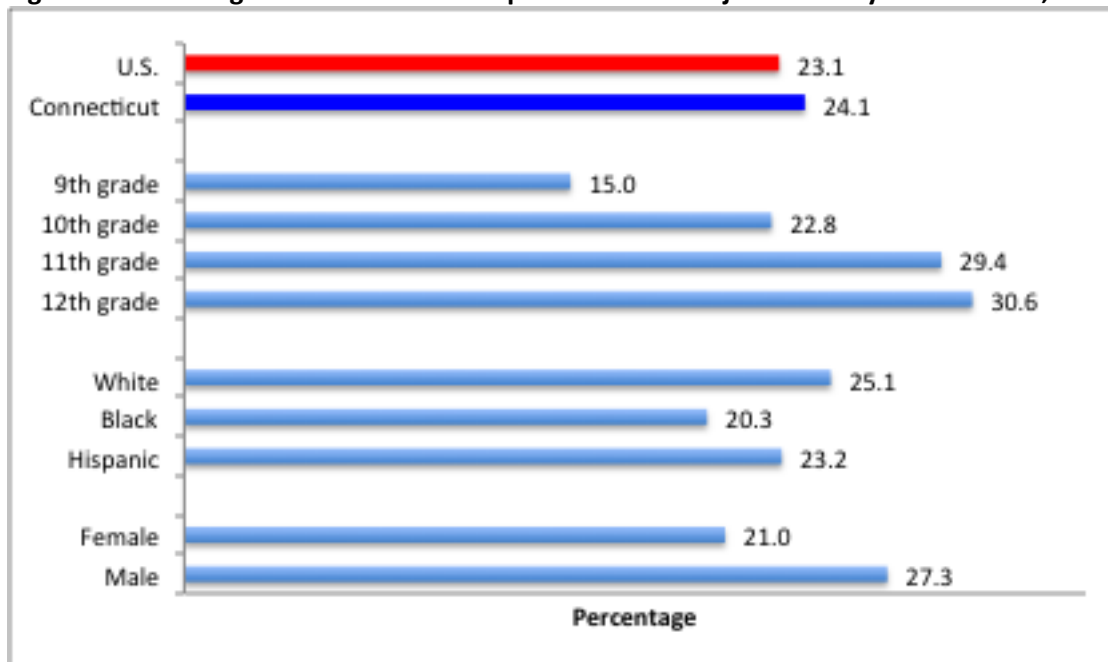
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who had one drink of alcohol on one day during the seven days prior to the survey. Demographic data is for State of Connecticut.

Figure U: Percentage of Students Who Report Binge Drinking by State and US, 2011



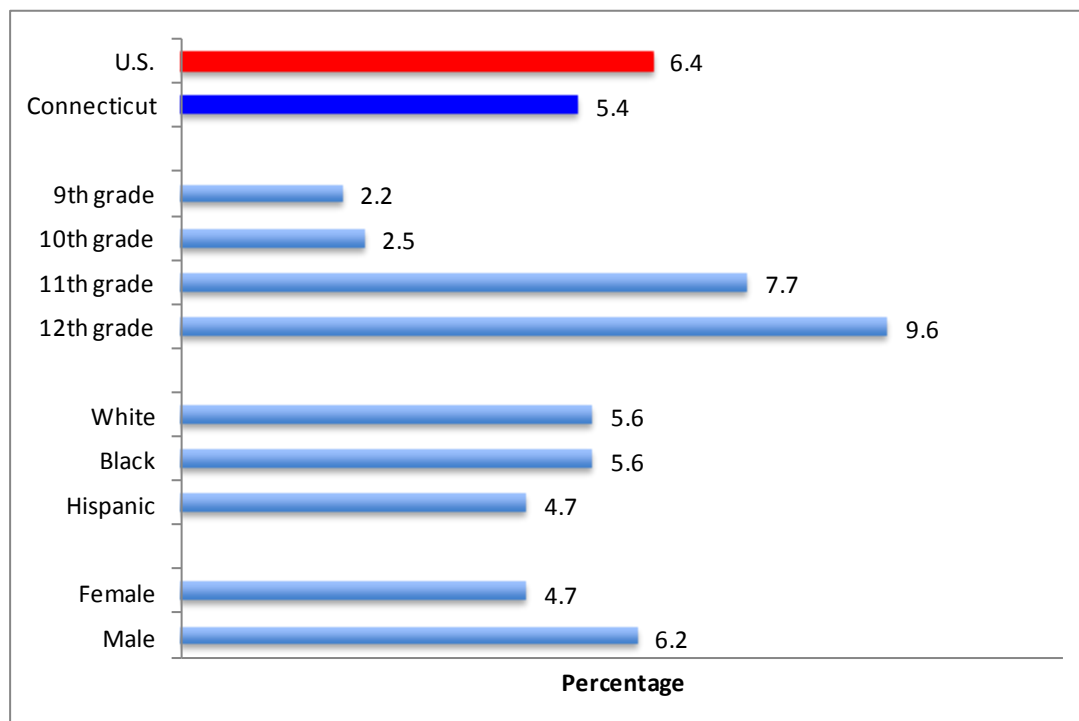
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who had five or more drinks of alcohol in a row within a couple of hours on at least 1 day during the 30 days before the survey. Demographic data is for State of Connecticut.

Figure V: Percentage of Students Who Report Current Marijuana Use by State and US, 2011



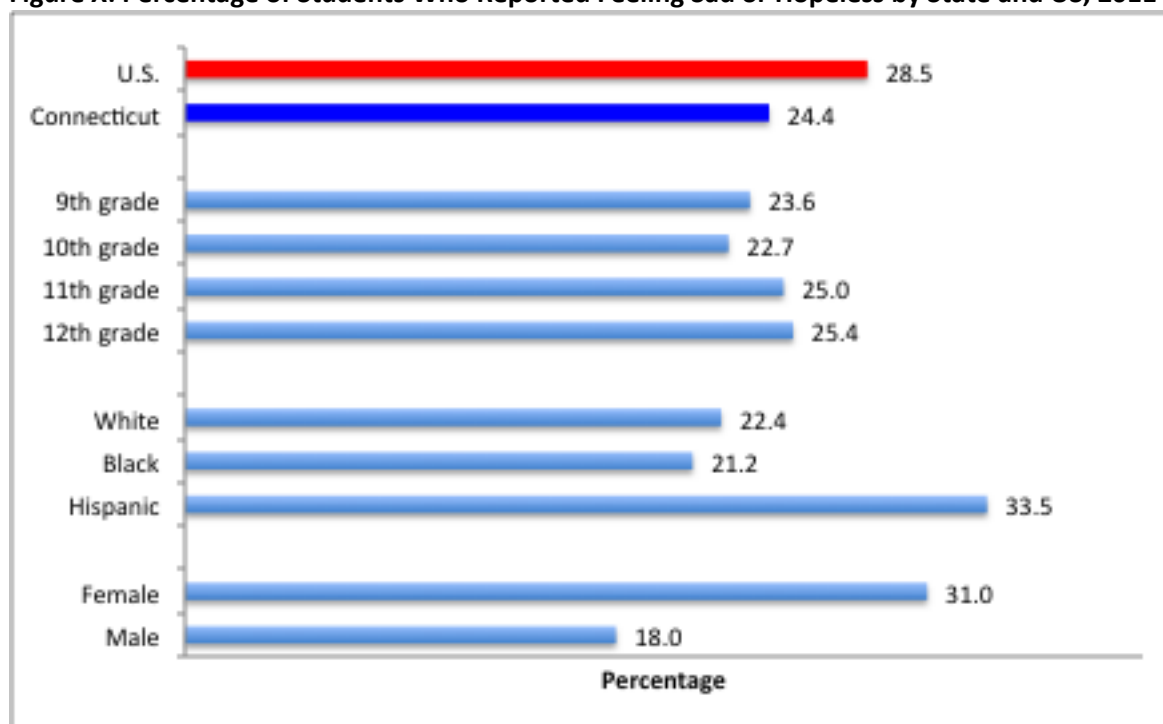
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who used marijuana one or more times during the 30 days before the survey. Demographic data is for State of Connecticut.

Figure W: Percentage of Students Who Report Frequent Cigarette Use by State and US, 2011



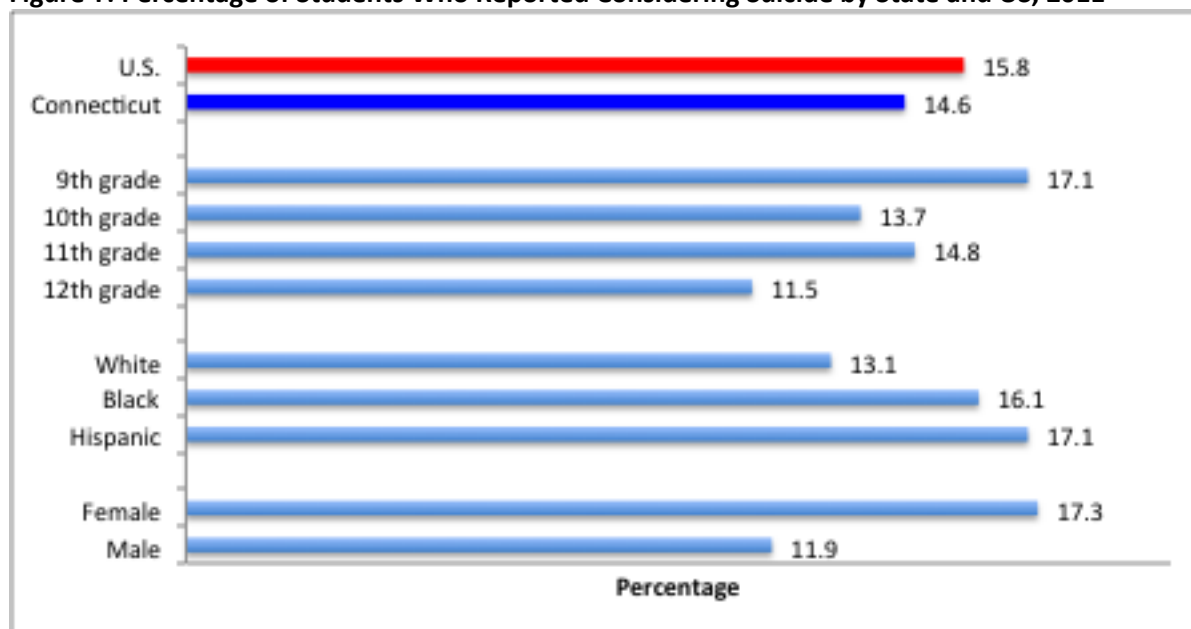
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who smoked cigarettes on 20 or more days during the 30 days before the survey. Demographic data is for State of Connecticut.

Figure X: Percentage of Students Who Reported Feeling Sad or Hopeless by State and US, 2011



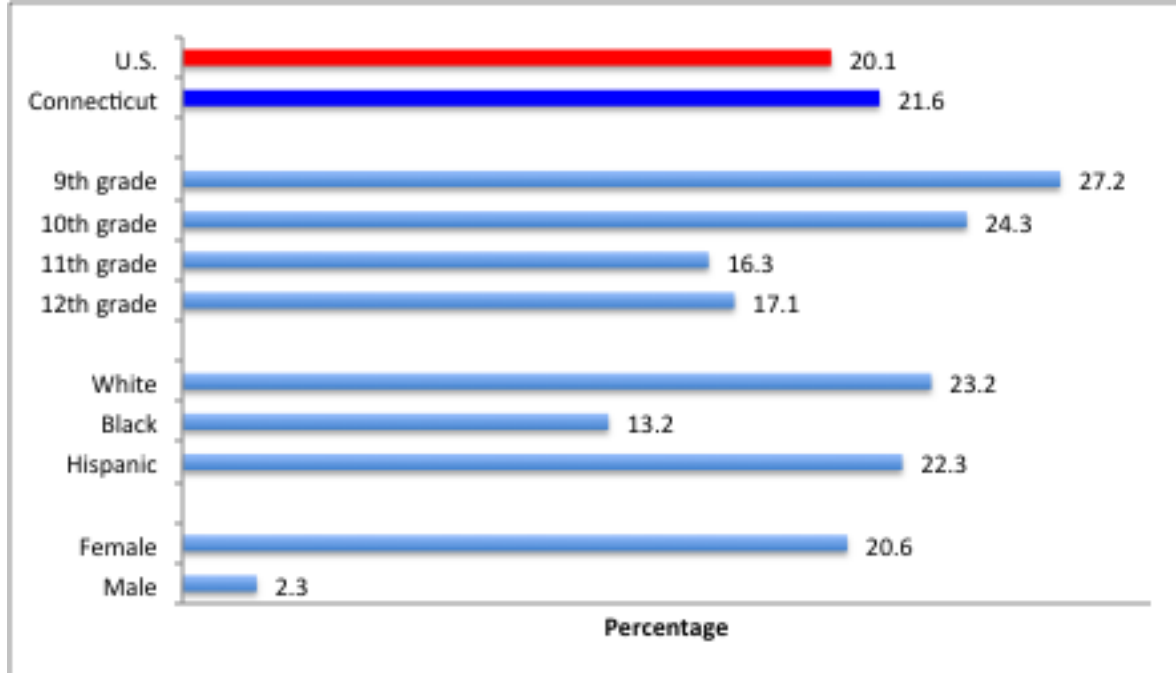
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who felt sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey. Demographic data is for State of Connecticut.

Figure Y: Percentage of Students Who Reported Considering Suicide by State and US, 2011



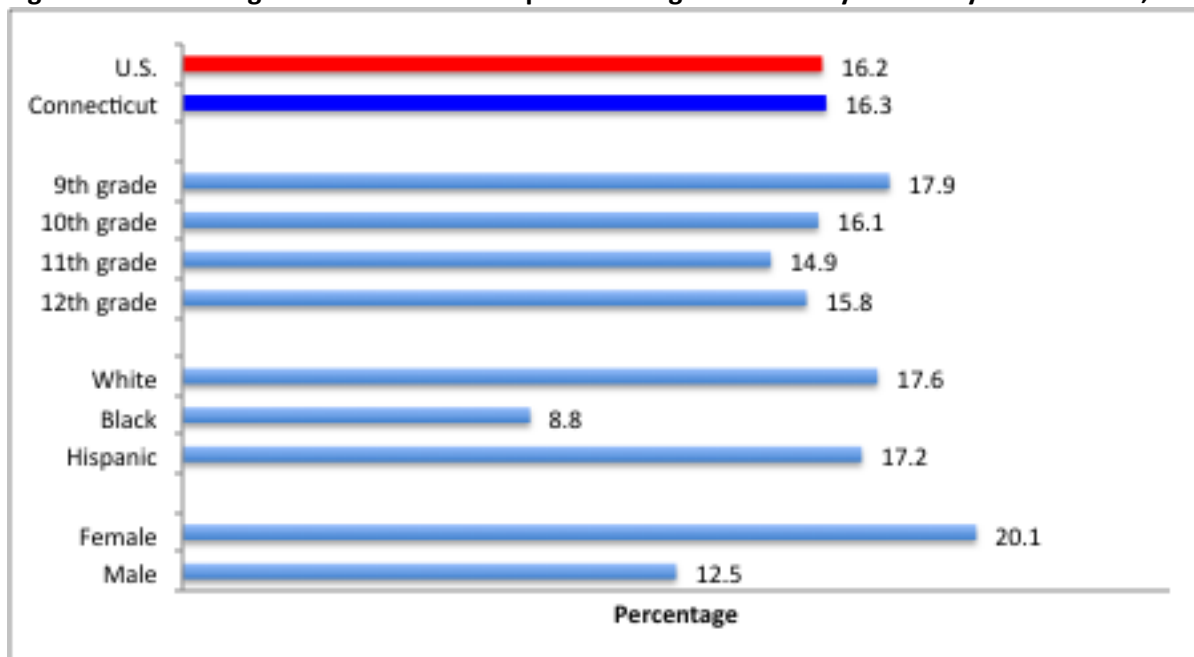
SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who seriously considered attempting suicide during the 12 months before the survey. Demographic data is for State of Connecticut.

Figure Z: Percentage of Students Who Reported Being Bullied on School Property by State and US, 2011



SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who reported being bullied on school property during the 12 months *before the survey*. Demographic data is for State of Connecticut.

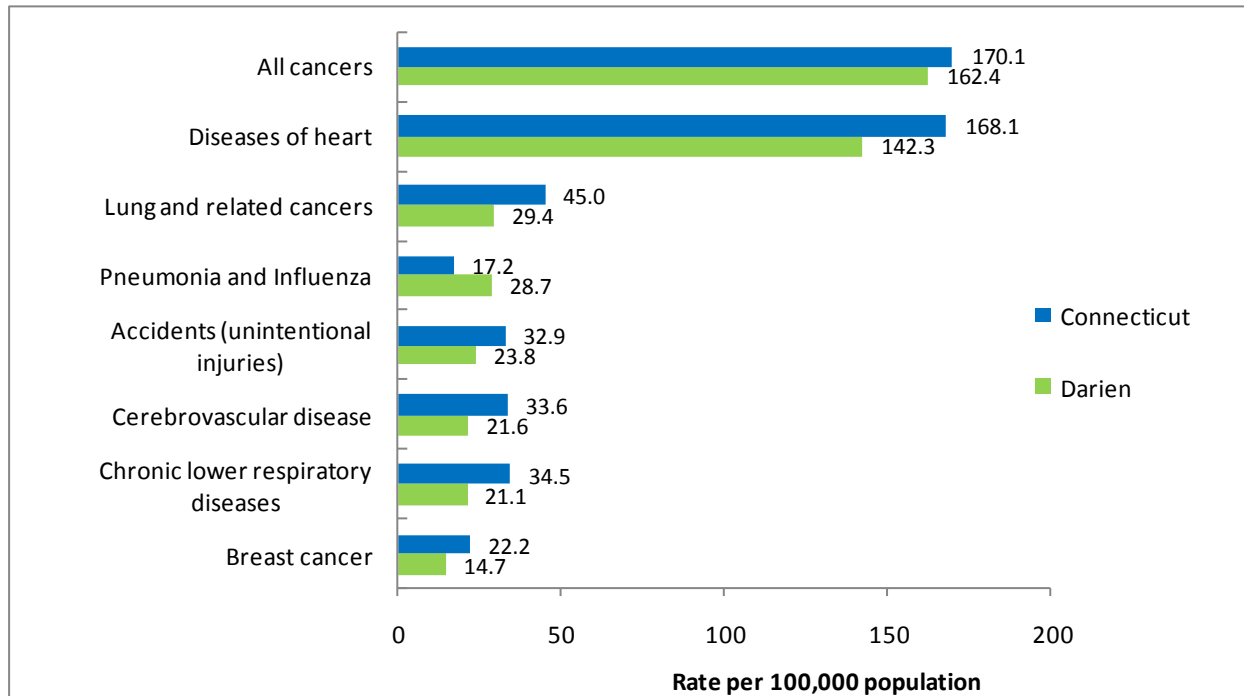
Figure AA: Percentage of Students Who Reported Being Electronically Bullied by State and US, 2011



SOURCE: Youth Risk Behavior Surveillance System (YRBSS). Percentage of students who reported even being electronically bullied including through e-mail, chat rooms, instant messaging, web sites, or texting during the 12 months *before the survey*. Demographic data is for State of Connecticut.

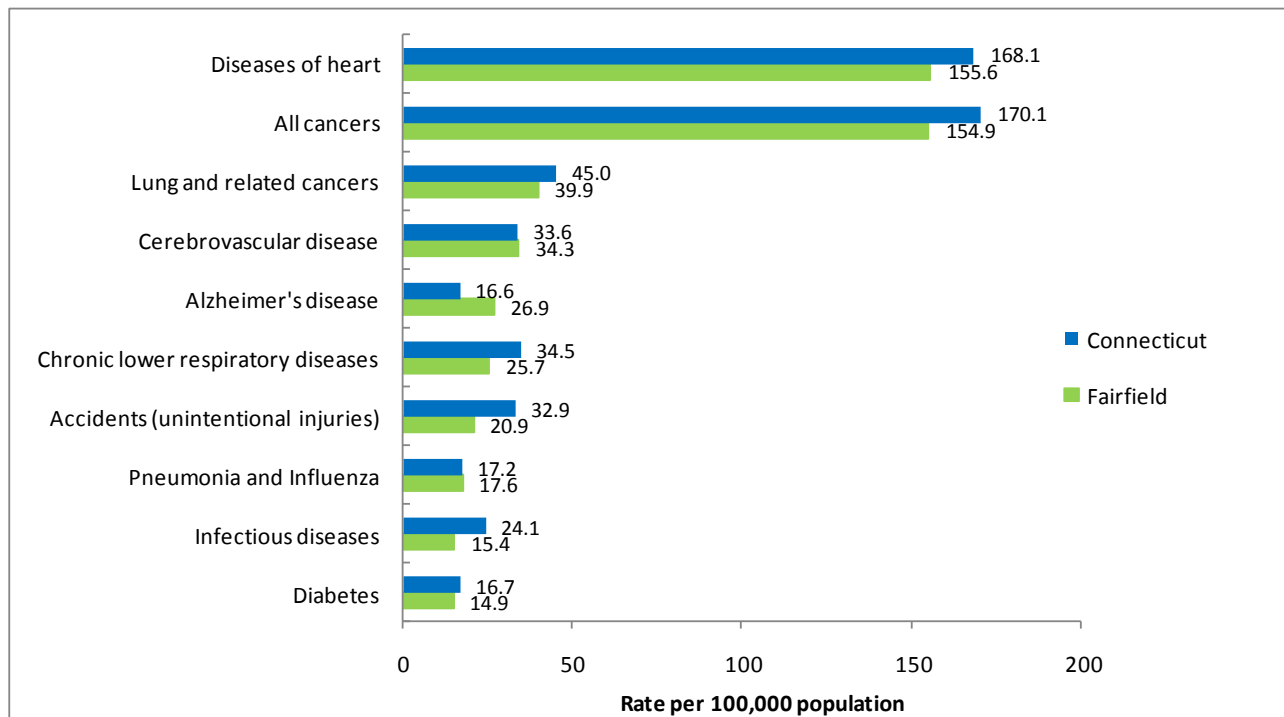
HEALTH OUTCOMES

Figure AB: Age-Adjusted Death Rate per 100,000 Population in Darien and Connecticut, 2005-2009 average



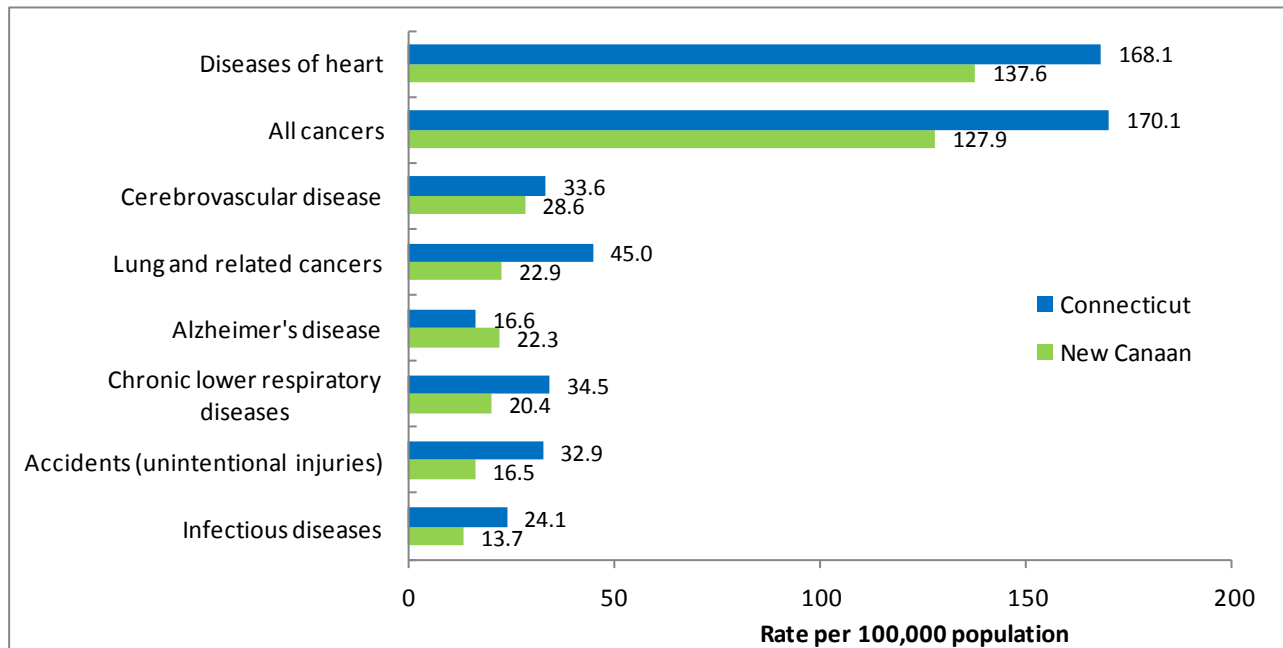
DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432>

Figure AC: Age-Adjusted Death Rate per 100,000 Population in Fairfield and Connecticut, 2005-2009 average



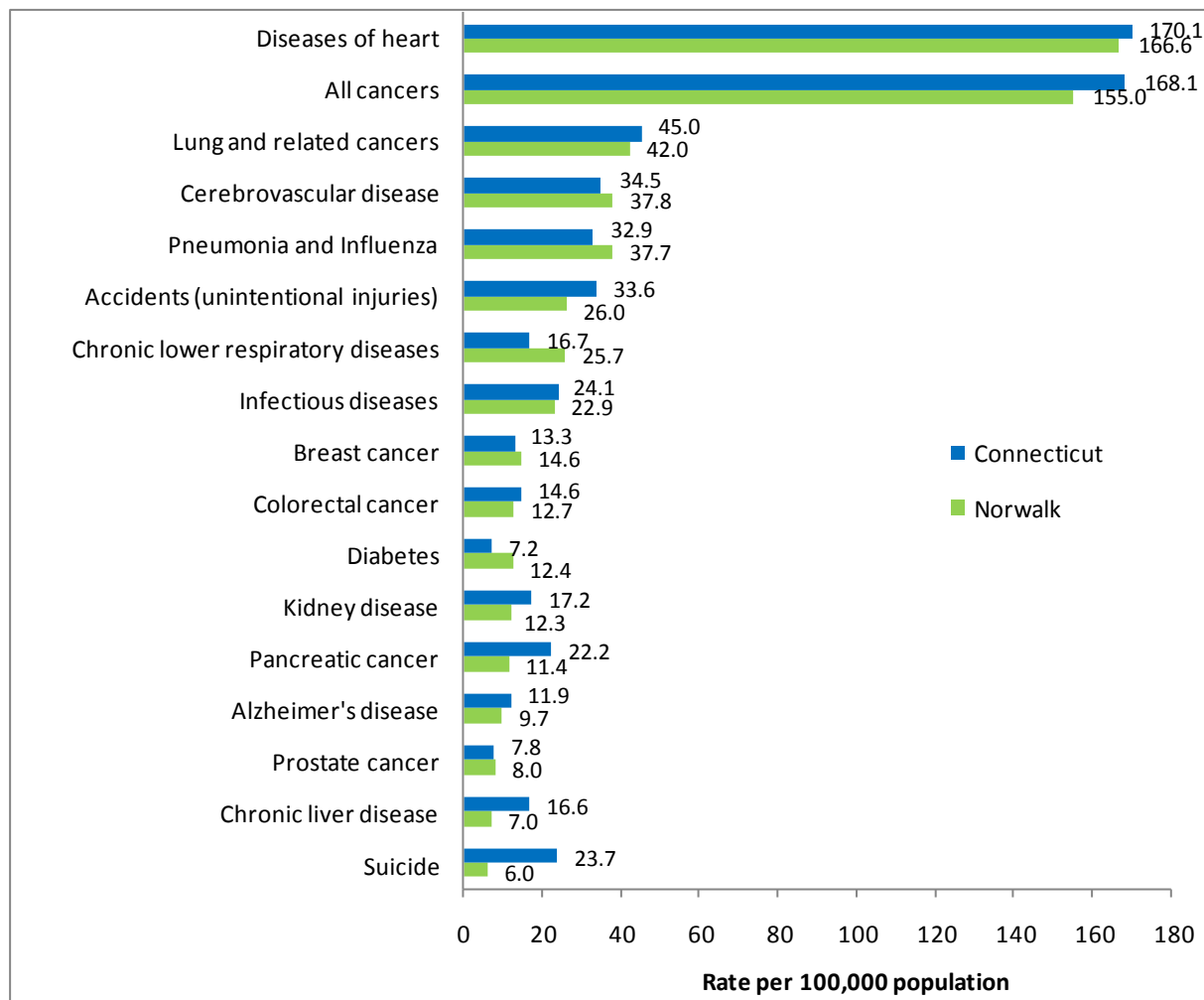
DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432>

Figure AD: Age-Adjusted Death Rate per 100,000 Population in New Canaan and Connecticut, 2005-2009 average



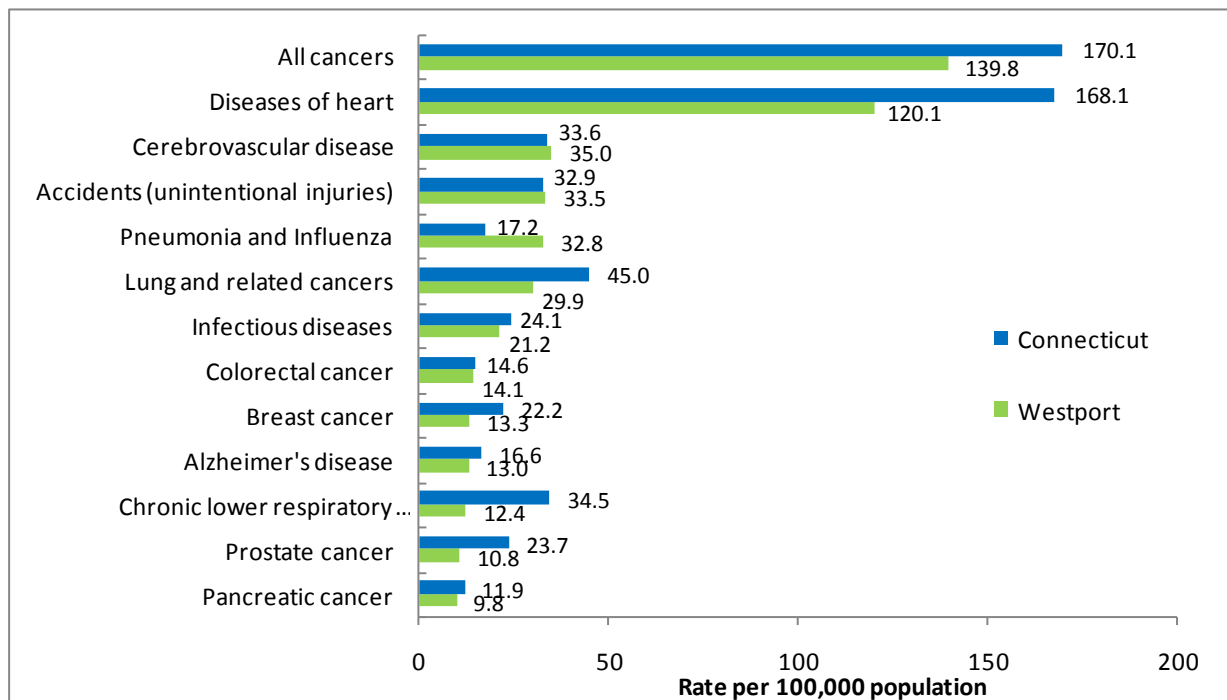
DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432>

Figure AE: Age-Adjusted Death Rate per 100,000 Population in Norwalk and Connecticut, 2005-2009 average



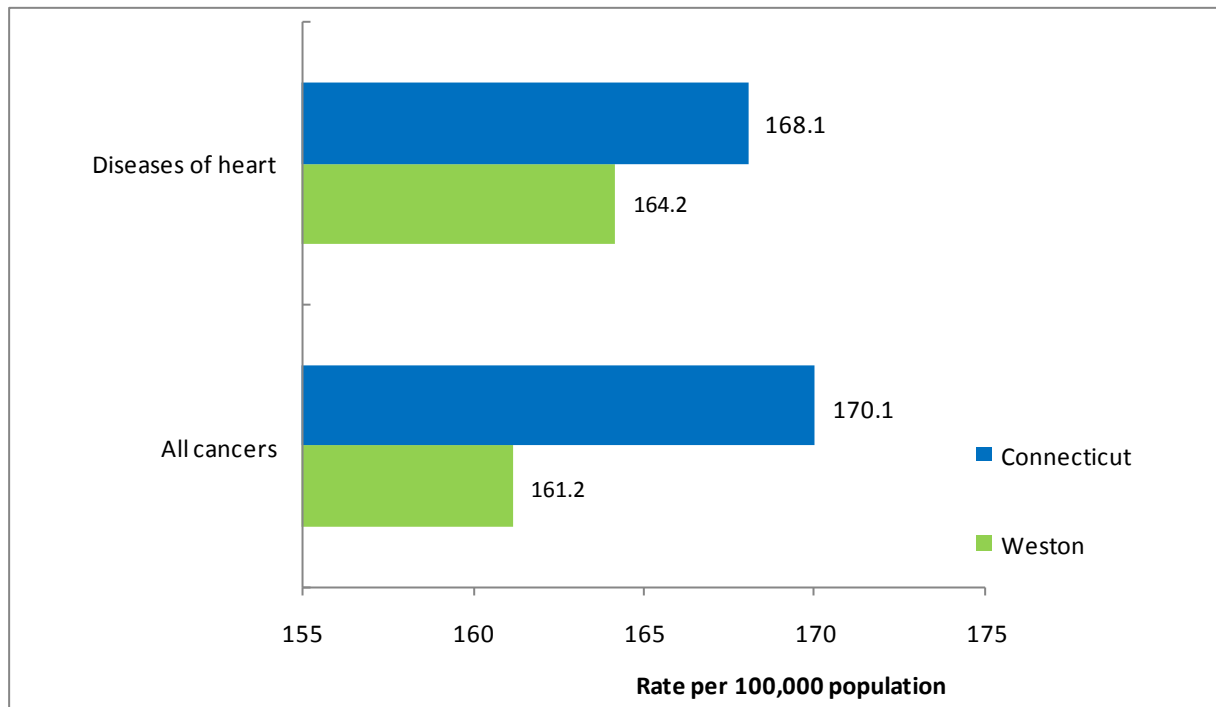
DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432>

Figure AF: Age-Adjusted Death Rate per 100,000 Population in Westport and Connecticut, 2005-2009 average



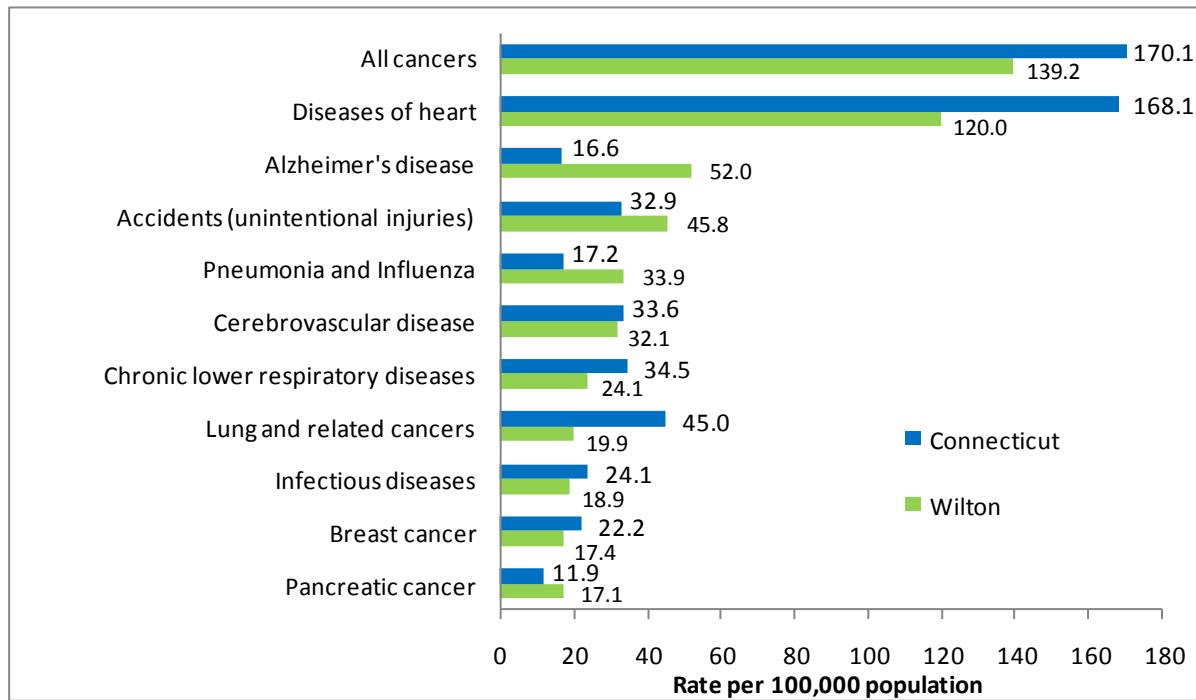
DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432>

Figure AG: Age-Adjusted Death Rate per 100,000 Population in Weston and Connecticut, 2005-2009 average



DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432>

Figure AH: Age-Adjusted Death Rate per 100,000 Population in Wilton and Connecticut, 2005-2009 average



DATA SOURCE: Connecticut Department of Public Health Mortality Statistics, retrieved on 6-12-12 from <http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397432>

APPENDIX F: HEALTH RELATED ASSETS AND RESOURCES

List of Health Related Assets and Resources Identified by Community Members through the Community Health Assessment

GENERAL ASSETS AND RESOURCES

Assets

- Collaborations focusing on promoting health, healthy eating and active living. Collaborators include:
 - Norwalk Health Department
 - Local high schools
 - Health fairs
- Commitment to helping others and sense of collective responsibility amongst residents
- Federally qualified health centers are well positioned to get federal funding
- Green space, parks, beaches
- Intellectual capital represented by large number of highly educated residents in the town and region
- Investment of families in addressing social and health concerns of their children
- Perceived low rates of crime and a general sense of safety in most areas
- Presence of both public and private-funded programs and initiatives
- Proximity to New York City for:
 - Employment opportunities
 - Medical resources
- Socioeconomic and racial and ethnic diversity of community
- Quantity of physicians in the region (but not all accept insurance or federally-funded insurance)
- Robust volunteer corps addressing health issues
- Transportation
 - Public transportation
 - Highways
 - Trains
- Value given to education of youth in community; Well-rated schools

Resources

- 211
- Americares
- Christian Community Action- non-profit that offers food and financial assistance (covers same towns as Norwalk CHA)
- Darien Community Association
- Darien Library
- G.E. initiative called Health Ahead
- Local health departments
- Local schools
 - School based services for students
 - Skilled teachers and tutors
 - Behavioral and special needs specialists

- Availability of social worker within the school
 - Well-trained nurses
 - School-based health centers
- Facilities – buildings, athletic venues, playgrounds
- Local social service departments
- NEON (energy assistance for low-income residents)
- Norwalk Community Healthcare Center
- Norwalk healthy families collaboration - Consortium of health care non-profits that are truly interested in working together to understand needs in an organized way
- Norwalk Hospital
- Operation Fuel- heating and utility assistance (income cut-off is 60% of area median income)

OBESITY AND CHRONIC DISEASE

Assets

- Dedication of parents to health and social issues facing their family
- Gardens at Norwalk schools – a dynamic effort to introduce fruits and vegetables and influence families
- Green space, parks, beaches
- Local initiative between Norwalk Hospital and Jefferson Elementary School targeting better nutrition and increased physical activity to lower BMI
- Local school systems
- Proactive health department, which is open to new ideas and collaborations

Resources

- Accountable Care collaboration between Norwalk Hospital, NCHC and large private practices
- ACHIEVE grant, which is trying to implement policy change (effort led by Norwalk Health Department)
- Beaches, parks, walking trails, rowing clubs, municipal golf course
- Boy & Girls Clubs
- Catholic Family (Senior meal program)
- Cooking program at housing developments
- Day Street Community Health Center
- Farmer's market coupons for eligible low-income residents
- Fitness clubs/gyms
- Food rescue organizations
- Headstart program
- Live Well (Chronic Disease Self-Management) program
 - Evidenced-based program, delivered in a number of communities for free to assist adults with the problems commonly shared by those with chronic conditions, no matter the cause. Developed for people over 55, age for participation is now 18 and older.
- Local city and town planners
- Local health departments
- Lower Fairfield County Food Bank
- Local Schools
 - School-based health centers
 - physical education department
 - Board of Education

- Principals
 - Teachers
 - Those who decide on/manage food choices
- Meals on Wheels
- Medicare obesity program (counseling program)
- Norwalk Chamber of Commerce
- Norwalk Early Childhood Coalition
- Norwalk Health Department
- Norwalk Hospital
- Parks and Recreation Departments in all towns
- Project Lean
- RWJ grant supported development of jogging and fitness stations
- Senior Centers: Nutrition classes, exercise classes
- Stew Leonard's
- US Department of Agriculture
- WIC
- Wilton Family YMCA - 16-week CDC program addressing pre-diabetes
- YMCA

SUBSTANCE ABUSE

Assets

- Many police officers have Crisis Intervention Training (CIT)
- Private, non-hospital based psychologists and psychiatrists
- Schools

Resources

- 211
- 24-Hour Crisis Intervention Services (for adults through Dubois Center; for children through Child Guidance of Southern CT)
- Alcoholics Anonymous or other self help programs
- Americares
- CT Community for Addiction Recovery
- CT Counseling Centers, Inc
- CT Department of Mental Health and Addiction Services
 - DMHAS Prevention Unit "Regional Drug Profile Priority" - Collaborative process lead by the Regional Action Councils in each region
- CT Renaissance
- DARE programs in schools
- Day Street Community Health Center
- EMS
- Faith-based organizations
- Family & Children's Agency (Project Reward)
- Fire Departments
- Law enforcement with Crisis Intervention Training (CIT)
- Liberation Programs – Family and Youth Options

- Local faith and clergy members
- Local social service departments
- Mid-Fairfield County Regional Action Council
- Mid-Fairfield Substance Abuse Coalition
- Norwalk Hospital
- Positive Directions (in Westport)
- Silver Hill Hospital (in New Canaan)
- St. Vincent's Behavioral Health Services

MENTAL HEALTH

Assets

- Advocacy amongst parents of children with disabilities at the state and national level
- Collaborations among towns and executive offices around mental health
- Community is very accepting about behavioral issues
- Counseling agencies already exist
- Extra-curricular activities for youth
- federally qualified health care centers
- Green space, parks, beaches
- Police have been understanding of behavioral issues and proper treatment (e.g., connect persons with behavioral issues mental health services rather than criminalizing behavioral issues)
- Positive youth development collaboration with Wilton, Weston, Westport and Fairfield
- Private counseling services
- Social service directors in suburban towns who meet together regularly

Resources

- 211
- 24-hour Crisis Intervention Services
- Beaches, parks, walking trails, rowing clubs, municipal golf course
- Catholic Charities
- Center for Hope - Program for boys 8-11 to work on esteem
- Child Guidance of Southern CT
- CT Counseling Service
- CT Council of Family Service Agencies
- CT Department of Children and Families
- CT Department of Mental Health and Addiction Services
- CT Renaissance
- Day Street Community Health Center
- Department of Children and Families Regional Advocacy Council
- Department of Mental Health and Addiction Services (DMHAS) (2)
- Domestic Violence Crisis Center
- Fairfield County Medical Association (for lists of mental health physicians by specialty)
- Families United for Children's Mental Health
- Family & Children's Agency
- Family Centers, Inc.
- Human Services Council's Mentor Program
- Human Services Council's School Based Health Centers – medical/mental health

- Jewish Family Services
- Keystone House
- Law enforcement with CIT (Crisis Intervention Training)
- Local faith and clergy leaders
- Local schools
 - School-based health centers
 - School nurses
 - Guidance counselors
 - Special education teachers
- Local social service departments
- Mid-Fairfield County Child Guidance
- NAMI
- Network of Care for Behavioral Health
- Norwalk Child Guidance Center
- Norwalk Community Healthcare Center
- Norwalk Hospital - Ambulatory psychiatric care
- Positive Directions
- Shelter
- Silver Hill
- Southwest Regional Mental Health Board
- St. Vincent's Behavioral Health Services
- Warm Line
- Water Street Clinic
- YWCA - Parent awareness programs, guest speakers