

# Naugatuck Valley Community Health Improvement Plan 2016 – 2018





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## Acknowledgements

Many health and social service organizations have contributed to the development of this Naugatuck Valley Community Health Improvement Plan (CHIP) by their active engagement in a series of rollout meetings for the 2016 Valley Community Index during the fall/winter of 2016. Special thanks are extended to the Valley Community Foundation (VCF) and to Griffin Hospital, whose funding helped enable the creation of the Valley Community Index – more specifically titled “Understanding the Valley Region – A Community of Well-Being.”

Additional sponsors of the document included: the Bassett Family Fund, Katharine Matthies Foundation, Bank of America, N.A., Trustee, the Valley United Way (lead sponsors); and Connecticut Community Foundation and Liberty Bank Foundation (contributing sponsors).

The following have served as the 2017-2020 CHIP Steering Committee:

- Daun Barrett, Director, Community Outreach & Valley Parish Nurse Program
- Gregory Boris, Chair, Department of Emergency Medicine, Griffin Hospital
- Cary Carpino, Acting Director, Valley Parish Nurse Program (*as of August 2017*) Carissa Caserta, Assistant Director, Community Health, Naugatuck Valley Health District
- Beth Comerford, Deputy Director, Yale-Griffin Prevention Research Center
- Victoria Costales, Director, Center for Prevention & Lifestyle Management, Griffin Hospital
- Susan Cutillo, Director, Psychiatric Services, Griffin Hospital
- Nick DeMaio, Lead Crisis Clinician, Griffin Hospital
- Jeff Dussetschleger, Director of Health, Naugatuck Valley Health District (*as of Sept. 2017*)
- Cathi Kellett, Safe Kids Greater Naugatuck Valley Coalition Coordinator
- Joan Lane, Public Health Specialist/Accreditation Coordinator, Naugatuck Valley Health District
- Christine Marr, Healthcare Analyst, Griffin Hospital
- Pam Mautte, Director, Alliance for Prevention & Wellness, A Program of BHcare
- Alicia Mulvihill, Health Educator, Naugatuck Valley Health District
- Ken Roberts, Director, Communications & Public Affairs, Griffin Hospital
- Karen Spargo, Director of Health, Naugatuck Valley Health District
- Amy Vitale, IOP Program Coordinator, Griffin Hospital

The Steering Committee has been responsible for overseeing the development of the seven Action Plans included in the CHIP, as well as the overall framework of the CHIP document.

## Background

A Community Health Improvement Plan, or CHIP, is part of an overall process whose objective is to identify strategies to improve the health of a specific community or region. The process begins with a Community Health Assessment, or CHA. Data obtained through the needs assessment is used “to identify priority issues, develop and implement strategies for action, and establish accountability to ensure measurable health improvement” (*National Association of County and City Health Officials*). Simply stated, agencies work together to look at community health needs, select those issues of most concern, and establish a plan to address these issues.

This 2016-2018 Community Health Improvement Plan (CHIP) for the Naugatuck Valley is the second such document for our seven (7) Valley towns: Ansonia, Beacon Falls, Derby, Naugatuck, Oxford, Seymour and Shelton. The 2013-2015 CHIP, an outgrowth of the Valley CARES Quality of Life Report released at the end of 2010, proved to be a good first effort for the coalition of organizations that developed it. However, a key lesson learned for this second CHIP was to better articulate goals and indicators that are more consistently quantified, with associated accountability and target dates. In addition, this new CHIP's Steering Committee has defined a tracking process that will help us remain focused on outcomes.

Continuity from the previous CHIP was provided through the active participation of key stakeholder agencies on the Valley Community Index Advisory Committee, which supported the production of an updated Community Health Needs Assessment (CHNA) in 2016. Titled *Understanding the Valley Region – A Community of Well-Being*, the updated Needs Assessment serves as “a single-source reference for community leaders, service providers and funders for the Valley.” The Index fulfills the common requirements of the Health District, for accreditation through the national Public Health Accreditation Board; and the local hospital, for its federal obligations under the Patient Protection and Affordable Care Act. ([www.valleyfoundation.org/About/NewsPublications/ViewArticle/tabid/96/ArticleId/189/Valley-Community-Index-Understanding-the-Valley-Region-2016.aspx](http://www.valleyfoundation.org/About/NewsPublications/ViewArticle/tabid/96/ArticleId/189/Valley-Community-Index-Understanding-the-Valley-Region-2016.aspx))

The process and the document's production were funded by the Valley Community Foundation and Griffin Hospital, who engaged Data Haven, whose statewide *2015 Community Wellbeing Survey* serves as the basis for a number of Connecticut communities' Community Health Needs Assessments. The *Index* draws from federal, state and local agencies' data, as well as information collected directly from residents of the Valley communities. The behavioral survey is conducted as a randomized survey, following accepted scientific methods, and resulting in primary data not available through other sources. Health District and Hospital staff participated in the *Index's* steering committee, and in the Health section meetings.

Preliminary data was posted on the Naugatuck Valley Health District and Griffin Hospital websites in July 2016; and a community survey was posted in August 2016, supported by a media release inviting public participation. This web-based survey served to enlist input from community members early in the review process. Also in August, a community conversation about the preliminary data was sponsored by Griffin Hospital, Naugatuck Valley Health District and the Valley Community Foundation. From October through December 2016, the *Index* was presented at more than a dozen community meetings, including a community launch and feedback session attended by 88 local partners/ community members representing 75 different organizations/coalitions. Members of the Valley Community Index Advisory Committee were fully engaged both in directing the local presentations/ conversations and in responding to the data.

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

**Note:** The data tables that follow throughout this document are derived from the *2016 Valley Community Index*, and attributable to: *Buchanan, Mary, and Mark Abraham. (2016). Understanding the Valley Region: 2016 Valley Community Index. Derby, CT: Valley Community Foundation and DataHaven.*

## Development of the Valley Community Health Improvement Plan for 2016-2018

As a result of the community conversations utilizing data from the Valley Community Index (which served as Griffin Hospital’s Community Health Needs Assessment), seven (7) critical population health Focus Areas emerged. In November 2016, a Lead was identified for each Focus Area. These Leads first met as a CHIP Steering Committee – co-chaired by Naugatuck Valley Health District and Griffin Hospital – in December 2016. The Leads were each charged with forming a team drawn from partner agencies deemed key stakeholders for the particular health concern. Each team developed a Team Charter and Aim Statement; these have subsequently been rolled into an Action Plan for each Focus Area, each containing key Goals, Indicators and associated Objectives/Strategies and Actions/Activities, as the foundation for successful implementation. A key element in each Action Plan is a statement of Alignment with Connecticut’s State Health Improvement Plan (SHIP), if applicable, and a description of how Community Involvement is being facilitated.

The diagram below represents the process employed in the development of the Valley CHIP:



### Vision

The Vision embodied in this CHIP – a slight modification from the 2013-2015 Plan – reads: ***We strive to be a caring community that nurtures the overall health and quality of life of all its residents by promoting healthy living and equitable access to health services.***

### Naugatuck Valley Population

Seven (7) municipalities are included in the scope of the Naugatuck Valley Community Health Assessment and Community Health Improvement Plan: Ansonia, Beacon Falls, Derby, Naugatuck, Oxford, Seymour and Shelton. These fall within New Haven County and Fairfield County in Connecticut.

As represented in the 2016 Valley Community Index, total population of the 7 communities as of 2014 was 139,674, representing just under 4% of the Connecticut's overall population. As represented in the table below, the Valley's population is aging, with the most notable growth projected in the population aged 65 (see below).

### 2.03 Population and Projected Growth by Age in the Valley, 1990-2025



In addition to the aging of the Valley population, the Community Index notes a steady increase in the number of foreign-born residents of the Valley, representing approximately 90 home countries. Together, these changes in the demographic mix will have a notable impact on the health issues of concern within our communities.

## **Framework for Ongoing Monitoring**

The Valley Community Health Improvement Plan is a living document, to be consistently monitored and modified. Each Focus Area is supported by a small team that meets on a regular basis to track implementation of its Action Plan, and to augment/course correct as needed. Meeting frequency is determined by each team. Updated Action Plans of all teams are reviewed quarterly by the Valley CHIP Steering Committee, a group of 14 key individuals drawn from five health and social service organizations. As noted earlier, the 2017-2020 Valley CHIP Steering Committee has committed to a more rigorous, outcomes-oriented, and evidence-based process than was applied to the 2013-2015 CHIP.

In addition to regular review by the Focus Area teams and the CHIP Steering Committee, a community forum will be held at least annually, to provide feedback on CHIP implementation progress, and on identifying emerging public health issues in the Valley. Community input will support the CHIP as a flexible and responsive document, and process.

## **Framework for Future Naugatuck Valley CHA and CHIP Development**

The timetable for creation of a Community Health Needs Assessment and a Community Health Improvement Plan are not synchronous for a Hospital (which has a three-year cycle) and a Local Health Department (a five-year cycle). As a result, these processes will continue to be developed, worked and refined on a rolling basis for Naugatuck Valley.

## **Action Plans**

Action Plans are included on the following pages of this document for each of the CHIP's seven (7) Focus Areas:

- 1) Creation of a Chronic Behavioral Health Community CARE Team
- 2) Lifestyle-Focused Chronic Disease Management & Prevention Programs
- 3) Substance Use Disorders
- 4) Childhood Obesity Prevention/Community Based Programming
- 5) Lung Cancer Screening/Smoking Cessation
- 6) Asthma Prevention & Self-Management
- 7) Healthy Homes

**Focus Area 1:** Creation of a Chronic Behavioral Health Community CARE Team

**Why Is This Issue a Priority?** Community care team is a team approach to help better serve patients with multiple emergency department visits for behavior health and substance abuse issues. A community care team consists of hospital staff, behavioral health community resources and social service resources within the valley community. The goal is to improve health outcomes for these individuals, increased linkage to community resources, improved patient experience and lower healthcare costs.

**Primary Partners:** Griffin Hospital Psychiatric Services, BHCare, Parent Child Resource Center, The Value Care Alliance (VCA), Spooner House, Midwestern Connecticut Council of Alcoholism (MCCA), Connecticut Community for Addiction Recovery (CCAR), Continuum of Care

**Overall Goal:** Create and implement a “Community Action Team”, modeled on the Middlesex Hospital community team, to work on an interdisciplinary, interagency basis to improve care management and outcomes of chronic behavioral health/substance abuse patients, The team will work to provide patient-centered care and improve health outcomes by developing and implementing a safety net of alternative services through multi-agency intervention and care planning.

**Indicators – How will we know we’re making progress?**

**Long term:** Decrease hospital readmissions by 8% through increased collaboration and maintenance of patients in their communities by 9/1/2018.

**Medium term:** Develop treatment plan for all patients discussed focusing on 10 high utilizers (individuals) of hospital emergency departments and community services by 4/1/2018. Develop a shared electronic system to review and update treatment plans by 4/1/2018.

**Short term:** All agencies represented at each meeting by 1/1/2018.



**GRIFFIN HEALTH**



**Focus Area 1: Creation of a Chronic Behavioral Health Community CARE Team**

*(continued)*

**Objectives/Strategies:**

Develop a network of agencies (CCT) in the Valley who treat patients with behavioral health and substance abuse issues.

**Actions/Activities:**

Complete shared agency release in 2016.  
Develop a network of agencies (CCT) in the Valley who treat patients with behavioral health and substance abuse issues.  
Establish monthly meetings to determine structure of CCT; plan to meet every other week for an hour.  
Hold Community Forum for all Valley providers of mental health and substance abuse issues.  
Implement schedule of CCT meetings towards realization of Goal.

**Alignment with Connecticut State Health Improvement Plan (SHIP):**

The goal is for all communities across the state to support successful Community Care Teams.

**Community Engagement:**

Community partners attend CCT meetings, collaborate around patient care, and assist in the development of multi-agency treatment plans and goals for shared patients.

**For further information on this Focus Area, contact: Susan Cutillo, LCSW, LADC, MBA, Director, Psychiatric Services, Griffin Hospital, [scutillo@griffinhealth.org](mailto:scutillo@griffinhealth.org)**

**Focus Area 2:** Lifestyle-focused Chronic Disease Management & Prevention Programs

**Why Is This Issue a Priority?** Half of United States adults have one or more chronic diseases<sup>1</sup>. Lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption are the major causes of morbidity (illness and suffering) and deaths related to chronic diseases<sup>2</sup>. Addressing these modifiable factors can lead to preventing and managing heart disease, diabetes, colon cancer, smoking-related cancers, and other diseases.<sup>3</sup> Individuals who have completed self-management programs addressing these factors have reported better satisfaction, improved coping skills, and social support<sup>4</sup>.

Sixty percent of Valley report their health as “very good/excellent” compared to 63% overall in Connecticut. Younger residents (ages 18-34) have better self-rated health (79% versus 45% and 38%, respectively) compared to their older counterparts (ages 65-79 and 80-94, respectively)<sup>5</sup>. Our team exists to ensure that lifestyle-focused resources (support groups and programs) are available to empower our community members to prevent and manage chronic diseases and promote good overall health and well-being. In turn, they can make a positive impact on their loved ones, workplace, and community.

**References:**

1 Ward BW, Schiller JS, Goodman RA. Multiple chronic conditions among US adults: a 2012 update. *Prev Chronic Dis.* 2014;11:130389.

2 Gerteis J, Izrael D, Deitz D, LeRoy L, Ricciardi R, Miller T, Basu J. Multiple Chronic Conditions Chartbook. AHRQ Publications No, Q14-0038. Rockville, MD: Agency for Healthcare Research and Quality; 2014.

3 Jamison, DT, Breman JG, Measham AR, et al. Disease Control Priorities in Developing Countries. Chapter 44. 2nd edition. Washington (DC): [The International Bank for Reconstruction and Development / The World Bank](#); 2006.

4 Adams, RJ. Improving health outcomes with better patient understanding and education. *Risk Manag Healthc Policy.* 2010; 3: 61–72.

5 Buchanan, Mary, and Mark Abraham. (2016). *Understanding the Valley Region: 2016 Valley Community Index.* Derby, CT: Valley Community Foundation and DataHaven.

**Primary Partners:** Griffin Hospital Center for Prevention & Lifestyle Management, Griffin Hospital Faculty Physicians, Griffin Hospital Communications and Public Affairs, Valley Parish Nursing

**Overall Goal:** To coordinate Griffin Hospital-based and similar community-based programs and resources that address lifestyle-focused chronic disease prevention and management targeting adults 18 years and older. Lifestyle-focused programs include those that address nutrition, physical activity, stress management, chronic disease prevention, and chronic disease self-management. Inventory and catalogue lifestyle focused programs available to the Valley community; monitor uptake of the services; and gauge community needs.

**Indicators:**

**Long term:** Using the tracking system, monitor uptake of services and identify gap areas. Create quality improvement projects to increase provider and community awareness and project uptake.

**Medium term:** Establish a tracking system, to include referrals from providers/offices and uptake of services.

**Short term:** Develop catalogue/inventory of lifestyle-focused chronic disease prevention and management programs and support groups. Establish baseline referrals to programs.

**Focus Area 2: Lifestyle-focused Chronic Disease Management & Prevention Programs** *(continued)*

<p><b>Objectives/Strategies:</b></p> <ul style="list-style-type: none"> <li>• Create a catalogue/inventory of lifestyle-focused chronic disease prevention and management programs/services.</li> <li>• Establish referral tracking system.</li> <li>• Tracking number of community members who sign up for programs/services.</li> <li>• Increase number of community members completing programs.</li> <li>• Increase community participation/involvement.</li> <li>• Maintain/increase provider/office referrals.</li> </ul>	<p><b>Actions/Activities:</b></p> <ul style="list-style-type: none"> <li>• Develop and disseminate catalogue/inventory</li> <li>• Use AthenaHealth EHR, run baseline numbers</li> <li>• Use records of Athena Health EHR, Griffin Faculty Physicians records, Griffin Outreach and Parish Nursing</li> <li>• Track using records noted above</li> <li>• Presentation to the Patient Family Council</li> <li>• Presentations to providers and staff at Griffin Faculty Practice and other community providers twice a year, and annual reminders about the programs</li> </ul>
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**Alignment with Connecticut State Health Improvement Plan (SHIP):**  
Aligns with 3 sections of the SHIP: Nutrition and Physical Activity section; Diabetes and Chronic Disease section; and Obesity section

**Community Engagement:**  
Opportunity for community representation from Griffin Hospital’s Patient Family Advisory Council.



**For further information on this Focus Area, contact: Victoria Costales, MD, MPH, Director, Griffin Center for Prevention and Lifestyle Management, Associate Program Director, Griffin Hospital Internal Medicine/Preventive Medicine Residency Program [vcostales@griffinhealth.org](mailto:vcostales@griffinhealth.org)**



**Focus Area #3: Substance Use Disorders**

**Why Is This Issue a Priority?**

According to the National Institute on Drug Addiction, 90 percent of all adults with a substance use disorder started using before the age of 18, and half before the age of 15. Additionally, children who first smoke marijuana before the age of 14 are more than five times as likely to abuse drugs as adults than those who first use marijuana at age 18. Substance Use Disorders affect every community, family, and business. Substance Use Disorders are common, disabling, and contribute to many social problems including driving under the influence, stress, domestic violence, child abuse, violence, and crime. Many people with Substance Use Disorders face many barriers which include stigma, shame, insurance barriers, access to treatment and recovery supports.

**Primary Partners:** Alliance for Prevention & Wellness/A Program of BHcare, Naugatuck Valley Health District/Medical Reserve Corps, Griffin Hospital, Valley Parish Nurses, police, EMS

**Overall Goal:** To address addiction as a chronic illness and identify opportunities and partnerships to reduce its negative impact on physical health and improve individual, family, and community quality of life; to reduce substance use disorders in the region, and promote a recovery community for those with substance use disorders and their families; to raise awareness and educate communities and providers; engage in advocacy, and identify connections through intervention, harm reduction, treatment, and aftercare/recovery.

**Indicators:**

**Long term (5 years):** **1)** Decrease the number of Valley 11th grade students reporting past 30 day use of alcohol from 20% to 15%; **2)** Reduce the number of Valley 11th grade students reporting past year use of marijuana from 39.8% to 35%; and **3)** Reduce access to prescription opioids across the lifespan as measured by increase in pounds collected at drop boxes and reduction in prescriptions written.

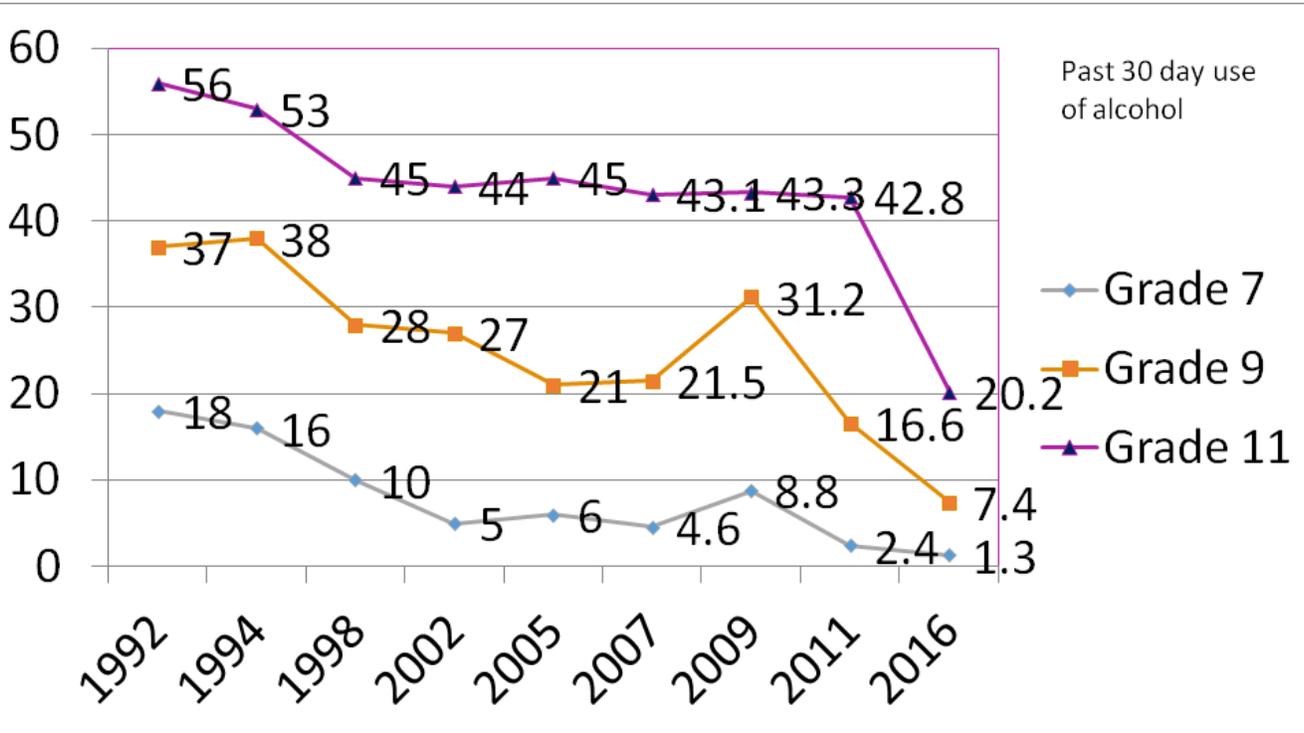
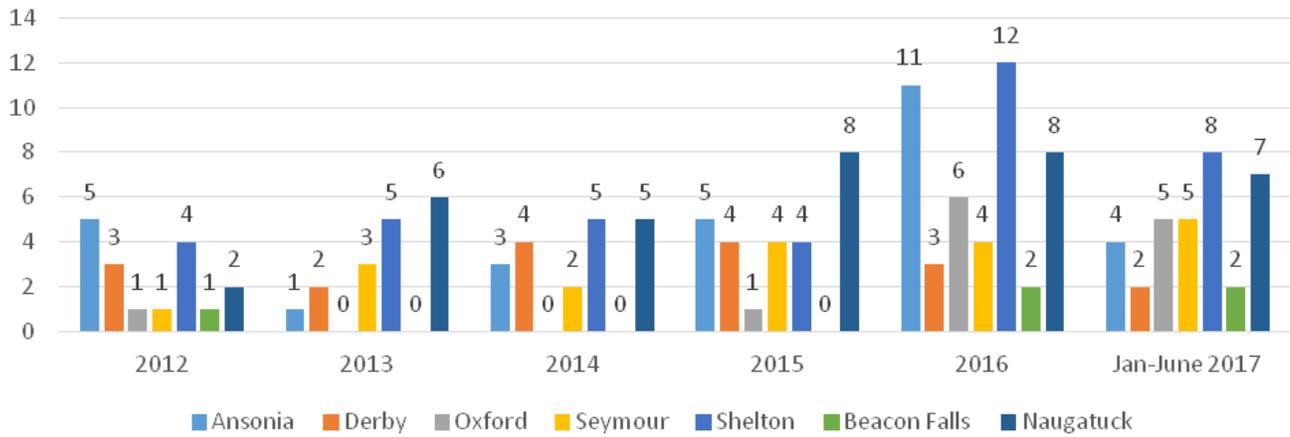
**Midterm (3years)** **1)** Reduce by 5% the rate of emergency room visits for people with substance use disorders across the lifespan; **2)** Implement Recovery Coaches in the Emergency Rooms to create linkages and connections to care; and **3)** Increase data collection and management efforts for community specific information regarding substance use disorders

**Short term (1 year)** **1)** Increase community engagement from various sectors in an effort to increase awareness and reduce alcohol and other drug use across the lifespan; **2)** Increase access to Naloxone to decrease overdose rates among residents; and **3)** Increase the number of residents who can identify connections to care.

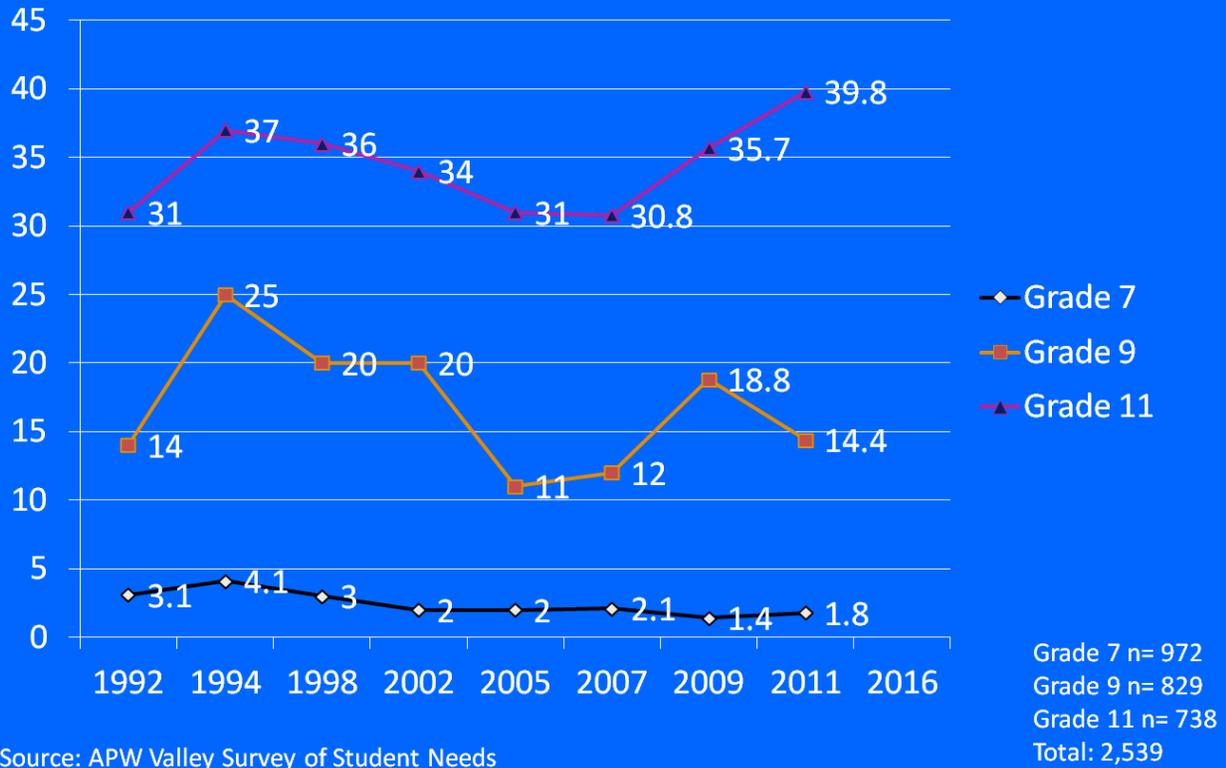


<b>Focus Area #3: Substance Use Disorders</b> <i>(continued)</i>	
<p><b>Objectives/Strategies:</b></p> <ul style="list-style-type: none"> <li>• Conduct inventory of community resources.</li> <li>• Establish baseline overdose data for the Valley.</li> <li>• Establish baseline substance use disorder data and DUI data.</li> <li>• Raising awareness /community education.</li> <li>• Advocacy</li> <li>• Identify connections to care</li> </ul>	<p><b>Actions/Activities:</b></p> <ul style="list-style-type: none"> <li>• Review current listing of community education, interventions, treatment and recovery options; edit as needed.</li> <li>• Review data.</li> <li>• Review data.</li> <li>• Provide community Drug Trends, Opioid, &amp; Naloxone Trainings;</li> <li>• Utilize social media to educate public regarding behavioral health issues;</li> <li>• Presentations highlighting local data</li> <li>• Distribute informational materials;</li> <li>• Promote medication drop boxes.</li> <li>• Advocate for blister packaging for opioid medication &amp; other opioid-related legislation.</li> <li>• Promote family support groups;</li> <li>• Promote recovery programs and initiatives;</li> <li>• Promote access to treatment bed availability in real time through DMHAS website;</li> <li>• Increase Mental Health First Aid Trainings in the community;</li> <li>• Implement Recovery Coaches in emergency departments;</li> <li>• Expand Screening, Brief Intervention, Referral to Treatment (SBIRT) in school and community settings;</li> <li>• Promote available treatment resources in the community.</li> </ul>
<p><b>Alignment with Connecticut State Health Improvement Plan (SHIP):</b>  The priority area aligns with the State Health Improvement Plan (SHIP) section 6 Mental Health, Alcohol, and Substance Abuse. The State Health Improvement Plan Objective 4: Reduce by 5% the rate of emergency department visits for people who are alcohol dependent across the lifespan; Objective 5: Reduce by 5% the non -medical use of pain relievers across the lifespan (ages 12 and older); and Objective 6: Reduce by 5% the use of illicit drugs across the lifespan (ages 12 and older).</p>	<p><b>Community Engagement:</b></p>
<p><b>For further information on this Focus Area, contact: Pam Mautte, Director, Alliance for Prevention &amp; Wellness, A Program of BHcare, pmautte@bhcare.org</b></p>	

Valley Overdose Data



# Valley Youth Past Year Use of Marijuana



Source: APW Valley Survey of Student Needs

**Focus Area #4: Childhood Obesity Prevention / Community Based Programming**

**Why Is This Issue a Priority?** Childhood obesity is a serious problem in the United States putting kids at risk for poor health. Despite recent declines in the prevalence among preschool-aged children, obesity amongst all children is still too high. In 2011-2014 For children and adolescents aged 2-19 years, the prevalence of obesity has remained fairly stable at about 17% and affects about 12.7 million children and adolescents. The causes of excess weight gain in young people are similar to those in adults, including factors such as a person’s behavior and genetics.

Obesity during childhood can have a harmful effect on the body in a variety of ways. Children who are overweight or obese are more likely to have: high blood pressure and high cholesterol, which are risk factors for cardiovascular disease (CVD); increased risk of impaired glucose tolerance, insulin resistance, and type 2 diabetes; breathing problems, such as asthma and sleep apnea; joint problems and musculoskeletal discomfort; fatty liver disease, gallstones, and gastro-esophageal reflux (i.e., heartburn). Childhood obesity is also related to: psychological problems such as anxiety and depression; low self-esteem and lower self-reported quality of life; social problems such as bullying and stigma.

Children who are obese are more likely to become adults with obesity. Adult obesity is associated with increased risk of a number of serious health conditions including heart disease, type 2 diabetes, and cancer.

<https://www.cdc.gov/obesity/childhood/causes.html>

**Primary Partners:** Yale-Griffin Prevention Research Center, Ansonia, Seymour, Derby, Shelton, and Naugatuck Public School Districts, Griffin Hospital, Valley YMCA, Naugatuck Valley Health District, Massaro Community Farm, ShopRite, Humane Society of the U.S., community residents.

**Overall Goals:** Reduce the prevalence of obesity among students enrolled in Lower Naugatuck Valley School Districts.

- Increase nutrition knowledge, healthy eating, and physical activity
- Promote student health, wellbeing and academic readiness
- Develop a comprehensive and sustainable obesity prevention initiative focused on nutrition and physical activity for grades Pre-K through 12
- Extend health promotion efforts to include parents/family and school staff

**Indicators:**

**Long term:** Reduce prevalence of obesity among students

**Medium term:** Successful delivery of interventions. Increase in # of physical activity and nutrition-related initiatives in the schools over 5-year period. Improvement in students’ behaviors. Improvement in physical fitness and academic achievement.

**Short term:** Continue and expand VITAHLS activities. Engage partners to ensure active participation from all schools. Comprehensive understanding of needs. Increased awareness of obesity and importance of health promoting programming. Partner engagement and satisfaction.

**Focus Area #4: Childhood Obesity Prevention / Community-Based Programming**  
*(continued)*

**Objectives/Strategies:**

- Sustain an obesity prevention initiative.
- Continue existing programming, including annual cooking contest.
- Continue subcommittee work programming development.

**Actions/Activities:**

- Create health promoting environment within the schools. Support programs that can be incorporated into the school day. Secure funding for program costs. Increase awareness of the issue. Develop sustainability plan. Evaluate impact of the VITAHLS initiative (9/2019).
- Identify/design/implement programming to increase nutrition knowledge, healthy eating, physical activity.
- Create mini-grant program for 2017-2018 school year.
- Reconvene subcommittees to meet current year goals.

**Alignment with Connecticut State Health Improvement Plan (SHIP):**

Aligns with Objective CD-27: Reduce by 5% the prevalence of obesity in children 5-12 years of age and students in grades 9-12.

**Community Engagement:**

Representation from each participating school district, community partners and community residents.

**For further information on this Focus Area, contact:**

**Beth Comerford**, Deputy Director, Yale-Griffin Prevention Research Center,  
 beth.comerford@yalegriffinprc.org;

**Kim Doughty, MPH, PhD**, Research Associate/VITAHLS Coordinator, Yale-Griffin Prevention Research Center, kim.doughty@yalegriffinprc.org



## Focus Area #5: Lung Cancer Screening / Smoking Cessation

**Why Is This Issue a Priority?** The National Lung Screening Trial (NLST) study findings revealed that participants who received low-dose helical CT scans had a 15 to 20 percent lower risk of dying from lung cancer than participants who received standard chest X-rays. Additionally, the results of a study conducted by Griffin Hospital that compared the stage of the lung cancer discovered by the high risk lung cancer screening program versus all other revealed that routine screening for lung cancer in a population of asymptomatic patients can detect lung cancer at an earlier stage than lung cancer detected in an unscreened population. The percentage of lung cancers diagnosed a stage 4 in patients who were enrolled in Griffin Hospital's Lung Cancer Screening Program is comparable to the percentages of lung cancers diagnosed stage 1 with patients who were not enrolled in a screening program or undergo routine screening. According to the Annals of Translational Medicine smoking cessation remains the most effective tool in the battle against lung cancer. A successful and targeted smoking cessation counseling program in lung screening programs may therefore be the most effective method to reduce mortality of thoracic smoke related diseases.

Through the Lung Cancer Screening/Smoking Cessation CHIP group, we will identify high-risk patients who would benefit from screening thus detecting lung cancer at earlier stages when it is most treatable, educate patients about screening and its associated radiation exposure risks, invest in infrastructure to help manage follow-up communication and incidental findings post-screening, and offer free smoking cessation programming.

**Primary Partners:** Griffin Hospital

**Overall Goal:** Lung Cancer Screening Program goal: Identify lung cancer early, when it is most treatable. Smoking Cessation Program goal: Provide individuals with knowledge and tools that work for them to successfully quit smoking.

### Indicators:

- **Long term:** Reduce lung cancer stage of detection and mortality. Increase number of available smoking cessation programs, and decrease self-reported smoking rates.
- **Medium term:** Expand smoking cessation initiatives: increase program offerings; provide patients with tools/resources to successfully quit smoking; pursue certification for Griffin Hospital's smoking cessation course instructor.
- **Short term:** Obtain and be trained to utilize a navigational component to LungView LCSP software.



# GRIFFIN HEALTH

**Focus Area #5: Lung Cancer Screening / Smoking Cessation** *(continued)*

**Objectives/Strategies:**

- Detect lung cancer at early stage(s) and decrease lung cancer mortality.
- Expand smoking cessation initiatives.
- Obtain and be trained to utilize navigational component to LungView LCSP software.

**Actions/Activities:**

- Detect 80% of lung cancers at stage 1 or 2, compared to 2016 baseline of 75%. Reduce lung cancer mortality by 16%.
- Increase smoking cessation offerings in community by 100%. Increase offering for Griffin employees by 100%. Provide patients with additional quit smoking tools. Pursue certification for Griffin Hospital’s smoking cessation instructor.
- Build navigation template for LungView. Receive extensive training on navigational component.

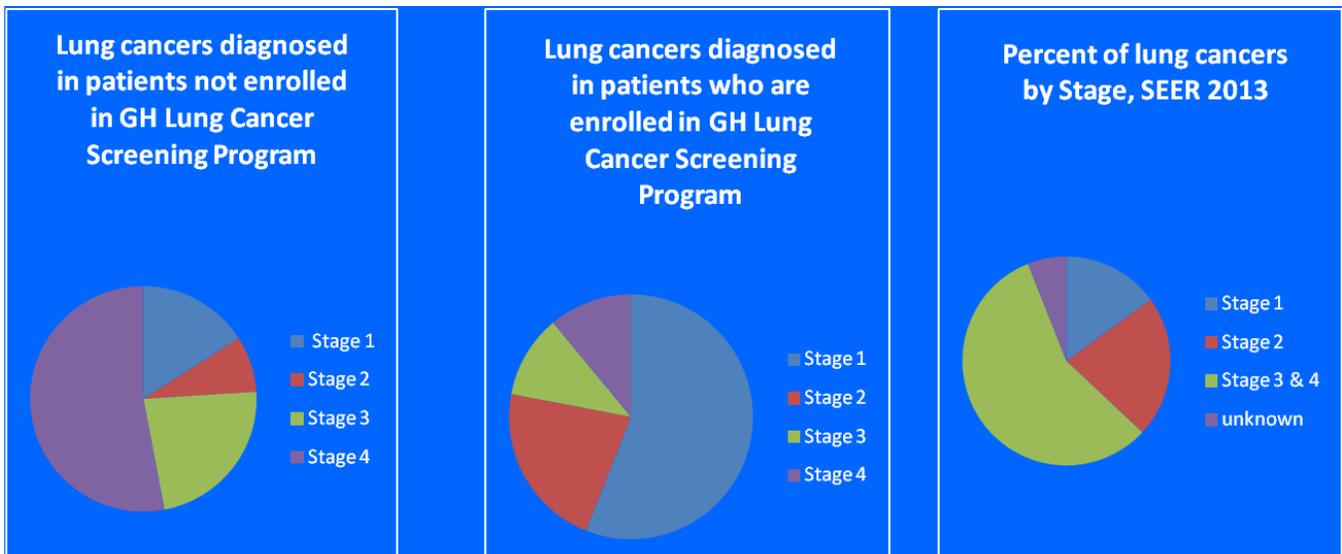
**Alignment with Connecticut State Health Improvement Plan (SHIP):**

Addresses Focus Area 3 of SHIP: Chronic Disease Prevention and Control (Objective CD-6: Decrease new cancer case incidence by 2%. Objective CD-7: Reduce late-stage diagnoses by 5%. Objective CD-8: Reduce specified age-adjusted cancer mortality rates by 5%. Objective CD-10: Increase 5-year relative survival rates of specified cancers by 5%).

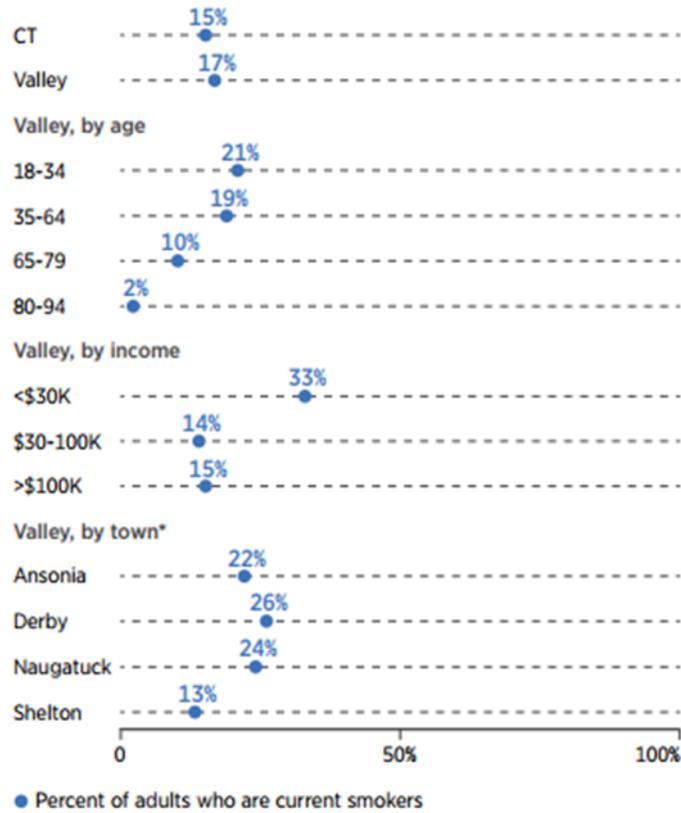
**Community Engagement:**

Griffin Hospital has provided hundreds of low-dose lung cancer screens free to high-risk individuals, and continues to assist patients who are uninsured or underinsured. The hospital offers a free smoking cessation program titled “That’s It, Learn to Quit.” The hospital offers smoking cessation programs specifically for its employees.

For further information on this Focus Area, contact: **Christine Marr, MPH**, Healthcare Analyst, Griffin Hospital, [cmarr@griffinhealth.org](mailto:cmarr@griffinhealth.org)



6.08 Cigarette Smoking in the Valley, 2015



Lung Cancers diagnosed in patients who are not enrolled in Griffin Hospital's Lung Cancer Screening Program:	Lung Cancers diagnosed in patients who are enrolled in Griffin Hospital's Lung Cancer Screening Program:	Percent of Cancers by Stage, SEER 2013*
Stage 1: 14 (16%) Stage 2: 7 (8%) Stage 3: 21 (23%) Stage 4: 48 (53%)	Stage 1: 5 (56%) Stage 2: 2 (22%) Stage 3: 1 (11%) Stage 4: 1 (11%)	Stage 1: 15% Stage 2: 22% Stage 3 & 4: 57% Unknown: 6%

**Focus Area #6: Asthma Prevention and Self Management**

**Why Is This Issue a Priority?**

According to the 2016 Valley Community Index, from 2009 to 2011, 1 out of every 7 students in grades PreK-12 were reported to have asthma, and these rates have increased from 13.2 percent in 2006 to 14.2 percent in 2011. In 2015, the percent of adults living in the Valley with asthma was 13% (2016 Valley Community Index). Asthma is an ongoing health concern in the Valley.

This focus area exists to mitigate the burden of asthma on the health and quality of life of those diagnosed with asthma in our community. The team will work together to form a strong collaboration between Griffin Hospital, Naugatuck Valley Health District, Community Doctors and Nurses and other essential community partners to address asthma within the Valley.

**Primary Partners:** Naugatuck Valley Health District, Griffin Hospital, Valley Parish Nurses, School Nurses, Daycare Providers, and Local Pediatrician Offices.

**Overall Goal:** Raise asthma awareness in the community. Provide asthma education to the community. Provide education to childcare providers on asthma and asthma action plans. Reduce rates of asthma visits and admissions to Griffin Emergency Department (ED).

**Indicators:**

- **Long term:** 10% reduction in asthma related visits to Griffin ED (3-year projection).
- **Medium term:** Provide minimum of 3 presentations per year on asthma management to childcare providers, parents/guardians.
- **Short term:** Attend minimum of 3 community events, documenting # of attendees and materials provided.

**Objectives/Strategies:**

- Increase asthma awareness.
- Increase community and provider education.
- Establish benchmark/tracking.

**Actions/Activities:**

- Provide education at health fairs and community events. Educate parents/guardians on asthma management.
- Educate child care providers about managing asthma and Asthma Action Plans.
- Track rates of asthma related visits to Griffin ED.



**Focus Area #6: Asthma Prevention and Self Management** *(continued)*

**Alignment with Connecticut State Health Improvement Plan (SHIP):**

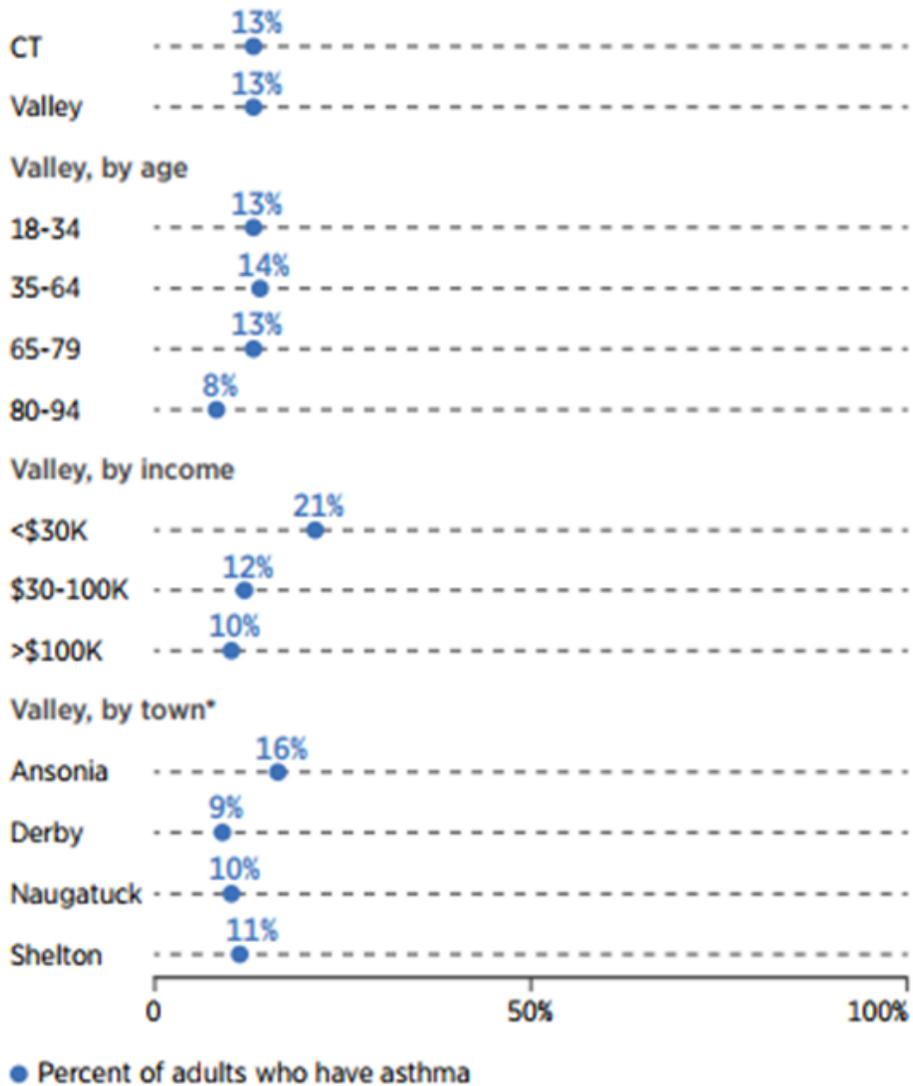
Aligns with SHIP section on Asthma and Chronic Respiratory Disease, with the objective of decreasing by 5% the rate of ED visits for asthma.

**Community Engagement:**

Development of an Asthma Action Plan PSA.

**For further information on this Focus Area, contact:** Alicia Mulvihill, Health Educator, Naugatuck Valley Health District, [amulvihill@nvhd.org](mailto:amulvihill@nvhd.org)

**6.07 Asthma in the Valley, 2015**



## Focus Area #7: Healthy Homes

### Why Is This Issue a Priority?

According to DPH, in 2015 the percentage of children ages 6 months-2 years tested for lead was 73% in Ansonia, 64% in Derby, 65% in Naugatuck, 73% in Seymour and 78% in Shelton. Our goal is to raise these numbers to 90% in the Valley by providing more education to parents with young children. In 2013, 2.4% of children living in the Valley had a confirmed blood lead level at or above the CDC reference value (5ug/dL)(Healthy CT 2020). Through our healthy homes CHIP group, we will educate the community about the importance of lead testing and the dangers of lead poisoning.

Smoking has always been a big public health issue, and although the rate of smoking has decreased, there are still nearly one quarter of adults living in Ansonia, Derby and Naugatuck that reported they currently smoke (2016 Valley Community Index). It is important for us to educate parents who smoke about the dangers of second- and third-hand smoke and the effect this has on their children.

**Primary Partners:** Naugatuck Valley Health District

**Overall Goal:** Reduce blood lead levels in children through early screening and lead-safe housing. Reduce the effects of tobacco smoke in the home, including second- and third-hand smoke, through education and awareness activities. The team operates under the principle that the connection between health and the home is one of the most important relationships that exist for the well-being of families.

### Indicators:

**Long term (5 years):** **1)** Increase to 98% the rate of children <3 yo that are tested for lead at least once; **2)** Increase to 80% in all towns the % of children <3 yo that received 2 annual lead tests; and **3)** Make 118 lead safe units and conduct 118 healthy homes inspections by October 2019 through the NauVEL program.

**Medium term (3 years):** **1)** Increase to 90% the rate of children <3 yo tested at least once for lead; **2)** Increase to 70% in all towns the % of children <3 yo that received 2 annual lead tests; **3)** Develop a baseline to determine a level of awareness of the effects of second- hand smoke in the home; and **4)** Provide a minimum of 5 health initiatives to increase awareness of parents/guardians relative to the effects of second- and third-hand smoke in the home.

**Short term (1 year):** Provide a minimum of 5 targeted health education interventions annually focused on the prevention of childhood lead poisoning.



<b>Focus Area #7: Healthy Homes</b> <i>(continued)</i>	
<p><b>Objectives/Strategies:</b></p> <ul style="list-style-type: none"> <li>• Advocacy</li>   <li>• Healthy Homes Assessments</li>   <li>• Remediation</li>   <li>• Education</li>           <li>• Surveillance</li> </ul>	<p><b>Actions/Activities:</b></p> <ul style="list-style-type: none"> <li>• Advocate and educate providers and the public about importance of lead testing for children &lt;6 yo (required to be tested twice by 36 months).</li> <li>• Complete 118 healthy homes assessments through NauVEL by 10/2019.</li> <li>• Offer remediation of unsafe lead homes through NauVEL by 10/2019.</li> <li>• Educate parents of children with elevated blood lead level (BLL) of 15 or higher in their homes and provide cleaning supplies to help clean lead dust. Educate parents about the effects of second- and third-hand smoke in the home.</li> <li>• Develop a baseline to determine the level of awareness of the health effects relative to secondhand and third-hand smoke in the home by 6/2018.</li> </ul>
<p><b>Alignment with Connecticut State Health Improvement Plan (SHIP):</b>  SHIP objective: To reduce to &lt;3% the prevalence rate of children &lt;6 yo with confirmed blood lead levels at or above the CDC reference value of 5ug/dL. SHIP strategies that most closely align are: to identify high risk areas (pre-1978 housing) and develop a plan to reduce exposure to lead-base painted surfaces, develop a program to conduct inspections on units, explore options to address abatement, partner with health care professionals to improve provider compliance with mandated lead testing.</p>	<p><b>Community Engagement:</b>  Use of community feedback form.</p>
<p><b>For further information on this Focus Area, contact:</b> Carissa Caserta, Assistant Director for Community Health, Naugatuck Valley Health District, ccaserta@nvhd.org</p>	

#### 4.02 Lead Poisoning and Lead Screenings, 2004-13

More children are being screened for lead, but some have high rates of lead poisoning.

Percent of Children age 1-2 Who Had a Lead Screening

	2004	2013	% Increase, 2004-2013
Connecticut	45%	71%	+26%
Valley	46%	71%	+25%
Ansonia	51%	72%	+21%
Beacon Falls	48%	59%	+11%
Derby	42%	70%	+28%
Naugatuck	35%	55%	+20%
Oxford	61%	70%	+9%
Seymour	52%	80%	+28%
Shelton	48%	76%	+28%

Percent of Children age 0-5 with Elevated Blood Lead

	2004: 10ug/dL	2013: 10ug/dL	2013: 5ug/dL
Connecticut	2.2%	0.7%	3.0%
Valley	1.7%	0.9%	2.4%
Ansonia			4.1%
Beacon Falls			2.4%
Derby			3.2%
Naugatuck			3.0%
Oxford			1.7%
Seymour			1.2%
Shelton			0.8%



We invite and encourage members of the community to participate in our ongoing effort to implement the strategies outlined in this document. Please contact the Lead for any of the Focus Area action plans detailed in this document to learn how you can participate. You can also contact Ken Roberts, Director, Communications & Public Affairs at Griffin Hospital ([kr Roberts@griffinhealth.org](mailto:kr Roberts@griffinhealth.org)) or Joan Lane, Public Health Specialist at Naugatuck Valley Health District ([jlane@nvhd.org](mailto:jlane@nvhd.org)) for more information or to get involved in our efforts to improve the health and well-being of the community.

