QVHD

Quinnipiack Valley Health District

Community Health Assessment

and

Community Health Improvement Plan

Community Health Assessment (CHA) adopted by the Community Health Coalition on May 5, 2017
Community Health Improvement Plan (CHIP) June 20, 2019

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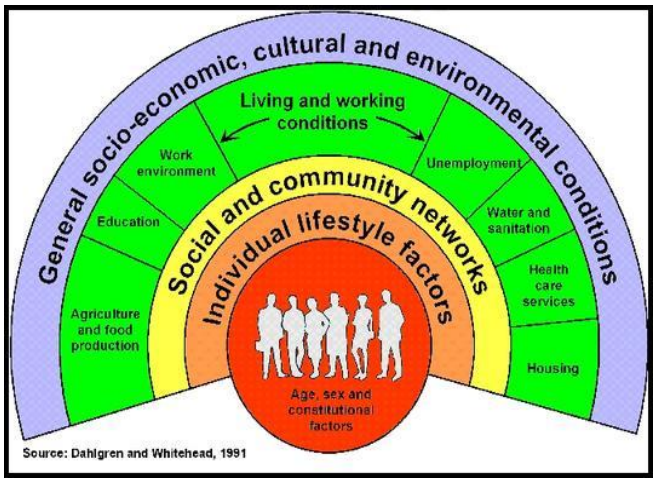
Part 1: Community Health Assessment

Introduction

Improving the health of a community is influenced by more than just illness or disease. It involves how all aspects of life, including economic, recreational, environmental, cultural and spiritual components affect its residents. The health of a community cannot be simply measured by the physical health data that is available. Health is made up of more than just the genetics and lifestyle of individuals. Social determinants also greatly impact the health of a community. Factors such as housing, employment, education and government policies can affect how people live their lives and their resulting health status. In fact, policy can affect greater behavioral change than health education alone.

The illustration below represents the Social Determinants of Health model.



Quinnipiack Valley Health District (QVHD) serving the towns of Bethany, Hamden, North Haven and Woodbridge CT, completed a Community Health Assessment (CHA) over the months of May 2016 to December 2016. In conducting the CHA, it was mindful of the full nature of good health and embraced the social determinant model when evaluating and analyzing the data.

I. The Process

QVHD used a modified MAPP (Mobilizing for Action through Planning and Partnerships) process in developing the CHA. It was also guided by the ACHI (Association for Community Health Improvement) “Six Step Community Health Assessment Process” through participation on the Healthier Greater New Haven Partnership.

A. Forming a Community Health Coalition

To properly conduct a CHA, QVHD formed a coalition/collaborative of a broad range of community organizations and individuals who contribute to the overall health of the community. This brought together diverse interests from the community. A core leadership team consisted of a coordinator, the director of health and an advisor. The team generated a list of potential participants from various sectors of the community and invited them to become a part of the QVHD Community Health Coalition (QVHDCHC). Representatives were

solicited from local government, fire, police, community services, community organizations and neighborhoods. Members were also solicited from a local, African American women's breast cancer support group and from elderly services, both representing populations that are at higher health risk for poorer health outcomes. The active coalition membership totaled 30 persons. (Appendix A)

B. Defining the Purpose and Vision

Through two in-person meetings and multiple electronic communications, the purpose of the coalition was defined:

Assess the health of the community in order to develop a community health improvement plan.

At the first coalition meeting, a mission and vision were put forth and adopted by the QVHDCHC.
The Mission: **Work collaboratively with the community to improve health and the quality of life in QVHD.**
The vision adopted: **A place where all people can be healthy.**

C. Data Sources

Data for the community was collected from several sources.
Primary data sources were:

- **A Community Health Assessment** survey was widely distributed throughout QVHD.
  In total, 346 persons completed the survey: 34 non-resident workers and 312 residents. The survey was distributed through Community Health Coalition members, at community events, through publicity in the newspaper, through the QVHD website and through social media. The survey was administered from May to September 2016.
- **The Healthier Greater New Haven Partnership (HGNHP) and DataHaven**
  The towns of QVHD are part of the HGNHP and as such have been included in their community health assessment. Hamden, one of the district towns, is part of the urban periphery around the core town of New Haven in the HCNHP survey. The other three district towns are classified as suburban or wealthy rings around the urban core. DataHaven utilized a weighted sample to represent data on 5,000 district residents.
- **Key informant Interviews**
  Seventeen key informant interviews were conducted. Key informants represented the full population of the district and included representation for subgroups such as the elderly, school age children, the disabled and civil service. Those interviewed included town CEOs, representatives from area agencies and services (Meals on Wheels, Greater New Haven Transit, The Children's Center of Hamden and Marrakech) town community service personnel, school system representatives, a local pediatric group, fire, police, emergency management, a local pastor and community residents. (Appendix B)
- **A Community Conversation**
  A Community Conversation was held in an open forum to present community members with data from the QVHD and Greater New Haven Partnership's Community Health Assessment. Input was solicited from this conversation regarding the findings and the priorities for a Community Health Improvement Plan (CHIP.)
- **Community Assets Survey**
  Members of the QVHD Community Health Coalition and key informants contributed to the identification and development of a list of community needs, barriers and assets.

Secondary data sources included:

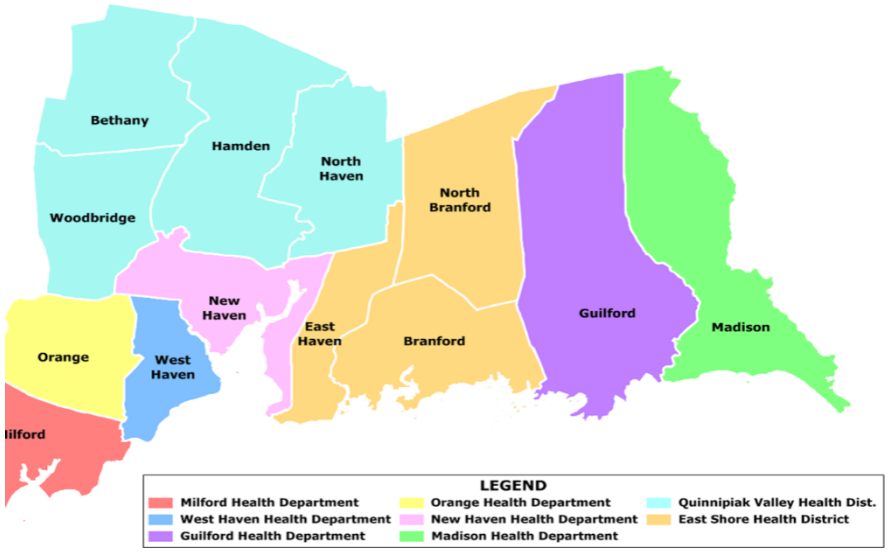
- CERC Town Profiles (produced by the CT Data Collaborative)
- Census data
- Mortality data
- Behavioral Risk Factor Surveillance System (BRFSS-State of CT)

D. Analyzing Data

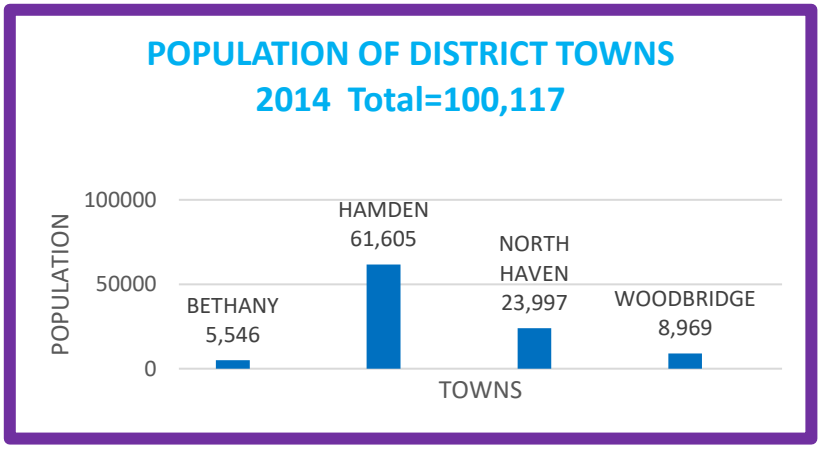
All data was analyzed internally with some primary data analyzed by DataHaven.

Part II: Findings

A. Demographics: The People in the District



Quinnipiack Valley Health District (QVHD) serves four Southern Connecticut towns: Bethany, Hamden, North Haven and Woodbridge. The total population in 2014 was 100,117, an increase of about 6% over 2000 (93,971)[3] which is slightly higher than the state increase in population during the same time period (about 5%.) The four towns vary widely in terms of classification and population. One town is rural with a small population: two of the towns are suburban; and one town is urban with the largest population at 10 times the smallest town. QVHD covers a total of 93.43 square miles. The population density ranges from a low of 262 population per square mile (Bethany) to a high of 1,887 population per square mile (Hamden) with North Haven and Woodbridge in between: 1,151 population per square mile and 477 population per square mile respectively.
(Data source: CRC Town Profiles, 2016. Produced by the CT Data Collaborative.)



Data Source: CRC Town Profile 2016 (Produced by the CT Data Collaborative)

In addition to the physical categorization of district towns ranging from urban to rural, the racial/ethnicity of the towns is also very diverse. Overall, the district is primarily white and this remains true in all four district towns. However, differences can be seen when examining race/ethnicity for individual towns. Hamden has the highest percentage of minorities and North Haven has the least percentage of minorities illustrated in Table 1.

TABLE 1: RACE/ETHNICITY BY GEOGRAPHIC AREA (expressed as a percent of the total population)					
RACE/ETHNICITY	**QVHD**	**BETHANY**	**HAMDEN**	**NORTH HAVEN**	**WOODBRIDGE**
WHITE	70%	91.6%	68.5%	95.5%	87%
BLACK	12%	1.9%	20.2%	1.3%	2%
HISPANIC	7%	2.5%	8.7%	2.9%	3.2%
ASIAN	6%	4.8%	5.5%	1.6%	8.7%
ALL OTHER	<1%	<1%	<1%	<1%	<1%
Data Sources: CERC Town Profile 2016: Years 2010-2014 for QVHD; Factfinder.census.gov for individual towns, 2010 census data					

Table 2 illustrates the age distribution for the District. (Shown in percentages of the total population)

TABLE 2: AGE DISTRIBUTION FOR QVHD (Expressed as a percent of the total population)						
AGE	STATE	QVHD	BETHANY	HAMDEN	NORTH HAVEN	WOODBRIDGE
0-14	18%	16.5%	18%	15%	17%	16%
15-24	14%	13.75%	9%	20%	11%	15%
25-44	25%	21%	23%	24%	22%	15%
45-64	29%	31.75%	36%	26%	31%	34%
65+	15%	17%	13%	15%	20%	20%

Data Source: CRC Town Profiles 2016 (Produced by the CT Data Collaborative)

Hamden has the youngest population with 59% of the population below age 44. Two of the four district towns have a higher percent of those 65 and older; North Haven and Woodbridge. The 45 year old age group and older comprises 48.75% of the overall district population making it older that than the state at 44%. CT BRFSS data (Behavioral Risk Factor Surveillance System) 2011-2014 demonstrates that QVHD has fewer 18-34 year olds and more 55+ year olds than the rest of the state. This could impact strategies for program planning.

Further breakdown of the 65 and older age groups for the district can be seen in Table 3. Woodbridge, which has the highest median income and highest level of those with a college degree or higher also has the largest per cent of those 75 years old and over (10.3%) suggesting a correlation between education, income and longevity. (Table 4)

TABLE 3: QVHD AGE DISTRIBUTION AGE 65 AND OVER Expressed as a percent of the total population)					
AGE GROUP IN YEARS	QVHD	BETHANY	HAMDEN	NORTH HAVEN	WOODBRIDGE
65-69	4.8%	4.8%	3.6%	5.0%	5.3%
70-74	3.2%	2.9%	2.9%	3.8%	3.5%
75-79	2.77%	2.4%	2.7%	2.8%	3.2%
80-84	2.65%	2.3%	2.5%	2.8%	3.0%
85+	3.05%	1.7%	3.3%	3.1%	4.1%
75 and older	8.47%	6.4%	8.5%	8.7%	10.3%

Data Source: https://factfinder.census.gov 2010 data

B. SOCIAL INDICATORS

Table 4 below illustrates some socioeconomic factors compared to population/population density that can potentially impact the health of a community. These values are compared to the State of CT. Due to the differences in towns, developing a CHA for the entire health district may appear challenging. Three of the four district towns have median incomes well-above the state median. The overall poverty and unemployment rates are lower than the state in all towns. Hamden, the largest town with the most diverse racial/ethnic distribution has the highest poverty rate of the district towns as well as the lowest median income. It also has a significantly lower per cent of owner-occupied dwellings.

TABLE 4: SELECTED SOCIOECONOMIC INDICATORS: QVHD AND STATE
Data source: CRC Town Profile 2016, produced by the CT Data Collaborative

TOWN AND State of CT	POPULATION DENSITY (population per square mile-2010)	OWNER-OCCUPIED DWELLINGS AS A PERCENT OF ALL DWELLINGS	MEDIAN HOUSEHOLD INCOME	EDUCATIONAL LEVEL: 1. HS GRADUATE 2. ASSOCIATES 3. BACHELORS OR HIGHER	UN-EMPLOYMENT RATE	POVERTY RATE
BETHANY	262	90.6%	$97,500	1. 23% 2. 8% 3. 51%	5.3%	3.9%
HAMDEN	1,887	65.5%	$67,771	1. 24% 2. 6% 3. 45%	5.9%	8.4%
NORTH HAVEN	1,151	86%	$84,078	1. 30% 2. 7% 3. 40%	5.5%	4.0%
WOODBRIDGE	477	90.6%	$134,045	1. 12% 2. 4% 3. 68%	4.2%	2.7%
STATE OF CT	742	67.3%	$69,899	1. 28% 2. 7% 3. 37%	6.6%	10%

The majority of District residents under age 65 have health insurance. This fact was also reflected in the QVHD Community Health Survey. The District also has fewer persons with disabilities under the age of 65 when compared to the state as a whole. Table 5 delineates sharp differences across towns when looking at the number of children on Husky, receiving benefits from the Supplemental Nutritional Assistance Program (SNAP) and the per cent of children living in poverty.

TABLE 5: INSURANCE, DISABILITY, AND CHILDREN IN POVERTY FOR DISTRICT

	CT	DISTRICT	BETHANY	HAMDEN	NORTH HAVEN	WOODBRIDGE
PERSONS WITHOUT HEALTH INSURANCE UNDER AGE 65[1]	8%	6.2%	3.7%	7.1%	5.2%	8.8%
PERSONS WITH A DISABILITY UNDER AGE 65[1]	8.6%	5%	4.2%	5.7%	6%	2.8%
DISTRICT CHILDREN ON HUSKY[2] 2014	NA	20%	7.6%	25%	15%	8.5%
CHILD RECIPIENTS OF SNAP[2] 2013	NA	7.5%	1.5%	10%	4%	1.6%
CHILDREN LIVING IN POVERTY[2]						
< 100% BELOW	13.4%	4.0%	2.3%	7.7%	3.6%	2.4%
100-200% BELOW	15.1%	8.6%	3.1%	16.4%	6.1%	8.6%

1. Data Source: US Census Bureau Quick Facts
2. HUSKY is CT Medicaid; SNAP is food stamps; Data Source: The 2015 CT KIDS COUNT, CT ASSOCIATION FOR HUMAN SERVICES. Denominators are based on ages 0 to 19, although SNAP only serves child recipients up to age 18.

SAFETY

Table 6 illustrates resident's perception of certain factors that affect community safety. Overall, the majority of District residents perceive their communities as a safe place to live. Three of four towns have a very high confidence level in their police department's ability to keep them safe. Safe sidewalks, crosswalks and bikeways are an issue for three of four towns. Two of these three towns are rural and have large lot sizes and generally do not have sidewalks.

Table 6: Perception of Community Safety

	CT	GNH (GREATER NEW HAVEN)	HAMDEN	BETHANY AND NORTH HAVEN GROUPING	WOODBRIDGE GROUPING
Police keep residents safe	75%	71%	63%	87%	92%
Safe sidewalks and crosswalks	59%	66%	82%	43%	49%
Safe bikeways	59%	66%	80%	64%	58%
Safe to walk at night	71%	67%	58%	81%	80%
People can be trusted	83%	81%	84%	94%	95%

Source: 2016 State of CT Wellbeing Survey, Datahaven

C. The Physical Environment

All four towns in the District are dedicated to protecting the environment as well as preserving open space through its citizen participation on various commissions. Each town has an Inland/Wetlands Commission as well as some form of a Conservation Commission. Additional environmental commissions include a Clean and Green Commission (Hamden) and a Clean Energy Task Force (North Haven.) There is one major river and one minor river. One town has a beach on a lake. The Regional Water Authority serves all four towns and maintains watershed areas.

There are many places that offer an opportunity for physical activity. Towns have numerous parks, ball fields and walking trails. Hamden also hosts two state parks: Sleeping Giant and West Rock Ridge. The state's walking trail system runs through several of the district towns. Three of four towns have indoor community swimming pools. One town has a public ice rink.

Three of four towns (Hamden, North Haven and Woodbridge) have banned outdoor wood burning furnaces. Two of four towns (Hamden and North Haven) prohibit smoking on public properties, including recreational fields.

Currently there is no passenger railway service available within the District although there is a major railway station located in New Haven. There is a bus line serving all four towns, although the route is limited to one major road in Woodbridge and Bethany. Greater New Haven Transit Authority provides transportation to appointments for seniors and the disabled for a small fee. Some towns maintain a bus for transport for elderly clients for shopping. The QVHD Community Health Survey revealed that 93% of respondents felt they had adequate transportation to meet their needs.

D. Leading Causes of Death

Quantitative data indicate that residents of the District have age-adjusted mortality rates for all causes similar to the State as a whole, with one exception noted for Woodbridge. (Table 8) An explanation of why Woodbridge, the wealthiest and best educated town within the district has a higher AAMR for all ages has not been identified. It may be connected to the fact that there is a higher proportion of those over age 75 residing in Woodbridge. (Table 7) Mortality data for the other towns was similar and in line with the State leading causes of death.

Table 7 : Age-Adjusted Mortality Rates (AAMR) for District Towns Compared to the State of CT		
TOWN	**AAMR ALL AGES**	**COMPARED TO THE STATE**
BETHANY	673.8/100,000	NO DIFFERENCE
HAMDEN	634.1/100,000	LOWER
NORTH HAVEN	614.0/100,000	NO DIFFERENCE
WOODBRIDGE	822.6/100,000	HIGHER

http://www.ct.gov/dph/lib/dph/hisr/instantatlas/lcod/atlas.html

Quantitative data also indicates that the leading causes of death in the District, as in the state, are heart disease and cancer and this holds true across all four district towns. Table 8 illustrates that the District is also in line with the state for the other top leading causes of death (Chronic lower respiratory disease, diabetes-related and accidents/unintentional injuries.) A most significant finding is that the diabetes-related death rate for Hamden is statistically higher than the state rate and the rate for other district towns.

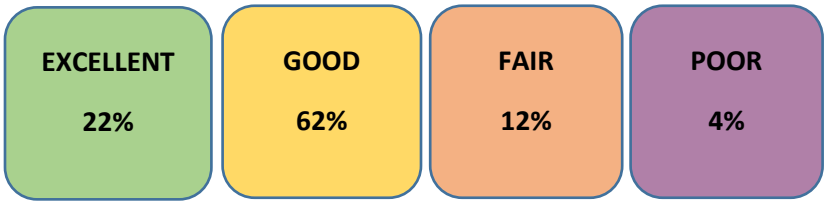
Table 8: LEADING CAUSES OF DEATH AGE ADJUSTED PER 100,000 PEOPLE 2008-2012					
CONNECTICUT	**DISTRICT (AVERAGE)**	**BETHANY**	**HAMDEN**	**NORTH HAVEN**	**WOODBRIDGE**
#1 DISEASES OF THE HEART **332.14**	#1 DISEASES OF THE HEART **247.04**	#1 DISEASES OF THE HEART **204.7**	#1 DISEASE OF THE HEART **292.34**	#1 DISEASES OF THE HEART **236.27**	#1 DISEASES OF THE HEART **254.87**
#2 MALIGNANT NEOPLASMS **159.95**	#2 MALIGNANT NEOPLASMS **141.77**	#2 MALIGNANT NEOPLASMS **129.1**	#2 MALIGNANT NEOPLASMS **157.08**	#2 MALIGNANT NEOPLASMS **141.16**	#2 MALIGNANT NEOPLASMS **139.75**
#3 CHRONIC LOWER RESPIRATORY DISEASE **64.54**	#3 DIABETES RELATED **45.45**	SUPPRESED (NUMBERS TOO SMALL)	#3 DIABETES RELATED **61.97**	#3 CHRONIC LOWER RESPIRATORY **50.87**	#3 CHRONIC LOWER RESPIRATORY **40.75**
#4 DIABETES RELATED **49.11**	#4 CHRONIC LOWER RESPIRATORY **39.41**	SUPPRESSED (NUMBERS TOO SMALL)	#4 ACCIDENTS **33.86**	#4 ACCIDENTS **39.85**	#4 DIABETES RELATED **36.38**
#5 ACCIDENTS (UNINTENTIONAL INJURIES) **33.53**	#5 ACCIDENTS **34.56**	SUPPRESSED (NUMBERS TOO SMALL)	#5 CHRONIC LOWER RESPIRATORY **26.61**	#5 DIABETES RELATED **38.01**	#5 ACCIDENTS **29.97**
SOURCE: CT DPH AAMREPORT_STATE_5Y_2008-2012.XLSX AND AAMREPORT_TOWNWITHSTATE_5Y_2008-2.XLSX					

E. QVHD Community Health Survey Findings

From May 2016 through October 2016, a community health survey was conducted by the QVHD Community Health Coalition. In addition to this survey, residents were also interviewed through the Healthier Greater New Haven Partnership. 346 people completed the QVHD Community Health Survey. The sample reflected the population percent of district residents, except for one of the towns. It also paralleled the racial composition of the district.

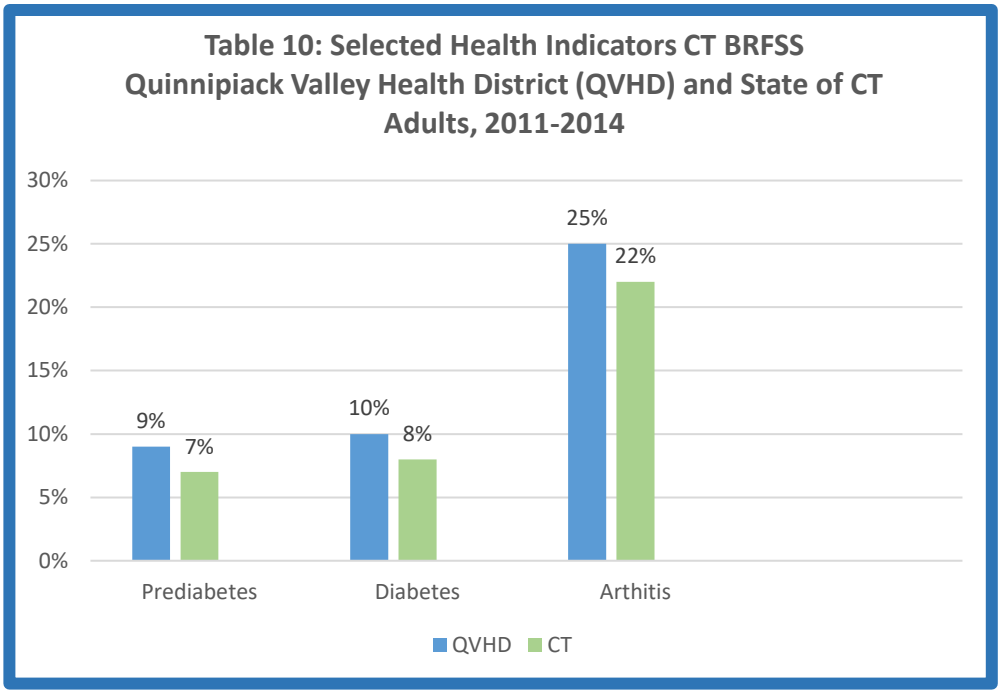
TABLE 9: Composite of Respondents Number Surveyed: 34 non-resident workers; 312 district residents		
TOWN	**Survey Respondents by Residence**	**QVHD Population percent by Residence**
BETHANY	7%	6%
HAMDEN	69%	61%
NORTH HAVEN	12%	24%
WOODBRIDGE	12%	9%
RACE/ETHNICITY	**Survey Respondents by Residence**	**QVHD Population percent by Residence**
CAUCASION	65%	70%
BLACK	15%	12%
HISPANIC	8%	7%
ASIAN	6%	6%
OTHER	6%	5%

Self-reported current health status is a good predictor of future disability, hospitalization and mortality. (E.L. Idler and Y. Benyamini, "Self-Rated Health and Mortality: A Review of Twenty-Seven Community Studies," *Journal of Health and Social Behavior*, 38, 1 (March 1997), 21–37.) Overall, the 84% of survey respondents indicated a high level of excellent or good health; 12% fair health and 4% poor health.



The 16% of respondents who indicated self-reported fair or poor health status were among the poorest of district residents. 64% of that group had incomes less than $39,000 while among all respondents with a self-reported health status, only 31% had incomes less than $39,000 and 33% had incomes of $100,000 or higher. This information suggests that income may be correlated with self-reported health status. Further, when looking at educational levels, the self-reported fair or poor health status group had 48% with a college degree or higher compared to 67% of all respondents with a self-reported health status.

Self-reported data from the CT BRFSS 2011-2014 (Connecticut Behavioral Risk Factor Surveillance System) identified that more adults in the QVHD received testing for blood glucose in the past three years and more adults received seasonal flu shots in the past year as compared to all CT residents. The fact that more residents have been tested for blood glucose may account for the fact that diabetes-related deaths are significantly higher in one district town. (Table 8) CT BRFSS data also showed that few adults in the QVHD engaged in binge drinking in the past month and fewer smoked cigarettes when compared to all CT residents. Selected chronic conditions from this survey revealed that adults in the QVHD had a higher prevalence of prediabetes (9% vs 7%), diabetes (10% vs 9%) and arthritis (25% vs 23%) as compared to all CT state residents (Table 10.)



The 2016 State of CT Wellbeing Survey administered by DataHaven (Groupings as applicable based on "Five Connecticuts") revealed that district residents had been told by a doctor or health professional that they had high blood pressure/hypertension, high cholesterol, heat disease/heart attack, asthma and/or stroke. The percentages of occurrence were in line with the State of CT and the surrounding greater New Haven area. There was one exception to the selected medical conditions and that was for diabetes, with Hamden being higher than the state, the surrounding New Haven towns and the other district towns. (Table 11)

Table 11: Have you ever been told by doctor or health professional that you have…					
Response = Yes	**CT**	**GNH**	**Hamden**	**Bethany, North Haven Grouping**	**Woodbridge Grouping**
High Blood pressure/Hypertension	28%	27%	27%	25%	20%
High Cholesterol	23%	23%	22%	23%	19%
Diabetes	9%	9%	13%	7%	4%
Heart Attack/Heart Disease	5%	6%	5%	5%	3%
Asthma	13%	13%	6%	12%	8%
Stroke	2%	3%	3%	2%	2%

Source: 2016 State of CT Wellbeing Survey, DataHaven; Grouping as applicable based on "Five Connecticuts" The "Five Connecticuts are groupings of the 169 towns in CT based on income, poverty and population density. The "Five Connecticuts" designations were created using 2010 Census Data by Don Levy, Director of the Siena College Research Institute.

Data from the survey demonstrated that the top family health issues facing respondents were similar regardless of how they identified their personal health.

TABLE 12: TOP FAMILY HEALTH ISSUES	
Self-identified fair or poor health (N=53)	All respondents (N=320)
Diabetes	Weight management
High Blood Pressure	High blood pressure
Weight management	Diabetes
Arthritis	Arthritis
Falls/fear of falling	Cancer
Joint/back pain, limited mobility	Heart disease/stroke
Source: QVHD Community Health Survey 2016	

The top community health needs were also similar by both groups.

TABLE 13: TOP COMMUNITY HEALTH NEEDS	
Self-identified fair or poor health (N=53)	All respondents (N=344)
Accessible health care	Accessible health care
Better transportation	Mental health services
Mental health services	Safe places to work and play
Substance abuse resources	Job opportunities
Job opportunities	Substance abuse resources
Source: QVHD Community Health Survey 2016	

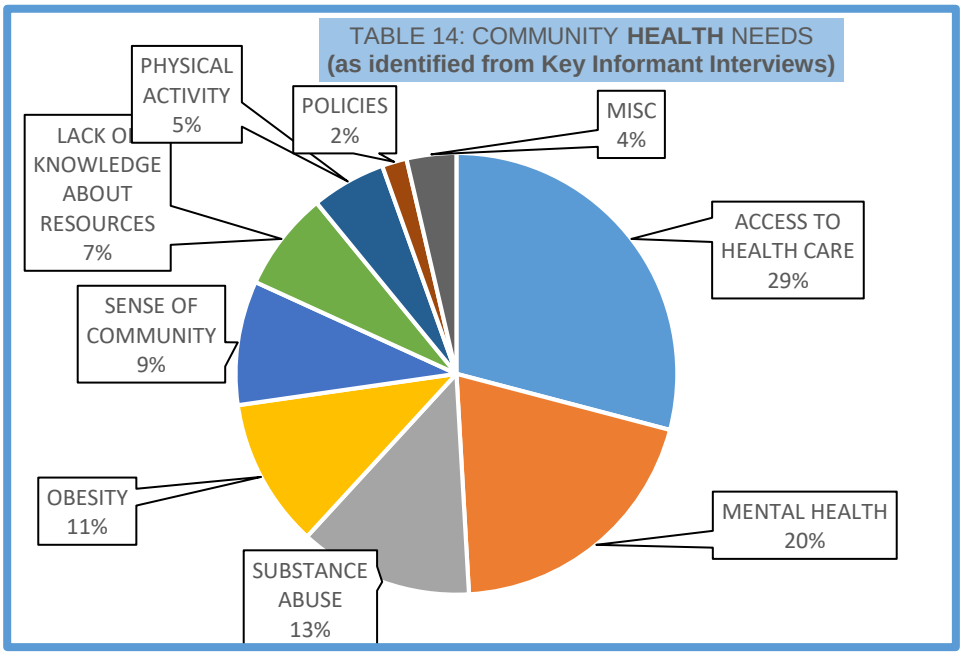
F. Community Conversation

Once the top health needs were identified through the completion of the QVHD Community Health Survey and from the Healthier Greater New Haven Partnership survey, the QVHD Community Health Coalition held a Community Conversation to present the results. All members of the coalition were invited as well as members of the general public and other town departments. Facebook, Twitter, local newspapers and the QVHD website were used to extend the invitation. Data from the surveys were presented. Attendees broke down into three groups to discuss 1) accessible health care, 2) safe places to work and play, and 3) mental health services. Themes and trends that were recurrent across the three discussion groups include:

- lack of awareness
- lack of health providers
- high insurance costs and co-pays
- funding and staffing needs for additional programs and services
- affordable afterschool programs

On a whole, the attendees accepted and discussed community health to include various dimensions including illness, wellbeing and the prevention of disease. A healthy community was defined as one that has individual recognition, is affordable; has safe and secure places to play, work and live; offers good access to health care and preventive services; and has recreation resources.

G. Key Informants Summary: Needs and Barriers



Seventeen key informants were interviewed. They were asked to identify health needs of the community as well as barriers to meeting these needs. Their input was also sought to develop a list of assets for the community. Table 14 identifies the community health needs identified by the key informants. (Rankings were based on the number of times a need was identified during key informant interviews.) What the key informants identified as needs of the community were in line with the findings from the QVHD Community Health Survey.

Further explanation of each category is described in Table 15.

TABLE 15: DETAIL ABOUT RANKINGS (Source: QVHD Key Informant Interviews, Fall 2016)	
RANKING CATEGORY (by frequency cited)	DETAIL
#1 ACCESS TO HEALTH CARE	Affordable health insurance-high co-pays and deductibles; lack of time; convenient care-location, appointment wait time, transportation, navigating the system
#2 MENTAL HEALTH	Addiction; developmental disabilities; youth with mental illness; early screening; depression; violence-domestic and community crime; stigma; services, especially for kids.
#3 SUBSTANCE ABUSE	Awareness programs; stigma; alcohol use; opioids-newly addicted vs long term users, balance availability of NARCAN with prevention, prevention information/intervention; parental support; tougher judicial system.
#4 OBESITY	Access to fruits and vegetables; poor food choices due to price/knowledge/availability; childhood BMI
#5 SENSE OF COMMUNITY	Safety; crime; increasing wildlife; efforts to make health a community concern and having more health fairs; broaden participation in activities; community connections; elderly isolation; help one another; after school programs for parents and children; coordination between elementary school and secondary schools; partnerships; lack knowledge about offerings; transportation; busy people.
#6 LACK OF KNOWLEDGE ABOUT AVAILABLE RESOURCES	Better promotion/notice, especially for newcomers; people are busy; avoid preventive care-fear of results; emerging condition information.
#7 PHYSICAL ACTIVITY (ranked equally with Type 2 Diabetes, More funding, poverty, aging population, air quality, safe alternative transportation)	Physical activity/diabetes: Low cost after school programs; active classrooms; convenient, safe, walkable outdoor play space; restrictive program times; limited options available; extended use of school facilities. Aging population: isolation in home, dementia/memory loss; transportation; outlive assets. Air quality: smoking Safe alternative transportation: lack of sidewalks and bike lanes; speeding and traffic congestion.
#8 MISCELLANEOUS	These topics were ranked equally: hunger-food access, knowledge, in school breakfast; stress; lack of focus on health and wellness; dental care; discrimination; housing.
#9 POLICIES	Promote health and wellness; encourage behavioral change.

The key informants also identified barriers to addressing the identified community health needs.

TABLE 16: BARRIERS TO ADDRESSING COMMUNITY HEALTH NEEDS As identified by the QVHD Key Informant Surveys, Fall 2016	
BARRIER	DETAIL
HEALTH CARE SYSTEM	Long wait times; health not a priority; transportation; inconvenient appointments for working people; overuse of ED due to convenience; cost of health insurance (self-employed, provider restrictions, high co-pays/deductibles, cost of ED for health care.)
MENTAL HEALTH	Stigma-substance abuse and mental illness; lack of enough service providers; lack of early screening/recognition; performance-related stress; substance abuse-denial, delayed treatment entry.
ISSUES OF AGING	Isolation in private homes; transportation; outliving assets.
COMMUNITY INVOLVEMENT	Lack of time; individual financial barriers to participation; lack of funding for needed programs; lack of awareness/notice of town activities; no town/neighborhood community

	centers; no sense of community; low participation rate in community events; timing of programs/number of sessions.
EDUCATION	Unrecognized value of attendance; minimal in class and after school physical activity
POVERTY/INCOME	Access to food; transportation; health care; distraction from day to day needs; worker belief only poverty impacts access and understanding; no recognition that everyone can't afford; unemployment; available assistance; school expenses for extras; lack of paying jobs for youth; general economic conditions.
PHYSICAL ACTIVITY	Lack of affordable after school programs; lack of safe accessible outdoor play space; no sidewalks or bike lanes; high cost of youth sports programs.
FOOD	Affordability; lack of knowledge; availability of inexpensive, nutrient-poor foods; difficult access for Woodbridge, Bethany and lower Hamden.
HOUSING	Not affordable; poorly maintained affordable rental properties; lack of assisted housing.

After analyzing data and information from the Community Health Survey, the Healthier Greater New Haven Partnership, the Key Informant interviews and the Community Conversation, a listing of personal health concerns, community health concerns and community health needs was generated. Participants in the survey identified the needs of the community as priority areas verses their own personal health needs. This was evident by cross-tabulating community health needs verses personal health concerns. This demonstrated a vison for the community as a whole, rather than a personal health plan. Overall, the findings of the top community health needs were similar from each data source and in line with the state of CT.

TABLE 17: QVHD PERSONAL AND COMMUNITY HEALTH PRIORITIES			
PERSONAL HEALTH CONCERNS	**COMMUNITY HEALTH CONCERNS**	**COMMUNITY HEALTH NEEDS**	**KEY INFORMANT COMMUNITY HEALTH NEEDS**
High Blood Pressure	Elderly Services	Accessible Health Care	Accessible Health Care
Weight Management	Substance Abuse	Safe places to work and play	Mental Health
Diabetes	Mental Health	Mental Health Services	Substance abuse
Arthritis	Physical Inactivity	Job opportunities	Obesity
Source: QVHD Community Health Survey Sept. 2016	Source: QVHD Community Health Survey Sept. 2016	Source: QVHD Community Health Survey Sept. 2016	Source: QVHD Key Informant Interviews Sept. 2016

H. Assets

There are many assets within the QVHD that can be utilized to address priority areas. Assets were identified by Coalition members as well as by Key Informants. As noted in the barriers, lack of awareness about resources is an area that needs to be addressed through strategies for the priority areas. (Appendix C)

III: PRIORTIES

A. Establishing Priorities

The top 10 areas of concern were put forth at a meeting of the QVHD Community Health Coalition. Members were asked to vote on the top three areas to address in the Community Health Improvement Plan (CHIP.)

TABLE 18: TOP 10 AREAS (RANDOM, NOT IN ORDER OF OCCURRENCE)	
ACCESS TO HEALTH CARE	AWARENESS ABOUT RESOURCES
MENTAL HEALTH	PHYSICAL ACTIVITY
SUBSTANCE ABUSE	TYPE 2 DIABETES
OBESITY	FUNDING
SENSE OF COMMUNITY	POVERTY

From this list, the QVHD Community Health Coalition members put forth three priority areas: Access to health care; mental health including opioid use, and preventable chronic disease (grouping obesity, Type 2 diabetes and physical activity together.)

B. Priority Areas

1. Access to Health Care

Access to health care was identified as a priority community health need by both survey respondents and key informants, even though 97% of survey respondents indicated that they had health insurance. Further investigation into this issue revealed that access to health care did not mean lack of insurance but rather addressed other factors. Table 19 illustrates these factors.

TABLE 19: ACCESS TO MEDICAL CARE
If you did not get care or postponed care during the past 12 months, the reasons included…

Response = Yes	CT	Greater New Haven	Hamden	Bethany, North Haven Grouping	Woodbridge Grouping
Doctor or hospital wouldn't accept your health insurance	16%	18%	12%	14%	15%
Health plan wouldn't pay for treatment	28%	26%	25%	27%	27%
Couldn't get an appointment soon enough	25%	28%	28%	20%	24%
Couldn't get there when the doctor's office or clinic was open	26%	24%	22%	25%	22%

Source: 2016 State of CT Wellbeing Survey, DataHaven; Groupings as applicable based on "Five Connecticuts" The "Five Connecticuts are groupings of the 169 towns in CT based on income, poverty and population density. The "Five Connecticuts" designations were created using 2010 Census Data by Don Levy, Director of the Siena College Research Institute.

The Key Informant interviews revealed additional information about this priority area. Specifically key informants addressed transportation issues, lack of convenient care, lack of knowledge about how to use the system, inappropriate use of Emergency Departments and high deductibles and co-pays. It was also suggested that people may also be fearful of the outcome of a visit and therefore postpone early intervention. The QVHD Community Health Assessment survey also asked about where people get their health information. The majority stated from their health care provider or other health professional, which can be a problem if people are not accessing health care. The second highest ranking for health information is from the internet. This can be problematic if people do not know how to identify reliable and credible sources of information.

2. Mental Health

Mental health issues, especially opioid use, are national and statewide concerns. For the QVHD, these issues are also of concern and were identified in all the data sources. The challenge for the QVHD Community Health Coalition was to define what mental health means. Overall there was consensus that it included stress, anxiety and depression as well as substance, particularly opioids, abuse and alcohol use. Early screening and intervention was also categorized as mental health issues.

3. Chronic Preventable Disease

Morbidity data illustrated that heart disease was the number one cause of death across the district and diabetes-related deaths were in the top 5 causes of death. Obesity, Type 2 diabetes and physical activity all impact these leading causes of death and have actionable interventions that can prevent these diseases. These three, obesity, Type 2 diabetes and physical activity were grouped together as chronic preventable

disease due to the interaction and relationship between the three factors. This would also address issues of food choice and access.

IV. Key Themes and Conclusion

A large quantity of data was analyzed for the CHA. Key themes and priorities were determined by data analysis as well as issues identified through the QVHD Community Health Coalition. Through a review of secondary data about the QVHD, results from the QVHD Community Health Assessment, the Healthier Greater New Haven Partnership and Key Informants and community input through a community conversation, this assessment report provides an overview of the people of the district, the social determinants, and the health conditions and behaviors that are present. It also presents perceptions on the needs, barriers and assets within the community. Several concepts emerged from examining this data.

- There is variation within the QVHD on many determinants including population size, median income, educational level, privately-owned dwellings (vs rented properties), and physical topography (urban vs rural.) However, despite these differences, the needs identified through each method of evaluation were in line with each other and with the state. All of the communities have assets to support health improvement. There are also regional assets serving the district towns. However, access to and/or knowledge of these assets may not be known. Several key informants as well as participants in the community conversation and QVHD Health Coalition noted that many assets are underutilized.

- Mental health and substance abuse emerged as important community issues, although consensus on the definition of this issue was hard to define. This issue is forefront in the community due to the epidemic of heroin overdoses. When evaluating how to formulate the priority focus area for mental health and substance abuse, many factors evolved and included stigma, lack of providers who treat mental illness/substance abuse, lack of rehabilitation services, education, and early screening/intervention.

- In alignment with the country and the state, issues around physical activity, healthy eating and obesity are issues for the residents of the district. These specifically impact chronic preventable disease and two of the top leading causes of mortality for the district: heart disease and diabetes. In general, there are grocery stores, parks and recreational facilities available to district residents, however concerns were related to the accessibility and affordability of these outlets.

- There are numerous assets available to community but they are often unknown or underutilized. In some instances, the cost of these programs makes them inaccessible. They may also be inaccessible to residents without cars. Consensus among those participating in the assessment was the need to promote information about the assets available to residents.

PART 2: The Community Health Improvement Plan (CHIP)

I. Introduction

The Community Health Coalition's Community Health Improvement Plan (CHIP) utilizes the information gained through the Community Health Assessment (CHA) to develop strategies for addressing the priorities identified through the CHA. The goal is to improve community health. The CHIP is unique to the needs and resources of the QVHD towns and partners. The CHIP provides guidance to QVHD, it's partners, and stakeholders for improving community health within the towns of Bethany, Hamden, North Haven, and Woodbridge, CT. The CHIP reflects the results of a collaborative planning process that includes involvement by community partners.

II. The Process

The Community Health Coalition (Appendix A), comprised of community representatives, began the work of developing the CHIP through its participation in the CHA with the understanding that there would be a link between assessing the health and needs of the community (the CHA) and the development of a CHIP. The purpose of the CHIP is to develop strategies to address the priority areas identified by the CHA and determine ways to put these strategies into action, as well as devising a plan for monitoring progress toward accomplishment of the objectives.

QVHD used a modified Mobilizing for Action through Planning and Partnerships (MAPP) process throughout the development of the CHA and CHIP. It was also guided by the Association for Community Health Improvement (ACHI) "Six Step Community Health Assessment Process" through participation on the Healthier Greater New Haven Partnership. Community members were solicited in March and April of 2016, with the first meeting of the QVHD Community Health Coalition occurring in May 2016. At that time, the Community Health Coalition developed a vision and mission, and the Assessment tool was initiated. Over the course of the subsequent months, data was collected and analyzed from both the assessment and key informant interviews. Coalition members were kept informed and input solicited via email communications as the process proceeded.

In November 2016, the group convened to review the data and establish priority health areas and goals for the CHIP and in February 2017, the CHA was adopted by consensus vote. In October 2018, the Community Health Coalition reviewed and finalized the objectives for the CHIP and coalition work groups recommended strategies to be included for each priority area. The recommended strategies were distributed to all coalition members for feedback, editing and suggested revisions/additions. The submitted suggestions were reviewed by the Accreditation Coordinator and incorporated into the development of the final CHIP strategies presented below and was then distributed to the coalition for their acceptance.

III. State and National Priorities

Both State and National priorities were also considered when identifying priority areas for the CHIP. National priorities were reviewed from the Office of Disease Prevention and Health Promotion's Healthy People 2020. Healthy People 2020 outlines 10-year national objectives for improving the health of all Americans. Access to Health Services, Mental Health, Substance Abuse and Diabetes are all topics included in Healthy People 2020. The State of Connecticut Department of Public Health developed a State Health Improvement Plan titled Healthy Connecticut 2020, which also included Access to Health Services, Mental Health and Mental Health Disorders, Substance Abuse and Diabetes as focus areas in the State Health Improvement Plan. The Community Health Coalition's CHIP aligns with the Connecticut State Health Improvement Plan and the national Healthy People 2020 objectives in identifying the following areas as priorities: Access to Health Care, Mental Health (Substance Use) and Chronic Disease Prevention (Diabetes).

MISSION

Work collaboratively with the community to improve health and the quality of life in QVHD.

VISION

A place where all people can be healthy.

COMMUNITY HEALTH ASSESSMENT (CHA)

Once the health priorities were selected, the Community Health Coalition began the process of developing the CHIP. The illustration below illustrates the timeline.

COMMUNTIY HEALTH IMPROVEMENT PLAN (CHIP)

IV. Top Priority Areas

Below are the three top priority areas which emerged from the CHA data.

Priority Area 1: Access to Health Care			
Goal: Improve access to integrated health services.			
Objective	**Strategy**	**Action Steps**	**Indicators**
• Increase by 10% the proportion of persons who obtain timely medical care, mental health services, dental care, or prescription medicines, and use emergency department for emergency visits within 3 years.	• Assess availability of physical and psychological health care services to the community. • Identify trends and barriers to utilization of physical and psychological health care	• Establish a subcommittee to work towards the goal, objectives and strategies for Priority Area 1: Access to Health Care. • Obtain baseline #'s for: ED visits for non-emergency visits, postponed	• Priority Area 1: Access to Health Care subcommittee member list and meeting dates. • #'s for: ED visits for non-emergency visits, postponed medical care and mental health care, postponed dental care and postponed prescription medicine.

Objective	Strategy	Action Steps	Indicators
	services for district residents.	medical care and mental health care, postponed dental care and postponed prescription medicine. • Identify and assess physical and psychological health care services in the community. • Compile a list of barriers that residents report as reasons for not obtaining physical and psychological health care services.	• List of physical and psychological health care services in the community. • List of barriers to utilization of physical and psychological health care services.
• Increase by 10% the proportion of persons who are aware of the availability, schedules and costs of community assistance and activities for people over 65 years of age and over within 3 years.	• Collaborate to identify and promote access to a resource file of low-cost preventive programs and services within the region. • Develop a shared data system for transportation resources and routes for affordable leisure and health care activities.	• Identify or compile a resource file of low-cost preventive programs and services. • Identify or compile a list of transportation resources and routes for affordable leisure and health care activities.	• Completed resource file of low-cost preventive programs and service. • # of agencies, town partners and individuals the list was shared with. • Completed data system for transportation resources and routes for affordable leisure and health care activities. • # of agencies and partners the completed data system was shared with.
• Increase by 5% provider awareness and roles of community assistance and activity programs and personal health tracking technology for personal compliance within 3 years.	• Collaborate to identify and promote personal health tracking technology for personal compliance among providers.	• Identify or compile a list of free or low-cost personal health tracking technology for personal compliance. • Obtain a list of medical providers	• List of free or low-cost personal health tracking technology for personal compliance • # of medical providers that list was shared with.

Objective	Strategy	Action Steps	Indicators
		(primary care) in the district to share list with.	• # of medical providers who responded that they would share the list with patients.
Priority Area 2: Mental Health (Substance Use)			
Goal 1: Improve mental health through prevention and by promoting access to appropriate, quality mental health services.			
Objective	**Strategy**	**Action Steps**	**Indicators**
• Increase by 10% the proportion of primary care and obstetrician offices where children and adults are routinely screened for depression and stress and explore other appropriate screening opportunities within 3 years.	• Advocate for routine use of validated instruments for depression, anxiety and substance use screenings into pediatric and primary care patient profile.	• Establish a subcommittee to work towards the goals, objectives and strategies for Priority Area 2: Mental Health (Substance Use). • Establish a baseline for proportion of primary care and obstetrician office routinely screening children and adults for depression and stress. • Identify current validated instruments for depression, anxiety and substance use screenings that are used for pediatric and primary care. • Encourage routine use of screenings.	• Priority Area 2: Mental Health (Substance Use) subcommittee member list and meeting dates. • Baseline # for proportion of primary care and obstetrician office routinely screening children and adults for depression and stress. • # of current validated instruments for depression, anxiety and substance use screenings • # of providers contacted to encourage routine use of screenings

Objective	Strategy	Action Steps	Indicators
• Increase by 10% the proportion of primary care and obstetrician offices that provide appropriate referral sources for positive screenings of depression and stress within 3 years.	• Expand provider training in the recognition, treatment or referral of mental health and substance use disorders. • Promote mental illness and substance use disorders as a manageable, chronic illness to providers and community at large. • Identify community health workers (or other health care professional) to facilitate entry and discuss benefits into treatment.	• Identify provider trainings for treatment or referral of mental health and substance use disorders. • Develop a unified message for mental illness and substance use disorders as a manageable, chronic illness. • Identify community health workers (or other health care professional) and trainings to facilitate entry into treatment.	• # of provider and community health worker trainings identified • Message developed for promoting mental illness and substance use disorders as a manageable, chronic illness. • # of community health workers (or other health care professional) identified.
Priority Area 2: Mental Health (Substance Use)			
Goal 2: Reduce the harms of opioids.			
Objective	**Strategy**	**Action Steps**	**Indicators**
• Increase by 10% community understanding of the scale of opioid and substance use and effective responses to decrease stigma within 3 years.	• Support community and regional organization collaboration to deliver educational opportunities to community members and medical providers about opioid and substance use.	• Develop a unified anti-stigma message for opioid and substance use to be shared with the community and medical providers.	• Anti-stigma message developed for opioid and substance use. • # of medical providers and agencies, the anti-stigma message was shared with.
• Increase by 10% data sharing across relevant agencies and organizations to monitor and	• Support data sharing regarding opioid related data	• Identify and compile a list of agencies that	• # of agencies that collect local opioid related data.

Objective	Strategy	Action Steps	Indicators
facilitate responses, including rapid responses to overdose and other opioid-related (e.g. HIV or HCV) events within 3 years.	across relevant agencies.	collect local opioid related data. • Facilitate a meeting among agencies to meet and discuss data sharing.	• Meeting date and sign in for agencies to meet regarding local opioid data.

Priority Area 3: Chronic Disease (Preventable Chronic Disease and Diabetes)			
Goal: Promote healthy lifestyles for disease prevention and management.			
Objective	**Strategy**	**Action Steps**	**Indicators**
• Promote awareness by 10% among adults of national physical activity and nutrition recommendations for healthy lifestyles within 3 years.	• Educate community members about national physical activity and nutrition recommendations for healthy lifestyle.	• Establish a subcommittee to work towards the goal, objectives and strategies for Priority Area 3: Chronic Disease (Preventable Chronic Disease and Diabetes). • Develop or identify educational material and messaging of national physical activity and nutrition recommendations and provide to community agencies and partners to distribute.	• Priority Area 3: Chronic Disease (Preventable Chronic Disease and Diabetes) subcommittee member list and meeting dates. • # of educational material • # of agencies and community members the educational material was provided to. • # of public places, community events, and groups the educational material was provided at/to.
• Increase awareness by 10% of available safe, clean, attractive places for physical activity for persons of various fitness levels with 3 years.	• Promote available local resources that support healthy behaviors. • Improve availability of affordable healthy food and beverage	• Identify and compile a list of safe, clean, attractive places in the district that persons of various fitness levels can use for physical activity.	• # of safe, clean, attractive places for physical activity • # of policy changes identified • Agencies identified for multi-agency workgroup addressing affordable

Objective	Strategy	Action Steps	Indicators
	choices in public service venues and grocery stores. • Promote and facilitate universal involvement in affordable recreational resources for physical activity.	• Identify policy changes needed to improve availability of affordable healthy food and beverage choices in public service venues and grocery stores. • Establish a multi-agency workgroup of individuals to address affordable recreational resources for physical activity.	recreational resources for physical activity.
• Increase the percentage of adults by 10% who understand the disease (differentiate Diabetes Type 1 & 2) and lifestyle management guidelines within 3 years.	• Educate community members about the risk factors for diabetes type 2 and the difference between Diabetes Type 1 and Type 2.	• Identify or develop educational material on understanding Diabetes and lifestyle management guidelines.	• # of educational material developed or identified. • # of agencies and community members the educational material was provided to. • # of public places, community events, groups the educational material was provided to.
• Promote awareness by 10% of healthy lifestyles for disease prevention and management within 3 years.	• Advocate for an integrated message to promote, prevent and detect chronic disease.	• Develop a coordinated resource file for diabetic management programs.	• Resource file for diabetic management programs. • # of agencies and community members the educational material was provided to. • # of public places, community events and groups the educational material was provided to.

APPENDIX A: COMMUNITY HEALTH COALTION FOR QUINNIPIACK VALLEY HEALTH DISTRICT (QHVD)

QUINNIPIACK VALLEY HEALTH DISTRICT (QVHD) CORE TEAM	
MEMBER	TITLE
Alicia Mulvihill	Coordinator for PHAB (present), QVHD
Leslie Balch	Director of Health, QVHD
Lynn Fox	Chief of Environmental Services, QVHD
Richard Matheny	PHAB Advisor
V. Deborah Culligan	Former Coordinator for PHAB (retired October 2018)

QVHD COMMUNITY HEALTH COALTION MEMBERS		
NAME	AFFILIATION	TOWN REPRESENTING
AMARONE, JUDY	DIRECTOR, NORTH HAVEN SENIOR CENTER	NORTH HAVEN
AMODEO, MARION	DIRECTOR, HAMDEN LIBRARIES	HAMDEN
AVITABLE, MARION	SCHOOL NURSE	NORTH HAVEN
BRACEY-WHITE, DAWN	SISTER'S JOURNEY	ALL TOWNS
BRANDER, DEBBIE	JEWISH COMMUNITY CENTER	ALL TOWNS
BURBAGE, SUZANNE	DIRECTOR, SENIOR SERVICES	HAMDEN
CAPOBIANCO, BETH	COMMUNITY HEALTH CARE VNA	ALL TOWNS
CIOCIOLA, CHRISTINA	COMMUNITY FOUNDATION OF NEW HAVEN	ALL TOWNS
DAY, BRIAN	QUINNIPIAC UNIVERSITY STUDENT	
DELVECHIO, ANDREW	PARKS AND RECREATION	NORTH HAVEN
DEMBSKI, ALEX	LION'S CLUB, RESIDENT	BETHANY
DONNELLY, PATRICK	MAYOR'S ASSISTANT	HAMDEN
DUMAIS, CHIP	SUPERINTENDENT, AMITY	BETHANY AND WOODBRIDGE
EVANS, MARION	RESIDENT	BETHANY
FITZSIMONS, CHRISTINE	VISITING NURSE SOUTH CENTRAL CT	ALL TOWNS
GORMAN, BETSY	ROTARY CLUB, RESIDENT	HAMDEN
HIRSCH, DIANE	UCONN EXTENSION SERVICE	ALL TOWNS
JACKSON, EMILY	DIRECTOR, HAMDEN NORTH HAVEN Y	HAMDEN AND NORTH HAVEN
JONES, SHARON	SOCIAL WORKER, HAMDEN COMMUNITY SERVICES	HAMDEN
KATZ, STACEY	SCHOOL NURSE	WOODBRIDGE
KUILAN, GUADALUPE	FAMILY RESOURCE CENTER	HAMDEN
LAMONACA, KATHERINE		
LAROCCA, MARY ELLEN	DIRECTOR, COMMUNITY SERVICES	WOODBRIDGE
LOCKERY, SARAH	THE CHILDREN'S CENTER OF HAMDEN	ALL TOWNS
MORROW, SCOT	LOCAL PASTOR	NORTH HAVEN
MURPHY, BETTY	ASTHMA PROGRAM, RESIDENT	ALL TOWNS, WOODBRIDGE
REINKS, VALERIE	GREATER NEW HAVEN TRANSIT	ALL TOWNS
RUBINO, SUE	DIRECTOR, YOUTH SERVICES	HAMDEN
SELINGER, HOWARD	QUINNIPIAC UNIVERSITY STAFF	
WILLIAMS, ANNA-LEILA	RESIDENT	HAMDEN
YAGLA, BETSY	FIRST SELECTMAN'S ASSISTANT	WOODBRIDGE
ZOZULIN, KRISTEN	QUINNIPIAC UNIVERSITY STUDENT	

*This is a living membership list; additional partners continue to be added as involvements evolve.

APPENDIX B: KEY INFORMANTS FOR THE QVHD COMMUNITY HEALTH COALTION COMMUNITY HEALTH ASSESSMENT		
NAME	AFFILIATION	TOWN(S) REPRESENTING
BUTLER, DARLENE	**HAMDEN TOWN SERVICES**	**HAMDEN**
CLARKE-LOFTERS, JENNIFER	**RESIDENT**	**WOODBRIDGE**
DUMAIS, CHARLES	**SUPERINTENDENT, AMITY SCHOOLS**	**BETHANY AND WOODBRIDGE**
FREDA, MICHAEL	**FIRST SELECTMAN**	**NORTH HAVEN**
JANUSZEWSKI, PAUL	**FIRE CHIEF**	**NORTH HAVEN**
LAROCCA, MARYELLEN	**WOODBRIDGE COMMUNITY SERVICES**	**WOODBRIDGE**
LATORRA, HEATHER	**MARRAKECH**	**ALL TOWNS**
LENG, CURT	**MAYOR**	**HAMDEN**
LOCKERY, SARAH	**THE CHILDREN'S CENTER OF HAMDEN**	**ALL TOWNS**
MELLILO, CHRISTOPHER	**ASSISTANT SUPERINTENDENT HAMDEN PUBLIC SCHOOLS**	**HAMDEN**
MORROW, SCOTT	**PASTOR NORTH HAVEN CHURCH**	**NORTH HAVEN**
MURPHY, BETTY	**PUTTING ON AIRS RESIDENT**	**ALL TOWNS WOODBRIDGE**
PONTIN, KATHY	**LIFEBRIDGE COMMUNITY SERVICES (MEALS ON WHEELS)**	**ALL TOWNS**
QUITKO, BETSY	**ELEMENTARY SCHOOL NURSE**	**BETHANY**
SANDILLO, DONNA	**OFFICE MANAGER WHITNEY PEDIATRIC GROUP**	**ALL TOWNS**
SCALLETAR, ELLEN	**FIRST SELECTMAN**	**WOODBRIDGE**
STUART, RAY	**DEPUTY POLICE CHIEF**	**WOODBRIDGE**

APPENDIX C: COMMUNITY ASSETS BY PRIORITY AREA

QVHD
Quinnipiack Valley Health District

MENTAL HEALTH	**Community recreational opportunities: public parks, trails, open space** **Excellent school system** **Access to Yale medical care** **AA, NA, NAR-Anon meetings in town** **Yale program: home treatment for addiction** **Marrakech:** **Town recreation program** **Active senior center and programming** **Town offered family activities** **Substance abuse program** **Dementia services/screening** **Youth services and senior services** **Community service town department (North Haven)** **Good medical care selection** **Substance abuse programs** **Drug info** **Healthy choices programs** **Elderly services** **Town Human resource departments** **Town counseling services (North Haven)** **Child abuse council (North Haven)** **Drug take back days** **Substance Abuse Action Council (North Haven)***
HEALTH CARE SYSTEM	**Connect through school systems, recreational activities, community meetings for advocacy** **Access to Yale medical care** **People are willing to collaborate** **School based health centers** **Public Transportation-Hamden** **Substance abuse program** **Good medical care selection** **VNA health and wellness programs (Subsidies?)** **Adult health clinic** **Mammogram van** **Flu shots** **Screenings** **New haven transit** **Volunteer rides to health care** **Cornell Scott-Hill Health Center Corporation***
AGING	**Access to Adler Center (Yale)** **Strong partnerships with state agencies and nonprofit organizations** **Food pantries** **Town libraries** **Active senior centers and programming** **Public Transportation** **New Haven Transit** **Dementia services**

AGING CONT.	**Youth services and senior services** **Elderly housing** **Elderly services** **Nutrition programs** **Senior centers, activities** **Volunteer rides to health care** **Meals on wheels** **CT elderly tax relief** **Community service town department (North Haven)**
COMMUNITY INVOLVEMENT	**Community recreational opportunities: public parks, trails, open space** **Family connections through school systems, recreational activities, community meetings** **Easy access to cities for employment/cultural events** **Strong partnerships with state agencies and nonprofit organizations** **People are willing to collaborate, but bureaucratic people aren't helpful.** **JCC partner café in Woodbridge** **Library programs for children** **Town libraries** **Local farm Massaro Farm community involvement (Woodbridge)** **School system and facilities** **Town recreation program** **Town offered family activities** **Updated infrastructure** **Pedestrian friendly (North Haven)** **Community gardens** **PTAs** **Town sponsored activities** **QVHD Board of Directors*** **Community Conversations*** **Town Community Services***
EDUCATION	**Good school systems** **GED program available** **School system for education** **School system and facilities** **No smoking policy** **School based health centers** **Community policing and involvement in juvenile review board** **School social workers** **Health Ed in schools** **School lunch program**
POVERTY	**Free school lunch programs** **Town sponsored family activities** **Concert series for leisure** **Public parks and open spaces** **Food pantries** **Library programs for children** **Good public school systems and facilities** **Town recreation programs** **Houses with yards** **School based health centers** **Public Transportation-Hamden** **Youth services programs**

POVERTY	**Project Choice** **Pedestrian friendly (north Haven)** **VNA health and wellness programs (Subsidies)** **Town Human resource departments** **Community gardens** **Toy chest at holiday time**
PHYSICAL ACTIVITY	**Walking trails** **Bike path** **Community recreational opportunities: public parks, trails, open space** **Town recreation programs** **No smoking in parks policy** **Community policing** **Pedestrian friendly (north Haven)** **Safe school facilities** **Youth sports programs** **Youth Services programs** **Community gardens** **YMCA**
FOOD	**Farmers markets** **Grocery store choice** **WIC** **Food stamps** **Food pantries** **Free lunch program at school** **School lunch availability** **Community gardens** **Food bank** **Healthy Food Drives***
HOUSING	**Community meetings for people like to get into politics** **Landlords that will work with people with disabilities** **Marrakech** **Town ordinance pesticide on lawn use (Woodbridge)** **Houses with yards** **Environmentally conscientious, Hamden Woodbridge** **Pedestrian friendly (North Haven)** **Good roads** **Blight ordinance (Hamden, North Haven)** **Section 8 housing (Hamden)** **P&Z over-site of development** **Housing code (Hamden)** **Property maintenance ordinance (Hamden/North Haven)** **Side walks** **OWF ban in all but Bethany** **Elderly housing**

***Added April 2019**

QVHD
Quinnipiack Valley Health District

APPENDIX D: INVENTORY OF TABLES