CONNECTICUT
HEALTH IMPROVEMENT COALITION
Partners Integrating Efforts and Improving Population Health

Healthy Connecticut 2025

STATE HEALTH IMPROVEMENT PLAN

SUGGESTED CITATION

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Healthy Connecticut 2025

STATE HEALTH IMPROVEMENT PLAN

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

410 Capitol Avenue
Hartford, Connecticut 06106

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CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

Deidre S. Gifford, MD, MPH

Acting Commissioner

Heather Aaron, MPH, LNHA

Deputy Commissioner

Adelita Orefice, MPM, JD, CHC

Chief of Staff

ACKNOWLEDGMENTS

The *Healthy Connecticut 2025 State Health Improvement Plan* was developed by members of the Connecticut Health Improvement Coalition, comprising health experts, stakeholders, and residents from throughout the state, and led by the Connecticut Department of Public Health.

The Coalition's Priority Area Planning Work Groups formulated goals, objectives, and strategies for their respective Priority Areas, and are acknowledged on the first page of each Priority Area section of this Plan.

Many DPH staff provided subject matter expertise, staffing for the Priority Area Planning Work Groups, and baseline data for this plan. Their names are listed in Appendix B to recognize their invaluable contribution to the Plan and the *Healthy Connecticut 2025* state health planning initiative.

We gratefully acknowledge the contributions of our consultant,
Health Resources in Action
Boston, MA
for facilitating and coordinating the activities of the Coalition's SHIP Advisory Council and Working Groups, and for developing and compiling this Plan, in cooperation with DPH.

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LETTER FROM COMMISSIONER

Dear Colleagues:

I am pleased to present the next iteration of the Connecticut State Health Improvement Plan, a collaborative framework for ensuring that all people in Connecticut have the opportunity to attain their highest potential for health. This Plan is based on findings from the 2019 Connecticut State Health Assessment. Together these efforts comprise *Healthy Connecticut 2025*, a five-year state health planning initiative developed by statewide partners and organizations in the Connecticut Health Improvement Coalition.

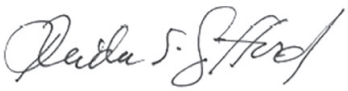
This Plan was developed at an unprecedented time for our State and nation. Responding to the COVID-19 pandemic tested the limits of the public health system to provide emergency relief to Connecticut residents, while exposing an even greater need to strengthen cross-sector collaboration and alignment of efforts to effectively address the health needs of our most vulnerable populations. The pandemic magnified the pervasive impacts of social and structural inequities in our communities. People who were already disadvantaged by their race and ethnicity, age, health status, residence, occupation, socioeconomic conditions, and other contributing factors have been disproportionately impacted by COVID-19. Our challenge moving forward is to build upon collaborative alignments developed during the initial phases of the pandemic, focus on investing in critical systems and infrastructure, and allocate resources to advance health equity.

This Plan focuses on four priority areas (Social Drivers of Health) that are critical for healthy people and healthy communities: Access to Health Care, Economic Stability, Healthy Food and Housing, and Community Strength and Resilience. These priorities are centered on the root causes of health inequities (structural racism and inherent bias). Many of the objectives and strategies in this plan align with Governor Ned Lemont's Connecticut's Plan for the American Rescue Plan Act of 2021.

As part of the implementation of this Plan, DPH intends to establish a Health Equity Metrics Alliance (HEMA) as an integral component of Healthy CT 2025. The HEMA will be a technical body dedicated to providing analytical support to SHIP Advisory Council and Action Team members, policymakers, system planners, and program managers. The DPH will formalize the Alliance's role in monitoring the status and dimension of health disparities, providing valid approaches for data disaggregation and interpretation, while advising on critical equity trends. Additionally, this group will be responsible for the monitoring and annual reporting of data indicators for the health conditions and objectives in this Plan.

Thank you and congratulations to our many SHIP partners and the DPH staff who contributed to this important process during this difficult time. I hope this Plan serves as a useful resource for your personal and organizational efforts to improve health, and I invite you to join us in fulfilling our vision of Connecticut as a state where everyone can attain their optimal health and well-being without social or physical barriers.

Sincerely,



Deidre S. Gifford, MD, MPH
Acting Commissioner

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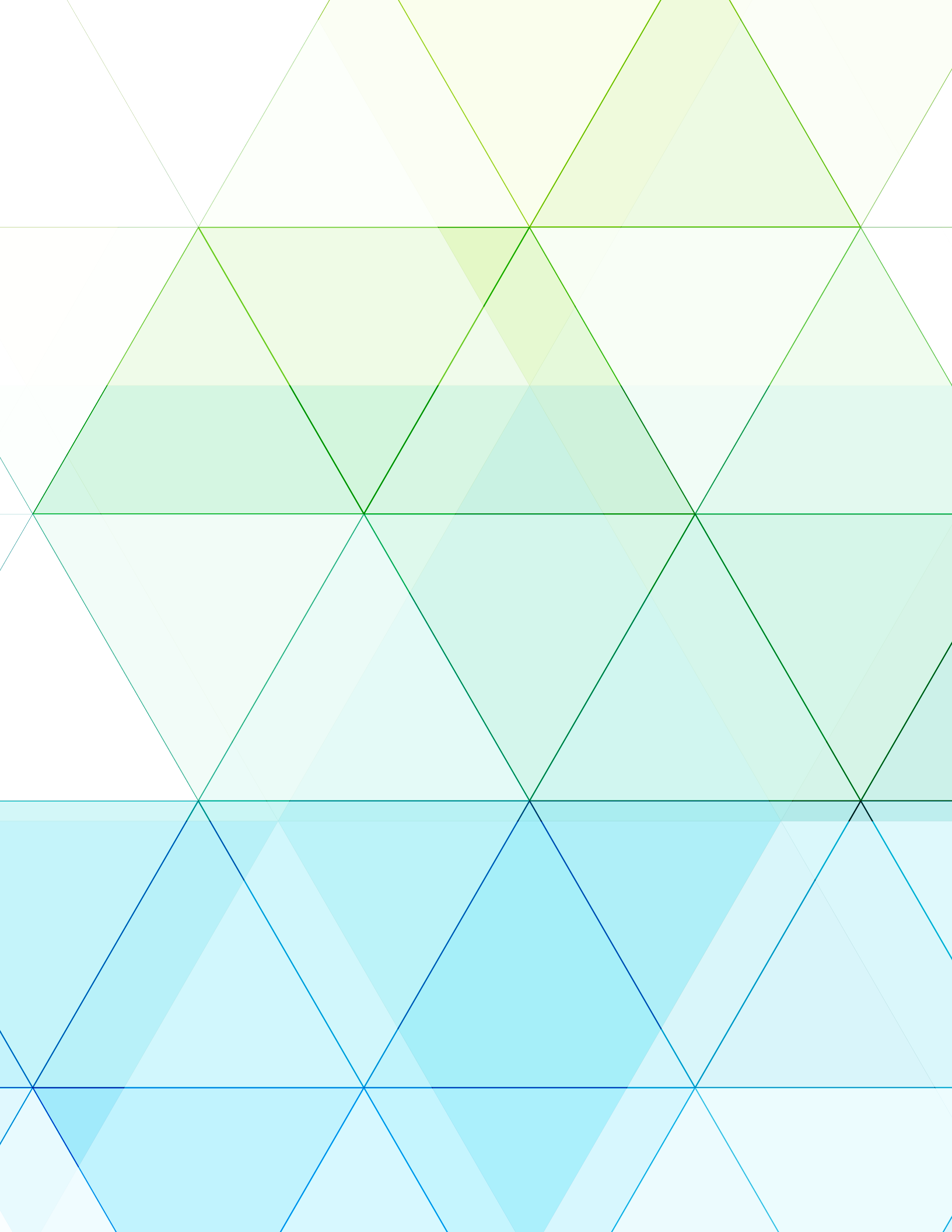


History & Retrospective: The Path to Healthy Connecticut 2025

BACKGROUND

PHAB ACCREDITATION

HCT2020 PROGRESS TO DATE

HISTORY & RETROSPECTIVE: THE PATH TO HEALTHY CONNECTICUT 2025

Background

While the state health department is responsible for protecting and promoting the health of the population, it cannot be effective acting unilaterally. Historically siloed funding streams, however, have often focused on singular health or community issues leading to either slightly mis-aligned efforts or a redundant use of resources within the state and with potential partners. In addition, the systemic lack of incentives for sharing data and bringing alternative perspectives to both planning and implementation efforts often perpetuated siloed approaches and reduced the impact of well-intentioned strategies and initiatives. In an attempt to address these issues, the Public Health Accreditation Board (PHAB) mandated the creation of a State Health Improvement Plan (SHIP) as part of the accreditation process for state health departments. In PHAB Standards and Measures under Domain 5, PHAB describes how the state health improvement plan is designed to provide a unifying framework that the state health department can use to work together with state and local partners on improving the health of the population of the state. Through collaborative planning, the SHIP creates a real-time opportunity to align priorities and leverage resources across sectors.

Connecticut state and local partners have recognized the value of building cross sector collaborations and they continue to strive for collective impact in addressing common issues that affect the health and wellbeing of Connecticut residents. The first Connecticut State Health Improvement Plan, *Healthy Connecticut 2020: State Health Improvement Plan (SHIP)*, was collaboratively developed with state and local partners in 2013, and originally released in March 2014. Plan implementation was officially launched in 2015, with the convening of the SHIP Advisory Council to guide Plan implementation, and the establishment of seven Action Teams to work towards advancing the goals, objectives, and strategies of the focus areas of the Plan. The SHIP has been a guiding roadmap for promoting and advancing population health and ensuring all people in Connecticut have the opportunity to attain their highest potential for health.

Building on past successes and honoring the feedback of partners, the Connecticut Department of Public Health (DPH) made some adjustments to the planning framework of Healthy Connecticut 2025 to better address the common issues related to the Social Determinants of Health (SDOH) that impact multiple health conditions and outcomes. This shift in framing is designed to improve the impact of collective efforts, to allow for more effective leveraging of existing resources, to recognize and address the systemic inequities that preserve the state's Communities of Color in a constant struggle to maintain a healthy lifestyle, and to recognize the broader impacts of the policies, systems and environmental conditions on the health and wellbeing of Connecticut residents.

Healthy Connecticut 2025 is intended to provide a vision for the health of the state and a framework for state and local government, communities, and organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for collective action. The plan is based on findings from the 2019 Connecticut State Health Assessment (SHA) and together these efforts comprise *Healthy Connecticut 2025*.

PHAB Accreditation

The Connecticut State Department of Public Health was accredited in March 2017, an indicator that the agency **meets or exceeds rigorous public health standards** as determined by the Public Health Accreditation Board (PHAB). Connecticut DPH is currently in Phase 2 of its Public Health Accreditation Sustainability and Reaccreditation Plan to maintain accreditation in 2022.

PHAB requirements for reaccreditation are clear and non-prescriptive: PHAB requires the SHIP to be based on a comprehensive State Health Assessment (SHA); to set community priorities for action; to identify measurable outcomes or indicators of health improvement and priorities of action; to consider Social Determinants of Health, causes of higher health risks and poorer health outcomes, and health inequities; to include plans for policy and system level changes for the alleviation of identified causes of health inequity; and to designate individuals and organizations that have accepted responsibility for implementing strategies.

PHAB requirements for implementation are likewise clear: PHAB requires that the SHIP be implemented, tracked, and reported on; and that the SHIP be a dynamic document that has flexibility in strategies and activities to accommodate changes in the environment.

HCT2020 Progress To Date

Healthy Connecticut 2020: State Health Improvement Plan (SHIP) launched its implementation infrastructure in 2015. At that time, the Coalition included 194 organizations (local, regional, and statewide). Over the course of the next five years, membership grew to more than 600 partners representing over 288 diverse organizations. The Coalition at Large was engaged through Coalition conference calls 2–3 times each year, participation in membership surveys, communication of SHIP-related events and information via the Coalition email distribution list, and an open invitation to participate in the work of the SHIP implementation Action Teams.

The Connecticut State Department of Public Health (DPH) provided leadership and coordination of meetings and activities under the guidance of a 34-member SHIP Advisory Council comprised of thought leaders from across the state. A five-member Executive Committee met on an ad hoc basis to address operational decisions based on the recommendations of the SHIP Advisory Council. Seven implementation Action Teams were formed around the seven focus areas included in the plan: Maternal, Infant, and Child Health, Environmental Health, Chronic Disease Prevention, Infectious Disease Prevention, Injury and Violence Prevention, Mental Health and Substance Abuse Prevention, and Health Systems. Each Action Team was comprised of subject matter experts and interested individuals from both the state and local levels. SHIP Action Teams were responsible for prioritizing objectives, creating annual Action Agendas (work plans), coordinating the implementation of strategies included in the plan, and monitoring and reporting progress to the SHIP Advisory Council. Members reported that their participation in the SHIP Action Teams enhanced their ability to network with a variety of partners, leading to increased collaboration across the state and more unified advocacy for common issues. Based on the feedback from Action Team and SHIP Advisory Council members, the Coalition will utilize a similar infrastructure to implement the Healthy Connecticut 2025 priority areas.

SHIP ACTION AGENDA ACHIEVEMENTS

Between 2015 and 2020, the SHIP Action Teams met quarterly to leverage existing resources and advance the work of the Healthy Connecticut 2020 SHIP. Highlights of their collaborative successes include:

- Every Woman CT helped to increase the awareness and utilization of One Key Question (OKQ) with many health professionals being trained to use the screening tool that provided women of childbearing age with recommendations for either becoming pregnant or preventing pregnancy.

- A coordinated screening and discussion among statewide Maternal, Infant and Child Health professionals of the documentary film *Resilience*, explored the dangerous, long-term effects of trauma and Adverse Childhood Events (ACEs).
- A coordinated media campaign was developed to address disparities in lead poisoning prevalence among Hispanic and Black children and families.
- The Connecticut Green and Healthy Homes Project coordinated collaborative input from state agencies, local health departments, community non-profits, residential housing, energy and safety partners, along with in-home health service providers to create a sustainable pilot design, which would utilize braided funding streams to provide wrap around home improvement and health education on asthma, lead poisoning prevention, and falls prevention for low to moderate income families.
- The Connecticut Oral Health Improvement Plan was collaboratively developed with input from public health advocates, and medical and dental practitioners from around the state. The framework of the plan was modeled after the Healthy CT 2020 SHIP and includes the four focus areas of prevention, access and utilization, medical and dental integration, and data collection and analyses.
- A Healthy Food Donation list was developed by Chronic Disease Prevention Action Team members to improve the availability and access of donated healthy food options for food insecure families. Distribution of this resource utilized the systemic reach of existing networks within the Coalition's participating organizations.
- Pre-Exposure Prophylaxis (PrEP) Navigation program utilized social media to increase enrollment and service access, a strategy that proved to be successful in reaching men who have sex with men (MSM) of color populations.
- Human Papillomavirus (HPV) fact sheet was distributed to pediatricians and nursing professionals statewide via existing networks of partner organizations.
- The Getting to Zero (G2Z) campaign was launched with the intent to get to zero new Human Immunodeficiency Virus (HIV) infections, zero HIV-related deaths and zero HIV-related stigma and discrimination in Connecticut. The campaign focused on the population groups and the areas in Connecticut where HIV continues to have a disproportionate impact, specifically the state's five largest cities and among young men having sex with men, particularly in communities of color; Black women; and transgender individuals.
- The "Where Do You Stand?" (WDYS) awareness campaign to end sexual violence was implemented on 17 college campuses within the state, as well as the Naval Submarine Base in New London.
- CT Zero Suicide Learning Community shared and encouraged adoption of evidence-based practices for suicide prevention in the clinical and community settings.
- Partners collaborated to provide Mental Health First Aid training and certification for over 500 public safety professionals.
- Partners collaborated to launch the "LiveLOUD — Live Life with Opioid Use Disorder" statewide awareness campaign to reduce the use of opioids in Connecticut. To help with this effort the state also launched the new Naloxone + Opioid Response App (NORA).
- Culturally and Linguistically Appropriate Services (CLAS) Standards 101 online training was made available for partners and an initial assessment of local health agencies utilizing CLAS standards was conducted.
- A repository of hospital and local health Community Health Needs Assessments (CHNAs) and Community Health Improvement Plans (CHIPs) was created to assist with linkage and alignment of health improvement priorities at the state and local levels.
- Public Health Accreditation has been promoted and encouraged for local health departments through funding opportunities, onsite technical assistance, as well as an open invitation distributed to local health departments to participate in the DPH Accreditation Learning Community to prepare for accreditation. DPH officially submitted its application and received accreditation in 2017.

HEALTHY CONNECTICUT 2020 SHIP PERFORMANCE DASHBOARD

The Healthy Connecticut 2020 Performance Dashboard has acted as the "living" version of the SHIP to track and display online progress in meeting measurable objectives and health improvement targets. Annual review of the Performance Dashboard by Action Team members provided an opportunity for data-informed prioritization and decision-making related to updating targets, revising objectives, or adjusting strategies based on the most currently available information. Dashboard displays provided a clear visual snapshot of baselines, targets, evidence-based strategies, and a graphic presentation of progress. The "story behind the curve" provided a narrative

explanation of data trends and changes in data collection methodology, and alerted members when data sources were no longer available to track progress on specific indicators. The visual display of the Performance Dashboard also provided a better opportunity to see where disparities existed for Connecticut's most vulnerable populations, even when overall state data appeared to easily meet or exceed designated targets.

Healthy CT2020 included 136 defined indicators based on the data sources available in 2014, and 32 designated "developmental" SHIP indicators across seven focus areas of the plan. Targets for defined indicators were typically set at 5–10% improvement based on methodology employed by Healthy People 2020 and consideration of intervention strategies and resources. Strategies selected for implementation by SHIP Action Teams and partners were selected based on evidence of impact on health improvement over time. Based on the most current available data at the time of this plan, 55 of the defined Healthy CT 2020 SHIP indicators have met or exceeded the original and/or revised targets defined in the plan.

While significant progress has been made over the last five years in operationalizing the performance dashboard, challenges remain in measuring and monitoring health improvement. Prioritized health outcome indicators often require the coordination of multiple strategies over a prolonged period of time before progress is reflected in the data. Having data available does not necessarily assure it is analyzed or applied consistently across different communities or settings, which could contribute to inequity in policy setting, implementation, and enforcement. As we move toward increasing cross-sector collaboration, the need for consistently defined data references becomes even more important, particularly as it relates to prioritizing equity in data aimed directly toward improving health disparities experienced by CT's residents of color. SHIP Advisory Council and Action Team members have recommended the establishment of a cross-sector data committee that would act as a technical body dedicated to providing analytical support to SHIP Advisory Council and Action Team members, policymakers, system planners, and program managers. Additionally, this group will coordinate identifying stable data sources, defining and establishing baseline data, setting and refining targets, monitoring and providing regular updates throughout the year, and providing an annual report on the status of all tracked indicators.

COALITION MEMBER INPUT

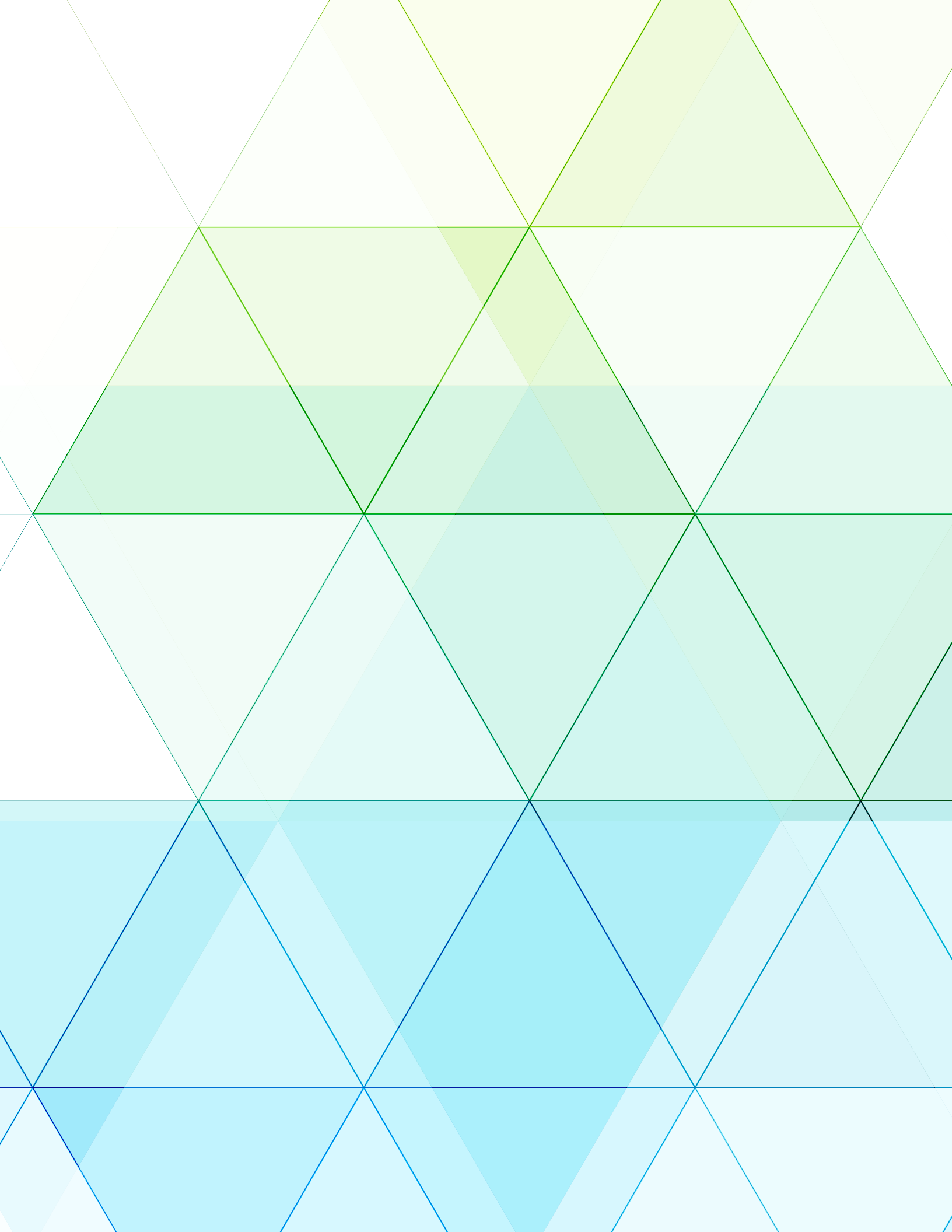
The key strength of the *Healthy Connecticut 2020 SHIP* was the active engagement of representatives from diverse local, regional, and statewide entities through the Connecticut Health Improvement Coalition. Members of the Coalition were foundational in informing and advising on all aspects of Plan development and implementation activities throughout Connecticut. As the Coalition evolved over the last five years, members recognized overlapping efforts of existing funding streams and initiatives established in Connecticut to address very specific diseases, health conditions, population health issues, or specific use services. These efforts were often duplicative and lacking in alignment and coordination. Cross-cutting themes began to emerge as SHIP Action Teams explored upstream approaches and implemented innovative solutions to address the objectives in the Healthy Connecticut 2020 SHIP.

In 2016, the Coalition hosted a statewide Summit to coordinate its first Policy Agenda for the 2017 legislative session. A second statewide Summit was hosted in 2019 to gather Coalition member input on the priority planning framework for Healthy Connecticut 2025. Member input and feedback have been foundational to the initiative's success and will continue to play a critical role in advancing the priorities of Healthy Connecticut 2025.

SHIP POLICY AGENDA

2017 was the first legislative year that partners from across the state came together to identify policies related to health improvement priorities that would have the largest impact on health. Guided by the Centers for Disease Control and Prevention (CDC) Health Impact Pyramid, these policies reflected the SHIP strategic priority to work toward health equity through policy and systems change strategies. Policy Agenda ideas were proposed annually by Coalition members, reviewed, and prioritized by the SHIP Advisory Council and Executive Committee, then finalized in the Fall prior to the next legislative session. Regular status update emails were sent to the entire Coalition, which included related proposed bill numbers and the most recent legislative activity updates that were publicly available on the www.cga.gov website. SHIP Coalition and SHIP Advisory Council members engaged in providing testimony, fact sheets, education, and coordination of advocacy efforts. From 2017–2019, twelve public acts were signed into law which supported SHIP Policy Agenda Priorities. A complete list of SHIP Policy Agenda Priorities can be found in Appendix F.


Support Group
member
Mary Smiths



Developing the Healthy Connecticut 2025 SHIP Framework

FOCUS ON EQUITY

HEALTHY CONNECTICUT 2025 FRAMEWORK

OVERVIEW

A State Health Improvement Plan (SHIP) is a strategic plan which provides guidance to health departments, community partners, and organizational/agency stakeholders for improving the health of the population.

The Connecticut Department of Public Health engaged Health Resources in Action, Inc. (HRiA), a Boston-based, nonprofit public health consulting firm, in the facilitation and development of Healthy Connecticut 2025, the second iteration of the State Health Improvement Plan (SHIP).

A SHIP includes:

- Statewide health priorities identified from the State Health Assessment (SHA)
- State level goals with measurable and evidence-informed objectives to address the SHIP priorities through Policy, Systems, Environmental Change and Primary Prevention strategies
- Tracking data for each objective, including indicators, baselines, targets, and sources. (*These will be defined as part of the early implementation efforts/activities by the Action Teams and included in an addendum to the SHIP.*)
- Annual Action Plans that include activities, person(s) responsible for implementation, and participating partners

A SHIP is a **collaborative process** with multi-sector partners that **aligns** priorities and initiatives across communities to identify ways to advance them, remove barriers at the state level, eliminate redundancies, and coordinate efforts for maximum impact.

FOCUS ON EQUITY

Healthy Connecticut 2025 offered an opportunity for Connecticut DPH, the SHIP Advisory Council, and its stakeholders to incorporate health and racial equity thoughtfully and meaningfully into the SHIP from the very beginning of the assessment and planning processes.

Key guiding principles that evolved during the assessment process embraced the philosophy that all Connecticut residents deserve to experience health and wellbeing throughout their lifetimes. These principles recognize that no one entity can advance health equity in isolation and that a multi-sector and community-engaged approach is necessary to effectively understand the interconnected Social Determinants of Health, and effectively address the practices, policies, and systems that support them. A multi-pronged approach through assessment, prevention, policy development and accountability is needed to achieve measurable improvements in health equity.

Health equity is defined as the attainment of the highest level of health for all people, regardless of age, sex, race or ethnicity, gender identity, sexual orientation, disability status, socioeconomic status, or geographic location factors that contribute to an individual's ability to achieve good health. A health disparity is a preventable difference in health status, risk factors, and/or health outcomes among subgroups of the population. Health disparities often stem from social, economic, or environmental disadvantages, which are collectively referred to as the Social Determinants of Health. The Social Determinants of Health (hereafter referred to as the **Social Drivers of Health**) are the conditions in which people are born, grow, live, work, age, and die, including the health system. The Social Drivers of Health disproportionately impact vulnerable or disadvantaged populations such as children and young people; people with disabilities; seniors; veterans; immigrants regardless of status; People of Color; current and recently incarcerated people; the poor; the homeless and those experiencing housing insecurity; people with Substance Use Disorders; and Lesbian, Gay, Bisexual, Pansexual, Transgender, Genderqueer, Queer, Intersex, Agender, Asexual and other Queer-identifying (LGBTQIA+) people.

The Impact of the COVID-19 Pandemic on SHIP and its Focus on Equity

The emergence of the COVID-19 pandemic reinforced the need to approach the planning process with a strategic focus on eliminating the historic and systemic roots of health disparities. The pandemic exacerbated the consequences of disparities that have existed in health outcomes, as well as highlighted policies, systems, and environmental structures that reinforce inequities. The identified systemic and structural contributors to the disparate impact of COVID-19 on CT residents include the Social Drivers of Health: educational attainment and economic stability, access to nutritious foods and experiencing hunger, housing and the surrounding physical environment, healthcare coverage and affordability, and the social context of healthcare.

As examples, health insurance gaps are estimated to account for 28% of the total number of COVID-19 cases in our state through February 1, 2021[1] and many of Connecticut's most food insecure and racially and ethnically diverse towns experienced higher rates of COVID-19 infection and death. Underlying each of these factors is the pervasive impact of racism, which resulted in higher COVID-19 age-adjusted case and death rates statewide among Hispanics and non-Hispanic Blacks than among non-Hispanic Whites throughout the epidemic.

There are significant arguments that support the assertion that racist and classist inequities that dictate everyday living have contributed to a public health crisis when considering the real-world health impacts these factors have on People of Color and those who cannot maintain a healthy lifestyle due to financial hardships. These inequities are highlighted in DataHaven's, "Towards Health Equity in Connecticut: The Role of Social Inequality and the Impact of COVID-19" report:

AN EQUITY LENS WAS INTEGRATED THROUGHOUT EVERY LAYER OF A NEARLY 2-YEAR, ITERATIVE PROCESS, WHICH INCLUDED:

- **Initial discussion with the SHIP Advisory Council** on potential new ways of organizing the SHA and SHIP around the Social Drivers of Health
- Development of the State Health Assessment (SHA) which identified multiple health conditions/risk factors for the state and related Social Drivers of Health
- **Presentation of the SHA at a state-wide Coalition Summit** in September 2019, attended by 133 diverse Coalition members which highlighted 30 key health indicators from the SHA as a basis for beginning the prioritization process for the SHIP
- Facilitation of an exercise at the Summit to **align the 5 most critical health conditions/ risk factors from the preliminary list of key indicators from the SHA with the Social Drivers of Health** that impact them the most
- **Feedback via (6) community dialogue sessions** held across the state (2 in-person, 4-virtual), and including 48 total participants, in the spring of 2020 to test and validate outcomes from the Summit (this report can be found on the www.ct.gov/dph/shipcoalition)
- **A Coalition-wide Survey** to reach consensus on where stakeholders solidified the focus for the Healthy CT 2025: State Health Improvement Plan (see ***Appendix D***)
- **Confirmation of the new SHIP Framework** by the SHIP Advisory Council to begin SHIP planning

- "The **economic impact of COVID-19 is evident** as whole sectors of the economy constrict in an effort to prevent the virus from spreading. While the most privileged have begun to adjust to working at home, the ripples of economic collateral damage are beginning to emerge," particularly for those most at risk."

- **"The socioeconomic forces that push vulnerable communities into food insecurity have also invited the circumstances for serious health complications related to COVID-19 that disproportionately affect BIPOC** (Black, Indigenous and People of Color) **communities** (e.g., diabetes, obesity, cardiovascular disease)."

- **"Overcrowded housing (households with more than one person per room) can facilitate the transmission of viral diseases like influenza and COVID-19….** Overcrowding [as it relates to the transmission of respiratory diseases like COVID-19] affects 7 percent of Latino households and 3 percent of Black households, but less than 1 percent of White households."

- **"Health insurance coverage is particularly urgent** during this public health crisis. So-called "essential" workers — including grocery store clerks, food preparers, on-demand delivery drivers, health care providers, and emergency medical personnel — are interacting with potentially sick people, and many do not have employer-provided health care benefits or adequate protective equipment."

- **"A lack of high-quality health care in underserved neighborhoods, perceived discrimination during clinical encounters, and difficulty accessing culturally competent care** often prevent people with the greatest health need from accessing necessary care."

- "The COVID-19 pandemic is **bringing the effects of this disparity into focus** — recent data indicate that Black and Latino populations are experiencing higher rates of infection and COVID-related death than their White counterparts in Connecticut and across the United States."

HEALTHY CONNECTICUT 2025 FRAMEWORK

Despite the challenges posed by the pandemic, the planning process ultimately confirmed and validated four Social Drivers of Health as the priority areas of Healthy Connecticut 2025, and elevated structural racism as the root cause of these drivers. The resulting framework for the SHIP codified the aims for equity and for the elimination of structural racism at each level of the plan, as follows.

The SHIP Advisory Council of the Connecticut Health Improvement Coalition developed the following vision, values, and operating principles to support the planning process and Healthy Connecticut 2025:

Vision

Connecticut is a state where everyone can attain their optimal health and well-being without social or physical barriers.

Values and Operating Principles

- **Health Equity:** Focusing on structural racism and inherent bias as the root causes of the Social Drivers of Health.
- **Collaboration:** Promoting an interdisciplinary, multi-sector approach.
- **Asset-based:** Building on and expanding from existing community strengths and initiatives.
- **Structural and Systemic Change:** Using promising, community- and evidence-informed policies, systems, environmental change, and primary prevention strategies.
- **Transparency and Accountability:** Sharing information and data in a meaningful and accessible way.

Organization of Plan Components

Healthy Connecticut 2025 is organized around four Social Drivers of Health, with related goals, objectives, and strategies for each, as depicted in the matrix below. The strategies were developed to focus on policies, systems, environmental change, and primary prevention approaches to meeting measurable objectives. Each set of strategies includes the cross-cutting thematic areas of structural racism, transportation, and education as appropriate.

The key impact/surveillance measures are the prioritized data indicators outlined in the SHA that were aligned with the Social Drivers of Health during the 2019 Coalition Summit. These measures will be monitored and tracked to evaluate progress, along with other, identified measures of progress.

As this SHIP embraces the emerging frontier of eliminating structural racism, it is recognized that dismantling these historically rooted structures and systems are long-term commitments, and that data may not currently exist to support the efficacy of promising or emerging strategies. As such, the SHIP's annual Action Plans may reflect necessary changes to data collection and/or analysis to determine progress over the long term.

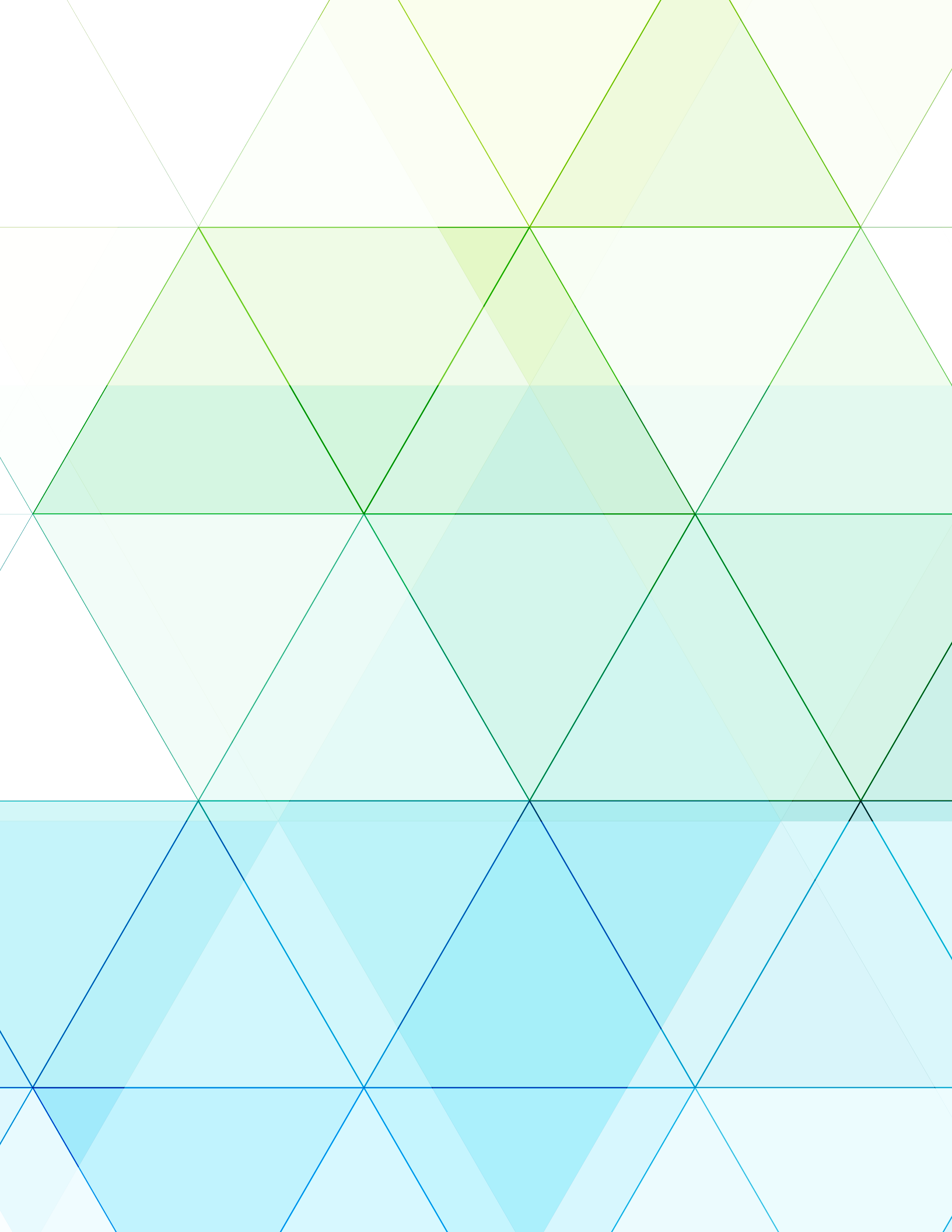
FOCUS: ROOT CAUSE OF HEALTH INEQUITIES (Structural racism and inherent bias)				
	PRIORITY AREAS: SOCIAL DRIVERS OF HEALTH			
Framework for HCT2025: The Connecticut State Health Improvement Plan	**A. Access to Health Care** Primary care, health/ mental health care	**B. Economic Stabiity** Poverty, unemployment	**C. Healthy Food and Housing** Housing quality/ accessibility, healthy food access	**D. Community Strength and Resilience** Cohesion, safety, emergency respose & preparedness
	GOALS & OBJECTIVES	**GOALS & OBJECTIVES**	**GOALS & OBJECTIVES**	**GOALS & OBJECTIVES**
KEY IMPACT/ SURVEILLANCE MEASURE • Obesity • Suicide • Drug Overdose • Sexual Violence • Domestic Violence • Percent Insured • ER Visits	Strategies (PSE & PP)	Strategies (PSE & PP)	Strategies (PSE & PP)	Strategies (PSE & PP)
	Considered PSE & PP (Policy, Systems, Environment, and Primary Prevention) Strategies			

CROSS-CUTTING THEMES ADDRESSED BY PSE & PP STRATEGIES

- Structural Racism
- Suicide
- Transportation
- Education

Organization of Action Teams

The Healthy Connecticut 2025 Action Teams will be comprised of multidisciplinary and cross-sector representatives who will be charged with addressing each of the four priority areas via development and implementation of annual action agendas (workplans). The structure of these Action Teams will provide the opportunity to step out of traditional public health "lanes" (singular focus on health conditions and/or indicators) in order to align Coalition efforts on fewer issues, leverage the state's multi-disciplinary expertise, and impact the key factors that influence health outcomes from the broader, common context within which our cross-sector agencies work.



The Planning Process

PLANNING MODEL
PARTNER ENGAGEMENT
COMMUNITY ENGAGEMENT
IDENTIFICATION OF PRIORITY AREAS
THE PLANNING SESSIONS
THE PLAN AND OTHER GUIDING DOCUMENTS AND INITIATIVES
MOVING FROM PLANNING TO ACTION
HOW YOU CAN USE THIS PLAN

PLANNING MODEL

Similar to the process for the State Health Assessment (described in Healthy Connecticut 2025, Part 1), development of this Plan utilized a participatory, community-driven approach guided by the Mobilization for Action through Planning and Partnerships (MAPP) process.[2]

The MAPP model outlines a series of assessments that form the basis for collaborative planning. The development of the SHA incorporated the MAPP framework and Public Health Accreditation Board (PHAB) standards and measures. A cross-disciplinary team of internal and external stakeholders was engaged to develop a vision for Healthy Connecticut 2025 and to prioritize a list of Social Drivers of Health and related health indicators for inclusion in the report. In addition, community members were provided opportunities to contribute to the development of the assessment through surveys and focus groups, and finally through a public comment period.

Local public health agencies participated in both the Planning Work Group sessions and on the SHIP Advisory Council and provided important perspectives on systems capacity *from various regions* of the state.

As this is a "living" document, DPH expects that information-gathering and sharing will be an ongoing process that will be facilitated by DPH during Plan implementation.

PARTNER ENGAGEMENT

Accountable and effective public health practice depends upon comprehensive and strategic health improvement planning that engages a wide range of partners. Development of this Plan was led by the Connecticut Department of Public Health in collaboration with SHIP partners from across the state.

The Connecticut Health Improvement Coalition (SHIP Coalition):

This large advisory body of representatives from diverse local, regional, and statewide entities whose policies and activities can affect and influence health, was responsible for reviewing the State Health Assessment data; participating in the Summit and Priority Area Planning Work Groups; making recommendations for the Plan; serving as community ambassadors for planning initiatives; and fostering connections with key networks and groups for action.

The Healthy CT SHIP Advisory Council:

Made up of 34 Connecticut leaders from various sectors, the Healthy CT SHIP Advisory Council was responsible for guiding DPH in framing the SHA and SHIP; reviewing the State Health Assessment data; participating in the Summit and Priority Area Planning Work Groups; reviewing and providing feedback on the State Health Improvement Plan; and reviewing and providing feedback on Priority Working Group products (*see Appendix A*).

CT DPH Public Health Systems and Equity (PHSE) Staff:

Staff from DPH's Public Health Systems and Equity team assisted in the identification and recruiting of Priority Area Planning Work Group members and worked with HRiA to facilitate virtual Planning Work Group discussions to develop goals, objectives, and strategies over six successive weeks. In addition, PHSE sought input from DPH subject matter experts throughout the process and acted as ambassadors and educators as the Plan was being developed (*see Appendix B*).

Health Resources in Action (HRiA):

This non-profit public health organization based out of Boston, MA, provided technical assistance, strategic guidance and facilitation throughout the SHA and SHIP processes.

COMMUNITY ENGAGEMENT

Community engagement at multiple levels is critical throughout all components of a health improvement planning process, from conducting the state health assessment, to developing and implementing the goals, objectives, and strategies of state health improvement plan. Involving a broad range of stakeholders and developing multi-sector partnerships led to the creation of this actionable and sustainable Plan. Coalition partners and stakeholders participated in Coalition prioritization activities, engaged in Priority Area Planning Work Groups, and responded to electronic surveys, which they also shared with their extended network partners.

Community members were invited to provide input via Community Feedback Sessions, which were held in six Connecticut regions — New Haven, Hartford, Northwest, Northeast, Southwest, and Southeast — during the months of March and May, 2020 to discuss the framework and priorities for the SHIP. Community members were also engaged via electronic survey as the Plan was drafted and developed (*see Appendix D*). An Online public comment period was promoted via Coalition distribution list and extended networks and made accessible via the SHIP Coalition website.

IDENTIFICATION OF PRIORITY AREAS

Healthy Connecticut 2025 addresses the following four distinct Priority Areas:

These four Priority Areas were identified through close examination of SHA data, alignment with topics in *Healthy People 2030*, and dialogue with critical partners in health over a series of engagements held over 18 months.

The feedback from these engagements was remarkably consistent and validated the approach and focus for this SHIP.

THE PLANNING SESSIONS

Planning for Healthy Connecticut 2025 took place virtually via Zoom due to the COVID-19 pandemic. The PHSE team at CT DPH developed profiles for participants in each of the four identified priority areas (*see Appendix E*) and recruited participants to engage in a series of virtual planning sessions over six weeks. All Coalition partners were invited to participate in a pre-planning webinar conducted by HRiA to ensure planning participants were well prepared for the planning sessions, understood the evolution and context for the SHIP framework, and were clear about expectations for engagement.

The planning sessions were structured in small and large group formats to develop plan components. Sessions were facilitated by HRiA and included opportunity for cross-priority feedback and refinement of each of the core elements of the plan, per the table below:

VIRTUAL PLANNING FOR STRATEGIC PLAN

Participation Criteria
- Able to participate via Zoom (audio AND visual)
- Available to participate in ALL sessions

Time Commitment per Participant:
14 hours of sessions + 4-6 hours of homework
(assumes participation in only one (1) Priority Area)

1.5 hours	**SHIP PLANNING** (Pre-Planning Webnar	• Zoom/Online Tools Overview • SHA Findings • SDoH Priorities • SHIP Structure	• Planning Process Overview • Time Commitment • Next Steps	
2 hours	**PRIORITY A** Draft Goals	**PRIORITY B** Draft Goals	**PRIORITY C** Draft Goals	**PRIORITY D** Draft Goals
1 hour	Goals Feedback			
2.5 hours	**PRIORITY A** Revise Goals Draft Objectives	**PRIORITY B** Revise Goals Draft Objectives	**PRIORITY C** Revise Goals Draft Objectives	**PRIORITY DD** Revise Goals Draft Objectives
2 hours	Objectives Feedback			
3 hours	**PRIORITY A** Revise Objectives Draft Strategies	**PRIORITY B** Revise Objectives Draft Strategies	**PRIORITY C** Revise Objectives Draft Strategies	**PRIORITY D** Revise Objectives Draft Strategies
	Strategies Feedback (Electronically)			
2 hours	**PRIORITY A** Finalize Strategies	**PRIORITY B** Finalize Strategies	**PRIORITY C** Finalize Strategies	**PRIORITY D** Finalize Strategies

THE PLAN AND OTHER GUIDING DOCUMENTS AND INITIATIVES

The *Healthy Connecticut 2025 State Health Improvement Plan* is closely aligned with the *National Prevention Strategy, Healthy People 2030* objectives, the Centers for Disease Prevention and Control, and with other existing local and State of Connecticut Plans, including hospital and local health department Community Health Improvement Plans (CHIPs).

This Plan is designed to complement and build upon the guiding documents, plans, initiatives, and coalitions already in place to improve the health of Connecticut residents. DPH sponsored interns collected data across the state from published Community Health Needs Assessments and Community Health Improvement Plans to supplement and inform the SHIP planning process.

Rather than conflicting with or duplicating the recommendations and actions of existing frameworks and coalitions, the participants in the Plan development process identified potential partners and existing networks and resources (statewide assets as defined in the Mobilizing for Action Planning and Partnerships model) wherever possible.

Those engaged in this process recognize that identifying partners, resources, and initiatives is an ongoing effort that is critical for successful implementation and sustainability. One of the first priorities of the implementation phase of the SHIP will be to identify and confirm partners for the Action Plan. DPH has assumed the role of convening partners and organizing available data to support collective action.

MOVING FROM PLANNING TO ACTION

Healthy Connecticut 2025 is designed to be a broad framework for state health improvement, and should be modified and adjusted as conditions, resources, and external environmental factors change. It is developed and written in a way that engages multiple perspectives, so that all community groups and sectors — private and nonprofit organizations, government agencies, academic institutions, community and faith-based organizations, and consumers — can unite to improve the health and quality of life for all people who live, work, study, and play in the state of Connecticut.

The Plan reflects a commitment of partners and stakeholders to collaborate in addressing shared issues in a systematic and accountable way. The next phase of the Plan will be to solidify a framework for implementation, including the convening of Priority Area Action Teams and the development of annual action plans (work plans) for each priority. Action Plans will include data indicators and sources for each objective. The implementation phase will include ongoing communication to partners and stakeholders on plan activities and progress, monitoring and evaluation of plan metrics and deliverables, and ongoing cultivation of partners across the Coalition and its SHIP Advisory Council.

HOW YOU CAN USE THIS PLAN

Community/Nonprofit/Faith-based Organizations

- Seek to identify and understand systemic challenges, including institutional racism, and promote priority issues among the community members and stakeholders you serve
- Talk with community members about the importance of wellness and connect them with available resources
- Align activities and outreach efforts with health improvement needs and recommendations in this Plan
- Advocate for changes that improve health by interacting with policy makers and legislative officials

Government (Local, State)

- Seek to understand and promote priority issues in the community
- Identify systemic barriers to health in the community and state, including institutional racism, and collaboratively make plans for effective action
- Invest in programs, services, systems, and policy changes that will support the health needs of the community and state, while assuring equity for all Connecticut residents
- Embrace the interconnectedness of all Social Drivers of Health in your communities and utilize a health and equity lens when developing or improving policies and systems or making broad reaching decisions

Individuals and Families

- Seek to understand and promote priority issues among family members and friends
- Create opportunities to educate others and take action at schools, churches, workplaces, etc. to support the objectives in this Plan
- Volunteer for service organizations in your community that address the Social Drivers of Health identified in this Plan
- Get involved in state or local health improvement efforts by contacting your local health department
- Learn about the impact of institutional racism on health

Businesses/Employers

- Seek to understand priority issues in this Plan and how they apply to/impact your workforce
- Change your work environment and enhance your benefits plans to support healthier employees
- Educate your management team and employees about the link between employee health and work productivity
- Consider your investments in employee retention and career development

Hospitals

- Incorporate recommendations into Community Benefits and organizational strategic planning
- Lead your organization and the health care industry in responding to the health needs of the community and state
- Partner with communities in your catchment areas to address upstream issues impacting the long-term outcomes of your patients and community residents
- Identify how your organization could contribute to the development of a statewide health education framework
- Explore ways that your institution can improve access, cultural competence, and cultural humility

Health Care Professionals

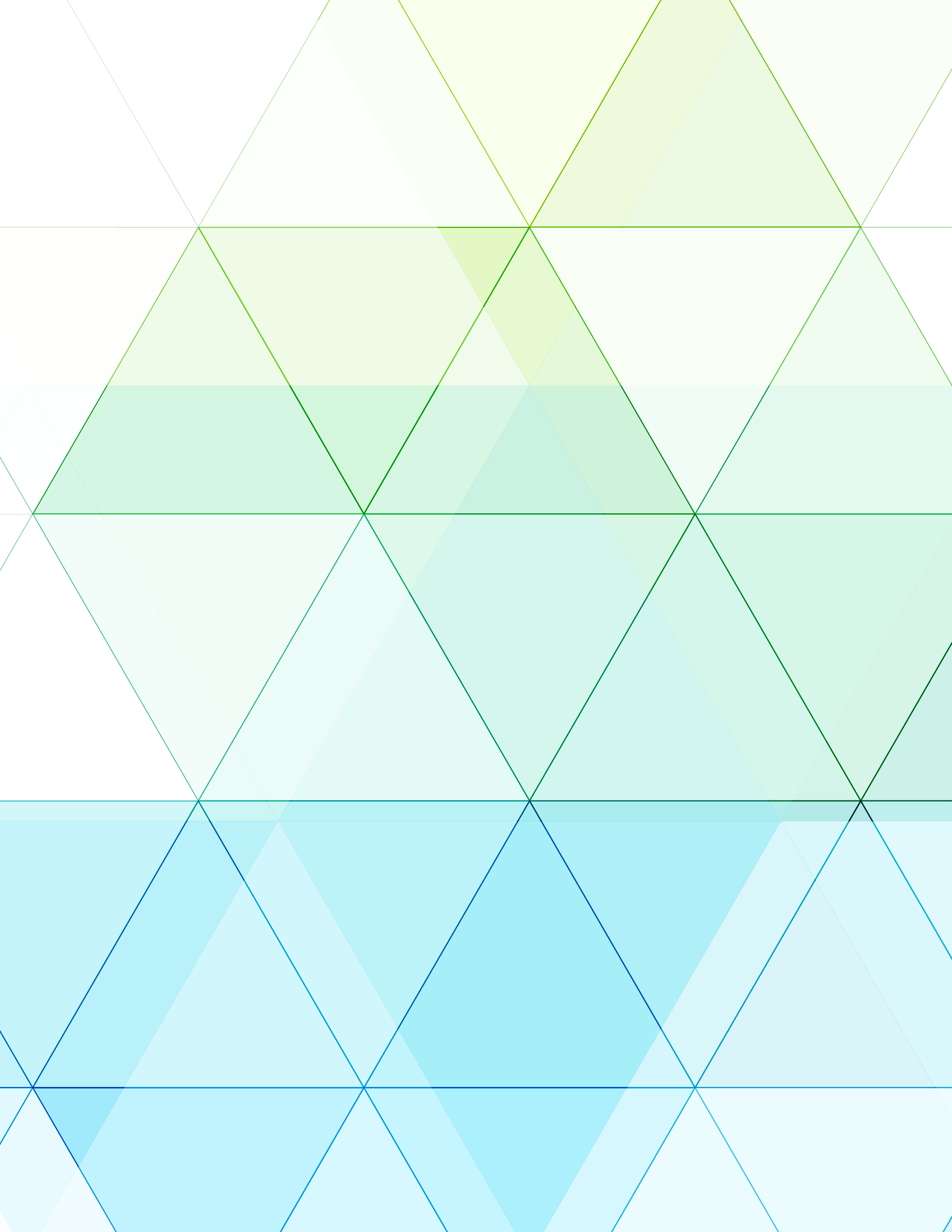
- Identify important health issues and racial/ethnic/cultural barriers that exist for your clients and use recommended practices to make changes
- Share the information in this Plan with your colleagues
- Lead your peers in advocating for actions that will improve the health of the community
- Explore ways that you can improve access, cultural competence, and cultural humility

Health Insurers/Payers

- Educate employers and other health insurance purchasers about the benefits of preventive health care and responding specifically to the health needs of the state
- Identify how your organization could contribute to the development of a statewide health education framework
- Consider how your organization assists communities in addressing the Social Drivers of Health identified in this Plan
- Explore the possible ways that institutional racism may be a contributing factor in your organization

Education Institutions

- Understand and promote priority health issues in this Plan and incorporate them as educational lessons in health, science, social studies, and other subjects, or when designing research studies or service projects within the community and state
- Create opportunities for action at schools to support the objectives in this plan that affect students, faculty, staff, and parents
- Identify how your organization could contribute to the development of a statewide health education framework
- Work with state and local partners to develop meaningful student engagement opportunities to better understand and address the Social Drivers of Health identified in this Plan



The Plan

SHIP-WIDE KEY IMPACT/SURVEILLANCE MEASURES

PRIORITY AREA A: ACCESS TO HEALTH CARE

PRIORITY AREA B: ECONOMIC STABILITY

PRIORITY AREA C: HEALTHY FOOD AND HOUSING

PRIORITY AREA D: COMMUNITY STRENGTH AND RESILIENCE


N
NE
SW
260
280
20
40

SHIP-WIDE KEY IMPACT/ SURVEILLANCE MEASURES

As part of the collaborative planning process, SHIP Coalition members, subject matter experts, and stakeholders reviewed data from the 2019 State Health Assessment (SHA) and prioritized six SHIP-wide key impact measures as the surveillance issues to monitor to assess improvements in the health and quality of life for Connecticut residents. **The goals, objectives and strategies in this plan were developed with the intent of impacting these SHIP-wide impact/surveillance measures via the policy, systems, environmental change, and primary prevention strategies outlined for each priority area.** The SHA data will act as the baseline measures for the plan and CT DPH will monitor and track the surveillance measures to assess and communicate progress across the SHIP.

Obesity

Body Mass Index, or BMI, is commonly used to measure overweight and obesity. Adults with a BMI of 30 or higher are considered obese.[3] Unlike adults, a child's weight status is determined using an age and sex-specific percentile for BMI. Children that are at or above the 95th percentile are considered obese.[4] According to the CDC, over 4 in 10 adults and 1 in 5 children in the U.S. are obese.[5] Although Connecticut adults are less likely to be obese when compared to U.S. adults, there has been a consistent increase in the prevalence of obesity in Connecticut adults for the past 20 years.[6] This trend is alarming because obesity is consistently associated with various long-term negative health outcomes, such as high blood pressure, type 2 diabetes, stroke, and coronary heart disease.[7] Obesity often disproportionately affects disadvantaged populations, including racial minorities, lower income populations, and those with less education.[8,9] A variety of factors impact a person's ability to maintain a healthy weight. Barriers include lack of access to consistent health care, safe neighborhoods and recreational spaces, healthy and affordable food, and stable and safe housing. Housing and neighborhood safety can contribute to a reduction in obesity rates by lowering stress, increasing stability, and improving access to recreation facilities, such as parks, playgrounds, and swimming pools.[10,11] Where someone lives is also critical to food access, as living farther than one mile from a full-service grocery store presents transportation, time, and cost barriers to accessing healthy food.

Suicide

The World Health Organization estimates that one person will lose their life to suicide every 40 seconds.[12] Intentional injuries caused by violence and self-harm behaviors also contribute to premature mortality and morbidity. Suicide attempts and suicides are the leading cause of intentional injury and death in Connecticut's population. The rate of suicides in our state continues to climb despite increased public awareness and educational efforts.[13]

This is particularly concerning in children and adolescents with low socioeconomic status, who may suffer from mental health problems more often than their peers with higher socioeconomic status.[14] Symptoms of economic crisis including housing and food insecurity may further compound mental stress.[15] In turn, frequent mental stress can exacerbate other chronic illnesses such as depression, anxiety, heart disease, high blood pressure, and stroke.[16]

Drug Overdose and Substance Misuse Disorders

Substance misuse disorders refer to dependence and continued use of substances in spite of serious harmful consequences.[17] Substance use not only contributes to major economic loss, but also results in social harms, impacting the families and loved ones of the affected individuals.[18,19] Substance use is often related to other social issues such as homelessness.[20] Over the past few years, Connecticut has seen an increase in drug overdose deaths that contributed to a rise in the unintentional death rate to levels above the U.S. rate.[21] While the rate for drug overdoses has consistently been higher for non-Hispanic Whites than any other racial or ethnic population in CT, their rate for drug-related overdoses has dropped from 2017 to 2018, while the rate for non-Hispanic Blacks and Hispanics continued to climb over the same time period.[22] Substance misuse disorders can be treated effectively, but the majority of persons in need of treatment either do not have access to treatment or do not perceive a need for treatment.[23] In addition, there are often gaps in the integration of prevention, treatment, and recovery services across the health care system that further impact the ability to address drug overdose and substance misuse disorders.[24]

Domestic Violence/Sexual Violence

Domestic or family violence is a pattern of behaviors that are used to maintain power and control over another person. Domestic violence includes physical and sexual violence, emotional and verbal abuse, threats and intimidation, and economic control. It can happen to anyone of any race, age, sexual orientation, religion, or gender from any socioeconomic background and education level.[25] Additional social factors, such as chronic stress stemming from economic instability, or the inability to secure safe housing with access to basic resources, may increase the rates of domestic violence and crimes.[26]

Family violence can affect children, elders, and people with disabilities in similar ways. Someone that has been abused may experience more than one form of family violence.[27] Once domestic violence is identified, access to mental health providers is crucial because victims often suffer from psychological effects and trauma.[28]

While sexual violence is often included as a subcategory under domestic violence, the topic extends beyond the home and familial relationships. Sexual violence refers to any sexual act or attempt to obtain a sexual act, or unwanted sexual comments or acts to traffic, that are directed against a person's sexuality using coercion by anyone, regardless of their relationship to the victim, in any setting, including at home and at work.[29] In Connecticut, the percentage of sexual dating violence reported is higher than the nation's across grades 9–12, as well as for non-Hispanic Black and Hispanic youth; only non-Hispanic White students reported experiencing sexual violence less than the national rate for that group. Since those who experience sexual violence in their youth are more likely to remain sexual violence victims as adults,[30] it is imperative that the public health sector do more to address the factors that correlate with an increased likelihood of sexual violence among youth to promote healthier adult lives both physically and mentally.

Percent Insured

Improving the opportunities to obtain health insurance is a key strategy to increasing access to regular and financially obtainable health care. Currently, social and economic factors including education, employment, and poverty rates, have a significant impact on an individual or family's ability to obtain insurance. Uninsured CT residents have a harder time accessing clinical preventive services and screenings, treatment of illness and injury, and managing chronic conditions since they are more likely to postpone or go without health care altogether. Uninsured CT residents also face barriers obtaining care when they do seek it and are more likely to experience financial hardship due to healthcare costs.[31] Consequently, many individuals and families face difficult financial decisions about sacrificing basic necessities like food and housing in order to pay for the purchase of health insurance, or to cover copay costs to get the health care treatment they need. Often, financial resources and government assistance play a role in decisions on whether to buy insurance and the type of insurance coverage. Medicaid eligibility and subsidies on the state's health insurance exchange, Access Health CT, are dependent on income.[32] Slightly over half of Connecticut's population may be covered by employer-sponsored health insurance.[33]

Strategies that address economic stability could result in an increase in the percent insured, although the decision to purchase health insurance may still face competing demands for basic needs for food and housing.

Emergency Room (ER) Visits

Approximately two-thirds of all ER visits are avoidable and can be treated at a primary care physician's office or an urgent care center, both of which cost one tenth of the average cost of treatment at ERs.[34] For the uninsured population who are unable to pay for medical care, the emergency department may be their sole source of care under the Emergency Medical Treatment and Labor Act (EMTALA).[35] Medicaid patients comprise approximately one in two emergency room visits, which is significantly higher than any other primary insurance payer group.[36]

It is notable that during 2016–2017 at least 80% of the preventable hospitalizations for each of the top five conditions for adults in CT were covered by public payers, and one in ten hospital stays for preventable hospitalizations generated about $1.5 billion in charges.[37] Regular access to primary care can help to identify and address health issues early and prevent deterioration to severe conditions that would require emergency care.[38] It is important to note that having access to insurance coverage addresses a critical barrier to seeking preventive health care; however, to effectively address this issue, a broader scope of strategies need to be considered.

PRIORITY AREA A: ACCESS TO HEALTH CARE

- Primary Care
- Health/Mental Health Care

What is Access to Health Care?

Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing, and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all Americans. This topic area focuses on three components of access to care: insurance coverage, health services, and timeliness of care. When considering access to health care, it is important to also include oral health care and obtaining necessary prescription drugs.[39]

Access to health services means "the timely use of personal health services to achieve the best health outcomes."[40] It requires three distinct steps:

- Accessing the health care system (usually through insurance coverage)
- Accessing a location where needed health care services are provided (geographic availability)
- Finding a health care provider whom the patient trusts and can communicate with (personal relationship)[41]

Access to health care impacts one's overall physical, social, and mental health status and quality of life. It is important to recognize that comfort and trust in a health care provider may mean finding a provider who is not only culturally humble but who looks like the patients she or he serves.

PRIORITY AREA A GOAL

Ensure all Connecticut residents have knowledge of, and equitable access to, affordable, comprehensive, appropriate, quality health care.

WHY THIS GOAL IS IMPORTANT FOR CONNECTICUT

Healthy People 2030 has set a national objective to increase the proportion of individuals with a usual primary care provider to 84.0%. In Connecticut, we have surpassed this benchmark, as 85.2% of adults overall have at least one primary care provider but disparities exist among the Hispanic population. While the percentages of non-Hispanic White and non-Hispanic Black adults exceed the Healthy People benchmark, only two out of three Hispanic adults report having at least one primary care provider. Overall, the high number of uninsured and those with "limited" healthcare coverage among Connecticut's Hispanic population indicate that they are disproportionately affected when it comes to healthcare access.[42]

CONTEXT FOR THIS GOAL

- Awareness of and access to a service does not always mean optimal utilization; need to consider cultural and social influences that may present barriers to use.
- "Comprehensive" includes all healthcare (primary, specialty, mental, and oral health).
- "Quality" includes coordinated, relevant, timely, effective, and culturally competent.
- Access includes accessibility for all, including those with disabilities, older adults, and those with transportation challenges.

PLANNING WORK GROUP ON ACCESS TO HEALTH CARE

Ellen Andrews
Connecticut Health Policy Project

Marijane Carey
Carey Consulting

Pareesa Charmchi Goodwin
The Connecticut Oral Health Initiative, Inc.

Nilda Fernandez
UCONN Health

Erica Garcia-Young
Connecticut State Dept of Social Services

Nancy Hamson
Yale New Haven Health

Ken Lalime
Community Health Centers Association of CT

Geralynn McGee
CT Health Foundation

Marty Milkovic
Connecticut Dental Health Partnership (CTDHP)

Laura Morris
Connecticut State Office of Health Strategy

Sherry Ostrout
Connecticut Community Care

Esther Pendola
L&M Hospital

Robin Tousey-Ayers
Connecticut State Dept of Public Health

A1: Increase the number of traditional and alternative (community- and technology-based) places people can access health care by 2025.

STRATEGIES

A1.1. Expand affordable, quality broadband internet and cellphone access across the state, and seek public or subsidized broadband access program for geographic areas and lower income residents, so telehealth can be expanded. (*See also B2.1, D3.3, D4.4, D5.2*)

A1.2. Ensure public access to internet capable devices/equipment, and training and Technical Assistance (TA) on how to use them for telehealth. (*See also D3.4, D3.5*)

A1.3. Conduct data analysis to understand current capacity and determine magnitude of need.

A1.4. Recommend policy enhancements for all providers, especially dental, to enable them to provide telehealth (e.g., Medicaid, Insurance payers).

A1.5. Promote the use of mobile units for delivering care to people where they need it in coordination with medical/dental home (i.e., to reduce number of people dependent on location-specific bricks and mortar).

A1.6. Broaden the definition of public health settings to include community-based settings, and ensure that care is still coordinated (e.g., school-based health centers, seniors accessing care in congregate settings) (*See also Objective A5*).

A1.7. Collaborate with clinics and medical schools, dental schools, dental hygiene schools, and nursing programs to teach recommended policies that address systemic racism.

A1.8. Conduct an educational campaign across CT to inform the consumer about standards for preventive healthcare and to increase utilization of preventative healthcare services (via billboards, social media, etc.). (*See also A2.4, A2.5, A3.4*)

A1.9 Explore policies to authorize, incentivize, and reimburse for high value/high efficiency services.

A2: Increase adoption of accepted best practices and standards of care among clinical health care providers by 2025.

STRATEGIES

A2.1 Assess current and emerging technology for its value to patient care, in protecting patient privacy, and in empowering patient consent. (*See also A3.1, D4.5*)

A2.2. Co-locate behavioral health, oral health, and primary care in comprehensive, integrated "health home" settings while ensuring that people have choice/options about their "health home". (*See also A3.2*)

A2.3. Identify models for how best practices can be introduced and adopted/implemented in different community cohorts in an effort to break down compartmentalized healthcare (see Project ECHO — (Extension for Community Healthcare Outcomes). (*See also A3.3*)

A2.4. Educate consumers and policy makers on quality benchmark scores for providers to improve care. (*See also A1.8, A2.5, A3.4*)

A2.5. Educate general public about health literacy and preventive care standards focused on different demographics. (*See also A1.8, A2.4, A3.4*)

A2.6. Adopt scorecard model for preventive clinical services state-wide (use the U.S. Preventive Services Task Force (USPSTF) recommendations from CDC as a guide). (*See also A3.5*)

A3: Increase adoption of accepted best practices and standards of care among community health preventive care providers by 2025.

STRATEGIES

A3.1 Assess current and emerging technology for its value in screening consumers to improve community-based care, including a standardized set of Social Drivers of Health data elements, and protections for patient privacy and empowering consumer consent. (*See also A2.1, D4.5*)

A3.2. Coordinate community-based preventive services for behavioral health, oral health and primary care in a comprehensive, integrated fashion while ensuring that people have choice/options about their setting. (*See also A2.2*)

A3.3. Identify models for how best practices can be introduced and adopted/implemented in different community cohorts in an effort to break down compartmentalized healthcare (see Project ECHO). (*See also A2.3*)

A3.4. Educate general public about health literacy and community prevention initiatives focused on different demographics. (*See also A1.8, A2.4, A2.5*)

A3.5. Adopt a scorecard model for community preventive services state-wide (use the Community Preventive Services Task Force (CPSTF) recommendations from CDC as a template). (*See also A2.6*)

A4: Develop a comprehensive, across-the-lifespan, statewide health education framework by 2025.

STRATEGIES

A4.1 Convene a group of cross sector partners (including community health providers, action agencies, schools and school-based health centers, other educators).

A4.2. Conduct and coordinate an assessment with local and regional partners.

A4.3. Identify information gaps in state-wide health education and develop recommendations on how to close the gaps across the lifespan.

A5: Increase the availability and diversity of primary care providers, community partners, and care management services by 2025, while respecting patients' rights to privacy and choice.

STRATEGIES

A5.1 Convene a group of cross-state, multi-sector partners to coordinate efforts.

A5.2. Assess the availability and diversity of and coordination among primary care providers, community partners, and care management services.

A5.3. Develop, execute, and evaluate a pilot plan for the enactment of system reforms based on assessment findings.

A6: Decrease the number of CT residents who are at risk of spending more than 10% of their net income on health care services and coverage by 2025.

STRATEGIES

A6.1 Establish baseline numbers (uninsured, under-insured, other, by individual income level) and benchmarks for improvement.

A6.2. Recommend limits on cost sharing and total costs for consumers in health insurance plans, including reduced copays for medical/oral health visits or pharmacy.

A6.3. Promote educating consumers about what their financial risks are when choosing between various insurance plans and options based on their individual ages/conditions (i.e., understand the ramifications if you end up in the hospital).

A6.4. Explore options to expand Medicaid and subsidized insurance coverage to ineligible individuals that remain uninsured or underinsured (e.g., low income, parents of HUSKY recipients, immigrants).

A6.5. Work with insurers to simplify plan designs to make them easier to understand.

A6.6. Promote expansion of supports and incentives for small businesses to offer health insurance to their employees (e.g., tax breaks).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Pay against this cheque
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Current Name
Street Name, City
Amount:
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TEN THOUSAND TWO HUNDRED AND FOURTY SEVEN 40/100 U.S. DOLLARS
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Street Name
City, State, ZIP
Date:
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Bank Branch Name
VOID AFTER ONE YEAR

PRIORITY AREA B: ECONOMIC STABILITY

- Unemployment
- Poverty

What is Economic Stability?

Social and economic factors, such as income, education, employment, community safety, and social supports can significantly affect how well and how long we live. These factors affect our ability to make healthy choices, afford medical care and housing, manage stress, and more.

The social and economic opportunities we have, such as good schools, stable jobs, and strong social networks are foundational to achieving long and healthy lives. For example, employment provides income that shapes choices about housing, education, childcare, food, medical care, and more. In contrast, unemployment limits these choices and the ability to accumulate savings and assets that can provide a cushion in times of economic distress.

Social and economic factors are not commonly considered when it comes to health, yet strategies to improve these factors can have an even greater impact on health over time than those traditionally associated with health improvement, such as strategies to improve health behaviors.

Across the nation, there are meaningful differences in social and economic opportunities for residents in communities that have been cut off from investments or have experienced discrimination. These gaps disproportionately affect People of Color — especially children and youth.[43]

PRIORITY AREA B GOAL

Achieve equitable economic wellbeing, stability, and security so all Connecticut residents have the opportunity to work here, and can afford to live, stay, and retire here.

WHY THIS GOAL IS IMPORTANT FOR CONNECTICUT

For many of Connecticut's residents, the optimal, healthy choice may not be the financially attainable choice. Economic position often shapes health behaviors and decisions, which in turn influence our health status. Economic position is influenced by factors such as income, income distribution, and poverty; education; and employment; and has repercussions in a person's ability to access healthy foods, quality housing, and appropriate health services as well as other environmental conditions that impact health.[44]

CONTEXT FOR THIS GOAL

- Economic wellness includes employment, Social Security, pensions, sustained social services, and philanthropy across the lifespan.
- This goal recognizes that education, affordable housing and food, childcare, and transportation are key drivers of economic well-being, and that strategies must focus on infrastructure, polices, and systems.
- Earnings and savings opportunities are both important for stability and security.

B1: Increase the percentage of all CT residents who can meet their living expenses and have the ability to contribute at least 10% of their earnings towards savings by 2025.

STRATEGIES

B1.1. Conduct a continuous impact assessment of wage increases across sectors.

B1.2. Promote the extension of and participation in the Asset Limited, Income Constrained, Employed (ALICE) Saves program beyond 2020.

B1.3. Promote banking polices that minimize the cost of bank accounts, incentivize savings, and support those with a poor banking history or lack of banking experience.

B1.4. Maintain, sustain, expand policies and systems that address income security with respect to key living expenses (e.g., housing, taxes, childcare, health care).

B1.5. Promote the value of pre-tax retirement savings and health savings account opportunities to employers of all sizes.

B1.6. Partner with financial institutions and school districts to encourage children to open a savings account.

PLANNING WORK GROUP ON ECONOMIC STABILITY

Supriyo Chatterjee
Consultant

Amanda Deloreto
Connecticut State Dept of Public Health

Erica Garcia-Young
Connecticut State Dept of Social Services

Robyn Gulley
North Central Area Agency on Aging (NCAAA)

Augusta Mueller
Yale New Haven Health

Michelle Riordan-Nold
Connecticut Data Collaborative

Sue Starkey
Northeast District Department of Health

B2: Increase the amount of capital investment in communities and local businesses to support workforce development, community development, and entrepreneurship by 2025.

STRATEGIES

B2.1 Expand affordable broad band internet and cellphone access across the state and seek public or subsidized broadband access program for geographic areas and lower income residents, so all people can work from anywhere. (*See also A1.1, D3.3, D4.4, D5.2*)

B2.2. Partner with financial services to provide and promote multiple community banking options and settings (e.g., low interest loans, incentives for bank locations in low income communities).

B2.3. Partner with local businesses, the media, public schools, vocational schools, and community colleges to promote education and opportunities for vocational/trade careers. (*See also B3.3, B4.1, B4.2*)

B2.4. Partner with funders to promote business startup grants and venture capital across the board with specific outreach to minority owned businesses, and to expand business incubators to underserved communities (ecosystems for small businesses).

B2.5. Educate on green sector jobs to facilitate a job sector shift.

B2.6. Enhance document management system to provide centralized, uniform, 24x7 access to government documents that support timely business growth.

B2.7. Educate about the impact of low-cost drivers' education to enable young people access to personal transportation and cost-effective auto insurance.

B2.8. Promote the inclusion of minority businesses and small businesses in community and industry networking events. (*See also B5.1*)

B3: Increase the number of employers who invest in employee retention and wellness programs/policies that support the continuity of their work by 2025.

STRATEGIES

B3.1 Establish partnerships between the business community and community support networks to offer Employee Assistance Program (EAP), behavioral health and substance abuse, general wellness, and childcare options for all employees.

B3.2. Promote and encourage participation in the network of community groups (e.g., libraries, chambers of commerce, etc.) that offer skills-building workshops to sustain workforce education and development.

B3.3. Promote incentives and risk mitigation for employers who invest in vocational education and retention strategies (e.g., tax breaks). (*See also B2.3, B4.1, B4.2*)

B3.4. Educate decision-makers and communities about the value of equitable distribution of state funds for behavioral health to increase availability of behavioral health services that support working while receiving treatment (e.g., behavioral health/substance use treatment center hours and Medication-Assisted Treatment (MAT) outlets in alignment with work hours).

B3.5. Educate on the impact of do-not-compete clauses for businesses and employees across the state.

B3.6. Partner with the United Way to expand the 211 system to facilitate increased awareness of available services (i.e., connect multiple directories within 211). (*See also C1.5, D4.3*)

B4: Increase the number of opportunities for children, young adults, adults, and retirees/older adults for equitable, affordable education on career development and personal finance by 2025.

STRATEGIES

B4.1 Promote the benefits of enrollment in Vocational education. (*See also B2.3, B3.3, B4.2*)

B4.2. Build/expand partnerships between employers and community colleges to expand apprenticeships and employment opportunities for entry level positions (e.g., Pratt & Whitney). (*See also B2.3, B3.3, B4.1*)

B4.3. Educate on the value of a policy to include good financial management as part of the curriculum for youth, teens, and young adults.

B4.4. Educate on the value of employee offered tuition reimbursement.

B4.5. Increase opportunities for those receiving public assistance to receive education on personal finance.

B4.6. Promote the value to large employers to offer on the job financial empowerment training to their employees, to smaller employers, and throughout the community.

B4.7. Partner with state associations that address the needs the unemployed, retired/senior community (e.g., United Way, senior centers) to promote financial wellness.

B5: Increase the number of employers across sectors that offer equitable and sustainable employment opportunities for all levels and demographics by 2025.

STRATEGIES

B5.1 Promote the inclusion of minority businesses and small businesses in community and industry networking events. (*See also B2.8*)

B5.2. Promote prison-to-work opportunities by facilitating transfer to gainful employment based on acquired skills.

B5.3. Capitalize on and promote healthy living and green spaces in state, especially in low resources neighborhoods, to attract employers and employees. (*See also Priority D*)

B5.4. Invest in jobs directed toward sustainable development, healthy living, culture/arts, green energy, and technology.

B5.5. Promote recruitment and selection of underrepresented groups, particularly in Science, Technology, Engineering, and Mathematics (STEM).

B5.6. Collaborate with employers to select and implement curricula (including a common language, tools, and frameworks) to elevate awareness of and eliminate systemic racism and inherent bias. (*See also D5.1*)

PRIORITY AREA C: HEALTHY FOOD AND HOUSING

- Housing Quality/Accessibility
- Healthy Food Access

What is Healthy Food and Housing?

Many of our health outcomes are influenced by what, how much, and how often we eat. Yet for many, making the healthy food choice is not the easy choice. For some CT residents, healthy and affordable foods are not as readily available in their communities as are places that prepare or sell processed pre-packaged foods that are more likely to be high in salt, sugars, and fats. Children within these communities are especially vulnerable since they are subject to the food choices made by their parents, and the eating habits developed during childhood are likely to carry into early adulthood. Although research indicates that eating habits can change as we get older and our environment changes, the stage is set for increased likelihood of chronic disease as we age. Therefore, healthy food access, which is influenced by the affordability and availability of food and household income, is an important factor that impacts population health both immediately and with lasting effects.[45]

Low-income families may be more likely to live in poor-quality housing that can damage health. Housing quality refers to the physical condition of a person's home as well as the quality of the social and physical environment in which the home is located. Aspects of housing quality include air quality, home safety, space per individual, and the presence of mold, asbestos, or lead. Housing quality is affected by factors like a home's design and age. Poor quality housing is associated with various negative health outcomes, including chronic disease and injury. In addition, the quality of a home's neighborhood is shaped in part by how well individual homes are maintained; living in a poor quality home and widespread residential deterioration in a neighborhood can both negatively affect mental health.[46]

Interventions to improve housing quality, such as restrictions on lead paint and renovations of older homes, have been shown to decrease certain health risks (e.g., through decreased rates of lead poisoning). Further research is needed to develop other effective interventions to improve housing quality.[47]

PRIORITY AREA C GOAL

Ensure that all Connecticut residents have equitable access to safe and affordable:

- nutritious and culturally appropriate food, and
- fair, stable, healthy housing

WHY THIS GOAL IS IMPORTANT FOR CONNECTICUT

Food

Improving access to foods that support healthy eating patterns is one method for addressing health disparities and population health. Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.[48]

Housing

Among the many environments we frequent in our daily lives, where we live and the affordability, stability, and quality of our housing are influential on our health and well-being.[49]

Households are considered cost burdened when they spend more than 30% of their gross income on housing.[50] In 2017, an estimated 27% of owners and 48% of renters in Connecticut were cost-burdened.[51] When families have to spend a large part of their income on housing, they may not have enough money to pay for things like healthy food or health care. This is linked to increased stress, mental health problems, and an increased risk of disease.[52]

PLANNING WORK GROUP ON HEALTHY FOOD AND HOUSING

Caleb Cowles
City of New Britain Health Department

Judith Dicine
State of Connecticut Division of Criminal Justice

Jenn Eielson
New Canaan Health Department

Nilda Fernandez
UConn Health//CT Children's HIV Program

Robyn Gulley
North Central Area Agency on Aging (NCAAA)

Sally Mancini
UConn Rudd Center for Food Policy & Obesity

Ali Mulvihill
Quinnipiack Valley Health District

Bill Nash
International Code Council

Donna Parker
Division of Criminal Justice Housing Unit

Kim Ploszaj
Connecticut State Dept of Public Health

Michael Santoro
Connecticut Dept of Housing

Gina Smith
Yale New Haven Health

Sue Starkey
Northeast District Department of Health

Mary Grace Webb
Connecticut Academy of Nutrition and Dietetics

Erin Windham
Connecticut State Dept of Agriculture

Our economic position influences the quality of housing that we can access. Throughout Connecticut, the housing stock is generally older with about 70% of housing units built in 1979 or earlier. Renters comprise 35% of households living in housing units built before 1980 but comprise only 30% of households living in housing units built from 1980 through present day. This breakdown indicates that newer and safer housing options are not being made available to people who most desperately need it.[53]

CONTEXT FOR THIS GOAL

- This goal recognizes that transportation, education, and the built environment are all key factors for healthy food and housing, and that Connecticut needs a structural framework for sustainability.
- "Quality" housing is housing that is safe, affordable, fair, stable, and healthy.
- There is a need to define a standard of housing that all can access and secure.

C1: Increase the utilization of available housing and food programs by eligible residents by 2025.

STRATEGIES

C1.1. Establish a common intake application in the top seven languages used by CT residents for all programs (e.g., Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Farmers Market Nutrition Program (FMNP), Supplemental Nutrition Assistance Program (SNAP), HUSKY, Housing Assistance). (*See also C1.2, D4.7*)

C1.2. Enhance partnerships among community organizations, state agencies, state and local health departments, healthcare providers and CHW's to improve communication, coordinate work, provide navigation supports, and share available resources/knowledge re food and housing. (*See also C1.1, D4.7*)

C1.3. Provide multi-modal education to community residents about benefit eligibility and support them in completing the common application process.

C1.4. Expand the Community Eligibility Provision (universal meals for kids in high need communities).

C1.5. Promote 211's information on housing and food resources and ensure that the information is comprehensive, up to date and accurate. (*See also B3.6, D4.3*)

C1.6. Promote housing/food programs/resources to reduce stigma, restore dignity, and provide incentives to participate ("Faces of WIC").

C1.7. Assess the capacity of the Emergency Food System (food banks, food pantries, faith-based food programs) to reduce need for and protect these resources from being used to meet day to day food needs. (*See also C1.8, C2.9, D1.6*)

C1.8. Promote increased coordination among community food resources to reduce draw on the Emergency Food System. (See also C1.7, C2.9, D1.6)

C2: Increase the number of access points where people can obtain affordable, healthy, and nutritious food by 2025.

STRATEGIES

C2.1 Promote/enhance policies that expand options to obtain affordable, healthy, nutritious, and culturally centered foods, with a focus on underserved communities.

C2.2. Promote hospitals and other healthcare providers as distribution points for access to healthy and nutritious food.

C2.3. Promote a vibrant agriculture system within urban centers via community gardens and education (e.g., gardening workshops, individual/incubator farms).

C2.4. Promote incentives to expand farmer's markets and mobile markets in areas where they are most needed; expand retail market of locally grown food; and to address food swamps and food apartheid.

C2.5. Promote incentives for farmers and other retailers to increase acceptance of SNAP and doubling programs (e.g., CT Fresh Match) especially within urban areas.

C2.6. Promote expansion of use of WIC benefits for multiple access points (e.g., curbside and online delivery).

C2.7. Promote Farm to School network and school gardens to increase access to healthy foods in schools.

C2.8. Ensure that all access/distribution points accommodate persons with physical and or mental/cognitive disabilities.

C2.9. Promote the utilization of the Supporting Wellness at Pantries (SWAP) system. (*See also C1.7, C1.8, D1.6*)

C2.10. Promote the continuation of the fruit and vegetable Rx program through health care providers, and work with payers to reimburse for food as medicine.

C2.11. Promote the processing and preparation of locally grown food.

C2.12. Promote policies that increase access to healthy food and beverage options (e.g., in vending machines limits on sugary drinks, healthy beverage options in kids' meals).

C3: Decrease the number of persons experiencing or at risk of homelessness and increase opportunities to obtain affordable and sustainable housing by 2025.

STRATEGIES

C3.1 Promote sustainable funding for programs that support housing stability, especially for the most at-risk populations (e.g., young adults, seniors, veterans, disabled, formerly incarcerated, non-White Lesbian, Gay, Bisexual, Pansexual, Transgender, Genderqueer, Queer, Intersex, Agender, Asexual and other Queer-identifying (LGBTQIA+) people).

C3.2. Expand support for energy savings and healthy home improvement through existing and promising innovative housing programs (e.g., Green Bank, CT Children's Hospital, Department of Housing, CT Green & Healthy Homes, solar incentives).

C3.3. Promote awareness of state and local policies that prevent landlord retaliation when tenants report issues.

C3.4. Educate on and reduce barriers that keep formerly incarcerated persons from obtaining secure housing, with particular focus on building awareness around public housing policies.

C4: Adopt and begin to implement a Connecticut property maintenance code that includes a statewide definition for safe and quality housing by 2025.

STRATEGIES

C4.1 Reconvene the agencies, partners, and stakeholders to continue the conversation, confirm consensus, and move things forward.

C4.2. Reorient partners, get buy in, define the code, pass the code, educate those who will be impacted

C4.3. Conduct resident education for owners and renters to help them understand the newly adopted housing standards, be able to determine whether they are being met, and understand their rights for remediation.

C4.4. Develop a system to allocate the costs for funding enforcement (other than regional or community funding).

C4.5. Improve access for code enforcement officials to information that will locate absentee landlords/property owners and use and enforce policies to hold them accountable.

C4.6. Educate property owners regarding available licensed trade and home improvement contractors for making property improvements (e.g., Department of Consumer Protection).

C5: Increase the percentage of owner-occupied housing in CT by 2025.

STRATEGIES

C5.1 Promote policies to incentivize owner occupied homes in key priority areas and for key demographics.

C5.2. Educate first-time home buyers, particularly in communities that are disproportionately high rental, and for low income individuals and families, about available incentives for homeownership. (See also C5.3)

C5.3. Educate consumers, especially priority populations, about financing a home, and available programs (e.g., Federal Housing Administration (FHA), home ownership, home maintenance, and domestic finances to understand the total cost of owning a home (mortgage, utilities, maintenance)). (See also C5.2)

C5.4. Expand policies and systems that enable key populations to live well and particularly for seniors to age in place.

C5.5. Promote fair housing choice and collaborate with partners to address and advance housing equity (e.g., new affordable housing construction, red lining, housing discrimination).

PRIORITY AREA D: COMMUNITY STRENGTH AND RESILIENCE

- Cohesion
- Safety
- Emergency Responses & Preparedness

What is Community Strength and Resilience?

Building a community's resilience requires a community to use its assets to strengthen public health and healthcare systems and to improve the community's physical, behavioral, and social health to withstand, adapt to, and recover from adversity.

Developing community resilience benefits disaster planners and community members alike. Community resilience expands the traditional preparedness approach by encouraging actions that build preparedness while also promoting strong community systems and addressing the many factors that contribute to health.

Key preparedness activities — such as continuity of operations plans for organizations, reunification plans for families, and compiling disaster kits and resources — continue to be essential, recommended steps to take. A resilience approach adds features like building social connectedness and improving everyday health, wellness, and community systems.

Community resilience is the sustained ability of communities to withstand, adapt to, and recover from adversity. Health — meaning physical, behavioral, social, and environmental health and wellbeing — is a big part of overall resilience. In many ways, health is a key foundation of resilience because almost everything we do to prepare for disaster and protect infrastructure is ultimately in the interest of preserving human health and welfare.[54]

PRIORITY AREA D GOAL

Ensure community strength, safety, and resiliency by providing equitable and sustainable access to community resources to address the unique physical, social, and behavioral health needs of all Connecticut residents.

WHY THIS GOAL IS IMPORTANT FOR CONNECTICUT

Communities with high levels of social capital and cohesion are more readily equipped to mobilize and organize for social, political, or interpersonal actions to vastly improve safety, trust, and community resilience. But for many communities of color and other historically underrepresented people, these social trusts are hard to attain when families must prioritize the accumulation of assets that pave the way for greater personal stability.[55]

CONTEXT FOR THIS GOAL

- Contributors to community strength and resilience include timeliness, community safety, personal sense of safety, affordability, accessibility, equity, adequate resources, sustainability, person-centered and community-based perspective, and interconnectedness.
- It is important to consider the ability of the community to control and have access to its own resources.
- A disaster or emergency does not discriminate whom it affects, but poor and medically underserved people bear an unequal amount of the burden.[56]

PLANNING WORK GROUP ON COMMUNITY STRENGTH & RESILIENCE

Mark Abraham
DataHaven

Arielle Levin Becker
Connecticut Health Foundation

Maritza Bond
New Haven Health Department

Kevin Borrup
Connecticut Children's Injury Prevention Center

Supriyo Chatterjee
Consultant

Andrea Duarte
Connecticut State Dept of Mental Health and Addiction Services

Ashley Frechette
Connecticut Coalition Against Domestic Violence

Robyn Gulley
North Central Area Agency on Aging (NCAAA)

Nancy Hamson
Yale New Haven Health

Jonathan Lillpopp
Connecticut Dept of Public Health

Susan Major
Connecticut Dept of Public Health

Geralynn McGee
CT Health Foundation

Katie McMullan
Student Intern

Carlos Rivera
Hispanic Health Council

Sue Starkey
Northeast District Department of Health

Orlando Velazco
Connecticut Dept of Public Health

Erica Garcia-Young
Connecticut State Dept of Social Services

D1: Increase the number of community members who have the critical, essential resources to meet emergencies by 2025.

STRATEGIES

D1.1. Conduct a culturally and linguistically appropriate awareness campaign to make people aware of the elements of emergency preparedness.

D1.2. Identify and publicize diverse distribution points (e.g., recovery centers, pop up spaces) for critical, essential resources (e.g., shelter, water, food, oxygen, medicines, and health services) during emergency responses).

D1.3. Review and identify opportunities to better coordinate and align emergency response efforts to ensure that all at risk populations are addressed in the State Response Framework, state agency Emergency Response Plans, and community-based Emergency Response Plans.

D1.4. Identify alternative options for local systems to distribute resources to community residents who may not have transportation/access to central distribution sites.

D1.5. Prioritize aid to individuals (e.g., those experiencing homelessness or at risk of experiencing homelessness) who are left out of address-based or employment-based assistance programs (e.g., COVID-19 stimulus check).

D1.6. Promote the establishment of a Reserve Food Pantry(ies) so that there is sufficient food in a crisis. (*See also C1.7, C1.8, C2.9*)

D2: Increase the capacity of first responders, public health departments, and municipal service and community-based providers to deliver barrier-free, timely, trauma informed, and transparent aid to the public by 2025.

STRATEGIES

D2.1 Support transparent sharing of information between responding agencies while ensuring protection of confidential health information.

D2.2. Promote de-escalation training and behavioral health first aid training to first responders and front line community services providers to address barriers to effective response (e.g., be able to identify dementia, someone who is having a diabetic attack, Post-Traumatic Stress Disorder (PTSD), domestic abuse, suicide prevention (Question, Persuade and Refer (QPR)).

D2.3. Educate on the need for increased and sustainable state funding for public health essential services and emergency preparedness at state and local levels.

D2.4. Educate on the need for increased or reinstated state funding for social services and senior services programs in municipalities.

D2.5. Promote the need for and benefit of volunteer opportunities in the Medical Reserve Corp and Community Emergency Response Team (CERT).

D2.6. Expand support and behavioral health services for first responders and the public health work force.

D3: Increase the number of residents who have access to safe, affordable, and accessible technology, including internet-based public health and emergency information, by 2025.

STRATEGIES

D3.1 Maximize and leverage existing coverage for health services to include the cost of technology for telehealth (e.g., Medicaid will pay for tech for certain programs).

D3.2. Promote the continuation of reasonable, cost effective telehealth services for all, including those who are un- or under-insured.

D3.3. Promote digital equity across healthcare, education, and socio-economic development by supporting efforts for community wide WIFI access (e.g., entire cities). (*See also A1.1, B2.1, D4.4, D5.2*).

D3.4. Promote and leverage the opportunities for community organizations to subsidize the cost of providing new or used tablets/devices to enable residents to connect to services. (*See also A1.2, D3.5*)

D3.5. Promote culturally and linguistically appropriate training on how to use tablets/devices to access internet-based public health and emergency information. (*See also A1.2, D3.4*)

D4: Align existing multi-sector communication networks to provide a central point for accessing information statewide by 2025.

STRATEGIES

D4.1 Inventory status of current communication systems to assess gaps in information or coordination.

D4.2. Assess available funding for necessary changes (including connection to existing networks like 211) and report findings to the legislative and executive branch offices.

D4.3. Promote training to municipal officials on availability of information through existing networks (e.g., 211) and the importance of contributing to the database. (*See also B3.6, C1.5*)

D4.4. Promote free WIFI for low socioeconomic and rural communities. (*See also A1.1, B2.1, D3.3, D5.2*)

D4.5. Establish a partnership for a true cross-platform Health Information Exchange (HIE) system to unite health info/claims data in one system. (*See also A2.1, A3.1*)

D4.6. Promote a public/private partnership to establish a secured, cross-platform case management system to increase interoperability between Community-Based Organizations (CBO's) (e.g., Enterprise Nonprofit Software (ETO)).

D4.7. Integrate care coordination across needs areas (e.g., housing, transportation, food) to best meet consumer needs. (*See also C1.1, C1.2*)

D4.8. Explore and recommend options for sharing and accessing information among providers, local health departments, CBOs, and community members.

D5: Increase the number of safe methods, spaces, and places for connecting residents to community life to measurably strengthen social capital by 2025.

STRATEGIES

D5.1 Collaborate with partners to select and implement curricula (including a common language, tools, and frameworks) to elevate awareness of and eliminate systemic racism and inherent bias. (*See also B5.6*)

D5.2. Promote digital equity across healthcare, education, and socio-economic development by supporting efforts for community wide WIFI access (e.g., entire cities). (*See also A1.1, B2.1, D3.3, D4.4*)

D5.3. Collaborate with partners to improve public spaces so that they are safer for community use.

D5.4. Promote the benefits of proactive, youth-directed, youth-chosen, and youth-centered community programming to improve positive youth development and outcomes.

D5.5. Promote policies and systems that support safe spaces and places for engaging seniors in community activities to improve health and decrease social isolation and depression.

D5.6. Promote the availability of resources across different communities and schools that support conversations around comprehensive sexual health and healthy relationships.

D5.7. Promote the importance of sustainably funding community-based arts, leisure, and sports activities.

D6: Increase the number of policies and systems that address environmental and social justice, health disparities, and community safety as a result of meaningful community engagement by 2025.

STRATEGIES

D6.1 Promote the benefits of institutions building and paying for community engagement and processes (recognize that we cannot work with communities without paying for it, providing compensation for community members to contribute).

D6.2. Provide and communicate measurable changes back to the community (e.g., safety) as a result of their engagement (feedback loop on change in meaningful things/outcomes).

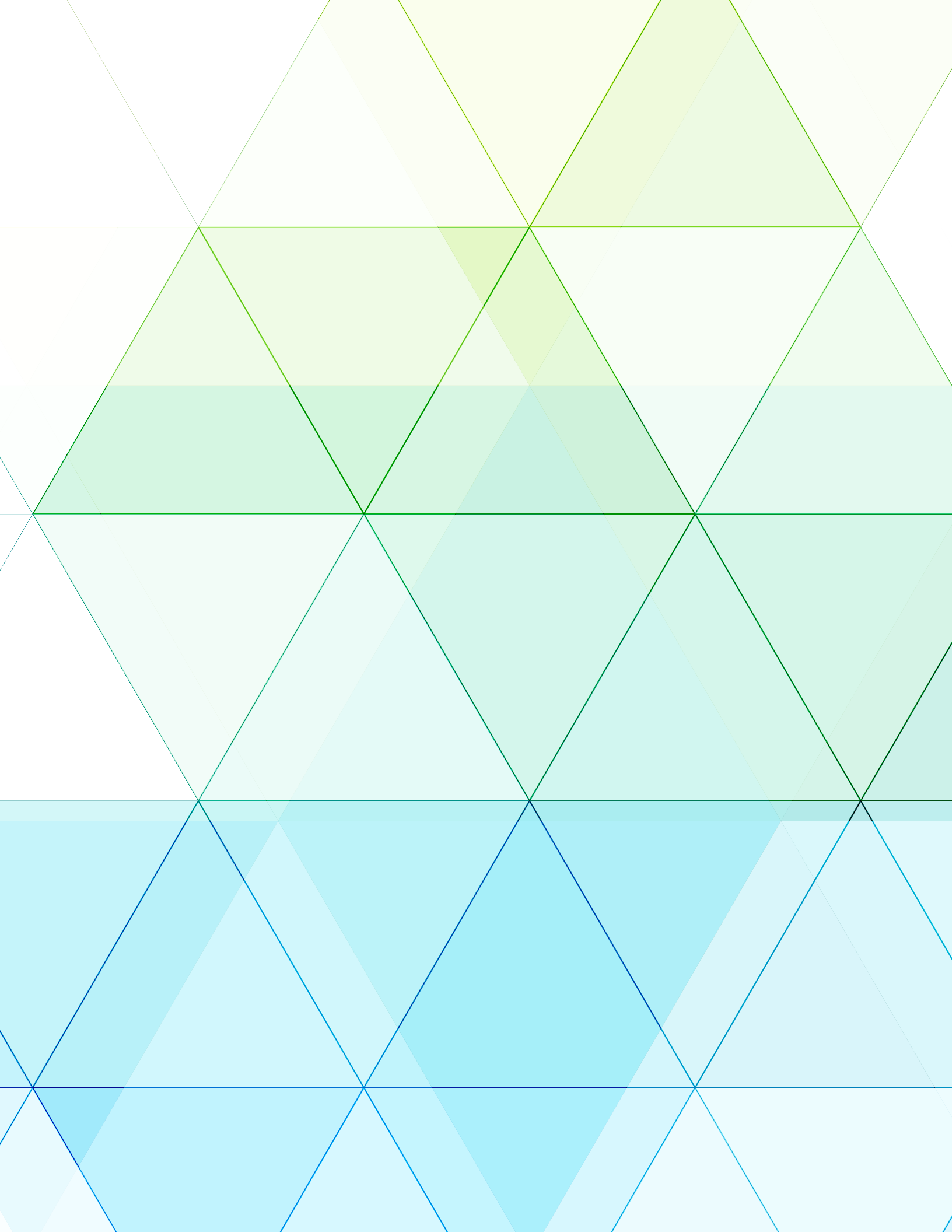
D6.3. Promote the development and enhancement of policies around wraparound services to ensure equitable access; monitor/ track regularly.

D6.4. Educate on the need for increased resources regarding sexual and intimate partner violence to decrease health disparities.

D6.5. Support efforts of the state of CT to address social justice and environmental justice through engagement and coordination of state agencies.

D6.6. Educate on the benefits of returning cost savings from lowering medical costs to the communities and the programs that generated the savings.

D6.7. Educate on the importance of conducting a Health Impact Assessment for all community development projects, policies and systems changes prior to the final approval process.



Appendices

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APPENDIX A. SHIP ADVISORY COUNCIL MEMBERS

Mark Abraham
DataHaven

Natalie Achong
Physician Representative

Robyn Anderson
CSTAC-Ministerial Health Alliance

Pat Baker*
Connecticut Health Foundation

Elizabeth Beaudin
Connecticut Hospital Association

Yvette Bello
Hartford Foundation for Public Giving

Fred Browne
Physician Representative

Beth Bye
CT Office of Early Childhood

Joseph Cassidy
CT Dept. of Administrative Services

Judy Dicine*
CT Office of the Chief State's Attorney

Phyllis DiFiore
CT Dept. of Transportation

Steve DiLella
CT Dept. of Housing

Tekisha Everette
Health Equity Solutions

Anne Foley
CT Office of Policy and Management

Jordana Frost
March of Dimes

Colleen Gallagher
CT Dept. of Correction

Terry Gerratana
CT Office of Health Strategy

Deidre Gifford
CT Dept. of Public Health/CT Dept. of Social Services

Pareesa Charmchi-Goodwin
Connecticut Oral Health Initiative

Robyn Gulley
North Central Area Agency on Aging

Brenetta Henry
Consumer Representative

Lynne Ide
Universal Health Foundation

Ken Lalime
Community Health Center Association of CT

Shawn Lang
AIDS CT

Patrick McCormack*
Uncas Health District

George McDonald
Consumer Representative

Terry Nowakowski
Partnership for Strong Communities

Michael Pascucilla
CT Association of Directors of Health

Michelle Riordan-Nold
CT Data Collaborative

Carlos Rivera
Hispanic Health Council

Lauren Siembab
CT Dept. of Mental Health & Addiction Services

Kathi Traugh
Connecticut Public Health Association

Erin Windham
CT Dept. of Agriculture

Nancy Yedlin
Donaghue Foundation

**Executive Committee Member*

APPENDIX B. CT DPH CONTRIBUTORS

Tameka Allen
Public Health Systems and Equity

Chantelle Archer
Public Health Systems and Equity

Edith Atwerebour
Community, Family Health and Prevention

Diane Aye
Health Statistics & Surveillance

Karyn Backus
Health Statistics & Surveillance

Ellen Blaschinski
Operational and Support Services

Hui Yee Diong
Student Intern

Randy Domina
Public Health Systems and Equity

Liora Fiksel
Student Intern

Mario Garcia
Public Health Systems and Equity

Sasha Gibbel
Student Intern

Sandra M Gill
Public Health Systems and Equity

Laura Hayes
Health Statistics & Surveillance

Celeste Jorge
Health Statistics & Surveillance

Susan Logan
Community, Family Health and Prevention

Michael Makowski
Community, Family Health and Prevention

Amy Mirizzi
Community, Family Health and Prevention

Yolanda Perez
Public Health Systems and Equity

Marcia Pessolano
Community, Family Health and Prevention

Justin Peng
Community, Family Health and Prevention

Francesca Provenzano
Operational and Support Services

Rebecca Schwartz
Student Intern

Shobha Thangada
Community, Family Health and Prevention

Trish Torruella
Public Health Systems and Equity

Melissa Touma
Public Health Systems and Equity

Orlando Velazco
Public Health Systems and Equity

Laurie Ann Wagner
Public Health Systems and Equity

Susan Yurasevecz
Community, Family Health and Prevention

APPENDIX C. SNAPSHOT OF SHIP GOALS AND OBJECTIVES

Priority Area A: Access to Health Care

GOAL A:

Ensure all Connecticut residents have knowledge of, and equitable access to, affordable, comprehensive, appropriate, quality health care.

A1: Increase the number of traditional and alternative (community- and technology-based) places people can access health care by 2025.

A2: Increase adoption of accepted best practices and standards of care among clinical health care providers by 2025.

A3: Increase adoption of accepted best practices and standards of care among community health preventive care providers by 2025.

A4: Develop a comprehensive, across-the-lifespan, statewide health education framework by 2025.

A5: Increase the availability and diversity of primary care providers, community partners, and care management services by 2025, while respecting patients' rights to privacy and choice.

A6: Decrease the number of CT residents who are at risk of spending more than 10% of their net income on health care services and coverage by 2025.

Priority Area B: Economic Stability

GOAL B:

Achieve equitable economic wellbeing, stability, and security so all Connecticut residents have the opportunity to work here, and can afford to live, stay, and retire here.

B1: Increase the percentage of all CT residents who can meet their living expenses and have the ability to contribute at least 10% of their earnings towards savings by 2025.

B2: Increase the amount of capital investment in communities and local businesses to support workforce development, community development, and entrepreneurship by 2025.

B3: Increase the number of employers who invest in employee retention and wellness programs/policies that support the continuity of their work by 2025.

B4: Increase the number of opportunities for children, young adults, adults, and retirees/older adults for equitable, affordable education on career development and personal finance by 2025.

B5: Increase the number of employers across sectors that offer equitable and sustainable employment opportunities for all levels and demographics by 2025.

Priority C Area: Healthy Food and Housing

GOAL C:

Ensure that all Connecticut residents have equitable access to safe and affordable:

- nutritious and culturally appropriate food, and
- fair, stable, healthy housing

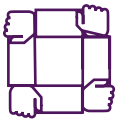
C1: Increase the utilization of available housing and food programs by eligible residents by 2025.

C2: Increase the number of access points where people can obtain affordable, healthy, and nutritious food by 2025.

C3: Decrease the number of persons experiencing or at risk of homelessness and increase opportunities to obtain affordable and sustainable housing by 2025.

C4: Adopt and begin to implement a Connecticut property maintenance code that includes a statewide definition for safe and quality housing by 2025.

C5: Increase the percentage of owner-occupied housing in CT by 2025.



Priority Area D: Community Strength and Resilience

GOAL D:

Ensure community strength, safety, and resiliency by providing equitable and sustainable access to community resources to address the unique physical, social, and behavioral health needs of all Connecticut residents.

D1: Increase the number of community members who have the critical, essential resources to meet emergencies by 2025.

D2: Increase the capacity of first responders, public health departments, and municipal service and community-based providers to deliver barrier-free, timely, trauma informed, and transparent aid to the public by 2025.

D3: Increase the number of residents who have access to safe, affordable, and accessible technology, including internet-based public health and emergency information, by 2025.

D4: Align existing multi-sector communication networks to provide a central point for accessing information statewide by 2025.

D5: Increase the number of safe methods, spaces, and places for connecting residents to community life to measurably strengthen social capital by 2025.

D6: Increase the number of policies and systems that address environmental and social justice, health disparities, and community safety as a result of meaningful community engagement by 2025.

APPENDIX D. COALITION SURVEY RESULTS

A survey was administered to the 600 members of the CT Health Improvement Planning Coalition to finalize the focus of the SHIP. 67 Responses were received.

CT State Health Improvement Plan — Finalizing the Focus of the SHIP

INTRODUCTION:

Dear CT Health Improvement Planning Coalition:

Thank you for being part of our ongoing, state-wide efforts to improve the health of all residents of Connecticut! Your engagement, activism, work, and insights have been invaluable since we began this process in 2012, when we developed our first State Health Assessment (SHA) and State Health Improvement Plan (SHIP), called *Healthy Connecticut 2020*.

The State Health Improvement Coalition is now working with local health departments and the Department of Public Health to develop our next State Health Improvement Plan (SHIP). Over the last year and a half, our partners and SHIP Advisory Council have reviewed health data and collected community input via focus groups on key health concerns of Connecticut residents. We have used this information to develop a framework for the next SHIP, which will act as a roadmap for health improvement activities in the state over the next five years, and to identify potential focus areas for the SHIP within this framework.

To this end, we gathered input at a state-wide Summit in September 2019 and then via (6) community dialogue sessions held across the state in the spring of 2020; the results of these sessions were extremely consistent. Most importantly, they offer us the opportunity to step out of our traditional public health "lanes" (health conditions and/or indicators) in order to focus our efforts on fewer issues, leverage our multi-disciplinary expertise, and impact the key factors that influence health outcomes from the broader, common context within which our cross-sector agencies work.

This new framework centers on the Social Determinants of Health (Social Indicators of Wellness?) which enables us to move from strategies centered on direct service and programming (which are appropriate for community and local contexts) to policy, systems, and environmental change strategies; these are the activities that a state-wide Coalition can implement with the power of its collective voice and reach to achieve greater impact on health outcomes.

WHAT WE ARE ASKING OF YOU:

As members of this state Coalition, we are asking for consensus on where we have solidified our focus for the next SHIP. Much work has been done to get to this point, and we both want to honor that work and provide this opportunity for a final check-in with you. We have focused on depth vs. breadth and therefore have identified four focus areas for the SHIP to concentrate our activities.

Thank you for participating in this process!

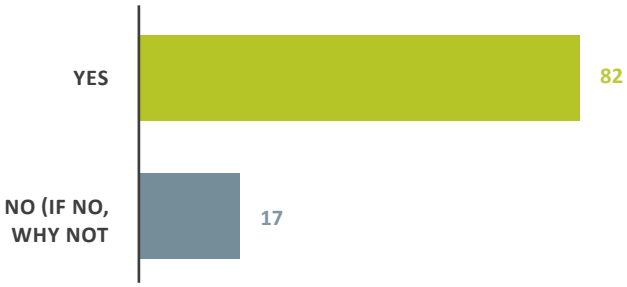
SHIP PRIORITY AREAS

We have identified and refined the following four focus areas for the SHIP framework. These focus areas will be the basis for developing goals, objectives, and strategies for the SHIP: (1) **Access** (primary care, health/mental health care); (2) **Economics** (poverty, employment); (3) **Healthy Food and Shelter**; and (4) **Community Strength and Resilience** (cohesion, safety, emergency preparedness and response).

Note: The priority area names were refined following the administration of this survey.

Q1: CAN YOU SUPPORT THESE AS THE PRIORITY AREAS OF SHIP?

Answered: 66 | Skipped: 1



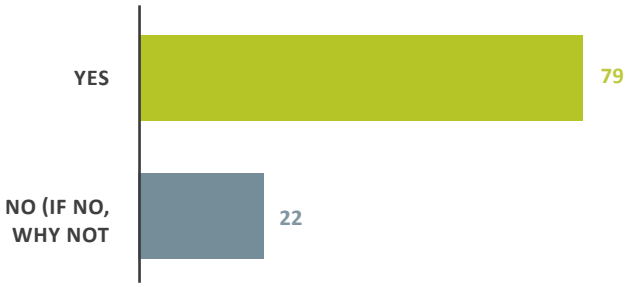
ANSWER CHOICES	RESPONSES	
Yes	79.10%	53
No (If no, why not?)	20.90%	14
TOTAL		67

Q1. If no, why not?

- These are all great areas, but I would like to see some emphasis put on preventive health for older adults. This is the fastest growing segment of CT's population, and this growth is expressed primarily in Hispanic and African American populations.
- No inclusion of oral health — please include dental in the access priority area, metrics could include % who have had a dental visit in the past 12 months (easily known for HUSKY, could be down for privately insured if dental were in APCD) and/or % of children with untreated tooth decay (ESC DSS by DPH/CDC, approx. 5 year data — should have data by 2022)
- Within Access, the term 'Health Care' is very broad. I hope that it truly does imply a broad context and that this plan recognizes essential aspects of health care beyond traditional medical care. Of note, I hope that oral health care, a critical component in achieving total health, is recognized in the Plan, in part because huge access issues still persist in this health care sector.
- Equity needs to be a Priority Area
- These priorities are too nebulous. For example, is the focus going to be on access to quality culturally informed/directed care? Does the economic priority encompass ensuring all employees are paid a living wage?
- A shouldn't just be about access but also about quality of care
- I can support all of the above, but I would add trust under community strength and resilience.
- Cost to taxpayers
- Because they are focused on Health care and social services. Housing is important!!!
- Anti-racism should be the top priority, not a cross cutting theme
- I think those are huge to take on all at once. One would be

Q2: CAN YOU SUPPORT THESE AS THE CROSS-CUTTING THEMES OF THE SHIP?

Answered: 67 | Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	79.10%	53
No (If no, why not?)	20.90%	14
TOTAL		67

Cross Cutting Themes

During the September 2019 breakout discussions and during the community feedback sessions, several topics were mentioned as key, cross-cutting issues that should be addressed in all policy, systems change, environmental change, and primary prevention strategies of the SHIP. These issues include:

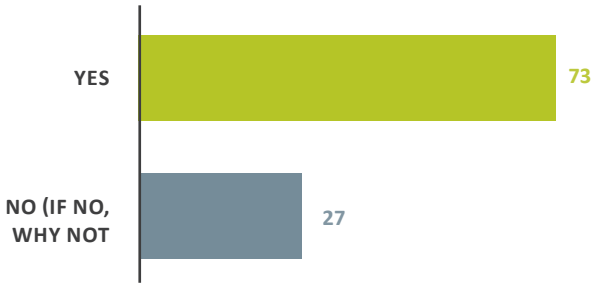
- Structural Racism
- Inherent Bias
- Transportation
- Education

Q2. If no, why not?

- These are all important issues. This is more of a note — I worry about combining structural racism and implicit bias. It is important to focus on structural changes and not let addressing implicit bias sidetrack us into thinking of racial inequities as an individual level issue.
- Structural racism and implicit/explicit bias are more determinants; education tends to be cross-cutting but may be impacted by bigotry and racism.
- Too costly.
- Because home care and remote access is more important than transportation. Housing is more important than transportation and so are housing policies. And the failure of the CT Judicial system to address housing inequities.
- See above
- Do these need to be reviewed given the events of the past 3 months: COVID, unemployment, racism
- I am not buying into structural racism... don't see it in action and it is a topic that keeps dividing and not uniting
- While I support the issues listed above, I believe housing and food should also be cross cutting themes.
- I thought we were use the Determinants of Health across themes-to be aligned with Healthy People 2030
- Those are important, and I do support them, but I was also hoping to see an emphasis on the health, development and early relationships of children prenatal — age 6 (I do not feel this falls under education), and indicators could be ASQ screenings, referrals to B-3, Home Visiting services and/or licensed childcare/HS
- Education does not fall within our purview
- It is not that I can't support these themes, I just want to know if racism and implicit bias will include all bias, all marginalized groups and stigma associated with groups, suicide, substance use disorders and mental illness.
- I wish there were something in-between — I would prefer something more general than racism in the first issue, especially around income inequality, possibly just Structural and implicit bias
- I support them if oral health is included in primary care.

Q3: CAN YOU SUPPORT THESE AS THE KEY IMPACT INDICATORS OF THE SHIP?

Answered: 66 | Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	72.73%	48
No (If no, why not?)	27.27%	18
TOTAL		66

Key Impact Indicators

We have identified and refined the following key impact indicators to capture how well our strategies are addressing the priority health issues/risk factors identified in the State Health Assessment. These are the measures that will be tracked via DPH surveillance and data analysis:

- Percentage of Children Who Are Obese/Obesity
- Suicide Rate
- Drug Overdose Deaths
- High School Students/Sexual Violence
- Percent Insured/ER Visits

Q3. If no, why not?

- Change in poverty rates, changes in communities that reflect safety, reduced pollution, improved housing stock, reduction in chronic diseases that are related to diet, movement, and access to quality health care. Also, some type of community residents' input related to indicators/outcomes.
- Family and personal choice issues.
- Not related to PHEP, infectious disease, water, air, high blood pressure, racism, housing
- These don't necessarily track with what is most important to communities at this time, like racial discrimination and food insecurity.
- Same as above comments
- In addition to the above, other recommended indicators: maternal morbidity ratio, maternal mortality rate, infant mortality rate and percent of low birth weight babies.
- Not clear about the last one (% insured/ED visits); if goal is to reduce health care costs, need to look at program activities effectiveness in terms of Return on Investment as it saves ED visits
- I don't think these measures capture enough. Mental illness, substance misuse and intimate partner violence are missing. There are many people dealing with (and struggling with) these challenges that do not overdose or attempt suicide. I also don't see an explanation for percentage insured/ER visits. Is this two different items or only counting if those going to ER have insurance? Overall, it is not that I can't support what is proposed, I would, I just also feel these things I mention are missing.
- Rates of segregation/low income housing desert maps/ numbers of undocumented and what services/resources are they accessing and what are still needed
- I think we need to add indicators related to birth outcomes too, to capture indicators across the life course. Maybe related to preterm births? I am assuming that the ER Visits may capture seniors as well.
- Not sure whether drug-overdose deaths are specific to illegal drugs or access to non-prescribe narcotics, alcohol, and/or unintended consequences of inhalants, etc.
- Indicator detail is inconsistent — 1st bullet (% children who are obese) is defined in detail the remaining key measures need to be better defined (more specific in regard to data collection)
- The topic in health neglect chronic conditions and racial and ethnic health disparities. Need to look at connection to primary care or a usual source of care and cost as an access issue for those insured

- I can, but I believe also believe that maternal mortality should also be included.
- I would like to see teen pregnancy included and tracked by the SHIP.
- Useful to track, relate to mental health, maybe access — but where measures racism, housing, etc.?
- Percentage insured does not translate to access to and the provision of healthcare.
- While I appreciate the broadening of the Priority areas, the Key Impact Indicators correlation with them seem particularly weak — For example: How will we measure access to food or housing? How will we measure the Community's strength and resilience?

APPENDIX E. PLANNING WORK GROUP PROFILES

Access to Health Care

Looking for state and local level organizations and networks that represent:

- Providers — Primary Care, Specialty Care, Behavioral Health, Dental, Senior Care, Pediatrics
- Hospitals
- Insurance Providers
- Community Health Centers
- Home Health Care
- Transportation Services
- Advocates for uninsured and under insured
- Local Health Departments
- Crisis Center Hotlines
- Education providers (K–12, higher education, trade schools, adult education)
- Veterans
- Social Service Providers

Healthy Food & Housing

Looking for state and local level organizations and networks that represent:

- Agriculture
- Food Policy Councils
- Children & Families
- Consumer Protection
- Developmental Services
- Energy Providers
- Primary Care Providers
- Homeless Populations
- Behavioral Health Services
- Previously Incarcerated
- Hospitals
- Food Access Advocates
- Affordable Housing
- Community Design/Planners
- Food Pantries
- Social Services
- Local Municipalities
- Education providers (K–12, higher education, trade schools, adult education)
- Veterans
- Seniors
- Grocery Providers
- Transportation Providers

Economic Stability

Looking for state and local level organizations and networks that represent:

- Children and Families
- Early Childhood
- Employment or Career Services
- Chamber of Commerce
- Energy/Utility Providers
- Previously Incarcerated
- Transportation Services
- Affordable Housing
- Local Municipalities
- Education providers (K–12, higher education, trade schools, adult education)
- Veterans
- Seniors
- Grocery Providers
- Homeless Populations
- Social Service Providers

Community Strength & Resilience

Looking for state and local level organizations and networks that represent:

- CT Long-term Recovery Committees
- Local Municipalities
- Transportation Services
- Advocates for uninsured and under insured
- Local Health Departments
- Crisis Center Hotlines
- Education providers (K–12, higher education, trade schools, adult education)
- Veterans
- Social Service Providers
- Faith Based Communities
- Emergency Response
- Law Enforcement
- Youth Services
- Previously Incarcerated
- Seniors
- Local Non-Profits
- Judiciary Services
- Chamber of Commerce

APPENDIX F. HCT2020 SHIP POLICY AGENDA PRIORITIES

SHIP Policy Agendas	2017	2018	2019
TOBACCO			
a. Raise the age to purchase tobacco and electronic nicotine delivery system (ENDS) products from 18 years of age to 21 years of age.			
i. **Public Act 19–13** — Signed by Governor 06–18–2019 — Raises age to purchase tobacco and vaping products to 21 years.			
b. **Tax parity for other tobacco products and Electronic Nicotine Delivery Systems (ENDS)** to match the current cigarette tax	✓	✓	✓
i. **Public Act 18–109 — Signed by the Governor 06–07–2018** Sale of ENDS treated like other tobacco products ± must be kept behind the counter			
c. (Upgrade Clean Indoor Air Laws to meet national recommendations for comprehensive law. Remove pre-emption clauses that hinder local tobacco control authority. — 2017 & 2018)			
d. **Tobacco Trust Fund Allocations** — advocate for appropriate and sustainable Tobacco Trust Fund allocations for education, prevention, and cessation			
COMMUNITY HEALTH WORKER CERTIFICATION			
a. **Public Act 17–74 — Signed by Governor 06–30–2017** to define Community Health Worker	✓		✓
b. **Public Act 19–117 — Signed by Governor 06–26–2019** establish Community Health Worker Certification			
SEATBELT USE FOR ALL SEATING POSITIONS IN AUTOMOBILES			
Update current law to include rear seated passengers in automobiles	✓	✓	✓
MOTORCYCLE HELMET USE BY OPERATORS AND PASSENGERS			
Adequate head protection	✓	✓	✓
PAID FAMILY AND MEDICAL LEAVE			
Require employers to provide paid Family and Medical Leave	✓	✓	✓
a. **Public Act 19–25 — Signed by Governor 06–25–2019** Establish Paid Family Medical Leave Fund for eligible employees			
PROPERTY MAINTENANCE CODE (PMC)			
Connecticut adoption of 2015 International Property Maintenance Code (IPMC)	✓	✓	✓
OPIOIDS			
Support evidence-based treatment and prevention efforts			
a. **Public Act 19–38 — Signed by Governor 06–21–2019** penalties for the sale of fentanyl			
b. **Public Act 19–159 — Signed by Governor 07–08–2019** mental health and substance use disorder benefits		✓	✓
c. **Public Act 19–191 — Signed by Governor 07–09–2019** addressing opioid use			
d. **Public Act 19–169 — Signed by Governor 07–08–2019** extends good Samaritan protections when Narcan stored in cabinet with AED			

SHIP Policy Agendas	2017	2018	2019
REL (RACE, ETHNICITY, AND LANGUAGE) DATA COLLECTION STANDARDS Improve standardization of demographic data collection			✓
CANCER PREVENTION: HUMAN PAPILLOMA VIRUS (HPV) VACCINE a. **Public Act 17–2 — Signed by Governor 10–31–2017** — included funding for education and Universal HPV vaccine (two-dose series) for children ages 11 and 12.	✓		
SAFE DRINKING WATER a. **Public Act 18–168 — Signed by Governor 06–13–2018** — requires public drinking water systems to review the age and condition of the water system's infrastructure		✓	
IMMUNIZATION Allow the release of aggregate immunization data for each school in Connecticut		✓	
LEAD PAINT ASSESSMENT FEE Create sustainable funding source to fund lead paint abatement projects for low income family housing. a. **Public Act 18–160 — Signed by Governor 06–13–2018** — surcharge added to certain insurance policies and establishing the Healthy Homes Fund — 15% of surcharge funds collected to be used for lead abatement		✓	
MEDICARE SHARED SAVINGS PROGRAM & MEDICAID ELIGIBILITY/CUTS Restore funding cuts that affect income and access to health care for 113,000 Connecticut residents. a. **Funds Restored end of 2018 session**		✓	
FUNDING FOR PUBLIC HEALTH AGENCIES Advocate for funding for state and local public health agencies to support prevention and health improvement.		✓	
INTEGRATION OF LOCAL HEALTH DISTRICTS Integration into larger health districts to improve health equity for all Connecticut residents and to better facilitate leveraging of resources.	✓		

APPENDIX G. INDEX OF ACRONYMS

ALICE	Asset Limited, Income Constrained, Employed Saves program
BIPOC	Black, Indigenous and People of Color
BRFSS	Behavioral Risk Factor Surveillance System
CBO	Community-based organizations
CDC	Centers for Disease Control and Prevention
CERT	Community Emergency Response Team
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
CLAS	Culturally and Linguistically Appropriate Services
COVID-19	Coronavirus disease 2019
CT	Connecticut
CTDHP	Connecticut Dental Health Partnership
DPH	Department of Public Health
EAP	Employee Assistance Program
ECHO	Project ECHO — Extension for Community Healthcare Outcomes
EMTALA	Emergency Medical Treatment and Labor Act
ER	Emergency Room
ETO	Enterprise Nonprofit Software
FHA	Federal Housing Administration
FMNP	Farmers Market Nutrition Program
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
HUSKY	Husky Health Program is Connecticut's Health Insurance Program for eligible children and adults
LBW	Low birth weight
LGBTQIA+	Lesbian, Gay, Bisexual, Pansexual, Transgender, Genderqueer, Queer, Intersex, Agender, Asexual and other queer-identifying community
MA	Massachusetts
MAPP	Mobilization for Action through Planning and Partnerships process
MAT	Medication-Assisted Treatment
MPH	Master of Public Health
MSM	Men who have Sex with Men
NCAAA	North Central Area Agency on Aging
NORA	Naloxone + Opioid Response App
OKQ	One Key Question
PHAB	Public Health Accreditation Board
PHHSBG	Preventive Health & Health Services Block Grant
PHSE	Public Health Systems and Equity
PrEP	Pre-Exposure Prophylaxis Navigation
PSE & PP	Policy, Systems, Environment, and Primary Prevention
PTSD	Post-Traumatic Stress Disorder
QPR	Question, Persuade and Refer
SDOH	Social Determinants of Health / Social Drivers of Health
SHA	State Health Assessment
SHIP	State Health Improvement Plan
SNAP	Supplemental Nutrition Assistance Program
STEM	Science, Technology, Engineering, and Mathematics
SWAP	Supporting Wellness at Pantries
TA	Technical assistance
UCONN	University of Connecticut
USPSTF	U.S. Preventive Services Task Force
WDYS	"Where Do You Stand?" awareness campaign to end sexual violence
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

APPENDIX H. GLOSSARY OF TERMS

OVERVIEW

- **Health Equity:** Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. (Robert Wood Johnson Foundation).
- **Inherent Bias:** The phrase "inherent bias" refers to the effect of underlying factors or assumptions that skew viewpoints of a subject under discussion, such as racism.
- **Racial Equity:** The condition when racial identity cannot be used to predict individual or group outcomes (e.g., wealth, income, employment, criminal justice, housing, health care, education) and outcomes for all groups are improved.
- **Structural Racism:** Racism across multiple institutions, combining to create a system that negatively impacts communities of color.

PRIORITY A

- **Cohorts:** A group of individuals having a statistical factor, such as age or class membership, in common.
- **Compartmentalized Healthcare:** Traditional medicine is very orderly and broken into sub-specialty areas.
- **Lifespan:** The duration of existence for an individual from birth to death.
- **Patient Choice:** The point of patient choice is that it demonstrates that doctors treat patients with dignity and respect, as adults capable and willing to be involved in decisions made about their medical care. Patient choice has an intrinsic value.
- **Patient Privacy:** According to HIPAA, privacy refers to the right of an individual to keep his or her health information private. Confidentiality refers to the duty of anyone entrusted with health information to keep that information private. (Source: Health Insurance Portability and Accountability Act of 1996 (HIPAA))

PRIORITY B

- **Capital Investment:** Capital investment is the amount invested in communities and local businesses to support specific objectives.
- **Equitable Distribution of Funds:** Equitable distribution of funds recognizes the importance of defining a needs-based, efficient use of limited financial, human, and other assets to improve conditions for the community.
- **Venture Capital:** Venture capital is capital invested in a project in which there is a substantial element of risk, typically a new or expanding business.

PRIORITY C

- **Cottage Food Industries:** Cottage Food is prepared food perceived to be low-risk for food-related injury or illness. As a low-risk product, Cottage Food can be prepared in a home environment without some of the controls used for a traditional ready-to-eat food such as those foods sold in a restaurant or grocery store. (Source: https://portal.ct.gov/DCP/Food-and-Standards-Division/Cottage-Food/Cottage-Food-Home)
- **Food Apartheid:** Food apartheid is a form of apartheid because in most cases, the lack of availability of healthy food disproportionately affects communities of color (Source: Food Justice Movement).
- **Fruit and Vegetable Rx Program:** In the fruit and vegetable Rx program, providers prescribe vouchers for patients to redeem for fruits and vegetables at local healthy food retailers.
- **Multi-Modal Education:** Providing education and training through a variety of mechanisms including online and in person, and in a way that addresses learning preferences (Visual, Auditory, and Kinesthetic).
- **Red Lining:** Red lining refers to the presumed practice of mortgage lenders of drawing red lines around portions of a map to indicate areas or neighborhoods in which they do not want to make loans. Redlining on a racial basis has been held by the courts to be an illegal practice.

- **Supporting Wellness at Pantries (SWAP):** SWAP is a stoplight system to rank food nutritionally. SWAP was developed in 2016 and is a program of the Institute for Hunger Research & Solutions at Foodshare/CT Food Bank. SWAP can help increase the supply and demand for healthy food in food banks and pantries

PRIORITY D

- **Critical, Essential Resources:** Critical, essential resources include shelter, water, food, oxygen, medicines, and health services. After an emergency, you may need to survive on your own for several days. Being prepared means having access to these essential resources and other supplies to last for several days.

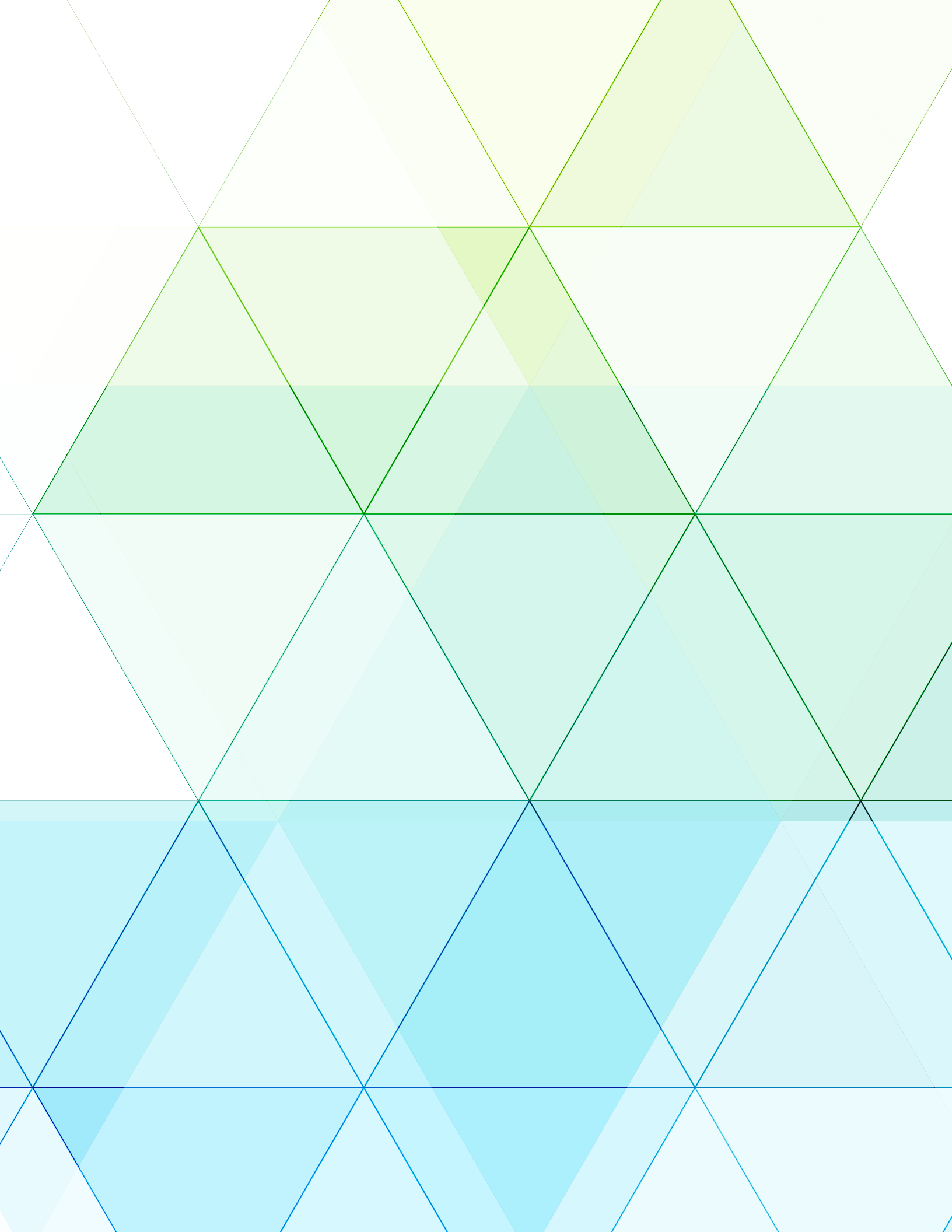
- **Culturally and Linguistically Appropriate services (CLAS):** Culturally and linguistically appropriate services (CLAS) are respectful of and responsive to the health beliefs, practices and needs of diverse patients. AHRQ has tools, training, and reports to help health systems deliver CLAS so that all patients receive high quality care and achieve good health outcomes.

- **Safe Methods:** Safe methods refers to the ways residents connect to community life including digital equity, digital security, public safety, town watches, getting to know your neighbors, initiating a buddy system, etc.

- **Social capital:** Social capital is the networks of relationships among people who live and work in a particular society, enabling that society to function effectively.

- **Social Cohesion:** Social cohesion refers to the extent of connectedness and solidarity among groups in society. It identifies two main dimensions: the sense of belonging of a community and the relationships among members within the community itself.

- **Trauma-Informed Care (TIC):** Trauma-Informed Care is an approach in the human service field that assumes that an individual is more likely than not to have a history of trauma. Trauma-Informed Care recognizes the presence of trauma symptoms and acknowledges the role trauma may play in an individual's life



References & Notes

REFERENCES & NOTES

1 Appendix 1 of The Catastrophic Cost of Un-insurance: COVID-19 Cases and Deaths Closely Tied to America's Health Coverage Gaps

2 MAPP, a comprehensive, planning process for improving health, is a strategic framework that local public health departments across the country have utilized to help direct their strategic planning efforts. MAPP is comprised of four distinct assessments that are the foundation of the planning process, and includes the identification of strategic issues and goal/strategy formulation as prerequisites for action. Since health needs are constantly changing as a community and its context evolve, the cyclical nature of the MAPP planning/implementation/evaluation/correction process allows for the periodic identification of new priorities and the realignment of activities and resources to address them. Advanced by the National Association of County and City Health Officials (NACCHO), MAPP's vision is for communities to achieve improved health and quality of life by mobilizing partnerships and taking strategic action. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. More information on MAPP can be found at: http://www.naccho.org/topics/infrastructure/mapp/

3 CDC. (2021, March 3). Defining Adult Overweight and Obesity. Centers for Disease Control and Prevention. www.cdc.gov/obesity/adult/defining.html

4 CDC. (2021, March 3). Defining Childhood Obesity. Centers for Disease Control and Prevention. www.cdc.gov/obesity/childhood/defining.html

5 CDC. (2021, March 1). Obesity and Overweight. Centers for Disease Control and Prevention. www.cdc.gov/nchs/fastats/obesity-overweight.htm

6 Connecticut Department of Public Health. (2019). Healthy Connecticut 2025: State Health Assessment. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/state_health_planning/SHA-SHIP/HCT2025/CT_SHA_Report_Final060520.pdf, 172.

7 Pi-Sunyer, X. (2009, November). The medical risks of obesity. Postgraduate medicine, 121(6), 21–33. 10.3810/pgm.2009.11.2074

8 Bell, C. N., Kerr, J., & Young, J. L. (2019, March 9). Associations between Obesity, Obesogenic Environments, and Structural Racism Vary by County-Level Racial Composition. International Journal of Environmental Research and Public Health, 16(5), 861. 10.3390/ijerph16050861, page 861.

9 CDC. (2019, April 11). CDC, Preventing Chronic Disease. www.cdc.gov/obesity/adult/causes.html

10 Powell, L. M., Slater, S., Chaloupka, F. J., & Harper, D. (2006). Availability of physical activity-related facilities and neighborhood demographic and socioeconomic characteristics: a national study. American journal of public health, 96(9), 1676–1680.

11 Suminski, R. R., Poston, W. S. C., Petosa, R. L., Stevens, E., & Katzenmoyer, L. M. (2005). Features of the neighborhood environment and walking by US adults. American journal of preventive medicine, 28(2), 149–155.

12 World Health Organization. (2019). Mental Health and Substance Abuse: Suicide Data. Retrieved from www.who.int/teams/mental-health-and-substance-use/suicide-data

13 Connecticut Department of Public Health. (2019). Healthy Connecticut 2025: State Health Assessment. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/state_health_planning/SHA-SHIP/HCT2025/CT_SHA_Report_Final060520.pdf, 247.

14 Reiss, F. (2013). Socioeconomic inequalities and mental health problems in children and adolescents: a systematic review. Social science & medicine, 90, 24–31.

15 Liu, Y., Njai, R. S., Greenlund, K. J., Chapman, D. P., & Croft, J. B. (2014). Relationships between housing and food insecurity, frequent mental distress, and insufficient sleep among adults in 12 US States, 2009. Preventing chronic disease, 11, E37. https://doi.org/10.5888/pcd11.130334

16 Scott, K. M., Bruffaerts, R., Tsang, A., Ormel, J., Alonso, J., Angermeyer, M. C., ... & Von Korff, M. (2007). Depression — anxiety relationships with chronic physical conditions: results from the World Mental Health Surveys. Journal of affective disorders, 103(1–3), 113–120.

17 Substance Abuse and Mental Health Services Administration. (2014). What is Substance Abuse Treatment? A Booklet for Families. https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4126.pdf

18 Daley D. C. (2013). Family and social aspects of substance use disorders and treatment. Journal of food and drug analysis, 21(4), S73–S76. https://doi.org/10.1016/j.jfda.2013.09.038

19 Miller, T. R., & Hendrie, D. (2009). Substance abuse prevention dollars and cents: A cost-benefit analysis. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention.

20 Johnson, G., & Chamberlain, C. (2008). Homelessness and substance abuse: Which comes first?. Australian Social Work, 61(4), 342–356.

21 Connecticut Department of Public Health. (2019). Healthy Connecticut 2025: State Health Assessment. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/state_health_planning/SHA-SHIP/HCT2025/CT_SHA_Report_Final060520.pdf, 247.

22 Connecticut Department of Public Health. (2019). Healthy Connecticut 2025: State Health Assessment. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/state_health_planning/SHA-SHIP/HCT2025/CT_SHA_Report_Final060520.pdf, 294.

23 Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19–5068, NSDUH Series H–54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf

24 Lowinson, J. H. (Ed.). (2005). Substance abuse: A comprehensive textbook. Lippincott Williams & Wilkins.

25 United Nations. www.un.org/en/coronavirus/what-is-domestic-abuse

26 Renzetti, C. M., & Larkin, V. M. (2009, September). Economic Stress and Domestic Violence. CRVAW Faculty Research Reports and Papers, 1.

27 Center Against Sexual and Family Violence, What is Family Violence?, https://casfv.org/what-is-abuse/what-is-family-violence

[28] Rakovec-Felser Z. (2014). Domestic Violence and Abuse in Intimate Relationship from Public Health Perspective. Health psychology research, 2(3), 1821. https://doi.org/10.4081/hpr.2014.1821

[29] Sexual Violence Research Initiative, Definitions, www.svri.org/research-methods/definitions

[30] Connecticut Department of Public Health. (2019). Healthy Connecticut 2025: State Health Assessment. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/state_health_planning/SHA-SHIP/HCT2025/CT_SHA_Report_Final060520.pdf, 273.

[31] Connecticut Department of Public Health. (2019). Healthy Connecticut 2025: State Health Assessment. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/state_health_planning/SHA-SHIP/HCT2025/CT_SHA_Report_Final060520.pdf, 316.

[32] Access Health CT. (2021). Financial Help. Retrieved February 27, 2021, from https://learn.accesshealthct.com/financialhelp/

[33] Kaiser Family Foundation. (2020). Health Insurance Coverage of the Total Population. KFF's State Health Facts. Data Source: 2008–2019 American Community Survey, 1–Year Estimates. Retrieved February 27, 2021, from www.kff.org/other/state-indicator/total-population/

[34] UnitedHealth Group. (2019). The High Cost of Avoidable Hospital Emergency Department Visits. Retrieved February 27, 2021, from www.unitedhealthgroup.com/newsroom/posts/2019-07-22-high-cost-emergency-department-visits.html

[35] Centers for Medicare & Medicaid Services. www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA

[36] Connecticut Department of Public Health. (2019). Healthy Connecticut 2025: State Health Assessment. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/state_health_planning/SHA-SHIP/HCT2025/CT_SHA_Report_Final060520.pdf, 330.

[37] Healthy Connecticut 2025, State Health Assessment (2019), from https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/state_health_planning/SHA-SHIP/HCT2025/CT_SHA_Report_Final060520.pdf, 321.

[38] Whittaker, W., Anselmi, L., Kristensen, S. R., Lau, Y. S., Bailey, S., Bower, P., ... & Hodgson, D. (2016). Associations between extending access to primary care and emergency department visits: a difference-in-differences analysis. PLoS medicine, 13(9), e1002113.

[39] Healthy People 2020, Access to Health Services, from www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

[40] Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services. Access to Health Care in America. Millman M, editor. Washington, DC: National Academies Press; 1993

[41] National Healthcare Quality Report, 2013 [Internet]. Chapter 10: Access to Healthcare. Rockville (MD): Agency for Healthcare Research and Quality; May 2014. Available from: www.ahrq.gov/research/findings/nhqrdr/nhqdr15/access.html

[42] Healthy Connecticut 2025, State Health Assessment (2019), from https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/state_health_planning/SHA-SHIP/HCT2025/CT_SHA_Report_Final060520.pdf, 318.

[43] County Health Rankings, Social and Economic Factors, from www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/social-and-economic-factors.

[44] Healthy Connecticut 2025, State Health Assessment (2019), from https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/state_health_planning/SHA-SHIP/HCT2025/CT_SHA_Report_Final060520.pdf, 31.

[45] Healthy Connecticut 2025, State Health Assessment (2019), from https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/state_health_planning/SHA-SHIP/HCT2025/CT_SHA_Report_Final060520.pdf, 20-21.

[46] Healthy People 2020, Quality of Housing, from www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/quality-of-housing.

[47] Healthy People 2020, Quality of Housing, from www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/quality-of-housing.

[48] Healthy People 2030, Nutrition and Healthy Eating, from https://health.gov/healthypeople/objectives-and-data/browse-objectives/nutrition-and-healthy-eating

[49] Taylor, L. (2018). Housing and Health: An Overview of the Literature. Health Affairs Health Policy Brief.

[50] HUD.gov. Affordable Housing, from www.hud.gov/program_offices/comm_planning/affordablehousing/

[51] U.S. Census Bureau. 2017 American Community Survey 1–year Estimates, B25106: TENURE BY HOUSING COSTS AS A PERCENTAGE OF HOUSEHOLD INCOME IN THE PAST 12 MONTHS. Retrieved from American FactFinder.

[52] Healthy People 2030, Reduce the proportion of families that spend more than 30 percent of income on housing — SDOH-04, from https://health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04

[53] Healthy Connecticut 2025, State Health Assessment (2019), from https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/state_health_planning/SHA-SHIP/HCT2025/CT_SHA_Report_Final060520.pdf, 42.

[54] Public Health Emergency, Community Resilience, from www.phe.gov/Preparedness/planning/abc/Pages/community-resilience.aspx#:~:text=Individual%20health%20and%20resilience%20is,People%20should%20try%20to%3A&text=Engage%20in%20community%20or%20neighborhood%20preparedness%20activities.

[55] Hamilton, L. M. (2019). Creating Opportunity for Communities of Color through Entrepreneurship. Stanford Social Innovation Review.

[56] PMC, US National Library of Medicine National Institutes of Health, PMC2875675, The Impact of Disasters on Populations With Health and Health Care Disparities. www.ncbi.nlm.nih.gov/pmc/articles/PMC2875675/

Connecticut Department of Public Health | 410 Capitol Avenue, Hartford, CT 06106