2022 Community Health Needs Assessment
Greenwich & Port Chester

YaleNewHavenHealth
Greenwich Hospital

PREPARED BY COMMUNITY RESEARCH CONSULTING, LLC
About the 2022 CHNA and Partners

Greenwich Hospital and its community partners conduct a Community Health Needs Assessment (CHNA) every three years. The 2022 CHNA was a community-wide undertaking with extensive data collection and input from community residents, health and social services experts, and people who serve our community every day.

The 2022 CHNA was conducted in collaboration with the Greenwich Community Health Improvement Partnership, serving Greenwich, Connecticut, and the Council of Community Services serving Port Chester, Town of Rye, and Rye Brook, New York. These coalitions represent groups of organizations and residents who are committed to working together to improve health across the region. A list of member organizations of each coalition is included on page 46.

Our CHNA research included:

- Analysis of Health and Socioeconomic Data
  Public health statistics, demographic and social measures, and healthcare utilization data were collected and analyzed to develop a comprehensive community profile.

- Community Survey of Lived Experiences
  As part of the DataHaven Community Wellbeing Survey across Connecticut, a telephone survey was conducted with community residents to document lived experiences and personal perspectives of health and wellbeing.

- Key Informant Survey and Interviews
  Surveys and interviews were conducted with key informants to better understand the impact of COVID-19 on the community and diverse populations.

- Input on Priority Health Needs from Community Representatives
  We asked residents from diverse communities what they saw as priority health needs, and how those issues impact their day-to-day lives.

- Input from Experts and Key Stakeholders
  Health and social service providers, public health experts, and representatives from a wide range of community-based organizations participated in the CHNA to guide the process and provide their expertise on community health needs.

The CHNA tracks the health and wellbeing of our community and monitors the social and environmental factors that influence health outcomes. These data illuminate health disparities across population groups and geographies and help us direct resources to advance health equity. Through the CHNA, we confirmed our understanding of community health priorities, and gathered new insights toward collaborative solutions.

Conducting the CHNA during the COVID-19 pandemic afforded a unique view of our community’s resources and needs. We saw the strength of our community come together to help one another. We witnessed innovative and swift responses to a health and economic crisis. We also documented gaps in our service delivery systems that reflect longstanding inequities in our society.

The triennial CHNA presents an opportunity to measure our progress toward equity, and to foster new partnerships and opportunities for collaboration. The information learned from the CHNA guides our collective work toward improving health and wellbeing, and advancing health equity so that all residents can benefit from the resources in our community.

We must work together as a community to develop collaborative solutions for these complex challenges. Making measurable progress will take time, but we continue to make significant strides every day.

The 2022 CHNA was conducted from March 2021 to June 2022 and aligned with IRS Code 501(r) requirements for not-for-profit hospitals to conduct a CHNA every three years as well as Connecticut state requirements for hospital community benefit reporting.
YaleNewHaven Health

Greenwich Hospital

Creating a world of difference in the healthcare we provide today and our support of the community.

About Greenwich Hospital

Greenwich Hospital is a 206-bed regional medical center serving Fairfield County, Connecticut and Westchester County, New York and a member of Yale New Haven Health. It is a major academic affiliate of Yale School of Medicine and a member of Yale New Haven Health.

Continuing our investment in long-term community health improvement, every year, we sponsor, develop, and participate in a wide array of community-based programs and services focused in five community benefit areas: guaranteeing access to care; advancing careers in healthcare; promoting health and wellness; building stronger neighborhoods; and creating healthier communities.

Anchored to our community

As large non-profit organizations and major employers, our Yale New Haven Health hospitals are “anchors” in their communities. We are committed to improving the long-term health and wellbeing of all residents, and we understand the impact of social and economic factors on health.

Our Anchor Mission includes a multi-pronged approach to align our everyday business activities in a way that improves living conditions and health equity in our community. We work together with our communities and like-minded organizations.

Yale New Haven Health Anchor Strategy

<table>
<thead>
<tr>
<th>Pillar</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local, diverse</td>
<td>Increase purchasing from local and women and minority-owned businesses</td>
</tr>
<tr>
<td>Local, inclusive</td>
<td>Increase hiring from underserved communities and support career growth of frontline workers</td>
</tr>
<tr>
<td>Impact investing</td>
<td>Invest in our local communities to improve the social determinants of health (e.g., housing, food, education, health)</td>
</tr>
<tr>
<td>Local volunteering</td>
<td>Harness the volunteer power of employees to improve the social determinants of health in our communities</td>
</tr>
<tr>
<td>Sustainability</td>
<td>Implement a healthcare sustainability program to improve the health of our communities</td>
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</tbody>
</table>
Greenwich is a town in Fairfield County, Connecticut. It is located at the border with New York State. It has a Life Expectancy at Birth of 84 years.

**Total Population**

62,587

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**Population by Race and Ethnicity**

**Greenwich**

- White: 73%
- Black: 14%
- Hispanic: 10%
- Other: 3%

**Fairfield County**

- White: 62%
- Black: 20%
- Hispanic: 8%
- Other: 11%

**Connecticut**

- White: 67%
- Black: 16%
- Hispanic: 7%
- Other: 10%

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**Percentages of Population by Age Groups**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Greenwich</th>
<th>Fairfield County</th>
<th>Connecticut</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5</td>
<td>6%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>5 to 19</td>
<td>22%</td>
<td>22%</td>
<td>20%</td>
</tr>
<tr>
<td>20 to 44</td>
<td>24%</td>
<td>24%</td>
<td>31%</td>
</tr>
<tr>
<td>45 to 64</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>65 and older</td>
<td>18%</td>
<td>16%</td>
<td>17%</td>
</tr>
</tbody>
</table>
Port Chester is a village in the Town of Rye, New York. It is surrounded by Rye Brook, Rye City, and the Town of Greenwich, Connecticut.

**Total Population 29,342**

### Population by Race and Ethnicity

**Port Chester**
- White: 64%
- Black: 3%
- Hispanic: 31%
- Other: 3%

**Westchester County**
- White: 53%
- Black: 13%
- Hispanic: 25%
- Other: 8%

**New York State**
- White: 56%
- Black: 19%
- Hispanic: 14%
- Other: 11%

### Percentages of Population by Age Groups

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Port Chester</th>
<th>Westchester County</th>
<th>New York</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5</td>
<td>7%</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>5 to 19</td>
<td>6%</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td>20 to 44</td>
<td>19%</td>
<td>18%</td>
<td>18%</td>
</tr>
<tr>
<td>45 to 64</td>
<td>38%</td>
<td>30%</td>
<td>34%</td>
</tr>
<tr>
<td>65 and older</td>
<td>34%</td>
<td>23%</td>
<td>28%</td>
</tr>
</tbody>
</table>

Sources: DataHaven Community Wellbeing Survey 2021; Centers for Disease Control and Prevention 2019; American Community Survey 2015-2019
A profile of the health and social factors that impact health in the **Greenwich** Community.

**Food Insecurity**
- 5% Received food from emergency services during COVID-19 Pandemic
- 17% Low availability of affordable high-quality fruits and vegetables

**Housing**
- Renters cost-burdened household 44%
- Home ownership 59%

**Economic Stability**
- 6% People below poverty level
- 11% No reliable transportation
- 20% Financially difficult or just getting by
- 3% Still be in debt if sold all major possessions and turned them into cash to pay off debts

**Town** | **Median Household Income $**
--- | ---
Town of Greenwich | 152,577
Fairfield County | 95,645
The State of Connecticut | 78,444

*Sources:* DataHaven Community Wellbeing Survey 2021; Centers for Disease Control and Prevention 2019; American Community Survey 2015-2019
A profile of the health and social factors that impact health in the Port Chester Community.

Sources: DataHaven Community Wellbeing Survey 2021; Centers for Disease Control and Prevention 2019; American Community Survey 2015-2019

**Food Insecurity**
- 25% Received food from emergency services during COVID-19 Pandemic
- 25% Low availability of affordable high-quality fruits and vegetables

**Housing**
- Renters cost-burdened household 53%
- Home ownership 47%

**Economic Stability**
- 11% People below poverty level
- 18% No reliable transportation
- 29% Financially difficult or just getting by
- 9% Still be in debt if sold all major possessions and turned them into cash to pay off debts

<table>
<thead>
<tr>
<th>Town</th>
<th>Median Household Income $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Westchester County</td>
<td>96,610</td>
</tr>
<tr>
<td>Port Chester Village, Rye, NY</td>
<td>74,920</td>
</tr>
<tr>
<td>New York State</td>
<td>68,486</td>
</tr>
</tbody>
</table>
A profile of the health and social factors that impact health in the **Greenwich** Community.

Sources: DataHaven Community Wellbeing Survey 2021; Centers for Disease Control and Prevention 2019; American Community Survey 2015-2019

**High School Graduation Rate**

96%

**Community Wellbeing**

Community Perspective of Living in Greenwich

- **93%** Satisfied with their city or area
- **90%** Think it is a good place to raise kids
- **85%** Report it is safe to walk at night

**Self-Reported Health, Life Satisfaction, and Happiness**

<table>
<thead>
<tr>
<th>Category</th>
<th>Greenwich</th>
<th>Fairfield County</th>
<th>Connecticut</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Health</td>
<td>71%</td>
<td>58%</td>
<td>58%</td>
</tr>
<tr>
<td>Life Satisfaction</td>
<td>75%</td>
<td>67%</td>
<td>66%</td>
</tr>
<tr>
<td>Happiness</td>
<td>71%</td>
<td>70%</td>
<td>68%</td>
</tr>
</tbody>
</table>

- **Greenwich**
- **Fairfield County**
- **Connecticut**
A profile of the health and social factors that impact health in the Port Chester Community.

Sources: DataHaven Community Wellbeing Survey 2021; Centers for Disease Control and Prevention 2019; American Community Survey 2015-2019

Self-Reported Health, Life Satisfaction, and Happiness

<table>
<thead>
<tr>
<th>Category</th>
<th>Port Chester</th>
<th>Westchester County</th>
<th>New York State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Health (%)</td>
<td>55%</td>
<td>53%</td>
<td>60%</td>
</tr>
<tr>
<td>Life Satisfaction</td>
<td>62%</td>
<td>63%</td>
<td>65%</td>
</tr>
<tr>
<td>Happiness (%)</td>
<td>56%</td>
<td>57%</td>
<td>59%</td>
</tr>
</tbody>
</table>

COMMUNITY WELLBEING

Community Perspective of Living in Port Chester

- **87%** Satisfied with their city or area
- **74%** Think it is a good place to raise kids
- **60%** Report it is safe to walk at night

Sources: DataHaven Community Wellbeing Survey 2021; Centers for Disease Control and Prevention 2019; American Community Survey 2015-2019
A profile of the health and social factors that impact health in the Greenwich Community.

Sources: DataHaven Community Wellbeing Survey 2021; Centers for Disease Control and Prevention 2019; American Community Survey 2015-2019

Health Risk Factors

- Adults never exercise
  - Greenwich: 12%
  - Fairfield County: 17%
  - Connecticut: 19%

- Adults experiencing obesity
  - Greenwich: 20%
  - Fairfield County: 27%
  - Connecticut: 30%

Self-Reported Chronic Diseases

<table>
<thead>
<tr>
<th>Disease</th>
<th>Greenwich</th>
<th>Fairfield County</th>
<th>Connecticut</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>6%</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td>19%</td>
<td>29%</td>
</tr>
<tr>
<td>Heart Diseases</td>
<td>2%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Asthma</td>
<td>12%</td>
<td>15%</td>
<td>17%</td>
</tr>
<tr>
<td>Depression</td>
<td>28%</td>
<td>31%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Sources: DataHaven Community Wellbeing Survey 2021; Centers for Disease Control and Prevention 2019; American Community Survey 2015-2019
A profile of the health and social factors that impact health in the **Port Chester** Community.

**Sources:** DataHaven Community Wellbeing Survey 2021; Centers for Disease Control and Prevention 2019; American Community Survey 2015-2019

### Health Risk Factors

**Adults never exercise**
- **Port Chester Overall:** 14%
- **Non-Whites:** 13%
- **Whites:** 16%

**Adults experiencing obesity**
- **Port Chester Overall:** 30%
- **Non-Whites:** 32%
- **Whites:** 24%

### Self-Reported Chronic Diseases

<table>
<thead>
<tr>
<th>Condition</th>
<th>Port Chester Overall</th>
<th>Non-Whites</th>
<th>Whites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>16%</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td>28%</td>
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<tr>
<td>Heart Diseases</td>
<td>10%</td>
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<tr>
<td>Asthma</td>
<td>16%</td>
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<td>33%</td>
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</tbody>
</table>
A profile of the health and social factors that impact health in the **Greenwich** Community.

**Sources:** DataHaven Community Wellbeing Survey 2021; Centers for Disease Control and Prevention 2019; American Community Survey 2015-2019

### Healthy Lifestyle

- **Workout one or more days per week**
  - Greenwich Overall: 88%
  - Non-Whites: 87%
  - Whites: 88%

- **Low availability of affordable high-quality fruits and vegetables**
  - Greenwich Overall: 17%
  - Non-Whites: 34%
  - Whites: 6%

- **Received food from emergency services during COVID-19 Pandemic**
  - Greenwich Overall: 5%
  - Non-Whites: 6%
  - Whites: 5%

### Access to Care

- **Didn't Get Needed Medical Care**
  - Greenwich Overall: 8%
  - Non-Whites: 10%
  - Whites: 7%

- **No One Person or Place as Primary Care Provider**
  - Greenwich Overall: 8%
  - Non-Whites: 7%
  - Whites: 3%

- **No Annual Dental Visit**
  - Greenwich Overall: 26%
  - Non-Whites: 24%
  - Whites: 26%
A profile of the health and social factors that impact health in the **Port Chester** Community.

**Healthy Lifestyle**

Port Chester Overall: 83%
Non-Whites: 87%
Whites: 80%

Workout one or more days per week:
Port Chester Overall: 25%
Non-Whites: 29%
Whites: 14%

Low availability of affordable high-quality fruits and vegetables:
Port Chester Overall: 25%
Non-Whites: 30%
Whites: 14%

Received food from emergency services during COVID-19 Pandemic:
Port Chester Overall: 40%
Non-Whites: 30%
Whites: 27%

**Access to Care**

- Didn't Get Needed Medical Care:
  - Port Chester Overall: 22%
  - Non-Whites: 24%
  - Whites: 19%

- No One Person or Place as Primary Care Provider:
  - Port Chester Overall: 23%
  - Non-Whites: 27%
  - Whites: 19%

- No Annual Dental Visit:
  - Port Chester Overall: 34%
  - Non-Whites: 35%
  - Whites: 33%

Sources: DataHaven Community Wellbeing Survey 2021; Centers for Disease Control and Prevention 2019; American Community Survey 2015-2019
A profile of the health and social factors that impact health in the **Greenwich** Community.

**Behavioral Health**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Greenwich Overall</th>
<th>Non-Whites</th>
<th>Whites</th>
</tr>
</thead>
<tbody>
<tr>
<td>25%</td>
<td></td>
<td>33%</td>
<td>23%</td>
</tr>
<tr>
<td>16%</td>
<td></td>
<td>21%</td>
<td>14%</td>
</tr>
<tr>
<td>28%</td>
<td></td>
<td>38%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Drug Overdose Death Rate Per 100,000 People

- **Greenwich**: 12.8
- **Fairfield County**: 23.9
- **Connecticut**: 35.2

**Protective Factors in Greenwich**

- **93%**: Percentage of people who think their neighbors can be trusted
- **88%**: Percentage of people who indicate they receive the emotional and social support they need

Sources: DataHaven Community Wellbeing Survey 2021; Centers for Disease Control and Prevention 2019; American Community Survey 2015-2019
A profile of the health and social factors that impact health in the **Port Chester** Community.

**Sources:** DataHaven Community Wellbeing Survey 2021; Centers for Disease Control and Prevention 2019; American Community Survey 2015-2019

### Behavioral Health

- **Know Someone Struggles with Opioid Misuse:**
  - Port Chester Overall: 17%
  - Non-Whites: 15%
  - Whites: 22%

- **Feel Mostly or Completely Anxious:**
  - Port Chester Overall: 13%
  - Non-Whites: 14%
  - Whites: 13%

- **Report Being Depressed or Hopeless:**
  - Port Chester Overall: 33%
  - Non-Whites: 35%
  - Whites: 31%

### Opioid Overdose Death, Age-Adjusted Rate per 100,000 People

- **Westchester County:** 10.0
- **New York State:** 14.9

### Protective Factors in Port Chester

- **Percentage of people who think their neighbors can be trusted:** 83%
- **Percentage of people who indicate they receive the emotional and social support they need:** 79%
A closer look at the factors that influence health in our community.

Social Drivers of Health

Social drivers of health (SDoH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.¹

SDoH are grouped into five domains that include factors like receiving timely healthcare; living in safe neighborhoods with transportation options; having nutritious food to eat; feeling valued and treated with respect; and having access to quality learning opportunities. The quality and availability of these “place-based” inputs directly contribute to health outcomes that can be measured in higher rates of disease and years of life lost.

By addressing each of these domains, we can dismantle longstanding inequities in our society and rebuild a healthier community for all people.

¹ World Health Organization who.int

What is Health Equity?

Health equity means everyone has a fair and just opportunity to be as healthy as possible.

To achieve health equity we need to focus efforts on the “upstream” factors like social drivers of health, and we need to acknowledge racism and discrimination as root causes of inequity.
Honoring Diversity in our Community

**Socioeconomic and Health Disparities by Race and Ethnicity**

The impact of social drivers of health and underlying inequities can be seen in health disparities experienced within population groups and in neighborhoods. These disparities are often the result of historical structural barriers that have prevented equal access to opportunity through racism and discrimination.

Using tools like the Community Needs Index (CNI) (right), supports place-based investments in people and neighborhoods to reduce disparities and advance health equity.

My community is:
“kind, nice people, and safe neighborhoods.” – Community Member

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**The Community Needs Index (CNI)**

The CNI Score shows highest socioeconomic needs among zip codes within and near the Village of Port Chester and Rye Brook, New York.

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**Diversity enriches communities.**

Communities benefit from embracing diversity of race, language, culture, identity, and perspectives. Different backgrounds and lived experiences contribute new ideas for solving longstanding challenges. In conducting the CHNA, significant efforts were made to collect input from people from all walks of life across our community and representatives of organizations that serve distinct populations.

Inviting diverse input from community stakeholders, we heard that we need more healthcare and social service providers who reflect the different cultural backgrounds, perspectives, and values of residents. Our community health improvement plan outlines ways we are pursuing strategies to advance Diversity, Equity, Inclusion and Belonging (DEIB) across our organizations and within our community.
Availability of high quality healthcare, receiving services when you need them, and being able to afford care are some of the key factors associated with this social driver of health domain.

The Greenwich and Port Chester areas are generally well served by healthcare primary care providers and dentists, but Fairfield County has fewer mental health providers than state and regional rates. More than 20% of people living in Port Chester report not receiving care when they need it. Across the Greenwich and Port Chester area, Hispanic residents are more than twice as likely as White residents not to receive care when they need it.

Lack of health insurance is one barrier that keeps people from accessing healthcare. Without health insurance residents are less likely to receive preventive care like health screenings and may postpone treatment.

Hispanic residents across the area have the highest uninsured rates. Rates among Black/African American residents are generally higher than White residents in all communities, except Port Chester.

During the past 12 months, was there any time when you didn’t get the medical care you needed?

Source: DataHaven Community Wellbeing Survey 2021
The 2022 CHNA was conducted during the COVID-19 pandemic, which created unprecedented health and socioeconomic challenges for people across the Greenwich and Port Chester communities, and the world. COVID-19 demanded equal measure in response from healthcare, social services, government, businesses, families, and individuals.

COVID-19 exacerbated existing disparities within the health and social service systems and exposed long-standing inequities in power and socioeconomic opportunities within our society.

COVID-19 did not impact all people equally. The graph below shows that Hispanic, Black/African American, Indigenous, and other People of Color (BIPOC) experienced disproportionately higher deaths due to COVID-19 relative to their overall population distribution. That means even though more White people died from COVID-19, a larger proportion of BIPOC populations died from COVID-19 than did White people.

This trend illuminated wider disparities in health outcomes for BIPOC communities and reflects structural factors like racism, lower wages, limited educational opportunities, inadequate housing, and unsafe working conditions, among other factors that contributed to poor outcomes from COVID-19 infection.

The dual impact of the COVID-19 pandemic and social justice movement helped shine a light on these disparities and the underlying inequities within our communities. Data tools like the COVID-19 Community Vulnerability Index (CCVI) were used to predict what communities could be most at-risk for high COVID-19 spread and infection.
Social Drivers of Health: Economic Stability

$\rightarrow$

**Economic Stability**

Having enough money to afford food, housing, healthcare, and daily needs is essential to wellbeing. Community representatives and individual residents alike told us that economic security was among the top needs in our community.

“I struggle to pay my bills.” –Community Member

Meet ALICE (Asset Limited, Income Constrained, Employed)
The ALICE Index represents the working poor, based on local cost of living. ALICE households have income above the poverty level, but not enough to meet all their basic needs.

Families and individuals whose economic means are just above the poverty level struggle to keep afloat. These individuals are Asset Limited, Income Constrained, Employed or ALICE. They make too much money to receive significant social assistance, but are one financial crisis away from falling into poverty. ALICE households were some of the most economically impacted by the COVID-19 pandemic.

Shown in this graphic, life expectancy is lower in communities with higher household economic instability.

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Percent of Population Below 100% Poverty, ALICE Households and Life Expectancy by Geography

*Source: American Community Survey 2015-2019; United for ALICE*

United for ALICE is a United Way initiative to drive innovation, research, and action to impact life across the country for ALICE and all.
Across the region, with a higher percentage of homeownership, there is a lower percentage of children in poverty.

“There is not enough affordable housing... for young and senior populations. You can live here your whole life, but as you age, find yourself unable to afford to stay.” –Community Resident
Social Drivers of Health: Economic Stability

**Home Ownership, Housing Cost Burden**

Owning a home is an investment. For many families, their home is their largest asset. People need to have resources to purchase and maintain a home, so it’s not surprising that people with less household income are less likely to own their home. However, clear disparities among racial and ethnic groups point at inequities that go beyond income. Wide disparities in home ownership are apparent in Greenwich and Port Chester between White and non-White* residents.

Practices like red-lining allowed, and enforced, community segregation and created economic inequities that can be seen today in disproportional homeownership among communities of color.

Equitable homeownership is important to building healthy communities. Having safe and appropriate housing is a key factor in one’s health. Neighborhood stability influences investments in community infrastructure, such as schools, roads, public transportation, and green spaces, creating a healthier environment for everyone.

*due to small percentages, data for populations other than White, non-Hispanic are combined as non-White to allow comparisons

“Housing is unaffordable in Greenwich and qualifying for affordable housing is extremely complicated.” – Community Resident

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**Survey respondents who stated that they own their own home.**

Source: DataHaven Community Wellbeing Survey 2021

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Our home environments impact our health. The graphics below show the relationship between housing and asthma. Lower income households are more likely to have inadequate housing and experience higher rates of asthma. White and non-White residents have inadequate housing, Non-white residents are more likely to have asthma.

**Housing Insecurity vs. Prevalence of Asthma, Greenwich**

Source: DataHaven Community Wellbeing Survey 2021

**Housing Insecurity vs. Prevalence of Asthma, Port Chester**

Source: DataHaven Community Wellbeing Survey 2021

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**By Income**

- $<30K: 22%
- $30K-$100K: 45%
- $>100K: 84%

**By Race/Ethnicity**

- Non-White: 46%
- White: 69%

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**By Income**

- CT: 9%
- Greenwich: 10%
- Below $30K: 13%
- $30K-$100K: 13%
- $100K or more: 8%

**By Race/Ethnicity**

- CT: 9%
- Greenwich: 10%
- Non-White: 10%
- White: 10%
Food Security

Food security depends on many factors including the type of food that is available in your neighborhood, the local cost of food, and the amount of household resources available to spend on food. Easy access to fresh foods is an important component of healthy living. In the Greenwich and Port Chester areas, there are wide disparities between income, race, and ethnicity among households who needed emergency food resources, as shown in the graphic below.

Survey respondents who stated that they or any other adult in their household received groceries or meals from a food pantry, food bank, soup, kitchen, or other emergency food service since February 2020.

Source: DataHaven Community Wellbeing Survey 2021

“Food is very important to good health. There are many people who don’t have food and go to food pantries for help.”

–Community Member

The inability to afford healthy food impacts health. The graph below shows the relationship between food affordability and prevalence of diabetes. People who are more likely to report struggling with diabetes are also more likely to report struggling to afford healthy food.

Survey respondents who stated that they did not have enough money to buy food that they or their family needed.

Source: DataHaven Community Wellbeing Survey 2021
Neighborhood and Built Environment

In addition to the resources available in communities, the physical environment and infrastructure of neighborhoods impact health. The availability of good schools, well-maintained roads, public transportation, green spaces, healthy environments, technology, and public safety promotes or hinders good health.

COVID-19 brought issues like access to high speed internet to the forefront as people needed reliable technology for school, work, health, and social connections.

Public transportation is essential to ensuring people can get to work, and the services that are available in their community. Safe neighborhoods and having access to free or low-cost recreational activities promotes physical activity and social engagement, which contribute to healthy bodies and minds.

In the Greenwich and Port Chester communities, residents in the village of Port Chester report the most needs for infrastructure investments.

The Digital Divide
Source: American Community Survey 2015-2019

During COVID-19 we were able to use technology to bring services to people in their homes, but we need to bridge the wide digital divide within our communities to effectively reach all residents.

<table>
<thead>
<tr>
<th>Location</th>
<th>Internet Subscription (any)</th>
<th>Broadband Subscription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mamaroneck Town, NY</td>
<td>91.9%</td>
<td>91.8%</td>
</tr>
<tr>
<td>Rye City (CDP), NY</td>
<td>93.6%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Rye Town, NY</td>
<td>88.7%</td>
<td>88.6%</td>
</tr>
<tr>
<td>Port Chester Village, Rye, NY</td>
<td>86.9%</td>
<td>86.8%</td>
</tr>
<tr>
<td>Rye Brook Village, Rye, NY</td>
<td>91.3%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Greater Greenwich</td>
<td>93.4%</td>
<td>93.3%</td>
</tr>
<tr>
<td>Fairfield County, CT</td>
<td>88.8%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>85.9%</td>
<td>85.5%</td>
</tr>
<tr>
<td>Westchester County, NY</td>
<td>86.4%</td>
<td>86.2%</td>
</tr>
<tr>
<td>New York</td>
<td>83.2%</td>
<td>82.8%</td>
</tr>
<tr>
<td>US</td>
<td>83.0%</td>
<td>82.7%</td>
</tr>
</tbody>
</table>

Households with higher income levels are more likely to have affordable recreation options and be more physically active. There are wider disparities between White and non-White residents in Port Chester than in Greenwich.
Survey respondents who perceived that the condition of public parks and other public recreational facilities was “good” or “excellent”

Source: DataHaven Community Wellbeing Survey 2021

Survey respondents who stated that there have been times in the past 12 months when they stayed home when they needed to go someplace because they had no access to reliable transportation.

Source: DataHaven Community Wellbeing Survey 2021

Survey respondents who stated that they “very often” or “fairly often” have access to a car when they need it

Source: DataHaven Community Wellbeing Survey 2021

Survey respondents who perceived that the availability of affordable, high-quality fruits and vegetables was “good” or “excellent”

Source: DataHaven Community Wellbeing Survey 2021
Education Access and Quality

Education is one of the best predictors of good health and long life. High school graduation rates in Greenwich are above the Connecticut state average. Port Chester rates are lower than the region and generally in line with the New York state average. This measure, combined with lower post-secondary education attainment for Black and Hispanic adults may indicate systemic barriers that contribute to a cycle of inequity.

Did you know: Higher levels of education create access to a wider range of employment opportunities, leading to increased access to healthy living resources, including health insurance and transportation.

High School Graduation Rate, Greenwich and Port Chester Area School Districts 2020-2021 School Year

Source: CT State Department of Education (SDE), 2020-2021.

<table>
<thead>
<tr>
<th>School District</th>
<th>Graduation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greenwich</td>
<td>96%</td>
</tr>
<tr>
<td>Port Chester</td>
<td>85%</td>
</tr>
<tr>
<td>CT</td>
<td>90%</td>
</tr>
<tr>
<td>NY</td>
<td>86%</td>
</tr>
</tbody>
</table>

Equity in Education

Availability of accessible, well-funded, and well-resourced public education opportunities and exposure to diverse employment pathways, such as in the healthcare and social services fields, increase the opportunity for upward mobility, economic security, and better health outcomes.

% of Population Age 25+ with Bachelor’s Degree or Higher by Race/Ethnicity

Source: American Community Survey 2015-2019

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
<th>Asian</th>
<th>Two or more Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greenwich Town, CT</td>
<td>68.0%</td>
<td>30.7%</td>
<td>41.4%</td>
<td>78.5%</td>
<td>48.7%</td>
</tr>
<tr>
<td>Mamaroneck Town, NY</td>
<td>69.3%</td>
<td>34.6%</td>
<td>35.8%</td>
<td>81.7%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Rye Town</td>
<td>48.2%</td>
<td>37.0%</td>
<td>17.1%</td>
<td>75.9%</td>
<td>29.5%</td>
</tr>
<tr>
<td>Port Chester Village, Rye, NY</td>
<td>33.9%</td>
<td>35.5%</td>
<td>15.2%</td>
<td>71.7%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Rye Brook Village, Rye, NY</td>
<td>69.1%</td>
<td>26.7%</td>
<td>31.3%</td>
<td>73.6%</td>
<td>70.2%</td>
</tr>
<tr>
<td>Rye City (CDP), NY</td>
<td>77.1%</td>
<td>58.9%</td>
<td>48.8%</td>
<td>69.4%</td>
<td>86.5%</td>
</tr>
<tr>
<td>Greater Greenwich</td>
<td>64.0%</td>
<td>34.1%</td>
<td>26.4%</td>
<td>77.8%</td>
<td>45.6%</td>
</tr>
<tr>
<td>Fairfield County, CT</td>
<td>53.1%</td>
<td>23.1%</td>
<td>18.6%</td>
<td>69.2%</td>
<td>37.1%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>41.9%</td>
<td>21.3%</td>
<td>17.3%</td>
<td>65.8%</td>
<td>31.0%</td>
</tr>
<tr>
<td>Westchester County, NY</td>
<td>55.6%</td>
<td>32.2%</td>
<td>23.7%</td>
<td>72.0%</td>
<td>42.3%</td>
</tr>
<tr>
<td>New York</td>
<td>40.8%</td>
<td>24.0%</td>
<td>19.4%</td>
<td>47.2%</td>
<td>35.0%</td>
</tr>
<tr>
<td>US</td>
<td>33.5%</td>
<td>21.6%</td>
<td>16.4%</td>
<td>54.3%</td>
<td>31.9%</td>
</tr>
</tbody>
</table>
Social and Community Context

Diversity of race, language, culture, and perspective enriches communities.

As much as communities are shaped by those who live there, people are impacted by the social context of the places where they live. Social context includes family, neighborhoods, school and work environments, political or religious systems, and other interpersonal infrastructures within a community. People’s lived experiences within their social context play a significant role in good health and wellbeing.

Feeling like you belong, are appreciated, and are valued in your community reinforces protective health factors that help people and communities overcome adversity. Poverty, violence, poor housing, racism, and discrimination create Adverse Community Environments that perpetuate trauma and increase Adverse Childhood Events (ACEs) that have lasting impact on people and their communities.

Residents in Greenwich were more likely to report unfairly treated in the workplace than those in Port Chester, but Port Chester residents were more than twice as likely as Greenwich residents to feel they were treated with less respect than others when seeking healthcare.

*Responses reflected any healthcare setting and are not specific to Greenwich Hospital or Yale New Haven Heath.

Survey respondents who perceived that at any time in their life, they have been unfairly fired, unfairly denied a promotion, or raise, or not hired for a job for unfair reasons.

Source: DataHaven Community Wellbeing Survey 2021

Survey respondents who perceived that, when seeking healthcare, they have been treated with less respect or received services that were not as good as what other people get.*

Source: DataHaven Community Wellbeing Survey 2021
Determining Priority Health Needs

To determine community health priorities, we must consider what the data are telling us, and more importantly, what our community sees as the most pressing health concerns.

Community engagement was a central part of the CHNA. We invited wide participation from community stakeholders and organizations, including experts in health, social service representatives, advocates, community champions, policy makers, and lay community residents. These stakeholders were asked to weigh in on data findings, share their perspectives on challenges facing our community, and provide input on collaborative solutions.

The CHNA data and stakeholder input reinforced that the areas we’ve been focused on are still the highest needs in our community. Through community conversations, we asked how residents experience these issues in their day to day lives, and how we could do a better job helping them to live a healthier life.

Residents shared their attitudes and experiences about community needs most important to them through a telephone survey of 400 households and community surveys with 133 diverse community residents across Greenwich and Port Chester.

Community Health Priorities:

- Access to Care and Services
- Behavioral Health: Healthy Minds
- Healthy Living: Healthy Bodies
Determining Priority Health Needs

What you told us:

We need to help all people benefit from our community’s robust health and social services. Many people are not aware of these resources or cannot access them.

We need to increase opportunities for community members to share lived experiences and participate in collaborative solutions to community challenges.

We need to grow trust in the healthcare system and that starts with honoring diversity and ensuring equitable delivery of services.

In your words

The top issues impacting our community are:

- Affording medical care, prescriptions, and supplies
- Affording food
- Stable housing
- Financial security (paying bills, etc.)
- Mental health
- Drugs and Alcohol
- Built environment

These needs are in line with requests for services to the 211 referral system.

How we will respond:

We developed a Community Health Improvement Plan (CHIP) to guide our efforts in responding to our community’s needs. Using recommendations from the people who deliver and use these services, we will foster collaboration to better coordinate our community resources. We will seek to better connect people to the services they need and reduce disparities in health and socioeconomic measures that stem from underlying inequities in our society.

The following pages highlight key findings from the CHNA that support community health priorities and how we are addressing these concerns.

Did you know you can dial “2-1-1” on any phone or visit uwc.211ct.org to connect to all kinds of services across our community?

Top Requested Services* to 211 Referral System

<table>
<thead>
<tr>
<th>Need Category</th>
<th># of times requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Housing &amp; Shelter</td>
<td>15,615</td>
</tr>
<tr>
<td>2 Mental Health &amp; Addictions</td>
<td>4,801</td>
</tr>
<tr>
<td>3 Utilities</td>
<td>2,738</td>
</tr>
<tr>
<td>4 Employment &amp; Income</td>
<td>2,659</td>
</tr>
<tr>
<td>5 Food</td>
<td>1,943</td>
</tr>
<tr>
<td>6 Government &amp; Legal</td>
<td>1,776</td>
</tr>
<tr>
<td>7 Clothing &amp; Household Goods</td>
<td>331</td>
</tr>
<tr>
<td>8 Transportation Assistance</td>
<td>281</td>
</tr>
<tr>
<td>9 Disaster</td>
<td>243</td>
</tr>
<tr>
<td>10 Child Care &amp; Parenting</td>
<td>103</td>
</tr>
</tbody>
</table>

*This list excludes requests for other healthcare services.
Access to Care and Services

The Greenwich and Port Chester areas have robust, engaged, and high quality healthcare and social services that are essential components to ensuring health and wellbeing in our community.

However, not all of our residents benefit from these community resources. The data show wide disparities among communities of color and those with lower incomes in receiving the services they need, when they need them. We need to address social drivers of health as the root causes of these disparities and a reflection of the underlying inequities within our society.

As health and social service providers we are doing this by bringing care to people in their neighborhoods through the use of community health workers and technology. We continue to provide free and low cost services regardless of ability to pay. We are working to better reflect the populations we serve through staffing, language capabilities, and honoring diverse people and cultures.

Survey respondents who stated that they do not have one person or place they think of as their personal doctor or healthcare provider

Source: DataHaven Community Wellbeing Survey 2021

We asked healthcare and social service providers about how COVID-19 will continue to impact our communities. This is what they told us:

- Postponed care during the pandemic has led to greater acuity in need or disease
- Providers are experiencing a backlog of patients, higher acuity, and longer wait times
- Staff shortages are reducing capacity of health and human services, childcare, and education institutions
- Loss of trust in healthcare and government are keeping people from proactively seeking services
- We need to re-establish positive relationships among residents of all ages

Having a trusted provider and medical home promotes positive health behaviors like receiving health screenings and ensures access to medical care when needed. Availability of providers and capacity of current services ensure timely care. Community members and key stakeholders alike agreed that wait times for essential services like affordable housing and behavioral healthcare are longer than ever before.
COVID-19 showed that we can achieve wide access to services across our community.

COVID-19 testing and vaccination sites were erected in days. Food distribution channels multiplied across the community. Virtual meetings, telehealth, mass text messaging, and online information allowed for safe interaction and continuation of services during the periods of isolation and community quarantine.

In collaboration with our community partners, Greenwich Health Improvement Partnership (GCHIP) and the Council of Community Services (CCS), collectively worked together to disseminate accurate health information and increase awareness of available health programs, resources and services. Our pandemic response included expanding the use of social media technology and creating a website with up to date information on COVID vaccines, testing, food assistance and more.

Greenwich Hospital is creatively meeting the needs of our community members by increasing the ways people can access healthcare including community, home, and telehealth services. As a result of the pandemic, the benefits of using telehealth technology was apparent and we continue to expand this option to keep patients connected to their care.

Greenwich Hospital’s Parish Nurse and Nurse In Program reduce barriers to care by connecting community members to hospital and community-based resources and services.

How we are improving access to care
Behavioral Health: Healthy Minds

Behavioral health encompasses mental health conditions, substance use disorders, and one’s overall sense of wellbeing. Nationwide, there has been an increase in demand for behavioral health services, a trend we have seen in Greenwich and Port Chester communities, too.

Referrals for mental health and addictions were the most common request to the 211 referral system in 2021. Feedback from community service providers and residents confirmed that, like most communities, demand for behavioral health services are outpacing our delivery system capacity. This challenge compels us to leverage our community assets in new ways, and rethink how we can create environments that reduce trauma and foster community connections.

Greenwich Hospital Visits, Any Setting, Mental Health and Substance Use Disorders as Percentage of Total Visits

The graph below shows the increase in Greenwich Hospital visits (in any setting) for mental health and substance use disorders as a percentage of the total visits during 2015-2020.

Suicide Death Rate Per Age-Adjusted 100,000

Source: CT Office of the Chief Medical Examiner (OCME), 2020

<table>
<thead>
<tr>
<th>Year</th>
<th>Fairfield County, CT</th>
<th>Connecticut</th>
<th>Westchester County, NY</th>
<th>New York</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>10.1</td>
<td>7.0</td>
<td>7.4</td>
<td>6.7</td>
<td>7.0</td>
</tr>
<tr>
<td>2017</td>
<td>10.5</td>
<td>7.4</td>
<td>7.2</td>
<td>6.2</td>
<td>7.2</td>
</tr>
<tr>
<td>2018</td>
<td>10.6</td>
<td>8.3</td>
<td>7.4</td>
<td>8.3</td>
<td>8.3</td>
</tr>
<tr>
<td>2019</td>
<td>11.4</td>
<td>9.1</td>
<td>8.0</td>
<td>9.3</td>
<td>8.0</td>
</tr>
<tr>
<td>2020</td>
<td>9.3</td>
<td>8.6</td>
<td>7.9</td>
<td>9.3</td>
<td>8.0</td>
</tr>
</tbody>
</table>

Overdose Death Rate per 100,000 (2020)

Source: CT Office of the Chief Medical Examiner (OCME), 2020

<table>
<thead>
<tr>
<th>Location</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greenwich Town, CT</td>
<td>12.8</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>23.9</td>
</tr>
<tr>
<td>Connecticut</td>
<td>35.2</td>
</tr>
</tbody>
</table>
How we are responding to behavioral health needs

+ Suicide Prevention and Awareness seminars were conducted with community partners and a Greenwich Hospital Emergency Department physician was appointed to serve on the Town of Greenwich’s Post-Intervention Suicide Task Force.

+ Greenwich Hospital in collaboration with the Greenwich YWCA co-hosted a variety of local domestic violence prevention and awareness programs building a safer community for all.

Survey respondents who have been bothered by feeling down, depressed, or hopeless “several days”, “more than half the days”, or “nearly every day” over the past 2 weeks

Source: DataHaven Community Wellbeing Survey 2021

Survey respondents who stated that they personally know anyone who has struggled with an addiction to heroin or other opiates such as prescription painkillers at any point during the last three years

Source: DataHaven Community Wellbeing Survey 2021

Many people throughout the Greenwich and Port Chester areas experienced increased stress or trauma since the advent of the COVID-19 pandemic. Nearly half of all adults ages 18-34 throughout the community reported feeling down.

1 in four Greenwich residents and just under 1 in five Port Chester residents personally know someone struggling with opiate addiction.
Youth Measures of Mental Health and Substance Use, 9th-12th Graders
Source: Centers for Disease Control and Prevention, Youth Risk Behavior Survey 2019
Connecticut Department of Public Health

<table>
<thead>
<tr>
<th></th>
<th>Feel Consistently Sad or Depressed</th>
<th>Attempted Suicide</th>
<th>E-cigarette Use (last 30 days)</th>
<th>Alcohol Use (last 30 days)</th>
<th>Marijuana Use (last 30 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>30.6%</td>
<td>6.7%</td>
<td>27%</td>
<td>25.9%</td>
<td>21.7%</td>
</tr>
<tr>
<td>US</td>
<td>36.7%</td>
<td>8.9%</td>
<td>32.7%</td>
<td>29.1%</td>
<td>21.7%</td>
</tr>
</tbody>
</table>

Adverse Childhood Experiences

Traumatic or stressful Experiences in childhood are called Adverse Childhood Experiences or ACEs. ACEs have been shown to have lifelong impacts on the economic, educational, and mental and physical health outcomes for individuals, and are associated with decreased life expectancy.

ACEs grow from Adverse Community Environments. By taking an upstream approach to emphasize interventions that address adverse community environments such as promoting “trauma informed care,” we can prevent, identify, and offset life’s negative events.

Focusing community health interventions on underlying social drivers of health, such as poverty and discrimination, can yield more effective and impactful treatment of downstream disease conditions, and pave the way for equitable health outcomes. The following diagram from the CDC illustrates the connection between environment and experiences.

Trauma, isolation, and lack of socialization during COVID-19 created environments that can have long lasting impact on youth.

The Pair of ACEs
Source: Centers for Disease Control and Prevention

Adverse Childhood Experiences

+ Maternal Depression
+ Emotional & Sexual Abuse
+ Substance Abuse
+ Domestic Violence
+ Physical & Emotional Neglect
+ Divorce
+ Mental Illness
+ Incarceration
+ Homelessness

Adverse Community Environments

+ Poverty
+ Discrimination
+ Community Disruption
+ Lack of Opportunity, Economic Mobility, & Social Capital
+ Poor Housing Quality & Affordability
+ Violence
Starting Out Strong

Ensuring pregnant people have the support they need to help each baby start life as healthy as possible is important. The data show that most pregnant people in the Greenwich and Port Chester areas are able to access early prenatal care, which is the best way to promote a healthy pregnancy and delivery.

Infant Mortality

Infant mortality (death of a child before age 1) is used as an international measure of overall community health. This is because the death of babies is impacted by social and economic factors and quality of life conditions for mothers.

Disparities in infant mortality are measures of structural socioeconomic inequities that happen long before pregnancy or birth. Upstream strategies that address the root causes of inequities can have far reaching impact on infant mortality, child wellbeing, reducing family trauma, and increasing life expectancy for all people.

Maternal and Child Health, 2019 Data

<table>
<thead>
<tr>
<th></th>
<th>% Low Birth Weight</th>
<th>Infant Death Rate per 1,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greenwich Town, CT</td>
<td>5.3%</td>
<td>0</td>
</tr>
<tr>
<td>Mamaroneck Town, NY</td>
<td>10.2%</td>
<td>NA</td>
</tr>
<tr>
<td>Rye City (CDP), NY</td>
<td>3.4%</td>
<td>NA</td>
</tr>
<tr>
<td>Rye Town, NY</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Port Chester Village, Rye, NY</td>
<td>8.3%</td>
<td>NA</td>
</tr>
<tr>
<td>Rye Brook Village, Rye, NY</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Greater Greenwich</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Fairfield County, CT</td>
<td>7.5%</td>
<td>4</td>
</tr>
<tr>
<td>Connecticut</td>
<td>7.8%</td>
<td>4.5</td>
</tr>
<tr>
<td>Westchester County, NY</td>
<td>7.5%</td>
<td>3.8</td>
</tr>
<tr>
<td>New York</td>
<td>8.0%</td>
<td>4.3</td>
</tr>
<tr>
<td>US</td>
<td>8.3%</td>
<td>5.6</td>
</tr>
</tbody>
</table>
Healthy Living: Healthy Bodies

Disparities, Impact of Social Drivers of Health

Prior to COVID-19, the top leading causes of death among all populations in the US were chronic diseases. Across Greenwich and Port Chester communities, it is clear that preventive care, early diagnosis, and comprehensive treatment are high quality and effective. However, wide health disparities exist between those that benefit from these lifesaving services and those that die prematurely. The data reinforce that social drivers of health directly impact health outcomes for chronic disease, resulting in inequities in life expectancy by race and neighborhood.

Average Life Expectancy by Race/Ethnicity, 2017-2019

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Asian</th>
<th>Black</th>
<th>Hispanic</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairfield County</td>
<td>94.2</td>
<td>80.8</td>
<td>87.7</td>
<td>82.8</td>
</tr>
<tr>
<td>Connecticut</td>
<td>92.9</td>
<td>79.0</td>
<td>84.7</td>
<td>80.6</td>
</tr>
<tr>
<td>Westchester County</td>
<td>92.7</td>
<td>80.7</td>
<td>89.1</td>
<td>83.5</td>
</tr>
<tr>
<td>New York</td>
<td>90.0</td>
<td>79.5</td>
<td>85.4</td>
<td>81.1</td>
</tr>
</tbody>
</table>

Adult Health Indicators, Age Adjusted, 2019 BRFSS

<table>
<thead>
<tr>
<th>Location</th>
<th>% Obese (BMI 30+)</th>
<th>% Tobacco Use Current Smokers</th>
<th>% Diabetes</th>
<th>% High Blood Pressure</th>
<th>% Asthma</th>
<th>% Depression</th>
<th>% Binge Drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairfield County, CT</td>
<td>24.4%</td>
<td>10.9%</td>
<td>7.9%</td>
<td>25.6%</td>
<td>8.2%</td>
<td>13.5%</td>
<td>17.0%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>28.7%</td>
<td>12.4%</td>
<td>8.2%</td>
<td>27.2%</td>
<td>10.8%</td>
<td>14.7%</td>
<td>17.3%</td>
</tr>
<tr>
<td>Westchester County, NY</td>
<td>26.2%</td>
<td>10.7%</td>
<td>8.9%</td>
<td>24.2%</td>
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Key informants were asked what factors most impacted residents’ good health. Their responses below reinforce that healthy lifestyles start with healthy environments.

1. Housing
2. Healthy food
3. Medical insurance
4. Employment
5. Adequate transportation
6. Open space
Populations that experience unfavorable social drivers of health, such as lack of access to quality education and employment, are also a greater risk for disease. In Greenwich and Port Chester, Hispanic and Non-White residents report chronic disease diagnoses more frequently than their White neighbors.

Self-Reported Chronic Diseases, Greenwich
Source: DataHaven Community Wellbeing Survey 2021

Self-Reported Chronic Diseases, Port Chester
Source: DataHaven Community Wellbeing Survey 2021

Note: Individuals participating in the 2021 DataHaven Community Survey from the Greenwich area who reported identifying as Black/African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander have been aggregated together as “Non-White” due to the small sample sizes participating from each of these populations.

How we are improving healthy living

- Each week, Greenwich Hospital donates unused/unsold food from our cafeterias, benefitting local emergency food programs.
- Via the Speakers’ Bureau, healthy lifestyle education programs were conducted to promote health and wellness and included the benefits of sleep and exercise, Tai Chi, mindful meditation and healthy eating programs (DASH, Plant Based, Mediterranean Diets).
- Injury Prevention Programs were expanded in collaboration with Yale’s Center for Injury and Violence Prevention.
- In partnership with the Greenwich Fire and Police Departments Infant and Child car seat safety check programs were initiated and included the creation of a video located on the Greenwich Hospital’s website and YouTube page.
Yale New Haven Health
Greenwich Hospital

Community Health Improvement Plan
2022-2025
Our continuing efforts to improve community health

What is a Community Health Improvement Plan (CHIP)?

A CHIP helps organizations move from data to action by addressing priority health and wellbeing needs identified in the CHNA. The CHIP serves as a guide for strategic planning and a tool by which to measure impact by detailing goals, strategies, and initiatives over the three-year reporting timeframe.

The CHIP aligns unmet community needs with high-level strategies and corresponding health system and hospital initiatives. The CHIP measures the impact of collective action initiatives and tracks progress over time. CHIP strategies focus on improving the health and wellbeing of our community and achieving health equity for all by addressing health disparities identified in the CHNA. CHIP initiatives reflect community focused initiatives, programs, and services planned for the next three years.

Alignment with Healthy Connecticut 2025

Healthy Connecticut 2025 State Health Improvement Plan (SHIP) is the five-year state health strategic plan for improving the health of CT residents. Representatives from YNHHS and other community organizations participated in creating Healthy Connecticut 2025 and serve on ongoing action teams. Connecticut Department of Public Health oversees the development of the SHIP, in collaboration with multi-sector partners from across the state.

The Healthy Connecticut 2025 State Health Improvement Plan is aligned with the National Prevention Strategy, Healthy People 2030 objectives, the Centers for Disease Control and Prevention, and with other existing local and State of Connecticut plans.

In addition to the SHIP, the 2022 hospital CHNA was aligned with IRS Code 501(r) requirements for not-for-profit hospitals as well as Connecticut state requirements for hospital community benefit reporting. Hospital CHIP goals align with SHIP goals to establish support for statewide initiatives at the local level.

Approach to Community Health Improvement

Like the CHNA, the CHIP reflects input from many stakeholders. It acknowledges existing work, community assets and gaps in resources. The success of the CHIP depends on collaboration with community partners and input from local residents to address social drivers of health (SDoH) and advance initiatives toward health and wellbeing.

The CHIP was developed by a hospital task force comprised of leaders from multiple departments to capture all hospital and health system efforts that impact the health of the local community. CHIP goals reflect identified needs and were confirmed through discussions with community leaders and stakeholders. Our priority areas come from the top needs identified by the CHNA and are aligned with those of our collective impact partnership, Greenwich Community Health Improvement Partnership and the Council of Community Services: Community Health and Wellbeing, Access to Care, Behavioral Health, and Healthy Living. These priority areas reflect the greatest needs in the community with health system and hospital generated strategies for action and also align with statewide efforts in the SHIP.

We used the top needs identified through community engagement as a foundation for our CHIP development to address the needs of greatest concern to community members. These individuals provided diverse perspectives on health trends, shared lived experiences among historically disenfranchised and underserved populations, and provided insights into service delivery gaps that contribute to health disparities and inequities. The community needs are: affordable healthcare, behavioral health, drug/alcohol misuse, education, financial security, food security, and housing. The CHIP provides direction for addressing the health and wellbeing needs of the community.

Affordable Healthcare
Behavioral Health
Drug/Alcohol Misuse
Education
Financial Security
Food Security
Housing
Community Health and Wellbeing

Greenwich Hospital Goal:
Improve the health and wellbeing of the community with a focus on social drivers of health and health equity.

Healthy CT 2025 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. (D)

STRATEGY: Align our everyday business activities in a way that improves living conditions in our communities and addresses health equity.

Initiative: Increase purchasing from local, women, and minority-owned businesses.
Initiative: Increase hiring from underserved communities and support career growth of frontline workers.
Initiative: Invest financially in our local communities to improve the social drivers of health.
Initiative: Harness the volunteer power of employees to improve the social drivers of health in local communities.
Initiative: Implement a healthcare sustainability program to improve the health of our communities.

STRATEGY: Develop strategies to address disparities by race and ethnicity to drive equitable care and outcomes.

Initiative: Develop and implement strategies to address disparities by race and ethnicity based on root cause analyses.
Initiative: Identify and decrease variation in clinical care (testing, referral, and treatment patterns) by race and ethnicity.
Initiative: Identify and decrease variation in clinical outcomes by race and ethnicity.

STRATEGY: Support local community organizations and events that help alleviate SDoH.

Initiative: Determine local community member SDoH needs in collaboration with community organizations and hold collection drives to support community organization recipient(s).
Initiative: Provide funding/financial contributions to local community based organizations that align with YNHHS mission, vision, and values.
Initiative: Participate in community events (e.g. health fairs, health talks) to provide health education and information to the community.

STRATEGY: Support a healthcare environment that honors and reflects the communities we serve.

Initiative: Partner with local community organizations to increase the health and wellbeing of the community.
Initiative: Partner with internal departments to include community information and a community focus in developing services and initiatives.
Initiative: Seek input from the community and provide feedback on YNHHS and hospital community health progress.
Initiative: Continue to invest in community benefit for our local community.

STRATEGY: Participate in local collective impact partnerships.

Initiative: Be a leadership member of partnerships.
Initiative: Support and actively participate in partnership initiatives.
Initiative: Increase the impact of partnerships to address community needs.
STRATEGY: Engage patients, families, physicians, and staff to increase YNHHS presence in the community to build stronger relationships.

**Initiative:** Provide continued enhancement of the Diversity, Equity, Inclusion & Belonging (DEIB) councils at each hospital.

**Initiative:** Support community health and wellbeing hospital initiatives.

**Initiative:** Increase awareness and education about health equity, health disparities, and cultural competence.

**Initiative:** Support community relationships through volunteerism and presence in the community to increase community trust and engagement.

**Initiative:** Provide DEIB education and resources.

**Initiative:** Establish Employee Resource Groups to assist in identifying the varied needs of the community and support the community through volunteer work.

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STRATEGY: Embed health equity within YNHHS and its hospitals.

**Initiative:** Build infrastructure to support health equity.

**Initiative:** Expand ethnicity categories in electronic medical records patient demographics.

**Initiative:** Redesign process and staff training to increase collection and use of Racial, Equity and Language (REaL), Sexual Orientation and Gender Identity (SOGI), and disability information in patient care.

**Initiative:** Identify opportunities to decrease healthcare disparities through analyzing hospital and health system performance data and community feedback to identify disparities, root causes, and ways to improve.

**Initiative:** Increase communication channels with our community members to listen, learn, and improve health equity for our patients and the community.

---

STRATEGY: Enhance the patient experience to reflect the community and patient population.

**Initiative:** Improve the diversity of Patient Family Advisors to reflect community and patient population.

**Initiative:** Partner with DEIB, Press Ganey, Office of Health Equity, and Patient Family Advisors to enhance health equity of patient survey questions and use results to increase patient experience.

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STRATEGY: Screen for socioeconomic needs and provide resources for support.

**Initiative:** Adopt a common set of SDoH questions across all care settings.

**Initiative:** Develop strategies to support patients with identified needs through referrals and interventions.

---

STRATEGY: Increase community input and diversity in research.

**Initiative:** Bring community perspective to research and identify areas of need through community advisory board, community research fellowship program, and community research innovation summits.

**Initiative:** Increase community-based cross-industry collaboration to increase diversity in clinical trials.
Access to Care & Services

Greenwich Hospital Goal:
Ensure access to quality healthcare and wellbeing services for all community members.

Healthy CT 2025 Goal:
Ensure all Connecticut residents have knowledge of, and equitable access to, affordable, comprehensive, appropriate, quality healthcare.

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**STRATEGY:** Support pediatric services offered in community settings to address areas of SDoH need.

**Initiative:** Provide pharmacy prescription at the Children’s Hospital prior to discharge to families with limited pharmacy access to support positive outcomes and prevent re-admissions.

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**STRATEGY:** Design community based programs targeted to heart/vascular health issues.

**Initiative:** Expand barbershop initiative to provide community education on blood pressure management.

**Initiative:** Provide blood pressure cuffs to patrons and shop owners.

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**STRATEGY:** Increase access to oncology services.

**Initiative:** Increase transportation options for patients in need and expand across system.

**Initiative:** Increase free and low cost community screening events.

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**STRATEGY:** Reduce barriers to care by assessing social drivers of health (SDoH).

**Initiative:** Screen patients for barriers to care and social drivers of health.

**Initiative:** Refer and connect patients to hospital and community resource programs.

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**STRATEGY:** Expand access to services and care for underserved populations.

**Initiative:** Provide follow-up care for patients challenged with continuity of care.

**Initiative:** Expand use of telehealth, in-home, and in-community care to underserved members.

**Initiative:** Provide broadband services to patients without personal broadband access to facilitate care via telehealth services through Federal Communication Commission (FCC) grant.

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**STRATEGY:** Provide access to health care and services and support underserved populations.

**Initiative:** Continue to provide free care and Medicaid services to those eligible.

**Initiative:** Provide educational support and financial assistance to uninsured patients.

**Initiative:** Assist and enroll individuals in appropriate healthcare programs: Federally Qualified Health Centers (FQHC,) hospital clinics, Medicaid, Medicare, and other programs.

**Initiative:** Increase residents’ awareness of free and low cost health care resources/options.

**Initiative:** Offer financial assistance information in English and Spanish.

**Initiative:** Provide access to prescription and medication assistance programs.
**STRATEGY:** Collaborate with community partners to promote access to care, services, and resources.

- **Initiative:** Provide in-kind and financial support to Greenwich Community Health Improvement Partnership (GCHIP) and Council of Community Services (CCS).
- **Initiative:** Participate, co-host, and sponsor events and programs with community partners.
- **Initiative:** Collaborate with community organizations to conduct health screenings at diverse locations.

**STRATEGY:** Promote Diversity, Equity, Inclusion & Belonging (DEIB) practices to reduce discrimination and decrease linguistic and cultural barriers.

- **Initiative:** Ensure health communications are inclusive for diverse needs of residents (multiple languages, Braille, American sign language etc.).
- **Initiative:** Implement education for staff regarding access for language and translation interpretation services.
- **Initiative:** Conduct Diversity, Equity, Inclusion & Belonging (DEIB) initiatives for staff and community members.

**STRATEGY:** Prevent and reduce chronic disease (Diabetes, Cardio Vascular Disease, Stroke, Hypertension, Cancer).

- **Initiative:** Conduct prevention health education programs via Greenwich Hospital Speakers’ Bureau (Diabetes, CAD, Stroke, Hypertension, Cancer).
- **Initiative:** Collaborate with the Breast Cancer Alliance to conduct free mammogram program.
- **Initiative:** Provide disease specific support groups.
- **Initiative:** Enroll hypertension patients in need into BP self-monitoring education program and provide free BP monitoring equipment.
- **Initiative:** Conduct Nurse Is In programs to provide Know Your Numbers (KYN) health education and counseling.
- **Initiative:** Collaborate and support diabetes education programs.
- **Initiative:** Participate in WGCH Spotlight on Medicine Programs.
- **Initiative:** Provide the Connecticut Early Detection and Prevention Program (CEDPP).
- **Initiative:** Participate in Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN).
Behavioral Health: Healthy Minds

**Greenwich Hospital Goal:**
Increase capacity and equitable availability of behavioral health services and support resources.

**Healthy CT 2025 Goal:**
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. (A3.2)

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**STRATEGY:** Support the behavioral health needs of children.

**Initiative:** Embed behavioral health providers and care coordinators in the Pediatric Primary Care Center Fairhaven FQHC, with a warm handoff from the pediatrician, and expand where possible to other YNHHS primary care centers.

**Initiative:** Embed behavioral health providers in the YNHHS Pediatric Specialty Centers.

**Initiative:** Implement Zero Suicide Grant initiative awarded to Yale New Haven Children’s Hospital to improve access to services and coordinate care.

**Initiative:** Provide educational forums to pediatricians focusing on identification of needs and development of interventions to manage children’s behavioral health in their practices.

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**STRATEGY:** Support the behavioral health needs of oncology patients.

**Initiative:** Screen oncology patients for behavioral health and SDoH needs and provide referrals.

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**STRATEGY:** Provide integrated behavioral health services to patients that address mental health needs via LCSWs for short term therapies.

**Initiative:** Expand integrated behavioral health services from current Maternal Wellness and Digestive Health initiatives to other areas.

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**STRATEGY:** Increase understanding that mental health is a public health concern.

**Initiative:** Collaborate with community-based organizations (CBOs) to sponsor and provide Narcan and mental health educational programs.

**Initiative:** Provide in-kind and financial support and resources to behavioral health organizations.

**Initiative:** Collaborate with community partners to conduct and promote positive youth development program and services (YMHFA).

**Initiative:** Promote and support Diversity, Equity, Inclusion & Belonging (DEIB) and Pride events.

**Initiative:** Conduct Speakers Bureau education on:
- Suicide prevention and awareness.
- Anxiety and depression.
- Coping skills and strategies regarding resiliency, mindful meditation and stress reduction techniques.

---

**STRATEGY:** Increase and expand access to care and treatment options for substance misuse and psychiatric disorders.

**Initiative:** Provide behavioral health/substance misuse education, counseling services and treatment options (Suboxone medication) through the GH Addiction Recovery Center (ARC)/Psych Dept. Program.

**Initiative:** Screen patients for barriers to care and provide referrals and resources.

**Initiative:** Assist and connect patients to hospital and community resources and services.

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**STRATEGY:** Expand access to community-based behavioral health services.

**Initiative:** Partner with local agencies to refer patients seeking behavioral health services and connect to providers.

**Initiative:** Include Greenwich Hospital ED physician to serve on town’s Greenwich Suicide Prevention Task Force.
Healthy Living

**Greenwich Hospital Goal:**
Achieve equitable life expectancy for community members through availability and coordination of healthy living services and resources.

**Related Healthy CT 2025/SHIP Objective:**
Assess the availability and diversity of and coordination among primary care providers, community partners, and care management services. (A5.2)

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**STRATEGY:** Promote health and wellness programs.

**Initiative:** Collaborate with community organizations to conduct health programs at diverse locations.

**Initiative:** Provide evidenced based resources and materials.

**Initiative:** Provide the Nurse Is In Program.

**Initiative:** Conduct Injury Prevention Programs.

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**STRATEGY:** Promote a culture of healthy living to reduce chronic disease.

**Initiative:** Conduct Speakers’ Bureau prevention education lectures to promote awareness of risk factors.

**Initiative:** Collaborate and conduct healthy lifestyles programs with community partners.

---

**STRATEGY:** Support community organizations and events that provide access to healthy food.

**Initiative:** Donate unused/unsold food to food programs.

**Initiative:** Promote awareness and availability of local food pantries.

**Initiative:** Conduct healthy food drives to support local food programs.

**Initiative:** Offer healthy food options in the cafeteria for patients, staff, and visitors.
Community Partners:
Thank you to our community partners that provide guidance, expertise, and ongoing collaboration to foster collective impact in improving the health and wellbeing of the Greenwich and Port Chester communities.

Greenwich Community Health Improvement Partnership (GCHIP) and Council of Community Services (CCS)

- Abilis
- Boys and Girls Club of Greenwich
- Byram Shubert Library
- Cancer Care
- Child Guidance Center
- Community Aiders
- Cos Cob Library
- DMHAS
- DMHAS F.S. DuBois Center
- Family Centers Health Center (FQHC)
- First Congregational Church
- Get Healthy CT
- Global Health Systems Consultants, LLC
- Greenwich Board of Education/ Greenwich Public Schools
- Greenwich Chamber of Commerce
- Greenwich Commission on Aging
- Greenwich Department of Health
- Greenwich Department of Human Services
- Greenwich Department of Parks and Recreation
- Greenwich Emergency Management Services
- Greenwich Hospital
- Greenwich Hospital Center for Behavioral
- Greenwich Hospital Center for Behavioral & Nutritional Health
- Greenwich Hospital Outpatient Center
- Greenwich Library
- Greenwich Police Department
- Greenwich Private Schools (Brunswick)
- Greenwich Rotary Club
- Greenwich Together
- Kids in Crisis
- Laurel House, Inc.
- Liberation Programs
- NAMI Stamford/Greenwich
- Neighbor to Neighbor
- Northeast Medical Group
- Optimus Healthcare
- Parkinson’s Body and Mind
- Pathways
- Perrot Memorial Library
- Resources to Recovery
- River House Adult Day Center
- Silver Hill Hospital
- Southwestern CT AHEC
- St. Catherine’s Church
- The Housing Authority of Greenwich
- The Rentrew Center of White Plains, NY
- United Way Greenwich
- YMCA of Greenwich
- YWCA of Greenwich
- The Hub: Behavioral Health Action Organization for Southwestern CT
- The Nathaniel Witherell Rehabilitation and Nursing Center
- The Rowan Center and Community Centers, Inc. of Greenwich (CCI)
- CCS
- Blind Brook Public School
- Don Bosco Parish
- Family Services of Westchester
- Forever Families through Adoption
- Greenwich Hospital
- Hispanic Resource Center
- Hudson Valley Health
- Human Development Services of Westchester
- Kiwanis Club Port Chester/Rye Brook
- KTI Synagogue
- Meals On Main Street
- NAACP
- Open Door Family Medical Center (FQHC)
- Port Chester - Rye Brook Public Library
- Port Chester Carver Center
- Port Chester Housing Authority
- Port Chester Police Department
- Port Chester Public Schools
- Port Chester Seniors
- Port Chester Village Board
- Port Chester-Rye Brook EMS
- RyeACT
- Rye Brook Public Library
- Rye Brook Chamber of Commerce
- Rye Chamber of Commerce
- Rye Police Department
- Rye Public Schools
- Rye Reading Room
- Rye Rotary Club
- Rye Seniors
- Rye YMCA
- St. Paul Church
- Staying Put in Rye and Enviros (SPRyE)
- The Osborne
- Westchester County Board of Legislators
- Westchester Department of Health

Research Partners:
Thank you to our research partners for their essential role in completing the 2022 CHNA.

DataHaven I ctdathaven.com
DataHaven conducted the DataHaven Community Wellbeing Survey (DCWS), a statistical household survey to gather information on wellbeing and quality of life in Connecticut’s diverse neighborhoods. The DCWS is a nationally-recognized program that provides critical, highly-reliable local information not available from any other public data source.

At DataHaven, our mission is to empower people to create thriving communities by collecting and ensuring access to data on wellbeing, equity, and quality of life. A 501(c)3 nonprofit organization and registered as a Public Charity with the State of Connecticut, DataHaven is a partner of the National Neighborhood Indicators Partnership, a learning network, coordinated by the Urban Institute, of independent organizations in 30 cities that share a mission to ensure all communities have access to data and the skills to use information to advance equity and wellbeing across neighborhoods.

Community Research Consulting I buildcommunity.com
CRC correlated data across all research efforts and facilitated multiple meetings with community partners and stakeholders. Applying insights from these sessions, CRC developed the CHNA report and led strategic planning in creation of the Community Health Improvement Plan (CHIP).

A woman-owned business based in Lancaster, Pennsylvania, Community Research Consulting (CRC) partners with our clients to build vibrant, healthier, sustainable communities. Our approach emphasizes wide participation in dynamic dialogue to both define and solve challenges with the people who experience them. Using quantitative and qualitative research methods, we conduct studies and develop solutions for community health, housing, socioeconomic disparities, capacity-building, population health management, and similar challenges. We specialize in transforming research into action through strategic planning, policy change, and collective impact.

Community Wisdom/NRC Health I nrchealth.com
Community Wisdom/NRC Health conducted community conversations through a series of interviews and surveys of 133 diverse community residents during March and April 2022 to collect feedback on community health priorities.

NRC Health helps partners know each person they serve—behaviors, preferences, wants, and needs—not as point-in-time insights, but as an ongoing relationship. Our approach to content development is guided by a single objective: information that will help our clients tangibly improve the experiences of the people they serve. We examine a broad variety of topics and share our point of view across formats, including the Community Wisdom Survey.
APPENDIX A:  
2019-2022 Community Health Improvement Plan Progress-to-Date

Greenwich Hospital Community Commitment
Greenwich Hospital is a 206-bed regional medical center serving Fairfield County, Connecticut and Westchester County, New York, and a member of Yale New Haven Health. It is a major academic affiliate of Yale School of Medicine and a member of Yale New Haven Health. Continuing our investment in long-term community health improvement, every year, we sponsor, develop, and participate in a wide array of community-based programs and services focused in five community benefit areas: guaranteeing access to care; advancing careers in healthcare; promoting health and wellness; building stronger neighborhoods; and creating healthier communities.

Preventive care saves lives. Greenwich Hospital is dedicated to the health and wellbeing of the many communities we serve. With a focus on preventive healthcare and wellness programs, the hospital provides a wide range of educational and health promotion programs across various departments and locations. We collaborate with community partners across our Connecticut and New York communities to meet the diverse needs of the communities we serve.

The Greenwich Hospital Board of Trustees is directly involved in and oversees community benefit activities thorough its Community Advisory Committee (CAC) subcommittee. The CAC is chaired by a member of the Board of Trustees and includes Greenwich Hospital senior leadership, in addition to representatives from diverse community organizations. The CAC is deeply engaged in the CHNA and CHIP and meets bi-annually to discuss community benefit strategies in response to identified health needs.

In addition to the CAC, Greenwich Hospital provides leadership and financial support for two local collaboratives: the Greenwich Community Health Improvement Partnership and the Council of Community Services (CCS) of Port Chester, Rye Brook, and Rye Town.

Greenwich Community Health Improvement Partnership (GCHIP)
GCHIP is a coalition of community leaders, health and wellness professionals, and social service providers who advocate for the physical and mental health of our communities. Through collaboration across diverse sectors, GCHIP shares resources and works to identify, prioritize, and improve the health of our community by providing educational programs and prevention services that promote health equity. Greenwich Hospital provides staff and financial support for the GCHIP. Greenwich Hospital representatives co-chair the GCHIP and lead monthly partnership meetings. A list of GCHIP member organizations is provided on page 46.

Council of Community Services (CCS)
CCS was founded in 1974 by a group of concerned citizens who believed that more community awareness and participation was necessary to meets the needs of all local residents, regardless of race, age, or income. The Council has grown over the past 45 years and today it continues to bring together an array of community members, organizations, and agencies to promote effective services and community integration. Greenwich Hospital provides staff and financial support for CCS and its health and wellness initiatives. CCS meets monthly in Westchester, NY and a Greenwich Hospital representative serves as a board member. The Council has approximately 15 board members that collaborate with other community organizations toward the mission of bringing together community leaders and linking people with the resources they need. A list of CCS member organizations is included on page 46.

Greenwich Hospital, GCHIP, and CCS collaborate on the Community Health Improvement Plan. This partnership results in collective impact that produces change through shared goals and coordinated initiatives. In 2019, Greenwich Hospital along with local health departments, GCHIP, and CCS members completed a CHNA and a prioritization process to identify priority health issues. From this work, three areas of focus were selected: Access to Care, Healthy Lifestyles, and Behavioral Health. A CHIP was developed to guide individual and collective work among the hospital and community partners in addressing these health needs.

From 2019-2022, Greenwich Hospital and its partners made significant progress towards the CHIP goals, conducting a myriad of education and outreach activities, community engagement initiatives, and events to increase awareness and expand access to community services.
Highlights of overall accomplishments include the following activities:
+ Provided hundreds of health screenings, educational programs, and community events to help community members better understand and manage their health.
+ Assisted in the creation of the CCS 10573 website resources directory.
+ Provided a collaborative, coordinated response to COVID-19 including education, testing, vaccination, and increased access to food and essential supplies; created an online COVID-19 resource page.
+ Launched GCHIP website to share important and ever-changing information relevant to health with our partners and communities; expanded social media to include Facebook.
+ Provided hundreds of pounds of food to local food banks and organizations to reduce food insecurity.

The following pages outline the services and initiatives provided by Greenwich Hospital, GCHIP, and CCS, the progress we made toward the goals in the 2019-2022 CHIP, and the efforts to respond to COVID-19 which redirected our resources.

Access to Care Accomplishments

Goal: By February 2022, increase adults who have a regular source of care in the Greenwich and Port Chester area by 2%.

Greenwich Hospital Initiatives
+ Smilow Cancer Center Programs: The Center provided free cancer screenings including prostate, mammogram, head, and neck; conducted dozens of speakers’ bureau and lectures on safety, risk factors, wellness, and treatment; held numerous cancer support groups; and hosted the Cancer Survivor Fair.
+ The Nurse Is In Program: This program providing free blood pressure screenings with health education and counseling to community members at health fairs and diverse community sites like the library, thrift shops, YMCA, and Senior Centers.
+ Parish Nurse Program: In collaboration with the First Congregational Church of Greenwich, a registered nurse conducts screenings, coordinates support groups, holds health education programs, provides flu shots, coordinates blood drives, and serves as confidant for over 2,000 church members.
+ Know Your Numbers: Free metabolic screenings conducted at hospital and other community sites to promote and provide to access to care; screenings included Body Mass Index, Blood Pressure, and Metabolic screening (Cholesterol, HDL, LDL, Triglycerides, and Glucose).
+ Health Fairs: Held health fairs including the Teddy Bear Clinic and Heart and Stroke Fair in collaboration with various healthcare professionals to promote interactive health and wellness education; more than 1,800 community residents attended; free metabolic screenings and resources were provided by healthcare professionals.

+ Consumer Health Librarian Programs: Greenwich Hospital provides a free medical library and onsite librarians to assist patients learn about their health. The library program offered multiple education programs for the community on topics including Alzheimer’s disease, chronic pain, sleep, alcohol abuse, prostate care, kidney disease, and palliative care.
+ Support Groups: Facilitated dozens of support groups including Better Breathers, Caregivers, Chronic Pain, Diabetes, Guillain-Barre, Heart, Parkinson’s Disease, Multiple Sclerosis, and Stroke.
+ Speakers’ Bureau and Lectures: Conducted more than 30 speaking presentations to diverse community groups; topics included safety, risk factors, health and wellness, and treatment.

Partnership Initiatives
+ Health Fairs: Collaborated with multiple community organizations to co-host 11 health fairs in Connecticut and New York to promote access to health resources, regional service providers, and healthy lifestyles.
+ DEI Training: Partnered with United Way of Greenwich, the Greenwich YWCA, and the LGBTQ Transgender/Gender Non-conforming Support Group to provide Culturally and Linguistically Appropriate Services (CLAS) cultural diversity and inclusion trainings.
+ Promoted Access to Dental Care: Conducted oral health seminar and provided resources on regional dental health services; distributed Guide to Oral Health Brochure to promote dental hygiene and care.
+ Explored access to care gaps: researched specialty care capacity in Lower Fairfield County for Medicaid, Medicare, and underinsured patients; conducted interviews and developed surveys to understand provider perspectives; the subcommittee will continue to determine interventions for limited access to care and develop strategies to increase patient access to specialist care.
Hosted community-based awareness and education programs: activities included

- Co-sponsored Relay for Life with American Cancer Society (ACS) to raise funds for the ACS.
- Held Great American Smoke-Out Program with American Cancer Society at local libraries and area schools.
- Supported initiatives in Port Chester and Mamaroneck to create school-based gardens and safe routes to schools.
- Participated in Westchester aging-in-place initiatives to assist older adults remain in their community.
- Co-sponsored American Cancer Society and American Heart Association fund raising events.
- Supported Family Centers Health Care request for a grant to obtain a Nurse Care Coordinator to promote, increase, and coordinate referrals between the FQHC, outside specialists, and behavioral health providers.
- Created a list of specialists who participate in Medicaid, Medicare, and/or discounts for uninsured with details of hours of operation, days, and locations.
- Facilitated coordination between Family Centers Health Care and Greenwich Hospital free mammogram programs.
- Family Centers Health Care Substance Misuse Educator and AmeriCorps staff member worked with Boys and Girls Club and YMCA to promote FQHC services and educational programs.
- Promoted availability of FQHC services for underinsured and underserved community.
- FQHCs worked closely with area hospitals to refer patients for COVID-19 testing. Provided telehealth appointments and triaged care to offset the use of vital hospital beds and resources for low level care.
- Family Centers Health Care provided information about the Medicare 340b Pharmacy Program to patients through mail and phone outreach to educate them about pharmacy saving programs and delivery services.
- FQHCs developed relationships with Uber Health and Lyft Health for low cost transportation services which has created cost savings and convenience for patients.
- Promoted the Town of Greenwich Transportation Association of Greenwich (TAG) program, which serves differently abled Greenwich residents of all ages with dignity and respect by providing specialized free, safe, and reliable transportation.
- GCHIP and CCS works in collaboration with SPRYE, the Greenwich Commission on Aging, and other organizations to support older adults to age-in-place, including transportation options and services. TAG employees and SPRYE volunteers helped deliver groceries to residents during the COVID-19 crisis.
- Distributed Silver Hill Hospital Support Group Resource Directory.
- GCHIP co-hosted a program with the Greenwich Commission on Aging to provide education and awareness about the COVID-19 vaccination to encourage the elderly population to get vaccinated.

Behavioral Health Accomplishments

Goal: By February 2022, there will be a 2% increase in adults in the Greater Greenwich region indicating that they receive the social-emotional support they need.

Greenwich Hospital Initiatives

- The Addiction and Recovery Center (ARC): Offered options to people seeking high-quality alcohol and substance abuse treatment. ARC’s continuum of care includes initial stabilization, early recovery skills, an intensive outpatient program, individual therapy, medication consultation, family education, and counseling. Program counselors are graduate level and licensed in substance abuse, social work, and family therapy.
- Outpatient Behavioral Health Program: provided medication and individual therapy to adults of all ages with a wide range of psychiatric diagnoses including depression, anxiety, bipolar, psychotic disorders, and patients who are facing challenges unique to the aging process.
- Promoted and supported community programs: YMCA Livestrong Foundation Partners in Healing the Whole Person; Shakers Anonymous (Parkinson’s support); teen anti-violence awareness; Drug Abuse Resistance Education (DARE) school-based substance abuse prevention program; The HUB Mental Health and Substance Use Resources; NAMI Southwest CT Treating Bipolar Disorder program; Stop the Mental Health Stigma with PTA Greenwich Council, Greenwich Together, and Kids in Crisis.
- Hosted and facilitated support groups: Alcoholics Anonymous (AA), Al-Anon, Drugs Anonymous (DA), LifeRing, Sleep Support Group, Caregiver Café, NAMI Mental Health Support Group (NAMI), Coping with Loss, Bereavement Support Group, Perinatal Bereavement Support Group, Den For Grieving Kids, Smilow Cancer Hospital Tobacco Cessation Treatment Program and Support, and Mental Illness Family-to-Family 8-week course.
APPENDIX A: 2019-2022 Community Health Improvement Plan Progress-to-Date

+ **Speakers’ Bureau and Lectures:** Conducted presentations to diverse community groups including nutrition and mental health, addiction, health and wellness, medications for anxiety, vaping and marijuana, and other topics.

+ **Provided Stress Reduction Programs:** Conducted mindful meditation programs to reduce and manage stress and promote physical and mental wellbeing. Offered yoga and Tai Chi programs to promote physical and mental well-being. Programs included Healing Touch; Meditation and Relaxation Techniques; Mindfulness to Manage Migraines and Stress; Rest and Restore with Sound Healing Meditation; Befriending Stress for a Healthy Heart; and Pause for Peace with Divine Sleep Yoga Nidra.

+ **Community Addiction and Recovery Education & Support (C.A.R.E.S.) group aligned with Confidant Health to provide education, empowerment, and resources to families and friends of those struggling with substance use disorder.

+ **Supported Liberation Programs advocacy effort to ban flavored vapes and tobacco products.**

+ **Conducted Annual Drug Take Back Day with Town of Greenwich, Police Department, and Greenwich Together.**

+ **Established a book club for older adults to socially connect during the pandemic; purchased books for organizations that support older adults to continue the book club.**

+ **Conducted diversity, equity, and inclusion education programs for employees to promote respectful cultural interactions and positive communications/behaviors.**

+ **Expanded Employee Assistance Programs to provide behavioral health services for employees and their family members.**

+ **A Greenwich Hospital psychiatrist was appointed to serve on the Town of Greenwich Suicide Prevention Task Force.**

**Healthy Lifestyles Accomplishments**

**Goal:** By February 2022, there will be a 2% reduction in CVD risk factors among adults in the Greater Greenwich region.

**Greenwich Hospital Initiatives**

+ **Health and Wellness Programs:** Greenwich Hospital collaborated with area healthcare educators and community partners to help develop wellness and health promotion programs to our diverse community members.

+ **Smilow Cancer Hospital Tobacco Treatment Program:** An evidence-based smoking cessation program that is designed to help smokers addicted to nicotine to stop smoking. The program includes intervention activities, problem-solving skills, social support, and medication education.

+ **Diabetes Self-Management Programs:** Certified diabetes educators provided individual and group counseling, education, and support to self-manage Types 1 and 2 diabetes control glucose levels and ways to reduce the risk of complications through food, physical activity, and medication.

+ **Scout Medical Explorers:** After-school program sponsored in partnership with the Greenwich Boy Scouts of America which gives an in-depth view of various healthcare careers.

+ **Kids in the Kitchen:** Annual program conducted at youth-based community centers and schools to promote health and wellness by teaching and empowering youth to make healthy lifestyle choices in order to prevent obesity and its associated health risks.
Partnership Initiatives

+ **Automated Blood Pressure equipment:** Donated and distributed 100 automated Blood Pressure equipment for low income residents to self-monitor their blood pressure.

+ **Health Care Careers Programs:** The four-week, after school program between Greenwich Hospital and high schools aimed to educate and inspire students to pursue fulfilling healthcare careers. Promotes healthy lifestyle education (smoking prevention and healthy diets).

+ **Heart and Stroke Fair:** Event held annually by healthcare professionals to provide Know Your Numbers free metabolic screenings and cardiovascular education and resources.

+ **Speaker's Bureau Lectures:** Conducted presentations to diverse community groups; topics included nutrition and exercise, risk factors for disease, chronic disease management, and other health and wellbeing education.

+ **Injury Prevention Programs:** Provided 15 educational presentations about in-home safety, fall prevention for older adults, car seat and bicycle safety, workplace safety, and related topics.

+ **Free Health Resources:** The Hospital provided free evidence-based information and resources to the community on topics like healthy eating, stroke awareness, cancer prevention, and exercise.

**APPENDIX A:** 2019-2022 Community Health Improvement Plan Progress-to-Date

- Health and Wellness Education Programs: held in-person and virtual seminars to increase knowledge and understanding of health topics including nutrition and exercise, healthy grocery shopping, vaping, and sun safety.

- Increased access and availability of free healthy food distribution: Collaborated with local food pantries including Carver Center, Caritas, and Neighbor to Neighbor (N2N) to provide a healthy food donation list using Choose Healthy Eat Well (CHEW in English and Spanish) and provide health education. Developed and distributed a Greater Greenwich Farmers’ Market list. Initiated and cultivated community gardens at senior centers, low-income housing developments, and area schools. Inventoried and disseminated information about Community Gardens in Greenwich.

- Developed community-wide distribution channels to disseminate health information: Distributed Get Healthy CT website resources; promoted community resources listed on local town recreational websites; created and distributed directory of food banks and community gardens.

- Promoted oral health: Conducted Mind-Body-Mouth seminars that included information on the impact of oral health on the cardiovascular system, oral hygiene screenings, educational materials, and free dental supplies for participants. Provided free toothbrushes, toothpaste, floss, and mouthwash at area soup kitchens.

- Held free health screenings: Collaborated with Town of Greenwich Department of Health to conduct free screenings and education at libraries, senior centers, subsidized housing, and other community-based organizations that reach underserved populations. Conducted free metabolic screenings at Greenwich Hospital Heart and Stroke Fair, Greenwich Senior Wellness Fair, the Byram Library Health Fair, and participated in the Health and Wellness Lifestyle Expo. Supported and conducted AHA Check-IT programs.

- Promoted and shared health education: Collaborated with community partners to collectively share and distribute evidence-based resources such as AHA Life’s Simple 7, My Plate, ASA Stroke Awareness, BE F.A.S.T., DASH diets, ADA, USDA, and CDC information at health fairs and community events. In partnership with Westchester Public/Private Partnership (WPPP) conducted a Telehealth Intervention Program for Seniors (TIPS) in Port Chester, NY. Promoted Greenwich Together Let’s Mention Prevention: Risks of Underage Drinking and Hosting Underage Drinking.

- Promoted local resources to support healthy lifestyles: Supported and advertised the Rye YMCA Diabetes Prevention Program to prevent prediabetes and diabetes; created and distributed a Greater Greenwich Diabetes Resource Directory; promoted community health and exercise programs including Greenwich and Rye YMCA, Greenwich YWCA, Greenwich Boys and Girls Club, Port Chester Carver Center, and senior centers.

- Provided Chronic Disease Management Programs: conducted free in-person and virtual education programs including How Sweet It Is: Managing My Diabetes; American Association of Diabetic Educators Diabetes Prevention Program; Department of Public Health chronic disease self-management programs.

- Supported community-wide events to promote health awareness: Supported, participated, and promoted American Cancer Society Breast Cancer Alliance and American Heart Association walks. At community health fairs distributed over 2,000 free pedometers to encourage community members to walk, track their steps, and reach the American Diabetes Association’s (ADA) goal of 10,000 steps per day.

- Provided education and programming for older adults: In collaboration with the Port Chester Senior Center, Greenwich Hospital offered free sound meditation and chair exercises to NY residents; provided educational programs, health screenings, and information for older adults.
COVID-19 Response

As the COVID-19 pandemic hit in March 2020, Greenwich Hospital collaborated with community partners to fight a common enemy we could not see and knew little about. COVID-19 put an enormous strain on our community members, who were struggling to survive even before the pandemic. National shortages of food and supplies, like hand sanitizer, wipes, soap, shampoo, and face masks, made it difficult to obtain essential items. Vulnerable populations were particularly impacted and sought help from local food banks, social service agencies, and healthcare providers. Greenwich Hospital, GCHIP, and CCS responded swiftly and effectively to meet the needs of our communities. Some of our specific activities are outlined below.

Greenwich Hospital Initiatives

+ In July 2020, Greenwich Hospital organized a food drive among hospital employees and donated thousands of pounds of food to two community food banks: Neighbor to Neighbor in Greenwich and Caritas in Port Chester, New York. The food donation was a way for the hospital and staff to thank our communities for supporting healthcare workers during COVID-19. The food donations filled hundreds of grocery bags and were delivered to homes every week.

+ To reduce food insecurity, Greenwich Hospital reached out to soup kitchens, food banks, and senior centers with food donations and provided financial support.

+ In February 2021, Greenwich Hospital employees participated in the YNHHS GiveHealthy virtual healthy food drive to support Caritas and Neighbor to Neighbor food banks.

+ Provided preschool programs and youth organizations with in-kind donations of healthy snacks, diapers, wipes, cereal, books, toys, pens, pencils, crayons, coloring books, first aid kits, masks, toothbrushes, toothpaste, soap, and hand-sanitizers.

+ Provided financial donations for low-income children to attend after-school and summer day camp programs.

+ Fostered collaboration between FQHCs, health departments, National Guard, and hospitals to promote COVID-19 testing and vaccine events.

+ Recognizing the hardships faced by homebound older adults, Greenwich Hospital provided financial assistance to organizations that serve older adults for programming to reduce social isolation. Books were purchased and a virtual book club was created to connect seniors via virtual technology.

+ To curb the transmission of COVID-19, Greenwich Hospital collaborated with local health and government organizations to disseminate over 10,000 CDC flyers in English and Spanish to schools, faith-based organizations, and food pantries. The flyers highlighted the benefits of mask-wearing, social distancing, proper hand hygiene, testing sites, and the availability of vaccines.

+ To address the spread of misinformation and reduce vaccine hesitancy, Greenwich Hospital medical staff conducted several virtual lectures to provide evidence-based education about COVID-19 prevention, testing, care, treatment, and types of vaccines.

+ Greenwich Hospital played a key role in testing and vaccination efforts. Approximately 122,000 COVID-19 tests were administered in 2020 and 77,000 since January 2021. A total of 49,000 vaccines were administered in the region at our mass vaccination sites. To encourage COVID-19 testing, the hospital rented outdoor heaters for our community FQHC partners’ sites to keep residents warm while waiting on lines.

+ The Greenwich Hospital Parish Nurse program organized church staff and volunteers to make wellness checks via telephone to vulnerable parishioners to ensure they had access to food, groceries, medicines, and socialization. Parishioners received weekly emails with continually updated information about CDC recommendations, quarantine tips, and testing sites; video messages were posted on the church’s YouTube channel. Printed copies of the emails were mailed to individuals who did not have access to email. The Parish Nurse also assisted with online vaccination scheduling. Medicare Part D assistance was transitioned from in-person to telephone or video meetings. Support groups and health education lectures were offered virtually.

By partnering with our diverse community partners, Greenwich Hospital made it easier for struggling families to navigate through tough COVID-19 times.
GREENWICH HOSPITAL CENTERS AND SERVICES

APPENDIX A: 2019-2022 COMMUNITY HEALTH IMPROVEMENT PLAN PROGRESS-TO-DATE

Greenwich Hospital Centers and Services

+ Community Health at Greenwich Hospital: CH@GH is the community outreach department of Greenwich Hospital and is devoted to improving the health status of communities we serve through screenings, support groups, Speakers’ Bureau, health education, and wellness promotion programs.

+ Center for Healthy Living: The Richard R. Piviotto Center for Healthy Living focuses on rehabilitation, prevention, and wellness for patients with cardiovascular, pulmonary, and other chronic diseases and conditions. The Medical Fitness Program assists people with conditions such as diabetes, obesity, multiple sclerosis, cancer, osteoporosis, stroke, and Parkinson’s disease, and those who have had bariatric surgery. An exercise physiologist customizes a fitness plan for cardiovascular health and physical strength.

+ Center for Behavioral & Nutritional Health: Living with chronic and complicated medical conditions can be challenging. The Center’s mission is the promotion of health and wellness as well as the management and prevention of acute and chronic diseases. The Center offers scientifically and medically-based outpatient services for individuals struggling with their health or seeking to prevent future health problems. The team includes clinical psychologists, registered dietitians, and certified diabetes educators who offer scientifically and medically-based services. Programs conducted include a 12-Week Comprehensive Medical Weight-Loss Program and Diabetes Self-Management Programs. Certified Diabetes Educators (CDE) provide individual and group counseling, education, and support to people living with diabetes and prediabetes; teach self-management of Types 1 and 2 diabetes and how to control glucose levels; and promote risk reduction of diabetes complications through food, physical activity, and medication.

+ Greenwich Outpatient Center Programs: the Outpatient Center is a healthcare resource for Greenwich residents who are uninsured or underinsured. Each year, more than 5,000 adults and children visit the Outpatient Center and Pediatric Outpatient Center for medical treatment and preventive care.

+ Center for Healthy Aging Programs: the center helps older adults and their families access outpatient services designed to improve quality of life, including aging assessments, psychiatric screenings, programs, and support groups for family and caregivers.

+ Consumer Health Librarian: a librarian located at Greenwich Hospital encourages, enables, and supports patients, families, and the community to make informed decisions about their healthcare needs by providing evidence-based resources.

+ The Addiction Recovery Center (ARC): Offers many options to people seeking high-quality alcohol and substance abuse treatment. ARC’s continuum of care includes initial stabilization, early recovery skills, an intensive outpatient program, individual therapy, medication consultation, family education, and counseling. Both in-person and telehealth services are available. Program counselors are graduate-trained and licensed in substance abuse, social work and family therapy. Support groups and programs including Al-Anon, AA, Drugs Anonymous and Lifering are provided.

+ Smilow Cancer Center: The Smilow Cancer Hospital Care Center on the Greenwich Hospital campus provides access to expert cancer care and treatment to patients from lower Fairfield County, Connecticut, and Westchester County, New York. Comprehensive outpatient cancer services, including consultation, screening, diagnosis, treatment, and follow-up care are located in The Bendheim Building. Patients with a cancer diagnosis admitted to Greenwich Hospital are cared for by specially trained staff on a dedicated oncology unit.

+ Maternity Department Services: Greenwich Hospital provides a full range of expert medical services in a warm and supportive environment. The maternity services team includes high-risk pregnancy specialists, anesthesiologists, neonatologists, pediatricians, and nurses. All are committed to providing comprehensive care for women and babies before, during, and after pregnancy. Tender Beginnings Programs are conducted and include pregnancy and parenting programs to help families prepare for pregnancy, labor, delivery, and well-baby care.

+ Occupational Health Services: Greenwich Hospital’s Occupational Health Services offers employers in Fairfield and Westchester counties a comprehensive program to improve the health, safety, and productivity of their employees. It focuses on prevention and early intervention, and can tailor a medical program that fits a company’s specific needs.

+ Long Ridge Medical Center: Located in Stamford the center provides a range of coordinated services delivered by expert teams of providers in one convenient location. Greenwich Hospital and Yale Medicine offer specialty care for orthopedics, neurology, rheumatology, and physical and occupational therapy. Northeast Medical Group internal medicine providers offer primary care services for adults.

+ Heart and Vascular Center: The Heart and Vascular Center at Greenwich Hospital offers a complete range of diagnostic and interventional cardiac services and vascular care. Patients receive exceptional care from some of the nation’s top cardiologists through our center.
Pain Management: Greenwich Hospital Center for Pain Management offers highly individualized inpatient and outpatient care to help people lead productive, enjoyable lives, free of the complications of chronic pain. Because each person perceives pain differently, patients are encouraged to be active partners in their care. Continued personal involvement is key to proper diagnosis and the most successful treatment and rehabilitation possible. Whether pain is from surgery, illness, accident, or another cause, Greenwich Hospital’s pain specialists employ a wide variety of therapies to provide relief for specific condition.

Sleep Medicine: People who experience more than an occasional sleepless night know that lack of sleep is a serious problem and requires specialized attention. The Sleep Center at Greenwich Hospital, which is nationally accredited by the American Academy of Sleep Medicine, provides help to people of all ages who suffer from sleep problems.

Physical Medicine and Rehabilitation: (inpatient) Greenwich Hospital’s Acute Care Team consists of occupational and physical therapists as well as speech language pathologists who care for patients with a wide array of medical conditions resulting from injury, disease, and surgery. These specialists work hand-in-hand with the multidisciplinary team to develop a plan that is focused on improving a person’s level of function in order to facilitate a safe and speedy recovery.

Physical Medicine and Rehabilitation: (outpatient) at Greenwich Hospital offers specialized treatment at three convenient outpatient locations in the Greenwich/ Stamford area. Our team of highly skilled professionals complete a thorough evaluation and develop an individualized treatment plan. Treatments are one-on-one with a licensed professionals and include a combination of manual therapy, therapeutic exercise and modalities.

GI Center: The Department of Gastroenterology at Greenwich Hospital treats patients with conditions of the digestive tract, including stomach, intestines, esophagus, liver, and colon. This highly trained group of board certified physicians specializes in advanced techniques to diagnose and treat a range of conditions, providing patients with customized care.
One goal of the Community Health Needs Assessment (CHNA) is to understand the strengths, needs and challenges communities face. Needs can vary across individuals, organizations, neighborhoods and even cities. Various community-based resources including community leaders, policies, social service agencies and welcoming physical spaces help alleviate burdens and elevate the quality of life of residents. Identifying and sharing information on available, well-liked and frequently used community resources increases awareness of existing gaps and best practices.

**Methodology:**
Community assets were derived from research of the United Way 2-1-1 online database and additional internet research. The following tables list examples of community resources that are categorized into seven areas of community needs. These seven areas are:

- **Access to Care:** Resources providing various healthcare services, ranging from reproductive health, dental care, general community clinics, health screenings, etc.
- **Behavioral Health:** Resources helping to connect community members to mental health services as well as services that deal with supporting and treating those dealing with substance abuse.
- **Financial Assistance:** Resources helping to connect community members to employment opportunities and financial support programs.
- **Food Assistance:** Resources comprised of programs and initiatives that provide food and education surrounding nutrition to community members.
- **Housing/Utility Assistance:** Resources on housing placement assistance in case of emergencies including domestic violence and homelessness as well payment rent, mortgage and utilities affordability.
- **Promoting Wellness & Healthy Lifestyles:** Resources that have to do with positive and health lifestyles, such as physical activity (green space, fitness centers), youth & family enrichment, and/or community establishments that foster both connectivity and fellowship amongst members.
- **Transportation Assistance:** Resources on transportation assistance for general regional needs as well as health services and medical appointments.

The following community resources listed across each category is not an exhaustive list. To learn about or access any services within the Greenwich area, visit uwc.211ct.org or call 2-1-1 from any phone. To learn about or access any services within the Port Chester area, visit 211hudsonvalley.org or call 2-1-1 from any phone.
## Greenwich Access To Care

<table>
<thead>
<tr>
<th>Organizations</th>
<th>Contact Information</th>
<th>Key Information</th>
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</table>
| **Greenwich Hospital, Yale New Haven Health** | 77 Lafayette Pl, Greenwich, CT 06830  
(203) 863-3700  
ynhhs.org  
| **Greenwich Hospital, Yale New Haven Health** | 5 Perryridge Rd, Greenwich, CT 06830  
(203) 863-3000  
ynhhs.org  
| **Town of Greenwich** | 101 Field Point Rd, Greenwich, CT 06830  
(203) 622-6460  
greenwichct.gov/436/Finance  
Mon-Fri 8 am-4 pm | The Finance Department consists of Accounts Payable, Budgeting and Systems, Internal Audit, Risk Management, Treasury and administration of the town’s retirement plans. |
| **Town of Greenwich - Department of Human Services** | 101 Field Point Rd, Greenwich, CT 06830  
(203) 622-3715  
N/A  
| **Family Centers** | 111 Willow Peck Court, Greenwich, CT 06830  
(203) 717-1760  
familycenters.org  
Mon-Fri 9 am-5 pm | Opportunities Through Education. Health Care Connections. Thriving Families and Communities. |
| **Optimus Health Care** | 305 Boston Avenue, Stratford, CT 06614  
(203) 375-7242  
optimushealthcare.org | Patient-centered medical home for our communities to achieve and maintain a positive state of wellness, particularly for the uninsured and underserved |
| **Greenwich Hospital, Yale New Haven Health** | 5 Perryridge Rd, Greenwich, CT 06830  
(855) 547-4584  
ynhhs.org  
| **Call a Ride of Greenwich** | 37 Lafayette Pl, Greenwich, CT 06830  
(203) 661-6633  
callaridegreenwich.org  
Mon - Fri | Provides free door-to-door transportation for Greenwich ambulatory senior citizens over age 60. Any location within the Town of Greenwich for any purpose: doctors, drug stores, attorneys, banks, shopping, hair appointments, election polls, Greenwich Senior Center, and visiting with friends. |
| **Town of Greenwich** | 299 Greenwich Ave, Greenwich, CT 06830  
(203) 862-6710  
greenwichct.gov/148/Departments-A---L  
Depends on department | Assessor. Commission on Aging. Community Development. Conservation |
| **Transportation of Greenwich (TAG)** | 13 Riverside Avenue, Riverside, CT 06878  
(203) 637-4345  
www.ridetag.org | Provides free door-to-door transportation for Greenwich senior citizens over age 60 and people of any age that are disabled. Any location within the Town of Greenwich for any purpose: doctors, drug stores, attorneys, banks, shopping, hair appointments, election polls, Greenwich Senior Center, and visiting with friends. |
| **Greenwich Department of Health** | 101 Field Point Rd, Greenwich, CT 06830  
(203) 622-7836  
greenwichct.gov/575/Health-Department  
| **Greenwich Commission on Aging** | Various Senior Sites  
(203) 862-6710  
greenwichct.gov/678/Commission-on-Aging-Board  
Please see next column | Meetings  
8:30 a.m. to 10 a.m.  
10 months of the year  
3rd Wednesday of every month |
**APPENDIX B: Greenwich Community Resources**

<table>
<thead>
<tr>
<th>Organizations</th>
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<tbody>
<tr>
<td>Greenwich Department of Human Services</td>
<td>101 Field Point Rd Greenwich, CT 06830 203-622-3800 Mon-Fri 8:30 am-4 pm</td>
<td>To enhance the quality of life of Greenwich residents through support in meeting basic human needs and promoting services that foster self-sufficiency. These resources provide the support you may need, such as: Access to Health Care Services, Educational and Employment Opportunities, Food, Personal Safety, &amp; Shelter.</td>
</tr>
<tr>
<td>Abilis</td>
<td>50 Glenville St, Greenwich, CT 06831 (203) 531-1880 Mon-Fri 9 am-3 pm</td>
<td>Abilis provides assistance to adults and children with developmental disabilities and their families in lower Fairfield County, CT and parts of Westchester.</td>
</tr>
<tr>
<td>Pathways of Greenwich</td>
<td>175 Milbank Ave, Greenwich, CT 06830 (203) 641-7683 <a href="https://pways.org">https://pways.org</a></td>
<td>A Caring Path to Mental Health of Housing and Urban Development, the CT Dept. of Mental Health and Addiction Services, the United Way of Greenwich, and corporate and private donors.</td>
</tr>
<tr>
<td>The Osborn</td>
<td>125 Mason Street Greenwich, CT 06830 (203) 641-7683 <a href="https://www.theosborn.org/home-care/fairfield-county-ct">https://www.theosborn.org/home-care/fairfield-county-ct</a></td>
<td>The Osborn is a not-for-profit continuing care retirement community for seniors who want to pursue the next chapter of life on their own terms. Our community has abundant resources to keep you fit, stimulate your intellect and expand your social network.</td>
</tr>
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</table>

*These resource lists were compiled in summer 2021 and are not meant to be exhaustive. For additional resources, and the most up-to-date contact information, please visit 211ct.org.

**Greenwich Food Insecurity**

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<td>To enhance the quality of life of Greenwich residents through support in meeting basic human needs and promoting services that foster self-sufficiency. These resources provide the support you may need, such as: Access to Health Care Services, Educational and Employment Opportunities, Food, Personal Safety &amp; Shelter.</td>
</tr>
<tr>
<td>Connecticut Food Bank</td>
<td>2 Research Pkwy, Wallingford, CT 06492 (203) 469-5000 ctfoodbank.org Depends on Program</td>
<td>Commodity Supplemental Food Programs. Mobile Food Pantry,</td>
</tr>
<tr>
<td>Neighbor to Neighbor</td>
<td>248 East Putnam Ave Greenwich, CT 06830 (203) 622-9098 ntngreenwich.org Mon - Sat 8:30 am - 12:30 pm, Wed &amp; Thurs 3:30 - 5:30 pm</td>
<td>Supplemental Food. Summer Supplement. Emergency Food.</td>
</tr>
<tr>
<td>Meals on Wheels of Greenwich</td>
<td>89 Maple Ave Greenwich, CT 06830 (203) 869-1312 mealsonwheelsofgreenwich.org Mon - Fri 9:00 am-12:00 pm</td>
<td>At Meals-on-Wheels we provide meals to seniors, disabled and home-bound individuals in Greenwich who require home delivered meals. Our volunteers deliver the nutritious meals, a friendly visits and safety checks that enable the people in our community to live nourished lives with independence and dignity. We continue to serve the Greenwich community during the coronavirus pandemic.</td>
</tr>
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*These resource lists were compiled in summer 2021 and are not meant to be exhaustive. For additional resources, and the most up-to-date contact information, please visit 211ct.org.
## Greenwich Healthy Lifestyles

<table>
<thead>
<tr>
<th>Organizations</th>
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<tbody>
<tr>
<td>Mianus River Park</td>
<td>450 Cognewaugh Road Greenwich, CT 06807&lt;br&gt;www.friendsofmianusriverpark.org/</td>
<td>Mianus River Park is a 391 acre nature reserve on the Greenwich / Stamford border in Connecticut. The park, one of a series of green areas in the Mianus River Watershed, features a two mile stretch of the beautiful Mianus River, forest lands, vernal pools, glacial outcroppings, varied wildlife and miles of rolling trails.</td>
</tr>
<tr>
<td>Town of Greenwich</td>
<td>101 Field Point Rd Greenwich, CT 06830&lt;br&gt;(203) 633-7814&lt;br&gt;greenwichct.gov/148/Departments-A---L&lt;br&gt;Depends on Department</td>
<td>Parks Department.</td>
</tr>
<tr>
<td>Greenwich Hospital, Yale New Haven Health</td>
<td>5 Pereyridge Rd Greenwich, CT 06830&lt;br&gt;(203) 863-3756&lt;br&gt;ynhhs.org</td>
<td>Healthy Living Center focuses on rehabilitation, prevention and wellness for patients with cardiovascular, pulmonary and other chronic diseases and conditions.</td>
</tr>
<tr>
<td>Greenwich Hospital, Yale New Haven Health</td>
<td>55 Holly Hill Ln Greenwich, CT 06830&lt;br&gt;(203) 863-2939&lt;br&gt;ynhhs.org</td>
<td>Center for Behavioral and Nutritional Health mission is the promotion of health and wellness as well as the management and prevention of acute and chronic diseases. The Center offers scientifically and medically based outpatient services for individuals struggling with their health or seeking to prevent future health problems. The team includes clinical psychologists, registered dietitians and certified diabetes educators who offer scientifically and medically based services.</td>
</tr>
<tr>
<td>Greenwich Hospital, Yale New Haven Health</td>
<td>5 Pereyridge Rd Greenwich, CT 06830&lt;br&gt;(203) 863-4373&lt;br&gt;ynhhs.org</td>
<td>Center for Healthy Aging center for older adults and their families to access outpatient services designed to improve quality of life, including aging assessments, psychiatric screenings, programs and support groups for family and caregivers.</td>
</tr>
<tr>
<td>Banksville Community House</td>
<td>12 Banksville Rd Greenwich, CT 06831&lt;br&gt;(203) 622-9597&lt;br&gt;thebch.org</td>
<td>The Banksville Community House, Inc., founded in 1937, is a non-profit community organization serving children, adults, and families in the Greenwich, North Castle, and North Stamford communities.</td>
</tr>
<tr>
<td>Boys and Girls Club of Greenwich</td>
<td>4 Horseneck Ln Greenwich, CT 06830&lt;br&gt;(203) 869-3224&lt;br&gt;bgcgp.org&lt;br&gt;Hours Upon Inquiry</td>
<td>Boys &amp; Girls Club of Greenwich offers kids and teens in our community a safe place to play, laugh, discover, and learn through quality programs. These programs are open to all youth from ages 6 to 18 years old for an annual membership of $75. By focusing on academic support and enrichment, healthy lifestyles, and character development, we’re helping youth find – and achieve – bright futures.</td>
</tr>
<tr>
<td>Boy Scouts of America, Greenwich Council</td>
<td>63 Mason St Greenwich, CT 06830&lt;br&gt;(203) 869-8424&lt;br&gt;greenwichscouting.org&lt;br&gt;Mon-Fri 10 am-5 pm</td>
<td>Boy Scouts.</td>
</tr>
<tr>
<td>Greenwich Together</td>
<td>N/A&lt;br&gt;(203) 622 - 6556&lt;br&gt;greenwichtogether.org&lt;br&gt;Hours Upon Inquiry</td>
<td>Greenwich Together mobilizes youth, parents and community partners to prevent substance misuse, promote behavioral and mental health and strengthen healthy choices through positive youth, family, and community development.</td>
</tr>
</tbody>
</table>

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## Greenwich Housing Assistance

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<tr>
<th>Organizations</th>
<th>Contact Information</th>
<th>Key Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greenwich Housing Authority</td>
<td>249 Milbank Ave Greenwich, CT 06830 (203) 869-1138 greenwichcommunity.org Hours Upon Inquiry</td>
<td>Provides the ability to live in quality, affordable housing, giving residents access to opportunities, excellent schools, and all of the amenities this beautiful town of Greenwich has to offer.</td>
</tr>
</tbody>
</table>

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## Greenwich Substance Abuse

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<tbody>
<tr>
<td>Silver Hill Hospital</td>
<td>208 Valley Rd, New Canaan, CT 06840 (866) 542-4455 silverhillhospital.org</td>
<td>Silver Hill Hospital is a non-profit psychiatric hospital in New Canaan, Connecticut, established in 1931. The hospital is accredited by the Joint Commission and provides behavioral health care treatment. This includes psychiatric and addiction services.</td>
</tr>
<tr>
<td>Greenwich Department of Human Services</td>
<td>101 Field Point Rd Greenwich, CT 06830 (203) 622-3800 Mon-Fri 8:30 am-4:00 pm</td>
<td>Is to enhance the quality of life of Greenwich residents through support in meeting basic human needs and promoting services that foster self-sufficiency. Resources provide the support d, such as: Access to Health Care Services, Educational and Employment Opportunities, Food Safety &amp; Shelter.</td>
</tr>
<tr>
<td>Greenwich Together</td>
<td>N/A (203) 622 - 6556 greenwichtogether.org, Hours Upon Inquiry</td>
<td>Greenwich Together mobilizes youth, parents and community partners to prevent substance misuse, promote behavioral and mental health and strengthen healthy choices through positive youth, family, and community development.</td>
</tr>
<tr>
<td>Kids In Crisis</td>
<td>1 Salem St, Cos Cob, CT 06807 (203) 661-1911 <a href="http://www.kidsincrisis.org">www.kidsincrisis.org</a></td>
<td>Trained Crisis Counselors help children and families cope with unsafe situations, family conflicts, substance abuse, mental health issues.</td>
</tr>
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## Greenwich Mental Health Assistance

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<tr>
<th>Organizations</th>
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<tbody>
<tr>
<td>Child Guidance Center of Southern Connecticut</td>
<td>81 Holly Hill Ln Greenwich, CT 06830 (203) 324-6127 chldguidancect.org Mon-Thurs 8:30 am-7 pm, Tues, Wed 8:30 am-8 pm, Fri 8:30 am-5 pm</td>
<td>Transgender and Gender Expansive Youth. Crisis. Groups. Specialized Treatment. Prevention. Testing and Assessment.</td>
</tr>
<tr>
<td>Kids In Crisis</td>
<td>1 Salem St, Cos Cob, CT 06807 (203) 661-1911 <a href="http://www.kidsincrisis.org">www.kidsincrisis.org</a></td>
<td>Trained Crisis Counselors help children and families cope with unsafe situations, family conflicts, substance abuse, mental health issues.</td>
</tr>
<tr>
<td>Family Centers</td>
<td>20 Bridge St Greenwich, CT 06830 (203) 629-2822 familycenters.org Mon-Fri 9 am-5 pm</td>
<td>Opportunities Through Education. Health Care Connections. Thriving Families and Communities.</td>
</tr>
<tr>
<td>Child Guidance Center of Southern Connecticut</td>
<td>81 Holly Hill Ln Greenwich, CT 06830 (203) 324-6127 chldguidancect.org Mon-Thurs 8:30 am-7 pm, Tues, Wed 8:30 am-8 pm, Fri 8:30 am-5 pm</td>
<td>Transgender and Gender Expansive Youth. Crisis. Groups. Specialized Treatment. Prevention. Testing and Assessment.</td>
</tr>
<tr>
<td>Greenwich Hospital, Yale New Haven Health</td>
<td>5 Perryridge Rd Greenwich, CT 06830 (203) 863-3316 ynhhs.org</td>
<td>Center for Psychiatric and Behavioral Health.</td>
</tr>
<tr>
<td>Laurel House Resource Center</td>
<td>1616 Washington Blvd, Stamford, CT 06902 (203) 324-1816 <a href="http://www.laurelhouse.net/">http://www.laurelhouse.net/</a></td>
<td>Laurel House provides mental health resources to people coping with mental illness, and their families, across numerous communities in and around.</td>
</tr>
<tr>
<td>Greenwich Hospital, Yale New Haven Health</td>
<td>77 Lafayette Pl Greenwich, CT 06830 (203) 863-3704 ynhhs.org</td>
<td>Smilow Oncology/Cancer Support and counseling services.</td>
</tr>
<tr>
<td>National Alliance of Mental Illness NAMI</td>
<td>P.O Box 1582 New Canaan, CT 06840 203-482-6864 namisouthwestct.org</td>
<td>NAMI Southwest CT provides Mental Health Support Group for families and individuals affected by severe mental illness. We offer free support groups, education, and advocacy opportunities. Our programs provide judgment-free spaces for people to share experiences and resources.</td>
</tr>
<tr>
<td>Depression and Bipolar Support Alliance, Greenwich</td>
<td>27 Stag Ln Greenwich, CT 06831 (203) 661-8282 dbagsgreenwichct.com Friday’s 2:30 pm-4:30 pm</td>
<td>Several years ago, recognizing the need within our community, contact was made with the national organization and a chapter was started in Greenwich, Connecticut. We have been pleased both with the response to the program and with our ability to have helped hundreds of patients and family members. We hold weekly meetings on Fridays from 2:30PM-4:30PM in a lovely residence in Greenwich, CT.</td>
</tr>
<tr>
<td>Family Centers</td>
<td>20 Bridge St Greenwich, CT 06830 (203) 629-2822 familycenters.org Mon-Fri 9 am-5 pm</td>
<td>Opportunities Through Education. Health Care Connections. Thriving Families and Communities.</td>
</tr>
<tr>
<td>Greenwich Hospital, Yale New Haven Health</td>
<td>5 Perryridge Rd Greenwich, CT 06830 (203) 863-2939 ynhhs.org</td>
<td>Center for Behavioral and Nutritional Health mission is the promotion of health and wellness as well as the management and prevention of acute and chronic diseases. The Center offers scientifically and medically based outpatient services for individuals struggling with their health or seeking to prevent future health problems. The team includes clinical psychologists, registered dietitians and certified diabetes educators who offer scientifically and medically based services.</td>
</tr>
</tbody>
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## APPENDIX B: New York-Westchester Community Resources

### New York-Westchester Access to Care

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<tr>
<th>Organizations</th>
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<tbody>
<tr>
<td>Open Door</td>
<td>5 Grace Church Street 914-60-CARES (914-632-2737) <a href="https://opendoormedical.org/services/behavioral-health-services/">https://opendoormedical.org/services/behavioral-health-services/</a></td>
<td>For nearly 50 years, we’ve provided accessible, high-quality health care and wellness services, regardless of a patient’s ability to pay.</td>
</tr>
<tr>
<td>Senior Shuttle</td>
<td>222 Grace Church Street Port Chester, NY 10573 (914) 939-4975 <a href="https://www.portchesterny.gov/senior-community-center/pages/transportation">https://www.portchesterny.gov/senior-community-center/pages/transportation</a></td>
<td>Our twenty-four passenger bus makes it possible for residents to get to and from the Senior Center. For a reservation call 939-4975. The Port Chester Senior Center Nutrition Program and Transportation/Supportive Services are funded through the Village of Port Chester, the US Department of Health Shuttle is available to take residents to the grocery store on Mondays at 1pm. Fee: 25 cents Please call (914) 939-4975 for a reservation. Senior Shuttle is available to take residents to Dr.’s appointments Tuesdays - 210 Westchester Avenue. Pick up at your home - between 10:30-10:45 am. Drop off at 210 Westchester at 11 am. Pick up at 210 at 1 pm and return home. Please make your appointments between 11 am -1 pm. Wednesday- 3020 Westchester Avenue &amp; all other local Dr’s. Please make your appointment between 11am - 1pm. Call for reservations. New York State Office for the Aging and the Westchester County Department of Senior Programs and Services.</td>
</tr>
<tr>
<td>Westchester County Health Dept WIC Program</td>
<td>1 Gateway Plaza, 1st floor, South Main St., Port Chester, NY 10573 (914) 813-7244 <a href="https://health.westchestergov.com/services/locations">https://health.westchestergov.com/services/locations</a></td>
<td>WIC is the popular name for the Special Supplemental Nutrition Program for Women, Infants and Children and provides supplemental foods, nutrition education, and referrals for health care and other services. The WIC Program was established in 1974 to reduce infant mortality and improve the health of our nation’s children. Today, the WIC Program is considered one of the most successful, cost-effective and important nutrition intervention programs in the country. The Westchester County Department of Health WIC Program has been providing WIC services to the community since 1979 and currently serves approximately 8,000 participants annually.</td>
</tr>
<tr>
<td>SPRYE</td>
<td>55 S. Main St., 3rd Floor Port Chester, N.Y. 10573 914-481-5706 <a href="https://www.sprye.org/">https://www.sprye.org/</a></td>
<td>SPRYE is an effort by residents to create a support network for themselves and their peers. Our services/programs help them enjoy a satisfying lifestyle while continuing to live in their homes and communities.</td>
</tr>
<tr>
<td>Port Chester Senior Center</td>
<td>222 Grace Church Street. Port Chester, NY 10573 Monday - Friday 9:00 am to 4:00 pm Saturday 9 am- 3 pm <a href="https://www.portchesterny.gov/senior-community-center">https://www.portchesterny.gov/senior-community-center</a></td>
<td>The Village of Port Chester is committed to the well-being and improving the quality of life for its aging population. The program is open to all Port Chester residents who are age 60 or older. There are no income requirements or membership fee. Guests are welcome.</td>
</tr>
<tr>
<td>Rye Brook Senior Center-Anthony J. Posillipo Community Center</td>
<td>32 Garibaldi Pl, Rye Brook, NY 10573 (914) 939-7904 <a href="https://ryebrook.org/departments/senior-services/">https://ryebrook.org/departments/senior-services/</a></td>
<td>Rye Brook Seniors Program is to create an environment where older adults can congregate, receive services and participate in activities that will enhance their involvement in and with the community. Our objective is to institute a multi-dimensional program of activities for older adults that simultaneously satisfies the most active and the most passive aged and promotes lifelong learning.</td>
</tr>
</tbody>
</table>
## New York-Westchester Food Insecurity

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<tr>
<th>Organizations</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Don Bosco Soup Kitchen</td>
<td>22 Don Bosco Place, Port Chester, NY 10573&lt;br&gt;914-939-0323 x11&lt;br&gt;<a href="http://www.donboscocenter.org/don-bosco-soup-kitchen-and-food-pantry/">http://www.donboscocenter.org/don-bosco-soup-kitchen-and-food-pantry/</a>&lt;br&gt;Soup Kitchen: Monday through Friday, 11:30 am – 12:45 pm</td>
<td>Soup Kitchen serves breakfast and lunch.</td>
</tr>
<tr>
<td>Port Chester Friendly Fridge</td>
<td>400 Westchester Avenue&lt;br&gt;Port Chester, NY, 10573&lt;br&gt;(914) 305-6009&lt;br&gt;<a href="https://www.instagram.com/thepcfriendlyfridge/">https://www.instagram.com/thepcfriendlyfridge/</a>&lt;br&gt;All day every day</td>
<td>The fridge provides fresh/frozen foods for food insecure families. It is available to those in Port Chester every day and all day.</td>
</tr>
<tr>
<td>Carver Center- Carver Market</td>
<td>400 Westchester Avenue&lt;br&gt;Port Chester, NY, 10573&lt;br&gt;(914) 305-6009&lt;br&gt;<a href="https://carvercenter.org/market/">https://carvercenter.org/market/</a>&lt;br&gt;Mondays, Wednesdays and Fridays, beginning at 1:00 pm</td>
<td>The Carver Market provide vital food resources to food-insecure people. The Market supplements need for food, three days a week on Monday, Wednesday, and Friday afternoons.</td>
</tr>
<tr>
<td>Don Bosco Food Panty</td>
<td>22 Don Bosco Place, Port Chester, NY 10573&lt;br&gt;914-939-0323 x11&lt;br&gt;<a href="http://www.donboscocenter.org/don-bosco-soup-kitchen-and-food-pantry/">http://www.donboscocenter.org/don-bosco-soup-kitchen-and-food-pantry/</a>&lt;br&gt;Food Pantry: Saturday and Tuesday, 7 am – 9:30 am</td>
<td>Food Pantry.</td>
</tr>
<tr>
<td>Bread of Life</td>
<td>65 Orchard Ave, Rye, NY 10580&lt;br&gt;(914) 602-9753&lt;br&gt;<a href="http://www.givingtreeglobal.org/">http://www.givingtreeglobal.org/</a></td>
<td>Bread of Life is a 501c3 that provides food, clothing, and other help throughout Westchester County.</td>
</tr>
<tr>
<td>Meals on Main Street</td>
<td>P.O. Box 682&lt;br&gt;Port Chester, NY 10573&lt;br&gt;(914) 305-3967&lt;br&gt;<a href="https://www.mealsonmainst.org/virtual-food-pantry?q=virtua">https://www.mealsonmainst.org/virtual-food-pantry?q=virtua</a> l%20food%20pantry&lt;br&gt;Available Mon-Fri Morning or afternoon</td>
<td>Bags of groceries and frozen family style meals packed and delivered. You can request a one time, once a month, or once a week delivery until you cancel. Bags are left outside and you are called to let you know it has arrived.</td>
</tr>
<tr>
<td>Rye Presbyterian Church</td>
<td>882 Boston Post Rd, Rye, NY 10580&lt;br&gt;(914) 967-0842&lt;br&gt;www.ryepc.com</td>
<td>Food Pantry.</td>
</tr>
<tr>
<td>Christ’s Church Rye</td>
<td>2 Rectory St, Rye, NY 10580&lt;br&gt;(914) 967-1749&lt;br&gt;<a href="http://www.ccraye.org/">http://www.ccraye.org/</a></td>
<td>Food Pantry.</td>
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## APPENDIX B: New York-Westchester Community Resources

### New York-Westchester Healthy Lifestyles

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<tbody>
<tr>
<td>Crawford Park</td>
<td>122 North Ridge Street</td>
<td>Crawford Park covers more than 35 acres between North Ridge Street and Lincoln Avenue in Rye Brook. The site includes gardens, lawns, woods, a walking/jogging path, playing fields, an historic mansion - making it a unique resource for Port Chester, Rye Brook and surrounding communities.</td>
</tr>
<tr>
<td>The Port Chester Rec Dept.</td>
<td>222 Grace Church Street</td>
<td>The mission of the Port Chester Recreation department is to create and promote recreational, cultural and play opportunities for all Village residents and to enrich their lives by preserving and enhancing all of Port Chester’s parks and nature areas.</td>
</tr>
<tr>
<td>Rye Brook Rec Dept.</td>
<td>938 King St, Rye Brook, NY 10573</td>
<td>The Recreation Department offers a wide variety of programs ranging from pre-k to senior citizen adults. The activities are published in the Recreation brochure tri-annually.</td>
</tr>
<tr>
<td>Rye Rec Dept.</td>
<td>281 Midland Ave, Rye, NY 10580</td>
<td>The Rye Recreation Department strives to enrich the lives of our residents by providing safe and welcoming parks, facilities, recreation programs and events for people of all ages. We work in partnership with our residents and in cooperation with other recreation service providers in the community in order to maximize all available resources. We are dedicated to building healthy communities and enriching the quality of life through people, parks and programs.</td>
</tr>
<tr>
<td>Rye YMCA</td>
<td>21 Locust Ave, Rye, NY 10580</td>
<td>The RYE YMCA is a family-oriented community service organization which welcomes all people and promotes positive values through programs that build spirit.</td>
</tr>
<tr>
<td>Port Chester Youth Bureau</td>
<td>220 Grace Church Street</td>
<td>The Youth Bureau of the Village of Port Chester was established to organize and create a comprehensive plan to provide a positive road map focused on leading our youth towards a safe and successful path to adulthood.</td>
</tr>
<tr>
<td>Carver Center</td>
<td>400 Westchester Avenue</td>
<td>Carver Center, acts as a community resource for Port Chester, N.Y., by providing educational programs and services to help children and youth maximize their potential for growth and self-sufficiency. Its after school program for children ages 6 to 12 years provides daily homework assistance to support the children in meeting their academic responsibilities. Aquatic programs and camp programs. The Carver Center pool in the Village of Port Chester provides an outstanding recreational experience for people of all ages. Private or group swim lessons and lifeguard certifications are available.</td>
</tr>
<tr>
<td>Westchester County Parks</td>
<td>450 Saw Mill River Rd Ardsley, NY 10502</td>
<td>Westchester County Parks’ mission is to create life-enriching experiences at safe, clean, affordable parks and preserve our natural resources through responsible leadership.</td>
</tr>
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### New York-Westchester Housing Assistance

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<tr>
<td>Port Chester Housing Authority</td>
<td>2 Weber Drive</td>
<td>PCHA is a local agency that receives financial assistance from the United States Department of Housing and Urban Development (HUD). The housing authority’s inventory consists of five developments: Midland Court, a 120 unit family development, Harborview and Parkview, each a 48 unit family development, and Drew Gardens and Brooksville Terrace, each a 62 unit senior citizen development.</td>
</tr>
<tr>
<td>Westchester County Housing Program</td>
<td>148 Martine Avenue, White Plains, NY 10601</td>
<td>Westchester County Housing Programs are designed to support Westchester County’s commitment to promoting fair and equitable housing across its six cities, 19 towns and 20 villages. Westchester County has been at the forefront of fair and affordable housing development, winning more than 50 awards in the process. Westchester is one of the most diverse counties in New York State, which is one of our greatest strengths. Diversity enhances our quality of life every day by attracting talented people, stimulating creative thinking, and promoting tolerance and understanding. The Housing Programs website offers a wealth of information on the specifics of Fair and Affordable Housing, Fair Housing laws and Fair Lending laws, and how to find accessible housing, among other topics.</td>
</tr>
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**APPENDIX B: New York-Westchester Community Resources**

### New York-Westchester Mental Health

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<tr>
<td><strong>Family Services of Westchester (FSW)</strong></td>
<td>One Gateway Plaza, Suite 3B Port Chester, NY 10573 914-305-6837</td>
<td>Family Services of Westchester’s seven Family Mental Health Centers are licensed by the New York State Office of Mental Health to offer comprehensive mental and behavioral health services at convenient locations throughout Westchester County. Each Family Mental Health Center is staffed by a highly trained team of social workers, psychologists and psychiatrists who are committed to offering confidential, customized care that’s tailored to your (and your family’s) needs. Our Family Centers offer therapy in English, Spanish, Portuguese, French, Swedish, German, Farsi and more.</td>
</tr>
<tr>
<td><strong>Open Door</strong></td>
<td>5 Grace Church St 914-OD-CARES (914-632-2737)</td>
<td>Behavioral Health is available to all Open Door patients. We provide: Psychiatry, Individual therapy, Family therapy, Play therapy, Group therapy, Substance Use Disorder Services.</td>
</tr>
<tr>
<td><strong>The Renfrew Center of White Plains</strong></td>
<td>1025 Westchester Avenue Suite 210 White Plains, NY 10604 <a href="https://renfrewcenter.com/">https://renfrewcenter.com/</a> 1-800-RENFREW</td>
<td>The Renfrew Center of White Plains, New York is an outpatient facility specializing in the treatment of anorexia, bulimia, and binge eating as well as the full range of eating disorders. We reinforce a sense of community by helping patients recognize shared themes and struggles. Programming at the White Plains location consists of a comprehensive range of in-person and virtual options including Day Treatment, Intensive Outpatient and Outpatient Services.</td>
</tr>
<tr>
<td><strong>St. Vincent’s Hospital Westchester</strong></td>
<td>275 North St, Harrison, NY 10528 (914) 967-6500 <a href="http://www.stvincentswestchester.org">www.stvincentswestchester.org</a></td>
<td>St. Vincent’s Hospital Westchester offers inpatient and outpatient mental health and addiction treatment services at its campus in Harrison.</td>
</tr>
<tr>
<td><strong>Greenwich Hospital, Yale New Haven Health</strong></td>
<td>5 Perryridge Rd Greenwich, CT 06830 (203) 863-3316 ynhhs.org</td>
<td>Center for Psychiatric and Behavioral Health.</td>
</tr>
<tr>
<td><strong>Westchester County Mental Health</strong></td>
<td>112 East Post Rd Suite 219, White Plains, NY 10601 914-995-6191</td>
<td>The Department of Community Mental Health plans, oversees and coordinates services for individuals - and their families - with mental illness, developmental/intellectual disabilities and substance use disorders.</td>
</tr>
</tbody>
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### New York-Westchester Substance Abuse

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<tr>
<td><strong>RyeAct</strong></td>
<td>21 Locust Ave, Rye, NY 10580 (914) 481-4141 <a href="https://ryeact.com/">https://ryeact.com/</a></td>
<td>RyeACT (Rye Action for Children and Teens) is a coalition of local organizations and individuals committed to promoting long term health and wellness.</td>
</tr>
<tr>
<td><strong>St. Vincent’s Hospital Westchester</strong></td>
<td>275 North St, Harrison, NY 10528 (914) 967-6500 <a href="http://www.stvincentswestchester.org">www.stvincentswestchester.org</a></td>
<td>St. Vincent’s Hospital Westchester offers inpatient and outpatient mental health and addiction treatment services at its campus in Harrison.</td>
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