YaleNewHavenHealth
Greenwich Hospital

2025

Community Health Needs Assessment

Greenwich & Port Chester

crescendo
Prepared by Crescendo Consulting Group

Yale NewHaven Health Greenwich Hospital

September 2025

Dear Community Member,

As president of Greenwich Hospital, I am proud to share our 2025 Community Health Need Assessment with you. Identifying and responding to the needs of our community is not only our responsibility, but also part of our history. Greenwich Hospital opened in 1903 in direct response to community needs. It has evolved into a progressive medical center and teaching institution with an internal medicine residency. It is a privilege to carry on that tradition.

This comprehensive assessment, conducted by the Yale New Haven Health Office of Health Equity & Community Impact, identified obstacles faced by many individuals in the communities served by Greenwich Hospital in Connecticut and New York when it comes to their health and wellbeing. The assessment also incorporated valuable input and insight from the Town of Greenwich Community Health Improvement Partnership (GCHIP) and the Council of Community Services (CCS) of the Town of Rye and the City of Rye, which include representatives from local health departments, Federally Qualified Health Centers and community-based organizations.

Recognizing the importance of different perspectives, we worked with our community partners in encouraging your voice and that of your neighbors to be heard during the data gathering process. Based on the results of the Community Health Need Assessment, Greenwich Hospital is committed to addressing issues related to access to care and services; mental health and wellness; promoting a culture of health; and supporting healthy generations in collaboration with our community partners.

Service to our community is at the heart of our mission. We also subscribe to continuous improvement and innovation as core principles in health care. If you have suggestions on how we can improve this work, please let us know at CHNAcommentsGH@greenwichhospital.org. Thank you for your continued support of our community.

Sincerely,

Robert Blenderman, PA, MBA

President, Greenwich Hospital
Executive Vice President, Yale New Haven Health

MISSION, VISION AND VALUES

MISSION

Yale New Haven Health is committed to innovation and excellence in patient care, teaching, research and service to our communities.

VISION

Yale New Haven Health enhances the lives of the people we serve by providing access to high value, patient-centered care in collaboration with those who share our values.

VALUES

Patient-Centered – Putting patients and families first
Respect – Valuing all people
Compassion – Being empathetic
Integrity – Doing the right thing
Accountability – Being responsible and taking action

YaleNewHaven**Health**

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EXECUTIVE SUMMARY

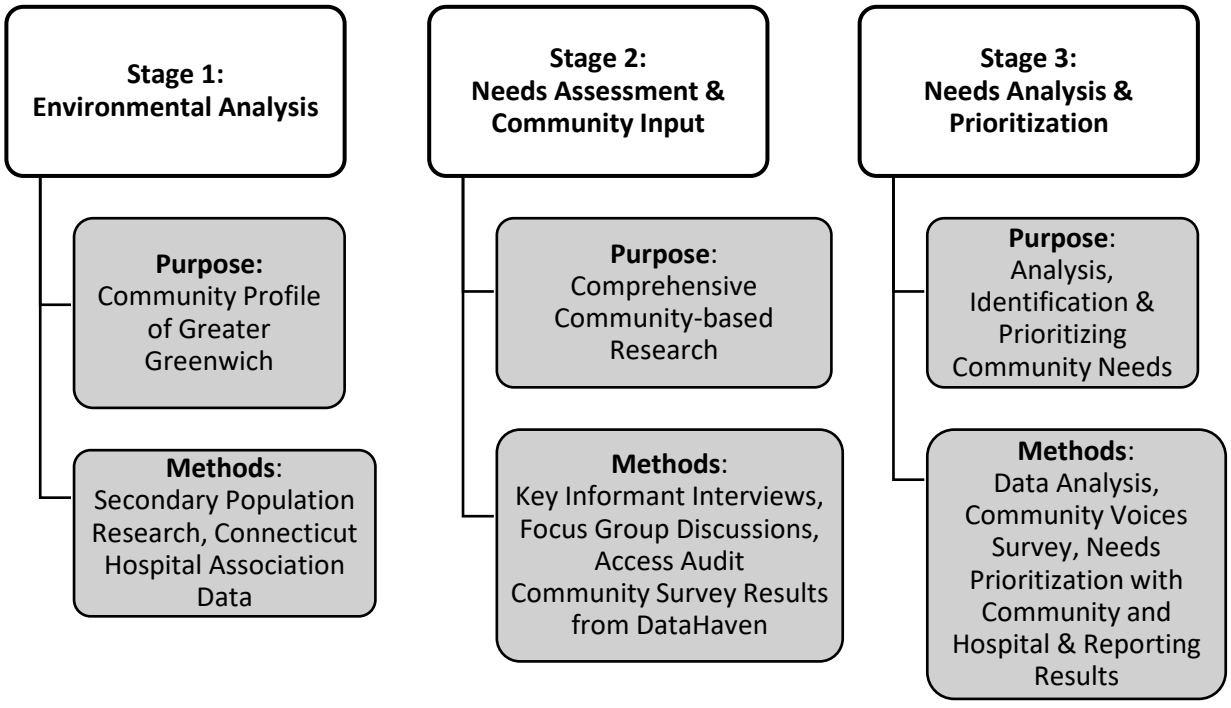
2025 Community Health Needs Assessment

Greenwich Hospital is dedicated to improving the health and well-being of patients and community members. As a not-for-profit hospital, Greenwich Hospital conducts a Community Health Needs Assessment (CHNA) every three years, as required by Section 501(r)(3) of the Internal Revenue Code. This assessment identifies the region's most pressing health challenges and helps guide the hospital's efforts to address them.

Our CHNA process included insights and input from a broad range of community members in the Greenwich Hospital region which includes the town of Greenwich, a town in Fairfield County, Connecticut, as well as Rye Town, Rye City, Mamaroneck, and Harrison located in Westchester County, New York. Our process included engaging public health experts and representatives of under-resourced populations from across the region in a collaborative approach that ensured the community health needs assessment would reflect diverse perspectives and community experiences.

CHNA Methodology and Data Gathering

The CHNA methodology involves a 3-stage process which includes environmental analysis, needs assessment and community input, and needs analysis and prioritization as outlined below.



Data Collection: Our robust data collection process included qualitative and quantitative data collection which provided critical insights into demographics of the greater Greenwich region, Social Drivers of Health (SDoH) and behavioral health-related measures.

Environmental Analysis & Collection of Secondary Data: 30 + secondary sources and 60 + Health Indicators including the American Community Survey (Census), Centers for Disease Control and Prevention, United Way of Connecticut, U.S. Department of Housing and Urban Development, County Health Rankings and Connecticut Hospital Association, among others, with information on demographics insurance status, health outcomes and more.

DataHaven Community Wellbeing Survey: 175 surveys completed by Greenwich community members and 130 completed by Port Chester community members as part of the probability sampling process conducted by DataHaven. The survey is used to evaluate health care, housing, employment, and community needs, gaps, and resources.

Key Informant Interviews: 40 one-on-one (Virtual and Telephonic) key informant interviews.

Focus Groups: Six focus groups with over 70 participants, offered in English and Spanish

Access Audit: Mystery shopper calls to evaluate how easily community members can access health care, social services, and resources in the Greenwich Hospital region.

Data Analysis and Community Health Prioritization

A structured prioritization process was conducted, integrating community feedback and evidence-based decision-making. This included:

- **Community Voices Survey** – online survey distributed through the Greenwich Community Health Improvement Partnership (GCHIP) and Council of Community Services (CCS), engaging **205 community members** who ranked the most serious community health needs for the regional prioritization session process.
- **A in-person regional prioritization session** was held with GCHIP and CCS community partners and included hospital representatives. Participants reviewed data books, and the results of the Community Voices Survey and completed a pre-session survey, scoring 25 health needs, which generated an initial prioritization score. The participants then systematically ranked, voted and selected four top health needs through an evidence-based process and criteria.

HOSPITAL PRIORITY AREAS

Access to Care & Services

Mental Health & Wellness

Promote a Culture of Health

Supporting Healthy Generations

The 2025-2028 community priorities identified were presented to the Greenwich Hospital senior leadership who agreed to adopt the same four community health priorities and needs identified by community partrners.

Category: Access to Care & Services	Category: Mental & Well ness
Improve access to care and services for under-resourced residents.	Expand access to and awareness of behavioral health services for all age groups. Support crisis intervention services for mental health and substance use.

Category: Promote a Culture of Health	Category: Supporting Healthy Generations
Conduct community education programs and events focused on preventive care to reduce chronic disease.	Improve access and awareness of community resources that support the physical, social and mental well-being of youth and seniors.
Collaborate and conduct community wellness programs that offer education, screenings and referrals to reduce risk factors of chronic disease.	Conduct injury prevention and safety programs across the lifespan.

Health System Priority Area

Community members, from across our hospital regions, identified cultural competency as a need during the 2025 CHNA process. This valuable feedback revealed opportunities to improve patient care by expanding language access and cultural sensitivity training and education for staff.

In response, YNHHS selected Culturally Competent Care as a 2025-2028 priority area and will be implementing national standards for Culturally and Linguistically Appropriate Services (CLAS) at each of our hospitals.

Next Steps: From Analysis to Action

The CHNA findings and selected four health priority areas were used to develop and create our 2025-2028 Implementation Strategy Plan and regional Community Health Improvement Plan for GCHIP and CCS.

The Greenwich Hospital documents can be found online at https://www.greenwichhospital.org/about/community/community-health/needs-assessment

The regional Community Health Improvement Plan can be found online at http://www.gchip.org and http://www.council10573.org

Prioritized Needs Executive Summary

Prioritization Data Highlights

Greater Greenwich Region

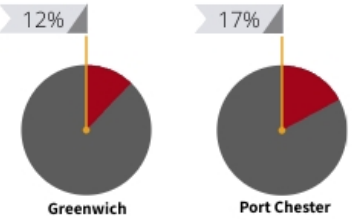
Access to Care & Services

Greenwich

Community members shared that residents with insurance often face long wait times or are turned away due to limited provider capacity.

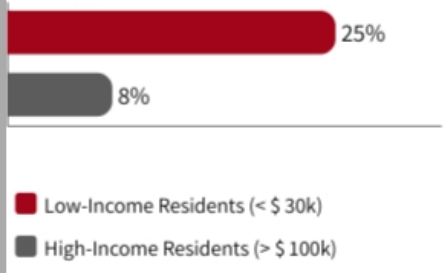
Port Chester

Community members noted that finding providers who accept new patients, specifically those without private insurance, is particularly difficult.



In Greenwich, 12% of survey respondents reported not having a personal doctor or healthcare provider.

In Port Chester 17% survey respondents reported not having a personal doctor or healthcare provider.[1]



The DataHaven Community Wellbeing Survey (DCWS) reinforced access disparities between income levels. 25% of Greenwich residents earning under $100,000 reported lacking a regular provider, compared to 8% of those earning over $100,000.

Lower-income Greenwich residents and Port Chester residents are more likely to lack consistent access to a primary care provider.[1]

Insurance Status

Greenwich

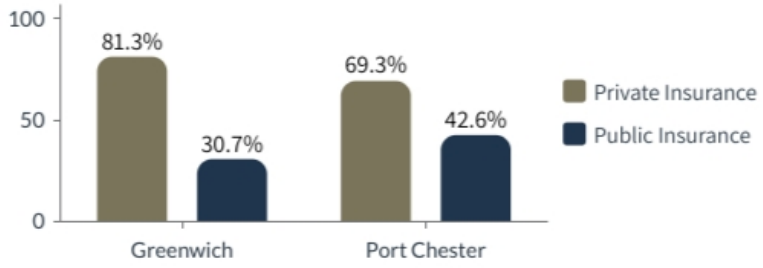
Community members shared that individuals with Medicaid or Medicare often encounter difficulty finding primary care and specialty providers who will accept their coverage.

Port Chester

Community members emphasized that publicly insured residents frequently struggle with limited provider availability.

Port Chester residents are more likely than Greenwich residents to rely on public insurance, leading to greater challenges accessing timely and appropriate healthcare services.[2]

Residents with public insurance may face longer wait times and fewer provider choices because some practices limit the number of publicly insured patients they accept.



30.7% of Greenwich residents have public insurance coverage (Medicaid, Medicare, or other government programs).[2]

42.6% of Port Chester residents have public insurance coverage, a higher rate compared to Greenwich.[2]

1. Exhibit 33
2. Table 42

Prioritization Data Highlights

Greater Greenwich Region

Mental Health & Wellness

Greenwich

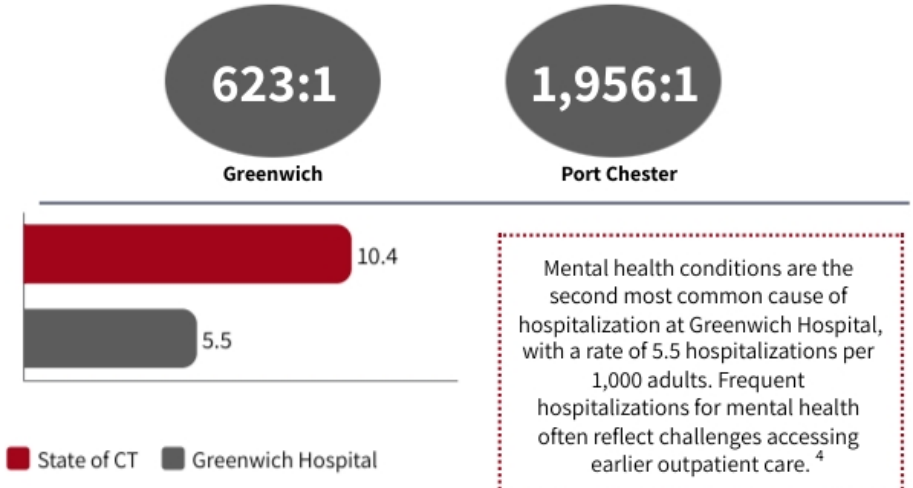
Community members reported long wait times for mental health services and a shortage of youth-focused behavioral health programs.

Port Chester

Community members shared concerns about stigma preventing some residents from seeking needed mental health care, especially among immigrant families.

Port Chester residents face significantly higher barriers to timely mental health care due to fewer available providers. Lower provider availability can lead to longer wait times and fewer choices for patients seeking care.

Mental health provider ratio in Greenwich: 623 residents per mental health provider.
Mental health provider ratio in Port Chester: 1,956 residents per mental health provider. [3]



Mental health conditions are the second most common cause of hospitalization at Greenwich Hospital, with a rate of 5.5 hospitalizations per 1,000 adults. Frequent hospitalizations for mental health often reflect challenges accessing earlier outpatient care. [4]

Crisis Services

Greenwich

Community members described gaps in mobile crisis services and limited after-hours behavioral health support, particularly for youth and families.

Port Chester

Community members noted that residents often struggle to find accessible, culturally appropriate crisis care and may rely on emergency rooms when outpatient crisis options are unavailable.

Residents without private insurance or reliable transportation, particularly in Port Chester, experience greater challenges accessing timely behavioral health crisis services.

3. Table 41
4. Table 50

Prioritization Data Highlights

Greater Greenwich Region

Culture of Health

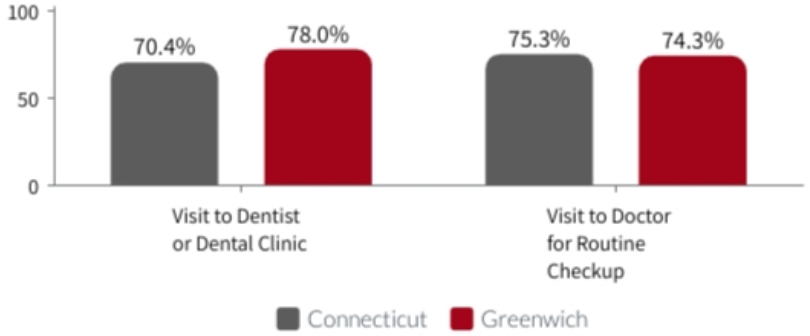
Greenwich

Community members shared that while many residents access preventive care, those without private insurance may delay visits due to cost.

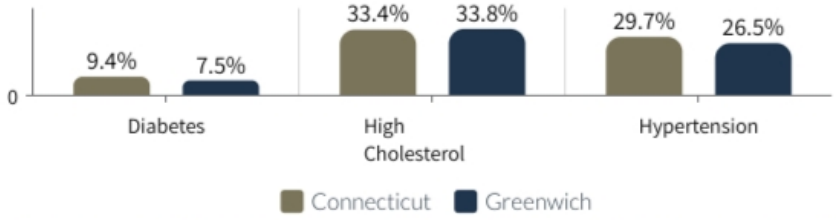
Port Chester

Community members noted that language barriers, immigration concerns, and limited provider availability reduce use of preventive services.

74.3% of adults in Greenwich reported having a routine doctor checkup in the past year, slightly below the statewide average of 75.3%. Routine checkups help prevent serious illness by catching problems early. [5]

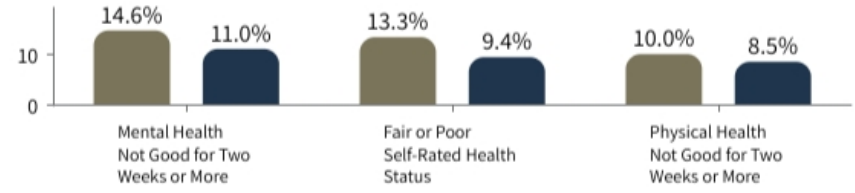


Residents who are uninsured or have limited English skills may face greater barriers to accessing preventive care.



Diabetes, high cholesterol, and hypertension are among the most frequently self-reported conditions in Greenwich. These chronic conditions often require ongoing care and medication to avoid serious complications. [6]

Chronic disease–related hospitalizations, including for heart disease and respiratory conditions, are among the top reasons for inpatient care. [7]



5. Table 49
6. Table 47
7. Table 48

Preventive Care Programs

Greenwich

Community members shared that older adults and residents with lower incomes may face challenges managing chronic conditions due to medication costs, limited transportation, and lack of care coordination. Older adults and residents with lower incomes face greater challenges managing chronic disease due to financial and logistical barriers.

Port Chester

Community members noted that patients often delay follow-up care for chronic conditions because of cost concerns or insurance issues.

Prioritization Data Highlights

Greater Greenwich Region

Supporting Healthy Generations

Greenwich

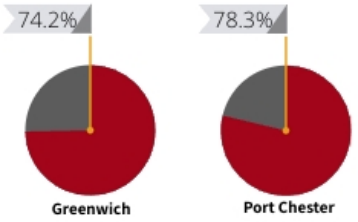
Community members noted that middle-income families often earn too much to qualify for subsidies but struggle to afford market-rate childcare.

Community members also shared that some older adults and immigrant youth have difficulty finding low-cost, culturally appropriate programs.

Port Chester

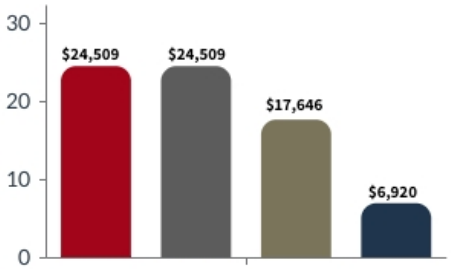
Community members shared that families face long waitlists for affordable childcare and that undocumented parents may be hesitant to engage with formal systems.

Community members shared that senior isolation is a concern. Members also noted that there are limited programs that engage youth in meaningful, structured ways.

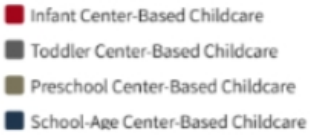


74.2% of children under age 6 in Greenwich and 78.3% in Port Chester live in households with working parents.

These figures reflect high demand for childcare in both communities, especially for families balancing work and caregiving. [8]

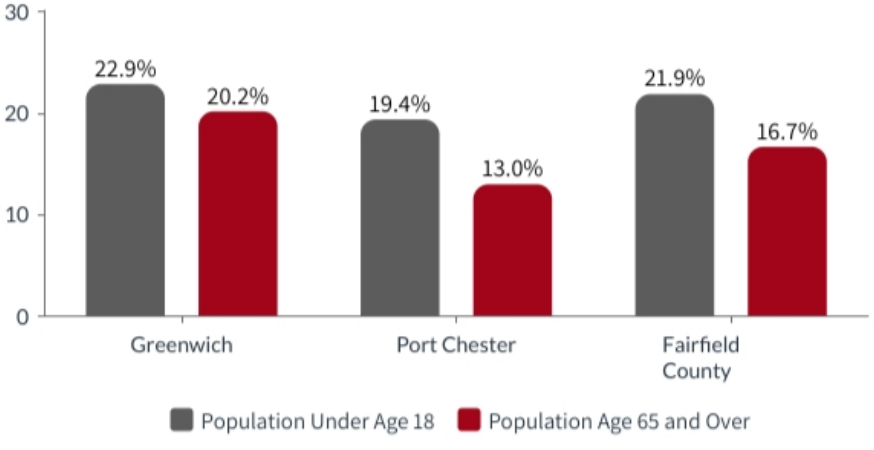


Annual cost of infant care in Fairfield County, CT exceeds $22,000. Middle-income families often fall through the gap—unable to afford care but ineligible for assistance. [9]



Low-income seniors and youth in both communities face barriers accessing consistent, affordable, and culturally relevant support programs.

20.2% of Greenwich residents are age 65 or older, higher than the Fairfield County average. An aging population may need more services to support health, transportation, and connection. [10]



8. Table 22
9. Table 24
10. Table 2

INTRODUCTION

Greenwich Hospital is committed to improving the health and well-being of residents in its service area, which includes Greenwich, a town in Fairfield County, Connecticut, as well as Rye Town and Rye City, located in Westchester County, New York. As a not-for-profit hospital, Greenwich Hospital conducts a Community Health Needs Assessment (CHNA) every three years, as required by Section 501(r)(3) of the Internal Revenue Code. This CHNA identifies the most pressing health needs in the community and helps guide the hospital's efforts to address them.

The CHNA process includes input from a broad range of community members, including public health experts and representatives of under-resourced populations. This collaborative approach ensures that the assessment and its findings reflect the diverse health needs and experiences of the community.

The CHNA report was approved by the Greenwich Hospital Board of Trustees on September 29, 2025. The findings in this report informed a separate Implementation Strategy Plan (ISP) that outlines specific actions Greenwich Hospital will take to address identified health needs over the next three years, which will receive Board of Trustees approval in Fiscal Year 2026. The documents are made publicly available, to ensure transparency and accountability.

This report presents the findings of 2025 CHNA, conducted in collaboration with the Greenwich Community Health Improvement Partnership (GCHIP) and Council of Community Services (CCS) community partners. It provides an overview of the health status of the hospital's service area, identifies key health challenges, and highlights Greenwich Hospital's and its community partners' commitment to addressing identified health needs. A collaborative Community Health Improvement Plan (CHIP) will be developed with GCHIP and CCS. By collaborating with key Informants, community organizations, partners, and community members, Greenwich Hospital aims to build a healthier future for all residents in its service area.

Community input is essential to ensuring that the Community Health Needs Assessment (CHNA) reflects the priorities and experiences of those who live and work in the region.

If you would like to share feedback or comments on this CHNA, we welcome your input. Please email CHNAcommentsGH@greenwichhospital.org to share your thoughts and help shape future efforts to improve community health.

ABOUT OUR HOSPITAL

Greenwich Hospital is a not-for-profit, acute care hospital serving the Town of Greenwich in Fairfield County, Connecticut, and parts of Westchester County, New York, including Port Chester, Rye Brook, Rye City, and surrounding communities. As a member of Yale New Haven Health (YNHHS), Greenwich Hospital provides high-quality medical, surgical, and specialty care, combining advanced technology with a patient-centered approach.

Greenwich Hospital offers emergency services, maternity care, cardiology, oncology, orthopedics, and behavioral health services, among others. It is affiliated with Smilow Cancer Hospital, ensuring access to leading cancer treatment and research. The hospital is also recognized for its commitment to women's health, geriatric care, and community wellness programs.

Through partnerships with local public health departments and community-based organizations Greenwich Hospital collaborates to address health disparities, expand initiatives that increase access to care, and improve overall community health in both Connecticut and New York.

For more information, visit the Greenwich Hospital website at www.greenwichhospital.org.

ABOUT OUR PARTNERS

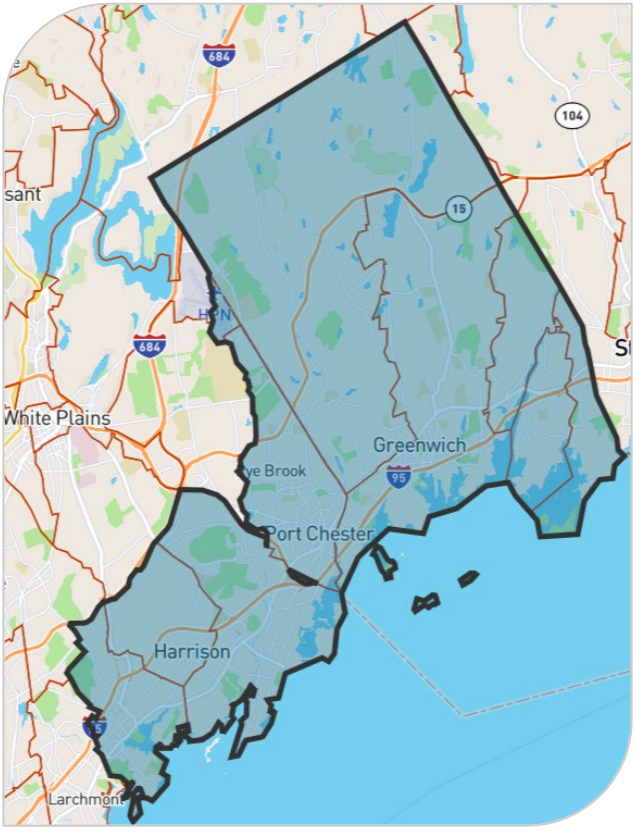
The 2025 CHNA for the Greater Greenwich region focuses on addressing the needs of residents in the communities served by Greenwich Hospital, a member of the Yale New Haven Health. The CHNA is conducted in collaboration with the Greenwich Community Health Improvement Partnership (GCHIP) in Greenwich, CT, and Council of Community Services (CCS) in Westchester, NY.

The GCHIP and CCS members are comprised of community partners including local health departments, federally qualified health care centers, healthcare providers, social service organizations, youth, senior and mental health professionals, to foster a shared commitment to improving the health and well-being of community residents.

This collective partnership effort brings together Key Informants from across the region, creating and building relationships among diverse community organizations and providers. These strong partnerships foster and reflect a shared commitment to understanding and addressing the various needs of the residents in the Greater Greenwich area.

OUR REGION

Zip	Town	County	Census- Designated Place
Greenwich			
06807	Greenwich	Fairfield	Cos Cob
06830	Greenwich	Fairfield	Greenwich
06831	Greenwich	Fairfield	Greenwich
06832	Greenwich	Fairfield	Greenwich
06836	Greenwich	Fairfield	Greenwich
06870	Greenwich	Fairfield	Old Greenwich
06878	Greenwich	Fairfield	Riverside
New York			
10543	Mamaroneck	Westchester	Mamaroneck
10528	Harrison	Westchester	Harrison
10580	Rye	Westchester	Rye
10581	Rye	Westchester	Rye
10573	Port Chester	Westchester	Port Chester / Rye Brook



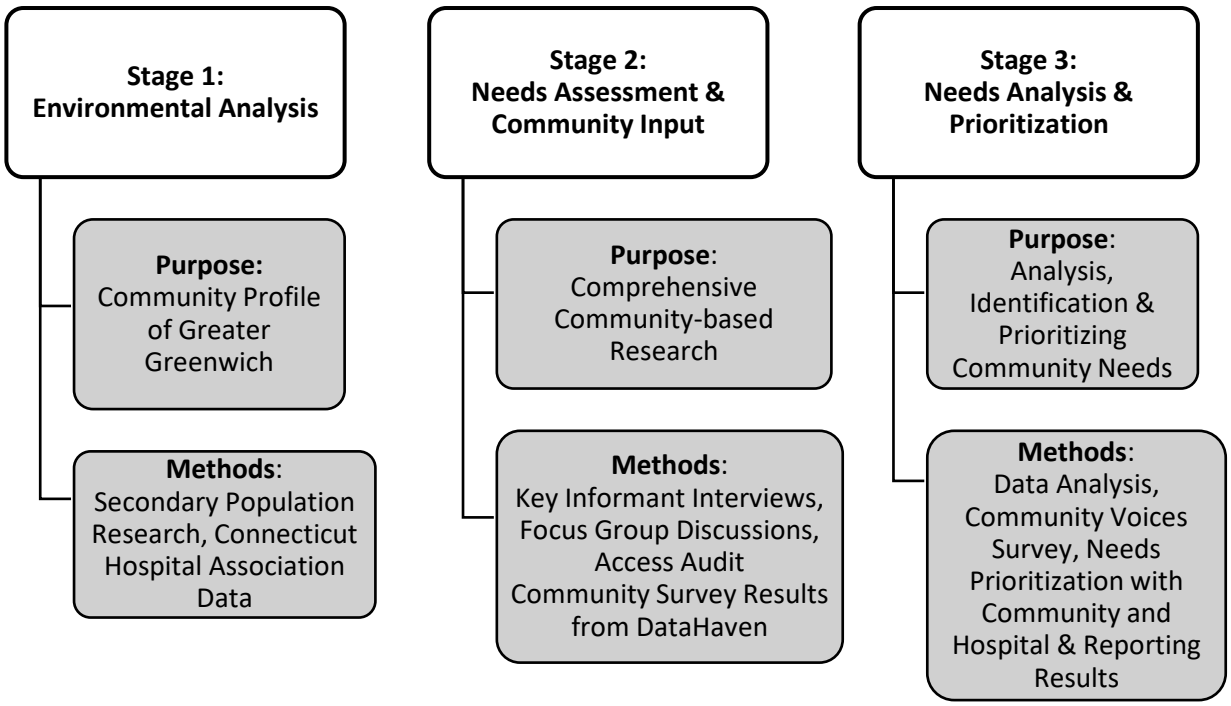
The Greenwich CHNA service area includes Greenwich, CT, and portions of Westchester County, NY. The Connecticut portion is in Fairfield County and includes Greenwich, while the New York portion is in Westchester County and includes Port Chester, Rye Brook, Rye, Harrison, and Mamaroneck.

Port Chester is a village within Zip Code 10573, which also includes Rye Brook. In this report, Port Chester is highlighted separately to emphasize its unique needs and health disparities.

Throughout this report, “Connecticut” refers specifically to Greenwich, while “New York” refers to the full New York service area, unless otherwise specified as Port Chester only.

CHNA METHODOLOGY

Results of the major research activities employed in this Community Health Needs Assessment (CHNA) include secondary population research, reviewing results of DataHaven community surveying efforts, conducting primary qualitative interviews with Key Informants and in focus groups, and conducting a needs prioritization process, all of which are explained in more detail below.



Data Sources

Stage 1: Environmental Analysis

Secondary Data and Internal Data Analysis provided a critical insight into demographics of the Greater Greenwich region, social determinants of health and behavioral health-related measures.

Stage 2: Needs Assessment & Community Input

Qualitative Research included 40 one-on-one Key Informant interviews and six focus groups, speaking with over 70 participants.

An **Access Audit** provided insights into access to care barriers and challenges experienced by Greater Greenwich residents when accessing services and resources.

A **Community Well Being Survey** was conducted by DataHaven to evaluate and address health care, housing, employment, community needs, gaps, and resources in the community. In Greenwich, 175 responses were collected and analyzed; in Port Chester, there were 130 responses.

Stage 3: Needs Analysis & Needs Prioritization

The **Needs Prioritization Process** was held with members of the GCHIP, CCS and other regional community-based organizations/partners, who prioritized community health needs using a structured scoring system. Greenwich Hospital leadership reviewed these regional findings, approved, and aligned hospital priorities with the community's selected focus areas.

- A **Community Voices Survey** was conducted with over 200 respondents. This survey allowed community members to provide input on how community health efforts were prioritized and helped guide future programs and services.

Data Limitations

Data collection methodologies inherently present certain limitations that can affect the comprehensiveness and representativeness of findings. These limitations underscore the importance of interpreting data within the context of its collection methods and acknowledging potential biases that may influence the findings.

Environmental Analysis: Utilizing publicly available secondary data sources, such as the U.S. Census Bureau's American Community Survey (ACS), provides valuable insights. However, these datasets are limited to respondents who completed the survey, potentially leading to underrepresentation of specific groups. Notably, ACS experienced a response rate decline from 86% in 2019 to 71% in 2020, with rates not fully rebounding to pre-pandemic levels by 2022. [1] This decline may result in nonresponse bias, affecting the accuracy and completeness of the data.

Qualitative Data: Efforts to engage diverse community sectors are crucial for comprehensive qualitative insights. Despite these efforts, participation is limited to those who chose or were able to engage, which may not fully capture the perspectives of all community segments.

[1] U.S. Census Bureau. *Response rates*. American Community Survey. Retrieved December 3, 2024, from https://www.census.gov/acs/www/methodology/sample-size-and-data-quality/response-rates/

DataHaven Community Well-being Survey (DCWS): The DCWS employs probability sampling to produce population-weighted, representative results for the region. The DCWS gathers reliable local information on quality of life, health, employment, and neighborhood resources. While the DCWS aims for comprehensive coverage, the reliance on respondents' willingness to participate can introduce nonresponse bias, potentially affecting the representativeness of the data.

All survey percentages represent weighted estimates of the adult population (ages 18+) and should be interpreted as estimates of adult prevalence, not just of respondents.

Regional Definition: Note that the region has a specific zip code definition, and all data, where possible, mirrors that definition. There are some data points that use a regional proxy (e.g. county for a region, etc.) in order to provide descriptive data.

How to Read This Report

This Community Health Needs Assessment aims to give a holistic depiction of the health and well-being of the hospital region. The report is organized by the five Social Drivers of Health domains. Each section includes summary data from the primary and secondary quantitative and qualitative data. While the report aims to be comprehensive, it is not an exhaustive list of all the strengths, challenges, and data for the region.

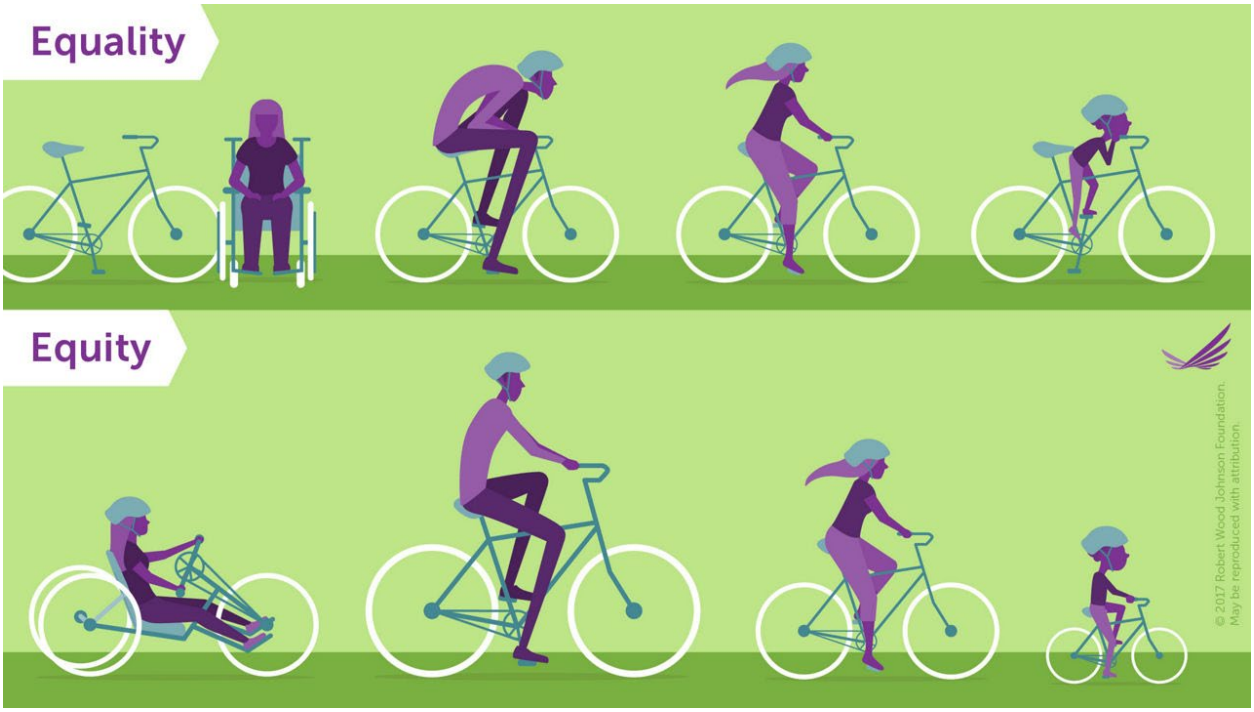
Report Terms and Definitions

Term	Definition
Health Equity	Everyone has a fair and just opportunity to be as healthy as possible (Katella, 2021).
Health Literacy	The ability to access, understand, evaluate, and apply health information to make informed decisions about one's health (CDC, 2024).
Key Informant	A person who has specialized knowledge, insight, or experience about a particular community, issue, organization, or population (Pahwa et al., 2023).
Language Barrier	A situation in which a person or household has limited or no ability to communicate in the dominant language of the surrounding community (Link et al., 2005).
Personal Health Record	An organized, secure record of one's health information, such as medical history, medications, test results, and immunizations (Mayo Clinic, n.d.).

Qualitative Data	Non-numerical information describing qualities, experiences, or perspectives of people or situations, often collected through interviews, focus groups, or observations (Hassan, 2024a).
Quantitative Data	Information that can be counted or measured and used to analyze patterns, relationships, or trends through statistics (Hassan, 2024b).
Secondary Data	Existing data, not gathered firsthand by the current researcher (Hassan, 2024c).
SNAP	Supplemental Nutrition Assistance Program (SNAP), the largest federal nutrition program in the United States, designed to help individuals and families with low incomes access food (USDA, n.d.).
Social Drivers of Health (SDoH)	Social, economic, and environmental factors that impact a person's health outcomes and access to care, including income, education, housing, transportation, food access, and social support (CMS, n.d.).
Stigma	Negative attitudes, beliefs, stereotypes, and discrimination directed towards individuals or groups based on certain characteristics, attributes, or conditions (Washington State Department of Health, n.d.).
Under-Resourced	Populations that have inadequate access to resources, such as healthcare, education, or social services. (AHRQ, 2021).
Underrepresented	Groups that are proportionately smaller in decision-making spaces, research, or policy considerations. (Bibbins-Domingo & Helman, 2022).

Health Equity Lens

Everyone should have the opportunity to be as healthy as possible but achieving that goal requires an understanding of health equality and health equity.



Source: Visualizing Health Equity: One Size Does Not Fit All Infographic – RWJF Alignment. Reproduced with permission of the Robert Wood Johnson Foundation, Princeton, N.J

Health Equality: Providing everyone with the same resources or services. However, because people have different needs, equal treatment does not always lead to fair health outcomes.

Health Equity: Ensuring that individuals receive the support necessary for their specific circumstances. Some people may need additional resources, such as more healthcare access, affordable medications, or transportation assistance, to achieve the same level of health as others.

Many factors influence health, including income, neighborhood conditions, healthcare availability, and reliable transportation. Some communities experience greater challenges due to systemic barriers and fewer resources. Greenwich Hospital is committed to identifying these gaps and addressing health disparities to promote fair access to healthcare.

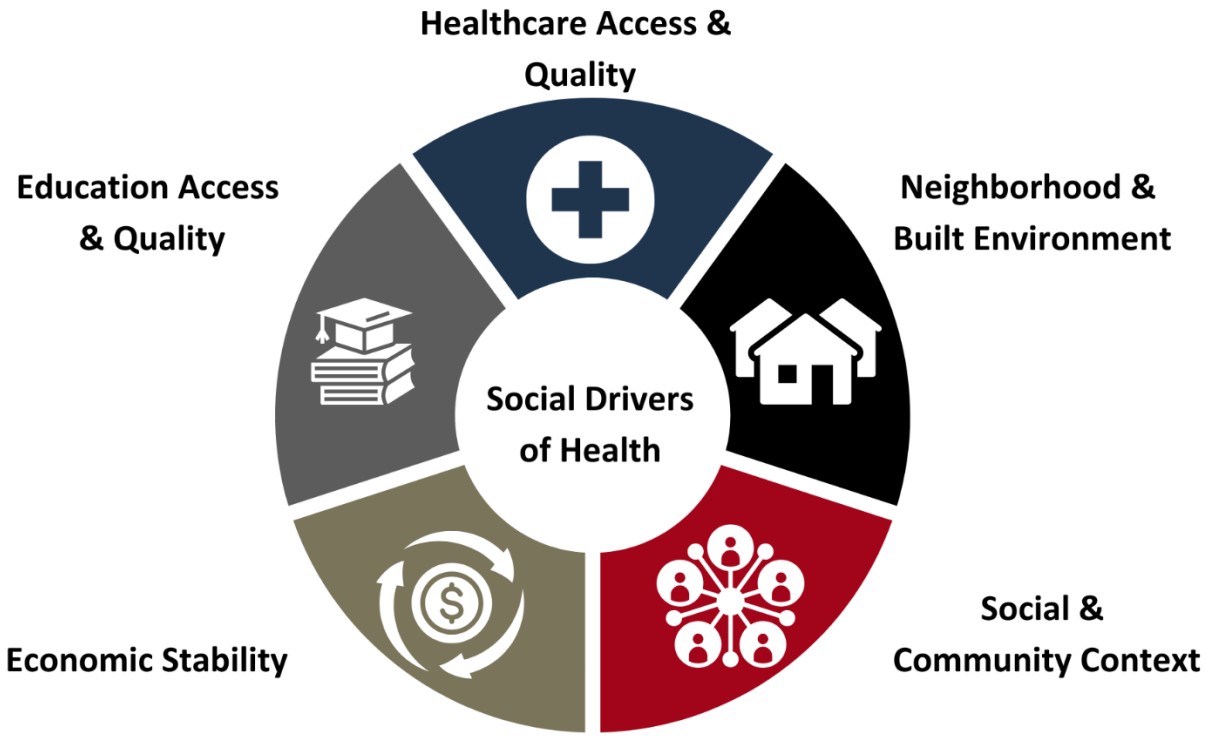
Where possible and relevant, this report presents data by race, ethnicity, and income to show differences in health outcomes and identify where health disparities exist. Breaking down the data in this way helps highlight gaps in access to care and can inform strategies to improve health for all. The goal is to provide a clearer picture of community health needs and support

efforts to ensure that every individual has the opportunity to achieve good health, regardless of background or circumstances.

Social Drivers of Health Framework

Social Drivers of Health (SDoH) are the environmental conditions in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, quality-of-life outcomes and risks. They also contribute to wide health disparities and inequities. The framework has been championed by the US Centers for Disease Control and Prevention (CDC) and other governmental agencies and is integrated into the Healthy People 2030 goals[2].

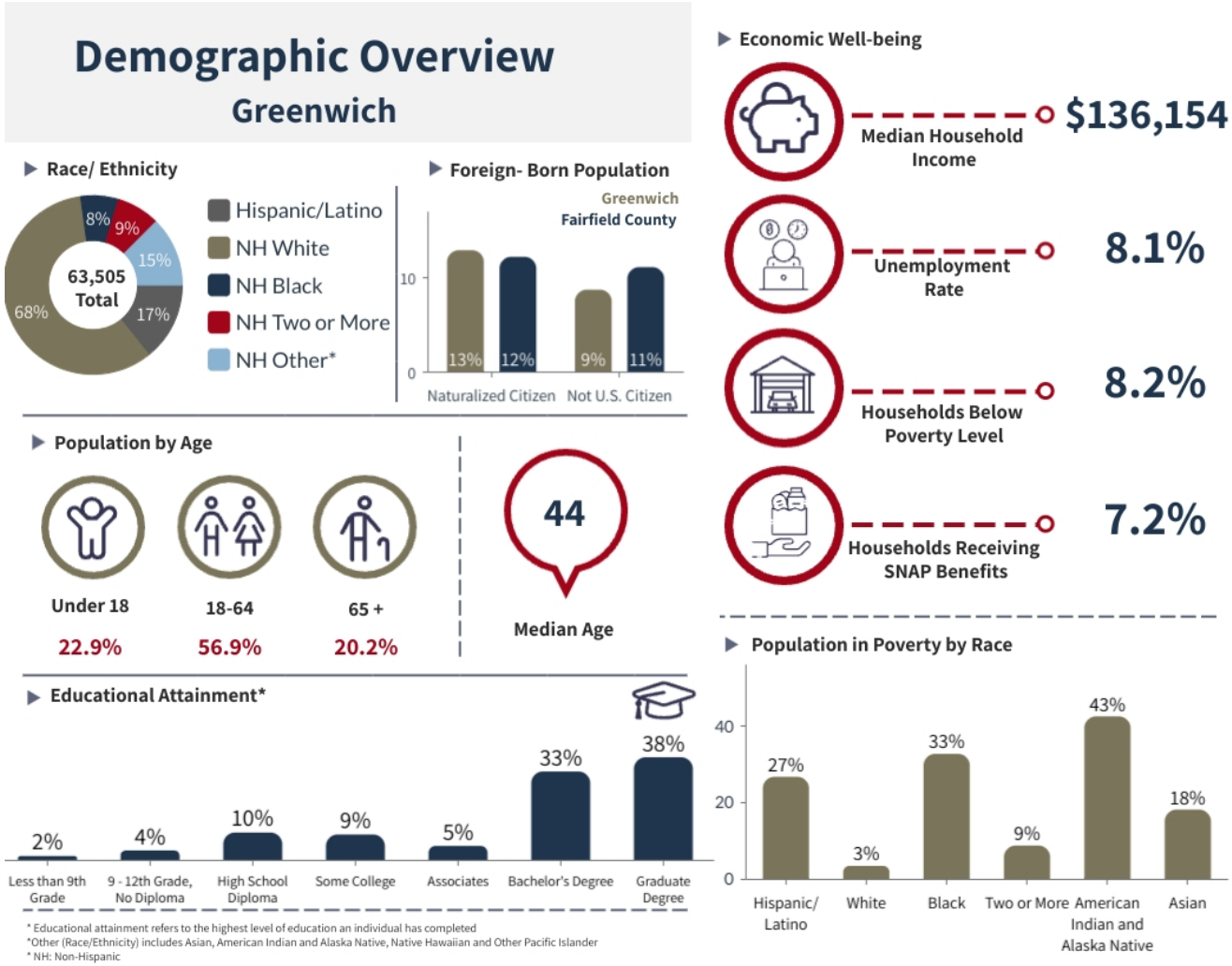
Social Drivers are also known as social determinants. "Determinants" suggests that nothing can be done to change our health fate. By using the term "drivers," we can reframe the conversation that social factors don't force health to be fated or destined, but rather something that people and communities can change.



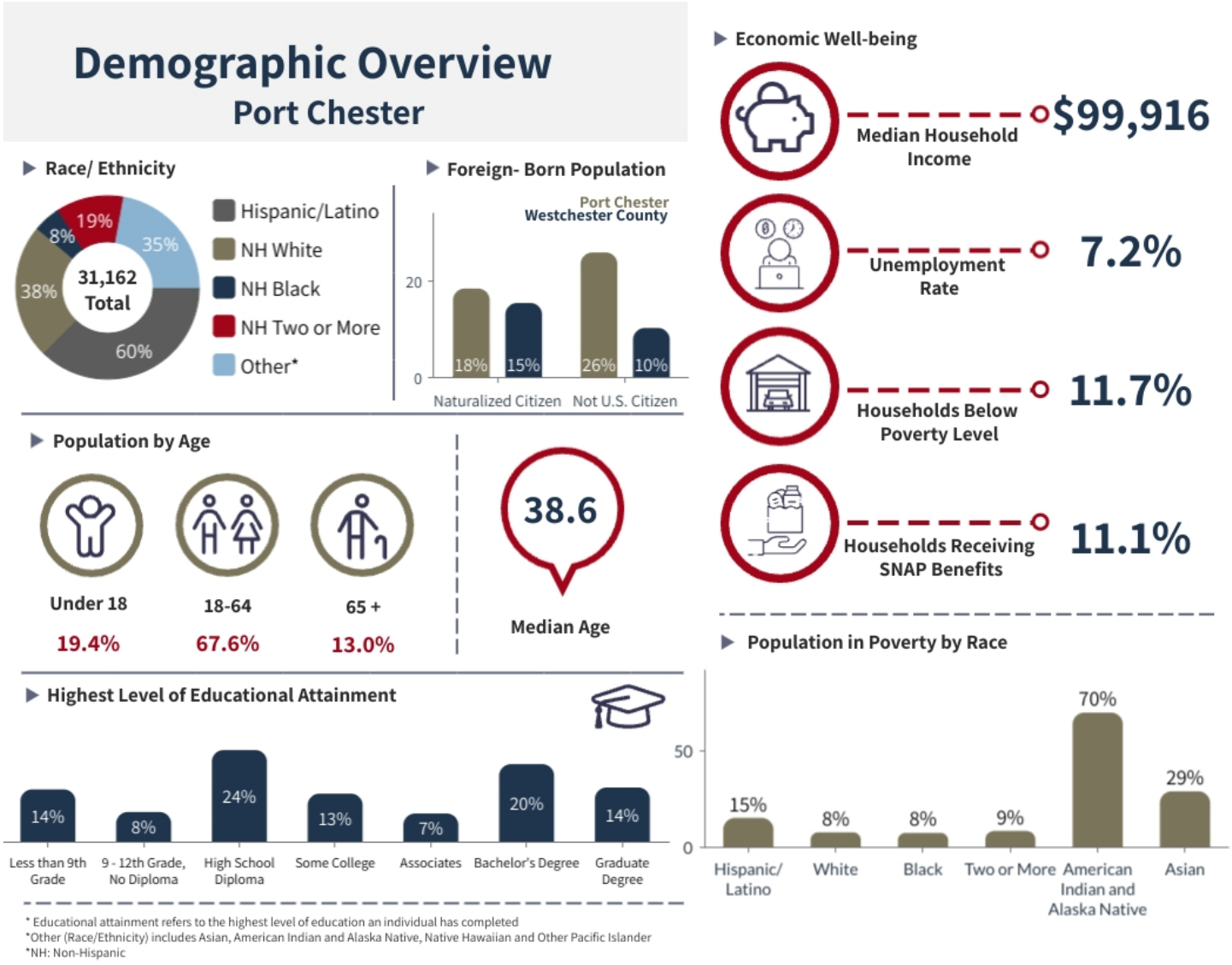
[2] Healthy People 2030. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health

COMMUNITY PROFILE

Demographic Overview: Greenwich



Demographic Overview: Port Chester



Community Strengths

Greenwich, CT

Greenwich, CT is a vibrant and well-rounded community that thrives on its exceptional quality of life. Greenwich, CT is known for its strong sense of community and civic engagement. Residents take pride in maintaining a high quality of life through active participation in local government, charitable organizations, and community events. The town is home to top-rated public and private schools, reflecting a strong commitment to education and lifelong learning. Greenwich celebrates diversity, welcoming residents from a wide range of cultural and professional backgrounds. Its thriving local economy is supported by a mix of small businesses, global firms, and entrepreneurs. With over 1,500 acres of parkland, beautiful beaches, and scenic trails, the town offers abundant opportunities for recreation and connection with nature. This combination of educational excellence, economic vitality, cultural richness, and natural beauty makes Greenwich a uniquely strong and appealing community. The town's commitment to cultural enrichment, education, public health and safety, and cultural enrichment fosters a supportive and connected environment for families and individuals alike.

Port Chester/ Rye Brook

Port Chester and Rye Brook, NY are dynamic and diverse communities that offer a unique blend of suburban comfort and urban energy. Known for their cultural richness and welcoming spirit, both towns are home to a wide range of residents, businesses, and community organizations. The area boasts strong schools, a variety of local and international dining options, and a thriving small business scene. With beautiful parks, recreational facilities, and access to nearby waterfronts, Port Chester and Rye Brook offer residents a high quality of life in a close-knit and inclusive environment. Their shared commitment to growth, education, and community well-being makes them a vibrant part of Westchester County.

Rye

The City of Rye, New York, is a community that prioritizes the well-being of its residents through strong civic engagement, accessible health resources, and a high quality of life. The city benefits from a well-educated population, excellent public and private schools, and a network of parks, trails, and waterfront areas that promote active living and mental wellness. Local organizations and community leaders collaborate to support public health initiatives, ensuring that services address the diverse needs of residents across all age groups. Rye's commitment to sustainability, public safety, and inclusive programming strengthens its capacity to support long-term community health.

Qualitative Key Findings

To understand how people interact in their communities and with the systems, policies, and programs they encounter, we must build relationships and engage in ways that are mutually beneficial. By incorporating narrative and lived experience, we can better understand the underlying causes of health and well-being behaviors and outcomes, rather than simply identifying what those behaviors and outcomes are.

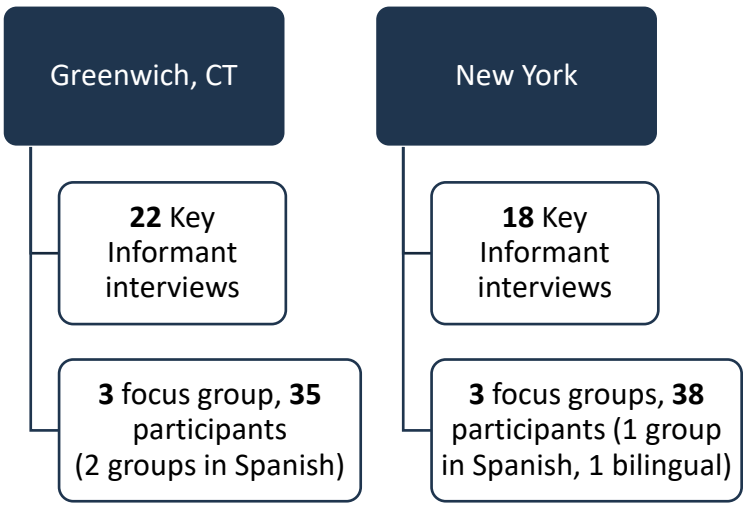
Qualitative data, resulting from community engagement, provides an important context for the health and well-being outcomes and trends contained in the numbers underlying the environmental analysis. In combination, qualitative and quantitative data produce a broader picture of what a community is experiencing and allow for a more thorough and well-rounded approach to program and policy development.

During the 2025 CHNA process, Yale New Haven Health (YNHHS) engaged with community members through community voices surveys, focus groups, and Key Informant interviews, actively listening and learning from their experiences.

Community Engagement Summary

This effort engaged individuals from social service and health organizations, healthcare providers, seniors, parents, individuals with lower socioeconomic status, Spanish-speaking residents, and concerned community members across the service area towns.

In total, input was collected from 40 Key Informants and six focus groups conducted in the Greater Greenwich region with 73 participants. Two focus groups were conducted in English, three in Spanish, and one with a bilingual mix of Spanish and English.



Additionally, there were 305 responses to the DataHaven Community Well-being Survey and two Community Advocates were engaged.

Community Advocates

This regional CHNA employed two Community Advocates to help engage historically underrepresented communities. Community Advocates are individuals who represent a specific community and have the knowledge to speak on their behalf. They participated in Key Informant interviews, the needs prioritization process, and the development of the Community Health Improvement Plan (CHIP). Their involvement strengthened relationships with communities that have not traditionally participated in past CHNAs, ensuring their voices were reflected in the assessment.

Themes

Conversations with individuals that live and work in Greater Greenwich demonstrated how the services provided by community organizations as well as healthcare systems are integral to the health of residents. Participants identified several community strengths, including a strong **sense of community and collaboration, a diverse population**, and **resourceful community organizations.**

In addition to strengths, the following qualitative themes were identified. The overarching qualitative themes coalesce to illustrate both the systemic difficulties and the interrelated challenges faced by residents of the Greater Greenwich region. While not mutually exclusive, the overarching themes extrapolated from the research include:

Throughout the interviews and focus groups, community members identified increasing **health equity** as an ever-present goal for the community. Many participants expressed concern that there is inequitable access to resources based on socioeconomic status, primary language spoken, and citizenship status. These inequities have a significant impact on the ability of residents in Greater Greenwich to maintain their health and well-being.

While healthcare access was often discussed in tandem with health equity within the community, it was also discussed as a concern shared by all community members. **Healthcare access** in Greater Greenwich is affected by several factors including insurance status, availability of primary and specialty care providers, and financial resources. A unique concern for the community is a recent trend toward concierge medicine primary care, which is often inaccessible to low-income individuals. Additionally, many participants shared that adequate behavioral health care, particularly for youth, is lacking.

Diversity of individuals living in the area was noted as a strength of the Greater Greenwich region as well as a theme that intersected with many of the needs of the community. Because of the diverse nature of the community, participants emphasized the importance of cultural competence both between healthcare and social service providers, community organizations, and residents. When individuals are understood, both linguistically and culturally, they are often more likely to seek care and follow recommendations.[3] Community members involved in the interviews and focus groups recommended approaches to build a community that supports the diversity of those living in it, such as recruiting providers and staff who reflect the community they serve.

A lack of adequate **economic opportunity** was frequently identified as a root-cause barrier that impacts individuals' health and quality of life. Participants shared that the increased cost of living, particularly the cost of housing, paired with low wages and inadequate employment opportunities, often prevents individuals and families from meeting their basic needs.

These themes are not mutually exclusive and often have compounding impacts on individuals. The interconnectedness of these themes highlights the need for a comprehensive integrated approach that utilizes the strengths of the community to improve the well-being of its residents.

[3]Parker, M., Fang, X., & Bradlyn, A. (2020). Costs and effectiveness of a culturally tailored communication training program to increase cultural competence among multi-disciplinary care management teams. *BMC Health Services Research, 20*(1), 784. https://doi.org/10.1186/s12913-020-05662-z

Access Audit

Yale New Haven Health Access Audit – Greenwich Service Area

Phone-based access audits serve as an effective tool to evaluate how easily community members can access healthcare services across the Yale New Haven Health– Greenwich service area, spanning both Greenwich and Port Chester, with a focus on assessing access rather than profiling specific sites. The main aim of these audits is to gain a thorough understanding of practical access to healthcare and other vital services, as well as to identify barriers faced by individuals seeking care. The findings from these audits offer valuable insights into existing gaps in access, strategies for improvement, and variations in service delivery.

The audit involved calls to seven facilities within Greenwich's service area, providing diverse services such laboratory services, orthopedic specialists, radiology services, and oncology specialists. The facilities included in the audit are:

Health System Facilities Included in Access Audit

1. Yale Orthopedics at Greenwich Hospital
2. Greenwich Smilow Cancer Center
3. Center for Behavioral & Nutritional Health
4. Greenwich Radiology
5. Greenwich Hospital, Center for Healthy Living Cardiac Rehab
6. Physical Medicine and Rehabilitation
7. Blood Draw Station

Phone calls were completed at different hours of the day during the end of November and the beginning weeks of December. A total of five out of the seven calls resulted in speaking with a live representative. These representatives were helpful and receptive to questions. There was only one instance when the representative was not fully able to answer questions regarding acceptance of insurance, but they were able to transfer the caller to the appropriate department to answer further questions.

Ability of Facilities to Accept New Patients

Facilities' ability to accept new patients varied greatly across services. Lab work and radiology services had the greatest availability of appointment availability. Their appointment availability offered times within the following week and at varied times. Clinics offering behavioral healthcare and oncology specialties had the longest wait times, appointments being available two to three months later. All of the facilities asked about insurance when looking to schedule an appointment, ensuring that the caller would be able to be seen at the provider before scheduling.

Ability of Facilities to Answer Questions and Refer the Caller Elsewhere When the Desired Services Are Unavailable

Offices were helpful in answering questions about accepting different forms of insurance, the services available at their location, and when their next available appointments. If they were unable to directly answer a question, they would transfer the call to someone who could answer or would seek out the answer.

Facilities referred callers to other available community resources at varying rates. Some offices were able to provide a list of other clinics or community organizations that offered similar services, specifically in the behavioral health field, when their wait times were long. Other facilities did not have contact information or recommendations for similar services and suggested callers look online at their insurance website for suggestions.

How Staff Inquiries Help to Determine Prospective Patient's Needs

The extent to which staff inquired about the caller's needs varied across the facilities. Most of the facilities require basic demographic information such as name, birthdate, phone number, and address to be able to schedule an appointment. A few facilities asked for further information regarding medical history and previous providers prior to an appointment to be able to provide complete care. These were things like asking for medical records and current/prior treatments. This was especially true when trying to schedule an appointment for a relative. When calling radiology and laboratory services, a copy of orders from a provider was also required when coming to appointments.

Ease of Speaking With a Person

Speaking with a person was straightforward for all locations included in the access audit. The majority, six out of seven locations, had phone trees that made it easy to call directly to the department the caller was trying to reach. However, there were two calls that ended in leaving a voicemail because they were not currently available to take the call. These facilities took about two days to return the call. The wait time after navigating the phone tree ranged from less than a minute to four minutes.

Language Offerings

Language accessibility varies across the facilities. On the phone calls, Spanish was widely offered as an option in phone trees. However, when asking about Spanish language availability at time of appointment, responses varied. Some facilities were unsure whether providers at the time of appointment were able to speak Spanish, but the assured that translation services would be available upon request. Other offices ensured that there would be someone available who speaks Spanish at time of appointment. This could potentially pose barriers for individuals who speak only Spanish, or any language other than English.

Economic Stability

Economic Stability is one of the five social drivers of health, encompassing factors such as income, poverty, employment, food security, and housing stability. Individuals living in poverty are more likely to experience food insecurity, unstable or inadequate housing, and limited access to healthcare services, all of which can negatively impact health outcomes.

High Cost of Living and Economic Disparities

The cost of living in both Greenwich and Port Chester presents challenges for many households, with high housing costs, food insecurity, and limited access to financial assistance impacting economic stability.

Despite high median household incomes in both communities—$136,154 in Greenwich and $99,916 in Port Chester—many residents struggle financially (Table 29).

EXHIBIT 1: PERCENT OF POPULATION LIVING IN POVERTY

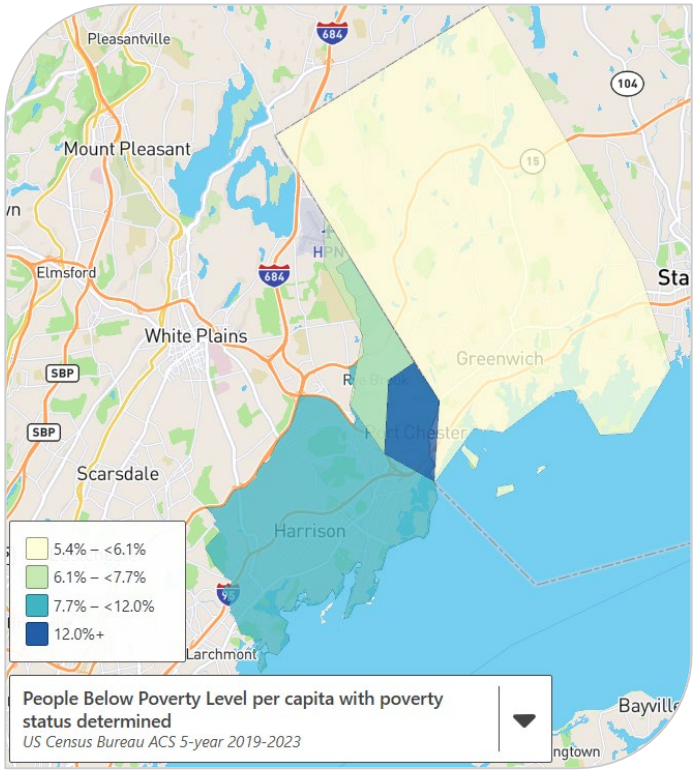
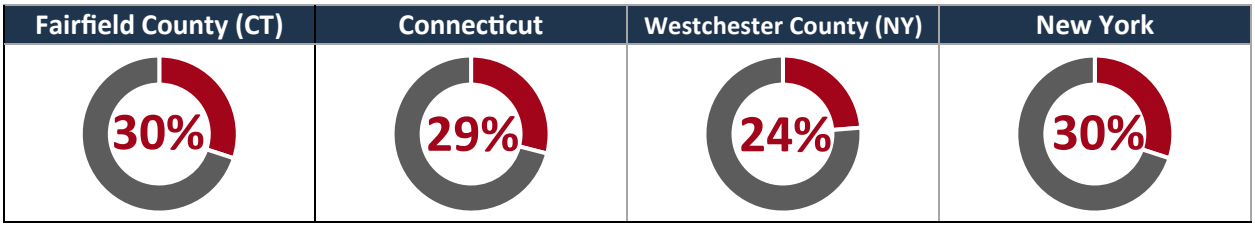


EXHIBIT 2: MEDIAN HOUSEHOLD INCOME

Geography	Income
Fairfield County (CT)	***$115,058***
Greenwich	$136,154
Westchester County (NY)	***$118,411***
Rye Brook	$236,968
Port Chester	$99,916
Other NY Zip Codes	$136,628

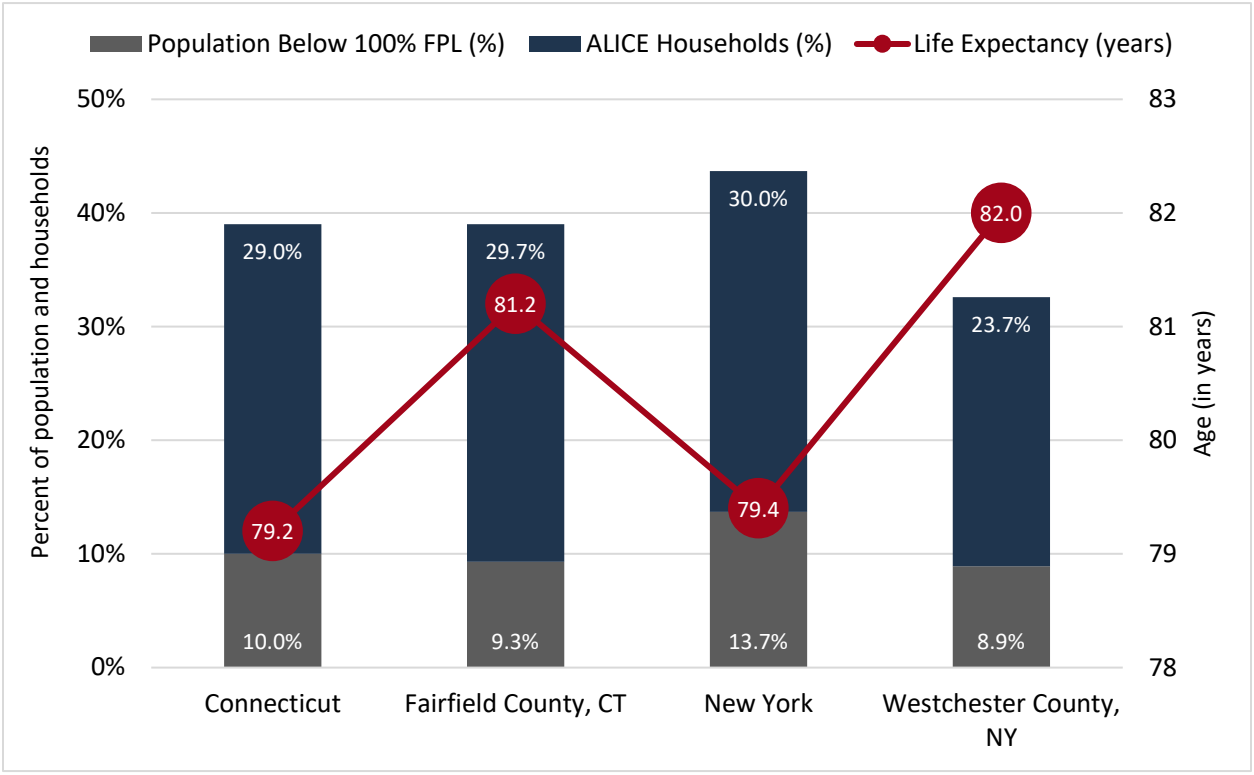
Port Chester has higher poverty levels, while Fairfield County, which includes Greenwich, has a significant ALICE (Asset Limited, Income-Constrained, Employed) population (Table 28). This means many families earn too much to qualify for financial assistance but still struggle to afford necessities.

EXHIBIT 3: POPULATION BELOW ASSET LIMITED INCOME-CONSTRAINED, EMPLOYED (ALICE) THRESHOLD



Source: United Way United for ALICE Research Center, Connecticut, 2022. Table 28

EXHIBIT 4: POPULATION LIVING IN POVERTY, ALICE HOUSEHOLDS, AND LIFE EXPECTANCY



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 27 | United Way United for ALICE Research Center, Connecticut, 2022. Table 28 | County Health Rankings, 2020-2022. Table 46

New York Perspective

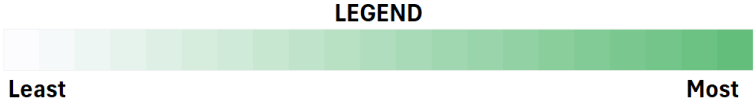
Key Informants in New York and Port Chester report that many families face economic hardship, particularly immigrants and lower-income residents. Housing costs are high, and many live in overcrowded, low-quality housing while paying excessive rent.

Despite community resources to assist with needs, economic pressures remain significant—10% of overall Port Chester survey respondents report that they are currently finding their financial well-being "very difficult."

While financial hardship is more common among lower-income Port Chester residents, even 5% of those earning over $100,000 report difficulty making ends meet, highlighting the high cost of living and economic strain across income levels.

EXHIBIT 5: DATAHAVEN COMMUNITY WELL-BEING SURVEY QUESTION – CURRENT FINANCIAL WELL-BEING (PORT CHESTER)

Financial Well-being	Income <$100K	Income >$100K
Living comfortably	22%	60%
Doing alright	31%	23%
Just getting by	23%	4%
Finding it difficult	12%	8%
Finding it very difficult	13%	5%



> **"[Greenwich] has a lot of ALICE families that are barely getting by and don't qualify for assistance because they make just enough money [to be over the threshold]."**
>
> **- Greenwich Key Informant**

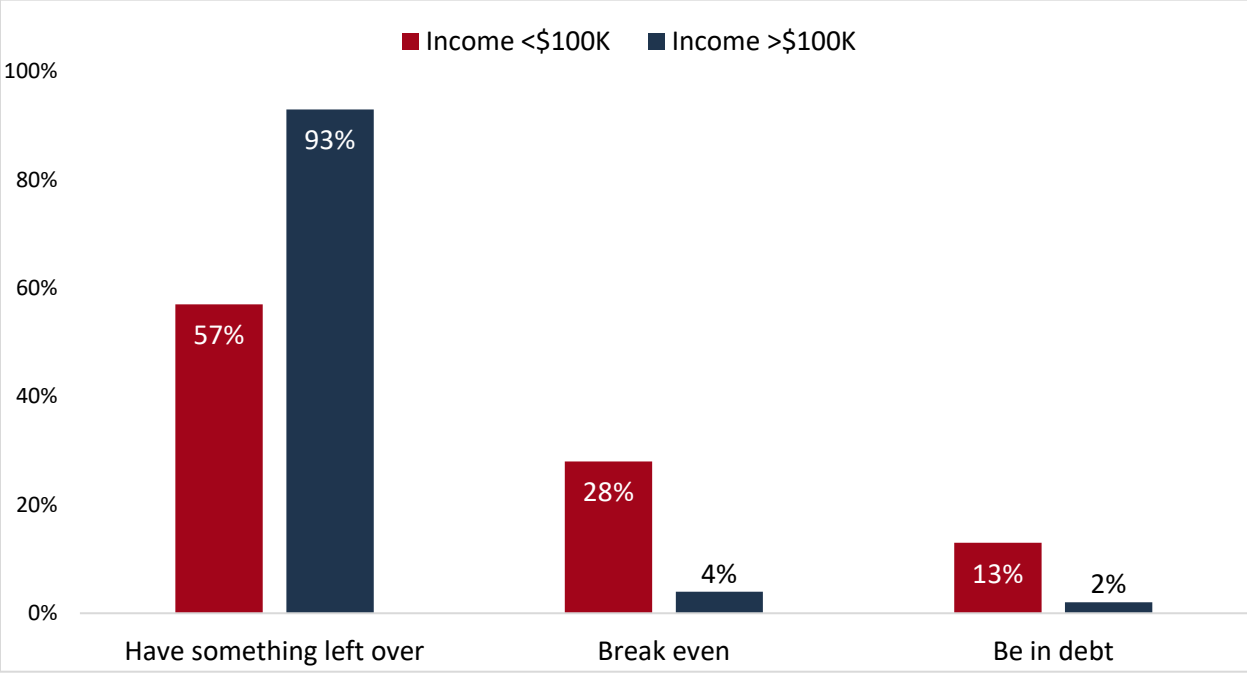
Greenwich Perspective

In Greenwich, Key Informants note that high living costs have priced out much of the workforce, with many hospital employees, teachers, and essential workers unable to afford to live where they work. While help is available, it is not far-reaching enough, as many ALICE families do not qualify for assistance despite financial strain. The economic divide is stark, with some residents struggling while others maintain significant wealth.

5% of overall Greenwich survey respondents reported that they would still be in debt even after selling all major possessions and paying off debts, reflecting financial hardship even among those who do not qualify as low-income.

While financial disparities are evident, even among higher-income Greenwich residents, only a small percentage would break even or remain in debt, whereas lower-income residents face a much greater risk of financial instability, underscoring the challenges of affording life in the community.

EXHIBIT 6: DATAHAVEN COMMUNITY WELL-BEING SURVEY QUESTION – FINANCIAL STATUS OF PARTICIPANTS AFTER SELLING ALL MAJOR POSSESSIONS, INVESTMENTS, ASSETS, AND PAYING OFF ALL DEBTS, (GREENWICH)



Employment

Access to stable, full-time employment is a challenge in both Greenwich and Port Chester, with barriers related to wages, benefits, language proficiency, and transportation.

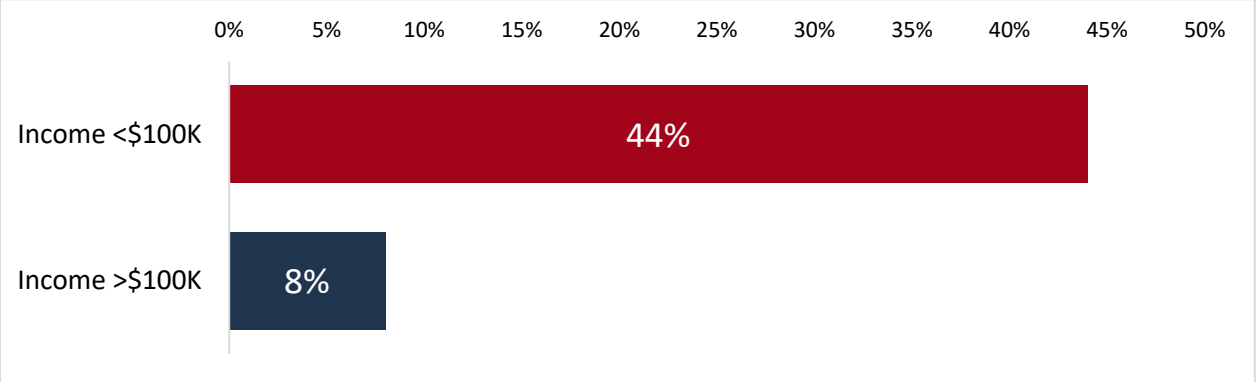
New York Perspective

Key Informants in Port Chester note that many residents struggle to find full-time jobs due to language barriers and work permit requirements. While some programs exist to help residents learn English, spaces are limited, making it difficult for non-English speakers to enter the workforce.

These barriers to finding employment may contribute to the high rate of part-time employment, with 44% of residents earning under $100,000 working part-time. This suggests that many are either unable to secure full-time positions or rely on multiple part-time jobs, which often means jobs without benefits.

Overall, 31% of Port Chester survey respondents are employed part-time.

EXHIBIT 7: DATAHAVEN COMMUNITY WELL-BEING SURVEY QUESTION – PARTICIPANTS WHO ARE EMPLOYED PART-TIME (PORT CHESTER)



Greenwich Perspective

In Greenwich, Key Informants highlight the difficulty of finding jobs that offer good wages and benefits. They note that it is impossible to live in Greenwich on a minimum-wage job, making it difficult for lower-income workers to remain in the community.

Food Insecurity

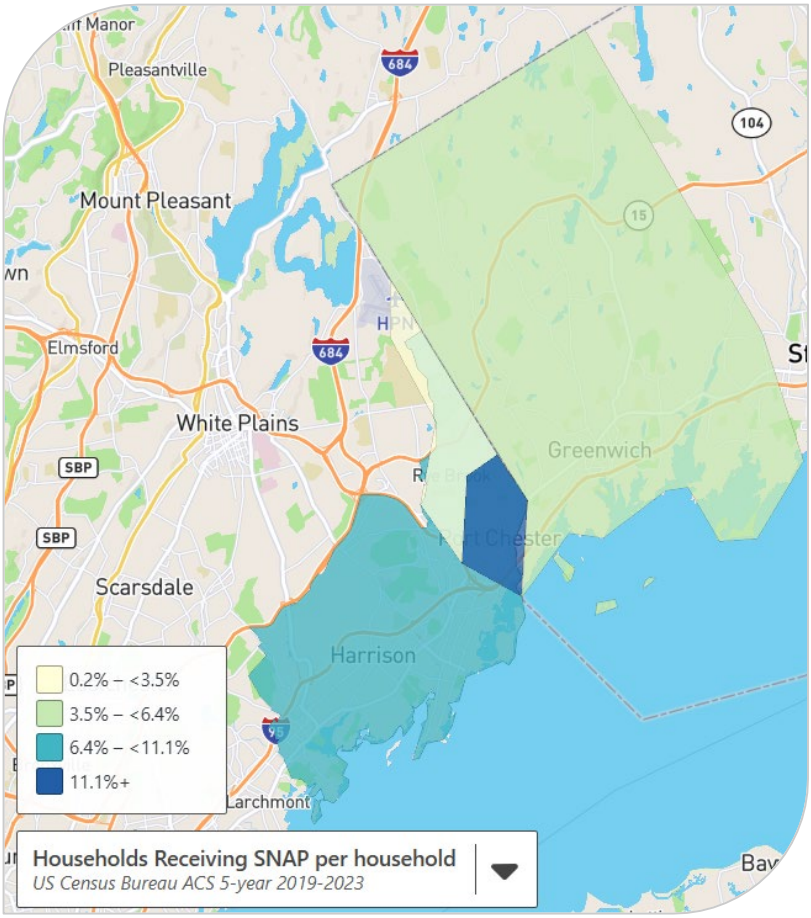
Access to affordable, nutritious food remains a challenge for many households in Greenwich and Port Chester, with some residents relying on food pantries and assistance programs to meet their needs.

4.1%

of 7,623 Greenwich Hospital patients screened reported **food insecurity.**

Source: Yale New Haven Health's SDoH screening initiative (10/01/23- 09/30/24)

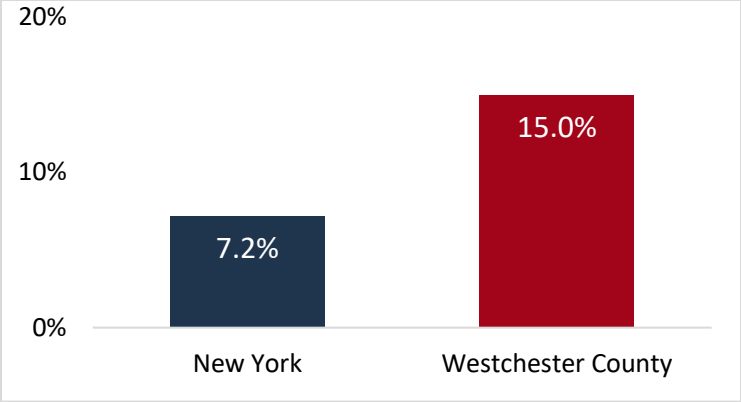
EXHIBIT 8: PERCENT OF HOUSEHOLDS RECEIVING SNAP BENEFITS



New York Perspective

Key Informants in New York and Port Chester report that many families struggle with hunger and food insecurity. While Key Informants report food pantries are widely available and walkable, they also shared that demand continues to grow. Some programs, such as Meals on Main, deliver food to school pick-up sites, making it easier for families to receive groceries. Food pantries have also expanded to offer fresh produce and culturally appropriate foods, which have been well received by the community. However, community members shared that many families still rely on expensive, low-quality food from local corner stores, making it difficult to maintain a healthy diet.

EXHIBIT 9: PERCENT OF HOUSEHOLDS RECEIVING SNAP BENEFITS



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 33

One in ten Port Chester households receive SNAP benefits, but the area's high level of need, surrounded by wealthier communities, creates additional barriers to accessing resources.

According to the survey, 12% of Port Chester respondents reported not having enough money in the last year to buy food, while 11% of respondents reported receiving groceries from a food pantry, food bank, soup kitchen, or other emergency food service in the last year.

According to an adult survey conducted for the 2023 Carver Center Community Needs Assessment Report, **80%** of respondents said that food was a '**high**' or '**medium**' **critical area of need** and **41%** said having enough food for their family was a '**big' area of concern** for adults.

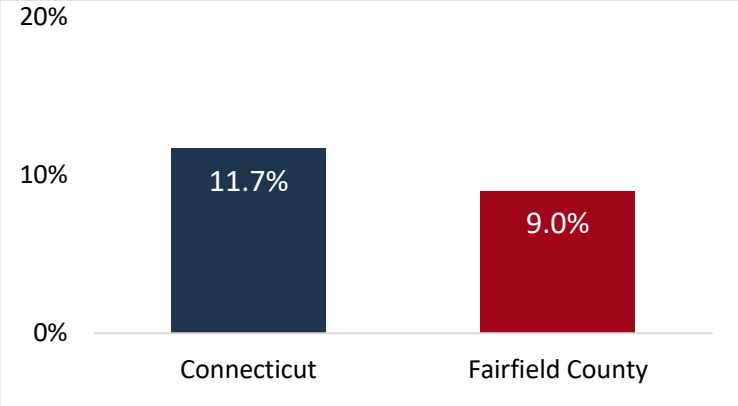
Source: Carver Center. *Community Needs Assessment Report.* Prepared by Aperio NY, INC. June 2023

Greenwich Perspective

In Greenwich, access to food assistance can be limited. Key Informants note that the town has limited food pantries and residents experiencing food insecurity have few options for support.

According to the survey, 6% of Greenwich respondents reported not having enough money in the past year to afford food and 4% reported receiving groceries or meals from a food pantry, food bank, soup kitchen, or other emergency food service in last year.

EXHIBIT 10: PERCENT OF HOUSEHOLDS RECEIVING SNAP BENEFITS



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 33

Neighborhood and Built Environment

Neighborhood and Built Environment is one of the five social drivers of health. It includes key factors such as quality of housing, access to transportation, and neighborhood crime and violence. Environmental conditions, such as air pollution, unsafe drinking water, and climate change also play a significant role in affecting both individual and community health.

Housing

Access to safe and affordable housing is a growing challenge in both Port Chester and Greenwich, impacting economic stability, workforce retention, and community well-being.

The hourly wage needed to afford a two-bedroom apartment is $50.54 in Fairfield County and $45.23 in Westchester County, far exceeding many workers' earnings. The lack of affordable housing options continues to widen economic divides in both communities.

Hourly Wage Necessary to Afford a 2-Bedroom Apartment at Fair Market Rent:

$50.54

in Stamford-Norwalk HUD Metro Area, Fairfield County, CT

$45.23

in Westchester County, NY

Source: National Low Income Housing Coalition (2023). Table 37

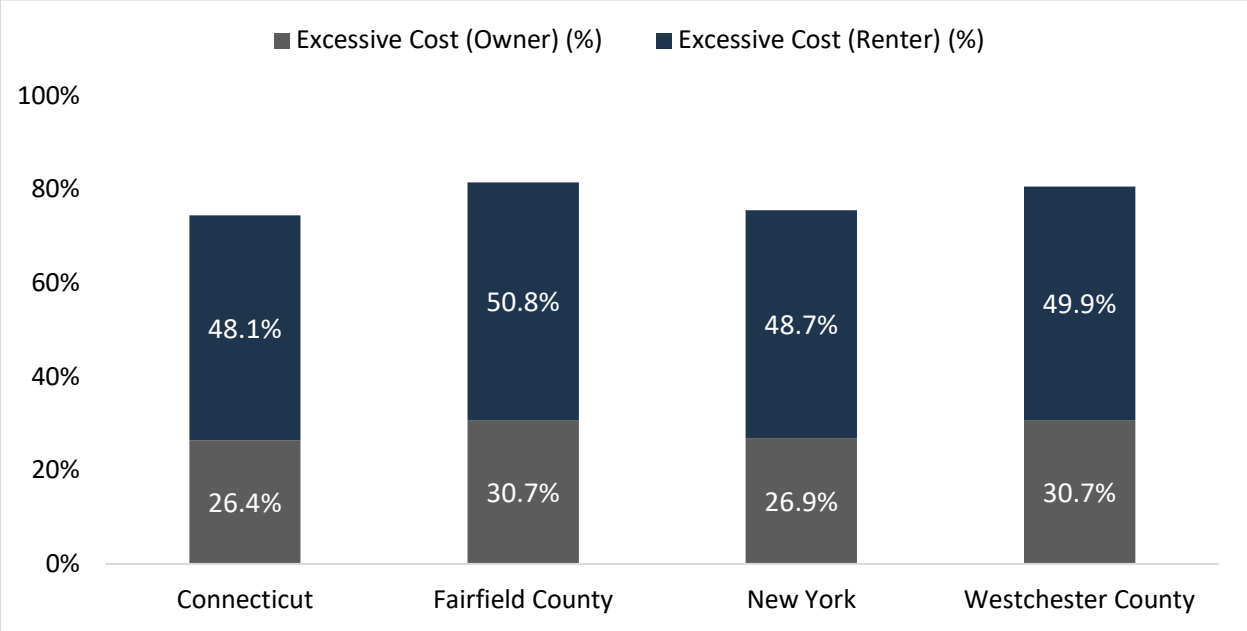
1.1%

of the 8,255 Greenwich Hospital patients screened reported **housing insecurity.**

Source: Yale New Haven Health's SDoH screening initiative (10/01/23- 09/30/24)

Across Connecticut and New York, nearly half of all renters spend an excessive portion of their income on housing, with rates even higher in Fairfield and Westchester Counties. Homeowners also face affordability challenges, particularly in Fairfield and Westchester, where over 30% experience excessive housing costs.

EXHIBIT 11: OWNER AND RENTER EXCESSIVE COST[4]



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 35

Greenwich Perspective

In Greenwich, Key Informants note that housing affordability is a major challenge for the town's working-class population, including teachers, domestic workers, and essential employees, who cannot afford to live where they work.

New York Perspective

Key Informants in New York and Port Chester describe housing as an overwhelming need, with rising costs making it difficult for long-term residents to stay in the community. Despite new apartment developments, prices remain unaffordable, raising concerns about displacement.

Community members shared that some families live in overcrowded, unsafe conditions, while some sleep in doorways due to a lack of local shelters. Unlike other parts of Westchester County, Port Chester has no shelters, and Rye Brook has none, due to its suburban nature. The Hispanic/Latino community is particularly affected, with community members sharing some families rely on unpermitted or unsafe housing, further straining local infrastructure.

[4] Excessive housing costs are defined by the U.S. Department of Housing and Urban Development (HUD) as spending more than 30% of household income on housing expenses, including rent or mortgage, utilities, and insurance.
Source: U.S. Department of Housing and Urban Development. "Affordable Housing."

Excessive <u>Renter</u> Housing Costs
(>30% of income on monthly rent):

45.1%
in Port Chester

77.8%
in Rye Brook

49.9%
in Westchester County, NY

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 35

In Port Chester, both homeowners and renters face significant housing affordability challenges, with costs taking up a large share of household income. Compared to the surrounding area, homeowners in Port Chester are more likely to be burdened by high housing costs.

Nearby Rye Brook, despite being an affluent community, has an even higher share of renters struggling to afford housing. This suggests that rental options in Rye Brook may be disproportionately expensive and limited, making it difficult for lower-income residents to secure affordable housing.

Excessive <u>Owner</u> Housing Costs
(>30% of income on monthly housing expenses):

41.8%
in Port Chester

30.7%
in Westchester County, NY

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 35

These differences highlight the varying housing pressures across the region, even between neighboring communities.

Transportation

Reliable transportation is essential for accessing jobs, healthcare, and community services, yet many residents face barriers to mobility.

1.0%
of 7,648 Greenwich Hospital patients screened reported **transportation insecurity.**

Source: Yale New Haven Health's SDoH screening initiative (10/01/23- 09/30/24)

Percent of Households Without a Vehicle:

9.1%
In Greenwich

13.9%
in Port Chester

Source: Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 3

New York Perspective

"[Residents] may not have a phone or money for Uber or a car. Some people have to turn down jobs because they can't get to a place of employment"

- New York Key Informant

Key Informants in New York and Port Chester report that many residents rely on public transit but face high taxi fees, especially for cross-border travel. Those living in public housing often lack vehicles, making it difficult to access fresh food and essential services. Public transportation options are limited in suburban areas, and safety concerns have contributed to a decline in transit use since COVID-19.

13.9% of Port Chester households do not have a vehicle, increasing dependence on unreliable transit. Limited transportation options also create barriers to employment, forcing some residents to turn down jobs due to lack of access.

Greenwich Perspective

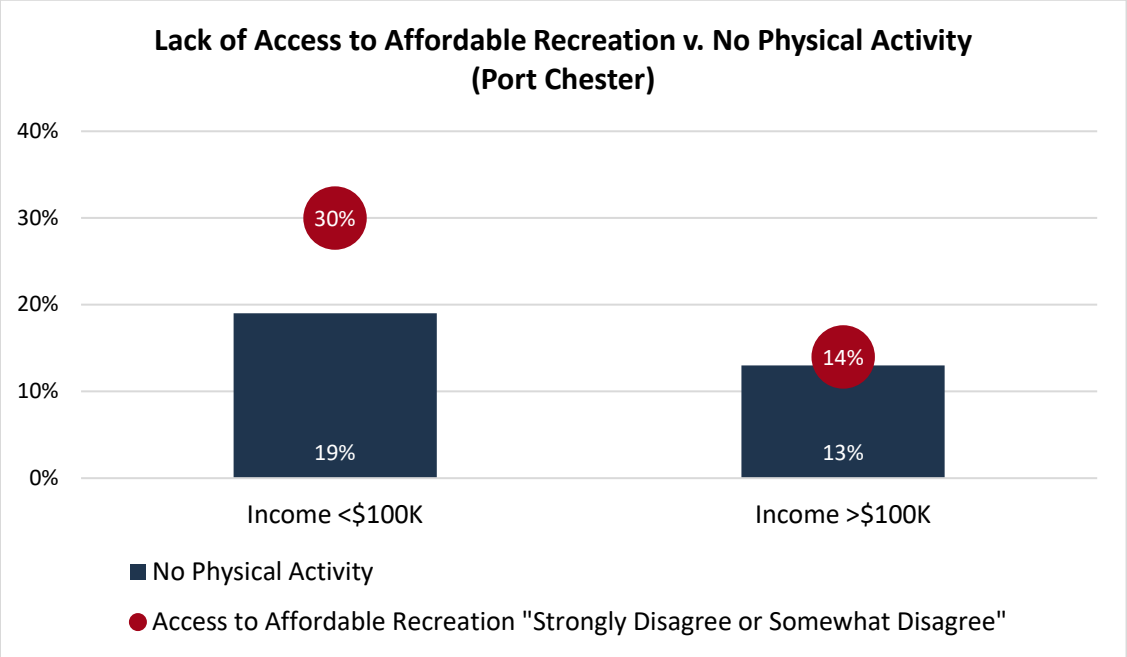
In Greenwich, 9.1% of households lack a vehicle (Table 3), and transportation challenges affect older adults and low-income workers. Some seniors struggle to reach community centers, even with taxi vouchers, as Key Informant's report taxis are difficult to secure. Expanding affordable and reliable transit could improve mobility for both communities.

Recreation and Physical Activity

New York Perspective

In Port Chester, survey respondents earning less than $100,000 reported both higher rates of physical inactivity and greater difficulty accessing affordable recreation. This suggests a clear connection: when cost and access are barriers, staying physically active becomes much more difficult. Over time, limited activity can increase the risk of chronic disease and other health challenges. Improving access to free or low-cost recreation—like parks, fitness programs, or walking paths—could help residents stay active and support better health for the broader community.

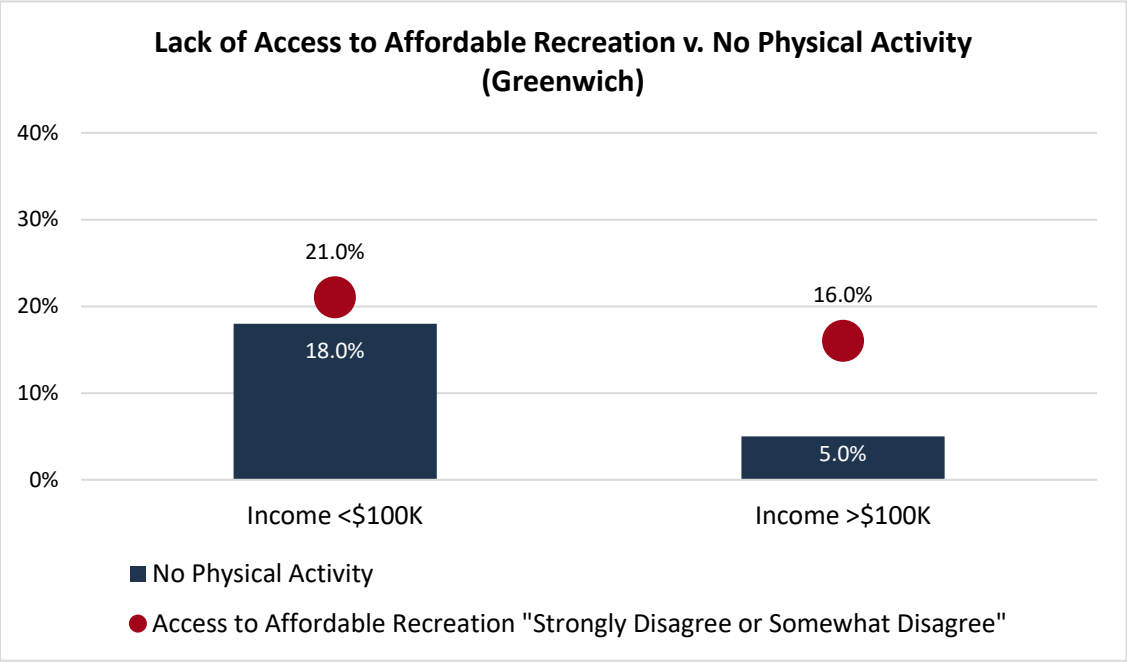
EXHIBIT 12: DCWS QUESTIONS – ACCESS TO AFFORDABLE RECREATION IN COMMUNITY (STRONGLY DISAGREE AND SOMEWHAT DISAGREE) VS. HOW MANY DAYS PER WEEK DO YOU EXERCISE (NONE), (PORT CHESTER)



Greenwich Perspective

Survey data from Greenwich show that residents with household incomes under $100,000 were more likely to report not getting any physical activity and to face challenges finding affordable recreation options. When cost is a barrier, residents may have fewer opportunities to exercise—whether that's joining a gym, accessing structured programs, or simply using local recreational spaces. These limitations can make it harder to maintain an active lifestyle and support long-term health. Expanding access to affordable, local recreation options may help reduce these gaps and promote healthier outcomes across income levels.

EXHIBIT 13: DCWS QUESTIONS – ACCESS TO AFFORDABLE RECREATION IN COMMUNITY (STRONGLY DISAGREE AND SOMEWHAT DISAGREE) VS. HOW MANY DAYS PER WEEK DO YOU EXERCISE (NONE) (GREENWICH)

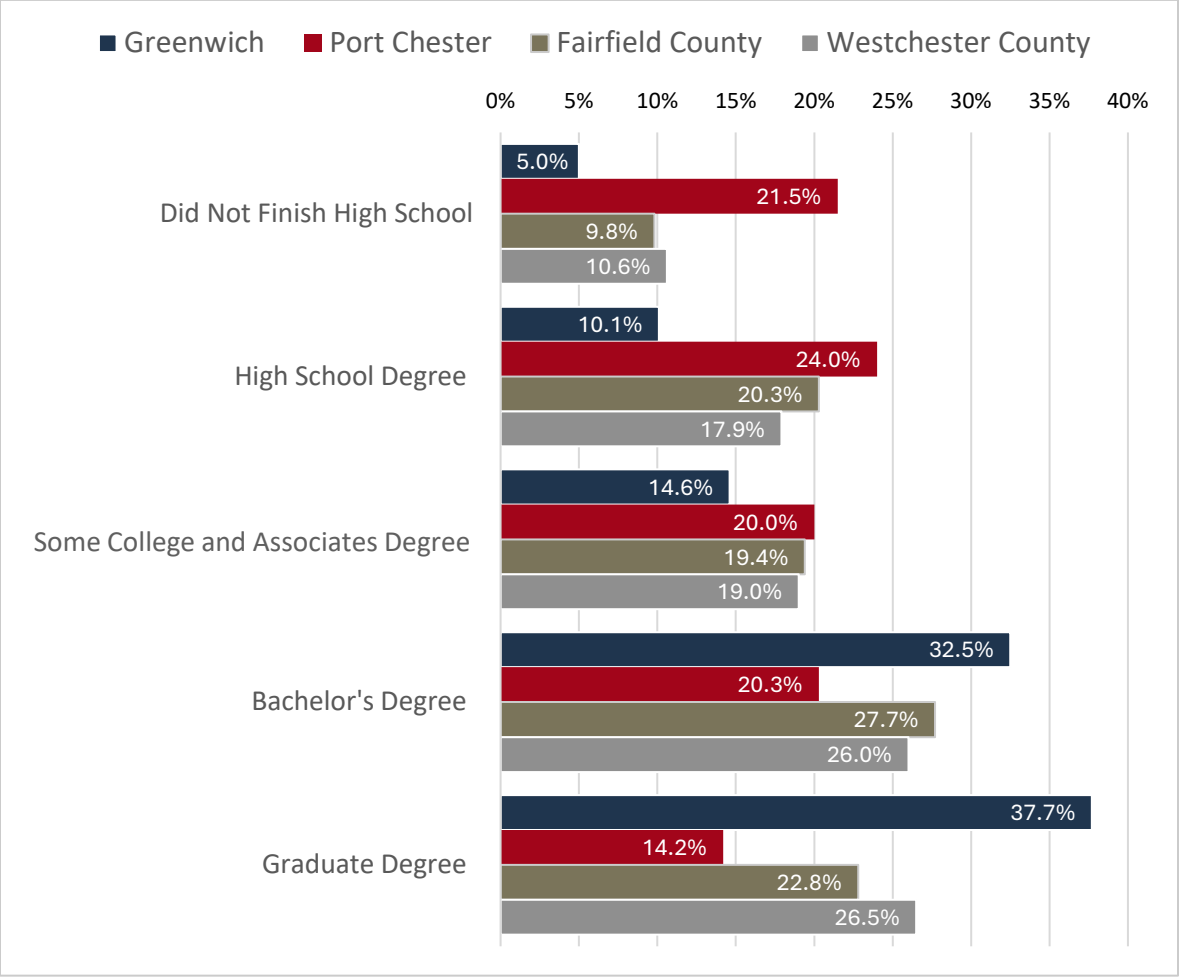


Education Access and Quality

Education Access and Quality is one of the five social drivers of health. High quality education and early childhood education programs can break intergenerational cycles of poverty by providing people with the skills and knowledge to promote social mobility and economic success. Higher income employment opportunities can increase a person's access to better quality healthcare, nutritious foods, and safe living environments.

Educational attainment influences economic stability, health literacy, and overall well-being. In Greenwich, 32.5% of adults hold a bachelor's degree, compared to 20.3% in Port Chester, and 37.7% in Greenwich have a graduate degree, compared to 14.2% in Port Chester (Table 18). However, 5.0% of Greenwich adults and 21.5% of Port Chester adults did not finish high school.

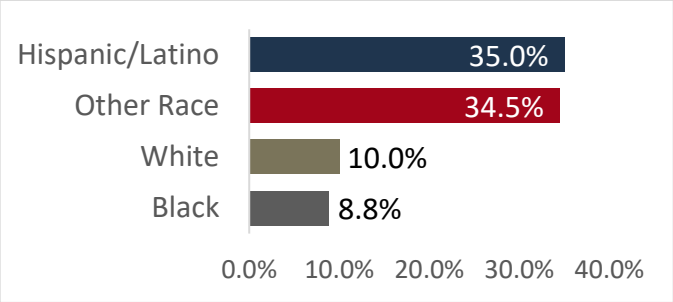
EXHIBIT 14: REGIONAL - HIGHEST LEVEL OF EDUCATIONAL ATTAINMENT, 25 YEARS AND OLDER



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 18

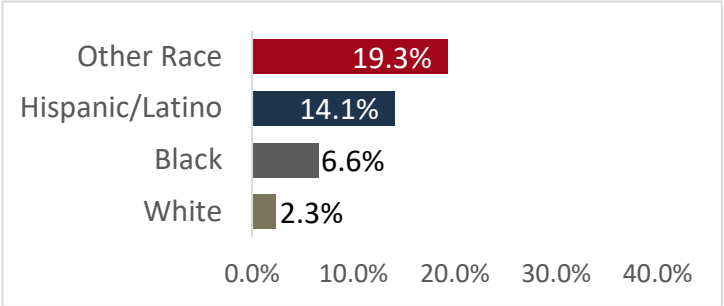
Educational levels also vary by race and ethnicity. In Greenwich, 14.1% of Hispanic/Latino adults lack a high school diploma, compared to 6.6% of Black and 2.3% of White residents. In Port Chester, 35.0% of Hispanic/Latino adults lack a diploma, compared to 8.8% of Black residents and 10.0% of White residents (Table 21).

EXHIBIT 15: ADULTS WITHOUT A HIGH SCHOOL DIPLOMA (AGE 25+), AS A SHARE OF THEIR RACIAL/ETHNIC GROUP (PORT CHESTER)



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 21

EXHIBIT 16: ADULTS WITHOUT A HIGH SCHOOL DIPLOMA (AGE 25+), AS A SHARE OF THEIR RACIAL/ETHNIC GROUP (GREENWICH)



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 21

Lower education levels contribute to reduced health literacy, making it harder for individuals to navigate healthcare systems, understand medical information, and engage in preventive care. Expanding educational and workforce development programs can help improve both economic and health outcomes for residents.[5]

[5] https://www.ncbi.nlm.nih.gov/books/NBK566338/

Social and Community Context

Social and Community Context is one of the five social drivers of health. A person's relationships and interactions with family, friends, coworkers, and community members can have a major impact on their health and well-being. Many people face challenges, such as unsafe neighborhoods, discrimination, or difficulty affording the basic things they need to survive, which can have a negative impact on their health and safety.

Community Resources for Seniors and Youth

Access to affordable childcare and senior support services is a concern in both Greenwich and Port Chester.

Percent of Households of Working Caregivers with Children Under 6:

71.8%
In Fairfield County

75.2%
in Westchester County

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 31

New York Perspective

Parents living in Port Chester frequently spoke of the need for affordable childcare, including after-school programs, in the area. They reported facing many barriers, including high costs, long wait lists, and difficult-to-navigate requirements:

- *"If people need daycare, then they need to pay for the full week, even if they only need one day. They ask for a lot of paperwork that [an employee's] boss won't always give." – Focus Group Participant*
- *"If you want to get kids to childcare or daycare, you have to show proof of income, even if it is free. It's hard to get help if you aren't working. Why do they want so much information? A lot of kids will be on the waitlist. – Focus Group Participant*

Key Informants spoke to the underlying issue, noting that a lack of funding inhibits the availability of childcare and after-school programs. They see community-focused collaboration as a strategy for maximizing the impact of funding and providing high-quality care:

- "*[We need] more funding for childcare and after-school programs - this is primary prevention, and this helps children and families.*" *-Key Informant*
- "*We need community goals and uniting childcare centers, not physically, but what can we do together*? *Maximize the funds to get as much as we can. We need more social workers who know Port Chester and can work alongside the schools, with the best interests of the community at heart. People in the community really care and we can do it.*" *-Key Informant*

Greenwich Perspective

In Greenwich, Key Informants highlight challenges for older adults, including social isolation and difficulty accessing help. Many seniors are reluctant to ask for assistance and lack a safe, affordable place to age with needed services. Family caregivers often struggle to balance their responsibilities, leaving some seniors without adequate support.

Additionally, a lack of affordable childcare was noted as a significant challenge for families living in Greenwich. A lack of affordable childcare can inhibit parents' ability to work or attend school outside of the home, thus limiting their opportunities for economic growth, as multiple Key Informants noted:

- *"They don't make enough money to pay for childcare, so they stay home because they don't make enough money to cover childcare."-Key Informant*
- *"Childcare is a huge concern. Our clients can't afford not to work, so they need childcare but it's so expensive." -Key Informant*

Residents were also concerned about the quality of childcare provided. Key Informants noted that a lack of funding prevents childcare facilities from hiring child-specific educators, who are essential for high-quality care. High-quality childcare provides children with opportunities to socialize and develop age-appropriate skills. This can address other needs that children in the community face, such as the need for early education:

- "*We need to focus more on prevention and brain health at an early age. We need to get kids to sleep the right amount and address their mental health and their basic needs and their basic developmental needs." -Key Informant*

Key Informants and focus group participants frequently identified alternative forms of childcare, such as after-school programs and summer camps, as key needs as well. Focus group participants shared their first-hand struggles with navigating childcare, work, and children's transportation to school:

"[I have] one kid that's ten and one kid that's four. I can't leave work to take kids to school because it starts at 11:15 am*. It feels really hard to get affordable childcare, and there is no transport at the time they leave." – Focus Group Participant*

"After-school programming and summer programming [are needed.] They're seen as luxuries, but they're not; they're requirements for a lot of working families. They need childcare."

- Greenwich Key Informant

Social Support

Mental and emotional well-being are closely linked to social support and a person's ability to manage stress and access care. In both Port Chester and Greenwich, survey data reflect the connection between emotional support, anxiety, and the risk of depression.

New York Perspective

Many Port Chester residents are experiencing high levels of stress and emotional strain. According to survey data, over half of respondents reported feeling anxious the previous day, and 17% screened as at risk for a major depressive episode.

EXHIBIT 17: DCWS QUESTION – HOW ANXIOUS DID YOU FEEL YESTERDAY? (PORT CHESTER)

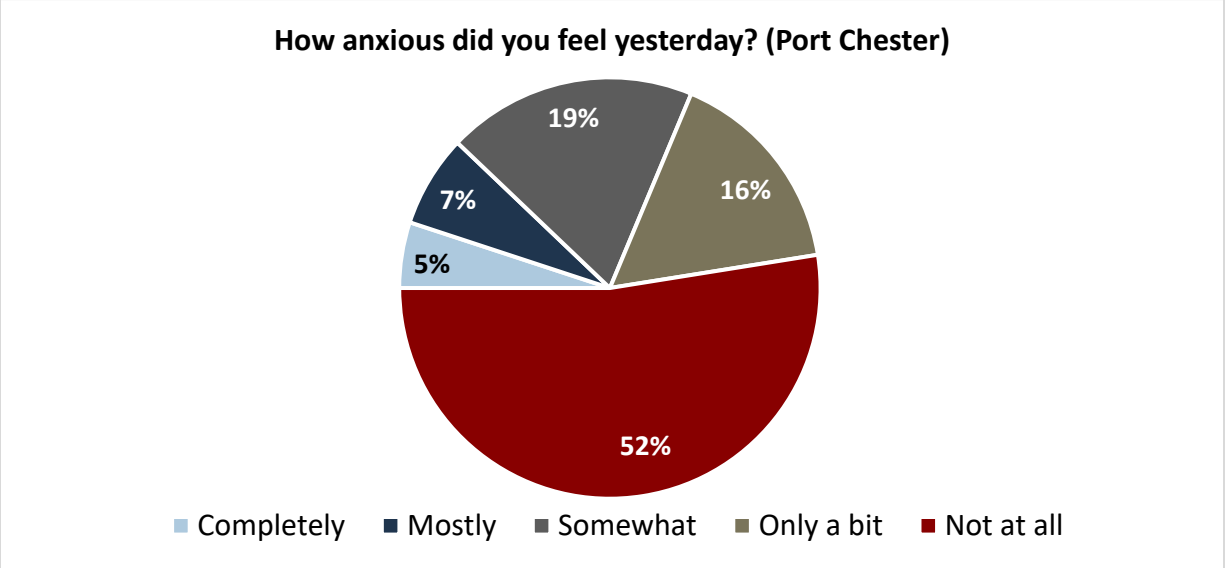
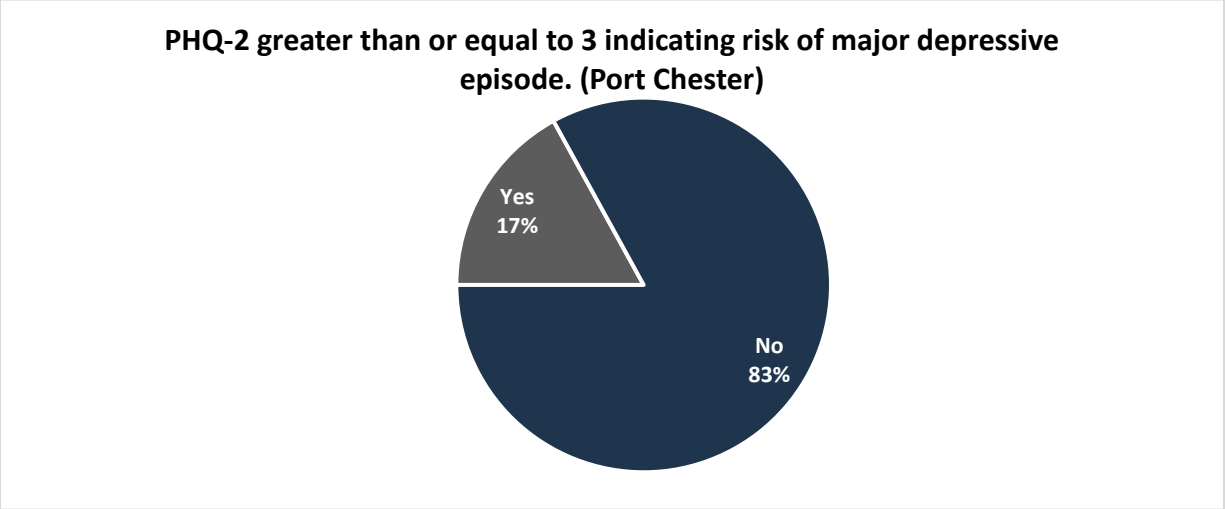
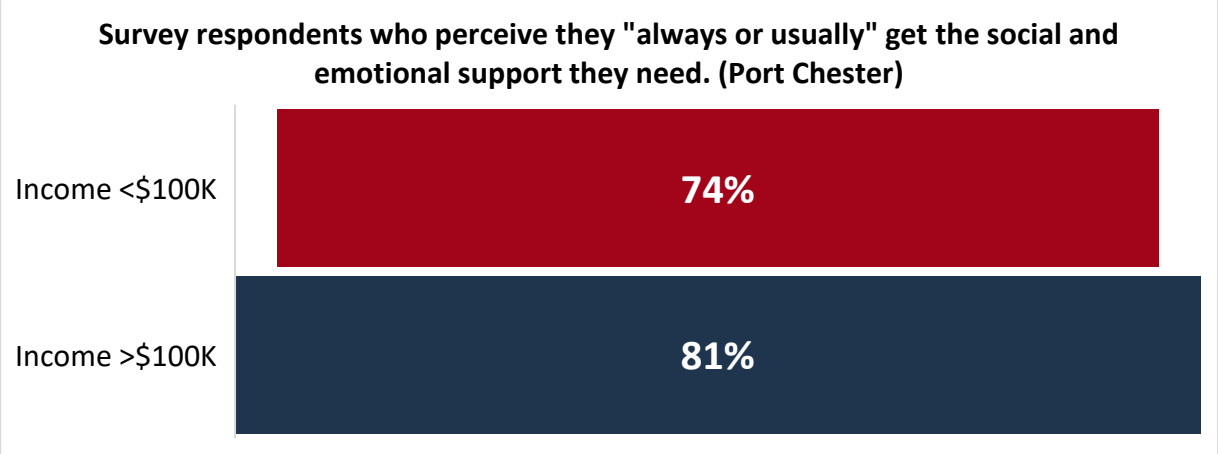


EXHIBIT 18: DCWS QUESTION – PHQ-2 GREATER THAN OR EQUAL TO 3 INDICATING RISK OF MAJOR DEPRESSIVE EPISODE[6] (PORT CHESTER)



Support systems are a protective factor, but emotional support is not always equally felt. While 74% of respondents with household incomes under $100,000 said they “always” or “usually” receive the emotional support they need, this still leaves a quarter of residents who may not feel consistently supported.

EXHIBIT 19: DCWS QUESTION - SURVEY RESPONDENTS WHO PERCEIVE THEY "ALWAYS OR USUALLY" GET THE SOCIAL AND EMOTIONAL SUPPORT THEY NEED (PORT CHESTER)



Greenwich Perspective

Survey data from Greenwich reveals a relatively positive picture of emotional well-being for many residents. The majority of respondents reported feeling little to no anxiety on the day prior to the survey, and only 10% screened as at risk for a major depressive episode.

[6] **PHQ-2** refers to the Patient Health Questionnaire-2, a brief screening tool used to identify possible depression. A score of 3 or higher suggests a risk of a major depressive episode and indicates the need for further evaluation.
Source: https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health

EXHIBIT 20: DCWS QUESTION – HOW ANXIOUS DID YOU FEEL YESTERDAY? (GREENWICH)

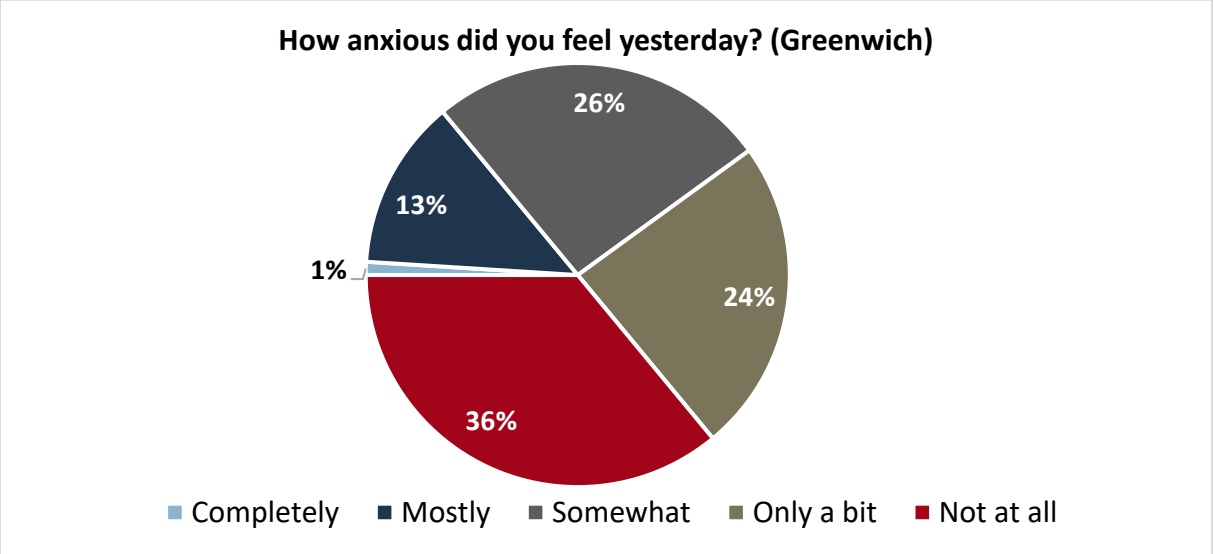
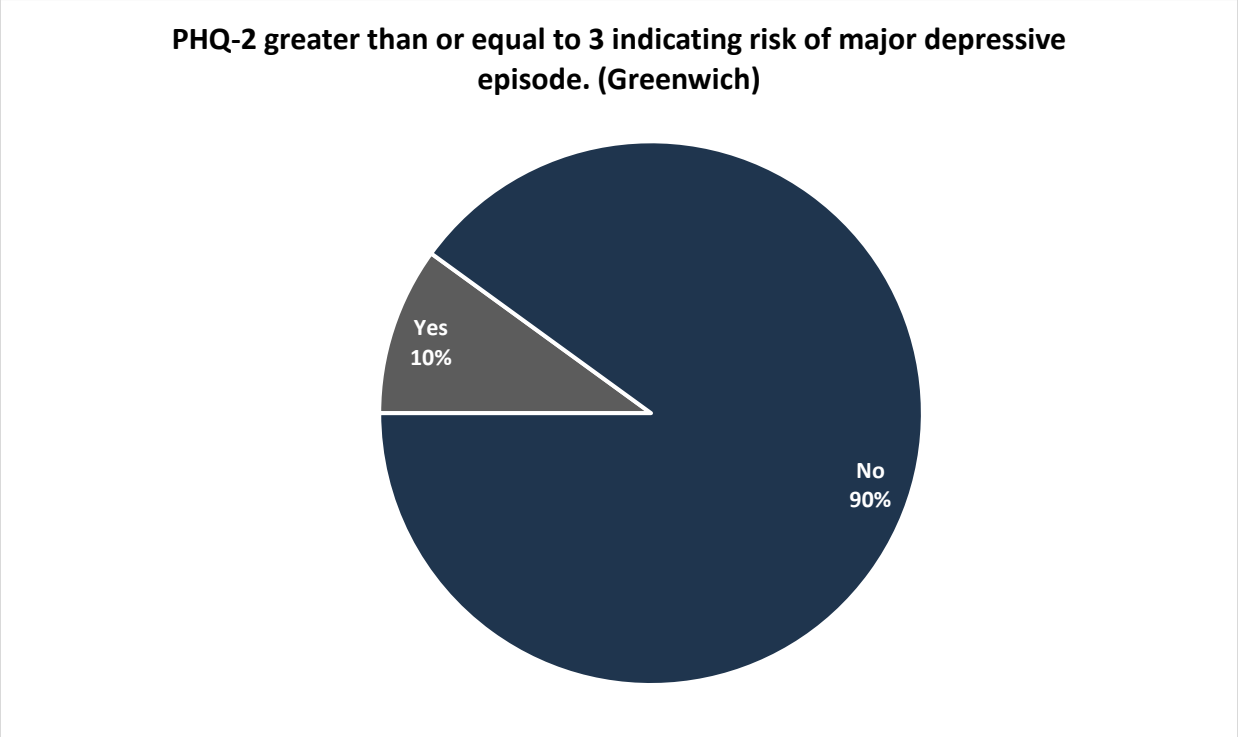


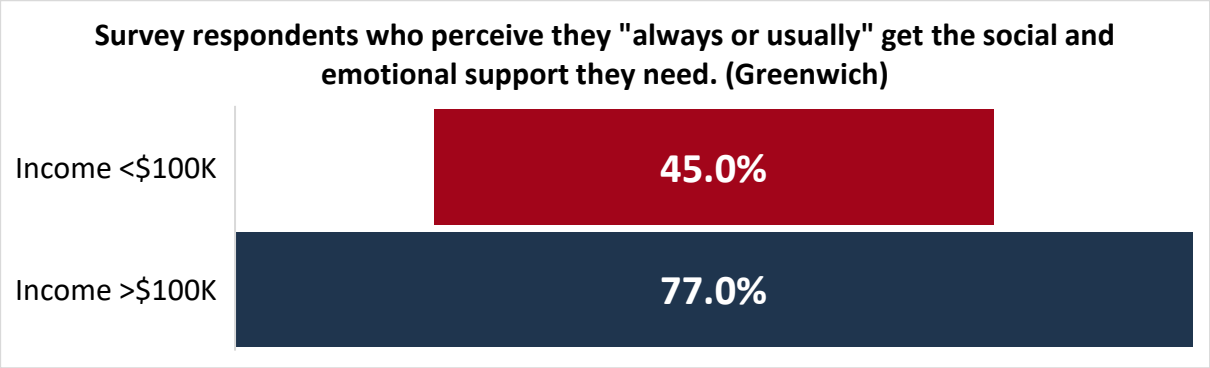
EXHIBIT 21: DCWS QUESTION – PHQ-2 GREATER THAN OR EQUAL TO 3 INDICATING RISK OF MAJOR DEPRESSIVE EPISODE[7] (GREENWICH)



[7] **PHQ-2** refers to the Patient Health Questionnaire-2, a brief screening tool used to identify possible depression. A score of 3 or higher suggests a risk of a major depressive episode and indicates the need for further evaluation.
Source: https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health

However, access to emotional support appears uneven. While most residents with household incomes over $100,000 said they “always” or “usually” receive the support they need, just 45% of respondents earning less than $100,000 reported the same.

EXHIBIT 22: DCWS QUESTION - SURVEY RESPONDENTS WHO PERCEIVE THEY "ALWAYS OR USUALLY" GET THE SOCIAL AND EMOTIONAL SUPPORT THEY NEED (GREENWICH)



These findings suggest that although many Greenwich residents feel emotionally well, there are gaps in support for lower-income community members. Strengthening local connections and expanding access to mental health and social resources may help ensure all residents feel supported.

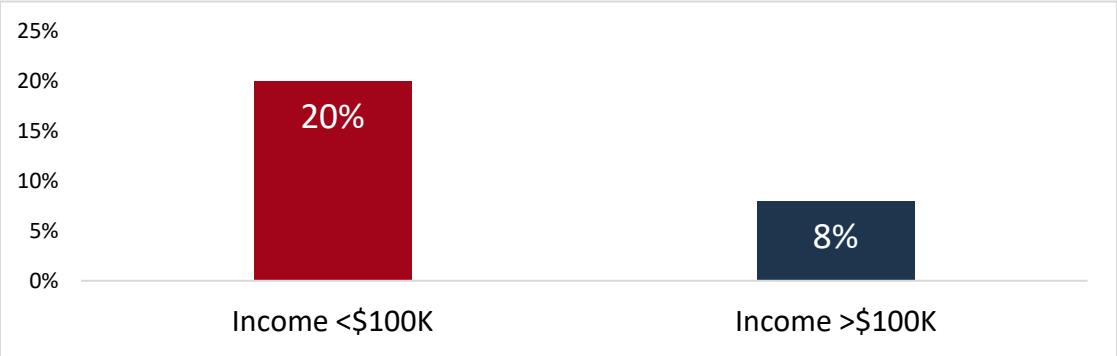
Health Care Access and Quality

Health Care Access and Quality is one of the five social drivers of health. Health care access and quality can impact a person's health outcomes and overall well-being by influencing the availability, effectiveness, and safety of health services. groups experiencing disadvantage often face barriers to high-quality health care due to socioeconomic disparities, insurance gaps, and limited availability or access to providers among other factors.

Access to Care

Survey results show that lower-income residents in Greenwich are more likely to experience chronic disease, struggle to access care, and lack a consistent healthcare provider. 20% of lower-income residents reported they did not have a primary care provider compared to just 8% of higher-income residents.

EXHIBIT 23: DATAHAVEN COMMUNITY WELL-BEING SURVEY QUESTION – PARTICIPANTS WHO NEEDED BUT DID NOT RECEIVE NECESSARY MEDICAL CARE (GREENWICH)



Barriers

Insurance

New York Perspective

Key Informants in Port Chester report that insurance type is one of the biggest barriers to care (Table 40), as many providers no longer accept insurance due to low reimbursement rates. For working-class older adults who do not qualify for Medicaid, affording care is particularly difficult.

A growing number of people are just above the Medicaid eligibility threshold but still struggle to afford healthcare costs. High deductibles prevent many from seeking preventive care, forcing them to pay out of pocket for essential services.

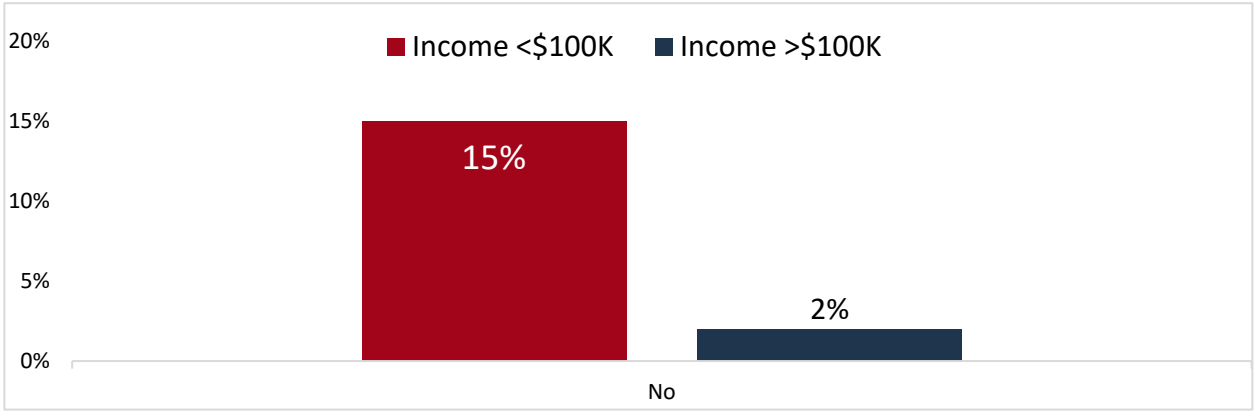
Key Informants also note that New York's health insurance marketplace has worsened, making it harder for people to find coverage that meets their needs.

> **"People aren't doing enough preventative care; they're not getting enough coverage because they have huge deductibles and have to pay out of pocket. During the pandemic more people were getting care, but then after they closed it down, and more people had to reapply for services."**
>
> **- New York Key Informant**

During the pandemic, temporary healthcare programs increased access, but many people lost coverage once these programs ended, requiring them to reapply for services.

Survey data reflects these challenges. Overall, 10% of Port Chester survey respondents report being uninsured, and rates are even higher for lower-income residents—15% of those earning under $100,000 do not have health insurance, compared to just 2% of higher-income residents.

EXHIBIT 24: DATAHAVEN COMMUNITY WELL-BEING SURVEY QUESTION – PARTICIPANTS WHO DO NOT HAVE HEALTH INSURANCE (PORT CHESTER)



In addition, 12.1% of Port Chester residents are uninsured, a much higher rate than Westchester County as a whole (4.9%), highlighting a higher level of need in this community (Table 1).

Greenwich Perspective

Overall, 5.6% of Greenwich residents are uninsured, which is lower than the Fairfield County average of 7.7% (Table 1). While the uninsured rate is lower in Greenwich, Medicaid patients and uninsured individuals still face significant barriers to care.

In Greenwich, Key Informants note that finding providers who accept Medicaid is a significant challenge, particularly for specialty and dental care. One Key Informant shared that a Medicaid patient needed urgent dental care on a Monday, but no providers were available.

Uninsured Population

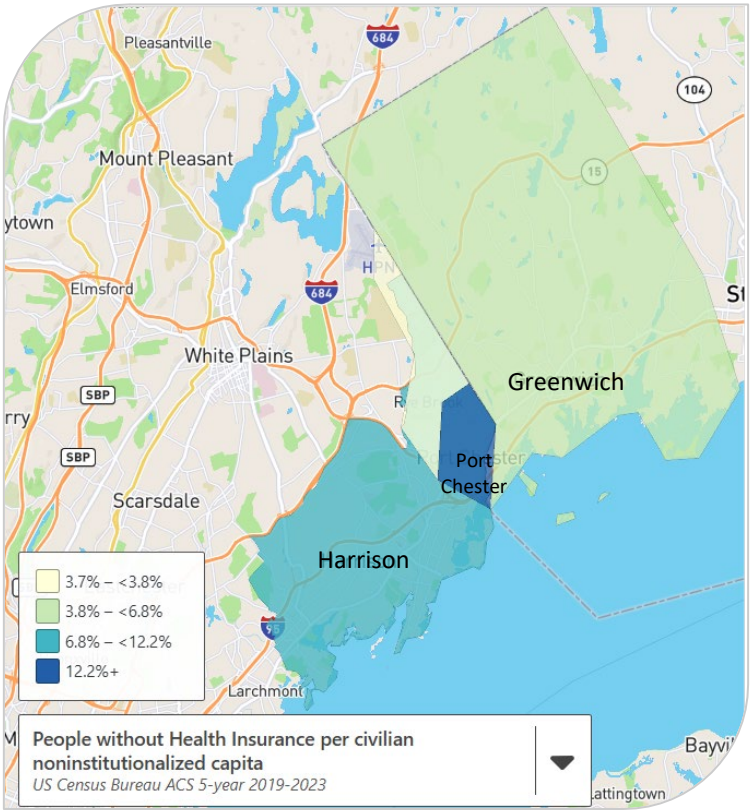
5.6%
Greenwich
Fairfield County: 7.7%

12.1%
Port Chester
Westchester County: 4.9%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 1

Specialist availability for those who are uninsured is another concern, especially for children with complex medical needs.

EXHIBIT 25: UNINSURED POPULATION BY GEOGRAPHY

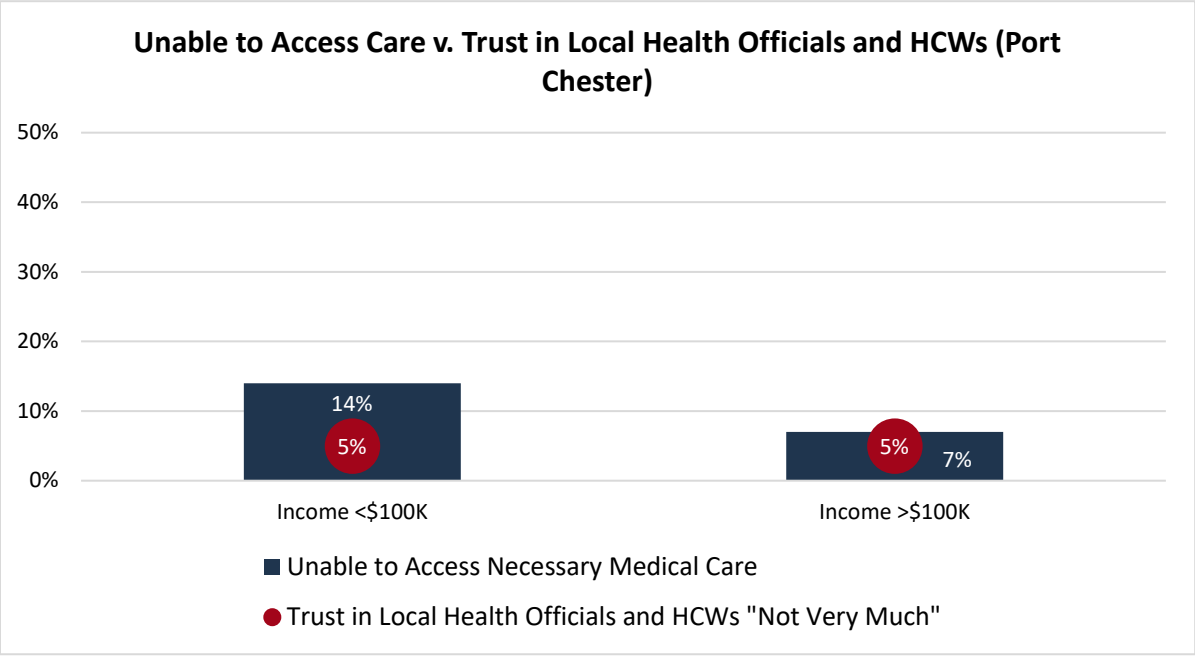


Trust

New York Perspective

According to survey data, Port Chester residents earning less than $100,000 were nearly twice as likely to report difficulty accessing necessary medical care compared to those with higher incomes. Survey respondents with lower incomes also expressed slightly less trust in local health officials and healthcare workers. These findings suggest that both financial and trust-related barriers may contribute to reduced access to care.

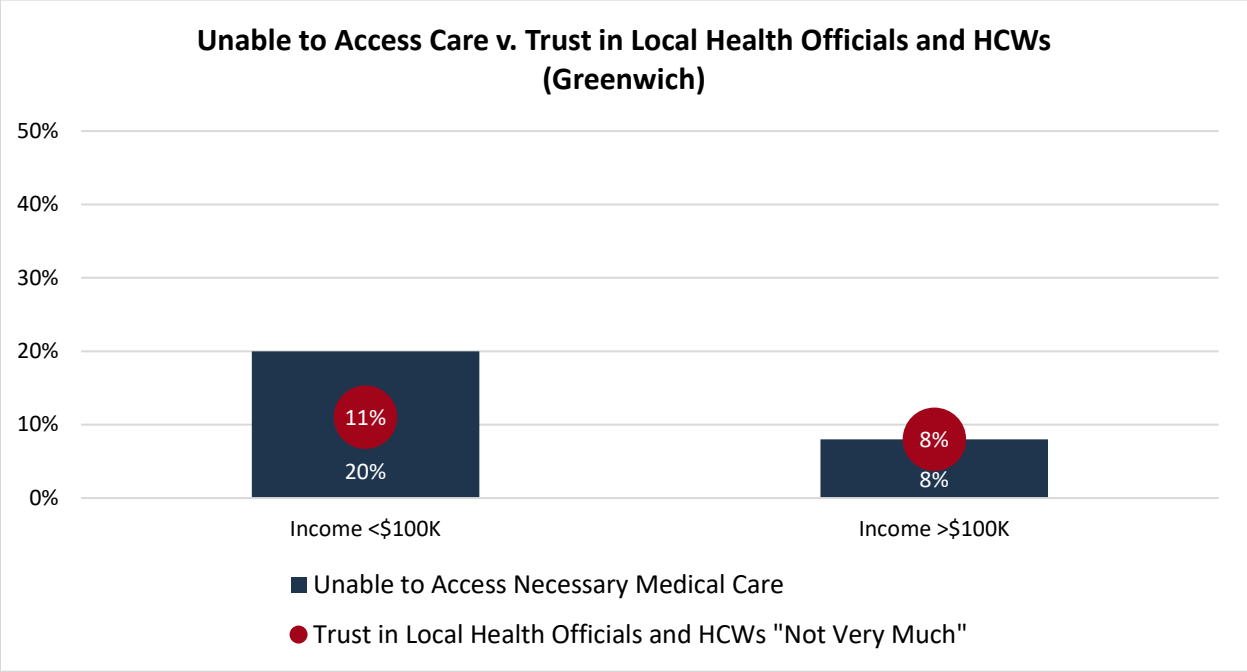
EXHIBIT 26: DCWS SURVEY QUESTIONS - DIFFICULTY ACCESSING MEDICAL CARE AND TRUST IN HEALTH OFFICIALS BY INCOME (PORT CHESTER)



Greenwich Perspective

In Greenwich, survey data shows that residents with household incomes under $100,000 were more than twice as likely to report being unable to access necessary medical care compared to those with higher incomes. They were also slightly more likely to report having low trust in local health officials and health care workers. These findings highlight how financial barriers and trust in the health system may influence whether people seek care, which can lead to delays in treatment and worse health outcomes over time.

EXHIBIT 27: DCWS SURVEY QUESTIONS - DIFFICULTY ACCESSING MEDICAL CARE AND TRUST IN HEALTH OFFICIALS BY INCOME (GREENWICH)



Providers

Access to primary and specialty care is a growing challenge in Port Chester, with provider shortages (Table 41), long wait times, and a lack of specialized services impacting residents' ability to receive timely care.

In Port Chester, provider shortages are severe, with significantly fewer primary care doctors and pediatricians compared to New York state, making it especially difficult for families to access timely care. The limited number of providers contributes to long wait times and overburdened healthcare facilities, particularly for children in Port Chester.

EXHIBIT 28: HEALTH CARE PROVIDER RATIOS, PEOPLE PER PROVIDER

PORT CHESTER VS. NY STATE	
Primary Care Physicians (PCP)	**Pediatricians**
2,607: 1	**3,165: 1**
NY State Ratio 889: 1	NY State Ratio 621: 1
Higher ratios indicate fewer providers per person.	

Greenwich Perspective

Key Informants report that finding a primary care provider is increasingly difficult, even for residents with insurance. Many doctors are not accepting new patients, and specialty care wait times are long, particularly for geriatric care. According to community members, geriatricians in private practice are nearly nonexistent, leaving aging residents with few options. Some long-term patients lost access to their providers when doctors switched to a concierge model, requiring membership fees that not all residents can afford.

Visit to Doctor for Routine Checkup Within Past Year

74.3%

Greenwich

CT: 75.3%

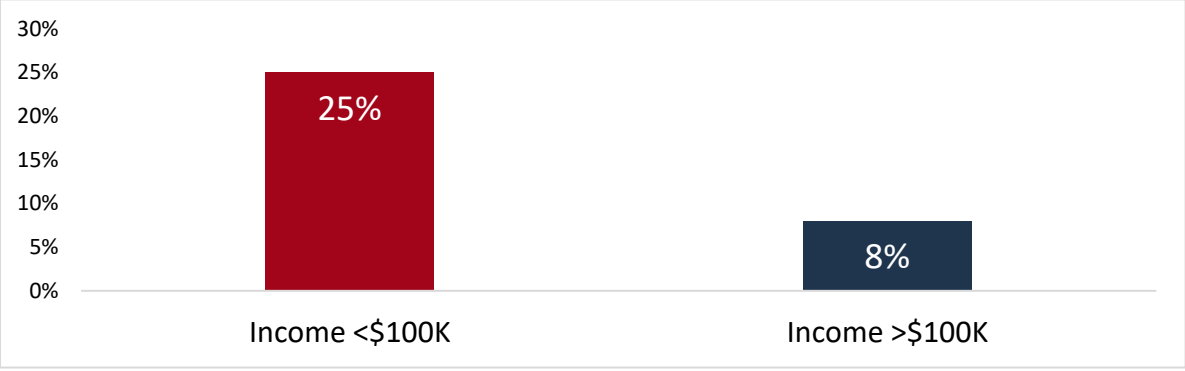
Source: CDC PLACES (2020-2021).
Table 51

"Primary care [is a top need] because of the demand. Even people with insurance, providers are not accepting new patients."

- Greenwich Key Informant

In Greenwich, 12% of overall survey respondents reported not having a personal doctor or healthcare provider, with lower-income residents more likely to lack a consistent source of care. 25% of those earning under $100,000 reported not having a regular provider, compared to 8% of higher-income residents.

EXHIBIT 29: DATAHAVEN COMMUNITY WELL-BEING SURVEY QUESTION – PARTICIPANTS WHO DO NOT HAVE ONE PERSON OR PLACE WHO IS CONSIDERED A PERSONAL DOCTOR OR HEALTH CARE PROVIDER (GREENWICH)



Despite these challenges, Key Informants suggested that pediatric and senior health-specific clinics could help meet the needs of populations struggling to access care.

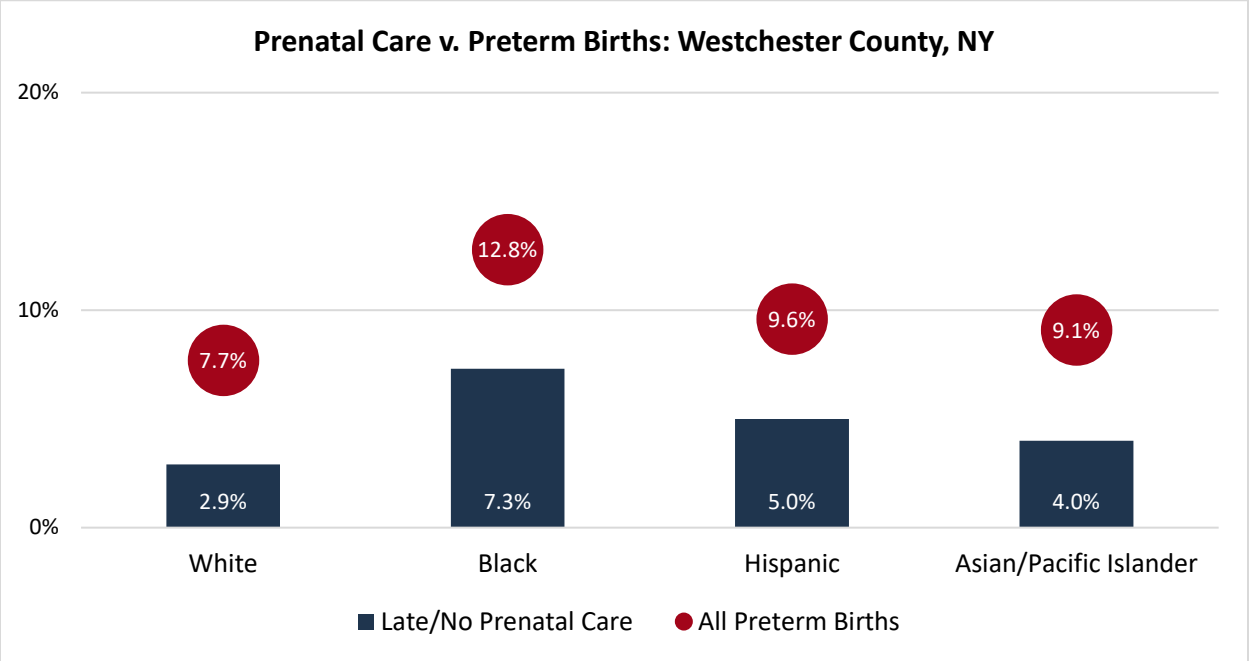
Maternal Health

New York Perspective

Timely prenatal care is important for identifying and managing health issues during pregnancy. In Westchester County, data show that Black mothers are more likely to receive late or no prenatal care and experience higher rates of preterm births compared to other groups. Hispanic and Asian/Pacific Islander mothers also face higher rates of delayed care than White mothers.

These patterns highlight the importance of improving access to early and consistent prenatal care for all pregnant individuals, especially in communities where disparities persist. Strengthening culturally appropriate outreach, reducing barriers to care, and supporting expectant parents early in pregnancy can help improve birth outcomes and reduce risks.

EXHIBIT 30: RACIAL/ETHNIC DIFFERENCES IN LATE OR NO PRENATAL CARE AND PRETERM BIRTHS, WESTCHESTER COUNTY, NY



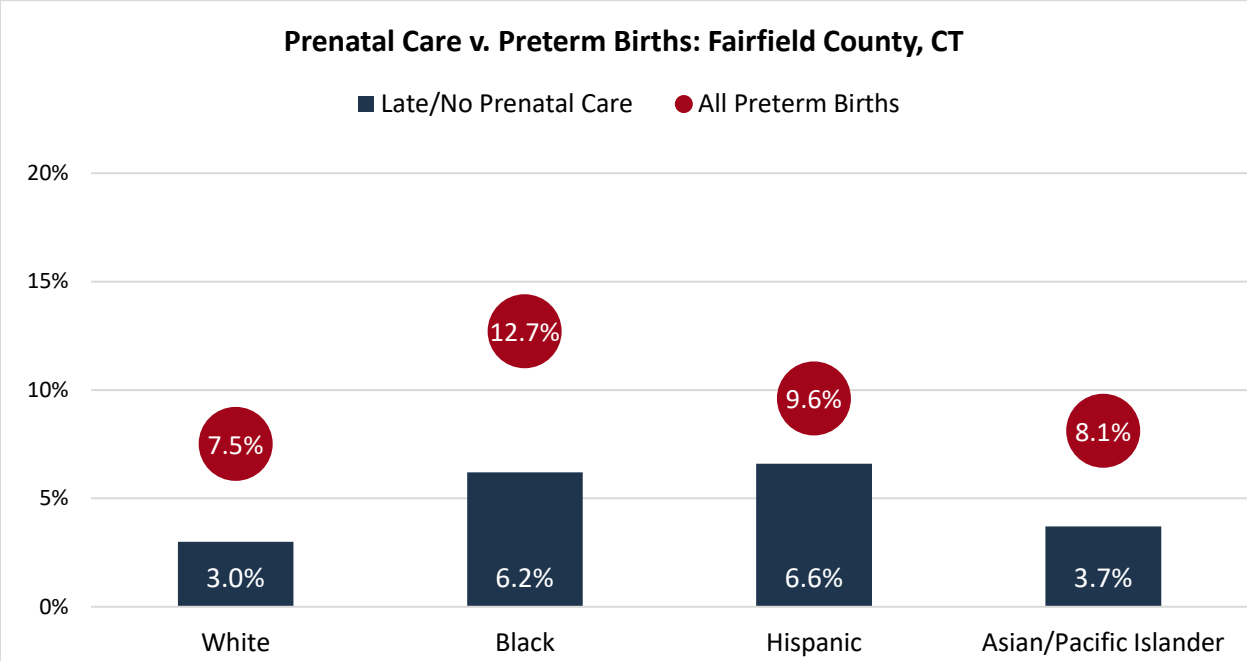
Source: National Center for Health Statistics, final natality data. Table 59 and Table 60

Greenwich Perspective

In Fairfield County, CT, differences in prenatal care and birth outcomes are visible across racial and ethnic groups. Black and Hispanic mothers are more likely to receive late or no prenatal care compared to White and Asian/Pacific Islander mothers. These same groups also experience higher rates of preterm births.

Getting prenatal care early can help prevent complications and improve the health of both the parent and the baby.[8] These findings underscore the need for targeted efforts to improve timely access to prenatal services, especially in communities facing systemic barriers. Reducing these gaps can lead to better birth outcomes and support healthier families.

EXHIBIT 31: RACIAL/ETHNIC DIFFERENCES IN LATE OR NO PRENATAL CARE AND PRETERM BIRTHS, FAIRFIELD COUNTY, CT



Source: National Center for Health Statistics, final natality data. Table 59 and Table 60

[8] Office of Disease Prevention and Health Promotion. *Increase the proportion of pregnant women who receive early and adequate prenatal care — MICH-08*. Healthy People 2030, U.S. Department of Health and Human Services. https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/increase-proportion-pregnant-women-who-receive-early-and-adequate-prenatal-care-mich-08

Health Equity

New York Perspective

New York Community members shared that there are notable language barriers regarding access to healthcare. New Americans[9] may be intimidated to call organizations or call for assistance because they believe no one will speak Spanish. The phone tree systems[10] are especially difficult for individuals with English as a second language according to New York Key Informants.

> **"There is a large Spanish-speaking population in Port Chester—about 60% have Spanish heritage. Many immigrants are first-generation or have been in the community for a few generations, and there are many needs in that community, including health issues, food insecurity, housing, and mental health."**
>
> **- New York Key Informant**

Greenwich Perspective

Greenwich Key Informants highlight disparities based on socioeconomic status, with low-income families facing limited options as healthcare shifts toward a concierge model.[11] Language barriers were a common barrier cited for both primary care and behavioral health care. Key Informants called for substance use prevention education to be offered in different languages throughout the community. Over 20 languages spoken in local high schools further complicate access, while parents working multiple jobs exacerbate challenges. Key Informants note that fear of paperwork and language barriers deter people from seeking help. Additionally, the LGBTQ+ community, especially transgender individuals, face barriers to accessing community resources.

> **"People don't feel comfortable with their doctors when they don't look like them or feel like their doctors don't understand what they're going through."**
>
> **- Greenwich Key Informant**

[9] This term includes foreign-born individuals (and their children and families) who seek to be fully integrated into their new community in the United States. These persons include Immigrants (foreign-born individuals who obtain lawful permanent resident status) and Refugees.

[10] A phone tree is an automated menu system that guides callers through a series of pre-recorded messages and prompts, directing them to the most relevant department or information within an organization.

[11] Concierge care is when a doctor or group of doctors charges you a membership fee before they'll see you or accept you into their practice

Mental Health

Mental health is a growing concern in both Greenwich and Port Chester, with high rates of hospital visits for mental health conditions and limited provider availability. In Greenwich, mental health was the second most common reason for hospital visits, reflecting the demand for care and the challenges in accessing outpatient services. In both communities, mental health provider shortages make it difficult to find timely, affordable care, with Greenwich residents facing higher-than-average provider-to-population ratios and Port Chester experiencing a severe shortage of mental health professionals (Table 41).

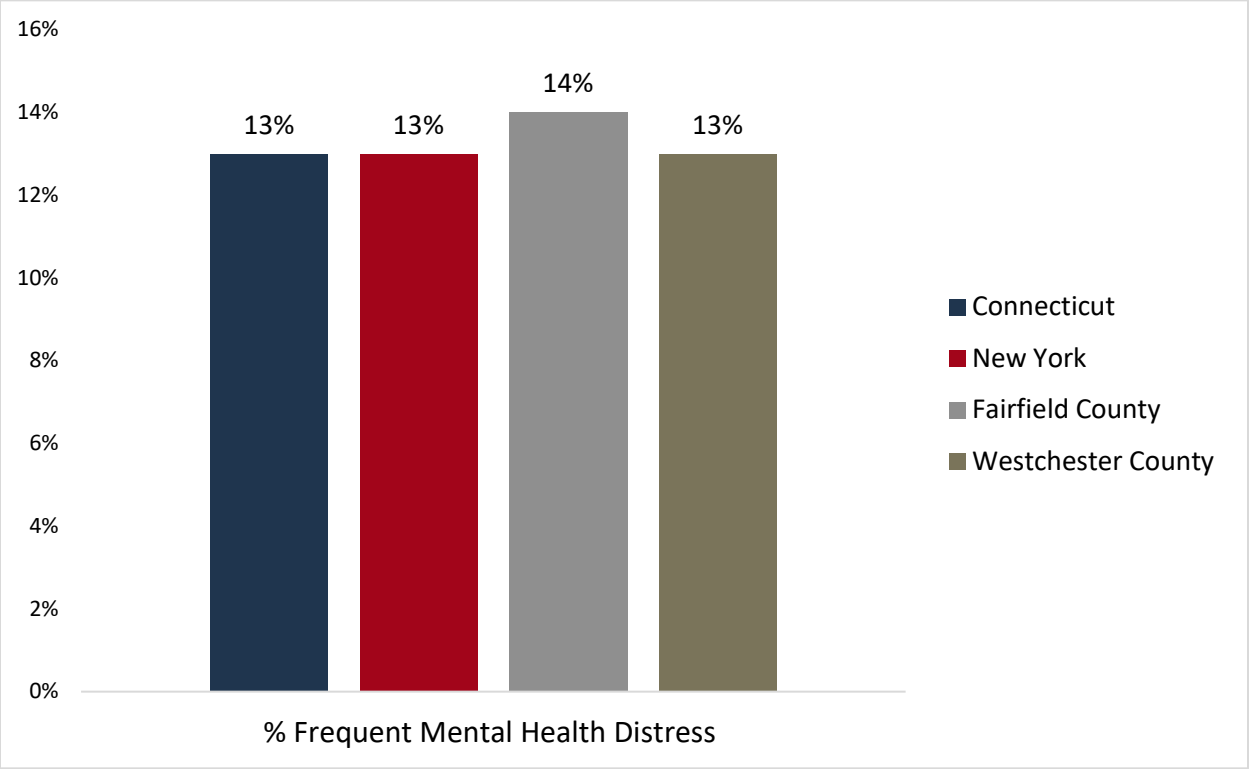
Mental health conditions were the **second** most common hospital diagnosis at Greenwich Hospital, with a rate of **5.5 per 1,000** adults.

Source: Connecticut Hospital Association CHIME Data. (Table 48)

EXHIBIT 32: HEALTH CARE PROVIDER RATIOS, PEOPLE PER PROVIDER

GREENWICH VS. CT STATE	PORT CHESTER VS. NY STATE
Mental Health Providers	**Mental Health Providers**
623: 1	**1,956: 1**
CT State Ratio 516: 1	NY State Ratio 585: 1
Higher ratios indicate fewer providers per person.	

EXHIBIT 33: PERCENT OF POPULATION EXPERIENCING FREQUENT MENTAL HEALTH DISTRESS, (CONNECTICUT & NEW YORK)



Source: County Health Rankings, 2021. Table 56

Greenwich Perspective

"Behavioral health and mental health services continue to be less available to the non-affluent and service periods are too short for effective treatment. Suicide prevention programs continue to be needed for many groups and age groups."
- Greenwich Key Informant

Key Informants report that youth mental health access is a growing issue, with long wait times, travel burdens, and cultural stigma preventing children from receiving care. High academic expectations and family pressures contribute to significant stress, particularly in high-achieving families. Some residents reported avoiding seeking help due to concerns about confidentiality and distrust in the school system.

Access is also reportedly a challenge for working-class families, as community members shared that mental health services remain costly with high co-pays, limiting affordability. Without affordable and accessible mental health services, many families struggle to get the care they need.

New York Perspective

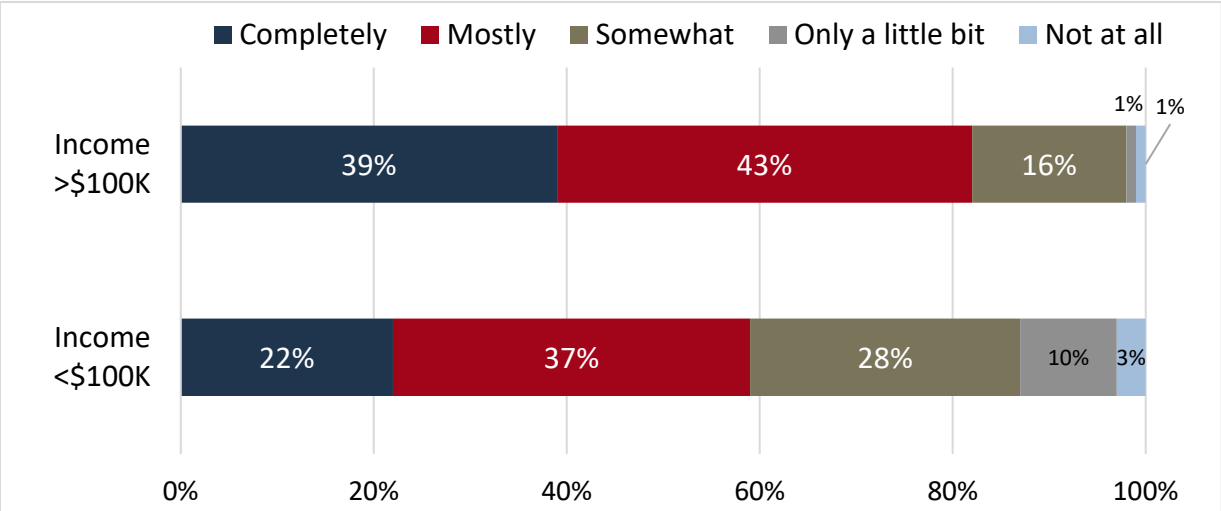
Key Informants in Port Chester highlight high rates of suicide ideation among middle and high school students, though they note a recent decline in frequency. They emphasized the need in the community for expanded mental health education for both parents and students to encourage early intervention.

According to community members, access to care is also restricted by high co-pays and a lack of providers, with many therapists charging rates that are unaffordable even for insured patients. Older adults face unique challenges, including loneliness, untreated mental health conditions, and difficulties managing medications.

Despite these challenges, 70% of Port Chester survey respondents report feeling "completely" or "mostly" satisfied with their lives, though disparities exist, particularly among those earning less than $100,000 per year (59% reporting "completely" or "mostly" satisfied with their lives).

> **"There's a lot of pressure on the kids, an expectation that if you don't succeed in academics, sports, volunteering, then you're a failure. It's a message that the kids hear and feel. There is a price of affluence on mental health; kids in high-achieving schools are an at-risk population for mental health and substance abuse from the pressure that kids feel every day."**
>
> **- New York Key Informant**

EXHIBIT 34: DATAHAVEN SURVEY QUESTION – OVERALL, HOW SATISFIED ARE YOU WITH YOUR LIFE NOWADAYS? (PORT CHESTER)



Substance Use

Substance use is a concern raised by community members in both Greenwich and Port Chester, particularly regarding youth alcohol and marijuana use, barriers to treatment, and stigma (Table 59).

At Greenwich Hospital, substance-related disorders were the third most common reason for hospital visits, with 4.8 per 1,000 adults requiring care. While Key Informants acknowledge existing efforts to address substance use, access to treatment and evolving patterns of use remain ongoing topics of discussion.

Substance-related disorders were the **third** most common hospital diagnosis at Greenwich Hospital, with a rate of **4.8 per 1,000 adults.** (Table 48)

Source: Connecticut Hospital Association CHIME Data. Table 45

New York Perspective

Key Informants in Port Chester express growing concern about youth substance use, particularly marijuana, which remains the most used substance among adolescents. Community members shared prescription medication misuse is low, and vaping rates occurs less, but it seems alcohol use is increasing due to lax parental oversight and access to fake IDs.

"The culture of alcohol use is all over the community. It's affecting kids brain development, even if they don't see it."

- New York Key Informant

Greenwich Perspective

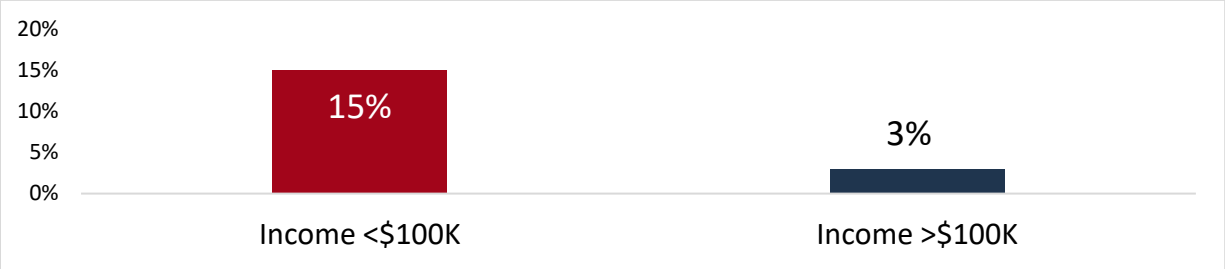
Key Informants in Greenwich highlight barriers to substance use treatment, particularly limited insurance coverage and persistent stigma. While attitudes toward mental health care have improved, substance use remains highly stigmatized, making it harder for individuals to seek support. Alcoholism is a growing concern for community members, yet Key Informants shared that funding for treatment and prevention efforts is limited. Expanding insurance coverage and public awareness efforts could help improve access to care and reduce stigma around substance use disorders.

Health Outcomes

Self-reported health data indicates ongoing health concerns.

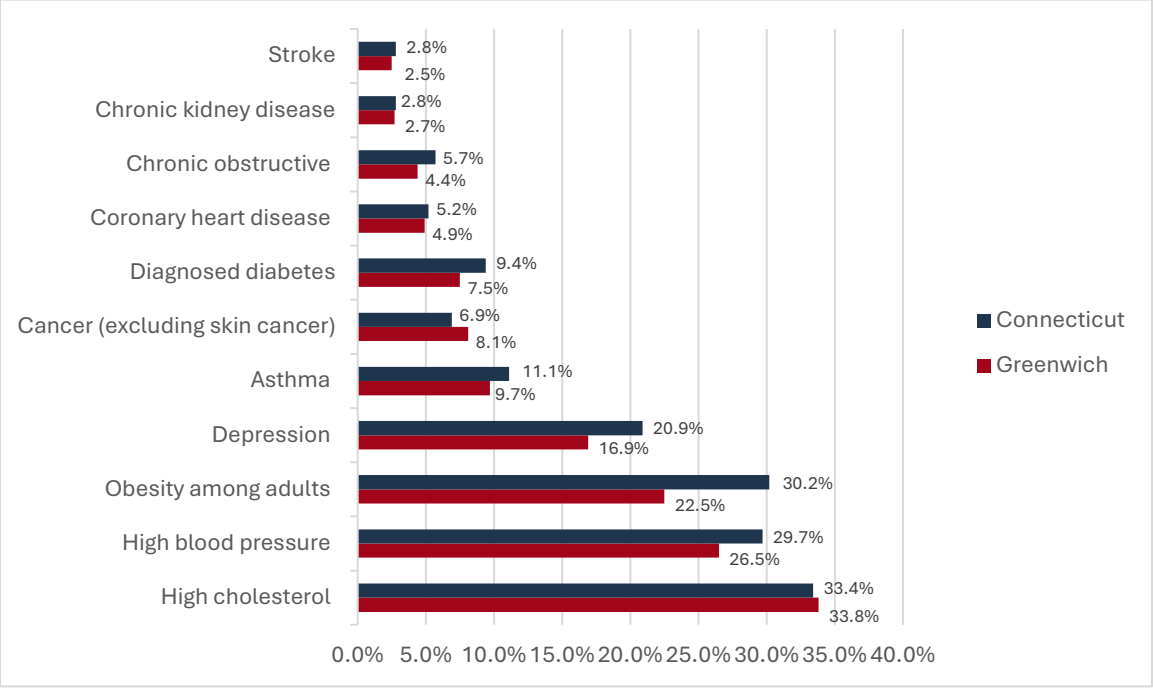
According to survey data, 6% of Greenwich residents have been diagnosed with diabetes, with significantly higher rates among lower-income individuals (15% among those earning less than $100,000 vs. 3% among those earning $100,000 or more).

EXHIBIT 35: DATAHAVEN COMMUNITY WELL-BEING SURVEY QUESTION – PARTICIPANTS EVER DIAGNOSED WITH DIABETES (GREENWICH)



Chronic disease prevalence reflects broader health trends. According to Connecticut Hospital Association data, the most commonly self-reported chronic conditions in Greenwich include high cholesterol, high blood pressure, and obesity, mirroring statewide trends (Table 49).

EXHIBIT 36: SELF-REPORTED CHRONIC DISEASE AMONG ADULTS, CONNECTICUT



Source: CDC PLACES (2020-2021). Table 49

NEEDS PRIORITIZATION

Regional Community Prioritization

To guide the 2025 Community Health Needs Assessment (CHNA) for Greenwich, a structured prioritization process was conducted, integrating community feedback and evidence-based decision-making.

The Community Voices Survey was distributed through the Greenwich Community Health Improvement Partnership (GCHIP) and Council of Community Services (CCS), engaging 205 community members who ranked the most serious health needs. Their input was shared with prioritization session participants.

A regional in-person prioritization session was held with GCHIP and CCS community partners using a modified Hanlon Method, an evidence-based approach approved by the National Association of County and City Health Officials (NACCHO).[12] Participants first completed a pre-session survey, scoring 25 health needs based on magnitude, severity, and feasibility, which generated an initial prioritization score.

During the session, participants applied the PEARL-E framework, an adaptation of the Hanlon Method's PEARL criteria—Propriety, Economics, Acceptability, Resources, and Legality. The "E" in PEARL-E adds an Equity component to ensure that systemic disparities were considered in decision-making. Needs that did not meet PEARL-E criteria were excluded from final consideration.

Following this structured process, the top 8 needs were categorized into four overarching priority areas for the next three years:

1. **Access to Care & Services**
2. **Mental Health & Wellness**
3. **Promote a Culture of Health**
4. **Supporting Healthy Generations**

These priorities will shape community health improvement efforts moving forward.

[12] NACCHO. (2023). *Guide to Prioritization Techniques.* National Association of County and City Health Officials. Retrieved from https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf

Internal Hospital Prioritization

Greenwich Hospital's senior leadership played an active role in the prioritization process, demonstrating a strong commitment to community health and alignment with regional efforts. Hospital leaders engaged in a thoughtful, data-driven review of key findings and feedback from the 2025 Community Health Needs Assessment, including:

- Outcomes from the Regional Community Prioritization Session
- Findings from the Community Voices Survey
- Qualitative insights from local stakeholders and residents
- Internal hospital data and strategic priorities

This comprehensive process ensured that the hospital's priorities were grounded in both community-identified needs and institutional capacity. After careful deliberation, Greenwich Hospital leadership formally aligned with the priority areas selected by regional community partners:

1. Access to Care & Services
2. Mental Health & Wellness
3. Promote a Culture of Health
4. Supporting Healthy Generations

This alignment reflects a shared vision for improving health across Greenwich and Port Chester and supports a unified, collaborative approach. By coordinating efforts with community partners, Greenwich Hospital is well positioned to maximize its impact and advance health equity over the next three years.

Final Prioritized Needs

	Community Voices Survey	Regional Prioritization	Greenwich Hospital Internal Prioritization
Category: Access to Care & Services		**X**	**X**
Improved access to primary care services, including reducing wait times and increasing provider availability.	X	X	
Increased number of providers accepting Medicaid and Medicare.	X	X	
Category: Mental Well-being		**X**	**X**
Mental health services for all age groups	X	X	
Crisis services for mental health and substance use		X	
Category: Promote a Culture of Health		**X**	**X**
Preventive care programs focused on diet and physical activity	X	X	
Chronic disease management programs (e.g., diabetes, cancer, cardiovascular) and education	X	X	
Category: Supporting Healthy Generations		**X**	**X**
Access to affordable childcare for working families	X	X	
Community-based resources for seniors and youth programs	X	X	
Additional Needs from Top 25			
Specialty care services (e.g. cardiology, endocrinology)	X		
Healthcare coverage to address gaps for uninsured	X		
Safe, affordable, and stable housing for low-income residents and seniors	X		

At Greenwich Hospital the experience of our patients is of the upmost importance to us. We strive to provide high quality equitable care to every patient every time. Community members identified culturally competent care needs during the CHNA process sharing valuable qualitative and quantitative feedback on their healthcare experiences. Opportunities arose in the areas of language access and cultural sensitivity training and educational opportunities for staff. In response, between 2025-2028 as a health system, we are implementing national standards for Culturally and Linguistically Appropriate Services (CLAS) in each of our hospital regions. These standards, when further implemented, will enhance our existing quality of service provided to all individuals, ensuring respect for the whole individual's health needs and health preferences. The progress of these standards as implemented over the next three years will be measured with both process and outcome measures aligned with system Patient Experience metrics connected to our Press Ganey Surveys.

What is the Press Ganey Survey?

The Press Ganey Survey is a patient survey that allows patients to provide valuable feedback on the care and services received during their hospital stay or ambulatory visit. The responses help us identify areas of opportunity, ensure the highest quality of care, and enhance overall patient experience. The survey covers various aspects of the patients' experience including communication with healthcare staff, the care environment and overall satisfaction with treatment.

APPENDICES

Appendix A: 2022-2025 Community Health Improvement and Implementation Strategy Plan Updates

- Greenwich Community Health Improvement Partnership (GCHIP) and Council Community Services (CCS) Update
- Greenwich Hospital 2022-2025 Implementation Strategy Plan Update
- Yale New Haven Health 2022-2025 Implementation Strategy Plan Update

Appendix B: Community Partners

Appendix C: List of Identified Community Health Needs

Appendix D: Secondary Data Tables

Appendix E: Asset Map and Community Resources

Appendix F: DataHaven Respondent Demographics

Appendix G: Key Informant Interview Guide

Appendix H: Focus Group Guide

Appendix A: 2022-2025 Community Health Improvement Plan and Implementation Strategy Plan Updates

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

Goal 1 Access to Care & Services
Ensure all residents have knowledge of, and equitable access to, affordable, comprehensive, appropriate, quality healthcare.

Prevention and Awareness Objectives

- Decrease the percentage of uninsured individuals and families.
- Decrease the percentage of adults that report putting off needed care or preventive screenings.
- Increase the percentage of residents who can obtain their prescriptions and medical supplies.

Strategies	**Summary Results** (10/1/2022 through 12/31/2024)
Partner with trusted community partners to promote health education in underserved communities.	Over 50 guest speakers presented promotion of: on-line and hard copy resource guides; support groups; self-empowerment and self-upskilling events and training; and free video webinars Collaborated and supported Port Chester Healthy Babies, Community Heros and Arts Festivals.
Ensure residents can access transportation for medical and social needs.	Initiated relationship with Transportation Association of Greenwich (TAG), Greenwich Emergency Management Services (GEMS) who have joined GCHIP as members and had conducted presentations.
Explore transportation barriers and solutions, including specialty care transportation issues.	Continued relationship with Family Centers Health Care for UBER/Lyft transportation services offered by this FQHC/CHC.
Partner with senior living providers to assist with medical transportation improvements.	Initiated relationship with Senior's Share a Ride Program & supported SPRYE and Greenwich aging in place organizations.
Improve access to/awareness of medication/prescription availability.	Participated in and supported events including Medication Turn-In Day, General history and essential medications, Medication management, use, misuse, and abuse, Prescription Drugs Use, Abuse and Addiction: What Physicians and Clinicians Can Do, Taking Medication Properly, What are the Roots of Addiction? The Self Medication Hypothesis in Practice, Accessing the 340B Program (FQHC/CHC-specific), Health Fairs with Information, Screenings and Activities. Medication Assisted Treatment (MAT). Centering, Medication and Scripture

Build Capacity Objectives

- Increase the number of traditional and alternative (community and technology-based) places people can access healthcare.
- Reduce the percentage of people who report missing a doctor's appointment or a visit to a healthcare provider because they did not have access to reliable transportation.
- Increase the percentage of adults who report having a regular primary care provider.

Strategies	**Summary Results (10/1/2022 through 12/31/2024)**
Examine processes that may be limiting access to services.	Committee/Task Force identified six key areas as factors that may be limiting access to care: 1. Healthcare Access and Affordability (transportation, costs, and insurance gaps) 2. Healthcare Workforce Shortages (shortages and burnout) 3. Public Health Crises (chronic disease management and substance abuse) 4. Health Equity (racial and socioeconomic disparities) 5. Technological and Cybersecurity Issues (digital bullying, the digital divide and AI) 6. Health Policy and System Reform (fragmented system, Medicaid expansion, cost transparency)
Expanded use of telehealth.	Eight partners explored this and facilitated telehealth and virtual activities to expand use of this technology.
Provide primary care in home and community settings.	GCHIP Partner, Family Centers Health Care, received support on expansion to Wilbur Peck Court Site, Greenwich High School (mental health), and Holly Hill Lane – a collaboration of Greenwich Hospital to enhance access to care.
Explore partnerships with school-based health centers.	Promotes activities of and programs at eight sites of Family Centers Health Care (School-Based): Participated and attended school based health fairs.
Increase the availability and diversity of primary care providers, community partners, and care management services.	Access to Care Committee/Task Force continues to collaborate with various community-based organizations to assess and improve on a more robust and inclusive recruitment and retention strategies with a focus-on primary care providers, community partners and care management/case workers.
Effective Intervention Objectives - Reduce the percentage of people who indicate they were treated with less respect or received services that were not as good as others in the community. - Reduce disparities and health outcomes among underserved populations.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Create welcoming care settings that honor diversity and reflect the community we serve.	YWCA Greenwich presents annually regarding DEI activities, events and training opportunities.
Improve coordination of primary and specialty healthcare.	GCHIPS Access to Care Committee/Task Force and Family Centers Health Care have identified that the barrier to accessing specialty care includes but is not limited to: 1. Very few specialists see Medicaid and uninsured individuals 2. Limited relationships among and between facilities that see/treat Medicaid and uninsured individuals and specialists.

	3. Poor case management/patients not making their specialists appointment.

Goal 2 Healthy Minds **Provide equitable and sustainable access to community resources to address the unique physical, social, and behavioral health needs of all residents.**	
Prevention and Awareness Objectives - Reduce the percentage of adults and youth who report feeling sad, depressed, or anxious. - Reduce the percentage of adults and youth who report using illegal substances. - Increase the percentage of people who indicate they receive the emotional and social support they need. - Increase the number of policies and systems that address environmental and social justice, health disparities, and community safety as a result of meaningful community engagement.	
Strategies	**Summary Results (10/1/2022 through 12/31/2024)**
Reduce stigma in accessing services.	Five key activities: 1. Erase the Stigma of Mental Health 2. 1st and 2nd Annual Hope Day (A Greenwich Community Effort to Smash the Stigma Around Mental Illness) 3. Addressing Addiction Stigma with family, friends, and our communities in Connecticut 4. Finding Solutions to the Opioid Crisis: Stigma and Substance Use Disorder – The Silent Killer 5. Stopping Stigma's around diseases, conditions, and lifestyles Support lectures on Domestic Violence and Digital Equality.
Ensure service providers reflect community.	Access to Care Committee/Task Force continues to collaborate with various community-based organizations to assess and improve on a more robust and inclusive recruitment and retention strategies with a focus-on primary care providers, community partners and care management/case workers. Hosted lectures on topics that include Digital Equality, Knowing your Rights, Foster Care, Home Evictions rights and support.
Increase screening and early intervention throughout the community.	Partnered and supported for health fairs and expos where free education and screenings occurred.
Build Capacity Objectives - Increase use of alternative places (community and technology based) where people can access behavioral healthcare.	

- Increase the number of safe methods, spaces, and places for connecting residents to community life to measurably strengthen social capital.	
Strategies	**Summary Results (10/1/2022 through 12/31/2024)**
Link clinical and non-clinical settings and services.	Identified regional events and activities to connect clinical services providers to non-clinical service providers to address the broader, social determinants of health challenges (i.e., utility and rent assistance, financial planning, and job training).
Increase availability and use of culturally reflective healthcare workers and peer support specialists.	Facilitate guest speakers, discussions and meditation sessions while providing valuable information, tools, tips, and techniques to enhance the presence of culturally reflective healthcare workers and peer support specialists.
Increase access to telehealth, mobile, and community-based services; ensure cultural competency and literacy.	Facilitated guest speakers and information dissemination sharing tools, tips, and techniques regarding increasing access to telehealth, mobile, and community-based services regarding cultural competency and literacy.
Effective Intervention Objectives - Increase adoption of accepted best practices and standards of care among clinical health care providers. - Increase the number of people who receive behavioral health care in the appropriate setting. - Reduce death from Substance Use Disorder.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Implement behavioral health screening at point of care/services and provide a direct referral to services.	Provided lectures to demonstrate behavioral health screenings at point of care/services and provide a direct referral to services.
Improve the coordination of care for frequent use of ED for behavioral health.	Partnered with Greenwich Library conducting educational events and seminars
Create welcoming service delivery settings that honor diversity and reflect the community we serve.	All GCHIP partners foster and execute a welcoming service delivery setting that honors diversity and reflects the community and population being served.

Goal 3 Healthy Bodies **Achieve equitable life expectancy for all residents by promoting healthy lifestyles to enhance and to maintain their health.**	
Prevention and Awareness Objectives - Reduce disparities in chronic disease prevalence and death rates. - Increase understanding of the benefits of healthy, nutritious, and culturally centered foods.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Reduce risk factors for disease by addressing Social Determinants of Health (SDOH).	Hosted and partnered in 15 lectures addressing SDoH.

Promote availability and use of community-based recreation opportunities.	Partnered with Community partners and hospitals on topics that include Multidisciplinary Care, Voice Disorders, Effects of Exercise on Your Health, Healthy Eating for Weight Loss, Preventing Summer Injuries, Exercise Opportunities for children and how to get kids more active.
Increase social and community activities and connections among residents.	Supported and partnered with Second Congregational Church to provide over 15 community residents programs in health, mental health and nutrition health.
Increase the number of preventive health screenings and programs available to at-risk and underserved populations.	Promoted and hosted over 12 preventive health screenings programs and events.
Reduce disparities through health screenings, programs, and events.	Promoted and hosted over 20 regional health screenings programs and events.
Build Capacity Objectives - Increase the number of safe places for connecting residents to available community resources. - Increase the awareness of access points where community members can obtain affordable, healthy, and nutritious food. - Promote the participation of residents in healthy nutrition and/or food programs.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Expanding the use of technology and social media.	Hosted several sessions regarding the use of technology and social media to facilitate access to health, human and social services.
Collaborate with community partners in areas such as housing, food insecurity, and other SDOH.	Facilitated and collaborated with guest speakers/presenters regarding housing, food insecurity and other SDOH challenges, along with mitigation strategies.
Identify healthy nutrition access points, vendors, supplemental food, and nutrition programs.	Identified additional resources and programs within the community to help promote and sponsor to educate community members on healthy food options and programs.
Effective Intervention Objectives **Promote a culture of health within communities.**	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Promote participation of underserved populations in chronic disease programs through community outreach.	Partnered with CBOs like Pathways to promote their programs for people who live with chronic mental health issues.

Greenwich Hospital 2022-2025 Implementation Strategy Plan Update

Goal 1 Access to Care **Ensure access to quality health care and well-being services for all community members.**	
Strategy 1 Reduce barriers to care by assessing social drivers of health (SDoH)	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Screen patients for barriers to care and social drivers of health.	10,070 Patients Screened (Fiscal Year 2023)
b. Refer and connect patients to hospital Case Management Department.	6,620 Patients referred to Case Management based on # screens completed (Fiscal Year 2023)
Strategy 2 Expand access to services & care for underserved population	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Provide follow-up to community resources & services for patients challenged with continuity of care.	3,391 Patients referred to community resources (FY 2023)
b. Expand use of telehealth to promote access to care for patients.	23,797 visits/appointments (Fiscal Year 2023)
Strategy 3 Provide access to health care and services and support underserved populations	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Continue to provide free care services to those eligible.	$47,667,156 provided for encounters 12,770
b. Continue to provide Medicaid services to those eligible.	$47,154,521 provided for encounters 78,125
c. Provide awareness of public/government health insurance options to patients and offer support, assistance and continual follow-up throughout the enrollment process.	628 Applications prepared, 471 Staff Hours
d. Increase residents' awareness of free and low-cost health care resources/options.	19 Programs
e. Offer financial assistance information in English and Spanish.	54 Documents Available in 18 languages
f. Provide access to prescription and medication assistance programs.	135 Patients assisted in FY 2023.
Strategy 4 Collaborate with community partners to promote access to care, services, and resources	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Provide in-kind and financial support to Greenwich Community Health Improvement Partnership (GCHIP) and Council of Community Services (CCS).	$81,060 in Support
b. Participate, co-host and sponsor events and programs with community partners.	278 Lectures/ Programs 25,179 Attendees

c. Collaborate with community organizations to conduct health screenings at diverse locations.	33 Events
Strategy 5 Promote Diversity, Equity, Inclusion and Belonging (DEIB) practices to reduce discrimination and decrease linguistic/cultural barriers	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Ensure health communications are inclusive for diverse needs of residents (multiple languages, Braille, American sign language etc.).	18 main langages plus Braille avalable
b. Implement education for staff regarding access for language and translation interpretation services.	1,170 staff completed language and translation interpretation education
c. Conduct Diversity, Equity, Inclusion and Belonging (DEIB) initiatives for staff and community members.	543 programs
Strategy 6 Prevent and reduce chronic disease (Diabetes, CAD, Stroke, Hypertension, Cancer)	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Conduct prevention health education programs via Greenwich Hospital Speakers' Bureau (Diabetes, CAD, Stroke, Hypertension, Cancer).	105 Lectures
b. Collaborate with the Breast Cancer Alliance to conduct free mammogram program.	605 Screening
c. Provide disease specific support groups.	9 Support Groups offered
d. Enroll hypertension patients in need into BP self–monitoring education program and provide free BP monitoring equipment.	35 Blood Pressure monitors Donated
e. Conduct Nurse Is In programs to provide Know Your Numbers (KYN) health education and counseling.	3,835 Participants
f. Collaborate and support Diabetes education programs.	30 Diabetes Educational Programs
g. Participate in WGCH Spotlight on Medicine Programs.	126 Spotlight on Medicine
h. Provide the Connecticut Early Detection and Prevention Program (CEDPP).	165 early detection screening (FY 2023)
i. Participate in Well-Integrated Screening and Evaluation for Women across the Nation (WISEWOMAN).	54 Screening (FY 2023)

Goal 2 Behavioral Health: Healthy Minds **Increase capacity and equitable availability of behavioral health services and support resources.**	
Strategy 1 Increase understanding that mental health is a public health concern	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Collaborate with Community Based Organizations (CBO) to sponsor and provide Narcan & mental health educational programs.	14 Educational Program
b. Provide in-kind and financial support and resources to behavioral health organizations.	$59,225 in donations
c. Collaborate with community partners to conduct and promote positive youth development programs and services (YMHFA).	5 Programs
d. Promote & support Diversity, Equity Inclusion & Belonging (DEIB) and Pride events.	7 Programs
e. Conduct Speakers Bureau education on: Suicide prevention and awareness, Anxiety and Depression, and Coping Skills and Strategies regarding resiliency, mindful meditation, and stress reduction techniques.	23 Programs
Strategy 2 Increase and expand access to care and treatment options for substance misuse and psychiatric disorders	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Provide behavioral health/substance misuse education, counseling services and treatment options (Suboxone Medication) through the GH Addiction Recovery Center (ARC)/Psych Dept. Program.	11,975 counseling provided
Strategy 3 Expand access to behavioral health community-based services	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Partner with local agencies to refer patients seeking behavioral health services and connect to providers.	8 Community Partners
b. Include Greenwich Hospital ED physician to serve on Town of Greenwich Suicide Prevention Task Force.	7 Suicide Prevention Task Force meetings attended

Goal 3 Healthy Living **Achieve equitable life expectancy for community members through availability and coordination of healthy living services and resources.**	
Strategy 1 Promote health and wellness programs	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Collaborate with community organizations to conduct health programs at diverse locations.	27 education programs collaborated with 18 organizations
b. Provide evidence based resources and materials.	3,450 materials provided
c. Conduct Injury Prevention Programs.	78 Injury Prevention Programs
Strategy 2 Promote a culture of healthy living to reduce chronic disease	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Conduct Speaker's Bureau prevention education lectures to promote awareness of risk factors.	43 Programs
b. Collaborate and conduct healthy lifestyle programs with community partners.	47 Programs

Yale New Haven Health (YNHHS) 2022-2025 Implementation Strategy Plan Update

Goal 1 Community Health & Well-being **Improve the health and well-being of the community with a focus on social drivers of health and health equity.**	
Strategy 1 **Align our everyday business activities in a way that improves living conditions in our communities and addresses health equity.**	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. i) Meet or exceed MBE (minority business enterprise) and WBE (women owned business enterprise) spend targets for defined construction projects. ii) Increase spend on local and diverse organizations to at least 5% of adjusted spend over a 5-year period (FY23-27).	i) YNHHS was able to meet and exceed MBE and WBE spend going from 3.4% and 15% in 2022 to 5.4% and 14.4% in 2024 respectively. ii) Local spend and diverse spend goals were met and exceeded.
b. Utilizing services from banks that participate in efforts to invest in or provide services and products to (e.g., loans, mortgages, etc.) communities to whom Yale New Haven Health is also providing care.	YNHHS has had $2 Million in banking assets in local banks from FY22 to the present day. Major banking partners have significant impact investment throughout Connecticut.
c. Place members of the management team on local organization boards to support the community.	As of FY23, YNHHS has 5 board placements (2 in Bridgeport, 3 in New Haven). 41 employees on community boards from Bridgeport Hospital. 6 senior leaders on 24 boards from Greenwich Hospital.
d. Implement initiatives to reduce emissions from the Center for Sustainability strategic plan and track process.	• Tracking energy consumption and purchasing electricity and food using digitized platforms. • Implementing system wide food waste reduction plan. Data from Lean Path, Foods waste tracking platform to minimize food waste. Staff training and data collection on food waste reduction and composting in progress.
Strategy 2 Develop strategies to address disparities by race and ethnicity to drive equitable care and outcomes.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Develop and implement strategies to address disparities by race and ethnicity based on root cause analyses.	Two root cause analysis conducted, and strategies implemented to address disparities.

b. Identify and decrease variation in clinical care (testing, referral, and treatment patterns) by race and ethnicity.	Developed systems to build analytics around readmissions outcomes for nine conditions with process measures ongoing.
c. Identify and decrease variation in clinical outcomes by race and ethnicity.	Completed for all inpatient and outpatient areas.
Strategy 3 Support a healthcare environment that honors and reflects the communities we serve.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Seek input from the community and provide feedback on health equity in order to inform future strategy (number of focus groups). b. Seek input from the community and provide feedback on health equity in order to inform future strategy (produce community health needs assessments).	i. 27 focus groups held across all delivery networks in effort to implement the We Ask Because We Care campaign. ii. Assessment produced with 4 of 5 collective impact partnerships in 2022. CHNA evaluation and redesign conducted and formed new governance structure with collective partnership participation for FY25 CHNA process
Strategy 4 Engage patients, families, physicians, and staff to increase YNHHS presence in the community to build stronger relationships.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Increase awareness and education about health equity, health disparities and cultural competence.	5 sessions offered including Cultural Intelligence and Critical Consciousness: A Strategic Praxis Framework for Inclusive excellence, Barriers and Opportunities to LGBTQ+ Healthcare Equity and Inclusion Excellence, and The Traumatic Impact of Structural Racism.
b. Support community relationships through volunteerism, and presence in the community to increase community trust and engagement.	2 per hospital conducted (details on length of program-help quantify dollar value, prep time of DEIB staff, how many participants at DN level), 10 total for FY 23 and 24
c. Provide DEIB education and resources.	201 total courses were to various departments reaching 1824 employees and 9 E-learnings reaching 7,332 employees.
d. Establish Employee Resource Groups/Affinity Groups to assist in identifying the varied needs of the community and support the community through volunteer work.	N/A Affinity Group launched 1/24/2025
Strategy 5 Embed health equity within YNHHS and its hospitals.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**

a. Build infrastructure to support health equity.	4 delivery network health equity structures established at all hospital locations (not NEMG). Office of Health Equity and Community Impact Established.
b. Expand ethnicity categories in electronic medical records patient demographics.	REAL data capture went from 90% in 2022 to 99.3% in 2024.
c. Redesign process and staff training to increase collection and use of Racial, Equity and Language (REaL) information in patient care.	Redesigned staff training is available to all delivery networks across YNHHS.
Strategy 6 Enhance the patient experience to reflect the community and patient population.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Improve the diversity of Patient Family Advisors to reflect community and patient population.	YNHHS has established PFACS in all hospitals across the Health System.
b. Partner with DEIB, Press Ganey, Office of Health Equity and Community Impact, and Patient Family Advisors to enhance health equity of patient survey questions and use results to increase patient experience.	In FY 24- we started to provide data by race for system objectives to all DNs. In order to capture more meaningful data for DEI questions we transitioned survey questions. This change has provided more actionable detail.
Strategy 7 Screen for socioeconomic needs and provide resources for support.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Adopt a common set of SDoH questions across all care settings.	140,292 inpatient total screened from 2022 to 2024, and 143,487 NEMG total screened from 2022 to 2024.
b. Develop strategies to support patients with identified needs through referrals and interventions in alignment with The Joint Commission (TJC) requirements.	7,306 referred cases using the Unite Us system. Implemented automated Resource list process. Renewed partnership with Unite Us. Enhanced Dashboard and implement pulse reporting. Expanded screening to include all inpatient, and children hospital inpatient units, and impatient Psych. 90% of NEMG sites implemented screening.

Goal 2 Access to Care **Ensure access to quality health care and well-being services for all community members.**	
Strategy 1 Design community-based programs targeted to heart/vascular health issues.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**

a. Expand barbershop initiative to provide community education on blood pressure management.	Continuing to screen blood pressures and enroll eligible participants at each of our 10 CBO's affiliated with Pressure Check, each month. For an average of 12 screenings (or more per month). Nine screening sites and community events were added during 2024 in addition to the existing CBO collaborations.
b. Provide blood pressure checks and blood pressure cuffs to patrons and shop owners.	114 Blood Pressure cuffs provided to shops and patrons from 2022 to 2024
Strategy 2 Expand use of telehealth, in-home, and in-community care to underserved neighborhoods.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Provide broadband services to patients without personal broadband access to facilitate care via telehealth services through the Federal Communication Commission (FCC) grant.	75 patients without personal broadband access were enrolled in the FCC grant to facilitate care via telehealth services.

Goal 3 Behavioral Health **Increase capacity and equitable availability of behavioral health services and support resources.**	
Strategy 1 Provide integrated behavioral health services to patients that address mental health needs via LCSWs for short term therapies.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Expand integrated behavioral health services to other areas.	Expanded to the Pediatric Specialty Clinic at Greenwich Hospital.

Goal 4 Healthy Living **Achieve equitable life expectancy for community members through availability and coordination of healthy living services and resources.**	
Strategy 1 Utilize evidence-based chronic disease screening, education, and maintenance programs.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Enhance confidential health coaching, care management and other services and programs for employees through the livingwellCARES program.	1,835 employee health plan members served in Fiscal Year 2023.

Appendix B: Community Partners

GCHIP

Abilis

At Home in Greenwich

Barbara's House

Boys and Girls Club of Greenwich

Byram Shubert Library

Cancer Care

Child Guidance Center

Community Answers

Cos Cob Library

DMHAS

DMHAS F.S. DuBois Center

Family Centers Health Center (FQHC)

First Congregational Church

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 & 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

Parkinson's Body and Mind

Pathways

Perrot Memorial Library

Resources to Recovery

River House Adult Day Center

Second Congregational Church of Greenwich

Silver Hill Hospital

Southwestern CT AHEC

St. Catherine's Church

The Housing Authority of Greenwich

The Renfrew 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

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-Rye Brook EMS

Port Chester-Rye Brook Chamber of Commerce

Port Chester/Rye Brook Rotary Club

Rye -Brook Police Department

Rye Brook Seniors

Rye Chamber of Commerce

Rye Police Department

Rye Public Schools

Rye Reading Room

Rye Rotary Club

Rye Seniors

Rye YMCA

RyeACT

St. Paul Church

Staying Put in Rye and Environs (SPRYE)

The Osborn

Westchester County Board of Legislators

Westchester Department of Health

Appendix C: List of Identified Community Health Needs

The following list highlights the community needs identified through the 2025 Community Health Needs Assessment for the Greater Greenwich region. These needs are categorized into high-level focus areas and are presented without prioritization.

Healthcare Needs

- Accessible preventive care programs focusing on diet and physical activity.
- Expanded maternal and prenatal care for under-resourced populations.
- Provide chronic disease management programs (e.g., diabetes, cancer, cardiovascular).
- Expanded community-based resources for seniors and youth programs.
- Financial assistance programs for underinsured individuals.
- Programs addressing the unique needs of ALICE (Asset Limited, Income Constrained, Employed) households.
- Improved access to dental care for low-income residents.
- Improved access to primary care services, including reducing wait times and increasing provider availability.
- Improved access to specialty care services (e.g., cardiology, endocrinology).
- Improved availability of pediatric healthcare services.
- Increased number of providers accepting Medicaid and Medicare.

Behavioral Health Needs

- Culturally sensitive behavioral health services for diverse populations.
- Expanded access to substance use treatment and recovery programs.
- Greater availability of crisis services for mental health and substance use.
- Increased availability of mental health services for all age groups.
- Integrated care models combining physical and behavioral health services.
- Programs addressing stigma around seeking mental health and substance use treatment.

Diversity and Equity Needs

- Community engagement initiatives and outreach programs for immigrant and non-English-speaking populations to build trust with groups who have been marginalized.
- Equitable distribution of healthcare resources across neighborhoods.
- Training for healthcare providers on cultural competence and implicit bias.

Social Drivers of Health

- Access to affordable childcare to support working families.
- Job training for employment opportunities with fair wages and job stability.
- Improved access to healthy and affordable food options.
- Reliable, affordable, and accessible transportation options to healthcare facilities, employment, and essential services.
- Safe, affordable, and stable housing for low-income residents and seniors.

Appendix D: Secondary Data Tables

TABLE 1: CDC SOCIAL VULNERABILITY INDEX DATA - SOCIOECONOMIC STATUS

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Total Population	359,8348	959,099	63,505	19,872,319	996,888	93,791	31,162	9,884
Population Below Poverty Level	10.0%	9.3%	8.9%	13.7%	8.9%	7.7%	12.0%	6.1%
Unemployment Rate	5.6%	6.0%	8.1%	6.2%	6.0%	5.7%	7.2%	6.5%
Median Household Income	$93,760	$115,059	$136,154	$84,578	$118,411	$136,628	$99,916	$236,968
Low Income Households Severely Cost Burdened	35.0%	43.4%	44.9%	37.3%	45.5%	51.7%	43.2%	63.5%
No High School Diploma	8.7%	9.8%	5.0%	12.1%	10.6%	11.5%	21.5%	21.5%
Uninsured Population	5.2%	7.7%	5.6%	5.0%	4.9%	6.8%	12.1%	12.1%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 2: CDC SOCIAL VULNERABILITY INDEX DATA - HOUSEHOLD CHARACTERISTICS & MINORITY STATUS[13]

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Population Under Age 18	20.4%	21.9%	22.9%	20.7%	21.5%	23.8%	19.4%	24.8%
Population Age 65 and Over	18.1%	16.7%	20.2%	17.4%	17.7%	14.9%	13.0%	19.9%
Living with a Disability	11.9%	10.5%	7.1%	12.1%	10.2%	7.6%	8.7%	8.6%
English Language Proficiency	8.6%	12.7%	7.2%	13.3%	12.4%	16.7%	31.6%	6.4%
Racial & Ethnic Minority	37.0%	42.6%	37.3%	46.6%	50.0%	44.3%	71.1%	24.4%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

[13] "Children Living in Single-Parent Households" was not included because it is unavailable at county subdivision and/or places level due to changes in Connecticut county-equivalents for certain data points in the 2023 American Community Survey. For more information, please visit https://www.census.gov/programs-surveys/acs/technical-documentation/user-notes/2023-01.htm.

TABLE 3: CDC SOCIAL VULNERABILITY INDEX DATA - HOUSING TYPE & TRANSPORTATION[14]

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Mobile Homes	0.7%	0.3%	0.1%	2.1%	0.2%	0.1%	0.3%	0.0%
No Vehicle	8.6%	7.8%	9.1%	29.0%	14.2%	10.2%	13.9%	6.4%
Overcrowded Housing Units	2.0%	2.7%	1.6%	5.2%	4.8%	4.2%	9.4%	1.7%
Group Quarters	2.7%	1.7%	1.1%	3.0%	2.5%	0.9%	0.8%	1.0%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 4: PROJECTED PERCENT CHANGE IN POPULATION, 2010 TO 2032

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Total Population (2010)	357,4097	916,828	13,345	19,378,102	949,118	87,949	28,926	93,889
Total Population (2023)	3,598,348	959,099	14,528	19,872,319	996,888	93,791	31,162	9,884
Percent Change (2010-2023)	+0.7%	+4.6%	+8.9%	+2.6%	+5.0%	+6.6%	+7.7%	+5.3%
Total Population (2032)	3,749,919	1,009,569	13,363	20,776,064	1,044,537	99,427	33,924	10,634
Percent Change (2023-2032)	+4.2%	+5.3%	-8.0%	+4.5%	+4.8%	+6.0%	+8.9%	+7.6%

Sources: U.S. Census Bureau American Community Survey 2010 One-year Estimates | U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 5: MEDIAN AGE PERCENT CHANGE, 2010 TO 2023

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Median Age (2010)	39.5	39.1	42.9	37.7	39.7	ND	35.6	44.1
Median Age (2023)	41.2	41.5	44.0	39.6	41.5	41.4	38.6	44.8
Percent Change (2010-2023)	+4.3%	+6.1%	+2.6%	+5.0%	+4.5%	ND	+8.4%	+1.6%

Sources: U.S. Census Bureau American Community Survey 2006-2010 Five-year Estimates | U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

[14] "Multi-Unit Housing Structures" was not included because it is unavailable at county subdivision and/or places level due to changes in Connecticut county-equivalents for certain data points in the 2023 American Community Survey. For more information, please visit https://www.census.gov/programs-surveys/acs/technical-documentation/user-notes/2023-01.htm

TABLE 6: POPULATION BY AGE GROUP

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Under Age 18	20.4%	21.9%	22.9%	20.7%	21.5%	23.8%	19.4%	24.8%
Age 18 to 64	61.5%	61.4%	56.9%	61.9%	60.7%	61.4%	67.6%	55.3%
Age 65 and Over	18.1%	16.7%	20.2%	17.4%	17.7%	14.9%	13.0%	19.9%
Age Under 5	5.0%	5.4%	5.9%	5.6%	5.3%	5.7%	6.5%	4.4%
Age 5 to 9	5.4%	5.9%	6.3%	5.6%	5.8%	7.2%	6.0%	4.3%
Age 10 to 14	6.0%	6.5%	6.2%	6.0%	6.4%	6.4%	4.6%	7.6%
Age 15 to 19	6.6%	6.8%	6.4%	6.1%	6.6%	7.0%	4.9%	12.0%
Age 20 to 24	6.5%	6.2%	4.8%	6.3%	5.9%	5.2%	6.6%	4.0%
Age 25 to 34	13.7%	12.5%	11.6%	10.6%	14.3%	10.3%	14.1%	5.5%
Age 35 to 44	13.1%	12.5%	12.9%	10.4%	12.9%	15.2%	16.2%	12.4%
Age 45 to 54	12.3%	12.9%	13.7%	13.6%	12.5%	15.7%	14.6%	18.2%
Age 55 to 59	6.4%	7.2%	7.3%	6.0%	6.8%	6.1%	5.9%	8.1%
Age 60 to 64	6.4%	7.2%	7.0%	9.7%	6.6%	6.3%	7.6%	3.6%
Age 65 to 74	10.0%	10.4%	9.5%	12.2%	10.1%	7.7%	7.6%	8.3%
Age 75 to 84	4.9%	5.2%	4.9%	5.8%	5.1%	4.4%	3.5%	7.2%
Age Over 85	1.9%	2.4%	2.3%	2.2%	2.2%	2.8%	1.9%	4.4%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 7: POPULATION BY RACE (ALONE)

	Connecticut	Westchester County	Greenwich	New York	Fairfield County	Other NY Zip Codes	Port Chester	Rye Brook
White	67.6%	54.7%	68.2%	57.1%	62.2%	61.3%	37.9%	78.8%
Black or African American	10.7%	14.0%	8.0%	14.7%	11.1%	4.7%	7.8%	0.6%
Two or More Races	9.5%	11.3%	9.1%	8.9%	10.9%	11.9%	18.9%	4.9%
Some Other	7.1%	13.3%	8.0%	9.8%	9.8%	15.4%	31.6%	4.4%
Asian	4.8%	6.1%	6.6%	8.9%	5.5%	5.9%	2.5%	11.1%
American Indian and Alaska Native	0.3%	0.5%	0%	0.5%	0.3%	0.8%	1.3%	0.0%
Native Hawaiian and Other Pacific Islander	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 8: POPULATION BY ETHNICITY

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Hispanic or Latino	17.8%	21.9%	16.6%	19.6%	27.0%	30.5%	59.7%	8.9%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 9: BIPOC POPULATION

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
BIPOC Population	37.0%	42.6%	30.3%	46.6%	50.0%	44.3%	71.1%	24.4%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 10: POPULATION BY SEX

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Females	50.9%	50.9%	53.8%	51.2%	51.2%	48.9%	45.5%	52.6%
Males	49.1%	49.1%	46.2%	48.8%	48.8%	51.1%	54.5%	47.4%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 11: LANGUAGE SPOKEN AT HOME (PEOPLE OVER AGE 5)

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
English Only	77.0%	69%	75.8%	69.4%	65.7%	60.5%	40.2%	78.6%
Spanish	12.6%	16.9%	8.7%	14.7%	20.8%	25.8%	52.7%	5.1%
Asian-Pacific Islander	2.5%	2.7%	5.8%	5.1%	3.5%	3.9%	1.3%	5.9%
Other Indo-European	6.9%	10.3%	9.5%	8.9%	8.4%	8.8%	5.4%	9.3%
Other	1.0%	1.0%	0.2%	1.9%	1.7%	1.0%	0.4%	1.1%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 12: FOREIGN-BORN POPULATION

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Naturalized US Citizen	8.6%	12.2%	12.9%	13.5%	15.4%	13.7%	18.4%	10.3%
Not US Citizen	6.9%	11.1%	8.7%	9.1%	10.2%	16.0%	25.9%	4.2%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 13: POPULATION LIVING WITH DISABILITY BY AGE

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Age Under 5	0.7%	0.6%	0.0%	0.6%	0.5%	0.0%	0.0%	0.0%
Age 5 to 17	6.3%	5.6%	5.3%	5.7%	4.8%	2.1%	2.2%	3.1%
Age 18 to 34	7.5%	7.1%	2.9%	6.6%	6.6%	5.3%	4.5%	1.6%
Age 35 to 64	10.7%	8.5%	5.5%	11.2%	8.0%	5.4%	7.6%	4.1%
Age 65 to 74	19.4%	17.6%	11.6%	22.1%	17.4%	15.6%	19.5%	6.4%
Age 75 and Over	43.1%	42.4%	26.8%	45.4%	41.9%	41.3%	49.3%	48.0%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 14: POPULATION LIVING WITH DISABILITY BY TYPE

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Ambulatory Difficulty	5.5%	4.8%	3.3%	6.3%	5.0%	3.6%	4.3%	4.3%
Cognitive Difficulty	4.9%	4.2%	2.0%	4.7%	3.9%	2.6%	2.8%	2.1%
Independent Living Difficulty	4.4%	3.8%	3.5%	4.8%	4.0%	2.6%	3.3%	2.8%
Hearing Difficulty	3.1%	2.6%	0.9%	2.8%	2.6%	2.0%	1.8%	2.3%
Vision Difficulty	2.1%	2.0%	1.0%	2.2%	2.0%	1.5%	2.8%	1.0%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 15: POPULATION LIVING WITH DISABILITY BY RACE

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Native Hawaiian and Other Pacific Islander	15.3%	9.9%	ND	15.5%	1.9%	ND	ND	ND
American Indian and Alaska Native	14.9%	10.1%	100.0%	15.5%	12.8%	27.7%	41.8%	ND
Black or African American	12.6%	13.2%	7.6%	13.7%	14%	12.3%	9.1%	54.2%
White	12.5%	10.5%	7.8%	12.5%	10.1%	7.5%	10.0%	9.1%
Some Other Race	12.5%	11.0%	4.9%	12.0%	9.0%	6.8%	6.5%	8.0%
Two or More Races	11.2%	9.8%	4.2%	11.6%	10.0%	9.0%	8.2%	4.1%
Asian	6.3%	6.4%	6.3%	7.8%	6.3%	3.2%	2.6%	5.0%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 16: POPULATION LIVING WITH DISABILITY BY ETHNICITY

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Hispanic or Latino	12.2%	11.1%	6.2%	12.2%	9.6%	8.4%	8.2%	4.0%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 17: POPULATION WITH A BACHELOR'S DEGREE OR HIGHER, PERCENT CHANGE

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Population with a Bachelor's Degree or Higher Attainment (2010)	35.7%	44.0%	62.7%	32.5%	44.5%	46.5%	22.4%	57.4%
Population with a Bachelor's Degree or Higher Attainment (2023)	41.9%	50.5%	70.2%	39.6%	52.5%	55.5%	34.5%	75.4%
Percent Change (2010-2023)	+17.5%	+14.7%	+11.9%	+21.7%	+17.9%	+19.4%	+54.2%	+31.4%

Sources: U.S. Census Bureau American Community Survey 2010 One-year Estimates | U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 18: HIGHEST LEVEL OF EDUCATIONAL ATTAINMENT

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Less than 9th Grade	4.0%	5.3%	1.5%	6.0%	5.4%	6.7%	13.7%	1.5%
9th to 12th Grade, No Diploma	4.7%	4.5%	3.5%	6.2%	5.2%	4.7%	7.8%	1.4%
High School Degree	25.5%	20.3%	10.1%	24.6%	17.9%	15.9%	24.0%	9.8%
Some College No Degree	16.2%	13.5%	9.4%	14.9%	12.6%	11.0%	12.6%	6.0%
Associate Degree	7.6%	5.9%	5.2%	8.9%	6.4%	6.1%	7.4%	6.0%
Bachelor's Degree	23.0%	27.7%	32.5%	22.0%	26.0%	28.6%	20.3%	37.2%
Graduate Degree	19.0%	22.8%	37.7%	17.5%	26.5%	26.9%	14.2%	38.2%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 19: EDUCATIONAL ATTAINMENT OF BACHELOR'S DEGREE OR HIGHER BY RACE

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Asian	66.2%	68.3%	65.1%	49.3%	75.2%	81.4%	70.3%	95.6%
White	45.9%	58.9%	75.8%	45.3%	62.2%	65.3%	49.1%	76.7%
Two or More Races	31.9%	36.1%	55.4%	34.1%	40.5%	41.5%	23.9%	52.1%
Black or African American	26.3%	29.1%	31.5%	26.7%	37.7%	40.9%	38.8%	19.7%
Native Hawaiian and Other Pacific Islander	22.0%	34.6%	ND	22.5%	11.3%	ND	ND	ND
American Indian and Alaska Native	20.7%	21.5%	0.0%	20.1%	24.5%	24.3%	25.9%	ND
Some Other Race	17.4%	17.9%	58.0%	18.0%	22.7%	20.6%	16.0%	49.7%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 20: EDUCATIONAL ATTAINMENT OF BACHELOR'S DEGREE OR HIGHER BY ETHNICITY

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Hispanic or Latino	20.0%	23.0%	36.6%	22.6%	28.3%	26.0%	18.0%	52.5%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 21: EDUCATIONAL ATTAINMENT LESS THAN HIGH SCHOOL BY RACE AND ETHNICITY[15]

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
White	5.5%	5.0%	2.3%	6.7%	5.5%	5.0%	10.0%	2.7%
Black or African American	12.3%	12.6%	6.6%	14.6%	11.8%	8.8%	8.8%	24.6%
Hispanic or Latino	25.0%	27.2%	14.1%	26.6%	25.0%	30.2%	35.0%	3.7%
Other Race	29.2%	34.5%	19.3%	31.5%	31.0%	34.7%	34.5%	5.6%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 22: CHILD CARE NEED

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	United States	Port Chester	Rye Brook
Children Under 6 with Working Parents	74.6%	71.8%	74.2%	69.0%	75.2%	67.7%	78.3%	86.6%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

[15] This percentage represents adults (age 25 and older) in each racial/ethnic group who have not completed high school, calculated as a share of the total adult population (age 25+) within that racial/ethnic group in each region.

TABLE 23: CHILD CARE CENTERS

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Child Care Centers	900	295	ND	6,008	382	38	ND	ND

Source: U.S. Census Bureau County Business Patterns 2021. https://www.census.gov/programs-surveys/cbp.html

TABLE 24: COST OF CHILDCARE BY TYPE AND AGE

	Connecticut	Fairfield County	New York	Westchester County
Infant Center-Based Childcare	$24,509	$24,509	$18,742	$18,742
Infant Home-Based Childcare	$17,300	$17,300	$17,300	$17,300
Toddler Center-Based Childcare	$24,509	$24,509	$17,300	$17,300
Toddler Home-Based Childcare	$17,300	$17,300	$16,724	$16,724
Preschool Center-Based Childcare	$17,646	$17,646	$16,897	$16,987
Preschool Home-Based Childcare	$17,300	$17,300	$15,859	$15,859
School-Age Center-Based Childcare	$8,650	$6,920	$14,417	$14,417
School-Age Home-Based Childcare	$8,881	$8,074	$14,417	$14,417

Source: U.S. Census Bureau County Business Patterns 2021. https://www.census.gov/programs-surveys/cbp.html

TABLE 25: POVERTY PERCENT CHANGE

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Households Below Poverty Level (2010)	9.4%	8.3%	5.9%	13.7%	8.5%	8.2%	15.2%	6.6%
Households Below Poverty Level (2023)	10.5%	9.5%	8.2%	13.8%	9.9%	8.1%	11.7%	6.9%
Percent Change (2010-2023)	+12.7%	+14.4%	+39.6%	+0.5%	+16.1%	-0.7%	-23.3%	+4.6%

Sources: U.S. Census Bureau American Community Survey 2010 One-year Estimates | U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 26: INCOME TO POVERTY RATIOS

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
100% - 124% FPL	2.8%	2.6%	0.6%	3.6%	2.3%	2.0%	3.4%	0.7%
125% - 149% FPL	3.0%	3.0%	6.0%	3.6%	2.7%	1.9%	4.1%	1.2%
150% - 184% FPL	4.3%	3.8%	2.6%	5.0%	3.6%	3.5%	5.5%	0.0%
185% - 199% FPL	2.0%	1.9%	1.2%	2.2%	1.6%	1.2%	1.7%	0.6%
200% and Over FPL	77.9%	79.5%	80.8%	71.9%	80.9%	83.6%	73.4%	91.5%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 27: PERCENT OF POPULATION LIVING IN POVERTY

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
People Below Poverty Level	10.0%	9.3%	8.9%	13.7%	8.9%	7.7%	12.0%	6.1%
American Indian and Alaska Native	22.2%	21.2%	0.0%	22.7%	16.5%	38.7%	69.7%	ND
Asian	8.8%	6.7%	18.1%	13.9%	4.7%	9.2%	29.0%	3.2%
Black or African American	17.1%	15.1%	32.7%	20.6%	15.0%	16.0%	7.5%	5.1%
Native Hawaiian and Other Pacific Islander	29.8%	29.3%	ND	22.2%	0.0%	ND	ND	ND
Some Other Race	22.1%	22.5%	24.4%	21.9%	15.9%	15.6%	16.6%	9.2%
Two or More Races	13.2%	10.8%	8.7%	16.0%	11.4%	5.7%	8.5%	4.9%
White	7.2%	6.0%	3.4%	10.0%	5.5%	5.0%	7.8%	6.5%
Hispanic or Latino	20.3%	18.8%	26.7%	20.1%	13.9%	13.2%	15.3%	7.6%
Age Under 5	13.4%	11.2%	17.9%	18.6%	10.2%	10.1%	13.2%	0.0%
Age Under 18	13.1%	12.0%	14.0%	18.2%	10.6%	8.6%	14.5%	10.4%
Age 18 to 64	9.5%	8.6%	7.3%	12.5%	8.1%	7.1%	10.5%	5.1%
Age 65 and Over	8.3%	8.3%	7.5%	12.7%	9.4%	8.8%	16.0%	3.7%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 28: UNITED WAY ALICE

	U.S.	CT	NY	Fairfield County	Westchester County
Households Below ALICE Threshold	29.0%	29.0%	30.0%	29.7%	23.7%

Source: United Way United for ALICE Research Center, Connecticut, 2022. https://unitedforalice.org/state-overview/Connecticut | United Way United for ALICE Research Center, New York, 2022.

TABLE 29: MEDIAN HOUSEHOLD INCOME PERCENT CHANGE

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Median Household Income (2010)	$69,243	$96,842	$109,400	$56,951	$94,775	$105,035	$62,063	$146,679
Median Household Income (2023)	$93,760	$115,058	$136,154	$84,578	$118,411	$136,628	$99,916	$236,968
Percent Change (2010-2023)	+35.4%	+18.8%	+24.5%	+48.5%	+24.9%	+30.1%	+61.0%	+61.6%

Sources: U.S. Census Bureau American Community Survey 2010 One-year Estimates | U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 30: MEDIAN HOUSEHOLD INCOME BY RACE

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Asian	$126,722	$141,892	ND	$94,665	$170,440	$179,958	ND	ND
White	$103,032	$122,129	$148,750	$94,737	$143,326	$135,937	$112,734	$235,880
Two or More Race	$76,435	$111,176	$46,890	$78,026	$103,959	$127,840	$98,563	ND
Black or African American	$62,712	$91,657	ND	$61,528	$77,471	$148,858	$100,030	$155,729
Other Race	$56,744	$85,951	ND	$58,747	$78,745	$81,436	$85,317	ND
American Indian and Alaska Native	$52,152	ND	ND	$63,315	$75,020	ND	$158,994	ND
Native Hawaiian and Other Pacific Islander	$41,573	ND	ND	$54,522	$167,114	ND	ND	ND

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 31: MEDIAN HOUSEHOLD INCOME BY ETHNICITY

	Connecticut	Greenwich	Fairfield County	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Hispanic or Latino	$60,136	$45,741	$103,111	$64,615	$87,717	$103,721	$88,931	$121,324

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 32: EMPLOYMENT BY INDUSTRY

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Management	11.6%	13.8%	23.4%	10.6%	13.5%	14.9%	6.4%	15.3%
Office and Administrative Support	9.3%	8.5%	7.4%	9.9%	8.5%	8.2%	9.3%	5.1%
Sales	9.0%	10.1%	10.6%	8.2%	8.3%	8.9%	8.2%	11.2%
Education, Training and Library	7.1%	6.2%	7.5%	7.3%	8.5%	7.8%	8.8%	6.9%
Business and Finance	6.5%	8.0%	8.9%	5.9%	7.2%	8.1%	4.4%	14.2%
Production	4.5%	3.0%	1.2%	3.1%	1.8%	2.0%	2.3%	1.9%
Health Diagnosis and Treating Practitioners	4.4%	4.0%	3.2%	4.5%	5.3%	3.1%	1.0%	7.8%
Food Preparation and Serving	4.3%	3.6%	1.6%	4.4%	3.2%	3.9%	6.0%	1.0%
Construction and Extraction	4.2%	4.6%	2.5%	4.0%	4.4%	5.6%	8.6%	1.7%
Healthcare Support	3.4%	2.8%	1.5%	4.6%	3.0%	1.7%	3.1%	0.9%
Building, Grounds Cleaning, and Maintenance	3.3%	4.1%	3.3%	3.3%	3.4%	6.0%	12.9%	0.5%
Computer and Mathematical	3.3%	3.4%	4.3%	3.1%	3.0%	3.0%	1.7%	3.7%
Transportation	2.9%	2.7%	0.6%	3.6%	2.6%	2.4%	4.4%	0.2%
Personal Care and Service	2.7%	2.8%	2%	2.7%	2.7%	2.5%	2.4%	2.2%
Material Moving	2.6%	2.0%	1.1%	2.3%	1.6%	1.2%	1.9%	0.7%
Architecture and Engineering	2.5%	1.8%	1.8%	1.6%	1.4%	0.9%	0.5%	0.6%

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Installation, Maintenance, and Repair	2.3%	1.9%	0.6%	2.2%	1.7%	1.6%	1.4%	2.3%
Arts, Design, Entertainment, Sports and Media	2.1%	2.7%	4.5%	3.0%	3.0%	3.2%	2.4%	4.0%
Health Technologist and Technicians	2.0%	1.7%	0.7%	1.8%	1.6%	0.5%	0.3%	2.0%
Community and Social Service	1.9%	1.7%	1.3%	2.0%	2%	1.5%	1.3%	1.6%
Legal	1.3%	1.9%	2.5%	1.8%	3.2%	4.0%	1.9%	6.4%
Life, Physical, and Social Science	1.2%	1.1%	0.9%	1.1%	1.3%	1.5%	1.1%	2.8%
Fire Fighting and Prevention	1.1%	0.9%	0.5%	1.5%	1.4%	1.0%	1.4%	0.0%
Law Enforcement	0.7%	0.4%	0.0%	1.2%	1.3%	0.8%	1.1%	0.4%
Farming, Fishing and Forestry	0.2%	0.1%	0.0%	0.2%	0.1%	0.3%	0.1%	0.0%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 33: HOUSEHOLDS RECEIVING SNAP

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Households Receiving Food Stamps/SNAP	11.7%	9.0%	7.2%	15%	9.5%	6.4%	11.1%	0.2%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 34: FOOD INSECURITY AMONG ADULTS IN CT

	Connecticut	Fairfield County	Greenwich
Food Insecurity Rate	14.8%	15.0%	8.0%

Source: CDC BRFSS PLACES, 2022

TABLE 35: HOUSING COSTS & HOME VALUE

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Median Household Income	$69,243	$96,842	$109,400	$56,951	$94,775	$105,035	$62,063	$146,679
Renter Excessive Housing Costs[16]	48.1%	50.8%	44.2%	48.7%	49.9%	46.5%	45.1%	77.8%
Owner Excessive Housing Costs[17]	26.4%	30.7%	29.2%	26.9%	30.7%	31.0%	41.8%	26.8%
Renter Housing Mobile Homes	0.4%	0.2%	0.0%	1.0%	0.3%	0.1%	0.0%	0.0%
Owner Housing Mobile Homes	0.8%	0.4%	0.0%	2.6%	0.2%	0.2%	0.8%	0.0%
Homeowner Vacancy Rate	0.9%	1.3%	2.3%	1.1%	0.9%	1.0%	1.3%	0.0%

Sources: U.S. HUD CHAS 2015-2019 | U.S. Census Bureau American Community Survey 2010 One-year Estimates | U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 36: FAIR MARKET RENT (FMR)

	Fairfield County	Westchester County
0 Bedrooms	$1,409	$1,436
1 Bedrooms	$1,709	$1,669
2 Bedrooms	$2,097	$2,029
3 Bedrooms	$2,636	$2,515
4 Bedrooms	$2,902	$2,782

Source: U.S. Department of Housing and Urban Development HOME Rent Limits 2023

[16] This dataset represents the percentage of renter-occupied housing units where gross rent exceeds 30% of household income. Gross rent includes the cost of rent plus utilities and fuels paid by the renter.

[17] This dataset represents the percentage of owner-occupied housing units where selected monthly owner costs exceed 30% of household income. These costs include mortgage payments, property taxes, insurance, utilities, and fees.

TABLE 37: HOUSING WAGE

	U.S.	CT	NY	Fairfield County – Stamford-Norwalk HMFA	Westchester County
Hourly Wage Necessary to Afford a 2-Bedroom Apartment at Fair Market Rent (FMR)	$32.11	$31.93	$44.77	$50.54	$45.23

Source: National Low Income Housing Coalition, Out of Reach 2023 – Connecticut #11, 2024. https://nlihc.org/sites/default/files/oor/Connecticut_2023_OOR.pdf | National Low Income Housing Coalition. Out of Reach 2024 – Full Report, 2024. https://nlihc.org/oor

TABLE 38: MEDIAN HOME RENT

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Median Home Rent	$1,431	$1,937	$2,482	$1,576	$1,876	$2,098	$1,922	$2,220

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 39: HOUSEHOLD COMPOSITION

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Households with Children	28.7%	32.2%	29.4%	27.8%	32.4%	38.9%	32.6%	42.2%
Households with Grandparents Responsible for Grandchildren	0.9%	0.8%	0.9%	1.1%	0.8%	0.3%	0.7%	0.0%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 40: TRANSPORTATION

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Mean Travel Time to Work (in minutes)	26.6	31.5	30.1	32.8	34.7	31.2	25.4	32.9
Commute by Public Transit	3.4%	6.9%	15.3%	22.4%	17.7%	17.5%	10.1%	13.8%
Commute by Drive Alone	70.6%	63.3%	48.6%	49.7%	51.6%	49.2%	56.4%	55.0%
Walkability	ND	ND	ND	ND	ND	56	89	82

Sources: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates | Walk Score, walkscore.com, 2024|

TABLE 41: BROADBAND

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Households Without Internet Access	6.5%	5.3%	4.7%	8.0%	5.4%	2.7%	4.2%	3.2%
Number of Internet Providers (2024)	16	14	7	67	11	ND	6	6

Sources: Federal Communications Commission Fixed Broadband Deployment Data 2024 | U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 42: HEALTH CARE PROVIDER RATIO (PEOPLE PER PROVIDER)

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Primary Care Physician	834:1	897:1	747:1	889:1	925:1	ND	2,607:1	1,240:1
Primary Care Nurse Practitioner	1,027:1	1,286:1	1,380:1	978:1	1,281:1	ND	2,407:1	3,307:1
Dentist	1,398:1	1,318:1	1,380:1	1,467:1	1,388:1	ND	1,422:1	1,240:1
Mental Health Provider	516:1	681:1	623:1	585:1	617:1	ND	1,956:1	763:1
Pediatrician	619:1	705:1	603:1	621:1	575:1	ND	3,165:1	325:1
Obstetrics Gynecology (OBGYN)	2,566:1	2,289:1	2,374:1	3,054:1	2,633:1	ND	7,317:1	ND
Midwife and Doula	15,745:1	32,507:1	ND	10,082:1	14,597:1	ND	ND	ND

Sources: National Plan & Provider Enumeration System NPI, 2023. https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/DataDissemination

TABLE 43: UNINSURED POPULATION

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Uninsured Age Under 6	2.4%	3.4%	3.9%	2.4%	2.8%	1.0%	0.8%	2.0%
Uninsured Age 6 to 18	3.1%	4.6%	1.8%	2.6%	1.9%	0.7%	1.6%	0.0%
Uninsured Age 19 to 64	7.5%	10.8%	8.7%	7.2%	7.3%	10.8%	17.7%	6.7%
Uninsured Age 65 and Over	0.8%	1.3%	1.0%	0.9%	0.7%	0.9%	1.9%	0.0%
People with Private Health Insurance	73.3%	75%	81.3%	69.7%	79.0%	80.8%	69.3%	88.5%
People with Public Health Insurance	39.3%	36.1%	30.7%	43.7%	35.0%	30.3%	42.6%	22.2%
Uninsured Age 18 and Under with a Disability	1.7%	2.7%	0.0%	1.8%	0.1%	0.0%	0.0%	0.0%
Uninsured Age 19 to 64 with a Disability	5.5%	9.2%	9.0%	4.9%	7.0%	12.4%	16.6%	0.0%
Uninsured People in Labor Force	7.2%	10.5%	4.9%	6.9%	7.0%	10.1%	16.5%	6.1%

Sources: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 44: BIRTH RATE (RATE PER 1,000 PEOPLE)

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Birth Rate	9.9	10.7	ND	10.6	10.1	ND	ND	ND

Source: CDC WONDER Natality Birth Rate, 2021 https://wonder.cdc.gov/

TABLE 45: DEATH RATE (RATE PER 100,000 PEOPLE)

	Connecticut	Fairfield County	Greenwich	New York	Westchester County	Other NY Zip Codes	Port Chester	Rye Brook
Death Rate	9.5	7.8	ND	9.1	8.1	ND	ND	ND

Source: CDC WONDER Causes of Death, 2021. https://wonder.cdc.gov/

TABLE 46: LIFE EXPECTANCY

	Connecticut	Fairfield County	New York	Westchester County
Life Expectancy (in years)	79.2	81.2	79.4	82.0

Source: County Health Rankings, 2020-2022. https://www.countyhealthrankings.org/health-data/connecticut/fairfield?year=2025 | https://www.countyhealthrankings.org/health-data/new-york/westchester?year=2025

TABLE 47: LEADING CAUSES OF DEATH (RATE PER 100,000 PEOPLE)

	Connecticut	Fairfield County	New York	Westchester County
Heart Disease	186.7	156.1	213.9	192.8
Cancer	181.0	155.1	164.4	151.5
COVID-19	75.5	54.2	109.3	93.5
Accidental Injuries	73.3	51.7	51.1	38.0
Stroke	40.0	33.9	33.7	30.5
Chronic Lower Respiratory Disease	32.4	22.1	29.8	20.5
Diabetes	21.4	16.7	24.4	17.6
Influenza / Pneumonia	11.3	10.2	18.9	17.6
Alzheimer's Disease	29.1	27.6	18.1	20.8
High Blood Pressure	9.1	8.2	14.6	14.5

Source: CDC WONDER Causes of Death, 2021. https://wonder.cdc.gov/

TABLE 48: OBESITY (ADULTS)

	U.S.	CT	NY	Fairfield County	Westchester County
Obesity (Adults)	34.0%	31.0%	29.0%	25.0%	28.0%

Source: County Health Rankings, Health Data – Adult Obesity, 2021. https://www.countyhealthrankings.org/health-data/health-factors/health-behaviors/diet-and-exercise/adult-obesity?year=2024&county=09001

TABLE 49: SELF-REPORTED CHRONIC CONDITIONS AMONG ADULTS

	Greenwich	CT
High cholesterol	33.8%	33.4%
High blood pressure	26.5%	29.7%
Obesity among adults	22.5%	30.2%
Depression	16.9%	20.9%
Asthma	9.7%	11.1%
Cancer (excluding skin cancer)	8.1%	6.9%
Diagnosed diabetes	7.5%	9.4%
Coronary heart disease	4.9%	5.2%
Chronic obstructive pulmonary disease (COPD)	4.4%	5.7%
Chronic kidney disease	2.7%	2.8%
Stroke	2.5%	2.8%

Source: CDC PLACES (2020-2021). Provided by Connecticut Hospital Association.

TABLE 50: SELF-REPORTED GENERAL WELL-BEING AMONG ADULTS

	Greenwich	CT
Mental health not good for two weeks or more[18]	11.0%	14.6%
Fair or poor self-rated health status	9.4%	13.3%
Physical health not good for two weeks or more[19]	8.5%	10.0%

Source: CDC PLACES (2020-2021). Provided by Connecticut Hospital Association.

TABLE 51: PREVENTIVE CARE HEALTH BEHAVIORS AMONG ADULTS

	Greenwich	CT
Visits to dentist or dental clinic	78.0%	70.4%
Visits to doctor for routine checkup with past year	74.3%	75.3%

Source: CDC PLACES (2020-2021). Provided by Connecticut Hospital Association.

[18] Adults who report that physical health was “not good” for 14 or more days in any given month.
[19] Adults who report that mental health was “not good” for 14 or more days in any given month.

TABLE 52: RANKED LIST OF SELECT HEALTH INDICATOR HOSPITAL UTILIZATION RATES FOR ADULTS IN CONNECTICUT

		Age-Adjusted Principal Diagnosis Rate per 1,000 Adults	
Rank	Health Indicator	Greenwich Hospital	State of CT
1	Sepsis	6.4	8.4
2	Mental Health Composite	5.5	10.4
3	Substance-Related Disorders (SRD)	4.8	8.1
4	Stroke	4.1	2.5
5	High Blood Pressure (HBP)	3.2	4.5
6	Community Acquired (CommAcq) Pneumonia	3.1	4.3
7	Diabetes - Uncontrolled/Short Term Complications (Unc-STC)	1.6	2.7
8	Asthma	1.5	2.8

Source: Community Health Profiles, Hospital utilization rates for key health indicators. Provided by Connecticut Hospital Association

TABLE 53: SMOKING STATUS

	U.S.	CT	NY	Fairfield County	Westchester County
Current Smokers (Adults)	15.0%	12.0%	12.0%	11.0%	11.0%

Source: County Health Rankings, Health Data – Adult Smoking, 2021. https://www.countyhealthrankings.org/health-data/health-factors/health-behaviors/tobacco-use/adult-smoking?year=2024&county=09001

TABLE 54: INFECTIOUS DISEASE

	U.S.	CT	NY	Fairfield County	Westchester County
Hepatitis B	3,544	15	43	0	0
Hepatitis A	18,846	0	265	0	4
HIV/AIDS	1,107,597[20]	171	23,045	51	2,899
Influenza	35,000,000	98	128,775	26	6,072
Lyme Disease	34,945	400	4,830	76	159
Tuberculosis	8,916	54	583	18	21

Source: Connecticut State Department of Public Health, Infectious Disease Statistics, 2020. https://portal.ct.gov/-/media/dph/eeip/infectious-diseases-statistics/ct-disease-cases-by-county_2020_final_ab.pdf | CDC, Selected nationally notifiable disease rates and number of new cases: United States, selected years 1950-2019, 2019. https://www.cdc.gov/nchs/data/hus/2020-2021/IDNotif.pdf | New York State Department of Health, 2020 Communicable Disease Annual Report – Reported Cases by Disease and Country, 2020. https://www.health.ny.gov/statistics/diseases/communicable/2020/docs/cases.pdf | New York State Department of Health, HIV/AIDS Statistics in New York State – New York State HIV/AIDS Annual Surveillance Report 2022. https://www.health.ny.gov/diseases/aids/general/statistics/annual/2022/2022_annual_surveillance_report.pdf | AIDSVu, Understanding the Current HIV Epidemic in the United States, 2022. https://map.aidsvu.org/profiles/nation/usa/overview | CDC, Estimated Flu Disease Burden 2019-2020, 2020. https://www.cdc.gov/flu-burden/php/data-vis/2019-2020.html

TABLE 55: SEXUALLY TRANSMITTED DISEASES

	U.S.	CT	NY	Fairfield County	Westchester County
Syphilis	129,813	280	10,548	52	246
Chlamydia	1,808,703	12,716	97,413	2,836	3,020
Gonorrhea	616,392	4,604	42,482	905	1,024
Chancroid	8	0	ND	0	ND

Source: Connecticut State Department of Public Health, Infectious Disease Statistics, 2020. https://portal.ct.gov/-/media/dph/eeip/infectious-diseases-statistics/ct-disease-cases-by-county_2020_final_ab.pdf | CDC, Selected nationally notifiable disease rates and number of new cases: United States, selected years 1950-2019, 2019. https://www.cdc.gov/nchs/data/hus/2020-2021/IDNotif.pdf | New York State Department of Health, 2020 Communicable Disease Annual Report – Reported Cases by Disease and Country, 2020. https://www.health.ny.gov/statistics/diseases/communicable/2020/docs/cases.pdf

[20] Please note the U.S. data for people living with HIV/AIDS is from 2022.

TABLE 56: MENTAL HEALTH AND BEHAVIORAL HEALTH STATUS

	U.S.	CT	NY	Fairfield County	Westchester County
Percent of Frequent Mental Distress	15.0%	13.0%	13.0%	14.0%	13.0%
Poor Mental Health Days	4.8	4.4	4.2	4.5	4.2
Poor Physical Health Day	3.3	2.9	3.1	2.9	2.6
Drug Overdose Death Rate (per 100,000)	32.0	42.0	29.0	26.0	20.0

Source: County Health Rankings, Health Outcomes – Frequent Mental Distress, Poor Mental Health Days, & Poor Mental Health Days, 2021. https://www.countyhealthrankings.org/health-data/health-outcomes | CDC National Center for Health Statistics, Drug Overdose Death Rate, 2021. https://www.cdc.gov/nchs/data-visualization/drug-poisoning-mortality

TABLE 57: SUICIDE

	U.S.	CT	NY	Fairfield County	Westchester County
Suicide Rate	14.0	10.0	8.0	8.0	7.0

Source: County Health Rankings, Health Data – Suicides, 2021. https://www.countyhealthrankings.org/health-data/health-factors/social-economic-factors/community-safety/suicides?year=2024&county=09001

TABLE 58: MATERNAL AND CHILD HEALTH

	U.S.	CT	NY	Fairfield County	Westchester County
Birth Rate (per 1,000)	11.0	9.9	10.6	10.7	10.1
Teen Birth Rate (per 1,000)	17.0	8.0	11.0	7.0	3.0
Low Birthweight	7.1%	8.0%	8.5%	7.1%	7.7%
Infant Mortality	6.0	5.0	4.0	4.0	3.0

Source: County Health Rankings, Health Data – Teen Births & Infant Mortality, 2021. https://www.countyhealthrankings.org/health-data/health-factors/health-behaviors/sexual-activity/teen-births?year=2024&county=09001 | CDC WONDER, Natality, 2021. https://wonder.cdc.gov

TABLE 59: MATERNAL PRENATAL CARE, 2021-2023 AVERAGE

Indicator	Maternal Race/Ethnicity							
	Fairfield County				Westchester County			
	White	Black	Hispanic	Asian/Pacific Islander	White	Black	Hispanic	Asian/Pacific Islander
Early Prenatal Care[21]	86.7%	75.4%	73.3%	83.7%	87.7%	73.2%	75.3%	83.5%
Late/No Prenatal Care[22]	3.0%	6.2%	6.6%	3.7%	2.9%	7.3%	5.0%	4.0%
Inadequate Prenatal Care[23]	7.3%	15.5%	15.4%	9.7%	7.0%	16.1%	13.6%	9.6%

Source: National Center for Health Statistics, final natality data. Retrieved February 28, 2025, from www.marchofdimes.org/peristats. | National Center for Health Statistics, final natality data. Kotelchuck M. An evaluation of the Kessner Adequacy of Prenatal Care Index and a proposed Adequacy of Prenatal Care Utilization Index. Am J Public Health 1994; 84: 1414-1420. Retrieved February 28, 2025, from www.marchofdimes.org/peristats.

TABLE 60: BIRTH DATA, 2021-2023 AVERAGE

Indicator	Maternal Race/Ethnicity							
	Fairfield County				Westchester County			
	White	Black	Hispanic	Asian/Pacific Islander	White	Black	Hispanic	Asian/Pacific Islander
All Preterm Births[24]	7.5%	12.7%	9.6%	8.1%	7.7%	12.8%	9.6%	9.1%
Late Preterm Births[25]	5.9%	8.5%	6.9%	5.8%	6.1%	8.2%	6.9%	6.9%
Very Preterm Births[26]	0.7%	2.8%	1.4%	1.2%	0.8%	2.9%	1.4%	1.0%

Source: National Center for Health Statistics, final natality data. Retrieved February 28, 2025, from www.marchofdimes.org/peristats.

[21] All race categories exclude Hispanics. Early prenatal care is pregnancy-related care beginning in the first trimester (1-3 months).
[22] All race categories exclude Hispanics. Late/No prenatal care is pregnancy-related care beginning in the 3rd trimester (7-9 months) or when no pregnancy-related care was received at all.
[23] Adequacy is measured using the Adequacy of Prenatal Care Utilization Index, which classifies prenatal care received into 1 of 4 categories (inadequate, intermediate, adequate, and adequate plus) by combining information about the timing of prenatal care, the number of visits, and the infant's gestational age.
[24] All race categories exclude Hispanics. Preterm is less than 37 weeks gestation.
[25] All race categories exclude Hispanics. Late preterm is between 34 and 36 weeks gestation.
[26] All race categories include Hispanics. Very preterm is less than 32 weeks gestation.

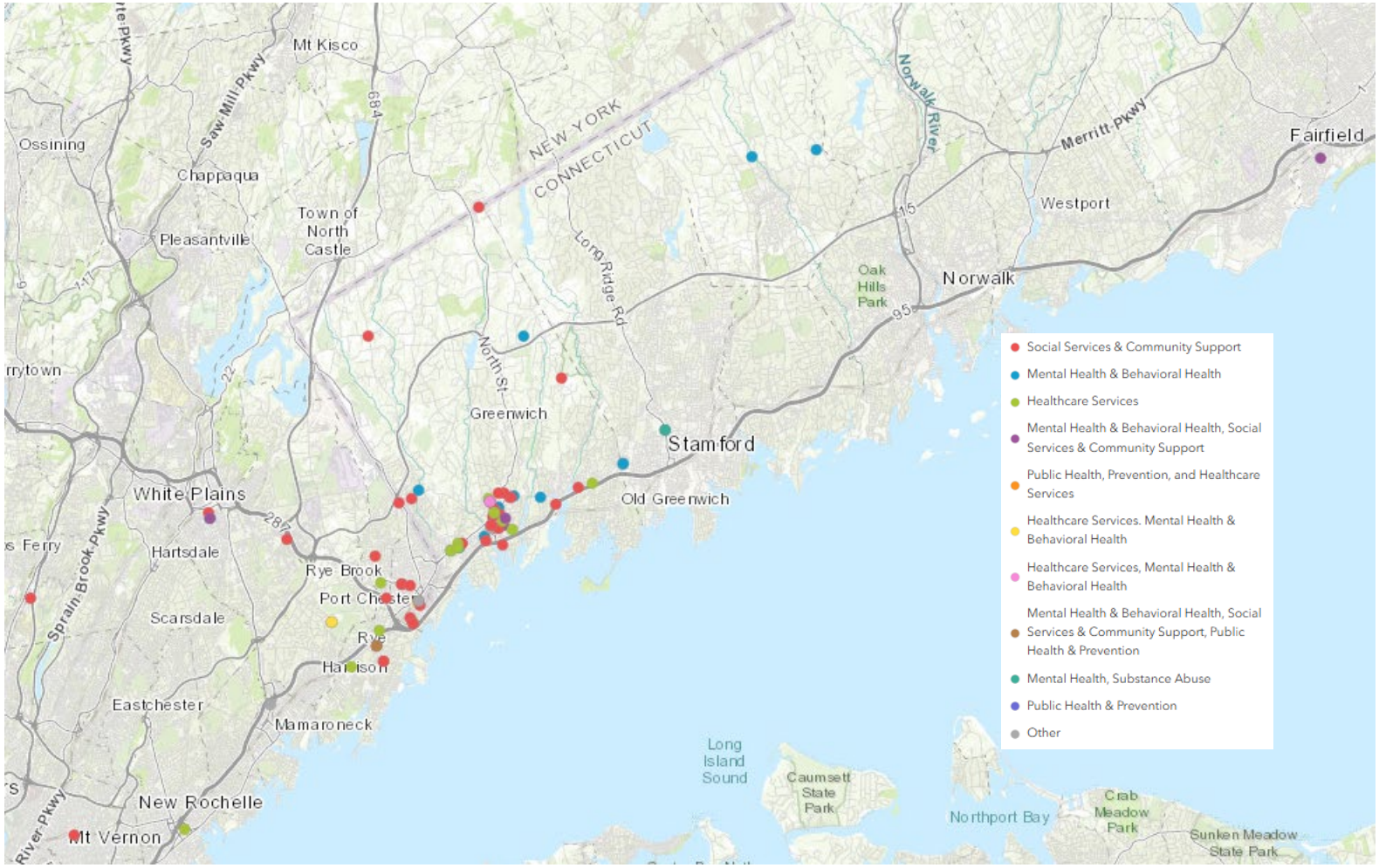
TABLE 61: YOUTH SUBSTANCE ABUSE

	U.S.	CT
Currently were binge drinking	10.5%	7.0%
Ever used illicit drugs	13.3%	ND
Ever used marijuana	27.8%	20.6%

Source: https://nccd.cdc.gov/youthonline/App/Results.aspx?TT=A&OUT=0&SID=HS&QID=QQ&LID=XX&YID=2021&LID2=&YID2=&COL=T&ROW1=N&ROW2=N&HT=C03&LCT=LL&FS=S1&FR=R1&FG=G1&FA=A1&FI=I1&FP=P1&FSL=S1&FRL=R1&FGL=G1&FAL=A1&FIL=I1&FPL=P1&PV=&TST=False&C1=&C2=&QP=G&DP=1&VA=No&CS=Y&SYID=&EYID=&SC=DEFAULT&SO=ASC

Appendix E: Asset Maps and Community Resources

ASSET MAP OF GREATER GREENWICH SERVICE AREA COMMUNITY RESOURCES



Link to interactive map: https://arcg.is/0jHj4f1

Greater Greenwich Service Area Community Resource Table

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
HEALTHCARE SERVICES			
Family Center FQHC	111 Wilbur Peck Court Greenwich, CT 06830	Medical & Dental Clinic	familycenters.org 203-717-1760
Greenwich Hospital	5 Perryridge Rd Greenwich, CT 06830	Acute and Emergency Care	Greenwichhospital.org 203-863-3000
Greenwich Urgent Care & Wellness Center	1200 E. Putnam Ave, Riverside, CT 06878	Urgent Care	203-698-1419
Northeast Medical Group (NEMG) General	15 Valley Dr. Greenwich, CT 06831	Primary & Specialty Care	northeastmedicalgroup.org 1-855-NEMG-MDS (855-636-4637)
Northeast Medical Group (NEMG) General	90 South Ridge St Rye Brook, NY 10573	Primary & Specialty Care	northeastmedicalgroup.org 1-855-NEMG-MDS (855-636-4637)
ONS Urgent Ortho Care	6 Greenwich Office Park, Greenwich, CT 06830	Urgent Care	203-636-7846
Open Door FQHC	5 Grace Church Street, Port Chester, NY 10538	Medical & Dental Clinic	opendoormedical.org 914-632-2737
Orthopedic and Neurosurgery Specialists (ONS)	6 Greenwich Office Park, Greenwich, CT 06830	Ortho & Neuro	onsmd.com 203-869-1145
Physician Referral (GHA)	4 Perryridge Rd Greenwich, CT 06830		greenwichhospital.org/find-a-doctor#sort=%40resulttitle%20ascending&f:deliverynetwork=[Greenwich%20Hospital]
Rye Walk-In Medical Center	150 Purchase St #2, Rye, NY 10580	Urgent Care	ryewalkinmedicalcenter.net 914-967-3266
Senior Shuttle- Port Chester Seniors	222 Grace Church Street	Transportation	portchesterny.gov/269/Transportation 914-939-4975
Summit Health/Westmed	644 W. Putnam Ave Greenwich, Ct 06830	Urgent Care, Primary & Specialty Care	203-210-2810

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
Summit Health/Westmed	1 Theall Road, Rye, NY 10580	Urgent Care, Primary & Specialty Care	summithealth.com/patient-hub 914-848-8000
The Osborn	125 Mason Street, Greenwich, CT 06830	Home Care	theosborn.org/home-care/fairfield-county-ct 203-641-7683
Westchester County Health Dept	145 Huguenot St. New Rochelle, N.Y. 10801	Health Promotion	health.westchestergov.com 914-813-5000
Westchester County Health Dept WIC Program	1 Gateway Plaza, 1st floor, South Main St., Port Chester, NY 10573	WIC Program	health.westchestergov.com/services/locations 914-813-7244
Yale Medicine	500 West Putnam Avenue, Ste 350	Medical & Specialty Care	877-YALEMDS (925-3637) yalemedicine.org
MENTAL HEALTH & BEHAVIORAL HEALTH			
988 Suicide and Crisis Lifeline		Suicide & Crisis Lifeline	988
Barbara's House	61 East Putnam Ave Greenwich, CT 06830	Outreach Programs /Youth Enrichment Program	barbarashousect.org 203-869-1276
Catalyst CT | The Hub	2470 Fairfield Ave, Bridgeport, CT 06605	Mental Health	catalystct.org/the-hub 203-579-2727
Child Guidance Center of Southern Connecticut	81 Holly Hill Ln Greenwich, CT 06830	Transgender And Gender Expansive Youth	childguidancect.org 203-324-6127
Depression and Bipolar Support Alliance, Greenwich	27 Stag Ln Greenwich, CT 06831	Mental Health Support Group	dbsagreenwich.com 203-661-8282
Family Center FQHC	20 Bridge St Greenwich, CT 06830	Substance Abuse, Mental Health	familycenter.org 203-629-2822
Family Services of Westchester (FSW)	One Gateway Plaza, Suite 3B, Port Chester, NY 10573	Mental Health	fsw.org/our-programs/family-mental-health-centers 914-305-6831
Greenwich Communities, Inc	249 Milbank Ave Greenwich, CT 06830	Housing	203-869-1138

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
Greenwich Hospital, Center for Psychiatric and Behavioral Health	5 Perryridge Rd Greenwich, CT 06830	Mental Health	greenwichhospital.org 203-863-3316
Greenwich Hospital's Addiction Recovery Center	2015 West Main St Stamford, 06905	Substance Abuse	203-863-4673
Greenwich Hospital's Center for Behavioral and Nutritional Health	2015 West Main St Stamford, 06905	Mental Health	203-863-2939
Greenwich Hospital's Outpatient Health for Psychiatric and Behavioral Health	5 Perryridge Rd Greenwich, CT 06830	Mental Health	203-863-3316
Greenwich Together	101 Field Point Rd Greenwich, CT 06830	Substance Abuse	greenwichtogether.org 203-622-6556
Jewish Family Services of Greenwich	1 Holly Hill Ln Greenwich, CT 06830	Mental Health	jfsgreenwich.org 203-622-1881
Kids In Crisis	1 Salem St, Cos Cob, CT 06807	Substance Abuse, Mental Health	kidsincrisis.org 203-661-1911
Laurel House Resource Center	1616 Washington Blvd, Stamford, CT 06902	Mental Health	laurelhouse.net 203-324-1816
Liberation Programs	50 East Putnam Ave Greenwich, CT 06830	Substance Abuse	liberationprograms.org 203-851-2077
National Alliance of Mental Illness (NAMI)	P.O Box 1582 New Canaan, CT 06840	Mental Health	namisouthwestct.org 203-482-6864
Pathways of Greenwich	175 Milbank Ave, Greenwich, Ct 06830		Mental Health of Housing and Urban Development
Resources to Recover	1616 Washington Blvd, Stamford, CT 06902	Free Resource Line	rtor.org 203-724-9070
Rye Youth Council, Inc.	21 Locust Ave, Rye, NY 10580	Mental Health Provider, Counseling, and Wellness Programs	ryeyouthcouncil.org, 914-967-3838
RyeAct	21 Locust Ave, Rye, NY 10580	Substance Abuse, Mental Health	ryeact.com 914-481-4141

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
Silver Hill Hospital	208 Valley Rd, New Canaan, CT 06840	Substance Abuse	silverhillhospital.org 1-866-542-4455
St. Vincent's Hospital Westchester	275 North St, Harrison, NY 10528	Substance Abuse, Mental Health	stvincentswestchester.org 914-967-6500
Town of Greenwich Department of Human Services	101 Field Point Rd Greenwich, CT 06830	Substance Abuse	203-622-3800
Town of Greenwich Park Department	101 Field Point Rd Greenwich, CT 06830	Recreation/Park	203-633-7814
Westchester County Mental Health	112 East Post Rd Suite 219, White Plains, NY 10601	Substance Abuse, Mental Health	mentalhealth.westchestergov.com 914-995-6500
Westchester County Mental Health	112 East Post Rd Suite 219, White Plains, NY 10601	Mental Health	mentalhealth.westchestergov.com/ 914-995-6191
Wilkins Center	7 Riversville Rd Greenwich, CT 06831	Eating Disorders	wilkinscenter.com 203-531-1909
YWCA Greenwich	259 East Putnam Ave Greenwich, CT 06830	Mental Health Support Group/ Domestic Violence	ywcagreenwich.org 203-622-0003
PUBLIC HEALTH & PREVENTION			
Greenwich Department of Health	101 Field Point Road	Public Health and Emergency Preparedness	greenwichct.gov/575/Health-Department 203-622-6488
Greenwich Department of Health	101 Field Point Road	Division of Family Health – Nursing visits, Immunizations, blood pressure screening, school physicals, TB screening	203-622-6495
Greenwich Department of Health	101 Field Point Road	Special Clinical Services	203-622-6460
Greenwich Department of Health	101 Field Point Rd Greenwich, CT 06830	Environmental and Laboratory Services	203-622-1001 Env. Services; 203-622-7843 Lab
Greenwich Department of Health	101 Field Point Rd Greenwich, CT 06830	Dental Program	203-622-7858

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
SOCIAL SERVICES & COMMUNITY SUPPORT			
211 Connecticut			211ct.org 211
AA	5 Perryridge Rd Greenwich, CT 06830	Mental Health & Behavioral Health	
Abilis	50 Glenville St, Greenwich, CT 06831	Support Special Needs Population	203-531-1880
At Home Greenwich	139 E. Putnam Ave, Greenwich, CT 06830	Support Services for aging Adults Living Independently	203-422-2342
Audubon Connecticut	613 Riversville Rd Greenwich, CT 06831	Recreation/Park	greenwich.audubon.org 203-869-5277
Banksville Community House	12 Banksville Rd Greenwich, CT 06831	Youth Enrichment Program	203-622-9597
Boy Scouts of America, Greenwich Council	63 Mason St Greenwich, CT 06830	Youth Enrichment Program	greenwichscouting.org 203-869-8424
Boys and Girls Club of Greenwich	4 Horseneck Ln Greenwich, CT 06830	Youth Enrichment Program	bgcg.org 203-869-3224
Bruce Museum	1 Museum Dr, Greenwich, CT 06830	Arts/ Cultural Enrichment	brucemuseum.org 203-863-0376
Bush Holly House	47 Strickland Rd, Cos Cob, CT 06807	Arts/ Cultural Enrichment	greenwichhistory.org/the-bush-holley-house 203-869-6899
Call a Ride of Greenwich	37 Lafayette Pl Greenwich, CT 06830	Transportation-Free Ride service	callaridegreenwich.org 203-661-6633
Carver Center	400 Westchester Avenue. Port Chester, NY 10573	Youth Enrichment Program	carvercenter.org 914-939-4464
Carver Center- Carver Market	400 Westchester Avenue Port Chester, NY 10573	Food Pantry	carvercenter.org/market/ 914-305-6009
Connecticut Food Bank	2 Research Pkwy, Wallingford, CT 06492	Food Pantry	ctfoodbank.org 203-469-5000

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
Crawford Park	122 North Ridge Street Rye Brook, NY 10573	Recreation/Park	townofryeny.com/parks/crawford-park 914-881-4532
Don Bosco Soup Kitchen	22 Don Bosco Place, Port Chester, NY 10573	Food Pantry	donboscocenter.org/don-bosco-soup-kitchen-and-food-pantry 914-939-0323x11
Greenwich Hospital's Center for Healthy Aging	5 Perryridge Rd Greenwich, CT 06830	Aging Seniors Programs & Support	203-863-4373
Greenwich Hospital's Healthy Living Center	500 W. Putnam Ave, Greenwich,CT	Cardiac Rehab & PT	203-863-3756
Greenwich Public Library	101 W. Putnam Ave, Greenwich, CT 06830	Education Support	greenwichlibrary.org 203-622-7900
Greenwich United Way	500 West Putnam Avenue #415, Greenwich, CT 06830	Resource for Financial, Food, Health, Transportation, Jobs & Housing	greenwichunitedway.org 203-869-2221
Horizons Program	100 Maher Avenue Greenwich, CT 06830	Youth Enrichment Program	horizonsatwick.org 203-625-5809
Meals on Wheels of Greenwich	89 Maple Ave Greenwich, CT 06830	Food Pantry	mealsonwheelsofgreenwich.org 203-869-1312
Mianus River Park	450 Cognewaugh Road Greenwich, CT 06807	Recreation/Park	friendsofmianusriverpark.org
Neighbor to Neighbor	248 East Putnam Ave Greenwich, CT 06830	Food Pantry	ntngreenwich.org 203-622-9208
Port Chester Youth Bureau	222 Grace Church Street, Port Chester, NY 10573	Youth Enrichment Program	portchesterny.gov/youth-bureau 914-758-2228
Port Chester Friendly Fridge	400 Westchester Avenue Port Chester, NY 10573	Food Pantry	instagram.com/thepcfriendlyfridge 914-305-6009
Port Chester Housing Authority	2 Weber Drive Port Chester NY 10573		riverhouse.org
Port Chester-Rye Brook Public Library	1 Haseco Ave, Port Chester, NY 10573	Education Support	portchester-ryebrooklibrary.org 914-939-6710

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
Putnam Cottage	243 E Putnam Ave, Greenwich, CT 06830	Arts/ Cultural Enrichment	putnamcottage.org 203-869-9697
River House	125 River Rd Ext, Cos Cob, CT 06807	Adult Daycare	203-622-0799
Rye Brook Rec Dept.	938 King St, Rye Brook, NY 10573	Recreation/Park	ryebrook.org/departments/parks-recreation 914-939-3235
Rye Brook Senior Center - Anthony J. Posillipo Community Center	32 Garibaldi Pl, Rye Brook, NY 1057	Seniors Services	ryebrook.org/departments/senior-service 914-939-7904
Rye Rec Dept.	281 Midland Ave, Rye, NY 10580	Recreation/Park	ryeny.gov/government/recreation-department 914-967-2535
Rye Senior	281 Midland Ave, Rye, NY 10580	Seniors Programs	ryeny.gov/government/recreation-department/seniors 914653-3081
Rye YMCA	21 Locust Ave, Rye, NY 10580	Youth Enrichment Program	ryeymca.org 914-967-6363
SPRYE	55S S. Main St. Port Chester, NY 10573	Aging in Place	sprye.org 914-481-5706
The Port Chester Rec Dept.	222 Grace Church Street, Port Chester, NY 10573	Recreation/Park	portchesterny.gov/recreation 914-939-2354
The Renfrew Center of White Plains	1025 Westchester Avenue Suite 210 White Plains, NY 10604	Mental Health	renfrewcenter.com 1-800-RENFREW
The Wallace Center	299 Greenwich Ave Greenwich, CT 06830	Seniors Programs	203-862-6700
Town of Greenwich Commission on Aging Department	299 Greenwich Ave Greenwich, CT 06830	Seniors Programs	203-862-6710
Town of Greenwich Department of Human Services	101 Field Point Rd Greenwich, CT 06830	Seniors Programs	203-622-3800
Transportation of Greenwich (TAG)	13 Riverside Avenue, Riverside, CT 06878	Transportation-Free Ride service	ridetag.org 203-637-4345

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
Westchester County Department of Senior Programs and Services	9 South First Avenue 10th Floor Mt. Vernon, NY 10550	Senior Programs	seniorcitizens.westchestergov.com/
Westchester County Housing Program	148 Martine Avenue, White Plains, NY 10601	Housing Support	homes.westchestergov.com 914-995-2000
Westchester County of Human Development Services	930 Mamaroneck Ave, Mamaroneck, NY 10543	Social Services	hdsw.org 914-835-8906
Westchester County Parks	450 Saw Mill River Rd Ardsley, NY 10502	Recreation/Park	parks.westchestergov.com
Yale New Haven Health Location Information		Referrals	ynhhs.org/physician-referral-info
Yale New Haven Health Physician Referral Information		Referrals	ynhhs.org/find-a-location/#sort=relevancy&numberOfResults=25
YMCA Greenwich	50 East Putnam Ave Greenwich, CT 06830	Mental and Behavioral Health	greenwichymca.org, 203-869-1630

Appendix F: DataHaven Respondent Demographics

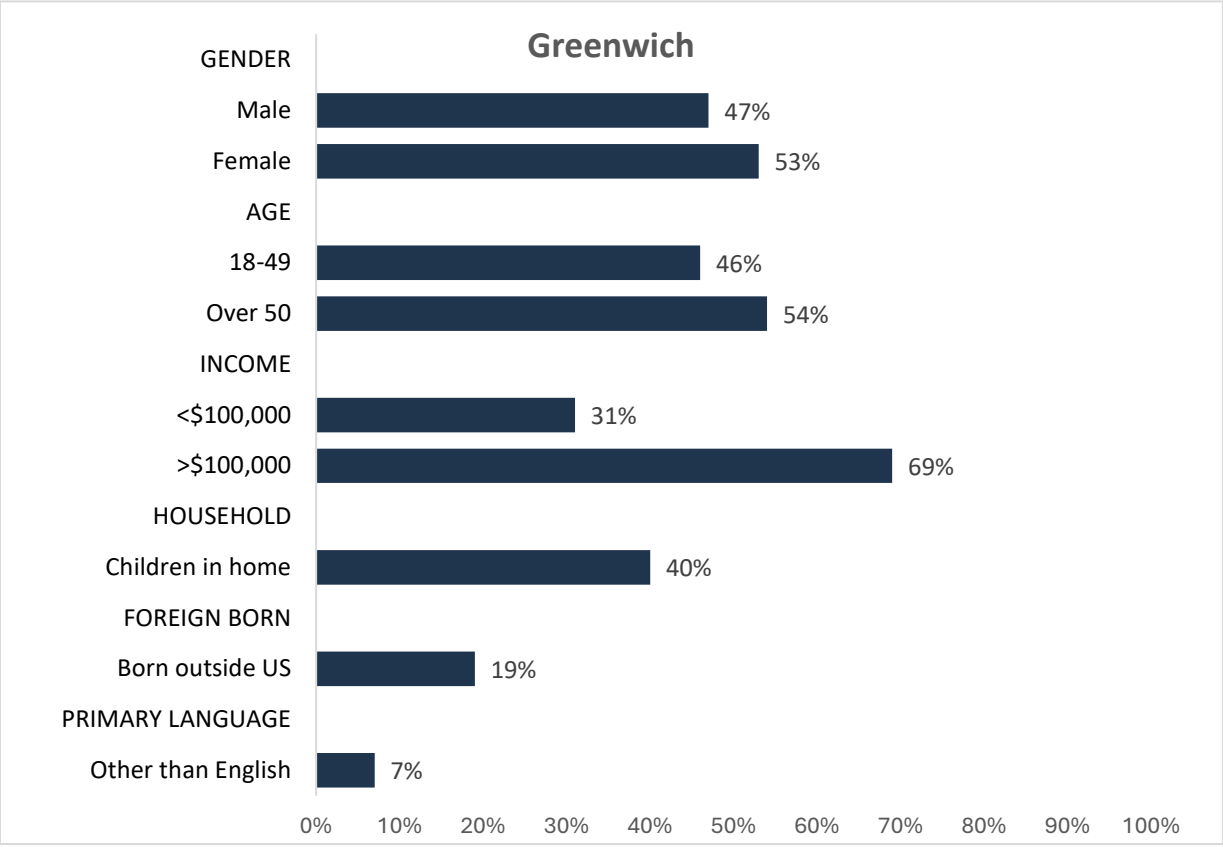
Additional information and data can be found online at the CT DataHaven website: www.ctdatahaven.org

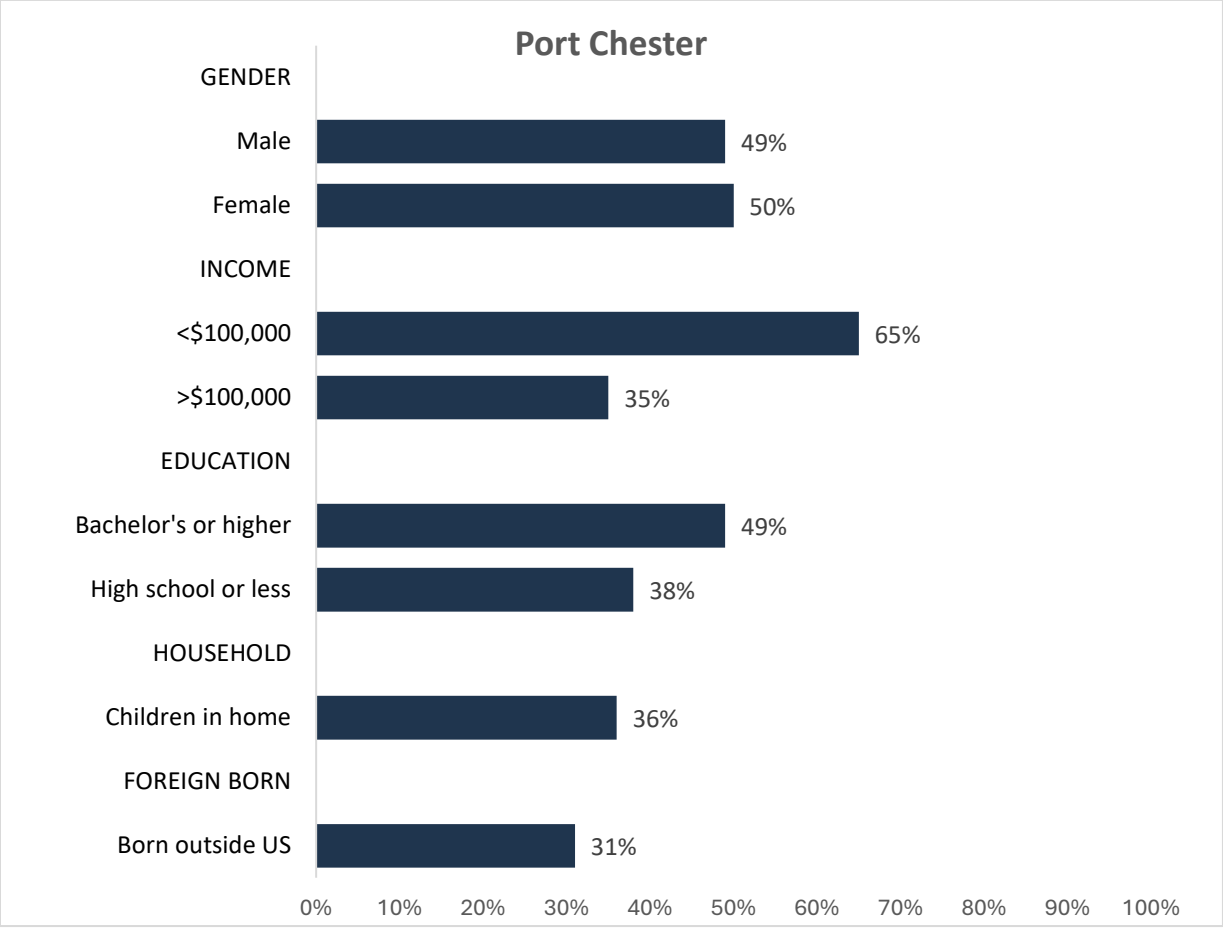
DataHaven Community Well-being Survey (DCWS)

The DataHaven Community Well-being Survey (DCWS) assesses issues such as quality of life, health, employment, and neighborhood resources. The DCWS uses probability sampling to create highly-reliable local information that is not available from any other public data source. The DCWS traces its origins to a series of locally-based efforts conducted over the past two decades to gather information about well-being in Connecticut neighborhoods. With guidance from an Advisory Council of 300 public and private organizations, DataHaven created a unified statewide survey shared by all cities and towns in the state.

DataHaven conducted in-depth interviews with 175 randomly-selected adults on the DCWS in Greenwich and 130 adults in Port Chester.

DCWS Respondent Demographics




Port Chester
GENDER
Male
49%
Female
50%
INCOME
<$100,000
65%
>$100,000
35%
EDUCATION
Bachelor's or higher
49%
High school or less
38%
HOUSEHOLD
Children in home
36%
FOREIGN BORN
Born outside US
31%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

Appendix G: Key Informant Interview Guide

Introductory Questions

1. Please tell me a little about yourself and how you interact with the local community (i.e., what does your organization do?)

2. When you think of good things about living and/or working in the community, what are the first things that come to mind?

3. If you had to pick the top two or three challenges or things people struggle with most in your community, what comes to mind?

Access to Care and Delivery of Services

4. What, if any, health care services are difficult to find and/or access? And why?

5. What are some health-related resources available in the community that are working well and why?

Behavioral Health

6. What, if any, behavioral health care services (including mental health and substance use) are difficult to find and/or access? Why?

7. What behavioral-health resources are available in the community?

8. What types of stigma, if any, are around seeking treatment for mental health and/or substance use disorders?

Health Equity, Groups Experiencing Disadvantage, Barriers

9. Do you think people in the community are generally **HEALTHY**? Please explain why you think people are healthy or not healthy in your community?

10. How can we improve the overall health of our community?

11. Would you say health care services are equally available to everyone in the community regardless of gender, race, age, or socioeconomics? What populations are especially experiencing disadvantage and/or under-resourced in your community?

12. What barriers to services exist, if any?

13. Do community health care providers care for patients in a culturally sensitive manner?

14. What would you say are the two or three most urgent needs for the most vulnerable?

Social Determinants, Neighborhood & Physical Environment

15. From your perspective what are the top three non-health-related needs in the community and why?

16. What are the top three non-health related assets and why?

Enhancing Outreach & Disseminating Information

17. How do individuals generally learn about access to and availability of services in the area?

18. What do you think are some challenges to spreading awareness and understanding of the availability of services and ways to access them? What might help overcome the challenges?

Magic Wand

19. From your perspective what are the 2 -3 most important health issues/concerns in the community?

20. Based on the health issues you selected/identified… if you had a Magic Wand that you personally could improve the health of the community, what interventions or resources (programs, services etc.) would you implement?

Appendix H: Focus Group Guide

Introductory Questions

1. To start, please briefly introduce yourself and share something you like about your community.
2. What is your definition of "community"?
3. What does a "healthy" community look like to you?
4. What are the two or three most important health needs in your community?

Access to Care and Delivery of Services

5. What services and resources for becoming and staying healthy are difficult to find or missing? What services and resources are difficult to access? Why?
6. How do most people learn about services in your community?
7. What health resources or services are easier to find? Why?

Social Determinants, Neighborhood & Physical Environment

8. What are the top three social or environmental health needs or challenges in the community? Why?
9. What resources and services are available and/or missing in your community to help people with [needs or challenges identified in Question 8]?

Health Equity and Groups Experiencing Disadvantage

10. What populations in your community experience more challenges than others? PROBE: veterans, youth, immigrants, LGBTQ+ populations, people of color, older adults, people living with disabilities, people with lower income, rural vs. urban, etc.
11. What are the two or three biggest needs or challenges faced by these groups/your group?
12. What health or social services are not equally available to everyone in your community regardless of gender, race, age, income, or ability? Why?

Protective and Risk Factors

13. Are there factors or lifestyle choices that help people stay healthier and happier? What are they? In your community, what factors or lifestyle choices help people stay healthier and happier?
14. What factors or lifestyle choices contribute the most to the health problems people in your community face?

Magic Wand

15. If you had all the money and resources in the world and could do any one thing to make your community healthier, what would it be?