



# Community Health Improvement Plan

2022 - 2025

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## INTRODUCTION

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**“For he who has health has hope; and he who has hope, has everything.” Owen Arthur**

Health assessments help us examine changes to the health of our community, provide insights as to how residents can lead healthy and happy lives, and identify key health issues facing the community. The definition of health now includes the quality of the community in which we live, work, and play – not just the lifestyle habits of individuals. A comprehensive assessment process must provide a framework that helps communities prioritize public health issues; identify resources for addressing them; and effectively develop and implement community health improvement plans.

The 2022 Community Health Needs Assessment (“CHNA”) for Charlotte Hungerford Hospital (CHH) (or the “Hospital”), part of Hartford HealthCare’s (HHC) Northwest Region, leveraged numerous sources of local, regional, state and national data along with input from community-based organizations and individuals to provide insight into the current health status, health-related behaviors and community health needs for the Hospital service area.

In addition to assessing traditional health status indicators, the 2022 CHNA took a close look at social influences of health (SIOH) such as economic insufficiency, housing, transportation, education, fresh nutritious food availability, and neighborhood safety and contains an Equity Profile. These two enhancements are in response to the lessons of COVID and in recognition of an emerging national priority to identify and address health disparities and inequities. HHC and CHH are committed to addressing these disparities and inequities through its Community Health Improvement Plan (CHIP).

The intent of our CHIP is to be responsive to community needs and expectations and create a plan that can be effectively executed to leverage the best of the system resources, regional hospital and network resources, and community partners. The CHIP supports HHC’s mission “to improve the health and healing of the people and communities we serve” and is part of HHC’s vision to be “most trusted for personalized coordinated care.” More specifically, this CHIP is collectively aimed at living our Value of Equity which reminds us all to do the just thing.

While a CHIP is designed to address these multiple needs, narrowing the focus to key areas of need and impact with associated key strategies best positions a health system for success. A CHIP is a dynamic rather than a static plan and should be modified and adjusted as external environmental factors change, including market conditions, availability of community resources, and engagement from community partners.

Furthermore, a CHIP should build on and leverage prior success while simultaneously adjusting strategies and actions as obstacles are encountered.

This CHIP is organized across five focus areas that are intended to address root causes of community health issues while recognizing where the Northwest Region in partnership with the community can be most effective in impacting change. The plan for each of these areas is outlined on the following pages. The driving rationale for each of these can be summarized as follows:

### 1. Better Meet the Social and Mental Well-Being Needs of Those We Serve

There is a growing recognition that medical care alone cannot address the complexity of overall health. Mental wellbeing, more significant mental illness and substance use disorders were consistently identified as a top issue by the community. In addition, economic conditions, racism and other forms of discrimination and social conditions, were all cited as risks impacting health. Reducing stigma, assuring timely access, and improving the social influencers of health that exacerbate stress and unhealthy living situations is essential to improving overall health and quality of life.

#### Rationale for Action

- Nearly one-third of the survey respondents reported that they or a member of their family currently has an unmet mental health or substance use need.
- Overall 11% of our service area adults report experiencing anxiety and 8% report being bothered by depression, but the reporting jumps along race/ethnicity lines with 28% for Blacks and 18% for Hispanics for anxiety and 12% for Blacks for depression.
- In 2015 and 2016, 40% of the drug overdose deaths in our service area involved fentanyl; in 2019 and 2020, this share was 89% and higher than the statewide rate of 84%.
- Connecticut has seen a rise in drug overdose deaths in the last several years – in 2020 it averaged 133 per month, up from 60 in 2015. White residents long comprised the bulk of deaths, but as overall death rates have increased, and increasing share of those deaths have been people of color.
- Torrington and Winsted are designated by the State of Connecticut as Distressed Municipalities and both communities meet the highest federal vulnerability standard under the Social Vulnerability Index.

### 2. Expand Access to Culturally Responsive Care

There are many factors that shape and confine health outcomes including obstacles related to accessing care and services, not only transportation barriers, but the awareness of available resources and the process of care which includes a patient's trust, experience and comfort with care and services. More systemically, racial and economic inequities and other unfavorable environmental and social conditions

provide powerful influencers in limiting individuals and communities from accessing care and services and reaching one's health potential. Navigating the healthcare system is difficult and expanding access requires many steps, including assuring that care is delivered in a culturally appropriate way.

### Rationale for Action

- Our service area has decreased in population by 3.7% since 2010 and we have become older and more diverse (6.1% people of color in 2010 versus 16% in 2020, a 160% increase compared to a 45% increase nationally).
- As of 2019, 3,013 residents in our service area (3%) were linguistically isolated with Hispanic and Asian Americans more likely to report this than any other racial/ethnic group.
- HHC affiliated outpatient service sites access audit revealed only two of the sites (18.2%) had Spanish as an option on the phone tree.
- When evaluating late or no prenatal care, the rate amongst White women is at 2.7% compared to 7.6 % for Hispanic women. When compared to the State of Connecticut data, the rates among White women were 2.5% and 4% for Hispanic women.

### 3. Address Health Through Housing

The relationship between housing and health is well established. Unstable housing and unhealthy living situations increase avoidable acute and emergency care utilization, give rise to and exacerbate chronic health conditions, and are associated with increased depression anxiety and substance use disorders. In addition, when households spend more than 30% of their income on housing and housing related costs, there is not enough money left over to afford everyday expenses like food and transportation, which also impacts an individual and families overall health.

### Rationale for Action

- In Litchfield County, against a 30% federal standard of measuring the cost-burden of a household, the average renter can afford \$728.00 per month in rent for a 2 bedroom apartment. However, the market rate for the same is \$1,280. The cost burden is even greater for a Supplemental Security Income recipient who at a fixed earnings of \$979 per month, against using the 30% standard can only afford a rent of \$294. For the wage earner, meeting the market rate and staying within the 30% standard would require an hourly rate of \$25.
- In general, housing costs have recently risen while wages have not increased at the same rate. Hence, lower-income workers are more likely to rent and spend more than 30% of their income on housing related expenses.

- Younger adults are less likely than older adults to own their homes across several race/ethnicity groups. However, in most towns, younger White adults own their homes at rates comparable to or higher than older Black and Hispanic/Latinx adults.
- Cost burden generally affects renters more than homeowners, and has greater impact on Black and Hispanic/Latinx households. Among renter households in the Charlotte Hungerford HSA, 46% are cost burdened, compared to 26% of owner households.

#### 4. Reduce Food Insecurity and Increase Access to Healthy Foods

Making access to healthy foods both convenient and affordable in our communities is an effective way to impact the social and environmental determinants that are the primary drivers of health or illness. Food insecurity and poor access to healthy foods limit people's ability to have a balanced diet and places children and adults at higher risk of obesity, diabetes and other diet-related health conditions, anxiety and depression, and reduced academic achievement.

##### Rationale for Action

- Food insecurity saw a significant jump from 2019 to 2020 with a 12.3% overall rate and 15.6% rate among children for Litchfield County.
- The Hispanic/Latinx community is a notable outlier regarding food insecurity. Nearly one in three (30%) Hispanic community members indicate that they do not have secure sources of affordable, nutritious food.
- Torrington and Winsted reported a significantly higher share of adults with obesity (31% and 42% respectively versus statewide at 29%).
- Almost one-third of Connecticut's youth are overweight or obese with non-Hispanic Black and Hispanic youth more likely to be obese compared with non-Hispanic White youth.

#### 5. Improve Community Health in Partnership with Others

Research has repeatedly shown that healthy habits are critical to averting lost or unproductive time at school or work, growing and maintaining cognitive and physical functioning, promoting mental health, and preventing and managing many chronic diseases such as heart disease, cancer, stroke, diabetes, mental health and osteoporosis. Developing and maintaining trusted community partnerships to improve health literacy, promote health equity, and creating an environment within which we live, work and play where the healthy choice is the easy choice.

## Rationale for Action

- Winsted reported significantly higher share of adults who smoke (39% versus statewide at 14%) and a significantly higher share of adults with obesity (42% versus statewide at 29%).
- Encounters to our 2 EDs are more likely compared to the rest of the state to be related to alcohol, substance use and COPD.
- When adjusted for age, encounters to our 2 EDs are more likely to see hypertension, mental disorder (any), Type 2 diabetes.
- Torrington and Winsted are designated by the State of Connecticut as Distressed Municipalities and both communities meet the highest federal vulnerability standard under the Social Vulnerability Index.

## The Call to Action

As community health leaders, this CHIP is essentially our call to action over the next three years to do our part to assure those we serve live long and healthy lives. Community partnerships will be a key ingredient to achieving success. This plan aims to further develop and pursue active engagement with the community. The good news is that we do not do this work alone. And, even though this work can be overwhelming at times, with important partnerships throughout the communities we serve, success is made possible. In the NW Region, we channel our work through five important collaboratives, including:

- 1. Fit Together** - A community collaborative of health and social service providers and public officials, formed in 2011, with the purpose of identifying and implementing environmental and social improvements in the Greater Torrington and Winsted areas that help make healthy choices for individuals, easy choices. With objectives to increase physical activity and promote healthy lifestyles, Fit Together serves as the main vehicle for implementing many of the CHIP strategies that relate to its purpose and is underwritten by CHH/HHC.
- 2. Building Healthier Communities Advisory Board** – As part of the Affiliation Agreement between The Charlotte Hungerford Hospital (CHH) and Hartford Health Care Corporation (HHC), a distribution of \$2,500,000 has been made to the Northwest Connecticut Community Foundation, Inc. (Foundation) for the express purpose of enhancing the economic and community well-being of the Greater Torrington and Winsted areas. Funds are to be used for the formulation of a regional economic and social development plan to improve the Social Influencers of Health (SIOH). The four areas pre-selected by the Board for their initial focus on SIOH impact include: Education, Health and Healthcare, Neighborhood and Environment, and Economic Stability.
- 3. The Litchfield County Opiate Task Force** – A Task Force formed in December 2013 to assure collaboration of area agencies, officials and community members who meet monthly to share information and develop interventions that will reduce the harm of opioid addiction. The Task Force organizes its work around four essential goals of improving access to care, enhancing collaboration and data sharing

between and among service providers, reducing opioid use and misuse in the community, and sharing helpful information about addiction, prevention, safety and treatment.

**4. CHH Diversity Equity Inclusion and Belonging Council-** CHH DEIB Council was formed to gain a deeper understanding of the disparities at CHH with a focus on the racial injustices within the staff, patients, and community with the goal to develop action steps to address any diversity, social injustice, and health disparity deficits within the organization and/or through the provision of our services. The council supports HHC's system wide DEIB initiative and is committed to the principle that all people deserve full participation in society regardless of race, language, religion, gender, minority status or other aspects of identity.

**5. Community Health Alliance –** A collaborative convened by CHH of health and human service providers and agencies and consumers in the area to help oversee the CHNA and CHIP processes and to tackle other health-related challenges in the community. Its purposes include information-sharing, coordination of resources, messaging and co-creating and co-administering of activities. This group jointly reviews the CHNA and helps develop and ultimately endorses the CHIP action plan. Members include:

Community Health and Wellness Center  
Northwestern CT YMCA  
New Beginnings  
Brooker Memorial  
FISH  
New Opportunities  
Torrington Community Soup Kitchen  
Torrington Area Health District  
The B.E.R.E.A.D.Y. Project  
Our Culture is Beautiful  
NW CT United Way  
Torrington Housing Authority

Winsted Senior Center  
Torrington Youth Service Bureau  
Winsted Youth Service Bureau  
Town of Winchester Social Services  
Town of Thomaston  
North Canaan Social Services  
NW Hills Council of Governments  
NW CT Community Foundation  
The Gilbert School  
Salvation Army - Winsted  
Sullivan Senior Center  
Friendly Hands Food Bank

## NW CT Community Health Improvement Plan

Focus Area #1: Better Meet the Social and Mental Well-Being of Those We Serve			
OBJECTIVE	STRATEGIES/TIMELINE	LEAD/PARTNERS	METRICS/MILESTONES - STATUS
<p><b>Primary:</b> <i>Establish and develop Community Care Team (CCT) in the NW Region</i></p>	<p>Develop and sustain NW CCT</p> <ul style="list-style-type: none"> <li>• Enter MOU with participating Agencies</li> <li>• Develop standard report and outreach process</li> <li>• Establish meeting cadence and work flow</li> <li>• Set targets and evaluate program</li> </ul> <p>NOTE: standard – 10 or more ED visits in a 6 month period and/or 5 or more Ambulance rides to ED in 30 days</p>	<p>Tasha LaViera/Dr. Anuj Vhora/Erinne Houton/Community Health and Wellness</p>	<p><b>Target:</b> Minimum of 15 patients served, 4 additional organizations participating by end of FY, and demonstrated reduction of unnecessary ED visits by patients served (6mos over 6mos)</p> <p><b>Actual</b></p>
<p><b>Secondary:</b> <i>Decrease negative consequences of substance use disorders, including opioid addictions, through harm reduction and increased access to services and supports</i></p>	<ol style="list-style-type: none"> <li>1. Support and promote LCOTF spike alert response initiative, including availability of case management</li> <li>2. Increase Narcan distribution and the provision of other harm reduction supplies</li> </ol>	<p>Carla Angevine/Thomas Narducci LCOTF</p>	<p><b>Target: TBD – consulting LCOTF</b></p> <p><b>Actual</b></p>

<p><b>Secondary:</b> Support mental well-being community-based services, community outreach and education development</p>	<ol style="list-style-type: none"> <li>1. Collaborate with mental health area providers to expand system response capacity, particularly with children and youth in the school setting. Work with superintendents and town officials to develop a shared intervention.</li> <li>2. Secure new clinical FTE within CHH Behavioral Health that is exclusively community facing – assist with Community Care Team and lead efforts around Community education and liaison work with schools.</li> <li>3. Expand SIOH screening and utilization of Connections that Matter at area Primary Care and Endocrine practices</li> <li>4. Create opportunities for regional trainings for Mental Health First Aid</li> </ol>	<p>Brian Mattiello/Joan Neveski</p> <p>Brian Mattiello/Thomas Narducci</p> <p>Tasha LaViera, Hilary Maynard</p> <p>Carla Angevine/Thomas Narducci</p>	<p><b>Target:</b> Gaps Analysis of Children and Adolescents Behavioral Health – Completed</p> <p>Pending grant application – November 2022</p> <p>Aligning with ICP/HHCMG goal for 100% screening</p> <p>Minimum one community partner training for Mental Health First Aid</p> <p><b>Actual</b></p>
<p><b>Secondary:</b> Better meet the needs of our aging population with a particular emphasis on living with and managing cognitive decline, dementia and other senior related mental health conditions and independent living needs</p>	<ol style="list-style-type: none"> <li>1. Enhance the NW dementia outreach activities by combining the resources of the Center for Healthy Aging (CHA) and CHH’s community health. Topics cover basics of communication and understanding behaviors, safety and how to structure daily activities, taking care of the caregiver and care options, and community resources. Support includes logistics, materials development, promotion and linkages to area providers and support services.</li> </ol>	<p>Carla Angevine Area’s Center for Healthy Aging</p>	<p><b>Target:</b> Number of CHA clients served in the NW with dementia needs Number of info sessions/events held with number of attendees Number of CHH ED providers trained</p> <p>Completed Outreach action plan with CHA and CHH</p>

## Focus Area #2: Expand Access to Culturally Responsive Care

OBJECTIVE	STRATEGIES/TIMELINE	LEAD/ PARTNERS	METRICS/MILESTONES – STATUS
<p><b>Primary:</b> <i>Assess and Adopt CLAS Standards (Culturally and Linguistically Appropriate Services) across acute care and ambulatory settings</i></p>	<ol style="list-style-type: none"> <li>1. HHC Equity Integration 90 Day Project Launch and execute assessment and corrections with Connecting to Care consultant.</li> <li>2. Improve telephone phone tree language options in ambulatory outpatient medical offices</li> </ol>	<p>Carla Angevine DEIB Council</p>	<p><b>Target:</b> 1) Complete CLAS review of ED, Maternity, and one other hospital-based service, along with Region’s PCP and Endocrine practices; 2) 100% Spanish telephone phone tree option for HHCMG practices in Region</p> <p><b>Actual:</b></p>
<p><b>Primary:</b> <i>Improve access to prenatal care and address known inequities to the service</i></p>	<ol style="list-style-type: none"> <li>1. DEIB Prenatal Project               <ul style="list-style-type: none"> <li>Focus 1 – Complete equity integration 90 Day project launch</li> <li>Focus 2 - Conduct Community Survey</li> <li>Focus 3 – Conduct Provider Survey</li> <li>Focus 4 - Mitigation Plan Development and Execution</li> </ul> </li> </ol>	<p>Tasha LaViera/Kelli Odenwalder DEIB Council</p>	<p><b>Target:</b> Align access and experience across patient demographics, in particular race and ethnicity – eliminate disparity</p> <p><b>Actual:</b></p>

<p><b>Secondary:</b> <i>Optimize current transportation resources and expand awareness of resources</i></p>	<ol style="list-style-type: none"> <li>1. Assess and plan for gaps in timely and convenient transportation as it relates to accessing health services and basic human needs.</li> <li>2. Create directory and promote awareness and access to existing resources.</li> <li>3. Provide for urgent transportation needs through use of CHH's Patient Support Fund.</li> </ol>	<p>Pam Tino Leo Ghio (NW COG), GEER</p>	<p><b>Target:</b> Completion of resource directory, maintenance of IR taxi arrangement, availability of Ride Health in NW Region</p> <p><b>Actual</b></p>
<p><b>Secondary:</b> <i>Provide Support to HHC Neighborhood Health Model to targeted communities and populations</i></p>	<ol style="list-style-type: none"> <li>1. Support NH clinics in target geographies aimed at target populations, and done in conjunction with key intermediaries (Torrington, Winsted, Thomaston, North Canaan)</li> </ol>	<p>Tasha LaViera HHC NH Team, Local Intermediaries</p>	<p><b>Target:</b> Number of clinics per month- 5 Monthly Volume- 35 Number of events/fairs per year-4</p> <p><b>Actual</b></p>
<p><b>Secondary:</b> <i>Develop and support a co-location of services "under one roof" plan in Winsted and Torrington</i></p>	<ol style="list-style-type: none"> <li>1. Convene ad hoc committee of local consumers, advocates and service providers to: <ul style="list-style-type: none"> <li>• Assess the feasibility and desirability of a common space, the range of services, and the potential for consolidations within the Region's health and human services sectors.</li> <li>• Determine funding opportunities for the second round of community impact grants that help advance the findings associated from the committee.</li> </ul> </li> </ol>	<p>Brian Mattiello/Patty Sullivan City of Torrington, Town of Winsted</p>	<p><b>Target:</b> Launch of site in Winsted and completion of feasibility study and resource development plan in Torrington</p> <p><b>Actual:</b></p>

### Focus Area#3: Address Health through Housing

OBJECTIVE	STRATEGIES/TIMELINE	LEAD/ PARTNERS	METRICS/MILESTONES – STATUS
<p><b>Primary:</b> <i>Convert existing housing stock into affordable housing by addressing its quality and safety, including lead abatement and removal of asthma triggers, and assuring affordability of rent over time.</i></p>	<p>1. In coordination with others, create a comprehensive program to work with current homeowners with vacant rental property to assess and address quality and safety concerns, provide resources to make upgrades and repairs affordable, and arrange for the at or below market rental rates in order to expand the number of affordable rental units in the area.</p>	<p>Brian Mattiello/John Capobianco/CCMC/TAHD/City of Torrington/Torrington Savings Bank</p>	<p><b>Target:</b> to be developed in connection with final plan – program development still taking place with partners – goal for plan completion 11/1/22</p> <p><b>Actual</b></p>
<p><b>Secondary:</b> <i>Stabilize and expand case management services and access to social and medical services for the highly vulnerable unsheltered individuals and families through The Gathering Place.</i></p>	<p>1. Conduct due diligence, resource assessment, and model options in supporting the management of The Gathering Place including scheduling, coordination and provision of services, resource development, budget management, and collection and distribution of supplies and equipment to clients.</p>	<p>Brian Mattiello Carla Angevine Nancy Cannavo Susan Schapp</p>	<p><b>Target:</b> to be developed in connection with consultations with DO, NW CT Community foundation and the New Beginnings board. Goal is a January 1, 2023 execution.</p> <p><b>Actual</b></p>
<p><b>Secondary:</b> <i>Expand efforts addressing unsheltered and rural homelessness by increasing availability of permanent supportive housing, service engagement, and improving health outcomes for those served.</i></p>	<p>1. Provide health services in cooperation with others pursuant to a special federal funding opportunity by HUD to Litchfield County. Funding over the next three years creates an opportunity to coordinate approaches to reduce the prevalence of homelessness and improve service engagement and health outcomes.</p>	<p>Brian Mattiello/ Community Health and Wellness/ New Beginnings</p>	<p><b>Target:</b> Development of a minimum of 6 permanent supportive housing units in Torrington with commensurate case management and health services</p> <p><b>Actual</b></p>

## Focus Area #4: Reduce Food Insecurity and Increase Access to Healthy Food

OBJECTIVE	STRATEGIES/TIMELINE	LEAD/ PARTNERS	METRICS/MILESTONES - STATUS
<p><b>Primary:</b> <i>Improve availability and access to good affordable nutritional food options</i></p>	<ol style="list-style-type: none"> <li>1. Food Pantry Relationships               <ul style="list-style-type: none"> <li>• Attend Northwest Food Collaborative monthly meetings</li> <li>• Assess food pantry healthy food options, placement and education resources (SWAP model)</li> <li>• Cooking demos/videos</li> </ul> </li> <li>2. Promote Produce Rx               <ul style="list-style-type: none"> <li>• In collaboration with NW Food Hub, provide produce shares insecure families</li> </ul> </li> <li>3. Advance Collaborative Food/Nutrition Security Initiative               <ul style="list-style-type: none"> <li>• Diabetes Prevention and Health Promotion Initiative with Walmart</li> </ul> </li> </ol>	<p>Carla Angevine/ CHH RDN team/ Friendly Hands Food Bank/ FISH/ Salvation Army/ NW Food Hub</p>	<p><b>Target:</b> Establish an MOU with area pantries outlining our services including nutrition guidance, provision of health services, and colleague giving.</p> <p>Complete 12 week Produce Rx program in 2023 reaching 150 food insecure families</p> <p>Complete program elements and clinical protocols</p> <p><b>Actual</b></p>
<p><b>Secondary:</b> <i>Enhance nutrition education opportunities</i></p>	<ol style="list-style-type: none"> <li>1. Farm to School:               <ul style="list-style-type: none"> <li>• Provide nutrition education in Torrington and Winsted in collaboration with Ed Advance and NW Food Hub</li> </ul> </li> </ol>	<p>Carla Angevine/RDN team/ NW Food Hub/ Ed Advance/ Fit Together</p>	<p><b>Target: TBD – working with Ed Advance, Food Hub and Fit Together – picking up where we left off pre-COVID</b></p> <p><b>Actual</b></p>

<p><b>Secondary:</b> <i>Improve availability and access to good nutritional choices</i></p>	<ol style="list-style-type: none"> <li>1. Provide better for you Hospital Vending machines options in café, second floor, and in Emergency department</li> <li>2. Create CHH Community Garden</li> <li>3. Duplicate Food as Medicine Program (HH)</li> </ol>	<p>Carla Angevine/ Peter Johnson</p> <p>Carla Angevine/John Capobianco</p> <p>Carla Angevine/ NW FOOD HUB</p>	<p><b>Target:</b></p> <p>By June 2023 all hospital based vending machines contain the healthiest profile available by the vendor.</p> <p>Complete feasibility study for community garden for FY 23</p> <p>Complete feasibility study for program expansion in NW Region – referral targets are endocrine, oncology, and maternal health</p> <p><b>Actual</b></p>
<p><b>Secondary:</b> <i>Better and more universally identify people experiencing food insecurity and connect them to resources</i></p>	<ol style="list-style-type: none"> <li>1. Expand SIOH food insecurity screening and Utilization of Connections that Matter at area PCP and Endocrine practices</li> </ol>	<p>Tasha LaViera/ HHCMG/ Hilary Maynard</p>	<p><b>Target:</b> 100% of practices are screening</p> <p><b>Actual</b></p>

## Focus Area #5: Improve Community Health in Partnership with Others

OBJECTIVE	STRATEGIES/TIMELINE	LEAD/ PARTNERS	METRICS/MILESTONES - STATUS
<p><b>Primary:</b> <i>Improve availability of and access to opportunities for physical activity</i></p>	<ol style="list-style-type: none"> <li>1. Mad River Trail Project</li> <li>2. Sue Grossman Trail- mile marker placement along 6 mile trail</li> <li>3. Build on Kid's Marathon</li> </ol>	<p>Carla Angevine/ Fit Together</p>	<p><b>Target:</b> Collaborate with Fit Together and the Town of Winchester to apply to CT Recreational Trails Grant 2022 for construction of 5 miles of trail improvement</p> <p>Placement of markers by December 2022</p> <p>Full participation rates hit a minimum of 400 students and involve a minimum of 5 school districts</p> <p><b>Actual</b></p>
<p><b>Primary:</b> <i>Provide Health Clinics and Health Fairs throughout service area in partnership with others</i></p>	<p>Continue special clinic offerings, outreach activities and partnerships and health promotion and education efforts with intermediaries</p>	<p>Pam Tino/ Community Health Alliance</p>	<p><b>Target:</b> 6-8 Regional Health Fairs/Clinics per year</p> <p><b>Actual</b></p>
<p><b>Secondary:</b> <i>Promote Health Education Opportunities</i></p>	<p>Community Provider Education Talks including social impact techniques</p>	<p>Carla Angevine</p>	<p><b>Target:</b> 6-8 Provider Talks per year</p> <p><b>Actual</b></p>

<p><b>Secondary:</b> <i>More actively seek out opportunities to support and collaborate with organizations that promote health</i></p>	<ol style="list-style-type: none"> <li>1. Sponsorships Donations- aligned with CHNA findings <ul style="list-style-type: none"> <li>• Brooker Memorial School Dental</li> <li>• Susan B. Anthony</li> <li>• Celebrate Belonging</li> <li>• Torrington Kids Marathon</li> </ul> </li> <li>2. Community Health Alliance (CHA) - Nurture role of and ensure they are meaningfully engaged and all sectors are represented and partnering</li> <li>3. Maintain our Regional Equity Champion contacts and interfaces</li> </ol>	<p>Pam Tino/ Community Health Alliance</p>	<p><b>Target:</b> Minimum of 40% of donations and sponsorships are guided by our CHNA health priorities</p> <p>Minimum of 4 meetings per year and sponsorship of a minimum of 2 focus group sessions</p> <p><b>Actual</b></p>
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