2025 - 2028

GCHIP & CCS
Community Health Improvement Plan

GCHIP Greenwich Community Health Improvement Partnership

Council of Community Services 10573
Port Chester, Town of Rye, Rye Brook

crescendo | cg
Prepared by Crescendo Consulting Group

Contents

Introduction

The Greater Greenwich region includes the Town of Greenwich in Fairfield County, Connecticut and the Town of Rye and Rye City, Harrison, and Mamaroneck in Westchester County, New York. Both communities have unique populations, demographics, cultures, resources, and needs. This region is known for its scenic coastal setting, charming neighborhoods, beautiful parks, and strong community commitment and engagement.

Many local organizations provide vital services to support residents and promote access to care, food, housing, mental and physical health, and wellness programs to prevent chronic disease. Even with these strong community efforts and outreach programs, some residents still face challenges and require additional supportive resources based on their individual Social Drivers of Health (SDoH) needs.

The 2025 Community Health Needs Assessment (CHNA) identified the most important health issues in the region. The CHNA report includes robust data, data analysis, Key Informant and community input collected between July 2024 and May 2025. The Community Health Improvement Plan (CHIP) was created based on the CHNA data findings and outlines goals and strategies that aim to improve the health and well-being of all community members in the Greater Greenwich area.

About a Community Health Improvement Plan

A Community Health Improvement Plan (CHIP) is a collaborative action plan to improve the health of a community. The CHIP is developed with the input of community leaders and members. To respond to the identified needs by bringing together resources and community partners to create a shared framework to improve community health. A CHIP is a collaborative plan that is formulated and implemented by local leaders and community-based organizations and is also an important document for accredited public health departments to be certified by the Public Health Accreditation Board (PHAB).

Greenwich Hospital Community Commitment

Greenwich Hospital is a 206-bed regional medical center serving portions of Fairfield County, Connecticut and Westchester County, New York. It is a major academic affiliate of Yale School of Medicine and a member of Yale New Haven Health System. For more than a century, Greenwich Hospital has focused on community benefit programs that bring preventive services and quality

medical care to all residents.

Greenwich Hospital invests in long-term community health improvement activities, by sponsoring, developing, and participating in a wide array of programs and services focusing on guaranteeing access to care; advancing careers in healthcare; promoting health and wellness; building stronger neighborhoods; and creating healthier communities. Preventive health and wellness education programs are conducted by the hospital's healthcare professionals at diverse community sites. Greenwich Hospital collaborates with partners across Connecticut and New York to meet the diverse needs of the communities we serve.

Greenwich Hospital's Community Advisory Committee (CAC) was established in 2003 and continues to meet biannually to help steer the hospital's efforts to meet community needs. The CAC monitors and provides updates on the progress of the CHNA and CHIP strategies. The CAC is composed of Greenwich Hospital senior leadership, and diverse leaders from regional organizations. In addition to the CAC, Greenwich Hospital provides leadership, financial and in-kind support for two coalitions: the Greenwich Community Health Improvement Partnership (GCHIP) and the Council of Community Services (CCS).

About CHIP Workgroups

This Community Health Improvement Plan (CHIP) was conducted in collaboration with the Greenwich Community Health Improvement Partnership (GCHIP) in Greenwich, CT, and the Council of Community Services (CCS) in Westchester, NY.

The GCHIP and CCS are composed of diverse community representatives from local health departments, federally qualified health centers; healthcare providers; social service organizations; faith-based organizations; EMS; government officials; schools; mental health professionals; youth and senior organizations.

This collective partnership brings together leaders from across the region, creating and building relationships among 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.

Greenwich Community Health Improvement Partnership (GCHIP)

GCHIP was founded in 2003 and is a coalition composed of community leaders, health and wellness professionals, and social service providers who advocate for the physical and mental health of our communities. Through collaboration across diverse sectors, GCHIP shares resources and works to identify, prioritize, and improve the health of our community by providing educational programs and prevention services that promote health equity. Greenwich Hospital provides staff and financial support for GCHIP and hospital representatives co-chair GCHIP and leads monthly partnership meetings.

Council of Community Services (CCS)

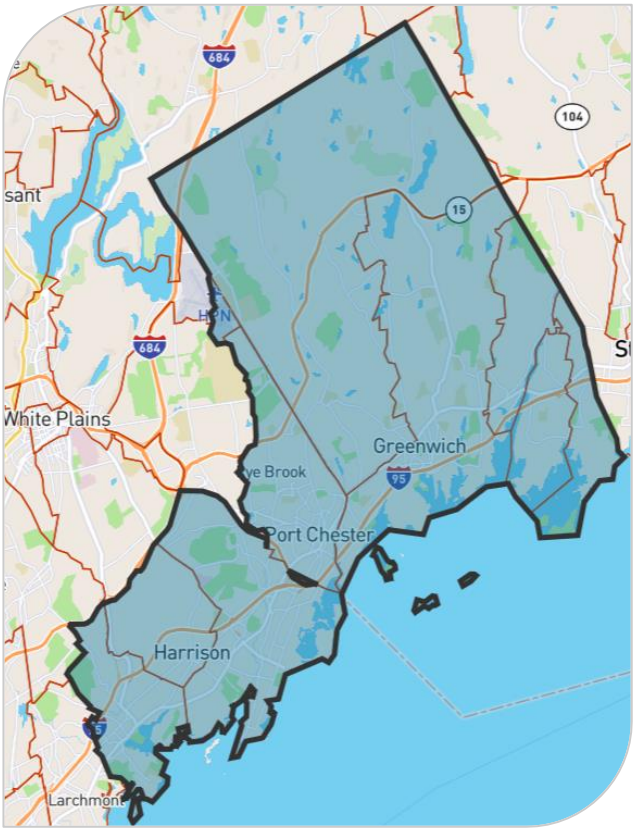
The CCS was founded in 1974 by a group of concerned citizens who believed that more community awareness and participation was necessary to meet the needs of all residents, regardless of race, age, or income. The Council has grown over the past 50 years and today it continues to bring together an array of community members, organizations, and agencies to promote effective services and community integration. Greenwich Hospital provides staff, in-kind and financial support for CCS and its health and wellness initiatives. CCS meets monthly in Westchester, NY and a Greenwich Hospital representative serves as a board member. The Council has approximately 15 dedicated members that collaborate with other community organizations toward the mission of bringing together community leaders and linking people with the resources they need.

For decades Greenwich Hospital continues to provide support to Greenwich Community Health Improvement Partnership (GCHIP) and the Council of Community Services (CCS) to advance the health improvement efforts identified in the Community Health Improvement Plan (CHIP).

Greenwich Hospital, GCHIP, and CCS collaborate on the Community Health Improvement Plan. This partnership approach results in a collective impact that produces change through shared goals and coordinated initiatives. In 2025, Greenwich Hospital, GCHIP, CCS, along with local health departments, and healthcare and social service agencies completed a CHNA and a health prioritization process to identify health needs. From this comprehensive work, four areas of focus were selected which include: Access to Care and Service, Promoting a Culture of Health, Supporting Healthy Generations, and Mental Health & Wellness. A CHIP was then developed to guide collective work between the hospital and community partners to address the identified health needs.

Greater Greenwich 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.

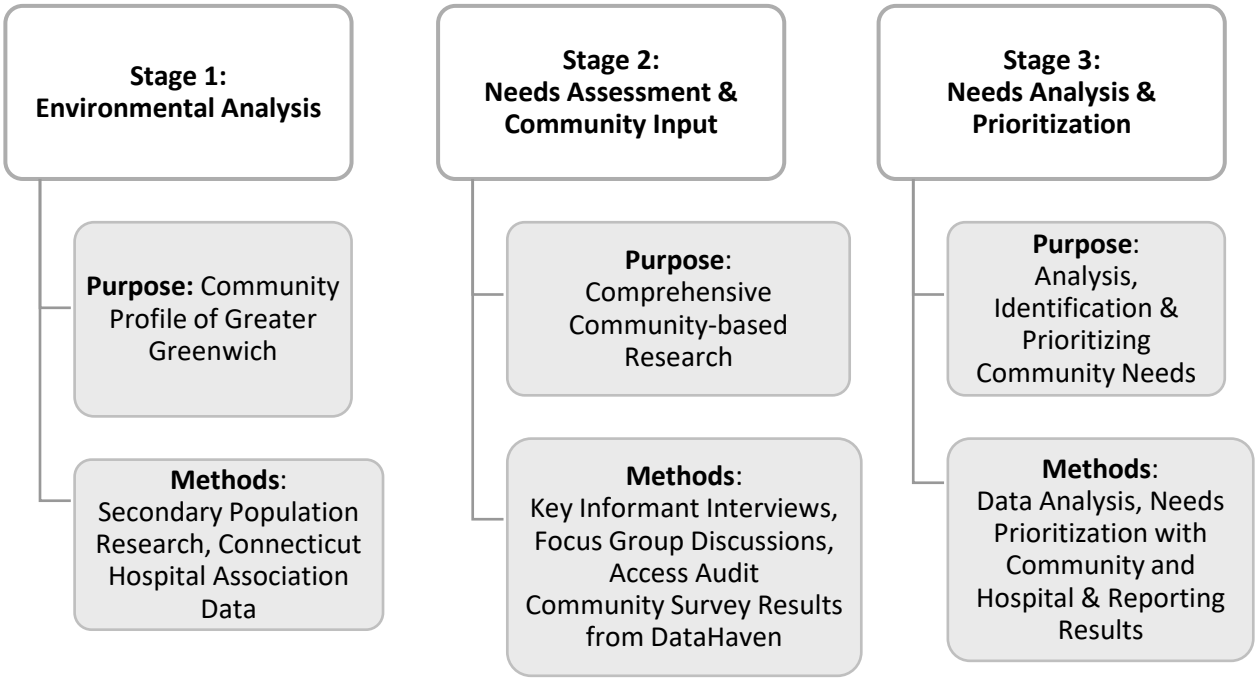
COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

To formalize and utilized a highly inclusive assessment framework Greenwich Hospital's Community Health Needs Assessment (CHNA) was conducted in 2025 in association with the Yale New Haven Health System (YNHHS). Crescendo Consulting Group, and the members of the Greenwich Community Health Improvement Partnership (GCHIP) and Council of Community Services (CCS).

At the conclusion of the process, GCHIP and CCS developed a prioritized list of community needs. To accomplish this, the methodology included a mixed modality approach of quantitative, qualitative, and technology-based techniques – to collect primary and secondary data and weave the human stories, voices, and data into a robust assessment. Crescendo engaged community partners, used data analytics, and invited others to join the discovery process to help create a positive change. The assessment activities met the following goals:

- Identify community resources, strengths, and barriers.
- Develop a deeper understanding of community access to care challenges, including those faced by groups historically underserved by healthcare facilities and programs.
- Enable partners to coalesce around and create action plans to address opportunities for population health improvement.

The following illustrates the three-stage approach used to support the CHNA project:



Final Priority Community Needs

Access to Care and Services	Improve access to care and services for under-resourced residents in the greater Greenwich region.
Supporting Healthy Generations	Improve access to and awareness of community resources that support physical, social, and mental wellbeing for seniors and youth.
Mental Health & Wellness	Expand access and awareness of mental and behavioral health services through improved collaboration, education and resource visibility.
Promoting a Culture of Health	Develop and implement community health education and communication initiatives on preventive care and chronic disease management to promote a culture of health and well-being.

CHNA Data Highlights

Prioritization Data Highlights

Greater Greenwich Region

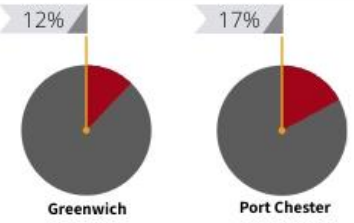
Access to Care & Services

Greenwich

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

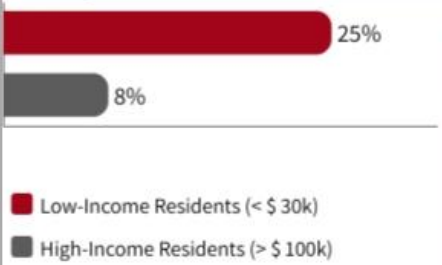
Port Chester

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



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

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



The DataHaven Community Wellbeing Survey 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 overall are more likely to lack consistent access to a primary care provider. [1]

Insurance Status

Greenwich

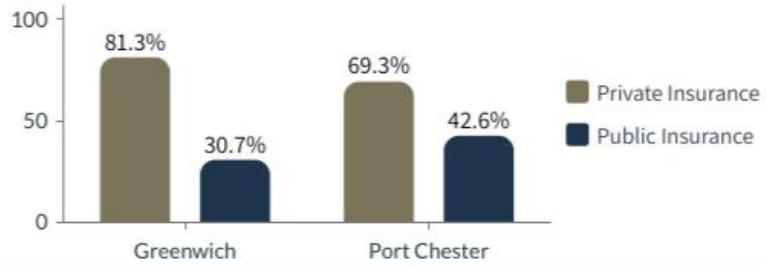
Community members shared that individuals with Medicaid or Medicare often encounter difficulty finding primary care and specialty providers who will accept their coverage.

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] DataHaven Community Wellbeing Survey
[2] U.S. Census Bureau American Community Survey 2019-2023 Five Year Estimates

Prioritization Data Highlights

Greater Greenwich Region

Mental Health & Wellness

Greenwich

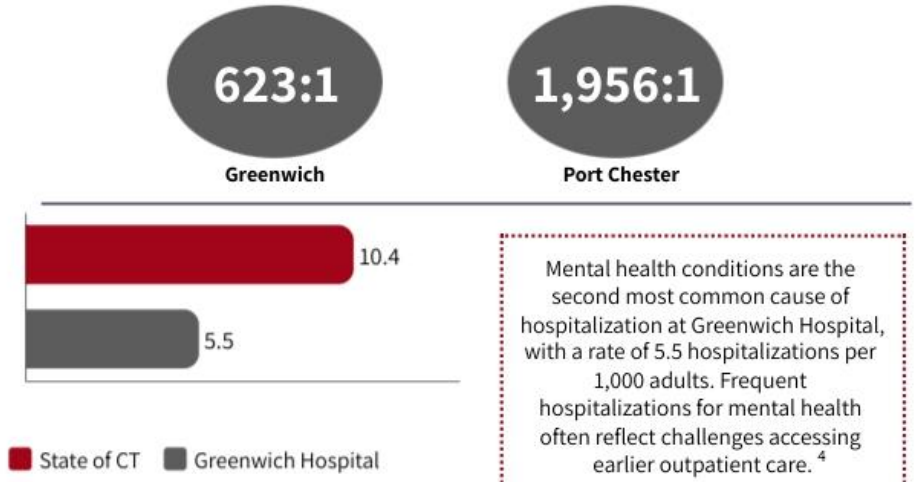
Community members reported long wait times for mental health services and a shortage of youth-focused behavioral health programs.

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] National Plan & Provider Enumeration System NPI, 2023
[4] Community Health Profiles, Hospital utilization rates for key health indicators. Provided by Connecticut Hospital Association

Prioritization Data Highlights

Greater Greenwich Region

Culture of Health

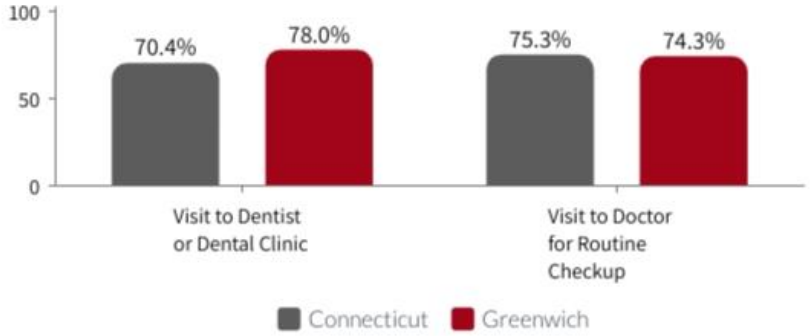
Greenwich

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

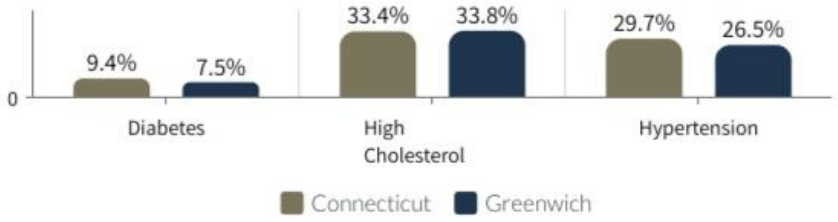
Port Chester

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]

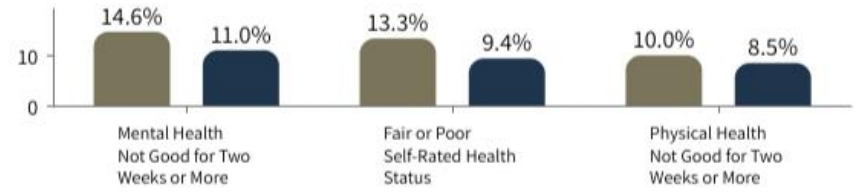


Residents who are uninsured or have limited English skills may face greater barriers to accessing preventive care.



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]



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.

[5] CDC PLACES (2020-2021). Provided by Connecticut Hospital Association
[6] CDC PLACES (2020-2021). Provided by Connecticut Hospital Association
[7] Community Health Profiles, Hospital utilization rates for key health indicators. Provided by Connecticut Hospital Association

Prioritization Data Highlights

Greater Greenwich Region

Supporting Healthy Generations

Greenwich

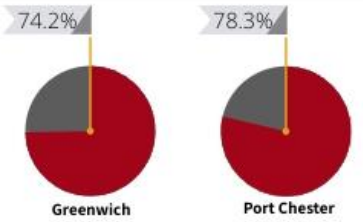
Community members noted that middle-income families often earn too much to qualify for subsidies but struggle to afford market-rate childcare.

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

Port Chester

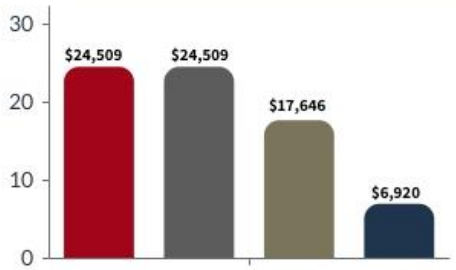
Community members shared that families face long waitlists for affordable childcare and that undocumented parents may be hesitant to engage with formal systems.

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

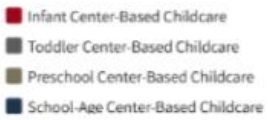


74.2% of children under age 6 in Greenwich and 78.3% in Port Chester live in households with working parents.

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

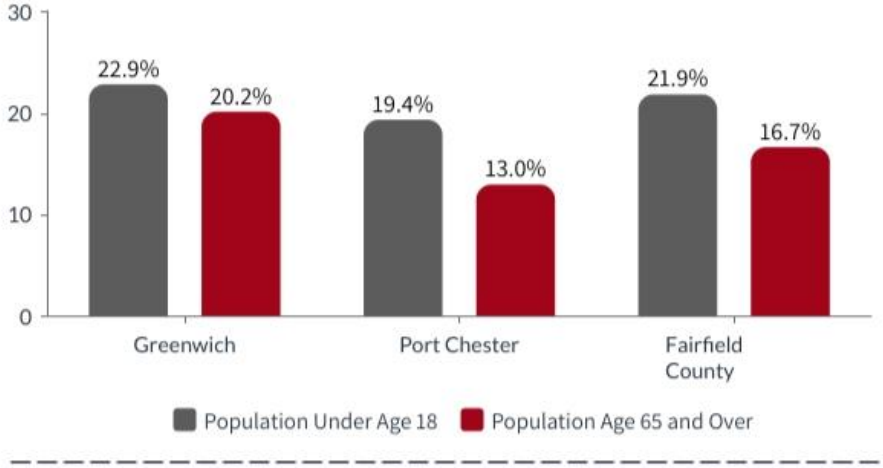


Annual cost of infant care in Fairfield County, CT exceeds $22,000. Middle-income families often fall through the gap—unable to afford care but ineligible for assistance. [9]



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] U.S. Census Bureau American Community Survey 2019-2023 Five Year Estimates
[9] U.S. Census Bureau County Business Patterns 2021
[10] U.S. Census Bureau American Community Survey 2019-2023 Five Year Estimates

COMMUNITY HEALTH IMPROVEMENT PLAN METHODOLOGY

The Greater Greenwich Community Health Improvement Plan (CHIP) was developed with extensive input from community-based organizations, including GCHIP and CCS, healthcare providers, social service agencies, and other key informants.

A four-hour in-person session was held to collaboratively design strategies addressing the region's four health priorities: Access to Care and Services, Supporting Healthy Generations, Mental Health & Wellness, and Promoting a Culture of Health.

Participants were divided into breakout groups based on their areas of expertise, with each group focused on one of the identified priorities. During the session, participants worked together to brainstorm SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) goals, identify feasible strategies, and discuss potential metrics to track progress. This interactive approach ensured that the strategies were grounded in the realities of those with lived and professional experience in the region.

To support the CHIP process, a review of existing community programs and services and a best practices literature review was conducted to guide the creation of goals and strategy options based on identified needs. These research-informed options were shared with participants as a starting point for discussion. The resulting strategies reflect both evidence-based solutions and community-driven insights and will guide the implementation efforts to improve health and well-being across the Greater Greenwich region.

Definition of Terms

Term	Definition
Priority Areas	Selected community health needs for the 2025-2028 CHIP.
Goal	Future desired result for each priority area written as a SMART goal statement.
Assets/Resources	Existing programs, services, or partnerships that support progress toward the goal.
Barriers	Factors that may limit access or slow progress toward the goal.
Metric	Data point that will measure success towards the goal.
Strategy	What the community is doing to reach the priority area goal.

Evaluation Plan

The evaluation plans identify the assets or resources that will be used to address each health priority. Assets or resources may include support from local coalitions, partnerships; departments of health; human and social services; community-based organizations; community members; and resources provided by healthcare organizations, all collaborating to improve the health and social needs of residents.

The Community Health Improvement Plan (CHIP) will be reviewed and updated annually. It will be adjusted as needed, based on new policies, data, government/legislative changes, new emerging public health threats, needs, and available funding and resources.

COMMUNITY HEALTH IMPROVEMENT PLAN SUMMARY

Priority Area: Access to Care and Services

Goal	**Improve access to care and services by 3%, for under-resourced residents in the Greater Greenwich Region service area.**
Assets/Resources	Partners include but are not limited to: FQHC (Family Centers & Open Door) Departments of Human Services, Departments of Health, Houses of Worship, Transportation Association of Greenwich (TAG), Call-A-Ride, Southwest AHEC (Area Health Education Centers), Greenwich United Way, Greenwich YMCA, Greenwich YWCA, Rye YMCA. For a full list of partners please see Appendix E.
Barriers	• Limited referral pathways between community organizations and healthcare providers • Inconsistent outreach to under-resourced populations • Insufficient number of providers serving Medicaid or uninsured patients • Gaps in cultural and linguistically appropriate services
Metrics	1. Number of Federally Qualified Health Center (FQHC) patients. 2. Number of rides/transportation assistance provided for medical appointments.
Strategy #1	Collaborate with community organizations to promote access to resources and connect under-resourced populations to appropriate healthcare providers and services. (Promote awareness of Medicaid, Medicare, Federally Qualified Health Center (FQHC) providers.)
Strategy #2	Offer and promote access to transportation for medical appointments.

Priority Area: Supporting Healthy Generations

Goal	**By 2028, improve access to and awareness of community-based resources that support the physical, social, and mental well-being of both youth and seniors.**
Assets/Resources	Partners include but are not limited to: Greenwich Commission of Aging, River House, At Home in Greenwich, Rye Seniors, Rye Brook Seniors, Port Chester Seniors, SPRYE, The Osborn, Rye Youth Council, Carver Center, Greenwich Together, Boys and Girls Club of Greenwich, Greenwich YMCA, Greenwich YWCA, Rye YMCA, Blue Skies, and other local youth and senior service providers. For a full list of partners please see Appendix E.
Barriers	• Lack of intergenerational programming and engagement opportunities • Transportation barriers limiting participation in programs • Cost of programs and services
Metrics	1. Number of senior events to promote awareness of community-based resources. 2. Number of youth events to promote awareness of community-based resources.
Strategy #1	Collaborate with senior service providers to conduct and promote senior programs that support health and wellness and increase social connectivity.
Strategy #2	Collaborate with youth and childcare services to conduct wellness events and support advocacy efforts to expand community programs that promote positive youth development.

Priority Area: Mental Health & Wellness

Goal	**By 2028, expand access to and awareness of mental and behavioral health services through improved collaboration, education, and resource visibility.**
Assets/Resources	Partners include but are not limited to: Liberation Program, NAMI, Resources to Recover, Silver Hill Hospital, Kids in Crisis, Catalyst CT: The Hub, Rowan Center, Barbara's House, Jewish Family Services (JFS) of Greenwich, RyeACT. For a full list of partners please see Appendix E.
Barriers	• Limited availability of behavioral health providers • Persistent stigma surrounding mental health care • Fragmented communication across providers and systems of care • Lack of awareness of existing community behavioral health resources
Metrics	1. Number of 988 /Suicide Awareness trainings and programs. 2. Number of behavioral health education programs conducted.
Strategy #1	Crisis Intervention: Provide and promote awareness of suicide support and community crisis intervention programs.
Strategy #2	Reduce the Stigma: Provide and promote community behavioral health education and awareness programs.

Priority Area: Promote a Culture of Health

Goal	**By 2028, develop and implement community health education and communication initiatives that deliver at least five annual community-focused events on preventive care and chronic disease management, to promote a culture of health and well-being.**
Assets/Resources	Partners include but are not limited to: Departments of Health, FQHC (Open Door & Family Centers), Greenwich YMCA, Greenwich YWCA, Horizon Program, Greenwich Library, local food pantries (Neighbor to Neighbor, Carver Center, Meals on Main St), Rye YMCA, Port Chester-Rye Brook Public Library, Rye Reading Room. For a full list of partners please see Appendix E.
Barriers	• Limited awareness of existing wellness programs and services • Competing demands on residents' time and attention • Inconsistent collaboration across community organizations • Limited funding or staffing to support outreach and event coordination
Metrics	1. Number of events. 2. Number of participants.
Strategy #1	Conduct community wellness programs and events that offer health education, screening services, and referrals to provide awareness of risk factors for chronic disease.
Strategy #2	Support and promote awareness of existing community-based services and resources in the region that promote wellness and prevent chronic diseases (e.g., Diabetes Prevention Programs , etc.)