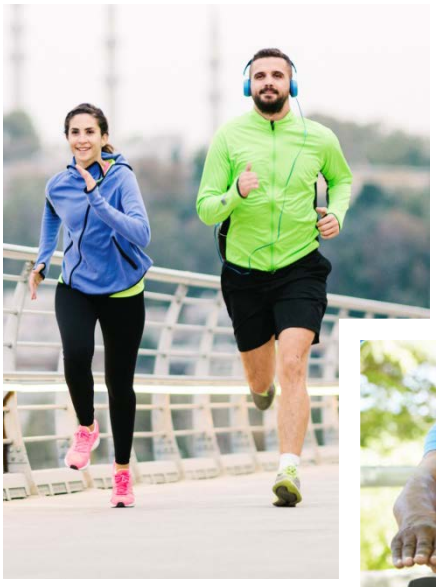
Community Health Needs Assessment For Northwest Connecticut

2015 Update



Charlotte Hungerford Hospital

Commissioned by:
Charlotte Hungerford Hospital (CHH)

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EDUCATION CONNECTION

Northwest CT Community Health Needs Assessment - 2015 Update

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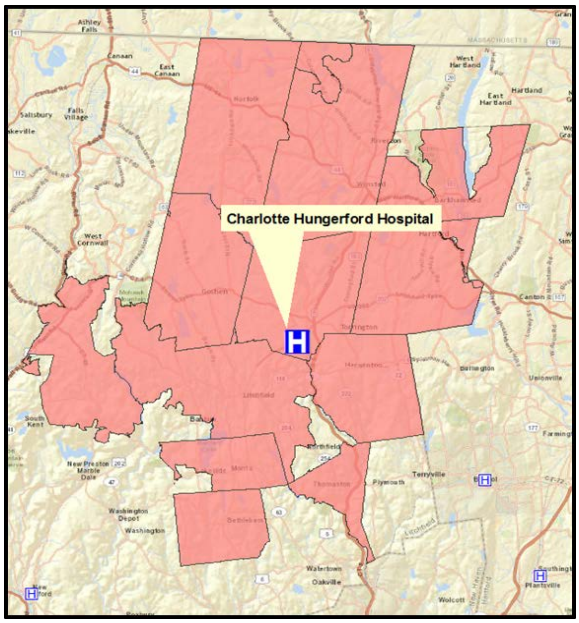
EXECUTIVE SUMMARY

The *Community Health Needs Assessment For Northwest CT 2015 Update* provides an overview of the social, economic, physical, and behavioral health of our region's population. Assessment of the current health status of community residents, and the diverse factors that influence health, provides an important foundation for community stakeholders to identify: priorities for health improvement planning, existing community strengths and assets upon which to build, and areas for further collaboration and collective action. This Assessment is an update to the first-ever Community Health Needs Assessment conducted in Northwest CT (NW CT), the 2012 Litchfield County Community Health Needs Assessment (CHNA). The 2012 county-wide assessment was funded by a CDC Community Transformation Grant through the CT State Department of Public Health (DPH), Torrington Area Health District (TAHD), Charlotte Hungerford Hospital (CHH), United Way of Northwest CT, and the Northwest CT YMCA.

This *Community Health Needs Assessment For Northwest CT 2015 Update* concentrates, to the extent possible, on the primary service area of Charlotte Hungerford Hospital, which includes the following 13 communities and zip codes shaded on the map below: Barkhamsted (06063), Bethlehem (06751), Colebrook (06021), Cornwall (06753), Goshen (06756), Harwinton (06791), New Hartford (06057), Norfolk (06058), Litchfield (06759), Morris (06763), Thomaston (06778), Torrington (06790), and Winchester (06098). When service area data was not available, or unreliable due to the small number of health-related events, we have used county-wide data as in the 2012 CHNA.



This CHNA is also informed by and aligned with the focus areas and key health indicators included in the most recent statewide health assessment, *Healthy Connecticut 2020,* and in the *State Health Improvement Plan*. The State Health Assessment and State Health Improvement Plan provide opportunities for organizations and agencies across Connecticut to focus and align dialogue around a common framework for improving health. These documents can be accessed and downloaded from the CT Department of Public Health (DPH) website at: *http://www.ct.gov/dph/cwp/view.asp?a=3130&Q=542346&PM=1*.

Summary of Findings

Northwest CT as a region meets most national targets for health and has better health outcomes compared to many other states, for many indicators, such as obesity prevalence, teen birth rates, and health insurance coverage. Although health statistics indicate an overall healthy profile for the region and the state, disparities are apparent by age, sex, race, ethnicity, geography, and socioeconomics, highlighting areas and populations in need. A summary of findings for Key Health Indicators by Focus Area follows:

Maternal, Infant, and Child Health

- During the past decade, the state and region have both experienced improvements in maternal, infant, and child health, including significant declines in births to teen mothers. However, recent data for several NW CT towns reveal rates of smoking during pregnancy and preterm births above the state average, and a higher infant mortality rate in the county than the state overall (influenced by a higher proportion of multiple-birth pregnancies).
- There were disparities among population groups for births to teen mothers, preterm births, low birthweight births, and non-adequate prenatal care. In CT, preterm birth, low birthweight, and infant mortality remain highest among infants born to Black non-Hispanic women relative to White non-Hispanic and Hispanic women.

Chronic Diseases and Their Risk Factors

- Similar to the rest of the state and nation, in NW CT, chronic conditions such as heart disease, cancer, stroke, and chronic lower respiratory disease rank among the leading causes of death. Some diseases and risk factors, such as asthma, diabetes, high blood pressure, and high cholesterol, are more prevalent among persons with lower educational attainment or lower incomes. Furthermore, there is greater mortality among Black non-Hispanics relative to other racial and ethnic groups for cancer and major cardiovascular diseases.
- The prevalence of overweight and obesity has increased in NW CT and the state during the past decade, and is most prevalent among adult and adolescent males and persons with lower educational attainment.
- There is much room for improvement in risk factors associated with chronic diseases, such as unhealthy eating, lack of physical activity, and smoking. Health behaviors associated with chronic diseases are shaped by socioeconomic status - persons with lower educational attainment or lower income are more likely to smoke, be less physically active, and less likely to consume a healthy diet.
- There are important disparities in cancer incidence and mortality. In CT, Black non-Hispanics experience higher breast cancer mortality, prostate cancer incidence and mortality, and colorectal cancer incidence and mortality. Hispanics have higher cervical cancer incidence; and White non-Hispanics have higher incidence rates of breast cancer, lung cancer, and melanoma.
- Chronic diseases are among the leading causes of death in the region and state, and they encompass many conditions that can be prevented or minimized. In the past decade, there has been a significant decline in certain risk factors, such as smoking in adolescents and adults, and increases in preventive screenings among adults. At the same time, there were increases in the prevalence of obesity, overweight, high blood pressure, high cholesterol, diabetes, and asthma among adults.

Infectious Diseases

- Consistent with the state and nation, the region has experienced significant improvements in the treatment, survival, and quality of life of persons with HIV, as evidenced by a decline in the number of new HIV cases and deaths among persons with HIV. Disparities remain, however, with males and Black non-Hispanics more likely than others to be diagnosed with HIV.
- Substantial reductions in the incidence of infectious disease have been achieved largely through vaccine development and delivery and advances in medication therapy, which have contributed to decreases in infectious disease deaths and increased life expectancy.

Mental Health, Alcohol, and Substance Use Disorders

- Connecticut and the Northwest region have experienced an increase in emergency department visits for alcohol and other substance use disorders. Specifically, deaths due to overdoses of prescription pain killers and heroin have increased in the state and region.
- Mental health and substance use disorders affect individuals, families, and communities in complex and challenging ways. In addition to premature mortality, mental health and substance use disorders contribute to substantial social and economic costs to families and communities.
- There are disparities by age, sex, race, ethnicity, and educational attainment in the prevalence of diagnosed depression and poor mental health days, emergency department visits due to mental health, alcohol and substance use disorders. Additionally, over the past decade, the region and state have experienced an increase in binge drinking among adults and adolescents. Prescription drug misuse and overdose are an emerging public health challenge and a leading cause of injury death.

Injuries and Violence

- Unintentional injuries are a major contributor to disability and premature death in the region. Falls, accidental poisonings, and motor vehicle accidents are the top three types of unintentional injuries.
- Unintentional injury is a leading cause of visits to emergency rooms in the state and region. Most causes of injury, disability, and injury-related death are preventable. In Connecticut, disparities by sex, age, race, ethnicity, or geography exist for death and premature death rates due to unintentional injury, and for traumatic brain injury, homicide, suicide, and sexual assault.

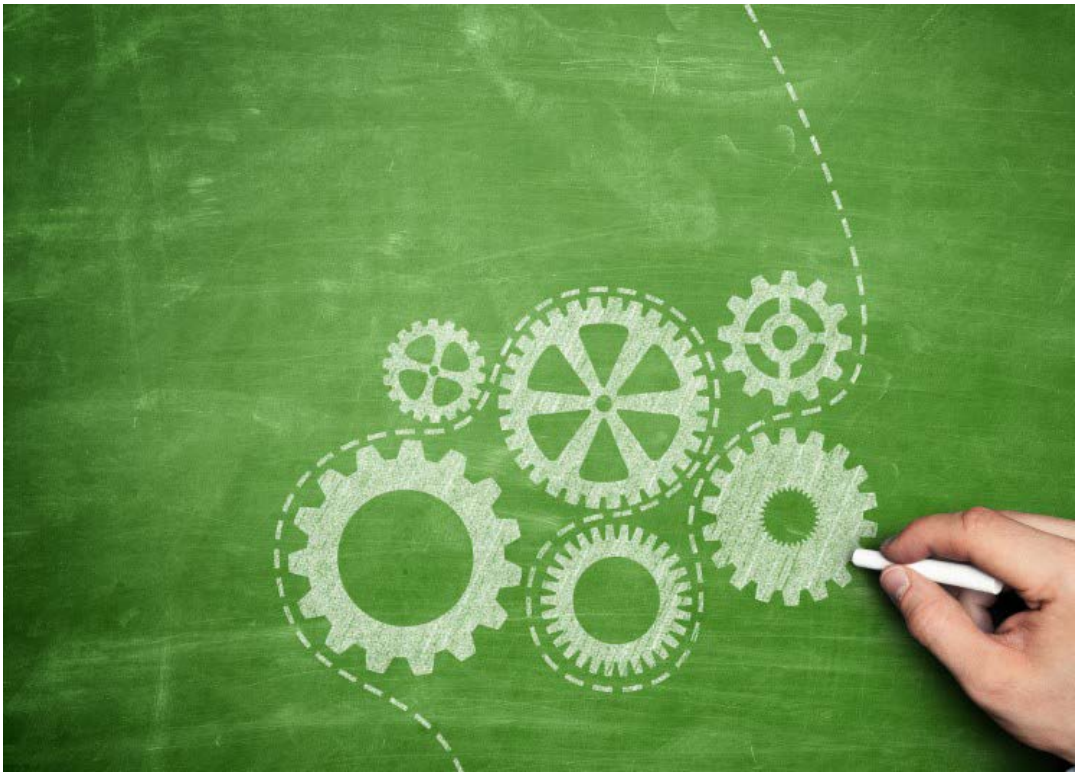
Local Health Care Environment

- Racial, ethnic, and geographic disparities exist in health insurance coverage and health care access and utilization. Hispanics are less likely than other racial or ethnic groups to have a usual source of care. Medically underserved and health professional shortage areas are apparent in the region.
- Equitable access to quality health care is important for eliminating health inequities, reducing health care costs, and improving quality of life. Furthermore, strengthening the public health infrastructure is an important factor for ensuring prevention related initiatives.

Data Availability Limitations

There are limitations in the availability of data needed to assess the health of Northwest CT residents. Local and county-level health indicators are less readily available than statewide indicators. There is a significant time lag in the availability of morbidity and mortality data to inform community health needs assessments, and currently no centralized public access community health assessment database exists to query and download data. This limited access to timely local and regional health data presents challenges to monitoring of progress in achieving health improvement objectives.

INTRODUCTION:
CHNA PROCESS AND METHODS



Introduction

Understanding the current health status of NW CT residents and the multitude of factors that influence health enables the identification of priorities for public health planning, existing community strengths and assets upon which to build, and areas for further collaboration and coordination.

This *Community Health Needs Assessment for Northwest CT 2015 Update* is intended to help program planners, policy makers, and other community stakeholders to develop a shared understanding of current and emerging health issues, and to provide access to the most recent measures of the health of area residents.

What is a Community Health Needs Assessment?

A Community Health Needs Assessment (CHNA) is a systematic examination of the health status of the population in a given geographic region and of the factors that influence health, using a set of key indicators that can be tracked over time. Conducting a CHNA is the critical first step in developing a community health improvement plan.

The CHNA describes the health of the community, by presenting relevant information on socioeconomic and demographic factors affecting health, personal health-related lifestyle practices, health status indicators, community health resources, and studies of current local health issues.

The CHNA identifies population groups that may be at increased risk for poor health outcomes, assesses the larger community environment and how it impacts health, and identifies areas where additional or better information is needed. The assessment process is highly collaborative, involving a broad spectrum of community stakeholders.

Focus on Prevention and Health Equity

The leading health issues in Northwest CT, as in the state and the nation, result from many underlying factors which can be controlled or modified. Harmful lifestyle behaviors such as smoking, overeating, poor nutrition, lack of physical activity, and substance abuse have major impacts on individual health. Economic, language, and cultural factors present barriers to access and utilization of medical care and preventive health services. Income, employment status, educational attainment, housing, and other social factors impact health or limit access to care.

Uncontrollable factors, including inherited health conditions or increased susceptibility to disease, also significantly influence health.

Poverty underlies many of the social factors that contribute to poor health. Differences for many health indicators are also apparent by gender, race, ethnicity, age, and geographic area of residence.

Recent trends in health indicators for NW CT residents show improvement in overall mortality rates for many leading causes of death. There are indications of improvement in personal health behaviors such as smoking and activity rates and accessing screening services for early detection of certain diseases. However, disparities in health care access and health status in certain populations persist. Coordinated planning of programs and services among community partners can reduce health disparities and improve the health of all county residents.

Policy, systems, and environmental changes that support efforts to promote *making the healthy choice the easy choice* will help to improve the health of all residents and reduce health disparities, whether social, economic, demographic, or geographic.

Collaborators

Development of the *Community Health Needs Assessment For Northwest CT 2015 Update* is a collaborative and inclusive process that has engaged organizations, agencies, and residents from across the region. The following section provides an overview of this process.

Partner Engagement

A comprehensive health assessment engages a wide range of partners. Charlotte Hungerford Hospital (CHH) commissioned *The Center for Healthy Schools & Communities @ EDUCATION CONNECTION* to prepare the CHNA 2015 Update. Mary Bevan, M.P.H., was the project director and primary author for this update and the previous 2012 Litchfield County CHNA. The CHH Community Relations Committee (CRC) was engaged as the CHNA Advisory Council. The Advisory Council provided feedback on the selection of *CHNA Focus Areas and Key Indicators* and reviewed and provided feedback on assessment sections as they were developed. A listing of CRC members is provided in Appendix A.

Guiding Documents and Initiatives

The *CHNA* was guided by and aligns with the *National Prevention Strategy*, *Healthy People 2020, and the CT statewide health assessment, Healthy CT 2020.*

Focus Areas and Key Indicators

The CRC CHNA Advisory Council identified seven Focus Areas and related key health indicators for inclusion in the *Community Health Needs Assessment for Northwest CT 2015 Update:*

1. Maternal and Infant Health
2. Child and Adolescent Health
3. Chronic Disease Prevention and Control
4. Infectious Disease Prevention and Control
5. Injury and Violence Prevention
6. Mental Health, Alcohol and Substance Use
7. Local Health Care Environment

The list of indicators and data sources for the CHNA were compiled through a collaborative, iterative process involving experts and stakeholders within the region, representing a multitude of sectors. The following is a brief description of the sources of information used in the Assessment.

Key Informant Interviews

To gain insight and perspective on preliminary assessment findings and emerging community health needs, 13 semi-structured interviews were conducted by the Center for Program Research and Evaluation @ EDUCATION CONNECTION with key informants--public and private sector stakeholders--from around the region. Interviews were held with chief elected officials, public health officials, community health center directors, early childhood and K-12 leaders, behavioral health service providers, and community and civic leaders. These interviews explored stakeholder views on emerging health issues in the region, the current state of resident health, and important issues to consider in the Assessment.

Focus Groups

The Center for Program Research & Evaluation @ EDUCATION CONNECTION also conducted focus groups with two vulnerable population groups – low income families with young children who receive services through the Torrington Family Resource Center, and older adults receiving Senior Services - to gain consumer perspectives on the accessibility and quality of health-related services and unmet needs for services.

Sources of Data Used

Data for the *CHNA for NW CT 2015 Update* were obtained from a variety of secondary sources.

- Sociodemographic indicators are from the U.S. Census, American Community Surveys, CT Economic Resource and Data Center, CT State Data Center, and the CT State Department of Education.
- Data on births, deaths, hospitalizations, emergency department visits, chronic and infectious diseases originate from DPH and CT Hospital Association (CHA) databases, analyzed by DPH and CHA, and from published surveillance and statistical reports.
- Indicators of self-reported chronic disease and health behaviors such as smoking, dietary practices, and physical activity are from the CT Behavioral Risk Factor Surveillance System (for adults 18 years of age and older) and from the CT School Health Survey (includes the Youth Risk Behavior Surveillance System and CT Youth Tobacco Survey) for middle and high school students. Data from these surveys were analyzed by DPH.
- Other sources of health data include, but are not limited to: The Centers for Disease Control and Prevention (CDC), Centers of Medicare/Medicaid Services, Charlotte Hungerford Hospital, County Health Rankings, Kaiser Foundation, National Cancer Institute, and the Substance Abuse and Mental Health Services Administration (SAMHSA).

When made available by secondary sources, statistically significant results ($p < 0.05$) for indicators are so noted.

Limitations of Health Indicator Data

As with most health assessments, the indicators presented have several limitations. One is the time lag between data collection, analysis, and availability for public reporting. This Assessment includes data for the most recently available years at the time the Assessment was performed. Some data are not available for specific populations of interest, such as town populations and racial and ethnic subgroups. This is often due to the small number of events or population sizes. Finally, some data, particularly those obtained through certain surveys, are based on self-reporting, and may over- or under-estimate the prevalence of the health issue or health behavior.

Despite these limitations, the key health indicators included in the *CHNA* provide important insight into health issues affecting NW CT residents to guide and inform the health improvement planning process.

DESCRIPTION OF THE COMMUNITY

POPULATION SIZE, GROWTH PROJECTIONS, AND DEMOGRAPHIC HIGHLIGHTS

Table 1: Service Area Town Population, 2013

Demographic Category	Indicator	Service Area Total	
Total Population	Total Population	89,767	100%
Age	Less than 18 Years Old	18,667	21%
	Over 64 Years Old	14,889	17%
Race and Ethnicity	White	80,595	90%
	Black	801	1%
	Hispanic	4,795	5%
	Asian	2,049	2%
	Other	1,527	2%
Gender	Male	43,931	49%
	Female	45,836	51%

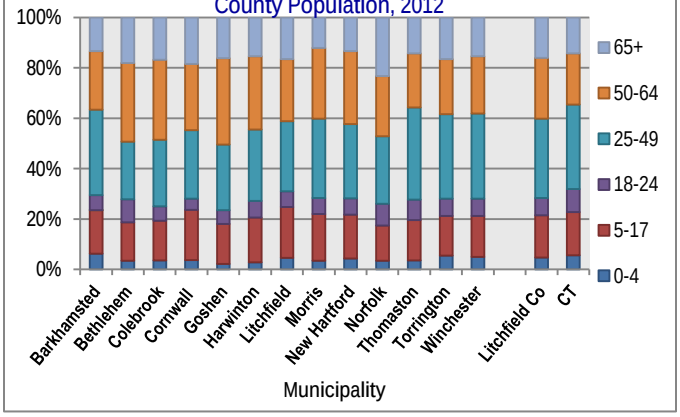
Source: Charlotte Hungerford Hospital (CHH) Community Health Profile November 2015 (2009-2013 ACS Census Data compiled by the CT Hospital Association).

Table 2: Census Population and Projections, 2015-2025

Municipality	2010	2015	2020	2025	% Change 2015-2025
Barkhamsted	3,799	3,883	3,935	3,966	2.1
Bethlehem	3,607	3,679	3,711	3,721	1.1
Colebrook	1,485	1,482	1,467	1,445	-2.5
Cornwall	1,420	1,383	1,329	1,263	-8.7
Goshen	2,976	3,092	3,175	3,240	4.8
Harwinton	5,642	5,740	5,779	5,789	0.9
Litchfield	8,466	8,464	8,409	8,293	-2.0
Morris	2,388	2,434	2,460	2,475	1.7
New Hartford	6,970	7,296	7,556	7,775	6.6
Norfolk	1,709	1,711	1,698	1,675	-2.1
Thomaston	7,887	8,029	8,112	8,162	1.7
Torrington	36,383	36,937	37,394	37,685	2.0
Winchester	11,242	11,503	11,694	11,813	2.7
Litchfield County	189,927	192,189	193,114	193,113	0.5%
Connecticut	3,574,097	3,644,546	3,702,472	3,746,184	2.8%

Sources: http://factfinder.census.gov and CT State Data Center, University of Connecticut.

Figure 1: Age Distribution of SAT and Litchfield County Population, 2012



Source: http://www.cerc.com/townprofiles/county.asp?county=Litchfield

Why Population Characteristics are Important

Improving and promoting the health of all NW CT residents requires an understanding of the influence of social and economic factors on health. Social determinants of health such as income levels, employment status, educational attainment, housing quality, environmental quality, and community safety strongly impact access to care and health outcomes.

The demographic characteristics of the region's residents and changes in population over time are important to consider in examining the distribution of health issues across the region and disparities among subpopulations. Population statistics are reported for Litchfield County as a whole as well as for the 13 service area towns (SATs) for Charlotte Hungerford Hospital, which include: Barkhamsted, Bethlehem, Colebrook, Cornwall, Goshen, Harwinton, Litchfield, Morris, New Hartford, Norfolk, Thomaston, Torrington, and Winchester.

Findings in Northwest CT

As noted in the 2012 Litchfield County CHNA, the county's population increased by about 4% between 2000 and 2010, which was below the state average of 5%. The region is becoming increasingly diverse by race and ethnicity. During the last decade, the number of White residents increased at a much slower rate (2%) compared with a 28% increase in the number of Black or African American residents, 36% increase in number of Asian residents, and 119% increase in the number of Hispanic or Latino residents.

The vast majority of county residents speak English (91%); 9% have a primary language other than English, and 3% speak English less than "very well". School district data for K-12 students in the service area towns (SATs) show between 0-7% of the student population is not fluent in English.

As shown in Table 1, the total population in SATs in 2013 was nearly 90,000. Population projections compiled by the CT State Data Center (Table 2) show a slower future rate of growth over the next ten years (from 2015-2025) of 0.5% compared with a state average of nearly 3%. However, population growth of 2% or greater is projected for the communities of Barkhamsted, Goshen, New Hartford, Torrington, and Winchester.

Based on 2014 CERC town profiles (reporting 2012 data), on average the county had a lower percentage of persons under age 18 and a higher percentage of persons ages 65 and over than in the state. In the county, 22% of residents were under 18 years of age, compared with 23% for the state, and 16% were ages 65 and over compared with 14% for the state. There are considerable differences by service area town (SAT) as seen in Figures 2 and 3, with Barkhamsted, Cornwall, and Litchfield having the highest percentages of persons under the age of 18 (23% each), and Norfolk having the highest percentage of persons ages 65 and over (23%).

Figure 2: Litchfield County Top 10 SATs with Highest % of Population Under Age 18, 2012

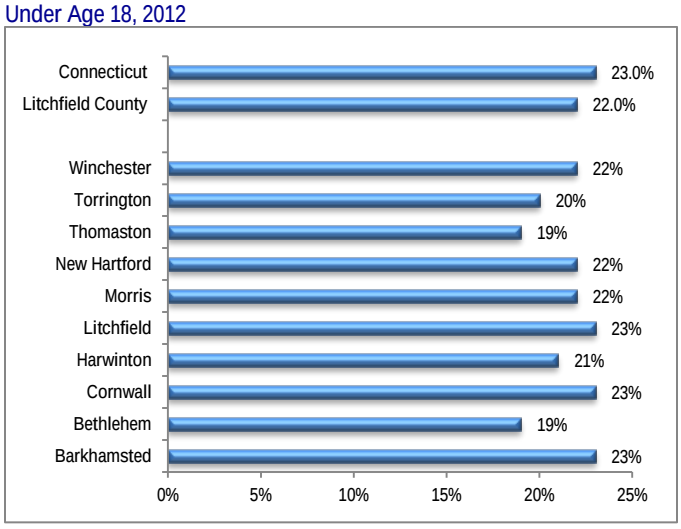


Figure 3: Litchfield County Top Ten SATs with Highest % of Population Age 65 and Over, 2012

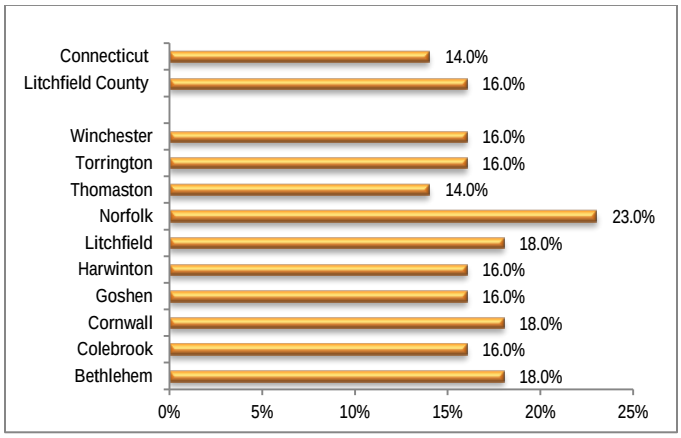
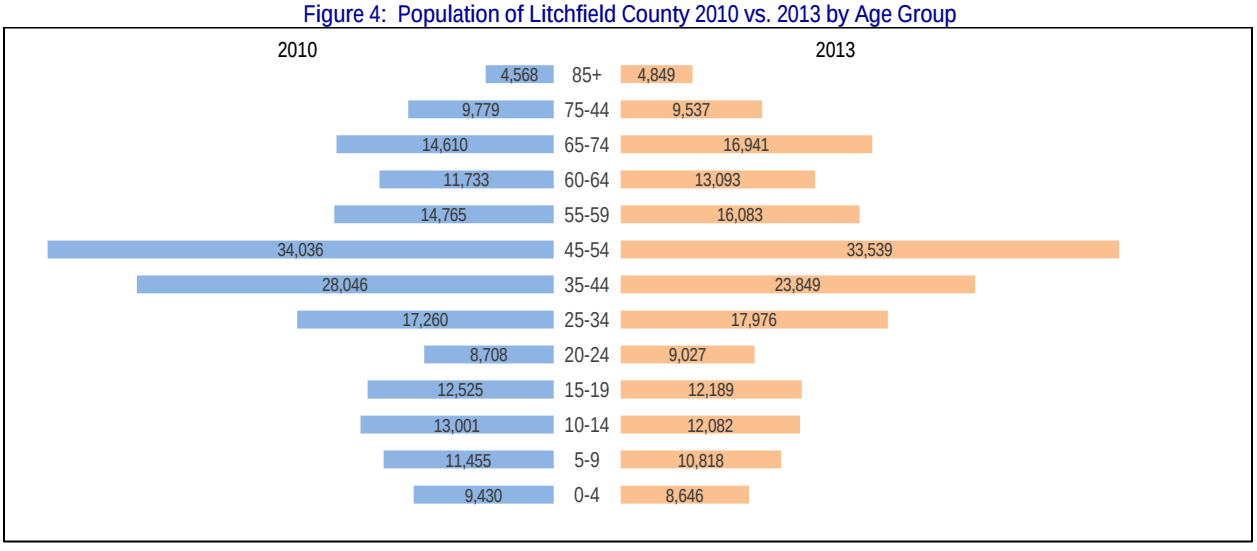


Figure 2 & 3 Source: http://www.cerc.com/townprofiles/county.asp?county=Litchfield, 2014

Figure 4 compares the Litchfield County population by age from the 2010 Census to the most recent (2013) county population estimates. As can be seen, the population over age 55 has increased considerably, most notably persons ages 65-74 due to the "baby boomer" generation advancing to this age range. Also noteworthy is the reduction in the population ages 0-9, due to declining birth rates over the last decade, which is consistent with statewide trends.

Figure 4: Population of Litchfield County 2010 vs. 2013 by Age Group



Sources: US Census, American Fact Finder, Litchfield County 2014 Population Estimates (for 2013); http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPAGESEX&prodType=table; CT DPH, Decennial Census 2010: CT Profile http://www.ct.gov/dph/cwp/view.asp?a=3132&q=489040

SOCIOECONOMIC STATUS

Table 3: Litchfield County & SAT Economic Characteristics, 2010 and 2012

Service Area Town	Median Household Income ($) in 2010	Median Household Income ($) in 2012	Poverty Rate (%) in 2012
Barkhamsted	80,359	84,861	0.6
Bethlehem	85,096	80,884	4.4
Colebrook	71,608	71,691	3.4
Cornwall	77,243	78,021	12.3
Goshen	78,571	74,333	7.9
Harwinton	80,943	89,429	4.6
Litchfield	73,510	84,063	6.8
Morris	69,436	89,688	5.6
New Hartford	89,456	85,598	3.2
Norfolk	73,426	78,214	6.6
Thomaston	62,898	67,426	2.7
Torrington	49,614	50,548	11.2
Winchester	53,233	60,994	5.5
Litchfield Co.	70,291	71,345	6.2
CT	65,686	67,276	10.0
US	50,046	51,371	10.7

Source: CERC town profiles, www.cerc.com; http://factfinder.census.gov; http://www.pschousing.org/news/Affordability-In-Connecticut-2010

Table 4: Students Eligible for Free Reduced Price Meals, 2011-2012 vs. 2012-2013 School Year

District Name	% Eligible for Free/Reduced Meals, 2011-2012	% Eligible for Free/Reduced Meals, 2012-2013
Barkhamsted, Colebrook, New Hartford, Norfolk (Region 7)	8.4	9.3
Bethlehem (Region 14)	6.3	5.8
Cornwall (Region 1)	20.3	19.2
Goshen, Morris (Region 6)	14.0	10.3
Harwinton (Region 10)	5.0	6.6
Litchfield	12.0	9.9
Thomaston	22.3	14.1
Torrington	45.7	46.9
Winchester	34.9	60.6
Connecticut	35.2	36.7

Source: http://sdeportal.ct.gov/Cedar/WEB/ResearchandReports/SSPReports.aspx

Table 5: High School Graduation and Non-Graduation Rates School Districts in Litchfield County, 2014

District Name	Graduation Rate, 2014	Non-Graduation Rate, 2014 *
Barkhamsted, Colebrook, New Hartford, Norfolk (Region 7)	98.4	1.6
Bethlehem (Region 14)	97.6	1.0
Cornwall (Region 1)	89.2	5.8
Goshen, Morris (Region 6)	93.5	5.4
Harwinton (Region 10)	94.8	2.8
Litchfield	95.5	3.0
Thomaston	93.0	N/A
Torrington	87.5	8.2
Winchester - Gilbert	91.6	6.0
Winchester - Explorations	66.7	11.1
Connecticut	87.0	7.3

Source: http://www.sde.ct.gov/sde/cwp/view.asp?a=2758&q=334898
*2014 Graduation and *non-graduation rates (not still enrolled)*

Why Socioeconomic Status is Important

Socioeconomic status and health are strongly correlated, with persons of higher socioeconomic status generally experiencing better health status and access to health care. Persons with higher socioeconomic status are also more likely to live in safe neighborhoods, be steadily employed at higher paying jobs with health benefits, and practice healthy lifestyle behaviors. There is a growing body of research suggesting that socioeconomic factors underlie many of the observed racial, ethnic, and gender inequalities in health status, and that socioeconomic factors are powerful predictors of health status and health outcomes.

Findings in Northwest Connecticut

Educational Attainment: Based on Census data, from 2000-2010 there was a favorable upward trend in the percentage of county residents completing high school and attaining a bachelor's degree. The overall county average for high school completion (96%) exceeded the state average (89%). Not surprisingly, lower levels of educational attainment are found in SATs with higher poverty rates and lower median household incomes - Torrington and Winchester. As shown in Table 5, graduation rates for high school students in 2014 were consistently above the state average of 87%, with the exception of Explorations in Winchester.

Income and Poverty: As shown in Table 3, consistent with the state and nation, overall median household incomes increased from 2010 to 2012 in the county, and in all SATs with the exception of Bethlehem, Goshen, and New Hartford. The poverty rate in SATs ranged from less than 1% to 12%. The highest poverty levels were reported in Torrington (11%) and Cornwall (12%), above the state average of 10%.

Student eligibility for free or reduced school meals, a timely indicator of financial hardship in families, decreased in Litchfield, Thomaston, Region 1, Region 6, and Region 14 in school years 2011-2012 to 2012-2013. Torrington, Winchester, Region 7, and Region 10 had increases in the percentage of students eligible for free or reduced school meals, with the largest percentage increase in Winchester compared with the previous school year. The school districts with the highest % of students eligible for free reduced meals were Torrington (47%) and Winchester (61%).

HOUSING, HOMELESSNESS & COMMUNITY SAFETY

Figure 5: Distribution of Sheltered and Unsheltered Population, 2013

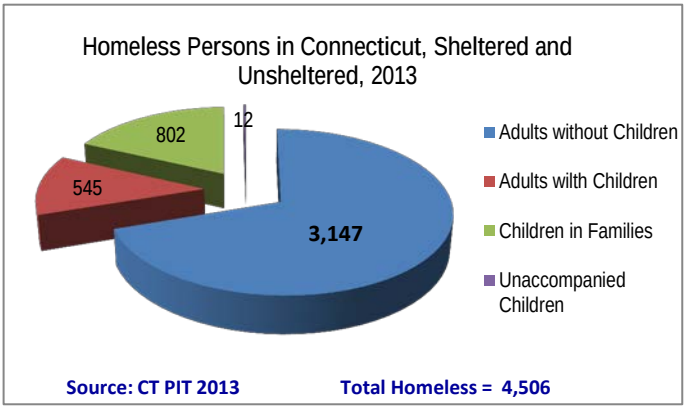


Table 6: Unstably Housed Youth (UHY) Reported by Teachers and Students, 2015

Schools	Total Complete Surveys	# Teachers and Students Reporting at Least 1 UHY	% Teachers and Students Reporting at least 1 UHY	Number of Unique UHY Reported	% Reported Unique UHY per 100 Survey Completers
Hartford (3 schools)	1159	204	17.6%	221	19.1
Bridgeport	492	93	18.9%	104	21.1
Meriden	681	133	19.5%	118	17.3
New Britain	1157	214	18.5%	221	19.1
New Haven	228	47	20.6%	41	17.9
Torrington	895	145	16.2%	107	11.9
Waterbury	827	124	14.9%	118	14.2
TOTALS	5,439	960	18.0%	930	17.2

Source: 2015 Report on Homelessness in Connecticut
https://cga.ct.gov/hsg/related/20150507_Reports,%20Briefings%20&%20Updates/Connecticut%20Coalition%20to%20End%20Homelessness%20-%202015%20Report%20on%20Homelessness%20in%20Connecticut%20.pdf

Table 7: Litchfield County and CT Crime Rates, 2014

Index Offense	Litchfield County		CT Non-Urban		CT Total	
	#	Rate	#	Rate	#	Rate
Murder	2	1.0	37	1.3	88	2.4
Rape	18	9.4	518	17.6	790	22.0
Robbery	24	12.5	1,163	39.4	3,168	88.2
Aggravated Assault	90	46.8	1,963	66.6	4,449	123.9
Burglary	407	211.8	8,260	280.0	12,005	334.2
Larceny	1,865	970.5	36,614	1,241.3	51,246	1,426.7
Motor Vehicle Theft	103	53.6	3,087	104.7	6,100	169.8
Arson	10	5.2	185	6.3	299	8.3
Crime Index Total	2,509	1305.6	51,642	1,750.8	77,846	2,167.2

Source:
http://www.dpsdata.ct.gov/dps/ucr/data/2014/Crime%20in%20Connecticut%202014.pdf
(Rates are per 100,000 persons)

Why Housing, Homelessness, and Community Safety are Important

Having a safe and affordable place to live is paramount to individual and family physical and emotional health and well-being. The age, condition, and cost of housing are important, as is the level of safety found within the community.

Findings in Northwest CT

The U.S. Department of Housing and Urban Development (HUD) defines cost-burdened renters or homeowners as those who pay more than 30% of their income for rent or mortgage payments. According to U.S. Census 2008-2012 American Community Survey data, 48% of renter households in the county are cost-burdened and 41% of households who are paying a home mortgage are cost-burdened.

The National Low Income Housing Coalition's 2015 *Out of Reach* Report indicates that Connecticut is the 8th most expensive state in the nation for housing. In Litchfield County, the hourly wage needed to afford a two-bedroom fair market rate apartment is $19.81 per hour, more than twice the minimum wage *<http://nlihc.org/oor/connecticut>*. Each January, the Connecticut Coalition to End Homelessness (CCEH) coordinates a Point-In-Time Count (PIT), to collect data on the exact number of persons experiencing homelessness on a single night in defined geographic areas. The breakdown by type for 2013 is shown in Figure 5. According to PIT data for 2015, the number of homeless individuals in CT was 4,047, compared with 4,506 in 2013.

The NW CT Collaborative for the Education of Homeless Children and Youth is a partnership between the Torrington Public Schools and EDUCATION CONNECTION, the Regional Educational Service Center in the county. This CSDE-funded initiative provides wraparound academic, social, and emotional support services to children living in homeless families, using the McKinney-Vento definition. In 2013-2014, 129 children in Torrington (pre-K through grade 12) were identified as homeless. As shown in Table 6, in response to a 2015 survey administered by CCEH, 12% of teacher and student respondents in the Torrington public schools reported they were aware of at least 1 unstably housed youth.

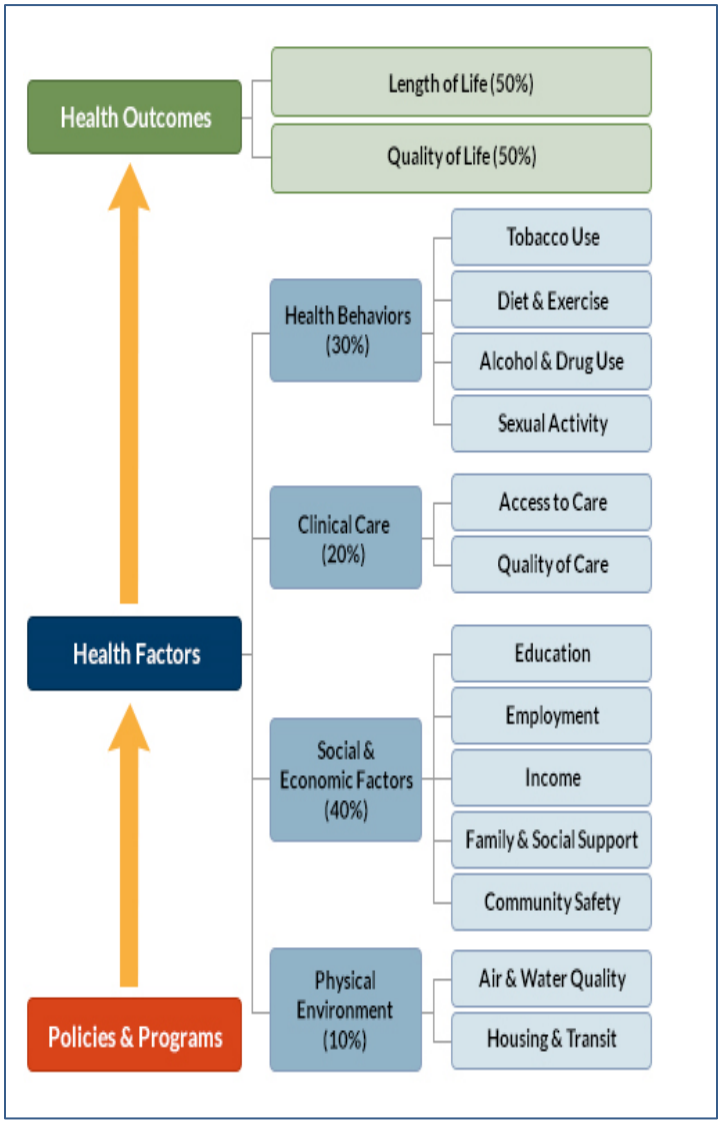
In terms of community safety, the Uniform Crime Reporting Program (URC) measures the extent, fluctuation, and distribution of crime in communities across the U.S.

Eight offenses were chosen to form the Crime Index, as shown in Table 7. All 102 CT police departments participate in the UCR Program. Litchfield County's overall 2014 crime index compares favorably with the state total average and the state average for non-urban (population < 100,000) areas, and has favorably declined since 2010.

STATE AND COUNTY HEALTH RANKINGS & BEHAVIORAL RISK FACTORS

STATE AND COUNTY HEALTH RANKINGS & BEHAVIORAL RISK DATA

Figure 6: County Health Rankings Weighting Structure



Source: 2015 County Health Rankings @ www.countyhealthrankings.org

Why Health Rankings and Behavioral Risk Data Are Important

Promoting healthier communities is greatly enhanced by information on the health status of the population and information on health behaviors and lifestyle factors that influence health outcomes. A number of indicators are used to describe the health status of residents in a specific geographic area. These include the presence or absence of health promoting behaviors; access to and utilization of health screenings, primary care and specialized health care services; the incidence and prevalence of chronic and communicable diseases; and the leading causes of premature death and disability. National health initiatives such as County Health Rankings and the CDC's Community Health Status Indicators (CHSI) track and report county level health status data on an annual basis, to monitor indicators over time. The County Health Rankings, a collaboration of the University of Wisconsin's Population Health Institute and the Robert Wood Johnson Foundation, compare counties within a given state to each other, whereas the CHSI compares counties to reference "peer counties" across the nation. Behavioral Risk Factor Surveillance Survey (BRFSS) data are collected annually by DPH, using a standardized random telephone survey for adults ages 18 and over developed by CDC.

Findings in Northwest CT

County Health Rankings

The 2015 County Health Rankings ranks CT counties based on health outcomes and health factors. Counties receive a Health Outcome rank based on mortality and morbidity indicators and a Health Factor rank based on health behaviors, clinical care, social-economic factors, and the physical environment. Figure 6 shows the weighting structure used to calculate the rankings. This quantifies the influence of personal health behaviors, clinical care, social and economic factors and the physical environment in which we live and work.

According to *Healthy People 2010*, individual behaviors and social-environmental factors together account for about 70% of premature deaths in the U.S. Health promoting lifestyle behaviors such as avoiding tobacco, illicit drug, and excessive alcohol use; healthy eating; regular physical activity; and managing stress are key to reducing the burden of chronic disease and premature death in NW CT residents.

Within CT, counties are ranked from 1 to 8 on health factors and outcomes, with a rank of one being the "healthiest". Health outcomes represent the overall health of the county; health factors represent what influences the health of the county. Health outcomes are based on an equal weighting of mortality (how long people live) and morbidity (how healthy people feel) factors. In 2015, Litchfield County ranked 4th out of the eight CT counties for both health factors and health outcomes.

Table 8: Litchfield County Health Indicators, 2015

Indicator	Litchfield County	Error Margin	National Benchmark	CT
Health Outcomes				
Length of Life				
Premature death	5,325	4,911-5,738	5,200	5,284
Quality of Life				
Poor or fair health	9%	8-11%	10%	11%
Poor physical health days	3.1	2.7-3.4	2.5	3.0
Poor mental health days	3.0	2.6-3.4	2.3	3.1
Low birthweight	7.2%	6.8-7.7%	5.9%	8.0%
Health Factors				
Adult smoking	17%	15-20%	14%	15%
Adult obesity	24%	21-26%	25%	24%
Food environment index	8.7	*	8.4	7.9
Physical inactivity	20%	18-22%	20%	22%
Access to exercise opportunities	92%	*	92%	95%
Excessive drinking	19%	17-21%	10%	19%
Alcohol-impaired driving deaths	29%	*	14%	34%
Sexually transmitted infections	122	*	138	364
Teen births	12	11-13	20	20
Clinical Care				
Uninsured	9%	8-10%	11%	11%
Primary care physicians	1,563:1	*	1,045:1	1,190:1
Dentists	1,699:1	*	1,377:1	1,285:1
Mental health providers	548:1	*	386:1	323:1
Preventable hospital stays	54	51-57	41	57
Diabetic monitoring	87%	83-91%	90%	85%
Mammography screening	65.9%	62.1-69.6%	70.7%	67.1%
Social & Economic Factors				
High school graduation	90%	*	93%	85%
Some college	66.4%	63.7-69.1%	71.0%	67.0%
Unemployment	7.2%	*	4.0%	7.8%
Children in poverty	9%	7-12%	13%	15%
Income inequality	4.1	3.9-4.3	3.7	5.0
Children in single-parent households	22%	20-24%	20%	31%
Social associations	10.8	*	22.0	9.3
Violent crime	111	*	59	279
Injury deaths	55	51-60	50	52
Physical Environment				
Air pollution - particulate matter	10.7	*	9.5	10.5
Drinking water violations	0%	*	0%	0%
Severe housing problems	16%	14-17%	9%	19%
Driving alone to work	83%	82-84%	71%	79%
Long commute - driving alone	38%	36-40%	15%	31%

Source: 2015 County Health Rankings @ www. Countyhealthrankings.org
** Not Applicable*

As noted in Table 8, Litchfield County meets National Benchmarks *and* compares favorably to the state on a number of health status indicators including: residents reporting poor or fair health, prevalence of adult obesity and physical inactivity, healthy food environments, teen births, sexually transmitted infections, health insurance, and children in poverty. The county does *not* meet National Benchmarks but compares favorably to the state for: low birthweight, preventable hospital stays, alcohol-impaired driving deaths, diabetic monitoring and has comparable rates for poor physical and mental health days, and excessive drinking.

Other county health status indicators that do <u>not</u> meet National Benchmarks include premature death; adult smoking; excessive drinking (county rate is almost double the National Benchmark); ratio of primary care physicians, dentists, and mental health providers; mammography screening; and injury deaths.

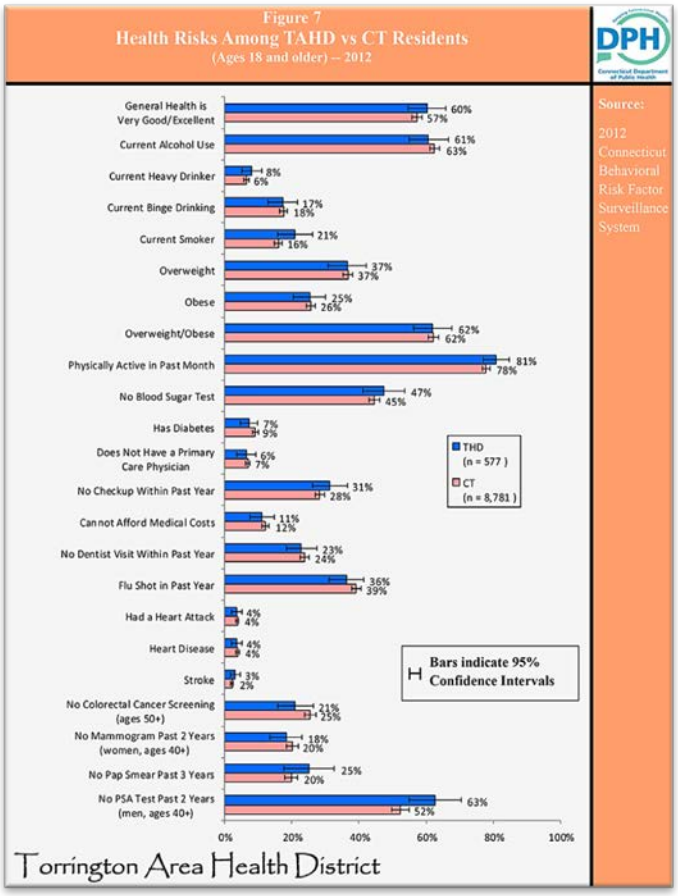
Behavioral Risk Factors

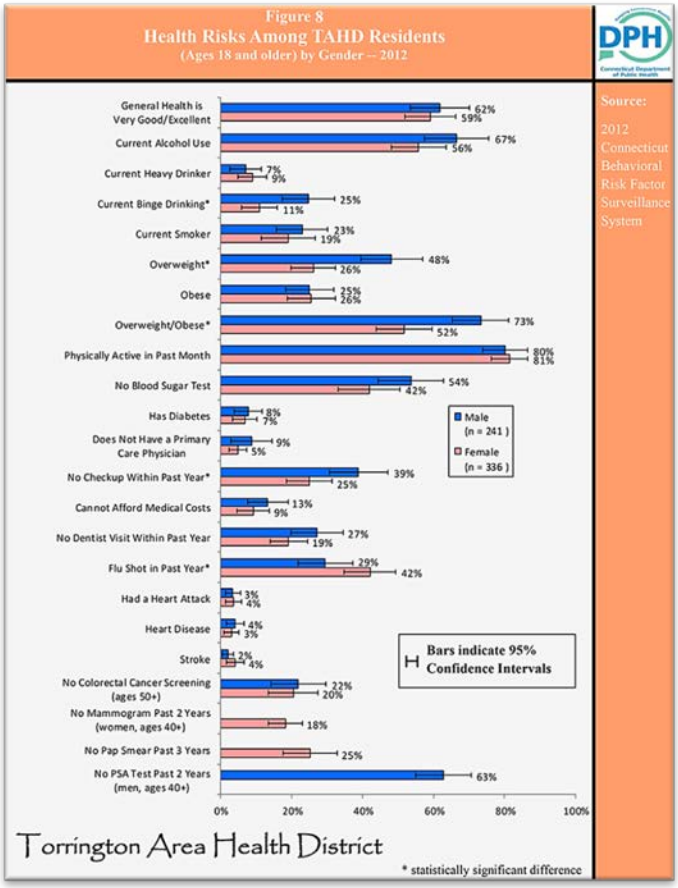
The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing random telephone survey of adults ages 18 and over conducted in all 50 states using a standardized questionnaire developed by CDC. The BRFSS originally only collected data on health behaviors related to the leading causes of death, but has since expanded to include survey questions related to health care access, utilization of preventive health services, and emerging health issues.

Comparative BRFSS data for communities in the service area of Torrington Area Health District (TAHD) in NW CT and the state were collected in 2012 and are presented in Figures 7-9 on the following page. In general, TAHD area residents reported similar rates (identical or within 1 point) as the overall state average related to current binge drinking, overweight and obesity, not being able to afford medical costs, not having a primary care physician, not seeing a dentist in the past year, and having a heart attack, heart disease, or stroke.

Area residents more frequently reported the following negative health behaviors: heavy drinking; current smoking; not having their blood sugar tested; not having a check-up in the past year, not having a flu shot, and not having a Pap smear or PSA screening than state residents on average. None of these differences were statistically significant.

Looking at responses by gender and income levels, male residents more frequently reported: good/excellent health, current alcohol use, current binge drinking*, current smoking, overweight/obesity*, no blood sugar testing, not having a primary care physician, no check-up within the past year*, not being able to afford medical care, not seeing a dentist within the past year, not having a flu shot*, and not having colorectal screening than female residents. Females more





frequently reported heavy drinking, and having a flu shot in the past year*. The differences in indicators noted with an asterisk were statistically significant ($p < .05$).

As shown in Figure 9, area residents with annual incomes below $35,000 per year more frequently reported: current smoking*, obesity, not being physically active in the past month*, not having a blood sugar test, having diabetes*, not being able to afford medical costs*, no dental visit in the past year*, having a heart attack*, having a stroke, not having a flu shot, no colorectal screening*, and no mammogram screening (females)*. Area residents with incomes above $75,000 per year more frequently reported very good/excellent health*, current alcohol use*, being physically active in the past month*, current heavy drinker, overweight, and having a flu shot. The differences in indicators noted with an asterisk were statistically significant ($p < .05$).

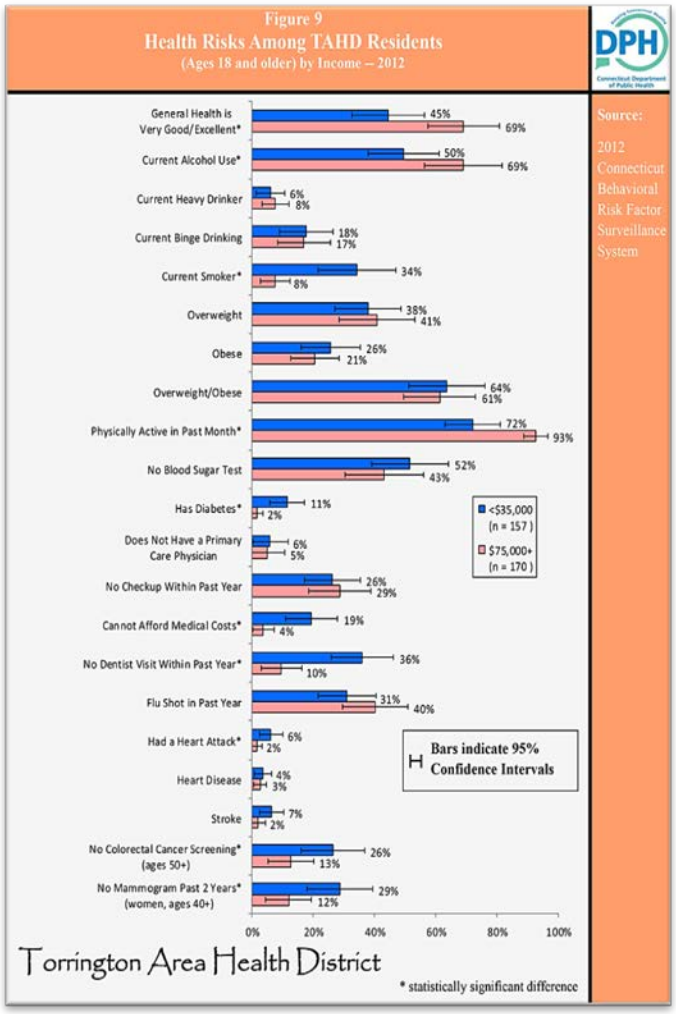
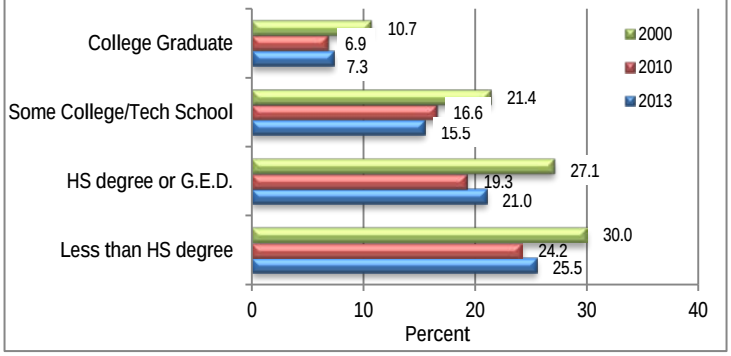


Table 9: Litchfield County CHSI Indicators, 2015

	Best (most favorable quartile)	Moderate (middle two quartiles)	Worse (least favorable quartile)
Mortality	Alzheimer's disease deaths Cancer deaths Diabetes deaths Motor vehicle deaths Unintentional injury (including motor vehicle)	Chronic kidney disease deaths Chronic lower respiratory disease (CLRD) deaths Coronary heart disease deaths Female life expectancy Male life expectancy Stroke deaths	
Morbidity	Adult diabetes Adult obesity Adult overall health status Gonorrhea Preterm births Syphilis	Cancer HIV	Alzheimer's diseases/dementia Older adult asthma Older adult depression
Health Care Access and Quality	Cost barrier to care Uninsured	Older adult preventable hospitalizations Primary care provider access	
Health Behaviors	Adult physical inactivity Adult smoking Teen Births	Adult female routine pap tests	Adult binge drinking
Social Factors	Children in single-parent households Inadequate social support On time high school graduation Poverty Violent crime	High housing costs Unemployment	
Physical Environment	Access to parks Limited access to healthy food	Annual average PM2.5 concentration Housing stress	Living near highways

Source: http://wwwn.cdc.gov/CommunityHealth/profile/currentprofile/CT/Litchfield/

Figure 10: Current Smokers Among Adults, by Educational Attainment, Connecticut, 2000, 2010, 2013



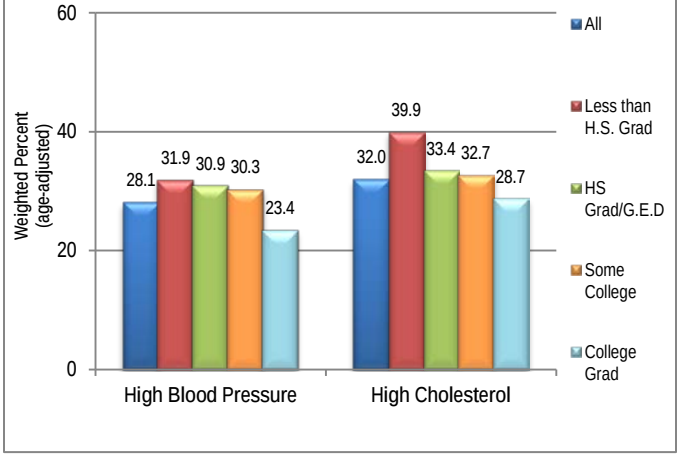
Source: CT Behavioral Risk Factor Surveillance System, 2000, 2010CT DPH: Stats and Reports, 2013 http://www.ct.gov/dph/cwp/view.asp?a=3137&q=388070&dphNav=|&dphNav_GID=1841

The Community Health Status Indicators (CHSI) is an online web application that produces health status profiles for each county in the United States. Each county profile contains indicators of health outcomes (mortality and morbidity); indicators on factors selected based on evidence that they potentially have an important influence on population health status (e.g., health care access and quality, health behaviors, social factors, physical environment); health outcome indicators stratified by subpopulations (e.g., race and ethnicity); important demographic characteristics; and *Healthy People 2020* (HP 2020) targets. A key feature of CHSI 2015 is the ability for users to compare the value of each indicator with those of demographically similar "peer counties," as well as to the U.S. as a whole, and to HP 2020 targets.

Litchfield County's rankings compared to "peer counties" across the U.S. based on similar sociodemographic characteristics are presented in Table 9. Health Indicators of concern include: Alzheimer's/dementia, asthma and depression in older adults, and adult binge drinking.

Examination of statewide BRFSS data is also useful, as this provides additional comparisons by population subgroups not possible in county level data due to the relatively small sampling size. Tobacco use data is particularly important, as according to CDC, tobacco use is the leading cause of preventable death in the United States. Disparities in the prevalence of smoking by income and educational attainment are apparent. As shown in Figure 10, in 2013, CT residents with less than a high school diploma were more than 3 times more likely to report they were current smokers than residents with a college degree. Likewise, high blood pressure and high blood cholesterol were more frequently reported by CT residents with lower educational attainment.

Figure 11: Adults Told by Provider They Had High Blood Pressure or High Cholesterol, by Educational Attainment, CT 2011-2013

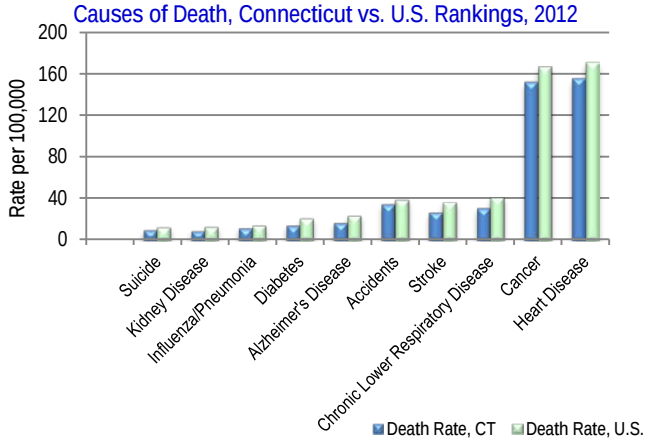


Source: Prevalence of High B.P. by Educational Attainment, CT, 2011-2013; http://www.ct.gov/dph/lib/dph/hems/chronic_dis/heartdisease/burden_of_cardiovascular_diseases_in_connecticut_apr2015_web_final.pdf

LEADING CAUSES OF DEATH AND HOSPITALIZATION

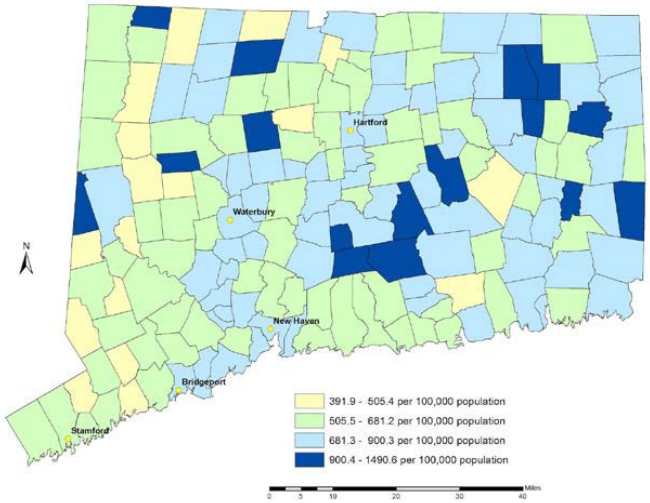
LEADING CAUSES OF DEATH AND HOSPITALIZATION

Figure 12: Age-Adjusted Mortality Rate for Leading Causes of Death, Connecticut vs. U.S. Rankings, 2012



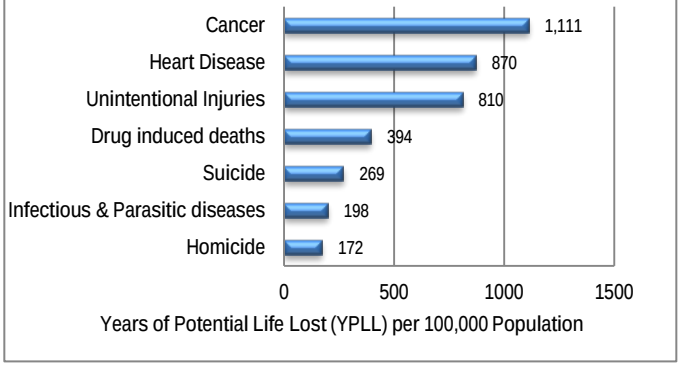
Source: http://www.cdc.gov/nchs/pressroom/states/CT_2014.pdf

Figure 13: All-Cause Mortality, By Town, Connecticut, 2006-2010



Source: CT Department of Public Health, Health Statistics & Surveillance, Statistics & Analysis Reporting, 2006-2010; as cited in Healthy CT 2020 http://www.ct.gov/dph/cwp/view.asp?a=3130&Q=542346&PM=1

Figure 14: Age-Adjusted Premature Mortality (Years of Potential Life Lost) for Leading Causes of Death, Connecticut, 2011



Source: CT Department of Public Health, Age-adjusted YPLL before 75 years of age, 2007-2011; http://www.ct.gov/dph/cwp/view.asp?a=3132&q=521462

Why Leading Causes of Death and Hospitalization Are Important

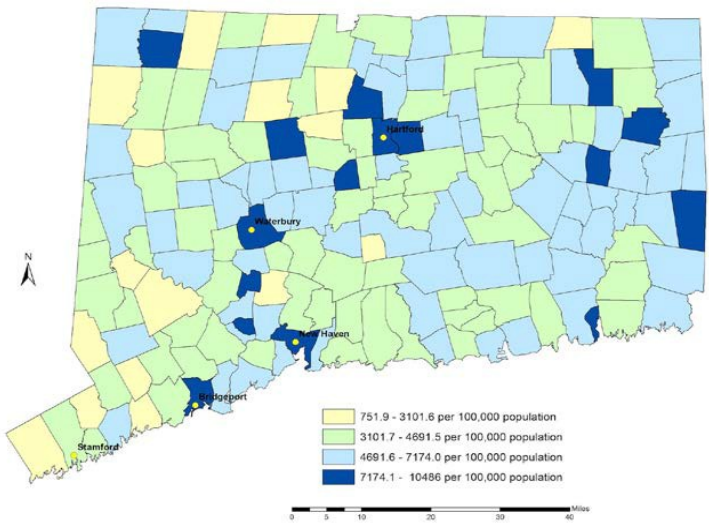
Examining the leading causes of death (mortality) and illness (morbidity) provides insight into the major health issues affecting the population in a geographic area. Fortunately, improvements in detecting and treating the leading causes of death, such as heart disease and cancer, have resulted in a steady decline in mortality rates over the past several decades. Indicators of the extent of illness in a population such as hospitalization and emergency department (ED) visit rates provide useful information about the burden of chronic and acute health conditions on area residents and the health care system. Looking at preventable hospitalizations is especially important, as this provides an indication of the availability and utilization of primary care services in the community. Examining disparities in the distribution of health conditions and diseases is critical to identifying vulnerable population groups and to targeting health promotion, screening, diagnostic, and treatment services for residents in the community.

Findings in the State and NW CT

Heart Disease has historically been the leading cause of death in the nation, state and in our region, closely followed by Cancer. As noted in Figure 12, these two causes of death account for more deaths than the next three leading causes of death – Chronic Lower Respiratory Disease, Stroke, and Unintentional Injuries (accidents) – combined. Differences in age-adjusted mortality rates (AAMR), as shown in Figure 13, are evident by municipality across the state and in the region. Age-adjusted mortality rates correct for differences in the age distribution in a given population, allowing comparisons from one geographic area to another. The following service area towns (SAT) had AAMRs in the highest (least desirable) quartile in the state: Barkhamsted and Morris.

Age-adjusted premature mortality is measured in years of potential life lost (YPLL). YPLL indicates the burden of premature deaths in a given population. As shown in Figure 14, for CT residents, Cancer, Heart Disease, and Unintentional Injuries were the primary causes of premature mortality, followed by drug-induced deaths. Within the service area, rates were highest in Barkhamsted, Bethlehem, Thomaston, Torrington, and Winchester (See Figure 15 on following page).

Figure 15: All-Cause Premature Mortality, By Town, CT, 2006-2010



Source: CT Department of Public Health, Health Statistics & Surveillance, Statistics & Analysis Reporting, 2006-2010; as cited in Healthy CT 2020

Table 10: AAMR Rates by Cause, Race, and Ethnicity, CT and Litchfield County, 2008-2012

Cause of Death	Age-Adjusted Mortality Rates (2008-2012) Per 100,000 Residents							
	Connecticut				Litchfield County			
	Total	White	Black	Hispanic	Total	White	Black	Hispanic
All causes	660.4	656.8	764.7	517.7	656.2	669.4	671.8	446.7
Malignant neoplasms	160.0	161.9	179.0	110.4	150.2	153.5	183.7	68.2*
Diabetes mellitus	14.8	13.4	31.9	20.8	10.4	10.4	-	-
Alzheimer's disease	16.9	17.4	13.5	9.5	17.6	17.8	-	-
Major cardiovascular diseases	200.2	199.9	231.8	149.9	216.9	220.9	231.8	161.0
Pneumonia and Influenza	13.7	13.5	16.1	12.4	13.0	13.3	-	-
Chronic lower respiratory diseases	32.2	33.7	22.7	17.6	38.0	39.4	-	-
Chronic liver disease and cirrhosis	7.4	7.5	4.9	11.1	8.4	8.5	-	-
Accidents (unintentional injuries)	33.3	34.8	29.3	28.8	36.4	37.4	-	26.5*
Alcohol-induced	4.9	5.3	3.6	3.9	6.6	6.8	-	-
Drug-induced	10.9	12.6	8.2	8.9	12.9	13.1	-	-

Backus K, Mueller L (2015) Age-Adjusted Mortality Rates by Race/Ethnicity for Litchfield County and Connecticut, 2008-2012. CT Department of Public Health.
Notes: Rates that are based on < 5 deaths are suppressed and indicated by a dash (-).
Rates noted with a (*) are based on < 15 deaths and should be interpreted with caution.

As shown in Table 10, overall Age-Adjusted Mortality Rates (AAMR) in 2008-2012 were ***higher*** (by one point or more) than the state rates for county residents for major cardiovascular diseases (CVD), chronic lower respiratory diseases (CLRD), chronic liver disease and cirrhosis, accidents, and alcohol and drug induced causes of death.

By race and ethnicity, deaths from all causes were highest in Black or African American residents in both the state and county; however AAMRs for Black residents were considerably lower in Litchfield County than in the state. Overall mortality rates in the state and county were lowest for Hispanic or Latino residents, which is consistent with the findings from the 2012 Community Health Needs Assessment (CHNA). This may be due in part to underreporting of ethnicity on death certificates.

Death rates were ***lower*** (by one point or more) for White residents of Litchfield County compared with the state average for White residents for malignant neoplasms (cancer) and diabetes, and ***higher*** (by one point or more) than the state average for all causes, major CVD, CLRD, chronic liver disease and cirrhosis, accidents, and alcohol induced deaths.

AAMR rates for many causes of death for Black or African American and Hispanic or Latino residents in the county are not indicated in Table 10 due to the small number of events (<5 deaths in the 5 year period). For rates based on 5 or more deaths in the 5-year time interval, AAMRs were ***lower*** for Black or African American county residents than the state average for all-cause mortality, and identical to the state rate for major CVD. AAMR rates were ***higher*** for Black or African American residents than the state average for malignant neoplasms.

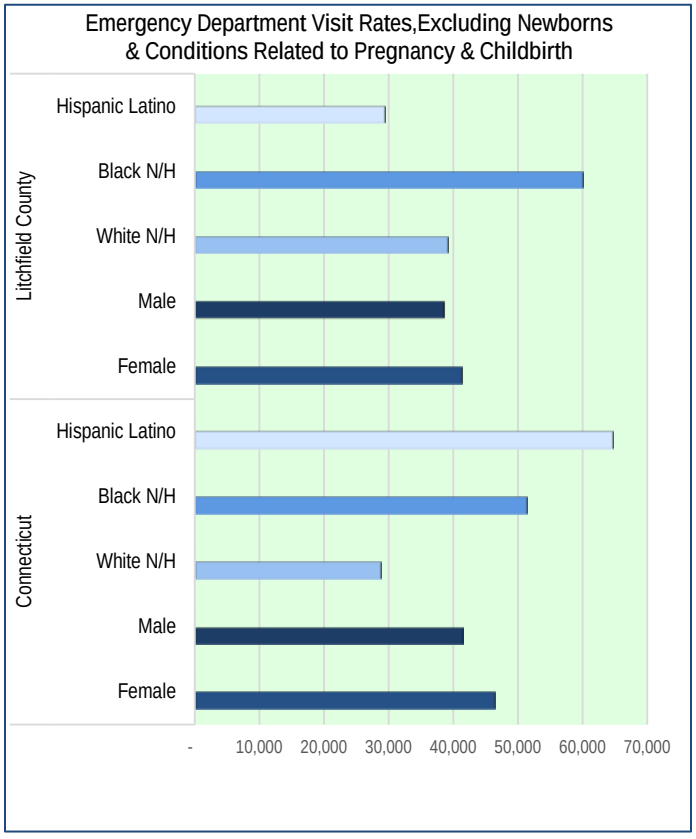
For Hispanic or Latino county residents, AAMR rates that could be calculated were ***lower*** than the state rates for all causes, malignant neoplasms, and accidents. AAMR rates were ***higher*** for Hispanic or Latino county residents than state residents for major CVD.

Table 11: Hospitalization Rates by Race and Ethnicity, CT and Litchfield County, 2008-2012 (Per 100,000 Residents)

	Connecticut				
	Female	Male	White N/H	Black N/H	Hispanic
TOTAL excluding newborns/ conditions related to pregnancy & childbirth	11,551.1	9,834.4	9,237.3	10,645.3	8,042.0
Conditions related to pregnancy & childbirth	2,004.0	NA	671.0	1,186.1	1,341.3
Newborns	935.7	1029.2	652.7	1,029.7	1,240.8
	Litchfield County				
	Female	Male	White N/H	Black N/H	Hispanic
TOTAL excluding newborns/ conditions related to pregnancy & childbirth	10,733.4	9,593.4	10,325.6	8,560.7	3,812.3
Conditions related to pregnancy & childbirth	1,524.5	NA	726.9	730.5	830.9
Newborns	724.4	788.2	692.0	723.9	818.5

Source: CT Department of Public Health, Office of Health Care Access Inpatient Discharge Database System (Data compiled by CT Department of Public Health)

Figure 16: Emergency Department Visit Rates, CT and Litchfield County, 2008-2012 (Per 100,000 Residents)



Source: CT Hospital Association CHIME Emergency Department Database System (Data compiled by CT Department of Public Health, Office of Health Care Access).

Examination of hospitalization and emergency department visit rates are indicators of the extent of acute and chronic illness in the population, and disparities in the frequency of use of these services by different population subgroups. As shown in Table 11, females in the state and in the county had higher overall rates of hospitalization (conditions related to pregnancy and childbirth were excluded). Looking at the frequency of hospitalization by race and ethnicity indicates higher rates of hospitalization for White county residents than the state average, and considerably lower rates of hospitalization for Black or African Americans and Hispanic or Latino county residents than the overall average for state residents.

Hospitalization rates by race and ethnicity for conditions related to pregnancy and childbirth followed the same trends as hospitalization rates excluding these conditions. Rates were higher than the state average for White female county residents and considerably lower for Black or African American and Hispanic or Latino female county residents. Rates of hospitalization were lower on average for newborns in the county (males and females) than in the state overall. Mirroring pregnancy and childbirth hospitalizations, newborn hospitalization rates were slightly higher for White newborns in the county and considerably lower for Black or African American and Hispanic or Latino newborns.

Emergency department visit rates for conditions other than pregnancy and childbirth are shown in Figure 16. Overall emergency room visit rates are lower than the state average for both male and female county residents. Looking at differences by race and ethnicity, emergency department visit rates were lower for Hispanic or Latino county residents and higher for Whites and Black or African American residents than the state averages for these same population subgroups.

As noted in the Department of Public Health's Office of Health Care Access *Databook Preventable Hospitalizations in Connecticut, 2008 - 2012*, "Preventable hospitalizations" are instances of inpatient hospital care for Ambulatory Care Sensitive Conditions (ACSCs). These hospitalizations are considered "preventable" because timely and effective primary care and medical management have been clinically demonstrated to reduce the need for hospitalization. The Prevention Quality Indicators (PQIs) tool developed by the Agency for Healthcare Research and Quality (AHRQ) helps assess the quality of and access to health care in the community. A team of national experts identified ACSCs for which effective primary care significantly reduces the incidence of hospitalization. Although these indicators are based on hospital inpatient data, they provide insight into the quality of the health care system outside the hospital setting.

Table 12: Prevention Quality Indicators (PQI) rates for Connecticut and Litchfield County by Race/Ethnicity, 2013 (per 100,000 population)

Quality Indicator	Black Non-Hispanic	Hispanic	White Non-Hispanic	All Races/ Ethnicities
CONNECTICUT				
Pediatric Quality Indicators (Ages 0 - 17)				
Asthma	337	171	44	116
Diabetes short-term complications	23	10	8	13
Gastroenteritis	74	81	39	55
Perforated appendix[1]	34	32	27	30
Urinary tract infection	18	34	14	21
Overall pediatric PQI rate	294	194	63	128
Adult Quality Indicators (Ages 18+)				
Angina without a procedure	15	9	10	11
Asthma	131	98	43	62
Bacterial pneumonia	219	134	293	258
Chronic obstructive pulmonary disease	716	576	429	457
Congestive heart failure	514	204	375	356
Dehydration	162	72	134	125
Diabetes - long-term complications	292	139	85	109
Diabetes - short-term complications	181	95	49	67
Diabetes - lower extremity amputation	28	14	10	12
Diabetes - uncontrolled	32	14	7	10
Hypertension	151	45	30	43
Low birth weight newborns[1]	9	6	5	6
Perforated appendix[1]	19	11	21	19
Urinary tract infection	192	111	211	191
Overall adult PQI rate	2,239	1,145	1,521	1,498
LITCHFIELD COUNTY				
Pediatric Quality Indicators (Ages 0 - 17)				
Asthma	0	31	23	25
Diabetes short-term complications	0	42	9	7
Gastroenteritis	0	0	9	8
Perforated appendix[1]	0	50	22	30
Urinary tract infection	0	0	3	3
Overall pediatric PQI rate	0	83	21	28
Adult Quality Indicators (Ages 18+)				
Angina without a procedure	0	0	10	9
Asthma	140	29	44	42
Bacterial pneumonia	262	77	274	261
Chronic obstructive pulmonary disease	418	361	398	392
Congestive heart failure	471	46	286	278
Dehydration	105	15	117	113
Diabetes - long-term complications	52	31	72	69
Diabetes - short-term complications	52	15	37	37
Diabetes - lower extremity amputation	0	0	4	4
Diabetes - uncontrolled	0	0	6	5
Hypertension	52	15	26	27
Low birth weight newborns[1]	8	0	6	6
Perforated appendix[1]	0	0	34	34
Urinary tract infection	105	46	147	141
Overall adult PQI rate	1,414	430	1,289	1,242

Source: CT DPH Office of Health Care Access Acute Care Hospital Discharge Database
[1]Condition-specific rates - Populations are those who had appendicitis and all births. These rates are per 100 appendicitis hospitalizations or 100 births. Low birth weight newborns are grouped with the adult PQI conditions because low birth weight is related to the mother's prenatal care.

As noted in the OHCA Databook, although other factors outside the direct control of the health care system such as poor environmental conditions or lack of patient adherence to treatment recommendations can result in hospitalization, the PQIs provide a good starting point for assessing quality of health services in the community.

Using the AHRQ PQIs, the Office of Health Care Access (OHCA) analyzed hospital admissions for ACSCs utilizing acute care inpatient hospital discharge data for the state and Litchfield County in 2013. This yielded the data presented in Table 12 which is helpful in examining the quality of and access to appropriate primary care within the county as compared with the state as a whole.

The overall pediatric PQI rate is considerably lower in the county when compared with the state average (28 vs. 128 per 100,000 population). This is true for all ACSCs, with the exception of perforated appendix (county rate is identical to the state rate).

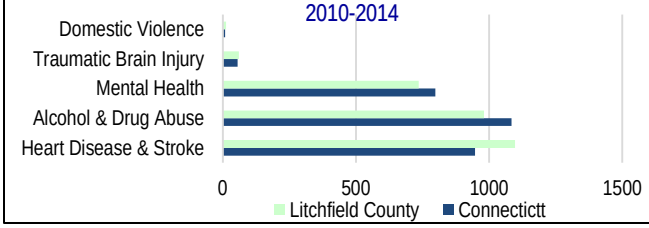
The overall adult PQI is also lower in the county than the state average, however the difference is less dramatic. This is true for all conditions with the exception of bacterial pneumonia, low birth weight newborns (county and state rate are identical), and perforated appendix.

In relation to differences by race and ethnicity, both pediatric and adult PQIs were consistently lower than state PQIs for all races and ethnicities. Within the county, the overall pediatric (ages 0-17) PQI was highest for Hispanic children. The overall adult PQI was highest for Black or African American adults, followed by Whites, and lowest for Hispanic or Latinos.

Disparities within racial and ethnic subgroups in the county are apparent, in PQI rates for both children and adults. PQI rates for asthma and hypertension in Black or African Americans adults were double the rate or more in White or Hispanic adult residents. For children, PQI rates for diabetes short-term complications and perforated appendix in Hispanic children were more than double the rate in White non-Hispanic children.

Emergency Department visit rates for selected diagnoses presented in Figure 17 show rates for heart disease and stroke were higher in Litchfield County than in the state overall; mental health and alcohol and drug abuse visit rates were lower than the state rates.

Figure 17: Emergency Department Visit Rates 2010-2014



Source: CT Department of Public Health, Office of Health Care Access inpatient discharge database system and CHA/CHIME Emergency Department database system. Rate per 100,000 population. Number of discharges/visits represents events, not unique persons.

Figure 18: Hospital Utilization by Type of Encounter, 2014

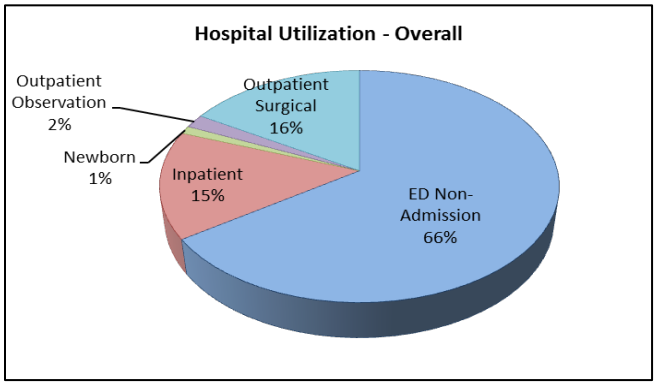


Figure 19: Most Common Medical Diagnoses in Hospitalized Patients, 2014

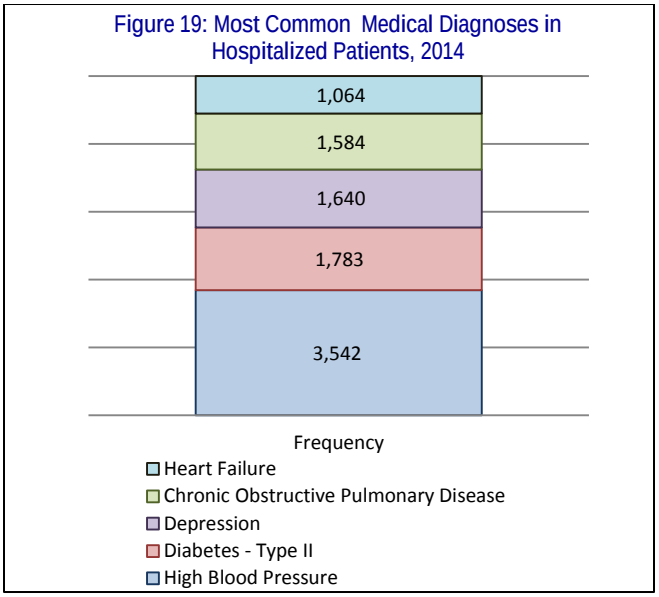


Figure 20: Most Common Medical Diagnoses in ED Non-Admissions, 2014

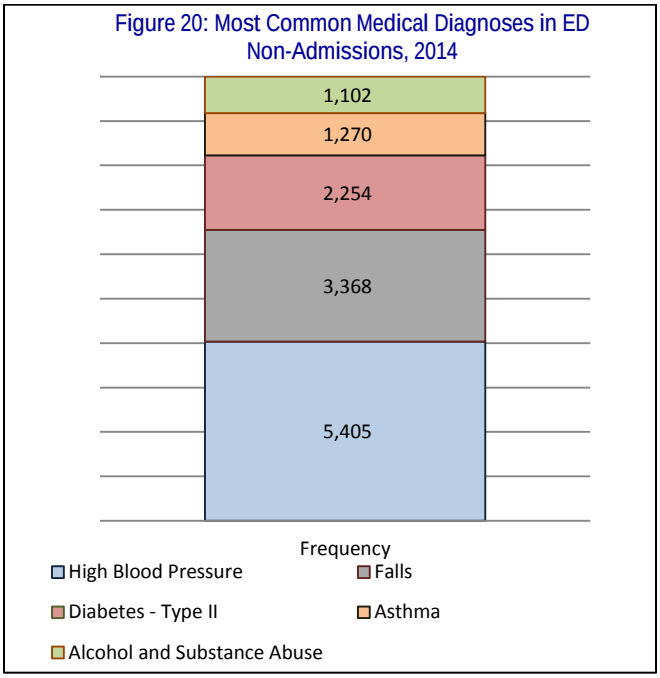


Figure 18-20 Source: The Connecticut Hospital Association FY 2014 CHIMEData

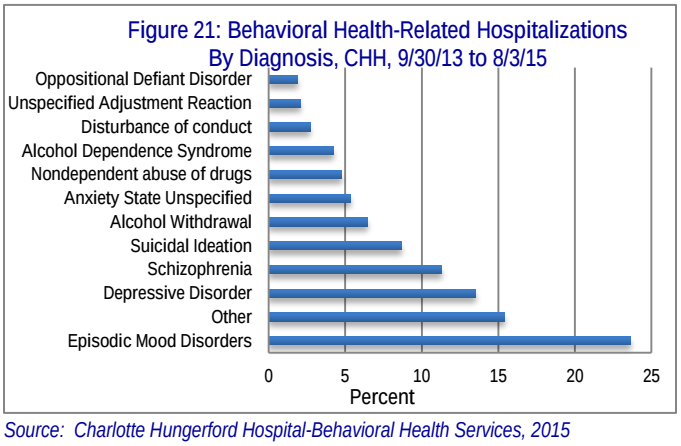
The Connecticut Hospital Association provides data collection and reporting services for its acute care hospital members through the ChimeData program. ChimeData is the most comprehensive hospital database in the state. ChimeData collects discharge data from inpatient admissions, hospital-based outpatient surgery, and emergency department (ED) non-admissions. Fiscal year (FY) 2014 data were analyzed and evaluated by CHA for the Charlotte Hungerford Hospital designated service area. Patient encounter data were extracted for those zip codes identified as being part of the hospital service area, including: Barkhamsted (06063), Bethlehem (06751), Colebrook (06021), Cornwall (06753), Goshen (06756), Harwinton (06791), New Hartford (06057), Norfolk (06058), Litchfield (06759), Morris (06763), Thomaston (06778), Torrington (06790), and Winchester (06098).

Hospital utilization data for Fiscal Year 2014 is presented in Figures 18-20. This data represents patient encounters across all CHA member hospitals with discharges from the 13 zip codes in CHH's service area. The highest frequency of hospital-based service utilization was for Emergency Department (ED) visits that did not result in an inpatient hospital stay; two-thirds of encounters in the service area were ED-based. The next highest areas of utilization were for outpatient surgical and inpatient services respectively.

As shown in Figure 19, the most prevalent medical diagnoses for persons hospitalized in the service area were Hypertension (High Blood Pressure), followed by Type II Diabetes, Depression, Chronic Obstructive Pulmonary Disease, and Heart Failure. Hypertension was also the most common medical diagnosis in persons seen in the emergency department (ED) who did not require hospitalization, followed by falls, Type II Diabetes, Asthma, and Alcohol and Substance Abuse. It is important to note that the data presented in Figures 19-20 does not reflect the primary *reason* for the ED visit or hospitalization.

CHH Behavioral Health Services data for primary and secondary mental health diagnoses (DSM-5) for hospitalized patients from 2013-2015 are shown in Figure 21 below. Episodic Mood Disorders, Depressive Disorder, and Schizophrenia were the top 3 behavioral health diagnoses.

Figure 21: Behavioral Health-Related Hospitalizations By Diagnosis, CHH, 9/30/13 to 8/3/15

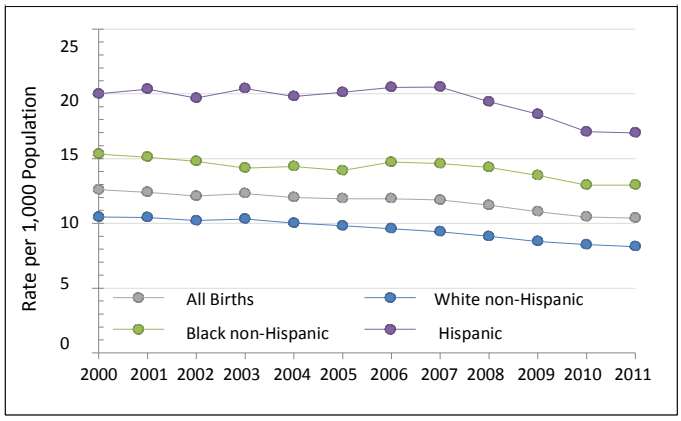


Source: Charlotte Hungerford Hospital-Behavioral Health Services, 2015

ASSESSMENT OF KEY HEALTH INDICATORS

MATERNAL AND INFANT HEALTH

Figure 22: Birth Rate, by Race and Ethnicity, Connecticut, 2000-2011



Source: Connecticut Department of Public Health: CT DPH, Vital Statistics, http://www.ct.gov/dph/cwp/view.asp?a=3132&q=394598&dphNav_GID=1601; as cited in Healthy CT 2020

Figure 23: Birth Rate to Teen Mothers (15-19 Years of Age), By Town, 2007-2011

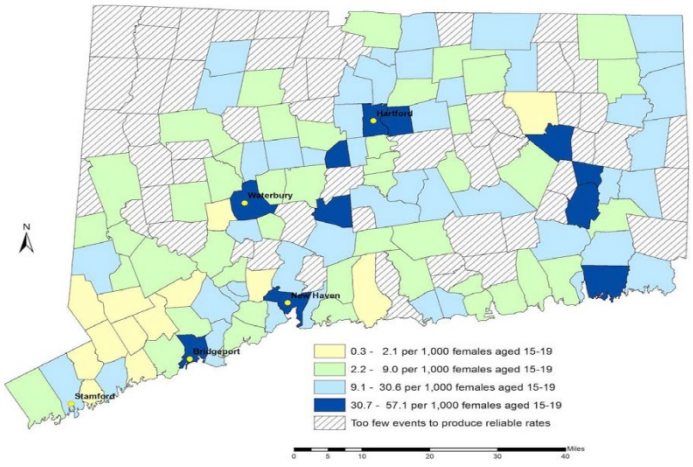


Figure 24: Percent of Mothers Who Received Late Prenatal Care, By Town, Connecticut, 2007-2011

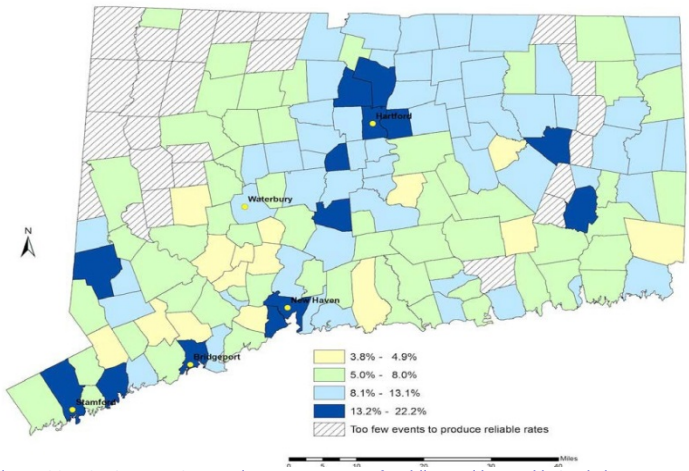


Figure 23 & 24 Source: Connecticut Department of Public Health, Health Statistics & Surveillance, Statistics & Analysis Reporting, 2007-2011; as cited in Healthy CT 2020

Why Maternal and Infant Health Are Important

The health and well-being of mothers and infants are crucial to the future health of a community, its economic stability, and overall quality of life. Maternal health during pregnancy is correlated with both positive birth outcomes and improved health status in infants. Adequate and timely prenatal care is important to assuring the best possible birth outcomes. Births occurring in the early and late stages of a woman's reproductive period - prior to age 20 and after age 40 - present health risks to both the mother and her infant.

Teen pregnancies often carry additional social, emotional and financial burdens, as teen mothers are more likely to be single parents, unemployed or low wage earners, and lack the support systems to enable them to continue with their education. Pregnancies in older women are more likely to include the use of assistive reproductive technologies (ART) to conceive, which increases the risk of multiple birth pregnancies, preterm delivery, and low birthweight infants (Healthy CT 2020). In addition, neonatal abstinence syndrome, a condition in which infants are born addicted to prescription or illicit drugs, is an emerging issue in maternal and infant health in Connecticut and the nation.

Birth rates are a primary indicator of the population growth in a given area.

Findings in the State and NW CT

As shown in Figure 22, birth rates have been declining for more than a decade overall in the state's major ethnic and racial groups. This trend includes births to teens in all major racial and ethnic groups. The overall rate of teen births in CT has declined by nearly 50% over the past decade, with the lowest decline in Hispanic or Latino teens. The number of births to teen mothers is too low to calculate reliable rates in many SATs; rates in Winchester and Torrington rank in the second highest quartile compared with the state as a whole.

Regardless of the mother's age, receiving late or inadequate prenatal care is a well-established risk factor for poor birth outcomes such as preterm (premature) and low birthweight births. For SATs with reliable rates, these were lower (more favorable) than the state average.

Preterm and low birthweight births are associated with higher infant mortality rates and health problems such as neurological and respiratory conditions and developmental delays. Risk factors for preterm and low birthweight births include: multiple-birth pregnancies, lack of prenatal care, inadequate weight gain in pregnancy, and smoking or drug use during pregnancy. In addition, women who are Black or African American are at disproportionate risk for low birthweight births.

Again, the rate for preterm and low birthweight births cannot be reliably calculated for many SATs due to the small number

Figure 25: Percent of Low Birthweight Births, By Town, Connecticut, 2007-2011

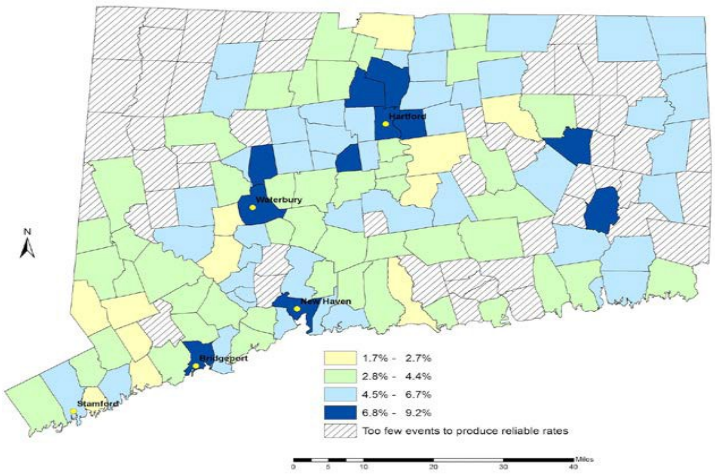


Figure 26: Percent of Preterm Births, By Town, Connecticut, 2007-2011

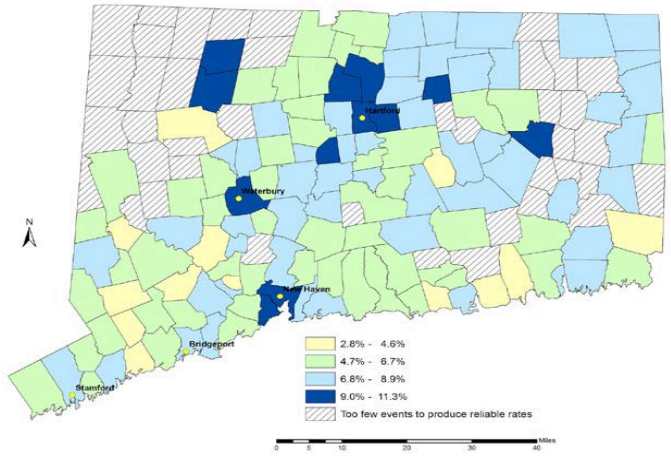
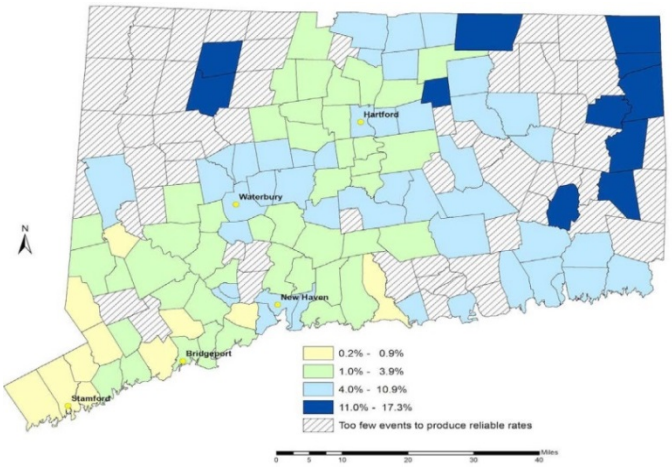


Figure 24 & 25 Source: Connecticut Department of Public Health, Health Statistics & Surveillance, Statistics & Analysis Reporting, 2007-2011 as cited in Healthy CT 2020.

Figure 27: Percent of Women Who Report That They Smoked Tobacco During Pregnancy, By Town, Connecticut, 2006-2010

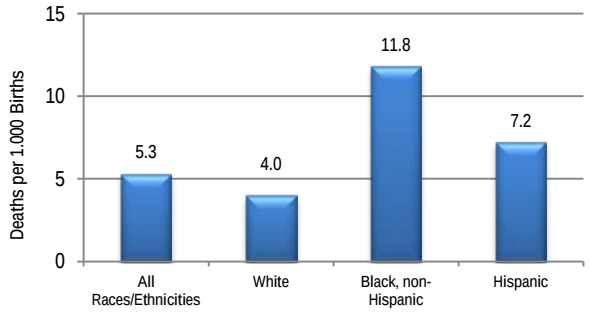


Source: Connecticut Department of Public Health, Health Statistics & Surveillance, Statistics & Analysis Reporting, Birth Certificates, 2006-2010, as cited in Healthy CT 2020.

of events; for those with sufficient numbers, rates in Torrington and Winchester are in the second highest quartile for low birthweight births and highest quartile for preterm births in the state. Notably, based on birth certificate data, mothers in these two communities reported the highest levels of smoking during pregnancy as well.

Infant Mortality is a strong indicator of the overall health of a nation, state, and community. Infant Mortality Rates (IMR) overall have declined in the U.S. and in Connecticut due to advances in prenatal and neonatal care, however significant disparities persist among racial and ethnic subgroups. As shown in Figure 28, Infant Mortality Rates in Connecticut are highest for Black or African American infants, followed by Hispanic or Latino infants, and lowest for White infants.

Figure 28: Infant Mortality in CT by Race/Ethnicity, 2012



Source: CT Dept. of Public Health, Vital Statistics, Registration Reports, 2012
http://www.ct.gov/dph/cwp/view.asp?a=3132&q=394598

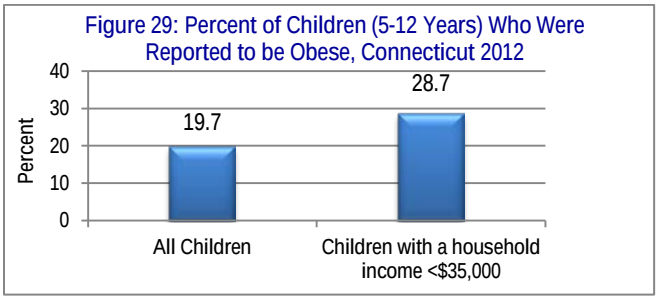
In 2010-2012, Infant Mortality Rates in Litchfield County were nearly twice the state rate as shown in Table 13 below. According to analyses performed by the CT Department of Public Health, these differences were statistically significant ($p < .05$). This difference is attributed in part to the higher proportion of multiple-birth pregnancies in Litchfield County mothers compared with the state, a known risk factor for poorer birth outcomes. IMRs for singleton births in the county are also higher than in the state during this time period; however these differences were not reported by DPH to be statistically significant.

Table 13: Infant Mortality Rates, Litchfield County and CT, 2010-2012

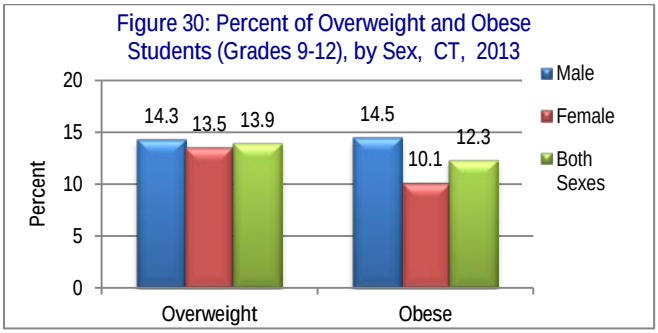
	Births	Infant Deaths	IMR
CT	111,193	582	5.2
Litchfield County	3,097	28	9.0

Source: CT Dept. of Public Health, Vital Statistics, Registration Reports, 2010-2012
(Data compiled by CT Department of Public Health)
IMR = Deaths in Infants less than 1 year of age per 1,000 Live Births

CHILD AND ADOLESCENT HEALTH



Source: Behavioral Risk Factor Surveillance System, 2012 results, 2014 report *http://www.ct.gov/dph/lib/dph/hisr/pdf/brfss2012_ct_report.pdf*



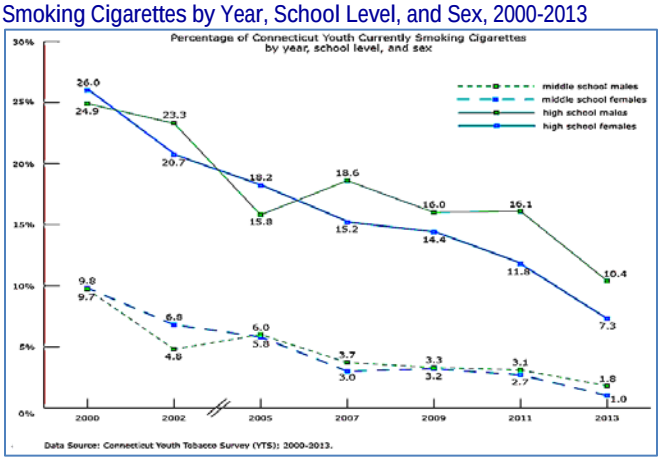
Source: Youth Risk Behavior Surveillance - Connecticut 2013; *http://www.ct.gov/dph/lib/dph/hisr/pdf/cshs_ybc2013_report.pdf*

Table 14: Percentage of K-12 Students Passing All Four Physical Fitness Components, 2012-2013

District	Percentage Passing
Litchfield	69.0
Harwinton (Region 10)	60.2
Bethlehem (Region 14)	56.8
Thomaston	49.1
Cornwall (Region 1)	43.8
Barkhamsted, Colebrook, New Hartford, Norfolk (Region 7)	42.8
Goshen, Morris (Region 6)	41.5
Torrington	34.3
Winchester	22.8
State	51.1

Source: http://sdeportal.ct.gov/Cedar/WEB/ct_report/CedarHome.aspx

Figure 31: Percentage of Middle and High School Students Currently Smoking Cigarettes by Year, School Level, and Sex, 2000-2013



Source: *http://www.ct.gov/dph/lib/dph/hems/tobacco/pdf/youth_trends_factsheet_2014.pdf*

Why Child and Adolescent Health Are Important

There is increasing evidence that poor health status in childhood and adolescence - such as overweight and obesity - increases the risk of developing chronic diseases later in life. Establishing positive personal health behaviors during childhood and adolescence - healthy eating; being physically active; avoiding the use of tobacco, alcohol, and illicit drugs; and receiving primary care for the early detection and treatment of physical and/or mental health issues - are critical to health maintenance.

Findings in the State and NW CT

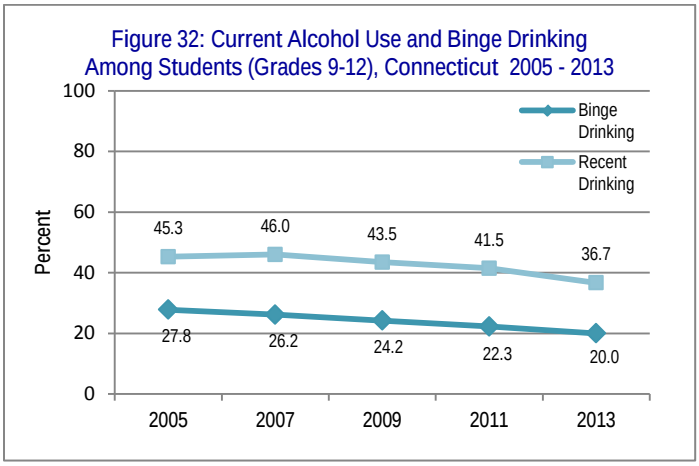
Obesity and overweight in children, adolescents, and adults have reached epidemic proportions in the U.S. According to CDC, childhood obesity has more than doubled in children and quadrupled in adolescents in the past 30 years; in 2012, more than one out of every three children and adolescents were overweight or obese. The long-term health consequences of childhood and adolescent obesity are serious. Youth who are obese are more likely to experience social and psychological problems due to poor self-esteem. They are more likely to be overweight adults, and consequently are at greater risk for developing heart disease, hypertension, Type II Diabetes, stroke, osteoarthritis, and certain types of cancer. *Source: CDC, Adolescent and School Health, http://www.cdc.gov/healthyyouth/obesity/facts.htm.*

According to 2012 BRFSS results, one in five CT children was obese according to Body Mass Index (BMI) for age standards. For children living in households with incomes below $35,000, this increased to one in every three children (based on adult parent responses to BRFSS questions).

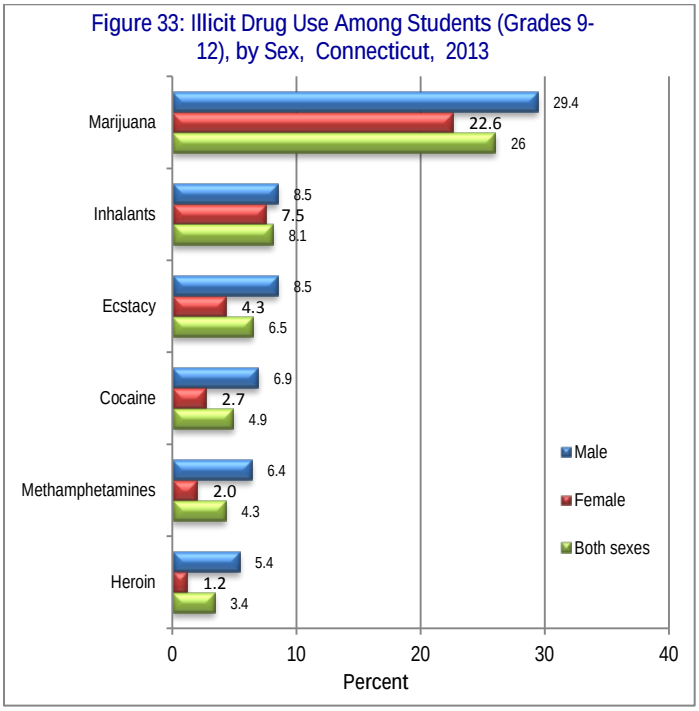
The DPH *2013 CT School Health Survey - Youth Risk Behavior Component* indicates that CT youth are more likely than their counterparts nationwide to be physically active five or more days per week (47% versus 27%) and less likely to spend three or more hours per day in front of a television (24% versus 33%) or a computer screen (37% versus 41%). Related to healthy eating practices, the report found that only 1 in 10 CT high school students consume the recommended 5 or more servings of fruits and vegetables per day. *Source: http://www.ct.gov/dph/lib/dph/hisr/pdf/cshs_ybc2013_report.pdf.*

Another measure of the level of physical fitness in youth is the percentage of students in local school districts passing all four components of state physical fitness tests. These include aerobic endurance, flexibility, muscular strength and endurance. Results for K-12 students enrolled in school districts within the county are presented in Table 14. In general, less affluent districts in the county scored lowest.

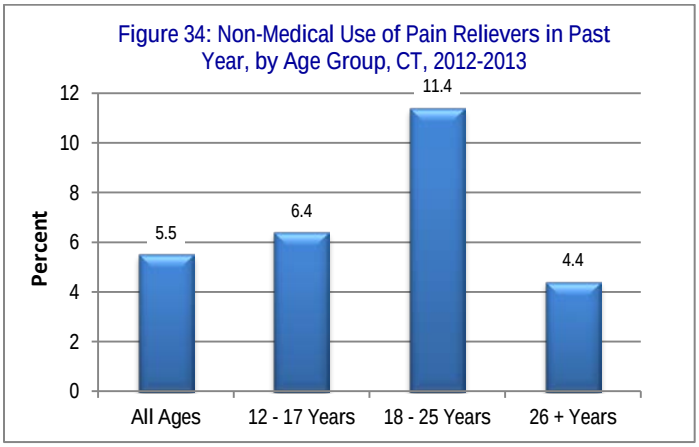
Smoking is the single most avoidable cause of chronic disease and death. As shown in Figure 31, based on CT Youth Tobacco Survey results, rates of cigarette smoking in adolescents have shown a dramatic decline from 2000-2013. In both middle school and high school, Hispanic or Latino students had the highest smoking rates.



Source: http://www.ct.gov/dph/lib/dph/hisr/pdf/CSHS2013_Factsheet.pdf



Source: Connecticut School Health Survey 2013 Results
http://www.ct.gov/dph/lib/dph/hisr/pdf/cshs_ybc2013_report.pdf

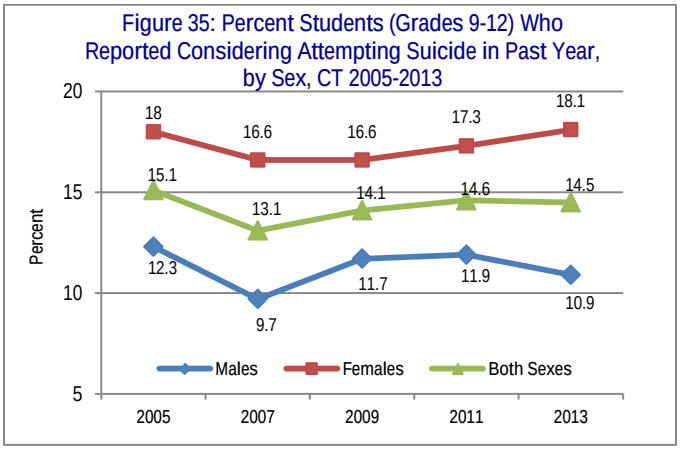


Source: SAMHSA, Reports by Topic
http://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2012-2013-p1/AgeGroupCompTab/NSDUHsaeQuintEndPTS2013.htm

In high school, non-Hispanic Blacks had the lowest smoking rates. National and state statistics indicate that the use of e-cigarettes and hookahs by high school students is increasing. In fact, e-cigarette use by high school youth is considerably higher in CT (5.3%) than in the U.S. overall (2.8%). *Sources: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6414a3.htm; http://www.lung.org/about-us/media/press-releases/e-cigarette-use-triples-in-nonsmokinr-youth.html http://www.ct.gov/dph/lib/dph/hems/tobacco/pdf/connecticut_youth_tobacco_survey_report_2013.pdf*

Binge drinking rates in CT high school youth are also above national averages. Illicit drug use and non-medical use of pain relievers by adolescents are critical public health issues in the region, state, and nation. As shown in Figure 33, the most frequently used illicit drug by high school students is marijuana (26%), followed by inhalants and Ecstasy. Non-medical use of prescription opiates leading to addiction and use of heroin as a less costly alternative is an emerging health issue in the region. As shown in Figure 34, more than 1 in 10 young adults ages 18-25 years reported the use of pain relievers for non-medical reasons, and 1 in 20 high school males reported heroin use. Reported heroin use in CT high school students (3.4%) exceeded national averages (2.2%).

Based on the findings of the 2013 CT School Health Survey, Youth Risk Behavior Component and Local Youth Surveys conducted in NW CT school districts in 2014-2015, mental health issues are relatively common in adolescents, including depression and suicidal ideation. More than one in four (27%) high school students reported feeling so sad or hopeless that they had stopped doing some usual activities; 14.5% of students reported they had seriously considered attempting suicide in the past 12 months.



Source: Youth Risk Behavior Surveillance - CT, 2005-2013
http://www.ct.gov/dph/lib/dph/hisr/pdf/cshs_ybc2013_report.pdf

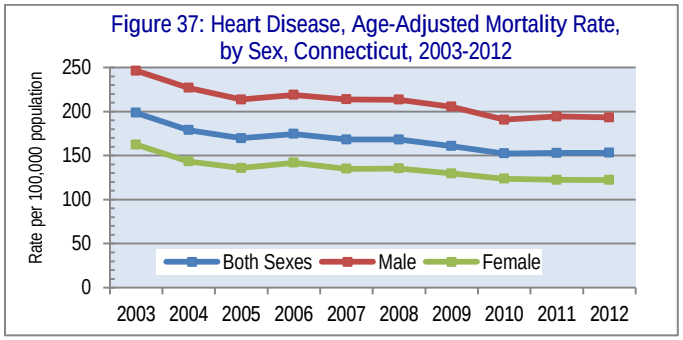
CHRONIC DISEASE PREVENTION AND CONTROL

Figure 36: Leading Causes of Death Connecticut Residents, 2011

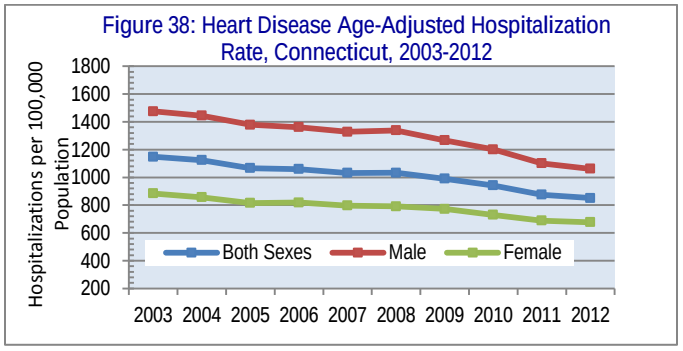
Rank	All Ages	65-74 years old	75-84 years old	85+ years old
1	Heart Diseases (7,183)	Cancer (1,567)	Cancer (1,935)	Heart Diseases (3,566)
2	Cancer (6,793)	Heart Diseases (786)	Heart Diseases (1,066)	Cancer (1,459)
3	Chronic Lower Respiratory Diseases (1,411)	Chronic Lower Respiratory Diseases (227)	Chronic Lower Respiratory Diseases (295)	Stroke (695)
4	Unintentional Injuries (1,322)	Stroke (132)	Stroke (228)	Alzheimer's Disease (584)
5	Stroke (1,308)	Diabetes (126)	Unintentional Injuries (113)	Chronic Lower Respiratory Diseases (531)

Source: CT DPH, Vital Records Mortality Files, 2011 data.

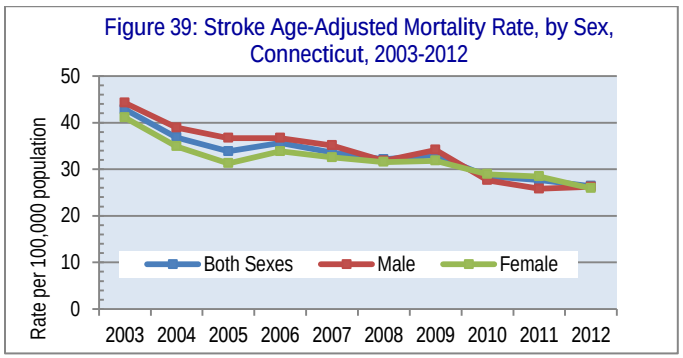
Source: CT DPH, Burden of Cardiovascular Diseases in CT 2015
http://www.ct.gov/dph/cwp/view.asp?a=3132&q=521462



Source: CT DPH, Mortality Statistics, Mortality Tables 2000-2012, AAMRreport_State_1yr_2000-2012.xlsx



Source: CT DPH, Hospitalization Tables, 2005-2012
http://www.ct.gov/dph/cwp/view.asp?a=3131&q=397512



Source: CT DPH, Mortality Statistics, Mortality Tables 2000-2012, AAMRreport_State_1yr_2000-2012.xlsx
Source: http://www.ct.gov/dph/cwp/view.asp?a=3132&q=521462

Why Chronic Disease Prevention and Control Are Important

According to the Centers for Disease Control and Prevention (CDC), 7 out of 10 deaths among Americans each year are the result of chronic diseases, and almost 1 out of every 2 adults has at least one chronic illness. Chronic diseases are also estimated to be responsible for 75% of the health care costs in the U.S. The burden of chronic disease is not shared equally among population subgroups in our nation, state or region - significant disparities exist. Powerful, complex relationships exist between health, genetics, personal behaviors, access to and utilization of quality health services, socioeconomic factors, and the physical environment. The burden of chronic disease in NW CT residents is best assessed in several ways - by examination of disease surveillance data related to the incidence and prevalence of disease, health - care utilization data (such as emergency department visit and hospitalization rates by diagnosis), and mortality data.

Findings in the State and NW CT

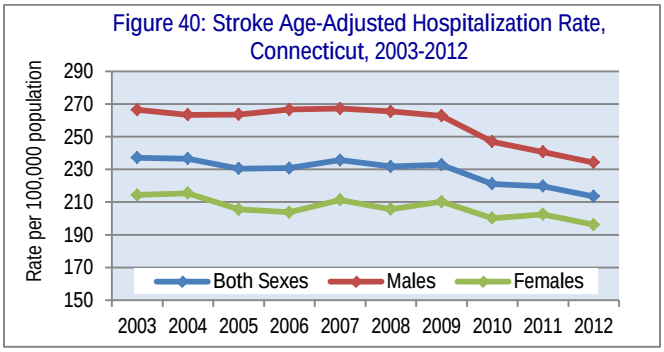
As shown in Figure 36, chronic diseases accounted for the majority of deaths in CT residents of all ages. The most prevalent chronic diseases in the U.S. and CT are cardiovascular diseases (CVD). Major cardiovascular diseases include coronary heart disease (CHD), cerebrovascular disease (stroke), and heart failure. CVD is the leading cause of death in CT, accounting for about one-third of all resident deaths. More than half (55%) of these deaths are in females. *http://www.ct.gov/dph/lib/dph/hisr/pdf/2010cvd_burdendoc_final.pdf*

Risk factors for CVD may be modifiable or non-modifiable. Modifiable risk factors include high blood pressure, high blood cholesterol, smoking, diabetes, obesity, and physical inactivity. Non-modifiable risk factors include increasing age and family history of heart disease and stroke.

As shown in Figures 37-40, the age-adjusted mortality rates for heart disease and stroke have declined significantly for both male and female CT residents over the past decade, as have hospitalization rates. There are considerable disparities in mortality rates from CVD however, with Black or African American residents having the highest rates. *Source: CTDPH, the Burden of Cardiovascular Disease in Connecticut, April, 2015. http://www.ct.gov/dph/lib/dph/hems/chronic_dis/heartdisease/burden_of_cardiovascular_diseases_in_connecticut_apr2015_web_final.pdf*

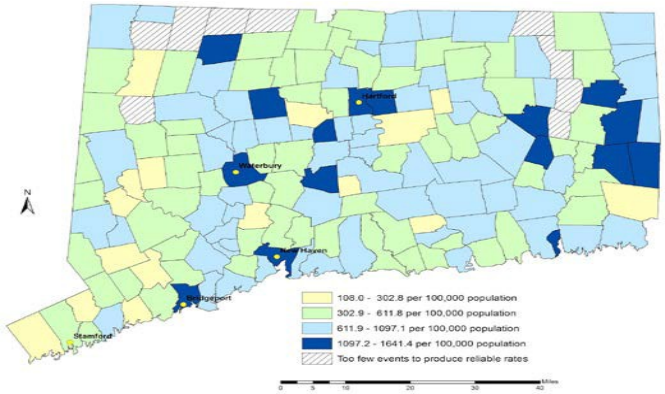
As shown in Figure 41, residents in many SATs experienced a higher than average burden of premature death in 2006-2010 from heart disease, measured in Years of Potential Life Lost (YPLL). YPLL rates for SATs were in the highest quartile in Winchester, and second highest quartile in Harwinton, Litchfield, Thomaston, and Torrington.

High blood pressure and elevated cholesterol levels are both major risk factors for CVD. Data from the 2013 BRFSS indicate that nearly one in three (31%) CT adults have been told they have high blood pressure by a health professional; that percentage increases to 54% for persons ages 55 and over. High blood pressure is more common in males, Black

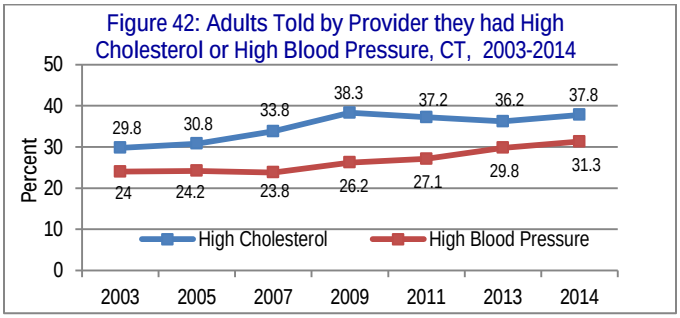


Source: CT Department of Public Health, Hospitalization Tables, 2002-2012, Table H-1 All Ages http://www.ct.gov/dph/cwp/view.asp?a=3131&q=397512

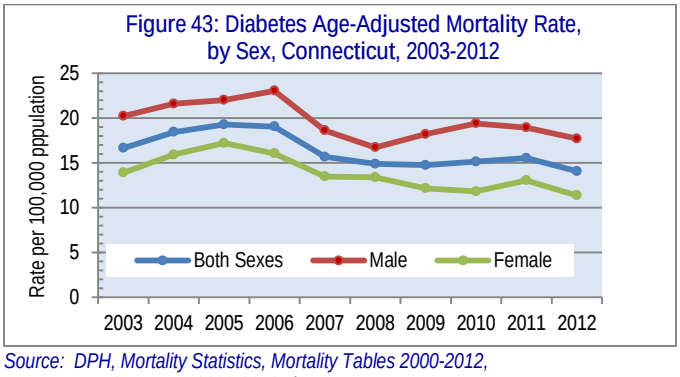
Figure 41: Premature Mortality Due To Heart Disease, Years of Potential Life Lost (YPLL) Under Age 75, By Town, Connecticut, 2006-2010



Source: Connecticut Department of Public Health, Health Statistics & Surveillance, Statistics & Analysis Reporting, 2006-2010.; as cited in Healthy CT 2020.



Source: America's Health Rankings, by State, 2003-2014
http://www.americashealthrankings.org/CT/High_Chol
http://www.americashealthrankings.org/CT/Hypertension



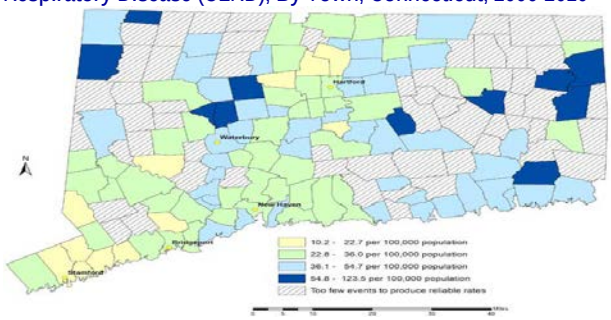
Source: DPH, Mortality Statistics, Mortality Tables 2000-2012, AAMRreport_State_1yr_2000-2012.xlsx
Source: http://www.ct.gov/dph/cwp/view.asp?a=3132&q=521462

non-Hispanic adults, and in persons with lower education and income levels. Over one-third of CT adults (38%) have been told they have high blood cholesterol; this increased to 54% for ages 55 and over. White non-Hispanics were most likely to report high cholesterol, as were individuals with lower educational attainment. *Source: CTDPH, Health Risk Behaviors in Connecticut, Results of the 2013 BRFSS, August 2015. Accessed at:* http://www.ct.gov/dph/lib/dph/hisr/pdf/brfss2013_ct_report.pdf

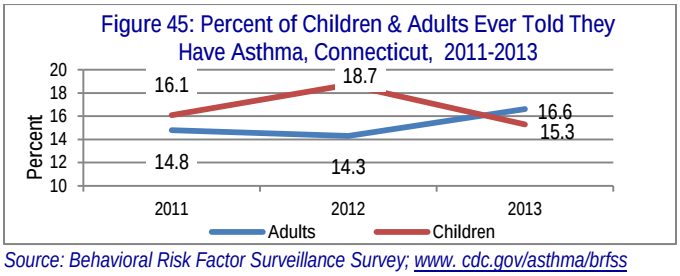
Based on 2013 BRFSS data, an estimated 8% of adults in CT aged 18 and older reported being diagnosed with diabetes; this increased to 16% for persons ages 55 and older. Diabetes was reported almost twice as frequently by Black non-Hispanics than by White non-Hispanics and was highest in persons with lower incomes and educational attainments. The most recent county-level BRFSS data is for 2012. The age-adjusted prevalence of diabetes in Litchfield County adults (ages 18+) in 2012 was 7%. The prevalence of Type II Diabetes in CT and in the nation has increased significantly since 1990. Type II Diabetes typically develops later in life and is strongly correlated with overweight and obesity. The increased prevalence of Type II Diabetes in adults is a major contributor to other chronic diseases and health conditions. Having diabetes increases the risk of heart disease, stroke, kidney disease, as well as blindness, and lower-extremity amputation. *Source: CTDPH, Health Risk Behaviors in Connecticut, Results of the 2013 BRFSS, August 2015.* http://www.ct.gov/dph/lib/dph/hisr/pdf/brfss2013_ct_report.pdf

Respiratory diseases are common in CT residents. As shown in Figure 44, several SATs had higher than average mortality rates from CLRD. Rates were in the highest quartile in Thomaston, and second highest quartile in Harwinton, Torrington, and Winchester. CT BRFSS results show asthma remains prevalent in adults and children, with an increased % of adults reporting they had been diagnosed with asthma.

Figure 44: Age-Adjusted Mortality Rate Due To Chronic Lower Respiratory Disease (CLRD), By Town, Connecticut, 2006-2010



Source: Connecticut Department of Public Health, Health Statistics & Surveillance, Statistics & Analysis Reporting, 2006-2010; as cited in Healthy CT 2020.



Source: Behavioral Risk Factor Surveillance Survey; www. cdc.gov/asthma/brfss

CHRONIC DISEASE PREVENTION AND CONTROL
Focus on Cancer

Figure 46: Number of New Cancer Cases, by Cancer Site, Males, All Ages, Litchfield County, 2008-2012

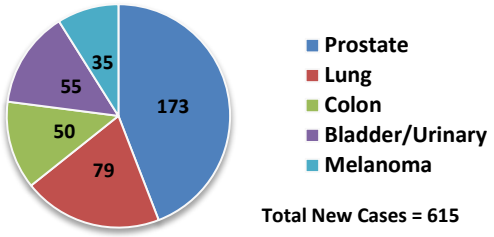
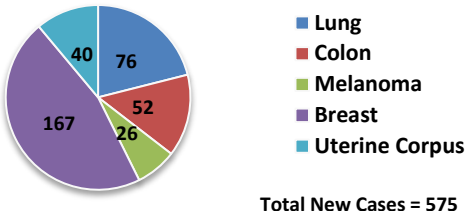


Figure 47: Number of New Cancer Cases by Cancer Site, Females All Ages, Litchfield County, 2008-2012



Source: National Cancer Institute: State Cancer Profiles
http://statecancerprofiles.cancer.gov/incidencerates/index.php?stateFIPS=09&cancer=020&race=00&sex=2&age=001&type=incd&sortVariableName=rate&sortOrder=default#results

Table 15: Age-Adjusted Cancer Incidence Rates by Site and Sex for CT and Litchfield County, 2008-2012 (* = Lower than state rate; ** = Higher than state rate)

Primary Site	State Rate	County Rate	Male Rate (State)	Male Rate (County)	Female Rate (State)	Female Rate (County)
All Sites	488.1	480.9	544.4	533.5	450.2	442.3
Brain & Other Nervous System	7.0	6.71	8.4	6.7	5.7	6.6
Breast	74.5	68.0*	1.6	n/a	137.1	127.3*
Cervix Uteri	n/a	n/a	n/a	n/a	6.2	4.0
Colon and Rectum	41.7	41.1	48.2	44.9	36.5	37.6
Corpus and Uterus, NOS	16.0	n/a	n/a	n/a	29.7	29.0
Esophagus	5.0	5.4	8.9	9.9	1.9	1.6+
Hodgkin Lymphoma	3.4	4.2	3.7	4.3	3.1	4.1
Kidney and Renal Pelvis	15.4	12.8*	21.9	16.5*	9.9	9.3
Leukemia	14.7	14.8	19.4	20.0	11.1	10.5
Liver and Intrahepatic Bile Duct	7.5	6.6	12.2	10.1	3.6	3.7
Lung and Bronchus	63.8	61.5	72.7	69.6	57.6	55.4
Melanoma of the Skin	22.0	25.9**	28.2	31.8	17.8	21.5**
Myeloma	6.2	5.3	7.6	5.6	5.2	5.2
Non-Hodgkin Lymphoma	21.1	20.3	25.4	27.0	17.7	14.7
Oral Cavity and Pharynx	11.1	11.3	16.1	16.4	6.7	6.8
Other Sites	34.6	33.9	40.6	40.1	30.2	29.2
Ovary	n/a	n/a	n/a	n/a	12.6	13.5
Pancreas	13.5	13.1	15.3	14.2	12.2	11.8
Prostate	63.6	n/a	139.9	139.4	n/a	n/a
Stomach	8.2	7.6	11.5	10.0	5.6	5.8
Testis	3.1	n/a	6.2	5.2	n/a	n/a
Thyroid	18.5	20.7	9.2	10.4	27.3	30.7
Urinary Bladder	27.3	29.5	47.3	49.8	12.6	13.9

*Source: SEER*Stat 8.2.1, seer.cancer.gov/seerstat, September 2015; statistical comparisons from Health Statistics & Surveillance Section, CT Department of Public Health, September, 2015. N/A = not applicable (gender-specific cancer) or rate not available.*
+ Rate is based on less than 15 deaths and should be interpreted with caution (statistically unreliable).

The second most frequent category of chronic diseases in the U.S. and CT are malignant neoplasms or cancer. The incidence rate (number of new cancer cases per year per 100,000 population) and age-adjusted cancer mortality rates (number of deaths per 100,000 population) have been steadily declining. This is the result of increased primary prevention efforts, earlier detection, and advances in treatment.
Source: CTDPH, Connecticut Comprehensive Cancer Control Program, Connecticut Cancer Plan 2009-2013; http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/cancer_plan_2009-2013.pdf

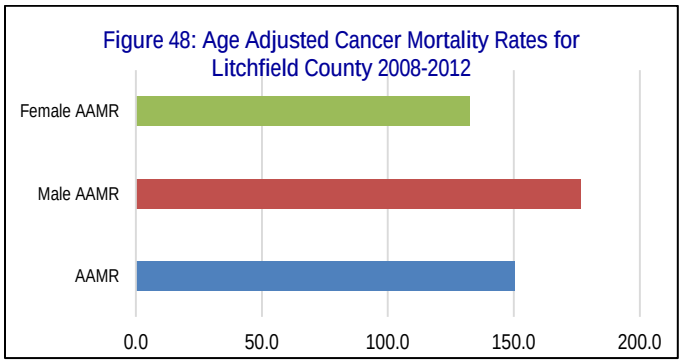
Nonetheless, according to the DPH State Health Assessment, *Healthy Connecticut 2020,* cancer remains the second leading cause of death in CT residents, and 1 in 2 males and 1 in 3 females will be diagnosed with some form of cancer in their lifetime.

As shown in Figures 46 and 47, in terms of number of newly diagnosed cancer cases from 2008-2012 by gender in Litchfield County, the most frequently diagnosed cancer in males was prostate, followed by lung, bladder/urinary, colon and skin cancer (melanoma). In females, the most commonly diagnosed cancer was breast, followed by lung, colon, uterine, and melanoma.

Incidence rates show overall males in the county were more frequently diagnosed with cancer than females. Incidence rates are considerably higher for males than females for many types of cancer as shown in Table 15. These include cancer of the colon and rectum, esophagus, kidney and renal pelvis, leukemia, liver and bile duct, lung and bronchus, melanoma, non-Hodgkin's lymphoma, oral cavity and pharynx, pancreas, stomach, and bladder. Females have higher incidence rates for breast cancer (less than 1% of all breast cancers occur in men), and thyroid cancer.

By site, cancer incidence rates for Litchfield County were *significantly lower* than the state rate for breast cancer, kidney and renal pelvis cancer, and *significantly higher* than the state rate for skin cancer (melanoma). The higher incidence rate for skin cancer in the county is likely attributable to the high proportion of Caucasians in the population (94%) compared with the state as a whole (81%). *Source: http://quickfacts.census.gov/qfd/states/09/09005.html*
Caucasians have lower levels of melanin in their skin, which is a protective factor against developing skin cancer.

As shown in Figure 48, overall age-adjusted cancer mortality rates in the county are also higher in males than in females. Disregarding gender-specific cancers such as prostate and cervical cancer, mortality rates for males are higher for all cancers by site. Overall mortality rates for cancer are higher for Black or African American residents in the county, as previously reported in Table 10, which is consistent with cancer mortality rates for state residents overall.



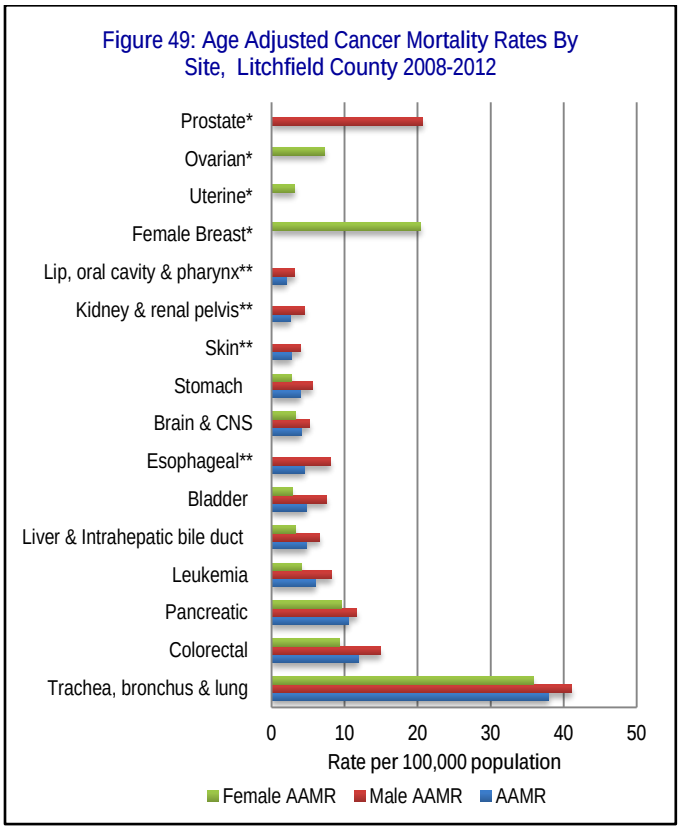


Figure 47 & 48 Source: Backus K, Mueller L (2015) Age-Adjusted Mortality Rates for Litchfield County and Connecticut, 2008-2012. CT Department of Public Health.
**Total AAMR are not provided for gender-specific cancer sites*
***Rates are based on less than 15 deaths and are considered to be statistically unreliable*

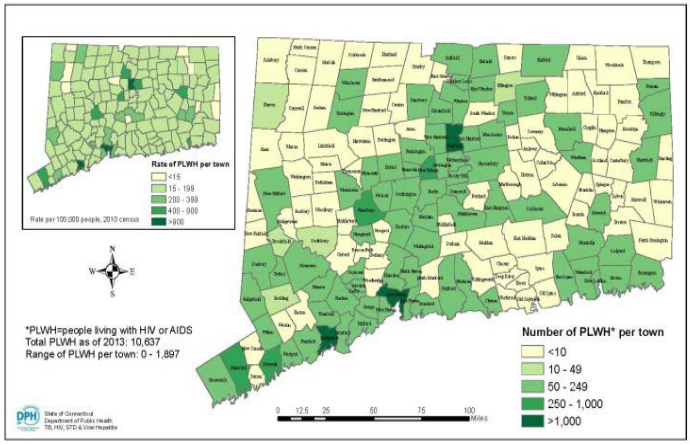
Many types of cancer, such as breast, lung and bronchus, and colorectal are linked to modifiable risk factors. Modifiable risk factors for cancers include such factors as: smoking tobacco; secondhand exposure to tobacco smoke; overweight and obesity; excessive alcohol consumption; physical inactivity; high fat, low fiber diets; ultraviolet light exposure; contracting human papillomavirus (HPV); and exposure to environmental contaminants such as radon and asbestos.

Cancer survival rates, or how long persons live after being diagnosed with cancer, are closely related to the stage of diagnosis. In general, persons diagnosed with localized cancers have the highest 5-year survival rates, followed by those diagnosed with regional cancers. Persons diagnosed with distant cancers in general have the lowest cancer survival rates.

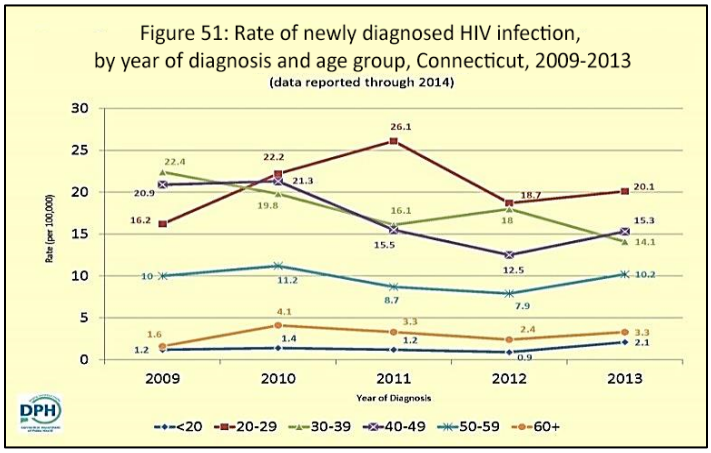
Due to the high incidence of cancer, access to and participation in cancer screenings is paramount to early detection and treatment. As reported previously in Figures 7 and 9, data from the 2012 BRFSS for the TAHD service area show that 21% of residents ages 50+ reported never having colorectal screening (sigmoidoscopy/colonoscopy); 18% of women ages 40+ reported never having a mammogram; 25% of women reported not having a PAP test in the past 3 years, and 63% of men ages 40+ indicated that they had not had PSA testing in the past two years. Participation rates in colorectal and mammography screening were significantly lower for persons reporting incomes below $35,000 per year than for those with incomes of $70,000 per year or higher.

INFECTIOUS DISEASE PREVENTION AND CONTROL

Figure 50: Prevalence of HIV infection cases (N=10,637), CT, 2013 (As of December 31, 2014)

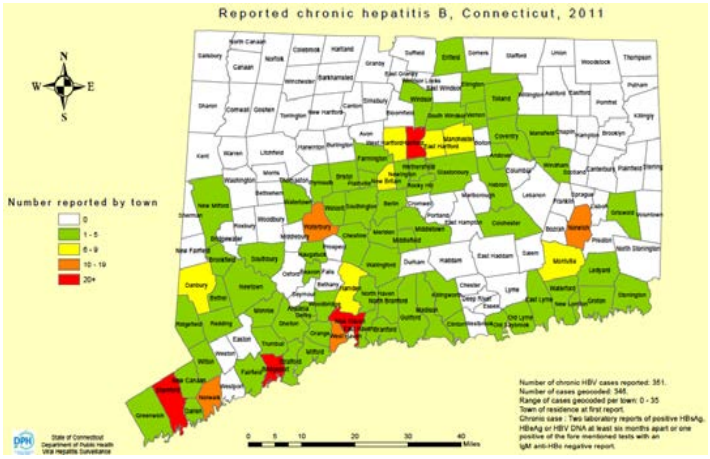


Source: CT Department of Public Health, AIDS and Chronic Diseases Section, http://www.ct.gov/dph/lib/dph/aids_and_chronic/surveillance/statewide/map_hiv_plw.pdf



Source: CT Department of Public Health AIDS and Chronic Diseases Section, Epidemiologic Profile of HIV/AIDS in Connecticut, 2013.

Figure 52: Chronic Hepatitis B, By Town, Connecticut, 2011



Source: CT Department of Public Health, Reported Chronic Hepatitis B, by Town, 2011; as cited in Healthy CT 2020.

Why Infectious Disease Prevention and Control Are Important

In addition to a significant decline in overall mortality and an increase in life expectancy over the past century, there has been a considerable shift in the leading causes of death. Chronic diseases have emerged as the leading causes of death in the 21st century, compared with infectious diseases in the 20th century. In 1900, the top 3 causes of death were infectious diseases - pneumonia and flu, tuberculosis, and gastrointestinal infections (a fourth disease, diphtheria, was the 10th leading cause of death). Improvements in sanitation, vaccine development, and medications such as antibiotics and antivirals, have all contributed to dramatic declines in deaths from infectious diseases during the 20th century. *Source: http://www.cdc.gov/nchs/data/dvs/lead1900_98.pdf*

Even with significant public health and medical advances, outbreaks of certain infectious diseases, such as tuberculosis and pertussis, have occurred periodically in the state and region over the past decade, reinforcing the need to remain vigilant to assure children and adults are vaccinated completely and on time, and to enhance disease surveillance efforts.

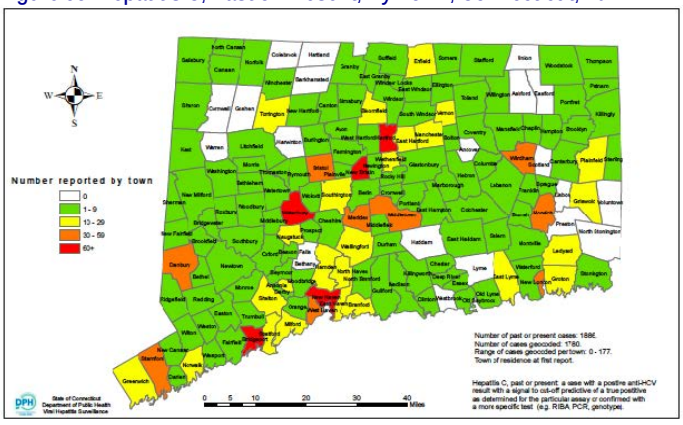
This section focuses on infectious diseases that have emerged as concerns in the state and region in recent decades, including Sexually Transmitted Infections (Chlamydia & Gonorrhea), HIV, Hepatitis B, Hepatitis C, and Tick-Borne Diseases.

Findings in the State and NW CT

For Service Area Towns (SATs), Chlamydia was the most commonly reported sexually transmitted infection (STI), followed by Gonorrhea, which is consistent with state trends. In CT, Chlamydia and Gonorrhea are most frequently diagnosed in young adults ages 20-24. Incidence rates for selected STIs are unreliable for most SATs, as the number of new cases each year is often less than 15. From 2011-2014, rates for Chlamydia and Gonorrhea in SATs were well below the state rate. Within SATs, rates for Chlamydia were consistently highest in Torrington. The number of diagnosed cases for both of these STIs in the county decreased from 2013 to 2014. *Sources: http://www.ct.gov/dph/cwp/view.asp?a=3136&q=388390; http://www.ct.gov/dph/lib/dph/infectious_diseases/std/table*

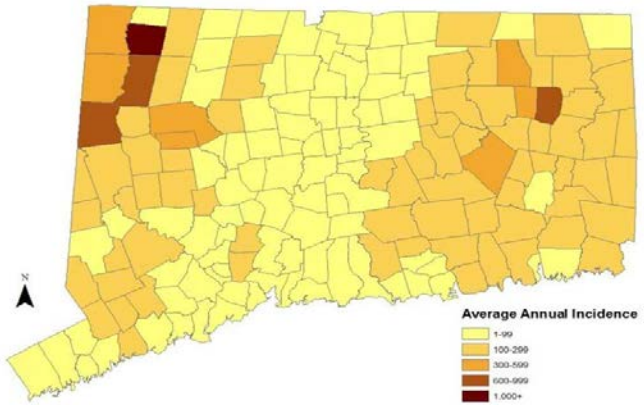
HIV infection continues to be a public health issue of concern. Rates are highest among males, and as shown in Figure 51, in residents ages 20-29, followed by residents ages 40-49. The primary risk factors for HIV infection in CT residents include men having unprotected sex with men (MSM), Injectable Drug Use (IDU), and unprotected heterosexual contact.

Figure 53: Hepatitis C, Past or Present, By Town, Connecticut, 2011



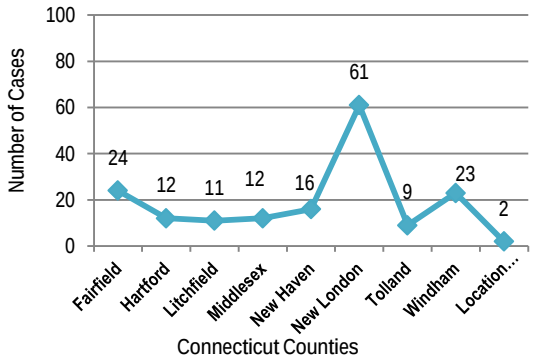
Source: CT Department of Public Health AIDS and Chronic Disease Section, Epidemiological Profile of HIV/AIDS in CT, 2013; as cited in Healthy CT 2020.

Figure 54: Average Annual Incidence of Lyme Disease, By Town, Connecticut, 2002-2012



Source: CT Department of Public Health; as cited in Healthy CT 2020.

Figure 55: Babesiosis Cases for All Connecticut Counties, 2014



Source: CT Department of Public Health - Infectious Disease Statistics, 2014http://www.ct.gov/dph/lib/dph/infectious_diseases/pdf_forms_/ct_disease_cases_by_county_2014.pdf

Hepatitis B, like HIV, is commonly acquired through unprotected sexual contact with persons who are infected and injection drug use. The number of cases reported in NW CT, as shown in Figure 52, is typically lower than those reported in the state overall.

Hepatitis C is most commonly transmitted through blood-to-blood contact with an infected person. Currently the most common risk factor is sharing injection drug syringes and equipment. Prior to screening of the blood supply in 1992, Hepatitis C was most commonly contracted through blood transfusions and transplants. The number of cases of chronic or resolved Hepatitis C in Litchfield County increased considerably from 2013 (89 cases) to 2014 (147 cases).

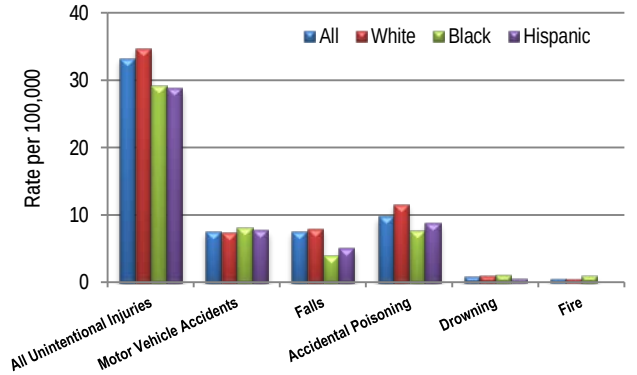
HIV, Hepatitis B, and Hepatitis C are preventable. Avoiding risky behaviors such as unprotected sex and injecting illicit drugs are critical. Childhood vaccination against Hepatitis B provides protection against contracting this disease. Early screening and detection for HIV and Hepatitis C are critical for persons in risk groups. Medication therapy for HIV and Hepatitis C has advanced considerably. For Hepatitis C, treatment with newly approved antiviral drugs has resulted in complete resolution of the infection in a high percentage of cases.

Tick-borne diseases, such as Lyme Disease and Babesiosis, are prevalent in rural areas of the state, such as NW CT. As can be seen in Figure 54, from 2002-2012, Canaan had the highest annual incidence of Lyme Disease in the state; among SATs, Litchfield and Morris the highest incidence rates.

Babesiosis is caused by microscopic parasites that infect red blood cells typically spread by certain ticks. Tick-borne disease transmission is most common during the summer months and can be prevented by wearing protective clothing, using repellants, and actively checking for ticks and showering after being outdoors.

INJURY AND VIOLENCE PREVENTION

Figure 56: Age-Adjusted Mortality Rate for Unintentional Injury, as Percent of Total Unintential Injury, by Type, Race and Ethnicity, CT, 2008-2012



Source: CT DPH-Mortality Tables, Age-Adjusted Mortality Rate Tables; http://www.ct.gov/dph/cwp/view.asp?a=3132&q=521462

Figure 57: Number of Deaths Due To Suicide, by Age Group, Connecticut, 2012

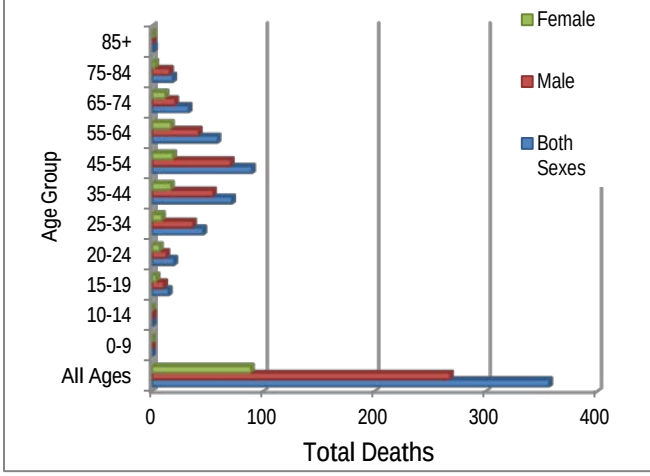


Figure 58: Total Deaths Due to Homicide, by Age Group, Connecticut, 2012

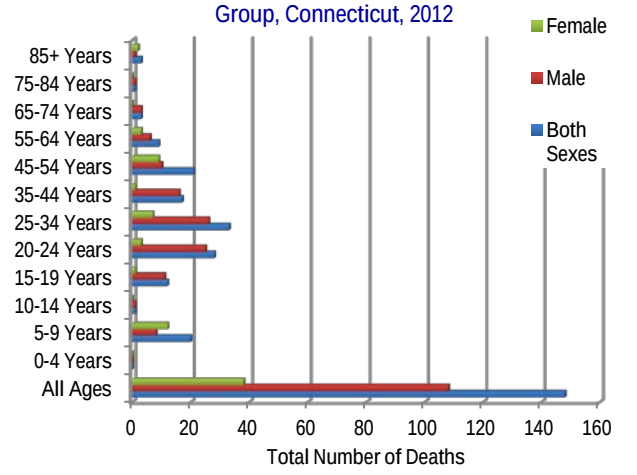


Figure 57 & 58 source: CT DPH: Vital Records; http://www.ct.gov/dph/cwp/view.asp?a=3132&q=394598&dphNav_GID=1601&dphPNavCtr=|#46987

Why Injury and Violence Prevention Are Important

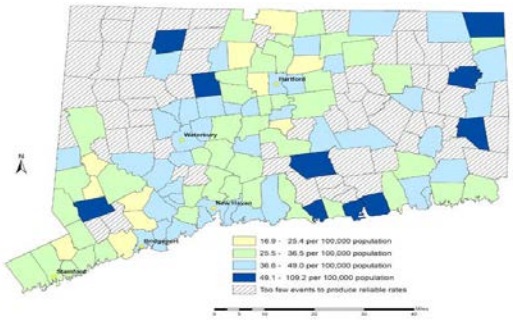
Injuries, whether intentional or unintentional, are a leading cause of premature death and disability, as well as health care costs and lost productivity in the workforce. Importantly, most unintentional injuries are preventable. For example, according to the National Institutes of Health, alcohol is a factor in 30 percent of suicides, 40 percent of crashes and burns, 50 percent of drownings and homicides, and 60 percent of falls. CDC reports that the use of seat belts reduces serious and fatal injuries by more than half. Intentional injuries include suicides, homicides, domestic violence and child abuse. Early intervention and treatment for mental health conditions and alcohol and drug abuse are preventive measures to reduce the rates of intentional injury.

Findings in the State and NW CT

In CT and the region, the major types of unintentional injury as shown in Figure 56, are accidental poisoning, falls, and motor vehicle accidents. Males were nearly twice as likely as females to die from unintentional injuries and motor vehicle accidents were the primary cause of injury death. The primary cause of unintentional injury-related death in females was falls. The rise in deaths by accidental poisoning is in large part attributable to deaths from prescription drug overdose in persons 15-24 years of age, which is addressed further in the Mental Health and Substance Use section of this report. Accidental drug intoxication deaths in CT (pure ethanol intoxications were excluded) are projected to increase by over 90% (from 355 to 679) from 2012-2015; heroin-related deaths are projected to more than double. *Source:http://www.ct.gov/ocme/lib/ocme/AccidentalDrugIntoxication2015.pdf*. Injury-related death rates in SATs were in the highest quartile for Winchester, and second highest quartile for Thomaston and Torrington.

As shown in Figures 57 and 58, CT males are more than twice as likely as females to die from suicide or homicide. Suicide deaths are most prevalent in males and females ages 35-54; homicides are most common in young adults, ages 15-34, with Black or African American males disproportionately affected. In CT, about two-thirds of all homicides and one-third of all suicides involve firearms (Healthy CT 2020).

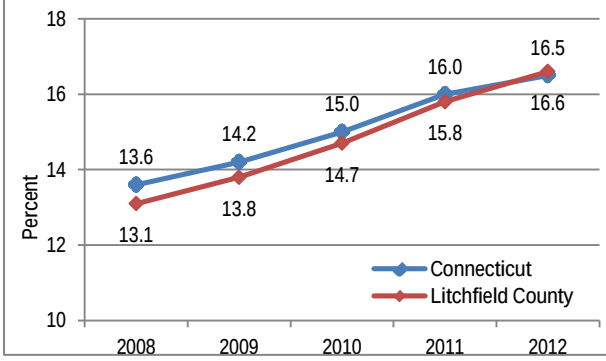
Figure 59: Unintentional Injury Age-Adjusted Death Rates, By Town, CT, 2006-2010



Source: Connecticut Department of Public Health, Health Statistics & Surveillance, Statistics & Analysis Reporting, 2006-2010.

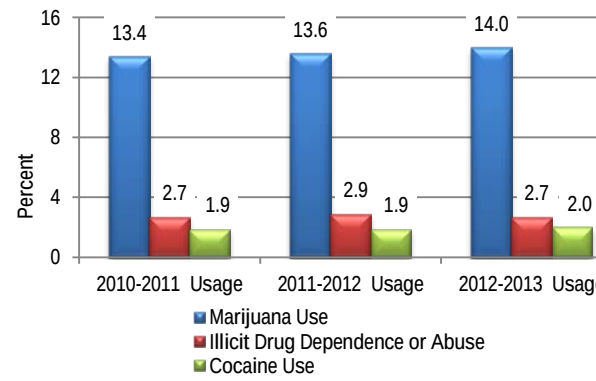
MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Figure 60: Percentage of Medicare Beneficiaries with Depression, CT & Litchfield County, 2008-2012



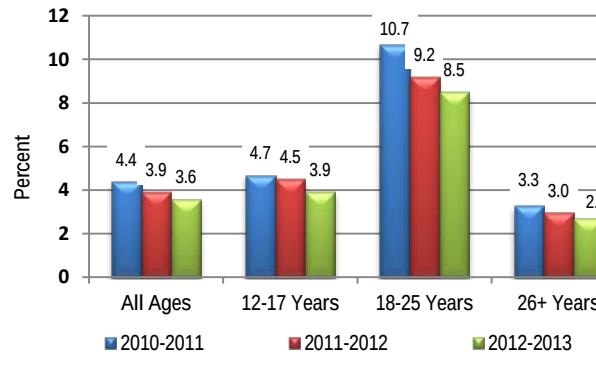
Source: Centers for Medicaid/Medicare Services, State-Level Chronic Conditions Reports, 2008-2012; https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CC_Main.html

Figure 61: Illicit Drug Use in Past Year, Among Persons Age 12+, Connecticut, 2010-2013



Source: SAMHSA - Survey on Drug Use and Health Model-Based Estimates, 2012-2013 http://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2012-2013-p1/ChangeTabs/NSDUHsaeShortTermCHG2013.htm

Figure 62: Non-Medical Use of Pain Relievers, by Age Group, Connecticut, 2010-2013



Source: SAMHSA-National Survey on Drug Use and Health Model-Based Estimates, 2010-2013; http://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2012-2013-p1/ChangeTabs/NSDUHsaeShortTermCHG2013.htm

Why Mental Health and Substance Use Disorders Are Important

Mental health and substance use disorders are inextricably linked to physical health. Mental health and substance use disorders are leading causes of disability in the state and region. Mental health disorders are widespread, with the main burden of illness concentrated among those suffering from a seriously debilitating mental illness. Just over 20 percent (or 1 in 5) children, either currently or at some point during their life, have had a seriously debilitating mental disorder. *Source: http://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml*

Findings in the State and NW CT

Results for the 2013 BRFSS indicate that 17% of CT adults had been diagnosed with some form of depressive disorder, with no differences by age group, racial/ethnic background, or health insurance status. Women were more likely than men to suffer from some kind of depression as were persons with lower income and educational levels, and persons with disabilities. As shown in Figure 60, analysis of data for Medicare beneficiaries (adults ages 65 and over) from 2008-2012 show an upward trend in the proportion of beneficiaries diagnosed with depression in the state and county.

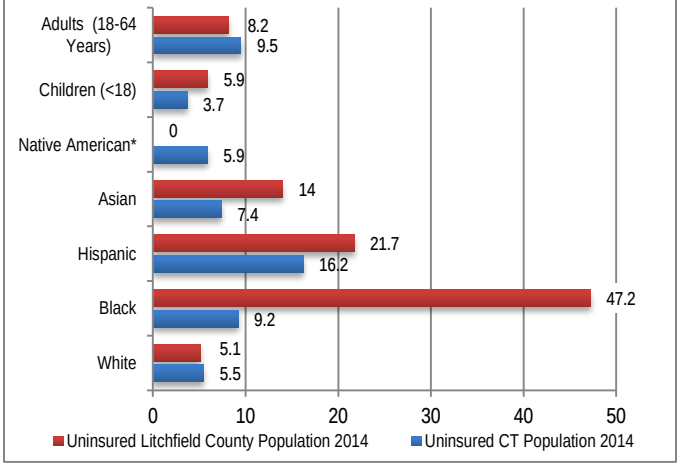
Depression is relatively common in adolescents, with one out of every three CT female high school students and 27% of high school (HS) students overall reporting they felt so sad or hopeless that they had stopped doing some usual activities. In addition, 18% of HS females and 14.5% of HS students overall indicated they had seriously considered attempting suicide. Local Youth Surveys conducted in NW CT high schools in 2014-2015 indicate that 21-24% of students were depressed and/or had attempted suicide.

Rates of illicit drug use in persons ages 12 and over have remained relatively stable from 2010-2013 with the exception of an increase in non-medical use of pain relievers, most notably in young adults ages 18-25 (Figure 62) . As detailed in the previous section, deaths due to accidental drug intoxication, especially heroin-involved deaths, have increased at an alarming rate statewide and within the region. Behavioral health, EMS, and health care providers in the region have responded proactively by forming the Litchfield County Opiate Task Force to develop and implement county-wide strategies for prevention, early detection, and counseling and treatment services for opiate use disorders.

Rates of underage drinking by adolescents and binge/excessive drinking by persons of all ages persist as key health concerns in the state and region, as state and NW CT rates far exceed national averages and *Healthy People 2020* targets.

LOCAL HEALTH CARE ENVIRONMENT - HEALTH CARE ACCESS

Figure 63: Percent of Uninsured CT Children and Adults, by Race and Ethnicity, CT and Litchfield County, 2014



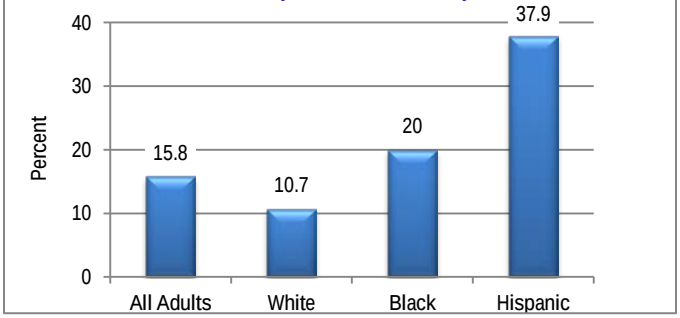
U.S. Census Bureau, American Fact Finder
http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_1YR_S2701&prodType=table

Table 16: Medically Underserved Areas or Populations (MUA/P) and Health Professional Shortage Areas (HPSA), CT, 2013

County	# of MUA/P Designations	# of HPSA Designations		
		Dental	Primary Care	Mental Health
Fairfield	6	9	7	8
Hartford	7	9	4	10
Litchfield	1	2	2	2
Middlesex	1	1	1	3
New Haven	8	7	6	7
New London	3	4	3	5
Tolland	1	2	1	2
Windham	2	3	2	3
Tribal Nation	*	2	1	1
Connecticut	29	39	27	41

Source: CT DPH, Primary Care Office, October 1, 2013; as cited in Healthy CT 2020
**Tribal Nations have their own special designation*

Figure 64: Percent of Adults Reporting Not Having a Personal Doctor, by Race and Ethnicity, CT, 2014



Source: The Henry J. Kaiser Family Foundation, State Health Facts, Providers and Service Use; http://kff.org/other/state-indicator/percent-of-adults-reporting-not-having-a-personal-doctor-by-raceethnicity/

Why Health Care Access is Important

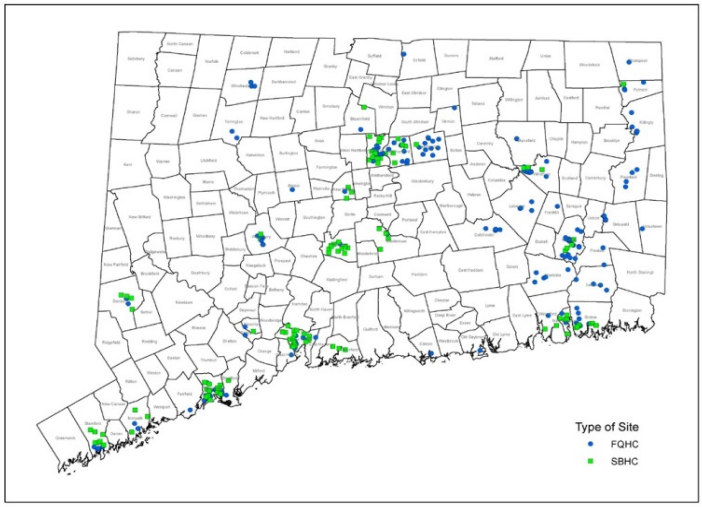
Equitable access to quality health care is important to eliminate health disparities and optimize individual and community health. Persons without health insurance coverage are less likely to have a usual and ongoing source of medical care ("medical home"), are more likely to report poor health, and to experience premature mortality than those with health insurance (Healthy CT 2020). With the enactment of the federal Patient Protection and Affordable Care Act (ACA), health insurance coverage is now required for U.S. citizens and legally documented residents. This federal law has increased the proportion of persons with health insurance coverage in the nation, state and region. Access Health CT <www.AccessHealthCT.com> was created by the Connecticut Legislature in 2011 to satisfy ACA requirements and serve as a central point of entry for individuals, families, and small employers to receive information on choices about their health care coverage options and to facilitate enrollment in a health insurance plan. Access Health CT also coordinates eligibility and enrollment with Medicaid and Children's Health Insurance Programs in CT.

Findings in the State and NW CT

Litchfield County is a federally-designated health professional shortage area. Within the county, Torrington is a federally designated primary care health professional shortage area. The *2015 County Health Rankings* report indicates that the county has a ratio of 1 mental health provider to every 548 residents, considerably below the national benchmark of 1 provider to every 386 residents. The county also has a shortage of primary care providers, with 1 primary care physician to every 1,563 residents, well below both the national benchmark of 1 primary care physician for every 1,045 persons and the state average of 1 primary care physician per 1,190 residents. There is also a shortage of dentists, with 1 provider for every 1,699 residents compared with the national benchmark of 1 per 1,377 residents.

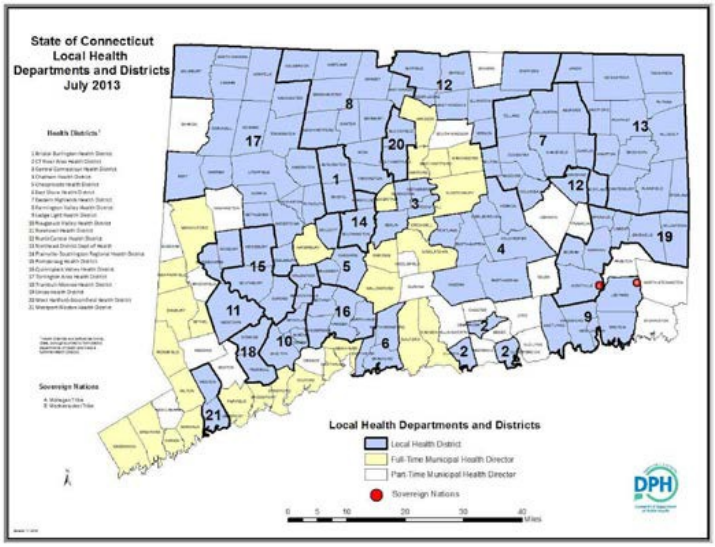
Litchfield County is home to three acute care hospitals: Charlotte Hungerford Hospital in Torrington, Western CT Health Systems-New Milford Campus of Danbury Hospital in New Milford, and Sharon Hospital in Sharon. In addition, there is one federally qualified health center located within the county, the Community Health and Wellness Center of Greater Torrington, with multiple service sites. Federally qualified health centers (FQHC) receive federal funding support to provide preventive, primary, and specialty care services in medically underserved areas. FQHC patients without insurance pay for care based on their income, using a sliding fee scale, however no one is refused care based on inability to pay. Analysis of Uniform Data System (UDS) Service Reports for 2014 show that the Community Health and Wellness Center patient population (> 7,000 patients) is disproportionately low-income (86% of family incomes were below 200% of the federal poverty level) , uninsured (15%), and minority (20%) when compared with the area population.

Figure 65: Federally Qualified Health Center and School-Based Health Center Locations, Connecticut, 2014



Note: FQHC indicates Federally Qualified Health Center, SBHC indicates School-Based Health Center. Source: Connecticut Department of Public Health, as cited in Healthy CT 2020

Figure 66: Local Health Departments and Districts, Connecticut, 2013



Source: Connecticut Department of Public Health, as cited in Healthy CT 2020

Table 17: 2-1-1 Service Requests for Litchfield County, 1/1/15-12/28/15

2-1-1 Request Category	Totals
Public Assistance Programs	1,354
Individual & Family Support Services	1,163
Utilities	935
Mental Health Evaluation & Treatment	911
Housing/Shelter	888
Counseling Settings	874
Health Supportive Services	663
Legal Services	480
Temporary Financial Assistance	281
Food	274
Substance Abuse Services	262

Source: United Way of CT: http://uwc.211ct.org

Muncipalities within the CHH service area are served by 2 full-time health districts. Torrington Area Health District serves the following SATs: Bethlehem, Cornwall, Goshen, Harwinton, Thomaston, Torrington, and Winchester. The Farmington Valley Health District serves Barkhamsted, Colebrook, and New Hartford. Phone, email, and website contact information is available at: http://www.ct.gov/dph/cwp/view.asp?a=3123&q=397740

There are a wide variety of additional health-related resources within the county. United Way of CT Infoline 2-1-1 maintains an up-to-date online searchable community resource database of health and human service providers, agencies, and organizations, available at http://www.211ct.org. United Way also publishes an annual report, The 2-1-1-Barometer - Identifying Unmet Needs in CT, highlighting gaps between service requests and available resources in the community. This report can be accessed at: http://www.ctunitedway.org/barometer.asp. There were over 9,500 service requests in NW CT to 2-1-1 in 2015. The most frequent service requests are presented in Table 17.

The *2012 Litchfield County Community Health Assessment* included GIS Asset Maps of Health-Related Programs & Services located within the county compiled by the CT Infoline Research & Evaluation Unit. Each map includes Resource Listings of the types of services provided. More detailed information on the programs and services included is available at www.infoline.org or by calling Infoline at 2-1-1. Key findings related to service availability and accessibility included:

- Tobacco cessation programs in the county are limited.
- Opportunities for physical activity appear to be available in most communities; however limited accessibility due to transportation may be a factor for many residents.
- There are no healthy eating/nutrition education programs presently available in the county.
- Clinical and preventive health services are concentrated in the three communities with acute care hospitals (New Milford, Torrington & Sharon); access to these services may be a factor for many residents.
- The geographic availability of health screening services in the county is limited as is the type.
- Health and mental health-related support groups are again concentrated in the three communities with acute care hospitals.
- The availability of mass transportation services in general, as well as medical transportation services and services for disabled persons, is limited in many communities.
- Housing for vulnerable population groups, including the elderly, disabled, and residents in need of emergency or supportive housing is limited and non-existent in many communities.

COMMUNITY INSIGHTS:

KEY INFORMANT INTERVIEW & FOCUS GROUP SUMMARY

KEY INFORMANT INTERVIEW & FOCUS GROUP SUMMARY FINDINGS

Background: This report section summarizes focus group and key informant interview findings conducted as part of the Community Health Needs Assessment (CHNA) for Northwest CT (NW CT). Findings are based on focus groups (FG) and key informant (KI) interviews conducted throughout the CHH primary service area during November and December of 2015. These attitude and perception discussions explored the current state of health care, health-related educational opportunities, emerging trends, and challenges and successes of the region's health delivery system. In all, 13 KI interviews and 2 focus groups were conducted. The individuals and groups interviewed were identified by Community Relations Committee (CRC) members for their respective expertise in the community.

Method: Members of CRC identified the following community leaders to participate in the KI interviews:

- Maria Abreu, Torrington area Latino community advocate
- Joanne Borduas, CEO, Torrington Community Health & Wellness Center
- Dr. Debra Brandt, Oncologist
- Donna Campbell, Executive Director, Greenwoods Counseling Referrals, Inc.
- Nancy Cannavo, Torrington Behavioral Health Center, Outreach to the Homeless
- Elinor Carbone, Mayor of Torrington
- Maria Coutant-Skinner, Executive Director, McCall Foundation
- Donna Labbe, Coordinator, Torrington Early Childhood Collaborative
- Dr. Roberta Meltzer, Primary Care Physician
- Tom Narducci, Administrative Director, Outpatient Behavioral Health at Charlotte Hungerford Hospital
- Leslie Polito, Public Health Nurse, Torrington Area Health District
- Ellen Schroeder, Director, Winsted Senior Center
- Joel Sekorski, Director, Elderly Care of Torrington

In addition to the KI interviews, a focus group was conducted with a group of 13 senior citizens at the Sullivan Center in Torrington. Additionally, a focus group with 9 young families was conducted in collaboration with the Family Resource Center in Torrington. Questions for both the KI and FG were adapted from the KI survey tools used in the CT Department of Public Health state health assessment, with input from CRC members, the Center for Healthy Schools and Communities, and the Center for Program Research & Evaluation (CPRE) at EDUCATION CONNECTION. CPRE staff then scheduled and conducted all interviews. Notes for each event were recorded and analyzed by CPRE research staff. Primary themes across all events were identified and are discussed below.

Results: Qualitative data analysis revealed eight overarching themes across the 13 KI interviews and 2 focus groups. Themes address access to services, emerging health trends, as well as major community provider strengths and areas in need of improvement.

Theme #1 - Positive Experiences with Care: Across many focus groups and KI interviews, participants reported satisfaction with available health services and positive feelings about care delivery. Participants discussed feeling listened to and understood by their clinicians, and many cited specific examples of incidences where CHH providers had a dramatic positive influence during a medical event. A prominent sub-theme identified was that many respondents who reported satisfaction with care reported receiving services from providers who took a personal interest in their cases.

Theme #2 - Bridges and Barriers to Trust: In many focus groups and KI interviews, participants discussed a variety of factors that either fostered or impeded the development of trust and a positive working relationship with and amongst health service providers. The open lines of communication between CHH and many of its community-based partners was one such factor. Many respondents spoke to the highly responsive nature of CHH staff in addressing problems within the community. "No issue ever falls on deaf ears at Charlotte. They go out of their way to make sure that our needs are being met." The language barrier that exists within the community, however, was identified as a barrier to trust. Respondents raised concerns about the lack of Spanish speaking providers at CHH. It was also noted that the wording on signage was sometimes inaccurate and not always culturally appropriate to native speaking individuals.

Several respondents discussed the need for enhanced respect for persons with substance use disorders receiving emergency department services. While respondents understood the tremendous burden these patients placed upon the system, they felt more empathy was warranted. A suggestion was made for patients to have a "Patient Navigator" to assist them in better understanding their condition as well as the services that are available to them once they are released from care.

Theme #3 - Systems Challenges and Barriers to Care: Systems challenges and barriers to care were prominent themes that emerged in all focus groups and KI interviews. Respondents discussed a range of experiences that they felt impeded their being able to receive or provide effective care. Examples of such experiences include:

- difficulty in attracting and retaining quality health care providers to the area
- lack of a local detoxification or pain management facility

- lack of communication around educational opportunities
- lack of available resources to expand much needed initiatives

Many respondents expressed frustration in their ability to recruit and hire qualified personnel. "It often takes several months to receive just a few applicants for a position we desperately need to fill" noted one individual. In some situations this results in services not being offered. When those services are offered, the staff is almost immediately overwhelmed. This is especially true of educational outreach opportunities. While many respondents discussed educational experiences they had been involved with which had improved their health dramatically, there was an overall sense of frustration with the lack of such opportunities. Some respondents went so far as to suggest they did not have the proper information to make the appropriate medical decisions. Staffing, financial and time constraints make the implementation of these much needed educational resources and services challenging.

There was an interest from those individuals for the health care community to do a better job in publicizing the resources and services available as well as reaching out to the community to determine what other needs are not being addressed.

Theme #4 - Community Access to Health Care: Access to health services outside of CHH was an area of focus for many participants. While most participants felt strongly that CHH does an excellent job in serving the community, the same participants expressed frustration in finding specialists close to where they lived. Additionally, many respondents noted that medical offices that did accept Medicare/Medicaid had very long waiting lists. Difficulties in accessing the following services were identified as major concerns:

- Primary Care
- Medical Specialists, specifically:
    - Neurologists
    - Cardiologists
    - Otolaryngologists
- Psychiatrists
- Psychologists
- Dentists
- Addiction Counseling and Treatment Facilities
- Clinical Laboratory/Diagnostic Services

Theme #5 - Emerging Trends: A question asked of all KI and focus group respondents focused on the identification of health care related trends in the community. Responses included:

- The increased use of opiates and other addiction related issues. While this issue has been well described, respondents discussed the trend of addiction starting at a much earlier age. The increased number of sober houses has strained the emergency services in some communities.
- Difficulty in navigating the insurance system. While most respondents agreed that the system has improved since the passing of the ACA, there was still a great deal of frustration in receiving services. This was especially true in the senior citizen community.
- Increased awareness around mental health disorders. The lack of mental health professionals and the dramatic increase in the need for their services was identified as a major area of need. The number of individuals diagnosed with Serious and Persistent Mental Illness (SPMI) puts a tremendous burden on the health care system. The added emphasis on dual diagnosis has made an impact on how patients are treated, however more work needs to be done on educating the broader community.

Theme #6 - Impacts to the Greater Community: The rise in addiction issues highlighted as an emerging trend in our findings has a broader impact in the community as described by several respondents. Several communities in the area have experienced a growth in the number of sober houses operating primarily in downtown locations. While these sober houses provide a valuable service to those individuals who need them, those individuals are often not town residents. Community members expressed concern that the services required by the sober houses may ultimately compromise the police and fire departments' abilities to respond to other emergencies.

Theme #7 - Transportation: The rural nature of the CHH catchment area results in unique challenges in regards to access to services. Many respondents identified their inability to receive and provide services because of a lack of reliable transportation. Many needed services (i.e. mental health services for minors, specialty and sub-specialty providers) cannot be found in the catchment area. It is often impossible for families in need to travel to areas where these services are available. Seniors also discussed the lack of reliable transportation as a major reason they do not receive the services they may need. Thomaston was discussed as having no clinical laboratory or diagnostic centers. If individuals did not have access to personal transportation it would be very difficult for them to travel to another town to receive the services they might need.

Theme #8 - Healthy Life Services: Many respondents discussed the issue of moving more toward a "wellness model" and away from a "treatment model" when it comes to providing services. Providing proper nutrition education and services was identified as the key starting point. This issue was also identified as a key factor in the differences between economic groups within the community. One respondent noted, "We are killing the poor by denying them access to better food options". Respondents mentioned greater educational opportunities to teach individuals how to make healthier life choices, especially amongst the younger individuals. It was suggested that more work should be done in educating schools and area doctors in identifying mental health disorders.

Discussion and Implications:

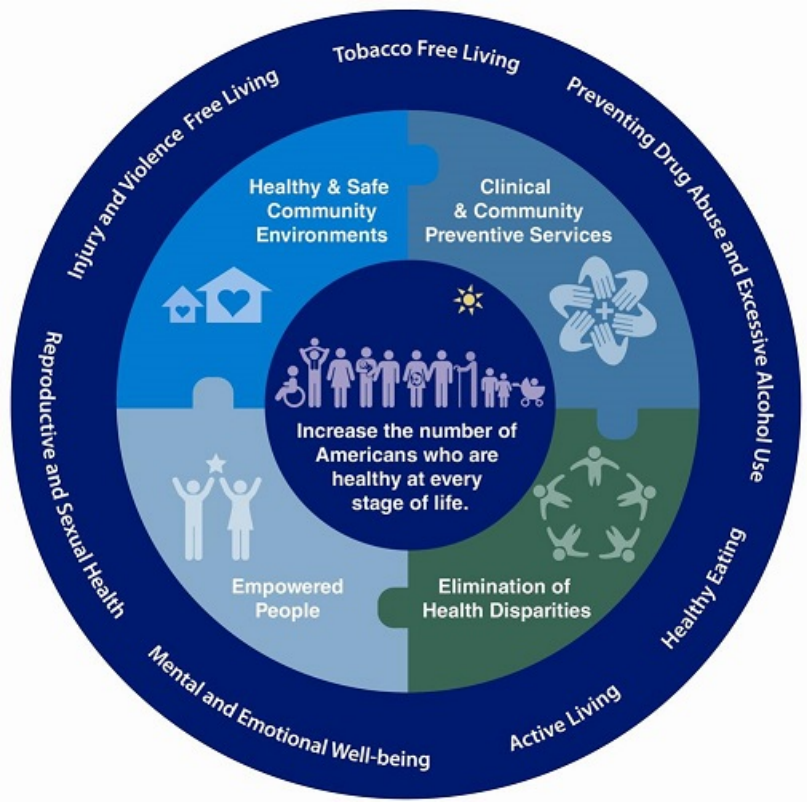
The findings discussed in this report highlight the complex and dynamic role that CHH and its partners play within the community. Eight overarching themes are discussed which summarize a range of positive, as well as negative, perceptions and attitudes. Further, it is important to note that many of the negative perceptions discussed exist within a broader context. For example, themes that suggest lack of resources are not unique to the rural setting of CHH; rather they mirror patterns that have challenged health care in such settings for decades. Nevertheless, the challenges discussed in this report represent an important call to action.

Service providers and users traditionally have a strong understanding of what works for them. This was well illustrated by the range of recommendations for improving services offered by respondents. While all may not be feasible to implement now, some represent actionable items that can be implemented with limited system effort or costs.

Conclusion:

Undertaking this evaluative work speaks to CHH's longstanding commitment to creating a system of care that is responsive to the community they serve. This same commitment will likely fuel next step efforts to build on system strengths. Working in partnership with all key stakeholders, it is imperative that recommendations offered are further developed and prioritized such that interventions are aligned from personnel, policy, fiscal, and administrative perspectives.

OPPORTUNITIES FOR ACTION



NEXT STEPS: OPPORTUNITIES FOR ACTION

Improving the health of the residents of NW CT will only be achieved through collaboration and coordination among key stakeholders throughout the region and state, across all sectors - government, schools and higher education institutions, health care providers, public health agencies, voluntary health agencies, civic organizations, businesses, and community and faith-based organizations. The next step - development of a Health Improvement Plan for Northwest Connecticut - will utilize a collaborative strategic planning process guided by the key findings from this 2015 *Community Health Needs Assessment Update*. Once developed, the NW CT Health Improvement Plan will serve as a roadmap for collective action by building on existing community assets, leveraging resources, and engaging public and private partners to improve the health of NW CT residents.

Based on the findings of this 2015 CHNA Update for NW CT, the following key and emerging health issues have been identified for prioritization and collective community health improvement planning.

Behavioral and Lifestyle Factors:

- ✧ Although not statistically significant, area residents more frequently reported the following negative health behaviors than state residents on average: heavy drinking; current smoking; not having their blood sugar tested; not having a check-up in the past year, not having a flu shot, a Pap smear, or PSA screening.
- ✧ Area males more frequently reported the following negative health practices/behaviors at statistically significant levels: current binge drinking, no check-up within the past year, and not having a flu shot.
- ✧ Area residents with annual incomes below $35,000 per year more frequently reported the following at statistically significant levels: current smoking, not being physically active in the past month, having diabetes, not being able to afford medical costs, no dental visit in the past year, having a heart attack, no colorectal screening, and no mammogram screening (for females).
- ✧ Data from the 2013 BRFSS indicate that nearly one in three (31%) CT adults have been told they have high blood pressure by a health professional; that percentage increases to 54% for persons ages 55 and over. High blood pressure is more common in males, Black non-Hispanic adults, and in persons with lower education and income levels.
- ✧ Over one-third of CT adults (38%) have been told they have high blood cholesterol; this increased to 54% for ages 55 and over. White non-Hispanics were most likely to report high cholesterol, as were individuals with lower educational attainment.

The Burden of Chronic Diseases:

- ✧ Residents in many Service Area Towns (SATs) experienced a higher than average burden of premature death from heart disease, measured in Years of Potential Life Lost (YPLL). YPLL rates for Service Area Towns (SATs) in 2006-2010 were in the highest quartile in Winchester, and second highest quartile in Harwinton, Litchfield, Thomaston, and Torrington.
- ✧ County Health Rankings and CHSI Health Indicators of highest concern include: Alzheimer's/dementia, asthma and depression in older adults, and adult binge drinking.
- ✧ By race and ethnicity, AAMR rates (2008-2012) were *higher* for Black or African American county residents than the state average for malignant neoplasms. For Hispanic or Latino county residents, AAMR rates were *higher* than state rates for major cardiovascular diseases (CVD). AAMR rates were *higher* than the state rates for White residents for all causes, major CVD, chronic lower respiratory diseases (CLRD), chronic liver disease and cirrhosis, accidents, and alcohol-induced deaths.
- ✧ Emergency department visit rates were *lower* for Hispanic or Latino county residents and *higher* for Whites and Black or African American residents than the state averages for these same population subgroups.
- ✧ Prevention Quality Indicator (PQI) rates for asthma and hypertension in Black or African American adults in the county were *double* the rate or more in White or Hispanic adults. For children, PQI rates for diabetes short-term complications and perforated appendix in Hispanic children were *more than double* the rate in White non-Hispanic children.
- ✧ Emergency Department visit rates for selected diagnoses show rates for heart disease and stroke were *higher* in Litchfield County than in the state overall; mental health and alcohol and drug abuse visit rates were *lower* than the state rates.
- ✧ The most frequent cause of inpatient hospitalization in the service area was Hypertension (High Blood Pressure), followed by Type II Diabetes, Depression, Chronic Obstructive Pulmonary Disease, and Heart Failure. Hypertension was also the most frequent reason for Emergency Department visits, followed by falls, Type II Diabetes, Asthma, and alcohol and substance abuse.

Cancer:

- ✧ By site, cancer incidence rates for Litchfield County were *significantly lower* than the state rate for breast cancer, kidney and renal pelvis cancer, and significantly *higher* than the state rate for skin cancer (melanoma). The higher incidence rate for skin cancer in the county is likely attributable to the high proportion of Caucasians in the population compared with the state.
- ✧ Overall mortality rates for cancer are *higher* for Black or African American residents in the county, which is consistent with cancer mortality rates for state residents overall.

- ✧ Data from the 2012 BRFSS specific to the TAHD service area in NW CT indicate that 21% of residents ages 50+ reported never having colorectal screening (sigmoidoscopy/colonoscopy); 18% of women ages 40+ reported never having a mammogram; 25% of women reported not having a PAP test in the past 3 years, and 63% of men ages 40+ indicated that they had not had PSA testing in the past two years. Participation rates in colorectal and mammography screening were significantly *lower* for persons reporting incomes below $35,000 per year than for those with incomes of $70,000 per year or higher.

Maternal, Infant, and Child Health:

- ✧ In 2007-2011, Torrington and Winchester were in the second highest quartile in the state for low birthweight births and highest quartile for preterm births in the state. Notably, based on birth certificate data, mothers in these two communities reported the highest levels of smoking during pregnancy during this period as well.
- ✧ In 2010-2012, Infant Mortality Rates in Litchfield County were nearly twice the state rate. According to analyses performed by the CT Department of Public Health, these differences were found to be statistically significant ($p < .05$). This difference is attributed in part to the higher proportion of multiple-birth pregnancies in Litchfield County mothers compared with the state, a known risk factor for poorer birth outcomes.
- ✧ According to 2012 BRFSS results, one in five CT children in the TAHD services area was obese according to Body Mass Index (BMI) for age standards. For children living in households with incomes below $35,000, this increased to one in every three children (based on adult parent responses to BRFSS questions).

Mental Health & Substance Use:

- ✧ E-cigarette use by youth is significantly higher in CT than in the U.S. overall.
- ✧ Reported heroin use in high school students in the state and region exceeded national averages.
- ✧ Rates of underage drinking by adolescents and binge/excessive drinking by persons of all ages remain key concerns in the state and region, as rates exceed national averages and benchmarks. Alcohol is a major contributor to both intentional and unintentional injuries.
- ✧ Mental health issues such as depression are relatively common in adolescents as well as adults.
- ✧ Mental health and substance use disorders are inextricably linked to physical health and are leading causes of disability in the state and region.

Infectious Diseases:

- ✧ HIV, Hepatitis B, and Hepatitis C are preventable. Vaccination for Hepatitis B and avoiding risky behaviors such as unprotected sex and injecting illicit drugs are critical.
- ✧ Tick-borne diseases, such as Lyme Disease and Babesiosis, are more prevalent in rural areas of the state, such as NW CT. For SATs, Litchfield and Morris had annual Lyme Disease incidence rates above the state average.

Injury:

- ✧ The rise in deaths by accidental poisoning is in large part attributable to deaths from prescription drug overdose in persons 15-24 years of age. Accidental drug intoxication deaths in CT are projected to nearly double from 2012-2015; heroin-related deaths are projected to more than double.
- ✧ Injury-related death rates in SATs were in the highest quartile in the state for Winchester, and second highest quartile for Thomaston and Torrington.

Health Care Access:

- ✧ Within the county, Torrington is a federally designated primary care health professional shortage area. The county has 1 primary care physician to every 1,563 residents, well below both the national benchmark of 1 primary care physician for every 1,045 residents and the state average of 1 primary care physician per 1,190 residents. The county has a ratio of 1 mental health provider to every 548 residents, considerably below the state average of 1 provider to every 323 residents, and national benchmark of 1 provider to every 386 residents. The county also has a lack of dentists, with 1 dentist for every 1,699 residents compared with the national benchmark of 1 provider to every 1,377 residents. Lack of available primary care, specialty, and sub-specialty health services in the region due to provider shortages was a common theme from the Key Informant Interviews and Focus Groups conducted as an integral component of the assessment process.

Looking Back: Comparisons to the 2012 CHNA

When compared and contrasted with the findings of the 2012 Litchfield County Community Health Needs Assessment (CHNA), this *Community Health Needs Assessment for Northwest CT 2015 Update* offers valuable insights into emerging and continuing trends. Due to its focus on the burden of chronic diseases, the 2012 CHNA did not include indicators related to Maternal and Infant Health, Child and Adolescent Health, Injury, and Infectious Disease Prevention and Control. The chart below highlights trends in key indicators that were included in both assessments when consistent data sources were used to permit comparisons.

Indicator	2012 Litchfield County CHNA	2015 CHNA Update	Trend
Demographics	2010 U.S. Census data shows that the median age of county residents is rising, with the greatest increase among persons ages 50 and over.	2013 U.S. Census county population estimates indicate that the number of persons ages 55-74 has increased considerably.	Increased proportion in population ages 55 and over
	County population is projected to increase at a rate *similar to state*, according to 2015-2030 projections from CT State Data Center.	Latest projections from the CT State Data Center show a reduced future rate of growth from 2015-2025 of 0.5% compared with a state average of nearly 3%.	County is growing *at a slower rate* than state.
	CERC and CSDE data show county residents overall have higher education and income levels than the state average.	CSDE data shows high school graduation rates in NW CT continue to be above the state average, with the exception of one school district. CERC data shows overall median household income increased from 2010-2012 in all but 3 SATs.	Positive trends in income and education levels continue.
	2010 CERC data report county residents have lower poverty rates (5.3%) than the state (8.7%).	2012 CERC data shows an average of 6.2% for the county, well below the state average of 10%.	Slight increase in county poverty rates, however remain below state rates
	Over two-thirds of the county's municipalities experienced a decline in household median income from 2009-2010.	Corresponding 2012 CERC data shows median household incomes increased in all SATs except Bethlehem, Goshen, and New Hartford.	Positive trend
	CSDE data for 2009-2011 indicates an increase in the proportion of children eligible for free or reduced school meals in most districts.	CSDE data for 2011-2013 shows that the percentage of students eligible for free or reduced meals decreased in 5 SAT school districts, and increased in 4 SAT districts.	Mixed trend
	According to 2010 UCR data, overall safety in the county compares favorably to state.	2014 UCR data shows the county's overall crime index compares favorably with the state *and* has declined since 2010.	Positive trend
Behavioral & Lifestyle Factors	According to 2010 County Health Rankings, the rate of adult smoking in the county (18%) exceeds the state average (16%).	According to 2015 County Health Rankings, the rate of adult smoking in the county (17%) remains above the state average (15%).	Favorable downward trend, however county's rate remains above the state's.
	Based on 2009 CT Youth Tobacco Survey results, cigarette smoking declined from 2000-2009 by 66% among middle school students and 40% in high school students in CT.	Based on 2013 CT Youth Tobacco Survey results, this decline in cigarette smoking has continued, dropping to a record low.	Positive trend for cigarette smoking, however e-cigarette use has increased.
	2010-2011 CSDE data shows students in *nearly half* of the county's school districts scored below the state average in standardized physical fitness tests.	2012-2013 CSDE data shows that students in *more than half* of the districts serving SATs scored below state average, with considerable declines in the % passing in several districts.	Mixed trend for SAT school districts
	According to 2012 *County Health Rankings,* county residents did not meet national benchmarks for poor physical and mental health days, adult smoking, excessive drinking, and preventable hospital stays.	According to 2015 *County Health Rankings,* County residents still do not meet national benchmarks for these same indicators.	Indicator with the largest discrepancy is excessive drinking: 19% in county compared with the national benchmark of 10%.

	According to the 2012 County Health Rankings report, Litchfield County ranked favorably -- 3rd of 8 counties -- for health factors, and 4th of 8 counties for health outcomes.	According to the 2015 County Health Rankings report, Litchfield County's ranking for health factors dropped to 4th. The ranking for health outcomes remained the same.	Slightly negative trend in overall health factor ranking
ED Visits & Hospitalizations	According to the 2012 County Health Rankings Report, the county has a ratio of 1 primary care physician to every 1,123 residents – well below state and national benchmarks.	According to the 2015 County Health Rankings Report, the county has a ratio of 1 primary care physician to every 1,563 residents – even further below state and national benchmarks.	Negative trend
	2005-2009 data from CT DPH shows that overall, county residents had higher ED visit rates than the CT average for major CVD, coronary heart disease, heart attacks, congestive heart failure, and stroke.	2010-2014 data from the CT DPH indicate that county ED visit rates for heart disease and stroke are still higher in the county than in the state overall.	Continuing trend
	2005-2009 data from the CT DPH shows that county residents had lower ED visit rates for alcohol & drug use than the CT average.	2010-2014 data from the CT DPH also shows that county residents had lower ED visit rates for alcohol & drug use than the state average.	Continuing trend
	2005-2009 CT DPH data shows ED visit rates for Black non-Hispanic residents well above state and county averages.	2008-2012 CT DPH data shows ED visit rates for Black non-Hispanic residents well above county averages and state averages.	Continuing trend
Mortality Data	2005-2009 AAMR data from the CT DPH shows that rates for the county and state are comparable, and that county all-cause mortality rates for White non-Hispanics are higher, and rates for Black non-Hispanics and Hispanics are considerably lower than the state rates.	2008-2012 AAMR data shows that county and state rates continue to be comparable; however county rates show an increase in AAMR for Black or African American residents. Overall mortality rates in the state and county were lowest for Hispanic or Latino residents, consistent with the 2012 CHNA.	Mixed trend
	According to CT DPH data, county AAMRs (2005-2009) are *lower than* state rates for many causes of death including malignant neoplasms, diabetes mellitus, and Alzheimer's disease.	2008-2012 AAMR data shows that county AAMRs continue to be lower than the state for malignant neoplasms and Diabetes Mellitus, and are comparable (< 1 point difference) for Alzheimer's disease.	Mixed trend
	2005-2009 CT DPH data shows county AAMR rates are *above* the state for major CVD, pneumonia and influenza, CLRD, accidents, and alcohol & drug-induced deaths.	2008-2012 AAMR data shows that rates remain higher than the state average for major CVD, CLRD, accidents, and alcohol & drug-induced deaths, but are now comparable to the state average for pneumonia and influenza.	Mixed trend
	CT DPH data show the largest contributors to premature death in the state and county are cancer, accidents, major CVD, and drug-induced deaths.	2008-2012 DPH data shows these remain the four leading causes of premature death in both the state and the county.	Continuing trend

PARTNERS AND CONTRIBUTORS

This *Community Health Needs Assessment for Northwest CT 2015 Update* reflects the contributions of many individuals and community stakeholders. First and foremost, the dedicated members of the Charlotte Hungerford Hospital Community Relations Committee listed below contributed their time and expertise in review of the content of the assessment and are now spearheading the development of a Community Health Improvement Plan based on the key findings of this report.

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In addition, by participating in the Key Informant Interviews or organizing the Focus Groups, the following official and community agency representatives provided vital insights to inform the assessment process:

- Maria Abreu, Torrington area Latino community advocate
- Joanne Borduas, CEO, Torrington Community Health & Wellness Center
- Dr. Debra Brandt, Oncologist
- Donna Campbell, Executive Director, Greenwoods Counseling Referrals, Inc.
- Nancy Cannavo, Torrington Behavioral Health Center, Outreach to the Homeless
- Elinor Carbone, Mayor of Torrington
- Maria Coutant-Skinner, Executive Director, McCall Foundation
- Donna Labbe, Coordinator, Torrington Early Childhood Collaborative
- Dr. Roberta Meltzer, Primary Care Physician
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- Ellen Schroeder, Director, Winsted Senior Center
- Joel Sekorski, Director, Elderly Care of Torrington
- Michelle Anderson, Coordinator, Torrington Family Resource Center

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- Office of Health Care Access
- Lloyd Mueller, PhD, Senior Epidemiologist, Connecticut Tumor Registry, Principal Investigator, Health Statistics & Surveillance Section
- Karyn Backus, MPH, Epidemiologist 3, Health Statistics & Surveillance Section
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The information which follows regarding selected measures and data sources included in this Community Health Needs Assessment for Northwest CT 2015 Update are excerpts from the Litchfield County 2012 Community Health Needs Assessment Technical Appendices and the Definition of Measures in the state health assessment, Healthy Connecticut 2020. Please consult these source documents for more detailed information.

Lifestyle and Behavioral Health Risk Data

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) survey is a state-based system of health surveys that generate information about health risk behaviors, clinical preventive practices, and health care access and use. The BRFSS, sponsored by the Centers for Disease Control and Prevention, is the world's largest telephone survey, and is conducted in all 50 states. This includes a randomly selected adult (aged 18 or older) within a randomly selected household with a landline telephone, or a randomly selected cellular telephone owned by an adult with no landline or who uses their cellular telephone for 90% of their calls. Only non-institutionalized adults are included (no nursing homes, prisons, college dorms, etc.). Racial and ethnic classifications are based on self-report and include White, non-Hispanic, Black, non-Hispanic, and Hispanic (including persons of any race). Other national and state-specific risk factor data and information regarding BRFSS methodology can be accessed on the CDC's BRFSS website at: *http://www.cdc.gov/brfss/.*

Connecticut School Health Survey - Youth Behavior Component

The Connecticut School Health Survey (CSHS) is a comprehensive survey that consists of two components: Youth Tobacco Component (YTC) and the Youth Behavior Component (YBC). The YBC collects data that is used to monitor priority health-risk behaviors and the prevalence of obesity and asthma among high school students in Connecticut. The CSHS is conducted by the Connecticut Department of Public Health in cooperation with the CDC, the Connecticut State Department of Education, and partners from local school health districts and local health departments. The YBC is administered to a representative sample of all regular public high school students in Connecticut. Racial and ethnic classifications are based on self-report and include White, non-Hispanic; Black, non-Hispanic; and Hispanic (including persons of any race). Further information about the CSHS can be found on the Connecticut Department of Public Health's web site: *http://www.ct.gov/dph/cshs.* Other national and state-specific youth risk factor data and information can be accessed on the CDC's web site: *http://www.cdc.gov/HealthyYouth/YRBS/.*

County Health Rankings

Rankings are based on a number of factors including health outcomes, social and behavioral risk, and policy/programmatic environment. For detailed information about the modeling factors, see: *http://www.countyhealthrankings.org/our-approach.* For a list of the indicators used to develop the rankings, see: *http://www.countyhealthrankings.org/sites/default/files/2012%20Measures%2C%20Data%20sources%20and%20years_0.pdf.*

Mortality and Morbidity Data

Connecticut Vital Records Mortality Files

The Connecticut Vital Records Mortality Files are part of the state's vital statistics database that contains records pertaining to deaths that occur within the state as well as deaths of Connecticut residents occurring in other states, or in Canada. Mortality statistics are compiled in accordance with the World Health Organization (WHO) regulations, which specify that deaths be classified by the current Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death.[1] Deaths for the 1999-2012 period are classified by the Tenth Revision of the International Classification of Diseases (ICD-10). The race-ethnicity designation is typically based on report by next of kin, a funeral director, coroner, or other official, often based on observations. As such, the race-ethnicity designation based on observation may be reported incorrectly. Death Registry data follow the National Center for Health Statistics guidelines for coding race and Hispanic ethnicity.

Connecticut Hospital Information Management Exchange (CHIME) Hospital Discharge and Emergency Department Data Set

Data on hospitalization, both inpatient admissions and emergency department (ED) visits, are available from individual hospitals and the Connecticut Hospital Information Management Exchange (CHIME), an affiliate of the Connecticut Hospital Association (CHA). The CHIME-Data Program is a proprietary healthcare information system that member hospitals use to record patient, clinical, provider, and financial information. CHIME began in 1980 with collection of inpatient data from Connecticut's acute care hospitals. Since then, the CHIME database has expanded to include information about care-related finances, hospital-based ambulatory surgery, ambulatory medical records, and ED data.

Connecticut hospitals are legally mandated to report financial, utilization, and certain statistical information to the DPH (Public Health Code § 19a-654). Accordingly, on the behalf of its member hospitals, CHA submits CHIME data to the DPH Office of Health Care Access (OHCA) annually; hospitals that do not participate in CHIME submit data directly to OHCA. Since 2006, hospital discharge and billing data from Connecticut's acute care hospitals have been submitted to OHCA. In addition to age, gender, and town of residence, the demographic data elements include race and ethnicity. Race and ethnicity may be based upon observation of the

patient or self-reporting by the patient. It should be noted that counts reflect hospitalizations not persons. For example, a patient admitted to a hospital on two separate occasions in 2012 would be counted twice in these data.

Age-Adjustment (Mortality Rates, Hospitalization Rates, and ED Visit Rates)
Age adjustment is the application of observed age-specific rates to a standard age distribution to eliminate differences in crude rates in populations of interest that result from differences in the populations' age distributions. This adjustment permits comparisons among two or more populations at one point in time or one population at two or more points in time. In this report, mortality rates, hospitalization rates, and ED visit rates have been age-adjusted.

Years of Potential Life Lost (YPLL) represents the number of years of potential life lost by each death before a predetermined end point (e.g., 75 years of age). Whereas the crude and adjusted death rates are heavily influenced by the large number of deaths among the elderly, the YPLL measure provides a picture of premature mortality by weighting deaths that occur at younger ages more heavily than those occurring at older ages, thereby emphasizing different causes of death. Age-adjusted YPLLs are calculated using the methodology of Romeder and McWhinnie.[2] This method consists of a summation of the number of deaths occurring at each age (between 1 and 75) multiplied by the remaining years of life had the deceased lived up to age 75.

Maternal & Infant Data

Birth Rates
The birth rate in a given population is the number of births per 1,000 population. The teen birth rate is calculated based on the number of births per 1,000 females in the population ages 15-19 years of age.

Infant Mortality Rate
The Infant Mortality Rate is the number of infant deaths before 1 year of age, per 1,000 live births in the population.

Low Birthweight Rate
The rate of low birthweight births is the number of low birthweight births (<2500 grams) per 100 live births in the population.

Preterm Birth Rate
The preterm birth rate is the number of infants born at less than 37 weeks gestation per 100 live births in the population.

Late Prenatal Care
Late prenatal care is the proportion of pregnant women who received prenatal care beginnning in the second or third trimester of pregnancy in the population.

Demographic Data

U.S. Census
The U.S. Census counts every resident in the United States. It is mandated by Article I, Section 2 of the Constitution and takes place every 10 years. The data collected by the decennial census determine the number of seats each state has in the U.S. House of Representatives and is also used to distribute billions in federal funds to local communities. 2010 Census data are available for all places regardless of size. *The results from the 2010 Census are available in a number of datasets in American FactFinder, which can be accessed at http://factfinder2.census.gov.*

American Community Survey
The American Community Survey (ACS) is a nationwide survey designed to provide communities with timely information about population changes. It is a critical element in the census program. The ACS collects information such as age, race, income, commute time to work, home value, veteran status, and other important data. As with the 2010 decennial census, information about individuals remains confidential.

U.S. Census Designations of Race and Hispanic Origin
The U.S. Census Bureau collects race and Hispanic origin information following the guidance of the U.S. Office of Management and Budget's (OMB) 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. These federal standards mandate that race and Hispanic origin (ethnicity) are separate and distinct concepts and that when collecting these data via self-identification. OMB requires federal agencies to use a minimum of two ethnicities: Hispanic or Latino and Not Hispanic or Latino. Hispanic origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be any race.

Starting in 1997, OMB required federal agencies to use a minimum of five race categories: White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander. For respondents unable to identify with any

of these five race categories, OMB approved the Census Bureau's inclusion of a sixth category—Some Other Race—on the Census 2000 and 2010 Census questionnaires.

The race categories included in the census questionnaire generally reflect a social definition of race recognized in this country and are not an attempt to define race biologically, anthropologically, or genetically. For more information on race and Hispanic origin in the United States, visit the Census Bureau's Internet site at *http://www.census.gov/population/hispanic* and *http://www.census.gov/population/race*.

Information on other population and housing topics is presented in the 2010 Census Briefs series, located on the Census Bureau's web site at *http://www.census.gov/2010census/*. This series presents information about race, Hispanic origin, age, sex, household type, housing tenure, and people who reside in group quarters.

Connecticut Economic Resource Center, Inc. (CERC) Town Profiles

Detailed information about the CERC Town Profile data sources can be found at *http://cerc.com/images/customer-files//CT_TP_Data_Sources.pdf*.

2010 Population Data - U.S. Census; American FactFinder

2012 Population Data & 2012 Poverty Rate - American Community Survey 2008-12

Connecticut Data Center (University of Connecticut) Population Data

2010 Population Data - U.S. Census

2015-2025 Population and Median Age Projections - information on the modeling methodology used can be accessed at: *http://ctsdc.uconn.edu/2015_2025_projections/*

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