Exhibit 2 – Community Health Needs Assessment (Item #2)

Please provide the CHNA reports for all years from 2012.

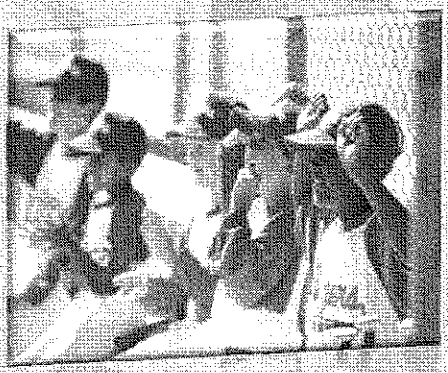
Response:

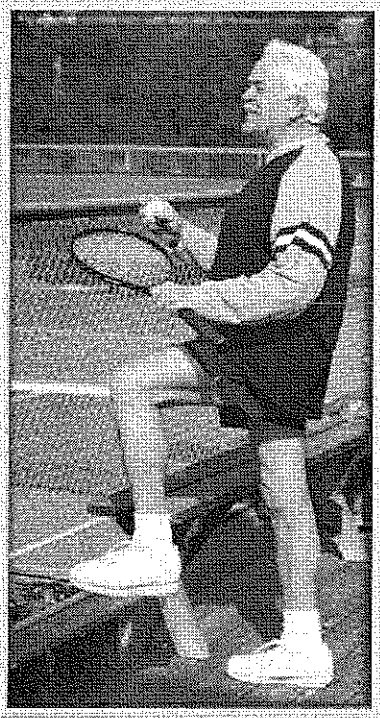
Prepared at the request of Counsel, please find attached the comprehensive CHNA from 2012 and the supplemental CHNA from 2015. We are also sending along our most recent CHIP for your review. We believe the participation in HHC's Health Transformation Grant (which we will become part of under an affiliation), along with their community benefit planning and management approach will enhance our ability to respond to the needs identified. In addition, this work will be given further shape by the grant to be made to the community foundation as contemplated in the affiliation agreement and as we integrate population health initiatives over time with HHC.

2012 Community Health Needs Assessment

Litchfield County

Community Transformation Grant Coalition





Making the Healthy Choice the Easy Choice through:

- **Tobacco Free Living**
- **Active Living & Healthy Eating**
- **Quality Clinical and Other Preventive Services**
- **Social & Emotional Wellness**
- **Healthy & Safe Physical Environments**

Funded by:

Connecticut Department of Public Health – CDC Community Transformation Grant
Torrington Area Health District
Charlotte Hungerford Hospital
United Way of Northwest Connecticut
Northwest Connecticut YMCA

Prepared by: The Center for Healthy Schools & Communities at EDUCATION CONNECTION

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Introduction

The 2012 Litchfield County Community Health Needs Assessment (CHNA) represents the collaborative efforts of the Litchfield County Community Transformation Grant (CTG) Coalition to begin to assess and prioritize health needs in our community and to collectively develop strategies and mobilize resources to improve the health of county residents.

The CTG Program is funded by the Centers for Disease Control and Prevention (CDC). The CTG Program's overarching goal is to create healthier communities by making healthy living easier and more affordable. The CTG program aims to improve the the health of all Americans by improving weight, nutrition, physical activity, tobacco use, emotional well-being, and overall mental health. By promoting healthy lifestyles and communities, especially among population groups experiencing the greatest burden of chronic disease, CTGs help improve health, reduce health disparities, and lower health care costs. *www.cdc.gov/communitytransformation/Cached*

Litchfield County is one of five counties in the state awarded CTG funding in partnership with the Connecticut Department of Public Health (CTDPH) to build capacity to support healthy lifestyles in a combined county population of over 889,000 including a rural population of 306,000. Connecticut's CTG Program targets evidence-based strategies to promote tobacco-free living, active living and healthy eating, quality clinical and other preventive services, healthy and safe physical environments, and social and emotional wellness.

The CTG Program is closely aligned with two other nationwide health promotion initiatives, the National Prevention Strategy and the Million Hearts Campaign™. The National Prevention Strategy is a comprehensive plan to increase the number of Americans who are healthy at every stage of life. The Prevention Strategy recognizes that good health comes not just from receiving quality medical care, but also from clean air and water, safe outdoor spaces for physical activity, safe worksites, healthy foods, violence-free environments and healthy homes. Prevention should be woven into all aspects of our lives, including where and how we live, learn, work and play. *http://www.healthcare.gov/prevention/nphpphc/strategy/index.html.* The Million Hearts™ Campaign aims to prevent one million heart attacks and strokes over the next five years. Million Hearts™ brings together communities, health systems, nonprofit organizations, federal agencies, and private-sector partners from across the country to fight heart disease and stroke. *http://millionhearts.hhs.gov/index.html*

Conducting a community health needs assessment is the first step to 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.

The leading health issues in Litchfield County, 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 and language/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. This information will be used to guide the development of programs and services to meet identified health needs.

Recent trends in health indicators for county residents show improvement in overall mortality rates for many leading causes of death. There are indications of improvement in personal health habits 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. Expanded joint planning and coordination of programs and services among community partners can reduce health disparities and improve the health of all county residents.

The intent is for the Community Health Needs Assessment to have significant value for the community, and to be widely used to advance community health improvement planning by a diverse constituency of private and public agencies. We welcome your comments and reactions to this report, and invite you to join in the assessment process going forward.

The Litchfield County CTG Coalition Steering Committee

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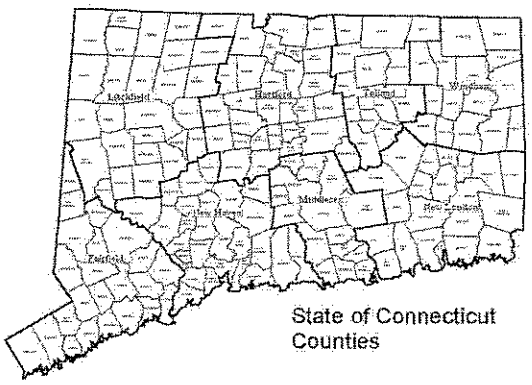
Litchfield County Population and Demographic Overview

Situated in the northwestern corner of Connecticut, Litchfield County occupies the largest land area of any county in the state (920 square miles). Consistent with the rural nature of many of its 26 municipalities, the county has the lowest population density of any county in CT. According to the 2010 Census, the total population of the county was 189,927 ranking 4th in population size among the eight CT counties. This represents a 4.3% increase in population since 2000, which is slightly less than the average state population growth rate of 4.9% over the past decade.

In 2010, as reported by the Census, there were 76,640 households in the county, and an average household size of 2.4 persons. Nearly 30% (29.9%) of households include persons under the age of 18 and 28.2% include persons ages 65 and over. Litchfield County has the distinction of having the highest proportion of residents ages 50 and over in the state (39%), compared with the CT average of 34%.

Overall, Litchfield County's population is relatively non-diverse; the Census 2010 racial/ethnic composition is 93.9% White and 1.3 % Black or African American, 1.5 % Asian, 0.2% American Indian, and 4.5% Hispanic or Latino (6.1% minority). However, as noted in Table 2, the county's two primary urban centers of Torrington and New Milford are considerably more diverse; the total minority population in Torrington is 11.3% and in New Milford is 8.3%.

According to the U.S. Census American Community Survey (ACS) 5-Year estimates for 2006-2010, the predominant ancestries in the county were: 23.0% Italian, 21.3% Irish, 14.8% English, 14.2% German and 9.5% French. Slightly over 6% (6.3%) of the county's population is foreign-born, and of those 42.5% are not U.S. citizens. The vast majority of county residents speak English (91.2%); 8.8% of residents have a primary language other than English, however only 2.7% speak English less than "very well". The predominant non-English



State of Connecticut Counties

languages spoken include "other Indo-European languages" and Spanish. It is important to note that Census ACS data are estimates based on a sample and therefore subject to sampling variability. In contrast, the decennial Census data are official population and housing counts. Additional information on the sampling methodology used in the ACS is available at www.census.gov.

Overall levels of educational attainment by Litchfield County residents surpass the state average - 96% of county residents are high school graduates, 29% completed some college, and 34% attained a bachelor's degree or higher.

The median income per household in the county as estimated by the 2006-2010 ACS was $69,639, and the median family income was $84,890. In 2009, 5.3% of the county's population was living in poverty, well below the state average of 8.7%. High poverty areas exist in certain communities, and poverty is most common in female-headed households with children under 18 years of age.

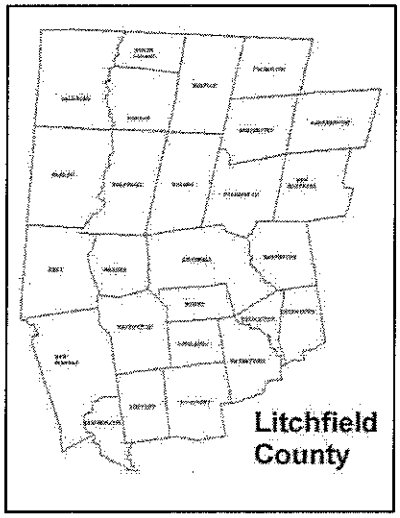
Related to housing characteristics, the majority of Litchfield County residents own their own homes (76.3%), with the remainder renting (23.7%). Homeownership in the county is well above the state average. According to CERC Town Profiles, one-third of the housing stock in the county was built prior to 1950 and there are over 3,400 subsidized housing units in the county.

County and Town Designations and Governance

There are 26 distinct municipalities in the county, including: Barkhamsted, Bethlehem, Bridgewater, Canaan, Colebrook, Cornwall, Goshen, Harwinton, Kent, Litchfield, Morris, New Hartford, New Milford, Norfolk, North Canaan, Plymouth, Roxbury, Salisbury, Sharon, Thomaston, Torrington, Warren, Washington, Watertown, Winchester, and Woodbury.

Although Connecticut is divided geographically into eight counties, these counties do not have any associated government structure. The Connecticut General Assembly abolished all county governments in the state on October 1, 1960. The 169 towns of Connecticut are the principal units of local government in the state and have full municipal powers including: corporate powers, eminent domain, ability to levy taxes, public services (low cost housing, waste disposal, fire, police, ambulance, street lighting), public works (highways, sewers, cemeteries, parking lots, etc.), regulatory powers (building codes, traffic, animals, crime, public health), environmental protection, and economic development.

Under Connecticut's Home Rule Act, any municipality in CT is permitted to adopt its own local charter and choose its own structure of government. The three principal municipal government structures used in the state are: 1) selectman–town meeting, 2) mayor–council, and 3) manager–council.



Five Regional Planning Organizations (RPOs) serve Litchfield County municipalities including Central Connecticut Regional Planning Agency, Council of Governments of the Central Naugatuck Valley, Housatonic Valley Council of Elected Officials, Litchfield Hills Council of Elected Officials, and Northwestern CT Council of Governments. Through local ordinance, the municipalities within each of these planning regions have voluntarily created one of the three types of RPOs permitted under CT statute to carry out a variety of regional planning and other activities on their behalf.

Litchfield County Municipality Population and Demographic Highlights

2000-2010 Census Comparisons, Growth Projections, and Ethnic/Racial Composition

As noted in Table 1, the county's two most populated urban centers are Torrington (2010 population – 36,383), and New Milford (2010 population – 28,142). Five of the county's 26 municipalities have populations of 10,000 or greater; the least populated town in the county is Canaan, with 1,234 residents. Population projections from the CT State Data Center show an overall net growth rate in the county of 6.5%, for the 15 year period 2015-2030, with the highest growth rate in Woodbury, closely followed by New Hartford, New Milford, Bethlehem, and Goshen. Negative growth rates are projected in eight municipalities, with the greatest percentage loss in population projected for Canaan and Roxbury.

Table 1: 2010 Census Population and Projections for Litchfield County Municipalities, 2015-2030

Municipality	Census 2010 Population	2015	2020	2025	2030	% Change 2015-2030
Barkhamsted	3,799	3,837	3,967	4,083	4,165	8.5%
Bethlehem	3,607	3,874	4,010	4,169	4,308	11.2%
Bridgewater	1,727	2,090	2,167	2,249	2,304	10.2%
Canaan	1,234	1,122	1,105	1,069	1,024	-8.7%
Colebrook	1,485	1,512	1,515	1,522	1,517	0.3%
Cornwall	1,420	1,540	1,586	1,620	1,655	7.5%
Goshen	2,976	3,198	3,351	3,478	3,569	11.6%
Harwinton	**5,642**	**5,293**	**5,248**	**5,204**	**5,148**	-2.7%
Kent	2,979	3,294	3,455	3,561	3,608	9.5%
Litchfield	**8,466**	**10,218**	**10,796**	**11,064**	**11,009**	7.7%
Morris	2,388	2,325	2,324	2,334	2,321	-0.2%
New Hartford	**6,970**	**6,980**	**7,303**	**7,635**	**7,881**	12.9%
New Milford	**28,142**	**31,429**	**32,835**	**34,226**	**35,446**	12.8%
Norfolk	1,709	1,916	1,987	2,042	2,006	4.7%
North Canaan	3,315	3,465	3,510	3,547	3,568	3.0%
Plymouth	**12,243**	**12,307**	**12,426**	**12,528**	**12,552**	2.0%
Roxbury	2,262	2,069	2,026	1,982	1,941	-6.2%
Salisbury	3,741	4,790	4,907	4,794	4,594	-4.1%
Sharon	2,782	3,351	3,411	3,340	3,231	-3.6%
Thomaston	**7,887**	**7,512**	**7,495**	**7,462**	**7,411**	-1.3%
Torrington	**36,383**	**41,378**	**43,546**	**44,942**	**45,213**	9.3%
Warren	1,461	1,305	1,327	1,346	1,367	4.8%
Washington	3,578	3,566	3,513	3,460	3,421	-4.1%
Watertown	**22,514**	**23,407**	**23,974**	**24,601**	**25,213**	7.7%
Winchester	**11,242**	**11,025**	**11,091**	**11,128**	**11,142**	1.1%
Woodbury	**9,975**	**10,661**	**11,133**	**11,624**	**12,047**	13.0%
Litchfield County	**189,927**	**193,489**	**197,751**	**202,218**	**206,087**	6.5%
Connecticut	**3,574,097**	**3,573,885**	**3,622,774**	**3,669,990**	**3,702,400**	3.6%

** Notes: Ten most populated municipalities are listed in **bold type**.*

Sources: CERC Town Profiles, accessed at http://www.cerc.com and Connecticut State Data Center, University of Connecticut, http://ctsdc.uconn.edu/projections/ct_towns.html

Changes in the ethnic and racial composition of the county by municipality over the past decade compiled by the CT State Data Center are shown in Tables 2 and 3. Overall, the county has become more diverse from 2000 - 2010, with the highest increase in the Hispanic or Latino population (4,641 persons or an increase of 119.2%), which is more than double the state average increase of 49.6%. Based on the increase in absolute numbers of persons, the next highest increase was in White residents (3,784 persons), followed by "other" (1,473 persons), Asian residents (771 persons), Black or African American residents (560 persons), followed by American Indian (85 persons) and lastly Pacific Islander. By far, the greatest gains in the number of minority residents were experienced in three communities - Torrington, New Milford, and Watertown.

Table 2: Litchfield County Municipality Census 2000 and 2010 Population Counts by Race/Ethnicity*

Municipality	Total population		White		Black		American Indian		Asian		Pacific Islander		Other		Hispanic or Latino	
	2000	2010	2000	2010	2000	2010	2000	2010	2000	2010	2000	2010	2000	2010	2000	2010
Barkhamsted	3,494	3,799	3,443	3,703	2	11	6	0	14	23	0	0	10	21	31	57
Bethlehem	3,422	3,607	3,336	3,532	9	16	2	4	27	18	1	0	13	6	22	61
Bridgewater	1,824	1,727	1,779	1,681	17	14	1	0	13	16	0	0	2	8	9	26
Canaan	1,081	1,234	1,049	1,204	16	8	0	1	2	3	1	1	4	1	4	19
Colebrook	1,471	1,485	1,427	1,448	10	4	0	2	9	9	0	3	13	3	36	17
Cornwall	1,434	1,420	1,398	1,386	3	3	0	1	10	9	0	0	3	3	21	34
Goshen	2,697	2,976	2,650	2,898	13	10	4	4	20	36	0	0	0	9	33	67
Harwinton	5,283	5,642	5,214	5,515	4	13	3	8	27	49	3	4	7	10	47	80
Kent	2,858	2,979	2,737	2,813	16	35	22	22	28	49	1	1	20	21	72	94
Litchfield	8,316	8,466	8,066	8,149	62	52	19	13	39	77	1	12	38	43	130	173
Morris	2,301	2,388	2,243	2,325	16	12	3	2	19	18	0	0	4	3	20	50
New Hartford	6,088	6,970	5,946	6,776	39	23	3	4	45	79	4	0	12	21	82	124
New Milford	27,121	28,142	25,583	25,809	383	484	40	68	518	779	7	11	184	464	751	1,693
Norfolk	1,660	1,709	1,612	1,659	8	12	4	2	9	11	0	0	10	7	16	30
North Canaan	3,350	3,315	3,247	3,194	40	40	6	3	6	8	0	0	13	41	79	195
Plymouth	11,634	12,243	11,325	11,748	91	102	18	22	49	100	1	2	37	78	147	370
Roxbury	2,136	2,262	2,077	2,179	5	13	4	3	20	18	0	0	14	18	28	48
Salisbury	3,977	3,741	3,808	3,559	66	52	13	6	38	41	0	0	18	18	61	107
Sharon	2,968	2,782	2,875	2,670	28	44	13	2	17	20	0	0	10	18	58	56
Thomaston	7,503	7,887	7,342	7,631	45	34	8	26	37	60	0	0	31	53	109	202
Torrington	35,202	36,383	32,749	32,278	757	974	70	90	643	785	7	9	460	1,330	1,162	3,193
Warren	1,254	1,461	1,228	1,418	2	8	4	1	10	20	0	0	1	8	3	31
Washington	3,596	3,578	3,440	3,429	23	21	4	3	56	27	0	0	28	48	77	142
Watertown	21,661	22,514	20,894	21,249	162	315	27	58	276	376	10	1	103	213	406	838
Winchester	10,664	11,242	10,071	10,468	132	201	25	26	99	109	1	1	180	225	338	583
Woodbury	9,198	9,975	8,945	9,547	49	57	20	33	106	168	6	0	20	38	152	245
Litchfield County	182,193	189,927	174,484	178,268	1,998	2,558	319	404	2,137	2,908	43	45	1,235	2,708	3,894	8,535
Connecticut	3,405,565	3,574,097	2,780,355	2,772,410	309,843	362,296	9,639	11,256	82,313	135,565	1,366	1,428	147,201	198,466	320,323	479,087

** Note: Hispanic or Latino population counts include persons of any race.*

Source: CT State Data Center, University of Connecticut,http://ctsdc.uconn.edu/data/2010_2000_PL_Census_data_comparison_towns.xls

Table 3: Litchfield County Municipality Census 2000 and 2010 Numeric and Percent Population Change

Municipality	Total Population		White		Black or African American		Asian		Hispanic or Latino	
	# Change	% Change	# Change	% Change	# Change	% Change	# Change	% Change	# Change	% Change
Barkhamsted	305	8.7	260	7.6	9	450.0	9	64.3	26	83.9
Bethlehem	185	5.4	196	5.9	7	77.8	(9)	-33.3	39	177.3
Bridgewater	(97)	-5.3	(98)	-5.5	(3)	-17.6	3	23.1	17	188.9
Canaan	153	14.2	155	14.8	(8)	-50.0	1	50.0	15	375.0
Colebrook	14	1.0	21	1.5	(6)	-60.0	0	0.0	(19)	-52.8
Cornwall	(14)	-1.0	(12)	-0.9	0	0.0	(1)	-10.0	13	61.9
Goshen	279	10.3	248	9.4	(3)	-23.1	16	80.0	34	103.0
Harwinton	359	6.8	301	5.8	9	225.0	22	81.5	33	70.2
Kent	121	4.2	76	2.8	19	118.8	21	75.0	22	30.6
Litchfield	150	1.8	83	1.0	(10)	-16.1	38	97.4	43	33.1
Morris	87	3.8	82	3.7	(4)	-25.0	(1)	-5.3	30	150.0
New Hartford	882	14.5	830	14.0	(16)	-41.0	34	75.6	42	51.2
New Milford	1,021	3.8	226	0.9	101	26.4	261	50.4	942	125.4
Norfolk	49	3.0	47	2.9	4	50.0	2	22.2	14	87.5
North Canaan	(35)	-1.0	(53)	-1.6	0	0.0	2	33.3	116	146.8
Plymouth	609	5.2	423	3.7	11	12.1	51	104.1	223	151.7
Roxbury	126	5.9	102	4.9	8	160.0	(2)	-10.0	20	71.4
Salisbury	(236)	-5.9	(249)	-6.5	(14)	-21.2	3	7.9	46	75.4
Sharon	(186)	-6.3	(205)	-7.1	16	57.1	3	17.6	(2)	-3.4
Thomaston	384	5.1	289	3.9	(11)	-24.4	23	62.2	93	85.3
Torrington	1,181	3.4	(471)	-1.4	217	28.7	142	22.1	2,031	174.8
Warren	207	16.5	190	15.5	6	300.0	10	100.0	28	933.3
Washington	(18)	-0.5	(11)	-0.3	(2)	-8.7	(29)	-51.8	65	84.4
Watertown	853	3.9	355	1.7	153	94.4	100	36.2	432	106.4
Winchester	578	5.4	397	3.9	69	52.3	10	10.1	245	72.5
Woodbury	777	8.4	602	6.7	8	16.3	62	58.5	93	61.2
Litchfield County	7,734	4.3	3,784	2.2	560	28.0	771	36.1	4,641	119.2
Connecticut	168,532	4.9	(7,945)	-2.9	52,453	16.9	53,252	64.7	158,764	49.6

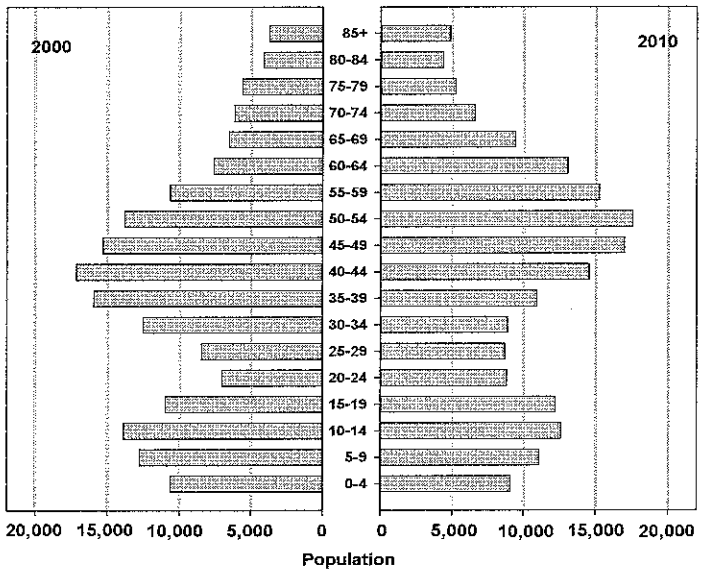
** Note: Hispanic or Latino population counts include persons of any race. Population change numbers in parentheses ( ) are negative and represent a loss in population for that subgroup.*

Source: CT State Data Center, University of Connecticut,http://ctsdc.uconn.edu/data/2010_2000_PL_Census_data_comparison_towns.xls

Age Distribution

As previously noted, the proportion of Litchfield County residents ages 50 and over exceeds the state average. Figure 1 graphically shows the increase in the county population ages 50 and over, and the decline in the population under the age of 14 from 2000-2010.

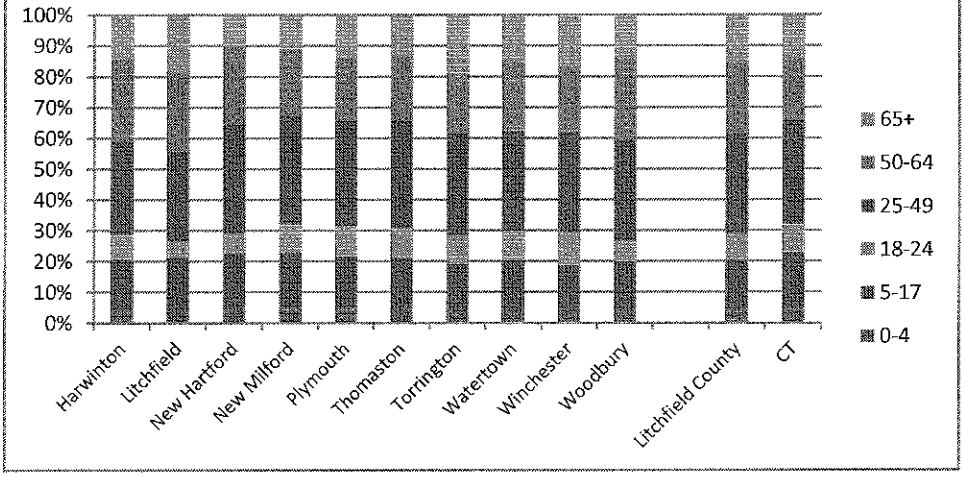
Figure 1
Population of Litchfield County 2000-2010, by Age Group



Source: U.S. Census, Decennial Census by Age, Race, Sex, Ethnicity, provided courtesy of HISR, Connecticut Department of Public Health http://www.ct.gov/dph/cwp/view.asp?a=3132&q=488832), accessed May 2, 2012.

Based on Census 2010 data, the age distribution of the county's ten most populated municipalities, compared with the county and the state is shown in Figure 2.

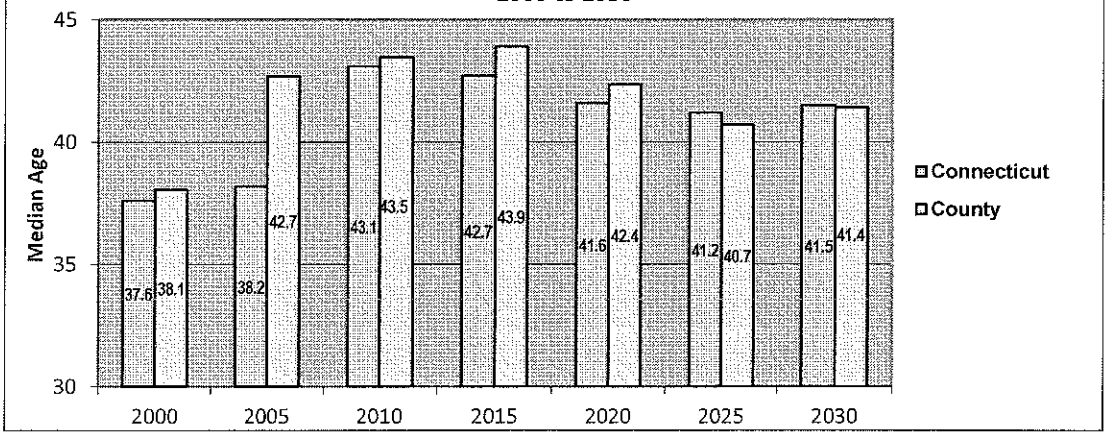
Figure 2: Litchfield County Population by Age, 2010



Source: CERC Town Profiles, http://www.cerc.com

The upward trend in the age distribution of Litchfield County's population is explained in large part by two factors - the advancing age of the "baby boomer" generation and declining birth rates, both of which are consistent with state and national trends. This shift in population demographics is noteworthy as the need for health care and support services by residents generally increases with advancing age. The CT State Data Center projects the median age in the county will to continue to rise through 2015, as shown in Figure 3.

Figure 3: Litchfield County Median Age Projections 2000 to 2030



Source: Connecticut State Data Center, University of Connecticut, http://ctsdc.edu/projections/ct_towns.html

In addition to having a higher percentage of residents ages 65 and over, overall the county has a lower percentage of residents under the age of 18 when compared with the state average. At the municipal level, the top 10 communities with the highest percentage of residents under the age of 18 and residents ages 65 and over are shown graphically in Figures 4 and 5. This information is important as it has broad implications for health, education, housing, and human services planning.

Figure 4: Top 10 Litchfield County Municipalities With Highest Percentage of Population Under Age 18, 2010

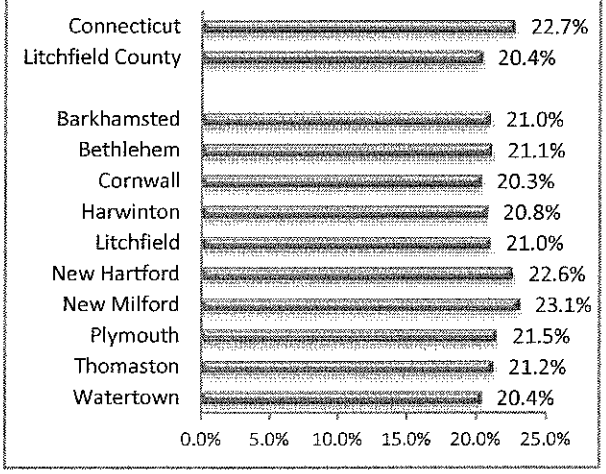
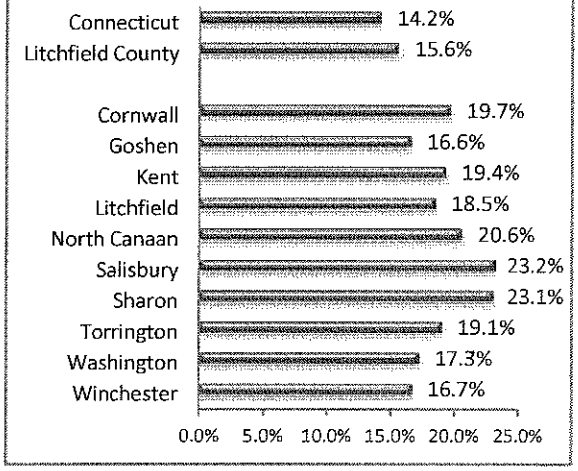


Figure 5: Top 10 Litchfield County Municipalities With Highest Percentage of Population Age 65 and Over, 2010



Source: CERC Town Profiles www.cerc.com

Educational Attainment

Advancing levels of education are strongly associated with increased income and the related benefits of improved socioeconomic status. According to the National Center for Educational Statistics, young adults with a bachelor's degree earned more than twice as much as those without a high school diploma or its equivalent in 2009, 50 percent more than young adult high school completers, and 25 percent more than young adults with an associate's degree. In 2009, the median earnings of young adults with a master's degree or higher was $60,000, one-third more than the median for young adults with a bachelor's degree. *http://nces.ed.gov/fastfacts/display.asp?id=77*

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.

As indicated in Table 4, from 2000-2010 there was a favorable upward trend in the percentage of Litchfield County residents completing high school and attaining a bachelor's degree. The overall county average for high school completion exceeds the state average. Not surprisingly, lower levels of educational attainment are found in the county municipalities with the highest poverty rates and lowest median household incomes – Torrington, Winchester, Thomaston, North Canaan, and Plymouth.

Table 4: Educational Attainment in Litchfield County Residents Ages 25 and Over, Census 2000 and 2010

Municipality	High School Graduate or Higher		Bachelor's Degree or Higher	
	Census 2000 (%)	Census 2010 (%)	Census 2000 (%)	Census 2010 (%)
Barkhamsted	92.7	96.0	36.4	40.0
Bethlehem	90.6	94.0	35.3	39.0
Bridgewater	93.3	96.0	48.2	52.0
Canaan	91.5	96.0	33.0	37.0
Colebrook	90.2	94.0	33.5	37.0
Cornwall	94.8	97.0	47.4	51.0
Goshen	90.0	94.0	32.4	37.0
Harwinton	92.3	96.0	33.0	38.0
Kent	93.0	96.0	42.0	46.0
Litchfield	89.8	94.0	35.9	40.0
Morris	84.6	91.0	25.3	30.0
New Hartford	88.1	93.0	42.8	47.0
New Milford	90.5	95.0	30.5	35.0
Norfolk	91.3	95.0	37.1	41.0

North Canaan	84.2	91.0	20.8	26.0
Plymouth	81.4	89.0	13.9	19.0
Roxbury	96.2	97.0	46.6	50.0
Salisbury	89.4	94.0	45.3	49.0
Sharon	90.2	95.0	36.3	41.0
Thomaston	87.1	92.0	18.5	22.0
Torrington	78.4	87.0	15.7	21.0
Warren	91.9	94.0	34.5	38.0
Washington	90.9	95.0	41.5	46.0
Watertown	83.8	90.0	25.0	30.0
Winchester	78.7	87.0	17.4	22.0
Woodbury	90.2	95.0	41.8	46.0
County	85.9	96.0	27.5	34.0
Connecticut	84.0	89.0	31.4	35.0

Sources: U.S. Census Bureau, 2000 Census of Population and Housing. Summary Social, Economic and Housing Characteristics. Connecticut and CERC 2011 Town Profiles.

The Connecticut State Department of Education's (CSDE) Comprehensive Plan for Education includes high school reform to assure all students graduate and are prepared for lifelong learning and careers in the global competitive economy. As noted in Table 5, Regional School District 12 and the Explorations Charter School in Winchester achieved the goal of 100% high school completion and 0% high school dropouts for the class of 2008 (the most recent published data). Three school districts (Plymouth, The Gilbert School, and Torrington) had dropout rates considerably higher than the state average. With one exception, districts in the county achieved the *Healthy People 2020* target of 82.4% of students graduating from high school.

Table 5: High School Graduation Rates and Dropout Rates, School Districts in Litchfield County, 2008

District Name	Graduation Rate, Class of 2008	Cumulative Dropout Rate (%)
Explorations District (Charter School)	100.0	0.0
Litchfield School District	91.4	7.8
New Milford School District	96.2	3.6
Plymouth School District	86.7	11.4
Regional School District 1 (Canaan, Cornwall, Kent, North Canaan, Salisbury, Sharon)	92.0	7.1
Regional School District 6 (Goshen, Morris, Warren)	97.8	1.8
Regional School District 7 (Barkhamsted, Colebrook, New Hartford, Norfolk)	99.4	0.5
Regional School District 12 (Bridgewater, Roxbury, Washington)	100.0	0.0

Regional School District 14 (Bethlehem, Woodbury)	94.8	5.2
The Gilbert School (Winchester)	81.3	11.8
Thomaston School District	92.3	7.3
Torrington School District	83.4	13.7
Watertown School District	95.2	4.5
Connecticut	92.1	6.8

Source: CSDE CT Data Education and Research http://sdeportal.ct.gov/Cedar/WEB/ct_report/DTHome.aspx
Note: Harwinton is served by Regional School District 10, located in Hartford County.

Consistent with local demographic trends, there was an increase in the minority population in most school districts in the county over the past two academic years - this increase was most dramatic in Winchester. In 2009-2010, the Torrington School District reported the highest percentage of minority students (24.3%) and also the highest percentage of students who were English Language Learners (7.0%). In addition, over 13% of Torrington students were reported to live in households where English is not the primary language. There is considerable variation in the minority population by school in some school districts, for example, several schools in Torrington have student populations that exceed 30% minority.

Table 6: Percent of Minority and ELL Students Enrolled by School District, Litchfield County 2008-2010

	Minority (%)		Not Fluent in English (%)	
District Name	2008-2009	2009-2010	2008-2009	2009-2010
Explorations District	7.1	6.3	0.0	0.0
Litchfield School District	6.7	6.6	0.0	0.5
New Milford School District	13.2	13.5	2.7	2.6
Plymouth School District	5.7	6.0	0.8	0.6
Regional School District 1	4.0	6.1	0.0	0.0
Regional School District 6	3.6	4.0	1.5	1.5
Regional School District 7	2.0	2.6	0.0	0.0
Regional School District 12	6.1	5.6	0.7	0.9
Regional School District 14	4.8	4.5	0.9	0.6
The Gilbert School	11.7	14.4	3.3	4.2
Thomaston School District	2.6	2.7	0.4	0.7
Torrington School District	23.6	24.3	6.1	7.0
Watertown School District	8.6	9.1	1.9	1.8
Winchester School District	15.4	19.4	3.5	2.4
Connecticut			5.2	5.4

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

Economic Stability – Income, Poverty, and Unemployment

Healthy People 2020 emphasizes the inseparable connections between health and the environments in which we are born, live, learn, work, play, and age. The relationship between poverty and health is particularly strong. It is well documented that low income persons are more likely to be uninsured, have fragmented health care, and have higher rates of tobacco use, substance abuse, mental illness and certain chronic diseases such as obesity and diabetes. In addition, poor persons are more likely to have low levels of education, live in substandard housing and unsafe neighborhoods, be unemployed, and be victims of crime.

As shown in Table 7, Litchfield County residents generally have median incomes above the state and well above the national average, and poverty rates lower than the state and national averages. Income by municipality varies considerably , and in 2010 ranged from a low of $44,817 in North Canaan to a high of $120,008 in Roxbury. Five municipalities have median household incomes below the state average - North Canaan, Plymouth, Thomaston, Torrington, and Winchester. North Canaan's household median income is below the national average. Two municipalities - North Canaan and Torrington - have poverty rates that exceed the state average. A concerning finding is that over two-thirds of the county's muncipalities experienced a decline in the household median income from 2009-2010, likely related to the economic recession and rise in unemployment.

Table 7: Economic Characteristics of Litchfield County Municipalities, 2009-2010

	Median Household Income ($) in 2009	Median Household Income ($) in 2010	Poverty Rate (%) in 2009
Barkhamsted	84,923	80,359	1.5
Bethlehem	88,771	85,096	1.8
Bridgewater	104,559	107,934	2.9
Canaan	69,246	68,150	5.7
Colebrook	72,845	71,608	3.0
Cornwall	68,904	77,243	3.6
Goshen	81,797	78,571	2.3
Harwinton	86,149	80,943	4.9
Kent	70,496	71,008	5.5
Litchfield	73,500	73,510	5.1
Morris	72,451	69,436	6.2
New Hartford	89,151	89,456	3.6
New Milford	85,105	80,887	2.1
Norfolk	74,234	73,426	4.2
North Canaan	47,769	44,817	12.7
Plymouth	68,402	63,940	5.6
Roxbury	116,057	120,008	1.3
Salisbury	66,780	64,758	5.2
Sharon	68,857	69,258	7.4
Thomaston	67,211	62,898	2.9

Torrington	52,746	49,614	11.0
Warren	79,586	76,122	3.8
Washington	86,712	86,439	1.9
Watertown	75,357	72,257	3.2
Winchester	57,799	53,233	8.3
Woodbury	85,843	83,649	3.2
Litchfield County	71,095	70,291	**5.3**
CT	67,034	64,321	**8.7**
US	50,221	50,046	**14.3**

*Note: Ten most populated towns are listed in **bold type**.*
Sources: CERC town profiles www.cerc.com and U.S. Census http://www.census.gov/prod/2010pubs/p60-238.pdf
Municipal 2009 & 2010 Median Income: http://pschousing.org/files/HC_2010_CTAffordability_Study.pdf
2009 U.S. Median Income: http://www.census.gov/newsroom/releases/archives/income_wealth/cb10-144.html
CT Median Income 2010: http://www.ers.usda.gov/data/unemployment/RDList2.asp?ST=CT
CT Median Income 2009:
http://www.census.gov/compendia/statab/cats/income_expenditures_poverty_wealth/income_and_poverty--state_and_local_data.html

In examining median income and poverty rates, it is important to note significant inequalities in income and poverty rates exist statewide and within Litchfield County by ethnicity, race, gender, and household composition. The Partnership for Strong Communities report, *2010 Housing in Connecticut: The Latest Measures of Affordabilit*y, indicates that the income disparity in Connecticut ranks second in the nation and has grown faster than any state in the nation, according to the CT Department of Economic and Community Development (DECD). *http://pschousing.org/files/hsginct2010.pdf.*

As noted in CT Department of Public Health's *2009 Connecticut Health Disparities Report*, Hispanic or Latino and Black or African American CT residents were 2 to 3 times more likely to live in poverty than White residents. In terms of household composition, according to U.S. Census ACS estimates, nearly one in four female-headed households (no husband present) in the county with children under the age of 18 live in poverty (23%); for female-headed households with children under the age of 5, this figure jumps to one in two (51%).

An additional consideration is that in areas with a high cost of living such as Litchfield County, families living well above the poverty level often struggle financially. The fair living wage in the county is double the current minimum wage. *http://www.universallivingwage.org/fmrtables_2011/CT_FMR2011.htm*

A timely indicator of financial hardship in the community is the percentage of school-age children who are eligible for free or reduced school meals. The income eligibility for free meals is 130% or below the federal poverty level; for reduced meals it is more than 130% and up to 185% of the federal poverty level. Data indicate that most school districts in the county fall below the statewide average for free or reduced price meal eligibility, with the exception of schools serving Torrington and Winchester. It is notable that over the past two years, there has been an increase in the proportion of eligible children in the majority of districts, with the highest percentage increases in Explorations (Winchester) , North Canaan, Cornwall, and Barkhamsted.

Table 8: Students Eligible for Free/Reduced Price School Meals, Rank Order by School District, 2009-2011

District Name	2009-2010 Eligible for Free/ Reduced Lunch (%)	2010-2011 Eligible for Free/ Reduced Lunch (%)
Explorations District	25.0	45.0
Torrington School District	38.2	42.6
Winchester School District	45.2	41.9
The Gilbert School	32.0	36.6
Plymouth School District	21.8	26.2
North Canaan School District	15.2	24.2
Regional School District 1 (Canaan, Cornwall, Kent, North Canaan, Salisbury, Sharon)	14.5	19.9
Sharon School District	16.6	18.8
Watertown School District	15.4	16.1
Thomaston School District	18.2	15.3
Colebrook School District	14.3	14.3
New Milford School District	13.9	15.7
Kent School District	11.3	12.9
Regional School District 6 (Goshen, Morris, Warren)	9.0	12.1
Cornwall School District	5.7	11.3
Salisbury School District	9.0	10.3
Litchfield School District	10.4	9.4
Canaan School District	11.6	9.3
Regional School District 14 (Bethlehem, Woodbury)	7.5	8.3
Norfolk School District	8.0	7.5
Barkhamsted School District	4.9	7.0
Regional School District 12 (Bridgewater, Roxbury, Washington)	5.0	6.9
New Hartford School District	8.2	5.8
Regional School District 07 (Barkhamsted, Colebrook, New Hartford, Norfolk)	6.4	5.5
State	32.9	34.4

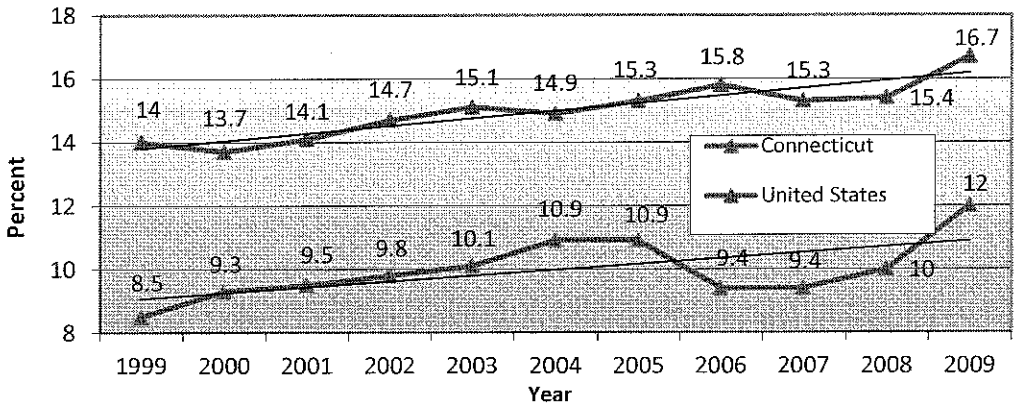
Source: Connecticut State Department of Education, Student Need Data, http://sdeportal.ct.gov/Cedar/WEB/ct_report/StudentNeedDT.aspx

Fortunately Connecticut counties and municipalities have experienced a decline in the unemployment rate over the past year. According to the CT Department of Labor, the state's unemployment rate in March 2011 was 9.2%, and as of March 2012 this had declined to 8.1%, slightly below the national rate of 8.4%. In March 2012, unemployment rates in Litchfield County ranked 4th among the 8 CT counties at 7.7%. Unemployment rates ranged from a low of 4.6% in Bridgewater to a high of 9.3% in North Canaan. http://www1.ctdol.state.ct.us/lmi/laus/laustown.asp. Unskilled workers, persons with low educational attainment, and minorities are historically at higher risk for unemployment.

Health Insurance Coverage

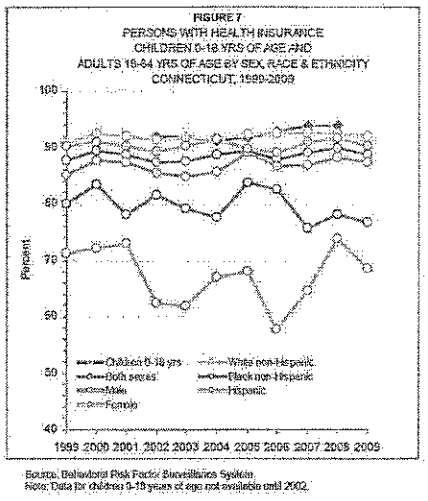
Having public or private health insurance coverage is a strong predictor of both access to and regular use of all types of health care services. Studies demonstrate that individuals lacking health insurance are far more likely to receive fragmented health care and experience delayed access to health screenings and diagnosis and treatment for disease. As shown in Figure 6, the percentage of CT residents who are uninsured is well below the national average. From 2007-2009, however, this percentage increased at a faster rate in CT than in the U.S. as a whole.

Figure 6: CT and U.S. Percent Uninsured Population, 1999-2009



Source: US Census Bureau, Historical Health Insurance Data, http://www.census.gov/hhes/www/hlthins/data/historical/index.html. Population as of March of the following year. Reprinted with permission from The 2011 Community Report Card For Western CT http://www.uwwesternct.org

The CT Department of Public Health's (DPH) report, *Healthy Connecticut 2010*, indicates that the likelihood of being insured in our state varies considerably by population subgroup. As shown in Figure 7, children in Connecticut are more likely than adults to have health insurance, females are more likely than males, and white non-Hispanic residents are significantly more likely than non-Hispanic Black and Hispanic residents to have coverage. HUSKY Health is Connecticut's comprehensive public health insurance program, designed to reduce the number of uninsured individuals and families and increase access to preventive care and diagnostic and treatment services.



Source: Healthy Connecticut 2010

As reported by the CT Voices for Children in *Uninsured Children in Connecticut, 2010*, the estimated percentage of uninsured persons in Litchfield County in 2010 based on U.S. Census ACS data, was 6.9% for persons of all ages and 2.4% for children under age 18. These percentages compare favorably with the 2010 CT rate of 9.1% overall and 3.0 % for children. The report also cites the impact of HUSKY in containing the numbers of uninsured children in spite of the recent economic downturn.

Housing and Homelessness

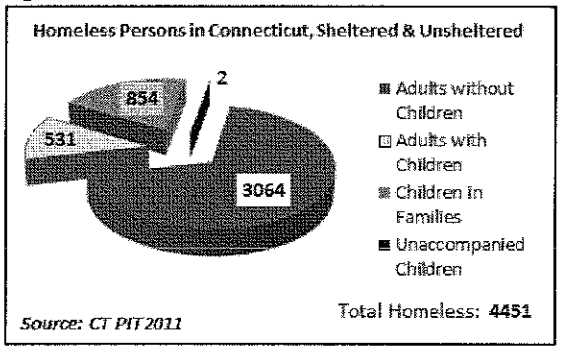
The U. S. Department of Housing and Urban Development defines cost-burdened renters or homeowners as those who pay more than 30% of their income for rent or mortgage payments. In many instances, this leaves little money for other necessities such as food, clothing, transportation, utilities, and healthcare. For renters, the situation is typically worse, as the median household income for renters is substantially less on average than for homeowners. According to U.S. Census 2006-2010 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 *2012 Out of Reach Study* indicates that Connecticut is the 7th 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 $20.44 per hour, 2.5 times the minimum wage. http://nlihc.org/sites/default/files/oor/2012-OOR.pdf

According to the 2010 U.S. Census, 76.3% of Litchfield County residents own their homes and 23.7% rent. There is considerable variation by muncipality, with the proportion of residents who rent exceeding one in three in Torrington (33.6%) and Winchester (37.4%). The number of subsidized housing units and the proportion of pre-1950 housing stock are also highest in these two communities. Torrington has 1,777 subsidized units and Winchester has 593 units. In Winchester 50% of the housing stock is pre-1950; in Torrington this is 39%. www.cerc.com

Since 2007, Connecticut has conducted a statewide standardized and coordinated "census" of homelessness, to enumerate homelessness both in shelters and on the street. Each January, the Connecticut Coalition to End Homelessness coordinates a Point-In-Time Count, to collect data on the exact number of persons experiencing homelessness on a single night in defined geographic areas in the state. The most recent data specific to Litchfield County are from 2007, when a total of 136 single adults and 11 families were counted. According to Point-In-Time Count data for 2011, the number of homeless individuals in Connecticut was 4,451, an 8% increase since 2009. The breakdown by type is shown below.

Figure 8



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 2010-2011, 129 children in Torrington (pre-K through grade 12) were identified as homeless.

The CT Coalition to End Homelessness reports that emergency shelters have been at capacity for over two years, and as a result, there has been a 37% increase in the number of unsheltered homeless statewide. http://www.cceh.org/files/publications/Connecticut_Point_in_Time_Count_2011_Brief_FINAL_2012.01.09.pdf.

According to United Way's 2-1-1 community services database, homeless shelters in the county are operated by the New Milford Shelter Coalition (winter emergency shelters at local churches), FISH of Torrington (25 beds), and the Northwest CT YMCA (17 beds).

Community Safety

The Uniform Crime Reporting Program (URC) measures the extent, fluctuation, and distribution of crime in communities across the United States. Eight offenses were chosen to form the Crime Index, including the violent crimes of murder, rape, robbery, and aggravated assault and the property crimes of arson, burglary, larceny-theft, and motor vehicle theft. The Connecticut Department of Emergency Services and Public Protection has all 102 CT police departments participating in the UCR Program.

As shown in Table 9, Litchfield County's overall 2010 crime index compares favorably with the state total average and the state average for non-urban (population < 100,000) areas. The county's index offense rates for all offenses other than rape are consistently below the state total and non-urban area rates.

Table 9 –Litchfield County and CT Crime Rates, 2010

Index Offense	Litchfield County		Connecticut Non-Urban		Connecticut Total	
	#	Rate	#	Rate	#	Rate
Murder	0	0	54	1.8	132	3.7
Rape	39	20.4	401	13.7	599	16.8
Robbery	30	15.7	1,308	44.6	3,554	99.4
Aggravated Assault	91	47.6	2,564	87.4	5,792	162.1
Burglary	579	302.8	10,161	346.2	15,158	424.1
Larceny	2,198	1,149.6	40,903	1,393.7	56,705	1,586.6
Motor Vehicle Theft	97	50.7	3,371	114.9	6,656	186.2
Arson	13	6.8	281	9.6	424	11.9
Crime Index Total	3,034	1,586.8	58,762	2,002.2	88,596	2,478.8

Notes: 2010 rates only include half-year data for Hamden.
Rates are per 100,000 residents.
Source: http://www.dpsdata.ct.gov/dps/ucr/data/2010

In examining crime index rates by municipality in 2010, those with rates above the county average included Torrington, Plymouth, Winchester, and Thomaston. The lowest total crime rate was found in Warren, followed by Roxbury. It should be noted that due to the small population size of many Litchfield County municipalities, rates may vary considerably from one year to the next.

Indicators of community safety from the CT Health Equity Index (a composite score based on crimes against persons and crimes against property) show considerable variation by community, ranging from a low score of 2 in Torrington to a high score of 10 in Bridgewater. Low levels of community safety are also correlated with certain undesirable health outcomes such as lower life expectancy, higher rates of accidents, and mental illness. Socioeconomic factors such as unemployment rates, educational attainment, and income levels are strongly associated with both the prevalence and types of crime in communities.

Domestic abuse crosses all socioeconomic levels and is chronically underreported in crime statistics. The Centers for Disease Control and Prevention estimates that one in four women will be a victim of domestic abuse in their lifetime. The Connecticut Coalition Against Domestic Violence reports that from 7/1/10 – 6/30/11 their 18 domestic violence agencies, including 2 located in Litchfield County, provided services to 54,178 victims of domestic violence. Litchfield County agencies include Women's Support Services in Sharon and the Susan B. Anthony Center located in Torrington. *http://www.ctcadv.org/Portals/0/Uploads/Documents/FACT-SHT%202010%20-2011%20for%20email%20%20.pdf*

As reported in the July 2011 edition of the *Litchfield County Times*, the Susan B. Anthony Project reported nearly a doubling in the need for services from the previous year, and the Torrington Police reported that between 2008 and 2010 they responded to about 2,400 reports of domestic violence, resulting in 960 arrests.
http://www.countytimes.com/articles/2011/07/06/news/doc4e14713e68326011064513.txt?viewmode=fullstory

Community Health-Related and Environmental Assets

Community Health –Related Assets

Litchfield County is home to three acute care hospitals: Charlotte Hungerford Hospital in Torrington, Western CT Health Systems-New Milford Hospital in New Milford, and Sharon Hospital in Sharon. Some key statistics related to each hospital are provided below:

Hospital	Licensed Beds	ED Beds	ICU Beds	2011 Patient Days	2011 ED Visits
Charlotte Hungerford	109	14	10	27,425	39,535
New Milford	85	12	6	9,347	18,780
Sharon	78	11	n/a	11,883	15,265

Sources: http://www.charlottehungerford.org/wp-content/uploads/2012/03/CHH-Community-Report-11.pdf; http://countytimes.com/articles/2012/01/30/business/doc4f26abc9d88e2184167697.txt?viewmode=fullstory; email communication

In addition, there is one federally qualified health center located within the county, the Community Health and Wellness Center of Greater Torrington. Federally qualified health centers (FQHC) receive federal funding support to provide preventive, primary, and specialty care services in medically underserved areas. Within the county, Torrington is a federally designated primary care health professional shortage area. 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.

According to data compiled by the Pomperaug Health District, there are 16 Long Term Care Facilities in the county, located in Canaan (1), Kent (1), Litchfield (1), Plymouth (1), New Milford (2), Salisbury (1), Sharon (1), Torrington (5), Watertown (2), and Winchester (1). The combined bed capacity of these facilities is 1,562.

Muncipalities within the county are served by 4 full-time health districts, 1 full-time health department, and 1 part-time health department. The majority (17 out of 26) of the county's muncipalities are served by the Torrington Area Health District, including Bethlehem, Canaan, Cornwall, Goshen, Harwinton, Kent, Litchfield, Morris, Norfolk, North Canaan, Plymouth, Salisbury, Thomaston, Torrington, Warren, Watertown, and Winchester.

Within the county, the Pomperaug Health District serves Woodbury, the Farmington Valley Health District serves Barkhamsted, Colebrook, and New Hartford, and the Newtown Health District serves Bridgewater and Roxbury. The New Milford Health Department serves the town of New Milford. The county's two part-time health departments are located in Sharon and Washington. Phone, email, and website contact information for all health department/districts is available at https://www.han.ct.gov/local_health/localmap.asp?cfilter=litchfield&bar=1&debug

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/referweb/search.aspx . 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/Media/Barometer/June2011.pdf

The *2012 County Health Rankings* report indicates that Litchfield County has a ratio of 1 primary care physician to every 1,123 residents, which ranks second to last among CT counties and well below both the national benchmark of 1 primary care physician for every 631 persons and the state average of 1 primary care physician per 729. Geographic areas with lower population densities such as Litchfield County are more likely to have health professional shortages. http://www.countyhealthrankings.org

Environmental Assets

With its sizable land mass and low population density, the County abounds in open space areas for recreation. Seven state parks, five state forests, and one state recreation area lie within its borders. In addition, the county offers countless opportunities for year round outdoor recreation through greenways, trails, conservation areas, and numerous lakes, ponds, rivers, and streams. However, access to many of these resources is limited to residents with private transportation. In terms of public transportation, the Houstanic Area Regional Transit operates a fixed route bus system in New Milford, Torrington Transit Authority provides scheduled service in Torrington, and Dial-A-Ride services are available in the remainder of the county through the Northwestern CT Transit District. According to the Census 2006-2010 ACS, only 1.3% of Litchfield County residents use public transportation to commute to work.

Due to the rural character of many of the county's town centers and roadways, there is limited existing infrastructure such as sidewalks, street lights, or bike lanes to promote walking or biking as a transportation mode within and among county communities.

Special Populations

Vulnerable groups include county residents experiencing financial hardships, language and cultural barriers, and difficulty accessing health care; perinatal women; the very young and very old; persons with disabilities; and persons residing in group quarters. As shown in Figure 1, there has been considerable growth in the county population ages 85 and over, increasing needs for supported living environments and health care services.

Persons in group quarters are in a group living arrangement, that is owned or managed by an independent entity. Group quarters include such places as college residence halls, residential treatment centers, skilled nursing facilities, group homes, military barracks, and correctional facilities. Census 2010 reports a total of 2,804 persons living in group quarters in the county, including 1,566 individuals (503 males and 1,063 females) in institutions. The remaining 1,238 individuals (682 males and 556 females) reside in non-institutional settings.

Recent Census data on the extent and type of disabilities in county residents of all ages was not yet available at the time of publication. Disability information for school- age children as reported by CSDE indicate that in 2010-2011, overall 11.7% of CT K-12 students had one or more disabilities. The most common types of disabilities reported were learning disabilities, followed by speech/language impairments, other health impairments, autism, and emotional disurbances. Data for individual schools in Litchfield County for 2010 - 2011 show a wide variation in the proportion of K-12 students with disabilties by school, ranging from a low of 5.4% to a high of 25%. http://sdeportal.ct.gov/Cedar/WEB/ct_report/SpecialEducationDT.aspx

Related to maternal, infant, and child health, the DPH *Maternal, Infant, and Early Childhood Home Visiting Needs Assessment* examined existing services and compared data to relevant risk factors of families of young families. http://www.ct.gov/dph/lib/dph/needs_assessment_complete_091510.pdf Torrington and Winchester were found to have a very high need for services and Plymouth was found to be in moderate need. EDUCATION CONNECTION's Early Head Start and Head Start Program 2012 Community Assessment details the significant health and social service needs of the families it serves in New Milford, Torrington, and Winchester. In addition, The Torrington Early Childhood Collaborative's *Birth through 8 Community Plan*, a Graustein Discovery Community initiative, presents a community-designed plan to assure "All of Torrington's children from birth through age 8 are healthy and successful learners".

Health Status of County Residents

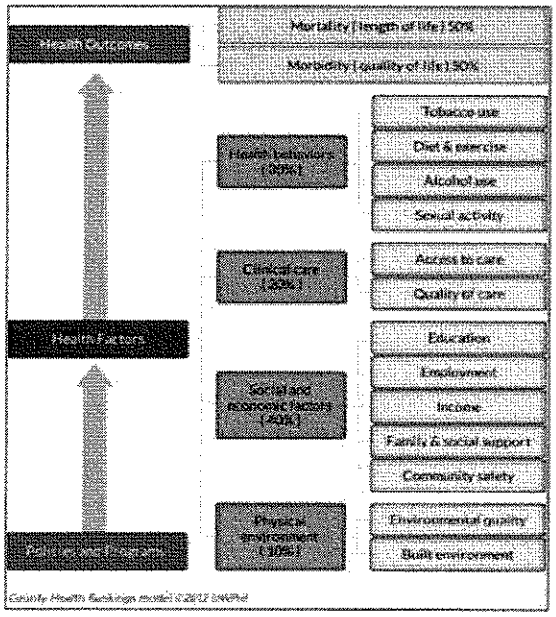
A number of indicators are used to describe the health status of residents in a specific geographic area. These include the presence or absence of health promoting behaviors; access to and utilization of health screenings, primary care and specialized health care services; the incidence and prevalence of chronic and communicable diseases; and the leading causes of premature death and disability.

State and County Health Rankings

According to the United Health Foundation, in 2011 Connecticut ranked third highest in health status in the nation, a continued positive trend from a rank of seventh in 2009 and fourth in 2010. Specific strengths cited include low rates of smoking, a lower prevalence of obesity when compared to other states in the nation, a low percentage of children in poverty, a low rate of uninsured population, high immunization coverage, and relatively high proportion of primary care physicians. Areas where improvements are needed include a high rate of binge drinking and moderate levels of air pollution. The report indicates that CT has demonstrated success in reducing deaths from cardiovascular disease and cancer and, in the past ten years, smoking prevalence has decreased dramatically. *Source: http://www.americashealthrankings.org/CT/2011*

The 2012 County Health Rankings, a collaboration of the University of Wisconsin's Population Health Institute and the Robert Wood Johnson Foundation, ranks CT counties based on health outcomes and health factors. Counties receive a Health Outcome rank based on mortality and morbidity and a Health Factor rank based on health behaviors, clinical care, social-economic factors, and the physical environment. Figure 9 shows the weighting structure used to calculate the rankings. This quantifies the interconnectedness of personal health behaviors, clinical care, social and economic factors and the physical environment in which we live.

Figure 9



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. Litchfield County ranked 4th out of the eight CT counties for health outcomes. Health factors rankings are based on the weighted average for the four different types of factors (% used for weighting are shown in parentheses in Figure 9). Litchfield County ranked 3rd out of the eight counties for health factors.

Rank	Health Outcomes	Rank	Health Factors
1	Tolland	1	Middlesex
2	Middlesex	2	Tolland
3	Fairfield	3	Litchfield
4	Litchfield	4	Fairfield
5	New London	5	New London
6	Hartford	6	Hartford
7	Windham	7	New Haven
8	New Haven	8	Windham

Selected findings specific to Litchfield County, with CT and U.S. comparisons follow.

Table 10 – Litchfield County Health Indicators, 2012

INDICATOR	Litchfield County	Error Margin	National Benchmark *	CT
Premature death	5,285	4,908-5,662	5,466	5,641
Poor or fair health	10%	8-12%	10%	11%
Poor physical health days	3.0	2.7-3.4	2.6	2.9
Poor mental health days	3.1	2.7-3.5	2.3	3.1
Adult smoking	18%	16-20%	14%	16%
Adult obesity	20%	18-23%	25%	23%
Physical inactivity	19%	17-22%	21%	23%
Excessive drinking	17%	15-19%	8%	18%
Preventable hospital stays	50	47-52	49	63
Diabetic screening	84%	80-88%	89%	83%
Mammography screening	74%	69-77%	74%	71%
Access to recreational facilities	12		16	14
Limited access to healthy foods	0%		0%	5%
Fast food restaurants	24%		25%	38%

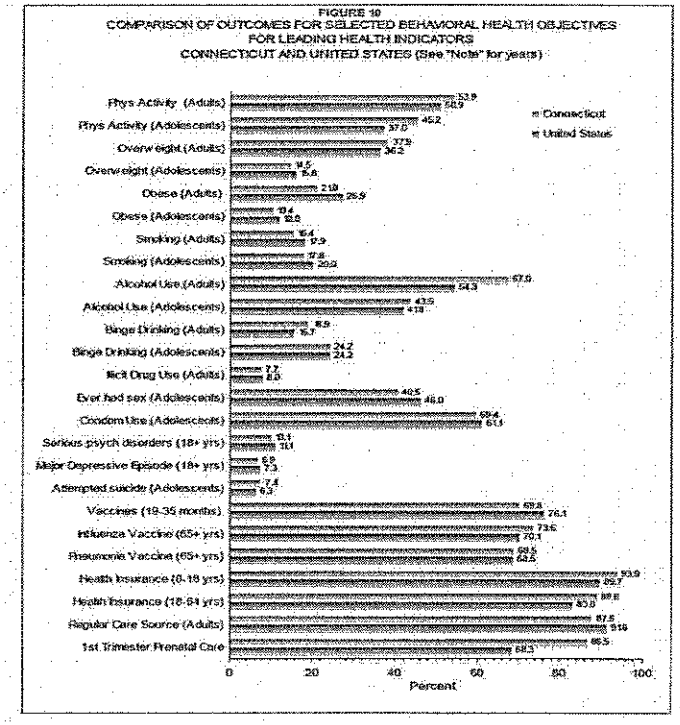
* 90th percentile, i.e., only 10% are better
Note: Blank values reflect unreliable or missing data
Source: http://countyhealthrankings.org

As noted in Table 10, Litchfield County meets National Benchmarks and compares favorably to the state on a number of indicators including: premature death, residents reporting poor or fair health, prevalence of adult obesity and physical inactivity, mammography screening, access to healthy foods, and percentage of fast food restaurants. The county also compares favorably to the state for preventable hospital stays and has comparable rates for excessive drinking and diabetic screening. County indicators that do *not* meet National Benchmarks include poor physical and mental health days, adult smoking, excessive drinking (county rate is more than double the National Benchmark), and preventable hospital stays.

Lifestyle Behaviors and Risk Factors

As stated in *Healthy People 2010*, individual behaviors and social-environmental factors 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 county residents.

The CT DPH report, *Healthy Connecticut 2010,* compares outcomes in U.S. and CT residents for selected behavioral health objectives related to *Healthy People 2010* leading health indicators - physical activity, overweight/obesity, tobacco use, substance abuse, sexual behaviors, mental health, injury and violence, environmental quality, immunization, and access to health care. Key findings are presented in Figure 10.



Sources: Behavioral Risk Factor Surveillance System, Connecticut School Health Survey, Youth Risk Behavior Survey, National Immunization Survey, National Survey on Drug Use and Health.
Notes: Data years: Physical Activity, Overweight, Obese, Smoking, Alcohol Use, Binge Drinking (Adults 2009, Adolescents 2009); Illicit Drug Use, Serious Psychological Disorders, Major Depressive Episode (2006-2007); Sex, Condom Use (during last sexual intercourse), Attempted Suicide (2009); Vaccines (2009); Health Insurance (Children 2007-2008, Adults 18-64 yrs 2009).

In general, CT residents had a lower prevalence of most behavioral risk factors than the average U.S. resident and were more likely to be physically active, not be obese, and not smoke. In contrast, there was a higher prevalence of alcohol use in both teens and adults, and overweight and binge drinking in adults.

The Centers for Disease Control and Prevention (CDC) Community Transformation and the national Million Hearts™ initiatives both target reduction of major risk factors for heart disease and stroke, which are leading causes of death and disability in the nation, state, and county. These risk factors include tobacco use, poor diet, physical inactivity, and unhealthy weight. In addition, control of high blood pressure and high cholesterol are imperative for maintaining cardiovascular health.

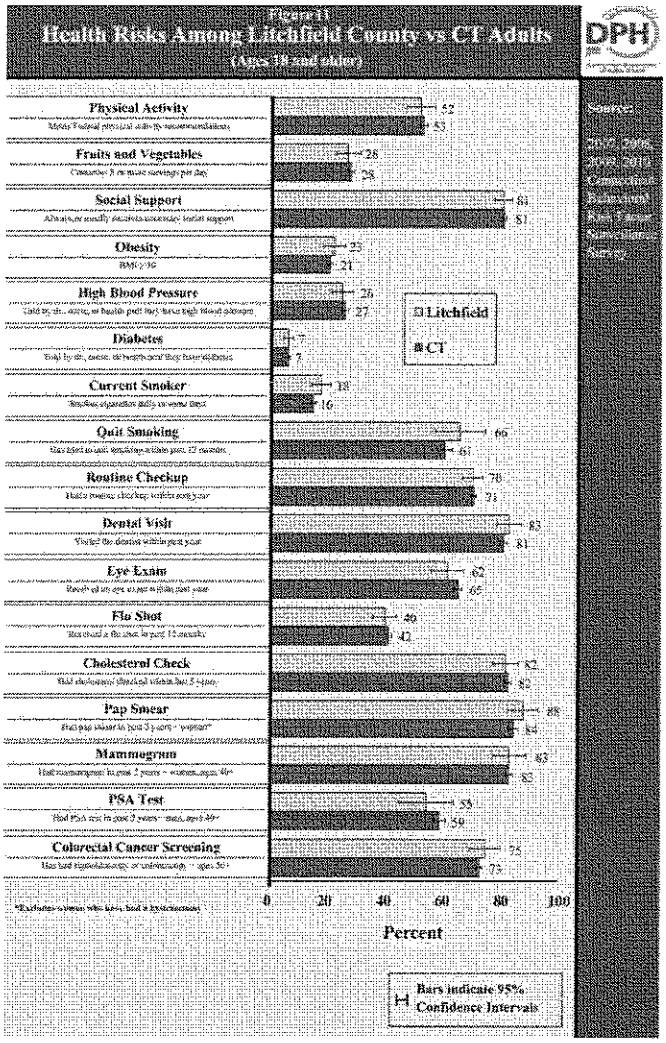
Behavioral Risk Factor Surveillance

The CDC Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing random telephone survey of adults ages 18 and over conducted in all 50 states. The BRFSS originally 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 Litchfield County and the state for the years 2007-2010 are presented in Figure 11. In general, Litchfield County residents had similar rates (identical or within 1 point) to the state related to social support, physical activity, fruit and vegetable consumption, prevalence of high blood pressure and diabetes, having routine medical check-ups, cholesterol testing and mammography.

County residents reported more frequent attempts to stop smoking than state residents as a whole (with co-existing higher smoking rates), and more frequent participation in routine dental care, pap smears and colorectal cancer screening.

County residents were more likely to be obese or current smokers than CT residents overall, and were less likely to participate in routine eye exams, influenza vaccination, and PSA testing (in men). None of the differences were statistically significant.

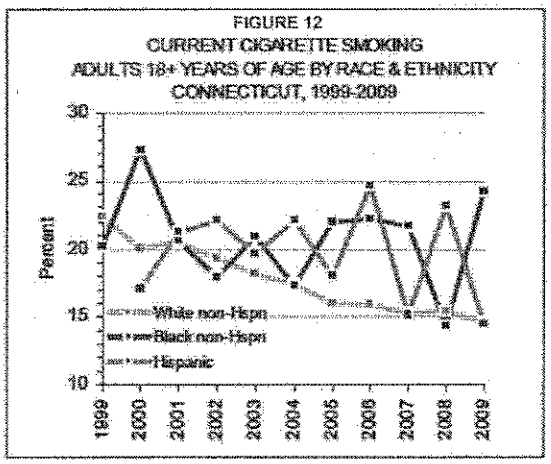


Tobacco Use

Smoking is the single most avoidable cause of chronic disease and death. Smoking increases the risk of lung, bronchus, trachea, and esophageal cancer as well as many other types of cancers, heart disease, stroke, and chronic lung diseases. As reported in *Healthy Connecticut 2010*, over 5,000 CT adults die each year due to smoking and from exposure to secondhand smoke. As reported in the *2011 United Health Foundation's Health Rankings*,

Connecticut has one of the lowest rates of current smoking in adults, and in 2011, ranked 3rd lowest among U.S. states (13.2% compared to 17.3% nationally).

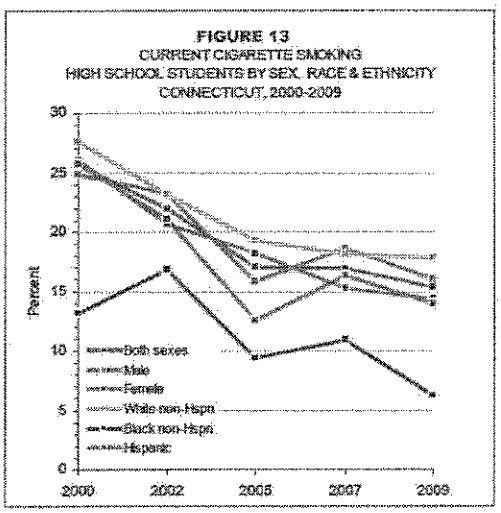
Smoking among Connecticut adults has declined by 40% over the past 20 years, with the greatest decrease occurring during the last decade. As shown in Figure 12, smoking prevalence has decreased for all adult groups other than Black non-Hispanics since 1999. *Source : http://www.ct.gov/dph/lib/dph/state_health_planning/healthy_people/hct2010_final_rep_jun2010.pdf.*



Source: Behavioral Risk Factor Surveillance System

In spite of these positive trends, continued efforts to avoid tobacco use are imperative to future reductions in morbidity and mortality from cancer, respiratory, and cardiovascular diseases. In CT adults, smoking prevalence is highest in males, persons ages 18-24, those with less than a high school education, and those with incomes below $25,000 (26.4%). Based on BRFSS age-adjusted rates, Litchfield County ranked third highest in smoking prevalence among CT counties in 2007-2009.

Healthy Connecticut 2010 reports smoking rates in adolescents have also shown a dramatic decline from 2000-2009 (66% among middle school and 40% among high school students). In middle school, Hispanic or Latino students had the highest smoking rates, while in high school, white non-Hispanics had the highest smoking rates.

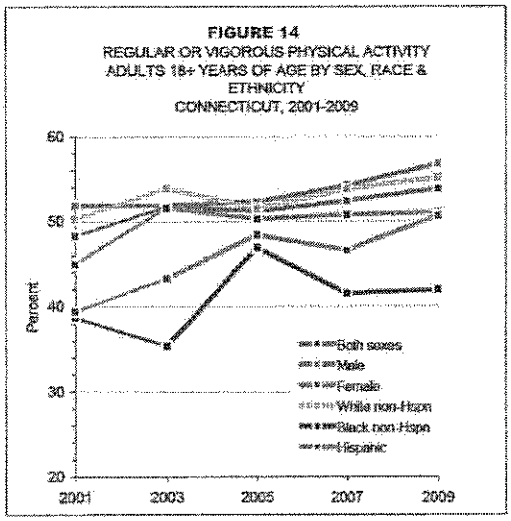


Source: Connecticut Youth Tobacco Survey

Physical Activity, Healthy Eating, and Healthy Weight

Regular or vigorous physical activity is important to overall health and weight management. Regular activity reduces the risk of obesity, heart disease and stroke, colorectal and breast cancers, type 2 diabetes and metabolic syndrome, high cholesterol, high blood pressure, and osteoporosis. Activity also improves mental health and mood and lowers the overall risk of premature death. As shown in Figure 14, physical activity among CT adults increased from 2001-2009, with the greatest gains in Hispanic residents. There was significant disparity in the reported level of activity for Black and White non-Hispanics.

Based on 2007-2009 BRFSS data, adults more likely to meet physical activity recommendations were male, white non-Hispanic, ages 18-24, and those with higher education and income levels. Based on age-adjusted data, Litchfield County ranked third highest among CT counties in the percentage of adults *not* meeting recommended requirements (moderate physical activity for 30 minutes or more 5 times per week or vigorous physical activity for 20 minutes or more 3 times a week).



Source: Behavioral Risk Factor Surveillance System

According to the National Survey of Children's Health, in 2007 CT children were more likely than their counterparts nationwide to be physically active for at least four days per week (36.2% versus 34.4%), and less likely to spend one hour or more a day in front of a television or computer screen (42.7% versus 50.1%). *Source: http://childhealthdata.org/docs/nsch-docs/connecticut-pdf.pdf*

The CT DPH *2009 CT School Health Survey - Youth Behavior Component* report indicates that the percentage of adolescents who are physically *inactive* increases by grade from 11.2% in grade 9 to 19.9% in grade 12; female and Black or Hispanic students are much more likely to be inactive.

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 standardized tests include four areas of fitness: aerobic endurance, flexibility, muscular strength and endurance.

The results for K-12 students enrolled in school districts within the county are presented in Table 11. In general, less affluent districts in the county scored lowest. There is also a trend towards lower percentages in regional middle schools and high schools when compared with their elementary school "home town" districts.

Table 11 – Percentage of K-12 Students Passing All Four Physical Fitness Test Components, 2010-2011

District	% K-12 Students Passing (Listed in Rank Order)
Cornwall School District	80.5
Regional School District 12 (Bridgewater, Roxbury, Washington)	76.9
Regional School District 6 (Goshen, Morris, Warren)	68.8
Kent School District	67.0
Canaan School District	65.2
Salisbury School District	64.6
Litchfield School District	60.1
Plymouth School District	58.6
Sharon School District	56.1
Thomaston School District	52.4
Colebrook School District	51.3
Watertown School District	50.1
Regional School District 14 (Bethlehem, Woodbury)	49.9
New Milford School District	46.9
New Hartford School District	45.9
Regional School District 7 (Barkhamsted, Colebrook, New Hartford, Norfolk)	43.8
Barkhamsted School District	43.2
Regional School District 1 (Canaan, Cornwall, Kent, North Canaan, Salisbury, Sharon)	35.1
Winchester School District	34.7
Norfolk School District	31.9
The Gilbert School	31.0
Torrington School District	30.4
North Canaan School District	28.7
State	51.0

Note: Data for Explorations unavailable. Source: CSDE http://sdeportal.ct.gov/Cedar/WEB/ct_report/PhysicalFitnessDTViewer.aspx

Available county level BRFSS survey data (2007-2010) on healthy eating are limited to fruit and vegetable consumption. Survey findings indicate that only 28% of adults consume the recommended 5 or more servings of fruits and vegetables per day. Eating the recommended amount of fruits and vegetables is more common in females, White non-Hispanics, persons ages 65 and over, and those with higher education and income levels. Based on age-adjusted data, Litchfield ranks fourth among CT counties in the percentage of persons

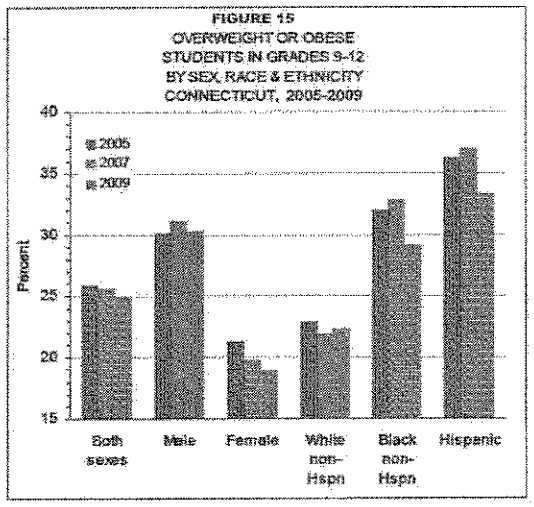
consuming less than the recommended quantity of fruits and vegetables. Related to healthy eating by youth, the *CT School Health Survey - Youth Behavior Component* (2009) reports that overall only 21% of CT high school students consume 5 or more servings of fruits and vegetables, and male students are more likely than female students to consume the recommended amounts (at statistically significant levels). *Source: http://www.ct.gov/dph/lib/dph/hisr/pdf/cshs_2009_ybcreport.pdf*

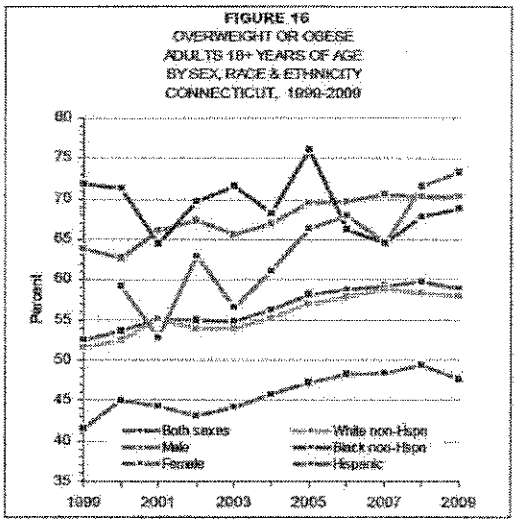
Obesity and overweight in children, adolescents, and adults have reached epidemic proportions in the U.S. According to CDC, the prevalence of childhood and adolescent obesity has more than tripled in the past 30 years. The percentage of children aged 6–11 years in the nation who were obese increased from 7% in 1980 to nearly 20% in 2008. Over this same time period, the percentage of adolescents aged 12–19 years who were obese increased from 5% to 18%.

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 at a greater risk for developing heart disease, hypertension, type 2 diabetes, stroke, osteoarthritis, and certain types of cancer. *Source: CDC, Adolescent and School Health, http://www.cdc.gov/healthyyouth/obesity/facts.htm.*

According to the National Survey of Children's Health, in 2007 approximately 95,000 Connecticut children ages 10-17 years (25.7%) were considered overweight or obese according to Body Mass Index (BMI) for age standards. Hispanic/Latino (40.4%) and Black/African American (38.1%) children in Connecticut are almost two times more likely than White children (21.8%) to be overweight or obese.

Healthy Connecticut 2010 reports racial and ethnic disparities in overweight and obesity in adolescents and adults, as shown in Figures 15 and 16. In high school students, obesity is more prevalent in males and in Hispanic students followed by Black non-Hispanic students. In adults, obesity is more prevalent in these same groups, with rapid rise in obesity in Hispanic adults from 2007-2009.





Based on 2007-2010 BRFSS data, 23% of adults in the county are obese. Obesity is also more common in adults with lower educational and income levels. Litchfield County ranked third highest among CT counties in the age-adjusted rate of obesity in adults.

The Burden of Chronic Disease

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 health care costs in the U.S.

The burden of chronic disease is not shared equally among population subgroups in our nation, state or county – significant disparities exist. *Healthy People 2020* defines a *health disparity* as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion." Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual's or population's health, are known as *determinants of health*.

The burden of chronic disease in county residents is assessed in several ways – through examination of disease surveillance data, health care utilization data (such as emergency department visit and hospitalization rates by type of diagnosis), and mortality data.

The most prevalent category of chronic diseases in the U.S. is 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 Connecticut, accounting for about one-third of all resident deaths. More than half (55%) of these deaths are among females. 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. The age-adjusted mortality rates for CVD have declined significantly for CT residents over the past decade. However, there are considerable disparities in mortality rates from CVD, with Black or African American residents having the highest rates. *Source: CTDPH, the Burden of Cardiovascular Disease in Connecticut, 2010 Surveillance Report, http://www.ct.gov/dph/lib/dph/hisr/pdf/2010cvd_burdendoc_final.pdf.*

High blood pressure and elevated cholesterol levels are both major risk factors for CVD. Data from the 2007-2010 BRFSS show that more than one in four (27%) CT adults have been told they have high blood pressure by a health professional. High blood pressure is more common in males, Black non-Hispanic adults, persons ages 65 and over, and in persons with lower education and income levels. Based on age-adjusted rates, Litchfield County ranks third lowest among CT counties in the prevalence of high blood pressure in adult residents (23.4%).

Data from the 2007-2010 BRFSS show that the majority of CT and county adults (82%) had their cholesterol checked in the past 5 years. BRFSS data from 2007-2009 indicate that adults most likely to have their cholesterol checked were female, white non-Hispanic, ages 65 and over, (95% vs. 40% in persons ages 18-24), and adults with higher education and income levels. Adults most frequently reporting they had *never* had their cholesterol checked were Hispanic or Latino (31%), and persons with less than a high school education and annual incomes below $25,000. Based on age-adjusted rates, Litchfield County ranked second to last in the percentage of adults who reported *never* having their cholesterol checked (20.8%).

Data on the prevalence of elevated cholesterol in adults compiled from the 2007-2009 BRFSS show that 37.8% of CT adults have been told by

a health professional that their blood cholesterol is high. High blood cholesterol is more common in males, White non-Hispanic residents, persons ages 65 and over, and persons with less education and income. Based on age-adjusted rates, Litchfield County residents have the lowest prevalence of high cholesterol among CT counties (29.3%).

The second most frequent type of chronic disease in CT is malignant neoplasms or cancer. The incidence rate of new cancer cases and mortality rates have been steadily decreasing. This is the result of increased primary prevention efforts, earlier detection and improved treatment options. *Source: CTDPH, Connecticut Comprehensive Cancer Control Program, Connecticut Cancer Plan 2009-2013, http://www.ct.gov/dph/lib/dph/comp_cancer/pdf_files/ctcancerplan_2009_2013_cdversion.pdf.* In 2008, the age-adjusted cancer incidence rate in Connecticut was estimated at 499.8 per 100,000 people, a decrease from the 2007 rate of 502.5 per 100,000 people. *Source: http://statecancerprofiles. cancer.gov.*

In Connecticut (2007-2009 BRFSS data), an estimated 6.9% or approximately 186,000 adults aged 18 and older reported being diagnosed with diabetes. An additional 93,000 adults are estimated to have undiagnosed diabetes. The prevalence of type 2 diabetes in CT and in the nation has increased significantly. Type 2 diabetes typically develops later in life and is strongly associated with overweight and obesity. *Source: CTDPH, The Burden of Diabetes in Connecticut, 2010 Surveillance Report, http://ct.gov/dph/lib/dph/hisr/pdf/2010diabetesburden_final.pdf.*

As reported in the 2007-2009 BRFSS, diabetes is twice as prevalent in Black non-Hispanic adults as in White non-Hispanic adults, and prevalence increases with age. Diabetes also occurs most frequently in adults with less education and lower incomes, who also experience disproportionately higher rates of obesity. The age-adjusted prevalence of diabetes in county adults ranks fifth among CT counties (6.7%).

Utilization of health care services, including emergency department (ED) visit and hospitalization rates are important measures of the burden of chronic disease. Frequent use of ED services for primary care conditions also indicates that a community may have an insufficient quantity of primary care providers or health providers serving the uninsured.

Table 12 depicts ED visit rates for CT and for Litchfield County. These rates represent ED visits by residents to any hospital within CT (visits to hospitals outside CT are excluded). Overall, ED visit rates for county residents are comparable to those for CT residents, however there are notable differences by race/ethnicity and diagnostic group. The ED visit rates for White and Black-non Hispanic residents are well above the state average, and those for Hispanics fall well below the state average. Lower ED visit rates for Hispanic residents may be explained in part due to underreporting of this ethnicity on ED intake records.

By diagnostic group, county residents overall had similar ED visit rates for cancer (all sites and lung/bronchus) and for liver disease, including cirrhosis. County residents had higher ED visit rates for major CVD, coronary heart disease, acute myocardial infarction (MI), congestive heart failure, and stroke. Black non-Hispanics had disproportionately high rates for diabetes, alcohol & drug abuse, major CVD, and congestive heart failure. County residents overall had lower ED visit rates for diabetes, drug and alcohol abuse, chronic obstructive lung disease and asthma, however again the rate for Black non-Hispanics was well above the state and county average. ED visits for most chronic conditions increased with advancing age, with the exception of asthma which is highest in children four years of age and under.

Table 12 - State and County Age-Adjusted ED Visit Rates per 100,000 Residents by Gender, Race, and Ethnicity, 2005-2009

	Connecticut						Litchfield County						
Diagnostic Group*	Total	Female	Male	White N/H	Black N/H	Hispanic Latino	Diagnostic Group	Total	Female	Male	White N/H	Black N/H	Hispanic Latino
All	36,400.8	38,135.6	34,626.8	24,064.9	46,846.4	55,649.1	All	36,635.0	37,346.3	35,654.5	35,455.8	64,926.6	21,092.8
Cancer, all sites	11.7	10.4	13.6	7.8	17.2	19.0	Cancer, all sites	12.2	11.0	14.3	11.3	a	a
Oral Cavity & Pharynx	0.3	0.1	0.5	0.2	0.7	0.6	Oral Cavity & Pharynx	a	-	a	a	-	-
Lung & Bronchus	2.4	2.0	3.0	1.7	3.4	2.9	Lung & Bronchus	2.5	2.4	2.9	2.4	a	a
Diabetes	182.0	162.8	202.7	93.4	487.9	452.4	Diabetes	142.6	120.3	168.2	130.1	442.8	118.8
Alcohol & Drug Abuse	775.9	420.8	1,140.1	560.0	1,018.2	1,077.9	Alcohol & Drug Abuse	732.8	489.3	966.2	709.8	961.0	309.5
Major CVD	388.0	349.2	433.3	267.1	616.8	509.9	Major CVD	476.6	405.2	550.0	462.0	706.0	264.0
CHD	37.1	23.3	53.0	29.6	19.7	40.5	CHD	68.9	43.9	96.3	68.8	63.9	a
Acute MI	20.4	11.7	30.3	17.3	8.6	17.5	Acute MI	36.5	21.9	52.5	36.8	a	a
CHF	36.2	31.0	43.3	24.1	72.6	57.7	CHF	57.7	52.0	65.8	55.3	168.2	a
Stroke	19.0	16.9	21.6	14.6	15.2	18.8	Stroke	35.2	26.3	44.8	33.9	a	24.7
COPD	984.2	1,085.2	877.1	549.1	1,602.5	2,094.0	COPD	786.1	865.6	691.1	751.5	2,068.9	613.0
Asthma	663.2	732.3	587.7	320.6	1,218.6	1,545.2	Asthma	463.7	516.5	401.7	432.4	1,655.0	459.4
LD & Cirrhosis	5.2	2.7	7.8	3.5	4.0	12.7	LD & Cirrhosis	5.3	2.4	8.1	5.3	-	-

Notes: CVD = Cardiovascular Disease; CHD= Coronary Heart Disease; MI = Myocardial Infarction (Heart Attack); CHF = Congestive Heart Failure; COPD = Chronic Obstructive Pulmonary Disease; LD =Liver Disease. a= data suppressed due to confidentiality. A dash (-) represents the number zero. Source: Connecticut Department of Public Health. 2012. Connecticut Hospital Information Management Exchange (CHIME) Emergency Department Data Set, 2005-2009.

Table 13 shows hospitalization rates for the state and county for the same diagnostic categories. County rates are below the state rates for the majority of diagnostic categories, including all diagnostic groups, cancer (all sites and lung/bronchus), diabetes, major CVD, CHD, acute MI, CHF, stroke, COPD, asthma, and liver disease and cirrhosis.

Table 13 - State and County Age-Adjusted Hospitalization Rates per 100,000 Residents by Gender and Race/Ethnicity, 2005-2009

	Connecticut						Litchfield County						
Diagnostic Group*	Total	Female	Male	White N/H	Black N/H	Hispanic Latino	Diagnostic Group	Total	Female	Male	White N/H	Black N/H	Hispanic Latino
All	10,036.5	11,180.6	9,078.6	9,114.1	14,351.4	11,583.8	All	8,845.3	9,952.5	7,910.5	8,822.8	10,268.2	3,886.7
Cancer, all sites	377.1	368.6	398.5	363.5	450.2	302.1	Cancer, all sites	351.0	329.5	388.3	346.4	293.1	115.9
Oral Cavity & Pharynx	6.4	3.8	9.4	6.2	8.3	4.1	Oral Cavity & Pharynx	9.1	4.6	14.6	9.1	-	a
Lung & Bronchus	42.9	38.4	49.6	42.7	46.7	26.2	Lung & Bronchus	38.6	31.3	47.7	38.2	a	a
Diabetes	132.9	112.6	157.1	97.3	403.5	249.6	Diabetes	86.7	60.0	116.5	87.8	180.9	23.9
Alcohol & Drug Abuse	139.3	84.8	196.4	143.3	160.1	129.5	Alcohol & Drug Abuse	165.5	97.8	235.7	173.3	233.3	37.0
Major CVD	1,401.8	1,111.2	1,773.9	1,313.4	1,986.6	1,509.6	Major CVD	1,177.0	918.0	1,488.7	1,152.2	1,425.4	476.3
CHD	406.5	265.9	578.4	392.3	396.8	427.1	CHD	338.6	206.2	492.0	323.0	231.3	129.3
Acute MI	163.0	115.9	221.9	158.0	153.0	180.0	Acute MI	146.2	101.4	197.8	141.9	96.6	75.9
CHF	172.8	144.3	214.2	154.6	306.7	230.6	CHF	115.6	102.6	133.0	114.2	226.4	32.1
Stroke	183.8	158.7	216.9	169.9	290.3	182.7	Stroke	166.0	146.9	189.4	162.9	170.5	45.4
COPD	277.8	297.6	258.2	222.8	515.9	548.5	COPD	207.2	230.9	182.5	210.5	266.2	78.8
Asthma	136.9	157.9	112.5	83.3	363.7	378.0	Asthma	69.5	83.5	54.0	69.8	170.3	52.0
LD & Cirrhosis	27.4	18.1	37.6	24.2	28.5	63.3	LD & Cirrhosis	21.1	14.3	28.3	21.7	a	17.0

Source: Connecticut Department of Public Health. 2012. Connecticut Hospital Information Management Exchange (CHIME) Hospital Discharge Data Set, 2005-2009.

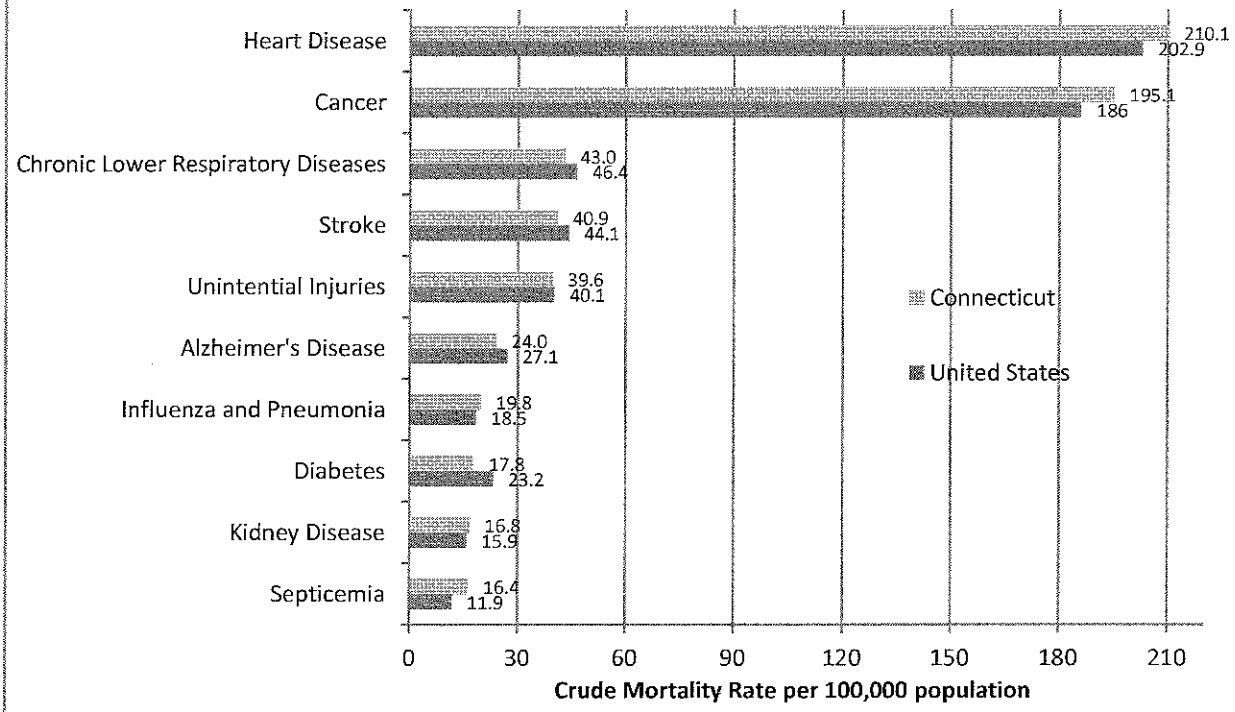
The rates provided in Table 13 represent admissions to any CT hospital. Hospitalization rates for county residents are higher than state rates for oral cavity/pharynx cancers and for alcohol and drug abuse. Within county hospitalization rates are higher for males for most diagnoses, and for Black non-Hispanic residents than other racial/ethnic groups. The low hospitalization rates for Hispanic county residents may in part reflect underreporting of Hispanic ethnicity on hospital records. As expected, hospitalization rates for chronic diseases generally rise with advancing age and are highest in persons ages 65 and over. The notable exception is again asthma, with the highest rates in children ages birth to four.

Mortality and Leading Causes of Death

Mortality data is highly useful in providing insight about priority health issues in a community by identifying the underlying causes of disease and monitoring changes in the leading causes of death over time. The leading causes of death in the county, state, and nation are closely linked to personal health behaviors, environmental and social factors, and the availability, accessibility, and utilization of quality preventive, primary, and specialty health care services.

Figure 17 presents the leading causes of death in the United States and Connecticut for 2008, based on crude rates. Although the 10 causes of death are not in the same exact rank order, the underlying causes remain chronic conditions which are related to behavioral risk factors. This is especially true of physical activity; healthy eating; avoiding tobacco use, alcohol abuse, and drugs; managing stress; and other preventive lifestyle behaviors.

Figure 17: Leading Causes of Death in Connecticut and the U.S. , 2008



Source: Centers for Disease Control and Prevention, National Center for Health Statistics http://www.cdc.gov/nchs/data/dvs/LCWK9_2008.pdf.

It is noteworthy that there are differences in the rank order of the leading causes of death in CT by gender and race/ethnicity. For example, in 2009 the leading cause of death for males of all races/ethnicities was cancer and for females it was heart disease. For both White males and females, the leading cause of death was heart disease, followed by cancer. For Black or African American and Hispanic or Latino residents, the leading cause of death was cancer for both genders, followed by heart disease. *Source: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, WISQARS Leading Causes of Death Reports, 1999-2009, http://ebappa.cdc.gov/cgi-bin/broker.exe.*

Figure 17 reflects crude mortality rates, which have not been age-adjusted. Crude mortality rates are useful in assessing the magnitude of the absolute number of deaths in a population, however they do not account for differences in rates that are attributable to differences in the age composition of the resident population.

Municipalities in Litchfield County with a higher proportion of older residents, such as Salisbury, would be expected to have higher crude mortality rates from chronic diseases, as the incidence and prevalence of these diseases increase with age. Age-adjusted mortality rates (AAMR) correct for differences in age distribution of communities, and therefore give a more accurate representation of excess disease mortality.

Significant disparities in health status, including mortality rates from the leading causes of death and premature death, measured as Years of Potential Life Lost (YPLL) exist in the U.S., CT, and the county. A major goal of *Healthy People 2020* is to achieve health equity, eliminate disparities, and improve the health of all population groups.

AAMR and YPLL data for Litchfield County for the five year period 2005-2009, with state and county comparisons, follow in Tables 14 and 15.

Table 14 - State and County Age-Adjusted Mortality Rates per 100,000 Residents by Gender and Race/Ethnicity, 2005-2009

	Connecticut						Litchfield County						
Cause of Death	Total	Male	Female	White N/H	Black N/H	Hispanic Latino	Cause of Death	Total	Male	Female	White N/H	Black N/H	Hispanic Latino
All	687.7	829.0	583.1	679.5	809.3	529.0	All	689.8	823.1	586.6	696.6	572.8	425.3
Malignant Neoplasms	170.1	206.2	147.1	171.9	190.5	108.4	Malignant Neoplasms	164.3	201.4	140.4	166.2	128.9	81.3
Diabetes Mellitus	16.7	19.7	14.4	15.1	35.9	24.5	Diabetes Mellitus	13.6	16.3	11.4	13.3	17.9	37.0
Alzheimer's Disease	16.6	13.8	17.8	17.1	15.1	8.9	Alzheimer's Disease	14.6	12.6	15.4	14.5	42.1	26.9
Major CVD	217.4	264.4	182.1	216.4	253.2	157.5	Major CVD	230.5	267.1	199.8	232.4	152.0	151.6
Pneumonia & Influenza	17.2	21.0	15.0	17.2	18.0	13.7	Pneumonia & Influenza	19.7	21.6	18.5	20.0	0.0	11.2
CLRD	34.5	38.9	31.9	35.9	24.4	20.5	CLRD	40.3	45.9	37.8	41.0	37.6	11.2
CLD & Cirrhosis	7.2	10.0	4.7	7.1	6.3	11.0	CLD & Cirrhosis	7.0	9.8	4.6	7.0	6.5	11.9
Nephritis, nephrotic syndrome, nephrosis	13.3	17.8	10.7	12.3	26.9	12.3	Nephritis, nephrotic syndrome, nephrosis	12.4	15.6	10.5	12.6	22.7	0.0
Accidents	32.9	47.1	20.4	33.9	32.0	29.4	Accidents	35.0	48.9	21.8	36.0	18.0	32.5
Alcohol Induced	5.1	7.8	2.6	5.2	4.6	5.2	Alcohol Induced	5.7	9.2	2.4	5.9	0.0	2.4
Drug Induced	11.1	15.1	7.1	12.2	10.3	10.0	Drug Induced	11.8	15.8	7.8	12.3	5.9	9.1

Source: Connecticut Department of Public Health. 2012. Vital Records Mortality Files, 2005-2009.

Age-adjusted all-cause mortality rates for the county and state are comparable, including rates for males and females. County all-cause mortality rates for White non-Hispanics (both genders) are higher, and rates for Black non-Hispanics and Hispanics are considerably lower than the state rates.

County rates are lower than state rates for many causes of death including malignant neoplasms (cancer), diabetes mellitus, Alzheimer's disease and kidney diseases, and comparable to the state for chronic liver disease and cirrhosis. County mortality rates are above the state for major CVD, pneumonia and influenza, chronic lower respiratory disease (CLRD), accidents, and alcohol and drug-induced deaths.

Within county AAMR comparisons by gender and race/ethnicity indicate higher mortality rates for males for all causes of death, and for White non-Hispanics (both genders) for all causes, malignant neoplasms, major CVD, pneumonia & influenza, chronic lower respiratory disease, accidents, and alcohol and drug-induced deaths. These same trends are evident statewide. Within the county, Black non-Hispanic residents have higher mortality rates from diabetes, Alzheimer's disease and kidney disease. Hispanic or Latino residents have higher mortality rates from diabetes.

Table 15 represents the years of potential life lost to age 75, or premature death, based on the leading causes of death in the state and county. By cause of death, the largest impact in the state and county is manifested by malignant neoplasms, followed by accidents, major CVD, and drug-induced deaths. Males and Hispanic or Latino residents have the highest rate of premature death in the county overall.

Table 15 - State and County Age-Adjusted Years of Potential Life Lost to Age 75, Rates per 100,000 Residents by Gender and Race/Ethnicity, 2005-2009

	Connecticut						Litchfield County						
Cause of Death	Total	Male	Female	White N/H	Black N/H	Hispanic Latino	Cause of Death	Total	Male	Female	White N/H	Black N/H	Hispanic Latino
All	5,315.0	6,710.9	3,956.3	4,766.3	8,827.5	5,705.6	All	4,986.0	6,426.9	3,549.6	5,025.2	3,782.6	5,051.5
Malignant Neoplasms	1,161.6	1,208.5	1,121.5	1,149.3	1,579.0	954.4	Malignant Neoplasms	1,114.1	1,151.2	1,081.2	1,129.7	541.5	936.9
Diabetes Mellitus	103.9	136.5	73.0	86.9	254.8	144.3	Diabetes Mellitus	102.2	138.9	67.3	97.8	261.7	54.4
Alzheimer's Disease	7.1	8.3	6.0	7.4	2.2	11.3	Alzheimer's Disease	4.3	8.3	0.5	4.5	0.0	0.0
Major CVD	904.6	1,273.9	557.5	830.1	1,757.1	888.8	Major CVD	888.5	1,185.7	599.1	893.2	1,298.0	959.7
Pneumonia & Influenza	51.5	58.3	45.5	42.1	108.5	70.2	Pneumonia & Influenza	50.0	41.4	59.6	51.7	0.0	0.0
CLRD	108.9	113.2	105.1	105.7	160.5	76.7	CLRD	100.7	90.6	110.4	104.2	143.8	0.0
CLD & Cirrhosis	110.2	154.5	68.2	110.5	93.4	160.8	CLD & Cirrhosis	104.9	146.6	64.4	104.0	189.6	125.5
Nephritis, nephrotic syndrome, nephrosis	53.7	66.4	41.9	38.5	170.0	94.9	Nephritis, nephrotic syndrome, nephrosis	43.4	55.5	31.9	45.2	84.2	0.0
Accidents	840.5	1,243.9	435.3	870.8	832.7	837.1	Accidents	989.9	1,503.3	466.9	1,034.6	297.6	900.9
Alcohol Induced	110.5	162.1	61.4	116.2	80.8	112.4	Alcohol Induced	144.2	228.0	61.7	146.9	0.0	131.1
Drug Induced	397.8	557.8	237.8	454.8	312.1	330.2	Drug Induced	454.8	617.6	291.3	474.0	297.6	334.6

Source: Connecticut Department of Public Health. 2012. Vital Records Mortality Files, 2005-2009.

Examination of mortality data over time and by municipality offers additional insight as to improvements in health status and emerging health issues. Reliable AAMR data is, however, unavailable for most towns in the county due to their small population size, and the corresponding low numbers of deaths, which causes the rates to be very unstable.

Five-year average AAMR data for 2000-2004 and 2005-2009 for the 5 most populated municipalities in Litchfield County, the 'rest of county' (excluding these municipalities) and the county and state as a whole for the 10 leading causes of death (with the addition of trachea, bronchus & lung cancer) are provided in Tables 16a and 16b. In order to permit rate comparisons across municipalities with the county and state, Census 2000 was used as the reference population base in calculating the state and county rates, to be consistent with the methodology used for municipal rates. This artificially inflates the rates for 2005-2009, as the Census 2000 population base is less than the 2005-2009 ACS population base used to calculate the state and county AAMR rates found in Table 14. Even with these limitations, review of this data does provide some useful comparisons across geographic areas within the county, and trends over time.

Table 16a: Leading Causes of Death, Five-Year Average Age Adjusted Mortality Rates, 2000-2004

Community	All Causes	Diseases of the Heart	Cancer	Trachea, Bronchus & Lung Cancer	Stroke	Chronic Lower Respiratory Diseases	Accidents	Alzheimer's Disease	Influenza & Pneumonia	Diabetes	Kidney Disease	Septicemia
Torrington	800.5	204.3	196.0	62.9	49.9	47.0	40.8	8.9	27.6	16.1	17.0	12.5
New Milford	796.4	193.4	192.5	51.6	41.3	47.5	41.5	25.4	34.8	20.8	--	20.1
Plymouth	827.5	232.1	192.8	46.5	43.6	47.0	37.7	--	40.4	--	--	--
Watertown	775.8	255.0	185.1	52.4	33.5	42.4	31.7	--	19.2	19.9	13.3	14.2
Winchester	904.2	217.7	229.7	59.7	69.0	51.7	29.1	--	29.4	--	--	22.4
Rest of County	724.3	207.4	177.3	40.3	45.4	45.7	37.7	12.0	24.4	11.2	9.5	11.8
Litchfield County	763.4	210.1	186.0	48.9	46.1	45.7	36.8	11.5	26.5	15.2	11.7	14.1
Connecticut	744.7	206.7	183.9	49.3	44.7	36.7	31.0	13.6	20.4	17.9	14.0	13.7

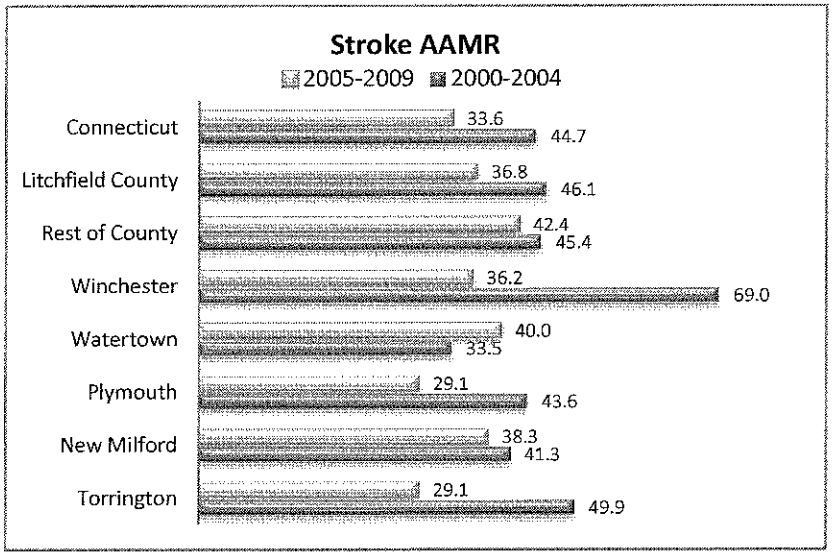
Table 16b: Leading Causes of Death, Five-Year Average Age Adjusted Mortality Rates, 2005-2009

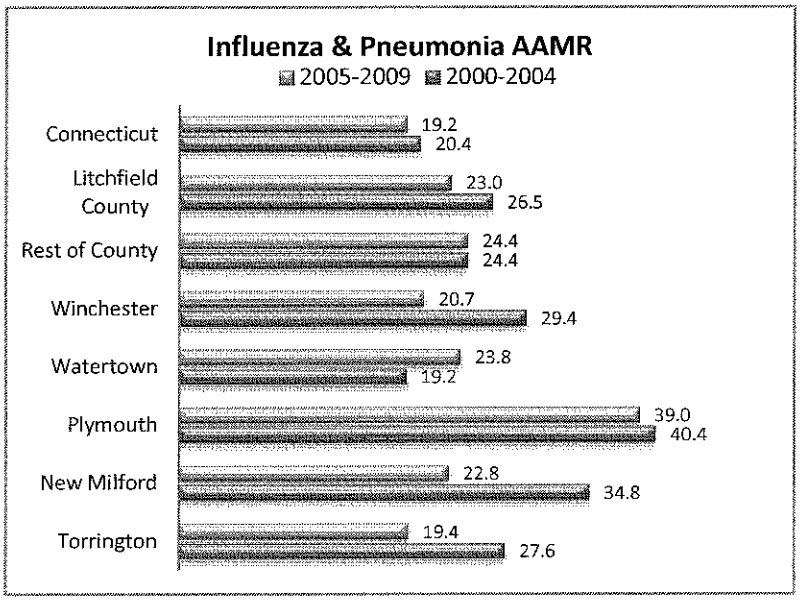
Community	All Causes	Diseases of the Heart	Cancer	Trachea, Bronchus & Lung Cancer	Stroke	Chronic Lower Respiratory Diseases	Accidents	Alzheimer's Disease	Influenza & Pneumonia	Diabetes	Kidney Disease	Septicemia
Torrington	736.1	203.8	162.6	47.2	29.1	41.3	40.4	10.1	19.4	20.8	21.9	12.0
New Milford	817.6	163.1	199.6	59.3	38.3	48.0	37.5	34.8	22.8	13.1	--	20.8
Plymouth	959.4	289.0	211.8	58.3	29.1	68.4	46.4	--	39.0	--	--	--
Watertown	793.4	206.7	199.0	51.2	40.0	38.1	40.6	14.1	23.8	14.5	14.6	24.1
Winchester	849.5	212.5	204.0	43.0	36.2	39.1	55.1	--	20.7	23.7	--	--
Rest of County	765.3	218.7	182.0	42.4	42.4	46.7	36.6	19.7	24.4	12.6	9.7	14.1
Litchfield County	771.5	208.5	182.2	46.8	36.8	44.3	38.7	16.8	23.0	15.2	14.0	14.9
Connecticut	745.4	184.9	181.4	47.6	33.6	36.8	34.9	18.8	19.2	18.0	14.5	15.1

Source: Connecticut Department of Public Health, 2012 Age-Adjusted Mortality Rates, 2005-2009. Note: To permit comparisons at the municipal and 'rest of county' level, all rates were age-adjusted to Census 2000 population, to be consistent with the reference population used to calculate town AAMR rates. Use of the Census 2000 reference population inflates the CT mortality rates for 2005-2009 above those shown in Table 14 and those published on the CTDPH website.

In reviewing municipal level data for 2000-2004 and 2005-2009, all-cause AAMR rates for the 'rest of county', which consists of more rural towns, are lower than those for the county as a whole and with one exception for the 5 most populated municipalities as well. For the county overall, a favorable decline in AAMR is evident from 2000-2004 to 2005-2009 for diseases of the heart, cancer (all sites and trachea, bronchus & lung), stroke, CLRD, and influenza and pneumonia.

Among county municipalities, both Torrington and Winchester show a decline in all-cause AAMR, and most of the five most populated municipalities show a reduction in AAMR for diseases of the heart, stroke, and influenza & pneumonia in 2005-2009 when compared with 2000-2004. It should be noted that additional AAMR reductions may have occurred but are masked by the rate calculation methodology used.





Healthy People 2020 Leading Health Indicators

Healthy People 2020 includes 26 Leading Health Indicators (LHIs) which will be tracked, measured, and reported regularly throughout the next decade at the national and state level. Baseline data and targets related to the Community Transformation Strategic Directions are provided below for future reference.

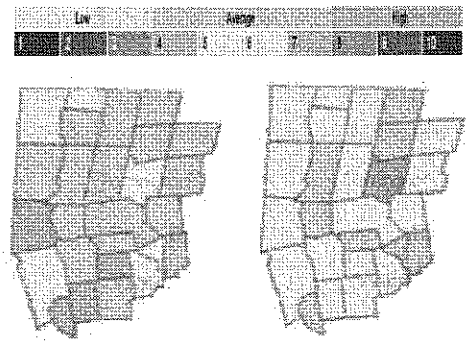
The most recent available county and/or state baseline data indicate that the following *Healthy People 2020* LHI targets have been met: 1) persons with a primary care provider, 2) adult colorectal screening, 3) children exposed to secondhand smoke (proxy measure), 4) adults meeting current physical activity guidelines, 5) adult obesity, 6) adolescent obesity, 7) high school graduation rates, 8) adult binge drinking, and 9) adolescents smoking cigarettes in the past 30 days. Data indicate the following targets have not yet been achieved: 1) persons with medical insurance, 2) adolescents using alcohol or any illicit drugs during the past 30 days, and 3) current adult cigarette smokers.

***HEALTHY PEOPLE 2020* INDICATOR** (LHI Reference Number)	Target	National Baseline	CT/County Baseline
Access to Health Services:			
Persons with medical insurance (AHS-1.1)	100.0	83.2	90.8/91.2
Persons with a usual primary care provider (AHS-3)	83.9	76.3	87.5 (CT) Adults
Clinical Preventive Services:			
Adults who receive a colorectal cancer screening based on the most recent guidelines (C-16)	70.5	54.2	73.0/75.0
Adults with hypertension whose blood pressure is under control (HDS-12)	61.2	43.7	n/a
Adult diabetic population with an A1c value greater than 9 percent (D-5.1)	14.6	16.2	n/a
Environmental Quality:			
Children aged 3 to 11 years exposed to secondhand smoke (TU-11.1)	47.0	52.2	37.1 (CT) MS students
Nutrition, Physical Activity, and Obesity:			
Adults who meet current Federal physical activity guidelines for aerobic physical activity and muscle-strengthening activity (PA-2.4)	20.1	18.2	53.1/52.2
Adults who are obese (NWS-9)	30.6	34.0	21.4/22.7
Children and adolescents who are considered obese (NWS-10.4)	14.6	16.2	10.4 (CT) HS students
Total vegetable intake for persons aged 2 years and older (NWS-15.1)	1.1 cup equivalent/ 1,000 calories	0.8 cup equivalent/ 1,000 calories	n/a
Social Determinants:			
Students who graduate with a regular diploma 4 years after starting 9th grade (AH-5.1)	82.4	74.9	92.1 (CT)
Substance Abuse:			
Adolescents using alcohol or any illicit drugs during the past 30 days (SA-13.1)	16.5	18.3	43.5 (CT) HS Students
Adults engaging in binge drinking during the past 30 days (SA-14.3)	24.3	27.0	18.0/17.0
Tobacco:			
Adults who are current cigarette smokers (TU-1.1)	12.0	20.6	18.0/16.0
Adolescents who smoked cigarettes in the past 30 days (TU-2.2)	16.0	19.5	15.3 (CT) HS Students

Sources: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=1#11; CTDPH Healthy Connecticut 2010; BRFSS 2007-2010; 2009 CT Youth Behavior and Tobacco Components; 2012 County Health Rankings. MS= Middle School; HS=High School.

Overview of Health Disparities & Inequities in Litchfield County

Litchfield County



Social Determinants **Health Outcomes**

In spite of the overall favorable health status in the county, health disparities and inequities are apparent, as they are in municipalities throughout CT. As noted in the previous sections of this report, health-related lifestyle behaviors, health status and outcomes are all strongly influenced by the social conditions that exist within a given community.

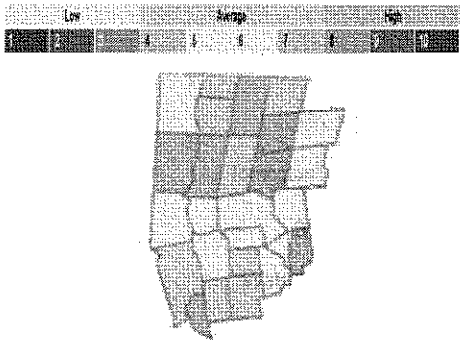
These conditions, also known as the social determinants of health, include such factors as civic involvement, community safety, economic security, education, employment, environmental quality, and housing. The Health Equity Index (Index) is a web-based assessment tool developed by the Connecticut Association of Directors of Health (CADH) that can be used to identify the social, economic, political, and environmental conditions within a community that are most strongly associated (or correlated) with specific health outcomes. Use of the Index findings facilitates collaboration among public health, community and civic leaders and residents to collectively develop and implement strategies to improve community-level policies and practices affecting health.

The Index provides data, scores, correlations and GIS mapping for all 169 communities in Connecticut. The scores for each social determinant and health outcome are calculated on a 10-point scale (based on decile values) with 1 (red) indicating the least desirable community social conditions or health outcomes, and 10 (green) indicating the most desirable. A score of 5 is the median value for the state.

For Litchfield County, the overall average social determinant score is 7, well above the state average. Of the 26 municipalities in the county, only Plymouth and Winchester score below the state average. A detailed narrative of community social conditions was previously presented in the Population and Demographics Overview section of this report, including education, economic stability, employment, housing, demographic trends, health insurance coverage, and community safety. Health outcome scores within the county vary widely, however the county average for all health outcome indicators is 5, equivalent to the state median.

For this report, the Health Equity Index was used to provide additional insight on the health outcomes most closely related to the five CTG health-related strategic directions: tobacco free living; active living & healthy eating; quality, high impact clinical and other preventive services; social & emotional wellness; and healthy & safe physical environments. The Index health outcomes include: Accidents & Violence, Cancer, Cardiovascular Disease, Diabetes, Health Care Access, Life Expectancy, Liver Disease, Mental Health, Renal Disease, and Respiratory Illness.

Accidents and Violence



The composite Index health outcome score for Accidents and Violence in a community include statistical data on: Age-Adjusted Mortality Rates (AAMR) and Years of Potential Life Lost (YPLL) for intentional and unintentional injuries, and for homicides and legal interventions. While most Litchfield County municipalities score either close to the state average (score of 5) or above, those for Plymouth, Torrington, and Winchester are lower (score of 3).

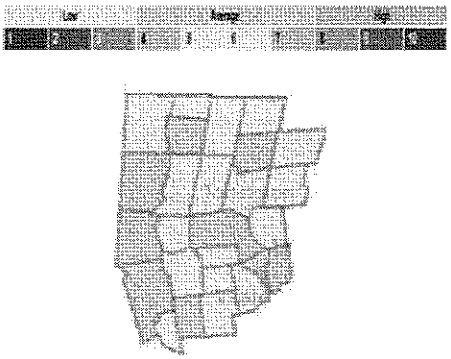
The prevalence of injuries and violence in a community are correlated with a number of social determinants. While these correlations do not imply a cause and effect relationship, a strong correlation indicates an association between a specific health outcome and a specific social determinant. Spearman's Rank Correlation Coefficient (R_s) values above 0.3 (either positive or negative) are considered statistically significant and could warrant further exploration of contributing factors.

Social Determinants Related to Accidents and Violence in Litchfield County	
Determinant	**R_s**
Civic Involvement	0.57
Education	0.55
Economic Security	0.53
Community Safety	0.48
Environmental Quality	0.42
Housing	0.40
Employment	0.37

Interpretation of Index scores becomes even more meaningful when Census tracts or block groups within a specific municipality are examined. Scores can be compared at the sub-town level to determine higher risk geographic areas and population groups.

Index Accident & Violence Data Sources: CTDPH, Office of Vital Records - Death Certificates (2005-2008). Population estimates - Nielsen Claritas Population Facts Demographic Report for 2007

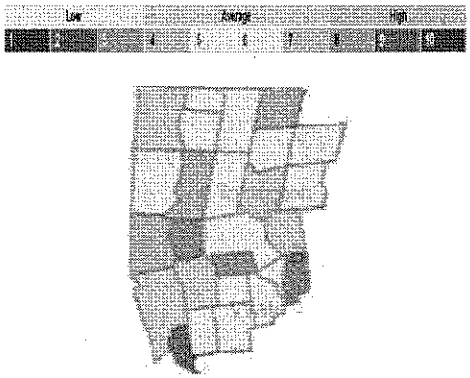
Cancer



The overall Index score for cancer is a composite of the incidence, age-adjusted mortality (AAMR), and premature death rates (YPLL) for a number of types of cancer, including: cervical, uterine, or ovarian; colorectal; female breast; lung; non-Hodgkins Lymphoma, pancreatic; prostate and skin cancer. Index scores within the county vary by community, however all fall within the average range of 4-7. According to the National Cancer Institute, personal lifestyle behaviors that contribute to cancer risk include: tobacco use and exposure to secondhand smoke, exposure to UV radiation, excessive alcohol use, risky sexual practices, poor diet, lack of physical activity, and overweight/obesity. The Litchfield County Community Transformation Coalition goals of tobacco-free living, active living and healthy eating, and quality clinical and other preventive services aim to reduce risk for prevalent chronic diseases, such as cancer and cardiovascular disease.

Index Cancer Data Sources: CTDPH, Office of Vital Records - Death Certificates (2005-2008) and Nielsen Claritas Population Facts Demographic Report for 2007.

Cardiovascular Disease

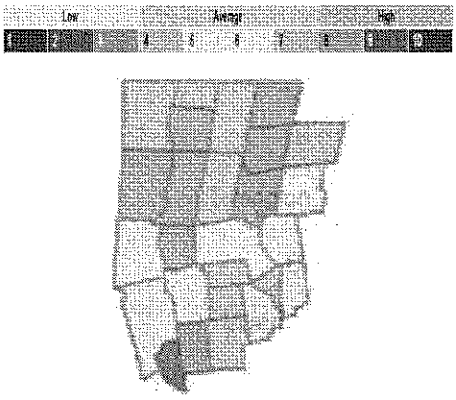


Index scores for cardiovascular disease are calculated using mortality (AAMR) and premature death rates (YPLL). Of the communities in Litchfield County, only Plymouth and Colebrook score lower than the state as a whole for this health outcome (town scores of 2 and 3 respectively vs. state score of 5). The rates of cardiovascular disease in county municipalities are correlated with a number of social determinants, with education and economic security being the strongest.

Social Determinants Related to Cardiovascular Disease in Litchfield County	
Determinant	**R_s**
Education	0.51
Economic Security	0.47
Civic involvement	0.42
Environmental Quality	0.36
Community Safety	0.33

Index Cardiovascular Disease Data Sources: CTDPH Office of Vital Records - Death Certificates (2005-2008) and Nielsen Claritas Population Facts Demographic Report for 2007.

Diabetes

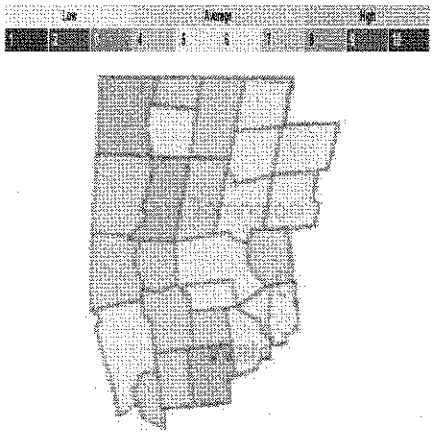


The Diabetes Index score for each municipality represents the age-adjusted mortality and premature death rates for the disease. Bridgewater has the least favorable health outcome score in the county at 2, with Colebrook, Roxbury, Winchester and Torrington all having scores that are less desirable than the state. Diabetes is correlated to a number of community conditions, with education levels having the strongest correlation.

Social Determinants Related to Diabetes in Litchfield County	
Determinant	**R_s**
Education	0.38
Economic Security	0.33
Community Safety	0.32
Environmental Quality	0.31

Index Diabetes Data Sources: CTDPH Office of Vital Records - Death Certificates (2005-2008) and Nielsen Claritas Population Facts Demographic Report for 2007.

Health Care Access

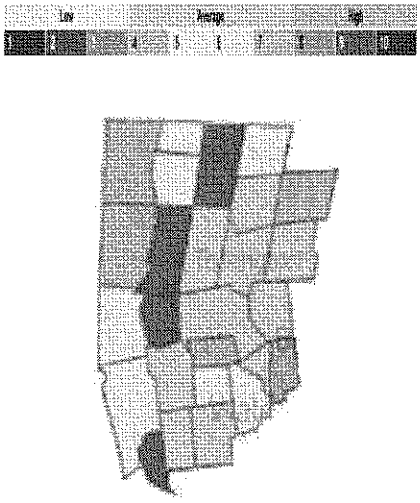


Indicators of health care access in the Index include: the number of emergency department visits without insurance, the number of emergency department visits for primary care services, and the number of births that have had delayed or non-adequate prenatal care. The vast majority of Litchfield County municipalities score favorably in this category, exceeding the state average. The town with the lowest Index score for health care access is Norfolk, at 4. A number of community conditions strongly correlate to a lack of health care access in the county.

Social Determinants Related to Health Care Access in Litchfield County	
Determinant	**R_s**
Economic Security	0.60
Education	0.52
Housing	0.51
Community Safety	0.50
Civic Involvement	0.49
Employment	0.47

Index Health Care Access Data Source: Connecticut Hospital Association, CHIME Hospital Discharge Data, FY 2005-2010.

Life Expectancy



For most of Litchfield County, life expectancy is greater than or equal to the state average. The community with the lowest life expectancy score in the county is Plymouth, followed by Torrington, Thomaston, and Winchester.

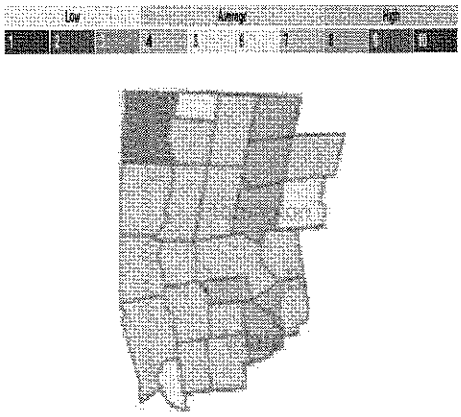
The highest life expectancy scores are found in Bridgewater, Cornwall, Norfolk, and Warren.

Life expectancy is correlated to all 7 of the social determinants included in the Index, with education and economic security having the strongest associations.

Social Determinants Related to Life Expectancy in Litchfield County	
Determinant	**R_s**
Education	0.64
Economic Security	0.60
Civic Involvement	0.50
Community Safety	0.41
Employment	0.35
Environmental Quality	0.34
Housing	0.31

Index Life Expectancy Data Sources: CTDPH Office of Vital Records - Death Certificates (2005-2008) and Nielsen Claritas Population Facts Demographic Report for 2007.

Liver Disease

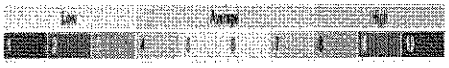


Low Index scores due to AAMR and premature deaths from chronic liver disease and cirrhosis are concerns for a number of communities in Litchfield County, with Salisbury having the least favorable Index score of any municipality in the area at 2. Social determinants associated with liver disease include those listed below:

Social Determinants Related to Liver Disease in Litchfield County	
Determinant	**R_s**
Civic Involvement	0.33
Environmental Quality	0.32
Community Safety	0.31

Index Liver Disease Data Sources: CTDPH Office of Vital Records - Death Certificates (2005-2008) and Nielsen Claritas Population Facts Demographic Report for 2007.

Mental Health

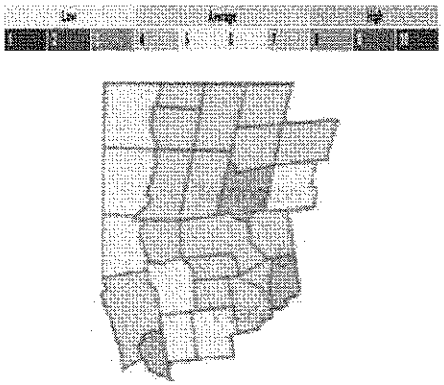


Mental health scores are determined by the emergency department visit and hospitalization rates for mental illness as well as alcohol and drug induced deaths. In Litchfield County, both Torrington and Winchester score below the state average for mental health (score of 2 vs. state average of 5). Both community safety and economic security are strongly associated with mental health, however numerous other community social conditions also play a role.

Social Determinants Related to Mental Health in Litchfield County	
Determinant	**R_s**
Community Safety	0.55
Economic Security	0.49
Environmental Quality	0.45
Civic Involvement	0.45
Education	0.42
Housing	0.37

Index Mental Health Data Sources: Connecticut Hospital Association, CHIME Hospital Discharge Data, FY2005-2010.

Renal Disease

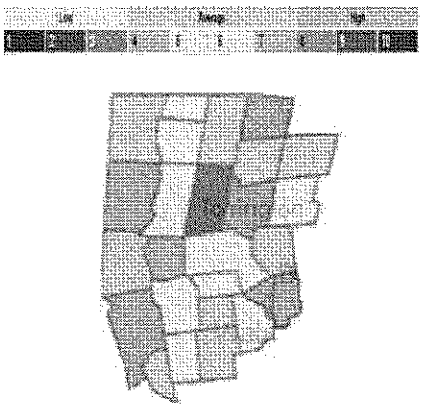


Social Determinants Related to Renal Disease in Litchfield County	
Determinant	R_s
Community Safety	0.47
Environmental Quality	0.45
Education	0.39
Housing	0.33
Civic Involvement	0.32
Economic Security	0.30

Index Renal Disease Data Sources: CTDPH Office of Vital Records - Death Certificates (2005-2008) and Nielsen Claritas Population Facts Demographic Report for 2007.

Scores for renal disease are calculated from the mortality and premature death rates for nephritis, nephrotic syndrome, and nephrosis. Index health outcome scores for renal disease in Litchfield County are least favorable in Bridgewater, Plymouth and Torrington. Renal disease is most strongly associated with community safety and environmental quality.

Respiratory Illness



Index scores for death rates and YPLL from chronic lower respiratory disease are slightly below the state average for a large portion of Litchfield County, with the lowest score (2) being found in Goshen, and the highest score found in Warren (8). The community conditions that more strongly correlate with respiratory illness are economic security and education.

Social Determinants Related to Respiratory Illness in Litchfield County	
Determinant	R_s
Economic Security	0.42
Education	0.41
Civic Involvement	0.31

Index Respiratory Illness Data Sources: CTDPH Office of Vital Records - Death Certificates (2005-2008) and Nielsen Claritas Population Facts Demographic Report for 2007.

Description of Local Health-Related Programs and Services

As previously noted, Connecticut lacks a county governance structure, therefore health-related programs and services are provided at the municipal, regional, or state level. This includes a diversity of public health programs and services provided by health departments and districts serving Litchfield County (districts serve two or more municipalities). The majority of the county's communities are served by the Torrington Area Health District, including Bethlehem, Canaan, Cornwall, Goshen, Harwinton, Kent, Litchfield, Morris, Norfolk, North Canaan, Plymouth, Salisbury, Thomaston, Torrington, Warren, Watertown, and Winchester. Within the county, the Pomperaug Health District serves Woodbury; the Farmington Valley Health District serves Barkhamsted, Colebrook, and New Hartford; and the Newtown Health District serves Bridgewater and Roxbury. The New Milford Health Department serves the town of New Milford. Two part-time health departments are located in Sharon and Washington.

Local health departments and districts provide essential public health services at the municipal level throughout Connecticut. These governmental entities are separate from the CT Department of Public Health (CTDPH), however they are linked by state statute in several important ways: approval of appointments of local directors of health by the Commissioner of Public Health; mandates to carry out critical public health functions in the areas of infectious disease control, environmental health, etc.; legal authority to levy fines and penalties for public health code violations and to grant and rescind license permits (such as for food services establishments or septic systems); as well as funding for prevention and education programs and services to promote and improve the health of residents in their communities.

Core services provided by all local health departments and districts serving county residents (either directly or by contract) include: immunization services; childhood lead poisoning prevention and control; communicable disease prevention and control (TB , STD, etc.); licensing and inspections for food service establishments and vendors; public health emergency planning including mass dispensing/vaccination; enforcement of public health codes and regulations, including inspections for compliance with health standards; and health information, education, and screening services.

There is a wide variety of additional health-related programs and services provided by other agencies and organizations within the county. As previously mentioned, United Way of CT Infoline 2-1-1 maintains an online searchable community resource database of health and human service providers, agencies, and organizations. This database contains information for over 4,600 health and human service providers and 48,000 service sites in CT. Infoline 2-1-1 is the most comprehensive database available and is updated regularly. The system is, however, dependent on service providers supplying comprehensive and up-to-date information. As part of the Litchfield County CTG Coalition assessment activities, the Steering Committee collaborated with United Way Infoline's 2-1-1 research and evaluation team to design a framework for asset mapping aligned with the 5 CTG Strategic Directions:

- *Tobacco Free Living*
- *Active Living and Healthy Eating*
- *High Impact Quality Clinical and Other Preventive Services*
- *Social & Emotional Wellness*
- *Healthy & Safe Physical Environment*

Infoline produced an electronic database of programs and services aligned with each strategic direction, and an accompanying series of GIS maps which integrate information on population density and transportation services. In addition, analysis of the most frequent calls by municipality related to unmet needs and top service requests by jurisdiction was conducted. *Highlights by Strategic Direction follow:*

Tobacco Free Living

Tobacco Free Living programs and services listed with Infoline 2-1-1 are limited to three tobacco cessation programs in the county. The attached GIS asset maps include the service locations, which are concentrated in the northern part of the county. Although these services are available to residents countywide, personal transportation is required, and two of the three charge fees. Tobacco cessation services are provided at Charlotte Hungerford and Sharon Hospitals and at an addiction treatment center. In addition, there are school-based tobacco prevention efforts underway at selected schools in Torrington and Winchester as an outgrowth of the Healthy & Tobacco Free Schools grant initiative previously funded by CTDPH. School nurses and health/PE teachers in each district have been trained as cessation counselors, and the libraries/media resource centers have tobacco prevention resource centers for students.

Phone and online resources for smoking cessation are also available to county residents through the CT QuitLine (1-800-QUIT-NOW), the American Lung Association in CT http://www.lung.org/stop-smoking/, and American Cancer Society http://www.cancer.org/Healthy/StayAwayfromTobacco/index.

Regarding tobacco use prevention, on a countywide level, tobacco free public and private school campuses are required pursuant to CGS Sec. 19a-342. In addition, The Child Nutrition and WIC Reauthorization Act of 2004 and Public Law 108-265 Section 204 - Local Wellness Policy mandate schools establish a school wellness committee and policies focused on a comprehensive approach to school health, which include tobacco free living.

Furthermore, in accordance with Indoor Clean Air Act provisions, CT statutes also prohibit tobacco use in all municipal facilities, health care facilities, child care centers, group day care facilities, public college dormitories, theaters, buses and trains, restaurants and bars, and businesses employing 5 or more employees. Additional information on policies relating to all five Strategic Directions, including tobacco free living, will be included in the Policy Scan section of this report once completed.

Active Living and Healthy Eating

Active Living and Healthy Eating programs and services included in the Infoline 2-1-1 database include obesity prevention programs and services, nutrition education programs for all ages, exercise and fitness programs, and eating disorder programs. As noted in the accompanying GIS asset maps (see Appendix A), service providers are primarily municipal parks and recreation departments, YMCAs, nature centers, municipal community centers and Police Athletic Leagues, hospital-sponsored community health promotion programs, private non-profit eating disorder treatment programs and recreation programs for persons with disabilities. Services span the county, and many are town-based. Additional resources for physical activity not noted on the maps are school district recreational facilities, often open for public use when not in use for school sports events. Joint use agreements, which promote use of existing school facilities such as outdoor tracks and playing fields, tennis courts, and indoor gymnasiums by community residents of all ages, are discussed in the Policy Scan section of this report.

As previously noted, there are abundant opportunities for outdoor physical activities in the county's seven state parks, five state forests, and one state recreation area. There are countless opportunities for year round outdoor recreation through greenways, walking and biking trails, and conservation areas. However, access to many of these resources is limited to residents with private transportation.

Importantly, local health departments and districts, hospitals, community health centers, voluntary health agencies, and visiting nurse

associations actively participate in health outreach and education events and provide information and guidance related to obesity prevention, healthy eating and physical activity at sites throughout the county. Fit Together is a multi-sector community-driven healthy eating and active lifestyles intitiative in Torrington and Winchester focused on health improvement in 5 target groups: pre-school children, school age children, workplaces, older adults, and the community-at-large. This initiative is further described in the CTG Coalition Overview and Activity section of this report.

High Impact Quality Clinical and Other Preventive Services

Quality clinical and other preventive services included in the Infoline 2-1-1 database include screening and detection services, as well as diagnostic, treatment and rehabilitation services for prevalent chronic diseases (private provider listings are not included). Health screening and chronic disease detection services are provided primarily by the 3 acute care hospitals in the county, 7 public health departments/districts described previously, 8 visiting nurse associations/services (Farmington Valley VNA, Foothills Visiting Nurse & Homecare, VNS of CT, VNA of Northwest CT, New Milford VNA, Salisbury VNA, VNA Health at Home, and Western CT Home Care), and one community health center (Community Health & Wellness Center of Greater Torrington). Oral health preventive services are provided by the Community Health & Wellness Center and the Brooker Memorial Children's Dental Centers. The most frequently listed screening and detection services include cancer screenings (mammography, cervical, colorectal cancer screening, etc.), and HIV testing. Chronic disease outpatient services most closely related to the strategic directions include those for cardiac, stroke, and pulmonary diseases. The accompanying asset map shows the service sites by type of chronic disease, and by type of service. Of note is the concentration of clinical and preventive services in New Milford, Torrington, and Sharon, the sites of the three acute care hospitals in the county.

Social & Emotional Wellness

Programs and services related to this Strategic Direction include Infoline 2-1-1 database listings for mental health and substance abuse/addiction prevention, screening, counseling and treatment; youth enrichment/leadership programs; family support services, as well as community support and support groups targeted to a variety of needs (youth, religious, GLBT, aging/seniors, women, families, health-related, persons with disabilities, and mental-health related). The most frequently listed types of support services available within the county include: Information/Referral Services for Older Adults, Child Abuse Prevention and Counseling, Latchkey/Home Alone Safety Programs, Parenting Education/Support, Caregiver Support, Bereavement Support, and Adoption and Foster/Kinship Support. Major providers of services include: Municipal Senior Centers/Offices for the Aging, Youth Service Bureaus and Social Service Departments, Hospitals, Substance Abuse Treatment Facilities, Family Resource Centers, Resident State Troopers, Non-profit Agencies, Regional Educational Service Centers, Visiting Nurse Associations/Services, and YMCAs. The accompanying GIS asset maps focus on health and mental health-related programs and services. Health-related support groups include hospital-based cancer, stroke, and diabetes programs. Mental health-related support groups include those for child and spouse/partner bereavement, child abuse, and sexual assault; these services are concentrated in New Milford, Torrington, and Sharon. Mapping of Mental Health and Substance Abuse/Addiction programs and services shows both a wider geographic availability and diversity of providers, i.e., hospitals, visiting nurse and non-profit mental health and substance abuse agency providers.

Healthy & Safe Physical Environment

Information related to this Strategic Direction will be captured in large part in the pending Policy Scan Section of this report, which will be informed by data, focus group, and key informant interview information collected and analyzed via the CDC CHANGE Tool. This will include such data as community design features such as the "complete streets" model that make streets safe for all users (vehicular traffic, public transit, biking, and pedestrian for people of all ages and abilities); presence and use of modes of transportation that require physical activity (walking and biking); existing or planned community development which promotes healthy and active lifestyles (green belts/trails, walking/biking paths, locally accessible and safe parks and recreation areas); joint use agreements for school recreation and athletic facilities; reduction in the number of alcohol and fast food retail outlets; and outreach and education programs to promote healthy homes, free of radon, asthma triggers, and lead.

In reviewing the Infoline 2-1-1 database, the following were determined to be aligned with this Strategic Direction: availability of food pantries, soup kitchens, and farmer's markets; home delivered meals; summer food service programs; disabled, medical, and senior transportation services; existence of emergency, supportive, and elder/disabled housing; and domestic violence victim support services and shelters. Major providers of services include: municipal senior centers and social services, regional transportation services, local public housing authorities, non-profit community service agencies, youth service bureaus, school districts, and Regional Educational Service Centers.

Related to *Food-Related Basic Needs*, there are 17 food pantries identified in the 2-1-1 database, serving 13 different communities. Communities without food pantries in general were more affluent. It should be noted that additional smaller faith-based pantries may exist, but not be captured in the database. In addition to food pantries, there are two soup kitchens in Torrington. There are eight congregate meal/home delivered meal programs in the county, operated primarily by municipalities. Summer school meal programs exist in two high need communities - Torrington and Winchester. Litchfield County has a number of local farms; there are 11 farmer's markets identified in the database.

In terms of *Transportation-Related Basic Needs*, disability and medical transportation services are provided by 14 municipal and non-profit providers in 12 communities, leaving many communities in the county inadequately covered for these services.

The availability of *Housing* for vulnerable population groups, including the elderly, the disabled, and residents in need of emergency or supportive housing is a growing concern in the county. GIS maps demonstrate a lack of parity in access to these services, with a number of municipalities having no available resources for residents located within their borders. The most common housing service providers include municipal housing authorities, and non-profit housing and mental health agencies. There are four homeless shelters in the county, and two additional shelters that serve runaway youth. As previously noted, there are two shelters for victims of domestic violence in the county, located in Sharon and Torrington.

Infoline 2-1-1 Top Requests and Unmet Needs for Services

Although not as closely aligned with the strategic directions, examination of FY 2012 Infoline 2-1-1 data related to the most frequent call requests and unmet needs (calls to Infoline 2-1-1 for which no services are listed in the database) shed additional insight on prevalent community needs, both health-related and other. It should be noted that the high volume of disaster service calls stems from the weather-related emergencies experienced by county residents in the summer- fall of 2011.

United Way 2-1-1 Top 20 Requests for Services in Litchfield County

Request Categories	FY 12 Requests for Services
Total Calls	**9,930**
Total Requests for Services	**14,159**
Utilities/Heat	1,763
Disaster Services	1,221
Public Assistance Programs	1,132
Financial Assistance	1,096
Outpatient Mental Health Care	1,085
Housing/Shelter	959
Information Services	899
Substance Abuse Services	666
Legal Services	601
Health Supportive Services	531
Holiday Assistance	449
Food	431
Individual and Family Support Services	305
Tax Organizations and Services	278
Transportation	267
Employment and Training Programs	262
Personal/Household Goods	205
Community Services	128
Consumer Complaints	120
Social Insurance Programs	105

Examining community-specific requests for services show that the call volume is not proportionate to the population size in all cases, with Canaan, Plymouth, Torrington, and Winchester showing a higher than "expected" number of calls, based on the county average. This may indicate a higher need for services and/or better awareness of Infoline 2-1-1 as a resource by residents in these communities.

The most common health-related requests received by 2-1-1 include outpatient mental health care, substance abuse services, food assistance, and health supportive services such as insurance information and referrals. Requests for outpatient mental health care services ranked first or second in call volume from residents of Goshen, Harwinton, Morris, New Milford, Plymouth, Torrington, and Woodbury.

The most common unmet needs for service requests by county residents are provided below; examination by municipality shows over 50% of the unmet need calls originate in Torrington and Winchester.

United Way 2-1-1 Unmet Needs Report for Litchfield County – FY12

Top 20 Unmet Needs - Litchfield County	Total Met & Unmet Needs	Total Unmet Needs	% Unmet Needs	Reason for Unmet Need			
				Service Unavail-able	Caller Not Eligible	Fee Too High	No Transport
Rental Deposit Assistance	102	98	96%	81	17	0	0
Rent Payment Assistance	207	93	45%	44	49	0	0
Utility Assistance	1,289	88	7%	65	23	0	0
Disaster Food Stamps	254	80	31%	70	10	0	0
Temporary Financial Assistance	547	63	12%	28	35	0	0
Disaster Claims Information	497	47	9%	10	37	0	0
Holiday Gifts/Toys	125	35	28%	35	0	0	0
Christmas Baskets	142	35	25%	33	2	0	0
Thanksgiving Baskets	136	25	18%	22	3	0	0
Section 8 Housing Choice Vouchers	68	10	15%	10	0	0	0
Food Stamps/SNAP	435	10	2%	0	10	0	0
Specialized Information and Referral	136	9	7%	3	6	0	0
Household Goods	27	8	30%	8	0	0	0
Transportation Expense Assistance	6	6	100%	5	1	0	0
Diapers	21	6	29%	6	0	0	0
General Assistance/SAGA	33	6	18%	0	6	0	0
General Clothing Provision	86	6	7%	6	0	0	0
Homeless Shelter	248	4	2%	1	1	1	4
Fans/Air Conditioners	5	3	60%	3	0	0	0
Food Cooperatives	10	3	30%	2	0	1	0
Total (All requests for services)	**12,490**	**753**	**6%**	**517**	**227**	**4**	**10**

CTG Coalition Overview and Collaborative Activities

The Litchfield County CTG Coalition was created in the fall of 2011 to collaboratively assess and prioritize health needs in our community and to collectively develop a community action plan and mobilize resources to improve the health of county residents. As the lead and fiduciary agent for the Litchfield County grant CDC CTG initiative, Torrington Area Health District (TAHD) convened leadership from the United Way of Northwest CT, Northwest CT YMCA, Charlotte Hungerford Hospital and the local health departments/districts serving the county to form the initial Steering Committee. TAHD subsequently signed a Memorandum of Understanding with Charlotte Hungerford Hospital, Northwest CT YMCA, and the United Way of Northwest CT to leverage one another's resources for contracted professional services from the *Center for Healthy Schools and Communities at EDUCATION CONNECTION* to design and prepare this Community Health Needs Assessment.

Representatives from these four organizations became the foundation of the Steering Committee, which, to date, has expanded to include representatives from Western CT Health Care Network, Sharon Hospital, the CT Office of Rural Health, and EDUCATION CONNECTION, the Regional Educational Service Center in western CT. The Coalition membership continues to evolve over time, with the goal of involvement by all major community sectors, especially those serving underrepresented groups in the county.

The CTG Coalition start-up has benefited greatly from the prior work of Charlotte Hungerford Hospital, which led the organization of a core group of health, social and educational agencies in the greater Torrington area to inventory existing and planned community programming efforts, identify gaps, and leverage knowledge and resources.

In early 2011, the Northwest CT YMCA received a grant from Pioneering Healthier Communities to address policy and system barriers to healthy living in its service area. Northwest CT YMCA is one of 118 communities nationwide to receive such funding.

Recognizing the parallelism of their efforts, the groups combined to form Fit Together, co-led by Stephanie Barksdale, Executive Director, United Way of Northwest Connecticut, and Greg Brisco, Chief Executive Officer, Northwest CT YMCA. Also on the Steering Committee of Fit Together are Leslie Polito, Assistant Director, TAHD, and Brian Mattiello, Vice President of Organizational Development, Charlotte Hungerford Hospital. These same individuals serve on the CTG Coalition Steering Committee, fostering coordination and communication in community assessment, planning, implementation, and evaluation activities.

The mission of Fit Together is to build the healthiest kids, families and communities in Torrington and Winchester through sustainable strategies that foster healthy eating and active living. Although concentrated in these two communities, the CTG Coalition benefits greatly from the forward-thinking and innovative approaches undertaken by this existing coalition. The Fit Together community action plan is well aligned with CTG objectives and strategic directions, and centers on policy, systems, and environmental changes to:

- *increase opportunities for healthy eating;*
- *increase opportunities for physical activity as a part of everyday life;*
- *improve community collaboration and assessment capacity; and*
- *improve community-wide communication to advance healthy eating and active living.*

Key accomplishments to date that advance CTG Coalition community assessment and action plan development include:

- Completed health surveys at Torrington & Winchester Senior Centers;

- Collaborated with Torrington School District to write a comprehensive school wellness policy;
- Completed community-wide, pre-school, school, afterschool, childcare, and worksite Community Healthy Living Index (CHLI) assessments;
- Coordinated a two-day Healthy Community Design Summit (October 16-17, 2012) in Torrington and Winchester featuring nationally-acclaimed community planning expert Mark Fenton. This initiative focused on creating healthier and more livable and walkable communities.

In addition, Pomperaug Health District, whose Health Director Neal Lustig serves on the CTG Steering Committee, is an ACHIEVE grantee. Although the specific ACHIEVE community reached by the Health District is not located within Litchfield County, (Southbury), the CTG Coalition benefits greatly from the best practices and lessons learned from this initiative, which is well-aligned with the CTG strategic directions. In addition, ACHIEVE uses CDC's CHANGE Tool for Community Health Improvement Action Planning.

Key ACHIEVE current and planned activities that advance CTG Coalition and action plan development include:

- The creation of Southbury's first-ever community garden. The Garden group strategically partnered with a variety of local organizations, including: Girl and Boy Scouts; Roots and Shoots; Garden Club; Master Gardeners Association; and an existing community garden group in Southbury's Heritage Village. The Southbury Community Garden is in full bloom with a variety of crops, some of which will be donated weekly to the Southbury Food Bank.
- Target projects for year two of the Southbury ACHIEVE Initiative include: 1) assessing the regional school district's school lunch program(s) and making recommendations for better nutrition; 2) creating a comprehensive map and facilities guide for the Southbury Parks and Recreation Department, outlining the vast resources offered to residents, and encouraging increased exercise; and 3) addressing Southbury's lack of bike trails, and exploring potential funding sources to address the need for designated trails/lanes.

The CTG Coalition Steering Committee meets monthly and serves as the Litchfield County CTG grant management team. Project activities, accomplishments, and challenges are reviewed at these meetings for Committee input and resolution. In addition, mentors from DPH and other CT CTG Coalitions provide education and training at these meetings on such topics as Coalition Building and use of the CHANGE Tool. Coalition meetings are organized and facilitated by Sharon McCoy, CTG Project Director.

Key Findings & Recommendations

Achieving major improvement in the health of county residents involves reducing the incidence and prevalence of chronic disease, which account for 7 of the 10 leading causes of death. CDC estimates that nearly 50% of Americans are living with at least one chronic disease.

The solution to this challenge is multi-dimensional, as chronic diseases result from a number of interconnected factors. Harmful individual lifestyle behaviors such as smoking, overeating, poor nutrition, lack of physical activity, tobacco use, and substance abuse greatly increase risk for developing chronic disease. Lack of health insurance, limited English proficiency, transportation and cultural factors present barriers to access and utilization of quality preventive health and screening services which delay or prevent the onset of disease. Social determinants of health such as income, employment status, educational attainment, housing, environmental quality, and community safety strongly impact access to care and health outcomes.

Developing a community action plan for health improvement involves collective action and leveraging of expertise and resources across agencies and organizations from many different sectors. The planning process involves identification of priority health needs and opportunities for action by all stakeholders. To assist this process, a summary of key findings from previous sections of this report follows.

Demographics

- ✓ The county has the highest proportion of residents ages 50+ in CT and the median age of county residents is rising. This carries significant implications for health, housing, and human service planning.
- ✓ The overall population size of the county continues to increase at a rate similar to the state as a whole.
- ✓ County residents overall have higher education and income levels and lower poverty rates than the state average, however income levels have recently declined in many communities and disparities are evident by municipality and household type.
- ✓ Most school districts in the county have recently experienced an increase in minority student enrollment and in students eligible for free/reduced price meals.
- ✓ The county has become more racially and ethnically diverse, and the growth in the Hispanic or Latino population from 2000-2010 was twice the state rate. Torrington, New Milford, and Watertown show the greatest gains in diversity.
- ✓ Overall community safety data compare favorably to the state; within the county, Plymouth, Thomaston, Torrington, and Winchester have higher crime rates.

Behavioral and Lifestyle Factors

- ✓ Rates of obesity and current smoking in county residents exceed the state average.
- ✓ County residents have *more frequent* smoking cessation attempts (with higher smoking rates), and are *more likely* to participate in routine dental care, and cervical and colon cancer screening. County residents are *less likely* to participate in routine eye exams, influenza vaccination, and PSA screening.
- ✓ County rates are *similar* to the state for: social support, activity, fruit & vegetable intake, prevalence of hypertension (high blood pressure) and diabetes, routine medical check-ups, cholesterol testing & mammography.
- ✓ Disparities in personal lifestyle behaviors are apparent across the state. Residents with lower education and income levels are *less likely* to access health screenings and practice healthy lifestyle choices.

- ✓ Overweight and obesity are *most common* in Hispanic or Latino, followed by Black or African American children and adults.
- ✓ Smoking prevalence in CT adults has *declined* 40% over the past 20 years, across all groups except Black non-Hispanics. Prevalence is *higher* in males and persons with lower education and income levels.
- ✓ In CT adolescents, smoking has *declined* 66% among middle school students and 40% among high school students.
- ✓ Students in *nearly half* of the school districts serving the county scored below the state average in standardized physical fitness tests.
- ✓ County residents did not meet national benchmarks for poor physical and mental health days, adult smoking, excessive drinking, and preventable hospital stays.

Burden of Chronic Disease

- ✓ Cardiovascular disease (CVD) accounts for one-third of CT resident deaths; over 50% of these are in women. Hypertension and elevated cholesterol are *major risk factors* for CVD.
- ✓ Nearly one in four county residents has hypertension. This condition is *more common* in males, Black non-Hispanic adults, persons ages 65 and over and those with lower socioeconomic status (SES).
- ✓ Nearly 40% of county residents have been told by a health professional that their cholesterol is high. Elevated cholesterol is *more common* in males, white non-Hispanic adults, persons ages 65+ and those with lower SES. Blood pressure screening is *least common* in Hispanic/Latinos (nearly one-third have *never* been screened), and in persons with low SES.
- ✓ Diabetes is *twice as prevalent* in Black non-Hispanics than whites, and in persons with low SES. Obesity is a *major risk factor* for Type II Diabetes.

Primary Care, ED Visits & Hospitalizations

- ✓ The county has a ratio of 1 primary care physician to every 1,123 residents, which falls well below both state and national benchmarks.
- ✓ Overall, county residents had *higher ED visit rates* than the CT average for major CVD, coronary heart disease, myocardial infarction (heart attack), congestive heart failure, and stroke.
- ✓ County residents had *lower ED visit rates* for diabetes, alcohol & drug abuse, chronic obstructive pulmonary disease, and asthma.
- ✓ ED visit rates for Black non-Hispanic residents were *well above* the state and county averages across most diagnostic categories.
- ✓ Hospitalization rates for county residents were *below* the state average for the majority of diagnostic categories, but *above* the state average for oral cavity/pharynx cancers and for alcohol and drug abuse.

Mortality Data

- ✓ Age-adjusted all-cause mortality rates for the county and state are *comparable*. County all-cause mortality rates for White non-Hispanics (both genders) are *higher*, and rates for Black non-Hispanics and Hispanics are considerably *lower* than the state rates.
- ✓ County AAMRs are *lower than* state rates for many causes of death including malignant neoplasms, diabetes mellitus, Alzheimer's disease and kidney diseases. County mortality rates are *above* the state for major CVD, pneumonia and influenza, CLRD, accidents, and alcohol & drug-induced deaths.
- ✓ Mortality rates from diabetes are highest in Hispanic or Latino residents, and above the state rate.
- ✓ The largest contributor to premature death in the state and county is malignant neoplasms (cancer), followed by accidents, major CVD, and drug-induced deaths.

- ✓ Males and Hispanic or Latino residents have the *highest* rate of premature death in the county overall.

Health Disparities & Inequities

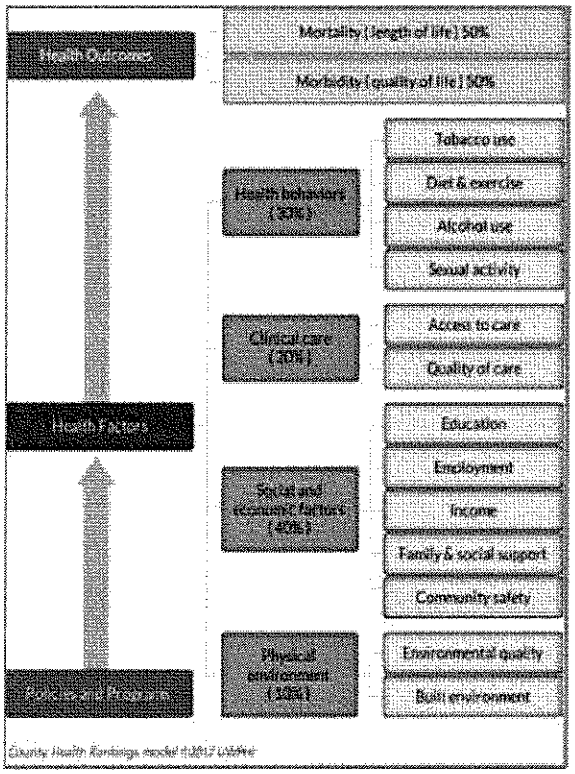
- ✓ Compared with the state, municipalities in the county rank *favorably* overall for social determinants of health and are *comparable* for health outcomes.
- ✓ Overall, municipalities in the county rank *most favorably* for health care access and life expectancy health outcomes.
- ✓ Health outcomes with *more frequent* low scores were diabetes, liver disease, mental health & respiratory illness.
- ✓ There is a wide variation in health outcome scores among municipalities. Those *most frequently* scoring low for health outcomes are: Plymouth, Torrington, Colebrook, and Winchester.
- ✓ The *most consistent correlations* between health outcomes and social determinants are found for: education, economic security, community safety, and civic involvement.

Health-Related Programs & Services

- ✓ Tobacco cessation programs in the county are extremely limited, and the Infoline 2-1-1 database lists no currently available tobacco use prevention programs.
- ✓ Opportunities for physical activity appear to be available in most communities; however limited accessibility due to transportation may be a factor for many residents.
- ✓ According to Infoline 2-1-1 data, 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.

In spite of the favorable health status enjoyed by most Litchfield County residents, health disparities exist and are concentrated in the uninsured and low income population groups. Families and individuals who live in poverty or are uninsured are more likely to have poor health status. Poverty underlies many of the social factors that contribute to poor health. Differences for many health status indicators are also apparent by gender, race/ethnicity, age, and place of residence. This information should be used to determine subgroups in the community in need of further assessment, as well as to guide the development of programs and services to meet identified health needs.

Developing a community action plan for improving health requires coordinated and systemic efforts among all stakeholders: health care providers; state, regional, and local health and human service agencies; community and faith-based organizations and groups; policy makers; schools; businesses and the residents they serve. All stakeholders need to consider policy, environmental, and systems changes to ***make the healthy choice the easy choice*** in their communities. As noted in the 2012 County Health Rankings report, social and economic factors and the physical environment are estimated to account for 50% of health status.



With this in mind, in Year 2 of the Community Transformation Grant (October 2012 - September 2013), the Litchfield County CTG Steering Committee will coordinate a strategic health planning process to guide the development of a Community Health Improvement Plan. This process will include environmental, systems, and policy scans to better define priority health needs, and opportunities for action for health improvement.

The CDC's Community Health Assessment aNd Group Evaluation (CHANGE) tool will be used to facilitate this process. CHANGE is a data collection tool and strategic planning resource which enables local stakeholders and community team members to survey and identify community strengths and areas for improvement regarding current policy, systems, and environmental change strategies. Five different community sectors are assessed: Community-At-Large, Community Institutions/Organizations, Health Care, Schools, and Work Sites.

The CHANGE tool assists communities to: 1) define improvement areas to guide the community toward implementing and sustaining policy, systems, and environmental changes around healthy living strategies (e.g., increased physical activity, improved nutrition, reduced tobacco use and exposure, and chronic disease management); 2) prioritize community needs and consider appropriate allocation of available resources; and 3) focus and mobilize cohesive action in the health priority areas selected to improve health and reduce health disparities.

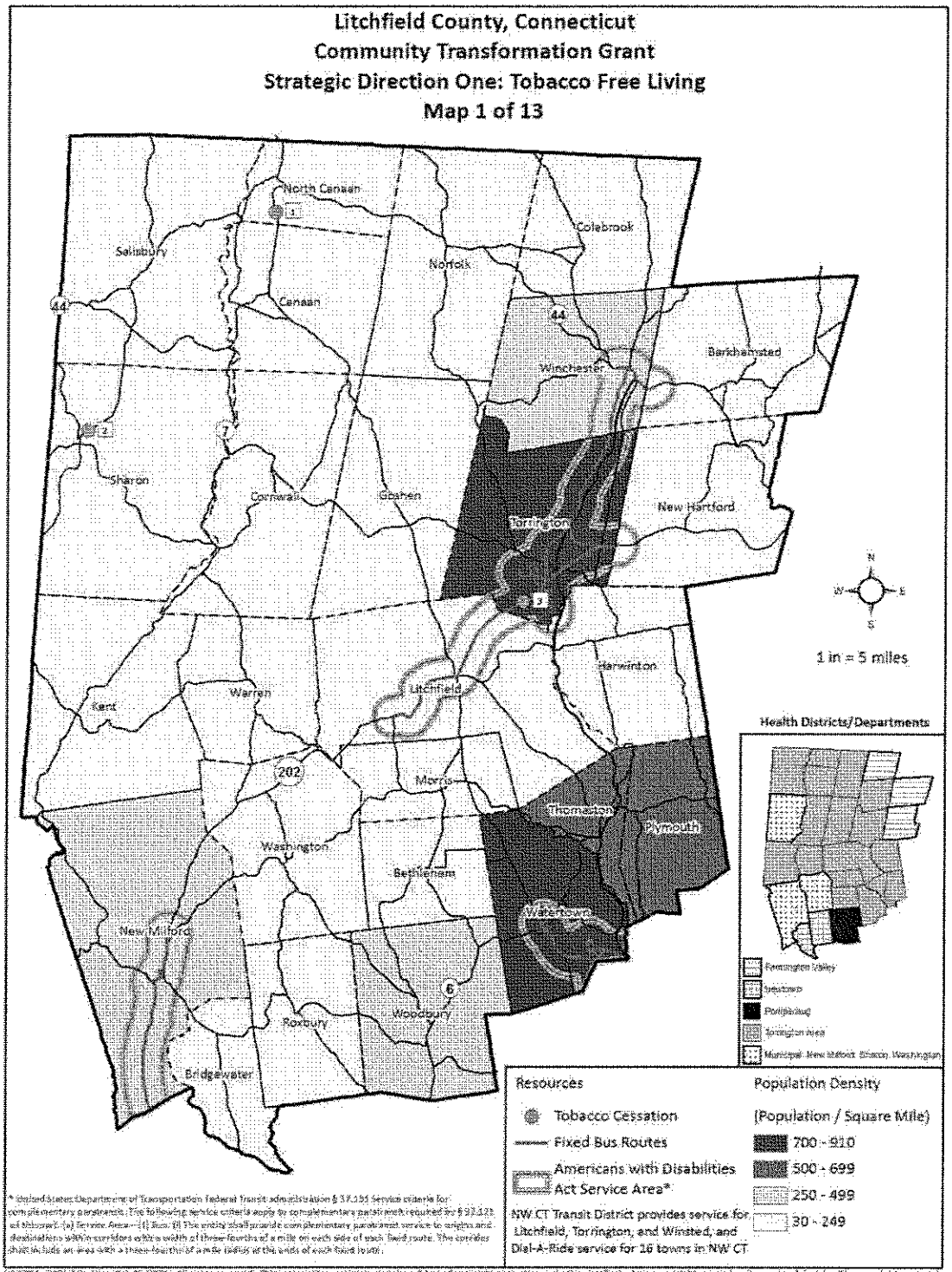
CHANGE will be used to facilitate community health planning by all five sectors. Findings from the CHANGE Strategic Planning process will be appended to this report in CTG Project Year 2.

Appendix A - Asset Maps of Programs & Services by Strategic Direction

The following GIS Asset Maps of Health-Related Programs & Services located within the county were compiled by the United Way of CT Infoline 2-1-1 Research & Evaluation Unit. Population density and transportation routes are included on each map. Each map aligns with a specific CTG Strategic Direction, and has an accompanying Resource Listing. The Resource Listings include the types of services provided, provider agency or organization names, and addresses. More detailed information on the programs and services included is available at www.infoline.org or by calling Infoline at 2-1-1.

Infoline is the most comprehensive online searchable database of health and human service providers, agencies, and organizations available in CT. This database contains information for over 4,600 health and human service providers and 48,000 service sites in CT.

It should be noted that private, for-profit service providers are not included in the database. In addition, although United Way Infoline 2-1-1 makes concerted efforts to assure the database is as complete and up-to-date as possible, service providers must supply the required information. Any omissions of programs or services in the following maps are unintentional, and may be the result of a particular provider not being registered with Infoline.



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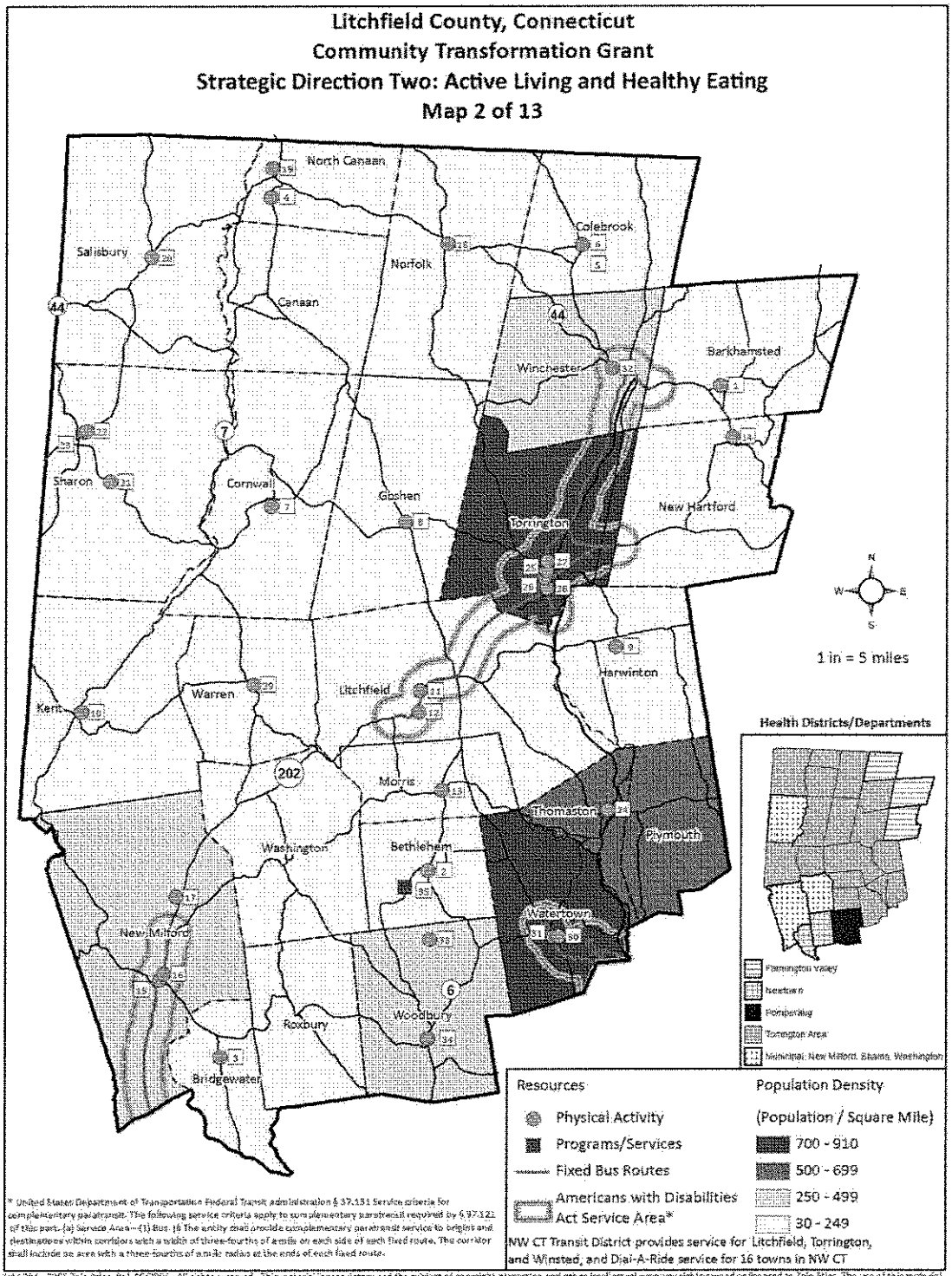
Litchfield County, CT
Community Transformation Grant
Strategic Direction One: Tobacco Free Living
Map 1 of 13 – Resource Listing

1. Smoking Addiction Support Groups
   MOUNTAINSIDE TREATMENT CENTER
   187 South Canaan Road, Route 7
   North Canaan, CT 06018
   Nicotine Anonymous

2. Smoking Cessation
   SHARON HOSPITAL - GOOD NEIGHBORS -
   THE COMMUNITY HEALTH PROMOTION PROGRAM
   One Low Road
   Sharon, CT 06069
   Smoking Cessation Program

3. Smoking Cessation
   CHARLOTTE HUNGERFORD HOSPITAL - PULMONARY EDUCATION
   780 Litchfield Street
   Torrington, CT 06790
   Freedom from Smoking



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Litchfield County, CT
Community Transformation Grant
Strategic Direction Two: Active Living and Healthy Eating
Map 2 of 13 – Resource Listing

PHYSICAL ACTIVITY

1. Recreational Activities/Sports
   BARKHAMSTED PARKS AND RECREATION
   67 Ripley Hill Road
   Barkhamsted, CT 06063

2. Recreational Activities/Sports
   BETHLEHEM RECREATION
   36 Main Street South
   Bethlehem, CT 06751

3. Recreational Activities/
   Sports
   BRIDGEWATER RECREATION COMMISSION
   PO Box 216
   Bridgewater, CT 06752

4. Recreational Activities/Sports, Swimming/Swim Lessons
   NORTHWEST CT YMCA/ CANAAN FAMILY YMCA
   77 South Canaan Road
   Canaan, CT 06018

5. Recreational Activities/Sports
   COLEBROOK, TOWN OF
   562 Colebrook Road Route 183
   Colebrook, CT

6. Recreational/Leisure/Arts Instruction
   COLEBROOK SENIOR/COMMUNITY CENTER
   2 School House Road
   Colebrook, CT 06021

7. Recreational Activities/
   Sports
   CORNWALL PARKS AND RECREATION
   PO Box 205
   Cornwall, CT 06753

8. Recreational Activities/Sports
   GOSHEN RECREATION
   42A North Street
   Goshen, CT 06756

9. Recreational Activities/Sports
   HARWINTON RECREATION
   100 Bentley Drive
   Harwinton, CT

10. Recreational Activities/Sports
    KENT PARK AND RECREATION
    41 Kent Green Boulevard
    Kent, CT 06757

11. Neighborhood Centers, Personal Enrichment,
    Recreational Activities/Sports, Rec./Leisure/Arts
    LITCHFIELD COMMUNITY CENTER
    421 Bantam Road
    Litchfield, CT 06759

12. Nature Centers/Walks
    WHITE MEMORIAL CONSERVATION CENTER
    80 Whitehall Road
    Litchfield, CT 06759

13. Recreational Activities/Sports
    MORRIS BEACH AND RECREATION
    3 East Street
    Morris, CT

14. Recreational Activities/Sports
    NEW HARTFORD RECREATION
    580 Main Street
    New Hartford, CT 06057

15. Recreational Activities/Sports,
    Swimming/Swim Lessons
    NEW MILFORD PARKS AND RECREATION
    47 Bridge Street
    New Milford, CT 06776

16. Recreational Activities/Sports * Youth
    NEW MILFORD YOUTH AGENCY
    50 East Street
    New Milford, CT 06776

Litchfield County, CT
Community Transformation Grant
Strategic Direction Two: Active Living and Healthy Eating
Map 2 of 13 – Resource Listing

PHYSICAL ACTIVITY (Cont.)

17. Nature Centers/Walks, Recreational Activities/Sports
PRATT NATURE CENTER, THE
163 Papermill Road
New Milford, CT 06776

18. Recreational Activities/Sports
NORFOLK, TOWN OF
19 Maple Avenue
Norfolk, CT 06058

19. Recreational Activities/Sports
NORTH CANAAN, TOWN OF
100 Pease Street, #1
North Canaan, CT 06018

20. Recreational Activities/Sports
SALISBURY RECREATION
PO Box 548
Salisbury, CT 06039

21. Nature Centers/Walks
AUDUBON CT - AUDUBON SHARON
325 Cornwall Bridge Road
Sharon, CT 06069

22. Recreational Activities/Sports
SHARON YOUTH AND RECREATION CENTER
99 North Main Street
Sharon, CT 06069

23. Personal Enrichment
SHARON HOSPITAL - GOOD NEIGHBORS
THE COMMUNITY HEALTH PROMOTION PROGRAM
One Low Road
Sharon, CT 06069

24. Recreational Activities/Sports
THOMASTON PARK AND RECREATION
158 Main Street
Thomaston, CT

25. Rec Activities/Sports * Disabilities/ Health Conditions
LARC
314 Main Street
Torrington, CT 06790

26. Physical Fitness
NORTHWEST CT YMCA - TORRINGTON BRANCH
259 Prospect Street
Torrington, CT 06790

27. Recreational Activities/Sports * Youth
TORRINGTON POLICE ATHLETIC LEAGUE
576 Main Street
Torrington, CT 06790

28. Rec Activities/Sports, Playgrounds, Swim Lessons
TORRINGTON, CITY OF - PARKS AND RECREATION
153 South Main Street
Torrington, CT 06790

29. Recreational Activities /Sports
WARREN, TOWN OF
50 Cemetery Road
Warren, CT 06754

30. Rec. Activities/Sports * Disabilities/Health Conditions
FAMILY OPTIONS
76 Westbury Park Road Suite 200E
Watertown, CT 06795

31. Recreational Activities/Sports, Swim Lessons
WATERTOWN PARKS
AND RECREATION
51 Depot Street Suite 108
Watertown, CT 06795

32. Recreational Activities/Sports, Swim Lessons
NORTHWEST CT YMCA - WINSTED BRANCH
480 Main Street
Winchester, CT 06098

Litchfield County, CT
Community Transformation Grant
Strategic Direction Two: Active Living and Healthy Eating
Map 2 of 13 – Resource Listing

PHYSICAL ACTIVITY (Cont.)

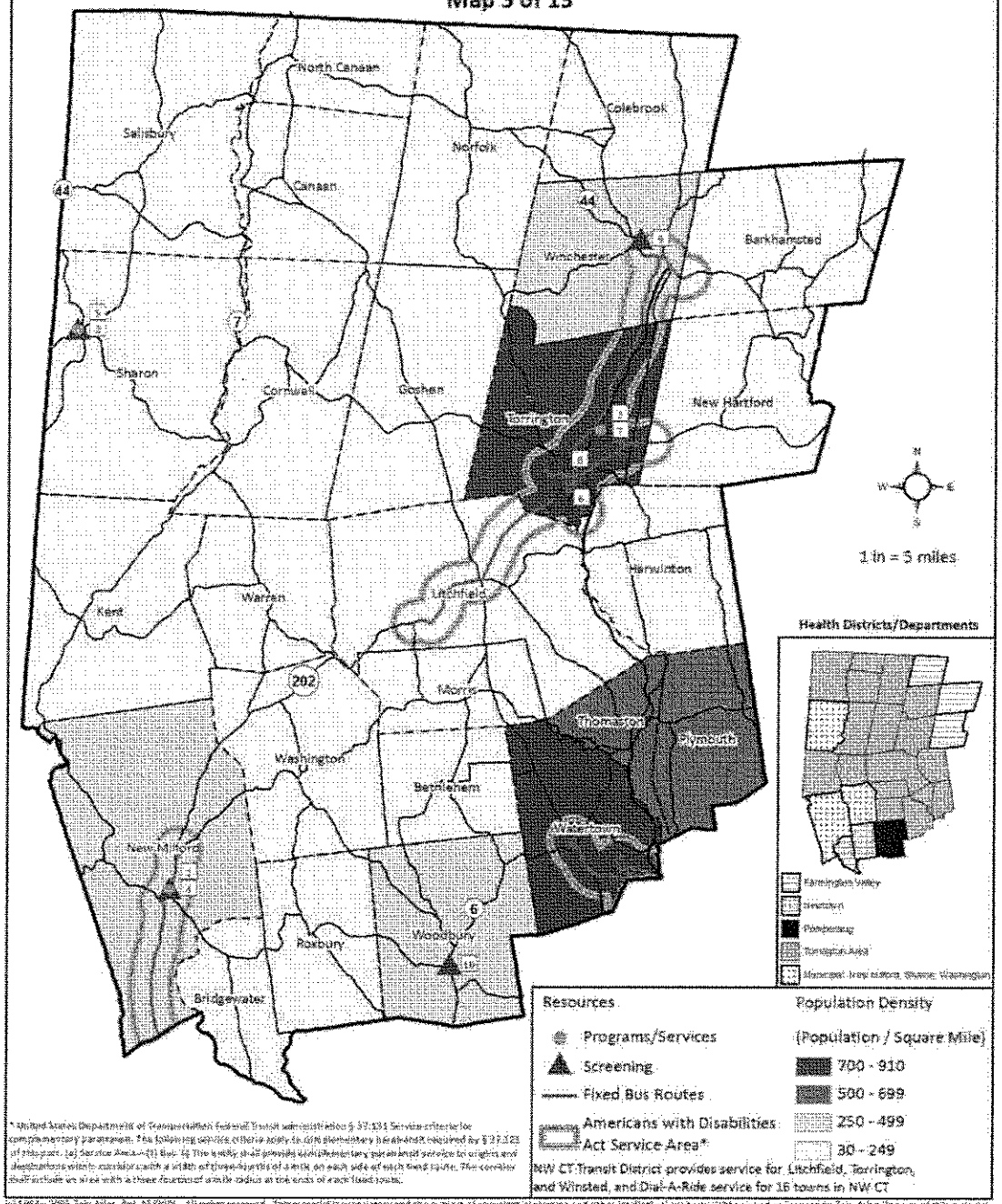
33. Nature Center/Walks
    FLANDERS NATURE CENTER AND LAND TRUST
    5 Church Hill Road
    Woodbury, CT 06798

34. Recreational Activities/Sports, Swimming/Swim Lessons
    WOODBURY PARK AND RECREATION
    7 Mountain Road
    Woodbury, CT 06798

PROGRAMS AND SERVICES

35. Specialized Treatment * Eating Disorders
    WELLSPRING
    21 Arch Bridge Road
    Bethlehem, CT 06751

Litchfield County, Connecticut
Community Transformation Grant
Strategic Direction Three: High Impact Quality Clinical and Other Preventive Services - Leading Causes: Cancer
Map 3 of 13



* United States Department of Transportation Federal Transit administration § 37.131 Service criteria for complementary paratransit. The following service criteria apply to all complementary paratransit required by § 37.121 of this part. (a) Service Area. (1) Bus. (i) The entity shall provide complementary paratransit service to origins and destinations within a corridor with a width of three-fourths of a mile on each side of each fixed route. The corridor shall include an area with a three-fourths of a mile radius at the ends of each fixed route.

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Litchfield County, CT
Community Transformation Grant
Strategic Direction Three: High Impact Quality Clinical and Other Preventive Services – Leading Causes
Map 3 of 13 – Resource Listing

CANCER – PROGRAMS AND SERVICES

1. Specialized Treatment * Cancer
   NEW MILFORD HOSPITAL
   REGIONAL CANCER CENTER
   21 Elm Street
   New Milford, CT 06776

2. Breast Cancer, Specialized Treatment
   SHARON HOSPITAL
   CANCER CARE
   50 Hospital Hill Road
   Sharon, CT 06069

3. Specialized Treatment * Cancer
   CHARLOTTE HUNGERFORD HOSPITAL
   CENTER FOR CANCER CARE
   200 Kennedy Drive
   Torrington, CT 06790

CANCER – SCREENING

4. Cancer Detection
   NEW MILFORD HOSPITAL
   REGIONAL CANCER CENTER
   21 Elm Street
   New Milford, CT 06776

5. Cancer Detection, Breast Cancer
   SHARON HOSPITAL
   CANCER CARE
   50 Hospital Hill Road
   Sharon, CT 06069

6. Cancer Detection * Breast Cancer, Cervical Cancer
   CHARLOTTE HUNGERFORD HOSPITAL - BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM
   540 Litchfield Street
   Torrington, CT 06790

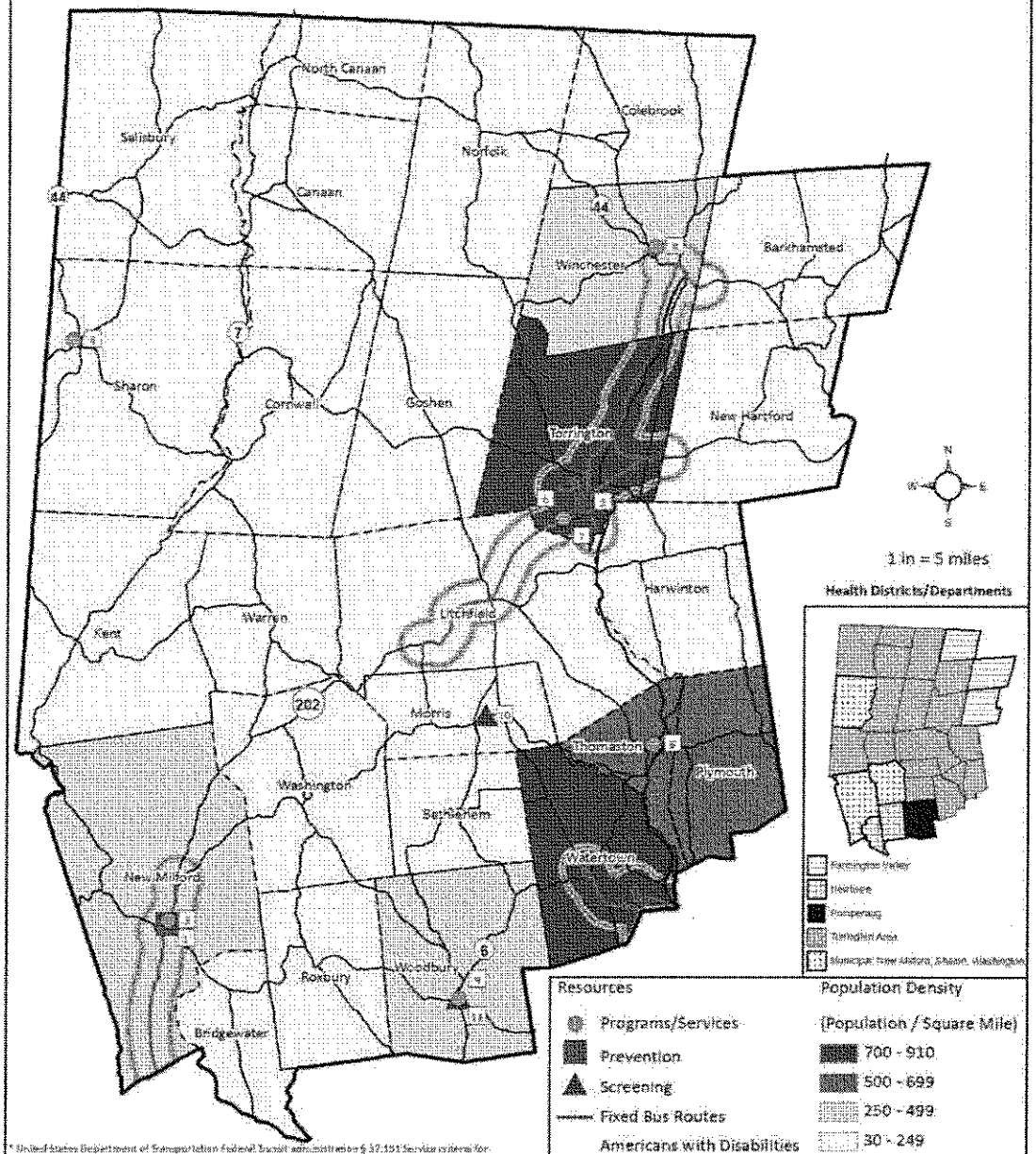
7. Cancer Detection * Breast Cancer
   CHARLOTTE HUNGERFORD HOSPITAL
   MAMMOGRAPHY CENTER
   220 Kennedy Drive
   Torrington, CT 06790

8. Cancer Detection * Colorectal Cancer
   COMMUNITY HEALTH AND WELLNESS CENTER OF GREATER TORRINGTON - COLORECTAL CANCER CONTROL PROGRAM
   459 Migeon Avenue
   Torrington, CT 06790

9. Cancer Detection * Breast Cancer
   CHARLOTTE HUNGERFORD HOSPITAL - HUNGERFORD EMERGENCY AND MEDICAL SERVICES
   115 Spencer Street
   Winchester, CT 06098

10. Skin Cancer Screening
    POMPERAUG HEALTH DISTRICT
    275 Main South St.
    Woodbury, CT 06798

Litchfield County, Connecticut
Community Transformation Grant
Strategic Direction Three: High Impact Quality Clinical and Other Preventive Services - Leading Causes: Cardiovascular
Map 4 of 13



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Litchfield County, CT
Community Transformation Grant
Strategic Direction Three: High Impact Quality Clinical and Other Preventive Services – Leading Causes - Cardiovascular
Map 4 of 13 – Resource Listing

CARDIOVASCULAR – PROGRAMS AND SERVICES

PREVENTION

1. CPR Instruction
   AMERICAN RED CROSS - CT CHAPTER
   40 Main Street
   New Milford, CT 06776

2. CPR Instruction
   AMERICAN RED CROSS - CT CHAPTER
   21 Prospect Street Suite B
   Torrington, CT 06790

PROGRAMS AND SERVICES

3. Cardiac Rehab, Specialized Treatment * Heart Disease
   NEW MILFORD HOSPITAL - REGIONAL HEART CENTER/CARDIAC REHABILITATION
   21 Elm Street
   New Milford, CT 06776

4. Cardiac Rehabilitation
   SHARON HOSPITAL CARDIOLOGY
   50 Hospital Hill Road
   Sharon, CT 06069

5. Stroke Rehabilitation
   ACCESS REHAB CENTERS - THOMASTON SITE
   131 Main Street Suite 105B
   Thomaston, CT 06787

6. Cardiac Rehabilitation
   CHARLOTTE HUNGERFORD HOSPITAL
   CARDIAC REHABILITATION
   780 Litchfield Street
   Torrington, CT 06790

7. Pulmonary Rehabilitation
   CHARLOTTE HUNGERFORD
   PULMONARY EDUCATION
   780 Litchfield Street
   Torrington, CT 06790

8. Cardiac and Pulmonary Rehabilitation
   CHARLOTTE HUNGERFORD EMERGENCY & MEDICAL SVCS.
   115 Spencer Street
   Winchester, CT 06098

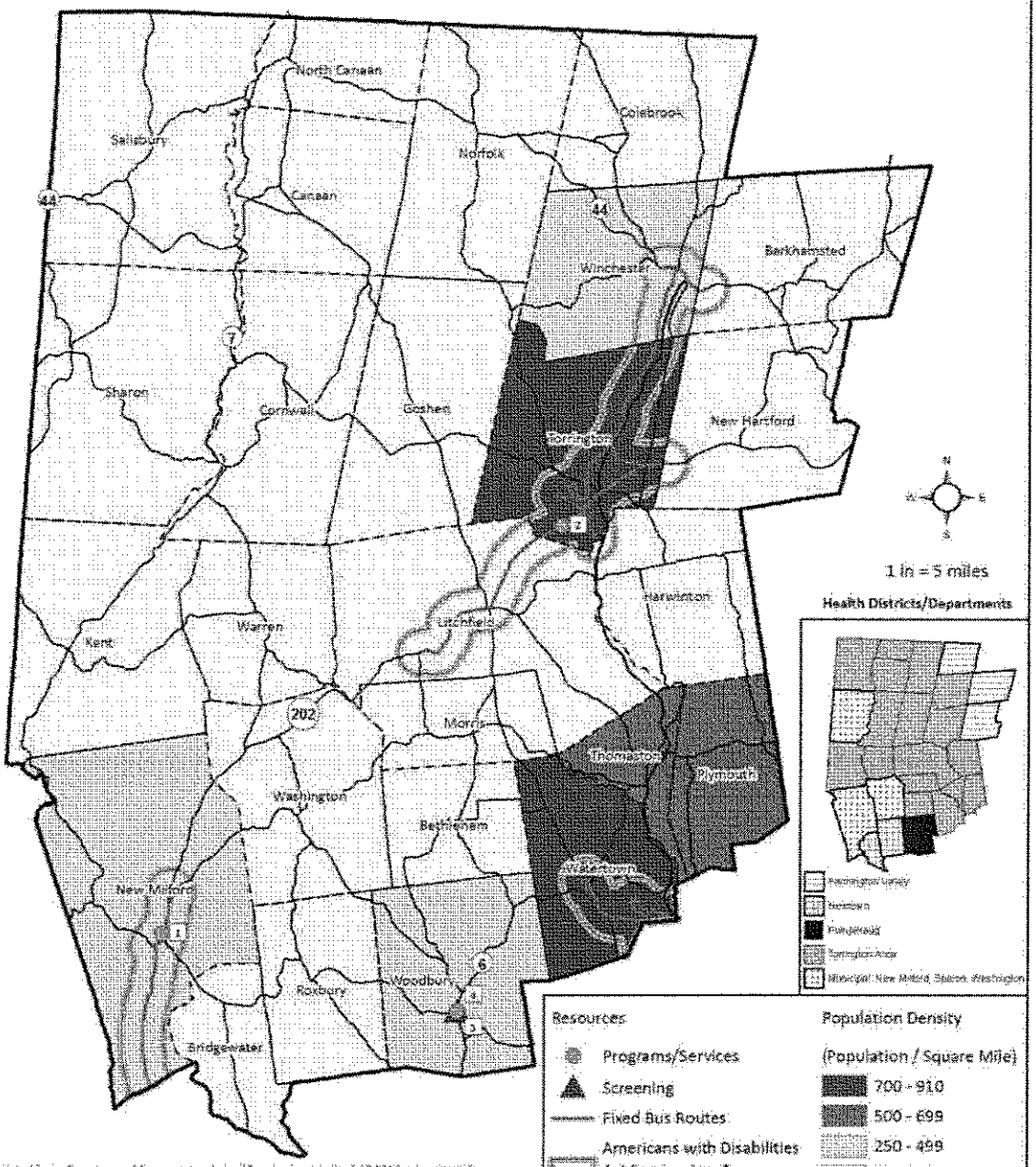
9. Chronic Disease Self-Management
   POMPERAUG HEALTH DISTRICT
   275 Main South St.
   Woodbury, CT 06798

SCREENING

10. Cardiovascular
    Health Screening/Diagnostic Services
    MORRIS SENIOR CENTER
    109-21 East Street
    Morris, CT 06763

11. Cardiovascular
    Health Screening/Diagnostic Services
    POMPERAUG HEALTH DISTRICT
    275 Main South St.
    Woodbury, CT 06798

Litchfield County, Connecticut
Community Transformation Grant
Strategic DirectionThree: High Impact Quality Clinical and Other Preventive Services - Leading Causes: Diabetes
Map 5 of 13



* United States Department of Transportation Federal Transit Administration § 37.131 Service criteria for complementary paratransit. The following service criteria apply to the complementary paratransit service required by § 37.121 of this part. (a) Service Area—(1) Rule. (i) The entity shall provide complementary paratransit service to origins and destinations within service areas with a width of three-fourths of a mile on each side of each fixed route. The corridor shall include an area with a three-fourths of a mile radius at the ends of each fixed route.

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[1] U.S Bureau of the Census | 2010 Summary File 3 (SF 3) | [2] Kelley Transit, CT Transit, 2-1-1 Infoline, United Way of Connecticut

Litchfield County, CT
Community Transformation Grant
Strategic Direction Three: High Impact Quality Clinical and Other Preventive Services – Leading Causes - Diabetes
Map 5 of 13 – Resource Listing

DIABETES – PROGRAMS AND SERVICES

1. Specialized Treatment * Diabetes
   NEW MILFORD HOSPITAL - DIABETES EDUCATION
   21 Elm Street
   New Milford, CT 06776

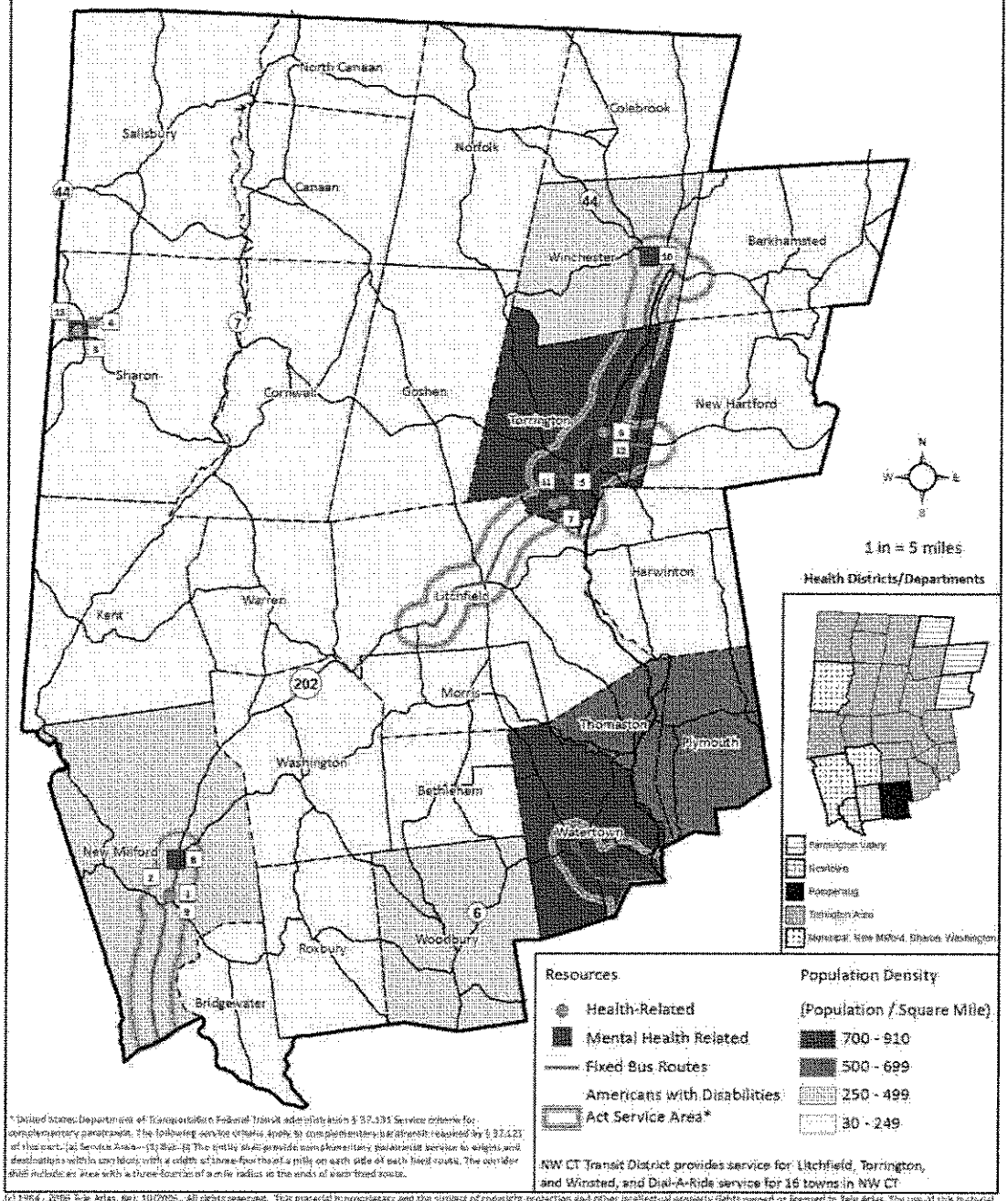
2. Specialized Treatment * Diabetes
   CHARLOTTE HUNGERFORD HOSPITAL
   DIABETES CENTER
   780 Litchfield Street
   Torrington, CT 06790

3. Chronic Disease Self-Management Program
   POMPERAUG HEALTH DISTRICT
   275 Main South St.
   Woodbury, CT 06798

DIABETES – SCREENING

4. Diabetes Control and Screening Programs
   POMPERAUG HEALTH DISTRICT
   275 Main South St.
   Woodbury, CT 06798

Litchfield County, Connecticut
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness -
Community Support and Support Groups - Health and Mental Health-Related
Map 6 of 13



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U.S Bureau of the Census (2010) Summary File 3 (SF 3) - Kelley Transit, CT Transit 2.4.1 Initiative, United Way of Connecticut

Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Community Support and Support Groups – Health and Mental Health-Related
Map 6 of 13 – Resource Listing

HEALTH RELATED

1. Health/Disability Related Support Groups
   * Cancer
   NEW MILFORD HOSPITAL -
   CARES SUPPORT GROUP
   21 Elm Street
   New Milford, CT 06776

2. Health/Disability Related Support Groups
   * Visual Impairments
   NEW MILFORD RICHMOND CITIZEN CENTER
   40 Main Street
   New Milford, CT 06776

3. Caregiver/Care Receiver Support Groups
   SHARON HOSPITAL - CAREGIVER SUPPORT GROUP
   50 Hospital Hill Road
   Sharon, CT 06069

4. Health/Disability Support Groups Stroke, Cancer
   SHARON HOSPITAL
   1 Low Road
   Sharon, CT 06069

5. Health/Disability Related Support Groups * Breast Cancer, Prostate Cancer
   CHARLOTTE HUNGERFORD -
   CANCER SUPPORT GROUPS
   540 Litchfield Street
   Torrington, CT 06790

6. Health/Disability Related Support Groups
   * Cancer
   CHARLOTTE HUNGERFORD CENTER FOR CANCER CARE
   200 Kennedy Drive
   Torrington, CT 06790

7. Health/Disability Related Support Group * Diabetes
   CHARLOTTE HUNGERFORD HOSPITAL - DIABETES CENTER
   780 Litchfield Street
   Torrington, CT 06790

MENTAL HEALTH RELATED

8. Bereaved Child Support Groups,
   General Bereavement Support Groups
   NEW MILFORD VISITING NURSE ASSOC.
   68 Park Lane Road, Route 202
   New Milford, CT 06776

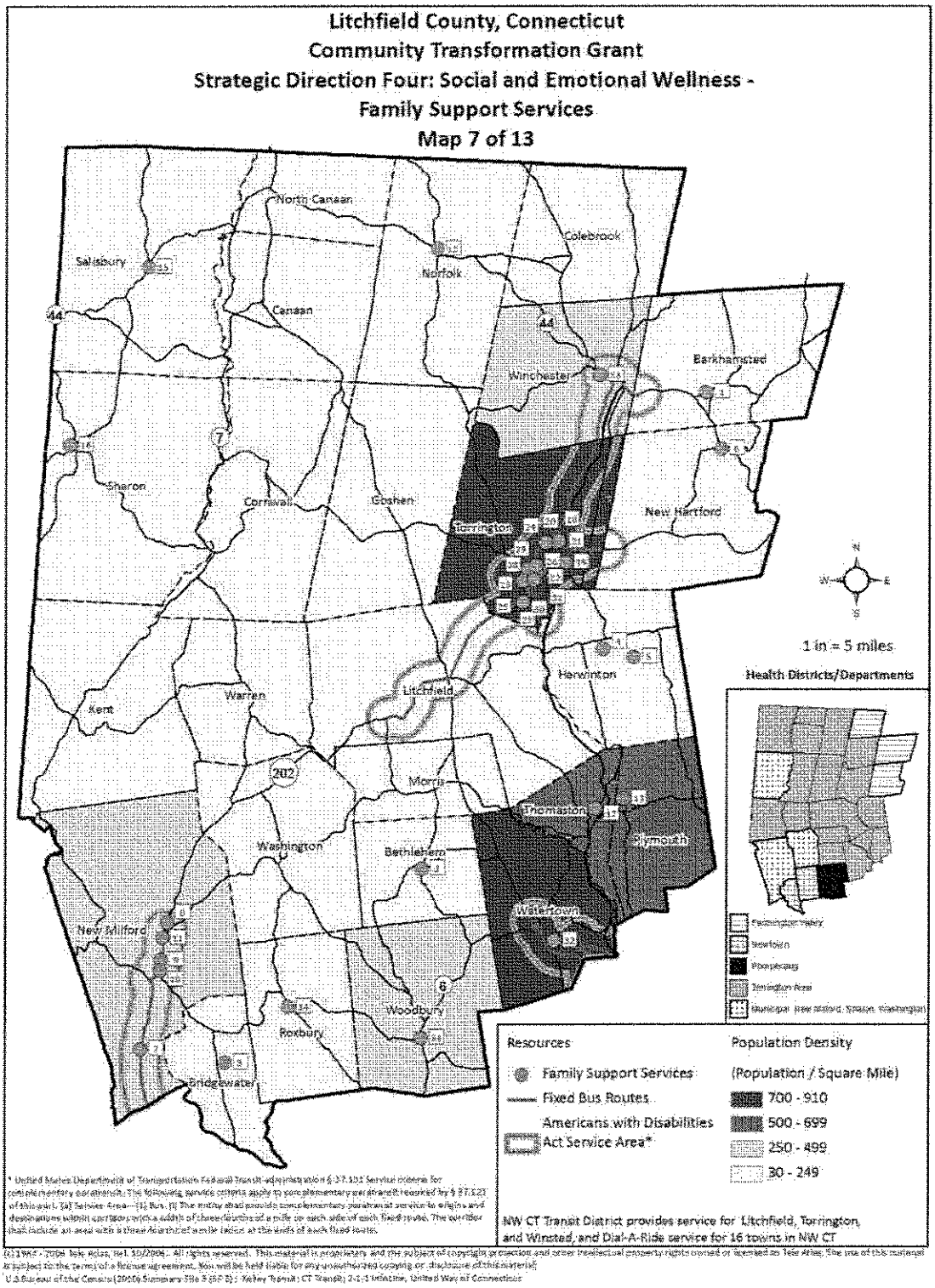
9. Planning/Coordinating/Advisory Groups
   UNITED WAY OF NORTHWEST CT
   16 Bird Street Suite 1
   Torrington, CT 06790

10. General Bereavement Support Groups
    FOOTHILLS VISITING NURSE AND HOME CARE
    32 Union Street
    Winchester, CT 06098

11. General Bereavement
    Support Groups
    CHARLOTTE HUNGERFORD HOSPITAL - BEHAVIORAL HEALTH
    540 Litchfield Street
    Torrington, CT 06790

12. Bereaved Child Support Groups
    VISITING NURSE SERVICES OF CT - TORRINGTON OFFICE
    65 Commercial Boulevard
    Torrington, CT 06790

13. Bereaved Parent, General Bereavement Support Groups
    SHARON HOSPITAL
    50 Hospital Hill Road
    Sharon, CT 06069



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U.S.Bureau of the Census (2000) Summary File 3 (SF 3) - Valley Transit; CT Transit; 2-1-1 Infoline, United Way of Connecticut

Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Family Support Services
Map 7 of 13 – Resource Listing

FAMILY SUPPORT SERVICES

1. Latchkey/Home Alone
   Safety Programs
   BARKHAMSTED RESIDENT STATE TROOPER
   67 Ripley Hill Road
   Barkhamsted, CT 06063

2. Latchkey/Home Alone
   Safety Programs
   BETHLEHEM RESIDENT STATE TROOPER
   36 Main Street South
   Bethlehem, CT 06751

3. Foster Homes for Dependent Children
   BRIDGE FAMILY CENTER,
   THE - HARWINTON SHELTER
   25 Plymouth Road
   Harwinton, CT 06791-2418

4. Latchkey/Home Alone Safety Programs
   BRIDGEWATER RESIDENT STATE TROOPER
   132 Hut Hill Road
   Bridgewater, CT 06752

5. Adoption Counseling and Support/Placement,
   Co-Parenting Workshops
   CATHOLIC CHARITIES - ARCHDIOCESE OF HARTFORD
   TORRINGTON
   132 Grove Street
   Torrington, CT 06790

6. Child Abuse Counseling, Children's
   Protective Services
   CHARLOTTE HUNGERFORD HOSPITAL
   CENTER FOR YOUTH AND FAMILIES
   1061 East Main Street
   Torrington, CT 06790

7. Parenting Education * Parents of Infants/Toddlers
   CHARLOTTE HUNGERFORD HOSPITAL
   NURTURING CONNECTIONS
   540 Litchfield Street
   Torrington, CT 06790

8. Adoption and Foster Parents, Children's Protective Services,
   Foster Homes,, Home Based Parenting Ed * Child Abuse Issues
   DEPT OF CHILDREN AND FAMILIES
   62 Commercial Boulevard
   Torrington, CT 06790

9. Children's Rights Groups, Guardians ad Litem, Individual
   Advocacy * Child Abuse, Juvenile Delinquency Prevention
   CHILDREN IN PLACEMENT - TORRINGTON
   410 Winsted Road
   Torrington, CT 06790

10. Co-Parenting, Family Preservation, Home Based Parenting Ed
    COMMUNITY MENTAL HEALTH AFFILIATES –
    NORTHWEST CENTER FOR FAMILY SERVICE
    100 Commercial Boulevard
    Torrington, CT 06790

11. Case/Care Management * At Risk Families
    NEW MILFORD VISITING NURSE ASSOCIATION
    68 Park Lane Road, Route 202
    New Milford, CT 06776

12. Co-Parenting
    Workshops
    COMMUNITY MENTAL HEALTH
    PARK LANE BEHAVIORAL
    120 Park Lane Road
    New Milford, CT 06776

13. Kinship Caregivers, Home Based Parenting Education,
    Parents of Infants/Toddlers
    EDUCATION CONNECTION
    TORRINGTON SITE
    57 Forest Court
    Torrington, CT 06790

14. Adoption and Foster/Kinship Care Support Groups
    EDUCATION CONNECTION
    TORRINGTON SITE
    57 Forest Court
    Torrington, CT 06790

Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Family Support Services
Map 7 of 13 – Resource Listing

FAMILY SUPPORT SERVICES (Cont.)

15. Child Abuse Counseling
FAMILY AND CHILDREN'S AID NEW MILFORD SITE
325 Danbury Road
New Milford, CT 06776

16. Case Management * At Risk Families, Teen Parents, Parenting Ed, Fathers, Home Based Parenting Ed
FAMILY STRIDES
350 Main Street Suite D
Torrington, CT 06790

17. Latchkey/Home Alone
Safety Programs
HARWINTON RESIDENT STATE TROOPER
100 Bentley Drive
Harwinton, CT 06791-2231

18. Home Based Parenting Education
* At Risk Families
MCCALL FOUNDATION
58 High Street
Torrington, CT 06790

19. Latchkey/Home Alone
Safety Programs
NEW HARTFORD, RESIDENT STATE TROOPER
530 Main Street
New Hartford, CT 06057-0316

20. Case Management, At Risk Families, Teen Parents /Fathers, Home Based Parenting Ed
NEW MILFORD VISITING NURSE ASSOCIATION
68 Park Lane Road, Route 202
New Milford, CT 06776

21. Latchkey/Home Alone Safety Programs
NEW MILFORD POLICE
49 Poplar Street
New Milford, CT 06776

22. Juvenile Diversion, Parenting Education
NEW MILFORD YOUTH AGENCY
50 East Street
Torrington, CT 06790

23. Latchkey/Home Alone
Safety Programs
NORFOLK RESIDENT STATE TROOPER
14 Shepard Road
Norfolk, CT 06058

24. Child Care Referrals, Family Support Centers, Home Based Parenting Ed, Parenting Ed/Infants/Toddlers
PLYMOUTH FAMILY RESOURCE CENTER
107 North Street
Plymouth, CT 06782

25. Latchkey/Home Alone
Safety Programs
ROXBURY RESIDENT STATE TROOPER
27 North Street
Roxbury, CT 06783

26. Latchkey/Home Alone
Safety Programs
SALISBURY RESIDENT STATE TROOPER
27 Main Street
Salisbury, CT 06068-0365

27. Parenting Education
Parents of Infants/Toddlers
SHARON HOSPITAL - NURTURING CONNECTIONS
50 Hospital Hill Road
Sharon, CT 06069

28. Juvenile Delinquency Programs
SUPERIOR COURT, CT - JUVENILE MATTERS AT TORRINGTON
410 Winsted Road
Torrington, CT 06790

Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Family Support Services
Map 7 of 13 – Resource Listing

FAMILY SUPPORT SERVICES (Cont.)

29. Latchkey/Home Alone
Safety Programs
THOMASTON POLICE
158 Main Street
Thomaston, CT 06787-1720

30. Juvenile Diversion
TORRINGTON AREA YOUTH SERVICE BUREAU (TAYSB)
8 Church Street
Torrington, CT 06790

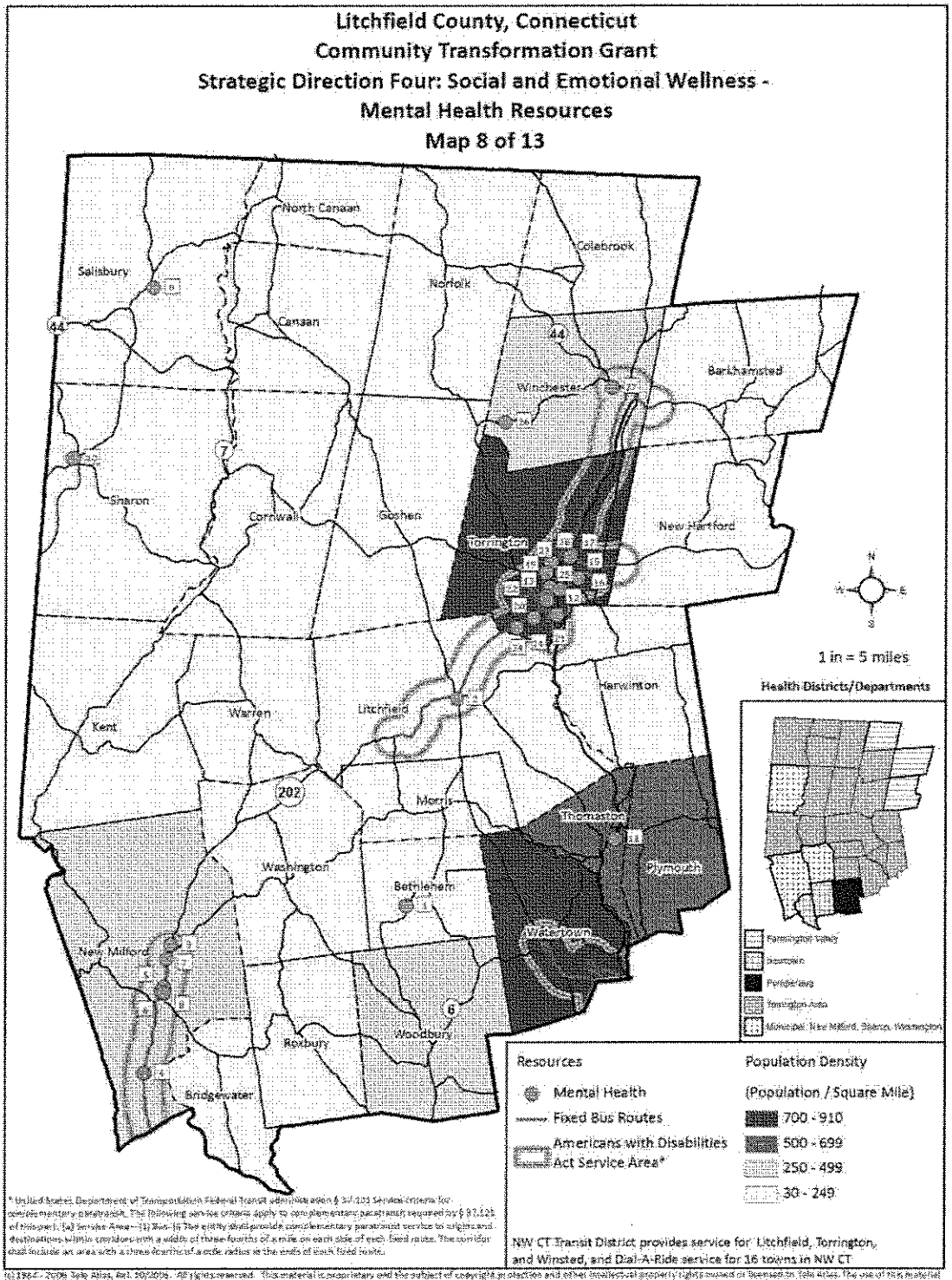
31. Latchkey/Home Alone Safety Programs
TORRINGTON, CITY OF - POLICE
576 Main Street
Torrington, CT 06790

32. Home Based Parenting Ed, Parenting Ed, Family Support Centers/Outreach, Child Care Provider Referrals
VOGEL-WETMORE FAMILY RESOURCE CENTER
68 Church Street
Torrington, CT 06790

33. Latchkey/Home Alone Safety Programs
WATERTOWN POLICE
195 French Street
Watertown, CT 06795

34. Home Based Parenting Education, Parenting Ed
WINCHESTER YOUTH SERVICE BUREAU (WYSB)
480 Main Street
Winchester, CT 06098

35. Latchkey/Home Alone
Safety Programs
WOODBURY RESIDENT STATE TROOPER
271 Main Street South
Woodbury, CT 06798-0369



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Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Mental Health Resources
Map 8 of 13 – Resource Listing

MENTAL HEALTH

1. General Counseling Services
   WELLSPRING
   21 Arch Bridge Road
   Bethlehem CT 06751

2. Therapy Referrals
   GREENWOODS COUNSELING REFERRALS
   25 South Street
   Litchfield CT

3. Adolescent/Youth Counseling,
   General Counseling Services
   COMMUNITY MENTAL HEALTH AFFILIATES - PARK LANE BEHAVIORAL HEALTH
   120 Park Lane Road
   New Milford, CT 06776

4. Adolescent/Youth Counseling, Child Guidance, Mental Health Evaluation, Psychiatric Disorder Counseling
   FAMILY AND CHILDREN'S AID - NEW MILFORD SITE
   325 Danbury Road
   New Milford, CT 06776

5. Adolescent/Youth Counseling General Counseling
   NEW MILFORD HOSPITAL
   BEHAVIORAL HEALTH SERVICES
   23 Poplar Street
   New Milford, CT 06776

6. Psychiatric Emergency
   Room Care
   NEW MILFORD HOSPITAL EMERGENCY DEPARTMENT
   21 Elm Street
   New Milford, CT 06776

7. Psychiatric Home Nursing
   NEW MILFORD VISITING NURSE ASSOCIATION
   68 Park Lane Road, Route 202
   New Milford, CT 06776

8. Adolescent/Youth Counseling,
   NEW MILFORD YOUTH AGENCY
   50 East Street
   New Milford, CT 06776

9. Psychiatric Home Nursing
   SALISBURY VISITING NURSE ASSOCIATION
   30A Salmon Kill Road
   Salisbury, CT 06068

10. Adult Psychiatric Inpatient Units, Mental Health Evaluation, Psychiatric Emergency Room Care
    SHARON HOSPITAL
    SENIOR BEHAVIORAL HEALTH
    50 Hospital Hill Road
    Sharon, CT 06069

11. Therapeutic
    Group Homes
    NAFI CT - THOMASTON GROUP HOME
    273 Prospect Street
    Thomaston, CT 06787

12. Psychiatric Home Nursing
    ALL ABOUT YOU HOME CARE SERVICES
    TORRINGTON OFFICE
    507 East Main Street Suite 305
    Torrington, CT 06790

13. Adolescent/Youth Counseling, General Counseling Services, Mental Health Evaluation
    CATHOLIC CHARITIES - ARCHDIOCESE OF HARTFORD -
    132 Grove Street
    Torrington, CT 06790

14. Adult Psychiatric Inpatient Units
    CHARLOTTE HUNGERFORD HOSP. BEHAVIORAL HEALTH
    540 Litchfield Street
    Torrington, CT 06790

Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Mental Health Resources
Map 8 of 13 – Resource Listing

MENTAL HEALTH (CONT.)

15. Psychiatric Day Treatment * Youth
CHARLOTTE HUNGERFORD HOSPITAL - BRIDGES CHILD EXTENDED DAY TREATMENT PROGRAM
241 Kennedy Drive
Torrington, CT 06790

16. Adolescent/Youth Counseling, Child Guidance,
CHARLOTTE HUNGERFORD
CENTER FOR YOUTH AND FAMILIES
1061 East Main Street
Torrington, CT 06790

17. Case/Care Management
* Youth Emotional Disturbance
CT DEPARTMENT OF CHILDREN AND FAMILIES
62 Commercial Boulevard
Torrington, CT 06790

18. Adolescent/Youth Counseling, Case/Care Management
COMMUNITY MENTAL HEALTH AFFILIATES - NORTHWEST CENTER FOR FAMILY SERVICE
100 Commercial Boulevard
Torrington, CT 06790

19. Individual Advocacy * Chronic/Severe Mental Illness
CT LEGAL RIGHTS PROJECT – TORRINGTON SATELLITE
810 Main Street
Torrington, CT 06790

20. Therapy Referrals
LITCHFIELD COUNTY MEDICAL ASSOCIATION (LCMA)
PO Box 416
Torrington, CT 06790

21. Pastoral Counseling
SALVATION ARMY - TORRINGTON CORPS COMMUNITY CENTER
234 Oak Avenue
Torrington, CT 06790

22. Adolescent/Youth Counseling,
TORRINGTON AREA YOUTH SERVICE BUREAU (TAYSB)
8 Church Street, Lower Level
Torrington, CT 06790

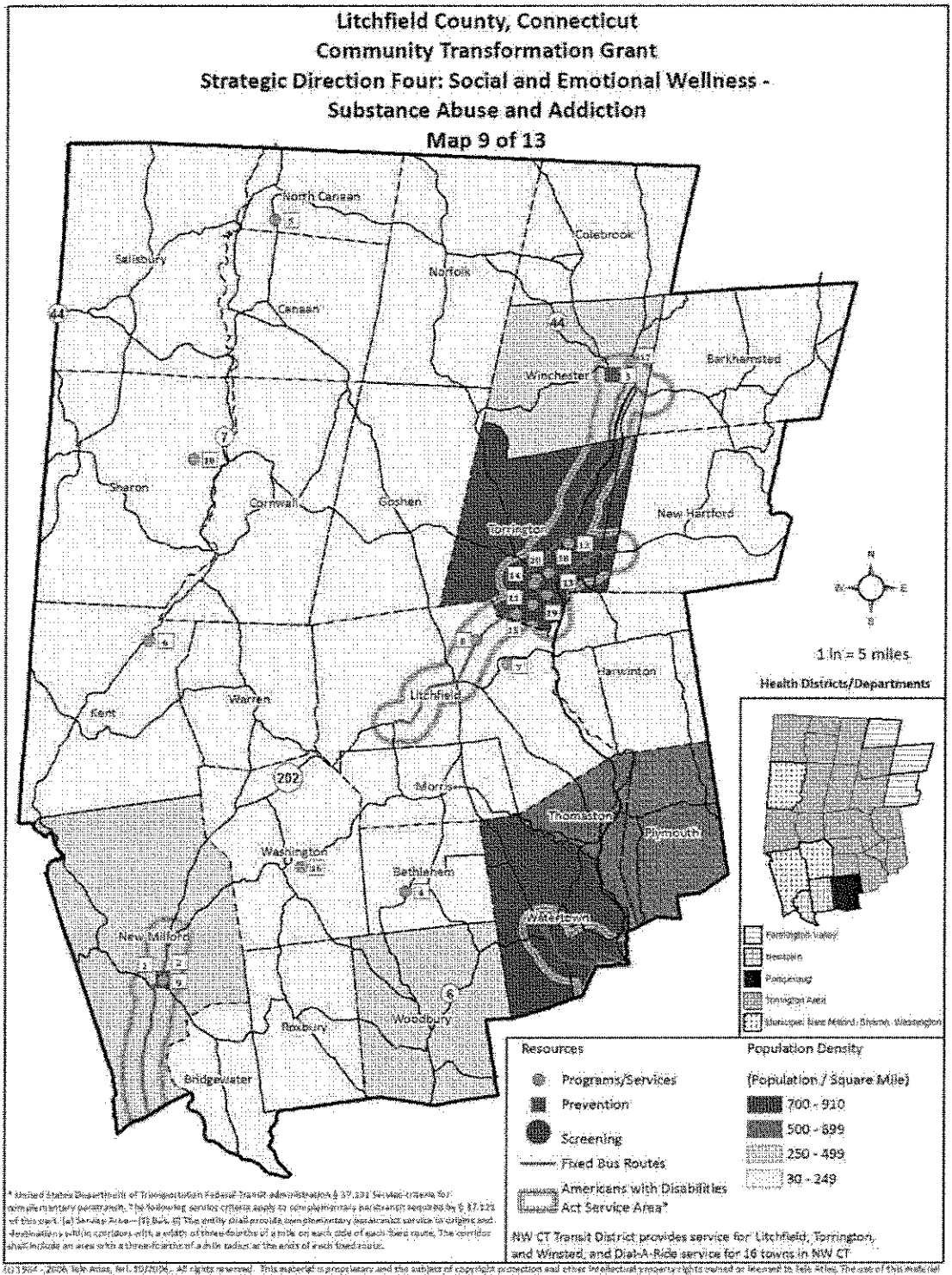
23. Psychiatric Home Nursing
VISITING NURSE SERVICES OF CT
TORRINGTON OFFICE
65 Commercial Boulevard
Torrington, CT 06790

24. Case/Care Management * Children and Youth with Emotional Disturbance, Home Based Mental Health
WELLMORE BEHAVIORAL HEALTH
30 Peck Road Suite 2203
Torrington, CT 06790

25. Case/Care Management * Chronic/Severe Mental Illness,
WESTERN CT MENTAL HEALTH NETWORK – TORRINGTON AREA
249 Winsted Road
Torrington, CT 06790

26. Therapeutic Group Homes
CT JUNIOR REPUBLIC - THERAPEUTIC GROUP HOME
131 Ashleigh Road
Winchester, CT 06098

27. Adolescent/Youth Counseling, Outreach Programs * Youth
WINCHESTER YOUTH SERVICE BUREAU (WYSB)
480 Main Street
Winchester, CT 06098



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Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Substance Abuse and Addiction
Map 9 of 13 – Resource Listing

PREVENTION

1. Substance Abuse Counseling, Substance Abuse Intervention Programs, DUI Offender Programs
MCCA - NEW MILFORD SATELLITE OFFICE
17 East Street
New Milford, CT 06776

2. Substance Abuse Education/Prevention
NEW MILFORD YOUTH AGENCY
50 East Street
New Milford, CT 06776

3. Substance Abuse Education/ Prevention
WINCHESTER YOUTH SERVICE BUREAU (WYSB)
480 Main Street
Winchester, CT 06098

PROGRAMS AND SERVICES

4. Children's/Adolescent Residential Treatment Facilities
WELLSPRING
21 Arch Bridge Road
Bethlehem CT 06751

5. Residential Substance Abuse Treatment Facilities
MOUNTAINSIDE TREATMENT CENTER
187 South Canaan Road Route 7
Canaan, CT 06018

6. Recovery Homes/Halfway Houses
HIGH WATCH RECOVERY CENTER
62 Carter Road
Kent, CT 06757

7. Children's/Adolescent Residential Treatment Facilities
NAFI CT – TOUCHSTONE
11 Country Place
Litchfield, CT 06759

8. Alcohol Dependency Support Groups, Drug Dependency Support Groups
RECOVERY GROUP
441 Torrington Road
Litchfield, CT 06750

9. DUI Offender Programs * Court Ordered Individuals
MCCA - NEW MILFORD SATELLITE OFFICE
17 East Street
New Milford, CT 06776

10. Residential Substance Abuse Treatment Facilities
MCCA - TRINITY GLEN
149 West Cornwall Road
Sharon, CT 06069

11. Inpatient Alcohol Detox
CHARLOTTE HUNGERFORD HOSPITAL EMERGENCY
540 Litchfield Street
Torrington, CT 06790

12. Case/Care Management * Substance Abusers * Youth
DEPT OF CHILDREN AND FAMILIES - TORRINGTON
62 Commercial Boulevard
Torrington, CT 06790

13. Home Based Mental Health Services * Children and Youth with Emotional Disturbance
CT JUNIOR REPUBLIC - TORRINGTON AREA
168 South Main Street
Torrington, CT 06790

Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Substance Abuse and Addiction
Map 9 of 13 – Resource Listing

PROGRAMS AND SERVICES (CONT.)

14. Recovery Homes/Halfway Houses
MCCALL FOUNDATION - MCCALL HOUSE
127 Migeon Avenue
Torrington, CT 06790

15. Case/Care Management * Substance Abusers * Youth
WELLMORE BEHAVIORAL HEALTH FOR CHILDREN & FAMILIES - TORRINGTON CLINICAL SERVICES
30 Peck Road Suite 2203
Torrington, CT 06790

16. Children's/Adolescent Residential Treatment Facilities
GLENHOLME SCHOOL, THE
81 Sabbaday Lane
Washington, CT 06793

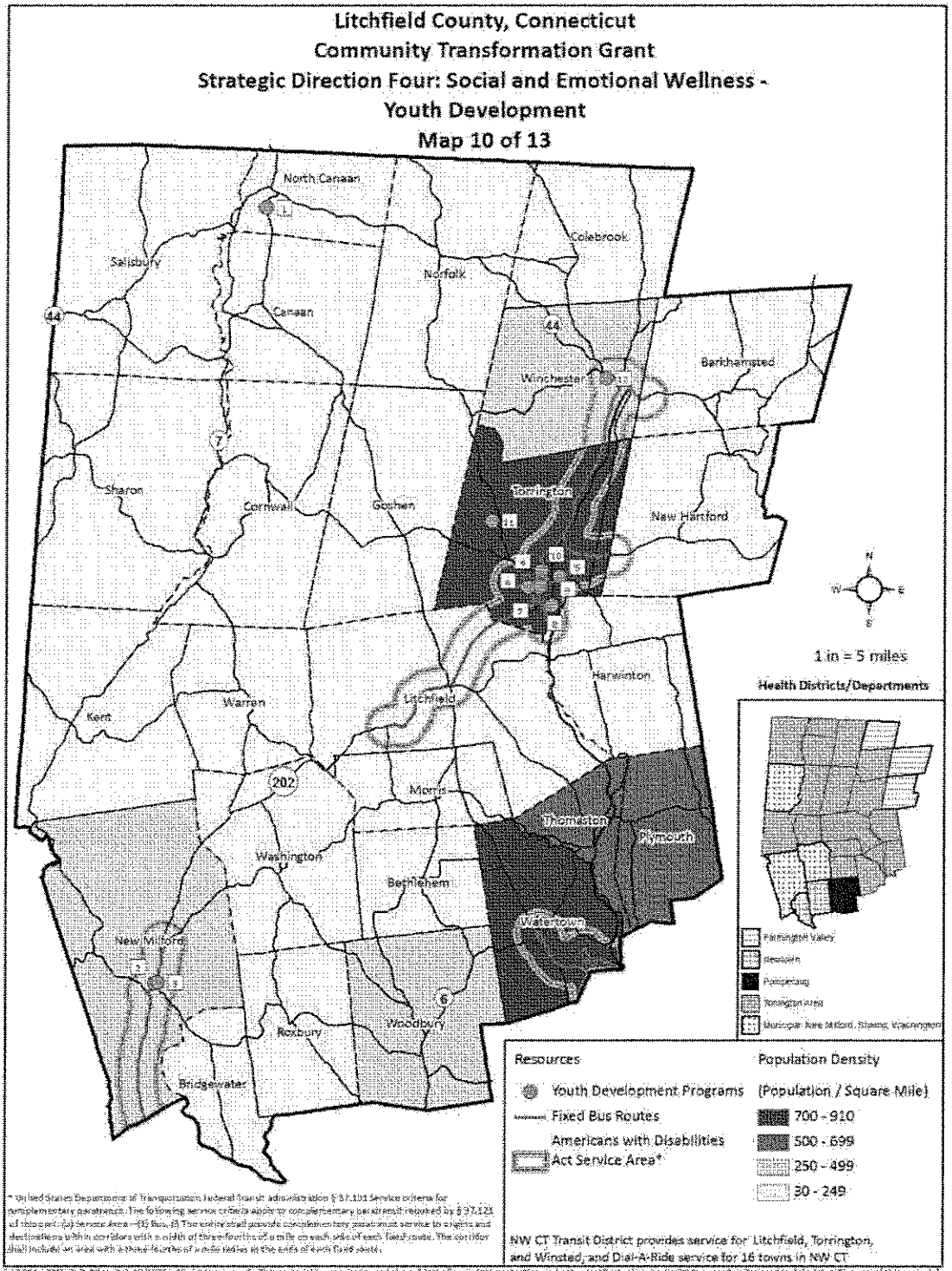
17. Substance Abuse Counseling
MCCALL FOUNDATION
WINSTED SATELLITE OFFICE
231 North Main Street
Winchester, CT 06098

SCREENING

18. General Assessment for Substance Abuse, General Assessment for Substance Abuse * Court Ordered Individuals, Substance Abuse Counseling
CATHOLIC CHARITIES - ARCHDIOCESE OF HARTFORD
132 Grove Street
Torrington, CT 06790

19. General Assessment for Substance Abuse, Inpatient Alcohol Detox, * Pregnant Women, Sub. Abuse Counseling
CHARLOTTE HUNGERFORD HOSPITAL – BEHAVIORAL HEALTH SERVICES
540 Litchfield Street
Torrington, CT 06790

20. Case/Care Management * Substance Abusers, Central Intake/Assessment for Substance Abuse * Older Adults, Families/Friends of Alcoholics Support Groups, General Assessment for Substance Abuse, Residential Substance Abuse Treatment Facilities, Substance Abuse Counseling, Substance Abuse Day Treatment, Substance Abuse Day Treatment * Dual Diagnosis, Substance Abuse Day Treatment * Youth, Substance Abuse Education/Prevention
MCCALL FOUNDATION
58 High Street
Torrington, CT 06790



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Litchfield County, CT
Community Transformation Grant
Strategic Direction Four: Social and Emotional Wellness
Youth Development
Map 10 of 13 – Resource Listing

1. Leadership Development * Youth, Youth Enrichment
   NORTHWEST CT YMCA
   CANAAN FAMILY YMCA
   77 South Canaan Road
   Canaan, CT 06018

2. Youth Enrichment
   NEW MILFORD SOCIAL SERVICES
   40 Main Street
   New Milford, CT 06776

3. Youth Enrichment
   NEW MILFORD YOUTH AGENCY
   50 East Street
   New Milford, CT 06776

4. Youth Enrichment
   FAMILY STRIDES
   350 Main Street Suite D
   Torrington, CT 06790

5. Leadership Development * Youth, Youth Enrichment
   GIRL SCOUTS OF CT - TORRINGTON SERVICE CENTER
   663 East Main Street
   Torrington, CT 06790

6. Youth Enrichment
   MCCALL FOUNDATION
   58 High Street
   Torrington, CT 06790

7. Leadership Development * Youth, Youth Enrichment
   NORTHWEST CT YMCA - TORRINGTON BRANCH
   259 Prospect Street
   Torrington, CT 06790

8. Youth Enrichment
   SALVATION ARMY - TORRINGTON CORPS COMMUNITY CENTER
   234 Oak Avenue
   Torrington, CT 06790

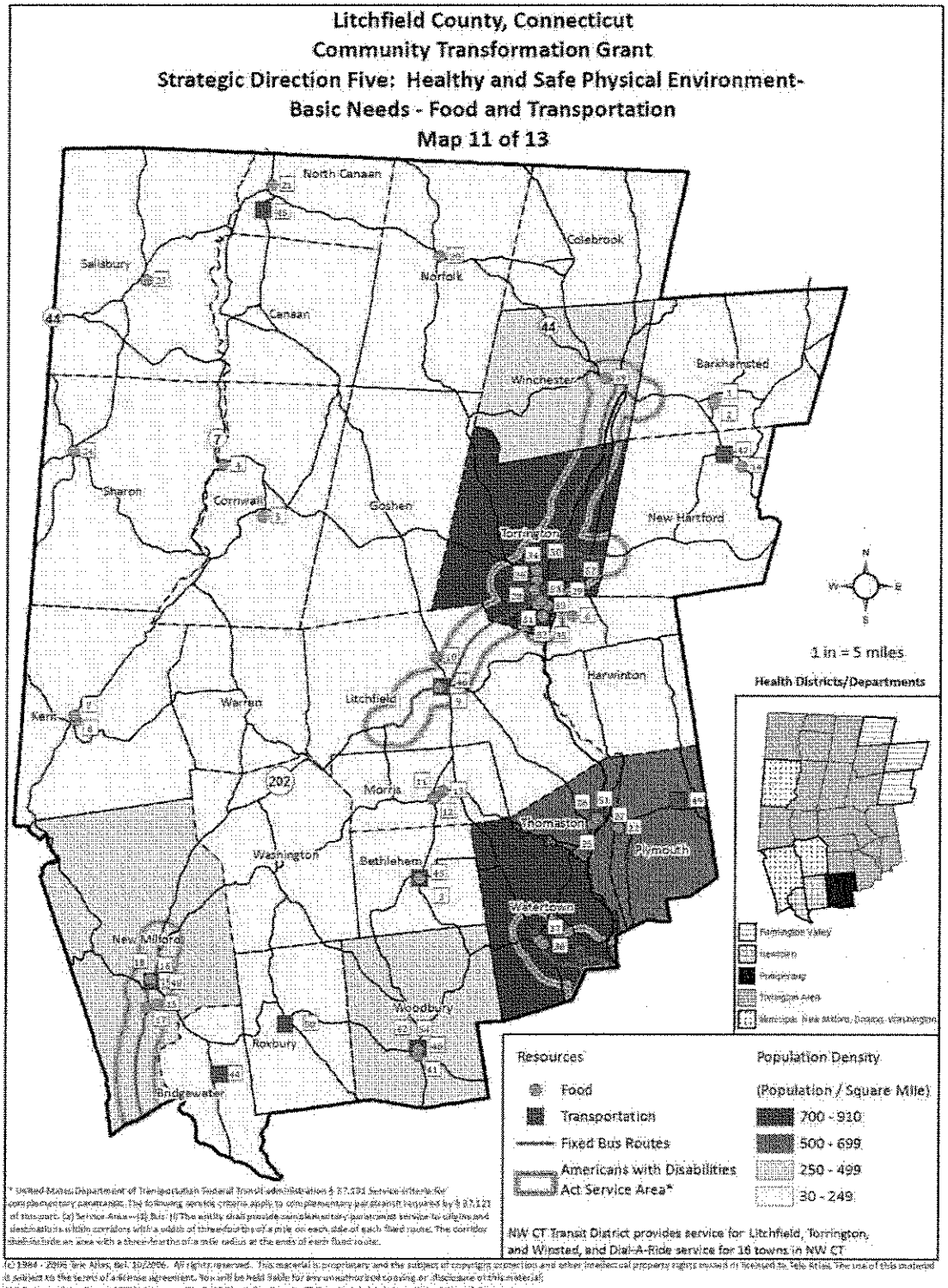
9. Youth Enrichment
   TORRINGTON AREA YOUTH SERVICE BUREAU (TAYSB)
   8 Church Street Lower Level
   Torrington, CT 06790

10. Youth Enrichment
    TORRINGTON POLICE ATHLETIC LEAGUE
    576 Main Street
    Torrington, CT 06790

11. Youth Enrichment
    UCONN COOPERATIVE EXTENSION - LITCHFIELD COUNTY
    843 University Drive
    Torrington, CT 06790

12. Leadership Development * Youth, Youth Enrichment
    NORTHWEST CT YMCA - WINSTED BRANCH
    480 Main Street
    Winchester, CT 06098

13. Youth Enrichment
    WINCHESTER YOUTH SERVICE BUREAU (WYSB)
    480 Main Street
    Winchester, CT 06098



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Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Basic Needs – Food and Transportation
Map 11 of 13 – Resource Listing

FOOD

1. Congregate Meals/Nutrition Sites
   BARKHAMSTED, TOWN OF - SENIOR CENTER
   109 West River Road
   Barkhamsted, CT 06063

2. Food Pantries
   COMMUNITY FOOD BANK
   BARKHAMSTED/NEW HTFD
   93 River Road
   Barkhamsted, CT 06063

3. Food Pantries
   BETHLEHEM, TOWN OF
   36 Main Street South
   Bethlehem, CT 06751

4. Farmers Markets
   CONNECTICUT FARMERS' MARKETS - CORNWALL
   413 Sharon Goshen Turnpike
   Cornwall, CT 06753

5. Food Pantries
   CORNWALL, TOWN OF - SOCIAL SERVICES
   26 Pine Street
   Cornwall, CT 06753-0097

6. Congregate Meals/Nutrition Sites
   HARWINTON, TOWN OF - SENIOR CENTER
   209 Weingart Road
   Harwinton, CT 06791

7. Farmers Markets
   CONNECTICUT FARMERS' MARKETS – KENT
   Kent Green
   Kent, CT 06757

8. Congregate Meals/Nutrition Sites, Food Pantries
   KENT, TOWN OF - PARK AND RECREATION
   41 Kent Green Boulevard
   Kent, CT 06757

9. Farmers Markets
   CT FARMERS' MARKETS - LITCHFIELD/LITCHFIELD HILLS
   125 West Street
   Litchfield, CT 06759

10. Summer Food Service Programs
    SUMMER FOOD SERVICE
    LITCHFIELD/TORRINGTON
    355 Goshen Road
    Litchfield, CT 06759-0909

11. Farmers Markets
    CONNECTICUT FARMERS' MARKETS - MORRIS
    31 East Street
    Morris, CT 06763

12. Food Pantries
    MORRIS, TOWN OF
    3 East Street
    Morris, CT 06763-0066

13. Congregate Meals/Nutrition Sites
    MORRIS, TOWN OF - SENIOR CENTER
    109-21 East Street
    Morris, CT 06763

14. Farmers Markets
    CONNECTICUT FARMERS' MARKETS - NEW HARTFORD
    17 Church Saint No 1
    New Hartford, CT 06057

15. Food Pantries
    CHRISTIAN LIFE FELLOWSHIP - FOOD PANTRY
    48 Anderson Road
    New Milford, CT 06776

16. Farmers Markets
    CONNECTICUT FARMERS' MARKETS - NEW MILFORD
    1209 Main Street
    New Milford, CT 06776

Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Basic Needs – Food and Transportation
Map 11 of 13 – Resource Listing

FOOD (CONT.)

17. Food Pantries
NEW MILFORD UNITED METHODIST
OUR DAILY BREAD FOOD PANTRY
68 Danbury Road
New Milford, CT 06776

18. Congregate Meals/Nutrition Sites
NEW MILFORD RICHMOND CITIZEN CENTER
40 Main Street
New Milford, CT 06776

19. Food Pantries
NEW MILFORD, TOWN OF - SOCIAL SERVICES
40 Main Street
New Milford, CT 06776

20. Farmers Markets
CT FARMERS' MARKETS - NORFOLK
19 Maple Avenue
Norfolk, CT 06058

21. Food Pantries
FISHES & LOAVES FOOD PANTRY - NORTH CANAAN
30 Granite Avenue
North Canaan, CT 06024

22. Home Delivered Meals
COOK WILLOW HEALTH CENTER
81 Hillside Avenue
Plymouth, CT 06782

23. Food Pantries/Vouchers
SALISBURY, TOWN OF - FAMILY SERVICES
30A Salmon Kill Road
Salisbury, CT 06068

24. Food Pantries
SHARON SOCIAL SERVICES
63 Main Street
Sharon, CT 06069

25. Farmers Markets
CT FARMERS' MARKETS
THOMASTON
South Main Street
Thomaston, CT 06787

26. Food Pantries
THOMASTON FOOD PANTRY
158 Main Street
Thomaston, CT 06787-1720

27. Congregate Meals/Nutrition Sites
THOMASTON HOUSING AUTHORITY - GREEN MANOR
63 Green Manor
Thomaston, CT 06787

28. Soup Kitchens
COMMUNITY SOUP KITCHEN - TORRINGTON
220 Prospect Street
Torrington, CT 06790

29. Farmers Markets
CT FARMERS' MARKETS - TORRINGTON
12 Daycoeton Place
Torrington, CT 06790

30. WIC
FAMILY STRIDES
350 Main Street
Torrington, CT 06790

31. Food Pantries
FISH OF TORRINGTON
332 South Main Street
Torrington, CT 06790

32. Food Pantries
FRIENDLY HANDS FOOD BANK – TORRINGTON
50 King Street
Torrington, CT 06790

Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Basic Needs – Food and Transportation
Map 11 of 13 – Resource Listing

FOOD (CONT.)

33. Congregate Meals/Nutrition Sites, Home Delivered
LITCHFIELD HILLS/NORTHWEST ELDERLY NUTRITION
88 East Albert Street
Torrington, CT 06790

34. Soup Kitchens
SAINT MARON'S CHURCH HOT DINNER PROGRAM
613 Main Street
Torrington, CT 06790

35. Food Pantries
SALVATION ARMY - TORRINGTON CORPS
234 Oak Avenue
Torrington, CT 06790

36. Community Gardening
TORRINGTON COMMUNITY GARDENS
c/o Trinity Episcopal Church
Torrington, CT 06790

37. Farmers Markets
CT FARMERS' MARKETS - WATERTOWN
470 Main Street
Watertown, CT 06795

38. Food Pantries
WATERTOWN, TOWN OF - SOCIAL SERVICES
51 Depot Street
Watertown, CT 06795

39. Summer Food Service Programs
SUMMER FOOD SERVICE PROGRAM WINCHESTER
30 Elm Street
Winchester, CT 06098

40. Food Pantries
COMMUNITY SERVICES COUNCIL OF WOODBURY
PO Box 585
Woodbury, CT 06798

41. Farmers Markets
CT FARMERS' MARKETS - WOODBURY
43 Hollow Road
Woodbury, CT 06798

42. Congregate Meals/Nutrition Sites, Home Delivered Meals
WOODBURY, TOWN OF - SENIOR CENTER
265 Main Street South
Woodbury, CT 06798

Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Basic Needs – Food and Transportation
Map 11 of 13 – Resource Listing

TRANSPORTATION

43. Medical Transportation, Senior Ride Programs
BETHLEHEM MUNICIPAL AGENT FOR THE ELDERLY
32 Main Street South
Bethlehem, CT 06751

44. Disability Related/Medical Transportation, Senior Rides
BRIDGEWATER HILLTOP FARM SENIOR CENTER
132 Hut Hill Road
Bridgewater, CT 06752

45. Disability Related/Medical Transportation, Senior Rides
GEER NURSING-REHABILITATION CENTER
83 South Canaan Road
Canaan, CT 06018

46. Escort Programs
COMPANIONS & HOMEMAKERS
LITCHFIELD OFFICE
82 West Street
Litchfield, CT 06759

47. Senior Ride Programs
NEW HARTFORD SENIOR CTR/
Elderly MUNICIPAL AGENT
530 Main Street
New Hartford, CT 06057

48. Disability Related/Medical Transportation, Senior Rides
NEW MILFORD - RICHMOND CITIZEN CENTER
40 Main Street
New Milford, CT 06776

49. Medical Transportation
COOK WILLOW HEALTH CENTER - COOK'S
81 Hillside Avenue
Plymouth, CT 06786

50. Medical Transportation, Senior Ride Programs
ROXBURY ELDERLY SERVICES/ MUNICIPAL AGENT
7 South Street
Roxbury, CT 06783

51. Disability Related/Medical Transportation, Senior Rides
THOMASTON - SOCIAL SERVICES/ MUNICIPAL AGENT
158 Main Street
Thomaston, CT 06787-1720

52. Disability/Medical Transportation, General Paratransit/Community Ride Programs, Senior Rides
NW CT TRANSIT DISTRICT
957 East Main Street
Torrington, CT 06790

53. Disability/ Medical Transportation
TORRINGTON SERVICES FOR THE ELDERLY
/SULLIVAN SENIOR CENTER
88 East Albert Street
Torrington, CT 06790

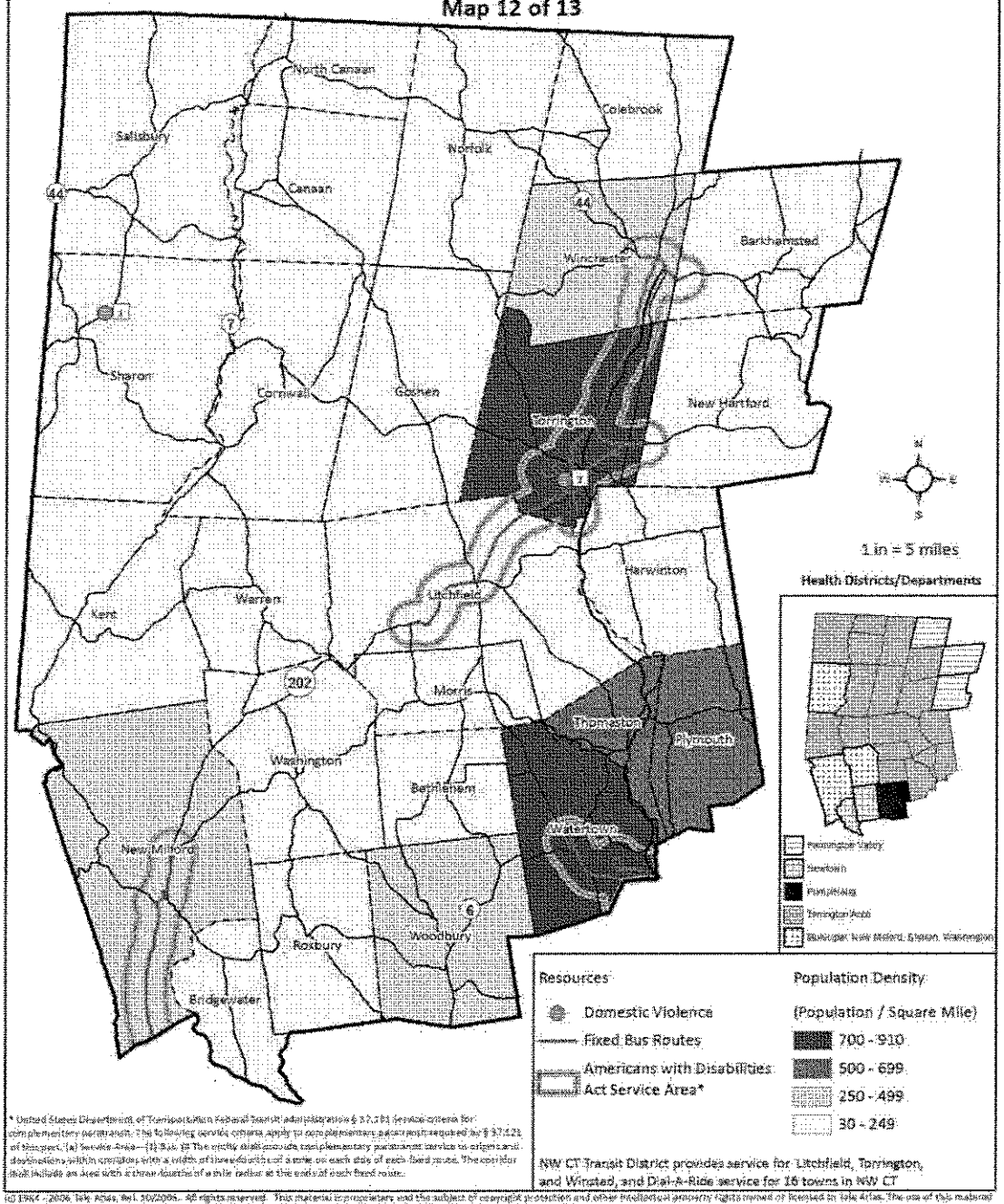
54. Disability Related/Medical Transportation, Senior Rides
WOODBURY
SENIOR CENTER
265 Main Street South
Woodbury, CT 06798

Medical Transportation
FISH OF WOODBURY
PO Box 216
Woodbury, CT 06798

Medical Transportation
FISH OF KENT
PO Box 852
Kent, CT 06757

NO STREET ADDRESS

Litchfield County, Connecticut
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment-
Domestic Violence
Map 12 of 13



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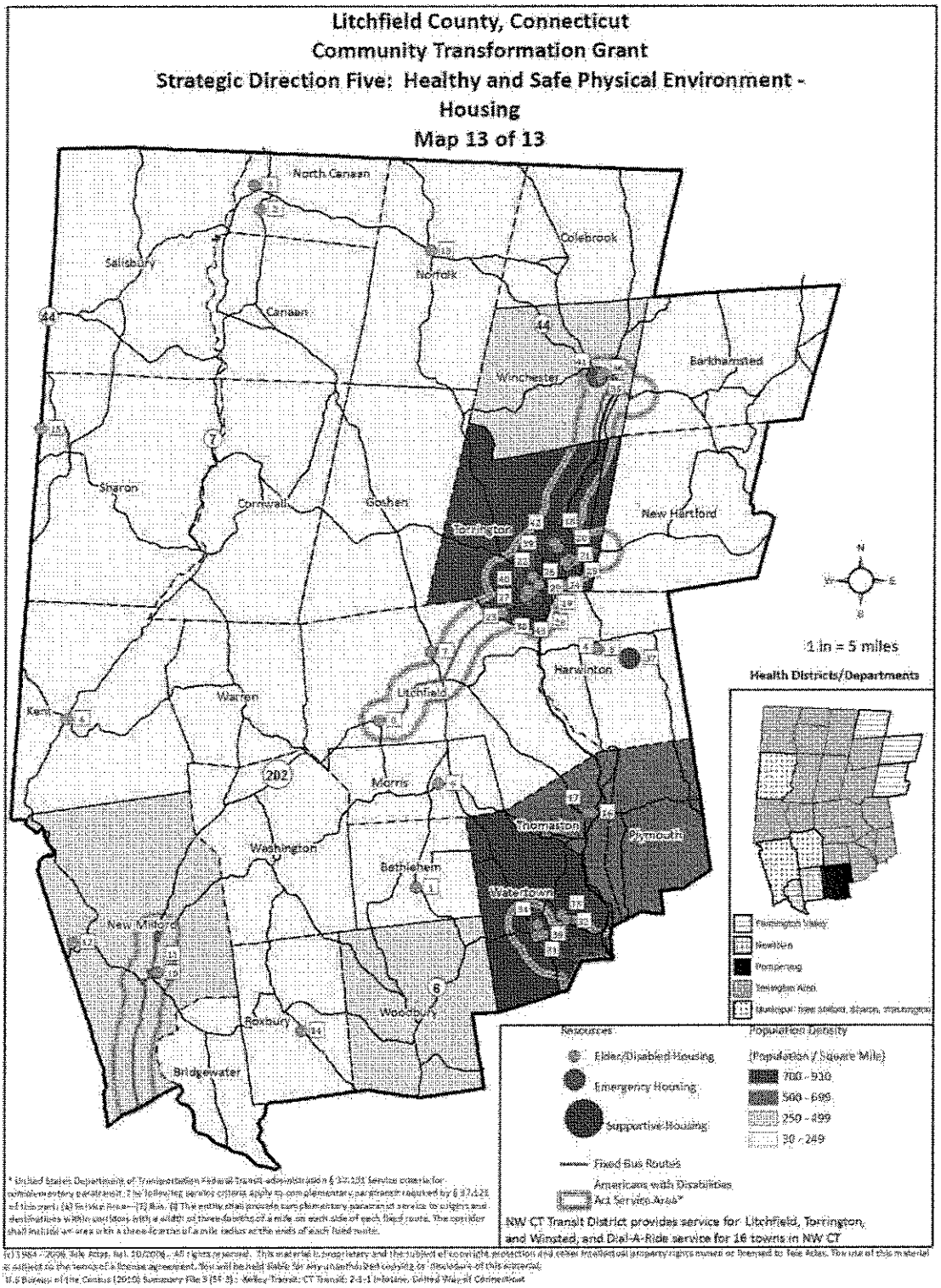
Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Domestic Violence
Map 12 of 13 – Resource Listing

DOMESTIC VIOLENCE

1. DV Shelter, Crime Victim Support, DV Hotlines/Dating Violence, DV Support Groups * Families/Friends of Battered Women/Men/ Battered Women, Spouse/Domestic Partner Abuse Counseling/Prevention
   WOMEN'S SUPPORT SERVICES
   158 Gay Street
   Sharon, CT 06069

2. DV Shelter, Crime Victim Support, DV Hotlines/Dating Violence, DV Support Groups * Families/Friends of Battered Women/Men Spouse/Domestic Partner Abuse Counseling/Prevention
   SUSAN B. ANTHONY PROJECT - DV SERVICE
   179 Water Street
   Torrington, CT 06790


Litchfield County, Connecticut
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment - Housing
Map 13 of 13
North Canaan
Colebrook
Salisbury
Norfolk
Canaan
Barkhamsted
Winchester
Sharon
Cornwall
Goshen
New Hartford
Torrington
Harwinton
Litchfield
Warren
Kent
Morris
Thomaston
Plymouth
Washington
Bethlehem
Watertown
New Milford
Roxbury
Woodbury
Bridgewater
1 in = 5 miles
Health Districts/Departments
Farmington Valley
Northern
Prospering
Torrington Area
Municipal: New Milford, Sharon, Washington
Resources
Elder/Disabled Housing
Emergency Housing
Supportive Housing
Fixed Bus Routes
Americans with Disabilities Act Service Area*
Population Density
(Population / Square Mile)
700 - 910
500 - 699
250 - 499
30 - 249
NW CT Transit District provides service for Litchfield, Torrington, and Winsted, and Dial-A-Ride service for 16 towns in NW CT
* United States Department of Transportation Federal Transit Administration § 37.131 Service criteria for complementary paratransit. The following service criteria apply to complementary paratransit required by § 37.121 of this part: (a) Service Area—(1) Size. (i) The entity shall provide complementary paratransit service to origins and destinations within corridors with a width of three-fourths of a mile on each side of each fixed route. The corridor shall include all areas within a three-fourths of a mile radius at the ends of each fixed route.
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Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Housing
Map 13 of 13 – Resource Listing

ELDER/DISABLED

1. Low Inc./Sub. Rental Housing * Dis./Health, Older Adults
   ELDERLY HOUSING MANAGEMENT - NORTH PURCHASE
   11 Jackson Lane
   Bethlehem, CT 06751

2. Low Inc./Subsidized Private Rental Housing * Older Adults
   ELDERLY HOUSING MANAGEMENT - BECKLEY HOUSE
   85 South Canaan Road
   Canaan, CT 06018

3. Public Housing * Dis. & Health Conditions* Older Adults
   NORTH CANAAN HOUSING AUTHORITY – WANGUM VILLAGE
   132 Quinn Street
   Canaan, CT 06018

4. Low Inc./Subsidized Private Rental Housing * Disabilities & Health Conditions * Older Adults
   ELDERLY HOUSING MANAGEMENT - WINTERGREEN
   21 Wintergreen Circle
   Harwinton, CT 06791

5. Low Inc./Subsidized Private Rental Housing * Disabilities & Health Conditions* Older Adults
   HARWINTON WINTERGREEN ELDERLY HOUSING
   21 Wintergreen Circle/Litchfield Road
   Harwinton, CT 06791

6. Low Inc./Subsidized Private Rental Housing * Disabilities & Health Conditions* Older Adults
   ELDERLY HOUSING MNGMT TEMPLETON FARM APTS
   16 Swifts Lane
   Kent, CT 06757

7. Group Residences for Adults with Disabilities, Supported Living Services for Adults with Disabilities
   EDUCATION CONNECTION
   355 Goshen Road
   Litchfield, CT 06759-0909

8. Public Housing, Disabilities/Health Conditions * Older Adults
   LITCHFIELD HOUSING AUTHORITY - BANTAM FALLS
   Doyle Road
   Litchfield, CT 06759

9. Public Housing, Disabilities/Health Conditions, Older Adults
   MORRIS HOUSING AUTHORITY
   109 East Street
   Morris, CT 06763

10. Low Inc./Sub. Private Rental Housing Older Adults
    DEMARCO MANAGEMENT - BUTTER BROOK HILL APTS
    105 Butter Brook Hill
    New Milford, CT 06776

11. Low Inc./Subsidized Private Rental Housing
    Older Adults
    ELDERLY HOUSING MANAGEMENT - GLEN AYRE
    One Glen Ayre Drive
    New Milford, CT 06776

12. Home Barrier Evaluation
    /Removal Services
    REBUILDING TOGETHER - LITCHFIELD COUNTY
    122 Stilson Hill Road
    New Milford, CT 06776

13. Low Inc./Subsidized Private Rental Housing * Disabilities & Health Conditions * Older Adults
    NORFOLK SENIOR HOUSING CORPORATION
    9 Shepard Road
    Norfolk, CT 06058

14. Low Inc./Subsidized Private Rental Housing
    * Older Adults
    ELDERLY HOUSING BERNHARDT MEADOW
    19 Bernhardt Meadow Lane
    Roxbury, CT 06783

Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Housing
Map 13 of 13 – Resource Listing

ELDER/DISABLED (CONT.)

15. Public Housing * Disabilities
& Health Conditions, Older Adults
SHARON HOUSING AUTHORITY
12E Sharon Ridge Road
Sharon, CT 06069

16. Public Housing
Older Adults
THOMASTON HOUSING AUTHORITY - GREEN MANOR
63 Green Manor
Thomaston, CT 06787

17. Public Housing, Disabilities/ Health Conditions
Older Adults
THOMASTON HOUSING AUTHORITY - GROVE MANOR
11 Grove Street
Thomaston, CT 06787

18. Supported Living Adults with Disabilities * Dual Diagnosis
CENTER FOR HUMAN DEVELOPMENT
51 Commercial Boulevard
Torrington, CT 06790

19. Supported Living Services/Group Residences for Adults
with Disabilities * Chronic/Severe Mental Illness
CENTRAL NAUGATUCK VALLEY HELP - WYNNEWOOD
44 Cook Street
Torrington, CT 06790

20. Supported Living Services / Group Residences
Adults/Disabilities * Chronic/Severe Mental Illness
COMMUNITY SYSTEMS
295 Alvord Park Road
Torrington, CT 06790

21. Low Inc./Subsidized Private Rental Housing * Older Adults
GEORGETOWN GARDENS
109 Sunny Lane
Torrington, CT 06790

22. Supported Living
Group Residences Disabilities
LARC
314 Main Street
Torrington, CT 06790

23. Supported Living Services for Adults with Disabilities *
Chronic/Severe Mental Illness
MENTAL HEALTH ASSOC. OF CT TORRINGTON
30 Peck Road
Torrington, CT 06790

24. Low Inc./Subsidized Private Rental Housing * Disabilities &
Health Conditions * Older Adults
TORRINGFORD WEST APARTMENTS
356 Torringford West Street
Torrington, CT 06790

25. Public Housing/Disabilities/Health Conditions * Older Adults
TORRINGTON HOUSING AUTHORITY - LAUREL ACRES
523 Torringford West Street
Torrington, CT 06790

26. Public Housing/Disabilities/Health Conditions
Older Adults
TORRINGTON HOUSING AUTHORITY MICHAEL KOURY
Tucker Drive
Torrington, CT 06790

27. Public Housing/Disabilities/Health Conditions
Older Adults
TORRINGTON HOUSING AUTHORITY - THOMPSON HEIGHTS
301 Litchfield Street
Torrington, CT 06790

28. Public Housing/Disabilities/Health Conditions * Older Adults
TORRINGTON HOUSING AUTHORITY - TORRINGTON TOWERS
52 Summer Street
Torrington, CT 06790

Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Housing
Map 13 of 13 – Resource Listing

ELDER/DISABLED (CONT.)

29. Public Housing/Disabilities/Health Conditions * Older Adults
TORRINGTON HOUSING AUTHORITY WILLOW GARDENS
52 Willow Street
Torrington, CT 06790

30. Group Residences for Adults with Disabilities
FAMILY OPTIONS
76 Westbury Park Road
Watertown, CT 06795

31. Supported Living Services for Adults with Disabilities * Developmental Disabilities
INSTITUTE OF PROFESSIONAL PRACTICE- WATERTOWN
680 Main Street
Watertown, CT 06795

32. Public Housing/Disabilities/Health Conditions * Older Adults
WATERTOWN HOUSING AUTHORITY - BUCKINGHAM
935 Buckingham Street
Watertown, CT 06795

33. Public Housing/Disabilities/Health Conditions * Older Adults
WATERTOWN HOUSING AUTHORITY - COUNTRY RIDGE
1091 Buckingham Street
Watertown, CT 06795

34. Public Housing/Disabilities/Health Conditions * Older Adults
WATERTOWN HOUSING AUTHORITY - TRUMAN TERRACE
100 Steele Brook Road
Watertown, CT 06795

35. Low Income/Subsidized Private Rental Housing * Older Adults
MILLENIUM REAL ESTATE SERVICES - THE GLEN
Maple & Willow Streets
Winchester, CT 06098

36. Public Housing/Disabilities/Health Conditions * Older Adults
WINCHESTER HOUSING AUTHORITY GREENWOODS GARDEN
Gay Street
Winchester, CT 06098

Subsidized Private Rental Housing/Disabilities/Older Adults
STATION PLACE APARTMENTS
Whitford Court
Canaan, CT 06018

NO STREET NUMBER

Litchfield County, CT
Community Transformation Grant
Strategic Direction Five: Healthy and Safe Physical Environment
Housing
Map 13 of 13 – Resource Listing

EMERGENCY HOUSING

37. Runaway/Youth Shelters
BRIDGE FAMILY CENTER, THE - HARWINTON SHELTER
25 Plymouth Road
Harwinton, CT 06791-2418

38. Homeless Shelter
FISH OF TORRINGTON
332 South Main Street
Torrington, CT 06790

39. Homeless Shelter
STATE DEPT OF SOCIAL SERVICES - TORRINGTON
62 Commercial Boulevard
Torrington, CT 06790

40. Transitional Housing/Shelter
SUSAN B. ANTHONY PROJECT - DV SERVICE
179 Water Street
Torrington, CT 06790

41. Homeless Shelter, Runaway/Youth Shelters
NW CT YMCA - WINCHESTER EMERGENCY SHELTER
480 Main Street
Winchester, CT 06098

Homeless Shelter
NEW MILFORD SHELTER COALITION
PO Box 1016
New Milford, CT 06776

NO STREET ADDRESS

SUPPORTIVE HOUSING

42. Homeless Permanent Supportive Housing
CENTER FOR HUMAN DEVELOPMENT
51 Commercial Boulevard
Torrington, CT 06790

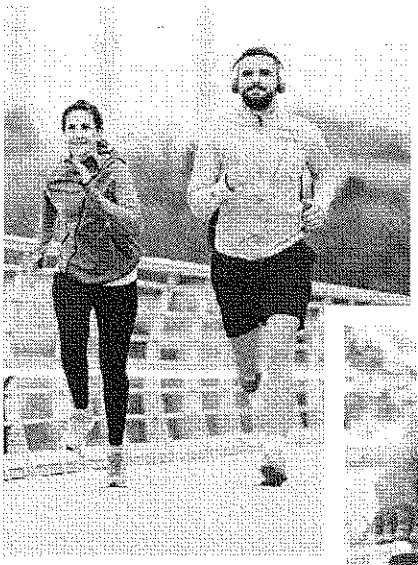
43. Case/Care Management * Homeless People
FISH OF TORRINGTON
332 South Main Street
Torrington, CT 06790

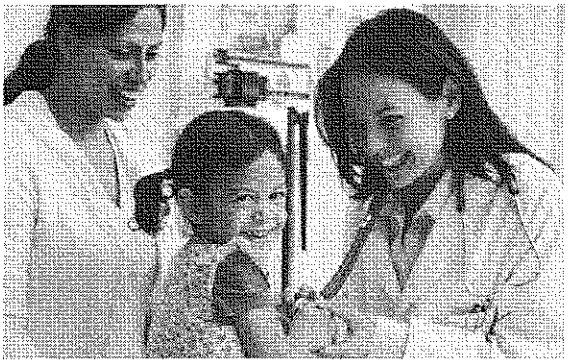
Appendix B – Glossary of Abbreviations

Abbreviation	Full Name/Title
AAMR	Age-Adjusted Mortality Rate
ACS	American Community Survey
BRFSS	Behavioral Risk Factor Surveillance System
CADH	Connecticut Association of Directors of Health
CDC	Centers for Disease Control and Prevention
CHANGE	Community Health Assessment aNd Group Evaluation
CHD	Coronary Heart Disease
CHF	Congestive Heart Failure
CHLI	Community Healthy Living Index
CHNA	Community Health Needs Assessment
CLRD	Chronic Lower Respiratory Disease
CLD	Chronic Liver Disease
COPD	Chronic Obstructive Pulmonary Disease
CSDE	Connecticut State Department of Education
CTDPH	Connecticut Department of Public Health
CTG	Community Transformation Grant
CVD	Cardiovascular Diseases
DECD	Department of Economic and Community Development
DPH	Department of Public Health
ED	Emergency Department
FQHC	Federally Qualified Health Center
Index	Health Equity Index
LD	Liver Disease
LHI	Leading Health Indicators
MI	Myocardial Infarction
RPO	Regional Planning Organization
TAHD	Torrington Area Health District
URC	Uniform Crime Reporting Program
YPLL	Years of Potential Life Lost

Community Health Needs Assessment For Northwest Connecticut

2015 Update





Charlotte Hungerford Hospital

Commissioned by:
Charlotte Hungerford Hospital (CHH)

Project Advisors:
CHH Community Relations Committee

Prepared by:
The Center for Healthy Schools & Communities @ EDUCATION CONNECTION

EDUCATION CONNECTION

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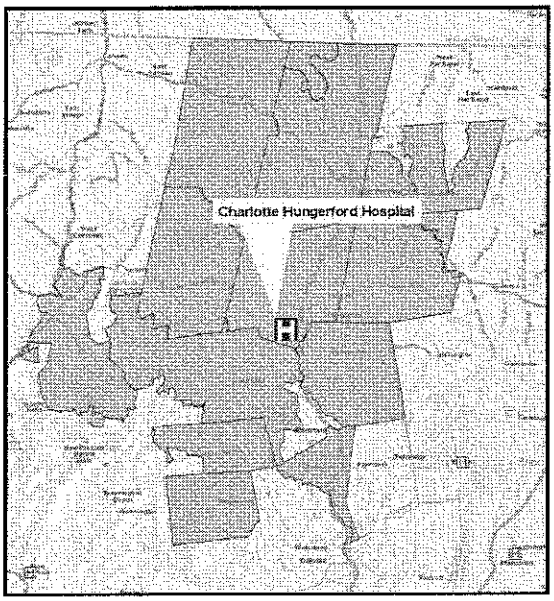
EXECUTIVE SUMMARY

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.

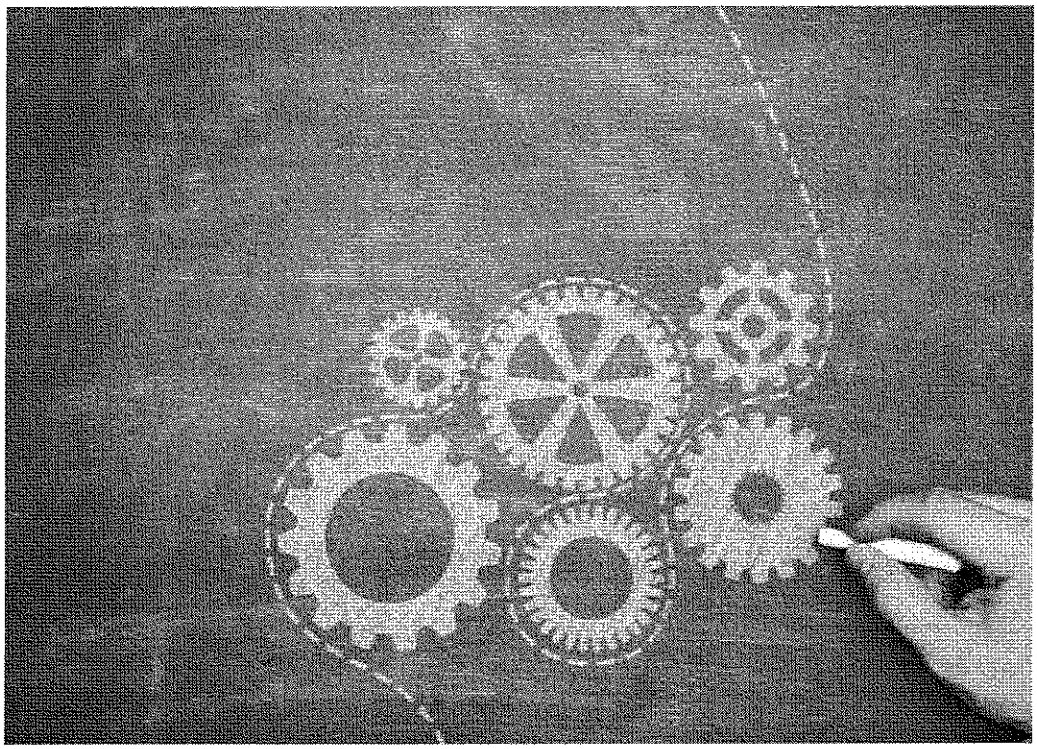
Local Health Care Environment

- 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).

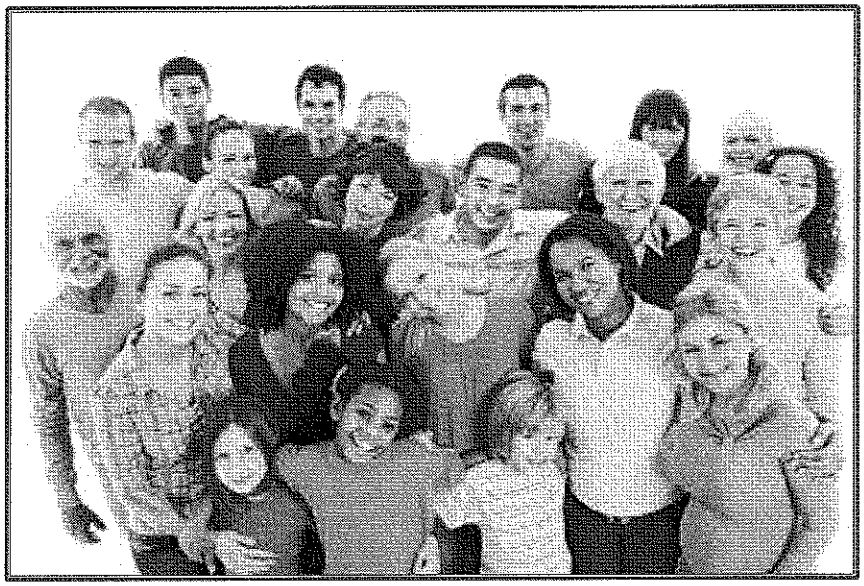
When made available by secondary sources, statistically significant results ($p < 0.05$) for indicators are so noted.

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	14,839	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%

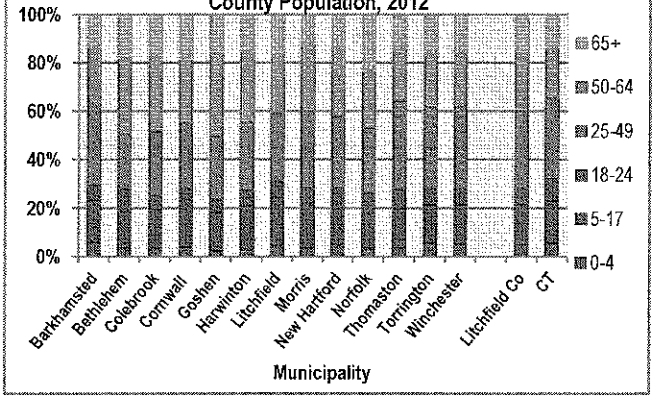
Source: Charlotte Hungerford Hospital (CHH) Community Health Profile November 2015 (2009-2013 ACS Census Data compiled by the CT Hospital Association).

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

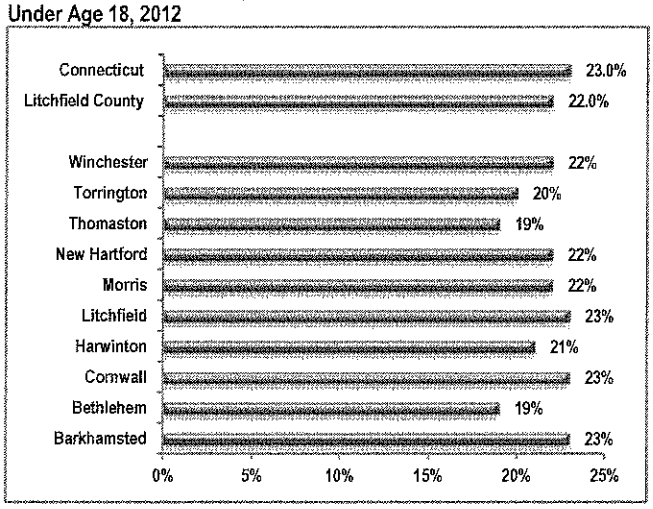


Figure 3: Litchfield County Top Ten SATs with Highest % of Population Age 65 and Over, 2012

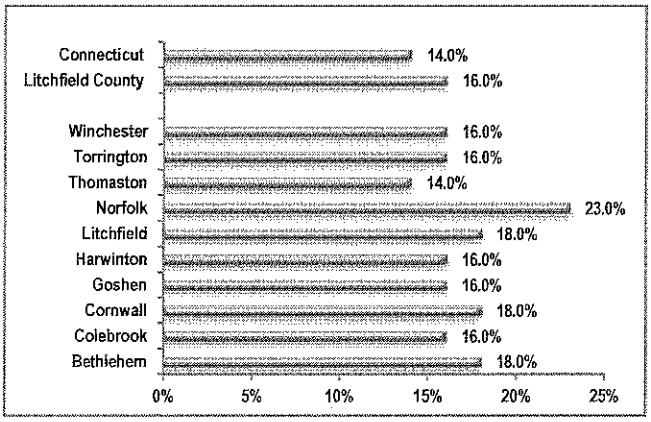
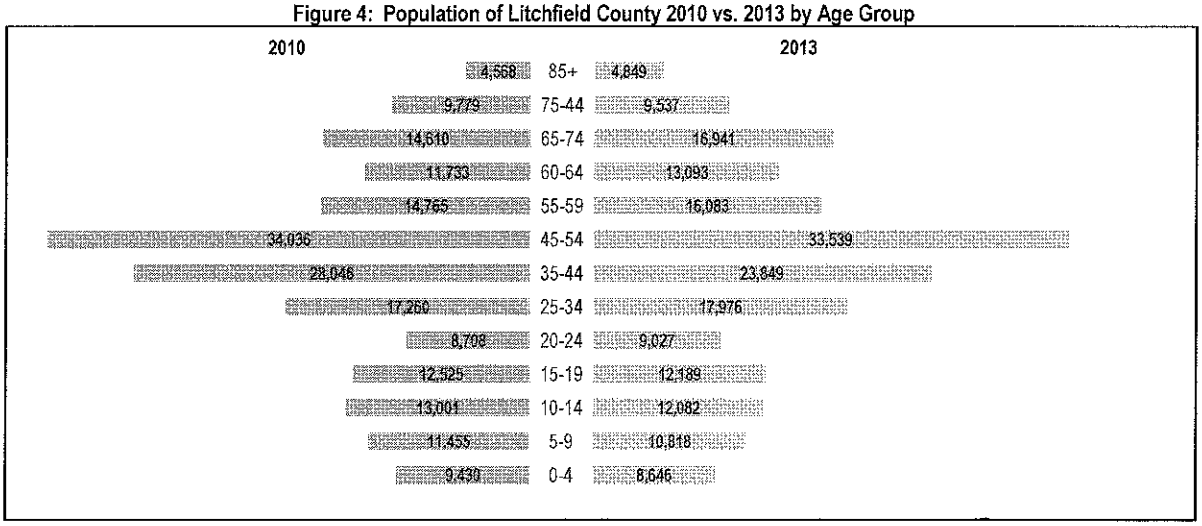


Figure 2 & 3 Source: http://www.cerc.com/townprofiles/county.asp?county=Litchfield, 2014

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

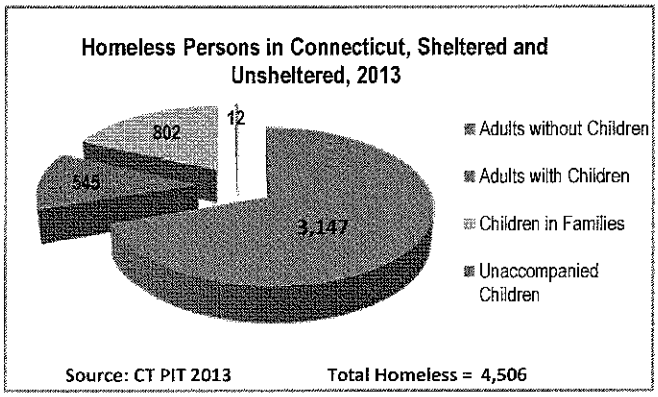


Table 6: Unstably Housed Youth (UHY) Reported by Teachers and Students, 2015

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.

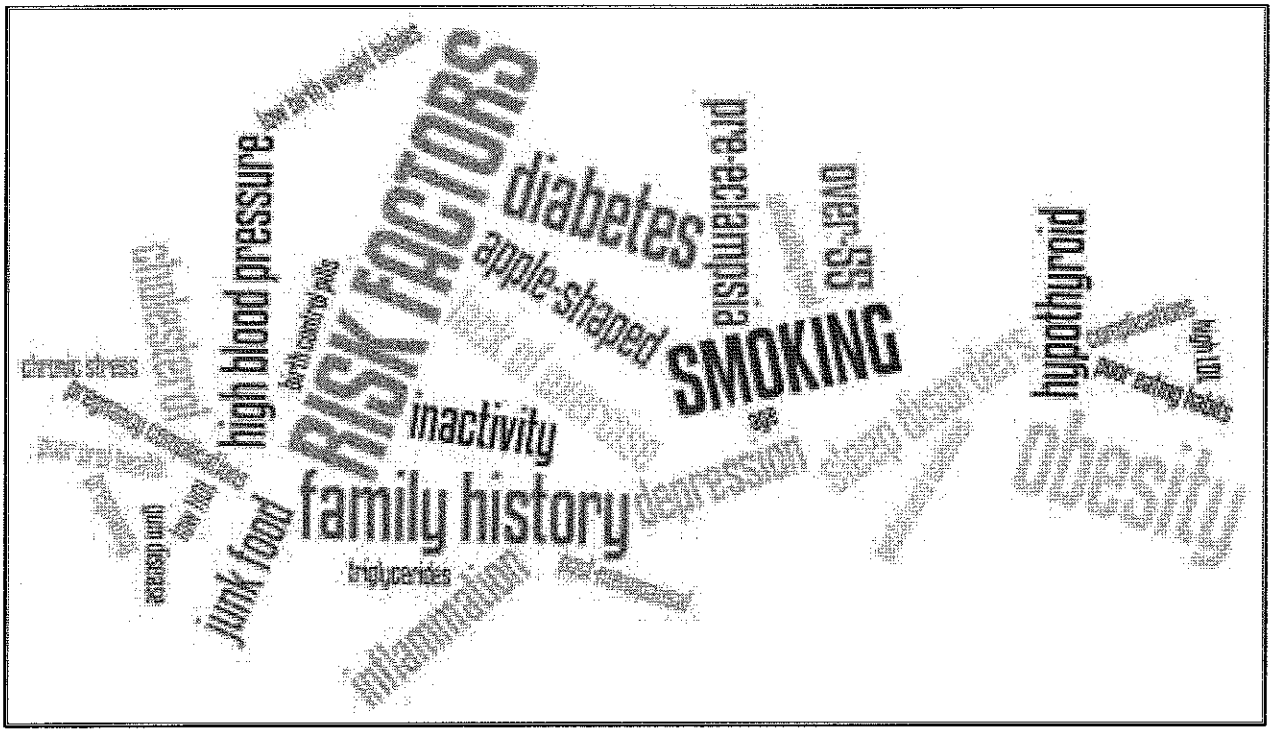
The National Low Income Housing Coalition's 2015 *Out of Reach* Report indicates that Connecticut is the 8th most expensive state in the nation for housing. In Litchfield County, the hourly wage needed to afford a two-bedroom fair market rate apartment is $19.81 per hour, more than twice the minimum 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.

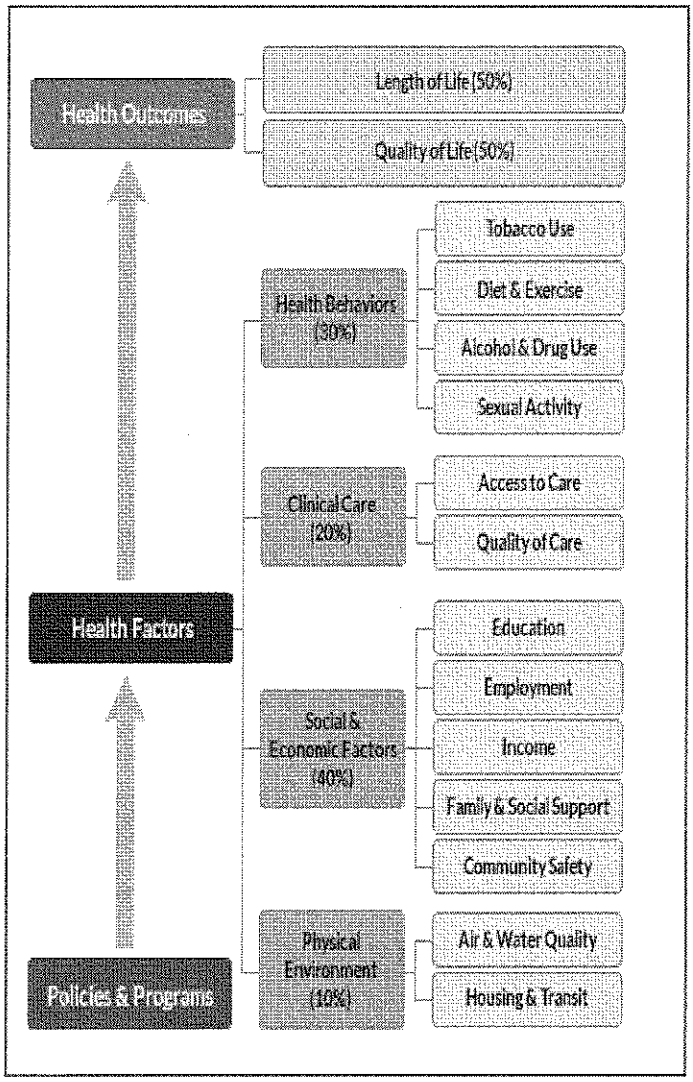
Eight offenses were chosen to form the Crime Index, as shown in Table 7. All 102 CT police departments participate in the UCR Program. Litchfield County's overall 2014 crime index compares favorably with the state total average and the state average for non-urban (population < 100,000) areas, and has 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 *not* 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.

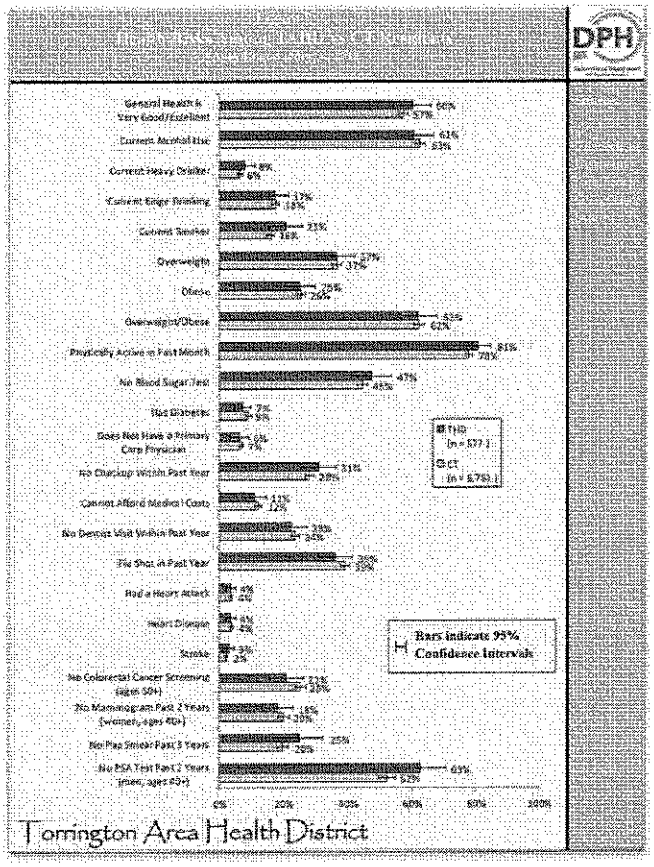
Behavioral Risk Factors

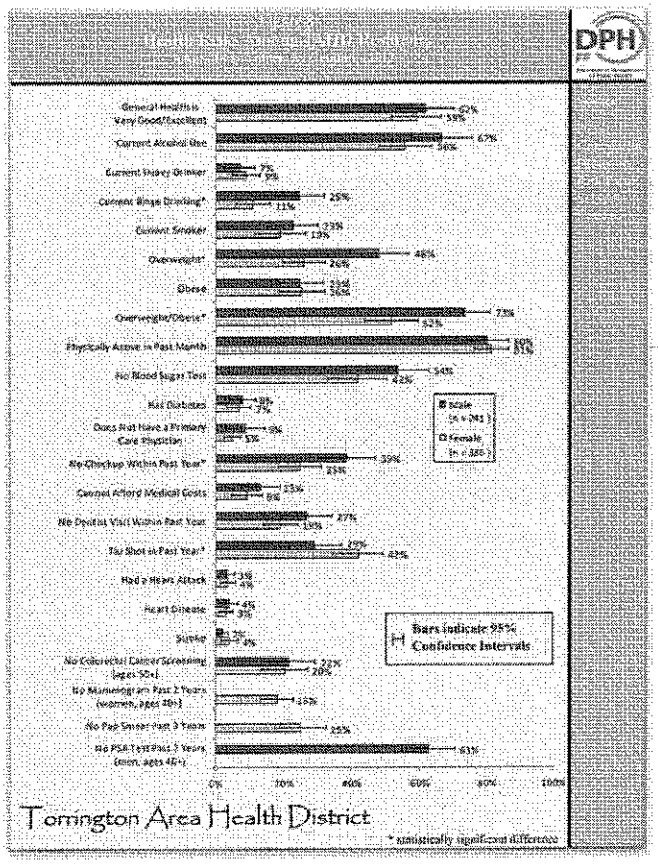
The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing random telephone survey of adults ages 18 and over conducted in all 50 states using a standardized questionnaire developed by CDC. The BRFSS originally only collected data on health behaviors related to the leading causes of death, 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$).

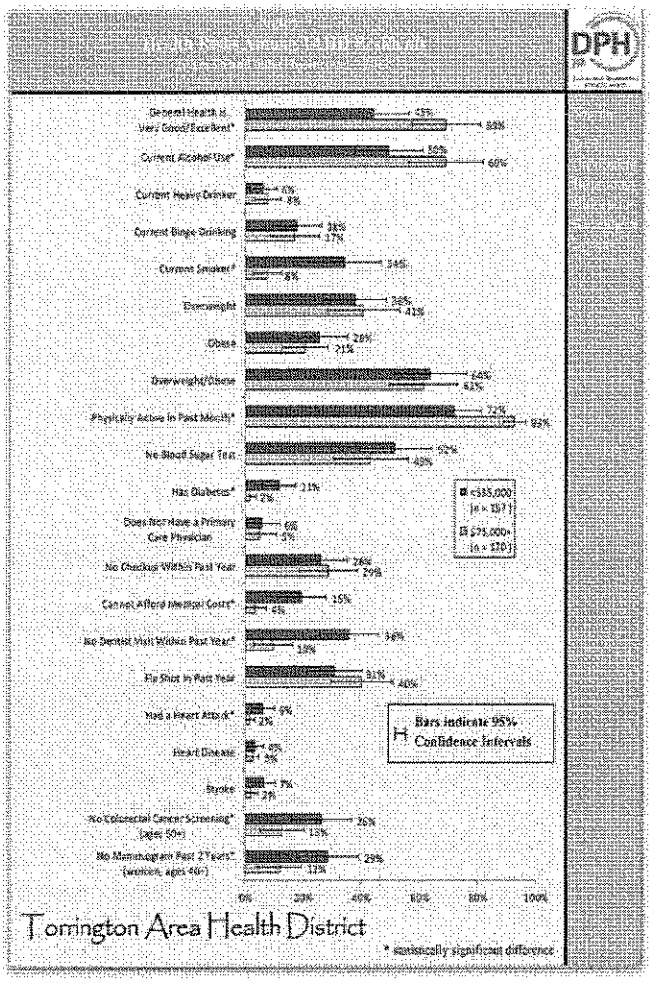
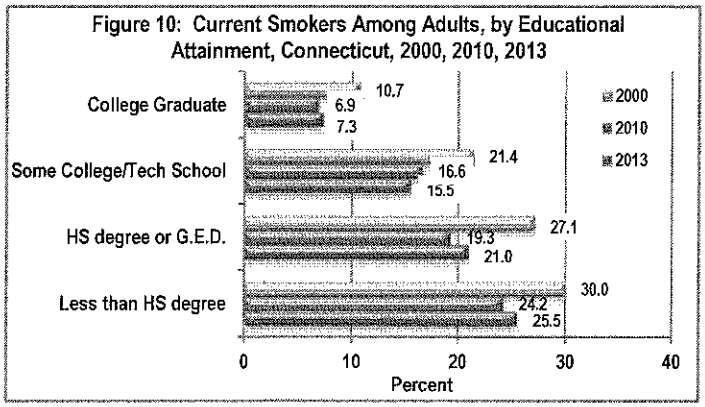


Table 9: Litchfield County CHSI Indicators, 2015

	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/

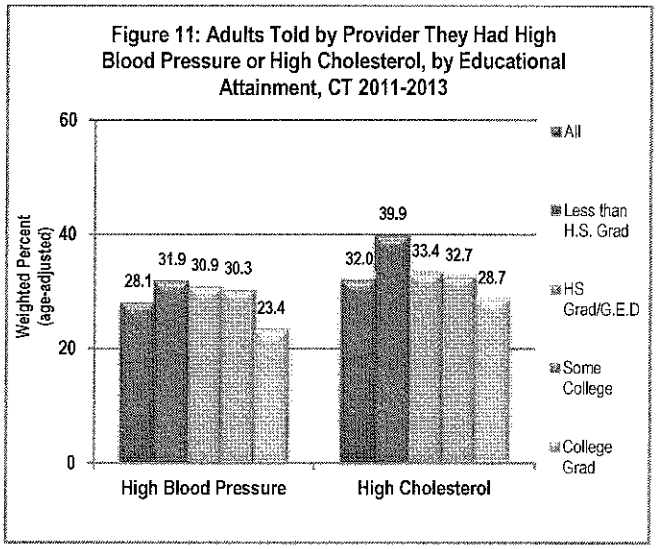


Source: CT Behavioral Risk Factor Surveillance System, 2000, 2010CT DPH: Stats and Reports, 2013
http://www.ct.gov/dph/cwp/view.asp?a=3137&q=388070&dphNav=|&dphNav_GID=1841

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.

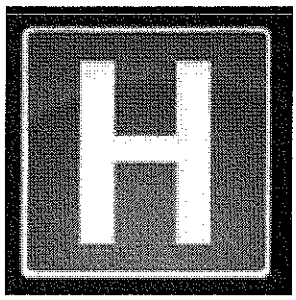
Litchfield County's rankings compared to "peer counties" across the U.S. based on similar sociodemographic characteristics are presented in Table 9. Health Indicators of concern include: Alzheimer's/dementia, asthma and depression in older adults, and adult binge drinking.

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.

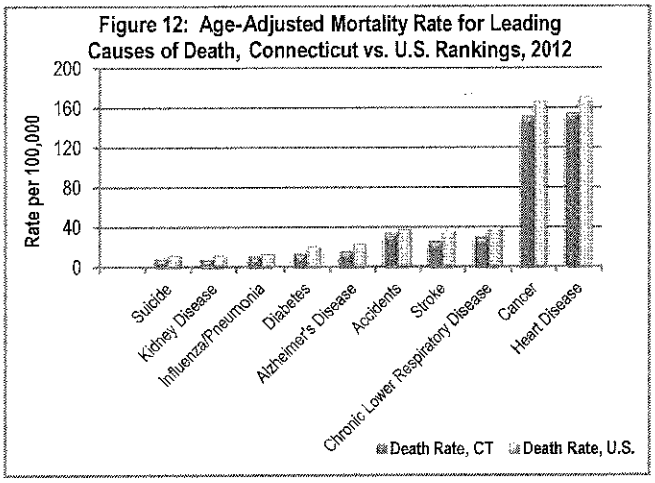


Source: Prevalence of High B.P. by Educational Attainment, CT, 2011-2013; http://www.ct.gov/dph/lib/dph/hems/chronic_dis/heartdisease/burden_of_cardiovascular_diseases_in_connecticut_apr2015_web_final.pdf

LEADING CAUSES OF DEATH AND HOSPITALIZATION

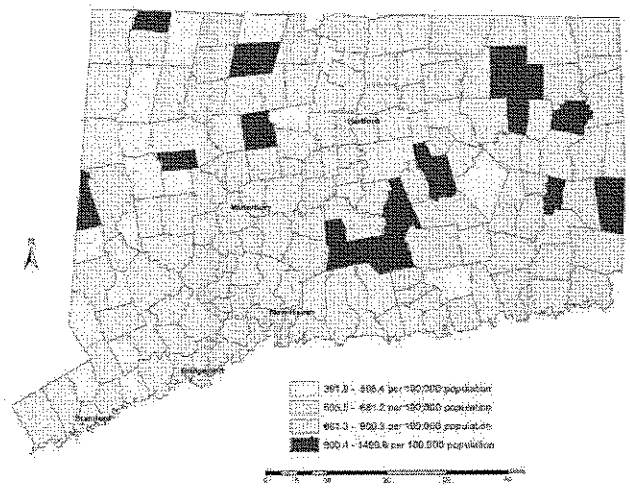


LEADING CAUSES OF DEATH AND HOSPITALIZATION



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
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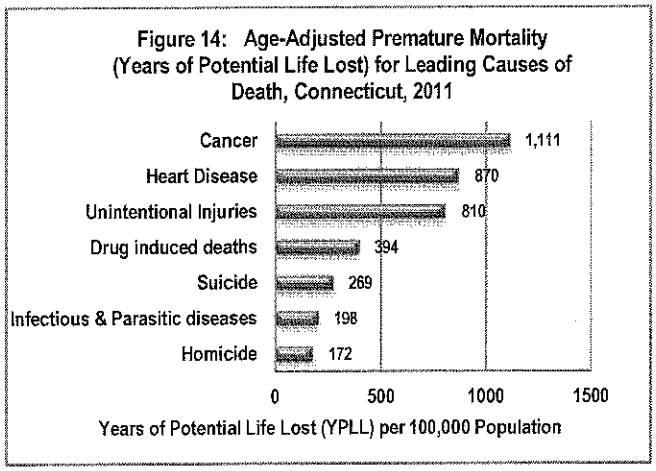


Source: CT Department of Public Health, Age-adjusted YPLL before 75 years of age, 2007-2011; http://www.ct.gov/dph/cwp/view.asp?a=3132&q=521462

Why Leading Causes of Death and Hospitalization Are Important

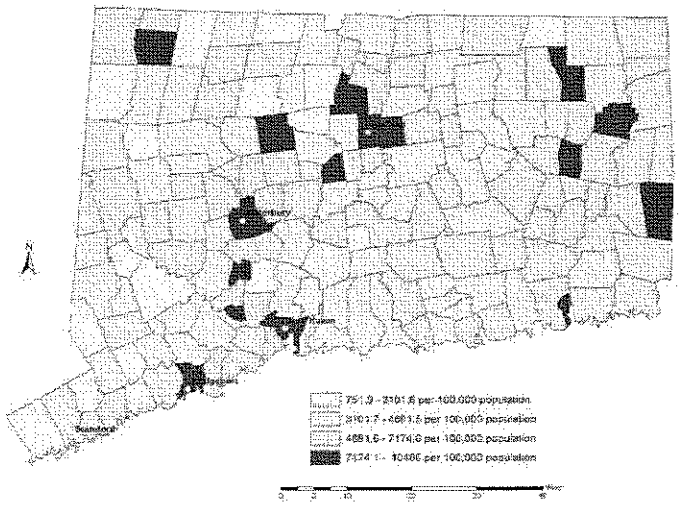
Examining the leading causes of death (mortality) and illness (morbidity) provides insight into the major health issues affecting the population in a geographic area. Fortunately, improvements in detecting and treating the leading causes of death, such as heart disease and cancer, have resulted in a 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	655.2	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	26.8	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.

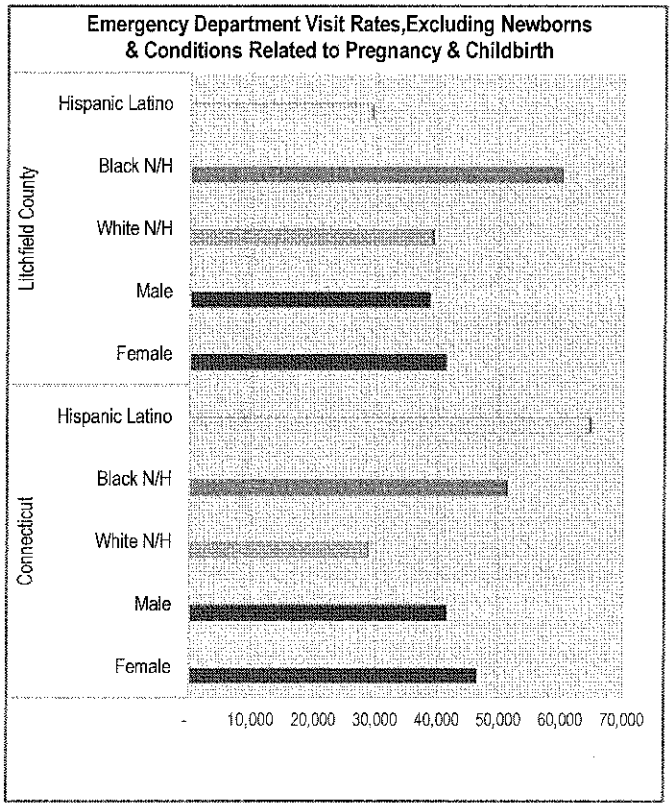
For Hispanic or Latino county residents, AAMR rates that could be calculated were *lower* than the state rates for all causes, malignant neoplasms, and accidents. AAMR rates were *higher* for Hispanic or Latino county residents than state residents for major CVD.

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	1,241.3
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	10
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).

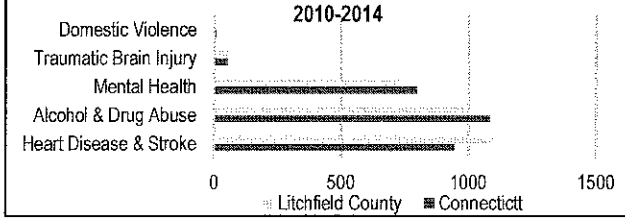
The overall adult PQI is also lower in the county than the state average, however the difference is less dramatic. This is true for all conditions with the exception of bacterial pneumonia, low birth weight newborns (county and state rate are identical), and perforated appendix.

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

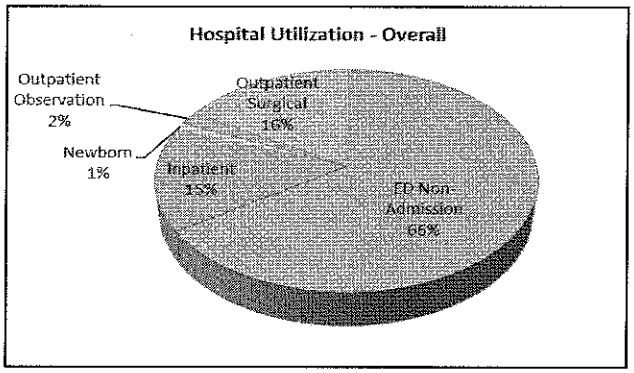


Figure 19: Most Common Medical Diagnoses in Hospitalized Patients, 2014

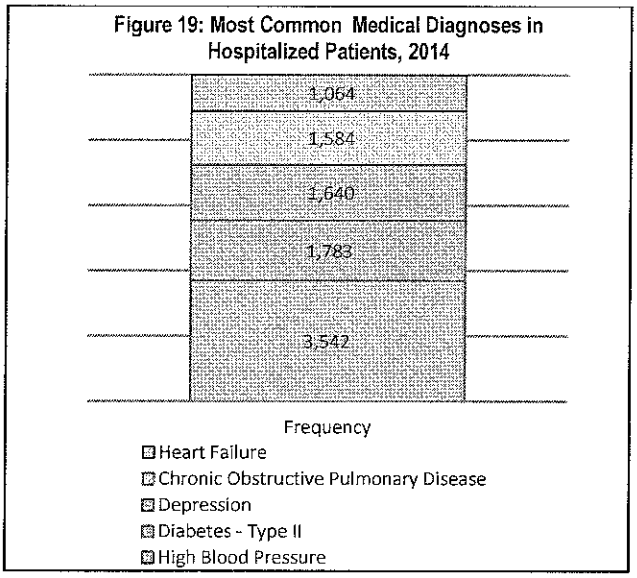


Figure 20: Most Common Medical Diagnoses in ED Non-Admissions, 2014

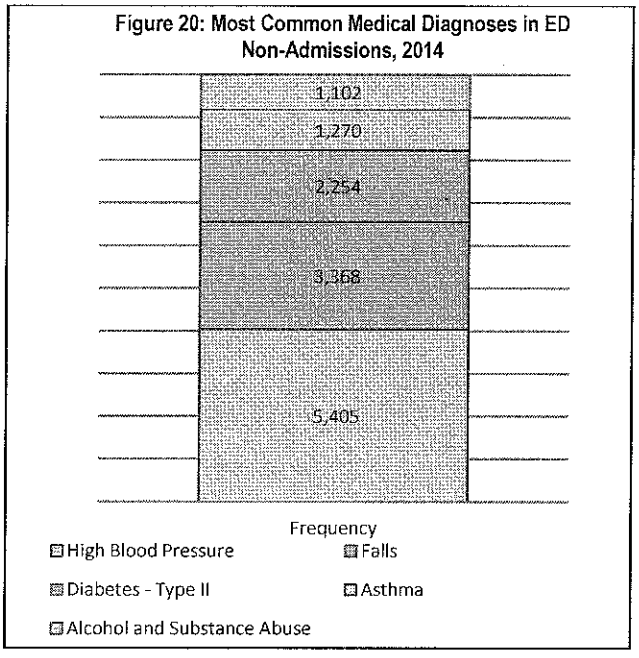


Figure 18-20 Source: The Connecticut Hospital Association FY 2014 CHIMEData

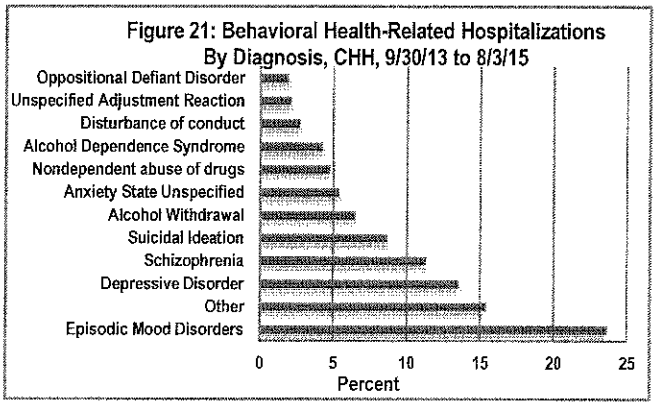
The Connecticut Hospital Association provides data collection and reporting services for its acute care hospital members through the ChimeData program. ChimeData is the most comprehensive hospital database in the state. ChimeData collects discharge data from inpatient admissions, hospital-based outpatient 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.

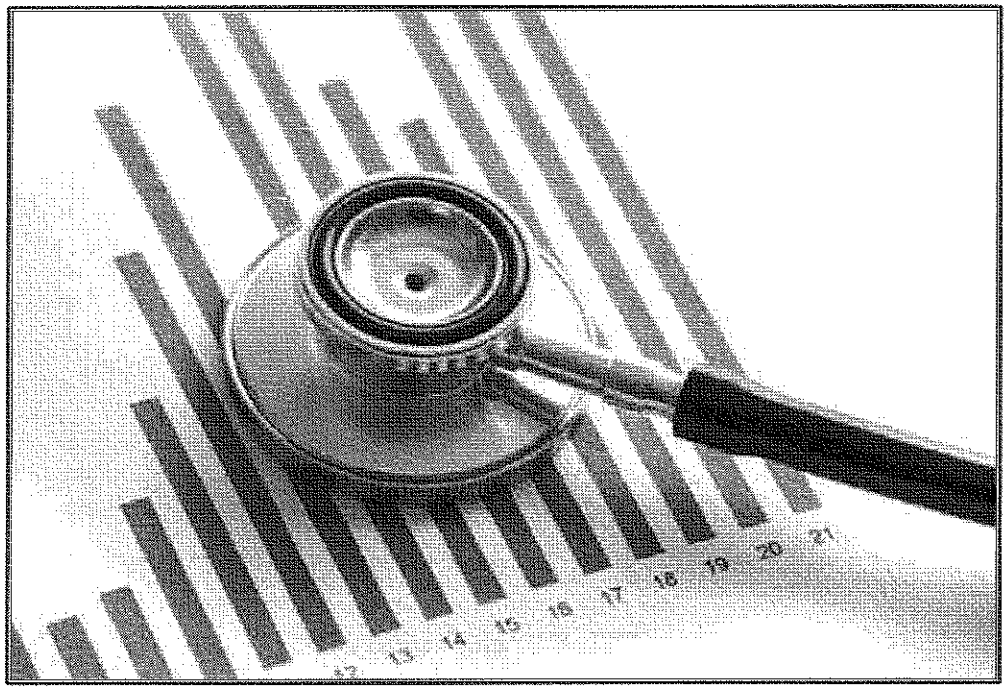
CHH Behavioral Health Services data for primary and secondary mental health diagnoses (DSM-5) for hospitalized patients from 2013-2015 are shown in Figure 21 below. Episodic Mood Disorders, Depressive Disorder, and Schizophrenia were the top 3 behavioral health diagnoses.

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



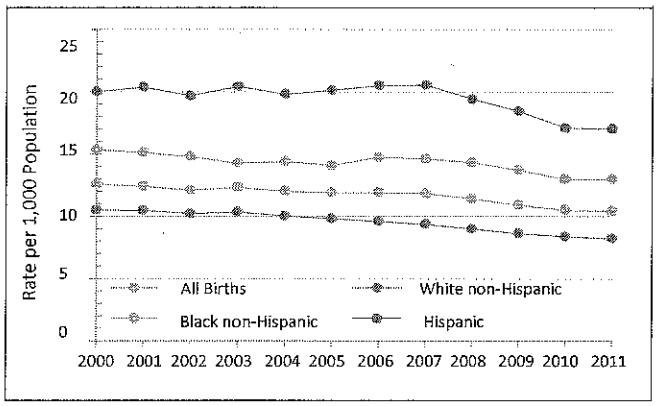
Source: Charlotte Hungerford Hospital-Behavioral Health Services, 2015

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

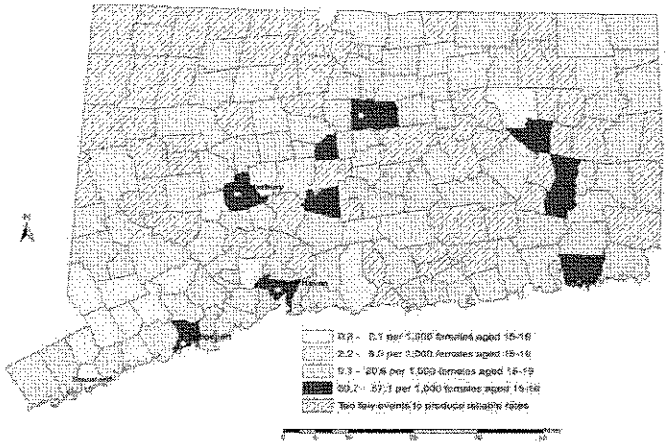


Figure 24: Percent of Mothers Who Received Late Prenatal Care, By Town, Connecticut, 2007-2011

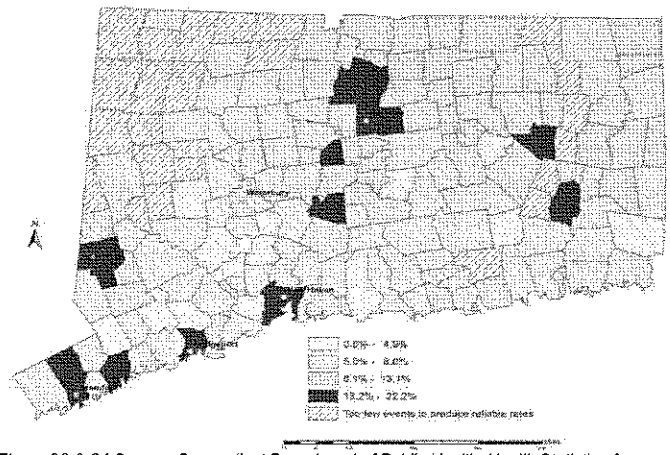


Figure 23 & 24 Source: Connecticut Department of Public Health, Health Statistics & Surveillance, Statistics & Analysis Reporting, 2007-2011; as cited in Healthy CT 2020

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

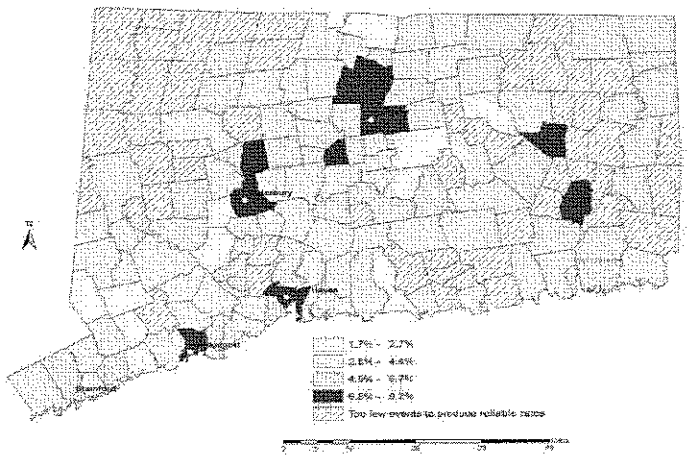


Figure 26: Percent of Preterm Births, By Town, Connecticut, 2007-2011

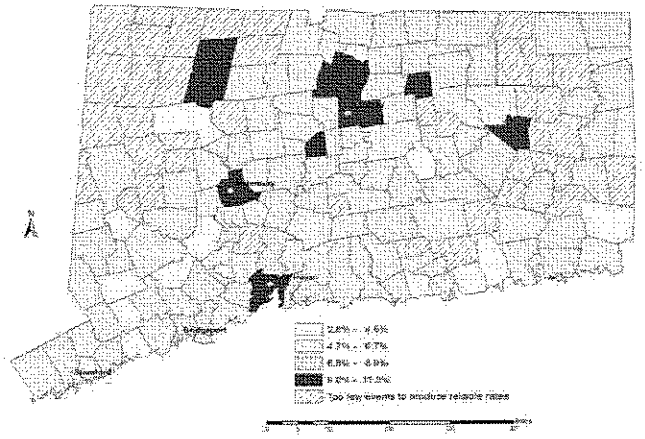
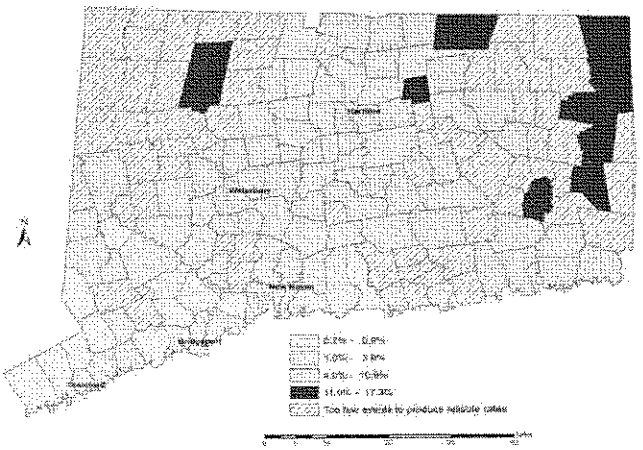


Figure 24 & 25 Source: Connecticut Department of Public Health, Health Statistics & Surveillance, Statistics & Analysis Reporting, 2007-2011 as cited in Healthy CT 2020.

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

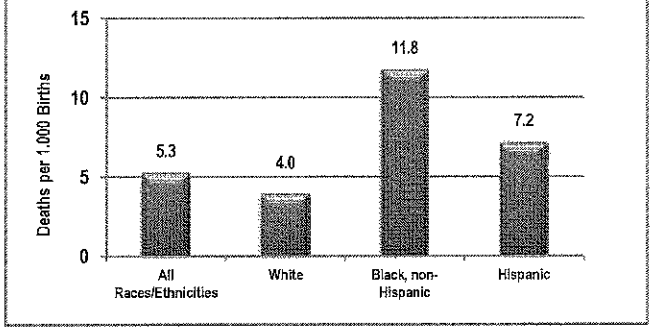


Source: Connecticut Department of Public Health, Health Statistics & Surveillance, Statistics & Analysis Reporting, Birth Certificates, 2006-2010, as cited in Healthy CT 2020.

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

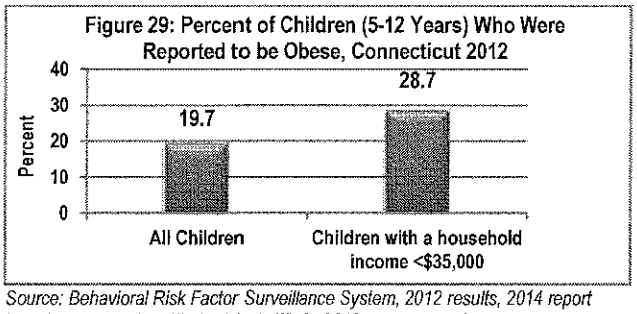
In 2010-2012, Infant Mortality Rates in Litchfield County were nearly twice the state rate as shown in Table 13 below. According to analyses performed by the CT Department of Public Health, these differences were statistically significant ($p < .05$). This difference is attributed in part to the higher 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

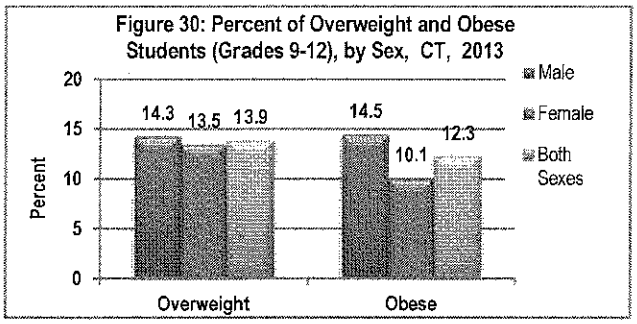
	Births	Infant Deaths	IMR
CT	111,193	582	5.2
Litchfield County	3,097	28	9.0

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



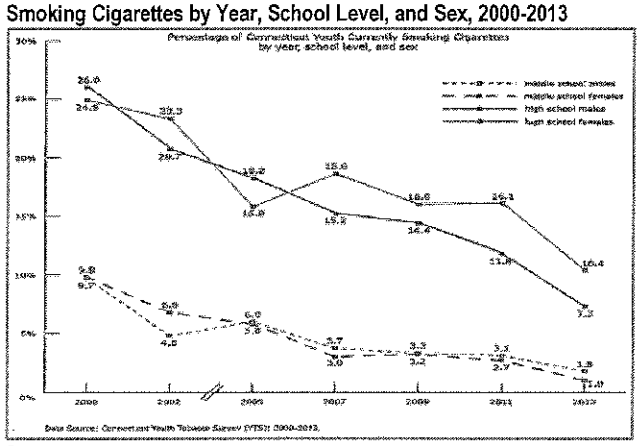
Source: Youth Risk Behavior Surveillance - Connecticut 2013;
http://www.ct.gov/dph/lib/dph/hisr/pdf/cshs_ybc2013_report.pdf

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

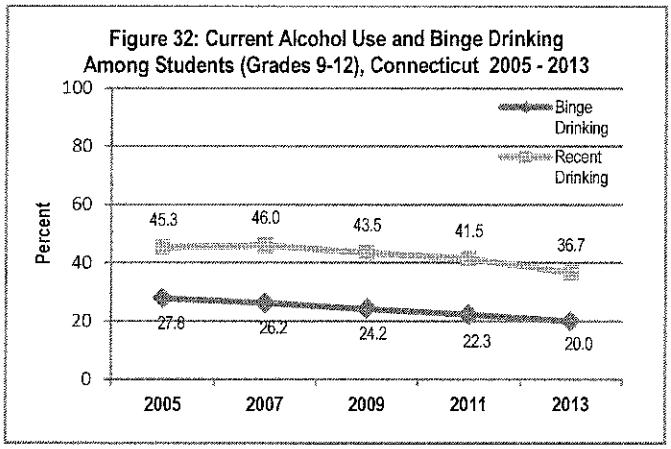
Obesity and overweight in children, adolescents, and adults have reached epidemic proportions in the U.S. According to CDC, childhood obesity has more than doubled in children and quadrupled in adolescents in the past 30 years; in 2012, more than one out of every three children and adolescents were overweight 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).

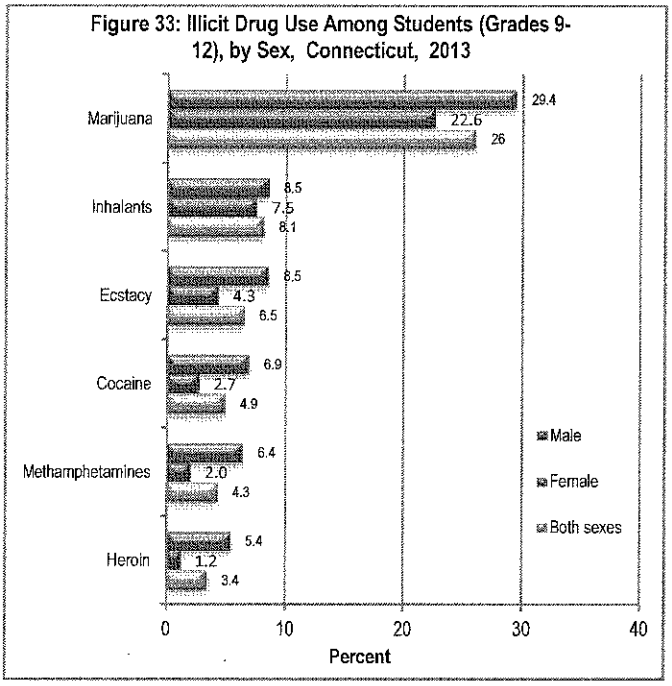
The DPH *2013 CT School Health Survey - Youth Risk Behavior Component* indicates that CT youth are more likely than their counterparts nationwide to be physically active five or more days per week (47% versus 27%) and less likely to spend three or more hours per day in front of a television (24% versus 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.

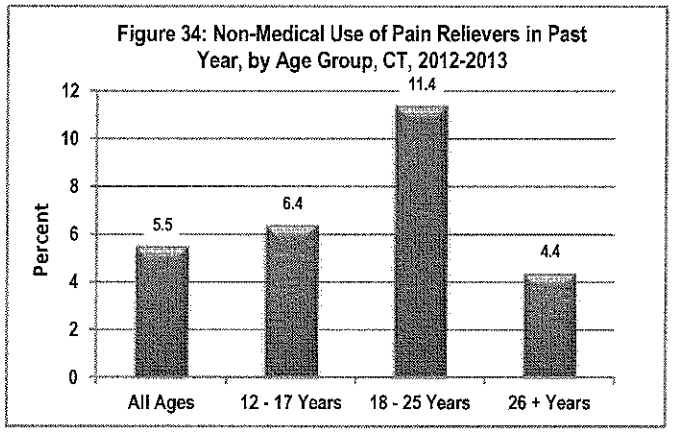
Smoking is the single most avoidable cause of chronic disease and death. As shown in Figure 31, based on CT Youth Tobacco Survey results, rates of cigarette smoking in adolescents have shown a dramatic decline from 2000-2013. In both middle school and high school, Hispanic or Latino students had the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

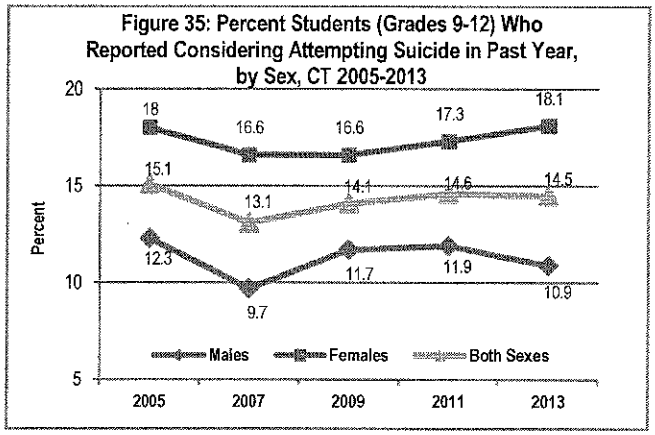


Source: SAMHSA, Reports by Topic
http://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2012-2013-p1/AgeGroupCompTab/NSDUHsaeQuintEndPTS2013.htm

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*

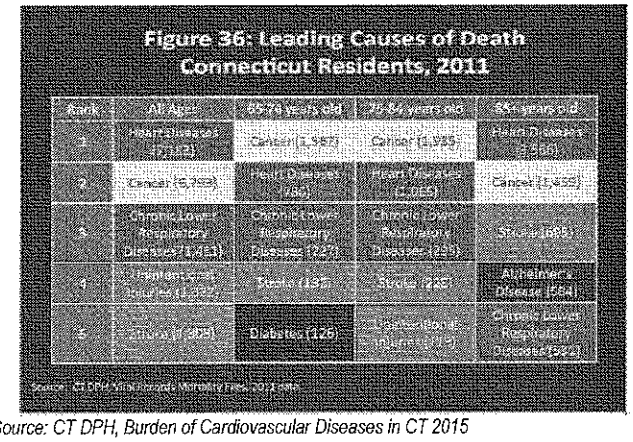
Binge drinking rates in CT high school youth are also above national averages. Illicit drug use and non-medical use of pain relievers by adolescents are critical public health issues in the region, state, and nation. As shown in Figure 33, the most frequently used illicit drug by high school students 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.

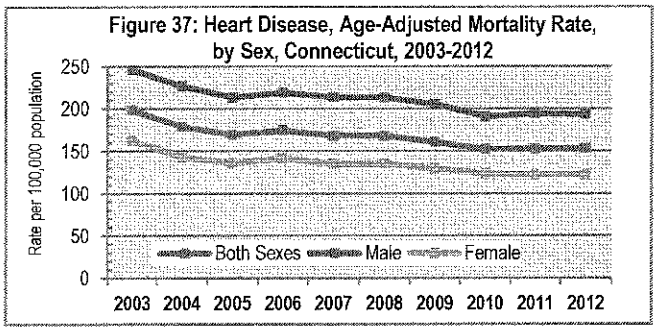


Source: Youth Risk Behavior Surveillance - CT, 2005-2013
http://www.ct.gov/dph/lib/dph/hisr/pdf/cshs_ybc2013_report.pdf

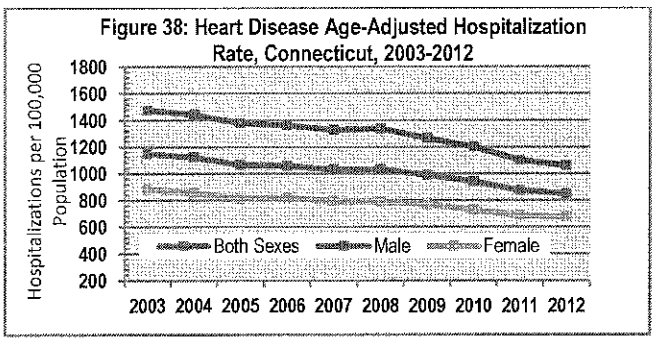
CHRONIC DISEASE PREVENTION AND CONTROL



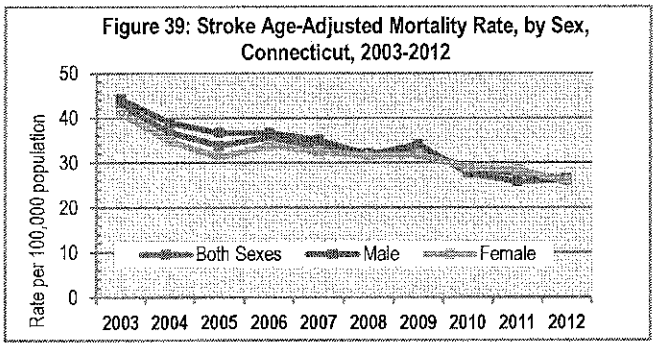
Source: CT DPH, Burden of Cardiovascular Diseases in CT 2015
http://www.ct.gov/dph/cwp/view.asp?a=3132&q=521462



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

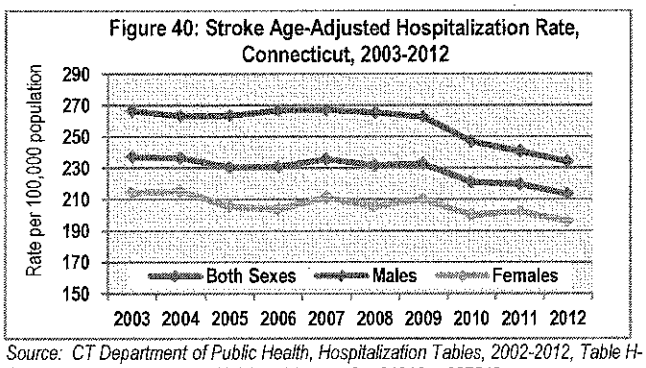
As shown in Figure 36, chronic diseases accounted for the majority of deaths in CT residents of all ages. The most prevalent chronic diseases in the U.S. and CT are cardiovascular diseases (CVD). Major cardiovascular diseases include coronary heart disease (CHD), cerebrovascular disease (stroke), and 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*

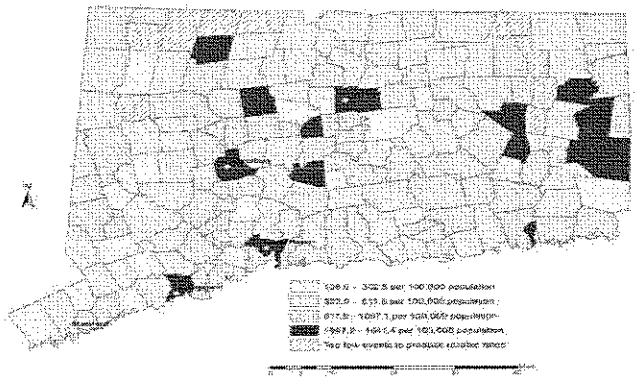
As shown in Figure 41, residents in many SATs experienced a higher than average burden of premature death in 2006-2010 from heart disease, measured in Years of Potential Life Lost (YPLL). YPLL rates for SATs were in the highest quartile in Winchester, and second highest quartile in Harwinton, Litchfield,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

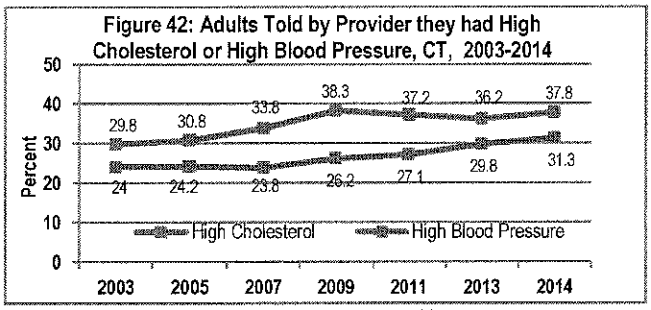


Source: CT Department of Public Health, Hospitalization Tables, 2002-2012, Table H-1 All Ages http://www.ct.gov/dph/cwp/view.asp?a=3131&q=397512

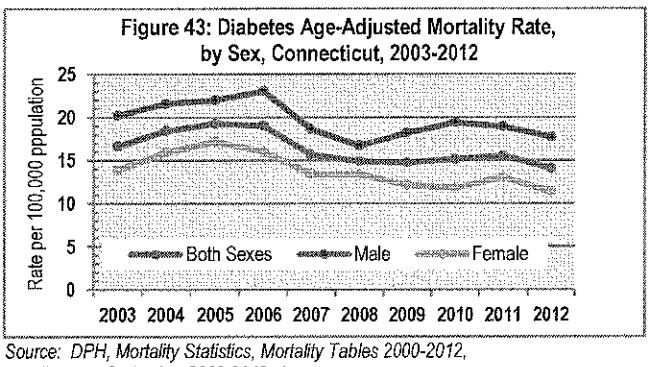
Figure 41: Premature Mortality Due To Heart Disease, Years of Potential Life Lost (YPLL) Under Age 75, By Town, Connecticut, 2006-2010



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



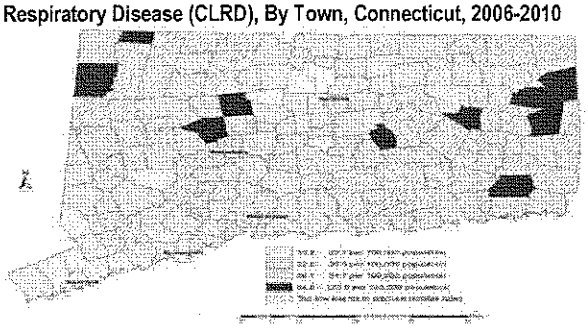
Source: DPH, Mortality Statistics, Mortality Tables 2000-2012, AAMRreport_State_1yr_2000-2012.xlsx
Source: http://www.ct.gov/dph/cwp/view.asp?a=3132&q=521462

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*

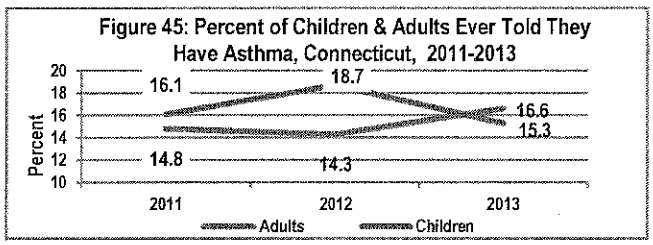
Based on 2013 BRFSS data, an estimated 8% of adults in CT aged 18 and older reported being diagnosed with diabetes; this increased to 16% for persons ages 55 and older. Diabetes was reported almost twice as frequently by Black non-Hispanics than by White non-Hispanics and was highest in persons with 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

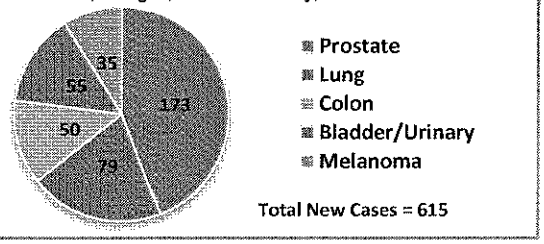
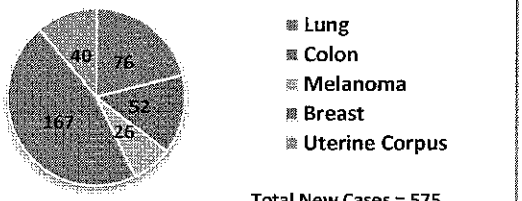


Figure 47: Number of New Cancer Cases by Cancer Site, Females All Ages, Litchfield County, 2008-2012



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

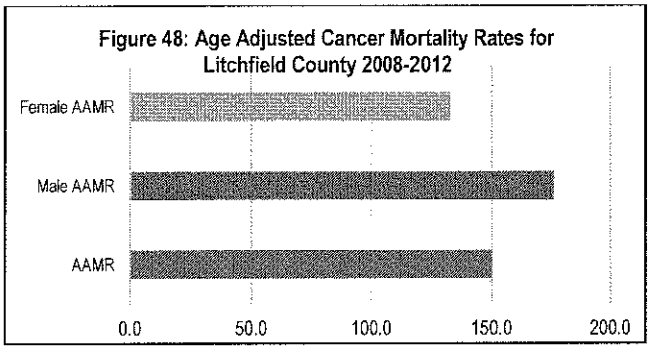
Nonetheless, according to the DPH State Health Assessment, *Healthy Connecticut 2020,* cancer remains the second leading cause of death in CT residents, and 1 in 2 males and 1 in 3 females will be diagnosed with some form of cancer in their lifetime.

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.



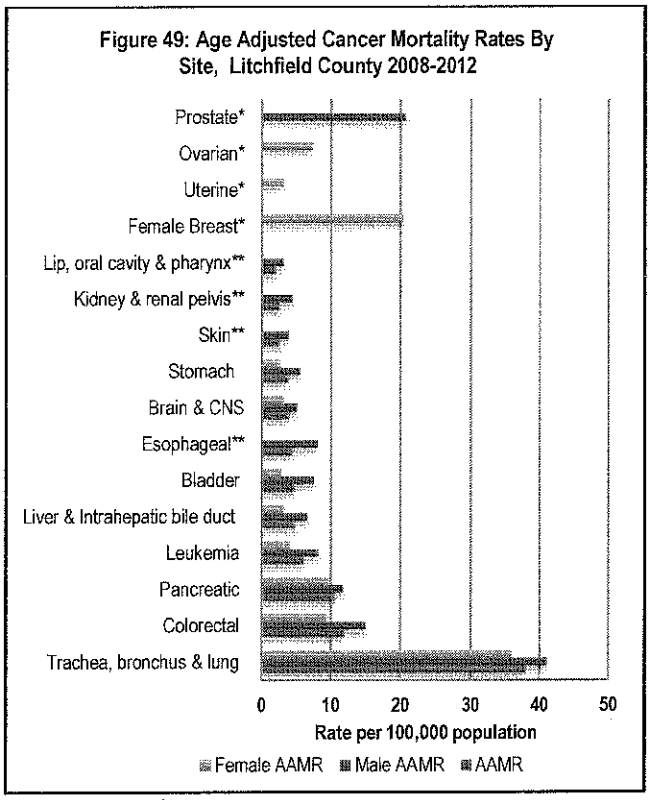


Figure 47 & 48 Source: Backus K, Mueller L (2015) Age-Adjusted Mortality Rates for Litchfield County and Connecticut, 2008-2012. CT Department of Public Health.
**Total AAMR are not provided for gender-specific cancer sites*
***Rates are based on less than 15 deaths and are considered to be statistically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

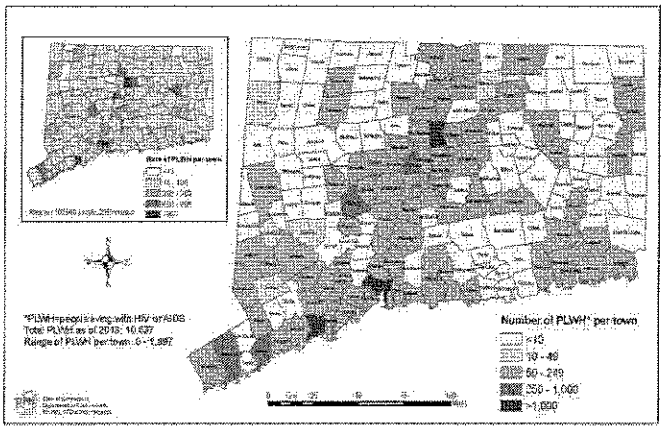
Many types of cancer, such as breast, lung and bronchus, and colorectal are linked to modifiable risk factors. Modifiable risk factors for cancers include such factors as: smoking tobacco; secondhand exposure to tobacco smoke; overweight and obesity; excessive alcohol consumption; physical inactivity; 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.

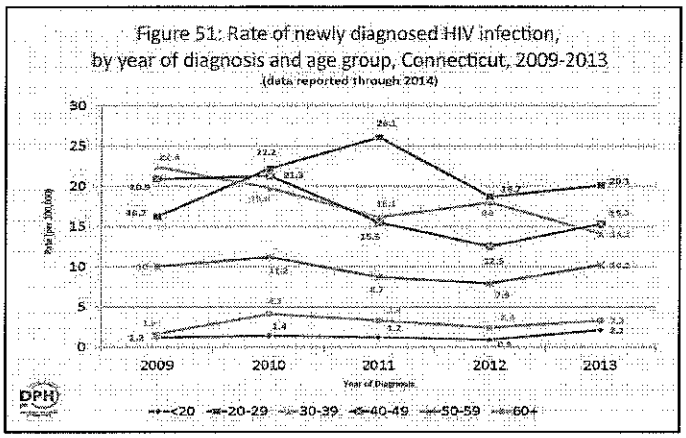
Due to the high incidence of cancer, access to and participation in cancer screenings is paramount to early detection and treatment. As reported previously in Figures 7 and 9, data from the 2012 BRFSS for the TAHD service area show that 21% of residents ages 50+ reported never having colorectal screening (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)

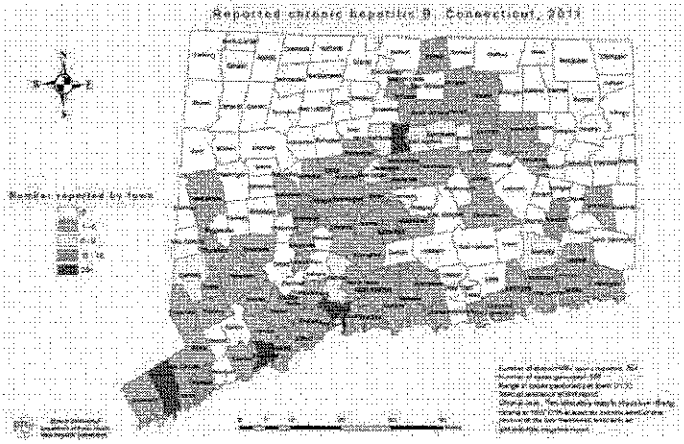


Source: CT Department of Public Health, AIDS and Chronic Diseases Section, http://www.ct.gov/dph/lib/dph/aids_and_chronic/surveillance/statewide/map_hiv_plw.pdf



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.

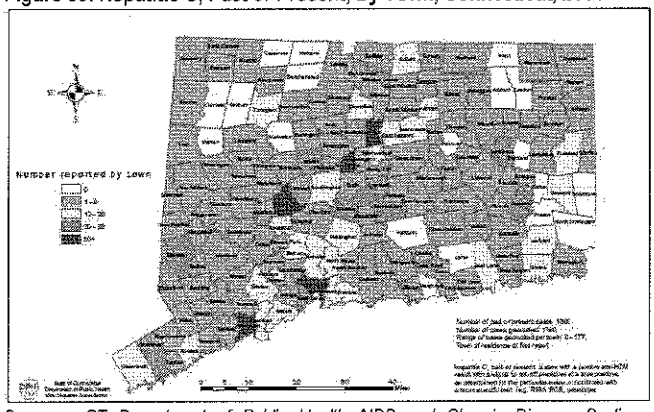
This section focuses on infectious diseases that have emerged as concerns in the state and region in recent decades, including Sexually Transmitted Infections (Chlamydia & Gonorrhea), HIV, Hepatitis B, Hepatitis C, and Tick-Borne Diseases.

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*

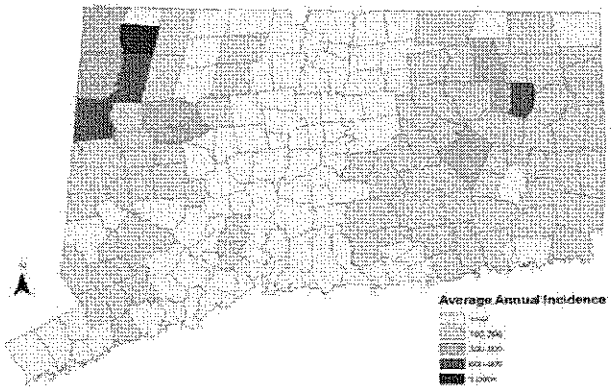
HIV infection continues to be a public health issue of concern. Rates are highest among males, and as shown in Figure 51, in residents ages 20-29, followed by residents ages 40-49. The primary risk factors for HIV infection in CT residents include men having unprotected sex with men (MSM), Injectable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

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



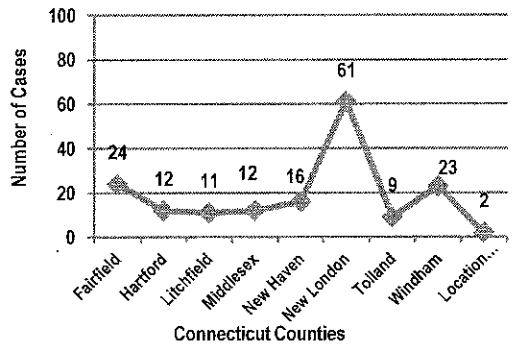
Source: CT Department of Public Health AIDS and Chronic Disease Section, Epidemiological Profile of HIV/AIDS in CT, 2013; as cited in Healthy CT 2020.

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).

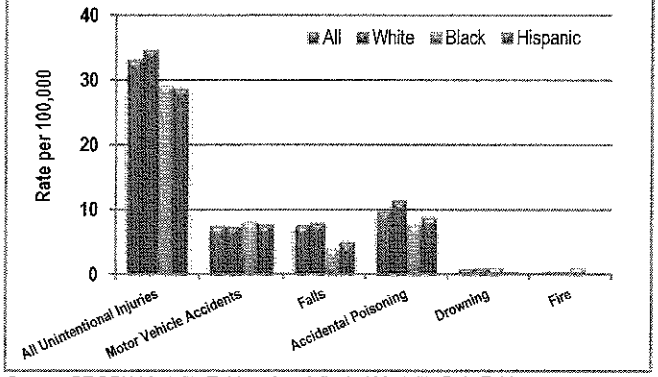
HIV, Hepatitis B, and Hepatitis C are preventable. Avoiding risky behaviors such as unprotected sex and injecting illicit drugs are critical. Childhood vaccination against Hepatitis B provides protection against contracting this disease. Early screening and detection for HIV and Hepatitis C are critical 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

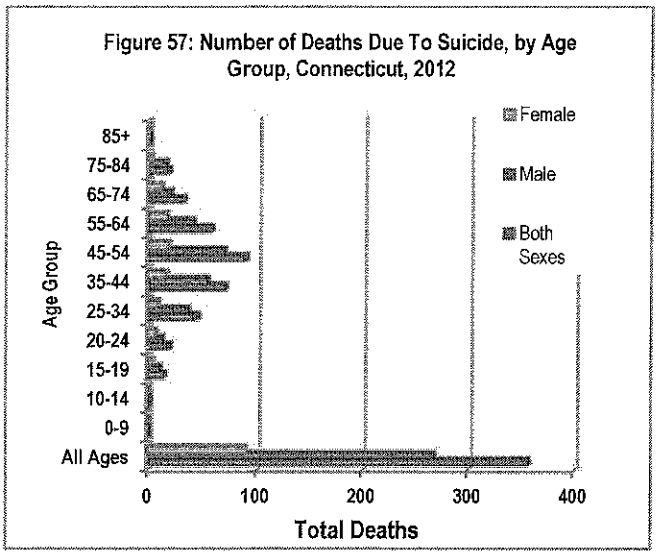


Figure 58: Total Deaths Due to Homicide, by Age Group, Connecticut, 2012

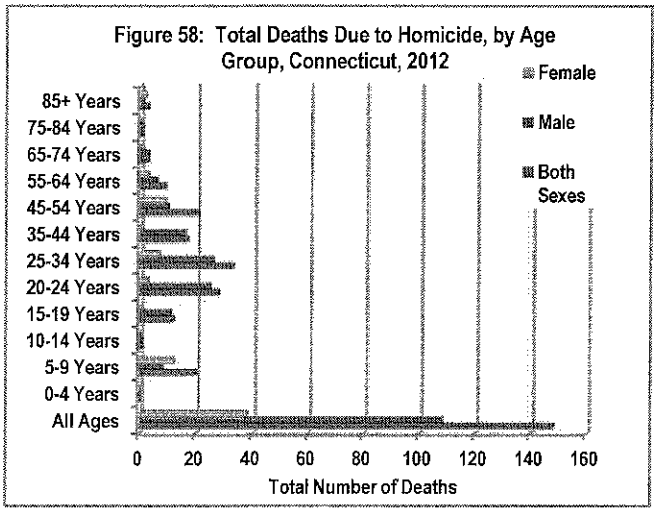


Figure 57 & 58 source: CT DPH: Vital Records; http://www.ct.gov/dph/cwp/view.asp?a=3132&q=394598&dphNav_GID=1601&dphPNavCtr=|#46987

Why Injury and Violence Prevention Are Important

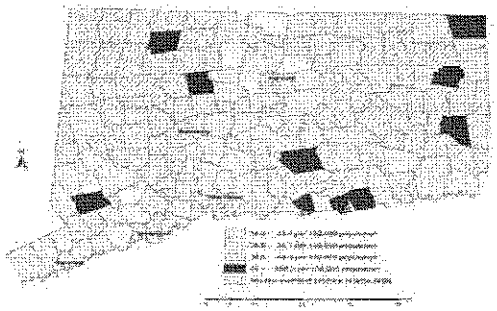
Injuries, whether intentional or unintentional, are a leading cause of premature death and disability, as well as health care costs and lost productivity in the workforce. Importantly, most unintentional injuries are preventable. For example, according to the National Institutes of Health, alcohol is 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.

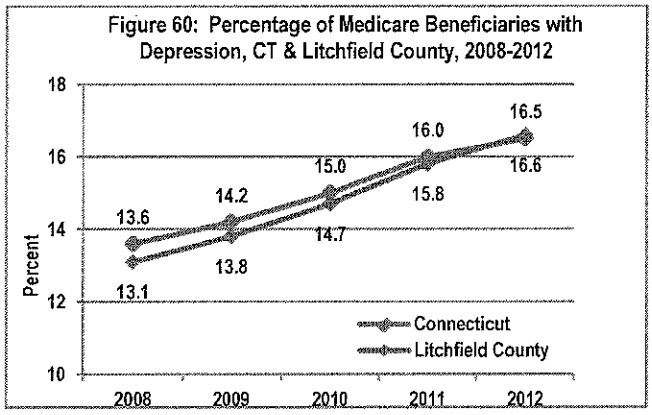
As shown in Figures 57 and 58, CT males are more than twice as likely as females to die from suicide or homicide. Suicide deaths are most prevalent in males and females ages 35-54; homicides are most common in young adults, ages 15-34, with Black or African American males disproportionately affected. 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

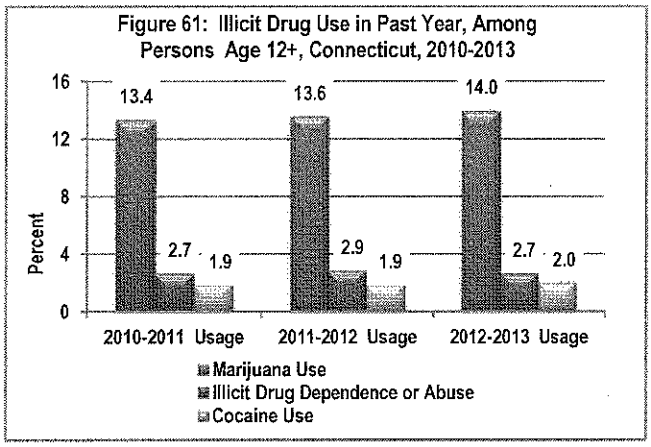


Source: Connecticut Department of Public Health, Health Statistics & Surveillance, Statistics & Analysis Reporting, 2006-2010.

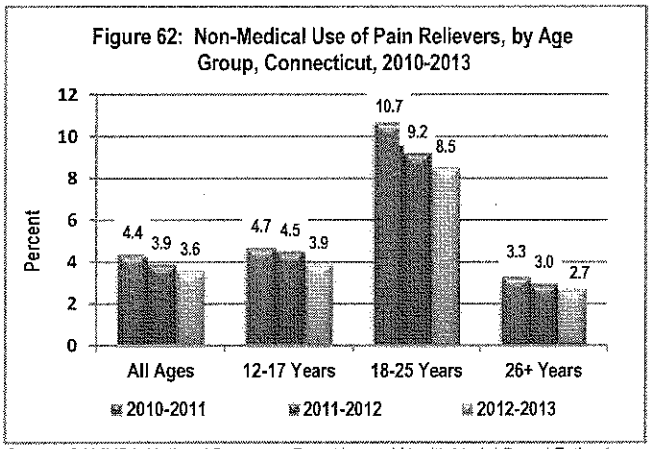
MENTAL HEALTH AND SUBSTANCE USE DISORDERS



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



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



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.

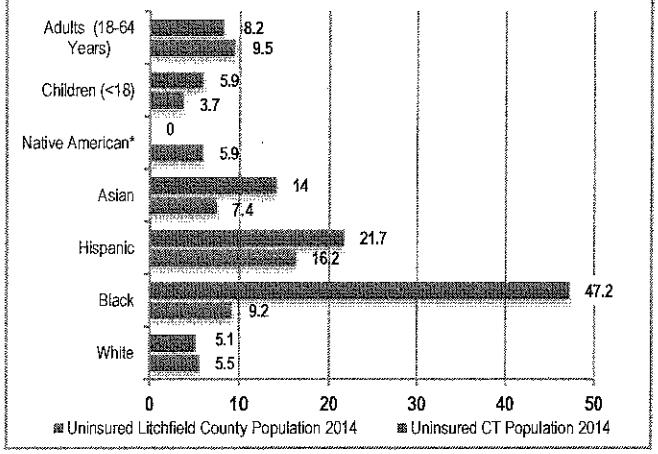
Depression is relatively common in adolescents, with one out of every three CT female high school students and 27% of high school (HS) students overall reporting they felt so sad or hopeless that they had stopped doing some usual activities. In addition, 18% of HS females and 14.5% of HS students overall 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



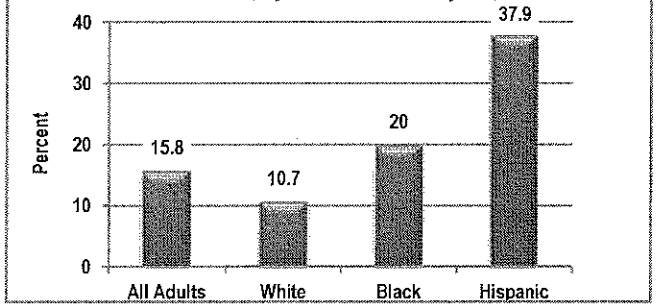
U.S. Census Bureau, American Fact Finder
http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_1YR_S2701&prodType=table

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

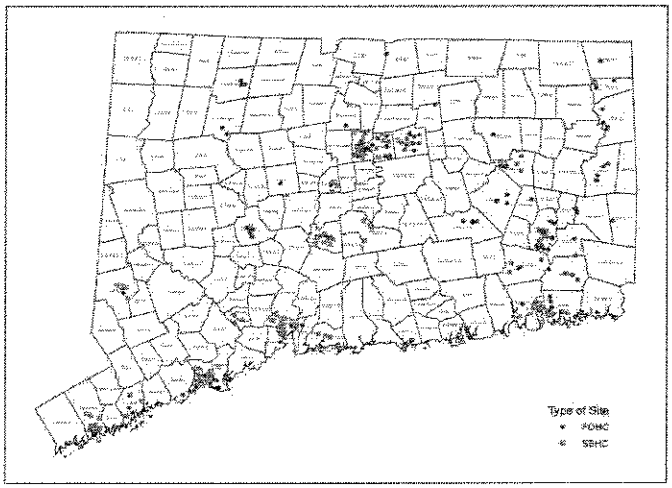
Equitable access to quality health care is important to eliminate health disparities and optimize individual and community health. Persons without health insurance coverage are less likely to have a usual and ongoing source of medical care ("medical home"), are more likely to report poor health, and 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.

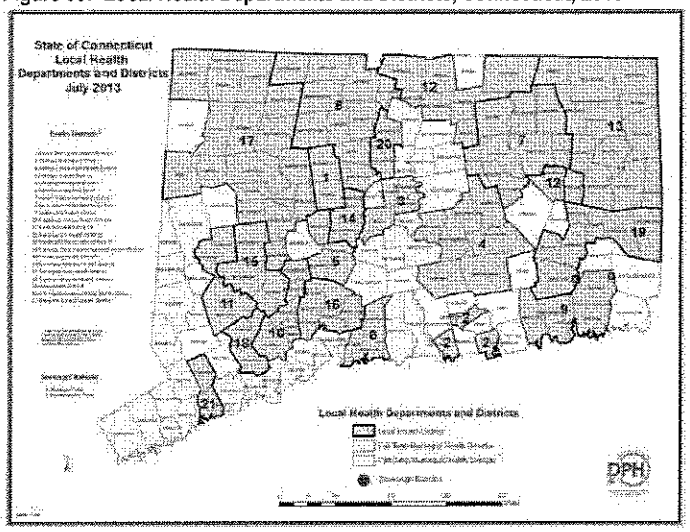
Litchfield County is home to three acute care hospitals: Charlotte Hungerford Hospital in Torrington, Western CT Health Systems-New Milford Campus of Danbury Hospital in New Milford, and Sharon Hospital in Sharon. In addition, there is one federally qualified health center located within the county, 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*

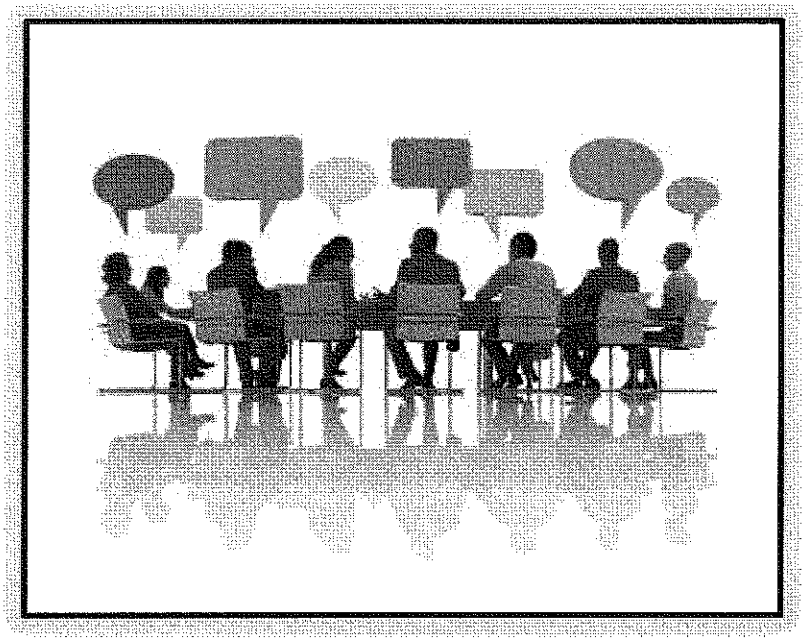
There are a wide variety of additional health-related resources within the county. United Way of CT Infoline 2-1-1 maintains an up-to-date online searchable community resource database of health and human service providers, agencies, and organizations, available at *http://www.211ct.org*. United Way 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:

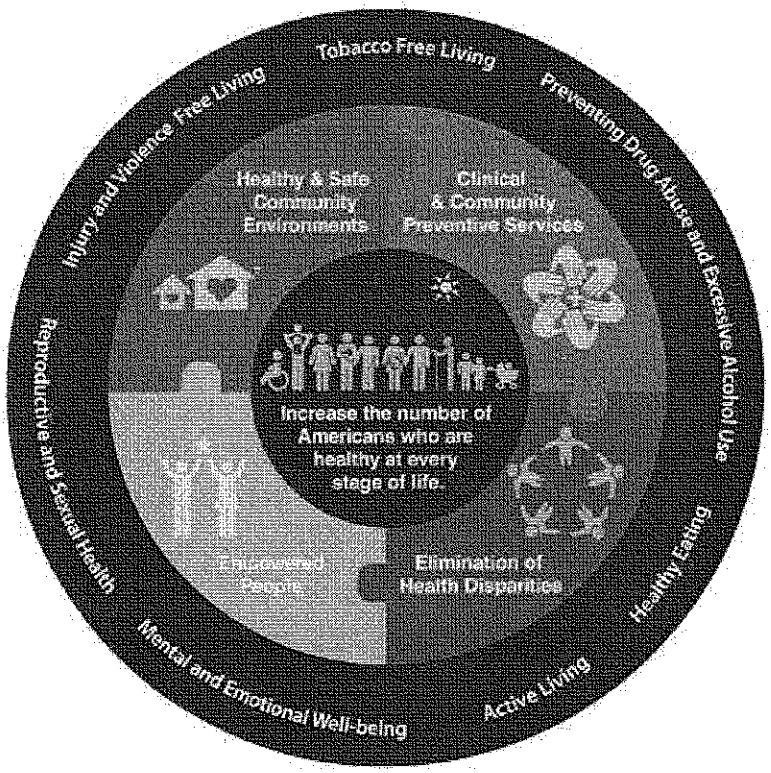
The findings discussed in this report highlight the complex and dynamic role that CHH and its partners play within the community. Eight overarching themes are discussed which summarize a range of positive, as well as negative, perceptions and attitudes. Further, it is important to note that many of the 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
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The contributions of the CT Department of Public Health were also essential in providing the morbidity and mortality data sets used in the assessment process, including:

- 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
- Jon Olson, DPM, DrPH, Epidemiologist 3, Health Statistics & Surveillance Section

Lastly, the excellent work of the assessment and evaluation team from EDUCATION CONNECTION is gratefully acknowledged: Mary Bevan, MPH, Director of the Center for Healthy Schools & Communities (primary CHNA author); Kevin Glass, M.S., R.S.M, Director of the Center for Program Research & Evaluation, and Margot Snellback, Research Associate.

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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1. *World Health Organization (WHO). 1992. Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, Based on the Recommendations of the Tenth Revision Conference, 1992. WHO, Geneva.*
2. *Romeder, J.M. and J.R. McWhinnie. 1977. Potential Years of Life Lost between Ages 1 and 70: An indicator of Premature Mortality for Health Planning. International Journal of Epidemiology 6: 143-151.*

Charlotte Hungerford Hospital

ONE THOUSAND CAREGIVERS. ONE JOB. YOUR HEALTH.

Charlotte Hungerford Hospital Community Health Improvement Plan

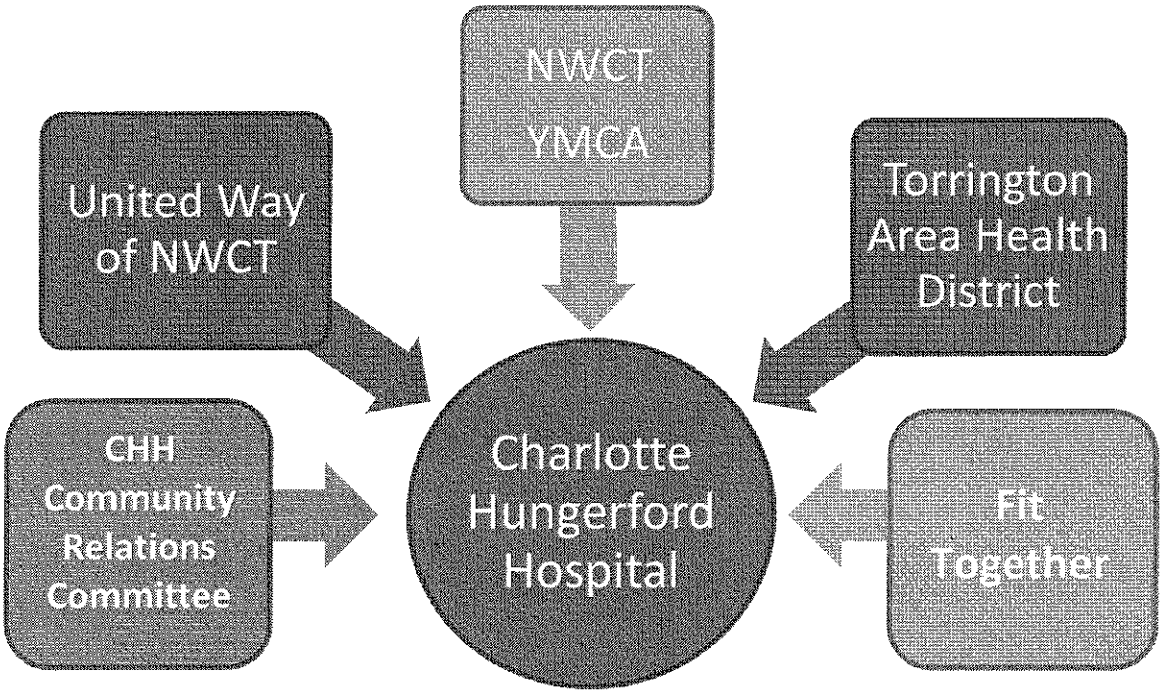
2016-2019

Executive Summary

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

To this end, Charlotte Hungerford Hospital (CHH) and a coalition of community health providers and agencies have completed a second Community Health Needs Assessment (CHNA). The most recent CHNA 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 in Northwest CT conducted in 2012. The original county-wide assessment was funded by a CDC Community Transformation Grant through the CT State Department of Public Health, Torrington Area Health District, Charlotte Hungerford Hospital, United Way of Northwest CT, and the Northwest CT YMCA. Both the 2012 and 2015 Community Health Needs Assessments for Northwest CT were prepared by the Center for Healthy Schools & Communities at EDUCATION CONNECTION.

Our Community Health Assessment Partners:



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Introduction

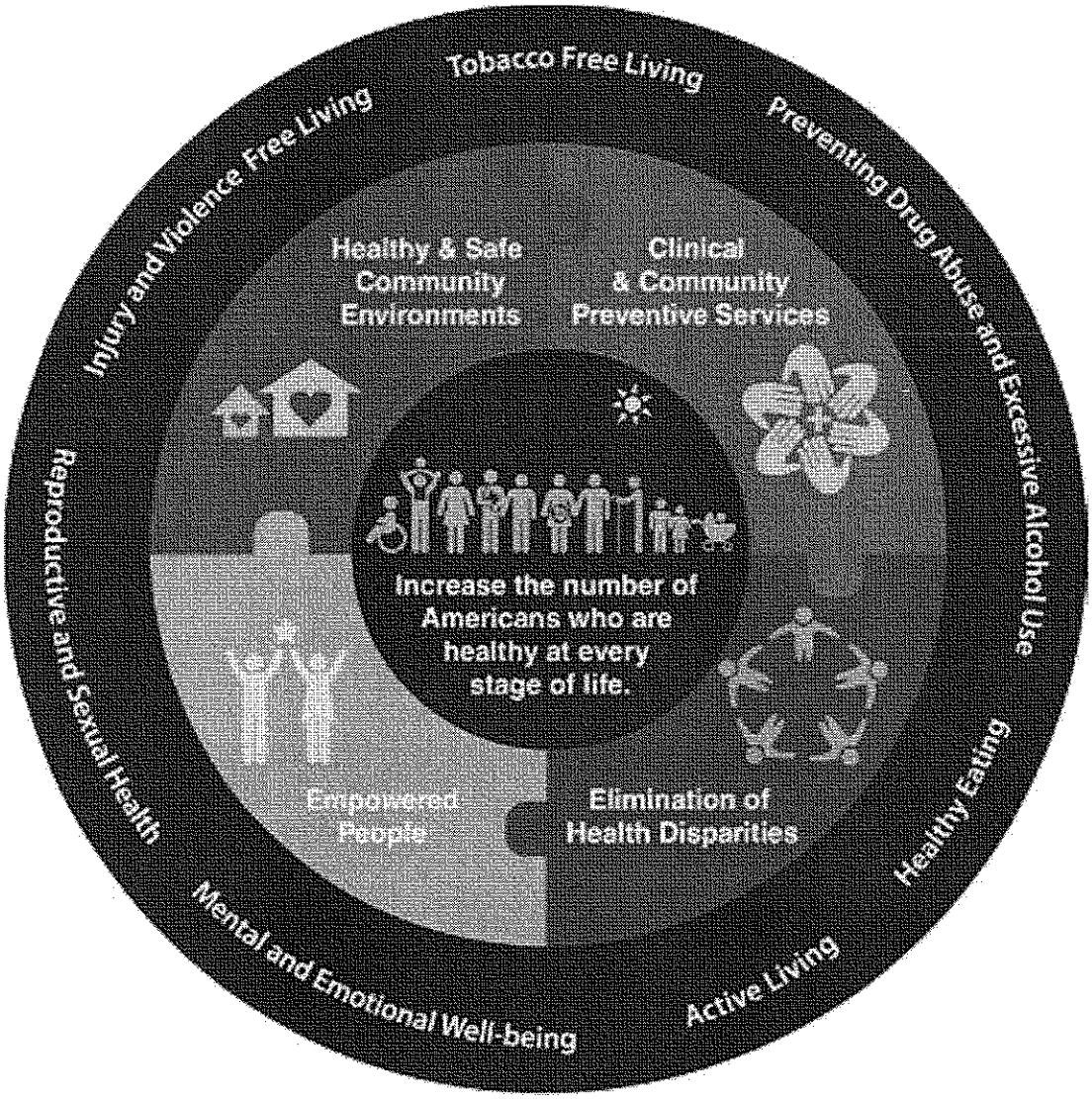
The 2015 Community Health Needs Assessment concentrates, to the extent possible, on the primary service area of CHH, which includes these 13 communities: Barkhamsted, Bethlehem, Colebrook, Cornwall, Goshen, Harwinton, New Hartford, Norfolk, Litchfield, Morris, Thomaston, Torrington, and Winchester (Winsted). 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.

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 are above the state average. 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.

Connecticut and the Northwest region have also 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.

As community health leaders, these findings are a call to action. Below is our initial response to the 2015 assessment, which constitutes our CHIP over the next three years. For greater detail regarding the referenced Fit Together initiatives and the Opioid Task Force, including their history, developments, and status of activities, please consult the complementary Fit Together and Opioid Task Force Strategic Plans.

Opportunities for Action



Community Health Improvement Plan

Strategic Area #1: Promote Healthy Behaviors and Lifestyles

OBJECTIVES	STRATEGIES	BASELINE 2015	STATUS
Decrease overall tobacco use, and specifically e-cigarette use among teens, as well as smoking during pregnancy – all measures to be below state average.	1) Offer "Freedom From Smoking" in conjunction with the American Lung Association at no charge to the public and our workforce - 3X per year. 2) Support school-based interventions through Tar Wars program model. Tar Wars is a tobacco-free education program for fourth- and fifth-grade students designed by the AAFP. The program is designed to teach kids about the short-term health effects of tobacco use, the cost associated with using tobacco products, and the advertising techniques used by the tobacco industry to market their products to youth. 3) Worksite Policy and Signage assistance – provide to area businesses tobacco free policies and signage without cost to the employer.	21% tobacco users in Litchfield County versus state average of 16%. E-cigarette use among youths at 5.3% in CT vs. 2.2% nationally. Area residents more frequently reported than state residents on average: heavy drinking and current smoking. Mothers in the Torrington and Winsted communities reported the highest levels of smoking during pregnancy in the state.	

Increase physical activity and healthy eating habits so that rates of obesity are below state averages, we rank as the highest county for percentage of adults meeting recommended exercise requirements, and we have the highest percentage of County residents consuming fruits and vegetables.	Utilizing the Fit Together collaboration, focus on long-term policy changes including the following activities (See Fit Together Strategic Plan): 1. Nutrition and Movement - CHH and local YMCA piloting project at Brooker Memorial, working with local pediatricians to refer overweight/obese children who are given access to a dietician, YMCA trainer, cooking classes, etc. 2. Promote 5210 Let's Go! in the workplace, which emphasizes increasing physical activity and healthy eating behaviors for employees to be carried over to their home life. (See Workplace Wellness Tool Kit and Assessment) 3. Promote educational talks and tips (English and Spanish) in the areas of nutrition, health navigation, and heart health risk factors. Promote 5210 Let's Go! in early childhood education by adopting healthy eating standards, wellness policies, and facility/program reviews for optimal health environments.	Only 1 in 10 CT high school students consume the recommended 5 or more servings of fruits and vegetables per day. The percentage of students in local school districts passing all four components of state physical fitness tests was 34% in Torrington and 22% in Winsted with a statewide average of 51%. Residents in many of CHH's Service Area Towns (SATs) experienced a higher than average burden of premature death from heart disease. Measured in Years of Potential Life Lost (YPLL) for SATs, Winchester was in the highest quartile, and in the second highest quartile was Harwinton, Litchfield, Thomaston, and Torrington 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	

Stem accidental drug intoxication deaths and heroin-related deaths which are projected to more than double, with heroin use in high school students in region exceeding national averages.	Through an Opioid Task Force co-chaired by the Hospital, several interventions are underway including (See Task Force Strategic Plan): • Enhanced mobile case management to improve access to care • Public and provider education and messaging • Planning for Suboxone treatment • Creation of pill drop boxes • Creation of a local pain clinic • Documentation and research • Use and training of Narcan	3.4% use rate versus 2.2% nationally Accidental drug intoxication deaths in CT (pure ethanol intoxications were excluded) increased by over 90% (from 355 to 679) from 2012-2015; heroin-related deaths are projected to more than double.	
Strategic Area #2: Reduce the Burden of Chronic Disease			
Objectives	**Strategies**	**Baseline-2015**	**Status**
Lower Rate of diabetes and improved diabetes disease management, as well as outcomes associated with the interrelationship this disease or its risk factors have with other health conditions that are highlighted in our assessments.	1) Diabetes center with endocrinologist, PA, diabetic nurse provides treatment and education: insulin pump training, weight loss programs, carbohydrate counting classes, blood glucose awareness training, and continuous glucose monitoring. Also provides support for patients with gestational diabetes. 2) Developed Pre-diabetes program with local YMCA for adults. Program sets the goal to reduce body weight by 7% and increase your physical activity at least 150	The most prevalent medical diagnoses for persons hospitalized in the CHH service area were Hypertension (High Blood Pressure), followed by Type II Diabetes. 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. Emergency Department visit rates for selected diagnoses show rates	

	minutes per week. Periodically launched with CHH subsidizing program fees for area residents. 3) Co-sponsoring chronic conditions self-management program. Six-week program teaches better ways to deal with pain, fatigue, difficult emotions, anxiety and stress. Focuses on easy exercises, improving nutrition and appropriate uses of medications and supplements. Periodically launched and free to area residents. 4) Case Management education initiatives for inpatient population emphasizing the following: • Create an At Home Care Plan (AHCP), which is an easy-to-understand discharge plan sent home with patient. • Review and orient patient to all aspects of AHCP and encourage patients to ask Q's. • Meet with the patient, family, and/or other caregivers to provide education and to begin discharge preparation. • Ask patients to explain in their own words the details of the plan (the teach-back technique). • Contact family members and/or other caregivers who will share in the care-giving	for heart disease and stroke were *higher* in Litchfield County than in the state overall	

	responsibilities. • Instruct on a specific plan of how to contact the primary care provider by providing contact numbers, including evenings and weekends. Instruct on what constitutes an emergency and what to do in cases of emergency.		
Strategic Area #3: Improve Access to Care			
Objectives	**Strategies**	**Baseline-2015**	**Status**
Address low birth-weights and pre-term births	Through programming and education, working with our OB/GYN and Women's health community, improve access to prenatal care, and more specifically assure: • At prenatal visits, the health of both mother and fetus are checked against latest medical standards. • Better educate about eating a healthy diet and gaining the proper amount of weight during pregnancy. • Assure Mothers are avoiding alcohol, cigarettes and illicit drugs, which can contribute to poor fetal growth, among other complications.	Torrington and Winchester were in the second highest quartile in the state for low birth-weight births and highest quartile for preterm births in the state. 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.	

Improve access to Primary and Preventive Care	Affiliation with HHC has emerged as our single best strategy at addressing this growing challenge. Working with local FQHC on expanding a clinic model for the expansion of behavioral and primary care services in rural NW CT. A feasibility grant was awarded to assess the inputs and outputs of such an initiative and we are in the final stages of making a formal proposal to a funder for the service.	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.	
Increase ratio of mental health providers	Affiliation with HHC has emerged as our single best strategy at addressing this growing challenge.	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.	

Exhibit 3 – Audited Financial Statements (Item #3)

Please provide all audited financial reports to support several key elements of Connecticut General Studies § 19a-639f. Years requested: 2012, 2013, 2014, 2015, and 2016.

Response:

Prepared at the request of the Counsel, please find attached the Audited Financial Statement for 2016. Please note that the Audited Financial Statement for 2016 is a draft. Audited Financial Statements for The Charlotte Hungerford Hospital for the years if 2012, 2013, 2014, and 2015 are on file with OHCA.

THE CHARLOTTE HUNGERFORD HOSPITAL

FINANCIAL STATEMENTS

September 30, 2016 and 2015

THE CHARLOTTE HUNGERFORD HOSPITAL

FINANCIAL STATEMENTS
September 30, 2016 and 2015

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INDEPENDENT AUDITOR'S REPORT

To the Board of Governors of
The Charlotte Hungerford Hospital:

We have audited the accompanying financial statements of The Charlotte Hungerford Hospital (the Hospital), a Connecticut not-for-profit, non-stock corporation, which comprise the balance sheets as of September 30, 2016 and 2015, and the related statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

(Continued)

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of The Charlotte Hungerford Hospital as of September 30, 2016 and 2015, and the results of its operations, changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

DRAFT

Simsbury, Connecticut
<>, 2016

THE CHARLOTTE HUNGERFORD HOSPITAL
BALANCE SHEETS
September 30, 2016 and 2015

	2016	2015
ASSETS		
Current assets:		
Cash and cash equivalents	$ 6,634,923	$ 5,598,887
Accounts receivable (less allowance for doubtful accounts of $2,021,028 in 2016 and $2,065,788 in 2015)	12,967,655	13,732,468
Inventories	2,014,584	1,969,907
Other current assets	1,629,999	1,624,373
Total current assets	23,247,161	22,925,635
Assets whose use is limited:		
Investments held in trust for estimated self-insurance liabilities	3,595,585	3,554,247
Investments held under bond indentures	10,851,304	-
Donor restricted assets	6,646,114	6,997,698
Beneficial interest in assets held in trust by others	20,312,336	19,644,506
Total assets whose use is limited	41,405,339	30,196,451
Long-term investments	35,437,220	39,204,252
Property, plant and equipment:		
Land	155,467	155,467
Land improvements	6,141,173	6,065,958
Buildings	87,737,951	85,337,412
Fixed equipment	18,211,110	17,320,195
Moveable equipment	54,184,457	51,167,168
	166,430,158	160,046,200
Less: accumulated depreciation	(126,819,150)	(120,950,456)
	39,611,008	39,095,744
Construction in progress	2,833,092	737,026
Total property, plant and equipment	42,444,100	39,832,770
Other assets	1,111,076	1,088,648
Total assets	$ 143,644,896	$ 133,247,756
LIABILITIES AND NET ASSETS		
Current liabilities:		
Accounts payable	$ 7,390,496	$ 8,062,260
Estimated amounts due to third-party reimbursement agencies	4,408,534	2,797,659
Accrued salaries, wages and fees	4,912,249	4,471,292
Current portion of long-term debt	650,000	-
Other current liabilities	543,860	531,004
Total current liabilities	17,905,139	15,862,215
Estimated self-insurance liabilities	4,200,015	3,763,019
Long-term debt, net of current portion	12,025,000	-
Accrued pension liability	53,813,088	42,419,641
Total liabilities	87,943,242	62,044,875
Net assets:		
Unrestricted	28,743,204	44,560,677
Temporarily restricted	2,893,733	3,245,317
Permanently restricted	24,064,717	23,396,887
Total net assets	55,701,654	71,202,881
Total liabilities and net assets	$ 143,644,896	$ 133,247,756

The accompanying notes are an integral part of these financial statements.

THE CHARLOTTE HUNGERFORD HOSPITAL
STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
For the years ended September 30, 2016 and 2015

	2016	2015
Unrestricted revenues:		
Net patient service revenues	$ 112,296,101	$ 116,129,644
Provision for bad debts, net of recoveries	(2,054,040)	(2,393,914)
Net patient service revenues less provision for bad debts	110,242,061	113,735,730
Other revenues	6,483,839	6,810,204
Total revenues	116,725,900	120,545,934
Expenses:		
Salaries and wages	55,898,471	57,705,714
Services	19,267,212	18,746,264
Supplies	15,365,100	15,718,481
Employee benefits	13,950,696	14,254,317
Depreciation and amortization	6,335,613	5,917,387
Physician fees	8,379,952	5,055,157
Repairs and maintenance	2,556,682	2,174,074
Insurance	1,748,447	2,407,852
Total expenses	123,502,173	121,979,246
Operating loss	(6,776,273)	(1,433,312)
Other income (expenses):		
Investment and other income, net	3,237,215	2,896,009
Non-operating expenses	(1,762,458)	(289,870)
Gifts and bequests	434,158	323,459
Gain from equity method investments	52,413	31,113
Total other income	1,961,328	2,960,711
Excess of revenues over expenses	$ (4,814,945)	$ 1,527,399

The accompanying notes are an integral part of these financial statements.

THE CHARLOTTE HUNGERFORD HOSPITAL
STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS (CONTINUED)
For the years ended September 30, 2016 and 2015

	2016	2015
Unrestricted net assets:		
Excess of revenues over expenses	$ (4,814,945)	$ 1,527,399
Change in unrealized gains (losses) on investments	1,057,285	(2,530,303)
Pension related changes other than net periodic pension costs	(12,059,813)	(13,805,331)
Change in unrestricted net assets	(15,817,473)	(14,808,235)
Temporarily restricted net assets:		
Investment income	40,265	145,921
Contributions	246,476	175,117
Change in unrealized losses on investments	(50,405)	(288,680)
Net assets released from restrictions	(587,920)	(295,159)
Change in temporarily restricted net assets	(351,584)	(262,801)
Permanently restricted net assets:		
Change in beneficial interest in assets held in trust by others	667,830	1,755,084
Change in permanently restricted net assets	667,830	1,755,084
Change in net assets	(15,501,227)	(13,315,952)
Net assets, beginning of year	71,202,881	84,518,833
Net assets, end of year	$ 55,701,654	$ 71,202,881

The accompanying notes are an integral part of these financial statements.

THE CHARLOTTE HUNGERFORD HOSPITAL
STATEMENTS OF CASH FLOWS
For the years ended September 30, 2016 and 2015

	2016	2015
Cash flows from operating activities:		
Change in net assets	$ (15,501,227)	$ (13,315,952)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	6,335,613	5,917,387
Realized gains on investments	(2,004,943)	(1,460,055)
Unrealized (gains) losses on investments	(887,580)	2,818,985
Increase in beneficial interest in assets held in trust by others	(667,830)	(1,755,084)
Unrealized (gains) losses on donor restricted assets	(119,313)	262,801
Provision for bad debts, net of recoveries	2,054,040	2,393,914
Loss (gain) on disposal of equipment	6,976	(2,304)
Changes in assets and liabilities:		
Accounts receivable	(1,289,227)	(2,973,803)
Inventories	(44,677)	(17,646)
Other current assets	(5,626)	547,397
Other assets, net	(52,121)	(48,452)
Accounts payable	(671,764)	786,790
Estimated amounts due to third-party reimbursement agencies	1,610,875	920,284
Accrued salaries, wages and fees	440,957	14,982
Other current liabilities	12,856	(184,522)
Estimated self-insurance liabilities	436,996	(208,321)
Accrued pension liability	11,393,447	10,834,453
Net cash provided by operating activities	1,047,452	4,530,854
Cash flows from investing activities:		
Proceeds from sales of investments	15,536,755	5,347,812
Purchases of investments	(19,298,945)	(5,032,983)
Purchases of property, plant and equipment	(8,924,226)	(6,470,146)
Net cash used in investing activities	(12,686,416)	(6,155,317)
Cash flows from financing activities:		
Proceeds from borrowings of long-term debt	13,000,000	-
Principal payments on long-term debt	(325,000)	-
Net cash provided by financing activities	12,675,000	-
Net change in cash and cash equivalents	1,036,036	(1,624,463)
Cash and cash equivalents, beginning of year	5,598,887	7,223,350
Cash and cash equivalents, end of year	$ 6,634,923	$ 5,598,887
Supplemental disclosure of cash flow information:		
Cash paid for interest	$ 104,347	$ -

The accompanying notes are an integral part of these financial statements.

NOTE 1 - GENERAL

Organization: The Charlotte Hungerford Hospital (the Hospital), located in Torrington, Connecticut, is a not-for-profit acute care hospital. The Hospital provides inpatient, outpatient and emergency care services for the residents of northwestern Connecticut.

In August 2016, the Hospital's Board of Governors entered into a formal affiliation with Hartford HealthCare. On November 28, 2016, the Hospital and Hartford HealthCare filed a Certificate of Need (CON) application with the Connecticut State Department of Public Health's Office of Health Care Access and the Office of the Attorney General to approve the affiliation with Hartford HealthCare. If approved the Hospital would become part of the Hartford HealthCare network.

As of September 30, 2016, management has not received all regulatory approvals to fully execute an affiliation agreement. The Hospital will continue with its normal operations for the foreseeable future.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation: The accompanying financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America (GAAP), as promulgated by the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC).

Use of Estimates: The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant estimates relate to contractual allowances and the allowance for doubtful accounts on patient accounts receivable, self-insurance liabilities, valuation of investments, estimated settlements due to third-party reimbursement agencies and pension plan assumptions. Actual results could differ from those estimates.

Net Asset Categories: To ensure observance of limitations and restrictions placed on the use of resources available to the Hospital, the accounts of the Hospital are maintained in the following net asset categories:

Unrestricted - Unrestricted net assets represent available resources other than donor restricted contributions. Included in unrestricted net assets are assets set aside by the Board of Governors (the Board) for future capital improvements, over which the Board retains control and may, at its discretion, subsequently use for other purposes.

Temporarily restricted - Temporarily restricted net assets represent contributions that are restricted by the donor either as to purpose or as to time of expenditure.

Permanently restricted - Permanently restricted net assets represent contributions received with the donor restriction that the principal be invested in perpetuity and that the income earned thereon be available for operations and beneficial interest in assets held in trust by others.

Assets Held in Trust by Others: The Hospital has been named sole or participating beneficiary in several perpetual trusts. Under the terms of these trusts, the Hospital has the irrevocable right to receive the income earned on the trust assets in perpetuity. The estimated present value of the future payments to the Hospital is recorded at the fair value of the assets held in the trust. Fluctuations in the value of such assets are recognized as changes in permanently restricted net assets.

(Continued)

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Recognition of Grant Revenue: Grants are generally considered to be exchange transactions in which the grantor requires the performance of specified activities. Entitlement to cost reimbursement grants is conditioned on the expenditure of funds in accordance with grant restrictions and, therefore, revenue is recognized to the extent of grant expenditures. Entitlement to performance based grants is conditioned on the attainment of specific performance goals and, therefore, revenue is recognized to the extent of performance achieved. The Hospital recognized $2,258,825 and $2,080,269 of grant revenue, included in other revenues, for the years ended September 30, 2016 and 2015, respectively. Grant receipts in excess of revenues recognized are presented as deferred grant support. Deferred grant support of $81,122 and $300,778 is included in other current liabilities in the accompanying balance sheets as of September 30, 2016 and 2015, respectively.

Cash and Cash Equivalents: Cash and cash equivalents include highly liquid investments with maturities of three months or less when purchased. In general, the Federal Deposit Insurance Corporation (FDIC) insures cash balances up to $250,000 per depositor, per bank. It is the Hospital's policy to monitor the financial strength of the banks that hold its deposits on an ongoing basis. During the normal course of business, the Hospital maintains cash balances in excess of the FDIC insurance limit.

Inventories: Inventories, used in general operations of the Hospital, are stated at the lower of cost or market. Cost is determined by the specific identification method.

Investments: The Hospital accounts for its investments in accordance with FASB ASC 320, *Investments - Debt and Equity Securities*. Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the accompanying balance sheets. Management determines the appropriate classification of its investments in invested securities at the time of the purchase and reevaluates such determination at each balance sheet date. Investment income (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income is restricted by donor or law. Unrealized gains and losses on investments are excluded from excess of revenues over expenses.

All of the Hospital's investments, as of September 30, 2016 and 2015, were classified as available for sale. Available for sale securities may be sold prior to maturity and are carried at fair value.

Assets Whose Use is Limited: Assets whose use is limited include assets set aside for self-insurance trust arrangements, assets held by trustees under bond indenture agreements, donor restricted endowments and assets held in trust by others.

Fair Value Measurements - The Hospital classifies its investments in accordance with FASB ASC 820, *Fair Value Measurements and Disclosures*, which defines fair value, establishes a framework for measuring fair value under GAAP and requires certain disclosures about fair value measurements (see Note 5). The definition of fair value under FASB ASC 820 focuses on the price that would be received to sell the asset, which is referred to as the exit price.

(Continued)

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Other Than Temporary Impairments on Investments: The Hospital accounts for other than temporary impairments in accordance with certain provisions of FASB ASC 320 *Investments - Debt and Equity Securities* and continually reviews its securities for impairment conditions, which could indicate that an other than temporary decline in market value has occurred. In conducting this review, numerous factors are considered, which include specific information pertaining to an individual company or a particular industry, general market conditions that reflect prospects for the economy as a whole, and the ability and intent to hold securities until recovery. The carrying value of investments is reduced to its estimated realizable value if a decline in fair value is considered to be other than temporary. There were no impairments recorded in 2016 or 2015.

Federal Income Taxes: The Hospital is a not-for-profit corporation under Section 501(c)(3) of the Internal Revenue Code (the Code) and is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code.

The Hospital accounts for uncertain tax positions in accordance with provisions of FASB ASC 740, *Income Taxes* which provides a framework for how companies should recognize, measure, present and disclose uncertain tax positions in their financial statements. The Hospital may recognize the tax benefit from an uncertain tax position only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The Hospital does not have any uncertain tax positions as of September 30, 2016 or 2015. As of September 30, 2016 or 2015, the Hospital did not record any penalties or interest associated with uncertain tax positions. The Hospital would recognize interest and/or penalties related to income tax matters in income tax expense. The Hospital's prior three tax years are open and subject to examination.

Property, Plant and Equipment: Property, plant and equipment purchased by the Hospital is recorded at cost, or if received as a donation, at fair value on the date received. The Hospital provides for depreciation of property, plant and equipment for financial reporting purposes using the straight-line method over the estimated useful lives of the various assets. American Hospital Association lives are generally used and provide for a 15-50 year life for buildings and a 3-20 year life for building fixtures and equipment. Leased equipment is amortized on a straight-line basis over the shorter of the life of the applicable lease or life of the leased asset.

Depreciation expense was $6,305,920 and $5,879,781 for the years ended September 30, 2016 and 2015, respectively.

(Continued)

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Investments in Joint Ventures: The Hospital has invested in certain joint ventures which are accounted for under the equity method of accounting and included within other assets on the balance sheets. The Hospital's investment in these joint ventures is as follows:

	Ownership Percentage
Advanced Medical Imaging of Northwest CT, LLC (AMI)	50%
MedConn Collection Agency, LLC (MedConn)	33%
Urology Center of Northwest CT, LLC (Urology)	62.5%

The Hospital has recorded its share of AMI's net income of $644,018 and $506,231 within other revenues as of September 30, 2016 and 2015, respectively, as these services are a component of the Hospital operations. In addition, the 62.5% investment in Urology is presented under the equity method of accounting as it is immaterial to present in a consolidated presentation. The Hospital has recorded an asset of $18,617 and $42,886 related to the ownership of Urology as of September 30, 2016 and 2015, respectively. The Hospital has recorded its share of MedConn and Urology's net income of $52,413 and $31,113 in gain from equity method investments as of September 30, 2016 and 2015.

Other Income: Activities other than in connection with providing health care services are considered to be non-operating. Non-operating income consists primarily of income on investment funds, unrestricted gifts and bequests and gains from equity method investments.

Statements of Operations and Changes in Net Assets: For purposes of display, transactions deemed by management to be ongoing, major or central to the providing of healthcare services are reported as operating revenues and expenses. Investment income and realized gains and losses on securities are considered non-operating activity. Changes in unrestricted net assets which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments, except for losses that are deemed to be other than temporary, certain changes in pension liabilities and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets).

Reclassifications: Some items in the prior year financial statements were reclassified to conform to the current presentation. Reclassifications had no effect on prior year net assets or the change in net assets.

Subsequent Events: Subsequent events have been evaluated through <>, 2016, the date through which procedures were performed to prepare the financial statements for issuance. Management believes there are no subsequent events having a material impact on the financial statements.

(Continued)

NOTE 3 - REVENUES FROM SERVICES TO PATIENTS AND CHARITY CARE

The following tables reconcile gross revenues to net revenues from services to patients:

	2016				
	Medicare	Medicaid and Medicaid HMOs	Blue Cross	Other	Total
Gross revenues from services to patients	$ 141,282,183	$ 65,352,800	$ 29,758,781	$ 57,669,060	$ 294,062,824
Deductions and allowances	(86,915,241)	(48,504,181)	(14,213,717)	(32,133,584)	(181,766,723)
Net revenues from services to patients	$ 54,366,942	$ 16,848,619	$ 15,545,064	$ 25,535,476	$ 112,296,101

	2014				
	Medicare	Medicaid and Medicaid HMOs	Blue Cross	Other	Total
Gross revenues from services to patients	$ 137,901,587	$ 61,199,842	$ 27,818,056	$ 56,786,623	$ 283,706,108
Deductions and allowances	(81,418,666)	(43,357,625)	(12,626,338)	(30,173,835)	(167,576,464)
Net revenues from services to patients	$ 56,482,921	$ 17,842,217	$ 15,191,718	$ 26,612,788	$ 116,129,644

Net Patient Service Revenues and Net Accounts Receivable: Net patient service revenue is reported at the established net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Net patient service revenue and accounts receivable are recorded when patient services are performed. Amounts received from most third-party payors are different from established billing rates of the Hospital, based on agreements with these payors, and these differences are accounted for as contractual allowances. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, per diem payments, and discounted charges, including estimated retroactive settlements under payment agreements with third-party payors. Adjustments and settlements under reimbursement agreements with third-party payors are accrued on an estimated basis in the period the related services are provided and adjusted in future periods as final settlements are determined.

For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue based on its discounted rates. On the basis of historical experience, a significant portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to uninsured patients in the period the services are provided.

Patient accounts receivable are based on gross charges and stated at net realizable value. Accounts receivable are reduced by an allowance for contractual adjustments, based on expected payment rates from payors under current reimbursement methodologies, and also by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Hospital analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate appropriate allowance for doubtful accounts and provision for bad debts based upon management's assessment of historical and expected net collections considering business and economic conditions, trends in health care coverage, and other collection indicators. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for contractual adjustments and allowance for doubtful accounts.

(Continued)

NOTE 3 - REVENUES FROM SERVICES TO PATIENTS AND CHARITY CARE (Continued)

For receivables associated with services provided to patients who have third-party coverage, the Hospital analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and co-payment balances due for which third-party coverage exists for part of the bill), the Hospital records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible.

For uninsured patients that do not qualify for financial assistance, the Hospital offers a discount off its standard rates for services provided. The difference between the discounted rates and the amounts actually collected after all reasonable collection efforts have been exhausted is written off against the allowance for doubtful accounts in the period they are determined uncollectible. The Hospital's allowance for doubtful accounts covers all accounts greater than six months for both self-pay accounts receivable and third party payors as of September 30, 2016 and 2015. The Hospital's provision for bad debts before recoveries totaled $3,814,026 and $3,985,617 for 2016 and 2015, respectively. The Hospital's bad debt recoveries totaled $1,759,986 and $1,591,703 for 2016 and 2015, respectively. The Hospital did not change its charity care or financial assistance policy during 2016 or 2015.

At September 30, 2016 and 2015, 63% and 64% of net patient accounts receivable were from governmental payors (Medicare and Medicaid) and 37% and 36% were from nongovernmental payors, respectively. Nongovernmental payors are primarily insurance companies and self-pay payors. Management has recorded an allowance for doubtful accounts, as noted above, which, in its opinion, is sufficient to provide for risk of nonpayment.

Charity Care: It is an inherent part of the Hospital's mission to provide necessary medical care free of charge, or at a discount, to individuals without insurance or other means of paying for such care. As the amounts determined to qualify for charity care are not pursued for collection, they are not reported as net patient service revenue. Patients who would otherwise qualify for charity care but who do not provide adequate information would be characterized as bad debt and included in the provision for bad debts. The amount of traditional charity care provided, determined on the basis of cost, was $817,622 and $695,328 for the years ended September 30, 2016 and 2015, respectively. The Hospital released assets whose use was restricted to fund free-care of $69,519 and $37,174, for the years ending September 30, 2016 and 2015, respectively.

Federal Regulatory Environment: The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services and Medicare and Medicaid fraud and abuse. Government activity continues to increase with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Hospital is in compliance with fraud and abuse regulations as well as other applicable government laws and regulations. While no known regulatory inquiries are pending, compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions known or unasserted at this time.

(Continued)

NOTE 4 - INVESTMENTS

Market values of investments, as of September 30, 2016 and 2015, are summarized as follows:

	2016	2015
Long-term investments:		
(including Board and donor restricted)		
Equity securities	$ 26,529,873	$ 28,652,281
Corporate bonds	5,509,556	7,343,599
Mutual and exchange traded funds	4,458,433	5,601,435
Money market funds	15,353,891	3,269,362
Certificates of deposit	973,253	1,222,102
Municipal bonds	109,161	112,545
U.S. treasury and government agencies	471	626
Total	$ 52,934,638	$ 46,201,950
Investments held in trust for estimated self-insurance liabilities:		
Mutual funds	$ 811,213	$ 2,249,107
Money market funds	2,784,372	1,305,140
	$ 3,595,585	$ 3,554,247

Beneficial interest in assets held in trust of $20,312,366 and $19,644,506, as of September 30, 2016 and 2015, respectively, are held by bank trustees and are not under the Hospital's investment control. These assets are invested within diversified portfolios.

Investment and other income net is comprised of the following for the years ended September 30, 2016 and 2015:

	2016	2015
Income, gains and (expenses):		
Interest and dividend income	$ 1,530,700	$ 1,706,268
Realized and unrealized gains on securities	3,012,685	4,413,368
Expenses	(219,025)	(229,926)
Total	$ 4,324,360	$ 5,889,710

(Continued)

NOTE 5 - FAIR VALUE MEASUREMENTS OF FINANCIAL INSTRUMENTS

U.S. GAAP defines fair value as the price that would be received for an asset or paid to transfer a liability (an exit price) in the Hospital's principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. A fair value hierarchy requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. There are three levels of inputs that may be used to measure fair value:

Level 1: Quoted prices (unadjusted) for identical assets or liabilities in active markets that the Hospital has the ability to access as of the measurement date. The fair values of money market funds, exchange traded funds, mutual funds, the self insurance trust and equity securities that are readily marketable are determined by obtaining quoted prices from nationally recognized securities exchanges. The unit investment trust is valued at the closing price reported on the active market on which the individual trust is traded.

Level 2: Significant other observable inputs other than Level 1 prices such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data. The fair values of the Hospital's Level 2 corporate, foreign, U.S. treasury and government agency and municipal bonds were determined by matrix pricing, which is a mathematical technique widely used in the industry to value debt securities without relying exclusively on quoted prices for the specific securities but rather by relying on the securities' relationship to other benchmark quoted securities. The fair value of certificates of deposit are estimated using a discounted cash flows calculation that applies interest rates currently being offered on certificates to a schedule of aggregated expected monthly maturities on time deposits.

Level 3: Significant unobservable inputs that reflect a reporting entity's own assumptions about the assumptions that market participants would use in pricing an asset or liability. Funds held in trust by others represents beneficial interest in certain assets held by third parties. These interests are classified as Level 3 investments as the reported fair values are based on a combination of Level 1 and Level 2 inputs and significant unobservable inputs as determined by the trustees who exercise control over the investments.

In many cases, a valuation technique used to measure fair value includes inputs from multiple levels of the fair value hierarchy. The lowest level of significant input determines the placement of the entire fair value measurement in the hierarchy.

(Continued)

NOTE 5 - FAIR VALUE MEASUREMENTS (Continued)

The following table presents the financial instruments, carried at fair value as of September 30, 2016, by the valuation hierarchy:

	Level 1	Level 2	Level 3	Total
Money market funds	$ 15,353,891	$ -	$ -	$ 15,353,891
Certificates of deposit	-	973,253	-	973,253
Equity securities:				
Industrials	3,005,210	-	-	3,005,210
Consumer discretionary	2,227,674	-	-	2,227,674
Financials	3,476,777	-	-	3,476,777
Technology	5,629,458	-	-	5,629,458
Consumer staples	2,849,100	-	-	2,849,100
Health care	4,553,596	-	-	4,553,596
Energy	1,904,551	-	-	1,904,551
Real estate	407,199	-	-	407,199
Utilities	2,476,308	-	-	2,476,308
Corporate bonds	-	5,509,556	-	5,509,556
Municipal bonds	-	109,161	-	109,161
Mutual and exchange traded funds:				
International	1,536,291	-	-	1,536,291
Index funds	1,189,089	-	-	1,189,089
Fixed income	907,566	-	-	907,566
Industry funds	533,000	-	-	533,000
Materials	138,996	-	-	138,996
U.S. large cap	99,493	-	-	99,493
U.S. mid and small cap	53,998	-	-	53,998
U.S. treasury and government agencies	-	471	-	471
Held under bond indentures	10,851,304	-	-	10,851,304
Self-insurance trust	3,595,585	-	-	3,595,585
Funds held in trust by others	-	-	20,312,336	20,312,336
Total	$ 60,789,086	$ 6,592,441	$ 20,312,336	$ 87,693,863

(Continued)

NOTE 5 - FAIR VALUE MEASUREMENTS (Continued)

The following table presents the financial instruments, carried at fair value as of September 30, 2015, by the valuation hierarchy:

	Level 1	Level 2	Level 3	Total
Money market funds	$ 3,269,362	$ -	$ -	$ 3,269,362
Certificates of deposit	-	1,222,102	-	1,222,102
Equity securities:				
Industrials	4,842,500	-	-	4,842,500
Consumer staples	4,383,341	-	-	4,383,341
Consumer discretionary	3,984,093	-	-	3,984,093
Health care	3,513,023	-	-	3,513,023
Energy	3,512,054	-	-	3,512,054
Financials	3,230,447	-	-	3,230,447
Technology	2,680,096	-	-	2,680,096
Utilities	1,968,485	-	-	1,968,485
Real estate	538,242	-	-	538,242
Corporate bonds	-	7,343,599	-	7,343,599
Municipal bonds	-	112,545	-	112,545
Mutual and exchange traded funds:				
Materials	2,460,530	-	-	2,460,530
Index funds	1,585,824	-	-	1,585,824
Fixed income	800,557			800,557
Industry funds	472,803	-	-	472,803
International	139,728	-	-	139,728
U.S. large cap	88,016	-	-	88,016
U.S. mid and small cap	53,977	-	-	53,977
U.S. treasury and government agencies	-	626	-	626
Self-insurance trust	3,554,247	-	-	3,554,247
Funds held in trust by others	-	-	19,644,506	19,644,506
Total	$ 41,077,325	$ 8,678,872	$ 19,644,506	$ 69,400,703

(Continued)

NOTE 5 - FAIR VALUE MEASUREMENTS (Continued)

A rollforward as of September 30, 2016 and 2015, of the amounts classified as Level 3 investments, within the fair value hierarchy is as follows:

	Funds Held in Trust by Others
Balance as of October 1, 2014	$ 17,889,422
Interest and dividends	414,231
Distributions	(547,525)
Net realized gains	173,157
Fees	(97,595)
Net unrealized gains	1,812,816
Balance as of September 30, 2016	19,644,506
Interest and dividends	344,236
Distributions	(522,317)
Net realized gains	(109,592)
Fees	(86,517)
Net unrealized gains	1,042,020
Balance as of September 30, 2016	$ 20,312,336

There were no transfers between fair value hierarchy Level 1, Level 2 and Level 3 for any invested assets recorded at fair value during 2016 and 2015. The valuation techniques used by the Hospital maximize the use of observable inputs and minimize the use of unobservable inputs.

The fair values of the Hospital's Level 2 and Level 3 investments are determined by management after considering prices received from third party pricing services.

As of September 30, 2016 and 2015, the Hospital's other financial instruments include cash and cash equivalents, accounts payable, accrued expenses, estimated settlements due to and from third-party payors and long-term debt. The carrying amounts reported in the balance sheets for these financial instruments approximate their fair value.

NOTE 6 - RESTRICTED ASSETS

The Hospital's endowment and other restricted assets consist of multiple funds established for a variety of purposes. The endowment and other restricted assets include both donor-restricted endowment funds and funds held in trust by others. As required by GAAP, net assets associated with endowment funds, are classified and reported based on the existence or absence of donor restrictions.

(Continued)

NOTE 6 - RESTRICTED ASSETS (Continued)

The Hospital has interpreted the relevant laws as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the Hospital during its annual budgeting process.

The Hospital considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the Hospital and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the Hospital; and (7) the investment policies of the Hospital.

The Hospital's endowment as of September 30, 2016 and 2015, was made up of investments restricted by donors of $24,064,717 and $23,396,887.

Changes in endowment for the year ended September 30, 2016, are as follows:

	Temporarily Restricted	Permanently Restricted	Total
Balance at beginning of year	$ -	$ 23,396,887	$ 23,396,887
Investment return:			
Investment income, net	1,171,871	-	1,171,871
Net change in market value	-	667,830	667,830
Appropriations	(1,171,871)	-	(1,171,871)
Balance at end of year	$ -	$ 24,064,717	$ 24,064,717

Changes in endowment for the year ended September 30, 2015, are as follows:

	Temporarily Restricted	Permanently Restricted	Total
Balance at beginning of year	$ -	$ 21,641,803	$ 21,641,803
Investment return:			
Investment income, net	476,901	-	476,901
Net change in market value	-	1,755,084	1,755,084
Appropriations	(476,901)	-	(476,901)
Balance at end of year	$ -	$ 23,396,887	$ 23,396,887

(Continued)

NOTE 6 - RESTRICTED ASSETS (Continued)

Funds with Deficiencies: From time to time, the fair value of assets associated with individual donor restricted endowment funds may fall below the level that the donor or relevant law requires the Hospital to retain as a fund of perpetual duration. In accordance with GAAP, deficiencies of this nature are reported in unrestricted net assets. As of September 30, 2016 and 2015, there were no funds that were below the level required by donor or law.

Return Objectives and Risk Parameters: The Hospital's investment and spending policies for endowment assets attempts to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets are invested in a manner that is intended to produce results that approximate the price and yield results of the S&P 500 index while assuming a moderate level of investment risk.

Strategies Employed for Achieving Objectives: To satisfy its long-term rate of return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Hospital targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints.

Spending Policy: During its annual budgeting process, the Hospital appropriates donor restricted endowment funds for expenditure in accordance with donor purpose and time restrictions. During the years ended September 30, 2016 and 2015 the Hospital appropriated $1,171,871 and $476,901, respectively, of temporary restricted funds for expenditure as donor restrictions on those funds were met.

Temporarily restricted net assets are available for the following purposes as of September 30, 2016 and 2015:

	2016	2015
Healthcare related services	$ 165,645	$ 335,364
Facility improvement	635,447	965,264
Purchases of equipment	513,000	513,000
Clinical educator	1,579,641	1,431,689
Total	$ 2,893,733	$ 3,245,317

Net assets released from donor restrictions by incurring expenses satisfying the restricted purposes or by occurrence of other events by donors as follows:

	2016	2015
Facility improvement	$ 518,401	$ 239,226
Clinical educator	69,519	55,933
Total	$ 587,920	$ 295,159

(Continued)

NOTE 6 - RESTRICTED ASSETS (Continued)

Endowment and other funds permanently restricted as of September 30, 2016 and 2015, consist of the following:

	2016	2015
Beneficial trusts	$ 20,312,336	$ 19,644,506
Held in perpetuity, income restricted for operations	3,752,381	3,752,381
Total	$ 24,064,717	$ 23,396,887

NOTE 7 - PROFESSIONAL AND GENERAL LIABILITY AND WORKERS' COMPENSATION INSURANCE

The Hospital self-insures the deductible amounts of the below coverages and all excess limits are covered by insurance policies purchased from commercial carriers. The Hospital's professional and general liability insurance limits are as follows:

Policy Year	Deductible Amounts Per Claim/ Aggregate	Excess Coverage Limits	Type of Coverage
Fiscal 1982-1984	$100,00/500,000	$ 10,000,000	Occurrence
Fiscal 1985	$250,000/750,000	$ 15,000,000	Occurrence
Fiscal 1986	$500,000/1,500,000	$ 15,000,000	Occurrence
Fiscal 1987-1988	$1,000,000/3,000,000	$ 20,000,000	GL Occurrence / PL Claims-made
Fiscal 1989-1990	$1,000,000/3,000,000	$ 25,000,000	GL Occurrence / PL Claims-made
Fiscal 1991-2001	$1,000,000/3,000,000	$ 30,000,000	GL Occurrence / PL Claims-made
Fiscal 2002	$1,000,000/3,000,000	$ 25,000,000	GL Occurrence / PL Claims-made
Fiscal 2003-2009	$1,000,000/3,000,000	$ 20,000,000	GL Occurrence / PL Claims-made
Fiscal 2010-2016	$1,000,000/4,000,000	$ 20,000,000	GL Occurrence / PL Claims-made

The Hospital's workers' compensation insurance limits are as follows:

Policy Year	Self-Insured Retention /Aggregate	Excess Coverage Limits	Type of Coverage
Fiscal 1993-2002	$300,000/1,000,000	Statutory	Occurrence
Fiscal 2003	$350,000/1,000,000	Statutory	Occurrence
Fiscal 2004-2012	$325,000/1,000,000	Statutory	Occurrence
Fiscal 2013-2016	$400,000/1,000,000	Statutory	Occurrence

(Continued)

NOTE 7 - PROFESSIONAL AND GENERAL LIABILITY AND WORKERS' COMPENSATION INSURANCE (Continued)

Professional, general liability and workers' compensation claims that fall within the Hospital's self-insurance levels have been asserted against the Hospital by various claimants. The claims are in various stages of activity and resolution. There are also known incidents that have occurred through September 30, 2016, that may result in the assertion of additional claims. Other claims may be asserted arising from services provided to patients or for other matters, for which no estimate of exposure can be determined at this time. The Hospital utilizes an independent actuary to estimate its self-insurance liability that reflects management's accrual of its best estimate of these self-insured losses under the policies described above, for occurrences through September 30, 2016.

The Hospital has established a trust for the purpose of setting aside assets for self-insurance purposes. Under the trust agreement, the trust assets can only be used for payment of professional and general liability losses, related expenses and the cost of administering the trust. The assets of, and contributions to the trust are reported in the accompanying financial statements. Income from trust assets and administrative costs are reported in the accompanying statements of operations and changes in net assets as other income.

Estimated self-insurance liabilities include estimates for claim obligations related to professional liability, general liability and workers' compensation claims. As of September 30, 2016 and 2015, the Hospital maintains a commercial policy for its employees' medical coverage. In fiscal years 2016 and 2015, management discounted accrued medical malpractice and workers' compensation losses at 3.00% and it is management's opinion that this provides for adequate loss contingencies.

NOTE 8 - LEASES

The Hospital has entered into non-cancellable operating and building rentals that expire in various years through fiscal year 2020 and beyond. Certain leases may be renewed at the end of their term.

The following is a schedule of future minimum lease payments under non-cancellable operating leases and building rentals as of September 30, 2016:

	Operating Leases	Building Rentals
For the year ended September 30:		
2017	$ 445,333	$ 1,140,605
2018	-	601,339
2019	-	445,727
2020	-	218,586
2021	-	219,908
Thereafter	-	670,620
Total minimum lease payments	$ 445,333	$ 3,296,785

Rental expense was $1,418,967 and $1,707,428 for the years ended September 30, 2016 and 2015, respectively and is included in "Services" on the statements of operations and changes in net assets..

(Continued)

NOTE 9 - PENSION PLAN

The Hospital has a noncontributory defined benefit pension plan (the Plan) that covers all eligible employees and provides for retirement, disability and optional survivor benefits. To participate in the Plan, an employee must meet certain eligibility requirements including attainment of age 21 and one-year of continuous service (defined as 1,000 hours of service in a 12-month period). The time period for employee benefits to become fully vested is five years of continuous service. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future. Effective January 1, 2011, the Hospital executed a "soft freeze" of the Plan allowing no new employees to participate. All employees that were currently enrolled in the Plan continued to vest and accrue benefits in line with Plan policies. Effective January 1, 2013, the Hospital executed a "hard freeze" of the Plan, freezing all vesting and accruing of benefits to employees enrolled in the Plan.

The Hospital's funding policy for the Plan is to contribute each year the amount as required by the Employee Retirement Income Security Act of 1974, as determined by actuarial valuations developed by the Plan's actuary. Such funding requirements have been met for fiscal years 2016 and 2015.

Significant disclosures relating to the Plan as of September 30, 2016 and 2015 are as follows:

	2016	2015
Change in benefit obligations:		
Benefit obligations at beginning of year	$ 125,603,363	$ 116,600,051
Interest cost	5,655,884	5,068,072
Actuarial loss	14,109,928	7,907,890
Benefits paid	(4,348,724)	(3,972,650)
Benefit obligations at end of year	$ 141,020,451	$ 125,603,363
Change in plan assets:		
Fair value of plan assets at beginning of year	$ 83,183,722	$ 85,014,863
Actual return on plan assets	7,495,799	(81,465)
Employer contributions	2,093,000	3,720,000
Expenses paid	(1,216,434)	(1,497,026)
Benefits paid	(4,348,724)	(3,972,650)
Fair value of plan assets at end of year	$ 87,207,363	$ 83,183,722
Accrued pension liability:		
Unfunded status and accrued pension liability	$ (53,813,088)	$ (42,419,641)

(Continued)

NOTE 9 - PENSION PLAN (Continued)

	2016	2015
Components of net periodic benefit cost:		
Service cost	$ 1,050,000	$ 850,000
Interest cost	5,655,884	5,068,072
Expected return on plan assets	(6,584,853)	(6,286,593)
Amortization of prior service cost	173,007	173,007
Recognized net loss	1,132,596	944,635
Net periodic benefit cost	$ 1,426,634	$ 749,121

Assumptions:

Weighted-average assumptions used to determine benefit obligations:	2016	2015
Discount rate	3.86%	4.58%
Rate of compensation increase	N/A	N/A
Weighted-average assumptions used to determine net periodic benefit cost:		
Discount rate	4.58%	4.42%
Rate of compensation increase	N/A	N/A
Expected long-term return on plan assets	7.75%	7.75%

The accumulated benefit obligation at September 30, 2016 and 2015, under the Hospital's Plan was $141,020,451 and $125,603,363, respectively.

The Hospital expects to contribute $1,500,000 to its pension plan for the fiscal year beginning October 1, 2016.

Amounts recorded in unrestricted net assets as of September 30, 2016 and 2015 not yet amortized as a component of net periodic benefit cost are as follows:

	2016	2015
Unamortized prior service costs	$ 4,364,972	$ 4,537,979
Unamortized actuarial loss	60,888,313	48,655,493
Total	$ 65,253,285	$ 53,193,472

The amortization of prior service costs expected to be recognized in net periodic benefit costs for the year ended September 30, 2017 is $173,007. The amortization of actuarial loss expected to be recognized in net periodic benefit costs for the year ended September 30, 2017 is $1,625,000.

The expected long-term rate of return assumption is determined by adding expected inflation to expected long-term real returns of various asset classes, taking into account expected volatility and the correlation between the returns of various asset classes.

(Continued)

NOTE 9 - PENSION PLAN (Continued)

The Hospital's target and actual pension plan weighted average asset allocations at September 30, 2016 by asset category was as follows:

Asset Category	Target Allocations	Actual Allocations
Equity securities	69%	65%
Debt securities	25%	30%
Short-term investments and other	6%	5%
Total	100%	100%

The asset mix was determined by evaluating the expected return against the Plan's long-term objectives. Performance is monitored on a monthly basis and the portfolio is rebalanced back to target levels to ensure the targets are within reasonable range. The investment policy describes which securities are allowed in the portfolios and the financial objectives of the Plan with which the Investment Committee of the Board of Governors oversees. The Investment Committee monitors the investment performance quarterly to determine the continued feasibility of achieving the investment objectives and the appropriateness of the investment policy.

The fair values of the Hospital's pension plan assets by asset category, are as follows, as of September 30, 2016:

	Level 1	Level 2	Level 3	Total
Common and preferred stocks	$ 44,562,469	$ -	$ -	$ 44,562,469
Exchange traded funds	12,525,095	-	-	12,525,095
Money market funds	5,306,562	-	-	5,306,562
Mutual funds	2,675,611	-	-	2,675,611
Unit investment trust	-	790,445	-	790,445
Corporate and foreign bonds	-	11,853,211	-	11,853,211
Certificates of deposit	-	6,805,529	-	6,805,529
U.S. treasury and government agencies		2,368,813	-	2,368,813
Municipal bonds	-	153,759	-	153,759
Other	-	165,869	-	165,869
Total	$ 65,069,737	$ 22,137,626	$ -	$ 87,207,363

(Continued)

NOTE 9 - PENSION PLAN (Continued)

The fair values of the Hospital's pension plan assets by asset category, are as follows, as of September 30, 2015:

	Level 1	Level 2	Level 3	Total
Common and preferred stocks	$ 40,652,066	$ -	$ -	$ 40,652,066
Exchange traded funds	18,675,024	-	-	18,675,024
Money market funds	4,244,356	-	-	
Mutual funds	2,690,104	-	-	2,690,104
Unit investment trust	-	615,690	-	615,690
Corporate and foreign bonds	-	12,948,982	-	12,948,982
Certificates of deposit	-	1,628,614	-	1,628,614
U.S. treasury and government agencies	-	1,173,896	-	1,173,896
Municipal bonds	-	359,240	-	359,240
Other	-	195,750	-	195,750
Total	$ 66,261,550	$ 16,922,172	$ -	$ 83,183,722

The valuation methods used to value these assets are described in Note 5.

The following are the benefit payments, which are expected to be paid in future years:

2017	$ 4,828,571
2018	5,187,000
2019	5,525,373
2020	5,859,675
2021	6,144,956
Years 2022-2025	35,658,796

The Hospital also has established a 403(b) plan covering all full-time and part-time employees of the Hospital. Participants may elect to contribute a specific percentage of their compensation in pre-tax deferrals subject to established Internal Revenue Code limitations. For the years ended September 30, 2016 and 2015, the Hospital contributed $611,317 and $966,910, respectively, to the 403(b) plan.

NOTE 10 - FUNCTIONAL EXPENSES

The Hospital provides general health care services to residents within its geographic location. Expenses related to providing these services for the years ended September 30, 2016 and 2015, are as follows:

	2016	2015
Patient care services	$ 108,268,606	$ 106,933,527
General and administrative	15,233,567	15,045,719
Total	$ 123,502,173	$ 121,979,246

(Continued)

NOTE 11 - LONG TERM DEBT AND LINES OF CREDIT

On February 1, 2016, the State of Connecticut Health and Educational Facilities Authority (CHEFA) issued $13,000,000 of Series D Bonds (the Series D Bonds or Bonds) on behalf of the Hospital. The Series D Bonds mature serially from 2016 through 2036. The interest rate on the Bonds initially bear interest at a fixed rate of 2.24% from issuance through and including December 31, 2025. On January 1, 2026, the interest rate on the Series D Bonds shall be adjusted to the Adjusted Federal Home Loan Bank (FHLB) Rate, such adjusted rate shall remain fixed and in effect until January 1, 2036. The Loan Agreement with CHEFA and the Trust Indenture for the Series D Bonds contain certain covenants that require the Hospital to maintain a debt service coverage ratio of at least 1.1 to 1 at each fiscal year end and to maintain a ratio of unrestricted and temporarily restricted net assets to long term debt of 1.0 to 1 or greater.

Below is a summary of the Hospital's annual principal payments due relating to CHEFA as of September 30, 2016:

2017	$ 650,000
2018	650,000
2019	650,000
2020	650,000
2021	650,000
Thereafter	9,425,000
Total	$ 12,675,000

Effective September 11, 2014 the Hospital secured a revolving line of credit loan up to $3,000,000 with Santander Bank, N.A.. As of September 30, 2016 and 2015, there were no outstanding borrowings against the line of credit.

NOTE 12 - COMMITMENTS AND CONTINGENCIES

The Hospital is party to various lawsuits incidental to its business. After consultation with legal counsel, management believes that the lawsuits and inquiries will not have a material adverse effect on the Hospital's financial position, results of operations or cash flows.

FASB ASC 410 *Asset Retirement and Environmental Obligations* addresses financial accounting and reporting for obligations associated with the retirement of tangible long-lived assets such as asbestos-containing facilities, when the amount of the liability can be reasonably estimated. Management currently believes that two facilities under their control could require a fair market value assessment of their Asset Retirement Obligation (ARO). As of September 30, 2016 and 2015, no ARO has been established, as no plans to renovate or sell any facility, or area within, with significant asbestos material have been identified and an estimate of the removal cannot be determined and therefore no settlement date has been determined. Management will continue to monitor its exposure for asbestos removal and establish an ARO for the fair market value of the associated costs once sufficient information has been obtained or a reasonable estimate can be made.

(Continued)

NOTE 13 - RISKS AND UNCERTAINTIES

Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statements of financial position.

In addition, the Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statements of financial position.

Exhibit 4 – Organizational Documents (Item #4)

Please provide copies of documents sufficient to describe the ownership, operational, contracting and clinical structure of your organization from 2012 to 2016.

Response:

Prepared at the request of Counsel, please find attached two Corporate Org Charts that represents our structure over the time period requested. Only recently was there a change which is reflected in the chart dated October 2016. Also attached are the organization's Bylaws, Deed, Articles of Incorporation, and our Functional Org Charts for each year requested by OHCA in their December 19th communication.

AN ACT INCORPORATING
THE CHARLOTTE HUNGERFORD
HOSPITAL

Be it enacted by the Senate and House of Representatives in General Assembly convened:

SEC. 1. Uri T. Hungerford of the city and state of New York, James A. Doughty, Robert C. Swayze, Luther G. Turner, Thomas W. Bryant, John Workman, F. F. Fuessenich, Charles F. Alvord and Willard A. Roraback, all of Torrington, Charles F. Brooker of Ansonia, Elisha J. Steele, Charles G. Agard, Frederick P. Weston and Edward H. Hotchkiss, all of Torrington, and John M. Wadhams of Goshen, John A. Coe, Jr., of Waterbury, William C. Hungerford of New Britain, Benjamin B. Phillips and Edmund Wall, Sr., both of Torrington, B. Austin Cheney of New Haven, Edward J. Kelley, John N. Rosenbeck, Frederick L. Braman and Frank J. Damon, all of Torrington, and their successors, selected in the manner hereinafter specified, are constituted a body politic and corporate, by the name of The Charlotte Hungerford Hospital and by that name may purchase, receive hold and convey any estate, real or personal, may have a common seal and alter the same, may make such bylaws, rules and regulations as may be necessary and may appoint such officers, agents, assistants and servants and define their powers and duties and determine their term of office or employment.

SEC. 2. The object of said corporation shall be to receive by conveyance from Uri T. Hungerford a certain estate situate within and near the westerly line of the borough of Torrington, as described in a deed from said Hungerford to said corporation, and to hold the same subject to all the terms, conditions, restrictions and provisions of said deed and for the purpose of carrying out the trust created by said deed, namely maintaining and supporting a hospital to be known as The Charlotte Hungerford Hospital. Said corporation is further authorized to receive any other property, real or personal, that may be transferred to it for the purpose of said corporation, and apply the same for that purpose as hereinafter directed.

SEC. 3. Said corporation is authorized in the administration of its trust to comply with the regulations, restrictions, and provisions in reference thereto contained in said deed of trust of said Uri Taylor Hungerford and with any regulations, restrictions or provisions which may be imposed by any other donor

in relation to the management or administration of any donations, provided the same shall not conflict with the provisions of said deed, with the provisions of this act or the laws of this state, and shall not be foreign to or inconsistent with the purposes of said organization.

SEC. 4. The number of corporators shall at no time be more than 40 nor less than 20 and vacancies shall be filled by a majority vote of the corporators at a meeting specially called for that purpose, provided no practicing physician shall be elected a corporator.

SEC. 5. All the property of said corporation which shall be actually used for the purposes of said hospital and from which it shall receive no revenue, including money at interest or investments the revenue from which shall be used for the benefit of said hospital, shall be free from taxation.

SEC. 6. The first meeting of said corporation shall be held on call of four of said corporators named in said deed, namely, James A. Doughty, Elisha J. Steele, Robert C. Swayze of Torrington and Charles F. Brooker of Ansonia, or any two of them, by written notice signed by them stating the time and place of the meeting, addressed to each of the corporators and either left at their usual places of abode or deposited in the post office at Torrington, at least five days before the date of said meeting. Ten corporators shall constitute a quorum at any meeting of said corporation, except at a special meeting called to elect a corporator.

Approved March 21, 1917
Section 4 amended February 20, 1991
Section 4 amended December 21, 2011

AN ACT INCORPORATING
THE CHARLOTTE HUNGERFORD
HOSPITAL

Be it enacted by the Senate and House of Representatives in General Assembly convened:

SEC. 1. Uri T. Hungerford of the city and state of New York, James A. Doughty, Robert C. Swayze, Luther G. Turner, Thomas W. Bryant, John Workman, F. F. Fuessenich, Charles F. Alvord and Willard A. Roraback, all of Torrington, Charles F. Brooker of Ansonia, Elisha J. Steele, Charles G. Agard, Frederick P. Weston and Edward H. Hotchkiss, all of Torrington, and John M. Wadhams of Goshen, John A. Coe, Jr., of Waterbury, William C. Hungerford of New Britain, Benjamin B. Phillips and Edmund Wall, Sr., both of Torrington, B. Austin Cheney of New Haven, Edward J. Kelley, John N. Rosenbeck, Frederick L. Braman and Frank J. Damon, all of Torrington, and their successors, selected in the manner hereinafter specified, are constituted a body politic and corporate, by the name of The Charlotte Hungerford Hospital and by that name may purchase, receive hold and convey any estate, real or personal, may have a common seal and alter the same, may make such bylaws, rules and regulations as may be necessary and may appoint such officers, agents, assistants and servants and define their powers and duties and determine their term of office or employment.

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in relation to the management or administration of any donations, provided the same shall not conflict with the provisions of said deed, with the provisions of this act or the laws of this state, and shall not be foreign to or inconsistent with the purposes of said organization.

SEC. 4. The number of corporators shall at no time be more than 40 nor less than 20 and vacancies shall be filled by a majority vote of the corporators at a meeting specially called for that purpose, provided no practicing physician shall be elected a corporator.

SEC. 5. All the property of said corporation which shall be actually used for the purposes of said hospital and from which it shall receive no revenue, including money at interest or investments the revenue from which shall be used for the benefit of said hospital, shall be free from taxation.

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Approved March 21, 1917
Section 4 amended February 20, 1991
Section 4 amended December 21, 2011

THE CHARLOTTE HUNGERFORD HOSPITAL

TORRINGTON, CONNECTICUT

BYLAWS

Revised December 2012

BYLAWS
OF
THE CHARLOTTE HUNGERFORD HOSPITAL

ARTICLE I

The purposes for which The Charlotte Hungerford Hospital (the "Hospital") is formed are set forth in its Certificate of Incorporation. The role of the Hospital shall be delineated in mission and vision statements which shall be reviewed from time to time as the Board of Governors deems appropriate.

ARTICLE II

MEMBERS AND MEETINGS OF THE CORPORATION

1. Membership. The hospital shall have no more than 40 nor less than 20 Corporators. The Corporators shall have the right to elect the Board of Governors of the Hospital and shall have all of the other rights, powers and privileges usually or by law accorded to the members of a nonstock, nonprofit hospital and not conferred thereby or by the bylaws upon the Board of Governors of the Hospital.

2. Annual Meetings. The annual meeting of the corporation shall be held at such time in the month of December and at such place in the City of Torrington as the Board of Governors shall appoint. The Chairman of the Board, President, or Secretary shall cause written notice of such meetings to be given to each corporator not less than seven days in advance. In addition to the annual meeting, two regular meetings of the Corporation shall be held each year. The times and places of such meetings shall be designated by the officer entitled to preside thereat, except that such meetings will be held in the months of April and August.

3. Special Meetings. Special meetings of the corporation may be called at any time by the Board of Governors or any three corporators. Notice of any such meeting, stating the purpose thereof, shall be given by the Chairman of the Board, President or Secretary in the same manner as is provided for annual meetings.

ARTICLE III

BOARD OF GOVERNORS

1. Composition and Election. The Board of Governors shall consist of no less than fifteen (15) nor more than eighteen (18) members, one of whom shall be the executive director, ex officio, and at least one of whom shall be a physician on the staff of the Hospital. The corporators, at the annual meeting, shall fix the number of governors and shall elect by three quarters of all corporators present, a sufficient number of

governors to comply with at least the minimum composition of the Board. Each governor shall serve for a term of two (2) years or until his or her successor is duly elected and qualified. Members of the Board may but need not be corporators. The Board of Governors may fill any vacancy arising in its own body for any unexpired term.

2. Qualifications. All Governors shall be selected for their ability to participate effectively in fulfilling the Board of Governors responsibilities and the role and purpose of the Hospital. Governors shall have such other qualifications as the Corporators and the Board of Governors may deem appropriate to assure that the Board of Governors represents a broad range of community interests.

3. Powers and Authority. The administrative powers of the Hospital shall be vested in the Board of Governors, which shall have charge, control, and management of the property, affairs, and management of the property, affairs, and funds of the Hospital, and which shall have the power and authority to do and perform all acts and functions not inconsistent with these Bylaws.

4. Conflict of Interest. All Governors shall avoid conflict of interest between personal/professional interests and Board responsibilities. Any duality of interest or possible conflict of interest on the part of any governing Board member must be disclosed to other members of the Board and made a matter of record, either through an annual procedure or when the interest becomes a matter of Board action.

5. Appointive Power, Executive Director. The Board of Governors shall appoint an Executive Director of the Hospital whose basic function is to provide leadership and overall direction and administration of the operations of the Hospital, and to interpret and apply the policies of the Board of Governors, and to recommend any new policies as needed, and further, to guide and develop long-range planning, and evaluate activities in terms of objectives.

His responsibilities are to:

Direct and generally supervise all Hospital activities. Prepare short and long-range objectives and recommend their adoption to the Board. Prepare plans and programs for attainment of approved objectives. Coordinate the activities of all departments.

See that adequate organization plans, procedures and controls are employed by each department to make possible the proper execution of their responsibilities and attainment of their goals.

Direct selection, employment, control and discharge of all employees.

Develop and maintain personnel policies and practices for the Hospital.

Delegate portions of these responsibilities and authority when necessary, but may not delegate overall responsibility for results nor any portion of his accountability.

Submit annual accomplishment objectives, the annual budget and proposed capital and extraordinary expenditure programs to the Board for approval, making appropriate recommendations. Report financial status and progress on programs to the Board.

Perform all duties within limits of the policies of the Board.

Refer to the Board all matters of major importance to the Hospital's progress and well being, for the purpose of securing authorization, or decision.

Assure that the Hospital complies with Hospital guidelines, rules and regulations and with governmental and voluntary codes and standards.

Maintain an intimate working relationship with the Medical Staff particularly with the President and Executive Committee. Act as liaison between the Medical Staff and the Board, attending Staff meetings, reporting and explaining Board actions and activities, coordinating Hospital departments with staff needs, and keeping the Board advised of the Medical Staff's activities and problems. Receive applications to the Medical Staff and enforce disciplinary policies set forth in the Board, or in the Medical Staff bylaws, on such questions as the maintenance of medical records, etc.

Act as liaison between the Board of Governors and the Hospital Auxiliary.

6. Regular Meetings. The annual meeting of the Board of Governors shall be held following the annual meeting of the corporation or at such other convenient time as may from time to time be designated by the officer entitled to preside at such meeting. In addition to the annual meeting, five regular meetings of the Board of Governors shall be held each year. The times and places of such meetings shall be designated by the officer entitled to preside thereat, except that such meetings shall be held in the months of February, April, June, August and October.

7. Notice. Notice of the time and place of the annual meeting of the Board of Governors may be announced at the annual meeting of the corporation, or may be given in the manner provided for regular meetings. The Secretary shall give a notice of the time and place of every regular meeting of the Board of Governors by mailing such notice to each member of the Board in sufficient time for delivery in the ordinary course of post at his last known address, or by oral notice, at least twenty-four hours in advance of such meeting.

8. Special Meetings. Special meetings of the Board of Governors may be called at any time by the Chairman of the Board, and such meetings shall be called by him on the written request of any five members of the Board stating the purpose of the meeting requested. Notice of the time and place of every special meeting, stating the purpose

9. Quorum. Nine members of the Board of Governors shall constitute a quorum for all business.

10. Chairman of the Board. The Board of Governors may elect a Chairman of the Board, who shall serve at its pleasure and preside at all meetings of the Board at which he is present.

11. Attendance at Meetings. Board members are expected to attend at least two-thirds of the meetings of the Board of Governors, unless excused for good cause by the President or Chairman of the Board. Failure to attend the requisite number of meetings, unless so excused, shall be deemed a resignation from the Board.

ARTICLE IV

COMMITTEES

1. Creation and Election. There shall be an Executive Committee, a Health Care Planning Committee, a Patient Care Conference Committee, a Community Relations Committee, a Finance Committee, a Human Resources Committee, a Nominating Committee, and such additional committees of the Board of Governors with such powers and duties as the Board may from time to time direct. Members of committees shall, except as otherwise provided, be elected at the annual meeting of the Board, or at any other meeting called for the purpose and shall serve for a term of one year at the pleasure of the Board and until their successors are elected.

2. Executive Committee. The Executive Committee shall consist of the Chairman, all other officers of the corporation, except salaried employees, and the chairmen of the Health Care Planning, Patient Care Conference, Community Relations, Building, if then in existence, Finance and Human Resources Committees. The Board of Governors shall designate a Chairman and a Vice Chairman of the Committee from the members of the Executive Committee. Except as otherwise expressly provided in these bylaws or any amendment thereto, the Executive Committee shall exercise all the powers of the Board of Governors in the intervals between meetings of the Board, shall be responsible to the Board and shall report all of its doings to the Board as requested, and may appoint such committees, officers and agents as it shall consider advisable for the efficient operation of the corporation's affairs. The Chairman of the Executive Committee, in case of the absence of any member from a meeting of that committee, may designate another member of the Board of Governors to attend in lieu of such absent member and any person so designated shall be entitled to vote on all questions arising at such meeting.

3. Finance Committee. The Finance Committee shall consist of the number of Governors as may from time to time be established by the Board of Governors. The Committee shall carry out the Board of Governors' responsibility to insure the financial integrity of the Hospital by determining that its present and future programs are within its present and future financial capabilities. The Committee shall (i) review, challenge and recommend annually operating and capital budgets which are in conformity with the Hospital's long range plan developed by the Health Care Planning Committee; (ii) manage the several funds of the Hospital; (iii) advise the Health Care Planning and Community Relations Committees of the financial needs of the Hospital and the recommended approach to obtaining the needed financial resources; (iv) ensure the development and implementation of a cost containment program which has the participation of Hospital administration and medical staff, (v) review quarterly the performance of the Hospital's investment managers, (vi) serve as the Hospital's Audit Committee, meeting at least annually with the Hospital's auditor to review the Hospital's financial performance, including the annual Management letter, and (vii) review at least quarterly, the Hospital's Compliance Program as reported by the Hospital's Compliance Officer and Compliance Committee.

4. Patient Care Conference Committee. The Patient Care Conference Committee shall consist of the Executive Director, with vote, together with equal numbers of representatives of the Board of Governors and the Medical Staff. Representatives of the Board of Governors shall be appointed to this Committee as herein provided; representatives of the Medical Staff shall be appointed in accordance with the bylaws of the Medical Staff. It is the responsibility of this committee to monitor and evaluate all aspects of quality assurance and report such information to the Board of Governors in order to ensure that all aspects of professional and administrative performance result in high quality patient care. The Committee shall:

i) review and recommend appointments and reappointments to the Medical Staff,

ii) monitor all patient care evaluation, utilization review and malpractice claim activity,

iii) obtain and evaluate information on patient attitudes,

iv) monitor the implementation of standards as set forth by appropriate professional and regulatory bodies, and

v) in the interest of better patient care, promote effective and constructive dialogue among the Board of Governors, Administration, and the Medical Staff.

5. Human Resources Committee. The Human Resources Committee shall consist of the number of Governors as may from time to time be established by the Board of Governors. The duties of this Committee shall be to develop and maintain personnel standards with regard to qualifications, position classification, salary ranges and benefits,

and personnel practices. To implement these duties, the Committee shall review and advise the Board in the following areas:

i) Professional development and recruitment.

ii) Staffing patterns.

iii) Position classification.

iv) Salary plan. This involves the recommendation of a salary and benefits structure for all employees other than top management employees and staff physicians related to the position classification that will attract and retain the needed staff, compensate them adequately and provide rewards for continued efforts and increased competence. It calls for annual review of such salary and benefit ranges to be recommended to the Finance Committee for action.

v) Continuing improvements in communication and employee relations.

The Committee shall complete and present annually to the Board of Governors an annual report covering Human Resource projects and annual goals.

6. Health Care Planning Committee. The Health Care Planning Committee shall consist of the number of members as may from time to time be established by the Board of Governors. The Committee shall include representatives of the administrative and Medical Staff. The Committee shall carry out the Board of Governors' responsibility for the preparation and periodic revision of a five year plan that supports the delivery of the most efficient, high quality patient care programs which are consistent with defined community needs. The Committee shall:

i) prepare for Board review and approval a long range plan that sets forth patient care programs developed from an evaluation of community needs and availability of financial resources. This plan will consider, among other things, the physical facilities needed, medical and support staff required as well as the capital funds and operating expenses needed to support the plan,

ii) prepare a three-year capital expenditure plan,

iii) prepare an annual update/revision of the Hospital's plans,

iv) meet with staff representatives of the Office of Health Care Access to (a) understand this regulatory agency's plan for the region's health care delivery system, and (b) communicate to this agency the health care needs of the Hospital's service area and the Hospital's plans to respond to these needs,

v) communicate with the Community Relations Committee to obtain information on this Committee's work relative to the health care needs of the community, and

vi) communicate with the Finance Committee to obtain information on the Hospital's financial limitations.

7. The Community Relations Committee (hereinafter "Committee") shall consist of the number of members as may from time to time be established by the Board of Governors, and shall include Governors, and may include representatives of the Medical Staff and Administrative Staff, as well as members from the community. The Committee Chair, which shall be appointed by the Board of Governors, shall be a current member of the Board of Governors.

The Committee shall carry out the Board of Governors' responsibility for establishing ongoing communication with the community in order to identify community health care needs, make recommendations to the Board of Governors for responses to those needs, and spread a deeper understanding within the community of the Hospital's mission, strategic plans, and resources.

More specifically, the functions of the Committee, subject to Board oversight, shall include:

i) Planning and supporting a strategic communications plan that fosters a positive community image of Charlotte Hungerford Hospital through a wide array of strategies;

ii) Planning and supporting the creation of community and public/private partnerships and community benefit programming for the service area based on real and perceived health care needs;

iii) Maintaining communication with the Hospital's Auxiliary;

iv) Planning and support a variety of outreach efforts aimed at patients, physicians, employees, volunteers, area elected officials, media, and the business and nonprofit community; and

v) Planning and supporting a marketing plan that promotes awareness of the Hospital's existing and planned programs and services through news releases, radio, public service announcements, talks, branding, new media, and other means.

Duties shall include:

i) Meet at least bi-monthly;

ii) Annually submit objectives as part of its planning process;

iii) Annually evaluate progress made in achieving these objectives and report the same to the Board;

iv) Routinely report to the Board on the status of activities related to the above functions; and

v) Develop necessary procedures and routines to accomplish these duties.

8. The Nominating Committee shall consist of four members. Three members, who shall be Governors, shall be appointed by the Chairman of the Board annually. One member, who shall be a Corporator who is not a Governor, shall be elected by the Corporators at the Annual Meeting of the Corporation. The Committee shall:

i) prepare a slate of candidates for nomination as Corporators of The Charlotte Hungerford Hospital to present at the Annual Meeting of the Corporation.

ii) prepare a slate of candidates for nomination as Board members of The Charlotte Hungerford Hospital to present at the Annual Meeting of the Corporation.

iii) prepare a slate of candidates for nomination as officers of the Board of Governors and Chairmen of the Board committees to present at the Annual Meeting of the Board of Governors.

iv) communicate with the Community Relations Committee to obtain the names of potential Board members and members of the Corporators which the Community Relations Committee has identified.

9. Building Committee. The Building Committee shall consist of the number of members as may from time to be established by the Board of Governors. The Committee shall include representatives of the Administrative Staff and the Board. The Committee shall carry out the Board of Governors' responsibility for overseeing Senior Management's activities related to all major new construction and existing facility renovation projects, including the architectural services, cost estimating services, engineering services, construction services, and construction administration services.

i) The Building Committee will review and evaluate the Administration's facility renovation and new construction project recommendations stemming from either the Health Care Planning Committee's strategic plan review process, or from the Administration's annual business plan and supporting capital budget process.

ii) The Building Committee will charge the Hospital's Administration with the responsibility of enforcing the Hospital's Competitive Bid Policy for selecting architects, designers, engineers and builders.

iii) Final project recommendations will be presented by the Administration to the Building Committee for review and approval, before being brought to the Finance Committee and the full Board.

10. Meetings. The Health Care Planning Committee, the Patient Care Conference Committee, the Community Relations Committee, the Finance Committee and the Human Resources Committee shall all meet at least six times a year on a bimonthly basis. The Nominating Committee shall meet at least once a year. The Executive Committee shall meet upon the call of the Chairman or Vice Chairman of the Corporation. Meetings of committees may be called by the Chairman or Vice Chairman of the corporation or by the Chairman of the Committee.

11. Attendance at Meetings. Members of a committee are expected to attend at least two-thirds of the meetings of that committee unless excused for good cause by the President, Chairman of the Board, or Chairman of the Committee. Failure to attend the requisite number of committee meetings unless so excused shall be deemed a resignation from the committee.

12. The committees of the Board of Governors shall include, but not be limited to, the Finance Committee, Patient Care Conference Committee, Human Resource Committee, Health Care Planning Committee, Community Relations Committee, Executive Committee, Building Committee, Bylaw Committee and Nominating Committee.

Said committees shall be established pursuant to Hospital Bylaws and conducted in a manner consistent with the Connecticut Peer review Statute, CGS Sec. 19a-17b when the responsibility of the members of these committees address issues focused on improving the quality of healthcare, reducing morbidity and mortality, or attempting to keep healthcare costs within reasonable bounds. Portions of committee proceedings dealing with these issues shall be conducted in accordance with the Peer Review Statute and such confidentiality shall be invoked by the committee members as part of their administrative responsibilities.

ARTICLE V

OFFICERS

1. Appointment. The Board of Governors shall annually appoint a President, one or more Vice Presidents, a Secretary and a Treasurer, and may also appoint a Chairman of the Board, one or more Vice Chairmen of the Board and such other officer as it may deem appropriate. Officers may, but need not be, governors. If the President, or Chairman of the Board, or Vice Chairman is not already a member of the Board of Governors, he shall be ex officio a member for the duration of the term of his office or offices.

2. Duties. The Chairman of the Board, if there be one, otherwise the President or his designate shall represent the Corporation at official ceremonies and functions, shall preside at all meetings of the Board of Governors, and except as the Corporators may otherwise direct, shall also preside at all meetings of the Corporation. In the absence of the Chairman or the President or upon his inability to act in any matter, his powers shall inhere in, and his duties shall be performed by any of the Vice Chairmen. The office of

Treasurer may be held by either an individual or a Corporation. Subject to the direction of the Board of Governors and the Finance Committee, the Treasurer shall supervise and conduct the financial matters of the corporation in accordance with sound business and accounting practice. The Secretary shall act as clerk at meetings of the corporation and Board of Governors and keep records of all their votes and minutes of all their proceedings. He shall keep the seal of the corporation. The Secretary or Treasurer may attest the seal of the corporation whenever it may be affixed to any document. The Executive Director of the Hospital shall hold office at the pleasure of the Board of

3. General Authority. The officers shall have such other and further powers and duties as the Board of Governors shall from time to time direct.

ARTICLE VI

MEDICAL STAFF

1. All physicians, surgeons, oral surgeons, and podiatrists granted clinical privileges in the Hospital shall constitute the Medical Staff. The Staff shall adopt bylaws for its operation and governance, which, together with any amendments thereto, shall be approved by the governing board, which approval shall not be unreasonably withheld. The bylaws shall provide, inter alia, for appropriate officers and committees of the Staff; for the qualification of members thereof; for procedures of appointment, reappointment, and termination of services, and the delineation, granting, curtailing, suspension and denial of clinical privileges, including a mechanism for review of decisions, including the right to be heard at each step of the process when requested by the staff member.

2. The Board of Governors may appoint such numbers of physicians, surgeons, oral surgeons and podiatrists to the Medical Staff as may be advisable to staff and operate the medical staff departments. The Board shall consider recommendations of the Medical Staff for appointment. All appointees shall meet the qualifications of the bylaws of the Staff. Appointments and reappointments and the granting of and denial of privileges shall be made in accordance with the provisions of the Staff bylaws. Each member of the Medical Staff shall observe all the ethical principles of his profession. Only a member of the Medical Staff shall admit a patient to the Hospital, and only a licensed practitioner with clinical privileges shall be directly responsible for the patient's diagnosis and treatment within the area of his privileges.

3. Subject to the overall direction of the Board of Governors, the Medical Staff shall ensure appropriate professional care to the Hospital's patients. The Staff shall conduct an ongoing review and appraisal of the quality of professional care rendered in the Hospital and shall regularly report such activities and their results to the Governing Board.

4. Any member of the Medical Staff aggrieved by a decision of the Executive Committee of the Medical Staff relating to clinical privileges shall have a right to appeal to

the Board of Governors, which appeal may be heard by a subcommittee of the Board of Governors consisting of not less than five members.

The hearing shall be conducted in accord with the procedures established by the Medical Staff bylaws within two weeks of the appeal, and the Board or subcommittee thereof shall render its decision within two weeks of the time of completion of the hearing.

In the event that the decision of the Board or subcommittee of the Board, as the case may be, is contrary to the decision of the Executive Committee of the Medical Staff, there shall be a review of the matter by a joint meeting of the Executive Committee of the Medical Staff and the Board, or the subcommittee of the Board considering the matter, prior to a final decision by the Board, or by a subcommittee of the Board, as the case may be.

5. Physicians employed by the Hospital shall be appointed and terminated in accordance with the personnel policies and practices prevailing at the time where applicable and/or the terms of their contracts or other conditions of employment.

All physicians employed by the Hospital whose functions, duties and responsibilities include the exercise of clinical skills and judgment and/or the direct supervision of professional activities of members of the Medical Staff subject to his direction, shall be members of the Medical Staff. If a physician's membership on the Medical Staff is terminated, his employment by the Hospital in any capacity involving such clinical skills, judgment or supervision shall be automatically terminated.

If the grounds, or one of the grounds, for termination of employment of a physician involves lack of, or failure to use clinical skills, judgment and/or supervision, termination of employment shall be made in accordance with the provisions of the Medical Staff Bylaws regarding suspension or revocation of staff membership. Termination of employment after hearing and appeal as therein provided may, but need not, result in revocation of Medical Staff membership.

6. The Medical Staff membership may be called upon to act in an administrative role while serving on one or more of the administrative committees and/or Medical Staff standing committees. These committees shall include but not be limited to the following: the Finance Committee, Patient Care Conference Committee, Human Resource Committee, Health Care Planning Committee, Community Relations Committee Executive Committee, Building Committee, Bylaw Committee, Nominating Committee, Critical Care Committee, and Infection Control Committee.

Said committees shall be established pursuant to Hospital Bylaws and conducted in a manner consistent with the Connecticut Peer Review Statute, CGS Sec. 19a-17b when the responsibility of the members of these committees address issues focused on improving the quality of healthcare, reducing morbidity and mortality, or attempting to keep healthcare costs within reasonable bounds. Portions of committee proceedings dealing with these issues shall be conducted in accordance with the Peer Review Statute and

such confidentiality shall be invoked by the committee members as part of their administrative responsibilities.

ARTICLE VII

MISCELLANEOUS

1. Salaries and Compensation. No member of the Board of Governors, nor any officer, member or employee of the corporation, shall receive any pecuniary profit from its operations except reasonable compensation for services in effecting one or more of its corporate purposes.

2. Fiscal Year. The fiscal year of the corporation shall end at the close of business on the 30th day of September in each year.

3. Surety Bonds. The Board of Governors may require the Treasurer, Assistant Treasurers and any other officers, agents or employees to give bond in such forms and amounts as it may determine, and may designate the custodian of such bonds.

4. Savings Provisions. All actions heretofore taken and all appointments heretofore made under any bylaw in effect at the adoption of these bylaws are hereby ratified and confirmed.

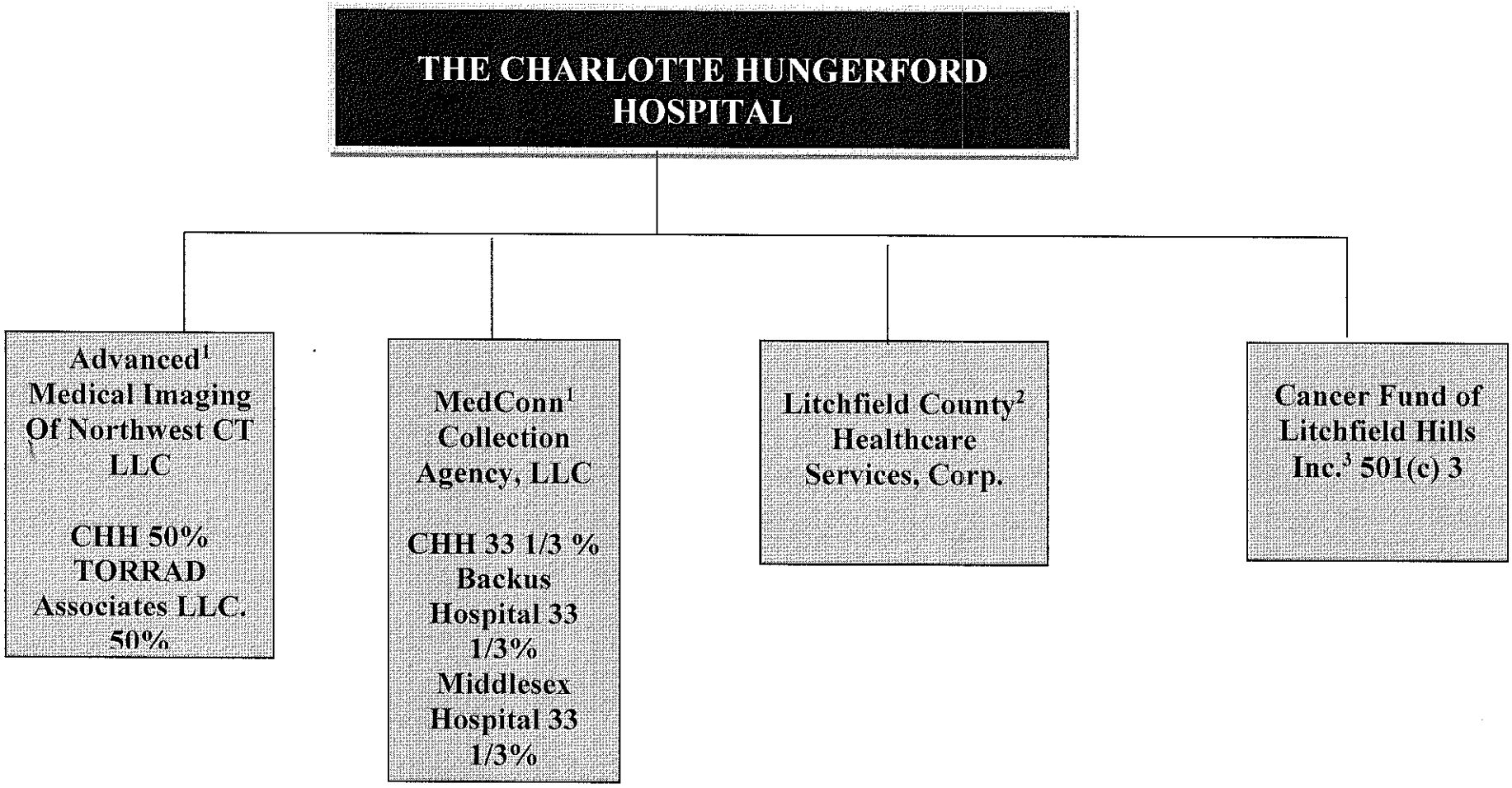
5. Amendments. These bylaws may be amended or repealed from time to time, and new bylaws may be added hereto, by the vote of two-thirds of the members who are present at any meeting of the Board of Governors warned and held for the purpose, but no such amendment enlarging or impairing the powers of the Board of Governors or changing its composition or the tenure or method of electing its members or the qualifications for membership on the Board shall be valid unless it shall be approved by vote of a majority of Corporators present at a meeting of the corporation warned and held for the purpose. The bylaws shall be reviewed by the Board of Governors at least every two years.

ARTICLE VIII

AUXILIARY

1. There shall be an auxiliary to be organized and governed according to the rules approved by the Board of Governors.

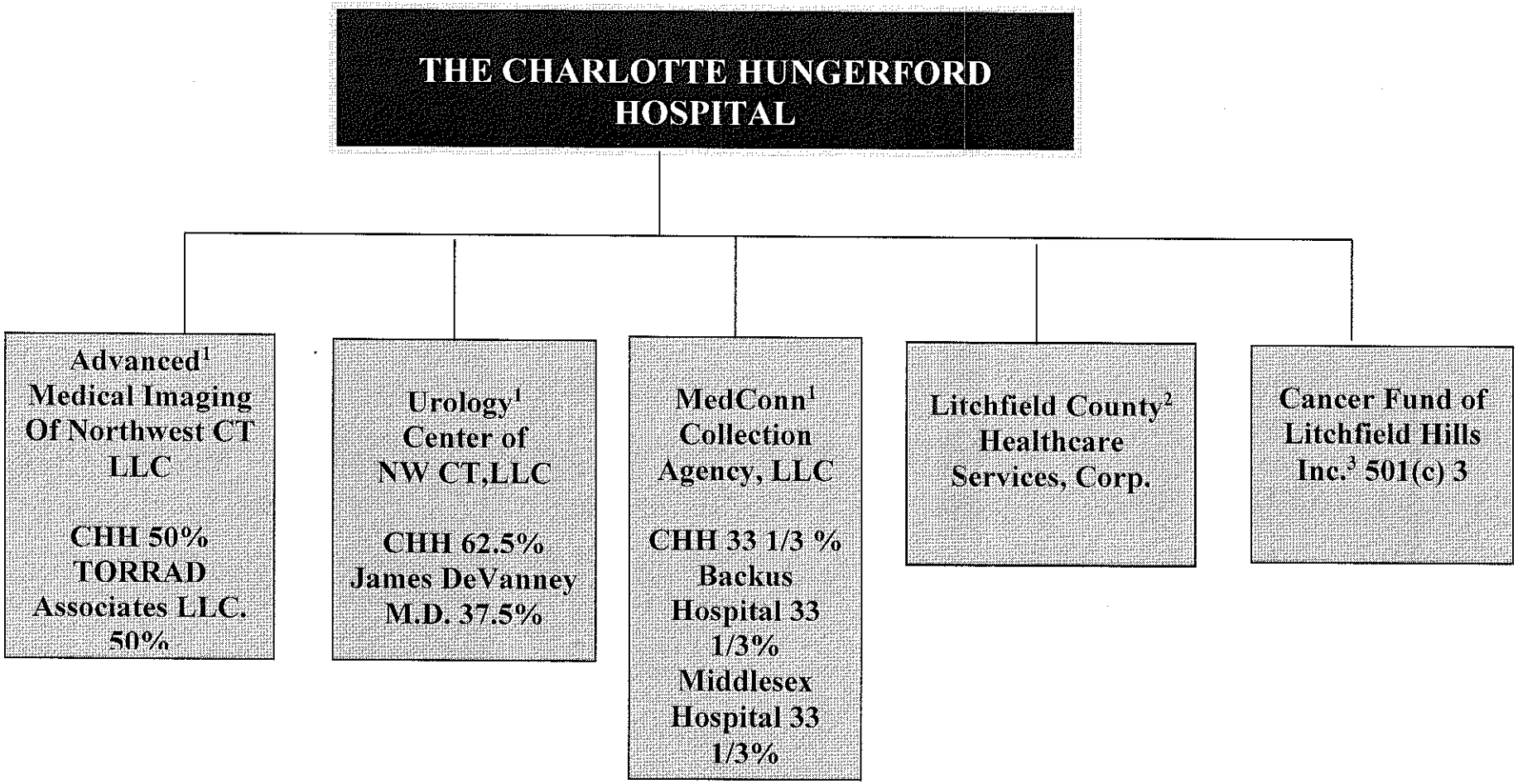
October 2016



FOOTNOTES:

1 - For Profit Entity
2 - For Profit Entity, Presently Inactive
3 - A 501 (c) 3

FY 2012 - September 2016



FOOTNOTES:

1 - For Profit Entity
2 - For Profit Entity, Presently Inactive
3 - A 501 (c) 3

Manuscript No. 101

Discharge of Lien

City of Torrington
to
Frank Craig

THIS CERTIFICATE witnesseth that the Lien heretofore claimed by the City of Torrington, Connecticut, upon the premises owned in whole or in part by Frank Craig Bunham St. which said Lien is dated December 16 1926, and is recorded in Torrington Land Records vol. 101 page 85 is hereby released and discharged, having been fully satisfied.

IN WITNESS WHEREOF, I have hereunto set my hand at said City, this 15th day of July, A.D. 1927.

John N Brooke Treasurer.
Of the City of Torrington.

Received July 19, 1927 at 2:50 P.M. and recorded by

17201

Mary M Carroll Asst Town Clerk.

Deed

Uri Taylor Hungerford
to
The Charlotte Hungerford Hospital

THIS INDENTURE, made this 28th day of May, 1917, by and between Uri Taylor Hungerford, of the city, county and State of New York, party of the first part, hereinafter designated as the grantor, and The Charlotte Hungerford Hospital, a corporation chartered by the State of Connecticut, and located in the Town of Torrington, County of Litchfield, and State of Connecticut, hereinafter designated as the grantee,

WITNESSETH:

WHEREAS the grantor is the owner of a certain tract of land comprising about one hundred and twenty (120) acres, situated in the town and borough of Torrington, County of Litchfield, and State of Connecticut, hereinafter described, on which he has caused to be erected buildings designated, adapted and equipped to be used for the purpose of a hospital, and

WHEREAS the grantor desires to establish a general hospital, to be located in said town of Torrington as a memorial to his mother, Charlotte Austin Hungerford, deceased, and with that object in view purposes to dedicate the aforesaid premises to that public and charitable use; and

WHEREAS said corporation has been formed for the purpose of carrying into effect the benevolent and charitable plans and purposes of the grantor,

NOW THEREFORE, the grantor, in consideration of the premises, does give, grant, bargain, sell and confirm unto the said The Charlotte Hungerford Hospital two certain pieces or parcels of land, situated in the town of Torrington, partly in the Borough of Torrington, and bounded and described as follows, to wit;

The first piece contains one hundred and nineteen (119) acres, more or less, with all buildings standing thereon, and is bounded Northerly by Roosevelt Avenue, Easterly by land now or formerly of Adelbert F. Hine and lands now or formerly of Frank Ducety, Joseph Paasch, Anton Garbin, Charles Boudet, Adele Zale, Joseph Zale, Felice Carri, James L. Farley, William E. Noonan, Daniel Noonan, and perhaps others, Southerly by land now or formerly of James L. Farley and by public highway known as the Old Litchfield Road, and in part by land now or formerly of Elson A. Bierce, and Westerly by land now or formerly of said Elson A. Bierce.

The above premises are subject to the rights of James A. Doughty for taking water from pipes and spring located on the eastern side of said above described land, and a right of way of William E. Noonan over a strip of land thirty (30) feet wide at the southeasterly corner of said land.

See Torrington Land Records, volume 55, pages 519 and 622 respectively.

The second piece is bounded Northerly by said public highway, Old Litchfield Street, one hundred and fifty (150) feet, Easterly by land of Daniel E. Noonan, one hundred and fifty (150) feet, Southerly by land of Albert F. Brooker, one hundred and fifty (150) feet, and Westerly by land of said Albert F. Brooker, one hundred and fifty (150) feet.

Both of the above described pieces are the same conveyed to the grantor herein by Charles F. Brooker, et als. by deed dated September 11, 1916, and recorded in Torrington Land Records, Volume 71, page 464, except that the first piece has been slightly altered on the northern boundary by two certain conveyances, one from Uri T. Hungerford to Edward J. Burns, dated May , 1917, and one from Edward J. Burns to Uri T. Hungerford, dated May , 1917.

TO HAVE AND TO HOLD the above granted and bargained premises, with the appurtenances thereof, unto said The Charlotte Hungerford Hospital, in trust, however, for the following uses and purposes, that is to say:

1. Said premises are to be held and used by said grantee for the purpose of maintaining and carrying on a general hospital, and if a majority of corporators so elect, a training school for nurses in connection therewith may be established, and for no other purpose whatsoever.

2. The number of corporators shall at no time be more than twenty-five, nor less than nineteen, and vacancies caused by the death or resignation or otherwise of any corporator shall be filled by a majority vote of the corporation at a meeting specially called for that purpose, provided that at all times a majority of said corporators shall be residents of said town of Torrington, and provided, further, that no practicing physician residing in said town of Torrington shall be a corporator, and provided, further, that in filling all vacancies, the election of a new corporator shall be so made that not more than eight corporators shall belong to the same religious denomination.

3. No patient shall be debarred from said hospital on account of race, nationality, or religious belief.

4. Any and all gifts, bequests, and devises made to or for the benefit of said hospital by any person or persons other than the grantor may be taken and accepted by the said grantee and devoted by it under the name and to the purposes specified or directed by the donor or testator, and in the absence of directions, then to the general purposes of said hospital.

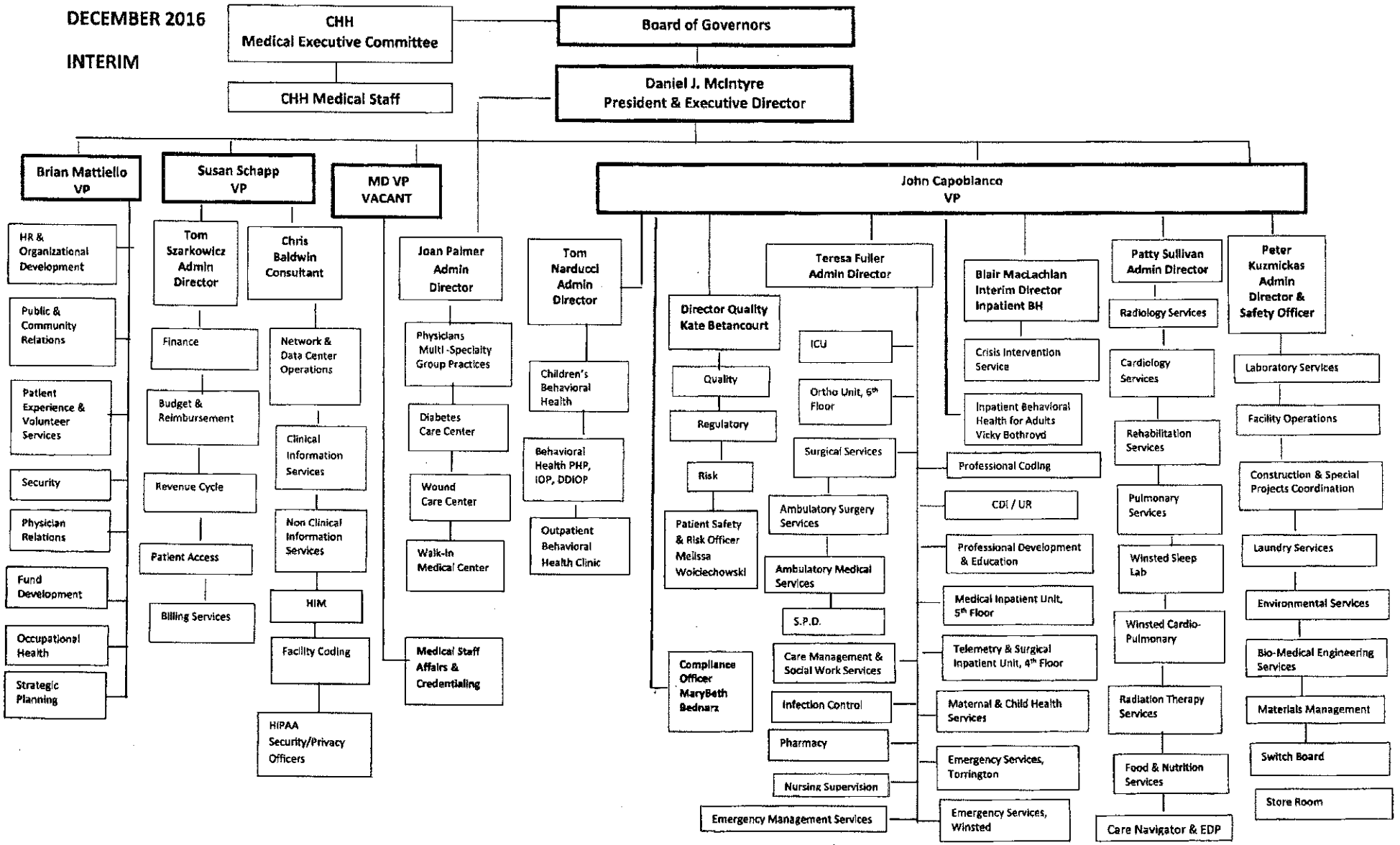
5. The estate hereby granted is upon the express condition that the name of said corporation shall not be changed from The Charlotte Hungerford Hospital and that the land herein conveyed shall be used and devoted to the purposes herein described and to no other purpose whatever, and if at any time the name of said corporation should be changed or if the land herein granted shall cease to be used for the purposes aforesaid, or if said corporation should attempt to sell and convey said land or any of it, then and in either of these events the estate herein granted to said corporation shall thereupon cease and determine and the title to the herein granted premises shall thereupon pass to and vest in the said Town of Torrington, never to be sold or leased by it, but to be used forever for a public park under the name of "Charlotte Hungerford Memorial Park".

IN WITNESS WHEREOF the said grantor, Uri Taylor Hungerford, has hereunto set his hand and seal this 28th day of May, 1917.

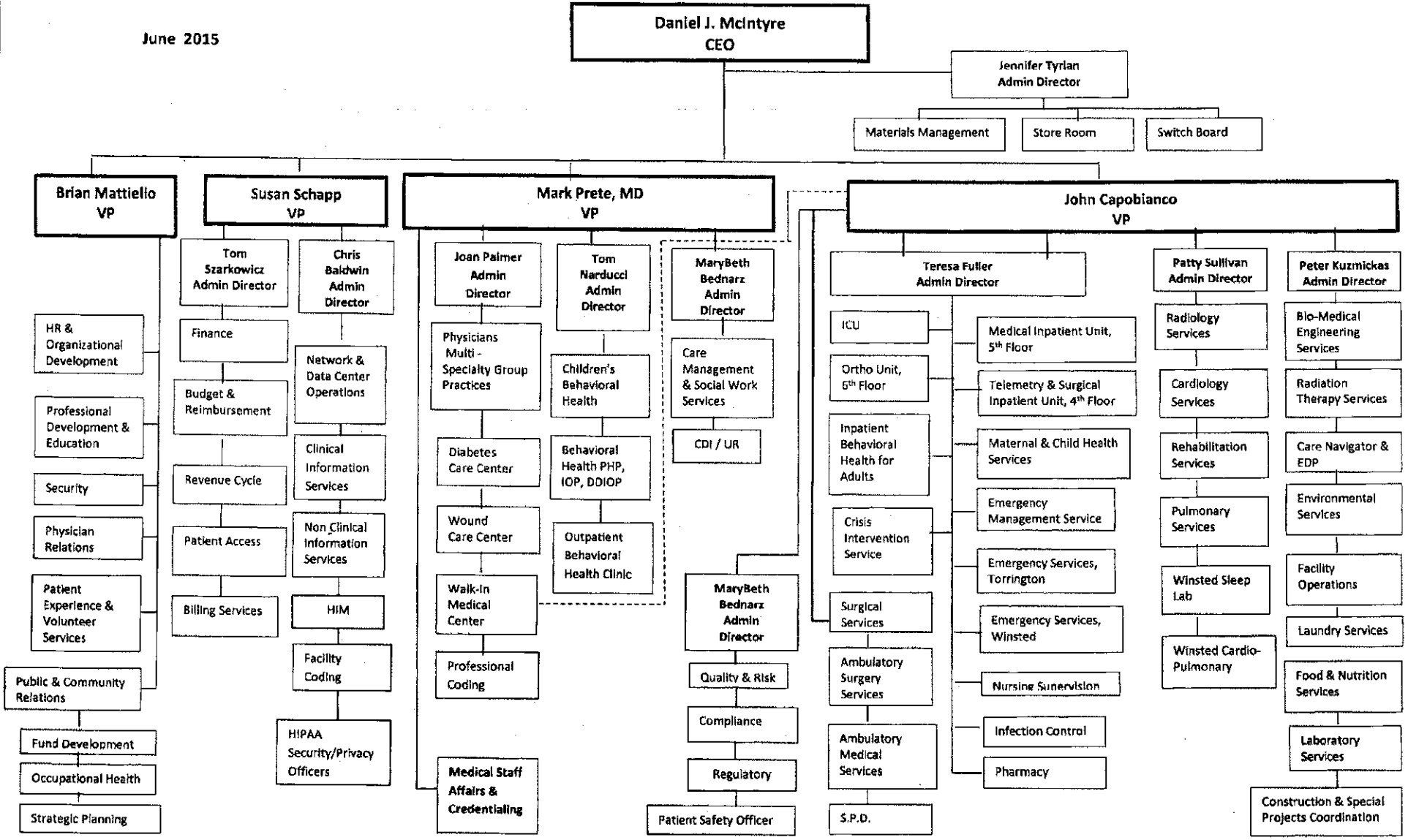
Signed, sealed and delivered
in presence of

DECEMBER 2016

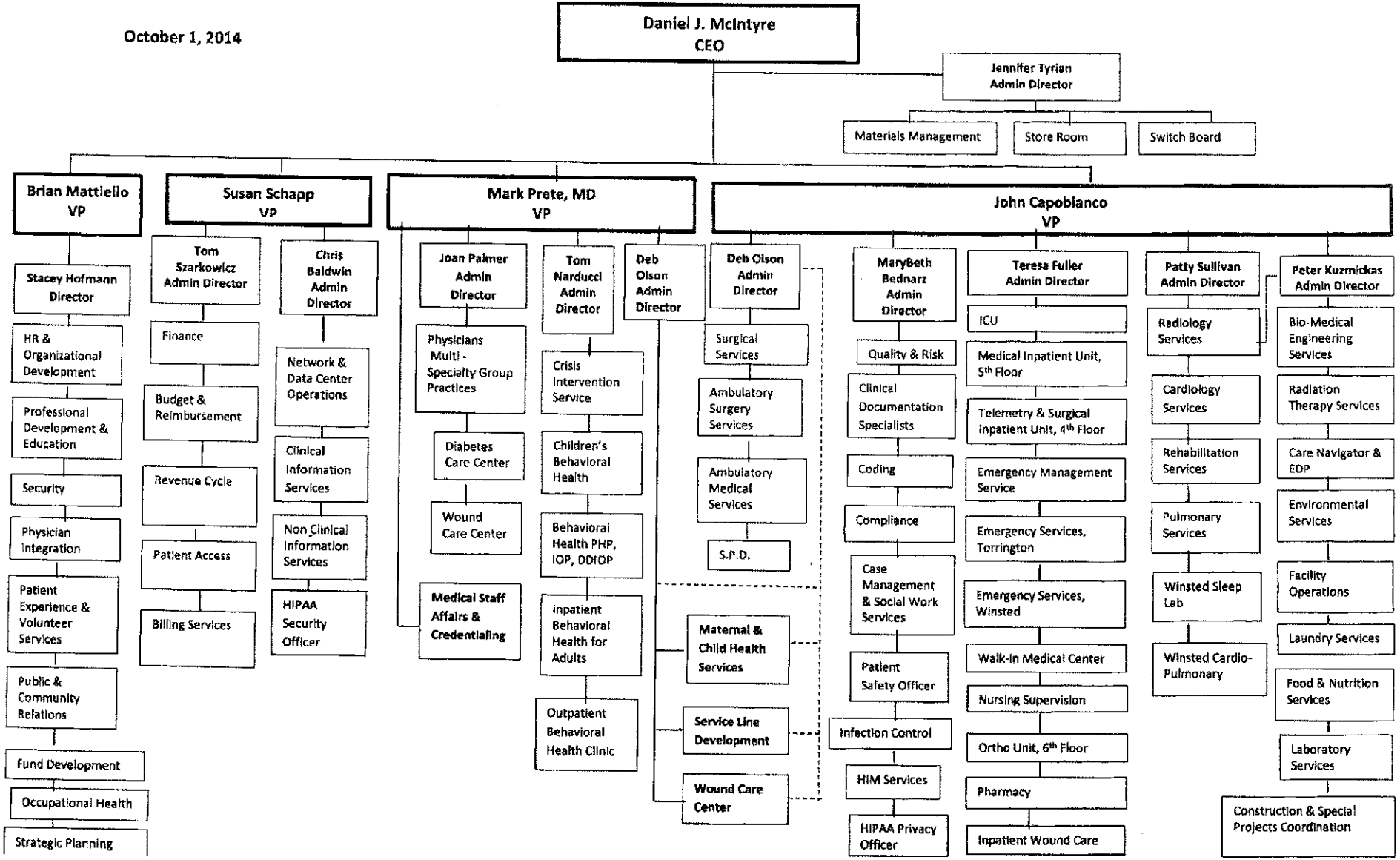
INTERIM



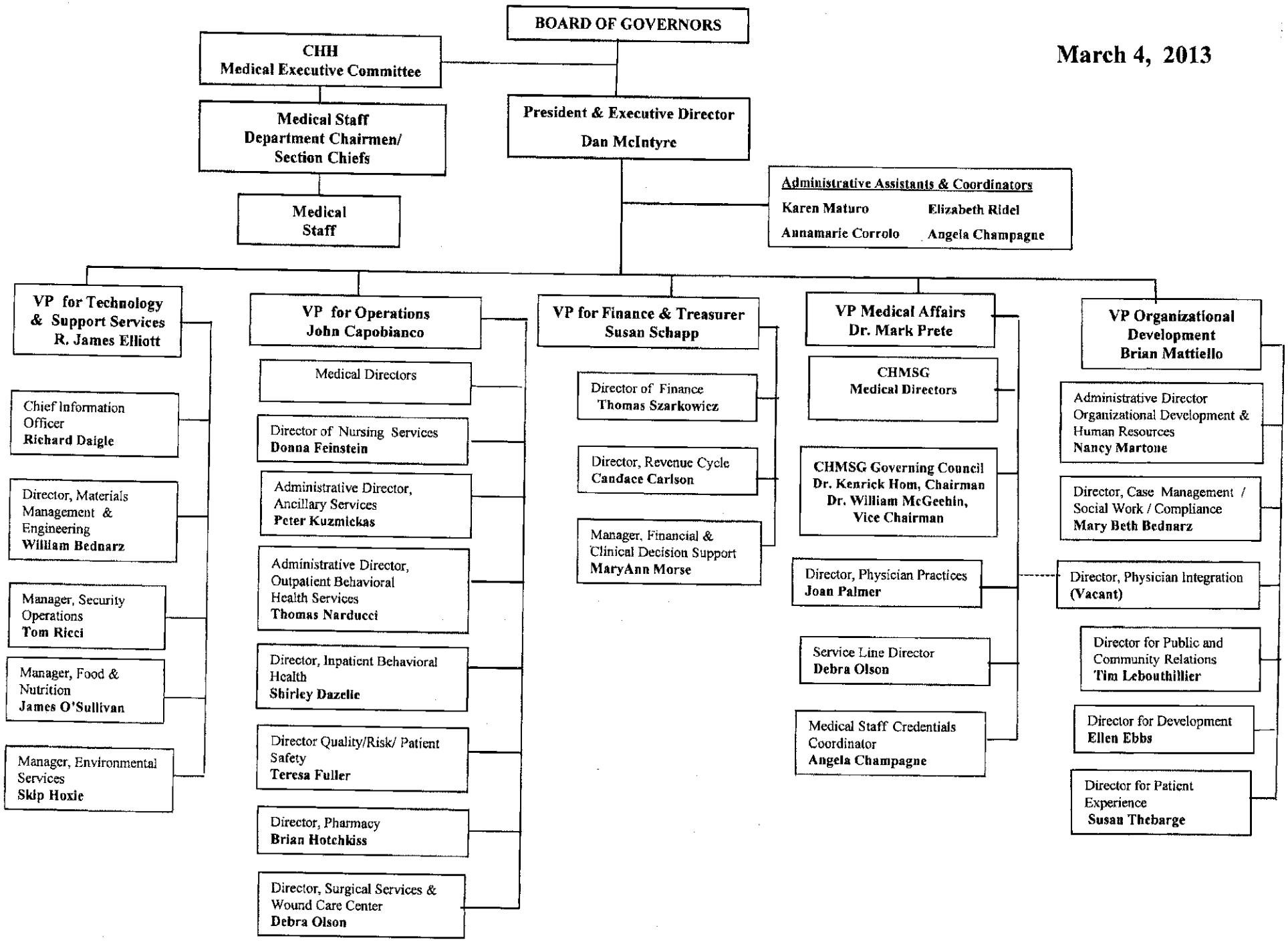
June 2015

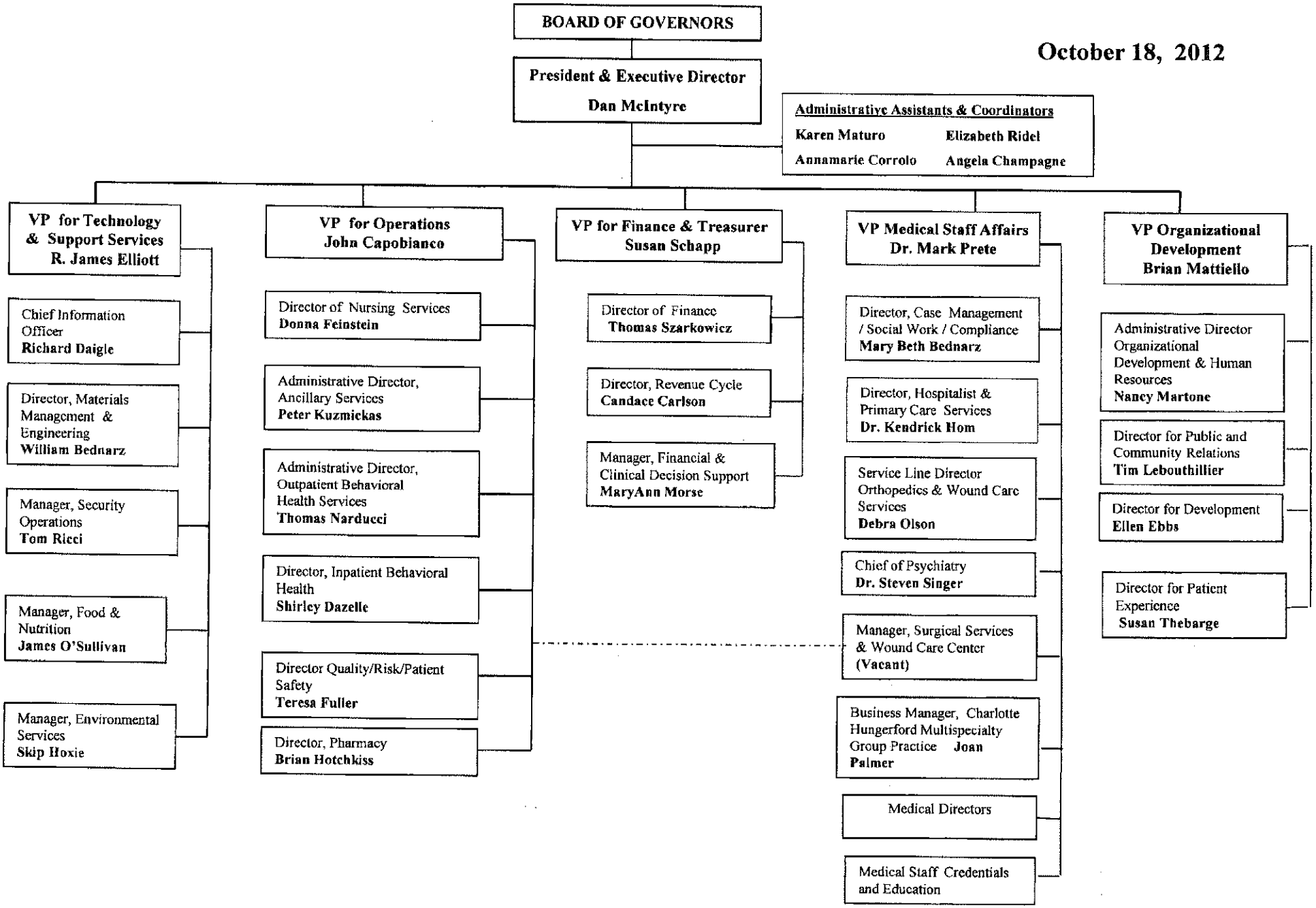

Daniel J. McIntyre
CEO
Jennifer Tyrlan
Admin Director
Materials Management
Store Room
Switch Board
Brian Mattiello
VP
HR & Organizational Development
Professional Development & Education
Security
Physician Relations
Patient Experience & Volunteer Services
Public & Community Relations
Fund Development
Occupational Health
Strategic Planning
Susan Schapp
VP
Tom Szarkowicz
Admin Director
Finance
Budget & Reimbursement
Revenue Cycle
Patient Access
Billing Services
Chris Baldwin
Admin Director
Network & Data Center Operations
Clinical Information Services
Non Clinical Information Services
HIM
Facility Coding
HIPAA Security/Privacy Officers
Mark Prete, MD
VP
Joan Palmer
Admin Director
Physicians Multi - Specialty Group Practices
Diabetes Care Center
Wound Care Center
Walk-In Medical Center
Professional Coding
Medical Staff Affairs & Credentialing
Tom Narducci
Admin Director
Children's Behavioral Health
Behavioral Health PHP, IOP, DDIOP
Outpatient Behavioral Health Clinic
MaryBeth Bednarz
Admin Director
Care Management & Social Work Services
CDI / UR
MaryBeth Bednarz
Admin Director
Quality & Risk
Compliance
Regulatory
Patient Safety Officer
John Capobianco
VP
Teresa Fuller
Admin Director
ICU
Ortho Unit, 6th Floor
Inpatient Behavioral Health for Adults
Crisis Intervention Service
Surgical Services
Ambulatory Surgery Services
Ambulatory Medical Services
S.P.D.
Medical Inpatient Unit, 5th Floor
Telemetry & Surgical Inpatient Unit, 4th Floor
Maternal & Child Health Services
Emergency Management Service
Emergency Services, Torrington
Emergency Services, Winsted
Nursing Supervision
Infection Control
Pharmacy
Patty Sullivan
Admin Director
Radiology Services
Cardiology Services
Rehabilitation Services
Pulmonary Services
Winsted Sleep Lab
Winsted Cardio-Pulmonary
Peter Kuzmickas
Admin Director
Bio-Medical Engineering Services
Radiation Therapy Services
Care Navigator & EDP
Environmental Services
Facility Operations
Laundry Services
Food & Nutrition Services
Laboratory Services
Construction & Special Projects Coordination

October 1, 2014



March 4, 2013


BOARD OF GOVERNORS
CHH
Medical Executive Committee
Medical Staff
Department Chairmen/
Section Chiefs
Medical
Staff
President & Executive Director
Dan McIntyre
Administrative Assistants & Coordinators
Karen Maturo
Elizabeth Ridel
Annamarie Corrolo
Angela Champagne
VP for Technology
& Support Services
R. James Elliott
Chief Information
Officer
Richard Daigle
Director, Materials
Management &
Engineering
William Bednarz
Manager, Security
Operations
Tom Ricci
Manager, Food &
Nutrition
James O'Sullivan
Manager, Environmental
Services
Skip Hoxie
VP for Operations
John Capobianco
Medical Directors
Director of Nursing Services
Donna Feinstein
Administrative Director,
Ancillary Services
Peter Kuzmickas
Administrative Director,
Outpatient Behavioral
Health Services
Thomas Narducci
Director, Inpatient Behavioral
Health
Shirley Dazelle
Director Quality/Risk/ Patient
Safety
Teresa Fuller
Director, Pharmacy
Brian Hotchkiss
Director, Surgical Services &
Wound Care Center
Debra Olson
VP for Finance & Treasurer
Susan Schapp
Director of Finance
Thomas Szarkowicz
Director, Revenue Cycle
Candace Carlson
Manager, Financial &
Clinical Decision Support
MaryAnn Morse
VP Medical Affairs
Dr. Mark Prete
CHMSG
Medical Directors
CHMSG Governing Council
Dr. Kenrick Hom, Chairman
Dr. William McGeehin,
Vice Chairman
Director, Physician Practices
Joan Palmer
Service Line Director
Debra Olson
Medical Staff Credentials
Coordinator
Angela Champagne
VP Organizational
Development
Brian Mattiello
Administrative Director
Organizational Development &
Human Resources
Nancy Martone
Director, Case Management /
Social Work / Compliance
Mary Beth Bednarz
Director, Physician Integration
(Vacant)
Director for Public and
Community Relations
Tim Lebouthillier
Director for Development
Ellen Ebbs
Director for Patient
Experience
Susan Thebarge


October 18, 2012
BOARD OF GOVERNORS
President & Executive Director
Dan McIntyre
Administrative Assistants & Coordinators
Karen Maturo
Elizabeth Ridel
Annamarie Corrolo
Angela Champagne
VP for Technology & Support Services
R. James Elliott
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Richard Daigle
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William Bednarz
Manager, Security Operations
Tom Ricci
Manager, Food & Nutrition
James O'Sullivan
Manager, Environmental Services
Skip Hoxie
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John Capobianco
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Donna Feinstein
Administrative Director, Ancillary Services
Peter Kuzmickas
Administrative Director, Outpatient Behavioral Health Services
Thomas Narducci
Director, Inpatient Behavioral Health
Shirley Dazelle
Director Quality/Risk/Patient Safety
Teresa Fuller
Director, Pharmacy
Brian Hotchkiss
VP for Finance & Treasurer
Susan Schapp
Director of Finance
Thomas Szarkowicz
Director, Revenue Cycle
Candace Carlson
Manager, Financial & Clinical Decision Support
MaryAnn Morse
VP Medical Staff Affairs
Dr. Mark Prete
Director, Case Management / Social Work / Compliance
Mary Beth Bednarz
Director, Hospitalist & Primary Care Services
Dr. Kendrick Hom
Service Line Director Orthopedics & Wound Care Services
Debra Olson
Chief of Psychiatry
Dr. Steven Singer
Manager, Surgical Services & Wound Care Center
(Vacant)
Business Manager, Charlotte Hungerford Multispecialty Group Practice Joan Palmer
Medical Directors
Medical Staff Credentials and Education
VP Organizational Development
Brian Mattiello
Administrative Director Organizational Development & Human Resources
Nancy Martone
Director for Public and Community Relations
Tim Lebouthillier
Director for Development
Ellen Ebbs
Director for Patient Experience
Susan Thebarge