

Summary Report

2015 Community Health Needs Assessment

Natchaug Hospital Service Area

Prepared for:
Natchaug Hospital

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2014-2615-02
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Introduction



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About This Assessment

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the Natchaug Hospital Service Area in Connecticut. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This assessment was conducted on behalf of Hartford HealthCare by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through an Online Key Informant Survey of various community stakeholders.

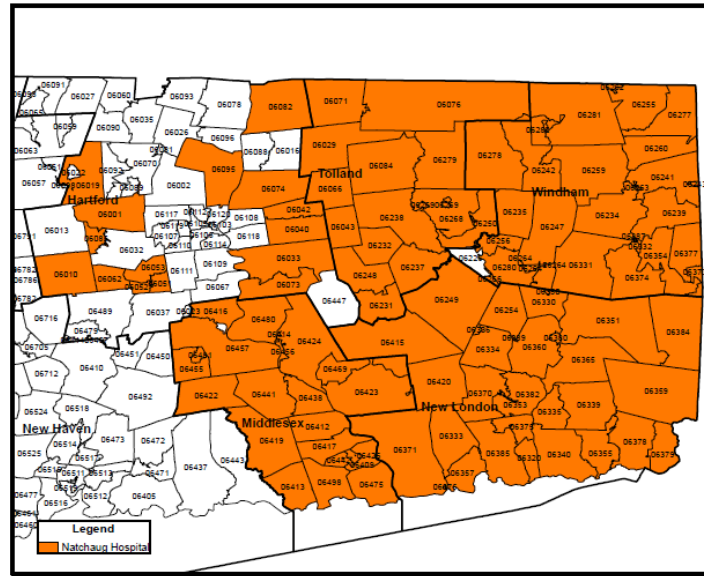
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Hartford HealthCare and PRC.

Community Defined for This Assessment

The study area for the survey effort (referred to as the “Natchaug Hospital Service Area” in this report, or “NHSA”) is defined by 103 residential ZIP Codes in Connecticut. This area definition is illustrated in the following map.



Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities.

The sample design used for this effort consisted of a random sample of 2,087 individuals age 18 and older in the Natchaug Hospital Service Area. Because this study is part of a larger effort involving multiple regions and hospital service areas, the surveys were distributed among various strata. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the service area as a whole. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

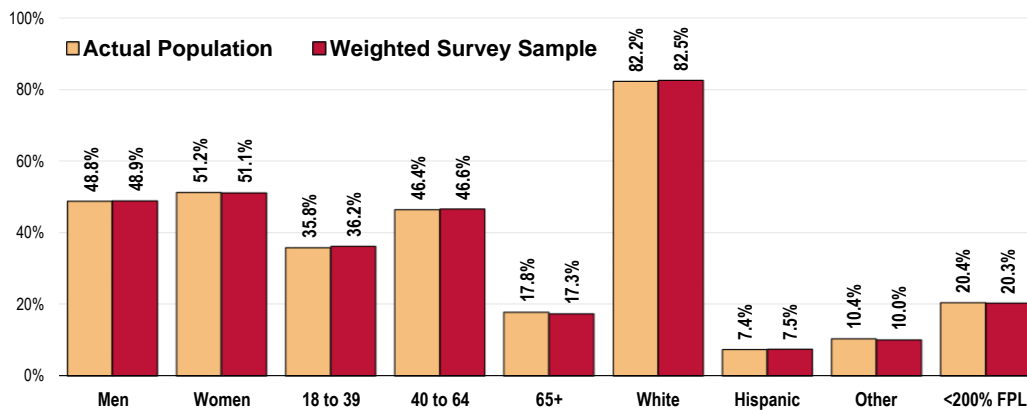
For statistical purposes, the maximum rate of error associated with a sample size of 2,087 respondents is $\pm 2.2\%$ at the 95 percent level of confidence.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. And, while this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

The following chart outlines the characteristics of the Natchaug Hospital Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's healthcare needs, and these children are not represented demographically in this chart.]

Population & Survey Sample Characteristics (Natchaug Hospital Service Area, 2015)



Sources:
 • Census 2010, Summary File 3 (SF 3). US Census Bureau.
 • 2015 PRC Community Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (*e.g., the 2014 guidelines place the poverty threshold for a family of four at \$23,850 annual household income or lower*). In sample segmentation: “**very low income**” refers to community members living in a household with defined poverty status; “**low income**” refers to community members living just above the poverty level, earning up to twice the poverty threshold; and “**mid/high income**” refers to those households living on incomes which are twice or more the federal poverty level.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by Hartford HealthCare; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 117 community stakeholders in the Natchaug Hospital Service Area took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation		
Key Informant Type	Number Invited	Number Participating
Physicians	16	4
Public Health Experts	19	10
Other Health Providers	58	32
Social Services Representatives	79	33
Community/Business Leaders	128	38

Final participation included representatives of the following organizations:

- American Ambulance Service, Inc.
- American Red Cross Blood Services
- Berlin Senior Center
- Boys and Girls Club of Meriden
- Bristol Community Organization
- Bristol-Burlington Health District
- Calendar House Southington Senior Center
- Capital Community College
- Catholic Charities
- Central Connecticut Health District
- Central Connecticut Senior Health Services
- Central Connecticut Senior Health Services
- Chamber of Commerce of Eastern Connecticut
- Charter Oak Health Center
- Chrysalis Center, Inc.
- Community Health Center, Inc.
- Community Health Services, Inc.
- Connecticut Association for Community Action
- Connecticut Association of Directors of Health
- Connecticut Children's Medical Center
- Connecticut Department of Public Health
- Connecticut State Colleges and Universities
- Connecticut State Medical Society

- Eastern Highlands Health District
- FaithCare, Inc.
- Farmington Valley Health District
- Generations Family Health Center, Inc.
- Girls Incorporated of Meriden
- Greater New Britain Chamber of Commerce
- Hartford Behavioral Health
- Hartford Food System, Inc.
- Hartford Foundation for Public Giving
- Hartford Gay and Lesbian Health Collective
- Hartford Hospital
- Hartford Public Schools
- Hispanic Health Council
- Intercommunity, Inc.
- LCS
- Legal Assistance Resource Center
- Malta House of Care Foundation
- Manchester Community College
- Manchester Health Department
- Manchester Public Schools
- Mental Health Association of Connecticut, Inc.
- Meriden Senior Center
- Meriden-Wallingford Chrysalis, Inc.
- MHT Christians in Action
- Mohegan Tribe
- Northeast District Department of Health
- Northern Connecticut Black Nurses Association
- Norwich Adult Education
- Quinnipiac Chamber of Commerce
- Reliance House, Inc.
- Rose City Senior Center
- South Central CT Substance Abuse Council
- South Windsor Human Services
- Southeastern Regional Action Council
- Southington Library
- Southington Public Schools
- St. Vincent de Paul Place Norwich
- Three Rivers Community College Nursing Program
- Town of Windham
- TVCCA

- Uncas Health District
- United Community and Family Services
- United Services, Inc.
- United Way
- University of Connecticut Student Health Services
- Urban Alliance, Inc.
- Wallingford Health Department
- Wallingford Senior Center
- West Hartford-Bloomfield Health District
- Windham Hospital
- Windham Public Schools
- Windham Region No Freeze Project
- Women and Families Center
- YMCA
- YWCA

Through this process, input was gathered from several individuals whose organizations work with **low-income, minority populations** (including African Americans, American Indians, Asians, at-risk youth, Bosnians, Cape Verdeans, Caucasians, children, Chinese, developmentally-disabled, Eastern Europeans, elderly, ex-offenders, French Creole, Haitians, Hispanics, HIV/AIDS patients, homeless, immigrants, lesbian/gay/bisexual/transgender individuals, low-income residents, the mentally ill, Middle Eastern peoples, migrant farm workers, mixed race individuals, multiple religion families, non-English speaking persons, Northern Europeans, Polish, poorly educated, refugee immigrants, undocumented immigrants, unemployed, uninsured/underinsured persons, victims of crime, West Indian residents, women), or other **medically underserved populations** (including those with access and functional needs, African-Americans, Asians, behavioral health issues, children, chronic pain, deaf/hard of hearing persons, diabetics, disabled individuals, the elderly, Hispanics, HIV/AIDS patients, homeless persons, immigrants, lesbian/gays/bisexual/transgender individuals, low-income residents, Medicaid/Medicare recipients, mentally ill persons, Native Americans, non-English speaking persons, people in rural areas, racial/ethnic minorities, single parents, those with substance abuse issues, undocumented immigrants, uninsured/underinsured residents, veterans, women and children, young adults).

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such, and how these might be better addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are based on perceptions, not facts.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the Natchaug Hospital Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Environmental Systems (CARES)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- Community Commons
- Connecticut Department of Public Health
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that town-specific secondary data were sought and included where available; the remainder of secondary data indicators reflect combined county-level data for Harford, New London, Middlesex, Tolland, and Windham counties.

Benchmark Data

State Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data are reported in the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trend Data* published by the Centers for Disease Control and Prevention and the US Department of Health & Human Services. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2013 PRC National Health Survey*; the methodological approach for the national study is identical to that employed in this

assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020

Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. The Healthy People initiative is grounded in the principle that setting national objectives and monitoring progress can motivate action. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across sectors.
- Guide individuals toward making informed health decisions.
- Measure the impact of prevention activities.



Healthy People 2020 is the product of an extensive stakeholder feedback process that is unparalleled in government and health. It integrates input from public health and prevention experts, a wide range of federal, state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level) using question-specific samples and response rates. For secondary data indicators (which do not carry sampling error, but might be subject to reporting error), "significance," for the purpose of this report, is determined by a 5% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

IRS Form 990, Schedule H Compliance

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Form 990 Schedule H, the following table cross-references related sections.

IRS Form 990, Schedule H	See Report Page(s)
Part V Section B Line 1a <i>A definition of the community served by the hospital facility</i>	5
Part V Section B Line 1b <i>Demographics of the community</i>	32
Part V Section B Line 1c <i>Existing health care facilities and resources within the community that are available to respond to the health needs of the community</i>	177
Part V Section B Line 1d <i>How data was obtained</i>	5
Part V Section B Line 1f <i>Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups</i>	Addressed Throughout
Part V Section B Line 1g <i>The process for identifying and prioritizing community health needs and services to meet the community health needs</i>	16
Part V Section B Line 1h <i>The process for consulting with persons representing the community's interests</i>	7
Part V Section B Line 1i <i>Information gaps that limit the hospital facility's ability to assess the community's health needs</i>	12

Summary of Findings



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Significant Health Needs of the Community

The following “areas of opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in Healthy People 2020. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

Areas of Opportunity Identified Through This Assessment	
Access to Healthcare Services	<ul style="list-style-type: none"> • Primary Care Physician Ratio
Cancer	<ul style="list-style-type: none"> • #2 Leading Cause of Death (All Cancers) <ul style="list-style-type: none"> ◦ Prostate Cancer Deaths • Female Breast Cancer Incidence
Chronic Kidney Disease	<ul style="list-style-type: none"> • Kidney Disease Deaths
Dementia, Including Alzheimer's Disease	<ul style="list-style-type: none"> • Alzheimer's Disease Deaths
Diabetes	<ul style="list-style-type: none"> • Prevalence of Borderline/Pre-Diabetes • <i>Diabetes ranked #4 as a “major problem” in the Online Key Informant Survey</i>
Heart Disease & Stroke	<ul style="list-style-type: none"> • #1 Leading Cause of Death • High Blood Pressure Prevalence • <i>Heart Disease & Stroke ranked #5 as a “major problem” in the Online Key Informant Survey</i>
Infant Health & Family Planning	<ul style="list-style-type: none"> • Infant Mortality
Injury & Violence	<ul style="list-style-type: none"> • Motor Vehicle Crash Deaths
Mental Health	<ul style="list-style-type: none"> • Suicide Deaths • <i>Mental Health ranked #1 as a “major problem” in the Online Key Informant Survey</i>
Nutrition, Physical Activity & Weight	<ul style="list-style-type: none"> • Low Food Access • Overweight & Obesity [Adults] • Lack of Leisure-Time Physical Activity • Meeting Physical Activity Guidelines <ul style="list-style-type: none"> ◦ Moderate & Vigorous Physical Activity • Access to Recreation/Fitness Facilities • <i>Nutrition, Physical Activity & Weight ranked #2 as a “major problem” in the Online Key Informant Survey</i>
Potentially Disabling Conditions	<ul style="list-style-type: none"> • Activity Limitations
Respiratory Diseases	<ul style="list-style-type: none"> • Chronic Lower Respiratory Disease (CLRD) Deaths • Chronic Obstructive Pulmonary Disease (COPD) Prevalence • Asthma Prevalence [Adults]
Substance Abuse	<ul style="list-style-type: none"> • Cirrhosis/Liver Disease Deaths • Overall Alcohol Use • <i>Substance Abuse ranked #3 as a “major problem” in the Online Key Informant Survey</i>

Prioritization of Health Needs

On June 11, 2015, Natchaug Hospital hosted a meeting of both internal stakeholders and representatives of community organizations to evaluate, discuss and prioritize health issues for the community, based on findings of the 2015 PRC Community Health Needs Assessment (CHNA). Professional Research Consultants, Inc. (PRC) began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research.

Following the data review, PRC answered any questions and facilitated a group dialogue, allowing participants to advocate for any of the health issues discussed. Subsequently, participants were provided an overview of the prioritization exercise that followed.

In order to assign priority to the identified health needs, a wireless audience response system was used in which each participant was able to register his/her ratings using a small remote keypad. The participants were asked to evaluate each health issue along two criteria:

- **Scope & Severity** — The first rating was to gauge the magnitude of the problem in consideration of the following:
 - How many people are affected?
 - How does the local community data compare to state or national levels, or Healthy People 2020 targets?
 - To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

- **Ability to Impact** — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each criteria were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of community health needs:

1. **Mental Health**
2. **Substance Abuse**
3. **Access to Healthcare Services**
4. **Heart Disease & Stroke**
5. **Nutrition, Physical Activity & Weight**
6. **Diabetes**
7. **Injury & Violence**
8. **Cancer**

- 9. Dementias, Including Alzheimer's Disease**
- 10. Infant Health & Family Planning**
- 11. Respiratory Diseases**
- 12. Potentially Disabling Conditions**
- 13. Chronic Kidney Disease**

While the hospital will likely not implement strategies for all of these health issues, the results of this prioritization exercise will be used to inform the development of the hospital's Implementation Strategy to address the top health needs of the community in the coming years.

Summary Tables: Comparisons With Benchmark Data



















The following tables provide an overview of indicators in the Natchaug Hospital Service Area. These data are grouped to correspond with the Focus Areas presented in Healthy People 2020.








Reading the Data Summary Tables






































- In the following charts, Natchaug Hospital Service Area results are shown in the larger, blue column.
- The columns to the right of the service area column provide comparisons between local data and any available state and national findings, and Healthy People 2020 targets. Symbols indicate whether the Natchaug Hospital Service Area compares favorably (☀️), unfavorably (☔️), or comparably (☁️) to these external data.








Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.








Access to Health Services	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% [Age 18-64] Lack Health Insurance	5.4	☀️ 12.3	☀️ 15.1	☔️ 0.0
% [Insured] Went Without Coverage in Past Year	6.2		☀️ 8.1	
% Difficulty Accessing Healthcare in Past Year (Composite)	35.5		☀️ 39.9	
% Inconvenient Hrs Prevented Dr Visit in Past Year	13.4		☁️ 15.4	
% Cost Prevented Getting Prescription in Past Year	10.5		☀️ 15.8	
% Cost Prevented Physician Visit in Past Year	11.1		☀️ 18.2	
% Difficulty Getting Appointment in Past Year	14.8		☁️ 17.0	
% Difficulty Finding Physician in Past Year	10.7		☁️ 11.0	
% Transportation Hindered Dr Visit in Past Year	5.6		☀️ 9.4	











Access to Health Services (continued)	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% Skipped Prescription Doses to Save Costs	10.8		 15.3	
% Difficulty Getting Child's Healthcare in Past Year	2.3		 6.0	
Primary Care Doctors per 100,000	92.5	 105.2	 85.8	
% [Age 18+] Have a Specific Source of Ongoing Care	76.4		 76.3	 95.0
% [Age 18-64] Have a Specific Source of Ongoing Care	76.7		 75.6	 89.4
% [Age 65+] Have a Specific Source of Ongoing Care	74.7		 80.0	 100.0
% Have Had Routine Checkup in Past Year	75.4	 71.8	 65.0	
% Child Has Had Checkup in Past Year	94.2		 84.1	
% Two or More ER Visits in Past Year	8.6		 8.9	
% Rate Local Healthcare "Fair/Poor"	10.7		 16.5	
		 better	 similar	 worse






Arthritis, Osteoporosis & Chronic Back Conditions	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% [50+] Arthritis/Rheumatism	38.2		 37.3	
% [50+] Osteoporosis	10.0		 13.5	 5.3
% Sciatica/Chronic Back Pain	21.0		 18.4	
		 better	 similar	 worse






Cancer	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Cancer (Age-Adjusted Death Rate)	154.5	 153.0	 166.2	 161.4
Lung Cancer (Age-Adjusted Death Rate)	39.4	 38.7	 44.7	 45.5
Prostate Cancer (Age-Adjusted Death Rate)	19.4	 18.2	 19.8	 21.8
Female Breast Cancer (Age-Adjusted Death Rate)	19.4	 19.2	 21.3	 20.7
Colorectal Cancer (Age-Adjusted Death Rate)	12.6	 12.1	 14.9	 14.5
Prostate Cancer Incidence per 100,000	146.2	 152.4	 142.3	
Female Breast Cancer Incidence per 100,000	133.5	 136.6	 122.7	
Lung Cancer Incidence per 100,000	65.9	 64.8	 64.9	
Colorectal Cancer Incidence per 100,000	42.4	 42.7	 43.3	
Cervical Cancer Incidence per 100,000	6.4	 6.2	 7.8	
% Skin Cancer	5.7	 5.8	 6.7	
% Cancer (Other Than Skin)	6.3	 7.5	 6.1	
% [Women 50-74] Mammogram in Past 2 Years	86.0	 81.5	 83.6	 81.1
% [Women 21-65] Pap Smear in Past 3 Years	87.7	 80.1	 83.9	 93.0
% [Age 50+] Sigmoid/Colonoscopy Ever	83.6	 74.5	 75.2	





Cancer (continued)	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% [Age 50+] Blood Stool Test in Past 2 Years	33.9	 16.4	 36.9	
% [Age 50-75] Colorectal Cancer Screening	81.8		 75.1	 70.5
		 better	 similar	 worse










Chronic Kidney Disease	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Kidney Disease (Age-Adjusted Death Rate)	13.8	 12.5	 13.2	
% Kidney Disease	2.7	 2.1	 3.0	
		 better	 similar	 worse


















Diabetes	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Diabetes Mellitus (Age-Adjusted Death Rate)	14.7	 14.8	 21.3	 20.5
% Diabetes/High Blood Sugar	9.6	 8.3	 11.7	
% Borderline/Pre-Diabetes	8.1		 5.1	
% [Non-Diabetes] Blood Sugar Tested in Past 3 Years	55.6		 49.2	
		 better	 similar	 worse










Dementias, Including Alzheimer's Disease	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Alzheimer's Disease (Age-Adjusted Death Rate)	18.5	 16.5	 24.0	
		 better	 similar	 worse















Family Planning	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Births to Teens (Percent)	5.3	 5.1	 7.8	
		 better	 similar	 worse
















Hearing & Other Sensory or Communication Disorders	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% Deafness/Trouble Hearing	8.8		 10.3	
		 better	 similar	 worse












Heart Disease & Stroke	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Diseases of the Heart (Age-Adjusted Death Rate)	157.7	 153.4	 171.3	 156.9
Stroke (Age-Adjusted Death Rate)	27.8	 27.9	 37.0	 34.8
% Heart Disease (Heart Attack, Angina, Coronary Disease)	5.1		 6.1	
% Stroke	2.1	 2.3	 3.9	












Heart Disease & Stroke (continued)	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% Blood Pressure Checked in Past 2 Years	96.8		 91.0	 92.6
% Told Have High Blood Pressure (Ever)	34.4	 31.3	 34.1	 26.9
% [HBP] Taking Action to Control High Blood Pressure	87.9		 89.2	
% Cholesterol Checked in Past 5 Years	93.8	 83.1	 86.6	 82.1
% Told Have High Cholesterol (Ever)	31.7	 37.8	 29.9	 13.5
% [HBC] Taking Action to Control High Blood Cholesterol	87.3		 81.4	
% 1+ Cardiovascular Risk Factor	83.3		 82.3	
		 better	 similar	 worse



HIV	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
HIV/AIDS (Age-Adjusted Death Rate)	2.0	 2.0	 2.2	 3.3
HIV Prevalence per 100,000	323.1	 359.7	 340.4	
% [Age 18-44] HIV Test in the Past Year	16.5		 19.3	
		 better	 similar	 worse











Immunization & Infectious Diseases	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% [Age 65+] Flu Vaccine in Past Year	68.8	 63.6	 57.5	 90.0
% [High-Risk 18-64] Flu Vaccine in Past Year	50.3		 45.9	 90.0
% [Age 65+] Pneumonia Vaccine Ever	75.1	 67.8	 68.4	 90.0
% [High-Risk 18-64] Pneumonia Vaccine Ever	37.1		 41.9	 60.0
% Have Completed Hepatitis B Vaccination Series	49.6		 44.7	
		 better	 similar	 worse









Injury & Violence Prevention	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Unintentional Injury (Age-Adjusted Death Rate)	37.5	 35.8	 39.2	 36.4
Motor Vehicle Crashes (Age-Adjusted Death Rate)	8.0	 7.1	 10.7	 12.4
% "Always" Wear Seat Belt	91.0		 84.8	 92.0
% Child [Age 0-17] "Always" Uses Seat Belt/Car Seat	97.2		 92.2	
% Child [Age 5-17] "Always" Wears Bicycle Helmet	65.6		 48.7	
Firearm-Related Deaths (Age-Adjusted Death Rate)	5.2	 5.5	 10.4	 9.3
% Firearm in Home	19.7		 34.7	
% [Homes With Children] Firearm in Home	18.8		 37.4	

















Injury & Violence Prevention (continued)	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% [Homes With Firearms] Weapon(s) Unlocked & Loaded	8.9		 16.8	
Homicide (Age-Adjusted Death Rate)	3.2	 3.8	 5.3	 5.5
Violent Crime per 100,000	222.7	 282.9	 386.8	
% Victim of Violent Crime in Past 5 Years	1.5		 2.8	
% Victim of Domestic Violence (Ever)	11.7		 15.0	
		 better	 similar	 worse










Maternal, Infant & Child Health	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
No Prenatal Care in First Trimester (Percent)	13.2	 13.0		 22.1
Low Birthweight Births (Percent)	7.9	 7.8	 8.0	 7.8
Infant Death Rate	5.3	 4.9	 6.0	 6.0
		 better	 similar	 worse














Mental Health & Mental Disorders	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% "Fair/Poor" Mental Health	10.7		 11.9	
% Diagnosed Depression	19.6		 20.4	













Mental Health & Mental Disorders (continued)	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% Symptoms of Chronic Depression (2+ Years)	26.4		 30.4	
Suicide (Age-Adjusted Death Rate)	10.3	 9.5	 12.5	 10.2
% Have Ever Sought Help for Mental Health	29.2		 23.7	
% [Those With Diagnosed Depression] Seeking Help	83.9		 76.6	
% Member of HH Sought Help for Mental Health/Past Year	20.6			
% Typical Day Is "Extremely/Very" Stressful	11.9		 11.9	
% [Children <18] Child Has "Fair/Poor" Mental Health	7.3			
% [Children <18] Couldn't Get Mental Help for Child in Past Year	1.5			
				
		better	similar	worse










Nutrition & Weight Status	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% Eat 5+ Servings of Fruit or Vegetables per Day	37.8		 39.5	
% "Very/Somewhat" Difficult to Buy Fresh Produce	20.8		 24.4	
Population With Low Food Access (Percent)	31.6	 29.8	 23.6	
% Medical Advice on Nutrition in Past Year	46.3		 39.2	
% Healthy Weight (BMI 18.5-24.9)	31.9	 35.6	 34.4	 33.9


















Nutrition & Weight Status (continued)	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% Overweight (BMI 25+)	66.6	 62.6	 63.1	
% Obese (BMI 30+)	30.1	 25.0	 29.0	 30.5
% Medical Advice on Weight in Past Year	30.6		 23.7	
% [Overweights] Counseled About Weight in Past Year	38.7		 31.8	
% [Obese Adults] Counseled About Weight in Past Year	54.0		 48.3	
% [Overweights] Trying to Lose Weight Both Diet/Exercise	35.9		 39.5	
% Child [Age 5-17] Healthy Weight	54.6		 56.7	
% Children [Age 5-17] Overweight (85th Percentile)	31.6		 31.5	
% Children [Age 5-17] Obese (95th Percentile)	17.0		 14.8	 14.5
		 better	 similar	 worse

















Oral Health	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% [Age 18+] Dental Visit in Past Year	78.4	 76.1	 65.9	 49.0
% Child [Age 2-17] Dental Visit in Past Year	90.3		 81.5	 49.0
% Have Dental Insurance	79.1		 65.6	
		 better	 similar	 worse






Physical Activity	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% No Leisure-Time Physical Activity	24.5	 24.9	 20.7	 32.6
% Meeting Physical Activity Guidelines	45.5		 50.3	
% Moderate Physical Activity	26.6		 30.6	
% Vigorous Physical Activity	34.6		 38.0	
Recreation/Fitness Facilities per 100,000	11.4	 13.2	 9.4	
% Medical Advice on Physical Activity in Past Year	53.4		 44.0	
% Child [Age 2-17] Physically Active 1+ Hours per Day	43.7		 48.6	
		 better	 similar	 worse

Respiratory Diseases	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
CLRD (Age-Adjusted Death Rate)	34.0	 30.9	 42.0	
Pneumonia/Influenza (Age-Adjusted Death Rate)	13.4	 12.9	 15.3	
% COPD (Lung Disease)	9.8	 5.9	 8.6	
% [Adult] Currently Has Asthma	11.4	 9.8	 9.4	
% [Child 0-17] Currently Has Asthma	8.5		 7.1	
		 better	 similar	 worse

Sexually Transmitted Diseases	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Gonorrhea Incidence per 100,000	53.6	 57.4	 107.5	
Chlamydia Incidence per 100,000	343.8	 364.9	 456.7	
% [Unmarried 18-64] 3+ Sexual Partners in Past Year	7.8		 11.7	
% [Unmarried 18-64] Using Condoms	34.6		 33.6	
		 better	 similar	 worse

Substance Abuse	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	8.4	 7.6	 9.9	 8.2
% Current Drinker	63.9	 62.6	 56.5	
% Excessive Drinker (Heavy or Binge Drinking)	22.4		 23.2	 25.4
% Drinking & Driving in Past Month	3.2		 5.0	
Drug-Induced Deaths (Age-Adjusted Death Rate)	14.2	 13.5	 14.1	 11.3
% Illicit Drug Use in Past Month	3.2		 4.0	 7.1
% Ever Sought Help for Alcohol or Drug Problem	3.8		 4.9	
		 better	 similar	 worse

Tobacco Use	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% Current Smoker	15.1	 15.5	 14.9	 12.0
% Someone Smokes at Home	9.3		 12.7	
% [Non-Smokers] Someone Smokes in the Home	3.7		 6.3	
% [Household With Children] Someone Smokes in the Home	6.5		 9.7	
% [Smokers] Received Advice to Quit Smoking	77.2		 67.8	
% [Smokers] Have Quit Smoking 1+ Days in Past Year	56.0		 55.9	 80.0
% Smoke Cigars	4.4		 4.1	 0.2
% Use Smokeless Tobacco	1.9		 4.0	 0.3
		 better	 similar	 worse

Vision	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% Blindness/Trouble Seeing	7.4		 8.5	
% Eye Exam in Past 2 Years	67.3		 56.8	
		 better	 similar	 worse

Data Charts & Key Informant Input



Professional Research Consultants, Inc.

Community Characteristics

Population Characteristics

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, density, age, race/ethnicity and language. Keep in mind:

- A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.
- Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.
- It is important to understand the age distribution of the population as different age groups have unique health needs which should be considered separately from others along the age spectrum.

Population Characteristics
















	Natchaug Hospital Service Area	Connecticut	United States
Total Population	1,603,049	3,572,213	309,138,709
Total Land Area (sq. miles)	2,691.69	4,841.1	3,530,997.60
Population Density	595.56	737.89	87.55
2000-2010 Population Change	5.8%	5.0%	9.7%
Urban Population	82.7%	88.0%	80.9%
Age 0-17	22.1%	22.7%	23.9%
Age 18-64	63.6%	63.0%	62.9%
Age 65+	14.3%	14.3%	13.2%
White Alone	79.5%	78.4%	74.2%
Black Alone	9.1%	10.0%	12.6%
Some Other Race	8.6%	9.1%	10.6%
Multiple Races	2.8%	2.5%	2.7%
Hispanic or Latino	11.6%	13.4%	16.4%
2000-2010 Hispanic Population Change	44.6%	49.6%	42.7%
Linguistically Isolated Population	3.9%	4.7%	4.9%

Social Determinants of Health

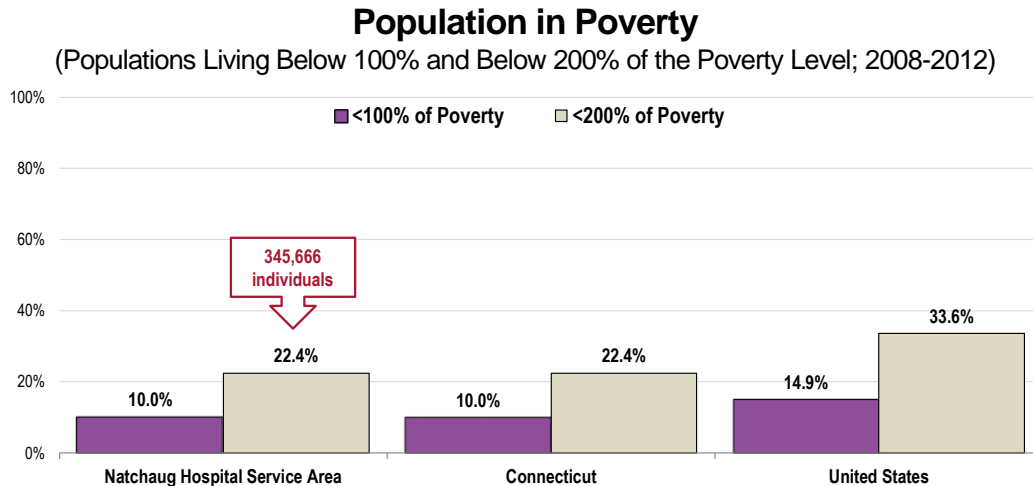
About Social Determinants

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.

- Healthy People 2020 (www.healthypeople.gov)

Social Determinants	Natchaug	Natchaug vs. Benchmarks		
		vs. CT	vs. US	
Linguistically Isolated Population (Percent)	3.9	 4.7	 4.9	
Population in Poverty (Percent)	10.0	 10.0	 14.9	
Population Below 200% FPL (Percent)	22.4	 22.4	 33.6	
Children Below 200% FPL (Percent)	13.3	 13.2	 20.8	
No High School Diploma (Age 25+, Percent)	10.9	 11.0	 14.3	
Unemployment Rate (Age 16+, Percent)	6.3	 6.3	 5.6	
		 better	 similar	 worse

The following chart outlines the proportion of our population below the federal poverty threshold, as well as below 200% of the federal poverty level, in comparison to state and national proportions.



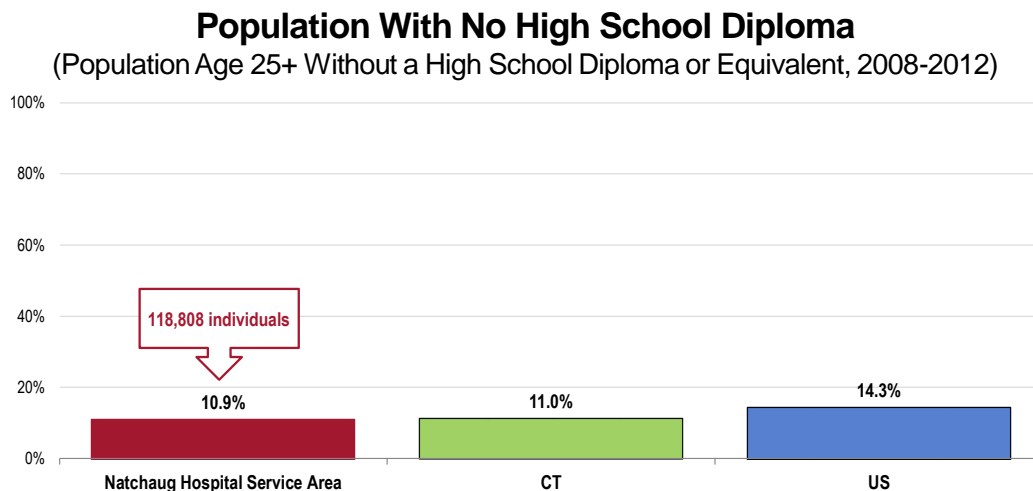
Sources:

- US Census Bureau American Community Survey 5-year estimates (2008-2012).
- Retrieved February 2015 from Community Commons at <http://www.chna.org>.

Notes:

- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Education levels are reflected in the proportion of our population without a high school diploma:



Sources:

- US Census Bureau American Community Survey 5-year estimates (2008-2012).
- Retrieved February 2015 from Community Commons at <http://www.chna.org>.

Notes:

- This indicator is relevant because educational attainment is linked to positive health outcomes.

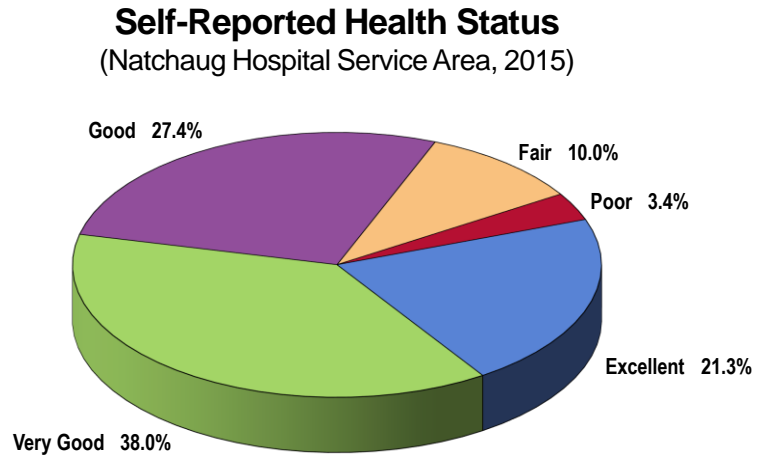
General Health Status

Overall Health Status

Self-Reported Health Status

The initial inquiry of the PRC Community Health Survey asked respondents the following:

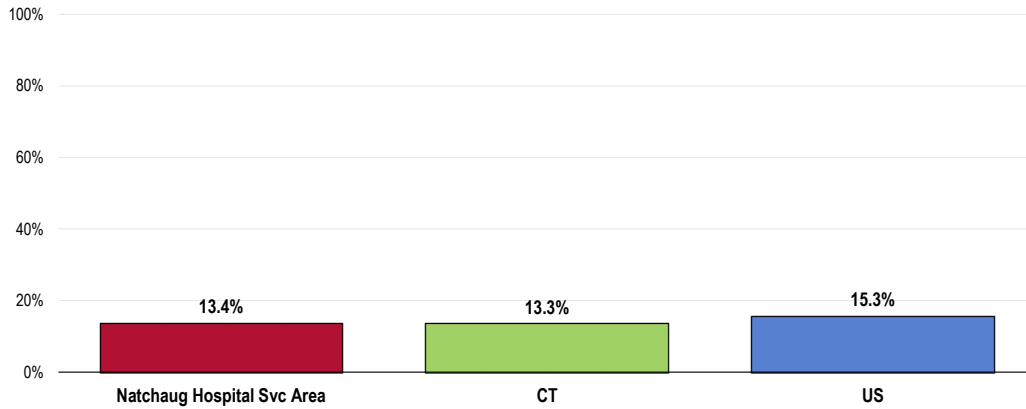
“Would you say that in general your health is: excellent, very good, good, fair or poor?”



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: • Asked of all respondents.

The following charts further detail “fair/poor” overall health responses in the Natchaug Hospital Service Area in comparison to benchmark data, as well as by basic demographic characteristics (namely by gender, age groupings, income [based on poverty status], and race/ethnicity).

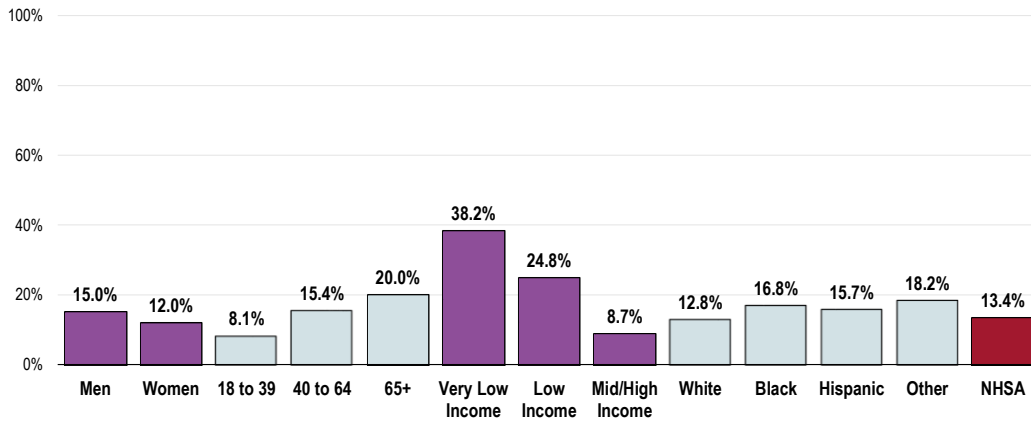
Experience “Fair” or “Poor” Overall Health



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Connecticut data.
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Overall Health (Natchaug Hospital Service Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]

Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes less than 100% of the federal poverty level; “Low Income” includes households with incomes from 100–199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Activity Limitations

About Disability & Health

An individual can get a disabling impairment or chronic condition at any point in life. Compared with people without disabilities, people with disabilities are more likely to:

- Experience difficulties or delays in getting the health care they need.
- Not have had an annual dental visit.
- Not have had a mammogram in past 2 years.
- Not have had a Pap test within the past 3 years.
- Not engage in fitness activities.
- Use tobacco.
- Be overweight or obese.
- Have high blood pressure.
- Experience symptoms of psychological distress.
- Receive less social-emotional support.
- Have lower employment rates.

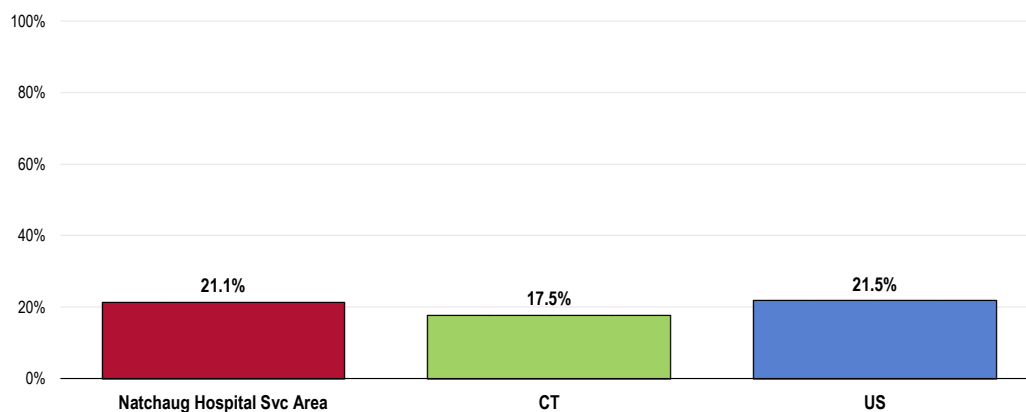
There are many social and physical factors that influence the health of people with disabilities. The following three areas for public health action have been identified, using the International Classification of Functioning, Disability, and Health (ICF) and the three World Health Organization (WHO) principles of action for addressing health determinants.

- **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.
- **Address the inequitable distribution of resources among people with disabilities and those without disabilities** by increasing: appropriate health care for people with disabilities; education and work opportunities; social participation; and access to needed technologies and assistive supports.
- **Expand the knowledge base and raise awareness about determinants of health for people with disabilities** by increasing: the inclusion of people with disabilities in public health data collection efforts across the lifespan; the inclusion of people with disabilities in health promotion activities; and the expansion of disability and health training opportunities for public health and health care professionals.

- Healthy People 2020 (www.healthypeople.gov)

“Are you limited in any way in any activities because of physical, mental or emotional problems?”

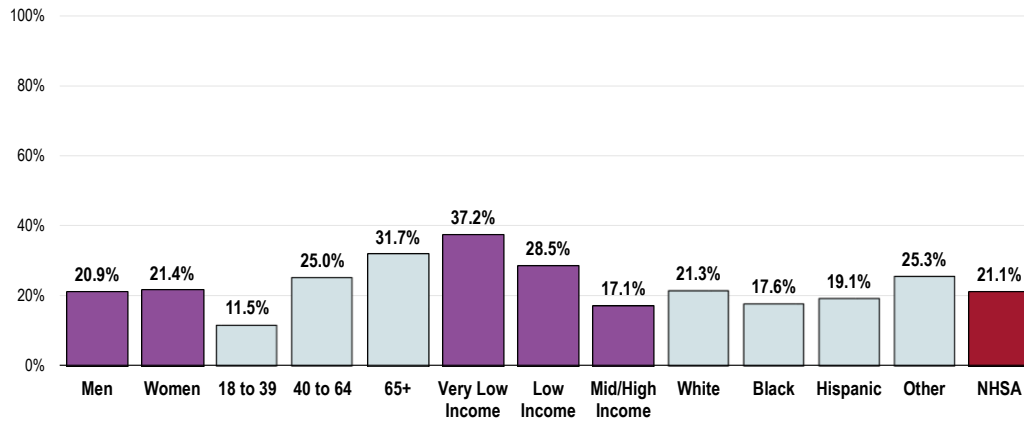
Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem



- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 105]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Connecticut data.
 - 2013 PRC National Health Survey, Professional Research Consultants, Inc.

- Notes:
- Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem (Natchaug Hospital Service Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 105]

- Notes:
- Asked of all respondents.
 - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes less than 100% of the federal poverty level; "Low Income" includes households with incomes from 100–199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Mental Health

About Mental Health & Mental Disorders

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

The existing model for understanding mental health and mental disorders emphasizes the interaction of social, environmental, and genetic factors throughout the lifespan. In behavioral health, researchers identify: **risk factors**, which predispose individuals to mental illness; and **protective factors**, which protect them from developing mental disorders. Researchers now know that the prevention of mental, emotional, and behavioral (MEB) disorders is inherently interdisciplinary and draws on a variety of different strategies. Over the past 20 years, research on the prevention of mental disorders has progressed. The major areas of progress include evidence that:

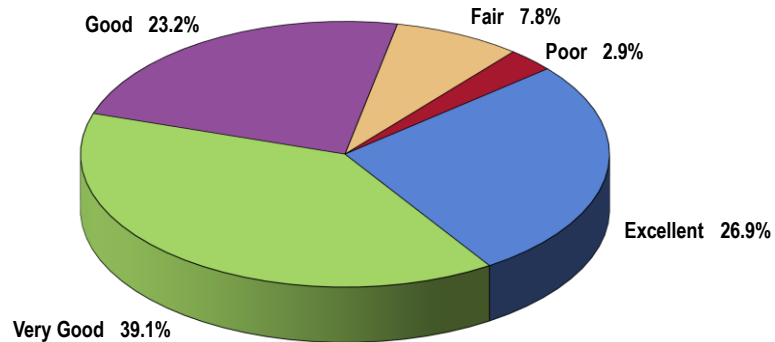
- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence of depression among pregnant women and adolescents can be reduced.
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33%.
- There are potential indicated preventive interventions for schizophrenia.
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk.
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression in children and increasing effective parenting.
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.
- Implementation is complex, it is important that interventions be relevant to the target audiences.
- In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

• Healthy People 2020 (www.healthypeople.gov)

Self-Reported Mental Health Status

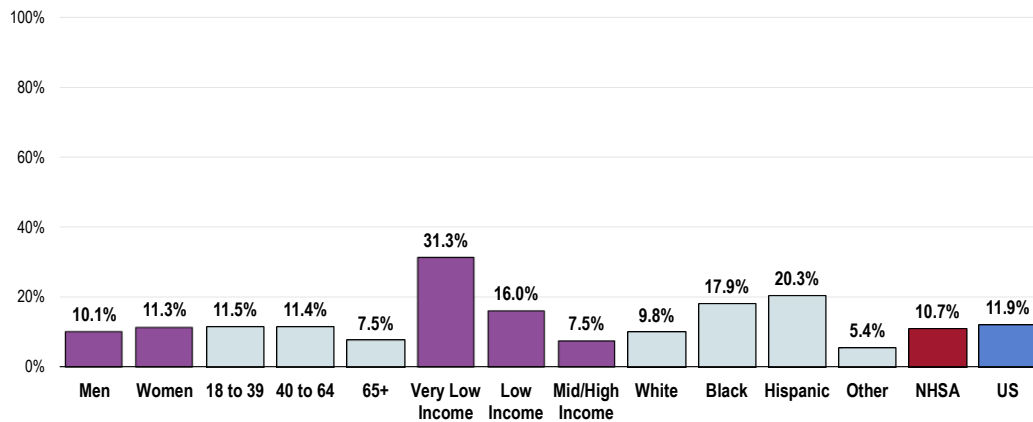
“Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair or poor?”

Self-Reported Mental Health Status (Natchaug Hospital Service Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]
 Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Mental Health (Natchaug Hospital Service Area, 2015)



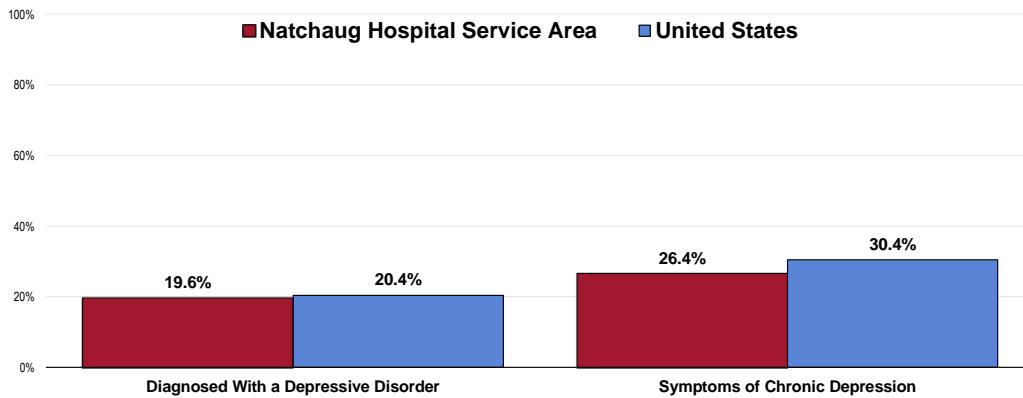
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes less than 100% of the federal poverty level; “Low Income” includes households with incomes from 100–199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Depression

Diagnosed Depression: *“Has a doctor or other healthcare provider ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?”*

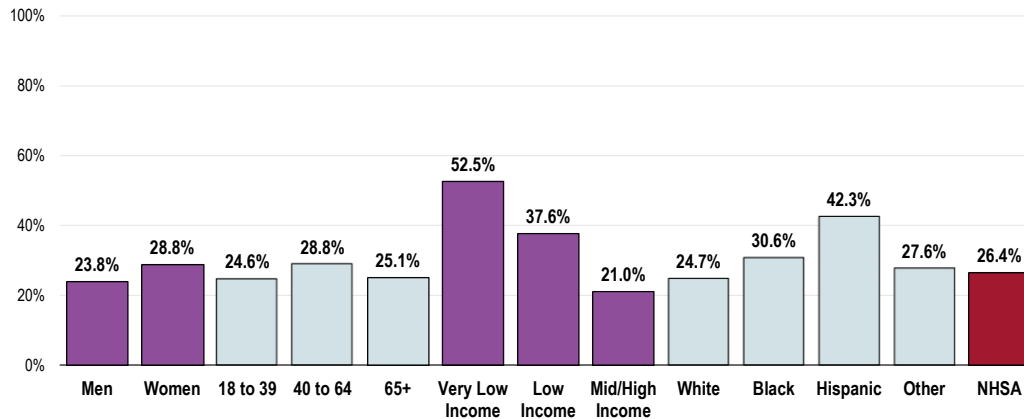
Symptoms of Chronic Depression: *“Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?”*

Depression



- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 100, 101, 103]
 - 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.
 - Depressive disorders include depression, major depression, dysthymia, or minor depression.
 - Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Have Experienced Symptoms of Chronic Depression (Natchaug Hospital Service Area, 2015)

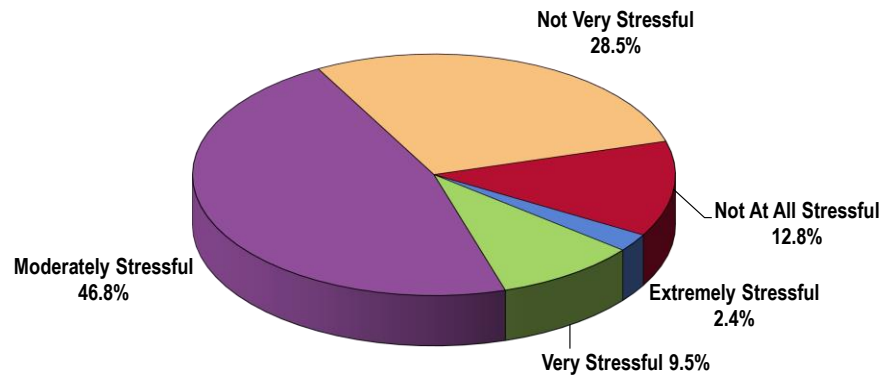


- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]
- Notes:
- Asked of all respondents.
 - Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.
 - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes less than 100% of the federal poverty level; "Low Income" includes households with incomes from 100–199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Stress

“Thinking about the amount of stress in your life, would you say that most days are: Extremely Stressful, Very Stressful, Moderately Stressful, Not Very Stressful or Not At All Stressful?”

Perceived Level of Stress On a Typical Day (Natchaug Hospital Service Area, 2015)



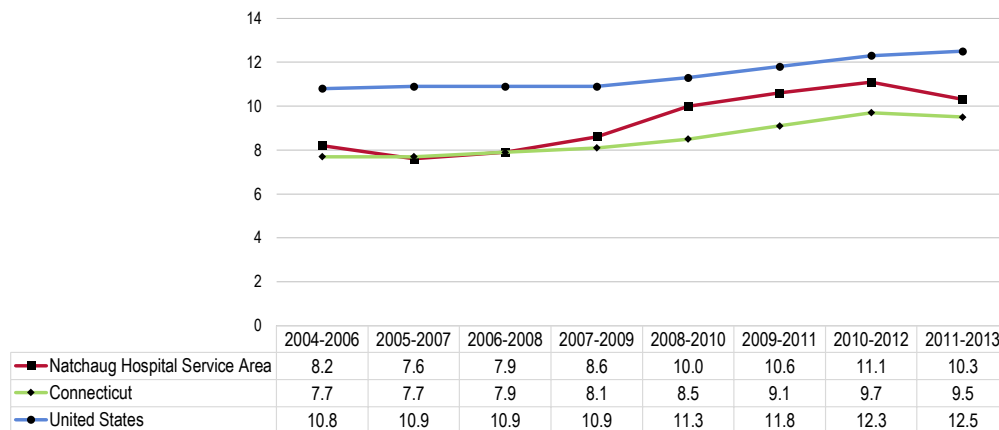
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 102]
 Notes: • Asked of all respondents.

Suicide

The following chart outlines the most current age-adjusted mortality rates attributed to suicide in our population. (Refer to “Leading Causes of Death” for an explanation of the use of age-adjusting for these rates.)

Suicide: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 10.2 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MHMD-1]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 • Local, state and national data are simple three-year averages.

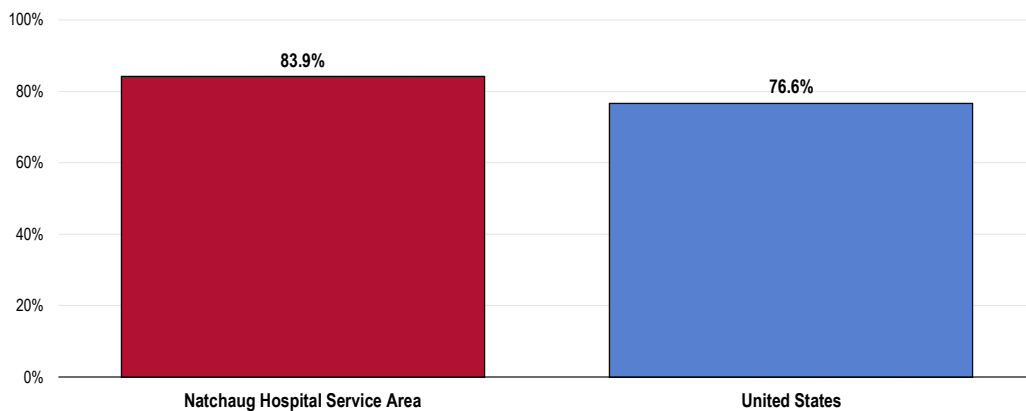
Mental Health Treatment

Treatment for Self

“Have you ever sought help from a professional for a mental or emotional problem?”

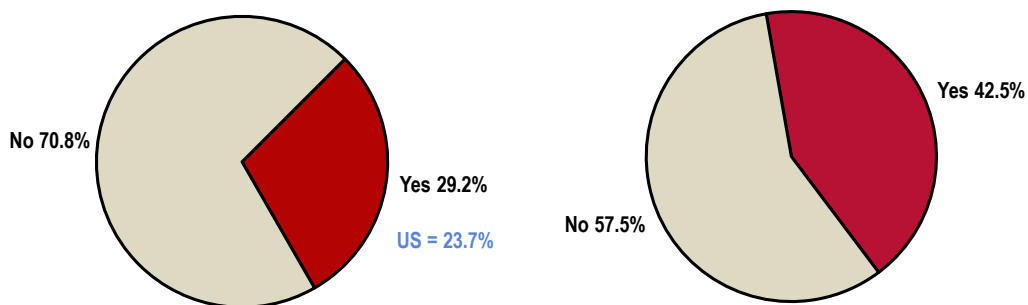
Note that the first chart shows responses among those with a “diagnosed depressive disorder,” which includes respondents reporting a past diagnosis of a depressive disorder by a physician (such as depression, major depression, dysthymia, or minor depression).

Adults With Diagnosed Depression Who Have Ever Sought Professional Help for a Mental or Emotional Problem
(Among Adults With Diagnosed Depressive Disorder)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 123]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Reflects those respondents with a depressive disorder diagnosed by a physician (such as depression, major depression, dysthymia, or minor depression).

Adults Seeking Professional Help for Mental Health Issues
(Natchaug Hospital Service Area, 2015)



Have Sought Professional Help for Mental Health Issues

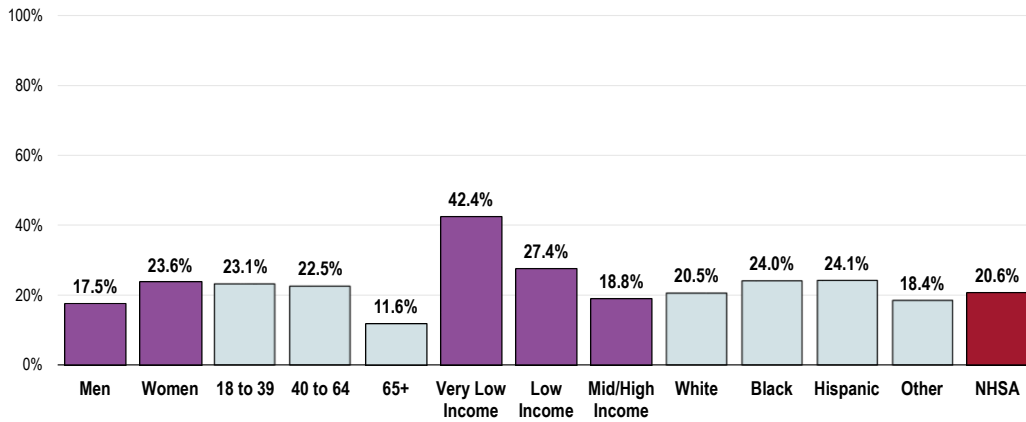
Sought Help in the Past Year
(Among Those Ever Seeking Help)

Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 104, 310]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Treatment for a Household Member

“During the past 12 months, has anyone in your household sought mental health services??”

Member of Household Sought Professional Help for Mental Health in the Past Year
(Natchaug Hospital Service Area, 2015)

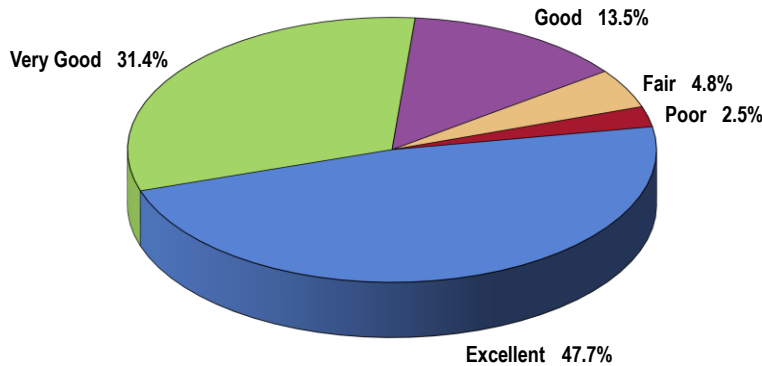


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 311]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes less than 100% of the federal poverty level; “Low Income” includes households with incomes from 100–199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Children’s Mental Health

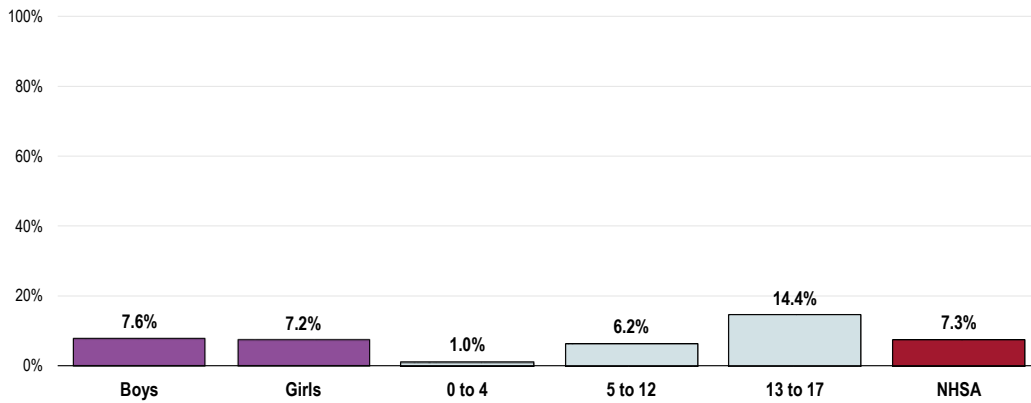
“Now thinking about this child’s mental health, which includes stress, depression, and problems with emotions, would you say that this child’s mental health is: excellent, very good, good, fair or poor?”

Child’s Reported Mental Health Status
(Natchaug Hospital Service Area Children <18, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 315]
 Notes: • Asked of all respondents with children under 18 at home.

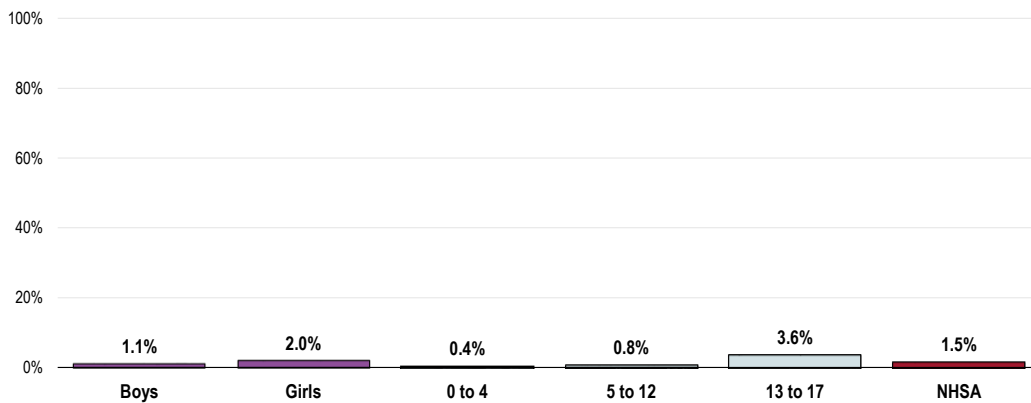
Child Experiences “Fair” or “Poor” Mental Health (Natchaug Hospital Service Area Children <18, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 315]
 Notes: • Asked of all respondents with children under 18 at home.
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes less than 100% of the federal poverty level; “Low Income” includes households with incomes from 100–199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

“Was there a time in the past 12 months when you needed mental health care for this child, but could not get it?”

Could Not Get Necessary Mental Health Services for Child in the Past Year (Natchaug Hospital Service Area Children <18, 2015)



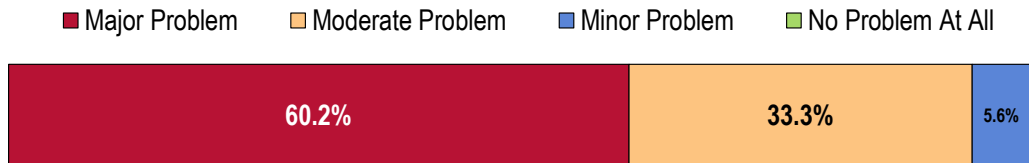
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 316]
 Notes: • Asked of all respondents with children under 18 at home.
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes less than 100% of the federal poverty level; “Low Income” includes households with incomes from 100–199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:

Perceptions of Mental Health as a Problem in the Community

(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Challenges

Among those rating this issue as a “major problem,” the following represent what key informants see as the main challenges for persons with mental illness:

Access to Care

Access to treatment and identifying of mental health issues. – Social Services Representative

One of the biggest challenges would be to look for treatment and maintain it. As far as I know there isn't that much information open to the community regarding organizations and or programs that help out with mental health. There is a skepticism of mental health being seen negatively. For example, among the Latino community and/or Haitian, mental health issues are a sign of weakness and/or punishment on the family (Disgrace). Therefore individuals in this community, do not foresee any treatment options and or even think about getting treated. – Social Services Representative

Unaware of services available or where to get help. Embarrassed to ask for help or attend a program that might give them options. – Community/Business Leader

Access to care. Continued long term follow up and transitions of care with chronic disease and mental illness. Limited providers equipped to meet the needs of those with mental illness. Varied approaches to screening for mental illness, including depression, anxiety and their co existence in chronic disease. – Other Health Provider

Access. When it comes to treatment of mental health, we look at the problem as if it was a short-term one. Insurance plans may cover four outpatient visits, use of medications as a quick fix, not allowing for mid or long term follow-up. Children and Youth have limited access to inpatient services, residential services, etc. Problems encountered in schools are not often dealt with properly due to limited resources. – Other Health Provider

Studies/assessments have determined that to be the case. – Community/Business Leader

Identification and access. – Community/Business Leader

Accessing affordable services. Accessing mental health providers who understand the needs of lesbian, gay, bisexual and transgender individuals. – Social Services Representative Representative

Access to outpatient care. – Other Health Provider

Mental health outpatient services at Backus are not doing well. Inpatient is adequate. – Social Services Representative

People with commercial or private insurance often have difficulty accessing participating providers or those who participate have limited capacity. Also, despite parity, benefits are often limited - Other Health

Resources are not readily available for individuals with third party insurance coverage. – Social Services Representative

Insurance limitations, including limiting the number of visits, preauthorization requirements and especially the fear people have that if they access mental health services, they'll be stigmatized. Also, given our diverse community, truly understanding cultural values and views regarding mental health issues is a gap. – Other Health Provider

Lack of Services

Inadequate resources, housing is often a challenge. Family education and support. – Community/Business Leader

There is limited community resources. – Other Health Provider

Access to services, lack of inpatient care, addressing mental illness of young adults, training for employers and school personnel about mental illness, suicide prevention programs, reducing stigma of mental illness. – Community/Business Leader

Lack of access to care, especially pediatric services and what is then covered tied to this care. Day programs are almost always uncovered and almost always the most needed for children. – Physician

Lack of access, lack of Providers, cost, Specialist work with youth. – Social Services Representative

Not enough services and the way that services are provided. The mental health system especially for low income people is very limited and often does not provide services in the way that people need them. – Social Services Representative

Mental Health Services is a much needed service in my community. The waiting list is long in some areas and people are having a multitude if mental health issues that are not being addressed on time. – Social Services Representative Representative

Lack of resources, lack of family support, cost for treatment, very difficult to navigate the mental systems. Medication adherence, cost, social acceptance, the connection with drug use. – Public Health Expert

Stigma

In addition to the stigma that is still associated with mental health and addiction issues, there are insufficient services and funding for services to meet the need, especially for children and adolescents. – Community/Business Leader

Access to immediate and quality care integration with primary care. Community perception/stigma and discrimination of patients lack of preventive services. – Other Health Provider

Stigma, poor communication between area hospital and community services, lack of appropriately funded outreach services, lack of accessible, integrative treatment. – Social Services Representative

The stigma attached to mental health issues still exists in this country and in our community. The availability of qualified providers of mental health services is very low and a local site for delivery of those services is lacking. – Community/Business Leader

Stigma Access to quality psychiatric care, including physicians and clinicians - and those who are available are not always very skilled or well qualified. For chronically mentally ill, a lack of financial

resources compounds the problem and they have significant issues with basic needs, and difficulties with their physical health, and managing day to day concerns. Case management resources for helping with this and their mental health concerns is lacking. More supportive housing is needed. – Social Services Representative

Stigma, lack of resources. – Other Health Provider

Stigma. Lack of access to therapy and medical treatment. Cultural barriers to seeking mental help. Criminalizing the mentally ill. – Public Health Expert

Finding Practitioners

Finding practitioners. – Other Health Provider

Insufficient number of practitioners, stigma and lack of awareness. – Public Health Expert

Our area cannot recruit enough providers to meet the need for all ages. Not enough capacity. – Other Health Provider

Access to residential and primary care specialists. – Community/Business Leader

Lack of Coordinated Care

Lack of coordinated care. Stigma. Reimbursement rates and coverage for individuals and agencies providing services. Lack of treatment facilities and programs for severe behavioral health issues and individuals struggling to function in society. – Public Health Expert

I think one of the biggest challenges for those with mental health in this area is lack of long term care. In other words, I think we do a great job in identifying and treating those in an acute phase of their illness, but after the initial 30 to 60 days the clients seem to fall off their treatment plans and there is no way to follow up until they re-enter the system in another acute episode. There is also a lack of resources at the school system level. Early identification of illness within families could help get clients directed to treatment resources before it becomes a crisis. – Public Health Expert

Accessing a variety of treatment resources and various levels of care. There is a gap in mid-level care. – Other Health Provider

Increased Awareness and Frequency of Diagnosis

Increased awareness and frequency of diagnosis and lack of affordable resources. – Social Services Representative

Co-morbidity of issues within in our community is growing and concerning, including serious mental health concerns and an inability of non-profit resources to meet the need. – Social Services Representative

Under-detection

If people are not well mentally they will develop other issues and will potentially hurt others if not treated. – Other Health Provider

Significantly under detected and treated. Not a priority. – Community/Business Leader

Case Management and Employment

Access to case management and employment. – Social Services Representative Representative

Timely Quality Care

Access to timely quality care and substance abuse treatment resources. – Social Services Representative Representative

Alcohol, Depression, Substance Abuse and Suicide

Suicide, depression, alcohol and other substance abuse. – Physician

Depression and Stress

Stress and depression are major and disproportionate mental health problems among Latinos, among others. Lack of bilingual mental health professionals is major deficit in the service system.
– Social Services Representative Representative

Support

Getting support, treatment, follow-up, in-patient services, firm programs requiring maintenance of treatment/management. – Community/Business Leader

Growing Number of Youth with Mental Health Needs

I see a growing need for services for youth with mental health needs. Also even though there are several agencies and services that deal with mental health it just does not seem to be enough. Individuals having access to support, medication, counseling is greatly needed at a higher level. With the youth I have a growing concern in the need for more services for them to reach them early enough and provide access to quality services they need to help them. – Community/Business Leader

Housing

Housing and consistent healthcare. – Community/Business Leader

Students

We are seeing increasing numbers of students with mental health and behavioral issues. – Community/Business Leader

Limited Funding

Mental Health is of epidemic proportions with little focus on funding. – Other Health Provider

Nationwide Topic

Mental health issues are not just a local community issue, but a hot nation-wide topic. Different ages suffer from different ailments, it is very broad. – Other Health Provider

Awareness

Not knowing where to go when in crisis. – Other Health Provider

Residential Homes

Approximately 60 State of CT managed Group Home, like residential homes are located in Manchester. Some serve individuals released from Prison for transition through a probation period. Other homes are identified for troubled youth, substance abuse, and a wide variety of behavioral health issues. Access to mental health care is provided to a large extent through services located in Manchester. However, there is a tipping point with the number of individuals being moved to reside in Manchester and the capacity to serve them in the medical community. – Public Health Expert

Social Issues

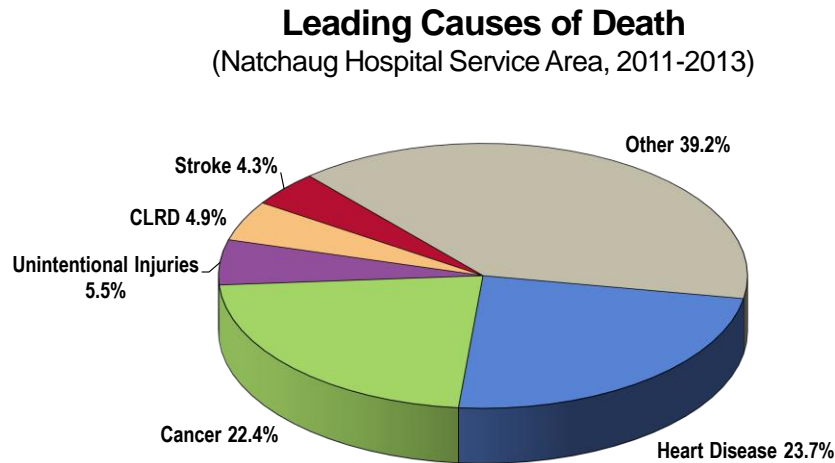
Many patients have social issues as well as BH issues along with their treating medical chronic condition. Many have substance abuse contributing to their need for BH services. Many are uninsured. – Other Health Provider

Death, Disease & Chronic Conditions

Leading Causes of Death

Distribution of Deaths by Cause

Cancers and cardiovascular disease (heart disease and stroke) are leading causes of death in the community.



- Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
- Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• CLRD is chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

In order to compare mortality in the region with other localities (in this case, the state and the United States), it is necessary to look at *rates* of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as *Healthy People 2020* targets.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in the area. (For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.)

Age-Adjusted Death Rates for Selected Causes (2011-2013 Deaths per 100,000 Population)

	NHSA	Connecticut	US	HP2020
Diseases of the Heart	157.7	153.4	171.3	156.9*
Malignant Neoplasms (Cancers)	154.5	153.0	166.2	161.4
Unintentional Injuries	37.5	35.8	39.2	36.4
Chronic Lower Respiratory Disease (CLRD)	34.0	30.9	42.0	n/a
Cerebrovascular Disease (Stroke)	27.8	27.9	37.0	34.8
Alzheimer's Disease	18.5	16.5	24.0	n/a
Diabetes Mellitus	14.7	14.8	21.3	20.5*
Drug-Induced	14.2	13.5	14.1	11.3
Kidney Diseases	13.8	12.5	13.2	n/a
Pneumonia/Influenza	13.4	12.9	15.3	n/a
Intentional Self-Harm (Suicide)	10.3	9.5	12.5	10.2
Cirrhosis/Liver Disease	8.4	7.6	9.9	8.2
Motor Vehicle Deaths	8.0	7.1	10.7	12.4
Firearm-Related	5.2	5.5	10.4	9.3
Homicide/Legal Intervention	3.2	3.8	5.3	5.5
HIV/AIDS	2.0	2.0	2.2	3.3

Sources:

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.

- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>.

Note:

- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.
- *The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart; the Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.
- Local, state and national data are simple three-year averages.

Cardiovascular Disease

About Heart Disease & Stroke

Heart disease is the leading cause of death in the United States, with stroke following as the third leading cause. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than \$500 billion in healthcare expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable.

The leading modifiable (controllable) risk factors for heart disease and stroke are:

- High blood pressure
- High cholesterol
- Cigarette smoking
- Diabetes
- Poor diet and physical inactivity
- Overweight and obesity

The risk of Americans developing and dying from cardiovascular disease would be substantially reduced if major improvements were made across the US population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use.

The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities in the following based on gender, age, race/ethnicity, geographic area, and socioeconomic status:

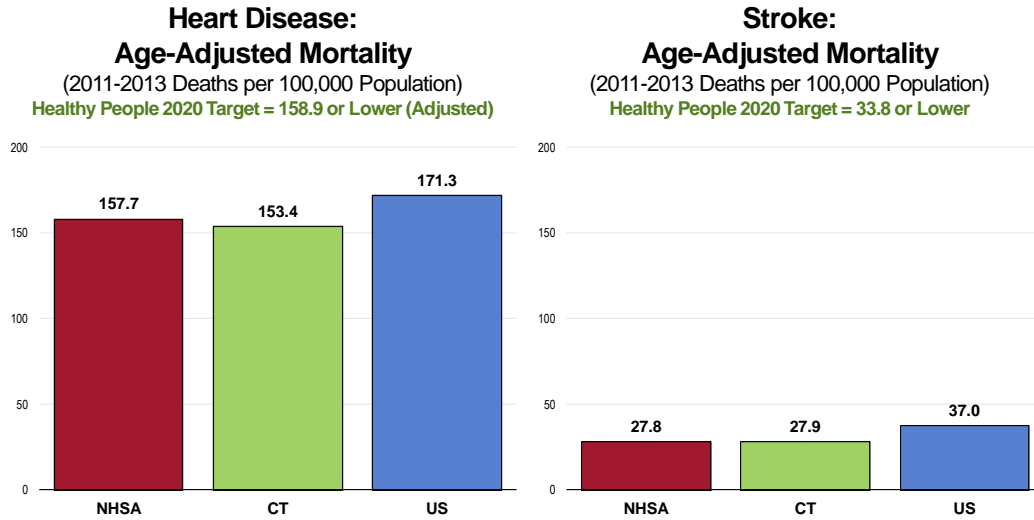
- Prevalence of risk factors
- Access to treatment
- Appropriate and timely treatment
- Treatment outcomes
- Mortality

Disease does not occur in isolation, and cardiovascular disease is no exception. Cardiovascular health is significantly influenced by the physical, social, and political environment, including: maternal and child health; access to educational opportunities; availability of healthy foods, physical education, and extracurricular activities in schools; opportunities for physical activity, including access to safe and walkable communities; access to healthy foods; quality of working conditions and worksite health; availability of community support and resources; and access to affordable, quality healthcare.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Heart Disease & Stroke Deaths

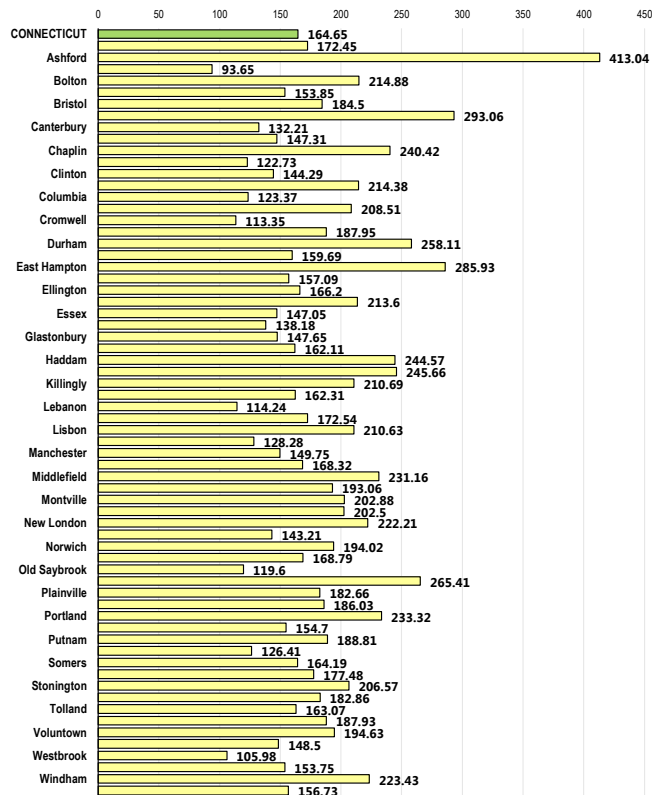
The greatest share of cardiovascular deaths is attributed to heart disease.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives HDS-2 and HDS-3]
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
• The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

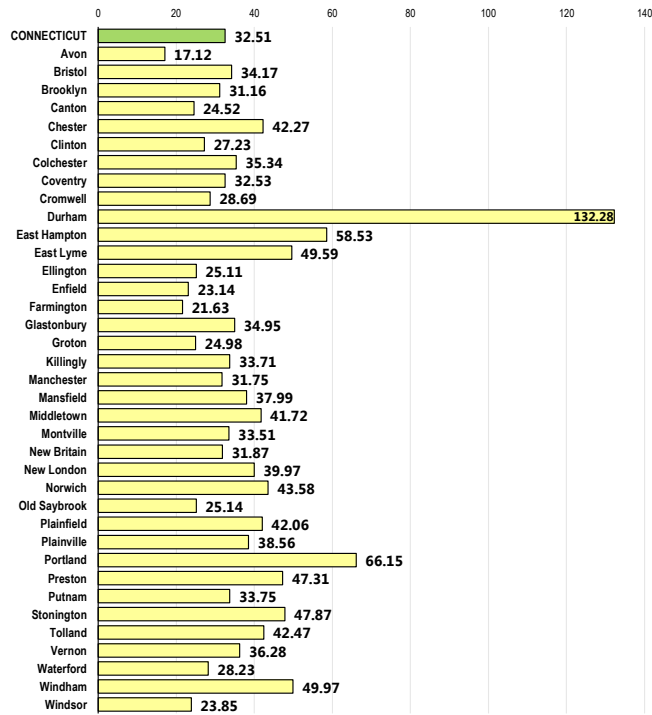
The following charts show available local death rates (age-adjusted) for select towns in the Natchaug Hospital Service Area.

Heart Disease: Age-Adjusted Mortality
(By Select Towns in the Natchaug Hospital Service Area, 2006-2010)



Source: • Connecticut Department of Public Health

Stroke: Age-Adjusted Mortality (By Select Towns in the Natchaug Hospital Service Area, 2006-2010)



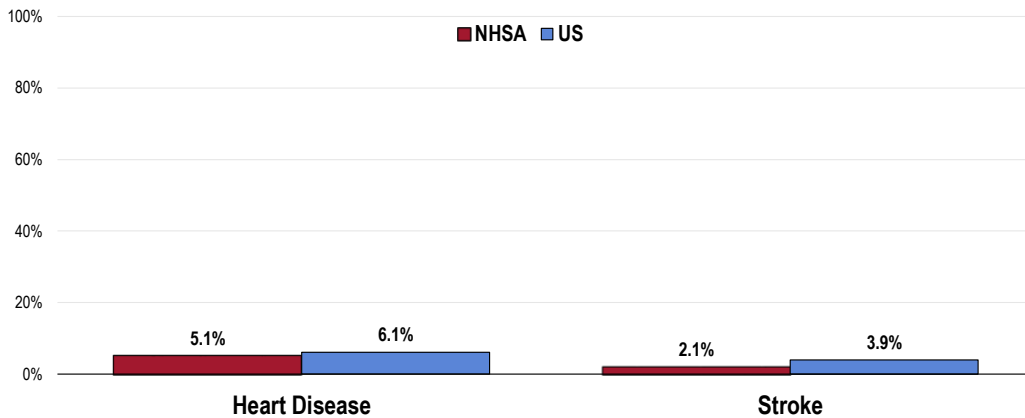
Source: • Connecticut Department of Public Health

Prevalence of Heart Disease & Stroke

“Has a doctor, nurse or other health professional ever told you that you had: A Heart Attack, Also Called a Myocardial Infarction; or Angina or Coronary Heart Disease?” (Heart disease prevalence below is a calculated prevalence that includes those responding affirmatively to either.)

“Has a doctor, nurse or other health professional ever told you that you had a stroke?”

Prevalence of Heart Disease & Stroke



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 36, 124]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • Heart disease includes diagnoses of heart attack, angina or coronary heart disease.

Cardiovascular Risk Factors

About Cardiovascular Risk

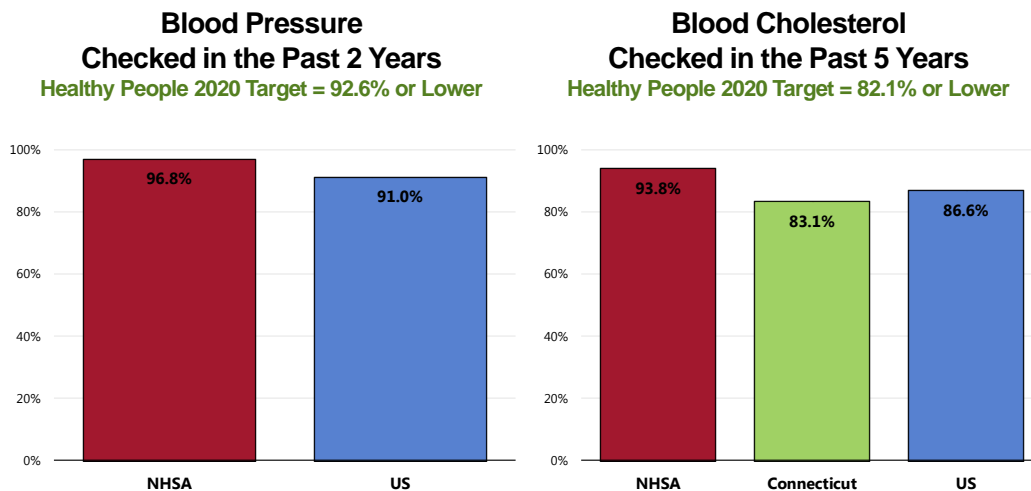
Controlling risk factors for heart disease and stroke remains a challenge. High blood pressure and cholesterol are still major contributors to the national epidemic of cardiovascular disease. High blood pressure affects approximately 1 in 3 adults in the United States, and more than half of Americans with high blood pressure do not have it under control. High sodium intake is a known risk factor for high blood pressure and heart disease, yet about 90% of American adults exceed their recommendation for sodium intake.

- Healthy People 2020 (www.healthypeople.gov)

High Blood Pressure & Cholesterol Testing

“About how long has it been since you last had your blood pressure taken by a doctor, nurse or other health professional?” (Chart below reflects responses indicating testing within the past 2 years.)

“About how long has it been since you last had your blood cholesterol checked?” (Chart below reflects responses indicating testing within the past 5 years.)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 45, 48]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives HDS-4, HDS-6]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Connecticut data.

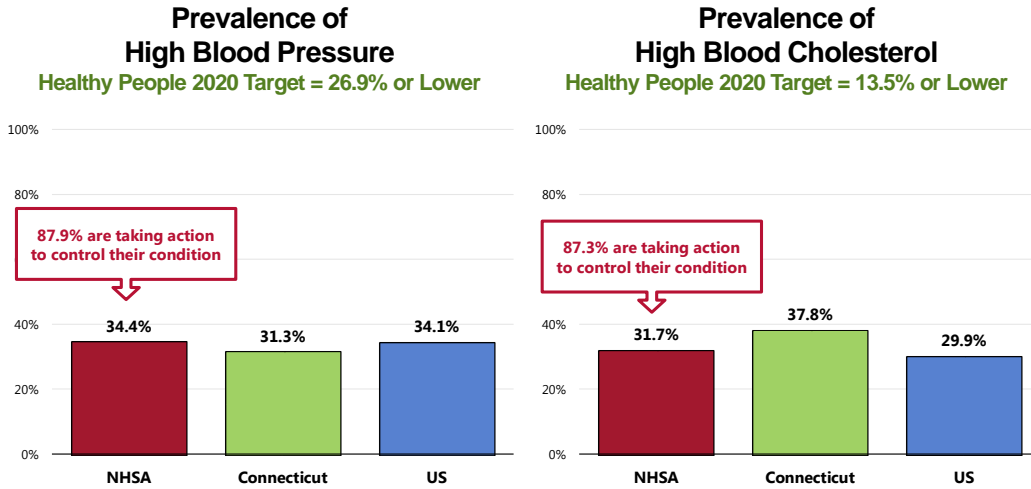
High Blood Pressure & Cholesterol Prevalence

“Have you ever been told by a doctor, nurse or other health care professional that you had high blood pressure?”

- *“Are you currently taking any action to help control your high blood pressure, such as taking medication, changing your diet, or exercising?”*

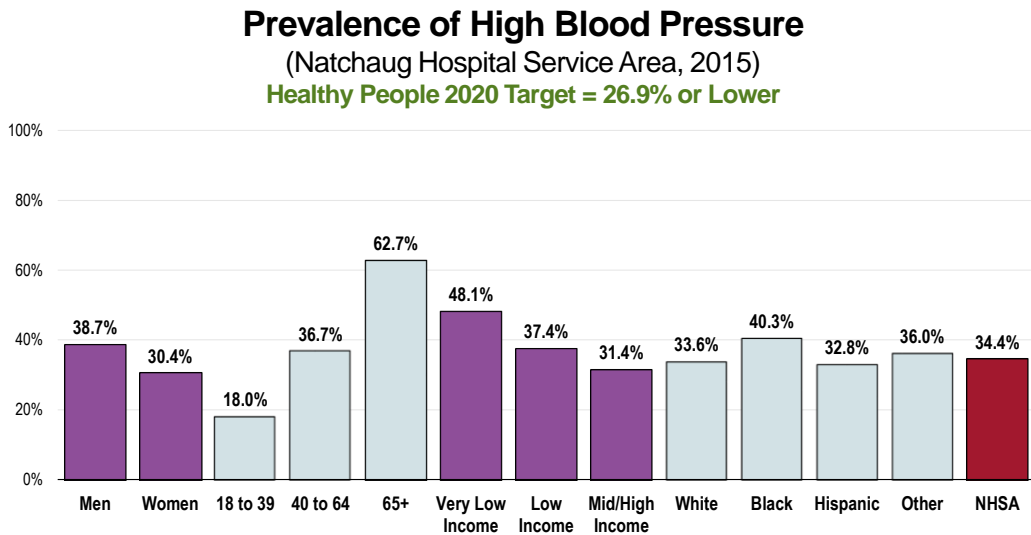
“Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?”

- “Are you currently taking any action to help control your high cholesterol, such as taking medication, changing your diet, or exercising?”



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 43, 47, 125, 126]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2013 Connecticut data.
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives HDS-5.1 and HDS-7]

Notes: • Asked of all respondents.

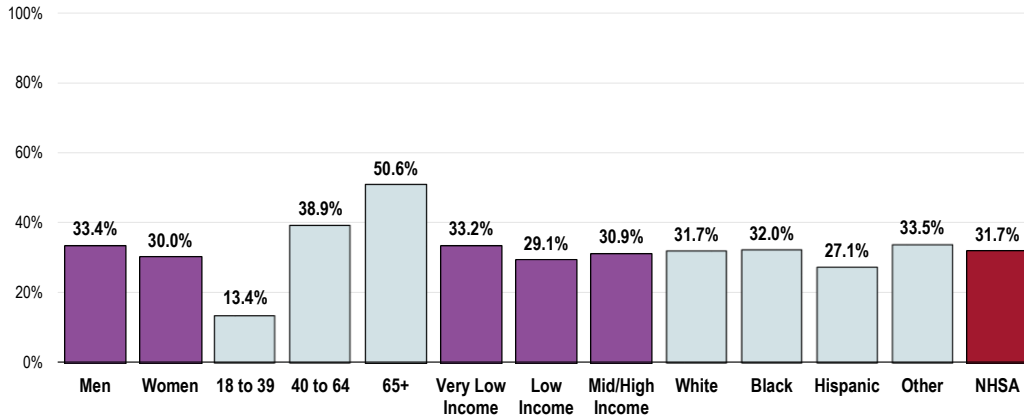


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 125]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-5.1]

Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes less than 100% of the federal poverty level; “Low Income” includes households with incomes from 100–199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Prevalence of High Blood Cholesterol (Natchaug Hospital Service Area, 2015)

Healthy People 2020 Target = 13.5% or Lower



- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 126]
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-7]
- Notes:
- Asked of all respondents.
 - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes less than 100% of the federal poverty level; "Low Income" includes households with incomes from 100–199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

About Cardiovascular Risk

Individual level risk factors which put people at increased risk for cardiovascular diseases include:

- High Blood Pressure
 - High Blood Cholesterol
 - Tobacco Use
 - Physical Inactivity
 - Poor Nutrition
 - Overweight/Obesity
 - Diabetes
- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Three health-related behaviors contribute markedly to cardiovascular disease:

Poor nutrition. People who are overweight have a higher risk for cardiovascular disease. Almost 60% of adults are overweight or obese. To maintain a proper body weight, experts recommend a well-balanced diet which is low in fat and high in fiber, accompanied by regular exercise.

Lack of physical activity. People who are not physically active have twice the risk for heart disease of those who are active. More than half of adults do not achieve recommended levels of physical activity.

Tobacco use. Smokers have twice the risk for heart attack of nonsmokers. Nearly one-fifth of all deaths from cardiovascular disease, or about 190,000 deaths a year nationally, are smoking-related. Every day, more than 3,000 young people become daily smokers in the US

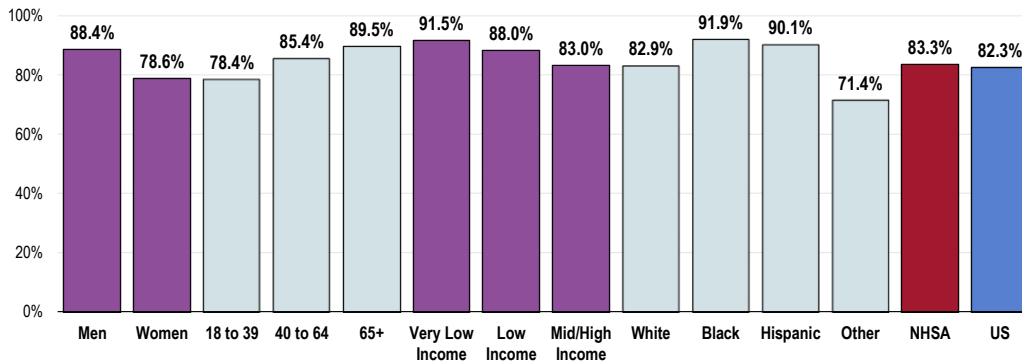
Modifying these behaviors is critical both for preventing and for controlling cardiovascular disease. Other steps that adults who have cardiovascular disease should take to reduce their risk of death and disability include adhering to treatment for high blood pressure and cholesterol, using aspirin as appropriate, and learning the symptoms of heart attack and stroke.

- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Total Cardiovascular Risk

The following chart reflects the percentage of adults in the Total Service area who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol. See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the Modifiable Health Risk section of this report.

Present One or More Cardiovascular Risks or Behaviors
(Natchaug Hospital Service Area, 2015)

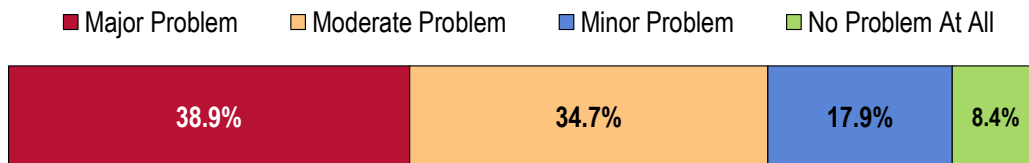


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 127]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.
 • Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes less than 100% of the federal poverty level; "Low Income" includes households with incomes from 100–199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:

Perceptions of Heart Disease and Stroke as a Problem in the Community
(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

Leading Cause of Death

Can lead to death and other life-threatening and expensive to treat illnesses. – Other Health Provider

Lead cause of death. – Public Health Expert

Based on mortality statistics and experience in the community. – Other Health Provider

It is a leading cause of death, not just in my community. – Other Health Provider

Heart disease and stroke is considered a major cause of morbidity and mortality. Incidence of the disease and the fact that they are endemic chronic conditions requires attention. Of course, everyone eventually succumbs to heart failure. – Community/Business Leader

Continues to be in the top five houses of death in our city. – Public Health Expert

Our clients are dying of heart attacks in their 50's. – Social Services Representative

Number one killer of men and women. – Other Health Provider

Data show. – Physician

Heart disease is the leading cause of death among minorities in the United States, according to the U.S. Department of Health and Human Services Office of Minority Health. Blacks and Hispanics are more likely to suffer from obesity and hypertension, two of the major risk factors for heart disease. – Other Health Provider

Poor Diet and Exercise

Bad habits of today, that offer immediate gratification, leads to these health risks down the road. Stress, poor diets, lack of exercise (no time) are all becoming more a part of our lives. Primary Care can address some challenges when people have coverage and can make their co-payments, but our society has become more "give me what I want now, I'll deal with the consequences later." While school meals seem to be improving for our children, the pressure to improve testing scores has led to the elimination of recess and cut down on physical education/activity in many school systems, another example of what we deem to be our priority. – Other Health Provider

Heart disease is a nationwide problem and we are included in that. Much of it is person choice but there is also a lack of healthy food establishments in Meriden, too many fast food chains and not enough affordable healthy food. We are also not as active as we can/should be. We need to take a look at what factors are present in the lives of those who do eat healthy and do exercise instead of so much data on why people are not eating healthy or exercising. There are plenty of places in Meriden where one can go for physical activities we need to look at why they are not being utilized. – Public Health Expert

Poor diet and exercise. Lack of education. Poor parks and recreation options. Poor urban planning, community infrastructure, barrier to physical activity. Food, desserts. – Public Health Expert

Poverty

Poor population/welfare with access to cheap, lousy food. Lack of education and knowledge of proper nutrition. Sedentary. – Community/Business Leader

Poverty, inadequate diets, not taking the problem serious. – Social Services Representative

Individuals who cannot afford care often go untreated with progression of disease states. Limited ability to refer patients to cardiology related to uninsured status. – Other Health Provider

Weight Issues

There is a high prevalence of obesity in Hartford which is linked to heart disease. Further there are a number of barriers to accessing nutritious food which make it difficult for families to eat regular balanced nutritious meals. – Community/Business Leader

Weight issues, lack of activity and other healthy behavioral issues seem to be prevalent in the population we deal with. – Community/Business Leader

Too many people and unfortunately children are obese and this leads to heart problems as well as others. – Community/Business Leader

Access to Healthcare

Access to healthcare, transportation, office hours that do not extend beyond the normal work day. Cost of medications, cost of healthier choices at the grocery store, excessive tobacco use. – Public Health Expert

The majority of our population does not have affordable, appropriate, and reliable access and information about these conditions. Translators and translation services that really work and are appropriate, are not in place for our population in need. We see students every day that suffer from conditions related to heart disease. Many of our students see a doctor/clinic initially but then cannot or do not follow up. Often times they do not use their medicine due to misunderstanding or miss-information or lack of Health Literacy. The information may be there, but their ability to understand and access it is quite limited. Accessible community health educators that speak their languages are desperately needed. We continue to teach Health Literacy within the context of ESOL education and look to community health resources for information, support and guidance. – Social Services Representative

Multiple Issues

I think that all sorts of issues bring about heart disease from poor medical care to poor nutrition, smoking, drug use and finally an aging population. – Other Health Provider

Heart disease and stroke in the community are usual as result of another chronic disease not being managed. – Social Services Representative

Volume

Number of people impacted and leading cause of death and disability. – Public Health Expert

It is so prevalent and education and prevention does not seem to have an impact as it is today. – Community/Business Leader

This is a major problem in the US in every community. – Social Services Representative

Minority Populations

African Americans and Hispanics which make up a large percentage of the Hartford population are often affected by heart disease and stroke. Reasons being due to genetics, but largely because of a poor unbalanced diet which contains a vast amount carbohydrates, fats and sodium and not enough grains, fruits and vegetables. – Other Health Provider

Aging population generally aligns with leading causes of morbidity and mortality in the United States. – Public Health Expert

High Rates of Diabetes Risk

With the high rates of diabetes in the city, the risk for heart disease and stroke is also elevated. – Community/Business Leader

Stress

High stress lifestyles, lack of exercise, lack of access to and affordability of healthy foods, heavy smoking and consuming alcoholic beverages in excess. – Social Services Representative

Poor Hospital Care

Backus Neurology is in disarray and in The Hartford Healthcare system as a whole is weak. Effective stroke support at Backus is nonexistent and in Hartford Healthcare is poor. – Social Services Representative

Change

Similar to diabetes, heart disease and stroke require major lifestyle changes to prevent and treat. Many residents, particularly low income, are not equipped to make and maintain those changes. – Other Health Provider

Cancer

About Cancer

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in five years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease.

Many cancers are preventable by reducing risk factors such as: use of tobacco products; physical inactivity and poor nutrition; obesity; and ultraviolet light exposure. Other cancers can be prevented by getting vaccinated against human papillomavirus and hepatitis B virus. In the past decade, overweight and obesity have emerged as new risk factors for developing certain cancers, including colorectal, breast, uterine corpus (endometrial), and kidney cancers. The impact of the current weight trends on cancer incidence will not be fully known for several decades. Continued focus on preventing weight gain will lead to lower rates of cancer and many chronic diseases.

Screening is effective in identifying some types of cancers (see US Preventive Services Task Force [USPSTF] recommendations), including:

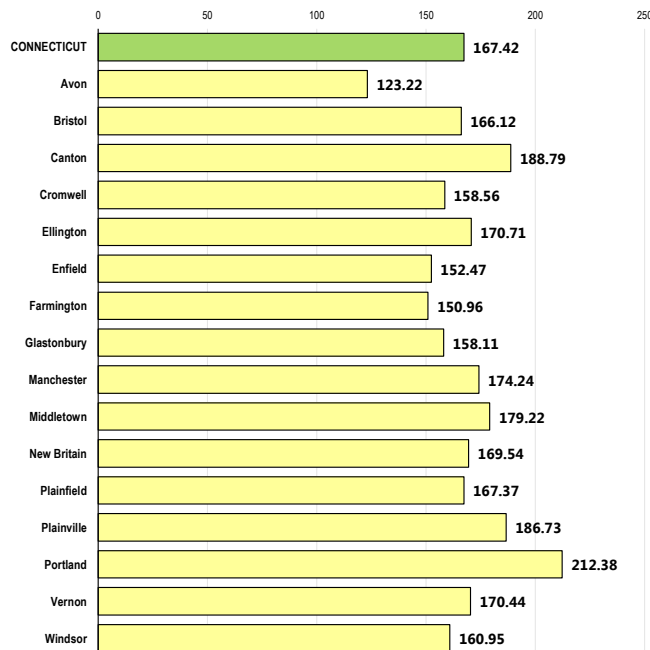
- Breast cancer (using mammography)
- Cervical cancer (using Pap tests)
- Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)

• Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted mortality in select towns in the Natchaug Hospital Service Area.

Cancer: Age-Adjusted Mortality
(By Select Towns in the Natchaug Hospital Service Area, 2006-2010)



Source: • Connecticut Department of Public Health

Lung cancer is by far the leading cause of cancer deaths in the area. Other leading sites include prostate cancer among men, breast cancer among women, and colorectal cancer (both genders).

Age-Adjusted Cancer Death Rates by Site (2011-2013 Annual Average Deaths per 100,000 Population)

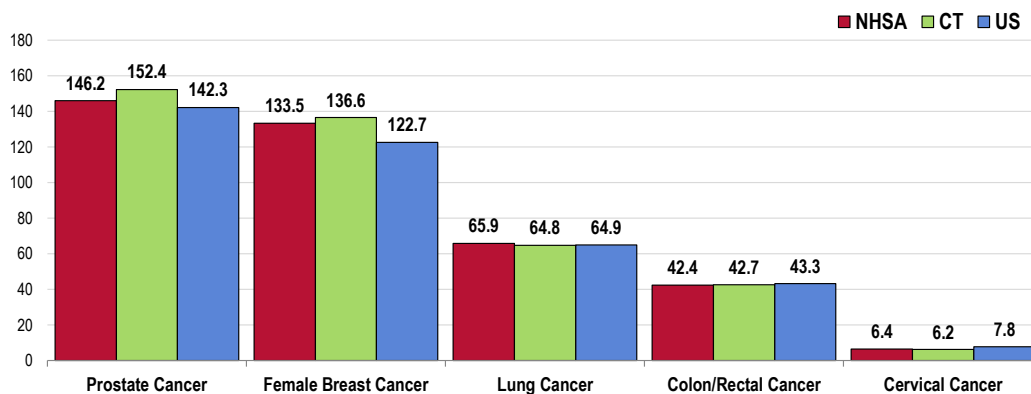
	Natchaug Hospital Service Area	Connecticut	US	HP2020
Lung Cancer	39.4	38.7	44.7	45.5
Prostate Cancer	19.4	18.2	19.8	21.8
Female Breast Cancer	19.4	19.2	21.3	20.7
Colorectal Cancer	12.6	12.1	14.9	14.5

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>

Cancer Incidence

Incidence rates (or case rates) reflect the number of newly diagnosed cases in a given population in a given year, regardless of outcome. They are usually expressed as cases per 100,000 population per year. Here, these rates are also age-adjusted.

Cancer Incidence Rates by Site (Annual Average Age-Adjusted Incidence per 100,000 Population, 2007-2011)



Sources: • State Cancer Profiles: 2007-11.
 • Retrieved February 2015 from Community Commons at <http://www.chna.org>.
 Notes: • This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

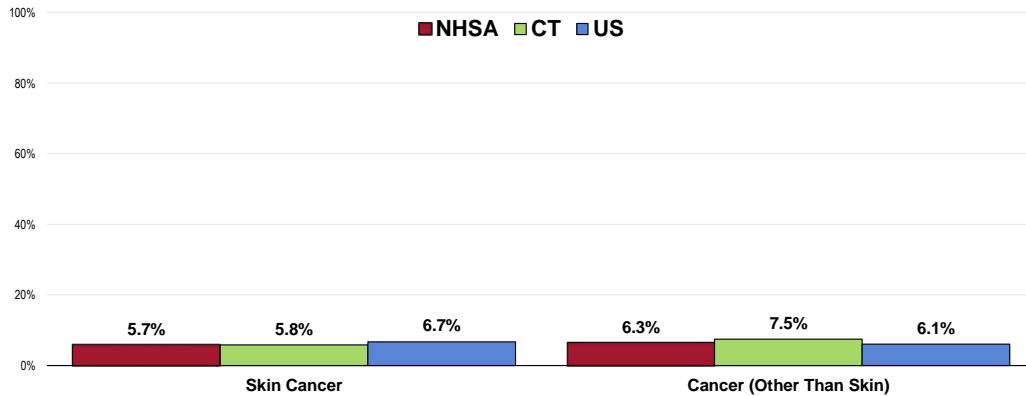
Prevalence of Cancer

Skin Cancer

“Would you please tell me if you have ever suffered from or been diagnosed with cancer, not counting skin cancer?”

“Would you please tell me if you have ever suffered from or been diagnosed with skin cancer?”

Prevalence of Cancers



- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 30, 31]
 - 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Connecticut data.
- Notes:
- Asked of all respondents.

Cancer Risk

About Cancer Risk

Reducing the nation’s cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.

- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor’s checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

Screening levels in the community were measured in the PRC Community Health Survey relative to: female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

Female Breast Cancer Screening

About Screening for Breast Cancer

The US Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women age 40 and older.

Rationale: The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women age 50-69, the age group generally included in screening trials. For women age 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50.

The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. The USPSTF concluded that the evidence is also generalizable to women age 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increase along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminish from ages 40-70. The balance of benefits and potential harms, therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. The USPSTF did not find sufficient evidence to specify the optimal screening interval for women age 40-49.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Cervical Cancer Screenings

About Screening for Cervical Cancer

The US Preventive Services Task Force (USPSTF) strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.

Rationale: The USPSTF found good evidence from multiple observational studies that screening with cervical cytology (Pap smears) reduces incidence of and mortality from cervical cancer. Direct evidence to determine the optimal starting and stopping age and interval for screening is limited. Indirect evidence suggests most of the benefit can be obtained by beginning screening within 3 years of onset of sexual activity or age 21 (whichever comes first) and screening at least every 3 years. The USPSTF concludes that the benefits of screening substantially outweigh potential harms.

The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer.

Rationale: The USPSTF found limited evidence to determine the benefits of continued screening in women older than 65. The yield of screening is low in previously screened women older than 65 due to the declining incidence of high-grade cervical lesions after middle age. There is fair evidence that screening women older than 65 is associated with an increased risk for potential harms, including false-positive results and invasive procedures. The USPSTF concludes that the potential harms of screening are likely to exceed benefits among older women who have had normal results previously and who are not otherwise at high risk for cervical cancer.

The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease.

Rationale: The USPSTF found fair evidence that the yield of cytologic screening is very low in women after hysterectomy and poor evidence that screening to detect vaginal cancer improves health outcomes. The USPSTF concludes that potential harms of continued screening after hysterectomy are likely to exceed benefits.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Colorectal Cancer Screenings

About Screening for Colorectal Cancer

The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years.

The evidence is convincing that screening for colorectal cancer with fecal occult blood testing, sigmoidoscopy, or colonoscopy detects early-stage cancer and adenomatous polyps. There is convincing evidence that screening with any of the three recommended tests (FOBT, sigmoidoscopy, colonoscopy) reduces colorectal cancer mortality in adults age 50 to 75 years. Follow-up of positive screening test results requires colonoscopy regardless of the screening test used.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

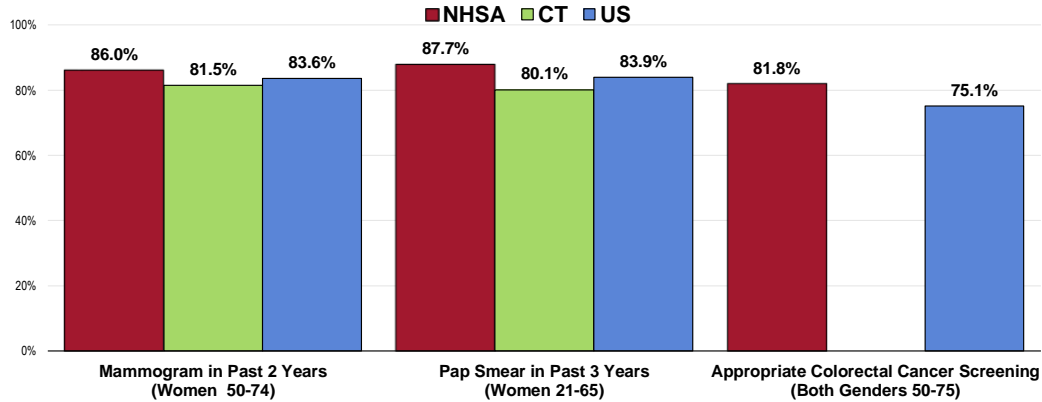
Breast Cancer Screening: *“A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?”* (Calculated below among women age 50 to 74 indicating screening within the past 2 years.)

Cervical Cancer Screening: *“A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?”* (Calculated below among women age 21 to 65 indicating screening within the past 3 years.)

Colorectal Cancer Screening: *“Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?”* and *“A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?”* (Calculated below among both genders age 50 to 75 indicating fecal occult blood testing within the past year and/or sigmoidoscopy/colonoscopy [lower endoscopy] within the past 10 years.)

Cancer Screenings

Healthy People 2020 Target = 81.1% or Higher (Mammograms)
 Healthy People 2020 Target = 93.0% or Higher (Pap Smears)
 Healthy People 2020 Target = 70.5% or Higher (Colorectal)



Sources:

- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 129,130,133]
- 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2013 Connecticut data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives C-15, C-16, and C-17]

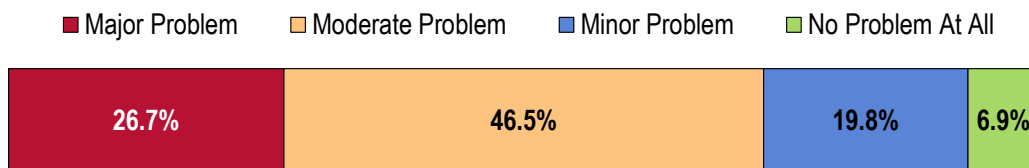
 Notes:

- *Note that the mammogram state data reflects all women 50 and older (vs. women 50-74 in local, US and Healthy People data); the Pap smear state data reflects all women age 18 and older.

Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:

Perceptions of Cancer as a Problem in the Community (Key Informants, 2015)



Sources:

- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

 Notes:

- Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

High Cancer Rates

Number of people impacted and lack of early detection. – Public Health Expert

There seems to be a significant diagnosis of cancer in our region and I'm not sure if everyone has access to treatment. There are new affiliations in our region but again I am not sure if transportation is an issue and I am not sure if payment is an issue. – Other Health Provider

Cancer is highly prevalent and early detection and intervention may not always be happening. –

Community/Business Leader

Seems to be a high incidence of cancer in our region of the state. – Social Services Representative

This case of cancer in the community are growing. There are lack of knowledge of education, prevent and screening regarding the issue of cancer. – Social Services Representative

High incidence - Social Service

Cancer is a major problem in all of Connecticut as it ranks 12th in the country for men, 8th in the country for females and 9th in the country for all cancers. – Public Health Expert

In both my professional and personal experience I have encountered an increasingly high number of individuals who are afflicted with cancer or have a family member with cancer. The number seems to be growing each year. – Community/Business Leader

Lack of Cancer Prevention Programs

Many of the people we work with have cancer from lifestyle issues like smoking and they are diagnosed late in the disease. – Social Services Representative

Due to lack of screening for early detection purposes. Not because of lack of availability but rather because of lack of education to access the services. – Community/Business Leader

So many families are struck by cancer. Early detection and awareness of disease and prevention needed. – Community/Business Leader

Not enough cancer prevention programs in the community. – Public Health Expert

Aging Population, Leading Cause of Morbidity

Aging population is generally aligned with the leading causes of morbidity and mortality in the United States. – Public Health Expert

As I am aging myself I know of and hear of more and more people with cancer diagnosis. – Social Services Representative

I think cancer is a major problem in every community. As we continue to be exposed to chemicals and products through our air and food. As we become an older, aging population, cancer will continue to be a major problem. – Other Health Provider

Data show it to be. – Physician

Specialists

There is little access locally to specialists. – Community/Business Leader

Since access to healthcare is so limited, people in our community don't have preventative doctor visits. Oftentimes patients learn about the disease at an advanced stage and they don't have the resources to receive appropriate treatment. – Social Services Representative

Minorities

It's a major problem in communities of color. There are more and more people who are diagnosed. – Social Services Representative

People of color are desperately impacted in most forms of cancer. – Other Health Provider

Cost of Cancer Medications

There is very good hospital based care and treatment but the drug costs are soaring and with high deductible plans patients are more and more responsible for the expense and it has caused access issues, as has the reduced Medicare and commercial insurer reimbursement for the drugs and the associated administration of the drugs. Most of these drugs require administration by trained medical professionals. – Physician

Distance to Travel for Cancer Treatment

A person must travel minimum 25 miles to nearest cancer treatment. Little or no public transportation available. – Social Services Representative

Lack of Services for Low-Income

Very low income. People don't get to the doctor for preventative or early detection services so don't seek treatment until they have advanced illness. – Social Services Representative

Hispanics

While Latinos have lower incidence rates for some cancers, they have higher rates for some others. They also have later detection rates and social determinants of health that impede adequate wellness support during and after treatment. – Social Services Representative

Access to Screenings

Poor access to screening. Poor adherence to screening guidelines. Late detection, unnecessarily high mortality rates. – Public Health Expert

Respiratory Disease

About Asthma & COPD

Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath. Daily preventive treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives.

COPD is a preventable and treatable disease characterized by airflow limitation that is not fully reversible. The airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lung to noxious particles or gases (typically from exposure to cigarette smoke). Treatment can lessen symptoms and improve quality of life for those with COPD.

The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at \$20.7 billion.

Asthma. The prevalence of asthma has increased since 1980. However, deaths from asthma have decreased since the mid-1990s. The causes of asthma are an active area of research and involve both genetic and environmental factors.

Risk factors for asthma currently being investigated include:

- Having a parent with asthma
- Sensitization to irritants and allergens
- Respiratory infections in childhood
- Overweight

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. Populations with higher rates of asthma include: children; women (among adults) and boys (among children); African Americans; Puerto Ricans; people living in the Northeast United States; people living below the Federal poverty level; and employees with certain exposures in the workplace.

While there is not a cure for asthma yet, there are diagnoses and treatment guidelines that are aimed at ensuring that all people with asthma live full and active lives.

- Healthy People 2020 (www.healthypeople.gov)

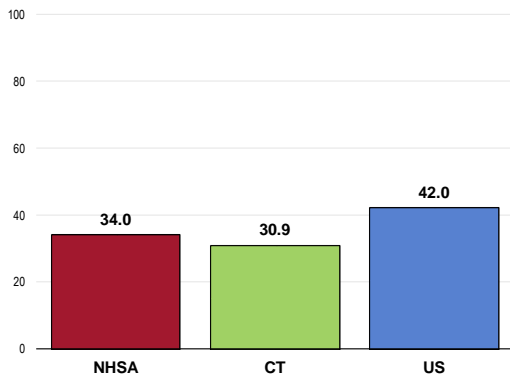
[NOTE: COPD was changed to chronic lower respiratory disease (CLRD) with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.]

Age-Adjusted Respiratory Disease Deaths

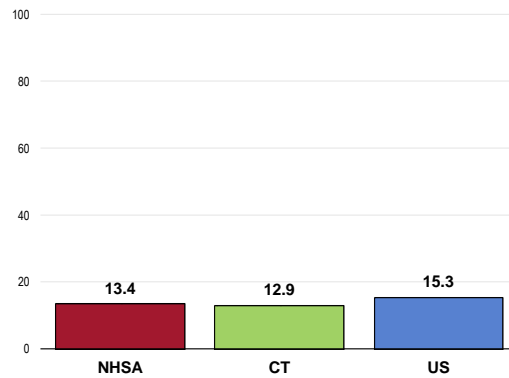
Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis.

Pneumonia and influenza mortality is also illustrated in the following chart. For prevalence of vaccinations against pneumonia and influenza, see also *Immunization & Infectious Disease*.

Chronic Lower Respiratory Disease: Age-Adjusted Mortality
(2011-2013 Annual Average Deaths per 100,000 Population)



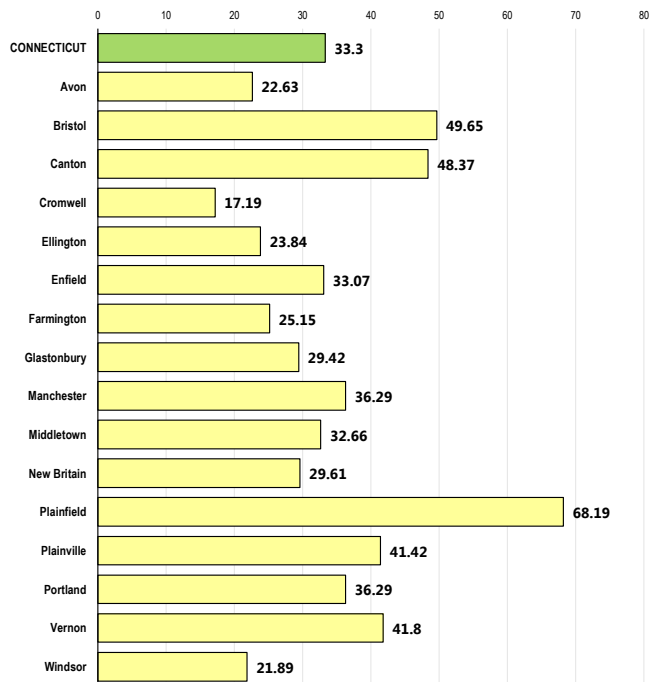
Pneumonia/Influenza: Age-Adjusted Mortality
(2011-2013 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 • Local, state and national data are simple three-year averages.
 • CLRD is chronic lower respiratory disease.

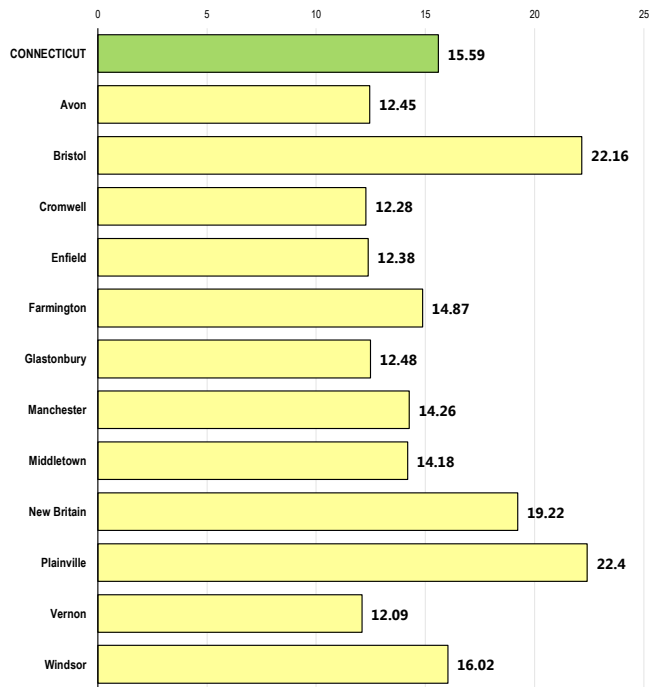
Town-level mortality rates are shown below.

CLRD: Age-Adjusted Mortality
(By Select Towns in the Natchaug Hospital Service Area, 2006-2010)



Source: • Connecticut Department of Public Health

**Influenza/Pneumonia:
Age-Adjusted
Mortality**
(By Select Towns in the
Natchaug Hospital Service
Area, 2006-2010)



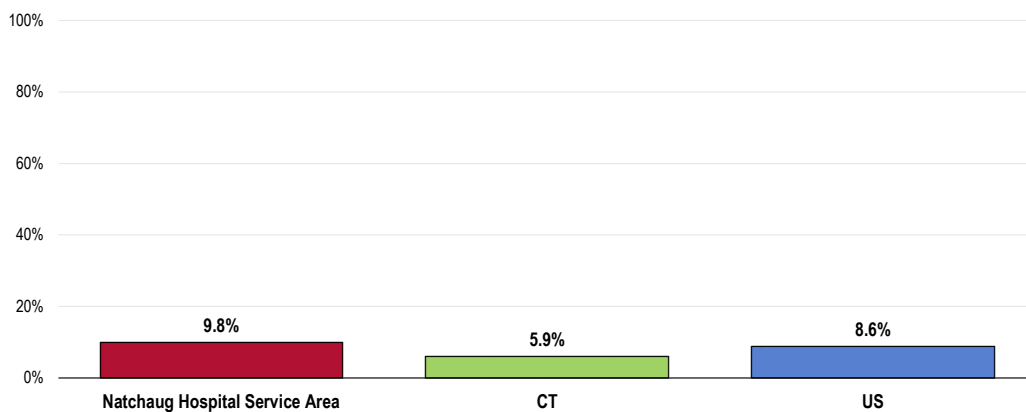
Source: • Connecticut Department of Public Health

Prevalence of Respiratory Diseases

COPD

“Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?”

**Prevalence of
Chronic Obstructive Pulmonary Disease (COPD)**



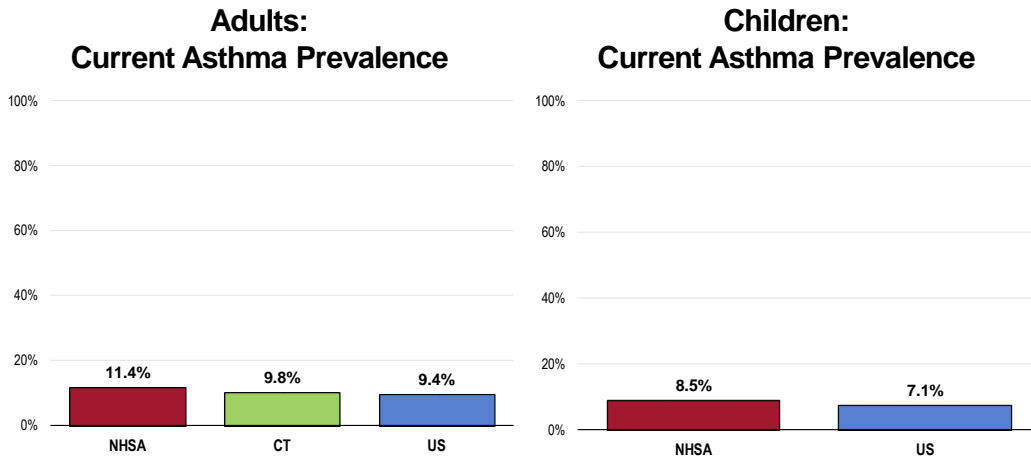
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 25]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Connecticut data.

Notes: • Asked of all respondents.
 • Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

Asthma

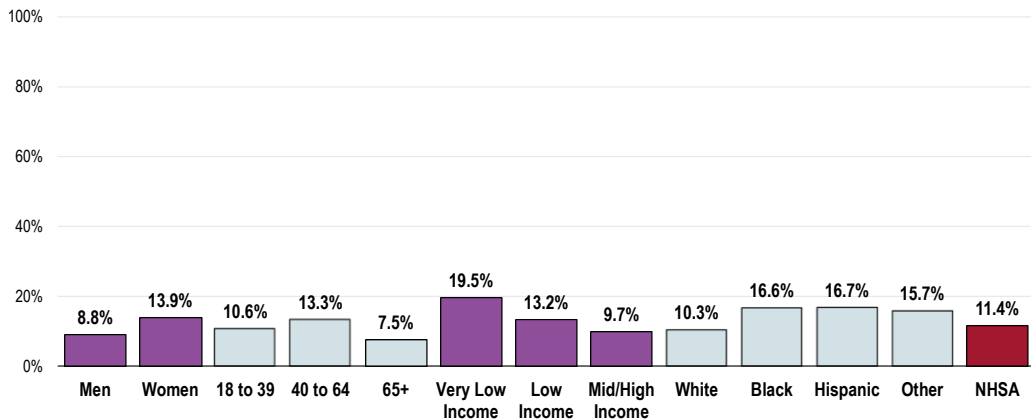
Adults: “Have you ever been told by a doctor, nurse, or other health professional that you had asthma?” and “Do you still have asthma?” (Calculated below as a prevalence of all adults who have ever been diagnosed with asthma and who still have asthma [“current asthma”]).

Children: “Has a doctor or other health professional ever told you that this child had asthma?” and “Does this child still have asthma?” (Calculated below as a prevalence of all children who have ever been diagnosed with asthma and who still have asthma [“current asthma”]).



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 134, 135]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2013 Connecticut data.
 Notes: • Includes those who have ever been diagnosed with asthma, and who report that they still have asthma.

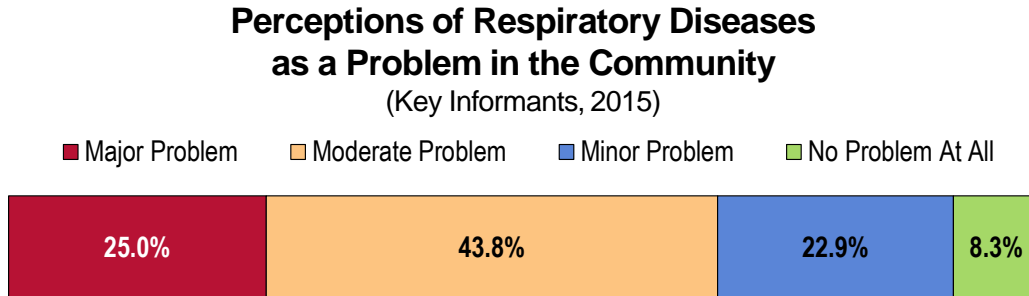
Adults: Currently Have Asthma
 (Natchaug Hospital Service Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 134]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes less than 100% of the federal poverty level; “Low Income” includes households with incomes from 100–199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

Asthma

- Very high rates of asthma. 40% or more for students in our schools. – Community/Business Leader*
- Asthma would be the top issue for Meriden followed by smoking related issues. – Public Health Expert*
- Asthma. – Physician*

Tobacco Use

- Tobacco use. Poor indoor air quality. Lack of affordable housing. High asthma rates. – Public Health Expert*
- High number of our clients smoke. – Social Services Representative*
- Tobacco use. Adults who are smokers, smoking in the presence of children, who develop asthma or other Reactive Airway Disease. – Public Health Expert*

Asthma and COPD

- Asthma and COPD rates. – Public Health Expert*
- High incidence of COPD and asthma - Social Service*

Allergies

- Allergies to things put in the air. Tobacco and weed. Dust and molds. Household cleaners. Town dump burning. Chlorine not removed from drinking water, before drinking. – Community/Business Leader*

Severity

- Can be life threatening. – Other Health Provider*

Pollution

- This is primarily due to the excessive amount of pollution in the community. – Other Health*

Provider

High Prevalence

Extremely high prevalence in northeastern CT. – Other Health Provider

Humidity and Mold

There are areas of high humidity and or mold nearby, as a result causing sinus infections, asthma and other respiratory diseases. Nearby complexes and apartments instead of looking for funding to upgrade their buildings and reduce the impact that these living conditions create in their residents, make tenants sign a waiver that releases them of any liability. – Social Services Representative

Hispanics

Latinos in CT suffer disproportionate rates of asthma and of inadequate asthma management. – Social Services Representative

Doctor's Orders

Patients not following the doctor's orders and follow-up care. – Other Health Provider

Larger Issues

Again, this issue is often a symptom of larger issues, obesity, heart disease, mill workers and aging population. – Other Health Provider

Injury & Violence

About Injury & Violence

Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as “accidents,” “acts of fate,” or as “part of life.” However, most events resulting in injury, disability, or death are predictable and preventable.

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death
- Disability
- Poor mental health
- High medical costs
- Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities.

Numerous factors can affect the risk of unintentional injury and violence, including individual behaviors, physical environment, access to health services (ranging from pre-hospital and acute care to rehabilitation), and social environment (from parental monitoring and supervision of youth to peer group associations, neighborhoods, and communities).

Interventions addressing these social and physical factors have the potential to prevent unintentional injuries and violence.

Efforts to prevent unintentional injury may focus on:

- Modifications of the environment
- Improvements in product safety
- Legislation and enforcement
- Education and behavior change
- Technology and engineering

Efforts to prevent violence may focus on:

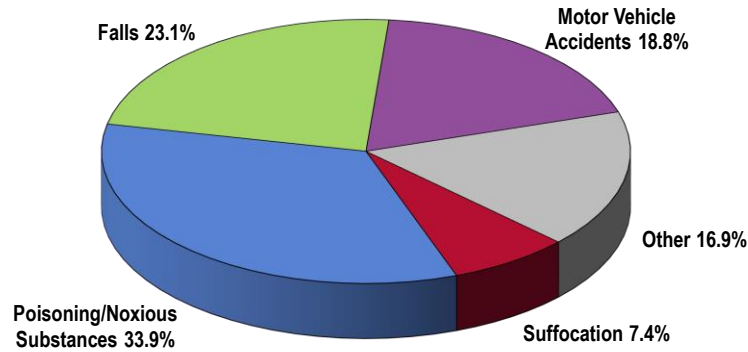
- Changing social norms about the acceptability of violence
- Improving problem-solving skills (for example, parenting, conflict resolution, coping)
- Changing policies to address the social and economic conditions that often give rise to violence

- Healthy People 2020 (www.healthypeople.gov)

Leading Causes of Accidental Death

Leading causes of accidental death in the area include the following:

Leading Causes of Accidental Death (Natchaug Hospital Service Area, 2011-2013)



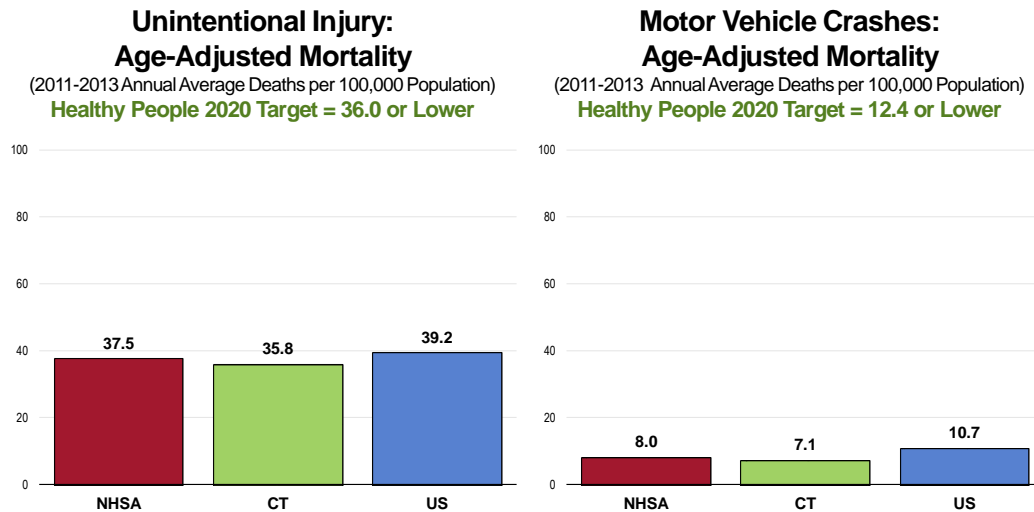
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in the area, including age-adjusted mortality rates attributed specifically to motor vehicle crashes.

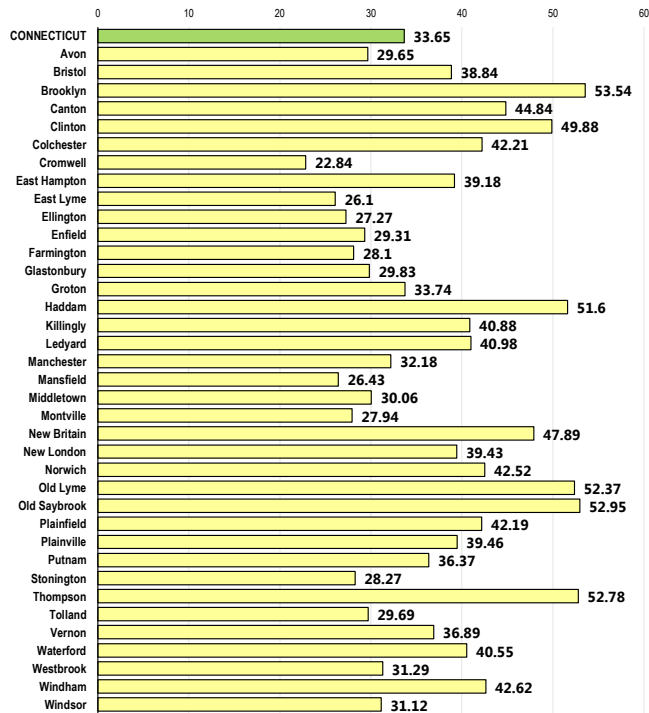
- Note the Healthy People 2020 targets.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives IVP-11 and IVP-13.1]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 • Local, state and national data are simple three-year averages.

Town-level mortality for unintentional injury is shown below.

**Unintentional Injury:
Age-Adjusted
Mortality**
(By Select Towns in the
Natchaug Hospital Service
Area, 2006-2010)



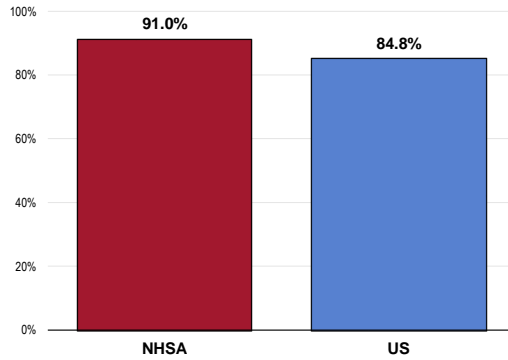
Source: • Connecticut Department of Public Health

Seat Belt/Car Seat Usage

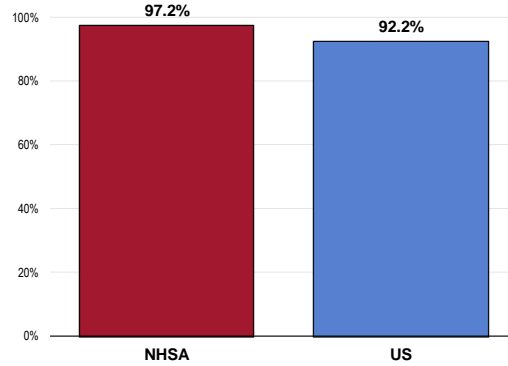
Adults: "How often do you use seat belts when you drive or ride in a car? Would you say: always, nearly always, sometimes, seldom, or never?"

Children: "How often does this child wear a child restraint or seat belt when riding in a car? Would you say: always, nearly always, sometimes, seldom, or never?"

**“Always” Wear a Seat Belt
When Driving or Riding in a Vehicle**
Healthy People 2020 Target = 92.0% or Higher

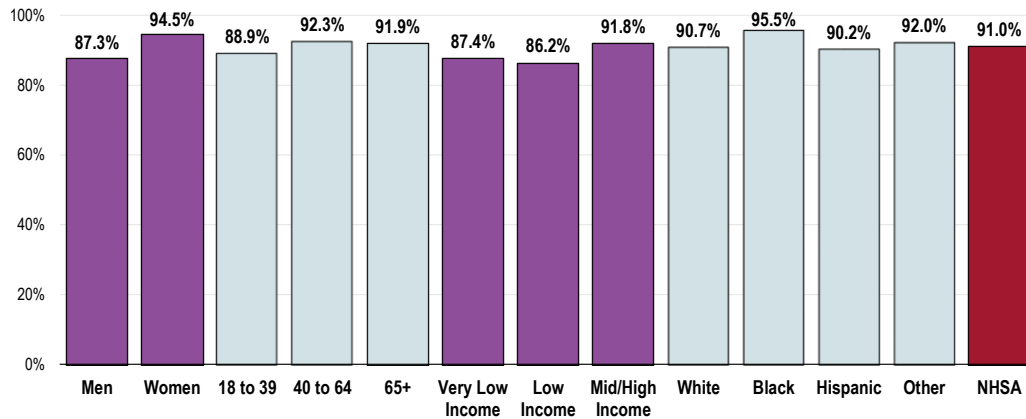


**Child “Always” Uses Appropriate
Safety Restraint (Seat Belt/Car Seat)
When Riding in a Vehicle**



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 49 and 122]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IPV-15]
 Notes: • Asked of all respondents.

**“Always” Wear a Seat Belt
When Driving or Riding in a Vehicle**
(Natchaug Hospital Service Area, 2015)
Healthy People 2020 Target = 92.0% or Higher

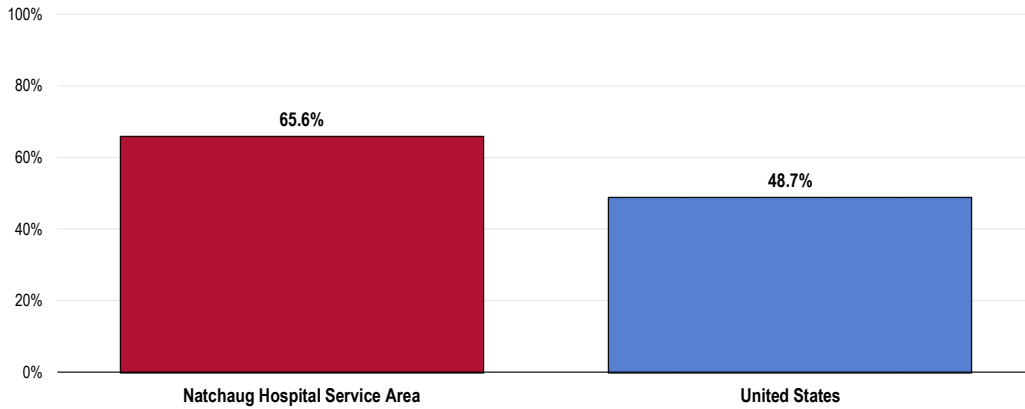


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IPV-15]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes less than 100% of the federal poverty level; “Low Income” includes households with incomes from 100–199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Bicycle Safety

Children Age 5-17: “In the past year, how often has this child worn a bicycle helmet when riding a bicycle? Would you say: always, nearly always, sometimes, seldom, or never?”

Child “Always” Wears a Helmet When Riding a Bicycle (Among Parents of Children Age 5-17)



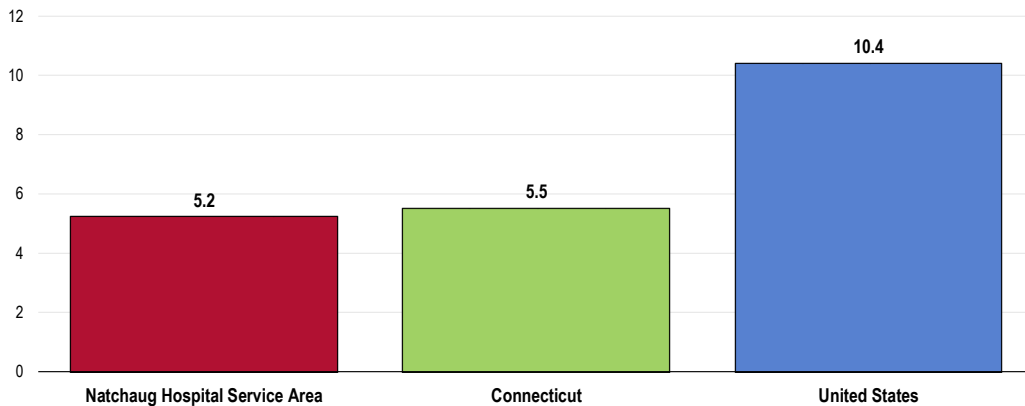
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 121]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents with children age 5 to 17 at home.

Firearms

Age-Adjusted Firearm-Related Deaths

The following chart outlines the age-adjusted mortality rate in the area attributed to firearms (including both accidental and intentional discharge), compared to state and national rates.

Firearms-Related Deaths: Age-Adjusted Mortality (2011-2013 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 9.3 or Lower



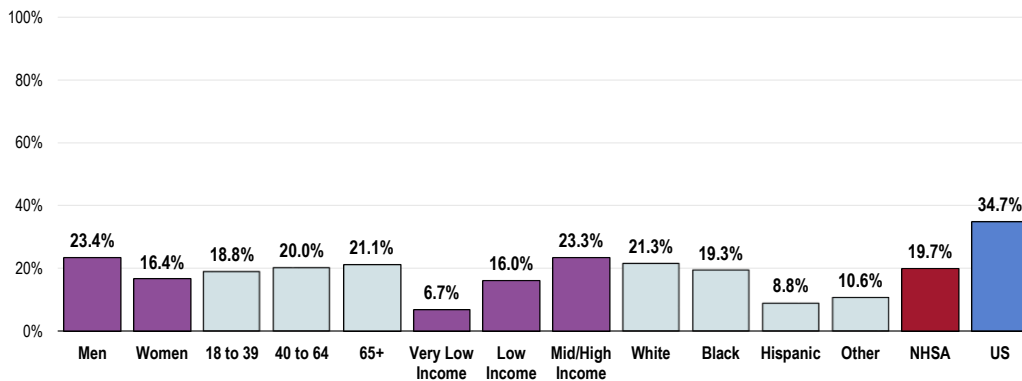
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-30]
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 • Local, state and national data are simple three-year averages.

Presence of Firearms in Homes

“Are there any firearms now kept in or around your home, including those kept in a garage, outdoor storage area, truck, or car? For the purposes of this inquiry, ‘firearms’ include pistols, shotguns, rifles, and other types of guns, but do NOT include starter pistols, BB guns, or guns that cannot fire.”

“An unlocked firearm is one that does NOT need a key or combination to get to the gun or fire it. The safety is NOT counted as a lock. Are any of these firearms unlocked?” and “Are any of these unlocked firearms now loaded?” (Calculated below as the percentage of respondents who have firearms at home and who keep at least one firearm unlocked and loaded.)

Have a Firearm Kept in or Around the House
(Natchaug Hospital Service Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 52]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.

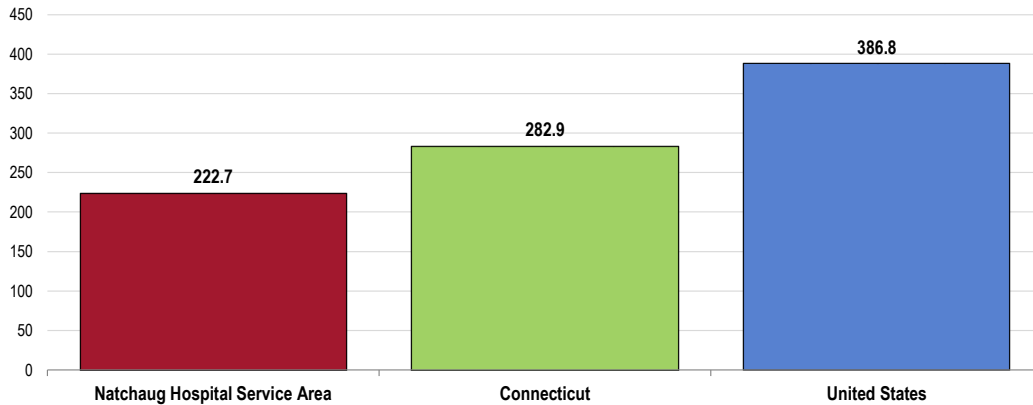
Notes: • Asked of all respondents.
 • In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes less than 100% of the federal poverty level; “Low Income” includes households with incomes from 100–199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Intentional Injury (Violence)

Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault. Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

Violent Crime (Rate per 100,000 Population, 2012)

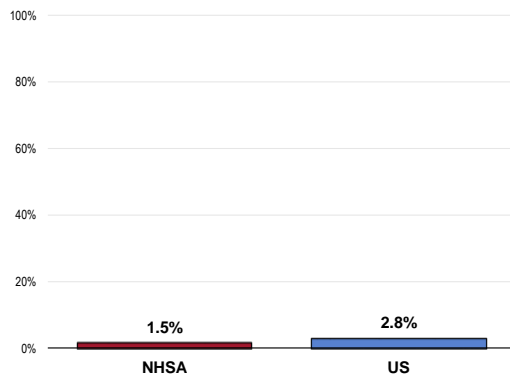


Sources: • Federal Bureau of Investigation, FBI Uniform Crime Reports: 2012.
 • Retrieved February 2015 from Community Commons at <http://www.chna.org>.
 Notes: • This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
 • Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics, but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

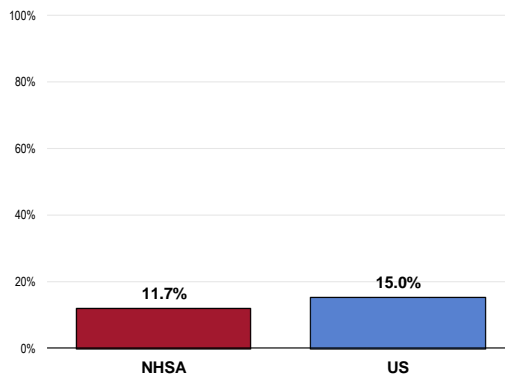
Violent Crime Experience: *“Have you been the victim of a violent crime in your area in the past 5 years?”*

Intimate Partner Violence: *“The next questions are about different types of violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?”*

Victim of a Violent Crime in the Area in the Past Five Years



Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt In Any Way by an Intimate Partner

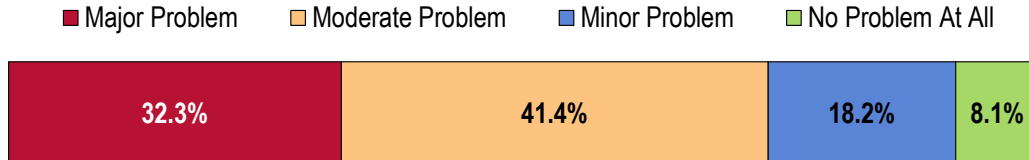


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 50, 51]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:

Perceptions of Injury and Violence as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

Domestic and Youth Violence

Every day there are people in my community either getting killed or injured due to guns, gang related matters, drug problems, etc. – Social Services Representative

Rates of community, sexual and domestic violence. – Social Services Representative

I believe that there is more harm done to children through intentional or unintentional injury than any childhood illness. The long term effects of being exposed to violence at an early age is not something we measure, but impacts our health system, educational system and judicial system. Access to weapons is a problem when mixed with stress, poverty, etc. Many unintentional injuries are easily preventable, but a hurried lifestyle along with “it won't happen to me” attitude are bad combinations. – Other Health Provider

Domestic violence and youth violence. – Community/Business Leader

Adult Violence

I think the very nature of our community brings violence of adult to adult and worse, adult to child. There is a large segment of the population that does not deal well with anger and uses violence as a means to solve problems. – Other Health Provider

There is a high prevalence of community violence and gang involvement in Hartford. Many young people are negatively influenced by peers and end up in unsafe situations. Many residents do not feel safe because of the violence and research has demonstrated the impact of high levels of community violence on child development and the stress that it creates which is can impact social/emotional development and wellbeing. – Community/Business Leader

Agricultural Accidents

Farming, agricultural accidents, falls and domestic abuse. – Public Health Expert

Economically Stressed Population

Hartford is an urban center with a significantly economically stressed population. Injury and violence statistics vary by neighborhood, but are above state averages. – Community/Business Leader

Gang Activity

We have a lot of gang activity. – Other Health Provider

Home Injuries, Especially in the Elderly

Injury in the home is one of the largest measures of incidence, especially in the elderly. Violence of person against person is a result of a society which is intolerant of others and has grown up that way. – Community/Business Leader

Homicide, Intentional Injury or Alcohol Related

Homicide and other intentional injury. Alcohol related injury. – Physician

Prevention

Many of these are preventable, so you would expect to see this decreasing as knowledge is disseminated. Instead we see family violence and unintentional injuries repeated generation after generation. – Social Services Representative

The first step in preventing violence is to understand the "who", "what", "when", "where" and "how" associated with it. Grasping the magnitude of the problem involves analyzing data such as the number of violence-related behaviors, injuries, and deaths. Data can demonstrate how frequently violence occurs, where it is occurs, trends, and who the victims and perpetrators are. – Public Health Expert

Self-Control

Watch the news on television. More and more people are not taught self control when they are young. Many are on drugs and don't realize they are injuring someone else because while on drugs they can't feel pain themselves. People need to see more images of positive relationships and conflict resolution. – Community/Business Leader

Ongoing Issue

Domestic violence is an ongoing issue and more needs to be done tied to helping physicians and other clinicians identify and then help direct patients who have been a victim of domestic violence. There is also a need for interpreter services tied to communicating with those often who have been abused. – Physician

Poverty

Poverty, people have many daily issues and they used substances, have little hope and are frustrated with their life and then resort to utilizing poor skills. – Other Health Provider

Risk of Homelessness

The community I am referring to is those experiencing or at risk of homelessness. For women and families, domestic violence is often related to episodes of homelessness. Also, for those experiencing homelessness, the threat of injury and violence is a significant issue. – Community/Business Leader

Students

Our students are affected by high rates of violence in our community. – Community/Business Leader

Housing Conditions

Unsafe housing conditions. Lack of safe play spaces. Young parents with lack of parenting skills, abuse and neglect. – Public Health Expert

Diabetes

About Diabetes

Diabetes mellitus occurs when the body cannot produce or respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. Many forms of diabetes exist; the three common types are Type 1, Type 2, and gestational diabetes. Effective therapy can prevent or delay diabetic complications.

Diabetes mellitus:

- Lowers life expectancy by up to 15 years.
- Increases the risk of heart disease by 2 to 4 times.
- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

The rate of diabetes mellitus continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with diabetes mellitus, and possibly earlier onset of type 2 diabetes mellitus, there is growing concern about the possibility that the increase in the number of persons with diabetes mellitus and the complexity of their care might overwhelm existing healthcare systems.

People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes in the US and represent the majority of children and adolescents with type 2 diabetes.

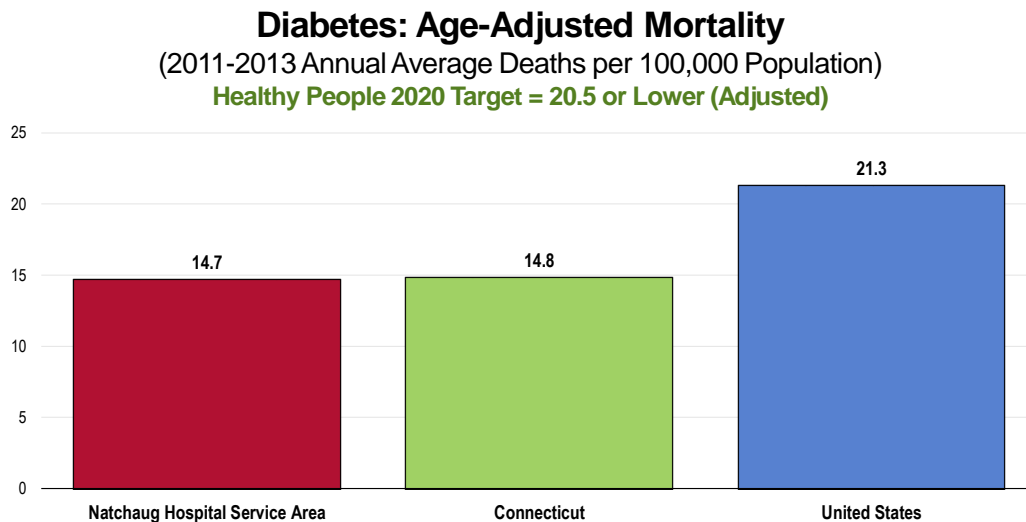
Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for the area is shown in the following chart.

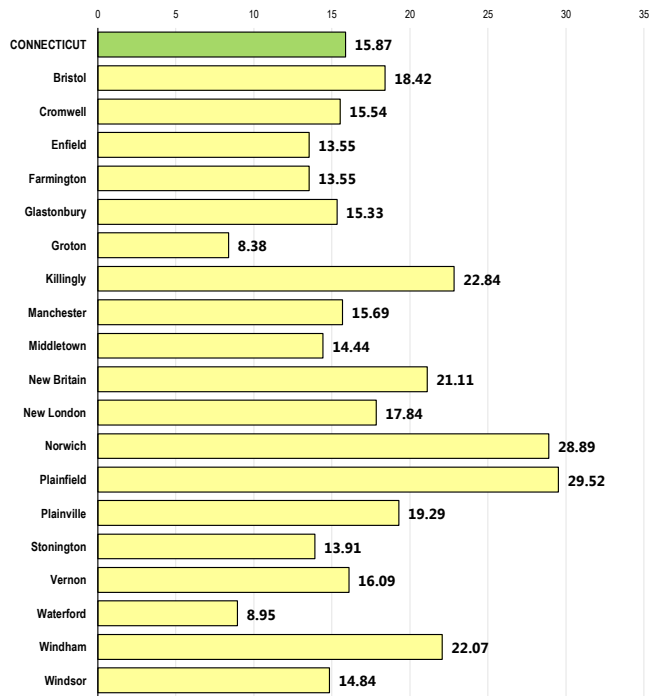
- Note the Healthy People 2020 target (as adjusted to account for diabetes mellitus-coded deaths).



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - Local, state and national data are simple three-year averages.
 - The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Local diabetes mortality for select towns in the Natchaug Hospital Service Area:

Diabetes: Age-Adjusted Mortality
(By Select Towns in the Natchaug Hospital Service Area, 2006-2010)



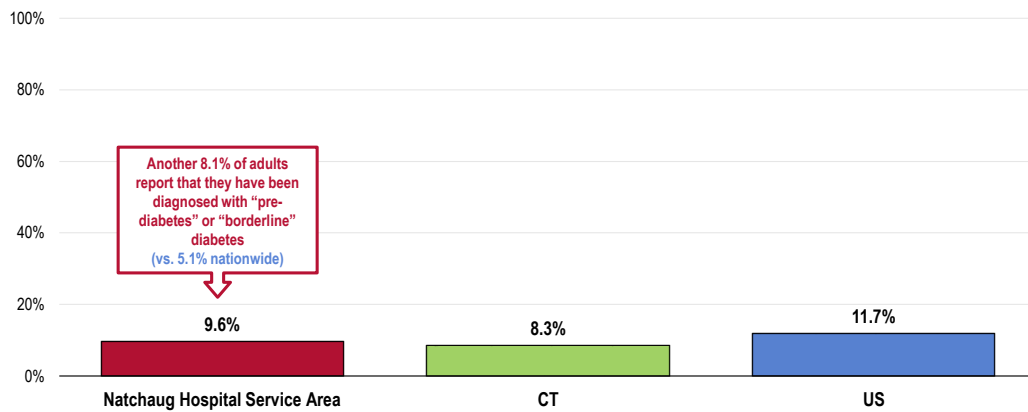
Source: • Connecticut Department of Public Health

Prevalence of Diabetes

“Have you ever been told by a doctor that you have diabetes? (If female, add: Not counting diabetes only occurring during pregnancy?)”

“(If female, add: Other than during pregnancy,) Have you ever been told by a doctor or other health professional that you have pre-diabetes or borderline diabetes?”

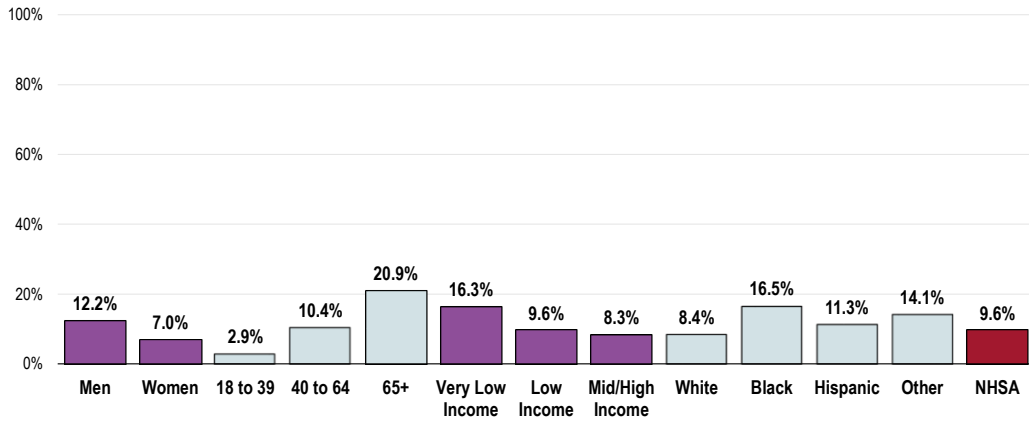
Prevalence of Diabetes



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 136]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Connecticut data.

Notes: • Asked of all respondents.
 • Local and national data exclude gestation diabetes (occurring only during pregnancy).

Prevalence of Diabetes (Natchaug Hospital Service Area, 2015)

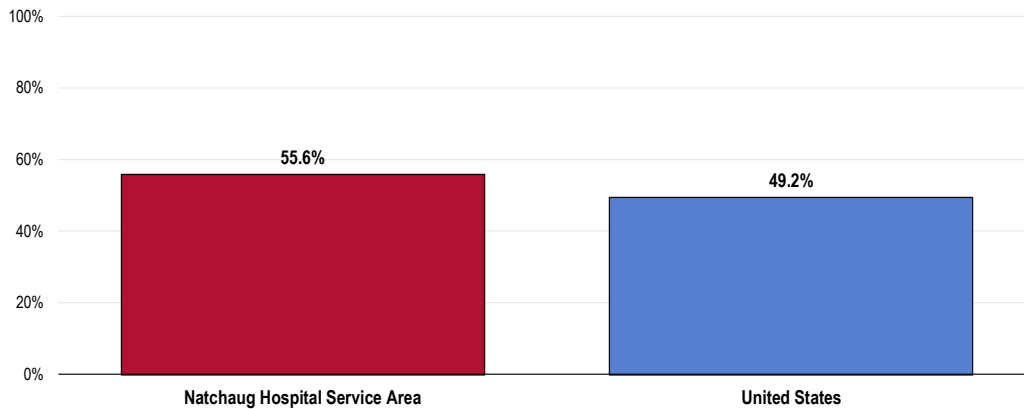


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 136]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes less than 100% of the federal poverty level; "Low Income" includes households with incomes from 100–199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 • Excludes gestation diabetes (occurring only during pregnancy).

Diabetes Testing

"Have you had a test for high blood sugar or diabetes within the past three years?"

Have Had Blood Sugar Tested in the Past Three Years (Among Non-Diabetics)

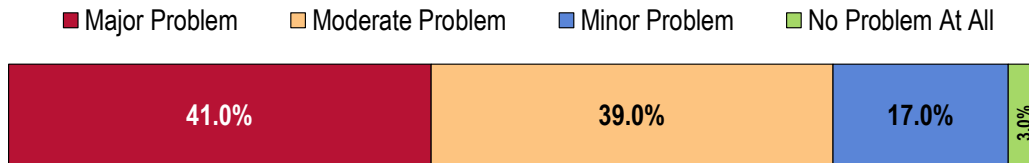


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 40]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of respondents who have not been diagnosed with diabetes.

Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:

Perceptions of Diabetes as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Challenges

Among those rating this issue as a “major problem,” the biggest challenges for people with diabetes are seen as:

Lack of Access to Nutritious Food

Lack of nutrition education and nutrition counseling. – Public Health Expert

Limited access to fresh fruit and vegetables. – Social Services Representative

I think two of the biggest challenges are obtaining quality nutritious food and maintaining proper physical activity levels. – Other Health Provider

Once diagnosed, limited staying healthy services, or disease progression prevention services are available- much more emphasis should be put on this to avoid significant disease complications - Social Service

Self-Management

Learning how to manage diabetes and if possible find a nutritional solution. The abundance of diabetic children brought on by poor nutrition is a sign of our economic standing as a community. – Other Health Provider

Self-management. – Social Services Representative

Identification and management/compliance. Diabetes in the young has been difficult to manage, both by the patient and by the parent/guardian. There are conflicting approaches by the parent with the caregiver and with the patient. Too many fragile children with diabetes. Diabetes in older people often goes undiagnosed, untreated and poorly managed in those in the lower social/income/education strata. Lack of commitment to the treatment protocol and follow-up on the part of the patient. – Community/Business Leader

Self-management, and the disproportionate impact on minorities and the poor. Diabetics have to change so much about their lives to manage their conditions, and it is overwhelming for even someone of means with adequate family and social support. – Other Health Provider

Education

Diabetic patients with care gaps for recommended services such as Optometry, Podiatry and Nutrition. Lacking appropriate education. – Other Health Provider

There are several challenge of people with diabetes including diabetes prevention, education and management. – Social Services Representative

Education of preventative care as well as healthy eating options to prevent and/or live with diabetes. – Community/Business Leader

Prevalence

High prevalence and insufficient resources which are accessible with or without insurance. – Other Health Provider

There is a high prevalence of diabetes in Hartford. Further we know obesity is a struggle and a high percentage of the population is overweight. Hartford is a food desert and there are a number of barriers to accessing healthy food and exercising. – Community/Business Leader

Studies/assessments have determined that to be the case. – Community/Business Leader

Disease Management

Management. – Public Health Expert

Disease management. – Public Health Expert

Education

Lack of understanding of diet/nutrition and impact on "sugar" Lack of exercise - Community/Business Leader

Learning and maintaining healthy eating habits. The cost of healthy food is high. For the older population is harder to understand how to choose the right foods and the importance of taking their medicines on a strict schedule. – Social Services Representative

Awareness to prevent onset of diabetes. – Public Health Expert

Hispanics

Latinos have higher diabetes incidence and more complications and mortality due to diabetes. A randomized controlled trial conducted by Hartford Hosp., Yale Univ. and HHC provided in-home peer counseling to Latinos patients of HH with diabetes. Findings included: a) this intensive service model, 17 home visits in one year decreased the HbA1 (b) down one full point compared to .4 in the control group, and the difference was sustained six months post-intervention and c) gaps in care, care coordination and cultural competence identified by the hospital's clinical team that partnered in the study - including the need for in-hospital care coordination and cultural competence training. The peer counseling service ended when the study ended. HHC is pursuing ways to sustain funding for community health workers through the affordable care act, including specialized, intensive models like this one that ultimately improve health and save health care dollars. – Social Services Representative

Diabetes is an issue that is affecting the Latino community at a alarming rate. It is not just about education my community on what to eat and so on, but it is also about educating the community on how certain foods will affect diabetes and what are the best approaches. Adherence to meds is another factor, if a patient truly understands what these meds are for, side effects, etc. They will make better informed decisions. – Social Services Representative

Weight Control

As obesity rates increase diabetes increases. Meriden has a large Hispanic population who also have higher prevalence rates of diagnosed diabetes, higher rates of mortality and premature mortality due to diabetes, higher rates of hospitalization due to diabetes, higher rates of diabetes-related lower-extremity amputations and a large contributor to diabetes and other chronic diseases is the higher rates of obesity in the Hispanic population. – Public Health Expert

Weight control. – Community/Business Leader

Specialists

Besides access to endocrinologists, patient education and information appears to be rather lacking, especially information in Spanish and other languages other than English. – Physician

Stigma

Access to unbiased, non-shaming care. – Social Services Representative

Affordable Medications

The biggest challenge is being able to afford diabetic medication, having access to healthier food alternatives and the biggest challenge is changing eating habits. – Other Health Provider

Cost

Healthy eating. It is expensive to eat healthy. – Social Services Representative

Some major issues would be affordability of the treatments, and especially clients that do not have current health coverage and cannot afford treatments to keep them out of relapse. Our area has quite a group of undocumented residents that unfortunately due to their status cannot obtain the necessary high priced treatments for themselves. Also, access to healthy fruits and vegetables in our area. There aren't that many points of access for families. Many families rely on canned fruit and high processed foods. – Social Services Representative

For those without health insurance the cost of testing supplies and medication as well as access to healthier choices for food are significant. There also seems to be a disconnect between those who need education about their disease and those who actually receive it. – Public Health Expert

Side Effects

Many of our clients have diabetes due to medication side effects or life style, poverty. – Social Services Representative

Education

Education and prevention awareness at early ages. – Community/Business Leader

Ongoing CAre

Being diagnosed in the first place, then once diagnosed finding a primary care physician to help with ongoing care, then being able to afford medications then changing lifestyle to become healthier. – Other Health Provider

Socioeconomic Barriers

High risk population with socio-economic barriers to wellness and nutrition strategies to prevent or mitigate diabetes. – Community/Business Leader

Prevention and Access to Treatment

Prevention and access to treatment. – Physician

Minorities

A serious problem in communities of color, and may grow in the general population with high obesity rate. – Community/Business Leader

Medication Management

Staying on top of their medication management and practicing good nutrition. – Other Health Provider

Alzheimer's Disease

About Dementia

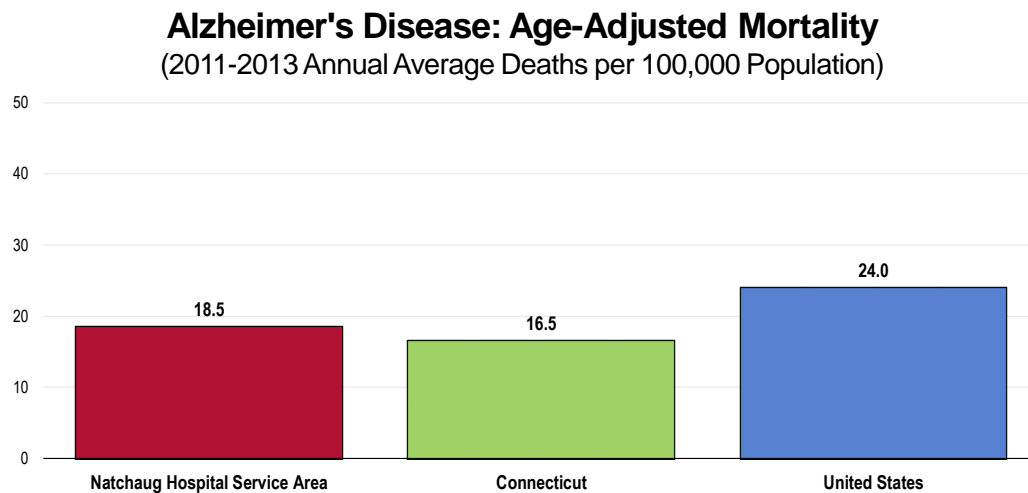
Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person's daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer's disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

Alzheimer's disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer's disease are found.

- Healthy People 2020 (www.healthypeople.gov)

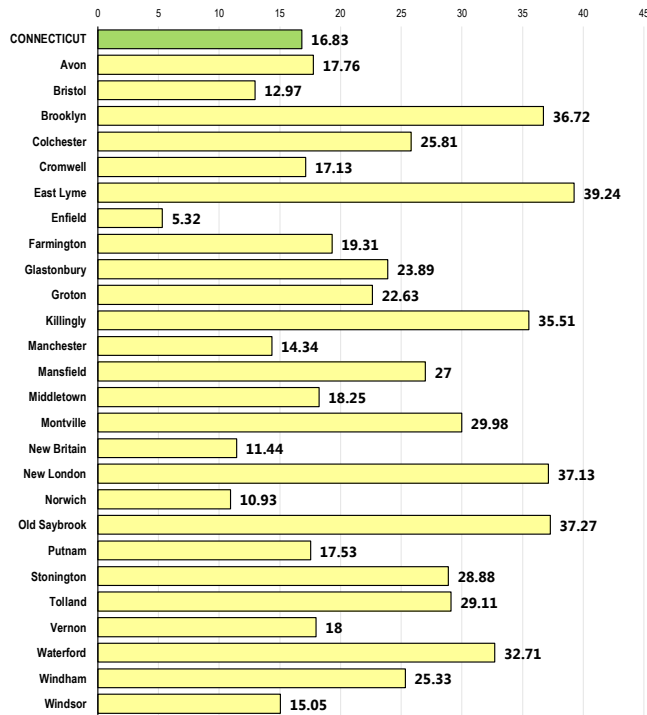
Age-Adjusted Alzheimer's Disease Deaths

Age-adjusted Alzheimer's disease mortality rates for the region and select towns are outlined below.



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - Local, state and national data are simple three-year averages.

**Alzheimer's Disease:
Age-Adjusted
Mortality**
(By Select Towns in the
Natchaug Hospital Service
Area, 2006-2010)

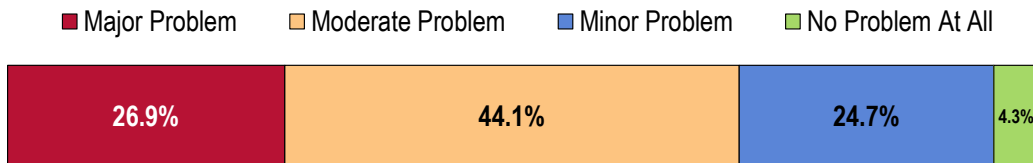


Source: • Connecticut Department of Public Health

Key Informant Input: Dementias, Including Alzheimer's Disease

The following chart outlines key informants' perceptions of the severity of *Dementias, Including Alzheimer's Disease* as a problem in the community:

**Perceptions of Dementia/Alzheimer's Disease
as a Problem in the Community**
(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons frequently related to the following:

Prevalence

Number of people impacted. – Public Health Expert

It is becoming more prevalent and working caregivers are often best positioned to provide care that can keep people at home as long as possible and out of more expensive, and less nurturing, nursing home. However, caregivers need respite and support to enable them to provide that level of care, to keep both themselves and the patient as healthy as possible. – Other Health Provider

We see increasing numbers of people referred to us with dementia related to aging, but few resources outside of nursing home care. – Social Services Representative

There have been many open community screenings which people have taken advantage of from our organization where a high number of participants suffered from severe cognitive impairment. Many were still driving or had no advocates. – Other Health Provider

Our population is living longer, rates in general are increasing, population of elderly in Meriden and their access to care. We still have a lot to learn about this disease and treatments among the medical community in the United States. There is also a great deal of denial among the patient and/or family members. – Public Health Expert

Aging Population

I didn't identify it as a major problem. However it is a condition of note in elderly persons. These are generally end-of-life matters for the population to deal with, and too few persons are knowledgeable in general terms or prepared to deal with it. This covers both patient and family/caregivers. – Community/Business Leader

Connecticut has a shortage or rather limited number of geriatricians and much of the care is limited to home care and nursing home facilities. There are simply not that many independently practicing geriatricians because the reimbursement is simply not sufficient. – Physician

There is only one geriatrician in town. Most PCP's tend to deal with this condition on their own but are not well versed in the management of the same. – Physician

There is only an option for expensive care nothing exists for those who cannot afford it. – Other Health Provider

Many low income seniors do not have adequate support or advocacy to deal with these challenges. – Community/Business Leader

Aging population; limited resources to handle the problem. – Social Services Representative

I am finding that more residents are looking for resources to help themselves or family members who have been diagnosis with it. – Community/Business Leader

Early Onset

Increased frequency of early onset and overall numbers. – Social Services Representative

Awareness of Services Available

I am not sure that everybody is aware of the services that are available to them if they are having a crisis. – Other Health Provider

Support

Lack of support for caregivers. Financial and emotional burden on families with little to no available support. – Public Health Expert

Insufficient community support for persons with dementia, Alzheimer's. – Public Health Expert

Limited support, evaluation process and treatment regimes varied and not standardized. – Other Health Provider

Timeliness

The medical community doesn't acknowledge it in a patient in time. Symptoms of Dementia can be caused by many things: ex. if a patient can't hear well, or see well they tend to "tune out". So what can appear as dementia can be something else. Symptoms of dementia are also said to be related to nutrition, metal or plastics toxins, wrong medication, depression. Personally, my dad has dementia but if he was in a nursing home, and he was, they kept trying to medicate him with various anti-anxiety medications. One doctor would put him on medications and the other doctor would take him off. I took him home and he is doing much better and we are glad to have him.

Resources for care at home are significantly limited and it makes it harder on the family. – Community/Business Leader

Stress on Families

Unsure of the prevalence, but the stress on families, especially when onset is rapid, can be debilitating. This is not solely about the individual. – Other Health Provider

Community Awareness/Attention

This disease does not get enough attention, nor resources. Most people cannot access caregiver support in an affordable way and we need more medical expertise locally. – Other Health Provider

Kidney Disease

About Chronic Kidney Disease

Chronic kidney disease and end-stage renal disease are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. Nearly 25% of the Medicare budget is used to treat people with chronic kidney disease and end-stage renal disease.

Genetic determinants have a large influence on the development and progression of chronic kidney disease. It is not possible to alter a person's biology and genetic determinants; however, environmental influences and individual behaviors also have a significant influence on the development and progression of chronic kidney disease. As a result, some populations are disproportionately affected. Successful behavior modification is expected to have a positive influence on the disease.

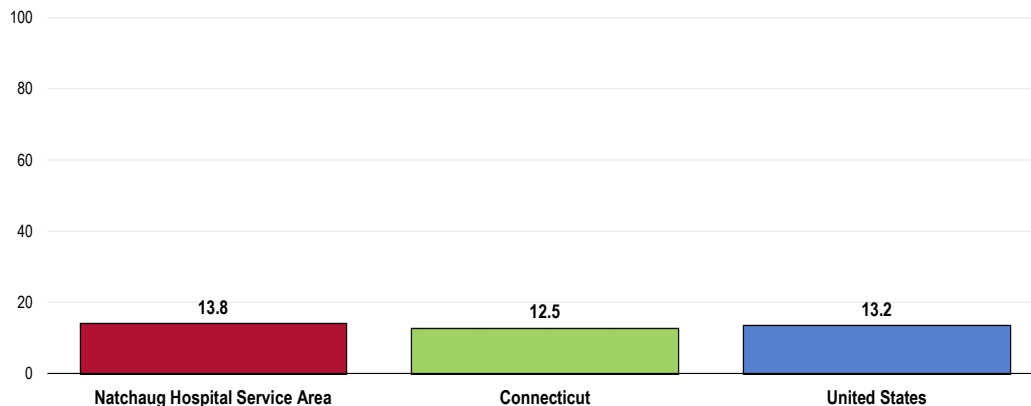
Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the national Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes in persons at risk.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Kidney Disease Deaths

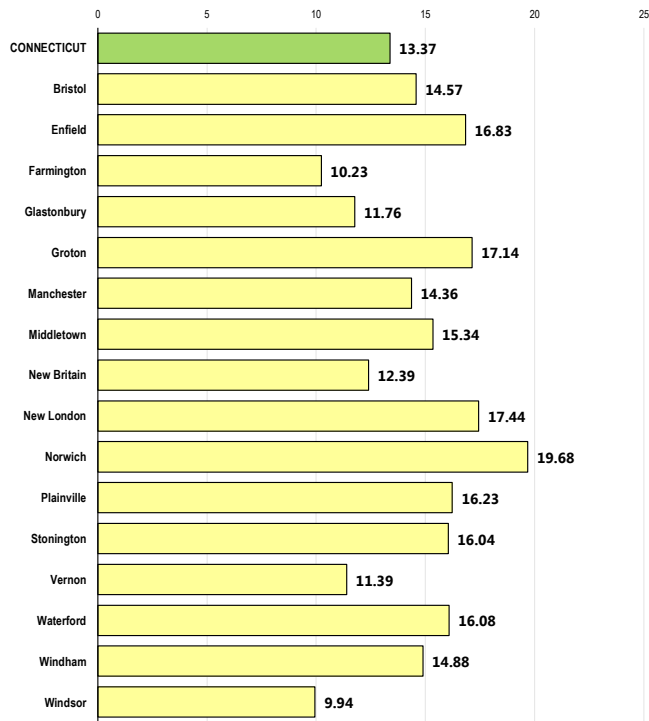
Age-adjusted kidney disease mortality is described in the following charts.

Kidney Disease: Age-Adjusted Mortality (2011-2013 Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - Local, state and national data are simple three-year averages.

Kidney Disease: Age-Adjusted Mortality (By Select Towns in the Natchaug Hospital Service Area, 2006-2010)

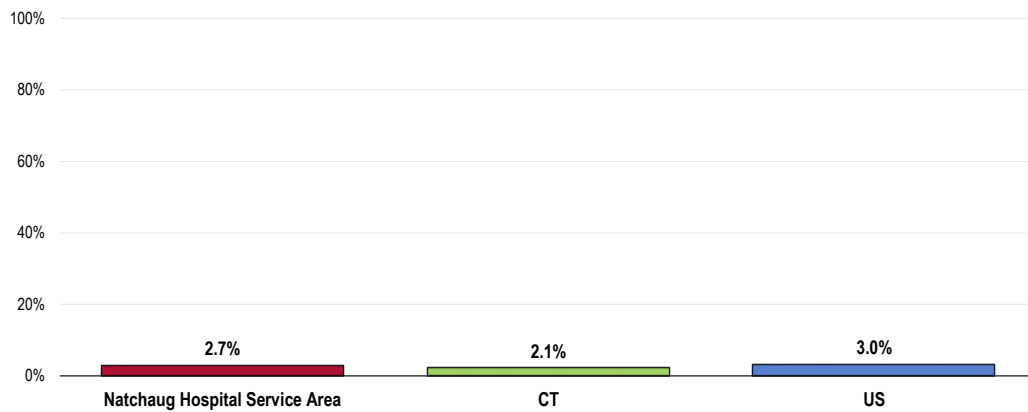


Source: • Connecticut Department of Public Health

Prevalence of Kidney Disease

“Would you please tell me if you have ever suffered from or been diagnosed with kidney disease?”

Prevalence of Kidney Disease

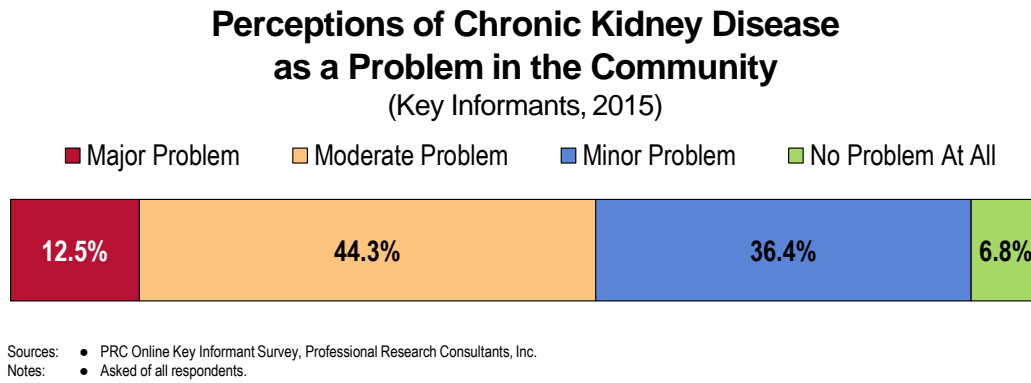


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 33]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Connecticut data.

Notes: • Asked of all respondents.

Key Informant Input: Chronic Kidney Disease

The following chart outlines key informants' perceptions of the severity of *Chronic Kidney Disease* as a problem in the community:



Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

Minorities

Chronic kidney disease is often suffered by members of the African American descent, which is the population group that makes up the majority of the Hartford area. This is due to the lack of proper diet, medical management of hypertension and diabetes, all of which are greatly suffered by members of this community as well. – Other Health Provider

African Americans are three times more likely to experience kidney failure than whites. – Other Health Provider

Co-existing Conditions

It leads to other serious ailments that can be life threatening. – Other Health Provider

Results from a number of other prevalent conditions. – Physician

There are many different factors that leads to chronic kidney disease such as diabetes or hypertension. – Social Services Representative

Nephrologists

There are very few actively clinically practicing nephrologists in Connecticut that are not tied to academic medical centers, it makes access to ESRD care very trying for patients in the outlying areas. – Physician

Potentially Disabling Conditions

About Arthritis, Osteoporosis & Chronic Back Conditions

There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active. Arthritis affects 1 in 5 adults and continues to be the most common cause of disability. It costs more than \$128 billion per year. All of the human and economic costs are projected to increase over time as the population ages. There are interventions that can reduce arthritis pain and functional limitations, but they remain underused. These include: increased physical activity; self-management education; and weight loss among overweight/obese adults.

Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures (broken bones). In the United States, an estimated 5.3 million people age 50 years and older have osteoporosis. Most of these people are women, but about 0.8 million are men. Just over 34 million more people, including 12 million men, have low bone mass, which puts them at increased risk for developing osteoporosis. Half of all women and as many as 1 in 4 men age 50 years and older will have an osteoporosis-related fracture in their lifetime.

Chronic back pain is common, costly, and potentially disabling. About 80% of Americans experience low back pain in their lifetime. It is estimated that each year:

- 15%-20% of the population develop protracted back pain.
- 2-8% have chronic back pain (pain that lasts more than 3 months).
- 3-4% of the population is temporarily disabled due to back pain.
- 1% of the working-age population is disabled completely and permanently as a result of low back pain.

Americans spend at least \$50 billion each year on low back pain. Low back pain is the:

- 2nd leading cause of lost work time (after the common cold).
- 3rd most common reason to undergo a surgical procedure.
- 5th most frequent cause of hospitalization.

Arthritis, osteoporosis, and chronic back conditions all have major effects on quality of life, the ability to work, and basic activities of daily living.

- Healthy People 2020 (www.healthypeople.gov)

Arthritis, Osteoporosis, & Chronic Back Conditions

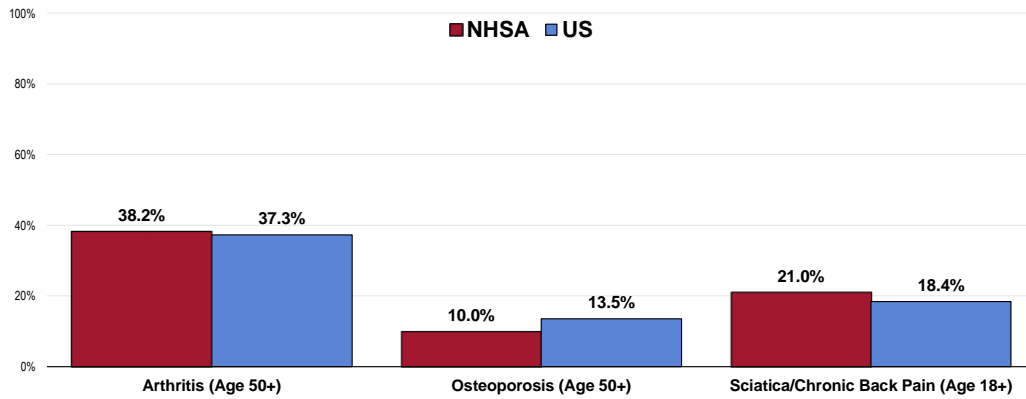
“Would you please tell me if you have ever suffered from or been diagnosed with arthritis or rheumatism?” (Reported below among only those age 50+.)

“Would you please tell me if you have ever suffered from or been diagnosed with osteoporosis?” (Reported below among only those age 50+.)

“Would you please tell me if you have ever suffered from or been diagnosed with sciatica or chronic back pain?” (Reported below among all adults age 18+.)

See also *Activity Limitations* in the General Health Status section of this report.

Prevalence of Arthritis, Osteoporosis & Chronic Back Conditions

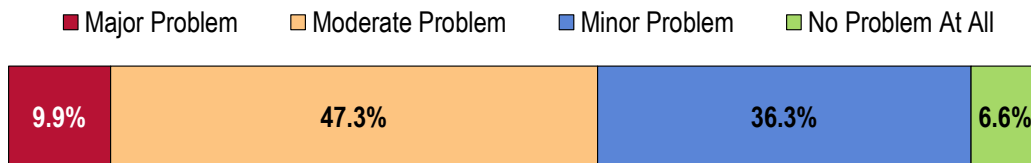


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 29, 139, 140]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

The following chart outlines key informants’ perceptions of the severity of *Arthritis, Osteoporosis & Chronic Back Conditions* as a problem in the community:

Perceptions of Arthritis/Osteoporosis/Back Conditions as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

High Occurrence Rate

- Is a common identified medical problem among our patients. – Other Health Provider
- Number of people impacted. – Public Health Expert

Lack of Accessible Resources

- There are not enough accessible resources for treatment, especially back pain. We need more education and treatment options that do not involve narcotics. – Other Health Provider

Lack of Providers Accepting Medicaid

There are very few or no providers who accept Medicaid readily in Norwich and that affects the patients we cater to. – Physician

Lack of Rheumatologists

There are fewer and fewer available Rheumatologists who are focusing full time on rheumatoid related conditions. Also, there are fewer clinically practicing orthopedists who are not hospital employed and who have available office hours. – Physician

Pain and Disability

Common chronic condition leading to pain and disability. – Physician

Vision & Hearing Impairment**Vision Trouble****About Vision**

Vision is an essential part of everyday life, influencing how Americans of all ages learn, communicate, work, play, and interact with the world. Yet millions of Americans live with visual impairment, and many more remain at risk for eye disease and preventable eye injury.

The eyes are an important, but often overlooked, part of overall health. Despite the preventable nature of some vision impairments, many people do not receive recommended screenings and exams. A visit to an eye care professional for a comprehensive dilated eye exam can help to detect common vision problems and eye diseases, including diabetic retinopathy, glaucoma, cataract, and age-related macular degeneration.

These common vision problems often have no early warning signs. If a problem is detected, an eye care professional can prescribe corrective eyewear, medicine, or surgery to minimize vision loss and help a person see his or her best.

Healthy vision can help to ensure a healthy and active lifestyle well into a person's later years. Educating and engaging families, communities, and the nation is critical to ensuring that people have the information, resources, and tools needed for good eye health.

- Healthy People 2020 (www.healthypeople.gov)

Hearing Trouble**About Hearing & Other Sensory or Communication Disorders**

An impaired ability to communicate with others or maintain good balance can lead many people to feel socially isolated, have unmet health needs, have limited success in school or on the job. Communication and other sensory processes contribute to our overall health and well-being. Protecting these processes is critical, particularly for people whose age, race, ethnicity, gender, occupation, genetic background, or health status places them at increased risk.

Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such as social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition, biological causes of hearing loss and other sensory or communication disorders include: genetics; viral or bacterial infections; sensitivity to certain drugs or medications; injury; and aging.

As the nation's population ages and survival rates for medically fragile infants and for people with severe injuries and acquired diseases improve, the prevalence of sensory and communication disorders is expected to rise.

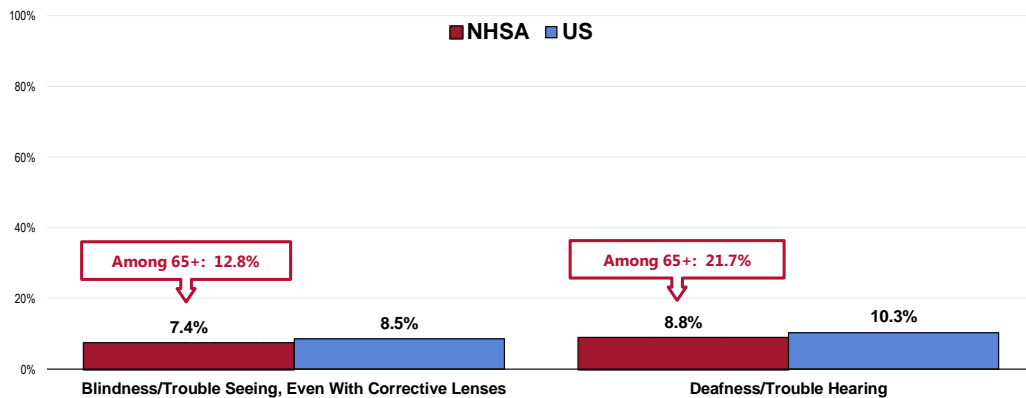
- Healthy People 2020 (www.healthypeople.gov)

“Would you please tell me if you have ever suffered from or been diagnosed with blindness or trouble seeing, even when wearing glasses?”

“Would you please tell me if you have ever suffered from or been diagnosed with deafness or trouble hearing?”

- Note the higher prevalence among older adults (age 65+).

Prevalence of Vision & Hearing Difficulty

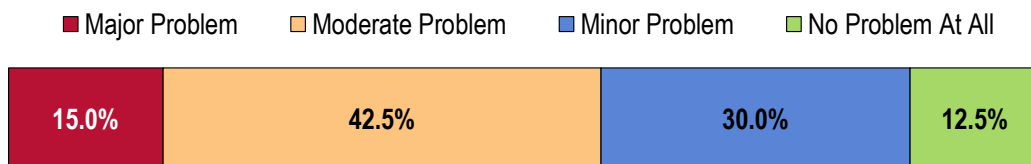


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 26-27]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Key Informant Input: Vision & Hearing

The following chart outlines key informants’ perceptions of the severity of *Vision & Hearing* as a problem in the community:

Perceptions of Hearing and Vision as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

Cost of Services

Cost of hearing aids and the cost of glasses but also the availability of specialized ophthalmologic are limited, especially for Pediatrics. – Physician

Vision services are difficult because of expense and little or no coverage through insurance. – Social Services Representative

The majority of our population does not have affordable, appropriate, and reliable access and information about these conditions. Translators and translation services that really work and are appropriate are not in place for our population in need. We see students every day that need vision and hearing services. The information may be there, but their ability to understand and access it is quite limited. Accessible community health educators that speak their languages are desperately needed. – Social Services Representative

Aging Population

There is growing aging population that these issues are starting to become a concern. – Social Services Representative

Diabetes

High incidence of diabetes, cardiovascular disease with microvascular complications, including retinopathy. Macular degeneration is prevalent and impacts one's quality of life and at times safety with regard to discharge disposition. – Other Health Provider

Development of Young People

I did not identify hearing and vision as a major problem in this community. It is, however, always an important aspect in development of young people. That's why there are public and volunteer programs to test hearing and vision in the school system. Same for spinal problems. – Community/Business Leader

Macular Degeneration

More people have macular degeneration. – Community/Business Leader

Insurance Coverage

Generally not covered by insurance and many are still without insurance. – Community/Business Leader

The number of providers accepting Medicare/Medicaid is limited, especially in the rural areas my agency serves. – Other Health Provider

Infectious Disease

About Immunization & Infectious Diseases

The increase in life expectancy during the 20th century is largely due to improvements in child survival; this increase is associated with reductions in infectious disease mortality, due largely to immunization. However, infectious diseases remain a major cause of illness, disability, and death. Immunization recommendations in the United States currently target 17 vaccine-preventable diseases across the lifespan.

People in the US continue to get diseases that are vaccine-preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death across the nation and account for substantial spending on the related consequences of infection.

The infectious disease public health infrastructure, which carries out disease surveillance at the national, state, and local levels, is an essential tool in the fight against newly emerging and re-emerging infectious diseases. Other important defenses against infectious diseases include:

- Proper use of vaccines
- Antibiotics
- Screening and testing guidelines
- Scientific improvements in the diagnosis of infectious disease-related health concerns

Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Childhood immunization programs provide a very high return on investment. For example, for each birth cohort vaccinated with the routine immunization schedule, society:

- Saves 33,000 lives.
- Prevents 14 million cases of disease.
- Reduces direct healthcare costs by \$9.9 billion.
- Saves \$33.4 billion in indirect costs.

- Healthy People 2020 (www.healthypeople.gov)

Influenza & Pneumonia Vaccination

About Influenza & Pneumonia

Acute respiratory infections, including pneumonia and influenza, are the 8th leading cause of death in the nation, accounting for 56,000 deaths annually. Pneumonia mortality in children fell by 97% in the last century, but respiratory infectious diseases continue to be leading causes of pediatric hospitalization and outpatient visits in the US. On average, influenza leads to more than 200,000 hospitalizations and 36,000 deaths each year. The 2009 H1N1 influenza pandemic caused an estimated 270,000 hospitalizations and 12,270 deaths (1,270 of which were of people younger than age 18) between April 2009 and March 2010.

- Healthy People 2020 (www.healthypeople.gov)

Flu Vaccinations

“There are two ways to get the seasonal flu vaccine, one is a shot in the arm and the other is a spray, mist, or drop in the nose called FluMist®. During the past 12 months, have you had either a seasonal flu shot or a seasonal flu vaccine that was sprayed in your nose?”

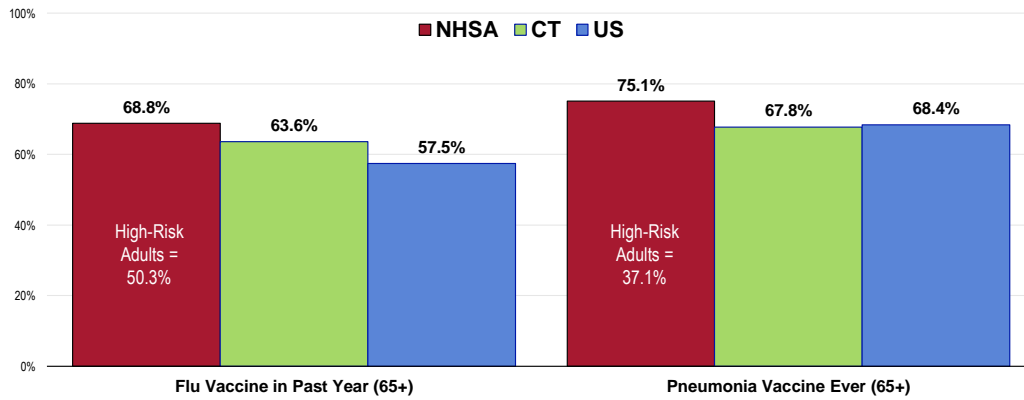
“A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person’s lifetime and is different from the seasonal flu shot. Have you ever had a pneumonia shot?”

Columns in the following chart show these findings among those age 65+. Percentages for “high-risk” adults age 18-64 in the Natchaug Hospital Service Area are also shown; here, “high-risk” includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.)

- Note also the Healthy People 2020 targets.

Influenza & Pneumonia Vaccination

Healthy People 2020 Target = 90.0% or Higher*



- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 141-144]
 - 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2013 Connecticut data.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives IID-12.6, 12.7, 13.1, 13.2]
- Notes:
- Asked of all respondents.
 - *The 2020 target is 90% for all 4 indicators, with the exception of pneumonia vaccines for high-risk adults (the related goal is 60% or higher).

HIV

About HIV

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 in 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.

HIV is a preventable disease, and effective HIV prevention interventions have been proven to reduce HIV transmission. People who get tested for HIV and learn that they are infected can make significant behavior changes to improve their health and reduce the risk of transmitting HIV to their sex or drug-using partners. More than 50% of new HIV infections occur as a result of the 21% of people who have HIV but do not know it.

In the era of increasingly effective treatments for HIV, people with HIV are living longer, healthier, and more productive lives. Deaths from HIV infection have greatly declined in the United States since the 1990s. As the number of people living with HIV grows, it will be more important than ever to increase national HIV prevention and healthcare programs.

There are gender, race, and ethnicity disparities in new HIV infections:

- Nearly 75% of new HIV infections occur in men.
- More than half occur in gay and bisexual men, regardless of race or ethnicity.
- 45% of new HIV infections occur in African Americans, 35% in whites, and 17% in Hispanics.

Improving access to quality healthcare for populations disproportionately affected by HIV, such as persons of color and gay and bisexual men, is a fundamental public health strategy for HIV prevention. People getting care for HIV can receive:

- Antiretroviral therapy
- Screening and treatment for other diseases (such as sexually transmitted infections)
- HIV prevention interventions
- Mental health services
- Other health services

As the number of people living with HIV increases and more people become aware of their HIV status, prevention strategies that are targeted specifically for HIV-infected people are becoming more important. Prevention work with people living with HIV focuses on:

- Linking to and staying in treatment.
- Increasing the availability of ongoing HIV prevention interventions.
- Providing prevention services for their partners.

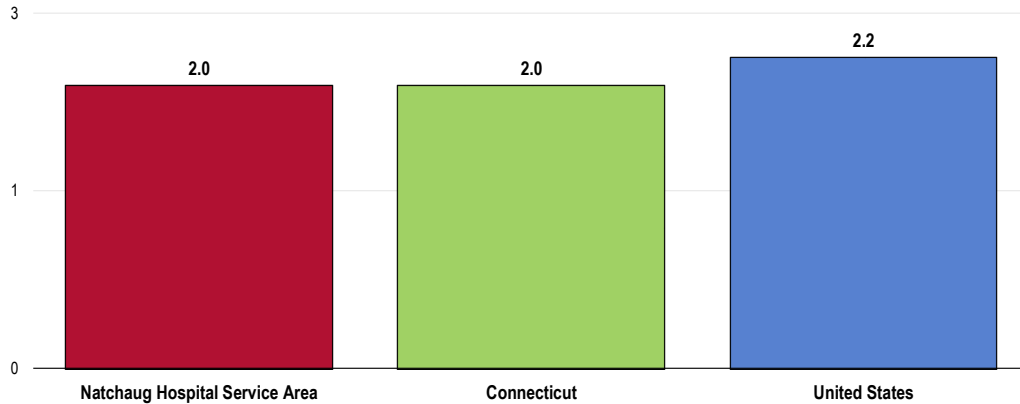
Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions for uninfected persons who engage in risky behaviors are critical.

- Healthy People 2020 (www.healthypeople.gov)

HIV/AIDS Deaths

The following chart outlines age-adjusted mortality rates for the area in comparison with state and national rates.

HIV/AIDS: Age-Adjusted Mortality
 (2011-2013 Annual Average Deaths per 100,000 Population)
 Healthy People 2020 Target = 3.3 or Lower



Sources:

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HIV-12]

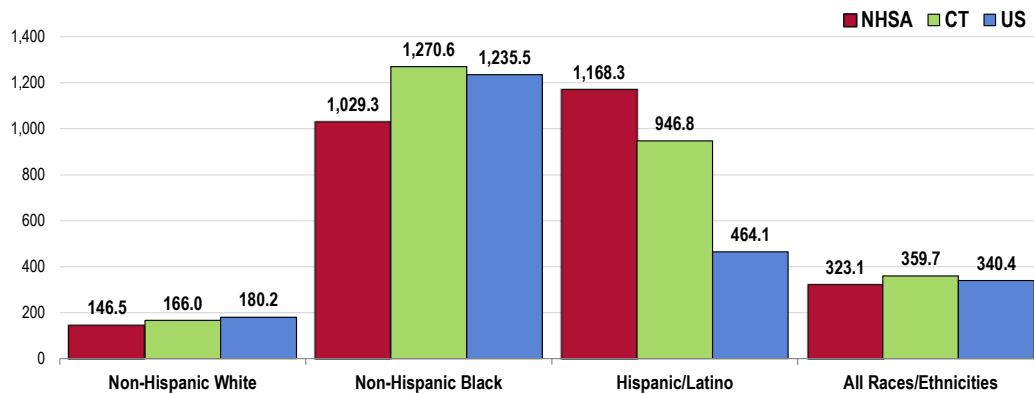
Notes:

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

HIV Prevalence

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area.

HIV Prevalence Rate by Race/Ethnicity
 (Prevalence Rate of HIV per 100,000 Population, 2010)



Sources:

- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2010.
- Retrieved February 2015 from Community Commons at <http://www.chna.org>.

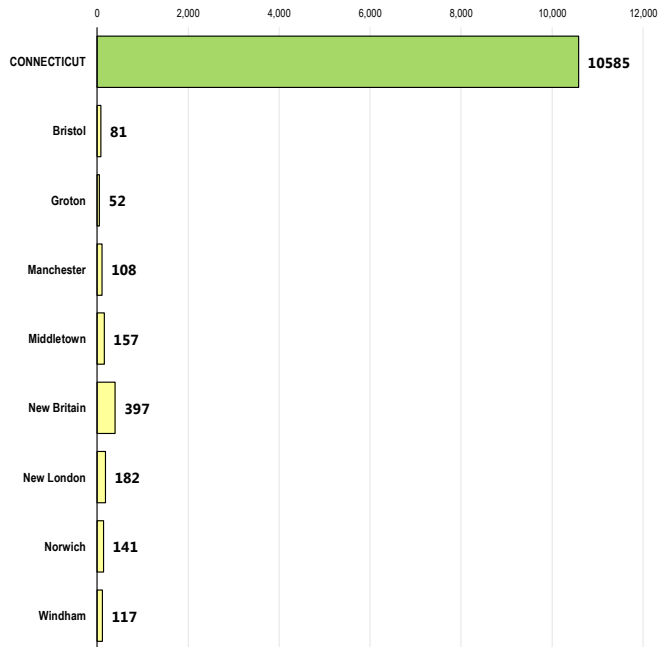
Notes:

- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

Persons Living With HIV

The following chart shows the number of persons living with HIV in select towns in the Natchaug Hospital Service Area.

Persons Living With HIV (PLWH)
(By Select Towns in the Natchaug Hospital Service Area, 2007-2011)

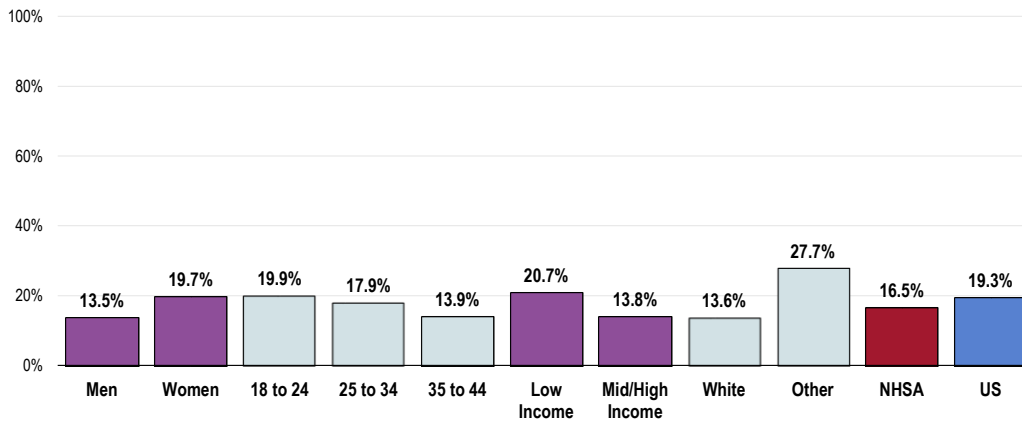


Source: • Connecticut Department of Public Health

HIV Testing

“Not counting tests you may have had when donating or giving blood, when was the last time you were tested for HIV?” (Reported below only among adults age 18 to 44.)

Tested for HIV in the Past Year
(Among Adults Age 18-44)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 145]

• 2013 PRC National Health Survey, Professional Research Consultants, Inc.

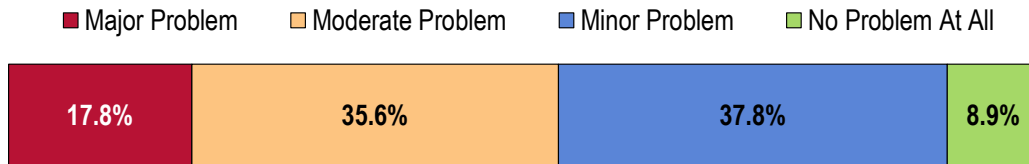
Notes: • Reflects respondents age 18 to 44.

• Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: HIV

The following chart outlines key informants' perceptions of the severity of *HIV* as a problem in the community:

Perceptions of HIV/AIDS as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

Prevalence

IN our area, we have the highest number of AIDS and HIV cases all concentrated in the area of New London. The reason for why we also have the highest number of cancer rates in the area as well. This can be due to several factors, inaccessibility to forms of protection, lack of education regarding aids and the way its spread, high prostitution rates - Social Service

There are growing case of HIV/AIDS in women of color and the senior population. This is due a number of reasons but mostly lack of education and reinforce knowledge of sexual. HIV/AIDS is result of not practicing safe sex. – Social Services Representative

While HIV/AIDS incidence overall has declined, it affects Latino communities disproportionately, especially in the northeast/Connecticut. Latinos are more likely to be tested after the infection has progressed beyond the early stages of the disease. – Social Services Representative

Men who have sex with men (MSM) is the population with significantly increasing rate of HIV. There is not enough prevention education. – Social Services Representative

As an HIV/AIDS organization, we are still engaging and diagnosing new cases. People are still thinking that it is not a major problem, but our young Latino and African American community is coming back infected. – Social Services Representative

There is a high prevalence of HIV/AIDS in Hartford compared to other CT communities. There is stigma associated with this illness and beliefs that residents hold that creates fear and keeps them from getting testing and treatment. – Community/Business Leader

Studies/assessments have determined that to be the case, particularly among the black community. – Community/Business Leader

Data show. – Physician

Substance Abuse

HIV/AIDS ties directly in with substance abuse which is also a major problem in the Hartford area. Promiscuous activity and unprotected sex. – Other Health Provider

Drug Use

High drug use. – Other Health Provider

Lack of Access to Specialists

It doesn't appear there is enough access to ID physicians and a good part of the population needs a lot of prompting to take medications and to be interested more in preventive services than crisis to crisis. – Social Services Representative

Education

Lack of education. High substance abuse rates, risky behaviors. – Public Health Expert

Sexually Transmitted Diseases

About Sexually Transmitted Diseases

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as: reproductive health problems; fetal and perinatal health problems; cancer; and facilitation of the sexual transmission of HIV infection.

Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. Several factors contribute to the spread of STDs.

Biological Factors. STDs are acquired during unprotected sex with an infected partner. Biological factors that affect the spread of STDs include:

- **Asymptomatic nature of STDs.** The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care.
- **Gender disparities.** Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy (pregnancy outside of the uterus), infertility, and chronic pelvic pain.
- **Age disparities.** Compared to older adults, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs.
- **Lag time between infection and complications.** Often, a long interval, sometimes years, occurs between acquiring an STD and recognizing a clinically significant health problem.

Social, Economic and Behavioral Factors. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates these factors. Social, economic, and behavioral factors that affect the spread of STDs include: racial and ethnic disparities; poverty and marginalization; access to healthcare; substance abuse; sexuality and secrecy (stigma and discomfort discussing sex); and sexual networks (persons “linked” by sequential or concurrent sexual partners).

- Healthy People 2020 (www.healthypeople.gov)

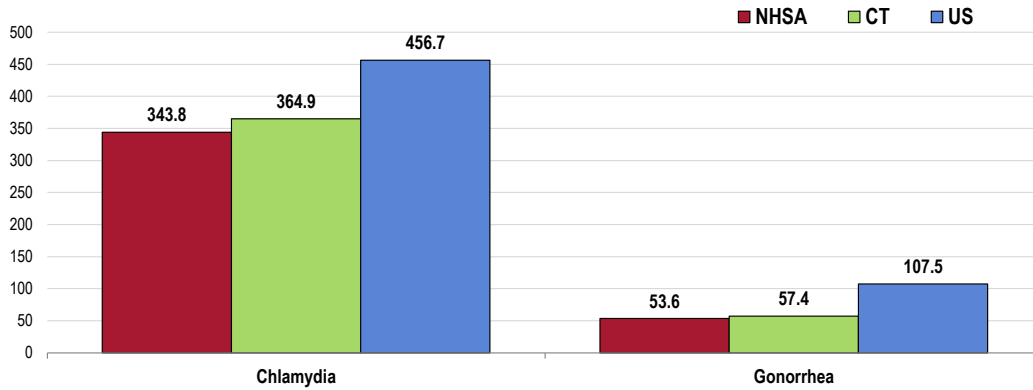
Chlamydia & Gonorrhea

Chlamydia. Chlamydia is the most commonly reported STD in the United States; most people who have chlamydia don’t know it since the disease often has no symptoms.

Gonorrhea. Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following charts outline local incidence for these STDs.

Chlamydia & Gonorrhea Incidence (Incidence Rate per 100,000 Population, 2012)



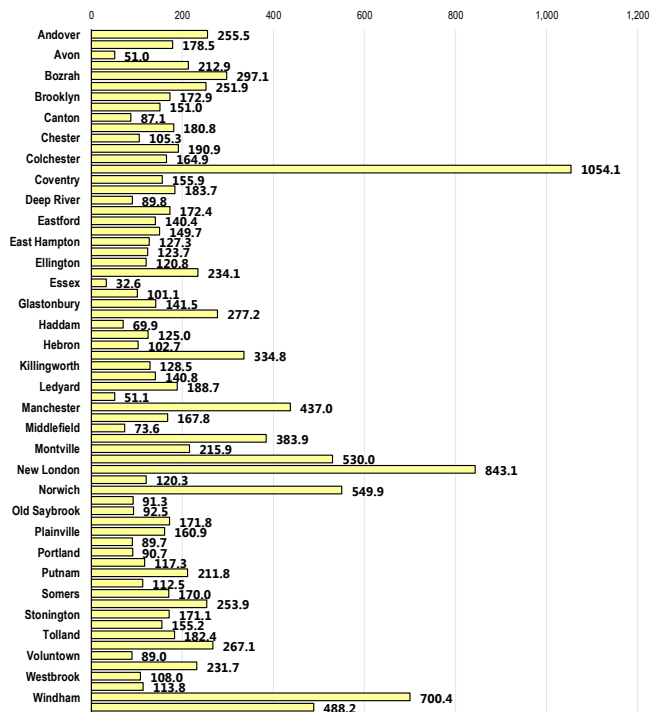
Sources:

- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2012.
- Retrieved February 2015 from Community Commons at <http://www.chna.org>.

Notes:

- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Chlamydia Incidence Rate per 100,000 (By Select Towns in the Natchaug Hospital Service Area, 2013)

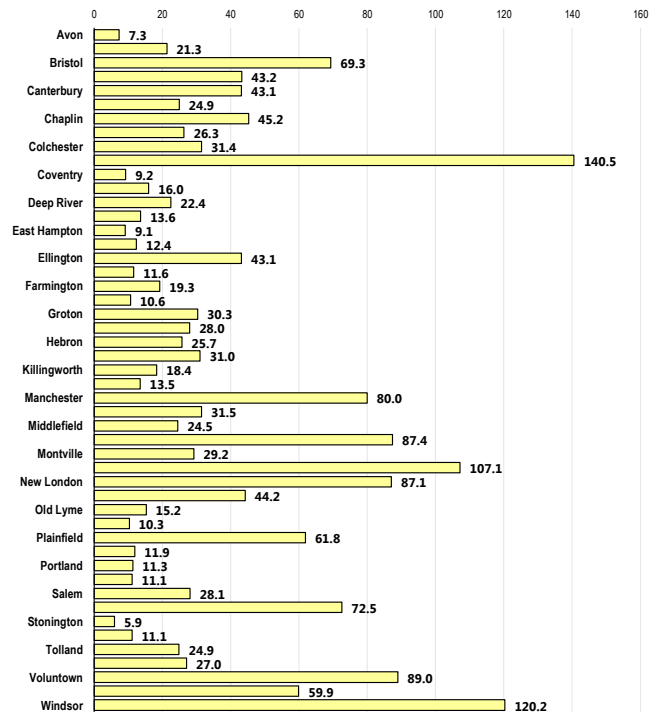


Source:

- Connecticut Department of Public Health

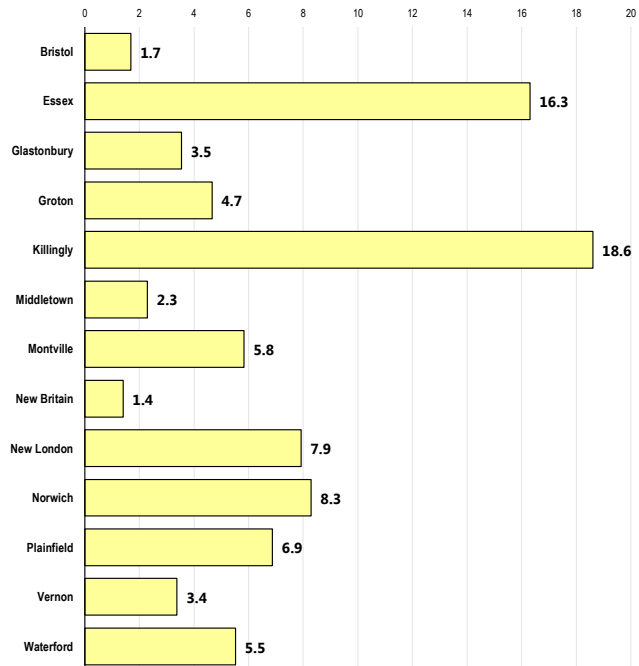
Gonorrhea Incidence Rate per 100,000 (By Select Towns in the Natchaug Hospital Service Area, 2013)

Source: Connecticut Department of Public Health



Primary & Secondary Syphilis Incidence Rate per 100,000 (By Select Towns in the Natchaug Hospital Service Area, 2013)

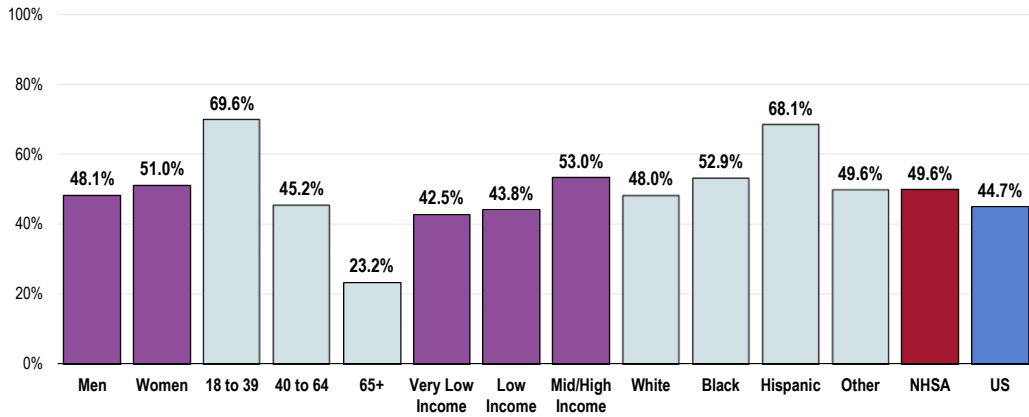
Source: Connecticut Department of Public Health



Hepatitis B Vaccination

“To be vaccinated against hepatitis B, a series of three shots must be administered, usually at least one month between shots. Have you completed a hepatitis B vaccination series?”

Have Completed the Hepatitis B Vaccination Series (Natchaug Hospital Service Area, 2015)

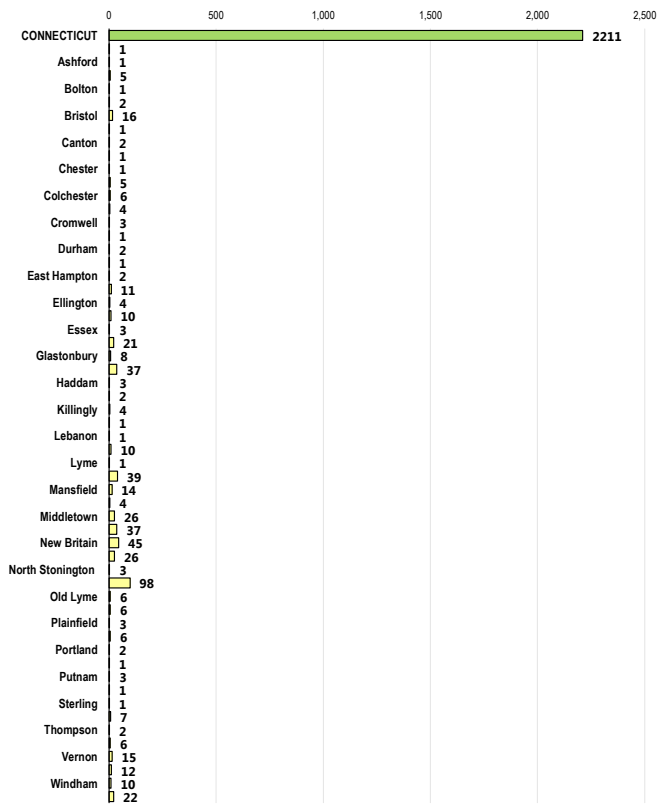


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 70]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes less than 100% of the federal poverty level; "Low Income" includes households with incomes from 100–199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Numbers of cases of hepatitis B for select towns in the Natchaug Hospital Service area are shown below.

Cases of Chronic Hepatitis B (By Select Towns in the Natchaug Hospital Service Area, 2007-2011)



Source: • Connecticut Department of Public Health

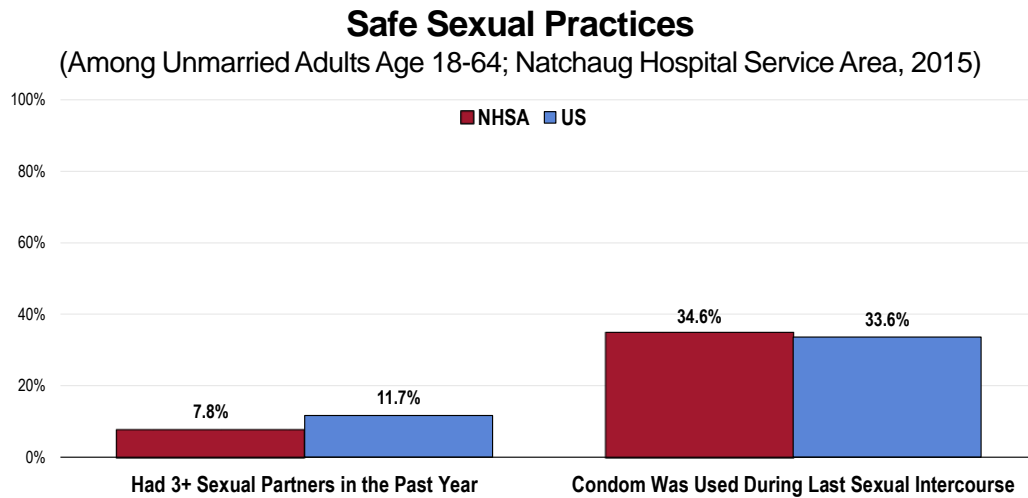
Safe Sexual Practices

Sexual Partners

“During the past 12 months, with how many people have you had sexual intercourse?”

“Was a condom used the last time you had sexual intercourse?”

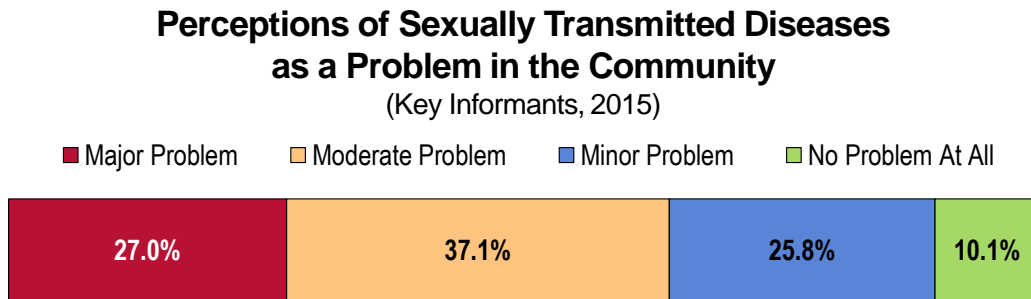
Each of these is reported below only among adults who are unmarried and between the ages of 18 and 64.



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 86-87]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all unmarried respondents under the age of 65.

Key Informant Input: Sexually Transmitted Diseases

The following chart outlines key informants’ perceptions of the severity of *Sexually Transmitted Diseases* as a problem in the community:



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

High Rates

Gonorrhea, chlamydia and syphilis have higher incidence rates in Hartford than elsewhere in the state and rates are disproportionately high among Latinos and Blacks. There has been a major increase in prevalence of syphilis. – Social Services Representative

CT has a high incidence of STI's, Gonorrhea, Chlamydia and Syphilis are in high numbers in my community, especially within the young MSM community and other youth. – Social Services Representative

Area STD data indicates relatively higher prevalence rates, likely due to behaviors associated with a very large university population within the area. – Public Health Expert

Hartford has high rates/100K of STDs, including Chlamydia, Gonorrhea Hepatitis C, etc. compared to most other communities in CT. Others of the larger cities have similar rates to Hartford. – Community/Business Leader

We have seen a slow but steady increase in Chlamydia over the last few years. – Community/Business Leader

Same-Sex Partners

Men who have sex with men account for the vast majority of syphilis cases in CT. Some are co-infected with HIV. They also test positive for other STDs. – Social Services Representative

Education

People need more educational services on practicing safe sex. – Other Health Provider

Low Income Young Pregnant Teens

Contributing factors include low income young pregnant teens. Unable to afford the cost of protection. – Other Health Provider

Risk and Substance Abuse

Misinformation. Substance abuse leading to risky sexual behaviors. Mental illness leading to risky sexual behaviors. Lack of education. – Public Health Expert

Access to Contraceptives

Even though we have several clinics nearby that have access to contraceptives and other forms of protection, there's lack of knowledge about these resources and how to access them. – Social Services Representative

Correlation

I think there is a strong correlation between STD's and IVDA. The individuals are getting younger and younger, often finding co-infection with both Chlamydia and gonorrhea. With many parents working long hours, the amount of parental supervision has declined allowing youth more opportunity to engage in risky sexual behaviors. – Public Health Expert

Youth Activity

Youth become sexually active at an early age and don't take the precautions necessary. Also a population of drug users engage in activities to procure money for drugs. – Other Health Provider

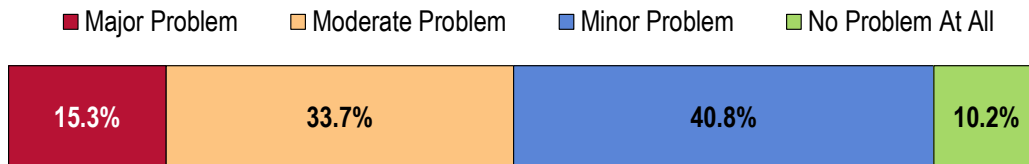
Immunization & Infectious Diseases

Key Informant Input: Immunization & Infectious Diseases

The following chart outlines key informants' perceptions of the severity of *Immunization & Infectious Diseases* as a problem in the community:

Perceptions of Immunization and Infectious Diseases as a Problem in the Community

(Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Births

Prenatal Care

About Infant & Child Health

Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty.

Infant and child health are similarly influenced by socio-demographic factors, such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African Americans. These differences are likely the result of many factors, including social determinants (such as racial and ethnic disparities in infant mortality; family income; educational attainment among household members; and health insurance coverage) and physical determinants (i.e., the health, nutrition, and behaviors of the mother during pregnancy and early childhood).

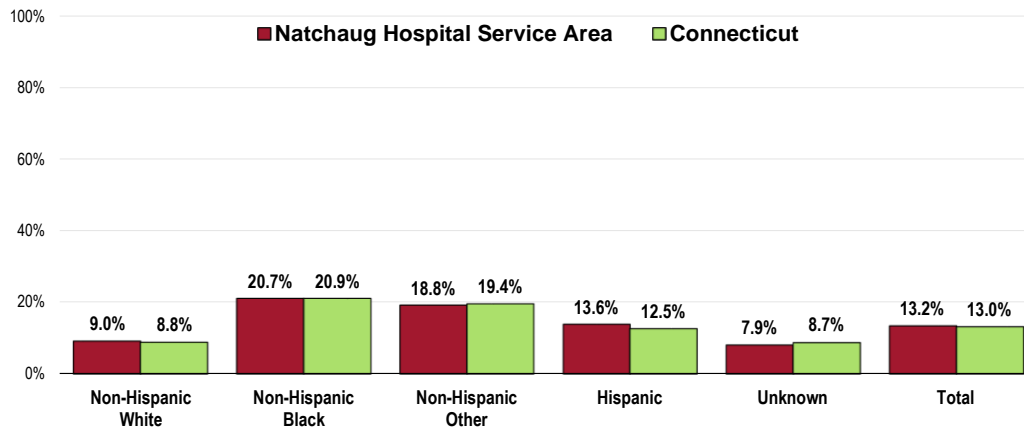
- Healthy People 2020 (www.healthypeople.gov)

Early and continuous prenatal care is the best assurance of infant health. Receipt of timely prenatal care (care initiated during the first trimester of pregnancy) is outlined in the following charts.

- Note the Healthy People 2020 target.

Lack of Prenatal Care in the First Trimester

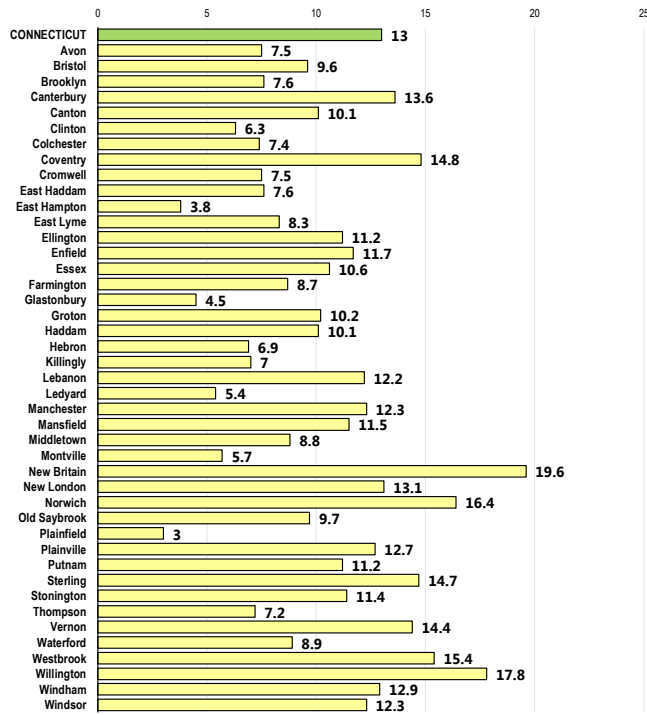
(By Race; Percentage of Live Births, 2011)
Healthy People 2020 Target = 22.1% or Lower



Sources: • Connecticut Department of Public Health.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-10.1]

Note: • This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health, knowledge insufficient provider outreach, and/or social barriers preventing utilization of services.

Percent of Births With Late or No Prenatal Care
(By Select Towns in the Natchaug Hospital Service Area, 2011)



Source: • Connecticut Department of Public Health

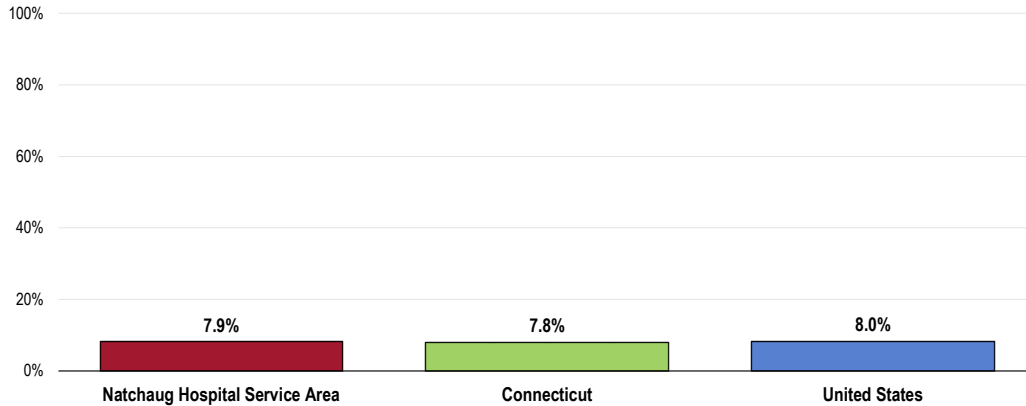
Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. Births of low-weight infants are described below.

- [Note the Healthy People 2020 target.](#)

Low-Weight Births (Percent of Live Births, 2011-2013) Healthy People 2020 Target = 7.8% or Lower



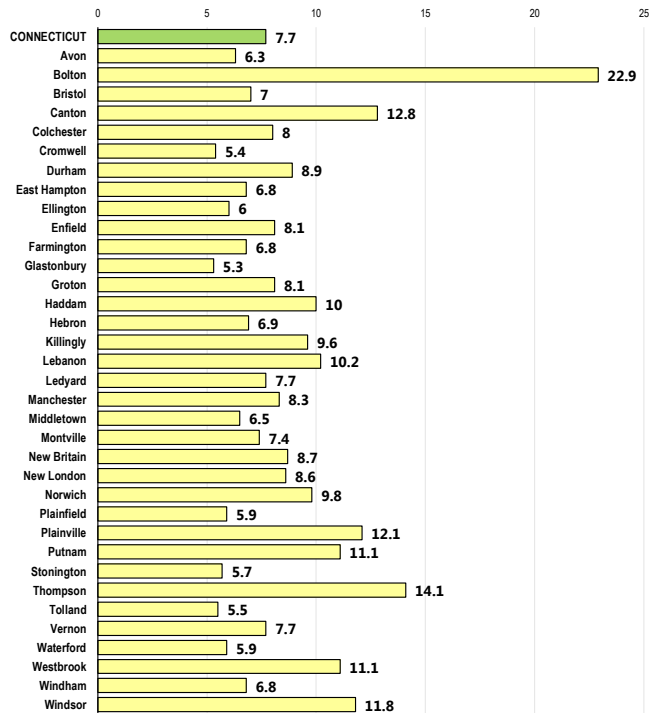
Sources:

- Centers for Disease Control and Prevention, National Vital Statistics System: 2011-13. Accessed using CDC WONDER.
- Retrieved February 2015 from Community Commons at <http://www.chna.org>.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-8.1]

Note:

- This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Percent of Births With Low Birthweight (By Select Towns in the Natchaug Hospital Service Area, 2011)



Source:

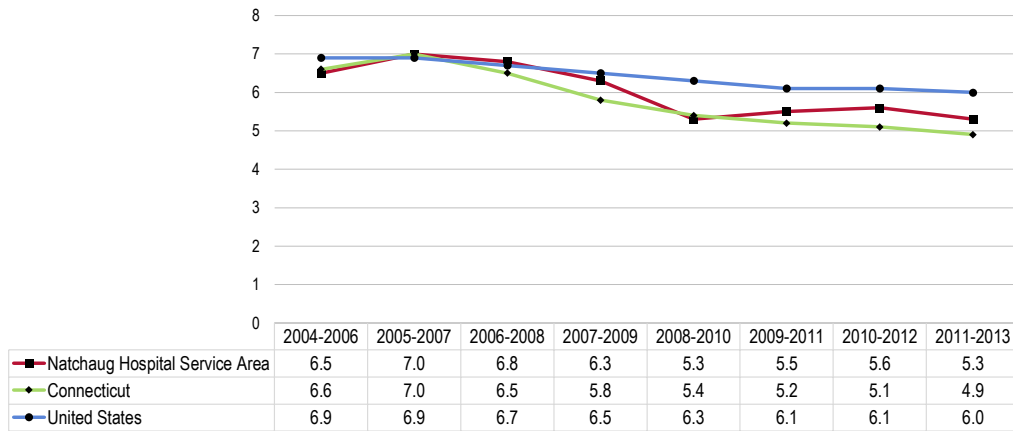
- Connecticut Department of Public Health

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. These rates are outlined in the following charts.

- Note the Healthy People 2020 target.

Infant Mortality Trends
 (Annual Average Infant Deaths per 1,000 Live Births)
Healthy People 2020 Target = 6.0 or Lower



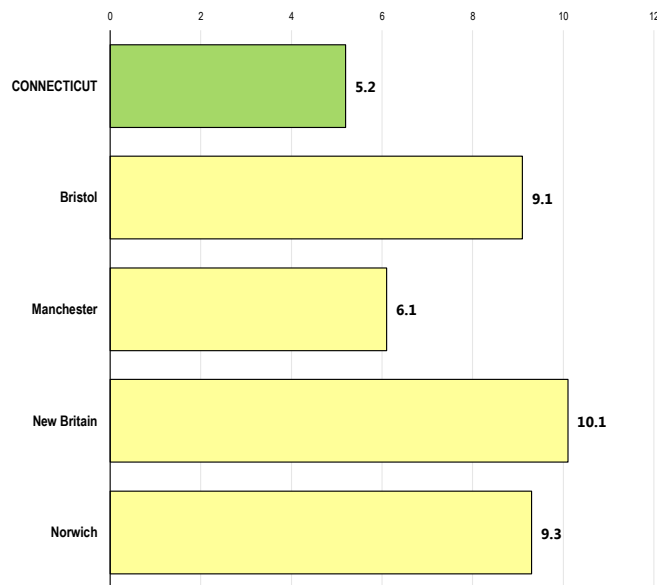
Sources:

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]

 Notes:

- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

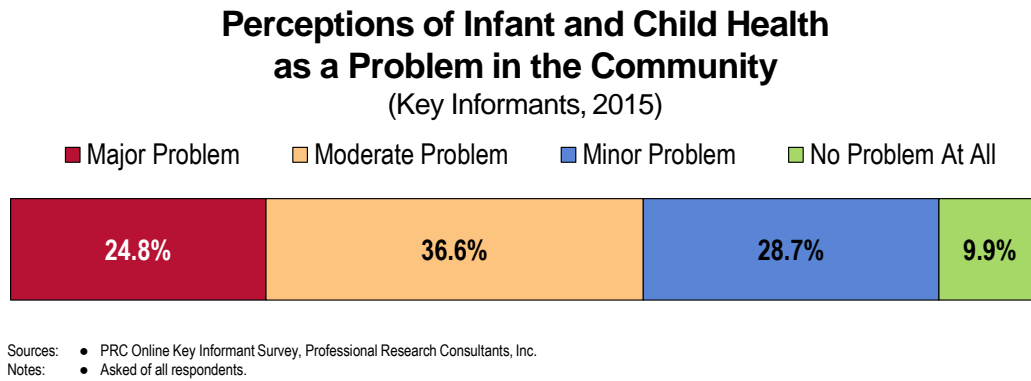
Infant Deaths per 1,000 Live Births
 (By Select Towns in the Natchaug Hospital Service Area, 2011)



Source: Connecticut Department of Public Health

Key Informant Input: Infant & Child Health

The following chart outlines key informants' perceptions of the severity of *Infant & Child Health* as a problem in the community:



Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

Education

Again this is not unique to Meriden. There are resources out there people just need to be made aware, directed and assisted. We have WIC and many other entitlement programs. Dental is a huge issue. – Public Health Expert

Need more preventative education and connection to resources. – Community/Business Leader

Access Barriers

While there have been major improvements in immunization rates, there continue to be barriers to adequate access to primary care. In addition, infant mortality rates are disproportionately high compared to state and national rates. Childhood overweight and obesity is a major problem, as is asthma. Breastfeeding incidence, duration and exclusivity rates have continued to improve, but have a long way to go citywide. – Social Services Representative

Families do not have the funds to adequately take care of children. – Other Health Provider

Due to a diverse community, there are many barriers and misconceptions regarding the care required and resources available. – Other Health Provider

Timely access and transportation are challenging for many families. Also, some parents and other caregivers are not informed about proper infant and child health. – Community/Business Leader

This is really only tied to Medicaid where there are some problems with the number of pediatric specialists in Husky/Medicaid. – Physician

Education, Nutrition and Infant Mortality

Learning, nutrition, infant mortality. – Physician

Asthma

High asthma rates continue to be a major health issue for our students/families. – Community/Business Leader

Pregnancy and Infant Loss

Statistically the town of Manchester has seen a higher than state average in pregnancy and infant loss. – Public Health Expert

Single Parenting

High rates of single motherhood, high correlation between single moms and poverty. Stigma against single parenting, and leaving DV relationships. – Social Services Representative

Vaccinations

Infants of uninsured moms often skip recommended required vaccines. Records of undocumented difficult to obtain. Lack of nutritional education for obese children. – Other Health Provider

Neglect

Neglected children. Poor access to childcare. Lack of access to primary care. Immigrant population. Food insecurity. – Public Health Expert

Specialists

No or limited OB/GYN practice in area - Community/Business Leader

Issues on the Rise

There are a number of issues that seem to be on the rise, obesity, asthma, autism and behavioral challenges. – Other Health Provider

Poor Population With Lower-Than-Average Education

Our community has a poor population with lower than average education. More education and outreach is needed to help insure the health of newborns. – Community/Business Leader

Family Planning

Births to Teen Mothers

About Teen Births

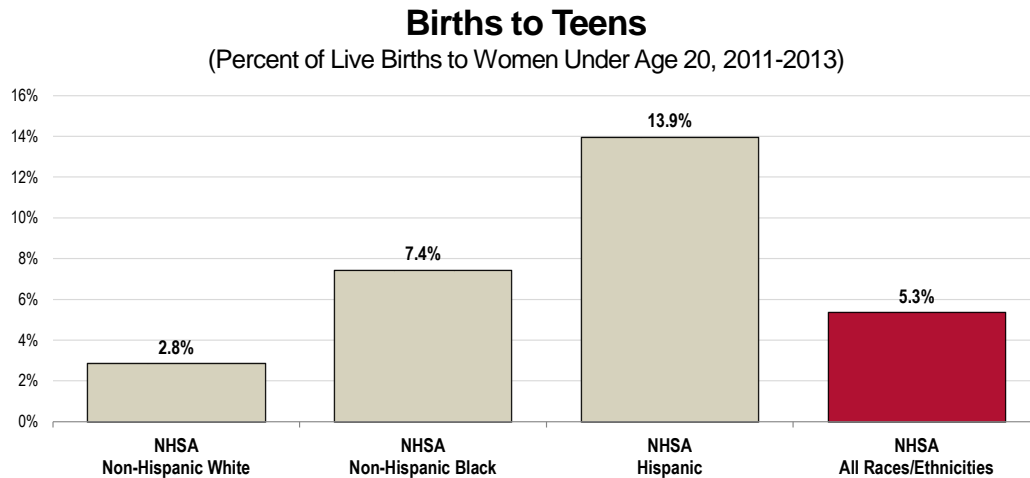
The negative outcomes associated with unintended pregnancies are compounded for adolescents. Teen mothers:

- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately \$3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

Similarly, early fatherhood is associated with lower educational attainment and lower income. Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

- Healthy People 2020 (www.healthypeople.gov)

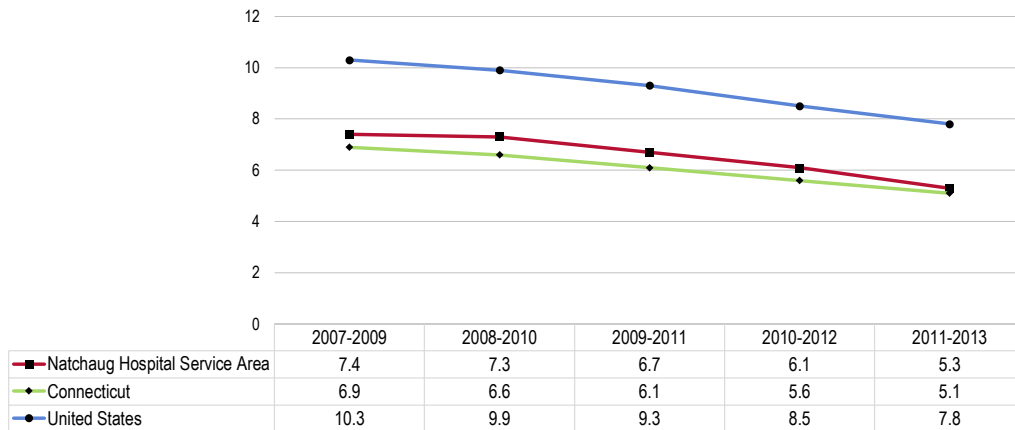
The following charts describe local teen births.



- Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2006-2012. Accessed using CDC WONDER.
 - Retrieved February 2015 from Community Commons at <http://www.chna.org>.

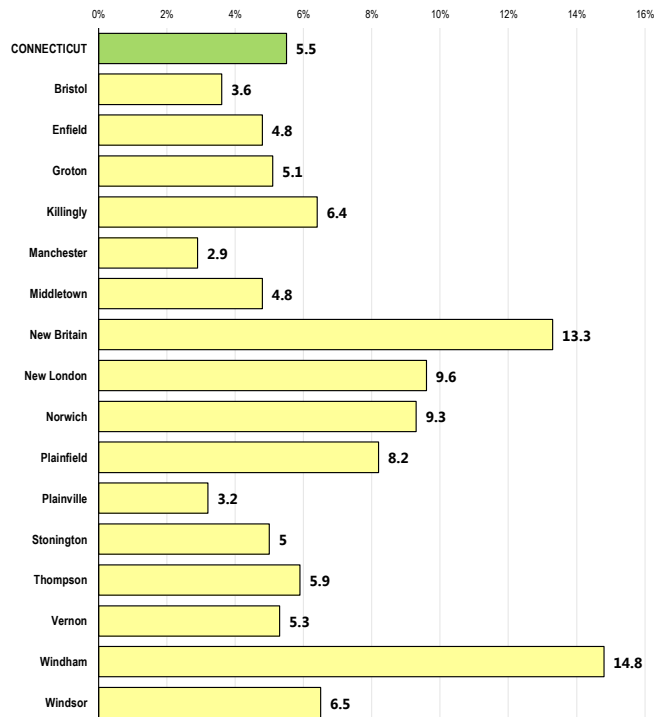
Birth to Teens

(Percent of Live Births to Women Under Age 20, 2011-2013)



Sources: ● Centers for Disease Control and Prevention, National Vital Statistics System: 2006-2012. Accessed using CDC WONDER.
 ● Retrieved February 2015 from Community Commons at <http://www.chna.org>.

Percent of Births to Mothers Under Age 20 (By Select Towns in the Natchaug Hospital Service Area, 2011)

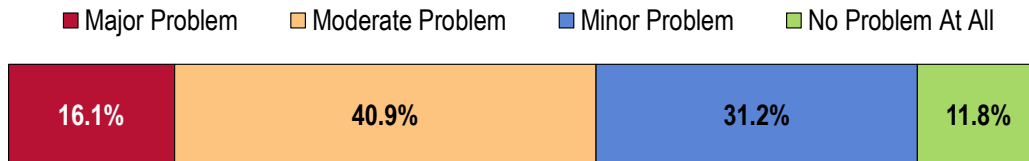


Source: ● Connecticut Department of Public Health

Key Informant Input: Family Planning

The following chart outlines key informants' perceptions of the severity of *Family Planning* as a problem in the community:

Perceptions of Family Planning as a Problem in the Community (Key Informants, 2015)



Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

Teen Births

Teen pregnancy remains an issue in our school community. – Community/Business Leader

Far too many babies having babies. Too many youth are having kids before they are ready to start a family. – Community/Business Leader

I think many young woman have unplanned pregnancy and are not emotionally or practically prepared for parenthood. While many choose to have the baby, it is a struggle and greatly impacts their life choices (i.e. education, work, job training). In addition many young mothers have emotional struggles from their childhood and need support in working through them (i.e. counseling, parenting education, support groups). – Community/Business Leader

Teen pregnancy continue to be an issue in our community. – Public Health Expert

High teen birth rate and low birth weight. – Physician

Lack of Education

I believe that a lot has to do with education, comfort level in talking to a partner about using birth control. In addition there are some social norms out there who are getting pregnant because they want to. This would be a great question to ask the youth in our community. – Public Health Expert

Lack of education. Competing priorities. Lack of life skills. – Public Health Expert

Discussion at Home

Cultural norms do not allow for discussion of family planning at home, school based health centers are restricted in what they can do. – Community/Business Leader

Birth Control

Lack of easy access to long term birth control. – Social Services Representative

It's not so much about family planning as about women having consistent access to pre-conception and pre-natal care regardless of income. – Community/Business Leader

Primary Care Physicians

Our demographic is changing dramatically and wellness is critical. We have a shortage of primary care doctors. – Community/Business Leader

Prevention

No community based centers for prevention of unwanted pregnancies. – Other Health Provider

Transient Population

We have a transient population with a large number being ESL. Many come from poor, agricultural nations or territories where a large family is an asset, rather than a financial burden. We also have a large number of broken families with single parents. – Community/Business Leader

Modifiable Health Risks

Actual Causes Of Death

About Contributors to Mortality

A 1999 study (an update to a landmark 1993 study), estimated that as many as 40% of premature deaths in the United States are attributed to behavioral factors. This study found that behavior patterns represent the single-most prominent domain of influence over health prospects in the United States. The daily choices we make with respect to diet, physical activity, and sex; the substance abuse and addictions to which we fall prey; our approach to safety; and our coping strategies in confronting stress are all important determinants of health.

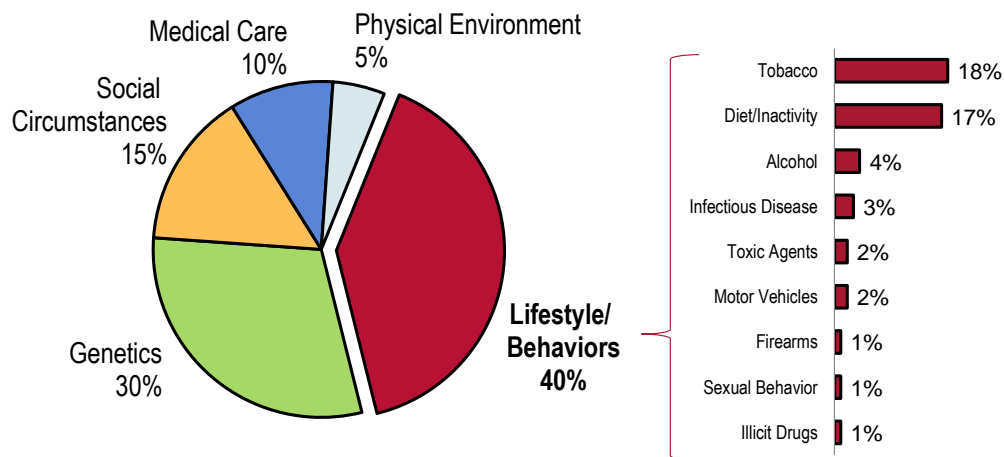
The most prominent contributors to mortality in the United States in 2000 were **tobacco** (an estimated 435,000 deaths), **diet and activity** patterns (400,000), **alcohol** (85,000), **microbial agents** (75,000), **toxic agents** (55,000), **motor vehicles** (43,000), **firearms** (29,000), **sexual behavior** (20,000), and **illicit use of drugs** (17,000). Socioeconomic status and access to medical care are also important contributors, but difficult to quantify independent of the other factors cited. Because the studies reviewed used different approaches to derive estimates, the stated numbers should be viewed as first approximations.

These analyses show that smoking remains the leading cause of mortality. However, poor diet and physical inactivity may soon overtake tobacco as the leading cause of death. These findings, along with escalating healthcare costs and aging population, argue persuasively that the need to establish a more preventive orientation in the US healthcare and public health systems has become more urgent.

- Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH. "Actual Causes of Death in the United States." JAMA, 291(2004):1238-1245.

While causes of death are typically described as the diseases or injuries immediately precipitating the end of life, a few important studies have shown that the actual causes of premature death (reflecting underlying risk factors) are often preventable.

Factors Contributing to Premature Deaths in the United States



Sources: • "The Case For More Active Policy Attention to Health Promotion"; (McGinnis, Williams-Russo, Knickman) Health Affairs. Vol. 32. No. 2. March/February 2002. "Actual Causes of Death in the United States"; (Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH.) JAMA. 291 (2000) 1238-1245.

Leading Causes of Death	Underlying Risk Factors (Actual Causes of Death)	
Cardiovascular Disease	Tobacco use Elevated serum cholesterol High blood pressure	Obesity Diabetes Sedentary lifestyle
Cancer	Tobacco use Improper diet	Alcohol Occupational/environmental exposures
Cerebrovascular Disease	High blood pressure Tobacco use	Elevated serum cholesterol
Accidental Injuries	Safety belt noncompliance Alcohol/substance abuse Reckless driving	Occupational hazards Stress/fatigue
Chronic Lung Disease	Tobacco use	Occupational/environmental exposures

Source: National Center for Health Statistics/US Department of Health & Human Services, Health United States: 1987. DHHS Pub. No. (PHS) 88-1232.

Nutrition, Physical Activity & Weight

Nutrition

About Healthful Diet & Healthy Weight

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including: overweight and obesity; malnutrition; iron-deficiency anemia; heart disease; high blood pressure; dyslipidemia (poor lipid profiles); type 2 diabetes; osteoporosis; oral disease; constipation; diverticular disease; and some cancers.

Diet reflects the variety of foods and beverages consumed over time and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that:

- Individuals have the knowledge and skills to make healthier choices.
- Healthier options are available and affordable.

Social Determinants of Diet. Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.

Social factors thought to influence diet include:

- Knowledge and attitudes
- Skills
- Social support
- Societal and cultural norms
- Food and agricultural policies
- Food assistance programs
- Economic price systems

Physical Determinants of Diet. Access to and availability of healthier foods can help people follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods.

The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home.

Marketing also influences people's—particularly children's—food choices.

- Healthy People 2020 (www.healthypeople.gov)

Daily Recommendation of Fruits/Vegetables

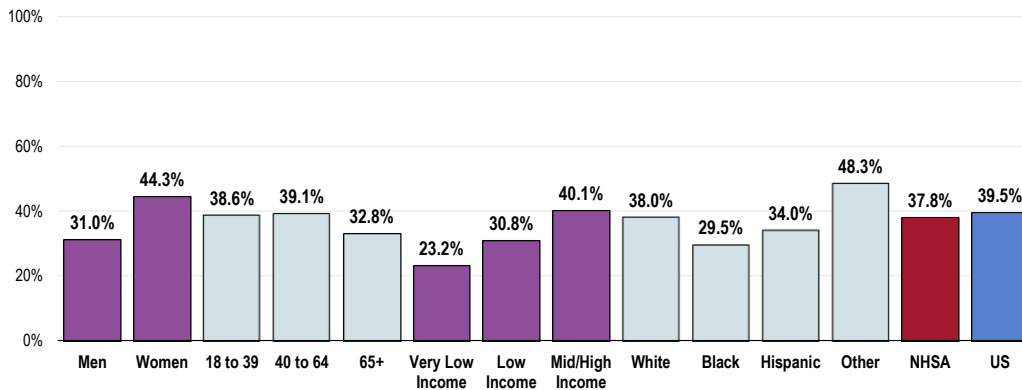
To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

“Now I would like you to think about the foods you ate or drank yesterday. Include all the foods you ate, both at home and away from home. How many servings of fruit or fruit juices did you have yesterday?”

“How many servings of vegetables did you have yesterday?”

The questions above are used to calculate daily fruit/vegetable consumption for adults at the respondent level. The proportion reporting having 5 or more servings per day is shown below.

Consume Five or More Servings of Fruits/Vegetables Per Day
(Natchaug Hospital Service Area, 2015)

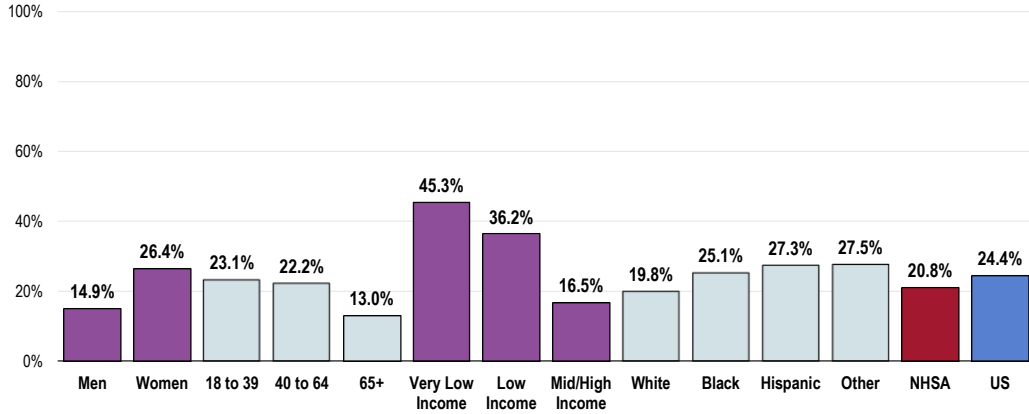


- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 146]
 - 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.
 - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 - Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes less than 100% of the federal poverty level; “Low Income” includes households with incomes from 100–199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
 - For this issue, respondents were asked to recall their food intake on the previous day.

Access to Fresh Produce

“How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?”

Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce (Natchaug Hospital Service Area, 2015)

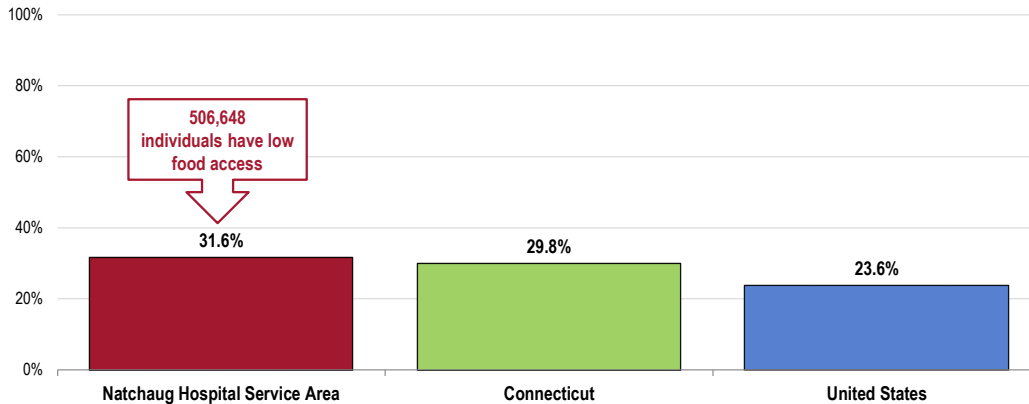


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 91]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes less than 100% of the federal poverty level; “Low Income” includes households with incomes from 100–199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

A food desert is defined as a low-income area where a significant number or share of residents is far from a supermarket, where “far” is more than 1 mile in urban areas and more than 10 miles in rural areas. The chart for this indicator below is based on US Department of Agriculture data.

Population With Low Food Access (Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2010)



Sources: • US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA): 2010.
 • Retrieved February 2015 from Community Commons at <http://www.chna.org>.

Notes: • This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as low-income areas where a significant number or share of residents is far from a supermarket, where “far” is more than 1 mile in urban areas and more than 10 miles in rural areas. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Physical Activity

About Physical Activity

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can: improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors **positively** associated with adult physical activity include: postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

Factors **negatively** associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Among children ages 4 to 12, the following factors have a positive association with physical activity: gender (boys); belief in ability to be active (self-efficacy); and parental support.

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity: parental education; gender (boys); personal goals; physical education/school sports; belief in ability to be active (self-efficacy); and support of friends and family.

Environmental influences positively associated with physical activity among children and adolescents include:

- Presence of sidewalks
- Having a destination/walking to a particular place
- Access to public transportation
- Low traffic density
- Access to neighborhood or school play area and/or recreational equipment

People with disabilities may be less likely to participate in physical activity due to physical, emotional, and psychological barriers. Barriers may include the inaccessibility of facilities and the lack of staff trained in working with people with disabilities.

- Healthy People 2020 (www.healthypeople.gov)

Recommended Levels of Physical Activity

Adults (age 18–64) should do 2 hours and 30 minutes a week of moderate-intensity, or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. Aerobic activity should be performed in episodes of at least 10 minutes, preferably spread throughout the week.

Additional health benefits are provided by increasing to 5 hours (300 minutes) a week of moderate-intensity aerobic physical activity, or 2 hours and 30 minutes a week of vigorous-intensity physical activity, or an equivalent combination of both.

Older adults (age 65 and older) should follow the adult guidelines. If this is not possible due to limiting chronic conditions, older adults should be as physically active as their abilities allow. They should avoid inactivity. Older adults should do exercises that maintain or improve balance if they are at risk of falling.

For all individuals, some activity is better than none. Physical activity is safe for almost everyone, and the health benefits of physical activity far outweigh the risks.

- 2008 Physical Activity Guidelines for Americans, U.S. Department of Health and Human Services. www.health.gov/PAGuidelines

Physical Activity Levels

Leisure-Time Physical Activity. Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

“During the past month, other than your regular job, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?”

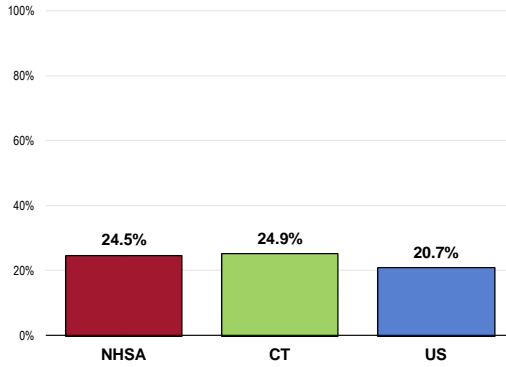
- Note the corresponding Healthy People 2020 target in the chart below.

Meeting Physical Activity Recommendations. Meeting physical activity requirements means satisfying a minimum threshold of minutes per week with a combination of vigorous- and/or moderate-intensity physical activity (as determined from the questions below). These thresholds are described in the orange box above.

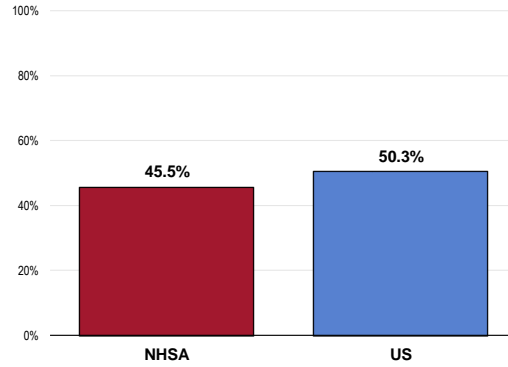
“Vigorous activities cause large increases in breathing or heart rate, while moderate activities cause small increases in breathing or heart rate. Now, thinking about when you are not working, how many days per week or per month do you do vigorous activities for at least 20 minutes at a time, such as running, aerobics, heavy yard work, or anything else that causes large increases in breathing and heart rate?”

“And on how many days per week or per month do you do moderate activities for at least 30 minutes at a time, such as brisk walking, bicycling, vacuuming, gardening, or anything else that causes some increase in breathing or heart rate?”

No Leisure-Time Physical Activity in the Past Month
 Healthy People 2020 Target = 32.6% or Lower

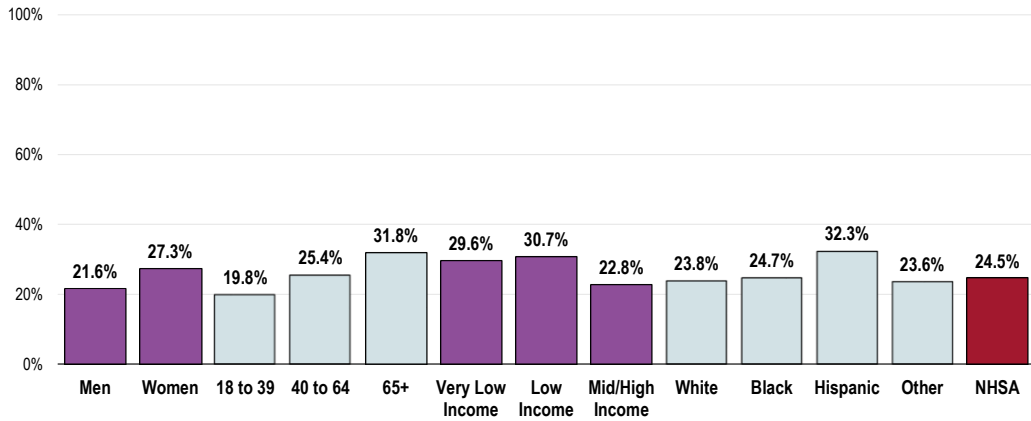


Meets Physical Activity Recommendations



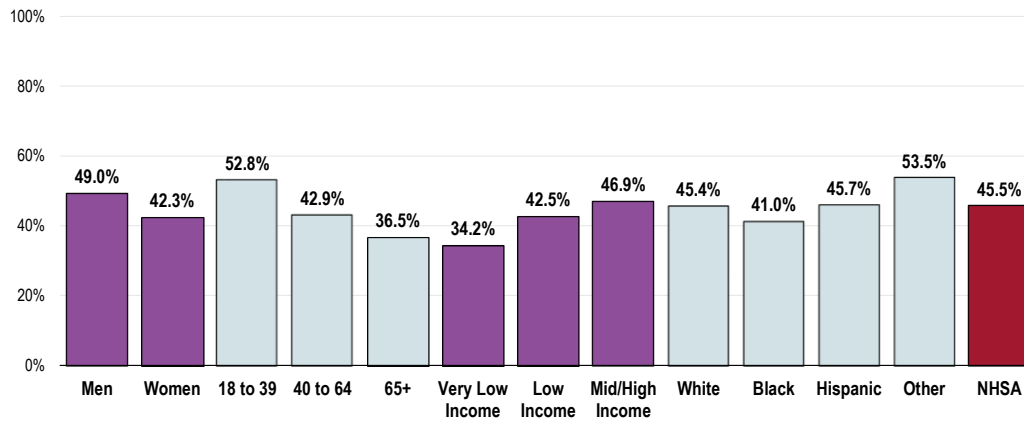
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 92, 147]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). 2013 Connecticut data.
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-1]
 Notes: • Asked of all respondents.
 • In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

No Leisure-Time Physical Activity in the Past Month
 (Natchaug Hospital Service Area, 2015)
 Healthy People 2020 Target = 32.6% or Lower



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 92]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-1]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes less than 100% of the federal poverty level; "Low Income" includes households with incomes from 100-199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Meets Physical Activity Recommendations (Natchaug Hospital Service Area, 2015)

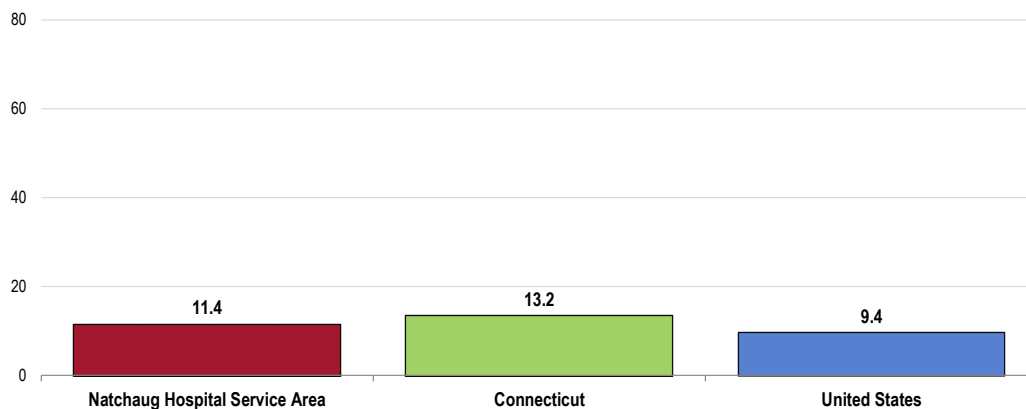


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 147]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes less than 100% of the federal poverty level; "Low Income" includes households with incomes from 100–199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 • In this case the term "meets physical activity recommendations" refers to participation in moderate physical activity (exercise that produces only light sweating or a slight to moderate increase in breathing or heart rate) at least 5 times a week for 30 minutes at a time, and/or vigorous physical activity (activities that cause heavy sweating or large increases in breathing or heart rate) at least 3 times a week for 20 minutes at a time.

Access to Physical Activity

Recreation & Fitness Facility Access. Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities." Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

Population With Recreation & Fitness Facility Access (Number of Recreation & Fitness Facilities per 100,000 Population, 2012)

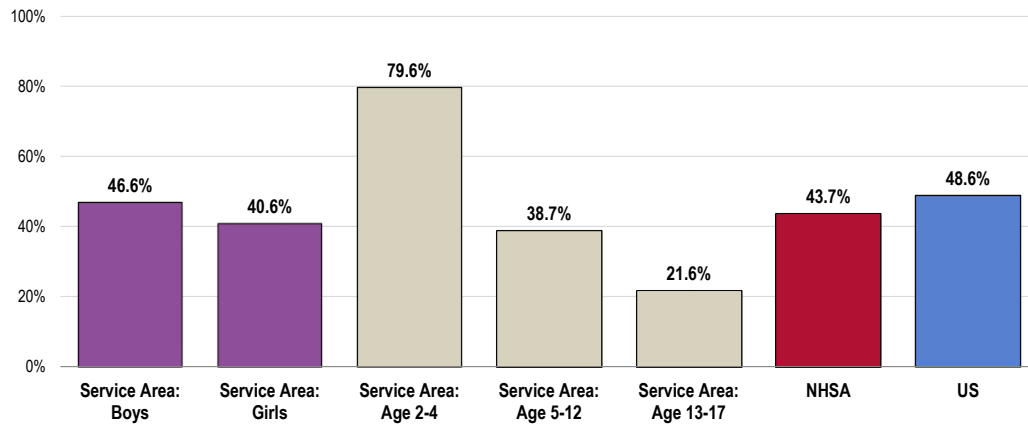


Sources: • US Census Bureau, County Business Patterns: 2012. Additional data analysis by CARES.
 • Retrieved February 2015 from Community Commons at <http://www.chna.org>.
 Notes: • Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940, which include Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities". Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools. This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

Children's Physical Activity

“During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?”

**Child Is Physically Active for One or More Hours per Day
(Among Children Age 2-17)**



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents with children age 2-17 at home.
 • Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Weight Status

About Overweight & Obesity

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

- Healthy People 2020 (www.healthypeople.gov)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m²). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared (inches²)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m² and obesity as a BMI ≥30 kg/m². The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m². The increase in mortality, however, tends to be modest until a BMI of 30 kg/m² is reached. For persons with a BMI ≥30 kg/m², mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m².

- Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Classification of Overweight and Obesity by BMI	BMI (kg/m ²)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight, not Obese	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

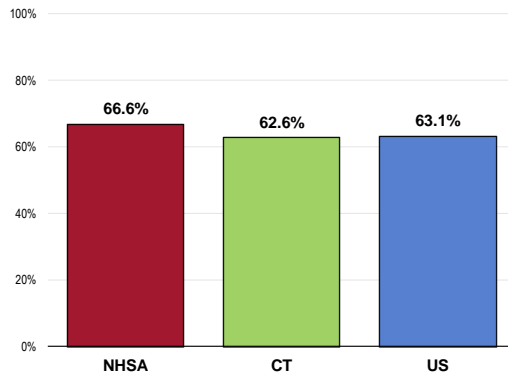
“About how much do you weigh without shoes?”

“About how tall are you without shoes?”

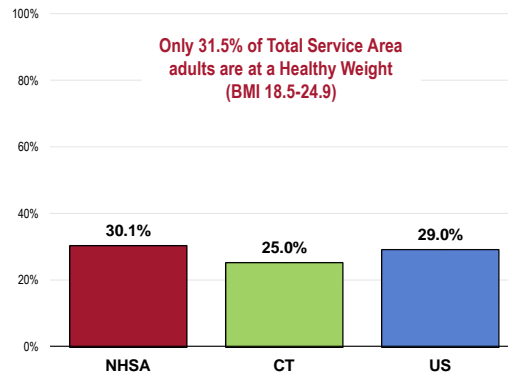
The survey questions above were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

- Note the Healthy People 2020 target for obesity.

Overweight or Obese (Adults With a BMI of 25+)



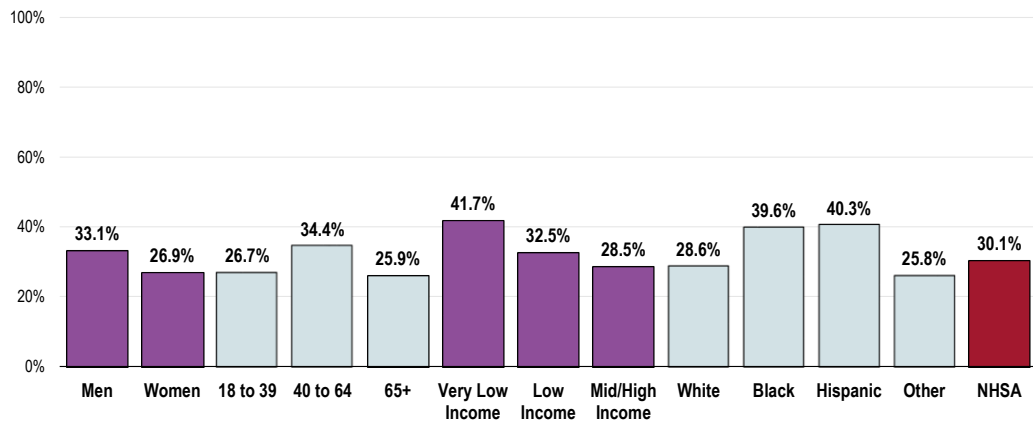
Obese (Adults With a BMI of 30+) Healthy People 2020 Target = 30.5% or Lower



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 151]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2013 Connecticut data.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]

Notes: • Based on reported heights and weights, asked of all respondents.

Prevalence of Obesity (Adults With a BMI of 30.0 or Higher; Natchaug Hospital Service Area, 2015) Healthy People 2020 Target = 30.5% or Lower



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 151]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]

Notes: • Based on reported heights and weights, asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes less than 100% of the federal poverty level; "Low Income" includes households with incomes from 100–199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 • The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Weight Control

About Maintaining a Healthy Weight

Individuals who are at a healthy weight are less likely to:

- Develop chronic disease risk factors, such as high blood pressure and dyslipidemia.
- Develop chronic diseases, such as type 2 diabetes, heart disease, osteoarthritis, and some cancers.
- Experience complications during pregnancy.
- Die at an earlier age.

All Americans should avoid unhealthy weight gain, and those whose weight is too high may also need to lose weight.

- Healthy People 2020 (www.healthypeople.gov)

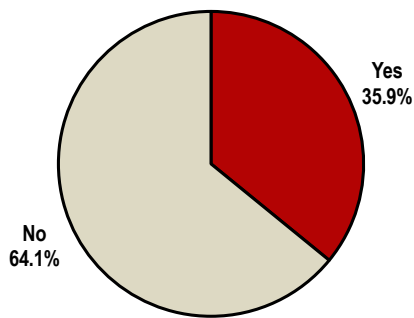
Weight Management. The following three questions were used to calculate the proportion of adults who are overweight or obese and who are using a combination of both diet and exercise in order to try to lose weight.

“Are you now trying to lose weight?”

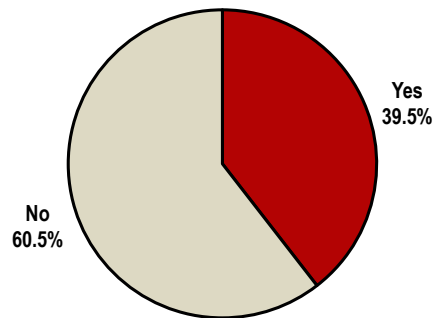
“Are you eating either fewer calories or less fat to lose weight?”

“Are you using physical activity or exercise to lose weight?”

**Trying to Lose Weight by Both
Modifying Diet and Increasing Physical Activity
(Among Overweight or Obese Respondents)**



Natchaug Hospital Service Area



United States

Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Reflects respondents who are overweight or obese based on reported heights and weights.

Childhood Overweight & Obesity

About Weight Status in Children & Teens

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

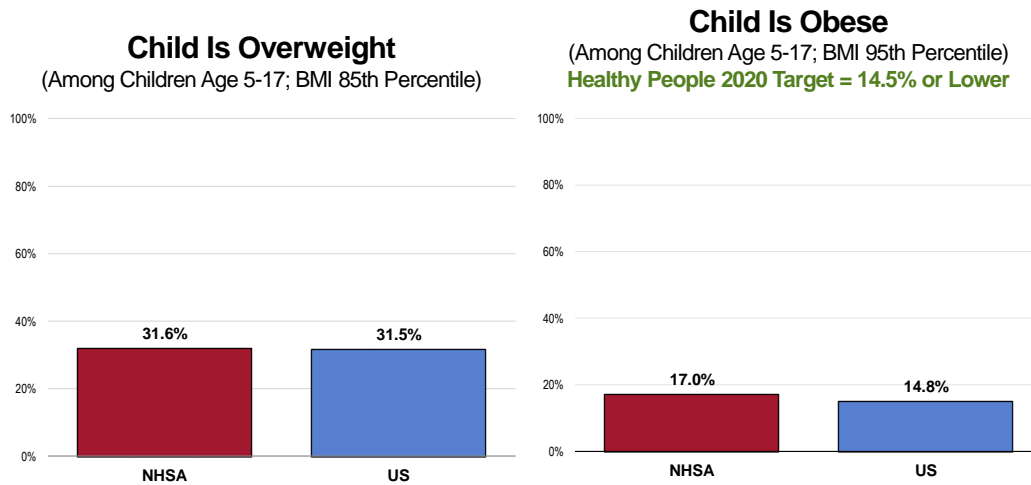
- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

• Centers for Disease Control and Prevention

The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

“How much does this child weigh without shoes?”

“About how tall is this child?”



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 155]

• 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents with children age 5-17 at home.

• Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

• Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Health Advice About Physical Activity & Exercise

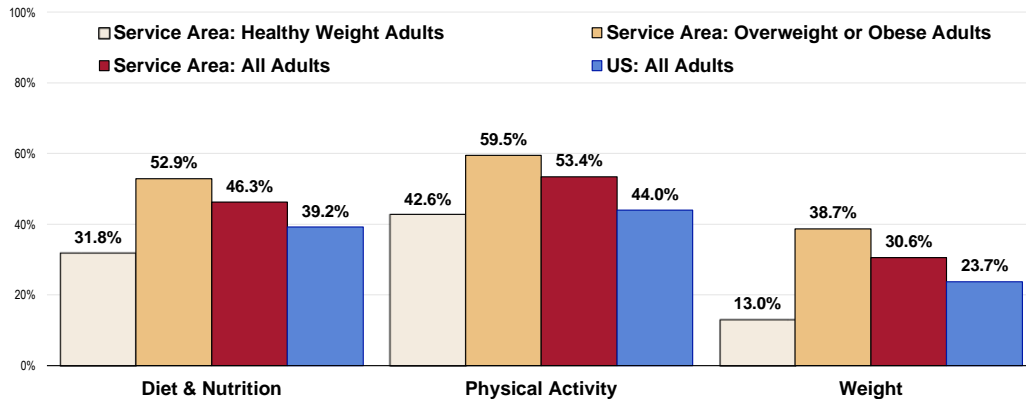
“During the past 12 months, has a doctor asked you about or given you advice regarding diet and nutrition?”

“During the past 12 months, has a doctor asked you about or given you advice regarding physical activity or exercise?”

“In the past 12 months, has a doctor, nurse or other health professional given you advice about your weight?”

The chart below details responses to these questions among the total sample of respondents, as well as responses segmented by weight classification based on calculated BMI.

Have Received Advice About _____ From a Physician, Nurse, or Other Health Professional in the Past Year
(By Weight Classification)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 18, 19, 98]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants’ perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community

(Key Informants, 2015)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

Food Access

Access to quality food and a basic knowledge about preparing nutritious food. – Other Health Provider

Lack of access to high quality, affordable food due to lack of financial resources and lack of quality food retail. Lack of safe physical activity opportunities for community members. Low health/nutrition education. Lack of long-term exclusive breastfeeding. – Social Services Representative

Poverty. Access to healthy affordable foods. Safe places. Low cost physical activity. Time and childcare. Stress. – Social Services Representative

The poor and low class citizens of the community do not have access to and cannot afford the market prices of fresh fruits and vegetables. – Other Health Provider

The majority of our population does not have affordable, appropriate, and reliable access and information about these conditions. Translators and translation services that really work and are appropriate are not in place for our population in need. We see students every day that suffer from conditions related to poor nutrition, lack of physical activity and weight. Often, their work schedules are irregular and at the mercy of casino schedules. This impacts their day-to-day lives on all levels. The information related to nutrition, activity and weight, may be there, but their ability to understand and access it is quite limited. Accessible community health educators that speak their languages are desperately needed. – Social Services Representative

Nutrition is sorely overlooked when attending to patient's chronic needs. Lack of resources available for obese children. Many patients are financially unable to provide balanced meals. – Other Health Provider

Cost of FF and V, cheap fast food. – Other Health Provider

Access to affordable healthy food and places for year round physical activity. Lack of desire/resources. Marketing and availability affordable healthy food. Lack of time and money. – Public Health Expert

High Obesity Rates

Our lifestyles. Take a trip to a mall and observe how many fall into the overweight/obese category. Go to a park and compare the number of people being active to the numbers you see in a mall. Look at what we've taken away from school children, recess, modified PE programs. After-school programs focus on academics, and many communities have "pay to play" sports programs. Marketing dollars spent by soda companies overwhelm any prevention education budgets. – Other Health Provider

Current studies of BMI in elementary school children places approximately 30% of children as obese. – Public Health Expert

Obesity is widespread in many communities, particularly troubling for children. Local markets often do not have fruits, vegetables and healthy meat options. Obesity is often intergenerational and therefore behavior and habits are difficult to change. – Community/Business Leader

High rates of childhood and adult obesity - poor nutritional habits, high rates of childhood poverty contribute to problem, lack of accessible places for community to exercise safely (walking paths, community centers etc.) lack of emphasis on exercise at schools, lack of availability of healthy food choices at restaurants (and lack of nutritional information about food choices at restaurants). – Social Services Representative

The rates of overweight and obesity in our community are high. – Social Services Representative

High obesity and diabetes rates. – Physician

Education

Being able to educate and incorporate healthy lifestyle changes for the entire family. Often families perceive that they don't have the time or resources to eat healthy or remain active. – Social Services Representative

Education on the issues, understanding why people don't put their health care first, usually because of family, work, children issues and time constraints. – Other Health Provider

Education and incentives to get people both aware and active to eat better and lead more active physical lives. – Community/Business Leader

People are really ignorant around healthy eating and living. Too much sitting and eating of fast foods. – Community/Business Leader

Lack of any consistent and connected education. There are programs here and there but education and information for patients on this is very limited. – Physician

Lack of educational opportunities. – Public Health Expert

Health education regarding proper nutrition and exercise is needed. – Community/Business Leader

Affordable Gyms/Exercise Facilities

Lack of low-cost or no-cost facilities for children and adults to exercise. There are a few parks here and there, but with transportation being a barrier, many folks who live a distance from those areas cannot take advantage of those resources. Schools are so pressured to push academics that any opportunity to add physical activity into the curriculum is quickly quashed. School budgets also impact the quality of foods sold in cafeterias and vending machines. I also think that video games contribute to a lot of the obesity, as kids and adults do not get outside to throw a football or have a game of tag. – Public Health Expert

Access to programs for those who do not traditionally belong to organizations that offer nutrition and exercise is a major hurdle. Sometimes it is a barrier of funds, other times it is one of location with poor transportation in the evening or none at all in Meriden and Wallingford. – Community/Business Leader

Food insecurity. Lack of access to free or low cost recreation. Lack of open spaces. Lack of education. Cultural barriers to diet modification and lack of access to primary care. – Public Health Expert

Difficult to access gyms, on limited income. – Social Services Representative

Lifestyles

Lifestyles, change in school day structure which does not put emphasis on physical activity, stress placed on children. Demands of work and pace of today's society has taken a toll on overall health

well-being of individuals and families. – Social Services Representative

Practicing consistently on living a healthier life style. – Other Health Provider

We are a fast food, tied to our desks and couches society. We no longer eat homemade family meals together, nor do we engage in family outdoor time on a regular basis. Schools no longer see the value of recess and PE, therefore those critical pieces of children's' development are eliminated or greatly reduced. – Other Health Provider

The challenges are the same that we see throughout our society. Families are buying and consuming too much junk food, soda etc. All students are not active enough outside of school. Some are very active, but many do not get outside to play. Another big challenge is that this issue is a life style, family education issue and not a school based issue. – Community/Business Leader

Access to Nutritional Services

Access to nutritional services as part of a primary care discussion or nutritional services somehow included. Safe and affordable public spaces for youth to find physical activities available. – Social Services Representative

Nutritional information and access to care and services, particularly for young people. – Community/Business Leader

People in Eastern Connecticut need more nutritional counseling and more physical activity to achieve adequate health. – Social Services Representative

Lack of Support

Not enough accessible support, especially for those who are uninsured or not yet diagnosed with a disease. – Other Health Provider

Our communities are not built to support integration of physical activity into daily life like walking to school, grocery store. Too much reliance on prepared foods. Overweight and obesity are leading risk factors for many of our chronic diseases. – Other Health Provider

Challenges of Rural Life

Rural character presents challenges to access to healthy foods, and opportunities for physical activity. – Public Health Expert

Early Intervention

Early interventions and healthy behaviors should be integrated throughout all aspects of care. Our focus and interventions often exist when disease and complications already exist. Need intense counseling. For those insured, there is limited coverage for these interventions. – Other Health Provider

Fast Food

This is a community of fast food eaters. There are many children who cannot play outside due to lack of supervision or danger. While there are a multitude of opportunities for exercise, often they are not used. – Other Health Provider

Policy

Government puts sales over health. Allowing and not labeling GMO's is an example. Products are allowed to make claims that really stretch the truth. Products have hidden byproducts that conflict with people's health, ex. putting sugar and salt in fast food that make the food addictive. Many people are told to do physical activity, but many are so tired or so large they can't do it. Weight loss is a long term issue. Stop trying to make people do it quickly. Regaining weight is more dangerous than having the weight in the first place. Stop pushing gastro surgery. People can still regain the weight after this procedure. Start studying extremely large people with amazement, that someone can survive at ex. 500 lbs., instead of as being a bad issue. Perhaps we can learn more about the body's ability to adapt or exist. – Community/Business Leader

Junk Food and Poverty

Junk food and poverty. – Community/Business Leader

Marketing and Advertising

Marketing and advertising strategies, availability of junk food and busy schedules of families. – Other Health Provider

Socioeconomic Challenges

Socio-economic challenges and stressed neighborhoods often make it difficult for residents to engage in healthful physical activity or purchase healthful/fresh foods. Information about healthy eating/healthy cooking is not consistently available. – Community/Business Leader

Substance Abuse

About Substance Abuse

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

- Healthy People 2020 (www.healthypeople.gov)

Related Age-Adjusted Mortality

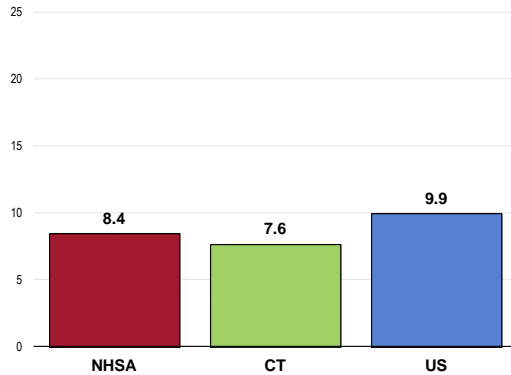
Cirrhosis/Liver Disease. Heavy alcohol use contributes to a significant share of liver disease, including cirrhosis. The chart below outlines age-adjusted mortality for cirrhosis/liver disease in the area.

Drug-Induced Deaths. Drug-induced deaths include all deaths for which drugs are the underlying cause, including those attributable to acute poisoning by drugs (drug overdoses) and deaths from medical conditions resulting from chronic drug use (e.g., drug-induced Cushing's syndrome). A "drug" includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. These deaths may also be either intentional (e.g., suicide) or unintentional (accidental). The chart below outlines local age-adjusted mortality for drug-induced deaths.

- Note the corresponding Healthy People 2020 targets.

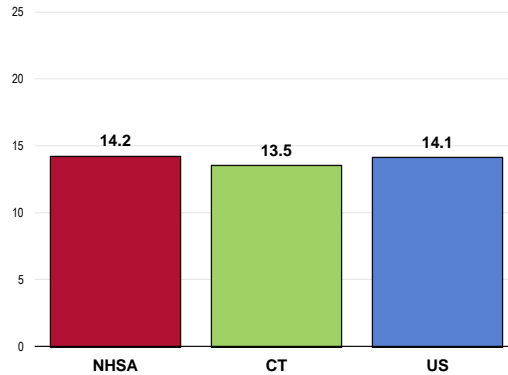
Cirrhosis/Liver Disease: Age-Adjusted Mortality

(2011-2013 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 8.2 or Lower



Drug-Induced Deaths: Age-Adjusted Mortality

(2011-2013 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 11.3 or Lower



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2015.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives SA-11 and SA-12]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
 - Local, state and national data are simple three-year averages.

Alcohol Use

Current Drinkers. “Current drinkers” include survey respondents who had at least one drink of alcohol in the month preceding the interview. For the purposes of this study, a “drink” is considered one can or bottle of beer, one glass of wine, one can or bottle of wine cooler, one cocktail, or one shot of liquor.

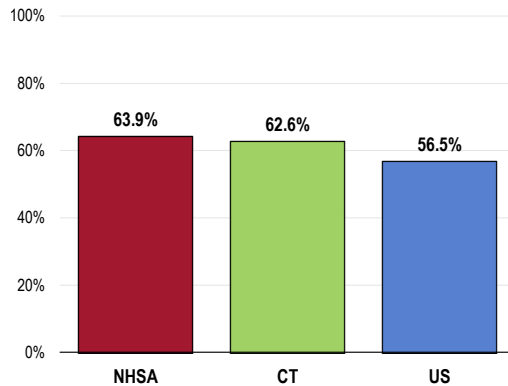
“During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?”

Excessive Drinkers. Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) or who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

“On the day(s) when you drank, about how many drinks did you have on the average?”

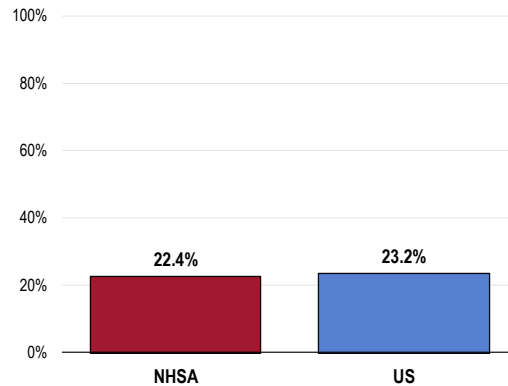
“Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)/4 (if female) or more drinks on an occasion?”

Current Drinkers



Excessive Drinkers

Healthy People 2020 Target = 25.4% or Lower

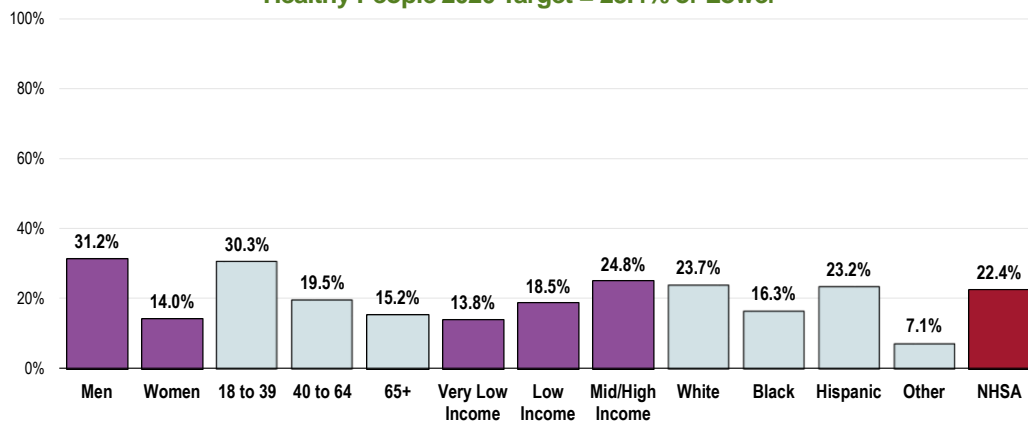


Sources: • PRC Community Health Surveys, Professional Research Consultants, Inc. [Items 160, 164]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2013 Connecticut data.
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Current drinkers had at least one alcoholic drink in the past month.
 • Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Excessive Drinkers

(Total Area, 2015)

Healthy People 2020 Target = 25.4% or Lower

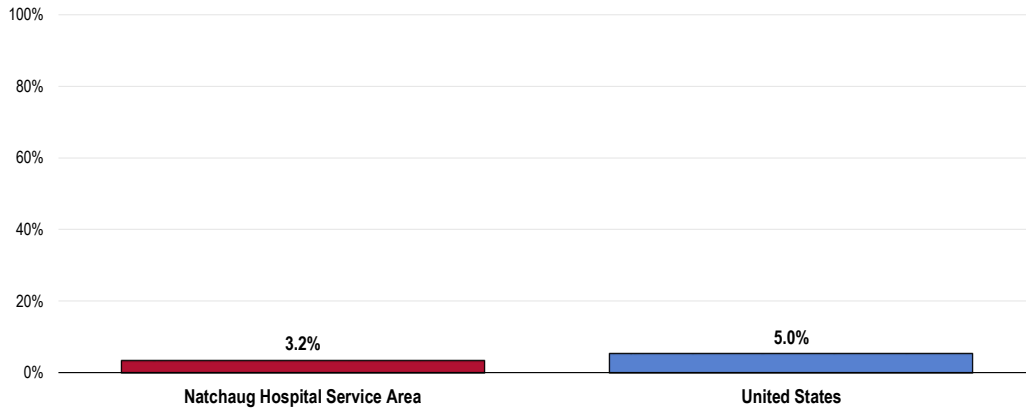


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 164]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-15]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes less than 100% of the federal poverty level; "Low Income" includes households with incomes from 100–199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 • Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drinking & Driving. As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that the actual incidence of drinking and driving in the community is likely higher.

“During the past 30 days, how many times have you driven when you’ve had perhaps too much to drink?”

Have Driven in the Past Month After Perhaps Having Too Much to Drink

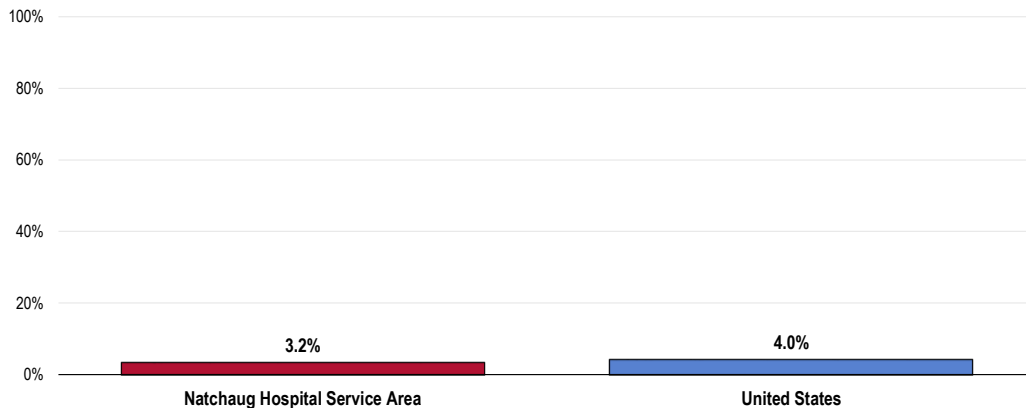


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 65]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Illicit Drug Use

“During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?”

Illicit Drug Use in the Past Month Healthy People 2020 Target = 7.1% or Lower

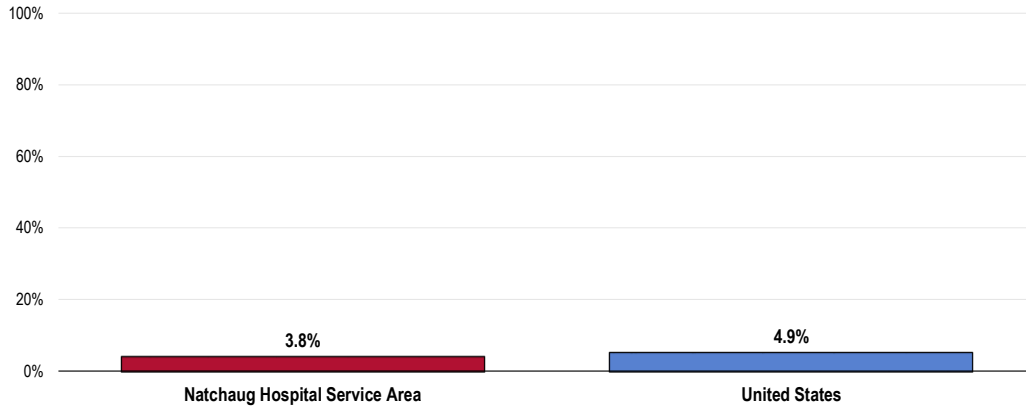


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 66]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-13.3]
 Notes: • Asked of all respondents.

Alcohol & Drug Treatment

“Have you ever sought professional help for an alcohol or drug-related problem?”

Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 67]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

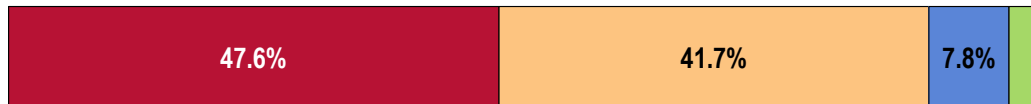
Key Informant Input: Substance Abuse

The following chart outlines key informants’ perceptions of the severity of *Substance Abuse* as a problem in the community:

Perceptions of Substance Abuse as a Problem in the Community

(Key Informants, 2015)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Barriers to Treatment

Among those rating this issue as a “major problem,” the greatest barriers to accessing substance abuse treatment are viewed as:

Motivation

Personal desire/recognition there is a problem. – Community/Business Leader

People need to want treatment, and that treatment needs to be available at exactly the time they seek it out. Therefore jumping through insurance hurdles and finding a provider with open spots can make that difficult, if not impossible. Substance abusers have often burned so many bridges that no one is there to help them navigate the system. There are so many stigmas attached to this disease, the most prevalent of which is the feeling that it's their own fault/weakness. – Other Health Provider

Silent epidemic in the young and old. – Public Health Expert

A lack of desire and the difficulty of finding a bed. – Other Health Provider

Lack of readiness to give up the habit, the lack of emotional and social support from family and or friends and for some people, the substance abuse environment is all they are accustomed to. – Other Health Provider

People need to know and want the help. Again, this usually is a longer term treatment. – Community/Business Leader

Access to Programs

Inability to access mental health resources. Contact with the criminal justice system before having the opportunity to receive help for mental illness. Stigma. – Public Health Expert

Lack of culturally relevant and language-appropriate services, social determinants of health/stress. – Social Services Representative

Lack of adequate and timely intake for services. Lack of integration with primary care and mental health services. Stigma and denial by general public and some elected officials. Lack of a system of coordinated care including detox, inpatient and intensive outpatient services. Lack of readily available overdose medications, i.e. Narcan/Naloxone. Lack of consistent and informed education on the effects of drugs and alcohol in the education system. – Other Health Provider

Lack of specific programs for lesbian, gay, bisexual, transgender individuals. – Social Services Representative

Access to programs. Ignoring it. Letting it stay below the radar. Inadequate enforcement. – Community/Business Leader

Access to detox and inpatient care. – Social Services Representative

Transportation, cost, lack of knowledge regarding available resources, denial. – Public Health Expert

Health insurance, not knowing where to go, not enough in-patient resources. – Community/Business Leader

Lack of Providers & Resources

There are limited resources available. – Other Health Provider

Insufficient treatment options. – Community/Business Leader

Lack of resources and follow up support. – Community/Business Leader

Not enough providers. – Physician

We simply do not have enough providers who deal with this issue or a local site where services can be accessed easily. In addition, there is community wide denial that a problem exists. – Community/Business Leader

There is a high prevalence of substance use in the Hartford community. Many struggle to find holistic treatment that address the underlying struggles often faced by those with addiction. –

Community/Business Leader

Not enough treatment beds. – Social Services Representative

Treatment resources for youth ages 13 and older. Also a gap in mid-level treatment. – Other Health Provider

Waiting lists, not ready for treatment, etc. – Social Services Representative

Prevalence

Perception of problem with alcohol. Lack of integrated medical and SA services. – Other Health Provider

High instance of substance abuse. – Other Health Provider

Increase in disclosures of substance use and abuse. – Social Services Representative

High percentage of arrests for substance abuse. – Community/Business Leader

Stigma

There is both a stigmatism and also a limited availability. Open slots for this care and treatment, especially inpatient and extended patient care. – Physician

Stigma, time, limited social supports, inconsistent messages from provider teams. – Other Health Provider

Stigma, Cost, waiting lists, lack of availability of both inpatient and outpatient care, including care that people can access while still maintaining employment. – Social Services Representative

Stigma, lack of providers. – Public Health Expert

Denial

They don't want them until it is too late; ignorance and their addiction make them blind to their problem. – Community/Business Leader

Denial, stigma. – Other Health Provider

Admitting individual has the problem. Cannot think clearly to identify what life would be like without the addiction. Low self-esteem. Fear of walking into facility and who will see them. – Social Services Representative

Awareness and Education

Awareness and education. Need more outreach to get to the people in need. – Community/Business Leader

Some degree of community acceptance of abuse. – Social Services Representative

Fear of Arrest

Fear of arrest, lack of options, cost and unwillingness. – Social Services Representative

Most Problematic Substances

Key informants (who rated this as a “major problem”) were further asked to identify what they view as the most problematic substances abused in the community.

	Most Problematic	Second-Most Problematic	Third-Most Problematic	Total Mentions
Alcohol	65.9%	10.0%	13.2%	36
Heroin or Other Opioids	19.5%	35.0%	28.9%	33
Cocaine or Crack	4.9%	17.5%	18.4%	16
Prescription Medications	2.4%	15.0%	13.2%	12
Marijuana	2.4%	7.5%	13.2%	9
Over-The-Counter Medications	2.4%	5.0%	5.3%	5
Club Drugs (e.g. MDMA, GHB, Ecstasy, Molly)	0.0%	5.0%	2.6%	3
Methamphetamines or Other Amphetamines	0.0%	5.0%	2.6%	3
Inhalants	0.0%	0.0%	2.6%	1
Hallucinogens or Dissociative Drugs (e.g. Ketamine, PCP, LSD, DXM)	2.4%	0.0%	0.0%	1

Tobacco Use

About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

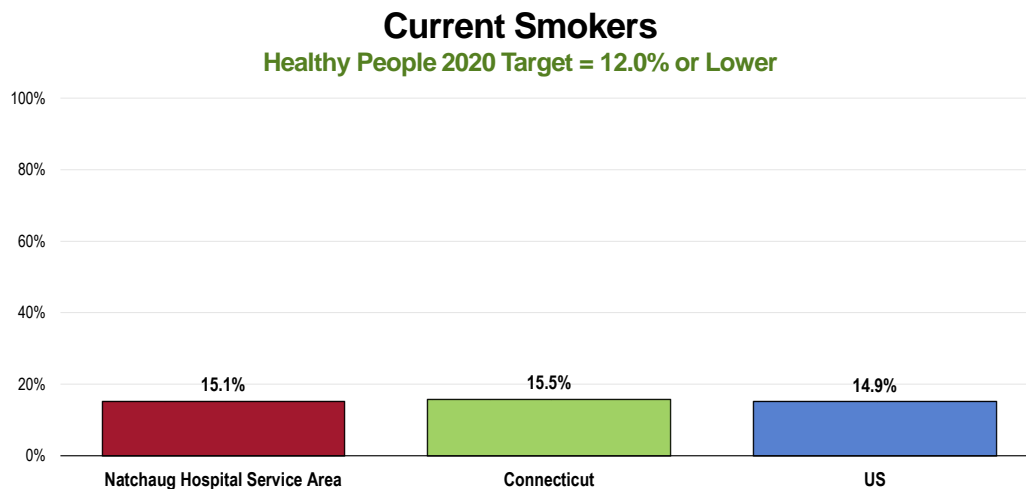
Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

- Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

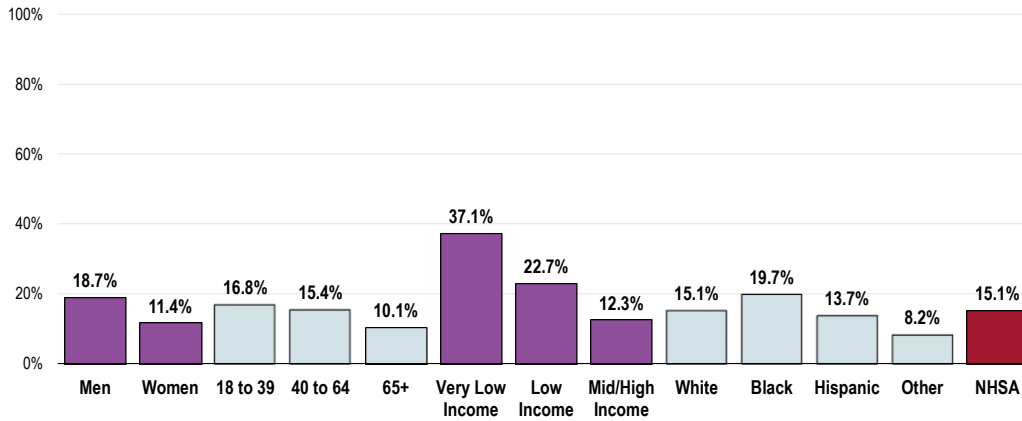
“Do you now smoke cigarettes every day, some days, or not at all?”

- Note the Healthy People 2020 target.



- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 156]
 - 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Connecticut data.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]
- Notes:
- Asked of all respondents.
 - Includes regular and occasional smokers (those who smoke cigarettes everyday or on some days).

Current Smokers
 (Natchaug Hospital Service Area, 2015)
 Healthy People 2020 Target = 12.0% or Lower



- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 156]
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]
- Notes:
- Asked of all respondents.
 - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes less than 100% of the federal poverty level; "Low Income" includes households with incomes from 100–199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 - Includes regular and occasion smokers (everyday and some days).

Smoking Cessation

About Reducing Tobacco Use

Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for Americans of all ages. People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting tobacco use is beneficial at any age.

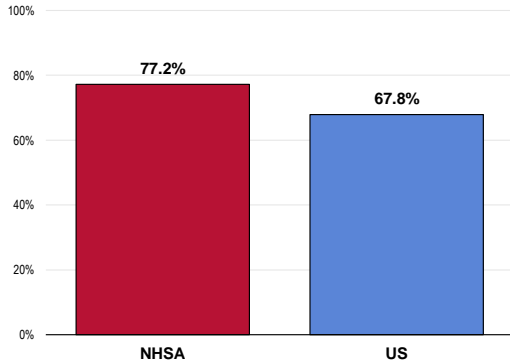
Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

- Healthy People 2020 (www.healthypeople.gov)

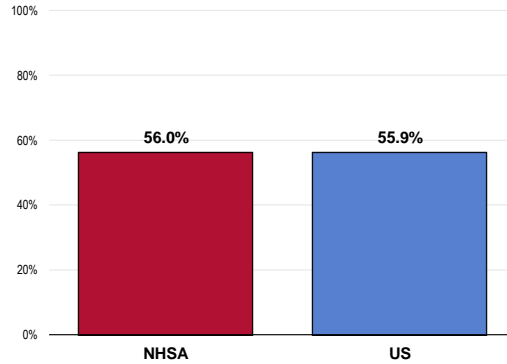
“In the past 12 months, has a doctor, nurse or other health professional advised you to quit smoking?”
 (Asked of respondents who smoke every day or on some days.)

“During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?” (Asked of respondents who smoke every day.)

Advised to Quit Smoking by a Healthcare Professional in Past Year
(Among Current Smokers)



Stopped Smoking for 1+ Days in Past Year in an Attempt to Quit
(Among Everyday Smokers)
Healthy People 2020 Target = 80% or Higher



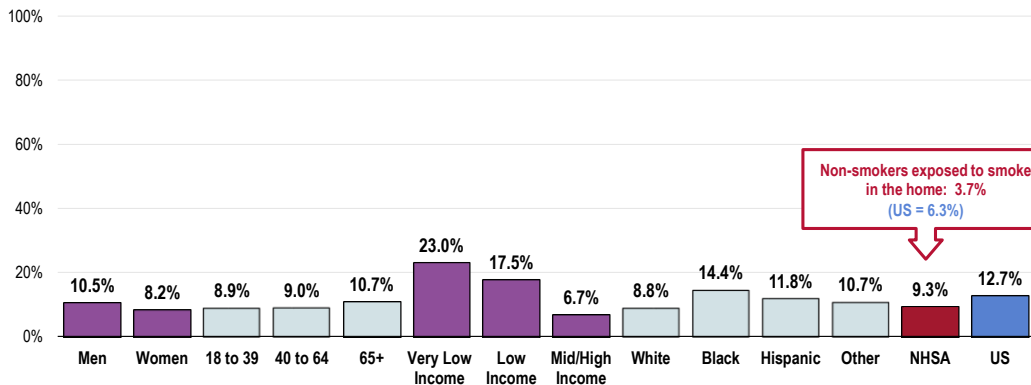
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 57, 58]
• 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Secondhand Smoke

“In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars or pipes anywhere in your home on an average of four or more days per week?”

The following chart details these responses among the total sample of respondents, as well as among only non-smokers and only households with children age 0-17.

Member of Household Smokes At Home
(Natchaug Hospital Service Area, 2015)

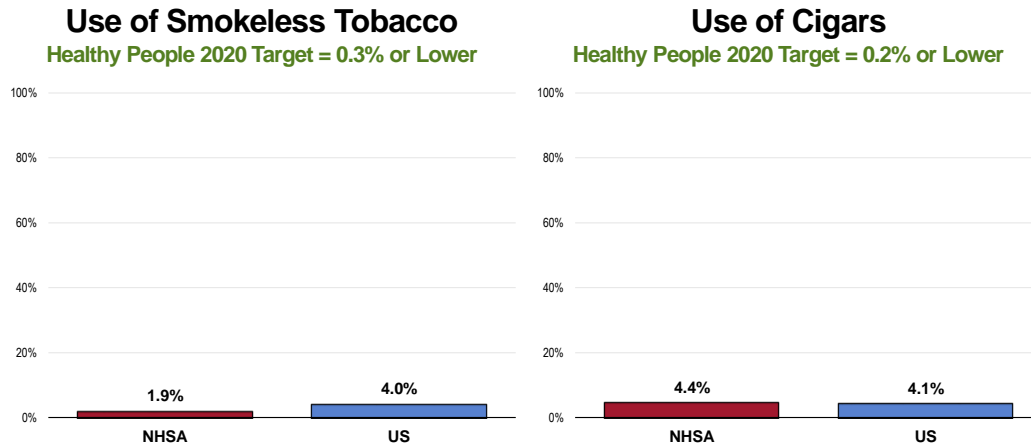


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 59, 158]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
• Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes less than 100% of the federal poverty level; “Low Income” includes households with incomes from 100–199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
• “Smokes at home” refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Other Tobacco Use

“Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all?”

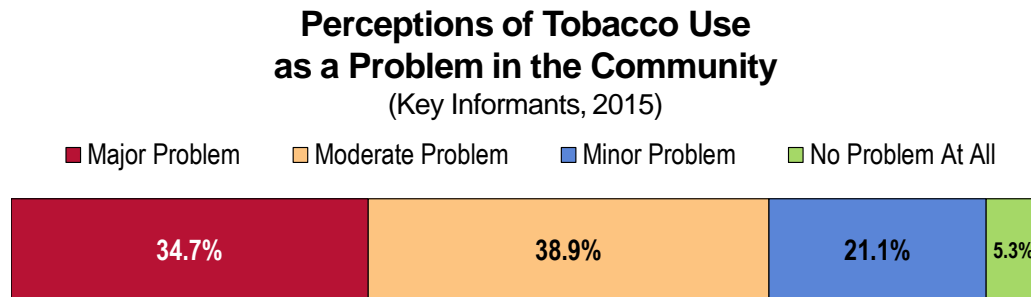
“Do you now smoke cigars every day, some days, or not at all?”



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 60, 61]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives TU-1.2 and TU-1.3]
 Notes: • Asked of all respondents.

Key Informant Input: Tobacco Use

The following chart outlines key informants’ perceptions of the severity of *Tobacco Use* as a problem in the community:



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

Prevalence

Percentage of smokers seems especially high. Not only a health problem, an economic problem among an impoverished population. – Community/Business Leader

Tobacco use is a major problem everywhere and until people stop smoking it will continue. – Other Health Provider

Despite the rising cost of cigarettes, as well as recent policy, legislative changes, individuals

continue with their addiction. There are some who will most likely never quit because they truly enjoy smoking or they just cannot seem to beat their addiction despite multiple attempts. – Public Health Expert

Too high of rates. – Other Health Provider

Perceived high use rate. – Other Health Provider

Total use rates. – Public Health Expert

High incidence of tobacco use has been documented; related disease use - high rates of cancer, heart disease, asthma and COPD. There is insufficient attention to this problem and smoking continues to be a concern not only in this community but in the State and Country and more creative programming needs to be developed to address it. – Social Services Representative

Among some of the towns in which there is a high use of tobacco products in our area are: Jewett City, Griswold, Baltic, New London. – Social Services Representative

Youth

Too many people still smoking, especially the younger people. – Community/Business Leader

Too many young people smoking. – Community/Business Leader

Smoking continues to pose a significant health risk to our students. – Community/Business Leader

Young smokers. – Other Health Provider

It is disheartening to see kids streaming out of NFA, lighting up when they walk down the sidewalk. Smoking is certainly declining, but when parents smoke, kids usually do, too. Smoking is also more prevalent in some of the immigrant communities in our region. It is a very hard habit to quit. – Other Health Provider

Addiction

Addiction. – Other Health Provider

Minorities

Tobacco use among Latinos and Blacks in CT is higher than among whites and higher than the state's average. Tobacco use is a major factor in development of chronic diseases. – Social Services Representative

Tobacco use has been a part of the lesbian, gay, bisexual culture for decades. Step outside a gay bar to find many smokers. – Social Services Representative

Tobacco use is widespread in some communities particularly amongst individuals with current or prior substance abuse challenges. Tobacco has become very expensive, yet many with limited income still smoke. – Community/Business Leader

High usage among mentally ill and poor. – Social Services Representative

Cigarettes are the poor man's treatment for mental illness. Lack of education. Food insecurity, cigarettes help hunger pangs. – Public Health Expert

High smoking in lower adults. – Physician

Lack of Education

Life styles, enough education on ramifications and relationship health disease. Life style choice. – Social Services Representative

Cessation Programs

There are very few smoking cessation programs that are paid for by Husky or commercial insurers and group programs are almost never covered under insurance but often the most effective. – Physician

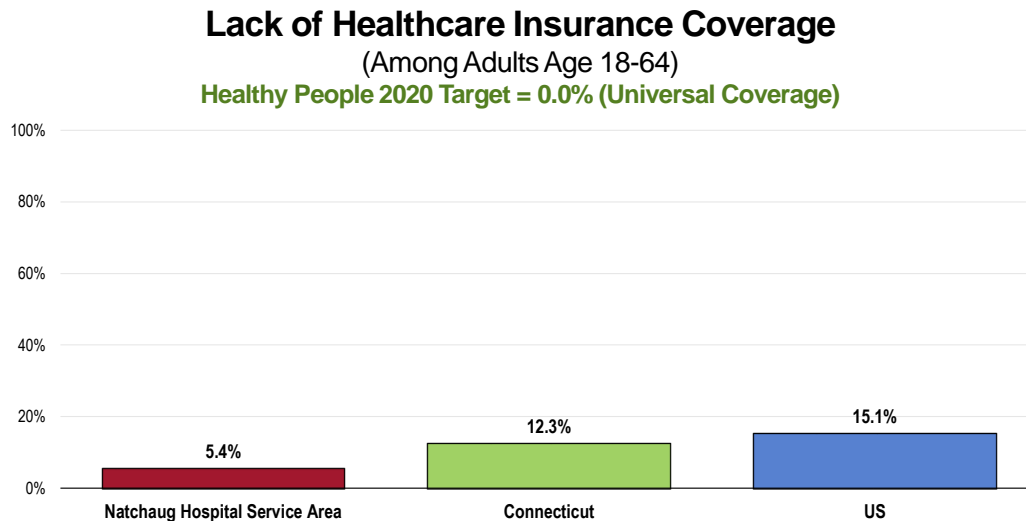
Access to Health Services

Lack of Health Insurance Coverage (Age 18 to 64)

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources. Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

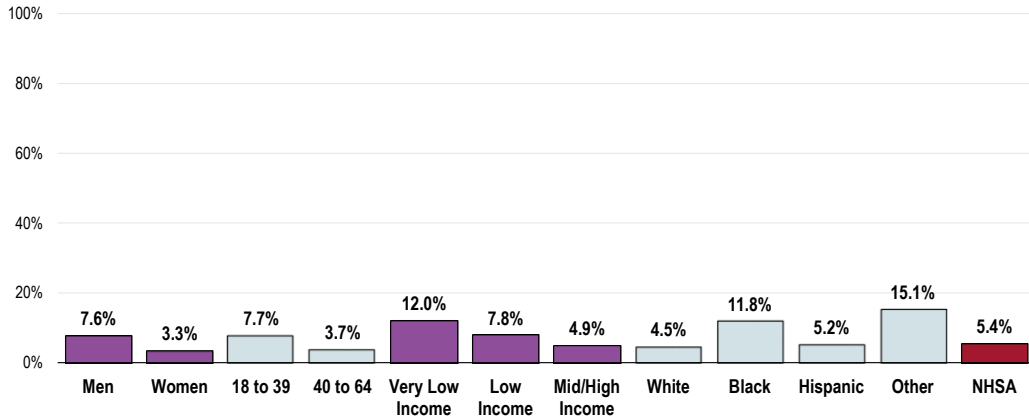
“Do you have any government-assisted healthcare coverage, such as Medicare, Medicaid (or another state-sponsored program), or VA/military benefits?”

“Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself; or, you do not have health insurance and pay for health care entirely on your own?”



- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 165]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Connecticut data.
 - 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1]
- Notes:
- Asked of all respondents under the age of 65.

Lack of Healthcare Insurance Coverage (Among Adults Age 18-64; Natchaug Hospital Service Area, 2015) Healthy People 2020 Target = 0.0% (Universal Coverage)



Sources:

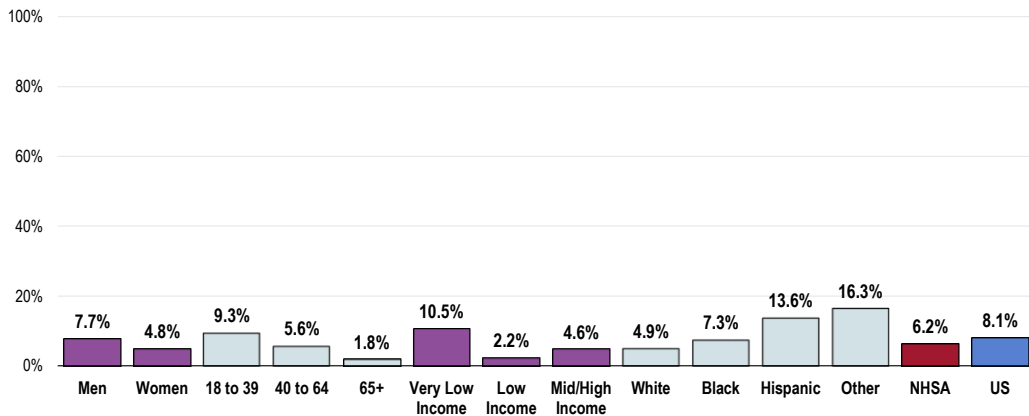
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 165]
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1]

Notes:

- Asked of all respondents under the age of 65.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes less than 100% of the federal poverty level; "Low Income" includes households with incomes from 100–199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Among insured respondents only: ***“During the past 12 months, did you have health insurance coverage ALL of the time, or was there a time in the year when you did NOT have any health coverage?”***

Went Without Healthcare Insurance Coverage At Some Point in the Past Year (Among Insured Adults; Natchaug Hospital Service Area, 2015)



Sources:

- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 79]

Notes:

- Asked of all insured respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes less than 100% of the federal poverty level; "Low Income" includes households with incomes from 100–199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Difficulties Accessing Healthcare

About Access to Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

- Healthy People 2020 (www.healthypeople.gov)

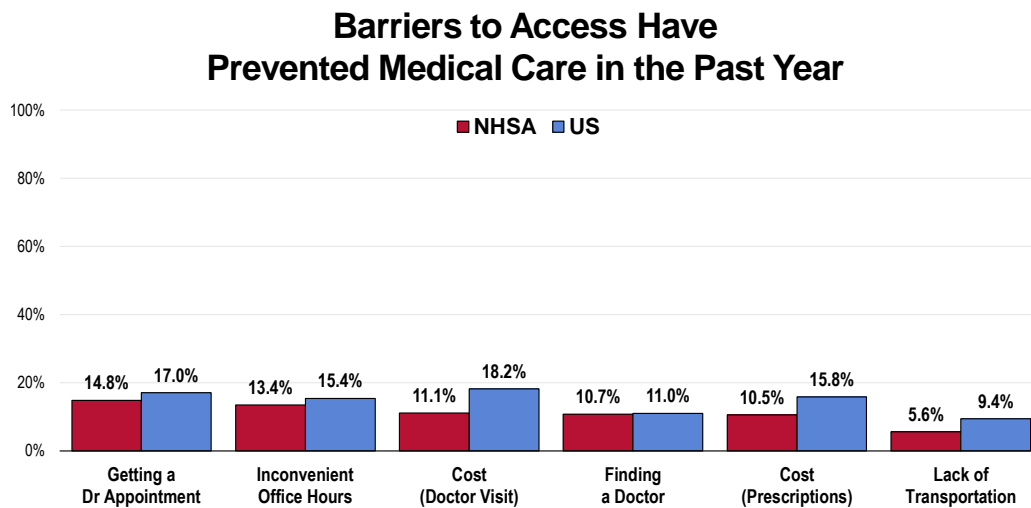
Barriers to Healthcare Access

To better understand healthcare access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

“Was there a time in the past 12 months when...

- ... you needed medical care, but had **difficulty finding a doctor?**”
- ... you had **difficulty getting an appointment to see a doctor?**”
- ... you needed to see a **doctor, but could not because of the cost?**”
- ... a **lack of transportation** made it difficult or prevented you from seeing a doctor or making a medical appointment?”
- ... you were not able to see a doctor because the **office hours were not convenient?**”
- ... you needed a **prescription medicine, but did not get it because you could not afford it?**”

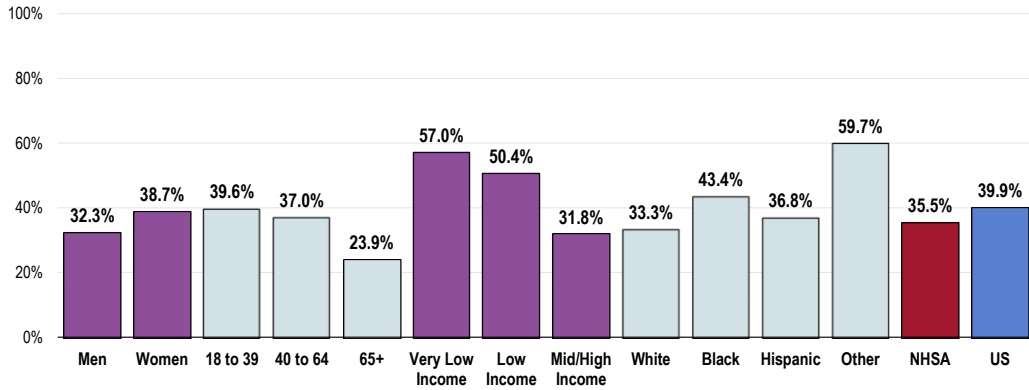
The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.



- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-12]
 - 2013 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.

The following chart reflects the composite percentage of the total population experiencing problems accessing healthcare in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year (Natchaug Hospital Service Area, 2015)

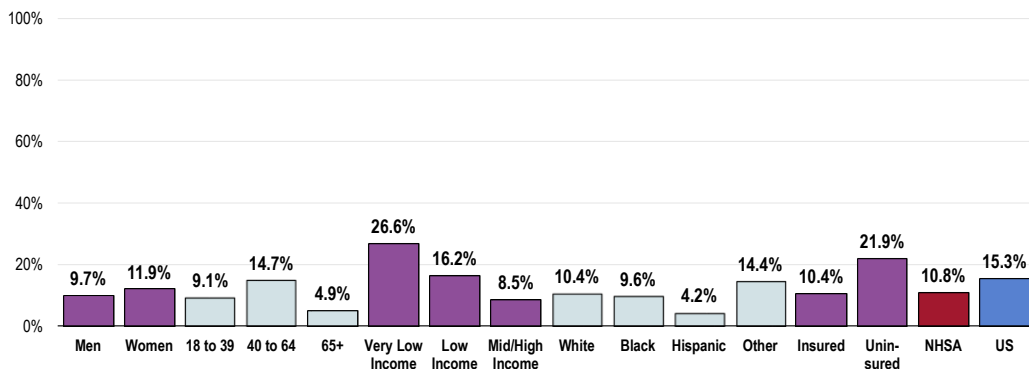


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 169]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes less than 100% of the federal poverty level; "Low Income" includes households with incomes from 100–199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Prescriptions

“Was there a time in the past 12 months when you skipped doses or took smaller doses in order to make your prescriptions last longer and save costs?”

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money (Natchaug Hospital Service Area, 2015)



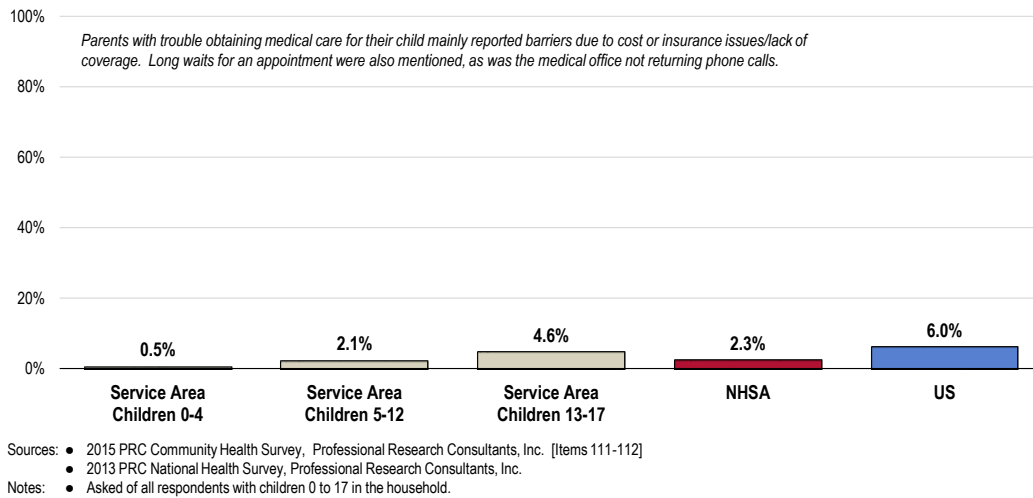
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 13]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes less than 100% of the federal poverty level; "Low Income" includes households with incomes from 100–199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Accessing Healthcare for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

“Was there a time in the past 12 months when you needed medical care for this child, but could not get it?”

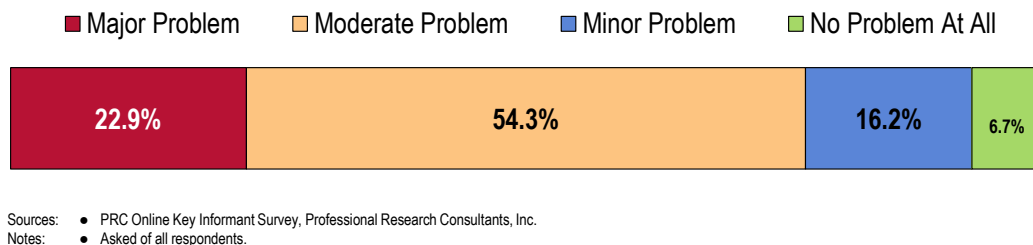
Had Trouble Obtaining Medical Care for Child in the Past Year (Among Parents of Children 0-17)



Key Informant Input: Access to Healthcare Services

The following chart outlines key informants’ perceptions of the severity of *Access to Healthcare Services* as a problem in the community:

Perceptions of Access to Healthcare Services as a Problem in the Community (Key Informants, 2015)



Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

Cost of Services

More and more we have people in this community who have been cut to Part time or have been laid off and can't afford healthcare. Even those who have healthcare have to pay an additional copay. If you pay \$20 or \$25 each doctor visit that can be a lot of money in a week or month. Then you have to pay for medications they prescribe in order to treat the ailment in question. More money. It is out of control. – Community/Business Leader

Because of consolidation and because of the high expense associated with medical practice in Connecticut, there are simply some services that are limited due to the limited number of physicians in clinical practice. Further, while the focus has been on increasing health insurance coverage, the state of Connecticut has done very little to focus on the access issue or further supporting the care delivery infrastructure necessary as more and more consumers have coverage, causing coverage to be confused with access. – Physician

Cost and the shortage of primary care physicians. – Other Health Provider

There are several challenges related to accessing health care service including affordability. Sometime the basic health care package doesn't cover all the services. Need education. Sometimes the community are not aware of services that are being provided. Accessibility. Service provided in the community are not at the standard care and to get that quality of service may take a person to travel beyond the community to get that care. – Social Services Representative

Lack of Insurance

For some it is lack of health insurance. For others it is arbitrary limitations placed on coverage by insurance companies. – Community/Business Leader

There are a number of individuals that do not have health insurance. Also many residents don't attend regular preventive care appointments and many large community health centers are not accepting new patients for routine care. Transportation is a barrier as well as changing the way people think of about health. – Community/Business Leader

Lack of insurance, lack of transportation, lack of knowledge of the services available wait lists. – Public Health Expert

The affordability of health insurance. – Social Services Representative

Insurance and not enough doctors available. – Social Services Representative

Subspecialty Care

Inadequate access to subspecialty care. – Physician

Accessing primary health care, behavioral health and patient navigation within the same facility. – Other Health Provider

Awareness of Services

Lack of knowledge about services. Lack of coordination of care or rather, inability to access coordinated care. – Public Health Expert

Generally speaking, those in the lower social strata and with poor education and life skills do not properly use or have access to primary medical care. They continue to use the hospital ED as their "doctor". Education of the lower social/life skills population need better outreach and redirection from Emergency Department to outpatient facilities. – Community/Business Leader

Stigma

Stigma around and discrimination towards lesbian, gay, bisexual and transgender individuals and

people living with HIV/AIDS. Lack of understanding and education on the part of health care providers. In some cases, barriers related to health insurance coverage, particularly for transgender individuals. – Social Services Representative

Stigma, lack of resources, lack of education. – Other Health Provider

Transportation Problems

Transportation and compliance. – Social Services Representative

For some, the ability to have adequate transportation is one major factor. In addition, since I work with primarily mono lingual clients, it is difficult when there are no adequate personnel trained to serve as medical interpreters for these clients at medical office, FQHC's, etc. In the Hartford area, to my knowledge there is only one FQHC on the North end of Hartford, to some clients living in other areas, it is difficult to get there and more over, whether they will have someone to provide understandable translation services. – Social Services Representative

Lack of Continuity of Care

Connection to a medical home to ensure continuity of care, attention to prevention, and adherence to care plans should there be a chronic condition. Also, adequate "intermediate" outpatient care for clients with very complex behavioral and/or substance abuse issues who could stay in the community with the proper intensive outpatient care. Finally, pain management and addiction to pain meds, leading to abuse of illegal drugs, continues to plague our region. – Other Health Provider

Providers

Insufficient number of practitioners and lack of access to transportation. – Public Health Expert

Undocumented Population

Residents without legal status have very limited access to healthcare. It is particularly challenging when they suffer from a serious disease that requires an expensive and long term treatment. – Social Services Representative

Type of Care Most Difficult to Access

Key informants (who rated this as a “major problem”) were further asked to identify they type of care they perceive as the most difficult to access in the community.

	Most Difficult to Access	Second-Most Difficult to Access	Third-Most Difficult to Access	Total Mentions
Mental Health Care	28.6%	42.9%	9.5%	17
Primary Care	23.8%	14.3%	0.0%	8
Dental Care	14.3%	4.8%	33.3%	11
Specialty Care	14.3%	9.5%	28.6%	11
Substance Abuse Treatment	9.5%	14.3%	9.5%	7
Chronic Disease Care	9.5%	4.8%	4.8%	4
All Services	0.0%	0.0%	4.8%	1
Elder Care	0.0%	4.8%	9.5%	3
Pain Management	0.0%	4.8%	0.0%	1

Primary Care Services

About Primary Care

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

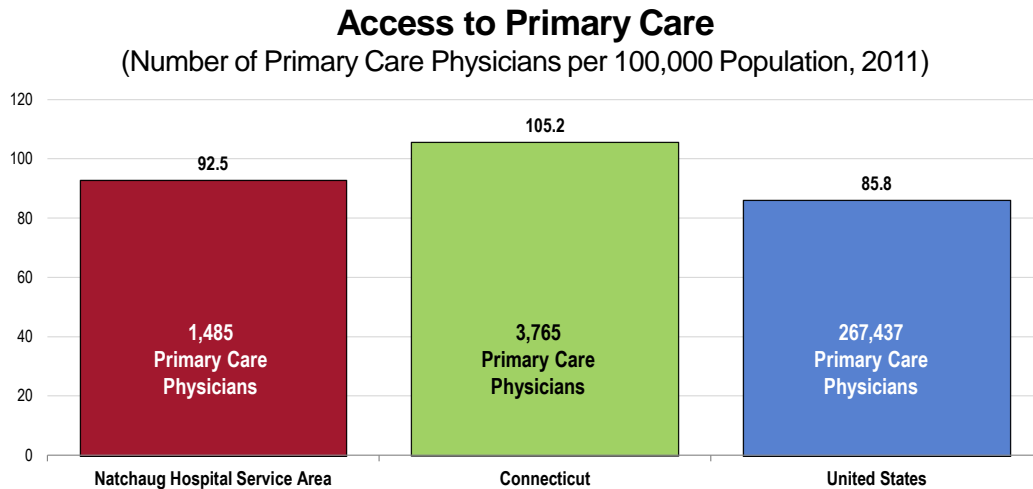
- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

- Healthy People 2020 (www.healthypeople.gov)

Access to Primary Care

This indicator is relevant because a shortage of health professionals contributes to access and health status issues.



- Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File: 2011.
 - Retrieved February 2015 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Specific Source of Ongoing Care

Having a specific source of ongoing care includes having a doctor’s office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of “patient-centered medical homes” (PCMH).

“Is there a particular place that you usually go to if you are sick or need advice about your health?”

“What kind of place is it: a medical clinic, an urgent care center/walk-in clinic, a doctor’s office, a hospital emergency room, military or other VA healthcare, or some other place?”

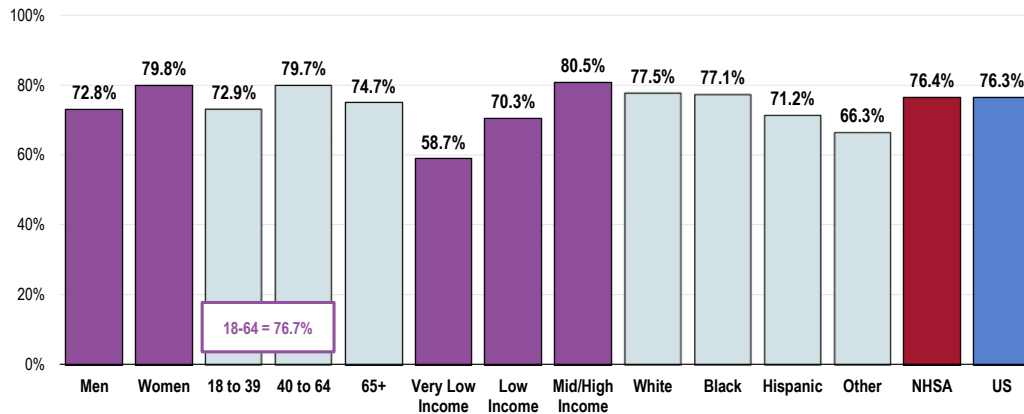
The following chart illustrates the proportion of the Natchaug Hospital Service Area population with a specific source of ongoing medical care. Note that a hospital emergency room is not considered a specific source of ongoing care in this instance.

- Note the Healthy People 2020 objectives.

Have a Specific Source of Ongoing Medical Care

(Natchaug Hospital Service Area, 2015)

Healthy People 2020 Target = 95.0% or Higher [All Ages]; ≥89.4% [18-64]; 100% [65+]



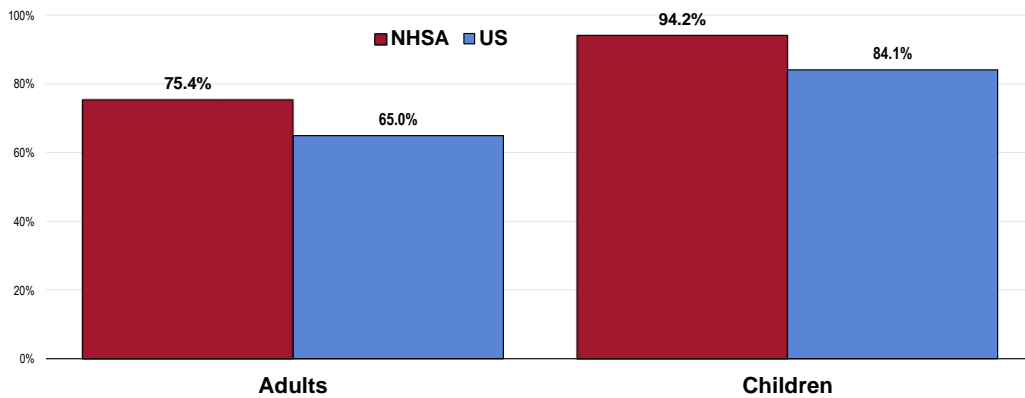
- Sources:
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 166-168]
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives AHS-5.1, 5.3, 5.4]
- Notes:
- Asked of all respondents.
 - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 - Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes less than 100% of the federal poverty level; “Low Income” includes households with incomes from 100–199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Utilization of Primary Care Services

Adults: “A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition. About how long has it been since you last visited a doctor for a routine checkup?”

Children: “About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?”

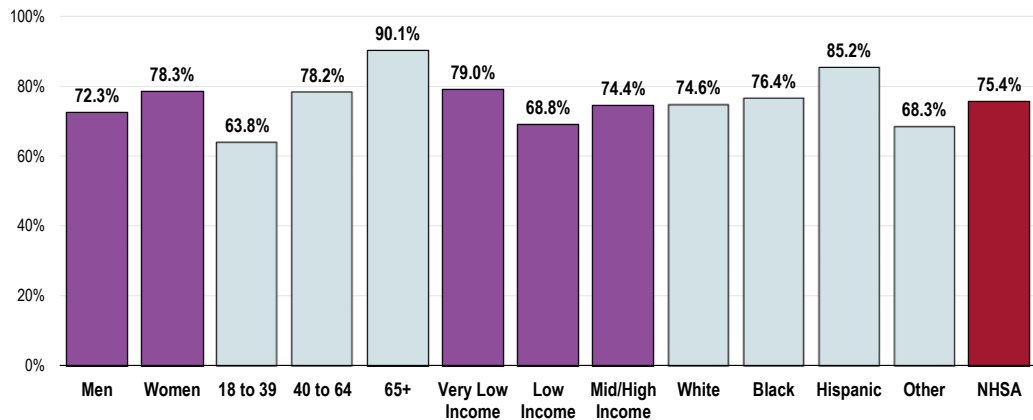
Have Visited a Physician for a Routine Checkup in the Past Year



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 17, 113]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

Adults: Have Visited a Physician for a Checkup in the Past Year (Natchaug Hospital Service Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 17]

Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes less than 100% of the federal poverty level; “Low Income” includes households with incomes from 100–199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

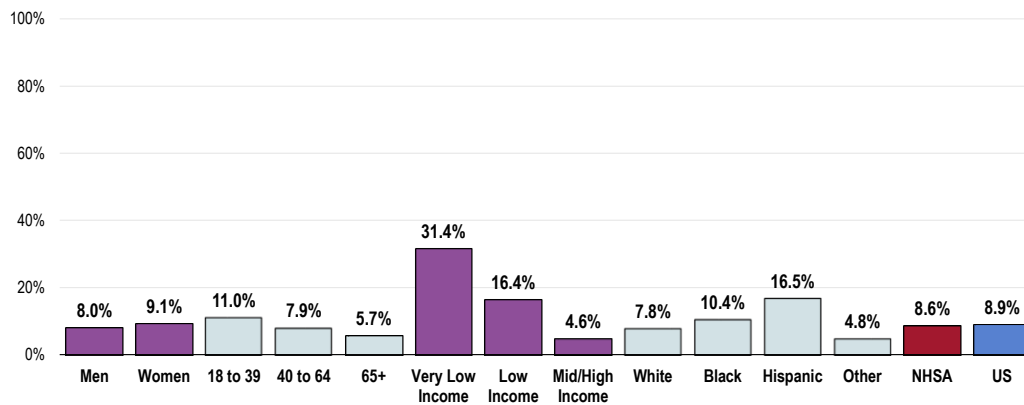
Emergency Room Utilization

“In the past 12 months, how many times have you gone to a hospital emergency room about your own health? This includes ER visits that resulted in a hospital admission.” (Responses below reflect the percentage with two or more visits in the past year.)

“What is the main reason you used the emergency room instead of going to a doctor’s office or clinic?”

Have Used a Hospital Emergency Room More Than Once in the Past Year

(Natchaug Hospital Service Area, 2015)



- Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 23]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes less than 100% of the federal poverty level; “Low Income” includes households with incomes from 100–199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Oral Health

About Oral Health

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: **tobacco use**; **excessive alcohol use**; and **poor dietary choices**.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

- Healthy People 2020 (www.healthypeople.gov)

Dental Care

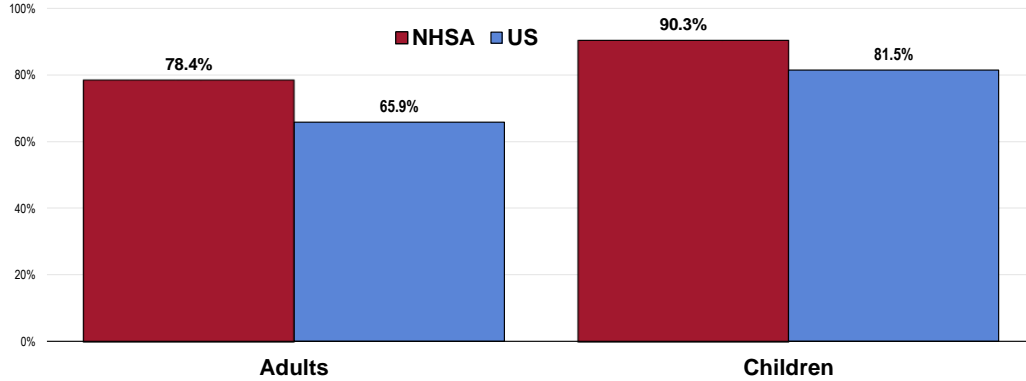
Adults: *“About how long has it been since you last visited a dentist or a dental clinic for any reason?”*

Children Age 2-17: *“About how long has it been since this child visited a dentist or dental clinic?”*

- Note the Healthy People 2020 target.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2020 Target = 49% or Higher (Adults & Children)

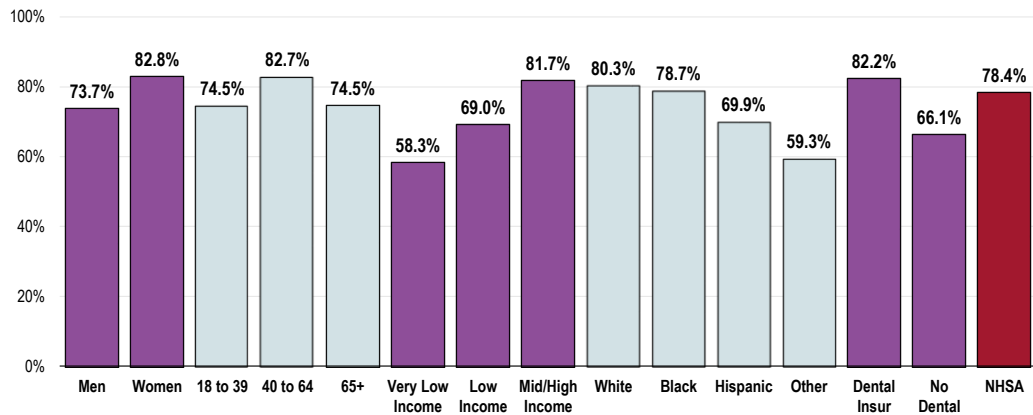


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 21, 116]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]

Have Visited a Dentist or Dental Clinic Within the Past Year

(Natchaug Hospital Service Area, 2015)

Healthy People 2020 Target = 49.0% or Higher



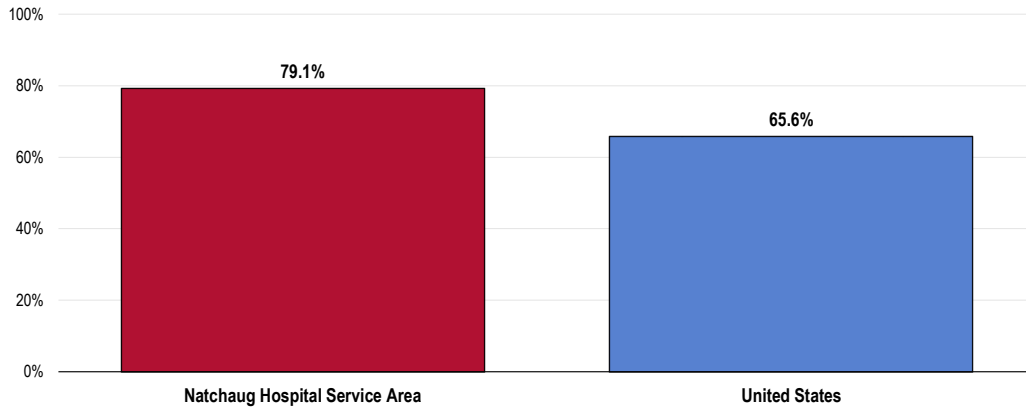
Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]

Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes less than 100% of the federal poverty level; "Low Income" includes households with incomes from 100–199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Dental Insurance

“Do you currently have any health insurance coverage that pays for at least part of your dental care?”

Have Insurance Coverage That Pays All or Part of Dental Care Costs

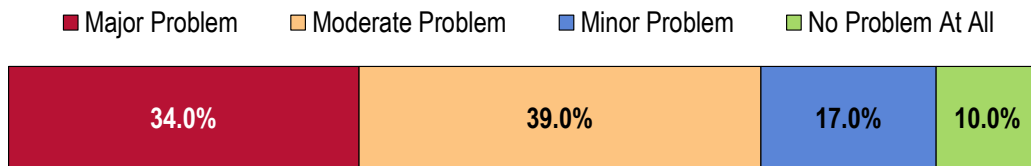


Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 22]
 • 2013 PRC National Health Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Key Informant Input: Oral Health

The following chart outlines key informants’ perceptions of the severity of *Oral Health* as a problem in the community:

Perceptions of Oral Health as a Problem in the Community (Key Informants, 2015)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
 Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons frequently related to the following:

No Insurance

Many of our seniors do not have proper insurance coverage for oral health and dental care. So because of that they go without proper dental care. – Community/Business Leader

No insurance. Not considered important to the persons overall health. – Community/Business Leader

Oral health is not covered by many insurances, including Medicare and the Affordable Care Act policies. Commercial coverage is often minimal. Medicaid has probably the best coverage, but people need to understand the value of oral healthcare in relation to overall health to make it a priority. We know that isn't the case. – Other Health Provider

Lack of insurance, screening are great but once there is a problem identified many do not have the money for specialists, emergency care is expensive. For those who do have insurance many places have long wait lists. – Public Health Expert

Not covered by some insurances. – Other Health Provider

Lack of good insurance to pay for cost. – Community/Business Leader

Although Husky enrolled patients have access to dental care, booking appointments can be challenging, especially for emergency dental needs. Patients are going to the Emergency Room rather than receiving preventive Oral Health care. A FQHC is located in Town, and they are expanding their dental operatory. However, we have received complaints of long wait times to get an appointment to receive emergency dental care. – Public Health Expert

Cost

High caries and unmet care needs. – Physician

Financial constraints and the cost of providing Dental services. – Other Health Provider

It is extremely costly. Even when the person has dental insurance, it only covers cleanings and minor procedures. There are no affordable resources for the insured and uninsured population. – Social Services Representative

Access to affordable screening and treatment is limited unless one knows what to pursue agency/program. – Community/Business Leader

The majority of our population does not have affordable, appropriate, and reliable access and information about oral health/dental care. Translators and translation services, that really work and are appropriate are not in place for our population in need. We see students every day that need these services. The information may be there, but their ability to understand and access it is quite limited. Accessible community health educators that speak their languages are desperately needed. – Social Services Representative

Access

This is a problem that is particularly prevalent in disadvantaged individuals in the community and relates to their nutritional status and access to dental care, particularly for adults who face long waiting lists for routine care and frequently have to travel out of the area to access specialized dental services/oral surgery. – Social Services Representative

Not having access to dental will cause other medical problems. – Other Health Provider

While access to services has improved after the Medicaid rate increase, rural areas continue to lag behind. – Other Health Provider

Limited education and access to education for many people. Access to care another contributing factor. – Other Health Provider

Beyond general oral health services, low income people must travel to Hartford to have extensive work on teeth. – Social Services Representative

Lack of Providers

Lack of providers. – Public Health Expert

There are not enough providers that accept Husky D. – Social Services Representative

Prevention

The community has major strides in the past eight years to increase access especially for children. There are still a high percentage of individual adults who do not have regular routine screening and care. – Social Services Representative

If you take a look around, there are numerous examples of people not taking care of oral hygiene. Problem with insurance coverage or lack of. – Other Health Provider

High Quality Dental Care

Consistent access to high quality dental care is not always achievable for low-income Hartford families. Dental issues are a significant cause of school absences. – Community/Business Leader

Discrimination

For people living with HIV/AIDS in particular, there is still discrimination and misunderstanding on the part of oral health professionals. – Social Services Representative

Volume

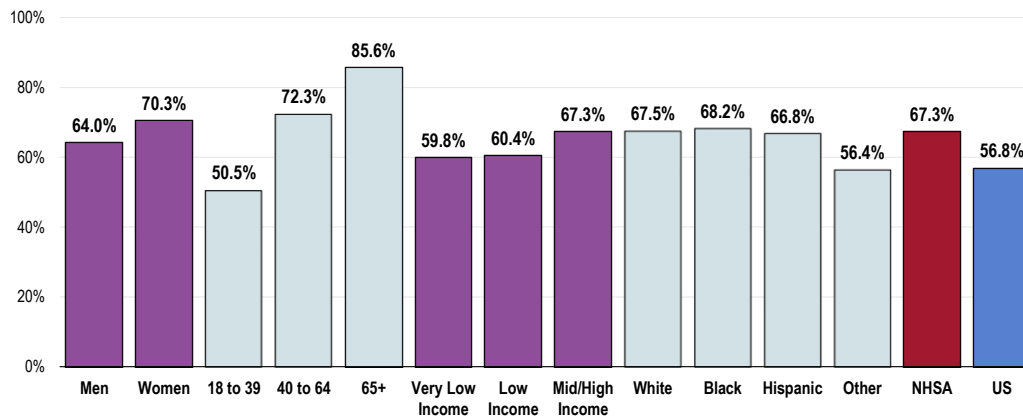
Evidence by the large number of people who access periodic free dental clinics. – Community/Business Leader

Vision Care

“When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light.” (Responses in the following chart represent those with an eye exam within the past 2 years.)

See also *Vision & Hearing* in the Death, Disease & Chronic Conditions section of this report.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated
(Natchaug Hospital Service Area, 2015)



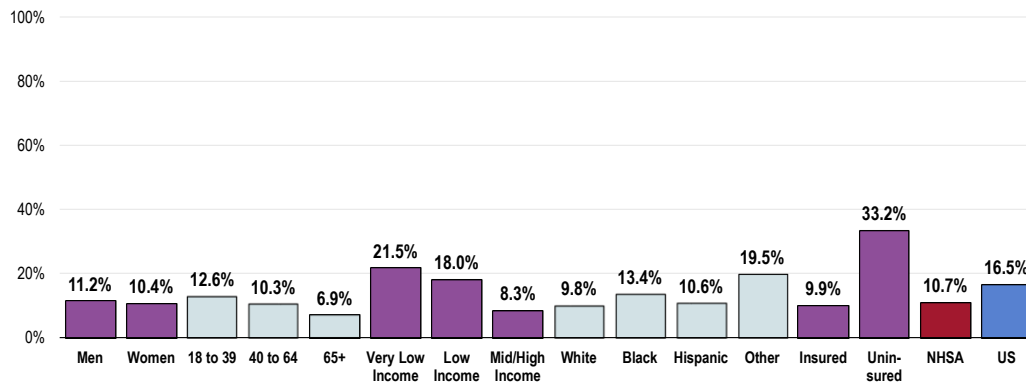
- Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Very Low Income" includes households with incomes less than 100% of the federal poverty level; "Low Income" includes households with incomes from 100–199% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Local Resources

Perceptions of Local Healthcare Services

“How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair or poor?” (Combined “fair/poor” responses are outlined in the following chart.)

Perceive Local Healthcare Services as “Fair/Poor”
(Natchaug Hospital Service Area, 2015)



Sources: • 2015 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]

- Notes:
- Asked of all respondents.
 - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 - Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Very Low Income” includes households with incomes less than 100% of the federal poverty level; “Low Income” includes households with incomes from 100–199% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report. This list is not exhaustive but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment.

Access to Healthcare Services

2-1-1 Hotline
 Access Health CT
 Access to Quality, Affordable Health Food
 AIDS CT
 Asylum Hill Family Services
 Brownstone Clinic
 Charter Oak
 Chronic Disease Management Programs
 Chrysalis Center
 Community Health Center
 Community Health Foundation
 Community Health Services
 Connecticut State Medical Society
 CT Transadvocacy Coalition
 Culturally Competent Nutritionists
 Curtis D. Robinson Center for Health Equity
 Day Kimball
 Diabetes Prevention Program
 Doc-in-a-Box Facilities
 FaithCare
 Federally Funded Clinics
 Federally Qualified Health Centers
 Generations
 Hartford Gay and Lesbian Health Collective
 Hartford Health Care
 Health Department
 Hispanic Health
 Hospital Clinics

Hospitals
 Insurance Policies
 Intercommunity, Inc.
 Latino Community Services
 Malta House of Care Mobile Clinic
 Master's Manna
 Meriden Health and Human Services
 MidState Medical Center
 Natchaug
 NECCOG
 New Opportunities
 Planned Parenthood
 Private Providers
 Project STEP
 Reliance House
 Revitalize
 Ryan White Medical Transportation Program
 SEMHA/DMHAS
 Social Services
 Sound Community Services
 UCFS
 Urban League of Greater Hartford
 Urgent Care
 Visiting Nurse Association
 Weight Loss Management Program
 Women, Infants and Children
 Yale New Haven Hospital

Arthritis, Osteoporosis & Chronic Back Conditions

Charter Oak Health Center
 Community Health Services
 Connecticut Orthopaedic Society
 Connecticut State Medical Society
 Health Centers
 HHC Brown Stone Building
 Hospital Clinics
 UCONN
 Yale

Cancer

American Cancer Society
 Backus Cancer Center
 Backus Hospital
 Cancer Awareness Groups
 Center For Hospice
 Clinics
 Community Health Centers
 Community Health Services
 Community Health Workers/Health Educators
 Community/Senior Centers
 Connecticut Cancer Partnership
 Connecticut Department of Public Health
 Curtis D. Robinson Center For Health Equity
 Dana Farber New London
 Day Kimball
 Eastern Connecticut Hematology and Oncology
 ECHN
 ECHO
 FQHC
 Generations
 Hartford Hospital
 Helen and Harry Gray Cancer Center
 Hispanic Health Council

Hospice
 Hospital-Based Services
 Internists
 Jefferson Radiology
 L & M Cancer Center
 L & M Hospital
 Local Health Department
 Local Support Groups
 Medicaid Breast and Cervical Cancer Program
 Meriden Health and Human Services
 MidState Medical
 Northeast District Department
 Oncologist Group
 Planned Parenthood
 Primary Care Providers
 Private Oncologists
 Public Health
 Quitline
 School Health Programs
 St. Francis Hospital
 Traditional Healthcare System
 Windham Chemo Treatment Facility
 Yale - Smilow Center
 Yale New Haven Hospital
 YMCA Live Strong Program

Chronic Kidney Disease

Connecticut State Medical Society
 Hospital Clinics
 KEEP Health Screening
 Local Hospitals
 National Kidney Foundation
 Private Providers
 Sub-Specialists

Dementias, Including Alzheimer's Disease

Adult Day Programs

Alzheimers Association
 Backus Hospital
 Berlin Senior Center
 Brief Care Program
 CCCI
 Center for Healthy Aging in Southington
 Community Caregiver Support Groups
 Connecticut State Medical Society
 CT Center for Healthy Aging
 Dr. Botta
 Dr. Muhammad Qureshi
 Elder Services
 Family Support Groups
 Home Care Organizations
 L & M
 Long-Term Care/Nursing Home
 Masonicare - Harth at Pond Ridge
 Assisted Living
 Memory Lane Adult Day Program
 Mental Health Providers
 Mulberry Gardens
 North Central Area Agency on Aging
 Nursing Homes
 Primary Care Providers
 Private Assisted Living Facilities
 Rehab Facilities/Skilled Nursing Care
 Ross Adult Day Care
 Senior Center
 Senior Citizen Services
 Senior Resources
 SMHA
 Social Services in Berlin
 UCFS
 UCONN
 Visiting Nurses Association
 Yale - Gerontology

Diabetes

American Diabetes Association
 Backus Community Education Series
 Backus Diabetes Center
 Backus Hospital
 CHS
 COHC
 Community Health Centers
 Community Health Workers/Health Educators
 Community Resources
 Community Support Groups
 Connecticut State Medical Society
 Curtis D. Robinson Center for Health Equity
 Day Kimball Healthcare
 Diabetes Education at the Hospital
 FaithCare
 Federally Funded Clinics
 Foot Clinics
 FQHC
 Freshplace
 Generations
 Hartford Hospital
 Health Classes in the School System
 Health Department
 HHC Brownstone
 Hospitals
 Joslin Diabetes Center
 Laplace Clinic
 Lawrence and Memorial Hospital
 Local Church Programs
 Local Hospitals and Community Centers
 Malta House of Care Mobile Clinic
 Meriden Health and Human Services Department
 Meriden/Wallingford NAACP Health Fair
 MidState

Northeast District Department of Health
 Nutritional Educators
 Primary Care Providers
 Private Pediatricians
 Public Clinics
 Public Health
 Revitalize Hartford
 School Nursing Personnel
 School-Based Health Centers
 SCOW
 St. Francis Hospital
 Support Groups at MidState
 THOCC
 UCFS
 UCONN Extension Center
 UNCAS Health District
 Wallingford Senior Center
 Windham Hospital Diabetes Group
 Yale New Haven Hospital
 YMCA
 YWCA and YMCA

Women's Ambulatory Health Center
 Youth Services, Health and Human Services
 YWCA Teen Center

Hearing & Vision

Audiology
 Backus Hospital
 Berlin Senior Center
 BESB
 Center for Healthy Aging
 Connecticut State Medical Society
 CT Eye and ENT Society
 Insurance
 Lions Club
 NCAAA
 Ophthalmology Consults
 Personal Physicians
 School Nurses
 UCFS Partners
 Uncas Health District Community Educators

Family Planning

Community Health Centers
 Community Health Workers/Health Educators
 Family Centers
 Generations Health Center
 Healthy Start
 Hispanic Health Council Comadrone Program
 Meriden Health Department
 MIOP
 Nurturing Families
 Planned Parenthood
 School-Based Health Centers at HPHS, BHS and JMA
 Teen Pregnancy Prevention

Heart Disease & Stroke

Achieve/Ledge Light Community Education
 After School Programs
 American Heart Association
 Backus Hospital
 Cardiac Units
 Church Programs
 Community Health Centers
 Community Support Groups
 CT DPH
 Day Kimball Healthcare
 Emergency Medical Dispatch
 Emergency Medical Services
 Emergency Room
 Employee Health and Wellness

Programs
FaithCare, Inc.
Farmer's Market
FQHC
Generations
Hartford Hospital Heart Center
Health Educators
Heart-Healthy Communities
Local Hospitals and Community Centers
Local Public Health Department
Malta House of Care Mobile Clinic
MidState Medical Center
Million Hearts Initiative
Neurology Associates
Northeast District Department of Health
Primary Care Physicians
Private Practice Physicians
Public Health
Public Health Department
Schools
Senior Centers
St. Francis Care Women's Heart Program
St. Francis Hospital
Traditional Healthcare System
UCFS
UNCAS Health District
WIC
Wyndham Hospital
YMCA

HIV/AIDS

AIDS CT
Alliance for Living
Backus Hospital AIDS Center
Behavioral Health Providers
Charter Oak
CHS

Church
Community Health Centers
CTARC
DPH
Government Sponsored HIV Programs
Hartford Gay and Lesbian Health Collective
Health Educators
Hispanic Health Council
HIV CT
HIV/AIDS Support Groups
Infectious Disease Clinics
Infectious Disease Specialists
Latino Community Services
Lawrence and Memorial AIDS Center
National Institute of Health
Needle Exchange
Planned Parenthood
Ryan White

Immunization & Infectious Diseases

Backus Hospital
Community Health Centers
Department of Public Health
Doctor's Office
Federally Funded Clinics
Federally Qualified Health Centers
Generations
Hartford Dispensary
Local Health Department
Malta House of Care Mobile Clinic
Meriden Health Department
MidState
Primary Care Providers
Protein Sciences
Schools and Colleges
UCFS
Walk-In Facilities

Infant & Child Health

Backus Hospital
 Birth to Three
 Building Bridges
 Chrysalis
 Clinical Programs Specializing in Autism
 Clinics
 Comadrona and MIOP
 Community Health Center
 Connecticut Children's Medical Center
 CT DSS
 Easy Breathing Programs
 First Choice
 FQHC
 Healthy Start
 Help Me Grow
 Home Visiting
 L & M
 Local Health and DPH Outreach
 Local Health Department
 Local Parks and Recreation Department
 Manchester Memorial Hospital
 MidState
 Pediatric Care
 Private Providers
 Public Health Department
 School-Based Health Centers
 UCFS
 WIC
 Women and Families Center
 Women, Infants and Children

Injury & Violence

2-1-1 Hotline
 Board of Education
 Boys and Girls Club
 CCDAV

Chrysalis
 Churches
 Churches and Youth Groups
 Community Agency Programs
 Community Mental Health Providers
 Conflict Resolution Programs
 Connecticut Behavioral Health Partnership
 Day Kimball
 Domestic Violence Shelters
 DPH Injury Prevention
 Generations
 Hartford Health Care
 Health Educators
 Injury Prevention Center
 Intercommunity, Inc.
 Juvenile Diversion Program
 Local Health Department
 Local Police Department
 Master's Manna
 Mental Health Programs
 Meriden Wallingford Chrysalis
 Meriden Youth Services
 Neighborhood Violence Prevention Programs
 OPP
 Outpatient Mental Health Facilities
 Prevention Programs for Car Seats
 Primary Care Providers
 Public Health
 Safe Kids Connecticut
 School Social Workers
 School-Based Health Centers
 Senior Ombudsman
 Strengthening Families Framework
 Suicide Prevention Advisory Board
 TEEG
 Teen Driver Laws

Village for Families and Children
Wheeler Clinic
Women and Families Center
YMCA

Mental Health

2-1-1 Crisis Intervention
ADRC
ARC of NLC
Backus Hospital
Behavioral Health Partnership
Brief Care
Capital Region Mental Health
Catholic Charities
Center for Healthy Aging
CHA
Child and Family Agency
Child and Family Limited Resources
Child Guidance Clinic
Chrysalis
City of Hartford Comm on Addiction and Public Health
Community Health Agency
Community Health Center
Community Health Resources
Community Mental Health Affiliates
Community Mental Health Providers
Community Services
Connecticut Behavioral Health Partnership
Connecticut Psychiatric Society
Connecticut State Medical Society
Day Kimball
DMHAS
Dry Dock
ECHN
Emergency Room
Employee Assistance Programs

EMPS
FQHC
Generations
Genesis
Hartford Behavioral Health
Hartford Healthcare
Hospital of Central CT Bradley Campus
Hospitals
Independent Non-Profits
Institute for Living
Intercommunity, Inc.
IOL
LCS/Hartford Behavioral Health
Local Health Department
MACC Charities
Madonna Place
Manchester Senior, Adult and Family Services
Manchester Youth Services Bureau
MCSC
Mental Health Clinics
Mental Health Providers
Meriden Health Department and Youth Services Dept
MidState
Natchaug Hospital
Natchaug Limited Resources
Norwich Human Services
Outpatient Mental Health Facility
Perception Programs
Private Providers
Regency Heights
Reliance House, Inc.
Rushford Center
SCAAD
School-Based Health Centers
SECT MHA
Social Workers

Southeastern Mental Health Authority
Southington Community Services Department
Southington Youth Service Department
Stonington Institute
Supportive Housing Programs
TEEG
The Village
UConn Health Center
United Community and Family Services
United Services
Village for Families and Children
Wheeler Clinic
Windham Hospital Emergency Room
WWBH
Yale Behavioral Health

Nutrition, Physical Activity & Weight

Aveena Wellness
Backus Hospital
Backus/TVCCA Collaborative Nutrition Program
Bariatric Program and Comprehensive Evaluations
Beat the Street
Biking, Walking and Running Clubs
Black Nurses Association
Board of Education for Cheshire School
Boys and Girls Club
Boys Club of Meriden and Wallingford
Chamber of Commerce
CHCs and Clinics
Cheshire Library
Chesprocott
CHS
Church and Town Pantries
COHC
Community Gardens

Cooking Matters
Day Kimball
Early Childhood Programs
Employers Supporting Breastfeeding
FaithCare, Inc.
Farmer's Market
Fast Food Restaurants
Food Pantry
Food Share
For-Profit Fitness Centers
FQHC
Fresh Fruits and Vegetables Distribution Vans
Generations
Gyms
Hartford Behavioral Health
Hartford Childhood Wellness Alliance
Hartford Food System
Hartford Healthcare
HHC Brownstone
HHC's Breastfeeding
Hispanic Nurses Association
Holistic Health
Hospital Nutrition Clinic
Hospitals
Ice Skating Rink
Intercommunity, Inc.
Manchester Health Department
Manchester Recreation Department
Manchester Youth Services Bureau
Mansfield Community Center Fitness
Mayor's Taskforce on Childhood Obesity
MidState
My City Kitchen
Northeast District Department of Health
Organized Sports
Parks and Recreation Department

Pediatrician's Offices
Pilot Grants
Planning and Zoning Departments
Primary Care Physicians
Private Nutritionists
Public Health
School-Based Health Centers
Schools
SNAP
Space for Outdoor Recreation
Spanish Community of Wallingford for Zumba
Summer Food
TOPS
UCFS
UCONN
UNCAS Health District Community Educators
Weight Management and Lifestyle Programs
Weight Watchers
Wellness Committee at Sanchez School
WIC
Windham Hospital Diabetes Education
Windham Recreation Department
YMCA
Yoga
Youth Recreation Programs
Youth Services
YWCA

Oral Health

Backus Hospital
Central CT Health District
Charter Oak Health Center
CHC Dental Clinic
Children's Dental Associates Clinics

Community Health Center
Community Health Services
CT Children's Medical Center
Dental Lifeline Network
Dr. Ted Fischer
First Choice
FQHC
Free Dental Cleaning Fairs
Generations
Hartford Gay and Lesbian Health Collective
Head Start
HHC Brownstone
Master's Manna
Meriden Public Schools
Mission of Mercy
Mobile Dental Clinics
Nothing
Private Dentists
Saint Francis Health Care
UCFS
UCONN School of Dentistry
Yale New Haven Hospital

Respiratory Diseases

American Lung Association
Backus Hospital
Building Bridges
CHS
Classes at Local Hospitals
COHC
Community Health Centers
Easy Breathing Program
HHC
HUD
Keep the City Clean Projects
Lawrence and Memorial Asthma Clinic
Local Health Department

Malta House of Care Mobile Clinic
 Northeast District Department of Health
 Nothing
 Private Practitioners
 Public Health
 Pulmonary Care and Primary Care Providers
 Pulmonologists
 Putting on Airs Program
 School-Based Health Centers
 Smoking Cessation Programs
 State Department of Public Health Smoking Cessation
 Support Groups
 UCFS
 Uncas Health District
 Visiting Nurses Association

Sexually Transmitted Diseases

Backus Hospital STD Clinic
 Charter Oak and CHS
 CHS
 City of Hartford Health and Human Services STD Clinic
 COHC
 Community Health Center
 FQHC
 Generations
 Hartford Gay and Lesbian Health Collective
 Hartford Health Department
 Hartford Hospital Brownstone Clinic
 HHC
 Latino Community Services/STI Testing Clinic
 Local Health Department
 Planned Parenthood
 Private Physicians
 Ryan White

School-Based Health Centers
 Schools
 St. Francis, CHS, Charter Oak and CCMC
 The Health Collective
 UCFS
 University Student Health Services Facility
 Various Clinic and Hospital Services
 Walk in Clinics

Substance Abuse

Alcohol and Drug Rehabilitation
 Alcoholics Anonymous
 Boys and Girls Club
 Bristol Hospital
 Catholic Charities
 CHC
 CHP
 Community Agencies for Outpatient Treatment Programs
 Community Health Services
 Community Renewal Team
 Community-Based MH/SA Providers
 Department of Mental Health and Addiction Services
 Dry Dock Cafe
 FQHC
 Halfway Houses
 Hartford Behavioral Health
 Hartford Dispensary
 Hartford Fishfry
 Hartford Healthcare
 Hospital and Ambulatory Detox
 Institute for Hispanic Families
 Institute of Living
 Intercommunity, Inc.
 IOL
 LCS/Project STEP

Linkage to Care
 Local Hospital
 Medicaid
 MidState Medical Center
 Narcotics Anonymous
 Natchaug Hospital
 NECASSA
 Needle Programs
 Outpatient Clinics
 Perception House
 Perception Program
 Police Department
 Prevention Programs
 Private Physicians
 Public Health Department
 Putnam Pride
 Reliance House
 Rushford Center
 SCAAD
 SCADD
 Schools
 SMHA
 Social Workers
 South Central CT Substance Abuse
 Council
 Southeast Mental Health Authority
 STEPS Program
 Stonington Institute
 UCFS
 Village for Families and Children
 Wheeler Clinic
 Windham Hospital
 Windham Regional Community Council
 Youth Challenge

Boys and Girls Club
 Cancer Society
 Community Health Center
 Community Health Providers
 Community Smoking Cessation Classes
 at an Agency
 FQHC
 Hospital-Based Program
 Intercommunity, Inc.
 L & M Hospital
 Ledge Light Community Education
 Local Health Department
 Local Pharmacy
 Medicaid
 MidState
 Nothing
 Public Health
 Quit Line
 SA/MH Providers
 School System
 School-Based Health Center
 Smoking Cessation Program
 Incorporated Into Care
 State Smoking Cessation Program
 UCFS
 UNCAS Health District
 Village for Families and Children
 Windham Hospital

Tobacco Use

Backus Hospital
 Beat the Street