

Hartford HealthCare 
Charlotte Hungerford Hospital

CHNA

Community
Health Needs
Assessment
and Implementation Plan
2025

Letter from Hartford HealthCare

Dear Reader,

Thank you for reading the 2025 Community Health Needs Assessment (CHNA) for Charlotte Hungerford Hospital.

Hartford HealthCare's (HHC) 2025 CHNA process presents us with a historic opportunity to align dialogue with action to improve health for all. Listening with humility and curiosity to the voices and lived experiences of the people, families, and organizations that shape each neighborhood we serve is essential.

It is our intention that the ensuing report provides an important foundation for community stakeholders to identify and define priorities for health improvement, to name and amplify existing community strengths and assets, and to outline areas for further collaboration and collective action.

This CHNA is designed to improve the lives and quality of life of local residents by helping the hospital focus its resources and activities on areas of greatest need. The CHNA process is highly inclusive and combines extensive amounts of quantitative and qualitative research, including direct feedback from community members.

Further, the CHNA is an important element of HHC's continual efforts to engage the communities it serves and be part of neighborhood conversations about health and healthcare in order to tailor and improve the services we offer. As with previous CHNA findings, we learned that people's health varies greatly across geographic and socioeconomic lines. Our community members' trust in healthcare also varies, often due to an inability to access timely, affordable, high-quality care, or a lack of information about what is available to them.

In the process of identifying our top community health priorities, we focused on the following objectives:

1. Enhance community engagement and better incorporate the community voice in our process
2. Sustain and grow our community-based partnerships through this work
3. Better align and integrate our community health priorities within health equity goals and across the HHC system
4. Bring greater clarity and impact to our community health actions and interventions

In conducting this CHNA with these objectives in mind, we found overarching themes that have a significant impact on health and will shape our community health improvement plans. These include:

- **Food insecurity has increased**, with notable differences by race and ethnicity: 13% white, 32% black, 29% Hispanic, and 9% Asian.
- **Housing insecurity has increased**, doubling from 6% in 2015 to 12% in 2024.
- **40% of households in CT** were earning more than the Federal Poverty Level, but not enough to afford the basics where they live (Asset Limited, Income Constrained, Employed, or ALICE households).
- Between 2010 and 2023 the total number of households in CT increased by 6%, but **the number of ALICE households increased by 13% and the number of households in poverty increased by 18%**.
- Recent changes to Medicaid affecting eligibility and reducing subsidies are expected to result in up to **11.8 million Americans losing public insurance by 2034** (Source: Congressional Budget Office), translating to over **100,000 covered lives in CT** (Source: Kaiser Family Foundation).

As we reflect on the above key findings, and the many insights and voices captured in this CHNA, we recognize the strength, resilience, and expertise of the communities we serve. Our path forward is to better serve them, and we invite the highest state of collaboration in working towards better health for all.

In good health,



Sarah S. Lewis
Chief Health Equity Officer
Hartford HealthCare

Table of Contents

Letter from Hartford HealthCare	
The Purpose of the Community Health Needs Assessment and the Structure of this Document	1
Needs Assessment “Compass” or “Roadmap”	1
The Regional, Collaborative, and Inclusive Approach	2
“What did we Learn?” – Executive Summary	3
Background	3
Process / Methodology	3
Results	4
2022 Final Prioritized List of Needs	5
“What is the Community Health Needs Assessment and why is it important?”	6
Introduction – About Hartford HealthCare	6
“What information did we collect and how did we identify community needs?”	8
CHNA Process Overview and Timeline	8
Needs Assessment Research Approach	8
Detailed Research Method	9
“What is unique about this community and its health needs?”	10
Service Area Description	10
Hospital Profile	11
Data Notes & Limitations	11
“What did the data tell us and what did we learn?”	12
Demographic Analysis and Community Input	13
Demographic and Secondary Research Highlights	13
Community Demographic Profile	15

Mortality and Morbidity	22
Most Common Causes of Death (Mortality)with County-level Incidence and Comparisons	23
Hospital Use Characteristics (Morbidity) and ChimeData from the Connecticut Hospital Association	25
Maternal Health	27
Life Expectancy.....	28
Health-related Social Needs and Other Factors Impacting Health and Predictive Analytics	30
Qualitative Research Highlights	34
Community Wellbeing Survey and Other Research.....	36
Chronic Disease	36
Community Satisfaction	37
Health risks.....	37
Healthcare access.....	38
Housing and financial well-being	38
Mental Health	39
Neighborhoods	39
Nutritional Security	39
Transportation	40
Well-being and Support	40
Data Analysis and Community Input Summary	41
“What have we already accomplished or initiated?”	43
Evaluation of 2023–2025 Implementation Plan	43
Summary	43
Local Charlotte Hungerford Hospital Activities.....	44
“What did we prioritize – how and why?”	47

Prioritization Process	47
Final Priorities	50
“What do we intend to do, and how will we know we are successful (CHIP)?”	51
Implementation plan	51
Appendix	64
Appendix 1: Qualitative Research Summary.....	65
Appendix 2: DataHaven Community Wellbeing Survey Raw Data Tables	66
Appendix 3: Wellbeing Survey Summary Tables and Graphics	68
Chronic Disease	68
Community Satisfaction	69
Health Risks	70
Healthcare Access	71
Housing and Financial Wellbeing	72
Mental Health	73
Neighborhoods	74
Nutritional Security	75
Transportation	76
Wellbeing and Support	77
Appendix 4: Maternal Health	78
Overview	78
National Maternal Health Trends	78
Maternal Health in Connecticut.....	79
Antecedent or Contributing Measures	80
Outcomes Measures	83

Appendix 5: Maternal Health Data Tables.....	86
Preterm Births.....	87
Low Birth Weight	88
First Trimester Prenatal Care	89
Appendix 6: Life Expectancy Data.....	90
Appendix 7: Life Expectancy	92
Introduction	92
Premature Death and General Health Indicators	92
Lifestyle and Behavioral Health Factors.....	93
Healthcare Access and Preventive Care.....	93
Health-related Social Needs.....	94
Health Risk Behaviors and Mortality.....	94
Conclusion and Recommendations	95
Appendix 8: Hospital Utilization Data	97
Appendix 9: CHIME Data References and Sourcing	99
Description of Data Sources.....	99
Methodology for Age-Adjusted Rates	100
Appendix 10: Code Reference Sheet	102
Appendix 11: Hartford Healthcare Board Meeting Summary: Northwest Region – Charlotte Hungerford Hospital	114
Appendix 12: Internal Revenue Service Requirements for Community Health Needs Assessments.....	116
Appendix 13: Community-based Health-related Resources.....	122

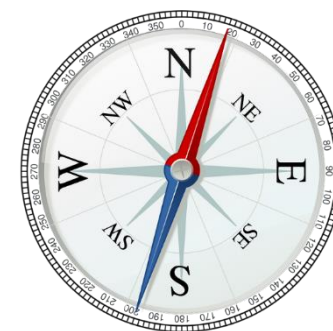
The Purpose of the Community Health Needs Assessment and the Structure of this Document

The Community Health Needs Assessment (CHNA) is designed to improve the lives and quality of life of local residents by helping the hospital focus its resources and activities on areas of greatest need. The CHNA is an important element of Hartford HealthCare's (HHC) continual efforts to engage the communities it serves, be part of neighborhood conversations about health and healthcare, and prioritize efforts to services offered — and the way they are offered — to the community.

Needs Assessment “Compass” or “Roadmap”

The following CHNA document is a summary of the research and collaborative activities conducted late in 2024 and early 2025. The document is structured to answer the following questions:

- *“What is the Community Health Needs Assessment and why is it important?”*
An introduction and description of Hartford HealthCare, the Charlotte Hungerford Hospital, and the community that it serves
- *“What information did we collect and how did we identify community needs?”*
A brief description of the process overview and timeline
- *“What is unique about this community and its health needs?”*
The hospital and community description
- *“What did the data tell us and what did we learn?”*
Research findings of the Community Input – secondary research and primary research (quantitative and qualitative) used to establish a prioritized list of community health needs
- *“What have we already accomplished or initiated?”*
A summary evaluation of 2023–2025 Implementation Plan emerging from the previous CHNA
- *“What did we prioritize and why?”*
A list of identified community needs and the approach taken to prioritize them
- *“What do we intend to do, and how will we know we are successful (CHIP)?”*
Implementation Plan-related actions illuminate the pathway to address higher-priority community health needs and describe metrics used to measure impact and success.



The following pages answer these questions and provide information that can be helpful in directing collaborative efforts to improve community health and well-being.

To align this CHNA with Internal Revenue Service (IRS) requirements, please see Appendix 12: Community Health Needs Assessment Requirements as per the Internal Revenue Service; the appendix provides a requirements list and page or section references.

The Regional, Collaborative, and Inclusive Approach

Hartford HealthCare (HHC) has long cultivated a collaborative, regional approach to addressing community health needs. Using this model for the Community Health Needs Assessment (CHNA) process emphasizes strong partnerships and inclusive planning. This approach incorporates several key elements: establishing a shared vision, fostering cross-organizational collaboration, engaging those most impacted by health disparities, and implementing continuous planning with shared accountability. These principles are reflected throughout the CHNA process and this report, which is designed to foster community dialogue around health concerns, mobilize local assets and collaborators, and guide priority-setting for future health initiatives.

HHC's regional model brings together a wide network of partners — spanning geographic regions, hospital service areas, and grassroots health advocates. This approach recognizes that eliminating health disparities and efficiently deploying resources within healthcare and community organizations are essential starting points for meaningful improvement. To do so, HHC intentionally engaged a broad spectrum of stakeholders representing a wide range of insights and perspectives – including those from communities that have traditionally lacked access to health services.

The inclusive approach to the CHNA required a wide range of quantitative and qualitative data to better understand core health-related issues and priorities.

HHC regional teams were led by onsite staff members well-versed in their communities and heavily engaged in leading ongoing community health initiatives. A table of the regional leaders follows.

HHC Hospital	Region	Regional Leaders
Backus Hospital	East	Regional Director Community Health
Charlotte Hungerford Hospital	Northwest	Regional Director of Community Health
Hartford Hospital	Hartford	Manager of Community Health and Health Promotion
Hospital of Central Connecticut	Central	Director, Community Health & Engagement
MidState Medical Center	Central	Director, Community Health & Engagement
Natchaug Hospital	East	Regional Director of Development
St. Vincent's Medical Center	Fairfield	Manager Mission Services and Community Impact
Windham Hospital	East	Regional Director Community Health

“What did we Learn?” – Executive Summary

Background

This executive summary serves as an introduction and an overview of the longer report. The full report and detailed data appendices are designed as a resource for HHC hospitals and their community, stakeholders, agencies, associations, and the public. All readers are encouraged to explore the main body of the report and experience the voices and insights of community members across the service area.

Process / Methodology

The assessment involved substantial secondary research (for example, collecting and analyzing existing data from the U.S. Census Bureau, online sources, and existing reports), as well as primary research using things like interviews, focus groups, surveys, and others. This “mixed method” approach provides a solid, data-based foundation for the CHNA while including personal stories, experiences, and a quantitative understanding of community perceptions and opinions about health and health-related topics. Some of the specific approaches and sources include, but are not limited to, the following:

- Data from the Connecticut Hospital Association, the U.S. Census Bureau, the March of Dimes, the National Cancer Institute’s Surveillance, Epidemiology and End Results (SEER) Program Database, the ALICE database,¹ DataHaven, and Predictive Analytics (e.g., insights on four health conditions in the SVI Torrington community provided by Based Analytics LLC)
- Stakeholder one-on-one interviews with 12 community members, providers, public health officials, community based organizations
- Focus group discussions (eight) with the Regional HHC Board of Directors, community members, providers, community based organizations
- Survey results from the DataHaven Community Wellbeing Survey – Hospital Service area and Torrington
- Quantitative and qualitative research with the Public Health officials and agencies

The combination of secondary and primary research approaches provided in-depth insight and a comprehensive evaluation of community health and factors directly impacting HHC’s ability to focus on the highest priority community health needs. Key themes and health-related issues include the following:

¹ United For ALICE, an initiative founded by United Way of Northern New Jersey, operates the ALICE database.

Access to Healthcare Services

Many communities are experiencing a decline in locally available health services due to insurance restrictions / affordability, transportation, inconvenient office hours, and – occasionally – a lack of specialized care providers.

Socio-economic Factor Impacting Healthcare

Issues such as the cost of healthy, nutritious food; affordable housing; jobs that do not pay a living wage; and other factors present both a financial and emotional burden for many households. In addition, individuals who are new to America or otherwise from non-English-speaking households often struggle to find healthcare providers who understand cultural aspects that impact community health and healthcare.

Behavioral Health Barriers

Behavioral health and substance use treatment health-related issues are widespread and impact all facets of life. Stakeholders emphasized the importance of addressing socio-economic issues simultaneously since the interrelationship is directly connected. Issues relating to reducing stigma, mental health and substance use early intervention and treatment, and the need to improve access to services are common.

Additionally, there is a need for increased staffing, enhanced community outreach, and better communication about available resources.

Chronic Health Conditions

Chronic health conditions such as heart disease, cancer, diabetes, and asthma continue to be the leading causes of death. However, CHNA research identified some detailed insight which provides a more detailed perspective and supports future planning.

Results

Within these key themes, the hospital deployed a quantitative and qualitative method to arrive at a prioritized list of specific health needs. The prioritized list of needs follows:

Aggregated Needs By Tier For Charlotte Hungerford Hospital	
Affordable and Quality Housing	
Nutrition and Food Security – Consistent access to healthy and affordable food	
Access to Mental Health Services across Lifespan, including Substance Use	
Affordable and Accessible Care- Including cost, insurance barriers, and provider shortages	
Aging in Place- Senior healthcare services and care navigation	
Pediatric and adolescent support services- Including healthcare and accessible affordable childcare	
Transportation to Health and Human Services	
Chronic Disease Prevention and Early Detection- Including diabetes, hypertension, heart disease and obesity	
Unemployment and underemployment – Access to stable jobs and workforce support	
Community Connection and Community Building Activities	
Maternal Health Services- prenatal, perinatal and postpartum care access	

The 2025 priorities (above) present a streamlined, high-level framework focused on broad health domains, while the 2022 list (below) provided a more detailed set of operational, Health-related Social Network (HRSN), and systemic challenges requiring attention.

- **Broader Community and Life-Stage Focus:** The 2025 list expands to include pediatric/adolescent services, maternal health, and aging in place, indicating more attention to needs across the lifespan compared to 2022’s narrower focus on service delivery infrastructure.
- **Refined Housing and Food Security:** Whereas 2022 emphasized “housing assistance” and “food insecurity in priority communities,” the 2025 framing elevates these into more comprehensive categories—“affordable and quality housing” and “nutrition and food security”—with a focus on consistent access.
- **Shift from System Integration to Community Connection:** The 2022 list highlighted integrated case management, multilingual services, and inpatient capacity, whereas 2025 emphasizes community connection, workforce stability, and unemployment/underemployment, reflecting a broader set of health-related social needs.

2022 Final Prioritized List of Needs

Aggregated Needs By Tier For Charlotte Hungerford Hospital
Housing Assistance For Cost-Burdened Households
Outpatient Mental Health Services Capacity for Adults, Adolescents, and Children – Including in-home and caregiver support – Including in-home and caregiver support
Transportation For All Community Members Needing but Unable To Get To Healthcare Services
Integrated Case Management And Multiple Health-Related Services “Under One Roof” For High Need Patients
Multilingual Medical And Mental Health Services
Food Insecurity In Priority Communities
Inpatient Bed Capacity Mental Health
Focused Initiatives Addressing Chronic Health Conditions
Addition Programs To Enhance Access to Care For Lower-income Families
Broad-based, integrated services --- Medical, Mental Health, Substance Use Disorder, HRSN – for People and Families Experiencing Homelessness
Care Coordination and Support to Help Manage Care for Patients With Complex Health Conditions
Enhanced Collaboration with Community Partners
Substance Use Disorder Crisis Care and Treatment

“What is the Community Health Needs Assessment and why is it important?”

Introduction – About Hartford HealthCare

With 45,000 colleagues, Hartford HealthCare’s unified culture enhances access, affordability, and excellence. Its care-delivery system — with 500 locations serving 185 towns and cities — includes two tertiary-level teaching hospitals, an acute-care community teaching hospital, an acute-care hospital and trauma center, three community hospitals, a behavioral health network, a multispecialty physician group, a clinical care organization, a regional home care system, an array of senior care services, a mobile neighborhood health program and a comprehensive physical therapy and rehabilitation network. Every day, Hartford HealthCare cares for more than 27,000 people. In every aspect of its work — from training to research to charitable care and screenings — Hartford HealthCare is committed to making the communities it serves healthier. The HHC health system is more fully described in the section “About Hartford HealthCare.”

As part of its mission “to improve the health and healing of all,” Hartford HealthCare and its hospitals conduct a Community Health Needs Assessment (CHNA) every three years.² This process includes working with community members to systematically identify community health priorities and create a plan for addressing them. This report shares the results from the current assessment of health needs in the community served by Charlotte Hungerford Hospital and the implementation plan to address those needs from 2026–2028. This report also highlights the hospital’s 2023–2025 activities to address needs identified in the 2022 assessment.

People’s health varies greatly across geographic and socioeconomic lines. Further, people’s trust in healthcare varies, often due to an inability to access timely and high-quality care or a lack of understanding about what’s available to them. The CHNA and Community Health Improvement Plan (CHIP) processes are grounded in Hartford HealthCare’s mission “to improve the



² Internal Revenue Code Section 501(r)(3). Available at [https://www.ecfr.gov/current/title-26/part-1/section-1.501\(r\)-3#p-1.501\(r\)-3\(b\)\(6\)](https://www.ecfr.gov/current/title-26/part-1/section-1.501(r)-3#p-1.501(r)-3(b)(6))

health and healing of all” and its Vision “to be most trusted for personalized coordinated care.” In addition to its mission, vision and values, Hartford HealthCare has also adopted the following Health Commitment: “We commit to specific actions that measurably improve access, intentionally eliminate barriers, and create opportunities for all.”

Charlotte Hungerford Hospital is part of Hartford HealthCare – Connecticut's most comprehensive healthcare network – and serves the Northwest Region of the state.



“What information did we collect and how did we identify community needs?”

CHNA Process Overview and Timeline

The CHNA process was highly inclusive and combined extensive amounts of quantitative and qualitative research – including direct feedback from scores of community members.

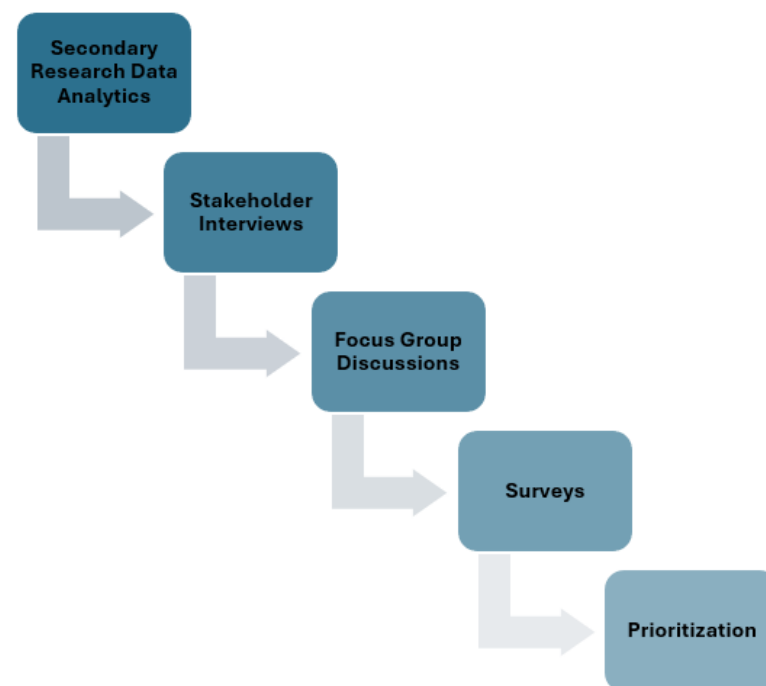
Needs Assessment Research Approach

Hartford HealthCare worked with its partner, DataHaven, and a diverse group of local, regional, and statewide resources to create and execute a comprehensive review of community needs and engagement of stakeholders. The approach engaged a breadth of stakeholders and community groups. The methodology included secondary and primary (quantitative and qualitative) research techniques to engage community partners and develop well-supported results.

HHC used research processes such as the following to conduct the CHNA:

- Secondary research from validated, publicly available sources.
- Primary research (qualitative) from key stakeholder interviews (KSI) and focus group discussions (FGD).
- Primary research (quantitative) as collected through the 2015-2024 DataHaven Community Wellbeing Survey.

The CHNA approach provided a thorough and inclusive way to identify and prioritize key community-based health needs. It also served as the basis for subsequent Implementation Plans, or Community Health Improvement Plans (CHIPs). The following section provides some additional details regarding each of the three major research processes.



Detailed Research Method

Charlotte Hungerford Hospital (CHH)'s research process utilized a mixed method approach. Quantitative data was collected from various secondary sources while qualitative data was gathered from community inputs as primary data sources. Research activities included the following steps:

Primary Data Collection and Review

- DataHaven Community Wellbeing Survey: CHH service area and the City of Torrington: August 2025.
- Stakeholder Interviews: CHH team engaged community leaders and internal colleagues, twelve key stakeholder interviews in August and September 2024.
- Focus Group Discussions: DataHaven consultants engaged a diverse group of community residents in eight focus groups in March / April 2025.
- Qualitative research summarized: May 2025.
- The Wellbeing Survey: Connecticut hospitals along with the Connecticut Hospital Association worked with DataHaven to create a shortened version of its Wellbeing survey to enlist the voices of more community members in the CHH service area and the city of Torrington (August 2025). HHC included several targeted survey questions; sponsored translation of the survey into different languages; developed and deployed strategies to increase community participation; and, assisted with analysis of survey results.

Secondary Data Collection and Review

- Secondary research included collection and analysis of existing data from the U.S. Centers for Disease Control and Prevention (CDC), the U.S. Census Bureau, the SEER database, and others. Highlights are included later in this assessment, and the appendices contain a more expansive array, for additional reference.
- Specific data sources and approaches deployed from August 2024 to April 2025 include, but are not limited to, the following:
 - Service Use and Demographic Data- HHC, DataHaven and Connecticut Hospital Association.
 - Predictive Analytics- Insights on four health conditions in the Torrington community provided by Based Analytics LLC.
 - Additional Data- Life Expectancy, ALICE Reports, Health-related Social Needs (HRSN), Women's Health, core data regarding access to care and other issues.
- Integrated quantitative and qualitative data: March- April 2025.
- Generated an aggregated research summary: May 2025.

“What is unique about this community and its health needs?”

Service Area Description

The service area is defined geographically (e.g., the town in which the hospital is located, as well as nearby ones) and it is described by a set of quantitative and qualitative data points. The Charlotte Hungerford Hospital service area — encompassing the towns of Barkhamsted, Canaan, Canton, Colebrook, Goshen, Harwinton, Litchfield, Morris, New Hartford, Norfolk, North Canaan, Thomaston, Torrington, and Winchester — represents a distinct region within Connecticut, characterized by its blend of rural landscapes, suburban communities, and rich culture. Many of the communities—such as Colebrook, Goshen, and Norfolk—are sparsely populated, with limited commercial development and large areas of protected land. Public transportation options are minimal, and residents often rely on personal vehicles for access to work, healthcare, and essential services. This rural character influences many aspects of daily life, including education, economic opportunity, and healthcare access.

While the region lacks large metropolitan centers, Torrington serves as the area's primary urban hub, offering more densely populated neighborhoods, healthcare facilities, retail centers, and public services. Nearby towns like Litchfield and Thomaston provide additional access to amenities while retaining their small-town charm. Although the region is relatively isolated from Connecticut's larger cities like Hartford or New Haven, its proximity to the greater New York metropolitan area via major highways still influences regional economics and commuter patterns. This combination of rural seclusion and limited metro access creates a unique balance of opportunity and challenge for residents.

- As noted, Hartford HealthCare uses a regional approach to enhance the efficiency of the needs assessment process, better understand the unique needs of each region it serves. This section frames community health status and serves as a research-based platform to launch or enhance initiatives to improve community well-being. Specifically, the section focuses on the following:
- Identifying available resources, existing strengths, and obstacles to improving health outcomes.
- Gaining deeper insight into barriers to healthcare access, particularly those affecting underserved communities.
- Fostering collaboration among community partners to capitalize on opportunities for population health improvement.

The CHNA and the data it includes are designed to be shared with community partners and updated as needed. Sharing this information in various formats is essential for keeping partners, stakeholders, community organizations, associations, and the public informed about the CHNA findings and empowering community members to act.



Hospital Profile

Charlotte Hungerford Hospital (“the hospital” or “CHH”) is a 109-bed acute care facility combined with a well-distributed ambulatory setting serving the regional health care needs of northwest Connecticut and is part of Hartford Healthcare Northwest Region. The hospital is the region’s largest employer, with over 1,200 employees and physicians.

For over a century, the hospital has served as the premier health care leader in the region. The hospital currently offers a comprehensive range of inpatient and outpatient services including general medicine and surgery, maternity and pediatrics, neurology, radiology, obstetrics, cardiology, urology, orthopedics, and behavioral health. For more information, please visit <https://hartfordhealthcare.org>

Data Notes & Limitations

Health disparities impact, and are impacted by, the conditions in the environments where people are born, live, learn, work, play, worship, and age.³

The secondary data collection portion of the CHNA report utilizes text and tables from Version 1.0 of the DataHaven town profiles, which DataHaven has published for all 169 towns and several regions of Connecticut. The health data was augmented with information from the United States Census Bureau American Community Survey (ACS), which covers a broad range of topics about the social, economic, demographic, and housing characteristics of the U.S. population.

The primary advantage of using multiyear estimates is the increased statistical reliability of the data for less-populated areas and small population subgroups. By collecting and analyzing data from a great breadth of publicly available data sources, proprietary databases, and other sources, the team developed a detailed view of each of the seven HSAs represented in this report.

Some health data can have percentage changes that look dramatic because the raw counts of some populations are so small. In addition, cross-tabulations by county or HSA may result in slight differences in totals.

As DataHaven notes in each HSA report found in the appendix, “throughout most of the measures in this report, there are important differences by race and ethnicity as well as neighborhood that reflect differences in access to resources and other health-related social needs. Wherever possible, data will be presented with racial and ethnic breakdowns. Data for White, Black, Asian, and other populations represent non-Hispanic/Latino members of each racial group.”

³ Health.gov. How does Healthy People 2030 define health disparities and health equity? Available at: <https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2030/questions-answers#a9>

“What did the data tell us and what did we learn?”

The Charlotte Hungerford Hospital CHNA was a comprehensive and collaborative effort. It took place over several months and included many voices from across the community. This section explains how the CHNA was planned, the timeline, and the ways data was collected and studied. The process was led by HHC and local hospital and regional leaders, and it included strong partnerships with other local hospitals and organizations to make sure the work matched the mission of improving health for all.

To understand community needs, the team used both quantitative data and personal stories and opinions (qualitative data). Information came from official sources like the U.S. Census and the federal Centers for Disease Control and Prevention, along with surveys, interviews, and focus groups. Special care was taken to include people from many different backgrounds — such as seniors, youth, new Americans, as well as people from a variety of racial, ethnic, and other communities. By working together with various community partners, the team gathered stronger, more complete data to produce a final report reflecting the real experiences and needs of people living in HHC’s Northwest Region.

The following section presents important statistical data (and other secondary research), qualitative research results, and other information that provide a clear profile of the hospital service area while highlighting specific health-related needs or service gaps. This section is divided into the eight topics, or sub-sections, listed below.

- Demographic Analysis and Community Input
- Mortality and Morbidity
- Maternal Health
- Life Expectancy
- HRSN Factors Impacting Health and Predictive Analytics
- Qualitative Research Highlights
- Community Wellbeing Survey and Other Research
- Data Analysis and Community Input Summary



Demographic Analysis and Community Input

Demographic and Secondary Research Highlights

Understanding the demographic composition of a community is essential for assessing health needs and identifying disparities in health outcomes. Population characteristics such as age, race/ethnicity, income, education, and geographic distribution influence access to healthcare, health behaviors, and overall well-being. Throughout this report, demographic data serve as a foundation for examining differences in health indicators and outcomes across various population groups.

Wherever possible, granular data are presented to highlight disparities that may exist – potentially due to differences in access to healthcare, economic opportunities, and other health-related social needs. Additionally, geographic variations in health outcomes are examined, where helpful, recognizing that neighborhood-level differences often reflect disparities in access to healthcare resources, economic stability, and other factors that shape community health.

The following are directly supported by the referenced data tables; each also has more granular data-supported observations:

- Charlotte Hungerford Hospital (CHH) service area is a less densely populated region of approximately 100,000 people, half (44.3%) of whom live in a designated rural area (suggesting access to care challenges and more difficult proximity to healthcare resources).⁴ See Table 1.
- The CHH service area is less demographically diverse than the state average (83.0% and 69.8% White, respectively), and the median age is older than the Connecticut average (44.5 and 40.9 years, respectively). The older median age and the higher percentage of people over 65 suggest a potentially greater need for chronic disease care and senior outreach activities. See Table 1.
- Consistent with data throughout the state of Connecticut (and nationally), Hispanic residents of the CHH CHNA service area are much younger (median age approximately 28 years) than the area average (i.e., 44.5 years); the variance compared to Whites (approximately 48 years) is even more notable. Overall, non-White communities tend to be more than ten years younger than White community members. See Table 2.
- People residing in the CHH CHNA service area tend to have somewhat less education and lower median household income than the state average. However, about the same percentage of service area residents have a poverty profile similar to the state average:

⁴ Note: Living in a rural area often impacts access to healthcare and increases the risk of chronic disease due to fewer local healthcare facilities, longer travel distances, and limited specialty care. (National Rural Health Association, 2023; CDC, 2022).

approximately the same percent (1) live below the poverty line, (2) are financially at-risk (as reflected in the ALICE score), and (3) are insured through Medicaid. See Table 3.

- There is an ongoing need for chronic disease care. Of the 14 health and chronic conditions included in Table 4, the percentage of CHH CHNA service area residents afflicted by the conditions is very similar to the Connecticut state average in each case. As with the state, high cholesterol, high blood pressure, and obesity are common conditions, as well as mental health conditions such as depression. See Table 4.
- Preventive health screening and substance use (i.e., tobacco and alcohol) in the CHH CHNA service area tend to be similar to the state averages. See Table 5.
- Cancer rates vary tremendously based on race and ethnicity. For example, at the state and Litchfield County levels, cancer rates among Asians are approximately one-half the rates for Whites. However, CHH CHNA service area cancer rates are very similar to the state averages. See Table 6.
- Hospital utilization ratesⁱ in the hospital service area vary notably versus the Connecticut state averages. The in-depth data in the CHNA document supports broad-based efforts to address maternal health and life expectancy issues, while the CHIME data in Tables 7 and 8 suggest that four additional health conditions are highly common and/or are higher than state rates; health conditions requiring attention include the following:
 - Maternal health (statewide)
 - Mental Health
 - Respiratory Illnesses (e.g., COPD, pneumonia)
 - Heart disease
 - Stroke

Community Demographic Profile

The Charlotte Hungerford Hospital CHNA service area is highly rural compared to the state average, yet life expectancy is the same.

Table 1: Charlotte Hungerford Hospital CHNA Service Area Characteristics

Charlotte Hungerford Hospital (CHH) service area is a less densely populated region of approximately 100,000 people, half (44.3%) of whom live in a designated rural area (suggesting access to care challenges and more difficult proximity to healthcare resources).

- The service area population density is less than one-third the Connecticut state average (212.8 compared to 705.2 per square mile).
- Even though the hospital service area is relatively rural, life expectancy is similar to the state average.

The Charlotte Hungerford service area is less demographically diverse than the state average (83.0% and 69.8% White, respectively) and the median age is older than the Connecticut average (44.5 and 40.9 years, respectively). The older median age and the higher percentage of people over 65 suggest a potentially greater need for chronic disease care and senior outreach activities.

- Black or African American residents of the Charlotte Hungerford service area comprise five percent (5.2%) of the population – less than half of the state average (10.7%).
- Approximately one of ten Charlotte Hungerford residents are Hispanic (10.7% compared to the 17.4% state average).
- The percent of people not proficient in English is notably lower in the Charlotte Hungerford CHNA service area is similar to the state average – 2.0% and 5.2%, respectively.
- The median age in the CHNA service area is nearly 45 years; however, there are notable differences based on race / ethnicity.

Measure	CHNA Area	State of CT
Population		
Total population	100,501	3,611,317
Population density (per square mile)	212.8	705.2
Life expectancy (years)	80.1	80.3
Population living in a rural area (%)	44.3%	12.4%
Age		
Under age 5 (%)	4.8%	5.1%
Over age 65 (%)	19.8%	17.4%
Median age	44.5	40.9
Race and Ethnicity		
Asian (%)	2.1%	4.7%
Black or African American (%)	5.2%	10.7%
White (%)	83.0%	69.8%
Hispanic (%)	10.7%	17.4%
Non-Hispanic (%)	89.3%	82.6%
Language and Birth Location		
Not proficient in English (%)	2.0%	5.2%
Born outside US (%)	9.5%	16.0%

Consistent with data throughout the state of Connecticut (and nationally⁵), Hispanic residents of the Charlotte Hungerford CHNA service area are much younger (median age approximately 28 years) than the area average (i.e., 44.5 years); the variance compared to Whites (approximately 48 years) is even more notable. Overall, non-White communities tend to be more than ten years younger than White community members.

Table 2: Median Age by Race-Ethnicity and Geography

Location	Asian		Black		White		Hispanic	
	Male	Female	Male	Female	Male	Female	Male	Female
State of CT	35.1	36.6	33.2	36.8	44.3	47.3	29.2	30.8
CHNA Area	34.9	41.2	36.4	33.5	46.3	49.7	27.5	29.1

- Statewide and in the CHNA service area, Whites are notably older than other racial or ethnic groups.
- Median ages for Asians, Blacks / African Americans, and Hispanics are approximately ten to 15 years younger than for Whites.



⁵ Median age of US Hispanics is 30.1 years compared to the overall median age of 38.5 years, according to the US Census Bureau.

People residing in the Charlotte Hungerford CHNA service area tend to have somewhat less education and lower median household income than the state average. However, about the same percentage of service area residents have a poverty profile similar to the state average: approximately the same percent (1) live below the poverty line, (2) are financially at-risk (as reflected in the Asset Limited, Income Constrained, [yet] Employed or “ALICE” score), and (3) are insured through Medicaid. The percentage of ALICE households is approaching two of five (39.2%) in Connecticut (only slightly higher than the service area (36.4%).

Table 3: Health-related Socioeconomic Measures

Measure	CHNA Area vs. CT Statewide			
	CHNA Area	State of CT	Point Variance	Percent Variance
Adults (over 25 years old) with a high school level education (%)	29.8%	25.8%	4.0	15.5%
Adults (over 25 years old) with at least a bachelor's degree (%)	35.4%	41.4%	-6.0	-14.5%
Employment rate, population aged 16 years-old and above (%)	94.8%	94.1%	0.7	0.7%
Gini Index of Income Inequality (0 = perfect equality in income distribution, 1 = perfect inequality in income distribution)	0.44	0.50	-0.06	-12.0%
Households with earnings below the poverty level (%)	9.4%	9.9%	-0.5	-5.1%
Median household income (\$)	\$87,778	\$90,213	-2,435	-2.7%
Households that are asset limited, income constrained, employed (ALICE) (%)	38.5%	39.2%	-0.7	-1.8%
Uninsured children (%)	2.0%	2.8%	-0.8	-28.6%
Uninsured adults (%)	4.6%	5.8%	-1.2	-20.7%
Population insured through Medicaid (%)	32.0%	32.1%	-0.1	-0.3%
Population living in areas with above median levels of area deprivation (ADI) (%)	58.3%	47.2%	11.1	23.5%
Population living in areas with above median levels of social vulnerability (SVI) (%)	36.1%	48.6%	-12.5	-25.7%
Population living in areas with below median rankings on the Environmental Justice Index (EJI) (%)	23.1%	42.2%	-19.1	-45.3%

- Nearly two of five Connecticut households are ALICE. ALICE households are made up of individuals and families who earn more than the federal poverty level but still struggle to afford basic necessities such as housing, childcare, food, transportation, and healthcare. Despite being employed, these households are financially vulnerable to healthcare and other crises due to low wages, high living costs, and limited savings.

- Notably fewer Charlotte Hungerford CHNA service area residents have a Bachelor's Degree (35.4% compared to 41.4% for the state), and median household income is about three percent lower than the Connecticut average (\$87,778 and \$90,213, respectively).
- Nearly three of five (58.3%) of Charlotte Hungerford CHNA service area residents live in areas with above median levels of area deprivation (ADI); one of three (32.0%) are Medicaid insured; and – as noted above – nearly two of five (38.5%) households are asset limited, income constrained yet employed (i.e., ALICE). This indicates that many working households are relatively affluent, but others struggle to remain economically viable.

There is an ongoing need for chronic disease care. Of the 14 health and chronic conditions included in Table 4, the percentage of Charlotte Hungerford CHNA service area residents afflicted by the conditions is very similar to the Connecticut state average in each case. Across the state, high cholesterol, high blood pressure, and obesity are common conditions, as well as mental health conditions such as depression.

Table 4: Health and Chronic Conditions

Measure	CHNA Area vs. CT Statewide			
	CHNA Area	State of CT	Point Variance	Percent Variance
Cancer (excluding skin cancer) among adults (%)	7.9%	6.9%	1.0	14.5%
Coronary heart disease among adults (%)	5.9%	5.2%	0.7	13.5%
High blood pressure among adults (%)	30.2%	29.7%	0.5	1.7%
High cholesterol among adults (%)	34.3%	33.4%	0.9	2.7%
Stroke among adults (%)	2.9%	2.8%	0.1	3.6%
Depression among adults (%)	22.0%	20.9%	1.1	5.3%
Mental health not good for two weeks or more among adults (%)	14.3%	14.6%	-0.3	-2.1%
Diagnosed diabetes among adults (%)	9.3%	9.4%	-0.1	-1.1%
Chronic kidney disease among adults (%)	3.0%	2.8%	0.2	7.1%
Obesity among adults (%)	28.5%	30.2%	-1.7	-5.6%
Chronic obstructive pulmonary disease among adults (%)	6.3%	5.7%	0.6	10.5%
Current asthma among adults (%)	10.5%	11.1%	-0.6	-5.4%
Fair or poor self-rated health status among adults (%)	12.8%	13.3%	-0.5	-3.8%
Physical health not good for two weeks or more among adults (%)	10.5%	10.0%	0.5	5.0%

- Though similar to state averages, chronic health conditions and vulnerabilities in the Charlotte Hungerford CHNA service area are sobering. Large numbers of residents require care for serious conditions. For many of these measures, the percentages are important, yet the numbers of individuals and families represented by the data is even more critical.
- Nearly one in three adults (30.2%, or over 20,000 adults) have high blood pressure; a similar percentage (34.3%) have high cholesterol.
- Nearly one in three (28.5%) are obese; more than one in 11 (9.3%, or approximately 8,000 adults) have diabetes.
- Data for the CHNA service area, as well as US data, underscore the ongoing presence of chronic condition-related health needs.⁶

⁶ According to the Rand Corporation, approximately three of five (60%) people suffer from one or more chronic diseases such as asthma, cancer, diabetes, or heart disease. Three of seven (42%) suffer from two or more. Available at [Reference Link](#)

Preventive health screening and substance use (i.e., tobacco and alcohol) in the Charlotte Hungerford CHNA service area tend to be similar to the state averages.

Table 5: Lifestyle and Behaviors

Measure	CHNA Area vs. CT Statewide			
	CHNA Area	State of CT	Point Variance	Percent Variance
Binge or heavy drinking (%)	15.4%	15.5%	-0.1	-0.6%
Current adult smokers (%)	14.0%	13.9%	0.1	0.7%
Fewer than 7 hours of sleep on average (%)	32.7%	33.6%	-0.9	-2.7%
No leisure time physical activity (% of adults)	20.5%	22.7%	-2.2	-9.7%
Taking medicine for high blood pressure control among adults with high blood pressure (%)	79.1%	75.9%	3.2	4.2%
Visits to dentist or dental clinic among adults (%)	70.4%	70.4%	0.0	0.0%
Visits to doctor for routine checkup within the past year among adults (%)	74.7%	75.3%	-0.6	-0.8%
Cervical cancer screening among adult women aged 21-65 years (%)	84.9%	86.0%	-1.1	-1.3%
Cholesterol screening among adults (%)	89.0%	88.3%	0.7	0.8%
Mammography use among women 50-74 years (%)	77.0%	80.2%	-3.2	-4.0%

- The percent of adult smokers in the CHNA service area is similar to the state average (14.0 and 13.9%, respectively).
- Reflecting adherence to medical advice, three of four (79.1%) Charlotte Hungerford CHNA service area residents who have been diagnosed with hypertension (High blood pressure) take condition-associated medication – slightly better than the state average.
- More than one in five service area adults (20.5%) have no leisure time physical activity – slightly lower than the state average (22.7%).
- Cervical cancer, cholesterol, and breast cancer screening rates are all similar to the Connecticut average.

Cancer rates vary tremendously based on race and ethnicity. For example, at the state and Litchfield County levels,⁷ cancer rates among Asians are approximately one-half the rates for Whites. However, Charlotte Hungerford CHNA service area cancer rates (measured at the Litchfield County level) are very similar to the state averages.

Table 6: Cancer Incidence Rates by County (Litchfield County), 2016 - 2020

Age-Adjusted Incidence Rate per 100,000 Population, 2016-2020										
Cancer Type	All Races		Asian		Black		White		Hispanic	
	County	State	County	State	County	State	County	State	County	State
All Cancer Sites	466.8	458.2	218.8	232.3	387.2	445.8	466.7	467.8	506.4	418.5
Breast (Female)	142.5	138.5	S	83.1	190.4	129.0	142.4	143.6	144.9	119.6
Colon & Rectum	31.2	33.6	S	19.2	S	38.0	31.9	33.0	S	36.4
Lung & Bronchus	59.5	55.2	S	24.0	S	53.7	60.4	57.7	S	38.4
Prostate	106.2	107.6	S	48.2	S	190.8	104.8	118.3	94.7	107.6

Note: "S" indicates the data have been suppressed at the source to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category.

Source: statecancerprofiles.cancer.gov

- Compared to the Connecticut state averages, Asians in the service area are diagnosed with cancer at a much lower rate – less than half of the “All Cancer Site” rates.
- Cancer rates among Whites are similar to the state average for most cancer sites.

⁷ Note that the CHH service area and “Litchfield County” are not synonymous though much of the CHH service area lays within Litchfield County. Second, cancer incidence and mortality data are only available at the county level.

Mortality and Morbidity

Including morbidity and mortality data in the CHNA is helpful for understanding the most pressing health challenges facing a population. Mortality data, such as the leading causes of death, provides insight into the diseases and conditions that have the most significant impact on life expectancy and community well-being. These statistics help identify patterns and disparities across different geographies or demographic groups. By analyzing causes of death — whether from chronic diseases like heart disease or cancer, or from external factors such as accidents — HHC may be better able to target services and allocate resources where they are most urgently needed.

Similarly, morbidity data — such as rates of hospitalizations, emergency department visits, and diagnoses of chronic or acute illnesses — offers a snapshot of the ongoing health burdens that affect residents' quality of life. This information highlights not only what conditions are most common, but also where gaps in preventive care, access to primary care, or health education may exist. Understanding patterns of illness and injury can guide the development of community health programs, outreach initiatives, and healthcare services aimed at reducing preventable hospitalizations and improving overall health outcomes.



Most Common Causes of Death (Mortality) with County-level Incidence and Comparisons

Litchfield County has mortality rates slightly higher than the Connecticut state rates for five of the six health conditions in the table below, yet each (except accidents) is notably lower than the US rates.

Table 7: Mortality Rates per 100,000 Population by County, Part 1 of 2 (The top six ranked causes of death)

County	Heart Disease	Cancer	Accidents & Adverse Effects	Chronic Lower Respiratory Disease	Cerebrovascular Disease	Alzheimer's Disease
Fairfield County	128.7	122.5	44.4	19.3	25.9	20.2
Hartford County	152.8	135.2	64.0	27.3	28.4	20.7
Litchfield County	136.3	139.1	69.8	31.9	30.6	23.5
Middlesex County	133.3	129.0	56.7	24.6	28.1	24.7
New Haven County	146.7	142.7	73.3	27.9	33.9	21.0
New London County	150.8	148.8	73.3	32.1	31.2	21.2
Tolland County	156.5	134.9	48.9	29.2	27.8	13.9
Windham County	179.5	159.3	76.7	47.0	29.0	23.4
Connecticut	144.0	135.6	62.1	26.6	29.4	20.9
US	167.5	146.0	56.6	36.9	38.9	30.8
Source: US DHHS, National Institute on Minority Health and Health Disparities, 2018-2022. Available at Data Link						

- For each of the six most common causes of death except Alzheimer's Disease, Fairfield County rates are better than (i.e., lower) other counties' rates, as well as the state and US rates.
- For each of the top six causes of death except Accidents & Adverse Effects, the Connecticut rates are better than (i.e., lower) the US rates.
- Litchfield County mortality rates tend to be slightly higher than the Connecticut average.

Table 8: Mortality Rates per 100,000 Population by County, Part 2 of 2 (Causes of death ranked seven through 13)

The following conditions are also among the most common – ranked seven through 13 – causes of death in the hospital CHNA service area. Again, Litchfield County rates of death per 100,000 population tend to be higher than some other counties, yet the Connecticut state average rates tend to be at, or below, US rates. In Litchfield County, rates tend to be higher than the state average.

County	Diabetes	Kidney Disease	Suicide & Self-Inflicted Injury	Liver Disease	Septicemia	Pneumonia	Influenza
Fairfield County	13.7	10.2	8.3	7.9	9.8	9.1	1.5
Hartford County	17.2	15.0	10.2	10.7	12.7	9.9	1.8
Litchfield County	16.1	11.5	13.9	14.2	11.2	11.5	1.5
Middlesex County	13.6	9.3	11.6	12.6	8.2	7.9	NA
New Haven County	17.3	15.2	9.9	10.8	12.5	9.1	1.5
New London County	16.2	15.0	12.9	12.7	12.2	12.8	2.1
Tolland County	13.3	13.9	13.3	13.1	10.0	11.9	NA
Windham County	24.2	12.6	14.4	12.9	14.5	13.6	3.0
Connecticut	16.1	13.2	10.3	10.6	11.5	9.9	1.6
US	23.5	13.2	13.9	12.8	10.0	11.0	1.5
Source: US DHHS, National Institute on Minority Health and Health Disparities, 2018-2022. Available at Data Link							

- The Litchfield County suicide, liver disease, pneumonia, and influenza mortality rates are approximately 20% to 30% higher than the Connecticut average rate.
- The Connecticut mortality rate for each condition on the table above is lower (or near) the US rates.

Hospital Use Characteristics (Morbidity) and ChimeData from the Connecticut Hospital Association

The following CHIME-based⁸ hospital data represent the count of patients who had at least one hospital encounter (based on discharge data), in either the Inpatient, Emergency Department, or Observation service settings, with a principal diagnosis that matches one of the ICD-10-CM codes associated with the given condition or health indicator.⁹ The data also allows the comparison of the CHH CHNA service area data to the Connecticut state average. When doing so, important differences sometimes arise.¹⁰



⁸ ChimeData, provided by the Connecticut Hospital Association, is a robust data and analytics resource that offers hospital and healthcare utilization data across the state. It features interactive tools that support analysis of key health issues impacting the hospital service area. In addition, ChimeData also enhances hospitals' ability to measure an area's health trends against statewide benchmarks.

⁹ A more complete and extensive description is found in the Appendices, and the ICD-10 codes associated with each health indicator are also all listed in Appendix 10: Code Reference Sheet.

¹⁰ All hospitals in the CHNA service area, not only Charlotte Hungerford Hospital.

Hospital utilization rates in the hospital service area notably vary versus the Connecticut state averages. The in-depth data in the CHNA document supports broad-based efforts to address maternal health and life expectancy issues, while the CHIME data below suggest that, in addition to maternal health, four additional health conditions are highly common and/or are higher than state rates.¹¹

Charlotte Hungerford Hospital			
Health Indicator	Utilization Rates per 100,000		Percent variance to the State
	Hospital CHNA Area	State of Connecticut	
Mental Health Composite	13.0	10.4	25.0%
Sepsis	8.1	8.4	-3.6%
Heart Failure (HF)	6.8	4.3	58.1%
Substance-Related Disorders (SRD)	9.3	8.1	14.8%
Community Acquired (CommAcq) Pneumonia	5.6	4.3	30.2%
High Blood Pressure (HBP)	4.5	4.5	0.0%
Chronic Obstructive Pulmonary Disease (COPD)	5.6	2.2	154.5%
Acute Myocardial Infarction (AMI)	3.0	1.8	66.7%
Stroke	4.8	2.5	92.0%
Diabetes - Uncontrolled/Short Term Complications (Unc-STC)	2.6	2.7	-3.7%
Asthma	2.1	2.8	-25.0%
Coronary Artery Disease (CAD)	1.4	1.0	40.0%
Arthritis	3.0	1.8	66.7%
Diabetes - Long Term Complications (LTC)	1.8	1.3	38.5%
Overweight/Obesity	0.8	1.0	-20.0%

Note that on a “Utilization Rate per 100,000 Population” measure, hospitalization rates for coronary artery disease (CAD), arthritis, and others is much higher than the state average, yet the raw numbers are relatively low. For instance, “2.2” is 120% higher than “1.0” (see CAD, below), yet the variance equates to only 1.2 people out of every 100,000. Therefore, variances to state data need to be carefully considered.

- Based on CHIME-reported utilization rates and other research, health conditions requiring special focus include the following:
 - Maternal health (statewide)
 - Mental Health
 - Respiratory Illnesses (e.g., COPD, pneumonia)
 - Heart disease
 - Stroke

¹¹ Note that tables reflecting all HHC hospital CHNA service areas and state comparisons are contained in the appendices.

Maternal Health

Maternal health remains a critical indicator of a health system's overall performance, reflecting access to quality care during pregnancy, childbirth, and the postpartum period. Nationally, the maternal mortality rate has fluctuated in recent years, with a slight decrease from 22.3 deaths per 100,000 live births in 2022 to 18.6 in 2023. However, stark disparities persist across racial and age groups. In 2022, non-Hispanic Black women experienced a maternal mortality rate of 49.5—more than twice the rate of their White counterparts. Additionally, maternal deaths among women aged 40 and older were significantly higher (87.1 per 100,000 live births) compared to younger women. Mental health conditions, cardiovascular disorders, and hypertensive complications continue to be leading causes of maternal mortality, underscoring the need for comprehensive, interdisciplinary care models that integrate mental and physical health services.

In Connecticut, maternal and infant health outcomes generally outperform national averages, though important disparities remain across racial, ethnic, and geographic lines. The state's maternal mortality rate (16.7 per 100,000 live births) is below the national average, and the infant mortality rate (4.5 per 1,000 live births) ranks among the nation's lowest. Nonetheless, outcomes vary significantly by county and demographic group. Rural areas such as Windham and Litchfield Counties face provider shortages and higher risk factors like tobacco use and preterm births, while urban counties like Hartford and New Haven show pronounced racial disparities in outcomes like low birth weight and first trimester prenatal care access. Black infants face mortality rates more than twice those of White infants, and Black women face increased barriers to care. These disparities point to persistent systemic challenges and emphasize the importance of targeted interventions, improved access to culturally responsive care, and sustained investments in maternal health infrastructure.

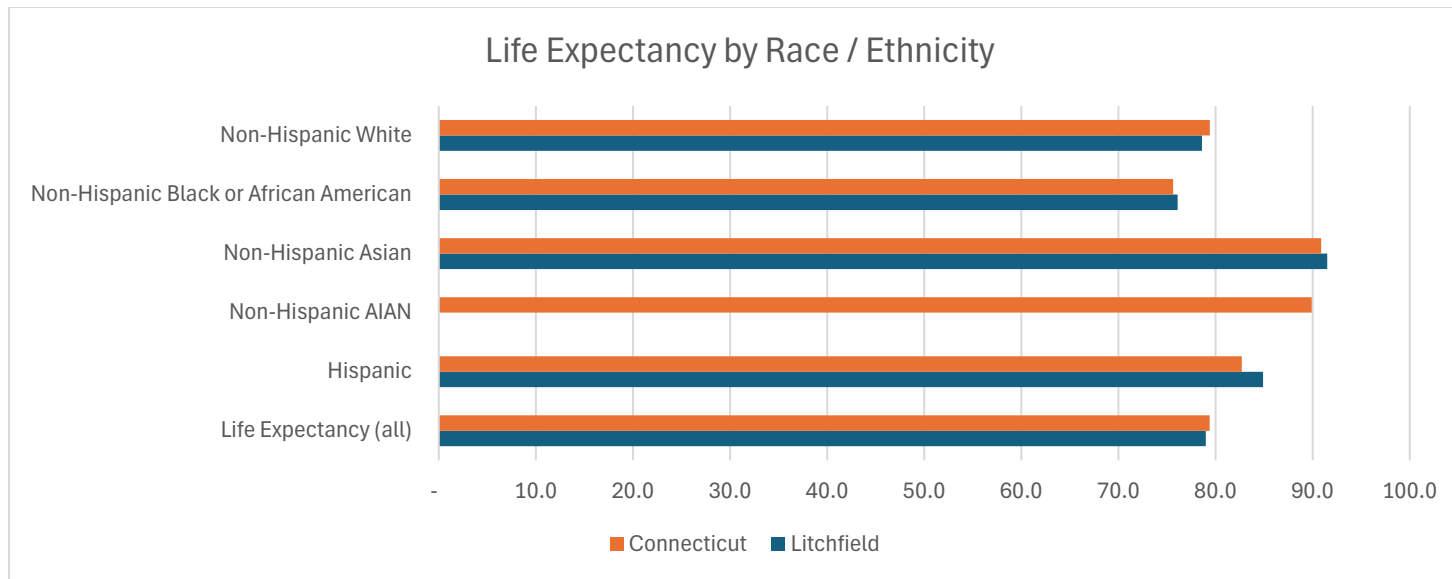
Additional narrative and data regarding maternal health is included in the appendices.

Life Expectancy

Life expectancy is a foundational indicator in community health needs assessments because it encapsulates the cumulative impact of various health, social, and economic conditions over a population's lifespan. It reflects not only the prevalence of chronic diseases and behavioral risk factors, but also broader issues such as access to care, education, income, and environmental quality. A lower life expectancy, as seen in Litchfield County, signals concerns about health challenges that may be targeted by public health strategies. Incorporating life expectancy data into a community health assessment helps identify priority populations, set benchmarks for improvement, and guide resource allocation to the areas most in need.

Life expectancy in Litchfield County is 79.0 years, which is near the Connecticut average of 79.6 years and closely mirrors the national average. This figure reflects a range of health challenges, including higher rates of premature death and poor physical and mental health. Litchfield County's premature death rate—measured as years of potential life lost before age 75—stands at 7,200 per 100,000, notably above Connecticut's 6,500. Indicators such as 11% of residents reporting poor or fair health, 3.0 poor physical health days per month, and 4.7 poor mental health days underscore chronic health burdens in the community. These statistics point to a need for stronger chronic disease management, mental health support, and access to quality healthcare.

Behavioral health risks and healthcare access issues further inform the county's life expectancy concerns. Smoking (13%) and obesity (27%) rates are slightly lower, or near, both state and national averages, while access to exercise opportunities (81%) lags behind the rest of Connecticut (93%). Healthcare provider shortages are evident, with Litchfield County's primary care ratio at 1,810:1, 50% higher (worse) than the state's 1,210:1. These barriers limit preventive care uptake and delay treatment for chronic conditions. Additionally, elevated injury death rates (90 per 100,000) and a spike in mortality among adults aged 40 to 44 highlight the urgency of targeted interventions to improve population health and life expectancy in Litchfield County.

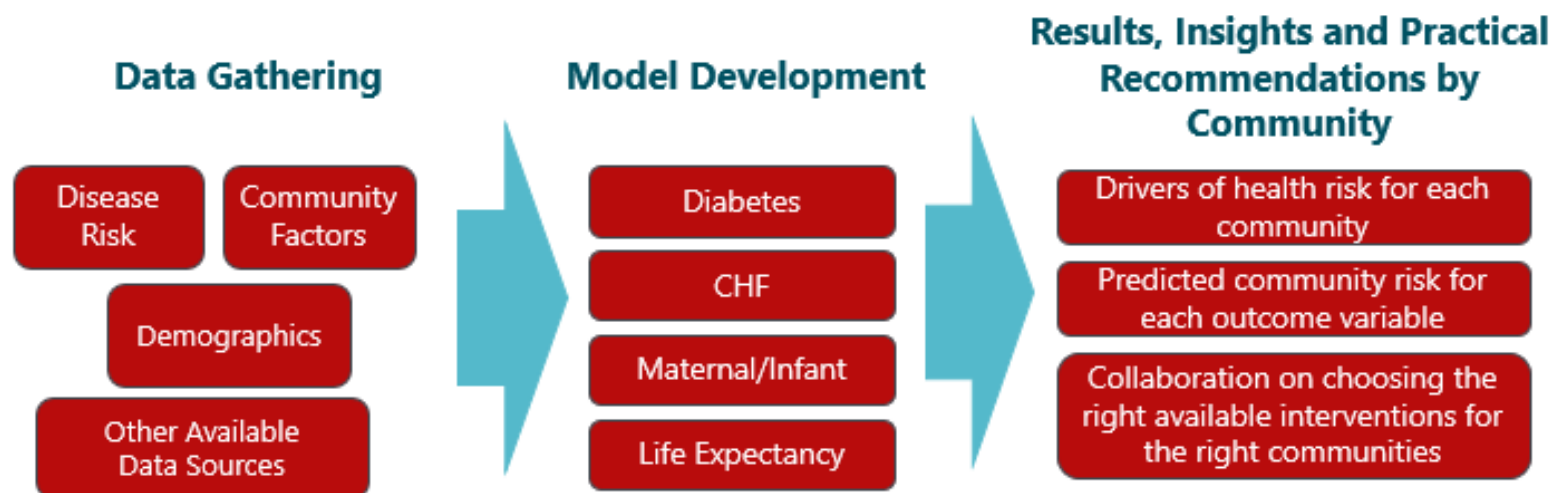


Additional narrative and data regarding life expectancy is included in the appendices.

Health-related Social Needs and Other Factors Impacting Health and Predictive Analytics

To increase the impact of its CHNAs and CHIPs, Hartford HealthCare (HHC) has taken additional steps to evaluate four core health conditions in the state. This deeper evaluation aims to better understand the underlying health-related social need factors driving risk for these outcomes. By understanding these factors, HHC can more effectively prioritize interventions and resources within the communities served, ultimately maximizing HHC's positive influence. Specifically, HHC examined community health risk profiles developed using machine learning and predictive analytics. These analyses identified and evaluated important factors contributing to negative outcomes associated with diabetes, congestive heart failure, maternal/child health, and life expectancy. The resulting insights allow HHC to optimize interventions by 1) identifying key factors driving risk in the four areas, 2) establishing a solid basis for data-driven decision-making while setting expectations around community-based trends, and 3) pinpointing where in our communities to focus efforts, both for improvement and for leveraging best practices.

Optimizing insights and interventions through predictive modeling followed three essential steps:



1. Data Gathering – disease risk, health-related social need factors, Demographics, Secondary Sources (as available)
2. Model Development – Machine Learning focused on: Diabetes, CHF, Maternal/Infant, Life Expectancy (Life Expectancy results not discussed herein, but are available)
3. Results, Insights, and Practical Recommendations – social/behavioral/community drivers of health risk, predicted health risk based on community profile, intervention selection

Using the predictive modeling approach outlined above, we focused on health issues within our service areas that are at risk of accelerating due to underlying demographic, lifestyle, and other community trends. To address these potential challenges proactively, we have identified the key drivers behind each issue (i.e., the impacting demographic or lifestyle trends) and potential key levers (actions or initiatives likely to positively impact the associated negative outcomes). The following provides a high-level summary of these findings.

Health-Related Social Need Factors Impact on Diabetes

Key Drivers of Risk

- Smoking is the single most important factor increasing diabetes risk
- Higher percentage (%) drive alone (physical and social isolation)
- Low housing occupancy rates

Key Levers (particularly in communities with high non-white and high elementary student to teacher ratios)

- Increase tobacco cessation activities, promote physical activity and good nutrition in communities identified as having both high smoking rates and high obesity rates
- Increase utilization and availability of transportation services, particularly in communities with high percentages of individuals who drive alone, which increases physical inactivity and social isolation

Health-Related Social Need Factors Impact on Cardiovascular Risk

Key Drivers of Risk

- High SNAP usage
- Low Educational Attainment
- Higher percentage (%) drive alone (physical inactivity and social isolation)

Key Levers (particularly in communities with poor, non-Hispanic white populations)

- Increase utilization and availability of transportation services, as driving alone is associated with increased cardiovascular risk (in addition to diabetes risk).
- Increase utilization and availability of language translation services, both in hospitals and community settings, particularly in areas where increasing services is likely to have an impact.

- Leverage worship facilities and libraries as community education outlets for cardiovascular health, considering bringing library-based services to communities lacking them.

Health-Related Social Need Factors Impact on Maternal Health and Delivery Risk

Key Drivers of Risk

- High SNAP and Medicaid Usage
- Low educational Attainment
- Low housing occupancy
- Higher percentage (%) drive alone (physical inactivity and social isolation)

Key Levers (particularly in communities with poor, diverse populations with industries focused on skilled labor/trade)

- Target smoking cessation efforts to communities with high SNAP utilization and low educational attainment, and specifically to individuals from Asia, Native Americans, and/or Pacific Islanders who are more likely to smoke while pregnant.
- Increase utilization of prenatal care in communities with low educational attainment and single expecting mothers and/or Black expecting mothers.

Health-Related Social Need Factors Impact on Infant Mortality, Low Birth Weight/Pre-term Births, Cesareans

Key Drivers of Risk

- High SNAP usage
- Higher percentage (%) drive alone (physical inactivity and social isolation)
- Low non-Hispanic White population
- Single parent households

Key Levers (particularly Hartford, which ranked in the top 2 of predicted risk for **all** delivery outcome risks measured; and Bridgeport with high cesarean risk)

- Increase health education efforts, addressing existing health conditions like diabetes or hypertension.

- Focus interventions on communities with high proportions of single-parent households and high SNAP benefit recipients, as these are major drivers of increased delivery risks across all measured outcomes.
- Promote physical activity and good nutrition efforts, as high rates of driving alone are associated with less physical activity and higher stress, contributing to delivery risks.
- Investigate effective programs within veteran communities for potential replication because they tend to be associated with better delivery outcomes. Additionally, prioritize resources in communities with low marriage rates to support single parents and address increased delivery risks.

Qualitative Research Highlights

Qualitative research was conducted to gain a deeper understanding of the healthcare challenges and opportunities facing the communities we serve. Interviews were conducted with hospital leaders and external community partners. They provided valuable insights into the experiences, concerns, and priorities of healthcare professionals, administrators, and community leaders, all of whom play a crucial role in ensuring access to healthcare services. The qualitative research respondents report that the community faces several critical challenges in addressing the health. In broad categories the challenges include limited access to healthcare services, behavioral health barriers, HRSN factors (e.g., housing, poverty, the effects of homelessness, etc.), chronic health conditions, and other factors. More granular details from the qualitative research follow.

Qualitative research identified the following lists of community health needs:

- **Access to Specialty Care & Financial Barriers** – Despite some improvements, access to specialty services (e.g., Orthopedics) remains difficult, especially for Medicaid patients.
- **Transportation Access** – Unreliable and insufficient transportation options (e.g., Veyo) hinder access to healthcare and other essential services.
- **Affordable Housing** – A worsening shortage of affordable housing, especially affecting the elderly, with a need for stronger use of available resources and case management.
- **Food Insecurity / Nutrition** – A growing concern, particularly following the closure of a grocery store, increasing food deserts despite positive feedback on Food4Health.
- **Mental Health Services** – Increased mental health issues across all demographics, with a lack of providers and added strain post-COVID, especially among Latino communities and youth.
- **Chronic Disease Management** – High prevalence and severity of chronic conditions (e.g., COPD, diabetes, fatty liver), often with multiple comorbidities.
- **Substance Use and Alcohol Misuse** – A reported increase in use and severity of issues, even with fewer overdose deaths, requiring ongoing attention.
- **Services for the Elderly** – Concerns about aging adults, caregiving challenges, and grandparents raising grandchildren; coupled with housing and financial struggles.
- **Support for Immigrant and Spanish-speaking Populations** – Increased immigration has created social needs that aren't being met due to a shortage of bilingual staff and culturally competent services.

- **Community Connection and Engagement** – Strong desire for more youth centers, faith-based partnerships, and safe spaces for recreation, trust-building, and cultural acceptance.
- **Case Management and Navigation Services** – Although positions like Housing Navigator are helpful, there's a need for more follow-up and support after initial assistance.
- **Isolation and Social Disconnection** – Feelings of fear and isolation persist, partly due to a lack of inclusive, welcoming community spaces.
- **Youth and Family Engagement Venues** – More venues are needed to support family engagement and healthy youth development.
- **Workforce Shortages in Healthcare and Social Services** – Shortages, especially among bilingual staff, impact care delivery in both urban and rural areas.
- **Rural Healthcare Access** – Rural communities still face greater challenges accessing primary and specialty care.

Community Wellbeing Survey and Other Research

The Community Wellbeing Survey was administered in 2024 throughout Connecticut. It included a diverse and geographically expansive set of respondents. The survey covered topics such as those listed below.

- Chronic disease
- Community satisfaction
- Health risks
- Healthcare access
- Housing and financial well-being
- Mental health
- Neighborhoods
- Nutritional Security
- Transportation
- Well-being and support

The resulting data was categorized and analyzed by hospital service area. Highlights of the Wellbeing Survey for the Charlotte Hungerford Hospital service area are shown below while more detailed visuals are included in the appendices.

Chronic Disease

The Chronic disease section of the Wellbeing Survey focused on hypertension, diabetes, and heart disease. Survey results showed that Charlotte Hungerford Hospital service area is a “mixed bag” of outcomes compared to state averages – favorable incidence rates compared to the state average for hypertension and diabetes, yet unfavorable (or similar to) the state averages for heart disease measures and asthma.

When examining chronic disease among specific communities within the hospital service area (as opposed to comparison to state averages), the incidence of diabetes and heart disease was slightly higher among men than women, while asthma rates among women were nearly twice as high as for men. Examples of other data-support results include the following:

- Hypertension prevalence is 13% among those with income under \$30,000, compared to 8% for higher-income groups.
- Diabetes is reported by 8% of respondents with income under \$30,000, versus just 4% for higher-income groups.
- Heart disease is relatively stable at 4% across most groups but slightly higher in low-income populations.



Community Satisfaction

Community satisfaction refers to impressions that may impact quality of life and lifestyle, such as overall satisfaction with the town where you live, opinions about whether you live in a place good to raise children, local greens spaces or parks being in good condition, and a responsive local government. The survey data shows that five of six Connecticut residents (83%) are satisfied with their town; about the same (82%) in the hospital service area believe so. Additionally, though, people with household incomes under \$30,000 tend to be less satisfied with each of the Community Satisfaction measures. One of the bigger variances is that six of seven hospital service area residents (82%) with incomes over \$100,000 believe that where they live is a good or excellent place to raise kids while far fewer (64%) of others with income below \$30,000 believe that to be true. In addition, note the following:



- Only 35% of low-income residents believe local government is responsive, compared to 59% of middle-income and 84% of high-income respondents.
- Satisfaction with local parks is 64% for low-income residents, but 94% for middle-income and higher groups.

Health risks

Health risks include a snapshot of issues that tend to reflect general health conditions in the hospital service area. They include self-reported overall health, the amount of leisure-time exercise and asthma rates.

Wellbeing survey results highlight several health risks among adults in the Charlotte Hungerford Hospital service area, with disparities evident by income level. Overall, slightly over half (53%) of adults in the service area rated their health as excellent or very good, similar to the statewide average (56%). This figure drops to 31% among those with incomes under \$30,000, while rising significantly to 59% among higher-income residents, reflecting a notable income-based disparity in perceived health. However, this may well also be correlated with age, as older respondents tend to face more health challenges than younger ones. Other examples of data-support results include the following:



- Smoking rates are nearly twice as high for those earning under \$30,000 compared to those earning over \$100,000.
- Obesity is reported more frequently among low-income respondents.
- Physical inactivity is significantly higher in the under \$30,000 group compared to other income tiers.

Healthcare access

Healthcare Access refers to community members who (1) have health insurance and, (2) have a medical home (a doctor, clinic, or other provider where they commonly seek – or could seek – medical care). The survey showed that most adults in the hospital service area (94%) have access to health insurance (slightly above the statewide average of 93%). One of six (18%) residents overall lack a medical home. Examples of other data-support results in the survey include the following:

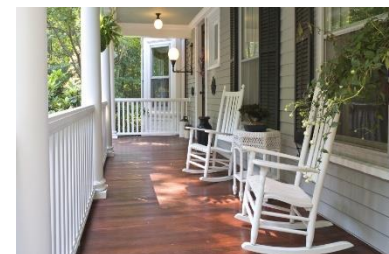


- Low-income individuals report notably greater difficulty affording medical care and prescriptions.
- Preventive care usage (e.g., annual checkups, dental care) increases steadily with income.
- Insurance coverage is nearly universal in higher-income groups, while coverage gaps remain in lower-income populations.

Housing and financial well-being

Nationally, as well as in the hospital service area, housing costs and the lack of affordable housing options are growing. Survey results reveal important insights into housing stability and financial well-being among adults in the Charlotte Hungerford Hospital service area.

Overall, two of three (68%) residents report owning a home or living with a homeowner – higher than the statewide average (63%). However, housing insecurity affected one of 11 (9%) area residents in the past year, aligning closely with the state average (10%), though this figure rises to 16% among Latino respondents. Financial strain is also more pronounced among lower-income individuals (i.e., under \$30,000), with two of three (68%) reporting they are “just getting by financially” (or worse) compared to only 19% of higher-income residents (i.e., over \$100,000 per year). While homeownership is relatively high in the hospital service area, a notable portion of lower-income residents continue to face financial and housing-related vulnerabilities that could negatively impact overall well-being. Additional survey results include the following:



- Over 50% of those earning under \$30,000 report difficulty paying for housing.
- Food insecurity is reported by a large proportion of low-income residents and virtually none in the highest income group.
- Eviction risk and inability to pay utility bills are strongly correlated with low income.

Mental Health

Mental health – or, feelings of being anxious or depressed – impact overall health and the ability to enjoy a quality lifestyle. In the hospital service area, one in eight (12%) of survey respondents say that they feel anxious while one of ten (10%) feel down or depressed – both rates are slightly better than the Connecticut state averages of 13% and 11%, respectively. Other data-support results include the following:

- Frequent stress is reported by a majority of respondents earning under \$30,000.
- Feelings of loneliness or isolation are significantly higher in lower-income groups.
- Access to mental health services is much lower among low-income respondents.



Neighborhoods

Neighborhood safety components – cleanliness, and community cohesion – are critical aspects of total community health and well-being. These perceptions tend to increase with income level. Other data-support survey results include the following:

- Only 44% of low-income residents feel their neighborhood is safe, compared to over 70% of high-income residents.
- Sidewalk availability and street lighting are rated lower in low-income areas.
- Sense of belonging is weaker in low-income neighborhoods.



Nutritional Security

Food insecurity means being unsure of being able to acquire healthful, nutritional food for yourself and family members. In the hospital service area, more than one of six survey respondents (17%) – and more than one of three (36%) of those with annual income under \$30,000 – experienced food insecurity within the past 12 months. About two of three people experiencing food insecurity visited a food pantry. As with most other measures reflected in the survey, higher annual income highly correlates with easier access to health and well-being. Examples of data-support results include the following:

- Access to fresh produce is reported as insufficient by a majority of respondents under \$30,000.
- Skipping meals due to financial concerns is a common occurrence in lower-income groups.
- Participation in food assistance programs is concentrated among the lowest income group.



Transportation

Reliable transportation is one of the fundamental components of being able to access health services as well as other resources impacting the quality of life. In the hospital service area, most people (86%) have access to reliable transportation – similar to the state average (86%). However, of those who did not have transportation, half (49%) said that at some point within the past year, lack of reliable transportation limiting their ability to access health services. Survey data points include the following:



- Dependence on others for rides is significantly higher among those earning under \$30,000.
- Missed medical appointments due to lack of transportation is a key barrier for low-income individuals.
- Use of public transit is more common among lower-income groups, though availability remains limited.

Well-being and Support

As with many other survey-included measures, feeling satisfied with life and receiving social and emotional support are highly correlated with income; however, higher income is no guaranty of positive outcomes. For example, four of nine (44%) of lower income hospital service area survey respondents (under \$30,000 per year) are satisfied with life, compared to more than three of four (78%) higher income survey respondents (i.e., those with annual income over \$100,000). Although people with higher incomes tend to be more satisfied a notable portion (22%) are not. Survey results support the idea that higher income positively impacts perceptions and access to healthy options, yet it is no guaranty. Examples of data-support results include the following:



- Self-reported well-being scores are lowest in the under \$30,000 annual income group.
- Health-relates social support – having someone to count on in a crisis – is reported as lacking by many low-income respondents.
- High-income groups report higher levels of optimism, resilience, and satisfaction with life.

The appendices contain detailed graphics reflecting Wellbeing Survey comments noted above.

Data Analysis and Community Input Summary

To develop a comprehensive and accurate understanding of community health needs, we employed a multi-modal approach that included the collection and analysis of quantitative data from validated secondary sources, qualitative feedback from focus groups and stakeholder interviews, results from a broad-based community survey, and trends in health service utilization data. Each contributed valuable perspectives and insights, offering both depth and breadth to our understanding of the health status, service gaps, and health-related social needs affecting the population. The resulting information reflects not only the voices of individuals and organizations within the community, but also the evidence base that supports data-driven planning for health improvement.

After gathering and reviewing all sources, we synthesized the findings into a single, integrated list of community health needs. This list represents a de-duplicated and thematically aligned summary of the priorities that emerged most consistently across data sources. The list of needs, in alphabetical order and grouped in seven broader categories, is shown below.

Access to Care

1. Affordable and accessible healthcare – Cost of care, insurance barriers, and provider shortages (especially Medicaid-accepting).
2. Primary care provider availability – Need for more PCPs, especially in underserved areas.
3. Specialized medical care access – Diabetes, respiratory illness, cardiovascular disease, stroke, liver disease.
4. Care navigation and case management – For complex needs and newcomers to healthcare.
5. Transportation to healthcare and services – Lack of access to transit is a barrier to care.
6. Health literacy and insurance navigation – Understanding services, coverage, and care options.
7. Language and interpretation services – For patients with limited English proficiency.
8. Culturally competent care – Sensitivity to cultural and ethnic differences, especially for Latino communities.
9. Increased capacity of health and social services – More providers, extended hours, and integrated care options.

Mental and Behavioral Health

10. Access to mental health services – General shortage of services for all ages.
11. Shortage of mental health providers – Especially acute for youth, families, and the Latino community.
12. Services for anxiety, stress, behavioral health – Widespread need across age groups.
13. Suicide prevention programs – Intervention, education, and support.
14. Substance use disorder prevention and treatment – Addressing drug use, overdoses, and addiction recovery.

Chronic Disease Prevention and Wellness

- 15. Chronic disease prevention and early detection – Especially diabetes, hypertension, and heart disease.
- 16. Obesity prevention and support – Nutrition education, fitness, and clinical care.
- 17. Nutrition and food security – Consistent access to healthy and affordable food.
- 18. Expanded preventive care and health education – Screenings, outreach, and self-management resources.

Maternal, Child, and Family Health

- 19. Maternal health services – Prenatal, perinatal, and postpartum care access.
- 20. Accessible and affordable childcare – Crucial for working families and child development.
- 21. Caregiver support services – For those supporting medically fragile or aging loved ones.
- 22. Pediatric and adolescent support services – Includes mental, physical, and social health services.

Aging and Senior Services

- 23. Senior healthcare and geriatric services – Coordinated care, chronic condition management, mobility.
- 24. Senior care navigation – Help with navigating benefits, services, and long-term support.

Health-related Social Need Factors

- 25. Affordable and quality housing – Stable, safe housing critical for health.
- 26. Risk of homelessness and housing insecurity – Emotional and financial stress from potential housing loss.
- 27. Unemployment and underemployment – Access to stable jobs and workforce support.
- 28. Food security and fresh food access – Affordable, nutritious options needed consistently.

Community and Social Well-being

- 29. Community connection and inclusion initiatives – Reducing isolation, fostering belonging.
- 30. Recreational and community-building activities – For youth, adults, and families to stay engaged and active.

“What have we already accomplished or initiated?”

Evaluation of 2023–2025 Implementation Plan

Summary

As a guide to developing the 2025-2027 CHNA, HHC evaluated the higher-priority issues identified in the previous (2022) CHNA and subsequent targeted Implementation Plan (IP) / Community Health Improvement Plan (CHIP) activities designed to address them. This section summarizes key activities and highlights how HHC worked in partnership with community members, underserved communities, and local organizations to improve health outcomes. Guided by the insights of stakeholders gathered through interviews, focus groups, and outreach to often hard-to-reach communities, HHC pursued initiatives that responded to critical issues such as the following:

- Promote Healthy Behaviors and Lifestyles
- Reduce the Burden of Chronic Disease
- Improve Health-related Social Needs, and Access to and Coordination of Care and Services
- Enhance Community-Based Behavioral Health Services.

It addressed these priorities between 2023 and 2025 through local and systemwide activities.

The 2025 -2027 CHNA builds on this momentum, offering a comprehensive overview of the progress made and lessons learned over the past three years. This CHNA report includes detailed data appendices and community narratives that illustrate both the challenges and the resilience found throughout the region. HHC’s regional teams have continued to prioritize community-informed solutions to support HHC’s commitment to community health, collaboration, and accountability.

A description of hospital service area initiatives follows.

Local Charlotte Hungerford Hospital Activities

The 2022 Community Health Needs Assessment (“CHNA”) for Charlotte Hungerford Hospital leveraged numerous sources of local, regional, state and national data along with input from community-based organizations and individuals to provide insight into the current health status, health-related behaviors and community health needs for the Hospital service area. In addition to assessing traditional health status indicators, the 2022 CHNA took a close look at factors such as economic insufficiency, housing, transportation, education, fresh nutritious food availability, and neighborhood safety. These two enhancements are in response to the lessons of COVID and in recognition of an emerging national priority to identify and address healthcare access.

HHC and CHH are committed to addressing these disparities and challenges through its Community Health Improvement Plan (CHIP). The intent of our CHIP is to be responsive to community needs and expectations and create a plan that can be effectively executed to leverage the best of the system resources, regional hospital and network resources, and community partners. The CHIP supports HHC’s mission “to improve the health and healing of the people and communities we serve” and is part of HHC’s vision to be “most trusted for personalized coordinated care.” More specifically, the CHIP is collectively aimed at living our values which remind us all to do the just thing.

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

The 2022 assessment identified the following as priority needs for 2022-2025 across all Charlotte Hungerford Hospital geography:¹²

- Better meet the social and mental well-being needs of those we serve
- Expand access to culturally responsive care
- Address health through housing
- Reduce food insecurity and increase access to healthy foods
- Improve community health in partnership with others

CHH addressed these priorities between 2023 and 2025 through local and systemwide activities. Some examples of the strategies and direction of the activities follow.

¹² Note: For each of the higher-priority needs, the greatest proportional impact can be seen by having additional focus on communities such as people of color, and others who have historically lacked adequate access to services.

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

- **Community Care Team:** continued development with 8 active patients and total of 12 patients assisted in partnership with 9 community organizations.
- **Center for Healthy Aging:** 247 Dementia Coaching Sessions, 44 Events held, 1368 event attendees, ED staff dementia training

Expand Access to Culturally Responsive Care

- **Culturally and Linguistically Appropriate Services (CLAS) Training:** Completed staff training in identified units- Emergency Dept., Outpatient Behavioral Health, Inpatient Maternity, as well as CHH Cabinet Leadership forum: 50 trained.
- **Diaper Connections Program:** Initiated CHH Community Health Dept. February 2023: To date 135,089 diapers distributed 160 clients served.
- **Maternal Health Project:** community survey developed and conducted sample size-50, Maternal Education Series Developed- Baby and Me: 4 sessions 37 participants.
- **Neighborhood Health Clinics:** Target communities Torrington and Winsted 4-5 clinics per month. 54 events, 882 patients.

Address Health Through Housing

- **Cold Weather Shelter Supportive Services:** *Provided* at no added cost for Operation Overflow 12/1/2022-4/15/2023 - 115 unduplicated people in shelter including 5 families. FY 23-24 provided healthcare services to clients- 89 patient visits.
- **Housing Navigator Position:** Grant awarded to support CT Coordinated Access Network (CAN) system for housing- 152 clients completed CAN assessments.
- **Affordable and Supportive Housing Initiatives:**
Vacant Housing Unit Assessment - Completed survey sample size 200. Multi-Family Unit Restoration for affordable rent- collaboration with Torrington Affordable Housing Corp., Torrington Savings Bank and Housing Solutions to increase affordable multi-family homes to market.
Supportive Housing Project- location identified for potential 40 Single Occupancy Units collaboration with Y Housing, CT DOH, Torrington Public Schools and the City of Torrington.

Reduce Food Insecurity and Increase Access to Healthy Foods

- **Summer Produce RX program:** Grant awarded in collaboration with COG, Regional FoodHub, Community Health and Wellness, and two Food Pantries to provide 16 weeks of fresh produce to 75 families in Winsted and Torrington 150 participants with CHH Registered Dietitian led monthly taste testing and Children’s Cookbook distribution.
- **CHH Food4 Health Clinic and Rooftop Farm:** December 2023 launch with patients from HHC provider clinics 75 patients assisted 690 clinic visits. Rooftop Farm installed 115 pounds of produce harvested for the clinic.
- **CHH Health Vending Machine Initiative:** assessed and updated all six CHH on campus vending machines to provide healthier options 60/40 balance.

Improve Community Health in Partnership with Others

- **Fit Together Initiatives:**
Sue Grossman Greenway Mile Marker Project: replaced mile markers in ½ mile increments for 6-mile round trip trail between Torrington and Winsted.

Family Bicycle Rally: May 2024 in collaboration with 12 Community Partners 100 participants with Helmet Giveaways, Biking promotion and safety.

Mad River Recreation Project: Advocacy for CT Recreational Trails Grant- Winchester awarded 60K for design phase 1 parking lot enhancement with the goal to increase physical activity utilization.

Blender Bike Summer 2024: 5 Events with over 200 community members engaged in healthy living tips and smoothie recipes.
- **Provider Education with Health Screening Events:** 10 events with 156 participants.
- **Social RX Programs:** RX for the Arts with Warner Theater and RX for KidsPlay Museum launched April 2023 Warner Theater- 198 tickets redeemed valued at \$7,572 KidsPlay Museum- 146 vouchers redeemed valued at \$2,044.
- **Torrington Kids Marathon:** 2023 Program underwritten for free 3 month for 85 area students \$2500.

All needs identified in the CHNA are currently being addressed.

To evaluate 2025 community needs, CHNA project leaders conducted a well-structured prioritization process to rank-order the list of needs shown above. The following section reviews the process and final results of the Prioritization Process.

“What did we prioritize – how and why?”

Prioritization Process

Research leaders paused after collecting secondary research and primary research (qualitative and quantitative) as described above. The secondary research analysis, the Wellbeing survey, key stakeholder interviews, and other CHNA activities provided a wealth of community-based strengths, needs, service gaps, and potential opportunities to improve community health. For example, the research illuminated an initial list of 30 community needs in the seven categories shown below.

Access to Care

1. Affordable and accessible healthcare – Cost of care, insurance barriers, and provider shortages (especially Medicaid-accepting).
2. Primary care provider availability – Need for more PCPs, especially in underserved areas.
3. Specialized medical care access – Diabetes, respiratory illness, cardiovascular disease, stroke, liver disease.
4. Care navigation and case management – For complex needs and newcomers to healthcare.
5. Transportation to healthcare and services – Lack of access to transit is a barrier to care.
6. Health literacy and insurance navigation – Understanding services, coverage, and care options.
7. Language and interpretation services – For patients with limited English proficiency.
8. Culturally competent care – Sensitivity to cultural and ethnic differences, especially for Latino communities.
9. Increased capacity of health and social services – More providers, extended hours, and integrated care options.

Mental and Behavioral Health

10. Access to mental health services – General shortage of services for all ages.
11. Shortage of mental health providers – Especially acute for youth, families, and the Latino community.
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13. Suicide prevention programs – Intervention, education, and support.
14. Substance use disorder prevention and treatment – Addressing drug use, overdoses, and addiction recovery.

Chronic Disease Prevention and Wellness

- 15. Chronic disease prevention and early detection – Especially diabetes, hypertension, and heart disease.
- 16. Obesity prevention and support – Nutrition education, fitness, and clinical care.
- 17. Nutrition and food security – Consistent access to healthy and affordable food.
- 18. Expanded preventive care and health education – Screenings, outreach, and self-management resources.

Maternal, Child, and Family Health

- 19. Maternal health services – Prenatal, perinatal, and postpartum care access.
- 20. Accessible and affordable childcare – Crucial for working families and child development.
- 21. Caregiver support services – For those supporting medically fragile or aging loved ones.
- 22. Pediatric and adolescent support services – Includes mental, physical, and social health services.

Aging and Senior Services

- 23. Senior healthcare and geriatric services – Coordinated care, chronic condition management, mobility.
- 24. Senior care navigation – Help with navigating benefits, services, and long-term support.

Health-related Social Needs Factors

- 25. Affordable and quality housing – Stable, safe housing critical for health.
- 26. Risk of homelessness and housing insecurity – Emotional and financial stress from potential housing loss.
- 27. Unemployment and underemployment – Access to stable jobs and workforce support.
- 28. Food security and fresh food access – Affordable, nutritious options needed consistently.

Community and Social Well-being

- 29. Community connection and inclusion initiatives – Reducing isolation, fostering belonging.
- 30. Recreational and community-building activities – For youth, adults, and families to stay engaged and active.

Once data collection and analysis have been completed, the next step of a community health needs assessment is to prioritize the community needs. To prioritize the issues and needs, HHC regional leaders, hospital representatives, and community members worked together to implement a well-structured prioritization process.¹³ This process involves identifying and ranking community health needs based on factors like importance and severity of the problem and the impact, and feasibility of interventions.

There are many steps that can be taken, but the process should at minimum include individuals from diverse backgrounds and representing different populations, opinions and knowledge of the community. CHH prioritization process included three focus group discussions to rank the top health needs. These conversations included community health staff, the NW Regional Executive Leadership, and Local Health Champions. The focus group discussions were framed around how each priority fell into one of four categories:

- Immediate Impact – *where is the low-hanging fruit?*
- Greatest Impact – *what will most influence health outcomes?*
- Most Desired Change – *what does the community most want?*
- Forging Opportunities – *where are the greatest opportunities for partnership?*

Following the series of focus groups, a final list of sixteen health priorities was developed. These identified needs were then presented to our Community Health Alliance – a coalition of key community-based organizations that collaborate with us daily in delivering care. Through a facilitated discussion and a ranking vote, the Alliance helped narrow the list to eleven prioritized health needs. This consensus-based approach ensured that even health issues not ranked highest by any single participant, but broadly supported across the group, could emerge as top priorities.

¹³ Note that prioritization processes were done separately by each HHC hospital in order to recognize and confirm the unique needs, interests, and resources in each service area.

Final Priorities

The process described above yielded the following list of prioritized community health needs:

Aggregated Needs By Tier For Charlotte Hungerford Hospital	
Affordable and Quality Housing	
Nutrition and Food Security – Consistent access to healthy and affordable food	
Access to Mental Health Services across Lifespan, including Substance Use	
Affordable and Accessible Care- Including cost, insurance barriers, and provider shortages	
Aging in Place- Senior healthcare services and care navigation	
Pediatric and adolescent support services- Including healthcare and accessible affordable childcare	
Transportation to Health and Human Services	
Chronic Disease Prevention and Early Detection- Including diabetes, hypertension, heart disease and obesity	
Unemployment and underemployment – Access to stable jobs and workforce support	
Community Connection and Community Building Activities	
Maternal Health Services- prenatal, perinatal and postpartum care access	

Additional prioritization details on select issues are included in the appendices.

“What do we intend to do, and how will we know we are successful (CHIP)?”

Implementation plan

The Implementation Plan also known as the Community Health Improvement Plan (CHIP), guides Hartford HealthCare’s activities and initiatives to address high-priority community needs. It is a critical component of the Community Health Needs Assessment (CHNA) process, translating identified community health needs into actionable strategies. By outlining specific goals, evidence-based initiatives, and measurable outcomes, the CHIP serves as a roadmap for improving health equity and population health.

A well-structured CHIP fosters collaboration between hospitals, community organizations, and local stakeholders, ensuring that efforts are aligned and resources are efficiently utilized. With it, the hospitals track progress and assess the effectiveness of their activities and initiatives. Ultimately, the CHIP helps bridge gaps in healthcare access, reduces disparities, and creates sustainable improvements in community health, reinforcing the hospital’s role as a key partner in public health efforts.

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

This CHIP is structured around five priority areas that aim to address the root causes of health issues in our region. Recognizing that meaningful change requires collaboration, the Northwest Region is committed to building strong partnerships with the community. Through ongoing assessments of these partnerships and the development of shared values and goals, **we strive to create a collective impact that drives progress across all health priorities—and beyond.** The plan for each of these areas is outlined on the following pages. The driving rationale for each of these can be summarized as follows:

1. Access to Care for Families and Individuals

Many factors create barriers to accessing care, including provider shortages, insurance restrictions, affordability, transportation issues, and limited office hours. Different populations also have unique needs that require specific support; for example, older adults and Spanish-speaking individuals may face distinct challenges. It is essential to take action to support individuals and families, ensuring that everyone has timely, affordable, and culturally responsive access to care.

Rationale for Action

- **Provider Shortages:** Litchfield County's primary care ratio is 1,810:1, significantly worse than the state average of 1,210:1.
- **Limited Specialty Services:** Especially for Medicaid patients, compounded by transportation barriers and gaps in care for low-income and Spanish-speaking residents.
- **Transportation Insecurity:** 49% of those without reliable transportation missed health services; 38% of individuals earning under \$30K are transportation insecure.
- **Aging Population:** Higher percentage of residents over 65 in the Charlotte Hungerford service area, indicating increased need for chronic disease care and senior support.

2. Mental and Behavioral Health Services and Supports

Mental and Behavioral services are needed more than ever, with an increased incidence of mental health concerns arising across all demographics. Services and providers are in demand to supply care for matters ranging from social isolation to substance use. There needs to be work done to reduce the stigma of mental health disorders, and early intervention for substance use and treatment.

Rationale for Action

- **Community Mental Health Burden:** In the Charlotte Hungerford Hospital (CHH) service area, 19% of survey respondents report feeling anxious, and 10% report feeling down or depressed. In Torrington, these rates rise to 20% and 15%, respectively.
- **Provider Shortage:** The ratio of mental health providers in Litchfield County is 330:1, compared to 220:1 statewide and 320:1 nationally, highlighting a significant access gap.
- **High Utilization Rates:** CHH reports higher hospital utilization for mental health and substance-related disorders than the state average, suggesting unmet needs and potential gaps in outpatient and community-based services.
- **Health Equity and Access Gaps:** There is a perceived lack of licensed professionals, particularly for children, families, and Spanish-speaking populations, underscoring the need for culturally competent and linguistically accessible care.

3. Socio-economic Factors Impacting Health

Non-clinical factors have been widely recognized for their significant impact on health. Issues such as the cost of healthy and nutritious food, access to affordable housing, earning a livable wage, and other associated challenges present both financial and emotional burdens for many households. To address health in a holistic and strategic manner that optimizes health outcomes, it is essential to understand the community and address the non-clinical and socio-economic factors that influence these outcomes.

Rationale for Action

- **Food Insecurity:** Nearly **1 in 5** (19%) of hospital area survey respondents reported food insecurity in the past year. This rate jumps to **58%** among individuals with annual incomes under \$30,000, highlighting a critical need for targeted interventions.
- **Access to Nutritious Food:** While 57% of Torrington residents surveyed reported access to affordable quality produce, this still leaves a sizable portion of the population without consistent access to nutritious food options—an essential component of preventive health.
- **Housing Instability:** Housing insecurity affected **13%** of area residents, closely mirroring the state average (12%). However, **Torrington-specific data** shows a higher rate at **16%**, indicating localized challenges that require focused solutions.
- **Income and Employment Challenges:** Approximately **38.5%** of households in the Charlotte Hungerford CHNA service area fall into the ALICE category—Asset Limited, Income Constrained, Employed—underscoring the prevalence of underemployment and financial strain even among working individuals.

4. Physical Health & Chronic Conditions

Chronic diseases such as heart disease, cancer, diabetes, asthma, and respiratory conditions remain leading causes of death in Litchfield County. These conditions are deeply connected to physical health, which encompasses the proper functioning of the body and the absence of illness. Promoting physical health through prevention strategies is essential. Education and community collaboration play a vital role in empowering individuals to make healthier choices and access resources, ultimately improving long-term health outcomes across the region.

Rationale for Action

- Litchfield County has **higher mortality rates** than the Connecticut average for five of the six leading causes of death.
- **30.2% of adults** have high blood pressure; **34.3%** have high cholesterol.
- **Access to exercise opportunities** is lower in Litchfield County (81%) compared to Connecticut (93%) and the U.S. (84%).
- **20.5% of adults** report no leisure-time physical activity, slightly lower than the state average (22.7%).
- **28.5% of adults** are obese; **9.3%** have diabetes.
- Key drivers of chronic disease include **smoking, social isolation, and unstable housing**.

5. Maternal, Child & Reproductive Health

With provider shortages, there is a limited number of Obstetrics/Gynecology providers in the area to support the needs of their patients. There is limited support for maternal health to combat issues like tobacco use, pre-term births, and racial maternal health disparities. To support healthy pregnancies, births and childcare, more work is needed in resource-efficient, targeted interventions and culturally responsive care.

Rationale for Action

- **Provider Shortages:** Litchfield County faces a critical shortage of OB/GYN providers, with a ratio of 1 provider per 5,977 females—more than double the state average.
- **Maternal Health Risks:** Tobacco use during pregnancy in the county (3.3%) exceeds the state average (1.8%), contributing to adverse birth outcomes.
- **Prenatal Care Gaps:** Early prenatal care is less accessible in low-income and racially diverse communities such as Torrington and Winsted.
- **Racial Disparities:** Black or African American women experience significantly higher rates of preterm births (11.9%) compared to the national average (10.2%).
- **Pediatric & Adolescent Needs:** Families report a strong need for expanded mental, physical, and social health services, as well as affordable childcare options to support child development and working caregivers.

Charlotte Hungerford Hospital Community Health Improvement Plan

Priority Area #1: Access to Care for Families and Individuals			
GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
Improve access to affordable, timely and culturally sensitive, health care services	- CHH Community Health Worker (CHW) education and outreach efforts to address medical and billing questions - Engage Rural Family Medicine Residency Program in community outreach efforts - Specialty care provider recruitment - Health Equity Council's Annual Health Equity Strategic Plan projects	CHH Community Health Residency Program Specialty Care Quality and Safety Health Equity Council	CHW # of people assisted Rural Family Medicine # of patient encounters - Reduction in provider shortage by 5% (2 full time PCP) Specialty Care Recruitment % Recruitment Health Equity Council - Health Equity Council's project milestones and metrics
Enhance Senior Healthcare Navigation and Support	- Center for Healthy Aging Resource Coordinator Services-assessments and referrals to community agencies - Senior Center Services Assessment and establishment of partnership goals	CHH Center for Health Aging Community NW Region Senior Centers	Center for Health Aging # assessments completed including dementia services # referrals for food, housing, and transportation insecurity Senior Centers # senior centers engaged - Partnership milestones
Improve Transportation Resources and Awareness	Provide funding for Northwest Hills Council of Governments (NWCOG) Transportation	CHH Community Health Community	- Transportation strategic plan initiatives addressed - Amount of funding allocated to transportation # people assisted/Dollars spent

Priority Area #1: Access to Care for Families and Individuals

GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
	strategic plan implementation projects • Offer transportation funds to patients/clients experiencing an emergency • Ride Health Program and Go GEER Program Promotion	NW Hills COG NW Transit District	• # promotional events/engagements
Optimize Mobile Health Services in Torrington and Winsted	• Enhance Neighborhood Health clinics, street medicine and data collection • Provide annual Medical Mission	CHH Community Health Neighborhood Health Administration Community Municipal Partners Health and Human Services Organizations	Neighborhood Health • # Medical visits • # Immunizations • # Clinics per month • # Referrals placed by NBHC for care and resources • # Individuals served with insurance • # Individuals served without insurance Medical Mission • # patients served • # services provided • # Community Organizations engaged

Priority Area #2: Mental and Behavioral Health Services and Supports

GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
Strengthen the capacity of mental health and behavioral health services to support individuals and communities	- Support and expand the Behavioral Health Residency Program - Provide Social RX Programs in collaboration with community partners	CHH Behavioral Health Center for Youth and Families Community Health HHC MG Pediatrics Community KidsPlay Warner Theater EdAdvance	BH Residency # residents enrolled annually - Retention rate of residents post-training # providers practicing in Litchfield County post-residency Social RX # prescriptions filled and related cost
Strengthen the capacity of substance use services to support individuals and communities	- Litchfield County Opiate Task Force (LCOTF) provide leadership and in-kind support to LCOTF initiatives - Sponsorship and donations to local organizations to support harm-reduction education and programming	CHH Community Health Emergency Medicine Behavioral Health Community LCOTF member organizations	LCOTF # of staff hours committed to LCOTF meetings and activities. - Amount of funding allocated to harm reduction initiatives % Change overdoses and overdose deaths # of harm-reduction programs implemented or supported
To enhance the effectiveness and sustainability of NW Community Care Team (CCT) to address complex health and social needs	NW CCT provide strong leadership, improve operational infrastructure, and maintain cross-sector collaboration to - Enhance Data Collection - Conduct Annual Memorandum of Understanding (MOU) review and partner membership - Conduct Annual in-person meeting for review and next year planning	CHH Community Health Behavioral Health Emergency Medicine Care Management Community FQHC Behavioral Health and Addiction Services Housing Support Organizations	Metrics # of patients served by the NW CCT - Change in ED visit rates over time for behavioral and social needs. - Percentage of patients achieving individualized, patient-centered goals.

Priority Area #2: Mental and Behavioral Health Services and Supports

GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
Improve Community Connection and Community Building	Facilitate community conversations through the Health Equity Council's Community Subcommittee	CHH Community Health Behavioral Health Community Health and Human Service Organizations Health Equity Champions	# of community conversation events held # of participants engaged # of actionable items identified and implemented from conversations

Priority Area #3: Socio-economic Factors Impacting Health

GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
Support Access to Affordable and Supportive Housing	Supportive Housing Initiatives collaborate with community partners by providing in-kind contributions, direct resources, and integrated health care services Torrington Affordable Housing efforts support the through in-kind services and financial support	CHH Community Health Neighborhood Health Community Housing Support Organizations City of Torrington	# of project milestones achieved (e.g., planning, funding secured, units developed) # of individuals housed through supported initiatives - Amount of in-kind services or funding contributed
Promote Housing Stability for Individuals Experiencing or At Risk of Homelessness	Housing Navigator staff time and expertise for front end case management, community outreach and hospital discharge planning Litchfield County CAN (Coordinated Access Network) partnership to support strategic housing plan implementation	CHH Community Health Emergency Medicine Behavioral Health Community Litchfield County CAN Collaborative Housing Collective	Housing Navigator # of CAN assessments completed. # of clients receiving case management or housing navigation services. Litchfield County Strategic Plan Milestones # of strategic plan objectives implemented or supported
Improve Access to Healthy Food and Nutrition for Food-Insecure Individuals to improve health outcomes	Food is Medicine enhance initiative through the <i>CHH Food4Health Clinic</i>, including program expansion and evaluation improvements Sponsorships and donations to local Food and Nutrition Security Organizations	CHH Community Health Ambulatory Clinics Community Local Food/Nutrition Security Organizations NW FoodHub/Farms	Food4Health - Implementation of a comprehensive evaluation plan for the Food4Health Clinic (including process and outcome measures). Sponsorships and donations - Amount of funding allocated to nutrition-focused organizations. # community organizations engaged or supported

Priority Area #3: Socio-economic Factors Impacting Health

GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
Strengthen the Local Healthcare Workforce	• Healthcare School-based partnerships through internships, volunteer engagements and speaker programs • CHH Workforce Program career ladder development • Project Search Program	CHH Community Health Human Resources Volunteer Services Community Local School Districts Local Community Colleges LARK	Healthcare School-based partnerships • # high school events or trainings held and # students attended • # student Volunteer hours CHH Workforce Program • Milestone Career ladder assessment and development plan Project Search • Conversion Rate of Interns to Gainful Employment

Priority Area #4: Physical Health and Chronic Disease

GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
Increase Access to Healthy Eating and Active Living Opportunities in NW CT	• Fit Together Healthy Eating Active Living (HEAL) initiatives in Torrington and Winsted provide leadership and in-kind support to areas of high tobacco use and obesity Focus on FT four action plan areas: ○ Communications and Content Development ○ Durational Environmental Change Projects ○ HEAL Policy Advocacy ○ Funding support for high Impact Community HEAL projects/programs	CHH Community Health Community Fit Together member organizations	• # staff hours dedicated to Fit Together activities • # Fit Together programs implemented or supported • Progress on Fit Together Action Plan indicators (e.g., engagements, milestones)
Expand Community Education on Chronic Disease Prevention and Management	• Health Education in community settings, including faith-based organizations and libraries • Targeted Nutrition Education programs led by community health Registered Dietitian Nutritionists (RDNs) • Resource opportunities and partnerships development provide expertise and donation/sponsorships	CHH Community Health Residency Programs Community Faith-based organizations Libraries Community based organizations Health Equity Champions	• # educational events held • # participants reached • Summary of post-event evaluations (knowledge gain, intent to change behavior) • Amount of Funding allocated to community-based programs
Strengthen Tobacco-Free Living Through Community Collaboration	• Litchfield County Alliance for Tobacco-Free Communities support by: ○ Providing interpretation and outreach via CHH's Spanish-speaking community health worker	CHH Community Health Behavioral Health Community EdAdvance Community based organizations	• # outreach events and attendees • # patients engaged in tobacco cessation support • Hours contributed to the Project Advisory Council • # of bills focused on tobacco free communities that we support

Priority Area #4: Physical Health and Chronic Disease

GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
	○ Connect residents to culturally competent tobacco cessation resources. ○ Engaging frequent Emergency Department users and Maternity patients with tobacco-free lifestyle support. ○ Offering communications and marketing support (e.g., tabling materials, educational content). ○ Participating in the Project Advisory Council. ● Support Legislative Initiatives-Federal, State and Local		

Priority Area #5: Maternal, Child and Reproductive Health

GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
Advance the health and well-being of women, children, and caregivers by expanding access to essential services and culturally responsive care—especially in communities facing systemic barriers	• Diaper Connections Program Provide essential supplies to families in need, reducing financial stress and improving infant care • NW CT Perinatal Community Group Projects Scale initiatives such: ○ Doula support program ○ Peer-led maternal mental health education to improve birth outcomes and maternal experience ○ Community Resource support – materials for benefit of recruitment ○ Nutrition education women who are child rearing age • Advance Health Equity Maternal Health Projects: Implement culturally responsive interventions that address racial disparities and promote equitable access to care • Child First Program-strengthen education and outreach efforts with internal and external stakeholders • Sponsorships and Donations provide local Child Serving Organizations to support maternal, child wellbeing	CHH Community Health Labor and Delivery Health Equity Council Center for Youth and Families Community Maternal support organizations OBGYN Practices	Diaper Connections • Volume of diapers distributed to support basic needs • Survey feedback on program effectiveness and satisfaction NW CT Perinatal Community Group • Achievement of key milestones • # staff hours dedicated to activities • # meetings held and organizations attended • # of doula attended births Health Equity Council Projects • Achievement of key milestones • # staff hours dedicated to activities Child First • Achievement of outreach milestones • # referrals Sponsorships and Donations • Amount of funds allocated to child serving organizations Outcome Measures • Health outcomes (e.g., preterm birth, low birth weight, maternal complications)

Appendix

The appendices include the following:

Appendix 1: Qualitative Research Summary

Appendix 2: DataHaven Community Wellbeing Survey Raw Data Tables

Appendix 3: Wellbeing Survey Summary Tables and Graphics

Appendix 4: Maternal Health

Appendix 5: Maternal Health Data Tables

Appendix 6: Life Expectancy Data

Appendix 7: Life Expectancy

Appendix 8: Hospital Utilization Data

Appendix 9: CHIME Data References and Sourcing

Appendix 10: Code Reference Sheet

Appendix 11: Hartford Healthcare Board Meeting Summaries

Appendix 12: Community Health Needs Assessment Requirements as per the Internal Revenue Service

Appendix 13: Community-based Health-related Resources

Appendix 1: Qualitative Research Summary

The following summary reflects qualitative comments collected via focus group discussions and stakeholder interviews.

Qualitative research data reveal that the Charlotte Hungerford Hospital service area faces a complex mix of healthcare access challenges, behavioral health needs, and socioeconomic pressures. Limited access to specialty services (especially for Medicaid patients) persists alongside transportation barriers, a shortage of affordable housing, food insecurity, and gaps in care for people in low socio-economic communities (e.g., Spanish-speaking residents and recent immigrants). Mental health and substance use concerns are perceived to be increasing, with shortages in providers and culturally competent care creating additional strain. Chronic disease management remains a significant challenge, with high rates of COPD, diabetes, and other long-term conditions often compounded by multiple comorbidities.

Community members also stress the importance of building stronger social connections, creating youth and family engagement venues, and expanding case management and navigation services to help residents access needed resources. Workforce shortages are thought to be affecting both rural and urban parts of the service area. While there are positive community attributes, including faith-based organizations, youth programs, and housing navigation resources, the scale and complexity of needs demand sustained collaboration, targeted investments, and culturally tailored approaches.

Community Changes and Challenges

Research indicates that while the CHH service area shows strengths in certain areas (e.g., such as high rates of health insurance coverage and homeownership) deep disparities persist, particularly along income lines. Lower-income residents are less likely to have a medical home, report lower life satisfaction, and face greater food insecurity. Housing insecurity affects one in 11 residents, with higher rates among Latino households, while financial strain is thought to be limiting ability to access healthcare, nutritious food, and wellness resources.

Social isolation, lack of culturally inclusive spaces, and insufficient youth and recreation opportunities are said to be eroding community connection. While programs like Food4Health and housing navigation services provide important supports, the need for coordinated case management, targeted chronic disease education, and expanded mental health and substance use services are frequently noted. Stakeholders emphasize that rural residents face additional access barriers to both primary and specialty care, making transportation solutions and outreach essential. Some suggest that addressing these challenges will require expanding the healthcare workforce (particularly bilingual and behavioral health providers) and strengthening community engagement to ensure access to quality care.

Relevance of Previous CHNA Priorities

The priorities identified in the previous Community Health Needs Assessment remain highly relevant, with several challenges persisting or intensifying. Key concerns include recruitment and retention of healthcare staff, access to care, mental health services, and community engagement.

Appendix 2: DataHaven Community Wellbeing Survey Raw Data Tables

Overall Health Status								
Response	Connecticut total	The Charlotte Hungerford Hospital total	Male	Female	Ages 18 to 34	Ages 65+	White	Latino
How would you rate your overall health? (% saying Excellent or Very Good)	56.4%	53.1%	51.8%	54.6%	63.3%	48.7%	54.5%	54.3%
How would you rate your overall health? (% saying Fair or Poor)	16.5%	18.7%	21.2%	15.9%	14.4%	19.5%	17.8%	24.0%
How satisfied are you with your life nowadays? (% saying Completely or Mostly)	65.6%	64.5%	62.1%	67.2%	62.8%	65.5%	68.0%	54.6%
How satisfied are you with your life nowadays? (% saying Only a little or Not at all)	11.3%	13.6%	13.5%	13.9%	11.5%	11.9%	11.5%	17.1%
Overall, how happy did you feel yesterday? (% saying Completely or Mostly)	68.5%	68.1%	69.7%	66.5%	72.3%	68.5%	71.3%	65.4%
Overall, how happy did you feel yesterday? (% saying Only a little or Not at all)	12.1%	13.3%	13.7%	12.9%	12.1%	9.2%	11.1%	18.2%
Overall, how anxious did you feel yesterday? (% saying Completely or Mostly)	13.6%	11.8%	10.5%	12.6%	16.7%	8.5%	10.3%	23.3%
Overall, how anxious did you feel yesterday? (% saying Only a little or Not at all)	65.4%	67.2%	70.6%	64.5%	59.4%	69.7%	69.9%	54.1%
Do you have health insurance? (% saying No)	5.8%	5.0%	8.1%	2.0%	4.2%	5.6%	4.0%	4.4%

Overall Health Status

Response	Connecticut total	The Charlotte Hungerford Hospital total	High school or less	Some college or Associate's	Bachelor's or higher	Income <\$30K	Income \$30K-\$100K	Income >\$100K	Children in home	No children in home
How would you rate your overall health? (% saying Excellent or Very Good)	56.4%	53.1%	42.9%	48.5%	63.7%	30.6%	59.0%	59.2%	58.3%	52.0%
How would you rate your overall health? (% saying Fair or Poor)	16.5%	18.7%	26.4%	19.1%	12.8%	37.5%	13.7%	12.7%	11.6%	20.1%
How satisfied are you with your life nowadays? (% saying Completely or Mostly)	65.6%	64.5%	55.8%	61.1%	73.1%	44.1%	63.3%	77.8%	72.2%	63.2%
How satisfied are you with your life nowadays? (% saying Only a little or Not at all)	11.3%	13.6%	17.6%	13.6%	11.1%	22.1%	13.6%	10.1%	10.8%	14.0%
Overall, how happy did you feel yesterday? (% saying Completely or Mostly)	68.5%	68.1%	65.4%	66.1%	72.0%	58.0%	66.6%	77.1%	70.9%	68.1%
Overall, how happy did you feel yesterday? (% saying Only a little or Not at all)	12.1%	13.3%	17.7%	12.6%	10.7%	19.7%	13.8%	9.6%	11.6%	13.2%
Overall, how anxious did you feel yesterday? (% saying Completely or Mostly)	13.6%	11.8%	17.0%	11.5%	8.1%	17.8%	13.2%	6.2%	11.9%	11.3%
Overall, how anxious did you feel yesterday? (% saying Only a little or Not at all)	65.4%	67.2%	63.6%	65.4%	72.0%	53.0%	68.1%	71.8%	60.1%	70.1%
Do you have health insurance? (% saying No)	5.8%	5.0%	9.4%	4.7%	1.5%	6.2%	5.5%	2.8%	4.5%	5.0%

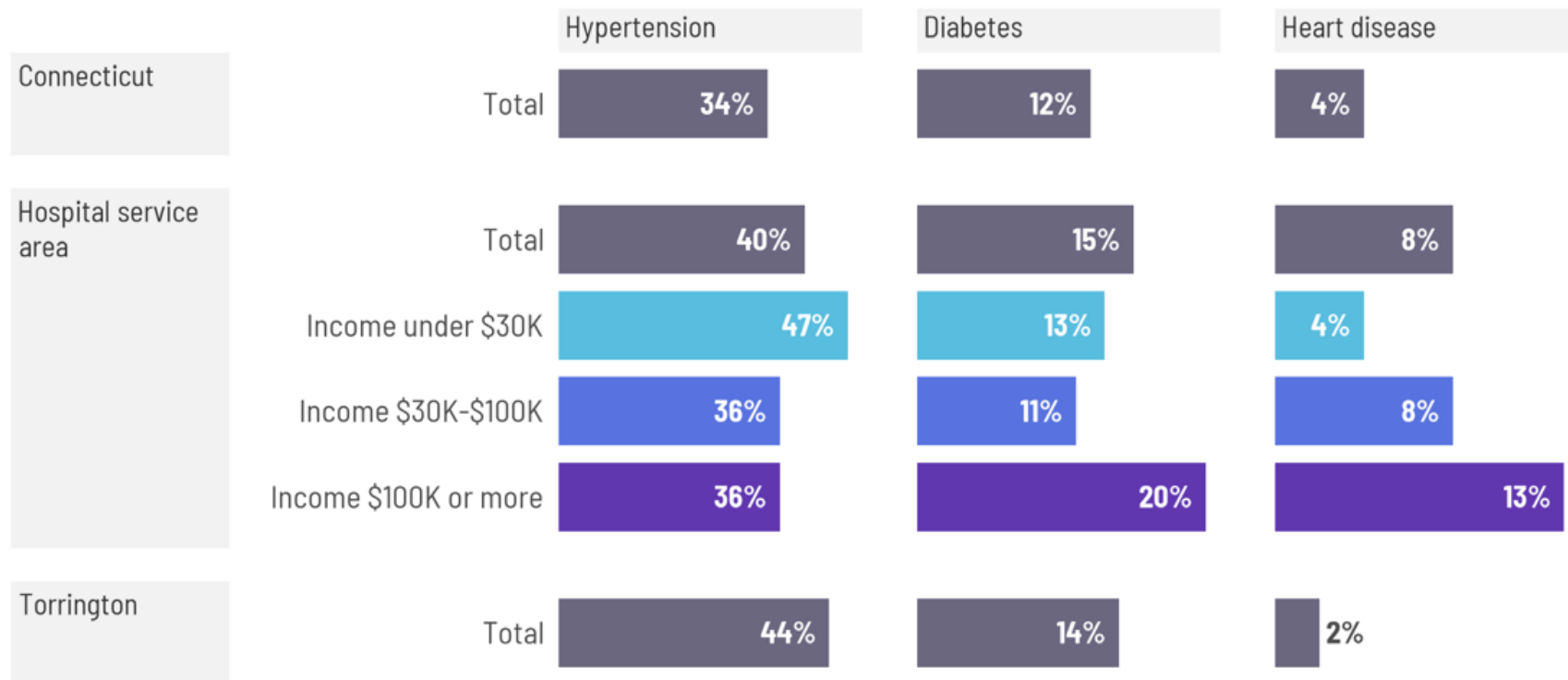
Appendix 3: Wellbeing Survey Summary Tables and Graphics

Chronic Disease

Figure 1: Charlotte Hungerford Hospital Service Area Chronic Disease by Income Level

Chronic disease

Share of adults, Charlotte Hungerford Hospital service area by location and income, 2024



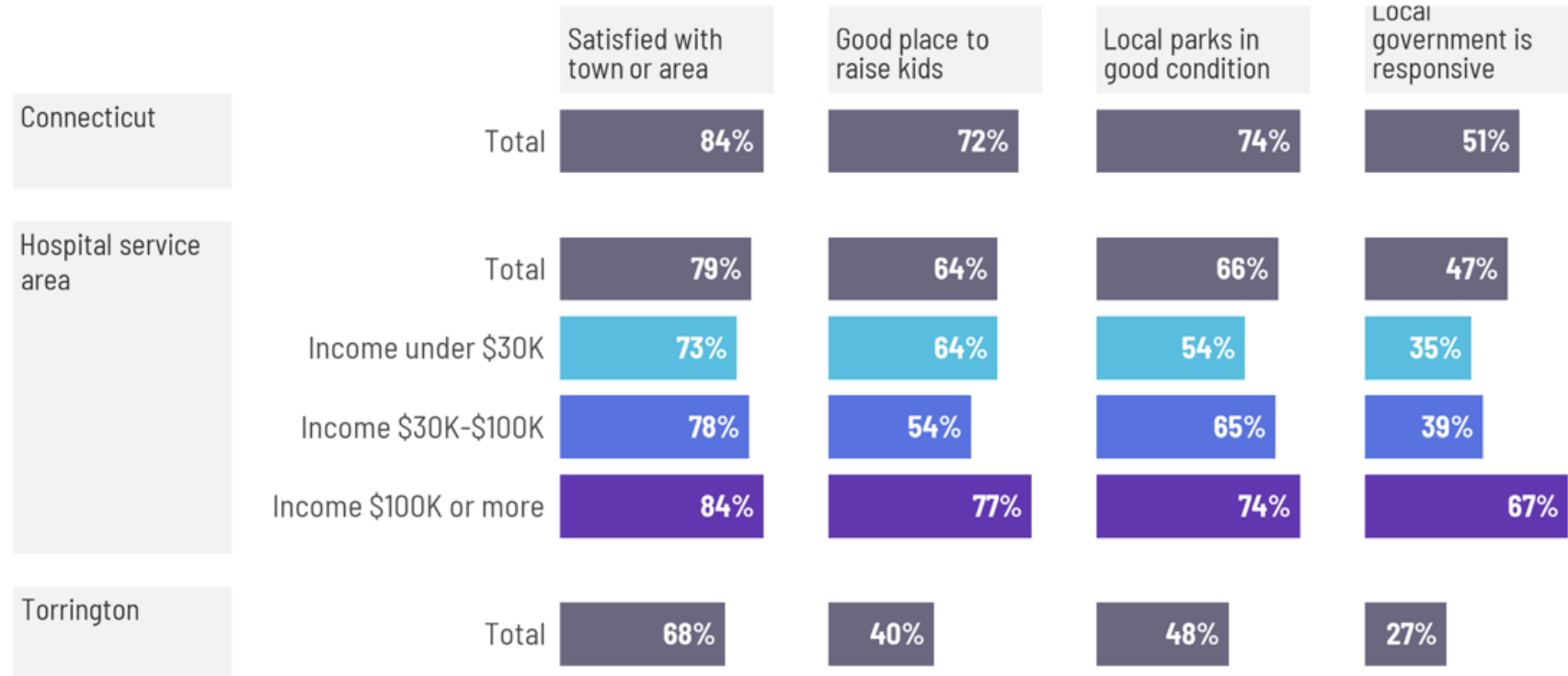
Source: 2024 DataHaven Community Wellbeing Survey

Community Satisfaction

Figure 2: Charlotte Hungerford Hospital Service Area Community Satisfaction by Income Level

Community satisfaction

Share of adults, Charlotte Hungerford Hospital service area by location and income, 2024



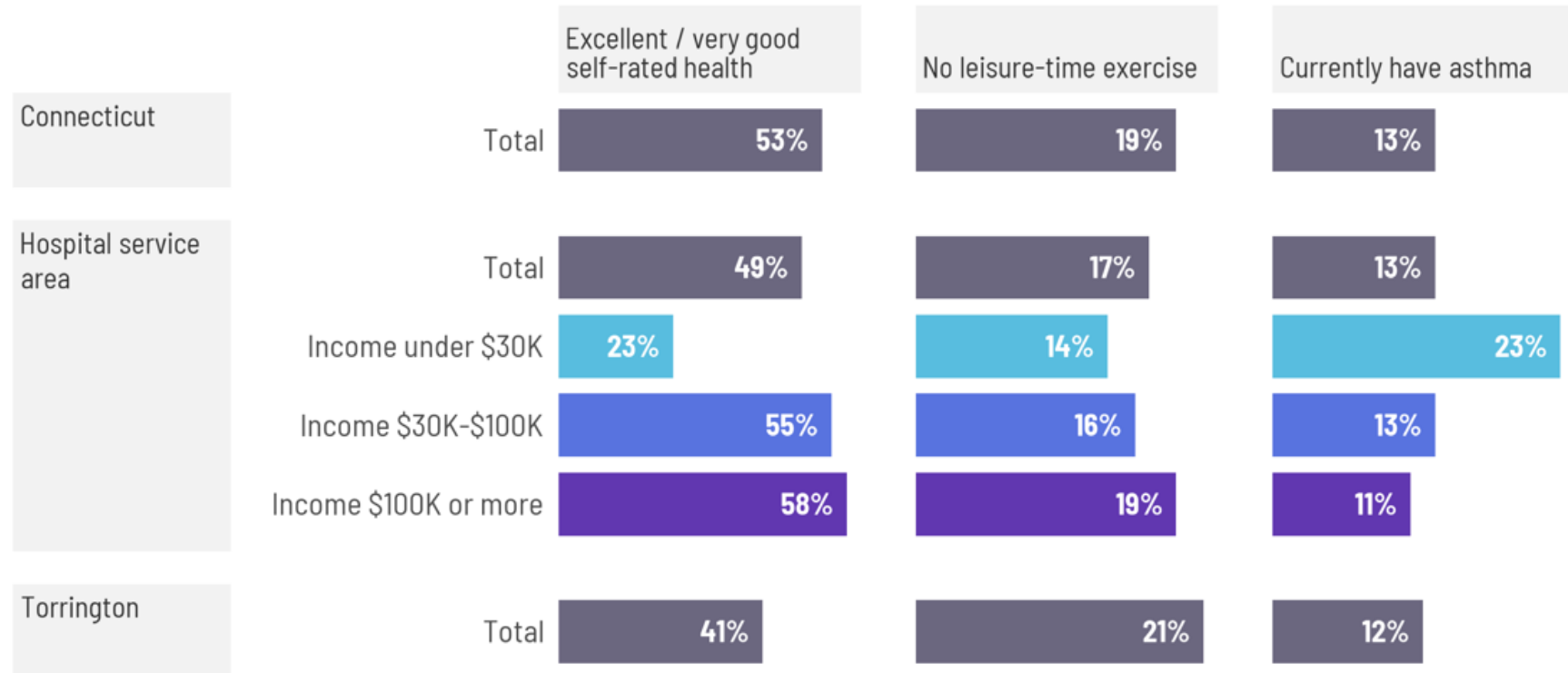
Source: 2024 DataHaven Community Wellbeing Survey

Health Risks

Figure 3: Charlotte Hungerford Hospital Service Area Health Risks by Income Level

Health risks

Share of adults, Charlotte Hungerford Hospital service area by location and income, 2024



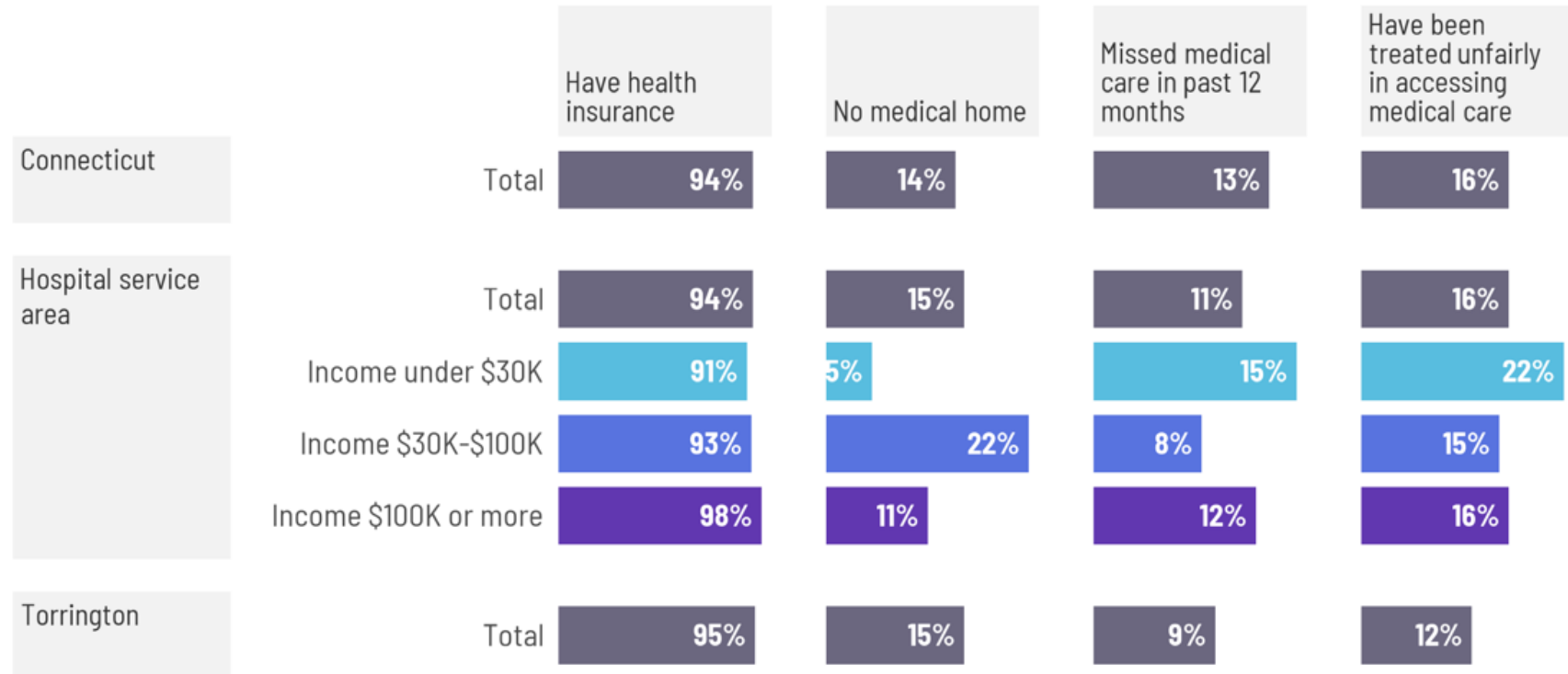
Source: 2024 DataHaven Community Wellbeing Survey

Healthcare Access

Figure 4: Charlotte Hungerford Hospital Service Area Healthcare Access by Income Level

Healthcare access

Share of adults, Charlotte Hungerford Hospital service area by location and income, 2024



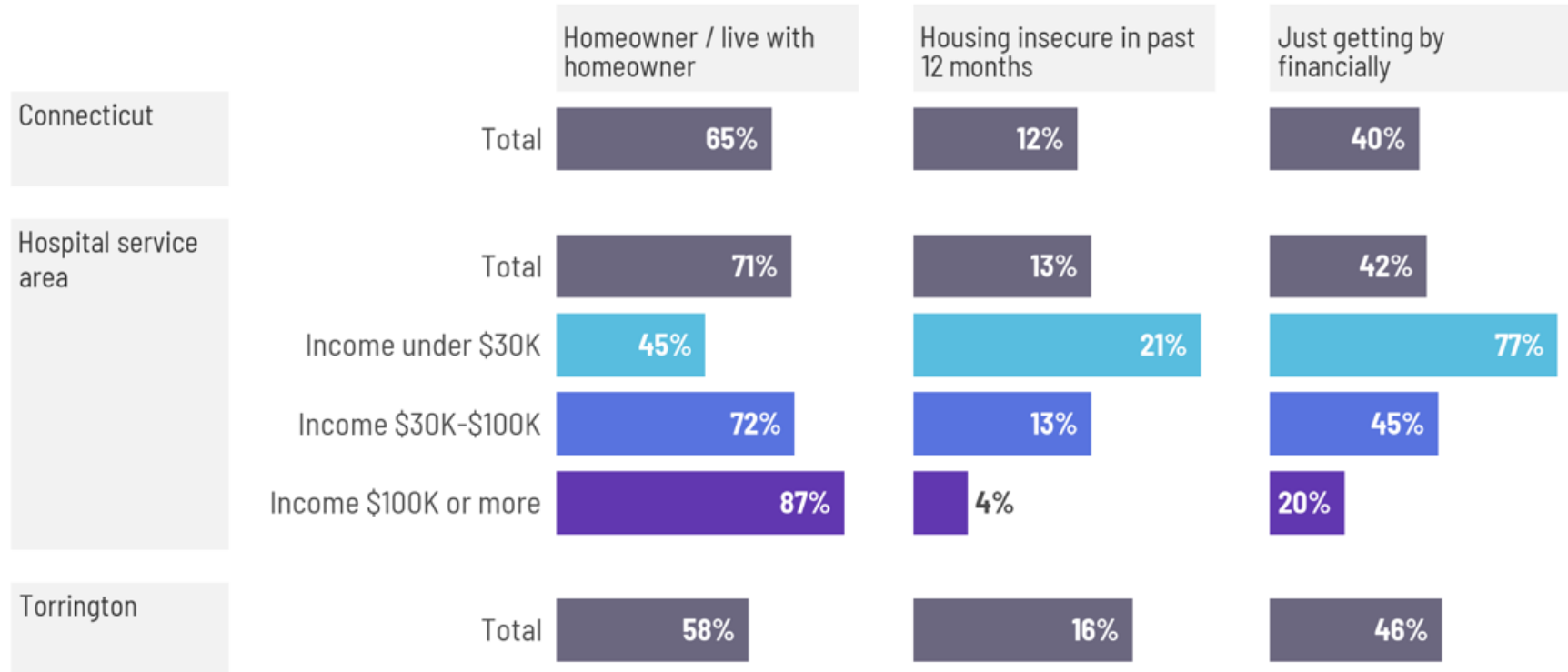
Source: 2024 DataHaven Community Wellbeing Survey

Housing and Financial Wellbeing

Figure 5: Charlotte Hungerford Hospital Service Area Housing and Financial Wellbeing by Income Level

Housing and financial well-being

Share of adults, Charlotte Hungerford Hospital service area by location and income, 2024



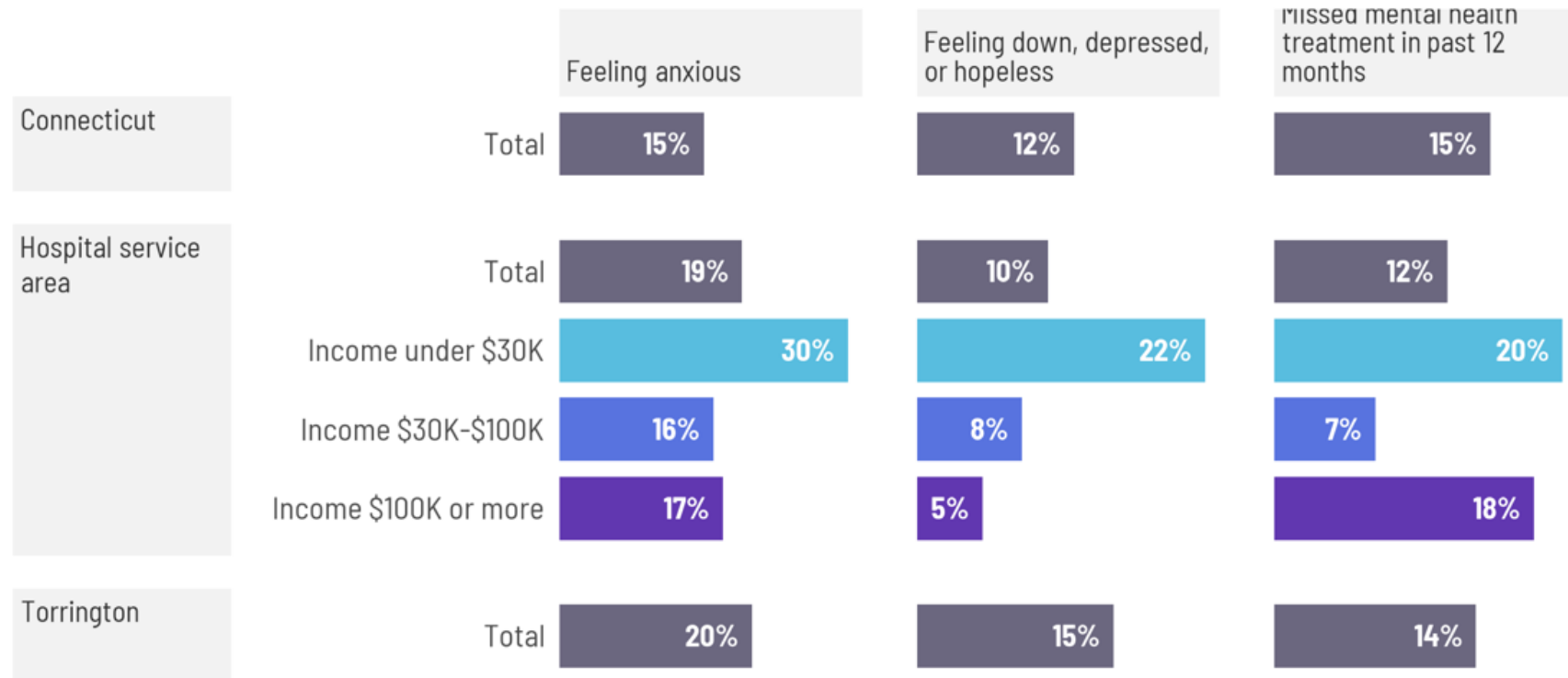
Source: 2024 DataHaven Community Wellbeing Survey

Mental Health

Figure 6: Charlotte Hungerford Hospital Service Area Mental Health by Income Level

Mental health

Share of adults, Charlotte Hungerford Hospital service area by location and income, 2024



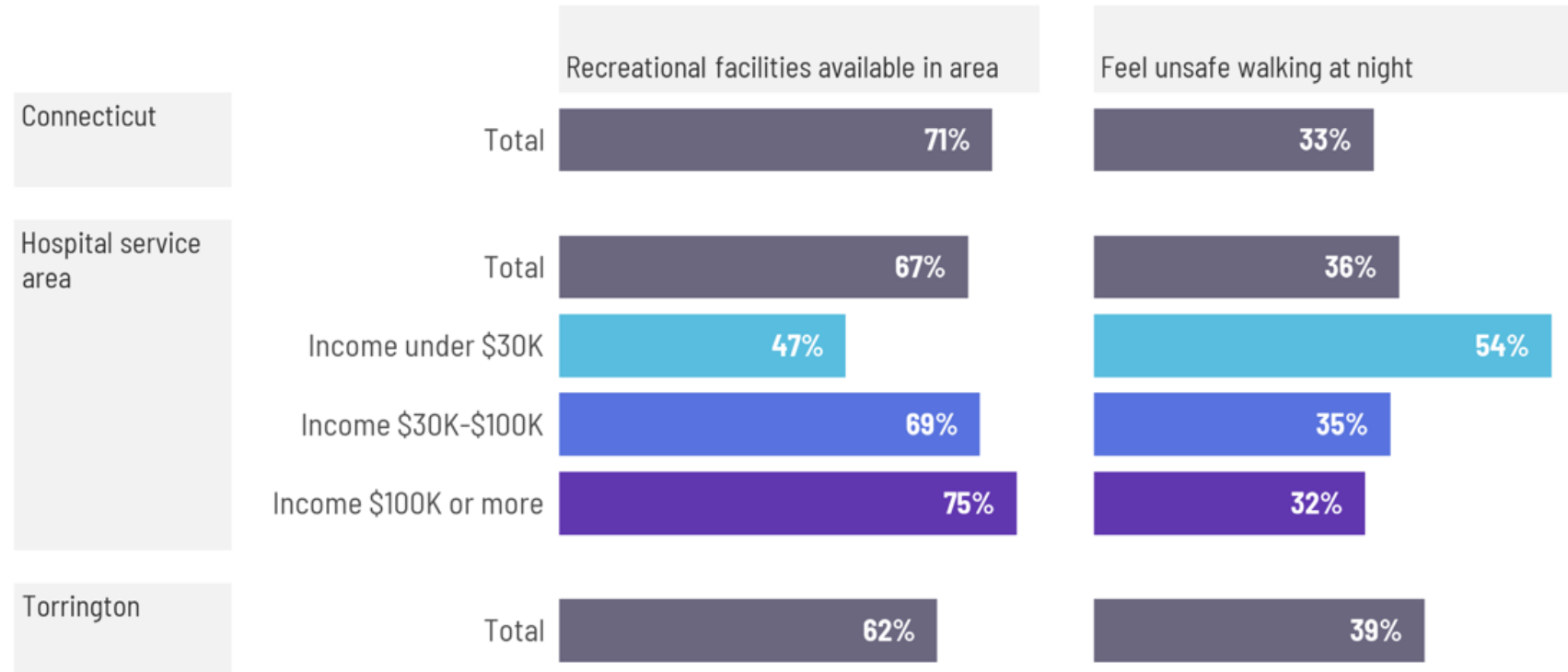
Source: 2024 DataHaven Community Wellbeing Survey

Neighborhoods

Figure 7: Charlotte Hungerford Hospital Service Area Neighborhood Safety and Facilities by Income Level

Neighborhoods

Share of adults, Charlotte Hungerford Hospital service area by location and income, 2024



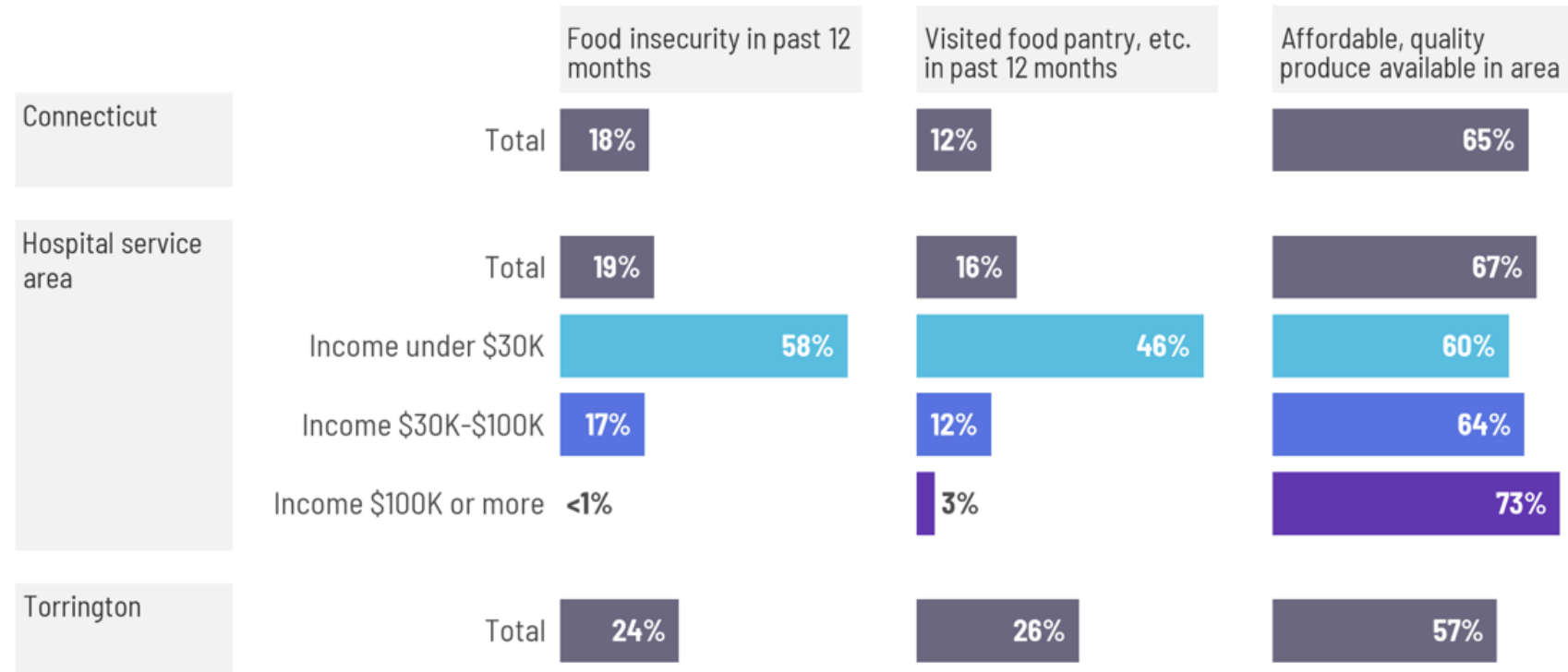
Source: 2024 DataHaven Community Wellbeing Survey

Nutritional Security

Figure 8: Charlotte Hungerford Hospital Service Area Nutritional Security by Income Level

Nutritional security

Share of adults, Charlotte Hungerford Hospital service area by location and income, 2024



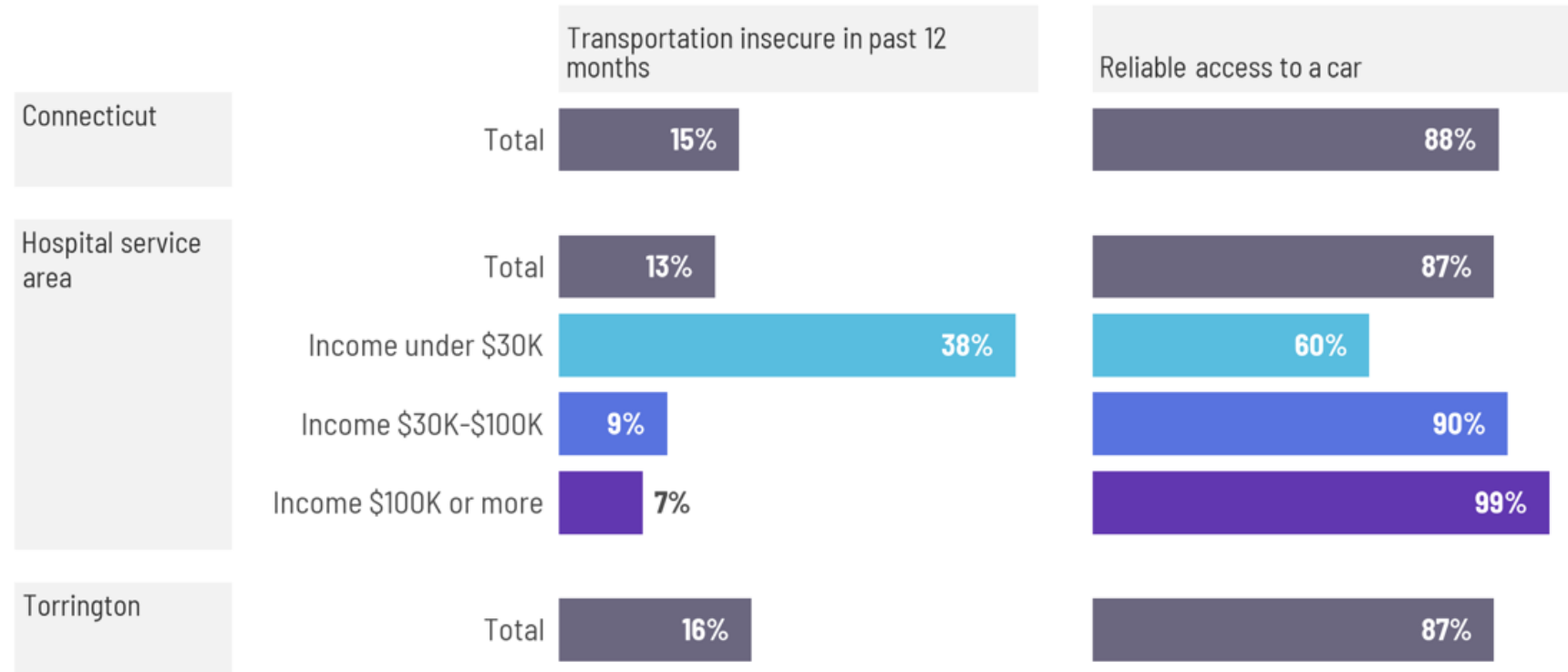
Source: 2024 DataHaven Community Wellbeing Survey

Transportation

Figure 9: Charlotte Hungerford Hospital Service Area Transportation Access and Security by Income Level

Transportation

Share of adults, Charlotte Hungerford Hospital service area by location and income, 2024



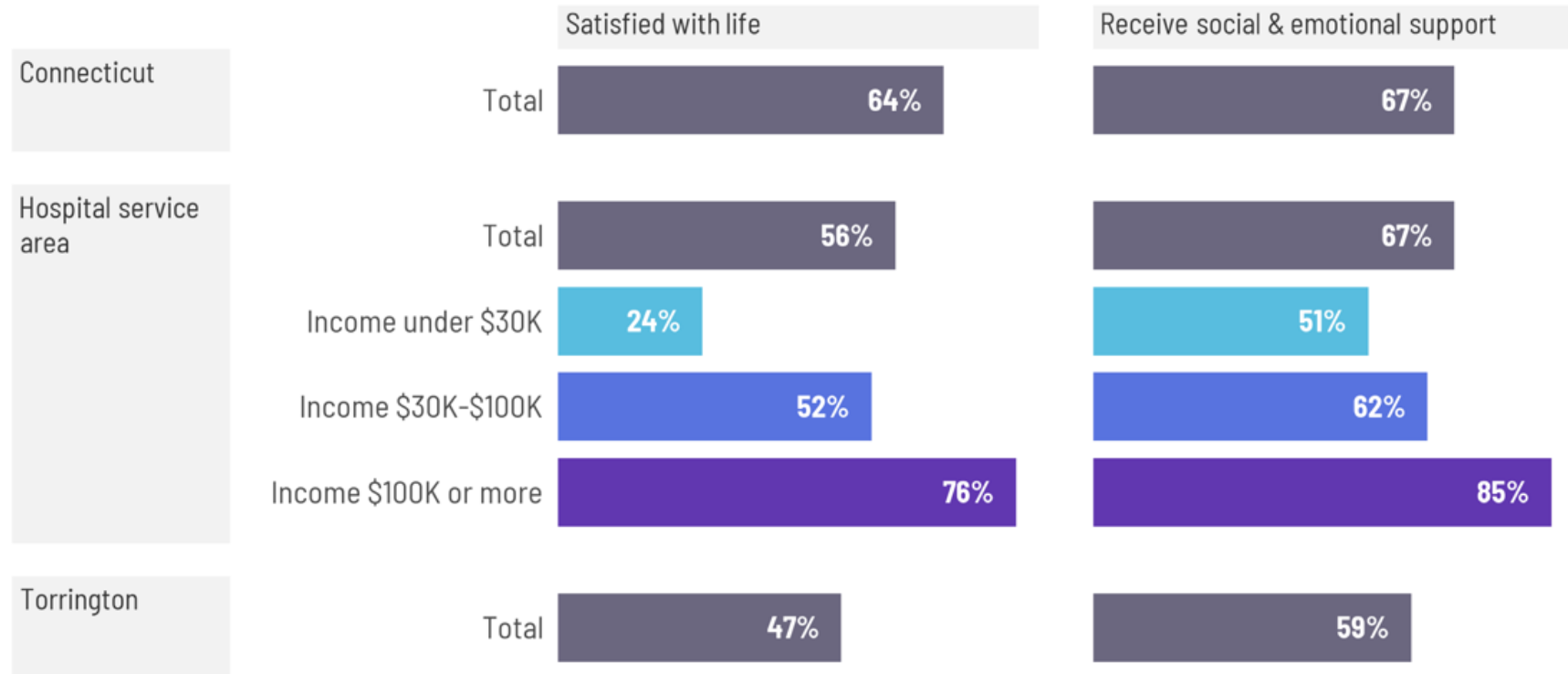
Source: 2024 DataHaven Community Wellbeing Survey

Wellbeing and Support

Figure 10: Charlotte Hungerford Hospital Service Area Wellbeing and Support by Income Level

Well-being and support

Share of adults, Charlotte Hungerford Hospital service area by location and income, 2024



Source: 2024 DataHaven Community Wellbeing Survey

Appendix 4: Maternal Health

Overview

Maternal health is a critical indicator of a nation's, and the state's, overall health system, reflecting the quality and accessibility of healthcare for women during pregnancy, childbirth, and the postpartum period. The following review provides an overview of maternal health trends in the United States, with a specific focus on Connecticut, highlighting key statistics, disparities, and recent developments.

National Maternal Health Trends

In recent years, the United States has experienced fluctuations in maternal mortality rates. According to the National Center for Health Statistics, the maternal mortality rate has drifted up from 17.4 deaths per 100,000 live births in 2018 to 23.8 in 2020, 22.3 in 2022, and 18.6 in 2023.¹⁴¹⁵ Disparities persist across different age groups and racial/ethnic populations. In 2022, women aged 40 and over had a maternal mortality rate of 87.1 per 100,000 live births, significantly higher than the rate of 14.4 for women under 25. Racial disparities are also evident; non-Hispanic Black women experienced a maternal mortality rate of 49.5 per 100,000 live births in 2022, more than double the rate for non-Hispanic White women, which stood at 19.0.¹⁶

The leading causes of pregnancy-related deaths in 2020 included mental health conditions, cardiovascular conditions, infection, hemorrhage, embolism, and hypertensive disorders of pregnancy, accounting for over 82% of such deaths. Notably, mental health conditions were the most frequent underlying cause, highlighting the linkage between comprehensive maternal care and mental health support.¹⁷

¹⁴ Note: Data indicates that the 2021 rate was over 32. However, the COVID-19 pandemic may have impacted reporting methodologies, making direct trend-based comparisons challenging.

¹⁵ Hoyert DL. Maternal mortality rates in the United States, 2022. NCHS Health E-Stats. 2024. Available at <https://dx.doi.org/10.15620/cdc/152992>

¹⁶ Ibid.

¹⁷ US CDC, Maternal Mortality Prevention, 2024, "Pregnancy-Related Deaths: Data From Maternal Mortality Review Committees in 38 U.S. States, 2020". Available at [Pregnancy-Related Deaths: Data From Maternal Mortality Review Committees in 38 U.S. States, 2020 | Maternal Mortality Prevention | CDC](#)

Maternal Health in Connecticut

As noted, maternal health is a fundamental indicator of a community's overall well-being. In Connecticut, as well as the US (generally), several antecedent (or contributing) factors impact maternal health outcomes. This section provides an overview of maternal health across Connecticut, with a focus on eight critical measures:

Antecedent or Contributing Measures

- Obstetrics/Gynecology (OB/GYN) ratios
- Tobacco use during pregnancy
- Preterm birth
- Low birth weight
- First trimester prenatal care
- Life expectancy at birth

Outcomes Measures

- Maternal deaths and mortality rates
- Infant mortality

Together, these indicators help illuminate the quality of maternal and infant health services, highlighting both strengths and areas in need of improvement. While Connecticut performs better than the national average on many of these measures, significant disparities persist across counties and racial and ethnic groups, pointing to underlying structural challenges that affect access and outcomes.

Geographic and demographic differences are evident in nearly most indicators. Rural counties such as Windham and Litchfield often face provider shortages and higher rates of adverse outcomes, while more urbanized areas like Fairfield and Hartford Counties tend to have better access to care but also exhibit pronounced racial disparities. For example, Black or African American and Hispanic women in several counties face greater barriers to timely prenatal care and experience higher rates of preterm births and low birth weight. Additionally, counties with lower life expectancy often align with those reporting poorer maternal and infant health outcomes. This data-driven perspective highlights the importance of resource-efficient, targeted interventions, insightful policies, and culturally responsive care to ensure Connecticut residents have the opportunity for healthy pregnancies and births.



Antecedent or Contributing Measures

1. Obstetrics/Gynecology (Females per 1 OBGYN) Ratio

The OBGYN ratio (using 2024 data) refers to the number of females of reproductive age per practicing obstetrician-gynecologist within a defined area. This measure is a key indicator of access to specialized maternal and reproductive health care. A lower ratio signifies better access to services such as prenatal care, family planning, and childbirth support, while a higher ratio may indicate potential shortages in provider availability, especially in rural or underserved regions. Ensuring an adequate OBGYN workforce is critical for improving maternal outcomes, reducing complications during pregnancy and childbirth, and supporting women's health across the lifespan.

The availability of obstetricians and gynecologists varies widely across Connecticut counties, with notable disparities in access. Tolland County has the highest ratio at 9,560 females per OBGYN, indicating a significant shortage of providers, while Hartford, Fairfield, and New Haven counties have the lowest ratios (1,959, 2,158, and 2,347 respectively), suggesting better per capita capacity. The statewide average (2,493) is below the national average (3,454), showing that Connecticut as a whole has relatively strong OBGYN coverage, although rural counties like Windham (6,510) and Litchfield (5,977) remain relatively underserved.¹⁸

2. Tobacco Use During Pregnancy

This measure reflects the percentage of pregnant individuals who report using tobacco at any point during their pregnancy. Tobacco use during pregnancy is associated with a range of adverse outcomes, including miscarriage, stillbirth, preterm birth, low birth weight, and developmental issues in infants. Monitoring this behavior is essential for identifying at-risk populations and targeting public health interventions. It also serves as a proxy for broader health education and support systems within a community and highlights the need for effective cessation programs tailored to pregnant individuals.

Tobacco use during pregnancy is lower in Connecticut (1.8%) than the national average (3.0%), with Fairfield County reporting the lowest rate (0.6%) and Windham County the highest (4.4%). Tobacco use is most prevalent among White (non-Hispanic) and individuals of more than one race, with rates reaching 8.0% and 12.7% in Windham, respectively. Use among Black or African American individuals varies by county, peaking at 4.1% in New Haven. Hispanic and Asian populations show lower tobacco use rates across the board, suggesting cultural or behavioral differences.¹⁹

3. Preterm Births

Preterm birth is defined as a live birth occurring before 37 completed weeks of gestation. It is a leading cause of neonatal morbidity and

¹⁸ County Health Rankings, 2024. Available at <https://www.countyhealthrankings.org/health-data/compare-counties?year=2024&compareCounties=09013%2C09000%2C00000%2C>

¹⁹ Ibid.

mortality and can have long-term consequences for a child's health, development, and educational outcomes. This measure is vital for assessing the quality of prenatal care, maternal health status, and other health-related social needs that contribute to early labor. High preterm birth rates often reflect disparities in health care access, stress, environmental exposures, and chronic disease burden among pregnant individuals.

Connecticut's preterm birth rate (9.1%) is slightly below the national average (10.2%), yet racial disparities are pronounced. Black or African American women face disproportionately high rates (up to 14.5% in Hartford and Windham), mirroring national trends. In contrast, White (non-Hispanic) and Asian women tend to experience lower rates of preterm births. Geographic variation also exists, with Windham and New Haven Counties at 9.6%, while Litchfield and Fairfield are at a lower 8.3% and 8.5%, respectively. These differences likely reflect varying access to care, socioeconomic factors, and structural challenges.²⁰

4. Low Birth Weight

Low birth weight is defined as a newborn weighing less than 2,500 grams (approximately 5.5 pounds) at birth, regardless of gestational age. It is an important marker of both maternal health and the intrauterine environment. Infants born with low birth weight are at increased risk of health complications, including respiratory issues, infections, delayed growth, and chronic health conditions later in life. This measure also provides insight into the cumulative effects of maternal nutrition, prenatal care access, substance use, and stress on fetal development.

Connecticut's overall low birth weight rate is 7.6%, slightly lower than the national average of 8.2%, but again, racial disparities are evident. Black or African American infants have the highest rates (13.0% statewide), particularly in Hartford (13.5%) and New Haven (13.4%), more than double the rate for White (non-Hispanic) infants (6.3%). Asian infants also experience elevated rates (9.0%), which exceeds their national rate. Fairfield County reports the lowest overall rate at 7.0%, while Hartford and New Haven are among the highest at 8.2%. These patterns highlight persistent disparities in maternal and infant health outcomes.²¹

5. First Trimester Prenatal Care

This measure tracks the percentage of pregnant individuals who begin prenatal care during the first trimester of pregnancy. Early initiation of prenatal care is crucial for monitoring fetal development, managing maternal health conditions, and providing education on healthy pregnancy behaviors. It also allows for early screening and intervention for complications that may affect both the mother and the fetus. High rates of first trimester prenatal care are indicative of good health system access and maternal health literacy, while lower rates often point to barriers such as lack of insurance, transportation issues, or distrust of the overall medical system.

²⁰ Ibid.

²¹ Ibid.

While Connecticut exceeds the national average (84.7% vs. 76.8%) in first trimester prenatal care access, disparities persist across racial and ethnic groups. White (non-Hispanic) women have the highest rates, with Tolland County reaching 90.7%, while Black or African American women report significantly lower access, especially in Fairfield (73.6%) and Litchfield (75.1%). Hispanic women also have lower rates, particularly in Fairfield (73.2%). American Indian/Alaska Native women show significant variation, with very low access in Fairfield (65.0%) but better rates in New London (85.4%). These disparities indicate ongoing barriers to early care for certain groups.

6. Life Expectancy at Birth

Life expectancy at birth is the average number of years a newborn is expected to live, assuming current mortality patterns continue throughout their lifetime. It is a comprehensive summary measure of population health, reflecting the cumulative impact of health behaviors, access to care, socioeconomic factors, chronic disease prevalence, and environmental conditions. Higher life expectancy generally indicates a healthier community, while lower life expectancy often reveals underlying challenges in health access, social support, and economic opportunity.

Connecticut's life expectancy at birth (80.3 years) is higher than the national average (78.8), with the highest figures in Fairfield (81.5), Tolland (81.1), and Middlesex (81.0) counties. The lowest is in Windham County (79.1), indicating regional disparities in overall health outcomes. Life expectancy closely correlates with broader health-related social needs such as income, education, access to care, and environmental conditions, which tend to be more favorable in suburban counties compared to rural or urban areas with higher poverty rates.²²



²² Ibid.

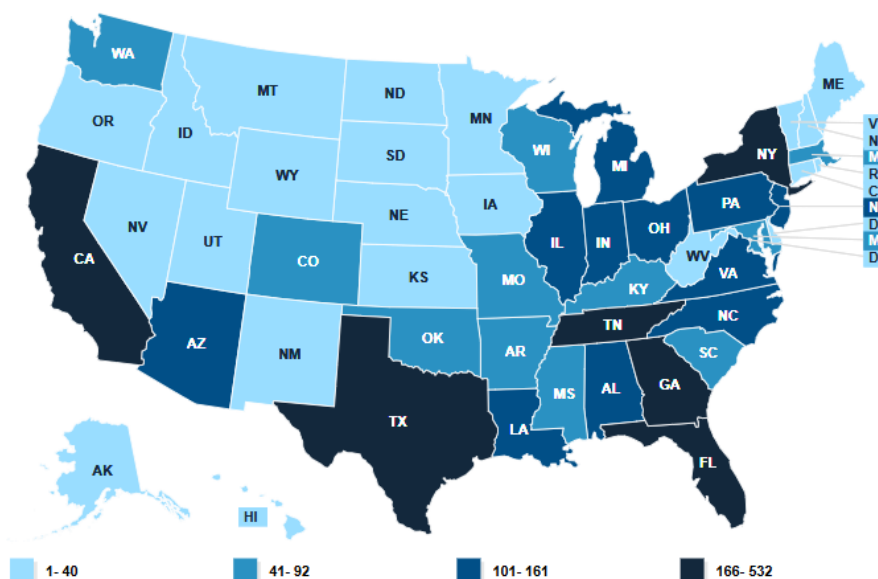
Outcomes Measures

Please note that the following two measures – Maternal Deaths and Mortality Rates and Infant Mortality – reflect outcomes often associated with the six antecedent or contributing measures described above.

7. Maternal Deaths and Mortality Rates

Maternal mortality – defined as the death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy-related cause – is one of the most critical measures of a health system’s ability to support women’s health. The maternal mortality rate represents the number of maternal deaths per 100,000 live births and serves as a sentinel indicator of both the quality of care and other factors affecting maternal well-being. These deaths are often preventable and linked to complications such as mental health conditions²³, hemorrhage, cardiovascular or hypertensive disorders, infection, and underlying chronic conditions, as well as systemic issues like delayed care and inadequate access to services. Monitoring maternal deaths and mortality rates helps public health officials identify risk factors, design targeted interventions, and allocate resources effectively to protect maternal lives.

In Connecticut, maternal mortality remains a concern, despite the state’s generally strong healthcare infrastructure. The state rate (16.7 per 100,000 live births) was well below the US average (23.0) – ranking Connecticut 33rd in the US (1 = the highest rate, or worst performing state).²⁴



²³ Mental health conditions include deaths of suicide, overdose/poisoning related to substance use disorder, and other deaths determined by the MMRC to be related to a mental health condition, including substance use disorder. Source: US CDC, “Maternal Mortality Prevention”, 2024. Available at <https://www.cdc.gov/maternal-mortality/php/data-research/index.html>

²⁴ Sources: CDC Wonder, Natality 2023; NPPES NPI 2024; US CDC; Centers for Disease Control and Prevention, National Center for Health Statistics (NCHS), National Vital Statistics System, “Maternal deaths and mortality rates: Each state, the District of Columbia, United States, 2018-2022”; KFF, State Health Facts, Preterm Births as a Percent of All Births by Race/Ethnicity, from the Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2016-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program; Osterman MJK, Hamilton BE, Martin JA, Driscoll AK, Valenzuela CP. Births: Final data for 2021. National Vital Statistics Reports; vol 72, no 1. 2023

While the overall maternal mortality rate is lower than the national average, disparities persist along racial and ethnic lines, with Black women experiencing disproportionately higher rates of death related to pregnancy and childbirth. These challenges reflect longstanding systemic challenges, unequal access to prenatal and postpartum care, and differences in chronic disease burden. Accurate reporting and analysis of maternal deaths are essential for understanding the root causes and for implementing meaningful changes that promote safer access to care for all women in the state.²⁵ (Note that county-level maternal morbidity data was not available due to sample size restrictions.)

8. Infant Mortality Rate by Race and Ethnicity

The infant mortality rate — defined as the number of deaths of infants under one year of age per 1,000 live births — is a vital measure of a community's overall health and the effectiveness of its maternal and child health systems. It reflects a range of factors, including prenatal care access, maternal health, birth outcomes, neonatal care quality, and the broader HRSNs affecting families. Reducing infant mortality is a key public health priority, as it signals improvements not only in medical care but also in HRSNs such as housing stability, nutrition, education, and income. Leading causes of infant death include preterm birth, low birth weight, congenital anomalies, and sudden unexpected infant death (SUID), many of which are preventable with timely, high-quality interventions.

In Connecticut, the overall infant mortality rate is lower than the national average, highlighting some relative strengths in healthcare delivery. As of 2022, Connecticut's infant mortality rate was 4.5 deaths per 1,000 live births, ranking 11th among US states. In comparison, the national average for the United States was 5.61 deaths per 1,000 live births in 2022.²⁶

Over the past decade, Connecticut has consistently maintained an infant mortality rate below the national average. For example, in 2017, the state's rate was 4.6 deaths per 1,000 live births, a decrease from 5.9 in 2005.²⁷

These statistics highlight Connecticut's ongoing efforts to improve infant health outcomes, resulting in rates consistently lower than the national average. Detailed tables showing the maternal data referenced above are included in the appendices for the state and by county.

However, significant disparities remain, particularly among racial and ethnic groups. Black or African American infants in Connecticut are more than twice as likely to die before their first birthday compared to White infants 9.9% compared to 4.7% — a pattern consistent with

²⁵ Note: Contributing factors such as Caesarian section and other factors also reflect racial or ethnic variances. For example, Caesarean deliveries as a percentage of all births show that an “All races and ethnicities” rate of 35% while differences exist for Hispanics and Non-Hispanic Whites (both 35%) and Blacks / African Americans (40%).

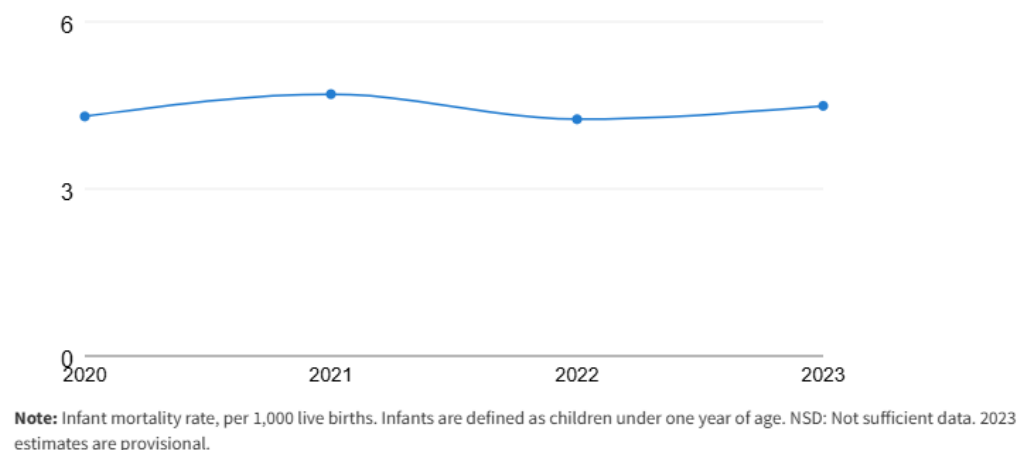
²⁶ US CDC, 2023. Available at www.cdc.gov/nchs/data/nvsr/nvsr73/nvsr73-05.pdf?utm_source=chatgpt.com

²⁷ US Department of Health and Human Services, HRSA, [MCHB Tvis Data](https://mchb.tvisdata.hrsa.gov/Narratives/Overview/ae9156da-f2fd-4afc-89a7-044d83c705f6?utm_source=chatgpt.com). Available at https://mchb.tvisdata.hrsa.gov/Narratives/Overview/ae9156da-f2fd-4afc-89a7-044d83c705f6?utm_source=chatgpt.com

national trends. Similarly, Hispanic infants have higher mortality rates (5.8%) than Whites (4.7%). These disparities are rooted in various HRSNs, as well as access to care before, during, and after pregnancy. Addressing infant mortality may benefit from comprehensive approaches that help ensure improved access to quality care. Note that county-level infant mortality data was not available due to sample size restrictions.

Total infant mortality rates have been stable, 2020-2023 fluctuating between 4.3% and 4.7%.²⁸

Infant Mortality Rate, 2020-2023, Connecticut



As noted above, detailed tables showing the maternal data referenced above are included in the appendices for the state and by county.

²⁸ Source: KFF, State Health Facts, Infant Mortality Rates by Race/Ethnicity from the United States Department of Health and Human Services (US DHHS), Centers of Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics (DVS). Linked Birth / Infant Death Records 2007-2021, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, on CDC WONDER On-line Database.

Appendix 5: Maternal Health Data Tables

Maternal Health: Select, Key Measures (2019-2023, unless otherwise cited)

	Hartford County	Litchfield County	Windham County	Middlesex County	Tolland County	Fairfield County	New Haven County	New London County	Connecticut	US
Total Population (2019-2023)	895,736	185,732	116,156	164,983	146,907	959,099	862,028	267,707	3,598,348	332,387,540
Obstetrics/Gynecology (Females per 1 OBGYN) Ratio (2024)	1,959	5,977	6,510	6,003	9,560	2,158	2,347	4,049	2,493	3,454
Tobacco Use During Pregnancy (2023)	1.9%	3.3%	4.4%	1.7%	1.8%	0.6%	2.3%	2.5%	1.8%	3.0%
American Indian or Alaska Native (not Hispanic or Latino)	NA	NA	NA	NA	NA	NA	NA	NA	8.3%	12.3%
Asian (non Hispanic or Latino)	NA	NA	NA	NA	NA	NA	NA	NA	0.2%	0.3%
Black or African American (not Hispanic or Latino)	2.1%	NA	NA	NA	NA	1.3%	4.1%	3.4%	2.6%	3.8%
Native Hawaiian or Other Pacific Islander (not Hispanic or Latino)	NA	NA	NA	NA	NA	NA	NA	NA	NA	2.6%
Hispanic or Latino	2.7%	2.4%	3.0%	2.7%	3.5%	0.6%	2.4%	2.6%	1.9%	1.2%
White (not Hispanic or Latino)	3.0%	5.7%	8.0%	3.1%	3.8%	0.8%	3.5%	5.1%	3.1%	6.7%
More than one Race (not Hispanic or Latino)	6.2%	NA	12.7%	7.0%	NA	2.1%	5.0%	7.5%	5.6%	7.7%

- OB/GYN care is highly limited in (especially) Tolland, Middlesex, Windham, and Litchfield Counties.
- Tobacco use during pregnancy in the state is better than the US average; however, there are pockets of much higher use – especially among White and multiracial mothers in Windham and some other counties.

Preterm Births

Maternal Health: Select, Key Measures (2019-2023, unless otherwise cited)

	Hartford County	Litchfield County	Windham County	Middlesex County	Tolland County	Fairfield County	New Haven County	New London County	Connecticut	US
Preterm Births	9.7%	8.3%	9.6%	8.6%	8.5%	8.5%	9.6%	9.0%	9.1%	10.2%
American Indian or Alaska Native (not Hispanic or Latino)	NA	NA	NA	NA	NA	NA	NA	NA	10.9%	12.0%
Asian (non Hispanic or Latino)	8.3%	8.8%	12.9%	6.6%	5.2%	8.0%	7.9%	8.7%	8.0%	8.9%
Black or African American (not Hispanic or Latino)	14.5%	11.9%	14.3%	12.5%	9.3%	12.3%	13.0%	12.1%	13.2%	14.5%
Native Hawaiian or Other Pacific Islander (not Hispanic or Latino)	NA	NA	NA	NA	NA	NA	NA	NA	NA	12.1%
Hispanic or Latino	11.1%	9.8%	8.6%	10.2%	11.5%	9.6%	10.2%	9.0%	10.1%	10.0%
White (not Hispanic or Latino)	8.3%	8.1%	9.7%	8.1%	8.5%	7.5%	8.6%	8.8%	8.2%	9.3%
More than one Race (not Hispanic or Latino)	10.2%	0.0%	8.2%	12.0%	0.0%	8.5%	11.1%	10.2%	10.0%	10.8%

- At the state level, Connecticut Preterm Births are better than the US average. However, in every Connecticut county preterm births among Black or African American women are notably higher than the state average – in several cases approximately 50% higher than the state average.

Low Birth Weight

Maternal Health: Select, Key Measures (2019-2023, unless otherwise cited)

	Hartford County	Litchfield County	Windham County	Middlesex County	Tolland County	Fairfield County	New Haven County	New London County	Connecticut	US
Low Birth Weight	8.2%	6.1%	7.2%	7.1%	7.5%	7.0%	8.2%	7.4%	7.6%	8.2%
American Indian or Alaska Native (not Hispanic or Latino)	0.0%	NA	NA	NA	NA	NA	NA	NA	9.6%	8.3%
Asian (non Hispanic or Latino)	9.3%	6.9%	NA	7.4%	8.0%	8.9%	9.3%	9.6%	9.0%	9.0%
Black or African American (not Hispanic or Latino)	13.5%	9.7%	NA	10.2%	8.1%	12.6%	13.4%	12.5%	13.0%	14.5%
Native Hawaiian or Other Pacific Islander (not Hispanic or Latino)	NA	NA	NA	NA	NA	NA	NA	NA	NA	8.6%
Hispanic or Latino	9.6%	6.0%	7.8%	9.7%	9.4%	7.9%	8.5%	8.4%	8.5%	7.7%
White (not Hispanic or Latino)	6.5%	6.0%	7.5%	6.5%	7.3%	5.4%	6.6%	6.6%	6.3%	7.0%
More than one Race (not Hispanic or Latino)	8.8%	NA	7.5%	9.5%	NA	9.0%	10.3%	9.8%	9.3%	9.2%

- Similarly, Black or African American communities across Connecticut are 30% to 60% (in most counties) more likely to have low birth weight babies.²⁹

²⁹ NOTE: Several studies have shown that low birth weight (LBW) babies require much greater initial hospital delivery and inpatient costs, as well as a much higher lifetime probability of severe health issues. “Studies have also established a correlation between LBW and high blood pressure, cerebral palsy, deafness, blindness, asthma, and lung disease among children, as well as with IQ, test scores, behavioral problems and cognitive development.” Citation: Kaelber and Pugh [1969], McCormick et al. [1992], Paneth [1995], Nelson and Grether [1997], Lucas, Morley, and Cole [1998], Brooks et al. [2001], Matte et al. [2001], and Richards et al. [2001].

First Trimester Prenatal Care

Maternal Health: Select, Key Measures (2019-2023, unless otherwise cited)

	Hartford County	Litchfield County	Windham County	Middlesex County	Tolland County	Fairfield County	New Haven County	New London County	Connecticut	US
First Trimester Prenatal Care	86.5%	87.9%	88.1%	88.2%	89.8%	81.3%	82.8%	88.4%	84.7%	76.8%
American Indian or Alaska Native (not Hispanic or Latino)	77.3%	NA	NA	NA	NA	65.0%	81.4%	85.4%	80.8%	62.8%
Asian (non Hispanic or Latino)	86.3%	83.1%	83.2%	87.5%	88.0%	81.9%	81.4%	86.7%	84.0%	80.5%
Black or African American (not Hispanic or Latino)	79.1%	75.1%	80.6%	86.7%	83.9%	73.6%	75.8%	77.1%	76.7%	66.1%
Native Hawaiian or Other Pacific Islander (not Hispanic or Latino)	NA	NA	NA	NA	NA	NA	NA	NA	78.9%	48.0%
Hispanic or Latino	82.8%	76.5%	82.9%	83.9%	84.9%	73.2%	76.9%	81.1%	77.7%	69.5%
White (not Hispanic or Latino)	89.7%	89.7%	89.4%	89.1%	90.7%	85.9%	87.0%	90.6%	88.2%	81.4%
More than one Race (not Hispanic or Latino)	81.6%	79.4%	84.3%	85.4%	82.1%	79.5%	75.4%	85.5%	80.2%	73.6%
Life Expectancy at Birth (2010-2015)	79.8	80.2	79.1	81.0	81.1	81.5	79.5	79.7	80.3	78.8

Sources for all tables above: CDC Wonder, Natality 2023; NPES NPI 2024; US CDC.

- First term prenatal care is, again, better in Connecticut (state average) than the US.
- Racial and ethnic minorities are much less likely to receive early care.

Appendix 6: Life Expectancy Data

Life Expectancy	Litchfield County	Connecticut	United States
Premature Death Definition: Years of potential life lost before age 75 per 100,000 population (age-adjusted)	7,200	6,500	8,000
Poor or Fair Health	11%	12%	14%
Poor Physical Health Days (past 30 days)	3	2.9	3.3
Poor Mental Health Days (past 30 days)	4.7	4.4	4.8
Low Birthweight	6%	8%	8%
Adult Smoking	13%	12%	15%
Adult Obesity	27%	31%	34%
Food Environment Index	8.4	8.3	7.7
Physical Inactivity	18%	22%	23%
Access to Exercise Opportunities	81%	93%	84%
Excessive Drinking	17%	17%	18%
Alcohol-Impaired Driving Deaths	33%	32%	26%
Sexually Transmitted Infections per 100,000 population	190.8	409.1	495.5
Teen Births	5	8	17
Uninsured	5%	6%	10%
Primary Care Physicians (X:1)	1,810	1,210	1,330
Dentists (X:1)	1,550	1,150	1,360
Mental Health Providers (X:1)	330	220	320
Preventable Hospital Stays	2,447	2,651	2,681
Mammography Screening	45%	47%	43%
Flu Vaccinations	54%	54%	46%
High School Completion	94%	91%	89%
Some College	69%	71%	68%
Unemployment	3.90%	4.20%	3.70%
Children in Poverty	10%	13%	16%
Income Inequality	4.2	5.1	4.9
Children in Single-Parent Households	22%	25%	25%

Life Expectancy	Litchfield County	Connecticut	United States
Social Associations	9.1	8.9	9.1
Injury Deaths	90	80	80
Air Pollution - Particulate Matter	5	7.4	7.4
Severe Housing Problems	14%	17%	17%
Driving Alone to Work	77%	72%	72%
Long Commute - Driving Alone	42%	35%	36%
Life Expectancy (all)	79	79.6	
Hispanic	84.9	NA	NA
Non-Hispanic AIAN		NA	NA
Non-Hispanic Asian	91.5	NA	NA
Non-Hispanic Black or African American	76.1	NA	NA
Non-Hispanic White	78.6	NA	NA
Source: County Health Rankings, 2024. Available at https://www.countyhealthrankings.org/health-data/compare-counties?year=2024&compareCounties=09013%2C09000%2C00000%2C			

Appendix 7: Life Expectancy

Introduction

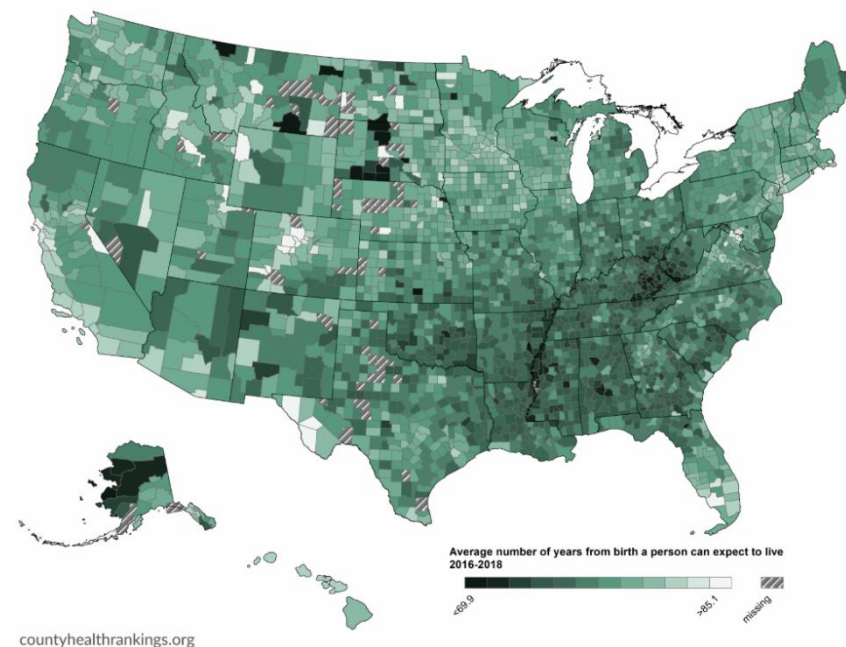
Life expectancy is a crucial measure of overall community health. Litchfield County data include several key health indicators that influence the overall life expectancy of its residents. With a life expectancy of 79.0 years, Litchfield County is similar to the Connecticut state average of 79.6 years. This section highlights the primary health challenges and areas for improvement related to life expectancy, analyzing how specific health measures compare with state and national data.³⁰

Premature Death and General Health Indicators

Premature death, measured as years of potential life lost before age 75, stands at 7,200 per 100,000 population, significantly higher than Connecticut's 6,500 but below the national rate. Addressing these health challenges through improved healthcare access, chronic disease management, and mental health support is critical to increasing life expectancy in the county

In Litchfield County, poor or fair health is reported by 11% of residents, similar to the state rate (12%) and below the national rate (14%). Similarly, Litchfield County residents experience 3.0 poor physical health days per month, which is slightly higher than Connecticut's 2.9 days and below the U.S. average of 3.3 days. Poor mental health days average 4.7 per month in Litchfield County, slightly exceeding the state (4.4) average. Regardless of nominal comparisons, there is a strong need for greater mental health support.³¹

Life Expectancy Among U.S. Counties (Rankings 2020)



³⁰ County Health Rankings, 2024. Available at <https://www.countyhealthrankings.org/health-data/compare-counties?year=2024&compareCounties=09013%2C09000%2C00000%2C>

³¹ Ibid

Lifestyle and Behavioral Health Factors

Lifestyle and behavioral health factors play a significant role in determining overall community well-being and longevity. Unhealthy behaviors such as smoking, excessive alcohol consumption, and physical inactivity contribute to chronic disease and premature mortality. In Litchfield County, several of these factors exceed state and national averages, underscoring the need for targeted health promotion initiatives and preventive care interventions.

Several behavioral factors contribute to health outcomes in Litchfield County. Adult smoking rates (13%) are similar to both the state (12%) and national (15%) rates, suggesting that tobacco cessation programs could be broadly beneficial. Adult obesity rates (27%) are well below the state average (31%) and the national average (34%).³²

Access to exercise opportunities is lower in Litchfield County (81%) compared to Connecticut (93%) and the U.S. (84%), highlighting a possible gap in infrastructure for recreational activities. Additionally, excessive drinking rates (17%) are similar to both the state (17%) and national (18%) averages.³³

Healthcare Access and Preventive Care

Access to quality healthcare services and preventive care is essential for improving health outcomes and reducing disparities in life expectancy. In Litchfield County, limited access to primary care, dental care, and mental health services presents challenges for residents, leading to potential delays in treatment and management of chronic conditions. Strengthening access to healthcare providers and increasing participation in preventive health measures can help improve overall community well-being.

As noted, healthcare access remains a concern, particularly in provider availability. Litchfield County has significantly fewer primary care physicians, with a provider-to-population ratio of 1,810:1, compared to Connecticut's 1,210:1 and the national ratio of 1,330:1. Similar shortages exist for dentists (1,550:1 vs. 1,150:1 in Connecticut and 1,360:1 nationally) and mental health providers (330:1 vs. 220:1 in Connecticut and 320:1 nationally). These challenges indicate a critical need for healthcare workforce development in the county.³⁴

Preventive care metrics also reveal areas for improvement. Mammography screening rates are slightly lower in Litchfield County (45%) compared to Connecticut (47%) but above the national average (43%). Flu vaccination rates in the county (54%) are equal to the state average (54%) but higher than the national rate (46%). Improving these rates could help reduce preventable diseases and hospitalizations.³⁵

³² Ibid.

³³ Ibid.

³⁴ Ibid.

³⁵ Ibid.

Health-related Social Needs

Health-related social and economic factors play a significant role in shaping community health outcomes. Education, income levels, employment, and housing conditions influence access to healthcare, healthy food, and overall well-being. Addressing these issues may help drive successful efforts to reduce health disparities and improve long-term health prospects for Litchfield County residents.

The Litchfield County high school completion rate (94%, one the highest in the state) is above Connecticut's rate of 91% and the national average (89%). However, the percentage of residents with some college education (69%) is slightly lower than the state (71%) figure and equal to the US average), suggesting that education initiatives could enhance long-term health outcomes.³⁶

Unemployment in Litchfield County stands at 3.9%, marginally below Connecticut's 4.2% yet above the national average of 3.7%. Additionally, 10% of children in Litchfield County live in poverty, a rate lower than the state average (13%) and much lower than the national rate (16%). These factors contribute to economic instability, which can negatively affect access to healthcare and healthy living conditions.³⁷

Housing and environmental concerns also play a role in community health. Severe housing problems affect 14% of Litchfield County residents, which is lower than both the state and national averages (17%).

Health Risk Behaviors and Mortality

Health risk behaviors and mortality indicators provide insight into preventable causes of death within a community. High rates of injury-related fatalities, substance abuse, and unsafe driving behaviors can significantly impact life expectancy. Addressing these risk factors through hospital-based or public health initiatives, education, and policy changes may help reduce mortality rates and improve overall community well-being.

Injury deaths are notably higher in Litchfield County (93 per 100,000 population) than in Connecticut (80) and the national average (80). Alcohol-impaired driving deaths (33%) also exceed the national average (26%).³⁸

Teen birth rates in Litchfield County (five per 1,000 females aged 15-19) are notably lower than the Connecticut average (eight) and dramatically lower than the national rate (17). Similarly, sexually transmitted infections are significantly lower in Litchfield County (190.8 per 100,000) compared to both the state (409.1) and national averages (495.5), suggesting better sexual health practices or lower rates of testing and reporting.³⁹

³⁶ Source: County Health Rankings, 2024. Available at <https://www.countyhealthrankings.org/health-data/compare-counties?year=2024&compareCounties=09013%2C09000%2C00000%2C>

³⁷ Ibid.

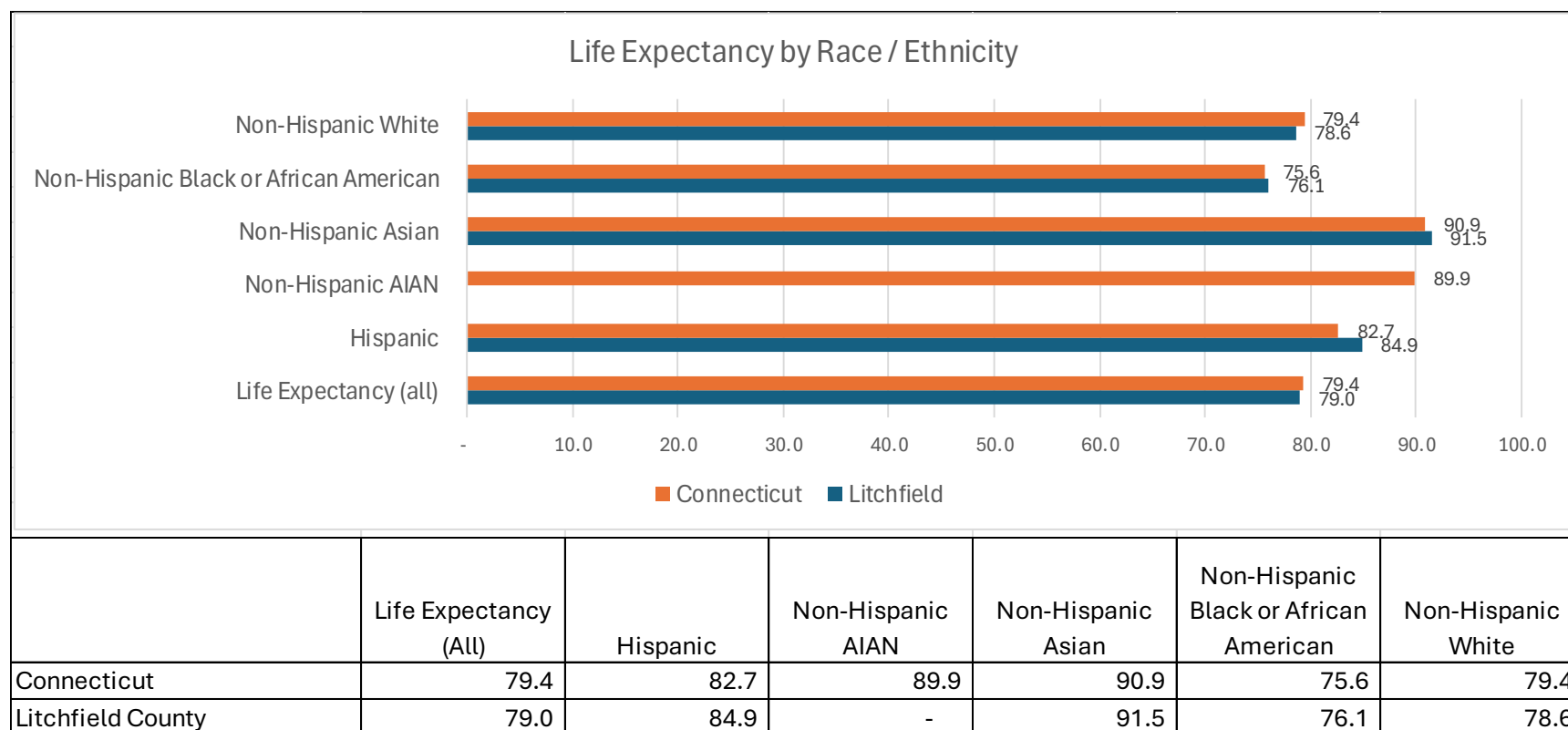
³⁸ Ibid.

³⁹ Ibid.

Conclusion and Recommendations

Litchfield County faces several challenges that impact its residents' health and life expectancy. Key areas for improvement include expanding access to primary and mental healthcare providers, increasing efforts in smoking cessation and obesity prevention, enhancing exercise opportunities, and addressing socioeconomic disparities. Improving preventive care measures, reducing injury-related deaths, and strengthening health education programs will be critical in ensuring a healthier future for Litchfield County residents.

Figure 11: Life Expectancy by Race and Ethnicity



40

⁴⁰ AIAN means American Indian / Alaska Native.

As expected, mortality rates in Litchfield County residents escalate with age; however, there is an atypical escalation of rates among people ages 45 to 49. Note that due to small population, mortality data is not available for Blacks / African Americans or Hispanics (in most cases).

Table 9: Crude Death Rate per 100,000 Population by Race / Ethnicity

Litchfield County		Race / Ethnicity	
Age Group	White	Black or African American	Hispanic or Latino
< 1 year	-	-	-
1-4 years	-	-	-
5-9 years	-	-	-
10-14 years	-	-	-
15-19 years	67.6	-	-
20-24 years	119.2	-	-
25-29 years	153.9	-	-
30-34 years	237.4	-	-
35-39 years	215.9	-	-
40-44 years	218.9	-	-
45-49 years	333.8	-	-
50-54 years	377.4	-	-
55-59 years	564.3	-	-
60-64 years	842.5	-	-
65-69 years	1,169.5	-	-
70-74 years	1,933.8	-	-
75-79 years	3,242.9	-	-
80-84 years	5,675.6	-	-
85-89 years	-	-	-
90-94 years	-	-	-
95-99 years	-	-	-
100+ years	-	-	-

Source: CDC Wonder Database, 2016-2020 (reported 2025). Available at Table "Underlying Cause of Death, 1999-2020 Results," (2026-2020), <https://wonder.cdc.gov/deaths-by-underlying-cause.html>

Note: Data is not shown for Black or African American or Hispanic or Latino communities due to small sample sizes.

Appendix 8: Hospital Utilization Data

Ranked List of 15 Select Health Indicator Hospital Utilization Rates for Adults in Connecticut								
Health Indicator	1	2	3	4	5	6	7	8
Mental Health Composite	10.4	13.2	13.0	12.8	9.9	15.5	10.4	9.4
Sepsis	8.4	9.1	8.1	9.1	8.1	9.4	7.3	7.7
Heart Failure (HF)	4.3	4.9	6.8	5.6	7.4	5.5	4.4	7.1
Substance-Related Disorders (SRD)	8.1	8.9	9.3	9.9	6.8	11.3	8.2	6.5
Community Acquired (CommAcq) Pneumonia	4.3	7.1	5.6	4.0	4.7	5.5	4.2	5.4
High Blood Pressure (HBP)	4.5	5.5	4.5	5.7	4.1	5.4	5.7	5.1
Chronic Obstructive Pulmonary Disease (COPD)	2.2	4.2	5.6	2.3	4.0	5.9	2.8	4.7
Acute Myocardial Infarction (AMI)	1.8	2.2	3.0	1.8	3.5	1.9	1.6	3.5
Stroke	2.5	2.7	4.8	2.7	2.5	2.7	2.6	3.4
Diabetes - Uncontrolled/Short Term Complications (Unc-STC)	2.7	3.0	2.6	3.9	2.8	3.5	3.0	2.4
Asthma	2.8	3.4	2.1	3.5	2.3	4.1	3.2	2.3
Coronary Artery Disease (CAD)	1.0	2.2	1.4	1.4	1.7	1.6	1.6	2.2
Arthritis	1.8	1.7	3.0	1.7	2.7	1.8	1.8	3.0
Diabetes - Long Term Complications (LTC)	1.3	1.5	1.8	1.6	1.1	1.6	1.3	1.9
Overweight/Obesity	1.0	1.0	0.8	1.7	1.1	1.4	1.2	0.9

See Legend below⁴¹

⁴¹ Legend:

1 = Connecticut state average; 2 = Backus Hospital; 3 = Charlotte Hungerford Hospital; 4 = Hartford Hospital; 5 = MidState Medical Center; 6 = The Hospital of Central Connecticut; 7 = St. Vincent's Medical Center; 8 = Windham Hospital

Ranked List of 15 Select Health Indicator Hospital Utilization Rates for Adults in Connecticut - Percent Variance to State

Health Indicator	1	2	3	4	5	6	7	8
Mental Health Composite	-	26.9%	25.0%	23.1%	-4.8%	49.0%	0.0%	-9.6%
Sepsis	-	8.3%	-3.6%	8.3%	-3.6%	11.9%	-13.1%	-8.3%
Heart Failure (HF)	-	14.0%	58.1%	30.2%	72.1%	27.9%	2.3%	65.1%
Substance-Related Disorders (SRD)	-	9.9%	14.8%	22.2%	-16.0%	39.5%	1.2%	-19.8%
Community Acquired (CommAcq) Pneumonia	-	65.1%	30.2%	-7.0%	9.3%	27.9%	-2.3%	25.6%
High Blood Pressure (HBP)	-	22.2%	0.0%	26.7%	-8.9%	20.0%	26.7%	13.3%
Chronic Obstructive Pulmonary Disease (COPD)	-	90.9%	154.5%	4.5%	81.8%	168.2%	27.3%	113.6%
Acute Myocardial Infarction (AMI)	-	22.2%	66.7%	0.0%	94.4%	5.6%	-11.1%	94.4%
Stroke	-	8.0%	92.0%	8.0%	0.0%	8.0%	4.0%	36.0%
Diabetes - Uncontrolled/Short Term Complications (Unc-STC)	-	11.1%	-3.7%	44.4%	3.7%	29.6%	11.1%	-11.1%
Asthma	-	21.4%	-25.0%	25.0%	-17.9%	46.4%	14.3%	-17.9%
Coronary Artery Disease (CAD)	-	120.0%	40.0%	40.0%	70.0%	60.0%	60.0%	120.0%
Arthritis	-	-5.6%	66.7%	-5.6%	50.0%	0.0%	0.0%	66.7%
Diabetes - Long Term Complications (LTC)	-	15.4%	38.5%	23.1%	-15.4%	23.1%	0.0%	46.2%
Overweight/Obesity	-	0.0%	-20.0%	70.0%	10.0%	40.0%	20.0%	-10.0%

See Legend below⁴²

⁴² Legend:

1 = Connecticut state average; 2 = Backus Hospital; 3 = Charlotte Hungerford Hospital; 4 = Hartford Hospital; 5 = MidState Medical Center; 6 = The Hospital of Central Connecticut; 7 = St. Vincent's Medical Center; 8 = Windham Hospital

Appendix 9: CHIME Data References and Sourcing

Description of Data Sources

ChimeData (FY 2024)

The hospital utilization rates reported in this Community Health Profile are sourced from ChimeData encounter records supplied by the Connecticut Hospital Association's (CHA) acute care member hospitals. ChimeData patient encounter records are flagged with "health indicators" based on the presence of ICD-10-CM diagnosis codes associated with key health conditions, aligning those reference code sets wherever possible with evidence-based quality indicators published by the Agency for Healthcare Research and Quality (AHRQ), available at: qualityindicators.ahrq.gov. Please see the "Code Reference" sheet (Appendix 9) for the full list of ICD-10-CM diagnosis codes used to classify ChimeData patient encounters in association with each health indicator included in this report.

All rates for each health indicator are based on a count of distinct patients in fiscal year 2024 (October 1, 2023 – September 30, 2024) who had at least one hospital encounter, in either the Inpatient, Emergency Department, or Observation service settings, with a principal diagnosis that matches one of the ICD-10-CM codes associated with the given condition. If a patient had more than one encounter for the same health indicator within this time period, the key characteristics from their record used to classify rates across towns, and categories of race/ethnicity and age, are assigned based on the recorded characteristics that held plurality across all of the patient's encounter records. For example, if a patient had six hospital encounters over the course of the year for asthma, and they resided in Town A for five of the encounters and in Town B for only one encounter, then that patient would be counted only once in the analysis and assigned to the asthma patient total in Town A. In instances where there is not a plurality, the response on the patient's most recent encounter is used. This was done to prevent the same patient from contributing to more than one group rate per health indicator.

American Community Survey (ACS, 2018-2022)

Population estimates by age, race, and ethnicity used as the denominators to calculate unadjusted and age-adjusted patient rates are sourced from the U.S. Census Bureau's American Community Survey 5-Year Data (2018-2022), available at data.census.gov. Note that the values presented are derived from a representative probability-based population survey and should be interpreted as best estimates and not as exact population values. Estimates were sourced at the county subdivision/town level to represent the selected Major Population Center, and in cases where towns are combined for this selection, have been further aggregated to cover both towns. Estimates have also been aggregated from the county subdivision/town level to cover the Community Health Needs Area for each hospital, as a direct sum of town-level population estimates. Statewide estimates for Connecticut (CT) are sourced directly from the state level data files.

Connecticut Department of Social Services Data Dashboard (CT DSS, 2023)

The number of Medicaid beneficiaries for 2023 are published for each town in Connecticut in the Department of Social Services' *People Served Report*, which can be accessed at data.ct.gov. We provide these data, for reference purposes, on the CHNA Definition sheet at the beginning of this report. Data have been suppressed (indicated by an "S") for two towns, Canaan and North Canaan, given suspected misattribution by DSS of enrollments between these neighboring locations. Data corrections may be issued by DSS in the future, and thus these data should be treated as preliminary and may be subject to change.

Methodology for Age-Adjusted Rates

Step 1: Patient Counts and Population Estimates

A tabular worksheet is provided for every health indicator presented in this Community Health Profile, each displaying the count of distinct patients with a hospital encounter associated with that condition along with population estimates by age, geography (Community Health Needs Area, Major Population Center, and the State of CT), and race/ethnicity. We use these characteristics to define unique “groups” by race/ethnicity and geography, in order to calculate rates that can be compared across racial/ethnic categories and across different geographic locations. The patient counts are sourced from ChimeData and the population estimates are sourced from the American Community Survey (see Description of Data Sources above for additional detail). In cases where there is insufficient patient volume to calculate a reliable rate for a given group and age category ($N < 16$), the patient count is suppressed and depicted in the table with an “S”. (For more information, see: [CDC Suppression Methodology for Reliable Rates](#)). Additionally, in cases where only one age category has a suppressed patient count for a given group, the total patient count is also suppressed to prevent patient counts and unreliable age-specific rates from being derived.

Step 2: Unadjusted Rates

The patient counts and population estimates for each group are used to calculate unadjusted rates per 1,000 population by dividing the total patient count within a given geographic location and category of race or ethnicity by the total estimated population size per 1,000.

Step 3: Age-Specific Rates

Age-specific rates per 1,000 population (i.e., observed patient rates within a single age category) are calculated across every age category for each group by dividing the patient count in each age category by the estimated population size per 1,000. If the patient count had been suppressed due to insufficient volume ($N < 16$), then the age-specific rate will not be calculated and instead depicted as “NA” in the table.

Step 4: Apply a Standard Population Age Structure, Calculate Expected Patients Under This Hypothetical Scenario

To facilitate the comparison of rates across different racial-ethnic groups or geographic locations that often differ in age structure, a standard population age structure is applied to all groups. We use the state-level population estimates by age category for Connecticut from the American Community Survey (2018-2022) for this purpose. The expected patient count that would be observed under this alternate age structure is calculated by multiplying a group's observed age-specific rates by the standard population size for a given age category. If the patient count had been suppressed due to insufficient volume ($N < 16$), then the expected patient count will not be calculated, and the standard population size will not be shown; both values will be depicted as "NA" in the table.

Step 5: Age-Adjusted Rates

Two sets of age-adjusted rates (i.e., the rate that would be observed under the standard population's age structure) are calculated for every group, one across all age categories with sufficient patient volume, and another across all adult age categories (18+) with sufficient patient volume. In both cases, the age-adjusted rate is calculated by summing the expected patient counts from the contributing age categories with sufficient volume and dividing by the sum of the standard population estimates per 1,000 from the contributing age categories with sufficient patient volume. In the charts for each health indicator, the adult age-adjusted rates are the datapoints plotted for all groups. To aid in making the most accurate comparisons, the age categories contributing to each age-adjusted rate based on the observed patient volume for each group are listed in the table below each rate and are also displayed at the bottom of each data bar in the accompanying charts. Caution should be taken when comparing rates that are based upon a different set of contributing age groups, and in such cases, referring to age-specific rates in the detailed tables will yield better comparisons. To provide insight into conditions that also have a significant impact on pediatric populations, such as asthma and mental health, we provide supplemental charts plotting the age-specific rates for 0- to 17-year-olds for these conditions across racial-ethnic groups and geographic locations.

Appendix 10: Code Reference Sheet

Health Indicator	External Standard(s) Referenced	ICD-10-CM Codes
Acute Myocardial Infarction	Centers for Medicare & Medicaid Services (CMS) Hospital Readmissions Reduction Program (HRRP); Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicator (IQI) 15	I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I21.9, I21.A1, I21.A9, I22.0, I22.1, I22.2, I22.8, I22.9

Health Indicator	External Standard(s) Referenced	ICD-10-CM Codes
Arthritis	None	M05.00, M05.011, M05.012, M05.019, M05.021, M05.022, M05.029, M05.031, M05.032, M05.039, M05.041, M05.042, M05.049, M05.051, M05.052, M05.059, M05.061, M05.062, M05.069, M05.071, M05.072, M05.079, M05.09, M05.10, M05.111, M05.111, M05.112, M05.119, M05.121, M05.122, M05.129, M05.131, M05.132, M05.139, M05.141, M05.142, M05.149, M05.151, M05.152, M05.159, M05.161, M05.162, M05.169, M05.171, M05.172, M05.179, M05.19, M05.20, M05.211, M05.212, M05.219, M05.221, M05.222, M05.229, M05.231, M05.232, M05.239, M05.241, M05.242, M05.249, M05.251, M05.252, M05.259, M05.261, M05.262, M05.269, M05.271, M05.272, M05.279, M05.29, M05.30, M05.311, M05.312, M05.319, M05.321, M05.322, M05.339, M05.341, M05.342, M05.349, M05.351, M05.352, M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.60, M05.611, M05.612, M05.619, M05.621, M05.622, M05.629, M05.631, M05.632, M05.639, M05.641, M05.642, M05.649, M05.651, M05.652, M05.659, M05.661, M05.662, M05.669, M05.671, M05.672, M05.679, M05.69, M05.70, M05.711, M05.712, M05.719, M05.721, M05.722, M05.729, M05.731, M05.732, M05.739, M05.741, M05.741, M05.742, M05.749, M05.751, M05.752, M05.759, M05.761, M05.762, M05.769, M05.771, M05.772, M05.779, M05.79, M05.7A, M05.80, M05.811, M05.812, M05.819, M05.821, M05.822, M05.829, M05.831, M05.832, M05.839, M05.841, M05.842, M05.849, M05.851, M05.852, M05.859, M05.861, M05.862, M05.869, M05.871, M05.872, M05.879, M05.89, M05.8A, M05.9, M06.00, M06.011, M06.012, M06.019, M06.021, M06.022, M06.029, M06.031, M06.032, M06.039, M06.041, M06.042, M06.049, M06.051, M06.052, M06.059, M06.061, M06.062, M06.069, M06.071, M06.072, M06.079, M06.08, M06.09, M06.0A, M06.1, M06.20, M06.211, M06.212, M06.219, M06.221, M06.222, M06.229, M06.231, M06.232, M06.239, M06.241, M06.242, M06.249, M06.251, M06.252, M06.259, M06.261, M06.262, M06.269, M06.271, M06.272, M06.279, M06.28, M06.29, M06.30, M06.311, M06.312, M06.319, M06.321, M06.322, M06.329, M06.331, M06.332, M06.339, M06.341, M06.342, M06.349, M06.351, M06.352, M06.359, M06.361, M06.362, M06.369, M06.371, M06.372, M06.379, M06.38, M06.39, M06.4, M06.80, M06.811, M06.812, M06.819, M06.821, M06.822, M06.829, M06.831, M06.832, M06.839, M06.841, M06.842, M06.849, M06.851, M06.852, M06.859, M06.861, M06.862, M06.869, M06.871, M06.872, M06.879, M06.88, M06.89, M06.8A, M06.9, M11.00, M11.011, M11.012, M11.019, M11.021, M11.022, M11.029, M11.031, M11.032, M11.039, M11.041, M11.042, M11.049, M11.051, M11.052, M11.059, M11.061, M11.062, M11.069, M11.071, M11.072, M11.079, M11.08, M11.09, M11.10, M11.111, M11.112, M11.119, M11.121, M11.122, M11.129, M11.131, M11.132, M11.139, M11.141, M11.142, M11.149, M11.151, M11.152, M11.159, M11.161, M11.162, M11.169, M11.171, M11.172, M11.179, M11.18, M11.19, M11.20, M11.211, M11.212, M11.219, M11.221, M11.222, M11.229, M11.231, M11.232, M11.239, M11.241, M11.242, M11.249, M11.251, M11.252, M11.259, M11.261, M11.262, M11.269, M11.271, M11.272, M11.279, M11.28, M11.29, M11.80, M11.811, M11.812, M11.819, M11.821, M11.822, M11.829, M11.831, M11.832, M11.839, M11.841, M11.842, M11.849, M11.851, M11.852, M11.859, M11.861, M11.862, M11.869, M11.871, M11.872, M11.879, M11.88, M11.89, M11.9, M12.00, M12.011, M12.012, M12.019, M12.021, M12.022, M12.029, M12.031, M12.032, M12.039, M12.041, M12.042, M12.049, M12.051, M12.052, M12.059, M12.061, M12.062, M12.069, M12.071, M12.072, M12.079, M12.08, M12.09, M12.10, M12.111, M12.112, M12.119, M12.121, M12.122, M12.129, M12.131, M12.132, M12.139, M12.141,

Health Indicator	External Standard(s) Referenced	ICD-10-CM Codes
		M12.142, M12.149, M12.151, M12.152, M12.159, M12.161, M12.162, M12.169, M12.171, M12.172, M12.179, M12.18, M12.19, M12.50, M12.511, M12.512, M12.519, M12.521, M12.522, M12.529, M12.531, M12.532, M12.539, M12.541, M12.542, M12.549, M12.551, M12.552, M12.559, M12.561, M12.562, M12.569, M12.571, M12.572, M12.579, M12.58, M12.59, M12.80, M12.811, M12.812, M12.819, M12.821, M12.822, M12.829, M12.831, M12.832, M12.839, M12.841, M12.842, M12.849, M12.851, M12.852, M12.859, M12.861, M12.862, M12.869, M12.871, M12.872, M12.879, M12.88, M12.89, M12.9, M13.0, M13.10, M13.111, M13.112, M13.119, M13.121, M13.122, M13.129, M13.131, M13.132, M13.139, M13.141, M13.142, M13.149, M13.151, M13.152, M13.159, M13.161, M13.162, M13.169, M13.171, M13.172, M13.179, M13.80, M13.811, M13.812, M13.819, M13.821, M13.822, M13.829, M13.831, M13.832, M13.839, M13.841, M13.842, M13.849, M13.851, M13.852, M13.859, M13.861, M13.862, M13.869, M13.871, M13.872, M13.879, M13.88, M13.89, M15.0, M15.1, M15.2, M15.3, M15.4, M15.8, M15.9, M16.0, M16.10, M16.11, M16.12, M16.2, M16.30, M16.31, M16.32, M16.4, M16.50, M16.51, M16.52, M16.6, M16.7, M16.9, M17.0, M17.10, M17.11, M17.12, M17.2, M17.30, M17.31, M17.32, M17.4, M17.5, M17.9, M18.0, M18.10, M18.11, M18.12, M18.2, M18.30, M18.31, M18.32, M18.4, M18.50, M18.51, M18.52, M18.9, M19.011, M19.012, M19.019, M19.021, M19.022, M19.029, M19.031, M19.032, M19.039, M19.041, M19.042, M19.049, M19.071, M19.072, M19.079, M19.09, M19.111, M19.112, M19.119, M19.121, M19.122, M19.129, M19.131, M19.132, M19.139, M19.141, M19.142, M19.149, M19.171, M19.172, M19.179, M19.19, M19.211, M19.212, M19.219, M19.221, M19.222, M19.229, M19.231, M19.232, M19.239, M19.241, M19.242, M19.249, M19.271, M19.272, M19.279, M19.29, M19.90, M19.91, M19.92, M19.93, M26.64, M26.641, M26.642, M26.643, M26.649

Health Indicator	External Standard(s) Referenced	ICD-10-CM Codes
Asthma	AHRQ Prevention Quality Indicator (PQI) 15; AHRQ Emergency Department Prevention Quality Indicator (PQE) 04; AHRQ Pediatric Quality Indicator (PDI) 14	J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998
Chronic Obstructive Pulmonary Disease (COPD)	AHRQ PQI 05; CMS HRRP	J41.0, J41.1, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J47.0, J47.1, J47.9
Coronary Artery Disease (CAD)	None	I20.0, I20.1, I20.8, I22.0, I22.1, I22.2, I22.8, I22.9, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61
Diabetes - Long Term Complications (LTC)	AHRQ PQI 03	E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.3211, E10.3212, E10.3213, E10.3219, E10.329, E10.3291, E10.3292, E10.3293, E10.3299, E10.331, E10.3311, E10.3312, E10.3313, E10.3319, E10.339, E10.3391, E10.3392, E10.3393, E10.3399, E10.341, E10.3411, E10.3412, E10.3413, E10.3419, E10.349, E10.3491, E10.3492, E10.3493, E10.3499, E10.351, E10.3511, E10.3512, E10.3513, E10.3519, E10.3521, E10.3522, E10.3523, E10.3529, E10.3531, E10.3532, E10.3533, E10.3539, E10.3541, E10.3542, E10.3543, E10.3549, E10.3551, E10.3552, E10.3553, E10.3559, E10.359, E10.3591, E10.3592, E10.3593, E10.3599, E10.36, E10.37X1, E10.37X2, E10.37X3, E10.37X9, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.69, E10.8, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.3211, E11.3212, E11.3213, E11.3219, E11.329, E11.3291, E11.3292, E11.3293, E11.3299, E11.331, E11.3311, E11.3312, E11.3313, E11.3319, E11.339, E11.3391, E11.3392, E11.3393, E11.3399, E11.341, E11.3411, E11.3412, E11.3413, E11.3419, E11.349, E11.3491, E11.3492, E11.3493, E11.3499, E11.351, E11.3511, E11.3512, E11.3513, E11.3519, E11.3521, E11.3523, E11.3529, E11.3531, E11.3532, E11.3533, E11.3539, E11.3541, E11.3542, E11.3543, E11.3549, E11.3551, E11.3552, E11.3553, E11.3559, E11.359, E11.3591, E11.3592, E11.3593, E11.3599, E11.36, E11.37X1, E11.37X2, E11.37X3, E11.37X9, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.69, E11.8, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.3211, E13.3212, E13.3213, E13.3219, E13.329, E13.3291, E13.3292, E13.3293, E13.3299, E13.331, E13.3311, E13.3312, E13.3313, E13.3319, E13.339, E13.3391, E13.3392, E13.3393, E13.3399, E13.341, E13.3411, E13.3412, E13.3413, E13.3419, E13.349, E13.3491, E13.3492, E13.3493, E13.3499, E13.351, E13.3511, E13.3512, E13.3513, E13.3519, E13.3521, E13.3522, E13.3523, E13.3529, E13.3531, E13.3532, E13.3533, E13.3539, E13.3541, E13.3542, E13.3543, E13.3549, E13.3551, E13.3552, E13.3553, E13.3559, E13.359, E13.3591, E13.3592, E13.3593, E13.3599, E13.36

Health Indicator	External Standard(s) Referenced	ICD-10-CM Codes
		E13.37X1, E13.37X2, E13.37X3, E13.37X9, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.69, E13.8
Diabetes - Uncontrolled/Short Term Complications (Unc-STC)	AHRQ PQI 01; AHRQ PQI 14	E10.10, E10.11, E10.641, E11.00, E11.01, E11.10, E11.11, E11.641, E13.00, E13.01, E13.10, E13.11, E13.641, E10.649, E10.65, E11.649, E11.65, E13.649, E13.65
Heart Failure (HF)	AHRQ PQI 08; CMS HRRP	I09.81, I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.8, I50.81, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9
High Blood Pressure (HBP)	AHRQ PQI 07; CMS HRRP	I10, I11.9, I12.9, I13.10, I16.0, I16.1, I16.9
Overweight/Obesity	None	E66, E66.0, E66.01, E66.09, E66.1, E66.2, E66.3, E66.8, E66.9, Z68.25, Z68.26, Z68.27, Z68.28, Z68.29, Z68.3, Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39, Z68.4, Z68.41, Z68.42, Z68.43, Z68.44, Z68.45, Z68.53, Z68.54

Health Indicator	External Standard(s) Referenced	ICD-10-CM Codes
Stroke	AHRQ IQI 17	I60.00, I60.01, I60.02, I60.10, I60.11, I60.12, I60.2, I60.20, I60.21, I60.22, I60.30, I60.31, I60.32, I60.4, I60.50, I60.51, I60.52, I60.6, I60.7, I60.8, I60.9, I61.0, I61.1, I61.2, I61.3, I61.4, I61.5, I61.6, I61.8, I61.9, I62.00, I62.01, I62.02, I62.03, I62.1, I62.9, I63.00, I63.011, I63.012, I63.013, I63.019, I63.02, I63.031, I63.032, I63.033, I63.039, I63.09, I63.10, I63.111, I63.112, I63.113, I63.119, I63.12, I63.131, I63.132, I63.133, I63.139, I63.19, I63.20, I63.211, I63.212, I63.213, I63.219, I63.22, I63.231, I63.232, I63.233, I63.239, I63.29, I63.30, I63.311, I63.312, I63.313, I63.319, I63.321, I63.322, I63.323, I63.329, I63.331, I63.332, I63.333, I63.339, I63.341, I63.342, I63.343, I63.349, I63.39, I63.40, I63.411, I63.412, I63.413, I63.419, I63.421, I63.422, I63.423, I63.429, I63.431, I63.432, I63.433, I63.439, I63.441, I63.442, I63.443, I63.449, I63.49, I63.50, I63.511, I63.512, I63.513, I63.519, I63.521, I63.522, I63.523, I63.529, I63.531, I63.532, I63.533, I63.539, I63.541, I63.542, I63.543, I63.549, I63.59, I63.6, I63.8, I63.81, I63.89, I63.9
Community Acquired (CommAcq) Pneumonia	AHRQ PQI 11	J13, J14, J15.211, J15.212, J15.3, J15.4, J15.7, J15.9, J16.0, J16.8, J18.0, J18.1, J18.8, J18.9
Sepsis	AHRQ Patient Safety Indicator (PSI) 13; CMS Early Management Bundle, Severe Sepsis/Septic Shock Measure (SEP-1)	A02.1, A22.7, A26.7, A32.7, A40.0, A40.1, A40.3, A40.8, A40.9, A41.01, A41.02, A41.1, A41.2, A41.3, A41.4, A41.50, A41.51, A41.52, A41.53, A41.59, A41.81, A41.89, A41.9, A42.7, A54.86, B37.7, R65.20, R65.21, T81.12XA, T81.44XA
Mental Health Composite	None	F06.0, F06.1, F06.2, F06.30, F06.31, F06.32, F06.33, F06.34, F06.4, F06.8, F07.0, F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F21, F22, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F29, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.89, F32.9, F32.A, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.0, F34.1, F34.81, F34.89, F34.9, F39, F40.00, F40.01, F40.02, F40.10, F40.11, F40.210, F40.218, F40.220, F40.228, F40.230, F40.231, F40.232, F40.233, F40.240, F40.241, F40.242, F40.243, F40.248, F40.290, F40.291, F40.298, F40.8, F40.9, F41.0, F41.1, F41.3, F41.8, F41.9, F42.2, F42.3, F42.4, F42.8, F42.9, F43.0, F43.10, F43.11, F43.12, F43.20, F43.21, F43.22, F43.23, F43.24, F43.25, F43.29, F43.81, F43.89, F43.9, F44.0, F44.1, F44.2, F44.4, F44.5, F44.6, F44.7, F44.81, F44.89, F44.9, F45.0, F45.1, F45.20, F45.21, F45.22, F45.29, F45.41, F45.42, F45.8, F45.9, F48.1, F48.8, F48.9, F50.00, F50.01, F50.02, F50.2, F50.8, F50.9, F51.01, F51.02, F51.03, F51.09, F51.11, F51.12, F51.19, F51.3, F51.4, F51.5, F51.8, F51.9, F52.0, F52.1, F52.21, F52.22, F52.31, F52.32, F52.4, F52.5, F52.6, F52.8, F52.9, F53.0, F53.1, F54, F59, F60.0, F60.1, F60.2, F60.3, F60.4, F60.5, F60.6, F60.7, F60.81, F60.89, F60.9, F63.0, F63.1, F63.2, F63.3, F63.81, F63.89, F63.9, F64.1, F64.2, F64.8, F64.9, F65.0, F65.1, F65.2, F65.3, F65.4, F65.50, F65.51, F65.52, F65.81, F65.89, F65.9, F66, F68.10, F68.11, F68.12, F68.8, F68.A, F69, F70, F71, F72, F73, F78, F78.A1, F78.A9, F79, F80.0, F80.1, F80.2, F80.89, F80.9, F81.0, F81.2, F81.81, F81.89, F81.9, F82, F84.0, F84.2, F84.3, F84.5, F84.8, F84.9, F88, F89, F90.0, F90.1, F90.2, F90.8, F90.9, F91.0, F91.1, F91.2, F91.3, F91.8, F91.9, F93.0, F93.8, F93.9, F94.0, F94.1, F94.2, F94.8,

Health Indicator	External Standard(s) Referenced	ICD-10-CM Codes
		F94.9, F95.0, F95.1, F95.2, F95.8, F95.9, F98.0, F98.1, F98.21, F98.29, F98.3, F98.4, F98.5, F98.8, F98.9, F99, G44.209, H93.25, O90.6, O99.340, O99.341, O99.342, O99.343, O99.344, O99.345, R37, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0, Z86.59, Z87.890

Health Indicator	External Standard(s) Referenced	ICD-10-CM Codes
Substance-Related Disorders (SRD)	None	F10.10, F10.120, F10.121, F10.129, F10.130, F10.131, F10.132, F10.139, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F10.920, F10.921, F10.929, F10.930, F10.931, F10.932, F10.939, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, O35.4XX0, O35.4XX1, O35.4XX2, O35.4XX3, O35.4XX4, O35.4XX5, O35.4XX9, O99.310, O99.311, O99.312, O99.313, O99.314, O99.315, P04.3, Z71.41, F11.10, F11.120, F11.121, F11.122, F11.129, F11.13, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.90, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99, T40.0X1A, T40.0X2A, T40.0X3A, T40.0X4A, T40.0X5A, T40.1X1A, T40.1X2A, T40.1X3A, T40.1X4A, T40.2X1A, T40.2X2A, T40.2X3A, T40.2X4A, T40.2X5A, T40.3X1A, T40.3X2A, T40.3X3A, T40.3X4A, T40.3X5A, T40.411A, T40.412A, T40.413A, T40.414A, T40.415A, T40.421A, T40.422A, T40.423A, T40.424A, T40.425A, T50.7X1A, T50.7X2A, T50.7X3A, T50.7X4A, T50.7X5A, P04.14, F12.10, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.220, F12.221, F12.222, F12.229, F12.23, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.90, F12.91, F12.920, F12.921, F12.922, F12.929, F12.93, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99, F13.10, F13.120, F13.131, F13.132, F13.139, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F13.90, F13.920, F13.921, F13.929, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.10, F14.120, F14.121, F14.122, F14.129, F14.13, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F14.90, F14.920, F14.921, F14.922, F14.929, F14.93, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.10, F15.120, F15.121, F15.122, F15.129, F15.13, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F15.90, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99, F16.10, F16.120, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.90, F16.920, F16.921, F16.929, F16.94, F16.950, F16.951, F16.959, F16.980, F16.983, F16.988, F16.99, F17.200, F17.203, F17.208, F17.209, F17.210, F17.213, F17.218, F17.219, F17.220, F17.223, F17.228, F17.229, F17.290, F17.293, F17.298, F17.299, F18.10, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.90, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.10, F19.120, F19.121, F19.122, F19.129, F19.130, F19.131, F19.132, F19.139, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181,

Health Indicator	External Standard(s) Referenced	ICD-10-CM Codes
		F19.182, F19.188, F19.19, F19.20, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29, F19.90, F19.920, F19.921, F19.922, F19.929, F19.930, F19.931, F19.932, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, F55.0, F55.1, F55.2, F55.3, F55.4, F55.8, O35.5XX0, O35.5XX1, O35.5XX2, O35.5XX3, O35.5XX4, O35.5XX5, O35.5XX9, O99.320, O99.321, O99.322, O99.323, O99.324, O99.325, O99.330, O99.331, O99.332, O99.333, O99.334, O99.335, P04.12, P04.2, P04.40, P04.41, P04.42, P04.49, P96.1, P96.2, T40.491A, T40.492A, T40.493A, T40.494A, T40.495A, T40.5X1A, T40.5X2A, T40.5X3A, T40.5X4A, T40.5X5A, T40.601A, T40.602A, T40.603A, T40.604A, T40.605A, T40.691A, T40.692A, T40.693A, T40.694A, T40.695A, T40.711A, T40.712A, T40.713A, T40.714A, T40.715A, T40.721A, T40.722A, T40.723A, T40.724A, T40.725A, T40.8X1A, T20.8X2A, T40.8X3A, T40.8X4A, T40.901A, T40.902A, T40.903A, T40.904A, T40.905A, T40.991A, T40.992A, T40.993A, T40.994A, T40.995A, T43.601A, T43.602A, T43.603A, T43.604A, T43.605A, T43.621A, T43.622A, T43.623A, T43.624A, T43.625A, T43.631A, T43.632A, T43.633A, T43.634A, T43.635A, T43.641A, T43.642A, T43.643A, T43.644A, T43.651A, T43.652A, T43.653A, T43.654A, T43.655A, T43.691A, T43.692A, T43.693A, T43.694A, T43.695A, T50.901A, T50.902A, T50.903A, T50.904A, T50.905A, T50.911A, T50.912A, T50.913A, T50.914A, T50.915A, T50.991A, T50.992A, T50.993A, T50.994A, T50.995A, U0.70, Z71.51, Z71.6

Health Indicator	External Standard(s) Referenced	ICD-10-CM Codes
Alcohol-Related Disorders	None	F10.10, F10.120, F10.121, F10.129, F10.130, F10.131, F10.132, F10.139, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F10.920, F10.921, F10.929, F10.930, F10.931, F10.932, F10.939, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, O35.4XX0, O35.4XX1, O35.4XX2, O35.4XX3, O35.4XX4, O35.4XX5, O35.4XX9, O99.310, O99.311, O99.312, O99.313, O99.314, O99.315, P04.3, Z71.41
Opioid-Related Disorders	None	F11.10, F11.120, F11.121, F11.122, F11.129, F11.13, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.90, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99, T40.0X1A, T40.0X2A, T40.0X3A, T40.0X4A, T40.0X5A, T40.1X1A, T40.1X2A, T40.1X3A, T40.1X4A, T40.2X1A, T40.2X2A, T40.2X3A, T40.2X4A, T40.2X5A, T40.3X1A, T40.3X2A, T40.3X3A, T40.3X4A, T40.3X5A, T40.411A, T40.412A, T40.413A, T40.414A, T40.415A, T40.421A, T40.422A, T40.423A, T40.424A, T40.425A, T50.7X1A, T50.7X2A, T50.7X3A, T50.7X4A, T50.7X5A, P04.14

Health Indicator	External Standard(s) Referenced	ICD-10-CM Codes
Non-Opioid-Related Disorders	None	F12.10, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.220, F12.221, F12.222, F12.229, F12.23, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.90, F12.91, F12.920, F12.921, F12.922, F12.929, F12.93, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99, F13.10, F13.120, F13.121, F13.129, F13.130, F13.131, F13.132, F13.139, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F13.90, F13.920, F13.921, F13.929, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.10, F14.120, F14.121, F14.122, F14.129, F14.13, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F14.90, F14.920, F14.921, F14.922, F14.929, F14.93, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.10, F15.120, F15.121, F15.122, F15.129, F15.13, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F15.90, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99, F16.10, F16.120, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.90, F16.920, F16.921, F16.929, F16.94, F16.950, F16.951, F16.959, F16.980, F16.983, F16.988, F16.99, F17.200, F17.203, F17.208, F17.209, F17.210, F17.213, F17.218, F17.219, F17.220, F17.223, F17.228, F17.229, F17.290, F17.293, F17.298, F17.299, F18.10, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.90, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.10, F19.120, F19.121, F19.122, F19.129, F19.130, F19.131, F19.132, F19.139, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29, F19.90, F19.920, F19.921, F19.922, F19.929, F19.930, F19.931, F19.932, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, F55.0, F55.1, F55.2, F55.3, F55.4, F55.8, O35.5XX0, O35.5XX1, O35.5XX2, O35.5XX3, O35.5XX4, O35.5XX5, O35.5XX9, O99.320, O99.321, O99.322, O99.323, O99.324, O99.325, O99.330, O99.331, O99.332, O99.333, O99.334, O99.335, P04.12, P04.2, P04.40, P04.41, P04.42, P04.49, P96.1, P96.2, T40.491A, T40.492A, T40.493A, T40.494A, T40.495A, T40.5X1A, T40.5X2A, T40.5X3A, T40.5X4A, T40.5X5A, T40.601A, T40.602A, T40.603A, T40.604A, T40.605A, T40.691A, T40.692A, T40.693A, T40.694A, T40.695A, T40.711A, T40.712A, T40.713A, T40.714A, T40.715A, T40.721A, T40.722A, T40.723A, T40.724A, T40.725A, T40.8X1A, T40.8X2A, T40.8X3A, T40.8X4A, T40.901A, T40.902A, T40.903A, T40.904A, T40.905A, T40.991A, T40.992A, T40.993A, T40.994A, T40.995A, T43.601A, T43.602A, T43.603A, T43.604A, T43.605A, T43.621A, T43.622A, T43.623A, T43.624A, T43.625A, T43.631A, T43.632A, T43.633A, T43.634A, T43.635A, T43.641A, T43.642A, T43.643A,

Health Indicator	External Standard(s) Referenced	ICD-10-CM Codes
		T43.644A, T43.651A, T43.652A, T43.653A, T43.654A, T43.655A, T43.691A, T43.692A, T43.693A, T43.694A, T43.695A, T50.901A, T50.902A, T50.903A, T50.904A, T50.905A, T50.911A, T50.912A, T50.913A, T50.914A, T50.915A, T50.991A, T50.992A, T50.993A, T50.994A, T50.995A, U0.70, Z71.51, Z71.6

Appendix 11: Hartford Healthcare Board Meeting Summary: Northwest Region – Charlotte Hungerford Hospital

Top Priority Issues Identified

1. Youth Mental Health

Youth mental health was repeatedly described as a top concern by multiple board members.

- Participants cited escalating rates of depression, anxiety, bullying, and social isolation among middle and high school students, worsened by social media and post-pandemic effects.
- There is a critical shortage of pediatric mental health providers despite some progress. Waitlists and access gaps remain persistent.
- Kinship caregiving is increasing, with many guardians in crisis and lacking resources.
- Youth lack recreational outlets, social support, and meaningful engagement.
- Existing programs are under strain and do not fully meet the scale of need.

2. Affordable Housing and Housing Insecurity

Rising rents, limited availability of units, and inadequate subsidy programs were named as root causes of financial instability and poor health outcomes.

- Vulnerable populations, including elderly residents and families with housing vouchers, face severe difficulty securing stable housing.
- Shelters are at capacity, and inconsistent funding makes the housing safety net unreliable.
- The board emphasized that housing directly impacts access to food, employment, education, and healthcare.

Additional Community Challenges Raised

- **Transportation:** Public transportation remains limited and difficult to navigate, especially for patients needing to access medical appointments, childcare, or food resources.
- **Childcare:** There is a growing shortage of qualified childcare staff, long waitlists, and inadequate wages for workers, further straining already stressed families.
- **Healthcare Affordability & Access:**
 - Concerns were raised about looming cuts to Medicaid and Medicare and Connecticut's low Medicaid reimbursement rates.
 - Access to pediatric dental and behavioral health services, especially for those on Husky insurance, is severely limited.
- **Food Insecurity:** The closure of local grocery stores has created food deserts, particularly affecting residents in congregate housing.

- **Misinformation & Mistrust:** Community mistrust in healthcare institutions and misinformation—especially around vaccination—were cited as major barriers to care.

Systemic and Structural Themes

- Board members noted that many of the same issues from the 2022–2024 CHNA remain unresolved, pointing to persistent structural challenges.
- The need to address **HRSNs** — including housing, transportation, education, and food access—was emphasized repeatedly.
- Members stressed the importance of **advocacy, policy change**, and leveraging existing legislation and funding more effectively.
- A call was made to improve trust-building, culturally competent care, and public communication in underserved and immigrant communities.

Next Steps & Recommendations

- **Update CHIP:** Align CHIP documents with the latest data and realities on the ground, focusing on the intersection of housing and mental health.
- **Leverage Community Assets:** Build on successful programs like Food4Health, kinship family support, and Brooker’s pediatric care—but expand access and staffing.
- **Advocate Systemically:** Engage in advocacy for better Medicaid/Medicare reimbursement, expanded services, and infrastructure improvements (e.g., transit, childcare).
- **Strengthen Community Trust:** Continue community outreach, especially in immigrant and underserved communities, to build relationships and address misinformation.
- **Define Clear Action Steps:** Board members requested specific next steps, aligned funding strategies, and a transparent prioritization process.

Conclusion

The meeting confirmed that **youth mental health** and **affordable housing** are urgent, interconnected priorities. While progress has been made in some areas, systemic barriers and widening disparities remain. The Board reaffirmed its commitment to responding flexibly and fairly to community needs, and called for immediate, coordinated action across sectors to improve outcomes for vulnerable populations.

Appendix 12: Internal Revenue Service Requirements for Community Health Needs Assessments

Internal Revenue Code § 501(r)(3) requires every tax-exempt hospital facility to perform a Community Health Needs Assessment (CHNA) at least once every three years and to adopt a written implementation strategy based on that assessment.⁴³ An authorized body must approve the CHNA report and adopt an implementation strategy to address the identified needs on or before the 15th day of the fifth month after the end of the taxable year in which the CHNA was conducted.⁴⁴ The CHNA report must be posted on a Web site and a paper copy available for public upon request and without charge at the hospital facility.⁴⁵

This CHNA report and implementation strategy (called the “Community Health Improvement Plan” or “CHIP”) adheres to the IRS requirements. The bulleted list below maps the requirements to sections within this report for easy reference. Note that for each reference, page numbers are provided; in addition, though, readers may find additional insight to the topic on other pages.

To conduct a CHNA, a hospital facility must:

1. Define the community it serves.
2. Assess the needs of that community
3. In assessing the health needs of the community, solicit and take into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health.
4. Document the CHNA in a written report (CHNA report) that is adopted for the hospital facility by an authorized body of the hospital facility
5. Make the CHNA report widely available to the public.⁴⁶

CHNA Documentation: The CHNA report must:

- 1. Define the hospital facility’s community.**

IRS Regulation Text: “A definition of the community served by the hospital facility and a description of how the community was determined.”⁴⁷

⁴³ 26 U.S.C. § 501(r)-3(a)(1).

⁴⁴ 26 U.S.C. § 501(r)-3(a)(2).

⁴⁵ 26 U.S.C. § 501(r)-3(b)(7).

⁴⁶ 26 U.S.C. § 501(r)-3(b).

⁴⁷ 26 U.S.C. § 501(r)-3(b)(6)(A).

In defining the community it serves...a hospital facility may take into account all of the relevant facts and circumstances, including the geographic area served by the hospital facility, target population(s) served (for example, children, women, or the aged), and principal functions (for example, focus on a particular specialty area or targeted disease). However, a hospital facility may not define its community to exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital facility draws its patients (unless such populations are not part of the hospital facility's target patient population(s) or affected by its principal functions) or otherwise should be included based on the method the hospital facility uses to define its community. [A] hospital facility must take into account all patients without regard to whether (or how much) they or their insurers pay for the care received or whether they are eligible for assistance under the hospital facility's financial assistance policy. In the case of a hospital facility consisting of multiple buildings that operate under a single state license and serve different geographic areas or populations, the community served by the hospital facility is the aggregate of such areas or populations.⁴⁸

Section within this CHNA: Hospital Description and Service Area (p10);Demographic and Secondary Research Highlights (p13 ff); and Community Demographic Profile (p15ff)

2. Process and Methods.

IRS Regulation Text: “A description of the process and methods used to conduct the CHNA.”⁴⁹ To assess the health needs of the community it serves...a hospital facility must identify significant health needs of the community, prioritize those health needs, and identify resources (such as organizations, facilities, and programs in the community, including those of the hospital facility) potentially available to address those health needs. For these purposes, the health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities). These needs may include, for example, the need to address financial and other barriers to accessing care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community. A hospital facility may determine whether a health need is significant based on all of the facts and circumstances present in the community it serves. In addition, a hospital facility may use any criteria to prioritize the significant health needs it identifies, including, but not limited to, the burden, scope,

⁴⁸ 26 U.S.C. § 1.501(r)-3(b)(3).

⁴⁹ 26 U.S.C. § 1.501(r)-3(b)(6)(B).

severity, or urgency of the health need; the estimated feasibility and effectiveness of possible interventions; the health disparities associated with the need; or the importance the community places on addressing the need.⁵⁰

A hospital facility's CHNA report [must] describe the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identify any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA. In the case of data obtained from external source material, the CHNA report may cite the source material rather than describe the method of collecting the data.⁵¹

Section within this CHNA: The Regional, Collaborative, and Inclusive Approach (p2); Process / Methodology (p3-4); Needs Assessment Research Approach (p8);Detailed Research Method (p9); Predictive Analytics and Socio-economic Factors Impacting Health (p30); and Community Wellbeing Survey and Other Research (p36).

3. Describe solicitation and Community Input

IRS Regulation Text: “A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves”⁵²: [A] hospital facility must solicit and take into account input received from all of the following sources in identifying and prioritizing significant health needs and in identifying resources potentially available to address those health needs:

(A) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency), or a State Office of Rural Health... with knowledge, information, or expertise relevant to the health needs of that community.

(B) Members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of such populations. Medically underserved populations include populations experiencing health disparities or at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers.

⁵⁰ 26 U.S.C. § 1.501(r)-3(b)(4).

⁵¹ 26 U.S.C. § 1.501(r)-3(b)(6)(ii).

⁵² 26 U.S.C. § 1.501(r)-3(b)(6)(C).

(C) Written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.

In addition ... a hospital facility may solicit and take into account input received from a broad range of persons located in or serving its community, including, but not limited to, health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers and community health centers, health insurance and managed care organizations, private businesses, and labor and workforce representatives.⁵³

A hospital facility's CHNA report [must] summarize, in general terms, any input provided by such persons and how and over what time period such input was provided (for example, whether through meetings, focus groups, interviews, surveys, or written comments and between what approximate dates); provide the names of any organizations providing input and summarize the nature and extent of the organization's input; and describe the medically underserved, low-income, or minority populations being represented by organizations or individuals that provided input. ... In the event a hospital facility solicits, but cannot obtain, input from a [required] source, the hospital facility's CHNA report also must describe the hospital facility's efforts to solicit input from such source.⁵⁴

Section within this CHNA: Detailed Research Method (p9); Process / Methodology (p3); Demographic Analysis and Community Input (p13); Qualitative Research Highlights (p34); Community Well-being Survey and Other Research (p36ff); Data Analysis and Community Input Summary (p41)

4. Prioritized list of community health needs.

IRS Regulation Text: "A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs"⁵⁵

⁵³ 26 U.S.C. § 1.501(r)-3(b)(5).

⁵⁴ 26 U.S.C. § 1.501(r)-3(b)(6)(iii).

⁵⁵ 26 U.S.C. § 1.501(r)-3(b)(6)(D).

Section within this CHNA: Results (p4); Qualitative Research Highlights (p34); Data Analysis and Community Input Summary (p41); Prioritization Process (p47-49); Final Priorities (p50ff)

5. Community resources

IRS Regulation Text: “A description of the resources potentially available to address the significant health needs identified through the CHNA”⁵⁶

Section within this CHNA: Local Activities (p44ff); and Appendix 13 (p122)

6. Impact Evaluation

IRS Regulation Text: “An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).”⁵⁷

Section within this CHNA: Evaluation of 2023–2025 Implementation Plan (p43); Local Activities (p44ff)

CHNA Availability: The CHNA report must be made widely available to the public by:

1. Posting on a website until two subsequent CHNAs are posted; and
2. Making a paper copy available for public inspection without charge until two subsequent CHNAs are available.⁵⁸

Implementation Strategy Requirements

1. Implementation Strategy:

IRS Regulation Text: A hospital facility’s implementation strategy to meet the community health needs identified through the hospital facility’s CHNA is a written plan that with respect to each significant health need identified through the CHNA, either—

- i. Describes how the hospital facility plans to address the health need; or

⁵⁶ 26 U.S.C. § 1.501(r)-3(b)(6)(E).

⁵⁷ 26 U.S.C. § 1.501(r)-3(b)(6)(F).

⁵⁸ 26 C.F.R. § 1.501(r)-3(b)(7)(i).

- ii. Identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address the health need.⁵⁹

Section within this Implementation Strategy: Priority Areas and Strategies (p51ff)

2. Description of how the hospital facility plans to address a significant health need.

IRS Regulation Text: A hospital facility's implementation strategy [...]:

- i. Describes the actions the hospital facility intends to take to address the health need and the anticipated impact of these actions;
- ii. Identifies the resources the hospital facility plans to commit to address the health need; and⁶⁰
- iii. Describes any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need.

Section within this Implementation Strategy: Priority Areas and Strategies; Lead and Partners (p51ff)

3. Description of why a hospital facility is not addressing a significant health need.

IRS Regulation Text: In explaining why it does not intend to address a significant health need [...], a brief explanation of the hospital facility's reason for not addressing the health need is sufficient. Such reasons may include, for example, resource constraints, other facilities or organizations in the community addressing the need, a relative lack of expertise or competency to effectively address the need, the need being a relatively low priority, and/or a lack of identified effective interventions to address the need.⁶¹

Section within this Implementation Strategy: Priority Areas and Strategies; Lead and Partners (p51ff)

⁵⁹ 26 C.F.R. § 1.501(r)-3(c)(1).

⁶⁰ 26 C.F.R. § 1.501(r)-3(c)(2).

⁶¹ 26 C.F.R. § 1.501(r)-3(c)(3).

Appendix 13: Community-based Health-related Resources



RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

These community resources represent assets for broad health and health-related needs, including resources for the significant health and health-related needs identified in this community health needs assessment. Please note that this list is not exhaustive and additional resources may be available.

Health Department
Torrington Area Health District, 860-489-0436, https://www.tahd.org/
Health Centers
Community Health and Wellness Center of Greater Torrington, 860-489-0931, https://www.chwctorr.org/locations--hours.html
Community Action Agencies
New Opportunities, 860-482-9749, https://newoppinc.org/Torrington
Senior Services
Center for Healthy Aging, 860-496-6240, https://hhcseniorservices.org/services/center-for-healthy-aging
Elderly Services, 860-489-2228, https://www.torringtonct.org/live-links-residents/pages/elderly-services
Sullivan Senior Center, 860-489-2211, https://www.torringtonct.org/sullivan-senior-center
Winsted Senior Center, 860-379-4252, https://www.townofwinchester.org/entities/senior-center
Youth and Family Services
Center for Youth and Families, 860-489-3391, https://charlottehungerford.org/locations/center-for-youth-families
Torrington Youth Service Bureau, 860-496-0356, https://www.nwcty.org/branch/torrington-youth-service-bureau/
Torrington Area Families for Autism, 860-759-3043, https://www.tafainc.org/
Heritage and Nature
Torrington Parks and Recreation, 860-489-2274, https://www.torringtonct.org/parks-recreation
Burr Pond State Park, 385 Burr Mountain Rd., Torrington
Torrington Trails Network, 860-489-3133, https://www.nwcty.org/torrington-trails-network/
Winsted Recreation, https://winstedct.myrec.com/info/facilities/default.aspx
White Memorial Conservation Center, 860-567-0857, https://whitememorialcc.org/

Need help finding free or low-cost services?

Go to www.connectionthatmatter.org



ⁱ ChimeData (FY 2024)

[From the Connecticut Hospital Association CHIME Reports] The hospital utilization rates reported in this Community Health Profile are sourced from ChimeData encounter records supplied by the Connecticut Hospital Association's (CHA) acute care member hospitals. ChimeData patient encounter records are flagged with "health indicators" based on the presence of ICD-10-CM diagnosis codes associated with key health conditions, aligning those reference code sets wherever possible with evidence-based quality indicators published by the Agency for Healthcare Research and Quality (AHRQ), available at: qualityindicators.ahrq.gov.

All rates for each health indicator are based on a count of distinct patients in fiscal year (FY) 2024 (October 1, 2023 – September 30, 2024) who had at least one hospital encounter, in either the Inpatient, Emergency Department, or Observation service settings, with a principal diagnosis that matches one of the ICD-10-CM codes associated with the given condition. If a patient had more than one encounter for the same health indicator within this time period, the key characteristics from their record used to classify rates across towns, and categories of race/ethnicity and age, are assigned based on the recorded characteristics that held plurality across all of the patient's encounter records. For example, if a patient had six hospital encounters over the course of the year for asthma, and they resided in Town A for five of the encounters and in Town B for only one encounter, then that patient would be counted only once in the analysis and assigned to the asthma patient total in Town A. In instances where there is not a plurality, the response on the patient's most recent encounter is used. This was done to prevent the same patient from contributing to more than one group rate per health indicator.