NW CT Health Enhancement Communities

Priority Aims Assessment Data Scan & Community Engagement Activities Report

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Charlotte Hungerford Hospital
A Hartford HealthCare Partner

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I. ACKNOWLEDGEMENTS

This Community Health Assessment Data Scan was compiled during the HEC Pre-Planning Phase to summarize data from existing local Community Health Needs Assessments and related reports relevant to the HEC Priority Aims. This document is intended to be a resource for NW CT HEC Communities in their review of data related to the Priority Aims, and to identify where information is lacking or in need of updating at the local level. The HEC Work Group and Steering Committee members listed below provided valuable guidance and insights related to the data presented in this report as well as indicators to be included in future Community Health Needs Assessments.

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II. INTRODUCTION

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

The Health Enhancement Community (HEC) Initiative recently launched by the CT State Office of Health Strategy (OHS) and Department of Public Health (DPH) aims to improve the health and well-being of all residents in Connecticut, and reduce the rising trends of health care costs by improving community health, health equity, and preventing poor health. The HEC Initiative has four ambitious yet achievable goals:

- Make Connecticut the healthiest state in the country.
- Achieve health equity for all Connecticut residents.
- Make Connecticut the best state in which children grow up.
- Slow the growth of Connecticut's health care spending.

The formation of HECs across the state is a primary strategy to achieve these goals. The vision is that HECs will support long-term, collaborative, and cross-sector efforts to improve community health in defined geographies. HECs will work to improve the social, economic, and physical conditions within communities that enable individuals and families to meet their basic needs, achieve health and well-being, and thrive throughout their lives. HECs will focus on two health priorities that are critical for Connecticut:

- **Improving Child Well-Being for Connecticut Children, Pre-Birth to Age 8 Years:** Assuring all children are in safe, stable, and nurturing environments through preventing Adverse Childhood Experiences (ACEs), and increasing protective factors that build resilience and mitigate the negative impact of toxic stress.
- **Improving Healthy Weight and Physical Fitness for All Connecticut Residents:** Assuring that individuals and populations maintain a healthy or healthier body weight, engage in regular physical activity, and have equitable opportunities to do so.

Data Supporting the Need for Health Enhancement Communities

Data supporting the need to establish HECs in Connecticut as presented in HEC Request for Proposals issued by OHS and DPH are restated here (See References for listing of original citations in the RFP). Although Connecticut ranks fifth in overall health nationwide[1], our state has experienced a downward trend in rankings related to healthy weight, including physical activity and diabetes, as well as measures related to child well-being, including children in poverty, low birth weight deliveries, and infant mortality.[2,3] Across these 5 measures, Connecticut currently ranks well below the top 10 states.[4] Additionally, these rankings represent the population on average, and mask the significant health disparities that persist in our state. Connecticut currently ranks 40th out of the 50 states in disparities in health status (the higher the ranking the larger the disparities). Statewide data indicates a significantly higher prevalence of having fair or poor health among: 1) Non-Hispanic Black and Hispanic adults, 2) Adults from households earning less than $75,000, 3) Adults without health insurance or with a disability, and 4) Adults with no more than a high school education.[5]

The Impact of Adverse Childhood Experiences on Health

Safe, stable, nurturing relationships and environments in the first five years of life increase a child's opportunity for a healthy adulthood. Achieving this aim for children throughout Connecticut requires preventing Adverse Childhood Experiences (ACEs), and mitigating the impact of ACEs. ACEs are stressful or traumatic events or situations experienced by children. Ample evidence reveals the associations between ACEs, health conditions, and indicators leading to adult morbidity and mortality. The Behavioral Risk Factor Surveillance System (BRFSS), conducted by the Department of Public Health in Connecticut, reports ACEs based on several types of abuse and adverse experiences: emotional, physical, and sexual abuse; intimate partner violence; household substance abuse; household mental illness; parental separation or divorce; and incarcerated household member. Three out of five adults reported having experienced at least one ACE, and over one out of five of adults reported three or

more ACEs. One third of those who experienced at least one ACE were from separated/divorced parents, and about one fifth experienced emotional abuse and drinking problems in their households. Emotional abuse and parental divorce were the most prevalent ACE events in the state.[6] A follow-up assessment of adults surveyed during 1995-1997 was conducted in 2009, and found that individuals with six or more ACEs compared to those who had none, died 20 years earlier on average.[7]

The Impact of Obesity and Physical Inactivity on Health

Excess weight leads to increased risk for heart disease, high blood pressure, stroke, type 2 diabetes, arthritis-related disability, and cancer. Maintaining a healthy weight involves choosing healthy foods, regular physical activity, and consuming about the same number of calories as your body needs.[8]

Based on Healthy Connecticut 2020 Performance Dashboard, the prevalence of obesity among Connecticut adults has increased consistently from 2011 to 2017. Approximately 27% of adults are obese, and 36% are overweight. Males, non-Hispanic Black residents, residents 35 to 55 years of age, those with lower educational attainment or household income, are disproportionately affected by obesity. Approximately 16% of children aged 5 to 11 years old are obese, and 13% are overweight. Disparities among children remain as the prevalence of obesity is higher among males, younger children, and children from low-income households. Also, Hispanic/Latino children and non-Hispanic Black children have obesity prevalence rates that are over 2.5 times higher than non-Hispanic White children. The prevalence of obesity among children with an annual household income of less than $25,000 is double the overall obesity prevalence among Connecticut children. The increased risk of obesity among children of lower socioeconomic status may result from a number of underlying causes, including lack of access to healthy foods, increased access to unhealthy foods, and fewer opportunities to engage in physical activity.

Further, children living with a parent who does not participate in leisure time physical activities show a greater prevalence of obesity (23%) compared to children living with a parent participating in leisure time physical activities (14%).[9] Close to one-third of Connecticut children eat fast food more than twice a week, and an estimated 30% drink soda or other sugar-sweetened beverages at least once per day.[10] An estimated 43% of children aged 2-17 exceed the threshold of excessive screen time (more than two hours) daily.[11] The prevalence of no leisure-time activity among adults in Connecticut is significantly greater among women (23%), non-Hispanic Black (25%) and Hispanic (32%) adults, adults from households earning less than $35,000 (34%), adults without insurance (32%), and adults with no more than a high school education (31%).[12]

Finally, Connecticut is a higher-cost state in overall health care spending per person relative to the national average, and health care spending has consistently outpaced growth in the state economy. While Connecticut is a comparatively high cost Medicaid state, Connecticut's Medicaid program led the nation in controlling cost trends on a per enrollee basis for the period from 2010-2014.[13] Connecticut reduced its per-person spending by a greater percentage (6%) than any other state in the country. Overall and in Connecticut, Medicaid tracked lower than private health insurance and Medicare.[14] This is likely due to Medicaid's innovative efforts to control costs through their managed fee-for-service model and Patient-Centered Medical Home (PCMH) initiatives, maintaining regulatory control over provider rates, and changes in case mix related to the Medicaid expansion. Medicare spending data for Connecticut, by contrast, shows a state that is both high-cost and higher-growth relative to national averages. Connecticut is also the highest cost state for Medicare in New England. Taken together, these historical trends demonstrate the need for Connecticut to control health care spending.

III. DEMOGRAPHIC & SOCIOECONOMIC INDICATORS

Improving and promoting the health of all residents in NW CT requires an understanding of the influence of social and economic factors on health. Social determinants of health such as income levels, employment status, educational attainment, housing quality, environmental quality, and community safety strongly impact access to care and health outcomes. Socioeconomic status and health are strongly correlated, with persons of higher socioeconomic status generally experiencing better health status and access to health care. Persons with higher socioeconomic status are also more likely to live in safe neighborhoods, be steadily employed at higher paying jobs with health benefits, and practice healthy lifestyle behaviors. Socioeconomic factors underlie many of the observed racial, ethnic, and gender inequalities in health status, and are powerful predictors of health status and health outcomes.

Table 1: HEC Area Town Population, 2013-2017

Demographic Category	Indicator	NW CT HEC Area Total	
		Number	Percentage
Population	Total Population	134,891	100%
Age	0-4 Years Old	5,513	4%
	5-9 Years Old	6,826	5%
	10-14 Years Old	8,319	6%
	15-24 Years Old	14,450	11%
	25-64 Years Old	72,589	54%
	65 and Over	27,194	20%
Race and Ethnicity	White	121,421	90%
	Black	2,506	2%
	Hispanic	6,985	5%
	Asian	2,666	2%
	Other	1,313	1%
Gender	Male	66,983	50%
	Female	67,908	50%

Data Sources for Tables 1, 2, 4, 5 & 7: 2019 CERC Town Profiles, profiles.ctdata.org. US Census, ACS Survey Data

Table 2: HEC Area Economic Characteristics by Town, 2008-2012 and 2013-2017

Town	Median Household Income ($) 2008-2012	Median Household Income ($) 2013-2017	Poverty Rate (%) 2008-2012	Poverty Rate (%) 2013-2017
Barkhamsted	84,861	111,198	0.61	2.44
Bethlehem	80,884	91,712	4.35	6.03
Bridgewater	83,750	102,250	2.17	3.27
Burlington	106,756	121,635	3.63	2.27
Canaan	58,021	77,417	6.82	4.08
Colebrook	71,691	84,583	3.37	4.61
Cornwall	78,021	76,563	12.35	5.72
Goshen	74,333	96,026	7.88	9.64
Hartland	91,875	94,569	3.75	2.97
Harwinton	89,429	104,205	4.60	4.74
Kent	66,641	64,464	10.52	9.19
Litchfield	84,063	78,375	6.83	7.28
Morris	89,688	89,107	5.65	2.83
New Hartford	85,598	96,291	3.19	3.02
Norfolk	78,214	74,844	6.65	3.63
North Canaan	45,992	72,411	10.25	5.88
Roxbury	97,031	119,167	2.54	2.47
Salisbury	65,625	83,217	4.45	5.28
Sharon	76,117	81,442	6.03	12.49
Thomaston	67,426	67,639	2.69	5.92
Torrington	50,548	61,313	11.25	9.84
Warren	96,250	98,750	6.29	5.56
Washington	75,865	93,975	6.99	6.16
Winchester	60,994	57,468	5.46	17.13
Woodbury	80,167	82,923	4.58	5.40
Connecticut	65,519	73,781	9.95	10.06

Table 3: Students Eligible for Free & Reduced Price Meals, 2017-2018 vs. 2018-2019 School Year

District Name	% Eligible for Free/Reduced Meals, 2017-2018	% Eligible for Free/Reduced Meals, 2018-2019
Barkhamsted PreK-6	11.7	20.6
Bethlehem PreK-5	14.6	22.8
Bridgewater K-5	NA	18.9
Burlington PreK-4	5.2	8.8
Canaan K-8	15.5	25.4
Colebrook K-6	18.4	26.2
Cornwall K-8	9.6	14.3
Goshen PreK-6	8.2	18.7
Hartland- PreK-8	8.7	19.1
Harwinton PreK-4	8.0	13.2
Kent PreK-8	14.2	28.2
Litchfield PreK-3	13.9	24.9
Litchfield-District	11.4	22.9
Morris PreK-6	14.2	18.2
New Hartford PreK-6	11.2	17.9
Norfolk PreK-6	27.4	33.3
North Canaan PreK-8	23.5	47.8
Roxbury K-5	NA	12.7
Salisbury PreK-8	16.1	26.8
Sharon PreK-8	30.9	40.0
Warren PreK-6	NA	14.5
Washington PreK-5	14.3	18.6
Woodbury PreK-5	7.9	18.8
Barkhamsted, Colebrook, New Hartford, Norfolk (Region 7)	10.1	16.7
Bethlehem, Woodbury (Region 14)	8.6	19.6
Bridgewater, Roxbury, Washington (Region 12)	8.2	17.8
Burlington, Harwinton (Region 10)	6.2	11.7
Cornwall, Canaan, Kent, North Canaan, Salisbury, Sharon (Region 1)	21.0	35.0
Goshen, Morris, Warren (Region 6)	9.7	17.3
Thomaston-District	21.4	31.4
Torrington-District	53.7	64.7
Winchester Pre-K-6	55.6	65.2
Winchester - Gilbert	37.8	46.2
Winchester - Explorations	41.7	60.2
Connecticut	36.7	42.1

Source: EdSight, Connecticut Report Cards, School and District Reports, http://edsight.ct.gov.

Table 4: Housing: Number and % of Cost-burdened Households in HEC Area Towns, 2013-2017

Town	Number of Cost-burdened Households		Percentage of Cost-burdened Households	
	Own	Rent	Own	Rent
Barkhamsted	299	8	36.4	7.1
Bethlehem	243	104	31.6	70.7
Bridgewater	136	15	33	26.9
Burlington	518	68	22	45
Canaan	89	11	33.9	20
Colebrook	104	11	31.9	19.6
Cornwall	130	52	50	59.8
Goshen	214	12	33.3	29.3
Hartland	118	26	26.4	43.3
Harwinton	391	35	31.8	77.8
Kent	262	183	49.7	75.9
Litchfield	698	274	35.9	44
Morris	203	39	38.6	33.3
New Hartford	515	107	30.9	38.1
Norfolk	166	77	51.4	67
North Canaan	124	225	16.8	52.8
Roxbury	190	65	38.4	42.8

Salisbury	157	220	24.5	53.1
Sharon	166	93	31	51.1
Thomaston	506	250	28.7	41.9
Torrington	2,163	2,054	32.8	44.4
Warren	125	35	32.2	71.4
Washington	332	93	47.7	36.9
Winchester	589	926	33.9	53.2
Woodbury	767	387	35.8	39.4
Connecticut	203,894	222,218	32.8	52.3

Table 5: Health Care Insurance Coverage (%) in HEC Area Towns by Age, 2013-2017

Town	Under 18	18-64	65 and over
Barkhamsted	100	100	100
Bethlehem	100	98.8	100
Bridgewater	100	96.4	100
Burlington	100	98	100
Canaan	98.4	89.8	100
Colebrook	100	100	100
Cornwall	100	98	100
Goshen	95.5	97.3	100
Hartland	100	100	100
Harwinton	98.9	100	100
Kent	73.4	80.3	100
Litchfield	100	98.8	100
Morris	99.2	99.1	100
New Hartford	99.2	98.2	100
Norfolk	96.9	93.2	100
North Canaan	100	97.9	100
Roxbury	100	98.5	100
Salisbury	90.3	86.5	100
Sharon	99.3	93.2	100
Thomaston	97.9	98.6	100
Torrington	100	93.4	100
Warren	100	95	100
Washington	100	97.3	100
Winchester	99.1	93.3	100
Woodbury	100	100	100
Connecticut	100	93.7	100

Table 6: Four-Year Cohort Graduation Rates in HEC Area School Districts, 2016- 2018

District Name	Graduation Rate, 2016-17	Graduation Rate, 2017-18
Barkhamsted, Colebrook, New Hartford, Norfolk (Region 7)	95.5	98.2
Bethlehem, Woodbury (Region 14)	95.3	97.4
Bridgewater, Roxbury, Washington (Region 12)	98.0	92.3
Burlington, Harwinton (Region 10)	94.5	95.5
Cornwall, Canaan, Kent, North Canaan, Salisbury, Sharon (Region 1)	94.8	94.6
Goshen, Morris, Warren (Region 6)	99.1	97.2
Hartland	NA	NA
Litchfield	92.2	98.4
Thomaston	93.7	96.6
Torrington	70.4	82.8
Winchester - Gilbert	90.7	87.0
Winchester - Explorations	81.8	82.1
Connecticut	87.9	88.3

Source: EdSight, Connecticut Report Cards, School and District Reports, http://edsight.ct.gov.

Table 7: Educational Attainment in HEC Area Towns, 2013-2017

Town	*High School Degree (%)*	*Associate's Degree (%)*	*Bachelor's Degree or Higher (%)*
Barkhamsted	23	11	44
Bethlehem	27	7	40
Bridgewater	18	5	57
Burlington	22	7	49
Canaan	24	11	41
Colebrook	30	10	29
Cornwall	17	10	54
Goshen	24	12	38
Hartland	32	12	32
Harwinton	25	13	36
Kent	22	9	46
Litchfield	30	9	41
Morris	26	9	40
New Hartford	20	8	46
Norfolk	28	7	44
North Canaan	48	5	22
Roxbury	16	7	62
Salisbury	15	9	60
Sharon	25	11	49
Thomaston	37	10	26
Torrington	35	10	23
Warren	25	6	45
Washington	13	7	57
Winchester	37	9	24
Woodbury	20	7	48
Connecticut	27	8	38

Table 8: Percentage of Kindergarten Students with Preschool Experience, 2018

	Kindergartners Entering with Preschool Experience (%)
Barkhamsted	100
Bethlehem	64.9
Bridgewater	88.9
Burlington	91.3
Canaan	50.0
Colebrook	50.0
Cornwall	90.9
Goshen	96.2
Hartland	84.6
Harwinton	100
Kent	100
Litchfield	89.5
Morris	87.5
New Hartford	71.0
Norfolk	100
North Canaan	93.5
Roxbury	92.9
Salisbury	50.0
Sharon	66.7
Thomaston	82.3
Torrington: Torringford	34.8
Torrington: Vogel-Wetmore	49.3
Warren	100
Washington	91.7
Winchester	83.8
Woodbury	81.0
Connecticut	79.6

Source: CSDE Performance Office, 2019 Report, as reported by Districts on October 1, 2018.

KEY FINDINGS IN NW CT HEC AREA TOWNS

Population Characteristics: As shown in Table 1, the total population in HEC Area Towns in 2017 was 134,891. Population projections compiled by the CT State Data Center, as cited in the NW CT Foundation's 2017 *Community Crossroads* Report, estimate a decline of 2% in the population in NW CT from 2015-2025. However, population growth of 2% or greater is projected for Canaan/Falls Village, Goshen, New Hartford, Torrington, Warren, and Winchester.

Based on the most recent 2019 CERC town profiles (reporting 2013-17 American Community Survey data), on average the county had a lower percentage of persons under age 9 and a higher percentage of persons ages 65 and over than in the state. In HEC Area Towns, 9% of residents were under 9 years of age, compared with 11% for the state, and 20% were ages 65 and over compared with 16% for the state. There are considerable differences by HEC Area Town, with Hartland, New Hartford, Thomaston, and Woodbury having the highest percentages of persons under the age of 9 (each with 11%), and Sharon having the highest percentage of persons ages 65 and over (36%).

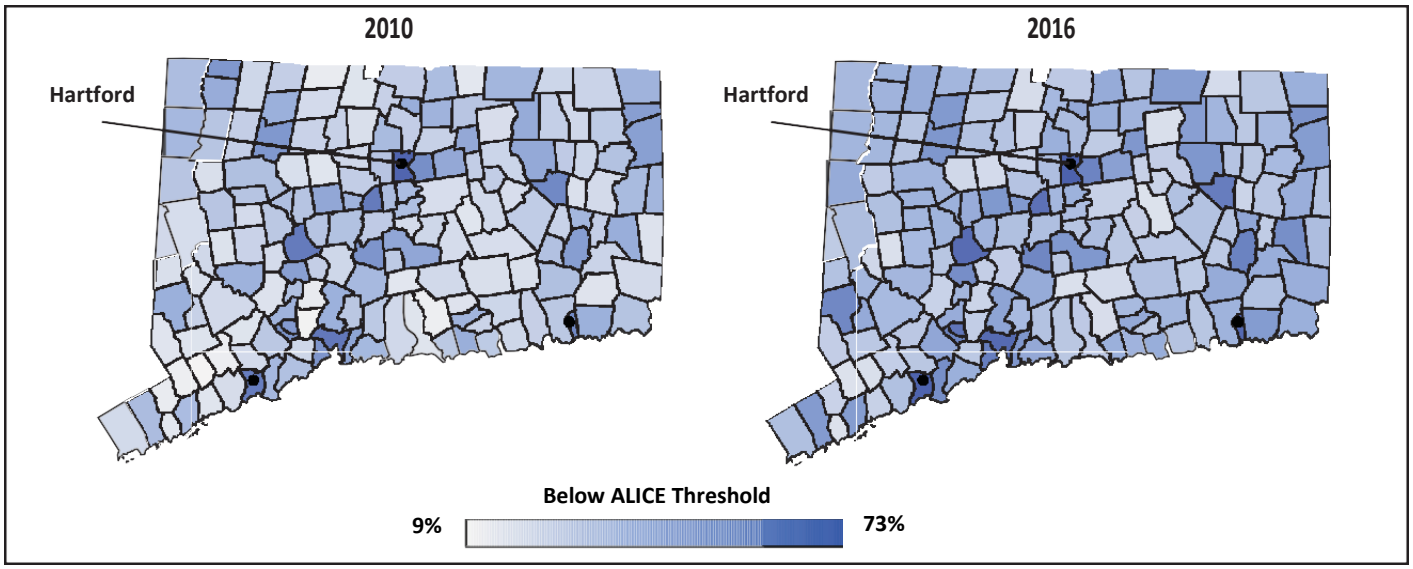
Educational Attainment: As reported in the *Community Health Needs Assessment for NW CT 2015 Update*, based on Census data, from 2000-2010 overall there was a favorable upward trend in the percentage of area residents completing high school and attaining a bachelor's degree. The most recent CERC Town Profile data show the following communities had a lower proportion of residents with bachelor's degrees than the state average: Colebrook, Hartland, Harwinton, North Canaan, Thomaston, Torrington, and Winchester. Four year cohort graduation rates for high school students in 2017-18 were generally above the state average of 88%, with the exception of Torrington and Winchester. There was considerable variation by school district in the percentage of children entering kindergarten with preschool experience in 2018, ranging from a low of 35% to a high of 100%.

Income and Poverty: The poverty rate in HEC Area Towns in 2013-17 ranged from 2% to 17%, and poverty levels increased in 11 of the 25 HEC Area Towns when compared to 2008-2012. The highest poverty rates were reported in Winchester (17%) and Sharon (12%), above the state average of 10%. Student eligibility for free or reduced school meals is a timely indicator of financial hardship in families with children. All school districts serving students in the HEC Area Towns showed significant increases in the percentage of students eligible for free or reduced school meals from 2017-2018 to 2018-2019, with the percentages more than doubling in Goshen, Hartland, Litchfield, North Canaan, Region 12, Region 14, and Woodbury. The school districts with the highest percentage of students eligible for free or reduced meals were Torrington (65%) and Winchester (Explorations: 60% and Winchester Public Schools PreK-6: 65%).

ALICE Report for HEC Area Towns

Connecticut United Ways *ALICE Project Report* for 2018 provides a better understanding of the true level of economic instability in our communities. The most recent *ALICE* - an acronym for ***A**sset **L**imited, **I**ncome **C**onstrained, **E**mployed* - documents the growing number of households from 2010 to 2016 that do not earn enough to afford basic necessities, as shown graphically in the map below.

Figure 1: Percent of Households Below the ALICE Threshold by Town, 2010 and 2016



Data Source: American Community Survey, 2010-2016, and the ALICE Threshold, 2010-2016 as cited in ALICE: A study of Financial Hardship in CT, 2018 Report.

IV. HOUSING, HOMELESSNESS & COMMUNITY SAFETY INDICATORS

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

Homelessness

Each January, the Connecticut Coalition to End Homelessness (CCEH) coordinates a Point-In-Time Count (PIT), to collect data on the exact number of persons experiencing homelessness on a single night in defined areas. The *Connecticut Counts*, 2019 Annual Point-in-Time (PIT) Count and Youth Outreach and Count report *(https://cceh.org/wp-content/uploads/2019/06/PIT_2019.pdf)* indicates that:

- 2019 represents the lowest total ever in a statewide CT PIT Count for the overall total population, families, and chronically homeless since the first statewide count in 2007.
- 337 youth age 24 and younger were experiencing unaccompanied literal homelessness, and 674 were counted as "unstably housed".
- The total number of homeless or unstably housed youth in the HEC Area towns surveyed was 91. The count by age was as follows: 29 youth were ages 14-17 and 62 were ages 18-24. A total of 82 out of the 91 homeless youth were reported in Torrington and Winchester, 4 in Thomaston, 2 in Canaan, and 2 in Salisbury. It should be noted that this number is likely an underestimation as not all HEC Area Towns were surveyed.
- The NW CT Collaborative for the Education of Homeless Children and Youth is a partnership between the Torrington Public Schools and EdAdvance, the Regional Educational Service Center in western CT. This CSDE-funded initiative provides wraparound academic, social, and emotional support services to children living in homeless families, using the McKinney-Vento definition of homelessness. In 2018-2019, 85 children in Torrington (pre-K through grade 12) were identified as homeless.
- In a 2015 survey administered by CCEH, 12% of teacher and student respondents in the Torrington Public Schools reported they were aware of at least 1 unstably housed youth.

Housing Affordability

- *Cost Burdened Renters or Homeowners*: The U.S. Department of Housing and Urban Development (HUD) defines cost-burdened renters or homeowners as those who pay more than 30% of their income for rent or mortgage payments. As shown in Table 4, 7-78% of renter households in HEC Area Towns are cost-burdened and 17-51% of households who are paying a home mortgage are cost-burdened. The highest percentage of cost-burdened homeowners are residents of Cornwall, Kent, and Norfolk and the highest percentage of cost-burdened renters are residents of Harwinton, Kent, and Warren.
- The National Low Income Housing Coalition's 2019 *Out of Reach* Report indicates that Connecticut is the 9th most expensive state in the nation for housing. In Litchfield County, the hourly wage needed to afford a two-bedroom fair market rate apartment is $21.94, nearly twice the minimum wage *(https://reports.nlihc.org/oor/connecticut)*.

Community Safety

The Uniform Crime Reporting Program (URC) measures the distribution of crime in communities across the U.S. Eight offenses were chosen to form the Crime Index, as shown in Table 8. Litchfield County's overall 2018 crime index compares favorably with the state total average and the state average for non-urban (population < 100,000) areas, and has declined since 2010.

The annual Family Violence Report compiled by the CT Department of Emergency Services and Public Protection indicates a slight increase in the number of reported incidents in the state from 2017 to 2018. Litchfield County ranks fifth out of the 8 CT counties in the rate of family violence incidents. As shown in Figure 2, within HEC Area Towns, the highest rate of offenses per 100,000 population were reported in Torrington and Winchester *(https://portal.ct.gov/DESPP/Division-of-State-Police/Crimes-Analysis-Unit/Crimes-Analysis-Unit)*.

Additional facts about family violence incidents in Connecticut:

- Females were the victim of two-thirds of all offenses; males were the victim of one-third of all offenses.
- Intimate partner incidents accounted for over three-fourths incidents in 2018.
- Children less than 18 years of age were involved in 9% of the incidents and were the victims of 6% of the incidents.

Table 9: Litchfield County and CT Crime Rates, 2018

Index Offense	Litchfield County		CT Non-Urban		CT Total	
	#	Rate	#	Rate	#	Rate
Murder	3	1.6	30	1.0	84	2.3
Rape	34	17.7	575	19.5	859	24.0
Robbery	34	17.7	932	31.7	932	61.6
Aggravated Assault	67	34.9	1,812	61.6	4,314	120.4
Burglary	275	143.4	5,266	179.0	7,997	223.2
Larceny	1,557	812.1	31,939	1,085.4	44,922	1,253.5
Motor Vehicle Theft	171	89.2	4,300	146.1	7,391	206.2
Arson	4	2.1	103	3.5	226	6.3
Crime Index Total	**2,141**	**1,116.8**	**44,854**	**1,524.3**	**67,774**	**1,891.2**

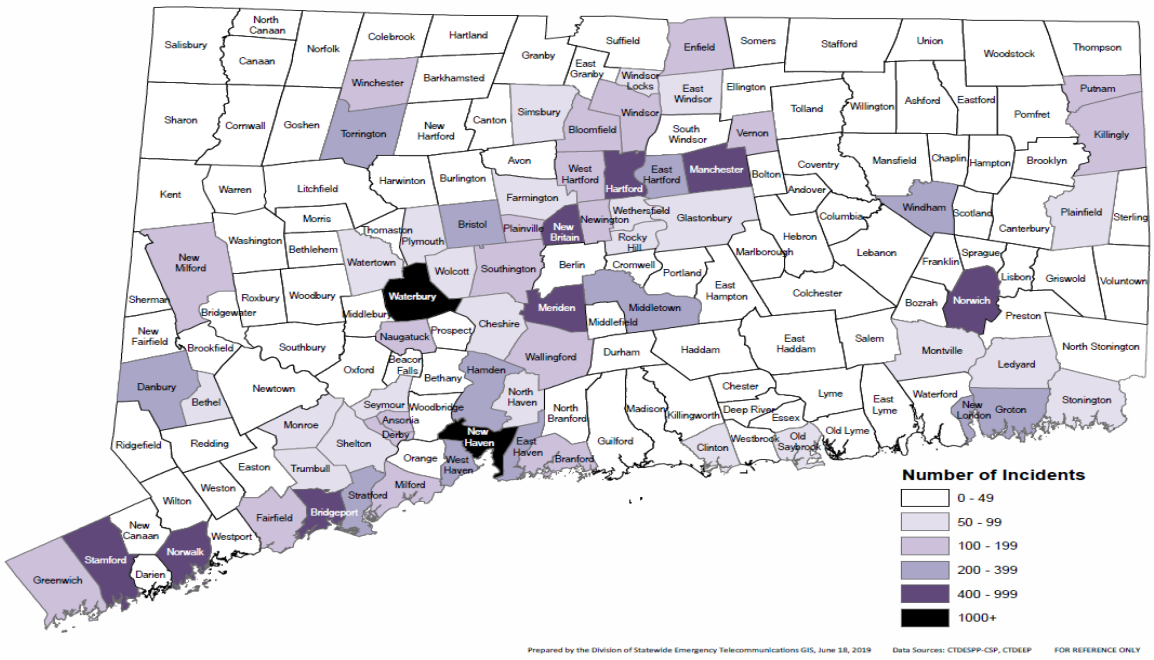
Source: Crime In Connecticut – 2018 Annual Report of the Uniform Crime Reporting Program CT Department of Emergency Services and Public Protection

Table 10: Family Violence Arrests by County, 2018

Family Violence Offense Type by County									
	Fairfield	Hartford	Litchfield	Middlesex	New Haven	New London	Tolland	Windham	Total
Homicide	2	7	2	2	6	2	0	1	22
Assault	1,357	1,862	237	186	2,735	545	154	223	7,299
Kidnapping	1	6	3	1	17	0	0	1	29
Sexual Assault	16	20	4	1	18	5	3	4	71
Strangulation	117	160	37	32	243	90	13	24	716
Stalking	21	20	8	7	24	7	3	1	91
Violation Court Order	404	850	263	132	1,072	315	86	149	3,271
Threatening	282	447	72	66	592	121	29	43	1,652
Risk of Injury	139	141	25	22	135	47	12	17	538
Breach/Disorderly	2,379	3,846	691	584	3,809	1,429	275	528	13,541
Other	295	489	87	87	405	212	43	82	1,700
Total Offenses	5,013	7,848	1,429	1,120	9,056	2,773	618	1,073	28,930
Population*	928,021	901,331	191,576	163,060	866,443	272,443	143,380	114,699	3,580,953
Offense Rate per 100,000	540	871	746	687	1,045	1,018	431	935	808

Source: CT Family Violence Arrest Report, CT Department of Emergency Services and Public Protection, Crime Analysis Unit, October 2019

Figure 2: Family Violence Incidents by Town, 2018



V. HEALTH RANKINGS AND HEALTH RISK BEHAVIORS

A number of indicators are used to describe the health status of residents in a specific geographic area. These include the presence or absence of health promoting behaviors; access to and utilization of health screenings, primary care and specialized health care services; the incidence and prevalence of chronic and communicable diseases; and the leading causes of premature death and disability. National health initiatives such as County Health Rankings track and report health status data on an annual basis, to monitor indicators over time. Behavioral Risk Factor Surveillance Survey (BRFSS) data are compiled annually in Connecticut by the CT State Department of Public Health (DPH).

Table 11: Litchfield County Health Indicators, 2019

Indicator	Litchfield County	Error Margin	National Benchmark	CT
Health Outcomes				
Length of Life				
Premature death	5,700	5,200-6,100	5,400	5,600
Quality of Life				
Poor or fair health	9%	9%	12%	14%
Poor physical health days	2.6	2.5-2.7	3.0	3.4
Poor mental health days	3.3	3.2-3.5	3.1	3.8
Low birthweight	7%	6-7%	6%	8%
Health Factors				
Adult smoking	12%	12-13%	14%	13%
Adult obesity	27%	25-30%	26%	26%
Food environment index	8.8	*	8.7	8.6
Physical inactivity	19%	17-21%	19%	19%
Access to exercise opportunities	80%	*	91%	94%
Excessive drinking	19%	18-20%	13%	18%
Alcohol-impaired driving deaths	37%	31-42%	13%	33%
Sexually transmitted infections	231.5	*	152.8	387.4
Teen births	7	7-8	14	12
Clinical Care				
Uninsured	5%	4-5%	6%	6%
Primary care physicians	1,600:1	*	1,050:1	1,180:1
Dentists	1,520:1	*	1,260:1	1,170:1
Mental health providers	430:1	*	310:1	270:1
Preventable hospital stays	3,893	*	2,765	4,220
Mammography screening	46%	*	49%	47%
Flu vaccinations	52%	*	52%	51%
Social & Economic Factors				
High school graduation	90%	*	96%	87%
Some college	69%	66-72%	73%	69%
Unemployment	4.3%	*	2.9%	4.7%
Children in poverty	8%	6-10%	11%	13%
Income inequality	4.1	3.9-4.2	3.7	5.0
Children in single-parent households	21%	19-23%	20%	32%
Disconnected Youth	5%	3-7%	4%	5%
Social associations	10.8	*	21.9	9.4
Violent crime	106	*	63	232
Injury deaths	72	67-78	57	65

Physical Environment				
Air pollution - particulate matter	7.9	*	6.1	8.0
Severe housing problems	16%	15-17%	9%	19%
Severe Housing Cost Burden	14%	13-15%	7%	17%

Source: 2019 County Health Rankings @ www.countyhealthrankings.org. * Not Applicable

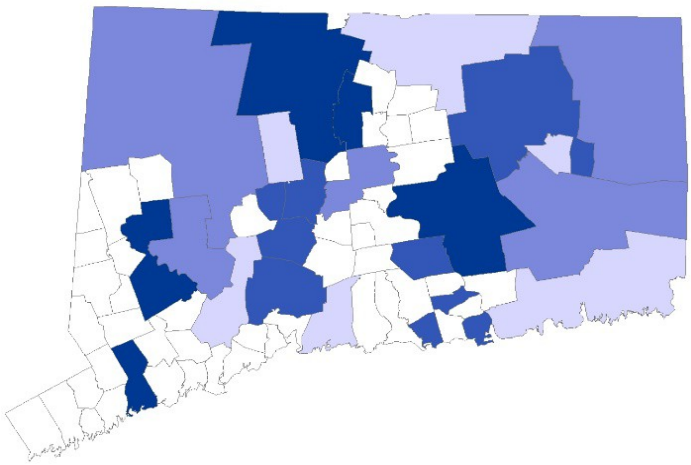
Behavioral Risk Factors

The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing random telephone survey (landlines and cell phones) of adults ages 18 and over conducted in all 50 states using a standardized questionnaire developed by CDC. The BRFSS has expanded to include survey questions related to health care access, utilization of preventive health services, and emerging health issues such as Adverse Childhood Events (ACEs).

Comparative BRFSS data for the NW CT HEC communities in the service area of Torrington Area Health District and other health districts across the state were analyzed by DPH for 2012-2016 and published in a report in April 2019, *Analysis of Health Indicators for Connecticut Health Districts and Departments* *(https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/BRFSS/CT-BRFSS-Health-District-Report.pdf).* Only data for Health Districts is included in the maps that follow; data for Local Health Departments was reported separately and is not included (shown as non-shaded areas).

Figure 3: Percentage of adults with good mental health, by quartile:

≤81.9 82.0 to 84.5 84.6 to 87.1 ≥87.2



These measures define adults in good physical or mental health if they reported less than 14 days (within the past 30 days) in which their physical or mental health was "not good".

Figure 4: Percentage of adults with good physical health, by quartile:

≤82.9 83.0 to 85.3 85.4 to 87.7 ≥87.8

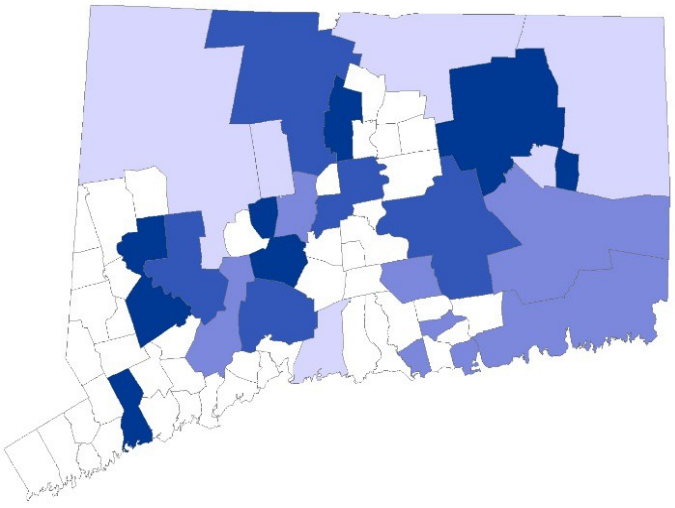
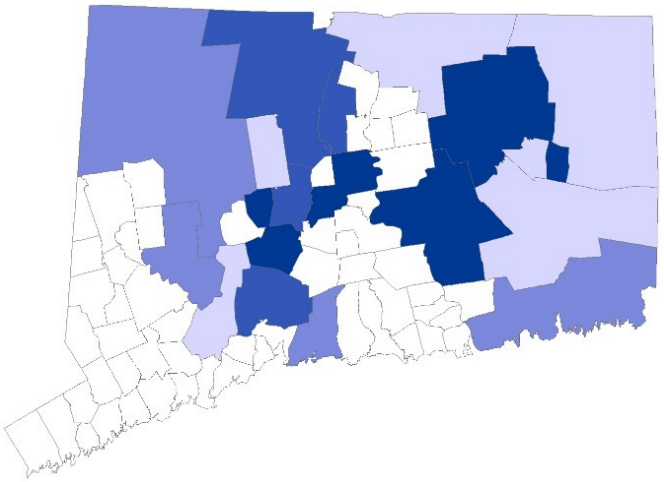


Figure 5: Current Health Care Coverage by District, in quartiles

≤92.9 93.0 to 95.2 95.3 to 96.1 ≥96.2



Residents were asked if they had any kind of health care coverage, including health insurance, prepaid plans, or government plans such as Medicare.

Figure 6: Housing Security by District, in quartiles

≤66.2 66.3 to 71.2 71.3 to 76.0 ≥76.1

Residents were asked to report how often in the past 12 months they felt worried or stressed about having enough money to pay for housing.

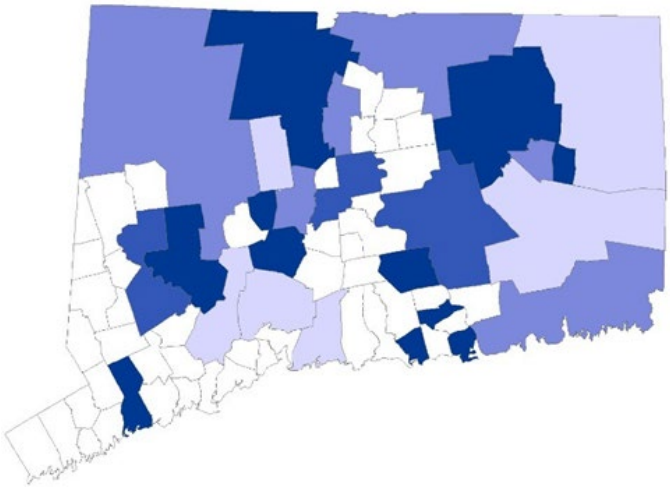
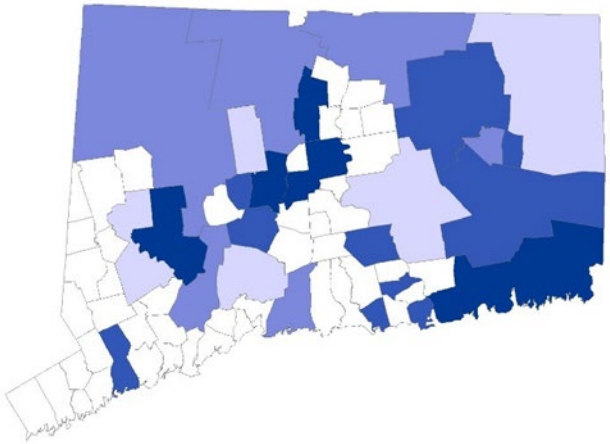


Figure 7: Routine Checkup in Past Year by District, in quartiles

≤87.2 87.3 to 87.6 87.7 to 88.4 ≥88.5



Residents were asked if they have at least one doctor or healthcare professional that they consider their personal doctor.

KEY FINDINGS IN NW CT HEC AREA TOWNS

Analysis of the 2019 County Health Rankings data for Litchfield County indicate that the county ranks *unfavorably* compared with the state and the nation for the following indicators:

- ✓ *premature death;*
- ✓ *adult obesity;*
- ✓ *access to exercise opportunities;*
- ✓ *excessive drinking;*
- ✓ *alcohol-impaired driving deaths;*
- ✓ *mammography screenings; and*
- ✓ *ratio of primary care physicians, dentists, mental health providers.*

As noted in the 2018 *Charlotte Hungerford Hospital Community Health Needs Assessment*, the area surrounding Torrington is federally-designated as a Medically Underserved Area (MUA) and a Health Professional Shortage Area (HPSA) for primary care and dental health. All of Litchfield county is designated as a HPSA for mental health services.

Comparative BRFSS data for the service area of Torrington Area Health District and the state compiled and analyzed from 2012-2016 show residents in NW CT reported health behaviors in the *lowest quartile* for good physical health, with nearly one in five reporting 14 or more days (within the past 30 days) for which their physical health was "not good". In addition, nearly one in five residents responded that they had been told they had a depressive disorder including depression, major depression, dysthymia, or minor depression at some time in their lives.

BRFSS data analyzed by DPH in 2012 as reported in the *2015 Community Health Needs Assessment Update for NW CT* indicate that area residents more frequently reported the following negative health behaviors: heavy drinking; current smoking; not having their blood sugar tested; not having a check-up in the past year, not having a flu shot, and not having a Pap smear or PSA screening than state residents on average. None of these differences were statistically significant *(https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/BRFSS/TAHDBRFSSfactsheet2013pdf.pdf?la=en)*.

Looking at responses by gender and income levels, male residents more frequently reported: good/excellent health, current alcohol use, current binge drinking*, current smoking, overweight/obesity*, no blood sugar testing, not having a primary care physician, no check-up within the past year*, not being able to afford medical care, not seeing a dentist within the past year, not having a flu shot*, and not having colorectal screening than female residents. Females more frequently reported heavy drinking, and having a flu shot in the past year*. *The differences in indicators noted with an asterisk were statistically significant ($p < .05$).*

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

Annual patient service data for 2018 from the Community Health & Wellness Center of Greater Torrington, a Federally Qualified Health Center (FQHC) serving 5,966 residents (5,765 adults) in 35 zip codes in the region, provides additional insights regarding need in their primarily low income patient population. For patients reporting income, 78% had incomes at 200% or below the federal poverty level.

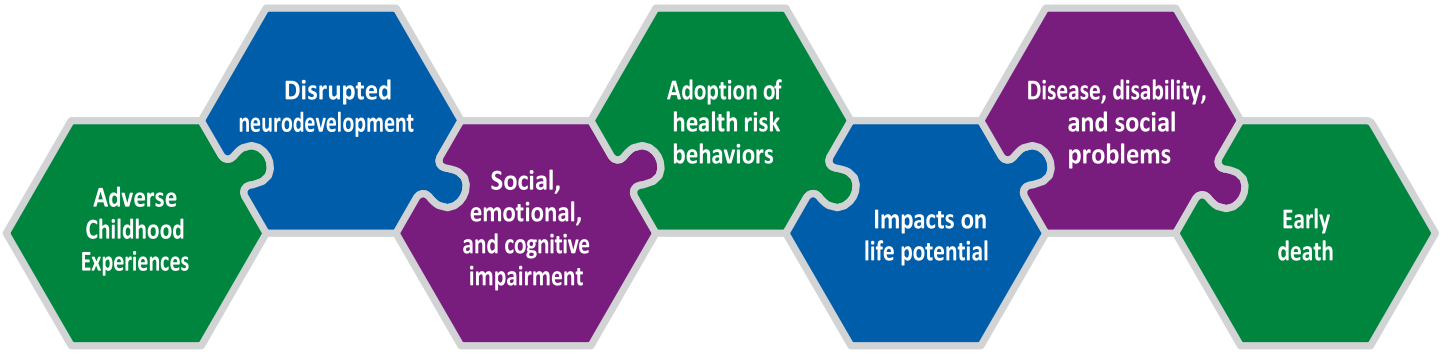
- 101 patients were homeless;
- 16% of adult patients had a diagnosis of overweight or obesity;
- 5% of adult patients had alcohol-related disorders, and 8% had other substance use disorders (excludes tobacco);
- 13% of adult patients had a diagnosis of depression or other mood disorders;
- 17% of adult patients had a diagnosis of anxiety, including PTSD; and
- 12% of adult patients had a diagnosis of other mental disorders, excluding drug or alcohol dependence.

VI. ASSESSMENT DATA BY HEC PRIORITY AIM

A. Improving Child Well-Being for Connecticut Children, Pre-Birth to Age 8 Years

The 2019 CDC Report, *Preventing Adverse Childhood Experiences (ACES): Leveraging the Best Available Evidence,* emphasizes that the childhood years, from the prenatal period to late adolescence, are the "building block" years that help set the stage for adult relationships, behaviors, health, and social outcomes. ACEs and associated conditions such as living in under-resourced or racially segregated neighborhoods, frequently moving, experiencing food insecurity, and other instability can cause toxic stress (i.e., prolonged activation of the stress-response system[4]). Some children may face further exposure to toxic stress from historical and ongoing traumas due to systemic racism or the impacts of multigenerational poverty resulting from limited educational and economic opportunities.

A large and growing body of research indicates that toxic stress during childhood can harm the most basic levels of the nervous, endocrine, and immune systems, and that such exposures can even alter the physical structure of DNA (epigenetic effects).[4,5] Changes to the brain from toxic stress can affect such things as attention, impulsive behavior, decision-making, learning, emotion, and response to stress.[5] Absent factors that can prevent or reduce toxic stress, children growing up under these conditions often struggle to learn and complete schooling.[5,22] They are at increased risk of becoming involved in crime and violence,[23,24] using alcohol or drugs,[6,7] and engaging in other health-risk behaviors (e.g., early initiation of sexual activity; unprotected sex; and suicide attempts).[9,13,16,23] They are susceptible to disease, illness, and mental health challenges over their lifetime.[5,14,15] Children growing up with toxic stress may have difficulty forming healthy and stable relationships. They may also have unstable work histories as adults and struggle with finances, family, jobs, and depression throughout life—the effects of which can be passed on to their own children.[5,12,17]



ACEs and their associated harms are preventable. Creating and sustaining safe, stable, nurturing relationships and environments for all children and families can prevent ACEs and help all children reach their full health and life potential.

The evidence tells us that ACEs can be prevented by:

- Strengthening economic supports for families;
- Promoting social norms that protect against violence and adversity;
- Ensuring a strong start for children and paving the way for them to reach their full potential;
- Teaching skills to help parents and youth handle stress, manage emotions, and tackle everyday challenges;
- Connecting youth to caring adults and activities; and
- Intervening to lessen immediate and long-term harms.

As previously noted, the BRFSS conducted by DPH includes questions about residents' exposure to ACEs as children, including: emotional, physical, and sexual abuse; intimate partner violence; household substance abuse; household mental illness; parental separation or divorce; and incarcerated household member. Findings from the *Heath Statistics and Surveillance Report on Adverse Childhood Events* published by DPH in 2018 analyzed the BFRSS data for the correlation between ACES and a variety of health factors are presented on the following page *(https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/BRFSS/ACEs_in_Connecticut_BRFSS2017_Factsheet.pdf).*

The prevalence of adults with three or more ACEs was significantly higher among:

- Adults less than 65 years old;
- The LGBT population (37%) compared to the heterosexual group (21%);
- Adults who never married (30%) compared to adults who are currently married (16%);
- Adults with disabilities (28%) compared to adults without disabilities (19%);
- Adults who did not graduate from high school (27%), graduated from high school (22%), and adults with some college education (26%), compared to adults who graduated from college or technical school (15%);
- Unemployed adults (35%) and adults who were unable to work (36%), compared to adults who are employed (23%);
- Renters (35%) and adults with other housing arrangements (26%), compared to adults who own their houses (17%);
- Adults with Medicaid (37%), compared to non-Medicaid adults (20%).

ACEs have a dose-response relationship with many health problems. After adjustment for age, gender, race/ethnicity, income and education, several health outcomes have increased odds of occurrence among individuals with ACEs.

In Connecticut, a person with three or more ACEs as compared to a person with no ACE is:

- **5.2** times more likely to be at risk for **depression**;
- **5.1** times more likely to be a victim of **sexual violence** in adulthood;
- **4.6** times more likely to have depression symptoms *(having more than 14 sad, blue, or depressed days in the past 30 days)*;
- **4.2** times more likely to engage in **HIV risk behaviors** *(including intravenous drug use, sexually transmitted disease, exchange sex for drugs or money, unprotected anal sex or having four or more sexual partners in the last year)*;
- **4.1** times more likely to be at risk **for poor mental health** *(had more than 14 bad mental health days in past month)*;
- **3.6** times more likely to **ever use e-cigarettes;**
- **3.0** times more likely to be a **current smoker**;
- **3.0** times more likely to be **usually or always worried about paying for housing**;
- **3.0** times more likely to be **usually or always worried about buying nutritious foods;**
- **2.4** times more likely to **lack emotional support**;
- **2.4** times more likely to be at risk for **COPD**;
- **2.1** times more likely to be at risk for **arthritis**;
- **2.1** times more likely to be at risk for **poor general health**;
- **2.0** times more likely to be at risk for **current asthma**.

Substance Use Disorders

Families, children, individuals, and their communities in NW CT continue to struggle with the devastating personal, social, health, safety, and financial impacts of the opioid epidemic and other substance use disorders. The Litchfield County Opioid Task Force co-chaired by Charlotte Hungerford Hospital and the McCall Center for Behavioral Health was created in December 2013 to develop systemic regional approaches to opioid use prevention, treatment, and recovery in the region. The Task Force has over 60 members including local and state elected officials, law enforcement, the juvenile justice system, Department of Mental Health and Addiction Services, Community Health and Wellness, EMS, the Torrington Area Health District, local substance abuse and mental health treatment providers, individuals in recovery, and parents of those struggling with addiction.

Preliminary data from DPH's EpiCenter Syndromic Surveillance System for Emergency Department (ED) visits and rates for suspected opioid overdoses by county for the fourth quarter of 2018 are presented in Figure 8. The number of ED visits for suspected opioid overdoses for the first two quarters of 2019 in the county has declined somewhat compared with the last two quarters of 2018 (total of 94 visits from January-June 2019 compared with 111 visits from July-December 2018). This data should be interpreted with caution as it is considered preliminary due to lags in reporting.

Figure 8:

Rate per 100,000 Population and Count of ED Visits for "Suspected Opioid Overdose" Syndrome in Connecticut, by County of Residence, Quarter 4 2018

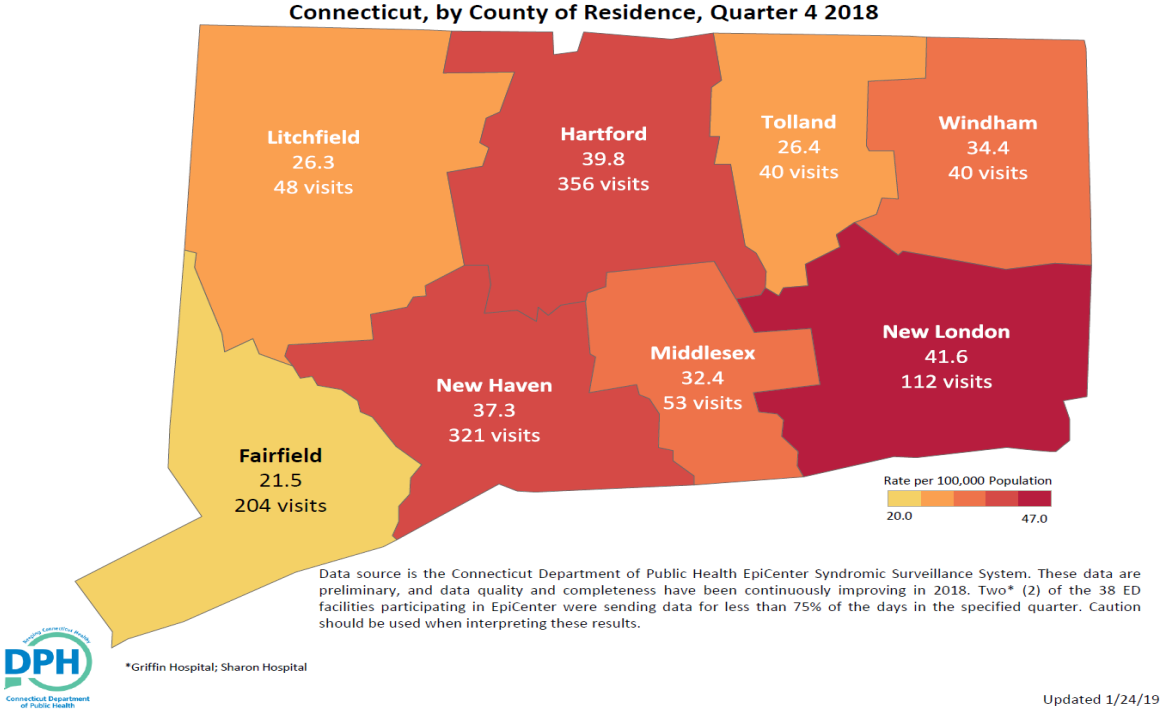


Table 11 below represents the number of admissions by state fiscal year for opioid disorder in the 20 towns served by Torrington Area Health District (TAHD) from 2014-2018. This includes individuals participating in treatment programs funded or operated by DMHAS; it does not include individuals in non-DMHAS supported programs. For the five-year period, the number of state-operated drug treatment admissions in the TAHD service area has increased by *43 percent*, more than twice the statewide rate as shown below:

Table 12: Opioid Treatment Admissions in CT and TAHD Service Area, 2018

	2014	2015	2016	2017	2018	5-Year % Change
State of CT						
# of Admissions to Opioid Treatment	24,332	27,535	27,773	30,141	29,027	+19%
Torrington Area Health District						
# of Admissions to Opioid Treatment	1,144	1,486	1,587	1,651	1,637	+43%

Source: data.ct.gov/Health-and-Human Services/Opioid-Related-Treatment-Admissions-by-Town; data compiled by TAHD.

TAHD requested ODMAP access in early July 2019 to better track suspected opioid related overdoses. Since then TAHD formed a Data Sharing Committee which focuses on efforts to immediately mobilize a response to a sudden increase, or spike, in suspected overdose events. Available ODMAP data for the State of Connecticut, Litchfield County, and Torrington from June 1 - October 24, 2019 is presented below. It should be noted that data for the state and Litchfield County only represent those municipalities or regions reporting data to ODMAP. It is also important to note that some of this data is duplicated in ED admission counts, i.e., for individuals agreeing to EMS transport to the hospital ED.

Table 13: ODMAP Suspected Overdoses in CT, Litchfield County, and Torrington, June - October 2019

	Suspected Overdoses	Fatal	Naloxone
Connecticut	2,126	151	1,676
Litchfield County	146	16	108
Torrington	66	6	60

Source: ODMAP/ https://odmapl2.hidta.org; data compiled by TAHD.

As reported by the CT Office of the Chief Medical Examiner, the number of accidental overdose deaths for residents of HEC Area Towns in 2018 was 42; 22 of these deaths were in Torrington residents. From January-November of 2019 the total number of overdose deaths in HEC Area towns was 37, and 19 of these deaths were in Torrington residents. Opioids (heroin and fentanyl) were implicated in 89% of these deaths due to overdose *(https://portal.ct.gov/OCME/Statistics)*.

Data from the CT Department of Mental Health and Addiction Services for HEC Area Towns for Mental Health and Substance Abuse Treatment reveals the following for individuals receiving services from DMHAS-supported facilities in 2018:

Table 14: Mental Health and Substance Abuse Clients by Town, 2018

Town	Mental Health Only	Substance Abuse Only	Mental Health & Substance Abuse	Total
Barkhamsted	34	65	5	104
Bethlehem	32	44	4	80
Bridgewater	6	17	1	24
Burlington	16	90	5	111
Canaan	45	78	5	128
Colebrook	19	17	-	36
Cornwall	7	6	-	13
Goshen	33	31	2	66
Hartland	3	15	2	20
Harwinton	70	76	3	149
Kent	30	37	2	69
Litchfield	141	121	13	275
Morris	22	36	-	58
New Hartford	58	82	8	148
Norfolk	20	31	1	52
North Canaan	4	6	-	10
Roxbury	13	21	3	37
Salisbury	19	40	4	63
Sharon	13	30	4	47
Thomaston	83	133	9	225
Torrington	1,483	1,063	179	2,725
Warren	13	22	1	36
Washington	24	54	6	84
Winchester	343	309	38	690
Woodbury	52	87	10	149
CT	48,039	50,554	6,947	105,540

Source: CT Department of Mental Health and Addiction Services, Annual Statistical Report, SFY 2018.

Child Abuse and Neglect (CAN)

Child abuse and neglect are significant public health problems. Safe, stable, nurturing relationships and environments are essential to prevent early adversity, including child abuse and neglect. Child abuse and neglect refer to behaviors that result in harm, potential for harm, or threat of harm directed toward a child under the age of 18 by a parent, caregiver, or other person in a custodial role, such as clergy, coach, or teacher. There are three types of abuse: physical, sexual, and emotional. Neglect is the failure to meet a child's basic physical and emotional needs, including housing, food, clothing, education, and access to medical care *(https://www.cdc.gov/violenceprevention/pdf/essentials-for-childhood-framework508.pdf)*.

Data on CAN Allegations in 2017 and 2018 from the CT Department of Children and Families (DCF) for HEC Area Towns is presented in Table 14. As CAN reports often contain multiple allegations, this does not represent the number of children. The number of children are not included as occurrences of less than ten are suppressed, preventing an accurate count.

Table 15: Child Abuse and Neglect Allegations in HEC Area Towns, 2017-2018

Town	# of Allegations, 2017	# of Substantiated Allegations, 2017	# of Allegations, 2018	# of Substantiated Allegations, 2018
Barkhamsted	41	*	32	*
Bethlehem	49	*	59	35
Bridgewater	*	*	*	-
Burlington	77	12	93	12
Canaan	42	*	96	33
Colebrook	15	*	17	*
Cornwall	20	*	*	-
Goshen	23	*	48	15
Hartland	37	*	47	16
Harwinton	78	18	74	32
Kent	30	*	52	19
Litchfield	108	16	120	23
Morris	42	*	30	*
New Hartford	58	*	61	14
Norfolk	14	*	15	*
North Canaan	20	*	18	*
Roxbury	*	*	18	-
Salisbury	43	*	13	-
Sharon	12	*	50	20
Thomaston	169	32	164	29
Torrington	1,114	187	1,109	298
Warren	18	*	16	*
Washington	23	*	13	*
Winchester	455	150	328	97
Woodbury	85	11	125	61
CT	76,006	15,636	72,452	16,889

*Source: ctdata.org. CT Department of Children and Families. Note: Towns with less than 10 substantiated cases in any category have their values suppressed to minimize the risk of revealing protected information that could lead to personal identification of individual children. Suppressed values are indicated by an *.*

B. Improving Healthy Weight and Physical Fitness for All NW CT Residents

Promotion of a healthy or healthier body weight at all ages involves healthy food choices and regular physical activity. Social determinants of health have an impact on weight and fitness. For example, access to affordable nutritious foods and safe places to engage in physical activity are important in maintaining a healthy weight.

The 2018 DPH *Connecticut Childhood Obesity Report* cites the following statistics regarding childhood obesity in CT:

Almost one-third of Connecticut's youth are overweight or obese.

- Approximately 29% of children (5-17 years old) are overweight or obese (2014-2016 BRFSS).
- An estimated 29% of high school students are overweight or obese (2017 YRBSS).
- About 31% of kindergarten and third grade students are overweight or obese (2016-2017 Every Smile Counts).
- Among children age 2 to 4 years participating in the WIC Program, 15% are overweight and 15% are obese (2018 WIC).
- The prevalence of obesity is higher among male children compared with female children (2014-2016 BRFSS and 2017 YRBSS).
- Non-Hispanic black and Hispanic youth are more likely to be obese compared with non-Hispanic white youth (2014-2016 BRFSS, 2017 YRBSS, and 2016-2017 Every Smile Counts).

Risk factors for obesity, such as the consumption of unhealthy foods and beverages and physical inactivity, are prevalent among Connecticut's youth.

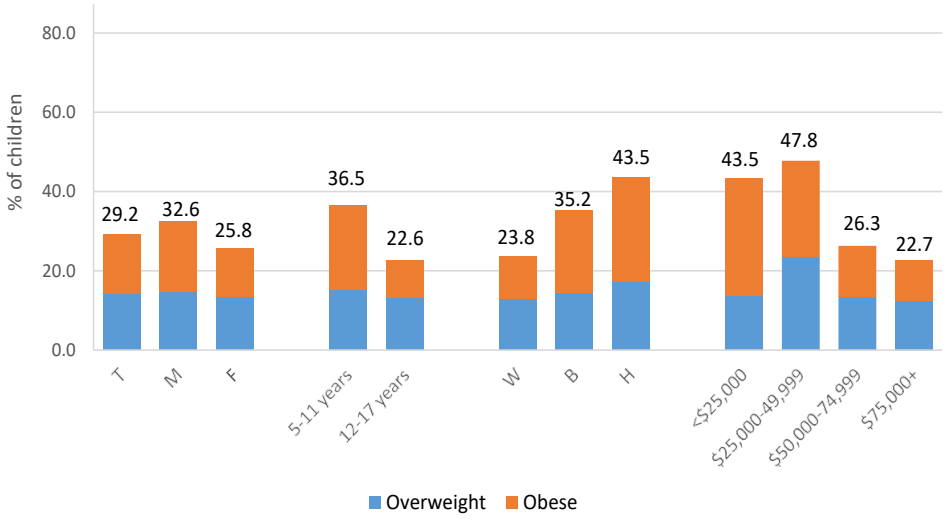
- Approximately 13% of high school students eat vegetables three or more times per day (2017 YRBSS).
- Nearly one-third of high school students eat fruit or drink 100% fruit juice two or more times per day (2017 YRBSS).
- Approximately 1 out of 10 high school students drank a can, bottle, or glass of soda one or more times a day in the past seven days (not counting diet soda) (2017 YRBSS).
- An estimated 25% of children (<18 years old) drink at least one 12 ounce (oz.) soda or sugar sweetened drink per day (2014-2016 BRFSS).
- Almost one-third of children (<18 years old) eat fast food or pizza two or more times per week (2014-2016 BRFSS).
- An estimated 60% of high school students attended physical education classes on one or more days during an average school week (2017 YRBSS).
- Approximately 22% of high school students were physically active at least sixty minutes on all of the past seven days (2017 YRBSS).
- One-sixth of high school students watch three or more hours of television on an average school day (2017 YRBSS).
- An estimated 42% of high school students played video games or used a computer three or more hours per day (for something that was not schoolwork) on an average school day (2017 YRBSS).
- An estimated 42% of all children (<18 years) have three or more hours of screen time (TV and computer) per day (2014-2016 BRFSS).

Source: https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/hems/nutrition/PDF/Childhood-Obesity-Report-2018-final.pdf?la=en.

BRFSS = Behavioral Risk Factor Surveillance System; YRBSS = Youth Risk Behavior Factor Surveillance System; WIC = Supplemental Food and Nutrition Program for Women, Infants, and Children. Percentages have been rounded to the nearest whole number.

As shown in Figure 9, the prevalence of obesity is highest in lower income families. Children from lower income families also report more frequent consumption of soda or other sugar sweetened drinks, pizza or other fast foods, and three or more hours of screen time per day. Data from the Litchfield County Head Start Program serving children ages 3-5 in low income families also indicates a high prevalence of overweight and obesity. In 2018-19, 16% of children participating in Head Start were overweight and 21% were obese based on CDC weight for height growth percentiles.

Figure 9: Overweight/Obesity Prevalence by Gender, Age, Race & Ethnicity, Annual Household Income, Connecticut Children 5-17 Years Old (BRFSS, 2014-2016)*†



*Total, Males & Females; Non-Hispanic (NH) White, NH Black, Hispanic, & NH Other Race

The most recent comparative data for adults (ages 18 and over) related to obesity and physical activity in HEC Area Towns is available from the April 2019 DPH Report, *Analysis of Health Indicators for Connecticut Health Districts and Departments*. Overweight and obese adults are at risk of developing a wide range of health problems, including high blood pressure, type 2 diabetes, coronary heart disease, certain cancers, stroke and other diseases.

Figure 10: Healthy Weight by Health District

Percentage of adults with healthy weight (BMI: 18.5-24.9kg/m^2), in quartiles

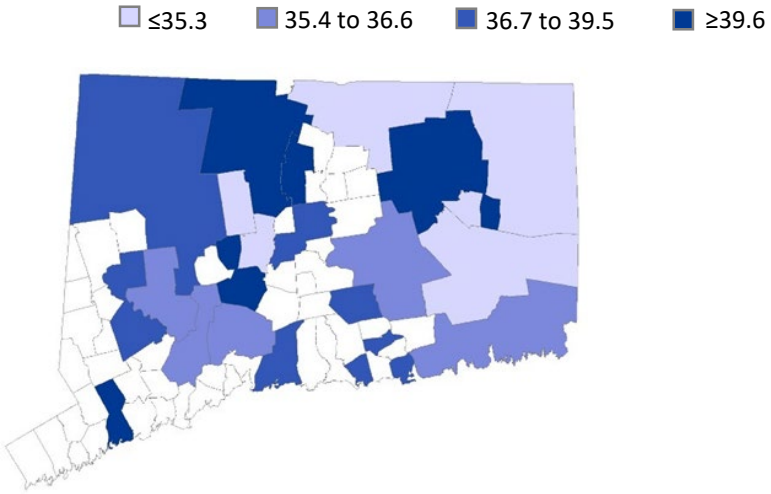


Figure 11: Food Security by Health District

Financial stress can negatively impact a person's health. Previous BRFSS data have shown that adults experiencing housing instability or food insecurity are significantly more likely to suffer from insufficient sleep and mental distress.[5] Among low-income adults, food insecurity is associated with chronic disease, such as diabetes or hypertension.[7]

Percentage of adults who never or rarely felt worried or stressed about having enough money to pay for nutritious meals, in quartiles.

≤80.2 80.3 to 83.1 83.2 to 86.9 ≥87.0

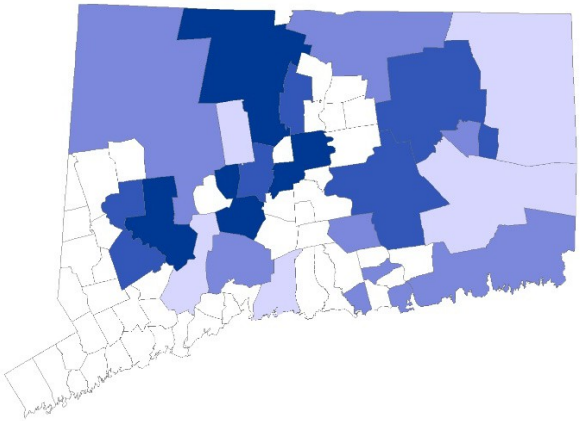


Figure 12: Met Aerobic and Strengthening Guidelines by Health District

Percentage of adults who met both aerobic and strengthening physical activity guidelines, in quartiles

≤ 20.3 20.4 to 23.2 23.3 to 24.8 ≥ 24.9

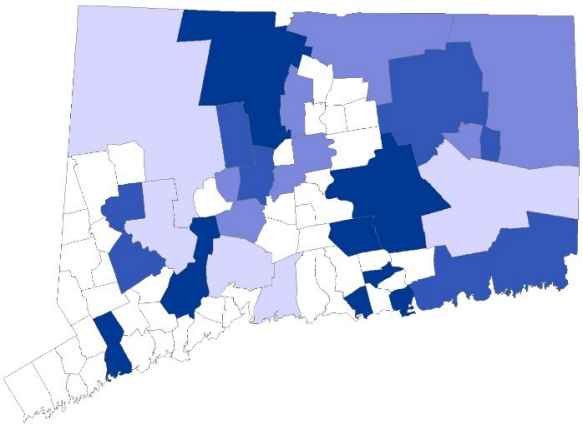


Figure 13: No Leisure Time Physical Activity by Health District

Percentage of adults who did not engage in any leisure or recreational physical activity in the past month, in quartiles

≤16.8 16.9 to 19.7 19.8 to 22.9 ≥23.0

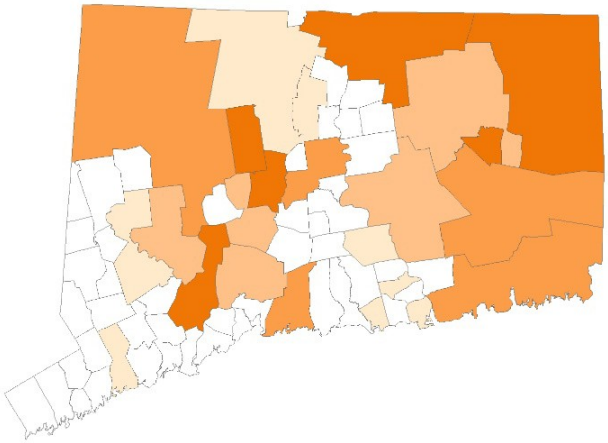


Figure 14: Fruit Consumption by Health District

The Dietary Guidelines for Americans recommend that people consume five to thirteen servings of fruits and vegetables daily, with different amounts based on total calorie intake.[12] The average American, however, only eats about three servings of fruits and vegetables each day. [13]

Percentage of adults who ate fruit one or more times daily, in quartiles

≤64.3 64.4 to 65.8 65.9 to 68.2 ≥68.3

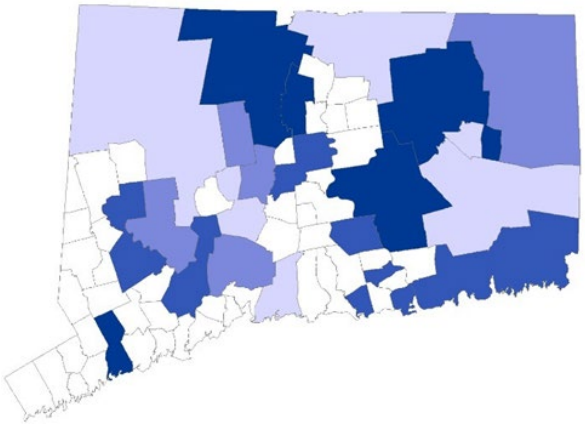
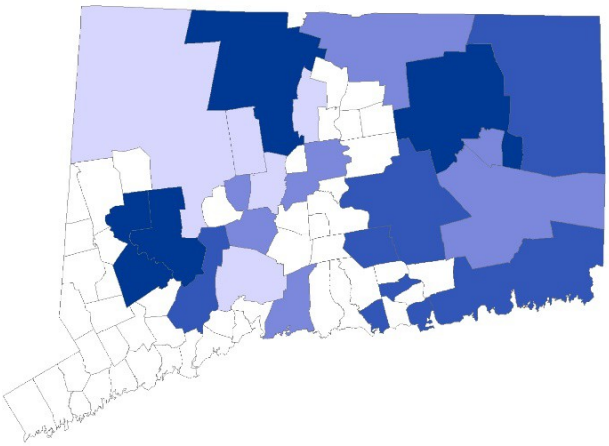


Figure 15: Vegetable Consumption by Health District

Percentage of adults who ate vegetables one or more times per day, in quartiles

≤77.5 77.6 to 78.5 78.6 to 85.7 ≥85.8



KEY FINDINGS IN NW CT HEC AREA TOWNS

- Two out of every three adults in NW CT were overweight or obese.
- One out of every five adults worried or stressed about having enough money to purchase healthy meals.
- One in five adults reported they did not engage in any leisure time physical activities in the past month and less than 20% reported they met national guidelines for strength and aerobic conditioning (150 minutes a week of moderate-intensity aerobic physical activity and at least two or more times a week of muscle-strengthening activities)
- NW CT adults were in the lowest quartile for fruit and vegetable consumption compared with other CT Health Districts surveyed.

VII. EXECUTIVE SUMMARY OF ASSESSMENT DATA SCAN FINDINGS

This data scan includes demographic, socioeconomic, housing, safety, and health indicators related to the HEC Priority Aims in 25 NW CT HEC communities. These communities include: Barkhamsted, Bethlehem, Bridgewater, Burlington, Canaan, Colebrook, Cornwall, Goshen, Hartland, Harwinton, Kent, Litchfield, Morris, New Hartford, Norfolk, North Canaan, Roxbury, Salisbury, Sharon, Thomaston, Torrington, Warren, Washington, Winchester, and Woodbury.

Demographic and Socioeconomic Indicators

- Socioeconomic factors underlie many of the observed racial, ethnic, and gender inequalities in health status, and are powerful predictors of health status and health outcomes. Connecticut ranks third highest in the nation in the level of income inequality (Economic Policy Institute, 2018), and NW CT HEC communities are no exception, with notable differences in household incomes and poverty rates.
- HEC Area Towns overall have experienced a decline in population, particularly in younger age groups. The proportion of older adults (ages 65 and over) continues to increase, which carries implications for health planning.
- There are indications that economic instability is increasing in the area, most strikingly evidenced by recent comparative data for eligibility for free or reduced school meals. This percentage increased in all school districts from 2017-18 to 2018-19, with the percentage more than doubling in Goshen, Hartland, Litchfield, North Canaan, Region 12, Region 14, and Woodbury.
- Families and individuals with the highest economic burdens, based on the poverty rate and free or reduced school meal eligibility, resided in Goshen, Kent, North Canaan, Sharon, Torrington, and Winchester.
- Health care coverage was less than optimal (100%) for residents under the age of 18 and ages 18-64 in several communities. Rates below 95% were reported for residents under the age of 18 in Kent and Salisbury; and for residents ages 18-64 in Canaan, Kent, Norfolk, Salisbury, Sharon, Torrington and Winchester.
- Four-year high school cohort graduation rates were above the state average in all school districts except Torrington and Winchester, with Torrington showing significant gains from 2016-17 to 2017-18.
- The percentage of students entering kindergarten with preschool experience was below the state average in the communities of Bethlehem, Canaan, Colebrook, New Hartford, Salisbury, Sharon, and Torrington.
- The following communities had a lower proportion of residents with bachelor's degrees than the state average: Colebrook, Hartland, Harwinton, North Canaan, Thomaston, Torrington, and Winchester.
- United Ways ALICE Reports showed an increase in economic instability for HEC area towns from 2011 to 2016.

Housing and Safety Indicators

- There are indications of a favorable decline in homelessness in the state and region.
- Area housing costs remain high, as evidenced by fair market rates for rentals and the percentage or renters and homeowners who are cost-burdened.
- HEC Area communities are relatively safe based on Uniform Crime Rate Reports, compared with the state and other non-urban areas in CT; Litchfield County ranks 5th out of the 8 CT counties in the rate of family violence incidents. Within HEC Area Towns, the highest rates were reported in Torrington and Winchester.

Health Rankings and Health Risk Behaviors

Lifestyle behaviors such as smoking, unhealthy eating, lack of physical activity, and excessive alcohol use or illicit drug use have major impacts on individual health. Health behaviors are shaped by socioeconomic status - persons with lower educational attainment or lower incomes are more likely to participate in unhealthy behaviors.

Analysis of the 2019 County Health Rankings data indicate that Litchfield County ranks *unfavorably* compared with the state and the nation for the following indicators:

- ✓ *premature death;*
- ✓ *adult obesity;*
- ✓ *access to exercise opportunities;*
- ✓ *excessive drinking;*
- ✓ *alcohol-impaired driving deaths;*

- ✓ *mammography screenings; and*
- ✓ *ratio of primary care physicians, dentists, mental health providers.*

Priority Aims

Improving Child Well-Being for Connecticut Children, Pre-Birth to Age 8 Years

- ACEs have a documented dose-response relationship with many health conditions.
- CT BRFSS data showed that after adjustment for age, gender, race/ethnicity, income and education, several health outcomes have increased odds of occurrence among individuals with three or more ACEs. The strongest associations were found for: depression, being a victim of sexual violence, engaging in HIV risk behaviors, poor mental health, smoking/e-cigarette use, usually or always worrying about affording a house or nutritious foods.
- Growing up in a family with substance use disorders is an ACE. Families and communities in NW CT continue to struggle with the devastating impacts of the opioid epidemic and other substance use disorders.

Improving Healthy Weight and Physical Fitness

- Nearly one-third of Connecticut's youth are overweight or obese; local data are unavailable.
- The prevalence of obesity in both children and adults is higher in minority and low-income groups.
- Risk factors for obesity, such as the consumption of unhealthy foods and beverages and physical inactivity, are prevalent among Connecticut's youth.
- The increased risk of obesity among children of lower socioeconomic status may result from a number of underlying causes, including lack of access to healthy foods, increased access to unhealthy foods, and fewer opportunities to engage in physical activity.
- Based on BRFSS survey data, two-thirds of NW CT adults were overweight or obese.
- One out of every five adults worried or stressed about having enough money to purchase healthy meals.
- One in five adults reported they did not engage in any leisure time physical activities in the past month and less than 20% reported they met national guidelines for strength and aerobic conditioning.
- NW CT adults were in the lowest quartile for fruit and vegetable consumption compared to other CT Health Districts.

Next Steps

The purpose of the NW CT HEC is to plan for, amplify, and sustain cross-sector efforts in our communities to enhance health, with an emphasis on the social, economic, and physical conditions that enable individuals and families to achieve physical and mental health and well-being.

The HEC Steering Committee, Work Group, and stakeholders from HEC Area Towns will collaborate in the next phase of this work to identify priorities for action and build on our collective community assets to achieve the maximum possible impact.

Many health-related conditions and ACEs are preventable or can be mitigated. Economic self-sufficiency, nurturing family relationships, and safe and health-supporting community environments will assist NW CT residents to reach their full health and life potential.

Data Availability Limitations

It is important to note that there are significant limitations in the availability and timeliness of community-level data related to the HEC Priority Aims. This presents challenges to assessing progress in achieving HEC goals. Some initial recommendations for consideration by CT State HEC leadership to support the availability of locally-relevant data are:

- Establish a statewide childhood BMI surveillance system using data from mandated school health forms;
- Support enhanced BRFSS local data collection related to Priority Aims by sociodemographic group; and
- Promote universal use of evidence-based ACE screening tools in health care settings.

VIII. REFERENCES

Original citations as reported in the *State Of Connecticut Office Of Health Strategy And Department Of Public Health State Innovation Model Program Request For Proposals (RFP) Health Enhancement Community (HEC) Initiative: HEC Pre-Planning, 2019* (as noted on pages 3-4):

[1]America's Health Rankings, 2017 Annual Report. https://*www.americashealthrankings.org/learn/reports/2017-* annual-report/state-summaries-connecticut. Date accessed 8/14/18.

[2] America's Health Rankings, 2016 Annual Report. https://assets.americashealthrankings.org/app/uploads/ahr_annual-report_executive_summary_v1.pdf. Date accessed 8/14/18.

[3] America's Health Rankings, 2015 Annual Report. https*://www.americashealthrankings.org/explore/annual/measure/Overall/state/CT?edition-year=2015.* Date accessed 10/17/18.

[4]The 2017 Connecticut rankings for the five measures are as follows: Physical Activity – 18, Diabetes – 19, Children in Poverty – 21, Low Birthweight Births – 22, and Infant Mortality – 15.

[5] CT DPH, *BRFSS Health Indicators and Risk Behaviors.* 2016

[6] CT DPH, *Adverse Childhood Experiences in CT.* 2018

[7]Brown, DW, Anda, RF, Tiemeier, H, et al. (2009). *Adverse childhood experiences and the risk of premature mortality. Am J Prev Med, 36*(5), 389-96.

[8] *CT DPH, Live Healthy Connecticut.*

[9] *CT DPH, BRFSS Children's Health in Connecticut: 2011-2015*

[10] *ibid*

[11] *ibid*

[12] *CT DPH, Health Indicators and Risk Behaviors, 2016.*

[13] Lassman, D., Sisko, A.M., Catlin, A., Barron, M.C., Benson, J., Cuckler, G.A., Hartman, M., Martin, A.B., and Whittle, L. (2017). Health Spending By State 1991-2004: *Measuring Per Capita Spending By Payers and Programs. Health Affairs, 36*(7). doi: 10.1377/hlthaff.2017.0416.

[14] Health Affairs, June 2017

Original citations as reported in *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2019* (as noted on page 16):

[4] Shonkoff, J. P., & Phillips, D. A. (eds). (2000). From neurons to neighborhoods: The science of early childhood development. National Research Council and Institute of Medicine. Washington DC: National Academy Press.

[5] Shonkoff, J. P., Garner, A. S., & Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care and Section on Developmental and Behavioral Pediatrics. (2012). The lifelong effects of early childhood adversity and toxic stress. Pediatrics, 129(1), e232-e246.

[6] Dube, S. R., Anda, R. F., Felitti, V. J., Edwards, V. J., & Croft, J. B. (2002). Adverse Childhood Experiences and personal alcohol abuse as an adult. Addictive Behaviors, 27(5), 713-725.

[7] Dube, S.R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., & Anda, R. F. (2003). Childhood abuse, neglect and household dysfunction and the risk of illicit drug use: The Adverse Childhood Experience Study. Pediatrics, 111(3), 564-572.

[9] Hillis, S. D., Anda, R. F., Felitti, V. J., & Marchbanks, P. A. (2001). Adverse childhood experiences and sexual risk behaviors in women: a retrospective cohort study. Family Planning Perspectives, 33, 206-211.

[13] Hillis, S. D., Anda, R. F., Dube, S. R., Felitti, V. J., Marchbanks, P. A., & Marks, J. S. (2004). The association between adverse childhood experiences and adolescent pregnancy, long-term psychosocial outcomes, and fetal death. Pediatrics, 113(2), 320-327.

[14] Edwards, V. J., Anda, R. F., Dube, S. R., Dong, M., Chapman, D. F., & Felitti, V. J. (2005). The wide-ranging health consequences of adverse childhood experiences. In Kathleen Kendall-Tackett and Sarah Giacomoni (eds.) Victimization of Children and Youth: Patterns of Abuse, Response Strategies, Kingston, NJ: Civic Research Institute.

[15] Gilbert, L. K., Breiding, M. J., Merrick, M. T, Parks, S. E, Thompson, W. W., Dhingra, S. S., & Ford, D. C. (2015). Childhood adversity and adult chronic disease: an update from ten states and the District of Columbia, 2010. American Journal of Preventive Medicine, 48(3), 345-349.

[16] Dube, S. R., Anda, R, F., Felitti, V. J., Chapman, D., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction and the risk of attempted suicide throughout the life span: findings from Adverse Childhood Experiences Study. Journal of the American Medical Association, 286, 3089-3096.

[22] National Scientific Council on the Developing Child. (2010). Persistent fear and anxiety can affect young children's learning and development. Working Paper No. 9. Retrieved from https://developingchild.harvard.edu/wp-content/ uploads/2010/05/Persistent-Fear-and-Anxiety-Can-Affect-Young-Childrens-Learning-and-Development.pdf

[23] Duke, N. N., Pettingell, S. L., McMorris, B. J., & Borowsky, I. W. (2010). Adolescent violence perpetration: associations with multiple types of adverse childhood experiences. Pediatrics, 125(4), e778-86.

[24] Fox, B. H., Pereza, N., Cass, E., Bagliviob, M. T., & Epp, N. (2015). Trauma changes everything: examining the relationship between adverse childhood experiences and serious, violent and chronic juvenile offenders. Child Abuse & Neglect, 46, 163-173.

Original citations as reported in *Analysis of Health Indicators for Connecticut Health Districts and Departments, Connecticut Department of Public Health, 2019* (as noted on pages 13-14, 22-24):

[5] Liu, Yong, et al. "Relationships between Housing and Food Insecurity, Frequent Mental Distress, and Insufficient Sleep among Adults in 12 US States, 2009." Preventing Chronic Disease. 11.1 (March 2014). *http://www.cdc.gov/pcd/issues/2014/13_0334.htm*

[7] United States Department of Agriculture Economic Research Center. "Food Security in the U.S: Measurement." October 2017. *https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the- us/measurement.aspx*

[12] U.S. Department of Agriculture and U.S. Department of Health and Human Services. "Dietary Guidelines for Americans, 2010." December 2010. *http://www.health.gov/dietaryguidelines/dga2010/DietaryGuidelines2010.pdf*

[13] Harvard School of Public Health. "Vegetables and Fruits." The Nutrition Source. 2015. *http://www.hsph.harvard.edu/nutritionsource/what-should-you-eat/vegetables-and-fruits/*

Listing of Additional Community Health Needs Assessments and State/Local Data Reports Reviewed:

ALICE Project Report for 2018, United Ways of CT *https://alice.ctunitedway.org/aliceupdate.*

Analysis of Health Indicators for Connecticut Health Districts and Departments, CT DPH, 2019 *(https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/BRFSS/CT-BRFSS-Health-District-Report.pdf).*

Charlotte Hungerford Hospital Community Health Needs Assessment 2018, prepared by Percival Health Advisors, *https://charlottehungerford.org/community-health-needs-assessment.*

Community Crossroads Report, Northwest Connecticut Community Foundation, prepared by Words and Numbers Research, Inc., 2017, *https://www.northwestcf.org/community-crossroads.*

Community Health Needs Assessment for Northwest Connecticut 2015 Update, Charlotte Hungerford Hospital, prepared by the Center for Healthy Schools & Communities at EdAdvance. *https://edadvance.org/uploads/files/CHNA/NW%20CT%20CHNA%20EdAdvance%20Update.pdf.*

Connecticut Childhood Obesity Report, CT DPH, 2018 (https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/hems/nutrition/PDF/Childhood-Obesity-Report-2018-final.pdf).

Connecticut Counts, 2019 Annual Point-in-Time (PIT) Count and Youth Outreach and Count, CT Coalition to End Homelessness *(https://cceh.org/wp-content/uploads/2019/06/PIT_2019.pdf).*

County Health Rankings 2019, www.countyhealthrankings.org.

Essentials for Childhood Framework, CDC, *(https://www.cdc.gov/violenceprevention/pdf/essentials-for-childhood-framework508.pdf).*

Family Violence Report, CT Department of Emergency Services and Public Protection *(https://portal.ct.gov/DESPP/Division-of-State-Police/Crimes-Analysis-Unit/Crimes-Analysis-Unit).*

Heath Statistics and Surveillance Report on Adverse Childhood Events, CT DPH, 2018 *(https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/BRFSS/ACEs_in_Connecticut_BRFSS2017_Factsheet.pdf).*

HRSA UDS Report 2018, produced by Community Health & Wellness Center of Greater Torrington.

National Low Income Housing Coalition's 2019 *Out of Reach* Report (*https://reports.nlihc.org/oor/connecticut).*

IX. COMMUNITY ENGAGEMENT – FOCUS GROUP AND KEY INFORMANT INTERVIEW SUMMARY FINDINGS

Instrument Development

The HEC Working Committee met to discuss the key questions that should be addressed focusing on the two Priority Areas. The EdAdvance project consultants (Mary Bevan, MPH and Kevin Glass, PhD) developed and proposed a preliminary set of questions which were subsequently approved by all members of the Working Committee and the Steering Committee.

The questions used in all Community Engagement Activities were:

1. *In what ways do you feel your community supports children in growing up healthy?*
2. *How do you feel about the quantity and quality of early childhood resources available in your community, such as Head Start, pre-school, school readiness programs, etc.?*
    a. *How affordable are these resources?*
3. *How do you feel about the quantity and quality of local resources available to families to support healthy growth and development in their children, such as health care and parenting programs?*
4. *In what ways does the physical environment in your community support healthy eating and physical activity for children and adults?*
    a. *How could this be improved for children? For adults?*
5. *What concerns do you have about safety in your community?*
6. *What do you think are the most common challenges families in your community are dealing with in raising their children today?*
7. *What other comments would you like to add?*

Site Selections

The seven questions listed above were initially intended to be used to collect responses from 15 focus groups as well as seven key informant interviews. Additional focus groups, key informant interviews, and online surveys were added to ensure as many voices from the community were heard as possible. Before the data collection efforts, a cognitive interview was conducted with a group (10 individuals) who were comparable to the target population, but not within the catchment area of the project activities. The individuals in this test group provided feedback while allowing the evaluation team to fine-tune the proposed questions further. The feedback obtained in this test group is not included in the final report. The test group was conducted in Groton Connecticut on Friday, November 1, 2019.

Participant Selection

The Working and Steering Committees worked to compile a list of appropriate community stakeholders. Special attention was paid to ensure that as many individuals from the HEC area communities were engaged as possible. Key informants were chosen because of their proximity to the issues being investigated. Focus group participants were selected because they had direct knowledge of the communities in which they live.

Focus Groups

A total of 21 focus groups were conducted between December 12, 2019, and January 16, 2020. There were more than 385 participants. The age groups ranged from high school students to senior citizens. Two of the focus groups were conducted in Spanish. Two of the focus groups were held with members of the community who identified themselves as receiving support from the state. More than 35 hours of audio were recorded and transcribed, resulting in more than 1,200 pages of data. At least one focus group was conducted in each town in the catchment area.

Key Informant Interviews

A total of 14 Key Informant Interviews were conducted between December 13, 2019 and January 17, 2020. More than 21 hours of audio was collected resulting in approximately 500 pages of data.

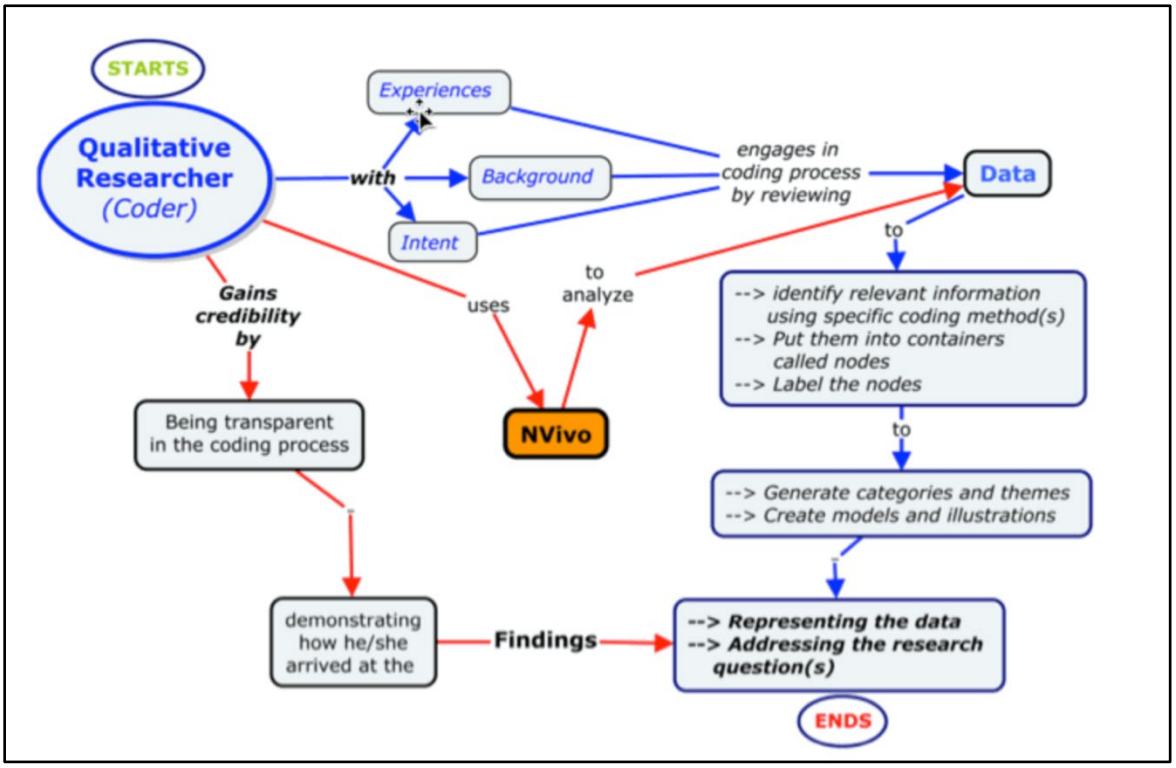
Online Feedback

An online version of the interview questions was developed (https://forms.gle/gCyuyzma2KG7xWSV7) and shared with members of the community. A total of 432 responses were collected, and the information gathered was entered into NVivo with a notation to identify them as asynchronous findings. There were 32 responses received in Spanish, 7 in Portuguese, and 3 in Mandarin. Those results were translated and entered into NVivo with a notation.

Methodology

Qualitative data, like that collected for this project, is characterized by its subjectivity, richness, and comprehensive text-based information. Qualitative data analysis is the pursuing of the relationship between categories and themes of data seeking to increase the understanding of the phenomenon. Traditionally, researchers utilized colored pens to sort and then cut and categorized these data. The innovations in software technology designed for qualitative data analysis significantly diminish complexity and simplify this difficult task, and consequently make the procedures more reliable. NVivo, the qualitative data analysis software developed to manage the 'coding' procedures is considered the best in this regard. *In the results section which follows, only those responses that were mentioned by more than 25% of the respondents were included. The percentages are included next to each summarizing statement.*

The image below explains the process used by the evaluation team in coding and analyzing the data collected for this project.



Results - Summary of Responses to Key Questions

1. *In what ways do you feel your community supports children in growing up healthy?*

A. School Age Programs – 41%.

In conversations with parents in focus groups, a large number mentioned programs their children participated in starting at a young age. BASES, Birth to Three, Police Activities League (PAL), and counseling services were the most commonly discussed. These services were presented as being a vital part of healthy child development. This was especially true in focus groups conducted with young parents, parents who self-identified as receiving services from the state, and parents who did not speak English natively. While a majority of the conversations around these services were positive, many participants were not aware of the services that were available to them. In one focus group conducted in a rural community, a parent, after expressing her gratitude for the Birth to Three Program, spend a great deal of time explaining how she received the service to the other parents who had never heard of the program before.

Both of my kids are in a pre-school program. The teachers work with them on building basic skills. I don't know what I'd do without them, I feel like all the other kids in my neighborhood have access to better programs because their parents can afford them. We can't, so we rely on the program to make sure our kids have a good start.

When my son was younger, he was in the Birth to Three Program. The folks who came to our house taught us as much as they taught him. I was super young when I became a mom and didn't really know what I was doing. A friend of mine got me involved with the program and it was a life saver for me and [my son].

I worked with a nurse from a school in town when my daughter was young. She was an overweight kid. No matter what we tried, we couldn't get her to lose weight. [Name] worked with all of us to help her lose weight. It's been a struggle since the beginning but we're making great progress.

I think people in town should do more to help families in need. There are a lot of us who struggle to pay our bills and get food on the table. We know there are things out there to help us but the attitude of most of us is that we don't want anyone to know we're struggling. We also don't want to get on the list of folks who need help. Whatever that list is, we're all sure they use it to make sure we have a hard time finding apartments and get our kids into the right programs in school.

All of my kids get counseling. They went through some intense stuff when they were young, I was in a bad way and they saw too much. The counselors have helped them figure out why they do what they do and to make sense of all the drama in their lives. At least as much as she can. I know you may not have been asking about the mental part of it, but I think that's more important than the physical stuff with my kids.

The after school programs, BASES I think they're called, are great. My girls do work with science teachers and it's helped get them excited about school for the first time.

How did you hear about all of these things? No one ever told me they were available. I feel like only the parents who spend a lot of time in schools or have older kids know how to find this stuff. I work all day; I don't even know how I'd get my kids into any of this.

I honestly think the schools could do a much better job in keeping our kids healthy. They do the bare minimum here for them. I work for a family that lives down on the coast and there are so many things they do for the kids that the parents don't even pay for. Why can't they do that here?

I wish there were programs that did more than change individual behaviors and instead focus on creating healthy environments for the community as a whole.

Attending early childhood education is associated with improved childhood development and individuals living in socio-economically marginalized communities, like ours, are less likely to have access to early childhood education facilities, and are less likely to experience the benefits of early childhood education.

B. School Food Programs – 38%.

Due to the nature of the priority areas identified at the beginning of the sessions, many participants focused on healthy eating in their responses. Parents, students, and many of the key informants interviewed pointed to the food provided in schools as an area of concern. In data collected online, a significant percentage of the Spanish speaking responses addressed school cafeteria food as both a strength and a weakness.

You can start with what they feed our kids in school. How are they supposed to learn and grow if they eat nothing but chicken nuggets and pizza? They spend so much time teaching the kids what they're supposed to eat and then they do the exact opposite.

We have a hard time affording the foods we know we're supposed to give our boys. We try, but it's just so expensive. When we moved to the states, we thought the schools would do so much better in feeding them. I love that they can eat breakfast and lunch there, but all they get is junk.

The schools do a good job in making sure our kids are fed and not hungry.

The work done by folks in town to try to improve what our kids are eating in schools is special. Having a garden at the school and having the food they grow show up in some of their meals teaches them so much.

I wish they would serve a more full breakfast for my kids. I feed them every day, but it makes me wake them up earlier, if they did it in the building it would make things so much easier.

I think the schools are doing a better job with what they give them. Our doctor told us not to let them eat school lunches because they are so unhealthy, but I think it's gotten a lot better the last few years.

C. Community-Based Sports – 37%.

Understandably, sports programs were mentioned in a large number of conversations and online responses. Most of the reactions were positive and spoke to the benefits of children participating in organized sports and physical activities. There was a significant number of individuals who argued that the programs became too expensive at a certain age, and that transporting children to games was also time-consuming, given the rural nature of the community.

The PAL programs in town are life-savers. Having our boys involved in sports at such a young age is so good for them. To have strong men to look up to and a place for them to learn how to work with other kids is awesome.

All of my kids are involved in sports teams. This is where they get most of their exercise. When they're home, they just play video games and look at their phones. We let them do it as long as they play sports.

PAL is the best. Those guys and girls do a great job with the kids. It's also where I met most of my friends, it's the people we hang out with the most.

I just wish they had something for the kids as they got older. Once they get into travel teams it becomes like another job driving them all over the place. I'm jealous of all the towns that are close together – here it's an hour just to get to every game.

The cost of having my older kids in sports is just too much. At the beginning of every season we have to figure out which two they can do. I hate that they can't do more.

2. *How do you feel about the quantity and quality of early childhood resources available in your community, such as Head Start, pre-school, school readiness programs, etc.? How affordable are these resources?*

A. Access to early childhood was viewed as a strength by most members of the community – 38%.

Key informants interviewed suggested that a great deal of energy had been spent in ensuring members of the community were aware of the resources available to them. Even those individuals who did not work directly with young children were keenly aware of resources available to parents. Most parents involved in focus groups and who completed the online questions were aware of and satisfied with the quality of these

programs. There was a discrepancy, however, in the online responses between those completed in English and those completed in Spanish. A more significant percentage of the Spanish respondents felt that there were limited programs available to students who were not fluent in English.

I miss the Head Start teachers. They were the first people in my kids' lives who I felt cared for them a lot. We got them involved because our doctor at CHH told us it would be good for them. Best decision we ever made.

My boys are just starting pre-school. I moved here because the town we came from didn't have a good enough program. Early childhood education is so important, and I can't stress enough how much I love the work they are doing with my kids. I'm not sure we'll stay here as they get older because of the schools, but the pre-school program they are in now is top notch.

I haven't been able to get my kids into a program that would benefit them. We just came from Puerto Rico and the school they were in was so good. I tried to put them in a pre-school in town, but no one spoke enough Spanish. I want my kids to be good with English, but they are too young to understand enough to make going there worth it.

B. Affordability of services was not identified as a major factor in decision making – 38%.

The affordability of programs was not brought up by any participant before the second part of the question being asked. When prompted, all of the participants who had direct knowledge of these programs noted that the programs were either free or reasonably priced.

My husband and I worked with the folks at the school my kids go to. We really wanted them to have that experience but knew it would be tough to afford. [Name] was so understanding and let us know that the money wouldn't be an issue. The program has been perfect for us and the kids.

I work with parents in communities who have traditionally struggled financially. I have been doing this job for almost 30 years. In the past, we basically had to beg parents to get their kids into Head Start. They were always so reticent to expose their kids to the schools for fear they wouldn't be able to afford it and then feel isolated. For the last ten years or so, this has changed. Our population is the same, but they are much more willing to let us place their kids. They appreciate any financial assistance they can get and work with us to make sure their kids are getting everything they need to develop as healthy as they possibly can.

C. Transportation to sites is an issue – 35%.

Not surprisingly, the rural nature of many of the communities makes transportation an issue. Many parents were frustrated that they could not get their children to and from programs. They were well aware of what was available to them and were more than willing to pay for the resources required. They could not transport their children to or from the programs due to work commitments.

This isn't anyone's fault, but we live so far away from everything. I would love for the girls to go to the Head Start program with EdAdvance. We have friends whose kids go there, and they love it. But I work in Danbury and I can't miss work to drop them off. I guess that's just the negative of living in the country.

I know having public transportation where we live is completely impractical, but is there any way the pre-school could get us on their bus route? We called the school in the summer and they said the stop would be almost 3 miles away. We only have one car and my boyfriend needs it for work. It just stinks that my kids can't go to school because we have to work.

3. *How do you feel about the quantity and quality of local resources available to families to support healthy growth and development in their children, such as health care and parenting programs?*

A. Local resources, beyond those provided by pre-school programs, were seen as limited – 42%.

Interviews conducted with key informants highlighted the successful programs that have been developed and implemented throughout the communities involved. Most discussed programs that Charlotte

Hungerford Hospital had piloted and grown over the last decade. They also spoke of all the mental health programs that have been established to help parents with children who have unique needs. Those parents who participated in focus groups also extolled the virtues of parenting programs they had been involved in. A focus group conducted in a Spanish speaking community center shared at length their appreciation for the parenting programs the center had provided them. They universally agreed the program had made a profound impact on their children. There was a general concern, however, that the resources available to them were limited to school readiness and young children parenting groups. There was a general sense that there were not enough doctors, especially mental health specialists, available for them and their families.

My kids are a little older. There were a ton of programs for them and us when they were little. Now I feel like we're on our own to figure things out. The school does a good job of identifying issues in the class as a whole, but not with individual kids. Does anyone know how to raise teenagers? I would love to join a group to help me with that. Bigger kids mean bigger problems. And with no support, it's incredibly stressful.

I've been trying to find a therapist for my son who has Asperger's for years. There just isn't anyone here who can work with him. The school has counselors, but they don't have time to work one-on-one more than once or twice a week.

B. Many participants were not aware of additional resources beyond those provided by schools and pediatricians - 29%.

Parents were almost universally confused as to what programs the question was referring to. They had a strong understanding of what was available in the schools, especially at the younger ages, but were unclear as to what was available as children grew older. Most spoke of their interactions with their pediatricians while, at the same time, expressing frustration with the limited time they could talk with a doctor during a visit.

What parenting programs are there? Seriously, who do you all talk to to help you get through this? My kids are first generation students. We come from a country [China] that's much different than it is here. I feel like a fish out of water and my daughters are really struggling.

Are there other resources out there besides what the school and my doc offer? If there are, this would be the first time I've ever heard of it. Even those are basic at best. When I go to my kids' doctor's office, I get maybe three minutes to talk to her. She is in and out so fast I don't get a chance to talk about what I'm worried about.

I loved the parenting classes when my kids were little. They exposed me to other people going through the same things as we were. That stopped once the kids got into grade school.

C. Parenting programs were viewed as necessary, especially in the development of socialization skills for young children. Additionally, those respondents who identified themselves as being new to the community (many of them through recent immigration) found these resources invaluable - 25%.

As was discussed in earlier questions, parenting programs are a vital aspect of the community. Those respondents who addressed this issue were overwhelmingly positive about the support their families received. More than 65% of the responses completed online by individuals who spoke a language other than English included parenting programs in their reactions as being a strength of their community.

I loved working with the people at the Community Center. When we moved here I didn't know what to expect. I didn't know how to get my kids into schools, they made the whole thing possible.

Both of my kids started off in [Name], and they had a hard time. When we got them into the pre-school program here, it was a game changer. The people there helped them so much. And they helped us figure out how to deal with our kids at home. It hasn't always been easy, but it's definitely gotten better.

4. *In what ways does the physical environment in your community support healthy eating and physical activity for children and adults? How could this be improved for children? For adults?*

A. There is a widely held belief that there is limited access to healthy food - 29%.

A large number of parents immediately responded to this question by addressing the lack of healthy food options in their communities. They noted there were fast food stores on most busy streets, but nowhere to go to buy healthy food for their families.

Healthy eating in Torrington? Where do you all go for that? I'm fine if I grocery shop and cook, but that's not always possible between sports, work, and play dates. If we have to grab a quick meal it's almost always fast food. I wish we had a Whole Foods or something like that closer to the house that I could grab. I hate feeding my family garbage, but it's that or nothing at all.

Eating healthy is so expensive. I can go to the store and get a frozen pizza for $4 and be ready to feed my family in 15 minutes. If I want to prepare a healthy meal, it takes three times as long and costs four times as much.

Living here is such a paradox. We have incredible access to all of these healthy physical activities. Hiking, skiing, snow shoeing, swimming is all available to us year-round. But when it comes to food, name me the healthy stores or restaurants in town.

Too many fast food restaurants are in the same area, and the big chain grocery stores are at far distances with poor transportation in Torrington.

B. Many adults expressed frustration for the lack of mental health professionals in the area - 29%.

Parents, key informants, and other members of the community identified the lack of mental health professionals as being an area for concern. While this question was not explicitly designed to address this concern, these conversations arose organically.

We can talk about healthy eating and sports as much as we want to, but the bigger issue is the lack of mental health resources around here. With all that's going on with the opioid epidemic, the rise of obesity in our kids, the domestic violence issues we're seeing, no one is going to get healthy if they are in a bad mental place.

The kids I see in our school are physically healthy for the most part. There are some overweight kids but the school and their parents seem to do a good job of controlling that. What is missing in our community, what makes us less healthy than other areas in my opinion, is the lack of mental health professionals. Try to find a qualified therapist around here, they just don't exist.

I would love a Whole Foods closer to my house. I would love a travel soccer team that I could afford. I would love for my kids to be able to swim in the winter without having to pay crazy memberships. But those are all things I would love, what I need is someone who can help my daughter with her anxiety and depression. All the rest of it is just window dressing.

C. Substance abuse facilities are limited and difficult to access – 25%.

In several of the focus groups, the critical point of discussion was the impact the opioid epidemic has had. In addition to the desire for access to more mental health professionals, many respondents discussed the need for improved access to affordable substance abuse facilities. This was especially true of those focus groups that were conducted in the more densely populated communities.

I know this may not be on point here, but can we talk about what the prescription drug and heroin problem has done to our community? Shady people are opening halfway houses to treat those affected but it's just a money grab, there's no treatment taking place in a lot of these houses. We need a better solution.

5. *What concerns do you have about safety in your community?*

A. Nearly all respondents addressed opioid addiction - 82%.

As was the case in several of the previous questions, the opioid epidemic was the primary topic of conversation when this question was asked. This was true regardless of the setting or the subpopulation responding.

The number of overdoses I've heard of in the last few years is astounding. I think the epidemic has hit our rural community harder than some of the more urban communities. There is just such a sense of hopelessness among some of our young people. They turn to drugs as an escape. When they can't afford them anymore, they turn to breaking into houses and cars. I used to be able to leave my door unlocked at night, now I check three times before I go to bed.

Our community is unsafe because of the heroin problem. You can see it when you walk down the street. The police are overwhelmed by the number of overdoses. They used to be able to respond to other calls so much faster, but now they are tied up with drug issues and they can't possibly cover everything.

It's hard to find someone who hasn't been touched by this in some way. It's personal to all of us in this room.

I know the Opioid Task Force has done great work on this subject, but when I talk to members of our community, this is the issue they bring up first. They want to know what can be done. They want to know how to keep their kids safe. They want to know what resources are available to them if they're affected.

B. Vaping was identified as a growing issue for students – 29%.

In focus groups with students, one of the primary issues they discussed was the rising popularity of vaping in their schools. They believed that it was a safety issue as a growing number of students were vaping marijuana and not just nicotine. They shared stories of violence and crimes that have occurred both in school and out of school as a result.

Have you been in any of bathrooms? They smell like Fruit Loops. The kids go in there and vape all day.

It used to be just vaping cigarettes. And that was fine, no real damage done, right? But now everyone is vaping weed oil. There are fights all the time about it. I saw a kid break his arm in a fight after school over a pen.

The vaping this is kind of out of control. I'm scared to use the bathrooms during the day and there are certain stores I won't go into in town because they sell the stuff. If someone sees you in there, they just assume you have a pen and will go after you to get it.

C. Many of the most trusted institutions were the result of individual relationships, and not the institutions themselves – 25%.

This was an interesting response and one that is not necessarily intuitive when it comes to this question. Many different conversations took place around this idea, and it was not easy to identify at first. The first quote presented below was the first time a participant discussed it in a way that made sense, given the context and the question.

When I think of safety in my community, I think of the relationships I have with people who are in charge of ensuring our safety. The police, the schools, the town office. I had an issue a few months back and I called the police department and asked for [name]. When they said she didn't work there anymore I got scared. I realized that I wasn't calling the police, I was calling her. As long as she worked there, I felt safe. I had someone I knew I could talk to and who would help me. Now that she's gone, I don't know where to go. I don't rely on buildings; I rely on people. So many of the people I used to rely on have left, so now I don't feel safe anymore.

When I think of safety I think of the police and fire departments. As someone who is new here from another country, I would never have called them. I would be afraid of what would happen if they knew I was here. Then I met a policeman at my son's soccer game. We talked for a bit and I told him about an issue I was having and how I didn't feel comfortable calling the police. He gave me his card and told me to call him directly if the issue was still a problem. That made me feel safe.

6. ***What do you think are the most common challenges families in your community are dealing with in raising their children today?***

A. Mental Health concerns and Opioid addiction – 48%.

Most responses involved the issues of mental health and addiction. So much so that it was impossible to separate the two during the final analysis. The concerns expressed in previous questions were echoed here.

How do you answer that question and not talk about the mental health issues our kids face and the impact that has on their health? It's not hard to see how so many of our youngsters turn to drugs to cope. I can't imagine being a parent today, the challenges they face and the issues they have to address daily – it's so much more than it used to be.

I worry about where my kids will be in five years. I know so many people who have kids who OD'd. They were good kids, nothing really wrong with them. All three of my kids have anxiety and depression, it wouldn't be a stretch to see them get into drugs. We talk about it all the time and try to encourage them to talk to anyone. But I'm still scared every day.

I lost my son to heroin. It was three years ago, almost to the day. He was a good student, played football and ran track. He had a girlfriend and was looking forward to college. Then one day he was just gone. Looking back on it, there are things I should have recognized, but I just didn't know it at the time. I wish someone had told me about depression and how it's not always what we think it looks like. For all of you here, pay attention to that. I know we talked earlier about how there aren't a lot of doctors to talk to in town. But do everything you can to get your kids help. Drive them to Hartford if you have to.

B. Financial limitations, lack of high-paying jobs – 39%.

Among most of the respondents, the lack of high-paying jobs was a serious concern. Many of the parents talked about working multiple jobs and were worried about the impacts that would have on their children. Adults were concerned about the stress that living paycheck to paycheck had on their health. They told stories about how that stress impacted their food choices, their lack of activity, and their increased consumption of alcohol.

It's hard raising your kids in an environment that's so divided. There are kids who have everything. We work hard and struggle but we're proud of what we're able to provide. And it's supposed to be hard. I just wish it was a little bit easier and we didn't have to work two jobs just to pay the rent.

The stress we go through because of money is unreal. It's all we talk about when we're home. When it gets bad, we have a glass of wine or two. I know that's not the healthy solution to it, but it works.

I worry about what our struggles are doing to our kids. They see us argue about money and what to do with what we have. Both of them have anxiety and I can't help but to think our problems have played a part in that. We've tried to hide it from them but they're too smart.

C. Social Media – 28%.

The impact of social media was discussed in several other questions but not to the magnitude necessary to include in this report. When responding to this question, however, many individuals, parents, students, and community members, took the time to address the effect social media has on children's health.

I know this is kind of off topic, but can we talk about Instagram and Snapchat for a minute? Social media has changed the way our kids interact with their world. I don't know if it's good or bad but it's definitely

different. The mental health impacts of seeing everyone else supposedly living a better life than you must be hard on kids.

I've seen my kids go through so much because of the online stuff. Bullying is so much worse when it's done online. Other kids accused my kids of doing something they didn't do, and they couldn't go to school for three days because of it.

Stress leads to anxiety. You have all talked about how anxious your kids are. Do you think some of that comes from their phones? I can't remember the last time I saw a young person walking around who wasn't looking at their phone.

Data Limitations

While every effort was made to ensure that as many members of the NW CT HEC communities were engaged as possible, the time limitations of the pre-planning phase of this project made this implausible. Many groups wanted to participate that could not during this first project phase due to time constraints. The analysis of the data was also constricted due to time limitations. The questions used were suitable given the Priority Areas; however use of a more focused approach, building on these initial findings, will be beneficial in future community engagement efforts.