Hartford HealthCare

Charlotte Hungerford Hospital

2021

Community Health Needs Assessment

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EXECUTIVE SUMMARY

Introduction

This Community Health Needs Assessment (CHNA) was conducted by Charlotte Hungerford Hospital to identify significant community health needs and to inform development of an Implementation Strategy to address those needs.

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

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

Charlotte Hungerford Hospital is a member of Hartford HealthCare. Hartford HealthCare operates seven acute-care hospitals, air-ambulance services, behavioral health and rehabilitation services, a physician group and clinical integration organization, skilled-nursing and home health services, and a comprehensive range of services for seniors, including senior-living facilities. For more information, please visit https://hartfordhealthcare.org/.

This CHNA was conducted using generally accepted methodologies to identify the significant health needs of the community served by Charlotte Hungerford Hospital. The CHNA also was conducted to comply with federal laws and regulations.

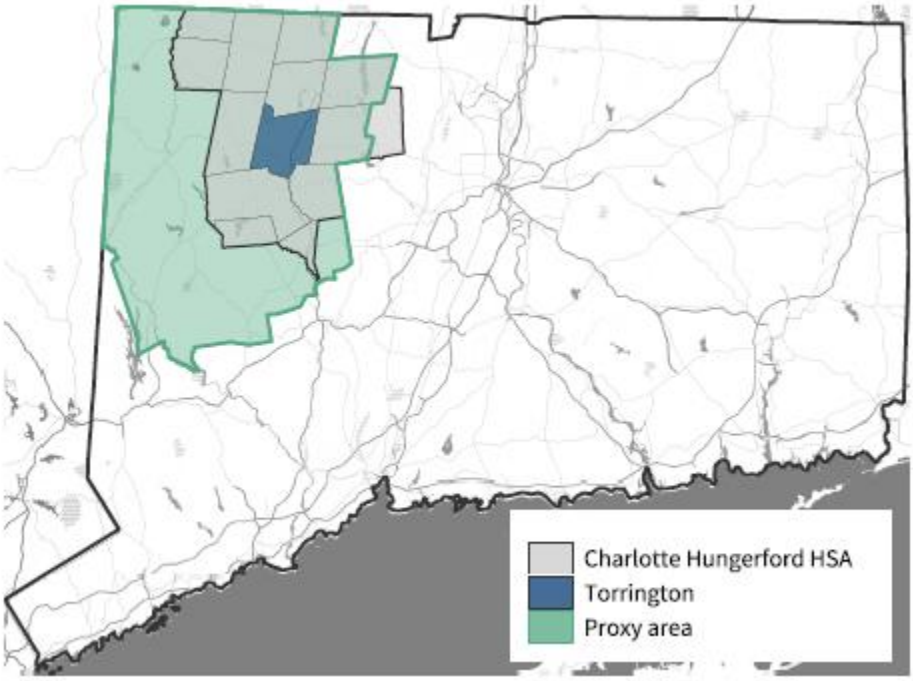
Community Assessed

For purposes of this CHNA, Charlotte Hungerford Hospital's community was defined as the following Connecticut towns and cities: Barkhamsted, Canaan, Canton, Colebrook, Goshen, Harwinton, Litchfield, Morris, New Hartford, Norfolk, North Canaan, Thomaston, Torrington, and Winchester.

In this report, these towns and cities are referred to as the Charlotte HSA (Hospital Service Area).

In calendar year 2020, these towns accounted for approximately 87 percent of the hospital's inpatient volumes and 90 percent of the hospital's emergency department visits. The total population of these towns in 2020 was 99,685.

The following map portrays the community assessed by Charlotte Hungerford Hospital.



The CHNA includes data for the Connecticut towns that comprise the hospital's HSA. Certain data also for the City of Torrington and for a proxy area (Litchfield County) have been considered in the assessment.

Significant Community Health Needs

As determined by analyses of secondary community health data and of input provided by community stakeholders, significant health needs in the community served by Charlotte Hungerford Hospital are:

- Mental health status in Torrington and for racial and ethnic minorities across the Charlotte Hungerford HSA and the state:
  - Above average age-adjusted suicide rate
  - Impacts of the COVID-19 pandemic on mental health of children and adults
- Social Determinants of Health, which are most problematic for racial and ethnic minorities, including:
  - Poverty
  - Unemployment
  - Levels of educational achievement
  - Access to affordable housing
  - Food insecurity in Torrington
- Transportation challenges, particularly for low-income, rural, and elderly populations
- Health disparities and outcomes for low-income, Black, Hispanic (or Latino), migrant and undocumented worker, and immigrant populations:

    - Systemic racism and a lack of trust in the healthcare system among minority populations
    - Language barriers
    - The cost of health services and gaps in health insurance coverage (particularly for Latino populations)
    - A comparatively high Black maternal mortality rate in Connecticut
- Comparatively few primary care physicians, dentists, and mental health professionals per-capita in Litchfield County
- Substance abuse (particularly opioids including fentanyl)
- Comparatively high rates of smoking in Torrington
- In Torrington, a comparatively percentage of women who receive late or no prenatal care
- Comparatively high prevalence of obesity in Torrington and in Litchfield County
- The COVID-19 pandemic, which has caused virus-related illness and death, increased isolation and mental health problems, and economic challenges

DATA AND ANALYSIS

This section summarizes findings from an assessment of secondary community health data and of community input for the Charlotte Hungerford Hospital CHNA.

Secondary Data Summary

Secondary community health data were provided by DataHaven. *See* Appendix B for a March 2021 report entitled *Charlotte HSA 2021 Equity Profile*.

Secondary data from two other sources were assessed:

- County Health Rankings (with benchmarking comparisons based on Community Health Status Indicators methodologies), and
- Data from SparkMap – including certain statistics regarding the COVID-19 pandemic.

DataHaven 2021 Equity Profile

The following table identifies unfavorable community health indicators within the DataHaven report for the community assessed by Charlotte Hungerford Hospital. The table focuses on Social Determinants of Health.

For example, the table indicates that 14 percent of households in the City of Torrington are experiencing food insecurity – a statistic above the 13 percent average for the State of Connecticut.

The rightmost column provides the exhibits (Tables and Figures) in the DataHaven report where the statistics can be found.

Unfavorable Secondary Data Indicators
Social Determinants of Health

Indicator	Area	Value	Benchmark		Exhibit
			Value	Area	
Homeownership rate - Black	Charlotte HSA	54.0%	78.0%	Homeownership rate - White	Table 3
Homeownership rate - Latino	Charlotte HSA	31.0%			
Housing cost burdened - Black	Charlotte HSA	41.0%	31.0%	Housing cost burdened - White	Figure 4
Housing cost burdened - Latino	Charlotte HSA	38.0%			
Adults with less than a high school diploma	Torrington	11.0%	9.0%	Connecticut	Table 1
No high school diploma - Black	Charlotte HSA	15.0%	6.0%	No high school diploma - White	Figure 7
No high school diploma - Latino	Charlotte HSA	29.0%			
Median household income	Torrington	$63,172	$78,444	Connecticut	Table 1
Poverty rate - Black	Charlotte HSA	13.0%	6.0%	Residents below poverty level - White	Table 6
Poverty rate - Latino	Charlotte HSA	23.0%			
Uninsured rate - Latino	Charlotte HSA	17.0%	5.0%	Uninsured rate - White	Figure 11
Linguistically isolated - Latino	Charlotte HSA	25.0%	1.0%	Linguistically isolated - White	Figure 2
Linguistically isolated - Asian	Charlotte HSA	24.0%	1.0%	Linguistically isolated - White	Figure 2
Unemployment rate - Black	Charlotte HSA	14.0%	6.0%	Unemployment rate - White	Figure 8
Unemployment rate - Latino	Charlotte HSA	9.0%			
Food Insecurity	Torrington	14.0%	13.0%	Connecticut	Figure 13

Source: Analysis of DataHaven Report, March 2021 (see Appendix B).

These unfavorable secondary data indicators suggest that the following community health issues are significant within the community assessed by Charlotte Hungerford Hospital:

- Homeownership and housing costs:
  - Black and Latino populations in the Charlotte HSA
- No high-school diploma:
  - City of Torrington
  - Black and Latino populations in the Charlotte HSA
- Poverty rates (and low median household incomes):
  - City of Torrington
  - Black and Latino populations in the Charlotte HSA
- Black and Latino unemployment rates in the Charlotte HSA
- Comparatively high uninsured rate:
  - Latino populations in the Charlotte HSA
- Food insecurity:
  - City of Torrington

The next table identifies additional, unfavorable community health indicators within the DataHaven report for the community assessed by Charlotte Hungerford Hospital. This table focuses on health behaviors and outcomes.

Unfavorable Secondary Data Indicators
Health Behaviors and Outcomes

Indicator	Area	Value	Benchmark		Exhibit
			Value	Area	
Life expectancy (years)	Torrington	77.8	80.3	Connecticut	Table 1
Self-rated health "excellent" or "very good"	Torrington	50.0%	60.0%	Connecticut	Figure 13
Smoking	Torrington	19.0%	14.0%	Connecticut	Figure 13
Obesity	Torrington	29.0%	26.0%	Charlotte HSA	Figure 13
Experiencing anxiety - Black	Connecticut	15.0%	11.0%	Experiencing anxiety - White	Table 8
Experiencing anxiety - Latino	Connecticut	19.0%			
Bothered by depression	Torrington	11.0%	9.0%	Connecticut	Table 8
Bothered by depression - Black	Connecticut	10.0%	8.0%	Bothered by depression - White	Table 8
Bothered by depression - Latino	Connecticut	14.0%			
Share of drug overdose deaths involving fentanyl, 2019-2020	Charlotte HSA	84.0%	40.0%	Share of drug overdose deaths involving fentanyl, 2015-2016	Figure 16
Late or no prenatal care	Torrington	3.9%	3.4%	Late or no prenatal care - Connecticut	Table 9
Maternal mortality per 100,000 births - Black	Connecticut	48.0	14.8	Maternal mortality per 100,000 births - White	Figure 19

Source: Analysis of DataHaven Report, March 2021 (see Appendix B).

These indicators suggest that the following additional community health issues are significant within the community assessed by Charlotte Hungerford Hospital:

- In the City of Torrington:
  - Comparatively short life expectancy
  - Comparatively few individuals rating their overall health to be “excellent” or “very good”
  - Comparatively high rates of smoking and obesity
  - Comparatively high proportions of people bothered by depression
  - A comparatively high percentage of women receiving late or no prenatal care
- A greater prevalence of anxiety and depression for Black and Latino residents (across Connecticut)
- Significant growth in the number of drug overdose deaths in the Charlotte HSA involving fentanyl
- A comparatively high Black maternal mortality rate in Connecticut

Additional Secondary Data

County Health Rankings has assembled community health data for all 3,143 counties in the United States. Following a methodology developed by the Centers for Disease Control’s *Community Health Status Indicators* Project (CHSI), County Health Rankings also publishes lists of “peer counties,” so comparisons with peer counties across the United States can be made. Each county in the U.S. is assigned 30 to 35 peer counties based on 19 variables including population size, population growth, population density, household income, unemployment, percent children, percent elderly, and poverty rates.

County-level data from SparkMap also were assessed. SparkMap is a product of the Center for Applied Research and Engagement Systems (CARES) and hosted by the University of Missouri.

Unfavorable County-Level Secondary Data Indicators
CHSI and SparkMap

Indicator	Area	Value	Benchmark		Exhibit
			Value	Area	
% Adults with Obesity	Litchfield County	27.7%	23.3%	Peer Counties	CHSI
% Physically Inactive	Litchfield County	20.8%	17.9%	Peer Counties	CHSI
Primary Care Physicians Per-Capita	Litchfield County	62.6	88.1	Peer Counties	CHSI
Dentists Per-Capita	Litchfield County	66.3	72.9	Peer Counties	CHSI
Mental Health Providers Per-Capita	Litchfield County	250.7	357.0	Peer Counties	CHSI
% Some College	Litchfield County	68.1%	73.3%	Peer Counties	CHSI
% Unemployed	Litchfield County	3.8%	3.3%	Peer Counties	CHSI
% Drive Alone to Work	Litchfield County	83.9%	74.3%	Peer Counties	CHSI
Preschool Enrollment (Age 3-4)	Litchfield County	61.1%	65.0%	Connecticut	SparkMap
Population 25+ with Bachelor's Degree or Higher	Litchfield County	35.4%	39.3%	Connecticut	SparkMap
Cancer Incidence All Sites	Litchfield County	481.5	470.6	Connecticut	SparkMap
Age Adjusted Death Rate - Suicide (Per 100,000)	Litchfield County	12.1	10.5	Connecticut	SparkMap

Sources: Verité analysis of County Health Rankings data; SparkMap.

The CHSI and SparkMap data suggest that certain additional issues are present in Litchfield County:

- Adults with obesity and who are physically inactive
- Per-capita supply of primary care physicians
- Per-capita supply of dentists
- Per-capita supply of mental health providers
- Cancer incidence
- Age-adjusted suicide rate

SparkMap also maintains data regarding the COVID-19 pandemic.

COVID-19 Cases and Deaths (as of June 3, 2021)

Area	Cases	Deaths	Incidence Rate per 100,000	Mortality Rate per 100,000	Adults Fully Vaccinated	Adults Hesitant About Receiving Vaccination
Litchfield County, CT	14,601	297	8,061.9	164.0	54.0%	5.3%
Connecticut	346,495	8,246	9,698.5	230.8	67.5%	5.2%
United States	**32,832,861**	**587,452**	**10,063.3**	**180.1**	**52.5%**	**10.4%**

Source: Johns Hopkins University via SparkMap, 2021

Per capita COVID-19 cases and deaths in Litchfield County have been lower than state and U.S. averages.

Community Input Summary

Community input regarding community health issues was obtained by conducting fifteen (15) interviews with sixteen (16) stakeholders. Participants included individuals representing public health departments, social service organizations, community health centers, and similar organizations. See Appendix C for information regarding those who participated in the community input process.

Questions focused first on identifying and discussing the most significant health issues in the community. Interviews then focused on impacts associated with the COVID-19 pandemic and on what has been learned about the community's health given those impacts. Stakeholders also were asked to describe the types of initiatives, programs, and investments that can be implemented to address the identified issues and risks.

Interviewees most frequently identified the following issues as significant:

- **Mental health status** is a significant concern. Interviewees cited an increasing prevalence of depression, anxiety, and severe mental health conditions. **Access to mental health providers** and resources is challenging due to costs, insurance, and lack of providers.

- **Social determinants of health** are significant for various segments of the population.

    - **Poverty and income disparities** are underlying contributors to many health needs, with many residents struggling to **access basic needs**.

    - The ability to find **safe and affordable housing** is limited for many. Much of the available housing is either prohibitively expensive or in poor condition, contributing to health issues such as asthma.

- **Transportation** is a significant issue, impacting the ability to travel to jobs, services, and health care providers. Low-income, rural, and elderly populations are particularly vulnerable to transportation issues.

- **Disparities in health** – both in the ability to access services and health outcomes – are widespread and significant.

    - Groups identified as particularly vulnerable include **low-income and impoverished populations**, **Black populations,** and **Hispanic (or Latino) populations**, particularly migrant and undocumented workers.

    - The **needs of immigrant communities** are disproportionately high, including language barriers and lack of insurance limiting healthcare access.

    - **Systemic racism** – including in the healthcare system – also is a prevalent issue.

- **Food insecurity and access to healthy foods** are significant issues due to financial barriers, transportation issues, and cultural norms. The **COVID-19 pandemic has contributed to a significant rise in food insecurity**.
    - The **cost of healthy foods** is often higher than processed, unhealthy food, contributing to poor nutrition.
    - More **education around healthy eating and nutrition** is needed to help address health risks associated with **obesity**.
- **Substance abuse** issues were identified as significant. The **opioid epidemic** is an issue, with rising use of opioids including fentanyl. **Alcohol abuse** is also a significant issue.
    - **Access to substance abuse treatment** is difficult due to a lack of providers, waitlists, and costs.
- Several other barriers to accessing health services are present, including:
    - The **cost of care** – which is considered most significant for **lower-income residents** and the uninsured.
    - **Gaps in health insurance coverage** including high copays and deductibles contribute to access problems, particularly for the "working poor" and immigrant communities.
- Stakeholders were asked about the impacts of the **COVID-19 pandemic.** All stated that the impacts have been significant.
    - The **economic impacts of the pandemic** are extensive and not yet fully realized, including job losses, housing instability, and business closures.
    - The pandemic's **impacts on mental health** have been significant, including social isolation, stress for essential workers due to their employment, and frustration with changing information and regulations all contributing to stress and fear. **Isolation** is affecting mental and physical health, particularly for rural, elderly residents.
    - The **impacts on children** have been severe, due to isolation, educational delays due to school closures and remote learning, and decreased social interactions.
    - The pandemic has highlighted the **need for service providers to communicate and collaborate**. Successful interventions have resulted from strong collaborations.
    - While **telehealth has expanded access to care**, it also presents another barrier for those without access to technology. This is described as a **"digital divide"** and is a particular problem for low-income, rural, and elderly populations.
- The health and wellness of **elderly populations** is a significant concern, particularly due to the anticipated growth in the number of elderly residents. **Isolation among seniors**

(particularly those living in rural areas) is significant and contributes to poor physical and mental health.

- Community members are experiencing difficulties **navigating the healthcare system and connecting to needed services**. Barriers include limited awareness about the services and their eligibility requirements, long wait times, and insurance restrictions.

- Interviewees identified **homelessness** as an issue in Charlotte Hungerford's HSA. Populations experiencing homelessness frequently have trouble connecting to needed health and social services.

OTHER FACILITIES AND RESOURCES IN THE COMMUNITY

This section identifies other facilities, clinics, and resources available in the Charlotte Hungerford Hospital community that are available to address community health needs.

Hospitals

The following table presents information on hospital facilities located in Litchfield County.

Hospitals Located in Community County, 2021

Name	Hospital Type	City	ZIP Code
Charlotte Hungerford Hospital, The	General Hospital	Torrington	06790
Sharon Hospital	General Hospital	Sharon	06069

Source: State of Connecticut eLicense web portal, 2021.

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are established to promote access to ambulatory care in areas designated as "medically underserved." These clinics provide primary care, mental health, and dental services for lower-income members of the community. FQHCs receive enhanced reimbursement for Medicaid and Medicare services and most also receive federal grant funds under Section 330 of the Public Health Service Act. There currently are 10 FQHC sites operating in the Charlotte Hungerford Hospital HSA.

Federally Qualified Health Centers Located in the Hospital HSA, 2020

Name	Address	City	ZIP Code
Mobile Medical Unit	469 Migeon Ave Bldg	Torrington	06790
Sullivan Senior Center	88 E Albert St	Torrington	06790
Community Health and Wellness Center	10 Center St	Winsted	06098
Community Health and Wellness Center of Greater Torrington	469 Migeon Ave	Torrington	06790
Oliver Wolcott Vocational Technical School	75 Oliver St	Torrington	06790
Batcheller Elementary Education Center SBHC	201 Pratt St	Winsted	06098
FISH Torrington Emergency Shelter	332 S Main St	Torrington	06790
Torrington High School	50 Major Besse Dr	Torrington	06790
The Isabelle Pearson School SBHC	2 Wetmore Ave	Winsted	06098
Torrington Middle School	200 Middle School Dr	Torrington	06790

Source: HRSA, 2021.

According to 2019 data published by HRSA:

- 13.0 percent of uninsured persons; and
- 21.8 percent of Medicaid enrollees in the Charlotte Hungerford Hospital community are served by FQHCs.

Nationally, FQHCs served 22 percent of uninsured patients and 19 percent of the nation's Medicaid recipients.[1]

Other Community Resources

Many social services and resources are available throughout the community and the State of Connecticut to assist residents. The United Way of Connecticut, with support from the State of Connecticut and Connecticut United Ways, maintains a database of resources to serve residents. The United Way 2-1-1 is available online and by telephone, 24-hours a day, seven days a week, and has resources in the following categories:

- Basic Needs;
- Children & Families;
- Crisis;
- Food;
- Health Care;
- Housing;
- Income;
- Legal Assistance;
- Mental Health;
- Older Adults;
- Re-Entry;
- Substance Use;
- Transportation;
- Utility Assistance; and
- Youth.

Additional information about these resources and participating providers can be found at: https://www.211ct.org/.

1 See: http://www.nachc.org/research-and-data/research-fact-sheets-and-infographics/chartbook-2020-final/ and https://www.udsmapper.org/.

APPENDIX A – OBJECTIVES AND METHODOLOGY

Regulatory Requirements

Federal law requires that tax-exempt hospital facilities conduct a CHNA every three years and adopt an Implementation Strategy that addresses significant community health needs.[2] In conducting a CHNA, each tax-exempt hospital facility must:

- Define the community it serves;
- Assess the health needs of that community;
- Solicit and take into account input from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health;
- Document the CHNA in a written report that is adopted for the hospital facility by an authorized body of the facility; and,
- Make the CHNA report widely available to the public.

The CHNA report must include certain information including, but not limited to:

- A description of the community and how it was defined,
- A description of the methodology used to determine the health needs of the community, and
- A prioritized list of the community's health needs.

Methodology

CHNAs seek to identify significant health needs for particular geographic areas and populations by focusing on the following questions:

- ***Who*** in the community is most vulnerable in terms of health status or access to care?
- ***What*** are the unique health status and/or access needs for these populations?
- ***Where*** do these people live in the community?
- ***Why*** are these problems present?

The focus on ***who*** is most vulnerable and ***where*** they live is important to identifying groups experiencing health inequities and disparities. Understanding ***why*** these issues are present is challenging but is important to designing effective community health improvement initiatives. The question of ***how*** each hospital can address significant community health needs is the subject of the separate Implementation Strategy.

Federal regulations allow hospital facilities to define the community they serve based on "all of the relevant facts and circumstances," including the "geographic location" served by the hospital facility, "target populations served" (e.g., children, women, or the aged), and/or the hospital

2 Internal Revenue Code, Section 501(r).

facility's principal functions (e.g., focus on a particular specialty area or targeted disease)."[3] Accordingly, the community definition considered the geographic origins of the hospital's patients and also the hospital's mission, target populations, principal functions, and strategies.

Data from multiple sources were gathered and assessed, including secondary data published by others and primary data obtained through community input. Input from the community was received through key stakeholder interviews. Interviewees represented the broad interests of the community and included individuals with special knowledge of or expertise in public health. *See* Appendix C.

Certain community health needs were determined to be "significant" if they were identified as problematic in at least two of the following three data sources: (1) the most recently available secondary data regarding the community's health and (2) input from community stakeholders who participated in the interview process.

In addition, data were gathered to evaluate the impact of various services and programs identified in the hospital's previous CHNA process. *See* Appendix D.

Collaborating Organizations

For this community health assessment, Charlotte Hungerford Hospital collaborated with the following Hartford Healthcare hospitals: Backus Hospital, Hartford Hospital, Hospital of Central Connecticut, MidState Medical Center, Natchaug Hospital, and Windham Hospital. These facilities collaborated by gathering and assessing secondary data together, scheduling and conducting interviews together, and by relying on shared methodologies, report formats, and staff to manage the CHNA process.

Data Sources

Community health needs were identified by collecting and analyzing data from multiple sources. Statistics for numerous community health status, health care access, and related indicators were analyzed, including data provided by local, state, and federal government agencies, local community service organizations, and Hartford HealthCare. Comparisons to benchmarks were made where possible.

Input from persons representing the broad interests of the community was taken into account through key informant interviews with sixteen (16) individuals. Stakeholders included: individuals with special knowledge of or expertise in public health; local public health departments; hospital staff and providers; representatives of social service organizations; and leaders, representatives, and members of medically underserved, low-income, and minority populations.

[3] 501(r) Final Rule, 2014.

Consultant Qualifications

Verité Healthcare Consulting, LLC (Verité) was founded in May 2006 and is located in Arlington, Virginia. The firm serves clients throughout the United States as a resource that helps hospitals conduct Community Health Needs Assessments and develop Implementation Strategies to address significant health needs. Verité has conducted more than 60 needs assessments for hospitals, health systems, and community partnerships nationally since 2012.

The firm also helps hospitals, hospital associations, and policy makers with community benefit reporting, program infrastructure, compliance, and community benefit-related policy and guidelines development. Verité is a recognized national thought leader in hospital community benefits and Community Health Needs Assessments.

DataHaven is a non-profit organization with a 25-year history of public service to Connecticut. Its mission is to empower people to create thriving communities by collecting and ensuring access to data on well-being, equity, and quality of life. DataHaven is a formal partner of the National Neighborhood Indicators Partnership of the Urban Institute in Washington, D.C.

APPENDIX B – DATAHAVEN 2021 EQUITY PROFILE

Please refer to the CHARLOTTE HUNGERFORD Hospital HAS 2021 EQUITY PROFILE PDF.

CHARLOTTE HUNGERFORD HSA 2021 EQUITY PROFILE

Contents

Compiled by DataHaven in March 2021.

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ctdatahaven.org

EXECUTIVE SUMMARY

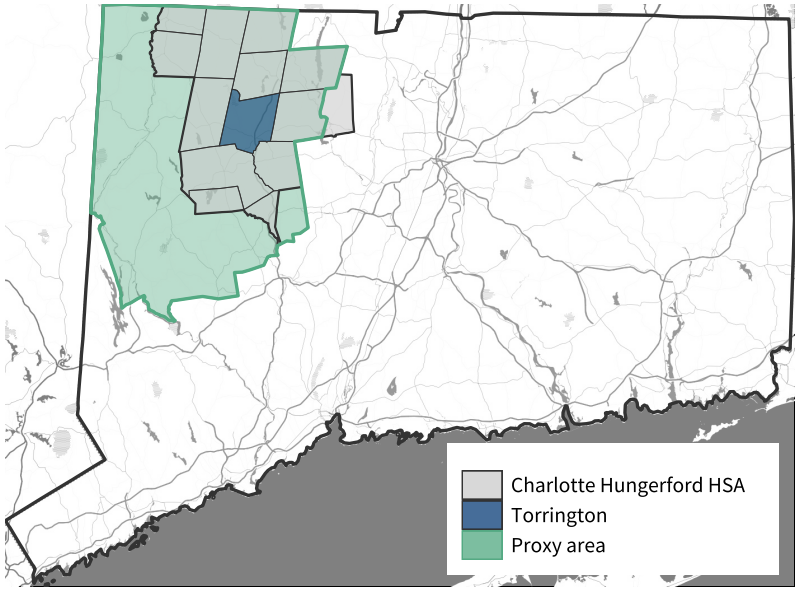
Throughout most of the measures in this report, there are important differences by race/ethnicity and neighborhood that reflect differences in access to resources and other health-related social needs. Wherever possible, data will be presented with racial/ethnic breakdowns.

- The Charlotte Hungerford HSA is a region of **99,685 residents**, including **18,817 children** and **20,415 seniors**.
- The population of the Charlotte Hungerford HSA is **12 percent** people of color and **7 percent** foreign-born.
- Of the region's **40,649 households**, **75 percent** are owner-occupied.
- **Thirty-two percent** of the Charlotte Hungerford HSA's households are cost-burdened, meaning they spend at least 30 percent of their total income on housing costs.
- **Ninety-three percent** of the region's public high school seniors graduated within four years in 2019.
- Among the region's adults ages 25 and up, **33 percent** have earned a bachelor's degree or higher.
- The Charlotte Hungerford HSA is home to **35,712 jobs**, with the largest share in the Health Care and Social Assistance sector.
- The median household income in the Charlotte Hungerford HSA is **$77,714**.
- The Charlotte Hungerford HSA's average life expectancy is **79.9 years**.
- **Fifty-nine percent** of adults in Charlotte Hungerford HSA say they are in excellent or very good health.
- In 2020, **44 people** in the Charlotte Hungerford HSA died of drug overdoses.
- **Eighty percent** of adults in Charlotte Hungerford HSA are satisfied with their area, and **51 percent** say their local government is responsive to residents' needs.
- In the 2020 presidential election, **82 percent** of registered voters in the Charlotte Hungerford HSA voted.
- **Forty-five percent** of adults in Charlotte Hungerford HSA report having stores, banks, and other locations in walking distance of their home, and **43 percent** say there are safe sidewalks and crosswalks in their neighborhood.

OVERVIEW

For the purposes of this report, the Charlotte Hungerford HSA will be compared to Connecticut, as well as to the area's core city of Torrington when available. Where necessary, data may be presented for Litchfield County as a proxy region, covering at least 90 percent of the HSA's population. **Charts and tables based on these proxy areas are noted as such in their titles.** In addition, DataHaven Community Wellbeing Survey data are presented for Litchfield County where sample sizes are otherwise too small.

Figure 1: Study area



Charlotte Hungerford HSA is made up of the following towns *(with population)*:

- Barkhamsted *(3,649)*
- Canaan *(1,143)*
- Canton *(10,288)*
- Colebrook *(1,484)*
- Goshen *(2,883)*
- Harwinton *(5,456)*
- Litchfield *(8,147)*
- Morris *(2,205)*
- New Hartford *(6,703)*
- Norfolk *(1,628)*
- North Canaan *(3,281)*
- Thomaston *(7,599)*
- Torrington *(34,489)*
- Winchester *(10,730)*

The proxy for the area is:

- Litchfield County *(182,002)*

Table 1: About the area

Indicator	Connecticut	Charlotte Hungerford HSA	Torrington
Total population	3,575,074	99,685	34,489
Total households	1,370,746	40,649	14,471
Homeownership rate	66%	75%	67%
Housing cost burden rate	36%	32%	34%
Adults with less than a high school diploma	9%	8%	11%
Median household income	$78,444	$77,714	$63,172
Poverty rate	10%	8%	10%
Life expectancy (years)	80.3	79.9	77.8
Adults w/o health insurance	10%	8%	10%

DEMOGRAPHICS

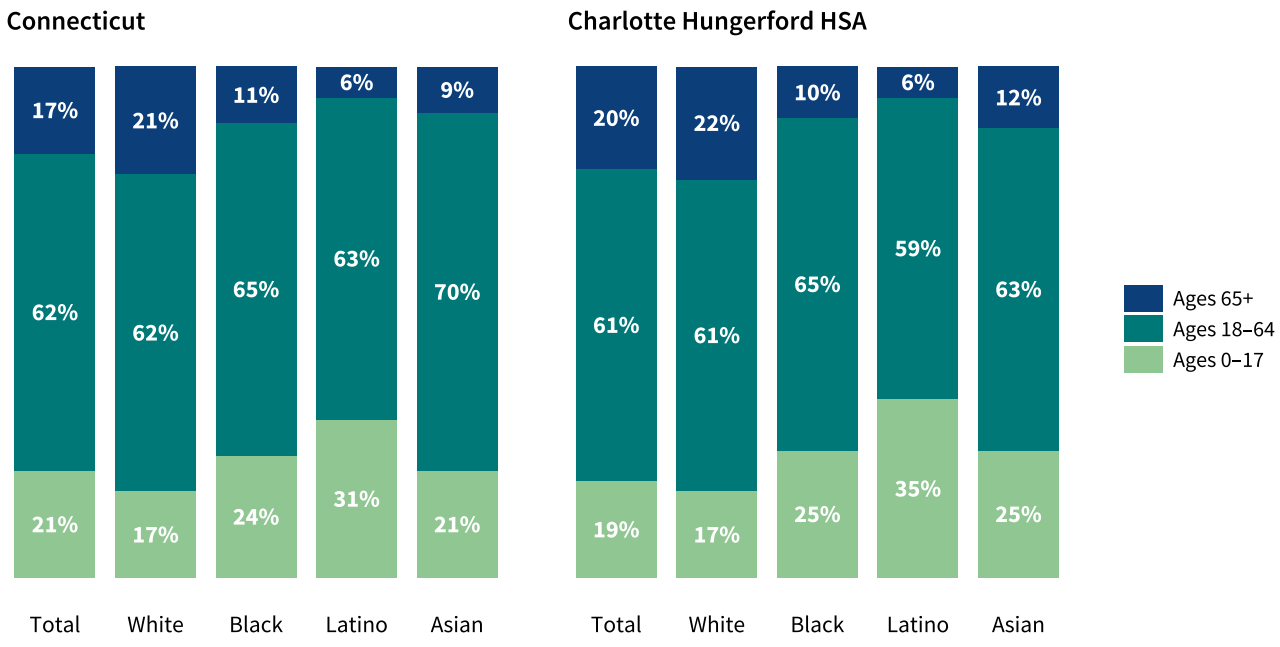
As of 2019, the population of the Charlotte Hungerford HSA is 99,685, including 7,039 residents (7 percent) who are foreign-born. Twelve percent of the Charlotte Hungerford HSA's residents are people of color.

Table 2: Population by race/ethnicity and age group, 2019

	White		Black		Latino		Asian		Native American		Other race/ethnicity	
Area	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**
Connecticut	2,392,013	67%	354,120	10%	574,240	16%	159,989	4%	5,596	<1%	89,116	2%
Charlotte Hungerford HSA	87,847	88%	1,816	2%	6,519	7%	1,944	2%	318	<1%	1,241	1%
Torrington	27,993	81%	973	3%	3,922	11%	993	3%	54	<1%	554	2%

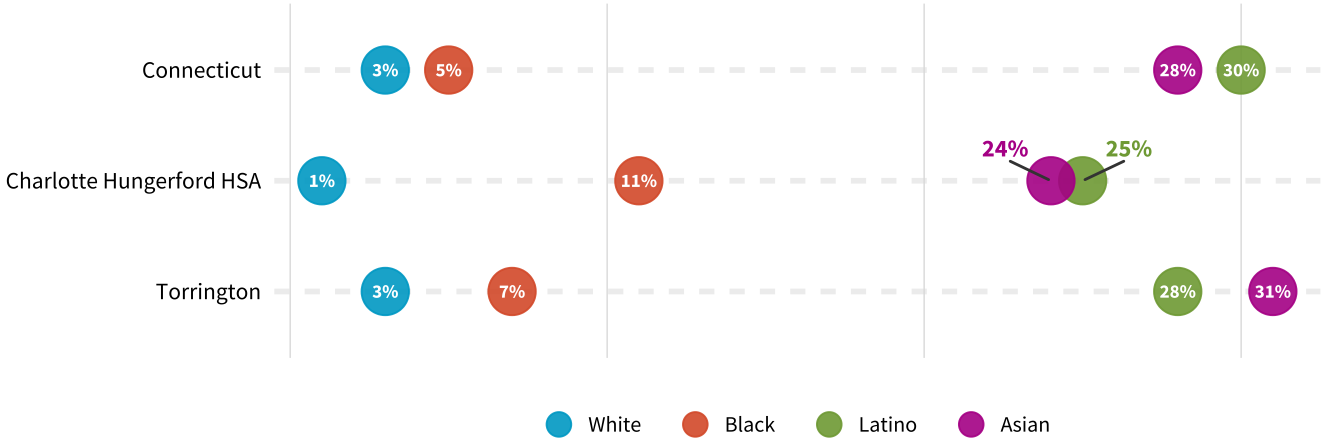
Nineteen percent of Charlotte Hungerford HSA's residents are children under age 18, and 20 percent are adults ages 65 and up. As Connecticut's predominantly white Baby Boomers age, younger generations are driving the state's increased racial and ethnic diversity. Black and Latino populations in particular skew much younger than white populations. In Charlotte Hungerford HSA, 32 percent of Black and Latino residents are children, compared to 17 percent of white residents.

Figure 2: Population by race/ethnicity and age group, 2019



Linguistic isolation is characterized as speaking English less than "very well." People who struggle with English proficiency may have difficulty in school, seeking health care, accessing social services, or finding work in a largely English-speaking community. In the Charlotte Hungerford HSA, 3,013 residents, or 3 percent of the population age 5 and older, are linguistically isolated. Latinos and Asian Americans are more likely to be linguistically isolated than other racial/ethnic groups.

Figure 3: Linguistic isolation by race/ethnicity, 2019



HOUSING

The Charlotte Hungerford HSA has 40,649 households, of which 75 percent are homeowner households. Of the Charlotte Hungerford HSA's 47,682 housing units, 72 percent are single-family and 28 percent are multifamily, compared to Torrington, where 58 percent are single-family and 42 percent are multifamily.

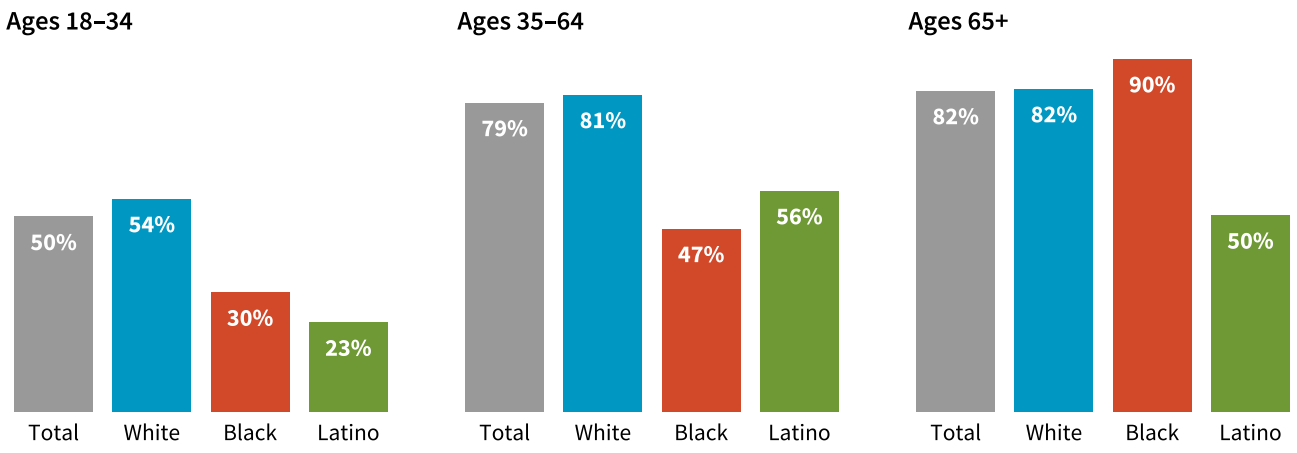
Homeownership rates vary by race/ethnicity. Purchasing a home is more attainable for advantaged groups because the process of purchasing a home has a long history of racially discriminatory practices that continue to restrict access to homeownership today. This challenge, coupled with municipal zoning dominated by single-family housing, results in de facto racial and economic segregation seen throughout Connecticut.

Table 3: Homeownership rate by race/ethnicity of head of household, 2019

Area	Total	White	Black	Latino	Asian	Native American
Connecticut	66%	76%	39%	34%	58%	40%
Charlotte Hungerford HSA	75%	78%	54%	31%	60%	N/A
Torrington	67%	71%	47%	26%	69%	N/A

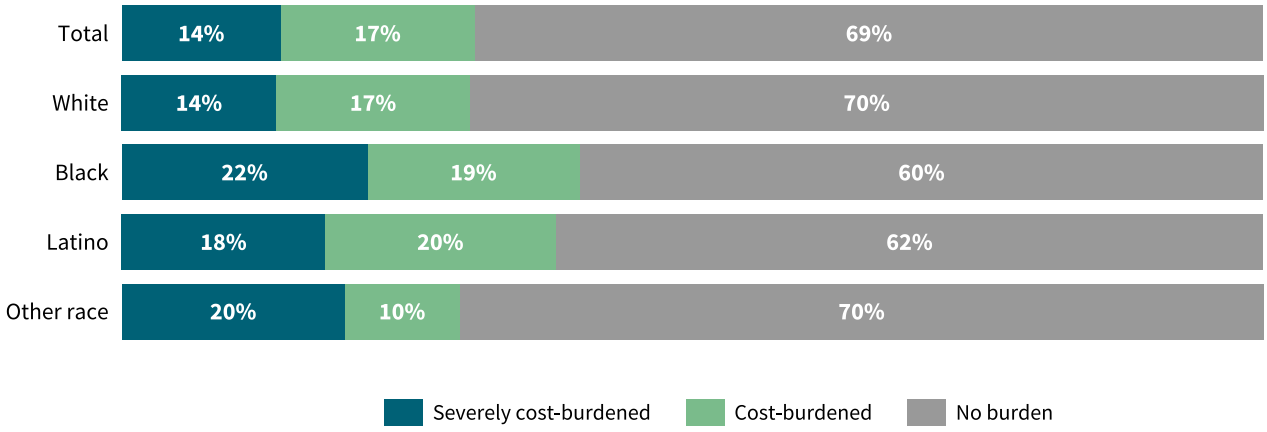
Younger adults are less likely than older adults to own their homes across several race/ethnicity groups; however, younger white adults own their homes at rates comparable to or higher than older Black and Latino adults.

Figure 4: Homeownership rates by age and race/ethnicity of head of household, Charlotte Hungerford HSA (with proxy area), 2019



A household is cost-burdened when they spend 30 percent or more of their income on housing costs, and severely cost-burdened when they spend half or more of their income on housing costs. Housing costs continue to rise, due in part to municipal zoning measures that limit new construction to very few towns statewide. Meanwhile, wages have largely stagnated, especially among lower-income workers who are more likely to rent. As a result, cost burden generally affects renters more than homeowners, and has greater impact on Black and Latino householders. Among renter households in the Charlotte Hungerford HSA, 50 percent are cost-burdened, compared to 26 percent of owner households.

Figure 5: Housing cost-burden rates by race/ethnicity, Charlotte Hungerford HSA (with proxy area), 2019



Household overcrowding is defined as having more than one occupant per room. Overcrowding may increase the spread of illnesses among the household and can be associated with higher levels of stress. Increasing the availability of appropriately-sized affordable units helps to alleviate overcrowding.

Table 4: Overcrowded households by race/ethnicity of head of household, 2019

	Total		White		Black		Latino		Asian		Native American	
Area	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**
Connecticut	25,541	2%	7,252	<1%	4,437	3%	10,771	6%	2,954	6%	158	4%
Charlotte Hungerford HSA	479	1%	326	<1%	<50	N/A	63	4%	<50	N/A	<50	N/A
Torrington	260	2%	158	1%	<50	N/A	<50	N/A	<50	N/A	<50	N/A

EDUCATION

As of the 2019–2020 year, there were 22,023 students enrolled in the public K–12 school districts serving towns in the Charlotte Hungerford HSA. Tracking student success measures is important since disparate academic and disciplinary outcomes are observed as early as preschool and can ultimately affect a person's long-term educational attainment and economic potential.

Figure 6: Public K–12 student enrollment by race/ethnicity per 100 students, 2019–2020

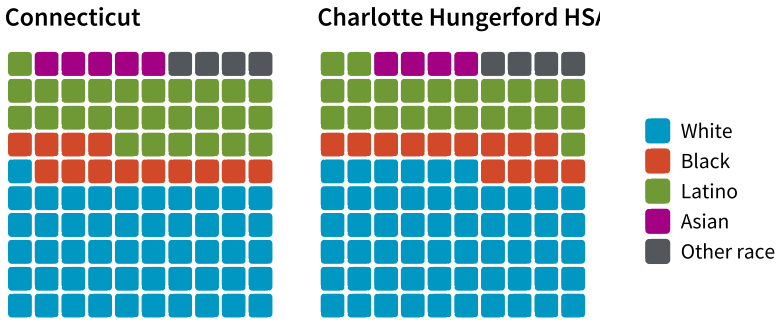
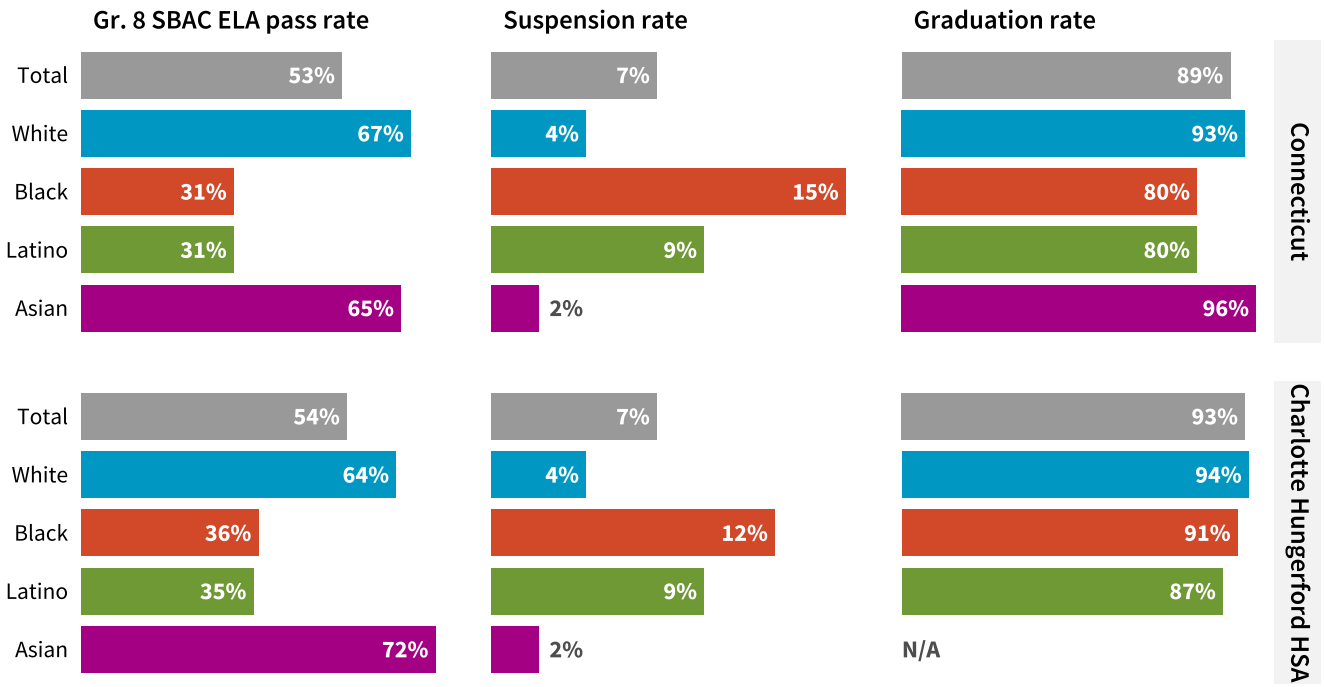
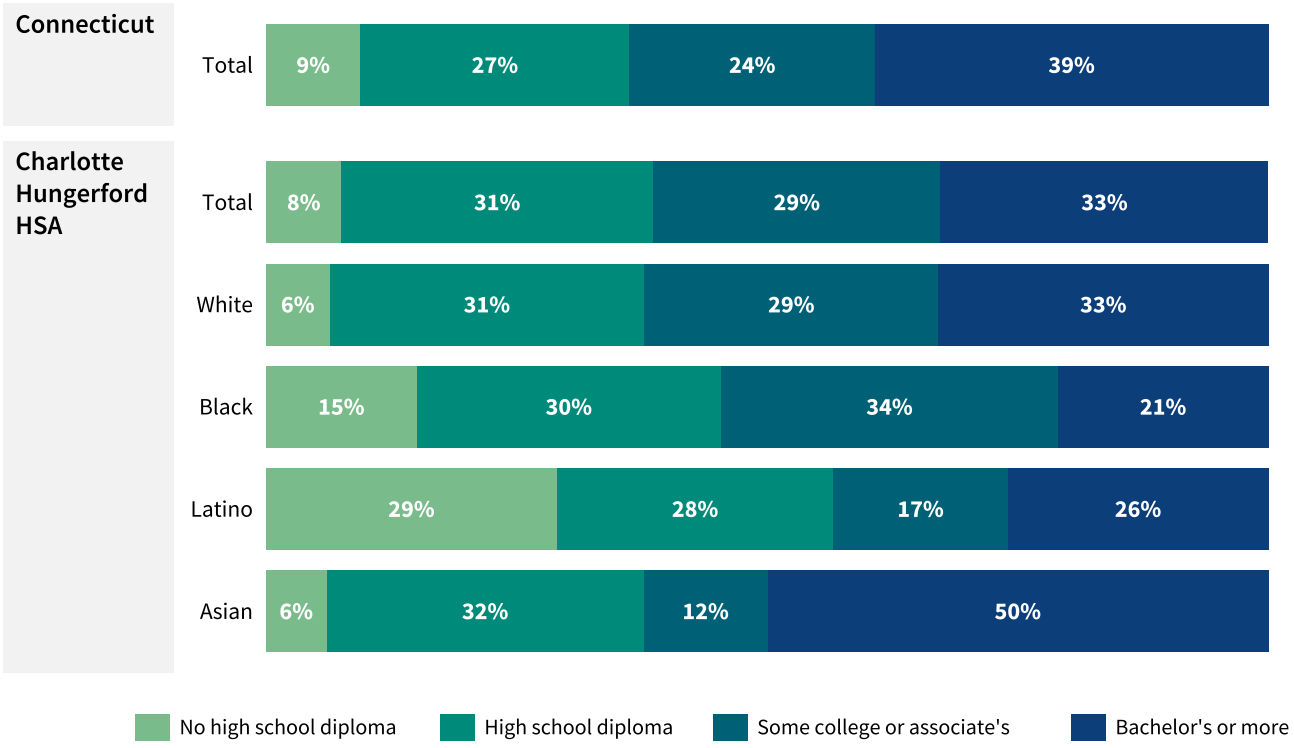


Figure 7: Selected academic and disciplinary outcomes by student race/ethnicity, 2018–2019



Adults with high school diplomas or college degrees have more employment options and considerably higher potential earnings, on average, than those who do not finish high school. In the Charlotte Hungerford HSA, 8 percent of adults ages 25 and over, or 5,480 people, lack a high school diploma; statewide, this value is 9 percent.

Figure 8: Educational attainment by race/ethnicity, share of adults ages 25 and up, 2019



ECONOMY

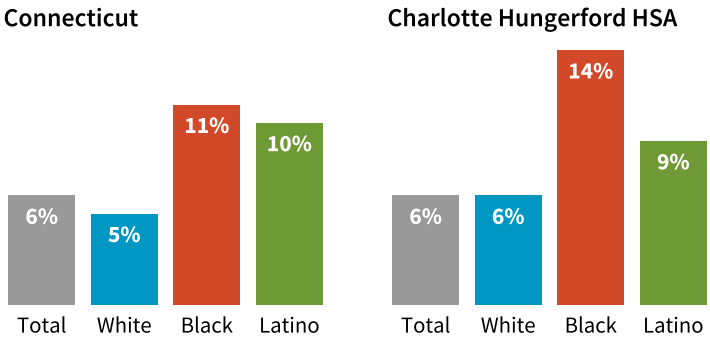
There are 35,712 total jobs in the Charlotte Hungerford HSA, with the largest share in the Health Care and Social Assistance sector. While these numbers are from 2019 and do not include economic outcomes related to the COVID-19 pandemic, they describe general labor market strengths and average wages for the area.

Table 5: Jobs and wages in Charlotte Hungerford HSA's 5 largest sectors, 2019

	Connecticut		Charlotte Hungerford HSA	
Sector	**Total jobs**	**Avg annual pay**	**Total jobs**	**Avg annual pay**
All Sectors	1,670,354	$69,806	35,712	$47,602
Health Care and Social Assistance	271,014	$54,858	6,137	$43,235
Retail Trade	175,532	$35,833	5,242	$32,716
Manufacturing	161,893	$85,031	5,009	$60,928
Accommodation and Food Services	129,012	$23,183	2,575	$19,758
Construction	59,659	$72,371	2,161	$72,538

Rates of unemployment tend to vary by race and ethnicity. Generally, workers of color are more likely to be unemployed due to factors ranging from hiring practices to proximity to available jobs. Overall unemployment in the Charlotte Hungerford HSA averaged 6 percent in 2019.

Figure 9: Unemployment rate by race/ethnicity, 2019



INCOME & WEALTH

The median household income in Connecticut is $78,444. Within the Charlotte Hungerford HSA, town-level median household incomes range from a minimum of $62,432 in North Canaan to a maximum of $111,202 in Harwinton. Racial disparities in outcomes related to education, employment, and wages result in disparate household-level incomes and overall wealth. Households led by Black or Latino adults generally average lower incomes than white households.

The Supplemental Nutritional Assistance Program (SNAP, or food stamps) is a program available to very low-income households earning less than 130 percent of the federal poverty guideline ($25,750 for a family of four in 2019). Throughout the state, poverty and SNAP utilization rates are higher among Black and Latino households than white households.

Table 6: Selected household economic indicators by race/ethnicity of head of household, 2019

		Total		White		Black		Latino		Asian		Native American	
Indicator	**Area**	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**
Below poverty level	**Connecticut**	344,146	10%	137,123	6%	65,664	18%	123,431	22%	12,398	8%	1,629	17%
	Charlotte Hungerford HSA	7,864	8%	5,679	6%	282	13%	1,482	23%	264	14%	54	16%
	Torrington	3,494	10%	2,076	8%	215	18%	1,002	26%	190	19%	<50	N/A
Receives SNAP	**Connecticut**	162,967	12%	67,339	7%	34,650	26%	56,091	32%	3,145	6%	958	26%
	Charlotte Hungerford HSA	3,779	9%	3,138	8%	89	15%	368	20%	51	9%	<50	N/A
	Torrington	1,937	13%	1,552	12%	<50	N/A	276	26%	<50	N/A	<50	N/A

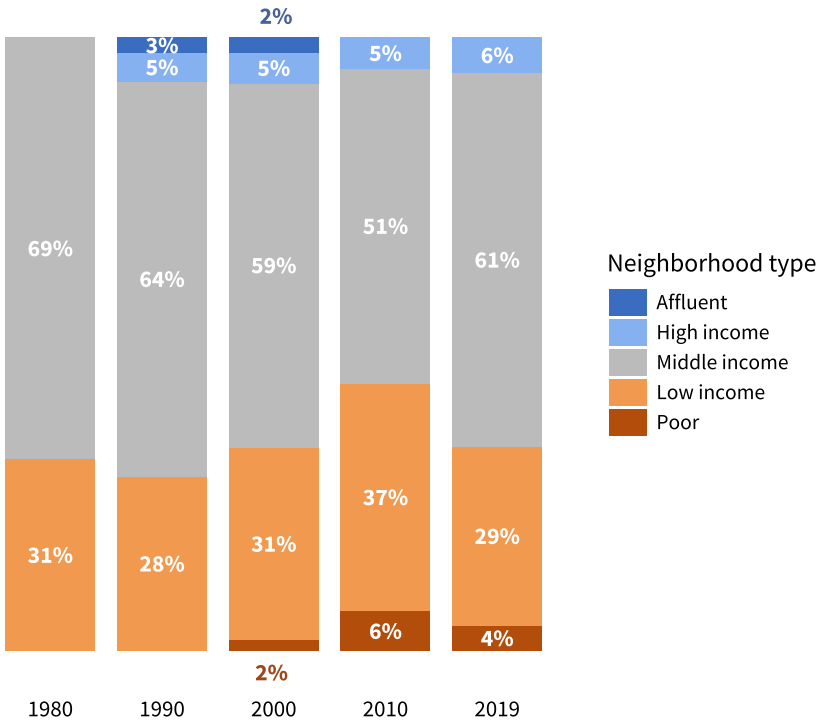
Access to a personal vehicle may also be considered a measure of wealth since reliable transportation plays a significant role in job access and quality of life. Vehicle access reduces the time a family may spend running errands or traveling to appointments, school, or work.

Table 7: Households with no vehicle at home by race/ethnicity of head of household (with proxy area), 2019

	Total		White		Black		Latino		Other race	
Area	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**
Connecticut	121,434	9%	55,942	6%	27,048	21%	30,496	17%	7,948	10%
Charlotte Hungerford HSA	3,860	5%	3,385	5%	55	5%	300	9%	120	6%

Over the past 40 years, neighborhood income inequality has grown statewide as the share of the population living in wealthy or poor neighborhoods has increased and the population in middle income areas declined in a process known as "economic sorting," which often leads to further disparities in access to economic opportunity, healthy environments, and municipal resources.

Figure 10: Distribution of population by neighborhood income level, Charlotte Hungerford HSA, 1980–2019

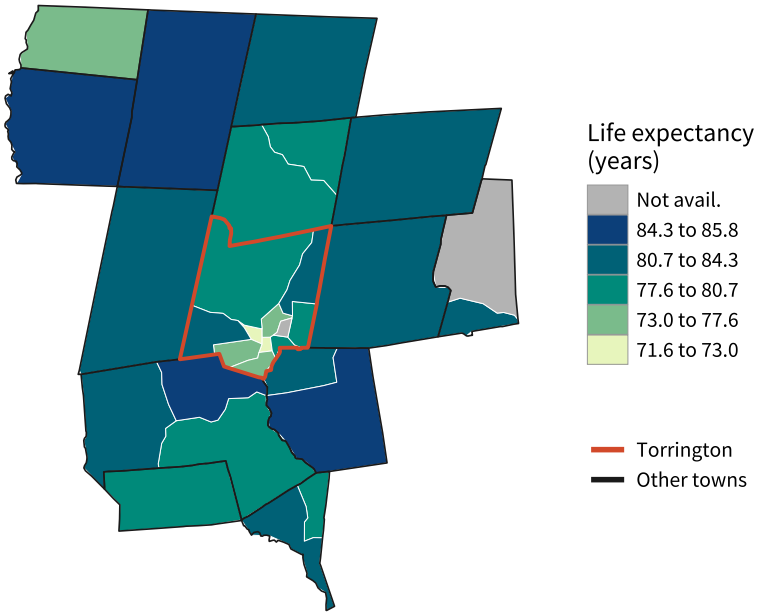


HEALTH

The socioeconomic disparities described above tend to correlate with health outcomes. Factors such as stable housing, employment, literacy and linguistic fluency, environmental hazards, and transportation all impact access to care, physical and mental health outcomes, and overall quality of life. Income and employment status often drive differences in access to healthcare, the likelihood of getting preventive screenings as recommended, the affordability of life-saving medicines, and the ability to purchase other goods and services, including high-quality housing and nutritious food.

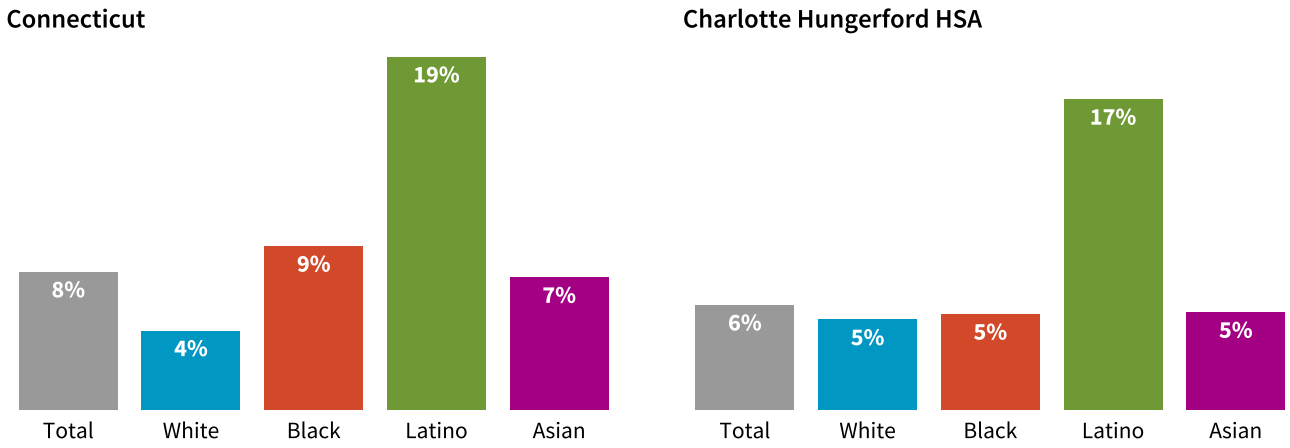
Life expectancy is a good proxy for overall health and well-being since it is the culmination of so many other social and health factors. The average life expectancy in the Charlotte Hungerford HSA is 79.9 years, and 80.3 years in Connecticut. Regionally, these values range from a low of 74.4 in North Canaan to a high of 85.6 in Norfolk.

Figure 11: Life expectancy, Charlotte Hungerford HSA by Census tract, 2015



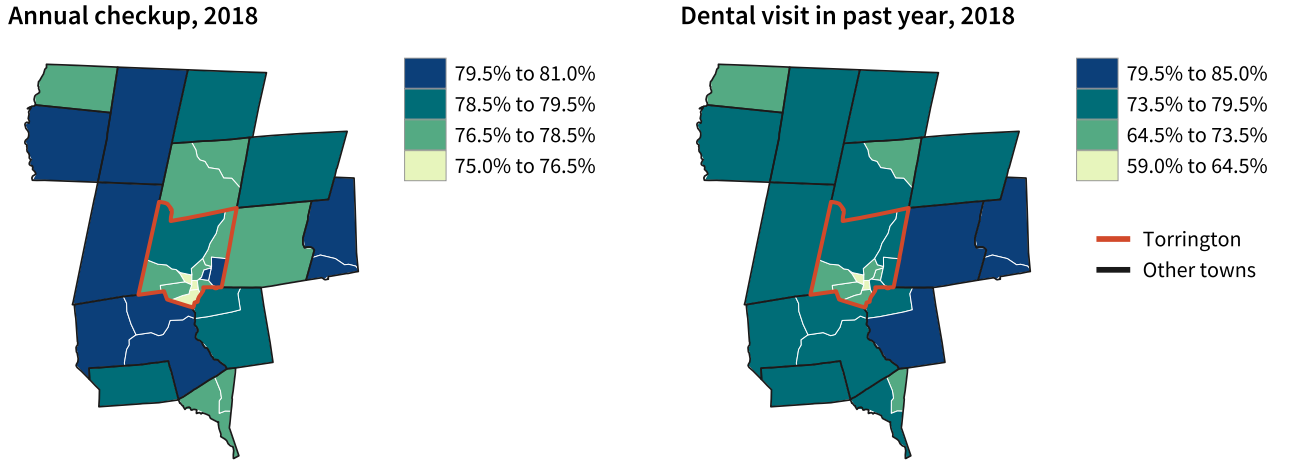
Health-related challenges begin with access to care. Due to differences in workplace benefits, income, and eligibility factors, Black and especially Latino people are less likely to have health insurance than white people.

Figure 12: Uninsured rate among adults ages 19–64 by race/ethnicity, 2019



Preventive care can help counteract economic disadvantages, as a person's health can be improved by addressing risk factors like hypertension and chronic stress early. Lack of affordable, accessible, and consistent medical care can lead to residents relying on expensive emergency room visits later on. Overall, 79 percent of the adults in the Charlotte Hungerford HSA had an annual checkup as of 2018, and 75 percent had a dental visit in the past year.

Figure 13: Preventive care measures, share of adults by Census tract, Charlotte Hungerford HSA



Throughout the state, people of color face greater rates and earlier onset of many chronic diseases and risk factors, particularly those that are linked to socioeconomic status and access to resources. For example, diabetes is much more common among older adults than younger ones, yet middle-aged Black adults in Connecticut have higher diabetes rates than white seniors.

Figure 14: Selected health risk factors, share of adults, 2015–2018

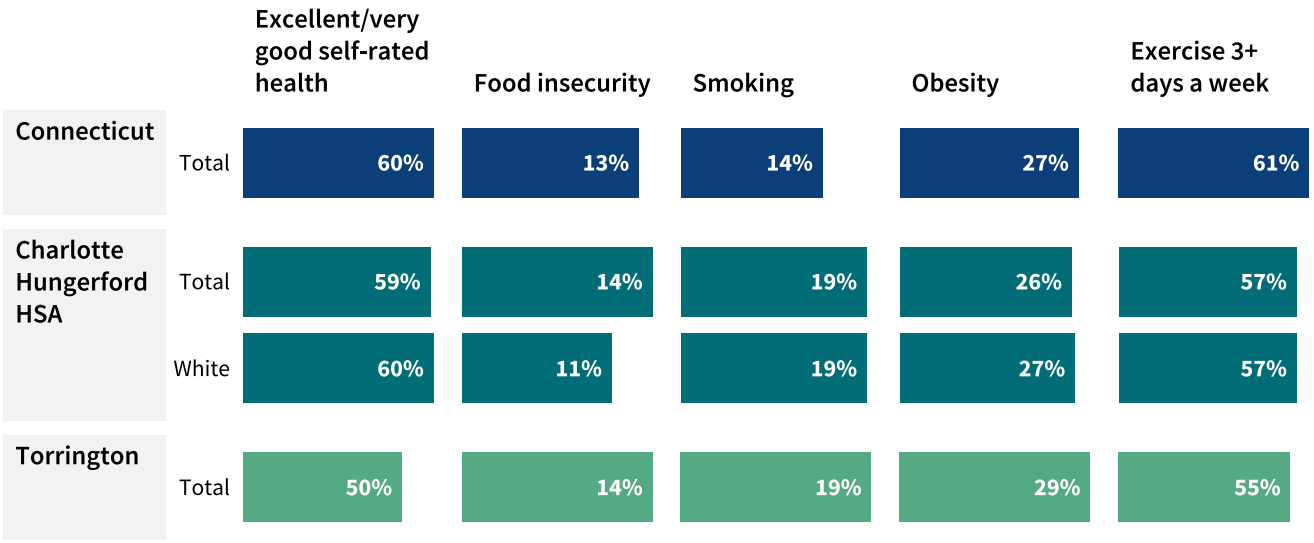
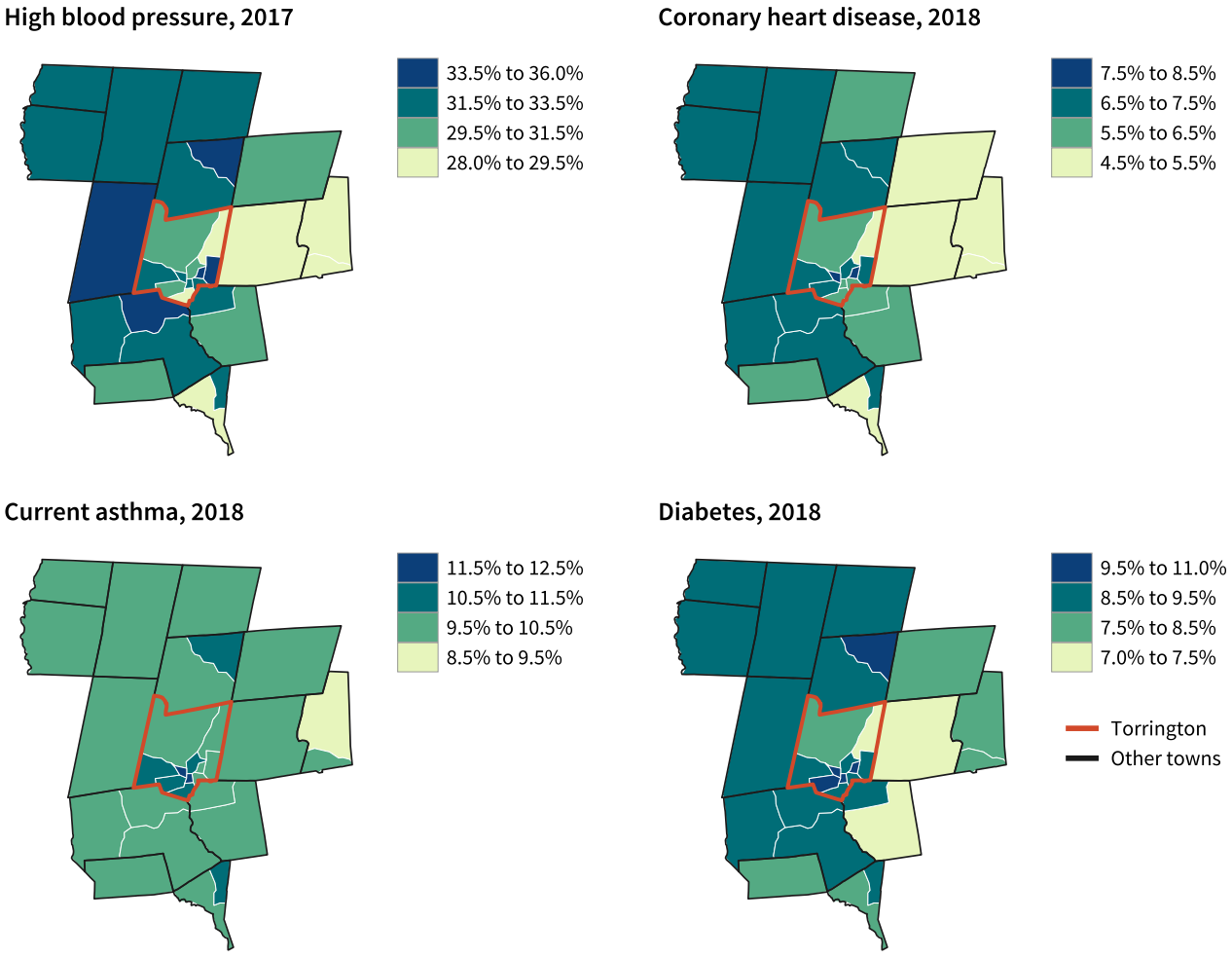


Figure 15: Chronic disease prevalence, share of adults by Census tract, Charlotte Hungerford HSA



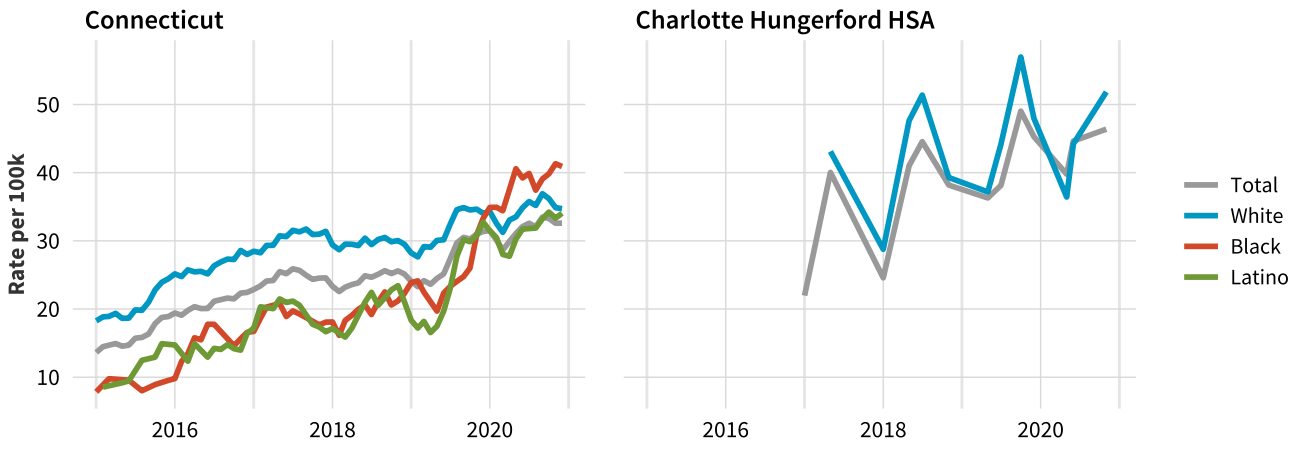
Mental health issues like depression and anxiety can be linked to social determinants like income, employment, and environment, and can pose risks of physical health problems as well, including by complicating a person's ability to keep up other aspects of their health care. People of color are slightly more likely to report feeling mostly or completely anxious and being bothered by feeling depressed or hopeless. Overall, 9 percent of Charlotte Hungerford HSA adults report experiencing anxiety regularly and 9 percent report being bothered by depression.

Table 8: Selected mental health indicators, share of adults, 2015–2018

Indicator	Area	Total	White	Black	Latino	Asian	Native American
Experiencing anxiety	**Connecticut**	12%	11%	15%	19%	14%	15%
	Charlotte Hungerford HSA	9%	8%	N/A	N/A	N/A	N/A
	Torrington	6%	6%	N/A	N/A	N/A	N/A
Bothered by depression	**Connecticut**	9%	8%	10%	14%	8%	12%
	Charlotte Hungerford HSA	9%	7%	N/A	N/A	N/A	N/A
	Torrington	11%	2%	N/A	N/A	N/A	N/A

Like other states, Connecticut has seen a rise in drug overdose deaths in the last several years. In 2020, Connecticut saw an average of 113 overdose deaths per month, up from 60 in 2015. White residents long comprised the bulk of these deaths, but with the increasing rate of overdose deaths overall has come an increasing share of people of color counted among overdose deaths.

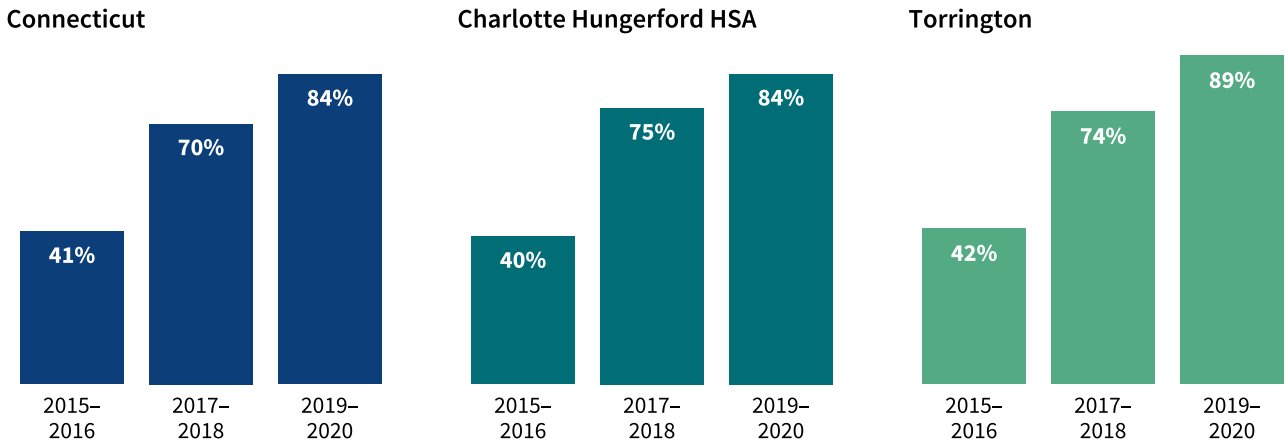
Figure 16: Age-adjusted monthly rates of drug overdose deaths per 100,000 residents by race/ethnicity, 6-month rolling averages, 2015–2020



Note: values suppressed for small populations or few overdose incidents.

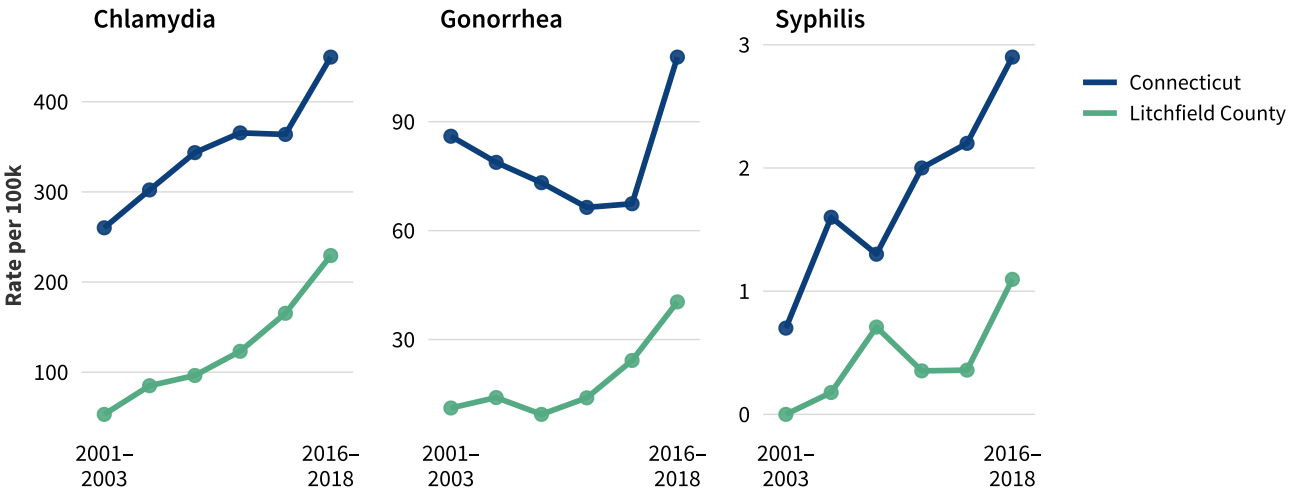
The introduction and spread of fentanyl in drugs—both with and without users' knowledge—is thought to have contributed to this steep rise in overdoses. In 2015 and 2016, 40 percent of the drug overdose deaths in the Charlotte Hungerford HSA involved fentanyl; in 2019 and 2020, this share was 84 percent.

Figure 17: Share of drug overdose deaths involving fentanyl, 2015–2020



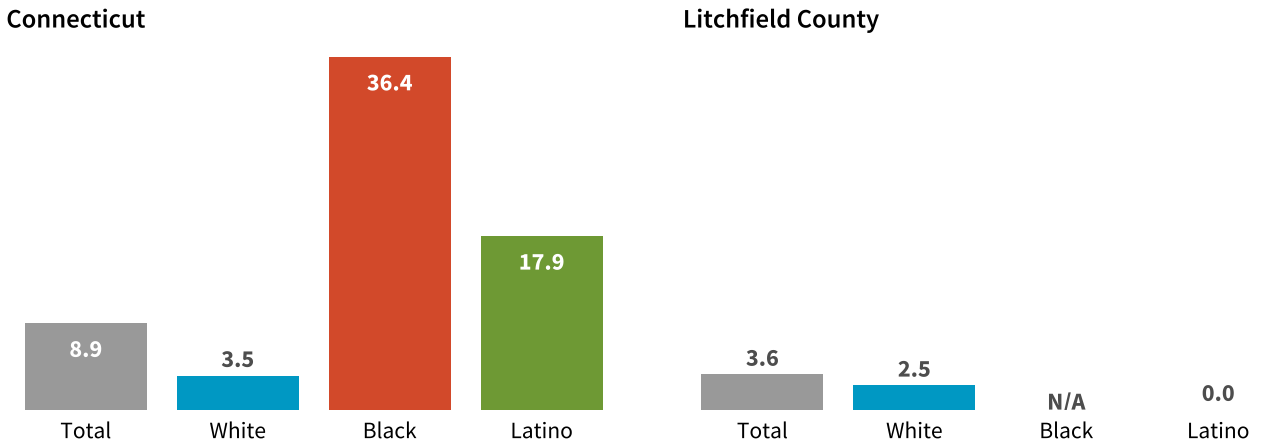
Sexually transmitted infections (STIs) can have long-term implications for health, including reproductive health problems and certain cancers, and can increase the risk of acquiring and transmitting diseases such as HIV and hepatitis C. Following nationwide trends, Connecticut has seen increases in the rates of STIs like chlamydia and gonorrhea over the past two decades. Between 2016 and 2018, Litchfield County had annual average case rates of 229 new cases of chlamydia per 100,000 residents, 40 cases of gonorrhea per 100,000, and 1.1 cases of syphilis per 100,000.

Figure 18: Annualized average rates of new cases of selected sexually transmitted infections per 100,000 residents, 2001–2003 through 2016–2018



Like many other diseases, Connecticut's Black and Latino residents face a higher burden of HIV rates. Statewide between 2016 and 2018, Black residents ages 13 and up were more than 10 times more likely to be diagnosed with HIV than white residents.

Figure 19: Annualized average rate of new HIV diagnoses per 100,000 residents ages 13 and over, 2016–2018

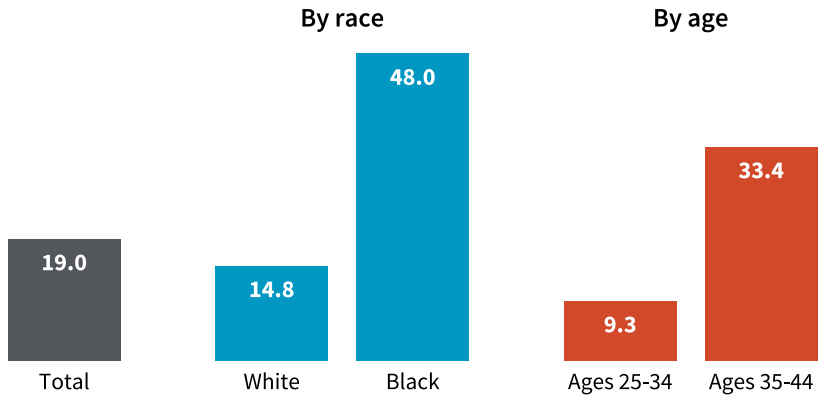


Birth outcomes often reflect health inequities for parents giving birth, and those outcomes can affect a child throughout their life. Often, parents of color have more complications related to birth and pregnancy than white parents. Complications during pregnancy or childbirth also contribute to elevated mortality among parents giving birth.

Table 9: Selected birth outcomes by race/ethnicity of parent giving birth, 2016–2018

					Latina			
Indicator	**Area**	**Total**	**White**	**Black**	**Latina (overall)**	**Puerto Rican**	**Other Latina**	**Asian**
Late or no prenatal care	**Connecticut**	3.4%	2.5%	5.7%	4.0%	2.9%	5.1%	3.5%
	Charlotte Hungerford HSA	3.5%	2.7%	N/A	7.6%	N/A	9.0%	7.8%
	Torrington	3.9%	2.5%	N/A	7.9%	N/A	9.1%	N/A
Low birthweight	**Connecticut**	7.8%	6.4%	12.1%	8.3%	10.2%	6.6%	8.7%
	Charlotte Hungerford HSA	6.0%	5.4%	N/A	N/A	N/A	N/A	N/A
	Torrington	5.7%	5.4%	N/A	N/A	N/A	N/A	N/A
Infant mortality (per 1k live births)	**Connecticut**	4.6	3.1	9.5	5.0	N/A	N/A	N/A
	Charlotte Hungerford HSA	3.4	2.5	N/A	N/A	N/A	N/A	N/A
	Torrington	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Figure 20: Maternal mortality rate per 100k births, Connecticut, 2013–2017



Children under 7 years old are monitored for potential lead poisoning, and 4.1 percent of these children in the Charlotte Hungerford HSA have blood-lead levels in excess of the state's accepted threshold. Children living in homes built before 1960 are at a higher risk of potential lead poisoning due to the more widespread use of lead-based paints in older homes. Black and Latino households are slightly more likely to live in structures built before 1960.

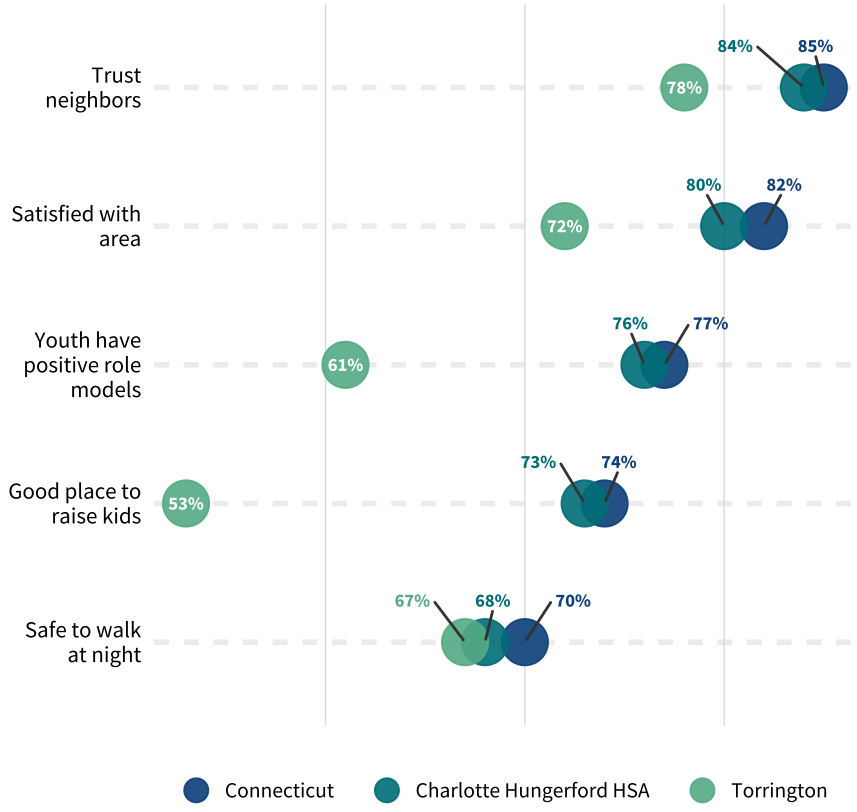
Table 10: Households living in structures built before 1960 by race/ethnicity of head of household (with proxy area), 2019

	Total		White		Black		Latino		Other race	
Area	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**	**Count**	**Share**
Connecticut	580,941	42%	399,512	40%	63,552	49%	93,011	53%	24,866	32%
Charlotte Hungerford HSA	29,470	40%	27,390	40%	359	33%	1,147	36%	574	31%

CIVIC LIFE & COMMUNITY COHESION

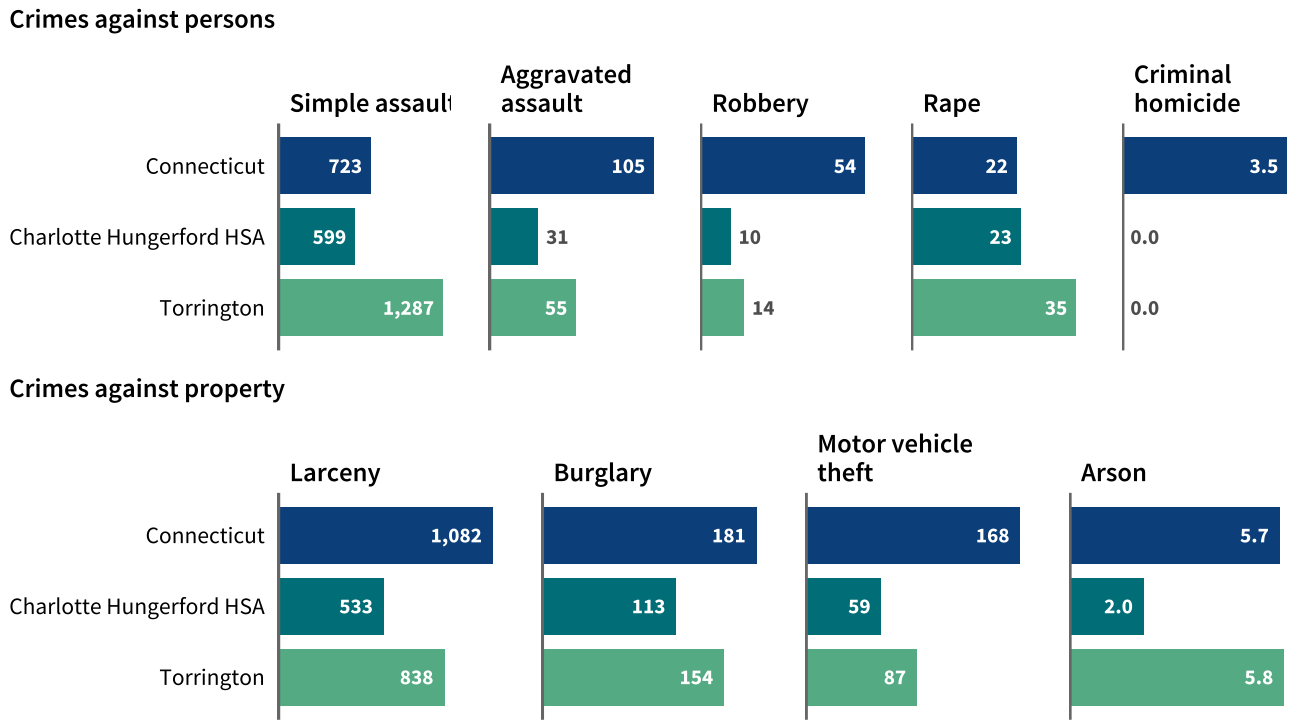
Beyond individual health, several measures from the DataHaven Community Wellbeing Survey show how local adults feel about the health of their neighborhoods. High quality of life and community cohesion can positively impact resident well-being through the availability of resources, sense of safety, and participation in civic life. For example, adults who see the availability of role models in their community may enroll their children in extracurricular activities that benefit them educationally and socially; residents who know and trust their neighbors may find greater social support. Overall, 80 percent of Charlotte Hungerford HSA adults reported being satisfied with the area where they live.

Figure 21: Residents' ratings of community cohesion measures, share of adults, 2015–2018



Crime rates per 100,000 residents are based on reports to law enforcement of violent force against persons, as well as offenses involving property. Not all crimes involve residents of the areas where the crimes occur, which is important to consider when evaluating crime rates in areas or towns with more commercial activity. Crime patterns can also vary dramatically by neighborhood. Crime can impact the social and economic well-being of communities, including through negative health effects.

Figure 22: Part I crime rates per 100,000 residents by town / jurisdiction, 2019



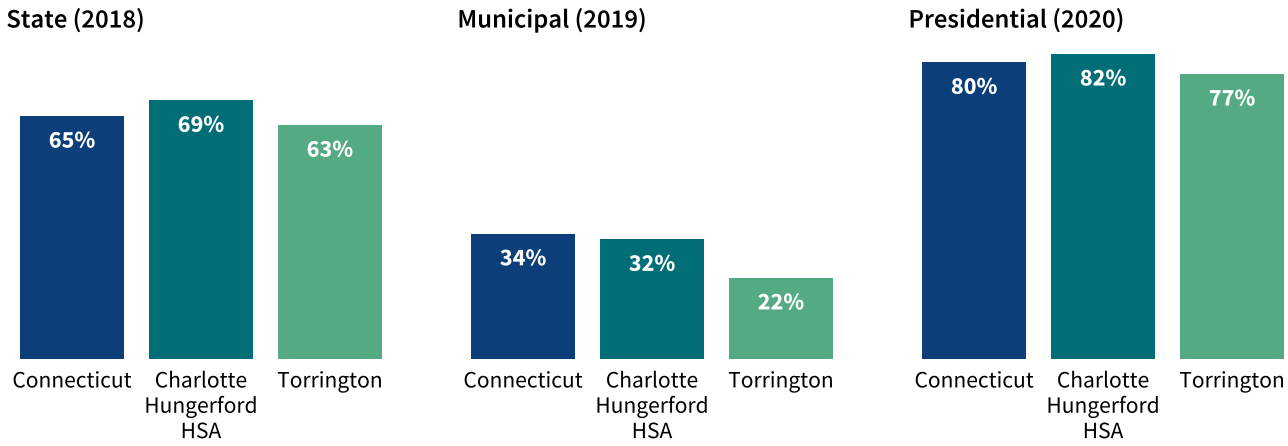
A lack of trust in and engagement with local government and experiences of unfair treatment by authorities can impair community well-being and cohesion. Fifty-one percent of Charlotte Hungerford HSA adults feel their local government is responsive to residents' needs, compared to 51 percent statewide.

Table 11: Residents' ratings of local government, share of adults, 2015–2018

Area	Unfairly stopped by police	Local govt is responsive	Have some influence over local govt
Connecticut	11%	51%	67%
Charlotte Hungerford HSA	6%	51%	70%
Torrington	6%	35%	63%

During the 2020 presidential election, 82 percent of Charlotte Hungerford HSA registered voters cast ballots, compared to 80 percent statewide, and to 81 percent in the 2016 presidential election.

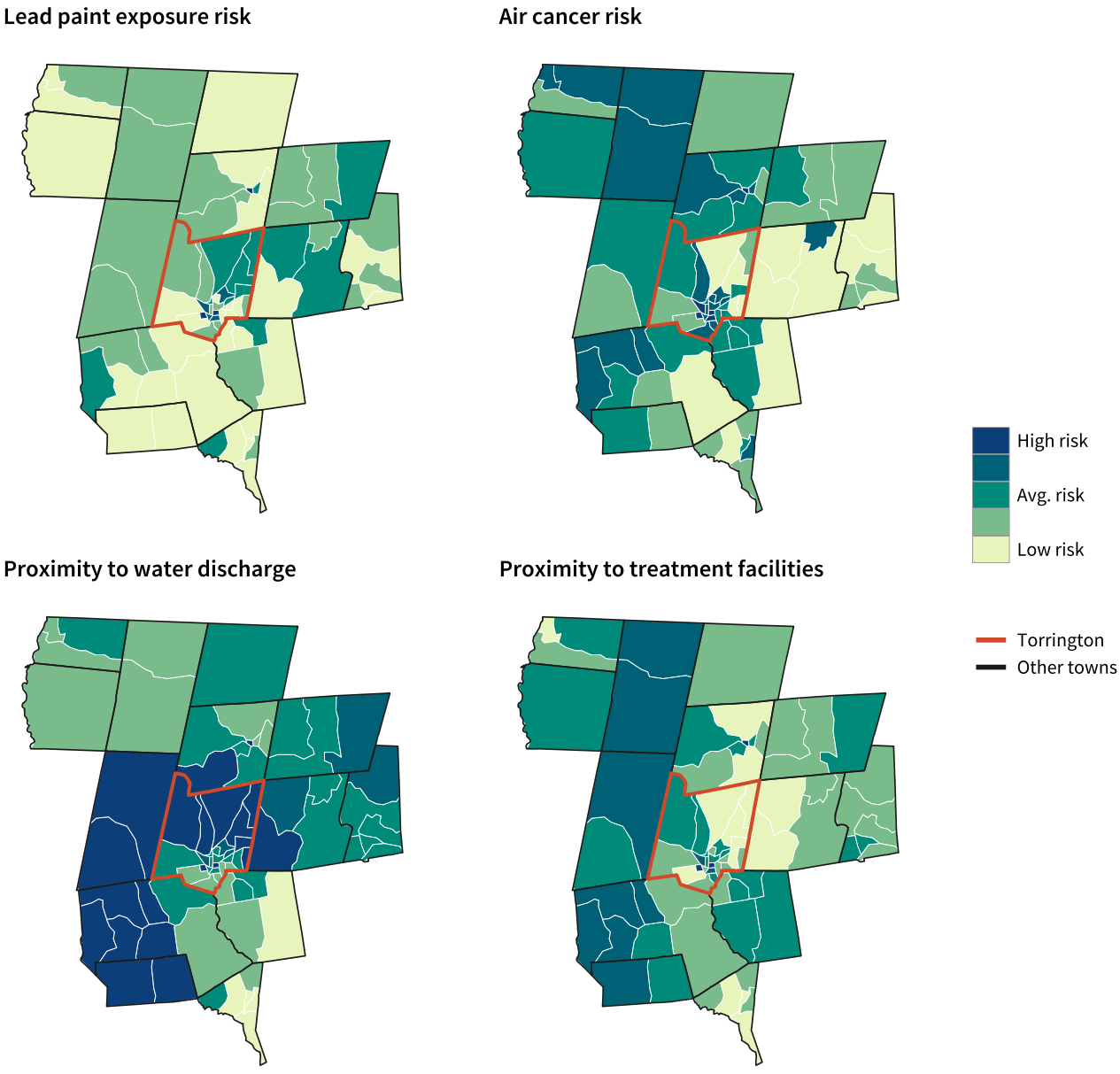
Figure 23: Registered voter turnout, 2018–2020



ENVIRONMENT & SUSTAINABILITY

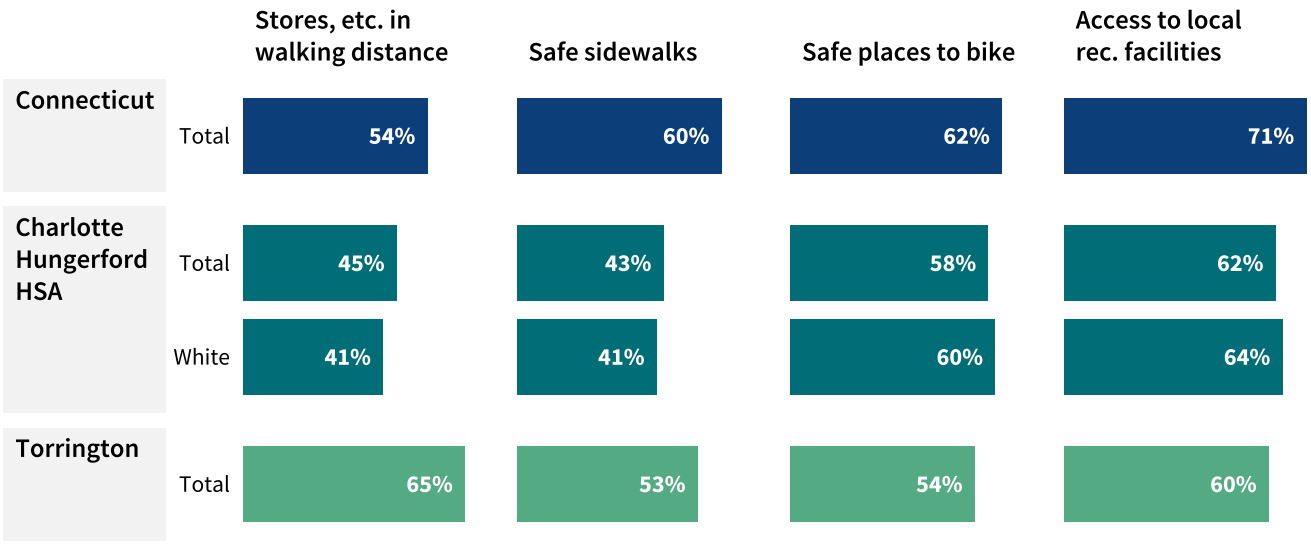
Many environmental factors—from access to outdoor resources to tree canopy to exposure to pollutants—can have direct impacts on residents' health and quality of life. Environmental justice is the idea that these factors of the built and natural environments follow familiar patterns of socioeconomic disparities and segregation. The federal Environmental Protection Agency (EPA) ranks small areas throughout the US on their risks of exposure to a variety of pollutants and hazards, scaled to account for the historically disparate impact of these hazards on people of color and lower-income people.

Figure 24: EPA Environmental Justice Index by block group, Charlotte Hungerford HSA



High-quality built environment resources, such as recreational facilities and safe sidewalks, help keep residents active and bring communities together. Walkable neighborhoods may also encourage decreased reliance on cars. Throughout Connecticut, Black and Latino residents are largely concentrated in denser urban areas which tend to offer greater walkability. Of adults in the Charlotte Hungerford HSA, 45 percent report having stores, banks, and other locations they need in walking distance, lower than the share of adults statewide.

Figure 25: Residents' ratings of local walkability measures by race/ethnicity, share of adults, 2015–2018



NOTES

Figure 1. Study area. Map tiles by Stamen Design, under CC BY 3.0. Data by OpenStreetMap, under ODbL.

Table 1. About the area. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates. Available at https://data.census.gov; PLACES Project. Centers for Disease Control and Prevention. Available at https://www.cdc.gov/places; and National Center for Health Statistics. U.S. Small-Area Life Expectancy Estimates Project (USALEEP): Life Expectancy Estimates Files, 2010–2015. National Center for Health Statistics. 2018. Available at https://www.cdc.gov/nchs/nvss/usaleep/usaleep.html

Table 2. Population by race/ethnicity, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Figure 2. Population by race/ethnicity and age group, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Figure 3. Linguistic isolation by race/ethnicity, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Table 3. Homeownership rate by race/ethnicity of head of household, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Figure 4. Homeownership rates by age and race/ethnicity of head of household, Charlotte Hungerford HSA (with proxy area), 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year public use microdata sample (PUMS) data, accessed via IPUMS. Steven Ruggles, Sarah Flood, Sophia Foster, Ronald Goeken, Jose Pacas, Megan Schouweiler and Matthew Sobek. IPUMS USA: Version 11.0 [dataset]. Minneapolis, MN: IPUMS, 2021. https://doi.org/10.18128/D010.V11.0

Figure 5. Housing cost-burden rates by race/ethnicity, Charlotte Hungerford HSA (with proxy area), 2019. DataHaven analysis (2021) of Ruggles, et al. (2019).

Table 4. Overcrowded households by race/ethnicity of head of household, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Figure 6. Public K–12 student enrollment by race/ethnicity per 100 students, 2019–2020. DataHaven analysis (2021) of 2019–2020 school year enrollment data from the Connecticut State Department of Education, accessed via EdSight at http://edsight.ct.gov

Figure 7. Selected academic and disciplinary outcomes by student race/ethnicity, 2018–2019. DataHaven analysis (2021) of 2018–2019 school year testing (8th grade English/language arts), discipline, and four-year graduation data from the Connecticut State Department of Education, accessed via EdSight.

Figure 8. Educational attainment by race/ethnicity, share of adults ages 25 and up, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Table 5. Jobs and wages in Charlotte Hungerford HSA's 5 largest sectors, 2019. DataHaven analysis (2021) of annual employment data from the Connecticut Department of Labor. Available at https://www1.ctdol.state.ct.us/lmi/202/202_annualaverage.asp

Figure 9. Unemployment rate by race/ethnicity, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Table 6. Selected household economic indicators by race/ethnicity of head of household, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Table 7. Households with no vehicle at home by race/ethnicity of head of household (with proxy area), 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Figure 10. Distribution of population by neighborhood income level, Charlotte Hungerford HSA, 1980–2019. DataHaven analysis (2021) of household income and population by Census tract. Values for 1980–2000 are from the US Census Bureau Decennial Census, provided by the Neighborhood Change Database (NCDB) created by GeoLytics and the

Urban Institute with support from the Rockefeller Foundation (2012). 2019 values are calculated from US Census Bureau American Community Survey 2019 5-year estimates.

Figure 11. Life expectancy, Charlotte Hungerford HSA by Census tract, 2015. Data from National Center for Health Statistics. U.S. Small-Area Life Expectancy Estimates Project (USALEEP): Life Expectancy Estimates Files, 2010–2015. National Center for Health Statistics. 2018. Available at https://www.cdc.gov/nchs/nvss/usaleep/usaleep.html

Figure 12. Uninsured rate among adults ages 19–64 by race/ethnicity, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Figure 13. Preventive care measures, share of adults by Census tract, Charlotte Hungerford HSA. Data from PLACES Project. Centers for Disease Control and Prevention.

Figure 14. Selected health risk factors, share of adults, 2015–2018. DataHaven analysis (2021) of 2015 & 2018 DataHaven Community Wellbeing Survey. Available at https://ctdatahaven.org/reports/datahaven-community-wellbeing-survey

Figure 15. Chronic disease prevalence, share of adults by Census tract, Charlotte Hungerford HSA. Data from PLACES Project. Centers for Disease Control and Prevention.

Table 8. Selected mental health indicators, share of adults, 2015–2018. DataHaven analysis (2021) of 2015 & 2018 DataHaven Community Wellbeing Survey.

Figure 16. Age-adjusted monthly rates of drug overdose deaths per 100,000 residents by race/ethnicity, 6-month rolling averages, 2015–2020. DataHaven analysis (2021) of Accidental Drug Related Deaths 2012–2018. Connecticut Office of the Chief Medical Examiner. Available at https://data.ct.gov/resource/rybz-nyjw. Rates are weighted with the U.S. Centers for Disease Control and Prevention (CDC) 2000 U.S. Standard Population 18 age group weights available at https://seer.cancer.gov/stdpopulations

Figure 17. Share of drug overdose deaths involving fentanyl, 2015–2020. DataHaven analysis (2021) of Accidental Drug Related Deaths 2012–2018. Connecticut Office of the Chief Medical Examiner.

Figure 18. Annualized average rates of new cases of selected sexually transmitted infections per 100,000 residents, 2001–2003 through 2016–2018. DataHaven analysis (2021) of data from Centers for Disease Control and Prevention. NCHHSTP AtlasPlus. Updated 2019. https://www.cdc.gov/nchhstp/atlas/index.htm

Figure 19. Annualized average rate of new HIV diagnoses per 100,000 residents ages 13 and over, 2016–2018. DataHaven analysis (2021) of data from Centers for Disease Control and Prevention. NCHHSTP AtlasPlus.

Table 9. Selected birth outcomes by race/ethnicity of parent giving birth, 2016–2018. DataHaven analysis (2021) of data from the Connecticut Department of Public Health Vital Statistics. Retrieved from https://portal.ct.gov/DPH/Health-Information-Systems--Reporting/Hisrhome/Vital-Statistics-Registration-Reports

Figure 20. Maternal mortality rate per 100k births, Connecticut, 2013–2017. America's Health Rankings analysis of CDC WONDER Online Database, Mortality files, United Health Foundation. Retrieved from https://www.americashealthrankings.org

Table 10. Households living in structures built before 1960 by race/ethnicity of head of household (with proxy area), 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Figure 21. Residents' ratings of community cohesion measures, share of adults, 2015–2018. DataHaven analysis (2021) of 2015 & 2018 DataHaven Community Wellbeing Survey.

Figure 22. Part I crime rates per 100,000 residents by town / jurisdiction, 2019. DataHaven analysis (2021) of 2019 Crimes Analysis Offenses. Connecticut Department of Emergency Services and Public Protection. Available at https://portal.ct.gov/DESPP/Division-of-State-Police/Crimes-Analysis-Unit/Crimes-Analysis-Unit

Table 11. Residents' ratings of local government, share of adults, 2015–2018. DataHaven analysis (2021) of 2015 & 2018 DataHaven Community Wellbeing Survey.

Figure 23. Registered voter turnout, 2018–2020. DataHaven analysis (2021) of data from the Connecticut Office of the Secretary of the State Elections Management System. Available at https://ctemspublic.pcctg.net

Figure 24. EPA Environmental Justice Index by block group, Charlotte Hungerford HSA. United States Environmental Protection Agency. 2019 version. EJSCREEN. Retrieved from https://www.epa.gov/ejscreen

Figure 25. Residents' ratings of local walkability measures by race/ethnicity, share of adults, 2015–2018. DataHaven analysis (2021) of 2015 & 2018 DataHaven Community Wellbeing Survey.

APPENDIX C – INTERVIEWEE ORGANIZATIONS

Interviewee Organizational Affiliations

Organization
Brooker Memorial
Center for Healthy Aging
Charlotte Hungerford Hospital Emergency Department
Community Health & Wellness Center (CHWC)
Connecticut Alliance for Basic Human Needs
Department of Social Services, Town of Winchester
FoodShare/CT Food Bank
McCall Center for Behavioral Health
New Opportunities, Inc.
Northwestern Connecticut YMCA
Our Culture is Beautiful
Prime Time House
Sullivan Senior Center
Torrington Area Health District
United Way of Central and Northeastern Connecticut

APPENDIX D – IMPACT EVALUATION

Charlotte Hungerford Impact Statement 2021

Promote Healthy Behaviors and Lifestyles- improve physical activity opportunities

- Sue Grossman Greenway Linear Fitness Park - Increase percentage of adults and children meeting recommended exercise requirements

  Six pieces of exercise equipment installed along existing Sue Grossman Greenaway in Torrington November 2019 with a soft ribbon cutting during COVID summer 2020

  Impact: SGG > 50,000 trips/year

Reduce the Burden of Chronic Disease

- Diabetes Boot Camp - Increase participation in chronic disease management programs

  Provided an annual intensive, programmed, 3-day weekend retreat for Type 1 and 2 diabetes patients. Featuring lectures, equipment demonstrations, group education sessions, nutrition and exercise instruction and glucose monitoring. With increased participation seen before COVID.

  Impact: 13 PP per year (cancelled Sept 2020 due to COVID)

Improve Coordination of Services and Access to Care

- Regional Medically Certified Interpreters - Increase # of Medical Interpreters from 3 to 5.

  Currently have 4 certified interpreters.

  Impact: FY19 - 149 Interpretations, Total of 197 hours
  FY20 – 196 Interpretations, total of 269 hours

Enhance Community-Based Behavioral Health Services

- Medication-assisted treatment (MAT) Program - Improve access to MAT providers in NWCT to rapidly respond to community and ED referrals for those individuals seeking Suboxone treatment or follow-up from an ED Suboxone induction.

  Impact: The number of non-profit and private agencies that provide MAT services in Torrington and surrounding towns has increased to 12.