

# 2016 Community Health Needs Assessment Report

## Manchester Memorial Hospital Service Area

---

*Prepared for:*

Eastern Connecticut Health Network | Manchester Memorial Hospital

*By:*

Professional Research Consultants, Inc.  
11326 P Street Omaha, NE 68136-2316  
[www.PRCCustomResearch.com](http://www.PRCCustomResearch.com)

---

2016-4449-02  
© October 2016



**Professional Research Consultants, Inc.**

---

# Table of Contents

<b>Introduction</b>	<b>6</b>
<b>Project Overview</b>	<b>7</b>
Project Goals	7
Methodology	8
<b>Summary of Findings</b>	<b>15</b>
Significant Health Needs of the Community	15
Summary Tables: Comparisons With Benchmark Data	17
<b>Community Description</b>	<b>33</b>
<b>Population Characteristics</b>	<b>34</b>
Total Population	34
Urban/Rural Population	36
Age	37
Race & Ethnicity	39
Linguistic Isolation	42
<b>Social Determinants of Health</b>	<b>43</b>
Poverty	43
Education	46
Employment	47
Housing Insecurity	47
Food Insecurity	48
<b>General Health Status</b>	<b>51</b>
<b>Overall Health Status</b>	<b>52</b>
Evaluation of Health Status	52
Activity Limitations	54
Caregiving	56
<b>Mental Health</b>	<b>58</b>
Evaluation of Mental Health Status	59
Depression	60
Stress	62
Suicide	63
Mental Health Treatment	64
Key Informant Input: Mental Health	66
<b>Death, Disease &amp; Chronic Conditions</b>	<b>67</b>
<b>Leading Causes of Death</b>	<b>68</b>
Distribution of Deaths by Cause	68

Age-Adjusted Death Rates for Selected Causes	68
<b>Cardiovascular Disease</b>	<b>70</b>
Age-Adjusted Heart Disease & Stroke Deaths	70
Prevalence of Heart Disease & Stroke	73
Cardiovascular Risk Factors	75
Key Informant Input: Heart Disease & Stroke	81
<b>Cancer</b>	<b>82</b>
Age-Adjusted Cancer Deaths	82
Cancer Incidence	85
Prevalence of Cancer	86
Cancer Screenings	87
Key Informant Input: Cancer	92
<b>Respiratory Disease</b>	<b>94</b>
Age-Adjusted Respiratory Disease Deaths	95
Key Informant Input: Respiratory Disease	99
<b>Injury &amp; Violence</b>	<b>101</b>
Unintentional Injury	101
Intentional Injury (Violence)	108
Key Informant Input: Injury & Violence	113
<b>Diabetes</b>	<b>114</b>
Age-Adjusted Diabetes Deaths	114
Prevalence of Diabetes	116
Key Informant Input: Diabetes	118
<b>Alzheimer's Disease</b>	<b>119</b>
Age-Adjusted Alzheimer's Disease Deaths	119
Progressive Confusion/Memory Loss	120
Key Informant Input: Dementias, Including Alzheimer's Disease	121
<b>Kidney Disease</b>	<b>123</b>
Age-Adjusted Kidney Disease Deaths	123
Prevalence of Kidney Disease	124
Key Informant Input: Chronic Kidney Disease	125
<b>Potentially Disabling Conditions</b>	<b>126</b>
Arthritis, Osteoporosis, & Chronic Back Conditions	126
Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions	127
Vision & Hearing Impairment	129
Key Informant Input: Hearing & Vision	130
<b>Infectious Disease</b>	<b>131</b>
<b>Influenza &amp; Pneumonia Vaccination</b>	<b>132</b>
Flu Vaccinations	132

Pneumonia Vaccination	133
<b>HIV</b>	<b>134</b>
HIV Prevalence	135
HIV Testing	136
Key Informant Input: HIV/AIDS	137
<b>Sexually Transmitted Diseases</b>	<b>138</b>
Chlamydia & Gonorrhea	138
Safe Sexual Practices	139
Key Informant Input: Sexually Transmitted Diseases	140
<b>Immunization &amp; Infectious Diseases</b>	<b>141</b>
Key Informant Input: Immunization & Infectious Diseases	141
<b>Births</b>	<b>142</b>
<b>Prenatal Care</b>	<b>143</b>
<b>Birth Outcomes &amp; Risks</b>	<b>145</b>
Low-Weight Births	145
Infant Mortality	145
Key Informant Input: Infant & Child Health	147
<b>Family Planning</b>	<b>148</b>
Births to Teen Mothers	148
Key Informant Input: Family Planning	149
<b>Modifiable Health Risks</b>	<b>151</b>
<b>Actual Causes of Death</b>	<b>152</b>
<b>Nutrition</b>	<b>153</b>
Daily Recommendation of Fruits/Vegetables	154
Access to Fresh Produce	155
Sugar-Sweetened Beverages	158
<b>Physical Activity</b>	<b>160</b>
Leisure-Time Physical Activity	160
Activity Levels	162
Access to Physical Activity	165
<b>Weight Status</b>	<b>166</b>
Adult Weight Status	166
Children's Weight Status	171
Key Informant Input: Nutrition, Physical Activity & Weight	172
<b>Sleep</b>	<b>174</b>
<b>Substance Abuse</b>	<b>176</b>
Age-Adjusted Cirrhosis/Liver Disease Deaths	176
Alcohol Use	178
Age-Adjusted Drug-Induced Deaths	179

Illicit Drug Use	180
Alcohol & Drug Treatment	182
Negative Effects of Substance Abuse	182
Key Informant Input: Substance Abuse	184
<b>Tobacco Use</b>	<b>186</b>
Cigarette Smoking	186
Other Tobacco Use	189
Key Informant Input: Tobacco Use	190
<b>Access to Health Services</b>	<b>192</b>
<b>Health Insurance Coverage</b>	<b>193</b>
Type of Healthcare Coverage	193
Lack of Health Insurance Coverage	194
<b>Difficulties Accessing Healthcare</b>	<b>195</b>
Difficulties Accessing Services	195
Barriers to Healthcare Access	196
Accessing Healthcare for Children	198
Key Informant Input: Access to Healthcare Services	199
<b>Health Literacy</b>	<b>201</b>
Understanding Health Information	201
Completing Health Forms	202
Population With Low Health Literacy	203
<b>Primary Care Services</b>	<b>204</b>
Access to Primary Care	204
Specific Source of Ongoing Care	205
Utilization of Primary Care Services	206
<b>Emergency Room Utilization</b>	<b>208</b>
<b>Advance Directives</b>	<b>210</b>
<b>Oral Health</b>	<b>212</b>
Dental Insurance	212
Dental Care	214
Key Informant Input: Oral Health	216
<b>Vision Care</b>	<b>217</b>
<b>Local Resources</b>	<b>218</b>
<b>Perceptions of Local Healthcare Services</b>	<b>219</b>
<b>Healthcare Resources &amp; Facilities</b>	<b>221</b>
Hospitals & Federally Qualified Health Centers (FQHCs)	221
Health Professional Shortage Areas (HPSAs)	222
<b>Resources Available to Address the Significant Health Needs</b>	<b>223</b>

# Introduction



**Professional Research Consultants, Inc.**

## Project Overview

### Project Goals

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

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- **To improve residents' health status, increase their life spans, and elevate their overall quality of life.** A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.
- **To increase accessibility to preventive services for all community residents.** More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

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

## Methodology

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

### PRC Community Health Survey

#### *Survey Instrument*

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

#### *Community Defined for This Assessment*

The study area for the survey effort (referred to as the “MMH Service Area” in this report) includes ZIP Codes 06042 and 06040 in Hartford County, Connecticut. This community definition, determined based on the ZIP Codes of residence of recent patients of Manchester Memorial Hospital, is illustrated in the following map.





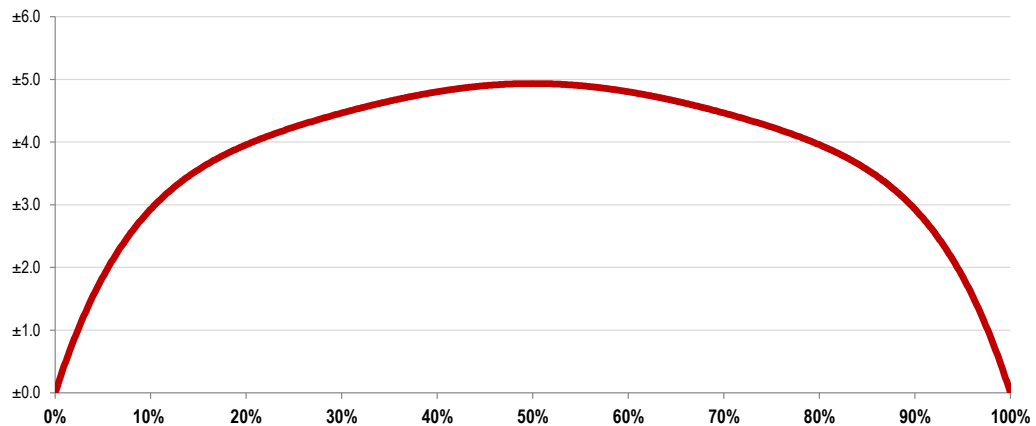
### Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed a telephone methodology was implemented, including surveys conducted via landline and cell phone.

The sample design used for this effort consisted of a random sample of 400 individuals age 18 and older in the MMH Service Area. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

For statistical purposes, the maximum rate of error associated with a sample size of 400 respondents is  $\pm 4.9\%$  at the 95 percent level of confidence.

### Expected Error Ranges for a Sample of 400 Respondents at the 95 Percent Level of Confidence



- Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.
- Examples:
- If 10% of the sample of 400 respondents answered a certain question with a "yes," it can be asserted that between 7.1% and 12.9% ( $10\% \pm 2.9\%$ ) of the total population would offer this response.
  - If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 45.1% and 54.9% ( $50\% \pm 4.9\%$ ) of the total population would respond "yes" if asked this question.

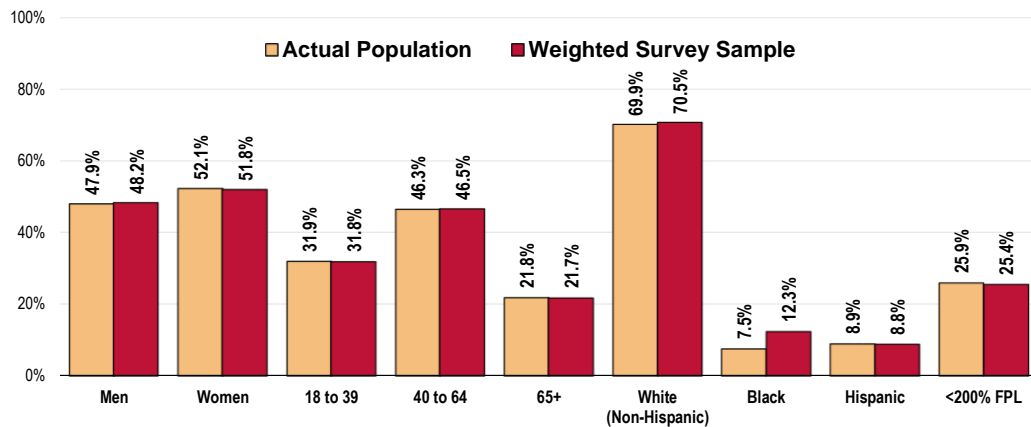
### Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. And, while this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely gender, age, race, ethnicity, and poverty status) and a statistical application package applies weighting variables that produce a sample which more closely matches the population for

these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

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

### Population & Survey Sample Characteristics (MMH Service Area, 2016)



Sources:   
 • Census 2010, Summary File 3 (SF 3). US Census Bureau.   
 • 2016 PRC Community Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2016 guidelines place the poverty threshold for a family of four at \$24,300 annual household income or lower). In sample segmentation: “**low income**” refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice the poverty threshold; “**mid/high income**” refers to those households living on incomes which are twice or more the federal poverty level.

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

### Online Key Informant Survey

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

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 20 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation		
Key Informant Type	Number Invited	Number Participating
Physicians	1	1
Public Health Experts	2	2
Other Health Providers	10	3
Social Service Representatives	7	1
Other Community Leaders	24	13

Final participation included representatives of the organizations outlined below.

- Community Health Resources (CHR)
- First Choice Health Centers, Inc.
- Healthwise Medical Associates, LLP
- Highland Park Market
- Lion Heart Health & Fitness
- Manchester Community Services Council
- Manchester Public Schools
- Manchester School Readiness Council
- Manchester Senior, Adult & Family Services
- Manchester Youth Services Bureau
- Paradigm Chiropractic & Functional Medicine
- PROHealth Chiropractic Center
- Town of Manchester Health Department
- Town of Manchester Senior Center
- Waverly Markets LLC, ShopRite of East Hartford
- WIC Program

Through this process, input was gathered from several individuals whose organizations work with low-income, minority populations, or other medically underserved populations.

**Minority/medically underserved populations represented:**

*African-Americans, the disabled, the elderly, Hispanics, homeless individuals, Indian, those lacking transportation, low income residents, Medicare/Medicaid recipients, those of mixed race, non-English speaking individuals, single parents, undocumented individuals, those who are uneducated, unemployed individuals, the uninsured/underinsured, veterans*

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

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

**Public Health, Vital Statistics & Other Data**

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

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

- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect Hartford County data. Where available, data for the city of Manchester is also included.

## Benchmark Data

### *Connecticut Risk Factor Data*

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

### *Nationwide Risk Factor Data*

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2015 PRC National Health Survey*, the methodological approach for the national study is identical to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

### *Healthy People 2020*

Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:



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

Healthy People strives to:

- Identify nationwide health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.
- Provide measurable objectives and goals that are applicable at the national, State, and local levels.
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
- Identify critical research, evaluation, and data collection needs.

### Determining Significance

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

### Information Gaps

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

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

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

## Summary of Findings

### Significant Health Needs of the Community

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

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue.

Areas of Opportunity Identified Through This Assessment	
<b>Access to Healthcare Services</b>	<ul style="list-style-type: none"> <li>• Cost of Prescriptions</li> <li>• Skipping/Stretching Prescriptions</li> </ul>
<b>Cancer</b>	<ul style="list-style-type: none"> <li>• <i>Cancer is a leading cause of death</i></li> <li>• Prostate and Female Breast Cancer Incidence</li> <li>• <i>Cancer ranked as a top concern in the Online Key Informant Survey.</i></li> </ul>
<b>Chronic Kidney Disease</b>	<ul style="list-style-type: none"> <li>• Kidney Disease Deaths</li> </ul>
<b>Diabetes</b>	<ul style="list-style-type: none"> <li>• Diabetes Prevalence</li> </ul>
<b>Heart Disease &amp; Stroke</b>	<ul style="list-style-type: none"> <li>• <i>Cardiovascular disease is a leading cause of death</i></li> <li>• High Blood Pressure Prevalence</li> <li>• <i>Heart Disease &amp; Stroke ranked as a top concern in the Online Key Informant Survey.</i></li> </ul>
<b>HIV/AIDS</b>	<ul style="list-style-type: none"> <li>• HIV Prevalence</li> </ul>
<b>Infant Health &amp; Family Planning</b>	<ul style="list-style-type: none"> <li>• Low-Weight Births</li> <li>• Infant Mortality</li> </ul>
<b>Injury &amp; Violence</b>	<ul style="list-style-type: none"> <li>• <i>Injury &amp; Violence ranked as a top concern in the Online Key Informant Survey.</i></li> </ul>
<b>Mental Health</b>	<ul style="list-style-type: none"> <li>• Diagnosed Depression</li> <li>• <i>Mental Health ranked as a top concern in the Online Key Informant Survey.</i></li> </ul>
<b>Nutrition, Physical Activity &amp; Weight</b>	<ul style="list-style-type: none"> <li>• Low Food Access</li> <li>• Overweight &amp; Obesity [Adults]</li> <li>• <i>Nutrition, Physical Activity &amp; Weight ranked as a top concern in the Online Key Informant Survey.</i></li> </ul>

—continued on next page—

<b>Areas of Opportunity (continued)</b>	
<b>Potentially Disabling Conditions</b>	<ul style="list-style-type: none"> <li>• Activity Limitations</li> <li>• Arthritis Prevalence (50+)</li> <li>• Blindness/Vision Trouble</li> </ul>
<b>Respiratory Diseases</b>	<ul style="list-style-type: none"> <li>• Asthma Prevalence [Adults]</li> <li>• Asthma Prevalence [Children]</li> <li>• Chronic Obstructive Pulmonary Disease (COPD) Prevalence</li> </ul>
<b>Sexually Transmitted Diseases</b>	<ul style="list-style-type: none"> <li>• Chlamydia Incidence</li> </ul>
<b>Substance Abuse</b>	<ul style="list-style-type: none"> <li>• Drug-Induced Deaths</li> <li>• Negatively Affected by Substance Abuse (Self or Other's)</li> <li>• <i>Substance Abuse ranked as a top concern in the Online Key Informant Survey.</i></li> </ul>



## Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the MMH Service Area, grouped to correspond with the Focus Areas presented in Healthy People 2020.

### *Reading the Summary Tables*

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











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

**Survey Data Indicators:**  
Note that survey data reflect the ZIP Code-defined MMH Service Area.

**Other (Secondary) Data Indicators:** Secondary data reflect county-level data.









**Social Determinants**

Linguistically Isolated Population (Percent)
Population in Poverty (Percent)
Population Below 200% FPL (Percent)
Children Below 200% FPL (Percent)
% Worry/Stress Over Rent/Mortgage in Past Year
No High School Diploma (Age 25+, Percent)
Unemployment Rate (Age 16+, Percent)

















MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
5.4	 4.8	 4.7	
12.1	 10.5	 15.6	
25.9	 23.6	 34.5	
33.6	 29.7	 44.2	
34.3		 31.6	
11.5	 10.5	 13.7	
5.9	 5.6	 5.3	
 better  similar  worse			

**Overall Health**

% "Fair/Poor" Physical Health
% Activity Limitations
% Caregiver to a Friend/Family Member



















MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
18.9	 14.3	 18.3	
26.7	 19.8	 20.0	
22.3		 20.9	
 better  similar  worse			

**Access to Health Services**

	MMH Service Area	MMH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% [Age 18-64] Lack Health Insurance	3.5	 10.6	 10.1	 0.0
% [Insured 18-64] Have Coverage Through ACA	8.2		 10.8	
% [Insured] Deductible or Co-Pay Prevented Medical Care	11.8			
% Difficulty Accessing Healthcare in Past Year (Composite)	37.1		 35.0	
% Inconvenient Hrs Prevented Dr Visit in Past Year	13.6		 14.4	
% Cost Prevented Getting Prescription in Past Year	15.3		 9.5	
% Cost Prevented Physician Visit in Past Year	9.6		 11.5	
% Difficulty Getting Appointment in Past Year	16.1		 15.4	
% Difficulty Finding Physician in Past Year	12.0		 8.7	
% Transportation Hindered Dr Visit in Past Year	6.3		 5.0	
% Language/Culture Prevented Care in Past Year	0.0		 1.7	
% Skipped Prescription Doses to Save Costs	15.4		 10.2	
% Difficulty Getting Child's Healthcare in Past Year	1.9		 3.9	
Primary Care Doctors per 100,000	93.6	 85.2	 75.8	





**Access to Health Services (continued)**




% [Age 18+] Have a Specific Source of Ongoing Care
% [Age 18-64] Have a Specific Source of Ongoing Care
% [Age 65+] Have a Specific Source of Ongoing Care
% Have Had Routine Checkup in Past Year
% Child Has Had Checkup in Past Year
% Two or More ER Visits in Past Year
% Rate Local Healthcare "Fair/Poor"
Live in a Health Professional Shortage Area (Percent)
% Have Completed Advance Directive Documents
% Low Health Literacy

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
<b>80.2</b>	 74.0	 95.0	
<b>81.4</b>	 73.1	 89.4	
<b>75.1</b>	 76.8	 100.0	
<b>81.8</b>	 72.0	 70.5	
<b>95.9</b>	 89.3		
<b>10.0</b>	 8.5		
<b>13.4</b>	 14.2		
<b>29.3</b>	 27.1	 33.1	
<b>39.1</b>	 33.7		
<b>20.0</b>	 23.3		
 better  similar  worse			

**Arthritis, Osteoporosis & Chronic Back Conditions**
























% [50+] Arthritis/Rheumatism
% [50+] Osteoporosis
% Sciatica/Chronic Back Pain

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
39.4		32.0	
10.7		8.7	
24.2		19.4	

 better    
  similar    
  worse

**Cancer**

Cancer (Age-Adjusted Death Rate)
Lung Cancer (Age-Adjusted Death Rate)
Prostate Cancer (Age-Adjusted Death Rate)
Female Breast Cancer (Age-Adjusted Death Rate)
Colorectal Cancer (Age-Adjusted Death Rate)
Prostate Cancer Incidence per 100,000
Female Breast Cancer Incidence per 100,000
Lung Cancer Incidence per 100,000
Colorectal Cancer Incidence per 100,000

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
150.4	 149.0	 163.6	 161.4
36.9	 37.4	 43.4	 45.5
18.5	 17.5	 19.2	 21.8
18.8	 18.5	 20.9	 20.7
12.8	 11.8	 14.6	 14.5
145.5	 139.9	 131.7	
134.0	 137.1	 123.0	
63.7	 63.8	 63.7	
43.1	 41.7	 41.9	

**Cancer (continued)**

Cervical Cancer Incidence per 100,000
% Skin Cancer
% Cancer (Other Than Skin)
% [Women 50-74] Mammogram in Past 2 Years
% [Women 21-65] Pap Smear in Past 3 Years
% [Age 50+] Sigmoid/Colonoscopy Ever
% [Age 50+] Blood Stool Test in Past 2 Years
% [Age 50-75] Colorectal Cancer Screening

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
5.6	6.2	7.7	
7.8	5.8	7.7	
7.7	7.1	7.7	
84.0	83.9	80.3	81.1
90.1	87.4	84.8	93.0
82.9	76.1	75.6	
37.8	15.5	31.8	
78.9	73.1	74.5	70.5

better    similar    worse

**Chronic Kidney Disease**

Kidney Disease (Age-Adjusted Death Rate)
% Kidney Disease

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
14.5	12.4	13.2	
3.4	2.5	3.6	

better    similar    worse

**Dementias, Including Alzheimer's Disease**

Alzheimer's Disease (Age-Adjusted Death Rate)
% [Age 45+] Increasing Confusion/Memory Loss in Past Yr

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
17.0	17.1	24.2	
14.2		12.8	
	better	similar	worse

**Diabetes**

Diabetes Mellitus (Age-Adjusted Death Rate)
% Diabetes/High Blood Sugar
% Borderline/Pre-Diabetes
% [Non-Diabetes] Blood Sugar Tested in Past 3 Years

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
14.4	14.6	21.1	20.5
15.9	9.2	14.5	
7.7		5.7	
54.0		55.1	
	better	similar	worse





**Family Planning**

Teen Births per 1,000 (Age 15-19)
-----------------------------------

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
25.7	20.1	36.6	
	better	similar	worse























**Hearing & Other Sensory or Communication Disorders**

% Deafness/Trouble Hearing
----------------------------

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
10.8		 8.6	
	 better	 similar	 worse

**Heart Disease & Stroke**







Diseases of the Heart (Age-Adjusted Death Rate)
Stroke (Age-Adjusted Death Rate)
% Heart Disease (Heart Attack, Angina, Coronary Disease)
% Stroke
% Blood Pressure Checked in Past 2 Years
% Told Have High Blood Pressure (Ever)
% [HBP] Taking Action to Control High Blood Pressure
% Cholesterol Checked in Past 5 Years
% Told Have High Cholesterol (Ever)
% [HBC] Taking Action to Control High Blood Cholesterol
% 1+ Cardiovascular Risk Factor

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
152.8	 149.9	 169.1	 156.9
26.3	 27.2	 36.5	 34.8
9.1		 6.9	
3.1	 2.6	 2.6	
97.8		 93.6	 92.6
43.5	 31.3	 36.5	 26.9
89.2		 92.5	
90.9	 83.1	 87.4	 82.1
38.9		 33.5	 13.5
87.5		 84.2	
84.4		 83.0	
















HIV

HIV Prevalence per 100,000
% [Age 18-44] HIV Test in the Past Year

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
405.7	 335.5	 353.2	
30.4		 21.3	
	 better	 similar	 worse
























Immunization & Infectious Diseases




% [Age 65+] Flu Vaccine in Past Year
% [High-Risk 18-64] Flu Vaccine in Past Year
% [Age 65+] Pneumonia Vaccine Ever
% [High-Risk 18-64] Pneumonia Vaccine Ever

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
64.0	 64.7	 58.9	 70.0
47.2		 48.0	 70.0
89.6	 70.6	 76.3	 90.0
51.2		 38.7	 60.0
	 better	 similar	 worse

**Injury & Violence Prevention**












Unintentional Injury (Age-Adjusted Death Rate)
Motor Vehicle Crashes (Age-Adjusted Death Rate)
[65+] Falls (Age-Adjusted Death Rate)
% [Age 45+] Fell in the Past Year
Firearm-Related Deaths (Age-Adjusted Death Rate)
% Firearm in Home
% [Homes With Children] Firearm in Home
% [Homes With Firearms] Weapon(s) Unlocked & Loaded
Homicide (Age-Adjusted Death Rate)
Violent Crime per 100,000
% Victim of Violent Crime in Past 5 Years
% Perceive Neighborhood as "Slightly/Not At All Safe"
% Victim of Domestic Violence (Ever)

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
<b>39.9</b>	 38.3	 39.7	 36.4
<b>8.0</b>	 7.5	 10.6	 12.4
<b>52.4</b>	 54.4	 57.0	
<b>27.9</b>		 28.2	
<b>5.6</b>	 5.3	 10.4	 9.3
<b>10.3</b>		 33.8	
<b>12.0</b>		 31.0	
<b>13.2</b>		 20.4	
<b>4.2</b>	 3.4	 5.2	 5.5
<b>323.2</b>	 280.6	 395.5	
<b>1.9</b>		 2.3	
<b>15.9</b>		 15.3	
<b>11.3</b>		 15.1	

 better   
  similar   
  worse














**Maternal, Infant & Child Health**

No Prenatal Care in First Trimester (Percent)
Low Birthweight Births (Percent)
Infant Death Rate




















MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
12.9	 12.8		 22.1
8.3	 7.8	 8.0	 7.8
6.7	 5.9	 6.5	 6.0
	 better	 similar	 worse

**Mental Health & Mental Disorders**

% "Fair/Poor" Mental Health
% Diagnosed Depression
% Symptoms of Chronic Depression (2+ Years)
Suicide (Age-Adjusted Death Rate)
% Have Ever Sought Help for Mental Health
% [Those With Diagnosed Depression] Seeking Help
% Taking Rx/Receiving Mental Health Trtmt
% Unable to Get Mental Health Svcs in Past Yr
% Typical Day Is "Extremely/Very" Stressful
% Average <7 Hours of Sleep per Night













MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
9.1		 15.5	
23.3	 18.3	 17.9	
30.3		 29.9	
8.9	 9.5	 12.7	 10.2
35.3		 27.4	
93.2		 91.7	
17.3		 13.6	
3.6		 4.4	
10.8		 11.7	
39.8		 39.5	




**Nutrition, Physical Activity & Weight**

	MMH Service Area	MMH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% Eat 5+ Servings of Fruit or Vegetables per Day	35.1			
			27.4	
% "Very/Somewhat" Difficult to Buy Fresh Produce	22.8			
			21.9	
Population With Low Food Access (Percent)	30.6			
		29.8	23.6	
% Food Insecure	21.6			
			25.9	
% 7+ Sugar-Sweetened Drinks in Past Week	31.0			
			30.2	
% Healthy Weight (BMI 18.5-24.9)	27.0			
		38.1	32.9	33.9
% Overweight (BMI 25+)	72.1			
		60.4	65.2	
% Obese (BMI 30+)	35.4			
		26.3	33.4	30.5
% Medical Advice on Weight in Past Year	26.4			
			20.4	
% [Overweights] Counseled About Weight in Past Year	33.0			
			27.1	
% [Obese Adults] Counseled About Weight in Past Year	41.6			
			40.8	
% Medical Resources for Wt Mgmt Are Insufficient/Unavailable	18.0			
% [Overweights] Trying to Lose Weight Both Diet/Exercise	61.6			
			57.0	
% Child [Age 5-17] Healthy Weight	52.9			
			67.2	

**Nutrition, Physical Activity & Weight (continued)**







% Children [Age 5-17] Overweight (85th Percentile)
% Children [Age 5-17] Obese (95th Percentile)
% No Leisure-Time Physical Activity
% Meeting Physical Activity Guidelines
Recreation/Fitness Facilities per 100,000
% Child [Age 2-17] Physically Active 1+ Hours per Day




MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
28.3		 24.2	
19.9		 9.5	 14.5
18.7	 20.6	 27.9	 32.6
22.2	 20.8	 23.6	 20.1
13.3	 13.4	 9.7	
74.8		 47.9	

 better   
  similar   
  worse

**Oral Health**

% [Age 18+] Dental Visit in Past Year
% Child [Age 2-17] Dental Visit in Past Year
% Have Dental Insurance

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
78.5	 74.9	 67.2	 49.0
89.9		 90.7	 49.0
79.6		 66.5	

 better   
  similar   
  worse

**Respiratory Diseases**

CLRD (Age-Adjusted Death Rate)
Pneumonia/Influenza (Age-Adjusted Death Rate)
% COPD (Lung Disease)
% [Adult] Currently Has Asthma
% [Child 0-17] Currently Has Asthma

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
28.9	30.3	41.4	
14.1	12.4	15.1	
9.5	5.1	9.5	
14.7	9.2	9.5	
14.7		6.5	
	better	similar	worse















**Sexually Transmitted Diseases**




Gonorrhea Incidence per 100,000
Chlamydia Incidence per 100,000
% [Unmarried 18-64] 3+ Sexual Partners in Past Year
% [Unmarried 18-64] Using Condoms

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
89.7	64.9	110.7	
462.4	369.0	456.1	
6.1		10.3	
34.1		44.5	
	better	similar	worse

**Substance Abuse**







Cirrhosis/Liver Disease (Age-Adjusted Death Rate)
% Current Drinker
% Excessive Drinker
% Drinking & Driving in Past Month
Drug-Induced Deaths (Age-Adjusted Death Rate)
% Illicit Drug Use in Past Month
% Used Opiates or Opioids in the Past Year
% Life Negatively Affected by Substance Abuse

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
8.2	 8.0	 10.2	 8.2
61.7	 60.8	 59.7	
17.3		 22.2	 25.4
0.4		 4.1	
16.2	 15.6	 14.6	 11.3
0.9		 3.0	 7.1
17.7			
38.6		 32.2	

 better   
  similar   
  worse










**Tobacco Use**

% Current Smoker
% Someone Smokes at Home
% [Nonsmokers] Someone Smokes in the Home
% [Household With Children] Someone Smokes in the Home

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
13.2	 15.4	 14.0	 12.0
8.9		 10.2	
4.8		 3.9	
3.0		 10.2	







**Tobacco Use (continued)**

% Smoke Cigars
% Use Smokeless Tobacco
% Currently Use Electronic Cigarettes

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
5.5		 3.6	 0.2
1.6	 1.8	 3.0	 0.3
1.0	 3.8		
 better  similar  worse			

**Vision**

% Blindness/Trouble Seeing
% Eye Exam in Past 2 Years

MMH Service Area	MMH Service Area vs. Benchmarks		
	vs. CT	vs. US	vs. HP2020
9.8	 3.3	 7.3	
79.8	 59.3		
 better  similar  worse			



# Community Description



**Professional Research Consultants, Inc.**

## Population Characteristics

### Total Population

The community examined for this assessment is within Hartford County, which encompasses 735.1 square miles and houses a total population of 897,374 residents, according to latest census estimates.

**Total Population**  
(Estimated Population, 2010-2014)

	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
<b>Manchester</b>	58,106	n/a	n/a
<b>Hartford County</b>	897,374	735.1	1,220.75
<b>Connecticut</b>	3,592,053	4,842.65	741.75
<b>United States</b>	314,107,083	3,531,932.26	88.93

Sources: 

- Community Commons. Retrieved August 2016 from <http://www.chna.org>.
- Town data (2014): Connecticut State Department of Public Health.

Notes: 

- Data are derived from the US Census Bureau American Community Survey 5-year estimates (2010-2014).

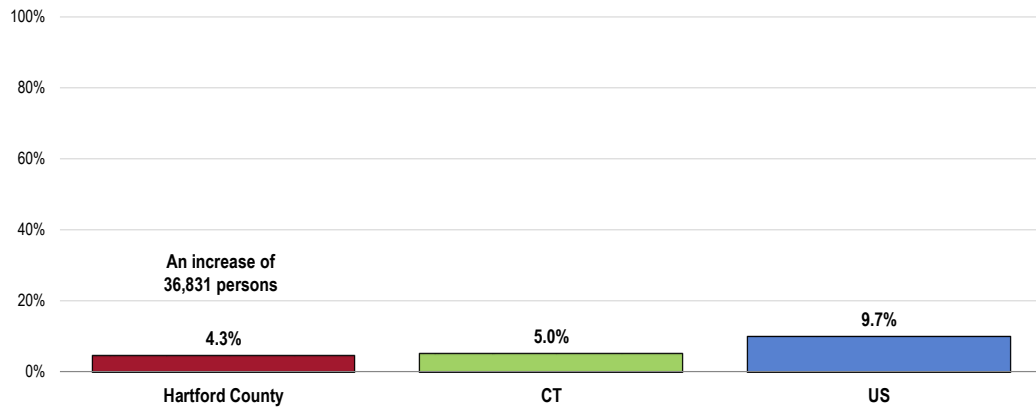
### Population Change 2000-2010

A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

**Between the 2000 and 2010 US Censuses, the population of Hartford County increased by 36,831 persons, or 4.3%.**

- A smaller proportional increase than seen across both the state and the nation overall.

### Change in Total Population (Percentage Change Between 2000 and 2010)



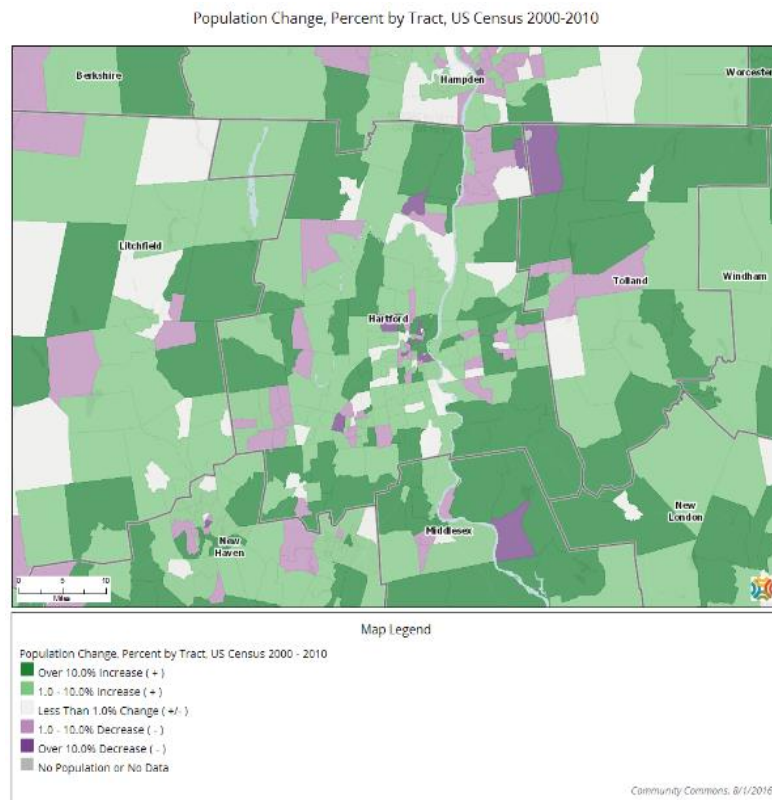
Sources: 

- Retrieved August 2016 from Community Commons at <http://www.chna.org>.
- US Census Bureau Decennial Census (2000-2010).

 Notes: 

- A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

Note the following map of the latest population change by census tract, according to census reports.



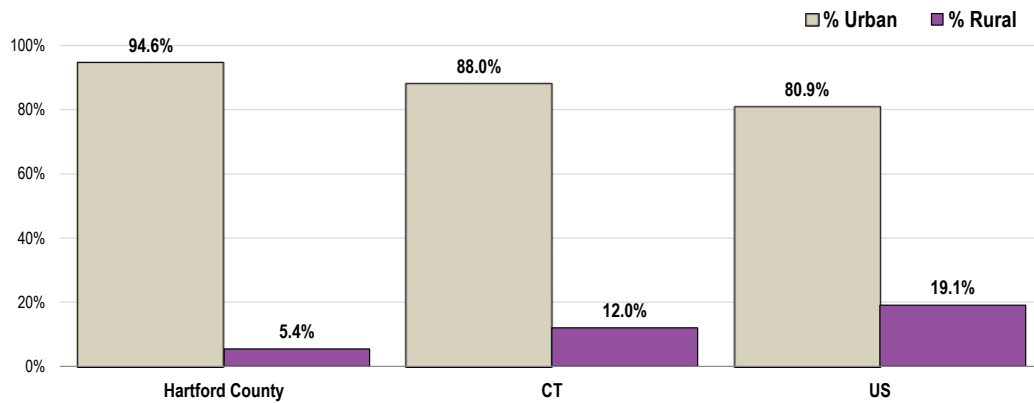
## Urban/Rural Population

Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

**Hartford County is predominantly urban, with 94.6% of the population living in areas designated as urban.**

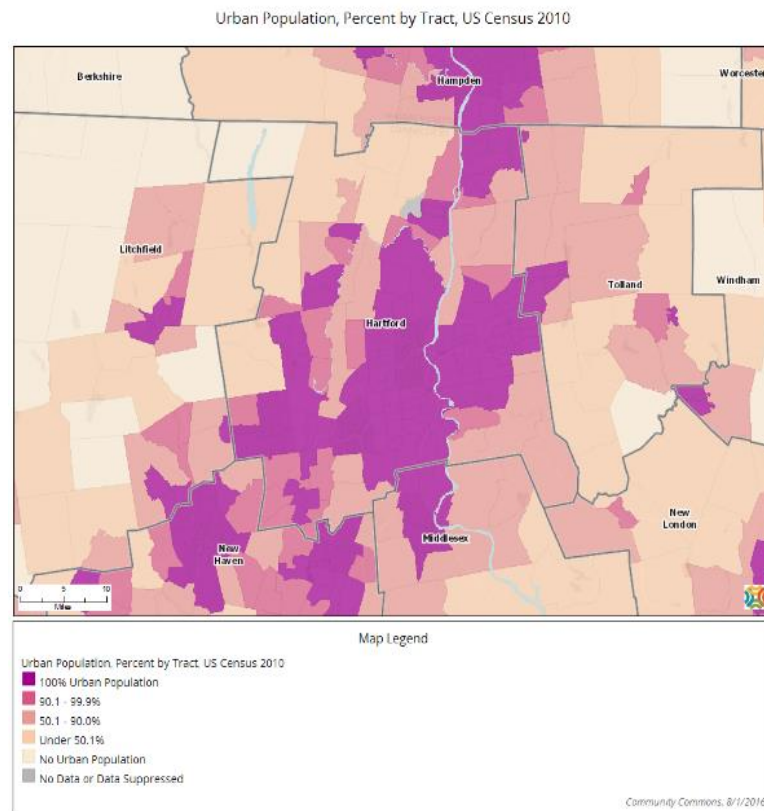
- Note that at least 80% of the state and national populations live in urban areas.

### Urban and Rural Population (2010)



- Sources:
- US Census Bureau Decennial Census (2010).
  - Retrieved August 2016 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator reports the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

- Note the following map outlining the urban population in Hartford County census tracts as of 2010.



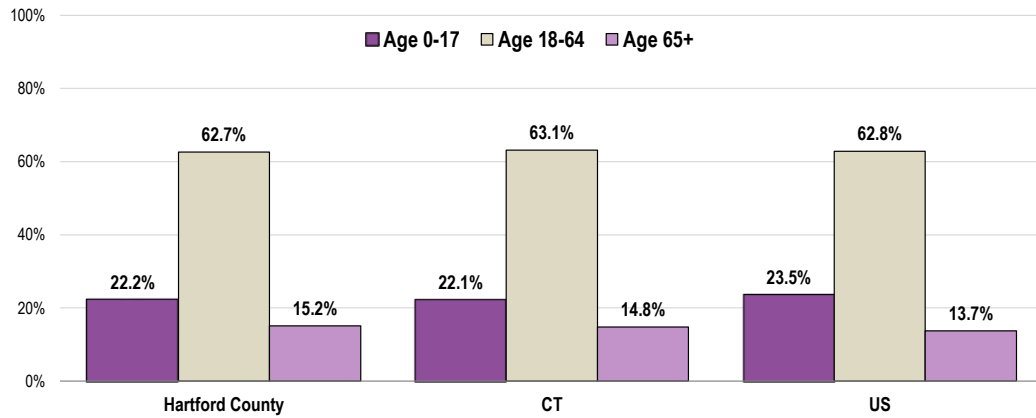
## Age

It is important to understand the age distribution of the population as different age groups have unique health needs which should be considered separately from others along the age spectrum.

**In Hartford County, 22.2% of the population are infants, children or adolescents (age 0-17); another 62.7% are age 18 to 64, while 15.2% are age 65 and older.**

- The breakdown by age is almost identical to that found statewide.
- The percentage of older adults (65+) is higher than the US figure.

### Total Population by Age Groups, Percent (2010-2014)



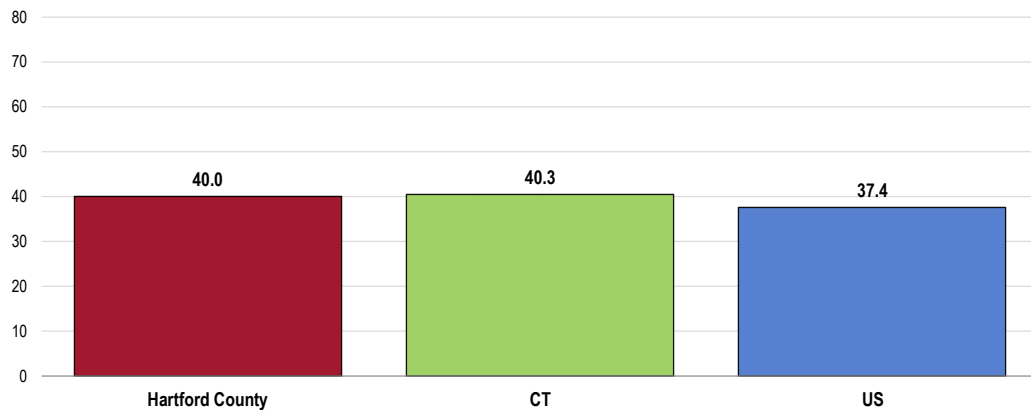
Sources:   
 • US Census Bureau American Community Survey 5-year estimates.   
 • Retrieved August 2016 from Community Commons at <http://www.chna.org>.

### Median Age

The county is slightly “younger” than the state in that the median age is lower.

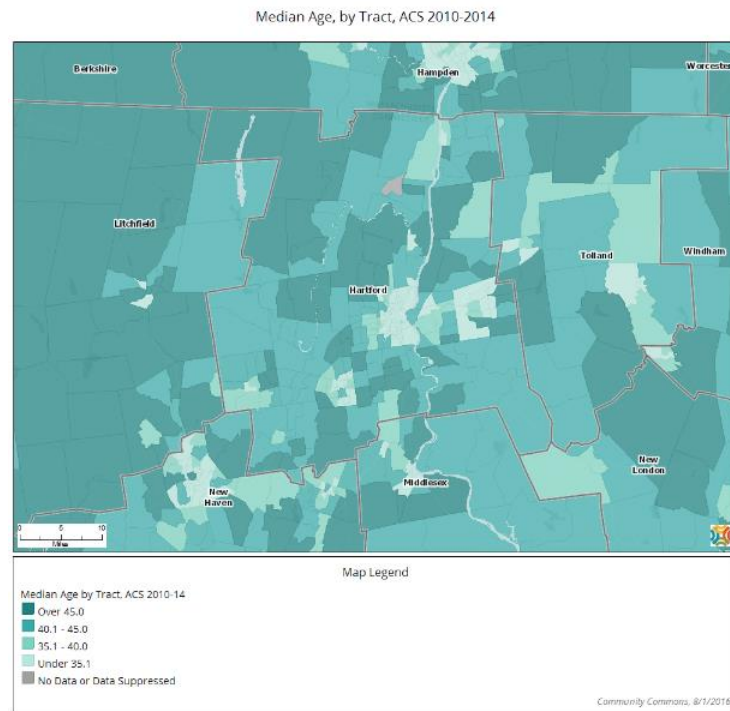
- On the other hand, the county is “older” than the US median age.

### Median Age (2010-2014)



Sources:   
 • US Census Bureau American Community Survey 5-year estimates.   
 • Retrieved August 2016 from Community Commons at <http://www.chna.org>.

- The following map provides an illustration of the median age in Hartford County, segmented by census tract.



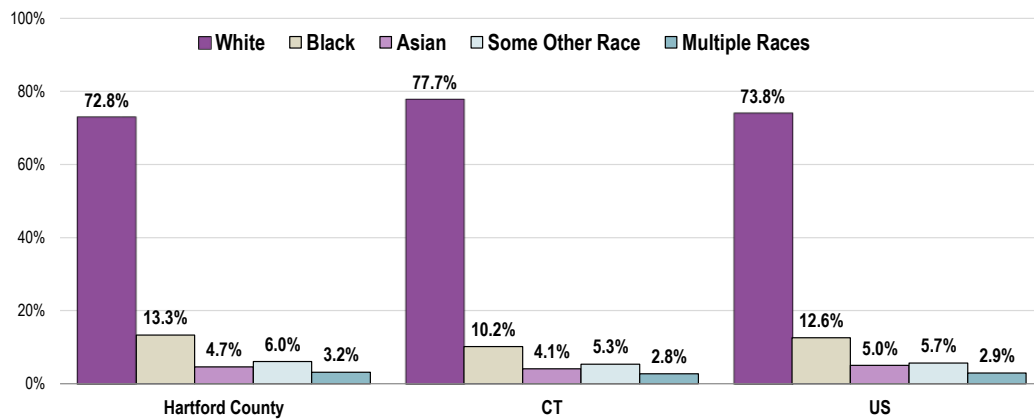
## Race & Ethnicity

### Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 72.8% of Hartford County residents are White and 13.3% are Black.

- This racial distribution is less White and more Black than the state distribution.
- Nationally, the US population is largely similar to Hartford County.

### Total Population by Race Alone, Percent (2010-2014)



Sources:

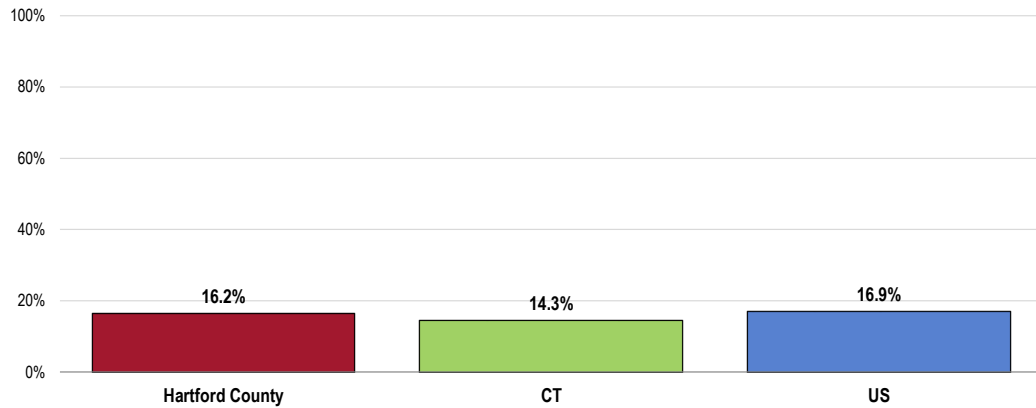
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved August 2016 from Community Commons at <http://www.chna.org>.

## Ethnicity

A total of 16.2% of Hartford County residents are Hispanic or Latino.

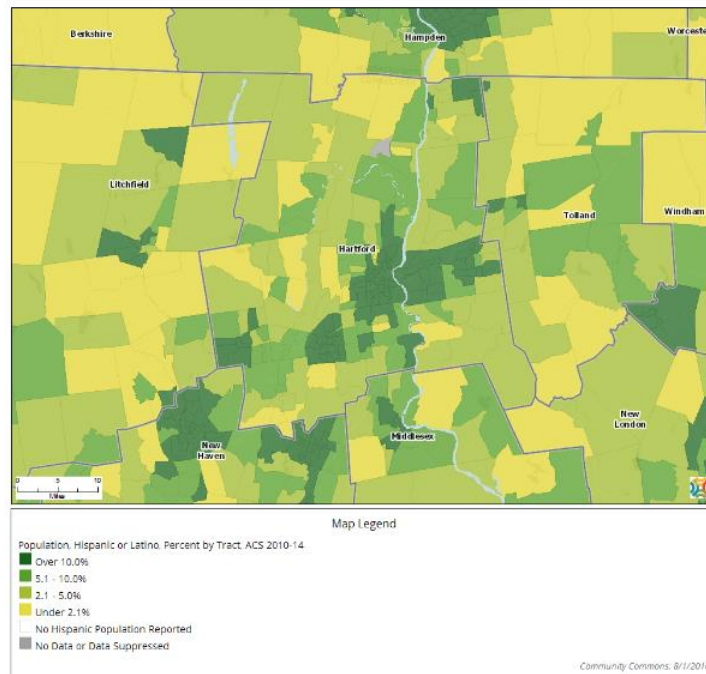
- Higher than the Connecticut proportion.
- Slightly lower than the nationwide percentage.

### Hispanic Population (2010-2014)



- Sources:
- US Census Bureau American Community Survey 5-year estimates.
  - Retrieved August 2016 from Community Commons at <http://www.chna.org>.
- Notes:
- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

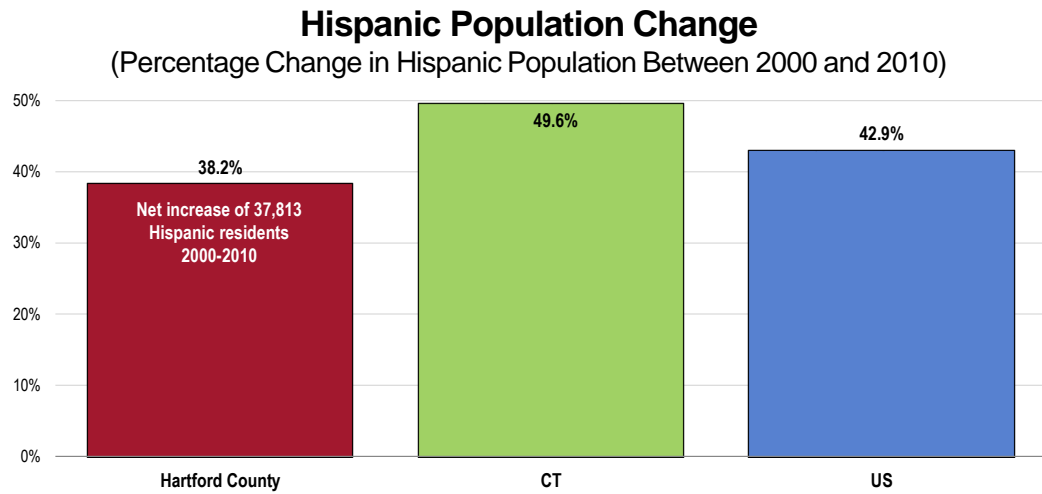
Population Hispanic or Latino, Percent by Tract, ACS 2010-2014





Between 2000 and 2010, the Hispanic population in the county increased by 37,813, or 38.2%.

- Lower (in terms of percentage growth) than found statewide and nationally.



Sources:

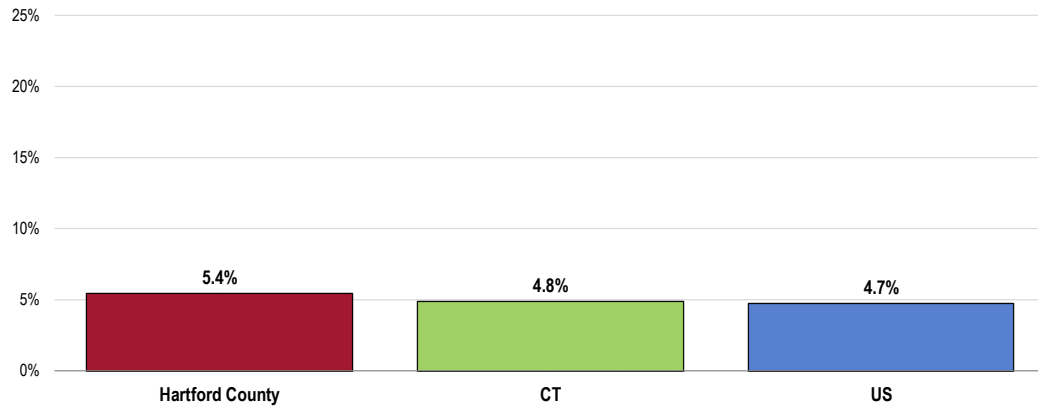
- US Census Bureau Decennial Census (2000-2010).
- Retrieved August 2016 from Community Commons at <http://www.chna.org>.

## Linguistic Isolation

A total of 5.4% of the Hartford County population age 5 and older live in a home in which no persons age 14 or older is proficient in English (speaking only English, or speaking English “very well”).

- Higher than found statewide and nationally.

### Linguistically Isolated Population (2010-2014)



- Sources:
- US Census Bureau American Community Survey 5-year estimates.
  - Retrieved August 2016 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator reports the percentage of the population age 5+ who live in a home in which no person age 14+ speaks only English, or in which no person age 14+ speak a non-English language and speak English “very well.”

- Note the following map illustrating linguistic isolation in Hartford County.



## Social Determinants of Health

### About Social Determinants

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

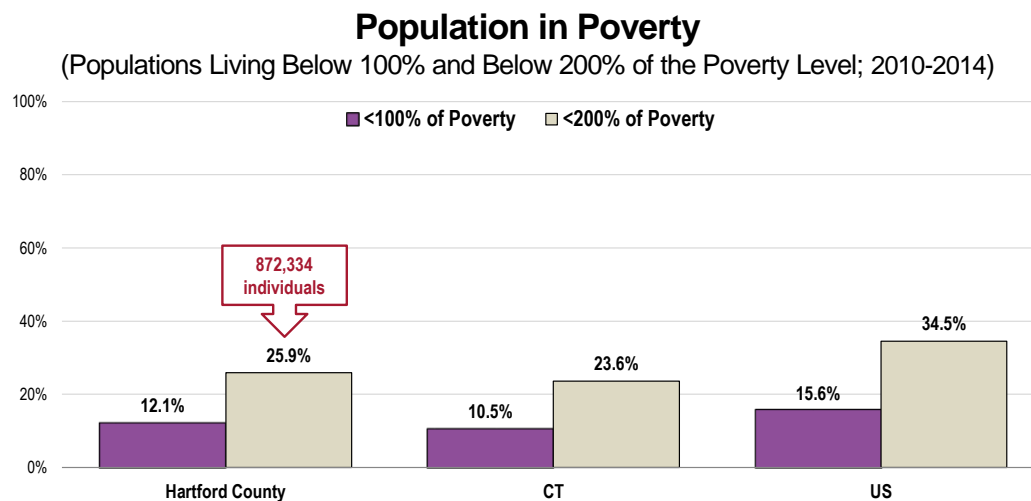
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Poverty

The latest census estimate shows **12.1%** of the Hartford County population living below the federal poverty level.

In all, **25.9%** of county residents (an estimated **872,334** individuals) live below 200% of the federal poverty level.

- Higher than the proportion reported statewide.
- Lower than that found nationally.

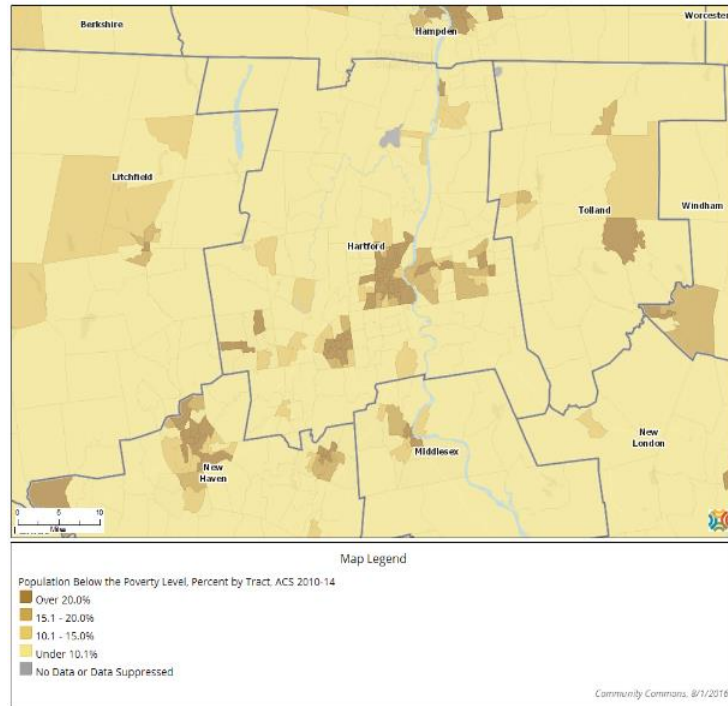


Sources: • US Census Bureau American Community Survey 5-year estimates.

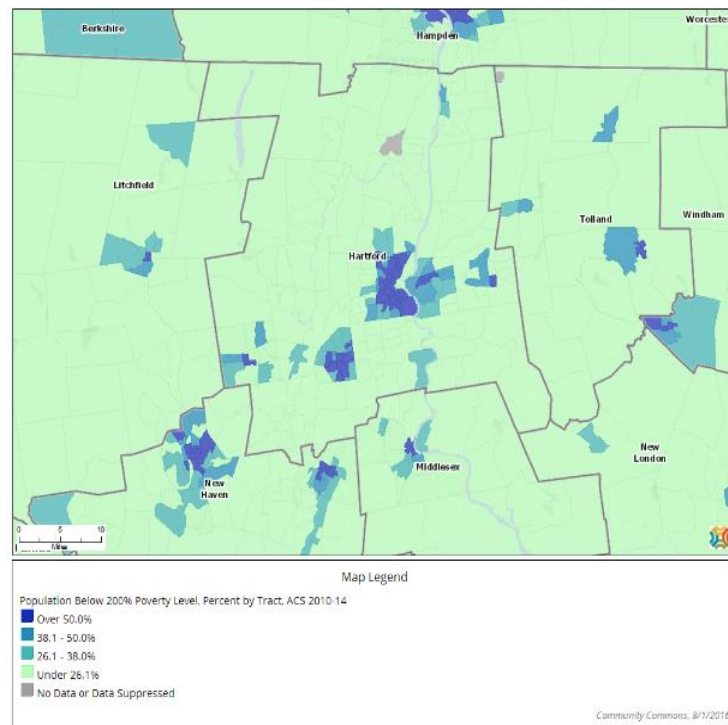
• Retrieved August 2016 from Community Commons at <http://www.chna.org>.

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

Population Below the Poverty Level, Percent by Tract, ACS 2010-14



Population Below 200% of Poverty, Percent by Tract, ACS 2010-2014

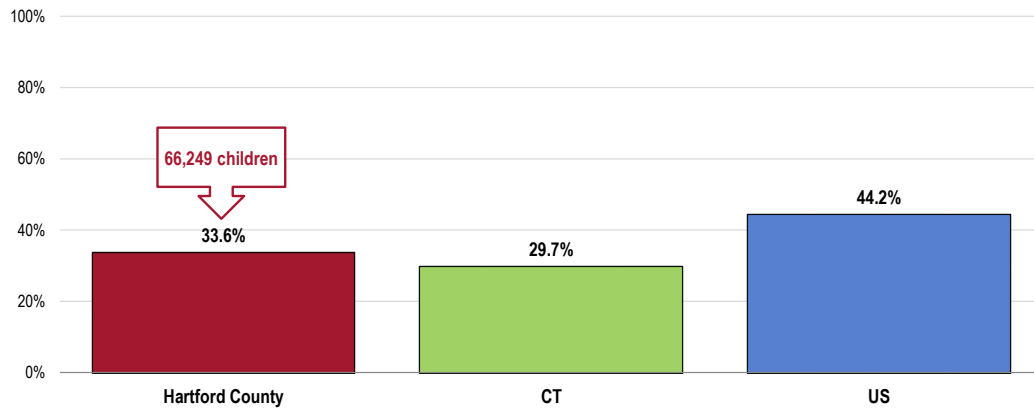


### Children in Low-Income Households

Additionally, 33.6% of county children age 0-17 (representing an estimated 66,249 children) live below the 200% poverty threshold.

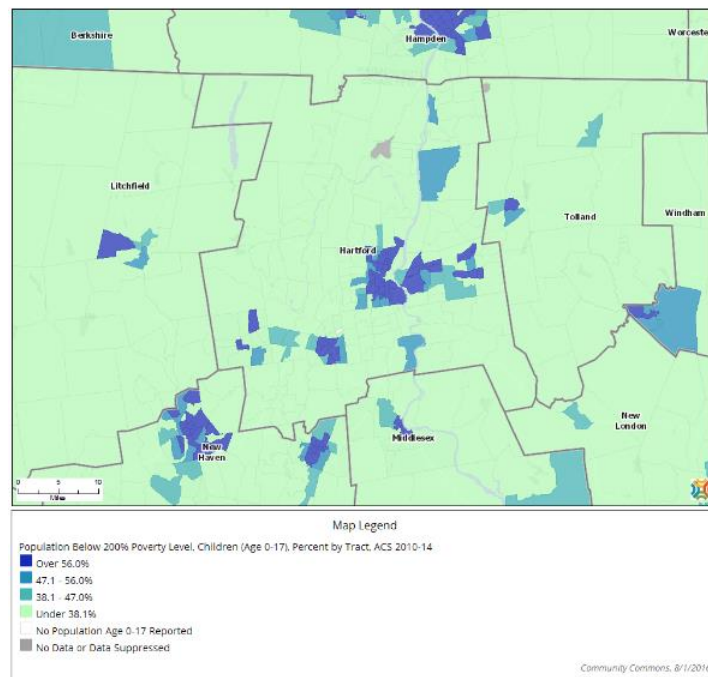
- Above the proportion found statewide.
- Below the proportion found nationally.

### Percent of Children in Low-Income Households (Children 0-17 Living Below 200% of the Poverty Level, 2010-2014)



- Sources:
- US Census Bureau American Community Survey 5-year estimates.
  - Retrieved August 2016 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator reports the percentage of children aged 0-17 living in households with income below 200% of the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Children (0-17) Living Below 200% of Poverty, Percent by Tract, ACS 2010-2014



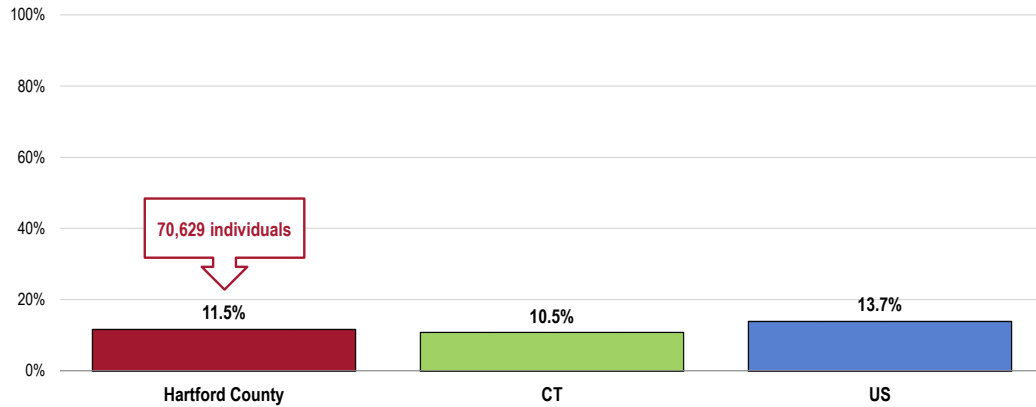
## Education

Among the Hartford County population age 25 and older, an estimated 11.5% (over 70,000 people) do not have a high school education.

- Less favorable than found statewide.
- More favorable than found nationally.

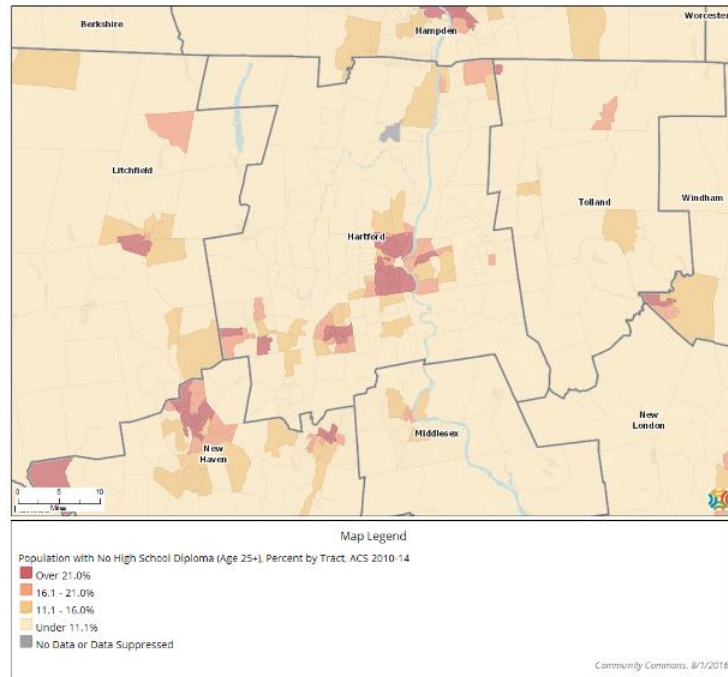
### Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2010-2014)



- Sources:
- US Census Bureau American Community Survey 5-year estimates.
  - Retrieved August 2016 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.

Population With No High School Diploma, Percent by Tract, ACS 2010-2014



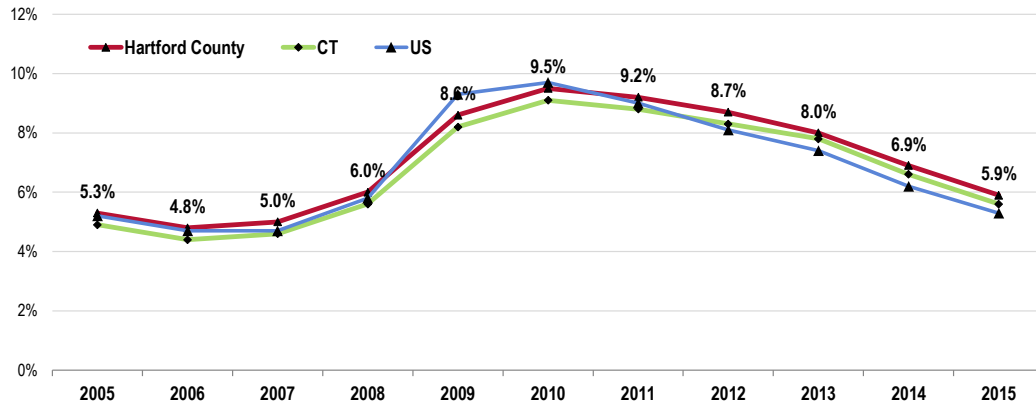
## Employment

According to data derived from the US Department of Labor, the 2015 unemployment rate in Hartford County was 5.9%.

- Higher than the state and national unemployment rates.

### Unemployment Rate

(Percent of Non-Institutionalized Population Age 16+ Unemployed, Not Seasonally-Adjusted)

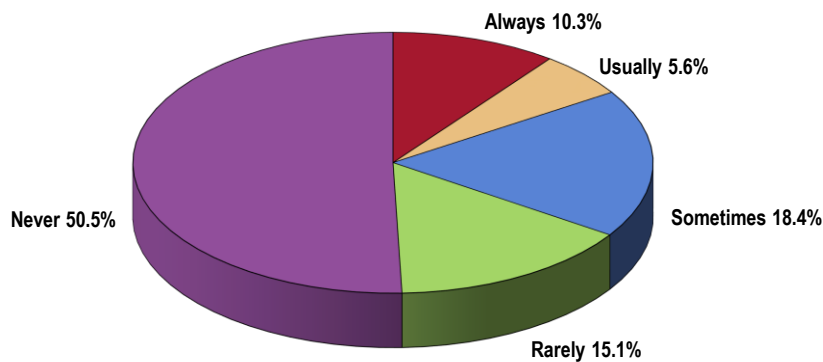


- Sources:
- US Department of Labor, Bureau of Labor Statistics.
  - Retrieved August 2016 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

## Housing Insecurity

While most surveyed adults in the MMH Service Area rarely, if ever, worry about the cost of housing, a considerable share (34.3%) do, reporting that they were “sometimes,” “usually” or “always” worried or stressed about having enough money to pay their rent or mortgage in the past year.

### Frequency of Worry or Stress Over Paying Rent/Mortgage in the Past Year (MMH Service Area, 2016)



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 81]
- Notes:
- Asked of all respondents.

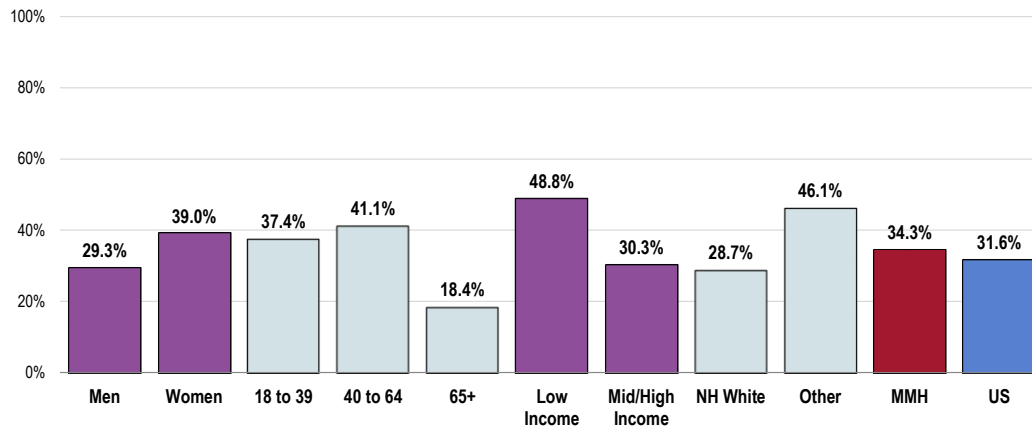
- Compared to the US prevalence, the MMH Service Area proportion of adults who worried about paying for rent or mortgage in the past year is similar.

Adults more likely to report housing insecurity include:

- Women.
- Adults under 65.
- Those in households with lower incomes.
- Other races.

Charts throughout this report (such as that here) detail survey findings among key demographic groups – namely by gender, age groupings, income (based on poverty status), and race/ethnicity.

### “Always/Usually/Sometimes” Worried About Paying Rent/Mortgage in the Past Year (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 81]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

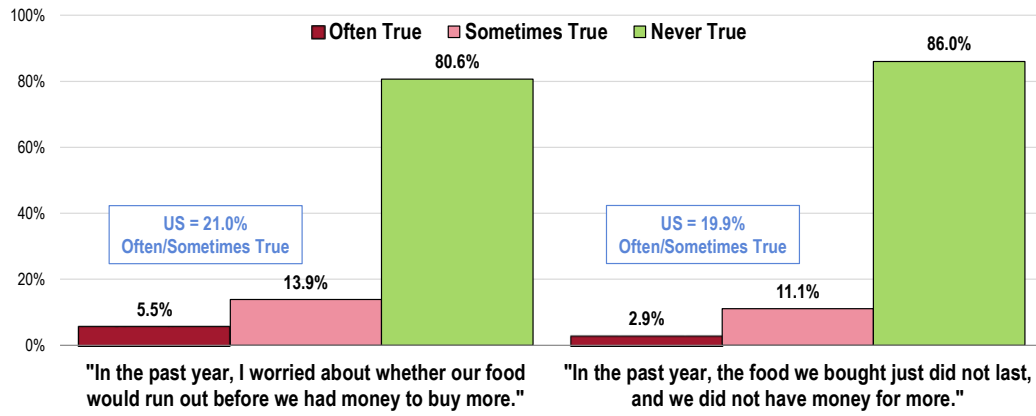
### Food Insecurity

In the past year, 19.4% of MMH Service Area adults “often” or “sometimes” worried about whether their food would run out before they had money to buy more.

Another 14.0% report a time in the past year (“often” or “sometimes”) when the food they bought just did not last, and they did not have money to get more.



### Food Insecurity (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 104-105]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Reflects the total sample of respondents.

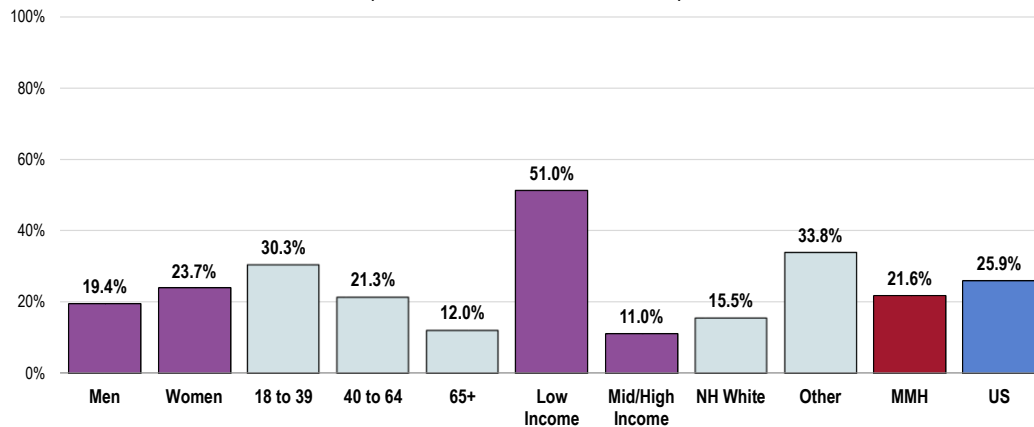
**Overall, 21.6% of community residents are determined to be “food insecure,” having run out of food in the past year and/or been worried about running out of food.**

- Comparable to US data.

Adults more likely affected by food insecurity include:

- Young adults (negative correlation with age), residents living at lower incomes, and Other races.
- Other differences within demographic groups, as illustrated in the following chart, are not statistically significant.

**Food Insecurity**  
(MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 169]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.  
 • Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

# General Health Status



Professional Research Consultants, Inc.

## Overall Health Status

### Evaluation of Health Status

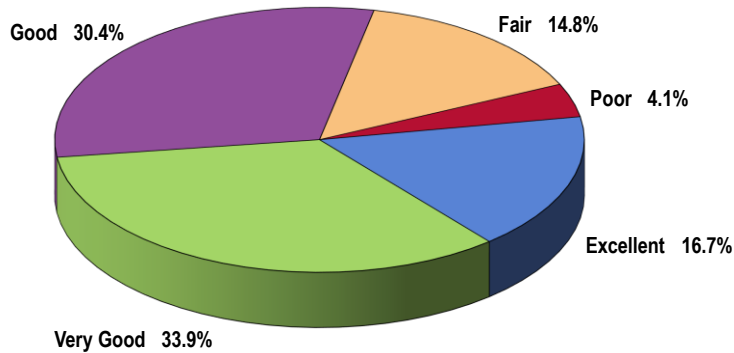
The initial inquiry of the PRC Community Health Survey asked respondents the following:

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

**A total of 50.6% of MMH Service Area adults rate their overall health as "excellent" or "very good."**

- Another 30.4% gave "good" ratings of their overall health.

### Self-Reported Health Status (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]  
Notes: • Asked of all respondents.

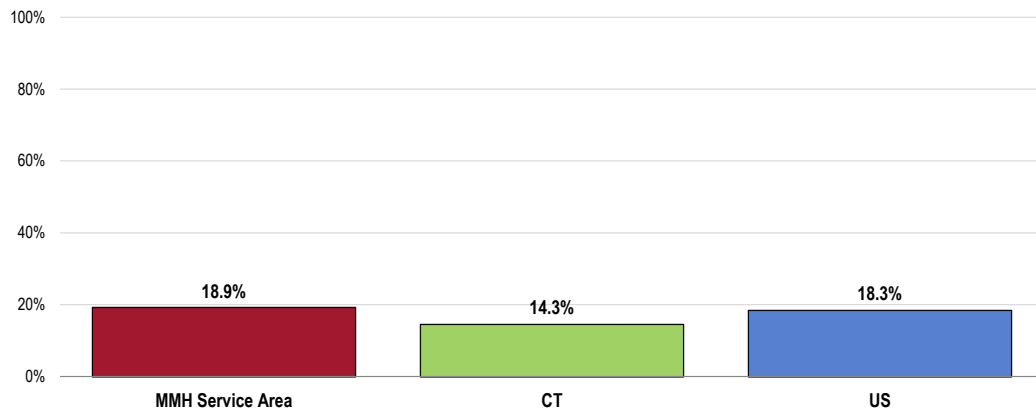
**However, 18.9% of MMH Service Area adults believe that their overall health is "fair" or "poor."**

- Worse than statewide findings.
- Similar to the US figure.

**NOTE:**

Differences noted in the text represent significant differences determined through statistical testing.

### Experience "Fair" or "Poor" Overall Health

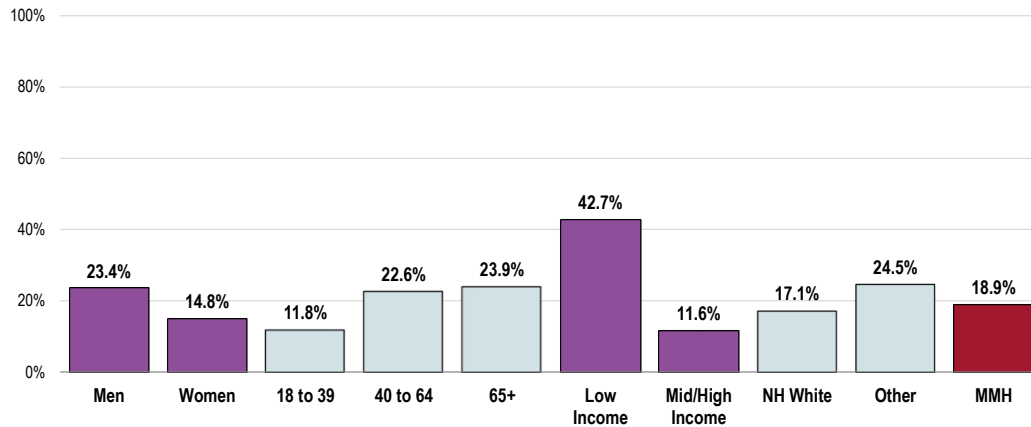


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]  
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Connecticut data.  
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

Adults more likely to report experiencing “fair” or “poor” overall health include:

- Men.
- Adults age 40 and older.
- Residents living at lower incomes.

### Experience “Fair” or “Poor” Overall Health (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]

Notes: • Asked of all respondents.

• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).

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

## Activity Limitations

### About Disability & Health

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

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

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

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

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

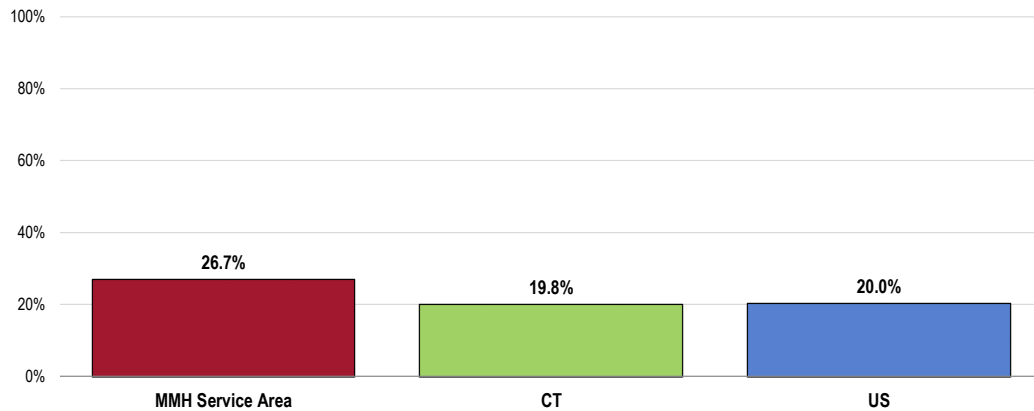
**A total of 26.7% of MMH Service Area adults are limited in some way in some activities due to a physical, mental or emotional problem.**

- **Less favorable than the prevalence statewide and nationally.**

#### RELATED ISSUE:

See also *Potentially Disabling Conditions in the Death, Disease & Chronic Conditions* section of this report.

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

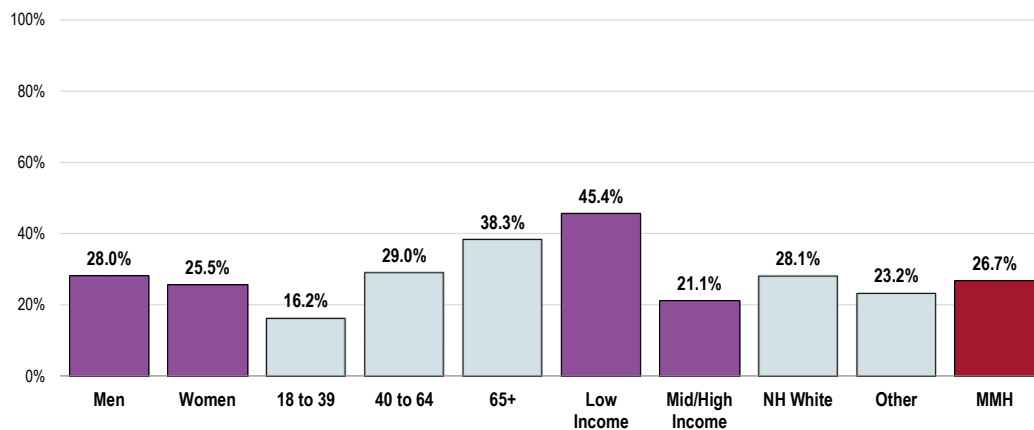


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2014 Connecticut data.  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

In looking at responses by key demographic characteristics, these adults are statistically more likely to report some type of activity limitation:

- Adults age 40 and older (note the positive correlation with age).
- Those in low-income households.

### Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem (MMH Service Area, 2016)



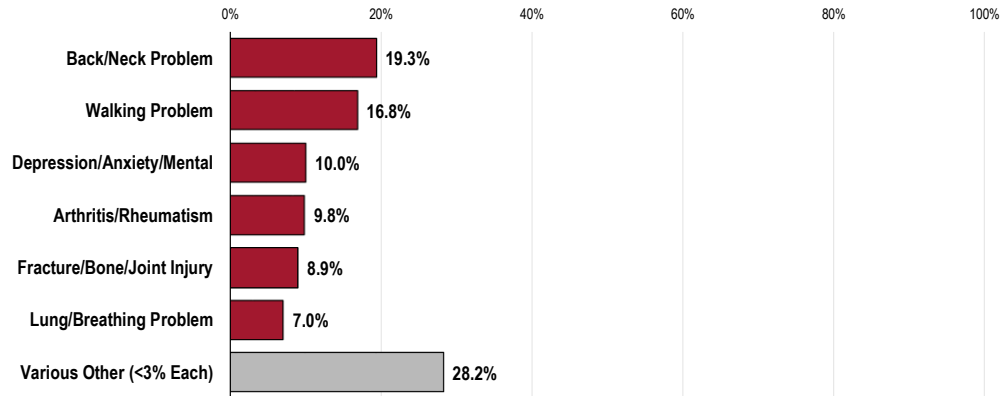
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Among persons reporting activity limitations, these are most often attributed to musculo-

skeletal issues, such as back/neck problems, difficulty walking, arthritis/rheumatism, or fractures or bone/joint injuries.

Other limitations noted with some frequency include those related to mental health (depression, anxiety) and lung/breathing problems.

**Type of Problem That Limits Activities**  
 (Among Those Reporting Activity Limitations; MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 129]  
 Notes: • Asked of those respondents reporting activity limitations.

## Caregiving

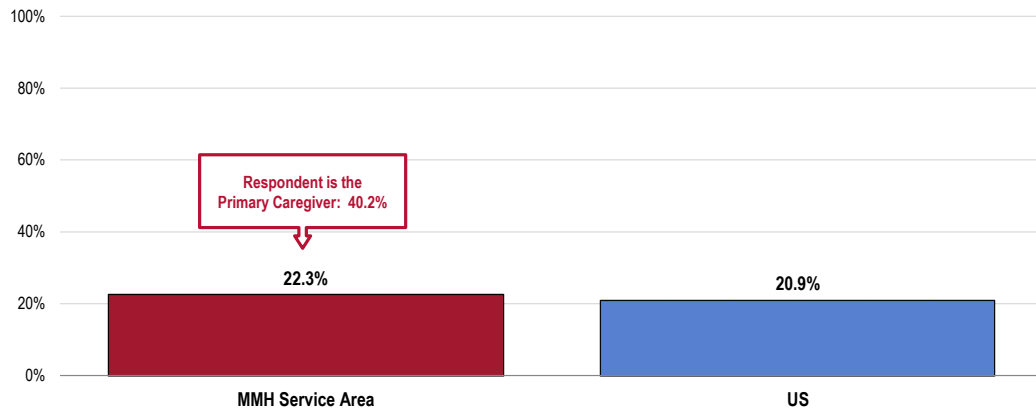
**A total of 22.3% of MMH Service Area adults currently provide care or assistance to a friend or family member who has a health problem, long-term illness, or disability.**

- Similar to the national finding.

Of these adults, 40.2% are the **primary** caregiver for the individual receiving care.



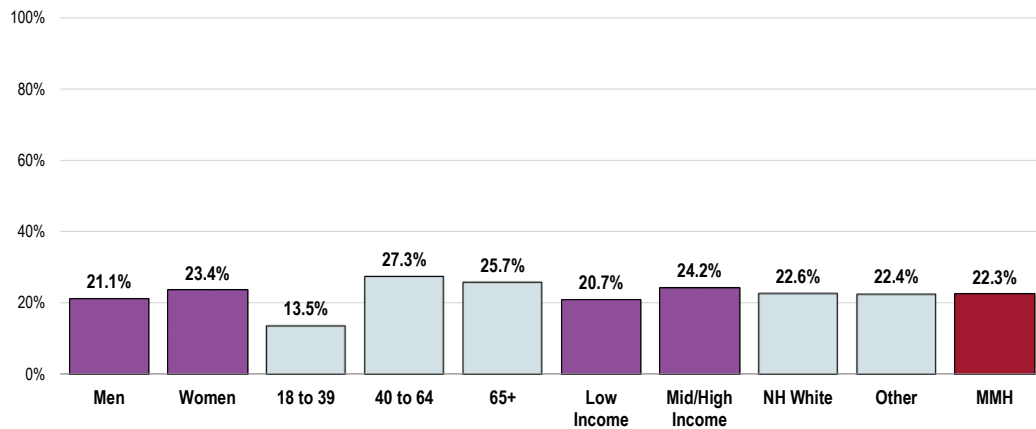
### Act as Caregiver to a Friend or Relative with a Health Problem, Long-Term Illness, or Disability



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 130-131]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

- The prevalence of caregivers in the community is notably higher among adults age 40 and older.

### Act as Caregiver to a Friend or Relative with a Health Problem, Long-Term Illness, or Disability (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 130]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Mental Health

### About Mental Health & Mental Disorders

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

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

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

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

• Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

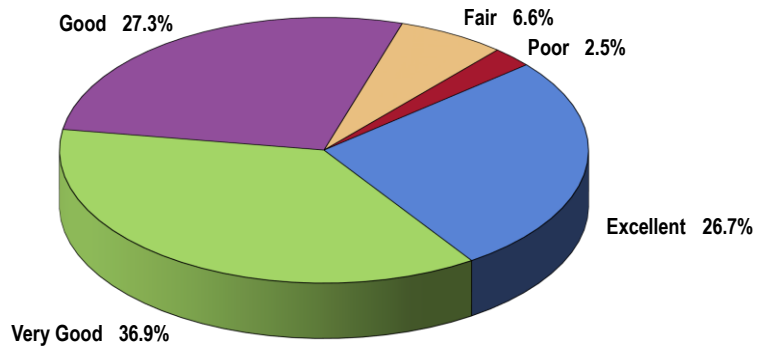
## Evaluation of Mental Health Status

A total of 63.6% of MMH Service Area adults rate their overall mental health as “excellent” or “very good.”

- Another 27.3% gave “good” ratings of their own mental health status.

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

### Self-Reported Mental Health Status (MMH Service Area, 2016)

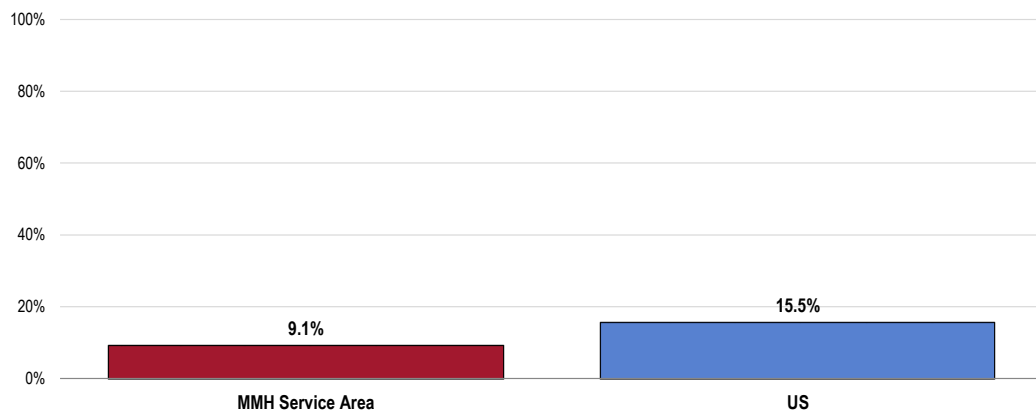


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]  
Notes: • Asked of all respondents.

A total of 9.1% of MMH Service Area adults, however, believe that their overall mental health is “fair” or “poor.”

- Well below the “fair/poor” response reported nationally.

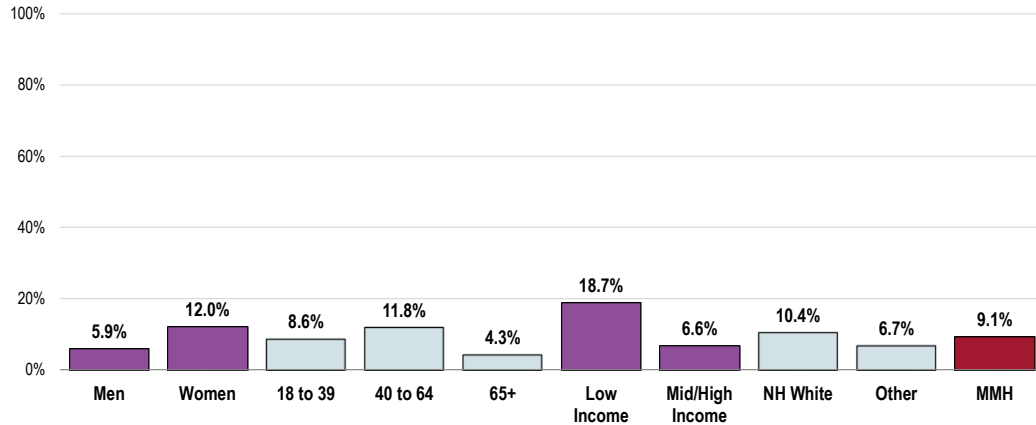
### Experience “Fair” or “Poor” Mental Health



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]  
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

- Women, adults age 40-64, and low-income residents are more likely to report experiencing “fair/poor” mental health than their demographic counterparts.

### Experience “Fair” or “Poor” Mental Health (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “NH White” reflects non-Hispanic White respondents).  
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

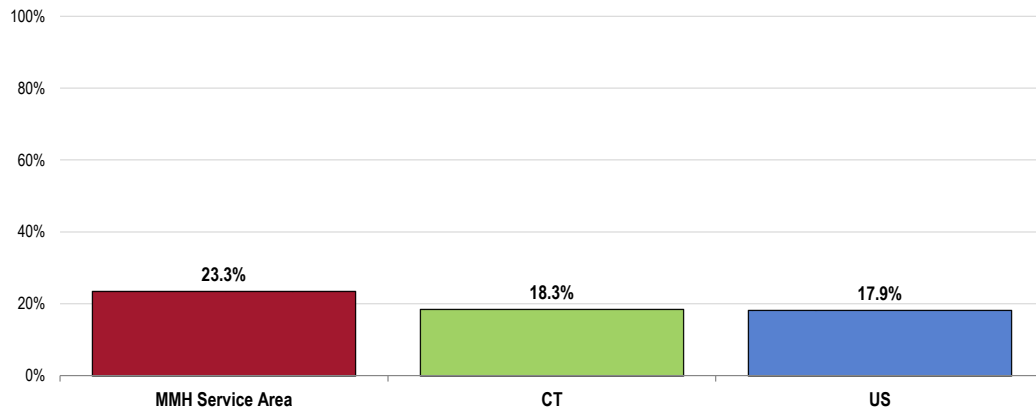
## Depression

### Diagnosed Depression

A total of 23.3% of service area adults have been diagnosed by a physician as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

- Worse than the state and national findings.

### Have Been Diagnosed With a Depressive Disorder



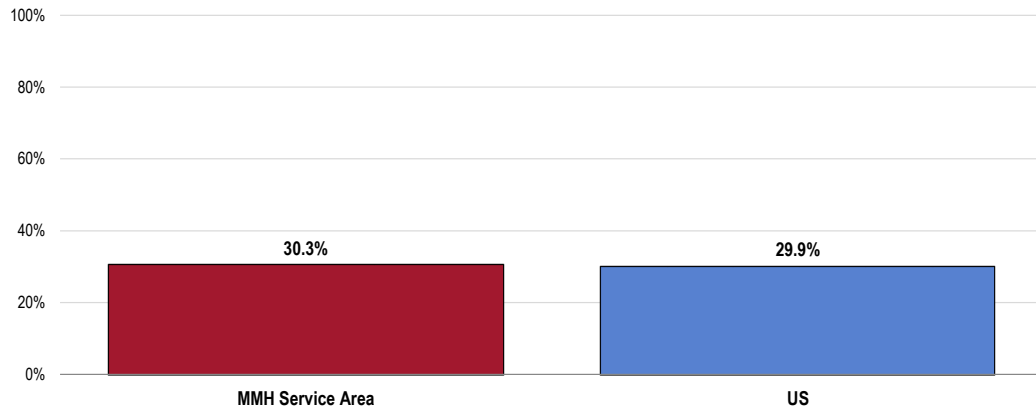
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 119]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2014 Connecticut data.  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.  
 • Depressive disorders include depression, major depression, dysthymia, or minor depression.

### Symptoms of Chronic Depression

A total of 30.3% of MMH Service Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (symptoms of chronic depression).

- Comparable to national findings.

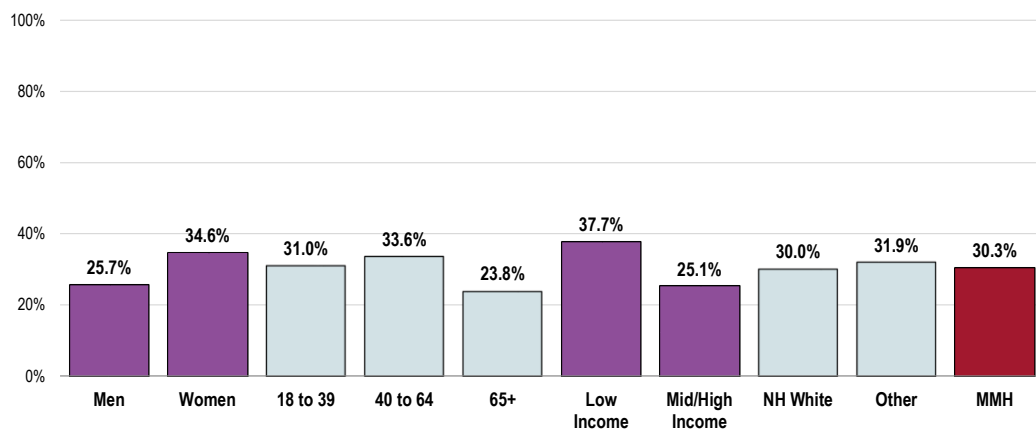
### Have Experienced Symptoms of Chronic Depression



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.
  - Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

- The prevalence of chronic depression is statistically comparable by demographic characteristics.

### Have Experienced Symptoms of Chronic Depression (MMH Service Area, 2016)



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
- Notes:
- Asked of all respondents.
  - Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Stress

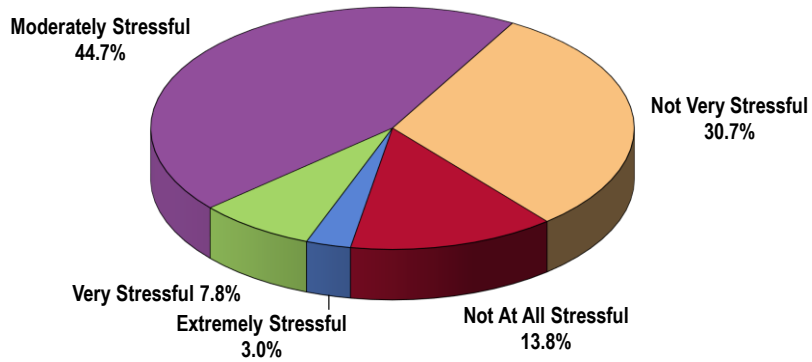
Nearly half of MMH Service Area adults considers their typical day to be “not very stressful” (30.7%) or “not at all stressful” (13.8%).

RELATED ISSUE:

See also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

- Another 44.7% of survey respondents characterize their typical day as “moderately stressful.”

**Perceived Level of Stress On a Typical Day**  
(MMH Service Area, 2016)

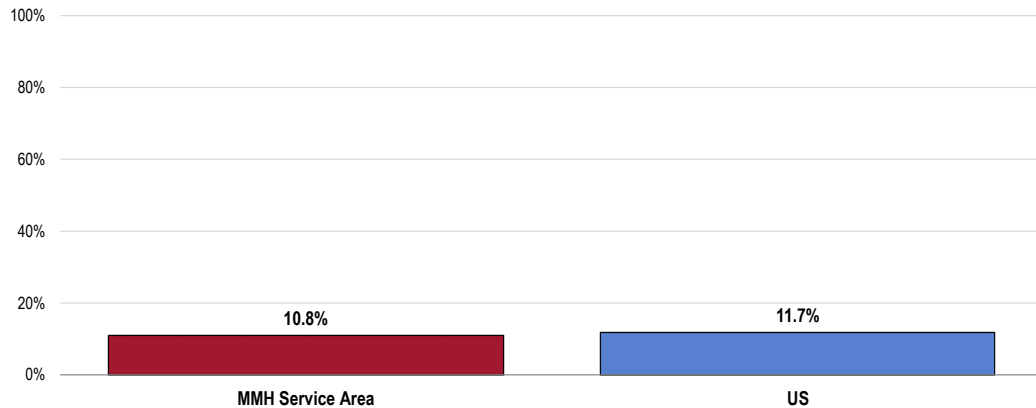


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 118]  
Notes: • Asked of all respondents.

In contrast, 10.8% of MMH Service Area adults experience “very” or “extremely” stressful days on a regular basis.

- Similar to national findings.

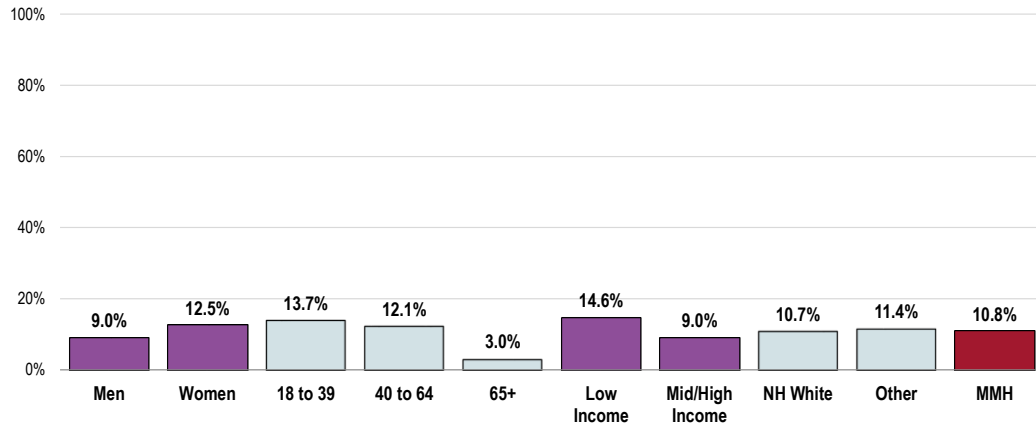
**Perceive Most Days As “Extremely” or “Very” Stressful**



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 118]  
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

- Note that high stress levels are more prevalent among adults under age 65 (negative correlation with age).

### Perceive Most Days as “Extremely” or “Very” Stressful (MMH Service Area, 2016)



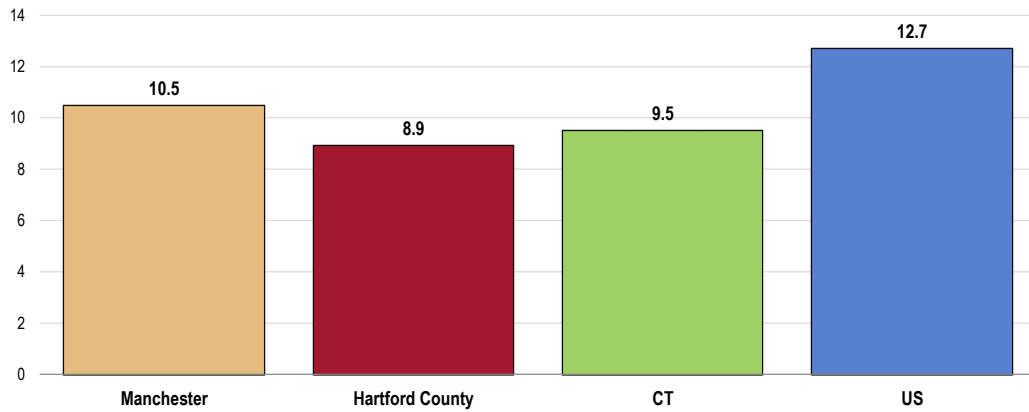
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 118]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Suicide

**Between 2012 and 2014, there was an annual average age-adjusted suicide rate of 8.9 deaths per 100,000 population in Hartford County.**

- Below the statewide and national rates.
- Satisfies the Healthy People 2020 target of 10.2 or lower.
- In the city of Manchester, the 2008-2012 suicide rate was 10.5 per 100,000 population.

### Suicide: Age-Adjusted Mortality (2012-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 10.2 or Lower



Sources: 

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
- Town data (2008-2012): Connecticut State Department of Public Health.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MHMD-1]

Notes: 

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

### Mental Health Treatment

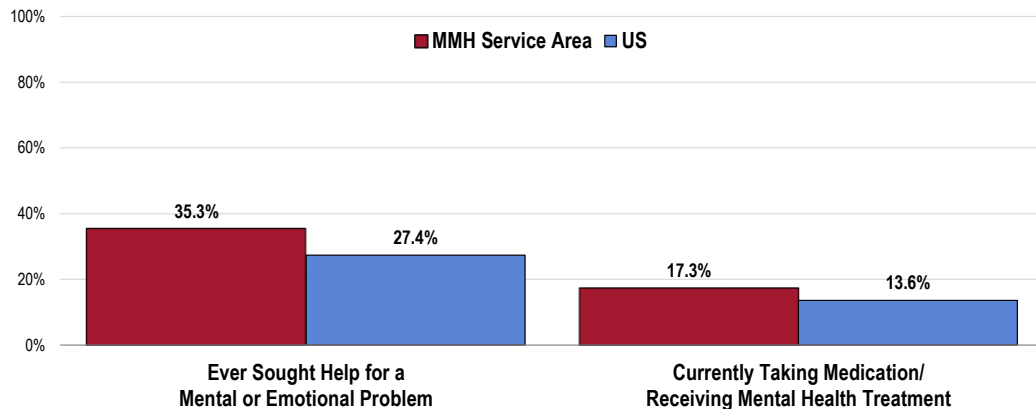
A total of 35.3% of MMH Service Area adults acknowledge having ever sought professional help for a mental or emotional problem.

- More favorable than the US prevalence.

A total of 17.3% are currently taking medication or receiving treatment from a doctor or other health professional for some type of mental health condition/emotional problem.

- Similar to the US prevalence.

### Mental Health Treatment



Sources: 

- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 120-121]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: 

- Reflects the total sample of respondents.

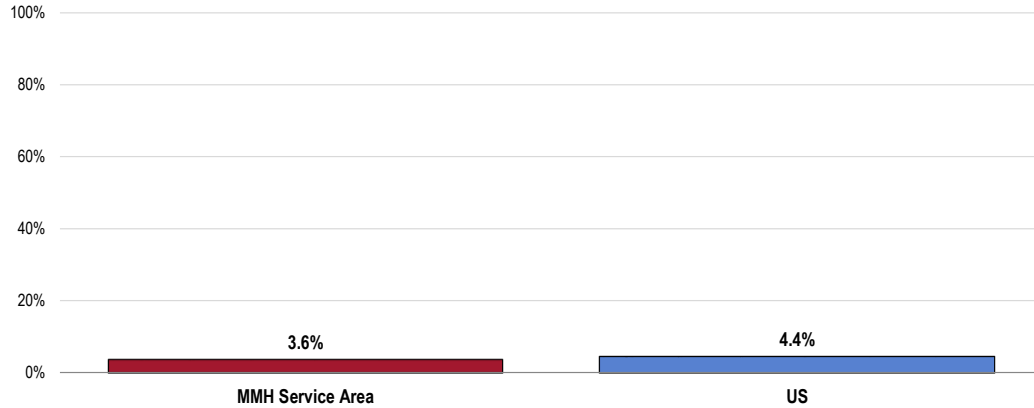


### Difficulty Accessing Mental Health Services

A total of 3.6% of MMH Service Area adults report a time in the past year when they needed mental health services, but were not able to get them.

- Similar to the national finding.

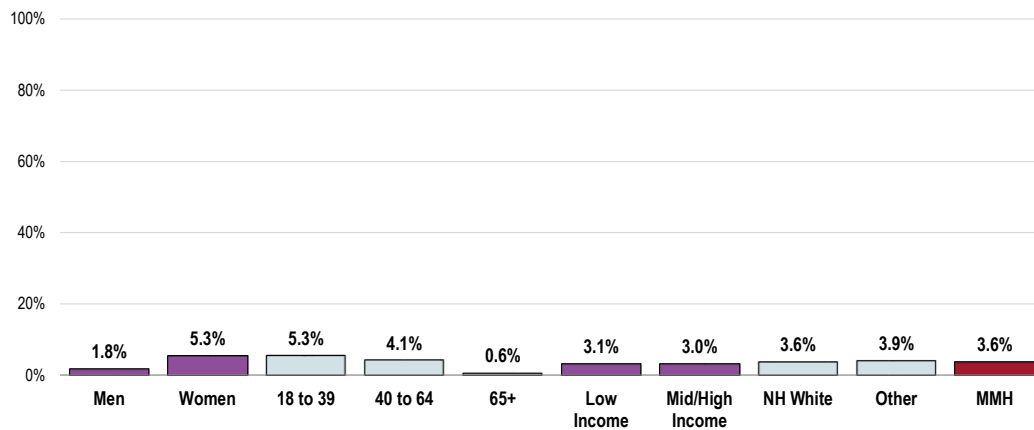
### Unable to Get Mental Health Services When Needed in the Past Year



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 122]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.

- Access difficulty is notably higher among adults under age 65 (negative correlation with age).

### Unable to Get Mental Health Services When Needed in the Past Year (MMH Service Area, 2016)

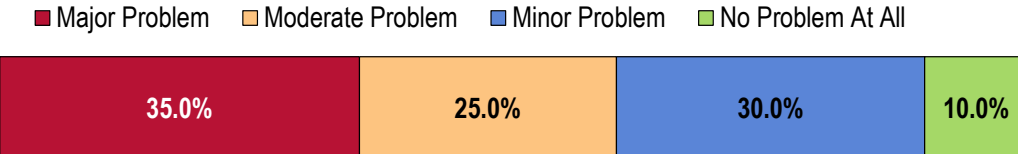


- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 122]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Key Informant Input: Mental Health

The greatest share of key informants taking part in an online survey characterized *Mental Health* as a “major problem” in the community.

### Perceptions of Mental Health as a Problem in the Community (Key Informants, 2016)



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

### Top Concerns

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

#### Access to Care/Services

- Access to proper care and lack of funding devoted to treatment programs. – Public Health Representative*
- Lengthy wait times for assessments and treatment at the local mental health authority (CHR), though this has gotten better recently. Limited resources for community-based services ACT Team, WISE Program, CSP, and other types of case management. – Community Leader*
- Lack of supported housing and employment opportunities. Social stigma. – Community Leader*
- There are not enough programs or group homes to deal with all the mental health issues in this town. Many folks with mental health issues live on their own but shouldn't be. – Community Leader*

#### Access to Providers

- There are not enough mental health providers to handle all the people who need help. – Physician*

# Death, Disease & Chronic Conditions



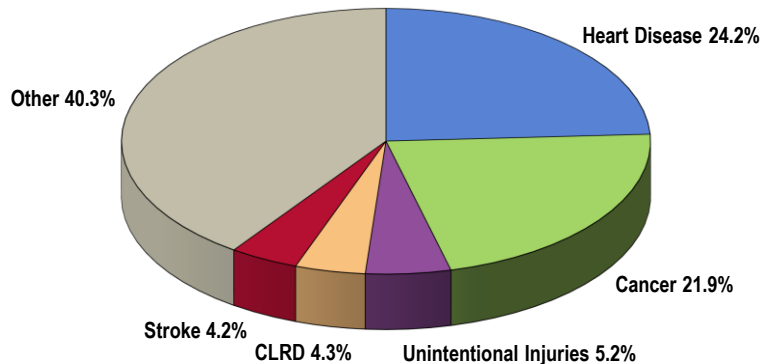
**Professional Research Consultants, Inc.**

## Leading Causes of Death

### Distribution of Deaths by Cause

Together, cardiovascular disease (heart disease and stroke) and cancers accounted for half of all Hartford County deaths in 2014.

**Leading Causes of Death**  
(Hartford County, 2014)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - CLRD is chronic lower respiratory disease.

### Age-Adjusted Death Rates for Selected Causes

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

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

The following chart outlines 2012-2014 annual average age-adjusted death rates per 100,000 population for selected causes of death in Hartford County. Where available, city of Manchester rates (2008-2012 data) are provided as well.

Each of these is discussed in greater detail in subsequent sections of this report.

For infant mortality data, see [Birth Outcomes & Risks](#) in the [Births](#) section of this report.

## Age-Adjusted Death Rates for Selected Causes (2012-2014 Deaths per 100,000 Population)

	Manchester	Hartford County	Connecticut	US	HP2020
<b>Diseases of the Heart</b>	139.7	152.8	149.9	169.1	156.9*
<b>Malignant Neoplasms (Cancers)</b>	160.5	150.4	149.0	163.6	161.4
<b>Fall-Related Deaths (65+)</b>	n/a	52.4	54.4	57.0	47.0
<b>Unintentional Injuries</b>	34.0	39.9	38.3	39.7	36.4
<b>Chronic Lower Respiratory Disease (CLRD)</b>	35.8	28.9	30.3	41.4	n/a
<b>Cerebrovascular Disease (Stroke)</b>	28.3	26.3	27.2	36.5	34.8
<b>Alzheimer's Disease</b>	13.0	17.0	17.1	24.2	n/a
<b>Drug-Induced</b>	10.2	16.2	15.6	14.6	11.3
<b>Kidney Disease</b>	15.0	14.5	12.4	13.2	n/a
<b>Diabetes Mellitus</b>	10.0	14.4	14.6	21.1	20.5*
<b>Pneumonia/Influenza</b>	15.0	14.1	12.4	15.1	n/a
<b>Intentional Self-Harm (Suicide)</b>	10.5	8.9	9.5	12.7	10.2
<b>Cirrhosis/Liver Disease</b>	11.2	8.2	8.0	10.2	8.2
<b>Motor Vehicle Deaths</b>	8.3	8.0	7.5	10.6	12.4
<b>Firearm-Related</b>	6.1	5.6	5.3	10.4	9.3
<b>Homicide/Legal Intervention</b>	n/a	4.2	3.4	5.2	5.5

- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
  - Town data (2008-2012): Connecticut State Department of Public Health.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>.
- Note:
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.
  - \*The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart; the Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.

## Cardiovascular Disease

### About Heart Disease & Stroke

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

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

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

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

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

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

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

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Age-Adjusted Heart Disease & Stroke Deaths

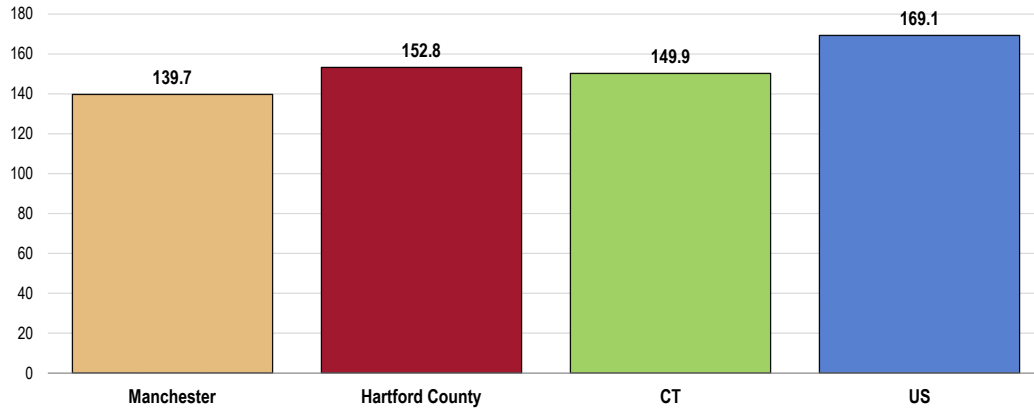
### Heart Disease Deaths

**Between 2012 and 2014 there was an annual average age-adjusted heart disease mortality rate of 152.8 deaths per 100,000 population in Hartford County.**

- Similar to the statewide rate.
- Lower than the national rate.
- Similar to the Healthy People 2020 target of 156.9 or lower (as adjusted to account for all diseases of the heart).
- The 2008-2012 Manchester rate was 139.7 per 100,000 population.

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

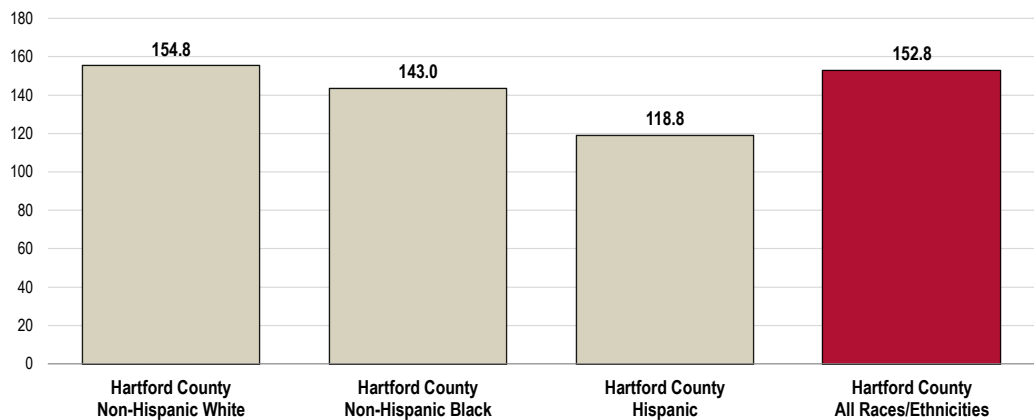
### Heart Disease: Age-Adjusted Mortality (2012-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 156.9 or Lower (Adjusted)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
  - Town data (2008-2012); Connecticut State Department of Public Health.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
  - The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

- By race, the heart disease mortality rate is notably lower among Hispanics when compared with Non-Hispanic Whites and Non-Hispanic Blacks in Hartford County.

### Heart Disease: Age-Adjusted Mortality by Race (2012-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 156.9 or Lower (Adjusted)



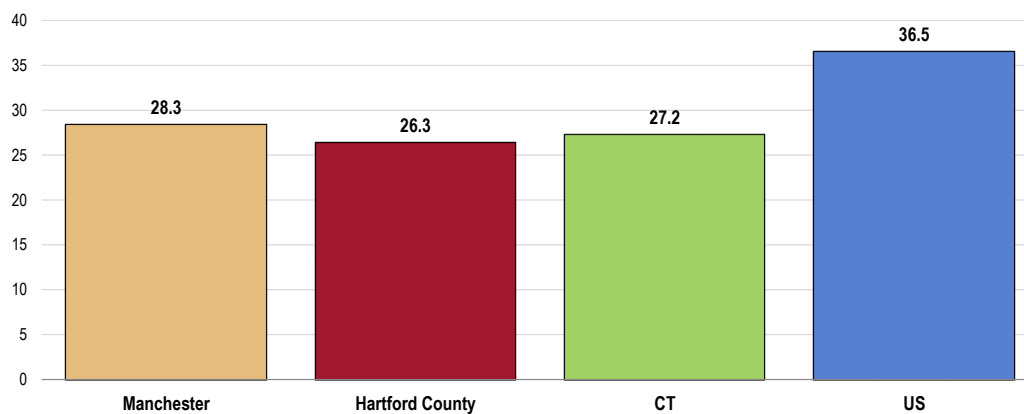
- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
  - The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

## Stroke Deaths

Between 2012 and 2014, there was an annual average age-adjusted stroke mortality rate of 26.3 deaths per 100,000 population in Hartford County.

- Similar to the state rate.
- Well below the national rate.
- Satisfies the Healthy People 2020 target of 34.8 deaths or lower.
- The 2008-2012 Manchester rate was 28.3 deaths per 100,000 population.

**Stroke: Age-Adjusted Mortality**  
(2012-2014 Annual Average Deaths per 100,000 Population)  
Healthy People 2020 Target = 34.8 or Lower

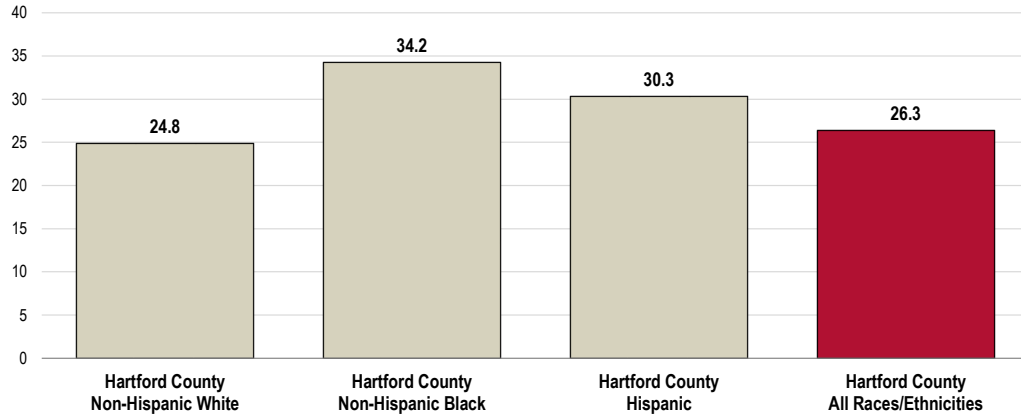


- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
  - Town data (2008-2012): Connecticut State Department of Public Health.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- In Hartford County, stroke mortality is higher among Blacks and Hispanics when compared with Whites.



### Stroke: Age-Adjusted Mortality by Race (2012-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 34.8 or Lower



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

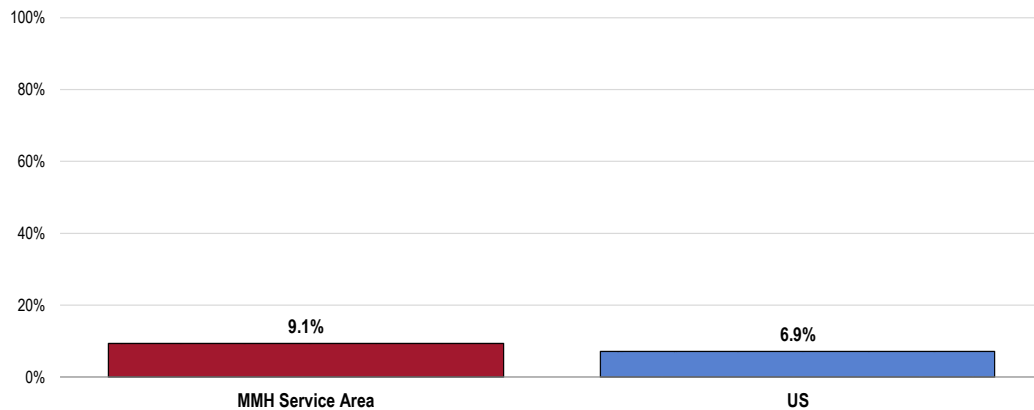
## Prevalence of Heart Disease & Stroke

### Prevalence of Heart Disease

A total of 9.1% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina or heart attack.

- Similar to the national prevalence.

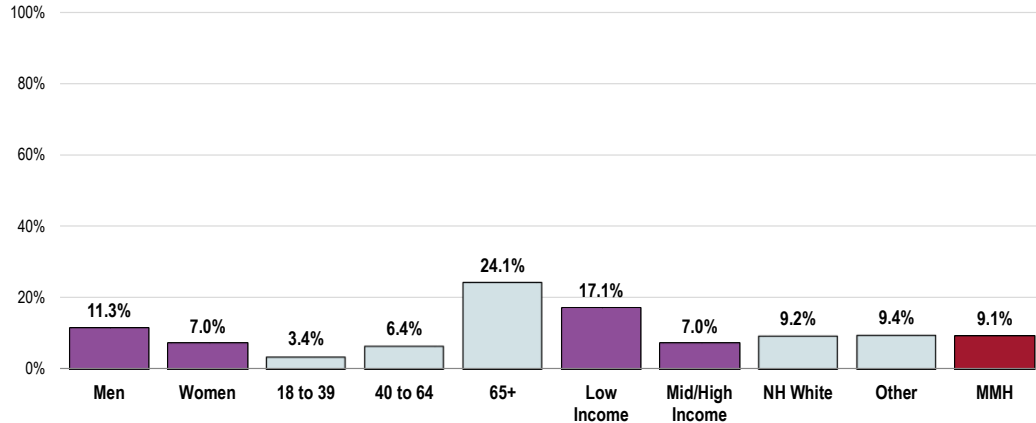
### Prevalence of Heart Disease



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 146]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.
  - Includes diagnoses of heart attack, angina or coronary heart disease.

- Seniors (age 65+) are especially likely to have been diagnosed with heart disease; note the positive correlation with age and heart disease in the service area.

### Prevalence of Heart Disease (MMH Service Area, 2016)



Sources:
 

- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 146]

 Notes:
 

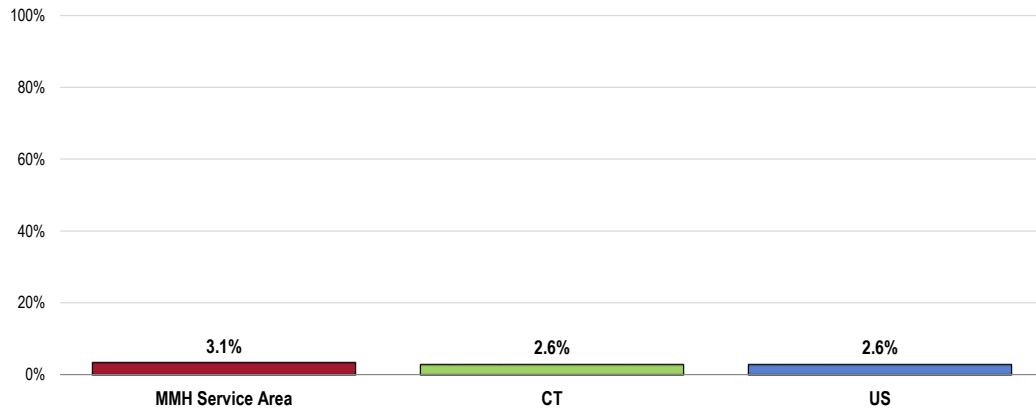
- Asked of all respondents.
- Includes diagnoses of heart attack, angina or coronary heart disease.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Prevalence of Stroke

A total of 3.1% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

- Similar to statewide and national findings.

### Prevalence of Stroke



Sources:
 

- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 35]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2014 Connecticut data.

 Notes:
 

- Asked of all respondents.

## Cardiovascular Risk Factors

### About Cardiovascular Risk

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

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### High Blood Pressure

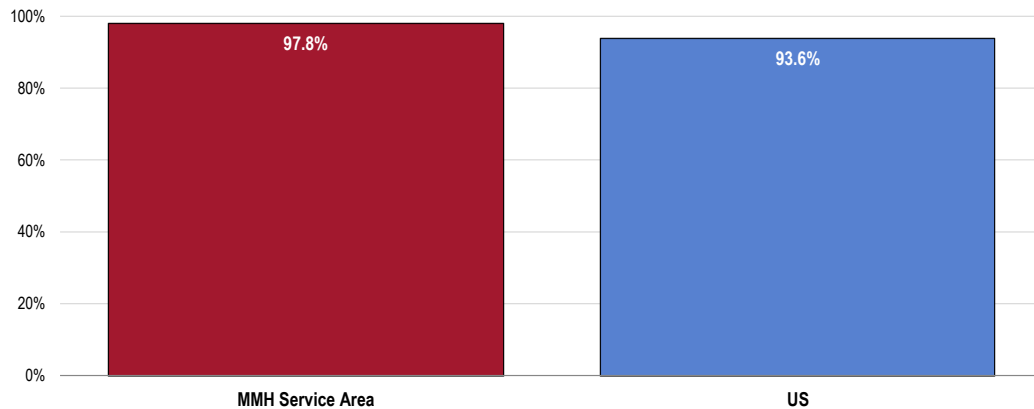
#### High Blood Pressure Testing

**A total of 97.8% of MMH Service Area adults have had their blood pressure tested within the past two years.**

- More favorable than national findings.
- Satisfies the Healthy People 2020 target (92.6% or higher).

### Have Had Blood Pressure Checked in the Past Two Years

Healthy People 2020 Target = 92.6% or Higher



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 44]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-4]
- Notes:
- Asked of all respondents.

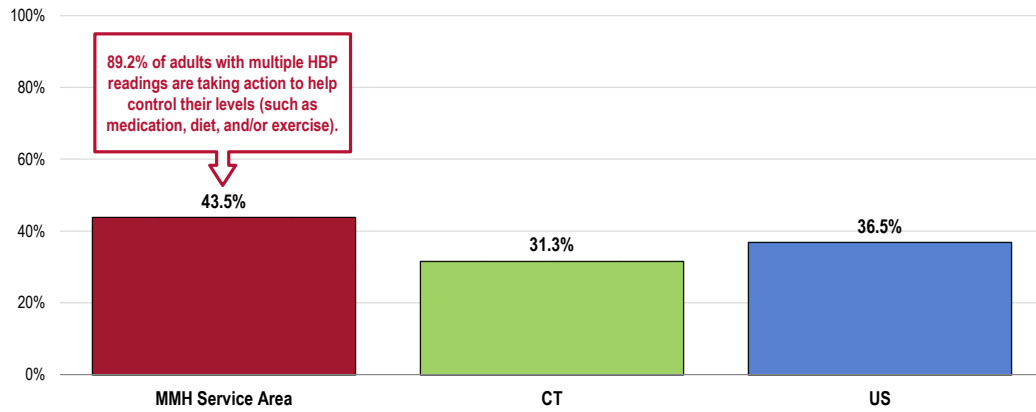
#### Prevalence of High Blood Pressure

**A total of 43.5% of MMH Service Area adults have been told at some point that their blood pressure was high.**

- Well above the state and US figures.
- Fails to satisfy the Healthy People 2020 target (26.9% or lower).
- Among adults with multiple high blood pressure readings, 89.2% are taking action to lower their blood pressure (such as medication, change in diet, and/or exercise).

### Prevalence of High Blood Pressure

Healthy People 2020 Target = 26.9% or Lower



Sources:

- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 43, 147]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Connecticut data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-5.1]

Notes:

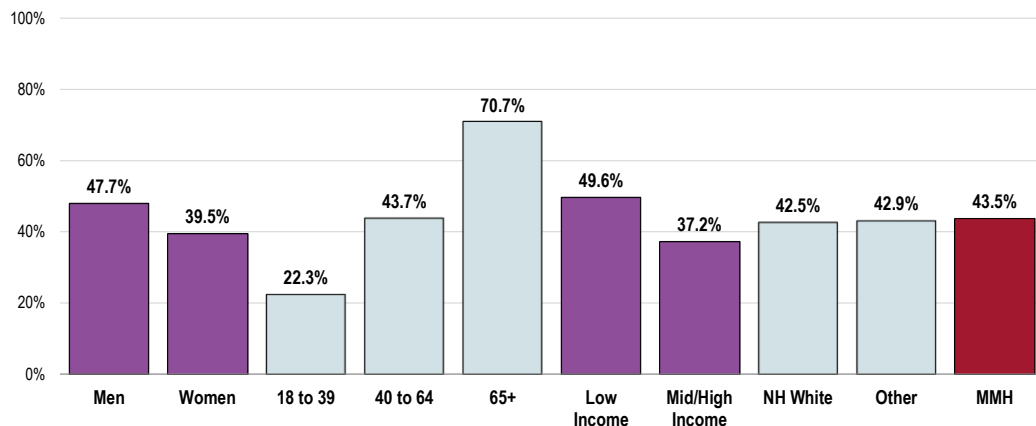
- Asked of all respondents.

- High blood pressure is more prevalent among adults age 40 and older (positive correlation with age).

### Prevalence of High Blood Pressure

(MMH Service Area, 2016)

Healthy People 2020 Target = 26.9% or Lower



Sources:

- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 147]
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-5.1]

Notes:

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

## High Blood Cholesterol

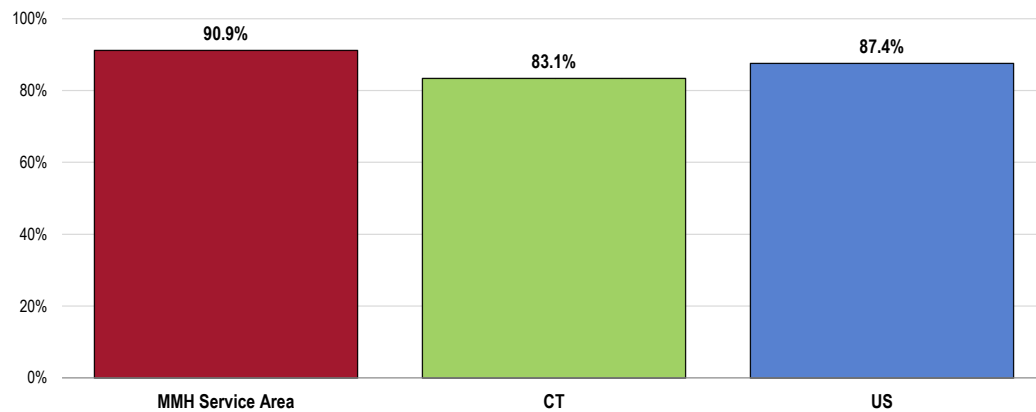
### *Blood Cholesterol Testing*

**A total of 90.9% of MMH Service Area adults have had their blood cholesterol checked within the past five years.**

- More favorable than Connecticut and US findings.
- Satisfies the Healthy People 2020 target (82.1% or higher).

### Have Had Blood Cholesterol Levels Checked in the Past Five Years

Healthy People 2020 Target = 82.1% or Higher



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 47]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Connecticut data.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-6]
- Notes:
- Asked of all respondents.

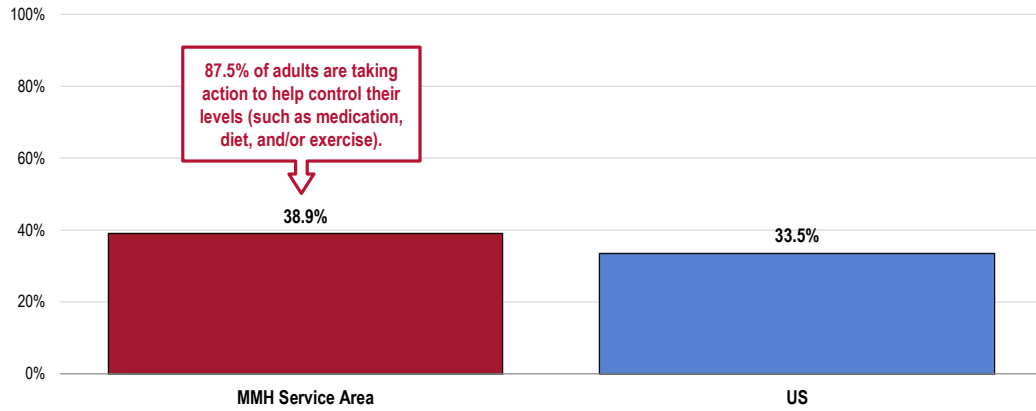
### *Prevalence of High Blood Cholesterol*

**A total of 38.9% of adults have been told by a health professional that their cholesterol level was high.**

- Similar to the national prevalence.
- Nearly three times the Healthy People 2020 target (13.5% or lower).
- Among adults with high blood cholesterol readings, 87.5% are taking action to lower their numbers (such as medication, change in diet, and/or exercise).

### Prevalence of High Blood Cholesterol

Healthy People 2020 Target = 13.5% or Lower



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 46, 148]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-7]  
 Notes: • Asked of all respondents.

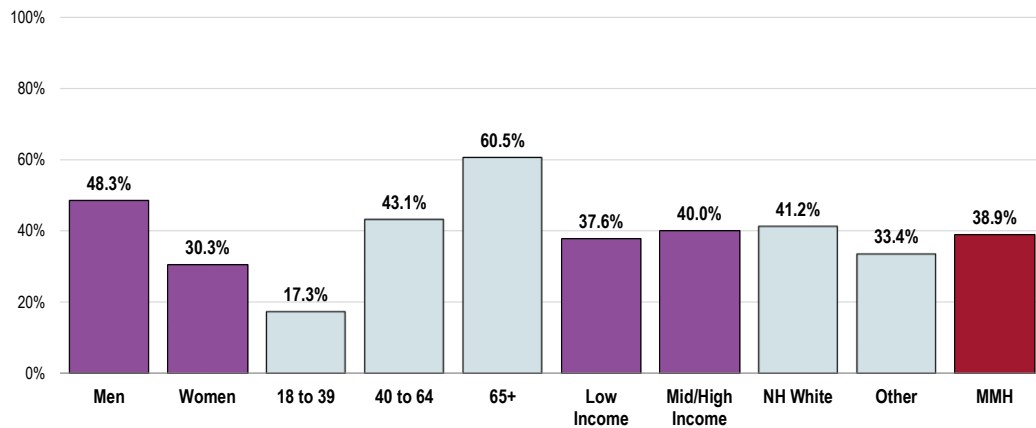
Further note the following:

- Service area men are more likely than women to have been diagnosed with high blood cholesterol.
- There is a positive correlation between age and high blood cholesterol.

### Prevalence of High Blood Cholesterol

(MMH Service Area, 2016)

Healthy People 2020 Target = 13.5% or Lower



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 148]  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-7]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### About Cardiovascular Risk

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

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

Three health-related behaviors contribute markedly to cardiovascular disease:

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

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

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

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

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

### Total Cardiovascular Risk

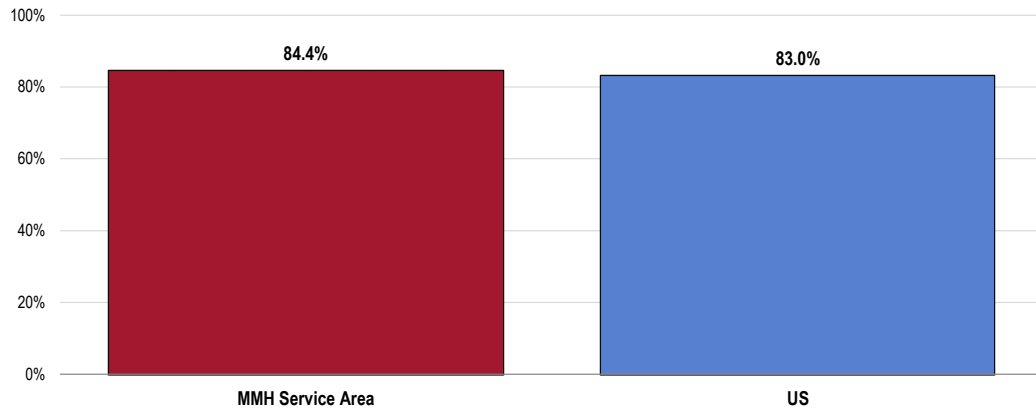
**A total of 84.4% of MMH Service Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.**

- Comparable to national findings.

#### RELATED ISSUE:

See also  
Nutrition & Overweight,  
Physical Activity & Fitness and  
Tobacco Use in the Modifiable  
Health Risk section of this  
report.

### Present One or More Cardiovascular Risks or Behaviors

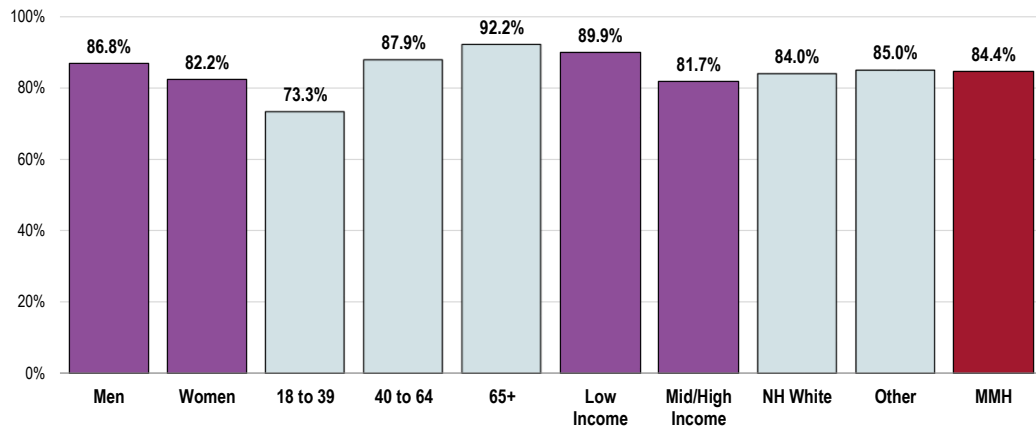


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.  
 • Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension;  
 4) high blood cholesterol; and/or 5) being overweight/obese.

- Adults age 40 and older are more likely to exhibit cardiovascular risk factors (positive correlation with age).

### Present One or More Cardiovascular Risks or Behaviors (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]  
 • Asked of all respondents.

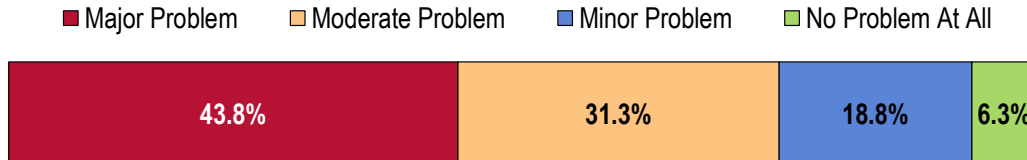
Notes: • Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.



## Key Informant Input: Heart Disease & Stroke

The largest share of key informants taking part in an online survey characterized *Heart Disease & Stroke* as a “major problem” in the community.

### Perceptions of Heart Disease and Stroke as a Problem in the Community (Key Informants, 2016)



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

### Top Concerns

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

#### Prevalence/Incidence

*Majority of patient have cardiovascular problems such as high blood pressure, AFib, etc. Most people don't exercise and take the necessary supplements to create heart health. – Community Leader*

*As a preventable disease, I personally see many customers with varying forms of heart disease. I think that lack of knowledge and motivation when it comes to healthy lifestyle is a huge factor. I see many customers with similar barriers, busy lifestyle. – Community Leader*

#### Aging Population

*Due to aging population with diabetes, heart disease and stroke go along with that. Population growth is stagnant. – Physician*

#### Leading Cause of Death

*Heart disease is the #1 killer in the U.S. Strokes can have long-term effects on patients as they try to recover function and prevent a reoccurrence. – Community Leader*

#### Nutrition

*Inadequate nutrition and education on prevention. – Community Leader*

## Cancer

### About Cancer

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

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

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

- Breast cancer (using mammography)
  - Cervical cancer (using Pap tests)
  - Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

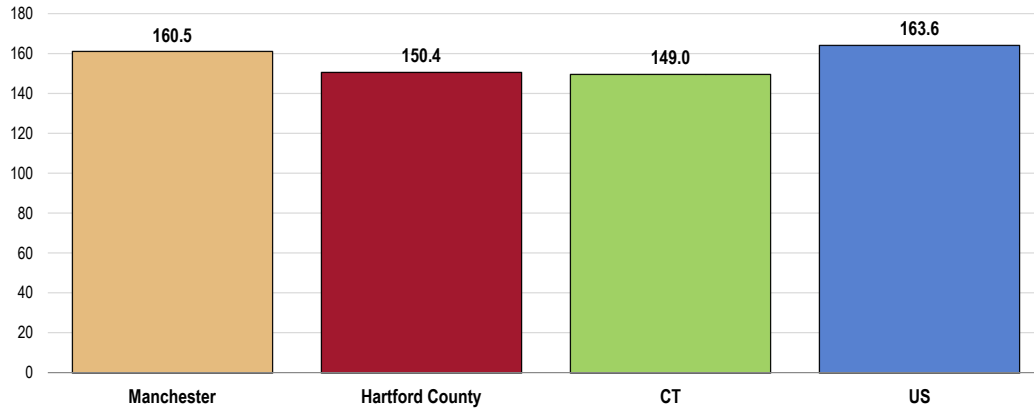
## Age-Adjusted Cancer Deaths

### All Cancer Deaths

**Between 2012 and 2014, there was an annual average age-adjusted cancer mortality rate of 150.4 deaths per 100,000 population in Hartford County.**

- Similar to the state rate.
- More favorable than the national rate.
- Satisfies the Healthy People 2020 target of 161.4 or lower.
- The 2008-2012 Manchester rate was 160.5 deaths per 100,000 population.

### Cancer: Age-Adjusted Mortality (2012-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 161.4 or Lower



Sources: 

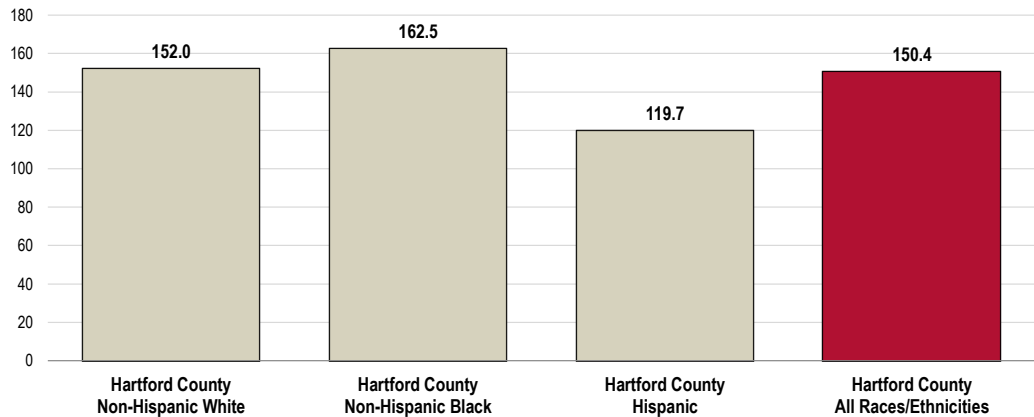
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
- Town data (2008-2012): Connecticut State Department of Public Health.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-1]

Notes: 

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

- The cancer mortality rate is notably higher among Whites and Blacks than among Hispanics.

### Cancer: Age-Adjusted Mortality by Race (2012-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 161.4 or Lower



Sources: 

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-1]

Notes: 

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

## Cancer Deaths by Site

**Lung cancer is by far the leading cause of cancer deaths in Hartford County.**

Other leading sites include prostate cancer among men, breast cancer among women, and colorectal cancer (both genders).

As can be seen in the following chart (referencing 2012-2014 annual average age-adjusted death rates):

- The county's **lung cancer** and **female breast cancer** death rates are similar to the related state rates and lower than the national rates.
- The Hartford County **prostate cancer** death rate is higher than the state rate but similar to the national rate.
- The Hartford County **colorectal cancer** death rate is higher than the state rate but lower than the US rate.

Note that each of the Hartford County cancer death rates detailed below satisfies the related Healthy People 2020 target.

**Age-Adjusted Cancer Death Rates by Site**  
(2012-2014 Annual Average Deaths per 100,000 Population)

	Manchester	Hartford County	Connecticut	US	HP2020
<b>ALL CANCERS</b>	160.6	150.4	149.0	163.6	161.4
<b>Lung Cancer</b>	47.0	36.9	37.4	43.4	45.5
<b>Female Breast Cancer</b>	n/a	18.8	18.5	20.9	20.7
<b>Prostate Cancer</b>	n/a	18.5	17.5	19.2	21.8
<b>Colorectal Cancer</b>	12.1	12.8	11.8	14.6	14.5

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.  
• Town data (2008-2012): Connecticut State Department of Public Health.  
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>

## Cancer Incidence

Incidence rates reflect the number of newly diagnosed cases in a given population in a given year, regardless of outcome. Here, these rates are also age-adjusted.

"Incidence rate" or "case rate" is the number of new cases of a disease occurring during a given period of time.

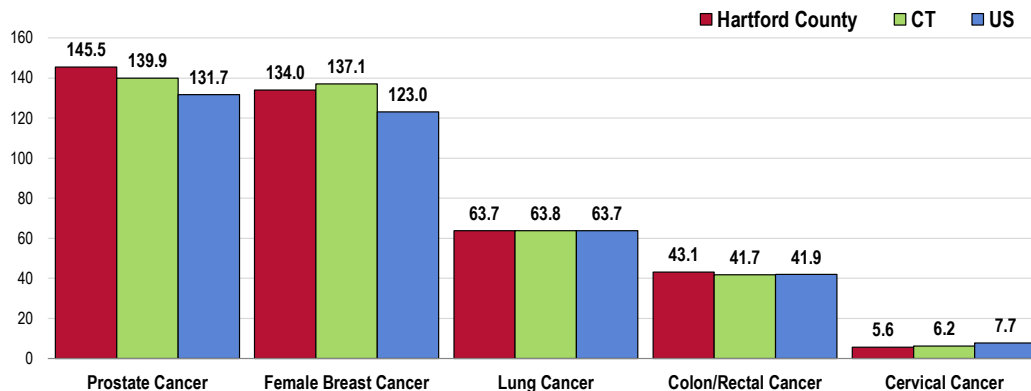
It is usually expressed as cases per 100,000 population per year.

**These 2008-2012 Hartford County annual average age-adjusted cancer incidence rates are worse than US rates:**

- Prostate cancer.
- Female breast cancer.

**All of the Hartford County cancer incidence rates are similar to (or better than) the state rates for the same years.**

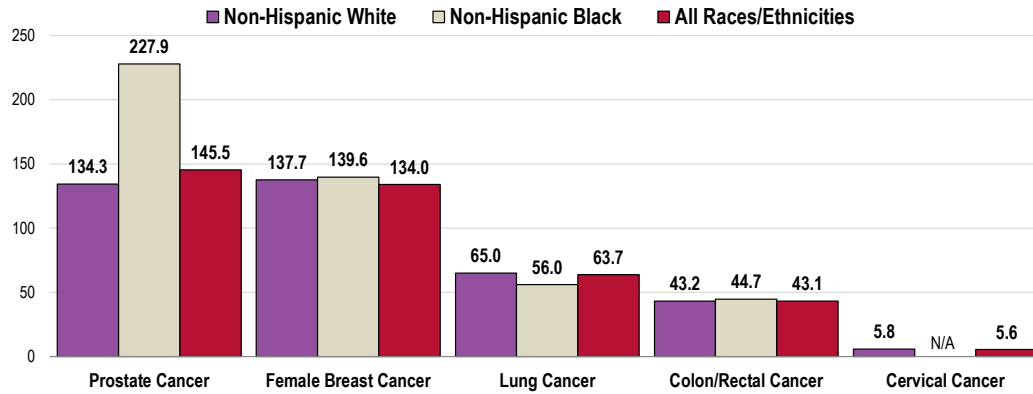
**Cancer Incidence Rates by Site**  
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2008-2012)



- Sources:
- State Cancer Profiles.
  - Retrieved August 2016 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

- By available race data, Blacks experience a notably higher prostate cancer incidence than Whites in Hartford County.
- Whites, on the other hand, report a higher lung cancer incidence rate than do Blacks in Hartford County.

### Cancer Incidence Rates by Site and Race/Ethnicity (Annual Average Age-Adjusted Incidence per 100,000 Population, Hartford County 2008-2012)



Sources: • State Cancer Profiles.  
 • Retrieved August 2016 from Community Commons at <http://www.chna.org>.  
 Notes: • This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

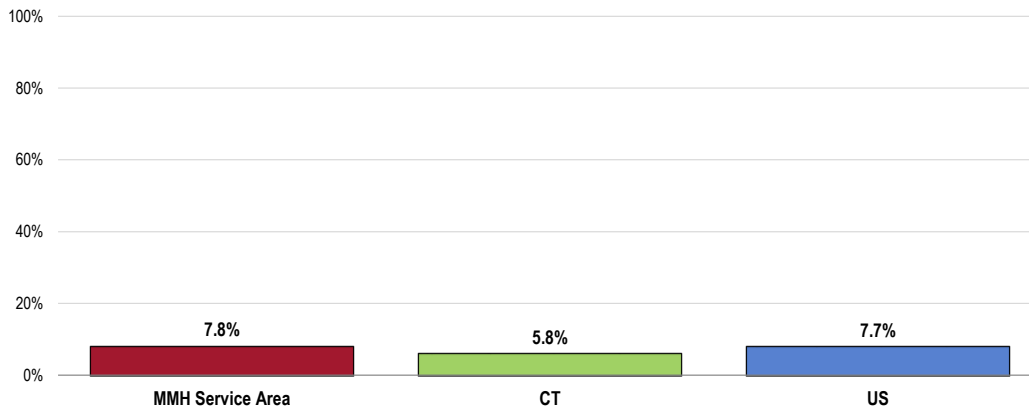
### Prevalence of Cancer

#### Skin Cancer

A total of 7.8% of surveyed MMH Service Area adults report having been diagnosed with skin cancer.

- Similar to what is found statewide and nationally.

### Prevalence of Skin Cancer



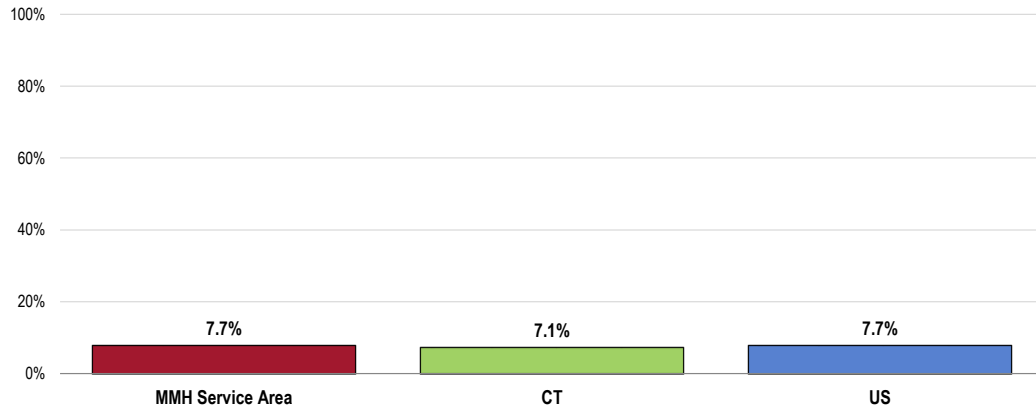
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 30]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Connecticut data.  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

### Other Cancer

A total of 7.7% of survey respondents have been diagnosed with some type of (non-skin) cancer.

- Similar to the statewide and national percentages.

### Prevalence of Cancer (Other Than Skin Cancer)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 29]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2014 Connecticut data.  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

RELATED ISSUE:  
 See also  
[Nutrition & Overweight, Physical Activity & Fitness and Tobacco Use](#) in the [Modifiable Health Risk](#) section of this report.

### Cancer Risk

#### About Cancer Risk

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

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

### Cancer Screenings

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

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

## Female Breast Cancer Screening

### About Screening for Breast Cancer

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

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

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

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

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

### *Mammography*

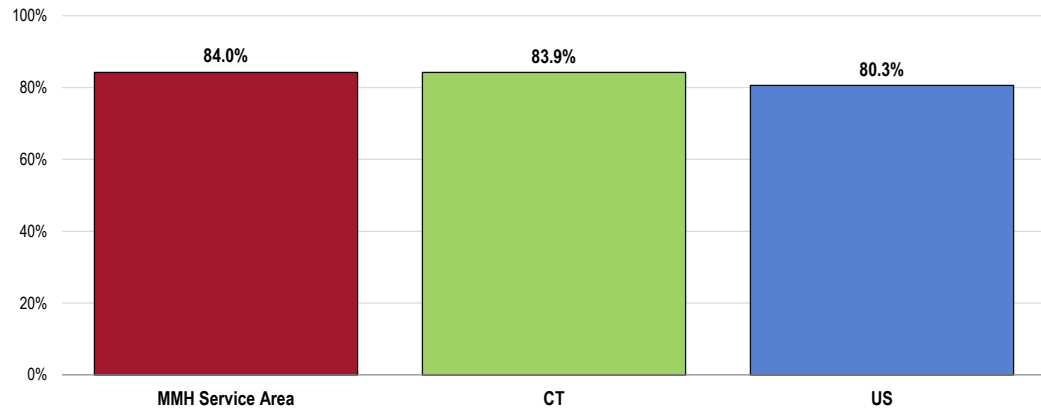
**Among women age 50-74, 84.0% have had a mammogram within the past 2 years.**

- Similar to statewide and US findings.
- Similar to the Healthy People 2020 target (81.1% or higher).



## Have Had a Mammogram in the Past Two Years (Among Women Age 50-74)

Healthy People 2020 Target = 81.1% or Higher



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 151]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Connecticut data.
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-17]
- Notes:
- Reflects female respondents 50-74.

## Cervical Cancer Screenings

### About Screening for Cervical Cancer

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

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

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

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

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

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

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

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

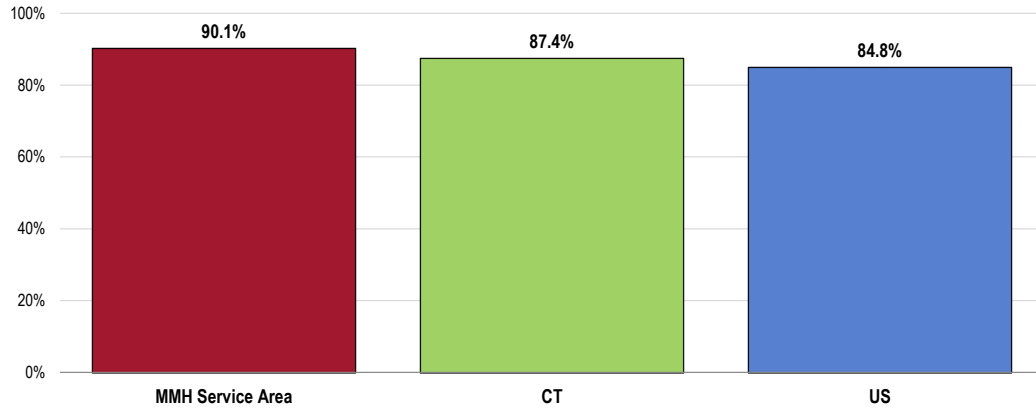
### *Pap Smear Testing*

**Among MMH Service Area women age 21 to 65, 90.1% have had a Pap smear within the past 3 years.**

- Comparable to Connecticut and US findings.
- Comparable to the Healthy People 2020 target (93% or higher).

## Have Had a Pap Smear in the Past Three Years (Among Women Age 21-65)

Healthy People 2020 Target = 93.0% or Higher



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Connecticut data.
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-15]
- Notes:
- Reflects female respondents age 21 to 65.

## Colorectal Cancer Screenings

### About Screening for Colorectal Cancer

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

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

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

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

### Colorectal Cancer Screening

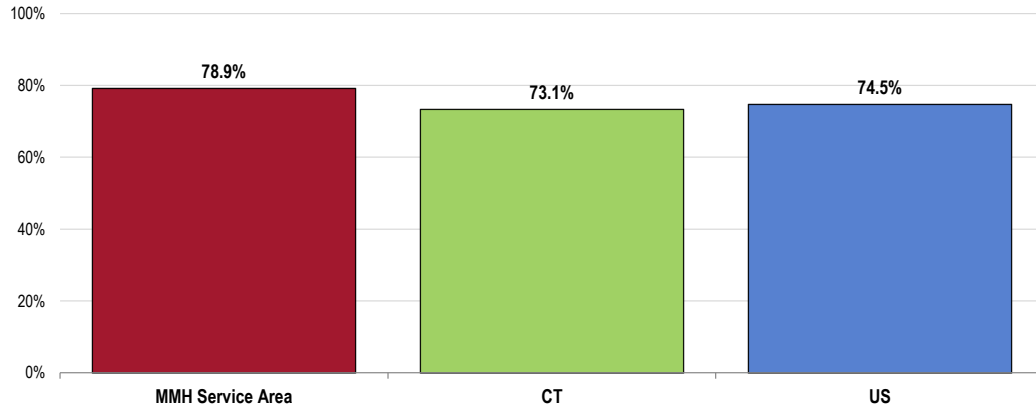
**Among adults age 50-75, 78.9% have had an appropriate colorectal cancer screening (fecal occult blood testing within the past year and/or sigmoidoscopy/colonoscopy [lower endoscopy] within the past 10 years).**

- Above the state figure.
- Similar to national findings.
- Satisfies the Healthy People 2020 target (70.5% or higher).

"Appropriate colorectal cancer screening" includes a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

## Have Had a Colorectal Cancer Screening (Among Adults Age 50-75)

Healthy People 2020 Target = 70.5% or Higher

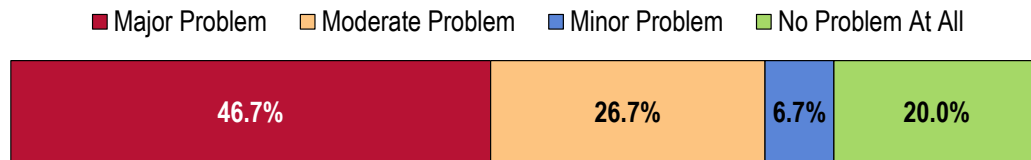


- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 155]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). 2014 Connecticut data.
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-16]
- Notes:
- Asked of all respondents age 50 through 75.
  - In this case, the term "colorectal screening" refers to adults age 50-75 receiving a FOBT (fecal occult blood test) in the past year and/or a lower endoscopy (sigmoidoscopy/colonoscopy) in the past 10 years.

### Key Informant Input: Cancer

Virtually half of key informants taking part in an online survey characterized **Cancer** as a "major problem" in the community.

### Perceptions of Cancer as a Problem in the Community (Key Informants, 2016)



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

### Top Concerns

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

#### Prevalence/Incidence

*As in all communities, we have a cancer center that is very busy. As more and more people get access to health coverage, more cancer will be detected. – Physician*

*Cancer is insidious in any community. – Community Leader*

*I believe cancer is a major problem in all communities. It is rare to find a family that has not been affected in some way by cancer. – Social Services Provider*

*As cancer becomes more of a chronic condition, rather than an automatic terminal diagnosis, many more people will be seeking treatment and living with the consequences of both the disease and treatment in the community. – Community Leader*

***Health Education***

*Most people don't believe that they will be the one that develops cancer, until they do. The community needs proactive lifestyle changes to create a healthy body and fight off disease. – Community Leader*

## Respiratory Disease

### About Asthma & COPD

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

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

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

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

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

Risk factors for asthma currently being investigated include:

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

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

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

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

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

## Age-Adjusted Respiratory Disease Deaths

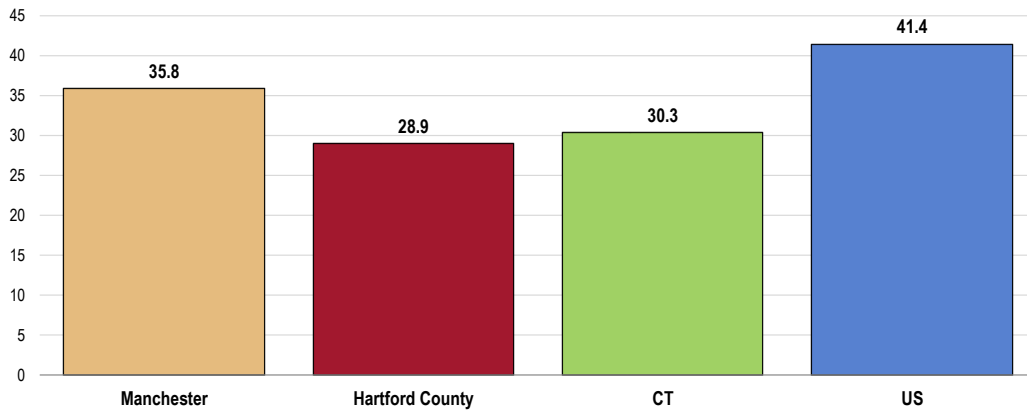
### Chronic Lower Respiratory Disease Deaths (CLRD)

Between 2012 and 2014, there was an annual average age-adjusted CLRD mortality rate of 28.9 deaths per 100,000 population in Hartford County.

- Similar to the Connecticut rate.
- Well below the national rate.
- The 2008-2012 Manchester rate was 35.8 per 100,000 population.

Note: COPD was changed to chronic lower respiratory disease (CLRD) in 1999 with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.

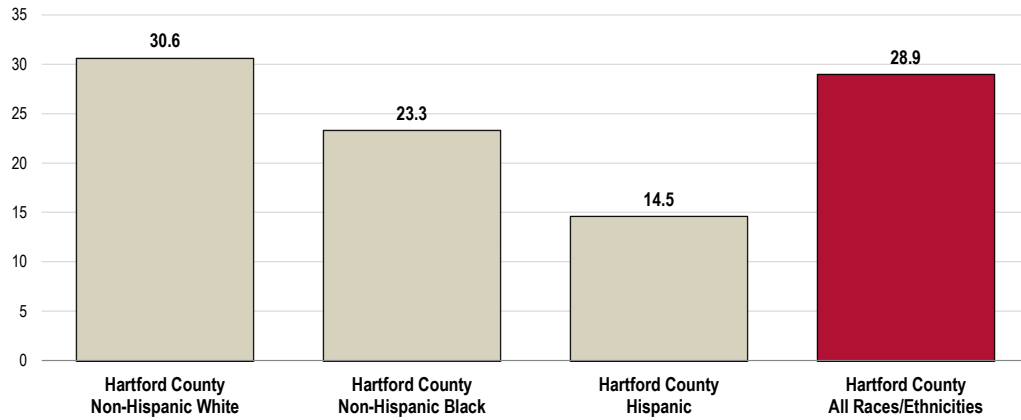
**CLRD: Age-Adjusted Mortality**  
(2012-2014 Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
  - Town data (2008-2012): Connecticut State Department of Public Health.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
  - CLRD is chronic lower respiratory disease.

- CLRD mortality appears notably higher among Whites in Hartford County.

### CLRD: Age-Adjusted Mortality by Race (2012-2014 Annual Average Deaths per 100,000 Population)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.

- Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.  
● CLRD is chronic lower respiratory disease.

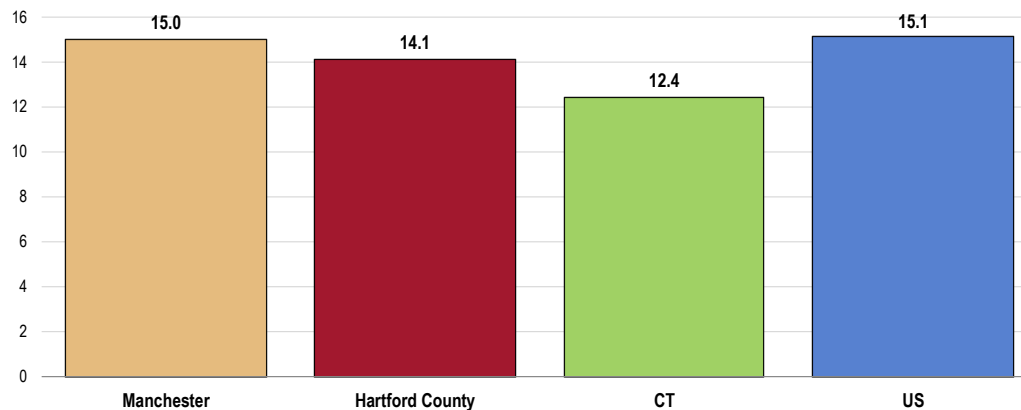
### Pneumonia/Influenza Deaths

Between 2012 and 2014, Hartford County reported an annual average age-adjusted pneumonia influenza mortality rate of 14.1 deaths per 100,000 population.

- Higher than the state rate.
- Lower than the US rate.
- The Manchester rate was 15.0 between 2008 and 2012.

For prevalence of vaccinations for pneumonia and influenza, see also *Immunization & Infectious Disease*.

### Pneumonia/Influenza: Age-Adjusted Mortality (2012-2014 Annual Average Deaths per 100,000 Population)



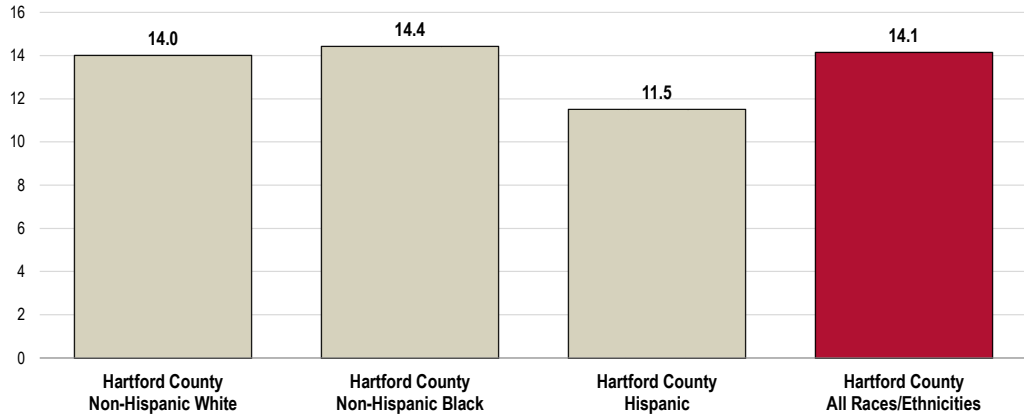
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.

- Notes: ● Town data (2008-2012): Connecticut State Department of Public Health.  
● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.



- The pneumonia/influenza mortality rate in Hartford County is higher among Whites and Blacks than among Hispanics.

**Pneumonia/Influenza: Age-Adjusted Mortality by Race**  
(2012-2014 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

**Asthma**

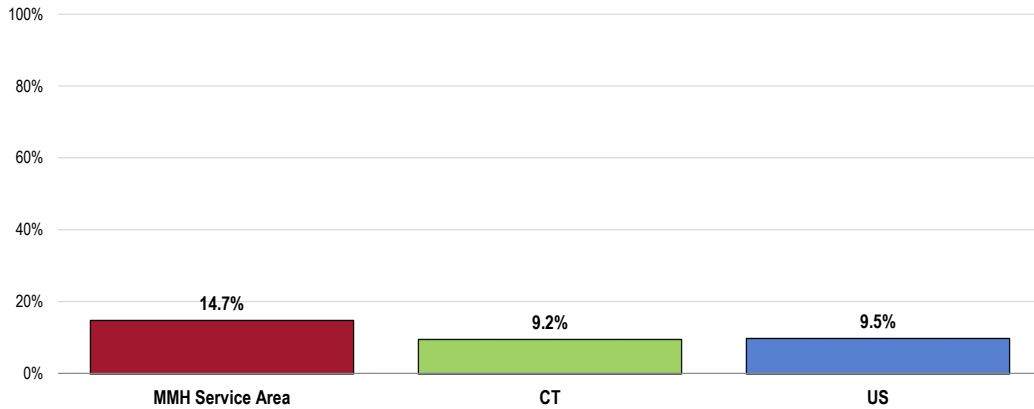
**Adults**

**A total of 14.7% of MMH Service Area adults currently suffer from asthma.**

- Well above the state and national prevalence.

Survey respondents were next asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma and COPD.

**Adult Asthma: Current Prevalence**

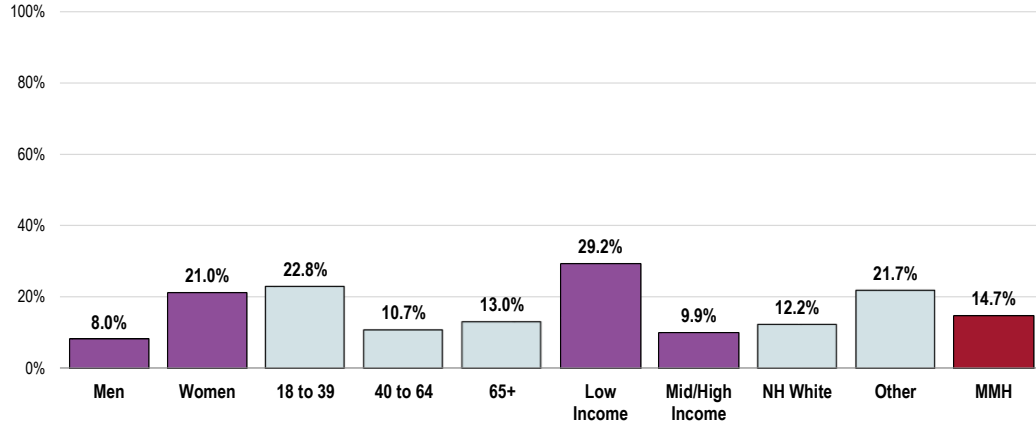


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 156]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2014 Connecticut data.  
 Notes: • Asked of all respondents.  
 • Includes those who have ever been diagnosed with asthma, and who report that they still have asthma.

The following adults are more likely to suffer from asthma:

- Women.
- Young adults.
- Low-income residents.

### Currently Have Asthma (MMH Service Area, 2016)



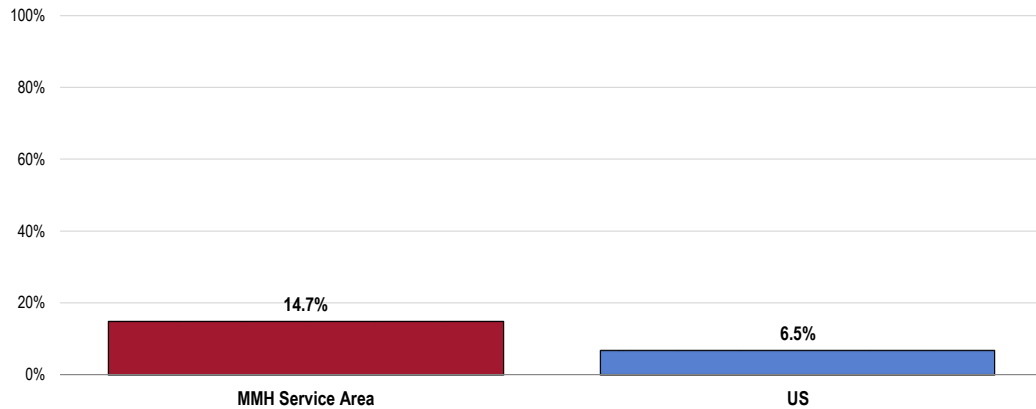
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 156]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Children

Among MMH Service Area children under age 18, 14.7% currently have asthma.

- Well above the national findings.

### Childhood Asthma: Current Prevalence (Among Parents of Children Age 0-17)

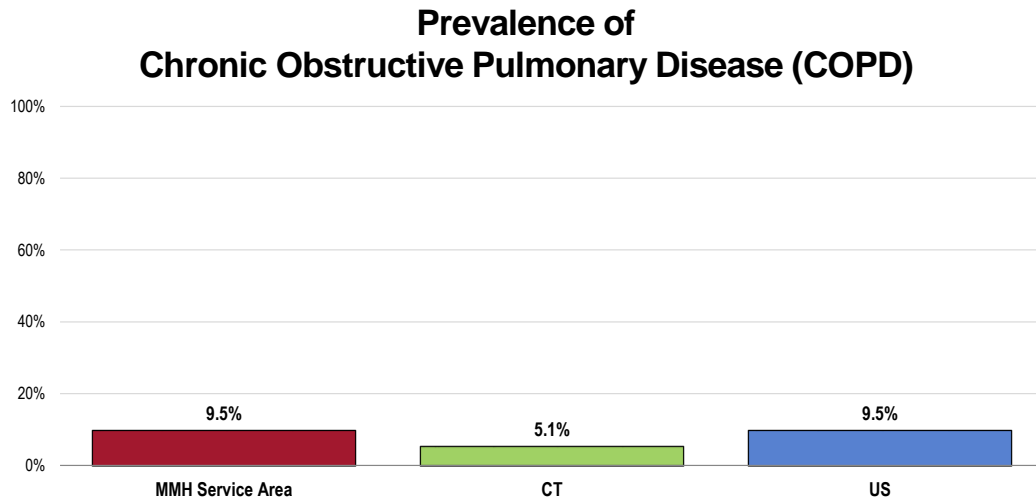


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 157]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents with children 0 to 17 in the household.  
 • Includes children who have ever been diagnosed with asthma, and whom are reported to still have asthma.

### Chronic Obstructive Pulmonary Disease (COPD)

A total of 9.5% of MMH Service Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

- Worse than the state prevalence.
- Identical to the national prevalence.

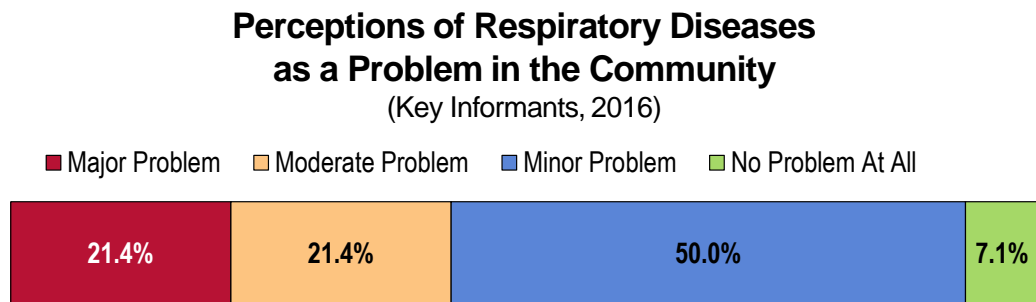


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 24]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2014 Connecticut data.  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.

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

### Key Informant Input: Respiratory Disease

Half of key informants taking part in an online survey characterized *Respiratory Disease* as a “minor problem” in the community.



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

## Top Concerns

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

### *Prevalence/Incidence*

*I believe respiratory diseases are a concern in our community due to the chronic nature of COPD, emphysema and lung cancer, and the toll it takes on patients- as well as the cost to Medicare, Medicaid and other health insurance programs. Education is needed. – Community Leader*

### *Tobacco Use*

*Smoking. Still many smokers in our community, despite the fact that cigarettes are heavily taxed in our state. – Physician*

## Injury & Violence

### About Injury & Violence

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

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

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

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

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

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

Interventions addressing these social and physical factors have the potential to prevent unintentional injuries and violence. Efforts to prevent unintentional injury may focus on:

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

Efforts to prevent violence may focus on:

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

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

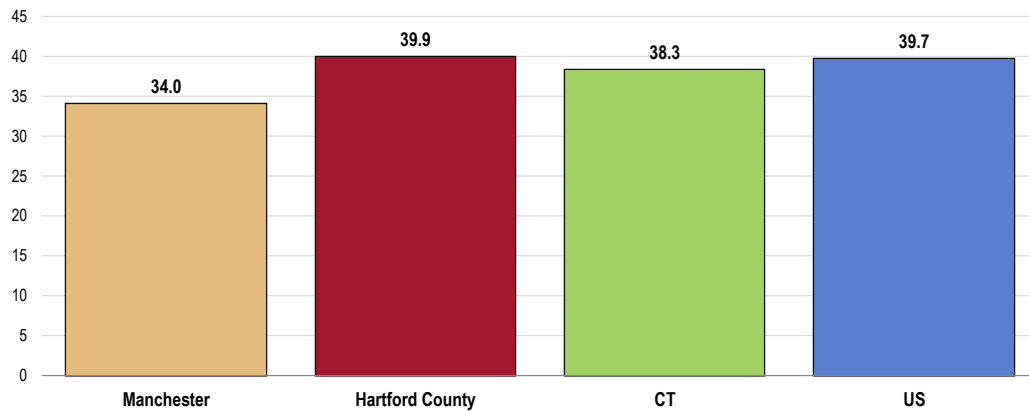
## Unintentional Injury

### Age-Adjusted Unintentional Injury Deaths

**Between 2012 and 2014, there was an annual average age-adjusted unintentional injury mortality rate of 39.9 deaths per 100,000 population in Hartford County.**

- Similar to the state and national rates.
- Fails to satisfy the Healthy People 2020 target (36.4 or lower).
- The mortality rate was 34.0 in Manchester (2008-2012 data).

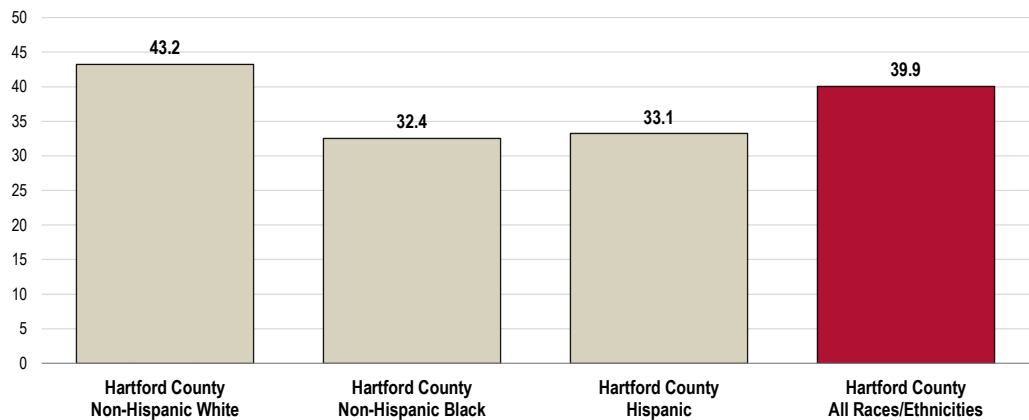
### Unintentional Injuries: Age-Adjusted Mortality (2012-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 36.4 or Lower



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
  - Town data (2008-2012): Connecticut State Department of Public Health.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The mortality rate is notably higher among Whites when compared with Blacks and Hispanics in Hartford County.

### Unintentional Injuries: Age-Adjusted Mortality by Race (2012-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 36.4 or Lower

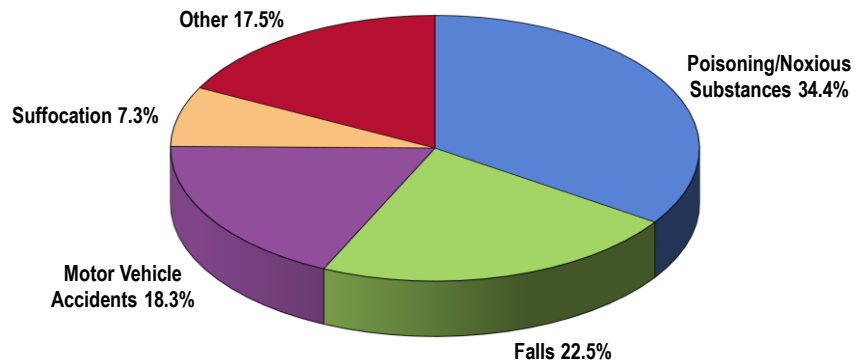


- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

### Leading Causes of Accidental Death

Poisoning (including accidental drug overdose), falls, motor vehicle accidents, and suffocation accounted for most accidental deaths in Hartford County between 2012 and 2014.

#### Leading Causes of Accidental Death (Hartford County, 2012-2014)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.  
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

#### *Selected Injury Deaths*

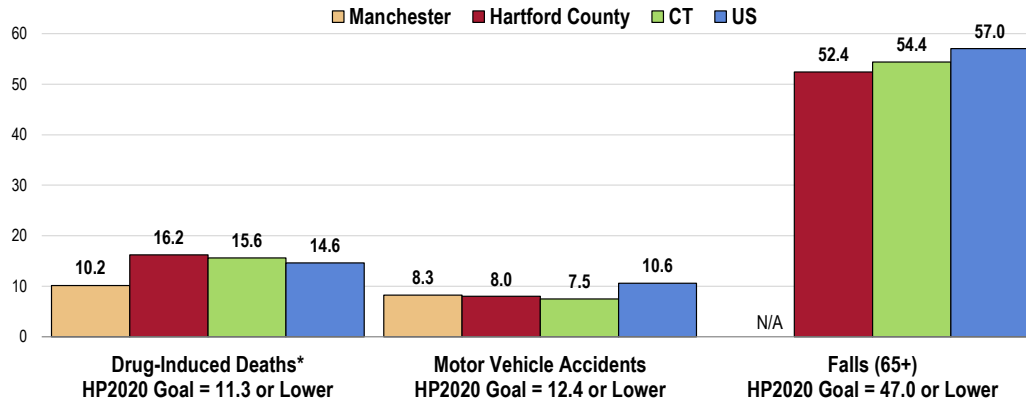
The following chart outlines mortality rates for drug-induced deaths (both intentional and unintentional overdoses), motor vehicle crashes, and falls (among adults age 65 and older).

**The Hartford County annual average age-adjusted drug-related mortality rate is worse than the US rate (similar to the state rate).**

**The county's motor vehicle mortality rate is worse than the state rate (better than the US rate).**

**Mortality from falls among seniors is similar to the state rate and better than the US.**

## Select Injury Death Rates (By Cause of Death; Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
  - Town data (2008-2012): Connecticut State Department of Public Health.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-13.1, IVP-23.2, SA-12]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
  - \*Drug-induced deaths include both intentional and unintentional drug overdoses.

## Falls

### Falls

Each year, an estimated one-third of older adults fall, and the likelihood of falling increases substantially with advancing age. In 2005, a total of 15,802 persons age ≥65 years died as a result of injuries from falls.

Falls are the leading cause of fatal and nonfatal injuries for persons aged ≥65 years ... in 2006, approximately 1.8 million persons aged ≥65 years (nearly 5% of all persons in that age group) sustained some type of recent fall-related injury. Even when those injuries are minor, they can seriously affect older adults' quality of life by inducing a fear of falling, which can lead to self-imposed activity restrictions, social isolation, and depression.

In addition, fall-related medical treatment places a burden on US healthcare services. In 2000, direct medical costs for fall-related injuries totaled approximately \$19 billion. A recent study determined that 31.8% of older adults who sustained a fall-related injury required help with activities of daily living as a result, and among them, 58.5% were expected to require help for at least 6 months.

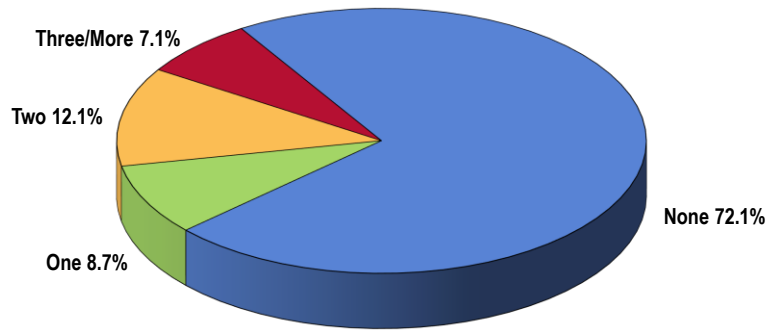
Modifiable fall risk factors include muscle weakness, gait and balance problems, poor vision, use of psychoactive medications, and home hazards. Falls among older adults can be reduced through evidence-based fall-prevention programs that address these modifiable risk factors. Most effective interventions focus on exercise, alone or as part of a multifaceted approach that includes medication management, vision correction, and home modifications.

- Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC



Among surveyed MMH Service Area adults age 45 and older, 27.9% fell at least once in the past year, including 7.1% who fell three or more times.

**Number of Falls in Past 12 Months**  
(Among Adults Age 45 and Older; MMH Service Area, 2016)

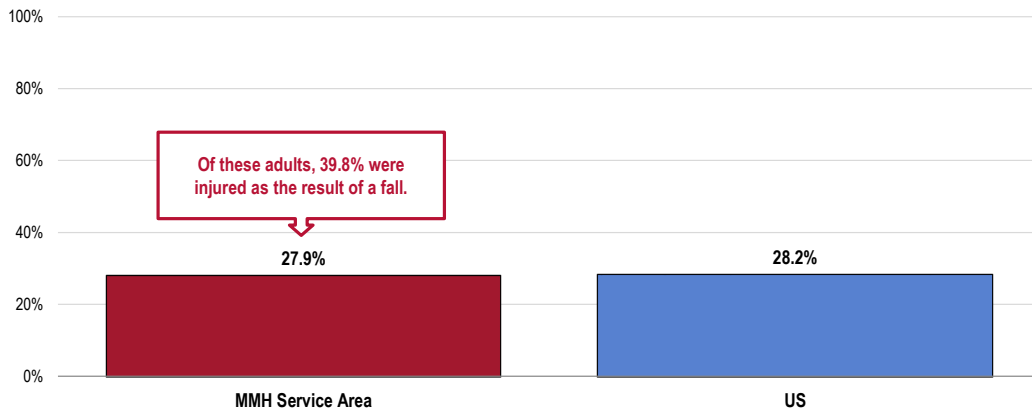


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 125]  
Notes: • Asked of all respondents age 45+.

- The prevalence of adults age 45+ who fell at least once in the past year is similar to the national proportion.

Among those who fell in the past year, 39.8% were injured as a result of the fall.

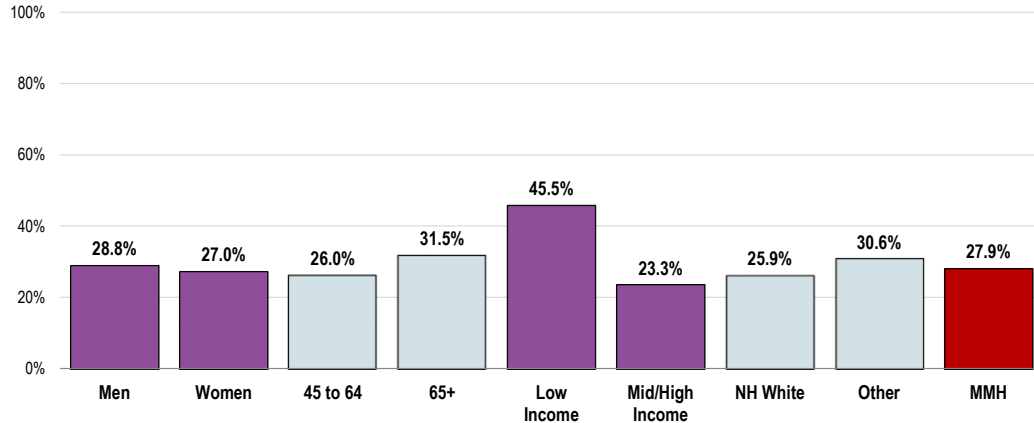
**Fell One or More Times in the Past Year**  
(Among Respondents Age 45 and Older)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 125-126]  
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of those respondents age 45 and older.

- Survey respondents in low-income households (age 45+) were more likely to have fallen in the past year.

**Fell One or More Times in the Past Year**  
(Among Respondents Age 45 and Older; MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 125]  
 Notes: • Asked of those respondents age 45 and older.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

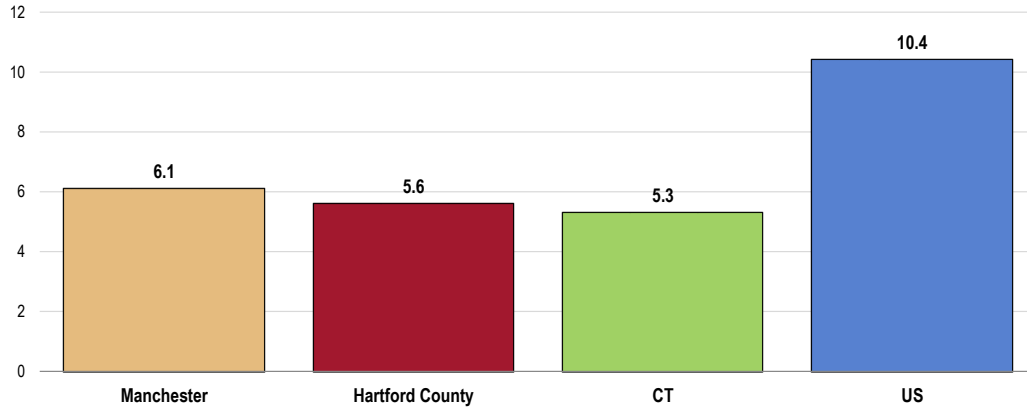
**Firearm Safety**

*Age-Adjusted Firearm-Related Deaths*

**Between 2012 and 2014, there was an annual average age-adjusted rate of 5.6 deaths per 100,000 population due to firearms in Hartford County.**

- Higher than found statewide.
- Well below that found nationally.
- Satisfies the Healthy People 2020 objective (9.3 or lower).
- The Manchester 2008-2012 rate was 6.1 deaths per 100,000 population.

### Firearms-Related Deaths: Age-Adjusted Mortality (2012-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 9.3 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.  
 • Town data (2008-2012): Connecticut State Department of Public Health.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-30]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

#### Presence of Firearms in Homes

**Overall, just 10.3% of MMH Service Area adults have a firearm kept in or around their home.**

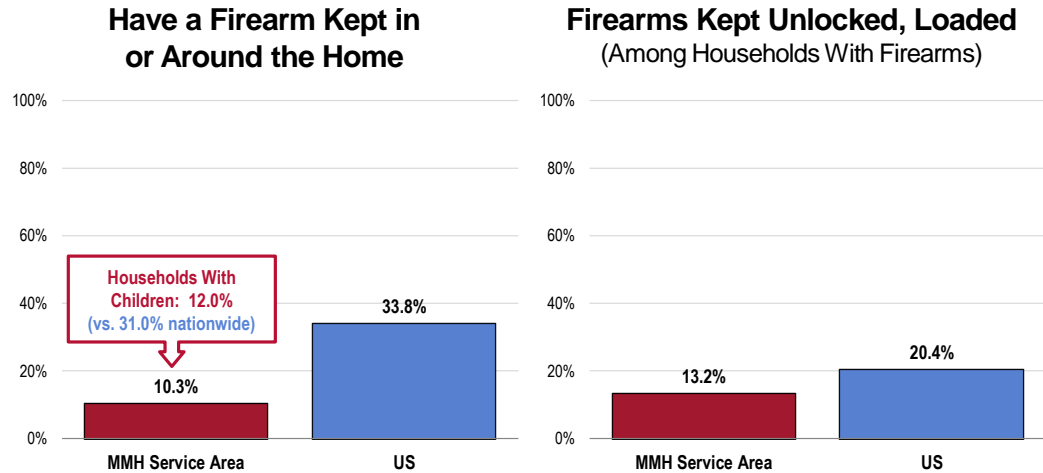
- Much lower than the national prevalence.
- Among MMH Service Area households with children, 12.0% have a firearm kept in or around the house (well below that reported nationally).

**Among MMH Service Area households with firearms, 13.2% report that there is at least one weapon that is kept unlocked and loaded.**

- Statistically similar to that found nationally.

Survey respondents were further asked about the presence of weapons in the home:

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



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 51, 159-160]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.  
 • In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.

## Intentional Injury (Violence)

### Age-Adjusted Homicide Deaths

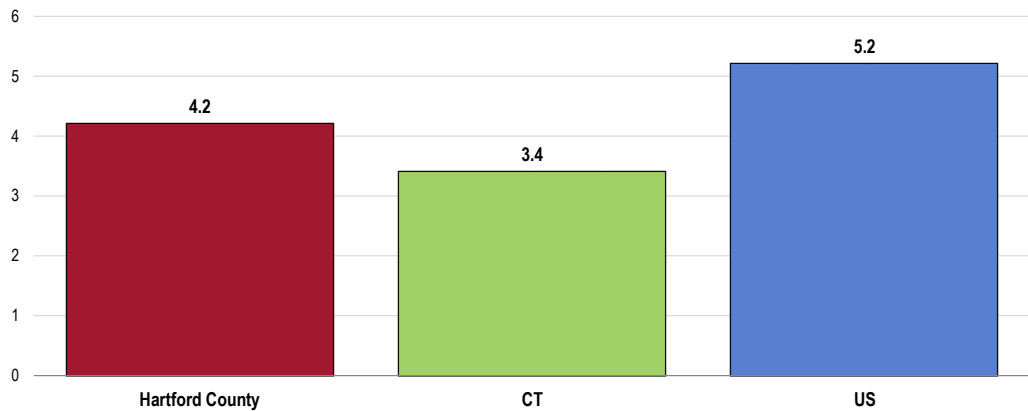
Between 2012 and 2014, there was an annual average age-adjusted homicide rate of 4.2 deaths per 100,000 population in Hartford County.

RELATED ISSUE:

See also *Suicide* in the **Mental Health** section of this report.

- Less favorable than the rate found statewide.
- More favorable than the national rate.
- Satisfies the Healthy People 2020 target of 5.5 or lower.

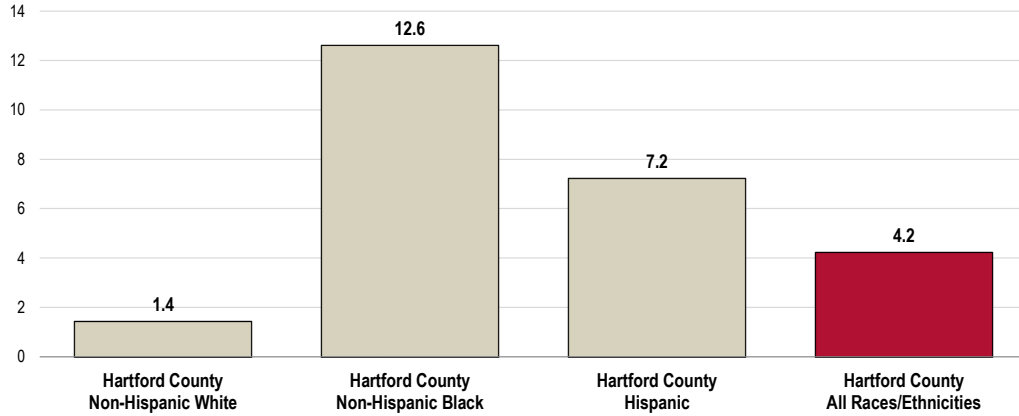
### Homicide: Age-Adjusted Mortality (2012-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 5.5 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-29]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The homicide rate is notably higher among Blacks in the county.

**Homicide: Age-Adjusted Mortality by Race**  
 (2012-2014 Annual Average Deaths per 100,000 Population)  
 Healthy People 2020 Target = 5.5 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-29]

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

**Violent Crime**

*Violent Crime Rates*

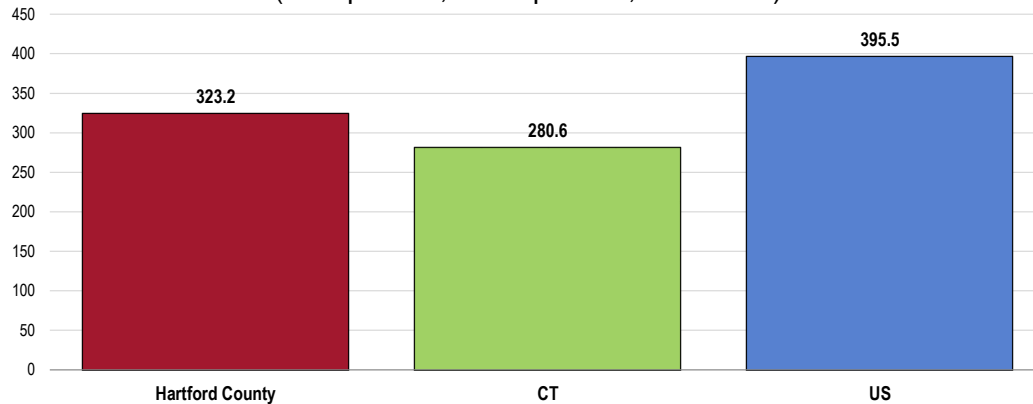
**Hartford County reported 323.2 violent crimes per 100,000 population between 2010 and 2012.**

- Worse than the Connecticut rate.
- Better than the national rate.

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

**Violent Crime**  
 (Rate per 100,000 Population, 2010-2012)



Sources: • Federal Bureau of Investigation, FBI Uniform Crime Reports.  
 • Retrieved August 2016 from Community Commons at <http://www.chna.org>.

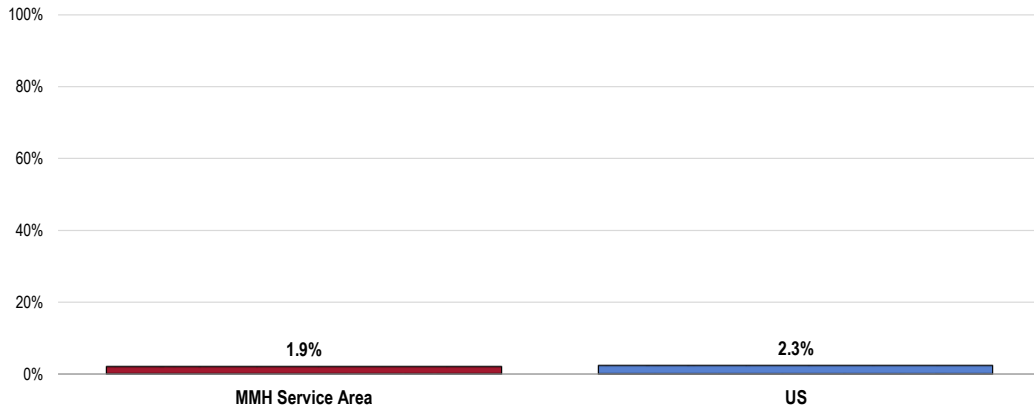
Notes: • This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.  
 • Participation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

**Community Violence**

**A total of 1.9% of surveyed MMH Service Area adults acknowledge being the victim of a violent crime in the area in the past five years.**

- Statistically similar to national findings.

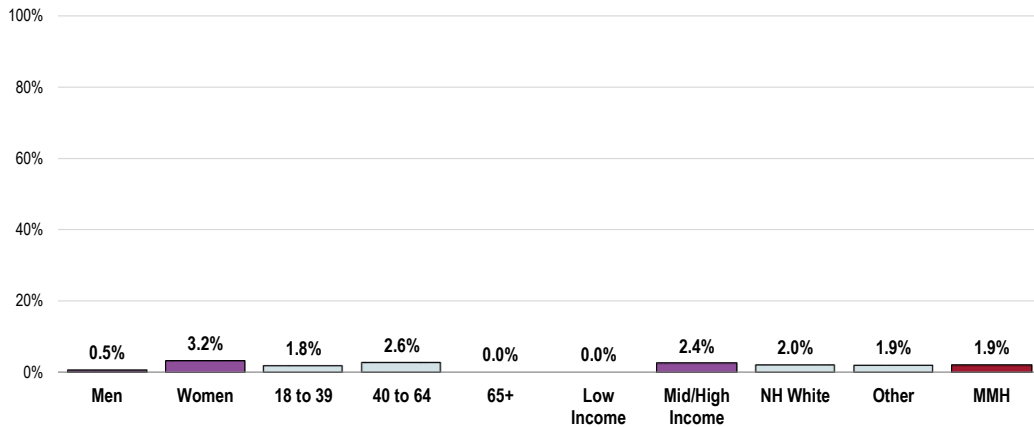
**Victim of a Violent Crime in the Past Five Years**



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

- Reports of violence are notably higher among women, adults age 40 to 64, and upper-income residents.

**Victim of a Violent Crime in the Past Five Years  
 (MMH Service Area, 2016)**



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

**Family Violence**

**A total of 11.3% of MMH Service Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.**

- Similar to the US figure.

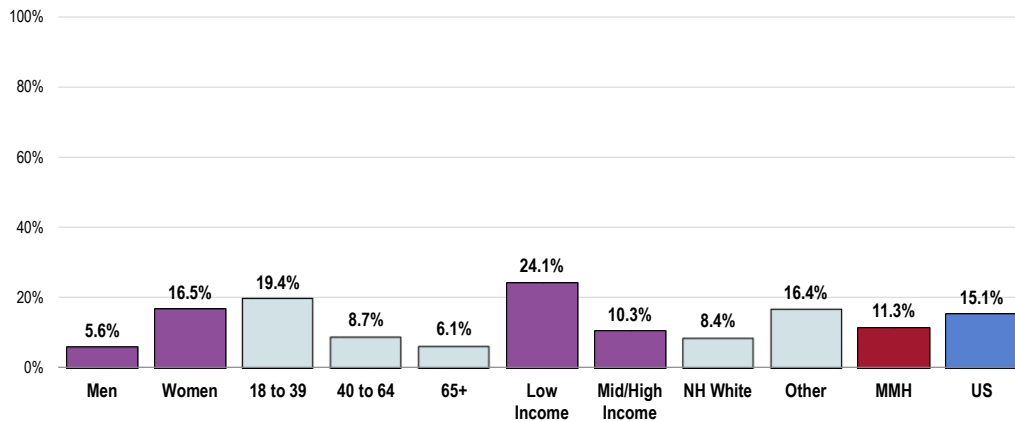
Reports of domestic violence are notably higher among:

- Women.
- Adults under 65 (negative correlation with age).
- Those with lower incomes.

Respondents were told:

"By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with would also be considered an intimate partner."

**Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner (MMH Service Area, 2016)**

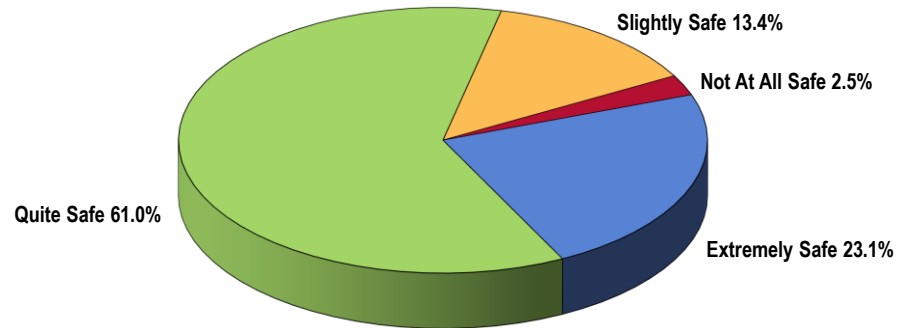


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 50]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

**Perceived Neighborhood Safety**

**While most MMH Service Area adults consider their own neighborhoods to be "extremely safe" or "quite safe," 15.9% considering them "not at all safe" or only "slightly safe."**

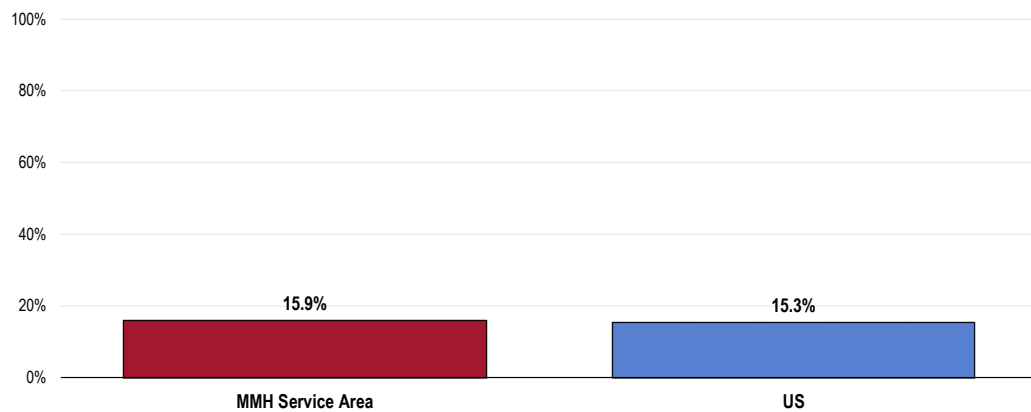
### Perceived Safety of Own Neighborhood (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

- The percentage of local adults who consider their neighborhood to be “slightly” or “not at all” safe is comparable to the US figure.

### Perceive Own Neighborhood as “Slightly” or “Not At All” Safe

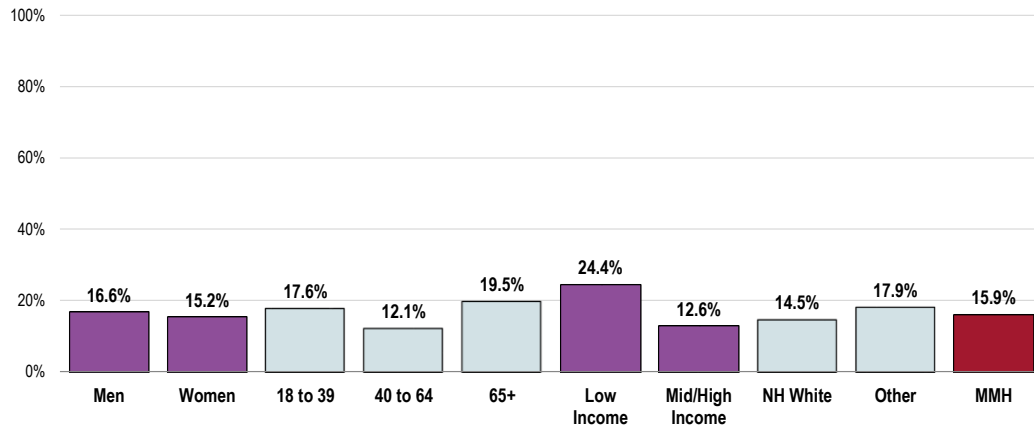


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

- Reports of unsafe neighborhoods are notably higher among lower-income residents.



### Perceive Own Neighborhood as “Slightly” or “Not At All” Safe (MMH Service Area, 2016)

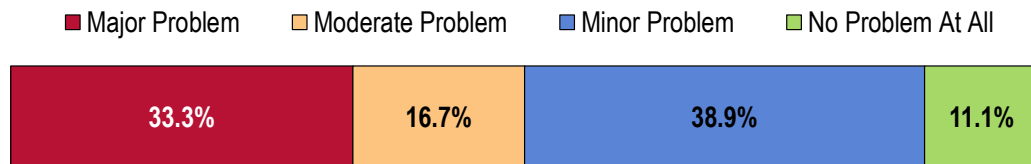


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Key Informant Input: Injury & Violence

The largest share of key informants taking part in an online survey characterized *Injury & Violence* as a “minor problem” in the community.

### Perceptions of Injury and Violence as a Problem in the Community (Key Informants, 2016)



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

### Top Concerns

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

#### Drug Use

More drug-related crimes. – Community Leader

#### Violent Crime

Gun control is a major issue at the local, state and federal level. Violent crimes are occurring at an alarming rate, as well. – Public Health Representative

Assaults, gun violence and the resulting trauma and neglect of children. – Community Leader

#### Poverty

Manchester has become increasing violent, due to low income and tensions between a diverse population. – Physician

## Diabetes

### About Diabetes

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

Diabetes mellitus:

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

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

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

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

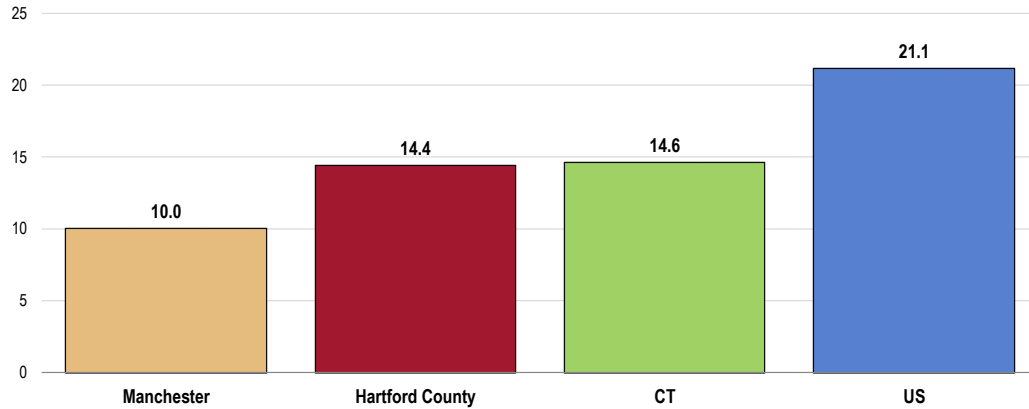
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Age-Adjusted Diabetes Deaths

**Between 2012 and 2014, there was an annual average age-adjusted diabetes mortality rate of 14.4 deaths per 100,000 population in Hartford County.**

- Similar to the state figure.
- More favorable than that found nationally.
- Satisfies the Healthy People 2020 target (20.5 or lower, adjusted to account for diabetes mellitus-coded deaths).
- The 2008-2010 Manchester mortality rate was 10.0 deaths per 100,000 population.

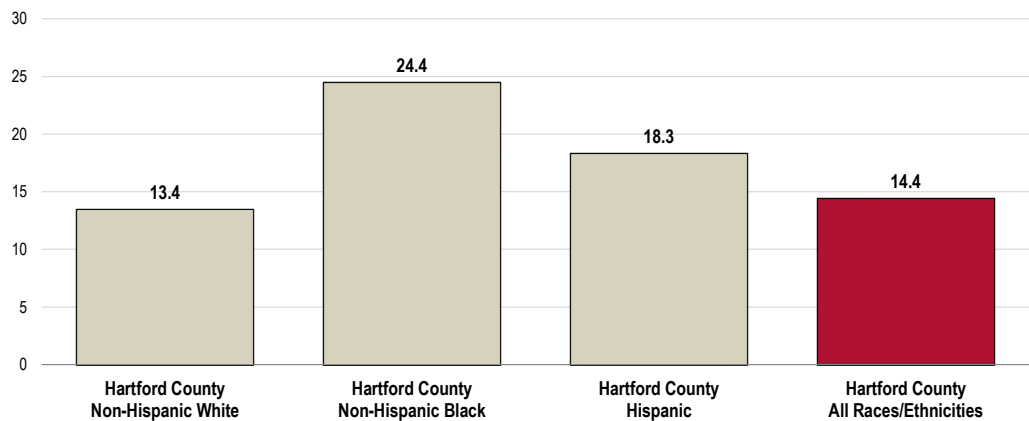
**Diabetes: Age-Adjusted Mortality**  
 (2012-2014 Annual Average Deaths per 100,000 Population)  
 Healthy People 2020 Target = 20.5 or Lower (Adjusted)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
  - Town data (2008-2012); Connecticut State Department of Public Health.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
  - The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

- The diabetes mortality rate in the county is notably higher among Blacks than among Whites and Hispanics.

**Diabetes: Age-Adjusted Mortality by Race**  
 (2012-2014 Annual Average Deaths per 100,000 Population)  
 Healthy People 2020 Target = 20.5 or Lower (Adjusted)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
  - The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

## Prevalence of Diabetes

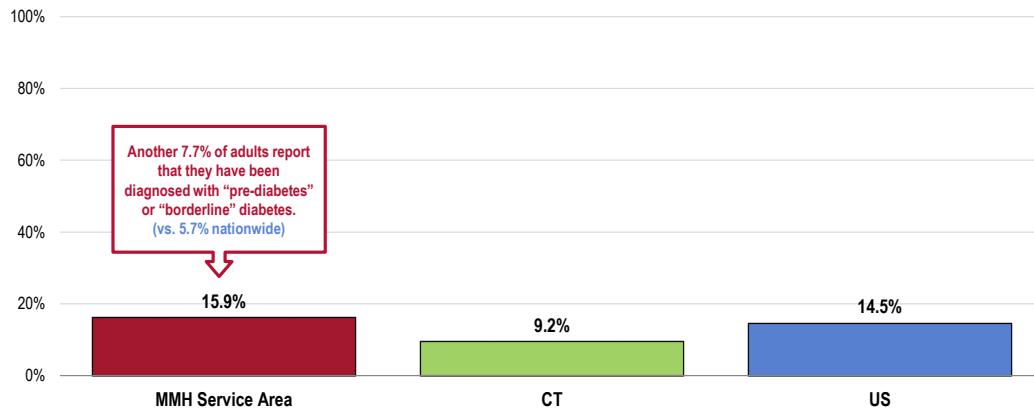
A total of 15.9% of MMH Service Area adults report having been diagnosed with diabetes.

- Worse than the statewide proportion.
- Similar to the national proportion.

In addition to the prevalence of diagnosed diabetes referenced above, another 7.7% of MMH Service Area adults report that they have “pre-diabetes” or “borderline diabetes.”

- Comparable to the US prevalence.

## Prevalence of Diabetes

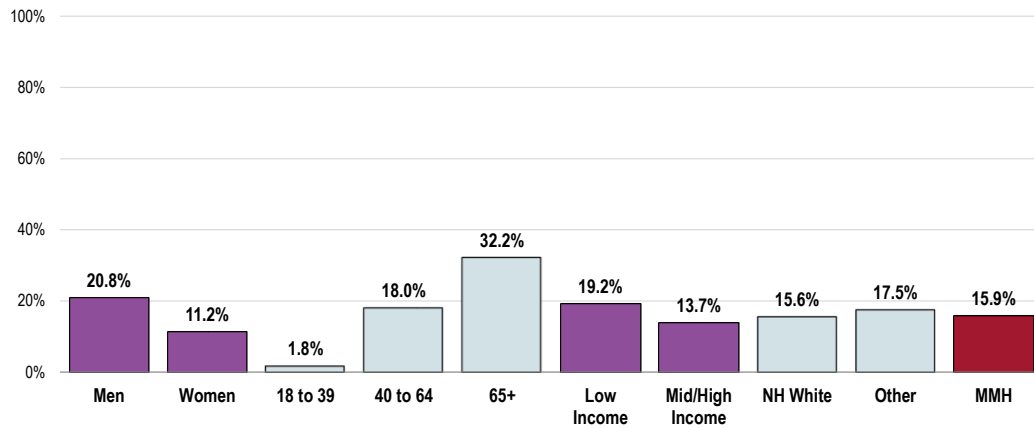


- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2014 Connecticut data.
- Notes:
- Asked of all respondents.

A higher prevalence of diagnosed diabetes (excluding pre-diabetes or borderline diabetes) is reported among:

- Men.
- Older adults (note the strong positive correlation between diabetes and age, with 32.2% of seniors with diabetes).

## Prevalence of Diabetes (MMH Service Area, 2016)



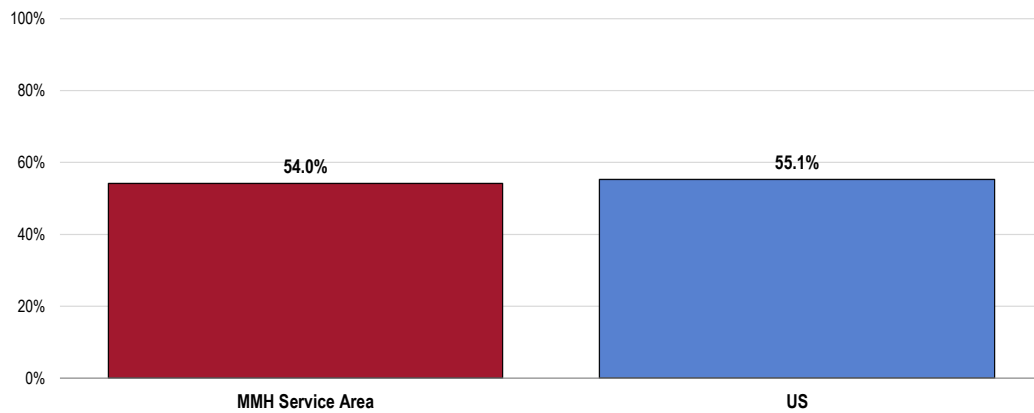
- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
  - Excludes gestational diabetes (occurring only during pregnancy).

### Diabetes Testing

Of area adults who have not been diagnosed with diabetes, 54.0% report having had their blood sugar level tested within the past three years.

- [Similar to the national proportion.](#)

### Have Had Blood Sugar Tested in the Past Three Years (Among Nondiabetics)

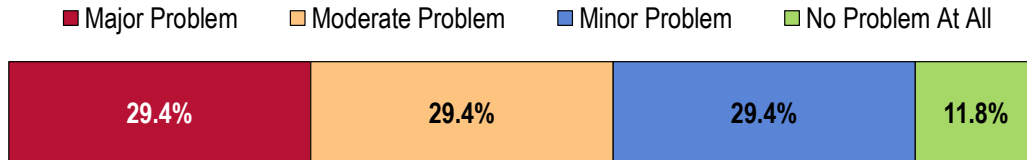


- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 39]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of respondents who have not been diagnosed with diabetes.

## Key Informant Input: Diabetes

Key informants taking part in an online survey equally characterized *Diabetes* as a “major problem,” “moderate problem,” and “minor problem” in the community.

### Perceptions of Diabetes as a Problem in the Community (Key Informants, 2016)



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

### Top Concerns

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

#### *Prevalence/Incidence*

*I would classify diabetes as a major problem for the fact that many people I see for consultations and in community settings have diabetes or prediabetes. The challenge I see is a lack of knowledge when it comes to nutrition and diabetes. – Community Leader*

#### *Disease Management*

*Continuing to control blood sugar and AC1 in an environment that encourages consumption of foods that create and aggravate diabetes. – Community Leader*

#### *Nutrition*

*Obesity. Lower-income people do not get enough fresh food from food pantries. – Physician*

## Alzheimer's Disease

### About Dementia

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

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

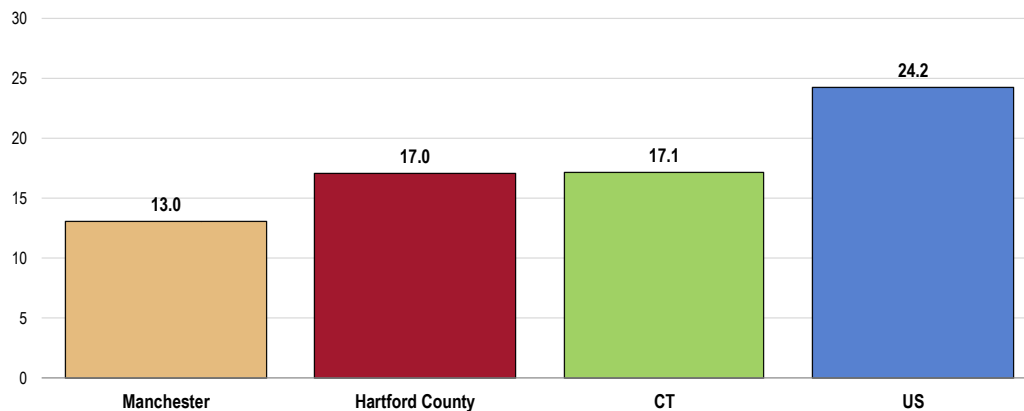
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Age-Adjusted Alzheimer's Disease Deaths

Between 2012 and 2014, there was an annual average age-adjusted Alzheimer's disease mortality rate of 17.0 deaths per 100,000 population in Hartford County.

- Almost identical to the statewide rate.
- More favorable than the national rate.
- The 2008-2010 Manchester rate was 13.0 deaths per 100,000 population.

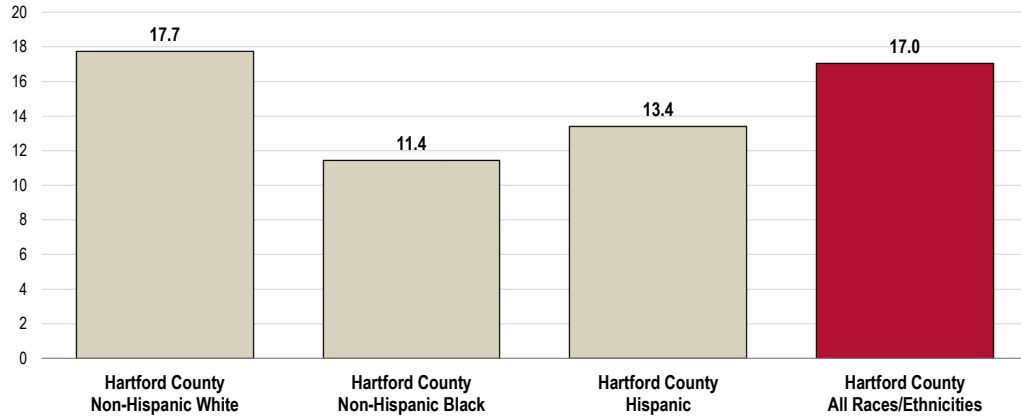
### Alzheimer's Disease: Age-Adjusted Mortality (2012-2014 Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
  - Town data (2008-2012): Connecticut State Department of Public Health.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The Alzheimer's disease mortality rate is much higher among Whites in Hartford County.

### Alzheimer's Disease: Age-Adjusted Mortality by Race (2012-2014 Annual Average Deaths per 100,000 Population)



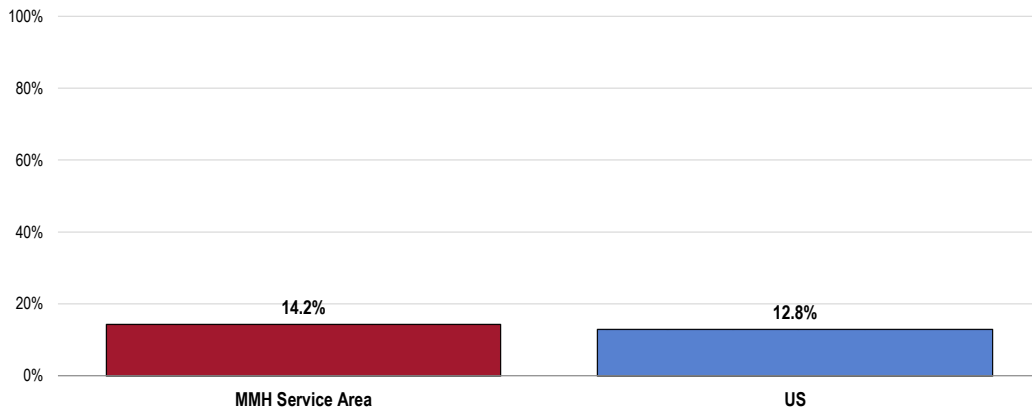
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

### Progressive Confusion/Memory Loss

A total of 14.2% of adults age 45 and older report experiencing confusion or memory loss in the past year that is happening more often or getting worse.

- Comparable to the US prevalence.

### Experienced Increasing Confusion/Memory Loss in Past Year (Among Respondents Age 45 and Older)

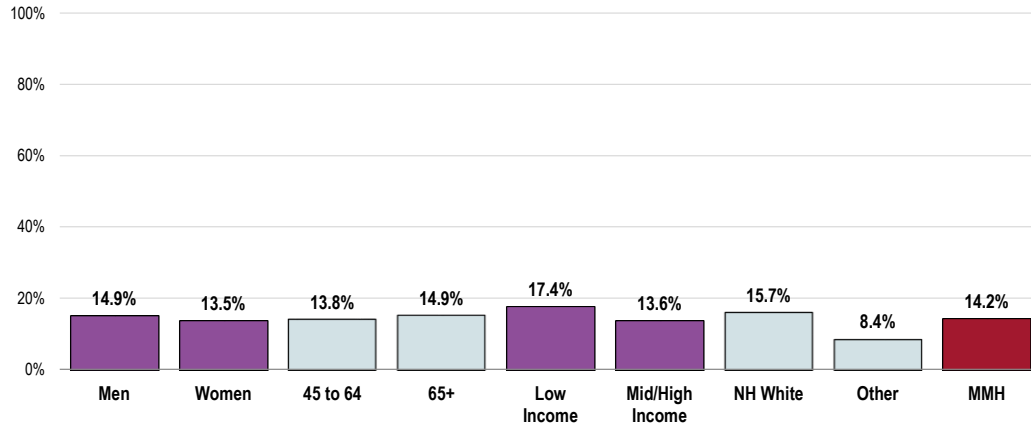


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 127]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of those respondents age 45 and older.



- Viewed by demographic characteristics, the prevalence of survey respondents age 45+ who have experienced increasing confusion or memory loss does not vary significantly.

### Experienced Increasing Confusion/Memory Loss in Past Year (Among Respondents Age 45 and Older; MMH Service Area, 2016)

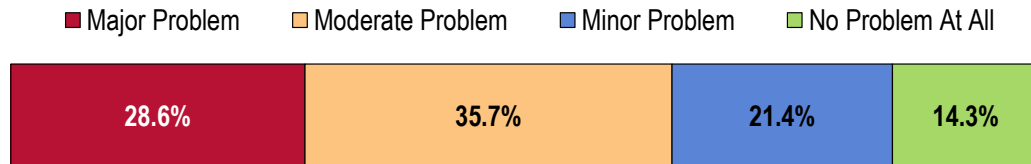


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 127]  
 Notes: Asked of those respondents age 45 and older. Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents). Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Key Informant Input: Dementias, Including Alzheimer's Disease

Key informants taking part in an online survey are most likely to consider *Dementias, Including Alzheimer's Disease* as a "moderate problem" in the community.

### Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community (Key Informants, 2016)



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

## Top Concerns

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

### *Aging Population*

*Aging baby boom population. – Physician*

*As our population ages, and 1 out of 2 people over the age of 85 suffer from some form of dementia, an enormous burden will be placed on family caregivers, transportation systems, medical and public safety resources. – Community Leader*

### *Insurance Issues*

*There are no geriatric psychiatrists who see all insurances in our area. – Other Health Provider*

### *Prevalence/Incidence*

*The number of cases are growing at alarming rates, without proper insurance and no adequate care. – Community Leader*

## Kidney Disease

### About Chronic Kidney Disease

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

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

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

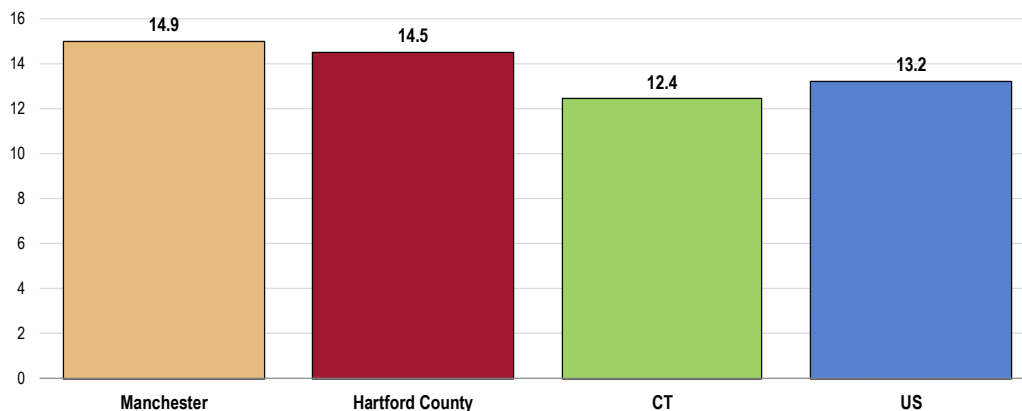
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Age-Adjusted Kidney Disease Deaths

**Between 2012 and 2014 there was an annual average age-adjusted kidney disease mortality rate of 14.5 deaths per 100,000 population in Hartford County.**

- Higher than the rates found statewide and nationally.
- The Manchester rate for 2008-2012 was 14.9 deaths per 100,000 population.

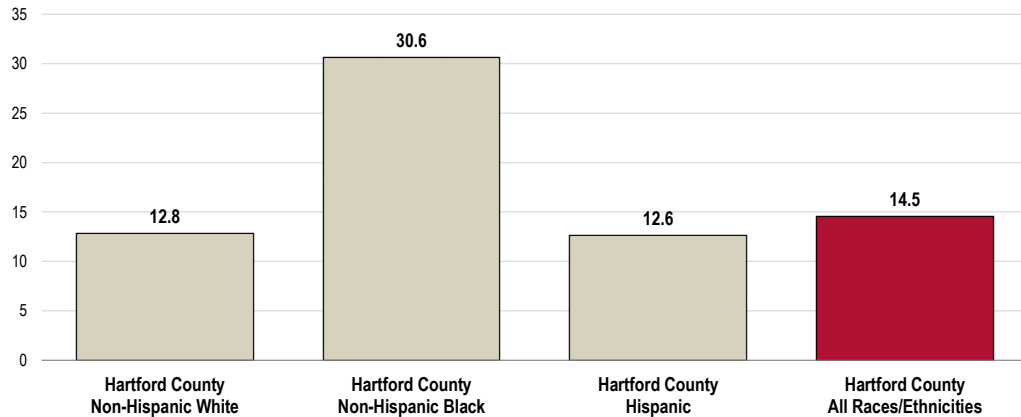
**Kidney Disease: Age-Adjusted Mortality**  
(2012-2014 Annual Average Deaths per 100,000 Population)



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
  - Town data (2008-2012): Connecticut State Department of Public Health.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The kidney disease mortality rate in Hartford County is dramatically higher in the Black population.

### Kidney Disease: Age-Adjusted Mortality by Race (2012-2014 Annual Average Deaths per 100,000 Population)



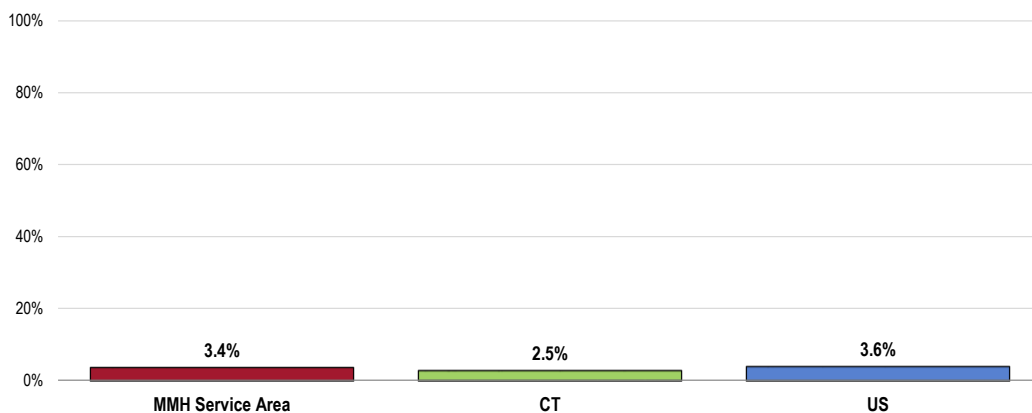
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

### Prevalence of Kidney Disease

A total of 3.4% of MMH Service Area adults report having been diagnosed with kidney disease.

- Similar to the state and national proportions.

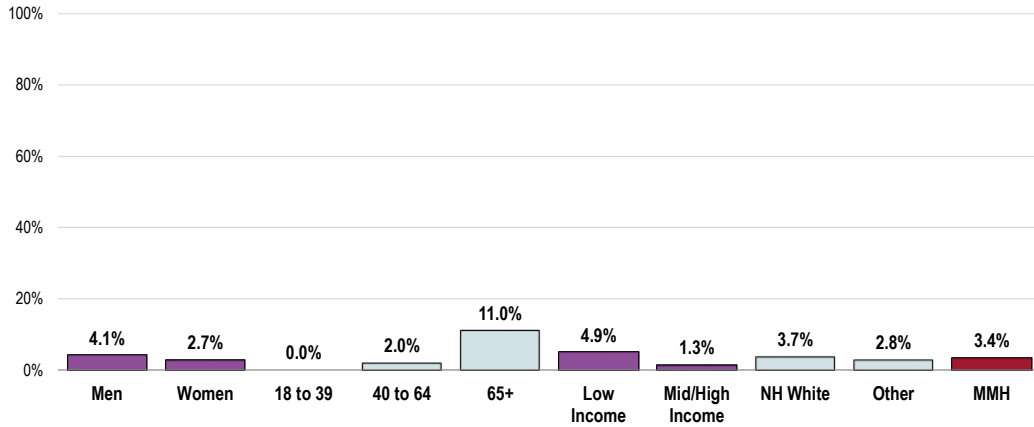
### Prevalence of Kidney Disease



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 32]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Connecticut data.  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

- The prevalence of kidney disease increases with age in the MMH Service Area.

### Prevalence of Kidney Disease (MMH Service Area, 2016)

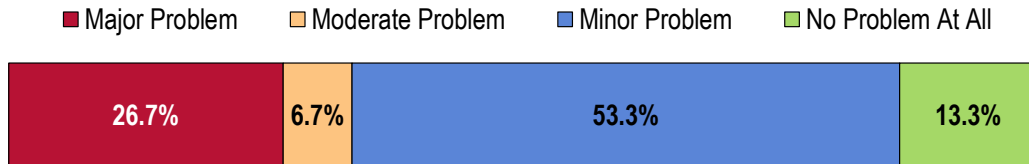


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 32]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Key Informant Input: Chronic Kidney Disease

Over half of key informants taking part in an online survey characterized *Chronic Kidney Disease* as a "minor problem" in the community.

### Perceptions of Chronic Kidney Disease as a Problem in the Community (Key Informants, 2016)



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

### Top Concerns

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

#### Aging Population

*Due to the rise in diabetes and aging baby boomers, more and more people are developing chronic kidney disease. – Physician*

#### Comorbidities

*As people live longer with chronic conditions- such as diabetes and complications from staph and other conditions requiring anti-biotic use- more people will find themselves with chronic kidney disease and/or in need of dialysis. – Community Leader*

## Potentially Disabling Conditions

### About Arthritis, Osteoporosis & Chronic Back Conditions

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

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

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

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

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

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

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

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Arthritis, Osteoporosis, & Chronic Back Conditions

**Nearly 4 in 10 MMH Service Area adults age 50 and older (39.4%) report suffering from arthritis or rheumatism.**

- Less favorable than that found nationwide.

**A total of 10.7% of MMH Service Area adults age 50 and older have osteoporosis.**

- Similar to that found nationwide.
- Fails to satisfy the Healthy People 2020 target of 5.3% or lower.

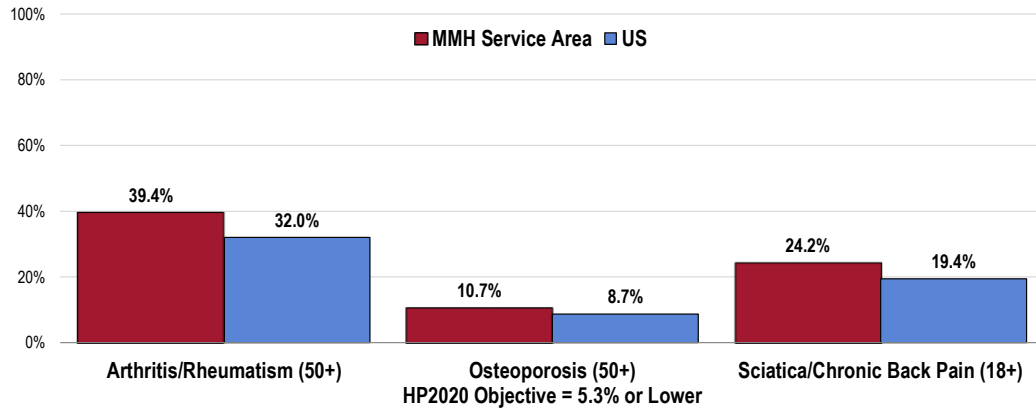
**A total of 24.2% of MMH Service Area adults (age 18 and older) suffer from chronic back pain or sciatica.**

- Similar to that found nationwide.

#### RELATED ISSUE:

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

### Prevalence of Potentially Disabling Conditions



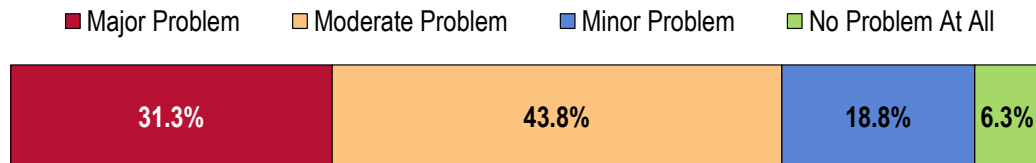
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 28, 161-162]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AOCBC-10]

Notes: • The sciatica indicator reflects the total sample of respondents; the arthritis and osteoporosis columns reflect adults age 50+.

### Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

A plurality of key informants taking part in an online survey characterized *Arthritis, Osteoporosis & Chronic Back Conditions* as a “moderate problem” in the community.

### Perceptions of Arthritis/Osteoporosis/Back Conditions as a Problem in the Community (Key Informants, 2016)



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

## Top Concerns

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

### **Access to Providers**

*There are not enough good rheumatologists. – Other Health Provider*

### **Aging Population**

*As our population ages, chronic conditions such as these will require more medical visits and increased costs. – Community Leader*

### **Diagnosis/Treatment**

*Without proper care, patients' health steadily declines. Depression. Loss of job. Loss of health insurance. It is the domino effect. If the cause is treated, people can live normal lives. – Community Leader*

### **Prevalence/Incidence**

*Majority of people I see have at least one region of their spine that is a problem. Most people don't realize how important their spinal health is until they start losing their health. – Community Leader*



## Vision & Hearing Impairment

### About Vision

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

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

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

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

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### About Hearing & Other Sensory or Communication Disorders

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

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

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

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Vision and Hearing Trouble

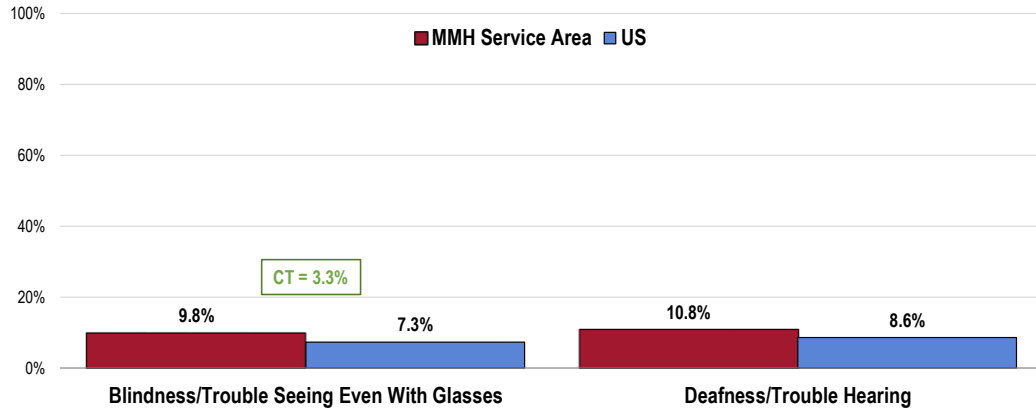
**A total of 9.8% of MMH Service Area adults are blind or have trouble seeing even when wearing corrective lenses, and 10.8% are deaf or have trouble hearing.**

- Compared with the statewide prevalence, the local prevalence of blindness is 3 times as high.
- Both figures are comparable to the related national benchmarks.

#### RELATED ISSUE:

See also *Vision Care* in the *Access to Health Services* section of this report.

### Prevalence of Blindness/Deafness



Sources:
 

- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 25-26]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2014 Connecticut data.

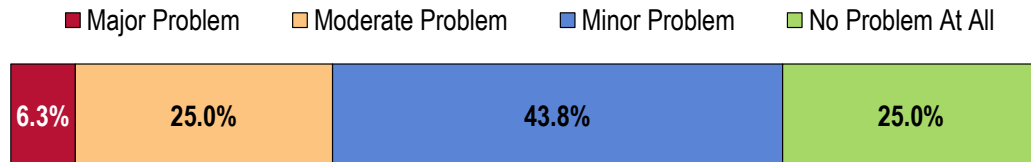
 Notes:
 

- Reflects the total sample of respondents.

### Key Informant Input: Hearing & Vision

Key informants taking part in an online survey most often characterized *Hearing & Vision* as a “minor problem” in the community.

### Perceptions of Hearing and Vision as a Problem in the Community (Key Informants, 2016)



Sources:
 

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

 Notes:
 

- Asked of all respondents.

### Top Concerns

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

#### Ageing Population

Ageing population. – Physician

# Infectious Disease



**Professional Research Consultants, Inc.**

## Influenza & Pneumonia Vaccination

### About Influenza & Pneumonia

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

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Flu Vaccinations

Among MMH Service Area seniors, 64.0% received a flu shot (or FluMist®) within the past year.

- Statistically comparable to the Connecticut and US findings.
- Comparable to the Healthy People 2020 target (70.0% or higher).

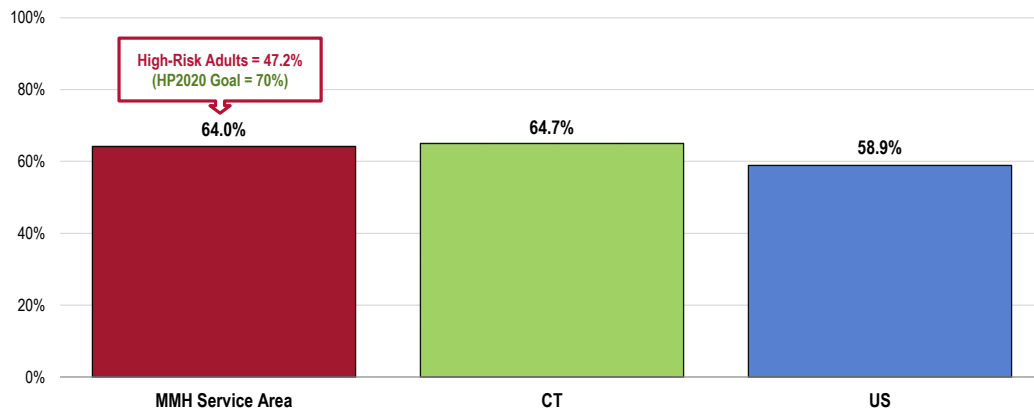
A total of 47.2% of high-risk adults age 18 to 64 received a flu vaccination (flu shot or FluMist®) within the past year.

FluMist® is a vaccine that is sprayed into the nose to help protect against influenza; it is an alternative to traditional flu shots.

"High-risk" includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.

### Older Adults: Have Had a Flu Vaccination in the Past Year (Among Adults Age 65+)

Healthy People 2020 Target = 70.0% or Higher



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 163-164]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Connecticut data.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IID-12.12]
- Notes:
- Reflects respondents 65 and older.
  - "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.
  - Includes FluMist as a form of vaccination.

## Pneumonia Vaccination

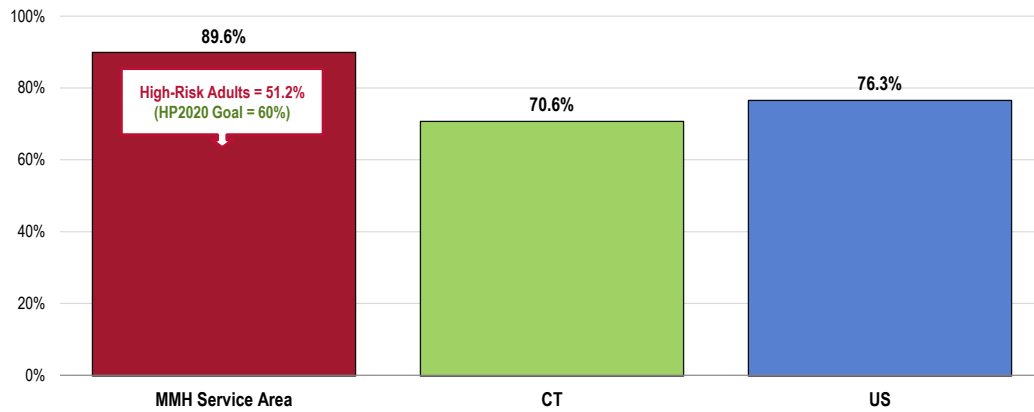
Among MMH Service Area adults age 65 and older, 89.6% have received a pneumonia vaccination at some point in their lives.

- Well above the state and national figures.
- Similar to the Healthy People 2020 target of 90.0% or higher.
- A total of 51.2% of high-risk adults age 18 to 64 have ever received a pneumonia vaccination.

### Older Adults: Have Ever Had a Pneumonia Vaccine

(Among Adults Age 65+)

Healthy People 2020 Target = 90.0% or Higher



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 165-166]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2014 Connecticut data.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives IID-13.1, IID-13.2]
- Notes:
- Reflects respondents 65 and older.
  - \*High-Risk\* includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.

## HIV

### About HIV

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

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

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

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

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

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

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

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

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

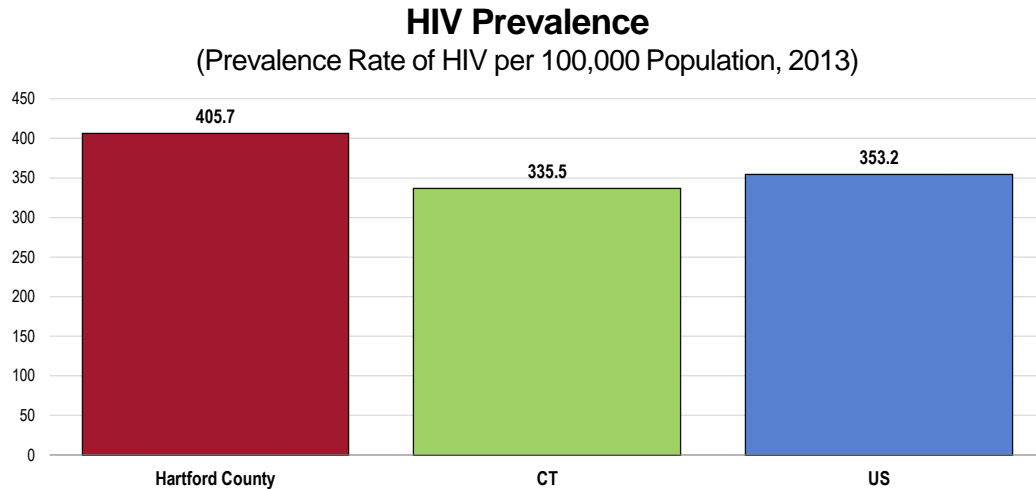
Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions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

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## HIV Prevalence

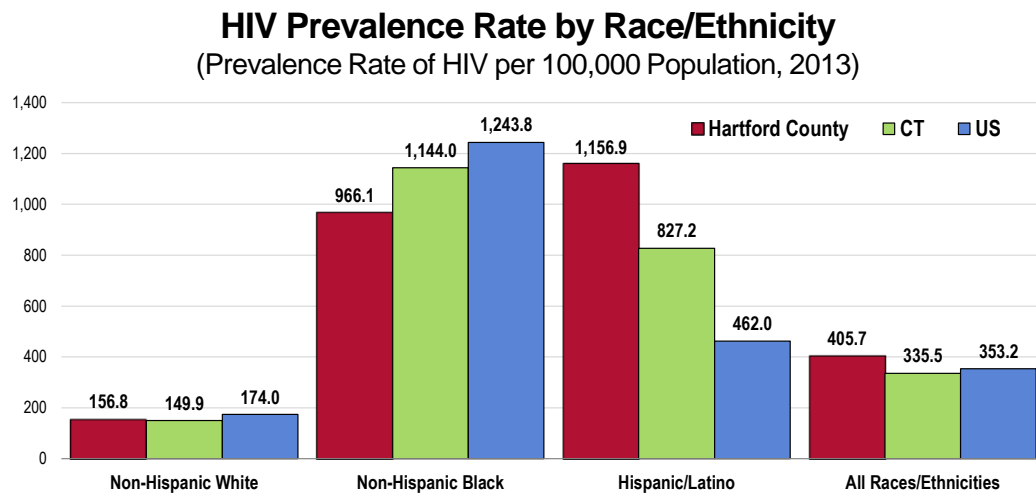
In 2013, there was a prevalence of 405.7 HIV cases per 100,000 population in Hartford County.

- Much higher than the state and US rates.



- Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
  - Retrieved August 2016 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

- By race and ethnicity, HIV/AIDS prevalence in Hartford County is particularly high among Hispanics (to a greater degree than found statewide or nationally) and Blacks (to a lesser degree than found statewide or nationally).



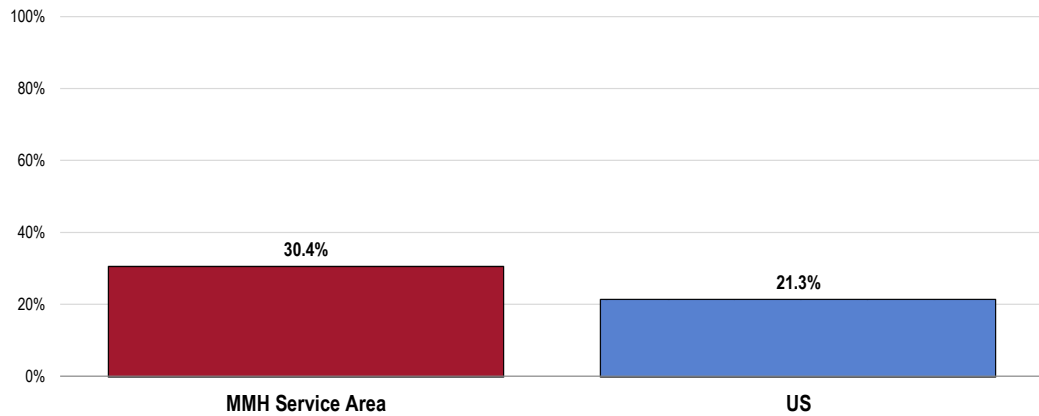
- Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
  - Retrieved August 2016 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

## HIV Testing

Among MMH Service Area adults age 18-44, 30.4% report that they have been tested for human immunodeficiency virus (HIV) in the past year.

- Statistically comparable to the proportion found nationwide.

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

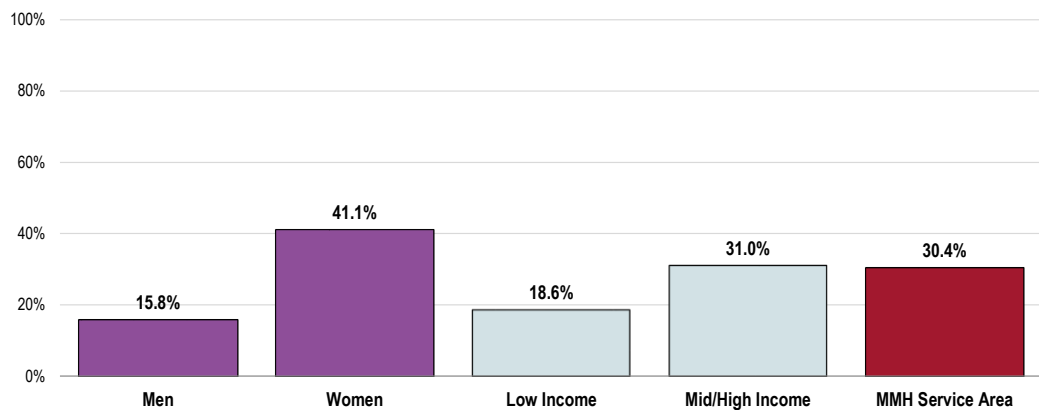


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 167]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Reflects respondents age 18 to 44.

By demographic characteristics:

- Men and low-income residents less often report having been tested for HIV.

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



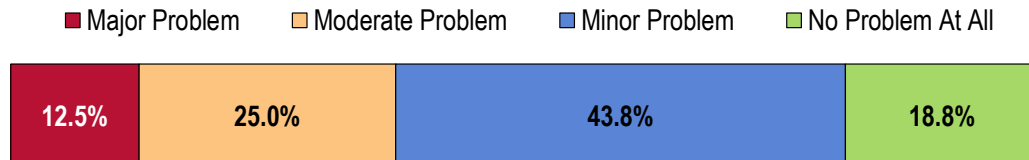
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 167]  
 • Reflects respondents age 18 to 44.  
 Notes: • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.



## Key Informant Input: HIV/AIDS

Key informants taking part in an online survey most often characterized *HIV/AIDS* as a “minor problem” in the community.

### Perceptions of HIV/AIDS as a Problem in the Community (Key Informants, 2016)



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

### Top Concerns

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

#### *Diagnosis/Treatment*

*HIV/AIDS is a chronic disease, which needs to be diagnosed early and monitored closely to obtain maximum health outcomes. Access to information and services is challenging if HIV-positive person is also battling substance abuse/addiction. – Community Leader*

## Sexually Transmitted Diseases

### About Sexually Transmitted Diseases

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

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

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

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

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

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Chlamydia & Gonorrhea

**In 2014, the chlamydia incidence rate in Hartford County was 462.4 cases per 100,000 population.**

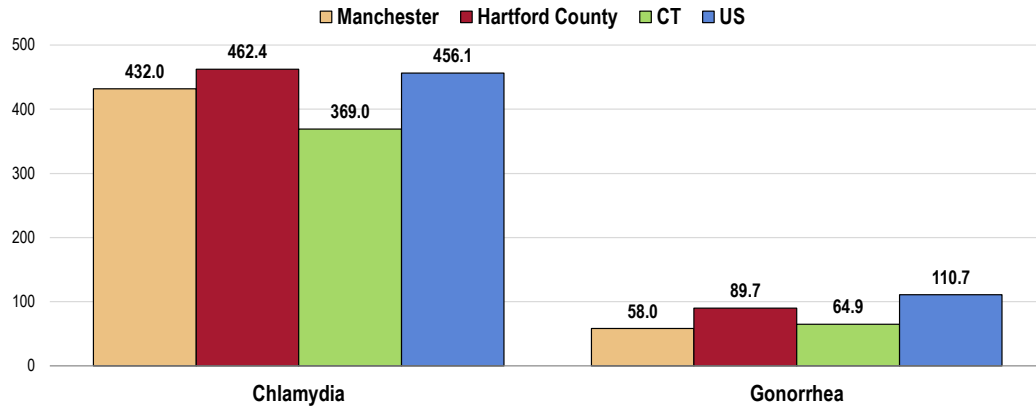
- Notably higher than the Connecticut incidence rate.
- Comparable to the national incidence rate.
- The 2015 Manchester rate was 432.0 cases per 100,000 population.

**The county’s gonorrhea incidence rate in 2014 was 89.7 cases per 100,000 population.**

- Higher than the Connecticut incidence rate.
- Lower than the national incidence rate.

- The 2015 Manchester rate was 58.0 cases per 100,000 population.

### Chlamydia & Gonorrhea Incidence (Incidence Rate per 100,000 Population, 2014)



Sources: • Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.  
 • Town data (2015): Connecticut State Department of Public Health, Connecticut STD Control Program.  
 • Retrieved August 2016 from Community Commons at <http://www.chna.org>.  
 Notes: • This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

### Safe Sexual Practices

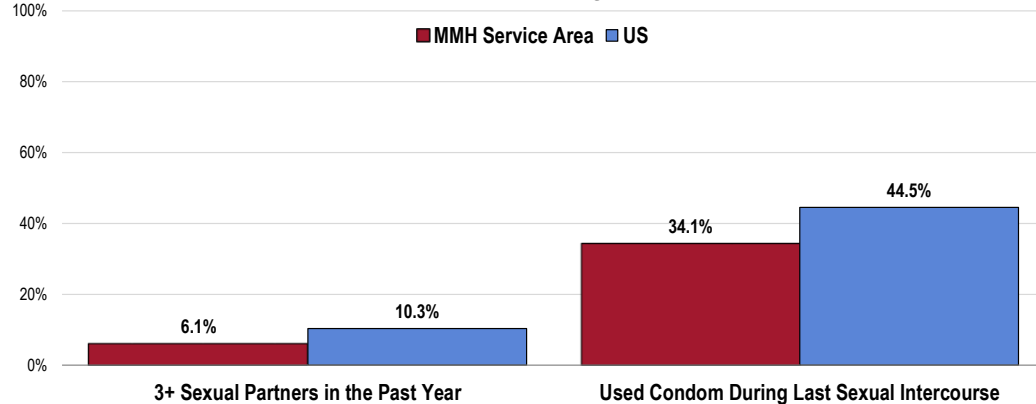
Among unmarried MMH Service Area adults under the age of 65, the majority cites having one (51.5%) or no (37.0%) sexual partners in the past 12 months. However, 6.1% report three or more sexual partners in the past year.

- Comparable to that reported nationally.

A total of 34.1% of unmarried MMH Service Area adults age 18 to 64 report that a condom was used during their last sexual intercourse.

- Statistically comparable to national findings.

### Sexual Risk (Unmarried Adults Age 18-64)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 97-98]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Reflects unmarried respondents under the age of 65.

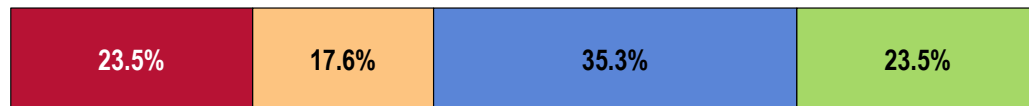
## Key Informant Input: Sexually Transmitted Diseases

A plurality of key informants taking part in an online survey characterized *Sexually Transmitted Diseases* as a “minor problem” in the community.

### Perceptions of Sexually Transmitted Diseases as a Problem in the Community

(Key Informants, 2016)

■ Major Problem   ■ Moderate Problem   ■ Minor Problem   ■ No Problem At All



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

### Top Concerns

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

#### *Prevalence/Incidence*

*Rates among young people- and to some degree the increase in STDs in older adults- need to be addressed, as the consequences to fertility and overall health are serious. – Community Leader*

#### *Immunizations*

*Parents are not allowing their children to get the Gardasil vaccine. – Physician*

## Immunization & Infectious Diseases

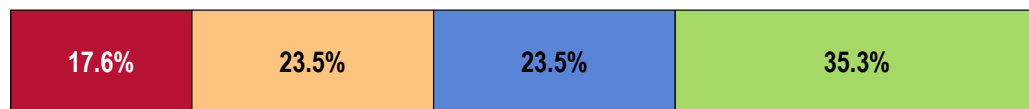
### Key Informant Input: Immunization & Infectious Diseases

Key informants taking part in an online survey most often characterized *Immunization & Infectious Diseases* as a “minor problem” in the community.

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

(Key Informants, 2016)

■ Major Problem   ■ Moderate Problem   ■ Minor Problem   ■ No Problem At All



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

### Top Concerns

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

#### *Health Education*

*With the rise of anti-vaxxers, more attention needs to be paid to the importance of immunizations and debunking some of the myths regarding vaccines. Also, infectious diseases such as hospital-acquired infections place a burden on health care costs. – Community Leader*

# Births



Professional Research Consultants, Inc.

## Prenatal Care

### About Infant & Child Health

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

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

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

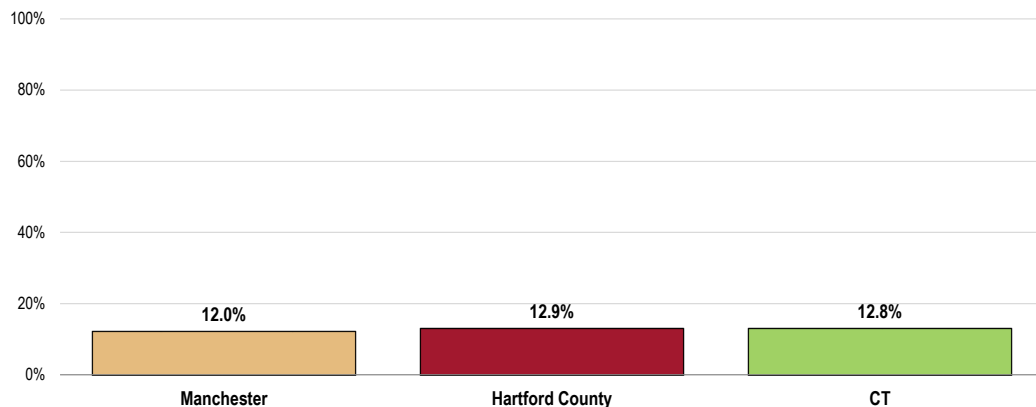
Early and continuous prenatal care is the best assurance of infant health.

**In 2013, 12.9% of all Hartford County births did not receive prenatal care in the first trimester of pregnancy.**

- Almost identical to the Connecticut proportion.
- Satisfies the Healthy People 2020 target (22.1% or lower).
- Lack of prenatal care was reported among 12.0% of births in Manchester.

### Lack of Prenatal Care in the First Trimester (Percentage of Live Births, 2013)

Healthy People 2020 Target = 22.1% or Lower



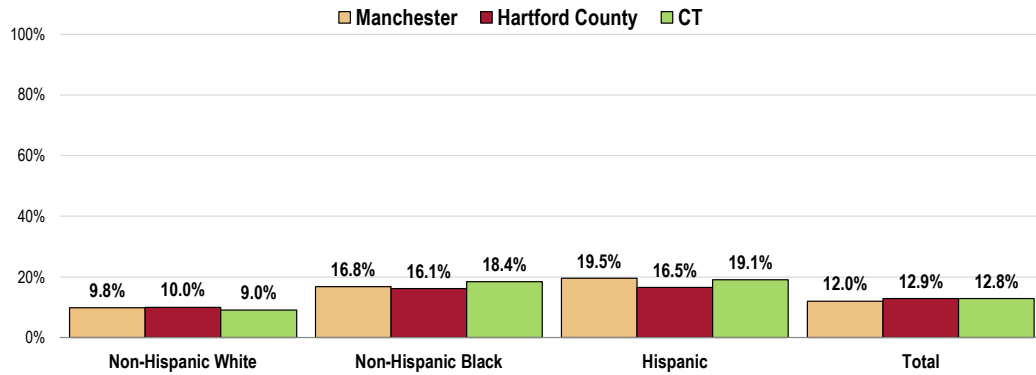
- Sources:
- Connecticut State Department of Public Health.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-10.1]
- Note:
- This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health, knowledge insufficient provider outreach, and/or social barriers preventing utilization of services.

- By race, lack of prenatal care was reported more often among births to Black and Hispanic mothers than births to White mothers.

### Lack of Prenatal Care in the First Trimester

(By Race; Percentage of Live Births, 2013)

Healthy People 2020 Target = 22.1% or Lower



- Sources:
- Connecticut State Department of Public Health.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-10.1]
- Note:
- This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health, knowledge insufficient provider outreach, and/or social barriers preventing utilization of services.



## Birth Outcomes & Risks

### Low-Weight Births

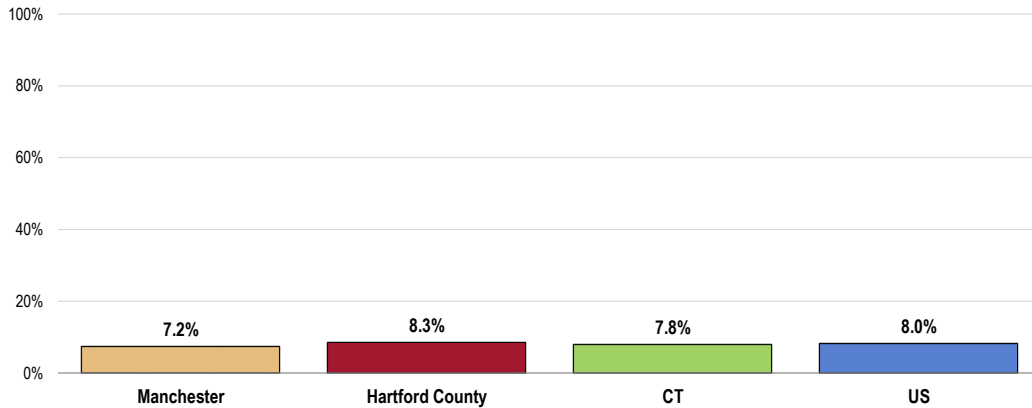
Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

**A total of 8.3% of 2013 Hartford County births were low-weight.**

- Worse than the Connecticut proportion.
- Similar to the national proportion (2012-2014 data).
- Fails to satisfy the Healthy People 2020 target (7.8% or lower).
- The percentage was 7.2% in Manchester.

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



Sources: • Connecticut State Department of Public Health, 2012 Connecticut Registration Report.  
 • US data (2012-2014): Retrieved August 2016 from Community Commons at <http://www.chna.org>.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-8.1]  
 Note: • This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

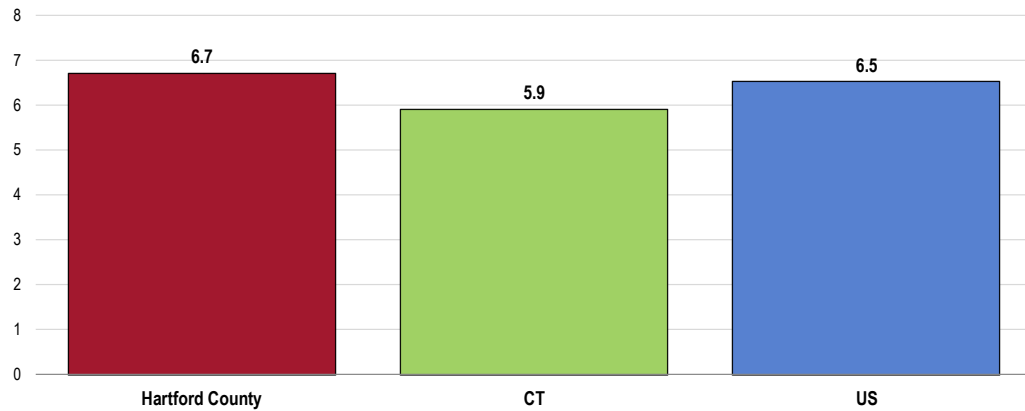
### Infant Mortality

**Between 2006 and 2010, Hartford County reported an annual average of 6.7 infant deaths per 1,000 live births.**

- Less favorable than the Connecticut rate.
- Comparable to the national rate.
- Fails to satisfy the Healthy People 2020 target of 6.0 infant deaths per 1,000 live births.

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

### Infant Mortality Rate (Annual Average Infant Deaths per 1,000 Live Births, 2006-2010) Healthy People 2020 Target = 6.0 or Lower



Sources: 

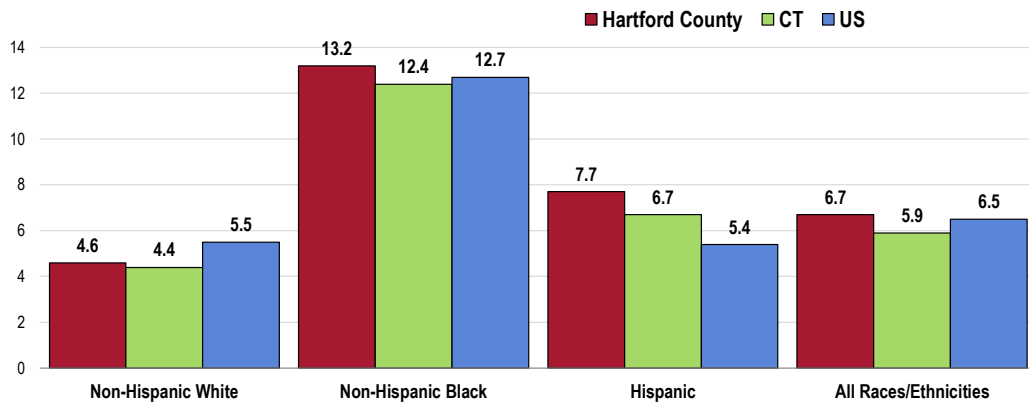
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.
- Retrieved August 2016 from Community Commons at <http://www.chna.org>.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]

Notes: 

- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

- The infant mortality rate is notably higher among births to Black mothers.

### Infant Mortality Rate by Race/Ethnicity (Annual Average Infant Deaths per 1,000 Live Births, 2006-2010) Healthy People 2020 Target = 6.0 or Lower



Sources: 

- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.
- Retrieved August 2016 from Community Commons at <http://www.chna.org>.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]

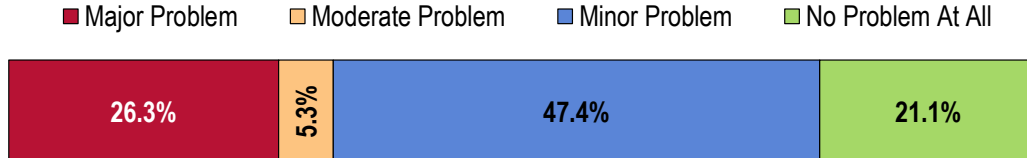
Notes: 

- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

## Key Informant Input: Infant & Child Health

Key informants taking part in an online survey generally characterized *Infant & Child Health* as a “minor problem” in the community.

### Perceptions of Infant and Child Health as a Problem in the Community (Key Informants, 2016)



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

### Top Concerns

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

#### Access to Care/Services

*Premature births, lack of prenatal care. – Community Leader*

*We lost a great resource in baby care when Rockville General Hospital stopped delivering babies. – Physician*

#### Insurance Issues

*If there is inadequate insurance, as well as education, children will not receive proper medical attention and immunizations. – Community Leader*

#### Obesity

*Childhood obesity and quality of health is a concern in this community, as well as many others. There are many reasons for this. Busy lifestyles, leading to food choices that are convenient but not necessarily nutrient-dense, limited access to healthy foods - Community Leader*

## Family Planning

### Births to Teen Mothers

#### About Teen Births

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

Teen mothers:

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

Similarly, early fatherhood is associated with lower educational attainment and lower income.

Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

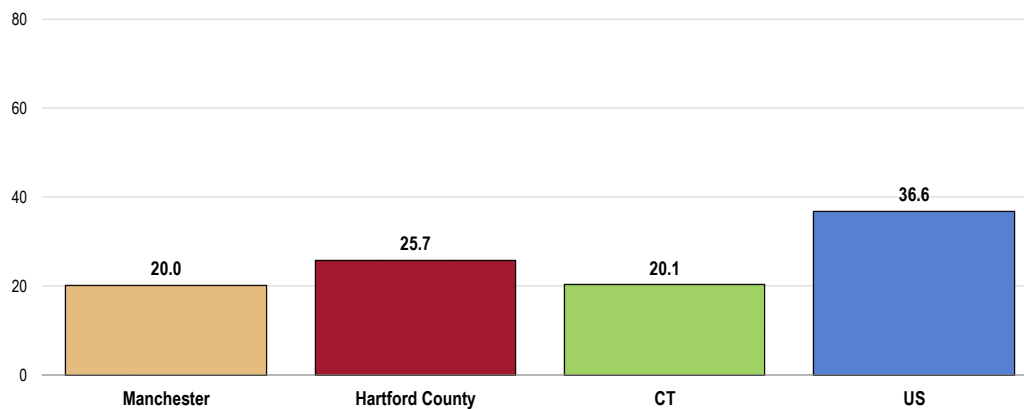
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

**Between 2006 and 2012, there was an annual average of 25.7 births to Hartford County women age 15-19 per 1,000 population in that age group.**

- Higher than the Connecticut proportion.
- Lower than the national proportion.
- The Manchester rate (2009-2013) was 20.0 births per 1,000 females age 15-19.

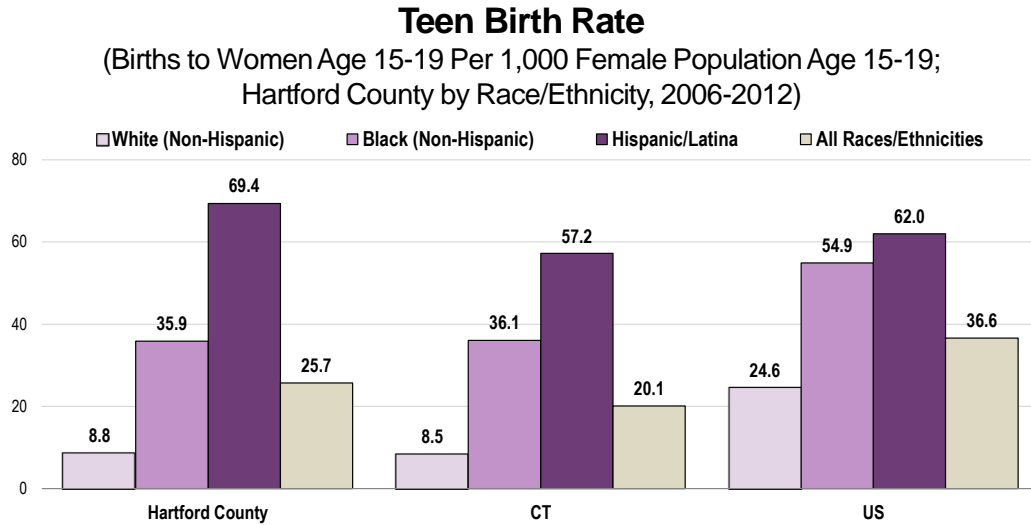
#### Teen Birth Rate

(Births to Women Age 15-19 Per 1,000 Female Population Age 15-19, 2006-2012)



- Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.
  - Retrieved August 2016 from Community Commons at <http://www.chna.org>.
  - Town data (2009-2013): Connecticut State Department of Public Health, 2012 Connecticut Registration Report.
- Notes:
- This indicator reports the rate of total births to women under the age of 15 - 19 per 1,000 female population age 15 - 19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

- By race and ethnicity, Hispanics/Latinas exhibit the highest teen birth rate in the county (as is also found statewide and nationally), followed by Blacks.



Sources: • Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.  
 • Retrieved August 2016 from Community Commons at <http://www.chna.org>.

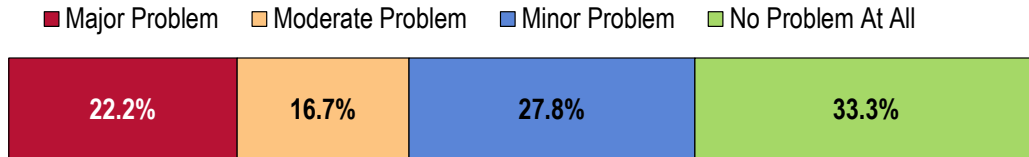
Notes: • This indicator reports the rate of total births to women under the age of 15-19 per 1,000 female population age 15-19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

## Key Informant Input: Family Planning

Key informants taking part in an online survey largely characterized *Family Planning* as a “minor problem” in the community.

### Perceptions of Family Planning as a Problem in the Community

(Key Informants, 2016)



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

## Top Concerns

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

### *Access to Care/Services*

*We no longer have a family planning center at Rockville General Hospital. – Physician*

*Too many young, single women having children with any means of support. Major sex education issue, as well as accessibility to birth control. – Community Leader*

### *Health Education*

*Diminishing resources and education regarding family planning impacts the ability of young people to make good decisions regarding reproductive health. – Community Leader*

# Modifiable Health Risks



Professional Research Consultants, Inc.

## Actual Causes of Death

### About Contributors to Mortality

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

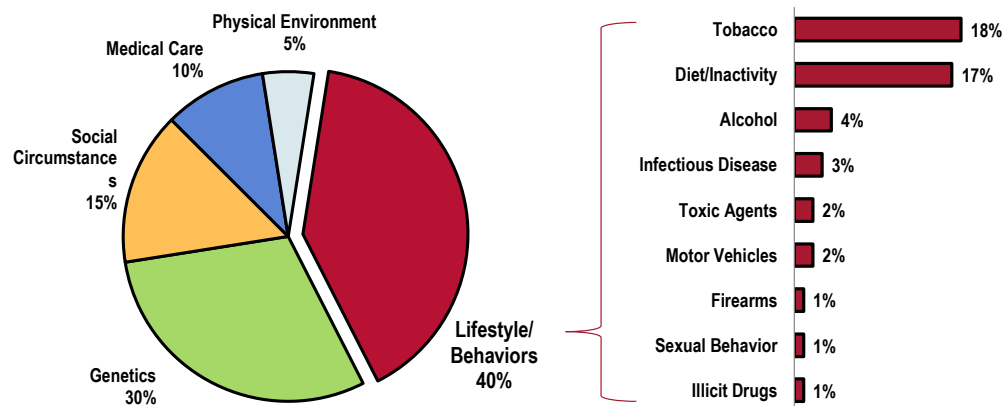
The most prominent contributors to mortality in the United States in 2000 were **tobacco** (an estimated 435,000 deaths), **diet and activity** patterns (400,000), **alcohol** (85,000), **microbial agents** (75,000), **toxic agents** (55,000), **motor vehicles** (43,000), **firearms** (29,000), **sexual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

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

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

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

### Factors Contributing to Premature Deaths in the United States



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



## Nutrition

### About Healthful Diet & Healthy Weight

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

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

Americans with a healthful diet:

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

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

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

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

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

Social factors thought to influence diet include:

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

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

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

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

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

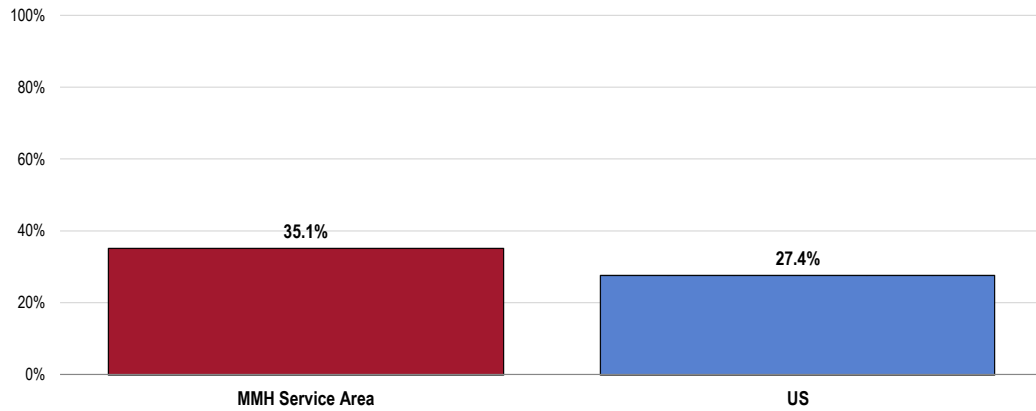
## Daily Recommendation of Fruits/Vegetables

A total of 35.1% of MMH Service Area adults report eating five or more servings of fruits and/or vegetables per day.

- Well above the US prevalence.

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

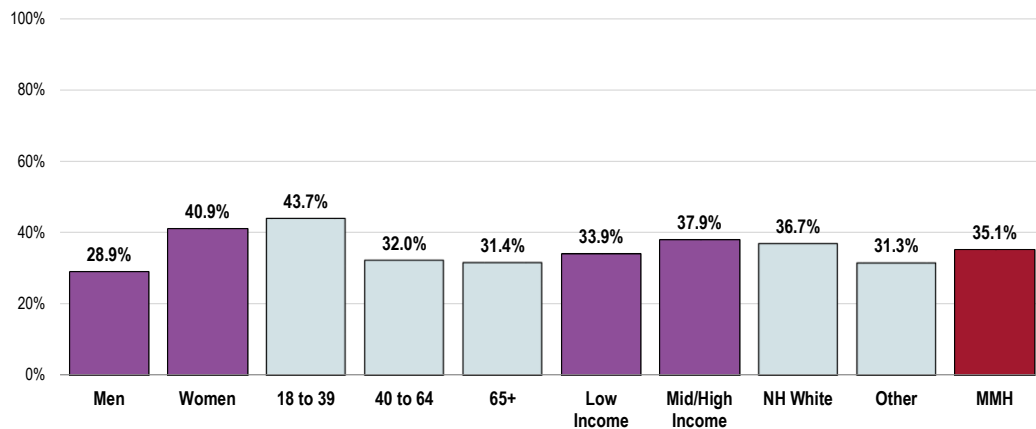
### Consume Five or More Servings of Fruits/Vegetables Per Day



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.
  - For this issue, respondents were asked to recall their food intake on the previous day.

- Area men are less likely to get the recommended daily servings of fruits/vegetables, as are residents age 40 and older.

### Consume Five or More Servings of Fruits/Vegetables Per Day (MMH Service Area, 2016)



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
  - For this issue, respondents were asked to recall their food intake on the previous day.

## Access to Fresh Produce

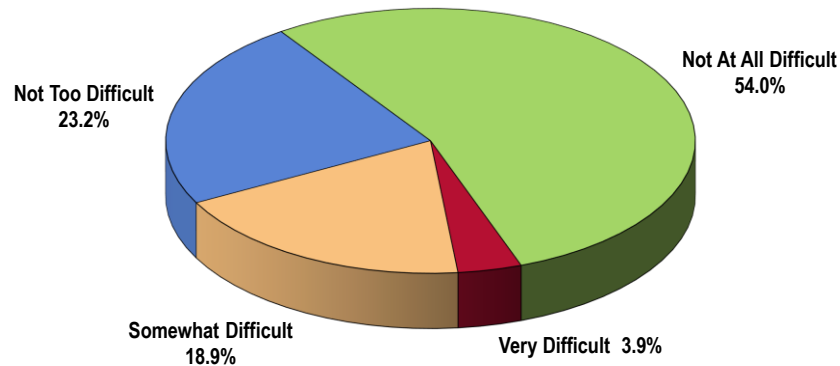
### Difficulty Accessing Fresh Produce

While most report little or no difficulty, 22.8% of MMH Service Area adults find it “very” or “somewhat” difficult to access affordable, fresh fruits and vegetables.

Respondents were asked:

“How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say: Very Difficult, Somewhat Difficult, Not Too Difficult, or Not At All Difficult?”

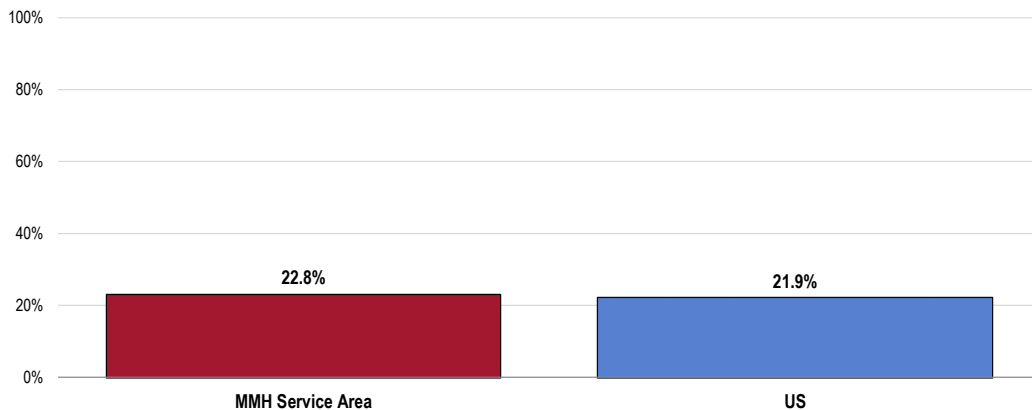
### Level of Difficulty Finding Fresh Produce at an Affordable Price (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]  
Notes: • Asked of all respondents.

- Similar to the US figure.

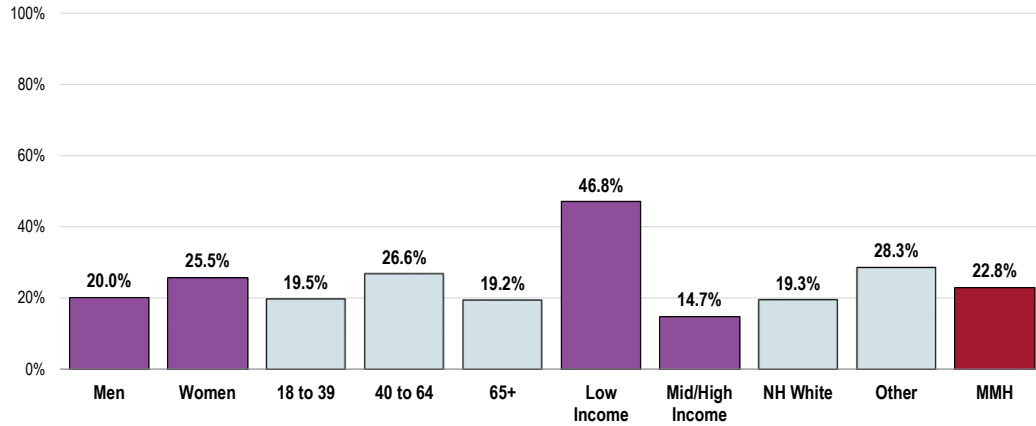
### Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]  
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

- Lower-income residents are much more likely to report difficulty getting fresh produce.

### Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Low Food Access (Food Deserts)

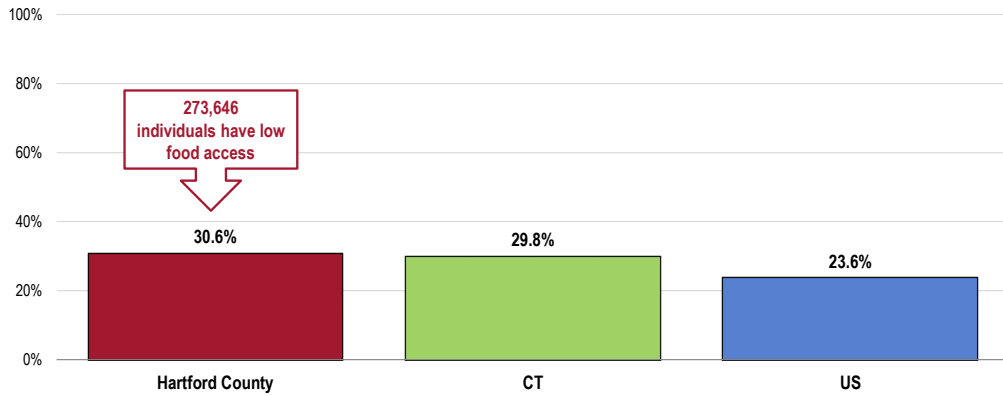
A food desert is defined as a low-income area where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas.

US Department of Agriculture data show that 30.6% of the Hartford County population (representing over 273,000 residents) have low food access or live in a “food desert,” meaning that they do not live near a supermarket or large grocery store.

- Comparable to statewide findings.
- Less favorable than national findings.

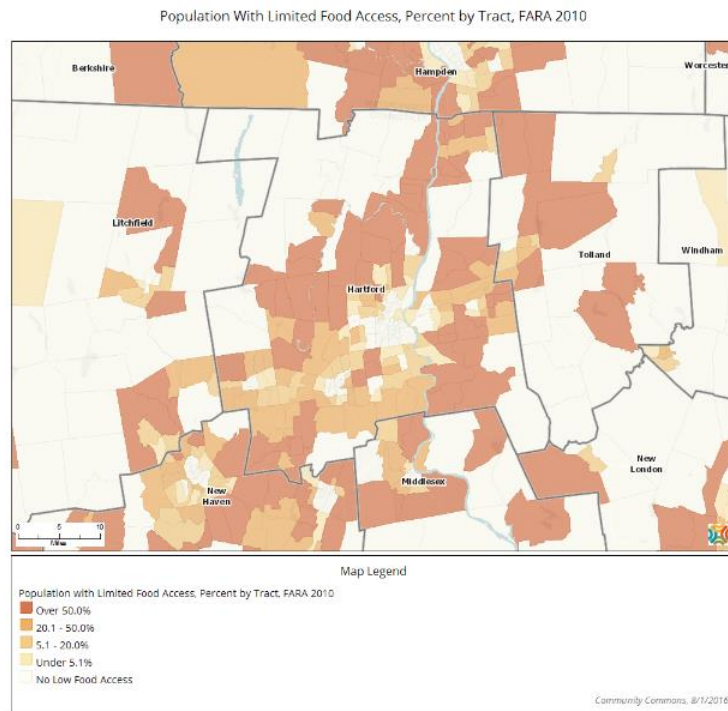
### Population With Low Food Access

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



- Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
  - Retrieved August 2016 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as low-income areas where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas. This indicator is relevant because it highlights populations and geographies facing food insecurity.

- The following map provides an illustration of food deserts by census tract.

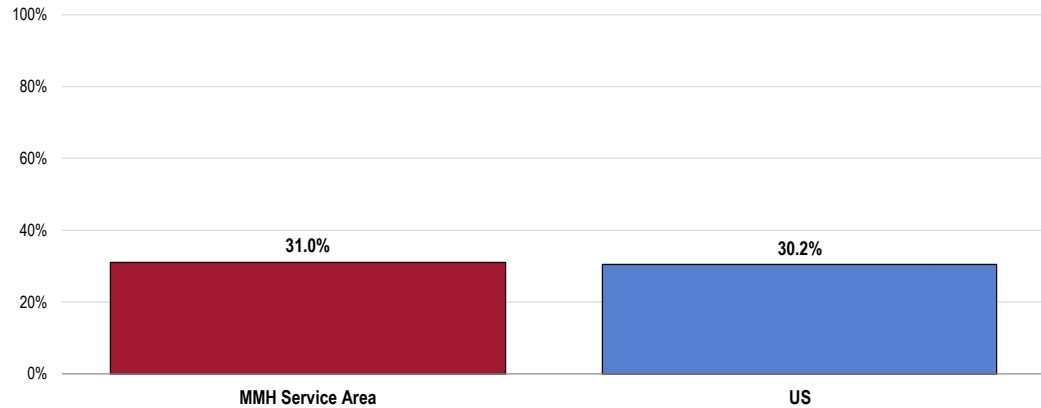


## Sugar-Sweetened Beverages

A total of 31.0% of MMH Service Area adults report drinking an average of at least one sugar-sweetened beverage per day in the past week.

- Comparable to national findings.

### Had Seven or More Sugar-Sweetened Beverages in the Past Week



Sources:
 

- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 212]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

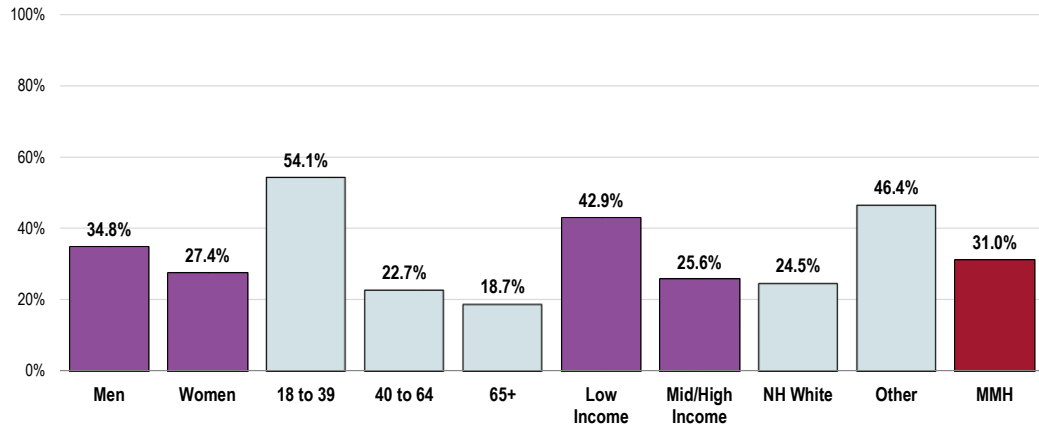
Notes:
 

- Asked of all respondents.

Those statistically more likely to consume this level of sugar-sweetened beverages include:

- Younger adults.
- Lower-income residents.
- Other races.

## Had Seven or More Sugar-Sweetened Beverages in the Past Week (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 212]

Notes: • Asked of all respondents.

• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).

• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with defined poverty status up to incomes just above the FPL, earning up to twice the poverty threshold; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Physical Activity

### About Physical Activity

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

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

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

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

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

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

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

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

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

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Leisure-Time Physical Activity

**A total of 18.7% of MMH Service Area adults report no leisure-time physical activity in the past month.**

- Similar to statewide findings.
- More favorable than national findings.

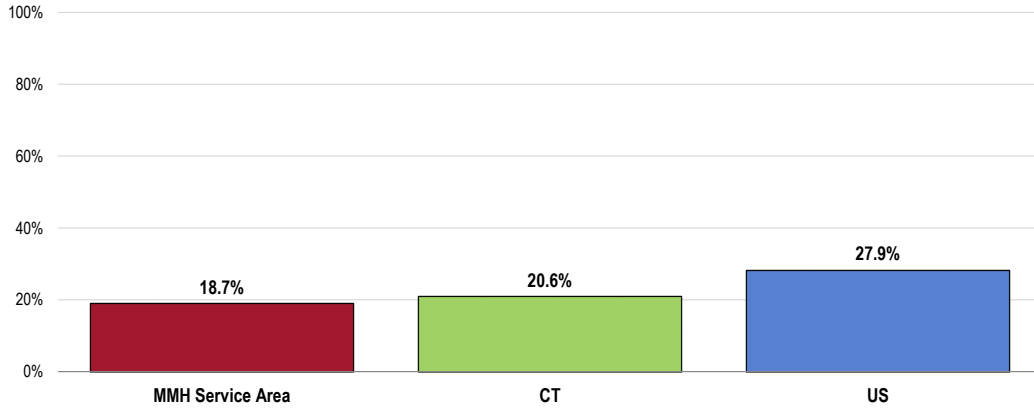
Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.



- Easily satisfies the Healthy People 2020 target (32.6% or lower).

### No Leisure-Time Physical Activity in the Past Month

Healthy People 2020 Target = 32.6% or Lower



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 106]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Connecticut data.
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-1]
- Notes:
- Asked of all respondents.

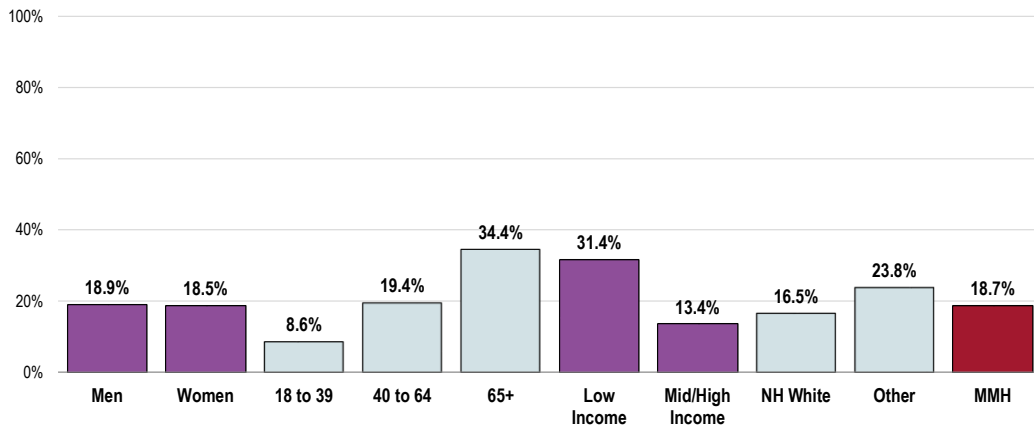
Lack of leisure-time physical activity in the area is higher among:

- Adults age 40 and older (positive correlation with age).
- Lower-income residents.

### No Leisure-Time Physical Activity in the Past Month

(MMH Service Area, 2016)

Healthy People 2020 Target = 32.6% or Lower



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 106]
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-1]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Activity Levels

### Adults

#### Recommended Levels of Physical Activity

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity **aerobic** physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

- 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. [www.cdc.gov/physicalactivity](http://www.cdc.gov/physicalactivity)
- Learn more about CDC's efforts to promote walking by visiting <http://www.cdc.gov/vitalsigns/walking>.

#### Aerobic & Strengthening Physical Activity

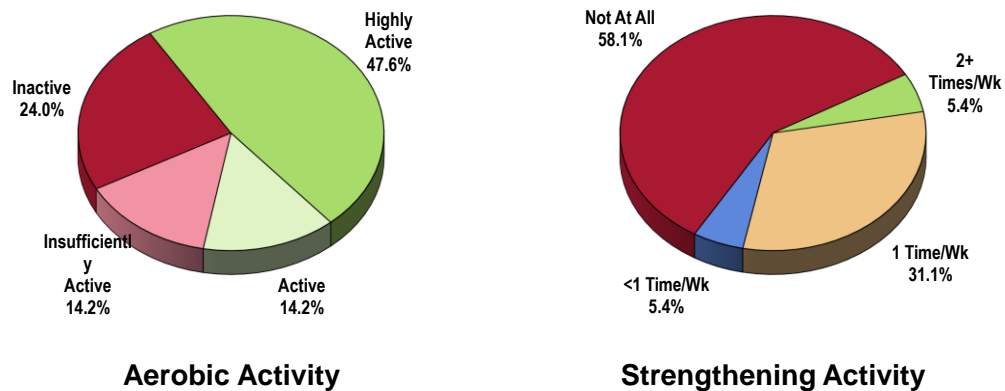
Based on reported physical activity intensity, frequency and duration over the past month, **38.2% of MMH Service Area adults are found to be “insufficiently active” or “inactive.”**

**A total of 58.1% of MMH Service Area adults do not participate in any type of physical activities or exercises to strengthen their muscles.**

Survey respondents were asked about the types of physical activities they engaged in during the past month, as well as the frequency and duration of these activities.

- “Inactive” includes those reporting no aerobic physical activity in the past month.
- “Insufficiently active” includes those with the equivalent of 1-150 minutes of aerobic physical activity per week.
- “Active” includes those with 150-300 minutes of weekly aerobic physical activity.
- “Highly active” includes those with >300 minutes of weekly aerobic physical activity.

#### Participation in Physical Activities (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 113, 173]

Notes: • Reflects the total sample of respondents.

• In this case, “inactive” aerobic activity represents those adults participating in no aerobic activity in the past week; “insufficiently active” reflects those respondents with 1–149 minutes of aerobic activity in the past week; “active” adults are those with 150–300 minutes of aerobic activity per week; and “highly active” adults participate in 301+ minutes of aerobic activity weekly.

### Recommended Levels of Physical Activity

**A total of 22.2% of MMH Service Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).**

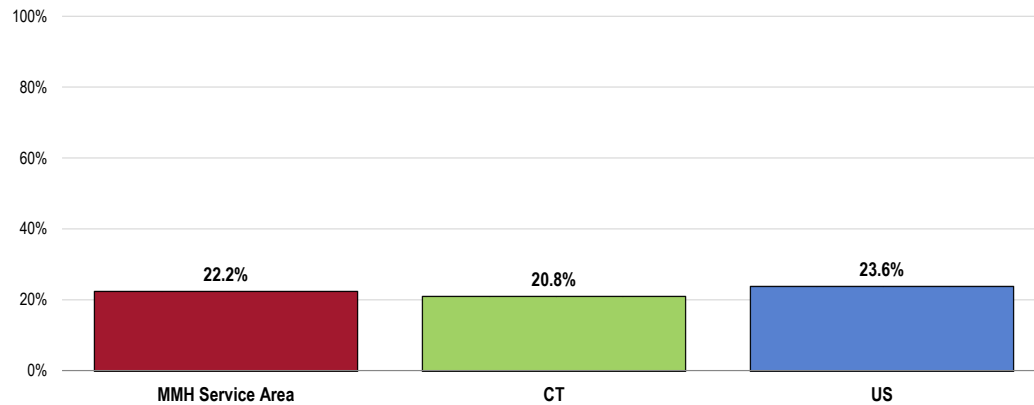
- Comparable to state and national findings.
- Comparable to the Healthy People 2020 target (20.1% or higher)

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

**Aerobic** activity is at least 150 minutes per week of light to moderate activity or 75 minutes per week of vigorous physical activity or an equivalent combination of both; and

**Strengthening** activity is at least 2 sessions per week of exercise designed to strengthen muscles.

### Meets Physical Activity Recommendations Healthy People 2020 Target = 20.1% or Higher



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 174]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). 2014 Connecticut data.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-4]
- Notes:
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity and report doing physical activities specifically designed to strengthen muscles at least twice per week.

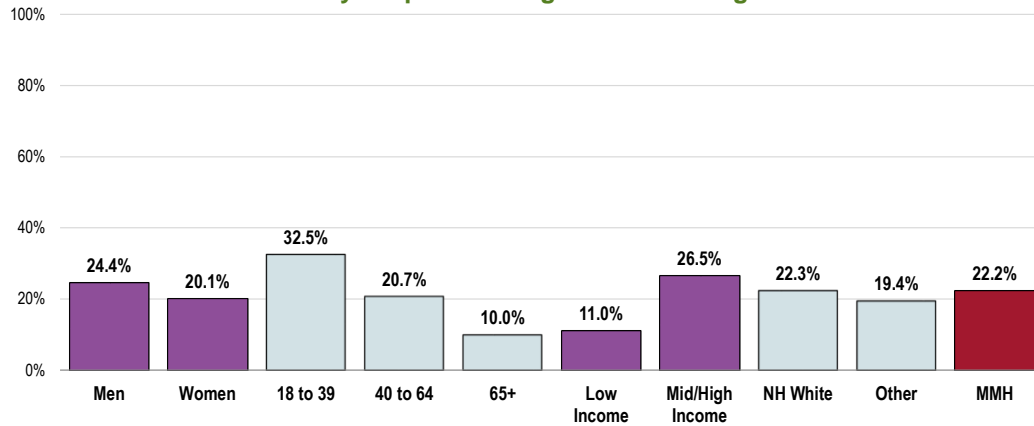
Those less likely to meet physical activity requirements include:

- Older residents (negative correlation with age).
- Adults in low-income households.

## Meets Physical Activity Recommendations

(MMH Service Area, 2016)

Healthy People 2020 Target = 20.1% or Higher



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 174]
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-4]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
  - Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity and report doing physical activities specifically designed to strengthen muscles at least twice per week.

## Children

### Recommended Levels of Physical Activity

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

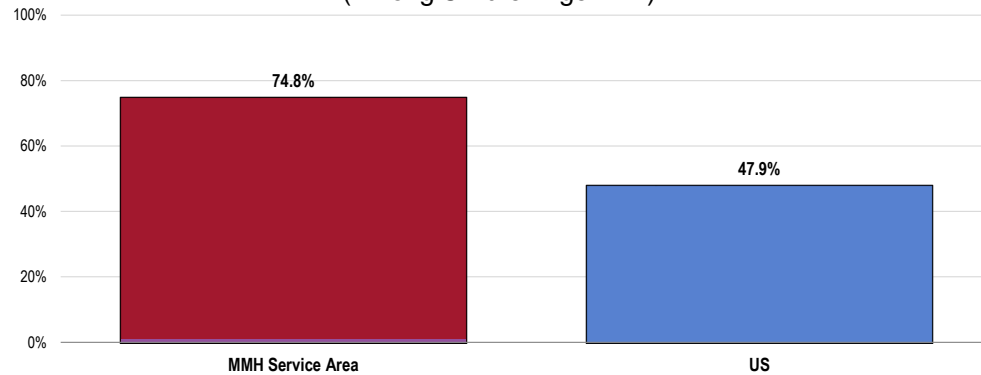
- 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. [www.cdc.gov/physicalactivity](http://www.cdc.gov/physicalactivity)

Among area children age 2 to 17, 74.8% are reported to have had 60 minutes of physical activity on each of the seven days preceding the interview (1+ hours per day).

- Well above that found nationally.

### Child Is Physically Active for One or More Hours per Day

(Among Children Age 2-17)



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 142]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents with children age 2-17 at home.
  - Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

## Access to Physical Activity

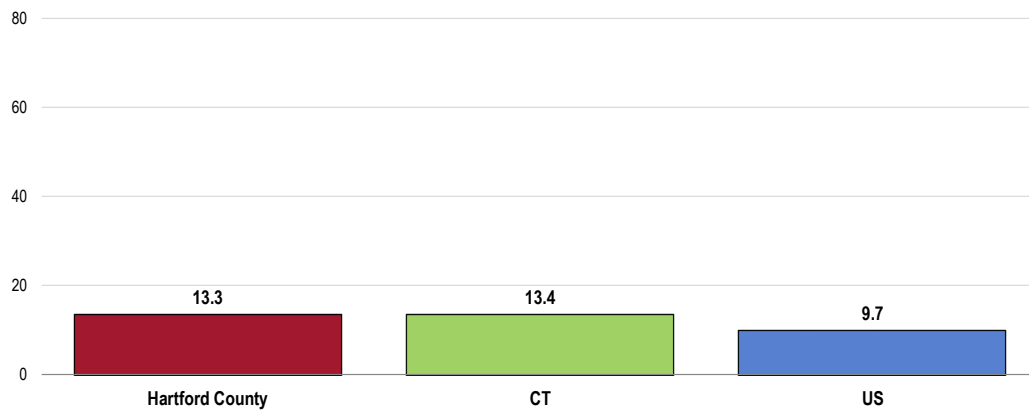
In 2013, there were 13.3 recreation/fitness facilities for every 100,000 population in Hartford County.

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

- Almost identical to the state ratio.
- Above what is found nationally.

### Population With Recreation & Fitness Facility Access (Number of Recreation & Fitness Facilities per 100,000 Population, 2013)



- Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
  - Retrieved August 2016 from Community Commons at <http://www.chna.org>.
- Notes:
- Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940, which include *Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities"*. Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools. This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

## Weight Status

### About Overweight & Obesity

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m<sup>2</sup>). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared (inches<sup>2</sup>)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m<sup>2</sup> and obesity as a BMI ≥30 kg/m<sup>2</sup>. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m<sup>2</sup>. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m<sup>2</sup> is reached. For persons with a BMI ≥30 kg/m<sup>2</sup>, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m<sup>2</sup>.

- Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

### Adult Weight Status

Classification of Overweight and Obesity by BMI	BMI (kg/m <sup>2</sup> )
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

### Overweight Status

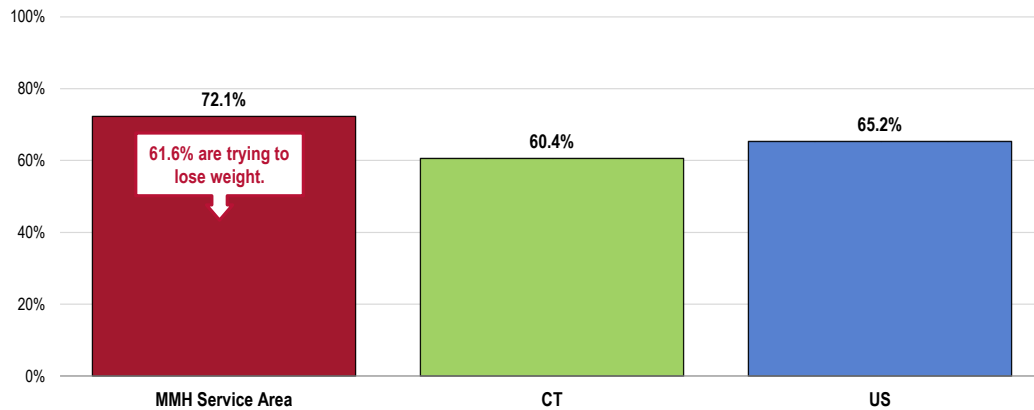
**Over 7 in 10 MMH Service Area adults (72.1%) are overweight.**

- Above both the state and US figures.

Note that 61.6% of overweight adults are currently trying to lose weight.

Here, "overweight" includes those respondents with a BMI value  $\geq 25$ .

**Prevalence of Total Overweight**  
(Percent of Adults With a Body Mass Index of 25.0 or Higher)



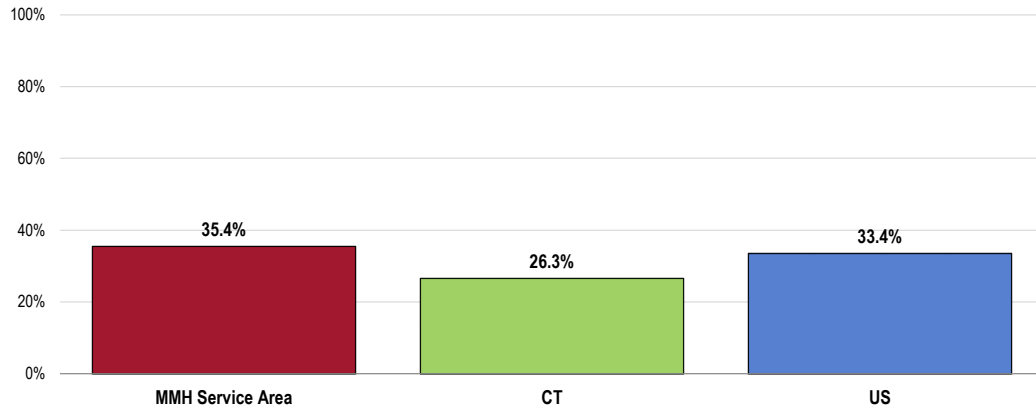
- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 176-177]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2014 Connecticut data.
- Notes:
- Based on reported heights and weights, asked of all respondents.
  - The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

**Further, 35.4% of MMH Service Area adults are obese.**

- Less favorable than Connecticut findings.
- Similar to US findings.
- Fails to satisfy the Healthy People 2020 target (30.5% or lower).

"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value  $\geq 30$ .

### Prevalence of Obesity (Percent of Adults With a Body Mass Index of 30.0 or Higher) Healthy People 2020 Target = 30.5% or Lower

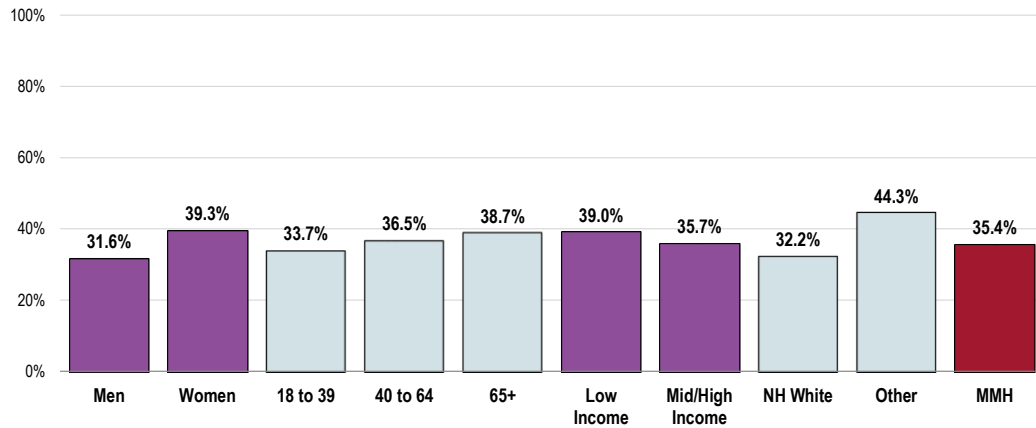


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 176]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2014 Connecticut data.

Notes: • Based on reported heights and weights, asked of all respondents.  
 • The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

• Obesity is statistically comparable by demographic characteristic.

### Prevalence of Obesity (Percent of Adults With a BMI of 30.0 or Higher; MMH Service Area, 2016) Healthy People 2020 Target = 30.5% or Lower



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 176]  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]  
 Notes: • Based on reported heights and weights, asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.  
 • The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

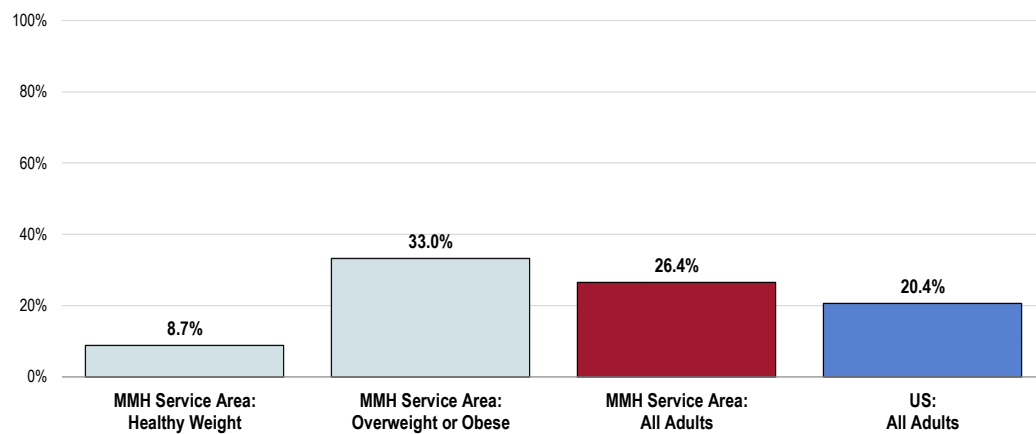


## Health Advice

A total of 26.4% of adults have been given advice about their weight by a doctor, nurse or other health professional in the past year.

- More favorable than the national findings.
- Note that 33.0% of overweight/obese adults have been given advice about their weight by a health professional in the past year (while 2 in 3 have not).

### Have Received Advice About Weight in the Past Year From a Physician, Nurse, or Other Health Professional (By Weight Classification)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 115, 178-179]  
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

## Relationship of Overweight With Other Health Issues

Overweight and obese adults are more likely to report a number of adverse health conditions.

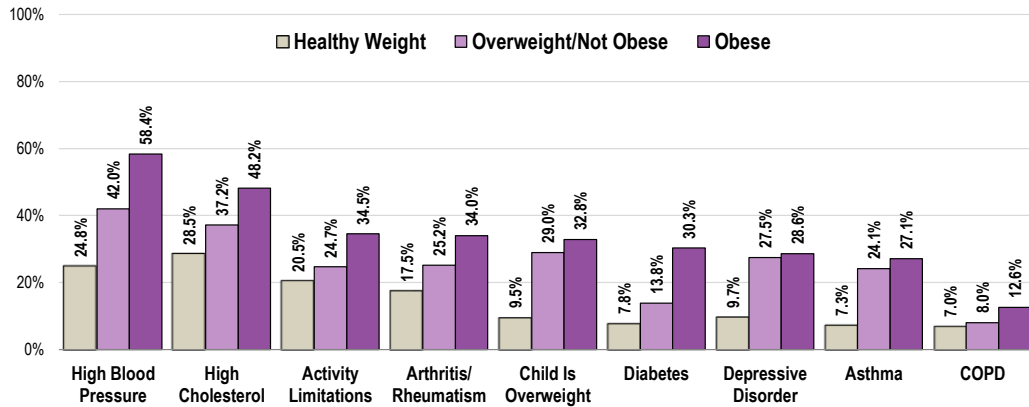
Among these are:

- High blood pressure.
- High cholesterol.
- Activity limitations.
- Arthritis/rheumatism.
- Diabetes.
- Depressive disorder.
- Asthma.
- COPD.

Overweight/obese residents are also more likely to have overweight children.

The correlation between overweight and various health issues cannot be disputed.

### Relationship of Overweight With Other Health Issues (By Weight Classification; MMH Service Area, 2016)



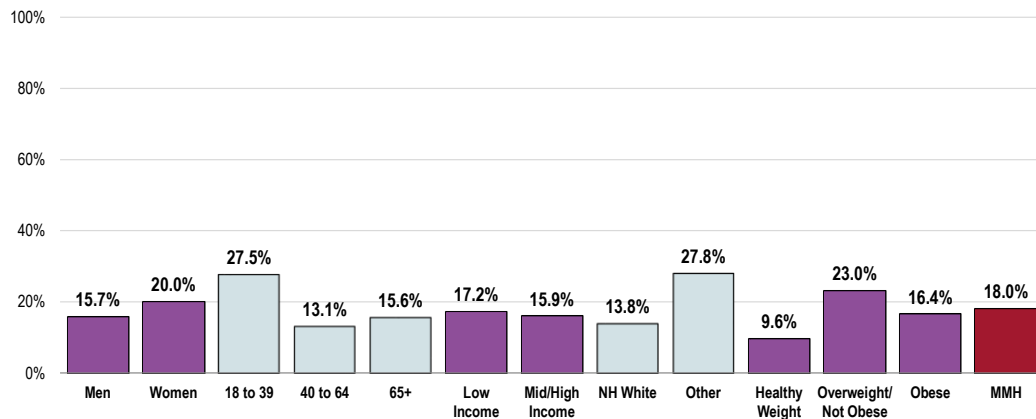
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 24, 27, 36, 38, 41, 45, 119, 128, 180]  
 Notes: • Based on reported heights and weights, asked of all respondents.

### Local Resources

Asked whether local medical resources for weight management are sufficient for the community’s need, 18.0% of survey respondents indicated that the resources are insufficient or unavailable.

- Residents more likely to give “insufficient” or “not available” responses include young adults, Other races, and overweight (but not obese) adults.

### Local Medical Resources for Weight Management Are “Insufficient” or “Not Available” (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 303]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “NH White” reflects non-Hispanic White respondents).  
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

## Children’s Weight Status

### About Weight Status in Children & Teens

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child’s BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5<sup>th</sup> percentile
- Healthy Weight ≥5<sup>th</sup> and <85<sup>th</sup> percentile
- Overweight ≥85<sup>th</sup> and <95<sup>th</sup> percentile
- Obese ≥95<sup>th</sup> percentile

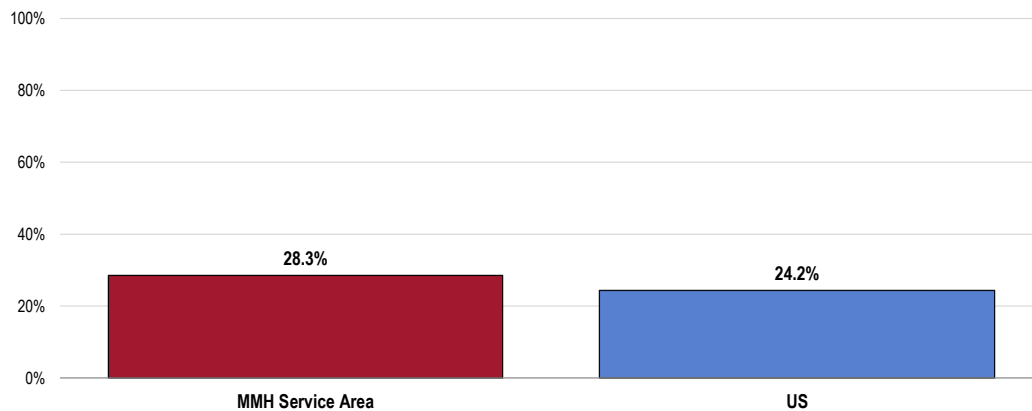
• Centers for Disease Control and Prevention

**Based on the heights/weights reported by surveyed parents, 28.3% of MMH Service Area children age 5 to 17 are overweight or obese (≥85th percentile).**

- Similar to the US figure.

### Child Total Overweight Prevalence

(Children Age 5-17 Who Are Overweight/Obese; BMI in the 85th Percentile or Higher)



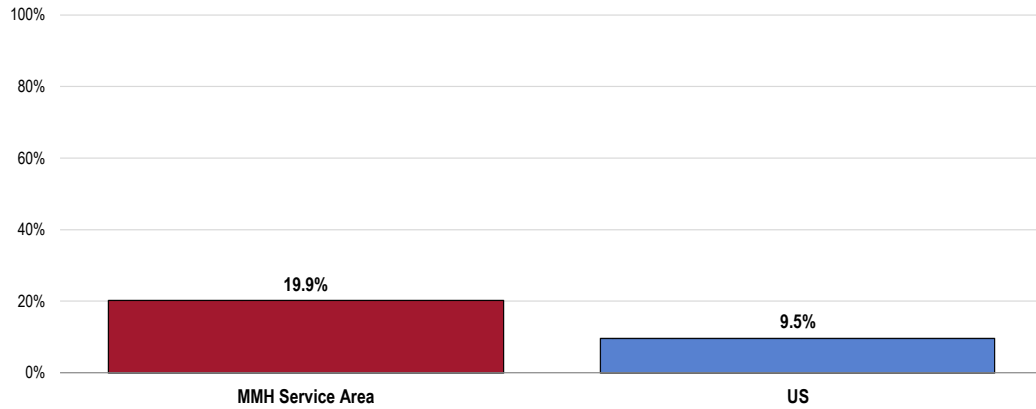
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 180]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents with children age 5-17 at home.  
 • Overweight among children is determined by children’s Body Mass Index status at or above the 85<sup>th</sup> percentile of US growth charts by gender and age.

**Further, 19.9% of area children age 5 to 17 are obese (≥95th percentile).**

- Statistically similar to the national percentage.
- Statistically similar to the Healthy People 2020 target (14.5% or lower for children age 2-19).

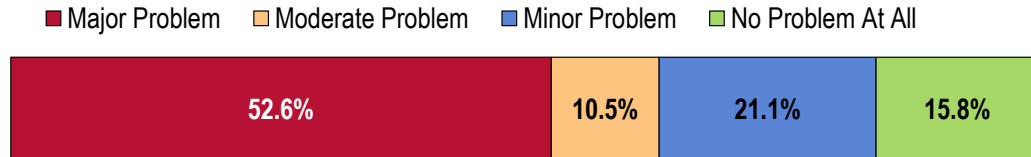
### Child Obesity Prevalence (Children Age 5-17 Who Are Obese; BMI in the 95<sup>th</sup> Percentile or Higher) Healthy People 2020 Target = 14.5% or Lower



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 180]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-10.4]  
 Notes: • Asked of all respondents with children age 5-17 at home.  
 • Obesity among children is determined by children’s Body Mass Index status equal to or above the 95<sup>th</sup> percentile of US growth charts by gender and age.

**Key Informant Input: Nutrition, Physical Activity & Weight**  
 Over half of key informants taking part in an online survey most often characterized *Nutrition, Physical Activity & Weight* as a “major problem” in the community.

### Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community (Key Informants, 2016)



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

### Top Concerns

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

#### Health Education

*There are many factors involved in the challenges related to nutrition, physical activity and weight. Many of what I see on a day-to-day basis is lack of knowledge or confusion regarding nutrition and healthy food choices. Confusion with label reading. – Community Leader*

*Lack of understanding about the importance of a healthy lifestyle and the many forms a healthy lifestyle can take. – Community Leader*

*Majority of people are unaware of what it is they are actually consuming in the food. The education of good fats, decreasing sugar etc., is very much needed. – Community Leader*

*Uneducated population. – Physician*

### **Obesity**

*In the prenatal and children under 5 population I see, obesity, lack of physical activity and too much screen time are a problem. Pregnant women gaining excess weight is more of an issue than inadequate weight gain. – Social Services Provider*

*Rates of obesity in adults and children remain steady, but too high. – Community Leader*

### **Access to Healthful Food**

*Access to healthy food options. – Public Health Representative*

### **Affordable Care/Services**

*Affordable accessibility. – Community Leader*

## Sleep

### Sleep

Sleep is an important part of good health, but an estimated 35% of US adults do not get enough sleep. Approximately 83 million US adults report usually sleeping less than 7 hours in a 24-hour period. According to professional sleep societies, adults aged 18 to 60 years should sleep at least 7 hours each night for the best health and wellness.

Sleeping less than 7 hours per night is linked to increased risk of chronic diseases such as diabetes, stroke, high blood pressure, heart disease, obesity, and poor mental health, as well as early death. Not getting the recommended amount of sleep can affect one's ability to make good decisions and increases the chances of motor vehicle crashes.

Habits for improving sleep health can include:

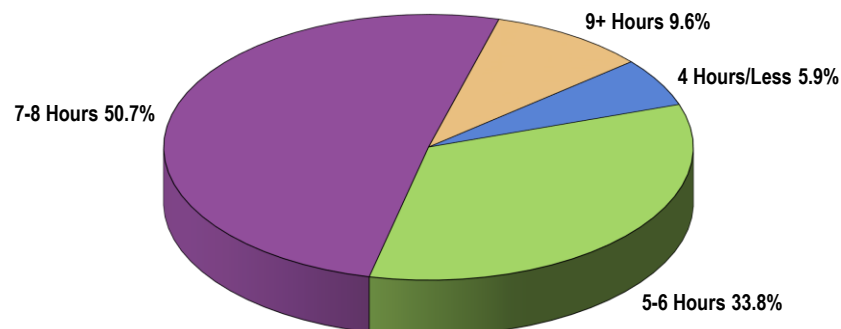
- Be consistent. Go to bed at the same time each night and get up at the same time each morning, including on the weekends.
- Make sure your bedroom is quiet, dark, relaxing, and at a comfortable temperature.
- Remove electronic devices, such as TVs, computers, and smart phones, from the bedroom.
- Avoid large meals, caffeine, and alcohol before bedtime.
- Avoid tobacco/nicotine.
- Get some exercise. Being physically active during the day can help you fall asleep more easily at night.

• Institute of Medicine (US) Committee on Sleep Medicine and Research; 2014 Behavioral Risk Factor Surveillance System (BRFSS), CDC

**When asked how many hours of sleep they average per night, 50.7% of survey respondents stated between 7 and 8 hours, and 9.6% get 9+ hours of sleep per night.**

- On the other hand, 4 in 10 local adults sleep **fewer than 7 hours** per night (including 5.9% who report sleeping 4 hours or less on an average night).

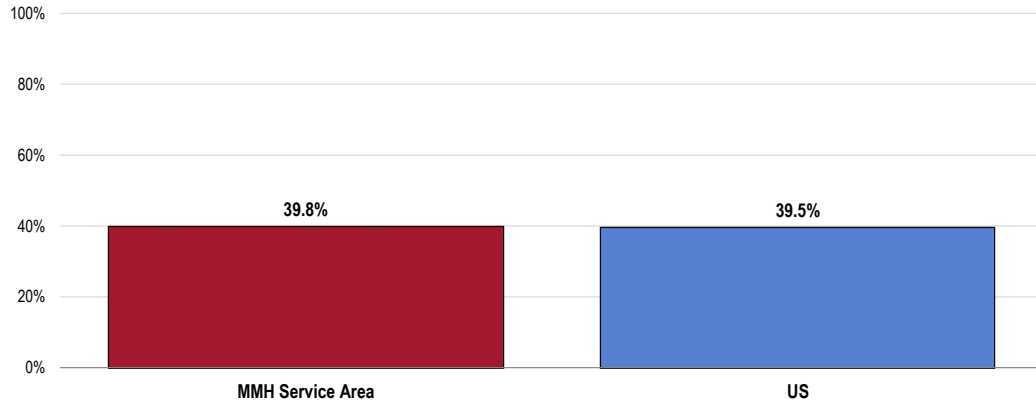
**Average Hours of Sleep Per Night**  
(MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 124]  
Notes: • Asked of all respondents.

- The percentage of survey respondents averaging fewer than 7 hours per night is similar to the national figure.

### Generally Sleep Less Than Seven Hours Per Night



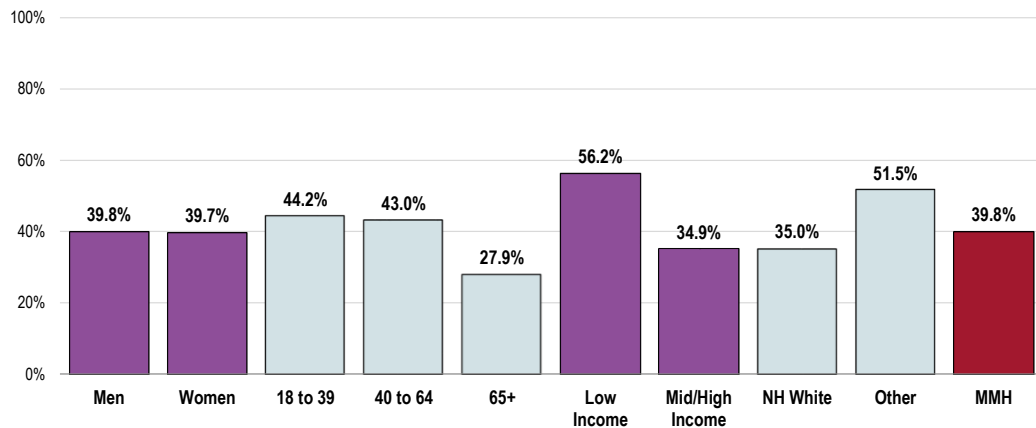
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 213]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

These adults are more likely to sleep fewer than 7 hours on an average night:

- Residents under age 65.
- Low-income adults.
- Other races.

### Generally Sleep Less Than Seven Hours Per Night (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 213]

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

## Substance Abuse

### About Substance Abuse

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

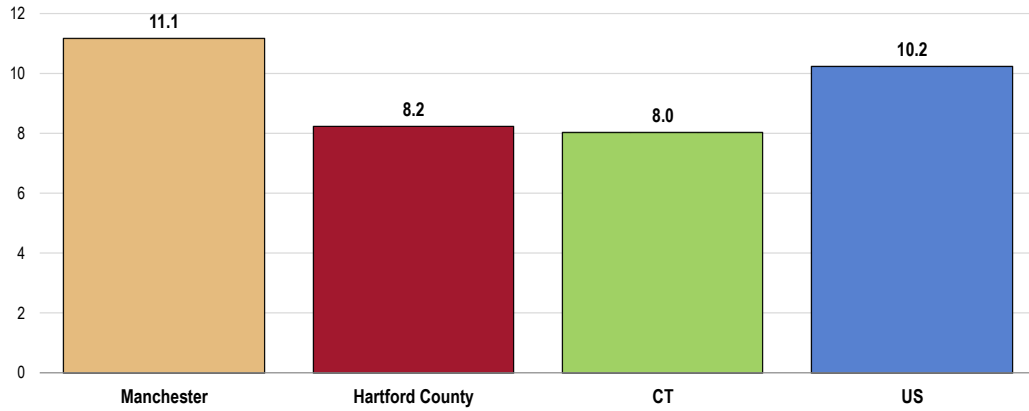
## Age-Adjusted Cirrhosis/Liver Disease Deaths

**Between 2012 and 2014, Hartford County reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 8.2 deaths per 100,000 population.**

- Similar to the statewide rate.
- Lower than the national rate.
- Similar to the Healthy People 2020 target (8.2 or lower).
- The 2008-2012 Manchester rate was 11.1 deaths per 100,000 population.



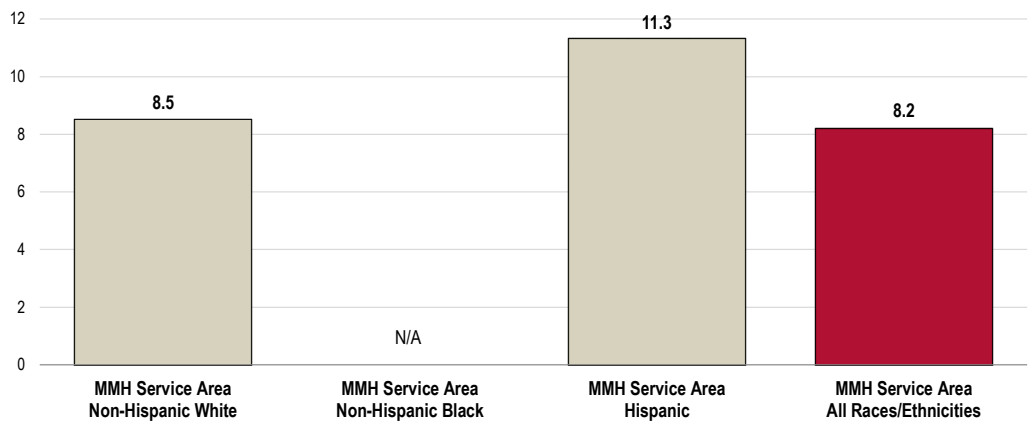
### Cirrhosis/Liver Disease: Age-Adjusted Mortality (2012-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 8.2 or Lower



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
  - Town data (2008-2012): Connecticut State Department of Public Health.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-11]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The cirrhosis mortality rate is higher among Hispanics when compared with Whites in Hartford County.

### Cirrhosis/Liver Disease: Age-Adjusted Mortality by Race (2012-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 8.2 or Lower



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-11]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

## Alcohol Use

### Excessive Drinking

**A total of 17.3% of area adults are excessive drinkers (heavy and/or binge drinkers).**

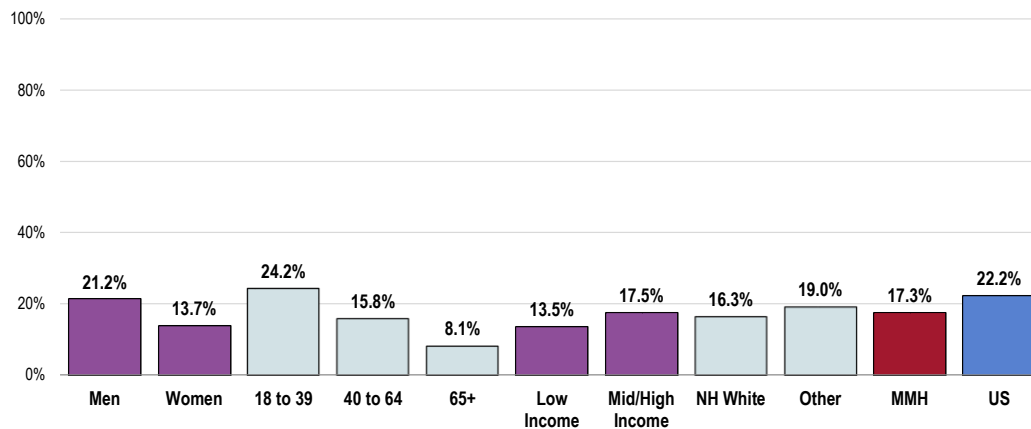
"Excessive drinking" includes heavy and/or binge drinkers:

- **Heavy drinkers** include men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- **Binge drinkers** include men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

- More favorable than the national proportion.
- Satisfies the Healthy People 2020 target (25.4% or lower).
- Note the negative correlation between excessive drinking and age in the MMH Service Area.

RELATED ISSUE:  
See also *Stress* in the **Mental Health** section of this report.

**Excessive Drinkers**  
(MMH Service Area, 2016)  
Healthy People 2020 Target = 25.4% or Lower



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 189]
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-15]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
  - Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

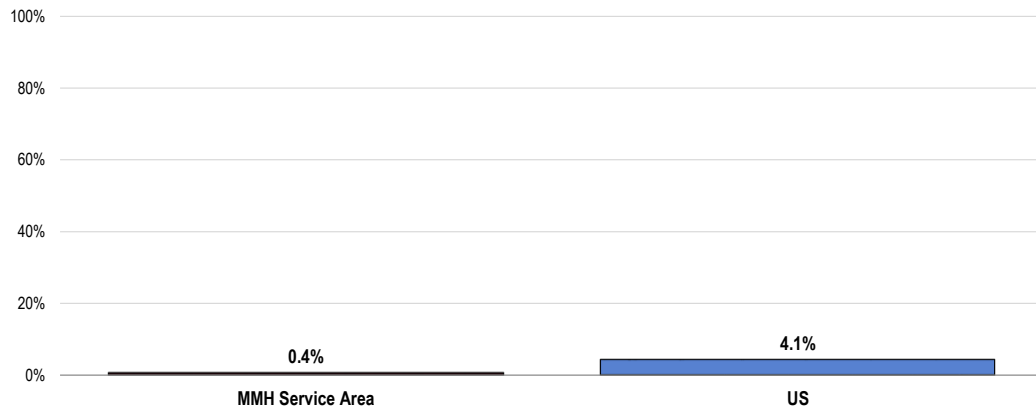
### Drinking & Driving

**Just 0.4% of MMH Service Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.**

- Well below the national findings.

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that the actual incidence of drinking and driving in the community is likely higher.

## Have Driven in the Past Month After Perhaps Having Too Much to Drink



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 66]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

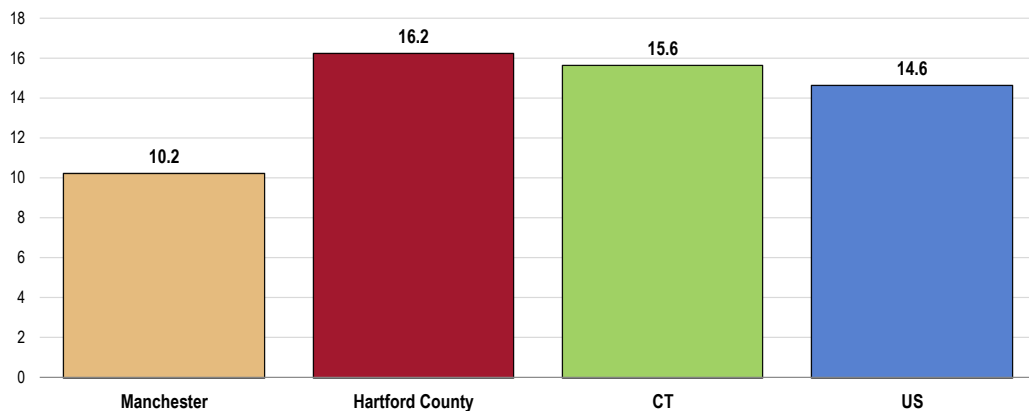
## Age-Adjusted Drug-Induced Deaths

Between 2012 and 2014, there was an annual average age-adjusted drug-induced mortality rate of 16.2 deaths per 100,000 population in Hartford County.

- Similar to the statewide rate.
- Higher than the national rate.
- Fails to satisfy the Healthy People 2020 target (11.3 or lower).
- The 2008-2012 Manchester rate was 10.2 deaths per 100,000 population.

## Drug-Induced Deaths: Age-Adjusted Mortality (2012-2014 Annual Average Deaths per 100,000 Population)

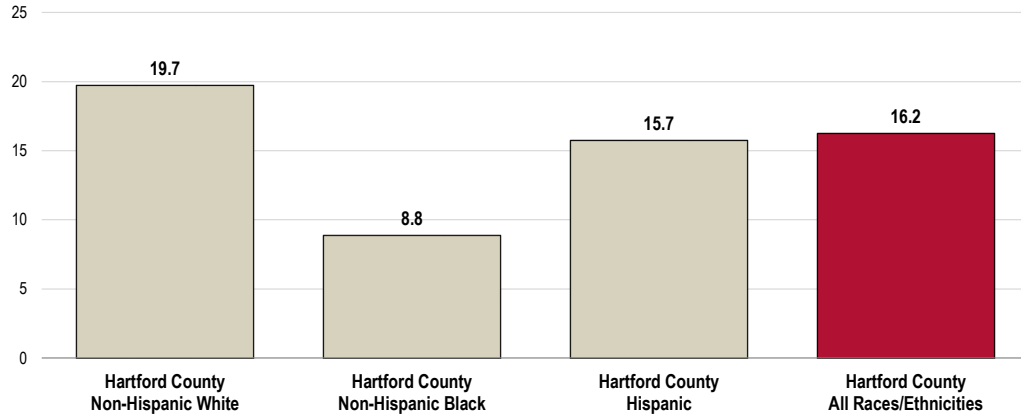
Healthy People 2020 Target = 11.3 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.  
 • Town data (2008-2012): Connecticut State Department of Public Health.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-12]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- The drug-induced mortality rate is higher among Whites when compared with Blacks and Hispanics in Hartford County.

### Drug-Induced Deaths: Age-Adjusted Mortality by Race (2012-2014 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 11.3 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-12]  
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

### Illicit Drug Use

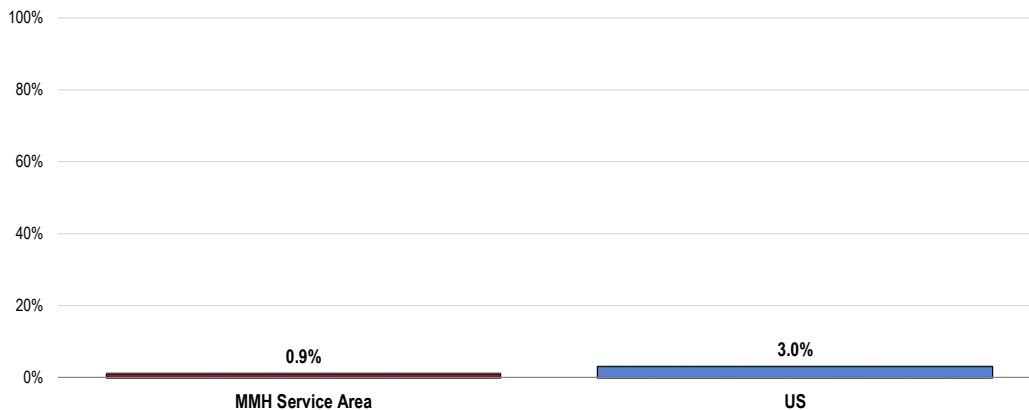
**A total of 0.9% of area adults acknowledge using an illicit drug in the past month.**

- Well below the proportion found nationally.
- Satisfies the Healthy People 2020 target of 7.1% or lower.

For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

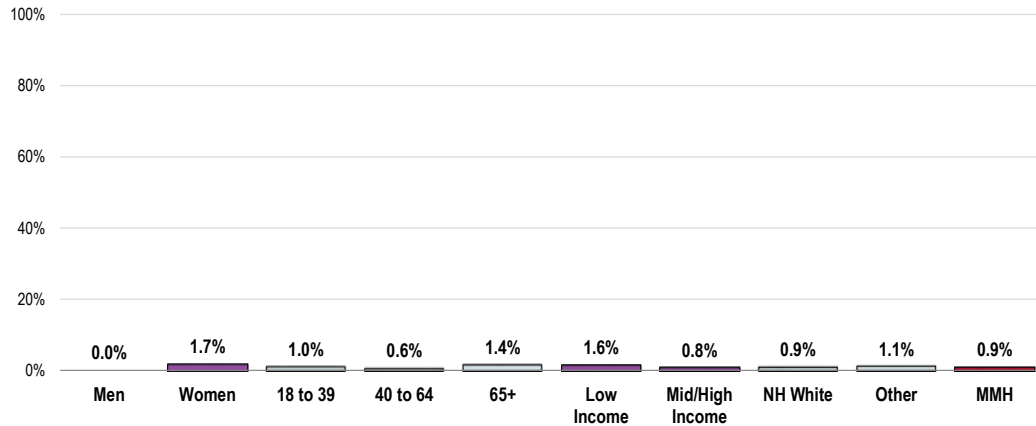
### Illicit Drug Use in the Past Month Healthy People 2020 Target = 7.1% or Lower



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 67]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-13.3]  
 Notes: • Asked of all respondents.

- Illicit drug use is statistically more prevalent among women in the service area.

### Illicit Drug Use in the Past Month (MMH Service Area, 2016) Healthy People 2020 Target = 7.1% or Lower



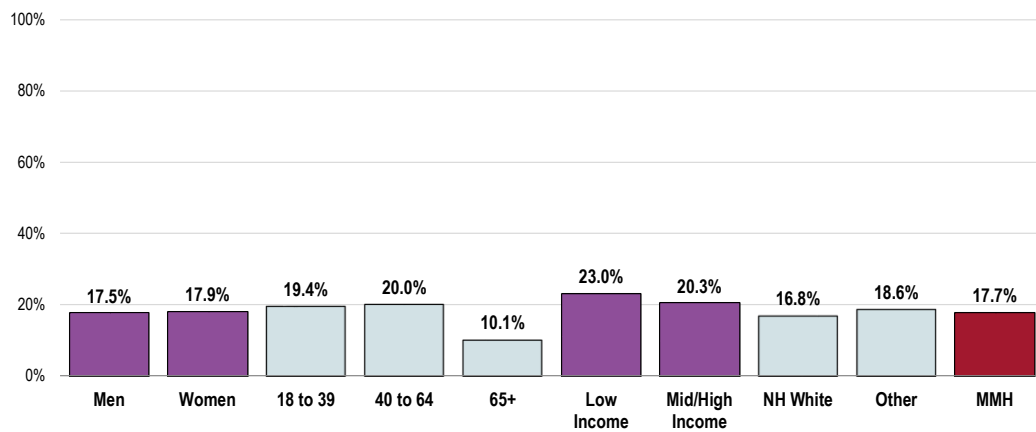
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 67]  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-13.3]

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

### Use of opiates or opioids (with or without a physician's prescription) in the past year is reported among 17.7% of MMH Service Area adults.

- Opiate/opioid use is significantly more prevalent among adults under 65.

### Used Opiates or Opioids in the Past Year (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 301]  
 • Asked of all respondents.  
 • Prescription opiates include morphine, codeine, hydrocodone, oxycodone, and methadone.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

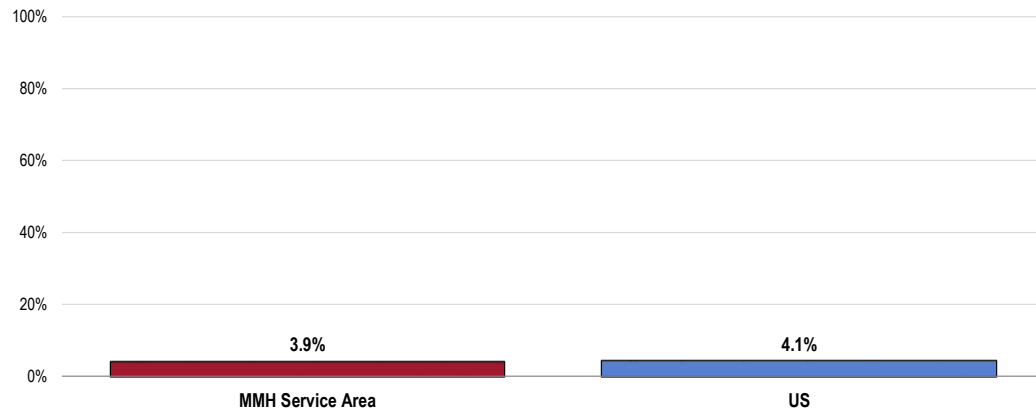
Opiates or opioids are drugs that doctors prescribe to manage pain.

## Alcohol & Drug Treatment

A total of 3.9% of MMH Service Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

- Similar to national findings.

### Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 68]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.

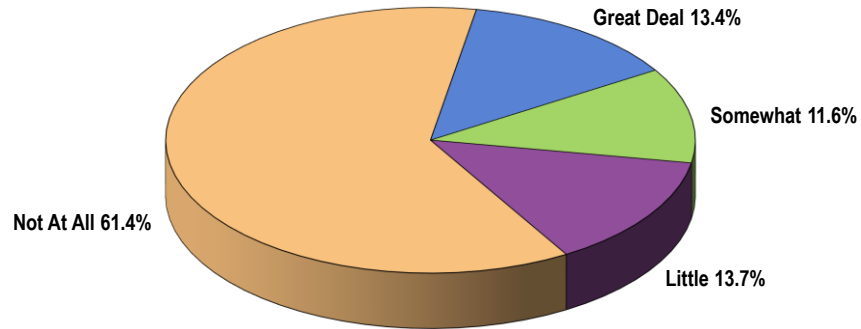
Notes: • Asked of all respondents.

## Negative Effects of Substance Abuse

Area adults were also asked to what degree their lives have been negatively affected by substance abuse (whether their own abuse or that of another).

**In all, most respondents have not been negatively affected (61.4% “not at all” responses).**

### Degree to Which Life Has Been Negatively Affected by Substance Abuse (Self or Other's) (MMH Service Area, 2016)

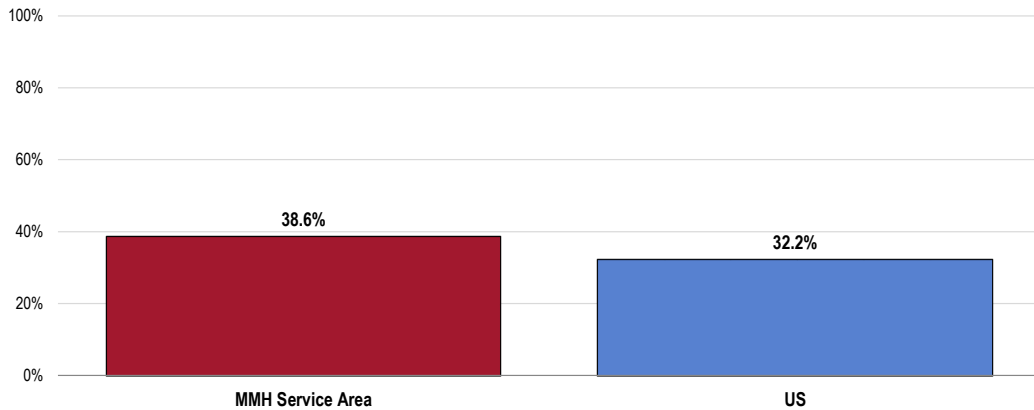


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]  
Notes: • Asked of all respondents.

**In contrast, 38.6% of survey respondents indicate that their lives have been negatively affected by substance abuse, including 13.4% who gave “a great deal” responses.**

- The prevalence of area adults whose lives have been negatively affected by substance abuse is higher than the national response.

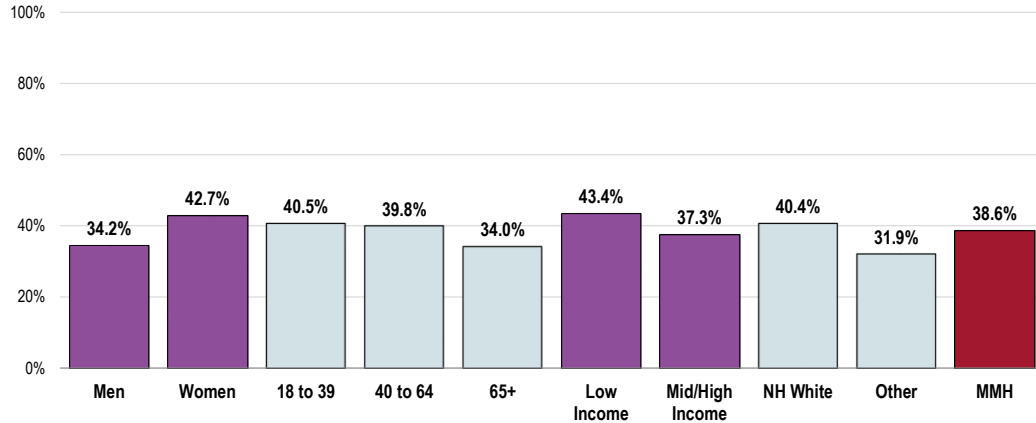
### Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]  
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

- The prevalence of survey respondents whose lives have been negatively impacted by substance abuse, whether their own abuse or that of another, does not vary significantly by demographic characteristics.

### Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else) (MMH Service Area, 2016)

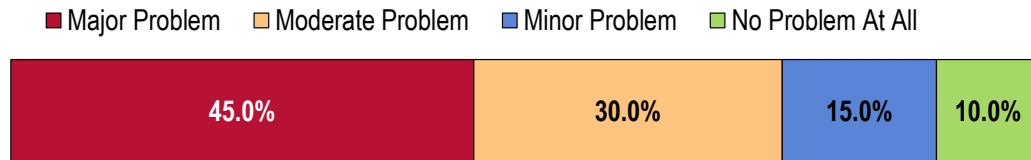


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Key Informant Input: Substance Abuse

The greatest share of key informants taking part in an online survey characterized *Substance Abuse* as a "major problem" in the community.

### Perceptions of Substance Abuse as a Problem in the Community (Key Informants, 2016)



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

### Top Concerns

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

#### Access to Care/Services

*I don't think we have enough resources around. Places seemed to be filled, and people are turned away a lot, where it begins to be frustrating. – Community Leader*  
*Lack of inpatient treatment beds. Lack of suboxone prescribers. – Community Leader*



**Denial/Stigma**

*Denial of substance abuse, difficulty of obtaining treatment in a timely manner, fear of consequences from law enforcement, lack of follow-up services, sober housing, employment and sober lifestyle support. – Community Leader*

*Actually having the community accept treatment programs. – Community Leader*

**Prevalence/Incidence**

*The opioid epidemic is startling. The availability of treatment beds and treatment facilities. Also, getting people want to seek treatment for their addiction. – Public Health Representative*

*Major problem in our community. There are not enough places for them to get successfully treated. – Physician*

Key informants identified **heroin/other opioids, prescription medications, alcohol, and cocaine/crack** as the most problematic substances abused in the community, with **heroin/other opioids** and **alcohol** receiving the highest first-mentions.

## Tobacco Use

### About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

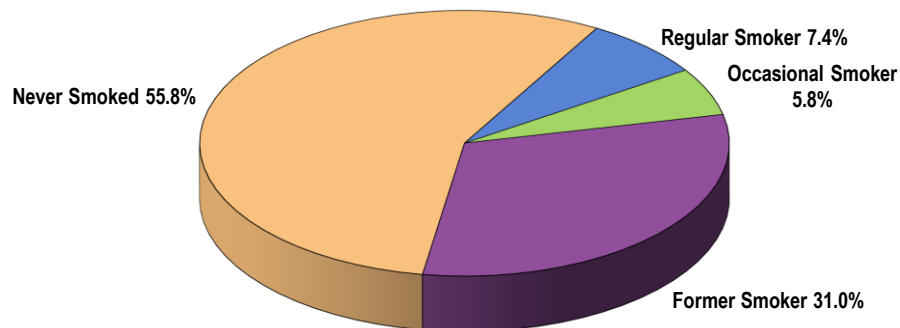
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Cigarette Smoking

### Cigarette Smoking Prevalence

A total of 13.2% of MMH Service Area adults currently smoke cigarettes, either regularly (7.4% every day) or occasionally (5.8% on some days).

**Cigarette Smoking Prevalence**  
(MMH Service Area, 2016)

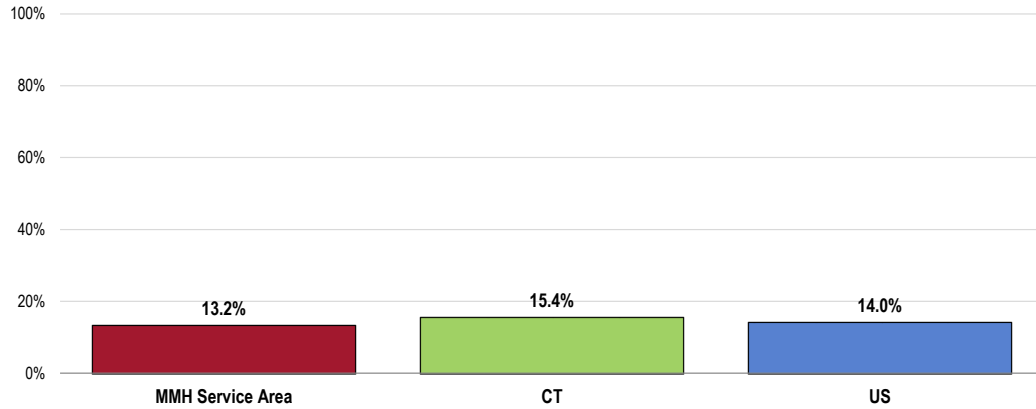


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]  
Notes: • Asked of all respondents.

- Similar to statewide and national findings.
- Similar to the Healthy People 2020 target (12.0% or lower).

### Current Smokers

Healthy People 2020 Target = 12.0% or Lower



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). 2014 Connecticut data.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]
- Notes:
- Asked of all respondents.
  - Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

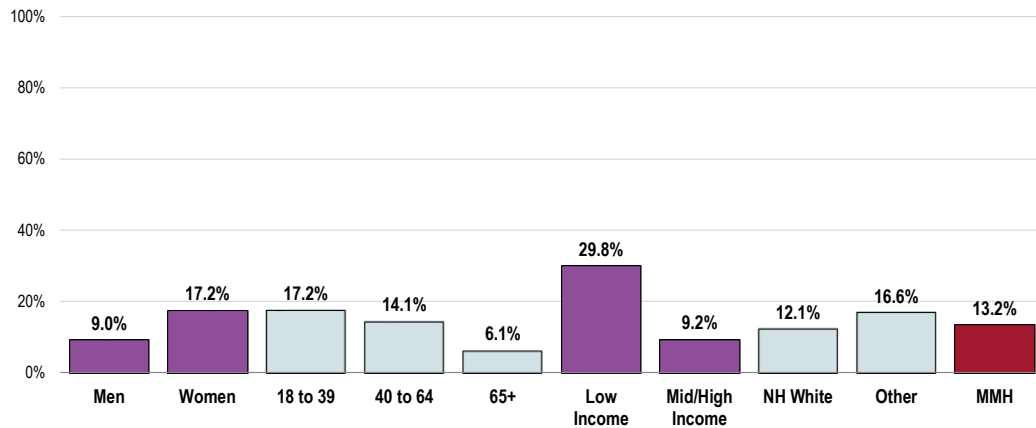
Cigarette smoking is more prevalent among:

- Women.
- Adults under age 40 (negative correlation with age).
- Lower-income residents.

### Current Smokers

(MMH Service Area, 2016)

Healthy People 2020 Target = 12.0% or Lower



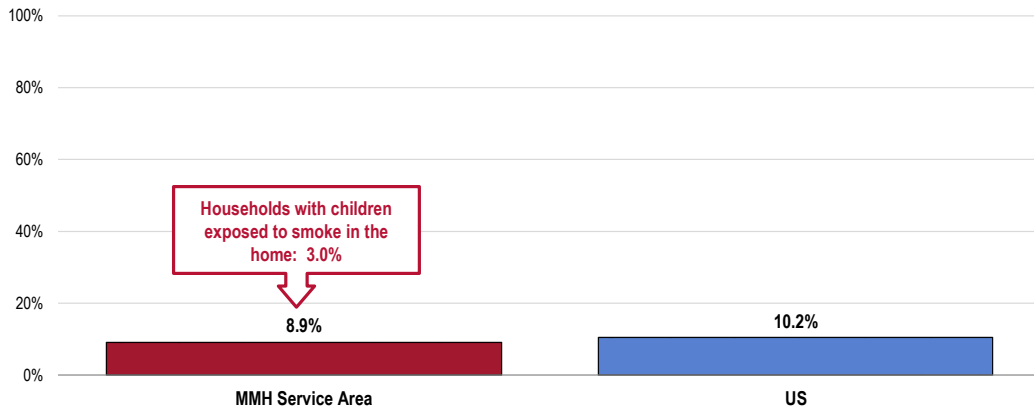
- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
  - Includes regular and occasion smokers (every day and some days).

### Environmental Tobacco Smoke

A total of 8.9% of MMH Service Area adults (including smokers and nonsmokers) report that a member of their household has smoked cigarettes in the home an average of 4+ times per week over the past month.

- Comparable to national findings.
- Note that 3.0% of MMH Service Area children are exposed to cigarette smoke at home, well below that reported nationally.

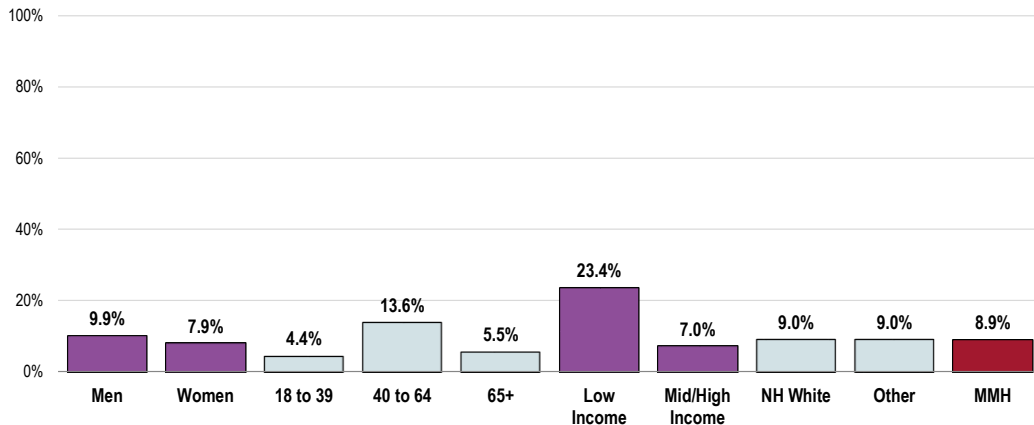
### Member of Household Smokes at Home



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 58, 184]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.  
 • "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

- Notably higher among those age 40 to 64 and residents with lower incomes.

### Member of Household Smokes At Home (MMH Service Area, 2016)



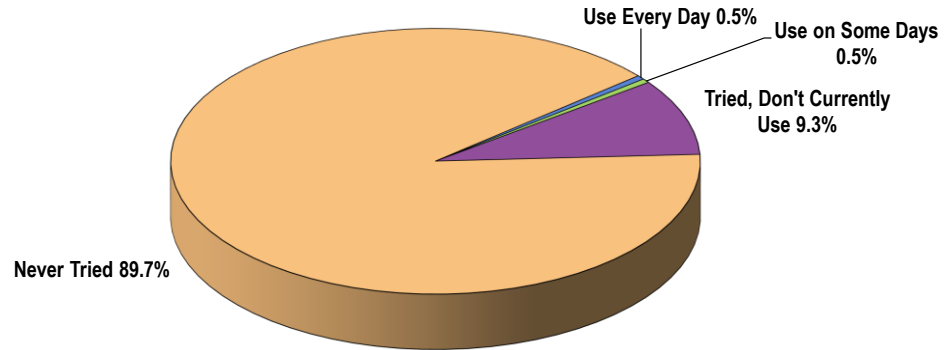
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 58]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.  
 • "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

## Other Tobacco Use

### Electronic Cigarettes

Just 1.0% of MMH Service Area adults currently use electronic cigarettes (“e-cigarettes”), either regularly (0.5% every day) or occasionally (0.5% on some days).

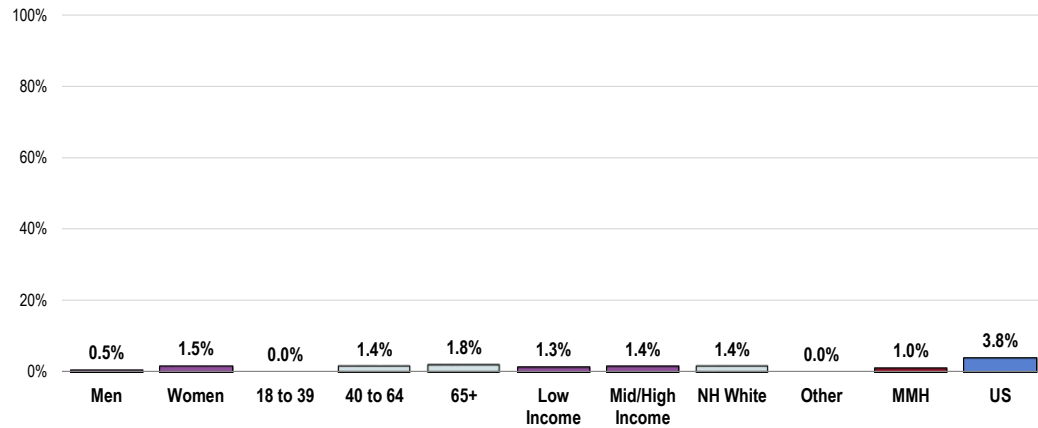
**Electronic Cigarette Use**  
(MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 208]  
Notes: • Asked of all respondents.

- Well below the US figure.
- Electronic cigarette use is more prevalent among Whites in the service area.

**Currently Use Electronic Cigarettes**  
(MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 208]  
Notes: • Asked of all respondents.  
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “NH White” reflects non-Hispanic White respondents).  
• Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.  
• Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

### Cigars & Smokeless Tobacco

A total of 5.5% of MMH Service Area adults use cigars every day or on some days.

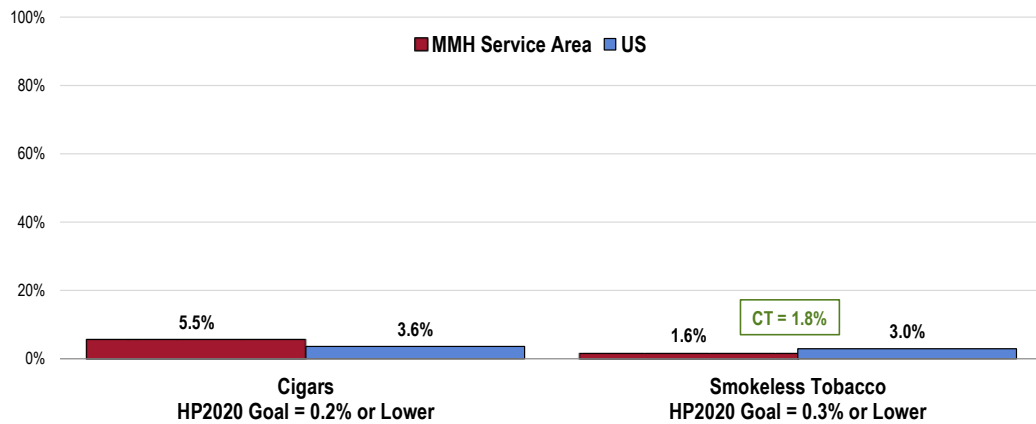
- Similar to the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.2% or lower).

A total of 1.6% of MMH Service Area adults use some type of smokeless tobacco every day or on some days.

- Comparable to the state and national percentages.
- Fails to satisfy the Healthy People 2020 target (0.3% or lower).

Examples of smokeless tobacco include chewing tobacco, snuff, or "snus."

### Other Tobacco Use

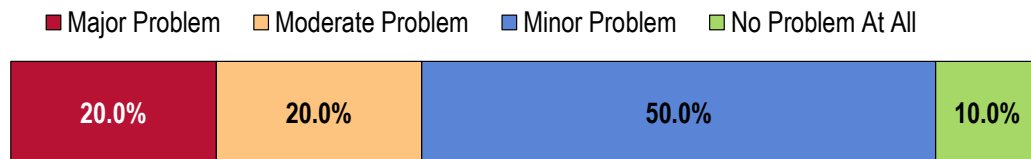


- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 59-60]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2014 Connecticut data.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives TU-1.2, TU-1.3]
- Notes:
- Reflects the total sample of respondents.
  - Smokeless tobacco includes chewing tobacco or snuff.

### Key Informant Input: Tobacco Use

Half of key informants taking part in an online survey characterized *Tobacco Use* as a “minor problem” in the community.

### Perceptions of Tobacco Use as a Problem in the Community (Key Informants, 2016)



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

## Top Concerns

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

### *Prevalence/Incidence*

*Although smoking has decreased, the incidences of smoking-related cancers and chronic disease still remain consistent. – Public Health Representative*

*Too many young people are starting to use tobacco products, despite years of education and strong science outlining the dangers of such use. – Community Leader*

### *Socioeconomic Status*

*I don't know why, but the lower income population continues to smoke. – Physician*

# Access to Health Services



**Professional Research Consultants, Inc.**



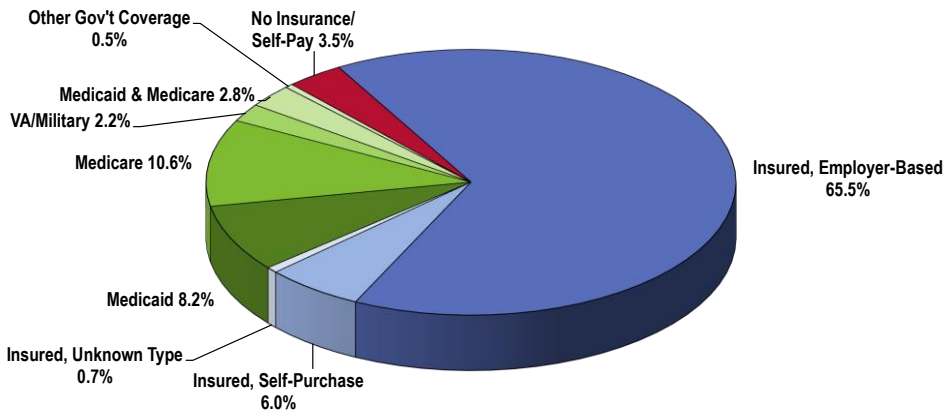
## Health Insurance Coverage

### Type of Healthcare Coverage

A total of 72.2% of MMH Service Area adults age 18 to 64 report having healthcare coverage through private insurance. Another 24.3% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

**Healthcare Insurance Coverage**  
(Among Adults Age 18-64; MMH Service Area, 2016)



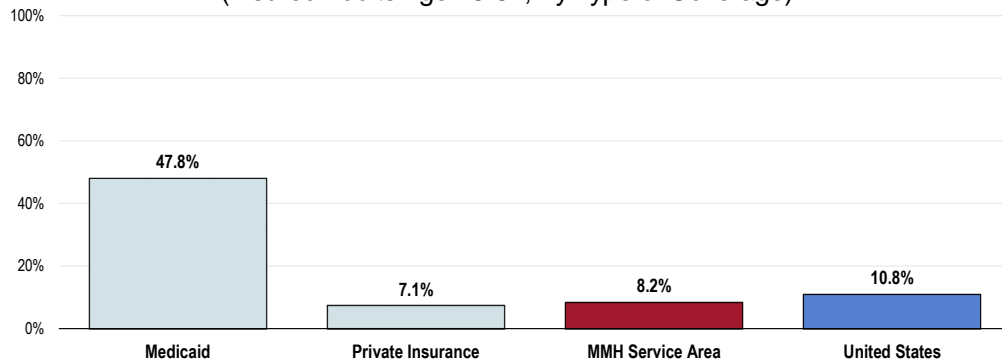
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]  
Notes: • Reflects respondents age 18 to 64.

A total of 8.2% of residents under 65 with private coverage or Medicaid secured their coverage under the Affordable Care Act (ACA), otherwise known as “Obamacare.”

- Similar to the national finding.
- Note the 47.8% of affirmative responses among adults with Medicaid.

### Insurance Was Secured Under the Affordable Care Act/“Obamacare”

(Insured Adults Age 18-64, By Type of Coverage)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 84]  
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents under 65 with private insurance or Medicaid.

## Lack of Health Insurance Coverage

Among adults age 18 to 64, 3.5% report having no insurance coverage for healthcare expenses.

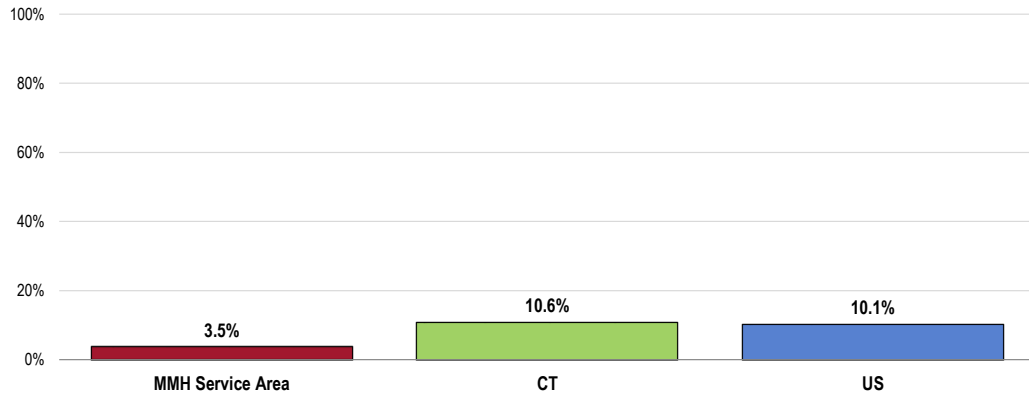
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

- Well below the state and national findings; note, however, that these data predate the implementation of the health insurance marketplace.
- The Healthy People 2020 target is universal coverage (0.0% uninsured).

### Lack of Healthcare Insurance Coverage

(Among Adults Age 18-64)

Healthy People 2020 Target = 0.0% (Universal Coverage)



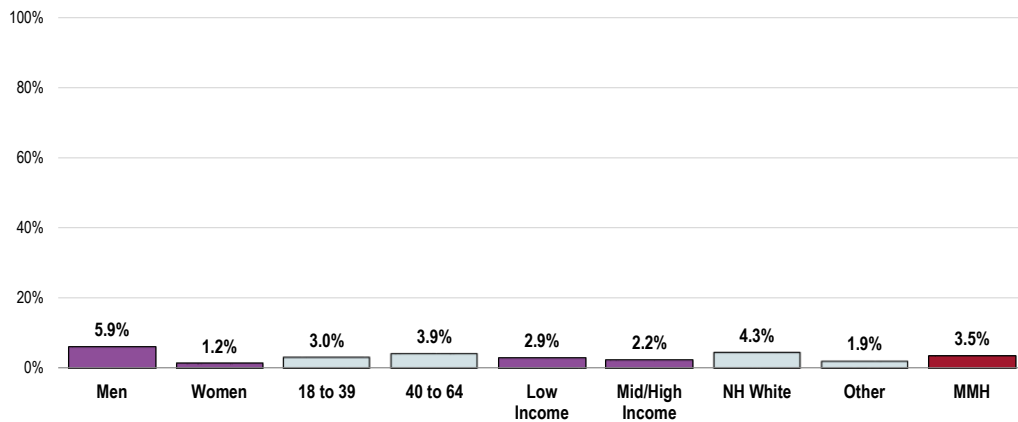
- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2014 Connecticut data.
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1]
- Notes:
- Asked of all respondents under the age of 65.

- Service area men are more likely to be without healthcare insurance coverage.

### Lack of Healthcare Insurance Coverage

(Among Adults Age 18-64; MMH Service Area, 2016)

Healthy People 2020 Target = 0.0% (Universal Coverage)



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1]
- Notes:
- Asked of all respondents under the age of 65.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Difficulties Accessing Healthcare

### About Access to Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

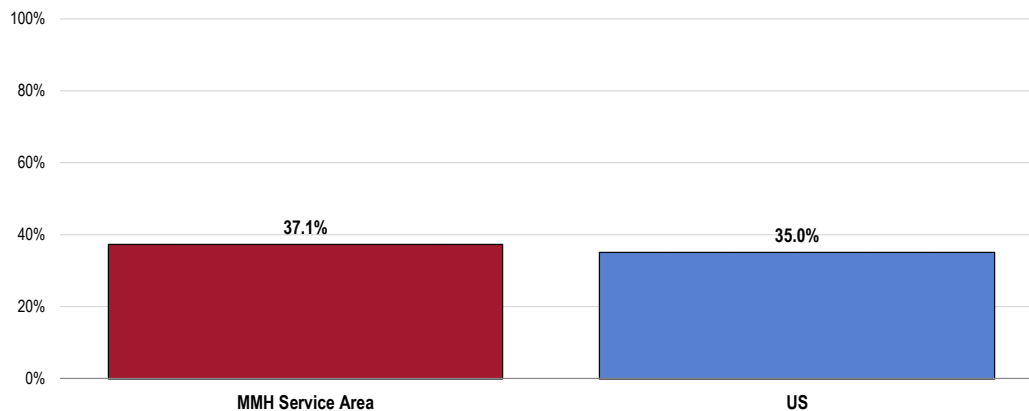
### Difficulties Accessing Services

A total of 37.1% of MMH Service Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

- Comparable to the US figure.

This indicator reflects the percentage of the total population experiencing problems accessing healthcare in the past year, regardless of whether they needed or sought care.

### Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year



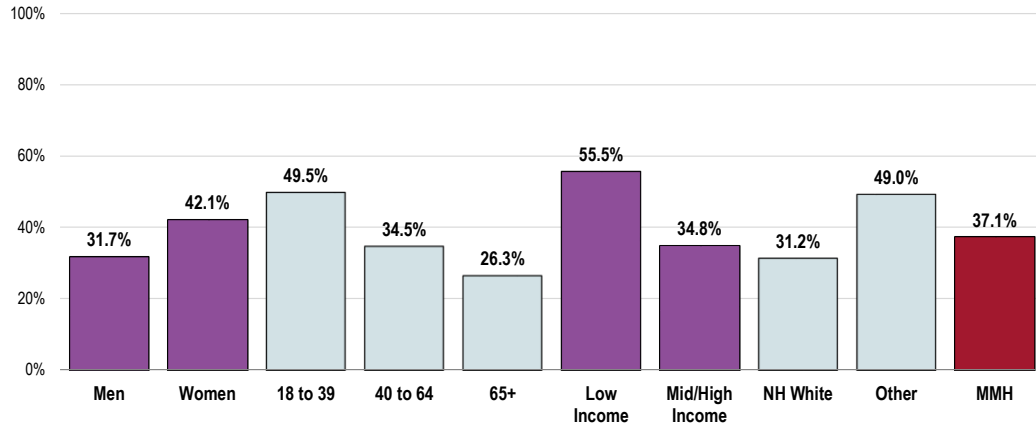
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 194]  
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.  
• Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

Note that the following demographic groups more often report difficulties accessing healthcare services:

- Women.
- Adults under the age of 65 (negative correlation with age).
- Lower-income residents.
- Other races.

## Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 194]  
 Notes: • Asked of all respondents.  
 • Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Barriers to Healthcare Access

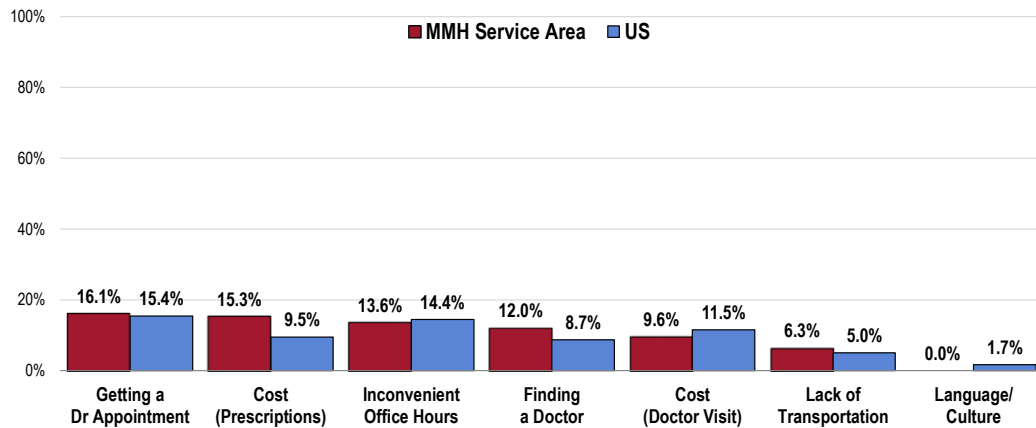
Of the tested barriers, difficulty obtaining a doctor's appointment impacted the greatest share of MMH Service Area adults (16.1% experienced difficulty getting a physician's appointment in the past year).

- The proportion of MMH Service Area adults impacted was statistically comparable to or better than that found nationwide for each of the tested barriers, with the exception of **prescription cost** (the area fared worse than the US overall).

To better understand healthcare access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

## Barriers to Access Have Prevented Medical Care in the Past Year



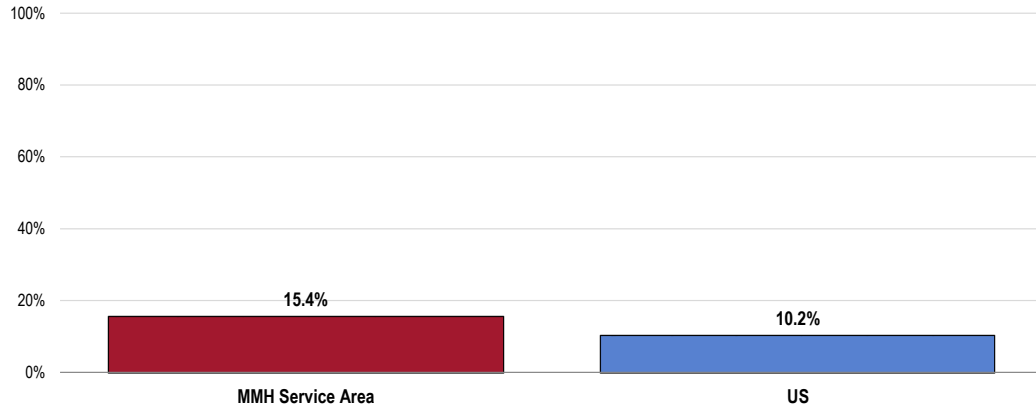
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-13]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

### Prescriptions

Among all MMH Service Area adults, 15.4% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.

- Less favorable than national findings.

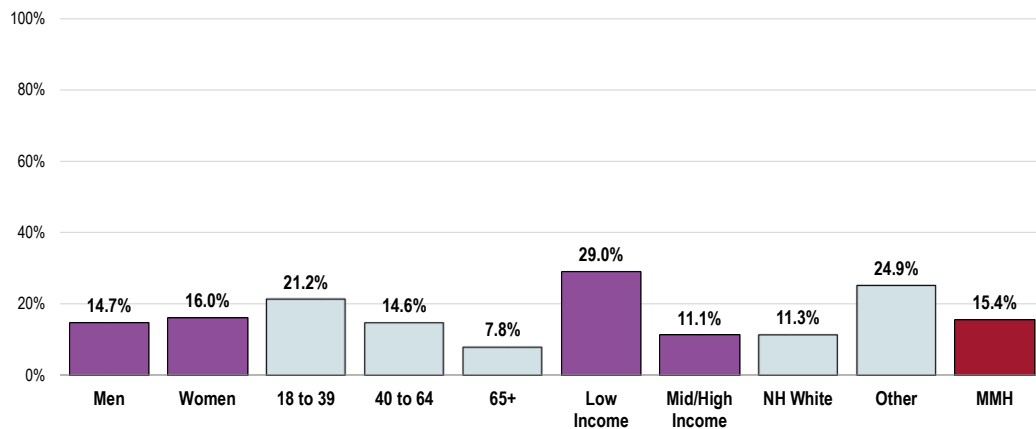
### Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 14]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

- Younger residents, those with lower incomes, and Other races are more likely to have skipped or reduced their prescription doses.

### Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money (MMH Service Area, 2016)



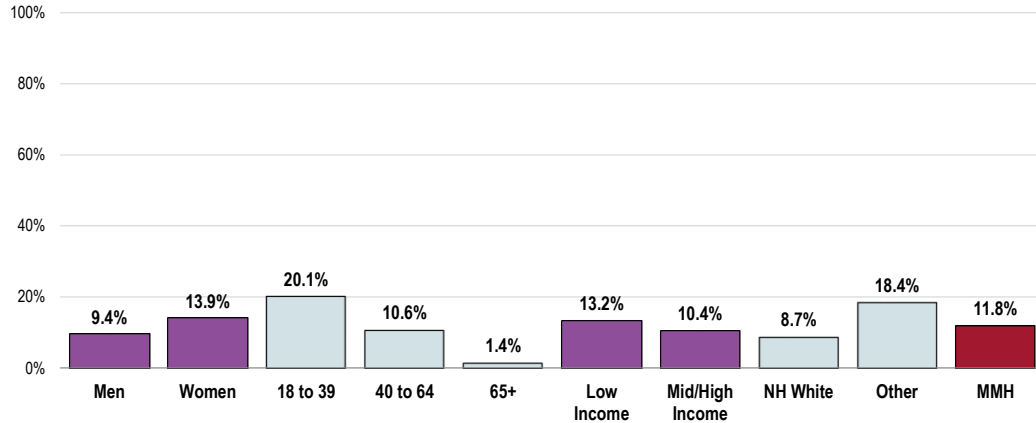
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 14]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

### Prohibitive Deductibles & Co-Pays

Among insured adults in the service area, 11.8% indicate that the size of their deductible or co-pay prevented them from obtaining medical care in the past year.

- Note the negative correlation with age.

#### Size of Deductible or Co-Pay Prevented Medical Care in the Past Year (Insured Adults; MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 302]  
 Notes: • Asked of all respondents with some type of healthcare coverage.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

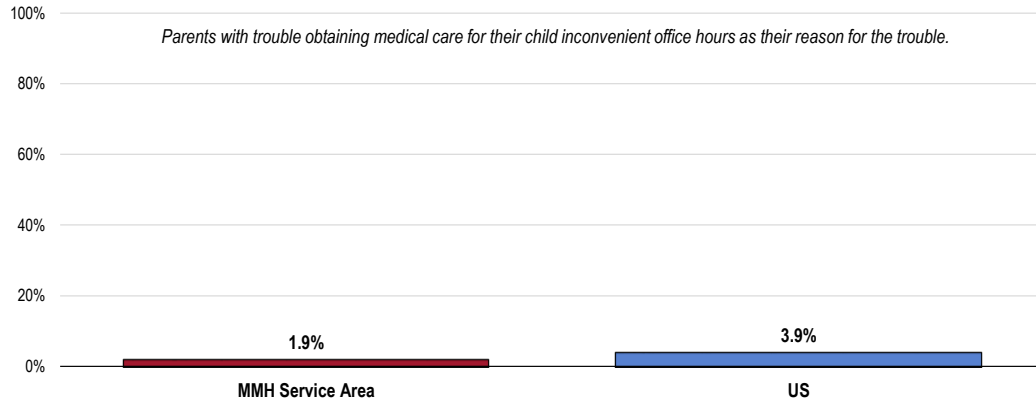
### Accessing Healthcare for Children

A total of 1.9% of parents say there was a time in the past year when they needed medical care for their child, but were unable to get it.

- Statistically similar to what is reported nationwide.

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

## Had Trouble Obtaining Medical Care for Child in the Past Year (Among Parents of Children 0-17)



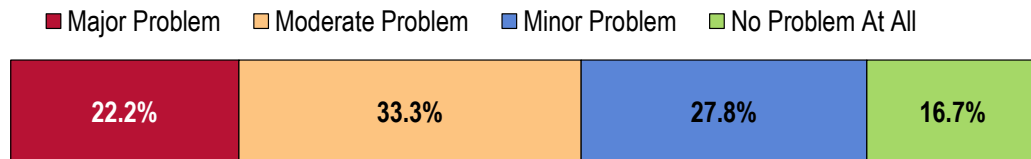
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 136-137]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents with children 0 to 17 in the household.

Among the parents experiencing difficulties, **inconvenient office hours** were cited as the primary reason.

### Key Informant Input: Access to Healthcare Services

One-third of key informants taking part in an online survey characterized *Access to Healthcare Services* as a “moderate problem” in the community.

### Perceptions of Access to Healthcare Services as a Problem in the Community (Key Informants, 2016)



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

### Top Concerns

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

#### Affordable Care/Services

- High-deductible insurance plans and patients with no insurance. – Other Health Provider
- Affordable and more than just adequate health care, for physical and mental health issues. – Community Leader
- High-deductible insurance plans and patients with no insurance. – Other Health Provider

### ***Lack of Specialists***

*Neurology. Not enough/no one to do EMGs. – Other Health Provider*

### ***Older Population***

*Aging in place. Maintaining good health outcomes for older adults by increasing knowledge of maintaining health with chronic conditions, access to transportation for health maintenance and social and recreational opportunities to promote physical and men. – Community Leader*

Key informants (who rated this as a “major problem”) most often identified **specialty care**, **chronic disease care**, **primary care**, and **pain management** as the most difficult to access in the community, with **specialty care** receiving the highest first mention by half of the respondents.



# Health Literacy

## Understanding Health Information

### Written & Spoken Information

Respondents were read:

“You can find written health information on the internet, in newspapers and magazines, on medications, at the doctor’s office, in clinics, and many other places.

How often is health information written in a way that is easy for you to understand?

How often is health information spoken in a way that is easy for you to understand?”

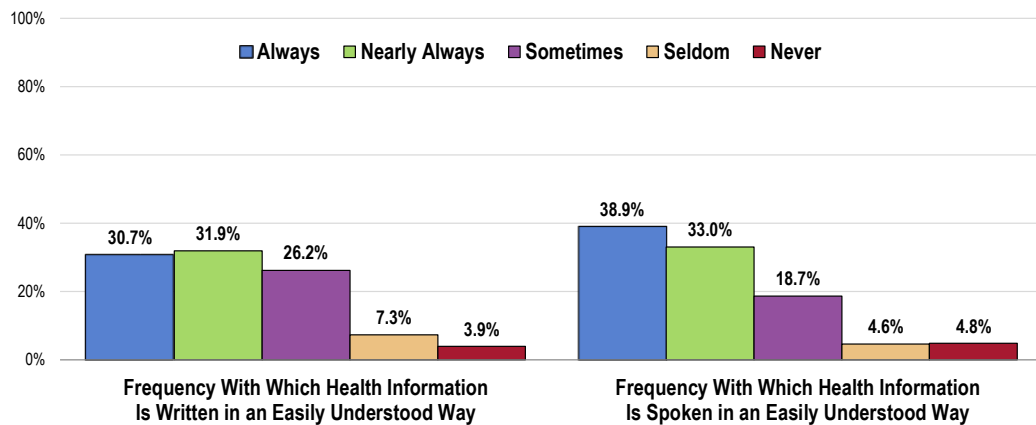
When asked about the frequency with which health information is written in an easily understood way, 62.6% of MMH Service Area adults said “always” or “nearly always.”

- On the other hand, 37.4% of MMH Service Area adults consider **written** health information to be difficult to understand, including 3.9% who gave “never” reports.

When asked about spoken health information, 71.9% stated that this is “always” or “nearly always” easy for them to understand.

- On the other hand, 28.1% of MMH Service Area adults consider **spoken** health information to be difficult to understand, including 4.8% who gave “never” reports.

**Understanding Health Information**  
(MMH Service Area, 2016)



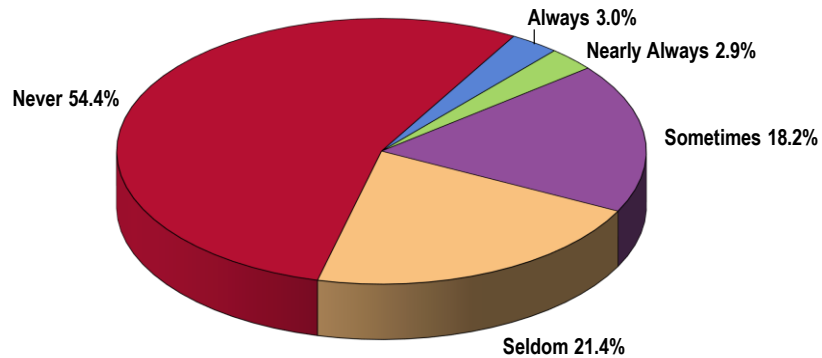
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 87, 89]  
Notes: • Asked of all respondents.

### Help Reading Health Information

A total of 75.8% of MMH Service Area adults report “seldom” or “never” needing help reading health information.

- Another 18.2% of community adults “sometimes” need someone to help them read health information.
- Note that 5.9% of residents “always” or “nearly always” need help reading health information.

### Frequency of Needing Someone to Help Read Health Information (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 88]  
 Notes: • Asked of all respondents.

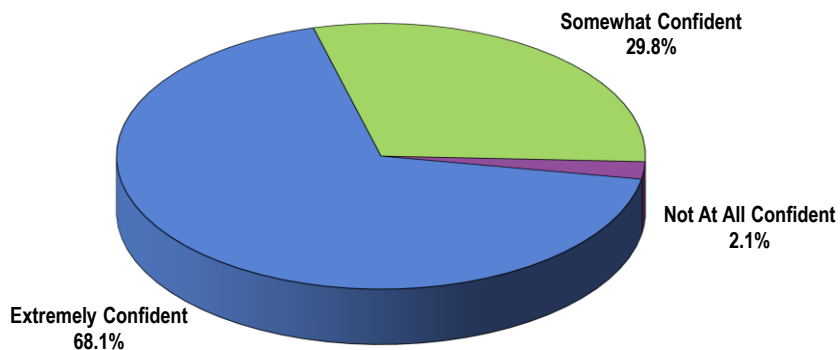
### Completing Health Forms

Asked to describe their confidence in filling out health forms, most survey respondents are “extremely confident” (68.1%).

Examples of health forms include insurance forms, questionnaires, doctor’s office forms, and other forms related to health and healthcare.

- Another 29.8% of community adults are “somewhat confident” in their own ability to fill out health forms.
- However, 2.1% of respondents gave “not at all confident” ratings.

### Self-Perceived Confidence in Ability to Fill Out Health Forms (MMH Service Area, 2016)



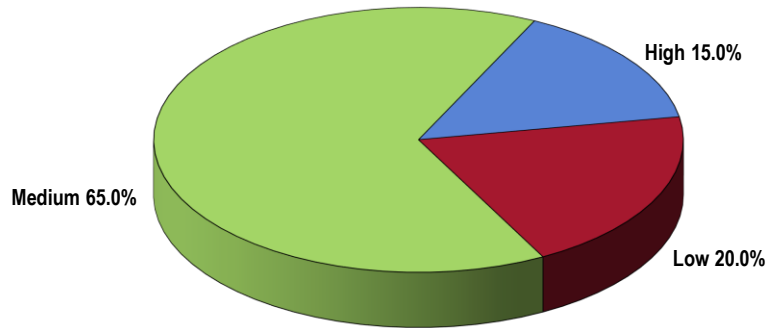
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 90]  
 Notes: • Asked of all respondents.  
 • In this case, health forms include insurance forms, questionnaires, doctor’s office forms, and other forms related to health and healthcare.

## Population With Low Health Literacy

Among MMH Service Area survey respondents, 15.0% are considered to possess high health literacy, while 65.0% have medium health literacy, and the remaining 20.0% are considered to be of low health literacy.

Low health literacy is defined as those respondents who "seldom/never" find written or spoken health information easy to understand, and/or who "always/ nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

**Level of Health Literacy**  
(MMH Service Area, 2016)

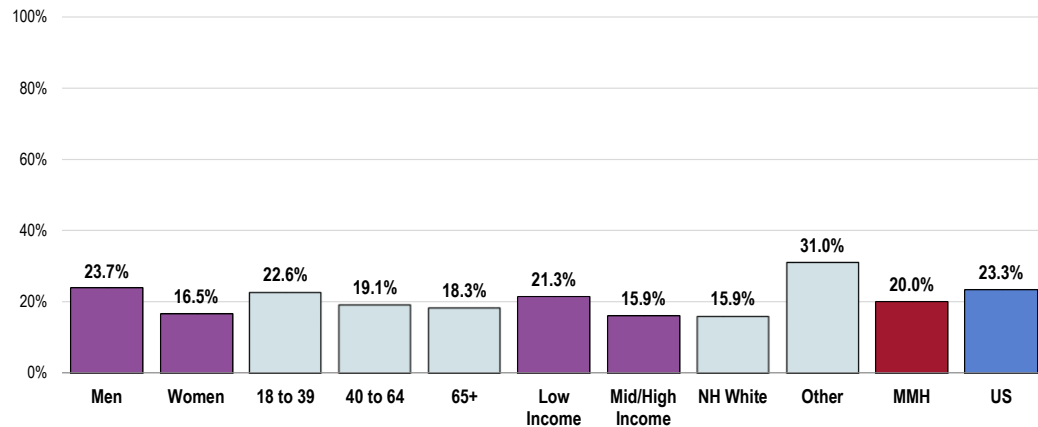


- Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]  
 Notes: • Asked of all respondents.  
 • Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

- The prevalence of MMH Service Area adults with low levels of health literacy is similar to the national average.
- Adults of Other races are more likely to have low health literacy levels.

## Low Health Literacy

(MMH Service Area, 2016)



- Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.  
 • Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

## Primary Care Services

### About Primary Care

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

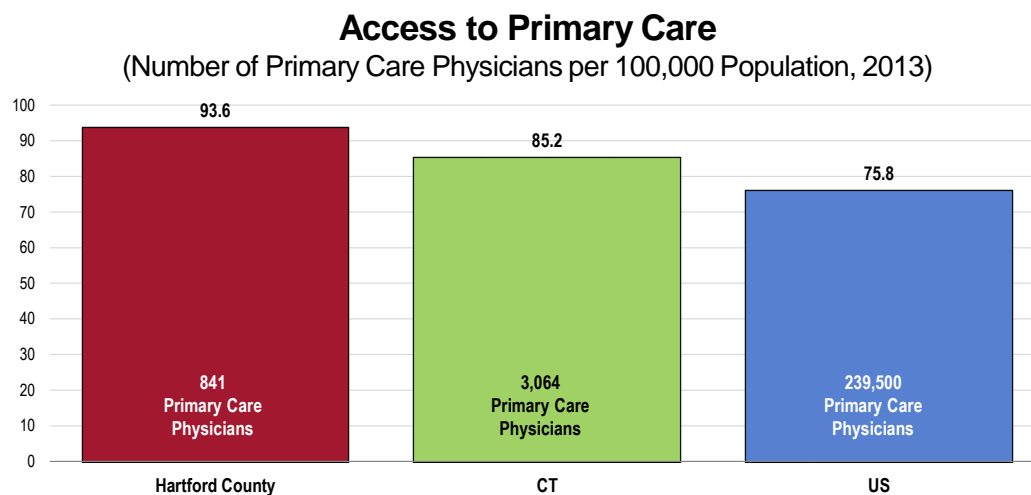
Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Access to Primary Care

In Hartford County in 2013, there were 841 primary care physicians, translating to a rate of 93.6 primary care physicians per 100,000 population.

- Above the primary care physician-to-population ratios found statewide and nationally.



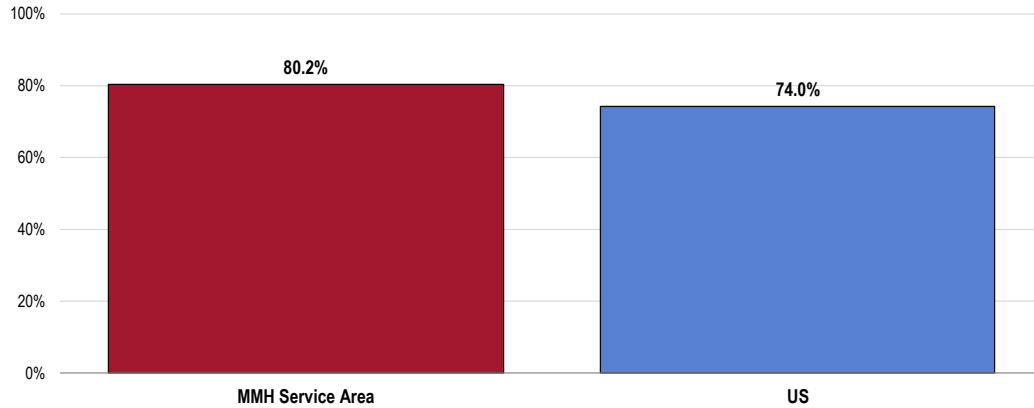
- Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
  - Retrieved August 2016 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

## Specific Source of Ongoing Care

A total of 80.2% of MMH Service Area adults were determined to have a specific source of ongoing medical care.

- Above the national percentage.
- Fails to satisfy the Healthy People 2020 objective (95.0% or higher).

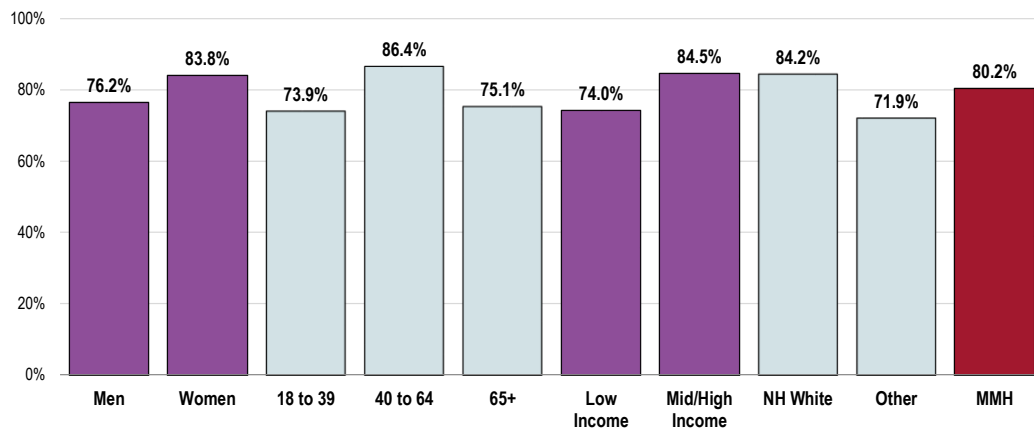
### Have a Specific Source of Ongoing Medical Care Healthy People 2020 Target = 95.0% or Higher



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 191]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-5.1]  
 Notes: • Asked of all respondents.

- When viewed by demographic characteristics, adults on either end of the age spectrum are less likely to have a specific source of care.

### Have a Specific Source of Ongoing Medical Care (MMH Service Area, 2016) Healthy People 2020 Target = 95.0% or Higher



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 191-193]  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-5.1]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

A hospital emergency room is not considered a specific source of ongoing care in this instance.

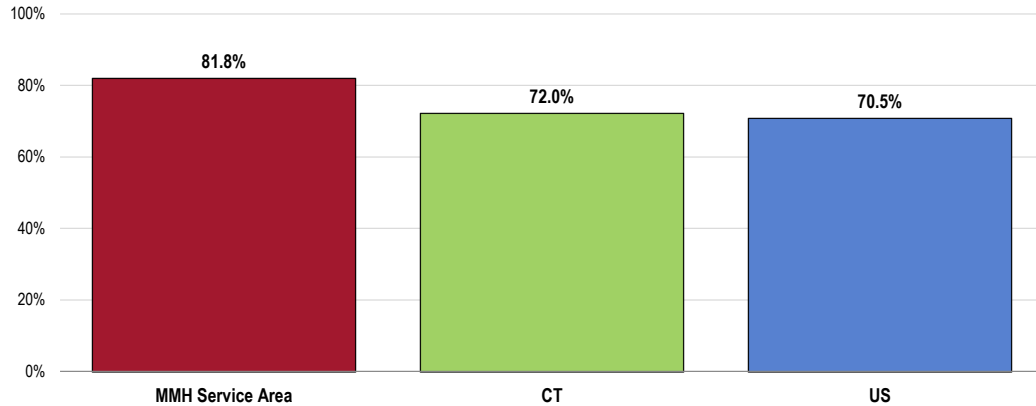
## Utilization of Primary Care Services

### Adults

Most service area adults (81.8%) visited a physician for a routine checkup in the past year.

- More favorable than state and national benchmarks.

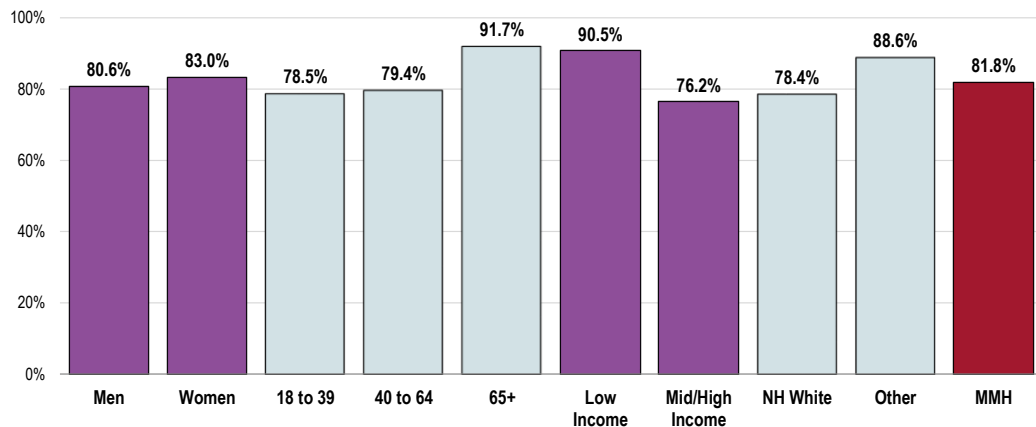
### Have Visited a Physician for a Checkup in the Past Year



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Connecticut data.
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.

- Adults under age 65 are less likely to have received routine care in the past year, as are upper-income residents and Whites.

### Have Visited a Physician for a Checkup in the Past Year (MMH Service Area, 2016)



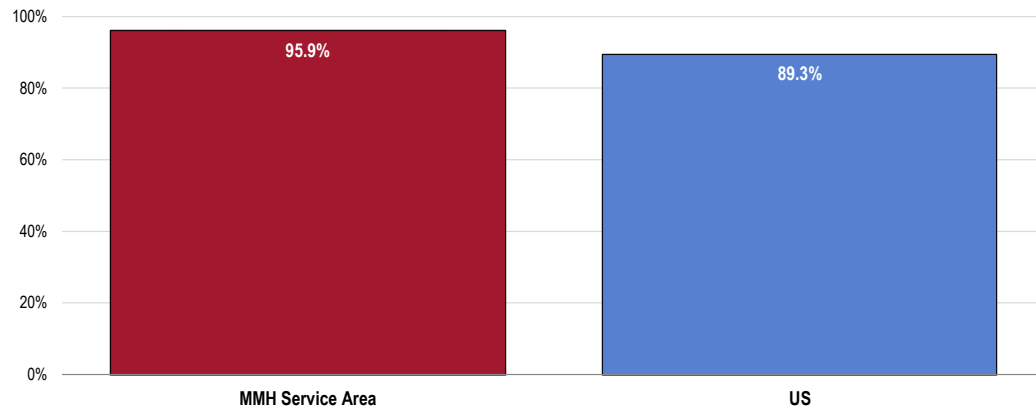
- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Children

Among surveyed parents, 95.9% report that their child has had a routine checkup in the past year.

- Above the national findings.

### Child Has Visited a Physician for a Routine Checkup in the Past Year (Among Parents of Children 0-17)



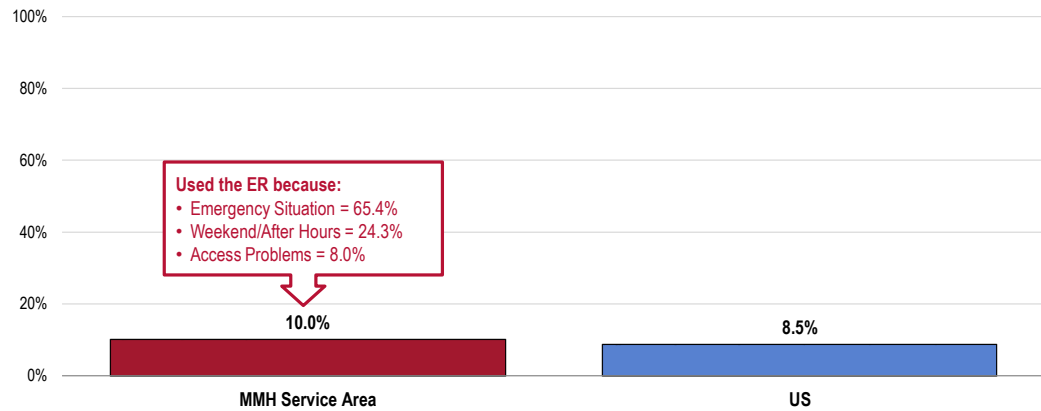
- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 138]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents with children 0 to 17 in the household.

## Emergency Room Utilization

A total of 10.0% of MMH Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

- Comparable to the US figure.

### Have Used a Hospital Emergency Room More Than Once in the Past Year



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 22-23]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.

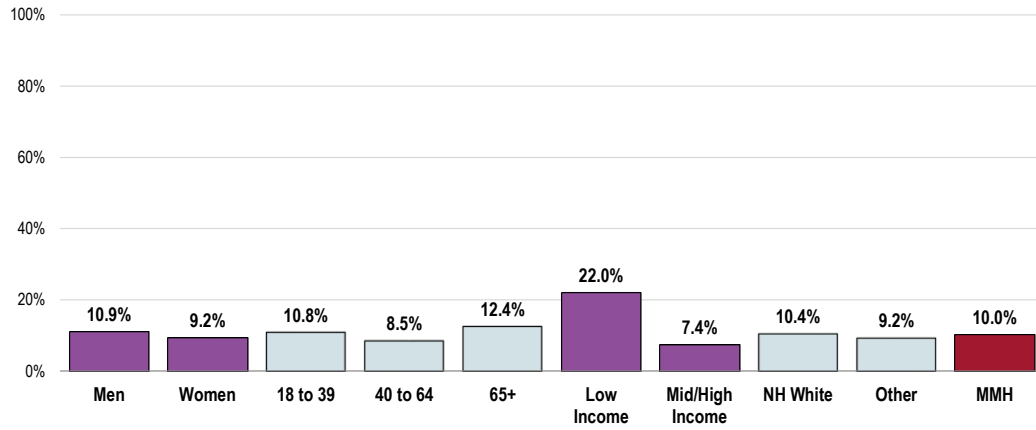
Notes: • Asked of all respondents.

Of those using a hospital ER, 65.4% say this was due to an **emergency or life-threatening situation**, while 24.3% indicated that the visit was during **after-hours or on the weekend**. A total of 8.0% cited **difficulties accessing primary care** for various reasons.

- Service area residents in low-income households are more likely to have used an ER for their medical care more than once in the past year.



## Have Used a Hospital Emergency Room More Than Once in the Past Year (MMH Service Area, 2016)



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 22]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Advance Directives

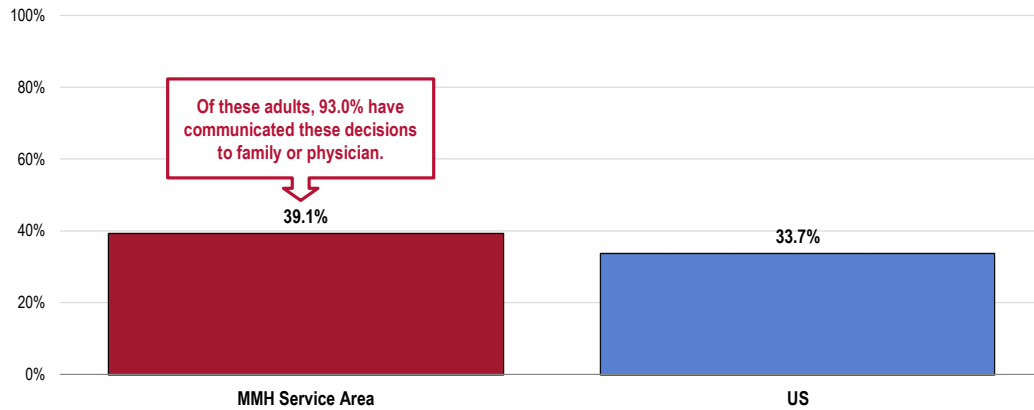
**A total of 39.1% of MMH Service Area adults have completed Advance Directive documents.**

An Advance Directive document is a set of directions given about the medical healthcare a person wants if he/she ever loses the ability to make those decisions. Formal Advance Directives include Living Wills and Healthcare Powers of Attorney.

An Advance Directive document is a set of directions given about the medical healthcare a person wants if he/she ever loses the ability to make those decisions. Formal Advance Directives include Living Wills and Healthcare Powers of Attorney.

- The prevalence is statistically similar to the US figure.
- Of those local adults who have completed Advance Directive documents, 93.0% have communicated these decisions to family and/or a physician.

### Have Completed Advance Directive Documents

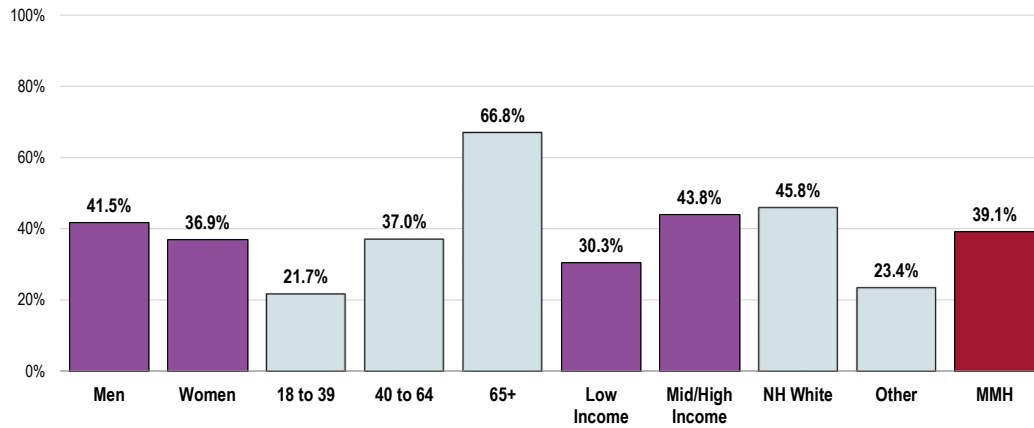


- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 85-86]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.
  - An Advance Directive is a set of directions given about the medical healthcare a person wants if he/she ever loses the ability to make those decisions. Formal Advance Directives include Living Wills and Health Care Powers of Attorney.

These survey respondents are less likely to have filled out Advance Directive documents:

- Young adults (positive correlation with age).
- Individuals living at the lower income level.
- Other races.

## Have Completed Advance Directive Documents (MMH Service Area, 2016)



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 85]

- Notes:
- Asked of all respondents.
  - An Advance Directive is a set of directions given about the medical healthcare a person wants if he/she ever loses the ability to make those decisions. Formal Advance Directives include Living Wills and Health Care Powers of Attorney.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Oral Health

### About Oral Health

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: **tobacco use**; **excessive alcohol use**; and **poor dietary choices**.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

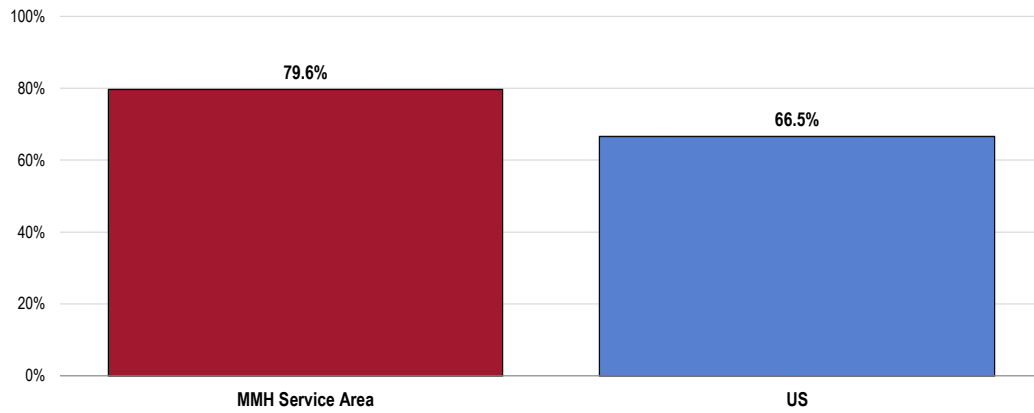
• Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Dental Insurance

**A full 8 in 10 MMH Service Area adults (79.6%) have dental insurance that covers all or part of their dental care costs.**

- Well above the national finding.

### Have Insurance Coverage That Pays All or Part of Dental Care Costs

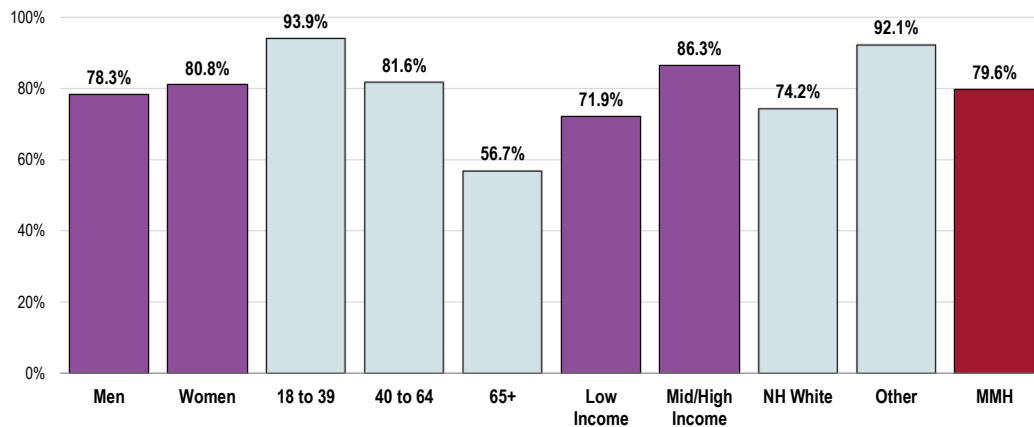


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

These adults are less likely to be covered by dental insurance:

- Older residents (negative correlation with age).
- Low-income adults.
- Whites.

### Have Insurance Coverage That Pays All or Part of Dental Care Costs (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

## Dental Care

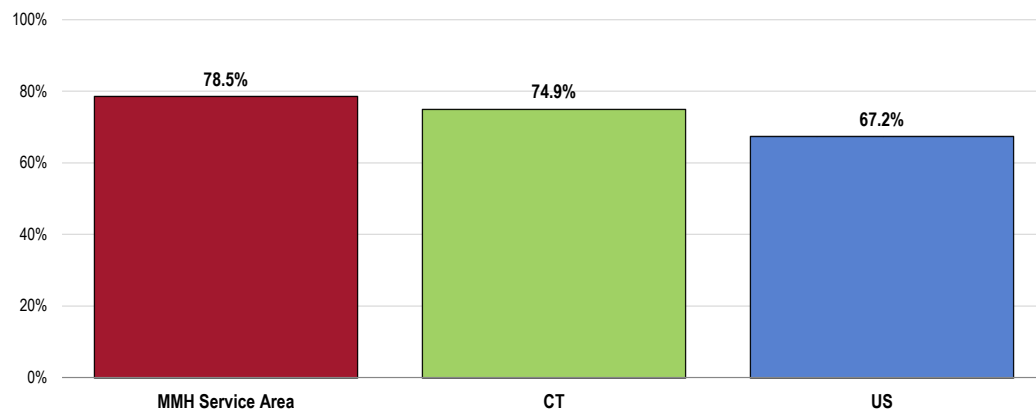
### Adults

A total of 78.5% of MMH Service Area adults have visited a dentist or dental clinic (for any reason) in the past year.

- Similar to statewide findings.
- More favorable than national findings.
- Satisfies the Healthy People 2020 target (49.0% or higher).

### Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2020 Target = 49.0% or Higher



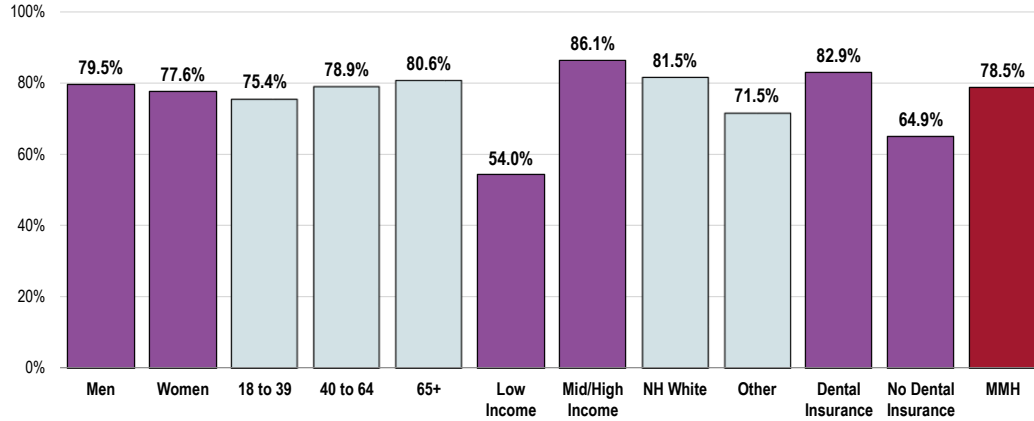
- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2014 Connecticut data.
- Notes:
- Asked of all respondents.

Note the following:

- Persons living in the lower income category report much lower utilization of oral health services.
- As might be expected, persons without dental insurance report much lower utilization of oral health services than those with dental coverage.

## Have Visited a Dentist or Dental Clinic Within the Past Year (MMH Service Area, 2016)

**Healthy People 2020 Target = 49.0% or Higher**



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]
- Notes:
- Asked of all respondents.
  - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
  - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

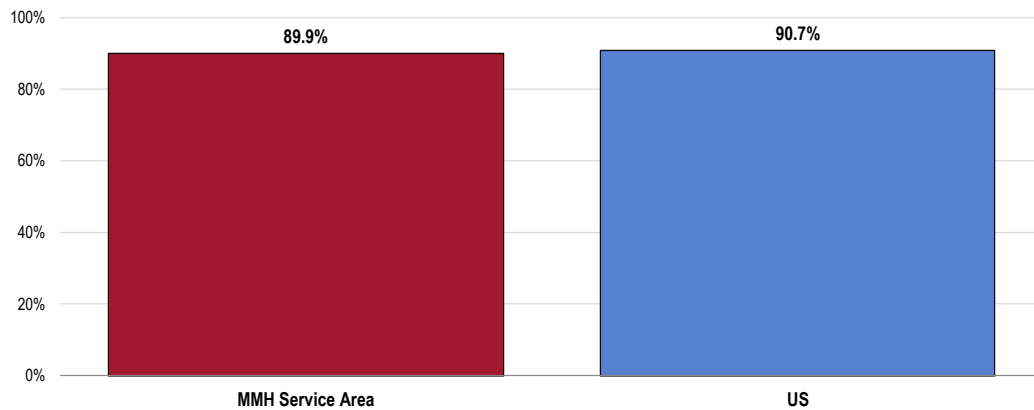
### Children

**A total of 89.9% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.**

- Similar to national findings.
- Easily satisfies the Healthy People 2020 target (49.0% or higher).

## Child Has Visited a Dentist or Dental Clinic Within the Past Year (Among Parents of Children Age 2-17)

**Healthy People 2020 Target = 49.0% or Higher**



- Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 141]
  - 2015 PRC National Health Survey, Professional Research Consultants, Inc.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]
- Notes:
- Asked of all respondents with children age 2 through 17.

## Key Informant Input: Oral Health

Key informants taking part in an online survey most often characterized *Oral Health* as a “minor problem” in the community.

### Perceptions of Oral Health as a Problem in the Community

(Key Informants, 2016)

■ Major Problem   ■ Moderate Problem   ■ Minor Problem   ■ No Problem At All



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

### Top Concerns

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

#### *Insurance Issues*

*Lack of insurance. Lack of a previous town program, a sliding fee program administered by the town Health Department. – Other Health Provider*

*Lack of dental insurance, and Medicare does not cover dental care. – Community Leader*

*Dentists unwilling to take Medicaid patients. – Physician*



## Vision Care

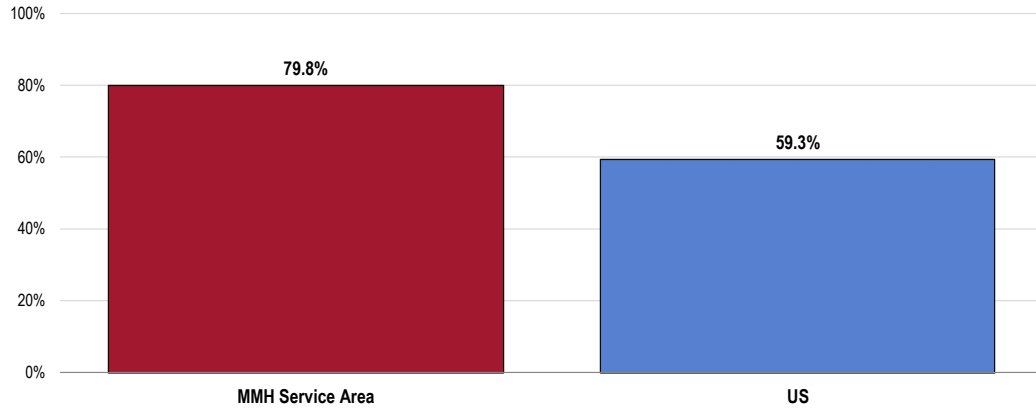
A total of 79.8% of MMH Service Area residents had an eye exam in the past two years during which their pupils were dilated.

RELATED ISSUE:

See also [Vision & Hearing in the Death, Disease & Chronic Conditions](#) section of this report.

- Well above the national figure.

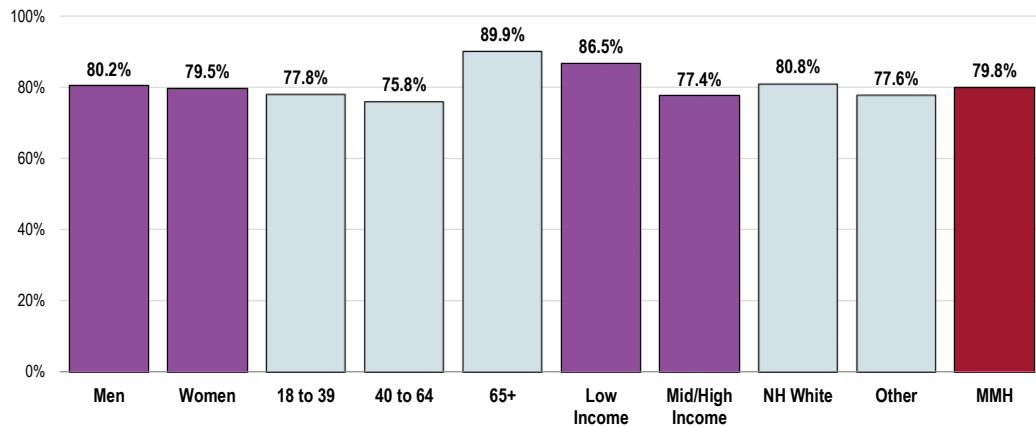
### Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 19]  
 • 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

- Recent vision care in the MMH Service Area is more often reported among seniors.

### Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 19]  
 Notes: • Asked of all respondents.  
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).  
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

# Local Resources



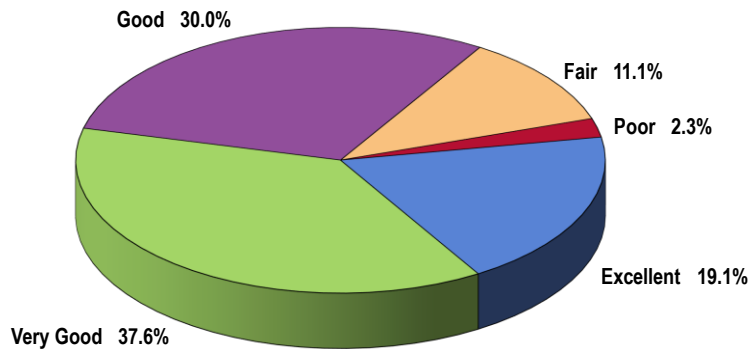
**Professional Research Consultants, Inc.**

## Perceptions of Local Healthcare Services

Over half of MMH Service Area adults (56.7%) rates the overall healthcare services available in their community as “excellent” or “very good.”

- Another 30.0% gave “good” ratings.

**Rating of Overall Healthcare Services Available in the Community**  
(MMH Service Area, 2016)

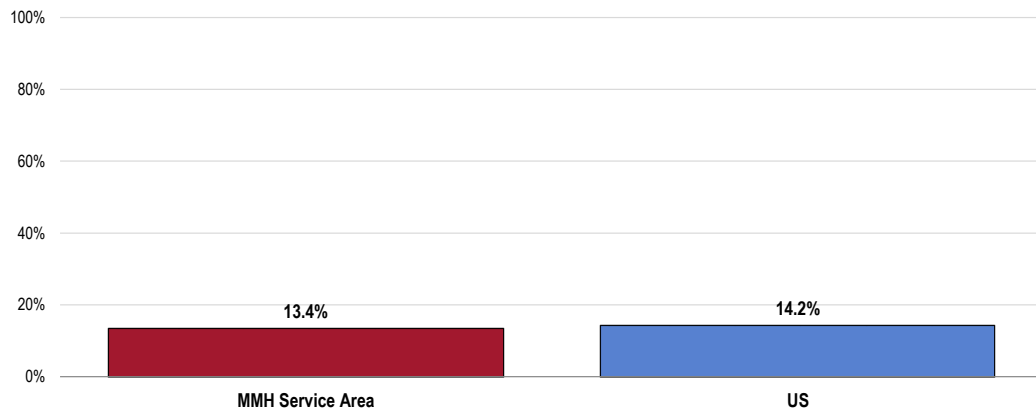


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]  
Notes: • Asked of all respondents.

However, 13.4% of residents characterize local healthcare services as “fair” or “poor.”

- Comparable to the US benchmark.

### Perceive Local Healthcare Services as “Fair/Poor”

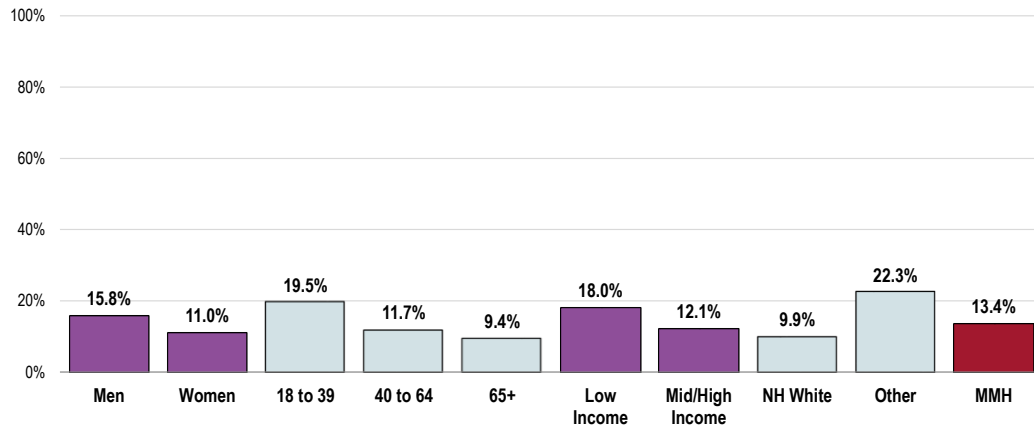


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]  
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

The following residents are more critical of local healthcare services:

- Adults under age 65 (negative correlation with age).
- Other races.

### Perceive Local Healthcare Services as “Fair/Poor” (MMH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]

Notes: • Asked of all respondents.

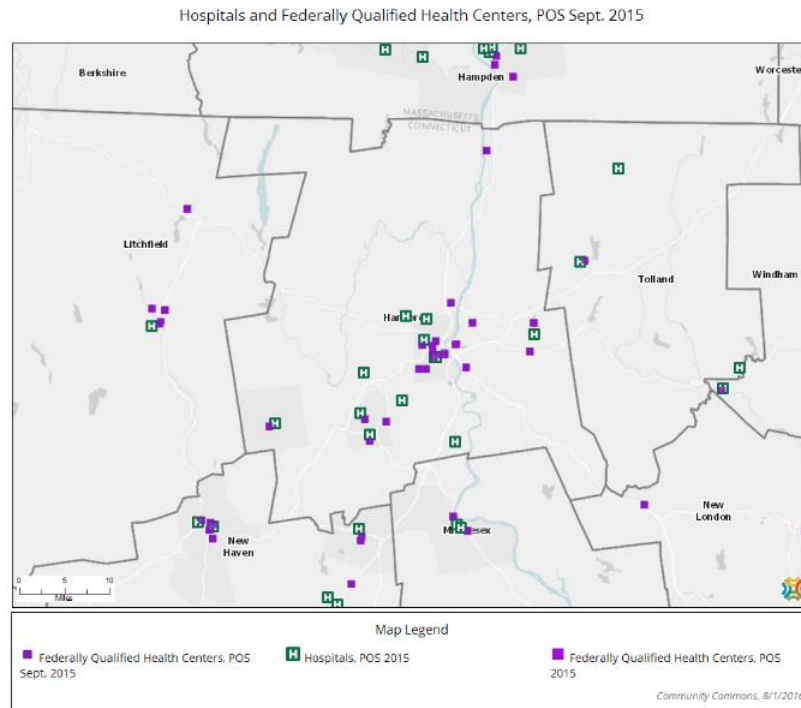
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).

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

## Healthcare Resources & Facilities

### Hospitals & Federally Qualified Health Centers (FQHCs)

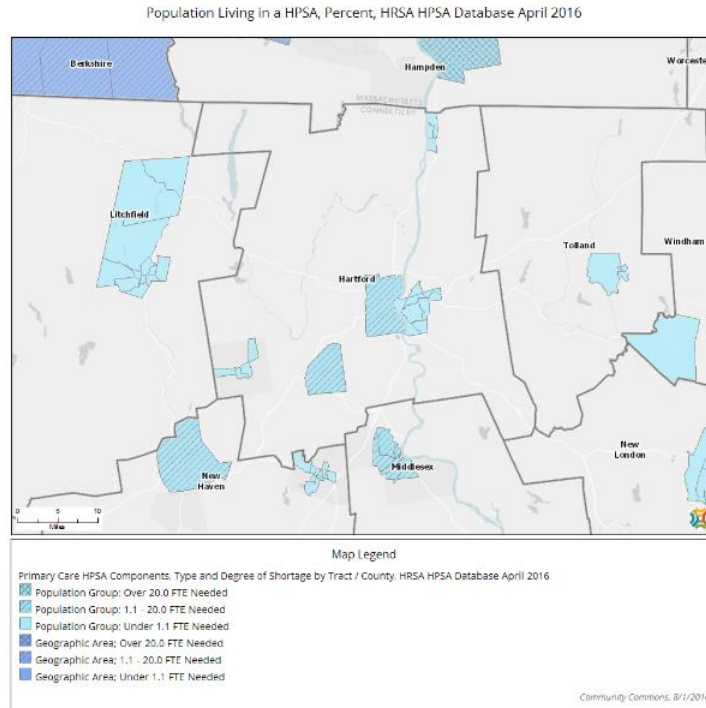
The following map details the hospitals and Federally Qualified Health Centers (FQHCs) within Hartford County as of September 2015.



## Health Professional Shortage Areas (HPSAs)

A "health professional shortage area" (HPSA) is defined as having a shortage of primary medical care, dental or mental health professionals.

The following map illustrates those areas within Hartford County that have been designated by the US Department of Health and Human Services as a health professional shortage area (HPSA).



## Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment.

### *Access to Healthcare Services*

- Building Healthy Families
- First Choice Health Center
- Manchester Community Services Council
- Manchester Senior, Adult and Family Services
- NAMI

### *Arthritis, Osteoporosis & Chronic Back Conditions*

- Doctor's Office
- Eastern Connecticut Health Network
- Manchester Health Department
- Non-Profit Organizations
- Parks and Recreation Department
- PROHealth Chiropractic Center

### *Cancer*

- American Cancer Society
- DeQuattro Cancer Center
- Doctor's Office
- Educational Programs
- Home Health Care Services
- Manchester Memorial Hospital
- Maximized Living Makeover

### *Chronic Kidney Disease*

- Dialysis Center
- Divito Dialysis Center
- Government Transportation
- Home Health Care Services
- Non-Profit Organizations

### *Dementias, Including Alzheimer's Disease*

- Adult Day Care/Long-Term Care Facilities
- Alzheimer's Association
- Connecticut Community Care Inc.
- Doctor's Office
- Government Transportation
- National Alliance on Mental Illness

### *Diabetes*

- Doctor's Office
- Healthcare Systems
- Home Health Care Services
- HVCC Counseling
- Manchester Memorial Hospital
- Novo Nordisk
- ShopRite of East Hartford and Manchester
- Wound Care Centers

### *Family Planning*

- First Choice Health Center
- Manchester Board of Education
- Manchester Health Department
- Planned Parenthood
- Town of Manchester Public Schools
- Youth Services Board

### *Heart Disease & Stroke*

- AEDs (defibrillators)
- American Heart Association
- American Red Cross

- Fitness Centers/Gyms
- Hartford Hospital
- Manchester Health Department
- Manchester Memorial Hospital
- Parkade Health Shoppe
- Visiting Nurses and Hospice Care Connecticut

#### **HIV/AIDS**

- Community Health Resources
- First Choice Health Center
- Manchester Health Department
- Planned Parenthood

#### **Immunization & Infectious Diseases**

- Doctor's Office
- Educational Programs
- Town of Manchester
- VNA Flu Clinics

#### **Infant & Child Health**

- 95210: Manchester Health Initiative
- Bennet Flash After School Program
- Family Place
- First Choice Health Center
- Manchester Health Department
- Planned Parenthood
- ShopRite of East Hartford and Manchester
- Substance Abuse Prevention Agencies
- WIC

#### **Injury & Violence**

- Crisis Response Team
- Human Services Department
- Interval House
- Police Department
- Town of Manchester Police Department

#### **Mental Health**

- Crisis Response Team
- Department of Social Services

- First Choice Health Center
- Genesis
- Human Services Department
- Hockanum Valley Community Counsel
- Manchester Area Conference of Churches
- Manchester Memorial Hospital
- MARCH, Inc.
- National Alliance on Mental Illness
- Town of Manchester EMS
- Town of Manchester Human Services Department

#### **Nutrition, Physical Activity & Weight**

- 95210: Manchester Health Initiative
- Doctor's Office
- Health Department
- Healthcare Systems
- Manchester Health Department
- Manchester Memorial Hospital
- ML Fitness
- Parkade Health Shoppe
- Parks and Recreation Department
- School System
- ShopRite of East Hartford and Manchester
- Silver Sneakers
- Supermarket
- Town of Manchester Public Schools

#### **Oral Health**

- First Choice Health Center
- Town of Manchester Oral Health Program
- Town of Manchester Public Schools
- University of Connecticut Dental Clinic



***Respiratory Diseases***

- American Lung Association
- Manchester Health Department

***Sexually Transmitted Diseases***

- Manchester Health Department
- Manchester School System
- Planned Parenthood
- Town of Manchester Public Schools
- Youth Services Board

***Substance Abuse***

- AA/NA
- Churches
- Community Health Resources
- Community Recovery Center
- Eastern Connecticut Health Network
- East of the River Action for Substance Abuse Elimination (ERASE)
- First Choice Health Center
- Hartford Dispensary
- Health Department
- Hospitals
- Human Services Department
- HVCC Counseling
- Institute of Living
- Manchester Memorial Hospital
- Pathways
- Police Department

***Tobacco Use***

- East of the River Action for Substance Abuse Elimination (ERASE)
- Manchester Health Department
- Town of Manchester Public Schools
- Town of Manchester Youth Services Bureau