2016 Community Health Needs Assessment Report

Rockville General Hospital Service Area

Prepared for:

Eastern Connecticut Health Network | Rockville General Hospital

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Introduction

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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 Rockville General 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 Rockville General 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.

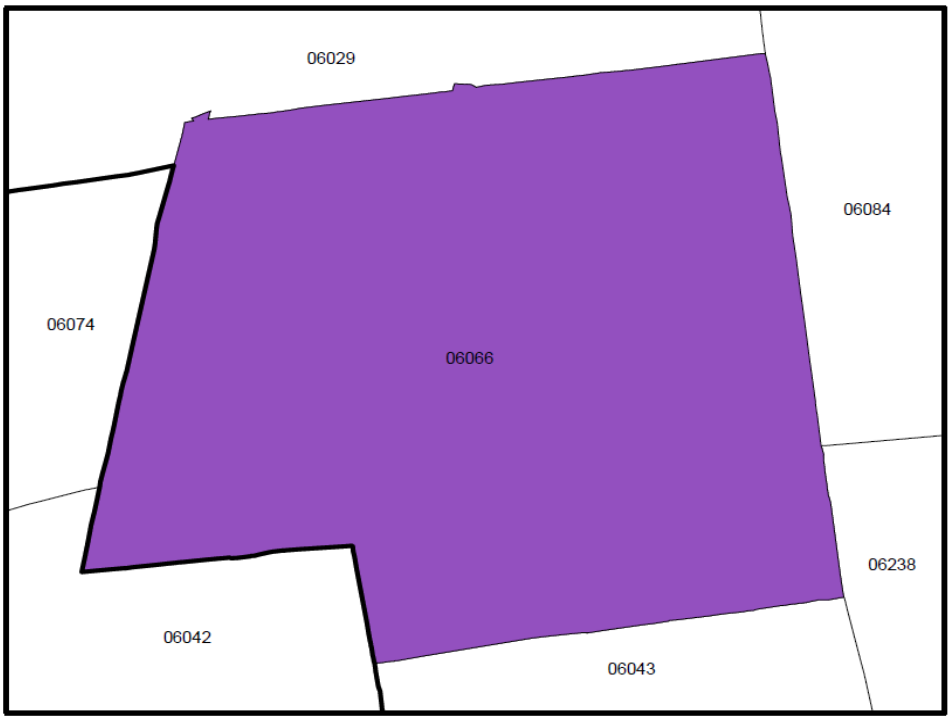
PRC Community Health Survey

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 the Eastern Connecticut Health Network and PRC.

Community Defined for This Assessment

The study area for the survey effort (referred to as the "RGH Service Area" in this report) includes ZIP Code 06066 in Tolland County, Connecticut. This community definition, determined based on the ZIP Codes of residence of recent patients of Rockville General Hospital, is illustrated in the following map.



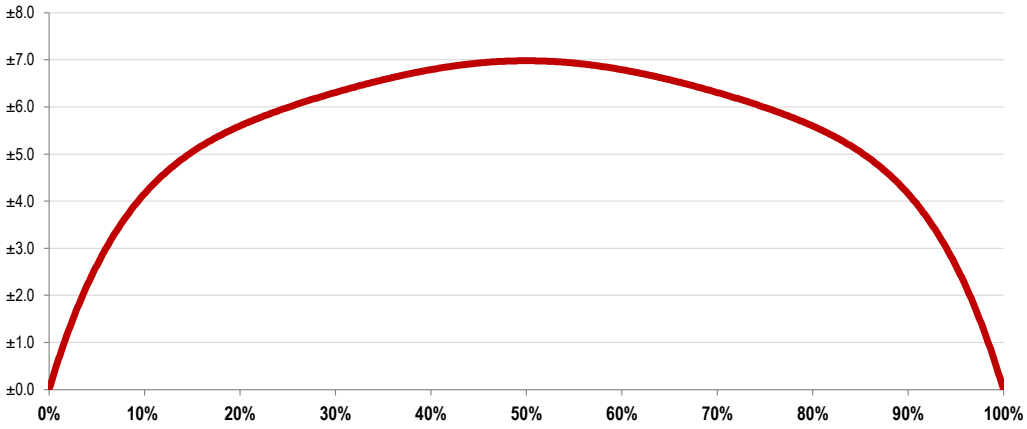
Sample Approach & Design

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 200 individuals age 18 and older in the RGH Service Area. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the RGH Service Area as a whole. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

For statistical purposes, the maximum rate of error associated with a sample size of 200 respondents is ±6.9% at the 95 percent level of confidence.

Expected Error Ranges for a Sample of 200 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 200 respondents answered a certain question with a "yes," it can be asserted that between 5.8% and 14.2% (10% ± 4.2%) 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 43.1% and 56.9% (50% ± 6.9%) of the total population would respond "yes" if asked this question.

Sample Characteristics

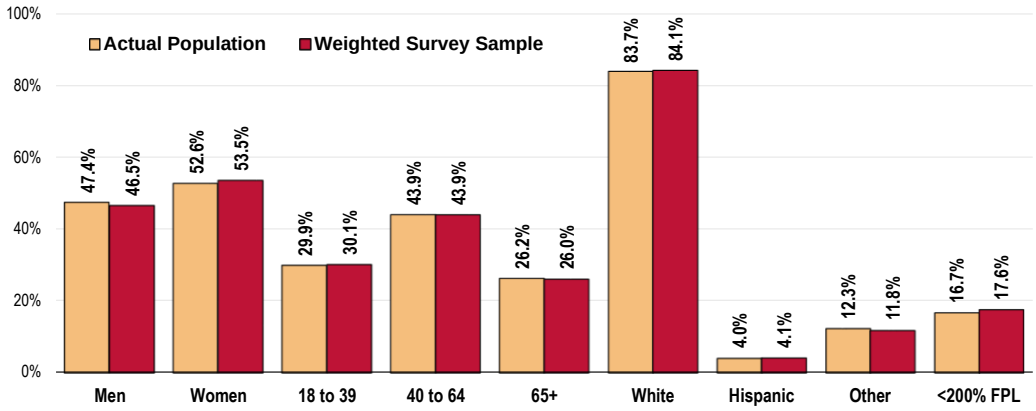
To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. And, while this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” 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 RGH 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

(RGH 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 Rockville General 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, 2 community stakeholders took part in the Online Key Informant Survey, representing the North Central District Health Department and Vernon Public Schools.

Given the low response, key informant input was solicited but ultimately very limited. Through this process, input was gathered from individuals whose organizations work with low-income, minority populations, or other medically underserved populations.

Minority/medically underserved populations represented:

> *African-Americans, Hispanics, low income individuals, Middle Easterners, the uninsured/underinsured*

In the online survey, key informants were asked about various health issues, including why they identify problem areas as such, and how these might be better addressed. Results of the 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
- 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 Tolland County data.

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 a number of 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	
Access to Healthcare Services	• Primary Care Physicians
Cancer	• *Cancer is a leading cause of death.* • Prostate Cancer Deaths • Female Breast Cancer Incidence
Heart Disease & Stroke	• *Cardiovascular disease is a leading cause of death.* • 1+ Cardiovascular Risk Factors
Injury & Violence	• [65+] Falls (Age-Adjusted Death Rate)
Mental Health	• Suicide Rate
Nutrition, Physical Activity & Weight	• Low Food Access • Overweight & Obesity [Adults] • Recreational/Fitness Facilities • *Nutrition, Physical Activity & Weight ranked as a top concern in the Online Key Informant Survey.*
Potentially Disabling Conditions	• Activity Limitations • Arthritis Prevalence (50+) • Osteoporosis (50+)
Respiratory Diseases	• CLRD Deaths • Asthma Prevalence [Adults] • Chronic Obstructive Pulmonary Disease (COPD) Prevalence
Substance Abuse	• Cirrhosis/Liver Disease Deaths • *Substance Abuse ranked as a top concern in the Online Key Informant Survey.*
Tobacco Use	• *Tobacco Use ranked as a top concern in the Online Key Informant Survey.*

Summary Tables: Comparisons With Benchmark Data

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

Reading the Summary Tables

Survey Data Indicators: Note that survey data reflect the ZIP Code–defined RGH Service Area.

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

In the following charts, RGH 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.

Social Determinants	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Linguistically Isolated Population (Percent)	0.8	better 4.8	better 4.7	
Population in Poverty (Percent)	6.6	better 10.5	better 15.6	
Population Below 200% FPL (Percent)	16.6	better 23.6	better 34.5	
Children Below 200% FPL (Percent)	17.1	better 29.7	better 44.2	
% Worry/Stress Over Rent/Mortgage in Past Year	24.2		better 31.6	
No High School Diploma (Age 25+, Percent)	6.8	better 10.5	better 13.7	
Unemployment Rate (Age 16+, Percent)	4.8	better 5.6	better 5.3	
		better	similar	worse

Overall Health	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% "Fair/Poor" Physical Health	9.9	better 14.3	better 18.3	
% Activity Limitations	27.7	worse 19.8	worse 20.0	
% Caregiver to a Friend/Family Member	20.2		similar 20.9	
		better	similar	worse

Access to Health Services	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% [Age 18-64] Lack Health Insurance	6.5	10.6	10.1	0.0
% [Insured 18-64] Have Coverage Through ACA	7.7		10.8	
% [Insured] Deductible or Co-Pay Prevented Medical Care	5.6			
% Difficulty Accessing Healthcare in Past Year (Composite)	28.8		35.0	
% Inconvenient Hrs Prevented Dr Visit in Past Year	12.2		14.4	
% Cost Prevented Getting Prescription in Past Year	4.5		9.5	
% Cost Prevented Physician Visit in Past Year	4.1		11.5	
% Difficulty Getting Appointment in Past Year	11.0		15.4	
% Difficulty Finding Physician in Past Year	9.0		8.7	
% Transportation Hindered Dr Visit in Past Year	2.7		5.0	
% Language/Culture Prevented Care in Past Year	1.4		1.7	
% Skipped Prescription Doses to Save Costs	6.6		10.2	
% Difficulty Getting Child's Healthcare in Past Year	0.0		3.9	
Primary Care Doctors per 100,000	53.5	85.2	75.8	

Access to Health Services (continued)	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% [Age 18+] Have a Specific Source of Ongoing Care	82.8		74.0	95.0
% [Age 18-64] Have a Specific Source of Ongoing Care	83.7		73.1	89.4
% [Age 65+] Have a Specific Source of Ongoing Care	81.7		76.8	100.0
% Have Had Routine Checkup in Past Year	84.1	72.0	70.5	
% Child Has Had Checkup in Past Year	94.2		89.3	
% Two or More ER Visits in Past Year	8.2		8.5	
% Rate Local Healthcare "Fair/Poor"	6.6		14.2	
% Have Completed Advance Directive Documents	38.9		33.7	
% Low Health Literacy	19.5		23.3	
		better	similar	worse

Arthritis, Osteoporosis & Chronic Back Conditions	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% [50+] Arthritis/Rheumatism	41.0		32.0	
% [50+] Osteoporosis	10.7		8.7	5.3
% Sciatica/Chronic Back Pain	22.3		19.4	

Cancer	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Cancer (Age-Adjusted Death Rate)	140.7	149.0	163.6	161.4
Lung Cancer (Age-Adjusted Death Rate)	34.1	37.4	43.4	45.5
Prostate Cancer (Age-Adjusted Death Rate)	18.5	17.5	19.2	21.8
Female Breast Cancer (Age-Adjusted Death Rate)	18.8	18.5	20.9	20.7
Colorectal Cancer (Age-Adjusted Death Rate)	10.8	11.8	14.6	14.5
Prostate Cancer Incidence per 100,000	129.3	139.9	131.7	
Female Breast Cancer Incidence per 100,000	132.4	137.1	123.0	
Lung Cancer Incidence per 100,000	63.2	63.8	63.7	
Colorectal Cancer Incidence per 100,000	42.6	41.7	41.9	
Cervical Cancer Incidence per 100,000	4.9	6.2	7.7	
% Skin Cancer	5.1	5.8	7.7	
% Cancer (Other Than Skin)	8.4	7.1	7.7	
% [Women 50-74] Mammogram in Past 2 Years	89.2	83.9	80.3	81.1
% [Women 21-65] Pap Smear in Past 3 Years	92.5	87.4	84.8	93.0
% [Age 50+] Sigmoid/Colonoscopy Ever	78.3	76.1	75.6	

Cancer (continued)

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% [Age 50+] Blood Stool Test in Past 2 Years	36.4	15.5	31.8	
% [Age 50-75] Colorectal Cancer Screening	78.6	73.1	74.5	70.5
		better	similar	worse

Chronic Kidney Disease

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Kidney Disease (Age-Adjusted Death Rate)	12.7	12.4	13.2	
% Kidney Disease	3.5	2.5	3.6	
		better	similar	worse

Dementias, Including Alzheimer's Disease

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Alzheimer's Disease (Age-Adjusted Death Rate)	9.5	17.1	24.2	
% [Age 45+] Increasing Confusion/Memory Loss in Past Yr	11.1		12.8	
		better	similar	worse

Diabetes

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Diabetes Mellitus (Age-Adjusted Death Rate)	14.6	14.6	21.1	20.5
% Diabetes/High Blood Sugar	12.4	9.2	14.5	
% Borderline/Pre-Diabetes	5.1		5.7	
% [Non-Diabetes] Blood Sugar Tested in Past 3 Years	50.1		55.1	
		better	similar	worse

Family Planning

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Teen Births per 1,000 (Age 15-19)	6.2	20.1	36.6	
		better	similar	worse

Hearing & Other Sensory or Communication Disorders

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% Deafness/Trouble Hearing	12.3		8.6	
		better	similar	worse

Heart Disease & Stroke	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Diseases of the Heart (Age-Adjusted Death Rate)	145.8	149.9	169.1	156.9
Stroke (Age-Adjusted Death Rate)	27.6	27.2	36.5	34.8
% Heart Disease (Heart Attack, Angina, Coronary Disease)	9.7		6.9	
% Stroke	2.5	2.6	2.6	
% Blood Pressure Checked in Past 2 Years	98.5		93.6	92.6
% Told Have High Blood Pressure (Ever)	37.7	31.3	36.5	26.9
% [HBP] Taking Action to Control High Blood Pressure	97.2		92.5	
% Cholesterol Checked in Past 5 Years	95.0	83.1	87.4	82.1
% Told Have High Cholesterol (Ever)	32.9		33.5	13.5
% [HBC] Taking Action to Control High Blood Cholesterol	88.5		84.2	
% 1+ Cardiovascular Risk Factor	88.1		83.0	
		better	similar	worse

HIV

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
HIV Prevalence per 100,000	91.3	335.5	353.2	
		better	similar	worse

Immunization & Infectious Diseases

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% [Age 65+] Flu Vaccine in Past Year	53.6	64.7	58.9	70.0
% [Age 65+] Pneumonia Vaccine Ever	74.8	70.6	76.3	90.0
		better	similar	worse

Injury & Violence Prevention

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Unintentional Injury (Age-Adjusted Death Rate)	38.4	38.3	39.7	36.4
Motor Vehicle Crashes (Age-Adjusted Death Rate)	9.6	7.5	10.6	12.4
[65+] Falls (Age-Adjusted Death Rate)	72.5	54.4	57.0	
% [Age 45+] Fell in the Past Year	21.6		28.2	
Firearm-Related Deaths (Age-Adjusted Death Rate)	4.4	5.3	10.4	9.3
% Firearm in Home	10.9		33.8	

Injury & Violence Prevention (continued)

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% [Homes With Children] Firearm in Home	4.0		31.0	
Violent Crime per 100,000	124.0	280.6	395.5	
% Victim of Violent Crime in Past 5 Years	0.5		2.3	
% Perceive Neighborhood as "Slightly/Not At All Safe"	4.8		15.3	
% Victim of Domestic Violence (Ever)	4.0		15.1	
		better	similar	worse

Maternal, Infant & Child Health

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Low Birthweight Births (Percent)	7.1	7.8	8.0	7.8
Infant Death Rate	2.9	4.8	5.9	6.0
		better	similar	worse

Mental Health & Mental Disorders

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% "Fair/Poor" Mental Health	4.7		15.5	
% Diagnosed Depression	13.9	18.3	17.9	
% Symptoms of Chronic Depression (2+ Years)	16.8		29.9	
Suicide (Age-Adjusted Death Rate)	11.2	9.5	12.7	10.2
% Have Ever Sought Help for Mental Health	25.6		27.4	
% Taking Rx/Receiving Mental Health Trtmt	11.3		13.6	
% Unable to Get Mental Health Svcs in Past Yr	0.7		4.4	
% Typical Day Is "Extremely/Very" Stressful	12.7		11.7	
% Average <7 Hours of Sleep per Night	40.7		39.5	
		better	similar	worse

Nutrition, Physical Activity & Weight

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% Eat 5+ Servings of Fruit or Vegetables per Day	34.8		27.4	
% "Very/Somewhat" Difficult to Buy Fresh Produce	18.8		21.9	
Population With Low Food Access (Percent)	34.1	29.8	23.6	

Nutrition, Physical Activity & Weight (continued)

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% Food Insecure	10.3		25.9	
% 7+ Sugar-Sweetened Drinks in Past Week	21.8		30.2	
% Healthy Weight (BMI 18.5-24.9)	19.5	38.1	32.9	33.9
% Overweight (BMI 25+)	80.0	60.4	65.2	
% Obese (BMI 30+)	33.5	26.3	33.4	30.5
% Medical Advice on Weight in Past Year	23.8		20.4	
% [Overweights] Counseled About Weight in Past Year	27.2		27.1	
% [Obese Adults] Counseled About Weight in Past Year	41.7		40.8	
% Medical Resources for Wt Mgmt Are Insufficient/Unavailable	14.5			
% [Overweights] Trying to Lose Weight Both Diet/Exercise	54.5		57.0	
% No Leisure-Time Physical Activity	18.1	20.6	27.9	32.6
% Meeting Physical Activity Guidelines	24.4	20.8	23.6	20.1
Recreation/Fitness Facilities per 100,000	9.2	13.4	9.7	
% Child [Age 2-17] Physically Active 1+ Hours per Day	62.1		47.9	
		better	similar	worse

Oral Health

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% [Age 18+] Dental Visit in Past Year	80.4	74.9	67.2	49.0
% Child [Age 2-17] Dental Visit in Past Year	96.4		90.7	49.0
% Have Dental Insurance	79.8		66.5	
		better	similar	worse

Respiratory Diseases

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
CLRD (Age-Adjusted Death Rate)	33.2	30.3	41.4	
Pneumonia/Influenza (Age-Adjusted Death Rate)	10.4	12.4	15.1	
% COPD (Lung Disease)	10.0	5.1	9.5	
% [Adult] Currently Has Asthma	14.4	9.2	9.5	
% [Child 0-17] Currently Has Asthma	15.5		6.5	
		better	similar	worse

Sexually Transmitted Diseases

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Gonorrhea Incidence per 100,000	25.1	better 64.9	better 110.7	
Chlamydia Incidence per 100,000	165.8	better 369.0	better 456.1	
		better	similar	worse

Substance Abuse

	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	9.2	worse 8.0	better 10.2	worse 8.2
% Current Drinker	50.1	better 60.8	better 59.7	
% Excessive Drinker	12.7		better 22.2	better 25.4
% Drinking & Driving in Past Month	1.1		better 4.1	
Drug-Induced Deaths (Age-Adjusted Death Rate)	13.8	better 15.6	better 14.6	worse 11.3
% Illicit Drug Use in Past Month	0.5		better 3.0	better 7.1
% Used Opiates or Opioids in the Past Year	14.5			
% Life Negatively Affected by Substance Abuse	31.9		similar 32.2	
		better	similar	worse

Tobacco Use	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% Current Smoker	10.3	15.4	14.0	12.0
% Someone Smokes at Home	3.4		10.2	
% [Nonsmokers] Someone Smokes in the Home	1.7		3.9	
% [Household With Children] Someone Smokes in the Home	0.4		10.2	
% Smoke Cigars	4.4		3.6	0.2
% Use Smokeless Tobacco	1.7	1.8	3.0	0.3
% Currently Use Electronic Cigarettes	2.3		3.8	
		better	similar	worse

Vision	RGH Service Area	RGH Service Area vs. Benchmarks		
		vs. CT	vs. US	vs. HP2020
% Blindness/Trouble Seeing	5.5	3.3	7.3	
% Eye Exam in Past 2 Years	72.9		59.3	
		better	similar	worse

Community Description

Professional Research Consultants, Inc.

Population Characteristics

Total Population

The community examined for this assessment is within Tolland County, which encompasses 410.28 square miles and houses a total population of 152,251 residents, according to latest census estimates.

Total Population

(Estimated Population, 2010-2014)

	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Tolland County	152,251	410.28	371.09
Connecticut	3,592,053	4,842.65	741.75
United States	314,107,083	3,531,932.26	88.93

Sources: • Community Commons. Retrieved August 2016 from http://www.chna.org.
Notes: • Data are derived from the US Census Bureau American Community Survey 5-year estimates (2010-2014).

Population Change 2000-2010

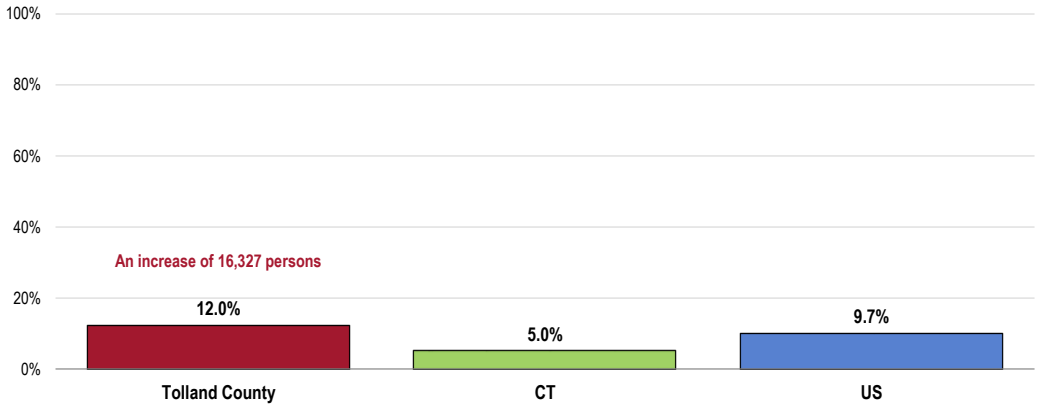
A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

Between the 2000 and 2010 US Censuses, the population of Tolland County increased by 16,327 persons, or 12.0%.

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

Change in Total Population

(Percentage Change Between 2000 and 2010)

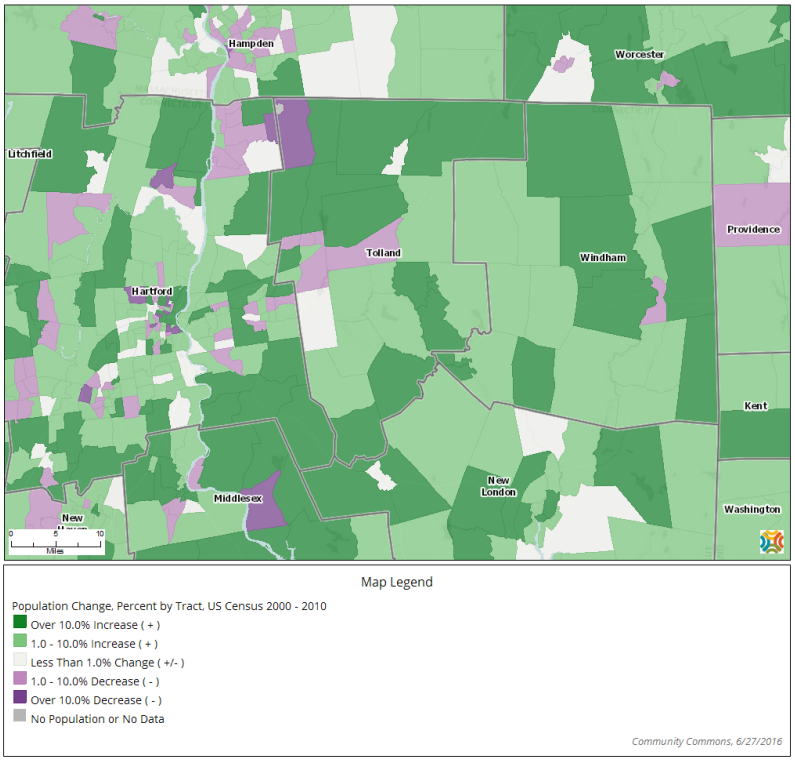


Sources:
- Retrieved August 2016 from Community Commons at http://www.chna.org.
- US Census Bureau Decennial Census (2000-2010).

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.

Population Change, Percent by Tract, US Census 2000-2010



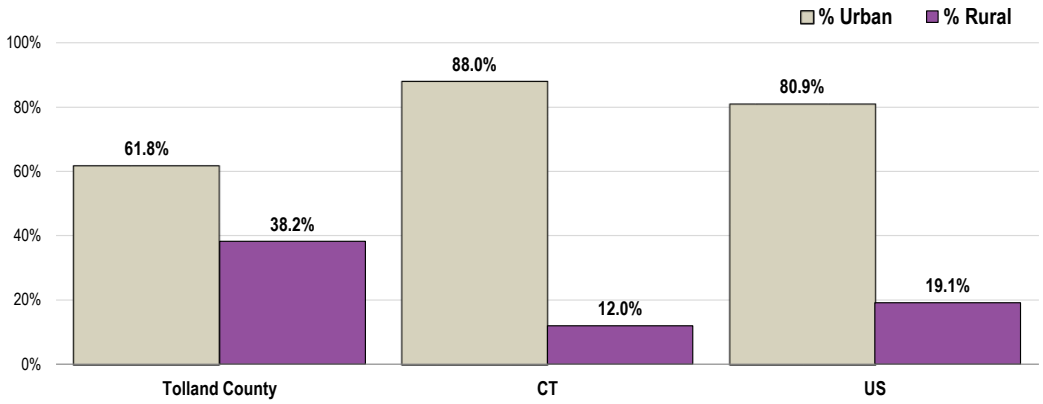
Urban/Rural Population

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.

Tolland County houses a large urban population, with 61.8% of the population living in areas designated as urban.

- This prevalence, however, is well below the state and national figures.

Urban and Rural Population
(2010)

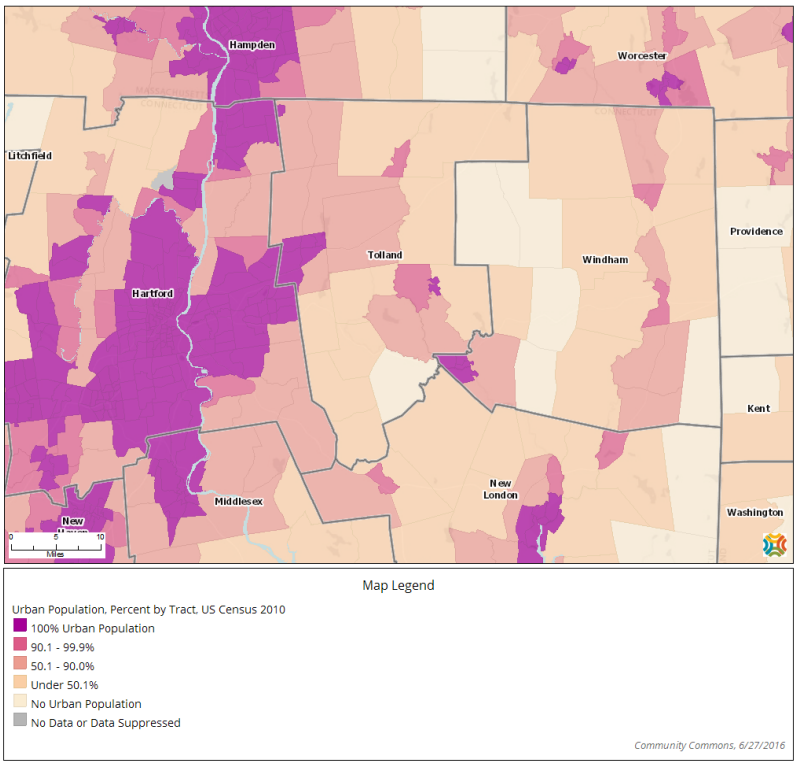


Sources:
- US Census Bureau Decennial Census (2010).
- Retrieved August 2016 from Community Commons at http://www.chna.org.

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 Tolland County census tracts as of 2010.

Urban Population, Percent by Tract, US Census 2010

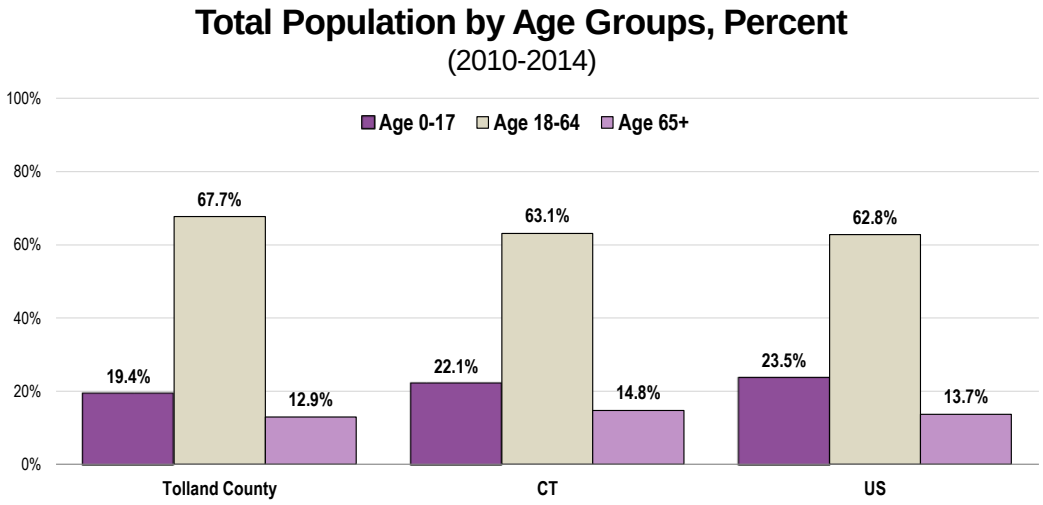


Age

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 Tolland County, 19.4% of the population are infants, children or adolescents (age 0-17); another 67.7% are age 18 to 64, while 12.9% are age 65 and older.

- A larger 18-64 population than found across Connecticut and the US overall.

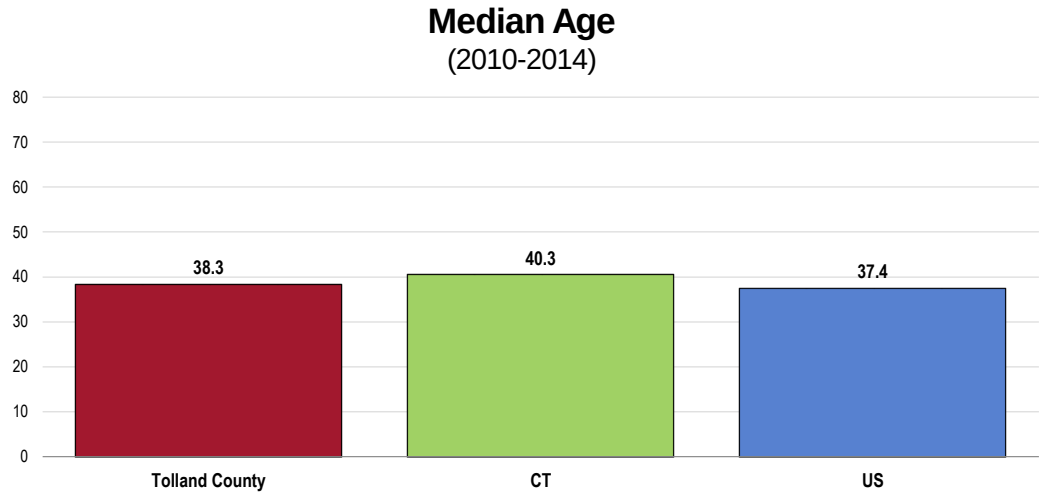


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved August 2016 from Community Commons at http://www.chna.org.

Median Age

The county is "younger" than the state in that the median age is lower.

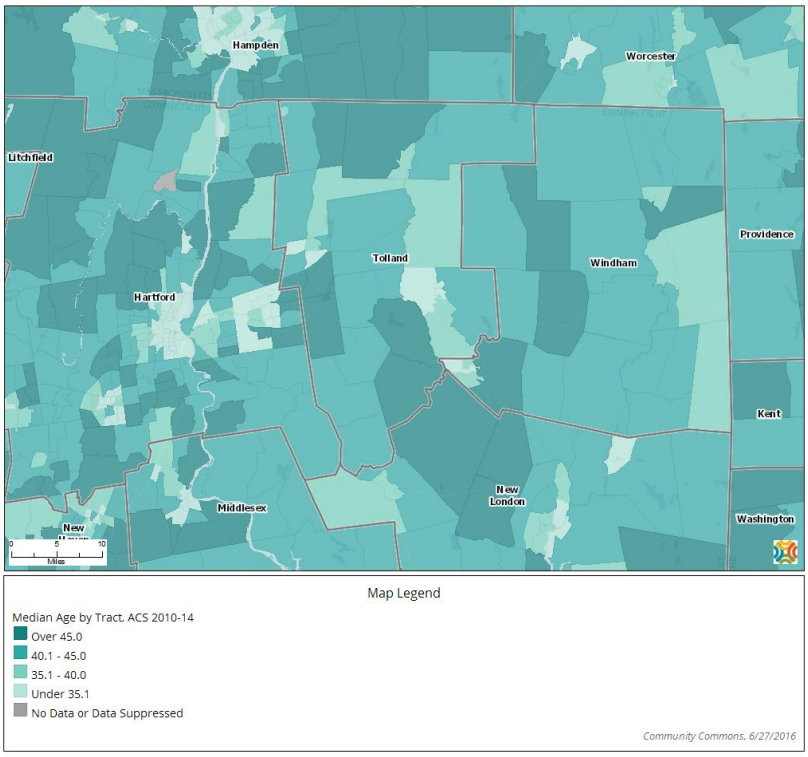
- On the other hand, the county is slightly "older" than the US median age.



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 Tolland County, segmented by census tract.

Median Age, by Tract, ACS 2010-2014



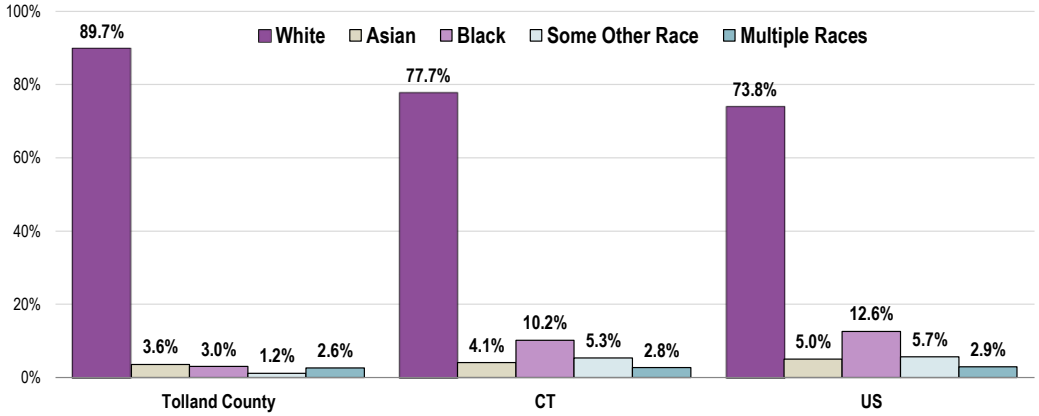
Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 89.7% of Tolland County residents are White, 3.6% are Asian, and 3.0% are Black.

- This racial distribution is more White and less Black than the state and US distributions.

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



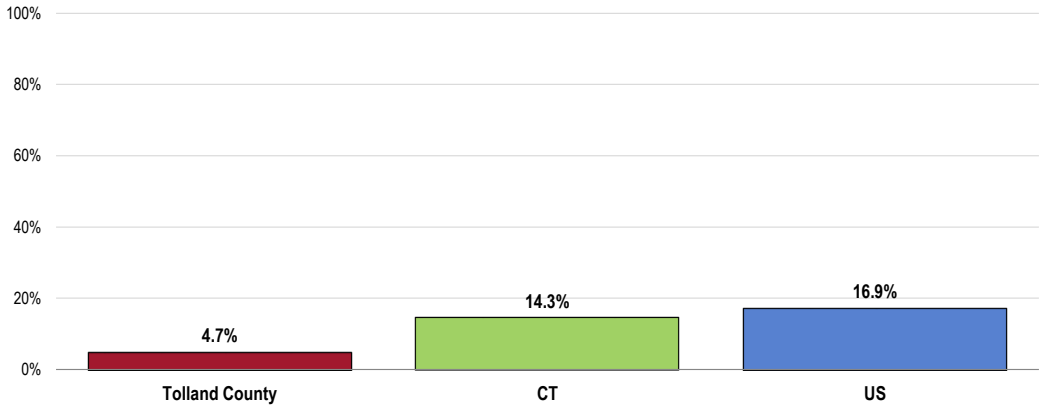
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved August 2016 from Community Commons at http://www.chna.org.

Ethnicity

A total of 4.7% of Tolland County residents are Hispanic or Latino.

- Well below the state and US populations.

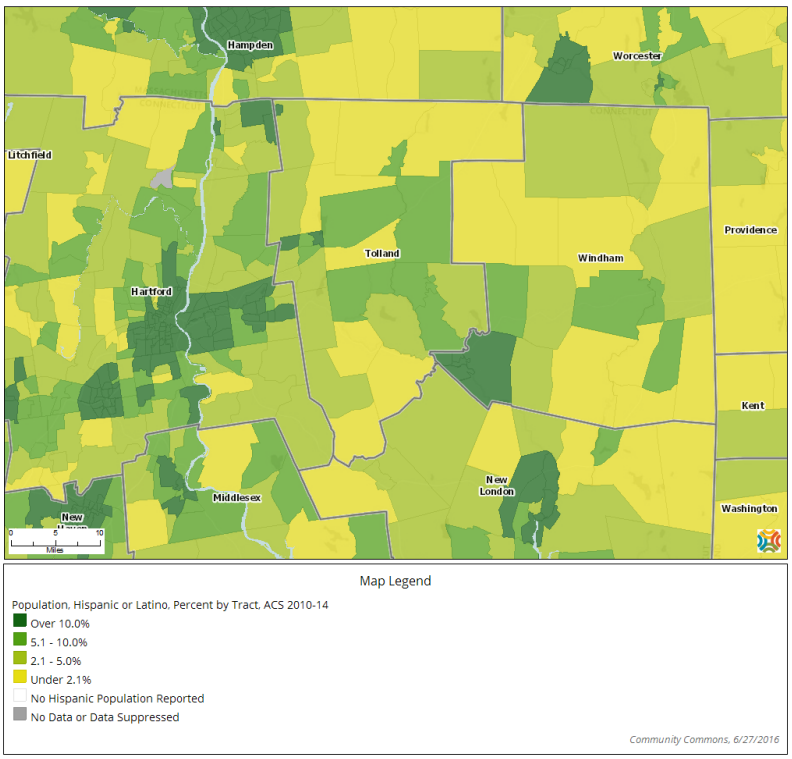
Hispanic Population
(2010-2014)



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

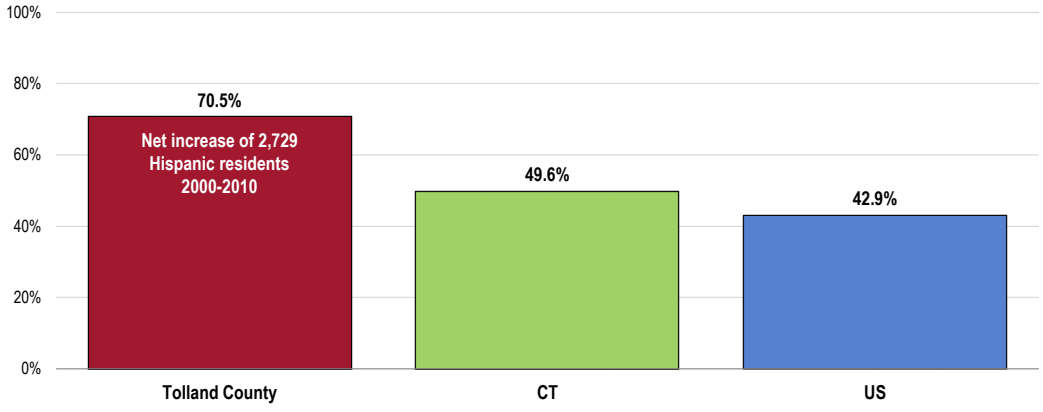


Between 2000 and 2010, the Hispanic population in the county increased by 2,729, or 70.5%.

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

Hispanic Population Change

(Percentage Change in Hispanic Population Between 2000 and 2010)



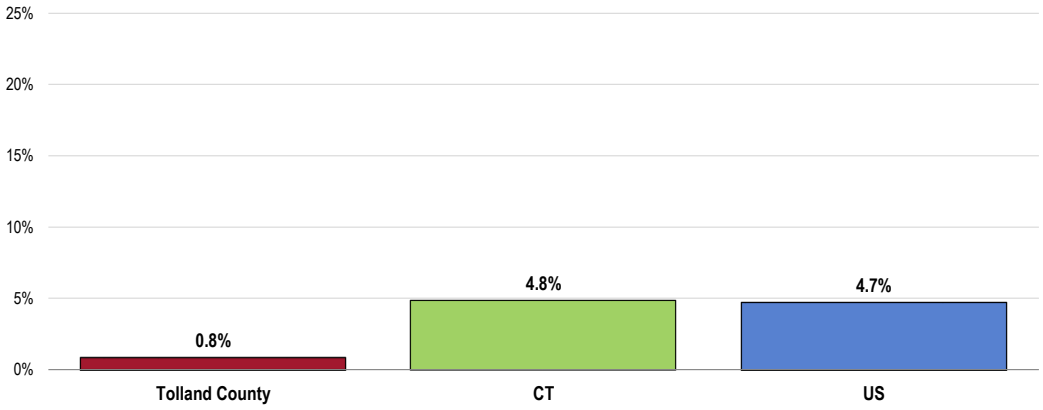
Sources:
- US Census Bureau Decennial Census (2000-2010).
- Retrieved August 2016 from Community Commons at http://www.chna.org.

Linguistic Isolation

Less than one percent of the Tolland County population age 5 and older lives in a home in which no persons age 14 or older is proficient in English (speaking only English, or speaking English "very well").

- A fraction of that found statewide and nationally.

Linguistically Isolated Population
(2010-2014)

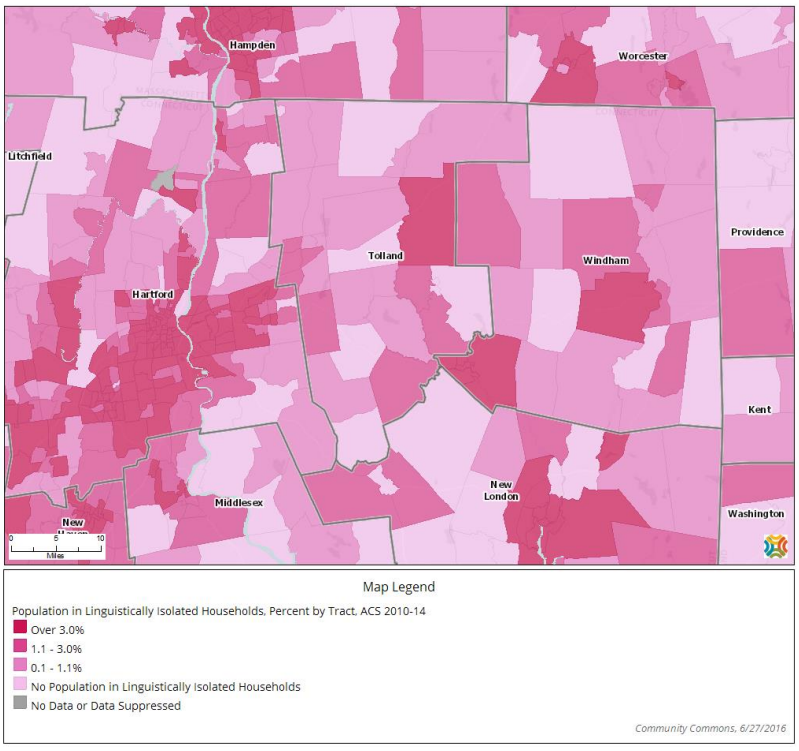


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved August 2016 from Community Commons at http://www.chna.org.

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.

Population in Linguistically Isolated Households, Percent by Tract, ACS 2010-2014



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)

Poverty

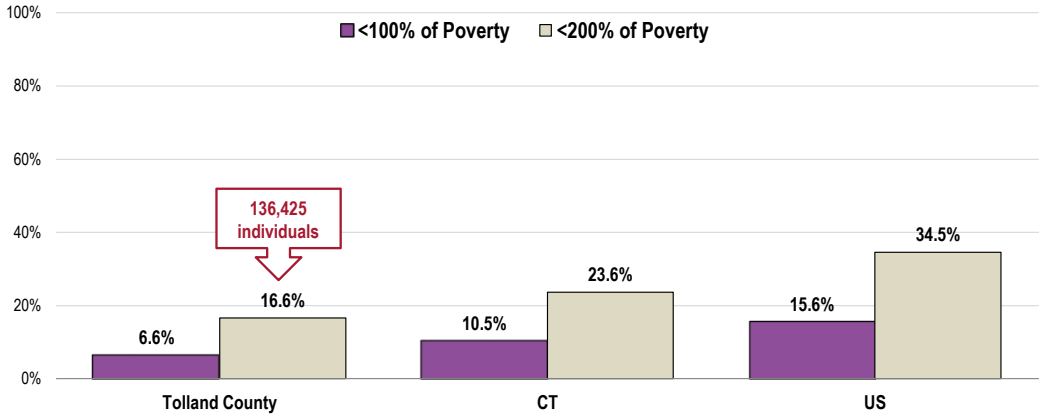
The latest census estimate shows 6.6% of Tolland County population living below the federal poverty level.

In all, 16.6% of county residents (an estimated 136,425 individuals) live below 200% of the federal poverty level.

- Lower than the proportion reported statewide and nationally.

Population in Poverty

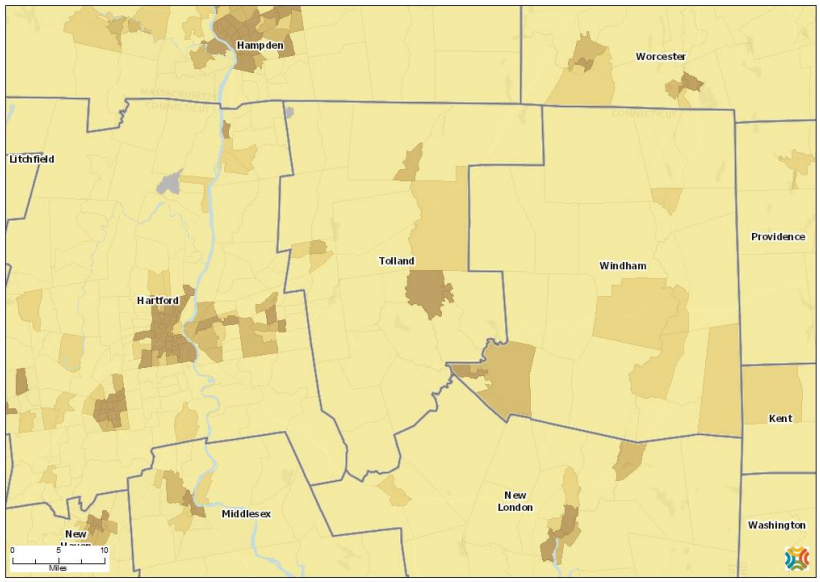
(Populations Living Below 100% and Below 200% of the Poverty Level; 2010-2014)



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

Notes:
- 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 2010-2014



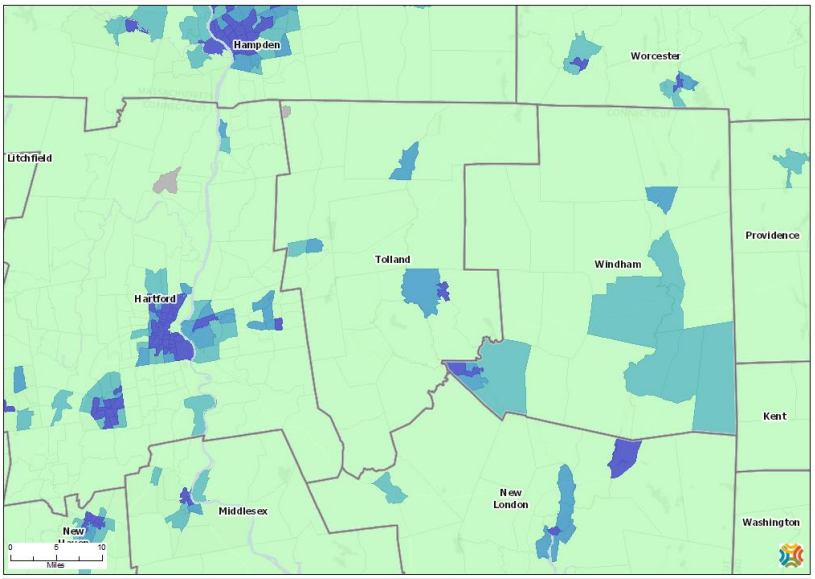
Map Legend

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

- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed

Community Commons, 6/27/2016

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



Map Legend

Population Below 200% Poverty Level, Percent by Tract, ACS 2010-14

- Over 50.0%
- 38.1 - 50.0%
- 26.1 - 38.0%
- Under 26.1%
- No Data or Data Suppressed

Community Commons, 6/27/2016

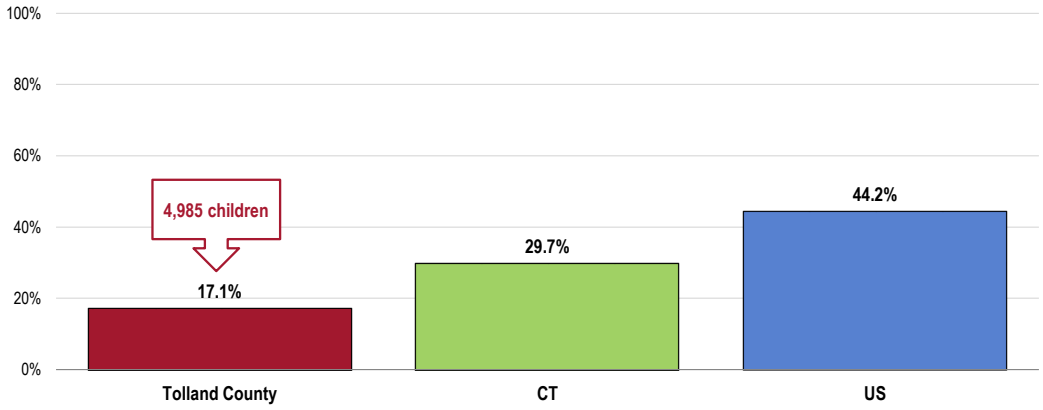
Children in Low-Income Households

Additionally, 17.1% of county children age 0-17 (representing an estimated 4,985 children) live below the 200% poverty threshold.

- Well below the state and national figures.

Percent of Children in Low-Income Households

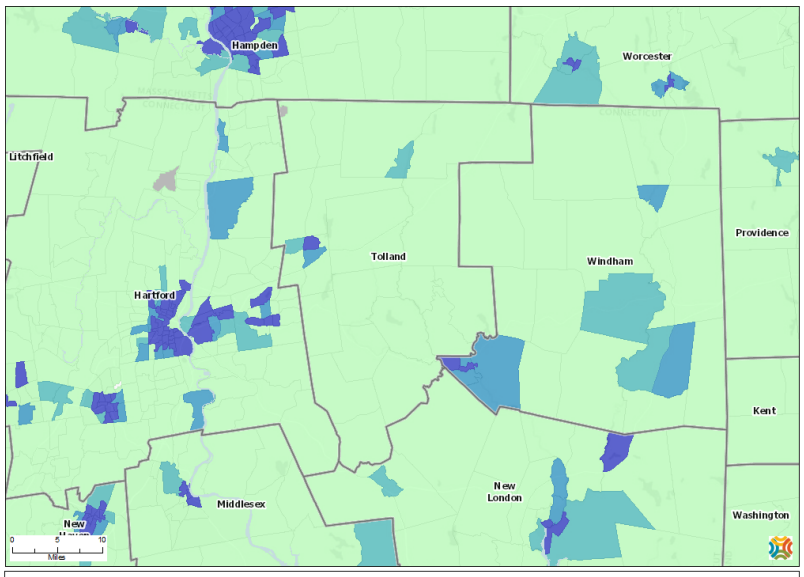
(Children 0-17 Living Below 200% of the Poverty Level, 2010-2014)

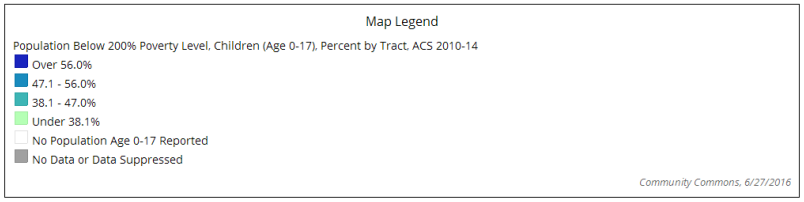


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved August 2016 from Community Commons at http://www.chna.org.

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





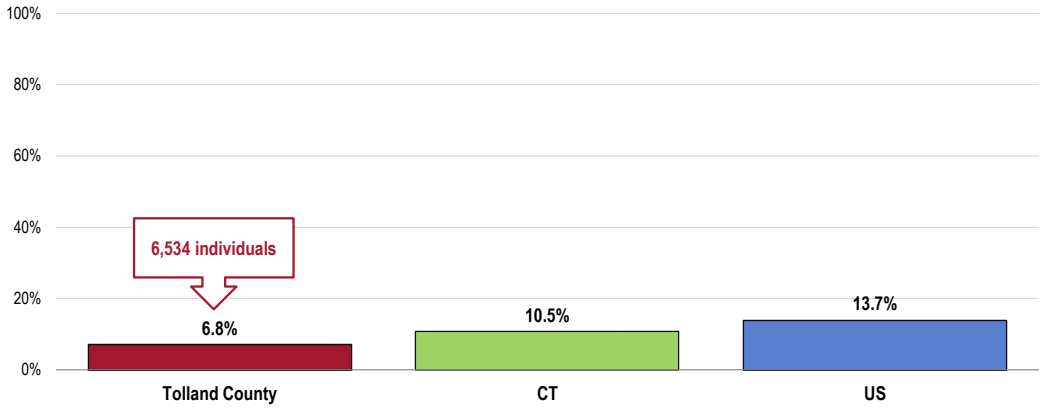
Education

Among the Tolland County population age 25 and older, an estimated 6.8% (over 6,500 people) do not have a high school education.

- More favorable than found statewide and nationally.

Population With No High School Diploma

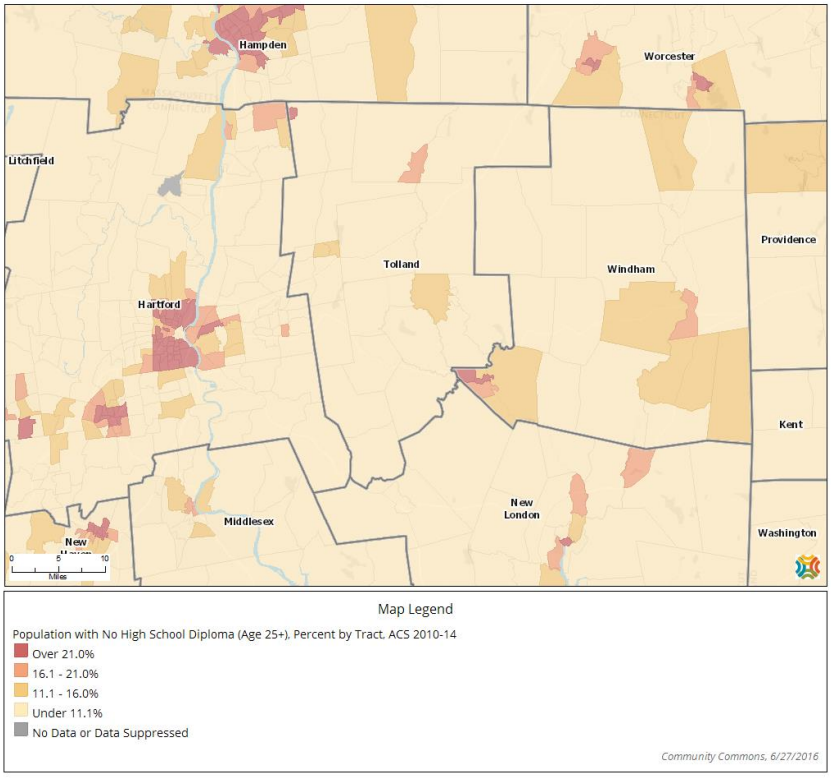
(Population Age 25+ Without a High School Diploma or Equivalent, 2010-2014)



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



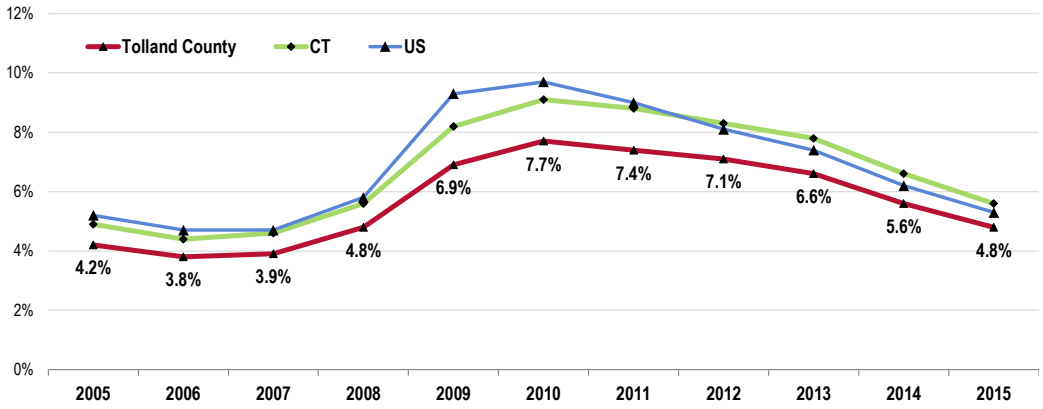
Employment

According to data derived from the US Department of Labor, the 2015 unemployment rate in Tolland County was 4.8%.

- Better than the state and national unemployment rates.

Unemployment Rate

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



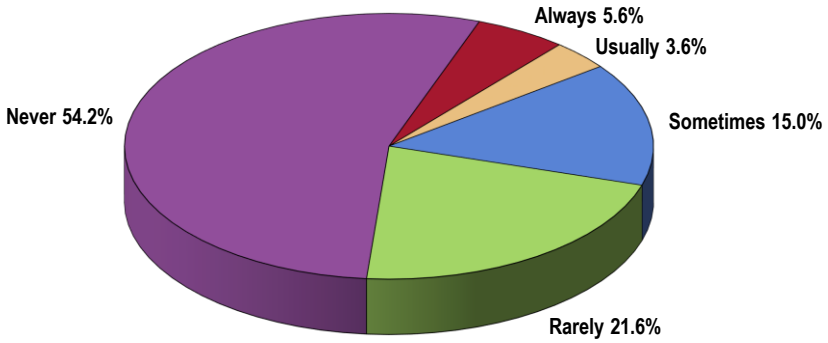
Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Retrieved August 2016 from Community Commons at http://www.chna.org.

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 rarely, if ever, worry about the cost of housing, a considerable share (24.2%) 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
(RGH Service Area, 2016)

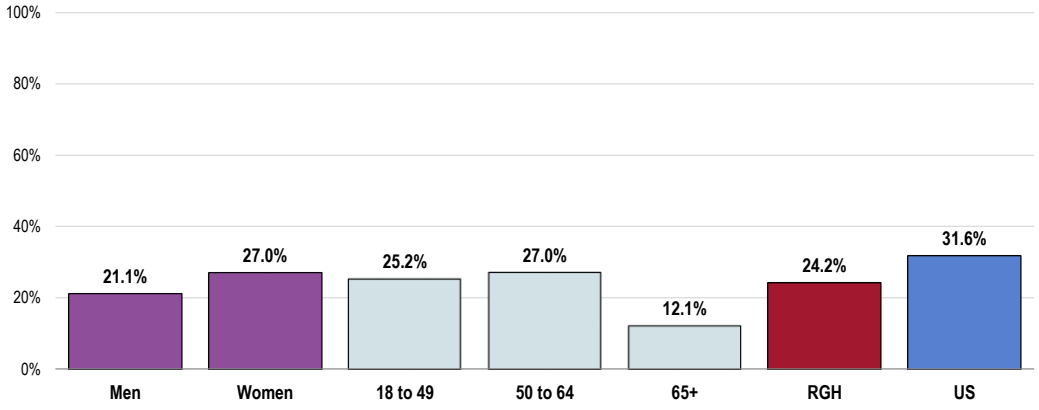


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 81]
Notes: • Asked of all respondents.

- Compared to the US prevalence, the RGH Service Area proportion of adults who worried about paying for rent or mortgage in the past year is lower.
- Viewed by demographic characteristics, seniors (age 65+) in the RGH Service Area are statistically less likely to report housing insecurity.

Charts throughout this report (such as that here) detail survey findings among key demographic groups – namely by gender and age groupings.

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year
(RGH Service Area, 2016)

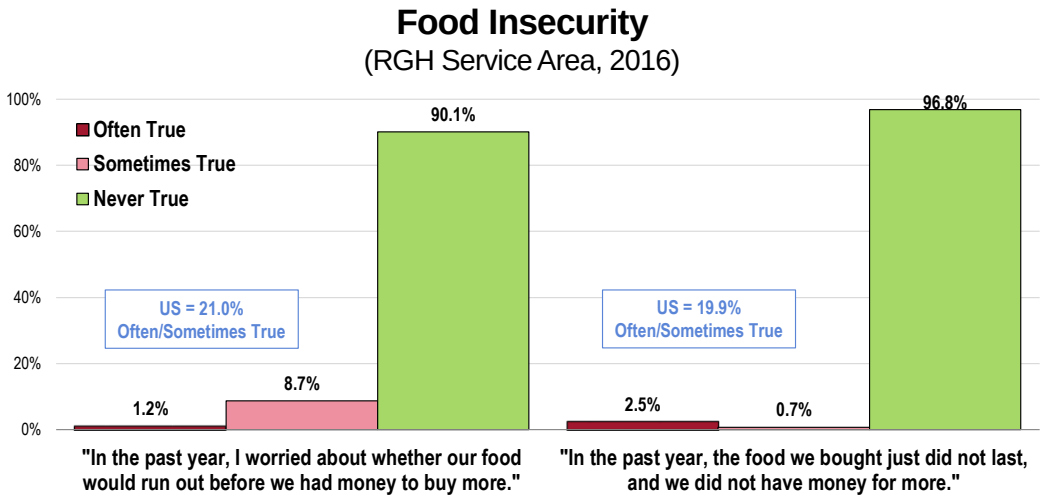


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 81]
Notes: • Asked of all respondents.

Food Insecurity

In the past year, 9.9% of RGH Service Area adults "often" or "sometimes" worried about whether their food would run out before they had money to buy more.

Another 3.2% 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.



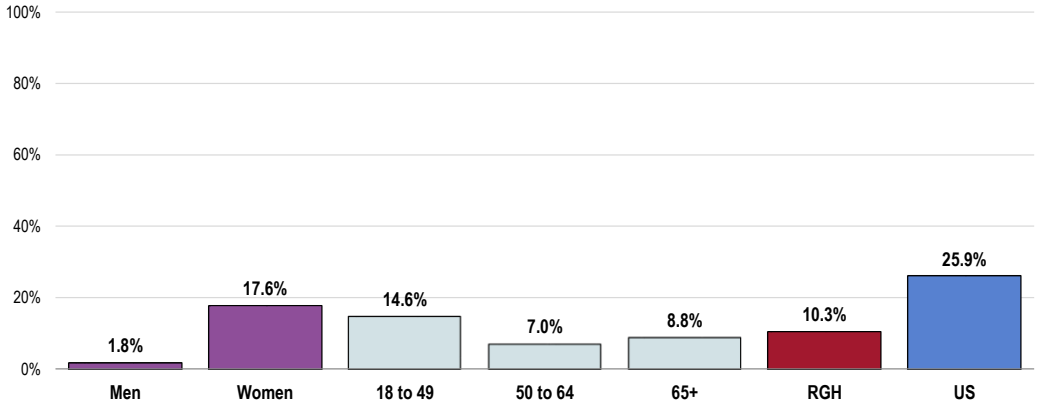
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 104-105]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects the total sample of respondents.

Overall, 10.3% of community residents are found to be "food insecure," having run out of food in the past year and/or been worried about running out of food.

- Well below the US figure.
- RGH Service Area women are statistically more likely to be affected by food insecurity.
- Other differences within demographic groups, as illustrated in the following chart, are not statistically significant.

Food Insecurity
(RGH Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 169]

Notes:
- Asked of all respondents.
- 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

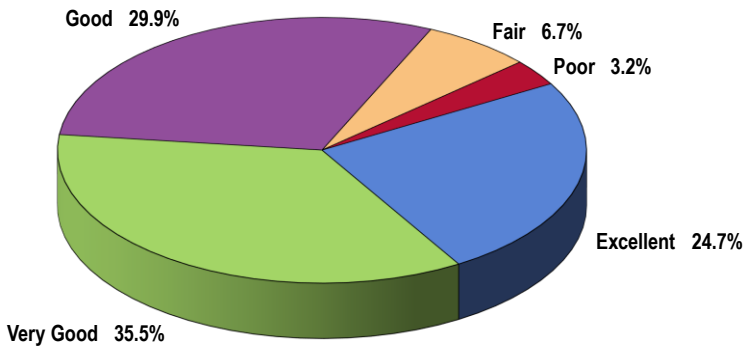
The initial inquiry of the PRC Community Health Survey asked respondents the following:

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

A total of 60.2% of RGH Service Area adults rate their overall health as "excellent" or "very good."

- Another 29.9% gave "good" ratings of their overall health.

Self-Reported Health Status
(RGH Service Area, 2016)



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

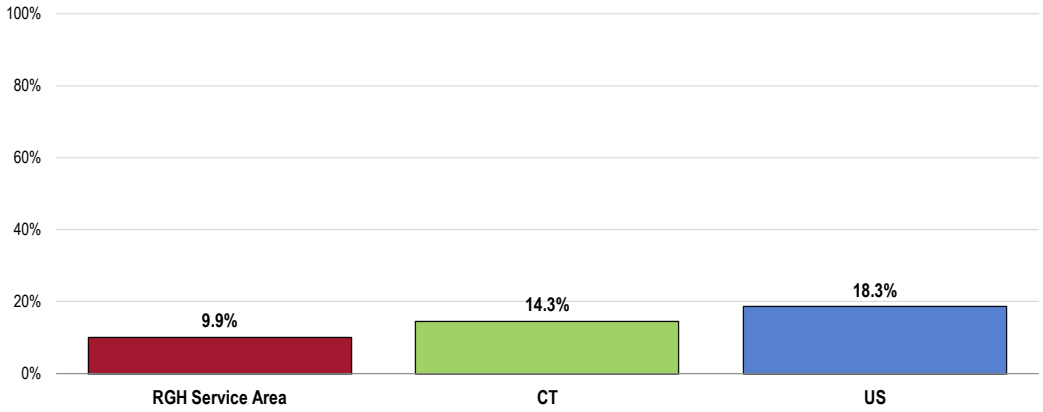
NOTE:

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

However, 9.9% of area adults believe that their overall health is "fair" or "poor."

- Better than the statewide and US figures.

Experience "Fair" or "Poor" Overall Health

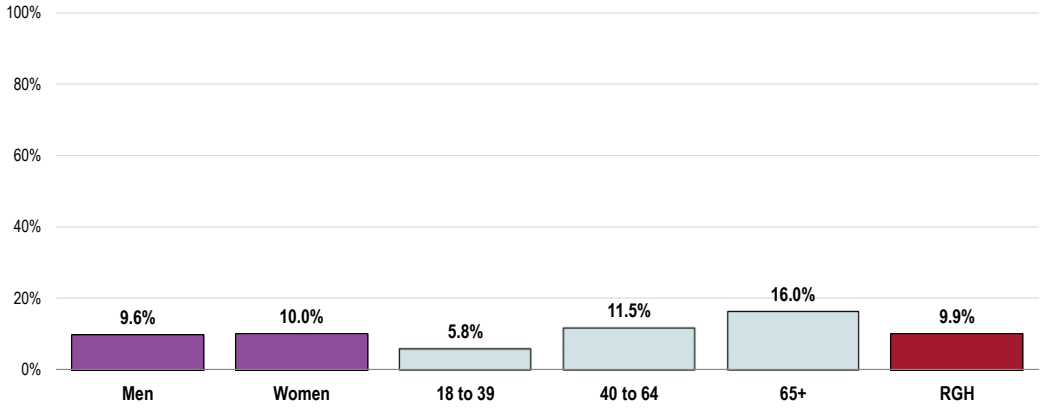


Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Connecticut data.
● 2015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

- The prevalence of "fair" or "poor" overall health does not vary significantly by the following demographic characteristics.

Experience "Fair" or "Poor" Overall Health

(RGH Service Area, 2016)



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

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.

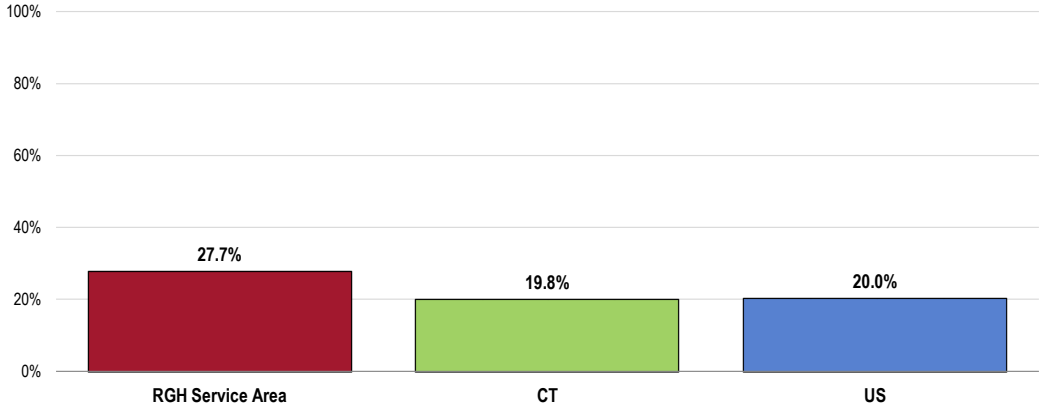
- Healthy People 2020 (www.healthypeople.gov)

A total of 27.7% of RGH Service Area adults are limited in some way in some activities due to a physical, mental or emotional problem.

- Less favorable than the prevalence reported 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



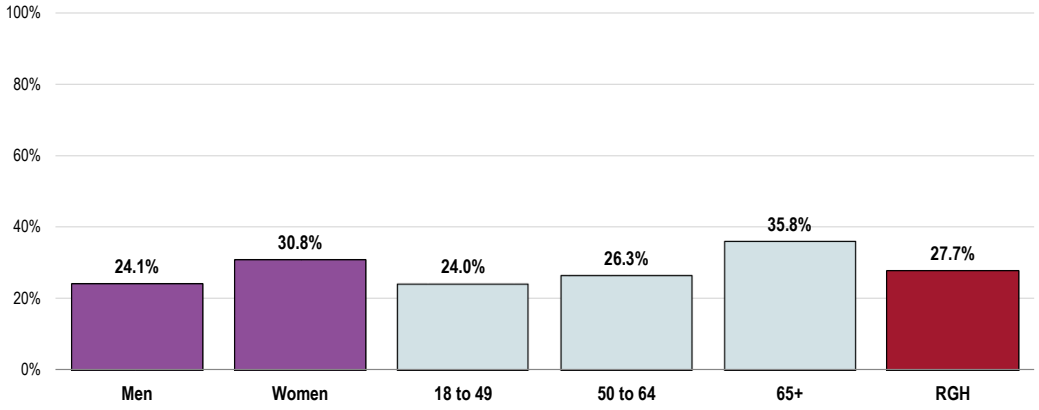
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Connecticut data.
-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

Notes:
- Asked of all respondents.

- In looking at responses by key demographic characteristics, seniors (age 65+) are statistically more likely to report some type of activity limitation.

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

(RGH Service Area, 2016)



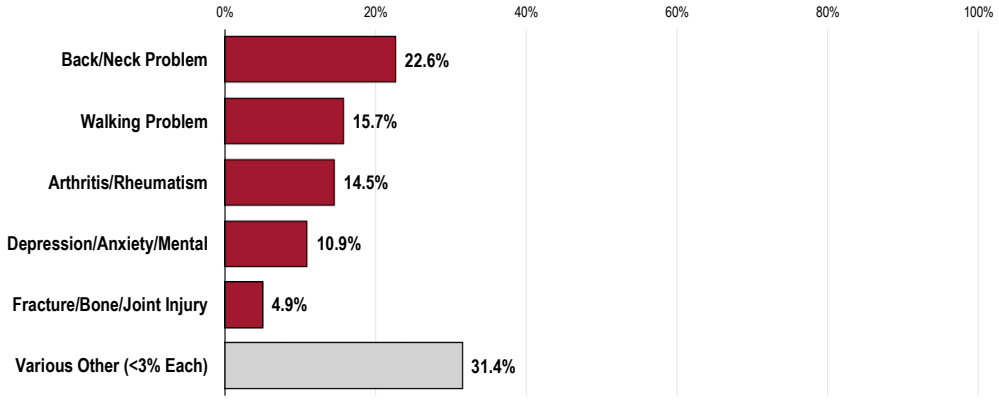
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]

Notes:
- Asked of all respondents.

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).

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



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

Caregiving

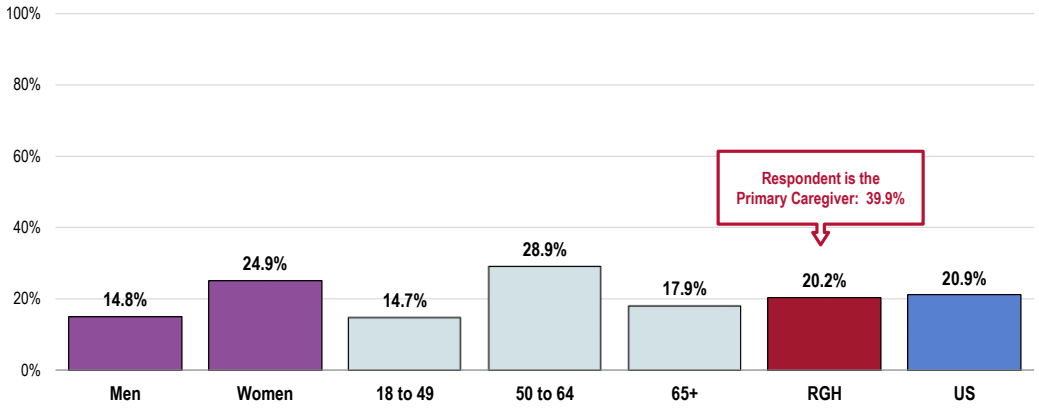
A total of 20.2% of RGH Service Area adults currently provide care or assistance to a friend or family member who has a health problem, long-term illness, or disability.

- Similar to the national finding.
- The prevalence of caregivers in the community is notably higher among women and residents age 50 to 64.

Of these adults, 39.9% 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

(RGH Service Area, 2016)



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.

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)

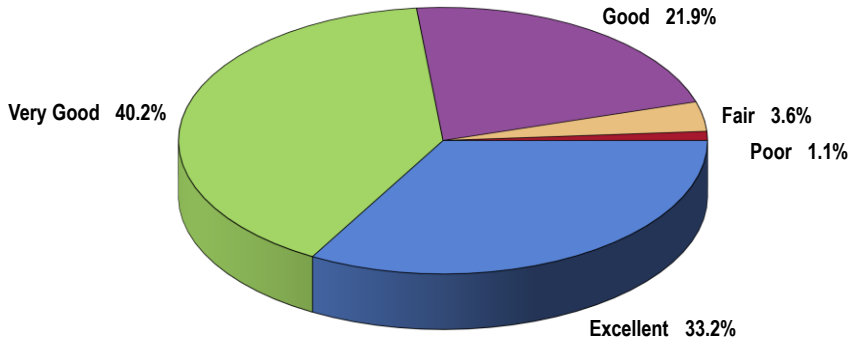
Evaluation of Mental Health Status

"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?"

A total of 73.4% of RGH Service Area adults rate their overall mental health as "excellent" or "very good."

- Another 21.9% gave "good" ratings of their own mental health status.

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

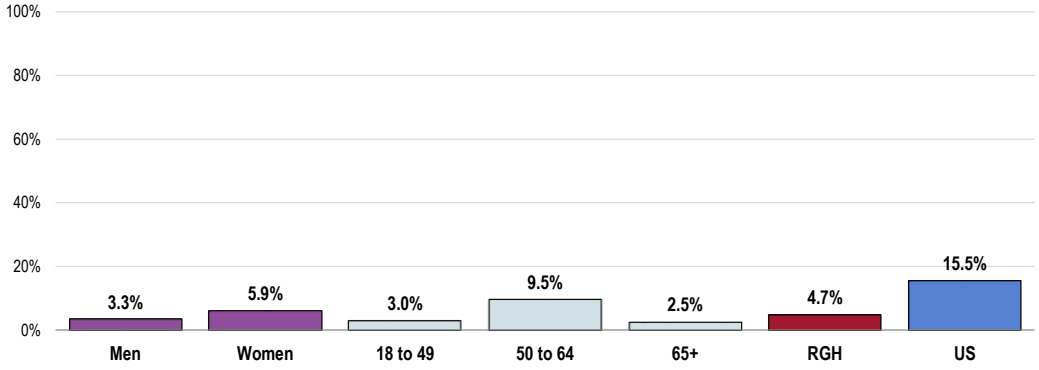


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
Notes: • Asked of all respondents.

A total of 4.7% of service area adults, however, believe that their overall mental health is "fair" or "poor."

- Well below the "fair/poor" response reported nationally.
- The prevalence of "fair/poor" mental health does not vary significantly by demographic characteristics.

Experience "Fair" or "Poor" Mental Health
(RGH Service Area, 2016)



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.

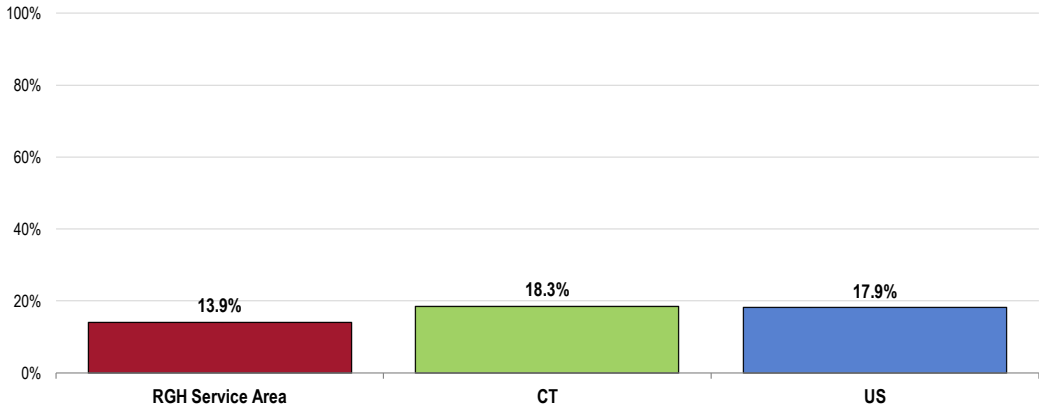
Depression

Diagnosed Depression

A total of 13.9% of service area adults have been diagnosed by a physician as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

- Comparable to 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.

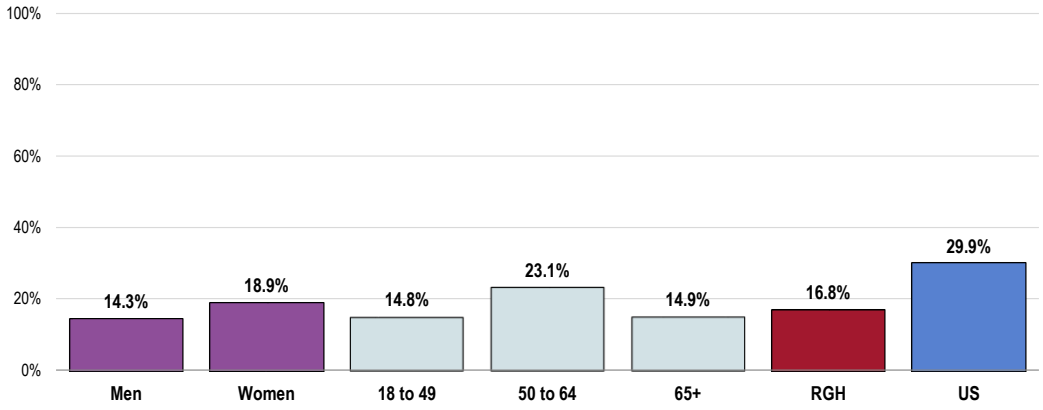
Symptoms of Chronic Depression

A total of 16.8% of RGH 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).

- Well below the national findings.
- The prevalence of chronic depression is statistically comparable by demographic characteristics.

Have Experienced Symptoms of Chronic Depression

(RGH Service Area, 2016)



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.

Stress

About half of RGH Service Area adults considers their typical day to be "not very stressful" (36.1%) or "not at all stressful" (13.3%).

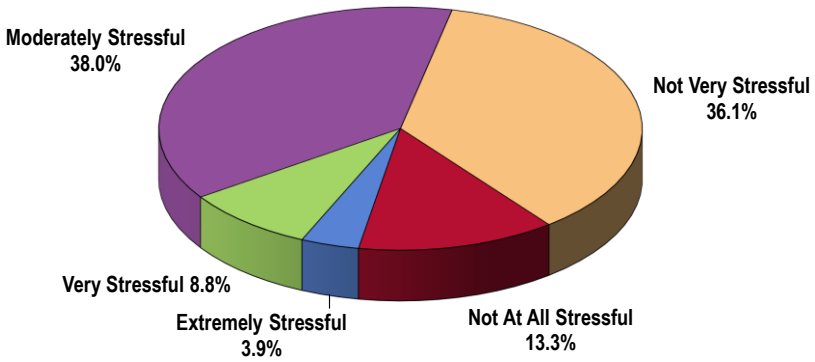
RELATED ISSUE:

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

- Another 38.0% of survey respondents characterize their typical day as "moderately stressful."

Perceived Level of Stress On a Typical Day

(RGH Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 118]

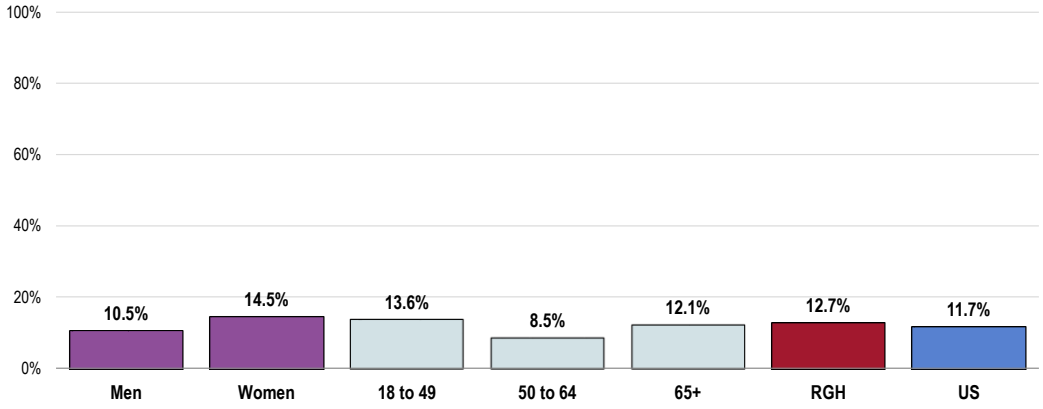
Notes:
- Asked of all respondents.

In contrast, 12.7% of RGH Service Area adults experience "very" or "extremely" stressful days on a regular basis.

- Similar to national findings.
- Note that high stress levels do not vary significantly by gender or age in the service area.

Perceive Most Days as "Extremely" or "Very" Stressful

(RGH Service Area, 2016)



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.

Suicide

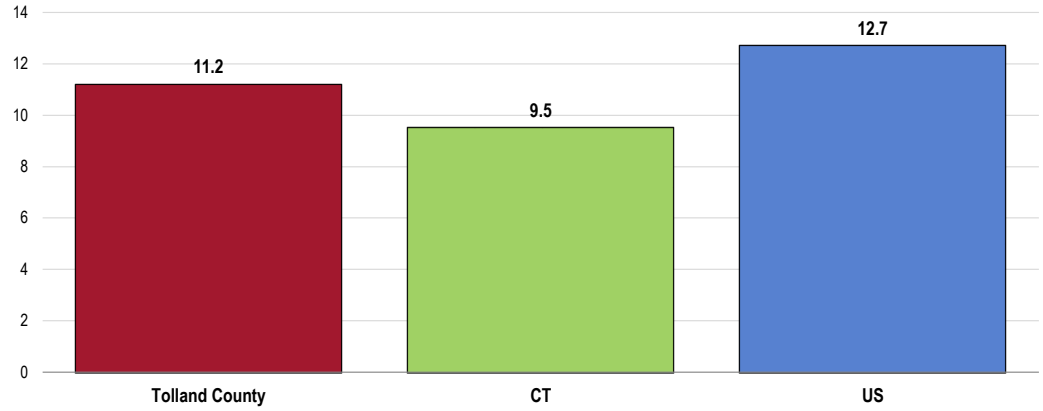
Between 2012 and 2014, there was an annual average age-adjusted suicide rate of 11.2 deaths per 100,000 population in Tolland County.

- Above the Connecticut rate.
- Below the national rate.
- Fails to satisfy the Healthy People 2020 target of 10.2 or lower.

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.
- 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

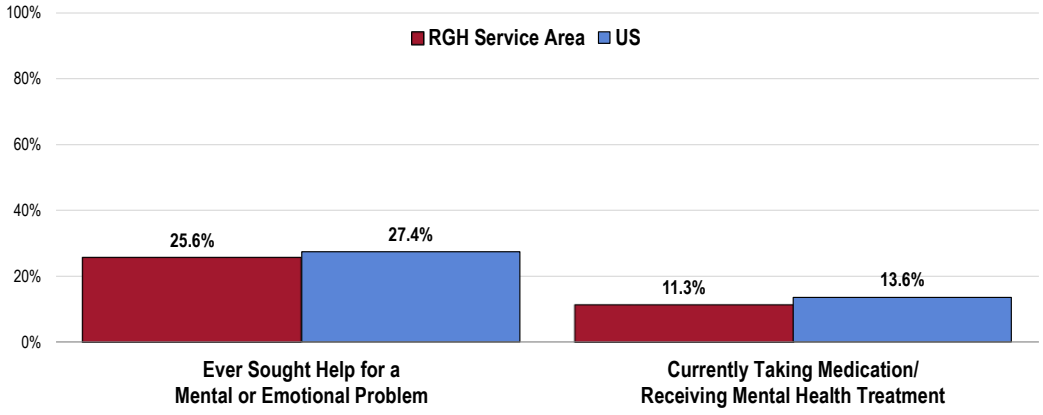
A total of 25.6% of RGH Service Area adults acknowledge having ever sought professional help for a mental or emotional problem.

- Comparable to the US prevalence.

A total of 11.3% 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.

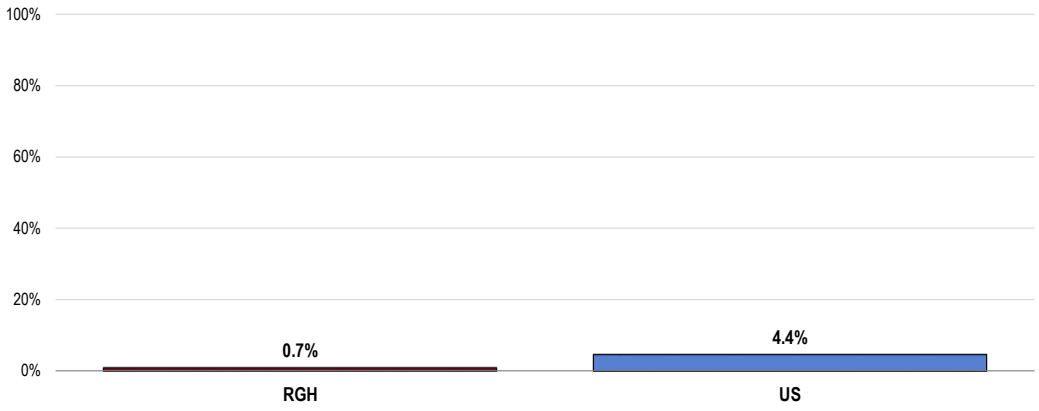
Notes:
- Reflects the total sample of respondents.

Difficulty Accessing Mental Health Services

Just 0.7% of RGH Service Area adults report a time in the past year when they needed mental health services, but were not able to get them.

- Well below the national finding.
- Access difficulty does not vary significantly by gender or age in the service area.

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



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.

Key Informant Input: Mental Health

One key informant rated this issue a “major problem” and provided the following explanation:

Denial/Stigma

> *The stigma surrounding behavior health issues, which causes people to not talk about the issue and receive care. Not recognizing that a condition is a treatable behavioral health issues. Also, it's extremely difficult to connect with the right care. – Public Health Representative*

Death, Disease & Chronic Conditions

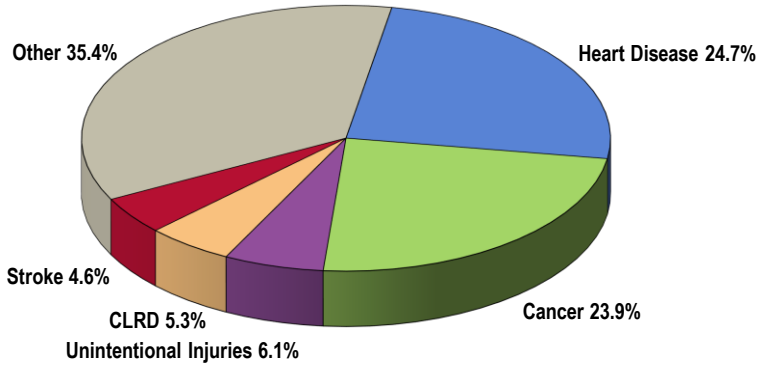
Professional Research Consultants, Inc.

Leading Causes of Death

Distribution of Deaths by Cause

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

Leading Causes of Death
(Tolland 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 Tolland County.

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)

	Tolland County	Connecticut	US	HP2020
Diseases of the Heart	145.8	149.9	169.1	156.9*
Malignant Neoplasms (Cancers)	140.7	149.0	163.6	161.4
Fall-Related Deaths (65+)	72.5	54.4	57.0	47.0
Unintentional Injuries	38.4	38.3	39.7	36.4
Chronic Lower Respiratory Disease (CLRD)	33.2	30.3	41.4	n/a
Cerebrovascular Disease (Stroke)	27.6	27.2	36.5	34.8
Diabetes Mellitus	14.6	14.6	21.1	20.5*
Drug-Induced	13.8	15.6	14.6	11.3
Kidney Disease	12.7	12.4	13.2	n/a
Intentional Self-Harm (Suicide)	11.2	9.5	12.7	10.2
Pneumonia/Influenza	10.4	12.4	15.1	n/a
Motor Vehicle Deaths	9.6	7.5	10.6	12.4
Alzheimer's Disease	9.5	17.1	24.2	n/a
Cirrhosis/Liver Disease	9.2	8.0	10.2	8.2
Firearm-Related	4.4	5.3	10.4	9.3

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

Age-Adjusted Heart Disease & Stroke Deaths

Heart Disease Deaths

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

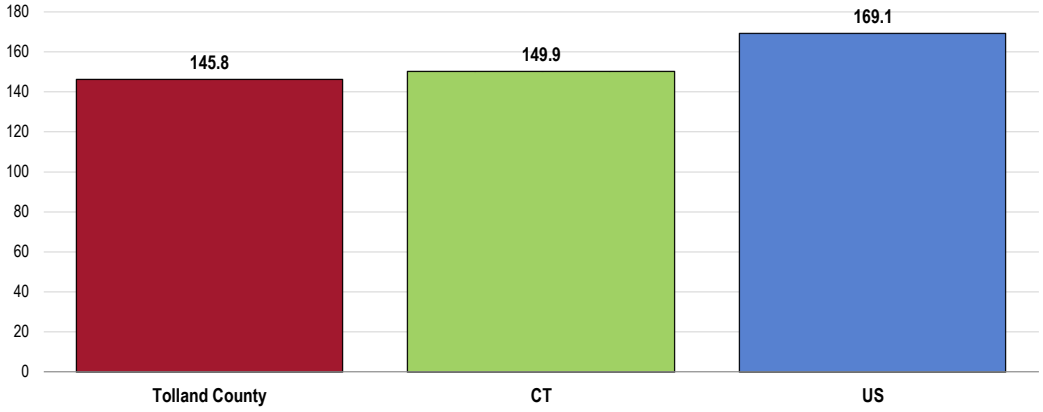
Between 2012 and 2014 there was an annual average age-adjusted heart disease mortality rate of 145.8 deaths per 100,000 population in Tolland County.

- Similar to the statewide rate.
- Lower than the national rate.
- Satisfies the Healthy People 2020 target of 156.9 or lower (as adjusted to account for all diseases of the heart).

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.
- 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

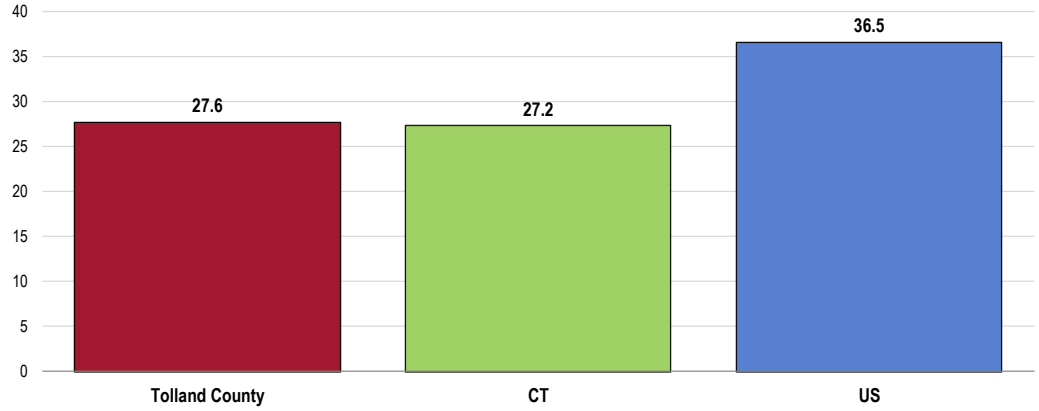
Between 2012 and 2014, there was an annual average age-adjusted stroke mortality rate of 27.6 deaths per 100,000 population in Tolland County.

- Similar to the state rate.
- Well below the national rate.
- Satisfies the Healthy People 2020 target of 34.8 or lower.

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.
- 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.

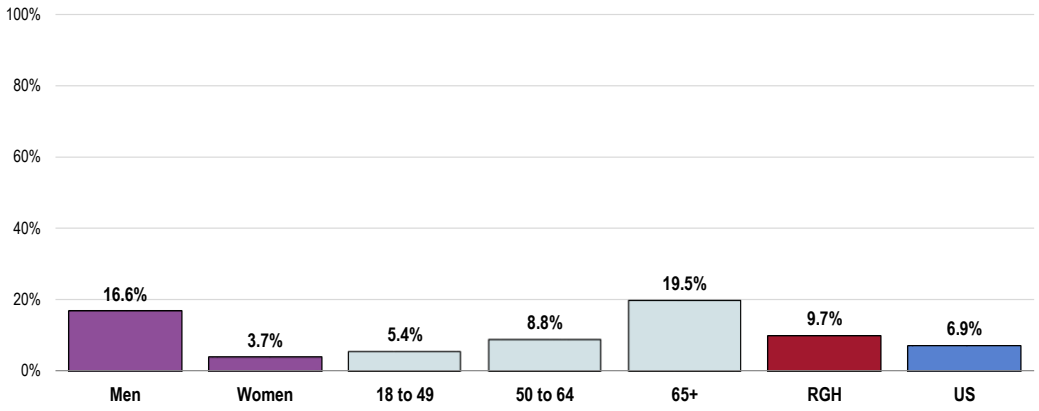
Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

A total of 9.7% 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.
- Men and adults 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
(RGH Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 146]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

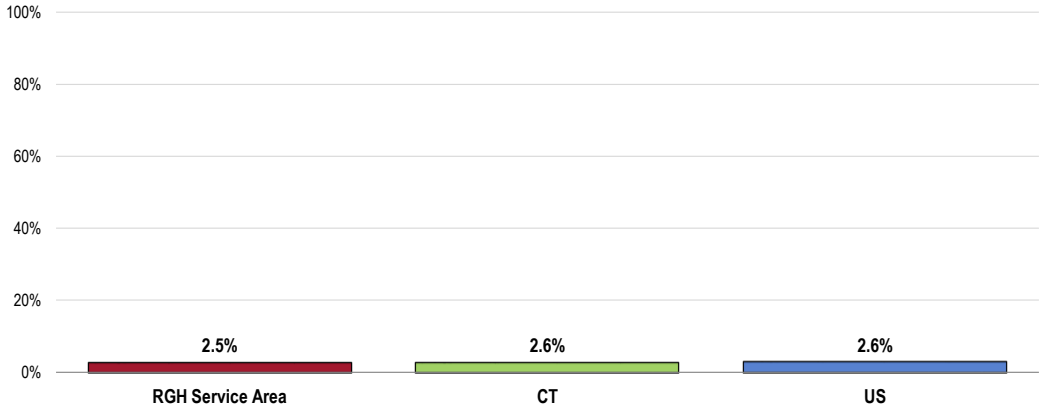
Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina or coronary heart disease.

Prevalence of Stroke

A total of 2.5% 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)

High Blood Pressure

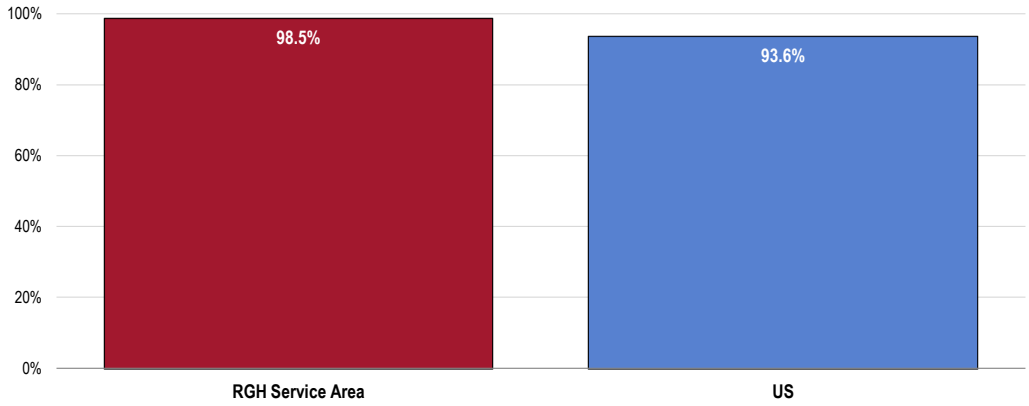
High Blood Pressure Testing

A total of 98.5% of RGH 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.

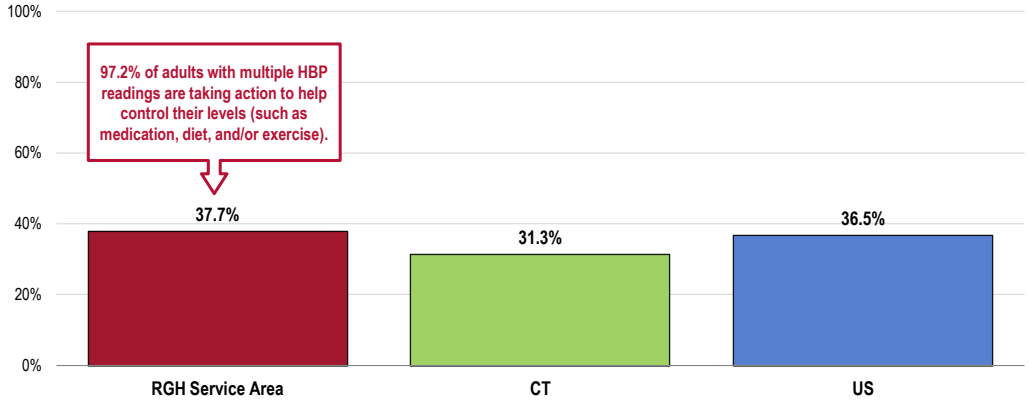
Prevalence of High Blood Pressure

A total of 37.7% of RGH Service Area adults have been told at some point that their blood pressure was high.

- Comparable to 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, 97.2% 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

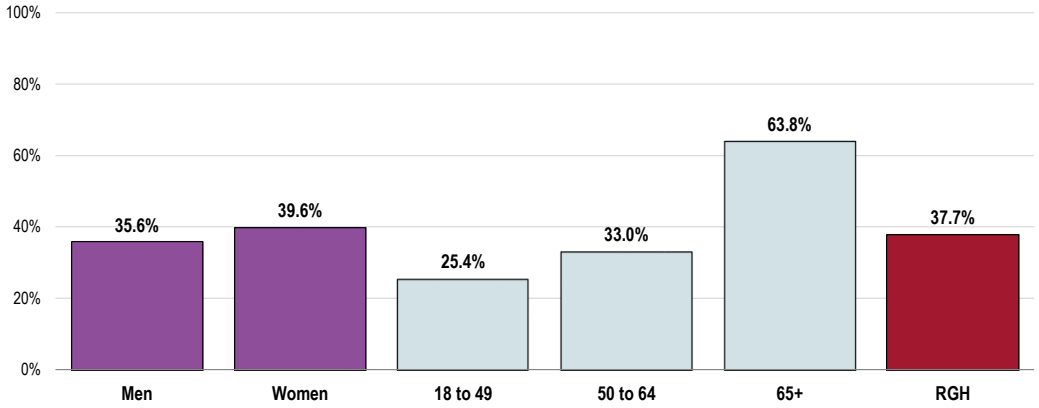


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 43, 147]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 Connecticut data.
- 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 50 and older (positive correlation with age).

Prevalence of High Blood Pressure
(RGH 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.

High Blood Cholesterol

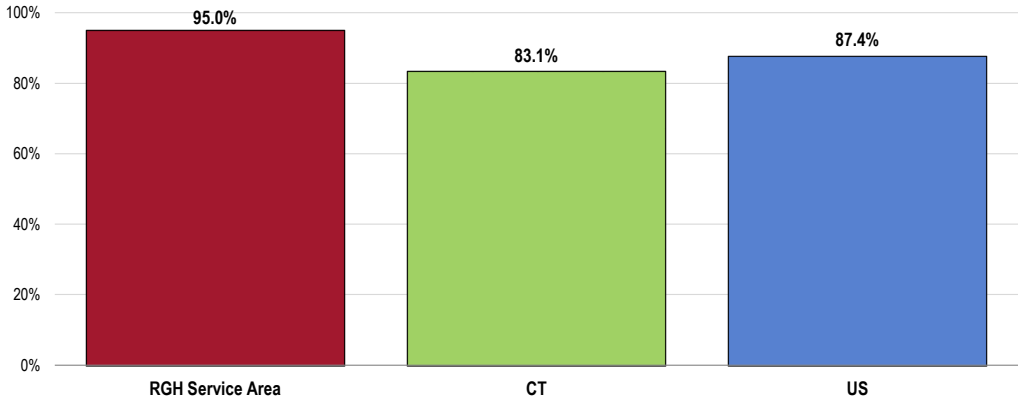
Blood Cholesterol Testing

A total of 95.0% of RGH 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

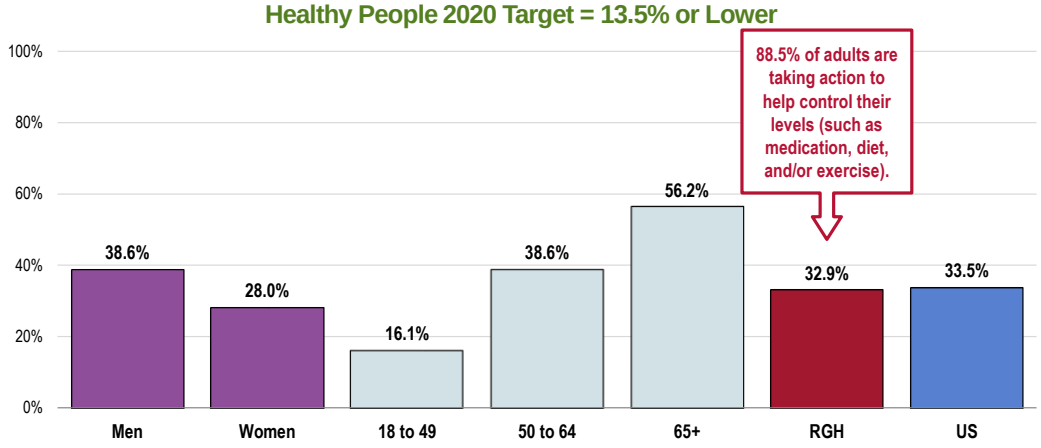
A total of 32.9% of adults have been told by a health professional that their cholesterol level was high.

- Similar to the national prevalence.
- More than twice the Healthy People 2020 target (13.5% or lower).
- Among adults with high blood cholesterol readings, 88.5% are taking action to lower their numbers (such as medication, change in diet, and/or exercise).
- There is a positive correlation between age and high blood cholesterol.

Prevalence of High Blood Cholesterol

(RGH Service Area, 2016)

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.

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

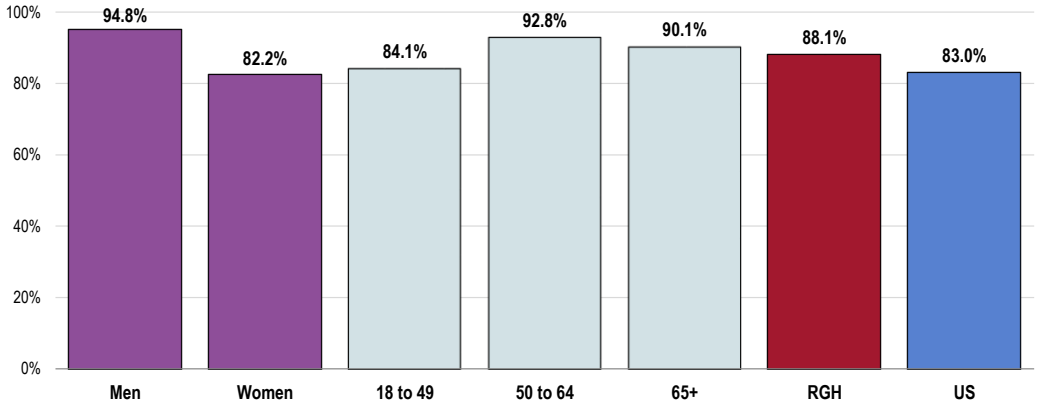
RELATED ISSUE:
See also Nutrition & Overweight, Physical Activity & Fitness and Tobacco Use in the Modifiable Health Risk section of this report.

A total of 88.1% of RGH 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.

- Worse than national findings.
- Service area men are more likely to exhibit cardiovascular risk factors.

Present One or More Cardiovascular Risks or Behaviors

(RGH Service Area, 2016)



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.

Key Informant Input: Heart Disease & Stroke

For the key informant considering this issue to be a "major problem," reasoning related to the following:

Incidence/Prevalence

> *Data demonstrates that this is the case throughout CT and the country. – Public Health Representative*

Cancer

About Cancer

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

All Cancer Deaths

The county's 2012-2014 cancer mortality rate was 140.7 deaths per 100,000 population.

- More favorable than the state and national rates.
- Satisfies the Healthy People 2020 target of 161.4 or lower.

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.
- 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 Tolland County.

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

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

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

Note that **each** of the Tolland 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)

	Tolland County	Connecticut	US	HP2020
ALL CANCERS	140.7	149.0	163.6	161.4
Lung Cancer	34.1	37.4	43.4	45.5
Female Breast Cancer	18.8	18.5	20.9	20.7
Prostate Cancer	18.5	17.5	19.2	21.8
Colorectal Cancer	10.8	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.
- 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.

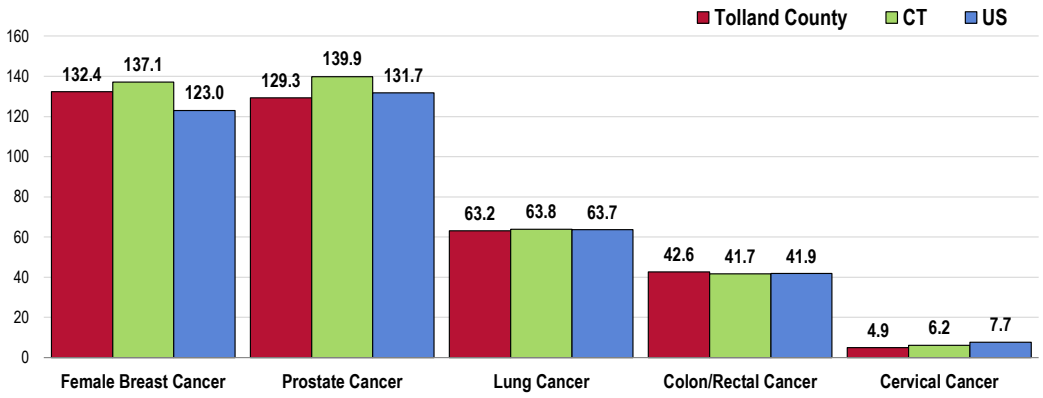
"Incidence rate" or "case rate" is the number of new cases of a disease occurring during a given period of time.

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

While most of the 2008-2012 Tolland County annual average age-adjusted cancer incidence rates were similar or better than the related US rates, the female breast cancer rate was higher.

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.

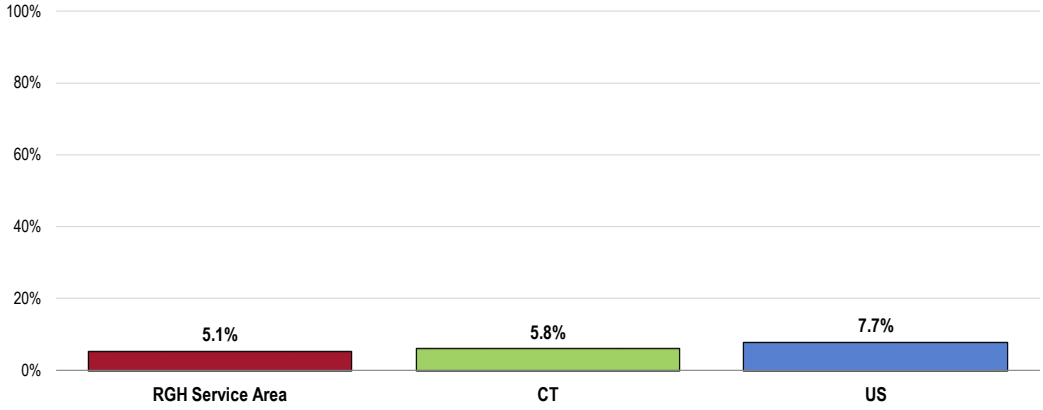
Prevalence of Cancer

Skin Cancer

A total of 5.1% of surveyed RGH 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.

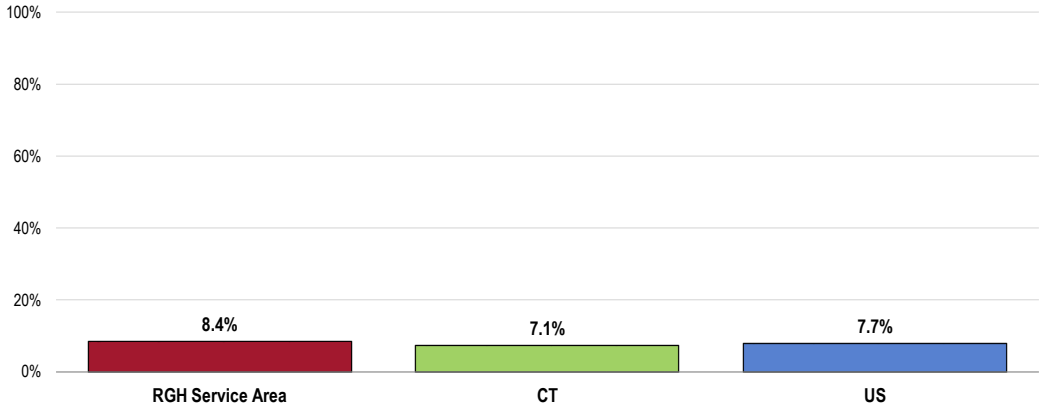
Notes:
- Asked of all respondents.

Other Cancer

A total of 8.4% 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.

Cancer Risk

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

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

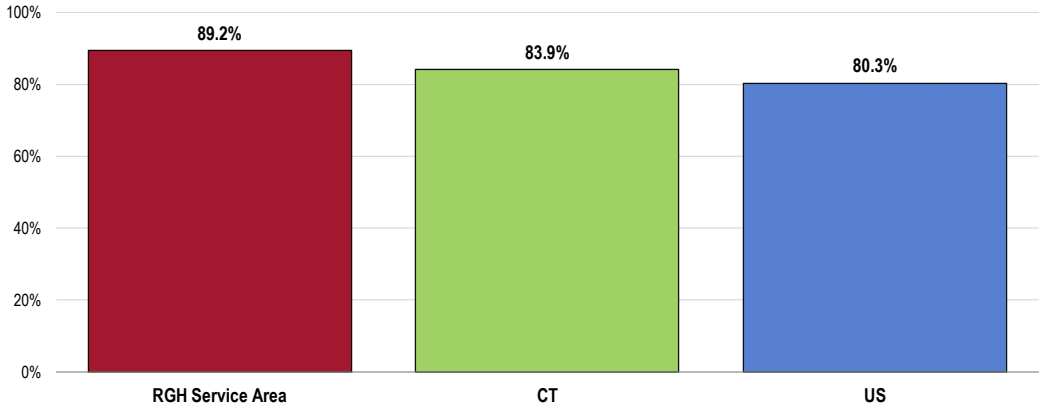
Among women age 50-74, 89.2% have had a mammogram within the past 2 years.

- Similar to the statewide percentage.
- More favorable than the US findings.
- Satisfies 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

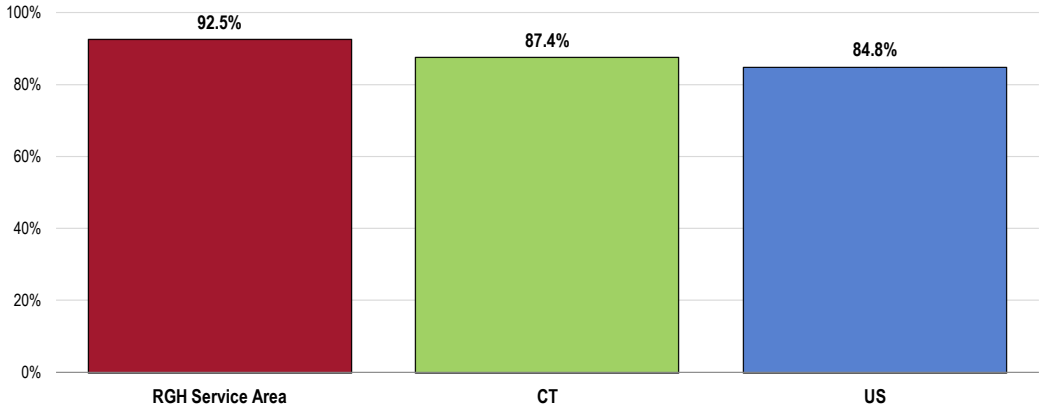
Among RGH Service Area women age 21 to 65, 92.5% have had a Pap smear within the past 3 years.

- Comparable to Connecticut findings.
- More favorable than 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, 78.6% 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).

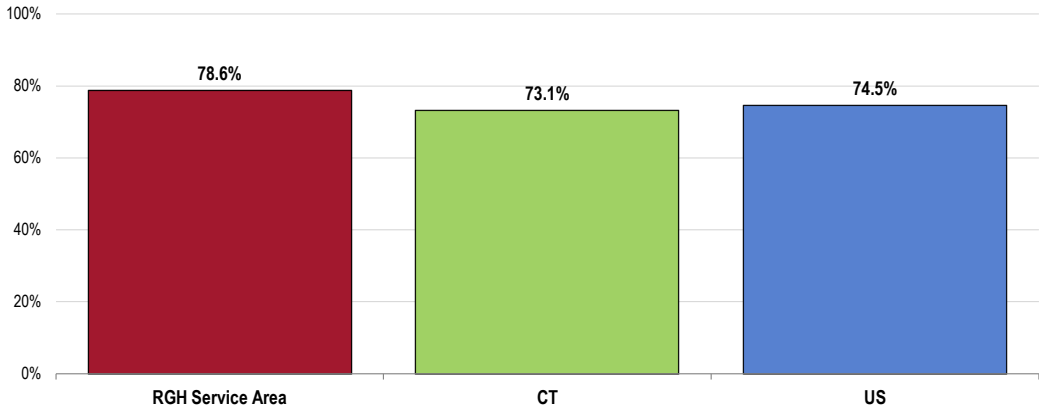
"Appropriate colorectal cancer screening" includes a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

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

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

Neither participating key informant rated this issue as a "major problem" in the community.

Respiratory Disease

About Asthma & COPD

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

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

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

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

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

Risk factors for asthma currently being investigated include:

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

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

Age-Adjusted Respiratory Disease Deaths

Chronic Lower Respiratory Disease Deaths (CLRD)

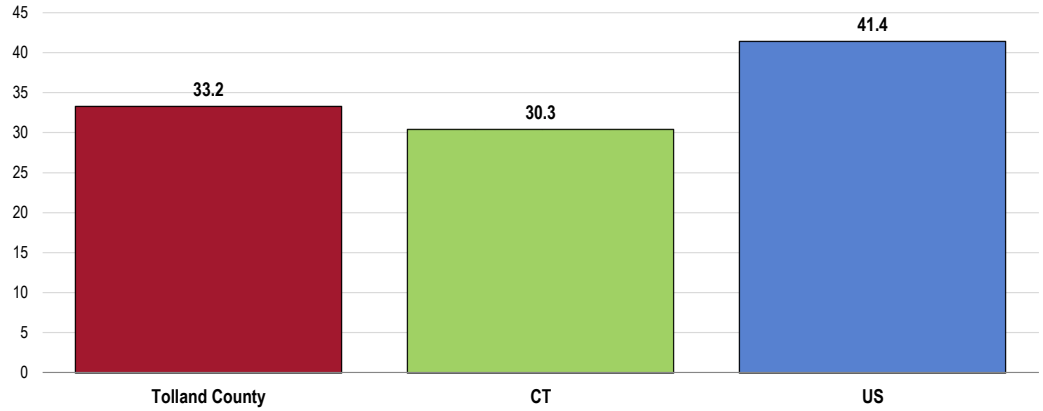
Note: COPD was changed to chronic lower respiratory disease (CLRD) in 1999 with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.

Between 2012 and 2014, there was an annual average age-adjusted CLRD mortality rate of 33.2 deaths per 100,000 population in Tolland County.

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

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.

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

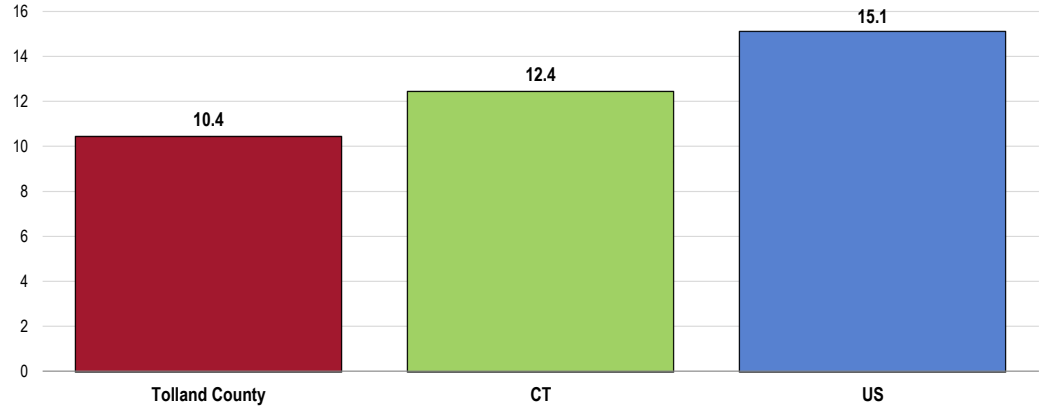
Between 2012 and 2014, Tolland County reported an annual average age-adjusted pneumonia influenza mortality rate of 10.4 deaths per 100,000 population.

- Lower than the state and US rates.

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:
- 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

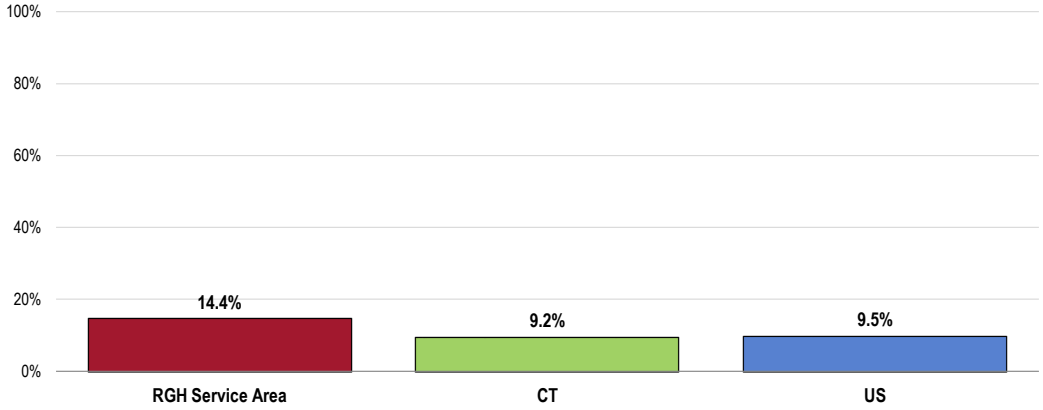
Adults

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

A total of 14.4% of RGH Service Area adults currently suffer from asthma.

- Higher than the state prevalence.
- Statistically similar to the US figure.

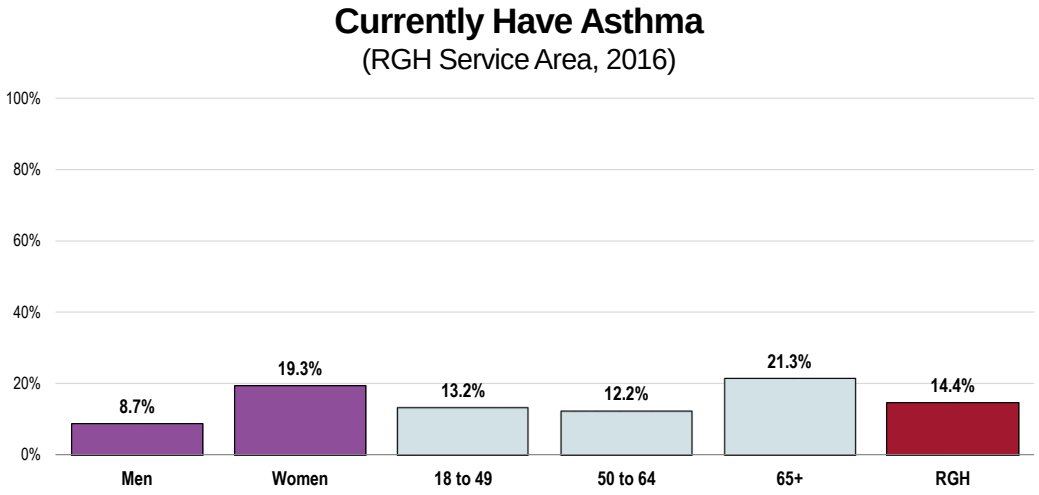
Adult Asthma: Current Prevalence



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.

- Women in the RGH Service Area are more likely to suffer from asthma.

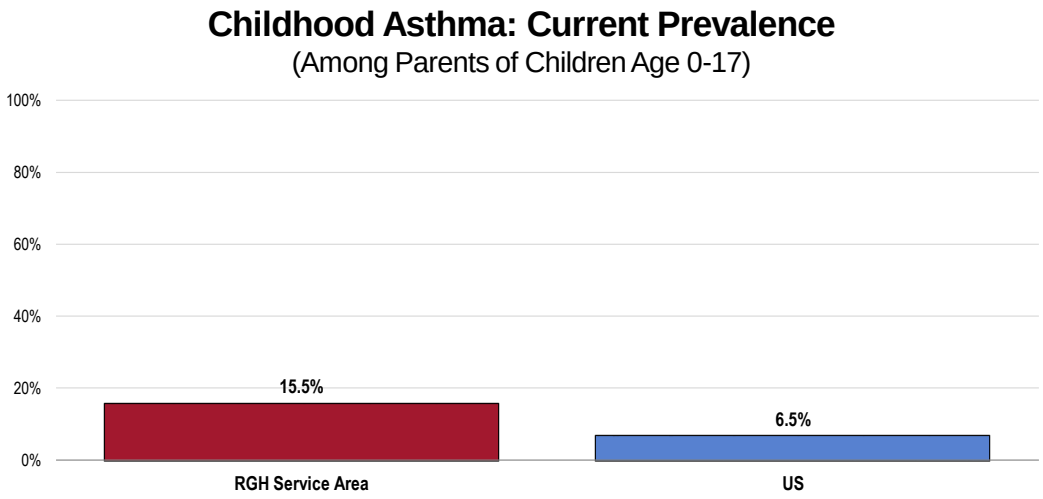


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 156]
Notes: • Asked of all respondents.

Children

Among RGH Service Area children under age 18, 15.5% currently have asthma.

- Statistically comparable to the national benchmark.

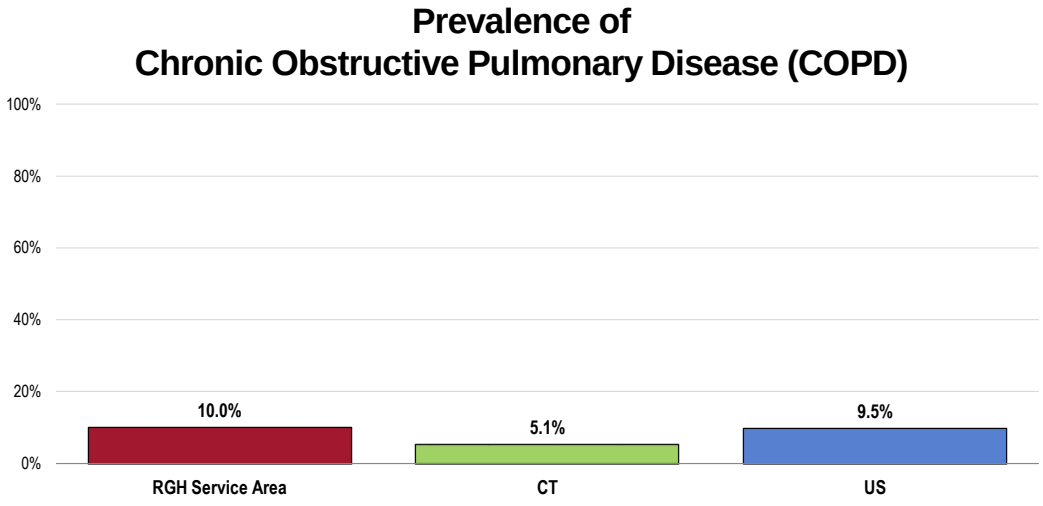


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 157]
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents with children 0 to 17 in the household.
• Includes children who have ever been diagnosed with asthma,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

Chronic Obstructive Pulmonary Disease (COPD)

A total of 10.0% of RGH Service Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

- Twice the state prevalence.
- Similar 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

Neither participating key informant rated this issue as a “major problem” in the community.

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)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

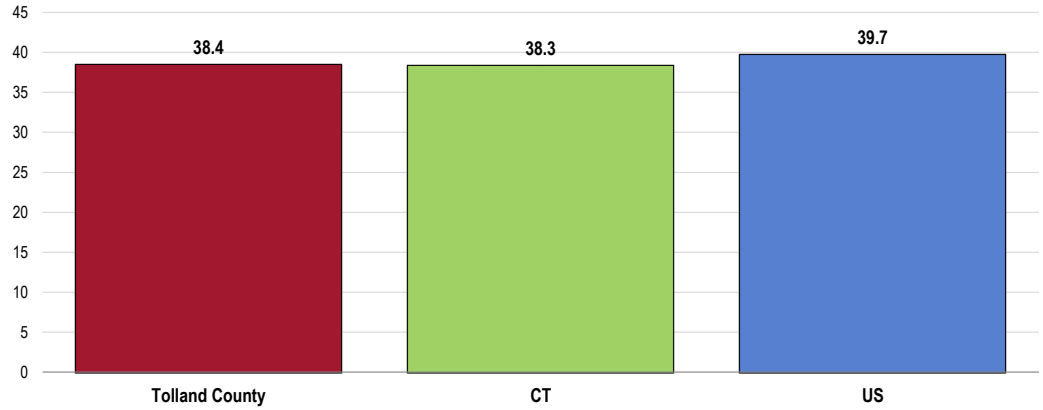
Between 2012 and 2014, there was an annual average age-adjusted unintentional injury mortality rate of 38.4 deaths per 100,000 population in Tolland County.

- Similar to the state and national rates.
- Fails to satisfy the Healthy People 2020 target (36.4 or lower).

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.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

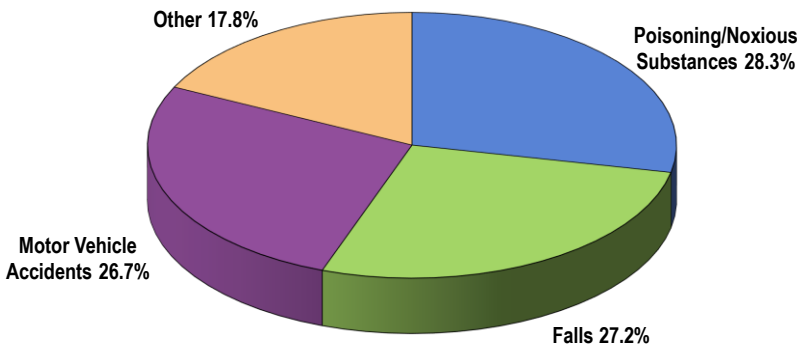
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Leading Causes of Accidental Death

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

Leading Causes of Accidental Death

(Tolland 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).

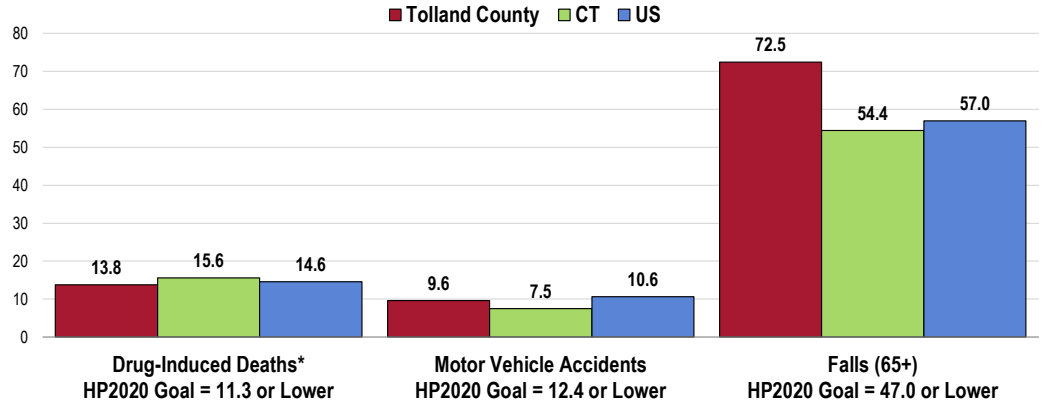
The Tolland County annual average age-adjusted falls-related mortality rate among seniors is worse than the US and state rates.

The county's motor vehicle mortality rate is also worse than the state rate.

- Other comparisons yield similar rates.

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.
- 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.

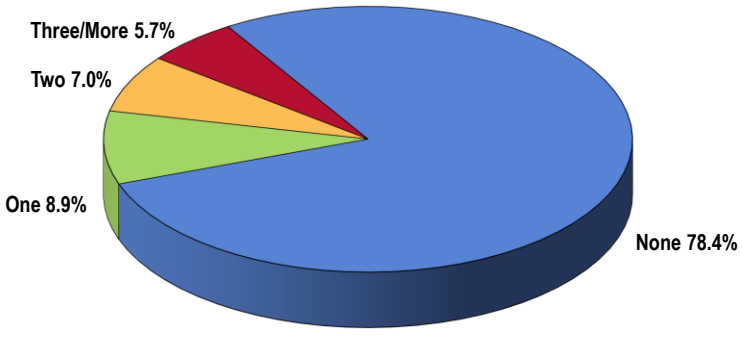
In addition, fall-related medical treatment places a burden on US healthcare services. In 2000, direct medical costs for fall-related injuries totaled approximately $19 billion. A recent study determined that 31.8% of older adults who sustained a fall-related injury required help with activities of daily 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 RGH Service Area adults age 45 and older, 21.6% fell at least once in the past year, including 5.7% who fell three or more times.

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



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

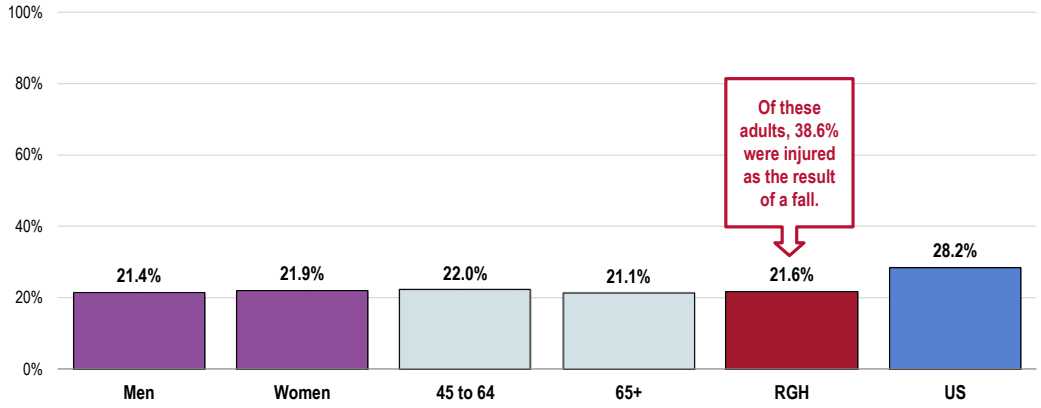
- The prevalence of adults age 45+ who fell at least once in the past year is similar to the national proportion.

Among those who fell in the past year, 38.6% were injured as a result of the fall.

- No statistical difference by gender or age in the service area.

Fell One or More Times in the Past Year

(Among Respondents Age 45 and Older; RGH Service Area, 2016)



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.

Firearm Safety

Age-Adjusted Firearm-Related Deaths

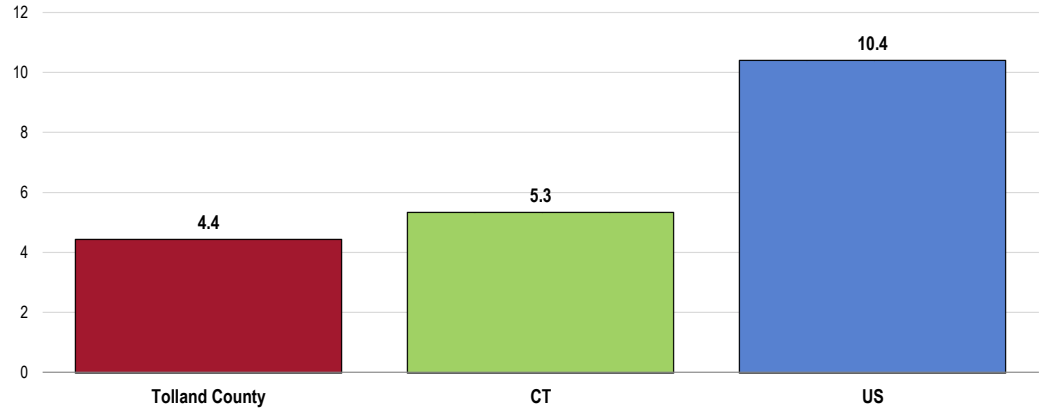
Between 2012 and 2014, there was an annual average age-adjusted rate of 4.4 deaths per 100,000 population due to firearms in Tolland County.

- Below the statewide rate and less than half the national rate.
- Satisfies the Healthy People 2020 objective (9.3 or lower).

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.
- 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

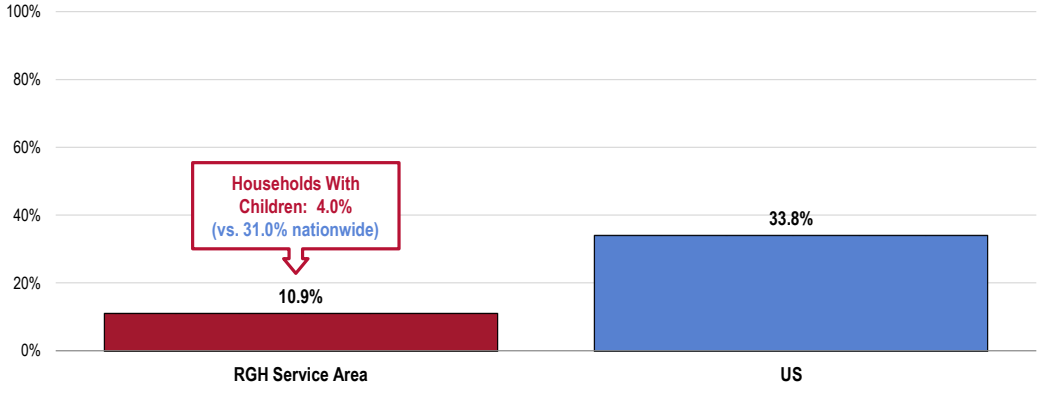
Survey respondents were further asked about the presence of weapons in the home:

"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."

Overall, just 10.9% of RGH Service Area adults have a firearm kept in or around their home.

- Much lower than the national prevalence.
- Among RGH Service Area households with children, 4.0% have a firearm kept in or around the house (well below that reported nationally).

Have a Firearm Kept in or Around the Home



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 51, 159]
- 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)

Violent Crime

Violent Crime Rates

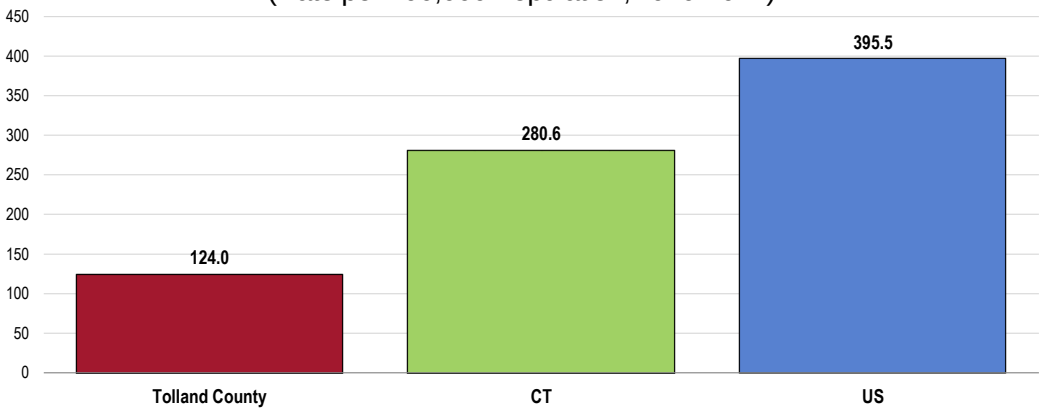
Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

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.

The county reported 124.0 violent crimes per 100,000 population between 2010 and 2012.

- Well below the state and national rates.

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.

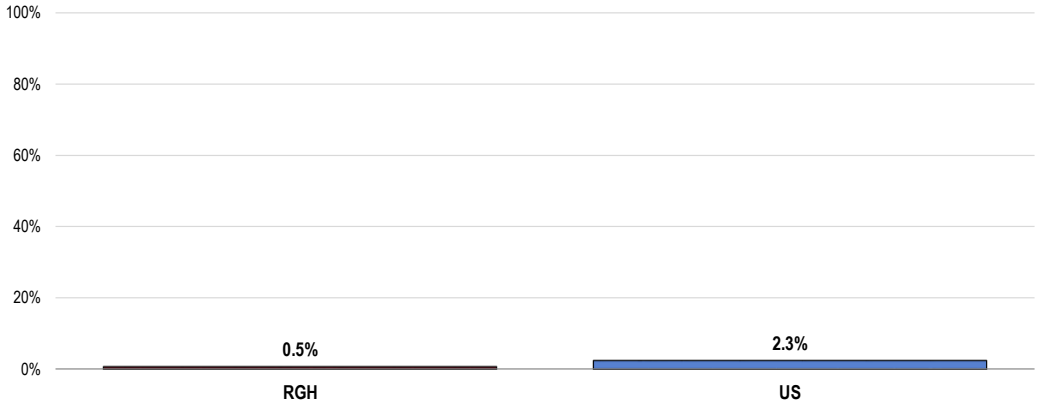
Community Violence

Less than one percent of surveyed RGH Service Area adults (0.5%) acknowledges being the victim of a violent crime in the area in the past five years.

- More favorable than national findings.

Victim of a Violent Crime in the Past Five Years

(RGH Service Area, 2016)



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.

Family Violence

Respondents were told:

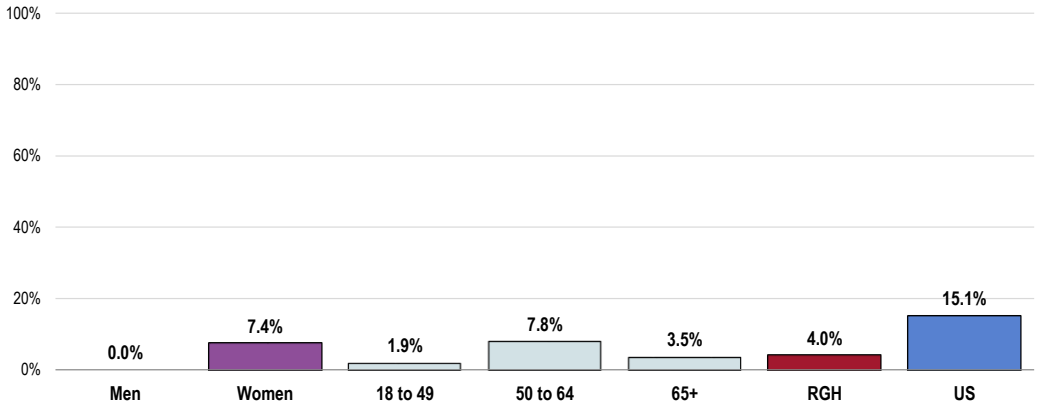
"By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with would also be considered an intimate partner."

A total of 4.0% of RGH Service Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

- Well below the US figure.
- Reports of domestic violence are notably higher among area women.

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

(RGH Service Area, 2016)



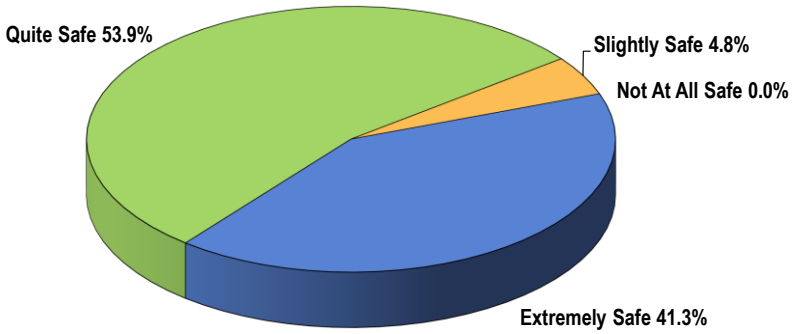
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 50]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Perceived Neighborhood Safety

While most RGH Service Area adults consider their own neighborhoods to be "extremely safe" or "quite safe," 4.8% considering them only "slightly safe" (no respondents gave "not at all safe" reports).

Perceived Safety of Own Neighborhood
(RGH Service Area, 2016)

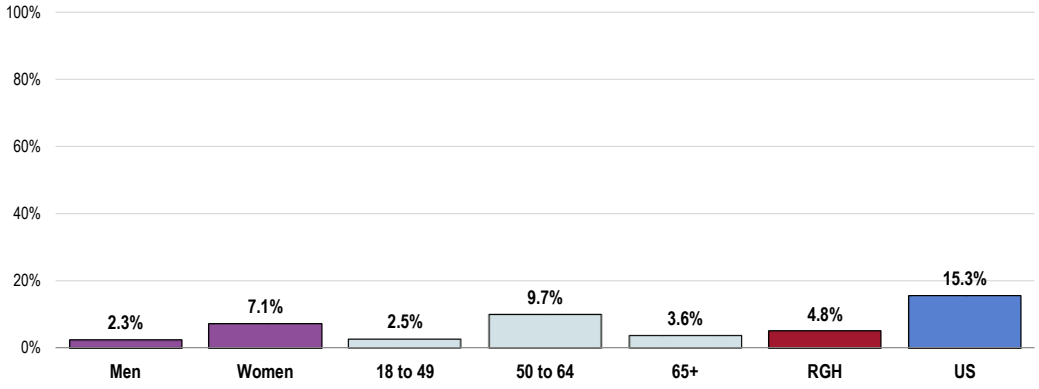


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

- The percentage of local adults who consider their neighborhood to be "slightly" or "not at all" safe is much lower than the US figure.
- Reports of unsafe neighborhoods are statistically similar by age and gender.

Perceive Own Neighborhood as "Slightly" or "Not At All" Safe
(RGH 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.

Key Informant Input: Injury & Violence

Neither participating key informant rated this issue as a "major problem" in the community.

Diabetes

About Diabetes

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

Diabetes mellitus:

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Diabetes Deaths

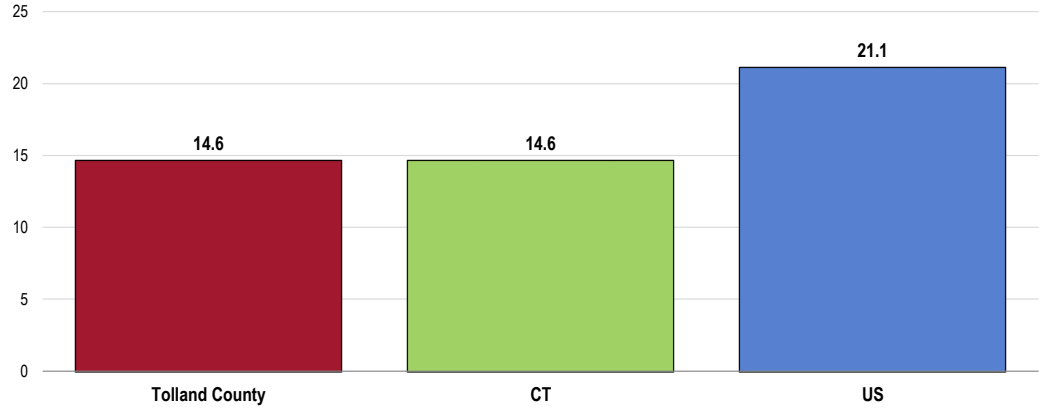
Between 2012 and 2014, there was an annual average age-adjusted diabetes mortality rate of 14.6 deaths per 100,000 population in Tolland County.

- Identical 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).

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.
- 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

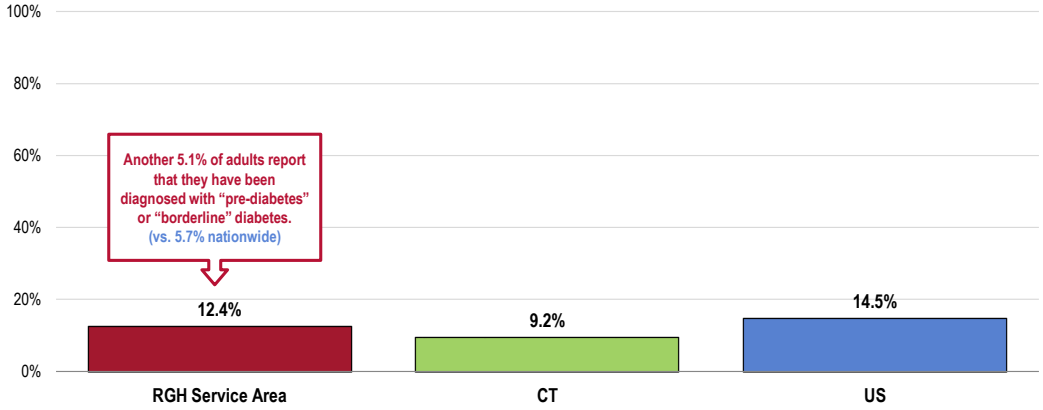
A total of 12.4% of RGH Service Area adults report having been diagnosed with diabetes.

- Similar to the statewide and national proportions.

In addition to the prevalence of diagnosed diabetes referenced above, another 5.1% of RGH Service Area adults report that they have "pre-diabetes" or "borderline diabetes."

- Similar to the US prevalence.

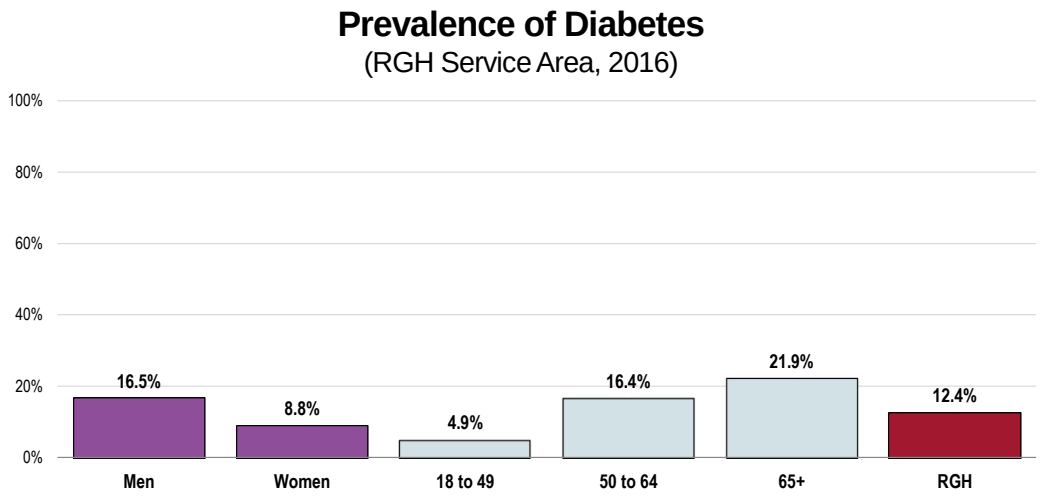
Prevalence of Diabetes



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.

- Note the strong positive correlation between diabetes and age, with 21.9% of seniors (age 65+) with diabetes.

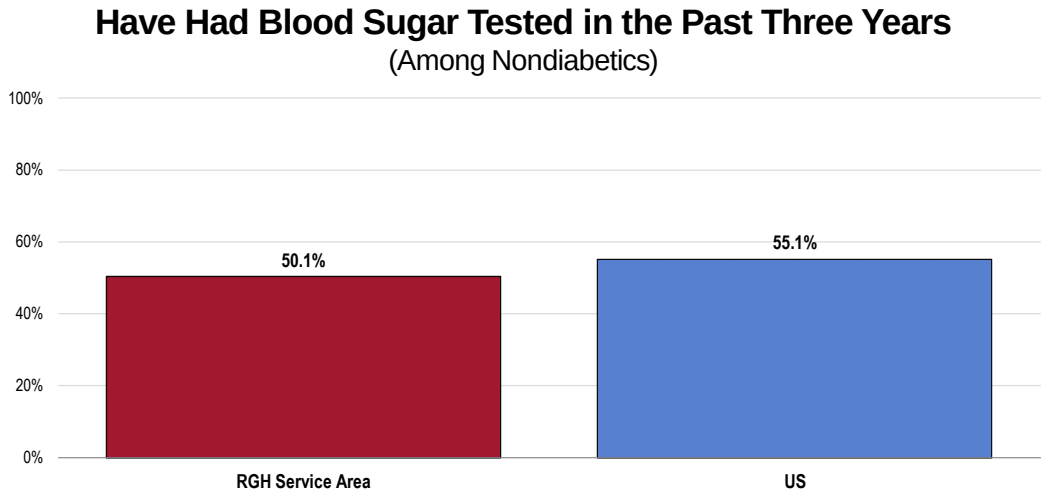


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
Notes: • Asked of all respondents.
• Excludes gestational diabetes (occurring only during pregnancy).

Diabetes Testing

Of area adults who have <u>not</u> been diagnosed with diabetes, 50.1% report having had their blood sugar level tested within the past three years.

- Similar to the national proportion.



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

The key informant who rated this issue as a “major problem” provided the following rationale:

Lifestyle

> *Living in a culture that blames the victim, there is not a culture of healthy eating and adequate physical activity. It's a culture of fast food, instant gratification and stressed out living that does not encourage, embrace a healthy amount of activity. – Public Health Representative*

Alzheimer's Disease

About Dementia

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

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

- Healthy People 2020 (www.healthypeople.gov)

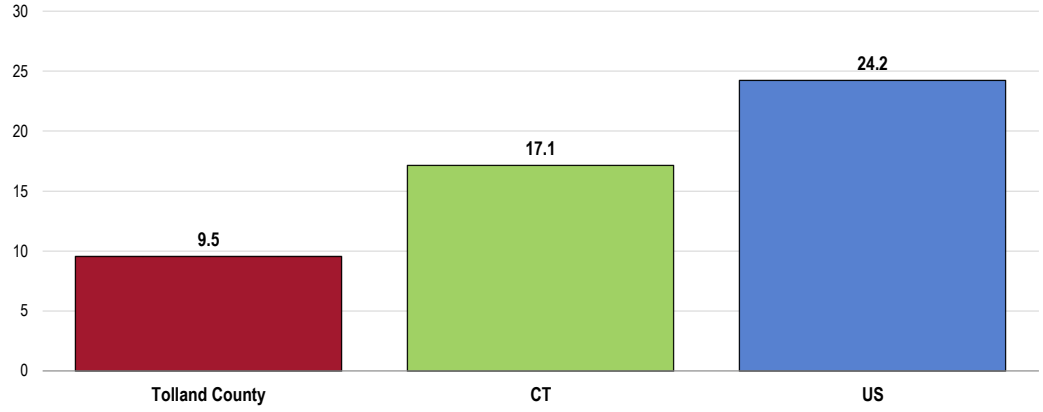
Age-Adjusted Alzheimer's Disease Deaths

Between 2012 and 2014, there was an annual average age-adjusted Alzheimer's disease mortality rate of 9.5 deaths per 100,000 population in Tolland County.

- More favorable than the state and national rates.

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.

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.

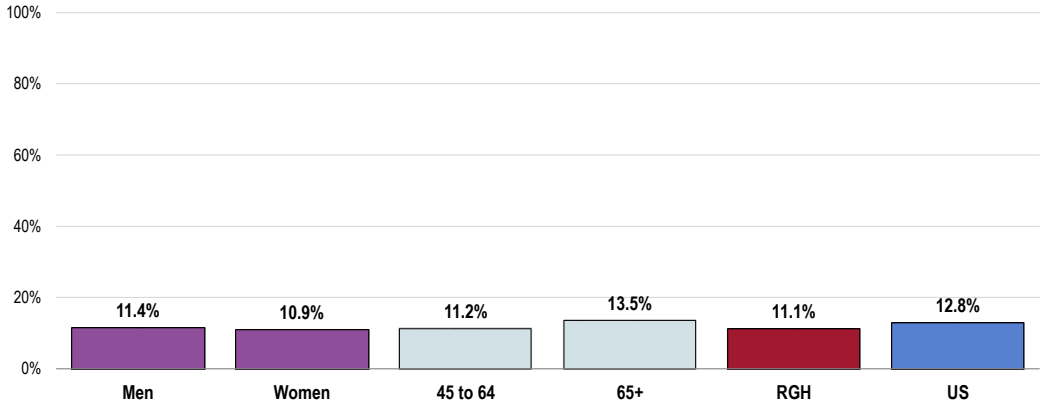
Progressive Confusion/Memory Loss

A total of 11.1% 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.
- 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; RGH Service Area, 2016)



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.

Key Informant Input: Dementias, Including Alzheimer's Disease

Neither participating key informant rated this issue as a "major problem" in the community.

Kidney Disease

About Chronic Kidney Disease

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Kidney Disease Deaths

Between 2012 and 2014 there was an annual average age-adjusted kidney disease mortality rate of 12.7 deaths per 100,000 population in Tolland County.

- Comparable to the rates found statewide and nationally.

Kidney Disease: Age-Adjusted Mortality

(2012-2014 Annual Average Deaths per 100,000 Population)

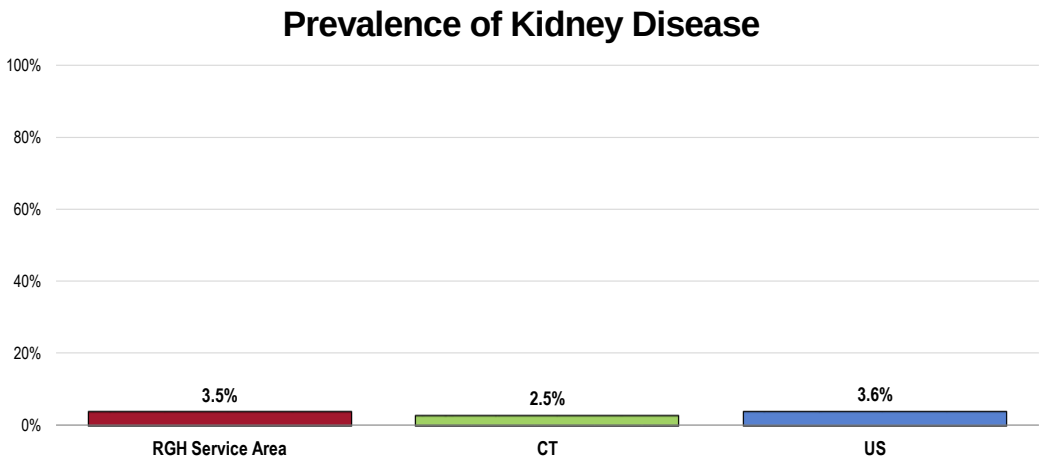
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted August 2016.

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 3.5% of RGH Service Area adults report having been diagnosed with kidney disease.

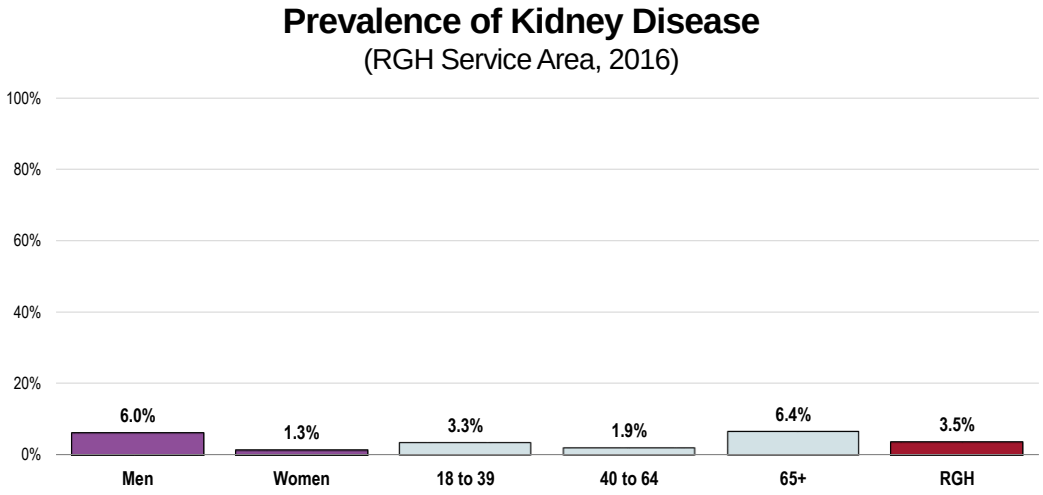
- Similar to the state and national proportions.



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 does not vary significantly by gender or age in the RGH Service Area.



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 32]

Notes:
- Asked of all respondents.

Key Informant Input: Chronic Kidney Disease

Neither participating key informant rated this issue as a “major problem” in the community.

Potentially Disabling Conditions

About Arthritis, Osteoporosis & Chronic Back Conditions

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

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

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

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Arthritis, Osteoporosis, & Chronic Back Conditions

Just over 4 in 10 RGH Service Area adults age 50 and older (41.0%) report suffering from arthritis or rheumatism.

RELATED ISSUE:

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

- Less favorable than that found nationwide.

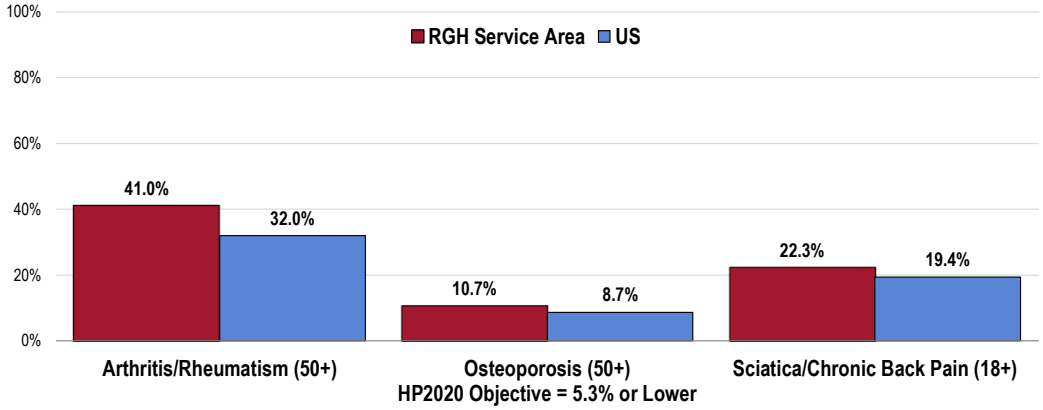
A total of 10.7% of RGH Service Area adults age 50 and older have osteoporosis.

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

A total of 22.3% of RGH Service Area adults (age 18 and older) suffer from chronic back pain or sciatica.

- Similar to that found nationwide.

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

Neither participating key informant rated this issue as a “major problem” in the community.

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)

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 a 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)

Vision and Hearing Trouble

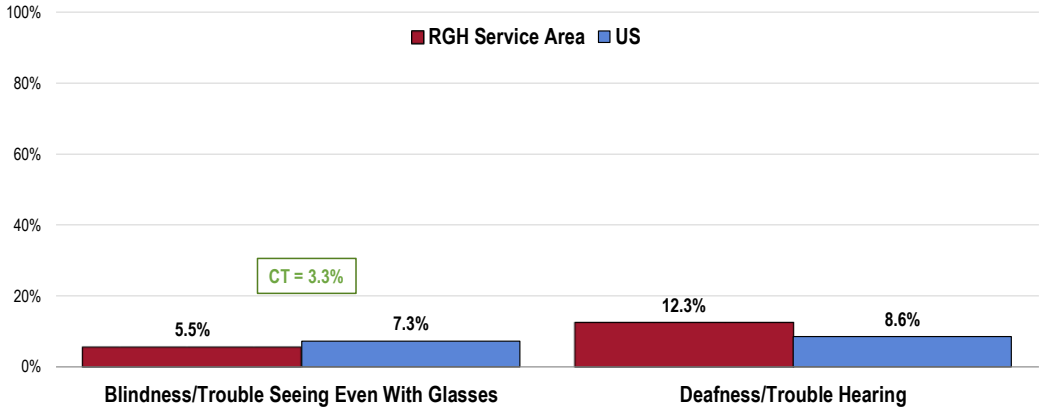
RELATED ISSUE:

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

A total of 5.5% of RGH Service Area adults are blind or have trouble seeing even when wearing corrective lenses, and 12.3% are deaf or have trouble hearing.

- Compared with the statewide prevalence, the local prevalence of blindness is similar.
- Both figures are similar to the related national benchmarks.

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

Neither participating key informant rated this issue as a “major problem” in the community.

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)

Flu Vaccinations

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

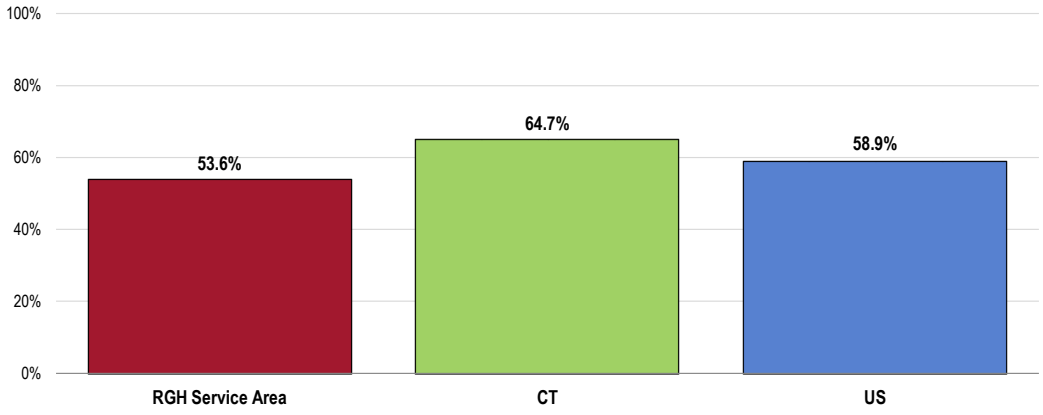
Among RGH Service Area seniors (age 65+), 53.6% received a flu shot (or FluMist®) within the past year.

- Statistically comparable to the Connecticut and US findings.
- Fails to satisfy the Healthy People 2020 target (70% or higher).

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.
- Includes FluMist as a form of vaccination.

Pneumonia Vaccination

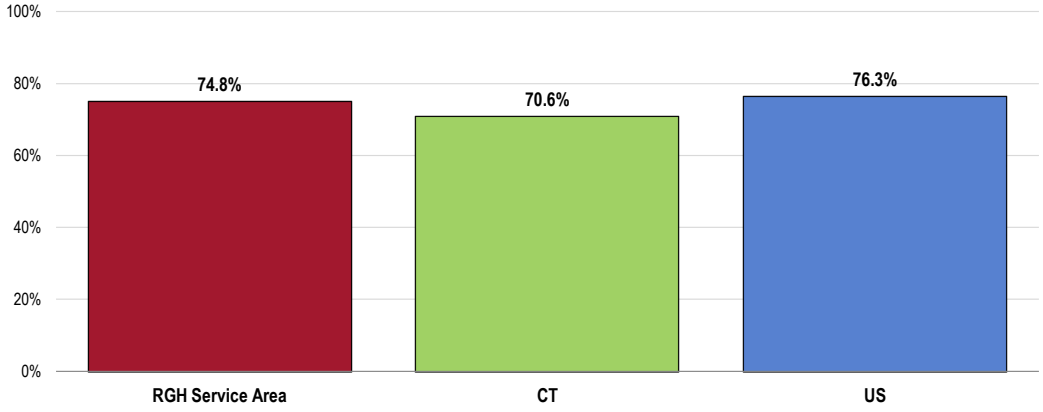
Among RGH Service Area adults age 65 and older, 74.8% have received a pneumonia vaccination at some point in their lives.

- Comparable to the state and national figures.
- Fails to satisfy the Healthy People 2020 target of 90% or higher.

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.

HIV

About HIV

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

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

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

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

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

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

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

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

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

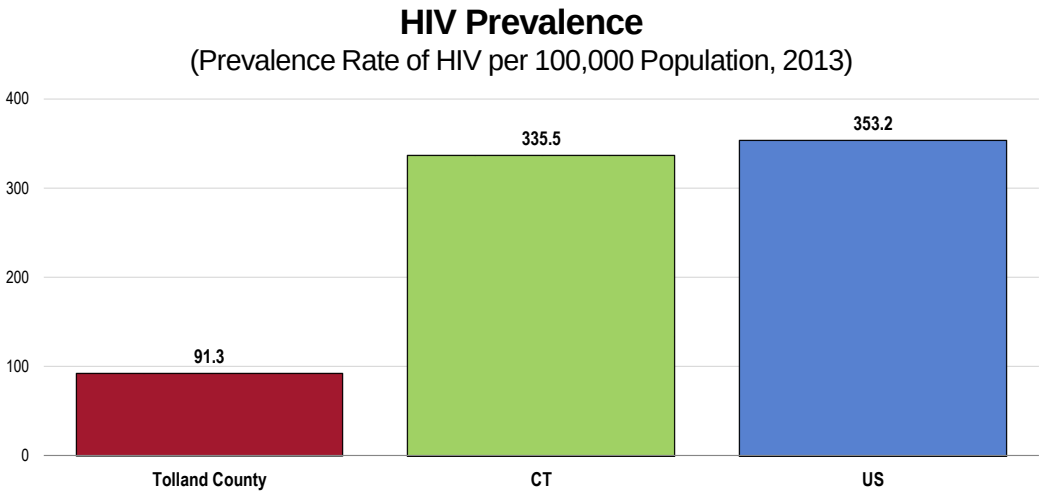
Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions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

- Healthy People 2020 (www.healthypeople.gov)

HIV Prevalence

In 2013, there was a prevalence of 91.3 HIV cases per 100,000 population in Tolland County.

- Much lower 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.

Key Informant Input: HIV/AIDS

Neither participating key informant rated this issue as a “major problem” in the community.

Sexually Transmitted Diseases

About Sexually Transmitted Diseases

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

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Chlamydia & Gonorrhea

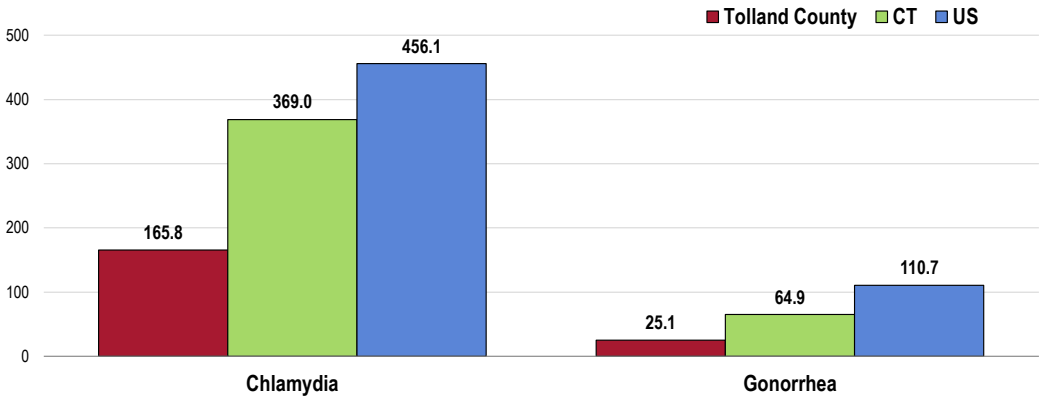
In 2014, the chlamydia incidence rate in Tolland County was 165.8 cases per 100,000 population.

- Notably lower than the Connecticut and US incidence rates.

The county’s gonorrhea incidence rate in 2014 was 25.1 cases per 100,000 population.

- Lower than the state and national incidence rates.

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.
- 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.

Key Informant Input: Sexually Transmitted Diseases

For the key informant rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> *I review communicable disease reports for our agency. There is a constancy of STDs reported, particularly chlamydia. – Public Health RepresentativeImmunization & Infectious Diseases*

Key Informant Input: Immunization & Infectious Diseases

Neither participating key informant rated this issue as a "major problem" in the community.

Births

Professional Research Consultants, Inc.

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.

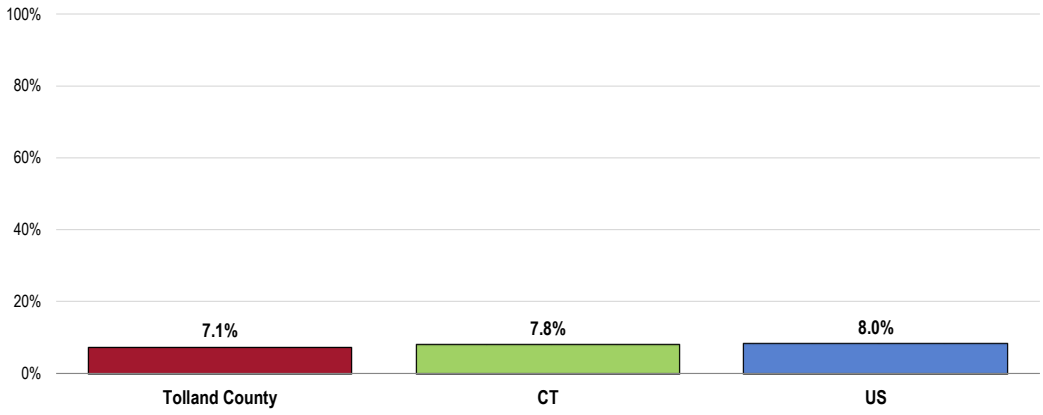
A total of 7.1% of 2013 Tolland County births were low-weight.

- Lower than the state and US proportions.
- Satisfies the Healthy People 2020 target (7.8% or lower).

Low-Weight Births

(Percentage of Live Births, 2013)

Healthy People 2020 Target = 7.8% or Lower



Sources:
- 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

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

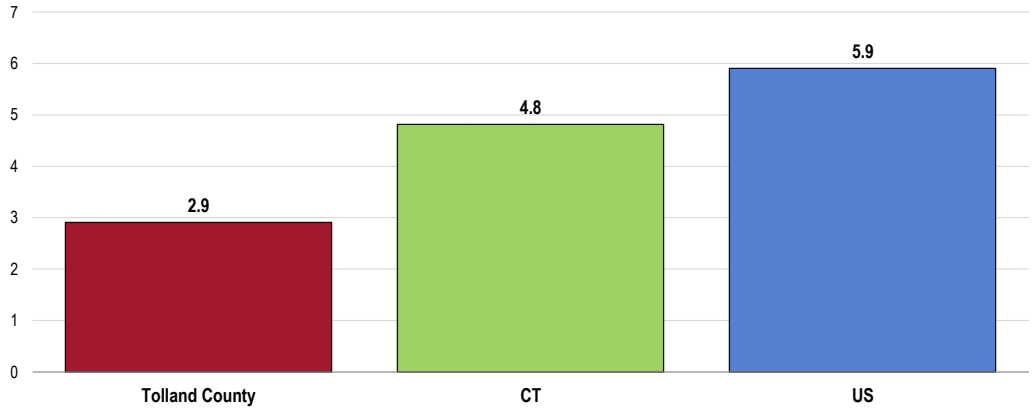
Between 2006 and 2010, Tolland County reported an annual average of 2.9 infant deaths per 1,000 live births.

- More favorable than the Connecticut and US rates.
- Satisfies the Healthy People 2020 target of 6.0 deaths 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.
- 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

Neither participating key informant rated this issue as a “major problem” in the community.

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.

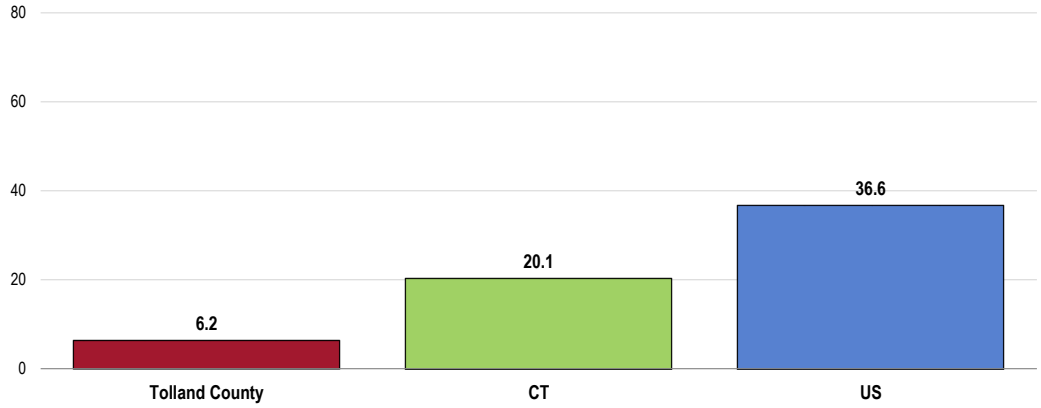
- Healthy People 2020 (www.healthypeople.gov)

Between 2006 and 2012, there was an annual average of 6.2 births to Tolland County women age 15–19 per 1,000 population in that age group.

- Well below the Connecticut and US proportions.

Teen Birth Rate

(Births to Women Age 15-19 Per 1,000 Female Population Age 15-19, 2006-2012)



Sources: • 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

Neither participating key informant rated this issue as a “major problem” in the community.

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.

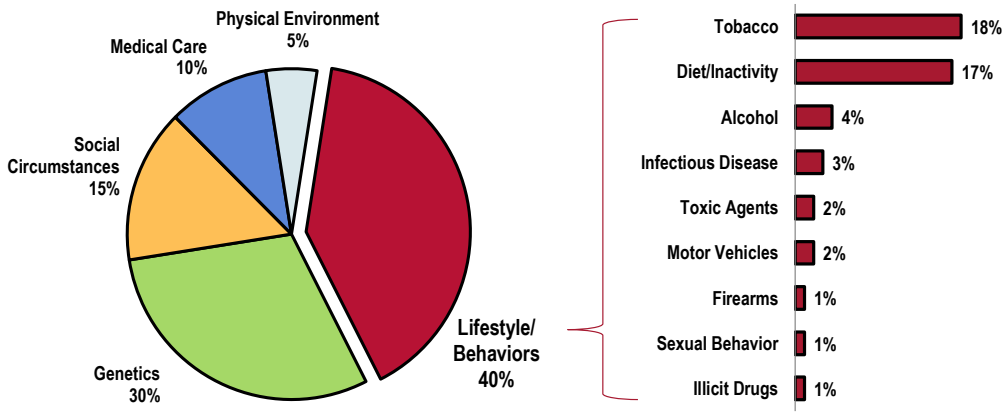
The most prominent contributors to mortality in the United States in 2000 were **tobacco** (an estimated 435,000 deaths), **diet and activity** patterns (400,000), **alcohol** (85,000), **microbial agents** (75,000), **toxic agents** (55,000), **motor vehicles** (43,000), **firearms** (29,000), **sexual 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)

Daily Recommendation of Fruits/Vegetables

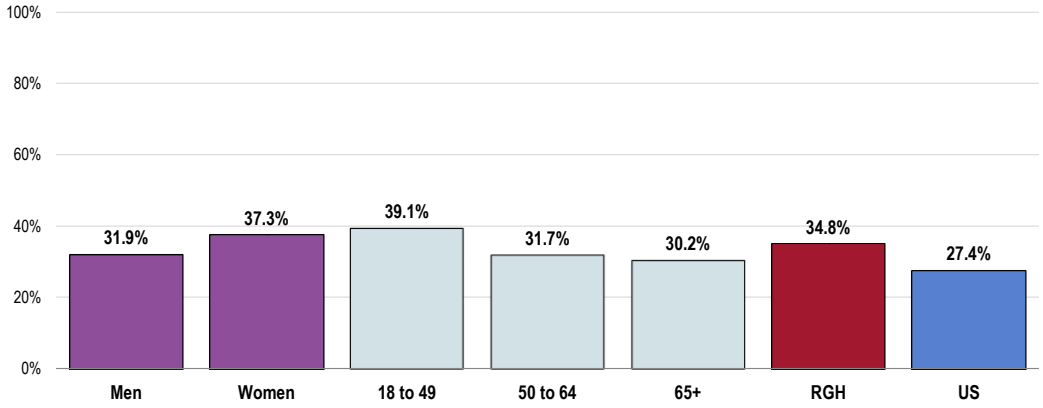
A total of 34.8% of RGH Service Area adults report eating five or more servings of fruits and/or vegetables per day.

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.

- Well above the US prevalence.
- The variations by gender and age are not statistically significant.

Consume Five or More Servings of Fruits/Vegetables Per Day

(RGH Service Area, 2016)



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.

Access to Fresh Produce

Difficulty Accessing Fresh Produce

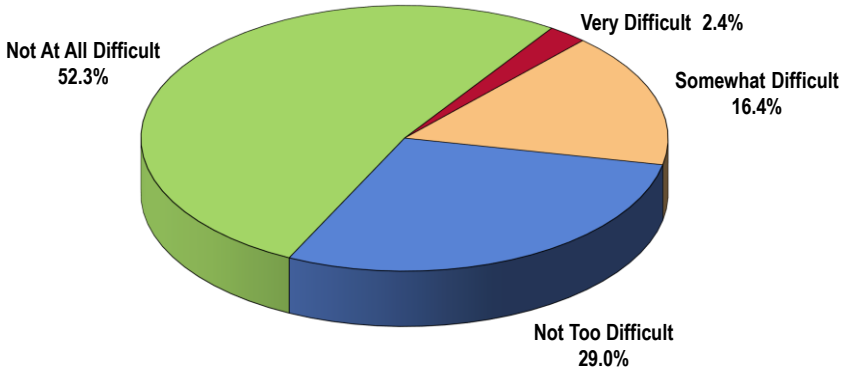
While most report little or no difficulty, 18.8% of RGH Service Area adults find it "very" or "somewhat" difficult to access affordable, fresh fruits and vegetables.

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

(RGH Service Area, 2016)



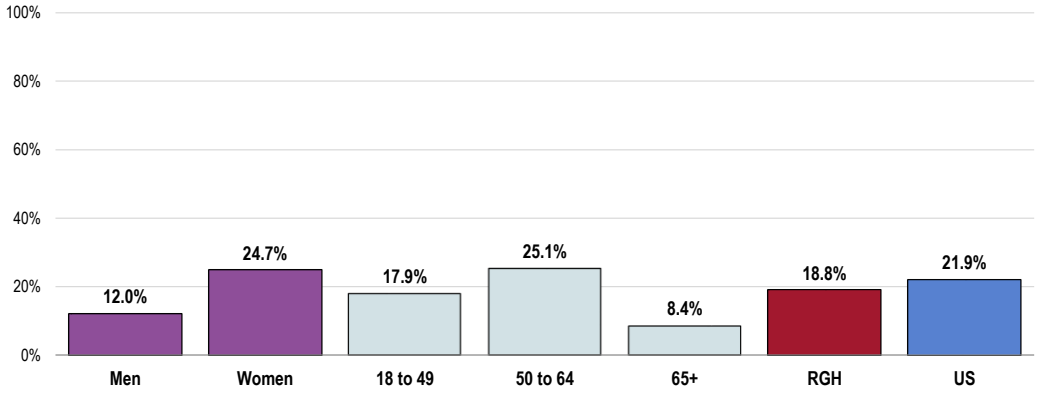
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]

Notes:
- Asked of all respondents.

- Similar to the US figure.
- Women and adults age 50 to 64 are much more likely to report difficulty getting fresh produce.

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce

(RGH Service Area, 2016)



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.

Low Food Access (Food Deserts)

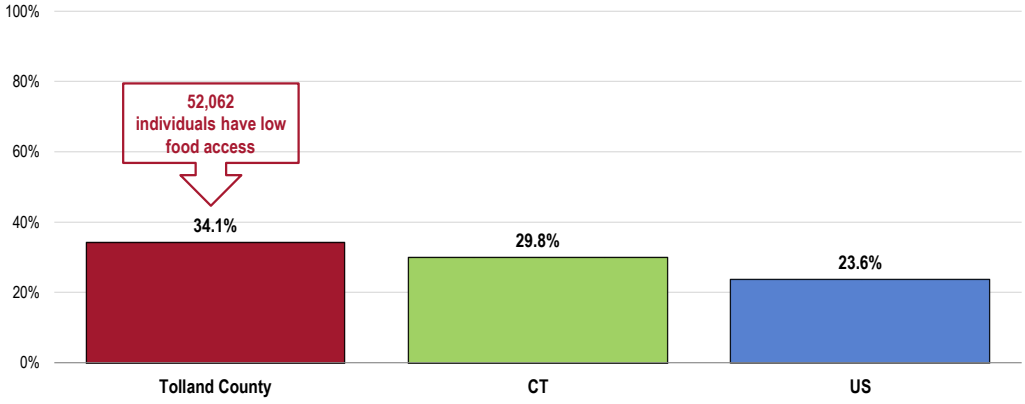
A food desert is defined as a low-income area where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas.

US Department of Agriculture data show that 34.1% of the Tolland County population (representing over 52,000 residents) have low food access or live in a "food desert," meaning that they do not live near a supermarket or large grocery store.

- Less favorable than statewide and national findings.

Population With Low Food Access

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

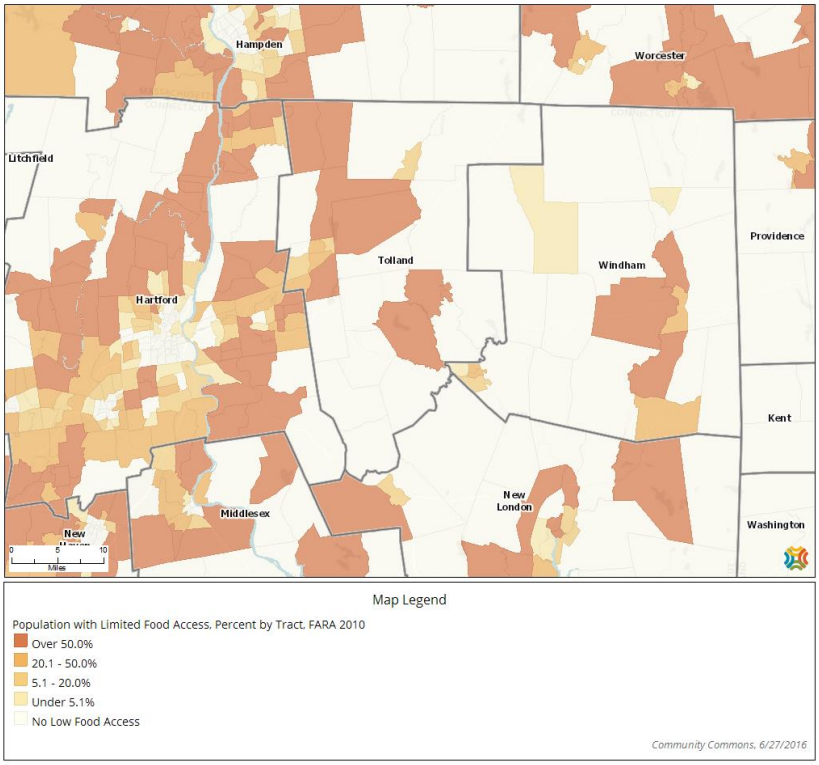


Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Retrieved August 2016 from Community Commons at http://www.chna.org.

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.

Population With Limited Food Access, Percent by Tract, FARA 2010



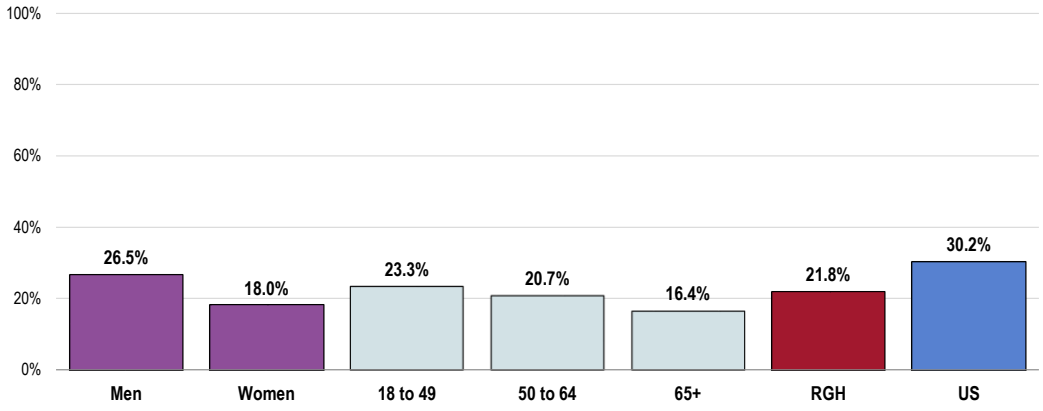
Sugar-Sweetened Beverages

A total of 21.8% of RGH Service Area adults report drinking an average of at least one sugar-sweetened beverage per day in the past week.

- Well below the national findings.
- Statistically similar findings by gender and age in the service area.

Had Seven or More Sugar-Sweetened Beverages in the Past Week

(RGH Service Area, 2016)



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.

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)

Leisure-Time Physical Activity

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

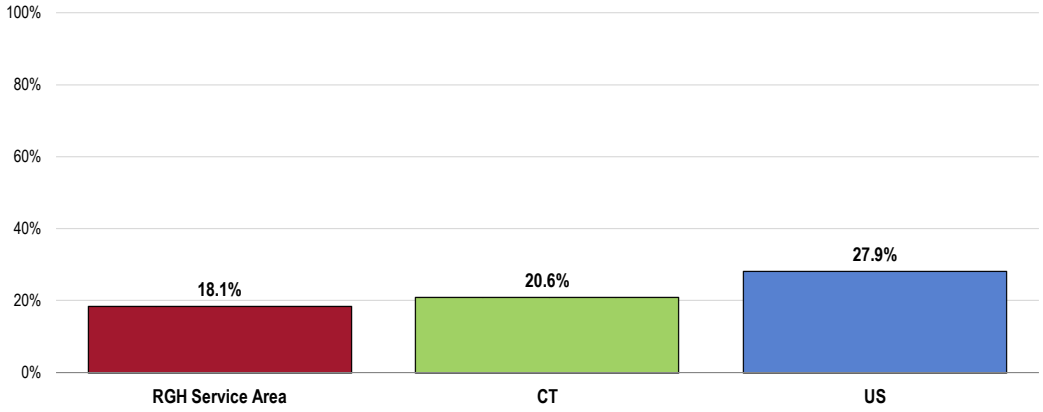
A total of 18.1% of RGH Service Area adults report no leisure-time physical activity in the past month.

- Similar to statewide findings.
- More favorable than national findings.

- 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]

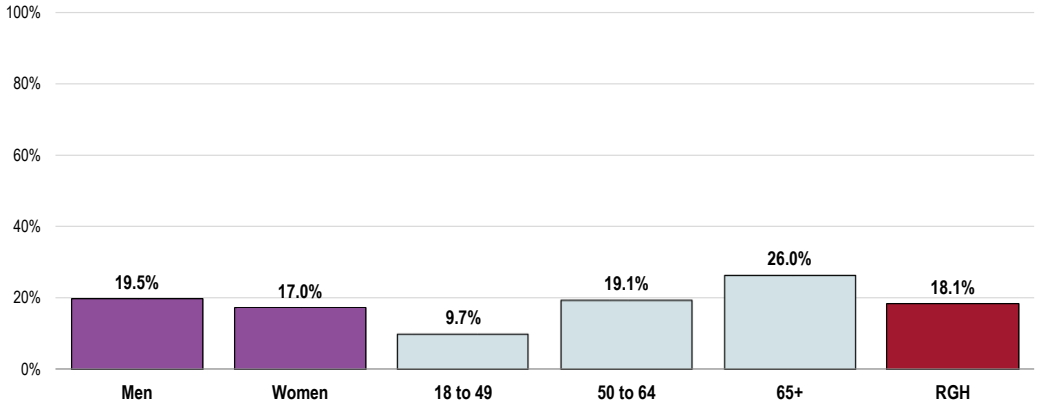
Notes:
- Asked of all respondents.

- Note the positive correlation between age and lack of leisure-time physical activity.

No Leisure-Time Physical Activity in the Past Month

(RGH Service Area, 2016)

Healthy People 2020 Target = 32.6% or Lower



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 106]
- 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.

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
- Learn more about CDC's efforts to promote walking by visiting http://www.cdc.gov/vitalsigns/walking.

Aerobic & Strengthening Physical Activity

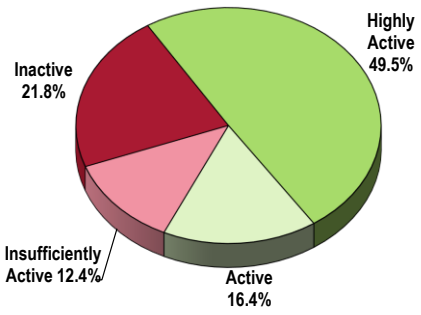
Survey respondents were asked about the types of physical activities they engaged in during the past month, as well as the frequency and duration of these activities.

- "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.

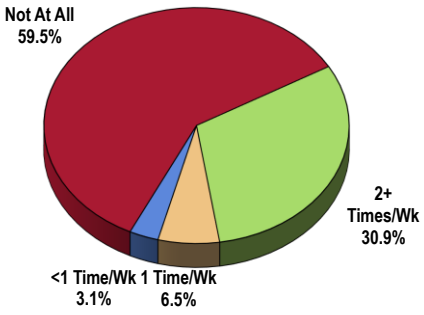
Based on reported physical activity intensity, frequency and duration over the past month, 34.2% of RGH Service Area adults are found to be "insufficiently active" or "inactive."

A total of 59.5% of RGH Service Area adults do not participate in any type of physical activities or exercises to strengthen their muscles.

Participation in Physical Activities
(RGH Service Area, 2016)



Aerobic Activity



Strengthening Activity

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

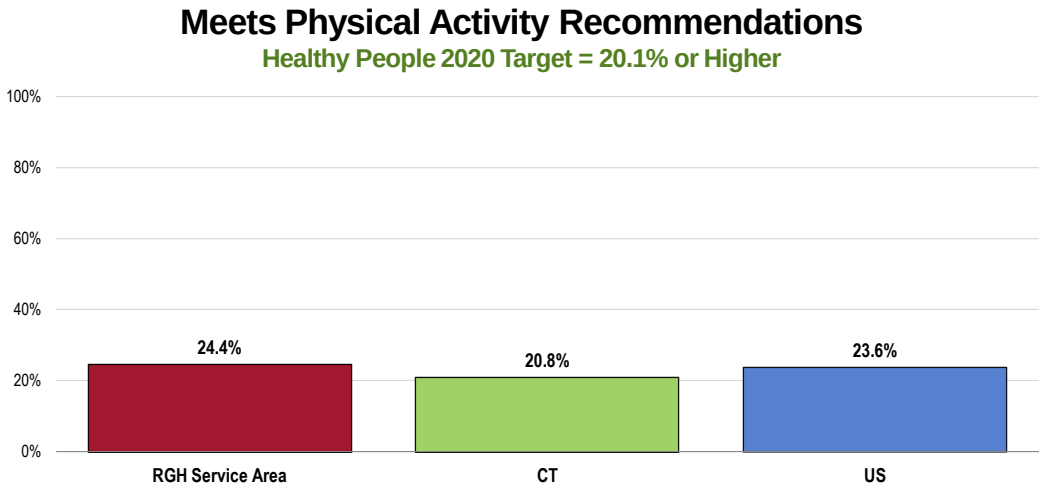
"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

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.

A total of 24.4% of RGH Service Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

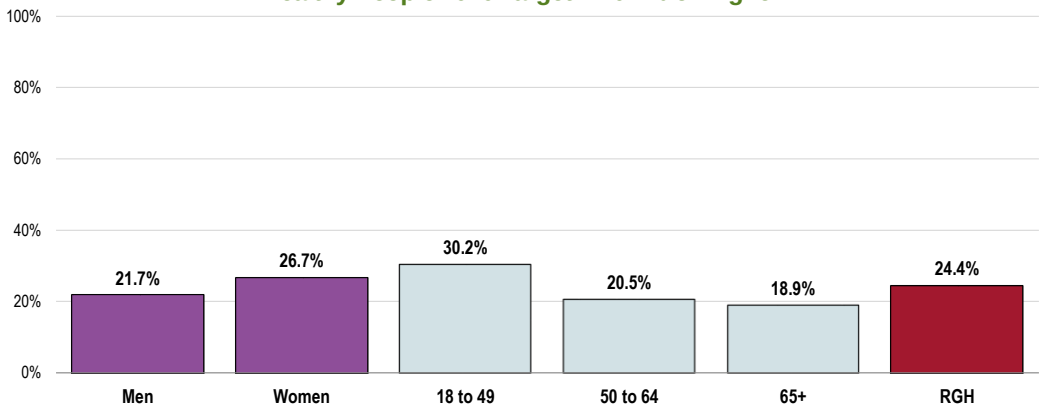
- Comparable to state and national findings.
- Comparable to the Healthy People 2020 target (20.1% or higher)



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:
- Asked of all respondents.
- 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.

- The prevalence does not vary significantly by gender or age in the service area.



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.
- 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.

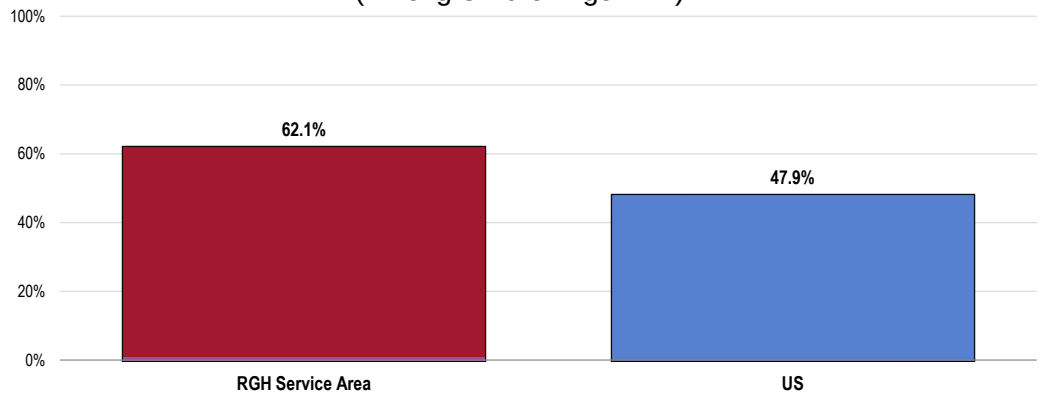
- 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Among area children age 2 to 17, 62.1% are reported to have had 60 minutes of physical activity on <u>each</u> of the seven days preceding the interview (1+ hours per day).

- Statistically comparable to 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 9.2 recreation/fitness facilities for every 100,000 population in Tolland County.

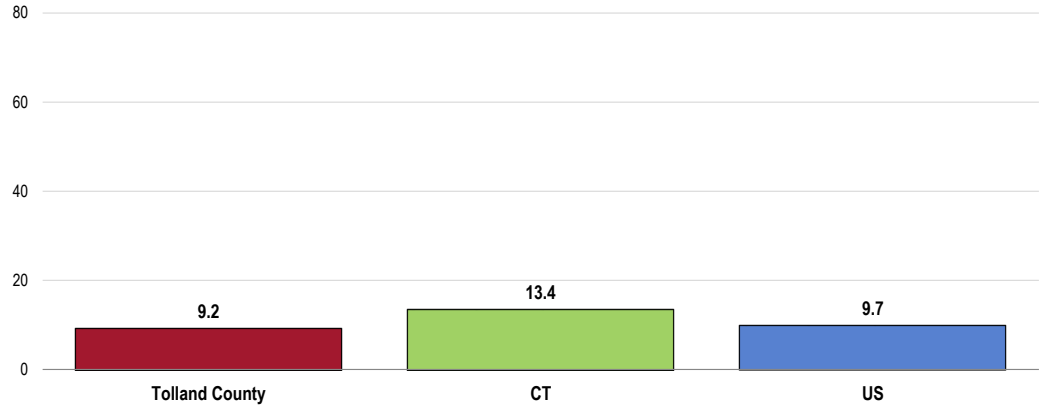
- Lower than the state and national ratios.

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

Population With Recreation & Fitness Facility Access

(Number of Recreation & Fitness Facilities per 100,000 Population, 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)

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^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, 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^2.

- 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^2)
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

A full 8 in 10 RGH Service Area adults (80.0%) are overweight.

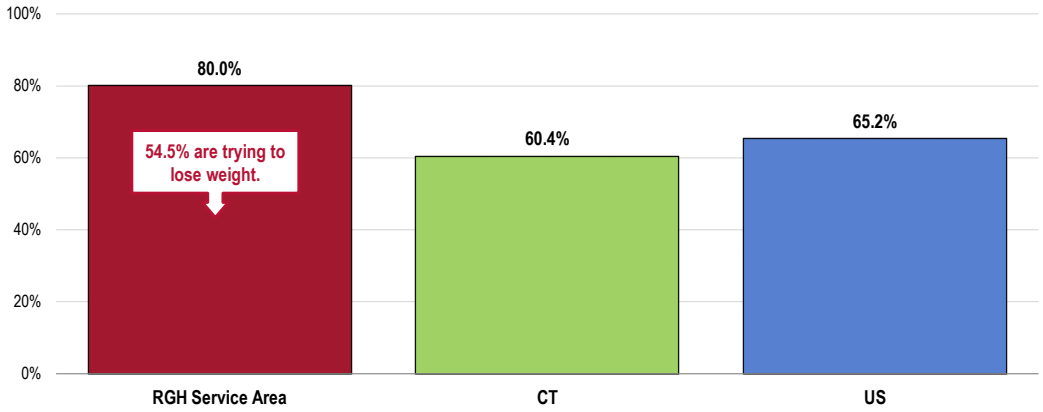
Here, "overweight" includes those respondents with a BMI value ≥25.

- Above both the state and US figures.

Note that 54.5% of overweight adults are currently trying to lose weight.

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, 33.5% of RGH Service Area adults are obese.

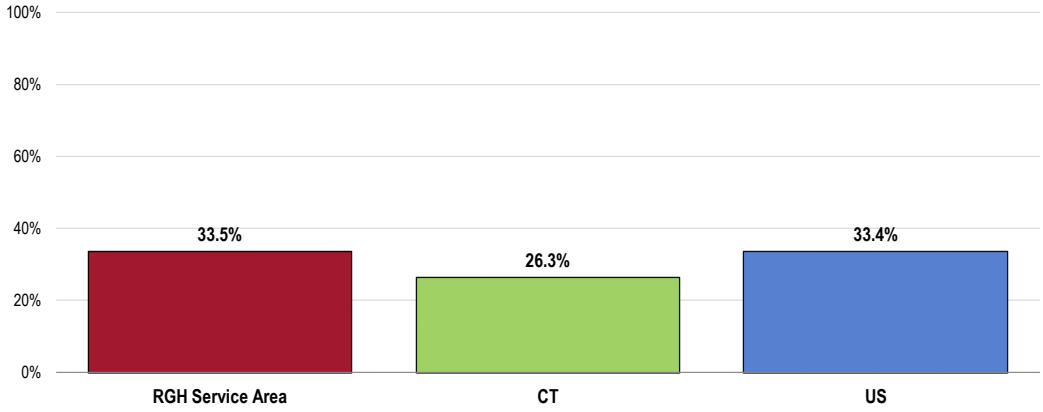
"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥30.

- Less favorable than Connecticut findings.
- Similar to US findings.
- Similar to the Healthy People 2020 target (30.5% or lower).

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.

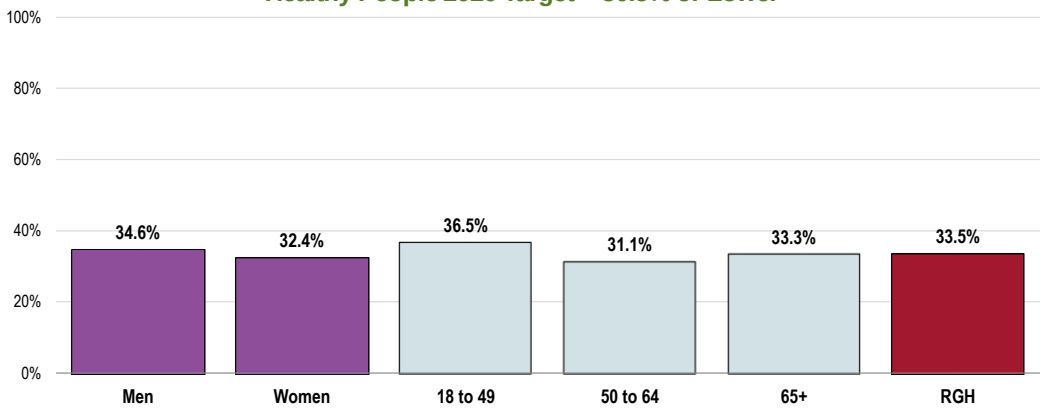
Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

- Obesity in the service area is statistically comparable by gender and age.

Prevalence of Obesity

(Percent of Adults With a BMI of 30.0 or Higher; RGH 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]

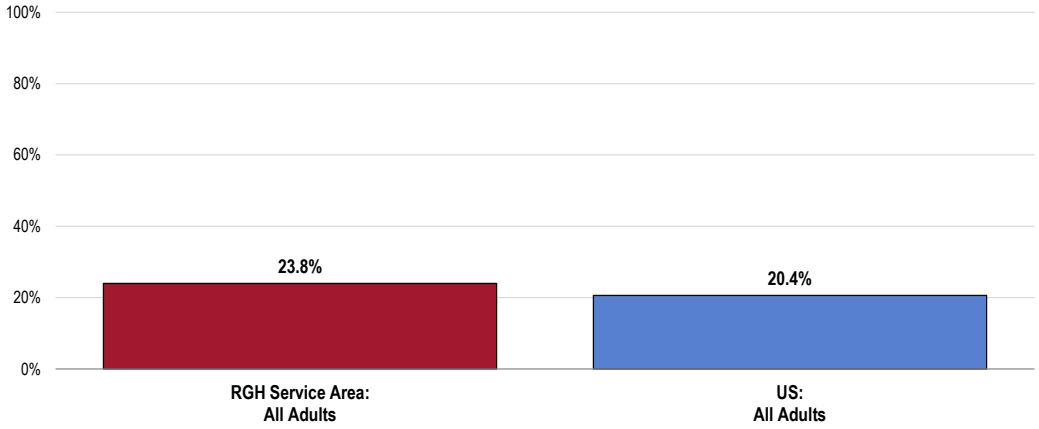
Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Health Advice

A total of 23.8% of adults have been given advice about their weight by a doctor, nurse or other health professional in the past year.

- Similar to the national findings.

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.

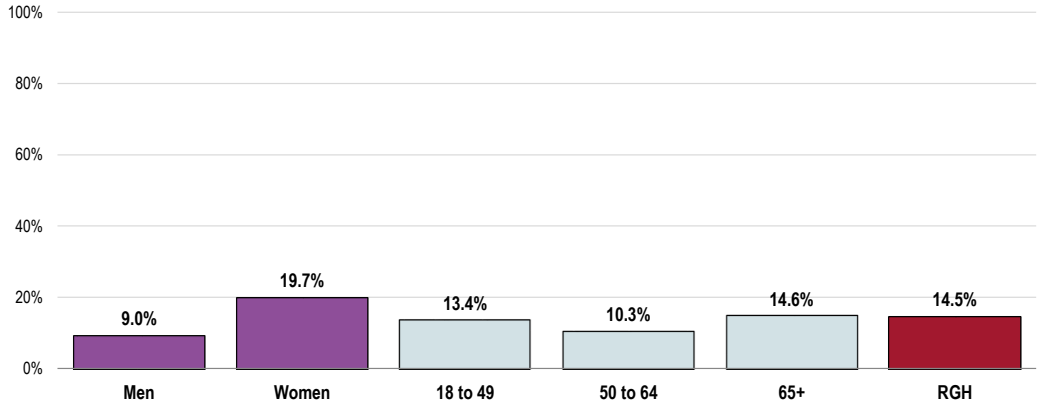
Notes:
- Asked of all respondents.
- Use caution when interpreting results; note that the Healthy Weight column represents <50 survey respondents.

Local Resources

Asked whether local medical resources for weight management are sufficient for the community's need, 14.5% of survey respondents indicated that the resources are insufficient or unavailable.

- Service area women are more likely to give "insufficient" or "not available" responses.

Local Medical Resources for Weight Management Are "Insufficient" or "Not Available"
(RGH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 303]
Notes: • Asked of all respondents.

Key Informant Input: Nutrition, Physical Activity & Weight

Both participating key informants rated this issue as a "major problem," for reasons related to the following:

Health Education

> *Lack of knowledge and too much information at the same time. It can become overwhelming to make the right choices for food. Food marketing and low prices for unhealthy food challenge healthy eating. Much of life is sedentary, people depend on cars. – Public Health Representative*

Obesity

> *Childhood obesity. – 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:

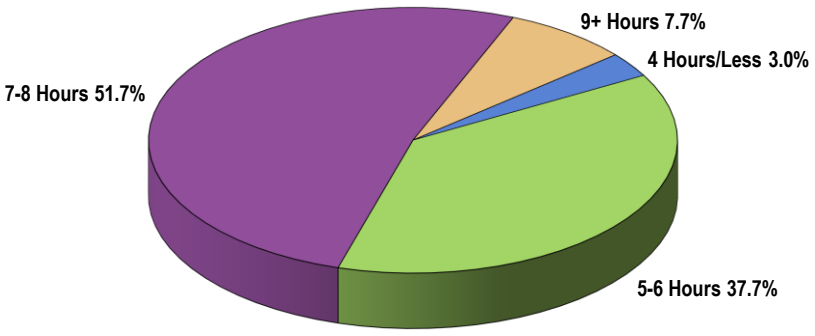
- Be consistent. Go to bed at the same time each night and get up at the same time each morning, including on the weekends.
- Make sure your bedroom is quiet, dark, relaxing, and at a comfortable temperature.
- Remove electronic devices, such as TVs, computers, and smart phones, from the bedroom.
- Avoid 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, 51.7% of survey respondents stated between 7 and 8 hours, and 7.7% get 9+ hours of sleep per night.

- On the other hand, 4 in 10 local adults (40.7%) sleep **fewer than 7 hours** per night (including 3.0% who report sleeping 4 hours or less on an average night).

Average Hours of Sleep Per Night
(RGH Service Area, 2016)

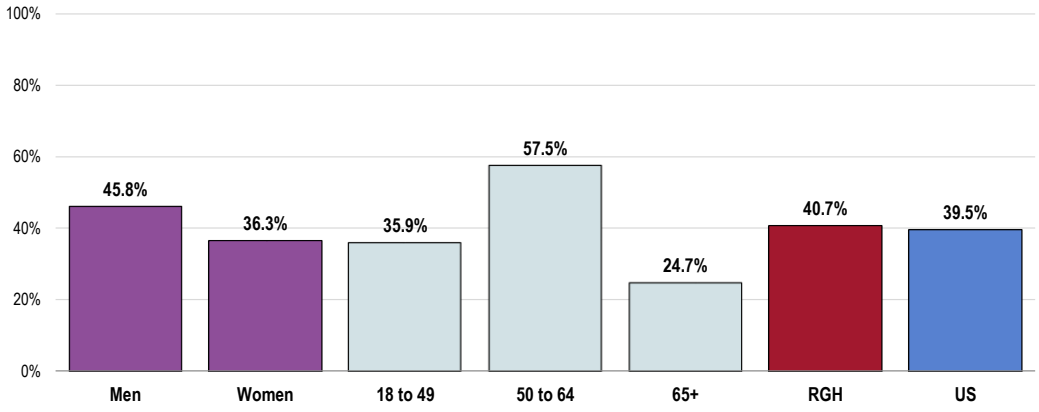


Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 124]
Notes: ● Asked of all respondents.

- The percentage of survey respondents averaging fewer than 7 hours per night is similar to the national figure.
- Residents age 50 to 64 are more likely to sleep fewer than 7 hours on an average night.

Generally Sleep Less Than Seven Hours Per Night

(RGH Service Area, 2016)



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.

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)

Age-Adjusted Cirrhosis/Liver Disease Deaths

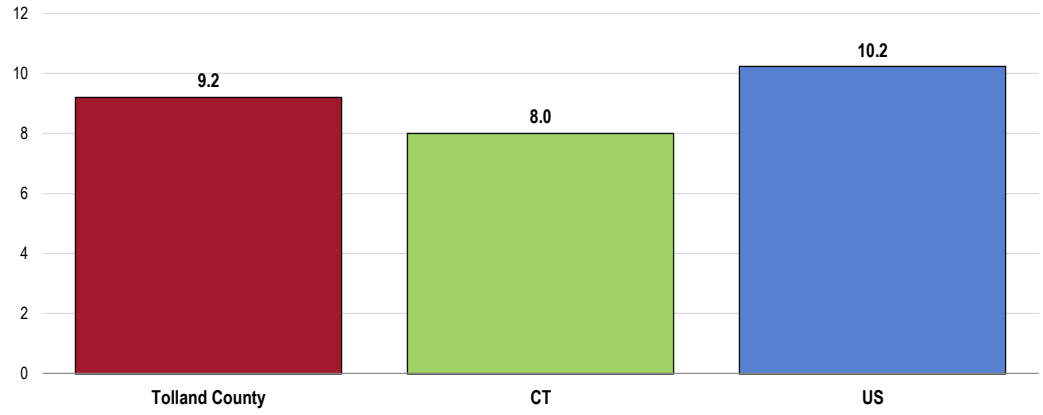
Between 2012 and 2014, Tolland County reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 9.2 deaths per 100,000 population.

- Higher than the statewide rate.
- Lower than the national rate.
- Fails to satisfy the Healthy People 2020 target (8.2 deaths or lower).

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.
- 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

"**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.

RELATED ISSUE:
See also *Stress* in the **Mental Health** section of this report.

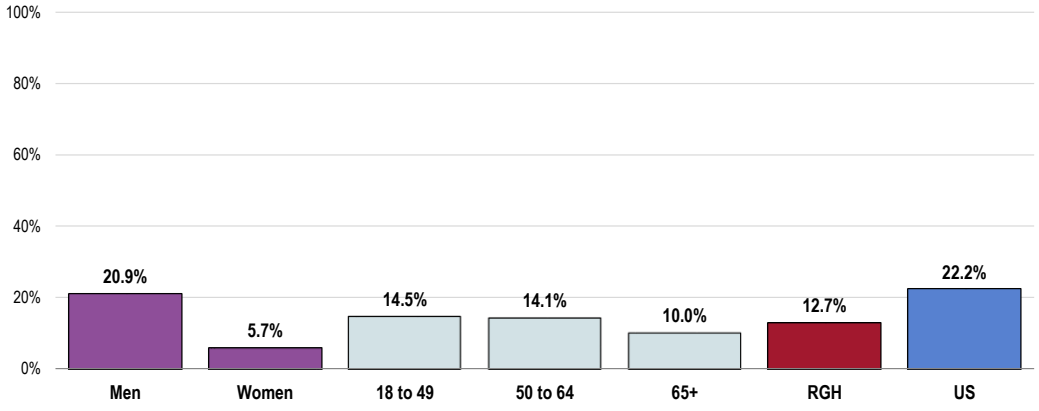
A total of 12.7% of area adults are excessive drinkers (heavy and/or binge drinkers).

- More favorable than the national proportion.
- Satisfies the Healthy People 2020 target (25.4% or lower).
- Service area men are more likely to be excessive drinkers.

Excessive Drinkers

(RGH Service Area, 2016)

Healthy People 2020 Target = 25.4% or Lower



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 189]
- 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-15]

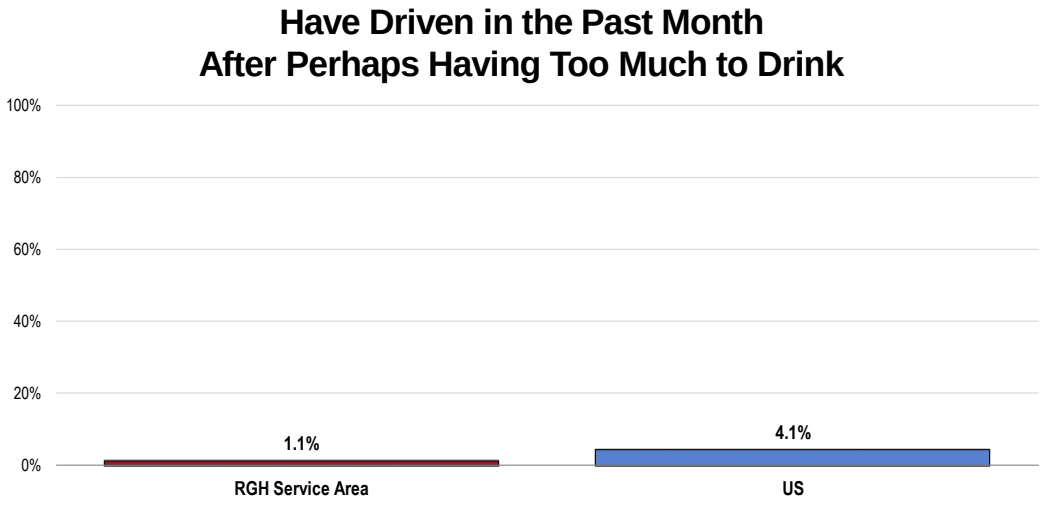
Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drinking & Driving

Just 1.1% of RGH Service Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

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.

- Well below the national findings.



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

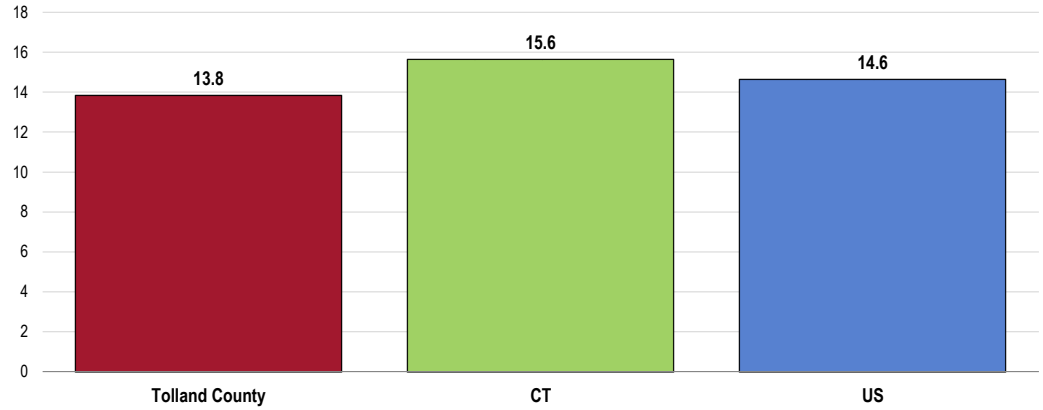
Between 2012 and 2014, there was an annual average age-adjusted drug-induced mortality rate of 13.8 deaths per 100,000 population in Tolland County.

- Lower than the statewide and national rates.
- Fails to satisfy the Healthy People 2020 target (11.3 deaths or lower).

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.
- 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

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.

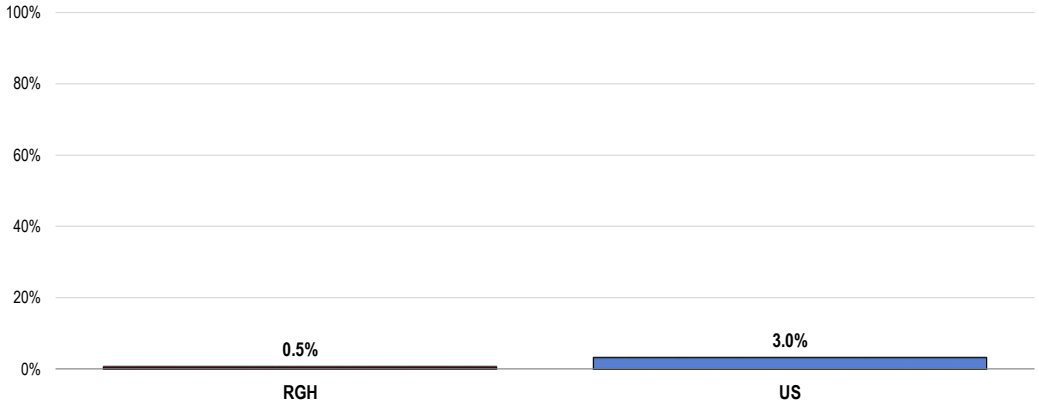
A total of 0.5% of area adults acknowledge using an illicit drug in the past month.

- Well below the proportion found nationally.
- Satisfies the Healthy People 2020 target of 7.1% or lower.

Illicit Drug Use in the Past Month

(RGH Service Area, 2016)

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.

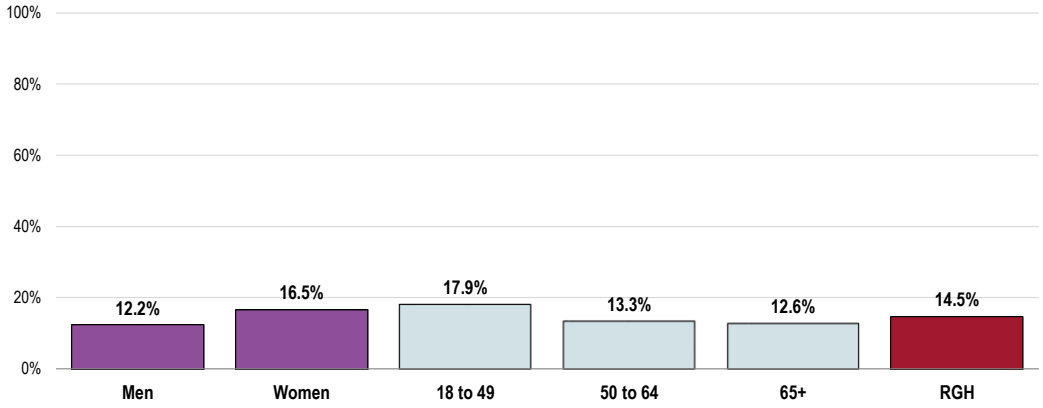
Opiates or opioids are drugs that doctors prescribe to manage pain.

Use of opiates or opioids (with or without a physician's prescription) in the past year is reported among 14.5% of RGH Service Area adults.

- Opiate/opioid use does not vary significantly by gender or age in the service area.

Used Opiates or Opioids in the Past Year

(RGH Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 301]

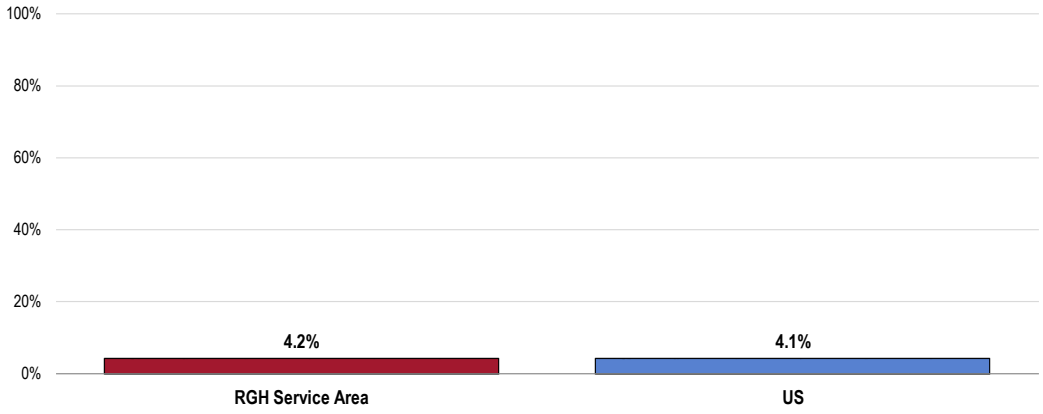
Notes:
- Asked of all respondents.
- Prescription opiates include morphine, codeine, hydrocodone, oxycodone, and methadone.

Alcohol & Drug Treatment

A total of 4.2% of RGH 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.

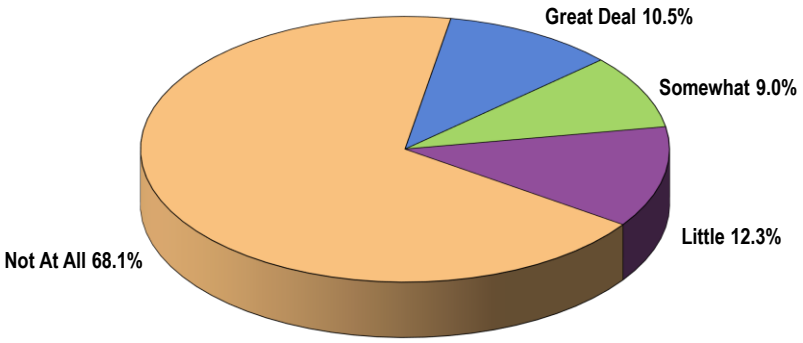
Negative Effects of Substance Abuse

RGH Service 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 (68.1% "not at all" responses).

Degree to Which Life Has Been Negatively Affected by Substance Abuse (Self or Other's)

(RGH Service Area, 2016)



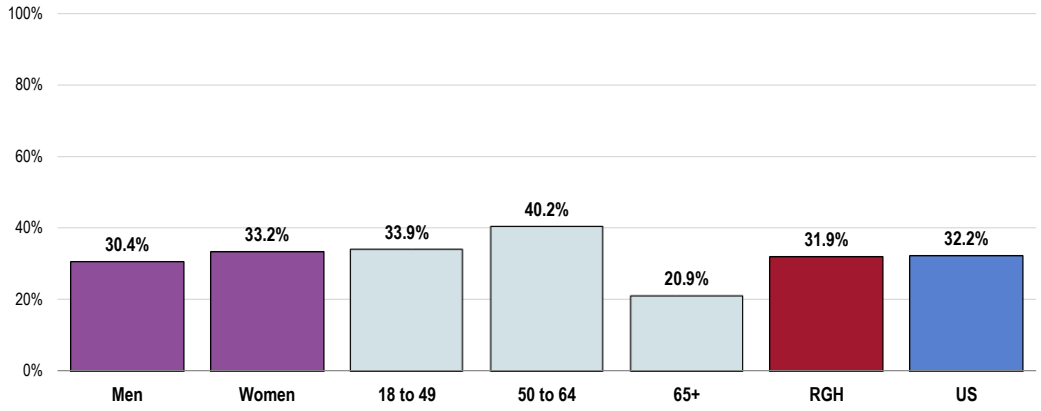
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]
Notes: • Asked of all respondents.

In contrast, 31.9% of survey respondents indicate that their lives have been negatively affected by substance abuse, including 10.5% who gave "a great deal" responses.

- The prevalence of area adults whose lives have been negatively affected by substance abuse is comparable to the national response.
- The prevalence of survey respondents whose lives have been negatively impacted by substance abuse, whether their own abuse or that of another, is higher in the 50-64 population sample.

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)

(RGH Service Area, 2016)



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.

Key Informant Input: Substance Abuse

One key informant provided the following reasoning for rating this issue as a "major problem" in the community:

Denial/Stigma

> *Stigma of substances abuse. Lack of understanding about the disease model in the community. People try to hide their problem. Also, there is a criminal aspect of illegal drug use that presents an additional barrier. – Public Health Representative*

The key informant who rated this as a "major problem" identified **alcohol** as being the most problematic substance in the community, followed by **prescription medications** and **heroin/other opioids**.

Tobacco Use

About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

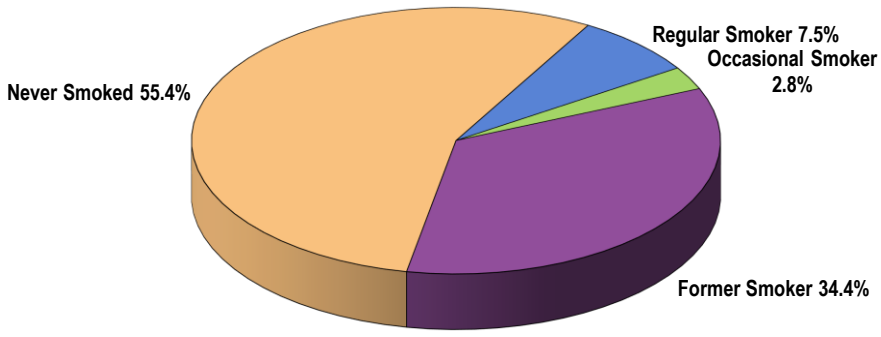
- Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 10.3% of RGH Service Area adults currently smoke cigarettes, either regularly (7.5% every day) or occasionally (2.8% on some days).

Cigarette Smoking Prevalence
(RGH Service Area, 2016)

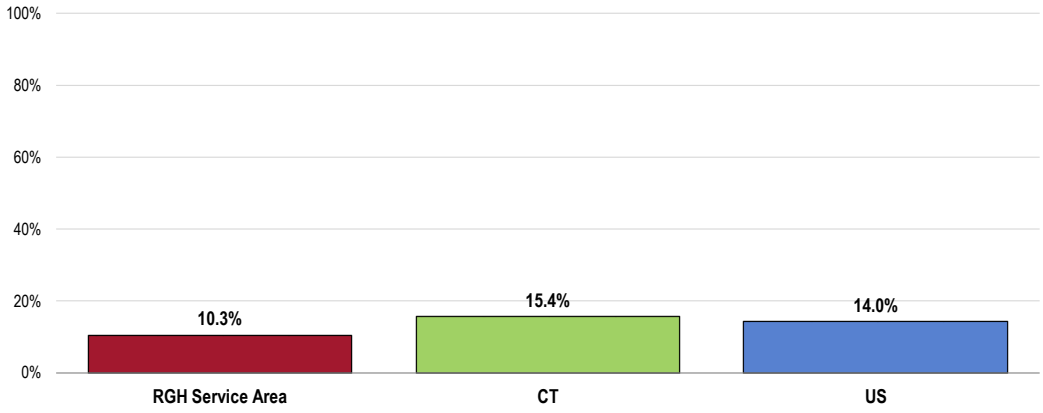


Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
Notes: • Asked of all respondents.

- Lower than the Connecticut prevalence.
- Similar to 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]

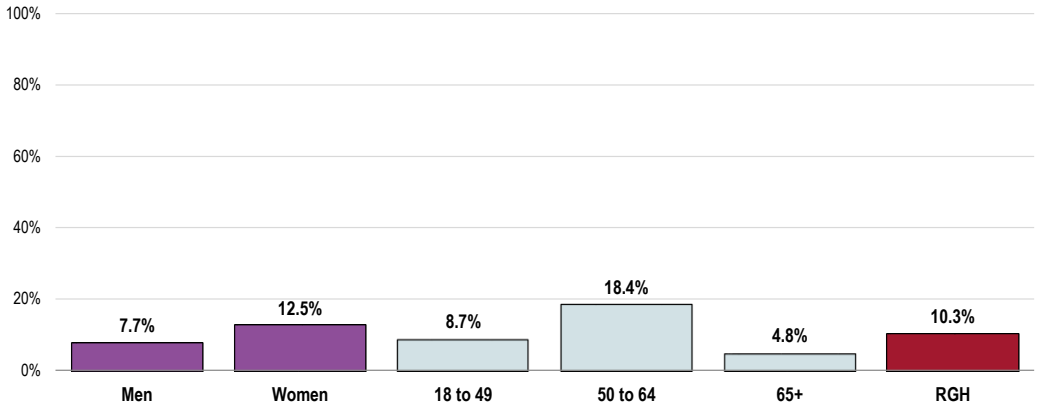
Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

- Cigarette smoking in the service area is more prevalent among adults age 50 to 64.

Current Smokers

(RGH 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]

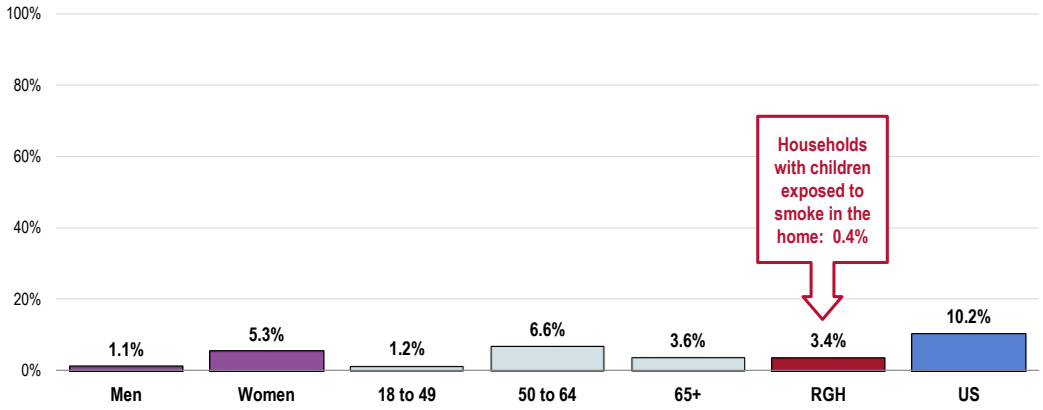
Notes:
- Asked of all respondents.
- Includes regular and occasion smokers (every day and some days).

Environmental Tobacco Smoke

A total of 3.4% of RGH 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.

- Well below the national figure.
- Just 0.4% of RGH Service Area children are exposed to cigarette smoke at home, a fraction of that reported nationally.
- Variations by gender and age in the chart below are not statistically significant.

Member of Household Smokes At Home
(RGH Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 58, 184]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

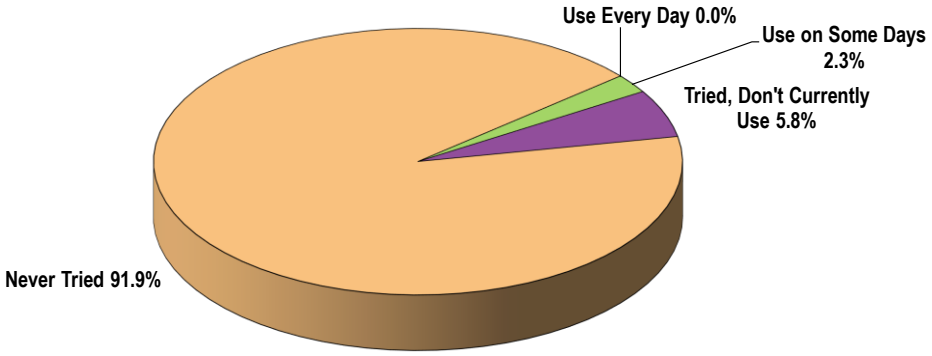
Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Other Tobacco Use

Electronic Cigarettes

Just 2.3% of RGH Service Area adults currently use electronic cigarettes ("e-cigarettes") occasionally [no survey respondents use them daily].

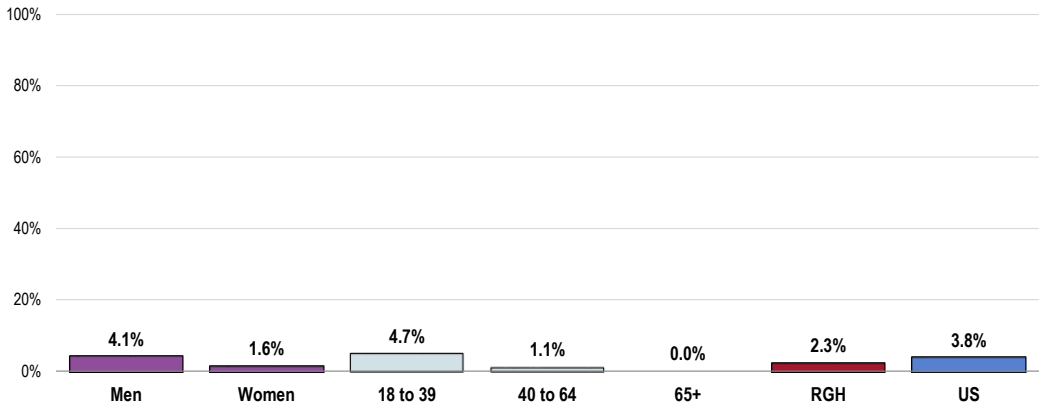
Electronic Cigarette Use
(RGH Service Area, 2016)



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 208]
Notes: ● Asked of all respondents.

- Similar to the US figure.
- The variations by gender and age are not statistically significant.

Currently Use Electronic Cigarettes
(RGH Service Area, 2016)



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 208]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
● Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Cigars & Smokeless Tobacco

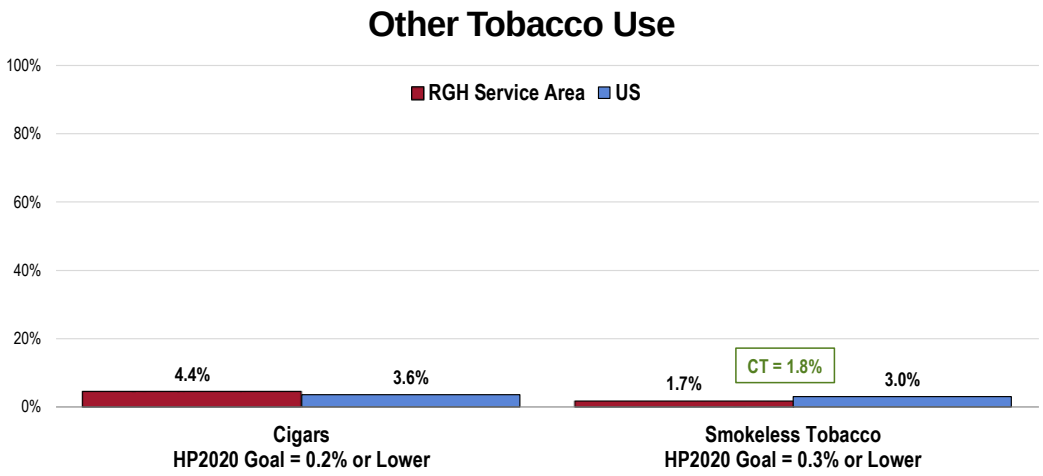
A total of 4.4% of RGH Service Area adults use cigars every day or on some days.

- Similar to the national percentage.
- Fails to satisfy the Healthy People 2020 target (0.2% or lower).

Examples of smokeless tobacco include chewing tobacco, snuff, or "snus."

A total of 1.7% of RGH Service Area adults use some type of smokeless tobacco every day or on some days.

- Comparable to the state and national percentages.
- Comparable to the Healthy People 2020 target (0.3% or lower).



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

One key informant explained their rating of this issue as a "major problem" for reasons related to the following:

Incidence/Prevalence

> *Tobacco is sold widely throughout the community and despite the cost, sales are very high. Young people, fully armed with knowledge of the dangers still use tobacco. – Public Health Representative*

Access to Health Services

Professional Research Consultants, Inc.

Health Insurance Coverage

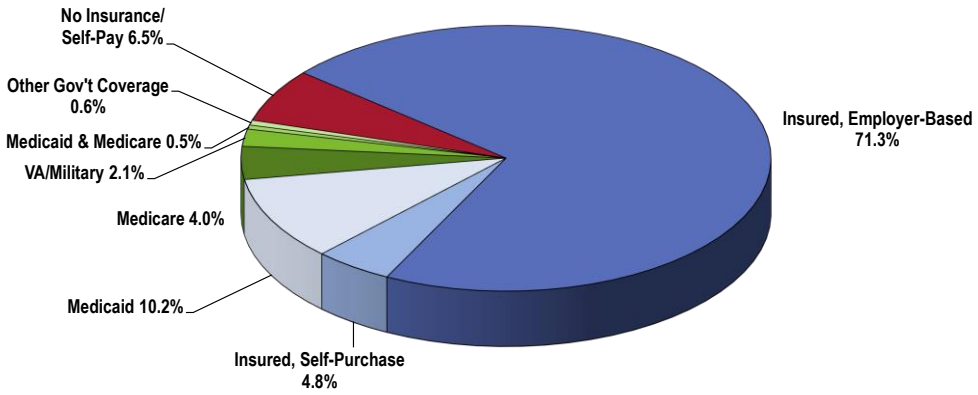
Type of Healthcare Coverage

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

A total of 76.1% of RGH Service Area adults age 18 to 64 report having healthcare coverage through private insurance. Another 17.4% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Healthcare Insurance Coverage

(Among Adults Age 18-64; RGH Service Area, 2016)



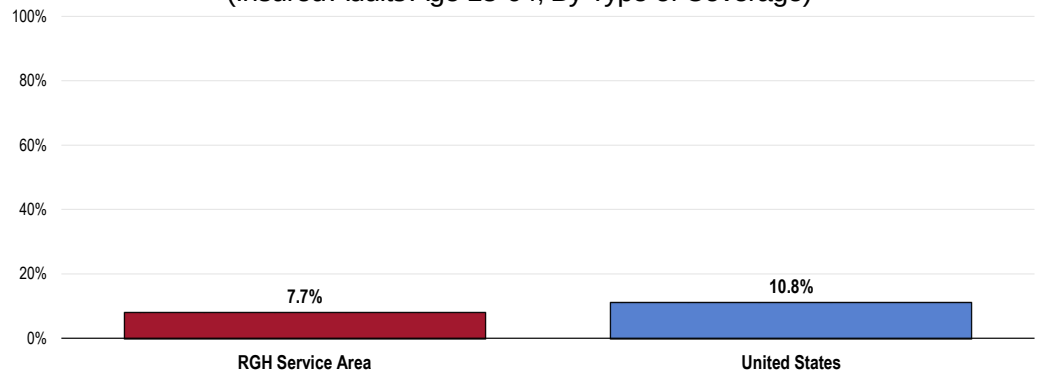
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
Notes: ● Reflects respondents age 18 to 64.

A total of 7.7% 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.

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, 6.5% report having no insurance coverage for healthcare expenses.

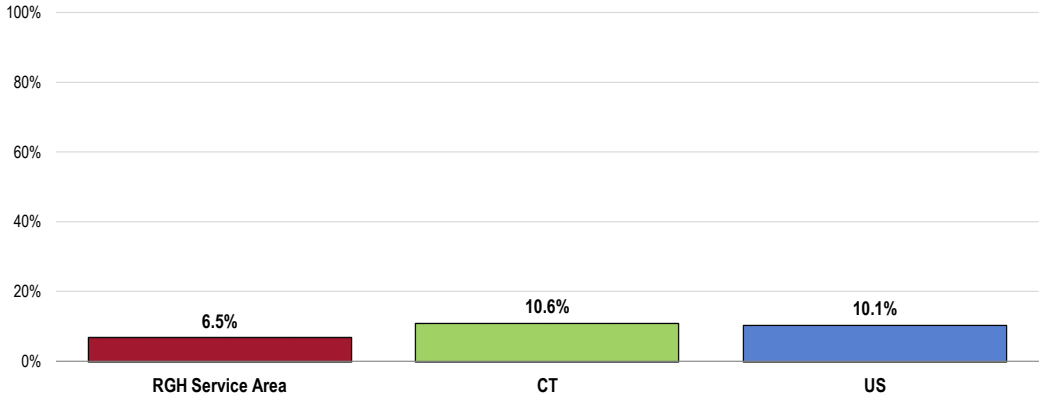
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

- Comparable to state and national findings.
- 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)

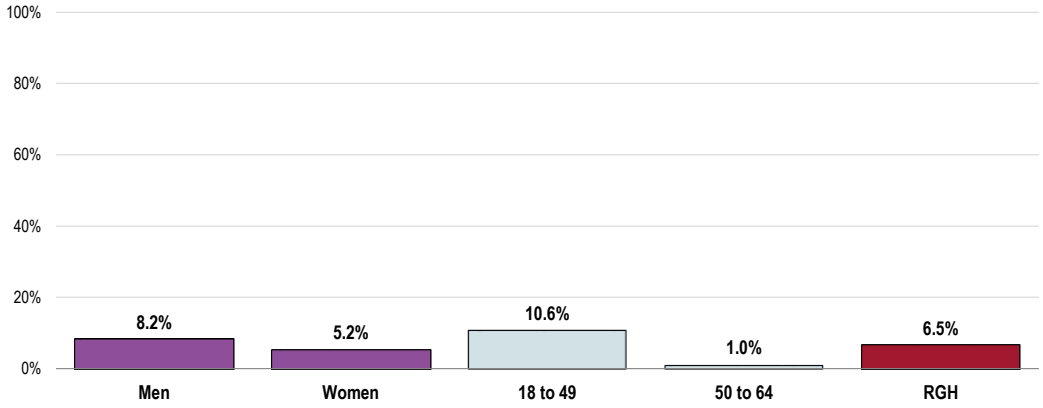


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Connecticut data.
- 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.

- The proportion of uninsured adults does not vary significantly by gender or age in the service area.

Lack of Healthcare Insurance Coverage
(Among Adults Age 18-64; RGH 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.

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)

Difficulties Accessing Services

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.

A total of 28.8% of RGH Service Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

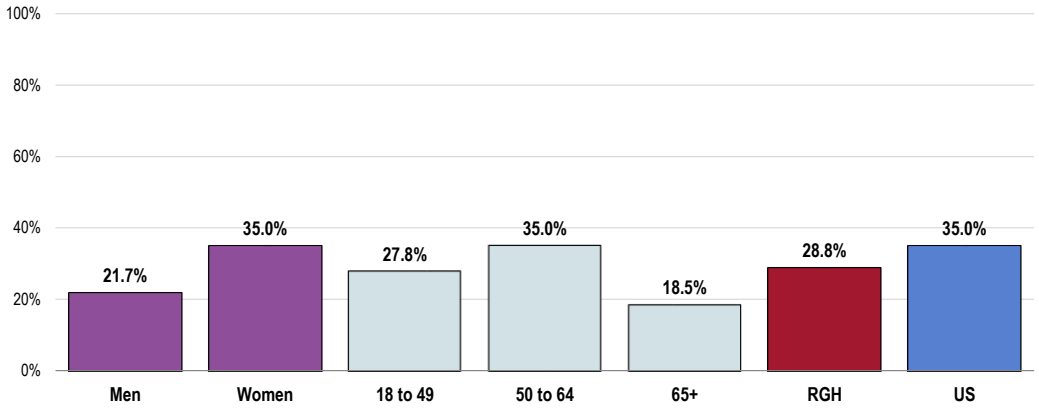
- Comparable to the US figure.

Note that the following demographic groups more often report difficulties accessing healthcare services:

- Women.
- Adults age 50 to 64.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year

(RGH Service Area, 2016)



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.

Barriers to Healthcare Access

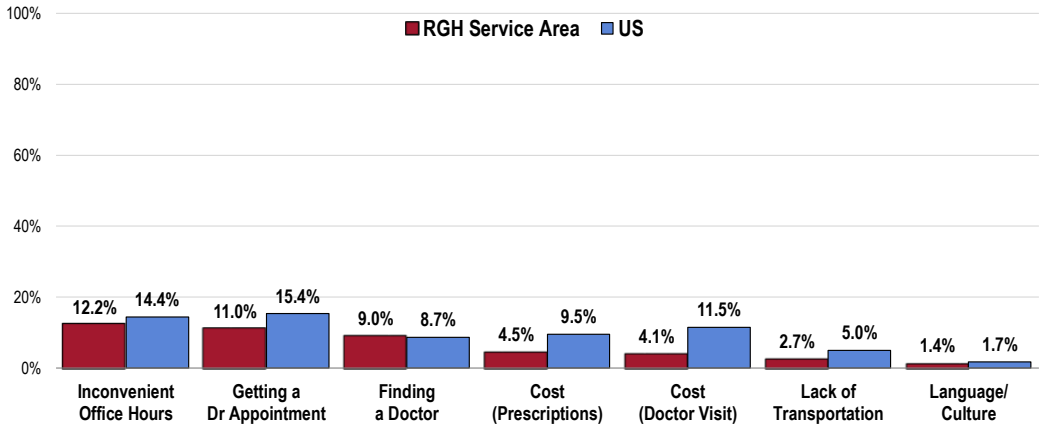
Of the tested barriers, inconvenient office hours impacted the greatest share of RGH Service Area adults (12.2% report that office hours prevented them from seeing a physician at some point in the past year).

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.

- The proportion of RGH Service Area adults impacted was statistically comparable to or better than that found nationwide for each of the tested barriers.

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.

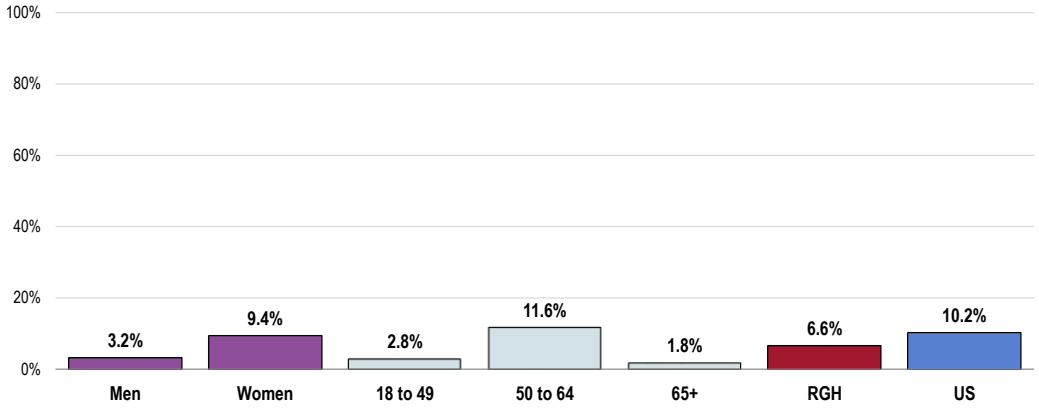
Prescriptions

Among all RGH Service Area adults, 6.6% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.

- Similar to national findings.
- Residents age 50 to 64 are more likely to have skipped or reduced their prescription doses.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money

(RGH Service Area, 2016)



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.

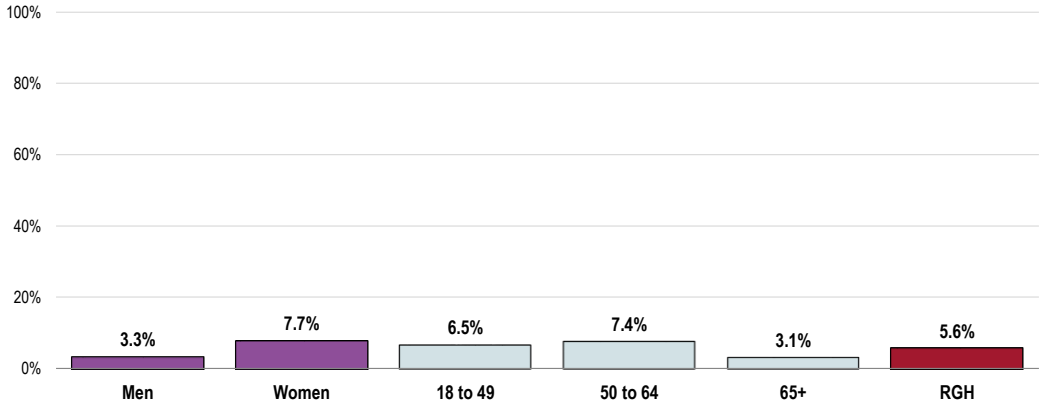
Prohibitive Deductibles & Co-Pays

Among insured adults in the service area, 5.6% indicate that the size of their deductible or co-pay prevented them from obtaining medical care in the past year.

- The prevalence does not vary significantly by gender or age.

Size of Deductible or Co-Pay Prevented Medical Care in the Past Year

(Insured Adults; RGH 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.

Accessing Healthcare for Children

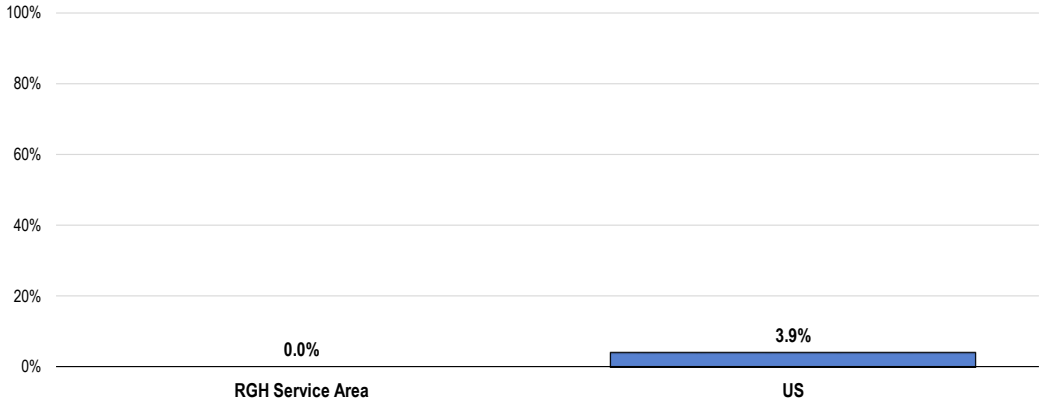
Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

None of the parents surveyed say there was a time in the past year when they needed medical care for their child, but were unable to get it.

- Well below that reported nationwide.

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. [Item 136]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Access to Healthcare Services

Neither participating key informant rated this issue as a “major problem” in the community.

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?"

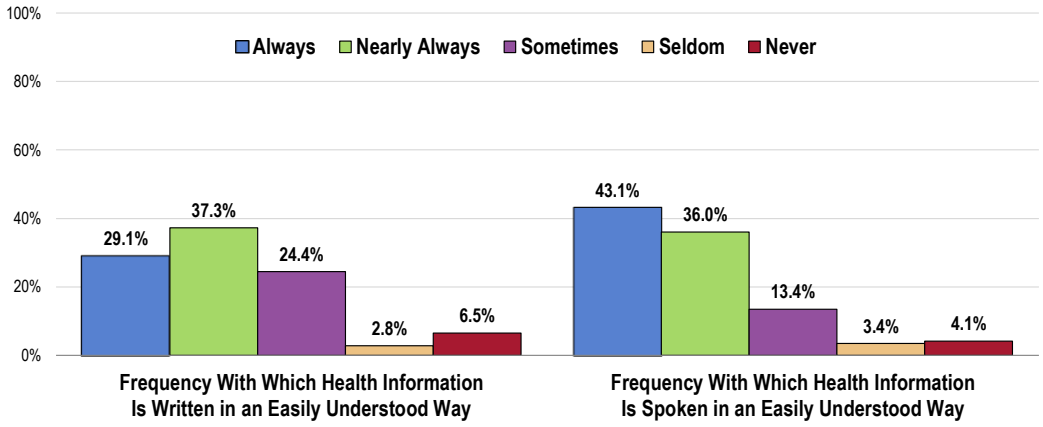
When asked about the frequency with which health information is written in an easily understood way, 66.4% of RGH Service Area adults said "always" or "nearly always."

- On the other hand, 33.7% of RGH Service Area adults consider **written** health information to be difficult to understand, including 6.5% who gave "never" reports.

When asked about spoken health information, 79.1% stated that this is "always" or "nearly always" easy for them to understand.

- On the other hand, 20.9% of RGH Service Area adults consider **spoken** health information to be difficult to understand, including 4.1% who gave "never" reports.

Understanding Health Information
(RGH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 87, 89]
Notes: • Asked of all respondents.

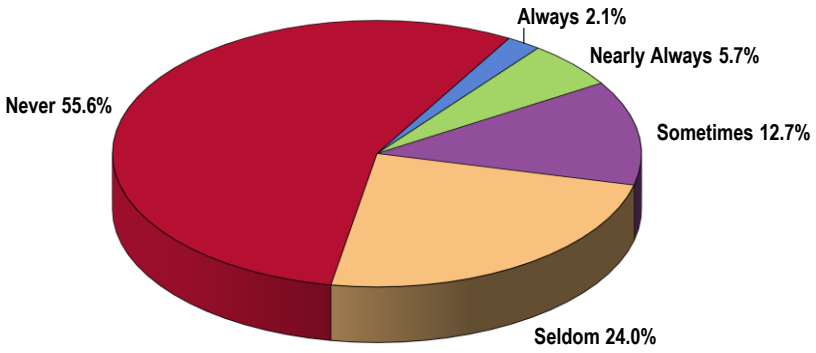
Help Reading Health Information

A total of 79.6% of RGH Service Area adults report "seldom" or "never" needing help reading health information.

- Another 12.7% of community adults "sometimes" need someone to help them read health information.
- Note that 7.8% of residents "always" or "nearly always" need help reading health information.

Frequency of Needing Someone to Help Read Health Information

(RGH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 88]
Notes: • Asked of all respondents.

Completing Health Forms

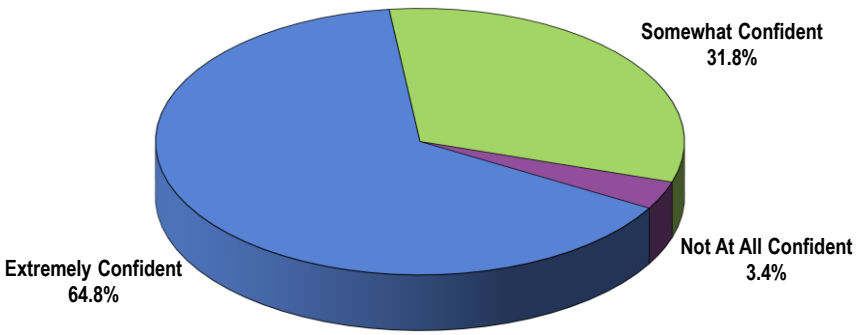
Asked to describe their confidence in filling out health forms, most survey respondents are "extremely confident" (64.8%).

Examples of health forms include insurance forms, questionnaires, doctor's office forms, and other forms related to health and healthcare.

- Another 31.8% of community adults are "somewhat confident" in their own ability to fill out health forms.
- However, 3.4% of respondents gave "not at all confident" ratings.

Self-Perceived Confidence in Ability to Fill Out Health Forms

(RGH Service Area, 2016)



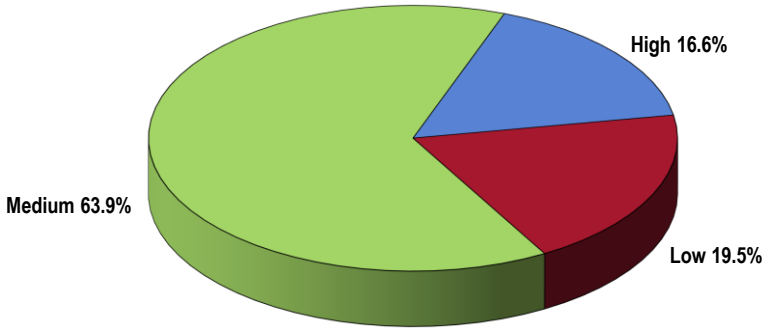
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 90]
Notes: • Asked of all respondents.
• In this case, health forms include insurance forms, questionnaires, doctor's office forms, and other forms related to health and healthcare.

Population With Low Health Literacy

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.

Among RGH Service Area survey respondents, 16.6% are considered to be of high health literacy, while 63.9% have medium health literacy, and the remaining 19.5% are considered to be of low health literacy.

Level of Health Literacy
(RGH Service Area, 2016)

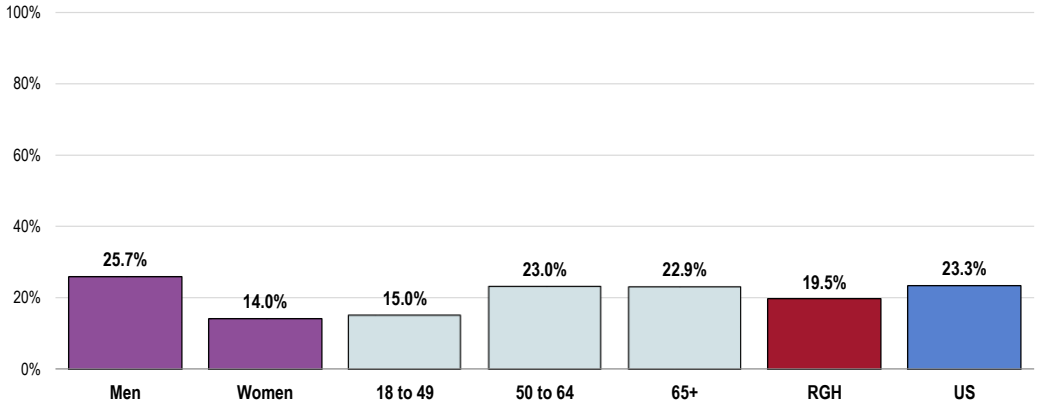


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]

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 low health literacy is similar to the national average.
- Service area men are more likely to have low health literacy levels.

Low Health Literacy
(RGH Service Area, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

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.

Primary Care Services

About Primary Care

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

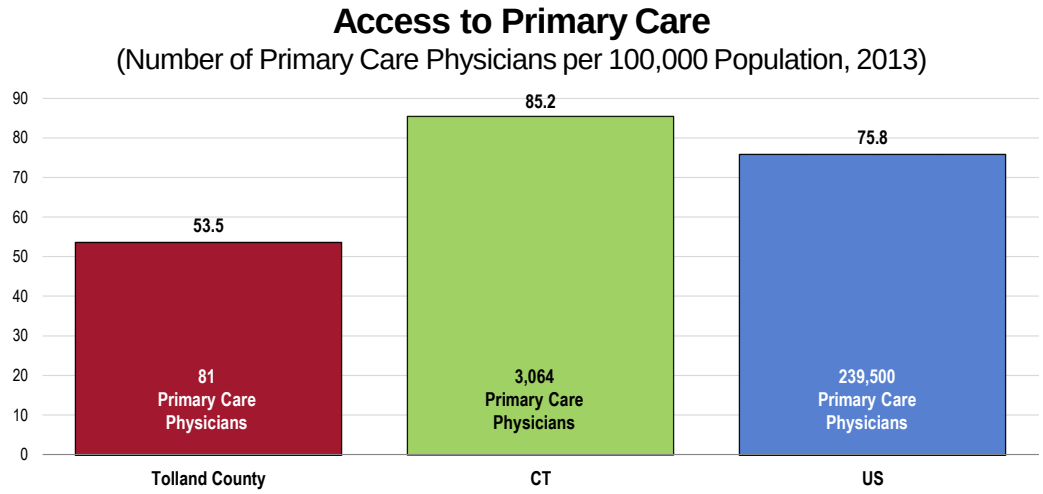
Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

- Healthy People 2020 (www.healthypeople.gov)

Access to Primary Care

In Tolland County in 2013, there were 81 primary care physicians, translating to a rate of 53.5 primary care physicians per 100,000 population.

- Below 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 82.8% of RGH Service Area adults were determined to have a specific source of ongoing medical care.

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

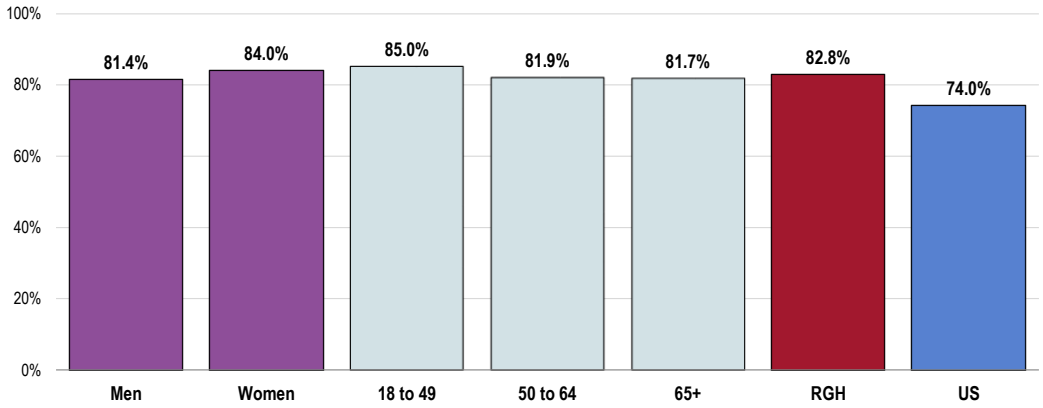
A hospital emergency room is not considered a specific source of ongoing care in this instance.

- Above the national percentage.
- Fails to satisfy the Healthy People 2020 objective (95% or higher).
- No statistical difference by age or gender in the service area.

Have a Specific Source of Ongoing Medical Care

(RGH Service Area, 2016)

Healthy People 2020 Target = 95.0% or Higher



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 191-193]
- 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.

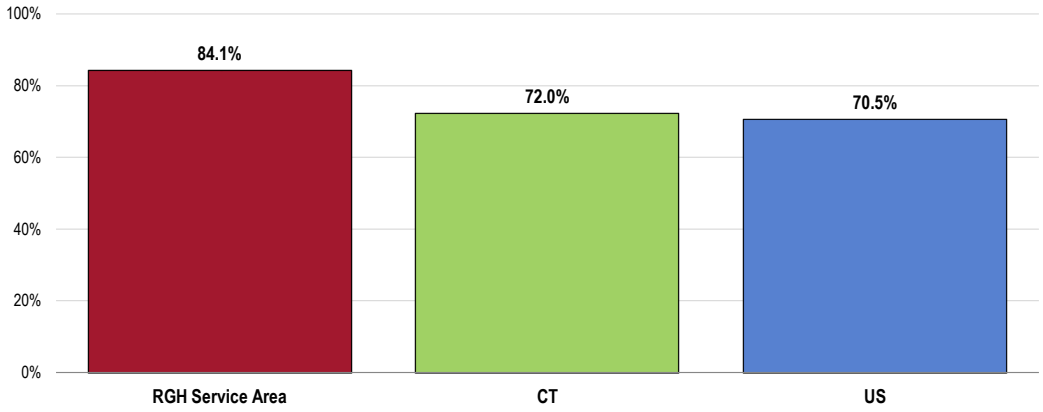
Utilization of Primary Care Services

Adults

Most service area adults (84.1%) 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



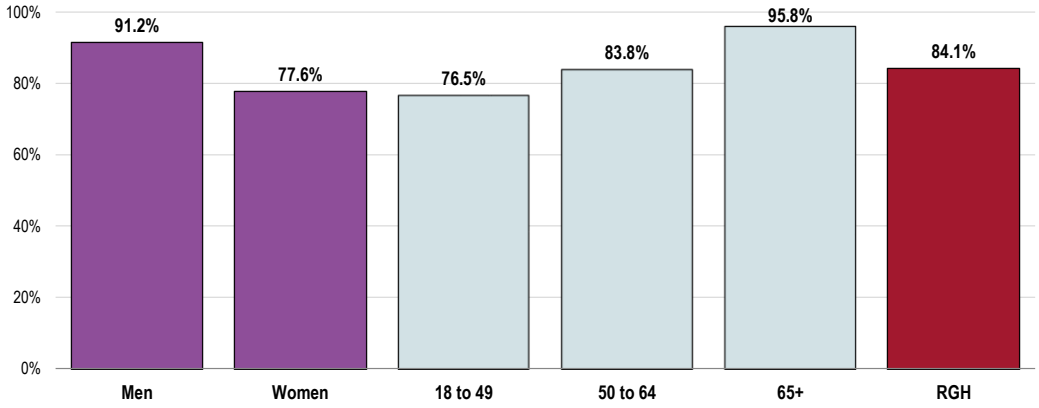
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Connecticut data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

- Women and adults under age 65 are less likely to have received routine care in the past year.

Have Visited a Physician for a Checkup in the Past Year

(RGH Service Area, 2016)



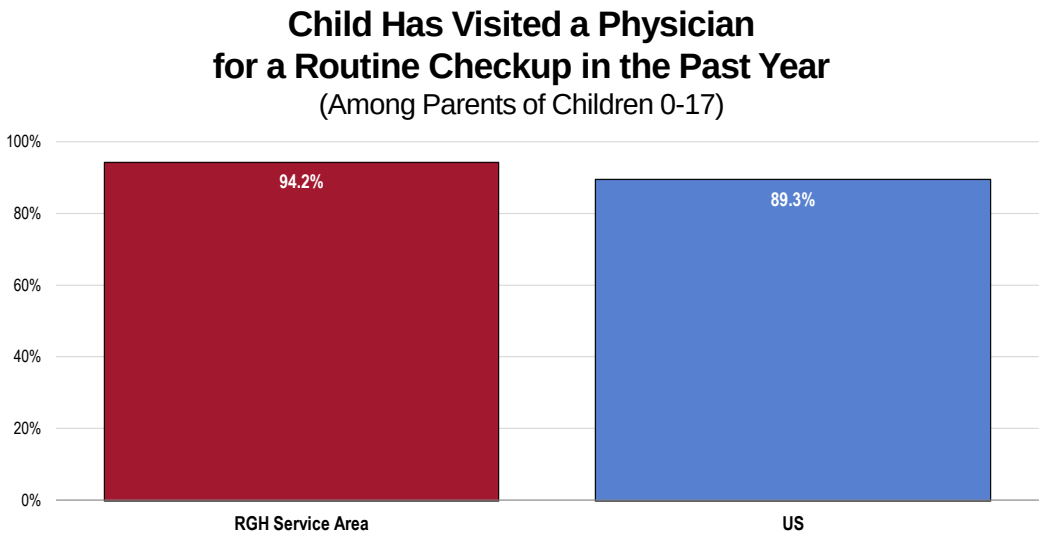
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Children

Among surveyed parents, 94.2% report that their child has had a routine checkup in the past year.

- Similar to the national findings.



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 8.2% of RGH Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

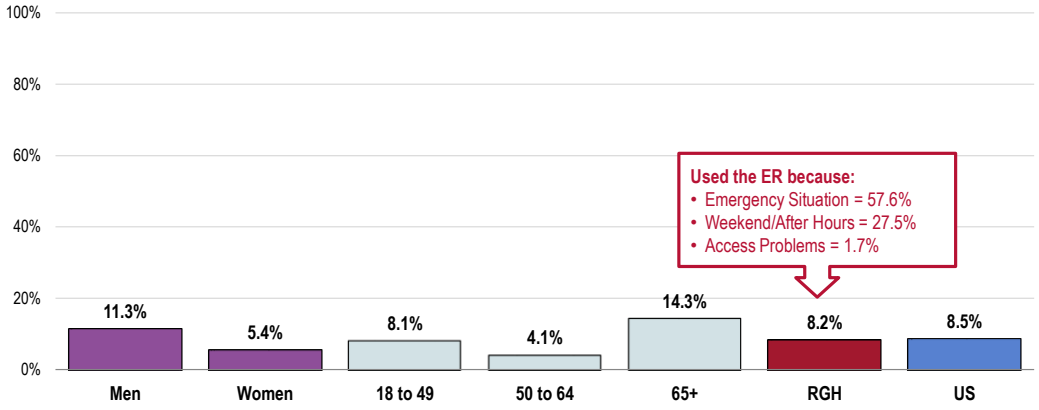
- Comparable to the US figure.

Of those using a hospital ER, 57.6% say this was due to an **emergency or life-threatening situation**, while 27.5% indicated that the visit was during **after-hours or on the weekend**. A total of 1.7% cited **difficulties accessing primary care** for various reasons.

- Seniors (age 65+) 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

(RGH Service Area, 2016)



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 22-23]
Notes: • Asked of all respondents.

Advance Directives

A total of 38.9% of RGH Service Area adults have completed Advance Directive documents.

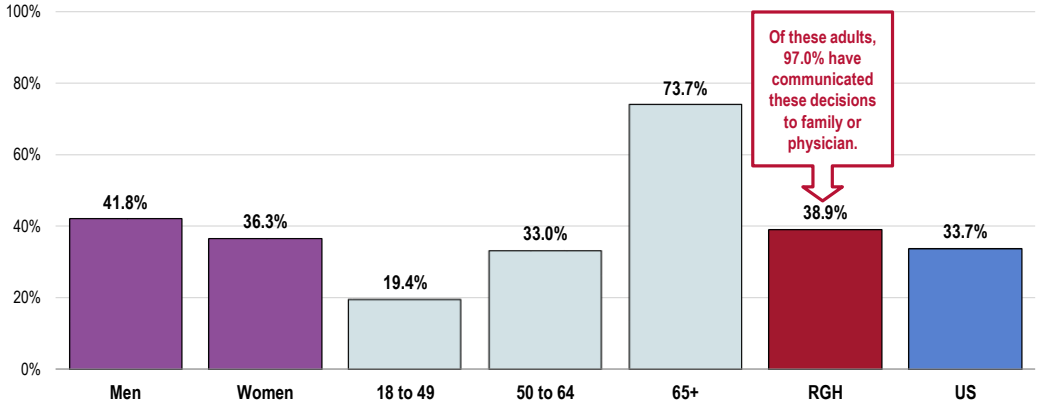
An Advance Directive document is a set of directions given about the medical health-care a person wants if he/she ever loses the ability to make those decisions. Formal Advance Directives include Living Wills and Healthcare Powers of Attorney.

- The prevalence is statistically similar to the US figure.
- Of those local adults who have completed Advance Directive documents, 97.0% have communicated these decisions to family and/or a physician.
- Young adults are less likely to have filled out Advance Directive documents (positive correlation with age).

An Advance Directive document is a set of directions given about the medical health-care 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.

Have Completed Advance Directive Documents

(RGH Service Area, 2016)



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.

Oral Health

About Oral Health

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: **tobacco use; excessive alcohol use;** and **poor dietary choices**.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

- Healthy People 2020 (www.healthypeople.gov)

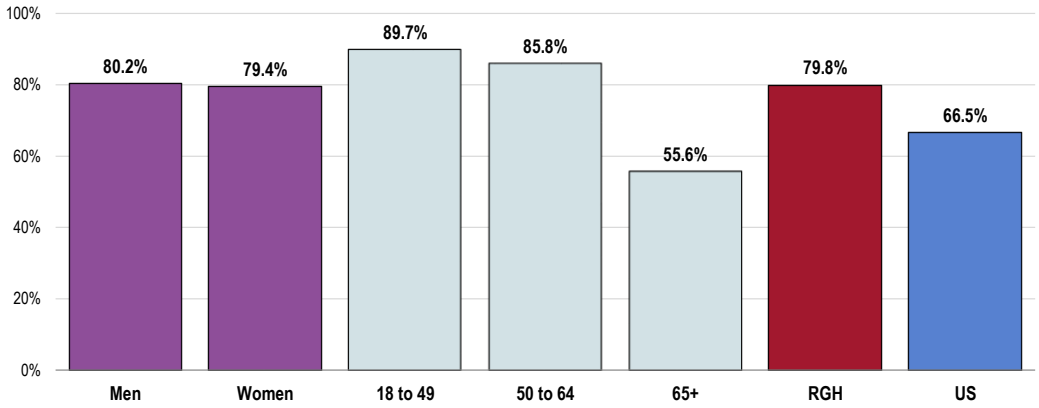
Dental Insurance

A full 8 in 10 RGH Service Area adults (79.8%) have dental insurance that covers all or part of their dental care costs.

- Well above the national finding.
- Seniors are less likely to be covered by dental insurance (negative correlation with age).

Have Insurance Coverage That Pays All or Part of Dental Care Costs

(RGH Service Area, 2016)



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.

Dental Care

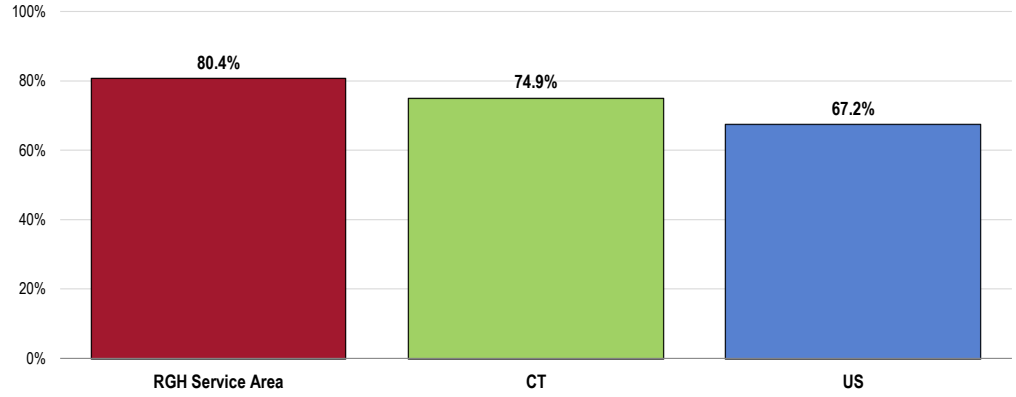
Adults

80.4% of 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



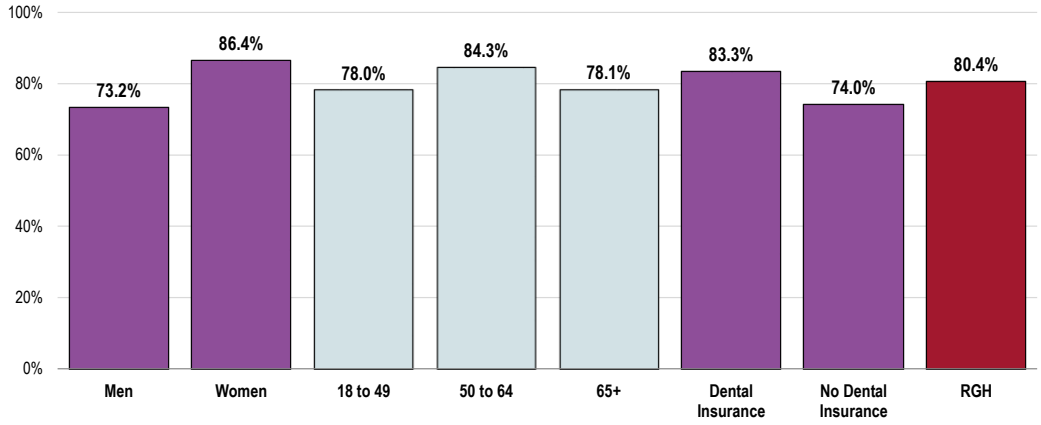
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]
- Behavioral 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:

- Men in the service area report lower utilization of oral health services than do women.
- 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
(RGH 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.

Children

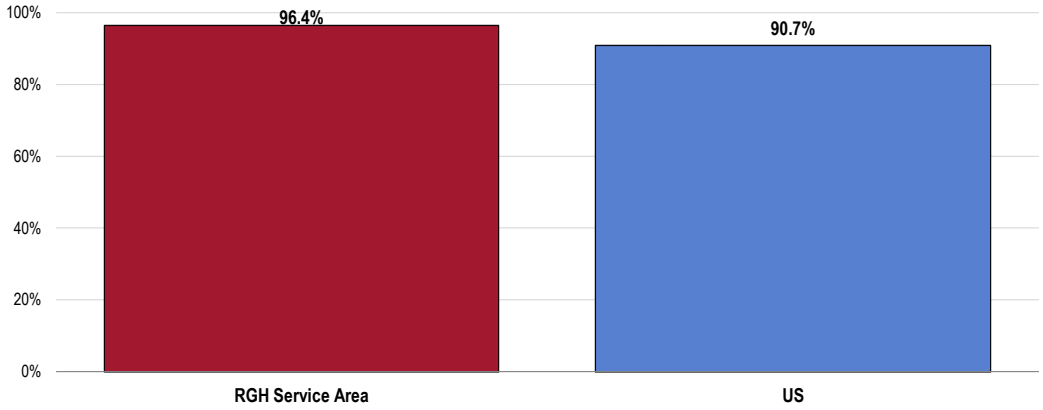
A total of 96.4% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

- 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

Neither participating key informant rated this issue as a “major problem” in the community.

Vision Care

RELATED ISSUE:

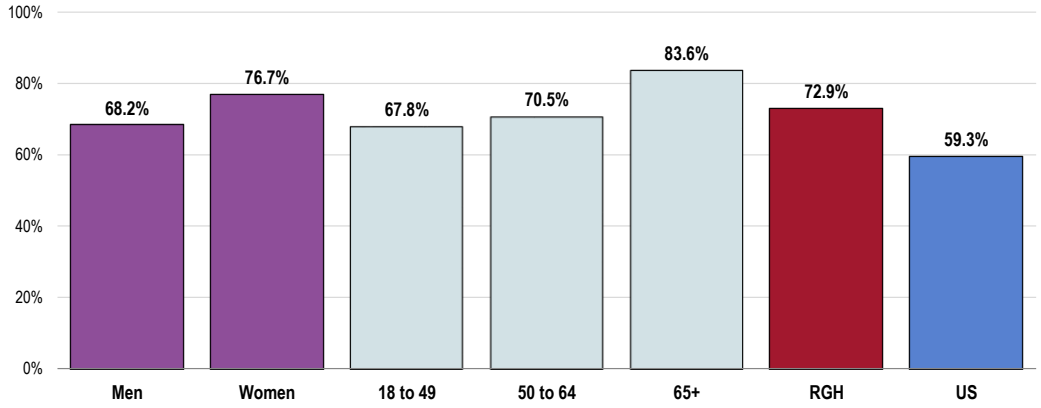
See also Vision & Hearing in the **Death, Disease & Chronic Conditions** section of this report.

A total of 72.9% of RGH Service Area residents had an eye exam in the past two years during which their pupils were dilated.

- Well above the national figure.
- Recent vision care in the RGH Service Area is more often reported among seniors.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

(RGH Service Area, 2016)



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.

Local Resources

Professional Research Consultants, Inc.

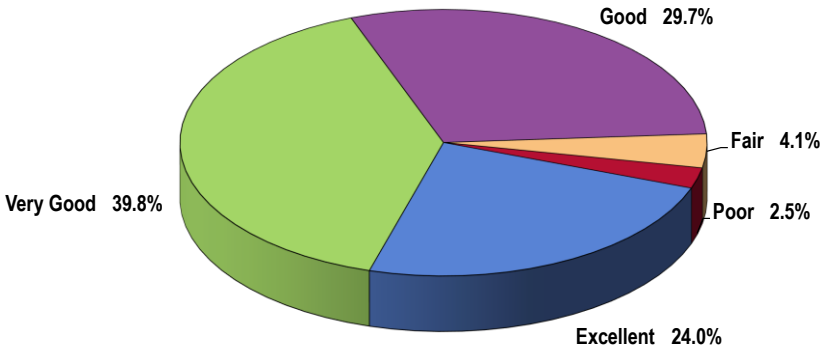
Perceptions of Local Healthcare Services

Over 6 in 10 service area adults (63.8%) rate the overall healthcare services available in their community as "excellent" or "very good."

- Another 29.7% gave "good" ratings.

Rating of Overall Healthcare Services Available in the Community

(RGH Service Area, 2016)



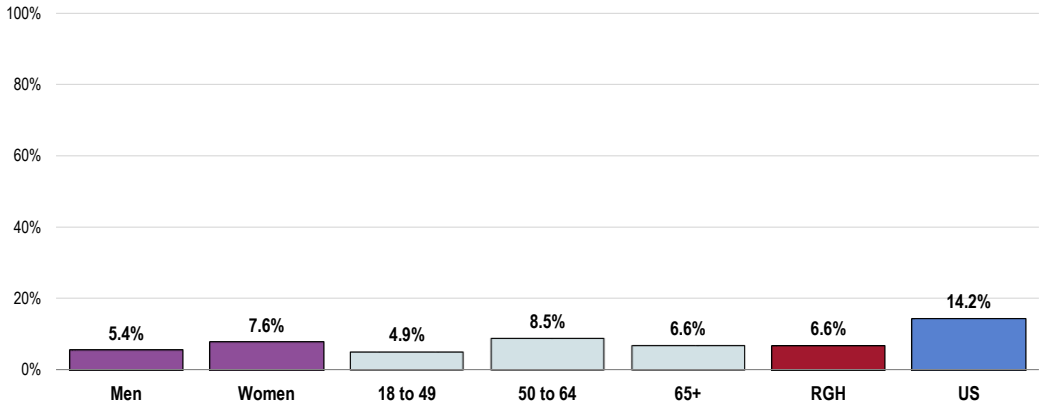
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: • Asked of all respondents.

However, 6.6% of residents characterize local healthcare services as "fair" or "poor."

- Well below the US benchmark.
- Statistically similar findings by gender and age.

Perceive Local Healthcare Services as "Fair/Poor"

(RGH Service Area, 2016)



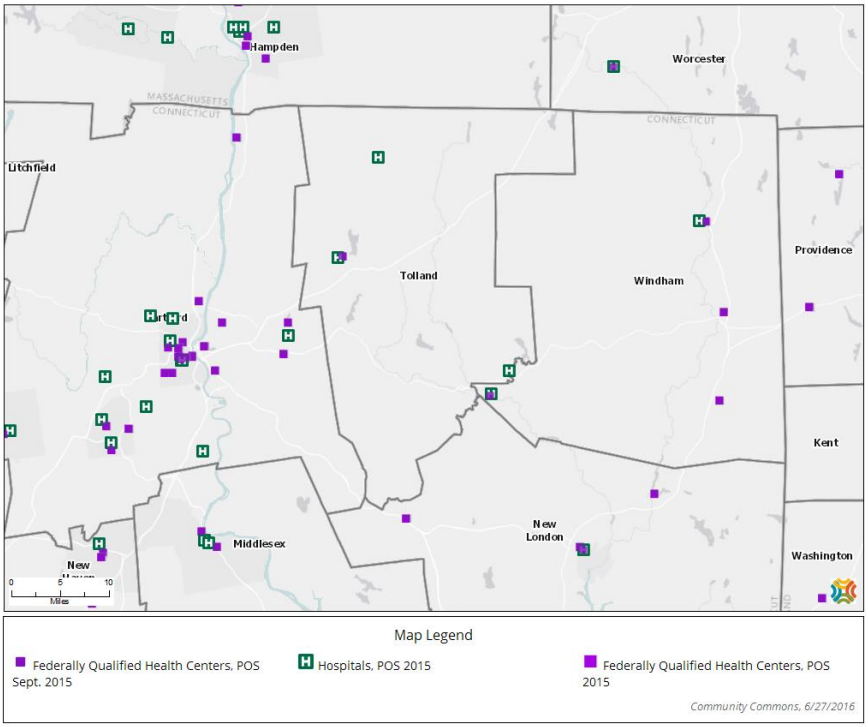
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Healthcare Resources & Facilities

Hospitals & Federally Qualified Health Centers (FQHCs)

The following map details the hospitals and Federally Qualified Health Centers (FQHCs) within Tolland County as of September 2015.

Hospitals and Federally Qualified Health Centers, POS Sept. 2015



Map Legend

Federally Qualified Health Centers, POS Sept. 2015

Hospitals, POS 2015

Federally Qualified Health Centers, POS 2015

Community Commons, 6/27/2016

Resources Available to Address the Significant Health Needs

Resources were identified by participants of the Online Key Informants Survey. This list is limited due to the low participation. Participants identified the following as available to address the significant health needs identified in this report:

- Doctor's Offices
- Health Department
- Hospitals
- Rockville General Hospital
- Senior Center