Hartford HealthCare
Windham Hospital

CHNA

Community Health Needs Assessment

and Implementation Plan

2025

Letter from Hartford HealthCare

Dear Reader,

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

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

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

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

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

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

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

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

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

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

In good health,

Sarah S. Lewis
Chief Health Equity Officer
Hartford HealthCare

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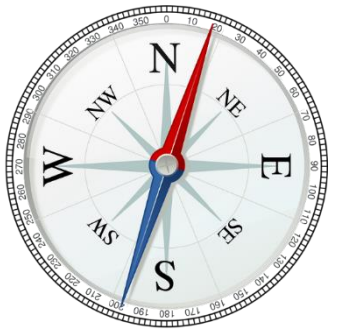
The Purpose of the Community Health Needs Assessment and the Structure of this Document

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

Needs Assessment "Compass" or "Roadmap"

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



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

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

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

The Regional, Collaborative, and Inclusive Approach

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

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

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

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

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

"What did we Learn?" – Executive Summary

Background

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

Process / Methodology

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

- Data from the Connecticut Hospital Association, the U.S. Census Bureau, the March of Dimes, the SEER Database, the ALICE database, DataHaven, and many others
- Stakeholder one-on-one interviews with community members, providers, Public Health officials, community based organizations
- Group Discussions and prioritization meetings with the Board of Directors, community members, providers, community based organizations
- The Community Well-being Survey
- Quantitative and qualitative research with Public Health officials and agencies

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

Access to Healthcare Services

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

Socio-economic Factor Impacting Healthcare

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

Behavioral Health Barriers

Behavioral health and substance use treatment issues are widespread and impact all facets of life. Stakeholders emphasized the importance of addressing socio-economic issues simultaneously since the interrelationship is directly connected. Issues relating to reducing stigma, mental health and substance use early intervention and treatment, and the need to improve access to services are common. Additionally, there is a need for increased staffing, enhanced community outreach, and better communication about available resources.

Chronic Health Conditions

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

Results

Within these key themes, the hospital deployed quantitative and qualitative methods to arrive at a prioritized list of specific health needs. Windham Hospital's 2025 priorities distill the wide-ranging 2022 needs list into four strategic categories— health-related socio economic factors, mental / behavioral health, access to care/chronic disease, and maternal health. The prioritized list of needs follows:

Aggregated Needs By Tier For Windham Hospital
Health-related Socio Economic Factors / Increased Workforce Capacity
Mental Behavior Health Services, Substance Use, Emergency Dept. Improvements
Access To Care /Physical Health Chronic Disease Preventative Care Initiatives Outreach and Resources Awareness Community Health Education
Maternal Health – Women's Health Services

Specifically, note the following:

- **Consolidation of Specific Services:** In 2022, priorities included targeted needs like inpatient SUD beds, transportation, gero-psych, and youth prevention. In 2025, priorities fell into broader categories such as "Mental/Behavioral Health" and "Access to Care/Physical Health."
- **Workforce Emphasis Elevated:** While 2022 noted recruitment and retention with DEI awareness, the 2025 list explicitly expands this into "Health-related Socio-Economic Factors / Increased Workforce Capacity," elevating workforce challenges as a core community-level determinant.
- **New Focus on Maternal and Women's Health:** In 2025, there was a notably stronger emphasis on "Maternal Health / Women's Health Services" as a stand-alone category, reflecting increased recognition of women's health as a distinct community priority.

2022 Final Prioritized List of Needs

Aggregated Needs By Tier For Windham Hospital
Inpatient Substance Use Disorder Treatment Beds
Mental Health And Substance Use Disorder Transition Care For Inmates Being Released From Jail
Transportation For All Community Members Needing but Unable To Get To Healthcare Services
Outpatient Mental Health Services Capacity for Adults, Adolescents, and Children – Including in-home and caregiver support – Including in-home and caregiver support
Recruit And Retain Medical and Mental Health Care Staff With DEI Awareness
Coordinated Efforts Between Larger Health Systems And Community-Based Health Services To Care For People With More Complicated Medical Needs
Substance Use Prevention Initiatives For Youth
Gero-Psych And Dementia Care
Focused Initiatives Addressing Chronic Health Conditions
Access to Healthy, Affordable Food
Additional Programs To Enhance Access to Care For Lower-income Families
Broad-based, integrated services --- Medical, Mental Health, Substance Use Disorder, HRSN – for People and Families Experiencing Homelessness
Care Coordination and Support to Help Manage Care for Patients With Complex Health Conditions
Enhanced Collaboration with Community Partners
Substance Use Disorder Crisis Care and Treatment

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

Introduction – About Hartford HealthCare

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

Windham Hospital is part of Hartford HealthCare, Connecticut's most comprehensive healthcare network. Windham Hospital and The William W. Backus Hospital (Backus) in Norwich are part of the East Region of HHC, which has seven acute care hospitals in five geographic regions across Connecticut. As part of its mission “to improve the health and healing of all,” Hartford HealthCare and its hospitals conduct a Community Health Needs Assessment (CHNA) every three years. This process includes working with community members to systematically identify community health priorities and create a plan for addressing them. This report shares the results from the current assessment of health needs in the community served by Windham Hospital and the implementation plan to address those needs from 2026–2028. This report also highlights the hospital’s 2023–2025 activities to address needs identified in the 2022 assessment.

People’s health varies greatly across geographic and socioeconomic lines. Further, people’s trust in healthcare varies, often due to an inability to access timely and high-quality care or a lack of understanding about what’s available to them. The CHNA/CHIP processes are grounded in Hartford HealthCare’s mission “to improve the health and healing of all” and its Vision “to be most trusted for personalized coordinated care.” In addition to its mission, vision and values, Hartford HealthCare has also adopted the following Health Commitment: “We commit to specific actions that measurably improve access, intentionally eliminate barriers, and create opportunities for all.”

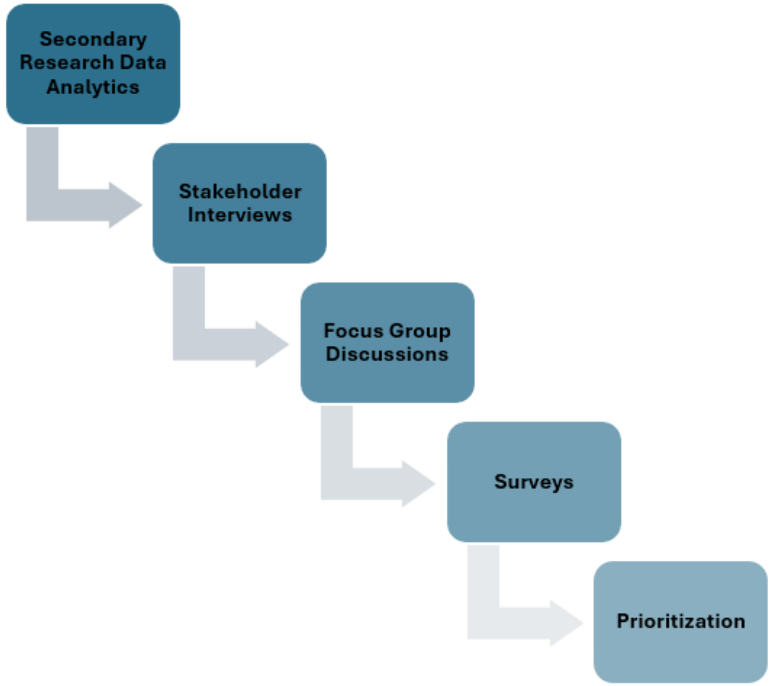
"What information did we collect and how did we identify community needs?"

CHNA Process Overview and Timeline

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

Needs Assessment Research Approach

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



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

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

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

Detailed Research Method

The 2025 CHNA for the Hartford HealthCare East Region of Connecticut was collaboratively conducted with the Health Improvement Collaborative of New London (HIC), Yale New Haven Health System's Lawrence + Memorial (L+M) Hospital, the Eastern Connecticut Health Collaborative (ECHC), and Hartford HealthCare's Backus and Windham Hospitals. These partnerships bring together a broad spectrum of organizations, healthcare providers, and community stakeholders, fostering collaboration to address the unique needs of the region. This collective effort reflects a shared commitment to understanding and addressing the health and well-being of residents across the East Region of Connecticut.

- Secondary research: Research included collection and analysis of existing data from the U.S. Centers for Disease Control and Prevention (CDC), the U.S. Census Bureau, the SEER database, and others. Highlights are included later in this assessment, and the appendices contain a more expansive array, for additional reference.
- Primary research (quantitative) – The Community-Based Assets and Needs Survey (CBANS) [also known as the Wellbeing Survey]: Connecticut hospitals along with the Connecticut Hospital Association negotiated with DataHaven to create a shortened version of its Well Being survey in order to be able to enlist the voices of more community members. Yale New Haven Health and HHC worked together on the inclusion of survey questions, translation of the survey into different languages, how to capture hospital service areas, and survey dissemination. In the area covered by HHC's East Region, both hospital systems worked in step with the two local health collaboratives to disseminate the survey to the community through food pantries, community events, social media, Community Benefit Organization daily operations, etc. This survey and this work enabled the East Region to eliminate the "not applicable" designation (apparent in past results) for many racial and ethnicity data points due to a previous lack of survey sample size.
- Primary research (qualitative): In addition to innovating the way data was collected in the East Region and ensuring unbiased samples, the collective (mentioned above) worked together to conduct 26 focus groups and 25 stakeholder interviews throughout the entire region. The collaboratives provided contact and suggestions on whom from the community to interview or attend focus groups. For organizations who were part of both collaboratives, their interviews or focus groups were facilitated by the leaders of those collaboratives. Organizations that were specific to only one collaborative were facilitated by the hospital and collaborative leader associated with that specific collaborative.

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

The Windham Hospital service area — encompassing the towns of Chaplin, Columbia, Coventry, Hampton, Lebanon, Mansfield, Scotland, and Windham — represents a distinct region within Connecticut, characterized by its blend of rural landscapes, small-town communities, and rich cultures. Unlike more densely populated or urbanized parts of the state, the area features a more dispersed population, limited public transportation infrastructure, and a higher proportion of residents facing economic hardship. The region is home to both long-established communities and a growing number of new, culturally rich communities, particularly in Windham.

The region is, in part, characterized by rural healthcare challenges, as well as some of the benefits offered by a more rural setting. There are some challenges due to its proximity to major metro regions, yet the presence of institutions like Quinebaug Valley Community College, Eastern Connecticut State University in Windham and the University of Connecticut in nearby Storrs (adjacent to Mansfield) brings a dynamic, younger population and opportunities for community-academic partnerships. These unique factors shape the community’s health profile and highlight the benefits of locally responsive strategies to improve community health.

As noted, Hartford HealthCare used a regional approach to enhance the efficiency of the needs assessment process, better understand the unique needs of each region it serves. This section frames community health status and serves as a research-based platform to launch or enhance initiatives to improve community well-being. Specifically, the section focuses on the following:

- Identifying available resources, existing strengths, and obstacles to improving health outcomes.
- Gaining deeper insight into barriers to healthcare access, particularly those affecting underserved communities.
- Fostering collaboration among community partners to capitalize on opportunities for population health improvement.

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

Hospital Description and Service Area

Windham Hospital is a 130-bed, not-for-profit acute care community hospital that has continuously provided inpatient, outpatient, rehabilitation, and emergency services in Northeastern Connecticut for more than 75 years. The hospital's oncology care, through the Hartford HealthCare Cancer Institute, includes a state-of-the-art infusion center; the Women's Health Center provides a wide range of critical health services; and The Center for Healthy Aging provides resources for seniors and their caregivers. For more information, please visit www.windhamhospital.org.

In Fiscal Year 2024, the hospital employed close to 600 individuals and had nearly 500 physicians. Windham Hospital had close to 35,000 emergency department visits and performed over 1,600 surgeries. The Lown Institute Hospital Social Responsibility Index has recognized Windham Hospital as the most racially inclusive hospital in Connecticut, and the hospital also earned The Joint Commission Gold Seal of Approval for Advanced Certification for total hip and total knee replacement after demonstrating continuous compliance with performance standards.

Data Notes & Limitations

Health disparities impact, and are impacted by, the conditions in the environments where people are born, live, learn, work, play, worship, and age.[1]

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

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

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

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

[1] Health.gov. How does Healthy People 2030 define health disparities and health equity? Available at: https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2030/questions-answers#q9

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

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

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

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

- Demographic Analysis and Community Input
- Mortality and Morbidity
- Maternal Health
- Life Expectancy
- Health-related Social Factors and Predictive Analytics
- Qualitative Research Highlights
- Community Well-being Survey and Other Research
- Data Analysis and Community Input Summary

Demographic Analysis and Community Input

Demographic and Secondary Research Highlights

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

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

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

- The Windham Hospital CHNA service area is highly rural compared to the state average, yet life expectancy is the same. *See Table 1.*
- The Windham Hospital CHNA service area has a low median age (35.7 years) and a mostly White demographic profile, as the population is less than 3% Black or African American (compared to nearly 11% for the state); the percent Hispanic population is also lower than the state average. *See Table 1.*
- Asian and Hispanic communities in the service area are notably young. Consistent with Connecticut state data, Hispanic residents in the CHNA service area are much younger (median age approximately 25 years) than the state Hispanic average (i.e., 30 years); Black / African American and Asian residents have an even lower median age in the service area (22 years) and the state (35 years). *See Table 2.*
- There are pockets of higher-need areas, even though parts of the Windham Hospital CHNA service area are somewhat affluent. Community members have good educational attainment and income, though both slightly lag state averages. However, nearly two of five households (39.3%) are asset-limited, income-constrained yet employed (“ALICE”). *See Table 3.*
- Mental health challenges (including depression) in the Windham Hospital CHNA service area are notably more prominent than statewide averages. However, most chronic disease conditions are less common in the service area. *See Table 4.*
- Even though chronic disease rates in the hospital CHNA service area tend to be lower than the state averages, preventive screenings are below state rates. *See Table 5.*
- Overall cancer rates are similar between the CHNA service area and the state, but there is tremendous variance by cancer site and race or ethnicity. *See Table 6.*

Community Demographic Profile

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

Table 1: Windham Hospital CHNA Service Area Characteristics

With about 100,000 people, the Windham Hospital CHNA service area is largely rural (62.4%) and much less densely populated (263.9 people per square mile) than the Connecticut state average (12.4% rural and 705.2 people per square mile).

- The service area life expectancy is the same as the state average.

The Windham Hospital CHNA service area has a low median age (35.7 years) and a mostly White demographic profile, as the population is less than 3% Black or African American (compared to nearly 11% for the state); the percent Hispanic population is also lower than the state average.

- One of eight residents (12.2%) is Hispanic – lower than the one of six (17.4%) for the Connecticut average.[2]
- As a percentage of the total population, children under age 5 is low – less than 3% – yet the median age (35.7 years) is also notably lower than the state average (40.9 years).
- The percent of Black or African Americans is about 70% less than the Connecticut average (2.7% and 10.7%, respectively).
- Statewide, approximately one in 20 residents are not proficient in English. In the Windham Hospital CHNA service area, the rate is much lower (about one in 40).

Measure	CHNA Area	State of CT
Total population	103,466	3,611,317
Population density (per square mile)	263.9	705.2
Life expectancy (years)	80.3	80.3
Population living in a rural area (%)	62.4%	12.4%
Age		
Under age 5 (%)	2.8%	5.1%
Over age 65 (%)	15.8%	17.4%
Median age	35.7	40.9
Race and Ethnicity		
Asian (%)	4.7%	4.7%
Black or African American (%)	2.7%	10.7%
White (%)	82.7%	69.8%
Hispanic (%)	12.2%	17.4%
Non-Hispanic (%)	87.8%	82.6%
Language and Birth Location		
Not proficient in English (%)	2.6%	5.2%
Born outside US (%)	8.6%	16.0%

[2] Note: The U.S. Census faces limitations in accurately counting migrant populations due to factors such as language barriers, fear of government interaction, frequent mobility (e.g., general transience or working on multiple farms), and lack of stable housing, which may contribute to undercounts.

Asian and Hispanic communities in the service area are notably young. Consistent with Connecticut state data, Hispanic residents in the CHNA service area are much younger (median age approximately 25 years) than the state Hispanic average (i.e., 30 years); Black / African American and Asian residents have an even lower median age in the service area (22 years) and the state (35 years).

Table 2: Median Age by Race-Ethnicity and Geography

	Asian		Black		White		Hispanic	
Location	Male	Female	Male	Female	Male	Female	Male	Female
State of CT	35.1	36.6	33.2	36.8	44.3	47.3	29.2	30.8
CHNA Area	22.6	23.8	22.5	21.8	37.7	39.2	23.3	26.8

- Excluding Whites, the median age in the CHNA service area is about 23 years; this may have notable implications on healthcare needs and helpful services.
- Statewide and in the CHNA service area, Whites are notably older than other racial or ethnic groups.
- Median ages for Asians, Blacks / African Americans, and Hispanics are approximately 15 years younger than for Whites.

There are pockets of higher-need areas, even though parts of the Windham Hospital CHNA service area are somewhat affluent. Community members have good educational attainment and income, though both slightly lag state averages. However, nearly two of five households (39.3%) are asset-limited, income-constrained [yet] employed ("ALICE").

Table 3: Health-related Socioeconomic Measures

			CHNA Area vs. CT Statewide	
Measure	**CHNA Area**	**State of CT**	**Point Variance**	**Percent Variance**
Adults (over 25 years old) with a high school level education (%)	28.7%	25.8%	2.9	11.2%
Adults (over 25 years old) with at least a bachelor's degree (%)	38.6%	41.4%	-2.8	-6.8%
Employment rate, population aged 16 years-old and above (%)	93.8%	94.1%	-0.3	-0.3%
Gini Index of Income Inequality (0 = perfect equality in income distribution, 1 = perfect inequality in income distribution)	0.43	0.50	-0.07	-14.0%
Households with earnings below the poverty level (%)	12.7%	9.9%	2.8	28.3%
Median household income ($)	$83,254	$90,213	-6,959	-7.7%
Households that are asset limited, income constrained, employed (ALICE) (%)	39.3%	39.2%	0.1	0.3%
Uninsured children (%)	2.2%	2.8%	-0.6	-21.4%
Uninsured adults (%)	3.8%	5.8%	-2.0	-34.5%
Population insured through Medicaid (%)	26.5%	32.1%	-5.6	-17.4%
Population living in areas with above median levels of area deprivation (ADI) (%)	46.5%	47.2%	-0.7	-1.5%
Population living in areas with above median levels of social vulnerability (SVI) (%)	39.4%	48.6%	-9.2	-18.9%
Population living in areas with below median rankings on the Environmental Justice Index (EJI) (%)	24.8%	42.2%	-17.4	-41.2%

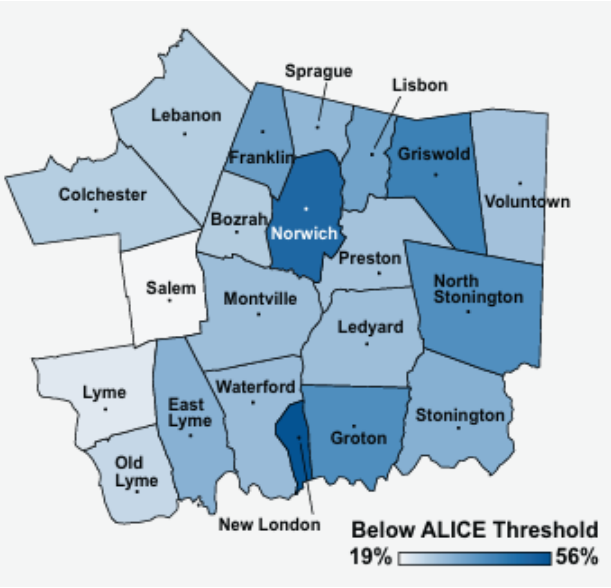
- CHNA service area residents are similarly educated (i.e., 38.6% have a bachelor's degree) and have lower median household income ($83,254) than the state average (i.e., 41.4% have a bachelor's degree and median household income is $90,213).
- Equal to the Connecticut average, nearly two of five (39.3%) CHNA area households are asset limited, income constrained yet employed; many working households still struggle to remain economically viable.

In Connecticut, nearly four in ten households struggle to afford the basic cost of living, with many falling into the ALICE category—Asset Limited, Income Constrained, Employed. These households earn above the federal poverty level but below what is needed to meet the rising costs of essentials like housing, childcare, food, transportation, and healthcare. In Southeastern Connecticut, encompassing New London County, financial hardship is particularly pronounced, with local data showing that 40% of households are either below the poverty line or living as ALICE. The information below provides a more detailed snapshot of ALICE households in the region, highlighting economic trends, survival budgets, and municipal disparities to inform policy and community response efforts.

- As of 2022, Connecticut had approximately 1,430,904 households, of which 151,105 (10.6 %) lived in poverty and 412,407 (28.8 %) were classified as ALICE (Asset-Limited, Income-Constrained, Employed) — meaning that together 39 % of households fell below the ALICE Threshold of Financial Survival.[3]
- This represents an ongoing decade-long upward trend in financial hardship, with modest wage gains failing to keep pace with rising costs of basics (housing, child care, food, transportation, health care, technology).
- The **ALICE Essentials Index** projects an **18.2 % increase in the cost of household essentials from 2021 to 2023**, making survival budgets significantly higher across the state — up to $39,141 annually for a single adult and $126,018 for a family of four.[4]

Town	Total Households	% Below ALICE Threshold
Bozrah	921	26%
Colchester	6,097	26%
East Lyme	7,570	32%
Franklin	705	36%
Griswold	4,885	43%
Groton	16,043	40%
Lebanon	2,847	26%
Ledyard	5,696	29%
Lisbon	1,668	35%
Lyme	951	21%
Montville	6,613	29%
New London	11,138	56%

Town	Total Households	% Below ALICE Threshold
North Stonington	2,106	40%
Norwich	16,923	50%
Old Lyme	3,100	24%
Preston	1,835	28%
Salem	1,652	19%
Sprague	1,163	31%
Stonington	8,324	32%
Voluntown	1,053	28%
Waterford	8,191	30%
Connecticut	1,397,324	39%
United Way of Southeastern Connecticut	109,481	37%



[3] United Way. Available at United For Alice+4uwsect.org+4alice.ctunitedway.org+4
[4] Ibid.

Mental health challenges (including depression) in the Windham Hospital CHNA service area are notably more prominent than statewide averages. However, most chronic disease conditions are less common in the service area.

Table 4: Health and Chronic Conditions

			CHNA Area vs. CT Statewide	
Measure	**CHNA Area**	**State of CT**	**Point Variance**	**Percent Variance**
Cancer (excluding skin cancer) among adults (%)	5.9%	6.9%	-1.0	-14.5%
Coronary heart disease among adults (%)	4.5%	5.2%	-0.7	-13.5%
High blood pressure among adults (%)	26.2%	29.7%	-3.5	-11.8%
High cholesterol among adults (%)	30.5%	33.4%	-2.9	-8.7%
Stroke among adults (%)	2.5%	2.8%	-0.3	-10.7%
Depression among adults (%)	25.7%	20.9%	4.8	23.0%
Mental health not good for two weeks or more among adults (%)	16.4%	14.6%	1.8	12.3%
Diagnosed diabetes among adults (%)	8.4%	9.4%	-1.0	-10.6%
Chronic kidney disease among adults (%)	2.4%	2.8%	-0.4	-14.3%
Obesity among adults (%)	31.6%	30.2%	1.4	4.6%
Chronic obstructive pulmonary disease among adults (%)	5.6%	5.7%	-0.1	-1.8%
Current asthma among adults (%)	12.0%	11.1%	0.9	8.1%
Fair or poor self-rated health status among adults (%)	12.4%	13.3%	-0.9	-6.8%
Physical health not good for two weeks or more among adults (%)	9.9%	10.0%	-0.1	-1.0%

- More than one in four service area adults (25.7%) report having depression. One of six (16.4%) say that their "Mental health [has] not [been] good for two weeks or more." Both data points are higher than the state averages.
- Rates of cancer, heart disease, hypertension, high cholesterol, and stroke are lower in the service area compared to statewide.

Even though chronic disease rates in the hospital CHNA service area tend to be lower than the state averages, preventive screenings are below state rates.

Table 5: Lifestyle and Behaviors

			CHNA Area vs. CT Statewide	
Measure	**CHNA Area**	**State of CT**	**Point Variance**	**Percent Variance**
Binge or heavy drinking (%)	17.3%	15.5%	1.8	11.6%
Current adult smokers (%)	14.3%	13.9%	0.4	2.9%
Fewer than 7 hours of sleep on average (%)	33.7%	33.6%	0.1	0.3%
No leisure time physical activity (% of adults)	21.2%	22.7%	-1.5	-6.6%
Taking medicine for high blood pressure control among adults with high blood pressure (%)	70.1%	75.9%	-5.8	-7.6%
Visits to dentist or dental clinic among adults (%)	68.7%	70.4%	-1.7	-2.4%
Visits to doctor for routine checkup within the past year among adults (%)	74.9%	75.3%	-0.4	-0.5%
Cervical cancer screening among adult women aged 21-65 years (%)	79.4%	86.0%	-6.6	-7.7%
Cholesterol screening among adults (%)	83.0%	88.3%	-5.3	-6.0%
Mammography use among women 50-74 years (%)	78.4%	80.2%	-1.8	-2.2%

- Binge or heavy drinking rates and tobacco use rates are slightly above state rates.
- The following preventive care rates in the service area are all lower than Connecticut rates:
    - Dental visits
    - Routine doctor visits
    - Cervical cancer screenings
    - Cholesterol screening
    - Mammography use

Overall cancer rates are similar between the CHNA service area and the state, but there is tremendous variance by cancer site and race or ethnicity.

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

Age-Adjusted Incidence Rate per 100,000 Population, 2016-2020										
Cancer Type	**All Races**		**Asian**		**Black**		**White**		**Hispanic**	
	County	**State**	**County**	**State**	**County**	**State**	**County**	**State**	**County**	**State**
All Cancer Sites	464.9	458.2	S	232.3	457.2	445.8	475.5	467.8	341.7	418.5
Breast (Female)	117.7	138.5	S	83.1	S	129.0	119.2	143.6	68.2	119.6
Colon & Rectum	34.9	33.6	S	19.2	S	38.0	34.7	33.0	41.9	36.4
Lung & Bronchus	71.6	55.2	S	24.0	S	53.7	74.2	57.7	52.9	38.4
Prostate	98.3	107.6	S	48.2	S	190.8	99.8	118.3	S	107.6

Note: "S" means "suppressed" due to low sample sizes

- Windham Hospital service area Hispanic community members are notably less likely to have been diagnosed with cancer than Black / African Americans or Whites. Note: This is also much lower than Hispanic rates in New London County, where Backus Hospital is located.
- Lung and bronchus cancer rates for Whites are much higher than the state average of 74.2 and 57.7 per 100,000 population, respectively.

Mortality and Morbidity

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

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

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

Windham County has the highest mortality rates of any Connecticut county for each of the four most common causes of death – notably higher than state and US rates.

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

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

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

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

The following conditions are also among the most common – ranked 7 through 13 – causes of death in the hospital CHNA service area. Again, Windham County rates of death per 100,000 population tend to be higher than other counties, yet the Connecticut state average rates tend to be at, or below, US rates.

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

- The Windham County mortality rate is approximately 50% higher than the Connecticut average rate.
- The Connecticut mortality rate for each condition in the table above is lower (or near) the US rates.

Hospital Use Characteristics (Morbidity) and CHIME / Connecticut Hospital Association Data

The following CHIME-based[5] hospital data represent the count of patients who had at least one hospital encounter (based on discharge data), in either the Inpatient, Emergency Department, or Observation service settings, with a principal diagnosis that matches one of the ICD-10-CM codes associated with the given condition or health indicator.[6] The data also allows the comparison of hospital CHNA service area data to the Connecticut state average. When doing so, important differences sometimes arise. [7]

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

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

[7] All hospitals in the CHNA service area, not only Windham Hospital.

For the Windham Hospital CHNA Service Area, hospitalizations for heart failure and COPD are notably higher than the state rate. However, hospitalization for mental health and substance use disorder (as well as sepsis) tend to be lower. [8]

Table 9: Hospital Service Utilization

Windham Hospital			
	Utilization Rates per 100,000		Percent variance to the State
Health Indicator	Hospital CHNA Area	State of Connecticut	
Mental Health Composite	9.4	10.4	-9.6%
Sepsis	7.7	8.4	-8.3%
Heart Failure (HF)	7.1	4.3	65.1%
Substance-Related Disorders (SRD)	6.5	8.1	-19.8%
Community Acquired (CommAcq) Pneumonia	5.4	4.3	25.6%
High Blood Pressure (HBP)	5.1	4.5	13.3%
Chronic Obstructive Pulmonary Disease (COPD)	4.7	2.2	113.6%
Acute Myocardial Infarction (AMI)	3.5	1.8	94.4%
Stroke	3.4	2.5	36.0%
Diabetes - Uncontrolled/Short Term Complications	2.4	2.7	-11.1%
Asthma	2.3	2.8	-17.9%
Coronary Artery Disease (CAD)	2.2	1.0	120.0%
Arthritis	3.0	1.8	66.7%
Diabetes - Long Term Complications (LTC)	1.9	1.3	46.2%
Overweight/Obesity	0.9	1.0	-10.0%

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

- Cardiac issues (e.g., Heart Failure and Coronary Artery Disease) in the Windham Hospital CHNA service area are approximately twice as common in Windham County as the Connecticut state average.
- COPD rates are also notably higher in Windham County.
- Mental Health and Substance-related Disorder rates in Windham County are lower than the state average.

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

Maternal Health

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

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

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

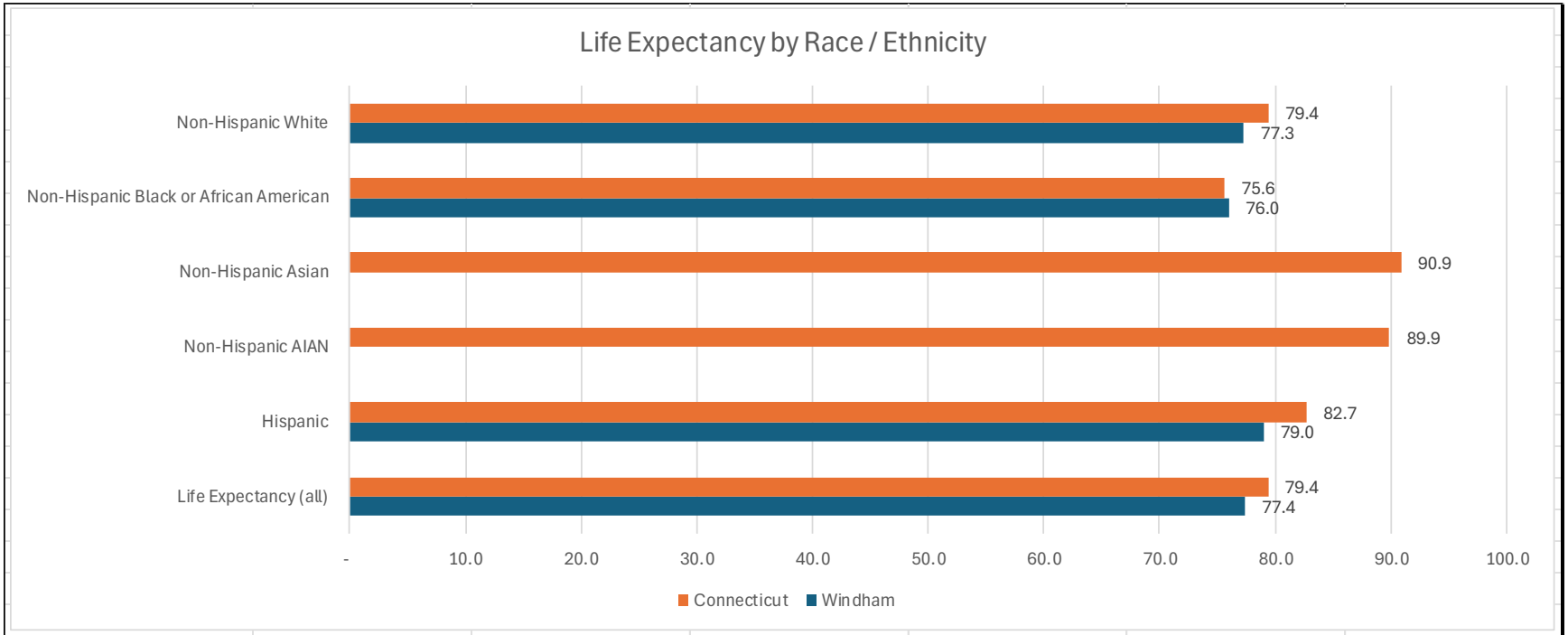
Life Expectancy

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

Life expectancy in Windham County is 77.4 years, which is below the Connecticut average of 79.6 years but closely mirrors the national average. This figure reflects a range of health challenges, including higher rates of premature death and poor physical and mental health. Windham County's premature death rate—measured as years of potential life lost before age 75—stands at 8,000 per 100,000, significantly above Connecticut's 6,500. Indicators such as 14% of residents reporting poor or fair health, 3.6 poor physical health days per month, and 5.2 poor mental health days underscore chronic health burdens in the community. These statistics point to a need for stronger chronic disease management, mental health support, and access to quality healthcare.

Behavioral health risks and healthcare access issues further compound the county's life expectancy concerns. Smoking (17%) and obesity (35%) rates are higher than both state and national averages, while access to exercise opportunities (74%) lags behind the rest of Connecticut (93%). Healthcare provider shortages are evident, with Windham County's primary care ratio at 2,330:1, nearly double the state's 1,210:1. These barriers limit preventive care uptake and delay treatment for chronic conditions. Health-related social need issues such as higher child poverty (17%) and lower educational attainment also contribute to health disparities. Additionally, elevated injury death rates (93 per 100,000) and a spike in mortality among adults aged 40 to 44 highlight the urgency of targeted interventions to improve population health and life expectancy in Windham County.

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



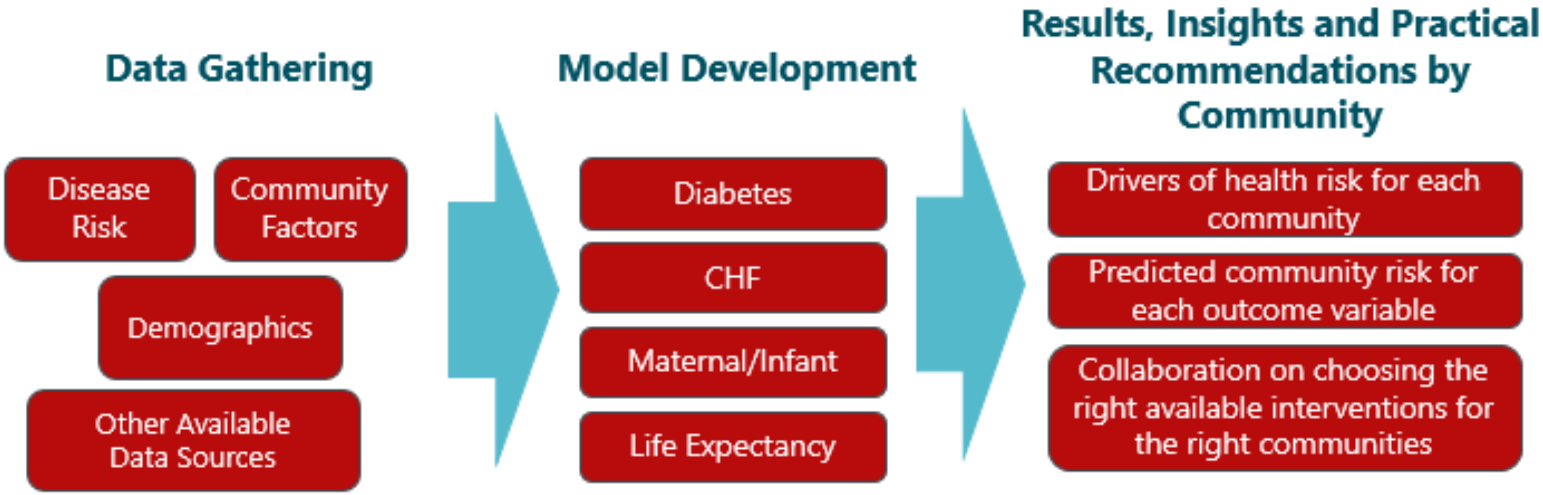
	Life Expectancy (all)	Hispanic	Non-Hispanic AIAN	Non-Hispanic Asian	Non-Hispanic Black or African American	Non-Hispanic White
Connecticut	79.4	82.7	89.9	90.9	75.6	79.4
Windham County	77.4	79.0	NA	NA	76.0	77.3

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

Health-related Social Factors and Predictive Analytics

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

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



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

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

Health-Related Social Need Factors Impact on Diabetes

Key Drivers of Risk

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

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

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

Health-Related Social Need Factors Impact on Cardiovascular Risk

Key Drivers of Risk

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

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

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

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

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

Key Drivers of Risk

- High SNAP and Medicaid Usage
- Low Educational Attainment
- Low Housing Occupancy
- Higher % drive alone (physical inactivity and social isolation)

Key Levers (particularly in communities with low income, those whose residents tend to work in industries focused on skilled labor/trade, locations where smoking rates are high [e.g., Windham/New London], and those requiring improved prenatal visits [e.g., Torrington/Winsted and Windham])

- Target smoking cessation efforts to communities with high SNAP utilization and low educational attainment, and specifically to individuals or groups who report higher rates of smoking while pregnant.
- Increase utilization of prenatal care in communities with low educational attainment and expecting mothers with higher-risk factors for social needs and maternal mortality.

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

Key Drivers of Risk

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

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

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

Qualitative Research Highlights

Qualitative research was conducted to gain a deeper understanding of the healthcare challenges and opportunities facing the communities we serve. Interviews were conducted with hospital leaders and external community partners. They provided valuable insights into the experiences, concerns, and priorities of healthcare professionals, administrators, and community leaders, all of whom play a crucial role in ensuring access to healthcare services. The qualitative research respondents report that the community faces several critical challenges in addressing the health and social needs. Key barriers include limited access to healthcare services, inadequate housing, and insufficient resources for vulnerable populations such as the elderly, individuals experiencing homelessness, and those with behavioral health or substance use disorders. More granular details from the qualitative research follow.

- **Behavioral Health Barriers**
  Behavioral health and substance use treatment are severely limited, with a shortage of providers and lengthy wait times for services. Residential treatment options, particularly for individuals with Medicare or Medicaid, are minimal. Patients often relapse or return to unsafe environments due to inadequate resources for long-term recovery and case management.

  Stakeholders also emphasized the importance of addressing health-related social needs, reducing stigma around mental health and substance use, and improving healthcare affordability. Additionally, there is a need for increased staffing, enhanced community outreach, and better communication about available resources.

- **Healthcare Access**
  Access to care remains a significant issue, with patients facing long wait times for primary and specialty care appointments. Preventive care, patient education, and early intervention are often overlooked, leading to late presentations of chronic illnesses such as diabetes, cancer, and cardiovascular disease. Food insecurity and a lack of affordable, healthy food options are widespread, exacerbating health disparities, particularly among populations managing chronic conditions.

- **Housing Instability**
  Homelessness and housing insecurity were identified as primary contributors to poor health outcomes. A lack of shelters and short-term housing options for individuals and families, including seniors with medical conditions, creates significant obstacles for discharge planning and care transitions.

- **Transportation Barriers**
  Transportation remains a top barrier to accessing care. Both medical and non-medical transportation services are insufficient, especially for seniors and low-income individuals. This lack of mobility limits access to healthcare, food, and social services, compounding health-related challenges.

Community Well-being Survey and Other Research

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

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

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

Chronic Disease

The Chronic disease section of the Wellbeing Survey focused on hypertension, diabetes, and heart disease. Survey results showed that the Windham Hospital service area consistently showed favorable incidence rates compared to the state average for all three chronic diseases.

When examining chronic disease among specific communities within the hospital service area (as opposed to comparison to state averages), the incidence of diabetes and heart disease was slightly higher among high income groups, while hypertension rates among lower income survey respondents were slightly lower than those with higher income levels above $100,000 per year.

Community Satisfaction

Community satisfaction refers to impressions that may impact quality of life and lifestyle, such as overall satisfaction with the town where you live, opinions about whether you live in a place good to raise children, local green spaces or parks being in good condition, and a responsive local government. The survey data show that five of six Connecticut residents (83%) are satisfied with their town; even more (88%) in the hospital service area believe so. Additionally, though, people with household incomes under $100,000 tend to be less satisfied with each of the Community Satisfaction measures. The biggest variance is that six of seven hospital service area residents (82%) with incomes over $100,000 believe that where they live is a good place to raise kids while only slightly over half (57%) of others believe that to be true.

Health risks

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

Wellbeing survey results highlight several health risks among adults in the Windham Hospital service area, with disparities evident by income level. Overall, slightly over half (52%) of adults in the service area rated their health as excellent or very good, similar to the statewide average (56%). This figure drops to 45% among those with incomes under $100,000, while rising significantly to 65% among higher-income residents, reflecting a notable income-based disparity in perceived health. However, this may well also be correlated with age, as older respondents tend to face more health challenges than younger ones.

Rates of no leisure-time exercise are relatively similar across groups, with 13% of all adults in the hospital area reporting no such activity—on par with the lower-income group and slightly below the statewide rate of 19%. Asthma prevalence is somewhat higher in the Windham area (16%) compared to the state (13%), and notably, 21% of higher-income residents report having asthma — more than the 13% reported by lower-income individuals (under $30,000).

Healthcare access

Healthcare Access refers to community members who (1) have health insurance and, (2) have a medical home (a doctor, clinic, or other provider where they commonly seek – or could seek – medical care). The survey showed that most adults in the hospital service area (97%) have access to health insurance (slightly above the statewide average of 93%). One of nine (11%) residents overall lack a medical home – slightly higher among those earning under $30,000 (12%) compared to 9% of higher-income individuals (over $100,000 per year).

Housing and financial well-being

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

Overall, three of four (77%) residents report owning a home or living with a homeowner – higher than the statewide average (65%). However, housing insecurity affected one of ten (10%) area residents in the past year, aligning closely with the state average (11%), though this figure rises to 12% among lower-income adults. Financial strain is also more pronounced among lower-income individuals, with half (50%) reporting they are “just getting by financially” (or worse) compared to only 29% of higher-income residents. While homeownership is relatively high in the hospital service area, a notable portion of lower-income residents continue to face financial and housing-related vulnerabilities that could negatively impact overall well-being.

Mental health

Mental health – or, feelings of being anxious or depressed – impact overall health and the ability to enjoy a quality lifestyle. In the hospital service area, one in eight (12%) of survey respondents say that they feel anxious while one of 11 (9%) feel down or depressed – both rates are slightly better than the Connecticut state averages of 15% and 12%, respectively. For both conditions, income significantly impacts the outcomes, as only 3% or fewer survey respondents with annual income over $100,000 say that they are anxious or depressed while much higher percentages of survey respondents with income under $100,000 are anxious (17%) or depressed (13%).

Nutritional Security

Food insecurity means being unsure of being able to acquire healthful, nutritional food for yourself and family members. In the hospital service area, more than one of six survey respondents (17%) – and more than one of four (26%) of those with annual income under $100,000 – experienced food insecurity within the past 12 months. About two of three people experiencing food insecurity visited a food pantry. As with most other measures reflected in the survey, higher annual income highly correlates with easier access to health and well-being.

Transportation

Reliable transportation is one of the fundamental components of being able to access health services as well as other resources impacting the quality of life. In the hospital service area, most people (93%) have access to reliable transportation – slightly better than the state average (86%). However, some (15%) said that at some point within the past year they did not have access to reliable transportation – limiting their ability to access health services.

Well-being and support

As with many other survey-included measures, feeling satisfied with life and receiving social and emotional support are highly correlated with income; however, higher income is no guarantee of positive outcomes. For example, six of 10 (60%) of lower income hospital service area survey respondents are satisfied with life, and three of four (76%) higher income survey respondents (i.e., those with annual income over $100,000). Although people with higher incomes tend to be more satisfied a notable portion (24%) are not. Survey results support the idea that higher income positively impacts perceptions and access to healthy options, yet it is no guarantee.

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

Data Analysis and Community Input Summary

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

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

Community Health Needs	Suggested, High-level Actions to Address the Needs
Affordable Childcare	Increase access to childcare services to support working families.
Affordable Housing Solutions	Increase availability of safe and affordable housing, including shelters and long-term options.
Affordable Nutrition Programs	Increase funding and resources for affordable, healthy food options, including community gardens and farmer's markets.
Behavioral Health Services Access	Expand mental health services, reduce wait times, and address capacity challenges for both children and adults.
Case Management Services	Offer centralized support to connect individuals with healthcare and social services.
Community Health Education	Expand education on nutrition, preventive care, diabetes management, and healthcare literacy.
Community-Based Programs	Leverage local leaders, churches, and community groups to build trust and resource access.
Dental Care Access	Increase access to affordable dental care, particularly for low-income and uninsured populations.
Elderly Support Services	Expand resources and advocacy for geriatric care, technology assistance, and housing for seniors.
Emergency Department Improvements	Develop specialized units for behavioral health crises and substance abuse management.
Healthcare Access	Address systemic barriers to ensure access healthcare for underserved populations.
Evening/Night Healthcare Services	Extend operating hours for healthcare services to improve access.
Hygiene Facilities for the Homeless	Establish locations for showers, laundry, and basic hygiene needs.
Increased Workforce Capacity	Recruit and retain healthcare providers and support staff, especially in underserved areas.
Language and Cultural Support	Provide interpretation services and culturally insightful care for non-English speakers.
Maternal Health and Life Expectancy	Continually focus on improving access to prenatal and newborn health and wellness services; measure impact of these and other activities by life expectancy
Medication Compliance Support	Create programs to assist with medication adherence and affordability.
Outreach and Resource Awareness	Centralize information hubs to increase awareness of healthcare and social services.
Palliative and Hospice Care	Expand end-of-life care services and provide education for families.
Preventive Care Initiatives	Focus on early interventions and chronic disease management through screenings and outreach programs.

Community Health Needs	Suggested, High-level Actions to Address the Needs
Substance Abuse Treatment	Enhance recovery programs, including specialized units for pregnant individuals and improved education on prevention and treatment.
Support for Undocumented Populations	Create safe access points for healthcare and basic needs for immigrant communities.
Transportation Services	Improve transportation options for accessing healthcare, particularly in rural areas and for vulnerable populations.
Veteran-Centered Care	Improve care for veterans by training providers and implementing veteran liaisons in healthcare settings.
Women's Health Services	Expand access to gynecology, labor and delivery care, and pelvic floor therapy.
Youth Programs and Education	Provide accessible and affordable activities and health education for adolescents.

As noted above, CHNA project leaders conducted a well-structured prioritization process. The following section reviews the process and final results of the Prioritization Process.

In the following section, we present these needs as the foundation for further prioritization and strategy development.

“What have we already accomplished or initiated?”

Evaluation of 2023–2025 Implementation Plan

Summary

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

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

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

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

A description of systemwide activities and hospital service area initiatives follows.

Local Windham Hospital Activities

The following section outlines local hospital-based activities that Windham Hospital implemented to address the highest-priority community health needs identified in the 2022 Community Health Needs Assessment. These initiatives reflect a deep commitment to advancing community health, improving access to care, and responding to the specific challenges voiced by community members across the hospital service area. Grounded in collaboration with local partners and guided by data-driven priorities, these efforts span a range of focus areas — from promoting healthful behaviors to reducing chronic diseases, and others. Each activity was designed to build healthier, more inclusive communities throughout the hospital service area.

Promote Healthy Behaviors and Lifestyles

- **RX For Health** — This program provides vouchers for fresh produce to individuals in need of nutritional support. Funded by Windham Hospital, vouchers are distributed in various settings such as pediatrician offices, soup kitchens, women's health centers, Head Start Programs, etc. Windham Hospital collaborates with local community partners to identify families and individuals who would benefit. Vouchers are currently exchanged at the Willimantic Farmers' Market, Willimantic Food Co-op and Windham hospital's farm stand. An HHC dietitian provides ongoing nutritional support to families. For Fiscal Year 2024, local farmers accepted 2,799 vouchers from residents.

Reduce the Burden of Chronic Disease

- **Universal Screening** —Multiple hospital departments provide free chronic disease screenings in a variety of environments and locations. During testing, participants are given education regarding the disease that they have been screened for and information about how to achieve a "normal" range. Participants are given information about access to primary care physicians as well as urgent care if needed. On February 2,2024, Go Red for Women was one of the key universal screenings events conducted at Windham hospital. This event featured health screenings, educational presentations, and activities related to cardiovascular disease. The health screenings and education topics included balance and strength screenings, stretching and exercise education, cardiovascular risk factors education, stress relief and essential oils education, nutrition education and cooking demonstration, blood pressure screening, A1C screening, hands-only CPR education, ABI screening, BMI screening, and more.

Improve Healthcare Access,* Health-related Social Issues*, and Access to and Coordination of Care and Services

- **Diaper Connections** — HHC has partnered with Windham Women's Health Center and Willi Wellness, as a co-chair of the Diaper Connections Program for the State of Connecticut. Between these two partnerships, 91,200 diapers have been distributed to 248 families. Willi Wellness operates on a reduced-cost lease at the professional building on the Windham Hospital campus to store and

distribute diapers. They also use this space as their headquarters for Special Olympic athletes of Eastern Connecticut, and dementia-friendly and intellectual disability creative and art-based programs. During Fiscal Year 2024, 67,400 diapers were distributed to 694 families.

- **Outpatient Services for Cancer Patients —** In collaboration with the Windham Hospital Integrative Medicine Department, cancer patients benefit from five free sessions of Therapeutic Massage, Reflexology and Energy Therapy. Research has shown that relaxation techniques through integrative medicine may help decrease anxiety, strengthen the immune system, diminish pain, and accelerate healing. Sessions are approximately 60 minutes. During Fiscal Year 2024, these services continued to be provided to cancer patients free of charge.

- **Pipeline Strategy —** To promote careers in the healthcare sector and address the pipeline issues that many students from underserved backgrounds face when it comes to education and training, Hartford HealthCare conducts a series of healthcare career events and opportunities within local high schools. Schools with established certification programs (for example, CNA, EMT, etc.) are given specific focus as partnerships with high schools can lead students to open positions at Hartford HealthCare hospitals, resolving department staffing needs. Students have exposure to different career pathways through interactions with department representatives, who educate them about specific job roles and responsibilities. Staff members who participate in this program are chosen for their ability to relate culturally to the students with whom they are interacting. In 2024, 123 students participated in program events and 78 students participated in job shadow/internships.

Enhance Community-Based Behavioral Health Services

- **Neighborhood Health** — This initiative was developed in collaboration with trusted community partners. These innovative health clinics continue to be adaptable, flexible, and open to feedback to ensure access to needed services and programs. Mobile "CareVans" visit and operate daytime health clinics at specifically chosen locations every week. They offer a variety of health services including screenings, mental health counseling, medical referrals, education and support. In Fiscal Year 2024, the net expense of this program was $146,038. The Neighborhood Health Team attended Health Fairs, facilitated 19 clinics, provided 258 immunizations, gave medical care to 286 individuals, and made numerous referrals to local community providers for ongoing care and support.

“What did we prioritize – how and why?”

Prioritization Process

Research leaders paused after collecting secondary research and primary research (qualitative and quantitative) as described above. The secondary research analysis, the Wellbeing survey, key stakeholder interviews, and other CHNA activities provided a wealth of community-based strengths, needs, service gaps, and potential opportunities to improve community health. For example, the research illuminated an initial list of 26 community needs (shown below in alphabetical order).

1. Affordable Childcare
2. Affordable Housing Solutions
3. Affordable Nutrition Programs
4. Behavioral Health Services Access
5. Case Management Services
6. Community Health Education
7. Community-Based Programs
8. Dental Care Access
9. Elderly Support Services
10. Emergency Department Improvements
11. Healthcare Access
12. Evening/Night Healthcare Services
13. Hygiene Facilities for the Homeless
14. Increased Workforce Capacity
15. Language and Cultural Support
16. Maternal Health and Life Expectancy
17. Medication Compliance Support
18. Outreach and Resource Awareness
19. Palliative and Hospice Care
20. Preventive Care Initiatives
21. Substance Abuse Treatment
22. Support for Undocumented Populations
23. Transportation Services
24. Veteran-Centered Care
25. Women’s Health Services
26. Youth Programs and Education

To prioritize the issues and needs, HHC regional leaders, hospital representatives, and community members worked together to implement a well-structured prioritization process.[9] Specifically, the prioritization approach included the following:

- Windham Hospital leaders held three prioritization meetings with (1) the Eastern Connecticut Health Collaborative, (2) Backus and Windham hospital executive leadership, and (3) the Hartford HealthCare East Region Board of Directors.
- In each meeting, participants participated in a Hanlon Method exercise to provide quantitative validity and qualitative inclusion to the prioritization.
- After the initial prioritization, rank-order needs were evaluated based on feasibility and organization fit using the PEARL-E test to reach a final prioritized set of community health needs which were practical / feasible for the health system to consider.
- A summary of the final results of the Prioritization Processes are shown below.

Prioritization Tools

The Hanlon Method is a validated technique which objectively considers well-defined criteria and feasibility factors based on baseline data and numerical values. Note the following two-step process:

- Step 1: Needs are ranked on a scale of 1-4 based on Relevance, Impact, and Feasibility and then calculated using the formula:
  D = [A + (2 x B)] x C where D = Priority Score; A = Size of health problem ranking (Relevance); B = Seriousness of health problem ranking (Impact); C = Effectiveness of intervention ranking (Feasibility)

  *Note: Seriousness of health issue is multiplied by two because, according to the Hanlon technique, it is weighted as being twice as important as size of health problem.

- Step 2: We apply the 'PEARL-E' test - Once health problems have been rated by criteria, use the 'PEARL-E' Test, to screen out health problems based on the following feasibility factors:
  - Propriety, Economics, Acceptability, Resources, Legality, Equity
  - Eliminate any health problems which receive an answer of "No" to any of the above factors or proceed with corrective action to ensure that potential health priorities meet all five of the feasibility factors. (https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf)

Note: Both the Hanlon Survey and the PEARLE-E test were administered via Red Cap. Specifically, Community Heath staff created these online surveys and utilized direct URLs (Zoom chat), QR codes (live sessions) and paper copies (live sessions) in order to record respondent's answers. Once surveys were completed, data were analyzed using the aforementioned algorithm and weighted appropriately. Slides were created noting the top 10 needs from each prioritization group. The final top 10 needs were weighted according to their rankings in the three prioritization groups. Needs that were only listed in two out of the three prioritization groups were weighted less. Feedback sessions were held with each prioritization group to share results, debrief and discuss process, and strategize next steps in addressing the community needs.

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

Final Priorities

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

Aggregated Needs By Tier For Windham Hospital
Increased Workforce Capacity
Behavioral Health Services
Emergency Department Improvements
Preventive Care initiatives
Substance Use Treatment
Outreach and Resource Awareness
Women's Health Services
Community Health Education
Evening/Night Healthcare Services
HealthCare Access

The ten needs listed above were categorized into three groups as follows.

Aggregated Needs By Tier For Backus Hospital
Socio-economic factors / Increased Workforce Capacity
Mental and Behavior Health Services, Substance Use, Emergency Dept. Improvements
Access To Care / Physical Health Chronic Disease Preventative Care Initiatives Outreach and Resources Awareness Community Health Education
Maternal health Women's Health Services

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

Implementation Plan

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

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

1. Socio-Economic Factors/Increased Workforce Capacity

Addressing socio-economic barriers and expanding workforce capacity is critical to ensure adequate healthcare coverage and reduce disparities caused by economic hardship and provider shortages.

Rationale for Action

- 39% of households in Windham County are classified as ALICE (Asset Limited, Income Constrained, Employed), compared to 38% statewide.
- Median household income in Windham County is $74,344, significantly below the Connecticut median of $90,213.
- Only 24% of employers in the region offer paid family leave, creating economic instability and challenges for workforce retention.

2. Mental & Behavioral Health Services (Behavioral Health, Substance Use, ED Improvements)

Expanding behavioral health services, integrating substance use treatment, and enhancing emergency department (ED) capacity will address high mental distress prevalence and growing ED utilization for behavioral health crises.

Rationale for Action

- Windham County has a suicide rate of 11.3 per 100,000, higher than the state average of 8.7.
    - 16% of adults report frequent mental distress, compared to 12% statewide.
    - Emergency department visits for mental health conditions have increased by 17% over the last five years.

3. Access to Care/Physical Health (Chronic Disease, Preventative Care, Outreach, Education)

Coordination of care is consistently identified as a key obstacle to achieving better access to care and services. Awareness of available resources, depth of patient and provider knowledge of community services, and tracking and follow-up of patients as they move from and between different provider organizations or points of care are challenged. Increasing access to affordable care, preventive screenings, and education will help reduce the chronic disease burden and improve early detection rates.

Rationale for Action

- 10% of adults under age 65 lack health insurance, compared to 6% statewide.
- 29% of adults have been diagnosed with high blood pressure, exceeding the state rate of 26%.
- Cancer screening rates are 12% lower than the state average for colorectal cancer and 9% lower for breast cancer.

4. Maternal Health/Women's Health Services

Expanding women's health services and improving prenatal access will reduce adverse birth outcomes and address gaps in OB/GYN availability.

Rationale for Action

- In Windham County, 22% of births mothers receive late or no prenatal care, compared to 16% statewide.
- The county's low birth weight rate is 8.4%, slightly higher than the state average of 7.9%.
- Windham County has fewer than 3 OB/GYN providers per 10,000 women, below state benchmarks.

Community Health Improvement Plan

Priority Area #1: Socio-Economic Factors and Increased Workforce Capacity			
GOALS	**STRATEGIES**	**LEAD/ PARTNERS**	**METRICS/MEASURES**
• Reduce Disconnection: Engage youth (ages 14–19) in structured career and education pathways. • Build Workforce Capacity: Develop a pipeline of skilled healthcare workers to fill critical roles in Connecticut's healthcare system. • Foster Long-Term Economic Mobility: Enable participants to achieve gainful employment and wage growth through education and mentorship.	Early talent pipeline - high school based	**Windham Hospital** Work Force Development **Community** Local Public Schools	**Yearly Follow Up** # Students in Health Science Programs, Results of Climate Surveys (Well Being, Self Esteem)
• Reduce Disconnection: Engage youth (ages 14–19) in structured career and education pathways. • Build Workforce Capacity: Develop a pipeline of skilled healthcare workers to fill critical roles in Connecticut's healthcare system. • Foster Long-Term Economic Mobility: Enable participants to achieve gainful employment and wage growth through education and mentorship.	School based partnerships (mock interviews, shadow opportunities, guest speakers)	**Windham Hospital** Work Force Development **Community** Local Public Schools	Conversion Rate of Candidates to Hire Results of Follow Up Surveys About Student Satisfaction/Interest

Priority Area #1: Socio-Economic Factors and Increased Workforce Capacity			
GOALS	**STRATEGIES**	**LEAD/ PARTNERS**	**METRICS/MEASURES**
• Reduce Disconnection: Engage youth (ages 14–19) in structured career and education pathways. • Build Workforce Capacity: Develop a pipeline of skilled healthcare workers to fill critical roles in Connecticut's healthcare system. • Foster Long-Term Economic Mobility: Enable participants to achieve gainful employment and wage growth through education and mentorship.	Project Search - program to support professional skill development and career exploration	**Windham Hospital** Work Force Development **Community** United Cerebral Palsy Eastern CT	Conversion Rate of Interns to Gainful Employment
• Partner with high schools within the Windham Hospital HSA to provide opportunities for high school students to explore careers and promote interest in the health care industry.	Educational observer	**Windham Hospital** Work Force Development Volunteer Services **Community** Local Public Schools	Increase in Shadow Occurrences Across Both Clinical and Non-Clinical Departments

Priority Area #2: Mental and Behavioral Health Service (Behavioral Health, Substance Use, Emergency Dept. Improvements)			
GOALS	**STRATEGIES**	**LEAD/ PARTNERS**	**METRICS/MEASURES**
• Reduce opioid-related morbidity and mortality by initiating evidence-based treatment in the ED. • Improve continuity of care by linking patients to MAT and programming (inpatient, outpatient, community) for long-term MAT and recovery support. • Decrease repeated ED visits and hospitalizations related to opioid use.	Implement a **standardized referral and treatment engagement protocol** across emergency departments (EDs) and inpatient units to connect patients with **Medication for Opioid Use Disorder (MOUD)**—including **Suboxone and Methadone**—and **Medication for Alcohol Use Disorder (MAUD)** when appropriate. Utilize partnerships with **Opioid Treatment Programs (OTPs)** and other community providers to ensure continuity of care.	**Windham Hospital** Behavioral Health Addiction Medicine Emergency Medicine Community Health Preventative Medicine MATCH program **Community** Local Community Benefit Organizations Opioid Task force Local FQHCs Carelon	**Formation of Work Group** # Regular Meetings # Community Resource Identified # CCT Referrals **Establish Support Groups in Hospital Spaces** # Groups Offered Attendance Rates **MOUD Protocol** Establish Standard Work for Referrals Creating Education for Clinical Staff/Providers # Patients Seen by Addiction Medicine # Patient's Connection to Care- PHP/IOP/MAT # Medications Started for AUD Or OUD # 30 Day/90 Day Re-Admissions- Length Of Stay Rates Death Rates # ER, Patients Seen/Connected to Treatment/Offered MOUD # MATCH Referrals # UCFS Referrals
To enhance the effectiveness and sustainability of Community Care Teams (CCTs) by establishing strong leadership, improving operational infrastructure, and expanding cross-sector collaboration to address complex health and social needs in the community.	CCTs	**Windham Hospital** Behavioral Health Addiction Medicine Emergency Medicine Community Health Preventative Medicine Neighborhood Health	**Milestones:** Standardized process for Intake Create connection to resources tracker Standard work on how to chair a CCT meeting Engage additional agencies Standardizing CCT workflow from intake to discharge

Priority Area #2: Mental and Behavioral Health Service (Behavioral Health, Substance Use, Emergency Dept. Improvements)			
GOALS	**STRATEGIES**	**LEAD/ PARTNERS**	**METRICS/MEASURES**
		Community Local Community Benefit Organizations Health District Opioid Task force Local FQHCs Carelon First Responders Municipal Human Services	**Metrics:** • #ED Utilization • # Hospital Admissions • # Community Referrals • # Missed Primary Care Appts • # Primary Care Appointments Attended • # CCT Individuals Tracked • # Partners Attending Meetings • # Community Referrals Completed • # Hospital Encounters • Change In ED Visit Frequency • # Referrals To Substance Abuse Programs

Priority Area #3: Access to Care/Physical Health (Chronic Disease Preventative Care Initiatives, Outreach, and Resource Awareness) and Community Health Education			
GOALS	**STRATEGIES**	**LEAD/ PARTNERS**	**METRICS/MEASURES**
Bring more health prevention services and clinical support directly to the people and communities we serve.	Increase the frequency and amount of services/support from the HHC Neighborhood Health Team in Windham County.	**Windham Hospital** Emergency Medicine Community Health Preventative Medicine Neighborhood Health	**Metrics:** # Medical visits # Locations # SDOH screenings # screened positive for (food, housing, transportation) # BH Referrals Community # BH Referrals HHC # Immunizations # clinics per month per region # Individuals served # Events per region (beyond hubs) # Referrals to community partners # telehealth visits # individuals served with insurance # served without insurance (free care) # Goods/clothing/necessities donated **Milestones**: Add a social worker once per week or 2x per month at Covenant/SVDPP Explore physicals for MAT treatment to negate the need for ER visits.

Priority Area #3: Access to Care/Physical Health (Chronic Disease Preventative Care Initiatives, Outreach, and Resource Awareness) and Community Health Education			
GOALS	**STRATEGIES**	**LEAD/ PARTNERS**	**METRICS/MEASURES**
Maintain a tertiary prevention program to identify at risk patients, implement interventions, and establish triple aim goals for experience of care, cost, and population health.	Preventative Medicine team	**Windham Hospital** Preventative Medicine Emergency Department Hospitalists Behavioral Health Care Management Addiction Medicine Geriatrics **Community** Local Community Benefit Organizations Health Districts Opioid Task force Local FQHCs First Responders Municipal Human Services Housing Authorities Residential Organizations	**General PMT** # Encounters Pre/Post Intervention # Referrals for Substance Use Support # Referrals to CCT **Older Adult Program** # Individuals Referred/Enrolled to PMT # Identified with Cognitive Impairment # Days PMT to Disposition Decision # Return home # Home with Additional Support # Conserved/Placed in Long-Term Care # Other Placements (not conserved, shelter, etc.) # Referrals to CCT
• Assist patients in understanding their plan of care. • Increase medication and care plan adherence through simple 1:1 screening (BP /A1c/BGL), education, and check-ins. • Assist patients with care coordination. • Assist with connection to Social Influencers of Health needs.	Community Health Care Coordination – LPN, RN, CHW Case Management Model	**Windham Hospital** Community Health Neighborhood Health Preventative Medicine Emergency Department	**RN** # Patients Receiving Medical Case Management # Nursing Services Provided #HHC Referrals # Community Referrals

Priority Area #3: Access to Care/Physical Health (Chronic Disease Preventative Care Initiatives, Outreach, and Resource Awareness) and Community Health Education			
GOALS	**STRATEGIES**	**LEAD/ PARTNERS**	**METRICS/MEASURES**
		Community Local Senior Centers Local Community Benefit Organizations	**LPN** # Seniors Receiving Medical Care Coordination # LPN Nursing Services Provided # HHC Referrals # Community Referrals **CHW** # Individuals Served # Hours Providing CHW Services # Days At Local Soup Kitchen # Blood Pressure Screenings # Documentation Forms Secured # Transportation Passes Distributed
To improve community health outcomes and reduce nutrition-related chronic diseases by expanding and integrating a comprehensive suite of nutrition-focused programs, including Rx for Health, Nutritional Education, hydroponic gardening, Food Pantry Services, and Annual Symposiums.	FOOD 4 Health Programs– RX for health, Nutritional Events, Food Pantries, and Gardens, Symposiums	**Windham Hospital** Community Health **Community** Local Community Benefit Organizations Local FQHCs Local Schools Faith based Organizations Senior Centers Local Farmers Local Soup Kitchens Local Food Pantries	**RX For Health** Pounds of Produce Brought to Soup Kitchens from Local Farmers. Amount of Money Redeemed in Produce from Vouchers Given in the Community and Partner Organizations. **Events** # of People Educated at Events # Nutritional Events **3 Month Senior Programs** % Improved Healthy Behaviors **Food Pantries** # Bags Given Out at Hospital Food Pantries.

Priority Area #3: Access to Care/Physical Health (Chronic Disease Preventative Care Initiatives, Outreach, and Resource Awareness) and Community Health Education			
GOALS	**STRATEGIES**	**LEAD/ PARTNERS**	**METRICS/MEASURES**
			Hydroponic Gardens Pounds of Produce Donated from Gardens
Increase community awareness and engagement in healthy behaviors by expanding culturally appropriate outreach, education, and events that connect residents to prevention resources and health services.	Community Health Education Outreach – Screenings, Presentations, and Events	**Windham Hospital** Community Health **Community** Local Community Benefit Organizations Health Districts Local FQHCs First Responders Municipal Human Services CT State Community Colleges Local Non-Profits Local Housing Complexes Regional Municipalities Chamber of Commerce Senior Centers Local Schools Veterans Groups Faith Based Orgs.	**RN** # Hands Only CPR/Education # Heartsaver/Education # Organizations Taught CPR # Presentations to Community # Participants at Presentations # Individuals Screened # Community Events **LPN** # Presentations to Senior Community # Senior Participants at Presentations # Senior Individuals Screened # Senior Community Events **CHW** # Individuals Served # Outreach Events Held # Screenings Conducted # CPR Training Facilitated # Community Partners Engaged # Volunteers or Staff Trained (Partners)

Priority Area #4: Maternal Health/Women's Health Services			
GOALS	**STRATEGIES**	**LEAD/ PARTNERS**	**METRICS/MEASURES**
• Strengthen the continuum of care for women across the reproductive lifespan, from preconception to postpartum. • Increase referrals and service integration among participating organizations. • Expand access to maternal and women's health services in underserved communities. • Promote health literacy and awareness through culturally responsive education and outreach. • Advocate for policy and funding support to address maternal health disparities in Eastern Connecticut.	Maternal Health Work group	**Windham Hospital** Women's Health Services **Community** Community Action Agencies Local FQHCs Maternal Support Organizations	**Milestones:** Recruit and host a maternal health work group Identify all community resources regarding maternal health Establish workflows, schedules and outreach strategies to increase the # of prenatal classes in the region. Create workflows and process for information sharing (Ubicare, events, patient interactions) Community awareness and participation in outreach events. **Metrics:** # Meetings # Symposiums # Educational Events/Health Fairs Attendance Rate
Enhance maternal health outcomes by increasing patient access to timely, relevant education and resources through digital engagement.	Utilize the Ubicare platform to provide education and resource awareness push notifications for every maternal health patient.	**Windham Hospital** Women's Health Services **Community** Community Action Agencies Local FQHCs Maternal Support Organizations	**Ubicare** # Clicks # Relevant Information **Prenatal Classes** # Prenatal Classes # Individuals Signed Up # Attended # Open Slots **Resources** # Received # of Cross-Referrals and Completed Care Transitions.

Priority Area #4: Maternal Health/Women's Health Services			
GOALS	**STRATEGIES**	**LEAD/ PARTNERS**	**METRICS/MEASURES**
			Health Outcomes Patient satisfaction and engagement scores. Health outcomes (e.g., preterm birth, low birth weight, maternal complications).

Appendix

The appendices include the following:

Appendix 1: Initial Set of Needs Based on Qualitative data

Appendix 2: Qualitative Research Summary

Appendix 3: DataHaven Community Well-being Survey Raw Data Tables

Appendix 4: Maternal Health

Appendix 5: Maternal Health Data Tables

Appendix 6: Life Expectancy Data

Appendix 7: Hospital Utilization Data

Appendix 8: CHIME Data References and Sourcing

Appendix 9: Code Reference Sheet

Appendix 10: Well-being Survey Summary Tables and Graphics

Appendix 11: Life Expectancy

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

Appendix 13: Community-based Health-related Resources

Appendix 1: Initial Set of Needs Based on Qualitative data

Prioritized Needs	Suggested, High-level Actions to Address the Needs
Affordable Housing	Advocate for policies that increase affordable housing and repurpose vacant buildings.
Food Insecurity	Expand food assistance programs and work with local grocers to improve healthy food access.
Access to Healthcare	Increase the number of primary care providers and expand mobile health initiatives.
Mental Health Services	Improve access to outpatient mental health care and integrate services with primary care.
Healthcare Provider Shortages	Strengthen recruitment and retention efforts, focusing on competitive wages and workplace support.
Emergency Department Overuse	Develop urgent care alternatives and improve patient education about when to seek emergency care.
Chronic Disease Management	Expand patient education initiatives and improve community-based disease management programs.
Transportation Barriers	Enhance transportation options for medical visits and food access through rideshare partnerships.
Health Literacy & Education	Increase community outreach and educational programs to empower residents in navigating healthcare.
Economic Hardships Affecting Health	Strengthen financial assistance programs and connect residents to social services.
Language & Cultural Barriers in Care	Expand interpreter services and hire more bilingual staff to improve patient-provider communication.
Youth & Family Support Services	Increase investment in early childhood programs and mental health resources for youth.
Substance Use & Addiction Services	Expand access to addiction treatment and harm reduction programs.
Gaps in Preventive Care	Promote regular health screenings and wellness programs through community partnerships.
Healthcare Cost Burdens	Enhance financial counseling and ensure awareness of available insurance and assistance programs.
Community Partnerships for Health	Strengthen collaborations with local organizations to address Health-related Social Needs.
Elder Care & Support Services	Improve home healthcare support and expand senior-focused community programs.
Workforce Development & Training	Increase training programs for community health workers and incentivize local hiring.
Access to Safe Recreational Spaces	Invest in public parks, walking trails, and wellness initiatives to encourage physical activity.
Improved Data Collection & Analysis	Develop standardized data collection systems to better track health disparities and inform policy.

Appendix 2: Qualitative Research Summary

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

Qualitative feedback from community stakeholders highlights persistent barriers to healthcare access, driven by provider shortages, inadequate care coordination, and systemic gaps in communication. Veterans and underserved populations report long wait times, lack of follow-up, billing errors, and insufficient understanding of their unique needs. The shortage of medical professionals—including palliative care providers, mental health clinicians, and diabetes educators—limits the community's ability to receive timely and culturally competent care. Health-related Social Needs (HRSN) such as transportation barriers, housing instability, food insecurity, and financial hardship, compound these access issues. While local partnerships, grants, and community networks are working to fill resource gaps, stakeholders emphasize the need for better staffing, care navigation, and coordination across hospital systems, the VA, and community providers. Specifically, research participants note the following:

Community Changes and Challenges

Access to timely and adequate healthcare remains a central challenge, particularly for veterans, uninsured individuals, undocumented residents, and rural populations. Transportation limitations—especially in winter months—create significant hardships for patients transferred to distant hospitals, limiting family support and continuity of care. Veterans report repeated difficulties navigating the VA system, fragmented communication, and lack of a dedicated liaison in local hospitals. Stakeholders stress the importance of culturally competent care, including training providers to understand veteran experiences and language, increasing in-language education for Spanish-speaking patients, and integrating patients into decision-making through care teams and case management.

Residents say that women's health issues remain. Though some well-liked providers exist, there are perceived shortages of social workers and providers of specialized services such as pelvic floor therapy, postpartum depression counseling, and endocrinology.

While grant funding and community partnerships help fill certain gaps (such as free birth control and food pantry support), needs remain high for mental health services, recovery programs for pregnant women, nutrition education, and dental care.

Housing instability is seen as an urgent issue, with evictions, unsafe conditions, and limited affordable options contributing to mental health strain. Stakeholders note that grant restrictions and low voucher rates hinder placement in safe, quality housing, while competition from higher-income renters exacerbates shortages. Broader social challenges such as poor local school performance, limited amenities, and difficulty attracting healthcare providers further impact community well-being. Despite strong local networks and nonprofit collaboration, many stakeholders agree that without expanded capacity, streamlined referral processes, and more flexible funding, many residents may continue to face compounded barriers to health and stability

Relevance of Previous CHNA Priorities

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

Appendix 3: DataHaven Community Well-being Survey Raw Data Tables

Windham Hospital

Overall Health Status

Response	Connecticut total	Windham Hospital total	Male	Female	Ages 18 to 34	Ages 35 to 49	Ages 50 to 64	Ages 65+	White	Latino
How would you rate your overall health? (% saying Excellent or Very Good)	56.4%	58.2%	55.0%	60.9%	61.9%	50.2%	64.0%	50.4%	61.1%	51.0%
How would you rate your overall health? (% saying Fair or Poor)	16.5%	14.2%	16.8%	11.9%	13.1%	15.1%	11.5%	19.8%	13.1%	15.8%
How satisfied are you with your life nowadays? (% saying Completely or Mostly)	65.6%	71.3%	69.4%	73.6%	67.7%	71.2%	72.3%	78.2%	72.5%	69.7%
How satisfied are you with your life nowadays? (% saying Only a little or Not at all)	11.3%	7.9%	8.2%	7.8%	7.9%	13.4%	8.0%	3.1%	7.0%	14.5%
Overall, how happy did you feel yesterday? (% saying Completely or Mostly)	68.5%	67.0%	59.3%	74.3%	57.0%	71.3%	73.7%	77.7%	71.8%	52.3%
Overall, how happy did you feel yesterday? (% saying Only a little or Not at all)	12.1%	11.2%	14.8%	7.8%	14.0%	8.2%	11.9%	6.5%	10.1%	20.7%
Overall, how anxious did you feel yesterday? (% saying Completely or Mostly)	13.6%	12.5%	14.8%	10.3%	19.8%	10.7%	6.9%	5.5%	10.6%	19.1%
Overall, how anxious did you feel yesterday? (% saying Only a little or Not at all)	65.4%	65.0%	67.1%	63.6%	50.0%	68.4%	76.0%	81.0%	67.7%	54.3%
Do you have health insurance? (% saying No	5.8%	4.1%	6.4%	1.9%	4.7%	6.9%	2.8%	0.6%	1.8%	11.4%

Overall Health Status

Response	Connecticut total	Windham Hospital total	High school or less	Some college or Associate's	Bachelor's or higher	Income <$30K	Income >$100K	Children in home	No children in home
How would you rate your overall health? (% saying Excellent or Very Good)	56.4%	58.2%	46.4%	51.8%	68.6%	36.7%	67.4%	59.7%	57.6%
How would you rate your overall health? (% saying Fair or Poor)	16.5%	14.2%	21.7%	16.7%	8.7%	28.9%	8.7%	10.2%	16.2%
How satisfied are you with your life nowadays? (% saying Completely or Mostly)	65.6%	71.3%	61.5%	64.4%	80.9%	48.7%	83.3%	73.7%	70.3%
How satisfied are you with your life nowadays? (% saying Only a little or Not at all)	11.3%	7.9%	13.0%	7.9%	5.3%	17.7%	3.0%	9.1%	7.5%
Overall, how happy did you feel yesterday? (% saying Completely or Mostly)	68.5%	67.0%	58.4%	55.0%	79.1%	41.9%	78.3%	67.9%	66.5%
Overall, how happy did you feel yesterday? (% saying Only a little or Not at all)	12.1%	11.2%	14.1%	15.9%	6.8%	22.6%	6.5%	11.0%	11.2%
Overall, how anxious did you feel yesterday? (% saying Completely or Mostly)	13.6%	12.5%	14.8%	20.5%	6.3%	25.8%	6.8%	13.7%	11.7%
Overall, how anxious did you feel yesterday? (% saying Only a little or Not at all)	65.4%	65.0%	60.0%	55.6%	73.6%	45.6%	72.4%	66.8%	64.5%
Do you have health insurance? (% saying No)	5.8%	4.1%	7.2%	4.9%	1.8%	9.9%	1.6%	5.4%	3.3%

Appendix 4: Maternal Health

Overview

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

National Maternal Health Trends

In recent years, the United States has experienced fluctuations in maternal mortality rates. According to the National Center for Health Statistics, the maternal mortality rate has drifted up from 17.4 deaths per 100,000 live births in 2018 to 23.8 in 2020, 22.3 in 2022, and 18.6 in 2023.[10][11] Disparities persist across different age groups and racial/ethnic populations. In 2022, women aged 40 and over had a maternal mortality rate of 87.1 per 100,000 live births, significantly higher than the rate of 14.4 for women under 25. Racial disparities are also evident; non-Hispanic Black women experienced a maternal mortality rate of 49.5 per 100,000 live births in 2022, more than double the rate for non-Hispanic White women, which stood at 19.0.[12]

The leading causes of pregnancy-related deaths in 2020 included mental health conditions, cardiovascular conditions, infection, hemorrhage, embolism, and hypertensive disorders of pregnancy, accounting for over 82% of such deaths. Notably, mental health conditions were the most frequent underlying cause, highlighting the linkage between comprehensive maternal care and mental health support.[13]

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

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

[12] Ibid.

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

Maternal Health in Connecticut

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

Antecedent or Contributing Measures

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

Outcomes Measures

- Maternal deaths and mortality rates
- Infant mortality

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

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

Antecedent or Contributing Measures

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

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

   The availability of obstetricians and gynecologists varies widely across Connecticut counties, with notable disparities in access. Tolland County has the highest ratio at 9,560 females per OBGYN, indicating a significant shortage of providers, while Hartford, Fairfield, and New Haven counties have the lowest ratios (1,959, 2,158, and 2,347 respectively), suggesting better per capita capacity. The statewide average (2,493) is below the national average (3,454), showing that Connecticut as a whole has relatively strong OBGYN coverage, although rural counties like Windham (6,510) and Litchfield (5,977) remain relatively underserved.[14]

2. **Tobacco Use During Pregnancy**

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

   Tobacco use during pregnancy is lower in Connecticut (1.8%) than the national average (3.0%), with Fairfield County reporting the lowest rate (0.6%) and Windham County the highest (4.4%). Tobacco use is most prevalent among White (non-Hispanic) and individuals of more than one race, with rates reaching 8.0% and 12.7% in Windham, respectively. Use among Black or African American individuals varies by county, peaking at 4.1% in New Haven. Hispanic and Asian populations show lower tobacco use rates across the board, suggesting cultural or behavioral differences.[15]

3. **Preterm Births**

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

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

[15] Ibid.

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

Connecticut's preterm birth rate (9.1%) is slightly below the national average (10.2%), yet racial disparities are pronounced. Black or African American women face disproportionately high rates (up to 14.5% in Hartford and Windham), mirroring national trends. In contrast, White (non-Hispanic) and Asian women tend to experience lower rates of preterm births. Geographic variation also exists, with Windham and New Haven Counties at 9.6%, while Litchfield and Fairfield are at a lower 8.3% and 8.5%, respectively. These differences likely reflect varying access to care, socioeconomic factors, and structural challenges.[16]

4. **Low Birth Weight**

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

   Connecticut's overall low birth weight rate is 7.6%, slightly lower than the national average of 8.2%, but again, racial disparities are evident. Black or African American infants have the highest rates (13.0% statewide), particularly in Hartford (13.5%) and New Haven (13.4%), more than double the rate for White (non-Hispanic) infants (6.3%). Asian infants also experience elevated rates (9.0%), which exceeds their national rate. Fairfield County reports the lowest overall rate at 7.0%, while Hartford and New Haven are among the highest at 8.2%. These patterns highlight persistent disparities in maternal and infant health outcomes.[17]

5. **First Trimester Prenatal Care**

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

[16] Ibid.

[17] Ibid.

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

6. **Life Expectancy at Birth**

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

Connecticut's life expectancy at birth (80.3 years) is higher than the national average (78.8), with the highest figures in Fairfield (81.5), Tolland (81.1), and Middlesex (81.0) counties. The lowest is in Windham County (79.1), indicating regional disparities in overall health outcomes. Life expectancy closely correlates with broader HRSN such as income, education, access to care, and environmental conditions, which tend to be more favorable in suburban counties compared to rural or urban areas with higher poverty rates.[18]

[18] Ibid.

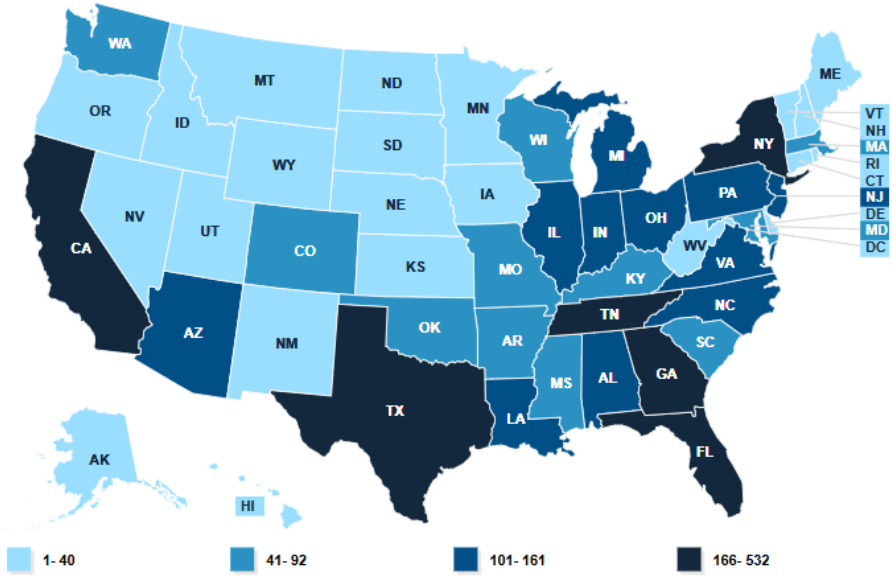
Outcomes Measures

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

7. Maternal Deaths and Mortality Rates

Maternal mortality – defined as the death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy-related cause – is one of the most critical measures of a health system's ability to support women's health. The maternal mortality rate represents the number of maternal deaths per 100,000 live births and serves as a sentinel indicator of both the quality of care and broader HRSNs affecting maternal well-being. These deaths are often preventable and linked to complications such as mental health conditions[19], hemorrhage, cardiovascular or hypertensive disorders, infection, and underlying chronic conditions, as well as systemic issues like delayed care, inadequate access to services, and racial and socioeconomic challenges. Monitoring maternal deaths and mortality rates helps public health officials identify risk factors, design targeted interventions, and allocate resources effectively to protect maternal lives.

In Connecticut, maternal mortality remains a concern, despite the state's generally strong healthcare infrastructure. The state rate (16.7 per 100,000 live births) was well below the US average (23.0) – ranking Connecticut 33rd in the US (1 = the highest rate, or worst performing state). [20]



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

[20] Sources: CDC Wonder, Natality 2023; NPPES NPI 2024; US CDC; Centers for Disease Control and Prevention, National Center for Health Statistics (NCHS), National Vital Statistics System, "Maternal deaths and mortality rates: Each state, the District of Columbia, United States, 2018-2022"; KFF, State Health Facts, Preterm Births as a Percent of All Births by Race/Ethnicity, from the Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER

While the overall maternal mortality rate is lower than the national average, disparities persist along racial and ethnic lines, with Black women experiencing disproportionately higher rates of death related to pregnancy and childbirth. These challenges reflect longstanding systemic challenges, including implicit bias in healthcare, unequal access to prenatal and postpartum care, and differences in chronic disease burden. Accurate reporting and analysis of maternal deaths are essential for understanding the root causes and for implementing meaningful changes that promote safer, more access for women.[21] (Note that county-level maternal morbidity data was not available due to sample size restrictions.)

8. Infant Mortality Rate by Race and Ethnicity

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

In Connecticut, the overall infant mortality rate is lower than the national average, highlighting some relative strengths in healthcare delivery. As of 2022, Connecticut's infant mortality rate was 4.5 deaths per 1,000 live births, ranking 11th among US states. In comparison, the national average for the United States was 5.61 deaths per 1,000 live births in 2022.[22]

Over the past decade, Connecticut has consistently maintained an infant mortality rate below the national average. For example, in 2017, the state's rate was 4.6 deaths per 1,000 live births, a decrease from 5.9 in 2005.[23]

Online Database. Data are from the Natality Records 2016-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program; Osterman MJK, Hamilton BE, Martin JA, Driscoll AK, Valenuela CP. Births: Final data for 2021. National Vital Statistics Reports; vol 72, no 1. 2023

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

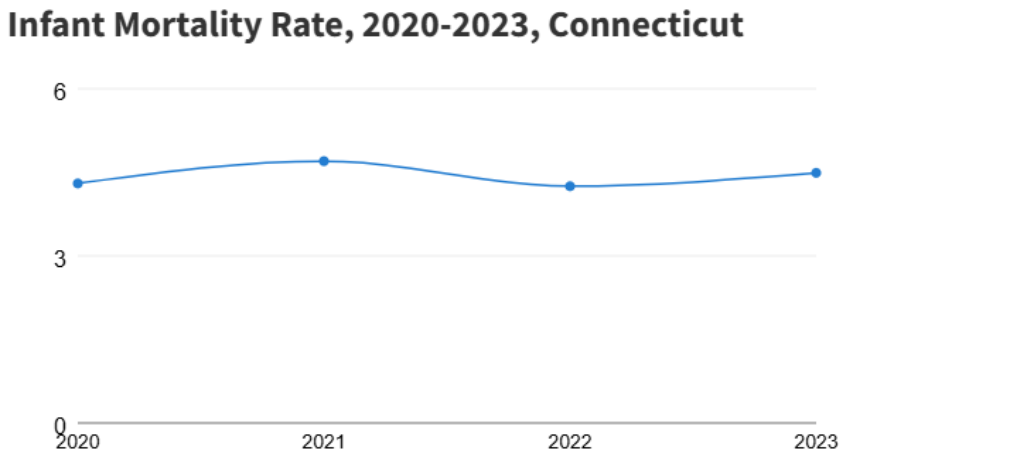
[22] US CDC, 2023. Available at www.cdc.gov/nchs/data/nvsr/nvsr73/nvsr73-05.pdf?utm_source=chatgpt.com

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

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

However, significant disparities remain, particularly among racial and ethnic groups. Black or African American infants in Connecticut are more than twice as likely to die before their first birthday compared to White infants – 9.9% compared to 4.7% —a pattern consistent with national trends. Similarly, Hispanic infants have higher mortality rates (5.8%) than Whites (4.7%). These disparities are rooted in various health-related social and economic factors, as well as unequal access to care before, during, and after pregnancy. Addressing infant mortality may benefit from comprehensive approaches that help ensure improved access to quality care. Note that county-level infant mortality data was not available due to sample size restrictions.

Total infant mortality rates have been stable, 2020-2023 fluctuating between 4.3% and 4.7%.[24]



Note: Infant mortality rate, per 1,000 live births. Infants are defined as children under one year of age. NSD: Not sufficient data. 2023 estimates are provisional.

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

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

Appendix 5: Maternal Health Data Tables

Provider Ratios

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

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

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

Preterm Births

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

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

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

Low Birth Weight

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

	Hartford County	Litchfield County	Windham County	Middlesex County	Tolland County	Fairfield County	New Haven County	New London County	Connecticut	US
Low Birth Weight	**8.2%**	**6.1%**	**7.2%**	**7.1%**	**7.5%**	**7.0%**	**8.2%**	**7.4%**	**7.6%**	**8.2%**
American Indian or Alaska Native (not Hispanic or Latino)	0.0%	NA[25]	NA	NA	NA	NA	NA	NA	9.6%	8.3%
Asian (non Hispanic or Latino)	9.3%	6.9%	NA	7.4%	8.0%	8.9%	9.3%	9.6%	9.0%	9.0%
Black or African American (not Hispanic or Latino)	13.5%	9.7%	NA	10.2%	8.1%	12.6%	13.4%	12.5%	13.0%	14.5%
Native Hawaiian or Other Pacific Islander (not Hispanic or Latino)	NA	NA	NA	NA	NA	NA	NA	NA	NA	8.6%
Hispanic or Latino	9.6%	6.0%	7.8%	9.7%	9.4%	7.9%	8.5%	8.4%	8.5%	7.7%
White (not Hispanic or Latino)	6.5%	6.0%	7.5%	6.5%	7.3%	5.4%	6.6%	6.6%	6.3%	7.0%
More than one Race (not Hispanic or Latino)	8.8%	NA	7.5%	9.5%	NA	9.0%	10.3%	9.8%	9.3%	9.2%

- Similarly, Black or African American communities across Connecticut are 30% to 60% (in most counties) more likely to have low birth weight babies.[26]

[25] In instances where "NA" is displayed, sample sizes are too low to report while maintaining confidentiality.

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

First Trimester Prenatal Care

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

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

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

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

Appendix 6: Life Expectancy Data

Life Expectancy	Windham County	Connecticut	United States
Premature Death Definition: Years of potential life lost before age 75 per 100,000 population (age-adjusted)	8,000	6,500	8,000
Poor or Fair Health	14%	12%	14%
Poor Physical Health Days (past 30 days)	3.6	2.9	3.3
Poor Mental Health Days (past 30 days)	5.2	4.4	4.8
Low Birthweight	8%	8%	8%
Adult Smoking	17%	12%	15%
Adult Obesity	35%	31%	34%
Food Environment Index	8.1	8.3	7.7
Physical Inactivity	23%	22%	23%
Access to Exercise Opportunities	74%	93%	84%
Excessive Drinking	19%	17%	18%
Alcohol-Impaired Driving Deaths	33%	32%	26%
Sexually Transmitted Infections per 100,000 population	211.3	409.1	495.5
Teen Births	10	8	17
Uninsured	6%	6%	10%
Primary Care Physicians (X:1)	2,330	1,210	1,330
Dentists (X:1)	2,010	1,150	1,360
Mental Health Providers (X:1)	250	220	320
Preventable Hospital Stays	2,695	2,651	2,681
Mammography Screening	45%	47%	43%
Flu Vaccinations	52%	54%	46%
High School Completion	90%	91%	89%
Some College	58%	71%	68%
Unemployment	4.30%	4.20%	3.70%
Children in Poverty	17%	13%	16%

Life Expectancy	Windham County	Connecticut	United States
Income Inequality	4.4	5.1	4.9
Children in Single-Parent Households	28%	25%	25%
Social Associations	8.1	8.9	9.1
Injury Deaths	93	80	80
Air Pollution - Particulate Matter	6.5	7.4	7.4
Severe Housing Problems	13%	17%	17%
Driving Alone to Work	81%	72%	72%
Long Commute - Driving Alone	39%	35%	36%
Life Expectancy (all)	77.4	79.6	
Hispanic	79	NA	NA
Non-Hispanic AIAN	NA	NA	NA
Non-Hispanic Asian	NA	NA	NA
Non-Hispanic Black or African American	76	NA	NA
Non-Hispanic White	77.3	NA	NA

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

Appendix 7: Hospital Utilization Data

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

See Legend below[27]

[27] Legend:

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

Ranked List of 15 Select Health Indicator Hospital Utilization Rates for Adults in Connecticut - Percent Variance to State								
Health Indicator	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Mental Health Composite	-	26.9%	25.0%	23.1%	-4.8%	49.0%	0.0%	-9.6%
Sepsis	-	8.3%	-3.6%	8.3%	-3.6%	11.9%	-13.1%	-8.3%
Heart Failure (HF)	-	14.0%	58.1%	30.2%	72.1%	27.9%	2.3%	65.1%
Substance-Related Disorders (SRD)	-	9.9%	14.8%	22.2%	-16.0%	39.5%	1.2%	-19.8%
Community Acquired (CommAcq) Pneumonia	-	65.1%	30.2%	-7.0%	9.3%	27.9%	-2.3%	25.6%
High Blood Pressure (HBP)	-	22.2%	0.0%	26.7%	-8.9%	20.0%	26.7%	13.3%
Chronic Obstructive Pulmonary Disease (COPD)	-	90.9%	154.5%	4.5%	81.8%	168.2%	27.3%	113.6%
Acute Myocardial Infarction (AMI)	-	22.2%	66.7%	0.0%	94.4%	5.6%	-11.1%	94.4%
Stroke	-	8.0%	92.0%	8.0%	0.0%	8.0%	4.0%	36.0%
Diabetes - Uncontrolled/Short Term Complications (Unc-STC)	-	11.1%	-3.7%	44.4%	3.7%	29.6%	11.1%	-11.1%
Asthma	-	21.4%	-25.0%	25.0%	-17.9%	46.4%	14.3%	-17.9%
Coronary Artery Disease (CAD)	-	120.0%	40.0%	40.0%	70.0%	60.0%	60.0%	120.0%
Arthritis	-	-5.6%	66.7%	-5.6%	50.0%	0.0%	0.0%	66.7%
Diabetes - Long Term Complications (LTC)	-	15.4%	38.5%	23.1%	-15.4%	23.1%	0.0%	46.2%
Overweight/Obesity	-	0.0%	-20.0%	70.0%	10.0%	40.0%	20.0%	-10.0%

See Legend below[28]

[28] Legend:

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

Appendix 8: CHIME Data References and Sourcing

Description of Data Sources

ChimeData (FY 2024)

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

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

American Community Survey (ACS, 2018-2022)

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

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

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

Methodology for Age-Adjusted Rates

Step 1: Patient Counts and Population Estimates

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

Step 2: Unadjusted Rates

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

Step 3: Age-Specific Rates

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

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

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

Step 5: Age-Adjusted Rates

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

Appendix 9: Code Reference Sheet

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

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

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

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

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

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

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

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

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

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

Health Indicator	External Standard(s) Referenced	ICD-10-CM Codes
Non-Opioid-Related Disorders	None	F12.10, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.220, F12.221, F12.222, F12.229, F12.23, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.90, F12.91, F12.920, F12.921, F12.922, F12.929, F12.93, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99, F13.10, F13.120, F13.121, F13.129, F13.130, F13.131, F13.132, F13.139, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F13.90, F13.920, F13.921, F13.929, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.10, F14.120, F14.121, F14.122, F14.129, F14.13, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F14.90, F14.920, F14.921, F14.922, F14.929, F14.93, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.10, F15.120, F15.121, F15.122, F15.129, F15.13, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F15.90, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99, F16.10, F16.120, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.90, F16.920, F16.921, F16.929, F16.94, F16.950, F16.951, F16.959, F16.980, F16.983, F16.988, F16.99, F17.200, F17.203, F17.208, F17.209, F17.210, F17.213, F17.218, F17.219, F17.220, F17.223, F17.228, F17.229, F17.290, F17.293, F17.298, F17.299, F18.10, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.90, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.97, F18.980, F18.988, F18.99, F19.10, F19.120, F19.121, F19.122, F19.129, F19.130, F19.131, F19.132, F19.139, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29, F19.90, F19.920, F19.921, F19.922, F19.929, F19.930, F19.931, F19.932, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, F55.0, F55.1, F55.2, F55.3, F55.4, F55.8, O35.5XX0, O35.5XX1, O35.5XX2, O35.5XX3, O35.5XX4, O35.5XX5, O35.5XX9, O99.320, O99.321, O99.322, O99.323, O99.324, O99.325, O99.330, O99.331, O99.332, O99.333, O99.334, O99.335, P04.12, P04.2, P04.40, P04.41, P04.42, P04.49, P96.1, P96.2, T40.491A, T40.492A, T40.493A, T40.494A, T40.495A, T40.5X1A, T40.5X2A, T40.5X3A, T40.5X4A, T40.5X5A, T40.601A, T40.602A, T40.603A, T40.604A, T40.605A, T40.691A, T40.692A, T40.693A, T40.694A, T40.695A, T40.711A, T40.712A, T40.713A, T40.714A, T40.715A, T40.721A, T40.722A, T40.723A, T40.724A, T40.725A, T40.8X1A, T20.8X2A, T40.8X3A, T40.8X4A, T40.901A, T40.902A, T40.903A, T40.904A, T40.905A, T40.991A, T40.992A, T40.993A, T40.994A, T40.995A, T43.601A, T43.602A, T43.603A, T43.604A, T43.605A, T43.621A, T43.622A, T43.623A, T43.624A, T43.625A, T43.631A, T43.632A, T43.633A, T43.634A, T43.635A, T43.641A, T43.642A, T43.643A,

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

Appendix 10: Well-being Survey Summary Tables and Graphics

Chronic Disease

Figure 1: Windham Hospital Service Area Chronic Disease by Income Level

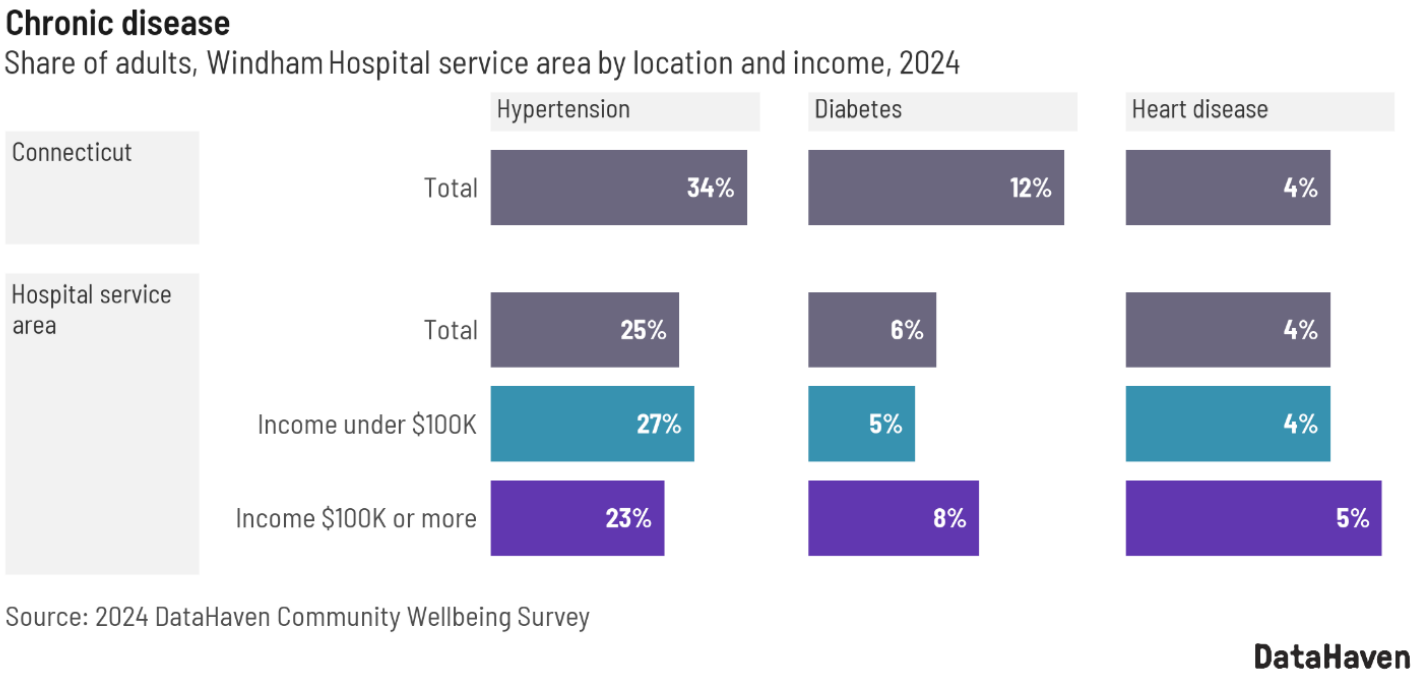


Figure 2: Windham Hospital Service Area Community Satisfaction by Income Level

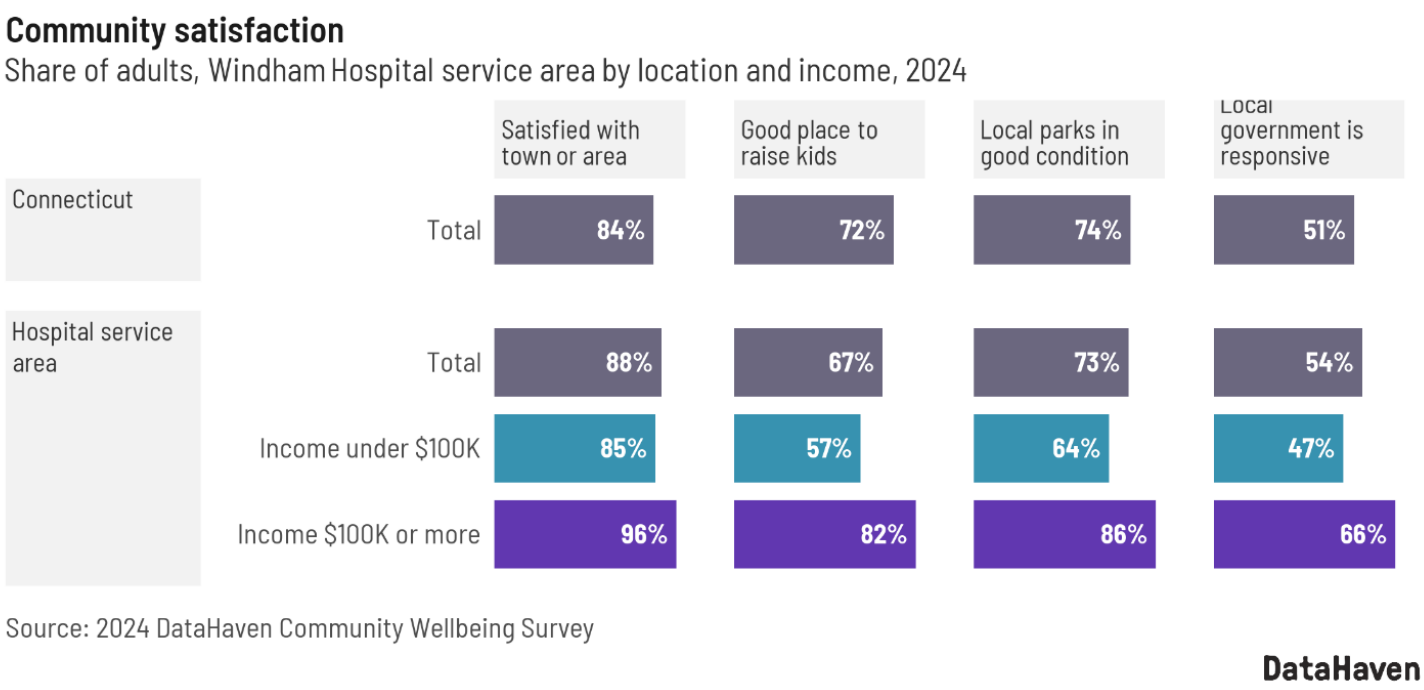
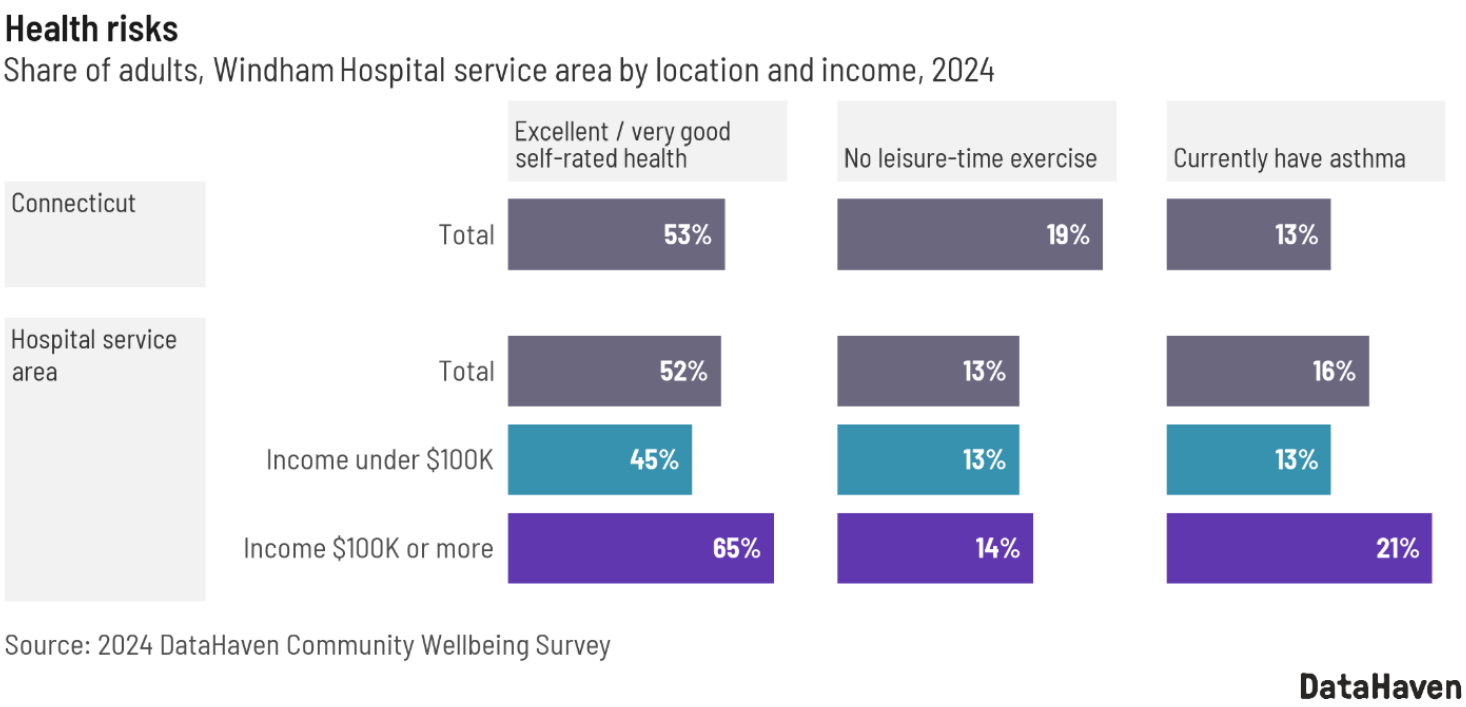


Figure 3: Windham Hospital Service Area Health Risks by Income Level



Healthcare Access

Figure 4: Windham Hospital Service Area Healthcare Access by Income Level

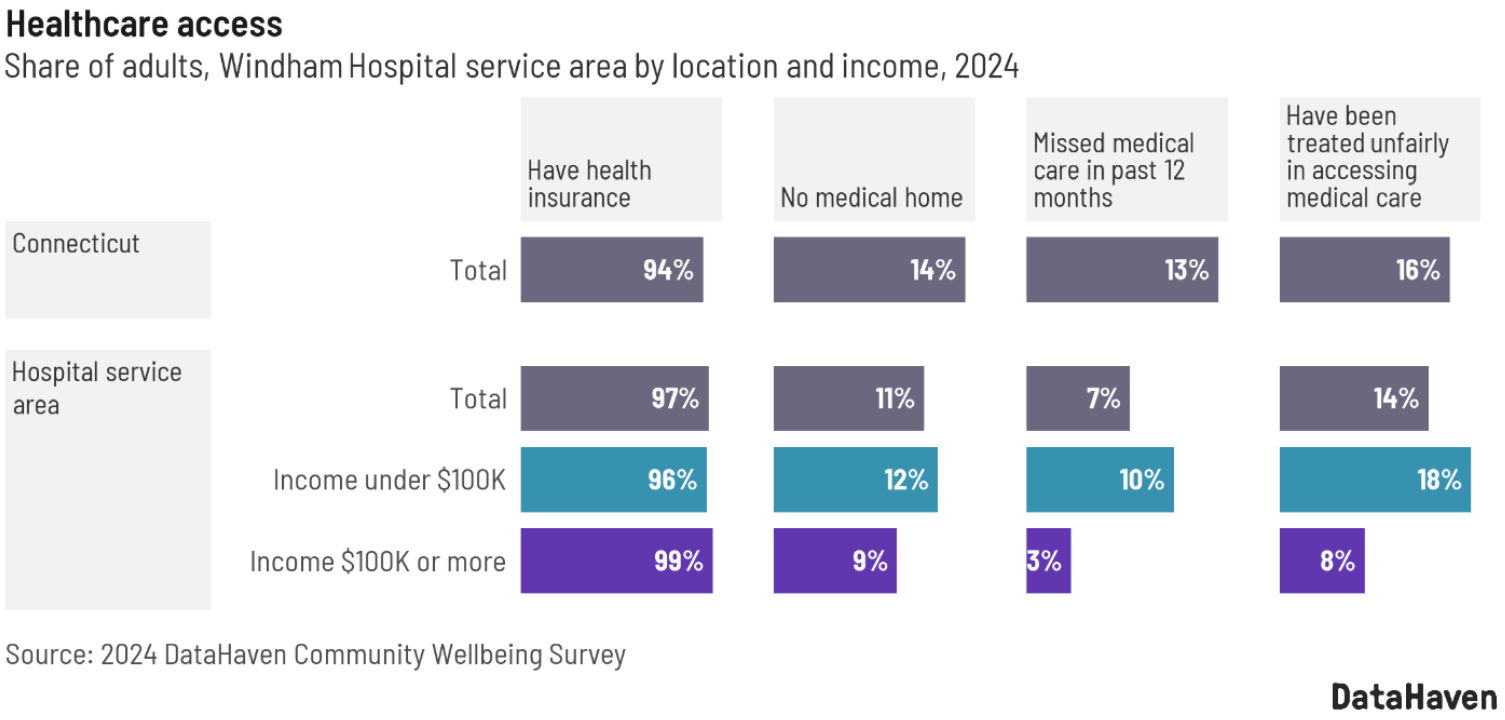


Figure 5: Windham Hospital Service Area Housing and Financial Well-being by Income Level

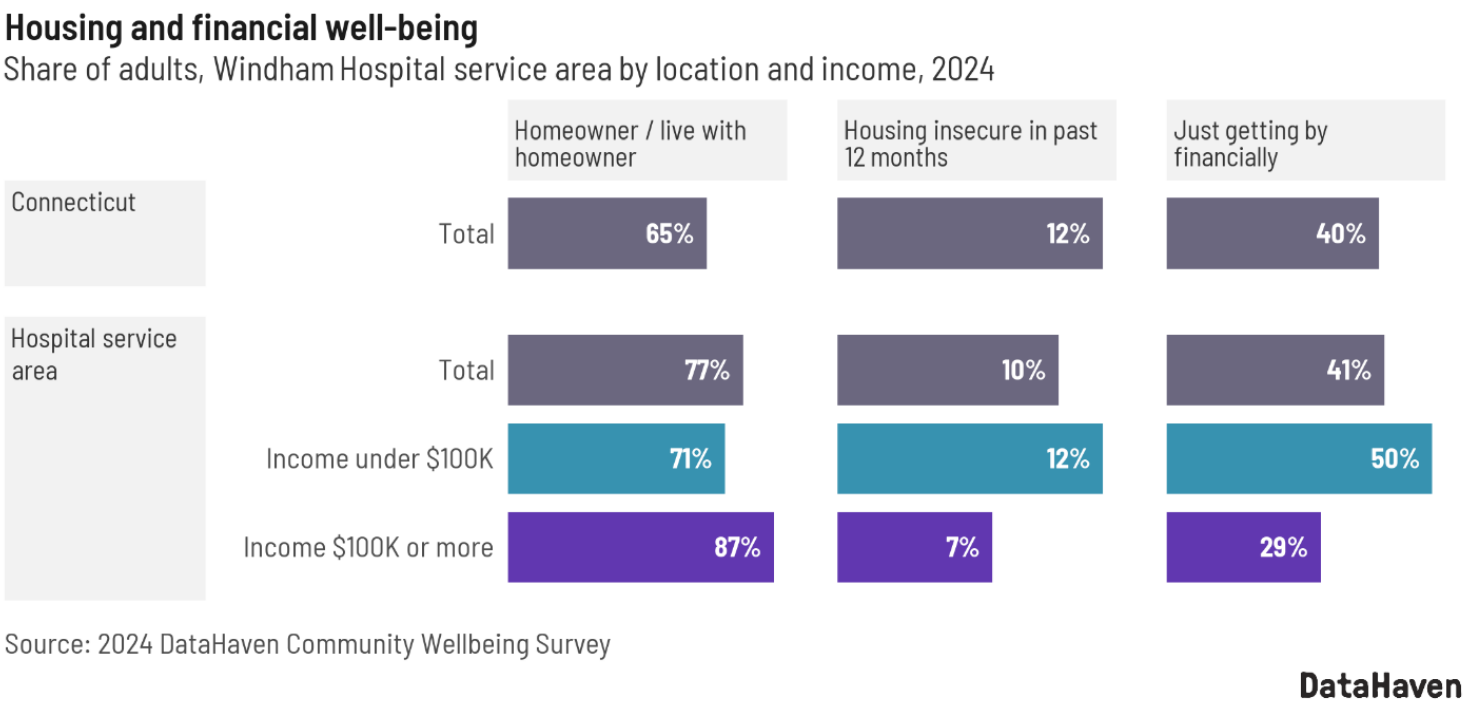


Figure 6: Windham Hospital Service Area Mental Health by Income Level

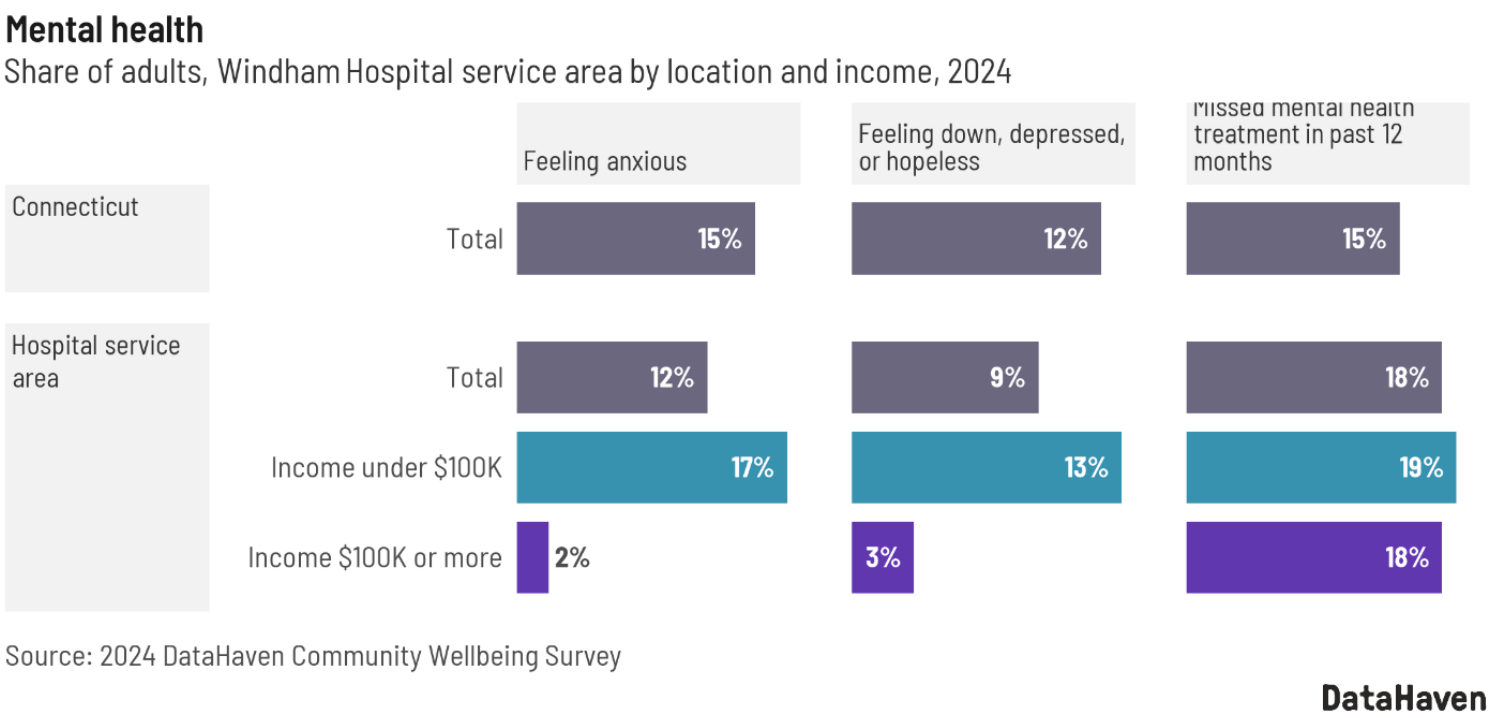


Figure 7: Windham Hospital Service Area Neighborhood Safety and Facilities by Income Level

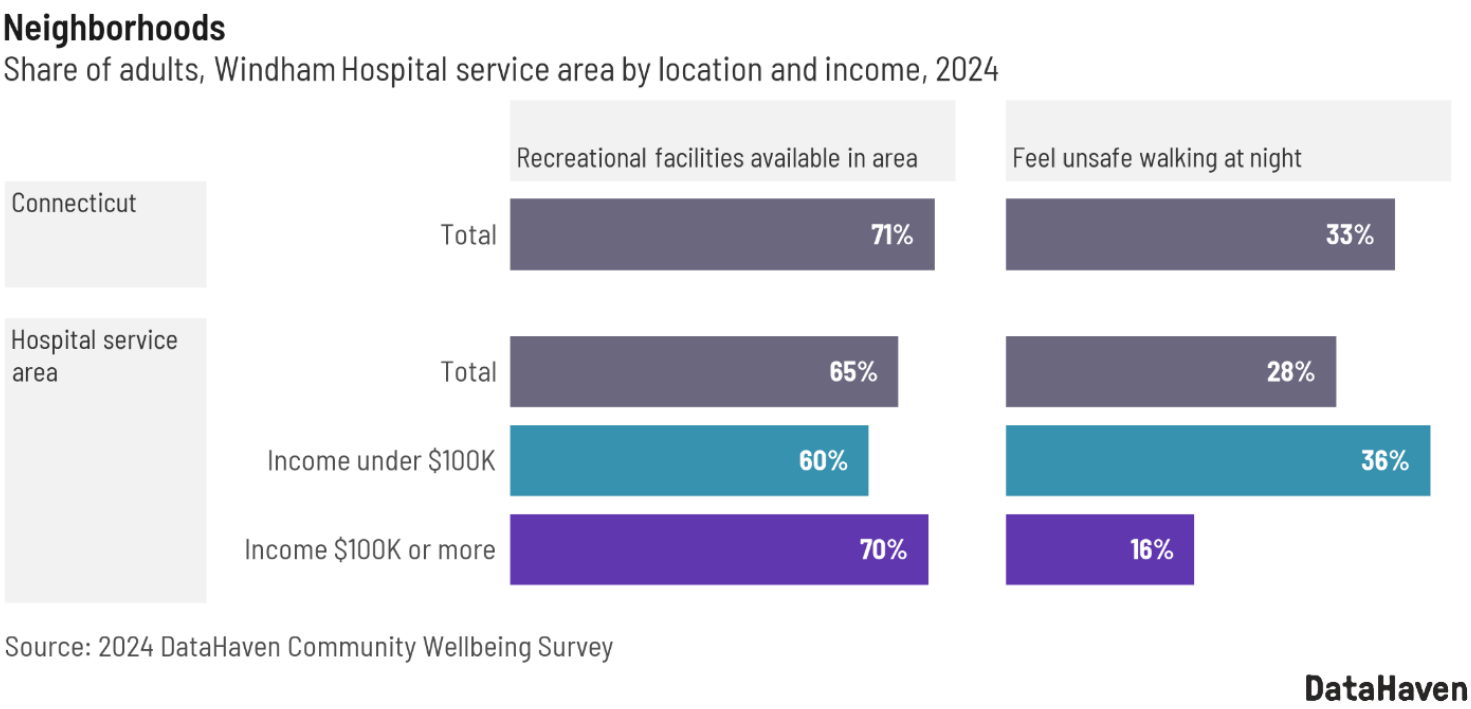


Figure 8: Windham Hospital Service Area Nutritional Security by Income Level

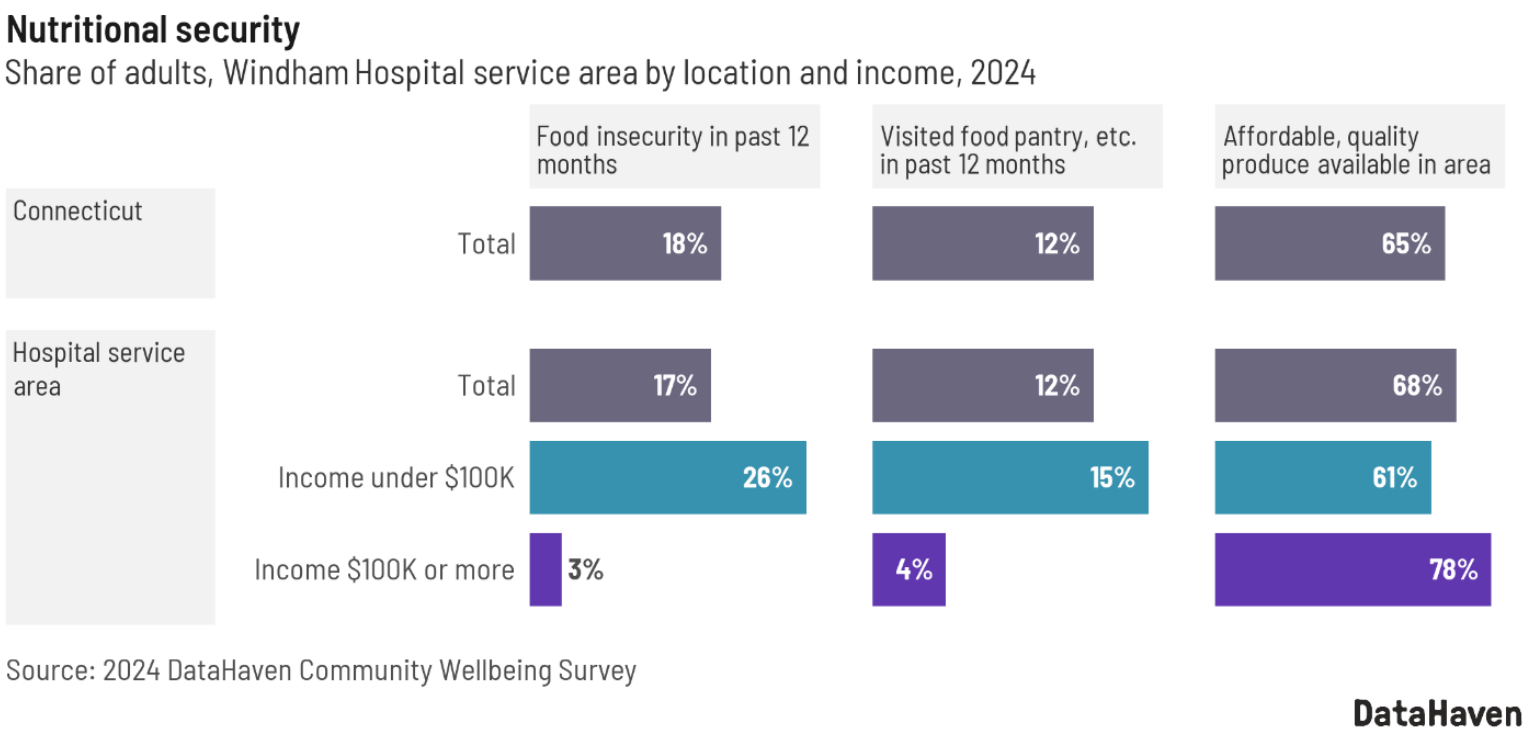
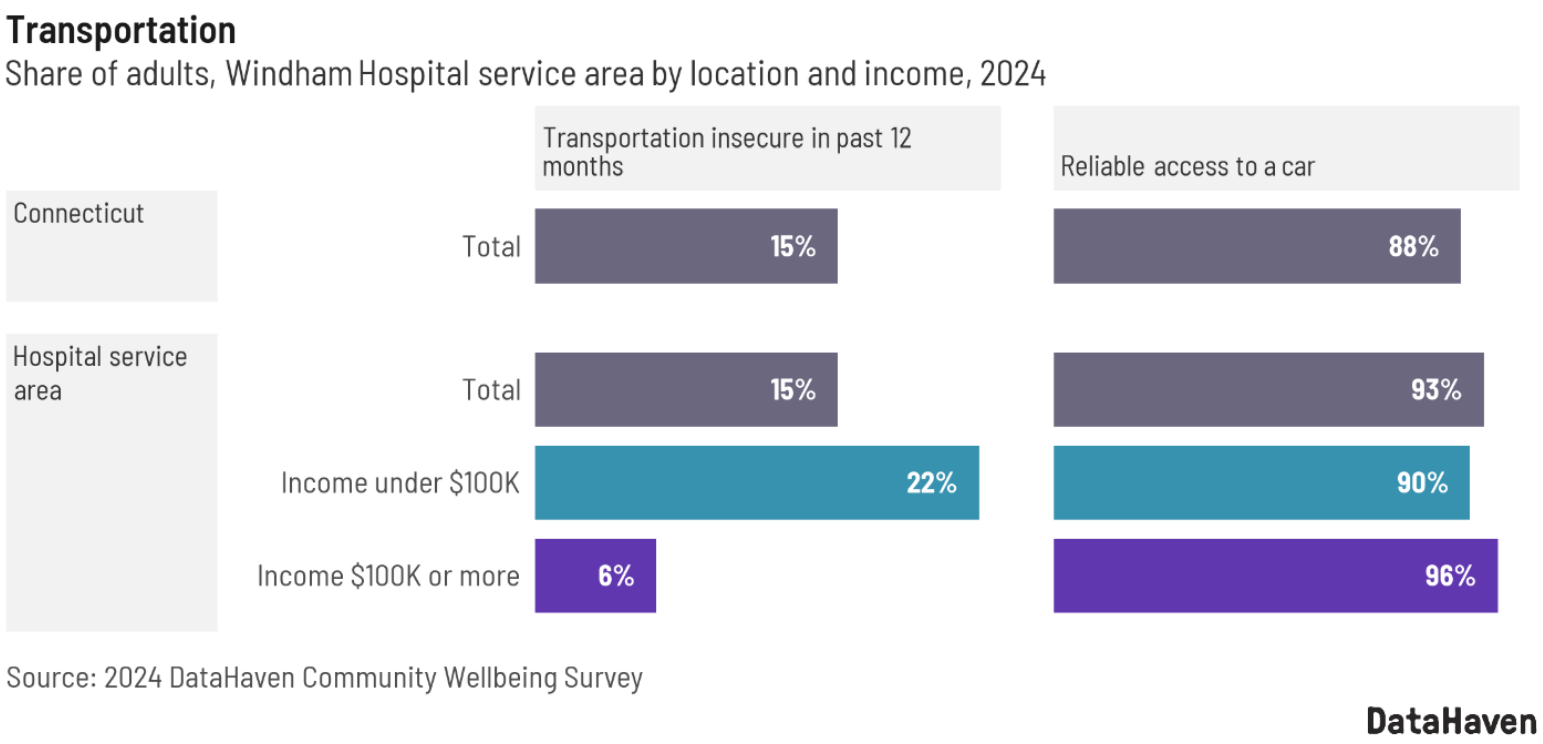
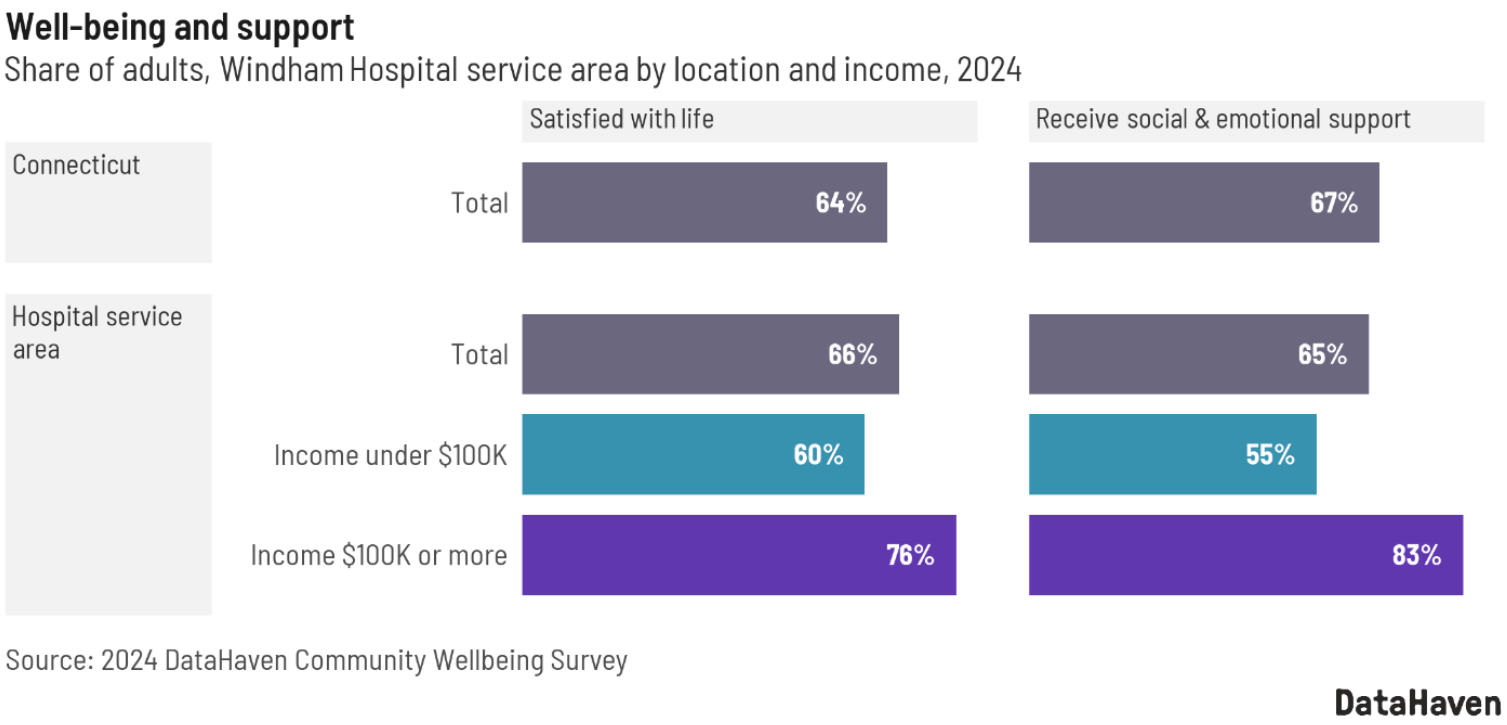


Figure 9: Windham Hospital Service Area Transportation Access and Security by Income Level



Well- being and Support

Figure 10: Windham Hospital Service Area Well-being and Support by Income Level



Appendix 11: Life Expectancy

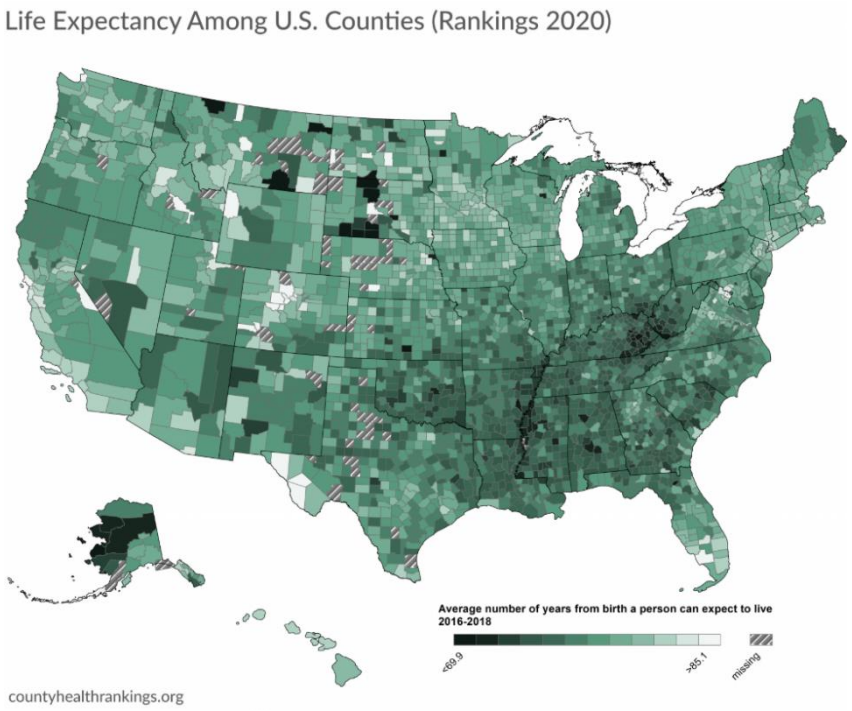
Introduction

Life expectancy is a crucial measure of overall community health. Windham County data include several key health indicators that influence the overall life expectancy of its residents. With a life expectancy of 77.4 years, Windham County falls below the Connecticut state average of 79.6 years but aligns closely with the national average. This section highlights the primary health challenges and areas for improvement related to life expectancy, analyzing how specific health measures compare with state and national data.[29]

Premature Death and General Health Indicators

Premature death, measured as years of potential life lost before age 75, stands at 8,000 per 100,000 population, significantly higher than Connecticut's 6,500 but in line with the national rate. Contributing factors include higher rates of poor physical and mental health days, with Windham County residents reporting more unhealthy days per month than the state and national averages. Addressing these health challenges through improved healthcare access, chronic disease management, and mental health support is critical to increasing life expectancy in the county.

Windham County experiences a premature death rate of 8,000 years of potential life lost per 100,000 population, which is notably higher than Connecticut's 6,500 but equal to the national rate. Poor or fair health is reported by 14% of residents, slightly above the state rate (12%) and equal to the national rate (14%). Similarly, Windham County residents experience 3.6 poor physical health days per month, which is higher than Connecticut's 2.9 days and above the U.S. average of 3.3 days. Poor mental health days average 5.2 per month in Windham County, exceeding both the state (4.4) and national (4.8) averages, indicating a need for greater mental health support.[30]



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

[30] Ibid

Lifestyle and Behavioral Health Factors

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

Several behavioral factors contribute to health outcomes in Windham County. Adult smoking rates (17%) exceed both the state (12%) and national (15%) rates, suggesting that tobacco cessation programs could significantly benefit the community. Adult obesity rates (35%) also surpass the state average (31%) and are slightly higher than the national average (34%), reinforcing the need for improved nutrition and physical activity initiatives.[31]

Access to exercise opportunities is significantly lower in Windham County (74%) compared to Connecticut (93%) and the U.S. (84%), highlighting a gap in infrastructure for recreational activities. Additionally, excessive drinking (19%) is slightly higher than both the state (17%) and national (18%) averages, indicating a need for targeted interventions to address substance abuse.[32]

Healthcare Access and Preventive Care

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

As noted, healthcare access remains a concern, particularly in provider availability. Windham County has significantly fewer primary care physicians, with a provider-to-population ratio of 2,330:1, compared to Connecticut's 1,210:1 and the national ratio of 1,330:1. Similar shortages exist for dentists (2,010:1 vs. 1,150:1 in Connecticut and 1,360:1 nationally) and mental health providers (250:1 vs. 220:1 in Connecticut and 320:1 nationally). These disparities indicate a critical need for healthcare workforce development in the county.[33]

Preventive care metrics also reveal areas for improvement. Mammography screening rates are slightly lower in Windham County (45%) compared to Connecticut (47%) but above the national average (43%). Flu vaccination rates in the county (52%) are slightly lower than the state average (54%) but higher than the national rate (46%). Improving these rates could help reduce preventable diseases and hospitalizations.[34]

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[31] Ibid.

[32] Ibid.

[33] Ibid.

[34] Ibd.

Health-related Social Needs

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

The Windham County high school completion rate (90%) is slightly below Connecticut's 91% but above the national average (89%). However, the percentage of residents with some college education (58%) is markedly lower than both the state (71%) and national (68%) figures, suggesting that education initiatives could enhance long-term health outcomes.[35]

Unemployment in Windham County stands at 4.3%, marginally above Connecticut's 4.2% and well above the national average of 3.7%. Additionally, 17% of children in Windham County live in poverty, a rate higher than the state average (13%) but comparable to the national rate (16%). These factors contribute to economic instability, which can negatively affect access to healthcare and healthy living conditions.[36]

Housing and environmental concerns also play a role in community health. Severe housing problems affect 13% of Windham County residents, which is lower than both the state and national averages (17%). Air pollution levels, measured in particulate matter, are lower in Windham County (6.5) compared to Connecticut and the U.S. (both 7.4), suggesting a relatively favorable environmental condition.[37]

Health Risk Behaviors and Mortality

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

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

Teen birth rates in Windham County (10 per 1,000 females aged 15-19) are higher than Connecticut's (8) but significantly lower than the national rate (17). Similarly, sexually transmitted infections are significantly lower in Windham County (211.3 per 100,000) compared to both the state (409.1) and national averages (495.5), suggesting better sexual health practices or lower rates of testing and reporting.[39]

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

[36] Ibid.

[37] Ibid.

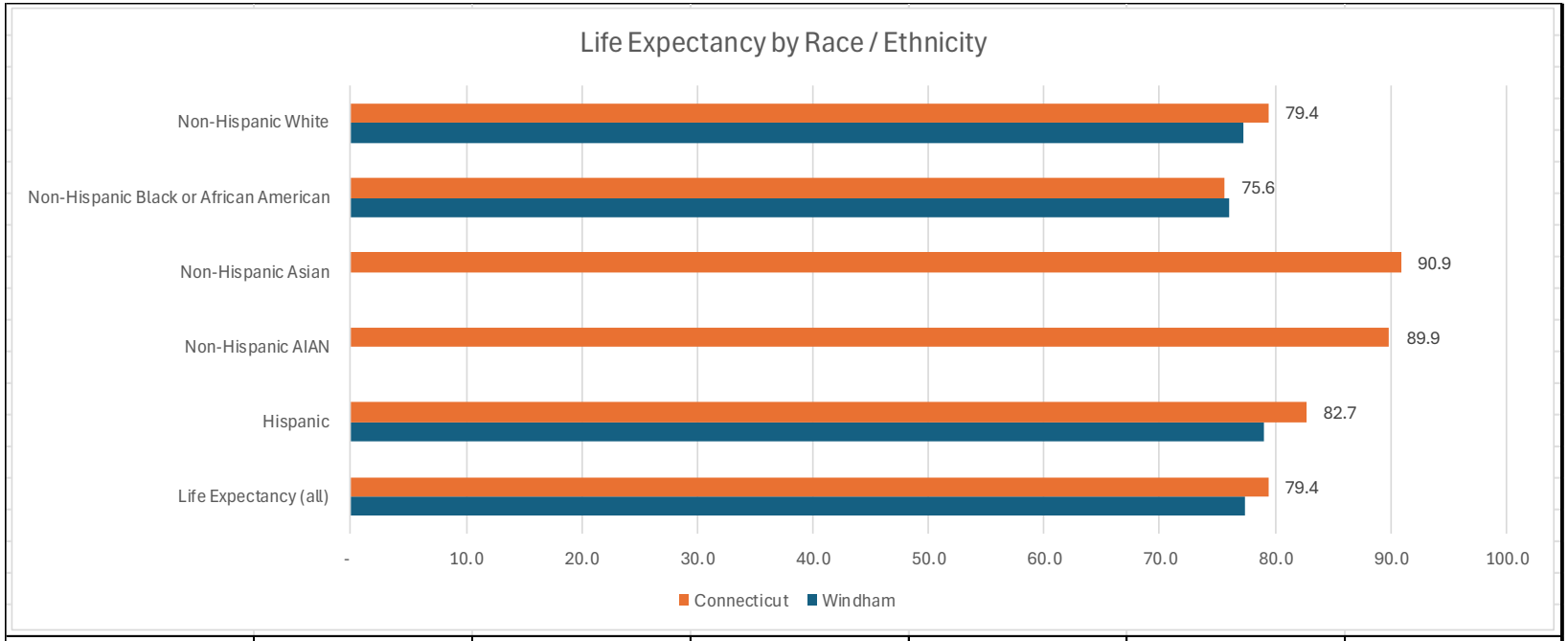
[38] Ibid.

[39] Ibid.

Conclusion and Recommendations

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

Figure 11: Life Expectancy by Race and Ethnicity



	Life Expectancy (all)	Hispanic	Non-Hispanic AIAN	Non-Hispanic Asian	Non-Hispanic Black or African American	Non-Hispanic White
Connecticut	79.4	82.7	89.9	90.9	75.6	79.4
Windham County	77.4	79.0	NA	NA	76.0	77.3

[40]

[40] AIAN means American Indian / Alaska Native.

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

As expected, mortality rates in Windham County residents escalate with age; however, there is an atypical escalation of rates among people ages 40 to 44. Note that due to small population, mortality data is not available for Blacks / African Americans or Hispanics (in most cases).

Windham County	Race / Ethnicity		
Age Group	White	Black or African American	Hispanic or Latino
< 1 year	-	-	-
1-4 years	-	-	-
5-9 years	-	-	-
10-14 years	-	-	-
15-19 years	-	-	-
20-24 years	99.1	-	-
25-29 years	175.4	-	-
30-34 years	239.7	-	-
35-39 years	220.8	-	-
40-44 years	312.7	-	-
45-49 years	261.3	-	-
50-54 years	476.7	-	-
55-59 years	734.6	-	-
60-64 years	1,039.8	-	-
65-69 years	1,475.9	-	-
70-74 years	2,320.1	-	2,474.2
75-79 years	4,120.3	-	-
80-84 years	6,673.1	-	-
85-89 years	-	-	-
90-94 years	-	-	-
95-99 years	-	-	-
100+ years	-	-	-

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

- Death before age one year is 2.5 times higher for Black or African Americans than Whites.
- Mortality before age 45 is approximately 20% higher for Black or African Americans than Whites.
- Death rates among Hispanic teens (ages 15-19) is 200% higher than for Whites.

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

Internal Revenue Code § 501(r)(3) requires every tax-exempt hospital facility to perform a Community Health Needs Assessment (CHNA) at least once every three years and to adopt a written implementation strategy based on that assessment.[41] An authorized body must approve the CHNA report and adopt an implementation strategy to address the identified needs on or before the 15th day of the fifth month after the end of the taxable year in which the CHNA was conducted.[42] The CHNA report must be posted on a Web site and a paper copy available for public upon request and without charge at the hospital facility.[43]

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

To conduct a CHNA, a hospital facility must:

1. Define the community it serves.
2. Assess the needs of that community
3. In assessing the health needs of the community, solicit and take into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health.
4. Document the CHNA in a written report (CHNA report) that is adopted for the hospital facility by an authorized body of the hospital facility
5. Make the CHNA report widely available to the public. [44]

CHNA Documentation: The CHNA report must:

1. **Define the hospital facility's community.**
   IRS Regulation Text: "A definition of the community served by the hospital facility and a description of how the community was determined."[45]

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[41] 26 U.S.C. § 501(r)-3(a)(1).

[42] 26 U.S.C. § 501(r)-3(a)(2).

[43] 26 U.S.C. § 501(r)-3(b)(7).

[44] 26 U.S.C. § 501(r)-3(b).

[45] 26 U.S.C. § 501(r)-3(b)(6)(A).

In defining the community it serves…a hospital facility may take into account all of the relevant facts and circumstances, including the geographic area served by the hospital facility, target population(s) served (for example, children, women, or the aged), and principal functions (for example, focus on a particular specialty area or targeted disease). However, a hospital facility may not define its community to exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital facility draws its patients (unless such populations are not part of the hospital facility's target patient population(s) or affected by its principal functions) or otherwise should be included based on the method the hospital facility uses to define its community. [A] hospital facility must take into account all patients without regard to whether (or how much) they or their insurers pay for the care received or whether they are eligible for assistance under the hospital facility's financial assistance policy. In the case of a hospital facility consisting of multiple buildings that operate under a single state license and serve different geographic areas or populations, the community served by the hospital facility is the aggregate of such areas or populations.[46]

Section within this CHNA: Hospital Description and Service Area (p10);Demographic and Secondary Research Highlights (p13ff); and Community Demographic Profile (p14ff)

2. **Process and Methods.**

IRS Regulation Text: "A description of the process and methods used to conduct the CHNA."[47] To assess the health needs of the community it serves…a hospital facility must identify significant health needs of the community, prioritize those health needs, and identify resources (such as organizations, facilities, and programs in the community, including those of the hospital facility) potentially available to address those health needs. For these purposes, the health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities). These needs may include, for example, the need to address financial and other barriers to accessing care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community. A hospital facility may determine whether a health need is significant based on all of the facts and circumstances present in the community it serves. In addition, a hospital facility may use any criteria to prioritize the significant health needs it identifies, including, but not limited to, the burden, scope,

[46] 26 U.S.C. § 1.501(r)-3(b)(3).

[47] 26 U.S.C. § 1.501(r)-3(b)(6)(B).

severity, or urgency of the health need; the estimated feasibility and effectiveness of possible interventions; the health disparities associated with the need; or the importance the community places on addressing the need.[48]

A hospital facility's CHNA report [must] describe the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identify any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA. In the case of data obtained from external source material, the CHNA report may cite the source material rather than describe the method of collecting the data.[49]

Section within this CHNA: The Regional, Collaborative, and Inclusive Approach (p2); Process / Methodology (p3-4); Needs Assessment Research Approach (p7);Detailed Research Method (p8); Predictive Analytics and Socio-economic Factors Impacting Health (p29); and Community Wellbeing Survey and Other Research (p34).

3. **Describe solicitation and Community Input**

IRS Regulation Text: "A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves"[50]: [A] hospital facility must solicit and take into account input received from all of the following sources in identifying and prioritizing significant health needs and in identifying resources potentially available to address those health needs:

> (A) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency), or a State Office of Rural Health… with knowledge, information, or expertise relevant to the health needs of that community.
>
> (B) Members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of such populations. Medically underserved populations include populations experiencing health disparities or at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers.

[48] 26 U.S.C. § 1.501(r)-3(b)(4).

[49] 26 U.S.C. § 1.501(r)-3(b)(6)(ii).

[50] 26 U.S.C. § 1.501(r)-3(b)(6)(C).

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

In addition … a hospital facility may solicit and take into account input received from a broad range of persons located in or serving its community, including, but not limited to, health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers and community health centers, health insurance and managed care organizations, private businesses, and labor and workforce representatives.[51]

A hospital facility's CHNA report [must] summarize, in general terms, any input provided by such persons and how and over what time period such input was provided (for example, whether through meetings, focus groups, interviews, surveys, or written comments and between what approximate dates); provide the names of any organizations providing input and summarize the nature and extent of the organization's input; and describe the medically underserved, low-income, or minority populations being represented by organizations or individuals that provided input. … In the event a hospital facility solicits, but cannot obtain, input from a [required] source, the hospital facility's CHNA report also must describe the hospital facility's efforts to solicit input from such source.[52]

Section within this CHNA: Detailed Research Method (p8); Process / Methodology (p3); Demographic Analysis and Community Input (p13); Qualitative Research Highlights (p33); Community Well-being Survey and Other Research (p34ff); Data Analysis and Community Input Summary (p37)

4. **Prioritized list of community health needs.**

IRS Regulation Text: "A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs"[53]

[51] 26 U.S.C. § 1.501(r)-3(b)(5).

[52] 26 U.S.C. § 1.501(r)-3(b)(6)(iii).

[53] 26 U.S.C. § 1.501(r)-3(b)(6)(D).

Section within this CHNA: Results (p4); Qualitative Research Highlights (p33); Data Analysis and Community Input Summary (p37); Prioritization Process (p42-44); Final Priorities (p44ff)

5. **Community resources**

IRS Regulation Text: "A description of the resources potentially available to address the significant health needs identified through the CHNA"[54]

Section within this CHNA: Local Activities (p40ff); and Appendix 13 (p114)

6. **Impact Evaluation**

IRS Regulation Text: "An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s)."[55]

Section within this CHNA: Evaluation of 2023–2025 Implementation Plan (p39); Local Activities (p40ff)

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

1. Posting on a website until two subsequent CHNAs are posted; and

2. Making a paper copy available for public inspection without charge until two subsequent CHNAs are available.[56]

Implementation Strategy Requirements

1. **Implementation Strategy:**

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

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

[54] 26 U.S.C. § 1.501(r)-3(b)(6)(E).

[55] 26 U.S.C. § 1.501(r)-3(b)(6)(F).

[56] 26 C.F.R. § 1.501(r)-3(b)(7)(i).

ii. Identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address the health need.[57]

Section within this Implementation Strategy: Priority Areas and Strategies (p45ff)

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

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

i. Describes the actions the hospital facility intends to take to address the health need and the anticipated impact of these actions;

ii. Identifies the resources the hospital facility plans to commit to address the health need; and[58]

iii. Describes any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need.

Section within this Implementation Strategy: Priority Areas and Strategies; Lead and Partners (p45ff)

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

IRS Regulation Text: In explaining why it does not intend to address a significant health need […], a brief explanation of the hospital facility's reason for not addressing the health need is sufficient. Such reasons may include, for example, resource constraints, other facilities or organizations in the community addressing the need, a relative lack of expertise or competency to effectively address the need, the need being a relatively low priority, and/or a lack of identified effective interventions to address the need.[59]

Section within this Implementation Strategy: Priority Areas and Strategies; Lead and Partners (p45ff)

[57] 26 C.F.R. *§ 1.501(r)-3(c)(1).*

[58] 26 C.F.R. *§ 1.501(r)-3(c)(2).*

[59] 26 C.F.R. *§ 1.501(r)-3(c)(3).*

Appendix 13: Community-based Health-related Resources

RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

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

Health Department
North Central District Health Department, 860-745-0383, https://www.ncdhd.org/
Health Centers
Generations Family Health Center, 860-450-7471, https://genhealth.org/locations/
SBHC (School Based Health Centers), 860-465-2465, https://www.windhamps.org/page/school-based-health-centers
Community Action Agencies
Access Community Action Agency, 860-450-7400, https://accessagency.org/
Senior Services
Windham Senior Center, 860-450-2100, https://windhamct.gov/173/Senior-Center
Hartford HealthCare Center for Healthy Aging, 860-456-6785, https://windhamhospital.org/services/senior-services
Youth and Family Services
Windham Human Services, 860-450-2100, https://www.windhamct.gov/170/Human-Services
Windham Regional Community Council, 860-423-4534
Heritage and Nature
Philip Lauter Park, 626 Jackson St. Willimantic
Recreation Park, 50 Main St. Willimantic
Beaver Brook State Park, 601 Back Rd. Windham

Need help finding free or low-cost services?

Go to www.connectionsthatmatter.org