# Sharon Hospital
# 2022 Community Health Needs Assessment Report

Nuvance Health

# A letter from Nuvance Health

**Communication. Collaboration. Commitment.**

These are essential elements for improving population health in our communities.

Nuvance Health is pleased to present our 2022 CHNA findings. This report includes a review and analysis of health and socio-economic data that impact the health of people across our service area. The purpose of this assessment is to identify the area's health needs so we may better align with stakeholders, such as public health and healthcare providers, about opportunities for improving the health of our region. These results allow Nuvance Health, state and county public health departments, our community partners, and other providers to set priorities, develop interventions, and commit the appropriate resources to our region more strategically.

Our workforce of more than 1 5,000 compassionate caregivers provides high-quality care through our six nonprofit hospitals on seven campuses, multiple outpatient care sites, numerous primary care and specialty provider locations, and increasing set of virtual healthcare services. Across the system, we offer state-of- the-art facilities, technology and a breadth of clinical services.

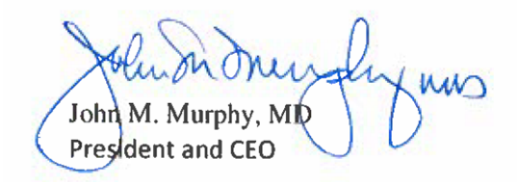
The staff of Nuvance Health are dedicated to the health and well-being of everyone in our region, regardless of race, ethnicity, age, gender, religion, sexual orientation, gender identity, gender expression, disability, economic status and other diverse backgrounds. This is our promise to the more than 1.5 million children and adults we serve in western Connecticut and the Hudson Valley of New York.

To ensure our services are aligned with the healthcare needs of our community, we complete a Community Health Needs Assessment (CHNA) every three years for each hospital community, and it was conducted January to September 2022. This helps us better serve our community by measuring the health status of residents, gathering community input on health concerns, and identifying opportunities to collaborate. With the help of many state, county and community partners, we had strong participation in our surveys, and we value this feedback and recognize all community stakeholders who play an integral part in advancing the health of our region.

And this is only the beginning. We continually assess how we serve our region so we can provide outstanding care, as well as education and outreach activities that meet priority needs. In doing so, we will continue to collaborate with our partners, educate our policy makers, and engage community residents to promote health for all residents of our region.

We look forward to our continued work together and thank you for putting your trust in us. At Nuvance Health, we are not only your caregivers—we are also your friends, family and neighbors. Through our community benefit initiatives, we aim to increase well-being for everyone.

With gratitude,



John M. Murphy, MD
President and CEO

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# Our Commitment to Community Health

Where some see impossible, we see what's possible. At Nuvance Health, we continually strive for progress and push past the status quo in all aspects of what we do. We are Nuvance Health!

Nuvance Health is an integrated health system offering convenient, accessible, and affordable care to community members. We're here for you–whenever and wherever you need us. Our talented team of more than 15,000 compassionate caregivers provides high-quality care through:

- Community hospitals
- Primary care and specialty practice locations
- Outpatient settings
- Home care services
- A skilled nursing and rehabilitation facility
- Telehealth visits

Our network also includes a well-known research institute, which brings breakthroughs from the lab directly to the bedside. We take research to heart and focus on treatments and cures that will benefit our community.

Improving the health of the community is essential to enhancing its residents' quality of life and supporting its future economic and social wellbeing. To effectively improve health, communities must address social, environmental, and behavioral factors in addition to ensuring access to medical services. Sharon Hospital, under the auspices of the Community Health Committee, partnered with community stakeholders and public health professionals to conduct a Community Health Needs Assessment (CHNA) to assess the health and social needs of the Sharon Hospital community.

This report provides an overview of key findings from the CHNA and the priority elements that will be used to develop the three-year Community Health Improvement Plan to guide our community benefit and community health improvement efforts.

# 2022 CHNA Executive Summary

## CHNA Leadership

The 2022 CHNA was overseen by the Community Health Committee of the Board of Directors of Nuvance Health. The Committee includes representations of the hospital communities, including hospital Board leadership, administrative leadership from the Nuvance Health network, local health department directors, community stakeholders, and other key hospital stakeholders.

### Sharon Hospital Community Health Committee

- **Katie Palmer-House – Chair – Board Member**
- John Charde, MD – Board Member
- Hugh Hill – Board Member
- Nancy Heaton – Community (CEO, Foundation for Community Health)
- Aisha M. Phillips – Community (Senior Public Health Education Coordinator, Dutchess Co. Dept. of Behavioral and Community Health)
- Stefanie Hubert – Community (Executive Director, Putnam Co. Cornell Cooperative Extension)
- Christine Sergent – Community (Executive Director, Northeast Community Center, Certified Dietician Nutritionist)
- Mimi Tannen – Board Member (Chair, Foundation for Community Health)

*Professional Staff*

- Marina Ballantine – SH Associate, Public and Community Affairs
- Rowena Bergmans – Nuvance VP Strategic Payer and Community Partnerships
- Sally Herlihy – VP Strategic Planning & Bus Development Planning
- Melissa Braislin – Director of Rehabilitation Services and Cardiac Rehab
- Jim Hutchinson – SH Clinical Navigator
- Christina McCulloch – Nuvance President Sharon Hospital
- Trista Parker – Nuvance Manager Strategic Business/Planning
- Ildiko Rabinowitz – Nuvance AVP of Health Equity, Diversity & Inclusion

## Our Research Partners

Nuvance Health contracted with Community Research Consulting to compile the CHNA reporting and guide the development of the Community Health Improvement Plan. CRC is a woman-owned business that specializes in conducting stakeholder research to illuminate disparities and underlying inequities and transform data into practical and impactful strategies to advance health and social equity. Their interdisciplinary team of researchers and planners have worked with hundreds of health and human service providers and their partners to reimagine policies and achieve measurable impact. Learn more about our work at buildcommunity.com.

DataHaven conducted the DataHaven Community Wellbeing Survey (DCWS), a statistical household survey to gather information on wellbeing and quality of life for Connecticut's neighborhoods. The DCWS is a nationally recognized program that provides critical, highly reliable local information not available from any other public data source. A

501(c)3 nonprofit organization and registered as a Public Charity with the State of Connecticut, DataHaven is a partner of the National Neighborhood Indicators Partnership, a learning network, coordinated by the Urban Institute, of independent organizations in 30 cities that share a mission to ensure all communities have access to data and the skills to use information to advance equity and wellbeing across neighborhoods.

Siena College Research Institute conducted a random-digit dial Regional Community Health Survey. The survey was designed to supplement the Regional CHNA and to gauge residents' perception of the health and resources in their communities. Founded in 1980 at Siena College in New York's Capital District, the Siena College Research Institute (SCRI) conducts regional, statewide, and national surveys on business, economic, political, voter, social, academic, and historical issues. The surveys include both expert and public opinion polls.

The Greater New York Hospital Association (GNYHA) conducted the 2022 GNYHA CHNA Survey of adults aged 18 or older who live in a zip code or county served by the hospital. The survey was intended to garner resident input on community health priorities based on perceived importance and satisfaction. The survey used a non-probability convenience sample. A web-based survey tool and a paper-based tools were used to collect the survey data. Surveys were available in a variety of languages. The GNYHA CHNA questionnaire was translated from English into Spanish, Chinese, Russian, Yiddish, Bengali, Korean, Haitian Creole, Italian, Arabic, and Polish.

## Methodology and Community Engagement

The 2022 CHNA included quantitative research methods and community conversations to determine health trends and disparities affecting the Sharon Hospital community. Community engagement was an integral part of the 2022 CHNA. In assessing community health needs, input was solicited and received from persons who represent the broad interests of the community, as well as underserved, low-income, and minority populations. These individuals provided wide perspectives on health trends, expertise about existing community resources available to meet those needs, and insights into service delivery gaps that contribute to health disparities and inequities.

The following research methods were used to determine community health needs:

- **Analysis of Health and Socioeconomic Data:** Public health statistics, demographic and social measures, and healthcare utilization data were collected and analyzed to develop a comprehensive community profile that illuminated health disparities and underlying inequities.
- **Community Surveys of Lived Experiences:** As part of the DataHaven Community Wellbeing Survey across Connecticut and Siena College Regional Community Health Survey within New York, statistical telephone surveys were conducted with households in the Sharon Hospital community to gather information on wellbeing and quality of life.

- **Community Perception Surveys:** As part of the Greater New York Hospital Association CHNA Survey, a web- and paper-based convenience survey was conducted with nearly 200 households in the Sharon Hospital community to garner perceptions on health priorities.
- **Input from Experts and Key Stakeholders:** Health and social service providers, public health experts, and representatives from a wide range of community-based organizations participated in the CHNA to guide the process and provide insights on community health needs.

## Community Health Priorities

To work toward health equity, Nuvance Health commits to ensuring hospital resources and activities build upon existing priorities and collaborative activities, while ensuring responsiveness to emergent needs. Determination of priorities made by leadership of Nuvance Health included review of existing commitments, new research findings, and community feedback.

Nuvance Health will focus efforts on the following community health priorities as part of its 2022-2025 Community Health Implementation Plan (CHIP):

- Prevent Chronic Diseases
- Promote Well-Being and Prevent Mental and Substance Use Disorders

Nuvance Health is committed to continuing its collaboration with the Community Health Committee and other stakeholders to further refine focus areas within the identified health priorities. Together with these partners and stakeholders, Nuvance Health will create a CHIP that reflects collective health impact strategy and the many strengths and assets of our community partners to address these needs.

## Board Approval

The 2022 CHNA was conducted in a timeline to comply with IRS Tax Code 501(r) requirements to conduct a CHNA every three years as set forth by the Affordable Care Act (ACA). The 2022 CHNA report was presented to the Nuvance Health Board of Directors and approved in September 2022.

Following the Board's approval, the CHNA report was made available to the public via the Nuvance Health website at Nuvance Health.

# Sharon Hospital Service Area

Sharon Hospital is located in Sharon, Connecticut in Litchfield County, along the Columbia County and Dutchess County, New York borders. The hospital serves residents of all three counties, although most patients reside in Litchfield or Dutchess. For purposes of the CHNA and partnering with state-based initiatives, Sharon Hospital focused on its Litchfield and Dutchess County service areas and conducted research for these communities separately.

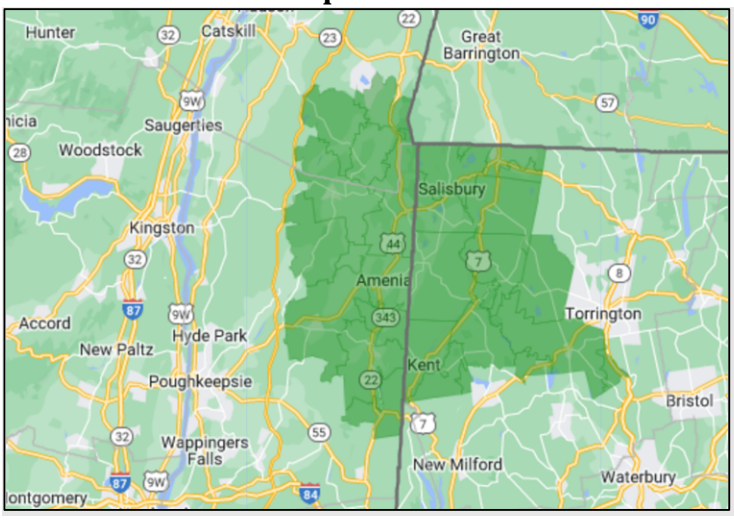
Sharon Hospital's CT and NY service areas, as depicted below, are referred to as the Connecticut Hospital Service Area (HSA) and New York HSA throughout the report. The CHNA data may also be presented for Dutchess and/or Litchfield counties, based on availability.

Connecticut HSA data includes DataHaven Community Wellbeing Survey results. Survey results are presented for the HSA with comparisons to Connecticut overall. Due to data limitations, results by respondent demographics, including race, ethnicity, and income, are only shown for Connecticut. New York HSA data includes Siena College Regional Community Health Survey results. Due to data limitations, survey results are presented for the aggregate service area only. The GNYHA CHNA Survey garnered feedback from residents across the Connecticut and New York HSAs.

Health and socioeconomic data for the New York HSA were collected as part of the Mid-Hudson Region CHNA, unless otherwise noted. The regional CHNA was led by seven health departments and area health systems serving Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester counties. Data are most robust at the county-level and generally compare Dutchess County to the region, New York State (NYS), and/or New York State excluding New York City (NYS excl NYC).

Note: Connecticut HSA data is presented by town, including Sharon and the surrounding communities of Canaan, Cornwall, Goshen, Kent, North Canaan, Salisbury, and Warren. New York HSA data is presented by zip code for the communities of Amenia, Dover Plains, Millbrook, Millerton, Pine Plains, Stanfordville, Wassaic, and Wingdale. This difference in service area definition reflects community partner data collection and reporting practices.

**Sharon Hospital Service Area**



Understanding changes in population demographics is critical to plan for changes in healthcare, housing, economic opportunity, education, social services, transportation, and other essential infrastructure elements.

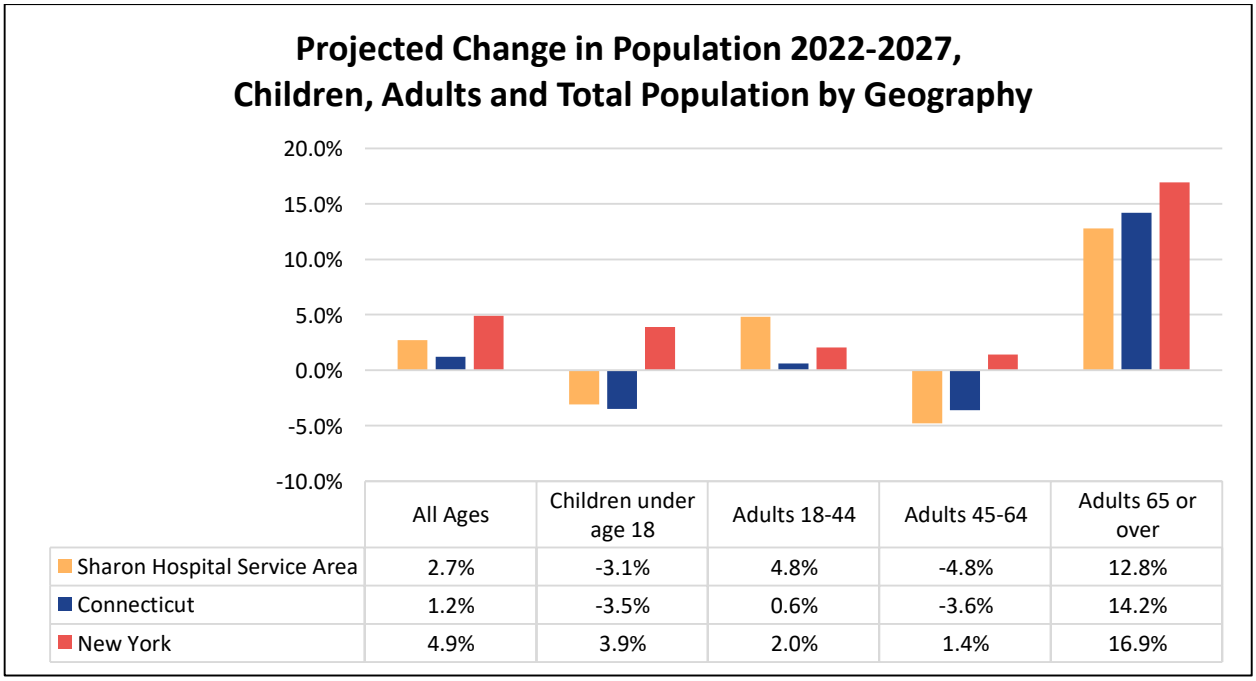
Connecticut and New York overall are aging states. Between 2022 and 2027, the population aged 65 or older is projected to increase 14.2% and 16.9%, respectively, the largest increase of any reported age group. The total population for Connecticut and New York is projected to increase 1.2% and 4.9%, respectively.

The Sharon Hospital Service Area population is projected to increase +1,549 people or 2.7% from 2022 to 2027, although consistent with an aging demographic, this growth will occur exclusively among adult populations. The population aged 65 or older will increase by +1,904 people or 12.8% from 2022 to 2027, while the child population under age 18 will decline by -297 people or -3.1%.

**Total Population and Population Change by Age Group**

| | 2022 Population | 2027 Population Projection | Projected Change |
|---|---|---|---|
| Sharon Hospital Service Area | | | |
| All Ages | 57,968 | 59,517 | +1,549 |
| Children under age 18 | 9,624 | 9,327 | -297 |
| Adults 18-44 | 16,109 | 16,877 | +768 |
| Adults 45-64 | 17,361 | 16,535 | -826 |
| Adults 65 or over | 14,874 | 16,778 | +1,904 |

Source: Claritas



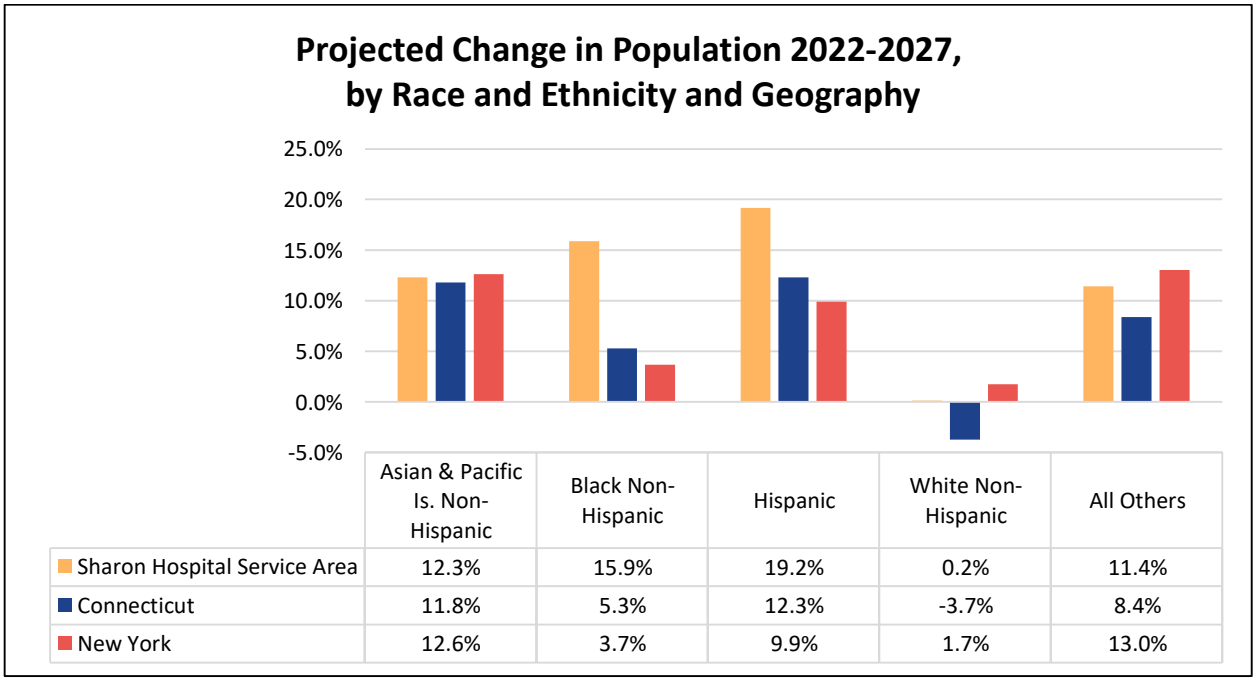

Source: Claritas

The Sharon Hospital Service Area is less racially and ethnically diverse than Connecticut and New York overall, although consistent with statewide trends, people of color are the fastest growing populations within the service area. Between 2022 and 2027, the white population within the Sharon Hospital Service Area is projected to grow 0.2%, while all other racial and ethnic groups are projected to grow 11% or more.

**2021 Total Population by Race and Ethnicity**

| | 2022 Population | | Projected Change 2022-2027 |
|---|---|---|---|
| | Count | Share of Population | |
| Sharon Hospital Service Area | | | |
| Asian & Pacific Islander Non-Hispanic | 838 | 1.5% | +103 |
| Black Non-Hispanic | 1,513 | 2.6% | +240 |
| Hispanic | 5,220 | 9.0% | +1,001 |
| White Non-Hispanic | 49,259 | 85.0% | +75 |
| All Others | 1,138 | 2.0% | +130 |

Source: Claritas

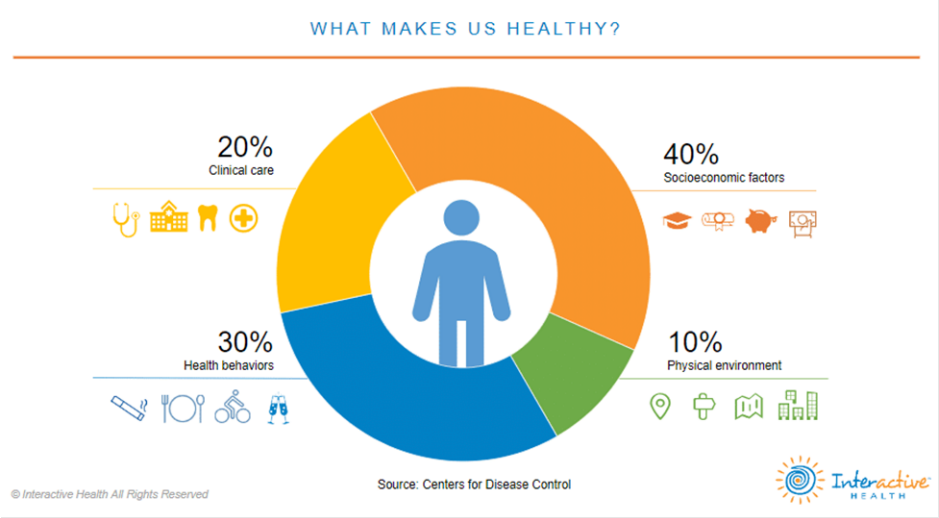



Source: Claritas

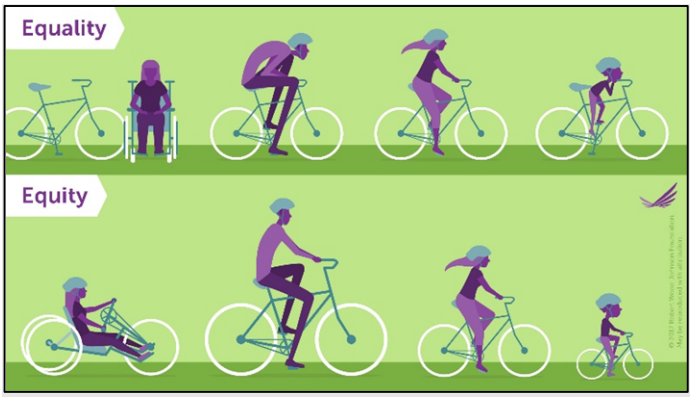
# Social Determinants of Health and Health Equity: A closer look at factors that influence well-being

Social determinants of health (SDoH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health risks and outcomes. Healthy People 2030, the CDC's national benchmark for health, outlines five key areas of SDoH: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.

While health improvement efforts have historically targeted health behaviors and clinical care, public health agencies, including the US Centers for Disease Control and Prevention (CDC), widely hold that at least **50% of a person's health profile is determined by SDoH.**




Addressing SDoH is a primary approach to achieving *health equity*. **Health equity can be simply defined as "a fair and just opportunity for every person to be as healthy as possible."** To achieve health equity, we need to look beyond the healthcare system to dismantle systematic inequities born through racism and discrimination like power and wealth distribution, education attainment, job opportunities, housing, and safe environments, to build a healthier community for all people now and in the future.



## Social Determinants of Health within the Sharon Hospital Service Area

### Economic Stability

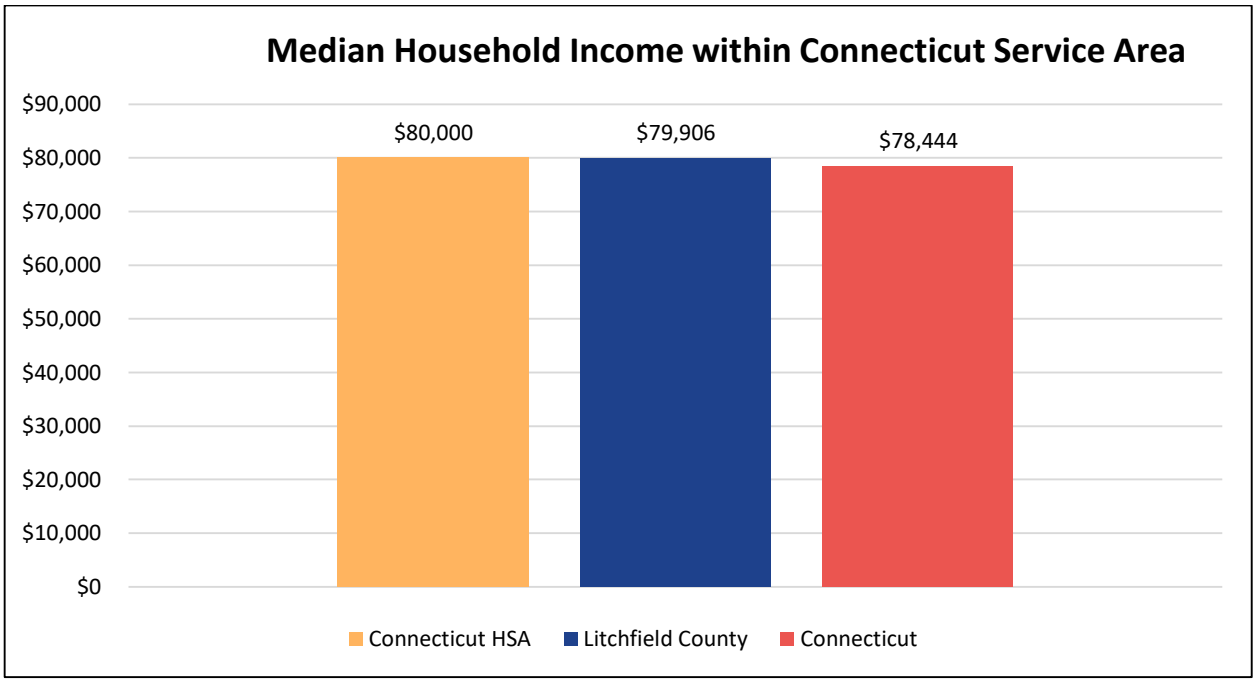
Income and work impact health outcomes. For example, many Americans access health insurance through their job, although not all types of work provide access to health insurance. Beyond health insurance, making healthy choices, such as purchasing lean meats and fresh produce or joining a gym, all cost money. Securing employment that allows individuals to provide a safe and decent home, nutritious food, transportation, child and elder care services, leisure activities, exercise, and medical needs depends on many factors. These factors can include education, age, access to employment opportunities, racism, language, and literacy, among others.

The median household income in the Connecticut HSA is $80,000, compared to $77,696 statewide, and fewer residents live in poverty compared to the state overall. However, this positive experience is not shared by all residents. Within the HSA, median household incomes by town range from $62,432 in North Canaan to $109,886 in Goshen. North Canaan also has higher poverty levels, affecting approximately 14% of all residents.

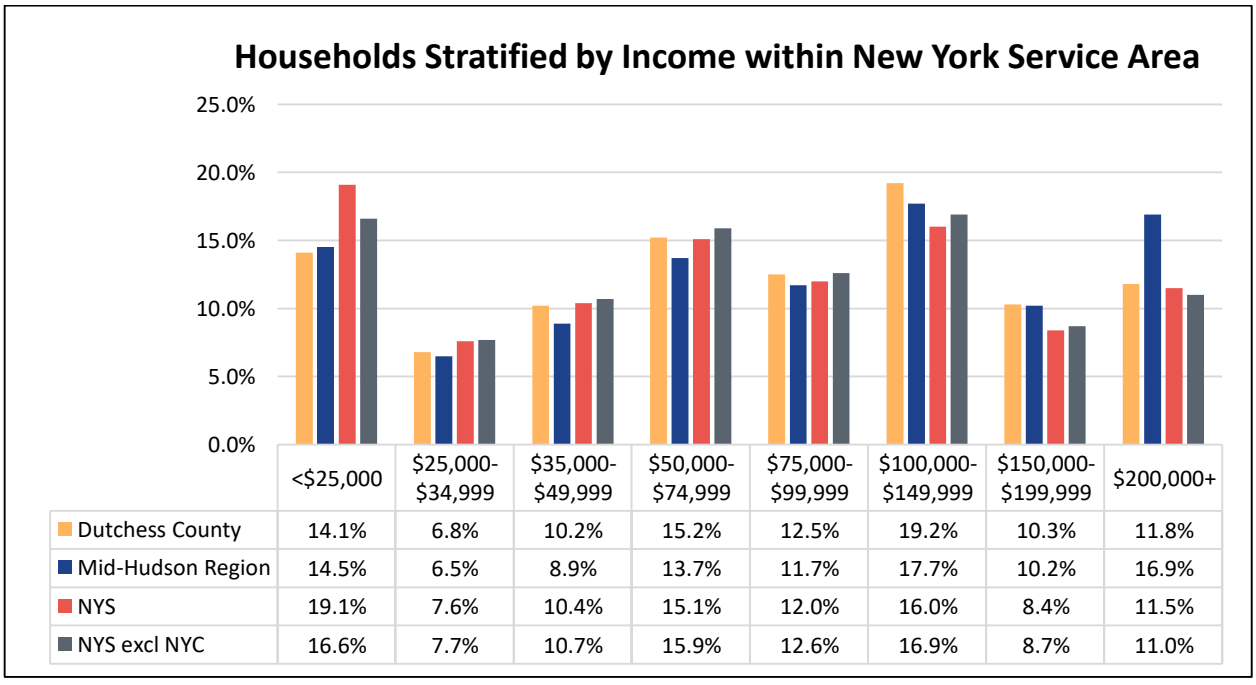
Residents of neighboring Dutchess County also have historically higher household incomes and lower poverty compared to New York overall. However, it is worth noting that across the county, more than 1 in 10 (14.1%) households have an annual income of less than $25,000.

Siena College Community Health Survey results indicate potentially higher socioeconomic need within Sharon Hospital's New York HSA relative to Dutchess County overall. Among survey respondents, 52% said it was "not very true" or "not at all true" that there are enough jobs that pay a living wage in their community. Approximately 18% of respondents had a time in the past 12 months when they or a member of their household were unable to get food when they needed it, and 8% had a time when they were unable to get utilities, including heat and electricity.

Across Dutchess County, the percentage of all food insecure residents was unchanged from 2017 to 2020, while the percentage of food insecure children declined. This finding may indicate increasing food insecurity among other vulnerable populations, such as older adults, communities of color, and/or individuals with low-income.




Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates




| | <$25,000 | $25,000-$34,999 | $35,000-$49,999 | $50,000-$74,999 | $75,000-$99,999 | $100,000-$149,999 | $150,000-$199,999 | $200,000+ |
|---|---|---|---|---|---|---|---|---|
| Dutchess County | 14.1% | 6.8% | 10.2% | 15.2% | 12.5% | 19.2% | 10.3% | 11.8% |
| Mid-Hudson Region | 14.5% | 6.5% | 8.9% | 13.7% | 11.7% | 17.7% | 10.2% | 16.9% |
| NYS | 19.1% | 7.6% | 10.4% | 15.1% | 12.0% | 16.0% | 8.4% | 11.5% |
| NYS excl NYC | 16.6% | 7.7% | 10.7% | 15.9% | 12.6% | 16.9% | 8.7% | 11.0% |

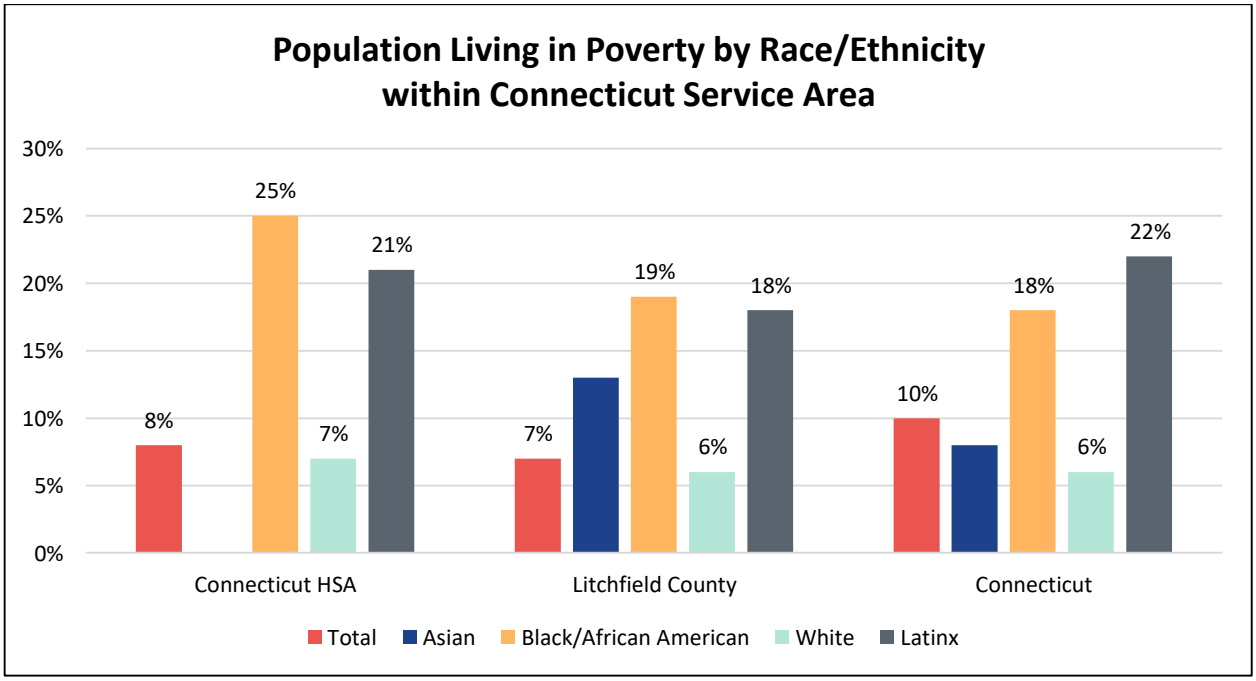
Source: Mid-Hudson Region CHNA, US Census Bureau American Community Survey 2020 5-year estimates

**Food Insecurity within New York Service Area**

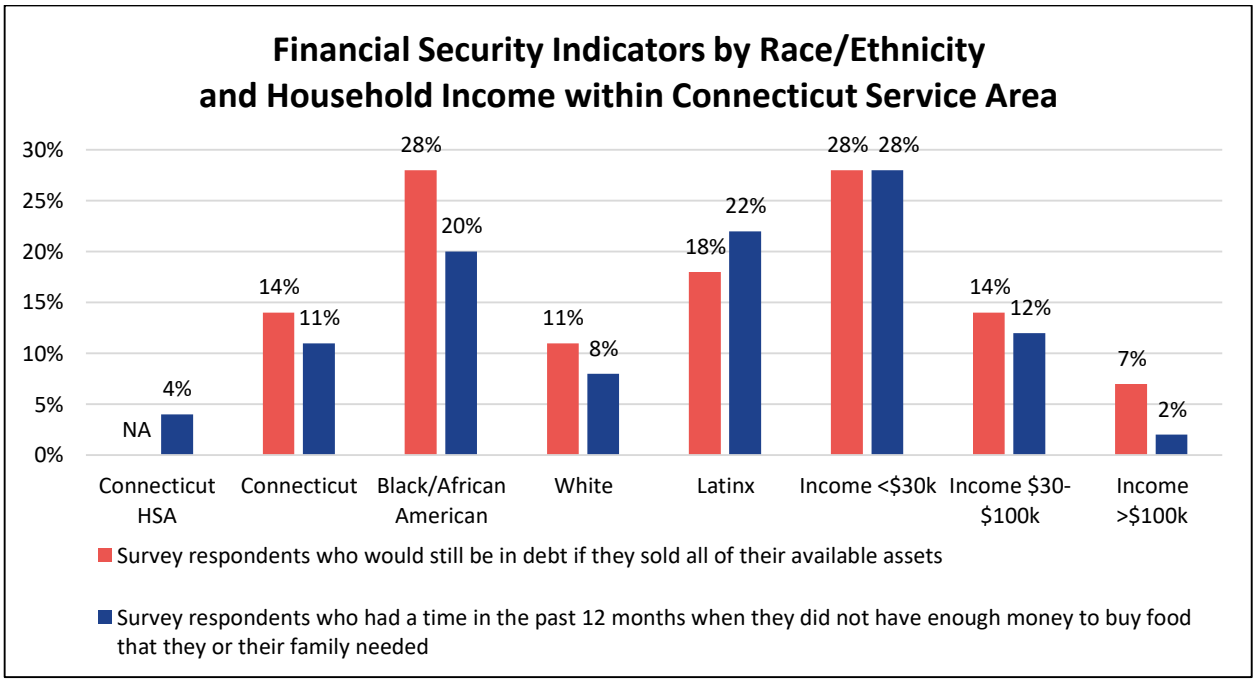
| | All Residents | | Children | |
|---|---|---|---|---|
| | Dutchess County | New York | Dutchess County | New York |
| 2017 | 8.6% | 11.4% | 14.5% | 17.6% |
| 2018 | 8.7% | 11.1% | 14.1% | 16.9% |
| 2019 | 8.5% | 10.7% | 12.5% | 15.7% |
| 2020 | 8.7% | 9.6% | 12.0% | 14.6% |

Source: Mid-Hudson Region CHNA, Feeding America, 2022

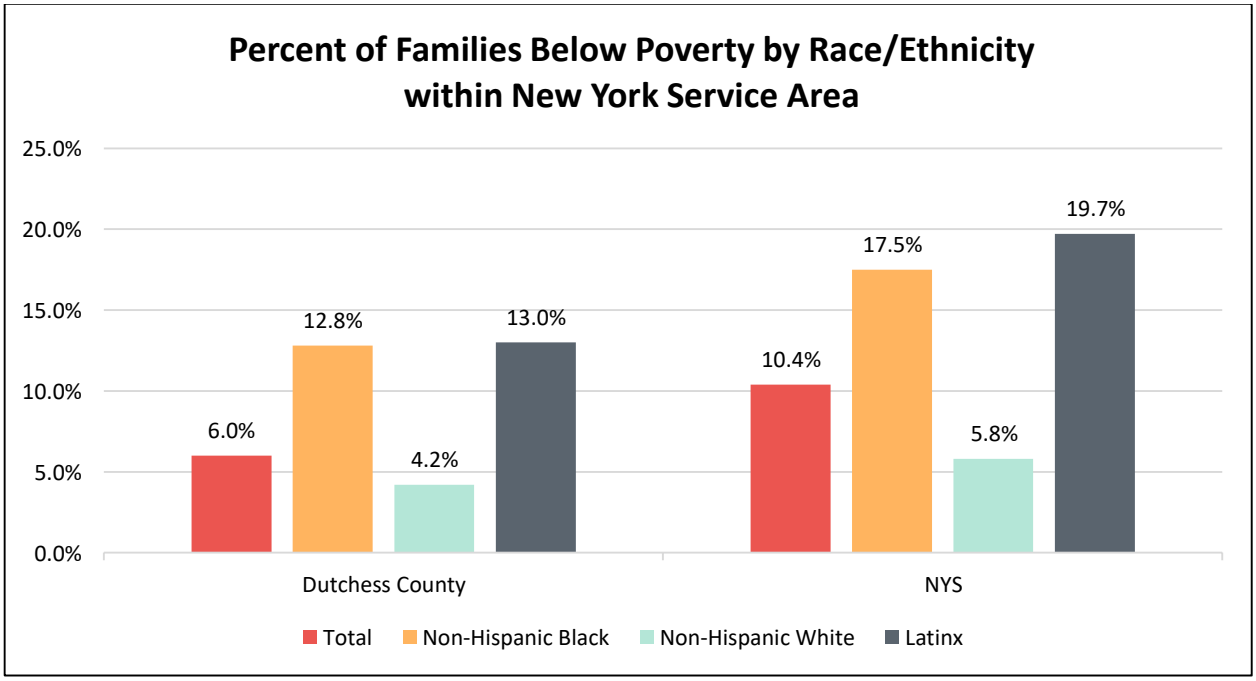
Historical barriers based on race, gender, ethnicity, and other factors continue to impact financial security and income for people today. For example, across the Connecticut and New York service areas, Black/African American and Latinx residents are more than twice as likely to live in poverty as white residents. Among Connecticut HSA Community Wellbeing Survey respondents, 28% of Black/African American respondents said they would still be in debt if they sold all of their assets, compared to 11% of white respondents. This disparity in economic resources impacts the ability of people with lower incomes to engage in health promoting activities, creating differences in the choices available to people to live their healthiest lives.




Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates




Source: 2021 DataHaven Community Wellbeing Survey



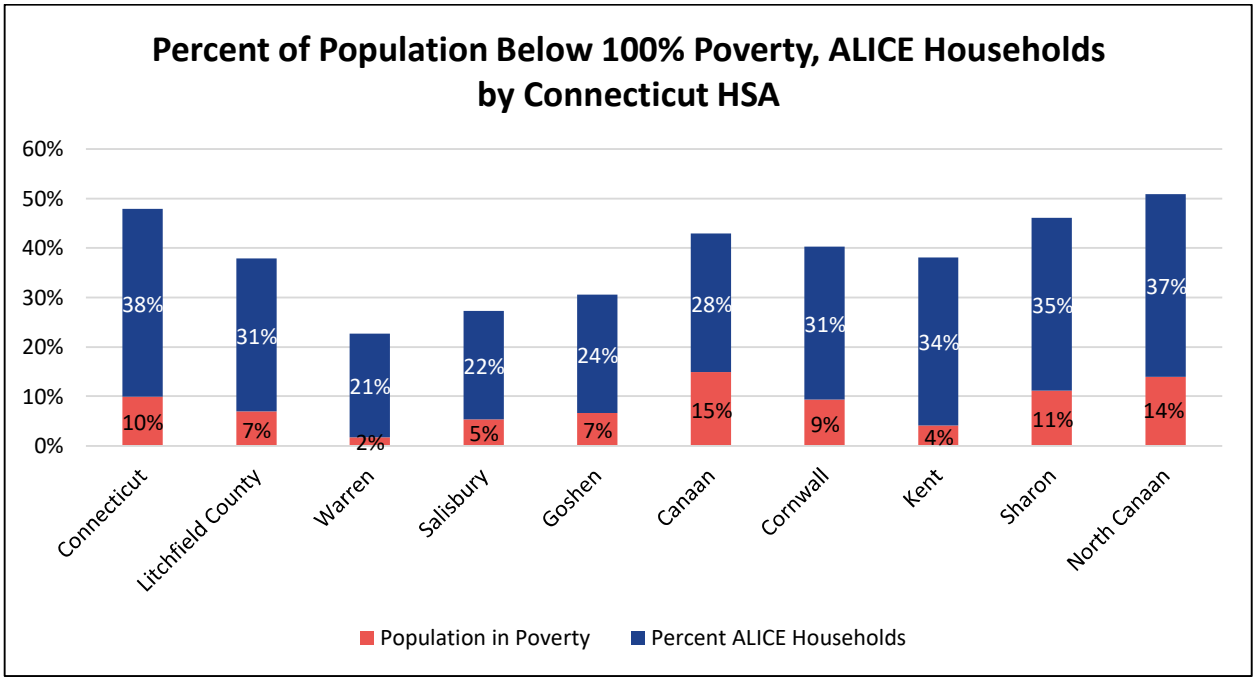

Source: Mid-Hudson Region CHNA, NYS Department of Health County Health Indicators, 2017-2019

**Asset Limited, Income Constrained, Employed (ALICE)** The ALICE threshold is an index that captures the percent of households whose income is above the federal poverty level, but below the threshold necessary to meet all basic needs based on localized cost of living and local average

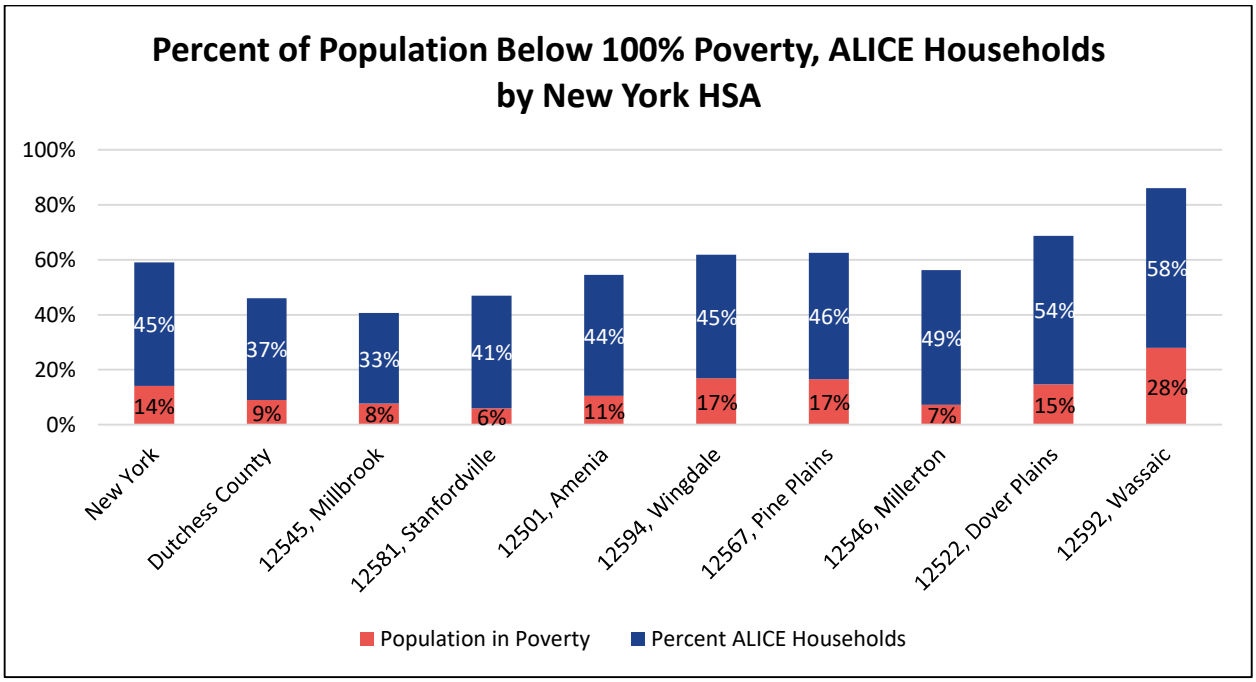
household sizes. ALICE measures the proportion of working poor and households who struggle to meet basic needs and are a paycheck or two away from acute financial strife.

While the proportion of people living in poverty is relatively low across the Connecticut HSA, more than 1 in 10 and up to 37% of all households throughout the area met the ALICE threshold. Within the New York HSA, Wassaic zip code 12592 is a pocket of economic disparity with 28% of residents living in poverty and 58% of households below ALICE. In comparison to the Connecticut HSA, New York HSA households overall are more likely to meet the ALICE threshold.

It is worth noting that ***ALICE findings reflect pre-COVID-19 pandemic data***. While the data regarding these measures during the pandemic are not yet available, anecdotal information suggests that the proportion of struggling households has increased during more recent years.




Source: United for ALICE and US Census Bureau American Community Survey 2019 5-year estimates



Source: United for ALICE and US Census Bureau American Community Survey 2019 5-year estimates

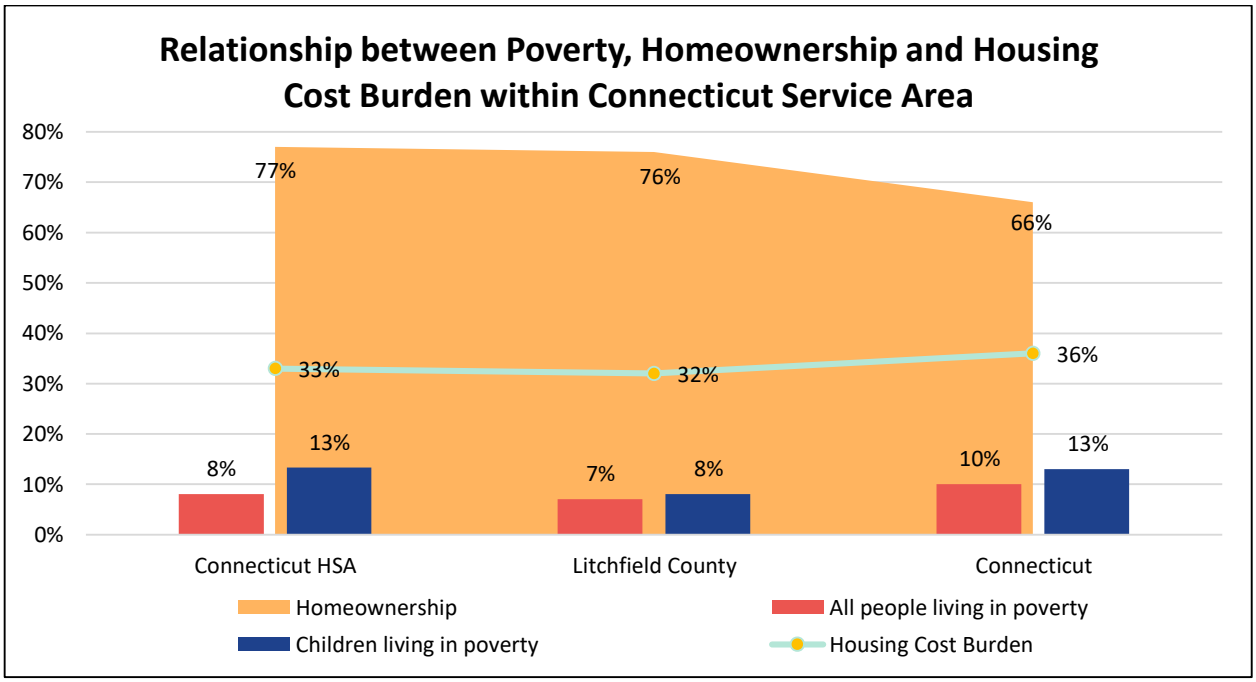
Where you live impacts the choices available to you. These choices impact your income, wellness, and ultimately how long you live. These place-based choices, as well as lived experiences like discrimination and racism, also inform perception of opportunities.

For neighborhoods, a higher proportion of homeownership means greater neighborhood stability. Greater neighborhood stability means greater opportunities for investment in infrastructure, such as schools, roads, public transportation, and green spaces, key elements for healthy living.

Owning a home is an investment. For many families, their home is their largest asset. However, historically, structures have been in place that prevent people of color and others from purchasing a home. Today, this historic structural inequity manifests in the financial assets that certain populations have been able to pass on to future generations. The security of knowing one has a home can also reduce chronic stress, a significant factor in developing chronic disease.

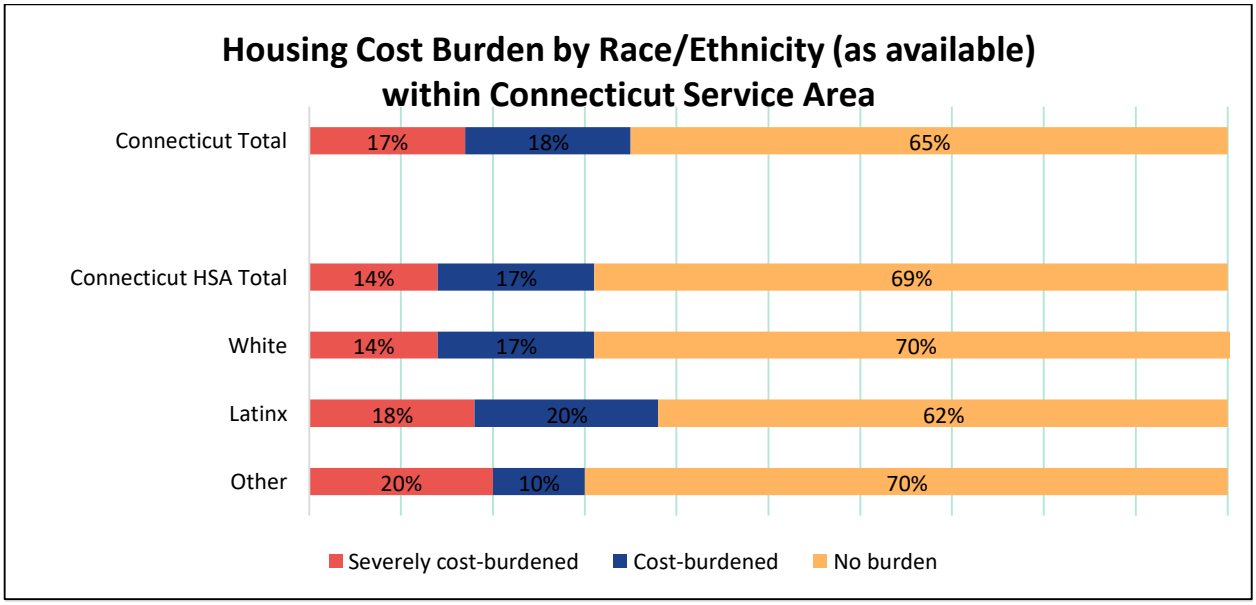
Housing is often the largest single monthly expense for households and should represent no more than 30% of a household's monthly income. When households spend more than 30% of their income on housing, they are considered housing cost-burdened. When housing costs consume more than 30% of a household budget, fewer resources are available for other necessities like food, transportation, and childcare.

The graph below demonstrates that across Connecticut, communities with greater proportions of homeowners are associated with fewer residents living in poverty and fewer cost burdened households. However, it is worth noting that within the Connecticut HSA, 1 in 3 households are considered housing cost burdened.




Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

Among renter households in the Connecticut HSA, 52% are cost-burdened compared to 25% of owner households. Among Latinx householders (owner or renter), approximately 38% are cost-burdened compared to 30% of white householders.

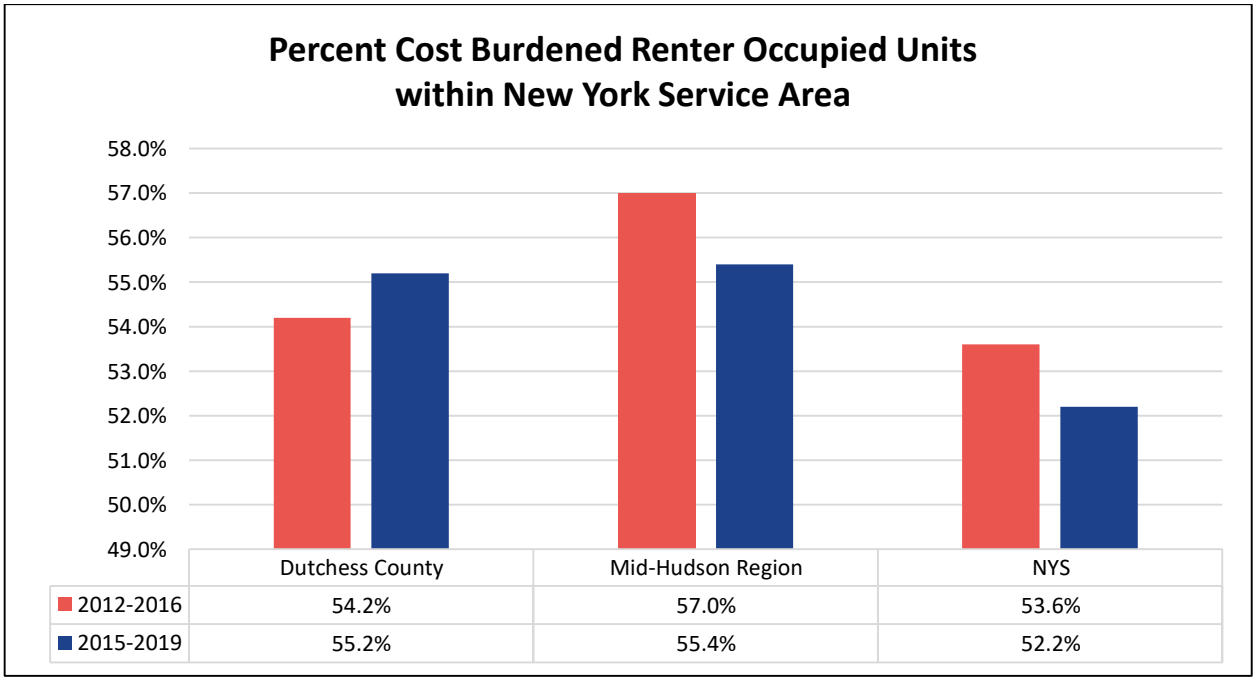



Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

Among renter households in Dutchess County, 55.2% are cost burdened, and contrary to Mid-Hudson Region and New York statewide trends, the percentage increased from prior years. Among

all households (renter or owner) in Dutchess County from 2016-2020, 16% were considered severely cost burdened compared to 19% statewide. Severely cost burdened is defined as spending more than 50% of household income on housing.

Housing affordability was a concern for New York HSA Community Health Survey respondents. Approximately 88% said it was "completely true" or "somewhat true" that people may have a hard time finding a quality place to live due to high costs. Approximately 12% had a time in the past 12 months when they or a member of their household were unable to get housing when they needed it.



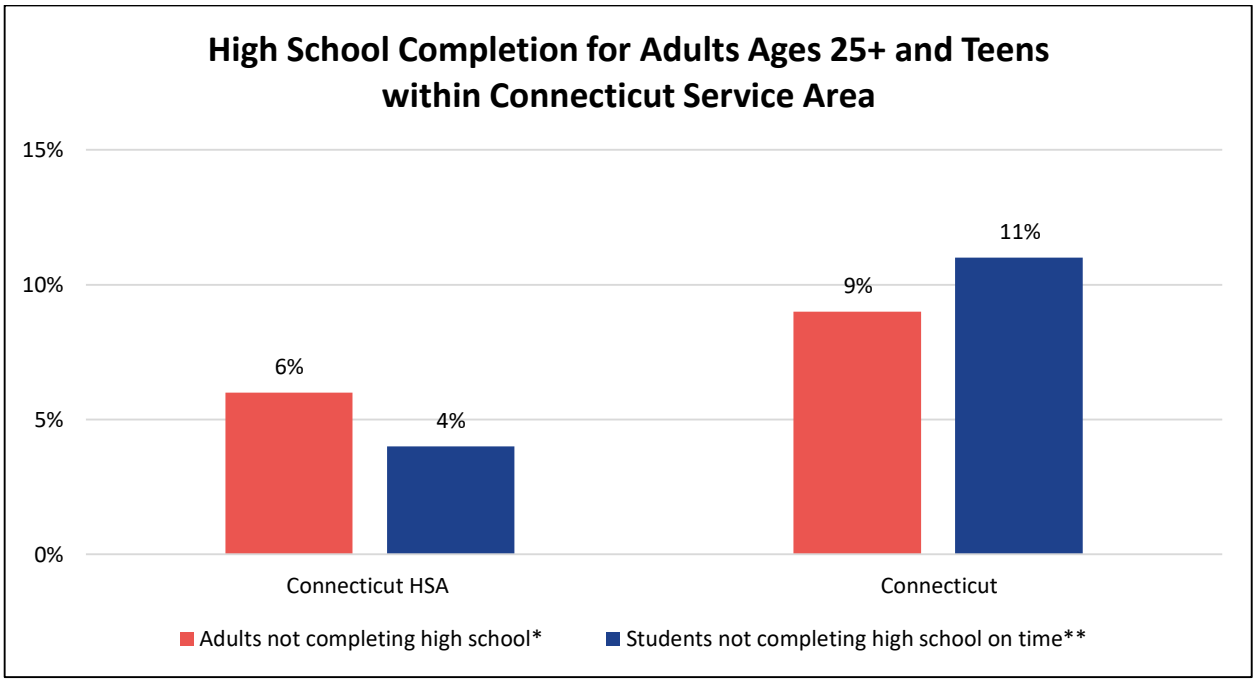

| | Dutchess County | Mid-Hudson Region | NYS |
|---|---|---|---|
| 2012-2016 | 54.2% | 57.0% | 53.6% |
| 2015-2019 | 55.2% | 55.4% | 52.2% |

Source: Mid-Hudson Region CHNA, NYS Department of Health County Health Indicators, 2021

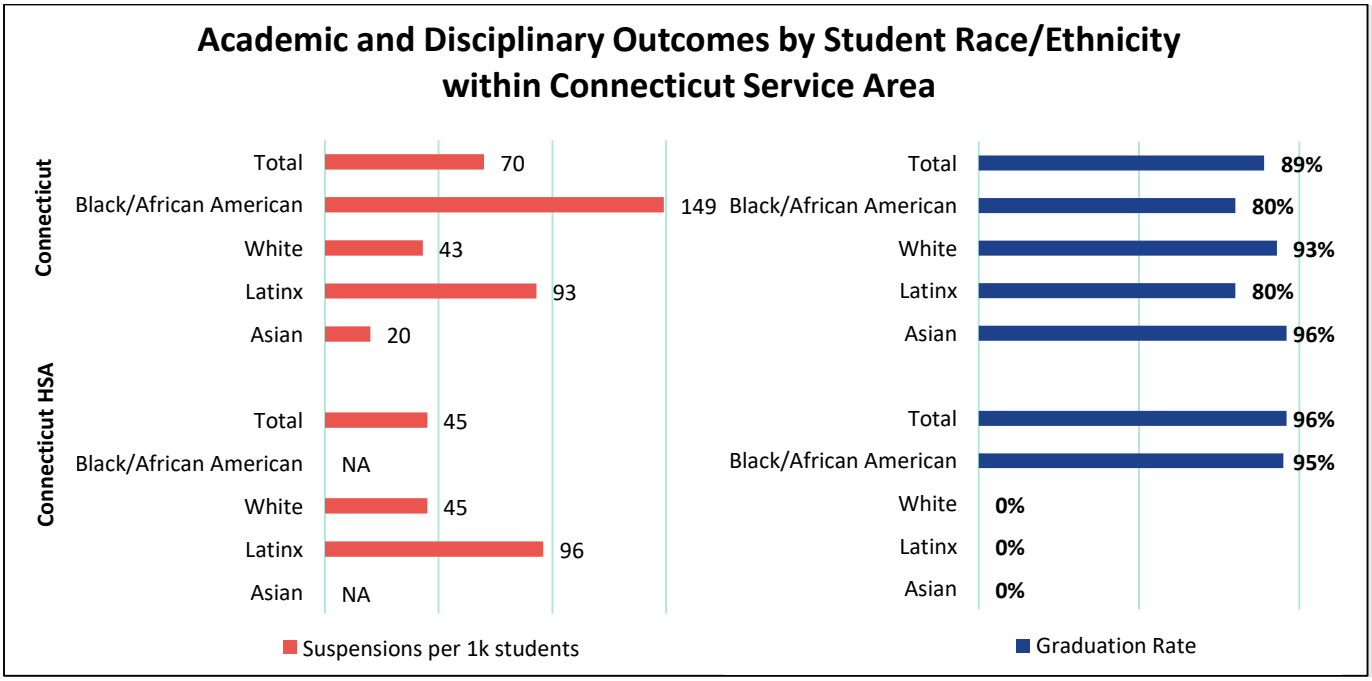
## Education Access and Quality

Education is one of the best predictors of good health and long lives. Availability of accessible, well-funded, and well-resourced public education opportunities and exposure to diverse employment pathways, such as in the healthcare and social services fields, build a strong foundation for young people and increase the opportunity for upward mobility, economic security, and better health.

Overall, people living in the Connecticut HSA are well educated. Nearly all adults complete high school and nearly all teens graduate from high school on time, exceeding statewide averages. However, statewide trends point to underlying inequities among students of color. Statewide, Black/African American and Latinx students are more likely to experience unfairly harsh discipline and are less likely to graduate high school due to these and other structural barriers.



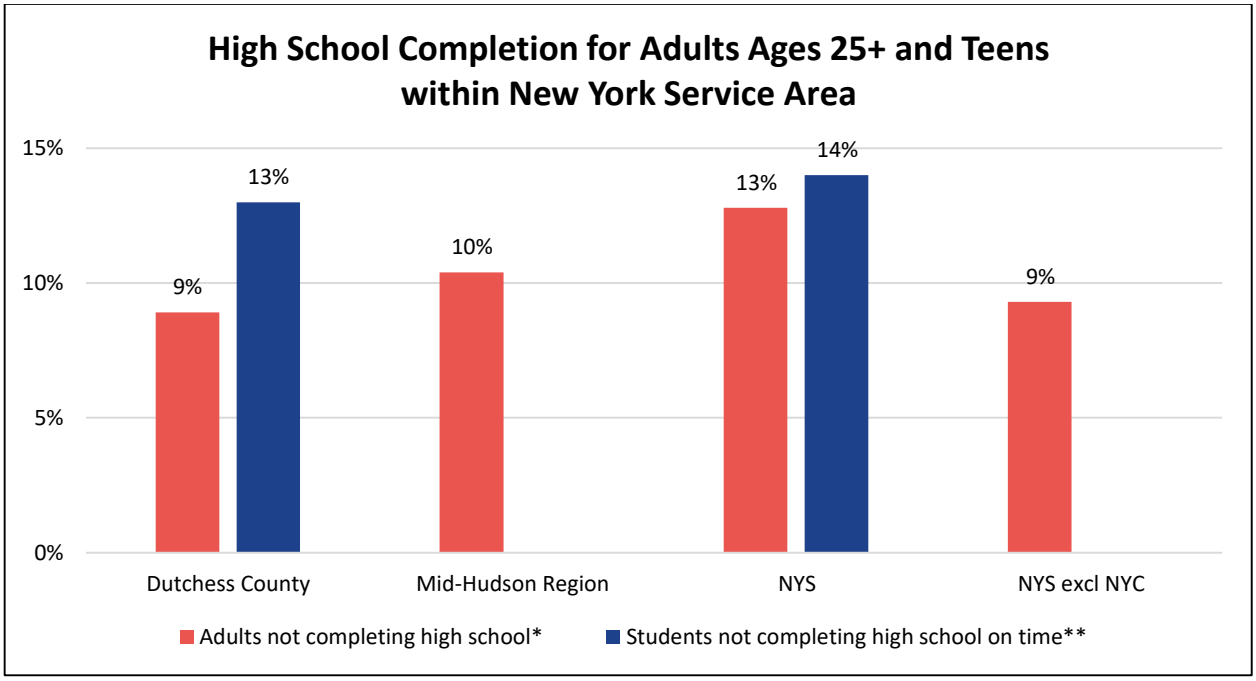

Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates* and Connecticut State Department of Education, 2018-2019**



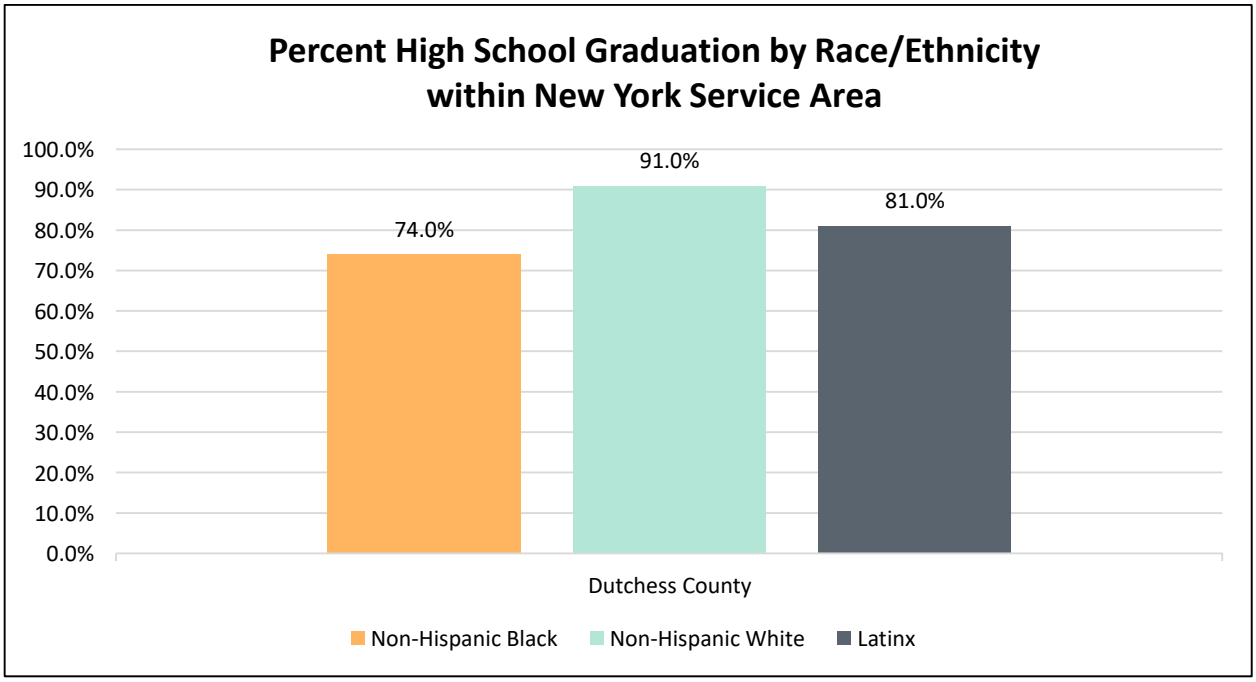

Source: Connecticut State Department of Education, 2018-2019 School Year

Residents of neighboring Dutchess County also benefit from higher educational attainment overall, although in comparison to Connecticut, residents are slightly less likely to complete high school and/or graduate on time. Additionally, educational inequities among students of color are more

evident in Dutchess County. Within the seven-county Mid-Hudson Region, Dutchess County has the largest disparity in graduation rates between non-Hispanic white (91%) and non-Hispanic black (74%) students.




Source: Mid-Hudson Region CHNA, US Census Bureau American Community Survey 2020 5-year estimates* and NYS Department of Education, 2021**

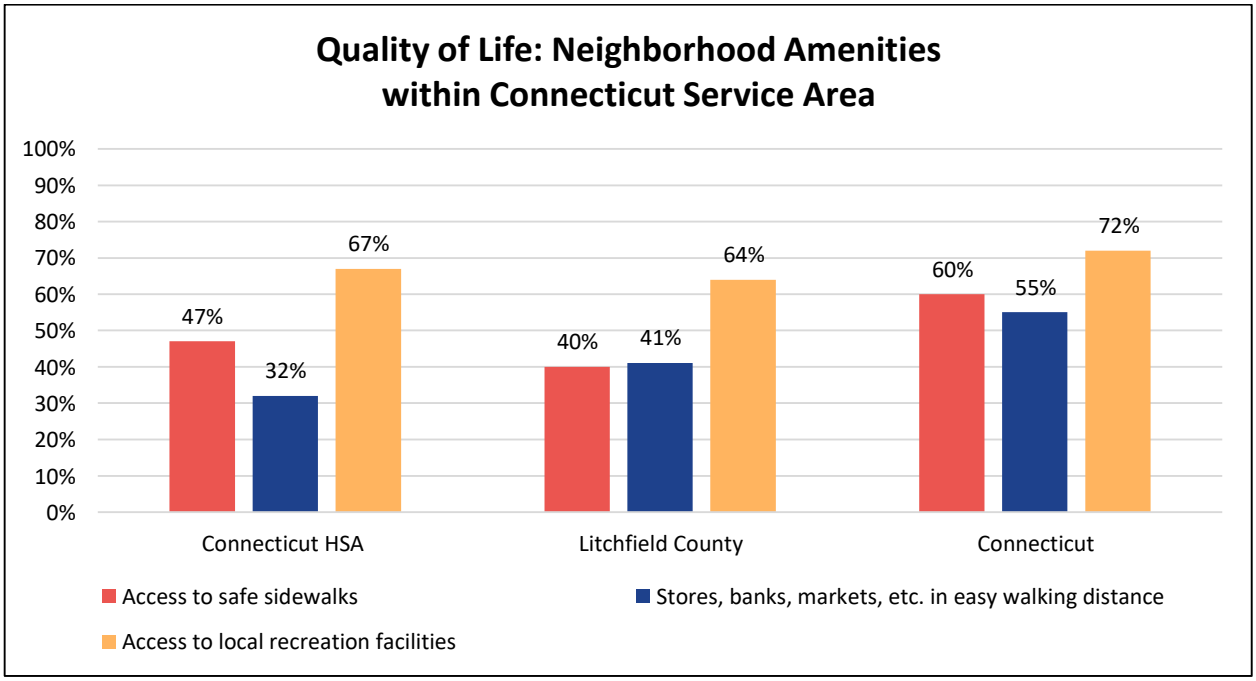



Source: Mid-Hudson Region CHNA, NYS Department of Education, 2022

## Neighborhood and Built Environment

In addition to the resources available in communities, the physical environment and infrastructure of neighborhoods impacts health. The availability of well-maintained roads and safe sidewalks, and access to recreation, stores, banks, and other amenities are important components for healthy living.

Access to safe sidewalks, recreation, and shopping is less available in the Connecticut HSA than the state as a whole. While residents are more likely to have a vehicle at home to access services not within walking distance, lack of transportation is a barrier for many people, particularly those with lower incomes. Among statewide Community Wellbeing Survey respondents, 32% of respondents in the low-income range stated that they stayed home when they needed or wanted to go someplace, because they did not have reliable transportation, compared to 12% of respondents in the mid-income range and 3% of respondents in the high-income range. Similar disparities affect Black/African American and Latinx respondents relative to their white counterparts.




Source: DataHaven analysis (2021) of 2015, 2018, and 2021 DataHaven Community Wellbeing Survey

**No Vehicle at Home within Connecticut Service Area**

| Connecticut HSA | Connecticut |
|---|---|
| 5% | 9% |

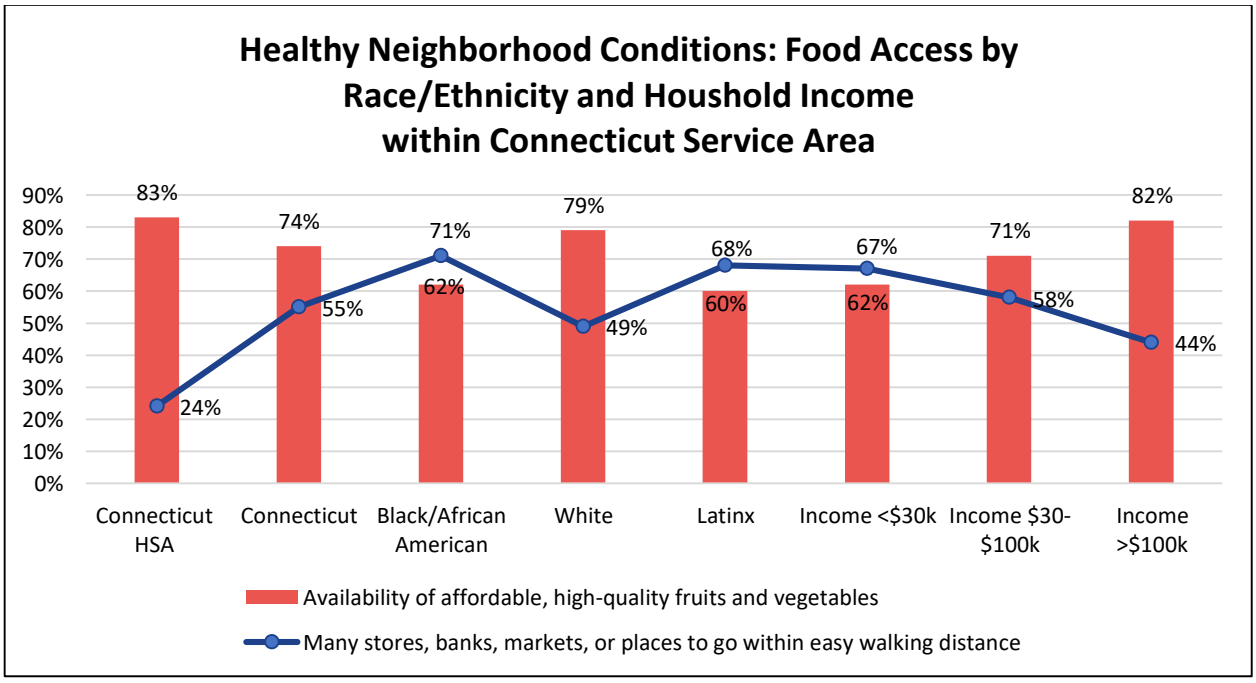
Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

**Connecticut HSA: Community Wellbeing Survey Respondents Who Stayed Home When Needed or Wanted to Go Someplace Because They Did Not Have Reliable Transportation**

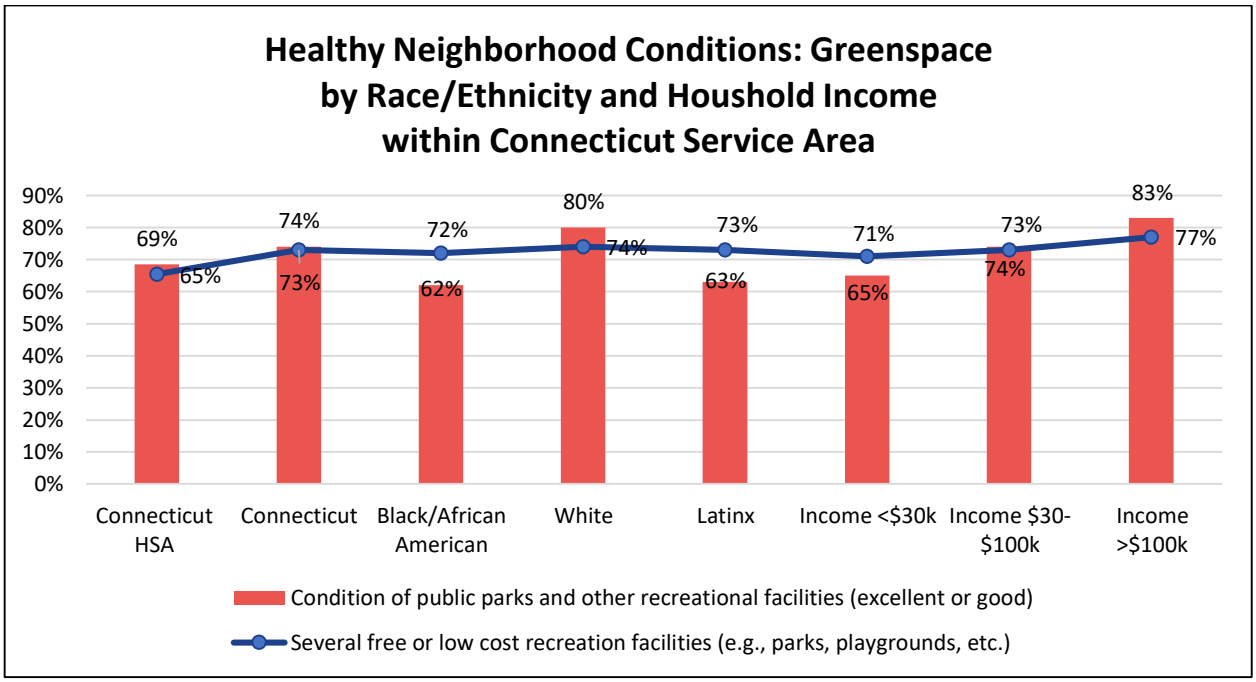
| | Percent |
|---|---|
| Connecticut HSA (All Adults) | 4% |
| Connecticut (All Adults) | 13% |
| Black/African American | 21% |
| White | 9% |
| Latinx | 22% |
| Household income <$30k | 32% |
| Household income $30-$100k | 12% |
| Household income >$100k | 3% |

Source: 2021 DataHaven Community Wellbeing Survey

Across Connecticut, there is wide variability in perceptions of the quality of available amenities within communities. Disparities are most evident among individuals with lower income and/or identifying as Black/African American or Latinx. Of note, statewide, 62% of individuals with lower income perceived having access to affordable and high-quality fruits and vegetables compared to 82% of individuals with higher income. Similarly, 62-63% of Black/African American and Latinx residents perceived having access to quality parks or other recreational facilities compared to 80% of white residents.




Source: 2021 DataHaven Community Wellbeing Survey



Source: 2021 DataHaven Community Wellbeing Survey

Across Dutchess County in 2019, approximately 6% of residents were estimated to have limited access to healthy foods compared to 2% of residents statewide. This estimate remained unchanged from 2015 data findings. Limited access to healthy foods measures the percentage of the population that is low-income and does not live close to a grocery store. Among New York HSA Community Health Survey respondents, 46% said it was "not very true" or "not at all true" that most people are able to access affordable food that is healthy and nutritious.

Fewer Dutchess County households do not have access to a personal vehicle compared to the state overall, and the percentage of households without a vehicle has declined. However, lack of public transportation is a concern, particularly for Sharon Hospital New York HSA residents. Among Community Health Survey respondents, 64% said it was "not very true" or "not at all true" that people can get to where they need using public transportation. Additionally, 19% of respondents had a time in the past 12 months when they or a member of their household were unable to get transportation when they needed it.

**No Vehicle at Home within New York Service Area**

| | Dutchess County | New York |
|---|---|---|
| 2014-2019 | 8.2% | 29.1% |
| 2015-2019 | 7.8% | 29.1% |
| 2016-2020 | 7.5% | 29.0% |

Source: Mid-Hudson Region CHNA, US Census Bureau American Community Survey 5-year estimates

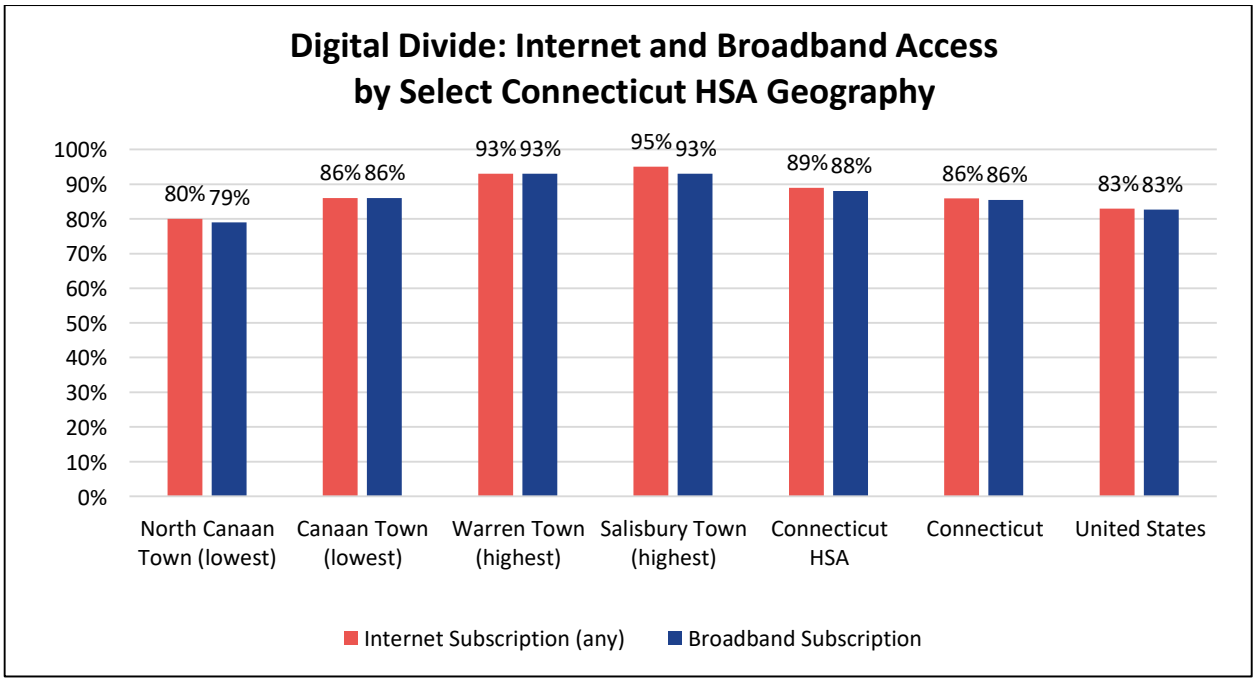
Approximately 17% of New York HSA Community Health Survey respondents had a time in the past 12 months when they or a member of their household were unable to get childcare when they needed it. Access to affordable, quality childcare is a primary barrier, with 65% of residents indicating it was "completely true" or "somewhat true" that parents struggle to find these services.

**New York HSA (All Adults): Community Health Survey Respondents Perceptions of Available Services**

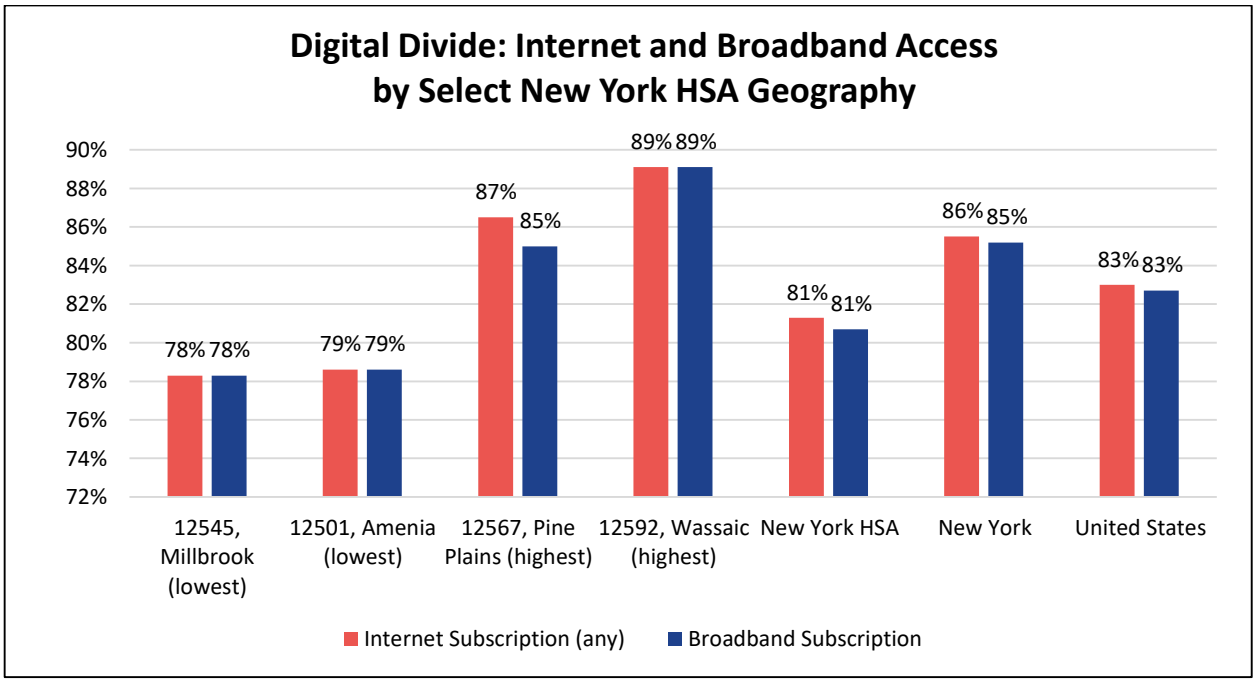
| | Most people are able to access affordable food that is healthy and nutritious. | People can get where they need using public transportation. | Parents struggle to find affordable, quality childcare. |
|---|---|---|---|
| Completely true | 10% | 9% | 36% |
| Somewhat true | 43% | 18% | 29% |
| Not very true | 30% | 26% | 6% |
| Not at all true | 16% | 38% | 2% |
| Don't know | 1% | 9% | 27% |

Source: 2022 Siena College Regional Community Health Survey

During COVID we were able to use technology to bring services to people in their homes, but we need to bridge the wide digital divide within our communities to effectively reach all residents. Within the Connecticut HSA, there is a more than 10-point difference in access to internet and broadband between residents of North Canaan and residents of Warren or Salisbury. Within the New York HSA, there is a more than 20-point difference between residents of Millbrook or Amenia and Pine Plains or Wassaic. Millbrook and Amenia are home to an older population overall, which likely impacts findings.




Source: US Census Bureau American Community Survey 2019 5-year estimates




Source: US Census Bureau American Community Survey 2019 5-year estimates

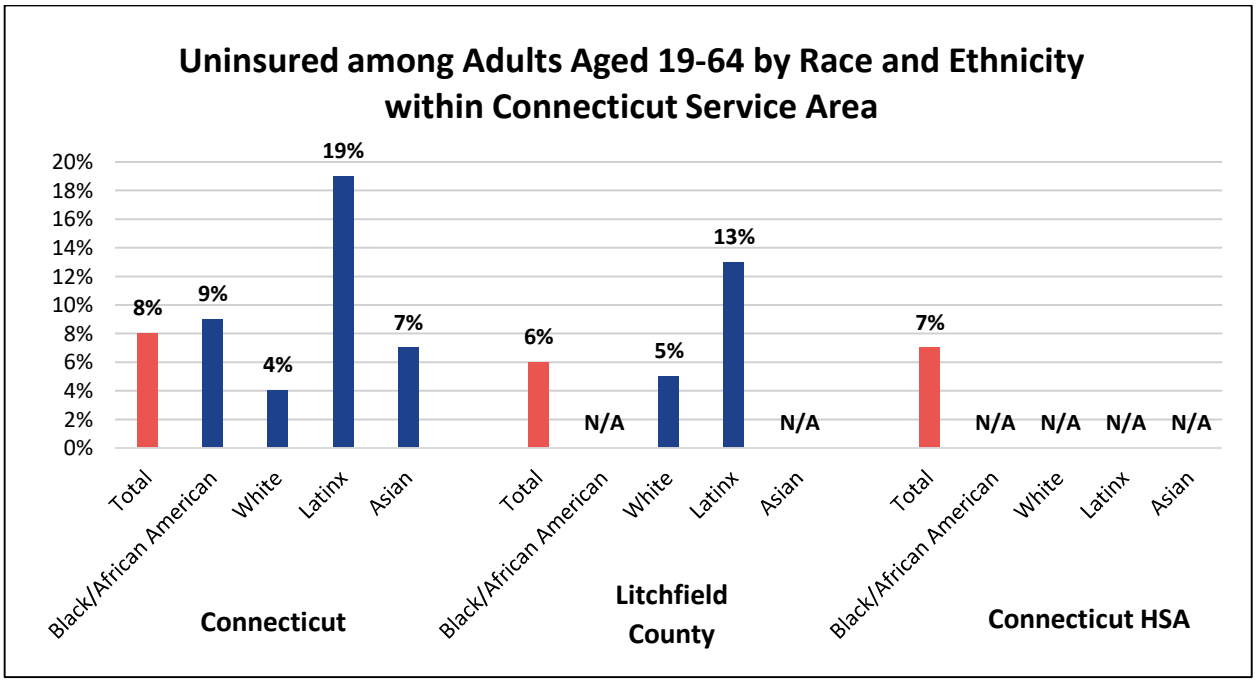
### Healthcare Access and Quality

Lack of health insurance is a barrier to accessing healthcare. Without health insurance, residents face high costs for care when they need it, and they are less likely to receive preventive care. Preventive care, such as well visits and screenings, can detect small problems that can be treated more easily and effectively than if treatment is delayed. More residents across the Connecticut and New York service areas have health insurance when compared to statewide benchmarks. However, Connecticut trends point to potential disparities among Latinx residents who are more than four times as likely to be uninsured as white residents.

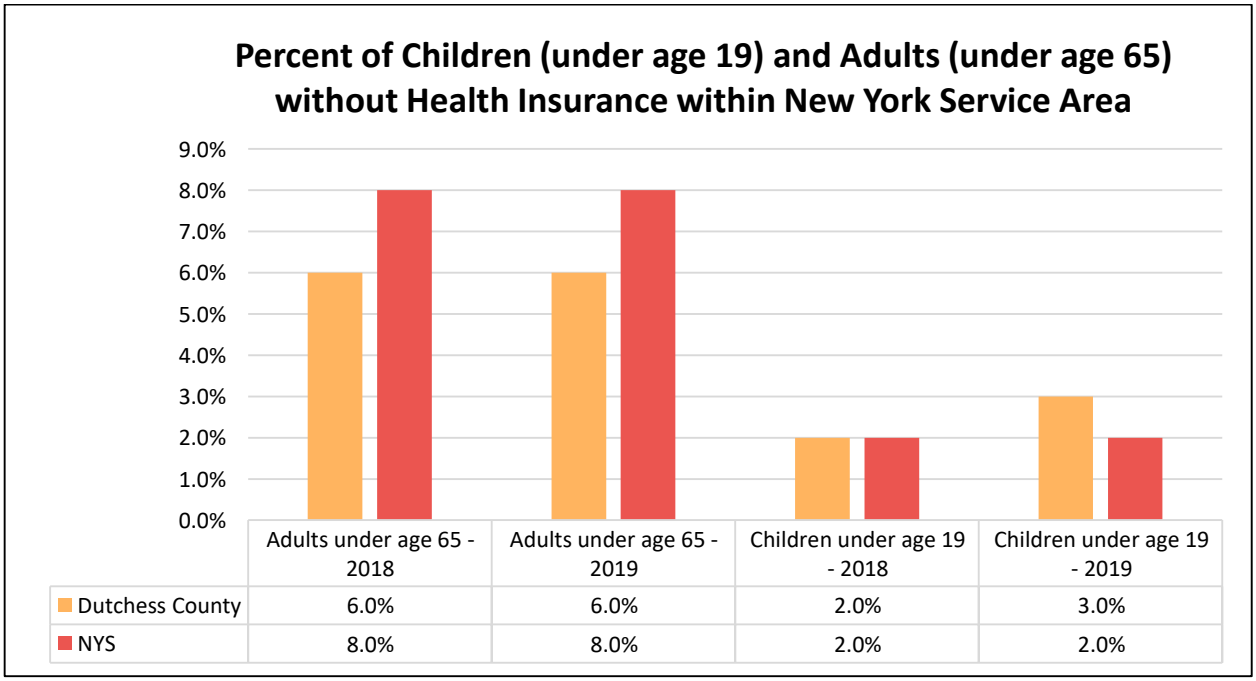
Having health insurance does not ensure access to healthcare when it is needed. Many other factors—like affordability, transportation, language, provider availability, and trust—keep people from receiving the care they need.

Litchfield County has lower provider availability than Connecticut and/or the nation, and all of the county is a Health Professional Shortage Area (HPSA) for mental healthcare. When viewed at the census tract-level, residents of North Canaan in Litchfield County are less likely to receive regular physical or dental checkups when compared to neighboring communities. This finding is consistent with existing economic barriers for North Canaan residents, including a lower median income and more households living below the ALICE threshold.

Dutchess County also has lower provider availability when compared to state benchmarks, and lower primary care provider availability when compared to the nation. While none of the county is a HPSA, migrant and seasonal farm workers are a Medically Underserved Population (MUP) within the eastern portion of the county, including the communities of Amenia, Wassaic, and Dover Plains. MUP designations identify geographic populations with a lack of access to primary care services.




Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates




| | Adults under age 65 - 2018 | Adults under age 65 - 2019 | Children under age 19 - 2018 | Children under age 19 - 2019 |
|---|---|---|---|---|
| Dutchess County | 6.0% | 6.0% | 2.0% | 3.0% |
| NYS | 8.0% | 8.0% | 2.0% | 2.0% |

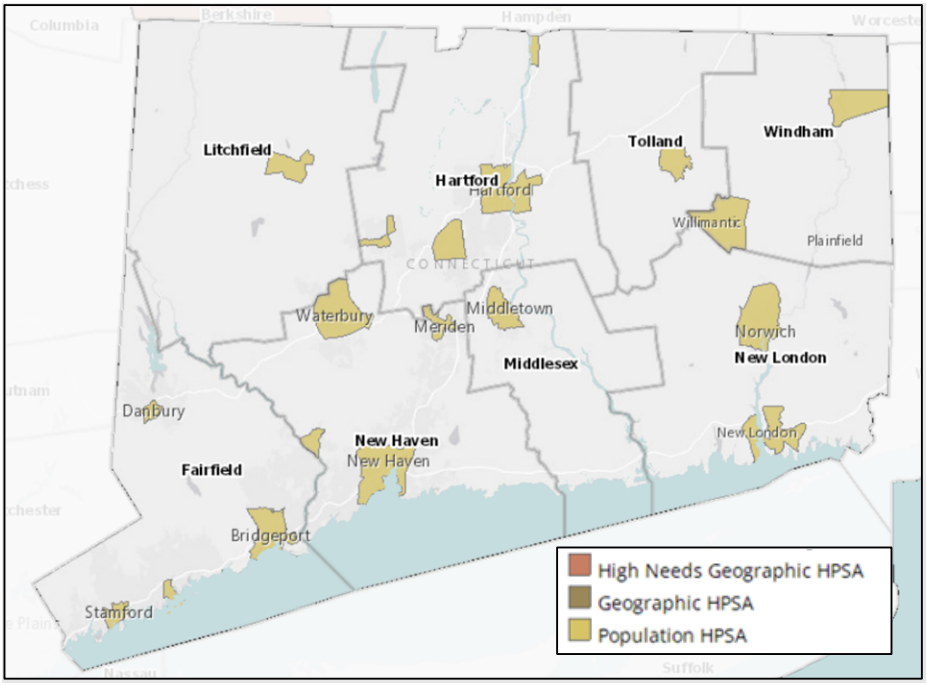
Source: Mid-Hudson Region CHNA, US Census Bureau American Community Survey 2020 5-year estimates

**Healthcare Provider Availability: Provider Rates per 100,000 Residents**

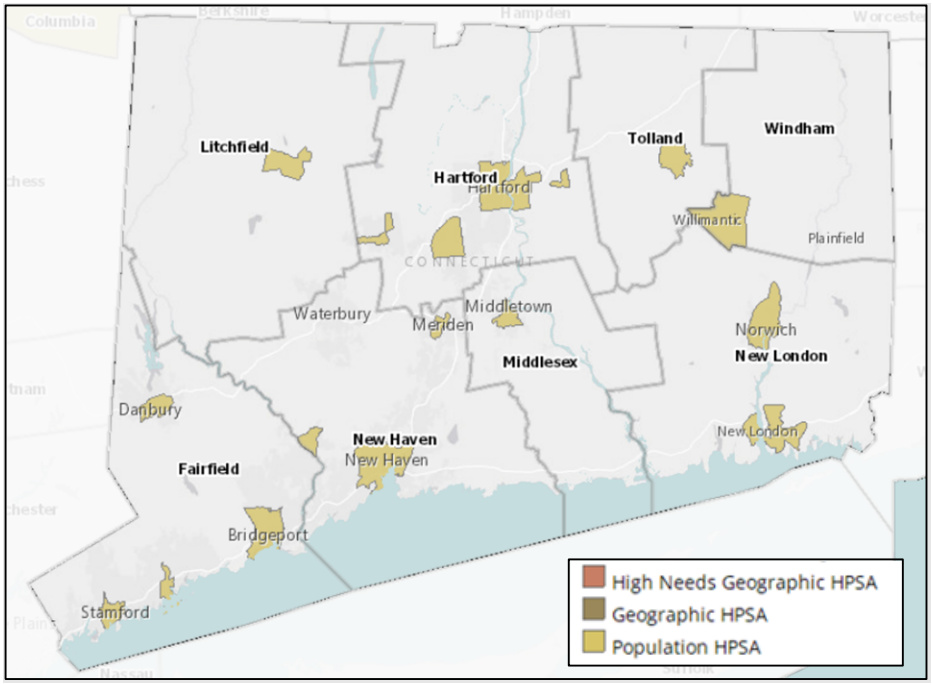
| | 2019 Primary Care Physicians | 2020 Dentists | 2021 Mental Health Providers |
|---|---|---|---|
| Litchfield County | 58.2 | 66.3 | 287.8 |
| Connecticut | 85.2 | 87.1 | 439.2 |
| Dutchess County | 66.6 | 72.6 | 310.3 |
| New York | 84.7 | 83.9 | 325.2 |
| United States | 76.3 | 71.4 | 285.7 |

Source: Health Resources and Services Administration and Centers for Medicare and Medicaid Services

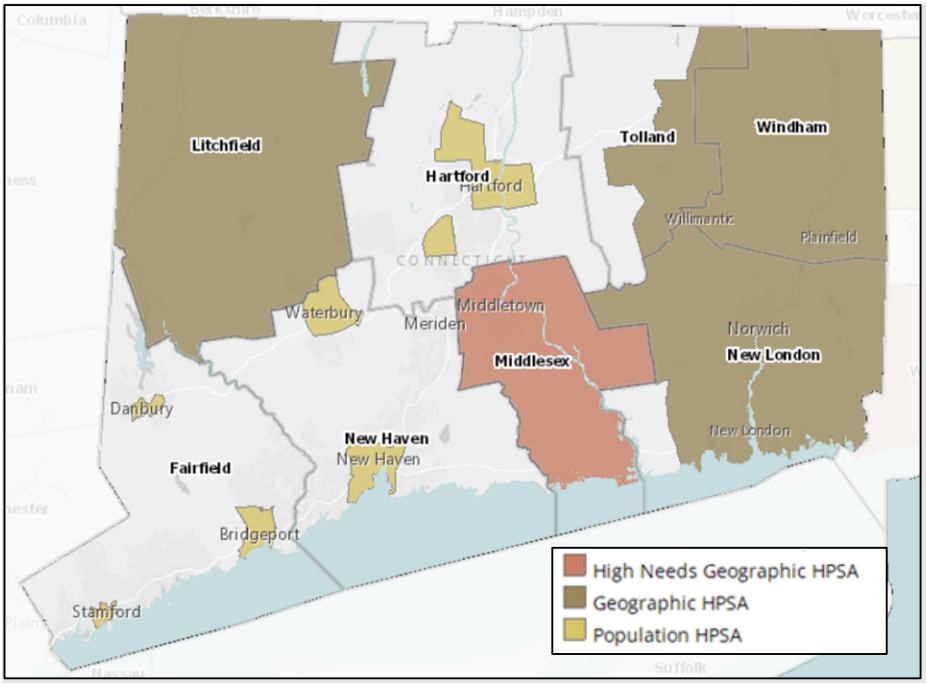
**Connecticut: Primary Care Health Professional Shortage Areas**



**Connecticut: Dental Health Professional Shortage Areas**

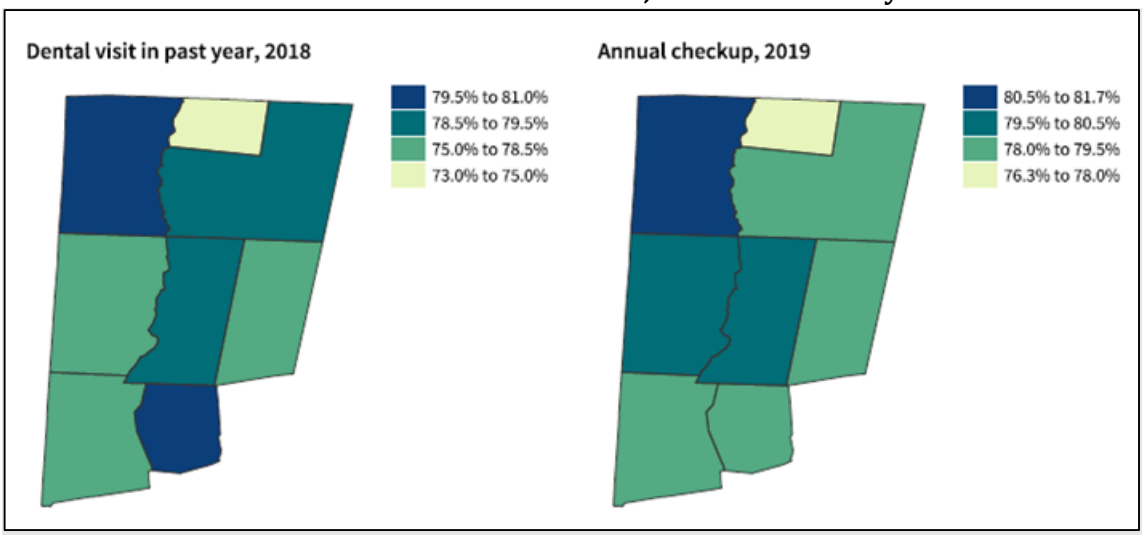



**Connecticut: Mental Healthcare Health Professional Shortage Areas**



**Dutchess County: Medically Underserved Populations**


**Connecticut HSA Preventive Care Measures, Share of Adults by Census Tract**




Source: PLACES Project. Centers for Disease Control and Prevention

Additional disparities in accessing healthcare are evidenced by resident survey results. Among Connecticut statewide Community Wellbeing Survey respondents, 21% of Latinx respondents reported not have a personal doctor or healthcare provider and 37% reported putting off or postponing needed medical care in the past 12 months. Among respondents with lower incomes, 36% reported putting off or postponing needed medical care in the past 12 months and 23% reported not visiting a dentist within the past two years.

Among New York HSA Community Health Survey respondents, 51% said it was "not very true" or "not at all true" that there are sufficient, quality mental health providers. Approximately 17% of respondents said there was a time in the past 12 months when they or a member of their household were unable to get medication when they needed it, and 16% said there was a time when they couldn't get healthcare, including dental or vision.

Approximately 78% of New York HSA Community Health Survey respondents received a routine physical or checkup within the past year, and 69% received a routine dental checkup or cleaning. It is worth noting that the top reason for not receiving a routine dental checkup was cost (33%), followed closely by inability to get an appointment (25%) and lack of insurance (24%).

**Connecticut HSA: Community Wellbeing Survey Respondents Healthcare Access**

| | No personal doctor or healthcare provider | Put off or postponed needed medical care in past 12 months | Saw a dentist more than two years ago |
|---|---|---|---|
| Connecticut HSA (All Adults) | 14% | 25% | 9% |
| Connecticut (All Adults) | 15% | 30% | 13% |
| Black/African American | 14% | 27% | 14% |
| White | 14% | 28% | 13% |
| Latinx | 21% | 37% | 14% |
| Household Income <$30k | 18% | 36% | 23% |
| Household Income $30-$100k | 16% | 31% | 15% |
| Household Income >$100k | 14% | 27% | 7% |

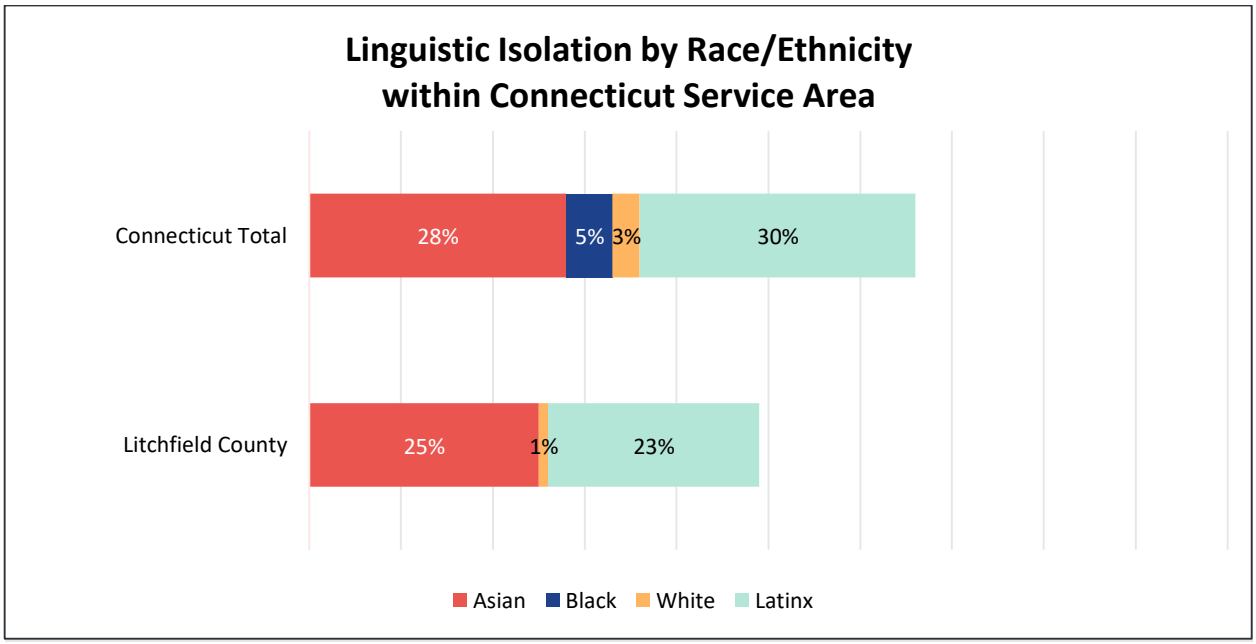
Source: 2021 DataHaven Community Wellbeing Survey

**New York HSA (All Adults): Community Health Survey Respondents**
**Top Reasons for Not Receiving Routine Physical or Dental Checkup in Past 12 Months**

| | No personal doctor or healthcare provider | Put off or postponed needed medical care in past 12 months |
|---|---|---|
| I chose not to go for another reason | 45% | 9% |
| I did not have enough money | 26% | 33% |
| I did not have time | 20% | 17% |
| I did not have insurance | 19% | 24% |
| Other | 11% | 11% |
| I chose not to go due to concerns over COVID | 6% | 19% |
| I couldn't get an appointment | 3% | 25% |
| I did not have transportation | 0% | 0% |

Source: 2022 Siena College Regional Community Health Survey

Healthcare access disparities among residents may be exacerbated by language barriers and lack of bilingual providers or interpreter services. Approximately 25% of Litchfield County Asian residents and 23% of Latinx residents are considered linguistically isolated, characterized as speaking English less than "very well." Across Dutchess County, approximately 4.7% of all residents are considered linguistically isolated compared to 13.1% across New York.



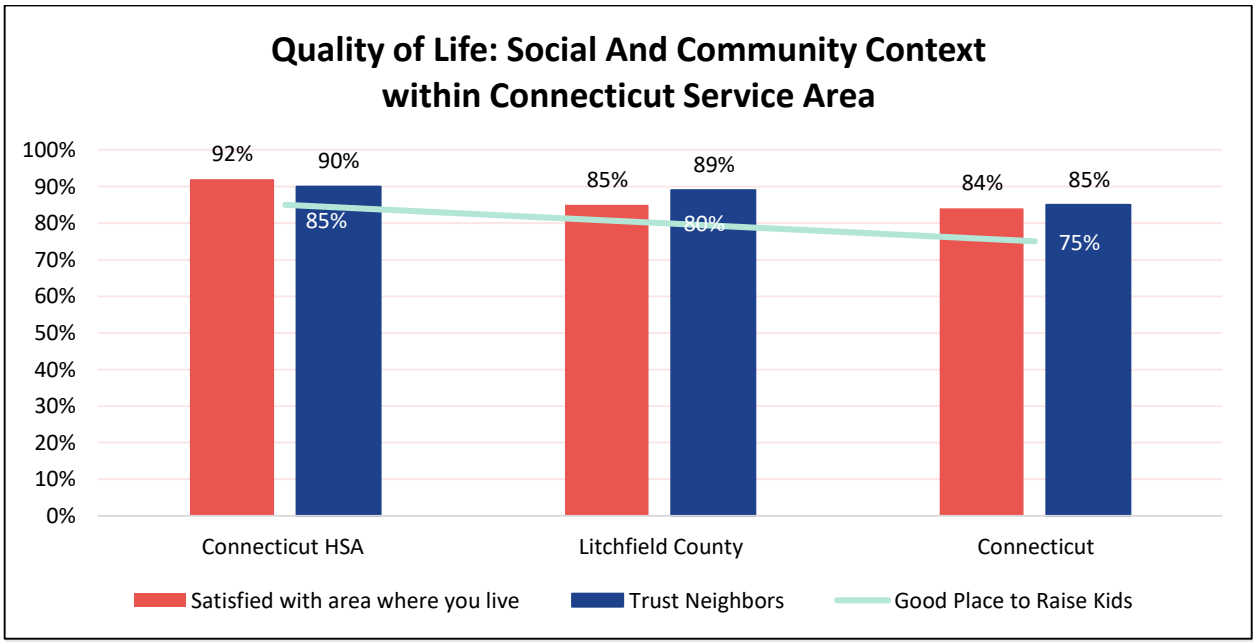
Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

## Social and Community Context

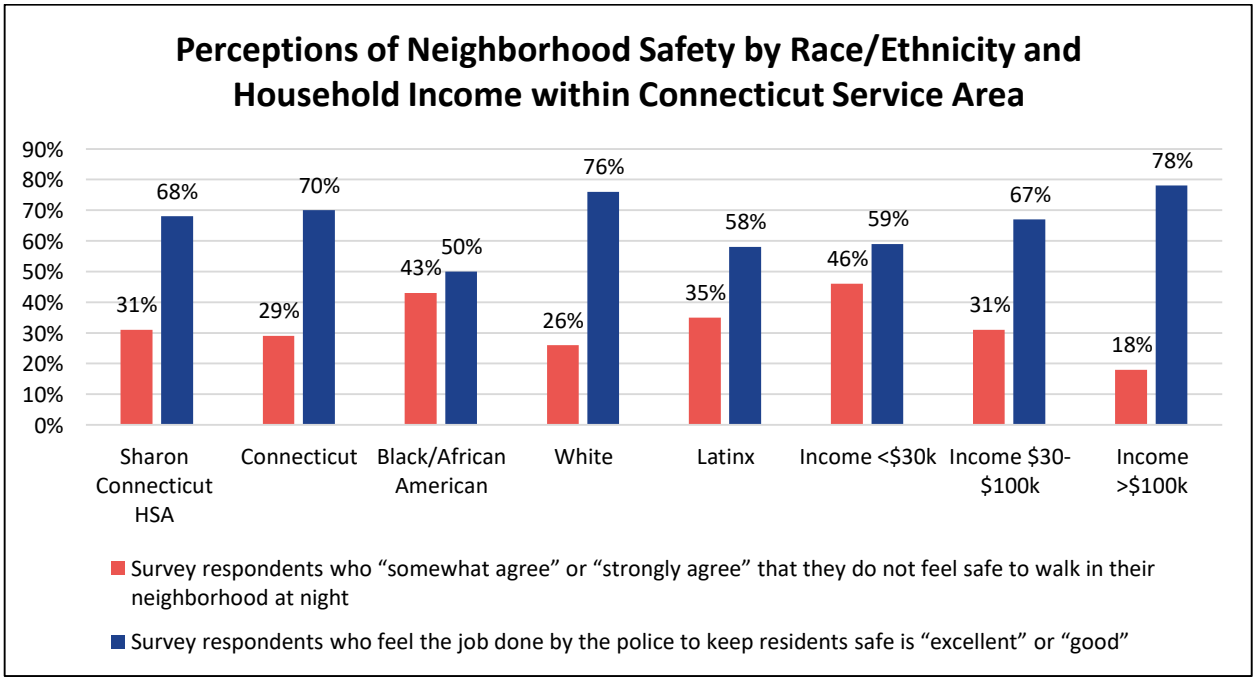
As much as communities are shaped by those who live there, people are impacted by the social context of the places where they live. Social context includes family, neighborhoods, school or work environments, political or religious systems, and other interpersonal infrastructures within a community. People's lived experiences within their social context play a significant role in good health and wellbeing.

Feeling like you belong, are appreciated, and are valued in your community reinforces protective health factors that help people and communities overcome adversity. Experiences of poverty, violence, poor housing, racism, and discrimination create Adverse Community Environments and chronic stress that perpetuate trauma and increase Adverse Childhood Events (ACEs) that have a lasting impact on people and their communities.

Residents of the Connecticut HSA have overall high perceived satisfaction in where they live, as well as positive perceptions of neighborhood safety, relative to the state. For example, approximately 85% of HSA residents feel it is a good place to raise kids compared to 75% of residents statewide. However, statewide trends illustrate that these experiences are not shared by all residents. Black/African American residents are less likely to feel safe walking in their neighborhood at night and/or that police are doing a "good" or "excellent" job of keeping residents safe. Disparities in safety along race lines indicate an opportunity to examine policies and procedures that can be amended to create greater equity of access and inclusion.




Source: DataHaven analysis (2021) of 2015, 2018, and 2021 DataHaven Community Wellbeing Survey




Source: 2021 DataHaven Community Wellbeing Survey

As stated in the Mid-Hudson Region CHNA, "Disconnected youth are teenagers and young adults between the ages of 16 and 19 who are neither working nor attending school. This vulnerable population is cut off from resources, people, and experiences that help them gain knowledge, skills, capital, and a sense of purpose. " From 2016 to 2020, approximately 5% of Dutchess County youth

were considered disconnected compared to 6% statewide. The percentage has been generally stable in recent years.

**Percent Disconnected Youth (Ages 16-19) within New York Service Area**

| | Dutchess County | New York |
|---|---|---|
| 2014-2018 | 4.0% | 6.0% |
| 2015-2019 | 5.0% | 6.0% |
| 2016-2020 | 5.0% | 6.0% |

Source: Mid-Hudson Region CHNA, University of Wisconsin Population Health Initiative County Health Rankings & Roadmaps 2022

Discrimination is also a measure of social and community context and can be measured by everyday or major discriminatory events. The Mid-Hudson Region CHNA states, "Residential segregation is an example of major discrimination, as it stems from structural racism. Causes vary and include being refused to be rented to or being unfairly denied a bank loan. The implications of residential segregation are extensive, impacting quality of education, access to healthy food options and physical activities, safety, and transportation, and contribute to disparities in health status across groups. In the US, residential segregation between non-Hispanic Black and non-Hispanic white populations is a key determinant of health disparity, leading to poor health outcomes including mortality, reproductive, and chronic diseases."

The residential segregation index measures the distribution of non-Hispanic Black and non-Hispanic white residents across census tracts, with an index of 0 representing complete integration and an index of 100 complete segregation. Dutchess County saw a small decline in its residential segregation index and has a lower index than New York overall.

**Index Score of Residential Segregation within New York Service Area**

| | Dutchess County | New York |
|---|---|---|
| 2013-2017 | 52 | 74 |
| 2016-2020 | 50 | 74 |

Source: Mid-Hudson Region CHNA, University of Wisconsin Population Health Initiative County Health Rankings & Roadmaps 2022

## Life Expectancy

Life expectancy is an overall measure of health and social equity within a community. Structural factors, including housing quality and affordability, environmental conditions, employment, education, transportation, food security, and experience of racism, all play a role in impacting the quality and length of lives.

The Community Need Index (CNI) is a zip code-based index of community socioeconomic need. The CNI is strongly linked to variations in community healthcare needs, and as such, represents a useful planning tool for prioritization of geographic interventions. The CNI scores zip codes on a scale of 1.0 to 5.0, with 1.0 indicating a zip code with the least need and 5.0 indicating a zip code with the

most need compared to the US national average of 3.0. The CNI weights, indexes, and scores zip codes by socioeconomic barriers, including income, culture, education, insurance, and housing.

Consistent with having overall positive social determinants of health factors, no zip code within the Connecticut HSA has a high CNI score. North Canaan zip code 06018 has the highest CNI score of 2.6. This finding is consistent with existing socioeconomic barriers within this community and lower average life expectancy of 74.4 years.

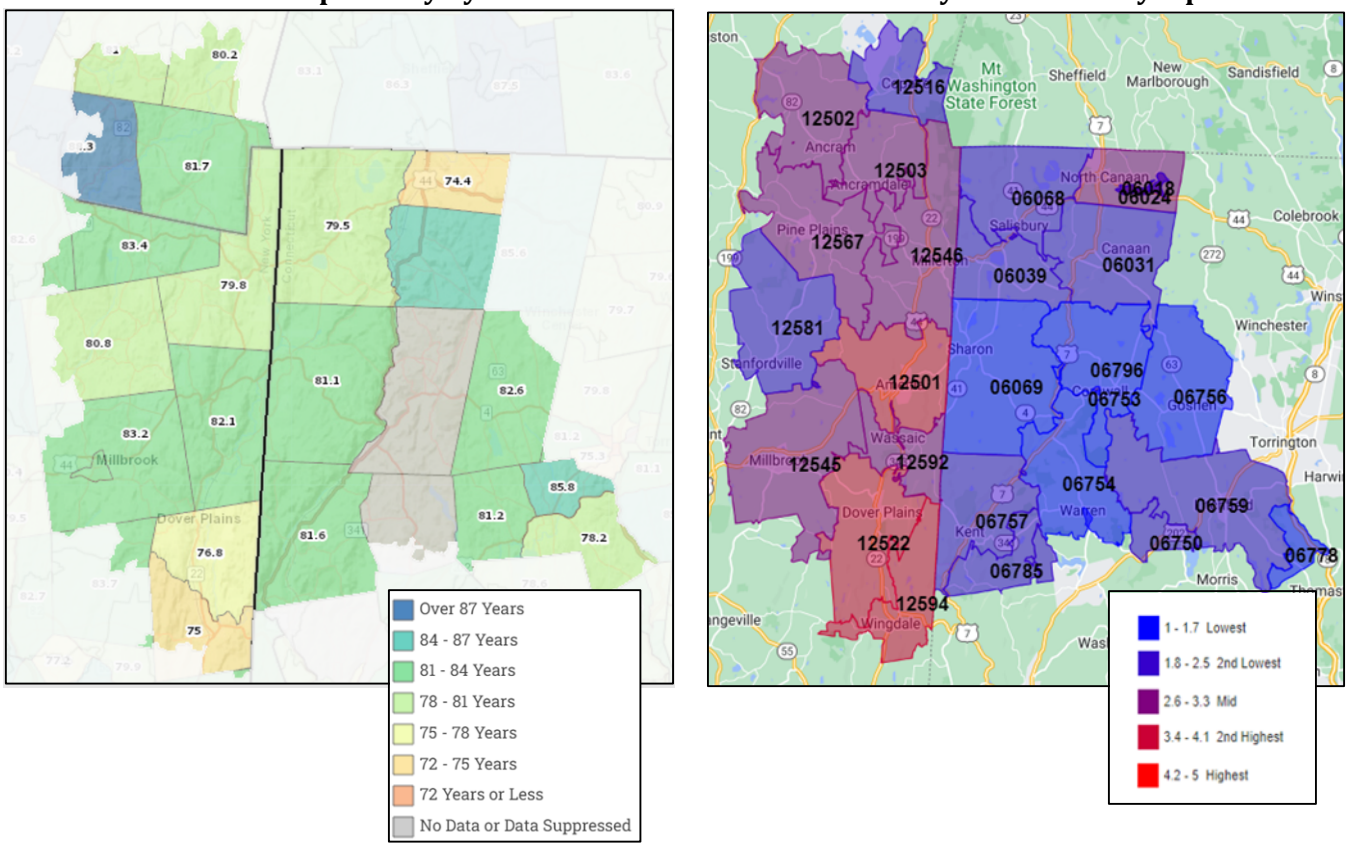
Within the New York HSA, the communities of Amenia, Dover Plains, and Wingdale have higher CNI scores of 3.4. In Dover Plains and Wingdale, these findings are consistent with lower average life expectancy. In comparison to neighboring Kent in Connecticut, there is a nearly 7-year difference in life expectancy for portions of Dover Plains and Wingdale.

**Average Life Expectancy (years)**

| Dutchess County | Litchfield County | Connecticut | New York |
|---|---|---|---|
| 80.1 | 79.2 | **80.1** | **80.3** |

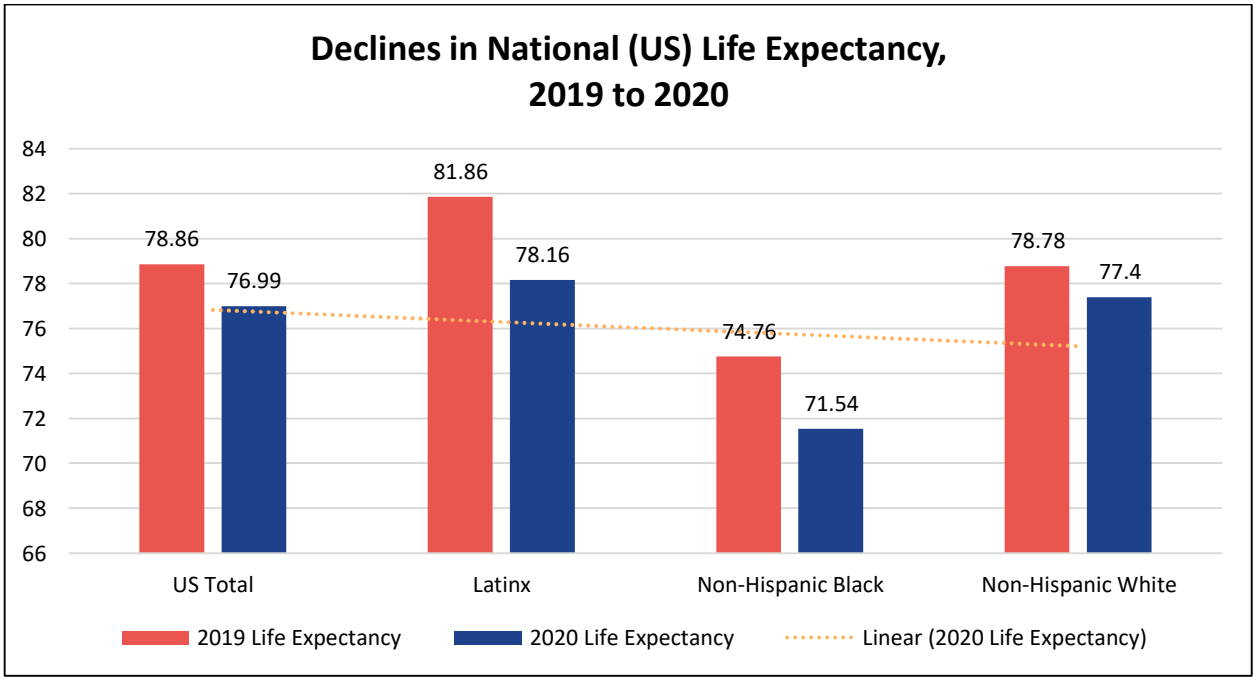
Source: National Center for Health Statistics, 2018-2020

**2010-2015 Life Expectancy by Census Tract and 2021 Community Need Index by Zip Code**

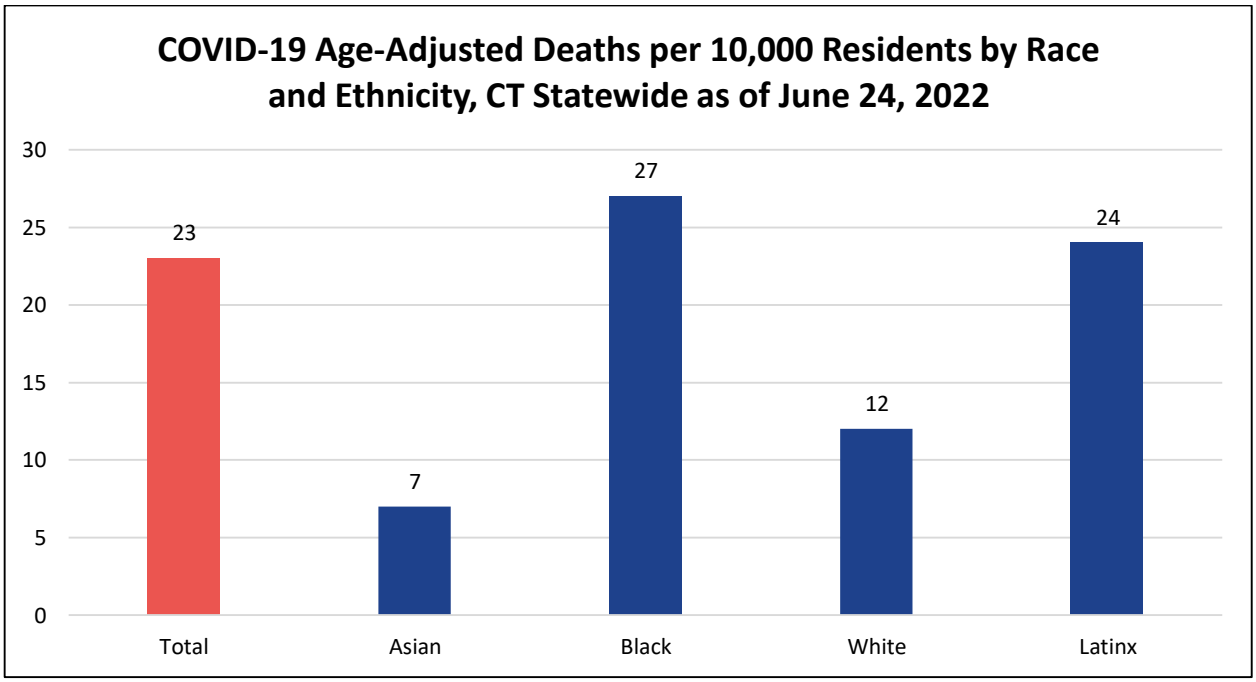


The COVID-19 pandemic both highlighted and deepened socioeconomic and health inequities and exposed disparities within the health and social services systems. COVID-19 has not impacted all people equally. Rather, certain structural issues—population density, low income, crowded workplaces, etc.—contribute to higher levels of spread and worse outcomes from COVID-19, and potentially other infectious diseases.

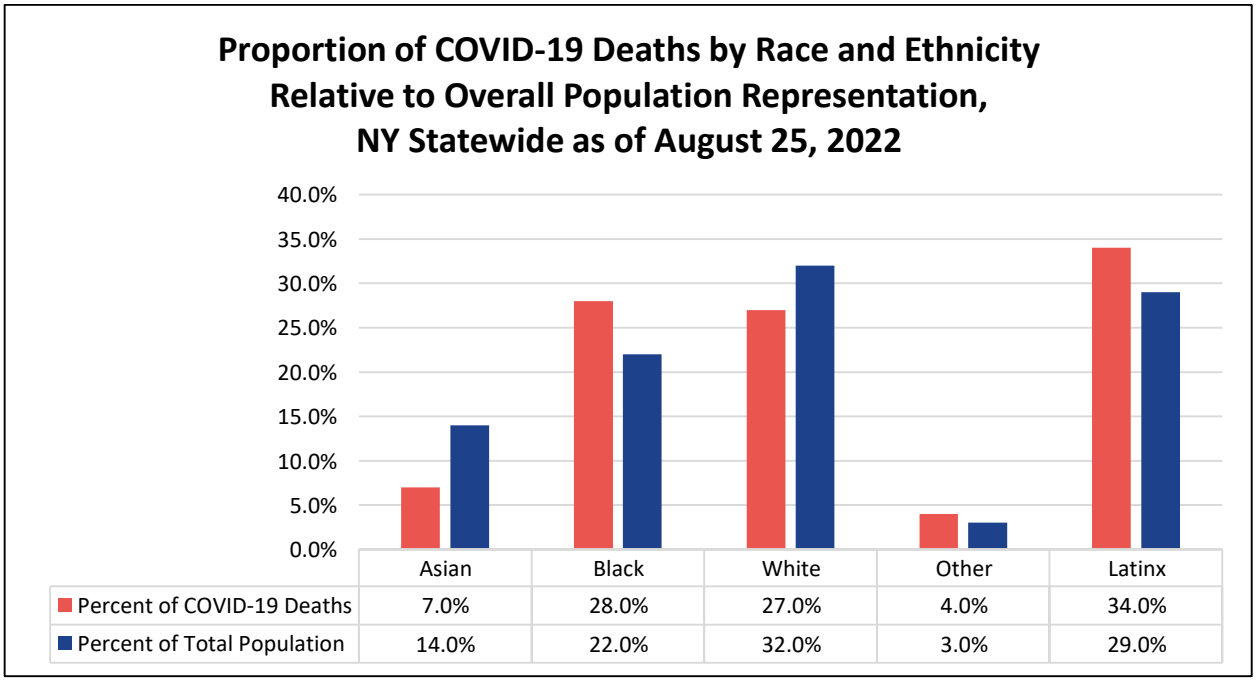
The graph below shows that while overall life expectancy decreased nationally from 2019 to 2020, it decreased by more than 3 years for Black/African American and Latinx residents compared to 1.4 years for white residents. This finding is also reflected in disproportionately higher deaths due to COVID-19 among people of color, as depicted by Connecticut and New York statewide findings.




Source: Centers for Disease Control and Prevention



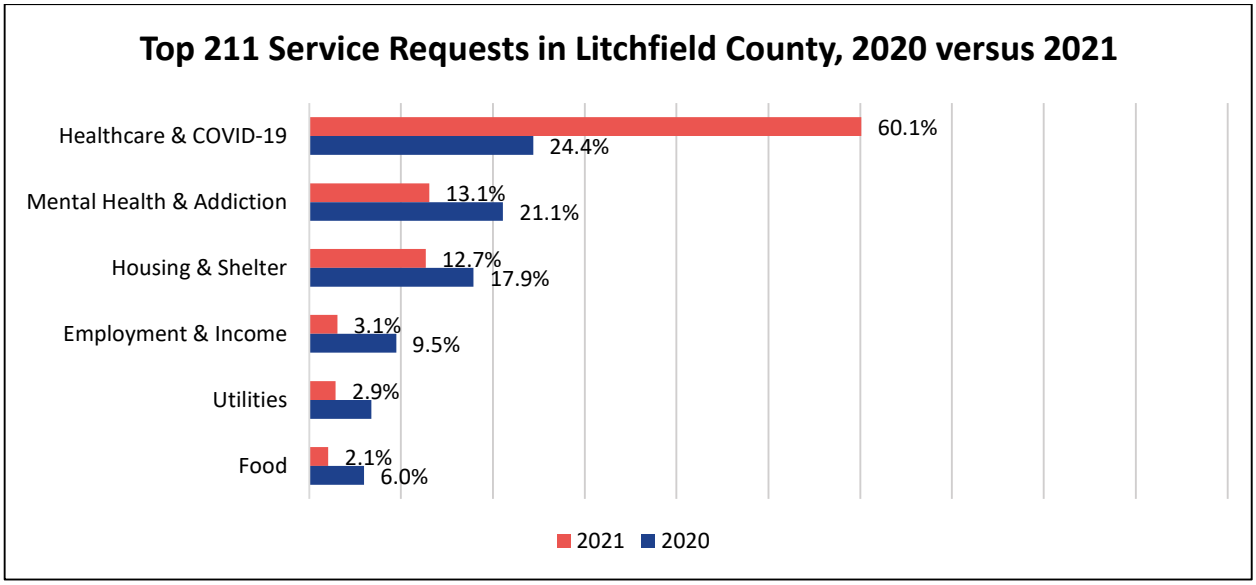

Source: Connecticut Department of Public Health



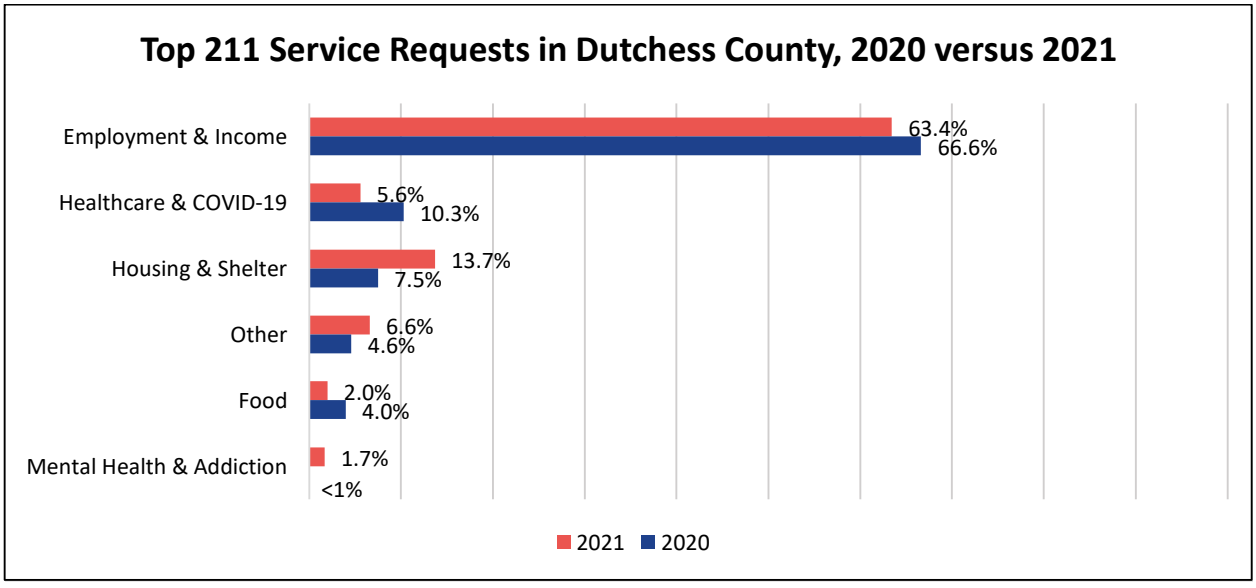

Source: New York State Department of Public Health

**United Way 211** is a 24/7 go-to resource that helps people across the nation find local resources they need. 211 is the most comprehensive source of information about local resources and services in the country. The following graphs depict the top 211 service requests by Litchfield and Dutchess County residents during the COVID-19 pandemic.

The COVID-19 pandemic had deep economic and mental health impacts. Among Litchfield County residents, the top 211 service requests, after healthcare and COVID-19, were mental health and addiction and housing and shelter. Among Dutchess County residents, the top 211 service request in both 2020 and 2021 was employment and income. Housing and shelter requests nearly doubled from 2020 to 2021 for Dutchess County residents.




Source: United Way 211

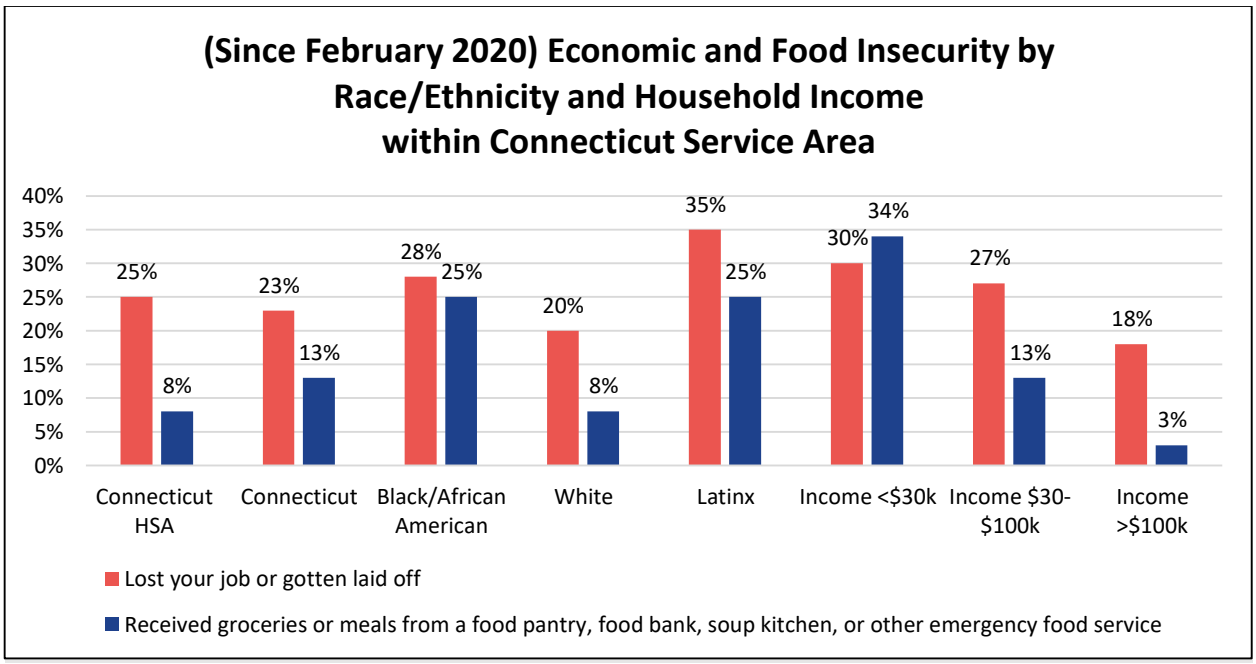



Source: United Way 211

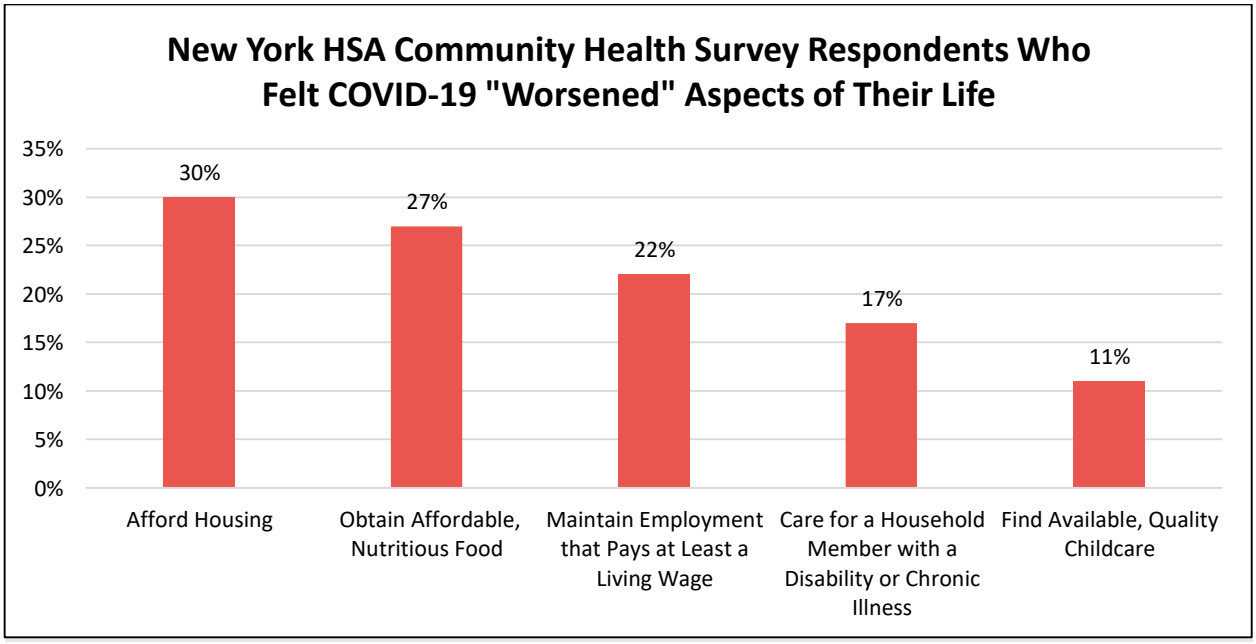
Community survey results demonstrated the economic impacts of the pandemic, including the disproportionate impact among low-income households and communities of color. Among Connecticut statewide Community Wellbeing Survey respondents, 35% of Latinx respondents and

28% of Black/African American respondents reported being laid off or losing their job compared to 20% of white respondents. Approximately 30% of low-income households received food assistance compared to 18% of high-income households.

Similar negative economic impacts were felt by New York HSA Community Health Survey respondents, with the most negative impacts on ability to afford housing and nutritious food.




Source: 2021 DataHaven Community Wellbeing Survey




Source: 2022 Siena College Regional Community Health Survey

# Community Health Needs

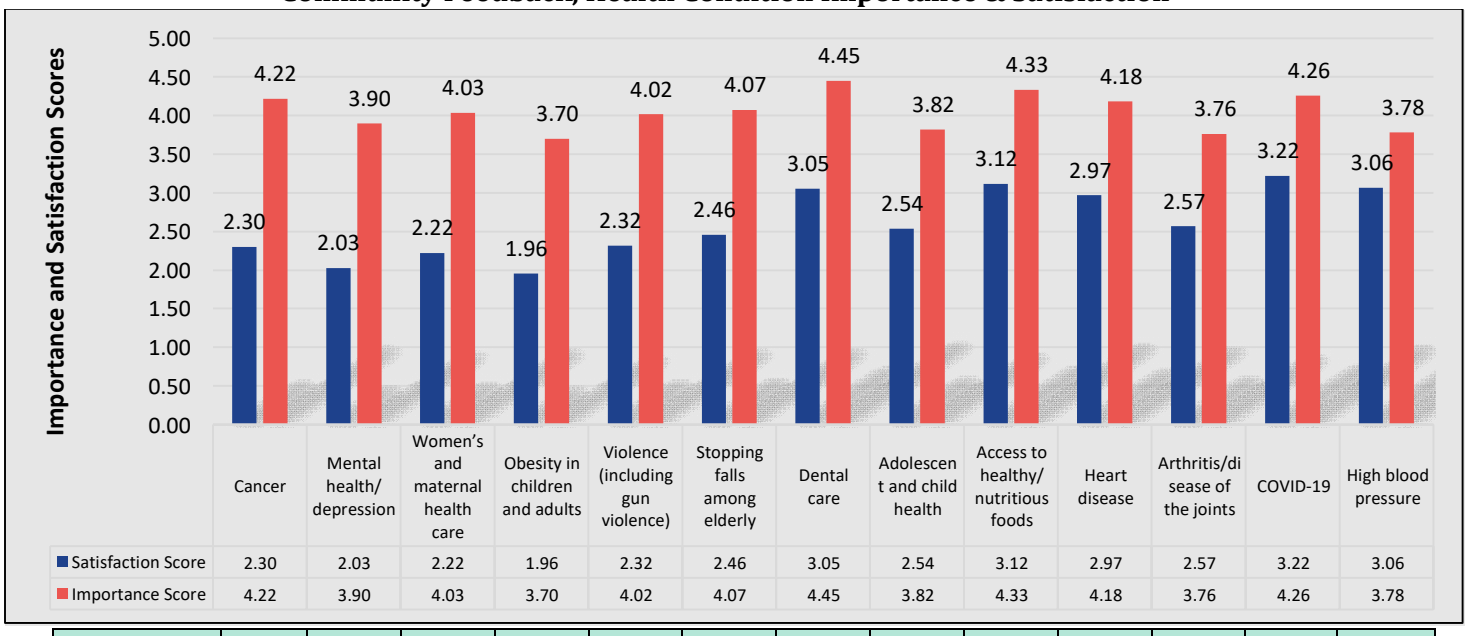
To determine community health priorities, we must consider what the data are telling us, and more importantly, what our community sees as the most pressing health concerns.

Community engagement was a central part of the CHNA. We invited wide participation from community stakeholders and organizations, including experts in health, social service representatives, advocates, community champions, policy makers, and lay community residents. These stakeholders were asked to weigh in on data findings, share their perspectives on challenges facing our community, and provide input on collaborative solutions.

The following graph depicts community feedback for the entire Sharon Hospital Service Area, as garnered from the GNYHA 2022 Community Health Survey. Feedback included perceived importance of community health conditions and satisfaction with current neighborhood services to address these conditions. Results are presented as aggregate scores on a scale of 1 (not at all) to 5 (extremely). The "Gap" represents the difference between importance and satisfaction scores.

The results demonstrated high perceived importance for issues like dental care, access to healthy/nutritious foods, COVID-19, cancer, and heart disease, but, with the exception of cancer, higher satisfaction in available services to address these needs. In contrast, there was a notable gap in perceived satisfaction in available services for issues like obesity, mental health, women's and maternal healthcare, violence, and stopping falls among elderly. These findings may help inform the prioritization of community interventions.

**What you told us: Sharon Hospital Service Area**
**Community Feedback, Health Condition Importance & Satisfaction**




| | Cancer | Mental health/ depression | Women's and maternal health care | Obesity in children and adults | Violence (including gun violence) | Stopping falls among elderly | Dental care | Adolescent and child health | Access to healthy/ nutritious foods | Heart disease | Arthritis/disease of the joints | COVID-19 | High blood pressure |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Satisfaction Score | 2.30 | 2.03 | 2.22 | 1.96 | 2.32 | 2.46 | 3.05 | 2.54 | 3.12 | 2.97 | 2.57 | 3.22 | 3.06 |
| Importance Score | 4.22 | 3.90 | 4.03 | 3.70 | 4.02 | 4.07 | 4.45 | 3.82 | 4.33 | 4.18 | 3.76 | 4.26 | 3.78 |
| **Gap*** | 1.92 | 1.87 | 1.81 | 1.74 | 1.70 | 1.61 | 1.39 | 1.28 | 1.21 | 1.21 | 1.19 | 1.04 | 0.72 |

Source: Greater New York Hospital Association CHNA Survey, 2022
*Difference between Importance Score and Satisfaction Score

The following report sections further highlight data relative to specific health areas like behavioral health, health risk factors and chronic disease, and maternal and child health.

## Behavioral Health

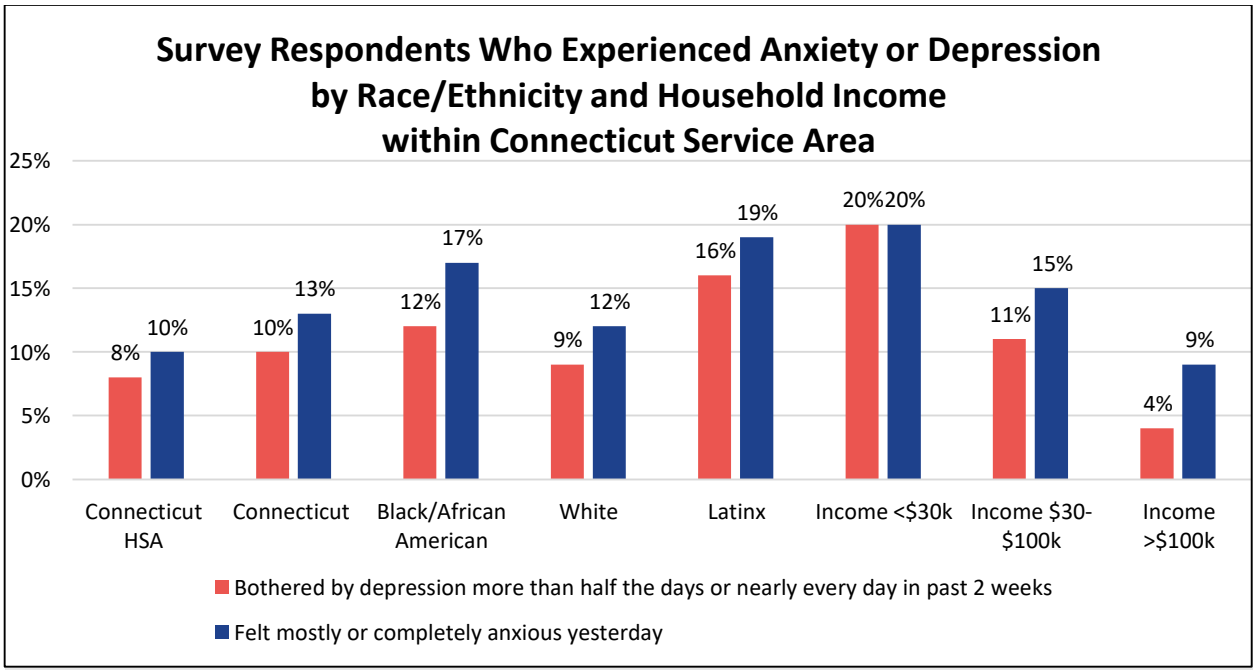
Mental health concerns like depression and anxiety can be linked to social determinants like income, employment, and environment, and can pose risks of physical health problems, including by complicating an individual's ability to keep up other aspects of their healthcare.

Overall, 10% of Connecticut HSA adults report experiencing anxiety regularly and 8% report being bothered by depression. Statewide, these experiences are more prevalent among Black/African Americans, Latinx, and individuals with lower income, a finding that is consistent with being more likely to experience chronic stress related to health and social inequities and/or racism and discrimination, among other factors.

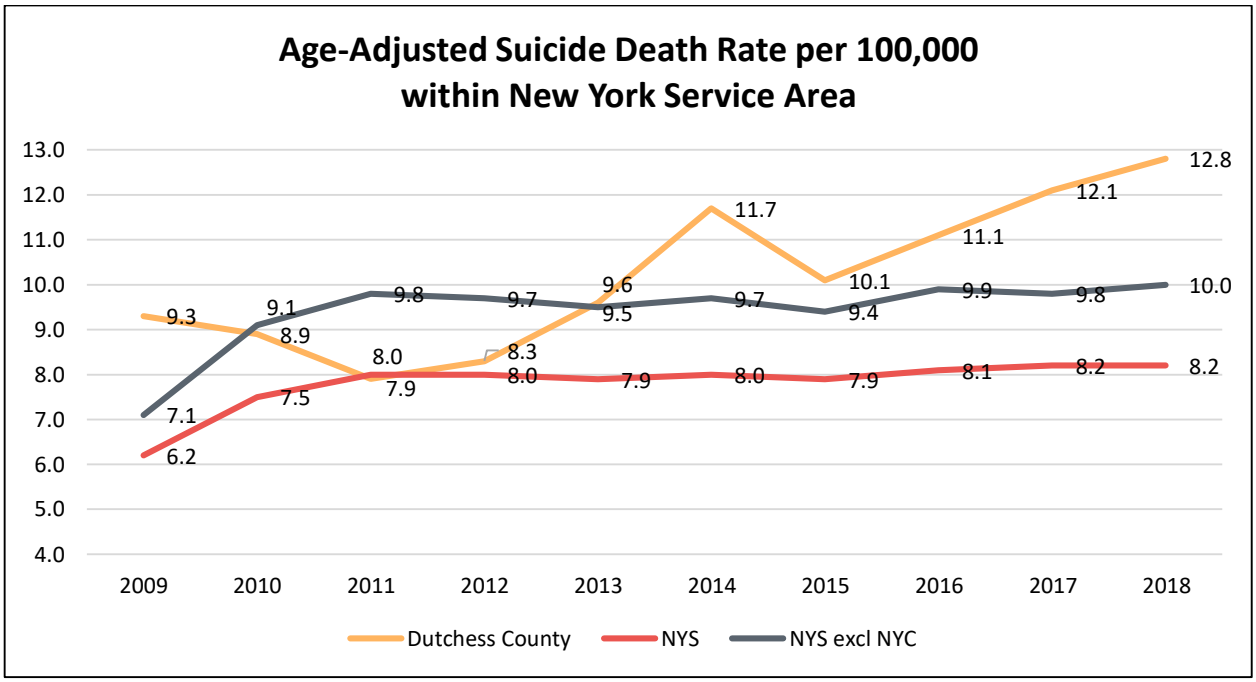
Across Dutchess County in 2018, 16.8% of adults reported having a depressive disorder, an increase from 12.9% in 2016 and higher than the statewide average of 15.3%. Within the seven-county Mid-Hudson Region, Dutchess County had the second highest proportion of adults with a depressive disorder, behind Sullivan County at 23.5%.

Depression is a risk factor for poor mental health and suicide. Among New York HSA Community Health Survey respondents, 27% rated their overall mental health as "fair" or "poor" and 63% said they were "somewhat stressed" or "very stressed" on an average day.

While Dutchess County met the Healthy People 2030 goal for suicide-related deaths as of 2018, it had a higher rate of death than the state overall and the second highest rate of death in the Mid-Hudson Region behind Ulster County (13.2). The death rate increased in recent years.




Source: 2021 DataHaven Community Wellbeing Survey




Source: Mid-Hudson Region CHNA, NYS Department of Health Vital Statistics, 2022
*Dutchess County data represent three-year averages; NYS data reflect single-year trends (2018.

The COVID-19 pandemic exacerbated many behavioral health concerns, particularly for youth, due to stress, isolation, and lost learning, among other factors. Before the pandemic, approximately 31% of Connecticut youth and 35% of New York youth reported feeling sad or depressed and 7-8.5% had attempted suicide. About one-fifth to one-quarter of youth used one or more substances like tobacco, alcohol, or marijuana. These findings should continue to be monitored in light of the pandemic.

**2019 Youth Measures of Mental Health and Substance Use**

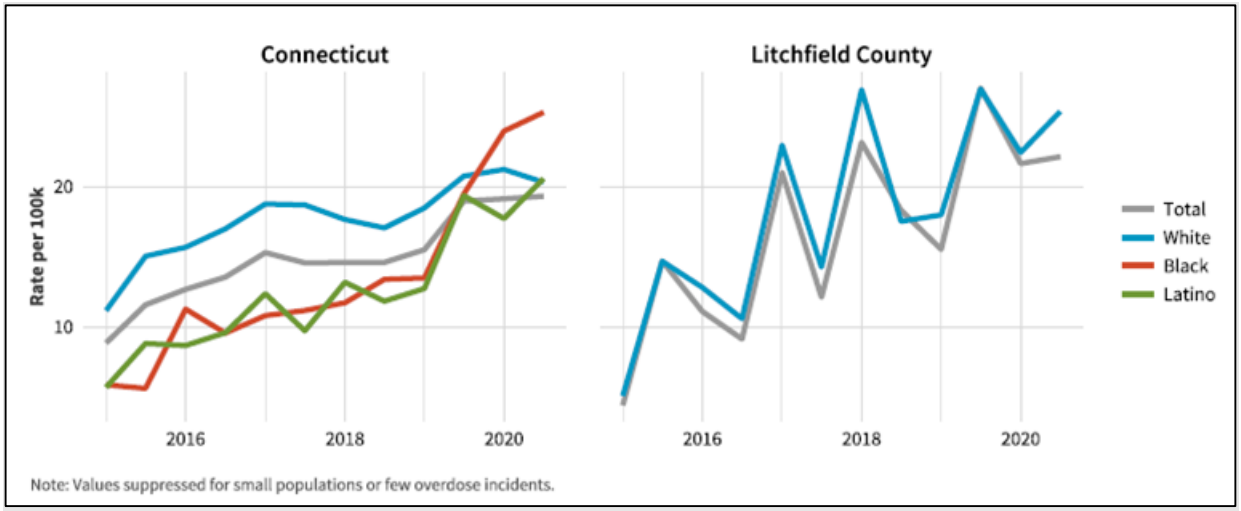
| | Feel Consistently Sad or Depressed | Attempted Suicide | E-cigarette Use (last 30 days) | Alcohol Use (last 30 days) | Marijuana Use (last 30 days) |
|---|---|---|---|---|---|
| Connecticut | 30.6% | 6.7% | 27.0% | 25.9% | 21.7% |
| New York | 35.1% | 8.5% | 22.4% | 26.4% | 19.1% |
| US | 36.7% | 8.9% | 32.7% | 29.1% | 21.7% |

Source: CDC Youth Risk Behavior Survey

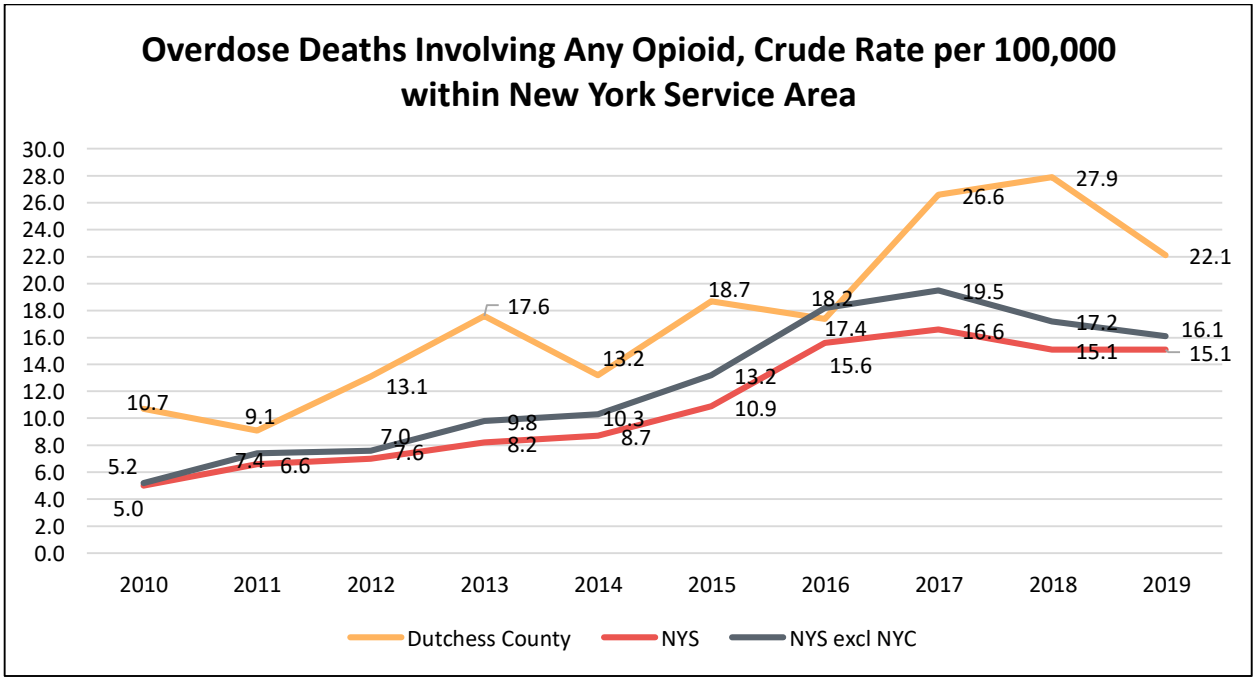
Like other states, Connecticut and New York have seen a rise in drug overdose deaths in the last several years. In 2020, Connecticut saw an average of 113 overdose deaths per month, up from 60 in 2015. Litchfield County overall has trended higher than the state for drug overdose deaths in recent years. Statewide, white residents long comprised the bulk of drug overdose deaths, but as overall death rates have increased, an increasing share of those deaths have been people of color.

Across New York, the rate of overdose death involving any opioid tripled from 2010 to 2019. Dutchess County has historically had a higher rate of overdose death than the state, and the death rate doubled from 2010 to 2019. Within the Mid-Hudson Region, Dutchess County has the second highest rate of opioid-related overdose death behind Sullivan County (39.8). Dutchess County has the highest rate of emergency department (ED) visits involving any opioid overdose in the region.

**Age-Adjusted Semi-Annual Rates of Accidental Overdose Death per 100,000 Residents By Race and Ethnicity within Connecticut Service Area**




Source: DataHaven analysis (2021)




Source: Mid-Hudson Region CHNA, NYS Department of Health Vital Statistics, 2022

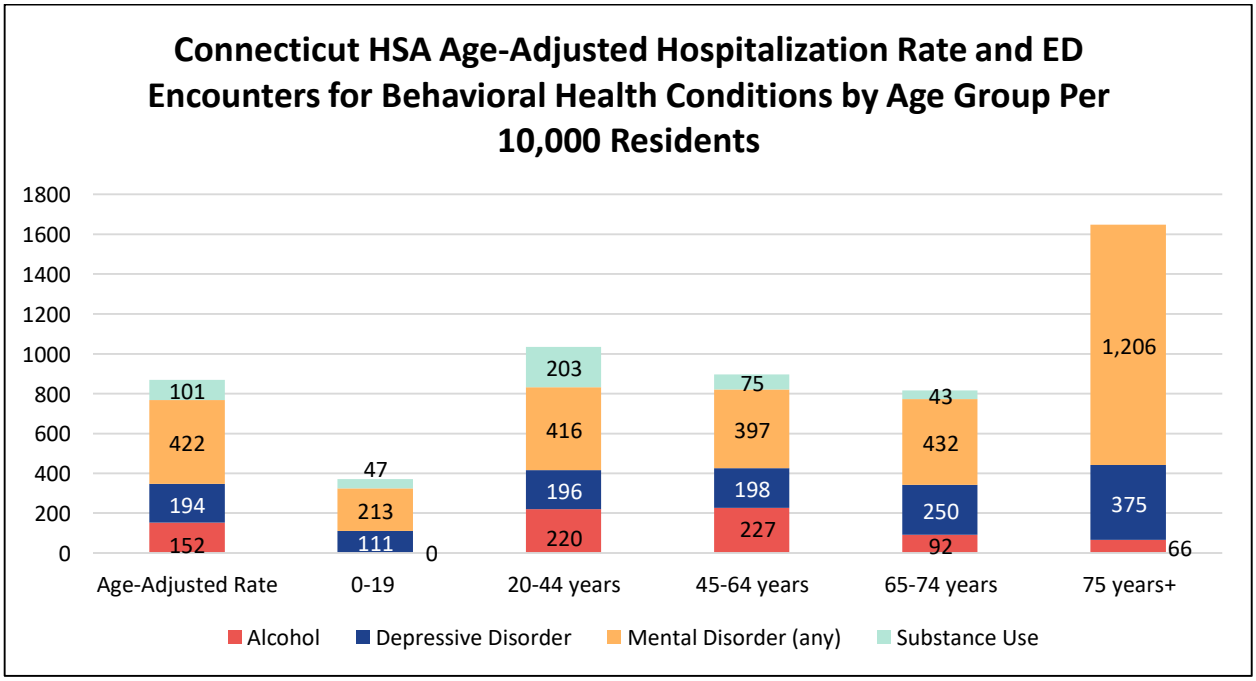
**Age-Adjusted Rate of ED Visits (including outpatients and admitted patients) Involving any Opioid Overdose per 100,000 within New York Service Area**

| Dutchess County | New York State | New York State excl New York City |
|---|---|---|
| 97.2 | 53.1 | **66.1** |

Source: Mid-Hudson Region CHNA, NYS Department of Health Statewide Planning and Research Cooperative System, 2019

Behavioral health conditions are considered ambulatory care sensitive (ACS) conditions, which if effectively managed in an outpatient setting, should not be the primary reason for a hospital visit. The following graph depicts hospital and emergency department (ED) encounters by residents of the Connecticut HSA for select behavioral health conditions, as provided by the Connecticut Hospital Association and analyzed by DataHaven.

Behavioral health encounter data include any encounter by any resident of any town in Connecticut to Sharon Hospital. Across all age groups, mental disorders are the most prevalent behavioral health conditions that patients seek help for at the hospital, and the rate of visits is approximately three times as high for older adults aged 75 or over compared to younger adult populations. It is worth noting that substance use disorder-related visits, including alcohol and drugs, follow an opposite trend, with increasing rates among younger adult populations.



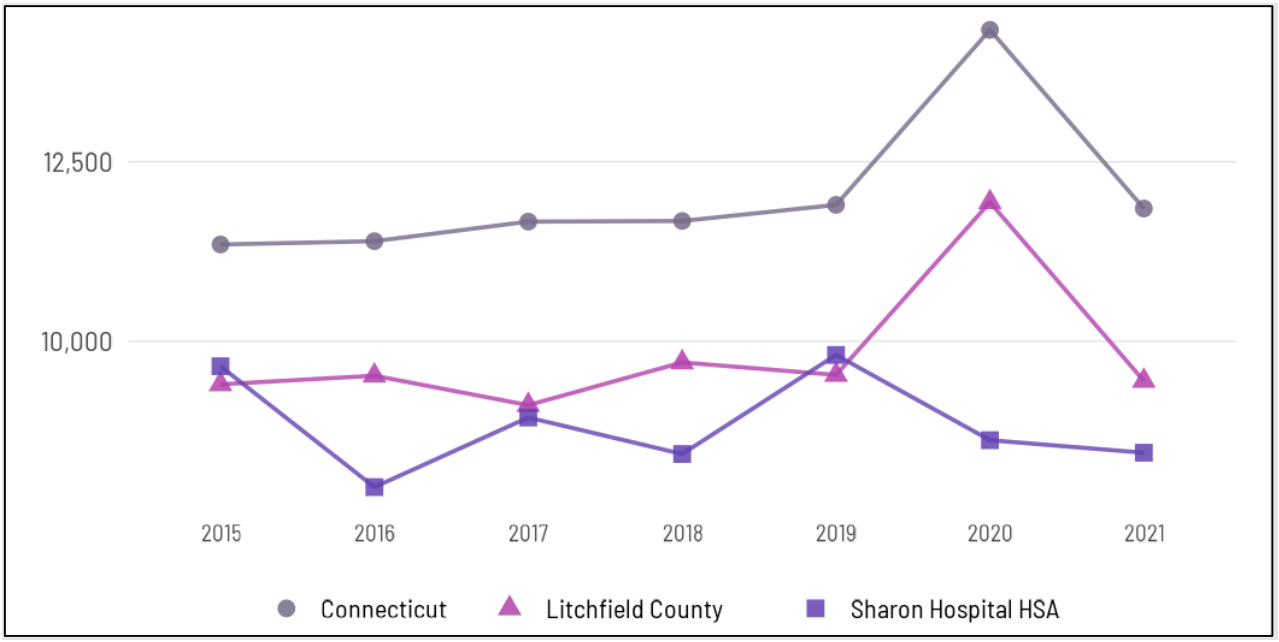

Source: DataHaven analysis (2021) of 2018-2021 Connecticut Hospital Association CHIME

## Health Risk Factors and Chronic Disease

All-cause mortality spiked in 2020 due to the COVID-19 pandemic. This trend is illustrated in the graph below for Connecticut and Litchfield County. Across Litchfield County in 2020, COVID-19

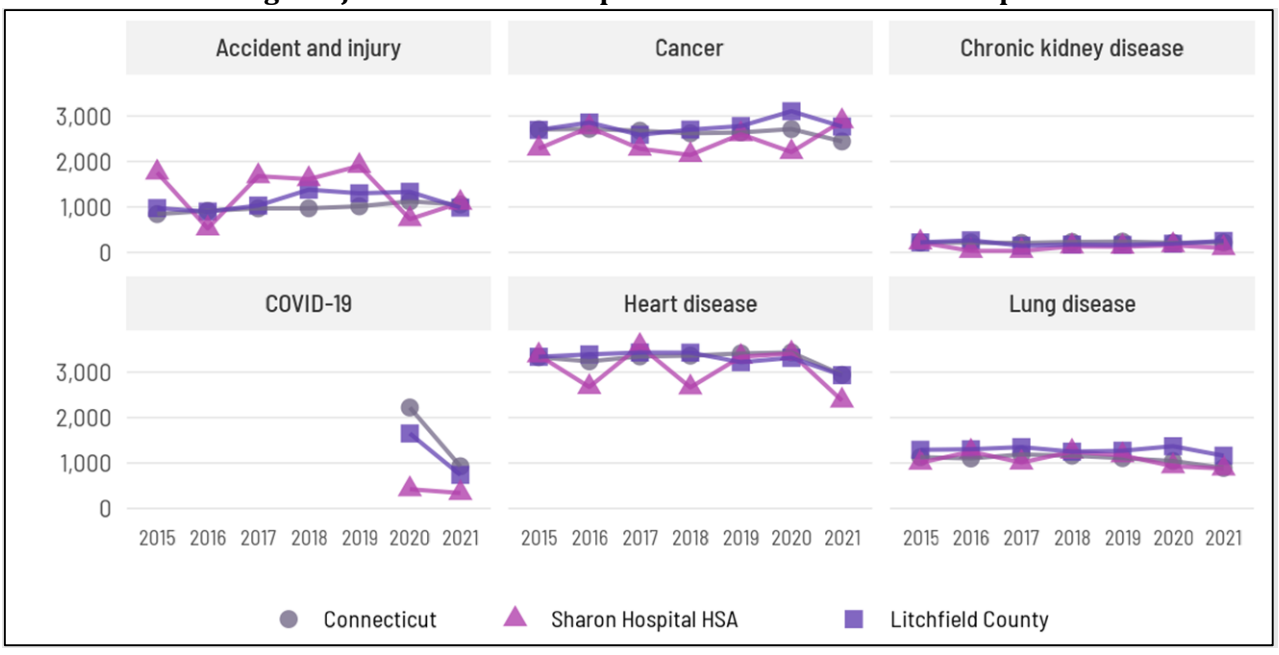
mortality rates were similar to mortality rates from heart disease and cancer. The Connecticut HSA differed from county and statewide findings with a declining rate of death in 2020, although residents of the HSA suffer a higher overall premature death rate per 100,000 (6,600) than the state (6,100). Within the Connecticut HSA, cancer, heart disease, and poisonings (including overdose) were the leading causes of premature death from 2015 to 2021.

**Connecticut HSA Age-Adjusted, All-Cause Mortality per 1 Million Residents 2015-2021**



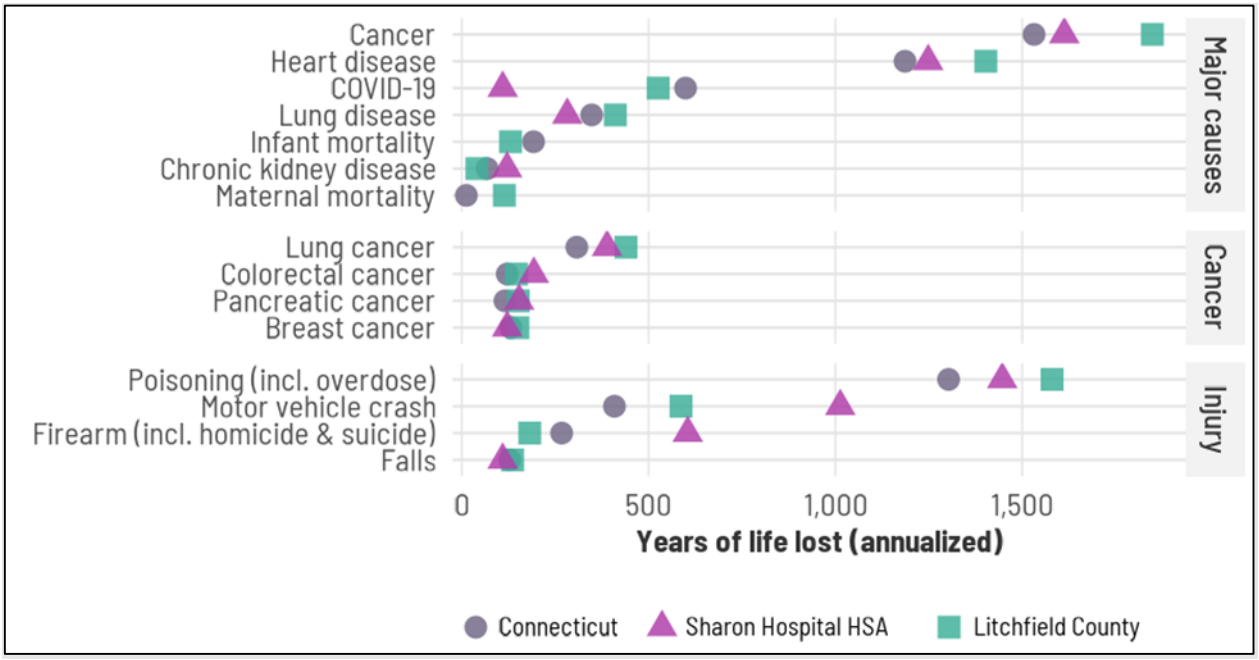

Source: DataHaven analysis (2021)

**Connecticut HSA Age-Adjusted Death Rates per 1 Million Residents for Top Causes of Death**




Source: DataHaven analysis (2021)

**Connecticut HSA Years of Potential Life Lost Before Age 75 per 100,000 Residents by Cause of Death 2015-2021**




Source: DataHaven analysis (2021)

Connecticut HSA residents generally report a lower burden of chronic disease relative to surrounding communities, as evidenced by hospital and ED encounters data. The following table compares age-adjusted encounter rates for leading causes of morbidity and mortality for the Connecticut HSA and neighboring Danbury and Norwalk regions.

**Age-Adjusted Hospitalization and ED Encounters for Leading Causes of Morbidity and Mortality**

| | Sharon Hospital HSA | Greater Danbury | Greater Norwalk |
|---|---|---|---|
| Hypertension | 668 | 905 | 733 |
| Type 2 Diabetes | 290 | 561 | 375 |
| Heart Disease | 143 | 203 | 201 |
| Asthma | 137 | 222 | 167 |
| COPD | 142 | 191 | 113 |
| Uncontrolled Diabetes | 25 | 64 | 54 |

Source: DataHaven analysis (2021) of 2018-2021 Connecticut Hospital Association CHIME

Prior to COVID-19, the top leading causes of death for US residents were chronic diseases. Within the New York Mid-Hudson Region, the leading cause of death for nearly all counties, including Dutchess, was heart disease. Other top causes of death included cancer, chronic lower respiratory disease (CLRD), and stroke.

The following table depicts deaths and death rates from the top five leading causes of death in Dutchess County and the state overall. Dutchess County has historically had similar or lower death rates than the state, except for accidents which trends higher. This finding is consistent with more positive health behaviors, like physical activity and nutrition, among Dutchess County residents. However, it is worth noting that more than one-quarter of Dutchess County adults had obesity in 2016, an increase from 2013-2014 findings (24%) and higher than the statewide average.

**Top Five Leading Causes of Death within the New York Service Area**

| | #1 Cause of Death | #2 Cause of Death | #3 Cause of Death | #4 Cause of Death | #5 Cause of Death |
|---|---|---|---|---|---|
| Dutchess County | Heart Disease | Cancer | CLRD | Accidents | Stroke |
| | No.: 665 | No.: 533 | No.: 134 | No.: 133 | No.: 95 |
| | Rate: 161.4 | Rate: 130.1 | Rate: 32.3 | Rate: 42.1 | Rate: 24.0 |
| New York State | Heart Disease | Cancer | Accidents | CLRD | Stroke |
| | Rate: 167.1 | Rate: 133.6 | Rate: 33.8 | Rate: 27.7 | Rate: 23.9 |
| New York State excl New York City | Heart Disease | Cancer | CLRD | Accidents | Stroke |
| | Rate: 161.3 | Rate: 143.1 | Rate: 33.7 | Rate: 39.6 | Rate: 27.0 |

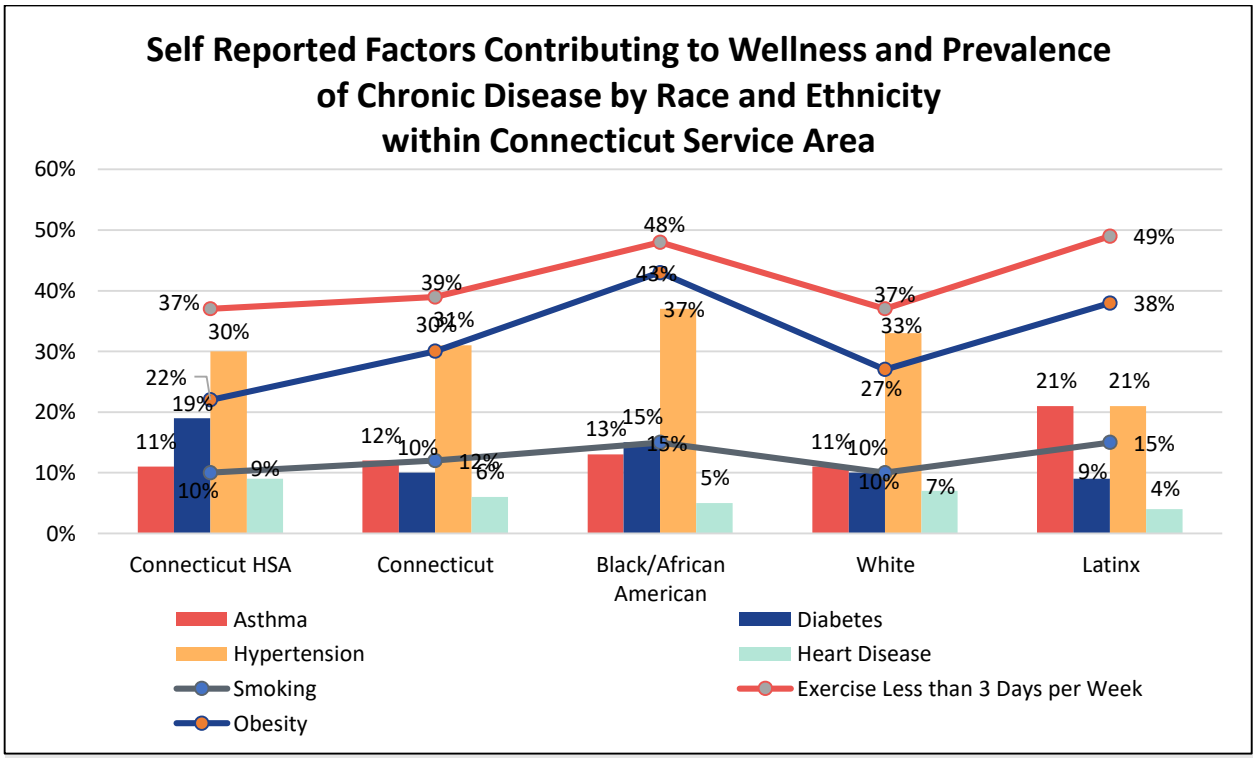
Source: Mid-Hudson Region CHNA, NYS Department of Health Vital Statistics, 2019

**Adult Health Risk Factor Indicators within the New York Service Area**

| | Dutchess County | Mid-Hudson Region | New York State | New York State excl New York City |
|---|---|---|---|---|
| Participation in leisure time physical activity (2018) | 80.2% | 78.1% | 76.4% | 78.3% |
| Consume less than one fruit and less than one vegetable daily (2018) | 25.4% | 25.8% | 28.1% | 26.1% |
| Consume one or more sugary beverages daily (2018) | 23.5% | 22.3% | 24.7% | 25.5% |
| Adults who have obesity (2016) | 26.2% | 22.9% | 25.5% | 27.4% |

Source: Mid-Hudson Region CHNA, NYS Department of Health Expanded Behavioral Risk Factor Surveillance system, 2016, 2018

Across the Connecticut and New York service areas, it is clear that social determinants of health directly impact health risk factors and ultimately chronic disease, resulting in inequities in life expectancy by race and neighborhood. This connection is demonstrated in the following graph which looks at prevalence of self-reported factors like obesity and physical inactivity and prevalence of chronic conditions like hypertension and diabetes within the Connecticut service area.




Source: 2021 DataHaven Community Wellbeing Survey

## Maternal and Child Health

Having a healthy pregnancy is the best way to have a healthy birth and a healthy start to life. The data show that most people in the Connecticut and New York service areas are able to access early prenatal care, which is the best way to promote a healthy pregnancy and delivery. However, this positive experience is not shared equally across communities or population groups. Trends to note include a slightly higher proportion of people within the Connecticut HSA receiving late or no prenatal care compared to the state overall, and wide disparities in access among pregnant people of color in both Connecticut and New York service areas. These disparities contribute to more negative birth outcomes like low birth weight and preterm birth among people of color.

Infant mortality measures the rate of death under one year of age per 1,000 live births. Maternal mortality measures the rate of death during pregnancy or within one year of the end of pregnancy. Both measures are internationally utilized as key community health indicators because they are particularly sensitive to structural factors including social and economic factors and quality of life conditions, such as housing insecurity, educational attainment of the mother, and ACEs.

Disparities in infant and maternal mortality are measures of structural inequities that are at play well before a mother gets pregnant or gives birth. Therefore, upstream strategies that address the root causes of inequities can have far reaching impact on these indicators. Statewide data show that infant mortality impacts Black babies at two to three times the rate as white babies and approximately twice the rate of Latinx babies. Maternal mortality impacts Black pregnant people at more than three times the rate of white pregnant people in Connecticut, and more than four times the rate of white pregnant people in New York.

**2016-2018 Selected Birth Outcomes by Race and Ethnicity of Parent Giving Birth within Connecticut Service Area**

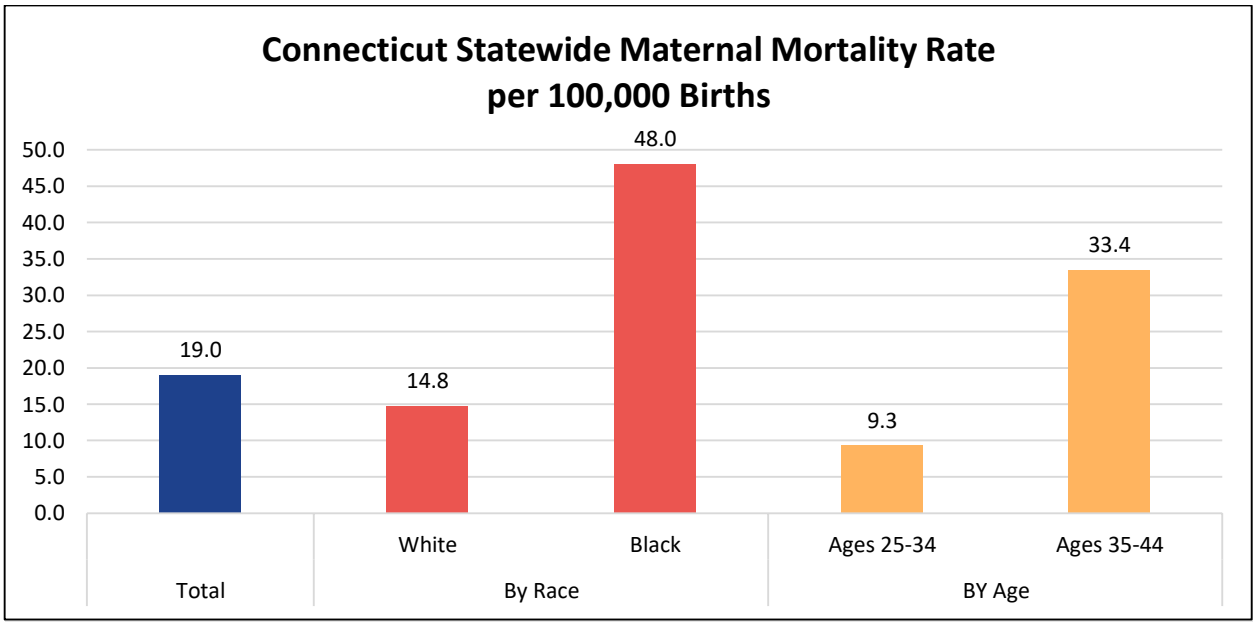
| | Total | Asian | Black | White | Latina | | |
|---|---|---|---|---|---|---|---|
| | | | | | Latina (overall) | Puerto Rican | Other Latina |
| Late or no prenatal care | | | | | | | |
| Connecticut HSA | 5.2% | NA | NA | 4.2% | NA | NA | NA |
| Litchfield County | 3.2% | NA | 5.4% | 2.8% | 5.4% | 4.7% | 5.6% |
| Connecticut | 3.4% | 3.5% | 5.7% | 2.5% | 4.0% | 2.9% | 5.1% |
| Low Birth Weight | | | | | | | |
| Connecticut HSA | 0.0% | NA | NA | NA | NA | NA | NA |
| Litchfield County | 6.4% | 8.4% | 8.7% | 6.5% | 4.9% | 6.8% | 4.2% |
| Connecticut | 7.8% | 8.7% | 12.1% | 6.4% | 8.3% | 10.2% | 6.6% |
| Infant Mortality (per 1,000 live births) | | | | | | | |
| Connecticut HSA | NA | NA | NA | NA | 0.0 | NA | NA |
| Litchfield County | 2.9 | NA | 0.0 | 1.7 | NA | NA | NA |
| Connecticut | 4.6 | NA | 9.5 | 3.1 | 5.0 | NA | NA |

Source: DataHaven analysis (2021) of data from the Connecticut Department of Public Health Vital Statistics.

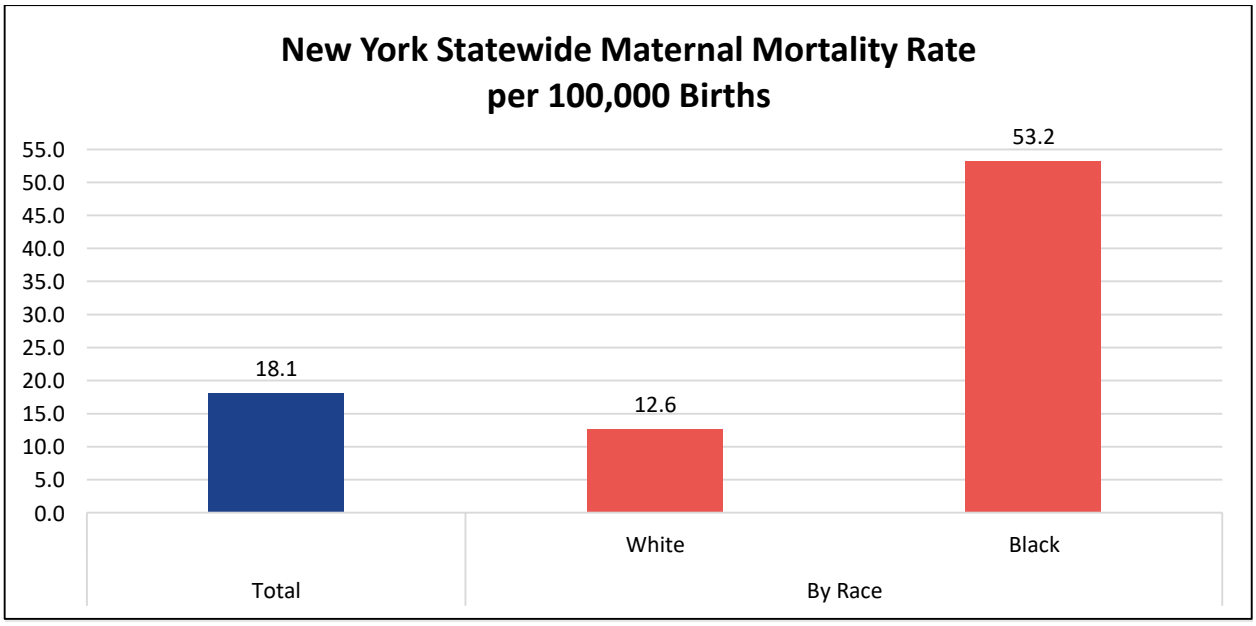
**2017-2019 Selected Birth Outcomes by Race and Ethnicity of Parent Giving Birth within New York Service Area**

| | Total | Non-Hispanic Black | Non-Hispanic White | Latinx |
|---|---|---|---|---|
| Early (1st trimester) Prenatal Care | | | | |
| Dutchess County | 84.4% | 77.8% | 88.0% | 79.7% |
| Mid-Hudson Region | 77.8% | NA | NA | NA |
| New York State | 73.6% | 69.2% | 81.8% | 73.2% |
| Teen Pregnancy Rate per 1,000 Females Under Age 18 | | | | |
| Dutchess County | NA | 8.1 | 2.0 | 5.9 |
| Mid-Hudson Region | NA | NA | NA | NA |
| New York State | NA | 8.2 | 1.8 | 7.0 |
| Preterm (before 37 weeks) Births | | | | |
| Dutchess County | 9.2% | NA | NA | NA |
| Mid-Hudson Region | 8.3% | NA | NA | NA |
| New York State | 9.0% | 12.9% | 7.6% | 9.8% |
| Low Birth Weight | | | | |
| Dutchess County | 7.5% | 12.4% | 6.5% | 8.1% |
| Mid-Hudson Region | 7.1% | NA | NA | NA |
| New York State | 8.1% | 12.9% | 6.3% | 8.3% |
| Infant Mortality (per 1,000 live births) | | | | |
| Dutchess County | 4.3 | NA | NA | NA |
| Mid-Hudson Region | 3.6 | NA | NA | NA |
| New York State | 4.3 | 8.8 | 3.3 | 3.9 |

Source: Mid-Hudson Region CHNA, NYS Department of Health Community Health Indicator Reports, 2021




Source: America's Health Rankings analysis of CDC WONDER Online Database, Mortality files, 2013-2017




Source: NYS Department of Health, 2016-2018

The CHNA data findings were analyzed to inform health priorities for the Sharon Hospital Service Area. The data included in this report are valuable for tracking and benchmarking community health status indicators, as well as for identifying emerging community needs. In addition to the research collected as part of the 2022 CHNA, community conversations were held to solicit feedback on health priorities and opportunities for community health improvement.

# Evaluation of Impact from 2019-2022 Community Health Improvement Plan

Each Nuvance Health hospital has a Community Health Committee (CHC) with representatives from the board, the executive team, hospital staff, community members and local health departments and community agencies. The CHC at Sharon Hospital convened workgroups to review the findings of the Regional Community Health Needs Assessment and review the local health department priority areas to determine the hospitals' community health improvement priorities for the 2019-2021 period.

Sharon Hospital identified the following two priorities:

- Prevent chronic diseases.
- Promote well-being and prevent mental and substance use disorders.

The workgroups developed goals, objectives, strategies, action steps, and metrics to measure success for these priority areas.

Due to the COVID-19 pandemic, many of the planned community health programming and activities related to the prevention agenda priorities and implementation plan outlined in the 2019-2021 plan were put on-hold or scaled back due to social distancing and hospital visitation policies. The Let's Improve our Nutrition School Pilot Program, kicked off during the 2018/2019 school year, was paused during the pandemic when schools moved to virtual learning. Where possible programs, like Mental Health First Aid and support groups, were moved to an online platform like Zoom.

As a result of the pandemic Sharon Hospital pivoted their community programming to focus on COVID-19 education, testing, and vaccinations. In 2020, the hospital set up drive-through COVID-19 testing for the community and partnered with the local private, residential schools to set up N95 fit test clinics for their staff. The Nuvance Health hospitals helped staff a community hotline for information and questions in the early pandemic. Additionally, from 2020 to 2022, there was a regular cadence of Facebook Live Q&A and informational sessions in English and Spanish, with over 35,000 views. Many of the Sharon Hospital staff became local resources on COVID and the impact of the pandemic on the community. They provided hours of radio and Zoom interviews for various local radio shows, newspapers, senior programs and local community groups.

Where CHIP efforts did continue to address chronic disease prevalence in the region, at the same time, the emerging mental health disparity brought on by the pandemic did make it necessary to prioritize the implementation of interventions that address the increased prevalence of anxiety and depression in the community. In addition to addressing urgent mental health needs throughout the greater Sharon Hospital Service Area, the pandemic also brought into focus the importance of connecting community members with services that address food insecurity, housing, transportation, and utilities.

# Next Steps

The Sharon Hospital Community Health Committee (CHC) is tasked with the review and oversight of the CHNA and CHIP in support of the organization's mission and population health initiatives.

## Responsibilities and scope of activities

- Monitor assessments of population health status and social determinants that impact health
- Guide priority issues for action to improve community health
- Monitor implementation of approved work plans to address identified priority issues
- Help inform, guide, share and link successful programs and strategies that address health and wellness throughout the network's service areas
- Support community health programs that are accountable and continuously measured to improve
- health outcomes and reduce inefficiencies in delivery of programs and services

Progress on the 2022 CHIP and implementation strategies will continue to be monitored at routine workgroup meetings and will be reported regularly to the Sharon Hospital CHC. The Sharon Hospital CHC, made up of community members and representatives from community health organizations, will meet on a quarterly basis, and report at least annually to the Sharon Hospital board and the network Strategic Planning Committee.

The work of the various task forces, workgroups and committees follows a collective impact model, which has proven to be an effective approach when addressing entrenched social and community issues. Collective impact begins with the idea that large-scale social change requires broad cross-sector coordination and occurs when organizations from different sectors agree to solve a specific social problem. The key elements of collective impact include:

- Creating and following a common agenda
- Aligning and coordinating efforts to ensure that they are mutually reinforcing
- Using common measures of success
- Maintaining excellent communication among partners
- Facilitating through "backbone" support organizations.