Farmington Valley Health District
Community Health Assessment

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Background

Farmington Valley Health District (FVHD) in north central Connecticut includes 108,700 residents across the ten towns of Avon, Barkhamsted, Canton, Colebrook, East Granby, Farmington, Granby, Hartland, New Hartford, and Simsbury. Health department accreditation through the Public Health Accreditation Board (http://www.phaboard.org/) requires a community health assessment, demonstrating the health department commitment to assessing and acting on health determinants, behaviors, and outcomes. This report provides an initial assessment based on analysis of existing data, and identified priority areas and future research.

The ten towns in the FVHD are grouped into three regions: wealthy, suburban, and rural. Avon and Simsbury (wealthy) have a very high median income, moderate population density, and a low poverty rate. Canton, East Granby, Farmington, and Granby (suburban), have above average median income, moderate population density, and low poverty rate. Barkhamsted, Colebrook, Hartland, and New Hartford (rural) have extremely low population density, and average income and poverty rates.\textsuperscript{1}

Objectives

1. Identify, analyze and synthesize available quantitative data to describe demographics, health outcomes and risk factors within the Farmington Valley Health District
2. Develop a framework for gathering qualitative data to further illuminate community health and contextual factors, fill data gaps and identify community assets and needs.

Methods

- Literature Review covering: previous local community health assessments (CHA), secondary data analysis, and the impact of community health assessments (CHAs).
- Analysis of secondary data on topics identified by FVHD staff were collected at state, county, and town level from a range of sources. Rates for specific data measures were calculated using population measures given by CT Data Collaborative from 2010-2014 and the American Community Survey. Town-level data was preferred, and district level or other data were analyzed when town level data was not available. Data from Connecticut DPH from 2003-2007 and 2008-2012 were compared for statistically significant differences or trends in age-adjusted mortality rates for different causes of death. For Youth Risk Behavioral Surveillance Survey data, z-tests were performed to compare differences in behaviors between genders at the .05 significance level.
  - Data sources: Connecticut Data Collaborative; Behavioral Risk Factor Surveillance System (BRFSS); DataHaven; Connecticut Department of Public Health
Key Findings: Demographics
The income of those in the Farmington Valley Health District is substantially higher than the Connecticut median income.

Over 80% of each town is white, so the population of FVHD is less racially diverse than the population of Connecticut overall. Farmington and Avon have the largest Asian populations and East Granby has the largest black population.

Key Findings: Chronic Disease
While chronic disease mortality rates for most causes of death have significantly decreased in Connecticut throughout the past decade, some FVHD towns experience higher mortality rates compared to the state average. East Granby, Granby, and Barkhamsted experience higher mortality rates due to cancer. East Granby, Colebrook, and Barkhamsted experience higher mortality rates due to cardiovascular disease. Colebrook and Canton experience higher mortality rates due to stroke.

Key Findings: Mental Health
Mental health and substance use treatment admissions are lower in FVHD towns than in the state, and suicide rates in FVHD towns are higher than the state average. Within FVHD East Granby has the highest admissions rates for both mental health and substance use in FVHD.
Key Findings: Infectious Disease

Lyme disease is a particular concern for Connecticut with an infection rate at 71 per 100,000 residents compared to the US at 8 per 100,000 residents. This rate is even higher in some town in FVHD, notably New Hartford and Barkhamsted.

Almost 3 out of 5 FVHD residents were not vaccinated for influenza in 2013, despite higher overall mortality rates due to influenza and pneumonia in FVHD compared to the Connecticut average, and in particular in the towns of Hartland, Colebrook, Avon, and East Granby.

Key Findings: Youth Health

Depression and rates of hopelessness or suicide are very high, especially for females. Statistically significant differences between male and female youth exist for all drug use of cocaine, methamphetamines, ecstasy, and marijuana. Many youth surveyed engage in risky sexual behaviors such as not using contraception during sexual activity.

Key Findings: Elder Health

Avon, Farmington, Granby, and Simsbury experienced higher age-adjusted mortality rates (23.2, 18.8, 36.3, 22.9) for Alzheimer’s disease compared to the Connecticut average (16.9). The elderly are more likely to be adversely affected by accidental falls. Four towns in FVHD have higher age-adjusted death rates from accidental falls: Canton (15.5), Colebrook (40.4), East Granby (15.5), and Farmington (11.0) compared to Connecticut (7.7).

Conclusions and Recommendations

FVHD performs far better than the rest of Connecticut in most areas examined. Based on our findings, recommendations for the future include:

1. Address major chronic diseases such as mortality from chronic lower respiratory disease and kidney disease in FVHD towns above the Connecticut average.
2. Ensure influenza vaccination coverage for FVHD residents.
3. Decrease substance use and related mortality due to accidental poisoning.
4. Increase research on age-specific care for adolescents around mental health, substance use, and sexual behaviors, and for elderly around accidental falls and Alzheimer’s disease.
5. Conduct qualitative data collection using guidelines included in CHA appendix. Including: expanding understanding of mental health behaviors, outcomes, and services at the town level and for specific age and gender categories.
Limitations
While demographic information for residents were available, epidemiological, behavioral, and other qualitative data were more difficult to access at the town or even district level for data collection. With FVHD existing across two geographic and heterogeneous counties of Litchfield and Hartford, data that was only available at the county level was unusable for our purposes. Additionally, secondary qualitative data regarding mental health and youth or elderly behaviors in depth. Further data collection methods such as qualitative interviews or survey questionnaires could have been conducted, given more time and resources.

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References