Hartford HealthCare

Regional Community Health Needs Assessment

The Hospital of Central Connecticut

June 8, 2022

crescendo

Letter from Project Sponsors

The COVID-19 pandemic led to a global health crisis which created urgency in our local efforts to address inequities as a health care system and ensure that everyone in the communities we serve has access to safe, quality care. The Hospital of Central Connecticut (HOCC) has made significant strides in making sure at-risk communities have the support and information they need to improve their health and well-being.

During the pandemic, we put tremendous resources into making sure everyone had access to COVID-19 vaccinations and testing at our facilities. We set up testing locations as a way to help identify positive cases and curb the spread of the virus. We then opened a mega vaccine clinic at One Liberty Square in downtown New Britain to accommodate the influx of people who needed to be vaccinated. This location, along with our partnerships with city departments and resources, helped save lives. That type of collaboration has had a profound impact on the community. Hartford HealthCare's Neighborhood Health Team, in collaboration with community partners, brought vaccinations, testing and preventative care directly to populations throughout our region as well.

Understanding the pandemic forced many to put off routine care, we have also gone into our communities through events at health fairs, local-nonprofits, virtual town halls with organizations, such as the New Britain NAACP, and other events to remind people of the services available to them. Health screenings, behavioral health services, and conversations with our experts have given countless people invaluable guidance and information. HOCC's Emergency Department and our Behavioral Health Network also formed a partnership with the New Britain Recovers Initiative, which provides help for homelessness, addiction, and youth prevention efforts in the community – helping our most vulnerable populations with treatment and care. HOCC is also proud to be part of H.O.P.E., which stands for Heroin/Opioid Prevention & Education. The programs is designed to assist people who are suffering from addiction from the moment they come in contact with law enforcement – using treatment options as an alternative to arrest.

We still have a long way to go to address inequity and access to care, but The Hospital of Central Connecticut is committed to that journey. This report identifies our strengths and areas for improvement. It also gives us a clear pathway to identify any barriers to care and develop a clear and measurable strategy to address them in real time. Making changes now will have a significant impact on countless people and improve quality of life for decades to come.

Sincerely,

Gary Havican

President, The Hospital of Central Connecticut

Senior Vice President, Hartford HealthCare

Dear Reader,

Thank you for reading the 2022 Community Health Needs Assessment for The Hospital of Central Connecticut.

Hartford HealthCare's 2022 Community Health Needs Assessment process presents us with an historic opportunity to align dialogue and action around a common framework for improving health. An ongoing global pandemic and a renewed national racial reckoning bring into sharp focus the imperative of listening with humility and curiosity to the voices and realities of the people, families, and organizations that form the fabric of each neighborhood we have the privilege to serve.

We improved our needs assessment process this year to assemble a meaningful picture of our community's current health status. Further, our process intentionally developed mechanisms through which we will continually learn, in real time, from and about the evolving realities and perspectives of residents and local stakeholders. It is our intention that the ensuing report provides an important foundation for community stakeholders to identify and define priorities for health improvement, to name and amplify existing community strengths and assets, and to outline areas for further collaboration and collective action.

The community-centered objectives that guided our process included:

1) Enhance our community engagement and better incorporate on an on-going basis the voices of those we serve in our community health work and priority setting, particularly those in historically marginalized and systemically under-resourced communities.

2) Focus on growing and sustaining our community-based partnerships with whom we share the responsibility and opportunity to improve health and address health disparities and inequities.

3) Better align community health work with HHC's overall equity value and journey, and assure an equitable distribution of resources and capabilities across its regions to advance this work.

4) Be more effective, measurable, and reportable with our community health work and interventions, particularly in addressing social influencers of health, health disparities and inequities, and social impact investing.

In pursuing these objectives, we accomplished the several process improvements. We expanded the use of qualitative methods of collecting data – ultimately conducting over 100 interviews, 30 focus groups, and 600 surveys across the state. We introduced *Equity Champions* into our CHNA process. Equity Champions are community-based opinion leaders who guided us through outreach and engagement, assisting with analysis and priority setting, and disrupting our thinking around long-standing assumptions and processes in health outcome assessments and intervention planning.

The resulting health needs assessments provide a comprehensive overview of the social, economic, physical, and emotional health of the populations residing in each region we serve. We invite you to actively engage with the findings offered in these pages, and to partner with us in creating a more equitable future.

In good health,

Sarah S. Lewis

Vice President,

Health Equity, Diversity & Inclusion

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Section 1: Introduction and Executive Summary

About the Hartford HealthCare Community Health Needs Assessment

The Hartford HealthCare Community Health Needs Assessment (CHNA) serves as a component in the overall efforts to improve community health and health equity in each of the seven hospital service areas (HSAs). It is a process that provides a means of identifying and collecting community data while engaging community members in both the data collection and the prioritization of collaborative efforts for improving the well-being of the area.

The ultimate purpose of the HHC CHNA is to improve community health and to do so in an effective and efficient way. The supporting objectives are to do the following:

1) Enhance Community Engagement and Better Incorporate the Consumer's Voice - CHNA/CHIP process leads to continuous and trusting feedback loops with diverse populations and enhances our methods for on-going engagement with the communities we serve.

2) Grow and Sustain our Community-based Partnerships - CHNA/CHIP process leads to more formalized partnerships with regional and community organizations and collaborations, and more meaningful relationships with key community opinion leaders.

3) Align Community Health with our Equity Value and Across the Regions - CHNA/CHIP process leads to a greater sense of team and purpose within HHC, assures each region is equitably resourced, and that collectively we know and understand more about identifying community health needs and improving health outcomes.

4) Bring Greater Clarity and Social Impact to our Community Health Work - CHNA/CHIP process leads to more effective, justified, measurable, and reportable interventions across our collective CHIPs and inspires and informs our social investment, sponsorship, and donation activities.

Executive Summary

Goals

The ultimate purpose of the CHNA is to improve the quality of life of people living in our service area, and to do so in an efficient and effective manner. To do this, the CHNA sought to do the following:

- Learn about the individuals and families who live here
- Explore the health-related impact of the social and physical environment (e.g., housing, access to affordable food, education, and similar "built environment" issues)
- Identify emerging or urgent community health issues
- Discover the impact of health inequities and patterns that can be used as a foundation to drive change

Approach

The major pieces of the assessment helped to assemble a large list of needs. Major assessment activities are listed below. Note that the survey and qualitative research numbers refer to HHC system CHNA activities – not solely this hospital.

- Data analysis – an extensive set of Hospital Service Area (HSA) data tables reflecting demographics, Social Influencers of Health, lifestyle characteristics, disease incidence (morbidity and mortality) and others
- Qualitative research – an in-depth series of 100 stakeholder interviews and 30 focus group discussions
- Survey research – a bilingual community survey with approximately 600 responses

Interestingly, ALL of the needs are important, yet to achieve the ultimate goal of the CHNA, HHC leaders deployed a needs prioritization process to identify a granular list of 14 needs. The prioritization process and other assessment activities are described in the body of this CHNA.

Categories of Needs

In order to truly affect change and address high-priority needs, needs were identified and categorized into the following groups:

- Ones with the greatest opportunity for Immediate impact (i.e., the "low hanging fruit" issues for which HHC can take a leadership role and rapidly deploy activities and resources).
- Issues supported by the data that have the greatest impact on health outcomes
- Needs identified by community as urgent or high-priority concerns
- Issues that present the greatest opportunity for collaboration and policy change

Final List of Prioritized Needs

Based on the results of the assessment research and the prioritization process, the final list of prioritized needs is shown below.

Aggregated Needs By Tier For The Hospital Of Central Connecticut	
Prioritized Need	Suggested Category of Need
Suicide Prevention	Community-based urgent or high-priority concern
Gero-Psych And Dementia Care	Data-based greatest impact on health outcomes
Support For Family Members Of A Person Being Treated For Substance Use Disorder	"Low hanging fruit" issue
Mental Health Stigma Reduction	Opportunity for collaboration and policy change
Outpatient Mental Health Services Capacity for Adults, Adolescents, and Children – Including in-home and caregiver support	Community-based urgent or high-priority concern
Mental Health Crisis Services And Community Awareness Of Available Resources	Community-based urgent or high-priority concern
Healthcare Services For Children With Special Needs	"Low hanging fruit" issue
Co-Locating Case Managers And Behavioral Health Providers With Primary Care	Opportunity for collaboration and policy change
Focused Initiatives Addressing Chronic Health Conditions	"Low hanging fruit" issue; and, Data-based greatest impact on health outcomes
Additional Programs To Enhance Access to Care For Lower-income Families	Data-based greatest impact on health outcomes
Broad-based, integrated services --- Medical, Mental Health, Substance Use Disorder, SDoH – for People and Families Experiencing Homelessness	Community-based urgent or high-priority concern
Care Coordination and Support to Help Manage Care for Patients With Complex Health Conditions	Community-based urgent or high-priority concern
Enhanced Collaboration with Community Partners	Opportunity for collaboration and policy change
Substance Use Disorder Crisis Care and Treatment	Data-based greatest impact on health outcomes; and, Community-based urgent or high-priority concern

Note that many of the issues shown above are particularly urgent among disadvantaged communities, people of color, and others who have historically lacked adequate access to services

Taking Action and Next Steps

The CHNA is formulated in a way to ultimately impact individuals and families in the service area. To accomplish this, HHC leaders will take CHNA results and deploy a systematic approach to developing the Community Health Improvement Plan (CHIP) – an activity critical to achieving this ultimate goal. Some of the initial, well-defined steps to develop and deploy the CHIP include the following:

STEP 1 - Culling the Findings – Brainstorming with your local collaboratives by answering the following questions:

CHNA Immediate Impact findings – where is the low hanging fruit?

CHNA Greatest Impact findings -- what will most influence health outcomes?

CHNA Most Desired Change findings - what change does the community most want?

CHNA Forging Opportunities findings - where are the greatest opportunities for partnership?

STEP 2 - Organizing the focus areas and assembling your rationale for action

STEP 3 - Selecting your Strategies and Interventions

Step 4 – Executing and Evaluation

Section 2: Body of the CHNA provides additional insight to the actions and next steps, as well as the background, approach, and results of the CHNA.

Section 2: Body of the CHNA

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Regions, Participating Hospitals & Health Equity Champions

The collaborative regional approach has been decades in the making across Connecticut. The Hartford HealthCare (HHC) regional approach improves the efficiency of the CHNA process and utilizes essential components of collaborative partnerships including:

- Creating a vision that is broadly understood
- Working across organizational boundaries
- Including those most affected by health challenges in solution-creation
- Utilizing ongoing planning and joint accountability to measure change

Throughout the process and this report, there is evidence of each of these key elements. The resulting document creates a frame of reference for community members to discuss the health status of a population. The purpose of this CHNA process and report has been to identify health issues, identify and engage local collaborators and assets, and prioritize the implementation activities needed to address the identified issues.

The regional approach includes partners within and across regions, hospital services areas, and health equity community-based health equity champions. Recognizing the need to reduce and eliminate health disparities and to increase diversity at the leadership and governance levels of health care and other local organizations is a central and necessary first step in community health improvement.

The second step to improving health equity is to collect and use data about race, ethnicity, and language preference to develop a shared understanding of the challenges in the community. Education about cultural sensitivity is also required. The HHC regional teams involved a team of health “Equity Champions” representing multiracial or other marginalized communities to help ensure the research is reflective of the community perspectives.

The following table describes this **regional approach** and leaders.

HHC Hospital	Region	Regional Leaders	Health Equity Champions
Backus Hospital	East	Joseph Zuzel Regional Director Community Health East Region Michele Brezniak, BSN, RN Community Health RN-East Region	Adela Cruz Dina Dufort Melanie Roberts Ryan K. Aubin Shiela Hayes
Charlotte Hungerford Hospital	Northwest	Carla Angevine, Manager of Community Health and Health Promotion Tasha La Viera, Community Health Outreach Case Manager Pamela Tino, Community Health Development Specialist	Effie Lucas Judy Kobylarz-Dillard Thalia Castro
Hartford Hospital	Hartford	Greg Jones, Vice President Community Health and Engagement Hartford HealthCare Dorely Roldan, Community Outreach Specialist Community Health, Hartford Region	Angela Harris Beverly Redd Donna Trowers-Morrison Pastor Roberto Calcano Suzanne Thomas
Hospital of Central Connecticut	Central	Lynn Faria, Community Relations Director, Central Region Rhea Highsmith Community Relations Specialist Central Region	Tracey Madden Hennessey Mary McCallister Paulette Fox
MidState Hospital	Central	Lynn Faria, Community Relations Director, Central Region Rhea Highsmith Community Relations Specialist Central Region	Adriana Rodriguez Marissa Cardona Dona Ditrio
Natchaug Hospital	East	Katherine M. McNulty, MA, CHC, CHRC Regional Director of Development Sherry Smardon, Manager of Philanthropy and Community Benefits	Dr. Maryann Brescia Erin Joudrey
Windham Hospital	East	Joseph Zuzel Regional Director Community Health East Region Michele Brezniak, BSN, RN Community Health RN-East Region	Adela Cruz Dina Dufort Melanie Roberts Ryan K. Aubin Shiela Hayes

Note that the survey and qualitative research numbers refer to HHC system CHNA activities – not solely this hospital. In addition, separate community groups were convened as part of the CHNA prioritization process.

Goals of the Assessment & Next Steps

To meet the objective of improving community health and health equity, the CHNA process has included meeting the following goals:

- Identifying resources, strengths, and barriers to improving health outcomes
- Developing a deeper understanding of community access to care challenges, including those faced by marginalized communities
- Enabling community partners to coalesce around the opportunities for population health improvement

On an ongoing basis, the CHNA data can be updated with information gathered at community meetings, forums, focus groups and surveys. Dissemination of the information in this document in different forms is a critical step in communications that inform partners, stakeholders, community agencies, associations, and the public about the availability of the community health needs assessment and what community members can do to make a difference.

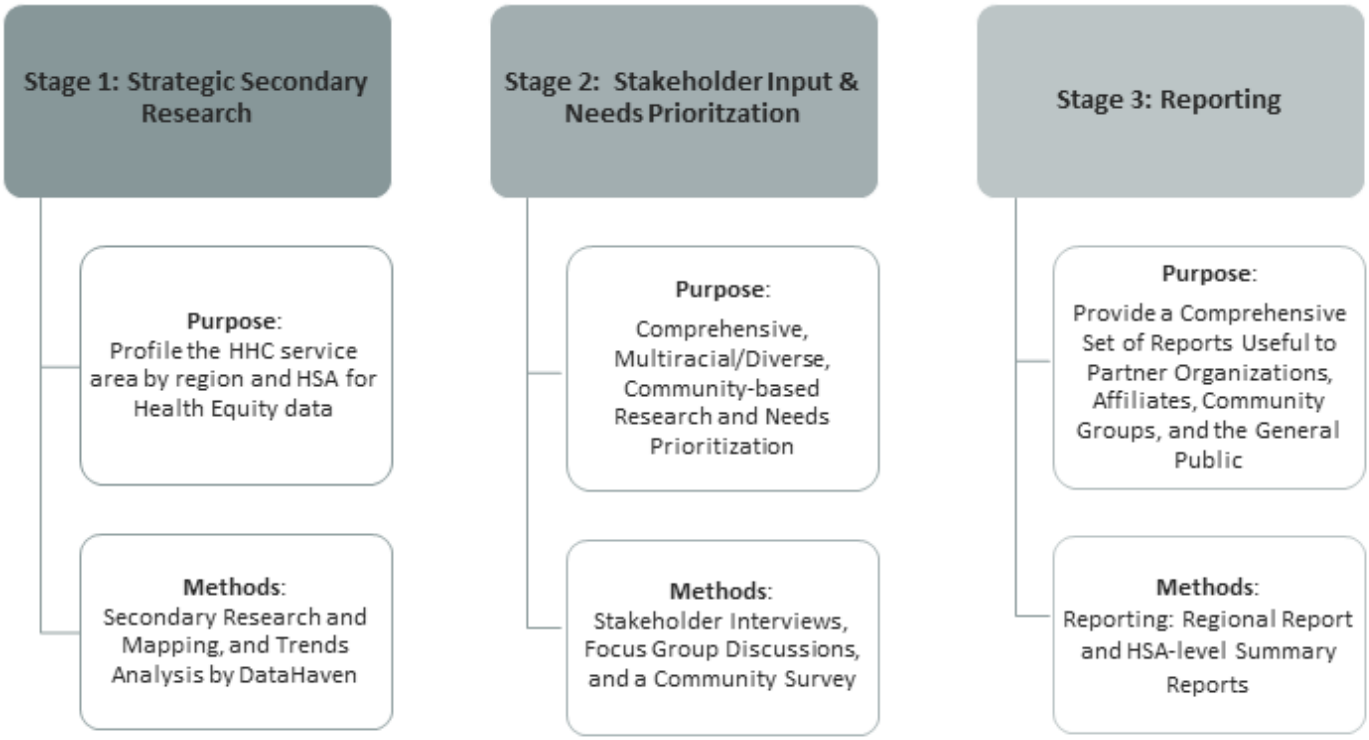
Assessment Approach & Methodology

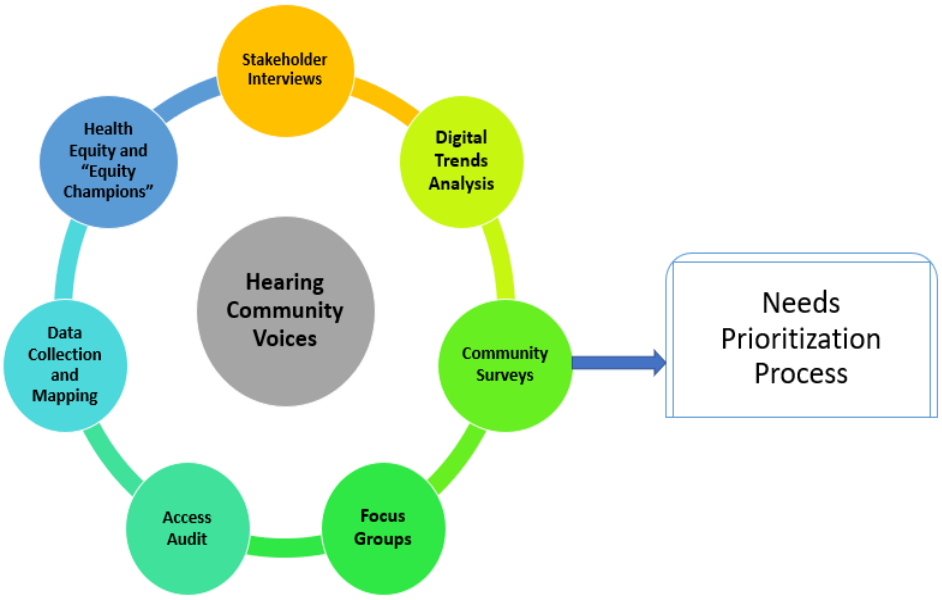
Hartford HealthCare (HHC) worked with its assessment partners Crescendo Consulting Group and DataHaven to formalize and deploy a highly inclusive assessment framework. The framework was structured to be welcoming to priority communities and others, steeped in best practices, and designed to triangulate insights. At the conclusion of the process, the local stakeholders developed a succinct, prioritized list of community needs. To do this, the methodology included a mixed modality approach – quantitative, qualitative, and technology-based techniques – to learn about the human stories and voices while weaving them with the best available data.

Crescendo engaged community partners, used data analytics, and invited others to join the discovery process to help describe a positive cycle of change. The assessment activities meet the following goals:

- Identify community resources, strengths, and barriers.
- Develop a deeper understanding of community health equity and inequalities.
- Enable the community to coalesce around, and act upon, the opportunities for population health improvement.

The following illustrates the three-stage methodology used to achieve the project goals.





Below is a graphic illustrating how the mixed modality research methodology used stakeholder interviews, focus group discussions, a large sample community survey, and an access audit to ensure community voices were combined and fed into the prioritization process. Based on the results of the mixed-modality approach, an extensive list of over 50 needs in each county was developed. Crescendo deployed a "Modified Delphi Technique" to prioritize the needs. Individual hospital facilities further refined their priorities.

Each technique deployed in the CHNA was part of the longer-term Assessment as Action Cycle which jump-starts the continuous process of assessing community needs, addressing high-priority needs, evaluating impact, adjusting strategies, and assessing community needs.

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Assessment as Action Cycle©

The CHNA provided an important opportunity for all the stakeholders in this complex landscape to work together to build a positive cycle of change. The ongoing cycle of assessment, strategy development, program development, program implementation, data collection, and program evaluation is a way to continually improve community health.

The approach endeavored to engage voices that are often hard to hear – young people, gender minorities, isolated seniors, BIPOC[1] households, households where English is rarely spoken, single-parent households, LGBTQ+ community members, and others.

Focus Group Discussions

HHC conducted 30 focus group discussions during the CHNA. The group embraced an inclusive set of community partners such as those listed in the table below:

HHC Region	Host / Partner	Community Group
Northwest	Northwestern Connecticut Community College	Students & Faculty
Central	Meriden Commission on Aging and Disabilities	Older Adults, People Living With Disabilities & Caregivers
Central	Meriden Senior Center	Older Adults
Central	North End Senior Center	Older Adults
Northwest	Winchester Senior Center	Older Adults
Northwest	New Opportunities	Hispanic & Latino, Low Socioeconomic Status
East	Southeastern Mental Health Network	Mental Health Professionals
Central	Meriden Council on Aging	Older Adults
Central	YWCA New Britain	Arabic Community
Northwest	Our Culture is Beautiful	Equality and Diversity
Northwest	The Be Ready Project	Parents and Caregivers of Children Living With Disabilities
East	Norwich Free Academy	Students & Faculty
Northwest	Regional Early Childhood Alliance Steering Committee & Northwest Regional Parent Advisory Committee	Parents
All	General Community	All

[1] Black, Indigenous & People of Color. BIPOC is person-first language. It enables a shift away from terms like "marginalized" and "minority." Available at: www.healthline.com/health/bipoc-meaning#meaning

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Data Notes & Limitations

Health disparities indicate differences in health linked with social, economic, and/or environmental disadvantages. Health disparities adversely affect communities who have systematically experienced greater barriers to health, based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.[2]

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

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

It is important to note that some health equity data can have percentage changes that look dramatic simply because the raw counts of some populations are so small. In addition, cross-tabulations by county or HSA may result in slight differences in totals. As DataHaven notes in each HSA report found in the appendix, “throughout most of the measures in this report, there are important differences by race and ethnicity as well as neighborhood that reflect differences in access to resources and other health-related social needs. Wherever possible, data will be presented with racial and ethnic breakdowns. Data for White, Black, Asian, and other populations represent non-Hispanic/Latino members of each racial group.”

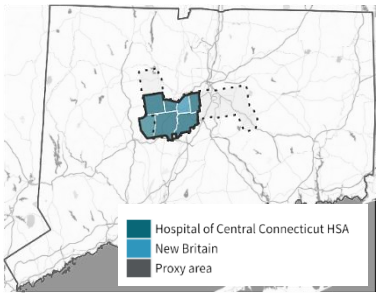
[2] Health.gov. How does Healthy People 2030 define health disparities and health equity? Available at: https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2030/questions-answers#q9

Community & HSA Definition – Description of the People Who Live Here

Note that much of the following secondary research section was contributed by DataHaven of New Haven, Connecticut. Our thanks to them! Their entire report is contained in the appendices.

The Hospital of Central Connecticut (HOCC) is a 414-bed, 32-bassinet acute care teaching hospital with two campuses, New Britain General and Bradley Memorial in Southington. HOCC services include emergency, inpatient, surgery, laboratory, outpatient, radiology, wound care, and a cancer center. Among specialty areas are cardiovascular care, metabolic health, obstetrics, oncology, orthopedics, and psychiatry/behavioral health. Some of the programs include the Hand Center, Spine Center, and Limb Preservation Program. For more information, please visit www.thocc.org.

The Hospital of Central Connecticut is a member of Hartford HealthCare. Hartford HealthCare operates seven acute-care hospitals, air-ambulance services, behavioral health and rehabilitation services, a physician group and clinical integration organization, skilled-nursing and home health services, and a comprehensive range of services for seniors, including senior-living facilities. For more information, please visit https://hartfordhealthcare.org/.



The Hospital of Central Connecticut HSA is made up of the following locations (with 2020 populations):

- Berlin (20,175)
- Bristol (60,833)
- New Britain (74,135)
- Newington (30,536)
- Plainville (17,525)
- Southington (43,501)
- Wolcott (16,142)

The proxy study area is made up of the following locations (with 2020 populations):

- PUMA 0900304 (113,853)
- PUMA 0900305 (111,835)
- PUMA 0900306 (119,971)

TABLE 1: STUDY AREA

Indicator	Connecticut	Hosp. of Central CT HSA	New Britain
Total population	3,605,944	262,847	74,135
Total households	1,370,746	104,268	28,232
Homeownership rate	66%	66%	40%
Housing cost burden rate	36%	33%	43%
Adults with less than a high school diploma	9%	11%	19%
Median household income	$78,444	$76,401	$46,499
Poverty rate	10%	11%	22%
Life expectancy (years)	80.3	79.1	76.6
Ages 18–64 w/o health insurance	11%	11%	18%

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Health Equity Data Results

Social Influencers of Health (SIoH)

SIoH (also known as Social Determinants of Health) describe the conditions that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[3] They are the conditions in which people are born, grow, work, live, and age - and often the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. The SDoH has an important influence on health inequities - the unfair and avoidable differences in health status seen within and between HSAs. Across the globe in countries with income levels, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.[4]

Community Overview Description

The Hospital of Central Connecticut Service Area is a region of 262,847 residents, 33% of whom are people of color. The region's population has increased by 0.49% since 2010. The composite snapshot indicates:

- Of the region's 104,268 households, 66% are homeowner households.
- Approximately 33% of the Hospital of Central Connecticut HSA's households are cost burdened, meaning they spend at least 30% of their total income on housing costs.
- Among the region's adults ages 25 and up, 30% have earned a bachelor's degree or higher.
- The Hospital of Central Connecticut HSA is home to 105,812 jobs, with the largest share in the Health Care and Social Assistance sector.
- The median household income in the Hospital of Central Connecticut HSA is $76,401. The Hospital of Central Connecticut HSA's average life expectancy is 79.1 years.
- Approximately 55% of adults in the Hospital of Central Connecticut HSA say they are in excellent or very good health.
- In 2020, 125 people in the Hospital of Central Connecticut HSA died of drug overdoses.
- Approximately 81% of adults in the Hospital of Central Connecticut HSA are satisfied with their area, and 50% say their local government is responsive to residents' needs.
- In the 2020 presidential election, 80% of registered voters in the Hospital of Central Connecticut HSA voted.
- Approximately 62% of adults in the Hospital of Central Connecticut HSA report having stores, banks, and other locations in walking distance of their home, and 70% say there are safe sidewalks and crosswalks in their neighborhood.

[3] Healthy People 2030, Social Determinants of Health. Available at: www.health.gov/healthypeople/objectives-and-data/social-determinants-health

[4] World Health Organization, Social Determinants of Health. Available at: www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Demographics & Health Equity Profile

Throughout most of the measures in this report, there are important differences by race/ethnicity and neighborhood that reflect differences in access to resources and other health-related social needs. Wherever possible, data will be presented with racial/ethnic breakdowns. Data for White, Black, Asian, and other populations represent non-Hispanic/Latino members of each racial group

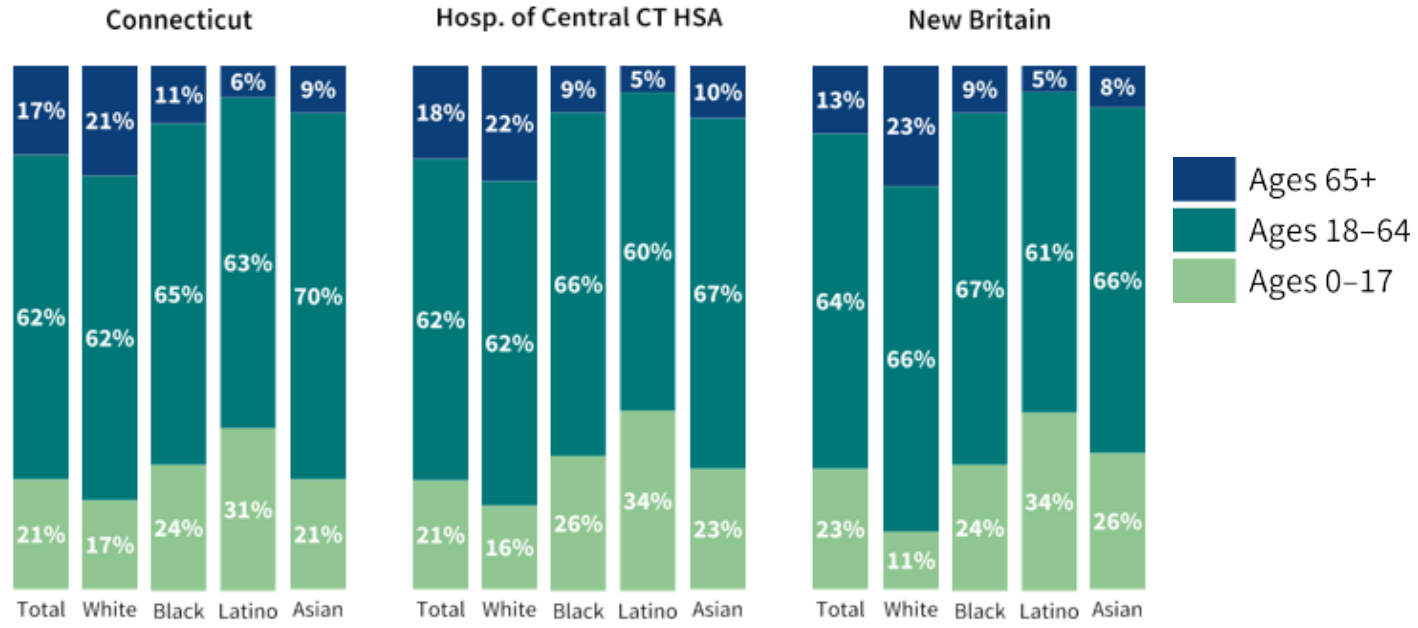
As of 2020, the population of the Hospital of Central Connecticut HSA is 262,847, including 52,672 children and 210,175 adults. Approximately 33% of the Hospital of Central Connecticut HSA's residents are people of color, compared to 37% of the residents statewide.

TABLE 2: POPULATION BY RACE & ETHNICITY, 2020

Area	White		Black		Latino		Asian		Native American		Other race/ethnicity	
	Count	Share	Count	Share	Count	Share	Count	Share	Count	Share	Count	Share
Connecticut	2,279,232	63%	360,937	10%	623,293	17%	170,459	5%	6,404	<1%	165,619	5%
Hosp. of Central CT HSA	175,728	67%	15,516	6%	52,657	20%	8,457	3%	243	<1%	10,246	4%
New Britain	27,535	37%	9,294	13%	32,620	44%	1,884	3%	74	<1%	2,728	4%

- As Connecticut's predominantly White baby boomers age, younger generations are driving the state's increased racial and ethnic diversity.
- Black and Latino populations in particular skew much younger than White populations.

FIGURE 1: POPULATION BY RACE/ETHNICITY AND AGE GROUP, 2019



Note: Only groups with at least 50 residents shown.

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Income, Jobs & Wages

Economic stability is a known social determinant of health as people living in poverty are less likely to have access to health care, healthy food, stable housing, and opportunities for physical activity. These disparities mean people living in poverty are more likely to die from preventable diseases.

TABLE 3: MEDIAN HOUSEHOLD INCOME BY RACE[5]

County	Median Household Income	White	Black or African American	Native American	Asian	Latino
Connecticut	$77,696	$89,527	$49,000	$43,350	$96,689	$47,753
Fairfield County	$95,645	$116,337	$53,679	$43,482	$125,033	$53,413
Hartford County	**$75,148**	**$87,104**	**$51,323**	**$34,435**	**$94,656**	**$42,002**
Litchfield County	$79,906	$81,230	$59,167	ND	$83,958	$66,103
New Haven County	**$69,905**	**$82,388**	**$44,566**	**$39,178**	**$89,427**	**$44,618**
New London	$73,490	$78,151	$42,190	$58,333	$78,125	$50,613
Tolland County	$87,069	$90,921	$29,071	ND	$88,517	$73,420
Windham County	$66,550	$70,843	$27,344	ND	$53,258	$40,998

Source: U.S. Census Bureau American Community Survey 5-Year Estimates, 2015-2019

There are a total of 105,812 jobs based in towns in the Hospital of Central Connecticut HSA, with 24,599 jobs based in New Britain. Jobs in the Health Care and Social Assistance sector make up the largest share in the region. While these numbers are from 2019 and do not include economic outcomes related to the COVID-19 pandemic, they describe general labor market strengths and average wages for the area.

TABLE 4: JOBS & WAGES IN HOSPITAL OF CENTRAL CONNECTICUT HSA'S 5 LARGEST SECTORS, 2019

Sector	Connecticut		Hosp. of Central CT HSA	
	Total jobs	Avg annual pay	Total jobs	Avg annual pay
All Sectors	1,670,354	$69,806	105,812	$58,073
Health Care and Social Assistance	271,014	$54,858	19,251	$48,291
Retail Trade	175,532	$35,833	15,033	$77,051
Accommodation and Food Services	129,012	$23,183	12,664	$32,144
Administrative and Support and Waste Management and Remediation Services	89,852	$47,443	8,307	$19,599
Manufacturing	161,893	$85,031	5,550	$70,384

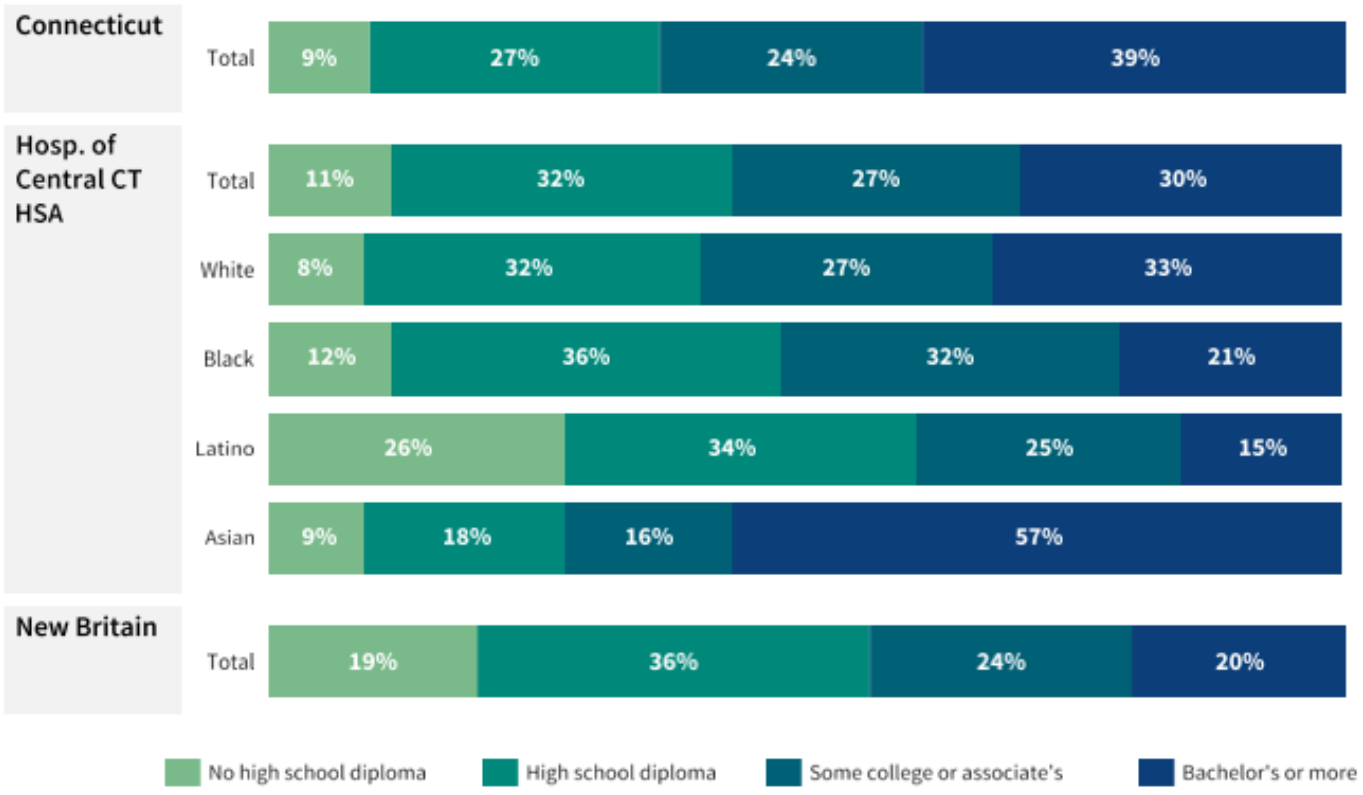
Education

Public school students in the Hospital of Central Connecticut HSA are served by seven school districts for pre-kindergarten through grade 12. During the 2019–2020 school year, there were a total of 35,727 students enrolled in these districts, with 10,093 enrolled in the New Britain School District. Tracking student success measures is important

[5] **"White"** indicator implies the percentage of the population that identifies as, "White alone, not Hispanic or Latino." **"Native American"** indicator implies the percentage of the population that identifies as "American Indian and Alaskan Native." **"Latino"** indicator implies the percentage of the population that identifies as "Hispanic or Latino origin (of any race)" according to the U.S. Census Bureau.

since disparate academic and disciplinary outcomes are observed as early as preschool and can ultimately affect a person's long-term educational attainment and economic potential.

FIGURE 2: EDUCATIONAL ATTAINMENT BY RACE & ETHNICITY, SHARE OF ADULTS AGES 25 & UP, 2019



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Social & Physical Environment

Housing

The Hospital of Central Connecticut HSA has 104,268 households, of which 66% are homeowner households. Of the region's 112,648 housing units, 61% are single-family units.

TABLE 5: HOMEOWNERSHIP RATE BY RACE & ETHNICITY OF HEAD OF HOUSEHOLD, 2019

Area	Total	White	Black	Latino	Asian	Native American
Connecticut	66%	76%	39%	34%	58%	40%
Hospital of Central Connecticut HSA	66%	75%	39%	32%	58%	21%
New Britain	40%	54%	37%	23%	31%	N/A

- Homeownership rates vary by race/ethnicity. Younger adults are less likely than older adults to own their homes across several race/ethnicity groups. However, in most towns, younger White adults own their homes at rates comparable to or higher than older Black and Latino adults.
- Cost burden generally affects renters more than homeowners and has a greater impact on Black and Latino householders. Among renter households in the Hospital of Central Connecticut HSA, 45% are cost burdened, compared to 25% of owner households.

Transportation

The mean travel time to get to work within the THoCC HSA (and most other areas) is about 25 minutes.

TABLE 6: POPULATION COMMUTING TO WORK

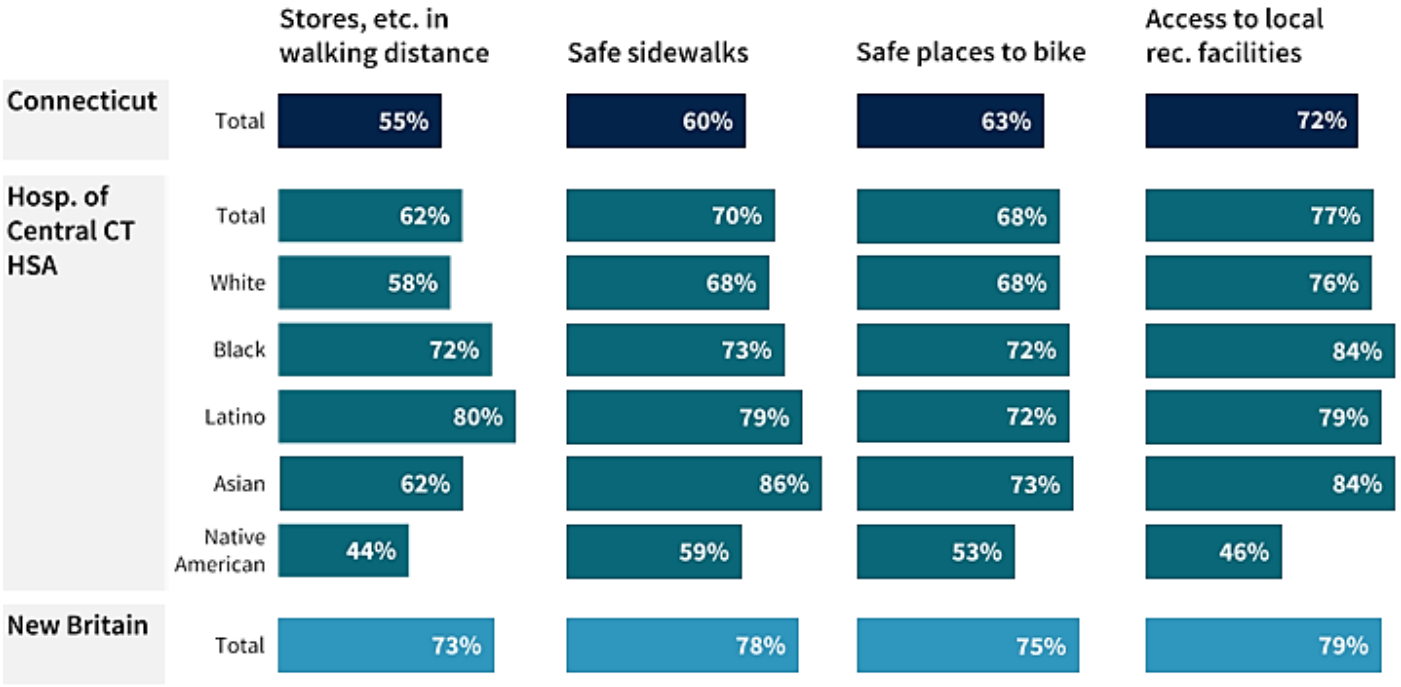
	Connecticut	Fairfield County	Hartford County	Litchfield County	New Haven County	New London	Tolland County	Windham County
Workers Aged 16 & Older	1,786,592	468,064	443,046	95,123	422,610	137,099	76,781	57,149
Mean travel time to work (minutes)	26.6	31.3	25.5	26.5	28.7	23.7	26.3	23.5
Car, truck, or van – drove alone	78.2%	72.2%	81.1%	83.2%	78.3%	80.4%	80.3%	83.3%
Car, truck, or van – carpooled	7.9%	8.1%	8.1%	6.0%	8.4%	8.6%	6.1%	8.0%
Public transportation (excluding taxicab)	4.7%	10.1%	3.2%	1.4%	3.8%	1.4%	1.9%	0.6%
Walked	2.7%	2.5%	2.0%	2.4%	3.3%	3.0%	4.2%	2.5%
Other means	1.2%	1.1%	1.0%	1.3%	1.5%	1.2%	0.9%	0.8%
Worked from home	5.3%	6.0%	4.6%	5.6%	4.7%	5.3%	6.6%	4.8%

Source: U.S. Census Bureau American Community Survey 5-Year Estimates, 2015-2019

Environment & Sustainability

High-quality built environment resources, such as recreational facilities and safe sidewalks, help keep residents active and bring communities together. Walkable neighborhoods may also encourage decreased reliance on cars. Throughout Connecticut, Black and Latino residents are largely concentrated in denser urban areas which tend to offer greater walkability. Of adults in the Hospital of Central Connecticut HSA, 62% report having stores, banks, and other locations they need in walking distance, higher than the share of adults statewide.

FIGURE 3: RESIDENTS' RATINGS OF LOCAL WALKABILITY MEASURES BY RACE & ETHNICITY, SHARE OF ADULTS, 2015-2021



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Food Insecurity

Food insecurity refers to USDA's measure of lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. It is important to note that the COVID-19 pandemic impacted access to nutritious foods for vulnerable populations and communities that had not experienced food insecurity prior to 2020. Research indicates that the pandemic ultimately ended years of declining rates of food insecurity – the lack of access to sufficient food because of limited financial resources.[6]

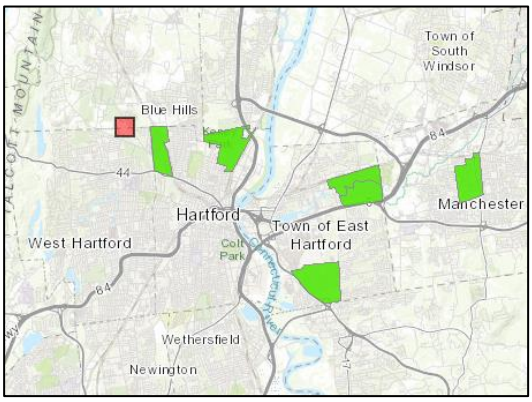
In 2019, food insecurity rates for the whole population were predominantly lower compared to the statewide figure of 12%..

TABLE 7: FOOD INSECURITY

	Connecticut	Fairfield County	Hartford County	Litchfield County	New Haven County	New London	Tolland County	Windham County
2019								
Food Insecure Population	12.0%	9.7%	11.3%	10.4%	11.9%	11.7%	9.8%	12.6%
Food Insecure Children	15.1%	11.1%	14.1%	11.8%	15.4%	14.9%	9.8%	15.3%
2021								
Food Insecure Population	ND	12.3%	13.9%	12.3%	14.5%	14.8%	11.6%	14.9%
Food Insecure Children	ND	15.5%	18.6%	15.6%	19.8%	20.2%	13.2%	19.4%

Source: USDA Food Environment Atlas, Map the Meal Gap from Feeding America

FIGURE 4: FOOD ACCESS RESEARCH ATLAS



Source: U.S. Department Of Agriculture. Economic Research Service, Food Access Research Atlas

Food Insecure Communities

The Food Access Research Atlas indicates low-income census tracts where a significant number or share of residents is more than one mile (urban) or 10 miles (rural) from the nearest supermarket.

The green shaded areas within Figure 3 indicate areas of potential food deserts within the HSA.

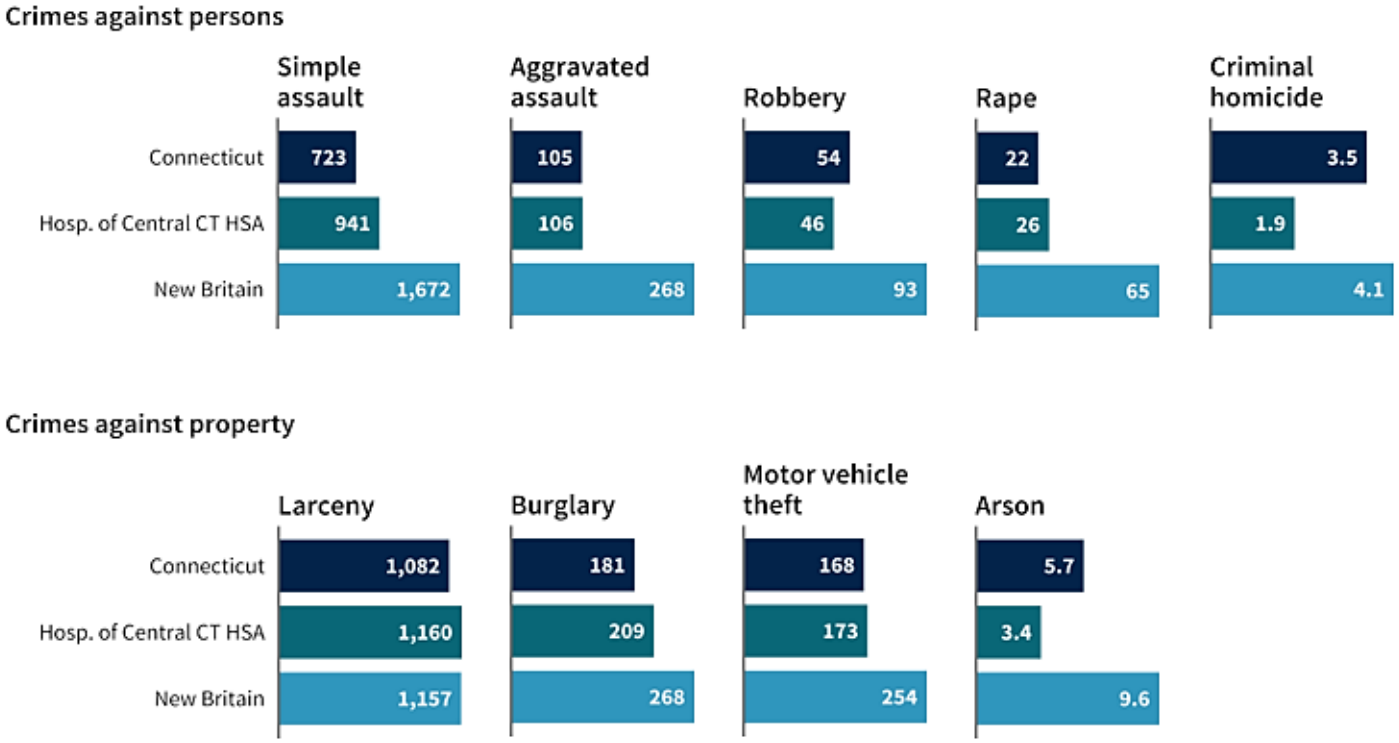
Crime Rates

Crime rates per 100,000 residents are based on reports to law enforcement of violent force against persons, as well as offenses involving the property. Not all crimes involve residents of the areas where the crimes occur, which is important to consider when evaluating crime rates in areas or towns with more commercial activity. Crime patterns can also vary

[6] Feeding America. The Impact of the Coronavirus on Food Insecurity in 2020 & 2021, March 2021. Available at: www.feedingamerica.org/sites/default/files/2021-03/National%20Projections%20Brief_3.9.2021_0.pdf

dramatically by neighborhood. Crime can impact the social and economic well-being of communities, including through negative health effects.

FIGURE 5: CRIME RATES PER 100,000 RESIDENTS BY TOWN/JURISDICTION, 2019



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Neighborhood Disinvestment

Neighborhood disinvestment and gentrification present significant risks or threats to lower income communities while simultaneously offering some economic opportunities (e.g., through Economic Opportunity Zones and similar programs). Disinvestment is the withdrawal of investment from communities by business owners, investors, and others. They no longer work to improve schools, neighborhoods, businesses, or the general community. Eventually, a lack of investment degrades the infrastructure needed to support the community.

As neighborhood disinvestment occurs, businesses vital to the fabric of the community leave, as well. This often leaves community members with reduced services and puts them at an even greater risk of experiencing barriers to health care services, reduced access to affordable, nutritious food, and other basic services. The ultimate impact may be a continuing (or accelerating) cycle of poverty for many lower-income residents.

From the Open Science Education organization some examples of how communities are impacted by disinvestment follow:[7]

- It is more challenging for members of these communities to secure a home loan to buy a new house. If a family member cannot get a loan for a home of their own, this leads to more family members sharing a single home together.
- Grocery store companies build new grocery stores in "more-desirable" neighborhoods. Their disinvestment in Black and Hispanic/Latinx communities means that these communities have very few grocery options. Fresh groceries, such as vegetables, fruits, fresh meats, and bakeries, can be hard to find in these communities.
- Homes in "desirable" communities are worth more money. Higher home values generate more property tax money for schools in the community. Disinvestment in communities keeps home values low, which generates less money for schools. Schools with less money to spend cannot upgrade their buildings, purchase new materials and technologies for classrooms, or pay teachers the same wage that other schools can pay.
- There are few job opportunities within a community experiencing disinvestment because there are not as many businesses hiring workers. People in these communities must seek jobs in other communities. Many will need to ride public transportation to and from their jobs in other communities.
- These communities can experience higher unemployment because of a low number of job opportunities, which creates a lack of access to health care. Individuals in these communities may not have health insurance, which could prevent them from seeing a doctor when they are sick. These communities also have few clinics and medical providers within the community, so they have to travel to other communities to see a doctor.
- These communities also have fewer green spaces or spaces for sports and outdoor recreation than the majority-White neighborhoods, making exercise and recreation much harder for people who live there.

The National Community Reinvestment Coalition conducted a recent study[8] that analyzed the impact of Opportunity Zones on neighborhood disinvestment and gentrification. Generally, areas that are eligible for gentrification are at-risk of neighborhood disinvestment. In addition, when (or if) economic expansion is attracted via some form of

[7] Open Science Education, 2020. Available at https://www.openscied.org/wp-content/uploads/2020/09/L6.Reading_-Systemic-Racism-and-Disinvestment-in-Communities.pdf

[8] National Community Reinvestment Coalition, "Gentrification and Disinvestment 2020", Available at https://ncrc.org/gentrification20/

gentrification, existing residents are often faced with accelerating apartment rental fees, higher property taxes, and similar, related issues.

The results of the national study identified 11 Connecticut cities in which gentrification had taken place (2012 to 2017) or was eligible to do so based on the following criteria:

Opportunity Zones (OZs) – created under the Tax Cuts and Jobs Act of 2017 – are a U.S. Federal Government economic tool that incentivizes people to invest in economically challenged areas. Their purpose is to raise local income and accelerate economic growth and job creation in low-income neighborhoods while providing tax benefits to investors.

- In Connecticut, most (i.e., seven of 11) targeted cities had experienced gentrification through 2017.
- Gentrification implies that individuals and families not benefiting from increased or modestly rising incomes can be priced out of their neighborhoods. Additionally, they may be compelled to sacrifice other basic needs (e.g., health care, food, education) in order to remain housed.
- Most neighborhoods in which gentrification is taking place in Connecticut are predominantly populated by racial or ethnic minorities.

The appendices contain maps showing each of the 11 Connecticut cities referenced above.

Neighborhood Classifications

Neighborhood Type	Description	Neighborhood Count
Eligible to gentrify	In the lower 40th percentile of income and home value but not gentrifying	9,743
Gentrifying	Eligible and with increases in income, home values, and college attainment	954
Opportunity Zone	Designated opportunity Zone with no evidence of gentrification	4,089 Urban
		4,581 Rural
Gentrifying Opportunity Zone	Opportunity Zone and gentrified	179
Other	Urban neighborhoods that were not eligible to gentrify and are not Opportunity Zones (usually middle- to- upper-income)	15,039

NCRC.ORG NATIONAL COMMUNITY REINVESTMENT COALITION

Neighborhood categories used in this study with description and count of census tracts, or neighborhoods in each category. Note that the "Gentrified Opportunity Zone" category duplicates neighborhoods in both "Gentrified" and " Opportunity Zone" categories.

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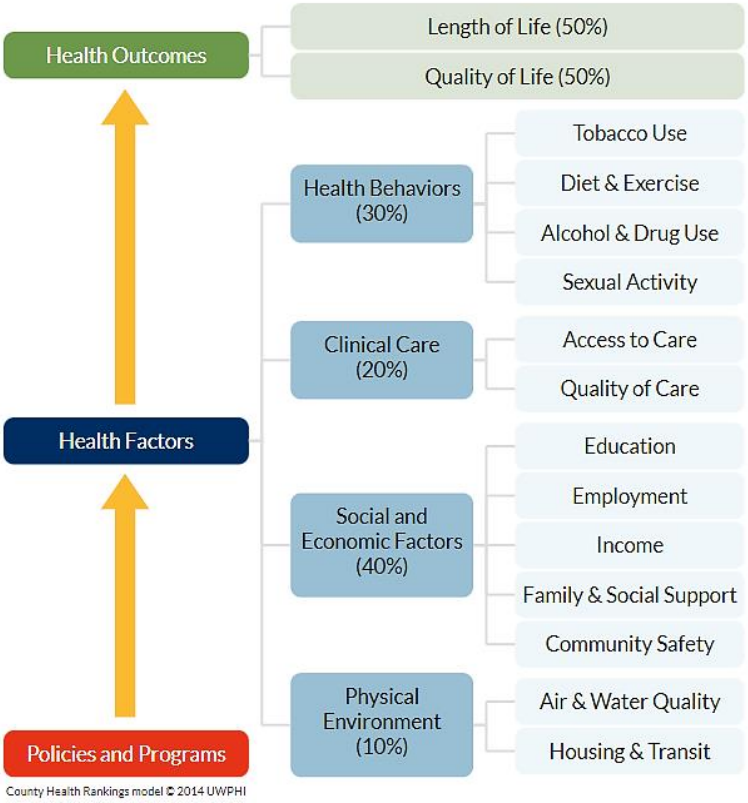
Community Health Status & Patterns

A mix of factors contributes to individual and community health status and range from the very personal health behaviors to programs and policies, but fundamental contributors are programs and policies designed to limit social inequality. In a seminal article two decades ago Christopher Jencks after years of studying social inequality noted: "My bottom line is that the social consequences of economic inequality are sometimes negative, sometimes neutral, but seldom as far as I can discover – positive."[9] The graphic to the right illustrates how the various factors contribute to and drive health outcomes. [10] The socioeconomic disparities described in this report tend to correlate with health outcomes. Factors such as stable housing, employment, literacy and linguistic fluency, environmental hazards, and transportation all impact access to care, physical and mental health outcomes, and overall quality of life.

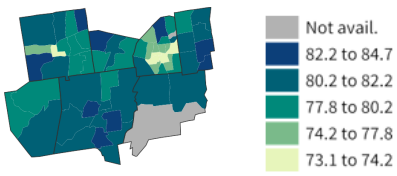


Income and employment status often drive differences in access to health care, the likelihood of getting preventive screenings as recommended, the affordability of life-saving medicines, and the ability to purchase other goods and services, including high-quality housing and nutritious food.

Life Expectancy

Life expectancy is a good proxy for overall health and well-being since it is the culmination of so many other social and health factors. The average life expectancy in the Hospital of Central Connecticut HSA is 79.1 years, compared to 76.6 years in New Britain and 80.3 years statewide

FIGURE 6: LIFE EXPECTANCY, HOSPITAL OF CENTRAL CONNECTICUT HSA BY CENSUS TRACT, 2015



[9] Jencks, C. 2002. "Does Inequality Matter? Daedalus 131, (Winter): 49-65.

[10] County Health Rankings and Roadmaps. Available at https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model

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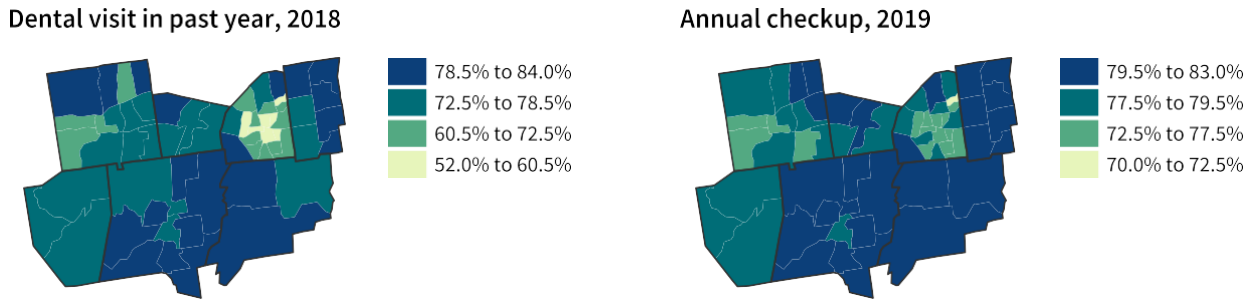
Preventive Care Measures

Preventive care can help counteract economic disadvantages, as a person's health can be improved by addressing risk factors like hypertension and chronic stress early. Lack of affordable, accessible, and consistent medical care can lead to residents relying on expensive emergency room visits later on. Overall, 79% of the adults in the Hospital of Central Connecticut HSA had an annual checkup as of 2018, and 75% had a dental visit within the previous 12 months.

FIGURE 7: PREVENTIVE CARE MEASURES, SHARE OF ADULTS BY CENSUS TRACT, HOSPITAL OF CENTRAL CONNECTICUT HSA



Throughout the state, people of color face greater rates and earlier onset of many chronic diseases and risk factors, particularly those that are linked to socioeconomic status and access to resources. For example, diabetes is much more common among older adults than younger ones, yet middle-aged Black adults in Connecticut have higher diabetes rates than White adults aged 65 and older.

FIGURE 8: SELECTED HEALTH RISK FACTORS, SHARE OF ADULTS, 2015-2021

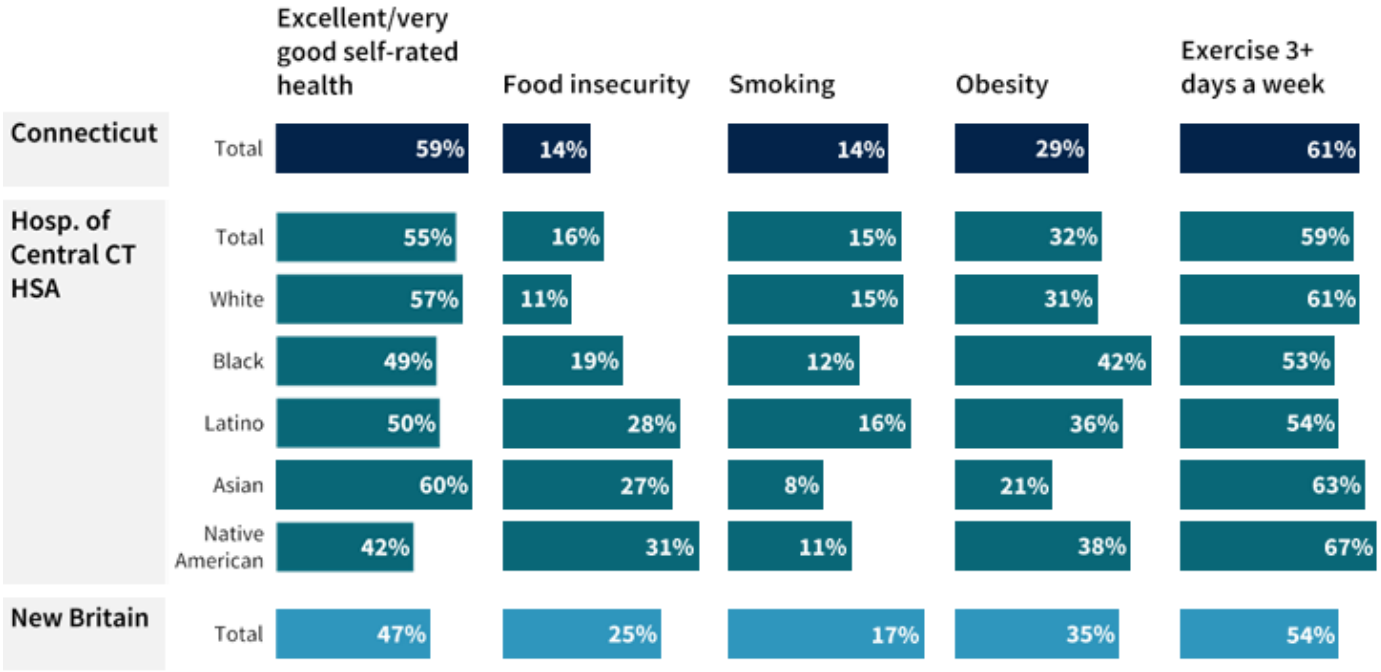


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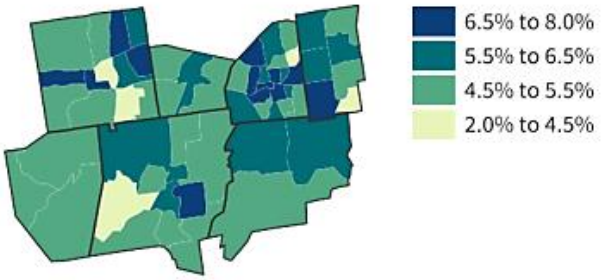
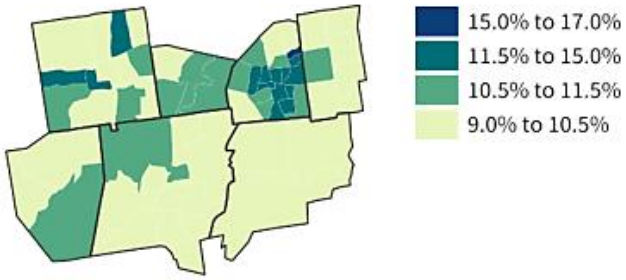
FIGURE 9: CHRONIC DISEASE PREVALENCE, SHARE OF ADULTS BY CENSUS TRACT, HOSPITAL OF CENTRAL CONNECTICUT HAS

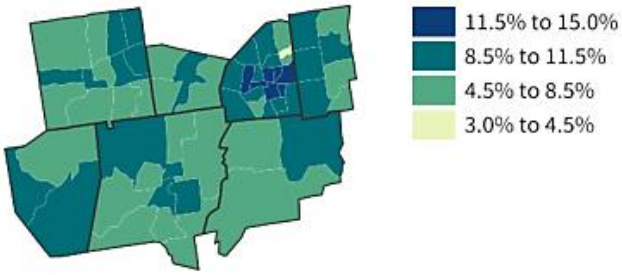
Coronary heart disease, 2019



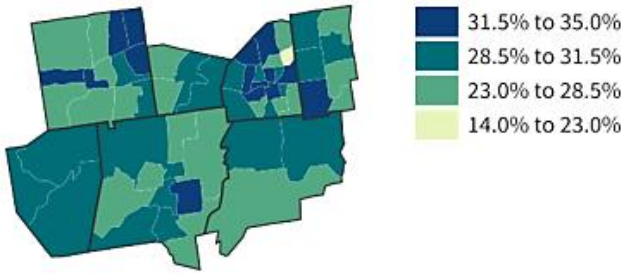
Current asthma, 2019



Diabetes, 2019



High blood pressure, 2019



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Birth outcomes often reflect health inequities for parents giving birth, and those outcomes can affect a child throughout their life. Often, parents of color have more complications related to birth and pregnancy than White parents. Complications during pregnancy or childbirth also contribute to elevated mortality among parents giving birth.

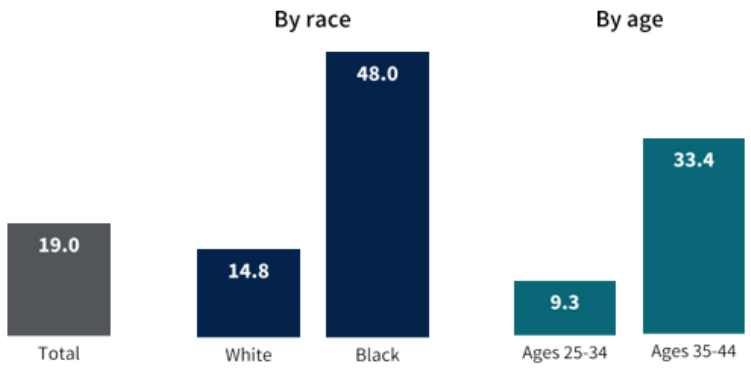
TABLE 8 A, B, C: SELECTED BIRTH OUTCOMES BY RACE & ETHNICITY OF PARENT GIVING BIRTH, 2016-2018

Area	Total	White	Black	Latina			Asian
				Latina (overall)	Puerto Rican	Other Latina	
Late or no prenatal care							
Connecticut	3.4%	2.5%	5.7%	4.0%	2.9%	5.1%	3.5%
Hosp. of Central CT HSA	2.7%	1.6%	6.1%	3.8%	3.3%	5.2%	3.3%
New Britain	4.0%	2.7%	7.4%	3.8%	3.1%	6.5%	N/A

Area	Total	White	Black	Latina			Asian
				Latina (overall)	Puerto Rican	Other Latina	
Low birthweight							
Connecticut	7.8%	6.4%	12.1%	8.3%	10.2%	6.6%	8.7%
Hosp. of Central CT HSA	8.9%	7.4%	11.2%	10.0%	10.8%	9.9%	N/A
New Britain	10.1%	8.4%	11.2%	10.6%	10.8%	N/A	N/A

Area	Total	White	Black	Latina			Asian
				Latina (overall)	Puerto Rican	Other Latina	
Infant mortality (per 1k live births)							
Connecticut	4.6	3.1	9.5	5.0	N/A	N/A	N/A
Hosp. of Central CT HSA	5.0	4.5	10.9	3.9	N/A	N/A	N/A
New Britain	6.2	N/A	14.3	5.1	N/A	N/A	N/A

FIGURE 10: MATERNAL MORTALITY RATE PER 100K BIRTHS, CONNECTICUT, 2013–2017



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Behavioral Health

Mental health issues like depression and anxiety can be linked to social influencers like income, employment, and environment, and can pose risks of physical health problems as well, including by complicating a person's ability to keep up with other aspects of their health care. People of color are slightly more likely to report feeling mostly or completely anxious and being bothered by feeling depressed or hopeless. Overall, 13% of Hospital of Central Connecticut HSA adults report experiencing anxiety regularly and 9% report being bothered by depression.

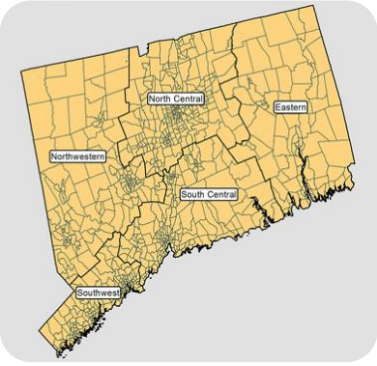
TABLE 9: SELECTED MENTAL HEALTH INDICATORS, SHARE OF ADULTS, 2015-2021

	Total	White	Black	Latino	Asian	Native American
Experiencing anxiety						
Connecticut	13%	11%	15%	19%	15%	15%
Hosp. of Central CT HSA	13%	11%	13%	19%	20%	26%
New Britain	17%	16%	17%	20%	N/A	N/A
Bothered by depression						
Connecticut	9%	8%	10%	14%	9%	11%
Hosp. of Central CT HSA	9%	8%	4%	16%	27%	25%
New Britain	12%	11%	5%	17%	N/A	N/A

TABLE 10: AVERAGE SELF-REPORTED POOR MENTAL HEALTH DAYS

18 +	Connecticut	Eastern	North Central	Northwestern	South Central	Southwest
Received Mental Health Services in the Past Year[11]	16.7%	16.8%	18.7%	15.9%	16.9%	14.1%
Serious Mental Illness in the Past Year	4.7%	5.0%	5.0%	4.4%	5.1%	3.5%
Any Mental Illness in the Past Year	18.9%	20.4%	21.4%	17.8%	18.3%	16.2%

Source: SAMHSA. 2018-2020 National Survey on Drug Use and Health, Substate Region Estimates



[11] Mental Health Services for adults includes inpatient treatment/counseling, outpatient treatment/counseling, or use of prescription medication for problems with emotions, nerves, or mental health.

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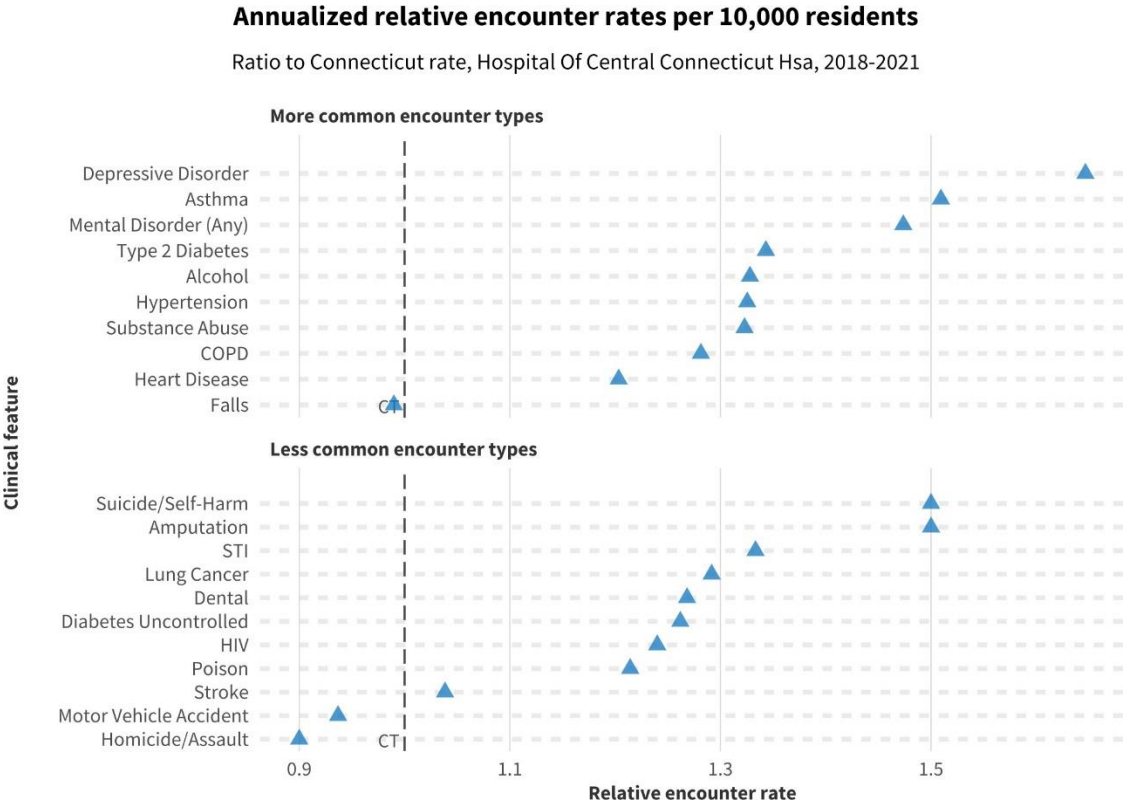
CHIME Data Results: Service Use

Data about residents' visits to hospitals and emergency rooms may be used as a tool to examine variations in health and quality of life by geography and within specific populations. Chime Data[12] is a member service of the Connecticut Hospital Association which offers data collection and reporting services to its acute care hospital members. In addition, Chime Data is used to help hospitals meet regulatory reporting requirements. ChimeData's database is the most comprehensive hospital database in the state, containing over 31 million patient encounters dating back to 1980.

The tables in this section are based on a DataHaven analysis (2022) of 2018-2021 CHIME for the HHC Hospital Service Area (HSA). Annualized encounter rates were calculated for the indicator flags assigned within the dataset including Asthma, COPD, Substance Abuse, and many other conditions. Analyses in this document describe data on "all hospital encounters" including inpatient, emergency department (ED), and observation encounters. Annualized encounter rates per 10,000 persons were calculated for the period from 2018 to October 2021 by merging CHIME data with population data. DataHaven also calculated rates by race, but those results are not included in this document because we believe that the collection of race/ethnicity data is not yet standardized in a way that allows for accurate comparisons across geographic areas. In some cases, results are not included in this report if the number of observations and/or populations in any given area were very small. Please see the appendix for the DataHaven report and additional data limitations.

Compared to the Connecticut rates, the encounter data HSA analysis for The Hospital of Central Connecticut suggests:

- With modest exceptions, all of the "more" and "less" common encounter types are above the state rate.
- Mental health, Depressive Disorder and Asthma encounters are significantly elevated above the state rate.



[12] CHIME Data description accessed: May 2022: https://cthosp.org/member-services/chimedata/

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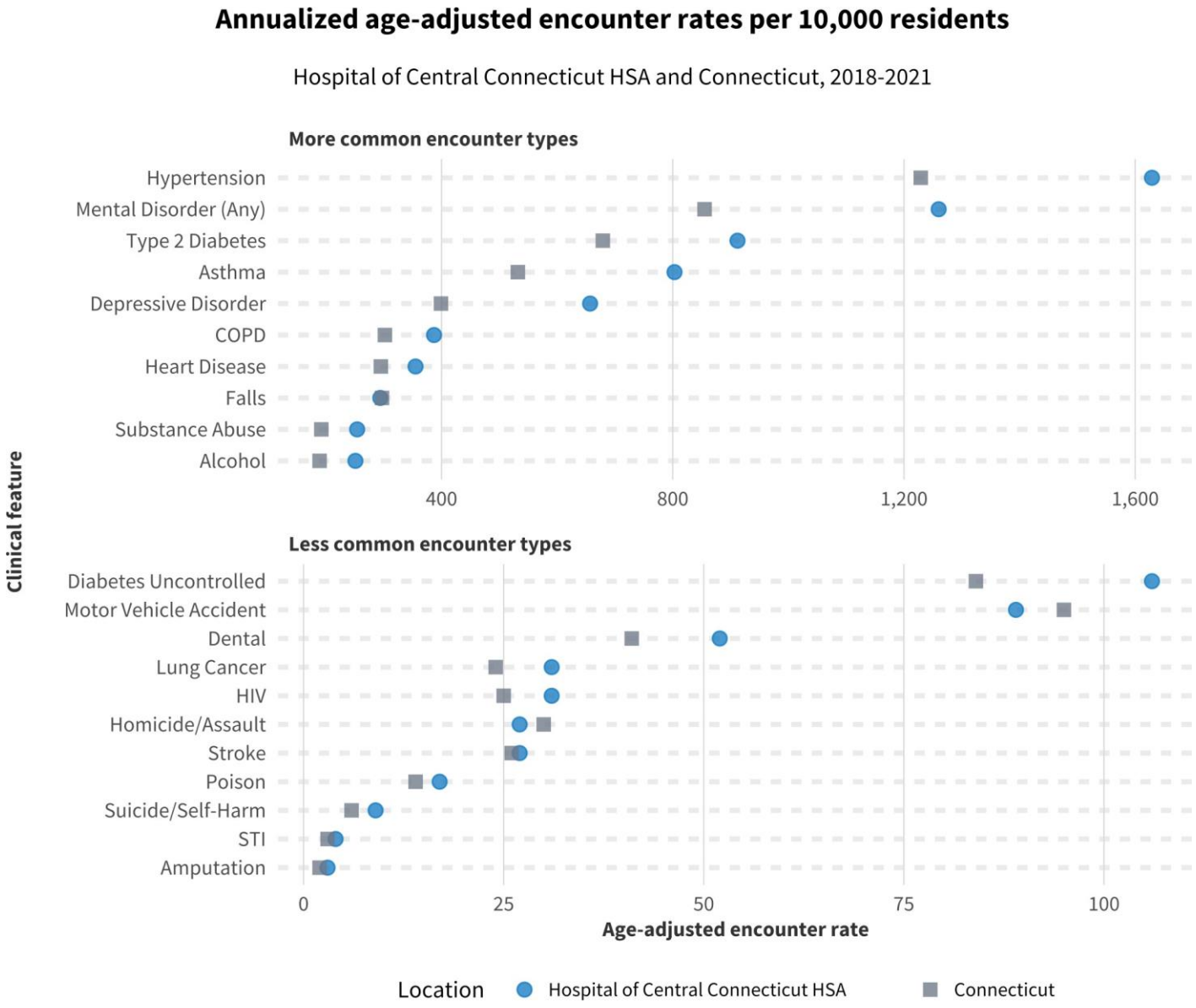

Demographics Used in The Analysis

Hospital of Central Connecticut HSA has a population of 261,163 people, with the following breakdown[2]:

Gender	All Ages	Age 0-19	Age 20-44	Age 45-64	Age 65-74	Age 75+
Female	134,967	30,011	41,011	36,993	14,004	12,948
Male	126,196	31,124	40,443	34,601	11,893	8,135
Total	261,163	61,135	81,454	71,594	25,897	21,083

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Qualitative Themes & Consensus Community Perceptions

The assessment involved substantial qualitative data gathering to highlight local knowledge and expertise, and support outreach efforts for community engagement. The primary qualitative mixed-mode approach engaged policy leaders, key stakeholders, nonprofit organizations, health care consumers, the criminal justice system, diversity representatives, people experiencing homelessness, and others throughout the hospital service area.

- → Health Equity Champions Outreach
- → Stakeholder One-to-One Interviews
- → Focus Group Discussions

Systemwide, 100 interviews and 30 focus group discussions were held. Crescendo staff interviewed **17** community stakeholders in the central Connecticut region. Participants primarily included leadership representing local health departments, community health centers, United Way, and housing authorities. Each conversation lasted approximately 20 minutes and took place over the course of three weeks in March and April of 2022. Primary themes that emerged from stakeholder conversations are described and illustrated below.

Conversations with community stakeholders helped us identify weaknesses of programs and resources in the community. Themes that emerged from the conversations are described below. Each of the themes includes an illustrative comment from a stakeholder interview or focus group discussion participant.

Equitable Access to Care

A majority of community stakeholders allude to inequitable access to health care services and general health equity - specifically for marginalized communities of color, individuals with low socioeconomic status, and uninsured/underinsured individuals. Stakeholders expressed the need for assessing further health outcomes post-COVID and what the community will look like among those who were and continue to be disadvantaged from accessing health care services. The central Connecticut region also presents higher rates of obesity and diabetes in communities of color compared to other races and ethnicities. Although the central region was described as extremely caring and full of organizations that have the greatest intentions, they often lack the capacity and workforce to take that necessary extra step in program planning or implementation – especially not-for-profits. A key example of this observation was noted during the pandemic, as more services were provided in White neighborhoods over more diverse communities.

> *"Diversity is a blessing to Meriden, and a curse. People develop programs without including the people they are impacting. It's top-down instead of taking the time of getting buy-in from the population. We saw this during COVID where following the data, based on census tracts, vaccines were offered in more White neighborhoods than more diverse communities. Then, we wonder why ethnic minorities have low vaccination rates. People have great intentions, but people need to pause to take that extra step - but a lot of nonprofits don't have the staff and capacity to do that extra step."*

Mental Health Care

Stakeholders expressed profound concern about long-term mental health issues as the COVID-19 pandemic stabilizes. One of the most difficult barriers to receiving behavioral health services was identified as the "ever-changing clinician in people's life." Mental health clinics were referred to as "factory farms" where young therapists may start out for three months, then leave for a better paying job. Culturally competent mental health services were also identified as a challenge and bleeds into equitable health access. This region is experiencing a growth of diversity, and with this comes new languages and customs, adding an additional level of need that is hard to address. The service area for the central region, especially for youth-focused mental health services was described as "stretched" as more youth are seeking services, outnumbering providers.

> *"There's more children suffering from mental health disorders now than there are counselors and professionals to deal with the volume. There's an inequality of resources and people struggling. It's a complex system to navigate unless you are a savvy parent and can have perseverance. You can't make one phone call and figure it out."*

Efficient Operations of Care - Collaboration

Regionally, inter-organizational collaboration and communication were cited as a challenge, and services were frequently referred to as "existing in silos." The state of Connecticut was described as, "hyper-local" indicating that information is focused on a well-defined community with its primary focus directed toward the concerns of the population in that community despite having regional organizations. Participants expressed frustration while navigating the complex web of services. Several stakeholders mentioned the necessary persistence required to obtain local community resources and services. Often times, there is very little assistance and no follow-up from the referral source.

> *"There is not always across-town lines depending on what the issue might be. Connecticut is hyperlocal, and while we're a regional organization, not all people and organizations think regionally. Not always do our political parties work well together."*

Community Survey

The Hartford HealthCare CHNA includes a large-sample community survey that contains 596 responses from community members throughout the aggregated HHC service areas. The survey was designed collect the opinions and insights of a diverse set of community members on issues regarding unmet community needs and several other related issues. Surveys were distributed in Spanish and English both online and on paper.

The following summary provides a snapshot of the survey respondents and their responses to key questions. A complete set of survey response demographic tables is contained in the appendices.

Participant Demographics

Survey respondents represent a breath of counties and community groups throughout the state. Skewed toward White respondents, the survey also includes a notable percent (approximately 20%) of people indicating that they are members of racial or ethnic minority communities.

TABLE 11: DEMOGRAPHICS OF SURVEY RESPONDENTS

Demographic Profile of Survey Respondents	
Race/Ethnicity	**Percent of respondents**
White or Caucasian	78.6
Black or African American	10.5
Hispanic/Latinx	8.2
Asian	1.3
Others	1.3
Annual Household Income	**Percent of respondents**
None	0.4
Under $15,000	1.1
$15,000 - $24,999	1.8
$25,000 - $34,999	5.7
$35,000 - $44,999	6.5
$45,000 - $54,999	10.0
$55,000 - $64,999	6.8
$65,000 - $74,999	7.5
$75,000 - $99,999	14.0
$100,000 or more	46.2

- Approximately one in three respondents indicate a low- to medium annual household income (i.e., less than $55,000).
- More than two of five (46.2%) earn over $100,000 per year.

Approximately one of seven survey participants live in a single-parent household (15.5%), and one in 10 (9.9%) live in a multigenerational household. Both of these household groups represent greater vulnerability to economic challenges and the related impact on access to health care services.

TABLE 12: HOUSEHOLD SITUATIONS

Home Situations	Percent saying, "Yes"
Situation	
Do you live in a single-parent household?	15.5
Do you live in a multi-generation household or in a home with three or more generations living together (such as grandparents, kids, and grandkids)?	9.9

Survey Results

The survey evaluated 34 granular community needs on the basis the percentage of respondents saying that there was a feel need more attention for improvement. Most of the needs fell into the following categories:

1. Counseling and other behavioral health services
2. Substance Use Disorder education, early intervention, and treatment services (including crisis care)
3. Access to care – specifically, topics around affordability and related childcare
4. The process of care – care coordination for complex medical or mental health patients requiring services from multiple providers.
5. Integrated medical and mental health services for seniors

The survey questions asked about participants' ratings on a wide range of programs and resources in the community on a scale of 1 (no more focus needed) to 5 (much more focus needed) in regard to, "Which of the issues need more attention for improvement?" The final surve7y tables show the top needs, as identified in the community survey by those "top box" respondents who indicated "Much more needed" attention needs to be given to these services.

- Four of the most common needs (of 15) indicate the service gaps, or need, for additional mental health services, apart from Substance Use Disorder care; two of the top three needs reflect the need for additional counseling services.
- An additional four of 15 of the most commonly noted needs are related to Substance Use Disorder care.
- Overall, respondents clearly illuminate the need for additional services in these focused areas, yet they also indicate the "need" to address the process of care – the way in which any/all services are provided.

In addition, three questions focused on Access to Care. More than one-third of respondents (37.3%) chose NOT to get care when they needed it (see appendices). Most commonly, they did not get needed care because the wait time to see a provider was too long (43.9%) or they could not afford it (36.3%). So while "access" is not a service or program, extrapolating these percentages to the actual number of individuals, children, and families in each HSA suggests a high percentage of the population is having difficulty accessing services.

A complete set of survey response tables is contained in the appendices.

Access Audit

Access audits or “mystery shopper” calls are an effective way to evaluate customer service data and consumer-level access to care issues. The goal is to understand practical access to service issues perceived by clients and prospective clients. The results provide insight to access gaps, improvement strategies, and service variations. The HHC affiliated outpatient service sites were “shopped” (i.e., called on the telephone) by Crescendo “shoppers” seeking to schedule an appointment or to learn about other factors that potentially impact consumer access to services. Calls were made at different times throughout the day during the first two weeks of May 2022.

Calls were made to 12 health care facilities in the Hospital of Central Connecticut service area. Callers asked about primary care and behavioral health care. The factors used to identify areas of opportunity during the calls included:

Ability of the site or facility to accept new patients

Ability of the facility to answer questions and refer the caller elsewhere when the desired services are not available

How staff asks questions to define prospective client needs

Ease of speaking with a person

A summary of the Access Audit follows.

Ability of the site or facility to accept new patients

Of the 12 sites, 11 of them are accepting new patients. Wait times range from two weeks to several months (i.e., January 2023). The site that is not accepting new patients until January 2023 is a primary care site. Another site has the availability to accept patients in September 2022. Four sites (two behavioral health, two primary care) that have availability within two to three weeks said that they can accommodate emergencies within the next couple of days. Four of the sites could not provide an estimate of wait times to the caller because they would have to put all patient information in the system to create a patient chart in order to see provider availability.

Ability of the facility to answer questions and refer the caller elsewhere when the desired services are not available

Seven of the 12 sites had staff members that went above and beyond. Staff members at these sites were extremely informative and eager to talk to the caller. Staff members gave detailed information about the process of becoming a new patient. Two staff members asked the caller for a phone number to send a text with a link to the preregistration paperwork. The site that is not accepting new patients is a pediatric site. When the caller asked if there were other pediatrician offices accepting new patients, the staff could not refer the caller to another site.

How staff asks questions to define prospective client needs

All staff members asked the caller what type of insurance he/she had to make sure that the site accepts their insurance. Seven of the sites had staff that asked questions that assessed appropriate levels of care and addressed access to care issues.

Ease of speaking with a person

All staff at the health care sites were very nice and eager to help the caller. All 12 sites had an automated phone tree, all of which had efficient phone tree options. Three of the sites had a phone tree that was descriptive and gave additional information about the site. The longest wait time to speak to staff was nine minutes. In one instance, the caller had an option to leave a message to receive a callback. After a seven-minute wait, the caller decided to use this option and received a callback three hours later. Three out of the 12 sites had Spanish as an option on the phone tree. The lack of Spanish language options may create a barrier for patients whose primary language is not English.

Section 3: Conclusions, Prioritized Needs, and Next Steps

Prioritization Process

Background

The Needs Prioritization Process brought together the summary of results from secondary research data references, qualitative research themes, and the community survey. The summary and the process were described for the participants in an advance email as follows:

Primary and secondary research. The needs included in the Prioritization Process were derived from the extensive secondary and primary research described below.

- Secondary research: Secondary research includes extensive amounts of data from the US Census Bureau; sites providing information on poverty and other social influencers of health measures; DataHaven Charts; and other validated data sources.
- Primary research: This includes a *community survey* with [system-wide] approximately 600 responses, results from *qualitative research* (i.e., approximately 100 in-depth stakeholder interviews and results from 30 focus groups).

Direct linkages between the "needs" and the research data. Each of the needs in the prioritization process directly links to data observations and/or qualitative feedback. Supporting data and a detailed list of 50 needs in each county was created. Duplicates were removed and similar needs were combined. The resulting list of needs represents the items participants were asked to evaluate in the Prioritization Process.

Crescendo then worked with seven sets of project leaders – one set for each HHC hospital – to implement a modified Delphi Method to construct a prioritized list of needs for each county. The "three-round" approach described for the participants in advance included:

- Round 1: The first step asked participants to evaluate and comment on each need in a provided list via an online survey derived from primary and secondary research.
- Round 2: The second step asked participants to evaluate the same or similar list of needs, but this list showed their colleagues' comments. The purpose of this process is to provide participants with additional insight as they evaluate each need.
- Round 3: Based on the results of the first two rounds of the Prioritization Process (conducted separately with teams from each of the seven hospital service areas), community survey results, secondary data, and qualitative research results, Crescendo assembled a draft version of the top 10 needs for each hospital. As a final stage of the Prioritization Process, Crescendo and approximately 35 HHC Regional Leaders reviewed the drafts versions to do the following:
    - Confirm and validate research results
    - Discuss additional, locally known or emerging needs to append to the initial lists of the top 10 needs

      Discuss project next steps.

Based on the results of the Round 3 discussion, the final list of prioritized needs is shown below.

Final Prioritized List of Needs

Aggregated Needs By Tier For The Hospital Of Central Connecticut Hospital
Suicide Prevention
Gero-Psych And Dementia Care
Support For Family Members Of A Person Being Treated For Substance Use Disorder
Mental Health Stigma Reduction
Outpatient Mental Health Services Capacity for Adults, Adolescents, and Children – Including in-home and caregiver support
Mental Health Crisis Services And Community Awareness Of Available Resources
Healthcare Services For Children With Special Needs
Co-Locating Case Managers And Behavioral Health Providers With Primary Care
Focused Initiatives Addressing Chronic Health Conditions
Additional Programs To Enhance Access to Care For Lower-income Families
Broad-based, integrated services --- Medical, Mental Health, Substance Use Disorder, SDoH – for People and Families Experiencing Homelessness
Care Coordination and Support to Help Manage Care for Patients With Complex Health Conditions
Enhanced Collaboration with Community Partners
Substance Use Disorder Crisis Care and Treatment

As noted in the Executive Summary, many of the issues shown above are particularly urgent among disadvantaged communities, people of color, and others who have historically lacked adequate access to services

Transferring Knowledge Into Change

Overview

The critical component of any CHNA is the efficiency and effectiveness of how it segues into strategies and plans. Strategies and plans must be designed to address the ultimate goal of improving community health and address high-priority needs. A systematic approach to developing the Community Health Improvement Plan (CHIP) is critical to achieving this ultimate goal.

Some of the initial, well-defined steps to develop and deploy the CHIP include the following:

STEP 1 - Culling the Findings – Brainstorming with your local collaboratives by answering the following questions:

CHNA Immediate Impact findings – where is the low hanging fruit?

CHNA Greatest Impact findings -- what will most influence health outcomes?

CHNA Most Desired Change findings - what change does the community most want?

CHNA Forging Opportunities findings - where are the greatest opportunities for partnership?

STEP 2 - Organizing the focus areas and assembling your rationale for action

STEP 3 - Selecting your Strategies and Interventions

Step 4 – Executing and Evaluation

Note that the timeline is designed to facilitate Board adoption of the CHIP in September 2022.

The appendices ("Key Steps to CHIP Development and Impact") provides additional detail and indicated actions.

Example to Help "Cull the Findings"

Culling the findings – Step 1, above – involves taking a systemic approach to begin to identify the "low hanging fruit" (i.e., needs that are high-priority and are within the hospital's ability to quickly make an impact), issues that most influence health outcomes, and ones desired**.**

As an initial step to consider, CHNA/CHIP leaders may choose to assign each of the high-priority community needs values based on the facility's ability to control community based activities and the timeline within which to impact the issue.

The table below is a sample using the actual CHNA prioritized needs. Upon completion of the table, CHIP leaders will have a clear understanding of initial projects (e.g., "low hanging fruit") and the degree and focus of required collaboration. Additional CHIP strategies, collaborations, and roadmaps will be constructed to further meet hospital-level needs, opportunities, and resource availability.

Needs	Timeline *Less than 1 year,* *1 to 3 years,* *3+ years*	Degree of Control *HHC can fully direct;* *HHC to collaborate;* *HHC to support partners*
Suicide Prevention		
Gero-Psych And Dementia Care		
Support For Family Members Of A Person Being Treated For Substance Use Disorder		
Mental Health Stigma Reduction		
Outpatient Mental Health Services Capacity for Adults, Adolescents, and Children – Including in-home and caregiver support		
Mental Health Crisis Services And Community Awareness Of Available Resources		
Healthcare Services For Children With Special Needs		
Co-Locating Case Managers And Behavioral Health Providers With Primary Care		
Focused Initiatives Addressing Chronic Health Conditions		
Additional Programs To Enhance Access to Care For Lower-income Families		
Broad-based, integrated services --- Medical, Mental Health, Substance Use Disorder, SDoH – for People and Families Experiencing Homelessness		
Care Coordination and Support to Help Manage Care for Patients With Complex Health Conditions		
Enhanced Collaboration with Community Partners		
Substance Use Disorder Crisis Care and Treatment		

Appendices

Appendix 1: Community Health Improvement Plan (CHIP) Objectives

1) Enhance Community Engagement and Better Incorporate the Consumer's Voice - CHNA/CHIP process leads to continuous and trusting feedback loops with diverse populations and enhances our methods for on-going engagement with the communities we serve.

2) Grow and Sustain our Community-based Partnerships - CHNA/CHIP process leads to more formalized partnerships with regional and community organizations and collaborations, and more meaningful relationships with key community opinion leaders.

3) Align Community Health with our Equity Value and Across the Regions - CHNA/CHIP process leads to a greater sense of team and purpose within HHC, assures each region is equitably resourced, and that collectively we know and understand more about identifying community health needs and improving health outcomes.

4) Bring Greater Clarity and Social Impact to our Community Health Work - CHNA/CHIP process leads to more effective, justified, measurable, and reportable interventions across our collective CHIPs and inspires and informs our social investment, sponsorship, and donation activities.

Appendix 2: HOSPITAL OF CENTRAL CONNECTICUT SERVICE AREA2022 EQUITY PROFILE – DataHaven

CONTENTS

Compiled by DataHaven in April 2022.

This report is designed to inform local-level efforts to improve community well-being and racial equity. This represents version 1.0 of the DataHaven town equity profile, which DataHaven has published for all 169 towns and several regions of Connecticut. Please contact DataHaven with suggestions for version 2.0 of this report.

ctdatahaven.org

EXECUTIVE SUMMARY

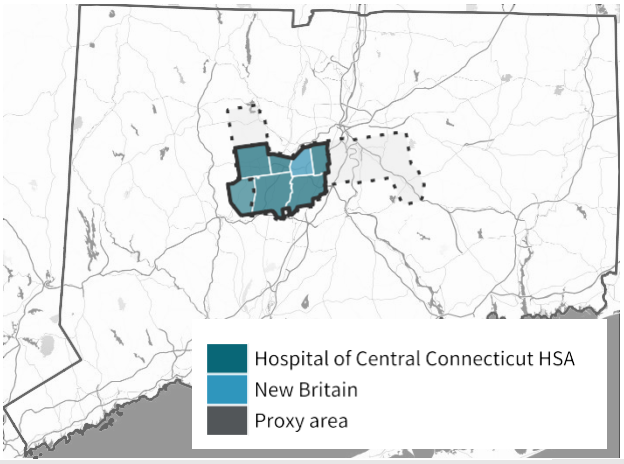
Throughout most of the measures in this report, there are important differences by race/ethnicity and neighborhood that reflect differences in access to resources and other health-related social needs. Wherever possible, data will be presented with racial/ethnic breakdowns. Data for White, Black, Asian, and other populations represent non-Hispanic members of each racial group.

- Of the region's 104,268 households, 66% are homeowner households.
- Thirty-three percent of the Hospital of Central Connecticut HSA's households are cost burdened, meaning they spend at least 30% of their total income on housing costs.
- Among the region's adults ages 25 and up, 30% have earned a bachelor's degree or higher.
- The Hospital of Central Connecticut HSA is home to 105,812 jobs, with the largest share in the Health Care and Social Assistance sector.
- The median household income in the Hospital of Central Connecticut HSA is $76,401. The Hospital of Central Connecticut HSA's average life expectancy is 79.1 years.
- Fifty-five percent of adults in the Hospital of Central Connecticut HSA say they are in excellent or very good health. In 2020, 125 people in the Hospital of Central Connecticut HSA died of drug overdoses.
- Eighty-one percent of adults in the Hospital of Central Connecticut HSA are satisfied with their area, and 50% say their local government is responsive to residents' needs.
- In the 2020 presidential election, 80% of registered voters in the Hospital of Central Connecticut HSA voted.
- Sixty-two percent of adults in the Hospital of Central Connecticut HSA report having stores, banks, and other locations in walking distance of their home, and 70% say there are safe sidewalks and crosswalks in their neighborhood.

OVERVIEW

For the purposes of this report, the Hospital of Central Connecticut HSA will be compared to Connecticut as a whole, as well as to New Britain where possible. Where necessary, data may be presented for a proxy region made up of public use microdata areas (PUMAs) designated by the US Census Bureau, including parts of Hartford County and New Haven County. **Charts and tables based on these proxy areas are noted as such in their titles**.

TABLE 13: STUDY AREA



The Hospital of Central Connecticut HSA is made up of the following locations (with 2020 populations):

- Berlin (20,175)
- Bristol (60,833)
- New Britain (74,135)
- Newington (30,536)
- Plainville (17,525)
- Southington (43,501)
- Wolcott (16,142)

The proxy study area is made up of the following locations (with 2020 populations):

- PUMA 0900304 (113,853)
- PUMA 0900305 (111,835)
- PUMA 0900306 (119,971)

Indicator	Connecticut	Hosp. of Central CT HSA	New Britain
Total population	3,605,944	262,847	74,135
Total households	1,370,746	104,268	28,232
Homeownership rate	66%	66%	40%
Housing cost burden rate	36%	33%	43%
Adults with less than a high school diploma	9%	11%	19%
Median household income	$78,444	$76,401	$46,499
Poverty rate	10%	11%	22%
Life expectancy (years)	80.3	79.1	76.6
Ages 18–64 w/o health insurance	11%	11%	18%

DEMOGRAPHICS

As of 2020, the population of the Hospital of Central Connecticut HSA is 262,847, including 52,672 children and 210,175 adults. Thirty-three percent of the Hospital of Central Connecticut HSA's residents are people of color, compared to 37% of the residents statewide.

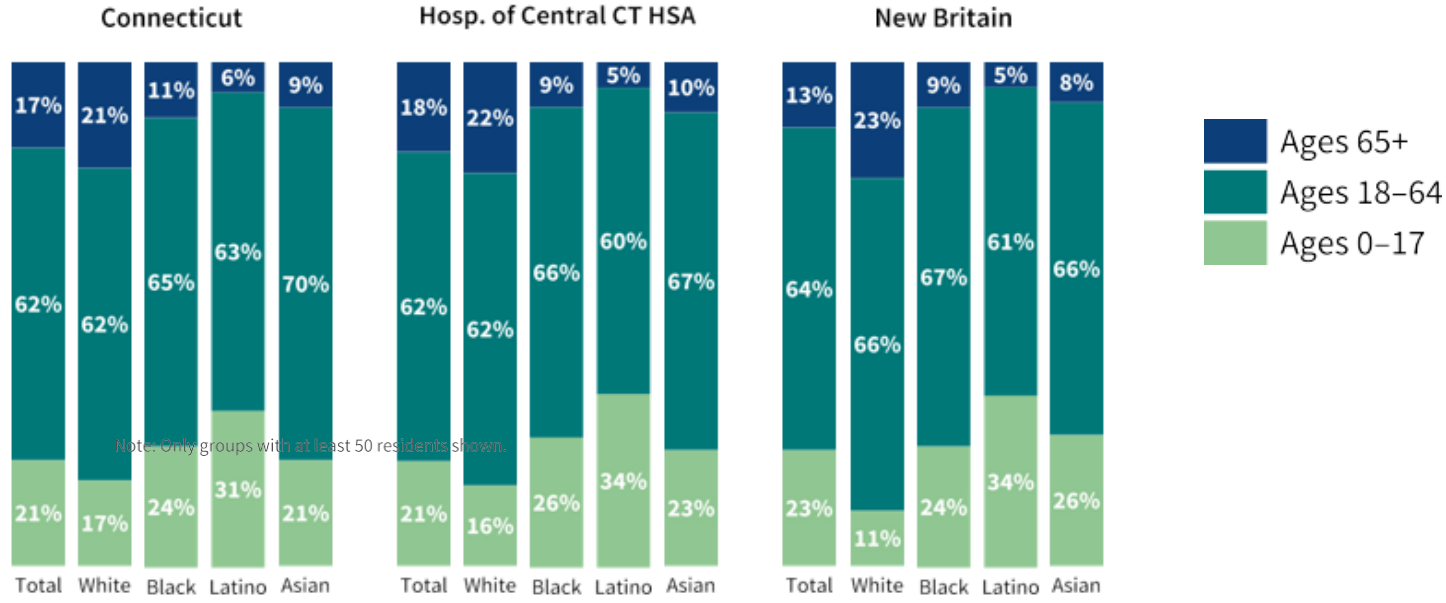
TABLE 14: POPULATION BY RACE & ETHNICITY, 2020

Area	Count	Share	Black Count	Black Share	Latino Count	Latino Share	Asian Count	Asian Share	Native White American Count	Native White American Share	Other race/ethnicity Count	Other race/ethnicity Share
Connecticut	2,279,232	63%	360,937	10%	623,293	17%	170,459	5%	6,404	<1%	165,619	5%
Hosp. of Central CT HSA	175,728	67%	15,516	6%	52,657	20%	8,457	3%	243	<1%	10,246	4%
New Britain	27,535	37%	9,294	13%	32,620	44%	1,884	3%	74	<1%	2,728	4%

- As Connecticut's predominantly White baby boomers age, younger generations are driving the state's increased racial and ethnic diversity.
- Black and Latino populations in particular skew much younger than White populations.

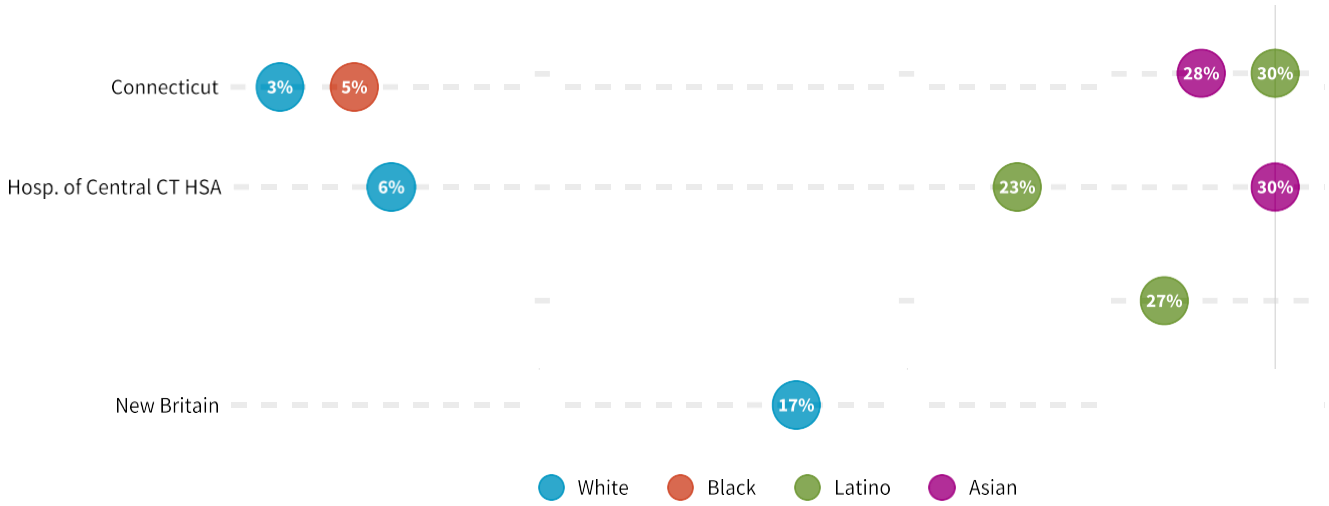
As Connecticut's predominantly White baby boomers age, younger generations are driving the state's increased racial and ethnic diversity. Black and Latino populations in particular skew much younger than White populations.

FIGURE 11: POPULATION BY RACE/ETHNICITY AND AGE GROUP, 2019



About 34,037 residents of the Hospital of Central Connecticut HSA, or 13% of the population, are foreign-born. Linguistic isolation is characterized as speaking English less than "very well." People who struggle with English proficiency may have difficulty in school, seeking health care, accessing social services, or finding work in a largely English-speaking community. As of 2019, 23,992 Hospital of Central Connecticut HSA residents, or 10% of the population age 5 and older, were linguistically isolated. Latinos and Asian Americans are more likely to be linguistically isolated than other racial/ethnic groups.

FIGURE 12: POPULATION BY RACE/ETHNICITY AND AGE GROUP, 2019



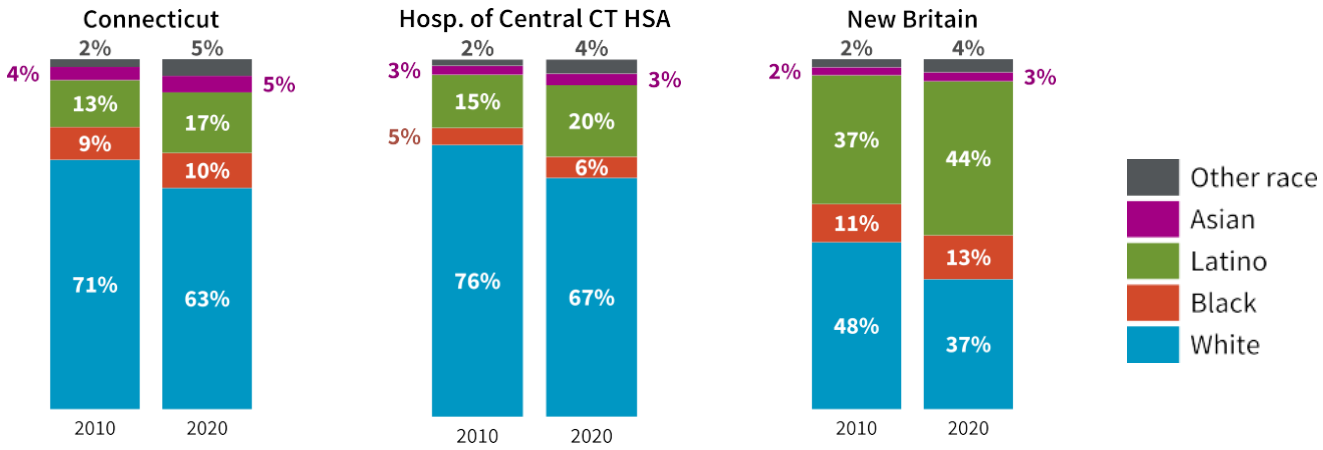
POPULATION CHANGE: 2020 CENSUS

The first set of data from the 2020 Census was released in August 2021, containing basic population counts by age and race/ethnicity. Between 2010 and 2020, Connecticut's population was nearly stagnant. During the same period, the Hospital of Central Connecticut HSA grew by 1,271 people, a less than 1% increase. The number of White residents in the Hospital of Central Connecticut HSA shrank by 12%, while the non-White population grew by 39%.

TABLE 15: POPULATION AND POPULATION CHANGE BY AGE GROUP, 2010–2020

	Population, 2010	Population, 2020	Change	Percent change
Connecticut				
All ages	3,574,097	3,605,944	+31,847	+0.9%
Children	817,015	736,717	−80,298	−9.8%
Adults	2,757,082	2,869,227	+112,145	+4.1%
Hospital of Central Connecticut HSA				
All ages	261,576	262,847	+1,271	+0.5%
Children	57,422	52,672	−4,750	−8.3%
Adults	204,154	210,175	+6,021	+2.9%
New Britain				
All ages	73,206	74,135	+929	+1.3%
Children	17,061	16,550	−511	−3.0%
Adults	56,145	57,585	+1,440	+2.6%

FIGURE 13: SHARE OF POPULATION BY RACE/ETHNICITY, 2010–2020



HOUSING

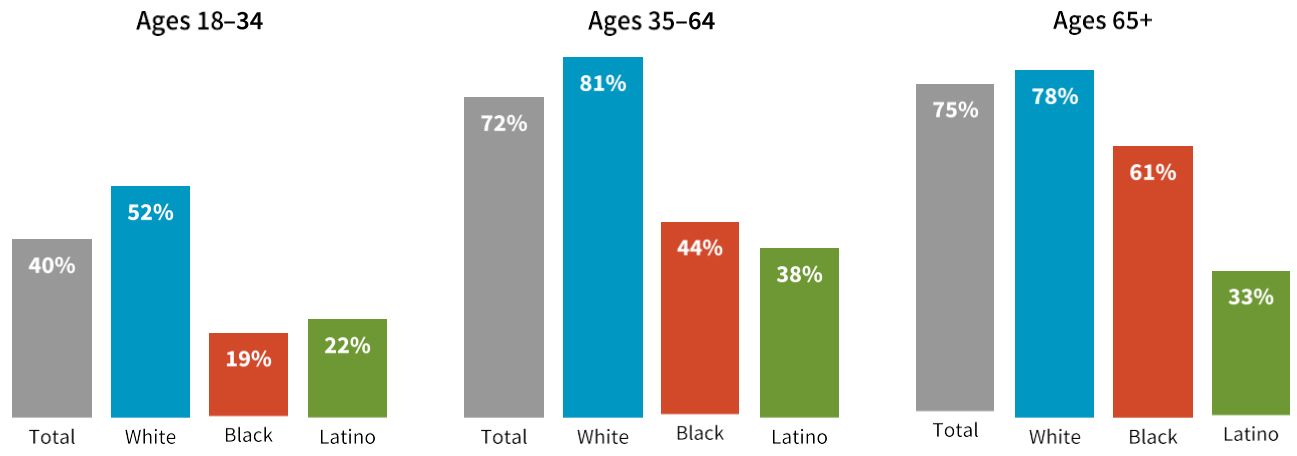
The Hospital of Central Connecticut HSA has 104,268 households, of which 66% are homeowner households. Of the region's 112,648 housing units, 61% are single-family units. Homeownership rates vary by race/ethnicity. Purchasing a home is more attainable for advantaged groups because the process of purchasing a home has a long history of racially discriminatory practices that continue to restrict access to homeownership today. This challenge, coupled with municipal zoning dominated by single-family housing, results in de facto racial and economic segregation seen throughout Connecticut.

TABLE 16: HOMEOWNERSHIP RATE BY RACE/ETHNICITY OF HEAD OF HOUSEHOLD, 2019

Area	Total	White	Black	Latino	Asian	Native American
Connecticut	66%	76%	39%	34%	58%	40%
Hospital of Central Connecticut HSA	66%	75%	39%	32%	58%	21%
New Britain	40%	54%	37%	23%	31%	N/A

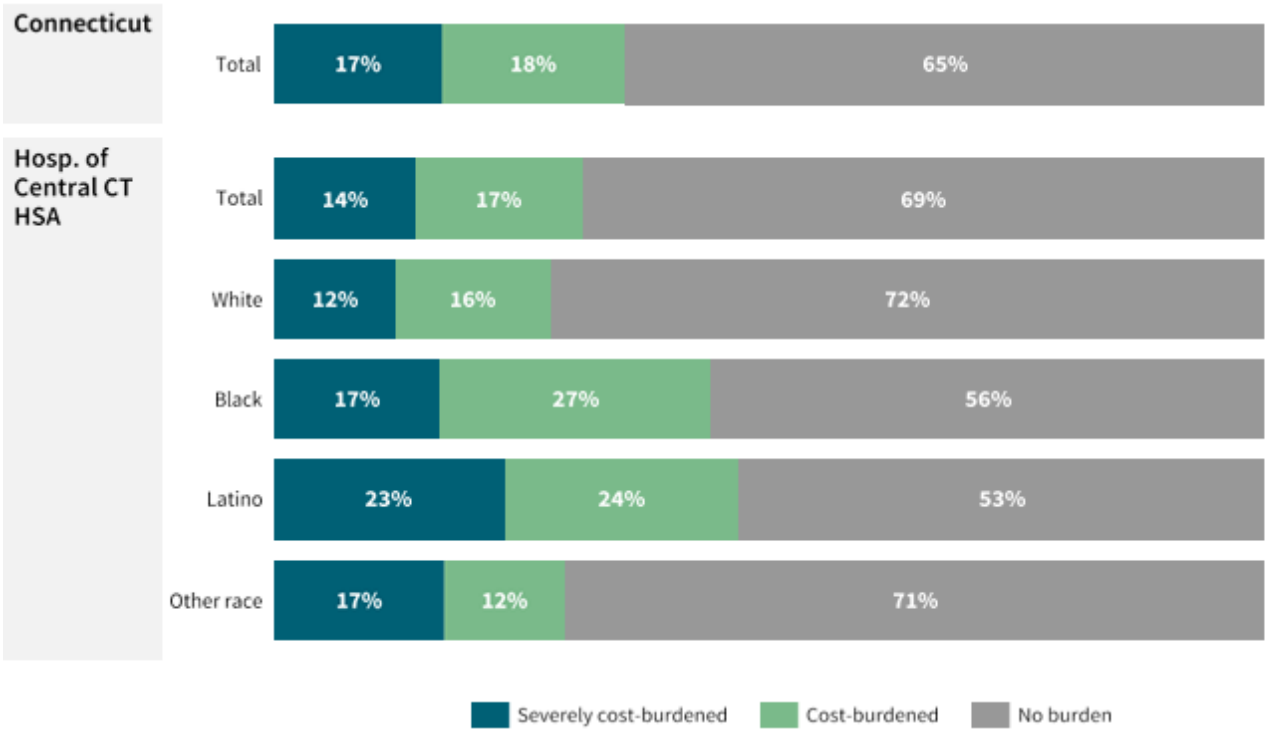
Younger adults are less likely than older adults to own their homes across several race/ethnicity groups. However, in most towns, younger White adults own their homes at rates comparable to or higher than older Black and Latino adults.

FIGURE 14: HOMEOWNERSHIP RATES BY AGE AND RACE/ETHNICITY OF HEAD OF HOUSEHOLD, HOSPITAL OF CENTRAL CONNECTICUT HSA (PROXY AREA), 2019



A household is cost burdened when they spend 30% or more of their income on housing costs, and severely cost-burdened when they spend half or more of their income on housing costs. Housing costs continue to rise, due in part to municipal zoning measures that limit new construction to very few towns statewide. Meanwhile, wages have largely stagnated, especially among lower-income workers who are more likely to rent. As a result, cost burden generally affects renters more than homeowners, and has greater impact on Black and Latino householders. Among renter households in the Hospital of Central Connecticut HSA, 45% are cost burdened, compared to 25% of owner households.

FIGURE 15: HOUSING COST BURDEN RATES BY RACE/ETHNICITY (WITH PROXY AREA), 2019



Household overcrowding is defined as having more than one occupant per room. Overcrowding may increase the spread of illnesses among the household and can be associated with higher levels of stress. Increasing the availability of appropriately- sized affordable units helps to alleviate overcrowding.

TABLE 17: OVERCROWDED HOUSEHOLDS BY RACE/ETHNICITY OF HEAD OF HOUSEHOLD, 2019

Total		White		Black		Latino		Asian Area		Native American	
	Count	Share	Count	Share	Count	Share	Count	Share	Count	Share	Count	Share
Connecticut	25,541	2%	7,252	<1%	4,437	3%	10,771	6%	2,954	6%	158	4%
Hosp. of Central CT HAS	1,719	2%	467	<1%	177	3%	843	5%	210	8%	<50	N/A
New Britain	1,089	4%	201	2%	109	3%	714	7%	55	8%	<50	N/A

EDUCATION

Public school students in the Hospital of Central Connecticut HSA are served by 7 school districts for pre-kindergarten through grade 12. During the 2019–2020 school year, there were a total of 35,727 students enrolled in these districts, with 10,093 enrolled in the New Britain School District.

Tracking student success measures is important since disparate academic and disciplinary outcomes are observed as early as preschool and can ultimately affect a person's long-term educational attainment and economic potential.

FIGURE 16: PUBLIC K–12 STUDENT ENROLLMENT BY RACE/ETHNICITY PER 100 STUDENTS, 2019–2020

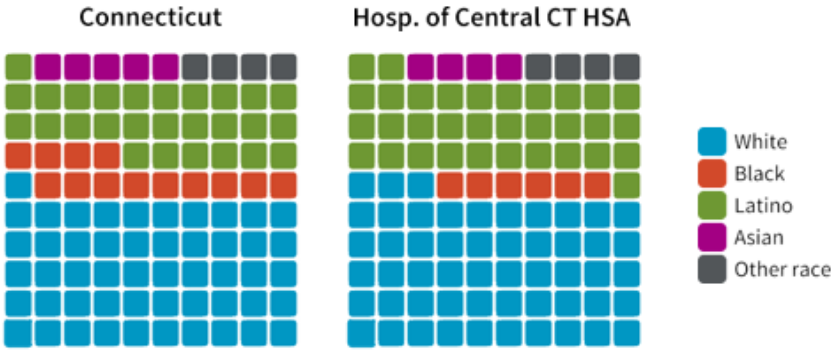
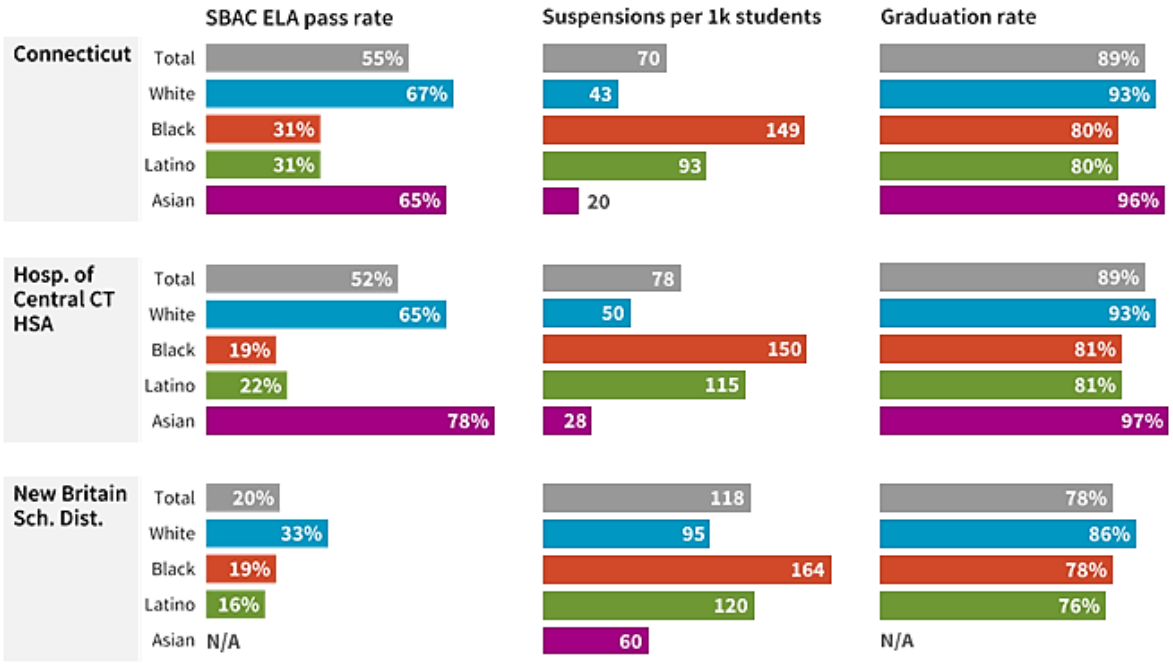
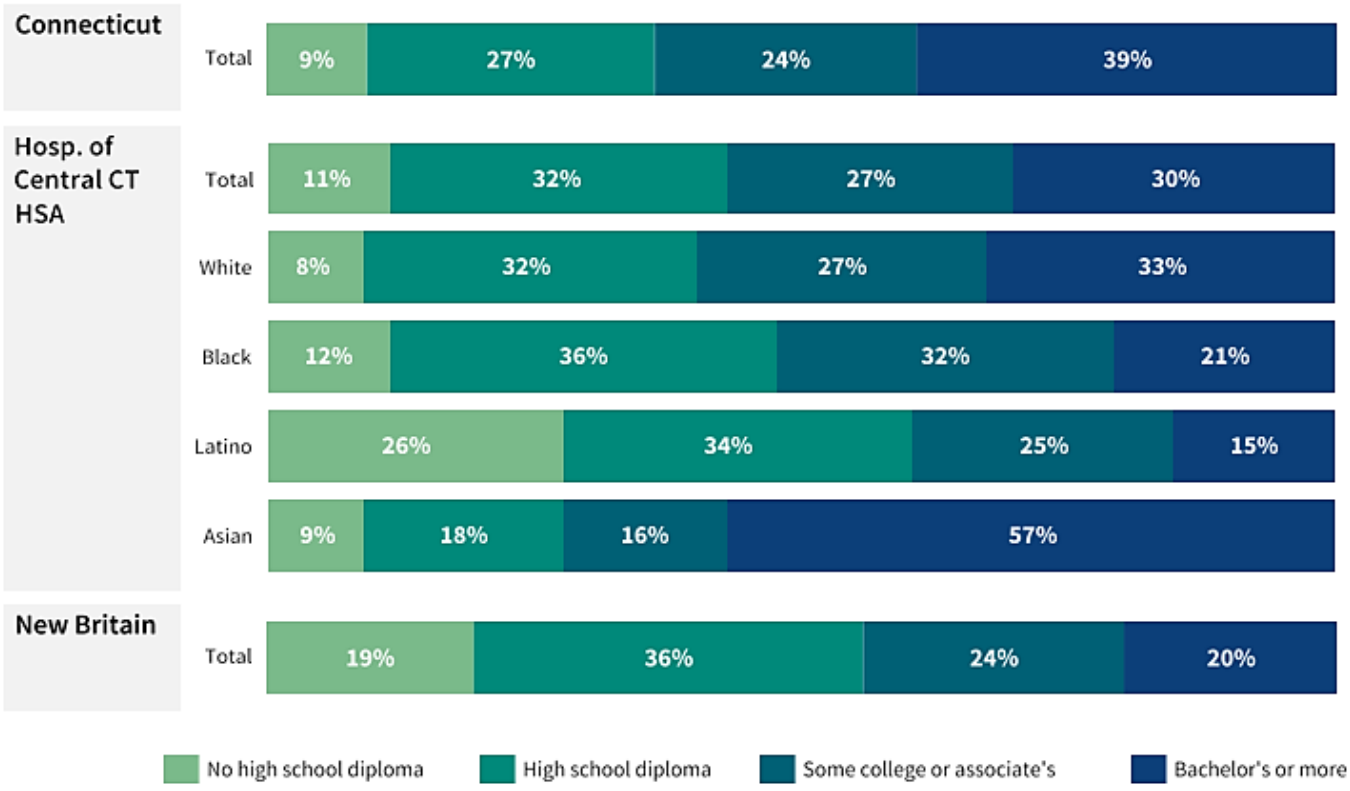


FIGURE 17: SELECTED ACADEMIC AND DISCIPLINARY OUTCOMES BY STUDENT RACE/ETHNICITY, 2018–2019



Adults with high school diplomas or college degrees have more employment options and considerably higher potential earnings, on average, than those who do not finish high school. In the Hospital of Central Connecticut HSA, 11% of adults ages 25 and over, or 20,742 people, lack a high school diploma; this share is 9% statewide and 19% in New Britain.

FIGURE 18: EDUCATIONAL ATTAINMENT BY RACE/ETHNICITY, SHARE OF ADULTS AGES 25 AND UP, 2019



ECONOMY

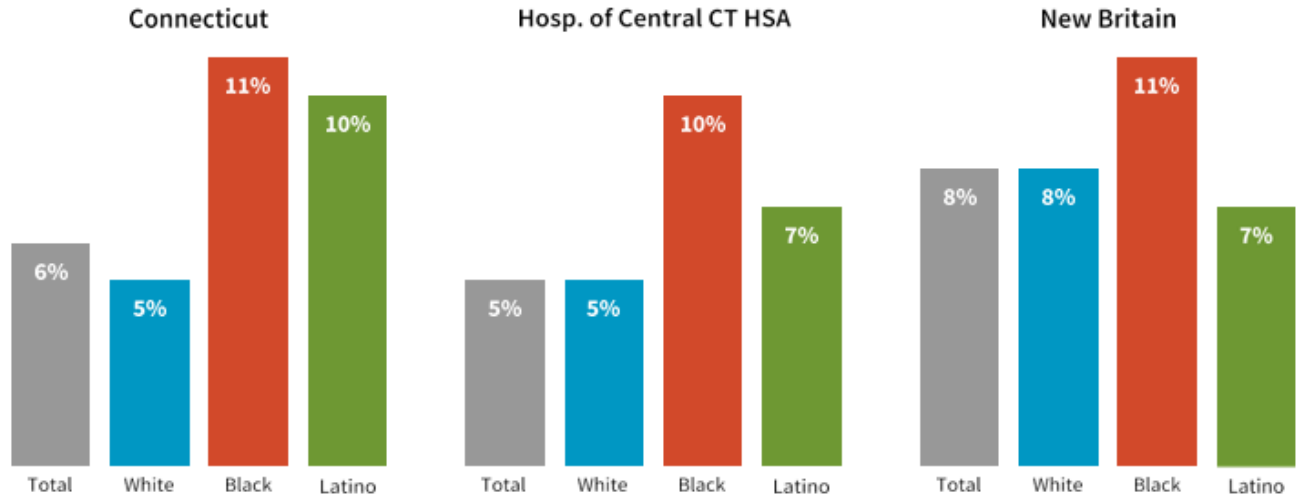
There are a total of 105,812 jobs based in towns in the Hospital of Central Connecticut HSA, with 24,599 jobs based in New Britain. Jobs in the Health Care and Social Assistance sector make up the largest share in the region. While these numbers are from 2019 and do not include economic outcomes related to the COVID-19 pandemic, they describe general labor market strengths and average wages for the area.

TABLE 5: JOBS AND WAGES IN HOSPITAL OF CENTRAL CONNECTICUT HSA'S 5 LARGEST SECTORS, 2019

Sector	Connecticut		Hosp. of Central CT HSA	
	Total jobs	Avg annual pay	Total jobs	Avg annual pay
All Sectors	1,670,354	$69,806	105,812	$58,073
Health Care and Social Assistance	271,014	$54,858	19,251	$48,291
Retail Trade	175,532	$35,833	15,033	$77,051
Accommodation and Food Services	129,012	$23,183	12,664	$32,144
Administrative and Support and Waste Management and Remediation Services	89,852	$47,443	8,307	$19,599
Manufacturing	161,893	$85,031	5,550	$70,384

Rates of unemployment also vary by race and ethnicity. Generally, workers of color are more likely to be unemployed due to factors ranging from hiring practices to proximity to available jobs. Overall unemployment in the Hospital of Central Connecticut HSA averaged 5% in 2019.

FIGURE 6: UNEMPLOYMENT RATE BY RACE/ETHNICITY, 2019

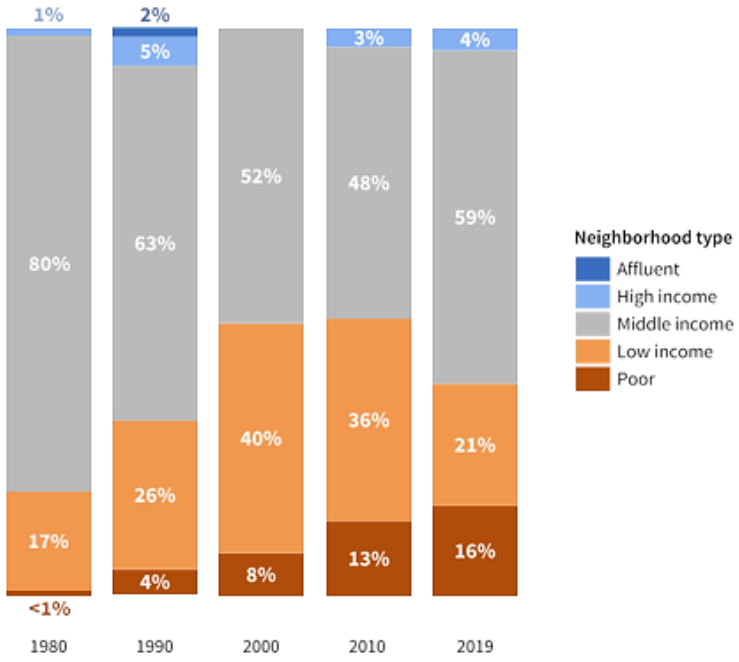


INCOME & WEALTH

The median household income in Connecticut is $77,696. Within the Hospital of Central Connecticut HSA, median household incomes by town range from $46,499 in New Britain to $101,127 in Berlin. Racial disparities in outcomes related to education, employment, and wages result in disparate household-level incomes and overall wealth. Households led by Black or Latino adults generally average lower incomes than White households.

Over the past 40 years, neighborhood income inequality has grown statewide as the share of the population living in wealthy or poor neighborhoods has increased and the population in middle income areas declined in a process known as "economic sorting," which often leads to further disparities in access to economic opportunity, healthy environments, and municipal resources.

FIGURE 19: DISTRIBUTION OF POPULATION BY NEIGHBORHOOD INCOME LEVEL, HOSPITAL OF CENTRAL CONNECTICUT HSA, 1980– 2019



The Supplemental Nutritional Assistance Program (SNAP, or food stamps) is a program available to very low-income households earning less than 130% of the federal poverty guideline ($25,750 for a family of four in 2019). Throughout the state, poverty and SNAP utilization rates are higher among Black and Latino households than White households.

TABLE 18: SELECTED HOUSEHOLD ECONOMIC INDICATORS BY RACE/ETHNICITY OF HEAD OF HOUSEHOLD, 2019

	Total		White		Black		Latino		Asian		Native American	
	Count	Share	Count	Share	Count	Share	Count	Share	Count	Share	Count	Share
Population living below poverty level												
Connecticut	344,146	10%	137,123	6%	65,664	18%	123,431	22%	12,398	8%	1,629	17%
Hosp. of Central CT HSA	27,418	11%	11,098	6%	2,007	13%	12,863	25%	689	9%	57	9%
New Britain	15,210	22%	3,035	11%	1,229	14%	10,194	33%	193	10%	57	48%
Households receiving food stamps/SNAP												
Connecticut	162,967	12%	67,339	7%	34,650	26%	56,091	32%	3,145	6%	958	26%
Hosp. of Central CT HSA	15,693	15%	6,819	9%	1,752	31%	6,811	42%	241	10%	<50	N/A
New Britain	8,727	31%	1,948	14%	1,090	32%	5,518	54%	86	13%	<50	N/A

Access to a personal vehicle may also be considered a measure of wealth since reliable transportation plays a significant role in job access and quality of life. Vehicle access reduces the time a family may spend running errands or traveling to appointments, school, or work.

TABLE 19: HOUSEHOLDS WITH NO VEHICLE AT HOME BY RACE/ETHNICITY OF HEAD OF HOUSEHOLD (WITH PROXY AREA), 2019

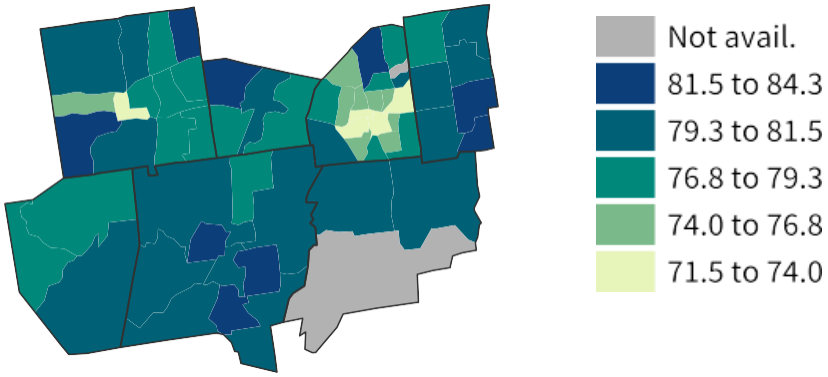
Area	Total		White		Black		Latino		Other race	
	Count	Share	Count	Share	Count	Share	Count	Share	Count	Share
Connecticut	121,434	9%	55,942	6%	27,048	21%	30,496	17%	7,948	10%
Hospital of Central Connecticut HAS	11,453	8%	6,902	7%	917	15%	2,983	17%	651	9%
New Britain	4,651	17%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

HEALTH

The socioeconomic disparities described above tend to correlate with health outcomes. Factors such as stable housing, employment, literacy and linguistic fluency, environmental hazards, and transportation all impact access to care, physical and mental health outcomes, and overall quality of life. Income and employment status often drive differences in access to health care, the likelihood of getting preventive screenings as recommended, the affordability of life-saving medicines, and the ability to purchase other goods and services, including high-quality housing and nutritious food.

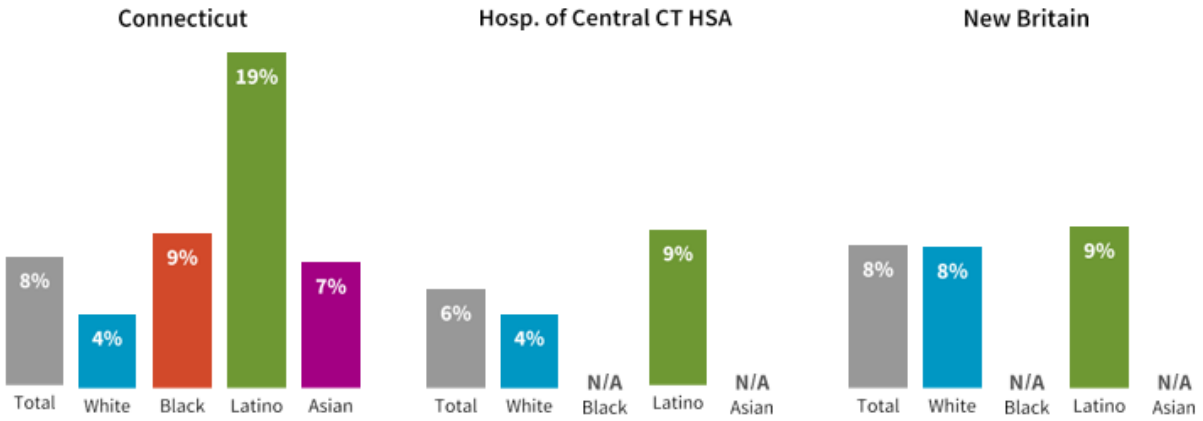
Life expectancy is a good proxy for overall health and well-being since it is the culmination of so many other social and health factors. The average life expectancy in the Hospital of Central Connecticut HSA is 79.1 years, compared to 76.6 years in New Britain and 80.3 years statewide.

FIGURE 20: LIFE EXPECTANCY, HOSPITAL OF CENTRAL CONNECTICUT HSA BY CENSUS TRACT, 2015



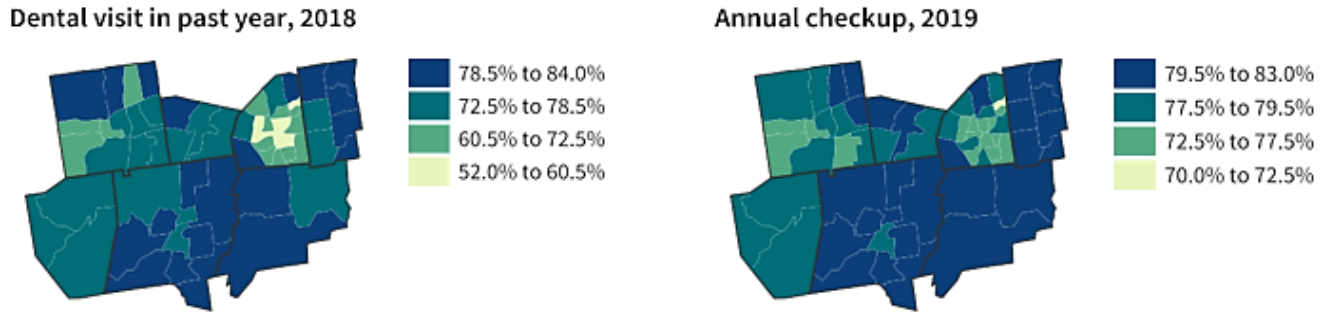
Health-related challenges begin with access to care. Due to differences in workplace benefits, income, and eligibility factors, Black and especially Latino people are less likely to have health insurance than White people.

FIGURE 12: UNINSURED RATE AMONG ADULTS AGES 19–64 BY RACE/ETHNICITY, 2019



Preventive care can help counteract economic disadvantages, as a person's health can be improved by addressing risk factors like hypertension and chronic stress early. Lack of affordable, accessible, and consistent medical care can lead to residents relying on expensive emergency room visits later on. Overall, 79% of the adults in the Hospital of Central Connecticut HSA had an annual checkup as of 2018, and 75% had a dental visit within the previous 12 months.

FIGURE 21: PREVENTIVE CARE MEASURES, SHARE OF ADULTS BY CENSUS TRACT, HOSPITAL OF CENTRAL CONNECTICUT HSA



Throughout the state, people of color face greater rates and earlier onset of many chronic diseases and risk factors, particularly those that are linked to socioeconomic status and access to resources. For example, diabetes is much more common among older adults than younger ones, yet middle-aged Black adults in Connecticut have higher diabetes rates than White seniors.

FIGURE 22: SELECTED HEALTH RISK FACTORS, SHARE OF ADULTS, 2015–2021

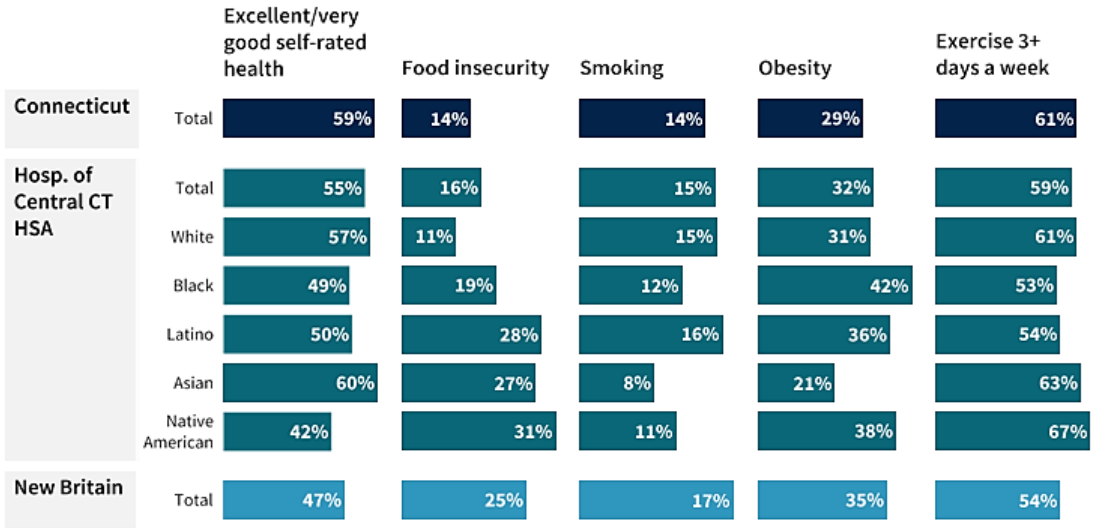


FIGURE 23: SELECTED HEALTH INDICATORS BY AGE AND RACE/ETHNICITY, SHARE OF ADULTS, HOSPITAL OF CENTRAL CONNECTICUT HSA, 2015–2021

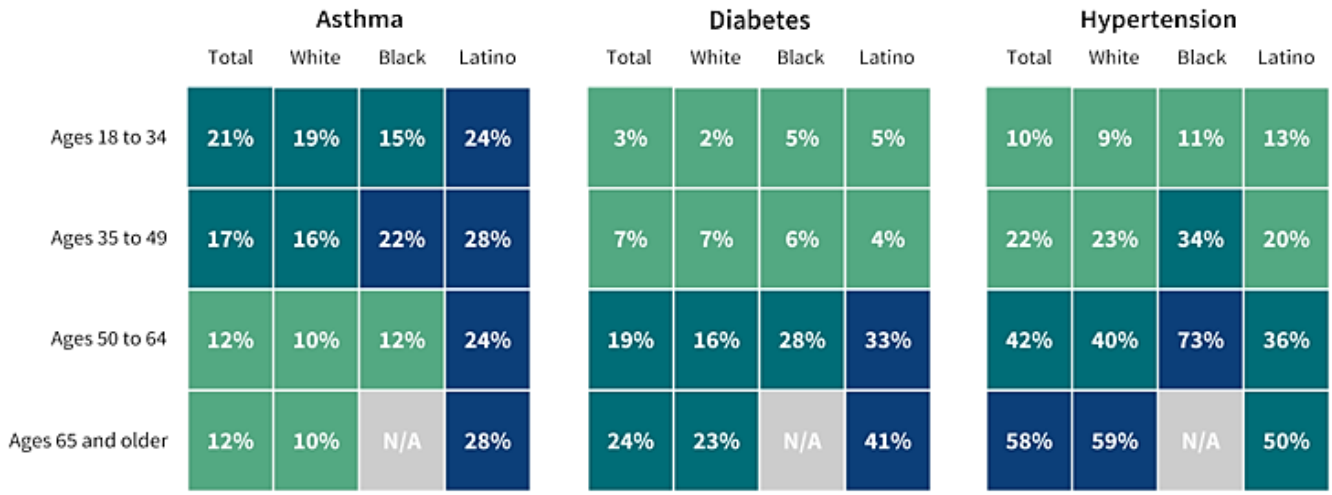
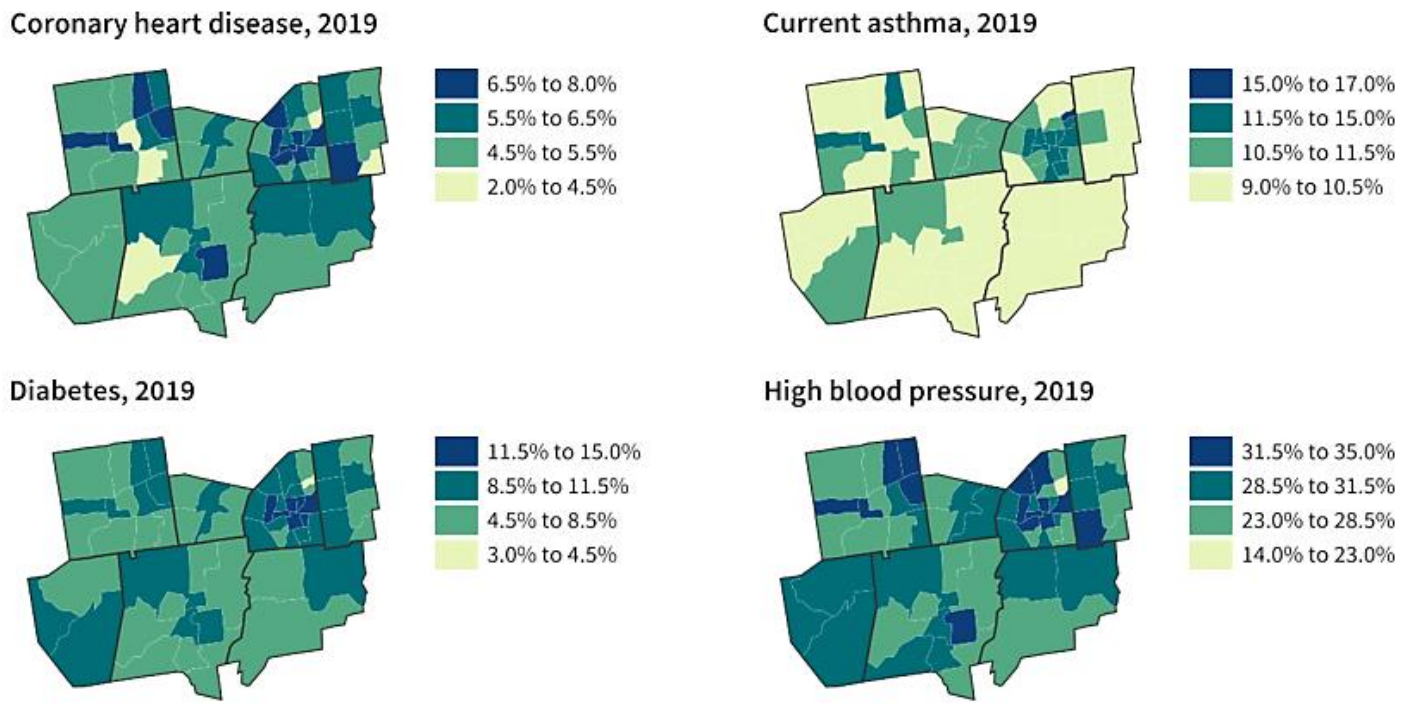


FIGURE 24: CHRONIC DISEASE PREVALENCE, SHARE OF ADULTS BY CENSUS TRACT, HOSPITAL OF CENTRAL CONNECTICUT HSA



Mental health issues like depression and anxiety can be linked to social influencers like income, employment, and environment, and can pose risks of physical health problems as well, including by complicating a person's ability to keep

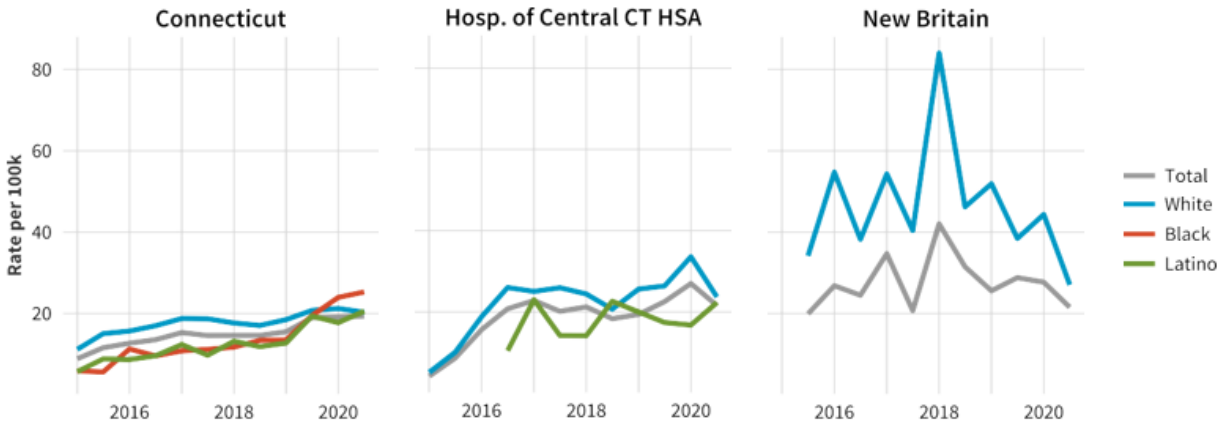
up other aspects of their health care. People of color are slightly more likely to report feeling mostly or completely anxious and being bothered by feeling depressed or hopeless. Overall, 13% of Hospital of Central Connecticut HSA adults report experiencing anxiety regularly and 9% report being bothered by depression.

TABLE 20: ELECTED MENTAL HEALTH INDICATORS, SHARE OF ADULTS, 2015–2021

	Total	White	Black	Latino	Asian	Native American
Experiencing anxiety						
Connecticut	13%	11%	15%	19%	15%	15%
Hosp. of Central CT HSA	13%	11%	13%	19%	20%	26%
New Britain	17%	16%	17%	20%	N/A	N/A
Bothered by depression						
Connecticut	9%	8%	10%	14%	9%	11%
Hosp. of Central CT HSA	9%	8%	4%	16%	27%	25%
New Britain	12%	11%	5%	17%	N/A	N/A

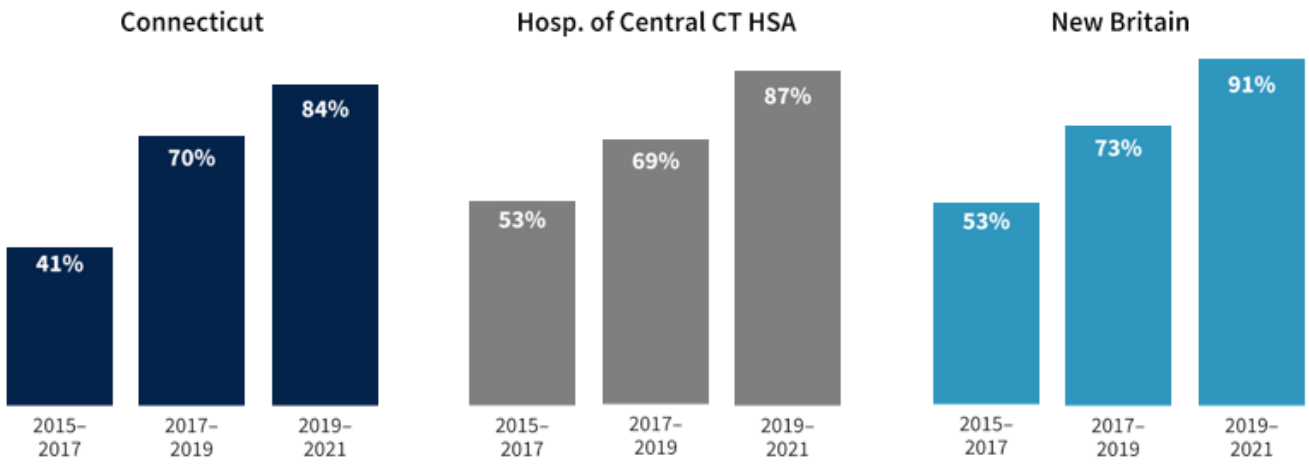
Like other states, Connecticut has seen a rise in drug overdose deaths in the last several years. In 2020, Connecticut saw an average of 113 overdose deaths per month, up from 60 in 2015. White residents long comprised the bulk of these deaths, but as overall overdose death rates have increased, an increasing share of those deaths have been people of color.

FIGURE 25: AGE-ADJUSTED SEMI-ANNUAL RATES OF DRUG OVERDOSE DEATHS PER 100,000 RESIDENTS BY RACE/ETHNICITY, 2015–2020



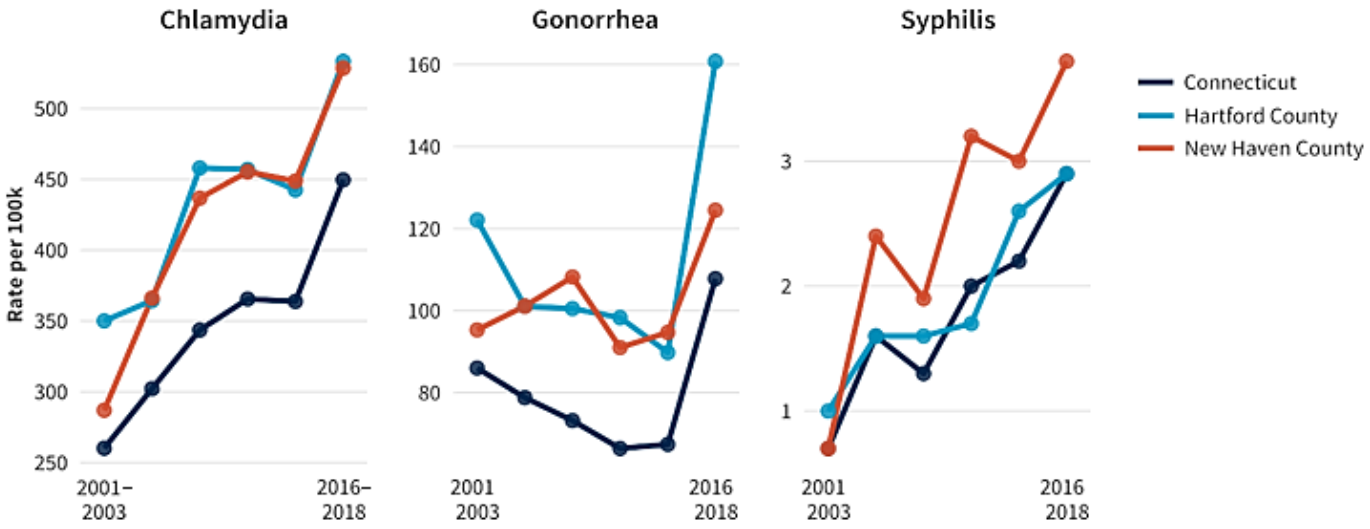
The introduction and spread of fentanyl in drugs—both with and without users' knowledge—is thought to have contributed to this steep rise in overdoses. In 2015 and 2016, 53% of the drug overdose deaths in the Hospital of Central Connecticut HSA involved fentanyl; in 2019 and 2020, this share was 87%.

FIGURE 26: SHARE OF DRUG OVERDOSE DEATHS INVOLVING FENTANYL, 2015–2020



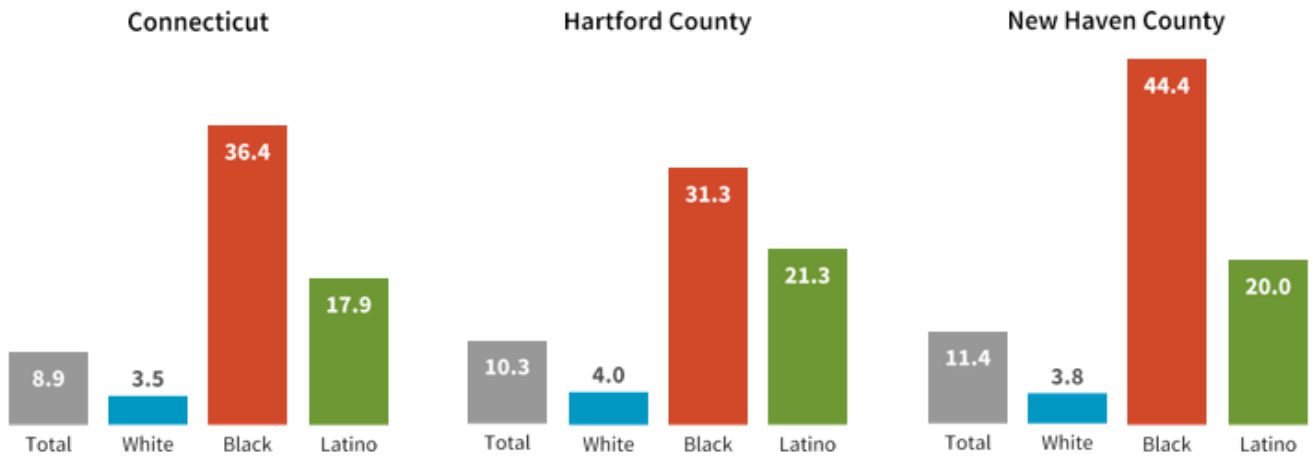
Sexually transmitted infections (STIs) can have long-term implications for health, including reproductive health problems and certain cancers, and can increase the risk of acquiring and transmitting diseases such as HIV and hepatitis C. Following nationwide trends, Connecticut has seen increases in the rates of STIs like chlamydia and gonorrhea over the past two decades. Between 2016 and 2018, Hartford County had annual average case rates of 533 new cases of chlamydia per 100,000 residents, 161 cases of gonorrhea per 100,000, and 2.9 cases of syphilis per 100,000; New Haven County had annual average case rates of 528 new cases of chlamydia per 100,000 residents, 124 cases of gonorrhea per 100,000, and 3.8 cases of syphilis per 100,000.

FIGURE 27: ANNUALIZED AVERAGE RATES OF NEW CASES OF SELECTED SEXUALLY TRANSMITTED INFECTIONS PER 100,000 RESIDENTS, 2001–2003 THROUGH 2016–2018



Like many other diseases, Connecticut's Black and Latino residents face a higher burden of HIV rates. Statewide between 2016 and 2018, Black residents ages 13 and up were more than 10 times more likely to be diagnosed with HIV than White residents.

FIGURE 28: ANNUALIZED AVERAGE RATE OF NEW HIV DIAGNOSES PER 100,000 RESIDENTS AGES 13 AND OVER, 2016–2018

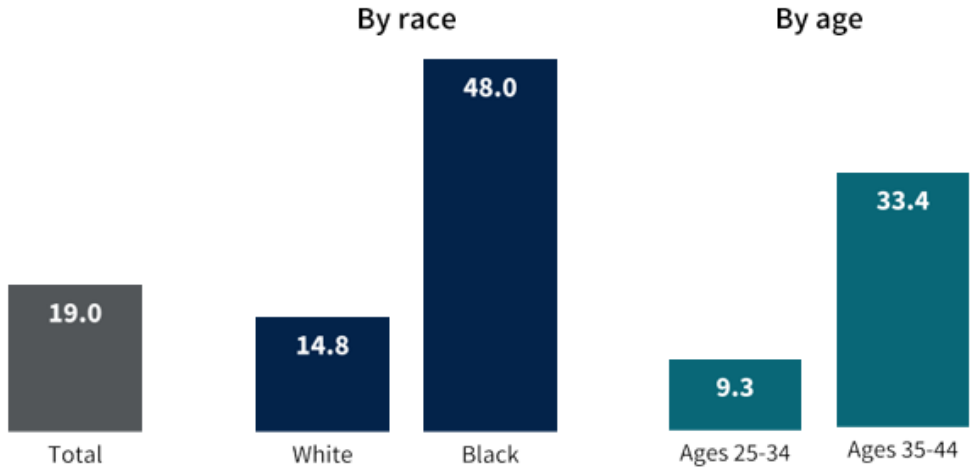


Birth outcomes often reflect health inequities for parents giving birth, and those outcomes can affect a child throughout their life. Often, parents of color have more complications related to birth and pregnancy than White parents. Complications during pregnancy or childbirth also contribute to elevated mortality among parents giving birth.

TABLE 21: SELECTED BIRTH OUTCOMES BY RACE/ETHNICITY OF PARENT GIVING BIRTH, 2016–2018

Area	Total	White	Black	Latina			Asian
				Latina (overall)	Puerto Rican	Other Latina	
Late or no prenatal care							
Connecticut	3.4%	2.5%	5.7%	4.0%	2.9%	5.1%	3.5%
Hosp. of Central CT HAS	2.7%	1.6%	6.1%	3.8%	3.3%	5.2%	3.3%
New Britain	4.0%	2.7%	7.4%	3.8%	3.1%	6.5%	N/A
Low birthweight							
Connecticut	7.8%	6.4%	12.1%	8.3%	10.2%	6.6%	8.7%
Hosp. of Central CT HAS	8.6%	7.4%	11.2%	10.0%	10.8%	9.9%	N/A
New Britain	10.1%	8.4%	11.2%	10.6%	10.8%	N/A	N/A
Infant mortality (per 1k live births)							
Connecticut	4.6	3.1	9.5	5.0	N/A	N/A	N/A
Hosp. of Central CT HSA	5.0	4.5	10.9	3.9	N/A	N/A	N/A
New Britain	6.2	N/A	14.3	5.1	N/A	N/A	N/A

FIGURE 29: MATERNAL MORTALITY RATE PER 100K BIRTHS, CONNECTICUT, 2013–2017



Children under 7 years old are monitored annually for potential lead poisoning, based on having blood-lead levels in excess of the state's accepted threshold. Between 2013 and 2017, 1.9% of children tested in the Hospital of Central Connecticut HSA were found to have elevated blood lead levels. Children living in homes built before 1960 are at a higher risk of potential lead poisoning due to the more widespread use of lead-based paints in older homes. Black and Latino households are slightly more likely to live in structures built before 1960.

TABLE 22: HOUSEHOLDS LIVING IN STRUCTURES BUILT BEFORE 1960 BY RACE/ETHNICITY OF HEAD OF HOUSEHOLD (WITH PROXY AREA), 2019

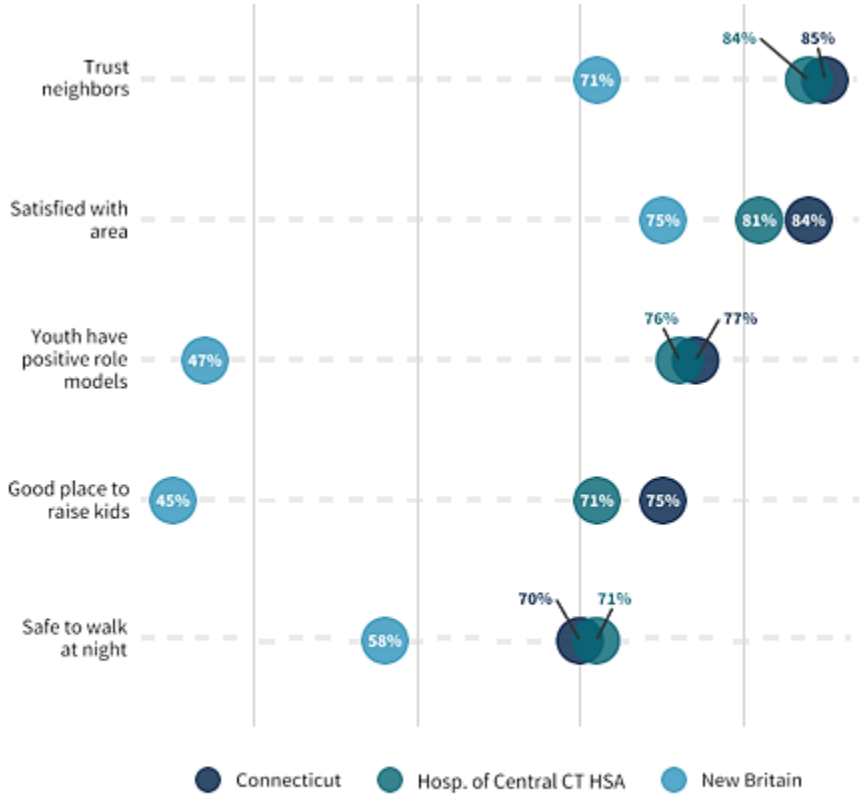
Area	Total		White		Black		Latino		Other race	
	Count	Share	Count	Share	Count	Share	Count	Share	Count	Share
Connecticut	580,941	42%	399,512	40%	63,552	49%	93,011	53%	24,866	32%
Hosp. of Central CT HSA	56,322	41%	41,915	40%	3,027	49%	9,414	53%	1,966	27%

CIVIC LIFE & COMMUNITY COHESION

Beyond individual health, several

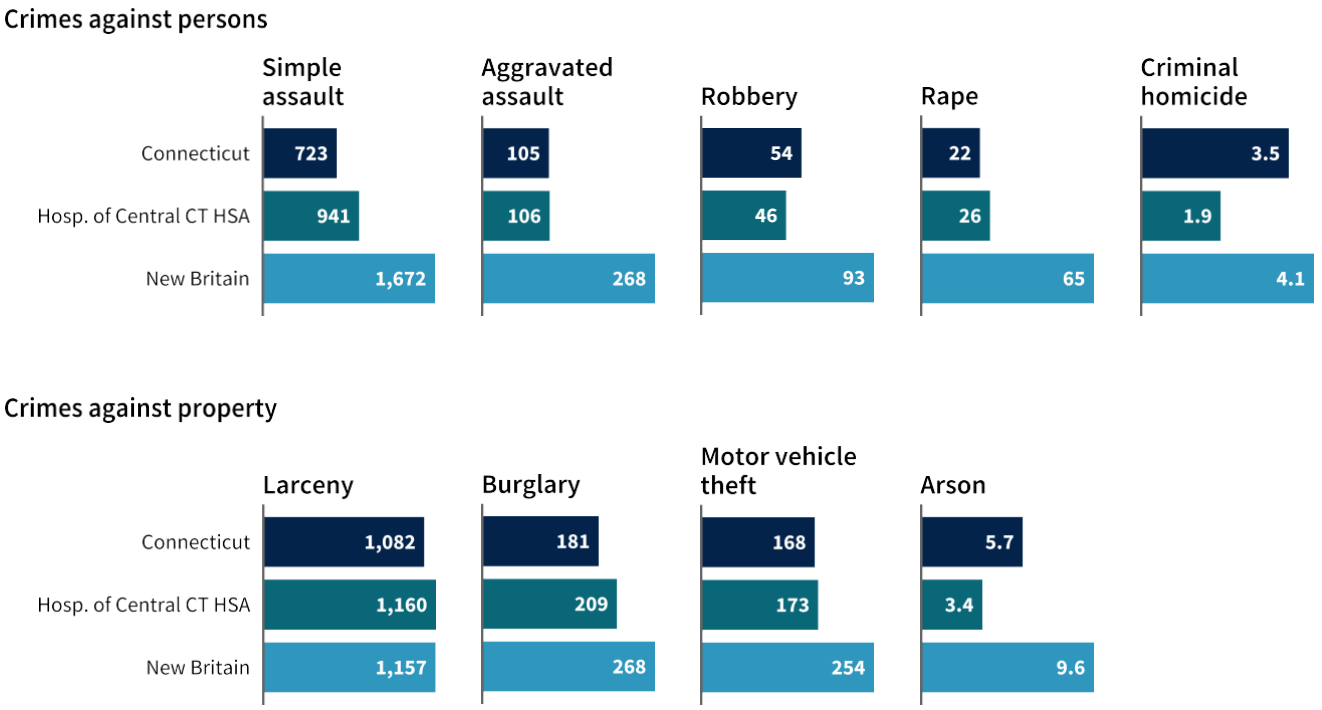
measures from the DataHaven Community Wellbeing Survey show how local adults feel about the health of their neighborhoods. High quality of life and community cohesion can positively impact resident well-being through the availability of resources, sense of safety, and participation in civic life. For example, adults who see the availability of role models in their community may enroll their children in extracurricular activities that benefit them educationally and socially; residents who know and trust their neighbors may find greater social support. Overall, 81% of Hospital of Central Connecticut HSA adults reported being satisfied with the area where they live.

FIGURE 30: RESIDENTS' RATINGS OF COMMUNITY COHESION MEASURES, SHARE OF ADULTS, 2015–2021



Crime rates per 100,000 residents are based on reports to law enforcement of violent force against persons, as well as offenses involving property. Not all crimes involve residents of the areas where the crimes occur, which is important to consider when evaluating crime rates in areas or towns with more commercial activity. Crime patterns can also vary dramatically by neighborhood. Crime can impact the social and economic well-being of communities, including through negative health effects.

FIGURE 31: PART I CRIME RATES PER 100,000 RESIDENTS BY TOWN/JURISDICTION, 2019



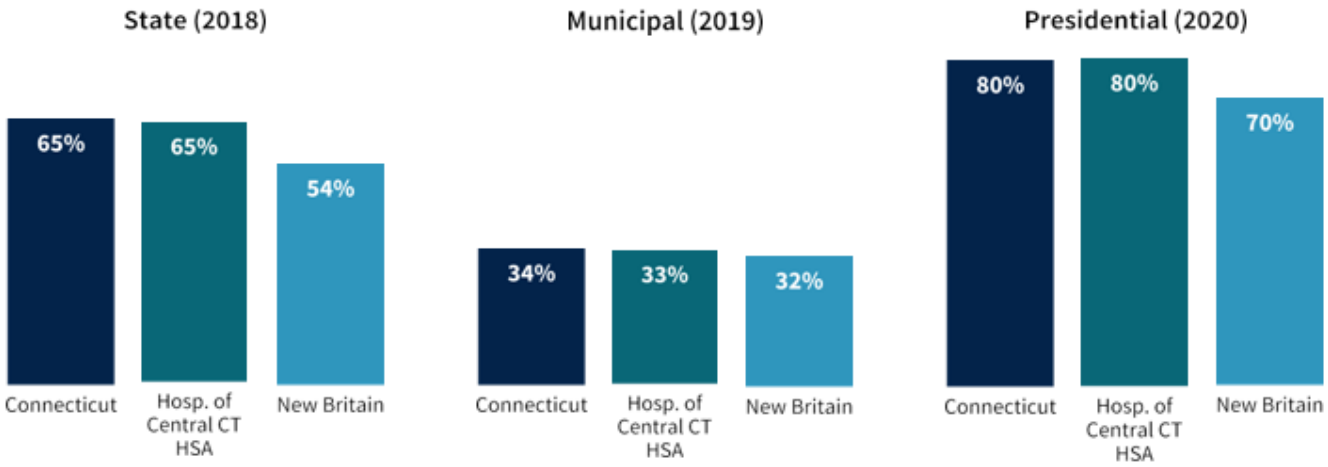
A lack of trust in and engagement with local government and experiences of unfair treatment by authorities can impair community well-being and cohesion. Fifty percent of Hospital of Central Connecticut HSA adults feel their local government is responsive to residents' needs, compared to 53% statewide.

TABLE 23: RESIDENTS' RATINGS OF LOCAL GOVERNMENT, SHARE OF ADULTS, 2015–2021

Area	Local govt is responsive	Have some influence over local govt
Connecticut	53%	67%
Hospital of Central Connecticut HAS	50%	65%
New Britain	42%	61%

During the 2020 presidential election, 80% of registered voters in the Hospital of Central Connecticut HSA cast ballots, as did 80% statewide. Seventy-nine percent of area voters voted in the 2016 presidential election.

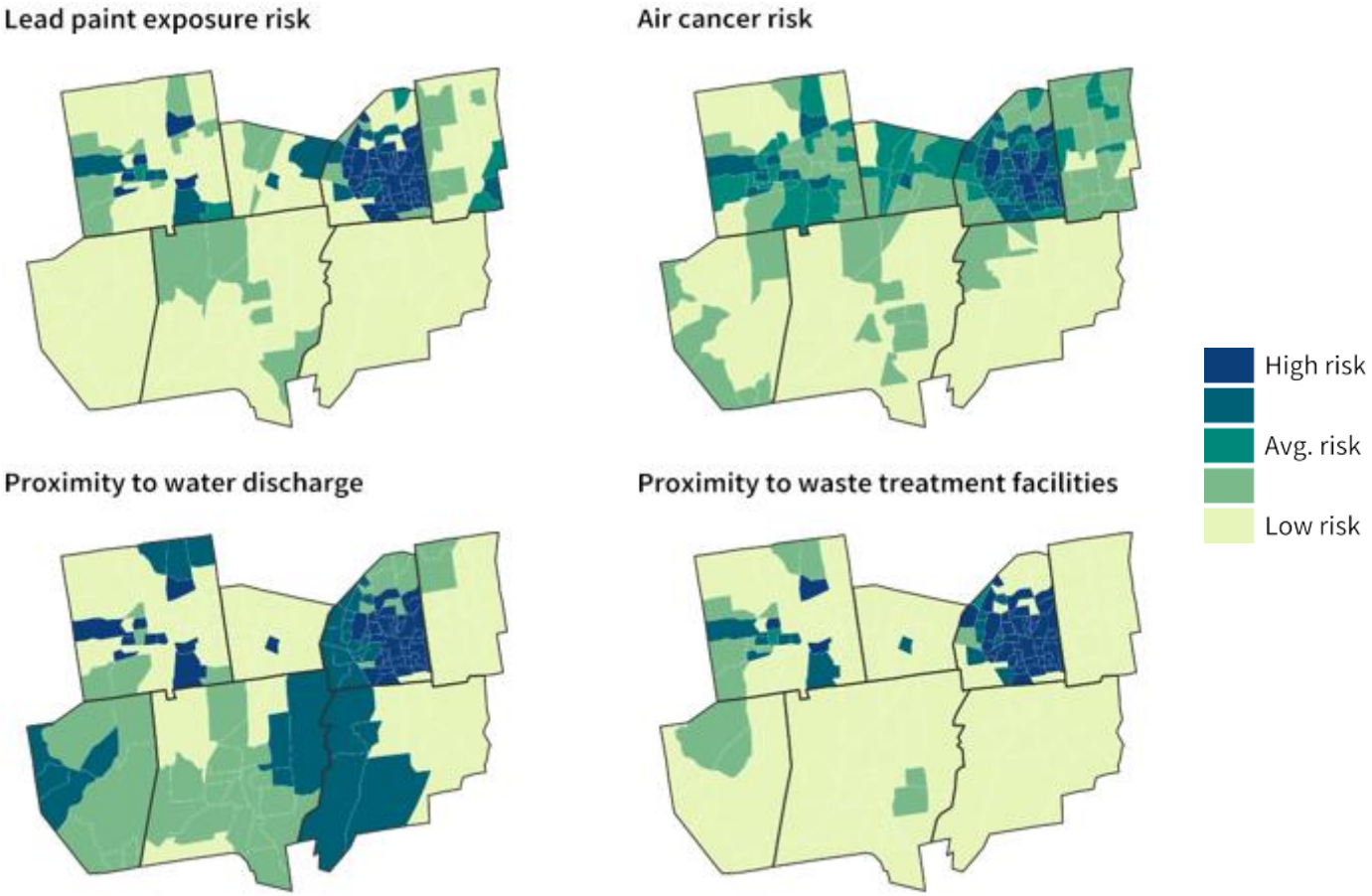
FIGURE 32: REGISTERED VOTER TURNOUT, 2018–2020



ENVIRONMENT & SUSTAINABILITY

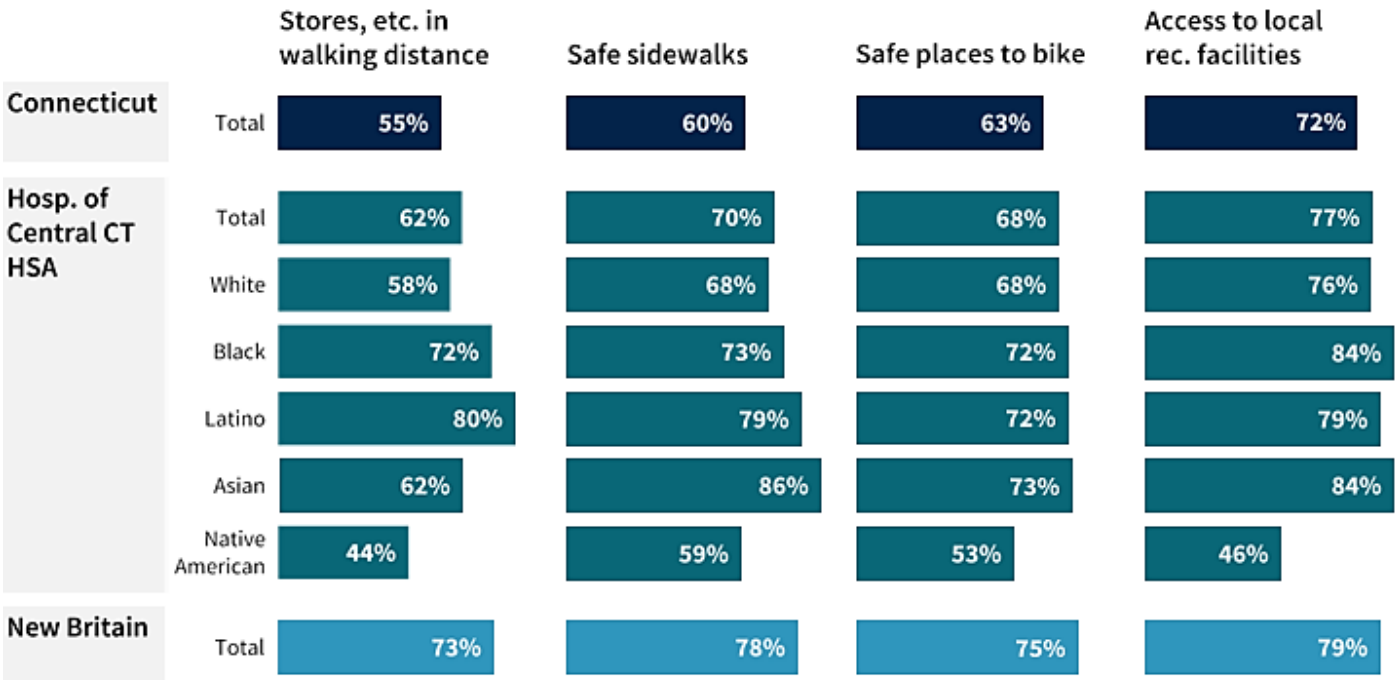
Many environmental factors—from access to outdoor resources to tree canopy to exposure to pollutants—can have direct impacts on residents' health and quality of life. Environmental justice is the idea that these factors of built and natural environments follow familiar patterns of socioeconomic disparities and segregation. The federal Environmental Protection Agency (EPA) ranks small areas throughout the US on their risks of exposure to a variety of pollutants and hazards, scaled to account for the historically disparate impact of these hazards on people of color and lower-income people.

FIGURE 33: EPA ENVIRONMENTAL JUSTICE INDEX BY BLOCK GROUP, HOSPITAL OF CENTRAL CONNECTICUT HSA



High-quality built environment resources, such as recreational facilities and safe sidewalks, help keep residents active and bring communities together. Walkable neighborhoods may also encourage decreased reliance on cars. Throughout Connecticut, Black and Latino residents are largely concentrated in denser urban areas which tend to offer greater walkability. Of adults in the Hospital of Central Connecticut HSA, 62% report having stores, banks, and other locations they need in walking distance, higher than the share of adults statewide.

FIGURE 34: RESIDENTS' RATINGS OF LOCAL WALKABILITY MEASURES BY RACE/ETHNICITY, SHARE OF ADULTS, 2015–2021



NOTES

Figure 1. Study area. Map tiles by Stamen Design, under CC BY 3.0. Data by OpenStreetMap, under ODbL.

Table 1. About the area. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates. Available at https://data.census.gov; US Census Bureau 2020 Decennial Census P.L. 94-171 Redistricting Data. Available at https://www.census.gov/programs-surveys/decennial-census/about/rdo.html; PLACES Project. Centers for Disease Control and Prevention. Available at https://www.cdc.gov/places; and National Center for Health Statistics. U.S. Small-Area Life Expectancy Estimates Project (USALEEP): Life Expectancy Estimates Files, 2010–2015. National Center for Health Statistics. 2018. Available at https://www.cdc.gov/nchs/nvss/usaleep/usaleep.html

Table 2. Population by race/ethnicity, 2020. US Census Bureau 2020 Decennial Census P.L. 94-171 Redistricting Data.

Figure 2. Population by race/ethnicity and age group, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Figure 3. Linguistic isolation by race/ethnicity, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Table 3. Population and population change by age group, 2010–2020. US Census Bureau 2010 & 2020 Decennial Census P.L. 94-171 Redistricting Data.

Figure 4. Share of population by race/ethnicity, 2010–2020. US Census Bureau 2010 & 2020 Decennial Census P.L. 94-171 Redistricting Data.

Table 4. Homeownership rate by race/ethnicity of head of household, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Figure 5. Homeownership rates by age and race/ethnicity of head of household, Hospital of Central Connecticut HSA (proxy area), 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year public use microdata sample (PUMS) data, accessed via IPUMS. Steven Ruggles, Sarah Flood, Sophia Foster, Ronald Goeken, Jose Pacas, Megan Schouweiler and Matthew Sobek. IPUMS USA: Version 11.0 [dataset]. Minneapolis, MN: IPUMS, 2021. https://doi.org/10.18128/D010.V11.0

Figure 6. Housing cost burden rates by race/ethnicity (with proxy area), 2019. DataHaven analysis (2021) of Ruggles, et al. (2019).

Table 5. Overcrowded households by race/ethnicity of head of household, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Figure 7. Public K–12 student enrollment by race/ethnicity per 100 students, 2019–2020. DataHaven analysis (2021) of 2019– 2020 school year enrollment data from the Connecticut State Department of Education, accessed via EdSight at http://edsight.ct.gov At the school district level, not all groups may be shown due to CTSDE data suppression rules for small enrollment counts, even though they may represent more than 1% of the school district population.

Figure 8. Selected academic and disciplinary outcomes by student race/ethnicity, 2018–2019. DataHaven analysis (2021) of 2018–2019 school year Smarter Balanced Assessment Consortium (SBAC) testing (8th grade English/language arts), discipline, and four-year graduation data from the Connecticut State Department of Education, accessed via EdSight. Because students can be suspended more than once in a school year, the suspension rate is given as the number of reported suspensions per 1,000 enrolled students rather than a percentage.

Figure 9. Educational attainment by race/ethnicity, share of adults ages 25 and up, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Table 6. Jobs and wages in Hospital of Central Connecticut HSA's 5 largest sectors, 2019. DataHaven analysis (2021) of annual employment data from the Connecticut Department of Labor. Note that in some cases, especially for smaller towns or where data were deemed unreliable for whatever reason, data have been suppressed by the department. In a few cases, that may mean large sectors in an area are missing from the analysis here. Available at https://www1.ctdol.state.ct.us/lmi/202/202 _annualaverage.asp

Figure 10. Median income by race/ethnicity and sex for full-time workers ages 25 and over with positive income, 2019. DataHaven analysis (2021) of Ruggles, et al. (2019).

Figure 11. Unemployment rate by race/ethnicity, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Figure 12. Median household income by race/ethnicity of head of household, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Table 7. Selected household economic indicators by race/ethnicity of head of household, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Table 8. Households with no vehicle at home by race/ethnicity of head of household (with proxy area), 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Figure 13. Distribution of population by neighborhood income level, Hospital of Central Connecticut HSA, 1980–2019. DataHaven analysis (2021) of household income and population by Census tract. Values for 1980–2000 are from the US Census Bureau Decennial Census, provided by the Neighborhood Change Database (NCDB) created by GeoLytics and the Urban Institute with support from the Rockefeller Foundation (2012). 2019 values are calculated from US Census Bureau American Community Survey 2019 5-year estimates.

Figure 14. Life expectancy, Hospital of Central Connecticut HSA by Census tract, 2015. Data from National Center for Health Statistics. U.S. Small-Area Life Expectancy Estimates Project (USALEEP): Life Expectancy Estimates Files, 2010–2015. National Center for Health Statistics. 2018. Available at https://www.cdc.gov/nchs/nvss/usaleep/usaleep.html

Figure 15. Uninsured rate among adults ages 19–64 by race/ethnicity, 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Figure 16. Preventive care measures, share of adults by Census tract, Hospital of Central Connecticut HSA. Data from PLACES Project. Centers for Disease Control and Prevention.

Figure 17. Selected health risk factors, share of adults, 2015–2021. DataHaven analysis (2021) of 2015, 2018, and 2021 DataHaven Community Wellbeing Survey. Available at https://ctdatahaven.org/reports/datahaven-community-wellbeing-survey

Figure 18. Selected health indicators by age and race/ethnicity, share of adults, Hospital of Central Connecticut HSA, 2015–2021. DataHaven analysis (2021) of 2015, 2018, and 2021 DataHaven Community Wellbeing Survey.

Figure 19. Chronic disease prevalence, share of adults by Census tract, Hospital of Central Connecticut HSA. Data from PLACES Project. Centers for Disease Control and Prevention.

Table 9. Selected mental health indicators, share of adults, 2015–2021. DataHaven analysis (2021) of 2015, 2018, and 2021 DataHaven Community Wellbeing Survey.

Figure 20. Age-adjusted semi-annual rates of drug overdose deaths per 100,000 residents by race/ethnicity, 2015–2020. DataHaven analysis (2021) of Accidental Drug Related Deaths 2012–2018. Connecticut Office of the Chief Medical Examiner. Available at https://data.ct.gov/resource/rybz-nyjw. Rates are weighted with the U.S. Centers for Disease Control and Prevention (CDC) 2000 U.S. Standard Population 18 age group weights available at https://seer.cancer.gov/stdpopulations

Figure 21. Share of drug overdose deaths involving fentanyl, 2015–2020. DataHaven analysis (2021) of Accidental Drug Related Deaths 2012–2018. Connecticut Office of the Chief Medical Examiner.

Figure 22. Annualized average rates of new cases of selected sexually transmitted infections per 100,000 residents, 2001– 2003 through 2016–2018. DataHaven analysis (2021) of data from Centers for Disease Control and Prevention. NCHHSTP AtlasPlus. Updated 2019. https://www.cdc.gov/nchhstp/atlas/index.htm

Figure 23. Annualized average rate of new HIV diagnoses per 100,000 residents ages 13 and over, 2016–2018. DataHaven analysis (2021) of data from Centers for Disease Control and Prevention. NCHHSTP AtlasPlus.

Table 10. Selected birth outcomes by race/ethnicity of parent giving birth, 2016–2018. DataHaven analysis (2021) of data from the Connecticut Department of Public Health Vital Statistics. Retrieved from https://portal.ct.gov/DPH/Health-Information-Systems--Reporting/Hisrhome/Vital-Statistics-Registration-Reports

Figure 24. Maternal mortality rate per 100k births, Connecticut, 2013–2017. America's Health Rankings analysis of CDC WONDER Online Database, Mortality files, United Health Foundation. Retrieved from https://www.americashealthrankings.org

Table 11. Households living in structures built before 1960 by race/ethnicity of head of household (with proxy area), 2019. DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates.

Figure 25. Residents' ratings of community cohesion measures, share of adults, 2015–2021. DataHaven analysis (2021) of 2015, 2018, and 2021 DataHaven Community Wellbeing Survey.

Figure 26. Part I crime rates per 100,000 residents by town/jurisdiction, 2019. DataHaven analysis (2021) of 2019 Crimes Analysis Offenses. Connecticut Department of Emergency Services and Public Protection. Available at https://portal.ct.gov/DESPP/Division-of-State-Police/Crimes-Analysis-Unit/Crimes-Analysis-Unit

Table 12. Residents' ratings of local government, share of adults, 2015–2021. DataHaven analysis (2021) of 2015, 2018, and 2021 DataHaven Community Wellbeing Survey.

Figure 27. Registered voter turnout, 2018–2020. DataHaven analysis (2021) of data from the Connecticut Office of the Secretary of the State Elections Management System. Available at https://ctemspublic.pcctg.net

Figure 28. EPA Environmental Justice Index by block group, Hospital of Central Connecticut HSA. United States Environmental Protection Agency. 2019 version. EJSCREEN. Retrieved from https://www.epa.gov/ejscreen

Figure 29. Residents' ratings of local walkability measures by race/ethnicity, share of adults, 2015–2021. DataHaven analysis (2021) of 2015, 2018, and 2021 DataHaven Community Wellbeing Survey.

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Visit DataHaven (ctdatahaven.org) for more information. This report was authored by Camille Seaberry, Kelly Davila, and Mark Abraham of DataHaven.

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About DataHaven

DataHaven is a nonprofit organization with a 25-year history of public service to Connecticut. Our mission is to empower people to create thriving communities by collecting and ensuring access to data on well-being, equity, and quality of life.

DataHaven is a formal partner of the National Neighborhood Indicators Partnership of the Urban Institute in Washington, D.C.

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Appendix 3: Previous CHNA Priority Needs & Activities to Address Them

Hospital of Central Connecticut Impact Statement 2022

Healthy Community/Lifestyles

Community collaboration:

Sustained community provider networks and promoted healthy behaviors and lifestyles. Expand racial justice initiatives.

Impact:

Support Community Education - 9 talks—243 attendees

New Britain – Sustained the provider network and expanded to include Racial Justice.

Bristol – Participates in Central CT Chamber of Commerce Health & Wellness Committee and Bristol Cares (A collaboration of Health & Human Service Organizations chaired by the City of Bristol Mayor).

Southington – Participates in Chamber of Commerce Health & Wellness Committee. Revived Activate Southington (A collaboration of Health & Human Services Organizations focused on improving health & wellness within the town of Southington)

Plainville – Participates in Healthy Plainville (A collaboration of Health & Human Services organizations). Participates in Plainville Anti-Racism collaboration.

Berlin – Participates in ACHIEVE (Central CT Health District for which the town of Berlin is a part of. We have added a Behavioral Health representative to their Substance Abuse and Behavioral health subcommittee.

Breast Cancer:

- Increase number of screening mammograms completed in the community
  Impact: 6,031 mammograms were completed

- Increase number of screening breast ultrasounds completed in the community
  Impact: 1,311 screenings were completed

- Increase number of patients screened for hereditary cancer risk through radiology
  Impact: 5,277 questionnaires were completed.

Healthy Living:

- Sponsorship Support to Farmer's Markets
- Sponsorship Support of 5K's, Community Walking Initiatives & Road Races
- 5-2-1-0 Healthy Living Program (5 servings –fruits and vegetables, 2 hrs. or less of recreational screen time, 1 hr. of exercise, 0 sugary drinks) in a pilot with early childhood providers.

  Impact: Provided training of 5-2-1-0 for the Southington Early Childcare group to promote healthy behaviors and lifestyles. COVID brought it to a halt. Looking to re- start it after the pandemic.

Behavioral Health:

- **Focus on building the H.O.P.E. (Heroin and Opioid Prevention Education) treatment path program** for those with heroin/opiate addiction with area police departments.

  Impact: The H.O.P.E. program was implemented in 2019.
  - Increase HOPE referrals for outpatient services – 15 Referrals (as of 2/1/22)

- **Fostering community care teams (CCTs)**, community-based organizations to review the cases and make referrals for those patients who have frequent emergency department visits and may have other health and social needs.

  Impact:
  - Increase community care team participation. 7 Referrals (as of 2/1/22)
  - Increase referrals to recovery coaches. 159 Referrals (as of 2/1/22)
  - Launch New Britain Recovers for medical detox beds (In building phase)

Appendix 4: Resources

This section identifies other facilities, clinics, and resources available in the Hospital of Central Connecticut community that are available to address community health needs.

Hospitals

The following table presents information on hospital facilities located in Hartford County.

Hospitals Located in Hartford County, 2021

Name	Hospital Type	City	ZIP Code
Bristol Hospital, Inc.	General Hospital	Bristol	06010
Connecticut Children's Medical Center	Children's Hospital	Hartford	06106
Hospital of Central Connecticut, The	General Hospital	Hartford	06106
Hebrew Senior Care	Hospital for Mentally Ill Persons	West Hartford	06117
Hospital for Special Care	Chronic Disease Hospital	New Britain	06053
Hospital of Central Connecticut, The	General Hospital	New Britain	06052
John Dempsey Hospital of the University Of Connecticut Health Center	General Hospital	Farmington	06032
Manchester Memorial Hospital	General Hospital	Manchester	06040
Mount Sinai Rehabilitation Hospital, Inc.	Chronic Disease Hospital	Hartford	06112
Saint Francis Hospital And Medical Center	General Hospital	Hartford	06105

Source: State of Connecticut eLicense web portal, 2021.

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are established to promote access to ambulatory care in areas designated as "medically underserved." These clinics provide primary care, mental health, and dental services for lower-income members of the community. FQHCs receive enhanced reimbursement for Medicaid and Medicare services and most also receive federal grant funds under Section 330 of the Public Health Service Act. There currently are 42 FQHC sites operating in the HOCC HSA.

Federally Qualified Health Centers Located in the Hospital HSA, 2020

Name	Address	City	ZIP Code
Jefferson Elementary School SBHC	140 Horseplain Rd	New Britain	06053
Bristol Technical High School	431 Minor St	Bristol	06010
Stafford School	212 Louisiana Ave	Bristol	06010
West Bristol School	500 Clark Ave	Bristol	06010
Ivy Drive School	160 Ivy Dr	Bristol	06010
Mountain View School	71 Vera Rd	Bristol	06010
Frank J Diloreto Elementary School SBHC	732 Slater Rd	New Britain	06053
Bristol Central High School	480 Wolcott St	Bristol	06010
Health & Wellness Center - Admin	74 East St	Plainville	06062
Northend Elementary School SBHC	160 Bassett St	New Britain	06051
Northeast Middle School	530 Stevens St	Bristol	06010
SouthSide School	21 Tuttle Rd	Bristol	06010
Roosevelt Middle School SBHC	40 Goodwin St	New Britain	06051
Friendship Service Center of New Britain	241 Arch St	New Britain	06051
Edgewood School	345 Mix St	Bristol	06010
Brookside School SBHC	505 S Main St	New Britain	06051
Smith Elementary School SBHC	142 Rutherford St	New Britain	06051
Gaffney Elementary School - SBHC	322 Slater Rd	New Britain	06053
Smalley Academy SBHC	175 West St	New Britain	06051
Bristol Preparatory Academy	210 Redstone Hill Rd	Bristol	06010
Vance Elementary School SBHC	183 Vance St	New Britain	06052
Wheeler Health and Wellness Center	10 N Main St	Bristol	06010
Plainville Family Health and Wellness Center	91 Northwest Dr	Plainville	06062
Chamberlain Elementary School SBHC	120 Newington Ave	New Britain	06051
Goodwin Technical High School SBHC	735 Slater Rd	New Britain	06053
Wheeler Health & Wellness Center - New Britain	75 N Mountain Rd	New Britain	06053
Community Health Center of Bristol	395 N Main St	Bristol	06010
East Side Community Center - YWCA	600 East St	New Britain	06051
WYA at Prudence Crandall Center		New Britain	06050
New Britain High School - SBHC	110 Mill St	New Britain	06051
Pulaski Middle School	757 Farmington Ave	New Britain	06053
Chippens Hill Middle School	551 Peacedale St	Bristol	06010
Community Health Center Of New Britain	1 Lafayette St	New Britain	06051
Holmes Elementary School SBHC	2150 Stanley St	New Britain	06053
Lincoln Elementary School SBHC	145 Steele St	New Britain	06052
Slade Middle School SBHC	183 Steele St	New Britain	06052
Hubbell School	90 W Washington St	Bristol	06010
Bristol Eastern High School	632 King St	Bristol	06010
Bristol Preparatory Academy/Adult Education Center SBHC	210 Redstone Hill Rd Ste 5	Bristol	06010
Bristol Central High School SBHC	480 Wolcott St	Bristol	06010
Greene-Hills School	718 Pine St	Bristol	06010
Bristol Health & Wellness Behavioral Health Center	225 N Main St	Bristol	06010

Source: HRSA, 2021.

Appendix 5: Neighborhood Disinvestment & Gentrification Maps

As noted in the body of the CHNA, neighborhood disinvestment and gentrification present significant risks or threats to lower income communities while simultaneously offering some economic opportunities (e.g., through Economic Opportunity Zones and similar programs). Disinvestment is the withdrawal of investment from communities by business owners, investors, and others. They no longer work to improve schools, neighborhoods, businesses, or the general community. Eventually, a lack of investment degrades the infrastructure needed to support the community.

The National Community Reinvestment Coalition conducted a recent study[13] that analyzed the impact of Opportunity Zones on neighborhood disinvestment and gentrification. Generally, areas that are eligible for gentrification are at-risk of neighborhood disinvestment. In addition, when (or if) economic expansion is attracted via some form of gentrification, existing residents are often faced with accelerating apartment rental fees, higher property taxes, and similar, related issues.

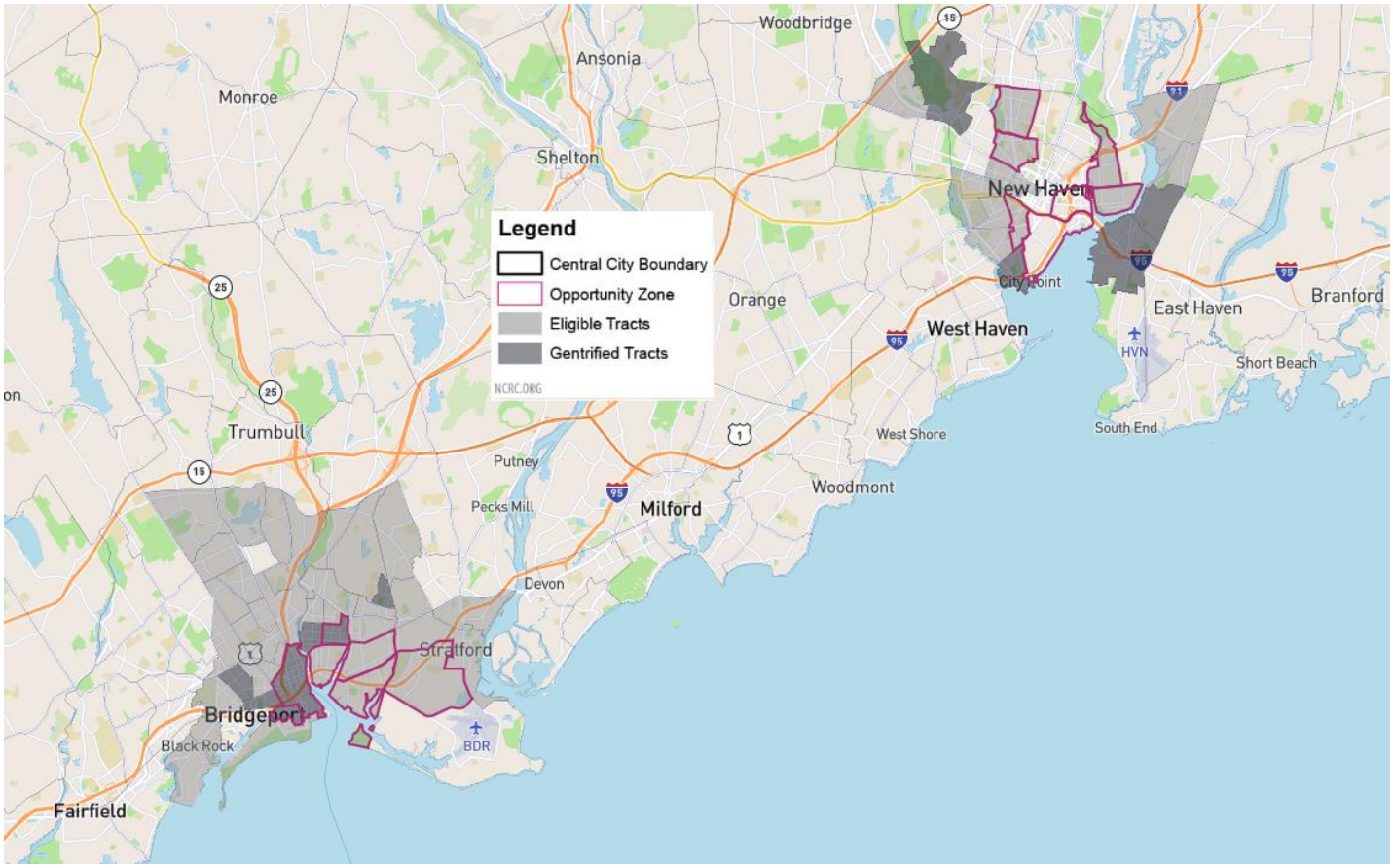
The results of the national study identified 11 Connecticut cities in which gentrification had taken place (2012 to 2017) or was eligible to do so based on the following criteria:

Opportunity Zones (OZs) – created under the Tax Cuts and Jobs Act of 2017 – are a U.S. Federal Government economic tool that incentivizes people to invest in economically challenged areas. Their purpose is to raise local income and accelerate economic growth and job creation in low-income neighborhoods while providing tax benefits to investors.

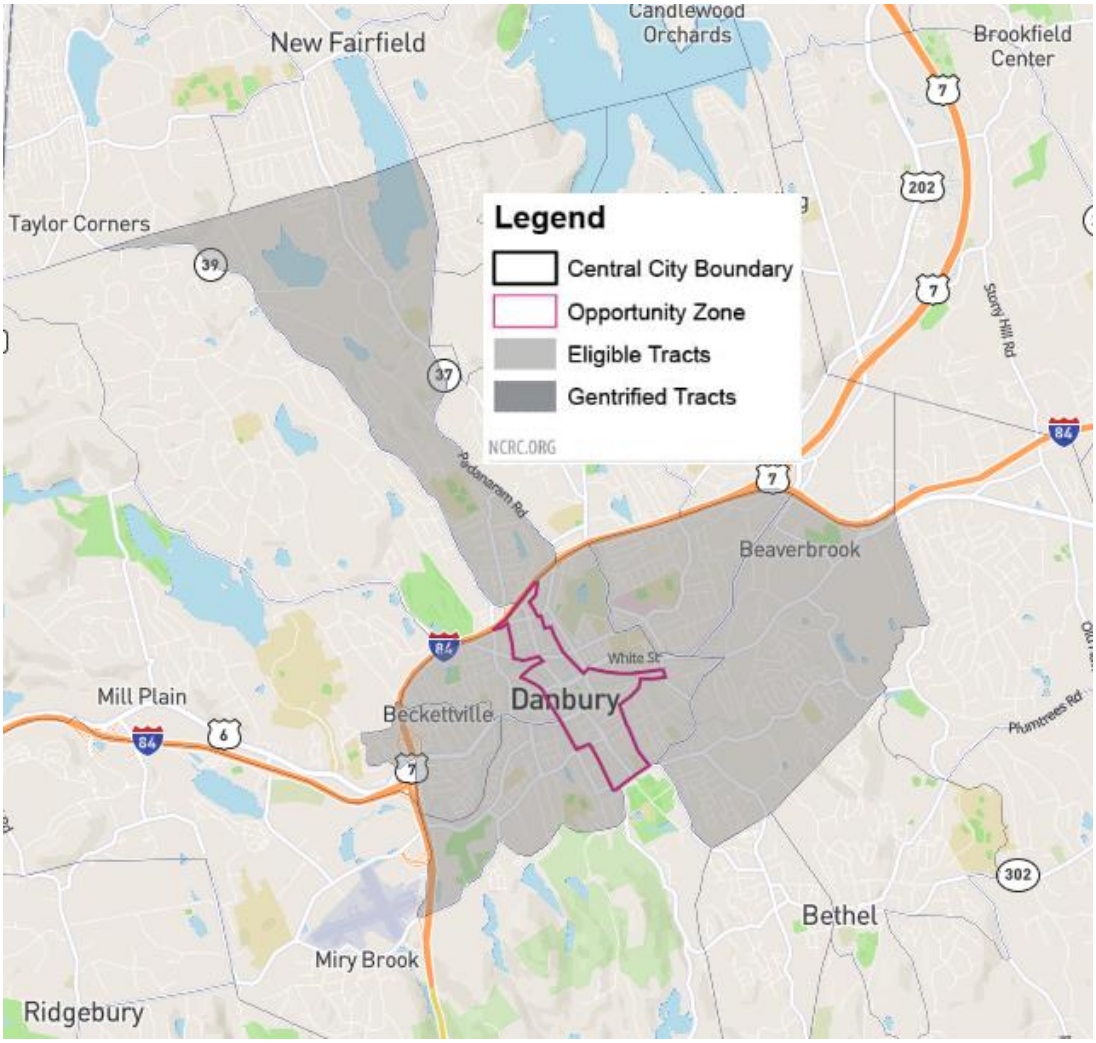
Maps of each site are shown below.

[13] National Community Reinvestment Coalition, "Gentrification and Disinvestment 2020", Available at https://ncrc.org/gentrification20/

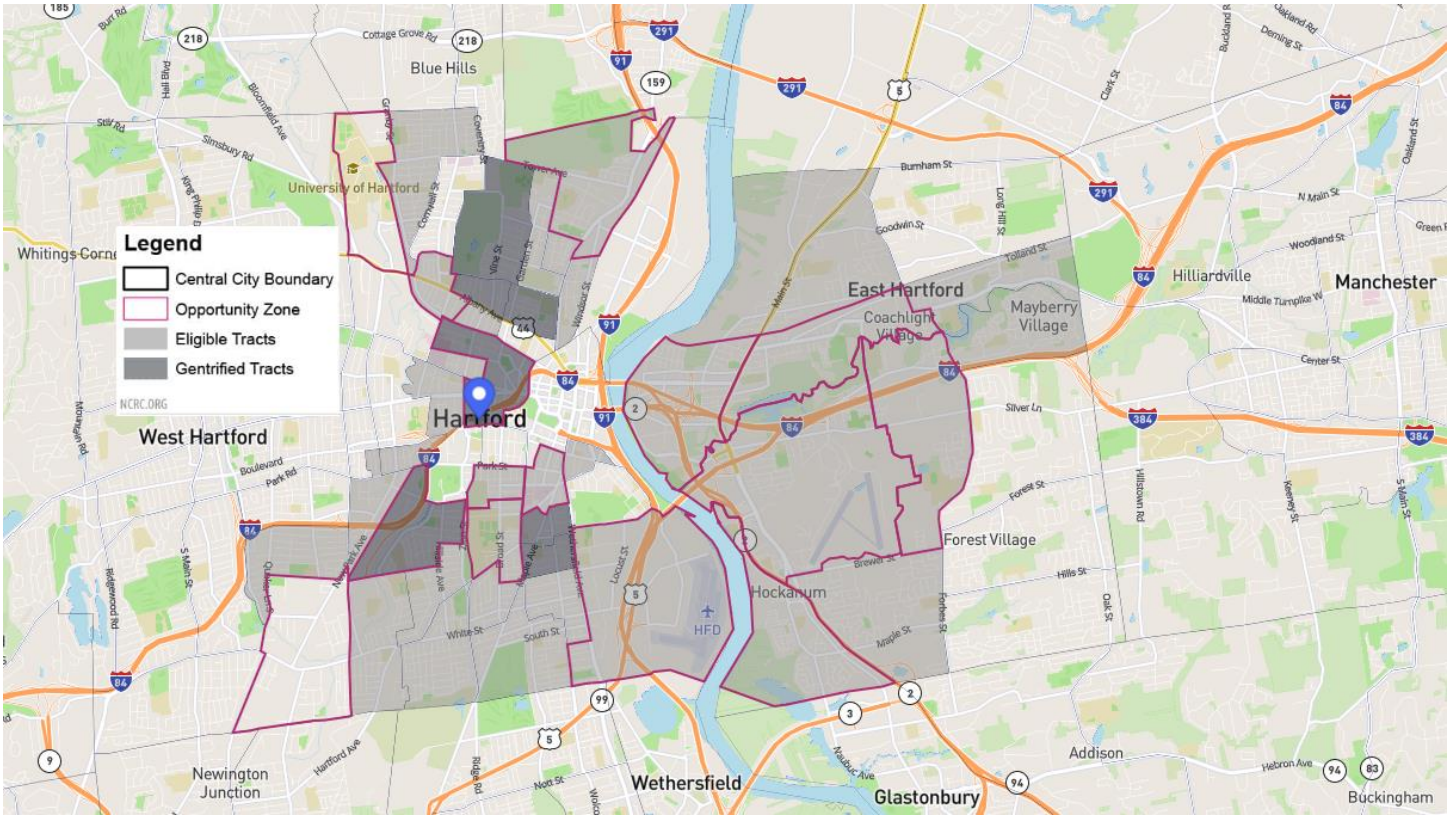
Bridgeport and New Haven



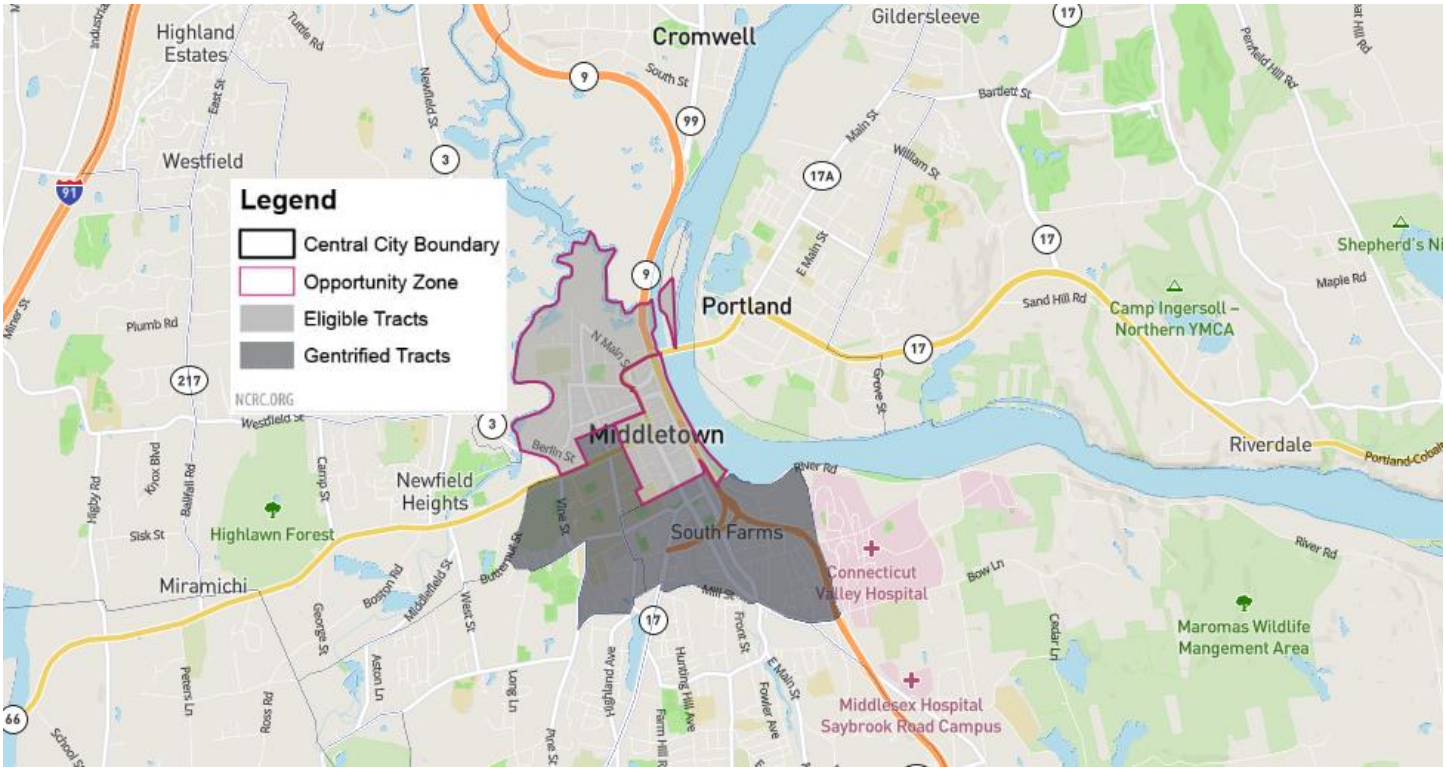
Danbury


Legend
Central City Boundary
Opportunity Zone
Eligible Tracts
Gentrified Tracts
NCRC.ORG
New Fairfield
Candlewood Orchards
Brookfield Center
Taylor Corners
Beaverbrook
Danbury
Beckettville
Mill Plain
Miry Brook
Ridgebury
Bethel
White St
Padanaram Rd
Story Hill Rd
Plumtrees Rd

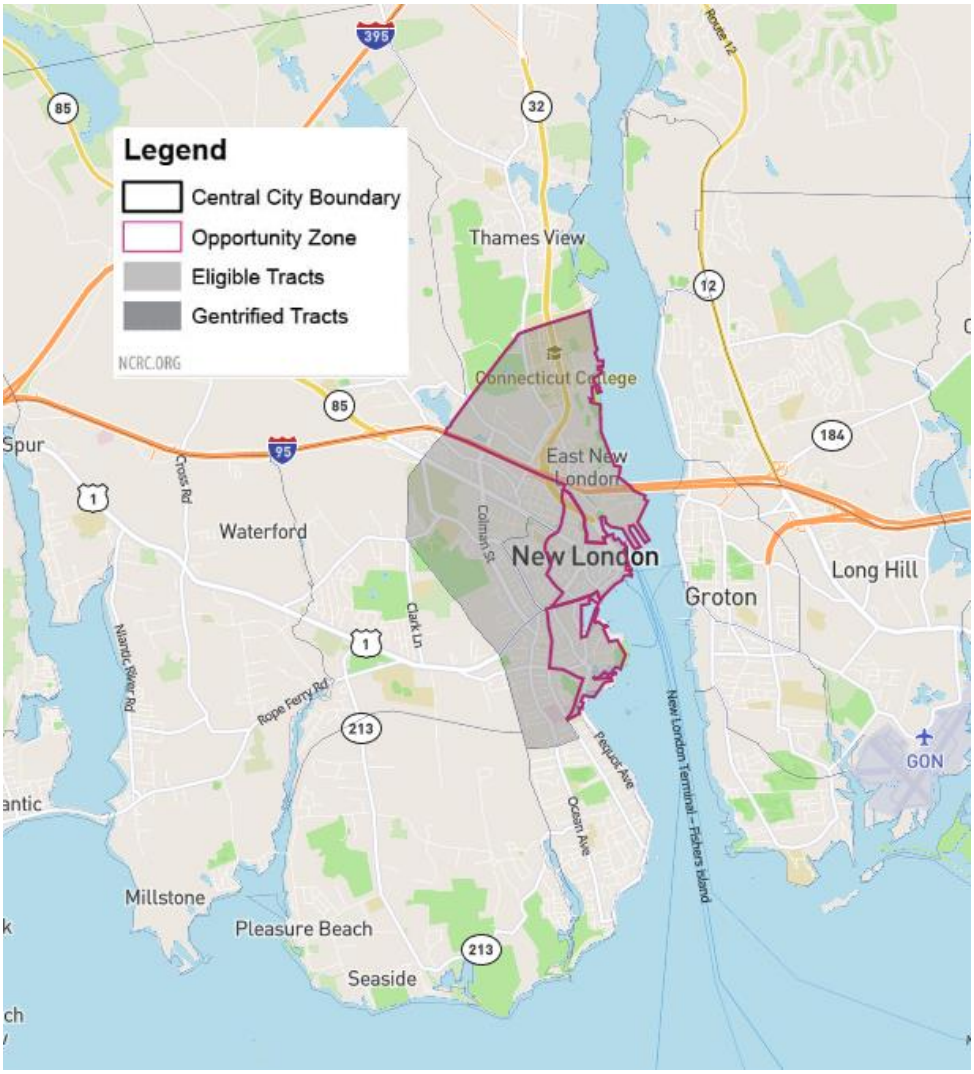
Hartford


Legend
Central City Boundary
Opportunity Zone
Eligible Tracts
Gentrified Tracts
NCRC.ORG
Hartford
West Hartford
East Hartford
Coachlight Village
Mayberry Village
Hilliardville
Manchester
Blue Hills
University of Hartford
Forest Village
Hockanum
HFD
Wethersfield
Glastonbury
Addison
Newington Junction
Buckingham

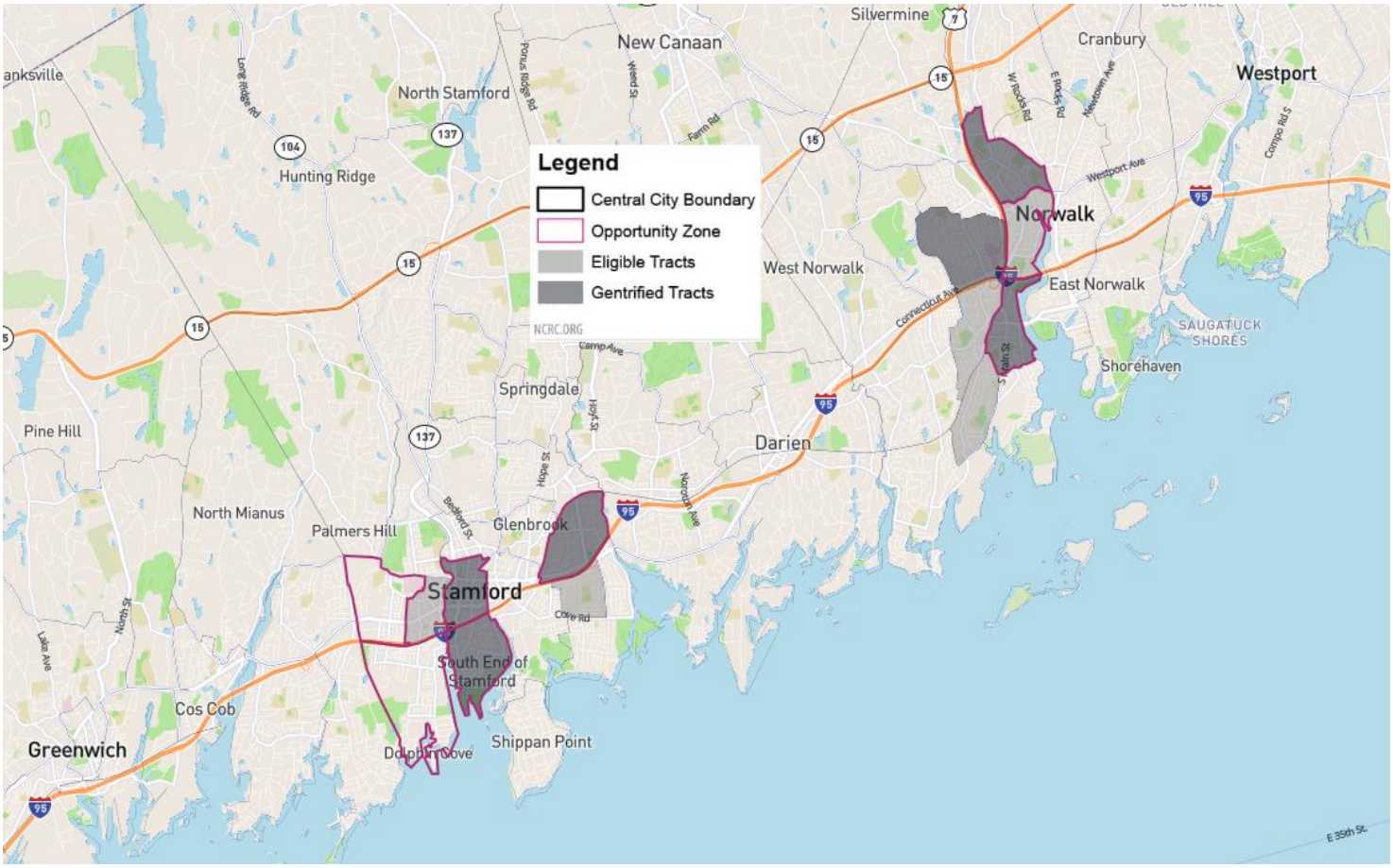
Middletown


Legend
Central City Boundary
Opportunity Zone
Eligible Tracts
Gentrified Tracts
NCRC.ORG
Middletown
Portland
Cromwell
Gildersleeve
Westfield
Highland Estates
Newfield Heights
South Farms
Miramichi
Highlawn Forest
Riverdale
Camp Ingersoll – Northern YMCA
Connecticut Valley Hospital
Middlesex Hospital Saybrook Road Campus
Maromas Wildlife Mangement Area

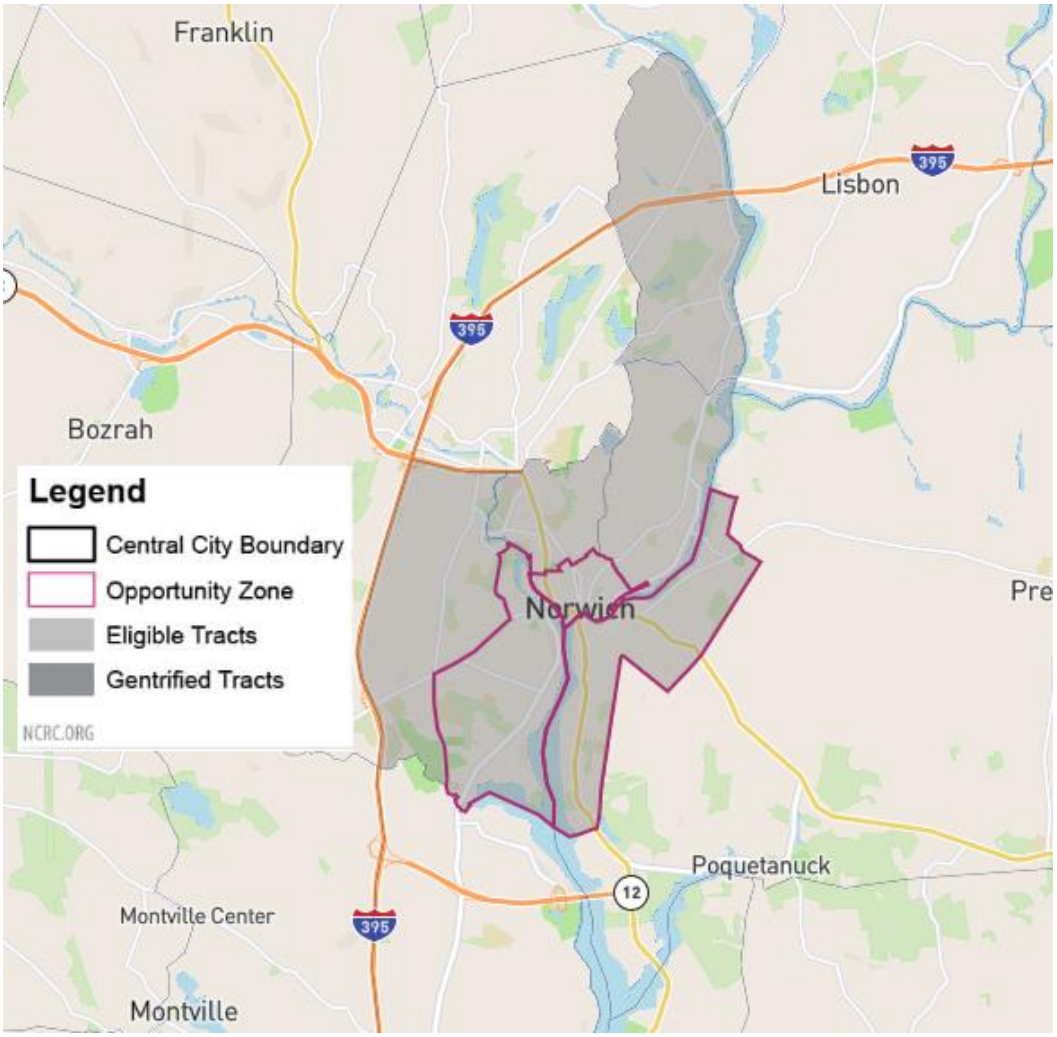
New London


Legend
Central City Boundary
Opportunity Zone
Eligible Tracts
Gentrified Tracts
NCRC.ORG
Thames View
Connecticut College
East New London
New London
Waterford
Groton
Long Hill
Millstone
Pleasure Beach
Seaside
GON
Spur
Cross Rd
Niantic River Rd
Rope Ferry Rd
Clark Ln
Colman St
Pequot Ave
Ocean Ave
New London Terminal – Fishers Island
395
85
32
12
184
95
1
213

Norwalk and Stamford



Norwich


Franklin
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Eligible Tracts
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Norwich
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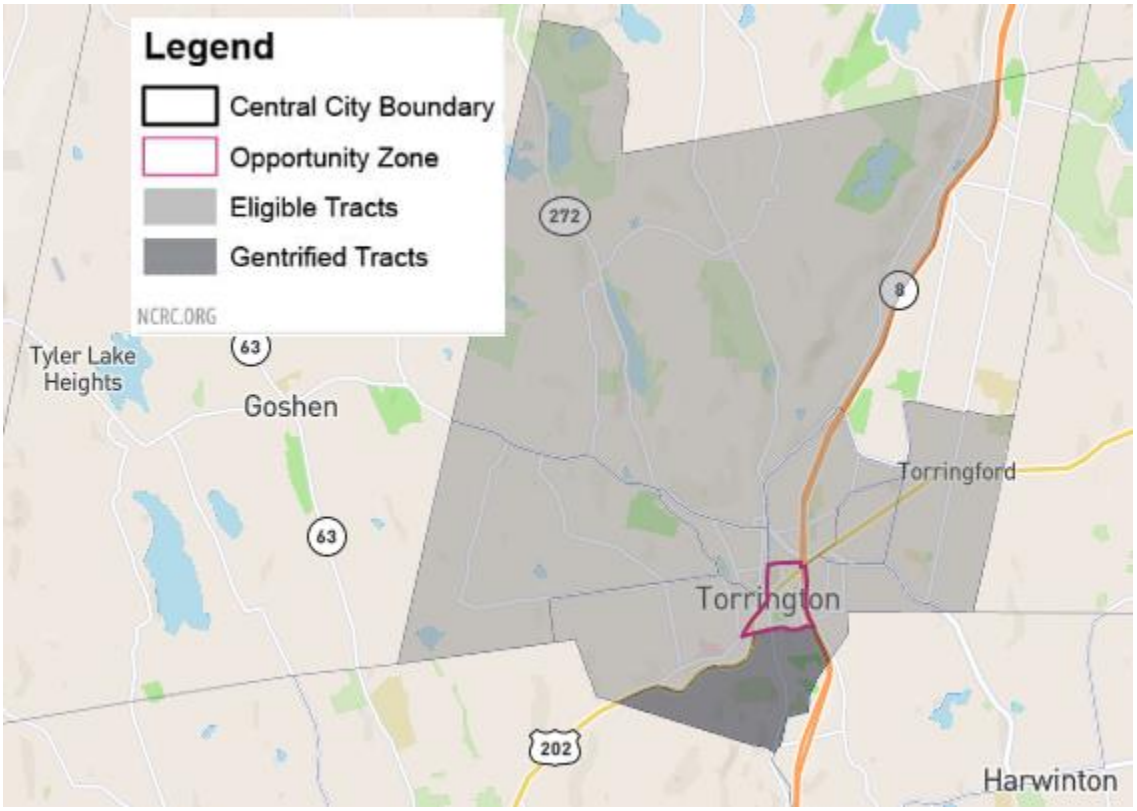
12
Montville Center
Montville

Torrington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Central City Boundary
Opportunity Zone
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Goshen
Torringford
Torrington
Harwinton
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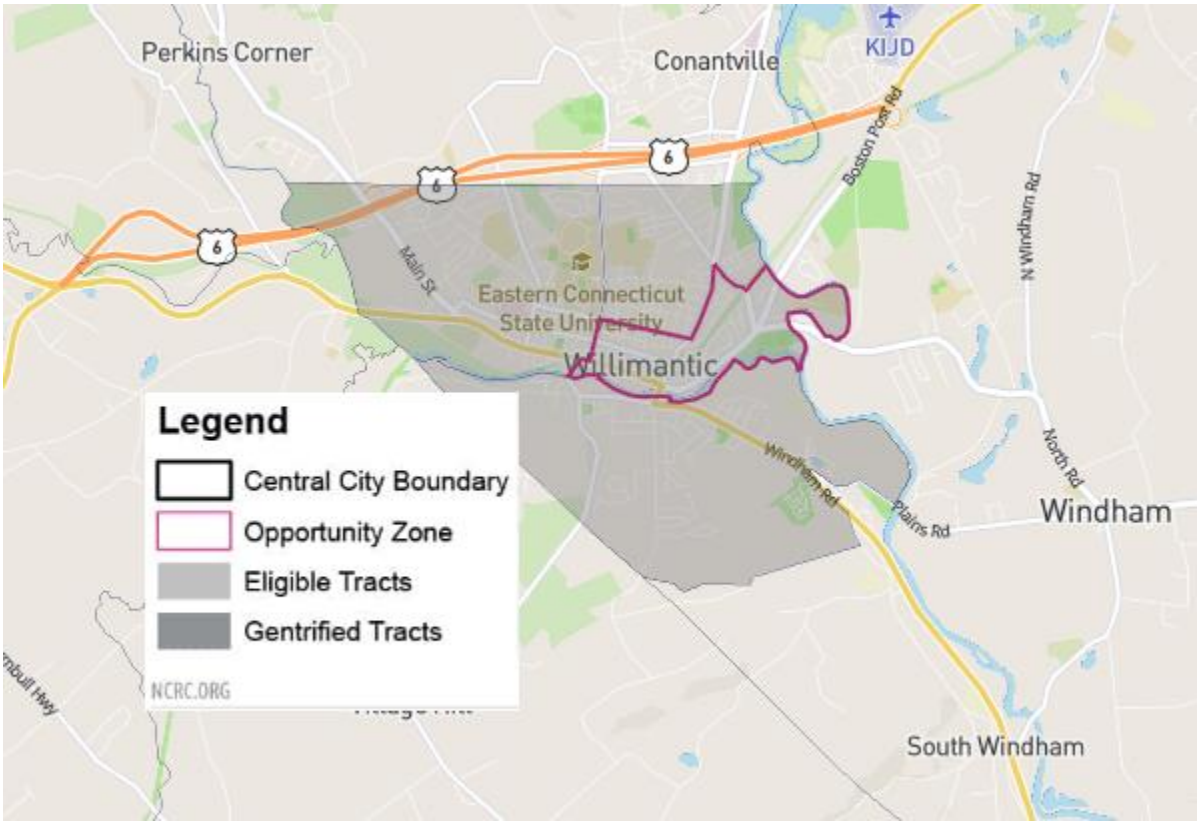
63
63
202

Willimantic / Windham



Appendix 6: CHNA Community Survey Tables
Demographic Profile of Survey Respondents

TABLE 24: COUNTY OF SURVEY RESPONDENTS

What county do you live in?	Percent of Respondents
Fairfield	1.3
Hartford	29.1
Litchfield	19.3
Middlesex	3.4
New Haven	26.2
New London	10.8
Tolland	4.5
Windham	5.4

TABLE 25: GENDER, RACE/ETHNICITY OF SURVEY RESPONDENTS

Gender & Race/Ethnicity	Percent of respondents
Female	77.0
Male	19.6
Non-binary	1.6
I'd rather not share	1.9
White or Caucasian	78.6%
Black or African American	10.5%
Hispanic/Latinx	8.2%
Asian	1.3%
Native American or Alaska Native	1.0%
Native Hawaiian or other Pacific Islander	0.0%
Another race/ethnicity	0.3%

TABLE 26: HOUSEHOLD INCOME OF SURVEY RESPONDENTS

Annual Household Income	Percent of respondents
None	.4
Under $15,000	1.1
$15,000 - $24,999	1.8
$25,000 - $34,999	5.7
$35,000 - $44,999	6.5
$45,000 - $54,999	10.0
$55,000 - $64,999	6.8
$65,000 - $74,999	7.5
$75,000 - $99,999	14.0
$100,000 or more	46.2
Age Group	
18 – 24	2.3
25 – 34	13.6
35 – 44	17.5
45 – 54	20.4
55 – 64	27.2
65 – 74	16.5
More than 75	2.6

Health Care Access

TABLE 27: ACCESS TO FAMILY DOCTOR

Do you have a family doctor or a place where you go for routine care?	
Response	**Percent of respondents**
Yes, family doctor, family health center, or clinic	94.8
Yes, emergency room	0.2
Yes, walk-in urgent care	1.4
No	3.3

TABLE 28: ACCESS TO MEDICAL OR MENTAL HEALTH CARE

In the past two years, has there been one or more occasions when you needed medical or mental health care but chose NOT to get it?	
Response	**Percent of respondents**
No	62.7
Yes	37.3
If yes, what prevented you from accessing health care or mental health services when you needed it?	
Reason	**Percent of those not getting needed services**
Long wait times to see a provider	43.9
Lack of money/ability to pay	36.3
COVID-19-related restrictions	27.4
Did not feel comfortable with available providers	19.7
Lack of health insurance	8.9
I don't like the providers	7.6
Lack of transportation	4.5
Providers are not culturally competent	3.8
Providers not knowledgeable about people with my sexual orientation or gender status	2.5
Providers did not speak my language, or they didn't know my culture	0.6
Concern about my immigration status	0.0

Additional Community and Access to Care Issues

TABLE 29: SENSE OF COMMUNITY

Concerning a Sense of Community Health, to what degree do you agree	
Community Issue	**Percent saying, "Disagree" or "Strongly disagree"**
I know my neighbors will help me stay healthy	37.1
My community has the resources to improve its health	25.6
My community works together to make positive change for health	21.2
My community can work together to improve its health	8.5
If you were experiencing a mental health or substance use challenge, would you know where to turn for help?	33.9
Do you or your family currently have unmet mental health or substance use needs?	
Yes, I have an unmet need	7.8
Yes, an adult family member has an unmet need other than me	14.7
Yes, a child family member has an unmet need	3.8
No	69.3

TABLE 30: MENTAL HEALTH CHALLENGES

Over the course of the COVID-19 pandemic, have you or someone you know experienced any of the following mental health challenges?	
Challenge	**Percent of respondents**
Depression or Anxiety	39.1
Loneliness or Isolation	32.0
Grief	22.8

TABLE 31: DAILY CHALLENGES

To what degree are you having any challenges with the following?	
Issue	**Percent struggling daily or having it as a common challenge**
Leisure activities	14.6
Feeling lonely	11.7
Managing major life issues such as relationship challenges, relocating, new job or change of school, loss of a loved one, or major illness	9.7
Establishing and maintaining trusted relationships	8.8
Regular living activities such as getting to school or work on time, grocery shopping, or doing other common tasks	6.3
Getting along with people at work or in the community	6.0
Performing adequately well at school or work	4.5
Getting along well with friends and family members	2.2

Community Survey Rating of Needs

TABLE 32: COMMUNITY ISSUES FOR IMPROVEMENT

Which of the following community and health-related issues do you feel need more attention for improvement?		
Rank	**Need**	**Percent saying, "Much more needed"**
1	Counseling services for mental health issues such as depression, anxiety, and others for adolescents/children	64.6
2	Affordable prescription drugs	62.3
3	Counseling services for mental health issues such as depression, anxiety, and others for adults	62.2
4	Drug and other substance abuse early intervention services	54.5
5	Crisis or emergency care programs for mental health	54.0
6	Affordable quality childcare	52.3
7	Social services (other than health care) for people experiencing homelessness	51.9
8	Drug and other substance abuse treatment services	50.7
9	Programs to help drug and other substance use disorder patients recover and stay healthy	49.4
10	Drug and other substance abuse education and prevention	48.7
11	Affordable health care services for individuals or families with low income	48.4
12	Support services for children with developmental disabilities	47.9
13	Long-term care or dementia care for seniors	47.4
14	Coordination of patient care between the hospital and other clinics, private doctors, or other health service providers	46.4
15	Health care services for people experiencing homelessness	45.5
16	Services to help people learn about, and enroll in, programs that provide financial support for people needing health care	42.6
17	Special care (for example, caseworkers or "navigators") for people with chronic diseases such as diabetes, cancer, asthma, and others.	41.1
18	Secure sources for affordable, nutritious food	41.0
19	Transportation services for people needing to go to doctor’s appointments or the hospital	39.5
20	Health care services for seniors	39.5
21	Education and job training	39.3
22	Education and job training	39.3
23	Services or education to help reduce teen pregnancy	37.2
24	Parenting classes for the "new Mom" or the "new Dad"	37.1
25	Crisis or emergency care services for medical issues	35.9
26	Women's health services/Prenatal care	34.3
27	Programs for obesity prevention, awareness, and care	33.1

Which of the following community and health-related issues do you feel need more attention for improvement?		
Rank	**Need**	**Percent saying, "Much more needed"**
28	General public transportation	32.6
29	Primary care services (such as a family doctor or other provider of routine care)	30.5
30	Programs for diabetes prevention, awareness, and care	29.5
31	Programs for heart health or cardiovascular health	27.8
32	HIV/AIDS education and screening	24.2
33	Emergency care and trauma services	23.6
34	HIV/AIDS treatment services	23.1

Appendix 7: CHIME Data Results Encounter Summary

DataHaven

Community Health Needs Assessment CHIME Data Profile: The Hospital of Central Connecticut HSA

By DataHaven, May 2022

Data about residents' visits to hospitals and emergency rooms may be used as an tool to examine variations in health and quality of life by geography and within specific populations[1]. Unless otherwise noted, all information in this profile is based on a DataHaven analysis (2022) of 2018-2021 CHIME data provided by the Connecticut Hospital Association upon request from a special study agreement with partner hospitals and DataHaven. The CHIME hospital encounter data extraction included de-identified information for each of several million Connecticut hospital and emergency department encounters incurred by any residents of any town in Connecticut. Any encounter incurred by any resident of these towns at any Connecticut hospital would be included in this dataset, regardless of where they received treatment.

In order to develop statewide geographic benchmark comparisons within the CHIME data that could be used to provide context, DataHaven developed a statewide aggregate as well as rates for individual Connecticut towns and regions. Comparisons should be made with caution, especially when examining data for towns or regions near the state border, given that residents in those towns may have been more likely to receive treatment at hospitals located outside of the state in some cases.

Each encounter observation had a unique encounter ID and was populated with one or more "indicator flags" repre- senting a variety of conditions. Each encounter could include multiple indicator flags.

Annualized encounter rates were calculated for the indicator flags assigned within the dataset including Asthma, COPD, Substance Abuse, and many other conditions. Analyses in this document describe data on "all hospital encounters" including inpatient, emergency department (ED), and observation encounters. Annualized encounter rates per 10,000 persons were calculated for the period from 2018 to October 2021 by merging CHIME data with population data.

For each geographic area and indicator, our analysis generally included an annualized encounter rate for populations in each of five age strata (0-19, 20-44, 45-64, 65-74, and 75+ years), and by gender, as well as a single age-adjusted annualized encounter rate. DataHaven also calculated rates by race, but those results are not included in this document because we believe that the collection of race/ethnicity data is not yet standardized in a way that allows for accurate comparisons across geographic areas. In some cases, results are not included in this report if the number of observations and/or populations in any given area were very small. It is important to note that there is no way to discern the unique number of individuals in any zip code, town, area, or region who experienced hospital encounters during the period under examination or the number of encounters that represented repeat encounters by the same individual for the same or different conditions. To better examine encounter rates for asthma, the age-strata used to calculate asthma encounter rates differed from age groupings used for the other disease encounter types (0-4, 5-19, 20-44, 45-64, 65-74, and 75+ years).

Please contact DataHaven or refer to our larger documents at ctdatahaven.org/reports for further information.

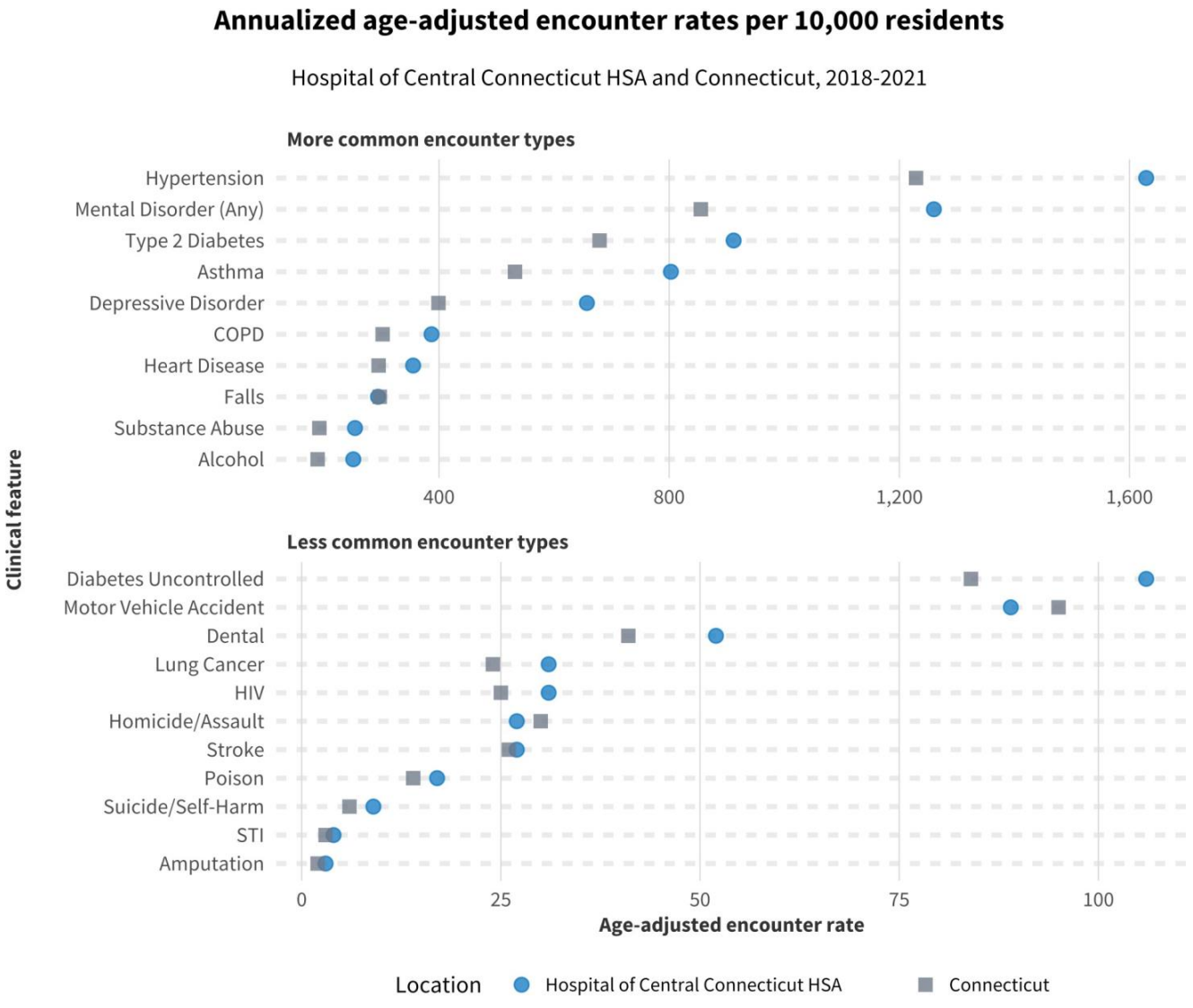
[1] Towns in Hospital of Central Connecticut HSA include New Britain, Berlin, Plainville, Newington, Southington, Wolcott, and Bristol. Data for other towns, zip codes, and regions are available via the regional Community Health Needs Assessment. We recommend comparing the information in this profile to information from surrounding towns, counties, and similar communities. General demographic information is also available at ctdatahaven.org/communities.

Demographics

Hospital of Central Connecticut HSA has a population of 261,163 people, with the following breakdown[2]:

Gender	All Ages	Age 0-19	Age 20-44	Age 45-64	Age 65-74	Age 75+
Female	134,967	30,011	41,011	36,993	14,004	12,948
Male	126,196	31,124	40,443	34,601	11,893	8,135
Total	261,163	61,135	81,454	71,594	25,897	21,083

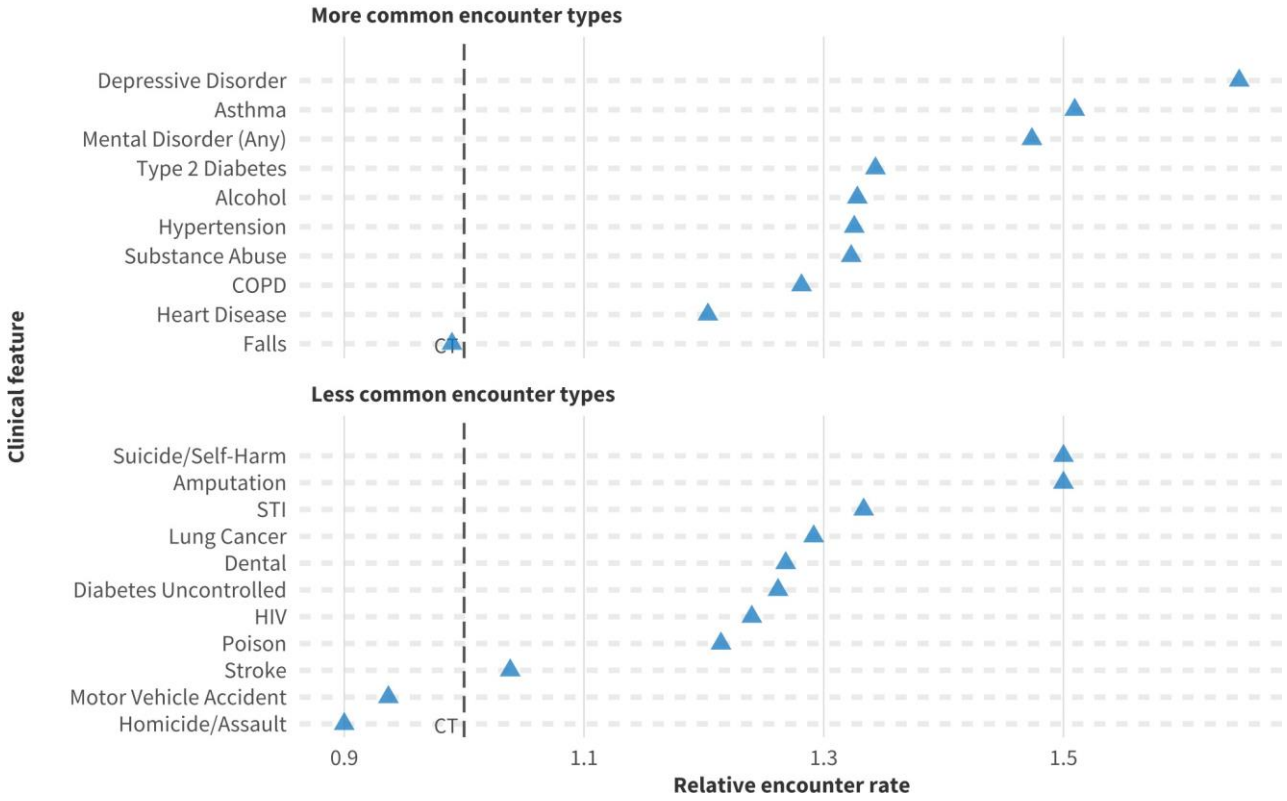
Hospital encounter data



[2]DataHaven analysis (2022) of population data from U.S. Census American Community Survey 2019 5-year estimates.

Annualized relative encounter rates per 10,000 residents

Ratio to Connecticut rate, Hospital Of Central Connecticut Hsa, 2018-2021



Encounter rates per 10,000, age-adjusted and by age

Hospital of Central Connecticut HSA, 2018–2021

Alcohol

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	251	249	12	282	468	254	57
Female	134	132	13	190	216	91	26
Male	379	374	10	375	739	445	105

Amputation

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	3	3	-	1	5	7	8
Female	1	1	-	-	2	-	-
Male	5	5	-	-	9	12	14

Asthma

Sex	Age-adjusted	All ages, crude rate	0-4 years	20-44 years	45-64 years	5-19 years	65-74 years	75+ years
All	803	802	-	1,080	836		606	550
Female	1,049	1,040	-	1,534	1,112		791	646
Male	544	546	-	619	541		389	398

COPD

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	387	399	1	35	504	1,150	1,677
Female	377	417	-	38	508	1,097	1,588
Male	401	379	-	33	500	1,212	1,819

Dental

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	52	52	59	69	42	29	24
Female	49	48	58	64	40	27	21
Male	56	56	60	75	45	32	30

Depressive Disorder

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	657	660	170	640	882	971	1,023
Female	801	818	240	829	1,027	1,147	1,171
Male	500	491	102	448	727	763	788

Diabetes Uncontrolled

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	106	108	9	56	165	225	254
Female	98	103	12	57	148	195	230
Male	117	113	5	55	184	260	291

Falls

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	294	300	254	168	251	396	994
Female	303	324	225	176	265	437	1,070
Male	281	275	282	160	236	349	874

Heart Disease

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	355	371	-	38	328	840	2,306
Female	312	362	-	40	274	698	2,108
Male	409	381	-	37	385	1,007	2,620

HIV

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	31	31	1	27	69	28	4
Female	27	26	-	22	66	12	-
Male	36	36	-	32	73	47	8

Homicide/Assault

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	27	27	17	55	18	7	-
Female	22	22	17	48	11	-	-
Male	32	32	17	62	25	12	-

Hypertension

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	1,629	1,657	20	686	2,459	3,772	4,835
Female	1,576	1,689	20	684	2,327	3,635	4,815
Male	1,687	1,623	20	688	2,600	3,934	4,866

Lung Cancer

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	31	32	-	1	35	114	134
Female	29	32	-	-	34	109	116
Male	34	32	-	-	35	120	161

Mental Disorder (Any)

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	1,260	1,272	386	1,359	1,439	1,514	2,639
Female	1,474	1,520	427	1,679	1,669	1,738	2,886
Male	1,025	1,006	346	1,034	1,192	1,249	2,245

Motor Vehicle Accident

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	89	89	58	152	73	44	38
Female	87	86	60	153	67	44	36
Male	91	91	56	152	80	45	40

Poison

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	17	17	15	21	17	11	13
Female	14	14	16	16	12	11	10
Male	19	19	13	25	22	11	17

STI

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	4	4	2	10	2	-	-
Female	4	4	3	9	-	-	-
Male	5	5	-	12	3	-	-

Stroke

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	27	28	-	6	26	64	149
Female	24	27	-	7	21	54	145
Male	30	28	-	6	33	77	155

Substance Abuse

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	254	252	52	455	306	120	29
Female	180	176	50	332	200	65	25
Male	332	334	53	580	419	185	36

Suicide/Self-Harm

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	9	9	15	13	4	-	-
Female	11	10	22	16	3	-	-
Male	7	7	8	11	5	-	-

Type 2 Diabetes

Sex	Age-adjusted	All ages, crude rate	0-19 years	20-44 years	45-64 years	65-74 years	75+ years
All	912	930	17	342	1,357	2,187	2,855
Female	873	931	24	402	1,297	2,025	2,476
Male	973	929	11	280	1,421	2,378	3,459

Appendix 8: Voice from the Community

Conversations with community stakeholders helped us identify weaknesses of programs and resources in the community. Themes that emerged from the conversations are described below. Each of the themes includes an illustrative comment from a stakeholder interview or focus group discussion participant.

Equitable Access to Care

A majority of community stakeholders allude to inequitable access to health care services and general health equity - specifically for marginalized communities of color, individuals with low socioeconomic status, and uninsured/underinsured individuals. Stakeholders expressed the need for assessing further health outcomes post-COVID and what the community will look like among those who were and continue to be disadvantaged from accessing health care services. The central Connecticut region also presents higher rates of obesity and diabetes in communities of color compared to other races and ethnicities. Although the central region was described as extremely caring and full of organizations that have the greatest intentions, they often lack the capacity and workforce to take that necessary extra step in program planning or implementation – especially not-for-profits. A key example of this observation was noted during the pandemic, as more services were provided in White neighborhoods over more diverse communities.

Sample voices from the community . . .

"Diversity is a blessing to Meriden, and a curse. People develop programs without including the people they are impacting. It's top-down instead of taking the time of getting buy-in from the population. We saw this during COVID where following the data, based on census tracts, vaccines were offered in more White neighborhoods than more diverse communities. Then, we wonder why ethnic minorities have low vaccination rates. People have great intentions, but people need to pause to take that extra step - but a lot of nonprofits don't have the staff and capacity to do that extra step."

"Access to health care for low-income people is a challenge. There is a gap in serving the uninsured population and low-income individuals."

"It feels like Hartford Health Care is really stretching itself to try and find ways to get through to people to make sure providers are being equitable and reaching out to communities. A lot of people are not in the BIPOC community, so they don't have inequities rubbed in their face every day. How many BIPOC people as decision-makers in our community?"

"We need to teach them and be inclusive in our community education. Providers need further education on how BIPOC people have been treated in the past and make an effort to reach out to these communities. It is an urgent need, and you need to get providers people trust."

"For new Americans without health insurance, they're having to wait months to get an appointment where they don't have to show documentation. It prevents kids from attending school due to vaccinations."

Mental Health Care

Stakeholders expressed profound concern about long-term mental health issues as the COVID-19 pandemic stabilizes. One of the most difficult barriers to receiving behavioral health services was identified as the "ever-changing clinician in people's life." Mental health clinics were referred to as "factory farms" where young therapists may start out for three months, then leave for a better paying job. Culturally competent mental health services were also identified as a challenge and bleeds into equitable health access. This region is experiencing a growth of diversity, and with this comes new languages and customs, adding an additional level of need that is hard to address. The service area for the central region, especially for youth-focused mental health services was described as "stretched" as more youth are seeking services, outnumbering providers.

Sample voices from the community . . .

"There are enough providers, but not enough that stay in people's lives. Unfortunately, health care is like any other business – we use quantitative measures to attain funding – not qualitative. There are limits on how many Husky clients mental health providers are willing to take. The biggest barrier to receiving mental health services is the ever-changing clinician in their life. People are investing in a relationship that is not sustainable. Those who don't receive mental health services create a barrier to receiving other community services."

Mental health access is a community-wide issue. It's hard to find services especially in your language, not only Spanish speaking. We're seeing an increase of other languages, so it adds an additional level of need that is hard to cover."

"Schools are dealing with a great deal of challenges, and it spills over into after-school programs. School counselors are not equipped to provide the level of care the kids need. School-based services are a win-win and help to eliminate barriers – but schools have the same issues because they are brick and mortar facilities. Where do you put more school counselors? Is it using telehealth? That requires innovation and buy-in from a lot of key community stakeholders."

"There's more children suffering from mental health disorders now than there are counselors and professionals to deal with the volume. There's an inequality of resources and people struggling. It's a complex system to navigate unless you are a savvy parent and can have perseverance. You can't make one phone call and figure it out."

Efficient Operations of Care - Collaboration

Regionally, interorganizational collaboration and communication were cited as a challenge, and services were frequently referred to as "existing in silos." The state of Connecticut was described as, "hyper-local" indicating that information is focused on a well-defined community with its primary focus directed toward the concerns of the population in that community despite having regional organizations. Participants expressed frustration while navigating the complex web of services. Several stakeholders mentioned the necessary persistence required to obtain local community resources and services. Often times, there is very little assistance and no follow-up from the referral source.

Sample voices from the community . . .

"The systems don't bridge. The persistence that people need to obtain all of these services is all left up to the client – there are only referrals and there's no follow-up. We need to create social capital and remove the lack of communication throughout organizations. Things like warm hand offs, case management, and conferences between providers. How do we communicate, collaborate, and coordinate amongst organizations?"

"There is not always across-town lines depending on what the issue might be. Connecticut is hyperlocal, and while we're a regional organization, not all people and organizations think regionally. Not always do our political parties work well together."

"Undocumented people have to wait five years before they're eligible for food stamps. What are they supposed to do in the meantime?"

Appendix 9: Key Steps to CHIP Development and Impact

STEP 1 - Culling the Findings – Brainstorming with your local collaboratives by answering the following questions:

CHNA Immediate Impact findings – where is the low hanging fruit?

CHNA Greatest Impact findings -- what will most influence health outcomes?

CHNA Most Desired Change findings - what change does the community most want?

CHNA Forging Opportunities findings - where are the greatest opportunities for partnership?

STEP 2 - Organizing the focus areas and assembling your rationale for action

HHC will organize its CHIP is across four focus areas that are intended to address root causes of community health issues while recognizing where HHC in partnership with the community can be most effective in impacting change. The driving rationale for each of these areas is derived from the CHNA findings and can be summarized as follows:

1. **Promote healthy behaviors and lifestyles**

Research has repeatedly shown that good eating and exercise choices are critical to averting lost or unproductive time at school or work, growing and maintaining cognitive and physical functioning, promoting mental health, and preventing and managing many chronic diseases such as heart disease, cancer, stroke, diabetes, and osteoporosis

Rationale for Action (Pull findings from your CHNA)

2. **Address health inequities and blunt social influencers of health**

There are many factors that shape and confine health outcomes including obstacles related to accessing care and services, awareness of available resources, and tracking patients as they move to and from points of care. More systemically, racial and economic inequities and other unfavorable environmental conditions provide powerful influencers in limiting individuals and communities from reaching their health potential.

Rationale for Action (Pull findings from your CHNA)

3. **Reduce the burden of chronic disease**

Proven interventions can prevent and reduce the effects of chronic and infectious diseases and are aimed at the **six** most common and costly health conditions – tobacco use, high blood pressure, healthcare-associated infections, asthma, unintended pregnancies, and diabetes – these conditions can be countered by proven specific interventions as highlighted by the CDC.

Rationale for Action (Pull findings from your CHNA)

4. **Enhance access to and the experience of care**

Access to care is effected by many circumstances including availability of providers and services, ability to schedule and keep appointments, cultural sensitivity of services, and financial means among many other factors. Frequently identified Issues include adult and child mental health and substance abuse services, dental care, and pediatric specialty care.

Improving screening, timely referrals, availability of providers and services, insurance coverage, and public awareness/patient empowerment are essential to reducing access issues.

Rationale for Action (Pull findings from your CHNA)

STEP 3 - Selecting your Strategies and Interventions

Consider the following tools and approaches:

- **Outreach** locates populations of interest or populations at risk and provides information about the nature of the concern, what can be done about it, and how to obtain services.
- **Screenings and other Clinical Interventions** identifies individuals or populations with health risk factors or disease conditions and offers services, education or referrals. Can be at an individual level or through clinic and other community-based opportunities to access care and services.
- **Case-finding** locates individuals and families with identified risk factors and connects them to resources.
- **Referral** makes a connection to necessary resources to prevent or resolve problems or concerns. Follow-up assesses outcomes related to the utilization of the resources.
- **Case management** is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual or family's needs.
- **Health teaching** involves sharing information and experiences through educational activities designed to improve health knowledge, attitudes, behaviors, and skills
- **Collaboration, Coalition–building, and Community Organizing** enhances the capacity to promote and protect health for mutual benefit and a common purpose. This effort involves exchanging information, co-creating activities, and shared resources
- **Internal Policy Reform** are opportunities to improve our policies, practice or workflows to improve access to care
- **Advocacy** is the act of promoting and protecting the health of individuals and communities by collaborating with relevant stakeholders, facilitating access to health and social services, and actively engaging key decision-makers to support and enact public policy to improve community health.
- **Social marketing** is a process that uses marketing principles and techniques to change target audience behaviors to benefit society as well as the individual
- **Community Relations** is a set of opportunities aimed at convening general and targeted populations to meet a purpose or for messaging and engagement including schools, underserved, support groups, etc.
- **Sponsorships and Funding** are any opportunities to support the activities of others that advance a public health goal or interest – in essence this is putting our money where our mouth is including Kids Marathon and PAL activities.

- **Time, Space and Community Health Expertise** are any opportunities to give of our time, expertise or if any of our physical space offerings help meet a need that advances a public health goal or interest

  Consider the following best practices:

  - What Works for Health | County Health Rankings & Roadmaps
  - Planning for and Selecting High-Impact Interventions (cdc.gov)
  - Advancing Health Equity and Preventing Chronic Disease | DNPAO | CDC
  - Rural Health Information Hub

Step 4 Executing and Evaluation

Appendix 10: Age Distribution Trends and Change since 2010

	Year	US	Connecticut	Fairfield County	Hartford County	Litchfield County	Middlesex County	New Haven County	New London County	Tolland County	Windham County
Total Population	2020	326,569,308	3,570,549	944,306	892,153	181,143	162,742	855,733	266,868	150,947	116,657
	2015	303,965,272	3,545,837	939,983	896,943	186,304	165,165	862,224	273,185	151,948	117,470
	2010	303,965,272	3,545,837	905,342	887,976	189,916	164,774	856,688	272,360	151,073	117,708
	Percent change since 2010	7.4%	0.7%	4.3%	0.5%	-4.6%	-1.2%	-0.1%	-2.0%	-0.1%	-0.9%
Under 5 years	2020	6.0%	5.1%	5.5%	5.3%	4.1%	4.1%	5.2%	4.9%	4.1%	4.9%
	2015	6.3%	5.3%	5.8%	5.5%	4.3%	4.6%	5.3%	5.1%	4.1%	5.2%
	2010	6.6%	5.8%	6.4%	5.8%	5.0%	5.2%	5.7%	5.6%	4.7%	5.6%
Change since 2010	Point change since 2010	-0.6%	-0.7%	-0.9%	-0.5%	-0.9%	-1.1%	-0.5%	-0.7%	-0.6%	-0.7%
Under 18	2020	22.4%	20.6%	22.5%	21.0%	18.2%	17.7%	20.2%	19.5%	17.3%	19.8%
	2015	23.3%	21.8%	23.8%	22.0%	20.0%	19.7%	21.3%	20.6%	19.0%	21.1%
	2010	24.3%	23.4%	25.2%	23.3%	22.4%	21.7%	22.8%	22.2%	20.8%	23.0%
Change since 2010	Point change since 2010	-1.9%	-2.8%	-2.7%	-2.3%	-4.2%	-4.0%	-2.6%	-2.7%	-3.5%	-3.2%
18 to 44	2020	35.8%	34.0%	33.0%	34.6%	28.6%	31.3%	35.1%	34.1%	40.1%	34.5%
	2015	36.3%	34.4%	33.6%	34.4%	28.7%	31.5%	35.5%	34.6%	39.4%	35.2%
	2010	36.9%	35.1%	34.3%	34.7%	30.5%	33.2%	36.2%	35.8%	40.0%	36.6%
Change since 2010	Point change since 2010	-1.1%	-1.1%	-1.3%	-0.1%	-1.9%	-1.9%	-1.1%	-1.7%	0.1%	-2.1%

	Year	US	Connecticut	Fairfield County	Hartford County	Litchfield County	Middlesex County	New Haven County	New London County	Tolland County	Windham County
45 to 64	2020	25.6%	28.2%	28.6%	27.2%	32.0%	30.7%	27.4%	27.9%	26.7%	29.1%
	2015	26.3%	28.8%	28.5%	28.2%	33.6%	31.7%	28.0%	29.2%	28.2%	29.5%
	2010	25.9%	27.8%	27.1%	27.6%	32.0%	30.4%	27.0%	28.2%	27.7%	27.8%
Change since 2010	Point change since 2010	-0.3%	0.4%	1.5%	-0.4%	0.0%	0.3%	0.4%	-0.3%	-1.0%	1.3%
65 and older	2020	16.0%	17.2%	15.9%	17.1%	21.3%	20.4%	17.4%	18.3%	15.8%	16.6%
	2015	14.1%	15.1%	14.1%	15.3%	17.7%	17.0%	15.2%	15.6%	13.4%	14.1%
	2010	12.7%	13.9%	13.3%	14.3%	15.2%	14.8%	14.1%	13.7%	11.5%	12.4%
Change since 2010	Point change since 2010	3.3%	3.3%	2.6%	2.8%	6.1%	5.6%	3.3%	4.6%	4.3%	4.2%

Source: US Census Bureau, 2010: ACS 5-Year Estimates Subject Tables; 2020: ACS 5-Year Estimates Subject Tables.