YaleNewHavenHealth
Bridgeport Hospital

2025

Community Health Needs Assessment

Greater Bridgeport

crescendo
Prepared by Crescendo Consulting Group

Yale NewHaven Health Bridgeport Hospital

September 2025

Dear Neighbor,

As president of Bridgeport Hospital, I am proud to share our 2025 Community Health Needs Assessment with you. Identifying and responding to the needs of our community is not only our responsibility, but part of our history as well. Bridgeport Hospital, the first hospital in Fairfield County, was founded in 1878 in direct response to community need. It is a privilege to carry on that tradition.

Our comprehensive assessment identified obstacles faced by many individuals in the Greater Bridgeport region when it comes to their health and wellbeing. The assessment also incorporated valuable input and insight from the Health Improvement Alliance, which includes representatives from area hospitals, local health departments, Federally Qualified Health Centers, colleges and universities, and community-based organizations.

Recognizing the importance of different perspectives, we worked with our community partners in encouraging your voice and that of your neighbors to be heard during the data gathering process. Based on the results of the Community Health Needs Assessment, Bridgeport Hospital is committed to addressing issues of behavioral health, maternal and prenatal care and pediatric health care services over the next three years in collaboration with our community partners.

Service to our community is at the heart of our mission. We also subscribe to continuous improvement and innovation as core principles in health care. If you have suggestions on how we can improve this work, please let us know at CHNAcommentsBH@ynhh.org. Thank you for your continued support of our community.

Sincerely,

Anne Diamond, DBA, JD
President, Bridgeport Hospital
Executive Vice President, Yale New Haven Health

MISSION, VISION AND VALUES

MISSION

Yale New Haven Health is committed to innovation and excellence in patient care, teaching, research and service to our communities.

VISION

Yale New Haven Health enhances the lives of the people we serve by providing access to high value, patient-centered care in collaboration with those who share our values.

VALUES

Patient-Centered – Putting patients and families first
Respect – Valuing all people
Compassion – Being empathetic
Integrity – Doing the right thing
Accountability – Being responsible and taking action

YaleNewHavenHealth

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EXECUTIVE SUMMARY

Bridgeport Hospital (BH), part of Yale New Haven Health (YNHHS), is committed to improving the health and wellbeing of residents in Greater Bridgeport, made up of Bridgeport, Easton, Fairfield, Milford, Monroe, Stratford, and Trumbull. As a not-for-profit hospital, BH conducts a Community Health Needs Assessment (CHNA) every three years, as required by Section 501(r)(3) of the Internal Revenue Code. This assessment identifies the most pressing health needs in the community and helps guide the hospital's efforts to address them.

The 2025 CHNA, conducted with the Health Improvement Alliance (HIA) and other community partners, contains insights from a wide range of community members, including public health experts and representatives of under-resourced populations. This inclusive approach ensures that the assessment and its findings reflect the diverse health needs and lived experience of the community.

Methodology

Data Collection Our robust process combined qualitative and quantitative data to understand the region's demographics, access to care, lived experiences, and the impact of social drivers on health outcomes.

Environmental Analysis & Collection of Secondary Data Secondary data was collected from numerous sources including the US Census American Community Survey (ACS), United Way (ALICE and 211), CDC (Wonder, PLACES, BRFSS), Connecticut Hospital Association (CHA) ChimeData.	**DataHaven Community Wellbeing Survey** In spring and summer 2024, DataHaven conducted a probability-based telephonic survey with 1,246 Greater Bridgeport residents in English and Spanish to assess health, housing, employment, and community needs.
Interviews 37 one-on-one (virtual and telephonic) interviews with partners from health and social service organizations and two regional Community Advocates between late summer through early fall 2024.	**DataHaven Community Based Assets and Needs Survey (CBANS)** 2,439 electronic surveys using convenience sampling were completed by Greater Bridgeport residents in English, Spanish, and Haitian Creole during summer 2024.
Focus Groups Eight focus groups across Greater Bridgeport were held with over 100 community members. Five in English, one in Spanish and two with a bilingual mix of English and Spanish.	**Access Audit** Mystery shopper calls to evaluate how easily community members can access health care, social services, and resources in Greater Bridgeport.

Data Analysis

Data analysis identified 25 community needs. These needs were categorized into the following four high-level focus areas:

Health Care Needs

Behavioral Health Care Needs

Culturally Competent Care Needs

Social Drivers of Health Needs

Prioritization

A structured multi-step needs prioritization process was conducted, integrating community feedback and evidence-based decision-making to select the 2025-2028 hospital priority areas.

- **Community Voices Survey** – An electronic survey in English and Spanish distributed through the HIA and community partners, engaged 418 community members to rank the most critical health needs for themselves and their family.
- **In-Person Regional Prioritization Session** – Local leaders, HIA members, and hospital staff, reviewed data on the top 25 health needs and Community Voices Survey results, then voted systematically using an evidence-based process.
- **Bridgeport Hospital Prioritization Session** – Hospital leaders used the Community Voices Survey results, regional prioritization findings, and data analysis to determine organizational priorities for the hospital's Implementation Strategy Plan.

Hospital Priority Areas

BH leadership adopted the following three 2025-2028 priority areas:

- **Mental Health and Crisis Services**
- **Maternal and Prenatal Care**
- **Pediatric Services**

Health System Priority Area

Community members, from across our hospital regions, identified cultural competency as a need during the 2025 CHNA process. This valuable feedback revealed opportunities to improve patient care by expanding language access and cultural sensitivity training and education for staff.

In response, YNHHS selected **Culturally Competent Care** as a 2025-2028 priority area and will be implementing national standards for Culturally and Linguistically Appropriate Services (CLAS) at each of our hospitals.

From Analysis to Action

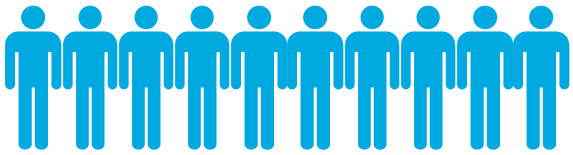
The CHNA findings and selected priority areas were used to inform the 2025-2028 BH Hospital Implementation Strategies. Both documents can be found at https://www.bridgeporthospital.org/about/community/health-needs-assessment. To request a copy, please email CHNAcommentsBH@ynhh.org.

Executive Summary

Mental Health & Crisis Services

Community members described stigma as a barrier to seeking behavioral health and substance use treatment, especially among youth and communities of color.

In addition to stigma, partners reported limited availability of affordable recovery programs, particularly for Medicaid and Medicare patients, leading to heavy reliance on emergency care.



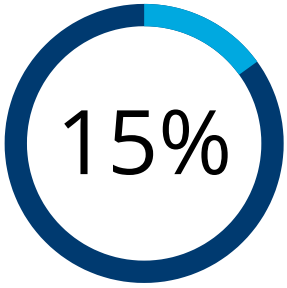
10.4 per 1000 Adults
Mental Health Hospitalization Rate

Mental health was the top cause of hospitalization for Greater Bridgeport residents (10.4 per 1,000 adults). Fairfield County has a shortage of mental health providers compared to the state (681:1 vs. 516:1). [1]

Fairfield County
Mental Health Providers Ratio

Connecticut
Mental Health Providers Ratio

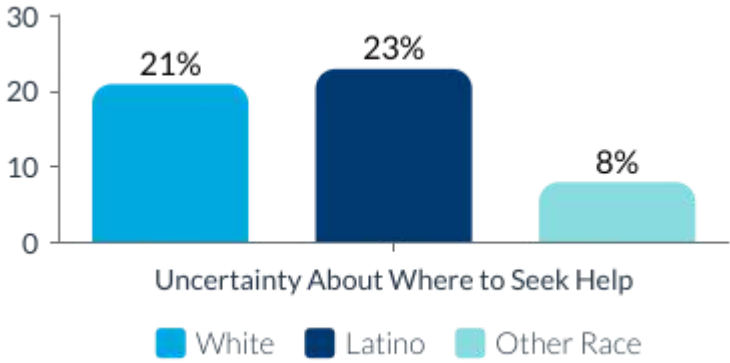
The DataHaven Community Wellbeing Survey (DCWS) data highlighted that 15% of residents needed but did not receive mental health care, citing cost, wait times, and lack of insurance coverage as the main barriers. [2]



17.0 per 1000 Adults
Substance Use Hospitalization Rate

Substance use disorders were the second most common reason for hospitalization in the region (17.0 per 1,000 adults). [3]

Community Based Assets and Needs Survey (CBANS) data reinforces that some residents are unaware of where to seek help or delay care because of stigma or fear. [4]



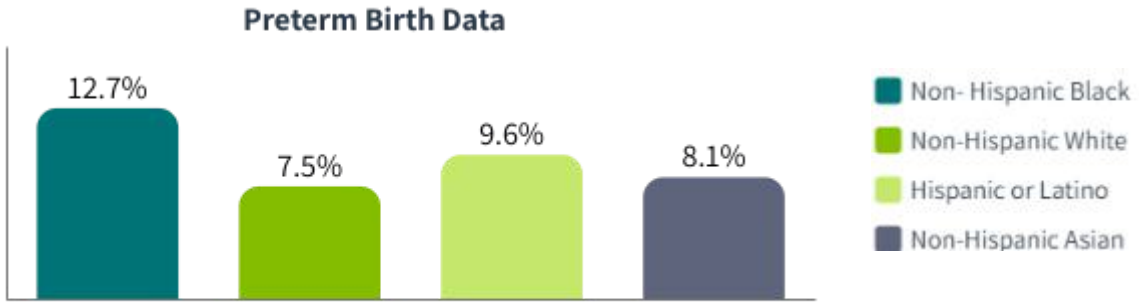
1. Table 46 & Exhibit 61
2. Exhibit 62
3. Table 46
4. Exhibit 63

Executive Summary

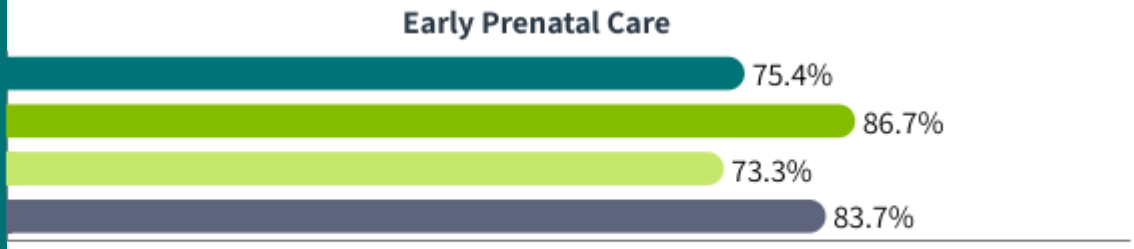
Maternal and Prenatal Care and Pediatric Services

Residents across the region reported long wait times and challenges finding providers who accept public insurance, contributing to delayed care.

Partners emphasized that publicly insured patients often face longer wait times and fewer options for specialty and behavioral health care.



Only 75% of Black mothers in the region received prenatal care in the first trimester compared to 87% of White mothers. Black and Hispanic mothers experienced higher rates of preterm births (12.7% and 9.6%, respectively) than White mothers (7.5%). [5]



Availability of Pediatric Healthcare Services:
There are 705 children per pediatrician in Fairfield County, compared to 619 children per pediatrician statewide. [6]

Partners reported long wait times for pediatric behavioral health and therapy services, creating challenges for families seeking timely care.

705:1

Fairfield County
Pediatrician Ratio

619:1

Connecticut
Pediatrician Ratio

5. Table 57 and 58
6. Exhibit 51

INTRODUCTION

Bridgeport Hospital is committed to improving the health and wellbeing of residents in Bridgeport and the surrounding communities. As a not-for-profit hospital, Bridgeport Hospital conducts a Community Health Needs Assessment (CHNA) every three years, as required by Section 501(r)(3) of the Internal Revenue Code. This assessment identifies the most pressing health needs in the community and helps guide the hospital's efforts to address them.

The 2025 CHNA process included input from a range of community members, including public health experts and representatives of under-resourced populations. This approach ensures that the assessment and its findings reflect the diverse health needs and experiences of the community.

This CHNA report was approved by the Bridgeport Hospital Board of Trustees on September 25, 2025. The report informed a separate Implementation Strategy Plan (ISP) that outlines specific actions Bridgeport Hospital will take to address identified health needs over the next three years, which will receive Board of Trustees approval in Fiscal Year 2026. The documents will be made publicly available, to ensure transparency and accountability.

Conducted in collaboration with the Health Improvement Alliance (HIA) and other community partners, the CHNA provides an overview of the health status of the hospital's service area, identifies key health challenges, and highlights Bridgeport Hospital's commitment to addressing these issues. By working with community partners, Bridgeport Hospital aims to expand access to care, reduce health disparities, and improve health outcomes for all residents in its service area.

Community input is essential to ensure that the CHNA reflects the priorities and experiences of those who live and work in the region.

If you would like to share feedback or comments on this CHNA, we welcome your input. Please email CHNAcommentsBH@ynhh.org to share your thoughts and help shape future efforts to improve community health.

OUR HOSPITAL

Bridgeport Hospital is a not-for-profit, acute care teaching hospital serving Greater Bridgeport. As part of Yale New Haven Health (YNHHS), the hospital provides comprehensive medical, surgical, and specialty care, including emergency services, cardiac care, oncology, orthopedics, neurology, and behavioral health services.

The hospital includes the Yale New Haven Children's Hospital Bridgeport Campus, offering specialized pediatric care, and the Milford Campus, which expands access to medical and surgical services. Bridgeport Hospital is also home to the Connecticut Burn Center, the only dedicated burn care facility in the state.

With a commitment to community health, Bridgeport Hospital collaborates with local organizations to expand access to care, reduce health disparities, and address social drivers of health. Through education, outreach, and clinical excellence, the hospital works to improve health outcomes for the diverse populations it serves. A summary of the progress made since the 2022-2025 CHNA is located in Appendix A. For more information about our hospital, visit www.bridgeporthospital.org.

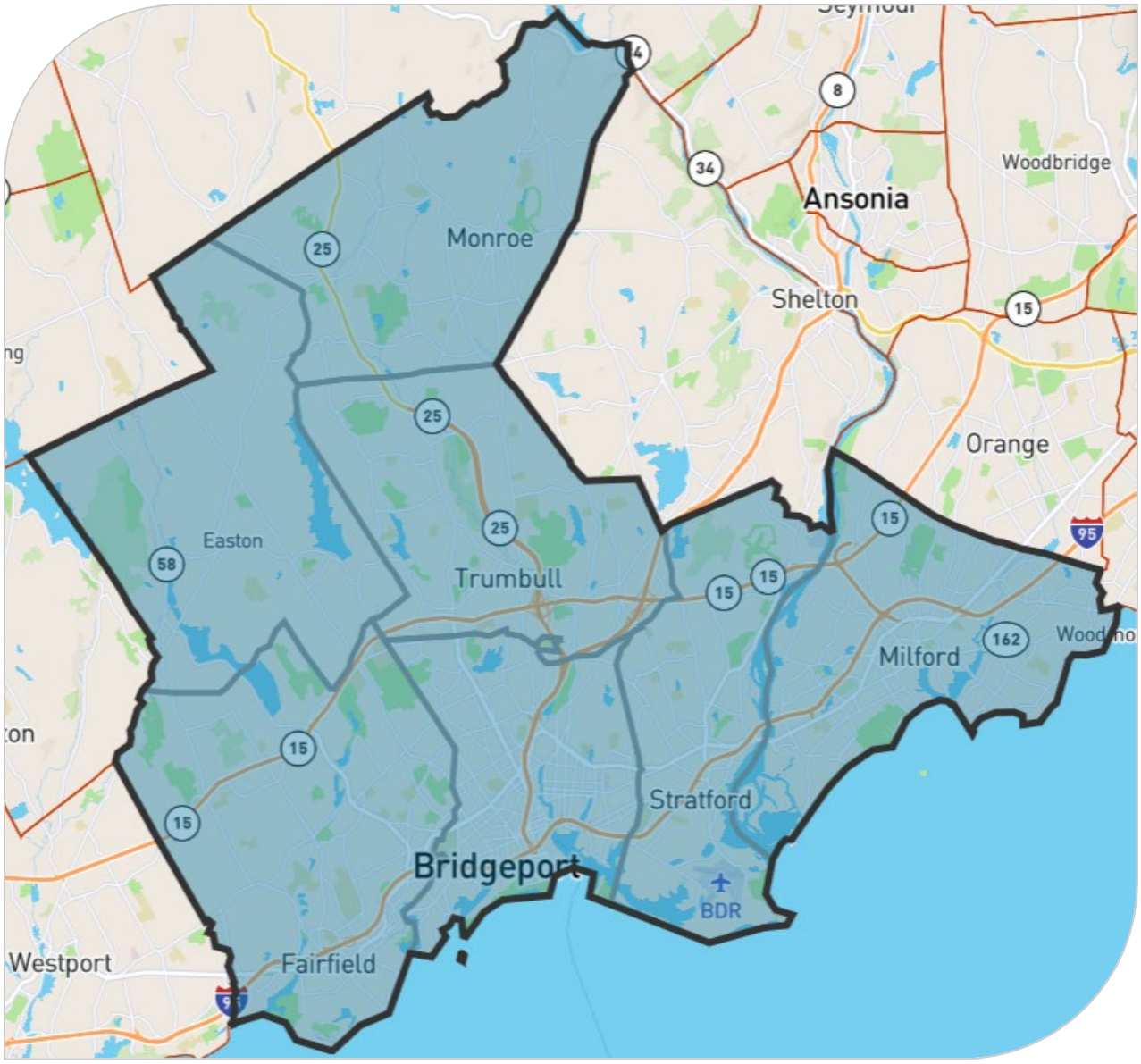
OUR PARTNERS

The 2025 CHNA was led by the HIA, a coalition co-led by the neighboring hospitals of Bridgeport Hospital and St. Vincent's Medical Center. Formed in 2003, HIA membership now includes seven local departments of health, two federally qualified health centers, and about 100 additional organizations from across Greater Bridgeport, fostering collaboration among health care providers, social services, and community organizations. A list of partner organizations is located on page 83. Our collaborative CHNA approach reflects a commitment to understanding and addressing the diverse needs of the region. A summary of HIA's progress since the 2022-2025 CHNA is located in Appendix A.

In addition to the members of HIA, several other local organizations participated in the 2025 CHNA process. This included hosting focus groups, participating in interviews, distributing surveys, and serving on committees that provided feedback and informed the work. We thank everyone for making this a robust and inclusive process.

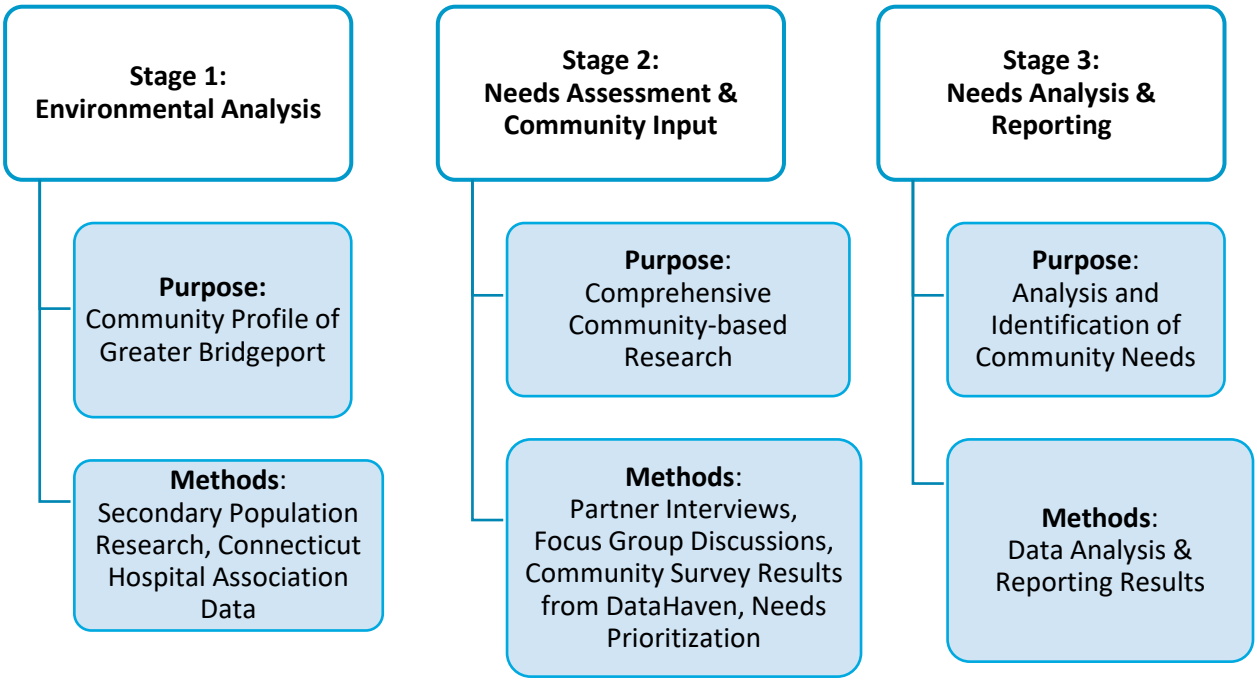
OUR SERVICE AREA

The municipalities that make up Greater Bridgeport include Bridgeport, Easton, Fairfield, Milford, Monroe, Stratford, and Trumbull. Milford is located in New Haven County, while the rest of the region is in Fairfield County.



CHNA OVERVIEW

Methodology



Secondary Population Research and Data Analysis provided critical insights into demographics, social drivers of health, and behavioral health-related measures, among many others.

Qualitative Research, through several forms of community engagement, allowed us to learn from community members during late summer through early fall 2024.

- 37 one-on-one interviews with partners from health and social service organizations.
- Two Community Advocates, from historically underrepresented communities, participated in several key parts of the process to represent populations that have not traditionally engaged in past CHNAs.
- Eight focus groups were conducted across Greater Bridgeport with 100 participants. Five were conducted in English, one in Spanish, and two with a bilingual mix of English and Spanish. Participants consisted of seniors, parents, educators, business owners, individuals with lower socioeconomic status, and concerned community members.

Two Community Surveys were conducted by DataHaven to evaluate and address health care, housing, employment, and other needs, gaps, and resources in the community.

- DataHaven Community Wellbeing Survey (DCWS) is a statewide survey that utilizes probability sampling to collect highly reliable local information. This randomized telephonic survey (available in English and Spanish) included 1,246 responses from across the region. Data collection took place throughout spring and early summer 2024.
- DataHaven Community Based Assets and Needs Survey (CBANS) was administered utilizing convenience sampling. This electronic survey (available in English, Spanish, and Haitian Creole) included a subset of questions from DCWS and had 2,439 responses from across the region. Data collection took place during summer 2024.

An **Access Audit** provided insights into access to care barriers and challenges experienced by residents when accessing services and resources.

A multi-step **Needs Prioritization Process** took place over several months from December 2024 through February 2025 and included:

- An electronic Community Voices Survey, which allowed community members to select the identified health needs that were most important to them.

- A regional prioritization session with local leaders and members of the HIA. Participants identified priority health needs through a structured process that incorporated data review, results from the Community Voices Survey, and scoring techniques. Utilizing a combination of the Hanlon (scoring needs based on magnitude, severity, and feasibility of addressing) and PEARL-E (Propriety, Economic Feasibility, Acceptability, Resource Availability, Legality, and Equity) methods followed by group discussion, attendees then voted on the most pressing regional health and wellbeing concerns.

- Bridgeport Hospital held an internal session where hospital leadership considered the regional prioritization findings and community ranked needs to vote on hospital priorities.

Data Limitations

Data collection methodologies inherently present certain limitations that can affect the comprehensiveness and representativeness of findings. These limitations underscore the importance of interpreting data within the context of its collection methods and acknowledging potential biases that may influence the findings.

Quantitative Data: Utilizing publicly available data sources, such as the U.S. Census Bureau's American Community Survey (ACS), provides valuable insights. However, these datasets are limited to respondents who completed the survey, potentially leading to underrepresentation of specific groups. Notably, the ACS experienced a response rate decline from 86% in 2019 to 71% in 2020, with rates not fully rebounding to pre-pandemic levels by 2022.[1] This decline may result in nonresponse bias, affecting the accuracy and completeness of the data.

Qualitative Data: Efforts to engage diverse community sectors are crucial for comprehensive qualitative insights. Despite these efforts, participation is limited to those who chose or were able to engage in interviews or focus groups, which may not fully capture the perspectives of all community segments.

DCWS and CBANS: While the DCWS aims for broad representation, participation is voluntary, which can introduce nonresponse bias and limit its ability to fully reflect certain populations. CBANS helps address this gap by amplifying the voices of groups that have been marginalized, though results are not statistically representative of Greater Bridgeport. Together, these two surveys provide a more inclusive picture of community needs, but their findings should be interpreted with an awareness of these limitations.

All survey percentages represent weighted estimates of the adult population (ages 18+) and should be interpreted as estimates of adult prevalence, not just of respondents.

Regional Definition: Note that the region has a specific zip code definition, and all data, where possible, mirrors that definition. There are some data points that use a regional proxy (e.g. county for a region, etc.) in order to provide descriptive data.

[1] U.S. Census Bureau. *Response rates*. American Community Survey. Retrieved December 3, 2024, from https://www.census.gov/acs/www/methodology/sample-size-and-data-quality/response-rates/

How to Read This Report

This CHNA aims to give an overall picture of the health and wellbeing of Greater Bridgeport. The report is framed using a health equity lens and organized by the five Social Drivers of Health domains (Economic Stability, Education Access and Quality, Neighborhood and Built Environment, Social and Community Context, and Health Care Access and Quality).

Each section includes relevant qualitative and quantitative data with supporting quotes from focus group participants and partner interviews. Tables of quantitative data can be found in Appendix B. The Partner Interview Guide and Focus Group Guides can be found in Appendix E.

One of Greater Bridgeport's strengths is the robust collection of community organizations offering a variety of health and wellbeing supporting resources (Appendix D). While the report aims to be comprehensive, it is not an exhaustive list of all the strengths, challenges, and data for the region.

Where possible and relevant, this report presents data by race, ethnicity, education, and income to show differences in health outcomes and identify where health disparities exist. Breaking down the data in this way helps highlight gaps in access to care and can inform strategies to improve health for all. The goal is to provide a clearer picture of community health needs and support efforts to ensure that every individual has the opportunity to achieve good health, regardless of background or circumstances.

Report Terms and Definitions

Term	Definition
Health Equity	Everyone has a fair and just opportunity to be as healthy as possible (Katella, 2021).
Health Literacy	The ability to access, understand, evaluate, and apply health information to make informed decisions about one's health (CDC, 2024).
Language Barrier	A situation in which a person or household has limited or no ability to communicate in the dominant language of the surrounding community (Link et al., 2005).
Marginalized	Individuals or groups who experience social, economic, and political disadvantages or exclusion within a particular society (EIGE, 2023).
Naturalized U.S. Citizen	An individual born outside of the United States who has legally acquired U.S. citizenship (USCIS, 2020).
Personal Health Record	An organized, secure record of one's health information, such as medical history, medications, test results, and immunizations (Mayo Clinic, n.d.).
Qualitative Data	Non-numerical information describing qualities, experiences, or perspectives of people or situations, often collected through interviews, focus groups, or observations (Hassan, 2024a).
Quantitative Data	Information that can be counted or measured and used to analyze patterns, relationships, or trends through statistics (Hassan, 2024b).
Secondary Data	Existing data, not gathered firsthand by the current researcher (Hassan, 2024c).
SNAP	Supplemental Nutrition Assistance Program (SNAP), the largest federal nutrition program in the United States, designed to help individuals and families with low incomes access food (USDA, n.d.).
Social Drivers of Health (SDoH)	Social, economic, and environmental factors that impact a person's health outcomes and access to care, including income, education, housing, transportation, food access, and social support (CMS, n.d.).
Stigma	Negative attitudes, beliefs, stereotypes, and discrimination directed towards individuals or groups based on certain characteristics, attributes, or conditions (Washington State Department of Health, n.d.).
Under-Resourced	Populations that have inadequate access to resources, such as health care, education, or social services. (AHRQ, 2021).
Underrepresented	Groups that are proportionately smaller in decision-making spaces, research, or policy considerations. (Bibbins-Domingo & Helman, 2022).
Groups Experiencing Disadvantage	Populations that face increased risks due to social, economic, environmental, or health factors. (Shivayogi, 2013).

Health Equality vs. Health Equity

Everyone should have the opportunity to be as healthy as possible, but achieving that goal requires an understanding of health equality and health equity.

Reproduced with permission of the Robert Wood Johnson Foundation, Princeton, N.J.

Health Equity means ensuring that individuals receive the support necessary for their specific circumstances. Some people may need additional resources, such as more healthcare access, affordable medications, or transportation assistance, to achieve the same level of health as others.	**Health Equality** means providing everyone with the same resources or services. However, because people have different needs, equal treatment does not always lead to fair health outcomes.

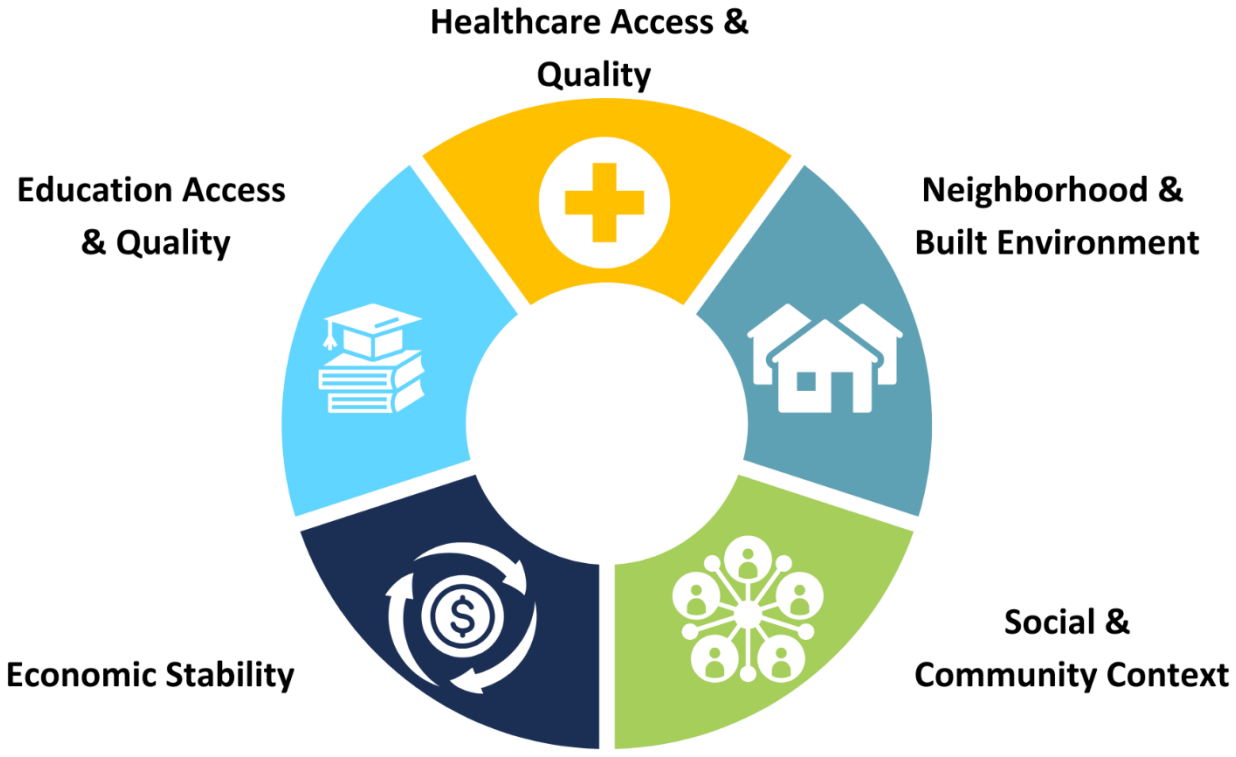
SOCIAL DRIVERS OF HEALTH FRAMEWORK

Social drivers of health (SDoH) are the conditions where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[2] They also contribute to wide health disparities and inequities.

The framework has been championed by the US Centers for Disease Control and Prevention (CDC) and other governmental agencies and is integrated into the Healthy People 2030 goals.[2]

Social Drivers are also known as social determinants. “Determinants” suggest that nothing can be done to change our health fate. By calling them "drivers," we move from seeing social factors as unavoidable causes of health to seeing them as elements that people and communities can transform.

EXHIBIT 1: SOCIAL DRIVERS OF HEALTH FRAMEWORK

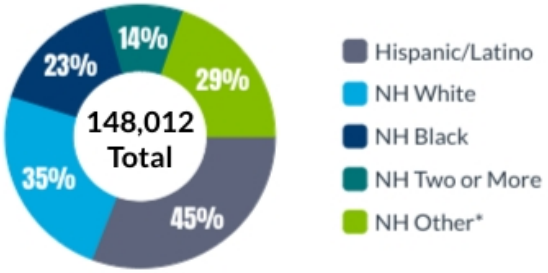


[2] Healthy People 2030. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health

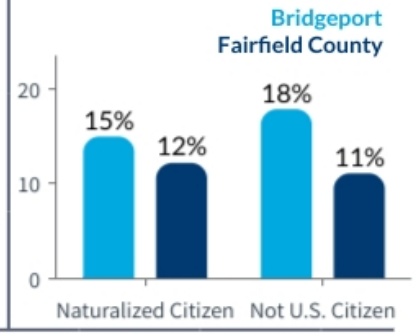
Demographic Overview
Bridgeport

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

Race/Ethnicity

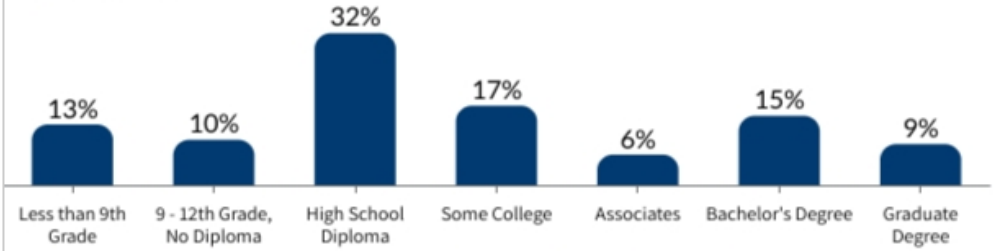


Foreign- Born Population



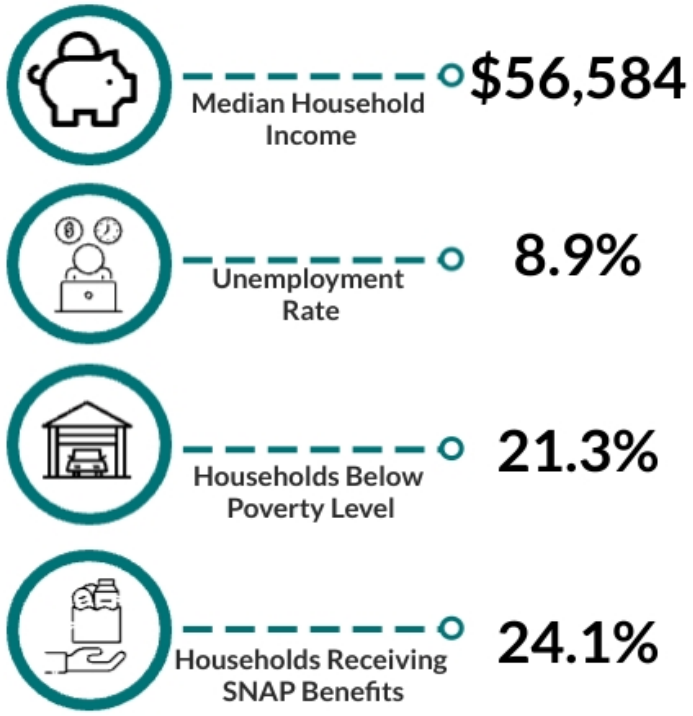
Population by Age

Education

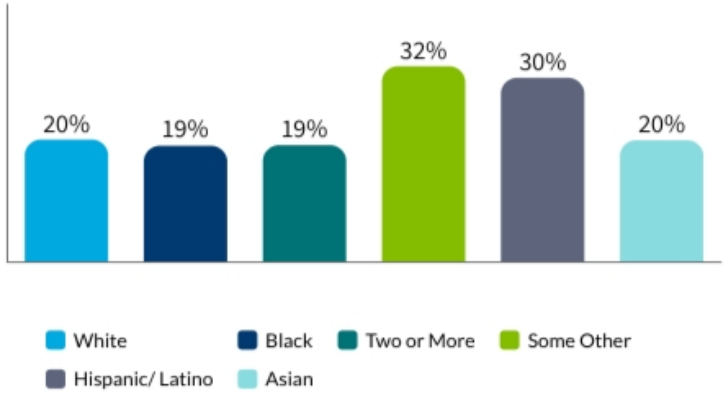


*Other (Race/Ethnicity) includes Asian, American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander
*NH: Non- Hispanic

Economic Well-being



Population in Poverty by Race/Ethnicity

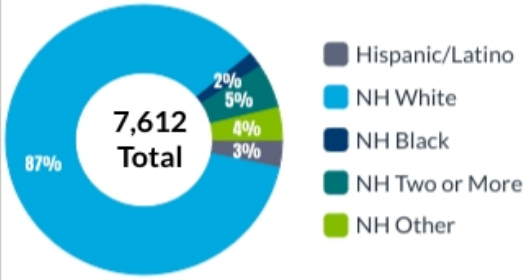


Demographic Overview

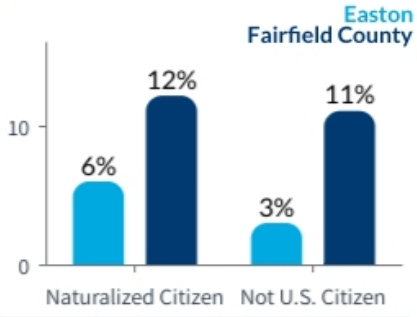
Easton

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

Race/Ethnicity



Foreign- Born Population

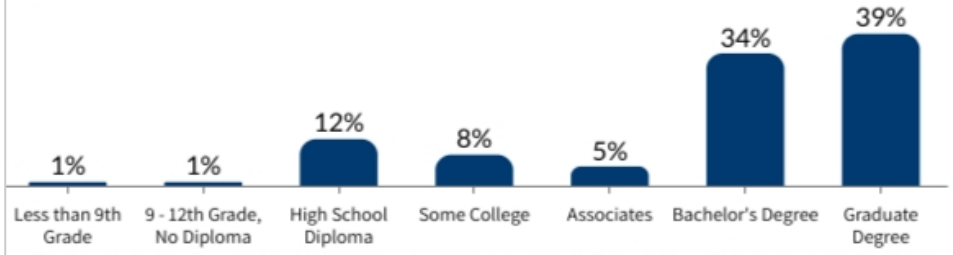


Population by Age

Under 18	18-64	65 +
25.2%	57.8%	17%

Median Age

Education



*Other (Race/Ethnicity) includes Asian, American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander
*NH: Non- Hispanic

Economic Well-being

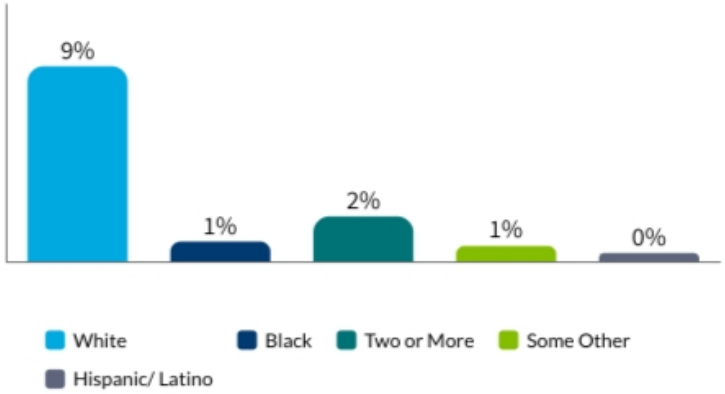
Median Household Income: $189,505

Unemployment Rate: 5.1%

Households Below Poverty Level: 4.7%

Households Receiving SNAP Benefits: 1.5%

Population in Poverty by Race/Ethnicity

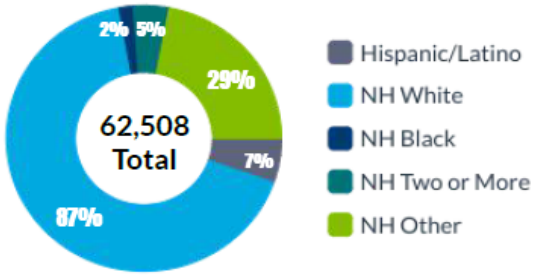


Demographic Overview

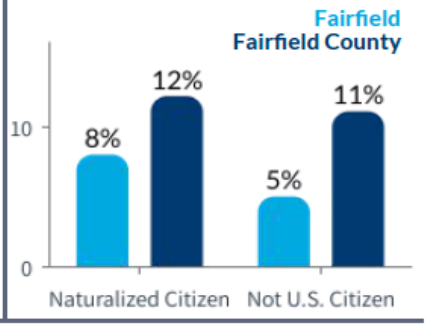
Fairfield

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

Race/Ethnicity



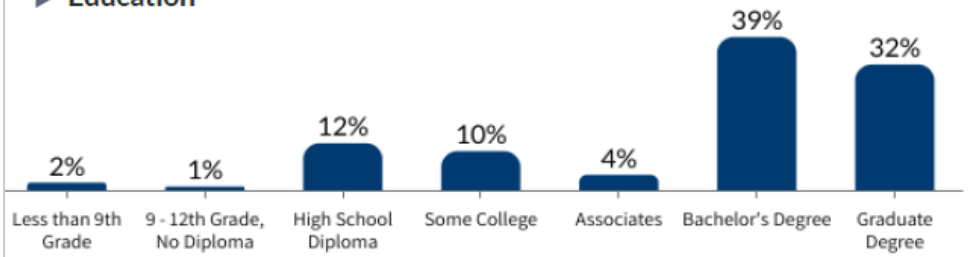
Foreign- Born Population



Population by Age

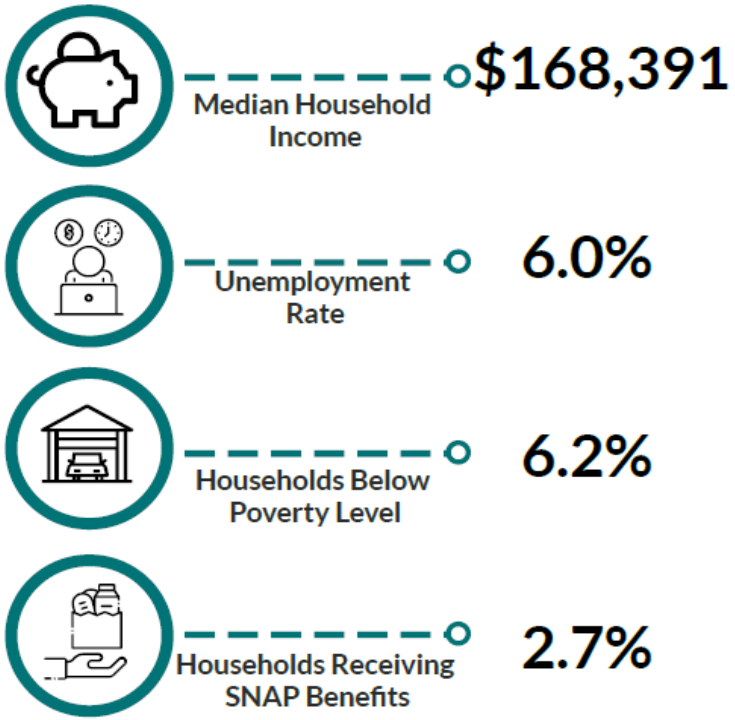
Under 18	18-64	65 +
24%	60.3%	15.7%

Education

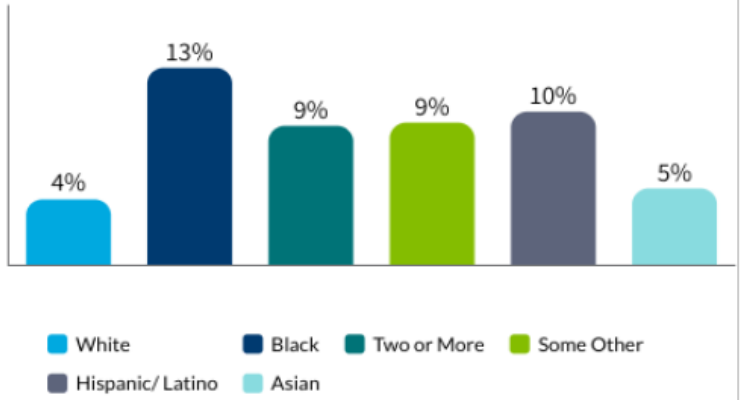


*Other (Race/Ethnicity) includes Asian, American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander
*NH: Non- Hispanic

Economic Well-being



Population in Poverty by Race/Ethnicity

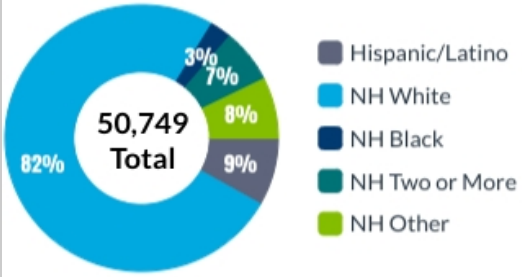


Demographic Overview

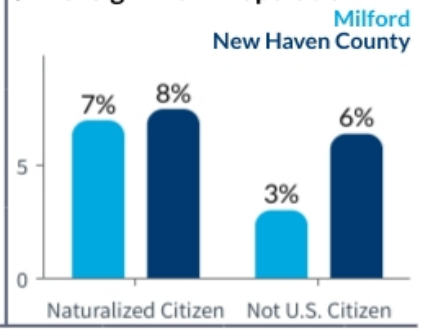
Milford*

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

Race/Ethnicity

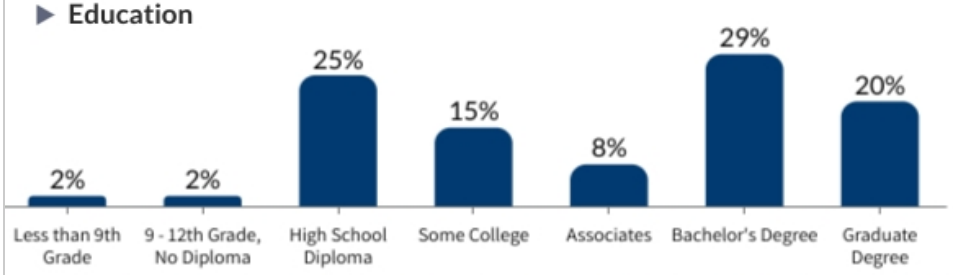


Foreign- Born Population



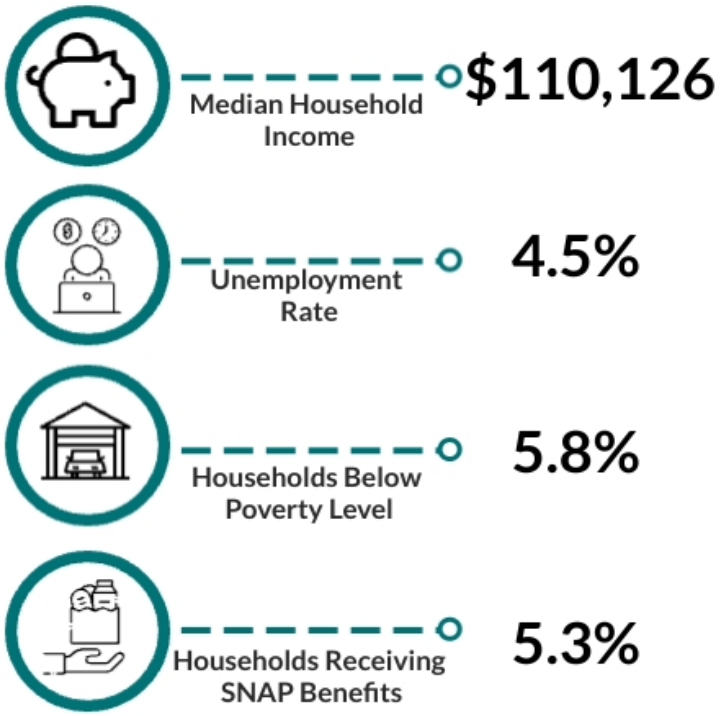
Population by Age

Education

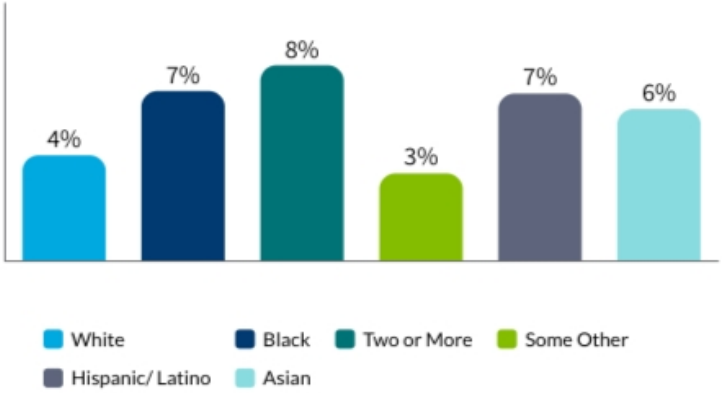


*Other (Race/Ethnicity) includes Asian, American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander
*Milford: Unlike the other municipalities in the Greater Bridgeport region, which are located in Fairfield County, the city of Milford is situated in New Haven County
*NH: Non-Hispanic

Economic Well-being



Population in Poverty by Race/Ethnicity

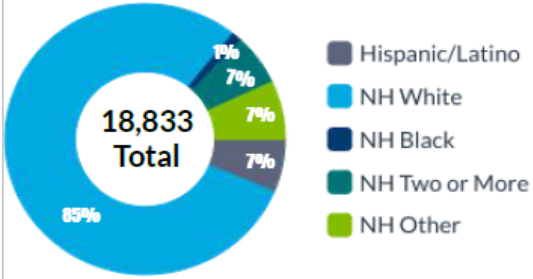


Demographic Overview

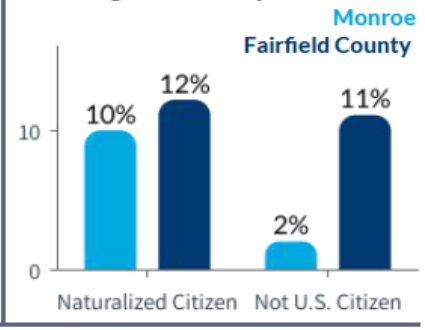
Monroe

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

Race/Ethnicity



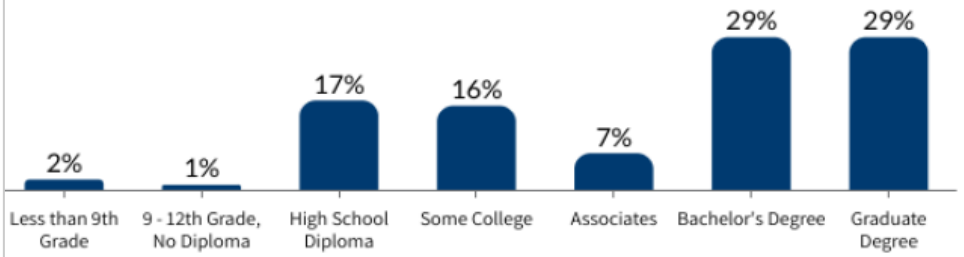
Foreign- Born Population



Population by Age

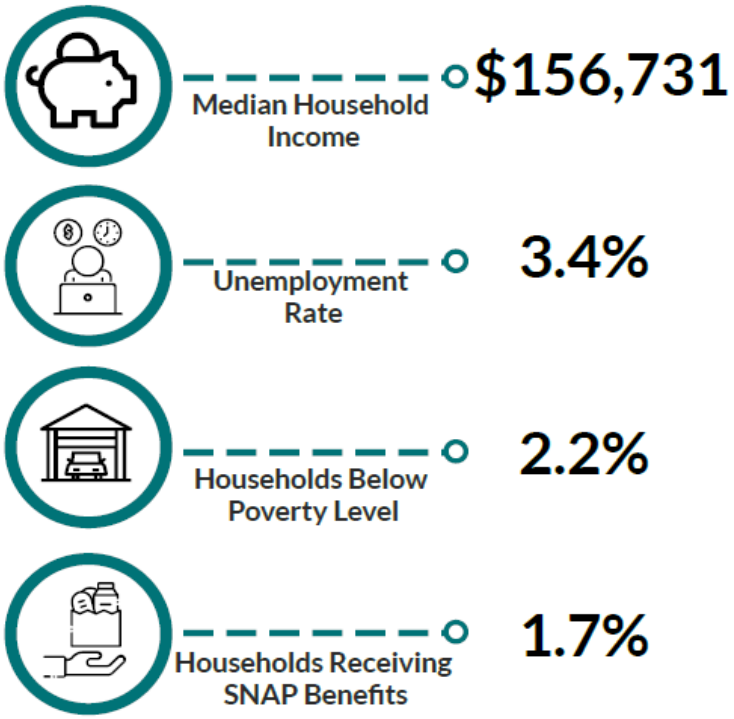
Under 18	18-64	65 +
25.2%	59.1%	15.7

Education

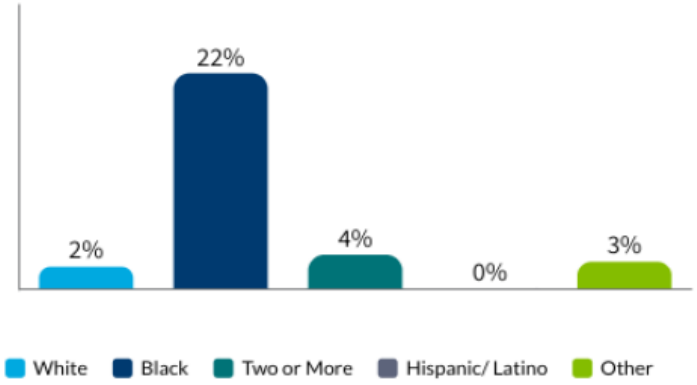


*Other (Race/Ethnicity) includes Asian, American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander
*NH: Non- Hispanic

Economic Well-being



Population in Poverty by Race/Ethnicity

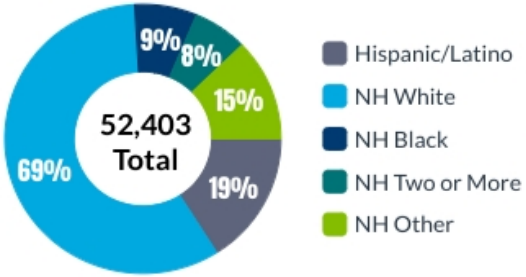


Demographic Overview

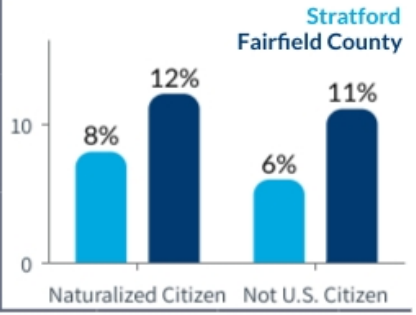
Stratford

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

Race/Ethnicity



Foreign- Born Population

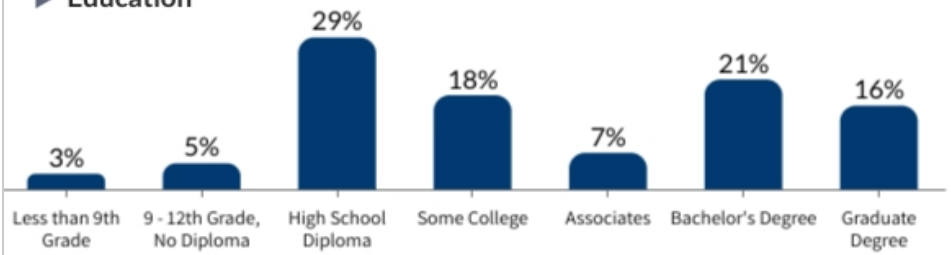


Population by Age

Under 18	18-64	65 +
17.7%	60.5%	21.8%

Median Age

Education



*Other (Race/Ethnicity) includes Asian, American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander
*NH: Non- Hispanic

Economic Well-being

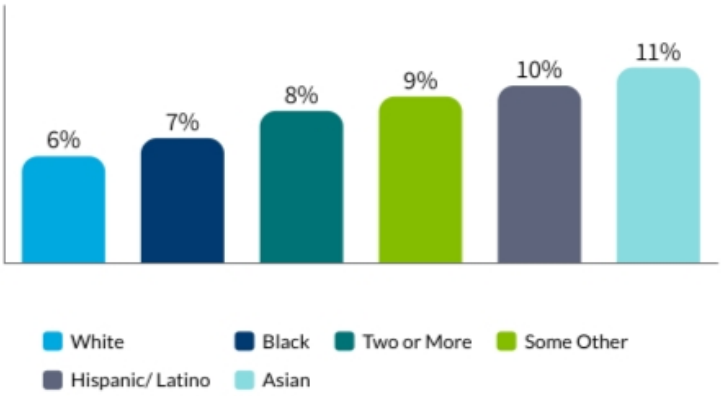
Median Household Income: $93,820

Unemployment Rate: 7.2%

Households Below Poverty Level: 7.6%

Households Receiving SNAP Benefits: 10.9%

Population in Poverty by Race/Ethnicity

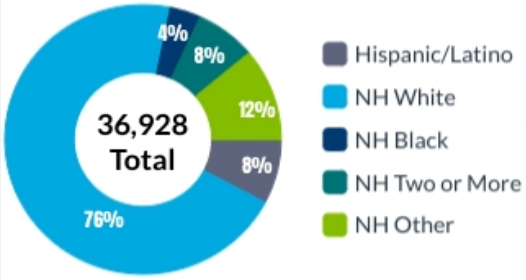


Demographic Overview

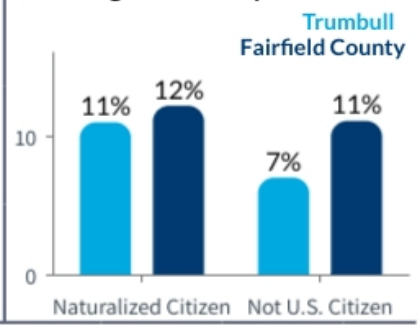
Trumbull

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

Race/Ethnicity



Foreign- Born Population

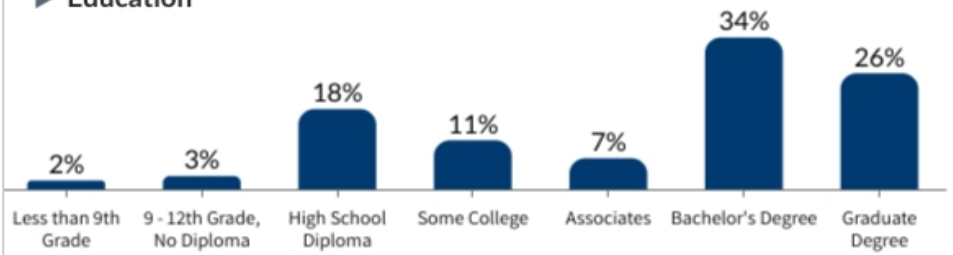


Population by Age

Under 18	18-64	65 +
27.0%	55.8%	17.2%

Median Age

Education



*Other (Race/Ethnicity) includes Asian, American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander
*NH: Non- Hispanic

Economic Well-being

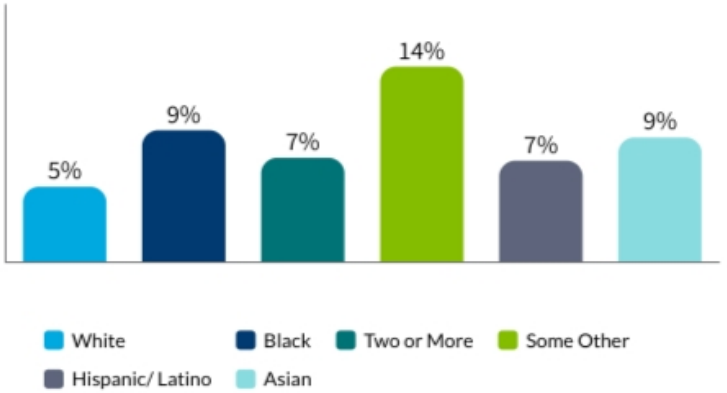
Median Household Income: $163,227

Unemployment Rate: 6.8%

Households Below Poverty Level: 6.6%

Households Receiving SNAP Benefits: 3.7%

Population in Poverty by Race/Ethnicity



Economic Stability

Economic Stability is one of the five social drivers of health, encompassing factors such as income, poverty, employment, food security, and housing stability. Individuals living in poverty are more likely to experience food insecurity, unstable or inadequate housing, and limited access to healthcare services, all of which can negatively impact health outcomes.

Income and Poverty

Economic stability plays a key role in overall health outcomes, as financial insecurity can limit access to health care, nutritious food, and stable housing. While some towns in Greater Bridgeport are more affluent, there are significant disparities in income and poverty levels. According to partners and community members, pockets of higher poverty exist, particularly in Bridgeport itself, where structural barriers contribute to generational poverty. Some residents face a difficult gap—earning too much to qualify for assistance programs but not enough to afford basic needs. Women are disproportionately affected by financial instability, facing unique challenges in economic security.

EXHIBIT 2: MEDIAN HOUSEHOLD INCOME

Geography	Income
Easton	$189,505
Fairfield	$168,391
Trumbull	163,227
Monroe	156,731
Fairfield County	***$115,059***
Milford	$109,580
Stratford	93,820
CT	***$93,760***
Bridgeport	$56,584
Greater Bridgeport Region	**$76,714**

Source:
U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 1

Bridgeport's median household income is significantly lower than nearby towns, highlighting the economic disparities in the region. Poverty is concentrated in certain areas, with some neighborhoods experiencing much higher rates than others.

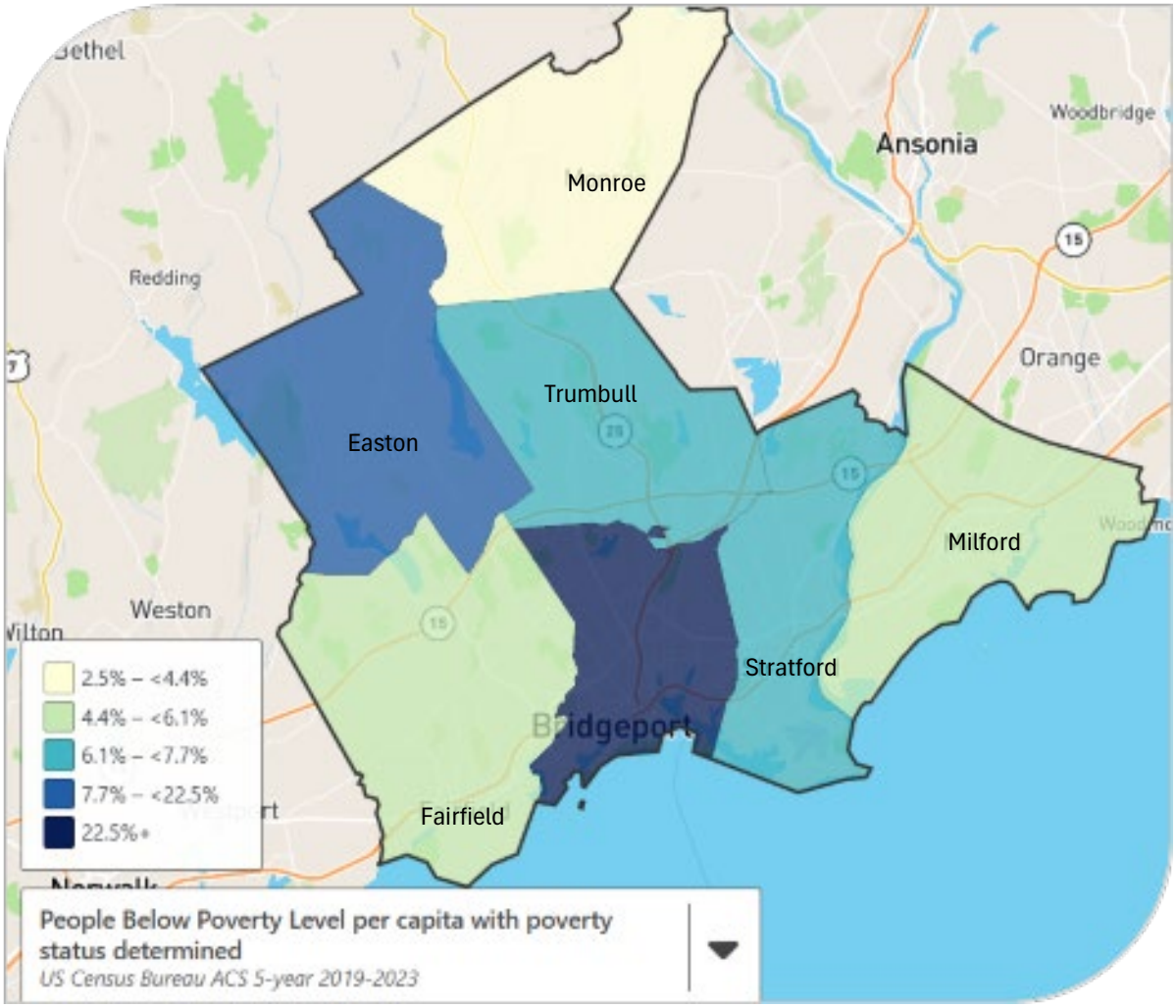
Beyond those living below the federal poverty line, many residents fall into the ALICE (Asset-Limited, Income Constrained, Employed) category, earning above the poverty level but struggling to afford necessities. This financial strain can impact their ability to seek health care, maintain stable housing, or invest in preventive care.

EXHIBIT 3: PERCENT OF POPULATION BELOW UNITED WAY ALICE THRESHOLD

United Way Asset-Limited, Income Constrained, Employed (ALICE) Population	
Fairfield County	**Connecticut**
	

Source: United Way ALICE. Table 27

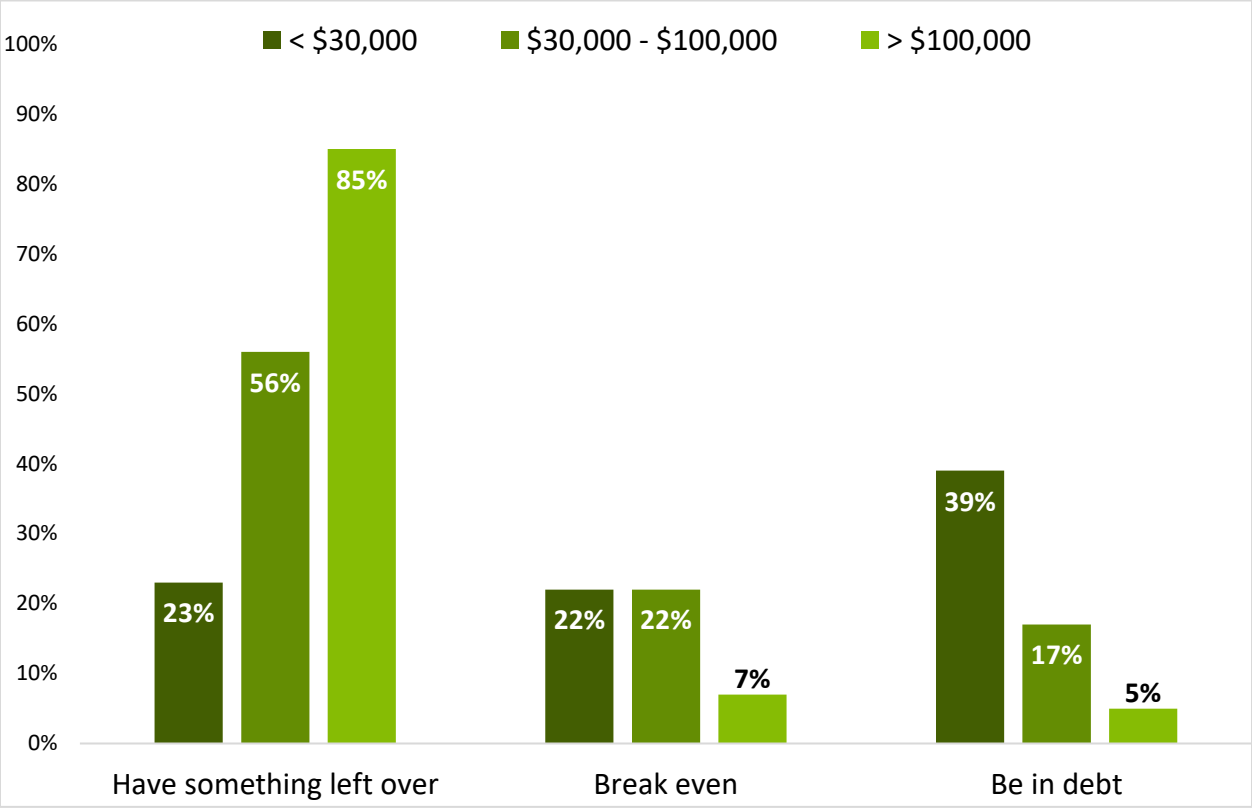
EXHIBIT 4: PERCENT OF POPULATION BELOW POVERTY LEVEL



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 26

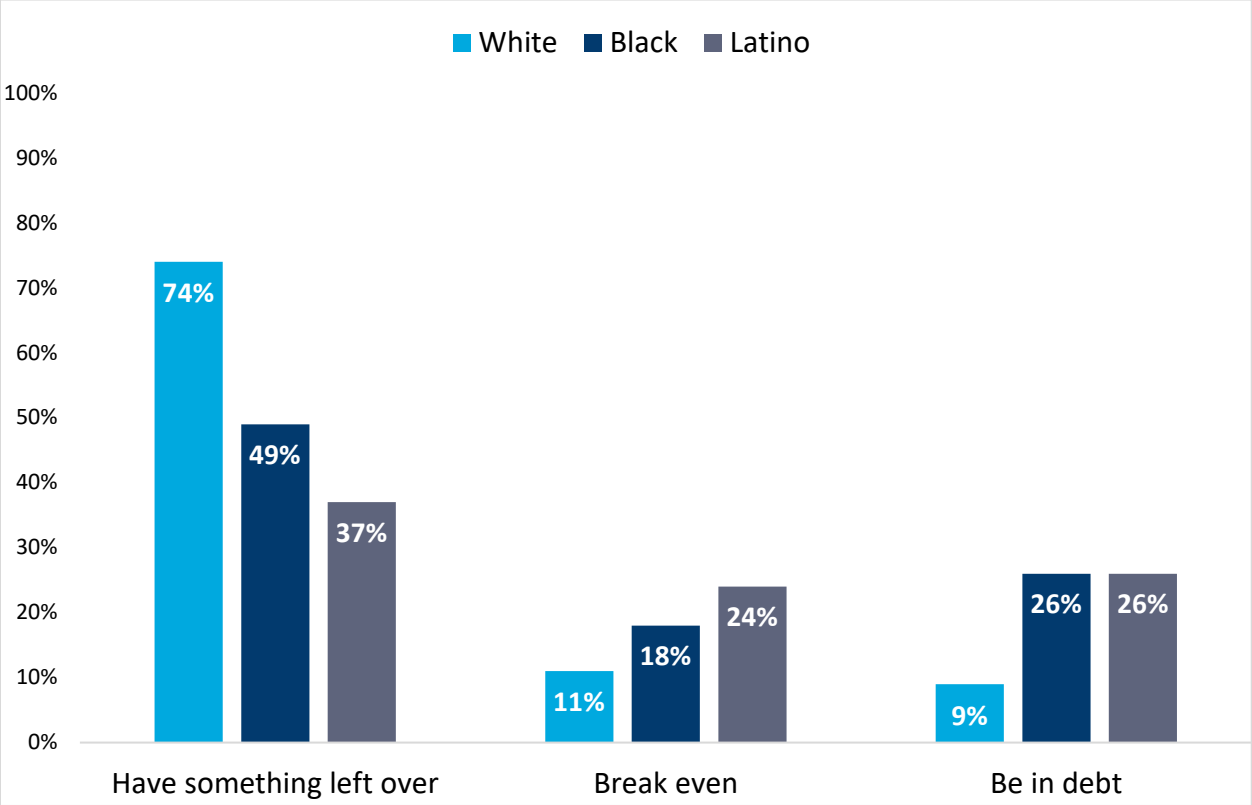
DCWS data further illustrates the financial challenges faced by low-income adults. Those earning less than $30,000 are far more likely to be in debt after selling all major possessions, investments, and assets, while those with higher incomes are more likely to have financial reserves. This disparity underscores the connection between income and financial security, which can directly impact access to health care and other essential resources.

EXHIBIT 5: DCWS QUESTION – FINANCIAL STATUS OF RESPONDENTS AFTER SELLING ALL MAJOR POSSESSIONS, INVESTMENTS, ASSETS, AND PAYING OFF ALL DEBTS, BY INCOME



Racial disparities in financial security are also evident, with Black and Latino residents less likely than White residents to have financial reserves after selling major assets and more likely to be in debt. These differences reflect broader structural inequities in wealth accumulation and economic opportunity, which can further limit access to health care and other necessities.

EXHIBIT 6: DCWS QUESTION – FINANCIAL STATUS OF RESPONDENTS AFTER SELLING ALL MAJOR POSSESSIONS, INVESTMENTS, ASSETS, AND PAYING OFF ALL DEBTS, BY RACE/ETHNICITY



Employment and Livable Wages

The ability to earn a livable wage directly affects residents' ability to meet their basic needs, access health care, and maintain overall wellbeing. Partners and community members highlighted the rising cost of living as a growing challenge. While some residents may experience slight income increases, these increases can disqualify them from essential services, leaving them in a difficult financial position. Partners described a "huge gap in the socioeconomic landscape," as Connecticut's costs continue to rise.

> **"Some families are cohabiting. It comes down to a livable wage that allows people to pay the rent and provide food for their families."**
>
> **- Partner**

EXHIBIT 7: DCWS QUESTION – RESPONDENT PERSPECTIVES ON THE ABILITY OF RESIDENTS TO OBTAIN SUITABLE EMPLOYMENT, BY RACE/ETHNICITY

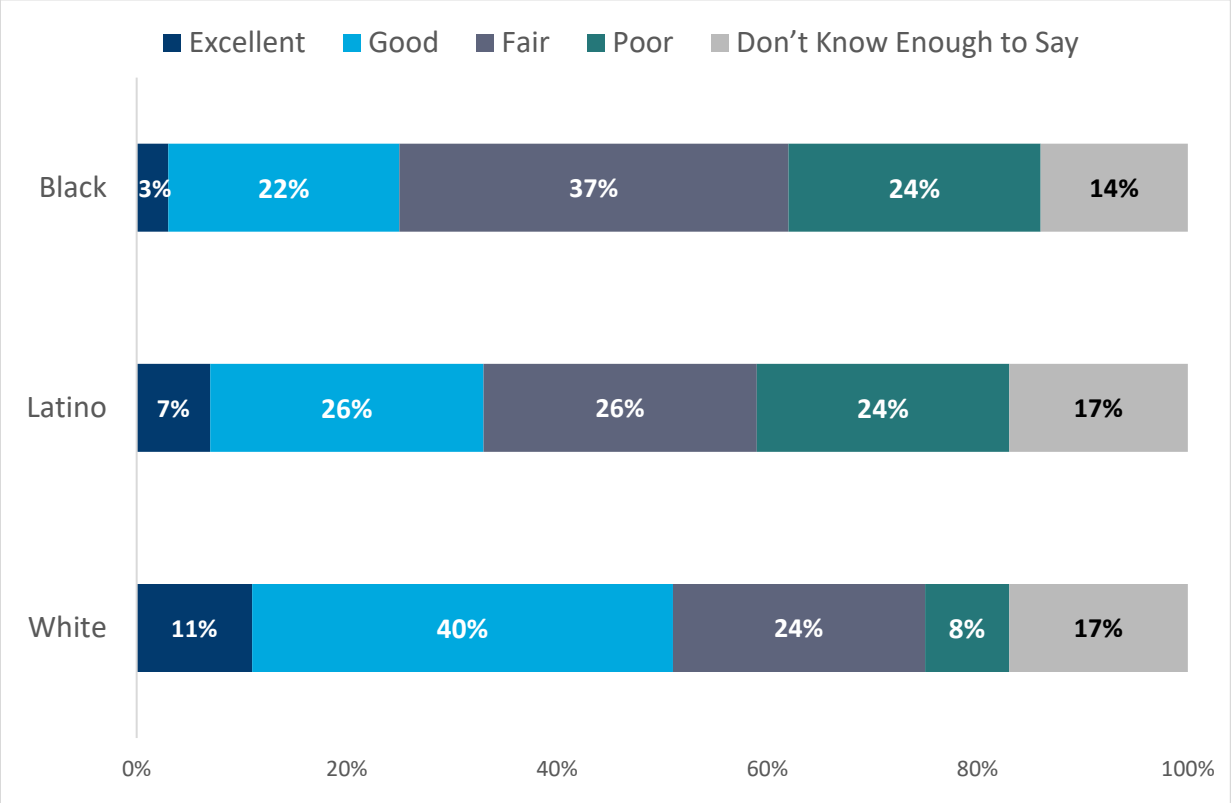
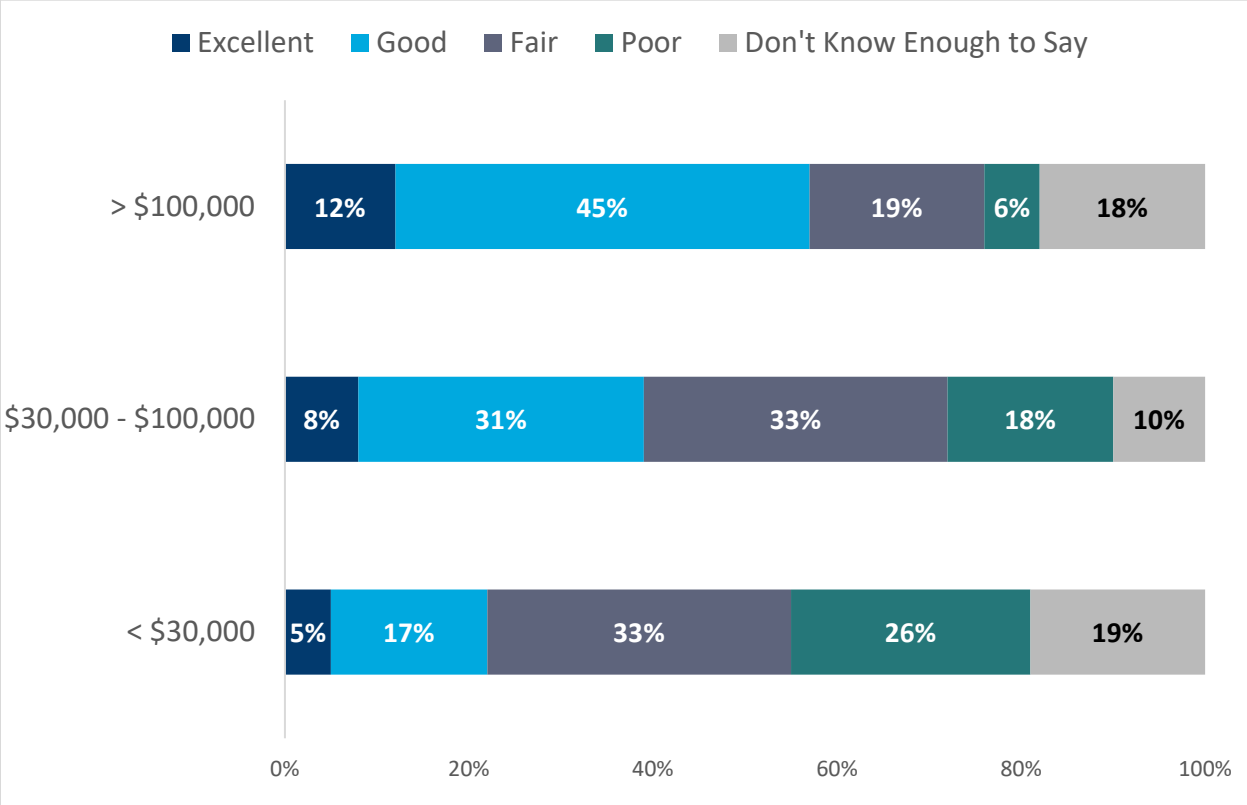


EXHIBIT 8: DCWS QUESTION – RESPONDENT PERSPECTIVES ON THE ABILITY OF RESIDENTS TO OBTAIN SUITABLE EMPLOYMENT, BY INCOME



According to DCWS data, 42% of respondents believe residents have an 'excellent' or 'good' ability to find suitable employment. However, the data shows disparities by both race and income. Black and Latino respondents were less likely to rate employment opportunities positively compared to White respondents, while lower-income residents were more likely to report difficulties finding work that meets their needs.

EXHIBIT 9: DCWS QUESTION – RESPONDENTS WHO HAVE NOT HAD A JOB IN THE PAST 30 DAYS, BUT WOULD LIKE TO WORK, BY RACE/ETHNICITY

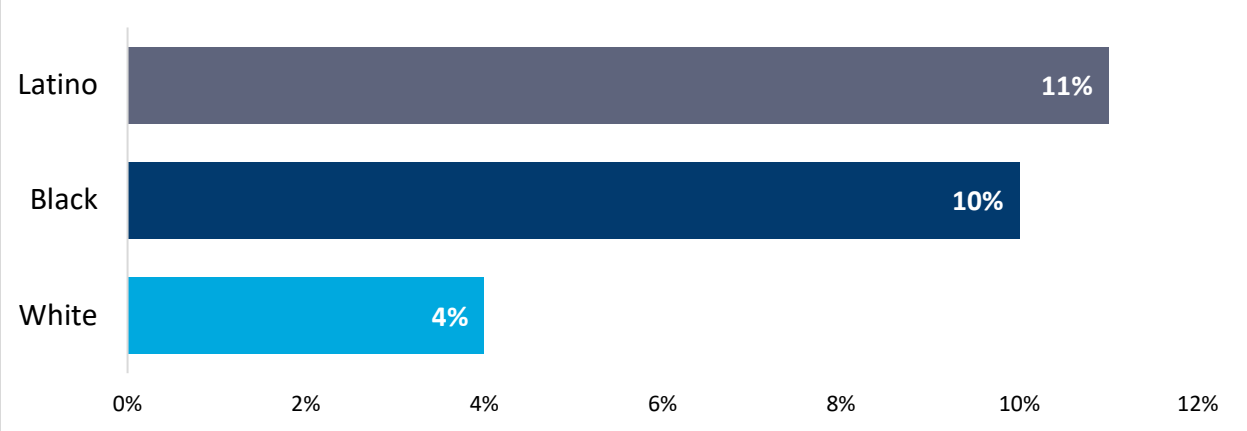
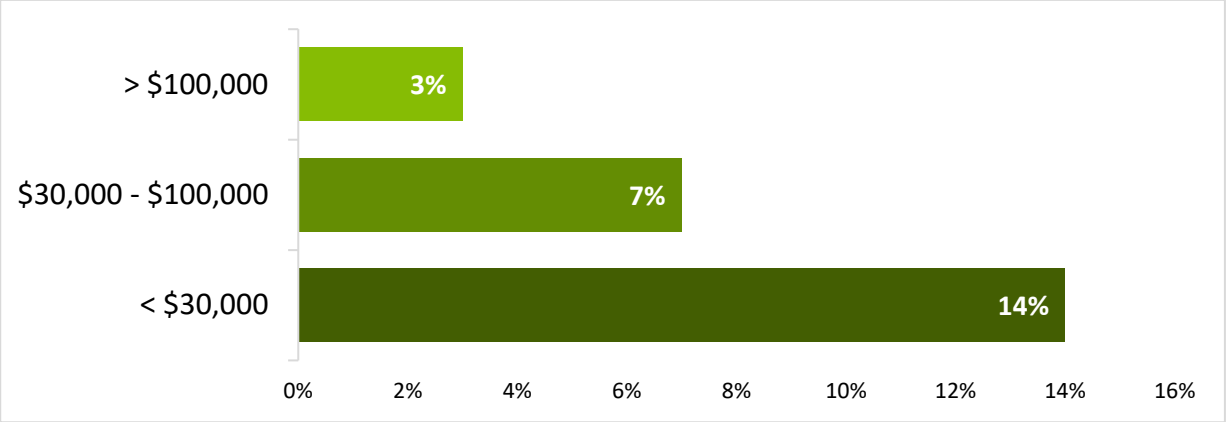


EXHIBIT 10: DCWS QUESTION – RESPONDENTS WHO HAVE NOT HAD A JOB IN THE PAST 30 DAYS, BUT WOULD LIKE TO WORK, BY INCOME



Survey data also highlights differences in unemployment across demographics. Latino and Black respondents were more likely to report being unemployed but looking for work than White respondents. Income-based disparities also emerged, with 14% of residents earning less than $30,000 reporting they had not worked in the past 30 days but would like to, compared to only 3% of those earning $100,000 or more. These disparities reflect broader structural barriers, including access to education, employment training, and transportation, that disproportionately impact lower-income and minority communities.

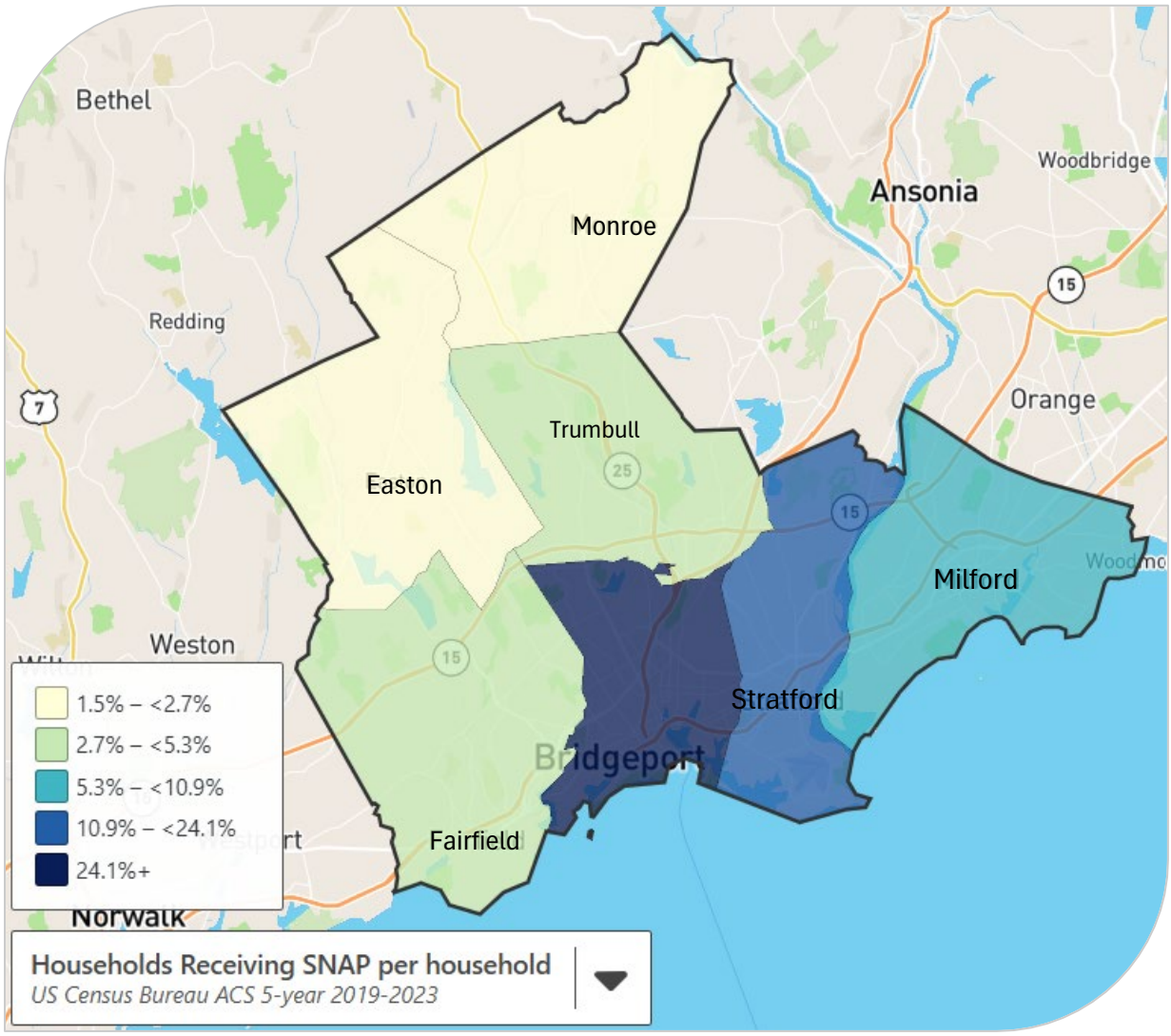
Food Insecurity

Food insecurity is a pressing issue in Greater Bridgeport, with many residents facing limited access to nutritious food. Partners and community members described parts of the region as a food desert, where convenience stores often stock unhealthy options while affordable, high-quality fresh food remains scarce. Some schools provide free breakfast and lunch for children, but partners raised concerns about the nutritional quality of these meals due to cost limitations.

From May 2019 - May 2025, Bridgeport Hospital served more than 18,000 people through a free food distribution program that is open to anyone in need.

Community members shared that, while local food banks have expanded their partnerships to include fresh and locally sourced food, additional nutrition education is needed to help community members make healthier food choices. Faith-based and nonprofit organizations serve tens of thousands of meals each month, yet there is a growing need for culturally sensitive food options to better meet the needs of diverse communities.

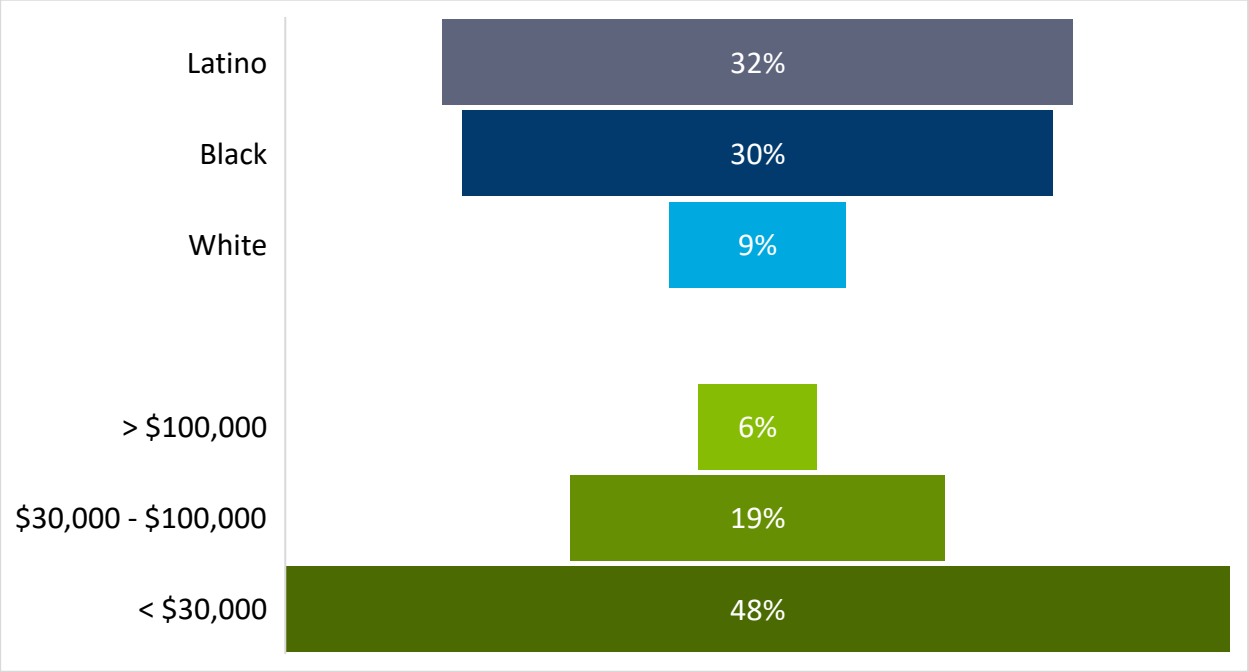
EXHIBIT 11: PERCENT OF HOUSEHOLDS RECEIVING SNAP BENEFITS



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 32

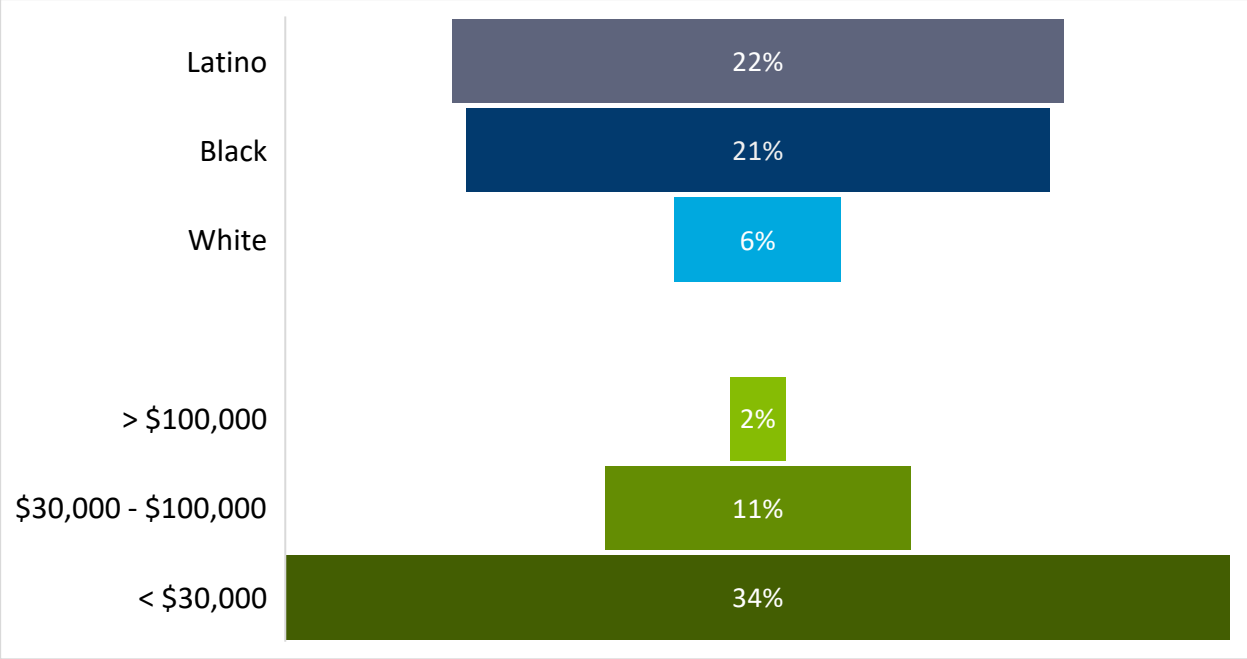
Data from DCWS highlights disparities in food insecurity across racial and income groups. Overall, 19% of respondents reported they did not have enough money to buy food for themselves or their family in the past year, but this percentage was much higher among Latino (32%) and Black (30%) respondents compared to White (9%) respondents. Income-based disparities were even more pronounced, with 48% of respondents earning less than $30,000 reporting food insecurity, compared to 19% of those earning $30,000–$100,000 and just 6% of those earning $100,000 or more.

EXHIBIT 12: DCWS QUESTION – RESPONDENTS WHO DID NOT HAVE ENOUGH MONEY TO BUY NECESSARY FOOD FOR SELF OR FAMILY IN THE PAST 12 MONTHS, BY RACE/ETHNICITY AND INCOME



Similarly, reliance on emergency food assistance varies significantly by race and income. Overall, 13% of DCWS respondents received groceries or meals from a food pantry, food bank, soup kitchen, or other emergency food service in the past 12 months, but this was reported at higher rates among Latino (22%) and Black (21%) respondents compared to White (6%) respondents. Income disparities are also evident, as 34% of respondents earning less than $30,000 relied on emergency food services, compared to 11% of those earning $30,000–$100,000 and just 2% of those earning $100,000 or more.

EXHIBIT 13: DCWS QUESTION – RESPONDENTS WHO RECEIVED GROCERIES OR MEALS FROM A FOOD PANTRY, FOOD BANK, SOUP KITCHEN, OR OTHER EMERGENCY FOOD SERVICE IN PAST 12 MONTHS, BY RACE/ETHNICITY AND INCOME



Beyond access, food affordability and quality also impact residents' ability to maintain a healthy diet. According to CBANS data, 72% of respondents rated the availability of affordable, high-quality fruits and vegetables in their area as ‘excellent’ or ‘good’, but differences exist by race and income. White (34%) and Asian (36%) respondents were more likely to rate availability as “excellent” compared to Black (20%) and Latino (14%) respondents. Income-based differences also emerged, with higher-income respondents ($75,000 or more) more likely to rate food availability as “excellent” (34%) compared to those earning less than $75,000 (21%). Without intervention, food insecurity in Greater Bridgeport could contribute to long-term health consequences, including higher rates of obesity, diabetes, and other chronic conditions.

EXHIBIT 14: CBANS QUESTION – PARTICIPANT PERSPECTIVES ON THE AVAILABILITY OF AFFORDABLE, HIGH-QUALITY FRUITS AND VEGETABLES, BY RACE/ETHNICITY

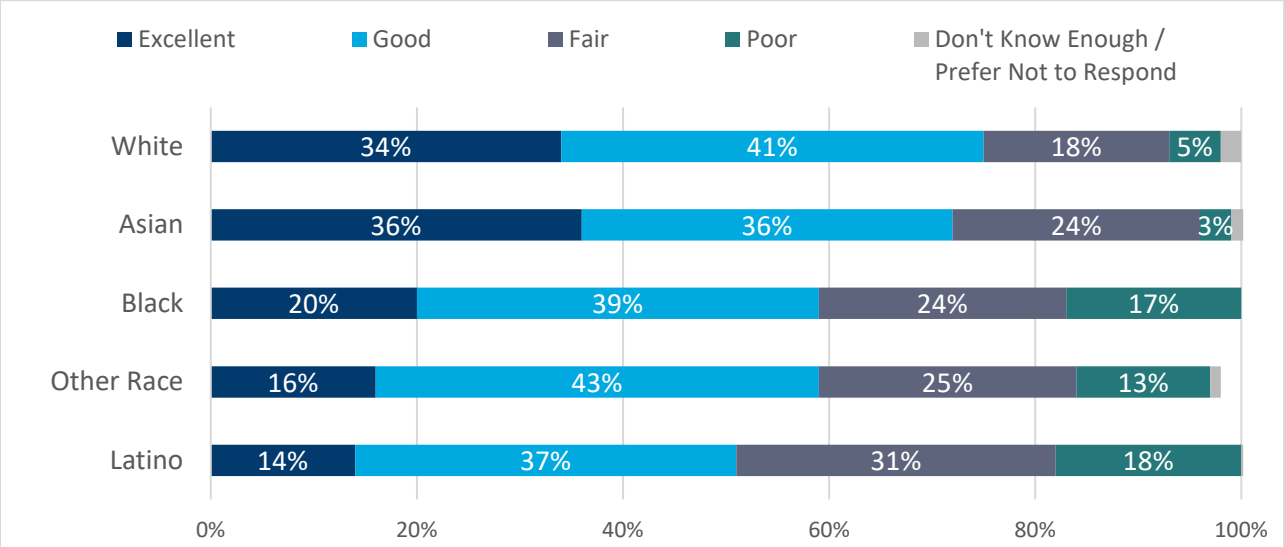
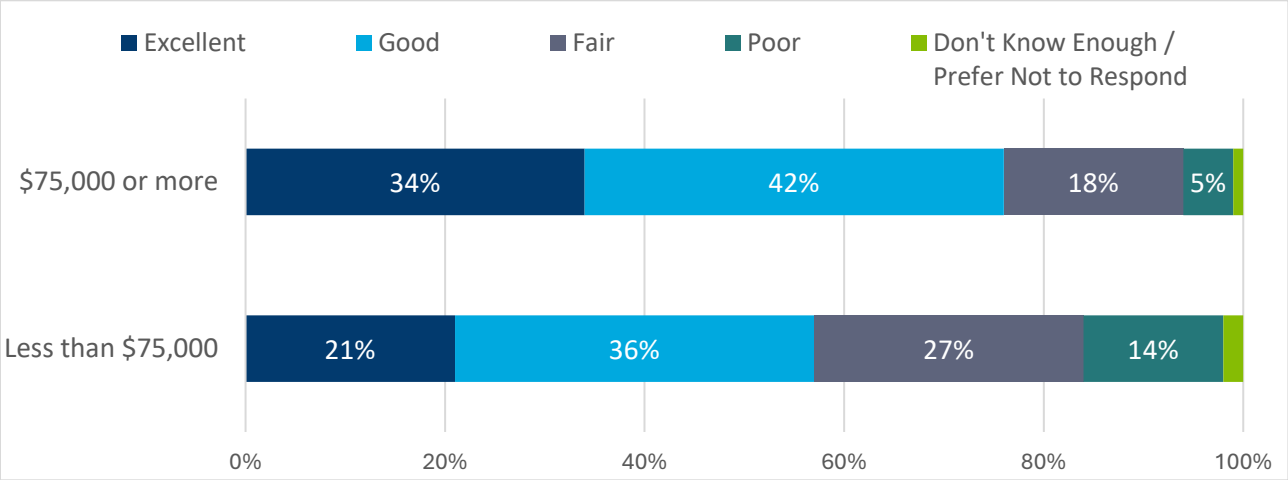


EXHIBIT 15: CBANS QUESTION – PARTICIPANT PERSPECTIVES ON THE AVAILABILITY OF AFFORDABLE, HIGH-QUALITY FRUITS AND VEGETABLES, BY INCOME



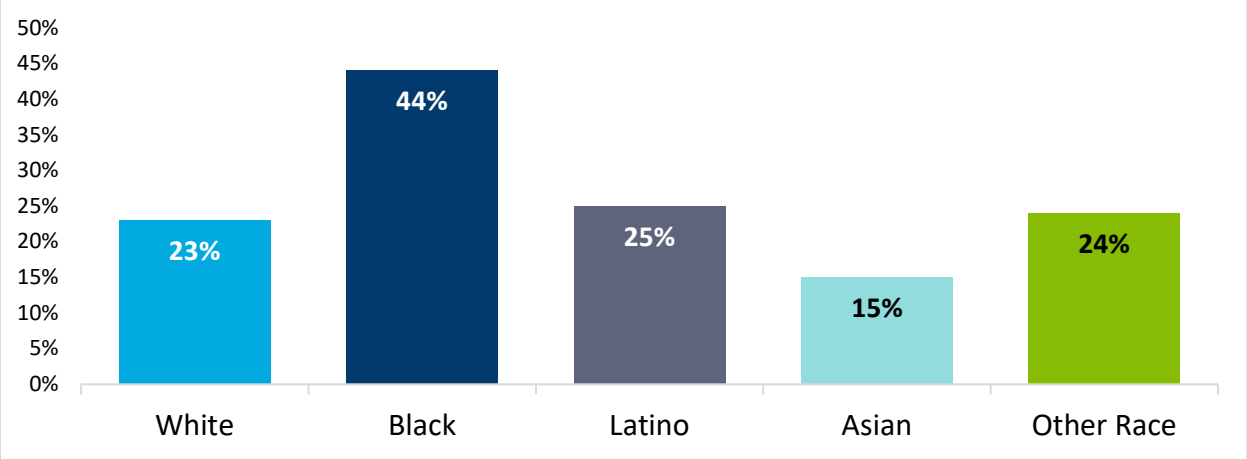
Housing

Access to stable, safe housing is essential for health, yet many residents in Greater Bridgeport face significant barriers. Partners and community members expressed concerns about housing access, noting that while empty buildings exist, they are not being repurposed to meet urgent needs such as shelters or warming centers. The end of federal COVID-19 housing assistance has further strained low-income households, leaving many without adequate support. Additionally, partners highlighted that navigating available resources, such as the 211 hotline, can feel frustrating and unhelpful, contributing to the ongoing housing crisis.

Housing affordability also remains a pressing issue, with the hourly wage needed to afford a two-bedroom apartment in Fairfield County reaching $37.83, far exceeding the earnings of many low- and middle-income workers—more than double Connecticut's minimum wage of $16.35 (Table 37). The state's population growth has also increased demand for housing, further increasing costs and making affordable options even more limited.

CBANS data shows that low-income and Black residents are disproportionately affected by housing instability, with Black respondents reporting the highest rates of financial difficulty securing housing.

EXHIBIT 16: CBANS QUESTION – RESPONDENTS WHO DID NOT HAVE ENOUGH MONEY FOR ADEQUATE HOUSING AND SHELTER IN THE PAST YEAR, BY RACE



Homeownership and rental patterns reflect significant disparities across income and racial groups. CBANS data shows that 93% of respondents with higher incomes ($75,000 or more) own their homes, compared to 63% of those earning less than $75,000. Black and Latino residents are far more likely to rent rather than own their homes, which can make long-term housing stability more challenging.

EXHIBIT 17: CBANS QUESTION – RESPONDENT LIVING ARRANGEMENTS

Race/Ethnicity					Living Arrangements	Income	
White	Black	Latino	Asian	Other Race		Less than $75,000	$75,000 or more
90%	61%	63%	81%	84%	I own my home	63%	93%
5%	32%	29%	5%	7%	I rent my home	24%	4%
3%	2%	6%	10%	3%	I live with family or friends who own	7%	2%
0%	0%	1%	3%	1%	I live with family or friends who rent	1%	0%
0%	2%	0%	0%	4%	Homeless	1%	0%
0%	0%	0%	0%	0%	Group quarters	1%	0%

LEGEND

Less More

Addressing housing affordability and security is crucial to improving public health outcomes. Without stable housing, individuals face challenges in accessing health care, maintaining employment, and ensuring proper nutrition, all of which contribute to overall wellbeing.

Childcare

Access to affordable, reliable childcare is a significant challenge for families. Partners highlighted that the high cost of childcare, particularly at credentialed centers, places a strain on working parents.

> **"Both parents work and they can't afford to pay for childcare because they need to pay the rent, diapers, bills, and food."**
>
> **-Partner**

Many families face additional financial burdens from limited hours, extra fees for extended care, and long waitlists, especially during the summer months. These barriers make it difficult for parents to secure stable employment or advance in their careers.

While state-funded childcare programs exist, eligibility requirements often exclude families who need assistance but earn just above the income threshold. Additionally, these programs require parents to have a job, creating a difficult cycle for those struggling to secure employment because of childcare responsibilities.

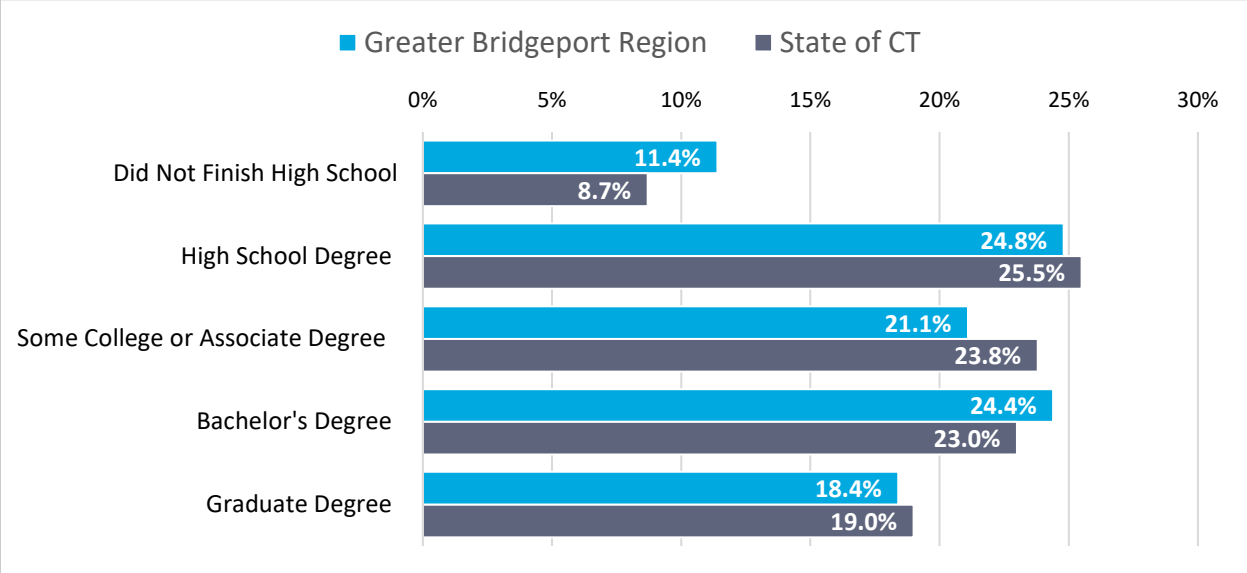
Partners emphasized the need for expanded access to childcare subsidies and lower income eligibility guidelines to ensure that more families can afford safe, high-quality childcare options. Addressing these challenges is critical, as limited childcare access directly impacts economic stability and workforce participation.

Education Access and Quality

Education Access and Quality is one of the five social drivers of health. High quality education and early childhood education programs can break intergenerational cycles of poverty by providing people with the skills and knowledge to promote social mobility and economic success. Higher income employment opportunities can increase a person's access to better quality healthcare, nutritious foods, and safe living environments.

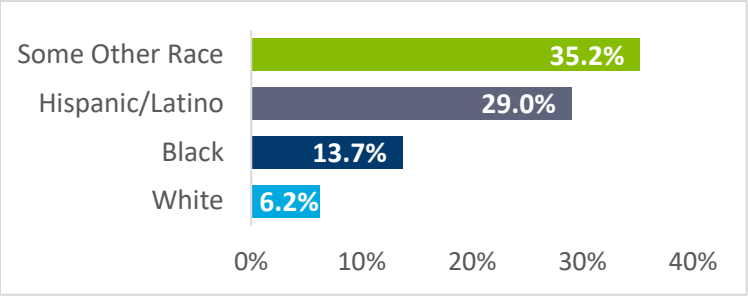
While the percentage of adults with a bachelor's or graduate degree in Greater Bridgeport is similar to the state average, a higher proportion of residents did not finish high school. Lower educational attainment can impact long-term economic stability, limiting access to jobs that provide livable wages and health benefits.

EXHIBIT 18: HIGHEST LEVEL OF EDUCATIONAL ATTAINMENT, 25 YEARS AND OLDER



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 19

EXHIBIT 19: ADULTS WITHOUT A HIGH SCHOOL DIPLOMA (AGE 25+), AS A SHARE OF THEIR RACIAL/ETHNIC GROUP IN GREATER BRIDGEPORT REGION



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 22

Educational disparities are evident across racial and ethnic groups. Hispanic/Latino and Black residents are more likely to have lower levels of educational attainment compared to their White counterparts.

EXHIBIT 20: PREVALENCE OF CHRONIC CONDITIONS BY EDUCATION LEVEL

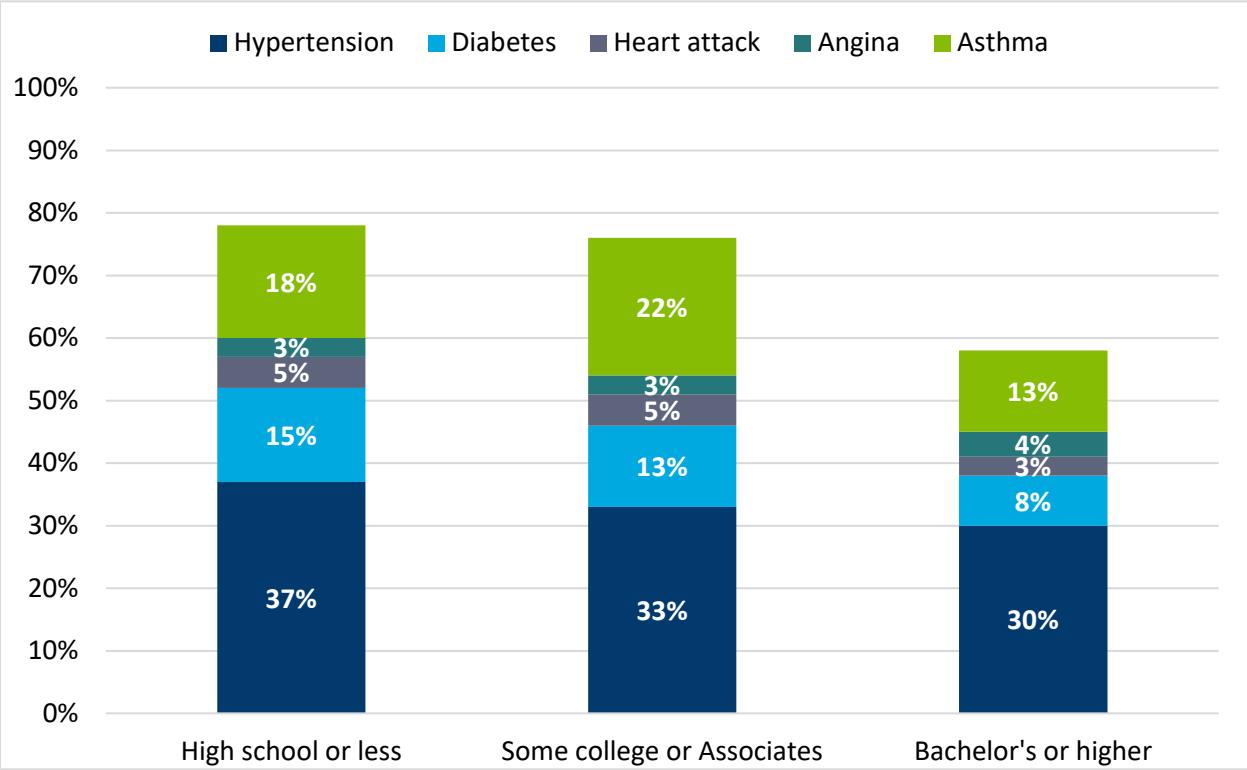
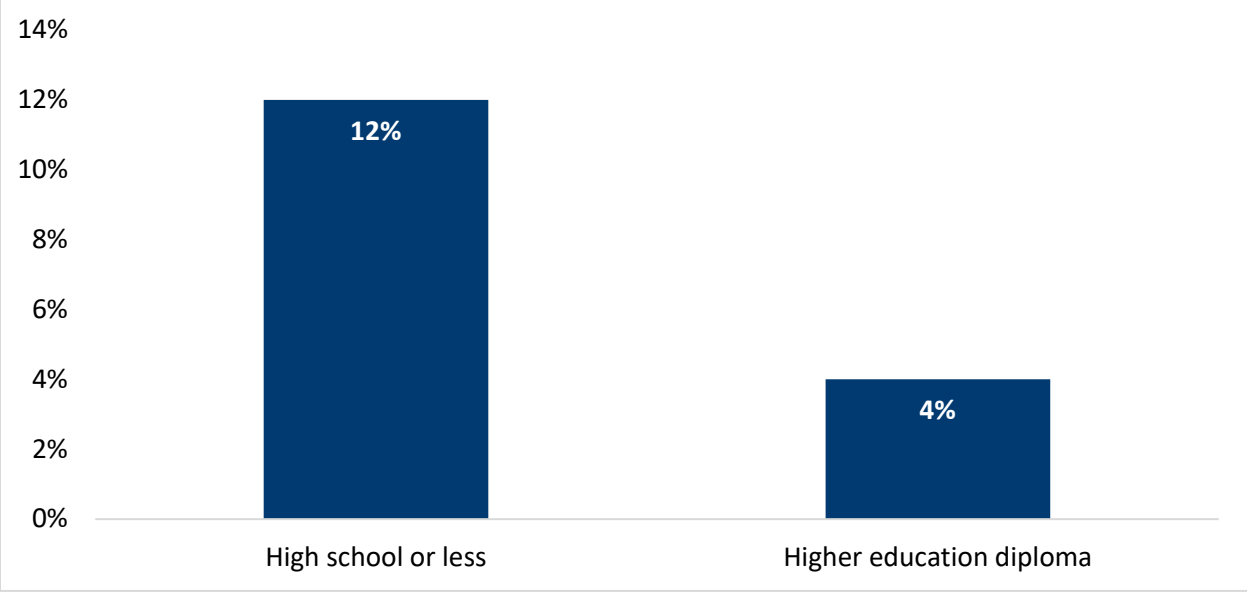


EXHIBIT 21: DCWS QUESTION – UNINSURED RESPONDENTS WITH NO HIGH SCHOOL DIPLOMA VS. HIGHER ED

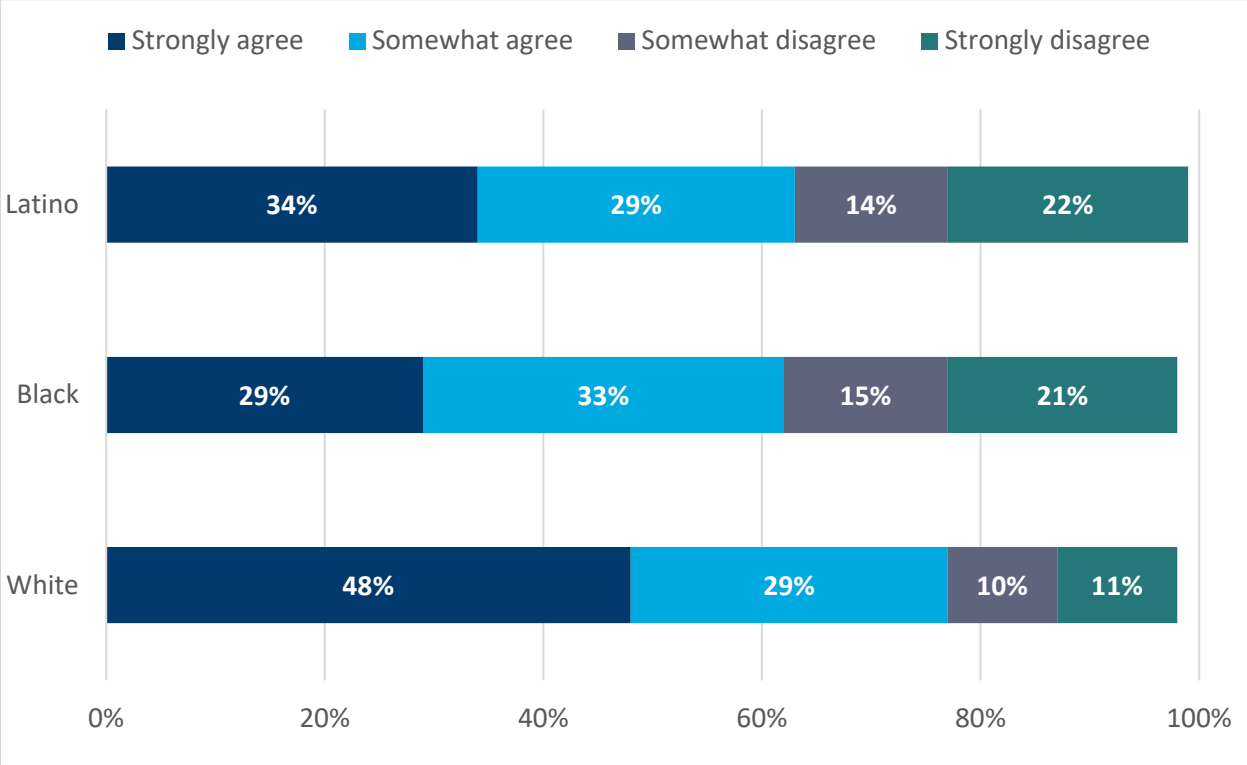


Neighborhood and Built Environment

Neighborhood and Built Environment is one of the five social drivers of health. It includes key factors such as quality of housing, access to transportation, and neighborhood crime and violence. Environmental conditions, such as air pollution, unsafe drinking water, and climate change also play a significant role in affecting both individual and community health.

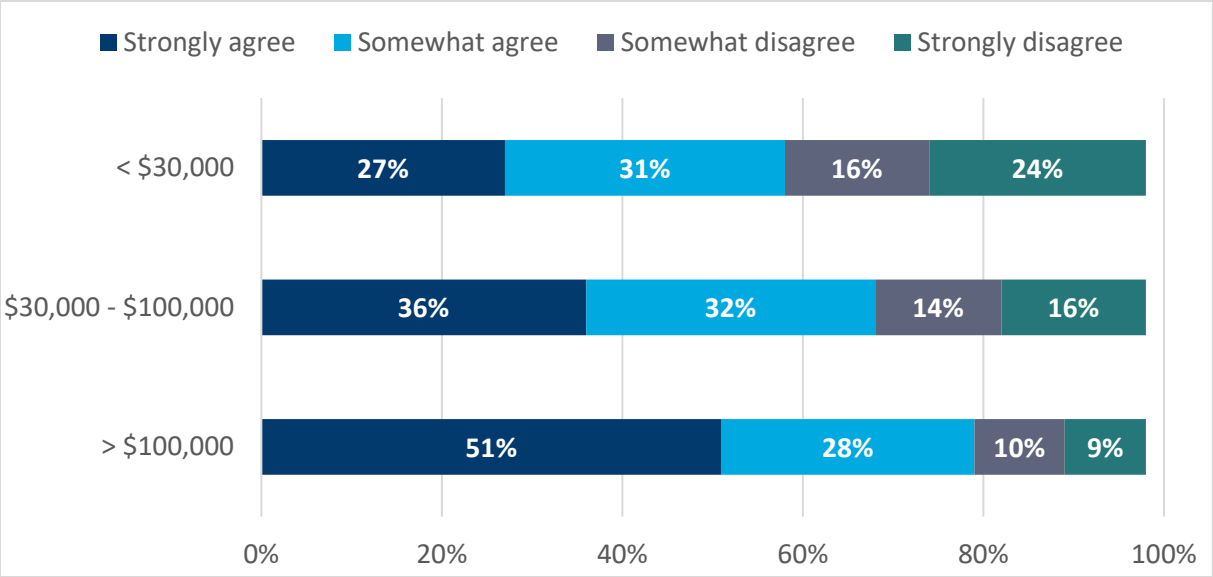
Overall, 27% of DCWS respondents reported that they 'somewhat disagree' or 'strongly disagree' that their neighborhood has several free or low-cost recreation facilities, such as parks, playgrounds, and public swimming pools. Access to these spaces is important for encouraging physical activity and fostering social connections, yet disparities exist across Greater Bridgeport.

EXHIBIT 22: DCWS QUESTION – RESPONDENTS' PERSPECTIVE ON WHETHER THEIR NEIGHBORHOOD HAS SEVERAL FREE OR LOST COST RECREATION FACILITIES, SUCH AS PARKS, PLAYGROUNDS, PUBLIC SWIMMING POOLS, ETC., BY RACE/ETHNICITY



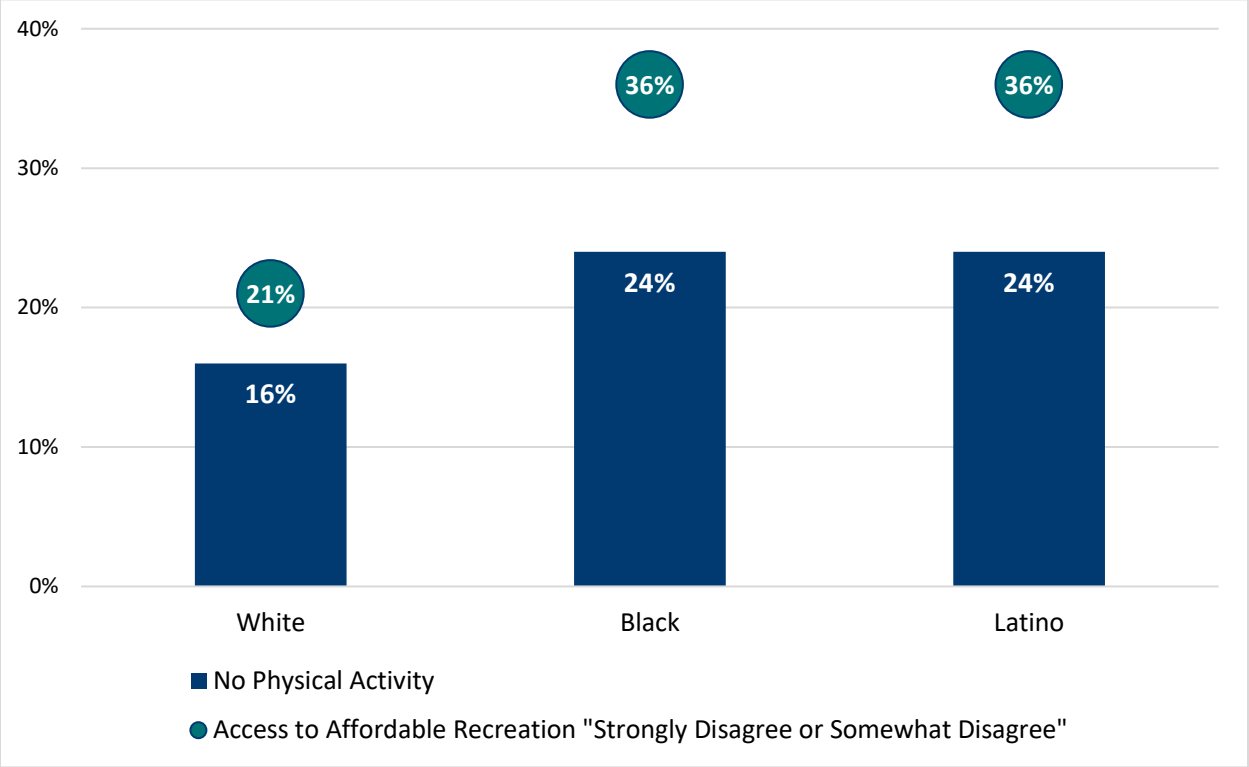
Survey data indicates differences in access by race, with Latino and Black respondents less likely than White respondents to strongly agree that their neighborhood has sufficient recreational spaces. Differences also emerge by income, with higher-income respondents more likely to report adequate access compared to lower-income respondents.

EXHIBIT 23: DCWS QUESTION – RESPONDENTS' PERSPECTIVE ON WHETHER THEIR NEIGHBORHOOD HAS SEVERAL FREE OR LOST COST RECREATION FACILITIES, SUCH AS PARKS, PLAYGROUNDS, PUBLIC SWIMMING POOLS, ETC., BY INCOME



These disparities highlight the need for equitable investment in community infrastructure to ensure that all residents, regardless of race or income, have access to safe and affordable places for physical activity and social engagement.

EXHIBIT 24: DCWS QUESTION – DCWS QUESTIONS - ACCESS TO AFFORDABLE RECREATION IN COMMUNITY (STRONGLY DISAGREE AND SOMEWHAT DISAGREE) VS. HOW MANY DAYS PER WEEK DO YOU EXERCISE (NONE), BY RACE/ETHNICITY



Transportation

Transportation access plays a critical role in ensuring residents can reach essential services, including health care, employment, and grocery stores. However, Partners and community members identified inadequate public transportation as a major challenge. They noted that inconsistent schedules and limited service hours make it difficult for residents to rely on public transit for daily needs. Medical transportation services are available but are often unreliable and require advanced booking, making them inaccessible for urgent health care needs. Recent changes in Medicare/Medicaid transportation services have further decreased service quality and reliability.

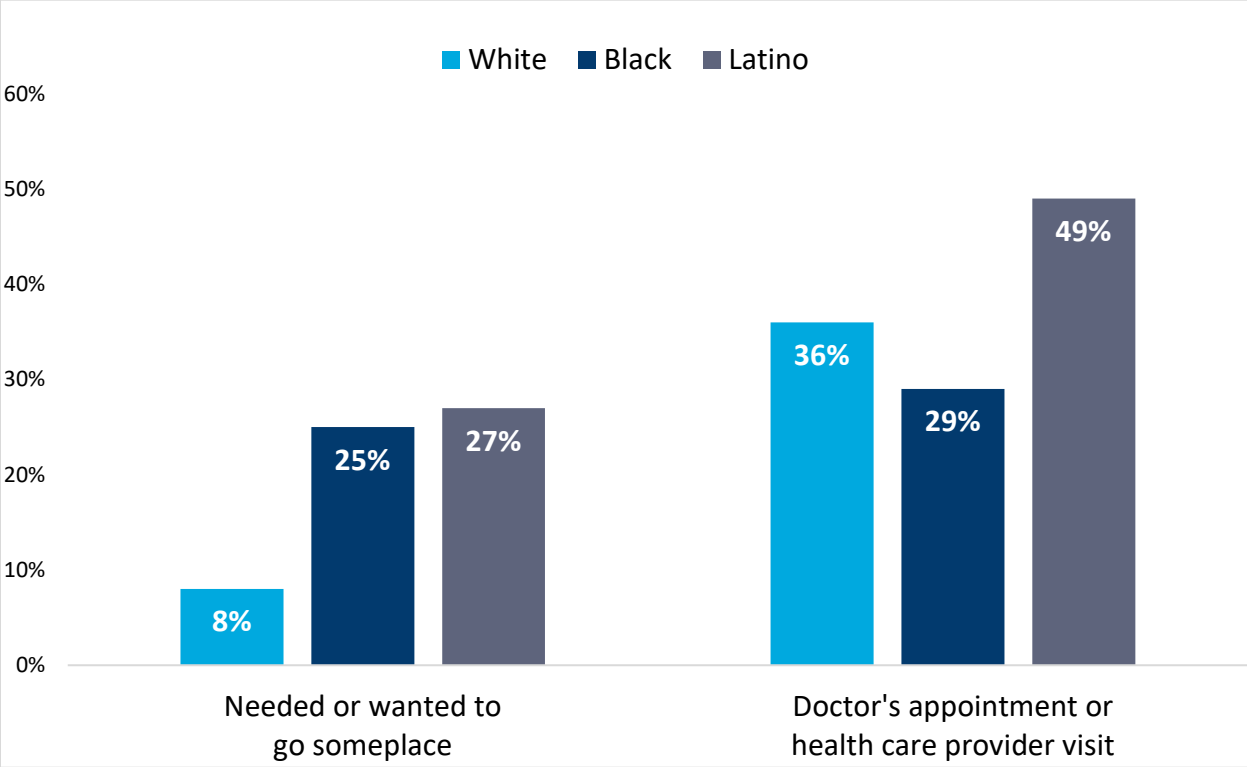
"Medical transportation is available, but they are not reliable. The buses are on their own schedule. You can't book the transportation more than 48 hours ahead, but then they say you should've done it sooner, so you miss the appointment. "

-Partner

Bridgeport Hospital has a Transportation Assistance Fund to help patients access public transportation to get to their medical appointments.

Lack of reliable transportation directly impacts health care access. Survey data from DCWS shows that 40% of respondents missed a health care appointment because they did not have access to a car. Black and Latino respondents were more likely to stay home due to transportation barriers, further exacerbating existing health disparities.

EXHIBIT 25: DCWS QUESTION – RESPONDENTS THAT STAYED HOME WHEN THEY NEEDED OR WANTED TO GO SOMEPLACE DUE TO A LACK OF ACCESS TO RELIABLE TRANSPORTATION, BY RACE/ETHNICITY



Social and Community Context

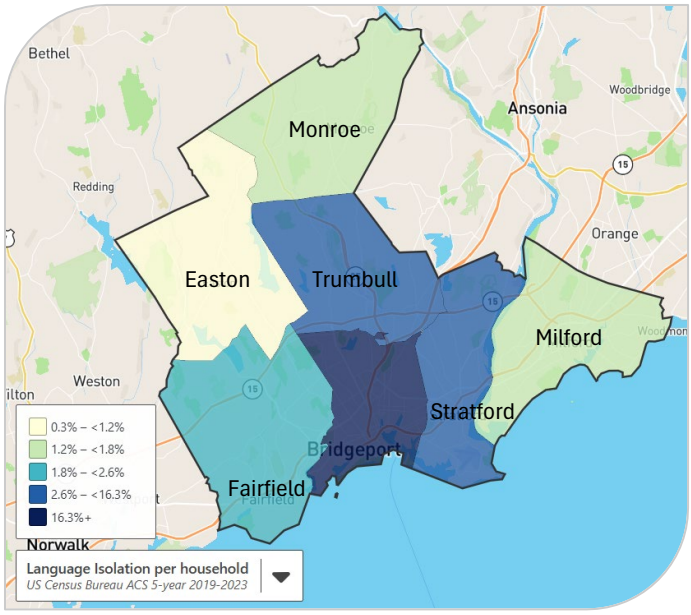
Social and Community Context is one of the five social drivers of health. A person's relationships and interactions with family, friends, coworkers, and community members can have a major impact on their health and wellbeing. Many people face challenges, such as unsafe neighborhoods, discrimination, or difficulty affording the basic things they need to survive, which can have a negative impact on their health and safety.

According to the Census, 20.8% of the population in Greater Bridgeport is foreign-born, including both U.S. naturalized citizens and non-citizens.

Language barriers are also a concern, with 7.6% of households in the region speaking limited English, a rate higher than the state average of 5.1%. Within Bridgeport itself, 16.3% of households experience language barriers, highlighting a greater need for multilingual services.

Survey data supports these findings, with 19% of DCWS respondents reporting they were not born in the United States.

EXHIBIT 26: LANGUAGE BARRIERS[3]



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 12

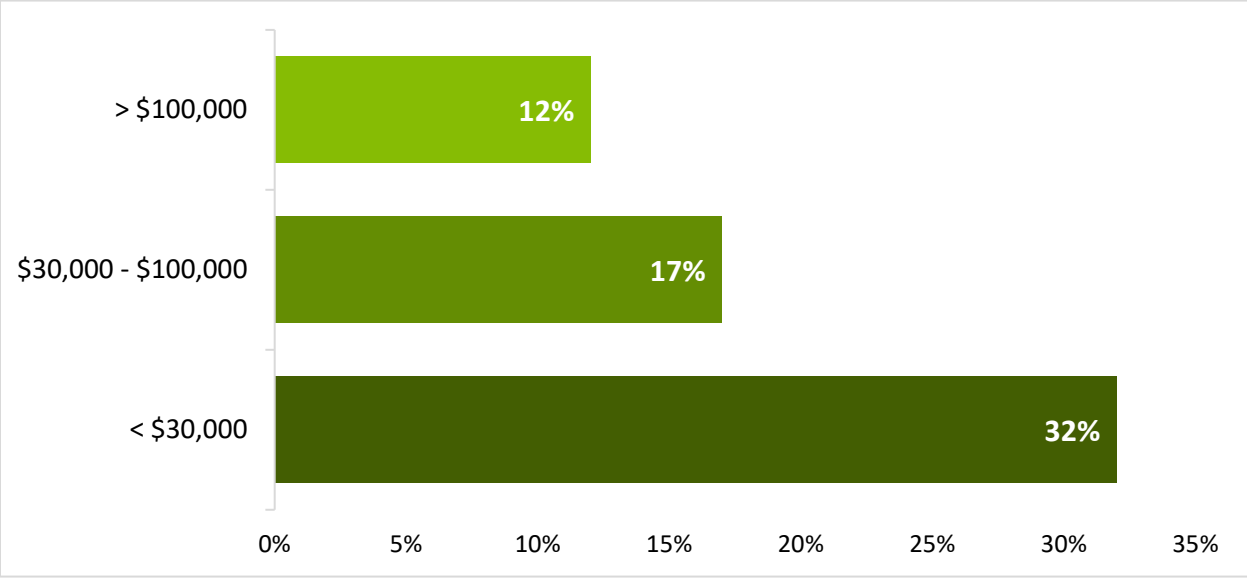
Breaking this down by income, foreign-born respondents were more likely to have lower incomes, with 32% of those earning less than $30,000 per year reporting they were born outside the U.S., compared to 12% of those earning more than $100,000 per year. This demonstrates the economic challenges many immigrants face, which can impact access to health care, employment, and community resources.

[3] This dataset represents the percent of limited English speaking households.

From October 2022-December 2024, roughly 220,000 patients were assisted through Bridgeport Hospital's language interpreter services.

Language barriers and cultural differences can make it difficult for residents to access critical services, including health care and social programs. Partners and community members emphasized that a lack of multilingual services and culturally competent care discourages many non-English speakers from seeking assistance.

EXHIBIT 27: DCWS QUESTION – PARTICIPANTS WHO WERE NOT BORN IN THE U.S., BY INCOME



Social Connectedness

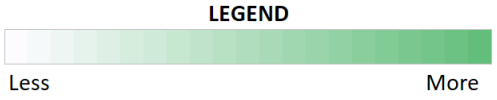
Social connectedness, the feeling of being close and connected to others, plays a vital role in overall wellbeing, influencing mental health, resilience, and access to support systems. According to the U.S. Surgeon General, the health risks associated with prolonged social isolation are comparable to smoking 15 cigarettes a day.[4]

> **"Focusing on engagement helps us define and redefine our own sense of community."**
> **- Community Member**

Partners and community members emphasized the importance of fostering community engagement to strengthen relationships and promote a sense of belonging.

EXHIBIT 28: DCWS QUESTION – FREQUENCY OF SOCIAL AND EMOTIONAL SUPPORT, BY RACE/ETHNICITY AND INCOME

White	Black	Latino	Frequency of Social & Emotional Support	< $30,000	$30,000 - $100,000	> $100,000
34%	36%	30%	**Always**	24%	34%	37%
35%	21%	29%	**Usually**	22%	30%	38%
19%	23%	17%	**Sometimes**	24%	18%	17%
6%	10%	10%	**Rarely**	15%	8%	3%
4%	8%	12%	**Never**	13%	8%	3%



- Data from DCWS highlights disparities in social and emotional support, with 7% of respondents reporting that they "never" feel supported.
- Individuals with lower incomes are more likely to experience limited social connections, while those with higher incomes report more consistent emotional support.
- Racial disparities are also evident, with Black and Latino respondents being less likely to report receiving frequent social support compared to White respondents.
- Addressing social isolation through community-building initiatives and outreach programs may help improve overall wellbeing and health outcomes.

[4] https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf

Social connection also plays a role in mental health. While many survey participants reported low levels of anxiety and depression, a meaningful share reported feeling anxious or at risk for a depressive episode. These responses highlight the importance of building community programs and support systems that help people feel seen, included, and connected.

EXHIBIT 29: DCWS QUESTION – HOW ANXIOUS DID YOU FEEL YESTERDAY?

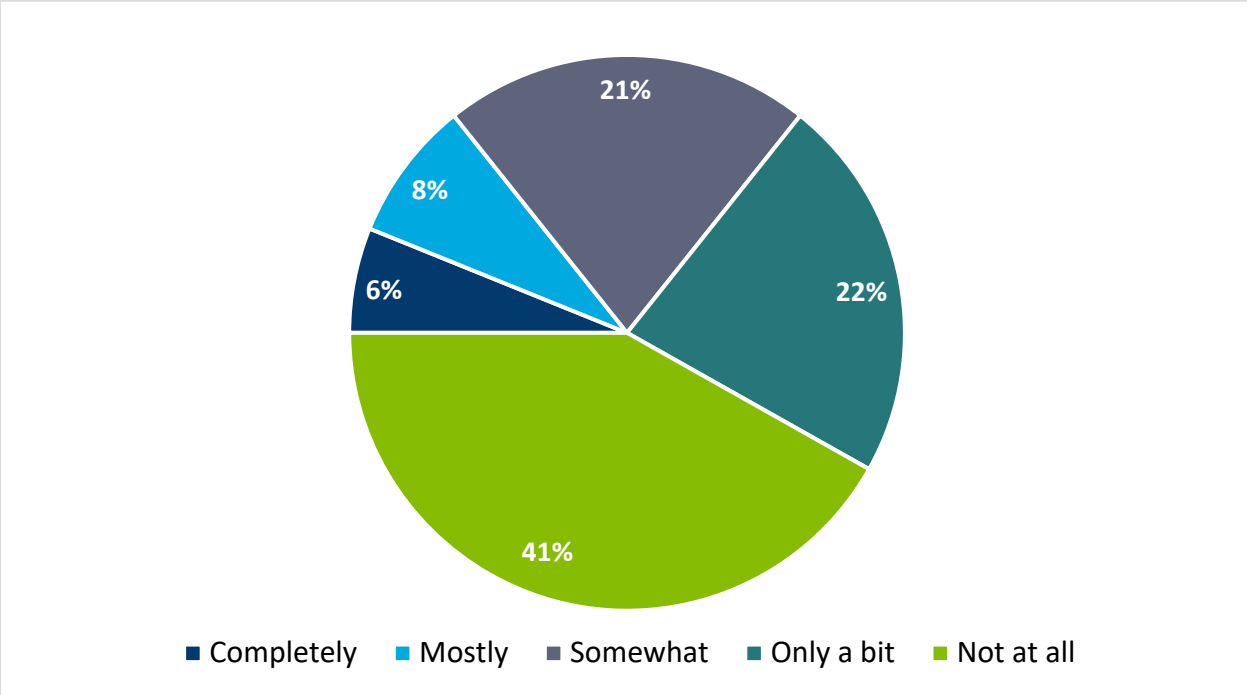
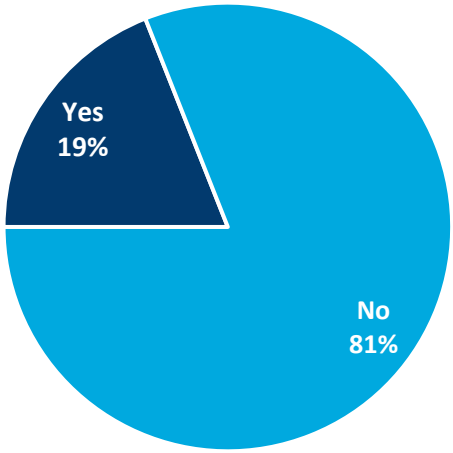


EXHIBIT 30: DCWS QUESTION - RESPONDENTS WITH PHQ-2 INDICATING RISK OF A MAJOR DEPRESSIVE EPISODE[5]

PHQ-2 greater than or equal to 3 indicating risk of major depressive episode.



Community Trust in Health Care

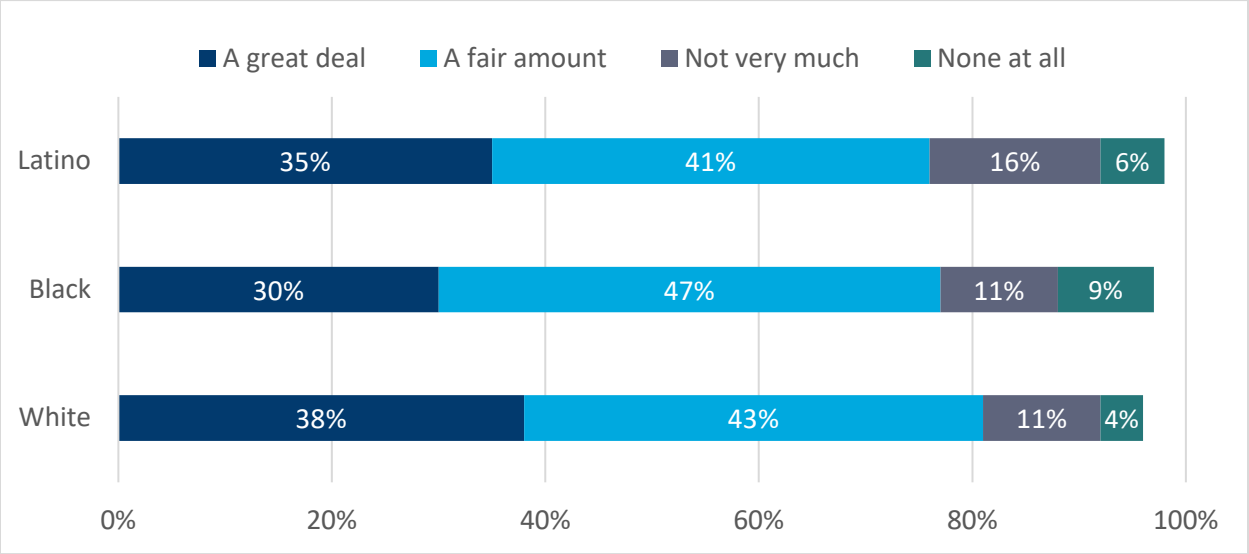
Trust in health care professionals is essential for ensuring individuals seek timely medical care, follow preventive health recommendations, and feel comfortable discussing their health concerns.

However, some partners and community members expressed concerns about distrust in health care settings, emphasizing the importance of community engagement from medical professionals. They highlighted the need for doctors and nurses to attend community events and build relationships with residents to reduce fear and increase confidence in seeking health care.

> **"We need doctors and nurses to come to community events to talk to people, so people aren't scared to seek help and health care." - Partner**

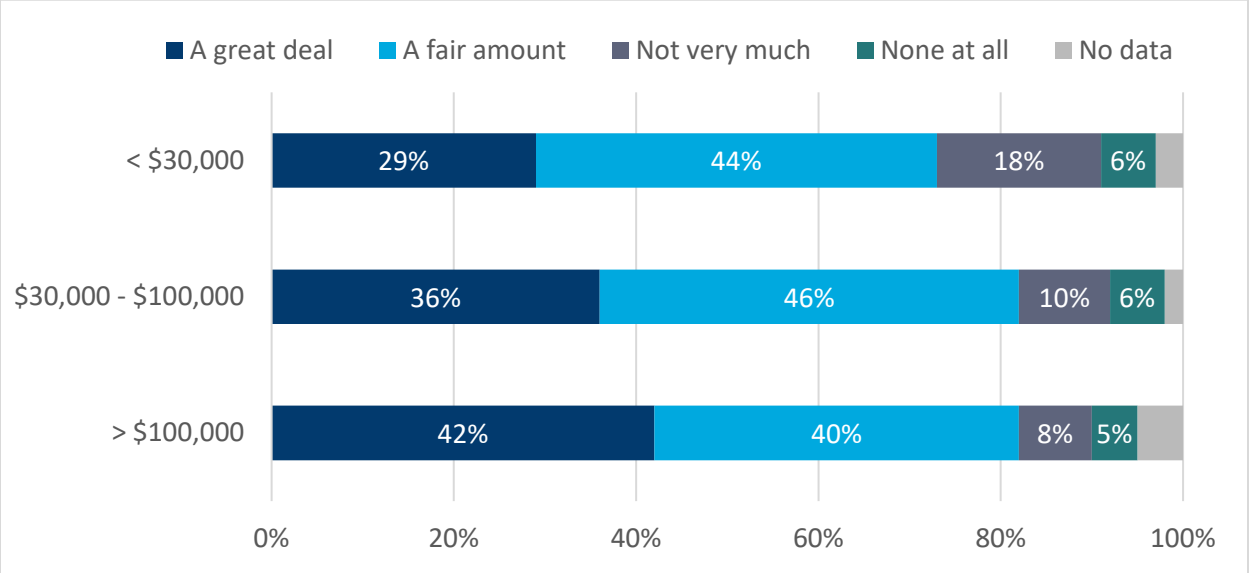
[5] **PHQ-2** refers to the Patient Health Questionnaire-2, a brief screening tool used to identify possible depression. A score of 3 or higher suggests a risk of a major depressive episode and indicates the need for further evaluation.
Source: https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health

EXHIBIT 31: DCWS QUESTION – RESPONDENTS' LEVEL OF TRUST IN HEALTH OFFICIALS AND HEALTH CARE WORKERS, BY RACE/ETHNICITY



Data from DCWS indicates that overall, 18% of respondents reported their trust in health officials and health care workers as "not very much" or "none at all." Trust levels vary by race and income, with Black and Latino respondents reporting lower trust than White respondents. Additionally, individuals with lower incomes were more likely to express distrust in health care providers compared to those with higher incomes.

EXHIBIT 32: DCWS QUESTION – RESPONDENTS' LEVEL OF TRUST IN HEALTH OFFICIALS AND HEALTH CARE WORKERS, BY INCOME



Health Care Access and Quality

Health Care Access and Quality is one of the five social drivers of health. Health care access and quality can impact a person's health outcomes and overall wellbeing by influencing the availability, effectiveness, and safety of health services. Groups experiencing disadvantage often face barriers to high-quality health care due to socioeconomic disparities, insurance gaps, and limited availability or access to providers among other factors.

Health Care Quality

Access to respectful, high-quality care is an important aspect of health equity. In Greater Bridgeport, 16% of DCWS survey respondents reported feeling they received less respect or poorer quality services when seeking health care. Experiences varied by race, income, and location of care.

The DCWS data indicates that Black (20%) and Latino (18%) respondents were more likely than White respondents (14%) to report experiencing disrespect or lower-quality care. The most cited reason among Black (77%) and Latino (59%) respondents was race, while White respondents more frequently attributed their experiences to gender or health insurance status.

EXHIBIT 33: DCWS QUESTION – SURVEY RESPONDENTS WHO FELT THEY RECEIVED LESS RESPECT OR POORER QUALITY SERVICES WHEN SEEKING HEALTH CARE, BY RACE/ETHNICITY

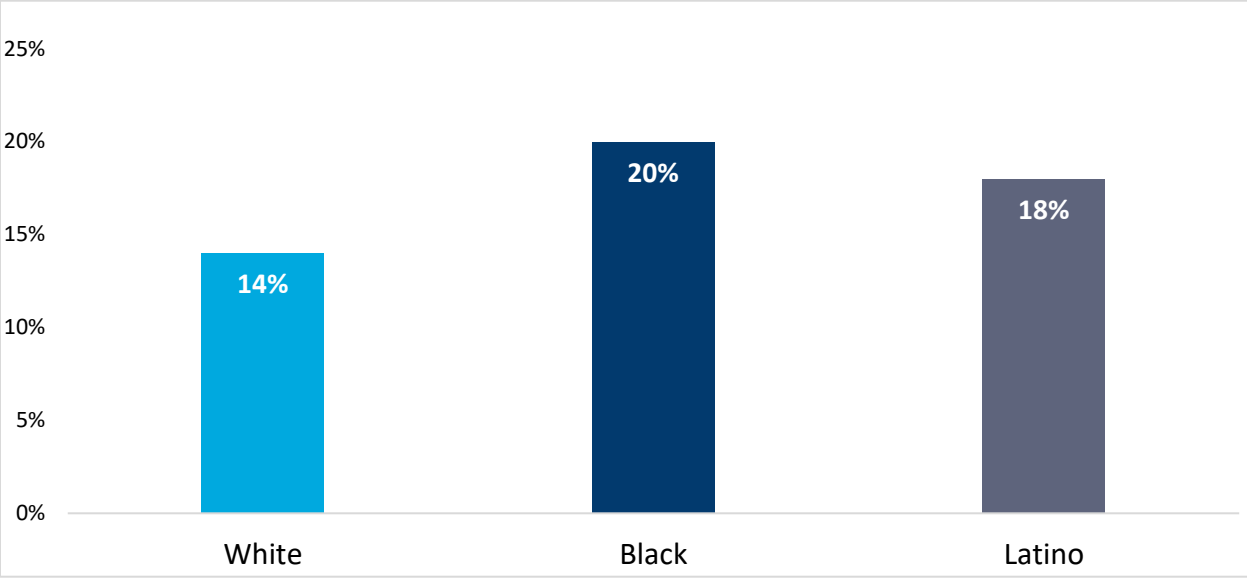


EXHIBIT 34: DCWS QUESTION – TOP 5 REASONS RESPONDENTS FELT THEY RECEIVED LESS RESPECT OR POOR QUALITY SERVICES WHEN SEEKING HEALTH CARE

	White	Black	Latino
Your Age	12%	17%	15%
Your Ancestry or National Origins	2%	8%	22%
Your Gender	30%	21%	15%
Your Health Insurance Status	22%	7%	14%
Your Race	8%	77%	59%

LEGEND

Less — More

Income disparities also influenced health care experiences. Lower-income DCWS respondents were more likely to feel they received lower-quality care, with 25% of those earning under $30,000 reporting these experiences, compared to 19% of those earning $30,000-$100,000 and 10% of those earning more than $100,000.

Among those who reported poorer quality care, the reasons varied by income. Respondents earning less than $30,000 were most likely to attribute their experience to their race (41%) or health insurance status (25%), while those earning over $100,000 were more likely to cite gender (35%) or age (16%) as contributing factors.

EXHIBIT 35: DCWS QUESTION – SURVEY RESPONDENTS WHO FELT THEY RECEIVED LESS RESPECT OR POORER QUALITY SERVICES WHEN SEEKING HEALTH CARE, BY INCOME

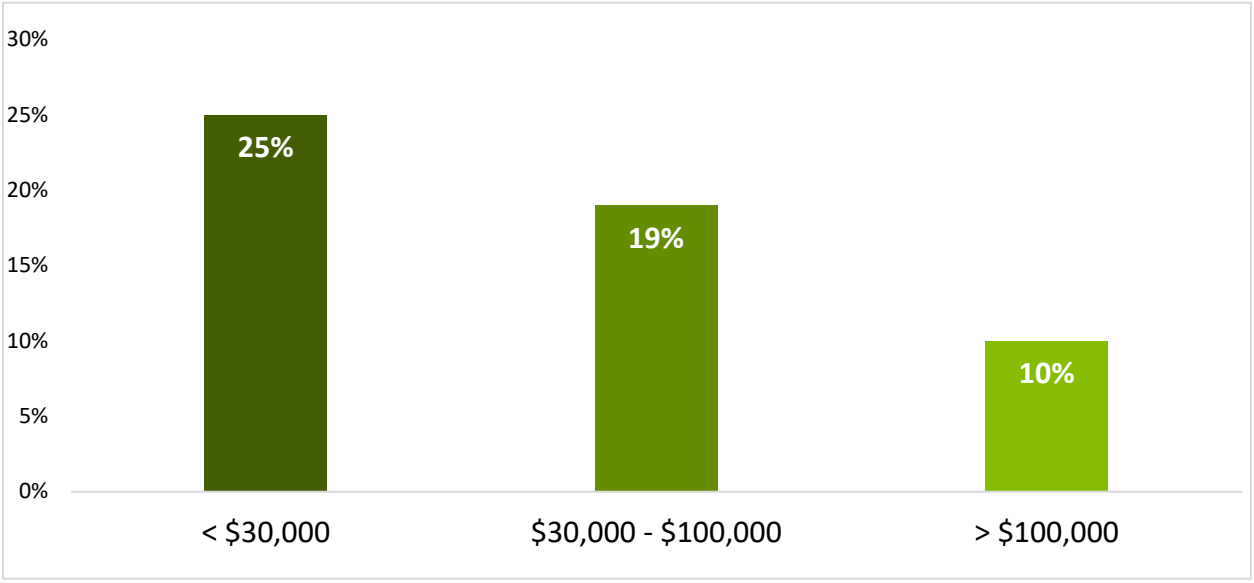


EXHIBIT 36: DCWS QUESTION – TOP 5 REASONS RESPONDENTS FELT THEY RECEIVED LESS RESPECT OR POOR QUALITY SERVICES WHEN SEEKING HEALTH CARE, BY INCOME

	< $30,000	$30,000 - $100,000	> $100,000
Some Other Aspect of Your Physical Appearance	14%	15%	8%
Your Age	7%	17%	16%
Your Gender	12%	28%	35%
Your Health Insurance Status	25%	15%	10%
Your Race	41%	45%	26%

LEGEND

Less — More

When asked how often they had these experiences, many reported experiencing them repeatedly over time. Nearly half of White respondents (48%) and 32% of Latino respondents reported feeling disrespected a few times over the past three years, with some experiencing it annually or even more frequently.

EXHIBIT 37: DCWS QUESTION – HOW OFTEN RESPONDENTS FELT THEY RECEIVED LESS RESPECT OR POOR QUALITY SERVICES WHEN SEEKING HEALTH CARE, BY RACE/ETHNICITY

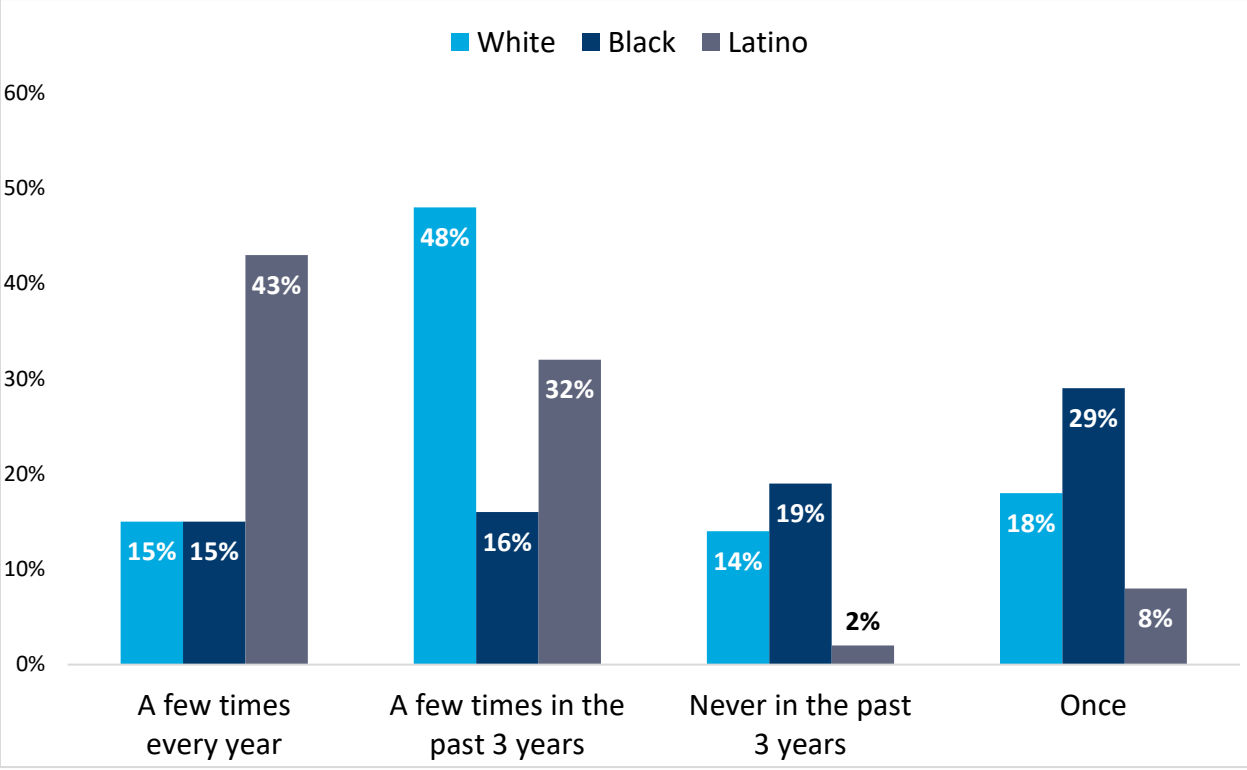


EXHIBIT 38: DCWS QUESTION – HOW OFTEN RESPONDENTS FELT THEY RECEIVED LESS RESPECT OR POOR QUALITY SERVICES WHEN SEEKING HEALTH CARE, BY INCOME

The settings where these experiences occurred also varied. Doctor's offices were the most common location for White DCWS respondents (63%), while Latino (56%) and Black (46%) DCWS respondents were more likely to report these experiences in hospitals or emergency rooms.

EXHIBIT 39: DCWS QUESTION – TOP 2 PLACES WHERE RESPONDENTS FELT THEY RECEIVED LESS RESPECT OR POOR-QUALITY SERVICES WHEN SEEKING HEALTH CARE, BY RACE/ETHNICITY

	White	Black	Latino
At a doctor's office or when visiting the doctor	63%	35%	39%
At a hospital or emergency room	44%	46%	56%

EXHIBIT 40: DCWS QUESTION – TOP 2 PLACES WHERE RESPONDENTS FELT THEY RECEIVED LESS RESPECT OR POOR-QUALITY SERVICES WHEN SEEKING HEALTH CARE, BY INCOME

	< $30,000	$30,000 - $100,000	> $100,000
At a doctor's office or when visiting the doctor	36%	48%	73%
At a hospital or emergency room	52%	56%	35%

Trust and Access to Care

Survey data suggests that trust in health officials and health care workers may influence whether people are able to access care or have health insurance. Respondents who reported low trust were often the same groups that reported challenges with accessing care or being uninsured. This connection between trust and access highlights the importance of building strong, culturally competent relationships between health care providers and the communities they serve. Ensuring clear communication, respectful treatment, and community engagement may help reduce barriers to care and improve health outcomes.

EXHIBIT 41: UNINSURED VS. LOW TRUST IN LOCAL HEALTH OFFICIALS AND HEALTH CARE WORKERS, BY RACE/ETHNICITY

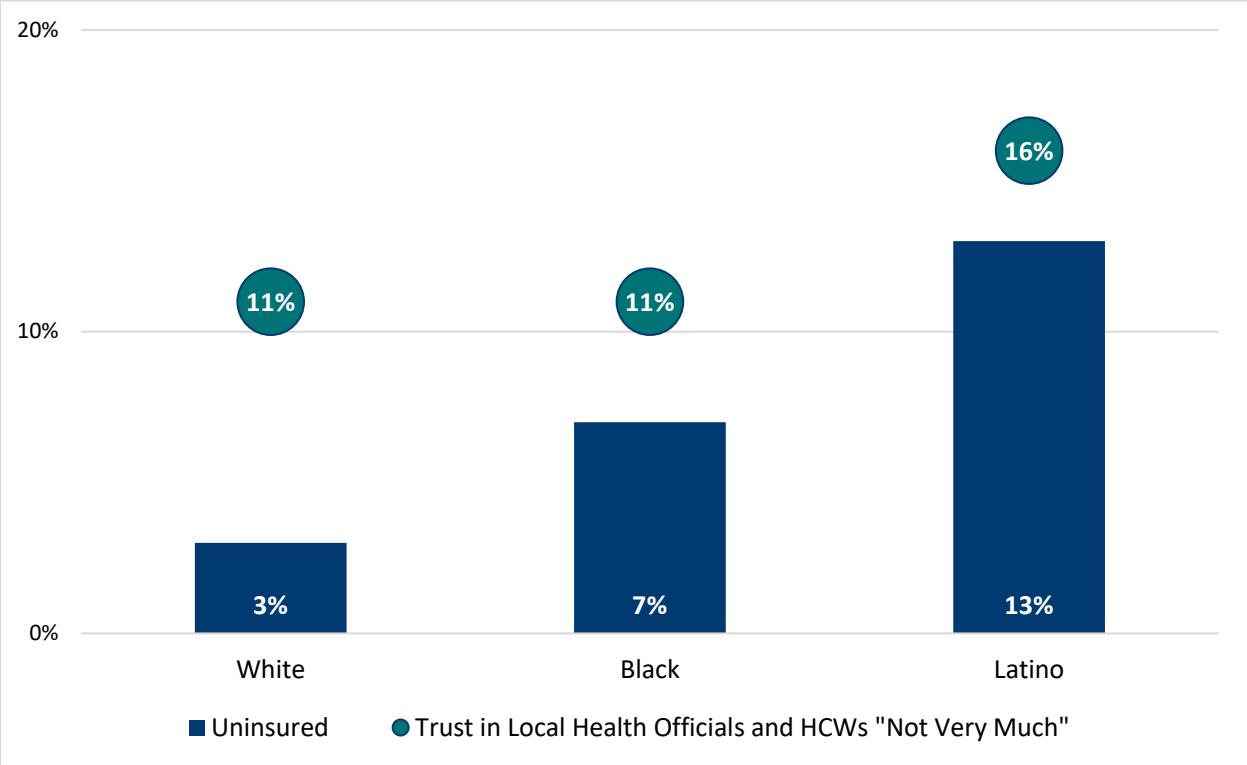
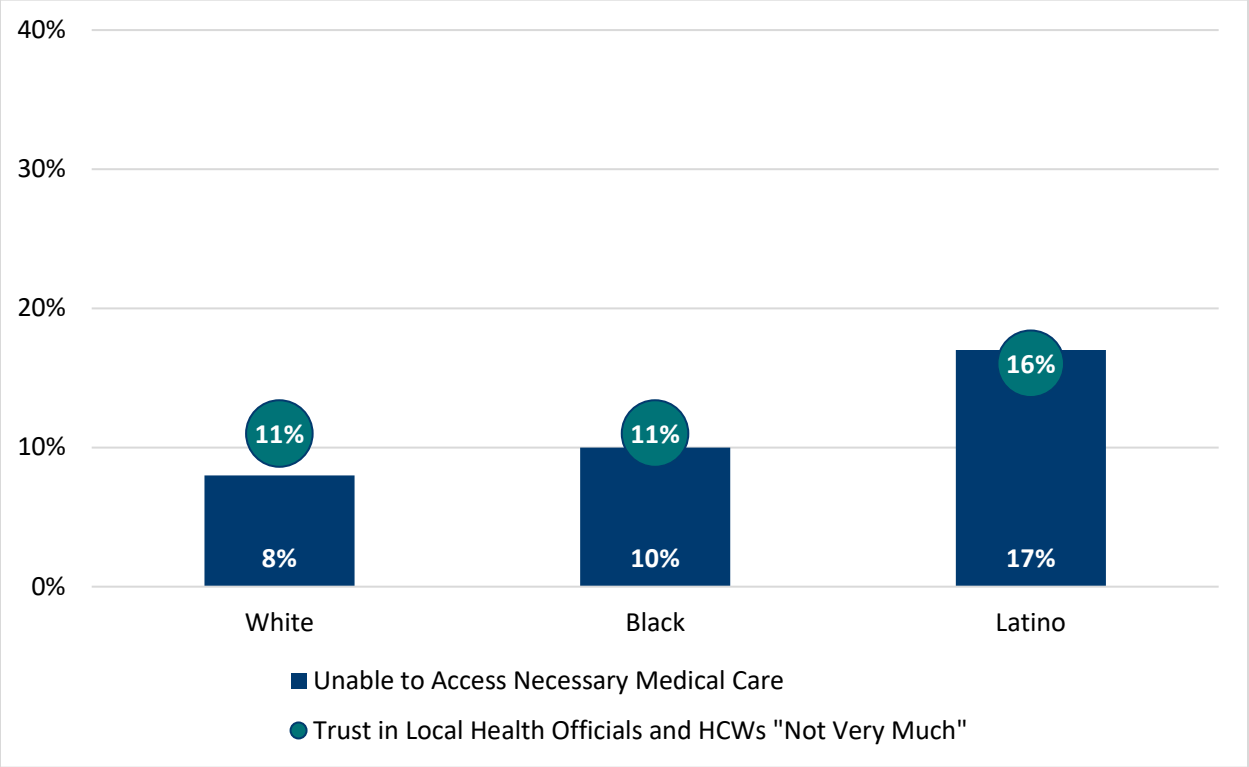


EXHIBIT 42: UNABLE TO ACCESS CARE VS. LOW TRUST IN LOCAL HEALTH OFFICIALS AND HEALTH CARE WORKERS, BY RACE/ETHNICITY



Health Equity

> **"You can have a child born on a certain town line and have access compared to someone in Bridgeport that struggles even though you are streets apart."**
>
> **- Partner**

Partners and community members reported disparities in health care access, quality, and cultural competency of providers and their ability to understand, appreciate, and interact with patients from diverse backgrounds. Some described discrimination in emergency rooms and health care settings, particularly against individuals of different racial, ethnic, and socioeconomic backgrounds. Concerns were raised about inequitable chronic disease management, especially among Black residents, who are disproportionately represented among those experiencing homelessness and therefore have increased difficulty accessing care.

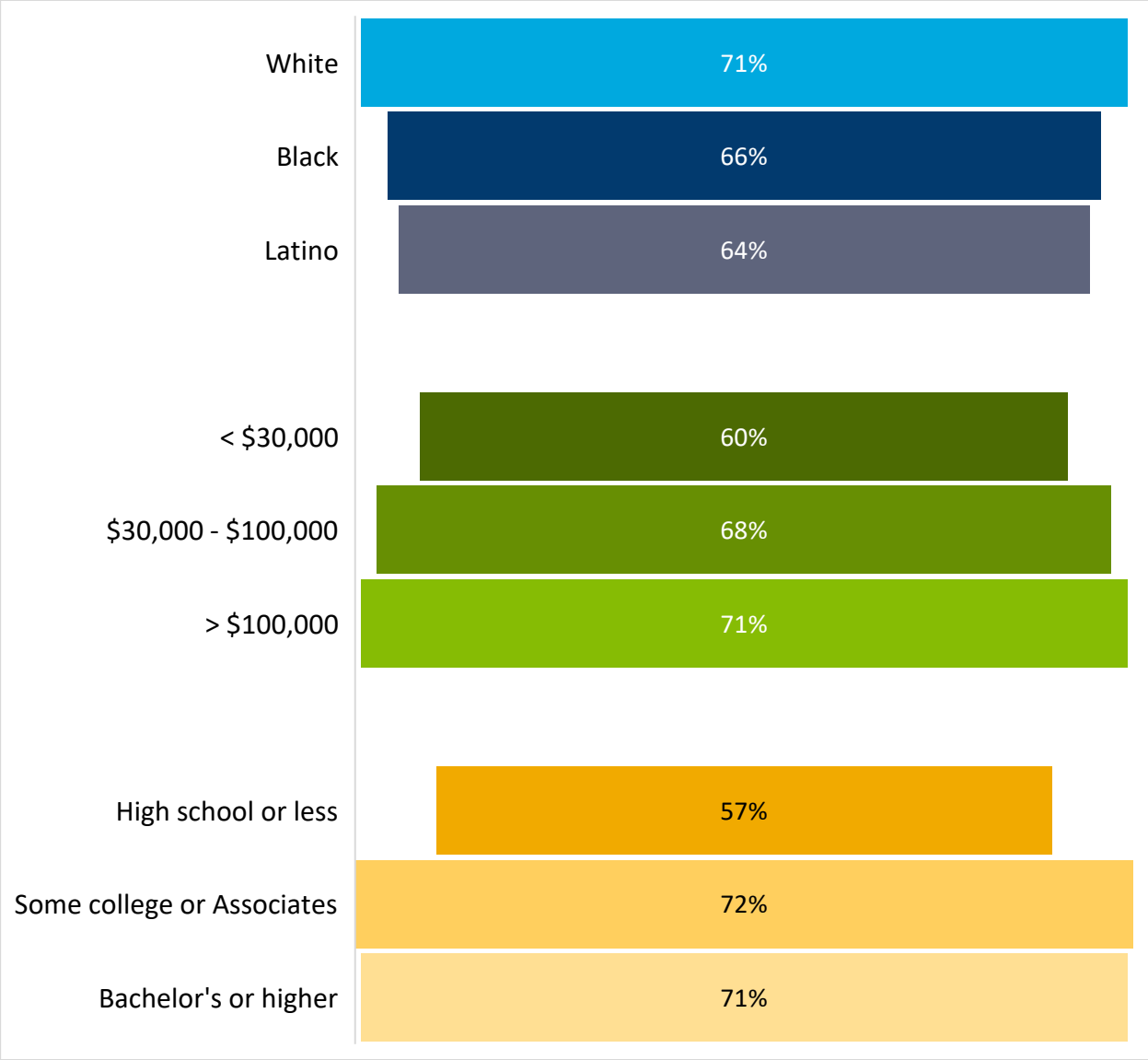
Partners highlighted the lack of culturally competent care, particularly for behavioral health and language accessibility. Finding providers who speak a language other than English is challenging, despite the diverse linguistic needs of the community.

Additionally, community members expressed a need for more culturally sensitive care for lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and other identities (LGBTQIA+), as some may not feel comfortable advocating for themselves in health care settings. Partners emphasized that health care providers should be trained to approach diverse patients with respect and awareness of their unique needs.

Use of Personal Health Records and Online Health Services

DCWS data reflects differences in digital access to health care resources, which may contribute to health equity disparities. Overall, 68% of DCWS respondents reported having a personal health record[6] with slightly lower rates among Black (66%) and Latino (64%) respondents, compared to White respondents (71%).

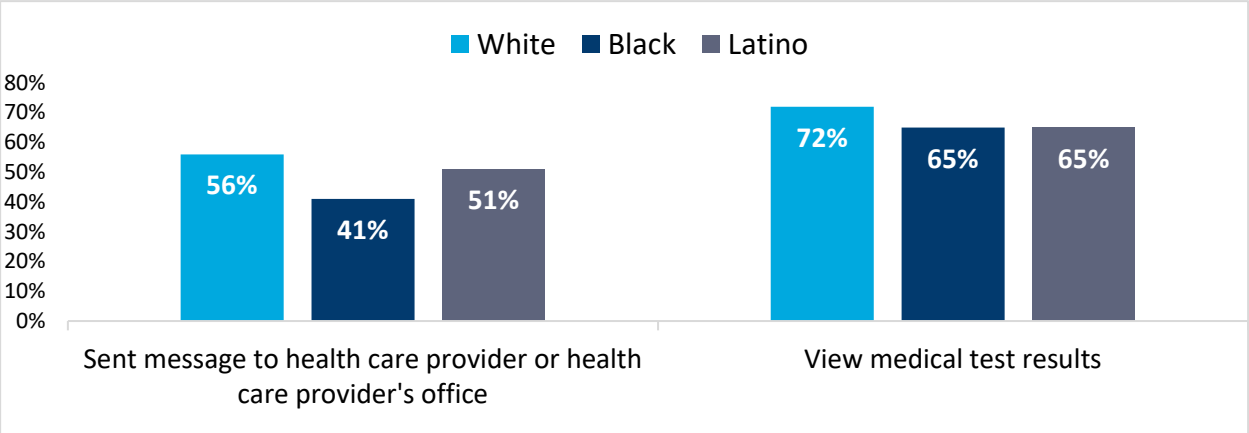
EXHIBIT 43: DCWS QUESTION – RESPONDENTS WITH A PERSONAL HEALTH RECORD



[6] Personal Health Record: A record that individuals manage themselves, containing their health information like medical history, medications, test results, and more. It can be digital or paper-based and is kept private and secure.
Source: Mayo Clinic (mayoclinic.org)

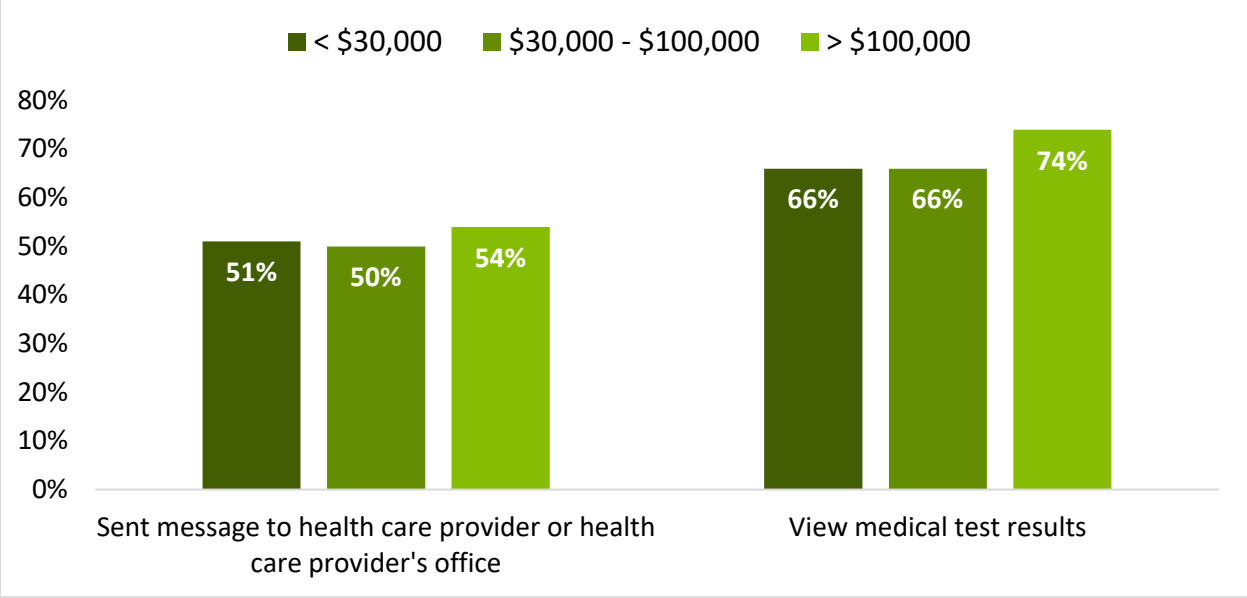
Internet use for health care-related needs also varied. The number of DCWS respondents who reported using the internet to message a health care provider was 52%, while 69% used it to view medical test results. White respondents were more likely than Black or Latino respondents to use online tools to communicate with providers.

EXHIBIT 44: DCWS QUESTION – RESPONDENTS THAT USED THE INTERNET TO TAKE CARE OF THE FOLLOWING HEALTH-RELATED NEEDS IN THE PAST 12 MONTHS, BY RACE/ETHNICITY



Income also played a role in digital access. Those earning $100,000 or more were most likely to use the internet for health care needs, which may be influenced by greater access to stable broadband, personal computers, and familiarity with digital health tools. In contrast, those in lower-income households may have more limited internet access or rely on mobile devices, making it harder to navigate patient portals or engage in online health management.

EXHIBIT 45: DCWS QUESTION – RESPONDENTS THAT USED THE INTERNET TO TAKE CARE OF THE FOLLOWING HEALTH-RELATED NEEDS IN THE PAST 12 MONTHS, BY INCOME



Access to Care Barriers

Partners identified insurance coverage, affordability, and health literacy as major barriers to care in Greater Bridgeport.

> **"The organization a doctor works for determines what insurance that they can take. [...] A lot of non-profits do take public insurance, but a lot of the private organizations don't take public insurance."**
>
> **- Partner**

According to DCWS data, 23% of respondents have Medicare and 21% have Medicaid, yet partners noted that few providers—particularly specialists—accept these plans, limiting access to essential services. Medicaid patients often face restrictions based on acuity level, while high-deductible private plans leave some struggling with out-of-pocket costs. As one partner stated, "Private insurance is making people feel like they're drowning." Additionally, insurance coverage does not always guarantee prescription access, as certain treatments are excluded from coverage.

Higher-income and White residents are more likely to have health insurance through an employer, while Black, Latino, and lower-income residents more often rely on Medicaid or other government programs. Because fewer doctors accept these plans, people with lower incomes may have a harder time finding care.

EXHIBIT 46: DCWS QUESTION – TYPE OF INSURANCE

Race/Ethnicity			Type of Insurance	Income		
White	Black	Latino		< $30,000	$30,000 - $100,000	> $100,000
56%	47%	46%	**Insurance obtained through a current/former employer or union**	13%	52%	76%
12%	8%	8%	**Insurance purchased directly from an insurance company**	8%	12%	11%
29%	19%	14%	**Medicare**	31%	25%	15%
13%	33%	32%	**Medicaid, Medical Assistance, HUSKY, etc.**	59%	21%	3%
7%	13%	15%	**State Health Insurance Exchange**	12%	12%	6%
2%	1%	2%	**Any other type of health insurance plan**	2%	2%	2%

LEGEND

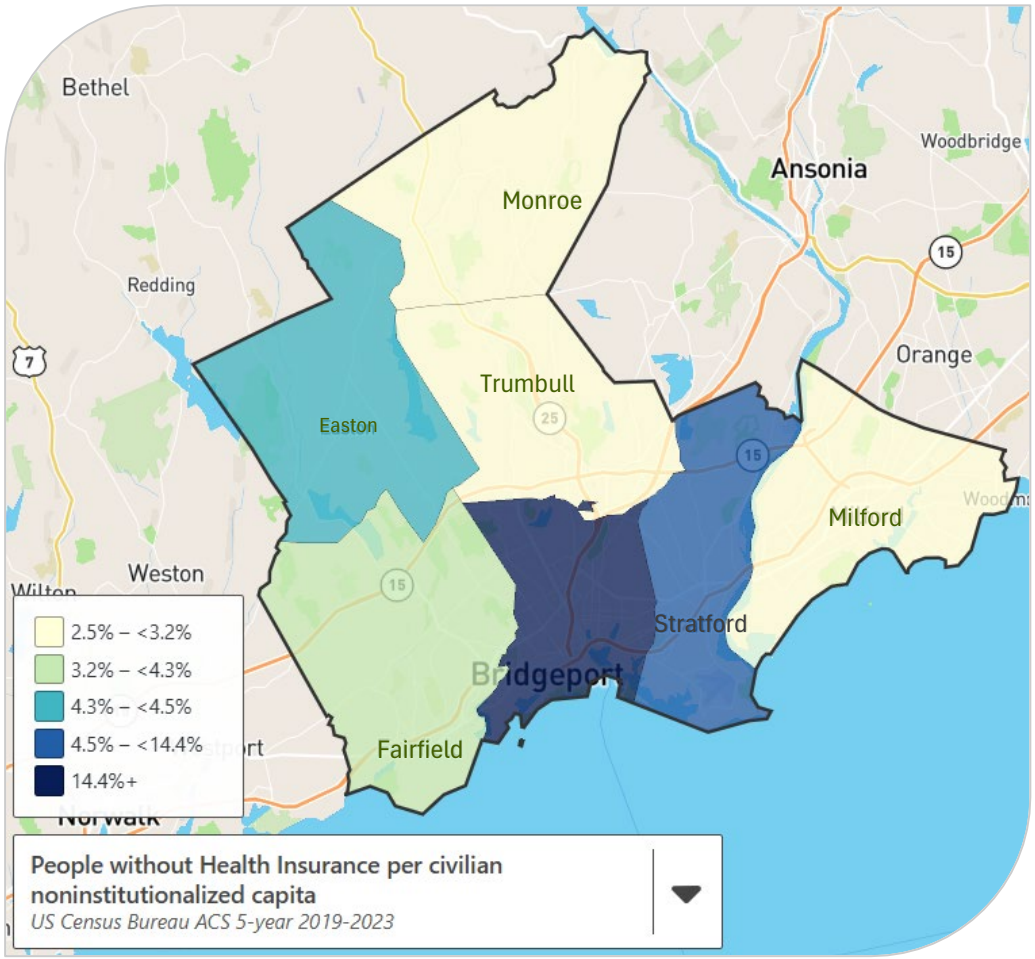
Less — More

Uninsured Individuals

Access to affordable health care is a challenge for uninsured individuals. According to secondary data (Exhibit 47), the uninsured population varies widely across the region, with some areas experiencing higher concentrations of uninsured residents. Partners noted that many rely on financial assistance including programs offered by local hospitals, but even those receiving such assistance often struggle to access prescriptions, further complicating disease management.

The hospital provides financial assistance for eligible patients, as well as offers a Medication Assistance Program (MAP) to reduce financial hardship.

EXHIBIT 47: UNINSURED POPULATION



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 1

Delays in Care and Emergency Room Utilization

Limited access to providers contributes to delays in care. According to CBANS data, 52% of overall respondents delayed medical care because they "couldn't get an appointment soon enough," with delays affecting both lower- and higher-income respondents, while 9% indicated that they "didn't think the problem was serious enough."

EXHIBIT 48: CBANS QUESTION – RESPONDENTS WHO WERE UNABLE TO RECEIVE TIMELY MEDICAL CARE, BY RACE

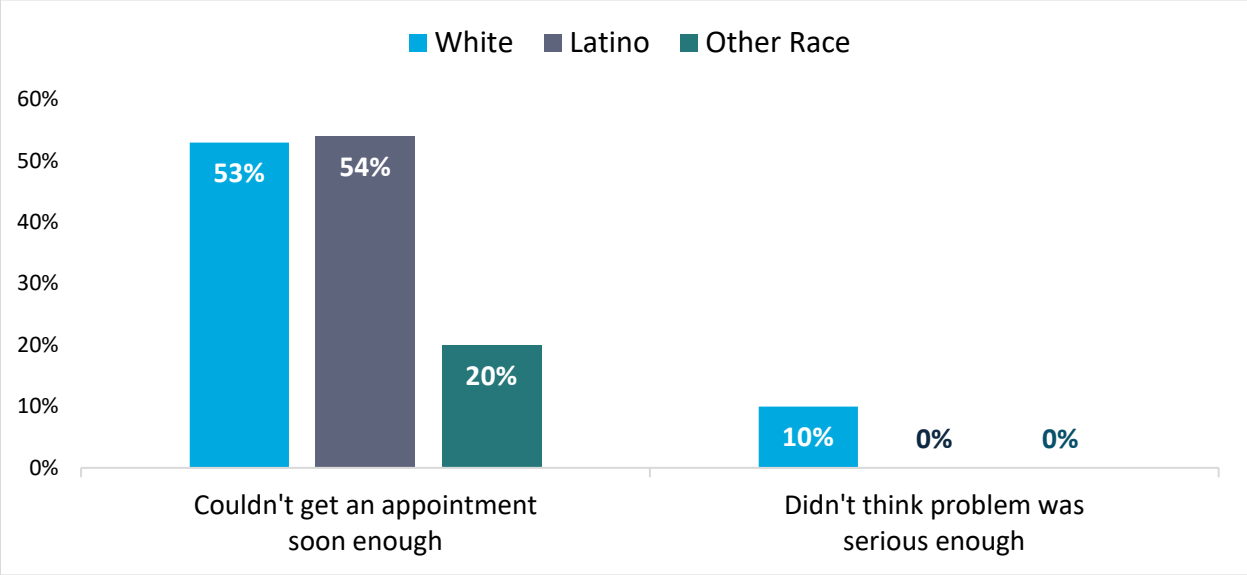
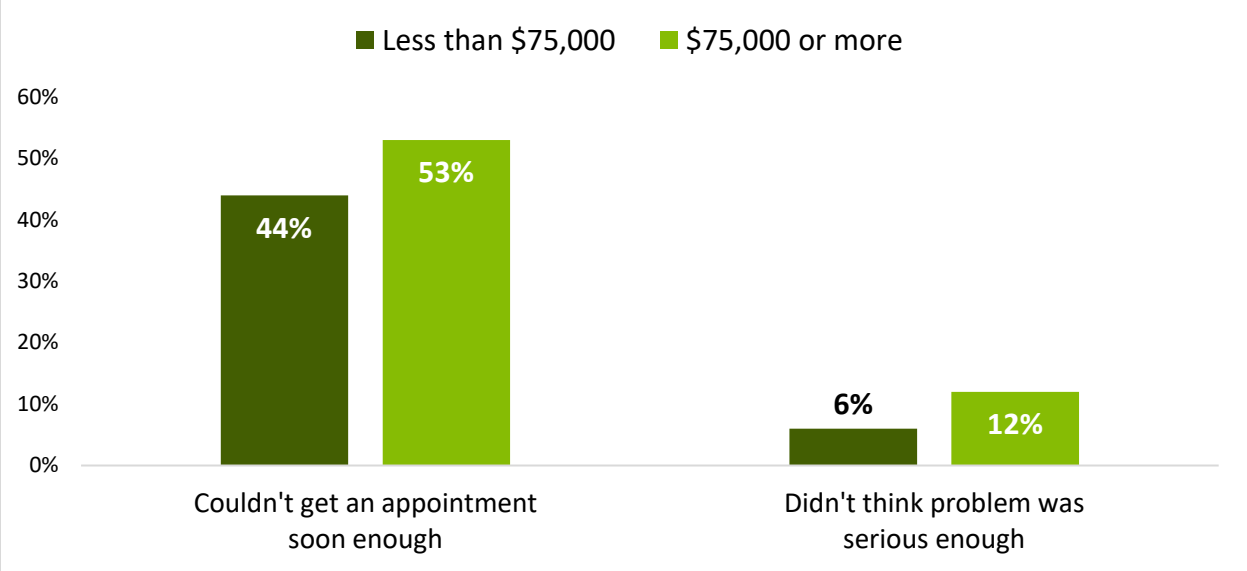


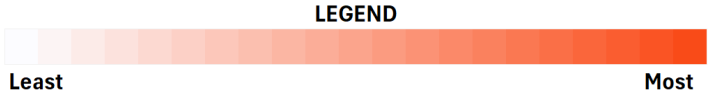
EXHIBIT 49: CBANS QUESTION – REASONS FOR RESPONDENTS' INABILITY TO RECEIVE TIMELY MEDICAL CARE, BY INCOME



Without timely access to care, some residents turn to the emergency room (ER) for non-emergent needs. According to DCWS data, 39% of those earning less than $30,000 made one to two trips to the emergency room in the past year, compared to 20% of middle-income respondents and 12% of those earning over $100,000. Frequent ER visits are often tied to challenges in accessing preventive and primary care, according to partners.

EXHIBIT 50: DCWS QUESTION – TRIPS TO EMERGENCY ROOM IN PAST YEAR

White	Black	Latino	Trips to the Emergency Room (past 12 months)	Less than $30,000	$30,000 - $100,000	$100,000 or more
23%	22%	8%	**1 to 2 trips**	39%	20%	12%
4%	8%	5%	**3 or more trips**	7%	3%	7%



Health Literacy

Limited health literacy further complicates access to care. Community members shared that short appointment times and complex medical terminology make it difficult for some patients to fully understand their health conditions. Patients with low literacy levels may struggle to follow medical instructions, especially when providers do not have time for thorough explanations.

Primary Care, Preventive Care & Chronic Disease Management

Primary Care

Partners and community members reported a growing shortage of primary care providers, making it harder for residents to find a consistent doctor or health care provider.

According to partners and community members, several factors contribute to this shortage, including medical graduates choosing higher-paying specialties, providers shifting to concierge medicine, and an increased reliance on the emergency room for routine care. Concierge medicine, where patients pay a membership fee for more personalized care, reduces the number of doctors accepting traditional insurance, limiting access for lower-income residents. As a result, many patients see mid-level clinicians instead of physicians, which some find frustrating, especially when managing complex health needs.

EXHIBIT 51: HEALTH CARE PROVIDER RATIOS

PROVIDER RATIOS FAIRFIELD COUNTY VS. CT STATE	
Primary Care Physicians (PCP)	**Pediatricians**
897 : 1	**705 : 1**
CT State Ratio 834 : 1	CT State Ratio 619 : 1
Higher ratios indicate fewer providers per person.	

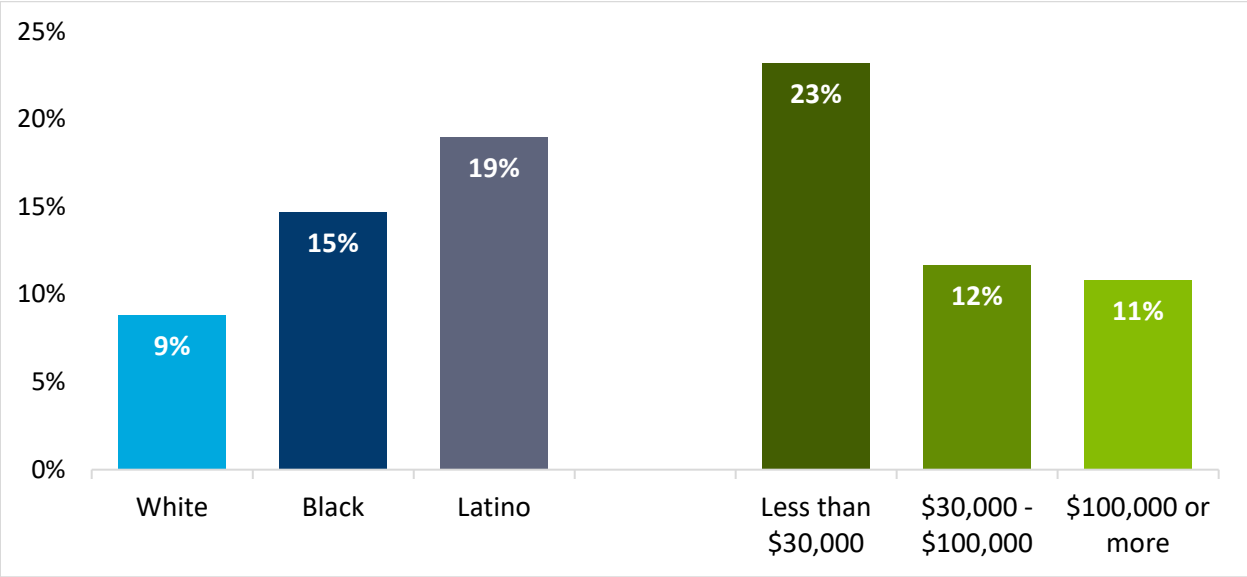
Source: National Plan & Provider Enumeration System NPI, 2023. Table 41

Fairfield County has fewer primary care doctors and pediatricians available per person compared to the Connecticut state average, meaning residents may struggle to find a doctor when they need one.

The shortage is especially concerning for pediatric care, where fewer providers can lead to longer wait times and difficulty accessing routine check-ups and specialty care for children. A limited supply of primary care providers may also result in delays in diagnosing health conditions and increased use of emergency rooms for non-urgent medical needs.

According to DCWS data, 19% of respondents reported not having a personal doctor or health care provider. Black (15%) and Latino (19%) respondents were more likely than White (9%) respondents to lack a regular provider, highlighting racial disparities in primary care access. Income also plays a role—23% of those earning less than $30,000 reported not having a personal doctor, compared to 12% of middle-income respondents and 11% of those earning over $100,000.

EXHIBIT 52: DCWS QUESTION – RESPONDENTS WHO DO NOT HAVE A PERSON OR PLACE WHO IS CONSIDERED A PERSONAL DOCTOR OR HEALTH CARE PROVIDER, BY RACE/ETHNICITY AND INCOME

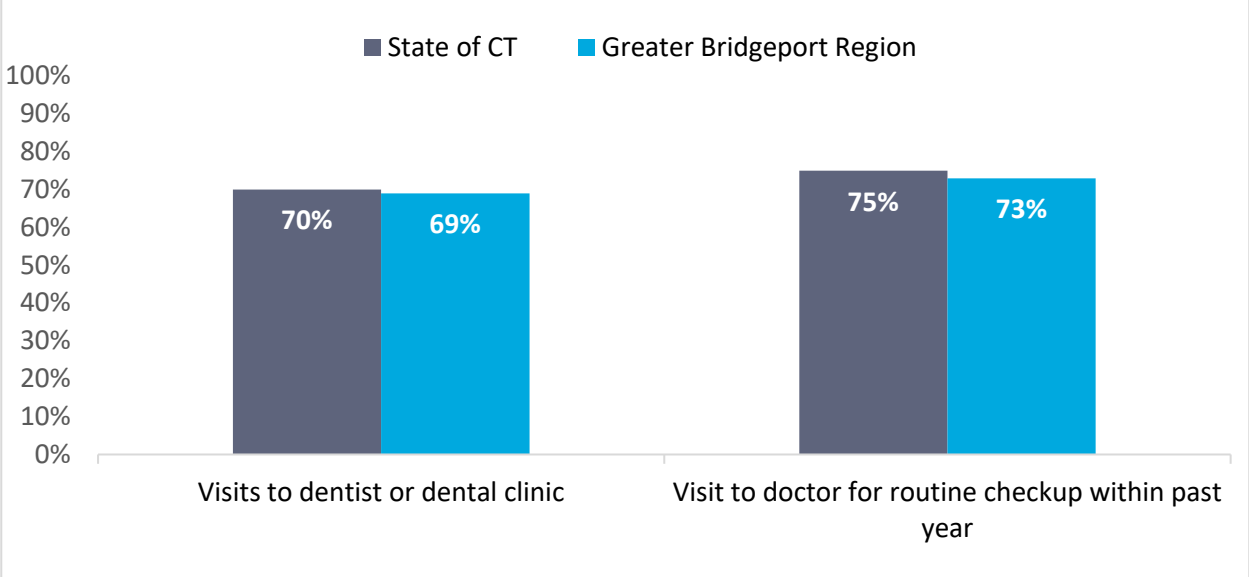


The shortage of primary care providers can lead to delayed diagnoses, increased emergency room visits, and difficulty managing chronic conditions. Patients without a regular doctor may struggle to get timely care, especially when providers are booked months in advance.

Preventive Care

Preventive care, including routine checkups and dental visits, plays a key role in maintaining overall health and catching health issues early. However, residents in Greater Bridgeport are less likely than the state average to have seen a doctor or dentist in the past year, suggesting potential barriers to accessing routine care.

EXHIBIT 53: SELF-REPORTED CHRONIC CONDITIONS AMONG ADULTS



Source: CDC PLACES (2020-2021). Provided by Connecticut Hospital Association. Table 45

Oral health is closely linked to overall wellbeing, with conditions like gum disease and tooth decay contributing to heart disease, diabetes complications, and other health concerns.[7]

Among CBANS respondents, 8% had not seen a dentist in more than two years, raising concerns about long-term health issues. Access to dental care varies by race and income, with White and higher-income residents more likely to have seen a dentist within the past six months. In contrast, Black, Latino, and lower-income residents were more likely to have gone over six months or longer without a dental visit. These gaps suggest that cost, insurance coverage, and provider availability may be barriers to routine dental care in the community.

[7] Centers for Disease Control and Prevention.https://www.cdc.gov/oral-health/

EXHIBIT 54: CBANS QUESTION – LAST TIME PARTICIPANTS SAW A DENTIST, BY RACE/ETHNICITY

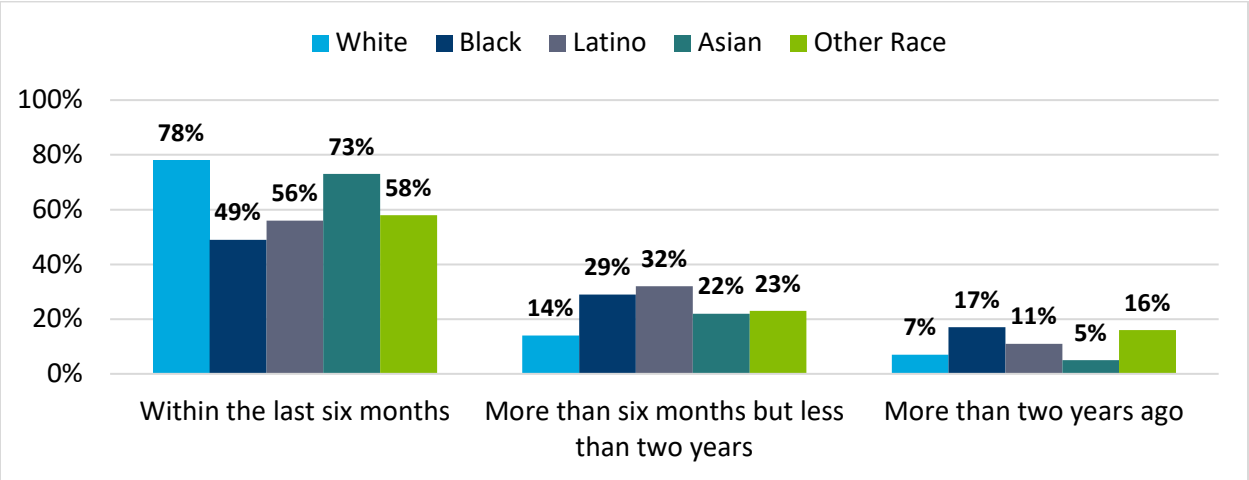
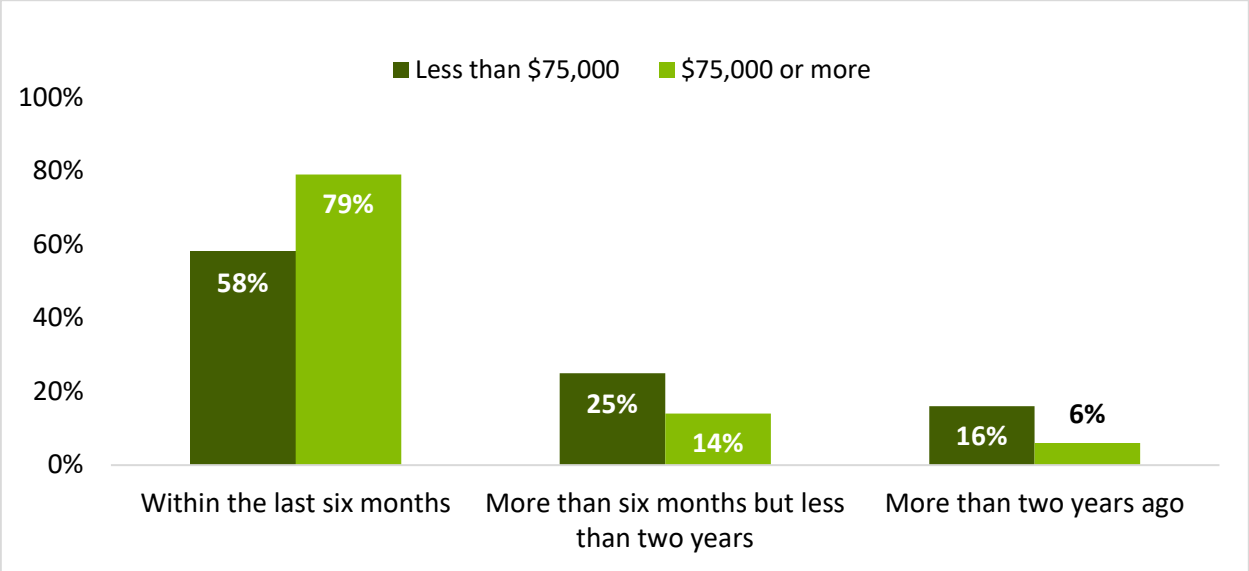


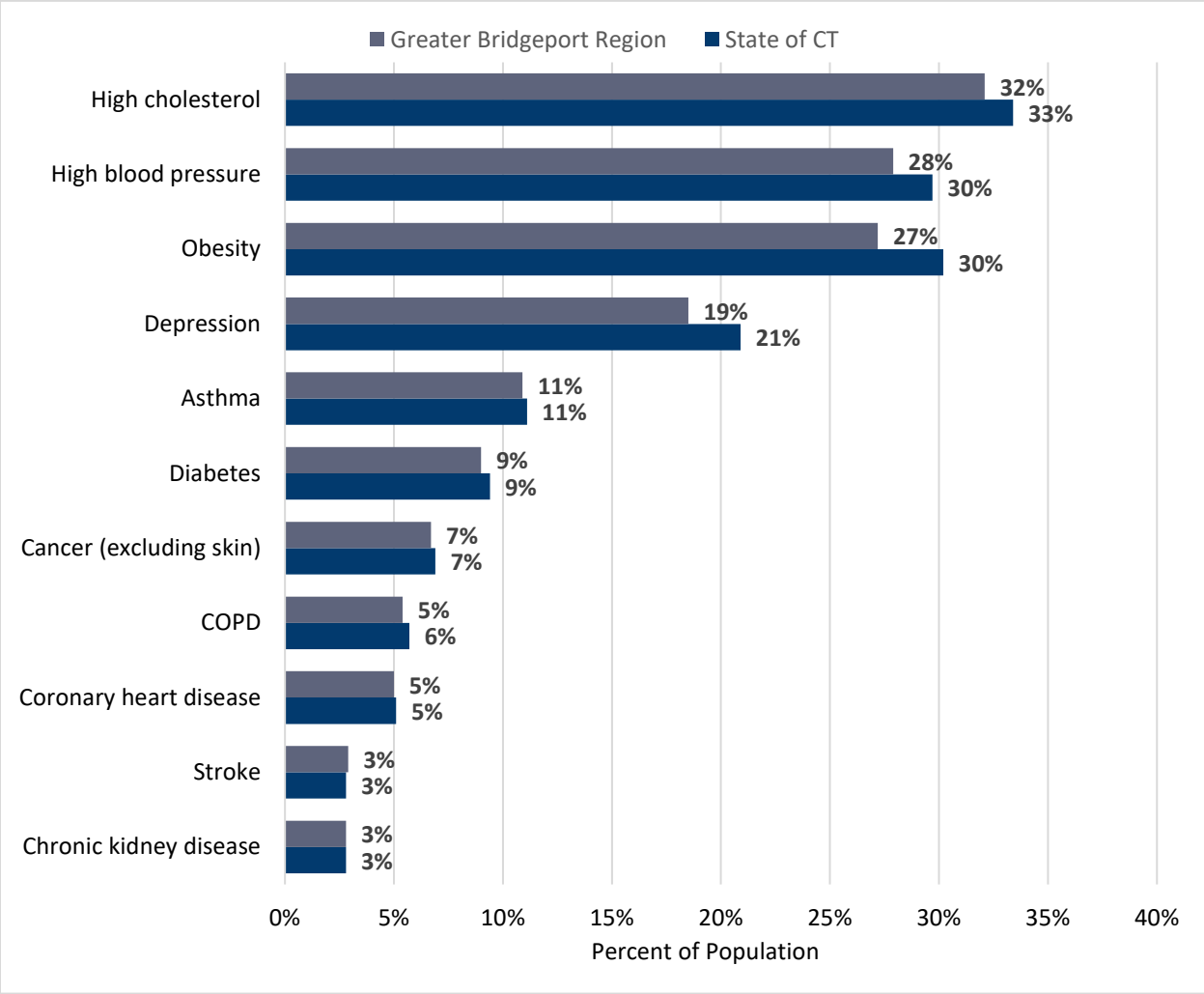
EXHIBIT 55: CBANS QUESTION – LAST TIME PARTICIPANTS SAW A DENTIST, BY INCOME



Chronic Disease

Chronic diseases like high blood pressure, diabetes, and obesity are common health concerns in Greater Bridgeport. Partners and community members shared that many people struggle to manage these conditions because they cannot access regular care. Without routine checkups and screenings, conditions get worse over time, often leading to health emergencies. People without access to primary care may wait until they are very sick and then go to the emergency room instead of getting ongoing treatment. This makes managing chronic diseases even harder.

EXHIBIT 56: SELF-REPORTED CHRONIC CONDITIONS AMONG ADULTS



Source: CDC PLACES (2020-2021). Provided by Connecticut Hospital Association. Table 43

Bridgeport Hospital's Preventative Health Maintenance Program has led to an increase in preventive screenings for cervical (22%), breast (14%), and colorectal (10%) cancer.

Data from CBANS shows that Black residents and lower-income residents are more likely to have chronic conditions like high blood pressure and diabetes. Partners said that many residents do not get care until their health problems become serious, which often leads to emergency room visits instead of early treatment. This highlights the importance of regular doctor visits and early care to prevent serious health issues.

EXHIBIT 57: CBANS QUESTION – RESPONDENTS WHO HAVE EVER BEEN TOLD BY A PROVIDER THAT THEY HAVE THE FOLLOWING CHRONIC CONDITIONS, BY RACE/ETHNICITY AND INCOME

Race/Ethnicity					Ever been told by a provider you have the following…	Income	
White	Black	Latino	Asian	Other Race		Less than $75,000	$75,000 or more
32%	54%	19%	17%	33%	**High blood pressure or hypertension**	41%	28%
7%	22%	13%	8%	12%	**Diabetes**	17%	6%
3%	2%	1%	7%	3%	**Angina or coronary heart disease**	2%	3%
2%	0%	1%	5%	3%	**A heart attack, also called myocardial infarction**	3%	1%

LEGEND

Least — Most

Chronic Disease Hospitalizations

Hospitalizations for chronic diseases in Greater Bridgeport exceed state averages, indicating gaps in preventive care and disease management.

- **High Blood Pressure:**
  - **5.7 per 1,000** in Greater Bridgeport
  - 4.5 per 1,000 statewide
- **Heart Failure**:
  - **4.4 per 1,000** in Greater Bridgeport
  - 4.3 per 1,000 statewide
- **Asthma**
  - **3.2 per 1,000** in Greater Bridgeport
  - 2.8 per 1,000 statewide
- **Diabetes - Uncontrolled/Short Term Complications**:
  - **3.0 per 1,000** in Greater Bridgeport
  - 2.7 per 1,000 statewide

Source: Connecticut Hospital Association ChimeData. Table 46

According to the Connecticut Hospital Association, hospitalization rates for chronic disease in Greater Bridgeport are much higher than the state average, suggesting that many residents are not getting the care they need to stay healthy. Partners reported that a shortage of doctors makes the problem worse, with people waiting months to get an appointment. High blood pressure, heart failure, asthma, and diabetes lead to frequent hospital stays, which could be prevented with better access to primary care and routine checkups.

> **"Chronic diseases remain a big concern: obesity, high blood pressure. Obesity is a huge problem in this community."**
>
> **- Partner**

Community members also raised concerns about more children developing obesity and high blood pressure. They shared that kids are spending more time indoors and being less active, which can lead to long-term health problems. Better access to primary care, screenings, and education on healthy habits could help more people prevent and manage chronic diseases before they become serious.

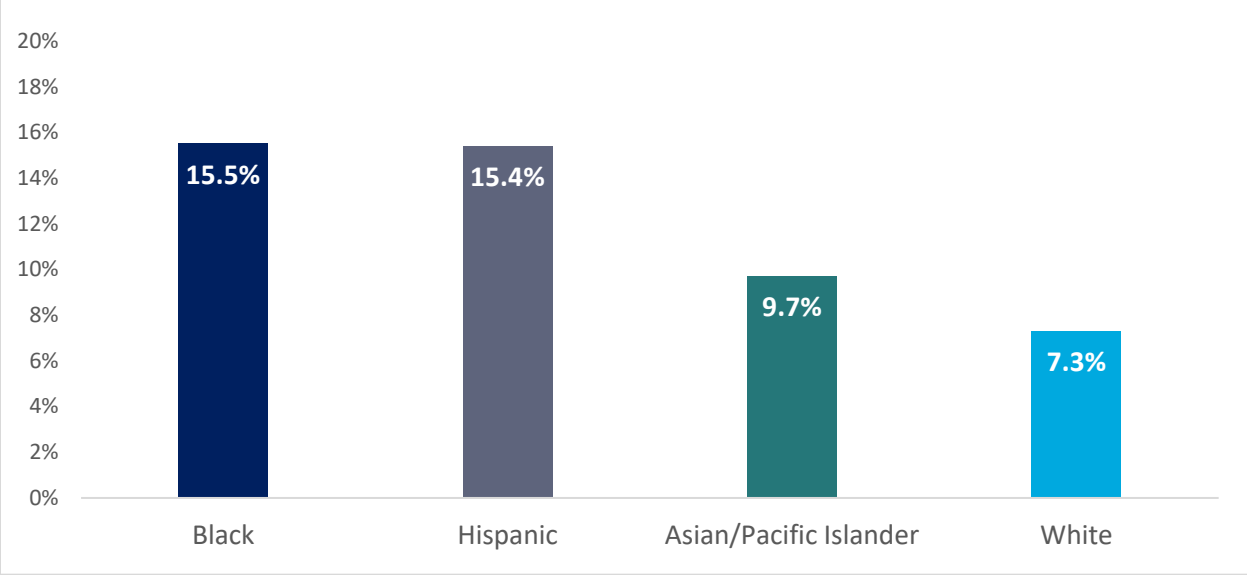
Maternal Care

Maternal health is critical for both mothers and infants, yet partners and community members shared that many women in Greater Bridgeport face barriers to care, particularly those experiencing disadvantage.

> **"For the pregnant and postpartum population, all the social and structural barriers, such as food insecurity, poverty in general, transportation, housing insecurity, all of these circumstances are a big challenge."** - **Partner**

New mothers often struggle because while their infants may qualify for insurance, they may not. Those who are undocumented face additional challenges, including fear and mistrust of the health care system, which may prevent them from seeking care. Single mothers also encounter difficulties balancing postnatal care with work obligations, limiting their ability to attend follow-up appointments. Partners highlighted the need for more postpartum health education to help new mothers understand changes in their bodies and prioritize their own health.

EXHIBIT 58: INADEQUATE PRENATAL CARE,[8] BY RACE



Source: National Center for Health Statistics, final natality data. Table 59

[8] Adequacy is measured using the Adequacy of Prenatal Care Utilization Index, which classifies prenatal care received into 1 of 4 categories (inadequate, intermediate, adequate, and adequate plus) by combining information about the timing of prenatal care, the number of visits, and the infant's gestational age.

National natality data shows that Black and Hispanic mothers in the region are more likely to receive inadequate prenatal care compared to White mothers.[9] Prenatal care is essential for monitoring fetal development, addressing maternal health concerns, and reducing complications during childbirth.

In Fairfield County, about one in ten infants (10.3%) were born to a mother who received inadequate prenatal care. The disparities in care access suggest systemic barriers that may include financial limitations, lack of transportation, or fear of seeking medical services.

Expanding access to culturally competent care and improving outreach to mothers experiencing disadvantage could help close these gaps.

The Bridgeport Hospital Foundation supports non-medical needs of new parents by providing necessities like scales, digital thermometers, diapers, formulas, pack-n-plays, and car seats for parents who do not have access to them.

[9] March of Dimes natality data| https://www.marchofdimes.org/peristats/

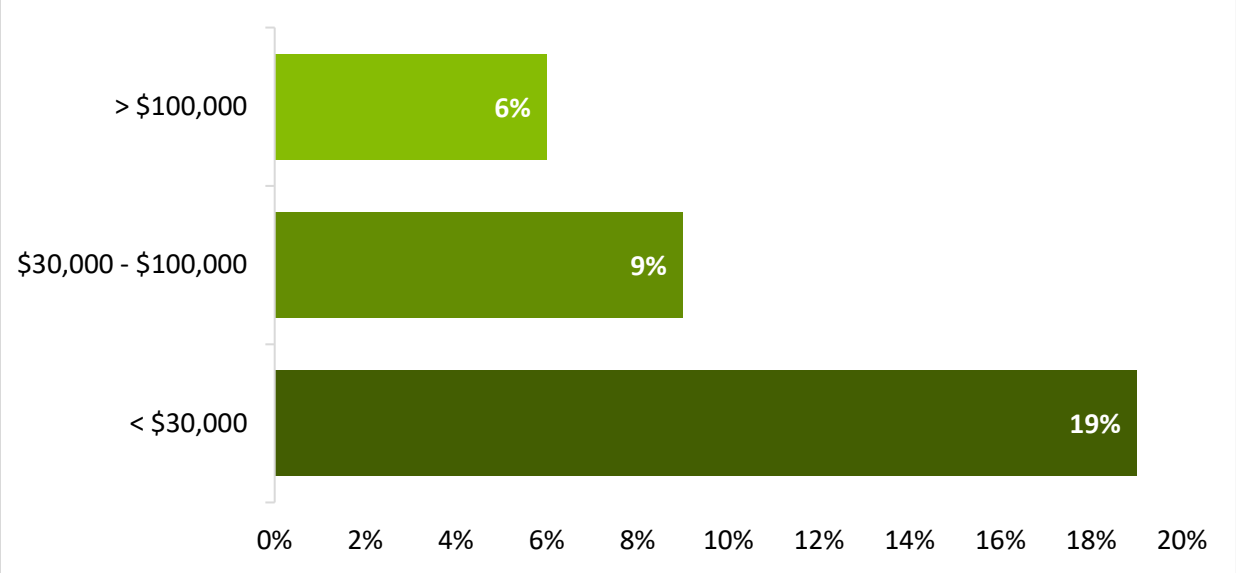
Substance Use

> **"Alcohol abuse treatment is so under-resourced. [...] We need tighter, more cohesive planning around those folks that are highly vulnerable and bouncing out of emergency rooms and shelter services." - Partner**

Partners identified alcohol use as a primary substance use concern in Greater Bridgeport, surpassing opioid and intravenous drug use. While substance use disorder treatment is available, access varies significantly by insurance type, with commercial insurance offering better options than Medicaid. Outpatient services lack resources, particularly integrated with behavioral health, highlighting the need for more community health workers to assist with treatment and recovery.

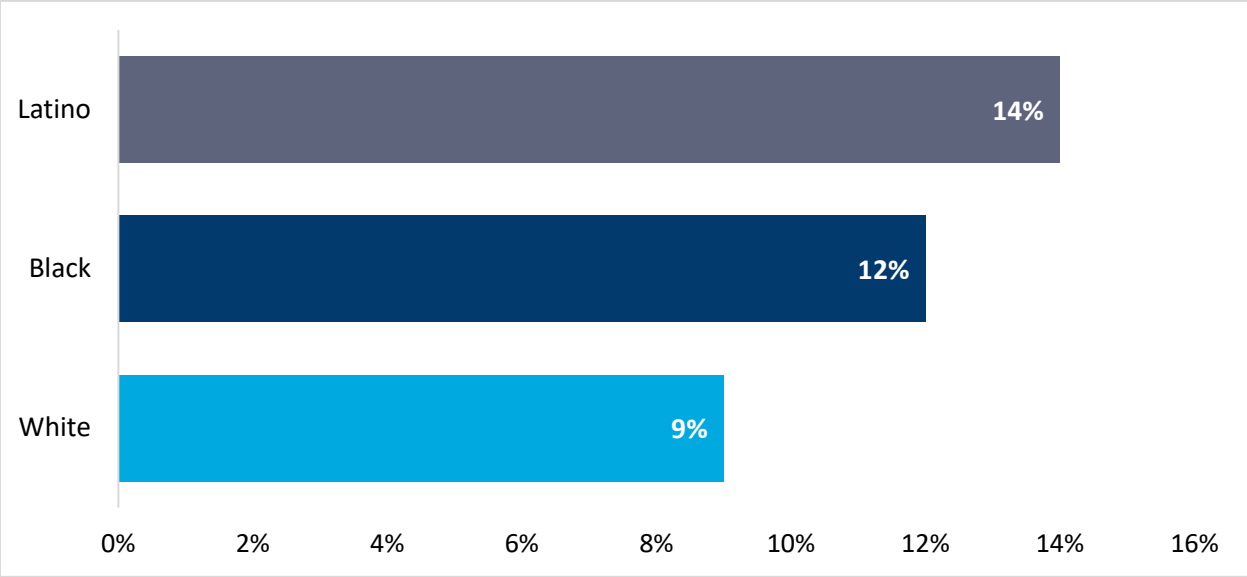
Survey data from DCWS respondents indicate that 11% currently use e-cigarettes or other vaping products. Vaping rates are highest among those with lower incomes, with 19% of respondents earning less than $30,000 reporting use, compared to 6% of those earning $100,000 or more.

EXHIBIT 59: DCWS QUESTION – RESPONDENTS WHO CURRENTLY USE E-CIGARETTES OR OTHER ELECTRONIC VAPING PRODUCTS, BY INCOME



Racial disparities in vaping are also evident, as Latino (14%) and Black (12%) respondents reported higher usage rates than White (9%) respondents (Exhibit 60). These findings suggest that targeted prevention and education efforts may be needed for populations at higher risk of vaping-related health concerns.

EXHIBIT 60: DCWS QUESTION – RESPONDENTS WHO CURRENTLY USE E-CIGARETTES OR OTHER ELECTRONIC VAPING PRODUCTS, BY RACE/ETHNICITY



Substance use-related disorders were the second most common hospital diagnosis for Greater Bridgeport residents, occurring at a rate of 17.0 per 1,000 adults (Table 46). Alcohol-related disorders were the most frequently diagnosed, followed by non-opioid-related and opioid-related disorders.

Substance-use related disorders were the **second** most common hospital diagnosis for Greater Bridgeport, with a rate of **8.2 per 1,000** adults.
Sub conditions:

1. Alcohol-related disorders
2. Non-Opioid-related disorders
3. Opioid-related disorders

Source: Connecticut Hospital Association ChimeData. Table 46

The high hospitalization rate for substance use suggests ongoing gaps in prevention and outpatient treatment services, leading individuals to seek care in emergency settings instead.

"If [a patient] came in for an alcohol detox at the hospital and needed to go to rehab with Medicaid and Medicare, that's probably not going to happen."

- Partner

Mental Health

Mental health care access is a significant challenge in Greater Bridgeport. Partners and community members reported that many residents struggle with anxiety, depression, and trauma-related conditions, yet long wait times, high costs, and a shortage of providers make care difficult to access.

Mental health disorders were the **most** common hospital diagnosis for Greater Bridgeport, with a rate of **10.4 per 1,000** adults.

Source: Connecticut Hospital Association ChimeData. Table 46

EXHIBIT 61: MENTAL HEALTH PROVIDER RATIOS

FAIRFIELD COUNTY VS. CT STATE
Mental Health Providers
681 : 1
CT State Ratio 516 : 1
Higher ratios indicate fewer providers per person.

Source:National Plan & Provider Enumeration System NPI, 2023. Table 43

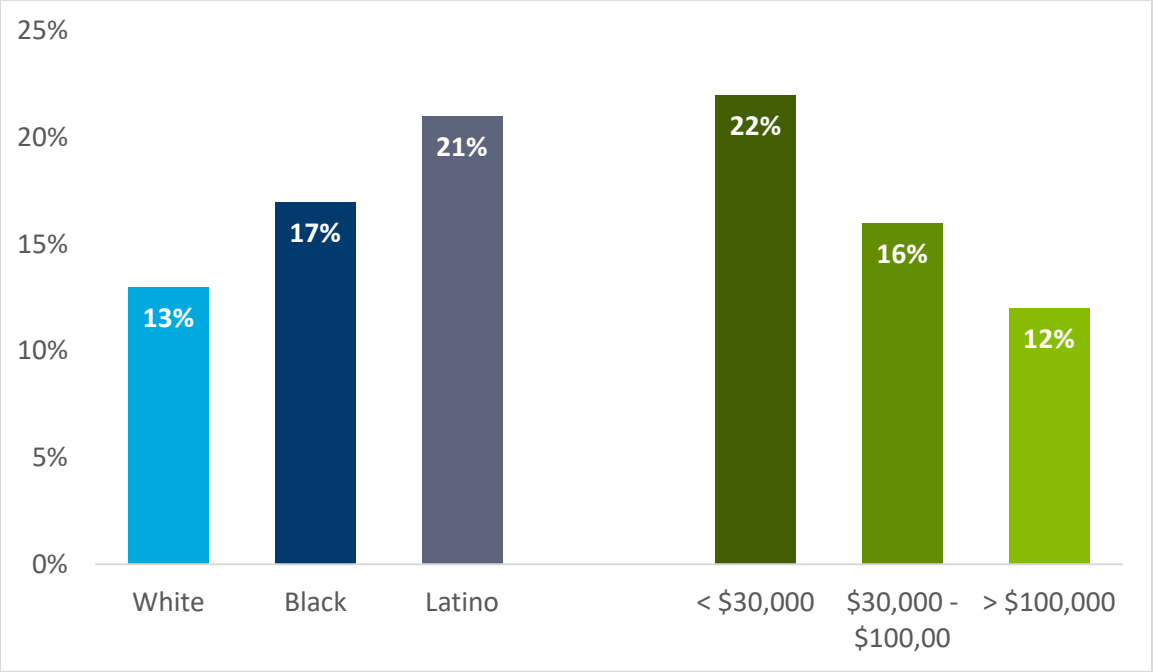
Youth mental health is a particular concern, with families waiting six to nine months for therapy or psychiatric care. Limited availability of cognitive behavioral therapy (CBT) and psychotherapy resources leaves many residents without the treatment they need, leading to untreated or improperly managed conditions.

Without accessible community-based mental health services, people in crisis often turn to emergency rooms or law enforcement, which are not equipped to provide long-term mental health care. The shortage of mental health providers in Fairfield County further exacerbates access challenges to receiving timely care.

Survey data further highlights these barriers. According to DCWS, 15% of respondents reported needing but not receiving mental health treatment in the past year. The most common barriers were affordability (43%), time constraints due to work or other commitments (37%), long wait times for appointments (26%), and insufficient health insurance coverage (25%).

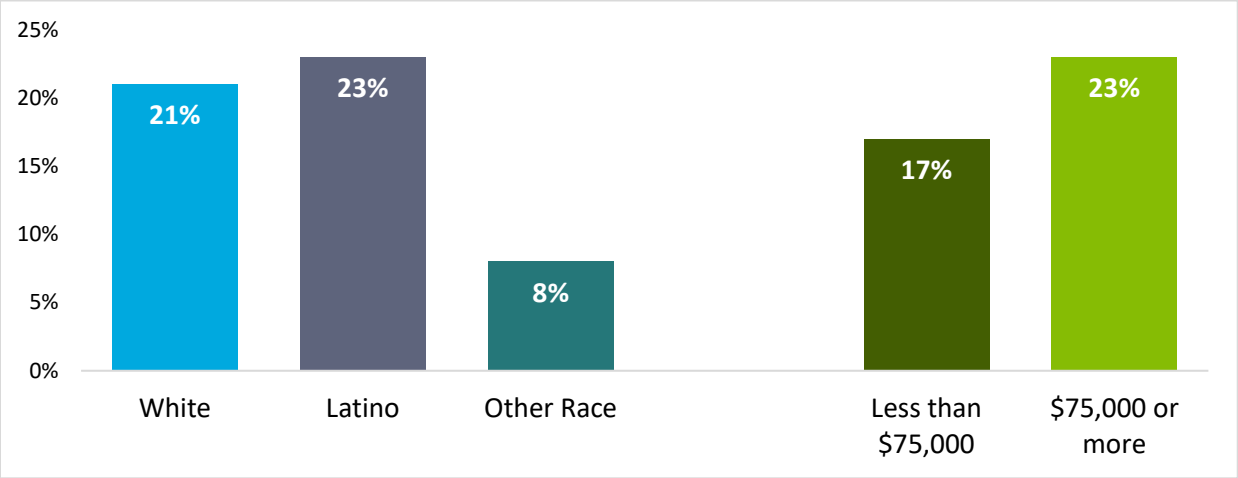
Racial disparities also exist, with Black (17%) and Latino (21%) respondents more likely to report unmet mental health needs than White (13%) respondents. Lower-income individuals are more affected, with 22% of those earning less than $30,000 unable to access care, compared to 12% of those earning more than $100,000.

EXHIBIT 62: DCWS QUESTION – RESPONDENTS WHO NEEDED BUT DID NOT RECEIVE MENTAL HEALTH TREATMENT, BY RACE/ETHNICITY AND INCOME



Additionally, CBANS data shows that 21% of respondents were unable to access mental health services because they did not know where to seek help. This uncertainty is particularly high among Latino (23%) and White (21%) respondents, as well as those earning $75,000 or more (23%). This suggests that improving awareness of available services could be a key strategy to increase access.

EXHIBIT 63: CBANS QUESTION – RESPONDENTS WHO WERE UNABLE TO ACCESS MENTAL HEALTH SERVICES DUE TO UNCERTAINTY ABOUT WHERE TO SEEK HELP, BY RACE/ETHNICITY AND INCOME



According to partners and community members, crisis response remains a major gap in mental health care. In emergency situations, police officers are often the first responders. Some hospitals lack on-site psychiatric services, requiring transfers to facilities further away.

Bridgeport Hospital staff participate in weekly meetings of the regional Community Care Team that connects behavioral health patients, with high numbers of emergency room visits, to necessary community support services.

Qualitative Research: Key Findings

The qualitative research component of this report draws on insights gathered through partner interviews, focus groups, and community discussions. Below is a summary of the key findings of the qualitative research, which is one component of all the data collected.

Strengths

Partner interviews and focus groups with individuals that live and work in Greater Bridgeport demonstrated how the services provided by community organizations as well as health care systems are integral to the health of residents. Participants identified several community strengths, including a **strong sense of connection**, **collaboration**, and **dedicated community organizations.**

Themes

In addition to strengths, several overarching themes illustrated the systemic difficulties and interrelated challenges faced by those living in Greater Bridgeport.

Throughout the partner interviews and focus groups, community members identified increasing **health equity** as an ever-present goal for the community. Many participants worried that unequal access to resources, opportunities, and education hurts the health and wellbeing of residents in Greater Bridgeport.

While participants often discussed health care access as a community wide concern in tandem with health equity, it was also recognized as a worry for them personally. **Health care access** in Greater Bridgeport is affected by several factors including insurance status, availability of primary and specialty care providers, geography and transportation, and financial resources. Mental and behavioral health care for youth was noted as particularly difficult to access.

Participants also emphasized the importance of **trust** between health care providers, community organizations, and residents. By establishing a relationship built on trust, individuals are often more likely to seek care and follow recommendations.[10] Community members involved in the partner interviews and focus groups recommended approaches to build trust, including collaborating with trusted local organizations, working with case managers familiar

[10] Te Winkel, M. T., Damoiseaux-Volman, B. A., Abu-Hanna, A., Lissenberg-Witte, B. I., van Marum, R. J., Schers, H. J., Slottje, P., Uijen, A. A., Bont, J., & Maarsingh, O. R. (2023). Personal continuity and appropriate prescribing in primary care. *Annals of Family Medicine, 21*(4), 305–312. https://doi.org/10.1370/afm.2994

with the community's needs, and recruiting providers and staff who reflect the community they serve.

A lack of **economic stability** was frequently identified as a root-cause barrier that impacts individuals' health and quality of life. Participants shared that the increased cost of living, particularly the cost of housing, paired with low wages and inadequate employment opportunities, often left individuals and families making tough decisions between meeting their basic needs and seeking medical care.

As with the strengths and needs of the community, these themes are not mutually exclusive and often have compounding impacts on individuals. The interconnectedness of these themes highlights the need for a holistic approach that utilizes the strengths of the community to improve the wellbeing of its residents.

NEEDS PRIORITIZATION

List of Identified Community Health Needs

The following list highlights the community needs identified through the 2025 CHNA for Greater Bridgeport. These needs are categorized into high-level focus areas and are presented without prioritization.

Health Care Needs

- Accessible preventive care programs focusing on diet and physical activity.
- Better maternal and prenatal care for under-resourced populations.
- Enhanced chronic disease management programs (e.g., diabetes, cardiovascular health).
- Expanded transportation services to health care facilities.
- Financial assistance programs for underinsured individuals.
- Improved access to dental care for low-income residents.
- Improved access to primary care services, including reducing wait times and increasing provider availability.
- Improved access to specialty care services (e.g., cardiology, endocrinology).
- Improved availability of pediatric health care services.
- Increased number of providers accepting Medicaid and Medicare.
- Health care coverage options to address gaps for uninsured individuals.

Behavioral Health Needs

- Culturally sensitive behavioral health services for diverse populations.
- Expanded access to affordable substance use treatment and recovery programs.
- Greater availability of crisis services for mental health and substance use.
- Increased availability of mental health services for all age groups.
- Integrated care models combining physical and behavioral health services.
- Programs addressing stigma around seeking mental health and substance use treatment.

Culturally Competent Care Needs

- Community engagement initiatives and outreach programs for immigrant and non-English-speaking populations to build trust with groups that have been marginalized.
- Equitable distribution of health care resources across neighborhoods.
- Training for health care providers on cultural sensitivity.

Social Drivers of Health Needs

- Access to affordable childcare to support working families.
- Employment opportunities with fair wages and job stability.
- Improved access to healthy and affordable food options.
- Reliable, affordable, and accessible transportation options to health care facilities, employment, and essential services.
- Safe, affordable, and stable housing for low-income residents.

Regional Community Prioritization

To ensure that the 2025 CHNA reflects the perspectives and priorities of Greater Bridgeport residents, a structured prioritization process was conducted using a combination of community input and evidence-based decision-making methods.

A Community Voices Survey was distributed by the HIA, engaging 418 community members who ranked the most essential community health needs. Their feedback informed the regional prioritization session. Those ranked top eight needs were:

1. **Increased availability of mental health services for all age groups.**
2. **Access to affordable childcare to support working families.**
3. **Increased number of providers accepting Medicaid and Medicare.**
4. **Greater availability of crisis services for mental health and substance use.**
5. **Improved access to healthy, affordable food options.**
6. **Employment opportunities with fair wages and job stability.**
7. **Better maternal and prenatal care for under-resourced populations.**
8. **Health care coverage options to address gaps for uninsured individuals.**

The prioritization session, conducted in person with HIA members, utilized a modified Hanlon Method, an evidence-based approach approved by the National Association of County and City Health Officials (NACCHO).[11] Participants first completed a pre-session survey, scoring 25 health needs based on Magnitude, Severity, and Feasibility, which generated an initial prioritization score.

During the session, participants applied the PEARL-E framework, a modified version of the Hanlon Method's PEARL criteria. This modification added an Equity component to ensure that systematic disparities were considered in decision making. Needs that did not meet PEARL-E criteria were excluded from final consideration. Following this process, participants identified 14 top-ranked needs that were categorized into three priority areas for future collaborative community health improvement strategies for HIA.

1. **Mental Wellbeing**
2. **Preventive Care & Quality of Life**
3. **Strengthening Communities**

[11] NACCHO. (2023). *Guide to Prioritization Techniques.* National Association of County and City Health Officials. Retrieved from https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf

Hospital Internal Prioritization

Bridgeport Hospital leadership engaged in a data-driven prioritization process, considering multiple inputs, including:

- Findings from the Community Voices Survey
- Outcome of the Regional Prioritization Session
- 25 community needs identified through the CHNA, with particular focus on four that closely align with the work of health care institutions:
    - Access to Specialty Care
    - Transportation to Health Care Facilities
    - Availability of Pediatric Health Care Services
    - Integrated Care Models Combining Physical and Behavioral Health
- Comprehensive data analysis

After reviewing this information, hospital leadership selected three key needs to serve as the 2025-2028 priority areas:

1. **Mental Health and Crisis Services**
2. **Maternal and Prenatal Care**
3. **Pediatric Services**

These three hospital priority areas align with community needs while ensuring that the hospital can leverage its expertise and resources for the most significant impact over the next three years.

Additional Health System Priority

At BH, the experience of our patients is of utmost importance to us. We strive to provide high quality equitable care to every patient every time. Community members, from across our hospital regions, identified cultural competency as a need during the 2025 CHNA process. This valuable feedback revealed opportunities to improve patient care by expanding language access and cultural sensitivity training and education for staff.

In response, Yale New Haven Health (YNHHS) selected Culturally Competent Care as a 2025-2028 priority area and will be implementing national standards for Culturally and Linguistically Appropriate Services (CLAS) at each of our hospitals. These standards will enhance the existing quality of service provided to all patients, ensuring respect for every patient's health needs and preferences.

Final Prioritized Needs

Regional Top-Ranked Needs

Mental Wellbeing

- **Availability of mental health and crisis services***
- Affordable treatment and recovery programs
- Address stigma for seeking treatment

Preventive Care & Quality of Life

- Prevention focused on diet and physical activity
- Access to primary care and reduced wait times
- **Improved maternal and prenatal care***
- Chronic disease management
- Increase acceptance of Medicaid/Medicare
- **Cultural sensitivity training for staff****

Strengthening Communities

- Access to healthy food
- Access to affordable childcare
- Employment opportunities
- Safe and affordable housing
- Health care coverage for uninsured

Additional Community Needs From CHNA Data

- Access to specialty care
- Transportation to health care facilities
- **Availability of pediatric health care services***
- Integrated care models combining physical and behavioral health

***Selected by hospital for 2025-2028 priority focus areas**

****Selected by health system as a 2025-2028 priority focus area, referred to as *Culturally Competent Care***

HIA Partners and CHNA Funders

Accomplishing Real Change INC/Parents Matter

Alliance for Community Empowerment

ALS United Connecticut

American Heart Association

Aspetuck Health District*

Bridgeport Caribe Youth Leaders

Bridgeport Farmers Market Collaborative

Bridgeport Hospital*

Bridgeport Prospers*

Bridgeport Public Schools

Bridgeport Rescue Mission

Bridgeport Tabernacle

Bridgeport Youth Lacrosse

Bridges Healthcare

Building Neighborhoods Together

Carelon Behavioral Health

Catalyst CT

Cebert Women's Services, PLLC

Chemical Abuse Services Agency, Inc.

Child and Family Guidance Center

Child First Bridgeport

Bridgeport Department of Health & Social Services*

Bridgeport Department of Youth Services

Community Health Network of Connecticut

Community Health Workers Association of Connecticut

Connecticut Center for Patient Safety

Connecticut Dental Health Partnership

Connecticut Legal Services

Connecticut Oral Health Initiative

Cornerstone Medical Training Center

CT Chapter of Hispanic Nurses

CT Department of Mental Health & Addiction Services

CT Department of Public Health

CT Early Detection and Prevention Program

CT Institute for Refugees and Immigrants

CT Worker Center

Do For Others

Fairfield CARES

Fairfield County Medical Association

Fairfield County Community Foundation

Fairfield Health Department*

Fairfield University

Food Rescue US

Fred Weisman AmeriCares Free Clinic of Bridgeport

Full Circle Youth Empowerment

Greater Bridgeport Area Prevention Program Inc.

Groundwork Bridgeport

Healthcentric Advisors

Heartbeats + Bare Feet: Womban Wellness, LLC

Hispanic Health Council

Hope Charitable Pharmacy of Greater Bridgeport

Housatonic Community College

Kingdom Life Christian Church

LifeBridge Community Services

Make the Road Connecticut

Mercy Learning Center

Milford Health Department*

Milford Human Services

Milford Youth & Family Services

Mindfulness Mom

Monroe Health Department*

Mozaic Senior Life

Norma Pfriem Breast Center

Optimal Interpreters and Translators, LLC

Optimus Health Care*

OurTransLife.org

Park City Communities*

PRIME Clinic Yale School of Medicine

Project Access New Haven

Recovery Network of Programs

Sacred Heart University

Sacred Heart University- Center for Nonprofits

Shiloh Baptist Church

Southwest Community Health Center*

Southwestern Connecticut Agency on Aging

Southwestern CT Area Health Education Center

Square Up for Others

St. Vincent's Medical Center*

State of Connecticut Office of Health Strategy

STEP Learning Collaborative

Sterling House Community Center

Stratford Board of Education

Stratford Health Department*

Stratford Parents' Place

Stratford Visiting Nurse Association

The Hub - under Catalyst CT

The Kennedy Collective

The Salvation Army

Town of Stratford Community & Senior Services

Trumbull EMS

Trumbull Health Department*

UConn Extension

United Way of Coastal and Western Connecticut*

University of Bridgeport

Wheel It Forward

Yale New Haven Health*

Yale School of Medicine

Your Wellness Way, LLC

2025 CHNA Funder

Research Partners

Thank you to our research partners for their essential role in completing the 2025 CHNA.

Crescendo Consulting Group | crescendocg.com

Crescendo Consulting Group facilitated the full Community Health Needs Assessment (CHNA) process for the 2025 cycle. This included quantitative analysis of secondary data and survey responses, as well as qualitative research through focus groups and partner interviews. Crescendo supported community engagement efforts, analyzed findings across data sources, and compiled the accompanying Implementation Strategy Plan in collaboration with hospital staff and community partners.

Crescendo is a consulting firm that specializes in community needs assessments, strategic planning, and program evaluation. With clients ranging from hospital systems and behavioral health organizations to public health departments and municipalities, Crescendo brings a national perspective and strong local knowledge to its work. The team emphasizes inclusive engagement strategies that reflect the experiences of Black, Indigenous, and People of Color (BIPOC), gender-diverse, linguistically isolated, and other historically marginalized communities. Crescendo's mission is to positively change the lives of the people, organizations, and communities it serves through thoughtful, data-driven solutions.

DataHaven | ctdatahaven.org

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

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

APPENDICES

- **Appendix A:** 2022-2025 Updates
  - 2022-2025 Bridgeport Hospital Implementation Strategy Plan Update
  - 2022-2025 Yale New Haven Health Implementation Strategy Plan Update
  - 2022-2025 HIA CHIP Evaluation of Impact
- **Appendix B:** Secondary Data Tables
- **Appendix C**: Access Audit
- **Appendix D:** Asset Maps and Community Resources
- **Appendix E:** Primary Data Tools
  - DataHaven Survey
  - Partner Interview Guide
  - Focus Group Guide
- **Appendix F:** References for Definitions of Terms

Appendix A: 2022-2025 Updates

2022-2025 Bridgeport Hospital Implementation Strategy Plan Update

Goal 1 Community Health and Wellbeing Improve the health and wellbeing of the community with a focus on social drivers of health and health equity.	
Strategy 1 Provide non-medical resources to patients in order to address social drivers of health needs.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Provide funding for non-medical needs through the Fay Fund for utilities, rent, and other necessities for patients in need.	$46,093 of basic needs assistance provided to 81 patients.
b. Provide referrals to Emergency Shelter Placement at Prospect House.	Bridgeport Hospital pays for monthly access to one room with four beds, for shelter placement.
Strategy 2 Provide opportunities to positively impact social drivers of health needs for community residents.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Expand the Having an Opportunity to Prepare for Employment (HOPE) Program to BH to help community residents return to the workforce.	Seven graduates attained gainful employment.

Goal 2 Access to Care **Ensure access to quality health care and wellbeing services for all community members.**	
Strategy 1 Provide medical resources to patients in need to ensure safe transition after hospital stay.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Provide temporary transitional charity care at post-acute care facilities after hospitalization for patients when they cannot return home.	$2,329,308 spent to support patients' transitional care costs.
b. Coordinate temporary transitional access to services needed for hospital discharge.	$2,546,713 spent to support patients' discharge needs as they transition back into the community.
c. Provide resources to assist patients who need to return to their home country for their continuation of care.	$562,107 spent on relocation services.
Strategy 2 Provide assistance to patients in need of non-emergency medical transportation.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Provide vouchers through Transportation Assistance Fund to assist patients in accessing medical appointments.	$7,175 spent on bus vouchers to assist patients who are able to access public transportation.
b. Provide free transportation through Uber Health.	22,619 trips provided to and from medical appointments, totaling $377,713.

c. Work with Veyo, Nelson Ambulance, and others to provide transportation home for patients in need.	$620,874 spent on transportation assistance for patients discharging from Bridgeport Hospital.
Strategy 3 Ensure language options meet the diverse needs of the community.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Increase ease of access for non-English speaking patients and individuals requiring American Sign Language.	219,130 patients assisted with language interpreter services.
b. Implement Bilingual Competency Program for staff in different languages.	68 staff participated in 16 different languages, with a 76.5% average pass rate.
c. Ensure written health communications are inclusive (multiple languages, Braille, etc.).	123 new documents translated in multiple languages.
Strategy 4 Increase access to preventative health screenings.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Increase breast, cervical, and colon cancer screenings through the Preventative Health Maintenance Program.	22% increase in cervical cancer screening rate 10% increase in colorectal cancer screening rate 14% increase in breast cancer screening rate **reporting covers averages from 10/1/22 through 9/30/24*
b. Decrease cardiac risk in women of color with pregnancy induced hypertension.	207 patients followed through OBGYN clinic. **reporting covers 10/1/22 through 9/30/24*
Strategy 5 Expand use of telehealth, in-home and in-community care to underserved neighborhoods.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Provide the Universal Nurse Home Visiting – Community Health Worker Pilot (Family Bridge) for new moms and babies.	1,018 patients served across 1,398 visits.
Strategy 6 Improve attendance at outpatient therapy visits by providing non-clinical support to patients.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Provide support to patients at high risk of poor attendance at therapy visits, including addressing transportation and other barriers.	Patient navigation support provided to 1,496 patients.
b. Coordinate visit scheduling with patient availability to increase attendance.	1,196 recaptured visits where patients would have otherwise canceled or no showed.
Strategy 7 Reduce barriers to care by connecting patients to appropriate community services to address social drivers of health (SDoH) needs.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Screen patients for barriers to care and provide community referrals, education, and support.	3,146 patients were enrolled in Community Health Worker (CHW) program to address social drivers of health, with 2,096 CHW interventions and 2,308 community-based referrals provided.

b. Provide navigation to patients identified via Test of Change Length of Stay pilot who are referred to the CHW Program.	28 patients enrolled in pilot; 13 CHW interventions; 37 community-based referrals. **reporting covers 10/1/22 through 9/30/23*
Strategy 8 Increase the percentage of community members who have health insurance coverage.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Provide resources to uninsured patients and support during the Medicaid or financial assistance programs application process.	Patients assisted by CHW program with: Cost of care needs: 1,088 Cost of medication: 387 Financial Assistance Program applications: 168 Access Health CT applications: 91
Strategy 9 Reduce preventable emergency department visits.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Provide philanthropic support for navigation services to decrease preventable ED visits for chronic disease patients.	ED visits decreased by 53.5% across initial cohort (funding was expended by end of FY23).
Strategy 10 Provide access to health care and services and support underserved populations.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Continue to provide financial assistance programs to those eligible.	$69,707,560 provided by Financial Assistance Program across 65,673 encounters. **reporting covers 10/1/22 through 9/30/24*
b. Continue to provide Medicaid services to those eligible.	293,049 encounters / $157,751,714 **reporting covers 10/1/22 through 9/30/24*
c. Provide educational support and financial assistance to uninsured patients. Provide awareness of public/government health insurance options to patients and offer support, assistance and continual follow-up throughout the enrollment process.	2,023 applications initiated / created, and 1,517.25 staff hours dedicated to enrollment assistance. **reporting covers 10/1/22 through 9/30/24*
d. Improve access to prescription and medication assistance programs through retail pharmacy at Bridgeport Hospital.	Bridgeport Hospital Retail Pharmacy opened to the public on April 1, 2025.
e. Offer the Medication Assistance Program (MAP) to help reduce financial hardship and increase patient medication adherence.	$4.2 million in medication savings provided for 1,514 patients served. **reporting covers 10/1/22 through 9/30/24*

Goal 3 Behavioral Health **Increase capacity and equitable availability of behavioral health services and support resources.**	
Strategy 1 Expand access to community-based behavioral health services.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Partner with and educate local organizations on behavioral health referral process and options through CT Community for Addiction Recovery (CCAR).	432 patients referred through CCAR.
Strategy 2 Provide education and personal strategies to community members on behavioral health.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Provide ongoing community presentations on mental illness, stress reduction and coping skills.	5 community presentations and events attended.
Strategy 3 Improve coordination of care for behavioral health patients in the emergency department (ED).	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Participate in regional Community Care Team (CCT) connecting behavioral health patients, with high ED utilization, to necessary support services.	103 CCT meetings held with an average of 10 patients discussed per week.
b. Partner with Health Promotion Advocates (HPA) for substance use referrals for high utilizers in the ED.	2,672 substance use referrals made by HPA's.
Strategy 4 Support postpartum behavioral health needs.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Develop an initiative to provide mental health screening for NICU parents and access to a mental health provider.	109 mental health screenings were provided. **reporting covers 10/1/22 through 9/30/24*
Strategy 5 Expand treatment options for substance misuse.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Offer substance misuse medication assisted treatment providing Suboxone and other options.	542 patient visits held for medication assisted treatment. **reporting covers 10/1/22 through 9/30/24*

Goal 4 Child Wellbeing **Promote child health, wellbeing, and resiliency through strengthening and supporting families and communities.**	
Strategy 1 Improve health outcomes for newborns by providing support to new parents.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Provide baby scales, digital thermometers, diapers, formulas, pack-n-plays, and car seats for parents who do not have access to them.	144 baby items were provided through Bridgeport Hospital Foundation.
b. Implement the CT Hospital Association/Diaper Bank of CT referral-based grant program.	409 women and children were enrolled in monthly diaper assistance pilot (ended June 2024).
c. Provide pasteurized donor human milk to all inpatient postpartum mothers who wish to feed their infants an exclusive human milk diet at no cost.	738 patients received pasteurized donor human milk.
d. Host events like the Community Baby Shower to support local families.	19 families served through Bridgeport Hospital Community Baby Shower.
Strategy 2 Support the health and wellbeing of parents while children are in the NICU.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Ensure access to breast pumps in NICU to encourage breastfeeding.	150 breast pumps loaned on a continual basis; approximately 38 per quarter.
b. Provide access to freezers for mothers to bank their breast milk, if they are unable to at home.	24 freezers purchased to support breast milk storage.
c. Working to obtain an automated blood pressure machine available for use by NICU parents to screen for high blood pressure.	Automated blood pressure machine acquired and made available to patients on a self-directed basis.

Goal 5 Healthy Living **Achieve equitable life expectancy for community members through availability and coordination of healthy living services and resources.**	
Strategy 1 Offer community education on disease prevention and maintenance.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Offer healthy lifestyle education to patients and the community through various presentations and events.	Over 56 community programs focusing on Nutrition and Heart Health.
b. Offer nutrition counseling and Medical Nutrition Therapy to the community to support the importance of healthy eating.	Completed 4,256 outpatient nutrition counseling visits.
c. Offer walk and talk with provider events in the community.	Providers from seven departments participated in five walk and talk events led by Milford and Stratford Health Departments.

Strategy 2 Provide access to healthy food to support the health of our patients and the community.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Offer healthy food options in the cafeteria for patients, staff and visitors.	1,708 different mindful options were offered during this period.
b. Host seasonal weekly farm stand that accepts several forms of food assistance benefits.	$9,644 in food assistance redeemed including Bridgeport Bucks vouchers, SNAP matching, and Farmers Market Nutrition Program benefits by way of Bridgeport Farmers Market Collaborative.
c. Provide farm stand vouchers to Milford residents redeemable at one of the local Milford Farmers' Markets.	$4,055 of produce assistance provided through Milford farm stand vouchers.
d. Continue to host free food distributions.	9,596 allotments of food were provided to community members across 56 events.
e. Promote awareness and availability of local food pantries.	A Bridgeport Hospital Food Resource Guide was developed in English and Spanish and receives updates once per year. The guide has been shared across 22 departments at both campuses for distribution to patients and the community.
Strategy 3 Support local community organizations and events that provide access to food.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Donate unused/unsold food to local emergency food programs.	10,684 pounds of food donated.
b. Work across departments to host healthy food drives to support local emergency food programs in Bridgeport and Milford.	7,419 pounds of food donated to East End Food Bank (Bridgeport) and Milford Food Bank.

2022-2025 YNHHS Implementation Strategy Plan Update

Goal 1 Community Health & Wellbeing **Improve the health and wellbeing of the community with a focus on social drivers of health and health equity.**	
Strategy **Align our everyday business activities in a way that improves living conditions in our communities and addresses health equity.**	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. i) Meet or exceed MBE (minority business enterprise) and WBE (women owned business enterprise) spend targets for defined construction projects. ii) Increase spend on local and diverse organizations to at least 5% of adjusted spend over a 5-year period (FY23-27).	i) YNHHS was able to meet and exceed MBE and WBE spend, going from 3.4% and 15% in 2022 to 5.4% and 14.4% in 2024, respectively. ii) Local spend and diverse spend goals were met and exceeded.
b. Utilizing services from banks that participate in efforts to invest in or provide services and products to (e.g., loans, mortgages, etc.) communities to whom Yale New Haven Health is also providing care.	YNHHS has had $2 Million in banking assets in local banks from FY22 to the present day. Major banking partners have significant impact investment throughout Connecticut.
c. Place members of the management team on local organization boards to support the community.	As of FY23, YNHHS has five board placements (two in Bridgeport, three in New Haven). 41 employees from Bridgeport Hospital on community boards. Six senior leaders on 24 boards from Greenwich Hospital.
d. Implement initiatives to reduce emissions from the Center for Sustainability strategic plan and track process.	• Tracking energy consumption and purchasing electricity and food using digitized platforms. • Implementing systemwide food waste reduction plan. Data from Lean Path, Foods waste tracking platform to minimize food waste. Staff training and data collection on food waste reduction and composting in progress.
Strategy Develop strategies to address disparities by race and ethnicity to drive equitable care and outcomes.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Develop and implement strategies to address disparities by race and ethnicity based on root cause analyses.	Two root cause analyses were conducted, with strategies implemented to address disparities.

b. Identify and decrease variation in clinical care (testing, referral, and treatment patterns) by race and ethnicity.	Developed systems to build analytics around readmissions outcomes for nine conditions with process measures ongoing.
c. Identify and decrease variation in clinical outcomes by race and ethnicity.	Completed for all inpatient and outpatient areas.
Strategy Support a healthcare environment that honors and reflects the communities we serve.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. i) Seek input from the community and provide feedback on health equity to inform future strategy (number of focus groups). ii) Seek input from the community and provide feedback on health equity to inform future strategy (produce community health needs assessments).	27 focus groups held across all delivery networks in effort to implement the We Ask Because We Care campaign. Assessment produced with four of five collective impact partnerships in 2022. CHNA evaluation and redesign conducted and formed new governance structure with collective partnership participation for FY25 CHNA process.
Strategy Engage patients, families, physicians, and staff to increase YNHHS presence in the community to build stronger relationships.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Increase awareness and education about health equity, health disparities and cultural competence.	Five sessions offered including Cultural Intelligence and Critical Consciousness: A Strategic Praxis Framework for Inclusive excellence, Barriers and Opportunities to LGBTQIA+ Healthcare Equity and Inclusion Excellence, and The Traumatic Impact of Structural Racism.
b. Support community relationships through volunteerism, and presence in the community to increase community trust and engagement.	Two per hospital conducted (details on length of program-help quantify dollar value, prep time of DEIB staff, how many participants at DN level), 10 total for FY 23 and 24.
c. Provide DEIB education and resources.	201 total courses were to various departments reaching 1824 employees and nine E-learnings reaching 7,332 employees.
d. Establish Employee Resource Groups/Affinity Groups to assist in identifying the varied needs of the community and support the community through volunteer work.	N/A - Affinity Group launched 1/24/2025.
Strategy Embed health equity within YNHHS and its hospitals.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Build infrastructure to support health equity.	Four delivery network health equity structures established at all hospital locations (not NEMG).

	Office of Health Equity and Community Impact Established.
b. Expand ethnicity categories in electronic medical records patient demographics.	Race, Ethnicity, and Language (REaL) data capture went from 90% in 2022 to 99.3% in 2024.
c. Redesign process and staff training to increase collection and use of REaL data in patient care.	Redesigned staff training is available to all delivery networks across the Health System.
Strategy Enhance the patient experience to reflect the community and patient population.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Improve the diversity of Patient Family Advisors to reflect community and patient population.	YNHHS has established Patient Family Advisory Councils (PFACs) in all hospitals across the Health System.
b. Partner with DEIB, Press Ganey, Office of Health Equity and Community Impact, and Patient Family Advisors to enhance health equity of patient survey questions and use results to increase patient experience.	In FY 24- we started to provide data by race for system objectives to all DNs. To capture more meaningful data for DEI questions, we transitioned survey questions. This change has provided more actionable detail.
Strategy Screen for socioeconomic needs and provide resources for support.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Adopt a common set of SDoH questions across all care settings.	140,292 inpatient total screened from 2022 to 2024, and 143,487 NEMG total screened from 2022 to 2024.
b. Develop strategies to support patients with identified needs through referrals and interventions in alignment with The Joint Commission (TJC) requirements.	7,306 referred cases using the Unite Us system. Implemented automated Resource list process. Renewed partnership with Unite Us. Enhanced Dashboard and implement pulse reporting. Expanded screening to include all inpatient, and children hospital inpatient units, and impatient Psych. 90% of NEMG sites implemented screening.

Goal 2 Access to Care **Ensure access to quality health care and wellbeing services for all community members.**	
Strategy 1 Design community-based programs targeted to heart/vascular health issues.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Expand barbershop initiative to provide community education on blood pressure management.	Continuing to screen blood pressures and enroll eligible participants at each of our 10 CBO's affiliated with Pressure Check, each month. For an average of 12 screenings (or more per month). Nine screening sites and community events were added during 2024 in addition to the existing CBO collaborations.
b. Provide blood pressure checks and blood pressure cuffs to patrons and shop owners.	114 Blood Pressure cuffs provided to shops and patrons from 2022 to 2024.
Strategy 2 Expand use of telehealth, in-home, and in-community care to underserved neighborhoods.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Provide broadband services to patients without personal broadband access to facilitate care via telehealth services through the Federal Communication Commission (FCC) grant.	75 patients without personal broadband access were enrolled in the FCC grant to facilitate care via telehealth services.

Goal 3 Behavioral Health **Increase capacity and equitable availability of behavioral health services and support resources.**	
Strategy 1 Provide integrated behavioral health services to patients that address mental health needs via LCSWs for short-term therapies.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Expand integrated behavioral health services to other areas.	Expanded to the Pediatric Specialty Clinic at Greenwich Hospital.

Goal 4 Healthy Living **Achieve equitable life expectancy for community members through availability and coordination of healthy living services and resources.**	
Strategy 1 Utilize evidence-based chronic disease screening, education, and maintenance programs.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Enhance confidential health coaching, care management and other services and programs for employees through the livingwell CARES program.	1,835 employee health plan members served in Fiscal Year 2023.

2022-2025 CHIP Evaluation of Impact

Introduction

The HIA is comprised of almost 300 individuals representing Bridgeport Hospital (BH), St. Vincent's Medical Center (SVMC), seven local health departments, federally qualified health centers (FQHCs), community agencies, faith-based organizations, universities, town and city agencies, and residents from Bridgeport, Easton, Fairfield, Milford, Monroe, Stratford, and Trumbull. In 2022, HIA completed a CHNA and prioritization process to identify priority health issues. Priority health needs were grouped into four overarching focus areas: access to care, behavioral health, child wellbeing and healthy lifestyles. Individual task forces, comprised of HIA members, worked together on each focus area. In October 2022, HIA launched the 2022-2025 Community Health Improvement Plans (CHIPs) for the four focus areas mentioned above. Since completing its last CHNA in 2022, the partnership has taken many steps to continue realigning its work, deepening relationships, increasing membership and serving the community.

Overall HIA Accomplishments:

- In 2022, HIA developed a Linktree to promote community resources in a more accessible manner. The Linktree is an interactive online list of regional resources for food assistance, health care, and other community services with maps to guide the user experience. The list of resources initially included information for the City of Bridgeport and by March 2025, covered all seven towns in the region.
- In partnership with Make the Road CT, an annual HIA Health Fair was established, focused on serving uninsured and underinsured community members. Two health fairs have been held, starting in May 2023, which have provided 89 people with free health screenings for blood pressure, A1C (blood sugar), height, weight, BMI, waist measurement, pulse oximetry (oxygen levels), and connection to follow-up care and community resources.
- 17 partner organizations attended the Inaugural Barnum Festival Health Fair in June 2024, sponsored by Hartford HealthCare, sharing resources, conducting screenings and providing education to more than 500 community members. The event also included a food distribution in partnership with nOURish.
- In partnership with Connecticut Hospital Association and The Diaper Bank of Connecticut, Bridgeport Hospital and St. Vincent's Medical Center implemented the Diaper Connections pilot program, which

addressed diaper need by supplying free diapers for children under the age of four. The two hospitals and their community partners enrolled over 600 women and children throughout Greater Bridgeport.

- Provided professional mentoring for Fairfield University Master of Public Health (MPH) students enrolled in a Community-Engaged Learning Program Planning and Evaluation course. Students worked closely with the task forces while reinforcing their learning on how to conduct a Community Health Assessment and planning and evaluating essential public health interventions.
- Using feedback from the 2023 HIA Partnership Survey, HIA co-chairs and health department leaders re-evaluated and revised the HIA structure. This resulted in the formation of the HIA Coordinating Team, composed of CHNA funders who enhance accountability and ensure equitable oversight.

Access to Care Accomplishments

The Access to Care Task Force organized and conducted multiple programs with the goal of increasing access to and reducing barriers to health care. Work throughout the region is supported by the efforts of HIA and both BH and SVMC.

Goal

Identify barriers and change processes to ensure equitable access to health care and community-based services.

Objectives

- Improve health outcomes across the region, focusing on at risk and vulnerable populations with high rates of chronic disease.
- Increase the percentage of community members who report having a primary care provider.
- Expand access to specialty care services to ensure people can receive care when they need it.
- Reduce the percentage of people who report being treated with less respect or received services that were not as good as others in the community.

Initiatives and Results

- Monthly Access to Care meetings continue to be a place where local health care professionals work together to troubleshoot healthcare access issues that their patients and clients are facing, allowing for sharing of resources and connections to services in real time.

- Created a local provider guide in English and Spanish, consisting of health offices that see uninsured and underinsured patients. This guide is updated annually and was expanded in fall of 2024. Partners distribute the guide regularly across community events, including health fairs, food distributions, and Know Your Numbers health screenings.
- Created a regional immunization guide in English and Spanish, to help address challenges of meeting the school immunization needs for under-resourced, immigrant populations. In 2024, Access to Care collaborated with the Child Wellbeing Task Force in expanding this guide to include locations in proximity to Greater Bridgeport that offer childhood vaccinations.
- Co-hosted a cultural awareness workshop series together with the Healthy Lifestyles Task Force. Approximately 50 HIA members were trained in Cultural Humility, and 35 members were trained in Defeating Unconscious Bias.

Behavioral Health Accomplishments

The Behavioral Health Task Force worked together on multiple initiatives with the goal of identifying barriers to behavioral health care and resources. Work throughout the region is supported by the efforts of HIA and both St. Vincent's Medical Center and Bridgeport Hospital.

Goal

Identify barriers and change processes to ensure equitable access to health care and community-based services.

Objectives

- Increase the percentage of adults and youth who report feeling satisfied with life and their community.
- Expand the use of additional sites for behavioral health care, including community, schools, home health, and telehealth.
- Increase behavioral health workforce and development.
- Increase the number of people who receive behavioral health care in the appropriate setting.

Initiatives and Results

- Participated in two resource fairs, including Network of Care's Regional Resource Fair and Make the Road CT. For the first time, we had an HIA presence, where we disseminated brochures to inform the community and recruit volunteers.

- Began development of a waitlist toolkit to provide resources to those who are waiting to see a behavioral health provider and exploring different ways to disseminate online and in-person.
- Compiled best practices to share across organizations on retention and recruitment of behavioral health professionals.
- Collaborated with Catalyst CT-The Hub to certify 155 Mental Health First Aid (MHFA) trainers: 119 Adult MHFA (44 Spanish) and 36 Youth MHFA, through funding provided by the State of Connecticut Social Equity Council and the United Way of Coastal and Western Connecticut.
- Developed a program in collaboration with the Child Wellbeing Task Force to expand the region's ability to deliver Youth Mental Health First Aid training across Greater Bridgeport. Primary goals are to train 18 Youth MHFA instructors and deliver training to a minimum of 540 residents and professionals. Currently seeking grant funding.
- Worked to establish a National Alliance for Mental Illness (NAMI) Affiliate in Bridgeport, the nation's largest grassroots mental health organization. Task Force members have agreed to take on interim leadership roles to get the affiliate started.
- Community Care Team continues to meet regularly – with over 13 agencies participating – to reduce the use of emergency departments and improve access to care by connecting participants with mainstream resources and providers.
- Since September 2023, the Behavioral Health Task Force membership has increased from 58 to 89 professionals, representing a 53% increase.

Child Wellbeing Accomplishments

The Child Wellbeing Task Force organized and conducted multiple programs with the goal of strengthening communities and families. Work throughout the region is supported by the efforts of HIA, St. Vincent's Medical Center, and Bridgeport Hospital.

Goal

Achieve equitable health and development outcomes for children by strengthening communities and families and promoting child wellbeing and resiliency.

Objectives

- Increase positive childhood experiences through youth engagement in social athletic, civic, cultural, recreational, and educational activities.
- Build community capacity by increasing awareness and prevention of Adverse Childhood Experiences (ACEs).
- Increase access to services offered by community-based organizations.

Initiatives and Results

- Hosted several Walk and Talks with local partners, such as family resource centers, United Way, behavioral health clinics, hospitals, and the YMCA. These events provided an opportunity for parents and caregivers of young children to get outside, socialize and meet new parents, while learning about important health topics from a group of public health and healthcare professionals.
- Formed the new monthly HIA Community Health Worker (CHW) Work Group to increase engagement of CHWs in the work of HIA and lift the voices of our community through those who are working to address social drivers of health.
- The CHW Work Group has grown from 12 members in June 2023 to a current roster of more than 40. In April 2024, St. Vincent's hosted a full-day meeting focused on training. The 14 participants representing multiple organizations received training in Question, Persuade, Respond (QPR) suicide prevention, Narcan Administration, Stop the Bleed and Hands-only CPR.
- Offered screenings of the documentary film, Resilience: The Biology of Stress and the Science of Hope, to raise awareness of ACEs and the lifelong effect they have on health and behavior. Initial screenings were held with Optimus Healthcare and St. Vincent's Medical Center, followed by Family Bridge – a free home visiting service for families with new babies – and the CHW Work Group.
- The Sparkler app, a free mobile app designed for families with children from birth through kindergarten to support early development, was actively promoted across all Stratford Health Department social media platforms. Additionally, it has been highlighted at Stratford Parent's Place and distributed to parents. The app has also been introduced to parents participating in Walk and Talks, ensuring usage among the community.

Healthy Lifestyles Accomplishments

The Healthy Lifestyles Task Force organized and conducted multiple programs with the goal of achieving equitable life expectancy across the region. Work throughout the region is supported by the efforts of HIA and both St. Vincent's Medical Center and Bridgeport Hospital.

Goal

Achieve equitable life expectancy by ensuring Greater Bridgeport residents have access to the health supporting resources they need.

Objectives

- Improve health outcomes across the region, focusing on at risk and vulnerable populations with high rates of chronic disease.
- Increase the percentage of community members who report having a primary care provider.
- Increase the utilization of available food programs by eligible residents.
- Reduce the percentage of people who report being treated with less respect or received services that were not as good as others in the community.

Initiatives and Results

- Hosted first #GiveHealthy virtual food drive collecting 1,119 pounds of healthy food for five food pantries across the region.
- Bridgeport Hospital, St. Vincent's Medical Center, and Stratford Health Department work with CT Foodshare to host biweekly free food distributions.
- Redesigned the healthy eating handout used at Know Your Numbers to include easier to understand language and graphics. This handout was tested with community members and found to be a useful tool for teaching the importance of healthy eating to prevent or control high blood sugar and high blood pressure.
- 2024 Heart Month efforts saw nine partners participate in heart health events in Greater Bridgeport, with the help of 28 students and interns from local universities. All nine partners conducted heart health screenings, with blood pressure being the most common (100%), followed by pulse, HbA1C, and BMI (55% each). Other parts of the screenings included waist circumference, AED education, and Pulse4Pulse diagnostic testing. All partners involved planned to do more in 2025, with a large desire for broader collaboration between HIA organizations for future heart health events.

- Know Your Numbers (KYN) celebrated 10 years
    - Since 2014, 177 screening events, 3,711 people screened, over 2,000 nursing student volunteers, and 610 blood pressure cuffs distributed.
    - Local health departments also continued to conduct KYN screenings in their respective towns and partnered with MPH students from Sacred Heart University to analyze their KYN data in 2024.
- Received funding to sponsor Bridgeport Bucks, $5 vouchers accepted at all nine Bridgeport Farmers Market locations. Two of those locations are held at HIA partner organizations, Bridgeport Hospital and St. Vincent's Medical Center.
- Partners worked on a Bridgeport Farmers Market Collaborative expansion pilot project to include the Paradise Green Farmers Market in Stratford for the 2024 season. This expansion allowed the Stratford market the ability to accept and double SNAP/EBT payments, as well as $2,000 worth of Bridgeport Bucks with a 100% redemption rate, to expand access to healthy food for those in need. This market will continue as a member of the collaborative under Town of Stratford funding.
- The Stratford and Milford Health Departments hosted several walk and talk events in their respective towns and one in partnership with each other. Topics included hip and knee arthritis, tips for healthy family meals, weight management, childhood development, immunizations, emergency preparedness, lead prevention, and food safety.

Appendix B: Secondary Data Tables

TABLE 1: CDC SOCIAL VULNERABILITY INDEX DATA - SOCIOECONOMIC STATUS

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Total Population	3,598,348	959,099	378,609	148,012	7,612	62,508	50,749	18,833	52,403	36,928
Population Below Poverty Level	10.0%	9.3%	12.0%	22.5%	7.7%	4.7%	4.5%	2.5%	6.7%	6.1%
Unemployment Rate	5.6%	6.0%	6.8%	8.9%	5.1%	6.0%	4.5%	3.4%	7.2%	6.8%
Median Household Income	$93,760	$115,058	$101,970	$56,584	$189,505	$168,391	$110,126	$156,731	$93,820	$163,227
Percent of Low-Income Households Severely Cost Burdened	35.0%	43.4%	42.6%	36.8%	48.8%	54.8%	37.9%	45.2%	42.2%	49.7%
No High School Diploma	8.7%	9.8%	11.4%	22.2%	2.0%	3.1%	4.0%	2.9%	8.3%	4.9%
Uninsured Populations	5.2%	7.7%	7.5%	14.2%	4.3%	3.2%	2.7%	2.5%	4.5%	2.7%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 2: CDC SOCIAL VULNERABILITY INDEX DATA - HOUSEHOLD CHARACTERISTICS & MINORITY STATUS[12]

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Population Under Age 18	20.4%	21.9%	21.5%	21.4%	25.2%	24.0%	17.0%	25.2%	17.7%	27.0%
Population Age 65 and Over	18.1%	16.7%	16.6%	13.3%	17.0%	15.7%	21.3%	15.7%	21.8%	17.2%
Living with a Disability	11.9%	10.5%	12.3%	16.6%	10.0%	7.3%	10.2%	8.6%	12.6%	8.9%
English Language Proficiency	8.6%	12.7%	13.1%	25.1%	2.8%	4.7%	3.8%	4.3%	7.2%	7.8%
Racial & Ethnic Minority	37.0%	42.6%	42.9%	74.4%	13.9%	15.3%	20.0%	16.6%	35.7%	25.4%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 3: CDC SOCIAL VULNERABILITY INDEX DATA - HOUSING TYPE & TRANSPORTATION[13]

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Overcrowded Housing Units	0.7%	0.3%	0.3%	0.3%	0.0%	0.1%	0.9%	0.0%	0.2%	0.0%
Mobile Home Housing Units	8.6%	7.8%	9.7%	18.7%	0.3%	2.7%	4.2%	3.4%	5.7%	3.3%
Group Quarters	2.0%	2.7%	2.6%	5.1%	0.0%	0.8%	0.9%	0.7%	1.6%	0.5%
No Vehicles Available	2.7%	1.7%	2.4%	2.5%	0.1%	6.6%	0.9%	0.4%	0.5%	1.0%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

[12] "Children Living in Single-Parent Households" was not included because it is unavailable at county subdivision and/or places level due to changes in Connecticut county-equivalents for certain data points in the 2022 American Community Survey. For more information, please visit https://www.census.gov/programs-surveys/acs/technical-documentation/user-notes/2023-01.htm.

[13] "Multi-Unit Housing Structures" was not included because it is unavailable at county subdivision and/or places level due to changes in Connecticut county-equivalents for certain data points in the 2022 American Community Survey. For more information, please visit https://www.census.gov/programs-surveys/acs/technical-documentation/user-notes/2023-01.htm

TABLE 4: PROJECTED PERCENT CHANGE IN POPULATION, 2010 TO 2031

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Total Population (2010)	3,574,097	916,828	370,738	144,221	7,490	59,404	51,259	19,479	51,384	36,001
Total Population (2023)	3,598,348	959,099	378,609	148,012	7,612	62,508	50,749	18,833	52,403	36,928
Percent Change (2010-2023)	+0.7%	+4.6%	+2.1%	+2.6%	+1.6%	+5.2%	-1.0%	-3.3%	+2.0%	2.6%
Total Population (2031)	3,749,919	1,009,569	390,400	151,492	8,136	65,437	51,625	19,585	53,691	38,874
Percent Change (2023-2031)	+4.2%	+5.3%	+3.1%	+2.4%	+6.9%	+4.7%	+1.7%	+4.0%	+2.5%	+5.3%

Sources: U.S. Census Bureau American Community Survey 2010 One-year Estimates | U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 5: MEDIAN AGE PERCENT CHANGE, 2010 TO 2023

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Median Age (2010)	39.5	39.1	ND	32.6	42.0	38.4	41.4	41.8	41.2	43.4
Median Age (2023)	41.2	41.5	41.4	36.4	45.5	41	46.7	42.6	46.5	41.9
Percent Change (2010-2023)	+4.3%	+6.1%	ND	+11.6%	+8.0%	+6.8%	+12.8%	+1.9%	+12.8%	-3.4%

Sources: U.S. Census Bureau American Community Survey 2010 Five-year Estimates | U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 6: POPULATION BY AGE GROUP

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Under Age 18	20.4%	21.9%	21.5%	21.4%	25.2%	24.0%	17.0%	25.2%	17.7%	27.0%
Age 18 to 64	61.5%	61.4%	61.9%	65.3%	57.8%	60.3%	61.8%	59.1%	60.5%	55.8%
Age 65 and Over	18.1%	16.7%	16.6%	13.3%	17%	15.7%	21.3%	15.7%	21.8%	17.2%
Age Under 5	5.0%	5.4%	5.2%	5.6%	4.5%	5.2%	3.8%	6.9%	4.1%	6.5%
Age 5 to 9	5.4%	5.9%	5.7%	5.5%	5.3%	6.4%	4.6%	6.4%	4.5%	7.8%
Age 10 to 14	6.0%	6.5%	6.5%	6.5%	9.1%	7.2%	4.8%	7.9%	5.8%	7.3%
Age 15 to 19	6.6%	6.8%	7.4%	7.2%	8.1%	11.0%	5.8%	6.0%	5.7%	7.3%
Age 20 to 24	6.5%	6.2%	6.5%	8.3%	5.3%	6.0%	4.8%	5.5%	5.8%	4.5%
Age 25 to 34	12.5%	11.6%	11.5%	14.8%	6.7%	8.1%	12.6%	7.9%	11.1%	6.6%
Age 35 to 44	12.5%	12.9%	12.7%	14.2%	10.1%	10.8%	11.5%	12.3%	11.2%	14.4%
Age 45 to 54	12.9%	13.7%	13.7%	12.2%	14.7%	14.1%	14.1%	15.5%	15.0%	15.3%
Age 55 to 59	7.2%	7.3%	7.2%	6.0%	10.0%	8.1%	8.1%	9.6%	7.4%	6.8%
Age 60 to 64	7.2%	7.0%	7.1%	6.4%	9.2%	7.4%	8.5%	6.4%	7.6%	6.3%
Age 65 to 74	10.4%	9.5%	9.7%	7.8%	10.1%	8.8%	13.2%	9.6%	12.4%	9.5%
Age 75 to 84	5.2%	4.9%	4.6%	3.6%	3.9%	4.1%	5.7%	4.5%	6.8%	5.0%
Age Over 85	2.4%	2.3%	2.3%	1.8%	3.0%	2.7%	2.4%	1.6%	2.6%	2.7%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 7: POPULATION BY RACE (ALONE)

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
White	67.6%	62.2%	62.3%	34.8%	87.3%	86.6%	82.2%	84.9%	69.1%	76.3%
Black or African American	7.1%	9.8%	11.4%	22.9%	1.9%	2.2%	2.8%	1.3%	8.7%	3.9%
Some Other Race	10.7%	11.1%	11.2%	22.4%	1.5%	0.9%	2.8%	0.8%	12.2%	2.1%
Two or More Races	9.5%	10.9%	9.4%	13.6%	5.4%	5.4%	7.1%	6.5%	7.6%	7.7%
Asian	4.8%	5.5%	5.2%	5.4%	3.9%	4.9%	5.0%	6.6%	2.3%	9.4%
American Indian and Alaska Native	0.3%	0.3%	0.4%	0.7%	0.0%	0.0%	0.2%	0.0%	0.1%	0.5%
Native Hawaiian and Other Pacific Islander	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 8: BLACK, INDIGENOUS, AND PEOPLE OF COLOR POPULATION

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
BIPOC Population	1,332,568	408,413	162,303	110,094	1,059	9,594	10,328	3,126	18,728	9,392

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 9: POPULATION BY ETHNICITY

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Hispanic or Latino	17.8%	21.9%	23.7%	44.6%	3.4%	7%	9%	6.8%	19.1%	8.4%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 10: POPULATION BY SEX

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Females	50.9%	50.9%	51.1%	51.2%	47.4%	51.9%	51.8%	49.5%	51.1%	49.5%
Males	49.1%	49.1%	48.9%	48.8%	52.6%	48.1%	48.2%	50.5%	48.9%	50.5%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 11: LANGUAGE SPOKEN AT HOME (PEOPLE OVER AGE 5)

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
English Only	77.0%	69.0%	69.1%	48.3%	89.6%	83.9%	87.0%	82.6%	78.2%	76.9%
Spanish	12.6%	16.9%	17.7%	35.0%	1.8%	5.1%	4.0%	4.9%	12.8%	6.1%
Asian-Pacific Islander	2.5%	2.7%	2.6%	2.5%	1.5%	2.2%	3.3%	3.4%	2.0%	3.3%
Other Indo-European	6.9%	10.3%	9.3%	12.3%	7.1%	6.8%	4.9%	8.8%	6.2%	13.0%
Other	1.0%	1.0%	1.3%	1.8%	0.0%	1.9%	0.9%	0.2%	0.9%	0.6%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 12: LANGUAGE ISOLATION[14]

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Percent of households	5.1%	7.1%	7.6%	16.3%	0.3%	1.8%	1.2%	1.4%	2.6%	2.7%

%Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 13: FOREIGN-BORN POPULATION

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Naturalized US Citizen	8.6%	12.2%	11.0%	15.0%	5.5%	8.2%	7.3%	9.8%	7.8%	11.4%
Not US Citizen	6.9%	11.1%	9.8%	17.9%	2.8%	4.7%	3.2%	1.7%	5.6%	6.9%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 14: POPULATION LIVING WITH DISABILITY BY AGE

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Age Under 5	0.7%	0.6%	0.3%	0.4%	0.0%	0.0%	0.4%	0.0%	1.1%	0.0%
Age 5 to 17	6.3%	5.6%	6.2%	10.3%	4.4%	2.4%	4.0%	4.1%	6.3%	2.9%
Age 18 to 34	7.5%	7.1%	8.1%	9.0%	4.5%	7.0%	5.0%	6.4%	11.2%	4.6%
Age 35 to 64	10.7%	8.5%	11.6%	18.5%	9.0%	4.6%	8.9%	7.0%	10.4%	6.7%
Age 65 to 74	19.4%	17.6%	20.9%	29.1%	13.1%	14.4%	19.3%	12.6%	18.6%	17.4%
Age 75 and Over	43.1%	42.4%	43.8%	60.1%	45.8%	37.8%	31.9%	41.6%	32.9%	43.7%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

[14] This dataset represents the percent of 'limited English-speaking' households

TABLE 15: POPULATION LIVING WITH DISABILITY BY TYPE

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Ambulatory Difficulty	6.3%	5.9%	5.5%	4.8%	8.3%	5.4%	3.0%	4.8%	3.1%	6.7%
Cognitive Difficulty	5.1%	5.2%	4.9%	4.2%	7.2%	2.9%	2.9%	3.8%	3.0%	5.6%
Independent Living Difficulty	4.5%	4.5%	4.4%	3.8%	6.0%	2.7%	2.5%	4.0%	2.4%	4.8%
Hearing Difficulty	3.6%	3.0%	3.1%	2.6%	3.3%	2.1%	2.6%	2.9%	3.9%	2.6%
Vision Difficulty	2.4%	2.4%	2.1%	2.0%	4.0%	1.1%	0.7%	1.3%	1.3%	2.4%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 16: POPULATION LIVING WITH DISABILITY BY RACE

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Black or African American	12.6%	13.2%	14.5%	15.8%	6.0%	3.2%	9.6%	17.8%	9.9%	12.2%
American Indian and Alaska Native	11.2%	9.8%	13.1%	16.2%	10.5%	6.5%	12.4%	3.0%	11.0%	7.6%
Some Other Race	12.5%	11%	13.0%	14.7%	4.1%	6.9%	7.3%	2.5%	8.0%	3.2%
Two or More Races	12.5%	10.5%	12.2%	19.7%	10.3%	7.6%	10.7%	9.6%	14.1%	9.6%
White	14.9%	10.1%	11.6%	11.5%	ND	ND	12.2%	ND	0.0%	15.5%
Asian	6.3%	6.4%	7.9%	12.1%	7.4%	5.6%	3.1%	0.0%	10.4%	5.9%
Native Hawaiian and Other Pacific Islander	15.3%	9.9%	0.0%	0.0%	ND	ND	ND	ND	ND	0.0%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 17: POPULATION LIVING WITH DISABILITY BY ETHNICITY

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Hispanic or Latino	12.2%	11.1%	14.2%	16.2%	10.1%	5.3%	9.4%	4.7%	10.5%	9.5%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 18: POPULATION WITH A BACHELOR'S DEGREE OR HIGHER, PERCENT CHANGE

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Population with a Bachelor's Degree or Higher (2010)	35.7%	44.0%	34.1%	15.2%	67.4%	60.1%	38.2%	46.2%	28.9%	50.8%
Population with a Bachelor's Degree or Higher (2023)	41.9%	50.5%	42.8%	23.1%	72.6%	71.4%	48.4%	57.8%	37.5%	59.5%
Percent Change (2010-2023)	+17.5%	+14.7%	+25.4%	+52.0%	+7.6%	+18.8%	+26.9%	+25.1%	+29.9%	+17.1%

Sources: U.S. Census Bureau American Community Survey 2010 One-year Estimates | U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 19: HIGHEST LEVEL OF EDUCATIONAL ATTAINMENT

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Less than 9th Grade	4.0%	5.3%	6.2%	12.7%	0.9%	1.7%	1.7%	1.6%	3.3%	2.1%
9th to 12th Grade, No Diploma	4.7%	4.5%	5.2%	9.5%	1.1%	1.3%	2.3%	1.3%	5.0%	2.8%
High School Degree	25.5%	20.3%	24.8%	31.7%	11.9%	11.8%	24.8%	16.9%	29.1%	18.3%
Some College No Degree	16.2%	13.5%	14.7%	16.6%	8.3%	9.5%	15.0%	15.7%	17.7%	10.8%
Associates Degree	7.6%	5.9%	6.4%	6.4%	5.3%	4.2%	7.7%	6.7%	7.3%	6.5%
Bachelor's Degree	23.0%	27.7%	24.4%	14.5%	33.6%	39.3%	28.6%	28.7%	21.4%	33.8%
Graduate Degree	19.0%	22.8%	18.4%	8.6%	39.0%	32.1%	19.8%	29.1%	16.1%	25.7%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 20: EDUCATIONAL ATTAINMENT OF BACHELOR'S DEGREE OR HIGHER BY RACE

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Asian	66.2%	68.3%	55.9%	30.2%	78.9%	78.9%	66.4%	69.5%	62.0%	73.9%
White	45.9%	58.9%	51.4%	33.4%	74.3%	72.7%	48.2%	58.9%	40.9%	59.0%
Two or More Races	31.9%	36.1%	29.7%	20.8%	39.3%	60.5%	47.2%	38.0%	20.4%	61.5%
American Indian and Alaska Native	26.3%	29.1%	22.2%	19.2%	54.9%	40.7%	42.2%	38.7%	27.8%	40.9%
Black or African American	22.0%	34.6%	18.9%	13.1%	ND	ND	ND	ND	ND	100.0%
Native Hawaiian and Other Pacific Islander	20.7%	21.5%	13.8%	3.1%	ND	ND	78.3%	ND	53.0%	44.0%
Some Other Race	17.4%	17.9%	13.0%	8.6%	50.0%	32.8%	29.8%	35.7%	20.1%	43.6%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 21: EDUCATIONAL ATTAINMENT OF BACHELOR'S DEGREE OR HIGHER BY ETHNICITY

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Hispanic or Latino	20%	23.0%	16.1%	10.7%	36.8%	46.5%	38.5%	35.5%	18.1%	42.5%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 22: EDUCATIONAL ATTAINMENT LESS THAN HIGH SCHOOL BY RACE AND ETHNICITY[15]

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
White	5.5%	5.0%	6.2%	16.2%	1.6%	2.0%	3.1%	2.2%	5.3%	4.3%
Black / African American	12.3%	12.6%	13.7%	14.9%	1.2%	9.8%	1.5%	7.3%	11.8%	10.9%
Hispanic or Latino	25.0%	27.2%	29.0%	34.1%	0.8%	13.2%	11.8%	7.1%	19.2%	6.0%
Some Other Race[16]	29.2%	34.5%	35.2%	40.5%	10.9%	13.7%	9.3%	11.9%	23.9%	6.7%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 23: CHILD CARE CENTERS

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Child Care Centers	900	295	102	ND	ND	ND	ND	ND	ND	ND

Source: U.S. Census Bureau County Business Patterns 2021. https://www.census.gov/programs-surveys/cbp.html

TABLE 24: POVERTY PERCENT CHANGE

[15] This percentage represents adults (age 25 and older) in each racial/ethnic group who have not completed high school, calculated as a share of the total adult population (age 25+) within that racial/ethnic group in each region.

[16] The U.S. Census Bureau collects race data in accordance with guidelines provided by the U.S. Office of Management and Budget (OMB), and these data are based on self-identification. OMB requires that race data be collected for a minimum of five groups: White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or other Pacific Islander. OMB permits the Census Bureau to also use a sixth category – Some Other Race.

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Households Below Poverty Level (2010)	9.4%	8.3%	10.6%	21.4%	1.6%	3.5%	4.0%	3.2%	5.9%	3.3%
Households Below Poverty Level (2023)	10.5%	9.5%	12.1%	21.3%	4.7%	6.2%	5.8%	2.2%	7.6%	6.6%
Percent Change (2010-2023)	+12.7%	+14.4%	+14.1%	-0.4%	+204.7%	+75.0%	+47.7%	-31.9%	+29.3%	+98.4%

Sources: U.S. Census Bureau American Community Survey 2010 One-year Estimates | U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 25: INCOME TO POVERTY RATIOS

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
100% to 124% FPL	2.8%	2.6%	3.0%	5.5%	0.6%	1.5%	1.6%	0.8%	1.7%	1.0%
125% to 149% FPL	3.0%	3.0%	2.6%	4.4%	0.2%	1.0%	1.5%	0.5%	3.1%	0.9%
150% to 184% FPL	4.3%	3.8%	4.4%	7.3%	0.4%	2.1%	2.8%	0.8%	4.1%	1.8%
185% to 199% FPL	2.0%	1.9%	2.5%	3.5%	0.2%	2.4%	1.3%	0.7%	2.9%	0.8%
200% and Over FPL	77.9%	79.5%	75.5%	56.8%	90.9%	88.3%	88.4%	94.6%	81.5%	89.5%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 26: PERCENT OF POPULATION LIVING IN POVERTY

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
People Below Poverty Level	10.0%	9.3%	12.0%	22.5%	7.7%	4.7%	4.5%	2.5%	6.7%	6.1%
American Indian and Alaska Native	22.2%	21.2%	25.9%	32.4%	ND	ND	0.0%	ND	30.3%	0.0%
Asian	8.8%	6.7%	11.9%	19.9%	0.0%	4.9%	5.9%	2.4%	10.8%	8.6%
Black or African American	17.1%	15.1%	16.6%	19.1%	0.9%	12.6%	6.6%	21.7%	6.9%	9.1%
Native Hawaiian and Other Pacific Islander	29.8%	29.3%	0.0%	0.0%	ND	ND	ND	ND	ND	0.0%
Some Other Race	22.1%	22.5%	27.1%	32.0%	0.7%	9.1%	3.4%	0.4%	9.2%	13.5%
Two or More Races	13.2%	10.8%	14.1%	19.1%	2.0%	8.9%	7.6%	3.5%	8.4%	7.2%
White	7.2%	6.0%	8.0%	20.0%	8.6%	4.2%	4.1%	2.3%	5.9%	5.2%
Hispanic or Latino	20.3%	18.8%	24.4%	30.1%	0.4%	9.8%	6.5%	0.1%	9.8%	7.0%
Age Under 5	13.4%	11.2%	17.6%	35.9%	6.2%	1.9%	4.9%	6.4%	4.5%	5.4%
Age Under 18	13.1%	12.0%	16.4%	34.2%	11.8%	2.1%	4.3%	2.8%	8.5%	6.4%
Age 18 to 64	9.5%	8.6%	11.0%	19.4%	7.2%	5.7%	4.4%	2.8%	5.6%	5.8%
Age 65 and Over	8.3%	8.3%	9.9%	18.9%	3.1%	5.0%	5.1%	1.4%	8.3%	6.5%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 27: UNITED WAY ALICE

	U.S.	CT	Fairfield County
Households Below ALICE Threshold	29.0%	29.0%	29.7%

Source: United Way United for ALICE Research Center, Connecticut, 2022. https://unitedforalice.org/state-overview/Connecticut

TABLE 28: MEDIAN HOUSEHOLD INCOME PERCENT CHANGE

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Median Household Income (2010)	$69,243	$96,842	$76,714	$42,284	$136,722	$129,757	$82,249	$109,053	$72,269	$104,700
Median Household Income (2023)	$93,760	$115,058	$101,970	$56,584	$189,505	$168,391	$110,126	$156,731	$93,820	$163,227
Percent Change (2010-2023)	35.4%	18.8%	32.9%	33.8%	38.6%	29.8%	33.9%	43.7%	29.8%	55.9%

Sources: U.S. Census Bureau American Community Survey 2010 One-year Estimates | U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 29: MEDIAN HOUSEHOLD INCOME BY RACE

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Asian	$126,722	$141,892	$132,688	$61,276	ND	$184,348	$143,750	ND	$131,250	$176,000
Two or More Race	$76,435	$111,176	$114,256	$67,386	$189,388	$126,719	$136,228	$152,243	$110,170	$175,536
White	$103,032	$122,129	$104,931	$60,948	$183,906	$171,518	$110,565	$150,658	$92,967	$163,555
Black or African American	$62,712	$91,657	$89,297	$57,569	ND	$100,125	$75,859	ND	$97,500	$164,167
Other Race	$56,744	$85,951	$69,744	$42,201	ND	$121,667	$83,616	ND	$92,891	$125,580
American Indian and Alaska Native	$52,152	ND	ND	$48,661	ND	ND	ND	ND	ND	ND
Native Hawaiian and Other Pacific Islander	$41,573	ND	ND	ND	ND	ND	ND	ND	ND	ND

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 30: MEDIAN HOUSEHOLD INCOME BY ETHNICITY

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Hispanic or Latino	$60,136	$103,111	$101,885	$48,942	$215,000	$110,234	$118,222	$156,908	$92,783	$170,437

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 31: EMPLOYMENT BY INDUSTRY

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Management	6.5%	8.0%	6.0%	5.9%	23.2%	19%	15.1%	18.2%	10.9%	14.5%
Office and Administrative Support	4.2%	4.6%	4.6%	10.6%	4.6%	7.3%	11.4%	6.7%	10.3%	7.4%
Sales	4.3%	3.6%	4.1%	9.3%	8.4%	11.7%	7.7%	7.8%	7.9%	9.5%
Education, Training, and Library	4.5%	3.0%	4.1%	4.4%	10.1%	7.5%	7.6%	10.2%	7.3%	10.3%
Business and Finance	4.4%	4%	4.0%	2.7%	7.3%	11.4%	6.9%	7.9%	6.5%	7.5%
Construction and Extraction	3.3%	4.1%	4.0%	6.4%	2.4%	2.6%	2.9%	3.0%	4.9%	3.7%
Food Preparation and Serving	3.4%	2.8%	3.5%	5.9%	2.9%	2.6%	3.4%	1.5%	3.2%	3.5%
Production	2.9%	2.7%	3.3%	6.3%	2.9%	1.3%	3.0%	2.5%	3.9%	2.2%
Health Diagnosis and Treating Practitioners	3.3%	3.4%	2.8%	1.8%	8.0%	5.3%	6.9%	5.9%	3.7%	4.9%
Building, Grounds Cleaning, and Maintenance	2.7%	2.8%	2.6%	6.5%	1.5%	1.7%	1.8%	2.1%	4.5%	1.5%

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Health Care Support	2.6%	2.0%	2.5%	5.7%	1.0%	0.9%	2.2%	2.7%	3.7%	0.9%
Transportation	2.1%	2.7%	2.4%	5.0%	0.2%	1.2%	2.8%	2.4%	3.3%	1.6%
Personal Care and Service	2.5%	1.8%	2.1%	1.6%	3.5%	3.4%	3.5%	3.3%	3.3%	4.3%
Computer and Mathematical	1.9%	1.7%	1.9%	3.0%	2.3%	2.5%	2.8%	1.3%	2.8%	1.6%
Material Moving	2%	1.7%	1.9%	4.0%	1.1%	1.1%	1.7%	2.8%	2.4%	0.3%
Arts, Design, Entertainment, Sports, and Media	2.3%	1.9%	1.8%	1.7%	4.0%	4.0%	2.2%	3.1%	2.2%	2.8%
Health Technologist and Technicians	1.3%	1.9%	1.4%	1.2%	1.8%	1.9%	2.5%	5.3%	1.6%	4.0%
Architecture and Engineering	1.1%	0.9%	1.1%	2.1%	0.2%	1.1%	1.8%	1.5%	1.9%	3.1%
Community and Social Service	1.2%	1.1%	0.8%	2.3%	1.4%	1.4%	2.6%	1.1%	1.3%	1.7%
Installation, Maintenance, and Repair	0.7%	0.4%	0.7%	2.1%	2.9%	0.6%	1.5%	1.2%	2.5%	2.2%
Legal	0.2%	0.1%	0.2%	0.4%	4.0%	3.0%	1.9%	1.4%	1.6%	1.5%
Fire Fighting and Prevention	6.5%	8%	6.0%	1.1%	0.7%	0.5%	1.2%	1.0%	1.5%	1.0%

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Life, Physical, and Social Science	4.2%	4.6%	4.6%	0.4%	0.5%	1.6%	0.8%	0.4%	0.7%	1.1%
Law Enforcement	4.3%	3.6%	4.1%	0.3%	0.2%	0.4%	1.0%	3.1%	0.8%	1.7%
Farming, Fishing, and Forestry	4.5%	3.0%	4.1%	0.2%	0.0%	0.1%	0.3%	0.4%	0.0%	0.2%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 32: HOUSEHOLDS RECEIVING SNAP

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Households	11.7%	9.0%	12.8%	24.1%	1.5%	2.7%	5.3%	1.7%	10.9%	3.7%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 33: FOOD INSECURITY AMONG ADULTS (2022)

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Food Insecurity Among Adults	14.8%	15.0%	18.7%	32.7%	6.8%	7.9%	8.7%	8.1%	14.6%	8.5%

Source: BFRSS PLACES 2022

TABLE 34: HOUSING COSTS & HOME VALUE

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Median Household Income	$69,243	$96,842	$76,714	$42,284	$136,722	$129,757	$82,249	$109,053	$72,269	$104,700
Owner Excessive Housing Costs	48.1%	50.8%	53.3%	55.7%	13.1%	48.5%	43.3%	46.9%	55.0%	56.6%
Renter Excessive Housing Costs	26.4%	30.7%	31.0%	40.5%	28.0%	25.0%	25.8%	26.1%	34.3%	25.6%
Renter Housing Mobile Homes	0.4%	0.2%	0.1%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Homeowner Vacancy Rate	0.8%	0.4%	0.4%	0.6%	0.0%	0.2%	1.3%	0.0%	0.2%	0.0%

Sources: U.S. HUD CHAS 2015-2019 | U.S. Census Bureau American Community Survey 2010 One-year Estimates | U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 35: FAIR MARKET RENT (FMR)

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
0 Bedrooms	ND	$1,409	ND	$1,105	$1,105	$1,105	$1,098	$1,105	$1,105	$1,105
1 Bedrooms	ND	$1,709	ND	$1,332	$1,332	$1,332	$1,406	$1,332	$1,332	$1,332
2 Bedrooms	ND	$2,097	ND	$1,652	$1,652	$1,652	$1,642	$1,652	$1,652	$1,652
3 Bedrooms	ND	$2,636	ND	$2,110	$2,110	$2,110	$1,998	$2,110	$2,110	$2,110
4 Bedrooms	ND	$2,902	ND	$2,464	$2,464	$2,464	$2,797	$2,464	$2,464	$2,464

Source: U.S. Department of Housing and Urban Development HOME Rent Limits 2023

TABLE 36: MEDIAN HOME MORTGAGE

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Median Home Mortgage	$1,431	$1,937	$1,644	$1,405	$2,719	$2,194	$1,822	$1,466	$1,610	$2,292

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 37: HOUSING WAGE

	U.S.	CT	Fairfield County – Bridgeport HMFA
Hourly Wage Necessary to Afford a 2-Bedroom Apartment at Fair Market Rent (FMR)	$32.11	$34.54	$37.83

Source: National Low Income Housing Coalition, Out of Reach 2023 – Connecticut #11, 2024. https://nlihc.org/sites/default/files/oor/Connecticut_2023_OOR.pdf | National Low Income Housing Coalition. Out of Reach 2024 – Full Report, 2024. https://nlihc.org/oor

TABLE 38: HOUSEHOLD COMPOSITION

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Households with Children	28.7%	32.2%	30.7%	30.0%	33.1%	36.7%	21.9%	37.7%	25.3%	44.6%
Households with Grandparents Responsible for Grandchildren	0.9%	0.8%	0.9%	1.2%	0.3%	0.2%	0.5%	0.5%	1.0%	1.2%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 39: TRANSPORTATION

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Mean Travel Time to Work (in minutes)	26.6	31.5	30.5	29.9	29.3	34.3	25.9	33.2	29.8	33.4
Commute via Public Transit	3.4%	6.9%	5.6%	7.1%	2.5%	9.0%	2.7%	2.5%	3.9%	2.9%
Commute via Driving Alone	70.6%	63.3%	67.4%	63.4%	68.1%	57.3%	75.2%	76.9%	74.8%	70.0%

Sources: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 40: BROADBAND

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Households Without Internet Access	6.5%	5.3%	7.2%	10.5%	1.3%	3.0%	5.6%	4.8%	7.0%	4.7%
Number of Internet Providers (2021)	16	14	ND	11	10	10	9	9	10	11

Sources: Federal Communications Commission Fixed Broadband Deployment Data 2021 | U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 41: HEALTH CARE PROVIDER RATIO (PEOPLE PER PROVIDER), 2023

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Primary Care Physician	834:1	897:1	ND	853:1	1,908:1	862:1	1,245:1	3,142:1	1,873:1	615:1
Primary Care Nurse Practitioner	1,027:1	1,286:1	ND	1,017:1	7,630:1	1,514:1	1,413:1	483:1	1,542:1	879:1
Dentist	1,398:1	1,318:1	ND	1,954:1	ND	839:1	1,341:1	1,714:1	1,279:1	1,538:1
Mental Health Provider	516:1	681:1	ND	669:1	848:1	481:1	670:1	496:1	1,873:1	2,308:1
Pediatrician	619:1	705:1	ND	700:1	1,908:1	828:1	812:1	469:1	927:1	675:1
Obstetrics Gynecology (OBGYN)	2,566:1	2,289:1	ND	1,731:1	ND	1,465:1	2,455:1	ND	9,045:1	2,618:1
Midwife and Doula	15,745:1	32,507:1	ND	25,385:1	ND	ND	ND	ND	ND	18,324:1

Sources: National Plan & Provider Enumeration System NPI, 2023. https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/DataDissemination

TABLE 42: UNINSURED POPULATION

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Age Under 6	2.4%	3.4%	2.3%	3.1%	0.0%	4.3%	0.9%	0.0%	0.0%	2.2%
Age 6 to 18	3.1%	4.6%	3.7%	6.5%	0.0%	2.8%	0.6%	0.7%	1.7%	2.8%
Age 19 to 64	7.5%	10.8%	11.0%	20.1%	7.5%	3.7%	4.2%	3.9%	7.0%	3.5%
Age 65 and Over	0.8%	1.3%	1.1%	2.4%	0.0%	1.3%	0.0%	0.6%	0.5%	0.1%
People with Private Health Insurance	73.3%	75.0%	70.8%	50.5%	88.0%	89.2%	81.3%	86.1%	72.6%	82.6%
People with Public Health Insurance	39.3%	36.1%	40.2%	57.9%	26.2%	21.9%	32.4%	25.1%	42.0%	27.8%
Age 18 and Under with a Disability	1.7%	2.7%	2.2%	2.6%	0.0%	6.6%	0.0%	0.0%	0.0%	0.0%
Age 19 to 64 with a Disability	5.5%	9.2%	8.2%	11.9%	18.1%	1.4%	1.8%	2.3%	3.6%	2.0%
People in Labor Force	7.2%	10.5%	10.7%	20.3%	5.8%	3.1%	3.9%	3.8%	7.0%	3.3%

Sources: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 43: SELF-REPORTED CHRONIC CONDITIONS AMONG ADULTS

	Greater Bridgeport	CT
High cholesterol	32.1%	33.4%
High blood pressure	27.9%	29.7%
Obesity among adults	27.2%	30.2%
Depression	18.5%	20.9%
Asthma	10.9%	11.1%
Diagnosed diabetes	9.0%	9.4%
Cancer (excluding skin cancer)	6.7%	6.9%
Chronic obstructive pulmonary disease (COPD)	5.4%	5.7%
Coronary heart disease	5.0%	5.2%
Stroke	2.9%	2.8%
Chronic kidney disease	2.8%	2.8%

Source: CDC PLACES (2020-2021). Provided by Connecticut Hospital Association.

TABLE 44: SELF-REPORTED GENERAL WELLBEING AMONG ADULTS

	Greater Bridgeport	CT
Mental health not good for two weeks or more[17]	14.5%	14.6%
Fair or poor self-rated health status	14.0%	13.3%
Physical health not good for two weeks or more[18]	10.2%	10.0%

Source: CDC PLACES (2020-2021). Provided by Connecticut Hospital Association.

[17] Adults who report that physical health was “not good” for 14 or more days in any given month.
[18] Adults who report that mental health was “not good” for 14 or more days in any given month.

TABLE 45: PREVENTIVE CARE HEALTH BEHAVIORS AMONG ADULTS

	Greater Bridgeport	CT
Visits to dentist or dental clinic	68.6%	70.4%
Visits to doctor for routine checkup with past year	73.1%	75.3%

Source: CDC PLACES (2020-2021). Provided by Connecticut Hospital Association.

TABLE 46: RANKED LIST OF SELECT HEALTH INDICATOR HOSPITAL UTILIZATION RATES FOR ADULTS IN CONNECTICUT

		Age-Adjusted Principal Diagnosis Rate per 1,000 Adults	
Rank	Health Indicator	Greater Bridgeport (including Bridgeport Hospital and Saint Vincent's Medical Center)	State of CT
1	Mental Health Composite	21.6	10.4
2	Substance-Related Disorders (SRD)	17.0	8.1
3	Sepsis	15.5	8.4
4	High Blood Pressure (HBP)	11.8	4.5
5	Heart Failure (HF)	9.2	4.3
6	Community Acquired (CommAcq) Pneumonia	8.9	4.3
7	Asthma	6.4	2.8
8	Diabetes - Uncontrolled/Short Term Complications (Unc-STC)	6.2	2.7
9	Stroke	5.6	2.5
10	Arthritis	3.7	1.8
11	Coronary Artery Disease (CAD)	3.6	1.0
12	Chronic Obstructive Pulmonary Disease (COPD)	3.4	2.2
13	Acute Myocardial Infarction (AMI)	3.3	1.8
14	Diabetes - Long Term Complications (LTC)	2.7	1.3
15	Overweight/Obesity	2.0	1.0

Source: Community Health Profiles, Hospital utilization rates for key health indicators. Provided by Connecticut Hospital Association

TABLE 47: BIRTH RATE (RATE PER 1,000 PEOPLE)

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Birth Rate	9.9	10.7	ND	ND	ND	ND	ND	ND	ND	ND

Source: CDC WONDER Natality Birth Rate, 2021 https://wonder.cdc.gov/

TABLE 48: DEATH RATE (RATE PER 100,000 PEOPLE), 2021

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Death Rate	9.5	7.8	ND	ND	ND	ND	ND	ND	ND	ND

Source: CDC WONDER Causes of Death, 2021. https://wonder.cdc.gov/

TABLE 49: LEADING CAUSES OF DEATH (RATE PER 100,000 PEOPLE), 2021

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
COVID-19	75.5	54.2	ND	ND	ND	ND	ND	ND	ND	ND
Accidental Injuries	67.4	51.7	ND	ND	ND	ND	ND	ND	ND	ND
Alzheimer's Disease	21.2	27.6	ND	ND	ND	ND	ND	ND	ND	ND
Birth Defects	2.2	ND	ND	ND	ND	ND	ND	ND	ND	ND
Cancer	133.5	155.1	ND	ND	ND	ND	ND	ND	ND	ND
Chronic Liver Disease	12.2	11.0	ND	ND	ND	ND	ND	ND	ND	ND
Chronic Lower Respiratory Disease	23.8	22.1	ND	ND	ND	ND	ND	ND	ND	ND

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Easton	Fairfield	Milford	Monroe	Stratford	Trumbull
Birth-related Conditions	3.8	ND	ND	ND	ND	ND	ND	ND	ND	ND
Diabetes	15.9	16.7	ND	ND	ND	ND	ND	ND	ND	ND
Heart Disease	136.7	156.1	ND	ND	ND	ND	ND	ND	ND	ND
High Blood Pressure	6.6	8.2	ND	ND	ND	ND	ND	ND	ND	ND

Source: CDC WONDER Causes of Death, 2021. https://wonder.cdc.gov/

TABLE 50: LIFE EXPECTANCY

	CT	Fairfield County
Life Expectancy (in years)	79.2	81.2

Source: County Health Rankings, 2020-2022: https://www.countyhealthrankings.org/health-data/connecticut/fairfield?year=2025

TABLE 51: OBESITY (ADULTS)

	U.S.	CT	Fairfield County
Obesity (Adults)	34.0%	31.0%	25.0%

Source: County Health Rankings, Health Data – Adult Obesity, 2021. https://www.countyhealthrankings.org/health-data/health-factors/health-behaviors/diet-and-exercise/adult-obesity?year=2024&county=09001

TABLE 52: SMOKING STATUS

	U.S.	CT	Fairfield County
Current Smokers (Adults)	15.0%	12.0%	11.0%

Source: County Health Rankings, Health Data – Adult Smoking, 2021. https://www.countyhealthrankings.org/health-data/health-factors/health-behaviors/tobacco-use/adult-smoking?year=2024&county=09001

TABLE 53: INFECTIOUS DISEASE

	U.S.	CT	Fairfield County
Hepatitis B	3,544	15	0
Hepatitis A	18,846	0	0
HIV/AIDS	1,107,597[19]	171	51
Influenza	35,000,000	98	26
Lyme Disease	34,945	400	76
Tuberculosis	8,916	54	18

Source: Connecticut State Department of Public Health, Infectious Disease Statistics, 2020. https://portal.ct.gov/-/media/dph/eeip/infectious-diseases-statistics/ct-disease-cases-by-county_2020_final_ab.pdf | CDC, Selected nationally notifiable disease rates and number of new cases: United States, selected years 1950-2019, 2019. https://www.cdc.gov/nchs/data/hus/2020-2021/IDNotif.pdf | AIDSVu, Understanding the Current HIV Epidemic in the United States, 2022. https://map.aidsvu.org/profiles/nation/usa/overview | CDC, Estimated Flu Disease Burden 2019-2020, 2020. https://www.cdc.gov/flu-burden/php/data-vis/2019-2020.html

TABLE 54: SEXUALLY TRANSMITTED DISEASES

	U.S.	CT	Fairfield County
Syphilis	129,813	280	52
Chlamydia	1,808,703	12,716	2,836
Gonorrhea	616,392	4,604	905
Chancroid	8	0	0

Source: Connecticut State Department of Public Health, Infectious Disease Statistics, 2020. https://portal.ct.gov/-/media/dph/eeip/infectious-diseases-statistics/ct-disease-cases-by-county_2020_final_ab.pdf | CDC, Selected nationally notifiable disease rates and number of new cases: United States, selected years 1950-2019, 2019. https://www.cdc.gov/nchs/data/hus/2020-2021/IDNotif.pdf

[19] Please note the U.S. data for people living with HIV/AIDS is from 2022.

TABLE 55: MENTAL HEALTH AND BEHAVIORAL HEALTH STATUS

	U.S.	CT	Fairfield County
Percent of Frequent Mental Distress	15.0%	13.0%	14.0%
Poor Mental Health Days	4.8	4.4	4.5
Poor Physical Health Day	3.3	2.9	2.9
Drug Overdose Death Rate (per 100,000)	32.0	42.0	26.0

Source: County Health Rankings, Health Outcomes – Frequent Mental Distress, Poor Mental Health Days, & Poor Mental Health Days, 2021. https://www.countyhealthrankings.org/health-data/health-outcomes | CDC National Center for Health Statistics, Drug Overdose Death Rate, 2021. https://www.cdc.gov/nchs/data-visualization/drug-poisoning-mortality

TABLE 56: SUICIDE

	U.S.	CT	Fairfield County
Suicide Rate	14.0	10.0	8.0

Source: County Health Rankings, Health Data – Suicides, 2021. https://www.countyhealthrankings.org/health-data/health-factors/social-economic-factors/community-safety/suicides?year=2024&county=09001

TABLE 57: MATERNAL AND CHILD HEALTH

	U.S.	CT	Fairfield County
Birth Rate (per 1,000)	11.0	9.9	10.7
Teen Birth Rate (per 1,000)	17.0	8.0	7.0
Low Birthweight	7.1%	8.0%	7.1%
Infant Mortality	6.0	5.0	4.0

Source: County Health Rankings, Health Data – Teen Births & Infant Mortality, 2021. https://www.countyhealthrankings.org/health-data/health-factors/health-behaviors/sexual-activity/teen-births?year=2024&county=09001 | CDC WONDER, Natality, 2021. https://wonder.cdc.gov

TABLE 58: BIRTH DATA, FAIRFIELD COUNTY 2021-2023 AVERAGE

Indicator	Maternal Race/Ethnicity			
	White	Black	Hispanic	Asian/Pacific Islander
All Preterm Births[20]	7.5%	12.7%	9.6%	8.1%
Late Preterm Births[21]	5.9%	8.5%	6.9%	5.8%
Very Preterm Births[22]	0.7%	2.8%	1.4%	1.2%

Source: National Center for Health Statistics, final natality data. Retrieved February 28, 2025, from www.marchofdimes.org/peristats.

TABLE 59: MATERNAL PRENATAL CARE, FAIRFIELD COUNTY 2021-2023 AVERAGE

Indicator	Maternal Race/Ethnicity			
	White	Black	Hispanic	Asian/Pacific Islander
Early Prenatal Care[23]	86.7%	75.4%	73.3%	83.7%
Late/No Prenatal Care[24]	3.0%	6.2%	6.6%	3.7%
Inadequate Prenatal Care[25]	7.3%	15.5%	15.4%	9.7%

Source: National Center for Health Statistics, final natality data. Retrieved February 28, 2025, from www.marchofdimes.org/peristats. | National Center for Health Statistics, final natality data. Kotelchuck M. An evaluation of the Kessner Adequacy of Prenatal Care Index and a proposed Adequacy of Prenatal Care Utilization Index. Am J Public Health 1994; 84: 1414-1420. Retrieved February 28, 2025, from www.marchofdimes.org/peristats.

[20] All race categories exclude Hispanics. Preterm is less than 37 weeks gestation.
[21] All race categories exclude Hispanics. Late preterm is between 34 and 36 weeks gestation.
[22] All race categories include Hispanics. Very preterm is less than 32 weeks gestation.
[23] All race categories exclude Hispanics. Early prenatal care is pregnancy-related care beginning in the first trimester (1-3 months).
[24] All race categories exclude Hispanics. Late/No prenatal care is pregnancy-related care beginning in the 3rd trimester (7-9 months) or when no pregnancy-related care was received at all.
[25] Adequacy is measured using the Adequacy of Prenatal Care Utilization Index, which classifies prenatal care received into 1 of 4 categories (inadequate, intermediate, adequate, and adequate plus) by combining information about the timing of prenatal care, the number of visits, and the infant's gestational age.

TABLE 60: YOUTH SUBSTANCE ABUSE

	U.S.	CT
Currently were binge drinking	10.5%	7.0%
Ever used illicit drugs	13.3%	ND
Ever used marijuana	27.8%	20.6%

Source: https://nccd.cdc.gov/youthonline/App/Results.aspx?TT=A&OUT=0&SID=HS&QID=QQ&LID=XX&YID=2021&LID2=&YID2=&COL=T&ROW1=N&ROW2=N&HT=C03&LCT=LL&FS=S1&FR=R1&FG=G1&FA=A1&FI=I1&FP=P1&FSL=S1&FRL=R1&FGL=G1&FAL=A1&FIL=I1&FPL=P1&PV=&TST=False&C1=&C2=&QP=G&DP=1&VA=No&CS=Y&SYID=&EYID=&SC=DEFAULT&SO=ASC

Appendix C: Access Audit

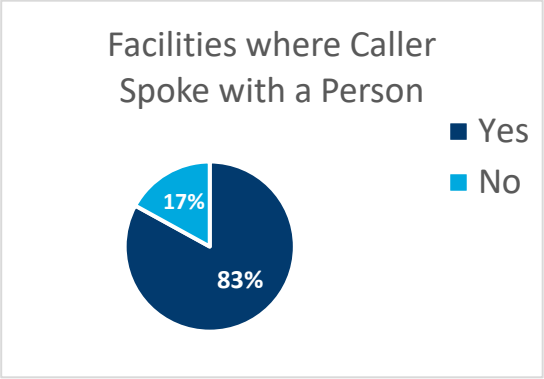
Greater Bridgeport Access Audit

Phone-based access audits serve as an effective tool to evaluate how easily community members can access healthcare services across an area, with a focus on assessing access rather than profiling specific sites. The main aim of these audits is to gain a thorough understanding of practical access to health care and other vital services, while identifying barriers faced by individuals seeking care. The findings from these audits offer valuable insights into existing gaps in access, strategies for improvement, and variations in service delivery.

The audit involved calls to six facilities within Greater Bridgeport, providing diverse services such as dental, cancer care, primary care, and behavioral health. The facilities included in the audit are:

Health System Facilities Included in Access Audit

1. Hartford Healthcare Medical Group
2. St. Vincent's Medical Center – Family Foot & Ankle Specialists, LLC
3. Bridgeport Hospital Primary Care Center
4. Southwest Community Health Center
5. Optimus Healthcare
6. LifeBridge Community Services



Phone calls were conducted at various times during standard business hours from Monday to Friday in early December of 2024. Out of the six calls placed, the caller was able to speak with a staff member at five facilities. At two of these facilities, staff members answered the call immediately. At the facility where the caller was unable to reach a staff member, an automated system required the caller to leave their contact information. The caller was able to collect helpful information at five of the six. However, at one facility, the automated phone system had too many similar options, leading to confusion and ultimately directing the caller to voicemail to leave a message for a callback.

Ability of Facilities to Accept New Patients

Facilities' ability to accept new patients varied greatly across services. While most facilities reported accepting new patients, appointment wait times ranged widely. Some facilities offered appointments within a week of the call, while others indicated waiting times of over two months. One facility shared that new patient appointments were unavailable for at least 90

days. Facilities that offered walk-in services, particularly for urgent care and family planning, were better able to accommodate immediate needs.

Ability of Facilities to Answer Questions and Refer the Caller Elsewhere When the Desired Services are Unavailable

The ability to provide referrals or alternative options when services were unavailable varied across facilities. Some clinics directed callers to nearby providers that could meet their needs. Others provided only general information about their own services without offering specific referral systems or additional resources. In some cases, facilities required callers to navigate referral systems or insurance processes independently, which could create barriers for individuals looking for immediate care.

How Staff Inquiries Help to Determine Prospective Patient's Needs

The level of engagement from staff members varied across facilities. Some staff asked detailed questions about the caller's insurance coverage and specific health needs, demonstrating a patient centered approach. However, other staff only provided basic information without asking follow-up questions, not leaving much room to answer the caller's concerns. In some cases, the call was focused on the procedural steps of obtaining an appointment, such as getting copies of referrals or orders and setting up a patient account with the office to verify insurance.

Ease of Speaking with a Person

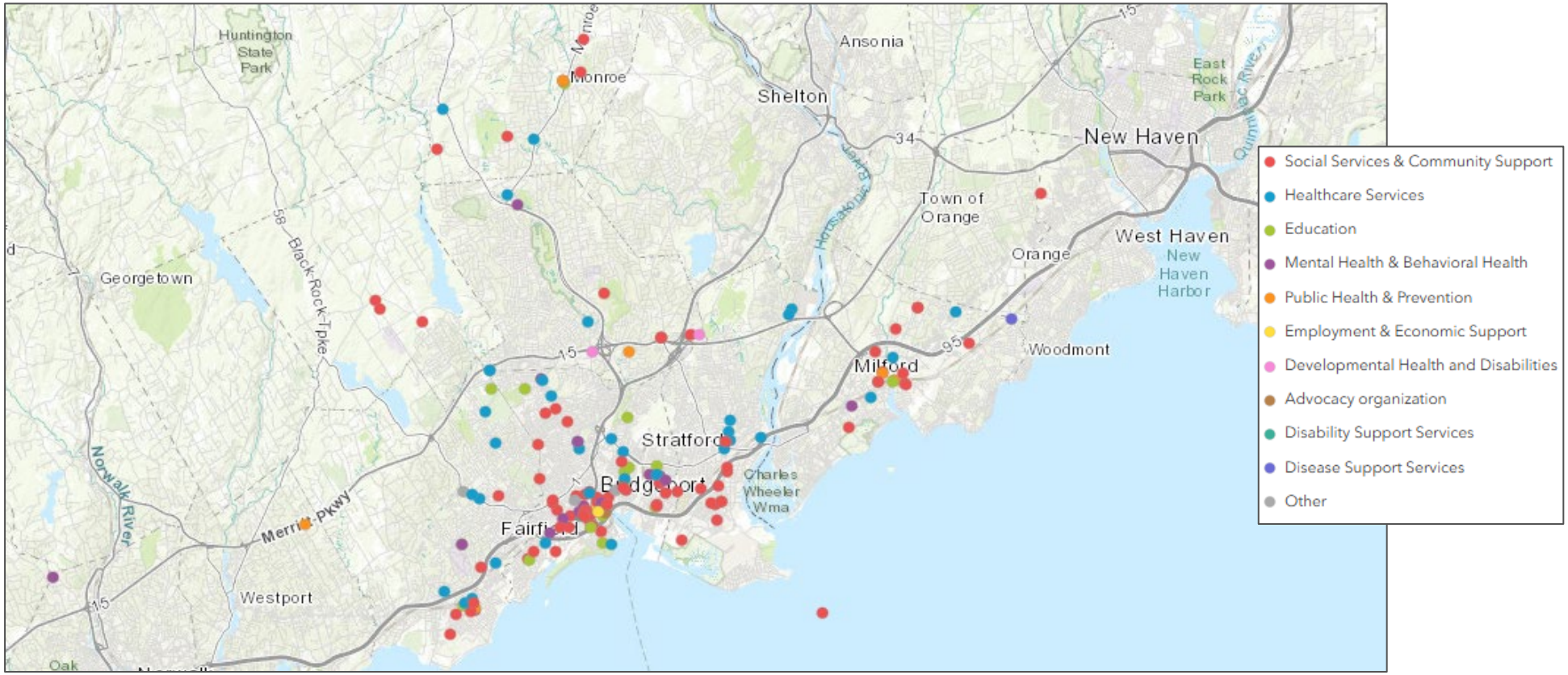
The ease of speaking to a person varied across the facilities. Some clinics had a direct call to a staff member, while most of them had an automated phone tree to navigate prior to speaking to a representative. There was one phone tree that was especially long, requiring multiple steps before connecting the caller to the appropriate department. This took several minutes to complete. Only one of the six facilities was unable to take the call, requiring the caller to leave their name, phone number, and the reason for calling to get in touch with the office. The facilities with simpler phone trees or direct calls to office staff provided an easier call experience.

Ability to Access Language Services

Language accessibility varies across the facilities. Spanish was the most offered alternative language. Most facilities included a Spanish language option in their phone tree system, and some of the locations had bilingual staff available to speak to the callers. When asked about Spanish language options in office during an appointment, most of the locations said they had bilingual staff available, or the caller could request translation services. Not much information was disclosed about languages other than English and Spanish, which could pose a barrier for individuals who only speak other languages.

Appendix D: Greater Bridgeport Asset Map and Community Resources

LINK TO INTERACTIVE MAP: HTTPS://ARCG.IS/K0FCQ1



Greater Bridgeport Resource Table

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
ADVOCACY			
Opening Doors Fairfield County (ODFC)	815 Main St #201, Bridgeport, CT, 06604	Homelessness advocacy, community outreach	https://www.openingdoorsfc.org/
DEVELOPMENTAL HEALTH & DISABILITIES			
The Kennedy Collective	2440 Reservoir Ave, Trumbull, CT, 06611	Disability support services - behavioral supports, community residential supports, workforce development support, transportation assistance, individualized home support programs	https://www.thekennedycollective.org/
Bridge House, Inc.	880 Fairfield Ave, Bridgeport, CT, 06605	Advocacy, employment, education, and housing services for adults living with mental illness	https://www.bridgehousect.org/
DISEASE SUPPORT SERVICES			
ALS Association Connecticut Chapter	4 Oxford Rd, Milford, CT, 06460	Care services, advocacy, research, public education & awareness	https://alsunitedct.org
EDUCATION			
Bridgeport Public Library - Beardsley Branch	2536 East Main St, Bridgeport, CT, 06610	Library	https://bportlibrary.org/beardsley-branch/
Bridgeport Public Library - Black Rock Branch	2705 Fairfield Ave, Bridgeport, CT, 06605	Library	https://bportlibrary.org/blackrock/
Bridgeport Public Library - Burroughs-Saden	925 Broad St, Bridgeport, CT, 06604	Library	https://bportlibrary.org/burroughs-saden/
Bridgeport Public Library - East Side Branch	1174 East Main St, Bridgeport, CT, 06608	Library	https://bportlibrary.org/east-side/
Bridgeport Public Library - Newfield Branch	755 Central Ave, Bridgeport, CT, 06607	Library	https://bportlibrary.org/newfield/

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
Bridgeport Public Library North Branch	3455 Madison Ave, Bridgeport, CT, 06606	Library	https://bportlibrary.org/north/
Caroline House	574 Stillman Street, Bridgeport, CT, 06608	English language learning and life skills	https://www.thecarolinehouse.org/
CT State Community College Housatonic	900 Lafayette Blvd. Bridgeport, CT, 06604.	Community College/Associate's Program	https://housatonic.edu/
Edith Wheeler Memorial Library	733 Monroe Tpke, Monroe CT, 06468	Library	https://ewml.org/
Fairfield Public Library - Main Library	1080 Old Post Rd, Fairfield CT, 06824	Library	https://fairfieldpubliclibrary.org/
Fairfield University	1073 N Benson Rd, Fairfield, CT, 06824	Higher Education/University	https://www.fairfield.edu/
Fairfield University Bellarmine Campus	460 Mill Hill Ave, Bridgeport, CT, 06610	Higher Education/University - Associate's Program	https://fairfield.edu/bellarmine/
Mercy Learning Center	637 Park Ave, Bridgeport, CT, 06604	Literacy and life skills education, high school equivalency, early childhood education	https://mercylearningcenter.org/
Milford Public Library	67 New Haven Ave, Milford, CT, 06460	Library	https://www.ci.milford.ct.us/milford-public-library
Neighborhood Studios of Fairfield County	510 Barnum Ave, Bridgeport, CT, 06608	Arts school - art, dance, theater, and music classes	https://www.nstudios.org/
Sacred Heart University	5151 Park Ave, Fairfield, CT, 06825	Higher Education/University	https://www.sacredheart.edu/
University of Bridgeport	126 Park Ave, Bridgeport, CT, 06604	Higher education/university	https://www.bridgeport.edu/

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
EMPLOYMENT & ECONOMIC SUPPORT			
American Job Centers	2 Lafayette Sq, Bridgeport, CT, 06604	Career development resources, job recruitment, workshops, employment services for veterans	https://portal.ct.gov/dol/divisions/american-job-centers?language=en_US#full_service
Career Resources, Inc.	1000 Lafayette Blvd, Bridgeport, CT, 06604	Job training, career development	https://careerresources.org/
Dress for Success Mid-Fairfield County	240 Fairfield Ave, Bridgeport, CT, 06604	Employment assistance	https://midfairfieldcounty.dressforsuccess.org/
The WorkPlace	1000 Lafayette Blvd Suite 501, Bridgeport, CT 06604	Job training center; employment assistance	https://www.workplace.org/
HEALTHCARE SERVICES			
AFC Urgent Care	1918 Black Rock Tpke, Fairfield, CT, 06825	Urgent care Center - walk-in care, lab services, onsite x-rays; family care, sports and camp physicals, physical examinations, vaccinations, minor injury treatment	https://www.afcurgentcare.com
AFC Urgent Care	57 Monroe Turnpike, Trumbull, CT, 06611	Urgent care Center - walk-in care, lab services, onsite x-rays; family care, sports and camp physicals, physical examinations, vaccinations, minor injury treatment	https://www.afcurgentcare.com
AFC Urgent Care	4200 Main St, Bridgeport, CT, 06606	Urgent care Center - walk-in care, lab services, onsite x-rays; family care, sports and camp physicals, physical examinations, vaccinations, minor injury treatment	https://www.afcurgentcare.com

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
AFC Urgent Care	161 Boston Ave, Bridgeport, CT, 06610	Urgent care Center - walk-in care, lab services, onsite x-rays; family care, sports and camp physicals, physical examinations, vaccinations, minor injury treatment	https://www.afcurgentcare.com
Ahlbin Rehabilitation Centers at Bridgeport Hospital - multiple locations (Bridgeport, Stratford, and Trumbull sites are in our region)	226 Mill Hill Ave, Bridgeport, CT, 06610	Allied Health Services; Physical rehabilitation/therapy services - Treats pediatric, adolescent, and adult patients: Physical therapy, occupational therapy, speech-language therapy, fall prevention and balance therapy, orthotics, numerous other types of rehab/therapy including but not limited to hand therapy, neurological rehabilitation, orthopedic and post-surgical rehabilitation, pelvic floor and women's health, sports rehabilitation, work injury rehabilitation	https://www.bridgeporthospital.org/services/rehabilitation
Ahlbin Rehabilitation Centers	3585 Main St, Stratford, CT, 06614	Allied Health Services; Physical rehabilitation/therapy services - Treats pediatric, adolescent, and adult patients: Physical therapy, occupational therapy, speech-language therapy, fall prevention and balance therapy, orthotics, numerous other types of rehab/therapy including but not limited to hand therapy, neurological rehabilitation, orthopedic and post-surgical rehabilitation, pelvic floor and women's health, sports rehabilitation, work injury rehabilitation	https://www.bridgeporthospital.org/services/rehabilitation
Ahlbin Rehabilitation Centers	Park Ave Medical Center, 5520 Park Ave, M1-800, Trumbull, CT, 06611	Allied Health Services; Physical rehabilitation/therapy services - Treats pediatric, adolescent, and adult patients: Physical therapy, occupational therapy, speech-language therapy, fall prevention and balance therapy, orthotics, numerous other types of rehab/therapy including but not limited to hand therapy, neurological rehabilitation, orthopedic and post-surgical rehabilitation, pelvic floor and women's health, sports rehabilitation, work injury rehabilitation	https://www.bridgeporthospital.org/services/rehabilitation

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
Bridgeport Hospital	267 Grant Street, Bridgeport, CT, 06610	Hospital -Specific services: Acute & Chronic Pain Management, Adolescent Services, Ahlbin Rehabilitation Center, Anesthesia & Pain Management, Blood Management Services, Brain Tumors, Cancer (Oncology), Children (Pediatrics), Diabetes, Ear Nose & Throat (Otolaryngology), Emergency Services, Geriatric (Aging), Gynecologic Cancer, Head & Neck Cancer, Heart & Vascular, Hospitalist Services, Lymphoma/Leukemia, Maternity, Neurology & Neurosurgery, Occupational Medicine & Wellness Services, Ophthalmology, Oral & Maxillofacial Surgery, Orthopedics, Ostomy Services, Palliative Care, Plastic & Reconstructive Surgery, Podiatry, Pulmonary Medicine, Radiation Oncology, Radiology Services, Sarcoma, Sleeping Disorders & Sleep Medicine, Stroke, Surgery, Trauma and Burn, Urology, Wait Times, Weight Loss (Bariatric) Surgery, Wound Care	https://www.bridgeporthospital.org/
Bridgeport Hospital Milford Campus	300 Seaside Ave, Milford, CT, 06460	Hospital	https://www.bridgeporthospital.org/
Bridgeport Hospital Primary Care Center	226 Mill Hill Ave, Bridgeport, CT, 06610	Primary Care Provider; Specialty Care Clinic	https://www.bridgeporthospital.org/locations/bridgeport-226-mill-hill-ave-primary-care
Cambridge Manor	2428 Easton Turnpike, Fairfield, CT, 06825	Long Term Care/Nursing Home	203-372-0313
Docs Urgent Care	427 Main St, Monroe, CT, 06468	Urgent Care Center	https://docsmedicalgroup.com/docsurgentcare/
Docs Urgent Care	200 E Main St, Stratford, CT, 06614	Urgent Care Center	https://docsmedicalgroup.com/docsurgentcare/

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
Docs Urgent Care	1677 E Main St, Bridgeport, CT, 06608	Urgent Care Center	https://docsmedicalgroup.com/docsurgentcare/
Hartford HealthCare Urgent Care	401 Monroe Tpke, Monroe, CT, 06468	Urgent Care Center - Behavioral and mental health, emergency services, orthopedics, urgent care, sport health, pain management	https://hartfordhealthcareurgentcare.org/
Hartford HealthCare Urgent Care	915 White Plains Rd, Trumbull, CT, 06611	Urgent Care Center - Behavioral and mental health, emergency services, orthopedics, urgent care, sport health, pain management	https://hartfordhealthcareurgentcare.org/
Hartford HealthCare Urgent Care	3272 Main St, Stratford, CT, 06614	Urgent Care Center - Behavioral and mental health, emergency services, orthopedics, urgent care, sport health, pain management	https://hartfordhealthcareurgentcare.org/
Hartford HealthCare Urgent Care	1262 Post Rd, Fairfield, CT, 06824	Urgent Care Center - Behavioral and mental health, emergency services, orthopedics, urgent care, sport health, pain management	https://hartfordhealthcareurgentcare.org/
Hartford HealthCare Urgent Care	1646 Boston Post Rd, Milford, CT, 06460	Urgent Care Center - Behavioral and mental health, emergency services, orthopedics, urgent care, sport health, pain management	https://hartfordhealthcareurgentcare.org/
Hope Charitable Pharmacy of Greater Bridgeport	2660 Main St Suite 115, Bridgeport, CT, 06606	Pharmacy - medication assistance	https://stvincents.org/health-wellness/community-benefit-programs/hope-charitable-pharmacy-of-greater-bridgeport

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
Lord Chamberlain Nursing and Rehabilitation Center	7003 Main St, Stratford, CT, 06614	Skilled Nursing Facility	https://www.lordchamberlain.net/
Norma Pfriem Breast Center at Smilow Cancer Hospital -Trumbull location	Park Avenue Medical Center 5520 Park Avenue, Trumbull, CT, 06611	Mammogram screening; wellness services; palliative care	https://www.bridgeporthospital.org/services/breast-cancer
Norma Pfriem Breast Center at Smilow Cancer Hospital - Bridgeport location	226 Mill Hill Ave, 3rd Fl, Bridgeport, CT, 06610	Mammogram screening; wellness services; palliative care	https://www.bridgeporthospital.org/services/breast-cancer
Norma Pfriem Breast Center at Smilow Cancer Hospital - Fairfield location	111 Beach Rd, 2nd Fl, Fairfield, CT, 06824	Mammogram screening; wellness services; palliative care	https://www.bridgeporthospital.org/services/breast-cancer
Northeast Medical Group Find a Location Tool		Primary Care; Specialty Care; Mental & Behavioral Health; Lab Services	https://www.northeastmedicalgroup.org/find-a-location
Optimus Health Care- Bridgeport & Stratford	982 E Main St, Bridgeport, CT, 06608	FQHC/Community Health Center - Primary care, specialty care, behavioral health, school-based health centers, pediatrics, dental care, women's health, Ryan White HIV/AIDS Program, WIC Program	https://optimushealthcare.org/
Planned Parenthood of Southern New England	4697 Main St, Bridgeport, CT, 06606	Abortion, birth control, emergency contraception, HIV services, gender-affirming care, pregnancy testing & services, STD testing & treatment, immunizations, women's care, wellness and preventive care	https://www.plannedparenthood.org/health-center/connecticut/bridgeport/06606/bridgeport-center-4275-90220
Southwest Community Health Center- Bridgeport Multiple Locations	46 Albion St, Bridgeport, CT, 06605	FQHC/Community Health Center - Primary care, specialty care, behavioral health, substance use treatment, geriatrics, school-based health centers, pediatrics, dental care, women's health, Ryan White HIV/AIDS Program, WIC Program	https://www.swchc.org/

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
Spring Village	6911 Main St, Stratford, CT, 06614	Assisted living and memory care	http://www.springvillagestratford.com
St. Vincent's Medical Center	2800 Main St, Bridgeport, CT, 06606	Hospital Specific services: Anesthesiology, Behavioral & Mental Health, Breast Health, Cancer Care, Emergency Services, Gastroenterology, Heart & Vascular, Hematology, Hospital Medicine, Imaging Services, Immunology, Infectious Disease, Intensive Care, Maternity, Nephrology, Neurosciences, Ophthalmology, Outpatient Pharmacy, Palliative Care, Podiatry, Primary Care & Family, Pulmonology, Rehabilitation Services, Rheumatology, Senior Services, Special Needs Services, Spine Care, Surgical Services, Surgical Weight Loss, Urgent/Walk-In Care, Urology & Kidney, Women's Health, Wound Care, Virtual Health	https://stvincents.org/
St. Vincent's Medical Center Find a Doctor Tool		Primary Care; Specialty Care	https://stvincents.org/find-a-doctor
Stratford VNA	3060 Main St, Stratford, CT, 06614	Visiting nurse services	https://www.stratfordvna.org/
Sturges Ridge of Fairfield	448 Mill Plain Rd, Fairfield, CT, 06824	Assisted living facility	https://www.benchmarkseniorliving.com/senior-living/ct/fairfield/sturges-ridge-of-fairfield
Sunrise of Fairfield	1571 Stratfield Rd, Fairfield, CT, 06825	Assisted living facility - Assisted Living, Memory Care, Skilled Nursing	https://www.sunriseseniorliving.com/communities/ct/sunrise-of-fairfield
University of Bridgeport Fones Dental Hygiene Clinic	60 Lafayette St, Bridgeport, CT, 06604	Dental clinic	https://www.bridgeport.edu/ub-clinics/dental-hygiene

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
Weisman Americares Free Clinic of Bridgeport	115 Highland Avenue, Bridgeport, CT, 06604	Primary care provider	https://www.americaresfreeclinics.org/our-clinics/bridgeport/
Yale New Haven Health Physician Referral Information (look up providers)		Primary Care; Specialty Care	To find a provider, visit: https://www.ynhhs.org/physician-referral-info To find office locations, visit: https://www.ynhhs.org/find-a-location/
Yale New Haven Health Urgent Care	1040 Barnum Ave, Stratford, CT, 06614	Urgent Care Center	https://www.ynhhs.org/urgent-care
Yale New Haven Health Urgent Care	340 Grasmere Ave, Fairfield, CT, 06824	Urgent Care Center	https://www.ynhhs.org/urgent-care
Yale New Haven Health Urgent Care	309 Stillson Rd Floor 2, Fairfield, CT, 06825	Urgent Care Center	https://www.ynhhs.org/urgent-care
Yale New Haven Health Urgent Care	831 Boston Post Rd #101, Milford, CT, 06460	Urgent Care Center	https://www.ynhhs.org/urgent-care
MENTAL HEALTH & BEHAVIORAL HEALTH			
APT Foundation	425 Grant Street, Bridgeport, CT, 06610	Substance use treatment	https://aptfoundation.org/
Bridges Healthcare	949 Bridgeport Ave, Milford, CT, 06460	Mental Health Provider; Substance use treatment; counseling; Child and Family Services	https://bridgesct.org/
Chemical Abuse Service Agency Inc. (CASA)	1124 Iranistan Ave, Bridgeport, CT, 06605	Medication assisted treatment, clinical residential services, supportive residential services, outpatient/day treatment, recovery support services, supportive housing	https://www.casaincct.org/

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
Child First Greater Bridgeport	1470 Barnum Ave, Suite 303Bridgeport, CT, 06610	Psychotherapy for parents and children, family support, child development assistance	https://www.bridgeporthospital.org/services/mental-health/child-first-greater-bridgeport
Continuum of Care, Inc.	113 Washington Terrace Bridgeport, CT, 06604	Crisis respite	475-282-4985
Fairfield Counseling Services	125 Penfield Rd, Fairfield, CT, 06824	Counseling services, family support, youth in crisis	
Greater Bridgeport Community Mental Health Center	1635 Central Ave, Bridgeport, CT, 06610	Mental Health Provider; Substance use treatment; counseling; outreach services; crisis intervention	https://portal.ct.gov/dmhas/swcmhs/agency-files/gbcmhc
Kinsella Treatment Center	1862 State St Ext, Bridgeport, CT, 06604	Substance use treatment	https://recovery-programs.org/program/kinsella-treatment-center/
Koslow Center for Marriage and Family Therapy - Fairfield University	1073 North Benson Road, Southwell Hall, Fairfield CT, 06824	Counseling	https://fairfield.edu/academics/schools-and-colleges/school-of-education-and-human-development/kathryn-p-koslow-center-for-marriage-and-family-therapy/index.html
Liberation Programs	399 Mill Ave, Bridgeport CT, 06850	Counseling; substance use treatment; housing; outreach services	https://www.liberationprograms.org/
LifeBridge Community Services	475 Clinton Ave, Bridgeport, CT, 06605	Counseling; substance use treatment; pediatric behavioral health therapy; domestic violence survivor support; intensive case management	https://lifebridgect.org/

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
Mary J. Sherlach Counseling Center	121 Old Mine Rd #1319, Trumbull, CT, 06611	Counseling (family & individual), family support, substance abuse counseling, youth in crisis, referral services, crisis and trauma intervention	https://www.trumbull-ct.gov/205/Counseling-Center
New Era Rehabilitation Bridgeport	4675 Main St, Bridgeport, CT, 06606	Substance use treatment; counseling	https://www.neweraerehabilitation.com/
REACH Program: Bridgeport Hospital	1558 Barnum Ave, Bridgeport, CT, 06610	Counseling	https://www.bridgeporthospital.org/services/mental-health/reach-program
St. Vincent's Medical Center - Bridgeport Inpatient/Outpatient Behavioral Health Services	2800 Main St, Bridgeport, CT, 06606	Inpatient mental health care, substance use services, outpatient counseling	https://stvincents.org/locations-partners/behavioral-health/bridgeport
The Child & Family Guidance Center	180 Fairfield Ave, Bridgeport, CT, 06604	Counseling services, family support, youth in crisis	https://cfguidance.com/
Recovery Network of Programs, Inc.	1438 Park Ave, Bridgeport, CT, 06604	Substance use treatment; counseling; emergency shelter; transitional and supportive housing	https://recovery-programs.org/
PUBLIC HEALTH & PREVENTION			
Aspetuck Health District	180 Bayberry Lane Westport	Public Health District	www.aspetuckhd.org
Fairfield Health Department	725 Old Post Rd, Fairfield, CT, 06824	Public Health Department	https://fairfieldct.org/service/health_department/index.php
Milford Health Department	82 New Haven Ave, Milford, CT, 06460	Public Health Department	https://www.ci.milford.ct.us/health-department-0
Milford Prevention Council	70 West River Street	Community health education; substance use/abuse prevention	203-783-6676

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
Monroe Health Department	7 Fan Hill Rd, Monroe, CT, 06468	Public Health Department - Immunizations, community health & education, environmental health, emergency preparedness	https://www.monroect.gov/p/health-department
Stratford Health Department	468 Birdseye Street, Stratford, CT, 06615	Public Health Department	https://www.stratfordct.gov/page/health
Trumbull Health Department	335 White Plains Rd, Trumbull, CT, 06611	Public Health Department	https://www.trumbull-ct.gov/179/Health
City of Bridgeport Department of Health and Social Services	999 Broad St, Bridgeport, CT, 06604	Immunizations, community health & education, department on aging, environmental health, emergency preparedness, fair rent commission, family health & wellness clinic, food policy council, housing & commercial code enforcement, veterans' affairs, vital records, case management, housing stability support, emergency relocation assistance, state and federal program administration, resource awareness	https://www.bridgeportct.gov/government/departments/health-social-services
SOCIAL SERVICES & COMMUNITY SUPPORT			
Access Independence, Inc.	300 Long Beach Blvd #1, Stratford, CT, 06615	Independent living assistance; Disability Support Services	https://www.accessinCT,.org
Alliance for Community Empowerment	1070 Park Ave, Bridgeport, CT, 06604	early childhood education, family resources, job training, financial wellness, energy assistance	https://www.alliancect.org
Alpha Community Services YMCA	650 Park Ave, Bridgeport, CT, 06605	Housing support services and case management	https://cccymca.org/locations/alpha/
American Legion	752 East Main St, Bridgeport, CT, 06608	Veterans support services	https://www.legion.org/ 203-333-5971
Beth-El Center	90 New Haven Ave, Milford, CT, 06460	Shelter services, case management, community kitchen/hunger relief	https://bethelmilford.org
Bigelow Center for Senior Activities and Social Services	100 Mona Terr, Fairfield, CT, 06824	Senior activities and services	https://www.fairfieldct.org/service/bigelow_

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
			senior_center/index.php
Bishop Jean Williams Food Pantry	3160 Park Ave, Bridgeport, CT, 06604	Hunger relief/food assistance	https://www.parkcityinitiative.org
Black Rock Senior Center	2676 Fairfield Ave, Bridgeport, CT, 06605	Senior activities and services	https://www.bridgeportct.gov/government/departments/department-aging/black-rock-senior-center
Bridgeport Farmer's Market Collaborative		Food/nutrition benefits assistance	https://bridgeportfarmersmarkets.org
Bridgeport Islamic Community Center	703 State St, Bridgeport, CT, 06604	Education, community programs, interfaith activities, outreach	https://www.mybicc.org/
Bridgeport Nutrition Program: Meals on Wheels	215 Warren St, Bridgeport, CT, 06604	Food assistance/hunger relief	https://www.cwresources.org/meals-on-wheels/
Bridgeport Rescue Mission	1088 Fairfield Ave, Bridgeport, CT, 06605	Shelter services, case management, community kitchen/hunger relief	https://bridgeportrescuemission.org/
Bridgeport YMCA	850 Park Ave, Bridgeport, CT, 06604	Community center	https://cccymca.org/locations/bridgeport/
Building Neighborhoods Together	570 State St, Bridgeport, CT, 06604	Housing assistance, financial literacy, first time homebuyer pre-purchase certificate classes	https://www.bntweb.org/
Bureau of Rehabilitation Services - Bridgeport Field Office	1057 Broad St #101, Bridgeport, CT, 06604	Disability support services	
Catalyst CT,	2470 Fairfield Avenue, Bridgeport, CT, 06605	Advocacy, violence prevention and intervention, restorative justice, behavioral health awareness and prevention, naloxone training	https://catalystct.org/
Catholic Charities of Fairfield County	238 Jewett Ave, Bridgeport, CT, 06606	Basic needs assistance	https://www.ccfairfield.org/

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
Connecticut Institute for Refugees and Immigrants (CIRI)	670 Clinton Ave, Bridgeport, CT, 06605	Refugee services, immigration legal services, assistance for survivors of human trafficking, economic empowerment, translation services	https://cirict.org/
Coordinated Transportation Solutions	35 Nutmeg Dr, #120 Trumbull, CT, 06611	Transportation services: non-emergency medical, students, veterans, injured workers	https://www.ctstransit.com/
Council of Churches of Greater Bridgeport	1718 Capitol Ave, Bridgeport, CT, 06604	FEED Center - free culinary courses for low-income residents. Oversees the mobile marketplace, serve as incubator kitchens for new food businesses and oversees a network of 40 food pantries	https://www.ccgb.org/
Dwight D. Eisenhower Senior Center	307 Golden Hill St, Bridgeport, CT, 06604	Senior activities and services	https://www.bridgeportct.gov/government/departments/department-aging/eisenhower-senior-center
East End Food Bank	1290 Stratford Ave, Bridgeport, CT, 06607	Food assistance/hunger relief	
East Side Senior Center	268 Putnam St, Bridgeport, CT, 06608	Senior activities and services	https://www.bridgeportct.gov/government/departments/department-aging/east-side-senior-center
Easton Community Center	364 Sport Hill Rd, Easton, CT, 06612	Community Center	http://www.eastoncc.com/
Easton Human Services	225 Center Road Easton	Food Pantry; Child and Family Services; Local Prevention Council; Basic Needs Assistance	www.eastonct.gov
Easton Senior Center	650 Morehouse Rd, Easton, CT, 06612	Senior activities and services	https://www.eastonct.gov/senior-center

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
Fairfield Housing Authority	15 Pine Tree Lane Fairfield, CT, 06825	Housing authority - Senior/disabled housing	https://fairfieldct.org/service/housing_authority/index.php
Fairfield YMCA	841 Old Post Rd, Fairfield, CT, 06824	Community center	https://cccymca.org/locations/fairfield/
Family Re-Entry of Bridgeport	75 Washington Ave, Bridgeport, CT, 06604	Re-entry services	https://www.familyreentrycrj.org/
Feed My Sheep Food Pantry	2271 North Avenue, Bridgeport, CT, 06605	Food assistance/hunger relief	
Feed the People Food Pantry	301 Bostwick Ave, Bridgeport, CT, 06605	Food assistance/hunger relief	
First Baptist Church of Stratford Agape Food Pantry	105 Hamilton Ave, Stratford, CT, 06615	Food assistance/hunger relief	
First Church/Food2Kids	34 West Main Street, Milford, CT 06460	Food assistance/hunger relief	203-258-8182
Fridgeport Community Refrigerator	219 James St, Bridgeport, CT, 06604	Food assistance/hunger relief	https://www.facebook.com/Fridgeport/
GBAPP	1470 Barnum Ave, Suite 301, Bridgeport, CT, 06610	Prevention services; HIV services; housing support; father mentoring	https://www.gbapp.org/
Greater Bridgeport Transport Authority	710 Water St, Bridgeport, CT, 06604	Transportation services	https://gogbt.com/
Habitat for Humanity of Coastal Fairfield County	1785 Stratford Ave, Stratford, CT, 06615	Housing assistance	https://habitatcfc.org/
Hall Neighborhood House	52 George E Pipkin's Way, Bridgeport, CT, 06608	Community center	https://hallneighborhoodhouse.org/

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
Homes for the Brave - Applied Behavioral Rehabilitation Institute, Inc.	655 Park Ave, Bridgeport, CT, 06605	Housing Services	https://www.homesforthebrave.org/
Isaiah House II	120 Clinton Ave, Bridgeport, CT, 06605	Housing services - halfway house	(203) 676-0616
King's Pantry	30 Florence St, Bridgeport, CT, 06607	Food assistance/hunger relief	203-576-0522
Lakewood-Trumbull YMCA	20 Trefoil Drive Trumbull, CT, 204 Stanley Road Monroe, CT, 06468	Community center	https://cccymca.org/locations/lakewood-trumbull/
Lighthouse Afterschool Program	45 Lyon Terr, #301, Bridgeport, CT, 06604	Youth and community programs, education, cultural and recreational opportunities	https://www.bridgeportct.gov/government/departments/youth-services/lighthouse-program
M7	65 Industry Dr, West Haven, CT, 06516	Transportation agency	https://www.m7ride.com/
Make the Road CT	87 Washington Ave, Bridgeport, CT, 06604	Advocacy	https://www.maketheroadct.org/
Mary Taylor/Community Dinner	168-176 South Broad Street	Food assistance/hunger relief	
Meals on Wheels	9 Jepson Drive Milford, CT, 06460	Food assistance/hunger relief	203-877-5131
Milford Boys & Girls Club	59 Devonshire Road Milford, CT, 06460	Community Center	203-713-8055
Milford Department of Human Services	150 Gulf Street, Milford, CT, 06460	Case management/basic needs assistance	https://www.ci.milford.ct.us/human-services

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
Milford Food Bank	9 Jepson Dr, Milford, CT, 06460	Food assistance/hunger relief	https://milfordctseniorcenter.com/mfb/
Milford Micro Transit		Transportation	203-916-9339; www.milfordmicro.com
Milford Redevelopment and Housing Partnership	75 Demaio Dr, Milford, CT, 06460	Housing Services	https://www.mrhp.org/
Milford Senior Center	9 Jepson Dr, Milford, CT, 06460	Senior activities and services; case management	https://milfordctseniorcenter.com/
Monroe Community and Social Services	7 Fan Hill Rd, Monroe, CT, 06468	Basic needs assistance-Provide information and referrals to Monroe residents, families and caregivers. Provide individual and family consultations, assessments and referrals for mental health needs. Coordinate Back to School Buddies and Holiday Giving Tree Programs. Assist residents with applications for Energy Assistance, SNAP, Below Budget Worksheets, New Start, Husky and more. Assist residents with applications for Energy Assistance, SNAP, Below Budget Worksheets, New Start, Husky and more. Administer Project Warmth Program, provides qualified residents assistance with energy needs when other programs have been exhausted. Administer Social Services Exchange Fund, assists qualified residents in crisis situations. Coordinate Monroe's statutory responsibilities during eviction proceedings.	https://monroect.gov/p/community-social-services
Monroe Food Pantry	980 Monroe Turnpike, Monroe, CT, 06468	Hunger relief/food assistance	https://www.monroect.gov/p/food-pantry
Monroe Housing Authority	358 Wheeler Rd # E7, Monroe, CT, 06468	Housing Authority	https://www.monroect.gov/p/housing-authority
Monroe Senior Center	235 Cutler's Farm Rd, Monroe, CT, 06468	Senior activities and services	https://www.monroect.gov/p/senior-center

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
North End Bethany Senior Center	20 Thorme St, Bridgeport, CT, 06606	Senior activities and services	https://www.bridgeportct.gov/government/departments/department-aging/north-end-bethany-senior-center
nOURish Bridgeport, Inc.	2200 North Ave, Bridgeport, CT, 06604	Food assistance/hunger relief	https://www.nourishbpt.org/
Operation Hope	636 Old Post Rd, Fairfield, CT, 06824 50 Nichols St, Fairfield, CT, 06824	Hunger relief, housing support, shelter services, case management	https://operationhopect.org/
Park City Communities	150 Highland Ave, Bridgeport, CT, 06604	Housing authority	https://www.parkcitycommunities.org/
Park City Initiative	4 Worth St, Bridgeport, CT, 06604	Basic needs assistance	https://www.parkcityinitiative.org/
Ralphola Taylor Community Center	790 Central Ave, Bridgeport, CT, 06607	Community center; leadership development; violence prevention; drug & alcohol prevention; education/after-school program	
Raymond E Baldwin Center	1000 West Broad St, Stratford, CT, 06615	Basic needs assistance - Needs assessment, food assistance, hoarding, home care and respite options, housing crisis assessment. Programs for 55 years of age and older	https://www.townofstratford.com/page/senior-services
Salvation Army- Bridgeport Corps Community Center	30 Elm St, Bridgeport, CT, 06604	Basic needs assistance	https://easternusa.salvationarmy.org/southern-new-england/bridgeport/
South End Community Center	19 Bates St, Stratford, CT, 06615	Community center	https://www.townofstratford.com/page/south-end-community-center
Southwestern Connecticut Agency on Aging	1000 Lafayette Blvd, Bridgeport, CT, 06604	Aging and disability support services; advocacy	https://www.swcaa.org/

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
St. Gabriel's Church	26 Broadway, Milford, CT, 06460	Food assistance/hunger relief	203-878-3075
St. John's Family Center	1067 Park Ave, Bridgeport, CT, 06604	Community center; basic needs assistance	https://stjohnsfamilycenter.org/
St. Mary's	70 Gulf Street, Milford, CT, 06460	Food assistance/hunger relief	203-783-3253
Sterling House Community Center	2283 Main St, Stratford, CT, 06615	Community center	https://www.sterlingcommunitycenter.org/
Stratford Community Services	468 Birdseye Street, Stratford, CT, 06615	Youth and family counseling, child and youth development, substance abuse prevention, and mental health promotion	https://www.townofstratford.com/page/community-services
Stratford Housing Authority	295 Everett St, Stratford, CT, 06615	Housing authority	https://www.stratfordha.org/
Stratford Parents' Place	Stratford Academy, Johnson House 719 Birdseye St Stratford, CT, 06615	Child and family services - Family resource center that provides programs for parents, grandparent groups, baby time, and activity groups. Provides parent educators and accesses information that supports family's social, medical, financial, emotional, and educational needs.	https://www.stratfordk12.org/page/stratford-parents-place/
Stratford Partnership for Youth and Families	468 Birdseye Street, Stratford, CT, 06615	Child and family services; prevention - Aims at reducing youth substance abuse and to create a safe healthy and drug free environment where youth and families thrive.	https://www.townofstratford.com/page/stratford-partnership-for-youth-and-families
Stratford YMCA	3045 Main St, Stratford, CT, 06614	Community center	https://cccymca.org/locations/stratford/
The Center for Family Justice	753 Fairfield Ave, Bridgeport, CT, 06604	Child and family services; crisis support; domestic violence survivor support; advocacy; legal help	https://centerforfamilyjustice.org/
The Connection	3885 Main St, Bridgeport, CT, 06606	Housing services	https://www.theconnectioninc.org/

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
The Pilot House	240 Colony St, Fairfield, CT, 06824	Support for children and young adults with Autism/dev. disabilities/mental health issues	https://www.thepilothouse.org/
The Storehouse Project	200 Meadow St, Milford, CT, 06461	Food assistance/hunger relief; basic needs assistance (clothing boutique)	http://www.storehouseprojectct.org/
Thomas Merton Family Center	1406 State St, Bridgeport, CT, 06605	Community center	https://www.ccfairfield.org/project/thomas-merton-center/
Town of Trumbull Social Services	23 Priscilla Pl #5123, Trumbull, CT, 06611	Basic needs assistance; emergency assistance - adult day care, elder abuse prevention, meals on wheels, housing, home health care, fuel assistance, legal referrals, elderly state and town tax relief, Medicare enrollment and insurances, social security benefits, and veterans programs	https://www.trumbull-ct.gov/308/Social-Services
Trumbull Food Pantry	23 Priscilla Pl, Trumbull, CT, 06611	Food assistance/hunger relief	https://www.trumbull-ct.gov/310/Food-Pantry
Trumbull Housing Authority	200 Hedgehog Cir, Trumbull, CT, 06611	Housing authority	https://sternvillage.com/
Trumbull Senior Center	23 Priscilla Pl, Trumbull, CT, 06611	Senior activities and services	https://www.trumbull-ct.gov/281/Senior-Center
United Way of Coastal and Western Connecticut	10 Middle St Suite 1101, Bridgeport, CT, 06604	Community impact investing; advocacy; social programs	https://www.unitedwaycwc.org/
United Way of Milford	20 Evergreen Ave, Milford, CT, 06460	Community impact investing; advocacy; social programs	http://unitedwayofmilford.org/
Veteran's Affairs Shuttle Bus Program	752 East Main Street, 1st Floor, Bridgeport, CT, 06608	Transportation agency - for veterans only	va.gov/healthbenefits/vtp/; 203-576-8348
Wellspring Community Center	9 Research Dr, Milford, CT, 06460	Community center	https://wellspringcef.org/

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information
Westbridge, Inc.	130 Nichols St, Fairfield, CT, 06824	Basic needs assistance - income-eligible home repair assistance	https://www.westbridgeinc.org/
Wheel it Forward (Bridgeport Branch)	955 Connecticut Ave, Bridgeport, CT, 06607	Durable medical equipment lending library	https://www.wheelitforwardusa.org/
Woodruff Family YMCA	631 Orange Ave, Milford, CT, 06461	Community center	https://cccymca.org/locations/woodruff/
YMCA - Milford	631 Orange Avenue, Milford, CT, 06461	Community center	203-878-6501
YMCA-Stratford	3045 Main St, Stratford, CT, 06614	Community center	https://cccymca.org/locations/stratford/
Kolbe Education Center	401 Kossuth St, Bridgeport, CT, 06608	Early childhood education - childcare, school readiness programs, and preschool	(203) 332-6447
Jewish Family Service of Connecticut	2490 Black Rock Tpke #454, Fairfield, CT, 06825	Adoption services; senior support services; counseling; basic needs assistance	http://www.jfsct.org/
YOUTH DEVELOPMENT			
Bridgeport Caribe Youth Leaders	1067 Park Ave, Bridgeport, CT, 06604	Sports, educational and community awareness, after-school tutoring, entrepreneurship	https://www.bcyl.org/

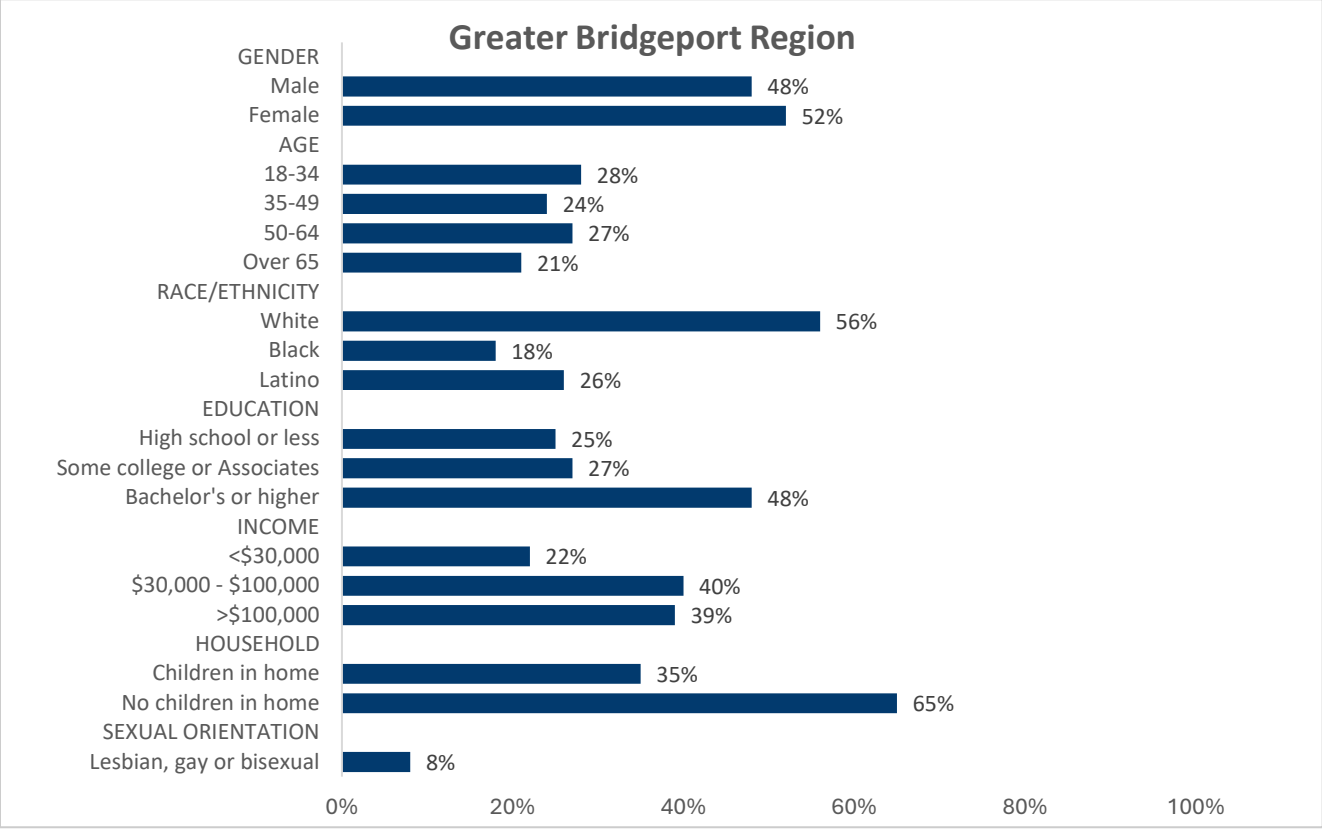
Appendix E: Primary Data Tools

DataHaven Community Wellbeing Survey (DCWS)

Additional information and data can be found online at the CT DataHaven website: www.ctdatahaven.orgThe DataHaven Community Wellbeing Survey (DCWS) assesses issues such as quality of life, health, employment, and neighborhood resources. The DCWS uses probability sampling to create highly-reliable local information that is not available from any other public data source. The DCWS traces its origins to a series of locally-based efforts conducted over the past two decades to gather information about wellbeing in Connecticut neighborhoods. With guidance from an Advisory Council of 300 public and private organizations, DataHaven created a unified statewide survey shared by all cities and towns in the state. Additional information and data can be found online at www.ctdatahaven.org.

A total of 1,246 randomly-selected adults living in Greater Bridgeport completed in-depth interviews with DataHaven as part of the 2024 survey.

DCWS Respondent Demographics

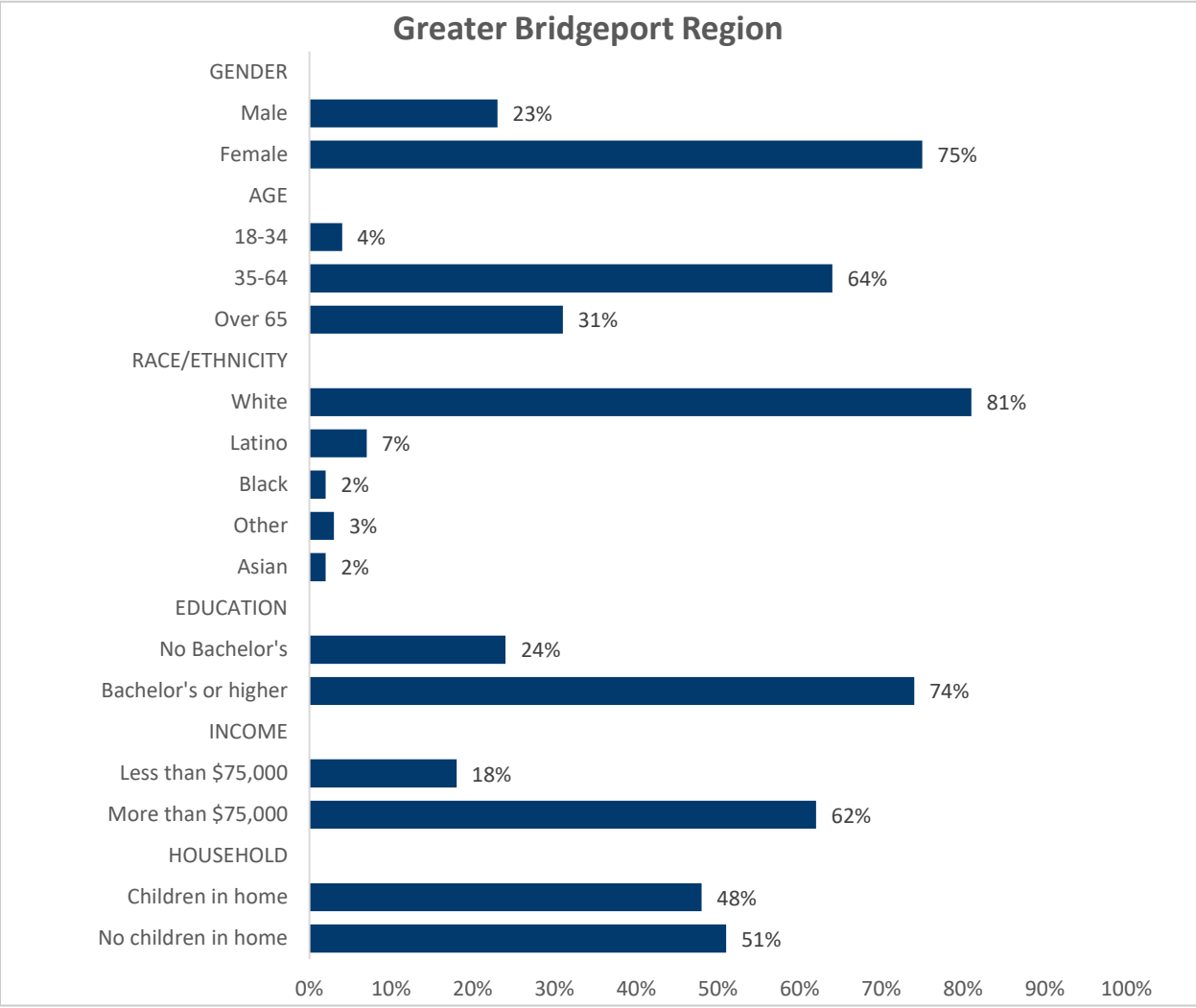


Community-Based Assets and Needs Survey (CBANS)

The DataHaven Community-Based Assets and Needs Survey (CBANS) was designed by DataHaven in collaboration with local partners to collect insights into the strengths, challenges, and needs of specific populations across Connecticut. Unlike traditional population-based surveys, CBANS uses a targeted approach, gathering data through community-based outreach to engage groups that may not be fully represented in larger-scale studies.

In Greater Bridgeport, 2,439 respondents participated in the survey, offering valuable insights into the priorities and needs of this area.

CBANS Respondent Demographics



Disclaimer: In categories where totals do not sum to 100%, discrepancies may be attributed to missing responses or participants selecting 'prefer not to respond.'

Partner Interview Guide

Introductory Questions

1. Please tell me a little about yourself and how you interact with the local community (i.e., what does your organization do?)
2. When you think of good things about living and/or working in the community, what are the first things that come to mind?
3. If you had to pick the top two or three challenges or things people struggle with most in your community, what comes to mind?

Access to Care and Delivery of Services

4. What, if any, health care services are difficult to find and/or access? And why?
5. What are some health-related resources available in the community that are working well and why?

Behavioral Health

6. What, if any, behavioral health care services (including mental health and substance use) are difficult to find and/or access? Why?
7. What behavioral-health resources are available in the community?
8. What types of stigma, if any, are around seeking treatment for mental health and/or substance use disorders?

Health Equity, Vulnerable Populations, Barriers

9. Do you think people in the community are generally **HEALTHY**? Please explain why you think people are healthy or not healthy in your community?
10. How can we improve the overall health of our community?
11. Would you say health care services are equally available to everyone in the community regardless of gender, race, age, or socioeconomics? What populations are especially vulnerable and/or underserved in your community?
12. What barriers to services exist, if any?
13. Do community health care providers care for patients in a culturally sensitive manner?
14. What would you say are the two or three most urgent needs for the most vulnerable?

Social Drivers, Neighborhood & Physical Environment

15. From your perspective what are the top three non-health-related needs in the community and why?
16. What are the top three non-health related assets and why?

Enhancing Outreach & Disseminating Information

17. How do individuals generally learn about access to and availability of services in the area?
18. What do you think are some challenges to spreading awareness and understanding of the availability of services and ways to access them? What might help overcome the challenges?

Magic Wand

19. From your perspective what are the 2 -3 most important health issues/concerns in the community?
20. Based on the health issues you selected/identified… if you had a Magic Wand that you personally could improve the health of the community, what interventions or resources (programs, services etc.) would you implement?

Focus Group Guide

Introductory Questions

1. Briefly introduce yourself and share something you like about your community.
2. What is your definition of “community”?
3. What does a “healthy” community look like to you?
4. What are the two or three most important health needs in your community?

Access to Care and Delivery of Services

5. What services and resources for becoming and staying healthy are difficult to find or missing? What services and resources are difficult to access? Why?
6. How do most people learn about services in your community?
7. What health resources or services are easier to find? Why?

Social Drivers, Neighborhood & Physical Environment

8. What are the top three social or environmental health needs or challenges in the community? Why?

9. What resources and services are available and/or missing in your community to help people with [needs or challenges identified in Question 8]?

Health Equity and Vulnerable Populations

10. What populations in your community experience more challenges than others? PROBE: veterans, youth, immigrants, LGBTQIA+ populations, people of color, older adults, people living with disabilities, people with lower income, rural vs. urban, etc.
11. What are the two or three biggest needs or challenges faced by these groups/your group?
12. What health or social services are not equally available to everyone in your community regardless of gender, race, age, income, or ability? Why?

Protective and Risk Factors

13. Are there factors or lifestyle choices that help people stay healthier and happier? What are they? In your community, what factors or lifestyle choices help people stay healthier and happier?
14. What factors or lifestyle choices contribute the most to the health problems people in your community face?

Magic Wand

15. If you had all the money and resources in the world and could do any one thing to make your community healthier, what would it be?

Appendix F: References for Definitions of Terms

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