

Greater Manchester Region

Manchester Memorial Hospital

Rockville General

A Campus of Manchester Memorial Hospital

CHNA

**Community
Health Needs
Assessment**

2025-2027

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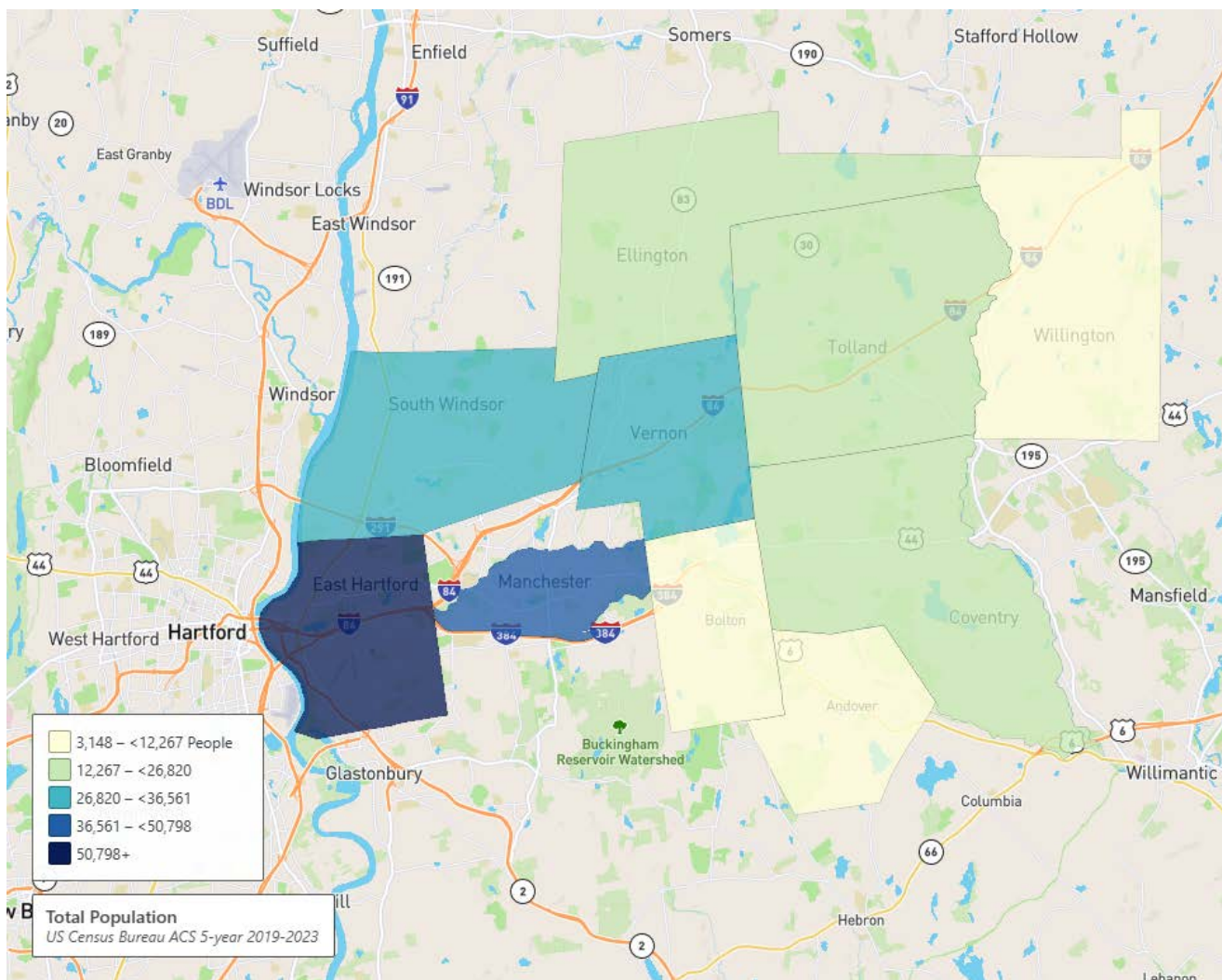
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The Purpose of the Community Health Needs Assessment and the Structure of this Document

The Community Health Needs Assessment (CHNA) is designed to improve the lives and quality of life of local residents by helping the hospital focus its resources and activities on areas of greatest need. The CHNA is an important element of ongoing efforts to engage the communities it serves, be part of neighborhood conversations about health and healthcare, and prioritize efforts to services offered — and the way they are offered — to the community. More specifically, the CHNA will provide local-level data about health and health-related needs within the hospital's primary service area, defined as 10 Connecticut towns located just east of Hartford — Andover, Bolton, Coventry, East Hartford, Ellington, Manchester, South Windsor, Tolland, Vernon, and Willington. The total population is approximately 200,000 most heavily concentrated in East Hartford and Manchester (see right).

Note: The Greater Manchester Region (GMR) is comprised of (1) Manchester Memorial Hospital and (2) Rockville General, a Campus of Manchester Memorial Hospital. This CHNA refers to “GMR” which is now understood to include both facilities —



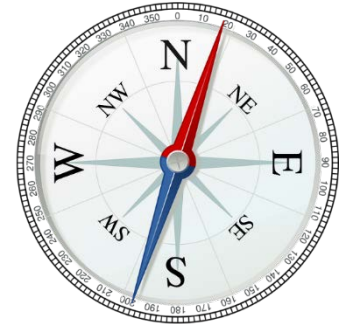
Needs Assessment “Compass” or “Roadmap”

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

- *“What is the Community Health Needs Assessment and why is it important?”*
An introduction and description of the hospital and the community that it serves
- *“What information did we collect and how did we identify community needs?”*
A brief description of the process overview and timeline
- *“What is unique about this community and its health needs?”*
The hospital and community description
- *“What did the data tell us and what did we learn?”*
Research findings of the Community Input – secondary research and primary research (quantitative and qualitative) used to establish a prioritized list of community health needs
- *“What have we already accomplished or initiated?”*
A summary of activities addressing higher-priority needs emerging from the previous CHNA
- *“What did we prioritize and why?”*
A list of identified community needs and the approach taken to prioritize them

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

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



“What did we Learn?” – Executive Summary

Background

This executive summary serves as an introduction and summary of the CHNA. The body of the report is designed as a resource for the health system and their community, stakeholders, agencies, associations, and the public. All readers are encouraged to explore the main body of the report and insights of community members across the service area.

Process / Methodology

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

- Data from the Connecticut Hospital Association, the U.S. Census Bureau, the March of Dimes, the SEER Database, the ALICE database, DataHaven, and many others
- Stakeholder one-on-one interviews with community members, providers, Public Health officials, community based organizations
- Focus Group Discussions (FGDs) with community members, providers, community based organizations
- Survey results from the DataHaven Community Wellbeing Survey
- Quantitative and qualitative research with the Public Health officials and agencies

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

Access to Healthcare Services

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

Health-related Social Needs (HRSN)

Issues such as the cost of healthy, nutritious food; affordable housing; jobs that do not pay a living wage; and other factors present both a financial and emotional burden for many households which have multiple, health-related implications.¹ In addition, individuals who are new to America or otherwise from non-English-speaking households often struggle to find healthcare providers who understand cultural aspects that impact community health and healthcare.

Behavioral Health Barriers

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

Chronic Health Conditions

Chronic health conditions such as heart disease, cancer, diabetes, and asthma continue to be the leading causes of death. However, CHNA research identified some insight which provides a more detailed perspective and supports future planning. The insight allows a more focused, helpful approach that targets the specific chronic conditions within our community and prioritizes interventions where they can have the greatest measurable impact.

There is also an important opportunity for GMR to further strengthen awareness and quality image of its services. Additionally, based on the qualitative research (summarized elsewhere in this CHNA), community members indicate a strong interest in developing a more engaged relationship with the hospital.

¹ For example, US CDC research (e.g., Office of Disease Prevention and Health Promotion, “Healthy People 2030”) shows that high costs of nutritious food and limited access to affordable healthy foods are associated with *food insecurity*, which in turn increases the risk of poor diet quality and diet-related diseases such as diabetes, obesity, and other chronic conditions, and can negatively affect children’s development and mental health.

Results

Within these key themes, the hospital deployed a quantitative and qualitative method to arrive at a prioritized list of specific health needs. The prioritized list of needs follows:

The final priorities (below) present a streamlined, high-level framework focused on broad health domains, while the 2019 list (next page) provided a somewhat different set of priorities.

Aggregated Needs For Greater Manchester Region	
Access to Care for Families and Individuals	
Mental and Behavioral Health Services and Supports	
Socio-economic Factors Impacting Health	
Physical Health and Chronic Conditions	
Maternal, Child and Reproductive Health Services	

Specifically, note the following:

- **Simplification and Consolidation:** Currently, over a dozen distinct priorities have been distilled into five overarching categories – Access to Care for Families and Individuals, Mental and Behavioral Health Services and Supports, Socio-economic Factors Impacting Health, Physical Health and Chronic Conditions, Maternal, Child and Reproductive Health Services; this reflects a potentially more strategic focus rather than granular detail.
- **Elevated Focus on Families and Prevention:** The current CHNA introduces “Maternal, Child and Reproductive Health Services” and “Socio-economic Factors Impacting Health” as distinct focus areas, showing greater emphasis on proactive care and family health compared to 2019’s heavier concentration on chronic conditions and general access.

2019 Final List of Needs (i.e., Broad Areas of Focus)

Note that the 2019 ECHN CHNA focused on broader categories of needs rather than the more granular approach adopted in 2025. Although the broader categories identified in 2019 were helpful and identified critical information, the 2025 CHNA provides more insightful guidance for strategy development and resource deployment.

Aggregated Needs For The Eastern Connecticut Health Network (and Manchester Memorial Hospital)	
Access to Healthcare Services	
Diabetes, Nutrition & Physical Activity	
Heart Disease & Stroke	
Mental Health & Substance Abuse	
Cancer Care	
a. Screening Programs	
b. Early Detection Program	
c. Smoking Prevention and Cessation	
d. Survivorship Care Plans	

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

Introduction – About the Greater Manchester Region

The Greater Manchester Region (including Manchester Memorial Hospital and Rockville General, a Campus of Manchester Memorial Hospital) serve approximately 19 towns and cities across eastern Connecticut. They provide a broad spectrum of wellness, prevention, acute care, rehabilitative and restorative care, and other healthcare support to the community. The two service locations are listed below:

- Manchester Memorial Hospital (249 licensed beds), 71 Haynes Street, Manchester, CT 06040 (Hartford County)
- Rockville General, a Campus of Manchester Memorial Hospital (102 licensed beds), 31 Union Street, Vernon, CT 06066 (Tolland County)

Together, the wider health services system provides a leading care-delivery system with 500 locations serving 185 towns and cities — includes two tertiary-level teaching hospitals, an acute-care community teaching hospital, an acute-care hospital and trauma center, three community hospitals, a behavioral health network, a multispecialty physician group, a clinical care organization, a regional home care system, an array of senior care services, a mobile neighborhood health program and a comprehensive physical therapy and rehabilitation network.

As part of its goal, the CHNA process includes working with community members to systematically identify community health priorities and create a plan for addressing them. This report shares the results from the current assessment of community health needs. This report also highlights the hospital’s 2019–2025 activities to address needs identified in the 2019 assessment.



“What information did we collect and how did we identify community needs?”

CHNA Process Overview and Timeline

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

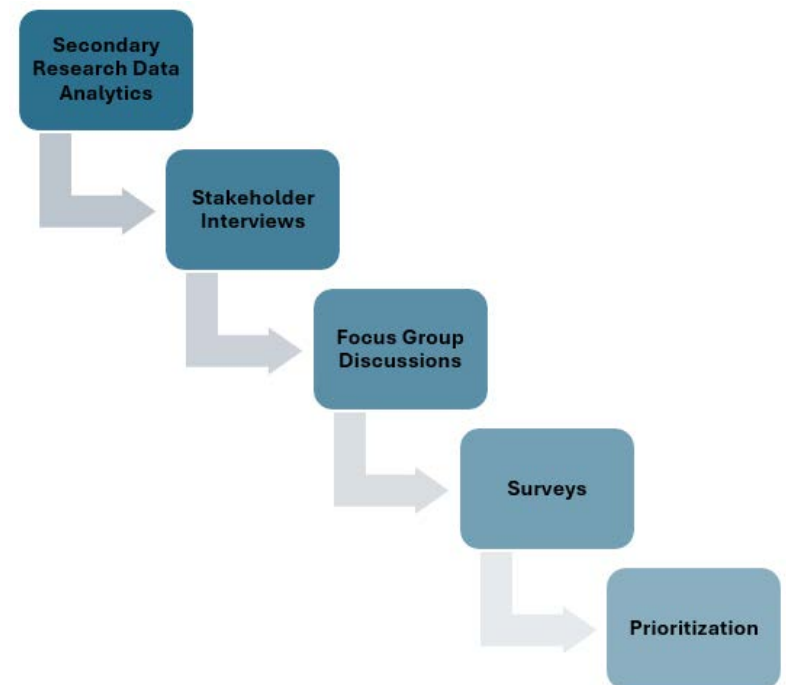
Needs Assessment Research Approach

Healthcare leaders, data experts, and a diverse group of local, regional, and statewide resources worked to create and review community needs and stakeholder engagement.

The CHNA research process deployed the following approaches:

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

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



Detailed Research Method

To develop the 2025 CHNA, a breadth of community partnerships brought together diverse organizations, healthcare providers, and community stakeholders, fostering collaboration to address the unique needs of the region. This collective effort reflects a shared commitment to understanding and addressing the health and well-being of residents across Connecticut.

- Secondary research: Research included collection and analysis of existing data from the U.S. Centers for Disease Control and Prevention (CDC), the U.S. Census Bureau, the SEER database,² and others. Highlights are included later in this assessment, and the appendices contain a more expansive array, for additional reference.
- Primary research (quantitative) – the Wellbeing Survey: Connecticut hospitals along with the Connecticut Hospital Association negotiated with DataHaven to create a shortened version of its Well Being survey to be able to enlist the voices of more community members. Hospital leaders worked in step with the local health collaboratives to disseminate the survey to the community through food pantries, community events, social media, Community Benefit Organization daily operations, etc.
- Primary research (qualitative): In addition to innovating the way data was collected, the hospital and its community partners worked together to conduct focus groups and stakeholder interviews throughout the entire region.
 - For example, in 2025 Q4, several focus groups were conducted. The focus groups were oriented almost entirely toward adult residents of the GMR service area. In total, approximately 40 adults participated in focus groups, representing a diverse cross-section of residents in terms of age, sex, race/ethnicity, town of residence, language, lived experiences, and health conditions.
 - For each focus group, a staff person introduced themselves and facilitated and moderated the discussion. A second staff person recorded detailed notes for each focus group. Spanish interpreters were provided, where necessary.

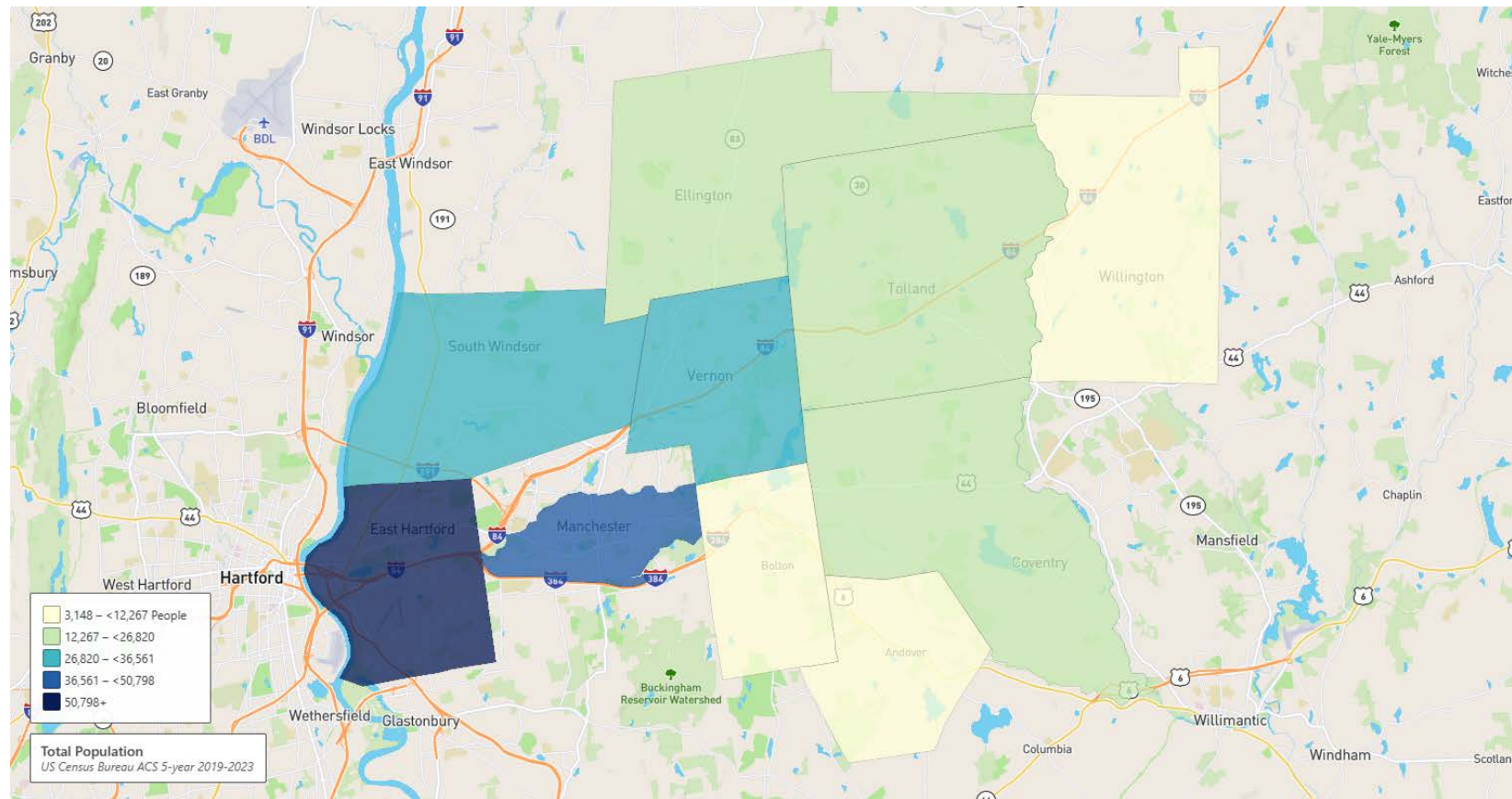
² National Cancer Institute's Surveillance, Epidemiology, and End Results Program.

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

Service Area Description

The service area is defined geographically (e.g., the town in which the hospital is located, as well as nearby ones) and it is described by a set of quantitative and qualitative data points. The hospital service area represents a distinct region within Connecticut, characterized by its blend of suburban resources, rural landscapes, and rich cultures. Unlike some parts of the state, the area features a concentration of community-based services, a mixture of urban and rural settings, some modest public transportation infrastructure (in western parts of the service area), yet pockets economic hardship. The region is home to both long-established communities and a growing number of new cultures and communities. As noted, this CHNA includes the Greater Manchester Region includes the Manchester Memorial Hospital service area, as well as the “Rockville General, a campus of the Manchester Memorial Hospital” service area. The two service areas overlap, yet this document also highlights unique differences between the two, when helpful. For ease of reading, when the terms “service area” or “GMR” are used, it refers to the combined catchment area.

The service area is, in part, characterized by urban healthcare challenges in the western sections of the service area map below, as well as some of the benefits offered by a more urban setting. The less densely populated areas such as Andover, Bolton, and Willington provide a more rural setting yet easy access to urban-area services. These unique factors shape the community's health profile and highlight the benefits of locally responsive strategies to improve community health.



The following section frames community health status and serves as a research-based platform to launch or enhance initiatives to improve community well-being. Specifically, the section focuses on the following:

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

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

Hospital Profile

As noted above, this CHNA includes the Greater Manchester Region comprised of Manchester Memorial Hospital service area, as well as the “Rockville General, a Campus of Manchester Memorial Hospital” service area. For more than 30 years, the two facilities operated within the Eastern Connecticut Health Network (ECHN). Though operating within the integrated regional health system, the facilities maintained separate licenses until October 1, 2025 when they were combined under the license.³ The transition streamlined operational functions, reduced administrative processes, and facilitated more resources to be directed to patient care and staff support.

Rockville General, a campus of Manchester Memorial Hospital will offer 52 beds of inpatient behavioral health care (and select other services) while Manchester Memorial Hospital will offer approximately 300 licensed beds for services such as the following:

- 24/7 Emergency Department
- Inpatient & outpatient medical and surgical services
- Behavioral health evaluation and triage services
- Services to address chronic conditions such as heart disease, diabetes, gastroenterology and digestive health issues, and others
- Outpatient imaging (CT scan, etc.) and lab services

Together, the two service sites operating under the license will provide a broad, accessible set of services to the residents of the catchment area.



³ Renaming “Rockville General, a campus of Manchester Memorial Hospital.”

Data Notes & Limitations

Health disparities impact, and are impacted by, the conditions in the environments where people are born, live, learn, work, play, worship, and age.⁴

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

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

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

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

⁴ Health.gov. How does Healthy People 2030 define health disparities and health equity? Available at: <https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2030/questions-answers#q9>

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

The Greater Manchester Region CHNA was a comprehensive and collaborative effort. It took place over several months and included many voices from across the community. This section explains how the data was collected and studied.

To understand community needs, the team used both quantitative data and personal stories and opinions (qualitative data). Information came from official sources like the U.S. Census and the federal Centers for Disease Control and Prevention, along with surveys, interviews, and focus groups. Special care was taken to include people from many different backgrounds — such as seniors, youth, new Americans, as well as people from a variety of racial, ethnic, and other communities. In addition, particular care was taken to include insights regarding behavioral health issues and other service lines particularly impactful for the analysis of needs impacting Rockville General, a campus of Manchester Memorial Hospital.

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

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



Demographic Analysis and Community Input

Demographic and Secondary Research Highlights

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

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

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

- The GMR service area includes some more densely populated towns such as East Hartford and Manchester, as well as more rural communities such as Tolland and Andover.⁵ See Table 1.
- The service area’s demographic diversity is similar to the state average. See Table 1.
- Consistent with data throughout the state of Connecticut (and nationally⁶), Hispanic residents of the GMR CHNA service area are much younger (median age approximately 30 years) than the area average (i.e., 39.8 years); the variance compared to Whites (approximately 45 years) is even more notable. See Table 2.
- People residing in the GMR CHNA service area tend to have household income similar to the state average, yet a slightly lower percentage of are living in poverty. See Table 3.
- Of the 14 health and chronic conditions included in Table 4, the percentage of GMR CHNA service area residents afflicted by the conditions is higher than the Connecticut state average in 13 of 14 instances. See Table 4.

⁵ Note: Living in a rural area often impacts access to healthcare and increases the risk of chronic disease due to fewer local healthcare facilities, longer travel distances, and limited specialty care. (National Rural Health Association, 2023; CDC, 2022).

⁶ Median age of US Hispanics is 30.1 years compared to the overall median age of 38.5 years, according to the US Census Bureau.

- Preventive health screening and substance use (i.e., tobacco and alcohol) in the GMR CHNA service area tend to be similar to the state averages. See Table 5.
- Cancer rates vary tremendously based on race and ethnicity. For example, cancer rates among Asians are approximately one-half the rates for Whites. However, GMR CHNA service area cancer rates are very similar to the state averages with the exception of prostate cancer which is approximately 25% higher in the CHNA service area than the state average. See Table 6.
- Hospital utilization rates in the hospital service area support broad-based efforts to address maternal health and life expectancy issues. In addition, four additional health conditions are highly common and/or are increasing as a percent of total hospital encounters. The health conditions requiring ongoing attention include the following:
 - Maternal health (statewide), including complications of pregnancy; childbirth; and the puerperium
 - Chronic disease such as heart disease (e.g., Diseases of the circulatory system), arthritis and chronic skeletal issues (Diseases of the musculoskeletal and connective tissue)⁷, cancer, and chronic organ conditions (Diseases of the genitourinary system)⁸
 - General acute care such as digestive system issues (e.g., Diseases of the digestive system)⁹
 - Mental Health
 - Lifestyle issues such as obesity and injuries / poisonings

⁷ Including conditions like arthritis (osteoarthritis, rheumatoid), back disorders (dorsopathies), bone diseases, connective tissue diseases (lupus, scleroderma), joint issues, fractures, sprains, and related procedures

⁸ Including a broad category of conditions affecting kidneys, bladder, ureters, urethra, and reproductive organs

⁹ Such as conditions from the mouth to the colon and pancreas, including esophagus, stomach, intestines, liver, and biliary tract issues

Community Demographic Profile

The Greater Manchester Region (GMR) CHNA service area includes a mixture of rural areas and urban/suburban areas such as East Hartford and Manchester. Life expectancy and several other demographic measures are near the state average.

Table 1: Greater Manchester Region CHNA Service Area Characteristics

The GMR service area includes slightly over 200,000 residents. Except for those living in East Hartford and Manchester, many residents live rural areas suggesting less proximity to healthcare resources.

- Life expectancy and median age are similar to the state average.

The service area is demographically diverse to the same degree as the state average.

- Black or African American residents of the service area comprise about 10 percent (10.1%) of the population – nearly the same as the state average (10.7%).
- Nearly one in six area residents are Hispanic (17.8% compared to the 17.4% state average).
- The percent of people not proficient in English is slightly lower in the GMR CHNA service area than the state average – 2.6% and 4.0%, respectively.
- The median age in the CHNA service area (and Connecticut) is about 40 years; however, there are notable differences based on race / ethnicity.

Measure	CHNA Area	State of CT
Population		
Total population	201,638	3,611,317
Life expectancy (years)	79.7	80.3
Age		
Under age 5 (%)	5.7%	5.1%
Over age 65 (%)	16.5%	17.4%
Median age	39.8	40.9
Race and Ethnicity		
Asian (%)	6.5%	4.7%
Black or African American (%)	10.1%	10.7%
White (%)	61.6%	63.0%
Hispanic (%)	17.8%	17.4%
Non-Hispanic (%)	82.2%	82.6%
Language and Birth Location		
Does not speak English well (%)	2.6%	4.0%
Born outside US (%)	13.6%	15.4%

Consistent with data throughout the state of Connecticut (and nationally¹⁰), Hispanic residents of the GMR CHNA service area are much younger (median age approximately 30 years) than the area average (i.e., 39.8 years); the variance compared to Whites (approximately 45 years) is even more notable.

Table 2: Median Age by Race-Ethnicity and Geography

	Asian		Black		White		Hispanic	
Location	Male	Female	Male	Female	Male	Female	Male	Female
State of CT	35.1	36.6	33.2	36.8	44.3	47.3	29.2	30.8
CHNA Area	32.0	39.0	39.0	38.0	43.0	48.0	26.0	30.0

- Statewide and in the CHNA service area, Whites are notably older than other racial or ethnic groups.
- Median ages for Asians, Blacks / African Americans, and Hispanics are approximately ten to 12 years younger than for Whites.



¹⁰ Median age of US Hispanics is 30.1 years compared to the overall median age of 38.5 years, according to the US Census Bureau.

People residing in the GMR CHNA service area tend to have household income similar to the state average, yet a lower percentage of are living in poverty.

Table 3: Health-related Socioeconomic Measures

CHNA Area vs. CT Statewide				
Measure	CHNA Area	State of CT	Point Variance	Percent Variance
Adults (over 25 years-old) with a high school level education (%)	29.3%	25.6%	3.8%	14.8%
Adults (over 25 years-old) with at least a bachelor's degree (%)	37.3%	41.9%	-4.7%	-11.2%
Employment rate, population aged 16 years-old and above (%)		94.1%	-94.1%	-100.0%
Households with earnings below the poverty level (%)	7.0%	9.9%	-2.9%	-29.3%
Median household income (\$)	\$95,775	\$93,760	\$2,015	2.2%
Uninsured children (%)	3.0%	2.9%	0.07%	2.6%
Uninsured adults (%)	4.4%	5.8%	-1.4%	-23.9%
Population insured through Medicaid (%)	23.2%	21.9%	1.3%	5.9%
Population living in areas with above median levels of social vulnerability (SVI) (%)	62.9%	48.6%	14.3	29.4%

- Notably fewer GMR CHNA service area residents have a Bachelor's Degree (37.3% compared to 41.9% for the state), and median household income is six percent (2.2%, or \$2,015) above the Connecticut average.
- Five of eight (62.9%) service area residents live in areas with above median levels of social vulnerability; nearly one of four (23.2%) are Medicaid insured.

Of the 14 health and chronic conditions included in Table 4, the percentage of GMR CHNA service area residents afflicted by the conditions is higher than the Connecticut state average in 13 of 14 instances.¹¹

Table 4: Health and Chronic Conditions (Hartford County)

Measure	CHNA Area vs. CT Statewide			
	CHNA Area	State of CT	Point Variance	Percent Variance
Cancer (excluding skin cancer) among adults (%)	6.7%	6.9%	-0.2	-2.9%
Coronary heart disease among adults (%)	5.7%	5.2%	0.5	9.6%
High blood pressure among adults (%)	33.2%	29.7%	3.5	11.8%
High cholesterol among adults (%)	33.7%	33.4%	0.3	0.9%
Stroke among adults (%)	3.0%	2.8%	0.2	7.1%
Depression among adults (%)	22.4%	20.9%	1.5	7.2%
Mental health not good for two weeks or more among adults (%)	16.2%	14.6%	1.6	11.0%
Diagnosed diabetes among adults (%)	11.3%	9.4%	1.9	20.2%
Chronic kidney disease among adults (%)	3.0%	2.8%	0.2	7.1%
Obesity among adults (%)	34.8%	30.2%	4.6	15.2%
Chronic obstructive pulmonary disease among adults (%)	5.9%	5.7%	0.2	3.5%
Current asthma among adults (%)	12.1%	11.1%	1.0	9.0%
Fair or poor self-rated health status among adults (%)	15.7%	13.3%	2.4	18.0%
Physical health not good for two weeks or more among adults (%)	10.8%	10.0%	0.8	8.0%

- Though similar to state averages, chronic health conditions and vulnerabilities in the GMR CHNA service area are noteworthy. Large numbers of residents require care for serious conditions. Note that these data represent Hartford County – an area that overlaps with the GMR service area yet includes the high-need city of Hartford (which the GMR service area does not).
- One in three adults (33.2%, or over 150,000 people) have high blood pressure; a similar percentage (33.7%) have high cholesterol.
- Notably higher than the state average, more than one in three (34.8%) are obese; more than one in nine (11.3%) have diabetes.
- CHNA service area, as well as US data, underscore the ongoing presence of chronic condition-related health needs.¹²

¹¹ Only available for Hartford County, not individual towns comprising the hospital service area.

¹² According to the Rand Corporation, approximately three of five (60%) people suffer from one or more chronic diseases such as asthma, cancer, diabetes, or heart disease. Three of seven (42%) suffer from two or more. Available at https://www.rand.org/pubs/articles/2017/chronic-conditions-in-america-price-and-prevalence.html?utm_source=chatgpt.com

Preventive health screening and substance use (i.e., tobacco and alcohol) in the GMR CHNA service¹³ area tend to be similar to the state averages.

Table 5: Lifestyle and Behaviors (Hartford County)

Measure	CHNA Area vs. CT Statewide			
	CHNA Area	State of CT	Point Variance	Percent Variance
Binge or heavy drinking (%)	16.2%	16.8%	-0.6	-3.6%
Current adult smokers (%)	12.4%	12.1%	0.3	2.5%
Fewer than 7 hours of sleep on average (%)	36.8%	35.9%	0.9	2.5%
No leisure time physical activity (% of adults)	24.6%	24.6%	0.0	0.0%
Taking medicine for high blood pressure control among adults with high blood pressure (%)	76.5%	75.8%	0.7	0.9%
Visits to dentist or dental clinic among adults (%)	70.1%	70.6%	-0.5	-0.7%
Visits to doctor for routine checkup within the past year among adults (%)	79.5%	78.4%	1.1	1.4%
Colorectal cancer screening among adult adults aged 21-65 years (%)	71.5%	71.5%	0.0	0.0%
Cholesterol screening among adults (%)	88.8%	88.4%	0.4	0.5%
Mammography use among women 50-74 years (%)	80.7%	79.1%	1.6	2.0%

- The percent of adult smokers in the CHNA service area is similar to the state average (14.4 and 13.9%, respectively).
- Reflecting adherence to medical advice, three of four (77.3%) GMR CHNA service area residents who have been diagnosed with hypertension (High blood pressure) take condition-associated medication.
- Notably higher than the state average, more than one in four service area adults (27.1%) have no leisure time physical activity – compared to the state average (22.7%).
- Cervical cancer, cholesterol, and breast cancer screening rates are all similar to the Connecticut average.

¹³ Only available for Hartford County, not individual towns comprising the hospital service area.

Cancer rates vary tremendously based on race and ethnicity. For example, cancer rates among Asians are approximately one-half the rates for Whites. However, GMR CHNA service area¹⁴ cancer rates are very similar to the state averages with the exception of prostate cancer which is approximately 25% higher in the Greater Manchester Region CHNA service area than the state average.

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

Age-Adjusted Incidence Rate per 100,000 Population, 2016-2020										
Cancer Type	All Races		Asian		Black		White		Hispanic	
	County	State	County	State	County	State	County	State	County	State
All Cancer Sites	459.8	458.2	218.3	232.3	445.4	445.8	473.2	467.8	420.0	418.5
Breast (Female)	142.3	138.5	71.7	83.1	139.7	129.0	149.8	143.6	120.2	119.6
Colon & Rectum	36.1	33.6	S	19.2	38.6	38.0	35.6	33.0	37.2	36.4
Lung & Bronchus	55.5	55.2	26.7	24.0	53.2	53.7	58.6	57.7	38.2	38.4
Prostate	130.7	107.6	53.3	48.2	201.7	190.8	123.5	118.3	119.2	107.6

Note: "S" indicates the data have been suppressed at the source to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category.

Source: statecancerprofiles.cancer.gov

- Prostate cancer rates in the CHNA service area (especially for Blacks / African Americans) is notably higher than the state average.
- Prostate cancer rates for Blacks/ African Americans are nearly twice as high as other races or ethnicities.
- Compared to the Connecticut state averages, Asians in the service area are diagnosed with cancer at a much lower rate – less than half of the “All Cancer Site” rates.
- Cancer rates among Whites are similar to the state average for most cancer sites.

¹⁴ Only available for Hartford County, not individual towns comprising the hospital service area.

Mortality and Morbidity

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

Similarly, morbidity data — such as rates of hospitalizations, emergency department visits, and diagnoses of chronic or acute illnesses — offers a snapshot of the ongoing health burdens that affect residents' quality of life.

This information highlights not only what conditions are most common, but also where gaps in preventive care, access to primary care, or health education may exist. Understanding patterns of illness and injury can guide the development of community health programs, outreach initiatives, and healthcare services aimed at reducing preventable hospitalizations and improving overall health outcomes.



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

Hartford County has mortality rates similar to the Connecticut average for most chronic conditions.

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

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

- For three of the six most common causes of death (e.g., cancer, cerebrovascular disease and Alzheimer's disease), Hartford County rates are similar to state rates.
- For heart disease, accidents, and CLRD rates are slightly higher than Connecticut rates.

Note: Most of the GMR service area is in Hartford County. However, Hartford County includes the city of Hartford (which is not part of the GMR service area) which may tend to skew some data points when considering the GMR service area.

Table 8: Mortality Rates per 100,000 Population by County, Part 2 of 2 (Causes of death ranked seven through 13)

The following conditions are also among the most common – ranked seven through 13 – causes of death in the hospital CHNA service area. Again, Hartford County rates of death per 100,000 population tend to be similar to state averages.

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

- The Hartford County diabetes mortality rate is approximately 8% higher than the Connecticut average rate.
- The Connecticut mortality rate for each condition on the table above is lower (or near) the US rates.

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

The following CHIME-based¹⁵ hospital data represent the count of patients who had at least one hospital encounter (based on discharge data), in either the Inpatient, Emergency Department, or Observation service settings, with a principal diagnosis that matches one of the ICD-10-CM codes associated with the given condition or health indicator.¹⁶ The data also allows the comparison of hospital CHNA service area data to the Connecticut state average. When doing so, important differences sometimes arise.¹⁷



¹⁵ ChimeData, provided by the Connecticut Hospital Association, is a robust data and analytics resource that offers hospital and healthcare utilization data across the state. It features interactive tools that support analysis of key health issues impacting the hospital service area. In addition, ChimeData also enhances hospitals' ability to measure an area's health trends against statewide benchmarks.

¹⁶ A more complete and extensive description is found in the Appendices, and the ICD-10 codes associated with each health indicator are also all listed in the appendices.

¹⁷ All hospitals in the CHNA service area, not only GMR.

For the Greater Manchester Region CHNA Service Area, hospitalizations for heart failure and mental health and substance-related disorders, diabetes, and coronary artery disease are notably higher than the state rate. However, hospitalization for respiratory conditions (as well as sepsis) tend to be similar to, or lower than, the state rates.¹⁸

Greater Manchester Region			
Health Indicator	Utilization by Year		Change
	2024 (ending 9/30/2024)	2025 (ending 9/30/25)	
Diseases of the circulatory system	13.7%	13.9%	0.2%
Diseases of the musculoskeletal system and connective tissue	10.0%	9.9%	-0.2%
Diseases of the digestive system	10.1%	9.5%	-0.6%
Injury and poisoning	7.3%	8.2%	0.9%
Diseases of the genitourinary system	8.7%	8.2%	-0.5%
Diseases of the nervous system and sense organs	7.8%	8.0%	0.2%
Neoplasms	8.8%	7.8%	-0.9%
Mental Illness	5.8%	5.9%	0.0%
Complications of pregnancy; childbirth; and the puerperium	4.7%	4.5%	-0.1%
Endocrine; nutritional; and metabolic diseases and immunity disorders	4.0%	4.4%	0.4%
Diseases of the respiratory system	4.0%	3.7%	-0.3%
Infectious and parasitic diseases	3.4%	3.1%	-0.3%
Diseases of the skin and subcutaneous tissue	1.5%	2.8%	1.3%
Diseases of the blood and blood-forming organs	1.1%	1.0%	-0.2%
Others	9.0%	9.1%	0.1%

- Cardiovascular and Metabolic Conditions Remain High and Increasing
 - Diseases of the circulatory system represent the largest share of hospital utilization (13.7% in FY2024 to 13.9% in FY2025), aligning with CHNA findings that heart failure and coronary artery disease hospitalization rates exceed the state average.

¹⁸ Note that additional data tables are contained in the appendices. MS-DRG stands for Medicare Severity Diagnosis Related Group which is a classification system used by the Centers for Medicare & Medicaid Services (CMS) to group inpatient hospital cases for the purpose of determining hospital payments.

- Endocrine, nutritional, and metabolic diseases (including diabetes) also increased slightly from 4.0% in FY2024 to 4.4% in FY2025, further highlighting the continued cardiac-related conditions in the service area.
- Behavioral Health Utilization Remains Elevated
 - Mental illness-related hospitalizations remained steady at 5.8% to 5.9%, consistent with CHNA findings that mental health and substance-related disorder hospitalization rates are notably higher than state benchmarks.
- Respiratory and Infectious Conditions Stable or Declining
 - Diseases of the respiratory system and infectious/parasitic diseases declined slightly (as a percent of utilization) from FY2024 to FY2025 – consistent with observations that respiratory-related hospitalizations are similar to or lower than state rates.

Maternal Health

Maternal health remains a critical indicator of a health system's overall performance, reflecting access to quality care during pregnancy, childbirth, and the postpartum period. Nationally, the maternal mortality rate has fluctuated in recent years, with a slight decrease from 22.3 deaths per 100,000 live births in 2022 to 18.6 in 2023. However, stark disparities persist across racial and age groups. In 2022, non-Hispanic Black women experienced a maternal mortality rate of 49.5—more than twice the rate of their White counterparts. Additionally, maternal deaths among women aged 40 and older were significantly higher (87.1 per 100,000 live births) compared to younger women. Mental health conditions, cardiovascular disorders, and hypertensive complications continue to be leading causes of maternal mortality, underscoring the need for comprehensive, interdisciplinary care models that integrate mental and physical health services.¹⁹

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

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

¹⁹ As noted earlier, most of the GMR service area is in Hartford County. However, Hartford County includes the city of Hartford (which is not part of the GMR service area) which may tend to skew some data points when considering the GMR service area.

Life Expectancy

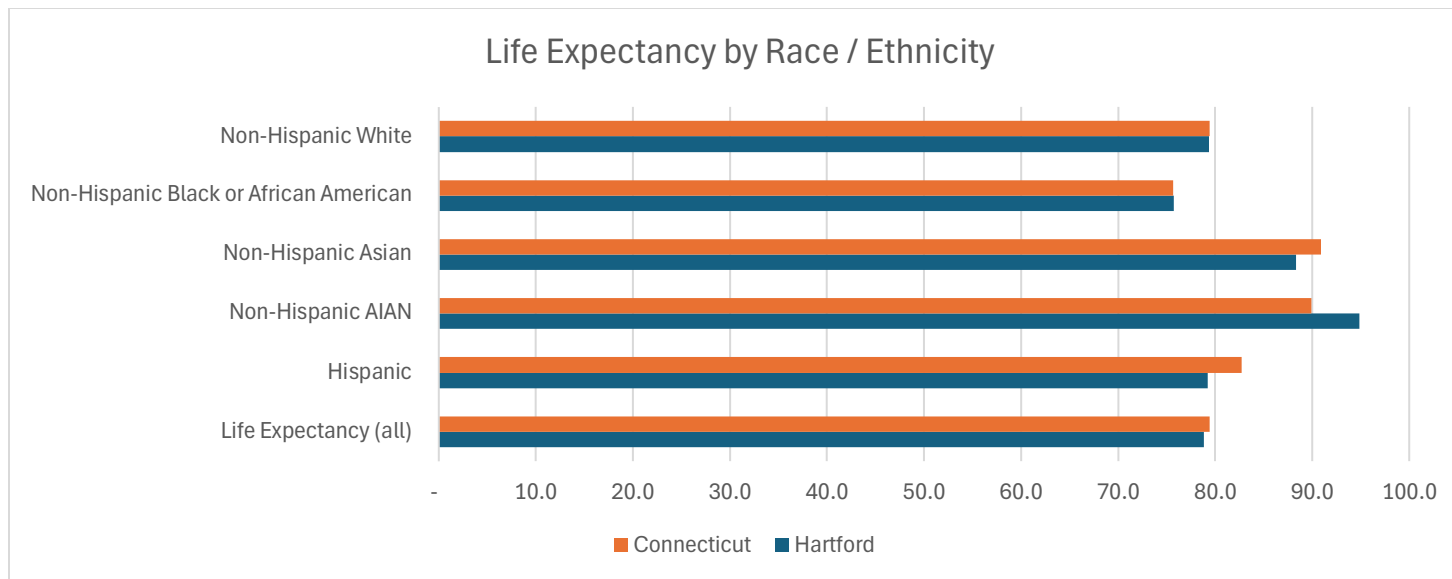
Life expectancy is a foundational indicator in community health needs assessments because it encapsulates the cumulative impact of various health, social, and economic conditions over a population's lifespan. It reflects not only the prevalence of chronic diseases and behavioral risk factors, but also broader determinants such as access to care, education, income, and environmental quality. A lower life expectancy (as seen in Hartford County compared to the state average) signals concerns about health challenges that may be targeted by public health strategies. Incorporating life expectancy data into a community health assessment helps identify priority populations, set benchmarks for improvement, and guide resource allocation to the areas most in need.²⁰

Life expectancy in Hartford County is 78.8 years, which is below the Connecticut average of 79.6 years but closely mirrors the national average.²¹ This figure reflects a range of health challenges, including higher rates of premature death and poor physical and mental health. Hartford County's premature death rate—measured as years of potential life lost before age 75—stands at 6,900 per 100,000, slightly above Connecticut's 6,500. Indicators such as 13% of residents reporting poor or fair health, 3.3 poor physical health days per month, and 5.0 poor mental health days underscore chronic health burdens in the community. These statistics point to a need for stronger chronic disease management, mental health support, and access to quality healthcare.

Behavioral health risks and healthcare access issues further compound the county's life expectancy concerns. Smoking (13%) and obesity (33%) rates are similar to both state and national averages, while access to exercise opportunities (96%) is higher than the Connecticut average (93%). Healthcare provider availability in Hartford County is better than the state average with Hartford County's primary care ratio at 1,050:1 – better than the state ratio of 1,210:1. The physician ratios are most helpful when access to providers (e.g., affordability, office location, hours of operation, language and services available, etc.) is strong. Without adequate access to care, barriers limit preventive care uptake and delay treatment for chronic conditions – regardless of provider status. HRSN such as higher child poverty (14%) and lower educational attainment also contribute to health disparities.

²⁰ Ibid.

²¹ Note: An early (2015) collaborative project ("U.S. Small-area Life Expectancy Estimates Project") was conducted by the National Center for Health Statistics (NCHS), the National Association for Public Health Statistics and Information Systems (NAPHSIS), and the Robert Wood Johnson Foundation (RWJF). The results showed that the life expectancy in two core MMA service area ZIP Codes were four to five years lower than the Hartford County Average: Hartford County, 78.8 years; ZIP 06120, approximately 75 years; 06125, approximately 74 years.



Additional narrative and data regarding life expectancy is included in the appendices.²²

²² Ibid.

Health-related Social Needs and Predictive Analytics

To better understand the health risks and urgent priorities in the Hospital Service Area (HSA), including those risks linked to social needs, predictive analytics were used to compare actual health outcomes with expected health outcomes given the characteristics of the HSA. The comparison evaluates community health performance discrepancies between actual and expected, pinpoints key drivers of health outcomes, and guides resource priorities and intervention selection.

Core findings at the Hartford and Tolland County levels included the following:

- Hartford County shows consistently elevated risk levels higher than expected across several domains, particularly in cardiovascular health.
- Hartford County's observed rates for Heart Failure and Total Cardiovascular Risk are significantly higher than expected suggesting local socioeconomic factors are driving adverse outcomes.
- Tolland County's prevalence of Low Birth Weight and Preterm Birth risks is slightly higher than expected even within the county's otherwise favorable overall standing.
- Adverse health outcomes in both Counties related to diabetes, cardiovascular health, and maternal/infant health were consistently correlated with identifiable, local, socioeconomic factors.
- Key local socioeconomic factors recurrent in this analysis across the HSA include economic stress related to high SNAP utilization and high housing cost burden and lower educational attainment, which are significantly associated with reduced longevity and increased cardiovascular/maternal risk.
- In addition, smoking behaviors were found to be impactful factors driving risk and significantly contributing to reduced life expectancy.

Further analysis focused on two high-priority census tracts within the HSA where compelling social vulnerabilities (census tracts 5302 in Vernon and 5147 in Manchester) were present. The goal of this section of the analysis was to further pinpoint socioeconomic and behavioral factors driving vulnerabilities and to identify the most influential predictors of risk – better informing selection of targeted interventions.

The additional modeling identified the following factors as the most powerful predictors of vulnerability across these two geographies and selected interventions should target these local factors:

- **Economic Barriers:** High rates of residents living below 150% of the poverty level, lack of a high school diploma, and high housing cost burdens.
- **Household Stressors:** A high prevalence of single-parent households and residents living with disabilities.
- **Systemic Barriers:** Minority status and limited English proficiency, which often serve as gateways to broader social risk.
- **Mobility Gaps:** A critical lack of personal vehicle access, which can be a leading physical barrier to healthcare utilization.

More specifically, the analysis revealed that while both census tracts are high-need areas, the *nature* of their risk profiles requires fundamentally different strategies:

Census Tract 5147 (Location – Manchester, Hartford Road, Pine Street and Spruce Street): Census Tract 5147 is impacted by multiple compounding factors (i.e., not a single or dominant one); particularly, it was found to be most highly impacted by housing and transportation factors. Further, the gap between expected and actual outcomes suggests existing community resources are insufficient to keep pace with these compounding factors. The analysis also suggests that the Census Tract lacks social safety nets for single parents and residents living with disabilities, and a need for greater investment in health navigation and home-based support services.

Census Tract 5302 (Location-Vernon, Union Street, Elm Street, and South and West Streets): Census Tract 5302 contains wide gaps between expected and actual risk specifically for housing and transportation factors. While the tract would expect to be medium risk overall (based on characteristics of the HSA), actual health outcomes indicate that residents are experiencing significant health challenges. The analysis suggests a less-resilient community, where even a small concentration of risk factors can lead to disproportionately negative community health outcomes. Findings also suggest a “transportation desert” with funding for non-emergency medical transportation or localized “micro-clinics” as having the highest ROI opportunity for improving health outcomes.

Qualitative Research Highlights

Qualitative research was conducted to gain a deeper understanding of the healthcare challenges and opportunities facing the communities we serve. Qualitative research consisted of two components

1. Key Stakeholder / Community Interviews (15)
2. Focus Group Discussions (5)

The interviews were conducted with hospital leaders and external community partners. Focus group discussions also provided unique insight to the area's perceived health-related strengths and challenges. Together the interviews and group discussions provided valuable insights into the experiences, concerns, and priorities of healthcare professionals, administrators, and community leaders, all of whom play a crucial role in ensuring equitable access to healthcare services.

Both qualitative research components independently highlight similar critical challenges in addressing the health. In broad categories the challenges include limited access to healthcare services, socio-economic factors (e.g., housing, poverty, access to healthful food, etc.), preventive care and wellness, and other themes. More granular details from the qualitative research follow.

Key Stakeholder / Community Interviews

The following sub-section summarizes key insights from several Key Informant / Community Interviews conducted across Manchester, Vernon, Andover, and surrounding communities. The interviews explored local conditions, unmet needs, health system performance, barriers to care, and community priorities. The prospective acquisition of Greater Manchester Region (GMR) by Hartford HealthCare (HHC) was a backdrop for many responses, and several stakeholders referenced it explicitly when describing hopes for improved access, capacity, and service quality. Qualitative research identified the following four major health-related themes shown below including details regarding select, specific health challenges:

Interviews identified the following five major health-related themes shown below, including lists of select, specific health challenges:

Major Themes

1. Access to Care Has Many Interconnected Barriers and Impacts Most Residents

Access to care was consistently described as a foundational issue affecting nearly every population group. For example, even with insurance, healthcare (especially preventive care) the cost of care can be prohibitive. Low wages and rising prices were described as major stressors, limiting access to healthcare, nutritious food, safe housing, childcare, and opportunities for healthy living. Young adults, working families, and seniors feel these pressures most acutely. Other select granular challenges include the following:

- a. Coordination of care across hospitals, FQHCs, behavioral health providers, and community-based organizations is limited and fragmented
- b. Cost of care and insurance coverage remain significant barriers for low-income and working families
- c. Limited provider availability, particularly in primary care, women’s health, mental health, and substance use treatment
- d. Transportation barriers, especially for seniors, low-income residents, and those without reliable vehicles
- e. Language barriers and inadequate interpretation services, particularly for Spanish-speaking and immigrant populations
- f. Limited health literacy and difficulty navigating the healthcare system
- g. Cultural competency gaps that hinder trust and effective care delivery
- h. Need for stronger hospital-based outreach and a more welcoming, community-centered hospital presence

2. Behavioral Health and Substance Use Disorder Are the Most Urgent and Evolving Needs

Mental health and substance use disorder were universally identified as the most critical and rapidly growing challenges. Specific needs include the following:

- a. Severe shortages in outpatient behavioral health and SUD treatment capacity
- b. Lack of inpatient and crisis mental health services
- c. Primary reliance on CHR for crisis services, with limited alternatives
- d. SUD frequently cited as the “number one issue” affecting all other aspects of health
- e. Growing need for youth mental health services
- f. Nearly nonexistent mental health services for seniors
- g. Persistent stigma that limits help-seeking behavior
- h. Need for more integrated physical and behavioral healthcare

Note: Several research participants stated that if someone presents at the hospital with SUD or acute mental health needs, they must be referred to CHR,²³ the region’s FQHC behavioral health provider—because most facilities lack proper crisis, detox, or inpatient capabilities.

²³ CHR is a Certified Community Behavioral Health Clinic (CCBHC). CCBHCs were established by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to help meet the unique needs of individuals with serious mental illness and addictions. They provide access to 24/7 crisis services, and an integrated care model to assess behavioral and physical healthcare services.

3. Health-Related Social Needs (HRSN) and Economic Stability Drive Health Outcomes

Respondents consistently noted that social and economic factors are the true drivers of health in the region. For example, housing emerged as one of the most pressing issues. Roughly 40% of families struggle to make ends meet (i.e., meet ALICE²⁴ qualifications), with housing instability affecting both individuals and families. Stakeholders repeatedly emphasized that “everything else comes from having safe, quality, affordable shelter.” Builders lack incentives to develop affordable homes, contributing to shortages that push vulnerable groups into precarious situations. Some specific community-based health-related needs include the following:

- a. Affordable, safe, and stable housing is the most frequently cited unmet need
- b. Rising rates of housing instability and homelessness
- c. Builders not incentivized to create affordable housing
- d. Food insecurity is widespread despite the presence of food pantries
- e. Limited access to healthy, affordable food
- f. Economic stress from low wages and high cost of living
- g. Transportation challenges affecting access to healthcare, food, and social services
- h. Environmental health risks in older housing stock (e.g., lead paint, unsafe conditions)

4. Seniors and Other Vulnerable Populations Face Growing Service Gaps

Older adults and other high-risk populations were repeatedly identified as underserved. Seniors are much more likely to face transportation barriers than others. For example, Vernon has some transit resources, but they are insufficient. Aging adults, low-income residents, and individuals without cars experience difficulty reaching primary care, behavioral health services, and specialty providers, as well as grocery stores and other basic living resources. Granular service gaps noted in the research include the following:

- a. Limited access to primary care and specialty services for seniors
- b. High levels of social isolation among older adults
- c. Lack of senior-specific mental health services
- d. Transportation barriers that disproportionately affect seniors
- e. Chronic disease management challenges
- f. Limited in-home support and community-based care resources
- g. Vulnerable immigrant populations avoiding care due to language barriers and immigration concerns

²⁴ Asset Limited, Income Constrained, [and] Employed.

5. Prevention, Wellness, and Community Health Infrastructure Need Strengthening

Stakeholders emphasized that improving long-term health requires better access to basic needs (e.g., food), stronger prevention, and more comprehensive wellness efforts. For example, food insecurity remains widespread. While food pantries exist, many “do not have enough healthy food to keep people healthy and away from the doctor,” and residents often lack transportation to obtain nutritious options. Some positive efforts are underway such as Vernon’s program to double SNAP benefits and provide transportation to farmers’ markets, but the need is significantly greater than existing capacity. Some other specific examples of needs include the following:

- a. Limited access to preventive screenings and wellness services
- b. Need for stronger nutrition and physical activity infrastructure
- c. Food pantries often lack healthful food options
- d. Strong interest in mobile health services, especially for seniors
- e. Support for farmers markets, double SNAP benefits, and food access programs
- f. Need for greater coordination among municipalities, hospitals, and community organizations
- g. Concern that Connecticut’s town-based governance limits regional service coordination
- h. Desire for the hospital to play a larger leadership role in community health strategy

Additional Insight from the Interviews

Qualitative research participants also commented on a few additional topics. Note the following.

Perceptions of progress since the previous CHNA

- The previous CHNA identified five major priorities. Interviewees largely affirmed their relevance but broadly noted that the list ignores health-related social needs – a significant oversight.
- Top Priorities Still Relevant
 - Mental Health & Substance Use Disorder – universally cited as the number one concern, impacting all aspects of community functioning
 - Access to Care – difficulties with transportation, provider shortages, language access, and care coordination
 - Diabetes, Nutrition & Physical Activity – still high, particularly among vulnerable populations
 - Seniors’ needs—especially social isolation, chronic disease management, and mental health—are growing rapidly and were identified as an emerging priority.
 - Food security remains a major gap.

- Some respondents felt prior priorities “missed the mark” because they did not reflect what community members experience daily in their neighborhoods.
- A repeated message was that true community health requires trust, which requires direct presence, outreach, and culturally responsive care from hospitals and health systems.

Cultural, Racial, and Ethnic Barriers

Building a more inclusive, welcoming, and accessible healthcare environment was described as essential. Cultural competency must be a foundational strategic element to improve health and access. Stakeholders described multiple ways in which cultural and immigrant communities face barriers:

- Language access is insufficient, including at hospitals, community organizations, and service locations.
- Immigrants may avoid care due to immigration status fears, mistrust, or limited understanding of how the health system works.
- Environmental risks such as lead paint and poor housing conditions disproportionately affect lower-income and minority neighborhoods.
- Respondents were not aware of significant hospital-led outreach to reduce disparities, noting that hospitals “haven’t done much to combat the issue.”

Vision for a Healthy Community (Looking Toward 2028)

Some research participants shared their hope that the potential link with Hartford HealthCare could bring the level of coordination and integration that the GMR area’s current health care system often lacks. Across interviews, a healthy 2028 community would include:

- Robust primary care access, especially for women, seniors, and low-income residents
- A strong, coordinated behavioral health network with crisis services, outpatient care, and integrated SUD treatment
- Effective health literacy and community education
- Housing stability as a foundational condition
- Reduced competition and improved collaboration among health and human service providers
- Culturally informed outreach, including Spanish-language and other needed services
- A more welcoming, accessible, and trusted hospital system

Interview Summary

The interviews reveal a community experiencing significant demographic change, economic strain, and evolving health needs—most urgently in mental health, substance use, health-related social needs (e.g., affordable, quality food; housing stability; higher income and/or better employment options) , and access to equitable care. Many residents and stakeholders are supportive of a potential Hartford HealthCare acquisition of Manchester Memorial Hospital but express clear expectations: increased capacity, stronger outreach, culturally competent care, and system-wide integration that addresses real social determinants of health.

Focus Group Discussions

Background and Methodology

To strengthen the Community Health Needs Assessment (CHNA) for the Manchester and Vernon region, Hartford HealthCare partnered with DataHaven and several community organizations to conduct a series of community focus groups between December 8, 2025 and January 30, 2026. The purpose of these sessions was to gather first-hand perspectives from residents, service providers, educators, business leaders, and other stakeholders regarding the most pressing health-related challenges and opportunities facing the community.

Five in-person focus groups were hosted by local partners, engaging approximately 60 participants representing seniors; public health; social service agencies; food bank clients, staff, and volunteers; Manchester Public Schools; the Chamber of Commerce; and, the broader public. Participants reflected a diverse cross-section of the region in age, race/ethnicity, gender, and professional background. Each 90-minute session was facilitated by DataHaven staff, with detailed notes recorded to capture direct quotations, emotional tone, and areas of group consensus.

DataHaven conducted a rigorous, multi-phase qualitative analysis. Over 250 individual comments were coded into dozens of open categories, then organized into a comprehensive codebook of sub-themes. These were clustered into overarching topics of community needs and assets. Some of the category, theme, and sub-theme wording was drafted to be consistent with that included in the interviews (for easier comparison and review).

Topline Priorities

The most common priorities noted in the focus group discussions include the following:

1. Access to care (i.e., high-quality, affordable health, cultural competency) for all with special focus for children and youth
2. Health-Related Social Needs (HRSN) and Economic Stability
 - a. Affordable, stable housing
 - b. Food security and healthy food access
 - c. Transportation
 - d. Social support
 - e. Employment and job quality
3. Prevention, Wellness, and Community Health Infrastructure especially access to information and education
4. Behavioral Health and Substance Use Disorder

Special Observation:

Access to high-quality, affordable health care emerged as the most frequently cited concern, representing 35% of all coded discussion themes—nearly three times higher than the next most commonly identified issue. The magnitude of this difference highlights concerns about provider availability, quality of care, cost barriers, and continuity of services are central to how residents and stakeholders define community well-being in the Manchester area.

Major Themes from Focus Groups

The following section provides additional details about the “Topline Priorities” noted above.

1. Access to Care for All—with Special Focus on Children and Youth

Participants consistently described access to high-quality, affordable, and culturally responsive healthcare as the foundation of community well-being. Concerns centered on whether Manchester-area residents will continue to have reliable local access to specialists, emergency services, and timely appointments. Many participants reported experiences with long emergency department waits, rushed office visits, and difficulty reaching providers by phone. Additionally, several noted severe provider shortages, including long waits for a wellness visit. Several participants described a pattern of provider turnover at clinics that disrupts continuity of care, leaving patients unknown to their doctors at each visit. The cost of care—particularly copays and deductibles—was repeatedly cited as a barrier that prevents families from seeking preventive and specialty services even when they are insured. Language barriers, limited interpretation services, and gaps in cultural competency were also identified as obstacles that undermine trust and effective care.

Families with children and youth were viewed as especially vulnerable. Parents described long waitlists for autism evaluations, limited developmental services after age 21, and difficulty finding providers willing to accept Medicaid. Participants advocated for more child-centered and family-friendly systems, including co-located services where children could receive medical, dental, behavioral health, and social supports in one setting. Many emphasized that a welcoming, community-centered hospital presence—one that communicates clearly, invests in outreach, and reflects the cultural diversity of the region—would be essential to rebuilding confidence in local care. Several participants also noted the need for additional Early Childhood Education programs.

The quality of care also registered with focus group participants. In addition to receiving excellent care from well-trained providers, quality of care was linked to various service aspects. Currently, some participants noted challenges around the limited range of insurances accepted, referral delays, difficulty reaching providers by phone, and time-consuming cancellation processes.

Community Assets: Urgent care centers, community health centers, and established primary care relationships were recognized as strengths. Hartford HealthCare’s partnership with Quinnipiac University to train nurses locally was seen as a promising investment in future workforce capacity.

2. Health-Related Social Needs (HRSN) and Economic Stability

Across all focus groups, residents linked health outcomes directly to housing, food, transportation, employment, and social connection.

Affordable and stable housing emerged as one of the more urgent non-medical needs. Participants described rents that exceed mortgage costs, multi-year waitlists for housing assistance, and the lack of affordable units for families, particularly single mothers. Housing instability was said to trigger a cascade of challenges affecting mental health, nutrition, school attendance, and the ability to maintain employment.

Food security and access to healthy food were also major concerns. Food pantry usage was said to have risen sharply, and while nutritious options exist, affordability is perceived as a central barrier. Participants emphasized the need for both financial assistance and practical education about healthy eating. *Transportation* limitations—especially for seniors, low-income households, and those without vehicles—were described as a daily barrier to healthcare appointments, employment, and grocery access. *Social support* was recognized as a protective factor, yet many residents experience isolation, particularly older adults and families under economic strain. Finally, *employment and job quality* shape nearly every aspect of health; low wages and high living costs leave working families unable to meet basic needs.

Community Assets: HVCC's food pantry and wraparound services, dial-a-ride programs, senior centers, and local assistance agencies were widely praised, though participants noted that demand far exceeds current capacity.

3. Prevention, Wellness, and Community Health Infrastructure

Participants expressed a strong desire to shift from crisis-driven care to prevention and wellness. Many felt that information about local services is fragmented and difficult to navigate, leaving residents unsure where to turn. Calls for better *access to information and education* were consistent: clearer communication about available specialists, school-based health education, nutrition and physical activity programming, and outreach to underserved neighborhoods.

Residents envisioned a more coordinated infrastructure in which hospitals, schools, municipalities, and community organizations work together rather than in silos. Suggestions included mobile health services for seniors, expanded SNAP-incentive programs, and stronger partnerships with trusted community hubs such as senior centers and schools. Participants emphasized that improving long-term health will require investments in prevention, health literacy, and easy-to-use entry points for care.

Community Assets: Existing education programs, farmers markets with SNAP incentives, and the trusted role of schools and senior centers provide a foundation on which to build a more integrated wellness strategy.

4. Behavioral Health and Substance Use Disorder

Mental health and substance use disorder were described as the most urgent and evolving challenges facing the region. Participants noted a shortage of outpatient treatment, limited crisis options in the region, and particular gaps for children and adolescents. Stigma remains a significant barrier, and the mental health effects of housing insecurity and financial stress were evident throughout discussions.

Parents and educators highlighted the need for youth counseling, mentorship, and restorative approaches rather than punitive responses. Adults with developmental disabilities who do not have an autism diagnosis were viewed as especially underserved. Participants called for greater integration of behavioral and physical healthcare, expanded provider training, and services that are accessible regardless of ability to pay.

Community Assets: HVCC's adult mental health clinic and existing autism programs were valued resources, though residents stressed that these must be expanded and better connected to hospital services.

Focus Group Discussion Summary

Together, these four themes reveal a community that views health through a broad lens—one that includes medical care, stable housing, nutritious food, transportation, economic opportunity, and emotional well-being. Participants expressed optimism that Hartford HealthCare's engagement could strengthen local systems, but they emphasized that success will depend on *accessible, culturally competent care, genuine community partnership, and coordinated action across health and social sectors*.

Qualitative Research: Aggregated Summary

Qualitative research for the GMR CHNA included Key Stakeholder/Community Interviews and Focus Group Discussions, providing complementary perspectives from healthcare leaders, service providers, educators, business representatives, and residents. Although the two methods were conducted independently, they revealed strongly overlapping priorities and a consistent picture of community need. Both interviews and focus groups identified four overlapping themes as the most urgent and rapidly growing challenges.

1. Access to high-quality, affordable, and culturally competent care—especially for children and youth.
2. Health-related social needs and economic stability (e.g., particularly housing affordability, food security, transportation, social support, and job quality).
3. Prevention, wellness, and community health infrastructure (including access to information and health education).
4. Behavioral health and substance use disorders.

Across both data sources, participants described a community in which medical care is intertwined with daily living conditions. Rising housing costs, increasing food pantry use, transportation barriers, and low wages were repeatedly linked to delayed care, worsening chronic disease, and mental health stress. Stakeholders from both interviews and focus groups expressed concern about provider shortages, fragmented systems, language and cultural barriers, and limited crisis behavioral health capacity. At the same time, participants highlighted important community assets—including community health centers, HVCC programs, senior centers, and school partnerships—and voiced cautious optimism that Hartford HealthCare’s involvement could strengthen coordination, expand services, and rebuild trust. Collectively, the qualitative findings provide a unified perspective that supports thoughtful consideration of integrated medical and social care, stronger behavioral health capacity, child- and family-centered services, and prevention-oriented community partnerships to improve health equity across Manchester and Vernon.

Community Wellbeing Survey and Other Research

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

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

The resulting data was categorized and analyzed by hospital service area. Highlights of the 2024 Wellbeing Survey for the Greater Manchester Region service area are shown below. Note also that a more longitudinal study (i.e., 2015-2024) was available. Where helpful, additional insights from that work are included.

Chronic Disease

The Chronic disease section of the Wellbeing Survey focused on hypertension, diabetes, heart disease (two measures) and asthma. Survey results showed that the GMR service area consistently showed unfavorable incidence rates compared to the state average for all listed chronic diseases.

When examining chronic disease among specific communities within the hospital service area (as opposed to comparison to state averages), the incidence of diabetes, hypertension, asthma, and heart disease (heart attack) were notably higher among high lower income groups (under \$30,000 per year) compared than those with higher income levels above \$100,000 per year.

Note that given the income differences among racial and ethnic minorities, Hispanic and Black or African American communities are notably more vulnerable to chronic health conditions, health risks, healthcare access, housing and financial wellbeing, and other issues



Have you ever been told by a doctor or health professional that you have any of the following?				
	Connecticut	CHNA Service Area	CHNA Service Area Income Under \$30,000	CHNA Service Area Income Over \$100,000
High blood pressure or hypertension	31%	36%	44%	30%
Diabetes	11%	12%	19%	8%
A heart attack also called myocardial infarction	3%	5%	NA	NA
Angina or coronary heart disease	4%	5%	NA	NA
Asthma	16%	20%	26%	15%

** From the more longitudinal 2015-2024 Wellbeing Survey

Community Satisfaction

Based on the 2024 Wellbeing Survey, community satisfaction refers to impressions that may impact quality of life and lifestyle, such as overall satisfaction with the town where you live, opinions about whether you live in a place good to raise children, local greens spaces or parks being in good condition, and a responsive local government. The 2024 survey data shows that five of six Connecticut residents (82%) are satisfied with their town; slightly more (84%) in the hospital service area believe so. Additionally, though, people with household incomes under \$30,000 tend to be less satisfied with each of the Community Satisfaction measures. One of the larger variances is that two of five hospital service area residents (81%) with incomes over \$100,000 believe that where they live is a good or excellent place to raise kids while notably fewer (52%) of others with income under \$30,000 believe that to be true.



Health risks

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

Wellbeing survey results highlight several health risks among adults in the GMR service area, with disparities evident by income level. Overall, slightly over half (51%) of adults in the service area rated their health as excellent or very good, similar to the statewide average (53%). This figure drops to 32% among those with incomes under \$30,000, while rising notably to 49% among higher-income residents, reflecting a notable income-based disparity in perceived health. However, this may well also be correlated with age, as older respondents tend to face more health challenges than younger ones.

Rates of no leisure-time exercise are relatively similar across groups, with 18% of all adults in the hospital area reporting no such activity. The rate is much higher (26% among people with income under \$30,000 – notably higher than among people with income over \$100,000 (13%). Asthma prevalence is somewhat higher in the service area (23%) compared to the state (18%), and notably, there is little variance based on income levels.



Healthcare access

Healthcare Access refers to community members who (1) have health insurance and, (2) have a medical home (a doctor, clinic, or other provider where they commonly seek – or could seek – medical care). The survey showed that most adults in the hospital service area (92%) have access to health insurance (equal to the statewide average). However, there is a notable difference among households with income under \$30,000 (79%) and those with income over \$100,000 (98%). Note, too, that among lower income households in the CHNA service area, one in four (24%) did not receive needed medical care in 2024 – largely due to financial issues and access challenges. Among higher income households, only one percent (1%) did not get needed care.



Housing and financial wellbeing

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

Overall, well over half (64%) of residents report owning a home or living with a homeowner – equal to the statewide average (65%). Financial strain is also more pronounced among lower-income individuals, with three of four (75%) reporting they are “just getting by financially” (or worse) compared to only 26% of higher-income residents. While homeownership is relatively high in the hospital service area, a notable portion of lower-income residents continue to face financial and housing-related vulnerabilities that could negatively impact overall well-being.



Survey results show that two of five CHNA service area residents (39%) say that they are financially worse in 2024 than 2023 – well above the Connecticut average (27%).

Mental health

Mental health – or, feelings of being anxious or depressed – impact overall health and the ability to enjoy a quality lifestyle. In the hospital service area, one in three (36%) of survey respondents say that they feel at least somewhat anxious while two of five (40%) feel down or depressed at least several days per month— both rates are slightly higher than the Connecticut state averages of 36% and 36%, respectively. Income significantly impacts the outcomes, as only about 32% of respondents with annual income over \$100,000 say that they are depressed while much higher percentages of survey respondents with income under \$30,000 are depressed (70%).



Nutritional Security

Food insecurity means being unsure of being able to acquire healthful, nutritional food for yourself and family members. In the hospital service area, more than one of four survey respondents (23%) – and two of five (41%) of those with annual income under \$30,000 – experienced food insecurity within the past 12 months. As with most other measures reflected in the survey, higher annual income highly correlates with easier access to health and well-being.



Transportation

Reliable transportation is one of the fundamental components of being able to access health services as well as other resources impacting the quality of life. In the hospital service area, most people (83%) have access to reliable transportation – about the same as the state average (85%). However, about one-third of those who did not have reliable transportation (33%) said that at some point within the past year they were not able to get to needed health services.



Wellbeing and support

As with many other survey-included measures, feeling satisfied with life and receiving social and emotional support are highly correlated with income; however, higher income is no guaranty of positive outcomes. Households with lower income also tend to be less likely to get needed social or emotional support, as two of five (54%) only “sometimes” or less frequently get needed support compared to only 25% among higher income households. Survey results support the idea that higher income positively impacts perceptions and access to healthy options, yet it is no guaranty.



Data Analysis and Community Input Summary

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

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

- Affordable and Accessible Healthcare
- Affordable Housing
- Chronic Disease Prevention
- Maternal and Child Health Services
- Mental and Behavioral Health
- Nutrition and Food Security
- Primary Care Access
- Services for Seniors
- Transportation Access
- STI and sexual health programming [Note: STI rates in Hartford County are 509 per 100,000 – 25% higher than the Connecticut state rate of 409 per 100,000]
- Culturally responsive care and language / translation service



“What have we already accomplished or initiated?”

Evaluation of 2019 Community Health Needs Assessment and Subsequent Initiatives

Summary

As a guide to developing the 2025-2027 CHNA, project leaders considered challenges common throughout the service area, as well as those identified in other parts of Connecticut. Since the prior CHNA (2019), the Greater Manchester Region has undergone significant structural challenges (e.g., Prospect Medical Holdings [i.e., Manchester Memorial Hospital and Rockville General Hospital] managing bankruptcy issues, funds typically used to engage community-facing initiatives being restricted, and others). Even though these challenges were present, the health system (GMR) was able to work to address core issues by providing general healthcare services and initiating some strategically focused community outreach and/or relationship building. Core services include (but are not limited to) the following:

- Behavioral health services
- Chronic disease care (e.g., asthma, cancer, heart disease, diabetes, and others)
- Emergency care
- Maternal care and obstetrics
- Primary care
- Radiology
- Rehabilitation services
- Others

These efforts worked to address health priorities to the greatest degree possible between 2019 and 2025.

“What did we prioritize – How and Why?”

Prioritization Process

Research leaders paused after collecting secondary research and primary research (qualitative and quantitative) as described above. The secondary research analysis, the Wellbeing Survey, key stakeholder interviews, and other CHNA activities provided a wealth of community-based strengths, needs, service gaps, and potential opportunities to improve community health. For example, the research illuminated an initial list of 30 community needs (listed below).

1. Affordable and accessible healthcare – Cost of care, insurance barriers, and provider shortages (especially Medicaid-accepting).
2. Primary care provider availability – Need for more PCPs, especially in underserved areas.
3. Specialized medical care access – Diabetes, respiratory illness, cardiovascular disease, stroke, liver disease.
4. Care navigation and case management – For complex needs and newcomers to healthcare.
5. Transportation to healthcare and services – Lack of access to transit is a barrier to care.
6. Health literacy and insurance navigation – Understanding services, coverage, and care options.
7. Language and interpretation services – For patients with limited English proficiency.
8. Culturally competent care – Sensitivity to cultural and ethnic differences, especially for Latino communities.
9. Increased capacity of health and social services – More providers, extended hours, and integrated care options.
10. Access to mental health services – General shortage of services for all ages.
11. Shortage of mental health providers – Especially acute for youth, families, and the Latino community.
12. Services for anxiety, stress, behavioral health – Widespread need across age groups.
13. Suicide prevention programs – Intervention, education, and support.
14. Substance use disorder prevention and treatment – Addressing drug use, overdoses, and addiction recovery.
15. Chronic disease prevention and early detection – Especially diabetes, hypertension, and heart disease.
16. Obesity prevention and support – Nutrition education, fitness, and clinical care.
17. Nutrition and food security – Consistent access to healthy and affordable food.
18. Expanded preventive care and health education – Screenings, outreach, and self-management resources.

19. Maternal health services – Prenatal, perinatal, and postpartum care access.
20. Accessible and affordable childcare – Crucial for working families and child development.
21. Caregiver support services – For those supporting medically fragile or aging loved ones.
22. Pediatric and adolescent support services – Includes mental, physical, and social health services.
23. Senior healthcare and geriatric services – Coordinated care, chronic condition management, mobility.
24. Senior care navigation – Help with navigating benefits, services, and long-term support.
25. Affordable and quality housing – Stable, safe housing critical for health.
26. Risk of homelessness and housing insecurity – Emotional and financial stress from potential housing loss.
27. Unemployment and underemployment – Access to stable jobs and workforce support.
28. Food security and fresh food access – Affordable, nutritious options needed consistently.
29. Community connection and inclusion initiatives – Reducing isolation, fostering belonging.
30. Recreational and community-building activities – For youth, adults, and families to stay engaged and active.

Once data collection and analysis have been completed, the next step of a community health needs assessment is to prioritize the community needs. To prioritize the issues and needs, HHC regional leaders, hospital representatives, and community members worked together to implement a well-structured prioritization process. This process involves identifying and ranking community health needs based on factors like importance and severity of the problem, and the impact and feasibility of interventions.

The GMR prioritization process included focus groups, key informant interviews and public forums. These conversations included members of the public, community health staff, GMR Executive Leadership and colleagues, and local health providers and advocates.

The focus group discussions were framed around how each priority fell into one of four categories:

- Immediate Impact – where is the low-hanging fruit?
- Greatest Impact – what will most influence health outcomes?
- Most Desired Change – what does the community most want?
- Forging Opportunities – where are the greatest opportunities for partnership?

Final Priorities

Following the engagements noted above, a final list of health priorities was developed. This consensus-based approach yielded the following list of prioritized community health needs:

Aggregated Needs For Greater Manchester Region	
Access to Care for Families and Individuals	
Mental and Behavioral Health Services and Supports	
Socio-economic Factors Impacting Health	
Physical Health and Chronic Conditions	
Maternal, Child and Reproductive Health Services	

With the prioritization phase complete, service area strategies (i.e., the CHIP) will work to shape programs, partnerships, and policy advocacy, and ensure community voices remain central in all decision-making processes.

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

INTRODUCTION

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

This CHIP represents a strategic call to action for the Greater Manchester Region’s health leadership. Over the next three years, our priority is to implement sustainable solutions that improve longevity and wellness across our service areas. Central to this mission is the active cultivation of community engagement. We acknowledge that the complexities of public health require a unified front; by leveraging the expertise of our partners, we move from overwhelming challenges to achievable outcomes. Our efforts are strategically channeled through sponsorship distribution, board representation and alliances with the following collaboratives:

Manchester Community Services Council – For over 50 years MCSC has served as the convener of community-based organizations, health and social service providers, public officials, and concerned citizens who are dedicated to the enhancement of human services as a critical component of the quality of life for all greater Manchester residents. HHC GMR board leadership and strong participation from GMR service lines increases the impact and drives the direction and mission with key stakeholders.

Vernon Community Network – Dedicated to connecting community-based organizations and coordination of resources for our most vulnerable population. VCN amplifies the voice of the Vernon community through advocacy and community impact projects that benefit the greater Vernon region. Council representation ensures collaborations with high impact programs, including the Annual Black History Breakfast.

Greater Manchester Chamber of Commerce – HHC board representation is vital with this active association that strives to foster a robust economic environment - supporting quality jobs and capital growth in the towns in our service area, aligning with HHC’s commitment to community prosperity. The Chamber’s partnerships with workforce development bureaus and support for minority business owners increase stability in our local economy. Their future- focused economic strategy for the Manchester region includes partnerships with schools- fortifying our commitment to fostering opportunities for disadvantaged youth to engage in post-secondary education and employment.

While the CHIP is designed to address multiple needs, narrowing the focus to key areas of need and impact with associated key strategies best positions a health system for success. A CHIP is dynamic rather than a static plan and will be modified and adjusted as external environmental factors change, including market conditions, availability of community resources, and engagement from community partners. Furthermore, this CHIP will build on and leverage prior success while simultaneously adjusting strategies and actions as obstacles are encountered.

THE PLAN

This CHIP is structured around five priority areas that aim to address the root causes of health issues in our region. Recognizing that meaningful change requires collaboration, the Greater Manchester Region is committed to building strong partnerships with the community. Through ongoing assessments of these partnerships and the development of shared values and goals, **we strive to create a collective impact that drives progress across all health priorities—and beyond.** The plan for each of these areas is outlined on the following pages. The driving rationale for each of these can be summarized as follows:

1. Access to Care for Families and Individuals

Many factors create barriers to accessing care, including provider shortages, insurance restrictions, affordability, transportation issues, and limited office hours. Different populations also have unique needs that require specific support; for example, older adults and non-English speaking individuals may face distinct challenges. It is essential to take action to support individuals and families, ensuring that everyone has timely, affordable, and culturally responsive access to care.

Rationale for Action

- Residents report a declining health sector in recent years, exacerbated by access barriers due to affordability, insurance limitations, transportation barriers, limited office hours, and a shortage of specialists.
- Coordination of care across area health and human service providers was also raised as a top concern, describing it as limited and fragmented.
- Language barriers and inadequate interpretation services, particularly for immigrant populations were cited.
- Limited health literacy, difficulty navigating the health system and technology barriers in accessing patient portals were cited.
- Residents expressed a desire for stronger hospital-based outreach and a more welcoming, community-centered hospital presence.

2. Mental and Behavioral Health Services and Supports

Mental and Behavioral Health services are needed more than ever, with an increased incidence of mental health concerns arising across all demographics. Services and providers are in demand to supply care for matters ranging from social isolation to substance use. More work needs to be done to reduce the stigma of mental health disorders, and early intervention for substance use and treatment.

Rationale for Action

- Elevation of Behavioral Health Utilization: Mental illness-related hospitalizations remain steady at 5.8% to 5.9% consistent with CHNA findings that mental health and substance-related disorder hospitalization rates are notably higher than state benchmarks.
- Severe shortages in outpatient behavioral health and substance use disorder treatment capacity.
- Residents felt mental health services for seniors were lacking.
- Residents also felt a need for more integrated physical and behavioral health care.

3. Socio-economic Factors Impacting Health

Non-clinical factors have been widely recognized for their significant impact on health. Issues such as the cost of healthy and nutritious food, access to affordable housing, earning a livable wage, and other associated challenges present both financial and emotional burdens for many households. To address health in a holistic and strategic manner that optimizes health outcomes, it is essential to understand the communities and address the non-clinical and socio-economic factors that influence these outcomes.

Rationale for Action

- Food Insecurity: More than one of four (23%) – and two of five (41%) of those with annual incomes under \$30,000 experienced food insecurity within the last 12 months.
- Access to Nutritious Food: Residents surveyed reported lack of access to nutritious food, which is an essential component of disease prevention.
- Transportation: 15% of people in the service area do not have reliable transportation, further, 33% of those without reliable transportation said they were not able to get to needed health services.
- 39% of households are ALICE (Asset Limited, Income Constrained, Employed) facing financial hardship despite employment.

4. Physical Health & Chronic Conditions

Chronic diseases such as diabetes, hypertension, heart disease, asthma, obesity and prostate cancer are prevalent and show disparities between populations of color and the white population. Earlier screening and health education could provide significant benefit. Education and community collaboration play a vital role in empowering individuals to make healthier choices and access resources, ultimately improving long-term health outcomes across the region.

Rationale for Action:

- The incidence of Prostate Cancer is 25% higher than the state average – twice as high for men of color as any other race.
- More than 1 in 3 residents (34.8%) are obese and 1 in 9 have diabetes- both higher than the state average.
- Diabetes mortality rate is approximately 8% higher than the state average.
- Heart failure is 14% of hospital utilization – heart failure and coronary artery disease rates exceed the state average.
- Disparity in chronic disease is prevalent in lower income groups (earning under 30,000 annually compared with those earning over 100,000 annually).

5. Maternal, Child & Reproductive Health

Mental health conditions, cardiovascular disorders, and hypertensive complications continue to be leading causes of maternity mortality, underscoring the need for comprehensive, interdisciplinary care models that integrate mental and physical health services. Racial maternal health disparities point to persistent, systemic challenges and emphasize the importance of targeted interventions and culturally responsive care to support healthy pregnancies, births and childcare.

Rationale for Action

- OBGYN care is highly limited in Tolland County with over 9,000 females per provider.
- Barriers to prenatal care, including lack of insurance, transportation, and childcare were cited.
- Racial disparities exist in higher rates of maternal complications, pre-term births and low birthweight as well as higher maternal and infant mortality.

Greater Manchester Region Community Health Improvement Plan

Priority Area #1: Access to Care for Families and Individuals			
GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
Promote Mobile Health Services	Neighborhood Health- Schedule 3 – 4 clinics monthly in combination with Street Medicine in locations with the most vulnerable patients in GMR service area - Provide GMR Medical Mission	Neighborhood Health- Melinda Lodge Community Health- CHW, Reverand Roberta Community Municipal Partners Health and Human Services Organizations	Neighborhood Health # Clinics per month # Medical visits Medical Mission # patients served # services provided # Community Organizations engaged
Improve Transportation Resources and Awareness	- No less than 10% of overall sponsorships/donations allocated to transportation funds to patients/clients through HVCC - HHC Ride Health Program Promotion	Community (HVCC) Hockanum Valley Community Council Dial-A-Ride program Ride Health	- Amount of funding allocated to transportation correlated to number of people served - promotional events/engagements # of practices/MA's receiving Ride Health education
Improve access to timely, affordable, and culturally-sensitive health care services	- Education and outreach efforts for navigation and connectivity - Education for practices on Propeo Language Services - Engage GMR colleagues in Health Equity Council's Annual Health Equity education and Strategic Plan projects	CHW, Reverand Roberta, RDN Liz Begley Health Equity Council	# of patients assisted # of practices educated # of patients served # of colleagues participating # of projects implemented

Priority Area #1: Access to Care for Families and Individuals

GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
Increase access to services for Seniors	- Promotion of Center for Healthy Aging programs in GMR service area Senior Centers - Connect Seniors to the UR Community Cares Tech Center for assistance with patient portal access	Center for Healthy Aging CHW, UR Community Cares	# of encounters #of Seniors receiving service from HHC referral

Priority Area #2: Mental and Behavioral Health Services and Supports

GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
Improve Community Connection and Community Building to support care transitions and continuity of care	Reinstate Community Care Team (CCT) for GMR	GMR BH and CHW CBOs and Health and Human Services (begin with historic membership and expand to include new organizations and representatives)	• #of patients addressed • Long term goal of decreasing ED visits and increase in appropriate level/site of care
Host support groups such as AA to invite the community into GMR spaces, fostering trust and partnership	Provide space, refreshments and marketing for organizations holding support groups	BH and program representatives	• # of organizations engaged
Reduce Social Isolation	sponsorship/donations to organizations addressing behavioral health supports including those aimed at reducing social isolation Conduct targeted community outreach	BH, CHW, Reverend Roberta, Community Organizations	• Sponsorship \$ allocated to organizations correlated to: • # of programs supported • #of community members attending
Reduce Stigma and improve access to Behavioral Health supports at every age	Partner with Family Development Center to offer programs for families focused on Mental Health. Collaborate with schools, adult education, and senior centers	Family Development Center, K. Forbes, Reverend Roberta, BH, Town Health and Human Services as well as organizations focused on Mental Health such as NAMI	• #of programs engaged in • # of partnerships/programs

Priority Area #2: Mental and Behavioral Health Services and Supports

GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
Increase awareness of community support for those receiving Mental Health care	Offer 3 annual education sessions focused on Mental Health Continue our NAMI/Manchester High School partnership: assembling care packages for BH patients transitioning home from inpatient	GMR BH, NAMI, chr K. Forbes, Donna Schneider, NAMI representatives	• # of sessions • # of students participating • # of care packages

Priority Area #3: Socio-economic Factors Impacting Health

GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
Engage in impactful partnerships with structured education programs focused on breaking the cycles of poverty through career readiness, training, and programs fostering long-term economic stability Build HHC talent pipeline with students who are invested in the community	- Continue colleague representation at MHS & RHS Careers in Healthcare Advisory Council - Mock interviews - On-site observation and lecture MMH, RH - Shadowing - Externships	Community Health, K. Forbes, Daria Thibodeau HHC colleagues	#of students participating # of departments engaging in Shadowing program #of departments engaging in externships program
Improve access to and increase education on benefits of healthy foods to improve health outcomes and preventable disease through initiatives such as Food 4 Health	- Engage leadership and philanthropy in a strategy that benefits GMR - Engage Project Search through MARC, Inc. - Engage RDs in Center for Healthy Living - Partner with MACC Charities and HVCC for partnership	GMR CHIP Governance committee David Juros K. Forbes RDs	We are actively exploring initiatives designed to mitigate the dual challenge of food and insecurity and chronic disease in our service area. As we review potential pathways, we are focused on solutions that maximize impact while maintaining strong fiscal and operational stewardship
Improve referral patterns and connectivity by implementing “Connections That Matter” in GMR hospitals and ambulatory office referral processes	- Education plan for Case Managers - Training for MAs	Hilary Maynard	# Case managers who received training # MAs who received training

Priority Area #3: Socio-economic Factors Impacting Health

GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
Improve stability in housing, including emergency solutions and access to food	• Sponsorships and donations • Fortify partnership and board representation with Rebuilding Together Manchester • Increase partnership and volunteer efforts with Midwest Food Bank • Increase support of Cornerstone Emergency Housing assistance	Community Health Colleague volunteers Colleague volunteers	• Amount of funding allocated to solutions for housing, and access to food • # of volunteers year over year • # of volunteers for food re-packing events • # of events collecting furniture and household essentials

Priority Area #4: Physical Health and Chronic Disease

GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
Expand Community Education on Chronic Disease Prevention and Management	- Health Education in community settings, including faith-based organizations and libraries - Targeted Nutrition Education programs led by community health Registered Dietitian Nutritionists (RDNs) Resource opportunities and partnerships: Kiosk in Manchester and Vernon Libraries providing blood pressure testing and information	Community Health- RDNs, Reverand Roberta Residency Program Community Faith-based organizations Libraries Community based organizations Health Equity Champions Health Fairs	# education events held # participants reached - Summary of post-event evaluations (knowledge gain, intent to change behavior)
Increase Tobacco-Free Living education through Community Education	- Provide Tobacco education in Manchester and Vernon Schools - Create referral mechanism for Cardiologists to refer directly to Tobacco cessation program - Incentivize participation with reimbursement of class fee	Karen Fiume Karen Fiume Community Health	# outreach events and attendees # patients engaged in tobacco cessation support #of participants completing program
Strengthen community trust and improve pathways to early detection	- Forge stronger partnerships with community based and faith-based organizations. Attend services/meetings to provide information and access to early detection education and testing - Coordination with TallWood Institute on community education, awareness campaigns, and special outreach efforts	Reverand Roberta, CHWs Dino Costanzo - VP for Operations and Steven Shichman, MD Physician in Chief	# of education sessions #of education/screening events focused on prostate and kidney cancer

Priority Area #4: Physical Health and Chronic Disease			
GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
	• Increase access to Early Detection and Prevention program	Edry O'Dwyer	• # of education events • # of patients enrolled in detection programs

Priority Area #5: Maternal, Child and Reproductive Health

GOALS	STRATEGIES	LEAD/ PARTNERS	METRICS/MEASURES
Improve awareness of maternal health issues and concerns through outreach and engagement and improved screening	• Provide outreach and education to area OBGYN offices on services available to underserved perinatal women • Expand services to patient population including SDOH screening and referral, Depression screening and referral, Nutritional counseling	CHW RN Social Worker, BH, RDN	• # of offices receiving education on services • # of SDOH screenings • #of Depression screenings • # of Nutritional Counseling visits
Increase culturally responsive care through interventions that address racial disparities and promote equitable access to care	• Colleague education including BMI and blood pressure monitoring to decrease complications resulting in emergency c-section births • Capture and review perinatal outcomes by patient characteristics, including race, to identify any potential health disparities and build an action plan to address gaps.	Maternal Health Equity RN Community: Dr. Clare-Kearney System support	• # of colleagues attending education sessions
Promote Safety for post-partum women	• Provide all postpartum people with an orange 'I GAVE BIRTH' bracelet and educate local community care centers and hospital departments to recognize high risk needs of	Family Birthing Center educators Bridge staff	• # of education sessions • #of home visits post-partum • #of home visits augmented by grant

	postpartum people and maternal early warning signs. • Engage in “The Bridge” program	System support	
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Appendix

The appendices include the following:

Appendix 1: Initial Set of Needs Based on Qualitative data

Appendix 2: DataHaven Community Wellbeing Survey Raw Data Tables

Appendix 3: Maternal Health

Appendix 4: Maternal Health Data Tables

Appendix 5: Life Expectancy

Appendix 6: Life Expectancy Data

Appendix 7: Wellbeing Survey Summary Tables and Graphics

Appendix 8: Community Health Needs Assessment Requirements as per the Internal Revenue Service

Appendix 9: Predictive Analytics – Original Profile

Appendix 10: Additional Predictive Analytics Highlights

Appendix 11: Community-based Health-related Resources

Appendix 1: Initial Set of Needs Based on Qualitative data

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

Appendix 2: DataHaven Community 2024 Wellbeing Survey Raw Data Tables

Overall Health Status

Response	Connecticut total	GMR total	Male	Female	Ages 18 to 34	Ages 35 to 49	Ages 50 to 64	Ages 65+	White	Black	Latino
How would you rate your overall health? (% saying Excellent or Very Good)	52.5%	50.8%	55.2%	46.7%	57.2%	53.9%	44.3%	49.9%	55.3%	47.9%	44.8%
How would you rate your overall health? (% saying Fair or Poor)	18.3%	22.6%	23.6%	21.6%	25.2%	16.5%	24.9%	21.0%	21.1%	23.3%	29.7%
How satisfied are you with your life nowadays? (% saying Completely or Mostly)	63.7%	62.5%	63.3%	61.7%	61.1%	56.4%	57.5%	80.4%	70.8%	59.0%	41.3%
How satisfied are you with your life nowadays? (% saying Only a little or Not at all)	12.6%	15.6%	14.6%	16.6%	12.6%	23.7%	17.4%	9.8%	13.8%	21.9%	18.1%
Overall, how happy did you feel yesterday? (% saying Completely or Mostly)	66.7%	67.2%	66.1%	68.1%	63.3%	70.3%	62.8%	75.3%	74.9%	50.3%	62.4%
Overall, how happy did you feel yesterday? (% saying Only a little or Not at all)	12.8%	13.4%	15.7%	11.3%	12.1%	14.3%	17.7%	9.7%	10.1%	23.7%	17.3%
Overall, how anxious did you feel yesterday? (% saying Completely or Mostly)	15.3%	18.5%	14.7%	22.1%	22.9%	18.4%	20.1%	9.6%	19.5%	13.7%	20.0%
Overall, how anxious did you feel yesterday? (% saying Only a little or Not at all)	62.7%	58.9%	64.0%	54.1%	46.0%	58.7%	61.5%	76.7%	66.3%	57.8%	36.1%
Do you have health insurance? (% saying No)	6.1%	6.1%	6.1%	6.2%	11.0%	6.7%	2.9%	0.8%	4.2%	4.1%	16.2%

Overall Health Status

Response	Connecticut total	GMR total	High school or less	Some college or Associate's	Bachelor's or higher	Income <\$30K	Income \$30K-\$100K	Income >\$100K	Children in home	No children in home
How would you rate your overall health? (% saying Excellent or Very Good)	52.5%	50.8%	45.3%	41.4%	61.4%	32.1%	48.7%	65.6%	51.2%	50.9%
How would you rate your overall health? (% saying Fair or Poor)	18.3%	22.6%	33.8%	23.4%	14.5%	39.4%	21.3%	11.4%	17.8%	24.3%
How satisfied are you with your life nowadays? (% saying Completely or Mostly)	63.7%	62.5%	53.4%	65.3%	66.3%	31.7%	67.6%	75.2%	67.6%	60.3%
How satisfied are you with your life nowadays? (% saying Only a little or Not at all)	12.6%	15.6%	24.1%	12.2%	13.6%	33.0%	13.0%	10.8%	17.0%	15.2%
Overall, how happy did you feel yesterday? (% saying Completely or Mostly)	66.7%	67.2%	62.5%	66.2%	71.3%	54.5%	69.9%	74.4%	70.1%	66.2%
Overall, how happy did you feel yesterday? (% saying Only a little or Not at all)	12.8%	13.4%	19.4%	9.8%	12.9%	25.0%	10.0%	11.7%	14.5%	13.1%
Overall, how anxious did you feel yesterday? (% saying Completely or Mostly)	15.3%	18.5%	22.5%	18.7%	16.6%	27.6%	17.7%	13.7%	19.7%	17.6%
Overall, how anxious did you feel yesterday? (% saying Only a little or Not at all)	62.7%	58.9%	44.3%	64.4%	64.8%	43.2%	60.9%	69.5%	56.9%	60.9%
Do you have health insurance? (% saying No)	6.1%	6.1%	13.7%	2.7%	4.3%	16.0%	5.3%	1.7%	6.8%	5.9%

Appendix 3: Maternal Health

Overview

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

National Maternal Health Trends

In recent years, the United States has experienced fluctuations in maternal mortality rates. According to the National Center for Health Statistics, the maternal mortality rate has drifted up from 17.4 deaths per 100,000 live births in 2018 to 23.8 in 2020, 22.3 in 2022, and 18.6 in 2023.^{25,26} Disparities persist across different age groups and racial/ethnic populations. In 2022, women aged 40 and over had a maternal mortality rate of 87.1 per 100,000 live births, significantly higher than the rate of 14.4 for women under 25. Racial disparities are also evident; non-Hispanic Black women experienced a maternal mortality rate of 49.5 per 100,000 live births in 2022, more than double the rate for non-Hispanic White women, which stood at 19.0.²⁷

The leading causes of pregnancy-related deaths in 2020 included mental health conditions, cardiovascular conditions, infection, hemorrhage, embolism, and hypertensive disorders of pregnancy, accounting for over 82% of such deaths. Notably, mental health conditions were the most frequent underlying cause, highlighting the linkage between comprehensive maternal care and mental health support.²⁸

²⁵ Note: Data indicates that the 2021 rate was over 32. However, the COVID-19 pandemic may have impacted reporting methodologies, making direct trend-based comparisons challenging.

²⁶ Hoyert DL. Maternal mortality rates in the United States, 2022. NCHS Health E-Stats. 2024. Available at <https://dx.doi.org/10.15620/cdc/152992>

²⁷ Ibid.

²⁸ US CDC, Maternal Mortality Prevention, 2024, "Pregnancy-Related Deaths: Data From Maternal Mortality Review Committees in 38 U.S. States, 2020". Available at [Pregnancy-Related Deaths: Data From Maternal Mortality Review Committees in 38 U.S. States, 2020 | Maternal Mortality Prevention | CDC](#)

Maternal Health in Connecticut

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

Antecedent or Contributing Measures

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

Outcomes Measures

- Maternal deaths and mortality rates
- Infant mortality

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

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



Contributing Measures

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

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

The availability of obstetricians and gynecologists varies widely across Connecticut counties, with notable disparities in access. Tolland County has the highest ratio at 9,560 females per OBGYN, indicating a significant shortage of providers, while Hartford County has the lowest ratio, 1,959, suggesting better per capita capacity. The statewide average (2,493) is below the national average (3,454), showing that Connecticut as a whole has relatively strong OBGYN coverage.²⁹

2. Tobacco Use During Pregnancy

This measure reflects the percentage of pregnant individuals who report using tobacco at any point during their pregnancy. Tobacco use during pregnancy is associated with a range of adverse outcomes, including miscarriage, stillbirth, preterm birth, low birth weight, and developmental issues in infants. Monitoring this behavior is essential for identifying at-risk populations and targeting public health interventions. It also serves as a proxy for broader health education and support systems within a community and highlights the need for effective cessation programs tailored to pregnant individuals. Hartford and Tolland Counties' rates generally mirror the state rate of 18%.

3. Preterm Births

Preterm birth is defined as a live birth occurring before 37 completed weeks of gestation. It is a leading cause of neonatal morbidity and mortality and can have long-term consequences for a child's health, development, and educational outcomes. This measure is vital for assessing the quality of prenatal care, maternal health status, and HRSN issues that contribute to early labor. High preterm birth rates often reflect disparities in health care access, stress, environmental exposures, and chronic disease burden among pregnant individuals.

Connecticut's preterm birth rate (9.1%) is slightly below the national average (10.2%), yet racial disparities are pronounced; Hartford County and Tolland County rates are similar to the state average, i.e., within 0.6%. Black or African American women face

²⁹ County Health Rankings, 2024. Available at <https://www.countyhealthrankings.org/health-data/compare-counties?year=2024&compareCounties=09013%2C09000%2C00000%2C>; U.S. Centers for Disease Control and Prevention (CDC). *CDC WONDER Natality — Live Births*, 2023. National Vital Statistics System (NVSS). Accessed via CDC WONDER.

disproportionately high rates (up to 14.5% in Hartford County), mirroring national trends. In contrast, White (non-Hispanic) and Asian women tend to experience lower rates of preterm births. Geographic variation also exists, that likely reflect varying access to care, socioeconomic factors, and structural issues.³⁰

4. **Low Birth Weight**

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

Connecticut's overall low birth weight rate is 7.6%, slightly lower than the national average of 8.2%, but again, racial disparities are evident. Black or African American infants have the highest rates (13.0% statewide), particularly in Hartford County (13.5%), more than double the rate for White (non-Hispanic) infants (6.3%). Asian infants also experience elevated rates (9.0%), which exceeds their national rate. Tolland County reports a lower rate at 7.5%, while Hartford and New Haven are among the highest at 8.2%. These patterns highlight persistent disparities in maternal and infant health outcomes.³¹

5. **First Trimester Prenatal Care**

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

While Connecticut exceeds the national average (84.7% vs. 76.8%) in first trimester prenatal care access, disparities persist across racial and ethnic groups. White (non-Hispanic) women have the highest rates, with Tolland County reaching 90.7%, while Black or African American women report significantly lower access (about 84%). Hispanic women also have lower rates (85%). These disparities indicate ongoing barriers to early care for certain groups.

³⁰ Ibid.

³¹ Ibid.

6. Life Expectancy at Birth

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

Connecticut's life expectancy at birth (80.3 years) is higher than the national average (78.8), with the highest figures in Fairfield (81.5) and Tolland (81.1) counties. Hartford County has a slightly lower average (79.8 years). Life expectancy closely correlates with broader HRSN issues such as income, education, access to care, and environmental conditions, which tend to be more favorable in suburban counties compared to rural or urban areas with higher poverty rates.³²



³² Ibid.

Outcomes Measures

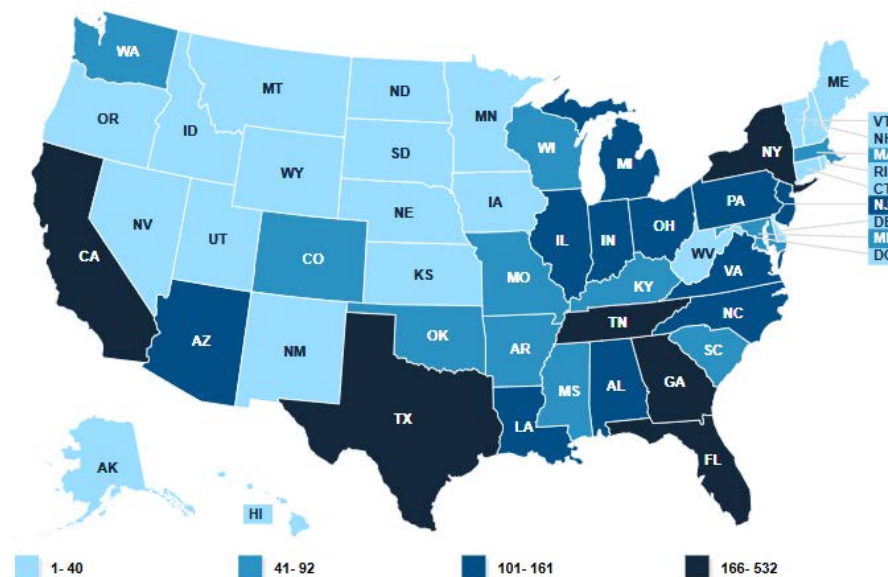
Please note that the following two measures – Maternal Deaths and Mortality Rates and Infant Mortality – reflect outcomes often associated with the six contributing measures described above.

7. Maternal Deaths and Mortality Rates

Maternal mortality — the death of a woman during pregnancy or within one year after pregnancy from a pregnancy-related cause — is a key indicator of how well a health system supports women’s health. The maternal mortality rate, expressed as the number of maternal deaths per 100,000 live births, reflects both the quality of clinical care and broader health-related social needs that influence maternal well-being.

Many maternal deaths are considered preventable. They are commonly associated with mental health conditions, hemorrhage, cardiovascular and hypertensive disorders, infection, underlying chronic illness, and systemic factors such as delayed care or limited access to services.³³ Tracking maternal mortality helps public health leaders identify risk factors, target interventions, and direct resources to protect maternal health.

In Connecticut, maternal mortality remains an important concern despite the state’s strong healthcare infrastructure. The state’s rate of 16.7 deaths per 100,000 live births is below the U.S. average of 23.0, placing Connecticut 33rd nationally (where 1 represents the highest — or worst — rate).³⁴



³³ Mental health conditions include deaths of suicide, overdose/poisoning related to substance use disorder, and other deaths determined by the MMRC to be related to a mental health condition, including substance use disorder. Source: US CDC, “Maternal Mortality Prevention”, 2024. Available at <https://www.cdc.gov/maternal-mortality/php/data-research/index.html>

³⁴ Sources: CDC Wonder, Natality 2023; NPPES NPI 2024; US CDC; Centers for Disease Control and Prevention, National Center for Health Statistics (NCHS), National Vital Statistics System, “Maternal deaths and mortality rates: Each state, the District of Columbia, United States, 2018-2022”; KFF, State Health Facts, Preterm Births as a Percent of All Births by Race/Ethnicity, from the Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2016-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program; Osterman MJ, Hamilton BE, Martin JA, Driscoll AK, Valenzuela CP. Births: Final data for 2021. National Vital Statistics Reports; vol 72, no 1. 2023

Although Connecticut's overall maternal mortality rate is lower than the national average, significant disparities remain. Black women experience disproportionately higher pregnancy-related mortality, reflecting longstanding systemic issues such as implicit bias in healthcare, unequal access to prenatal and postpartum care, and differences in chronic disease burden. Continued, accurate reporting and analysis of maternal deaths are critical to understanding these underlying causes and to guiding actions that improve safety and access in maternal care statewide. Note that county-level maternal mortality data were not available due to small sample size limitations.³⁵

8. Infant Mortality Rate by Race and Ethnicity

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

In Connecticut, the overall infant mortality rate is lower than the national average, highlighting some relative strengths in healthcare delivery. As of 2022, Connecticut's infant mortality rate was 4.5 deaths per 1,000 live births, ranking 11th among US states. In comparison, the national average for the United States was 5.6 deaths per 1,000 live births in 2022.³⁶

Over the past decade, Connecticut has consistently maintained an infant mortality rate below the national average. For example, in 2017, the state's rate was 4.6 deaths per 1,000 live births, a decrease from 5.9 in 2005.³⁷

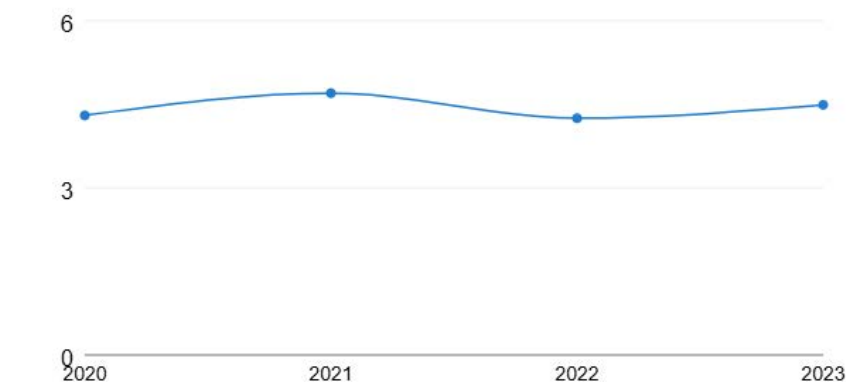
³⁵ Note: Contributing factors such as Caesarian section and other factors also reflect racial or ethnic variances. For example, Caesarean deliveries as a percentage of all births show that an "All races and ethnicities" rate of 35% while differences exist for Hispanics and Non-Hispanic Whites (both 35%)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

³⁶ US CDC, 2023. Available at www.cdc.gov/nchs/data/nvsr/nvsr73/nvsr73-05.pdf?utm_source=chatgpt.com

³⁷ US Department of Health and Human Services, HRSA, [MCHB Tvis Data](https://mchb.tvisdata.hrsa.gov/Narratives/Overview/ae9156da-f2fd-4afc-89a7-044d83c705f6?utm_source=chatgpt.com). Available at https://mchb.tvisdata.hrsa.gov/Narratives/Overview/ae9156da-f2fd-4afc-89a7-044d83c705f6?utm_source=chatgpt.com

Total infant mortality rates have been stable, 2020-2023 fluctuating between 4.3 and 4.7 per 1,000 live births.³⁸

Infant Mortality Rate, 2020-2023, Connecticut



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

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

However, significant disparities remain, particularly among racial and ethnic groups. Black or African American infants in Connecticut are more than twice as likely to die before their first birthday compared to White infants—a pattern consistent with national trends. Similarly, Hispanic infants also have higher mortality rates than Whites.³⁹ These disparities are rooted in various health-related social and economic factors, as well as unequal access to care before, during, and after pregnancy. Addressing infant mortality may benefit from comprehensive approaches that help ensure improved access to quality care. Note that county-level infant mortality data was not available due to sample size restrictions.

³⁸ Source: KFF, State Health Facts, Infant Mortality Rates by Race/Ethnicity from the United States Department of Health and Human Services (US DHHS), Centers of Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics (DVS). Linked Birth / Infant Death Records 2007-2021, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, on CDC WONDER On-line Database.

³⁹ The percentage of infant mortality varied by race / ethnicity: Whites 4.7%, Black or African Americans 9.9%, Hispanics 5.8%.

Appendix 4: Maternal Health Data Tables

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

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

- OB/GYN care is highly limited in (especially) Tolland County of over 9,000 females per provider. Hartford County has the most advantageous ratio of providers to females of 1,959:1.
- Tobacco use during pregnancy in the state is better than the US average; however, there are pockets of much higher use – especially among multiracial mothers in Hartford County and some other counties.

Preterm Births

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

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

- At the state level, Connecticut Preterm Births are better than the US average. However, in every Connecticut county preterm births among Black or African American women are notably higher than for Whites and well above the state average. Note that the variance between Black or African American Women and White women is small in Tolland County (i.e., less than 1.0%) – the smallest of any county.

Low Birth Weight

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

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

- Similarly, Black or African American communities across Connecticut are 30% to 60% (in most counties) more likely to have low birth weight babies.⁴⁰ The variance is slightly lower in Tolland County

⁴⁰ NOTE: Several studies have shown that low birth weight (LBW) babies require much greater initial hospital delivery and inpatient costs, as well as a much higher lifetime probability of severe health issues. “Studies have also established a correlation between LBW and high blood pressure, cerebral palsy, deafness, blindness, asthma, and lung disease among children, as well as with IQ, test scores, behavioral problems and cognitive development.” Citation: Kaelber and Pugh [1969], McCormick et al. [1992], Paneth [1995], Nelson and Grether [1997], Lucas, Morley, and Cole [1998], Brooks et al. [2001], Matte et al. [2001], and Richards et al. [2001].

First Trimester Prenatal Care

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

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

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

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

Appendix 5: Life Expectancy

Introduction

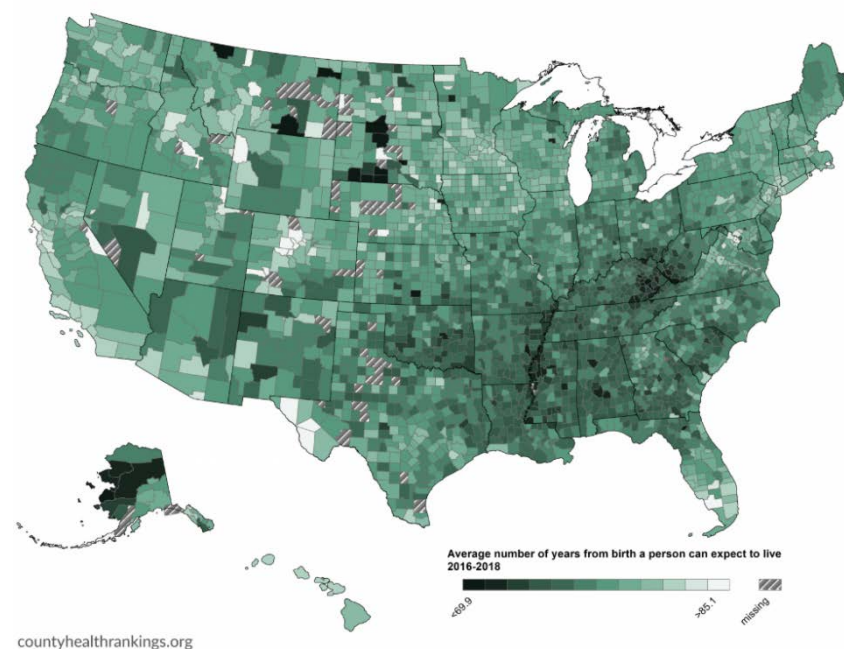
Life expectancy is a crucial measure of overall community health. Hartford County data include several key health indicators that influence the overall life expectancy of its residents. With a life expectancy of 78.8 years, Hartford County falls slightly below the Connecticut state average of 79.6 years. This section highlights the primary health challenges and areas for improvement related to life expectancy, analyzing how specific health measures compare with state and national data.⁴¹ Note that GMR service area includes towns / cities in Hartford County (excluding the city of Hartford) and Tolland County. Life expectancy data was not available on the mixed-county level, so Hartford County data is shown below.

Premature Death and General Health Indicators

Premature death, measured as years of potential life lost before age 75, stands at 6,900 per 100,000 population, slightly higher than Connecticut's 6,500 but well below the national rate (8,000). Contributing factors include the rates of poor physical and mental health days, with Hartford County residents reporting similar numbers of unhealthy days per month than the state and national averages. Addressing these health challenges through improved healthcare access, chronic disease management, and mental health support is critical to increasing life expectancy in the county

Poor or fair health is reported by 13% of residents, slightly above the state rate (12%) and equal to the national rate (14%). Similarly, Hartford County residents experience 3.3 poor physical health days per month, which is higher than Connecticut's 2.9 days and above the U.S. average of 3.3 days. Poor mental health days average 5.0 per month in Hartford County, exceeding both the state (4.4) and national (4.8) averages, indicating a need for greater mental health support.⁴²

Life Expectancy Among U.S. Counties (Rankings 2020)



⁴¹ County Health Rankings, 2024. Available at <https://www.countyhealthrankings.org/health-data/compare-counties?year=2024&compareCounties=09013%2C09000%2C00000%2C>

⁴² Ibid

Lifestyle and Behavioral Health Factors

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

Several behavioral factors contribute to health outcomes in Hartford County. Adult smoking rates (13%) are similar to both the state (12%) and national (15%) rates, suggesting that tobacco cessation programs could widely benefit the community. Adult obesity rates (33%) also surpass the state average (31%) and are slightly higher than the national average (34%), reinforcing the need for improved nutrition and physical activity initiatives.⁴³

Access to exercise opportunities are among the highest in the state in Hartford County (96%) compared to Connecticut (93%) and the U.S. (84%). Additionally, excessive drinking (16%) is slightly higher than both the state (17%) and national (18%) averages, indicating a need for targeted interventions to address substance abuse.⁴⁴

Healthcare Access and Preventive Care

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

As noted, healthcare access remains a concern, particularly in provider availability. However, Hartford County has notably more primary care physicians per capita, with a provider-to-population ratio of 1,050:1, compared to Connecticut's 1,210:1 and the national ratio of 1,330:1. Similar numbers exist for dentists (930:1 vs. 1,150:1 in Connecticut and 1,360:1 nationally) and mental health providers (170:1 vs. 220:1 in Connecticut and 320:1 nationally). Though advantageous for Hartford County, ongoing service capacity reflects an ongoing need for healthcare workforce development in the county.⁴⁵

Preventive care metrics also reveal areas for improvement. Mammography screening rates are slightly lower in Hartford County (46%) compared to Connecticut (47%) but above the national average (43%). Flu vaccination rates in the county (55%) are slightly above the state average (54%) but much higher than the national rate (46%). Further improving these rates could help reduce preventable diseases and hospitalizations.⁴⁶

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ Ibid.

Health-related Social Needs (HRSN)

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

The Hartford County high school completion rate (91%) is equal to Connecticut's 91% but slightly above the national average (89%). The percentage of residents with some college education (72%) is similar to both the state (71%) and national (68%) figures, suggesting that education initiatives could enhance long-term health outcomes.⁴⁷

Unemployment in Hartford County stands at 4.3%, marginally above Connecticut's 4.2% and well above the national average of 3.7%. Additionally, 14% of children in Hartford County live in poverty, a rate slightly higher than the state average (13%) but slightly lower than the national rate (16%). These factors contribute to economic instability, which can negatively affect access to healthcare and healthy living conditions.⁴⁸

Housing and environmental concerns also play a role in community health. Severe housing problems affect 16% of Hartford County residents, which is similar to both the state and national averages (17%). Air pollution levels, measured in particulate matter, are slightly higher in Hartford County (7.7) compared to Connecticut and the U.S. (both 7.4), suggesting a relatively similar environmental condition.⁴⁹

Health Risk Behaviors and Mortality

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

Injury deaths are higher in Hartford County (84 per 100,000 population) than in Connecticut (80) and the national average (80). Alcohol-impaired driving deaths (34%) also exceed the national average (26%).⁵⁰

Teen birth rates in Hartford County (10 per 1,000 females aged 15-19) are higher than Connecticut's (eight) but significantly lower than the national rate (17). Similarly, sexually transmitted infections are higher in Hartford County (509.4 per 100,000) compared to both the state (409.1) and national averages (495.5), suggesting additional better sexual health education and/or services may be helpful.⁵¹

⁴⁷ Source: County Health Rankings, 2024. Available at <https://www.countyhealthrankings.org/health-data/compare-counties?year=2024&compareCounties=09013%2C09000%2C00000%2C>

⁴⁸ Ibid.

⁴⁹ Ibid.

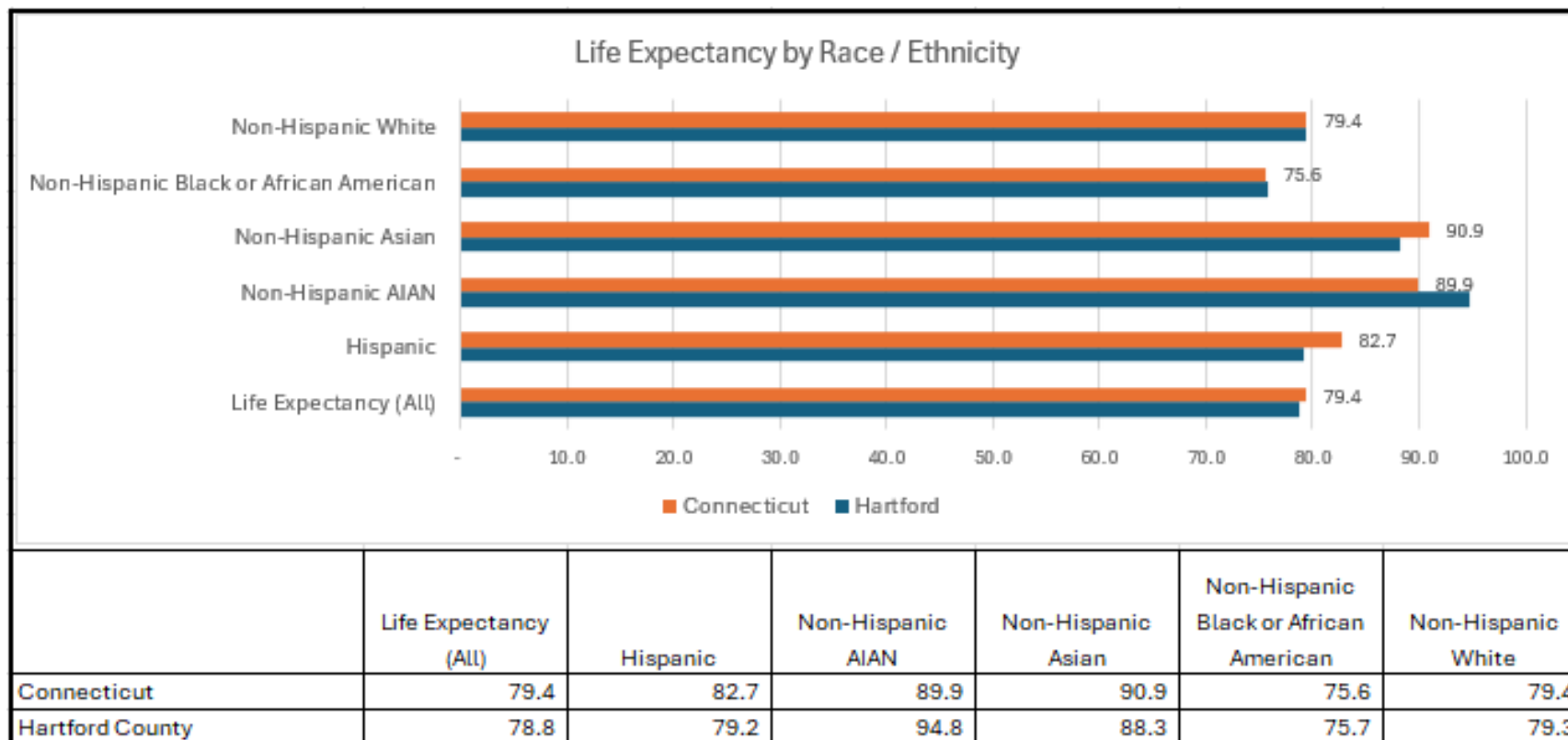
⁵⁰ Ibid.

⁵¹ Ibid.

Conclusion and Recommendations

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

Figure 1: Life Expectancy by Race and Ethnicity



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⁵² AIAN means American Indian / Alaska Native.

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

Table 9: Crude Death Rate per 100,000 Population by Race / Ethnicity

Hartford County	Race / Ethnicity		
Age Group	White	Black or African American	Hispanic or Latino
< 1 year	326.9	1,044.5	578.3
1-4 years	-	-	-
5-9 years	-	-	-
10-14 years	-	-	-
15-19 years	29.7	63.9	35.4
20-24 years	76.0	100.3	87.2
25-29 years	115.9	127.8	158.9
30-34 years	171.6	175.6	150.6
35-39 years	184.2	191.1	184.4
40-44 years	238.0	208.7	288.4
45-49 years	262.1	364.5	427.9
50-54 years	444.6	642.6	588.0
55-59 years	582.9	868.2	902.0
60-64 years	856.0	1,247.0	1,245.0
65-69 years	1,262.9	1,653.5	1,686.0
70-74 years	1,987.9	2,456.5	2,010.2
75-79 years	3,158.0	4,246.6	3,892.9
80-84 years	5,761.2	6,058.3	5,923.7
85-89 years	-	-	-
90-94 years	-	-	-
95-99 years	-	-	-
100+ years	-	-	-

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

- Death before age one year is 2.5 times higher for Black or African Americans than Whites.
- Mortality before age 45 is approximately 20% higher for Black or African Americans than Whites.
- Death rates among Hispanic teens (ages 15-19) is 30% higher than for Whites.

Appendix 6: Life Expectancy Data

Note that GMR service area includes towns / cities in Hartford County (excluding the city of Hartford) and Tolland County. Life expectancy data was not available on the mixed-county level, so Hartford County data is shown below.

Life Expectancy	Hartford County	Connecticut	United States
Premature Death Definition: Years of potential life lost before age 75 per 100,000 population (age-adjusted)	6,900	6,500	8,000
Poor or Fair Health	13%	12%	14%
Poor Physical Health Days (past 30 days)	3.3	2.9	3.3
Poor Mental Health Days (past 30 days)	5	4.4	4.8
Low Birthweight	9%	8%	8%
Adult Smoking	13%	12%	15%
Adult Obesity	33%	31%	34%
Food Environment Index	8.2	8.3	7.7
Physical Inactivity	24%	22%	23%
Access to Exercise Opportunities	96%	93%	84%
Excessive Drinking	16%	17%	18%
Alcohol-Impaired Driving Deaths	34%	32%	26%
Sexually Transmitted Infections per 100,000 population	509.4	409.1	495.5
Teen Births	10	8	17
Uninsured	6%	6%	10%
Primary Care Physicians (X:1)	1,050	1,210	1,330
Dentists (X:1)	930	1,150	1,360
Mental Health Providers (X:1)	170	220	320
Preventable Hospital Stays	2,739	2,651	2,681
Mammography Screening	46%	47%	43%
Flu Vaccinations	55%	54%	46%
High School Completion	91%	91%	89%
Some College	72%	71%	68%
Unemployment	4.30%	4.20%	3.70%
Children in Poverty	14%	13%	16%

Life Expectancy	Hartford County	Connecticut	United States
Income Inequality	5.1	5.1	4.9
Children in Single-Parent Households	28%	25%	25%
Social Associations	9.8	8.9	9.1
Injury Deaths	84	80	80
Air Pollution - Particulate Matter	7.7	7.4	7.4
Severe Housing Problems	16%	17%	17%
Driving Alone to Work	74%	72%	72%
Long Commute - Driving Alone	29%	35%	36%
Life Expectancy (all)	78.8	79.6	
Hispanic	79.2	NA	NA
Non-Hispanic AIAN	94.8	NA	NA
Non-Hispanic Asian	88.3	NA	NA
Non-Hispanic Black or African American	75.7	NA	NA
Non-Hispanic White	79.3	NA	NA
Source: County Health Rankings, 2024. Available at https://www.countyhealthrankings.org/health-data/compare-counties?year=2024&compareCounties=09013%2C09000%2C00000%2C			

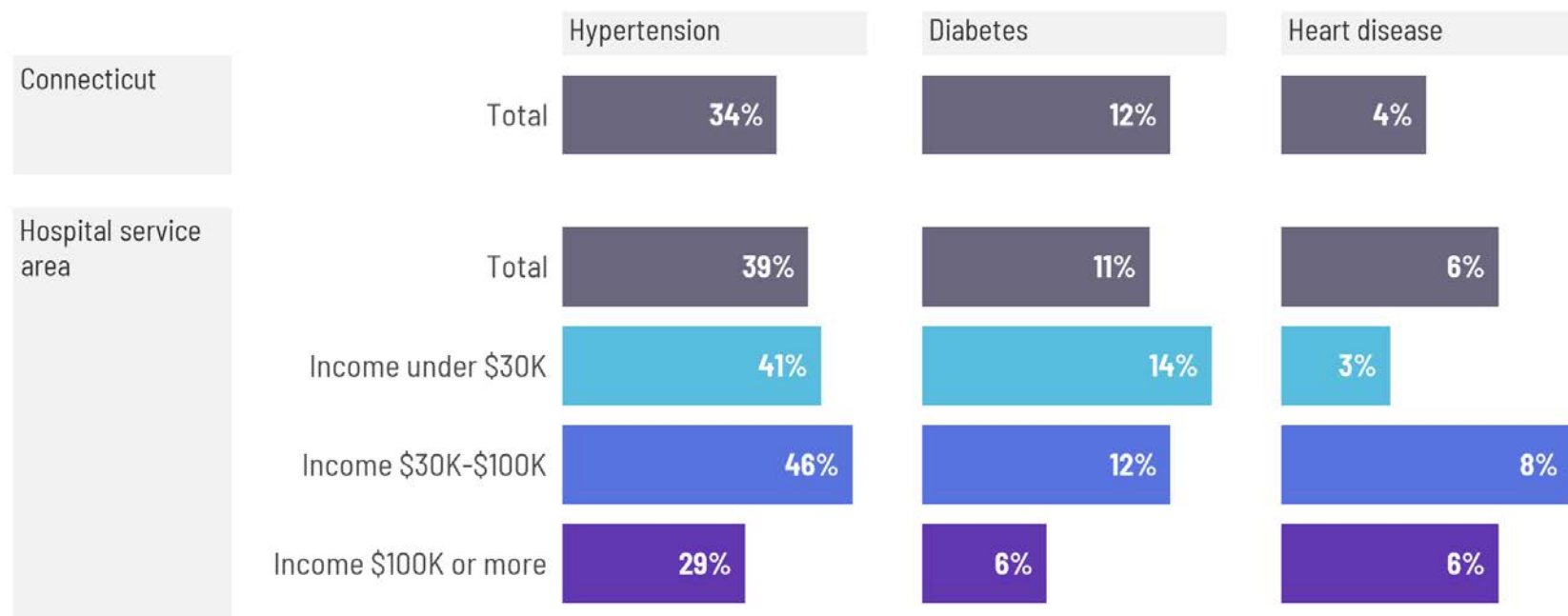
Appendix 7: Wellbeing Survey Summary Tables and Graphics

Chronic Disease

Figure 2: Greater Manchester Region Service Area Chronic Disease by Income Level

Chronic disease

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and income, 2024



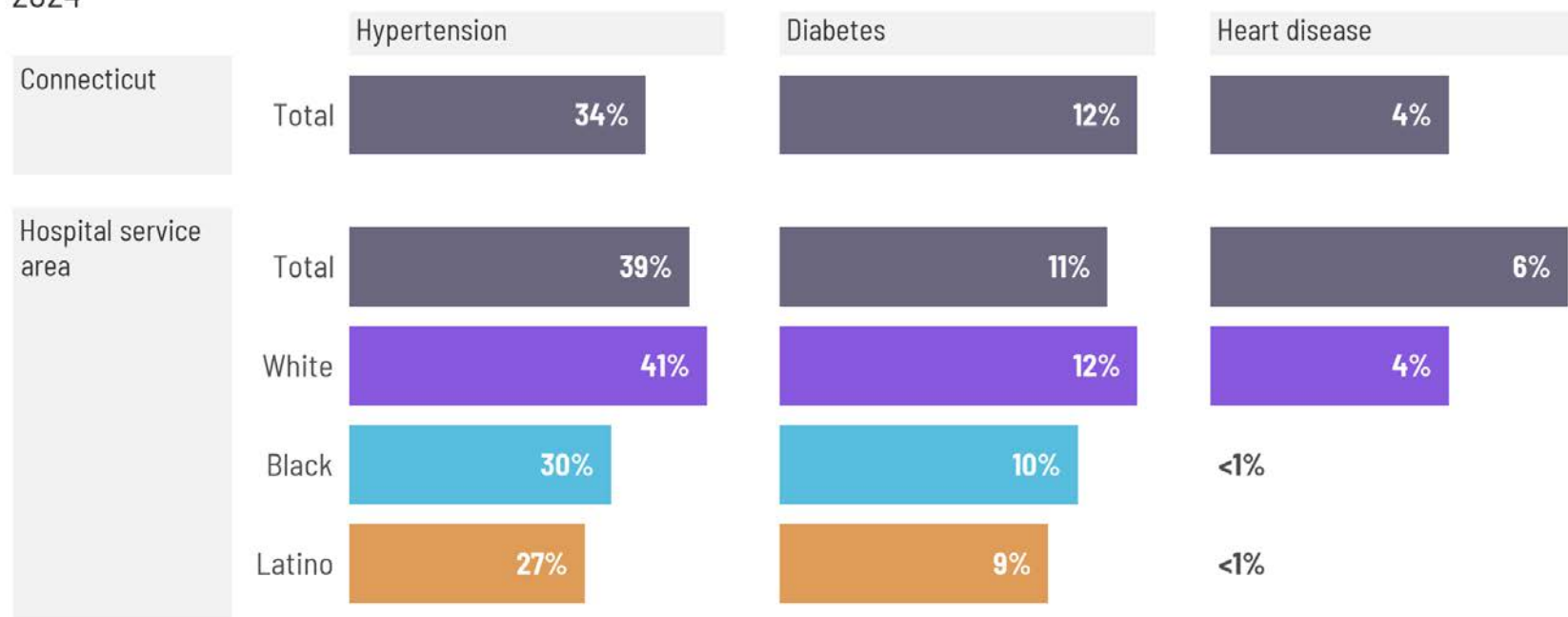
Source: 2024 DataHaven Community Wellbeing Survey

DataHaven

Figure 3: Greater Manchester Region Service Area Chronic Disease by Race and Ethnicity

Chronic disease

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and race/ethnicity, 2024



Source: 2024 DataHaven Community Wellbeing Survey

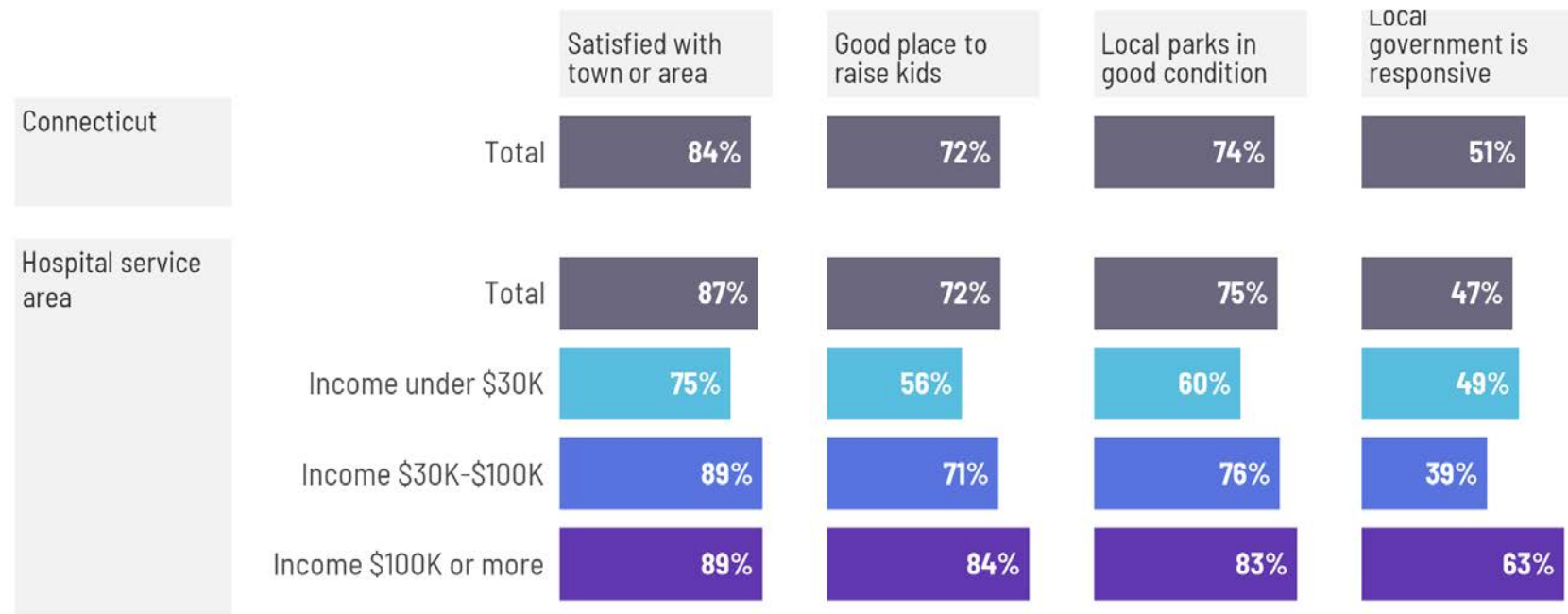
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Community Satisfaction

Figure 4: Greater Manchester Region Service Area Community Satisfaction by Income Level

Community satisfaction

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and income, 2024



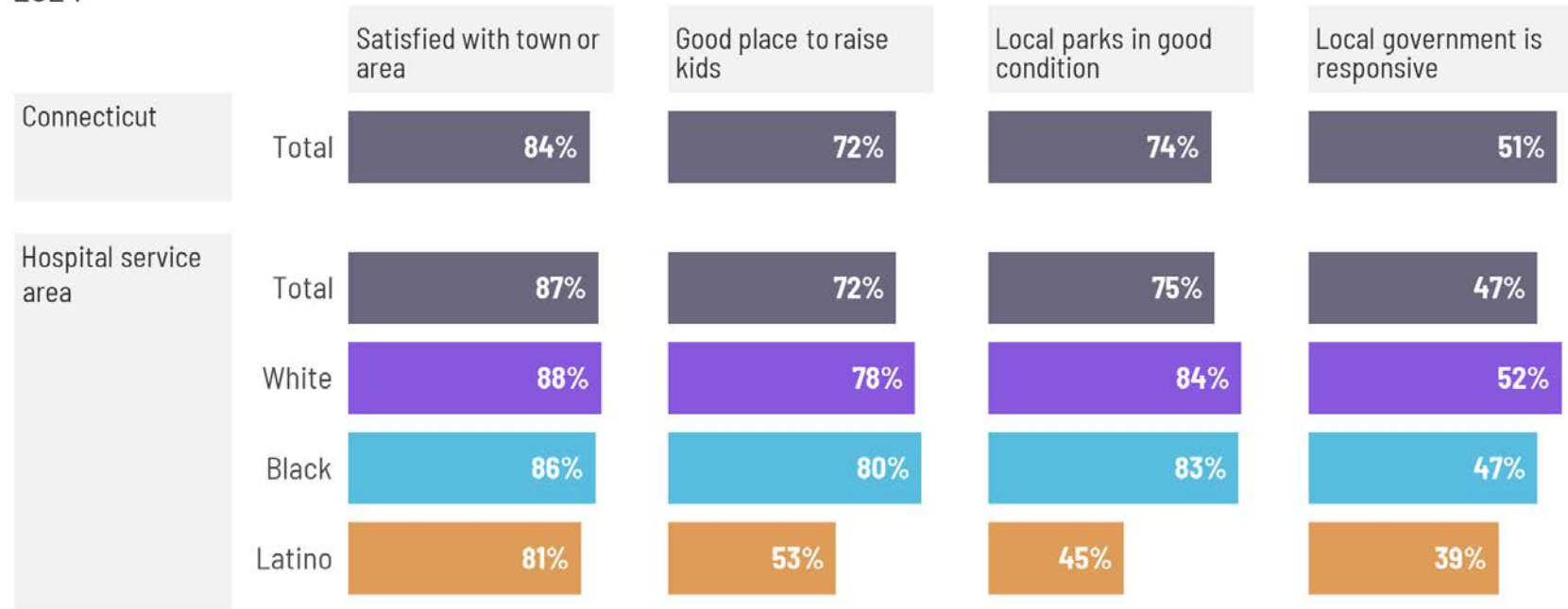
Source: 2024 DataHaven Community Wellbeing Survey

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Figure 5: Greater Manchester Region Service Area Community Satisfaction by Race and Ethnicity

Community satisfaction

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and race/ethnicity, 2024



Source: 2024 DataHaven Community Wellbeing Survey

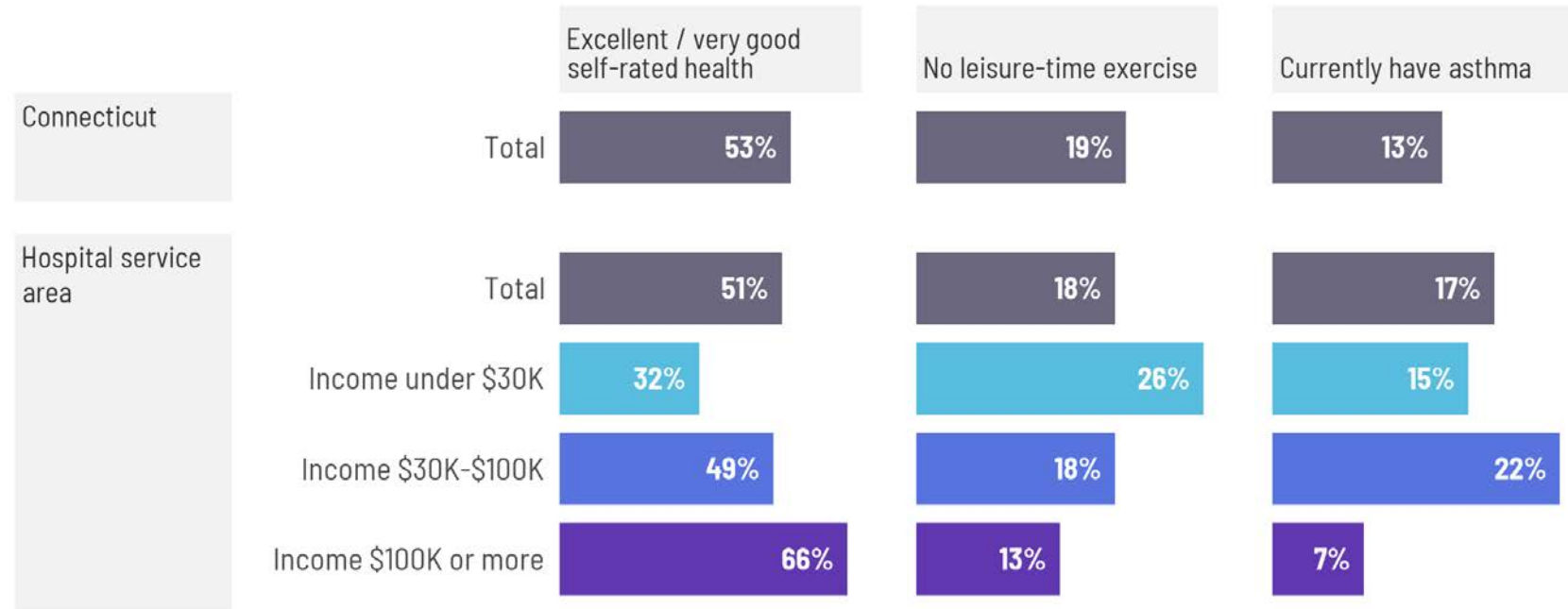
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Health Risks

Figure 6: Greater Manchester Region Service Area Health Risks by Income Level

Health risks

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and income, 2024



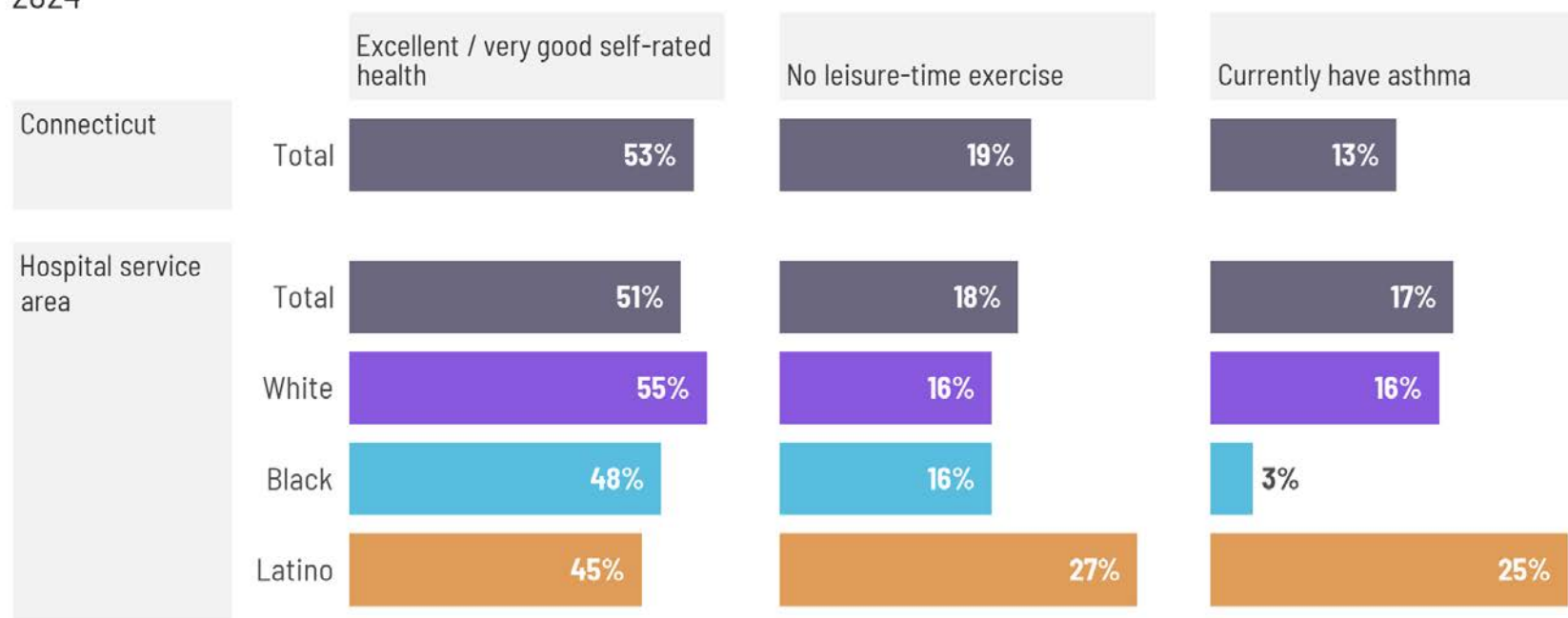
Source: 2024 DataHaven Community Wellbeing Survey

DataHaven

Figure 7: Greater Manchester Region Service Area Health Risks by Race and Ethnicity

Health risks

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and race/ethnicity, 2024



Source: 2024 DataHaven Community Wellbeing Survey

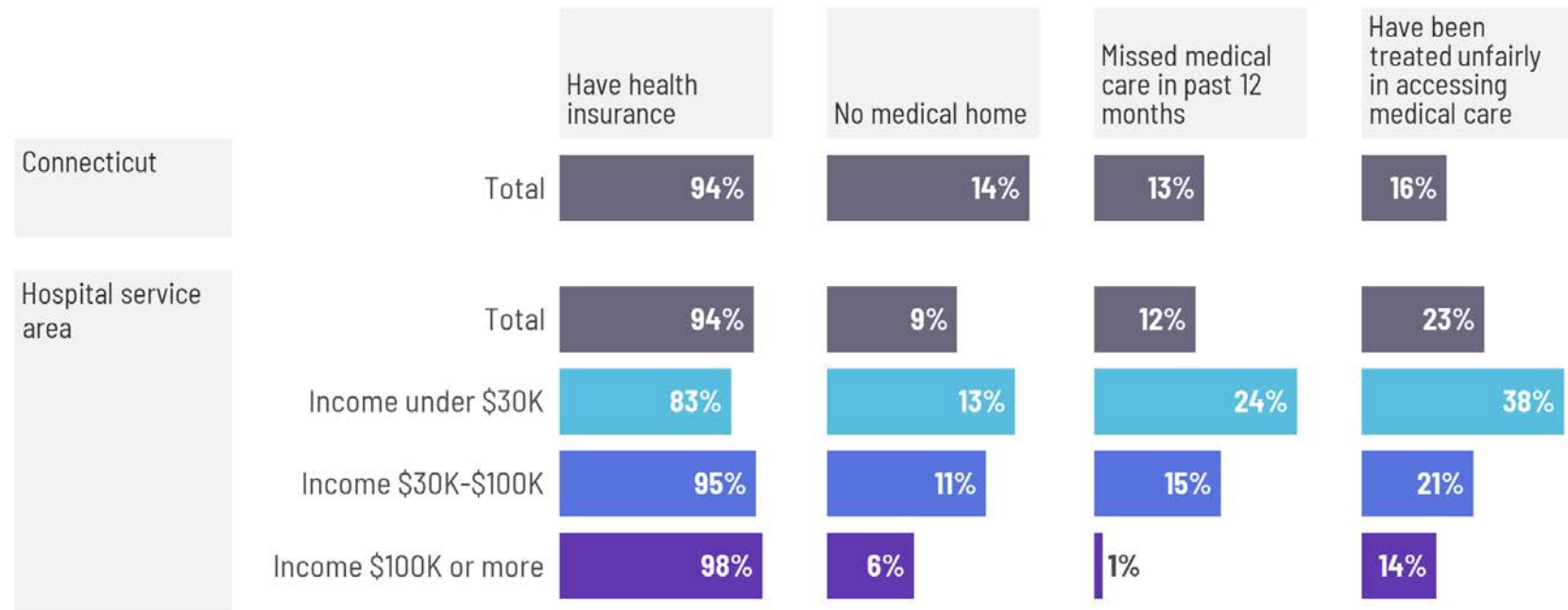
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Healthcare Access

Figure 8: Greater Manchester Region Service Area Healthcare Access by Income Level

Healthcare access

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and income, 2024



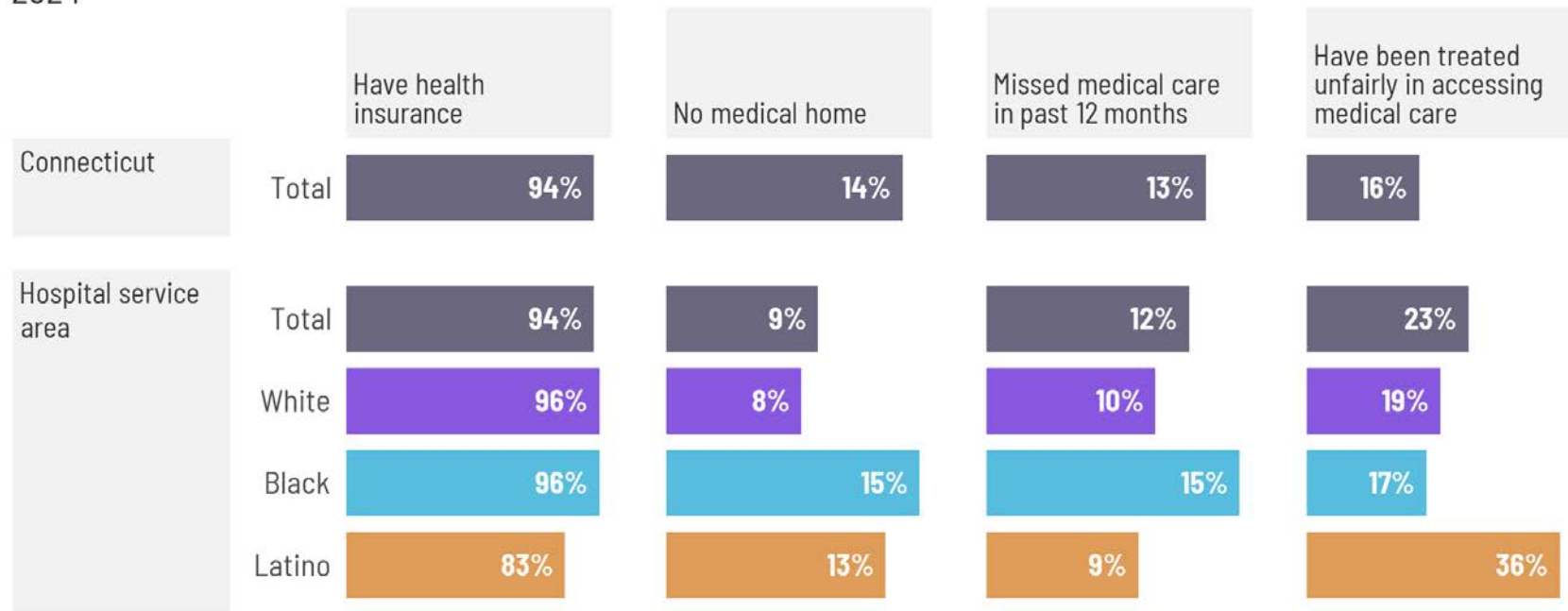
Source: 2024 DataHaven Community Wellbeing Survey

DataHaven

Figure 9: Greater Manchester Region Service Area Healthcare Access by Race and Ethnicity

Healthcare access

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and race/ethnicity, 2024



Source: 2024 DataHaven Community Wellbeing Survey

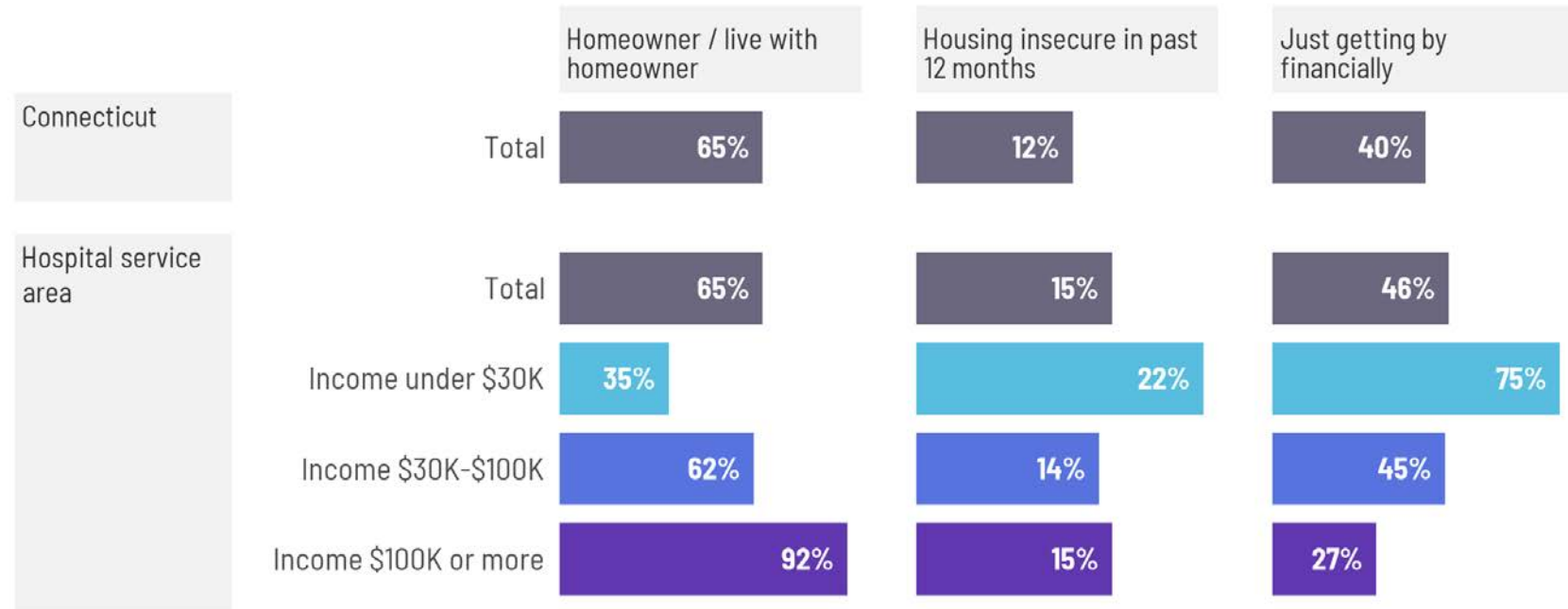
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Housing and Financial Wellbeing

Figure 10: Greater Manchester Region Service Area Housing and Financial Wellbeing by Income Level

Housing and financial well-being

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and income, 2024



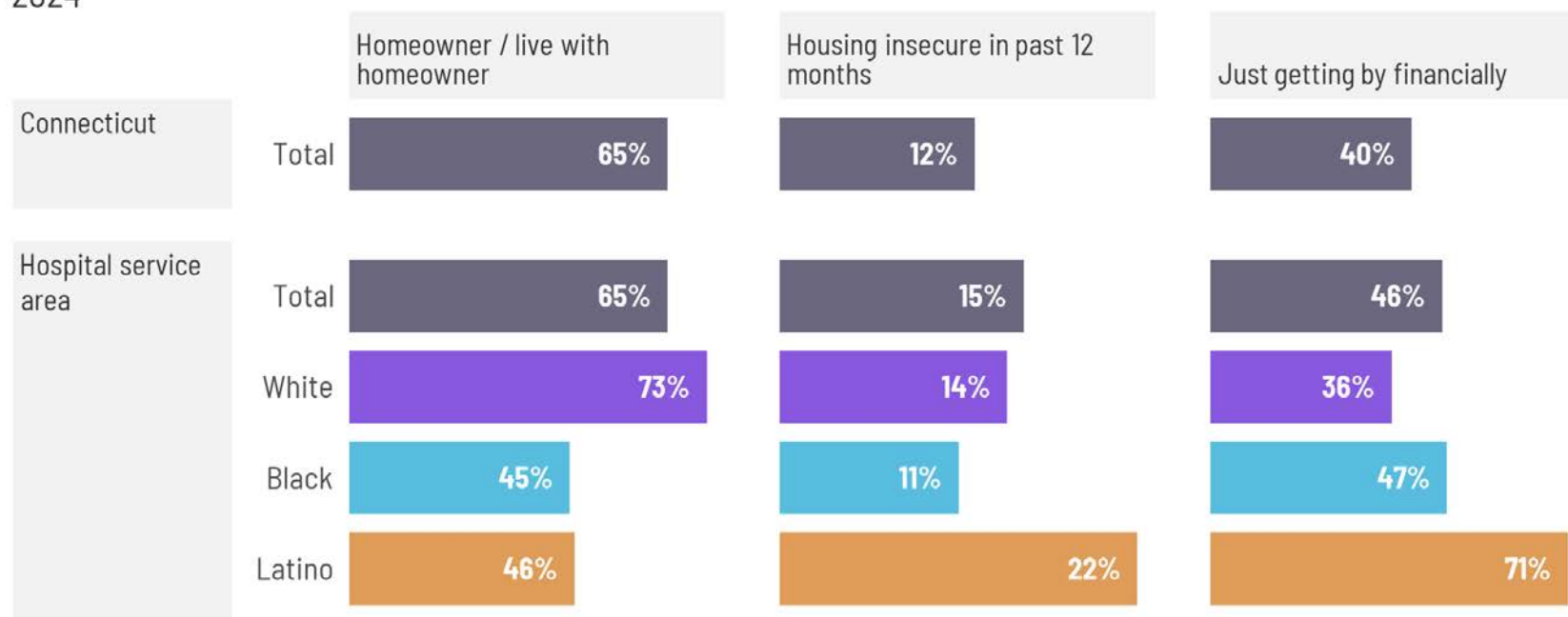
Source: 2024 DataHaven Community Wellbeing Survey

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Figure 11: Greater Manchester Region Service Area Housing and Financial Wellbeing by Race and Ethnicity

Housing and financial well-being

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and race/ethnicity, 2024



Source: 2024 DataHaven Community Wellbeing Survey

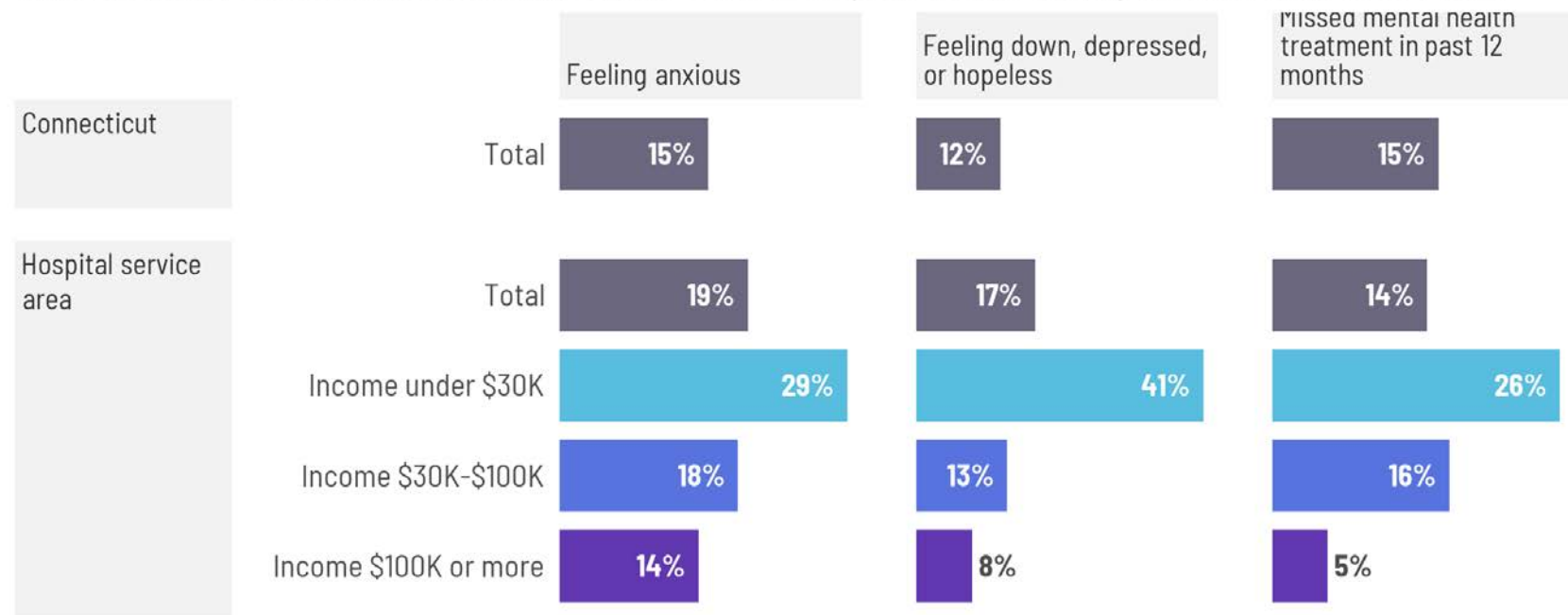
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Mental Health

Figure 12: Greater Manchester Region Service Area Mental Health by Income Level

Mental health

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and income, 2024



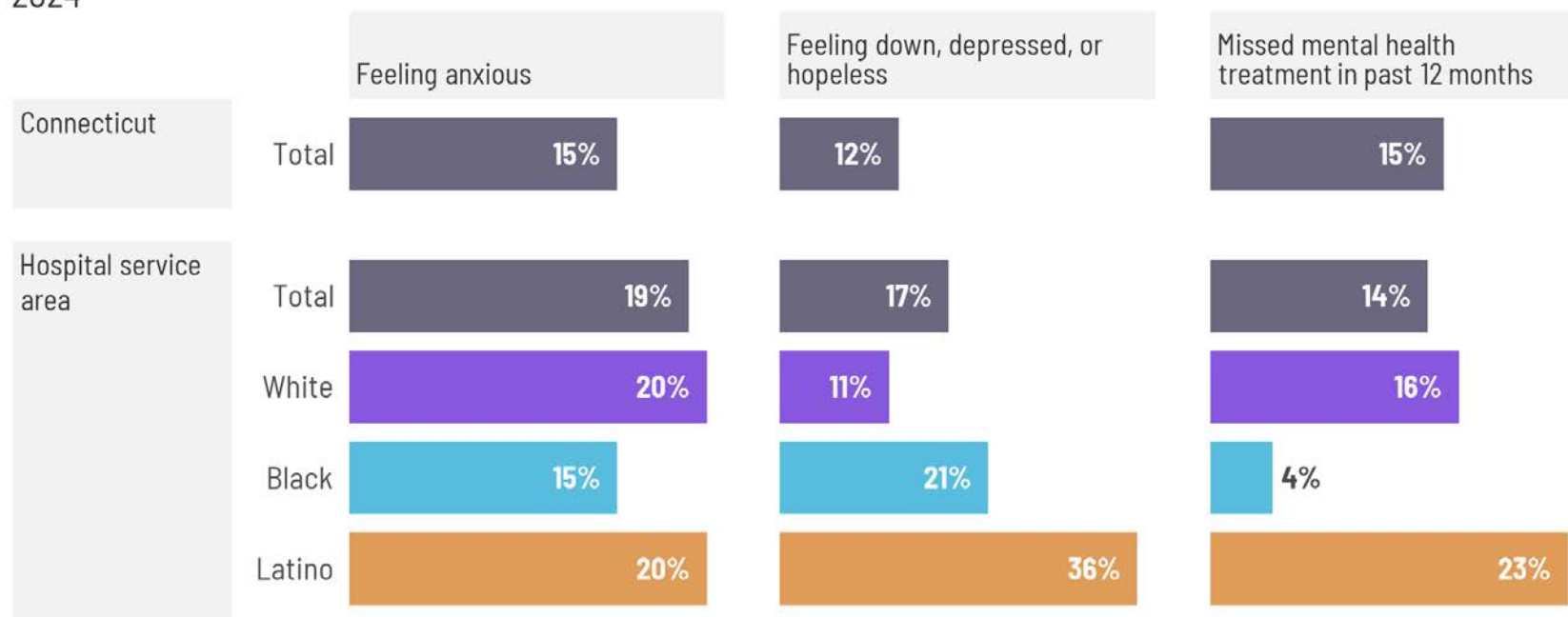
Source: 2024 DataHaven Community Wellbeing Survey

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Figure 13: Greater Manchester Region Service Area Mental Health by Race and Ethnicity

Mental health

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and race/ethnicity, 2024



Source: 2024 DataHaven Community Wellbeing Survey

DataHaven

Neighborhoods

Figure 14: Greater Manchester Region Service Area Neighborhood Safety and Facilities by Income Level

Neighborhoods

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and income, 2024



Source: 2024 DataHaven Community Wellbeing Survey

DataHaven

Figure 15: Greater Manchester Region Service Area Neighborhood Safety and Facilities by Race and Ethnicity

Neighborhoods

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and race/ethnicity, 2024



Source: 2024 DataHaven Community Wellbeing Survey

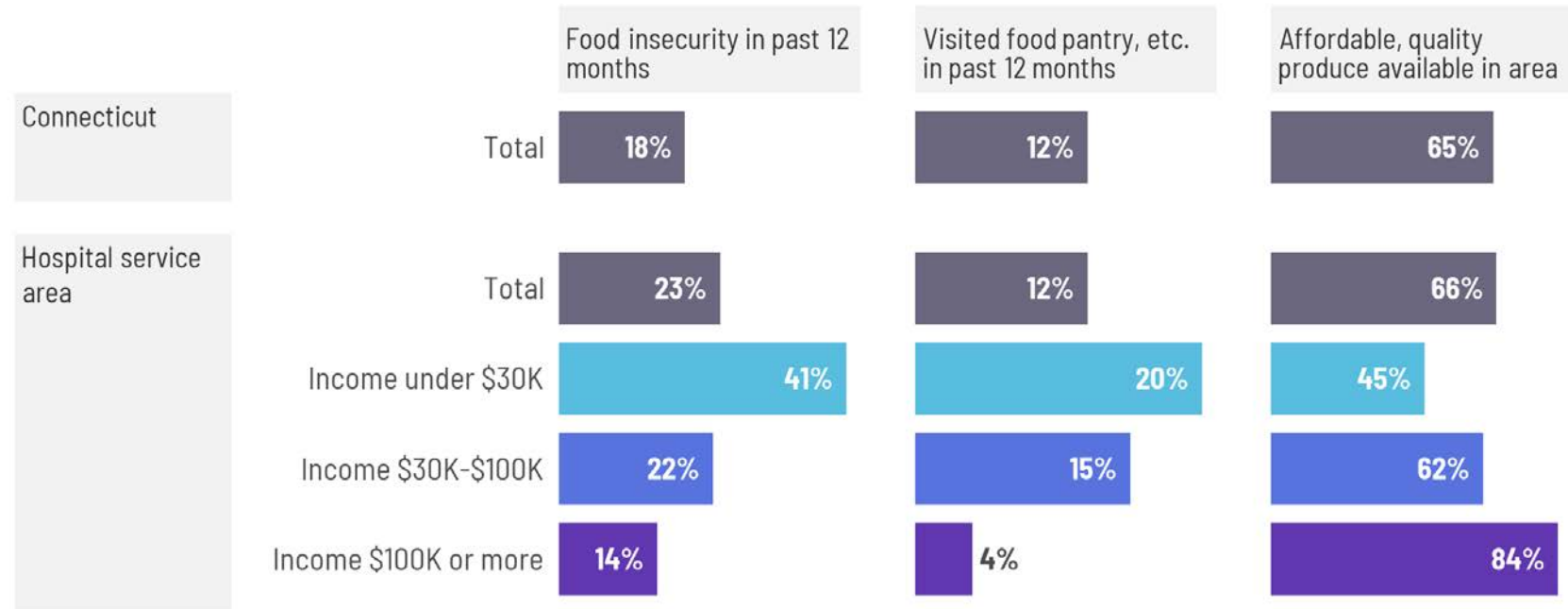
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Nutritional Security

Figure 16: Greater Manchester Region Service Area Nutritional Security by Income Level

Nutritional security

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and income, 2024



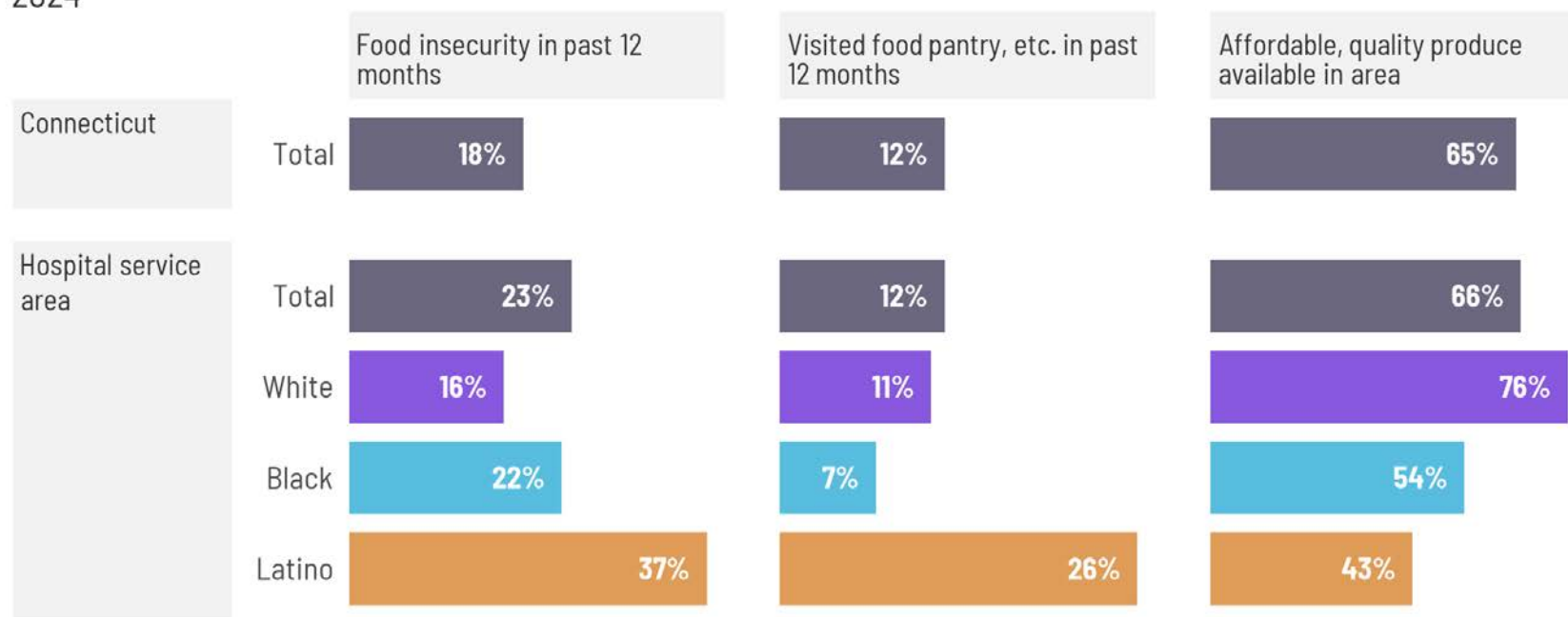
Source: 2024 DataHaven Community Wellbeing Survey

DataHaven

Figure 17: Greater Manchester Region Service Area Nutritional Security by Race and Ethnicity

Nutritional security

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and race/ethnicity, 2024



Source: 2024 DataHaven Community Wellbeing Survey

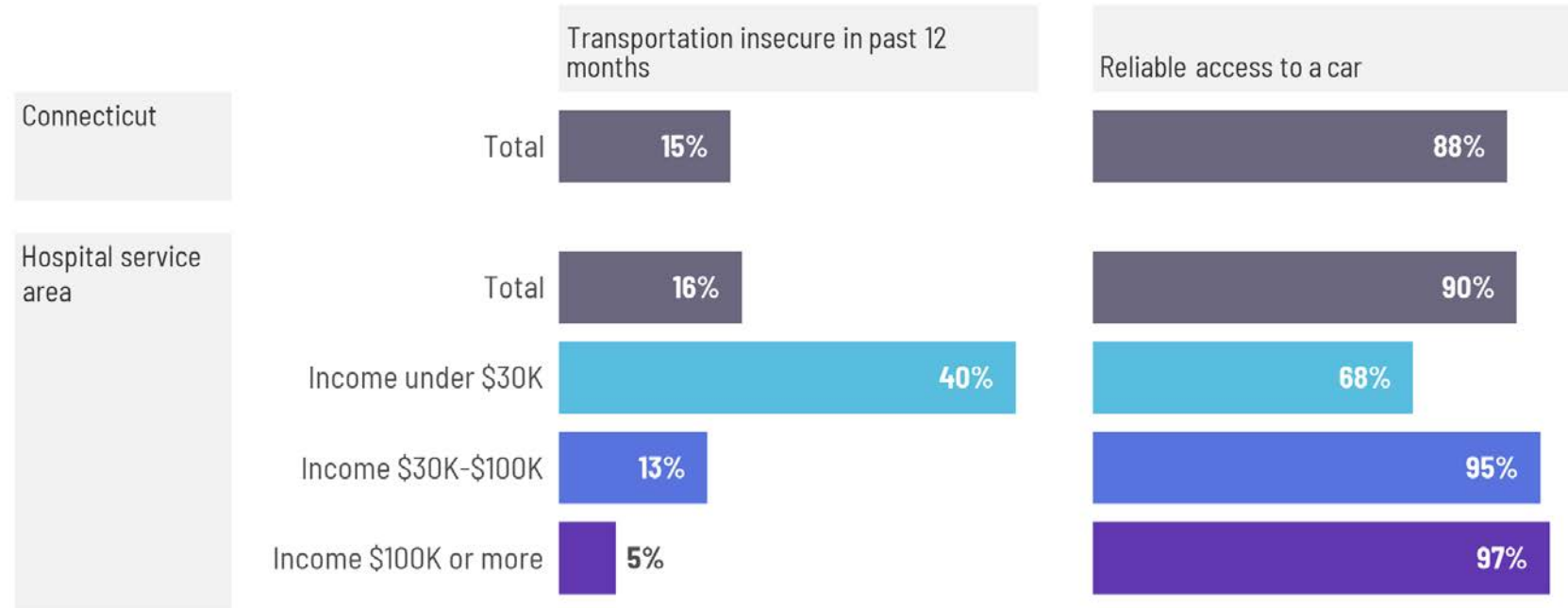
DataHaven

Transportation

Figure 18: Greater Manchester Region Service Area Transportation Access and Security by Income Level

Transportation

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and income, 2024



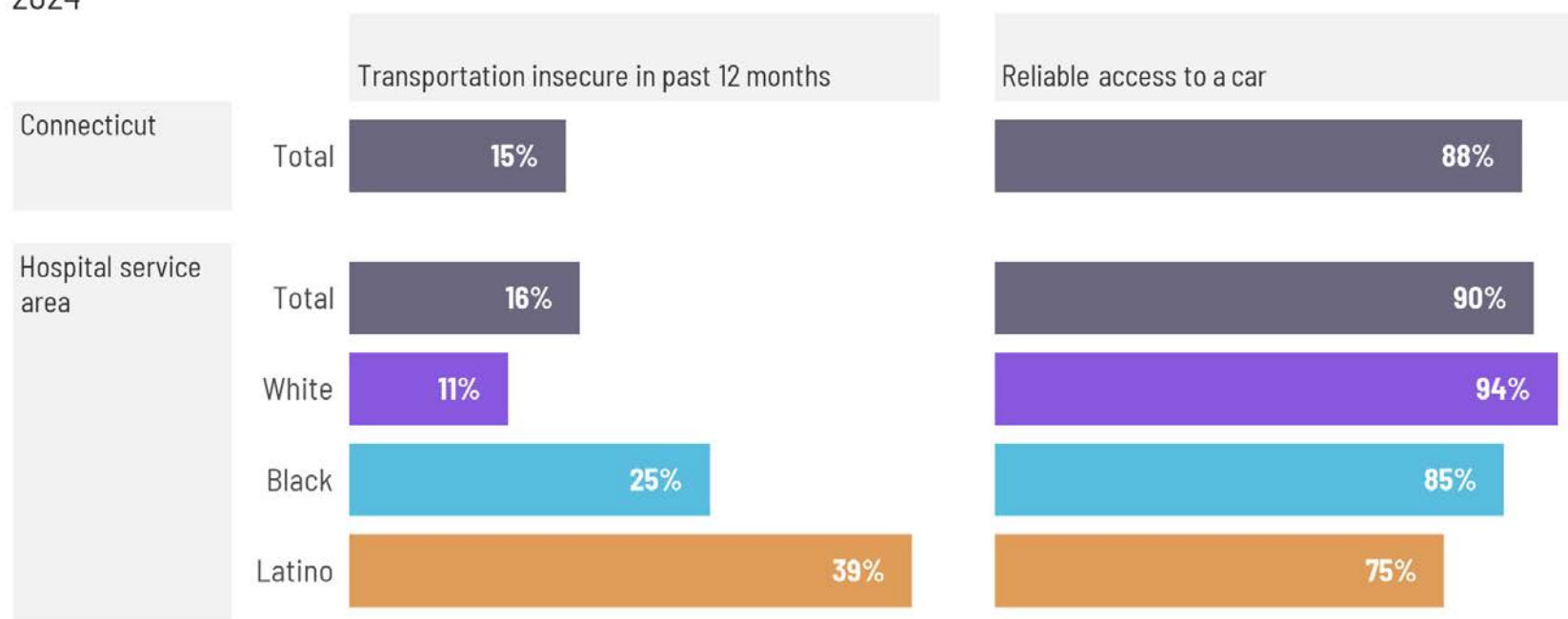
Source: 2024 DataHaven Community Wellbeing Survey

DataHaven

Figure 19: Greater Manchester Region Service Area Transportation Access and Security by Race and Ethnicity

Transportation

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and race/ethnicity, 2024



Source: 2024 DataHaven Community Wellbeing Survey

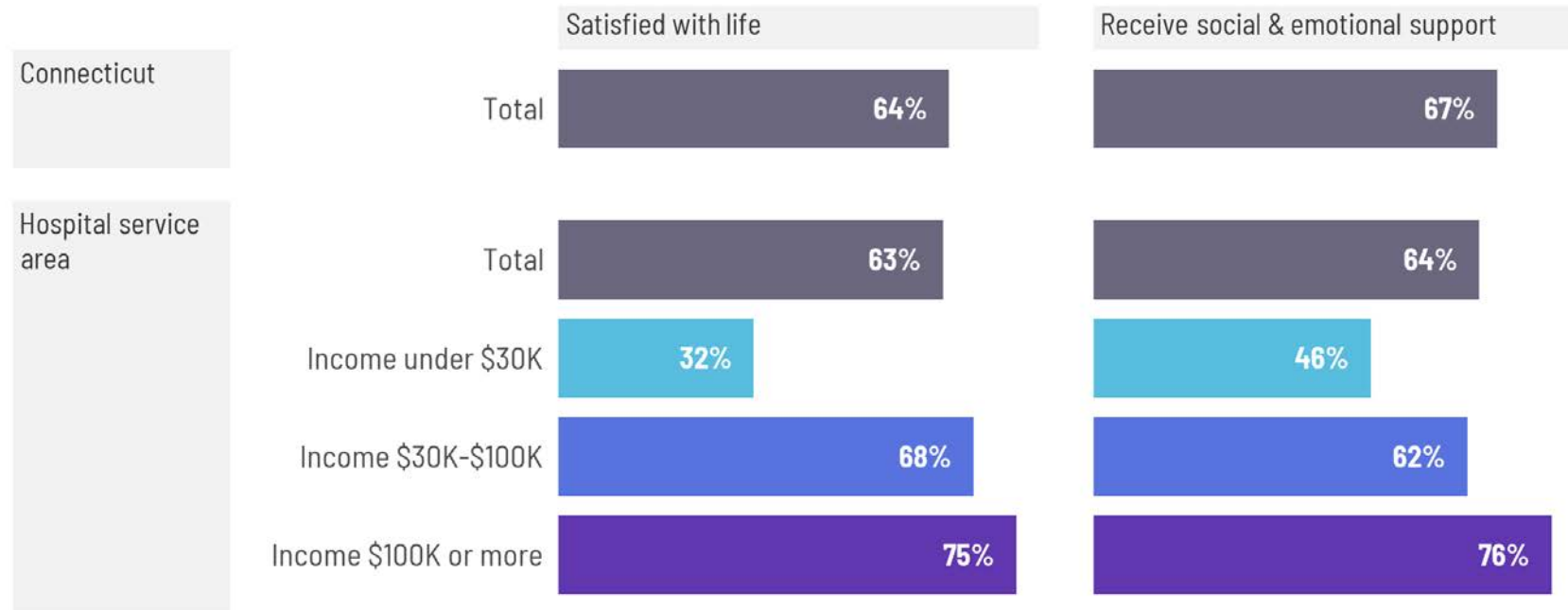
DataHaven

Wellbeing and Support

Figure 20: Greater Manchester Region Service Area Wellbeing and Support by Income Level

Well-being and support

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and income, 2024



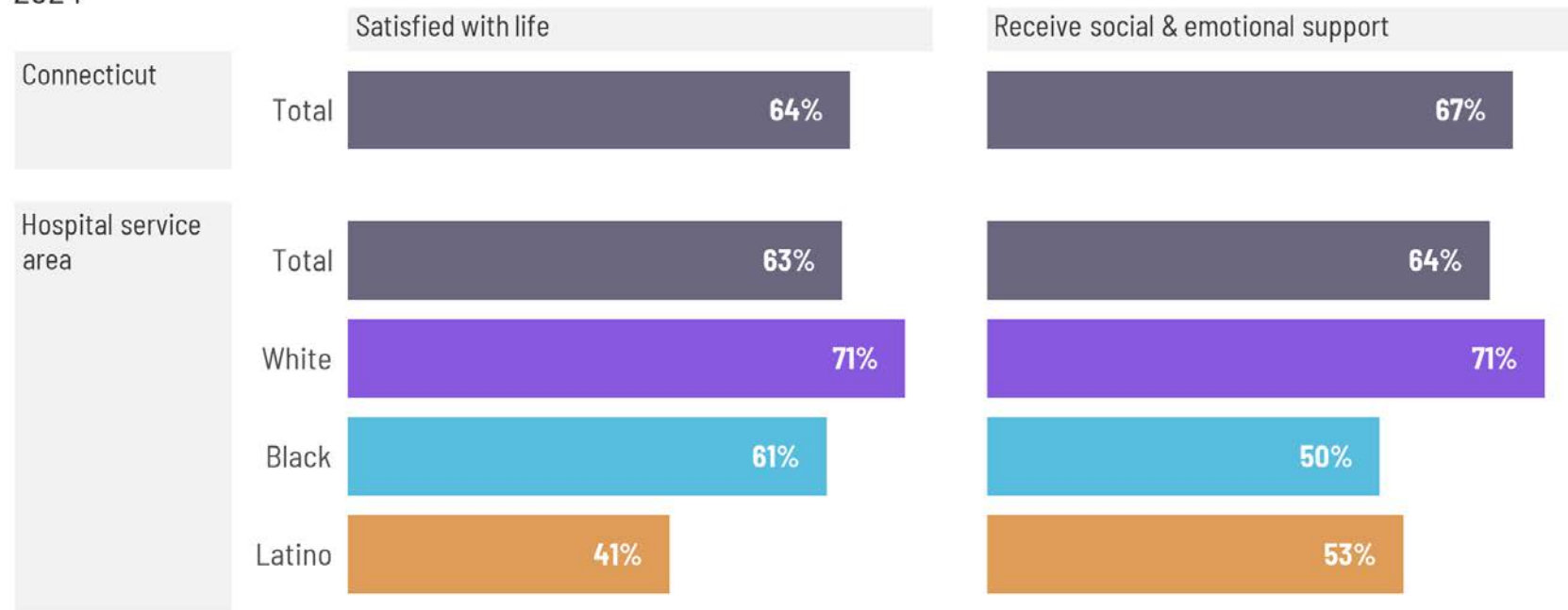
Source: 2024 DataHaven Community Wellbeing Survey

DataHaven

Figure 21: Greater Manchester Region Service Area Wellbeing and Support by Race and Ethnicity

Well-being and support

Share of adults, Manchester Memorial/Rockville General Hospital service area by location and race/ethnicity, 2024



Source: 2024 DataHaven Community Wellbeing Survey

DataHaven

Appendix 8: Internal Revenue Service Requirements for Community Health Needs Assessments

Internal Revenue Code § 501(r)(3) requires every tax-exempt hospital facility to perform a Community Health Needs Assessment (CHNA) at least once every three years and to adopt a written implementation strategy based on that assessment.⁵³ An authorized body must approve the CHNA report and adopt an implementation strategy to address the identified needs on or before the 15th day of the fifth month after the end of the taxable year in which the CHNA was conducted.⁵⁴ The CHNA report must be posted on a Web site and a paper copy available for public upon request and without charge at the hospital facility.⁵⁵

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

To conduct a CHNA, a hospital facility must:

1. Define the community it serves.
2. Assess the needs of that community
3. In assessing the health needs of the community, solicit and take into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health.
4. Document the CHNA in a written report (CHNA report) that is adopted for the hospital facility by an authorized body of the hospital facility
5. Make the CHNA report widely available to the public.⁵⁶

CHNA Documentation: The CHNA report must:

- 1. Define the hospital facility’s community.**

IRS Regulation Text: “A definition of the community served by the hospital facility and a description of how the community was determined.”⁵⁷

⁵³ 26 U.S.C. § 501(r)-3(a)(1).

⁵⁴ 26 U.S.C. § 501(r)-3(a)(2).

⁵⁵ 26 U.S.C. § 501(r)-3(b)(7).

⁵⁶ 26 U.S.C. § 501(r)-3(b).

⁵⁷ 26 U.S.C. § 501(r)-3(b)(6)(A).

In defining the community it serves...a hospital facility may take into account all of the relevant facts and circumstances, including the geographic area served by the hospital facility, target population(s) served (for example, children, women, or the aged), and principal functions (for example, focus on a particular specialty area or targeted disease). However, a hospital facility may not define its community to exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital facility draws its patients (unless such populations are not part of the hospital facility's target patient population(s) or affected by its principal functions) or otherwise should be included based on the method the hospital facility uses to define its community. [A] hospital facility must take into account all patients without regard to whether (or how much) they or their insurers pay for the care received or whether they are eligible for assistance under the hospital facility's financial assistance policy. In the case of a hospital facility consisting of multiple buildings that operate under a single state license and serve different geographic areas or populations, the community served by the hospital facility is the aggregate of such areas or populations.⁵⁸

Section within this CHNA: “What is unique about this community and its health needs?” (p10-13); Demographic Analysis and Community Input (p15 ff); and Community Demographic Profile (p15ff)

2. Process and Methods.

IRS Regulation Text: “A description of the process and methods used to conduct the CHNA.”⁵⁹ To assess the health needs of the community it serves...a hospital facility must identify significant health needs of the community, prioritize those health needs, and identify resources (such as organizations, facilities, and programs in the community, including those of the hospital facility) potentially available to address those health needs. For these purposes, the health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities). These needs may include, for example, the need to address financial and other barriers to accessing care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community. A hospital facility may determine whether a health need is significant based on all of the facts and circumstances present in the community it serves. In addition, a hospital facility may use any criteria to prioritize the significant health needs it identifies, including, but not limited to, the burden, scope,

⁵⁸ 26 U.S.C. § 1.501(r)-3(b)(3).

⁵⁹ 26 U.S.C. § 1.501(r)-3(b)(6)(B).

severity, or urgency of the health need; the estimated feasibility and effectiveness of possible interventions; the health disparities associated with the need; or the importance the community places on addressing the need.⁶⁰

A hospital facility's CHNA report [must] describe the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identify any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA. In the case of data obtained from external source material, the CHNA report may cite the source material rather than describe the method of collecting the data.⁶¹

Section within this CHNA: Process / Methodology (p3-4); CHNA Process Overview and Timeline (p8ff), [Needs Assessment Research Approach (p8); Detailed Research Method (p9)].

3. Describe solicitation and Community Input

IRS Regulation Text: “A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves”⁶²: [A] hospital facility must solicit and take into account input received from all of the following sources in identifying and prioritizing significant health needs and in identifying resources potentially available to address those health needs:

(A) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency), or a State Office of Rural Health... with knowledge, information, or expertise relevant to the health needs of that community.

(B) Members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of such populations. Medically underserved populations include populations experiencing health disparities or at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers.

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

⁶⁰ 26 U.S.C. § 1.501(r)-3(b)(4).

⁶¹ 26 U.S.C. § 1.501(r)-3(b)(6)(ii).

⁶² 26 U.S.C. § 1.501(r)-3(b)(6)(C).

In addition ... a hospital facility may solicit and take into account input received from a broad range of persons located in or serving its community, including, but not limited to, health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers and community health centers, health insurance and managed care organizations, private businesses, and labor and workforce representatives.⁶³

A hospital facility's CHNA report [must] summarize, in general terms, any input provided by such persons and how and over what time period such input was provided (for example, whether through meetings, focus groups, interviews, surveys, or written comments and between what approximate dates); provide the names of any organizations providing input and summarize the nature and extent of the organization's input; and describe the medically underserved, low-income, or minority populations being represented by organizations or individuals that provided input. ... In the event a hospital facility solicits, but cannot obtain, input from a [required] source, the hospital facility's CHNA report also must describe the hospital facility's efforts to solicit input from such source.⁶⁴

Section within this CHNA: Process / Methodology (p3-4); CHNA Process Overview and Timeline (p8ff) [Needs Assessment Research Approach (p8); Detailed Research Method (p9)]; Demographic Analysis and Community Input (p15); Qualitative Research Highlights (p34ff); Community Well-being Survey and Other Research (p45 ff); Data Analysis and Community Input Summary (p52).

4. Prioritized list of community health needs.

IRS Regulation Text: "A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs"⁶⁵

Section within this CHNA: Results (p5); "What did we prioritize and how?" (p54ff), [Prioritization Process (p54-55); Final Priorities (P56)].

⁶³ 26 U.S.C. § 1.501(r)-3(b)(5).

⁶⁴ 26 U.S.C. § 1.501(r)-3(b)(6)(iii).

⁶⁵ 26 U.S.C. § 1.501(r)-3(b)(6)(D).

5. Community resources

IRS Regulation Text: “A description of the resources potentially available to address the significant health needs identified through the CHNA.”⁶⁶

Section within this CHNA: Appendix 11 (p130ff).

6. Impact Evaluation

IRS Regulation Text: “An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).”⁶⁷

Section within this CHNA: Evaluation of 2019 Community Health Needs Assessment and Subsequent Initiatives (p53ff).

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

1. Posting on a website until two subsequent CHNAs are posted; and
2. Making a paper copy available for public inspection without charge until two subsequent CHNAs are available.⁶⁸

Implementation Strategy Requirements

1. Implementation Strategy:

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

- i. Describes how the hospital facility plans to address the health need; or
- ii. Identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address the health need.⁶⁹

Section within this Implementation Strategy: “What do we intend to do, and how will we know we are successful?” P57ff).

⁶⁶ 26 U.S.C. § 1.501(r)-3(b)(6)(E).

⁶⁷ 26 U.S.C. § 1.501(r)-3(b)(6)(F).

⁶⁸ 26 C.F.R. § 1.501(r)-3(b)(7)(i).

⁶⁹ 26 C.F.R. § 1.501(r)-3(c)(1).

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

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

- i. Describes the actions the hospital facility intends to take to address the health need and the anticipated impact of these actions;
- ii. Identifies the resources the hospital facility plans to commit to address the health need; and⁷⁰
- iii. Describes any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need.

Section within this Implementation Strategy: "What do we intend to do, and how will we know we are successful?" P57ff).

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

IRS Regulation Text: In explaining why it does not intend to address a significant health need [...], a brief explanation of the hospital facility's reason for not addressing the health need is sufficient. Such reasons may include, for example, resource constraints, other facilities or organizations in the community addressing the need, a relative lack of expertise or competency to effectively address the need, the need being a relatively low priority, and/or a lack of identified effective interventions to address the need.⁷¹

Section within this Implementation Strategy: "What do we intend to do, and how will we know we are successful?" P57ff).

⁷⁰ 26 C.F.R. § 1.501(r)-3(c)(2).

⁷¹ 26 C.F.R. § 1.501(r)-3(c)(3).

Appendix 9: Predictive Analytics – Original Profile

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

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

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

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

Core Findings

Key Drivers of Community Risk

Our modeling identified the following factors as the most powerful predictors of vulnerability across these geographies. To improve health outcomes, interventions should target these specific root causes:

- Economic Barriers: High rates of residents living below 150% of the poverty level, lack of a high school diploma, and high housing cost burdens.
- Household Stressors: A high prevalence of single-parent households and residents living with disabilities.
- Systemic Barriers: Minority status and limited English proficiency, which often serve as gateways to broader social risk.
- Mobility Gaps: A critical lack of personal vehicle access, which can be a leading physical barrier to healthcare utilization.

Census Tract Risk Profiles

The analysis reveals that while both census tracts are in high-need regions, the nature of their risk profiles requires fundamentally different strategies:

- **Census Tract 5147: Systemic Vulnerability.** This tract is categorized as High Impact overall. The core finding here is a multifaceted risk: the tract simultaneously scores high in minority status (0.781) and underperforms significantly in housing and transportation (PRR 3.76). This indicates that the community is not just "at risk" due to one factor, but is suffering from a compounding effect where social barriers prevent residents from accessing the care they need. The gap between what the data predicts (0.429) and what is observed (0.838) suggests that existing community resources were insufficient to keep pace with these overlapping challenges.
- **Census Tract 5302: Performance Gaps & Hidden Barriers.** While this tract is categorized as Medium Impact overall, it contains the widest gaps between predicted and observed risk in the study. Specifically, in the realm of Housing and Transportation, this community's observed risk is 6.5 times higher than predicted (PRR 6.48). This finding suggests a hidden vulnerability—on paper, the tract looks more stable than its peer, but in practice, the residents are experiencing difficulty. This suggests a less-resilient community, where even a small concentration of risk factors can lead to disproportionately negative community outcomes.

Strategic Interventions – Where to Focus Efforts for Increased Impact

- **Outcome-Driven Outreach:** Deploy mobile units and non-emergency medical transportation (NEMT) specifically to Tract 5302 to bridge the mobility-access gap.
- **Community Partnership:** Launch multi-lingual health navigation and equity programs in Tract 5147 to address the high observed vulnerability in underserved minority households.

Brief Interpretation Guide: To assist in navigating this report, please keep the following metrics in mind:

- **Weighted Predicted Risk (0.0 to 1.0):** This represents the "expected" vulnerability of a neighborhood. Rather than a simple average, this score is **weighted**; the model identifies which specific challenges (like poverty or education) are the strongest predictors of negative outcomes and prioritizes them.
 - **Higher Scores (e.g., 0.85 - 1.0):** Indicate a high concentration of the most powerful drivers of risk.
 - **Lower Scores (e.g., 0.0 - 0.20):** Indicate the area lacks the specific high-impact drivers that typically lead to poor outcomes.
- **PRR Index (The Performance Gap):** This "Performance to Risk Ratio (PRR)" compares actual vulnerability to our weighted prediction.
 - **Score > 1.5 (High):** The area is **Underperforming**. Vulnerability is higher than expected, signaling a need for focused support.
 - **Score < 0.8 (Low):** The area is **Resilient**. The community is performing better than its risk profile suggests.

Comparative Theme Analysis – The Details

1. Overall Community Vulnerability (Total SVI)

This composite metric aggregates all social factors to provide a bird's-eye view of community fragility.

- Top 3 Key Drivers:
 - i. Poverty Residents living below 150% of the poverty level.
 - ii. Education Gap Adults without a high school diploma.
 - iii. Racial and Ethnic Minority Status Proportion of people with racial and ethnic minority status
- Census Tract 5147: High Impact. (Weighted Risk: 0.429 | PRR: 1.91). This tract shows multifaceted risk stemming from the overlap of a number of economic, racial, and household factors. With a PRR nearly at 2.0, the community is experiencing twice the vulnerability the model expects. This is the highest priority area for comprehensive, multi-disciplinary health programs.
- Census Tract 5302: Medium Impact. (Weighted Risk: 0.393 | PRR: 2.18). Although the weighted risk is lower than its peer, the performance gap (PRR) is higher. This indicates that while there are fewer risk factors strongly influencing outcomes, the community is still struggling to manage them, resulting in an underperforming status.

2. Socioeconomic Status (Theme 1)

Evaluates economic health, including income, employment, and education.

- Top 3 Key Drivers:
 - i. Poverty: Residents living below 150% of the poverty level.
 - ii. Education Gap: Adults without a high school diploma.
 - iii. Housing Cost Burden: Families spending over 30% of their income on rent or mortgages.
- Census Tract 5302: High Impact. (Weighted Risk: 0.394 | PRR: 2.14). This tract is the economic "hotspot" of the study. The high weighted predicted risk indicates that the specific drivers here—poverty and educational attainment—are strong predictors of poor outcomes. The high PRR suggests that current economic assistance programs may not be reaching enough residents to offset these foundational risks.
- Census Tract 5147: Medium Impact. (Weighted Risk: 0.352 | PRR: 1.96). While the risk is slightly lower than Tract 5302, it remains nearly double what the model expects, indicating that socioeconomic stressors are compounded by other local environmental factors.

3. Household Characteristics & Disability (Theme 2)

Examines vulnerability related to age, physical ability, and family structure.

- Top 3 Key Drivers:
 - i. Single-Parent Households: Increased demand for childcare and single-income stability.
 - ii. Persons with Disabilities: Need for specialized healthcare access and physical infrastructure.
 - iii. Limited English Proficiency: Potential barriers to navigating health instructions and insurance.
- Census Tract 5147: High Impact. (Weighted Risk: 0.241 | PRR: 3.45). This tract is an outlier. The observed vulnerability is more than triple the predicted risk. This suggests a lack of social safety nets for single parents and disabled residents. Investments in multi-lingual health navigators and home-based support services would likely close this performance gap.
- Census Tract 5302: High Impact. (Weighted Risk: 0.197 | PRR: 4.05). A PRR over 4.0 is a red flag for unmet need. Despite having fewer expected key drivers, the actual vulnerability is extreme, signaling that even a small population of disabled or non-English speaking residents in this area likely face disproportionately high barriers.

4. Racial & Ethnic Minority Status (Theme 3)

Identifies communities facing systemic barriers to health equity.

- Primary Key Driver: Racial and Ethnic Minority Status.
- Census Tract 5147: High Impact. (Weighted Risk: 0.781 | PRR: 1.06). The observed vulnerability aligns almost perfectly with the high weighted risk. This indicates that minority status is the dominant driver of the community's profile, and targeted health equity initiatives (e.g., culturally tailored wellness programs) are fundamentally necessary here.
- Census Tract 5302: Medium Impact. (Weighted Risk: 0.359 | PRR: 1.44). This tract shows more resilience in this category, with community performance aligning more closely with the model's predictions.

5. Housing Type & Transportation (Theme 4)

Looks at mobility, housing density, and physical living environments.

- Top 3 Key Drivers:
 - Lack of Vehicle Access: One of the strongest predictors of missed medical appointments and delayed care.
 - Group Living Environments: Increased risk in institutionalized or shared housing.
 - Household Crowding: More residents than rooms, impacting chronic stress and infectious disease spread.

- Census Tract 5147: High Impact. (Weighted Risk: 0.193 | PRR: 3.76). Mobility is a significant barrier. Despite a low predicted score, the high observed vulnerability suggests that residents are likely isolated from services by lack of mobility.
- Census Tract 5302: Medium Impact. (Weighted Risk: 0.118 | PRR: 6.48). o Strategic Insight: This represents the most extreme disparity in the entire report. While the area has very few expected housing risks, the observed vulnerability is nearly 6.5 times higher than predicted, suggesting a “transportation desert.” Funding non-emergency medical transportation (NEMT) or localized "micro-clinics" here is the highest ROI opportunity for improving outcomes.

Appendix 10: Additional Predictive Analytics Highlights

To anticipate future high-risk health-related needs (not only better understand existing ones), MMA conducted a “predictive analytics” analysis. Specifically, to increase the impact of its CHNAs and CHIPs, took additional steps to evaluate core health conditions. This deeper evaluation aims to better understand the underlying health-related social need factors driving risk for these outcomes. By understanding these factors, systems can more effectively prioritize interventions and resources within the communities served, ultimately maximizing positive influence. Specifically, health systems examined community health risk profiles developed using machine learning and predictive analytics. These analyses identified and evaluated important factors contributing to negative outcomes and life expectancy. The resulting insights allow hospitals to optimize interventions by 1) identifying key factors driving risk in the four areas, 2) establishing a solid basis for data-driven decision-making while setting expectations around community-based trends, and 3) pinpointing communities to focus efforts, both for improvement and for leveraging best practices.

The predictive modeling focused on health issues within the service areas that are at risk of accelerating due to underlying demographic, lifestyle, and other community trends. To address these potential challenges proactively, the CHNA identified the key drivers behind each issue (i.e., the impacting demographic or lifestyle trends).

The following results summarize and present the following:

- Location Description
- Measuring risk
- Variables that reflect community risk and vulnerability
- Summary of Key Findings and a Comparison Between the Two Census Tracts
- Detailed Narrative of the Findings
- Recommendations

Location Description

There are two US Census Tracts that require particular focus – 5147 and 5302. To do so, the CHNA Predictive Analytics model compared data from the two tracts to other local and regional benchmarks. While both Census Tracts 5147 and 5302 are situated within high-need regions, their risk profiles differ substantially. Tract 5147 reflects layered, systemic vulnerability across multiple domains. Tract 5302 reveals performance gaps and hidden barriers—particularly in mobility and transportation—that disproportionately amplify risk beyond predictive expectations.

- Census Tract 5147 (Location description: Route 44 and Hartford Road (south to north boundaries); Pine Street and Spruce Street (east to west boundaries): Systemic Vulnerability.
- Census Tract 5302 (Location description: Union Street and Elm Street (west boundary); South Street and West Street (east boundary); Tunnel Road and the Turnpike (north and south boundaries)

Measuring Risk

The predictive analytics model uses two important measurements to evaluate , or “rate,” issues impacting future, anticipated health-related needs.

- Performance to Risk Ratio(PRR).
The PPR simply compares the actual vulnerability of a community to the “weighted predicted” value. Both scores are based on current demographic and/or health-related data and predicted values.
 - If the PRR is 1.5 or higher, the community is (in actuality) more vulnerable to poor health outcomes than predicted.
 - If the PRR is less than 0.80, the community is performing better than expected (a “good thing”).
- Weighted Predictive Risk (WPR) noted on a zero to one scale).
 - If the WPR is 0.85 to 1.00, the community is at a particularly high risk for poor health outcomes.
 - If the WPR is less than 0.20, the community lacks the things usually leading to poor health outcomes (i.e., a “good” thing).

Variables that Reflect Community Risk and Vulnerability

Modeling identified the following factors as the most powerful predictors of vulnerability (i.e., “root causes”) across these geographies.

- Economic Barriers: Rates of residents living below 150% of the poverty level, lack of a high school diploma, and high housing cost burdens.
- Household Stressors: A high prevalence of single-parent households and residents living with disabilities.
- Systemic Barriers: Limited English proficiency which often serve as gateways to broader social risk.
- Mobility Gaps: A critical lack of personal vehicle access, which can be a leading physical barrier to healthcare utilization.

The table below provides a summary of the predictive analytics analysis for Census Tracts 5147 and 5302.

Summary of Key Findings and a Comparison Between the Two Census Tracts – 5147 and 5302

The table below four Key Themes that impact social and demographic vulnerability and related health risks. The themes are listed in the first (left-most) column below. For each Census Tract and each Key Theme, four items are listed: Impact (i.e., the degree of impact or influence the theme has on the overall health-related vulnerability in the Census Tract, the WPR, the PRR, and a remark to help add clarity.

Key Themes	Census Tract 5147	Census Tract 5302
Socioeconomic Status (Theme 1)	Medium Impact WPR: 0.352 PRR: 1.96 Remark: Economic stress compounded by other factors.	High Impact WPR: 0.394 PRR: 2.14 Remark: Economic hotspot; poverty and education strongly predictive.
Household Characteristics & Disability (Theme 2)	High Impact WPR: 0.241 PRR: 3.45 Remark: Significant safety net gaps.	High Impact WPR: 0.197 PRR: 4.05 Remark: Extreme performance gap; acute unmet need.
Racial & Ethnic Minority Status (Theme 3)	High Impact WPR: 0.781 PRR: 1.06 Remark: Dominant structural driver.	Medium Impact WPR: 0.359 PRR: 1.44 Remark: Present but comparatively more resilient.
Housing Type & Transportation (Theme 4)	High Impact WPR: 0.193 PRR: 3.76 Remark: Mobility barriers exceed expectations.	Medium Impact WPR: 0.118 PRR: 6.48 Remark: Largest disparity; likely transportation desert.
Overall Community Vulnerability (Total SVI)	High Impact WPR: 0.429 PRR: 1.91 Remark: Multifaceted, overlapping structural risk.	Medium Impact WPR: 0.393 PRR: 2.18 Remark: Fewer drivers but larger performance gap.

Detailed Narrative of the Findings

6. Socioeconomic Status (Theme 1)

Evaluates economic health, including income, employment, and education.

- Top 3 Key Drivers:
 - iv. Poverty: Residents living below 150% of the poverty level.
 - v. Education Gap: Adults without a high school diploma.
 - vi. Housing Cost Burden: Families spending over 30% of their income on rent or mortgages.
- Census Tract 5302: High Impact. (Weighted Risk: 0.394 | PRR: 2.14). This tract is the economic "hotspot" of the study. The high weighted predicted risk indicates that the specific drivers here—poverty and educational attainment—are strong predictors of poor outcomes. The high PRR suggests that current economic assistance programs may not be reaching enough residents to offset these foundational risks.
- Census Tract 5147: Medium Impact. (Weighted Risk: 0.352 | PRR: 1.96). While the risk is slightly lower than Tract 5302, it remains nearly double what the model expects, indicating that socioeconomic stressors are compounded by other local environmental factors.

7. Household Characteristics & Disability (Theme 2)

Examines vulnerability related to age, physical ability, and family structure.

- Top 3 Key Drivers:
 - iv. Single-Parent Households: Increased demand for childcare and single-income stability.
 - v. Persons with Disabilities: Need for specialized healthcare access and physical infrastructure.
 - vi. Limited English Proficiency: Potential barriers to navigating health instructions and insurance.
- Census Tract 5147: High Impact. (Weighted Risk: 0.241 | PRR: 3.45). This tract is an outlier. The observed vulnerability is more than triple the predicted risk. This suggests a lack of social safety nets for single parents and disabled residents. Investments in multi-lingual health navigators and home-based support services would likely close this performance gap.
- Census Tract 5302: High Impact. (Weighted Risk: 0.197 | PRR: 4.05). A PRR over 4.0 is a red flag for unmet need. Despite having fewer expected key drivers, the actual vulnerability is extreme, signaling that even a small population of disabled or non-English speaking residents in this area likely face disproportionately high barriers.

8. Racial & Ethnic Minority Status (Theme 3)

Identifies communities facing systemic barriers to health equity.

- Primary Key Driver: Racial and Ethnic Minority Status.
- Census Tract 5147: High Impact. (Weighted Risk: 0.781 | PRR: 1.06). The observed vulnerability aligns almost perfectly with the high weighted risk. This indicates that minority status is the dominant driver of the community's profile, and targeted health equity initiatives (e.g., culturally tailored wellness programs) are fundamentally necessary here.
- Census Tract 5302: Medium Impact. (Weighted Risk: 0.359 | PRR: 1.44). This tract shows more resilience in this category, with community performance aligning more closely with the model's predictions.

9. Housing Type & Transportation (Theme 4)

Looks at mobility, housing density, and physical living environments.

- Top 3 Key Drivers:
 - i. Lack of Vehicle Access: One of the strongest predictors of missed medical appointments and delayed care.
 - ii. Group Living Environments: Increased risk in institutionalized or shared housing.
 - iii. Household Crowding: More residents than rooms, impacting chronic stress and infectious disease spread.
- Census Tract 5147: High Impact. (Weighted Risk: 0.193 | PRR: 3.76). Mobility is a significant barrier. Despite a low predicted score, the high observed vulnerability suggests that residents are likely isolated from services by lack of mobility.
- Census Tract 5302: Medium Impact. (Weighted Risk: 0.118 | PRR: 6.48). o Strategic Insight: This represents the most extreme disparity in the entire report. While the area has very few expected housing risks, the observed vulnerability is nearly 6.5 times higher than predicted, suggesting a "transportation desert." Funding non-emergency medical transportation (NEMT) or localized "micro-clinics" here is the highest ROI opportunity for improving outcomes.

10. Overall Community Vulnerability (Total SVI)

This composite metric aggregates all social factors to provide a bird's-eye view of community fragility.

- Top 3 Key Drivers:
 - i. Poverty Residents living below 150% of the poverty level.
 - ii. Education Gap Adults without a high school diploma.
 - iii. Racial and Ethnic Minority Status Proportion of people with racial and ethnic minority status
- Census Tract 5147: High Impact. (Weighted Risk: 0.429 | PRR: 1.91). This tract shows multifaceted risk stemming from the overlap of a number of economic, racial, and household factors. With a PRR nearly at 2.0, the community is experiencing twice the vulnerability the model expects. This is the highest priority area for comprehensive, multi-disciplinary health programs.
- Census Tract 5302: Medium Impact. (Weighted Risk: 0.393 | PRR: 2.18). Although the weighted risk is lower than its peer, the performance gap (PRR) is higher. This indicates that while there are fewer risk factors strongly influencing outcomes, the community is still struggling to manage them, resulting in an underperforming status.

Recommendations that May Help Inform Future Health-related Focus Areas and Activities

Based on the predictive analytics summarized above, some suggested recommendations follow:

- Outcome-Driven Outreach: Deploy mobile units and non-emergency medical transportation (NEMT) specifically to Tract 5302 to bridge the mobility-access gap.
- Community Partnership: Launch multi-lingual health navigation and equity programs in Tract 5147 to address the high observed vulnerability in underserved minority households.

Appendix 11: Community-based Health-related Resources



RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

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

Health Department
Manchester Health Department, Weiss Center 479 Main St. Manchester CT, 860-647-3173, https://www.manchesterct.gov/Government/Departments/Health-Department Rockville, North Central District Health Department, 860-745-0383, https://www.ncdhd.org/
Health Centers
First Choice Health Center, Howell Cheney Technical High School-School Based Health Center 791 Middle Turnpike W, Manchester, CT 06040, 444 Center Street, Manchester, CT 06040, 150 N Main Street Suite 230 & 240, Manchester, CT 06042, 94 Union Street, Vernon, CT 06066 860-528-1359 https://firstchc.org/
Community Action Agencies
https://www.manchesterct.gov/Government/Departments/Human-Services , 860-647-3092
Community Partners in Action, https://cpa-ct.org/
Access Community Action Agency, https://accessagency.org/who-we-are/ , WILLIMANTIC: 860-450-7400, DANIELSON: 860-412-1600
Senior Services
https://www.manchesterct.gov/Government/Departments/Human-Services , 860-647-3092
Vernon Senior Center 135 Bolton Road, Vernon, CT 06066, https://www.vernon-ct.gov/page/vernon-senior-center , 860-870-3680
Hartford HealthCare Center for Healthy Aging, 80 Seymour St. Hartford CT, 877-424-4641, https://hhcseniorservices.org/locations/center-for-healthy-aging/hartford-hospital
Youth and Family Services
https://www.manchesterct.gov/Government/Departments/Human-Services , 860-647-3092
9 Elm Street, Vernon CT 860-870-3555, https://www.vernon-ct.gov/page/youth-services
Heritage and Nature
Wickham Park, 1329 Middle Turnpike W, Manchester, CT 06040, (860) 528-0856
Center Springs Park, 39 Lodge Dr, Manchester, CT 06040, (860) 647-3084
Northwest Park, 448 Tolland Turnpike, Manchester, CT 06042, (860) 647-3162
Valley Falls Park, 300 Valley Falls Rd, Vernon, CT 06066, (860) 870-3520
Henry Park, 120 South St, Vernon, CT 06066, (860) 870-3520

Need help finding free or low-cost services?

Go to www.connectionsthatmatter.org

