

BRISTOL HEALTH

2025 Community Health Needs Assessment



 **Bristol Health**

SUBMITTED BY HOLLERAN

 **HOLLERAN**
COMMUNITY ENGAGEMENT RESEARCH & CONSULTING

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EXECUTIVE SUMMARY

Bristol Health is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. The Patient Protection and Affordable Care Act of 2010 set forth new requirements for non-profit hospital organizations in order to maintain their tax-exempt status as a charitable hospital, 501(c)(3). One of the regulations is a requirement that all non-profit hospitals conduct a Community Health Needs Assessment (CHNA) and adopt an implementation strategy that meets the community health needs identified in the assessment every three years. Bristol Health has conducted previous CHNA's during the fiscal years 2013, 2016, 2019 and 2022 to identify needs and resources in the community.

Beginning in November 2024, Bristol Health undertook a comprehensive CHNA to evaluate the health needs of individuals living in the city of Bristol in Hartford County, Connecticut. The aim of the assessment is to reinforce Bristol Health's commitment to the health of residents and align its health prevention efforts with the community's greatest needs. The CHNA will provide primary and secondary data that will demonstrate the needs and opportunities for health equity in the community, guiding priorities and implementation strategies for the hospital to support the community at large. Bristol Health contracted with Holleran Consulting, a research firm based in Wrightsville, Pennsylvania, to execute this project.

The findings from the assessment will be utilized by Bristol Health to prioritize public health issues and develop a community health implementation plan focused on meeting community needs. The results will identify the existing health issues, outcomes and disparities including but not limited to those related to chronic and preventable diseases, mental and behavioral health, and other emergent communal health issues. The CHNA is conducted using Social Determinants of Health (SDOH) as a guiding framework of analysis ensuring equitable, and representative inclusion of all Service Area residents through proactive, broad, and diverse community engagement.

This CHNA 2025 Final Summary Report serves as a compilation of the overall findings of each research component.

2025 CHNA Components

- Secondary Data Profile
- Key Informant Surveys

Key Community Health Issues

An examination of the Findings of the Secondary Data and Key Informant Surveys resulted in the following overarching issues being identified (presented in alphabetical order):

- Access to Care and Care Coordination
- Affordable Housing, Income and Poverty
- Morbidity and Mortality
- Physical/Mental Health and Well-Being

Prioritized Community Health Issues

Bristol Health, together with its community partners, including health care providers, public health experts, health and human service agencies, and other community representatives, selected and prioritized the topics contained within the overarching issues and plans to focus its community health improvement efforts on the following health priorities over the next three-year cycle:



Previous CHNA and Prioritized Health Issues

Bristol Health conducted a comprehensive CHNA in previous 3-year cycles to evaluate the health needs of individuals living in the city of Bristol. Following is a description of the Prioritized Health Issues identified beginning in 2013 and continuing through 2022.

Prioritized Health Issues in 2022:

- Mental/Behavioral Health and Substance Misuse
- Chronic Disease Management
- Access to Care and Care Coordination
- Senior's Health and Services

Prioritized Health Issues in 2019:

- Mental Health and Substance/Alcohol Abuse
- Access to Care
- Overweight/Obesity
- Chronic Conditions

Prioritized Health Issues in 2013 and 2016:

- Mental Health and Substance/Alcohol Abuse
- Senior Support
- Access to Care
- Overweight/Obesity

Major Outcomes from the 2022 CHNA Priorities:

- Wheeler Clinic offers doubles its behavioral health patients to 188
- A referral coordinator role is added to contact patients within 48 hours to remove barriers to care
- 83 EMS and 125 Emergency Department personnel support the COBRA program, collaborating to address behavioral health crises.
- Percentage of patients meeting blood pressure goals increased from 72.17% in 2022 to 77.06% in 2024.
- 27 blood pressure screening events were held.
- A provider survey was conducted to assess future physician retirements and a physician-to-population analysis is underway to inform recruitment strategies

- 14 articles were published in the Healthy Living column of The Bristol Press to educate the public.
- A Lyft ride program is in effect to address the transportation issue.
- 27 educational seminars were held at the Bristol Senior Center.
- Care is now provided in Ingraham Manor to over 1,500 patients including primary care, psychiatry, pulmonary care, orthopedics, geriatrics and cardiology.

A full description of outcomes can be found in Appendix E.

Major Outcomes from the 2019 CHNA Priorities:

- Depression screenings done annually with primary care patients
- Added multiple access points for referral services for mental health and substance misuse
- Adopted telehealth services in Emergency Department and in Weight Loss Surgery Program
- Virtual health seminars made available to community
- Consolidated primary care physician offices into one centrally located Bristol medical office
- Opened state of the art medical office in Southington, CT
- Bariatrics team offering Lyft rides for patients with transportation barriers
- Increased proportion of patients with health insurance and offered financial counseling
- Offered virtual pre-operative patient education class and support group in Weight Loss Surgery Program
- Developed Bariatric Surgery Exercise Program
- Updated nutrition materials and published over 40 articles in local media

A full description of outcomes can be found in Appendix F.

Major Outcomes from the 2016 CHNA Priorities:

- Bristol Hospital opened a new Senior Behavioral Health In-patient Unit in 2018.
- The Bristol Health Counseling Center hosted a free monthly mental health and substance recovery educational series for the community from August 2017 to February 2018.
- The leadership of the Bristol Health Counseling Center were called upon to participate in the Mayor's Opioid Task Force, The Community Care Team and COBRA (City of Bristol's Recovery Alliance) and the State of Connecticut Health Partnership Oversight Council.
- The Counseling Center staff received a grant for free community programs and coordinated a QPR Suicide training.
- Bristol Health opened a new 60,000-square-foot medical office in downtown Bristol, housing an array of medical sub-specialties. 66 new providers have joined the medical staff of the Bristol Health Medical Group.
- From 2016 – 2019, the Bristol Health Public Relations Department has tripled the number of community events which offer screenings and educational outreach with more than 25,000 local resident attendees.
- The Bristol Health Medical Group's Center for Geriatric and Palliative Care —led by Dr. Margarita Reyes—offered a highly-successful dementia free education series.
- The Center for Geriatric and Palliative Care added geriatric two nurse practitioners.
- The Bristol Hospital Parent and Child Center continues its great success with obesity prevention efforts through its Family Wellness Programs.
- A video (which can be viewed at home) was produced that educates patients considering weight loss surgery about the program and the surgery options.

- The Bristol Hospital Weight Loss Surgery Program offers numerous support groups for its patients.

A full description of outcomes can be found in Appendix G.

Major Outcomes from the 2013 CHNA Priorities:

- Hosted a roundtable discussion in January 2014 with approximately 30 community leaders and stakeholders to discuss the issue of mental health and substance/alcohol abuse.
- Entered an agreement with the Wheeler Clinic in 2015 in which the Wheeler Clinic assumed responsibility for Bristol Hospital's Emergency Department Crisis Service from 8 a.m. to midnight, seven days a week, and provide immediate intervention and facilitation connections to community services and resources.
- Since 2013, Bristol Hospital and the Bristol Hospital Multi-Specialty Group have added 74 new medical staff and added 16 new medical offices throughout the community.
- Increased the number of free screenings offered throughout the community to include the senior center.
- Provided free educational seminar at senior center on topics such as dementia, living with diabetes, and nutrition and wellness.
- Since 2015, approximately 330 low-income families have participated in the Bristol Hospital Parent and Child Center Family Wellness Program's including "Gardening for Health", "Cooking Matters in the Store", and free Zumba and exercise programs.

A full description of outcomes can be found in Appendix H.

COMMUNITY HEALTH NEEDS ASSESSMENT BACKGROUND

Organization Overview

Founded in 1921, Bristol Health continues to be the leading health provider for people who live and work in the Greater Bristol area in Connecticut. Bristol Health has 169 licensed beds (at Bristol Hospital) and offers a complete range of patient services including an emergency center that cares for more than 40,000 patients each year. Bristol Health has grown from a community hospital to an integrated network that provides a full continuum of services – both inpatient and outpatient. In 2019, Bristol Hospital and Healthcare Group became Bristol Health. The name change reflects an integrated network of providers and the full scope of care offered to the community.

The organization remains committed to quality, compassionate and advanced care. Its mission "Caring today for your tomorrow" and vision "Advancing the health of our community by providing integrated, innovative and individualized care" reflects this commitment. Bristol Health now has more than 20 locations throughout Central Connecticut and over 100 primary and specialty care providers. It is able to provide accessible and convenient care, focused on wellness and prevention. Services range from primary care to orthopedics; cardiology to physical therapy; and skilled nursing to a highly rated community hospital. It is ranked the No. 1 full-service hospital in Connecticut for preventing hospital-acquired infections. Bristol Health has a Magnet nursing designation and earned an "A" for patient safety from the Leapfrog Group, a national group that rates hospitals on how well they keep their patients safe from errors, injuries, accidents

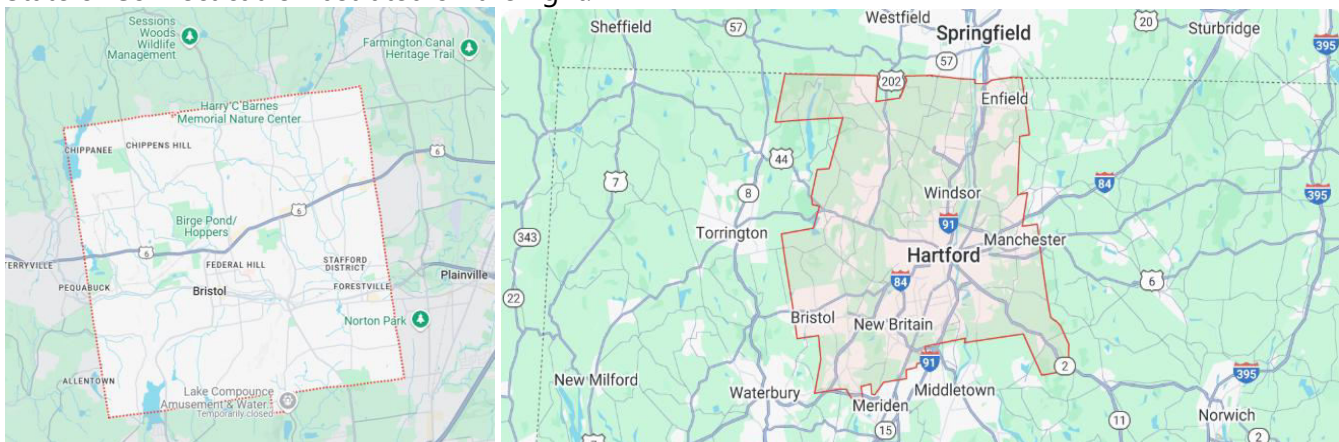
and infections. It also received an ExcellenceNorth Alliance Silver Recognition Baldrige-based Quality Award program and was recognized by the International Hospital Federation for innovation, agility and innovation in COVID response.

Bristol Health offers a complete range of emergency, inpatient and outpatient services including the Beekley Center for Breast Health & Wellness, Behavioral Health, the Cancer Care Center, the Emergency Center, the Connecticut Gastrointestinal Institute, the Families Are First Birthing Center, the Center for Surgery and Endoscopy, the Sleep Center, the Wound Care Center, an Orthopedics and Joint Replacement Program and Rehab Dynamics, Cardiac and Pulmonary Rehabilitation, Robotic Surgery and Diagnostic Imaging/Radiology. Bristol Health Medical Group has physician practices located throughout the greater Bristol area including Bristol, Burlington, Farmington, New Britain, Plainville, Southington, Terryville, Torrington and Wolcott.

Community Served

For purposes of this assessment, “community” is defined as the city of Bristol and geographical area in which the hospital facility is located including the community served by a hospital and those individuals residing within its hospital service area. The hospital service area is an analysis of the geographic area surrounding the hospital, which includes all residents, and does not exclude low-income or underserved individuals. For all demographic and health indicator statistics, data from the city of Bristol’s geographical area were used to represent local level data unless otherwise noted. If data from the city of Bristol were not available, county level data for Hartford County was utilized.

A map of the bounds of the city of Bristol is shown on the left below and a map of Hartford County in the State of Connecticut is illustrated on the right.



Methodology

The CHNA was comprised of both quantitative and qualitative research components. A brief synopsis of the research components is included below with further details provided throughout the document.

A Secondary Data Profile was compiled which uses existing local-level data with state and national comparisons of demographic and health data, also known as “secondary data.” The specific data sources depict population and household statistics, education and economic measures, morbidity and mortality

rates, incidence rates, and other health statistics for the city of Bristol and were compiled and compared to state and national level data, where applicable. Demographic and health indicator statistics have been collated to portray the current health status of the city of Bristol. It should be noted that in some cases, local-level data may be limited or dated. This is an inherent limitation with secondary data. The most recent data were used whenever possible. When available, state and national comparisons were also provided as benchmarks for the regional statistics. National comparisons include United States data and Healthy People 2030 (HP 2030) goals when available. Sources for secondary data are included as References in Appendix A. In addition, definitions for statistical terms used in the report are included in Appendix B.

An online Key Informant Survey was conducted with 52 key informants to gather a combination of quantitative and qualitative feedback through closed and open-ended questions from April and May 2025. Key informants are defined as community stakeholders with expert knowledge, including public health and health care professionals, business leaders, government/housing/transportation, social service/aging

providers, non-profit leaders, and other community leaders. The survey assessed key informant's views on the overall key health issues in Bristol, as well as asked questions related to health issues and barriers for people in the community, social determinants of health, health care access, missing services and underserved populations. The majority of key informants were affiliated with health care/public health organizations. A full list of key informants and their affiliations can be found in Appendix D.

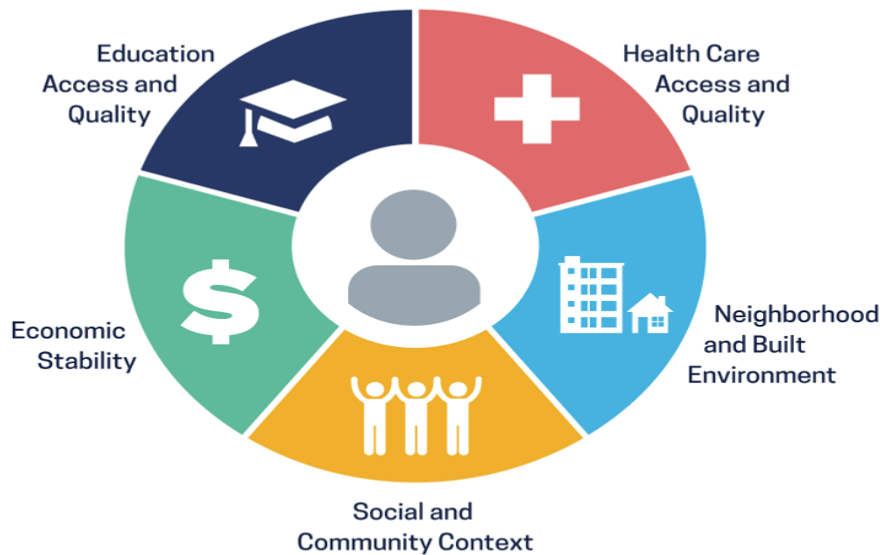
Social Determinants of Health

An individual's health is influenced by numerous factors including a range of personal, social, economic, and environmental factors known as social determinants of health. These reach beyond the boundaries of traditional healthcare into public health sectors and can be important allies in improving population health. Addressing social determinants of health is important for improving health outcomes and reducing disparities. Research demonstrates that lower educational attainment, poverty, and race/ethnicity are risk factors for certain health conditions.

The U.S. Department of Health and Human Services Healthy People 2030 addresses conditions in the environment in which people are born, live, learn, work, play, worship, and age. The conditions affect a wide range of health, function, and quality-of-life outcomes and risks. Healthy People 2030 groups these determinants into 5 domains; economic stability, education access and quality, healthcare access and quality, neighborhood and the built environment, and social and community context.

Throughout this report, data related to the social determinants of health and their impact on county, region, state and national health is provided.

Social Determinants of Health



Social Determinants of Health
Copyright-free

Healthy People 2030

Research Partner

Bristol Health contracted with Holleran Consulting (Holleran), an independent research and consulting firm located in Wrightsville, Pennsylvania, to conduct research in support of the CHNA. Holleran has 30 years of experience in conducting public health research and community health assessments. The firm provided the following assistance:

- Collected, analyzed and interpreted data from secondary data sources
- Collected, analyzed and interpreted data from key informant surveys
- Prepared a Final Summary Report

Community Representation

Community engagement and feedback were an integral part of the CHNA process. Bristol Health sought community input through key informant surveys with community leaders and partners and inclusion of community leaders in the prioritization and implementation planning process. Public health and health care professionals shared knowledge and expertise about health issues, and leaders and representatives of non-profit and community-based organizations provided insight about the community, including the medically underserved, low income, and minority populations.

Research Limitations

As with all research efforts, there are some limitations related to this study's research methods that should be acknowledged. Due to the availability of secondary data, some of the health indicator statistics represent counts or crude rates only. Crude rates are generally defined as the total number of cases or deaths divided by the total population at risk. A crude rate is generally presented as per populations of 1,000, 10,000 or 100,000 (which will be noted on each table). It is based on raw data and does not account for characteristics such as age, race, and gender.

In some instances, key informant survey participants may over or underreport behaviors and issues based on fear of social stigma depending on the health outcome of interest or misunderstanding the question being asked. In addition, respondents may be prone to recall bias where they may attempt to answer accurately but remember incorrectly.

In addition, timeline and other restrictions may have impacted the ability to survey all key community stakeholders. Bristol Health sought to mitigate limitations by including representatives of diverse and underserved populations throughout the research components.

Prioritization of Needs

Following the completion of the CHNA research, Bristol Health will prioritize community health issues in collaboration with community leaders and partners and will develop an implementation plan to address prioritized community needs.

KEY HEALTH FINDINGS

The components of the CHNA come together to reveal a unique perspective of the health status of residents living in Bristol. A number of health issues were found in both components and are general themes in the Bristol community. The key findings have been pulled from the secondary data and the key informant surveys and highlight the key takeaways that stand out across the research components, as identified by the Holleran team.

Before examining the health issues the Bristol community is facing, it is useful to review positive comments from key informants related to the work that Bristol Health is doing to improve health in the community. Selected feedback is provided here.

Select Positive Feedback for Bristol Health:

- I believe Bristol Hospital - through great leadership - continues to strive to meet all the needs.
- Bristol Hospital was very pro-active with setting up clinics to receive the vaccine...and being very pro-active to follow protocol and help people.
- I believe Bristol Hospital has excellent, above average leadership throughout the organization. The hospital is not just another business in town...it is one of our best assets. Because of the current leadership, it has truly become more visible, more respected. It is one of the few 'stand alone' hospitals...just received exemplary recognition...above average nursing care - Magnant Status! We are not the biggest.....WE ARE THE BEST! More people need to walk through our doors...they will see and feel a difference.
- The leadership at Bristol Hospital as well as the Board members continue to make all of the above a priority.
- Bristol Health primary and specialty care are more visible in the community.
- To the leadership of Bristol Hospital: You have been a shining star for our community. Your knowledge, your leadership, your true heart and soul have been dedicated to our community. THANK YOU!
- I believe that the emergency department at the hospital is a definite success and provides excellent care.
- Bristol Health outreach and community involvement is essential and being done well.
- While Bristol Health, along with the Bristol, Burlington Health District provide excellent services to our community and outreach programs in coordination with the Bristol Police Department for those afflicted with Substance Abuse, we need to continue to find alternative ways and new approaches to those who, while reluctant and/or afraid to seek help from our local resources, that benefit not only the patient, but the families and communities impacted by the affects of Substance/alcohol abuse.
- Overall, the Bristol Health System continually seeks ways to improve upon and offer access to low cost, quality health care.
- I do know that between Bristol Health and Bristol Burlington Health District that are considerable opportunities for individuals and families to receive most basic essential health care needs.
- Strong mental/behavior health emergency care infrastructure at Bristol Health, coupled with a strong partnership between the city and the hospital.
- Bristol Hospital has done a great job educating the community on health and quality of life.. Still has a long way to go...

- Bristol has great support groups and Health Care.
- Our greatest asset in our community is Bristol Health. They have a wide variety of physicians and medical staff at the hospital and the Medical Care Center.
- Bristol Health has a tremendous team of doctors and nurses to help patients navigate cancer care along with some technology to help find and diagnosis cancer.
- Bristol hospital seems to have done a good job serving our community, and the addition of Wheeler Clinic helped to provide mental health and addiction services.
- The Bristol Health system did a good job with COVID 19 at the time of the pandemic.
- The Administration has done an outstanding job to keep Bristol Hospital solvent in a very challenging environment.
- Applaud the efforts of Bristol health in identifying health needs despite an environment of insufficient reimbursements and poor government support.

The findings are organized by overarching themes and are presented alphabetically as follows. A summary of each issue follows and includes primary and secondary data as well as powerful comments by key informants.

- Access to care and care coordination
- Affordable housing and poverty
- Morbidity and mortality
- Physical/mental health and well-being

Access to Care and Care Coordination:

Healthy People 2030 describes barriers that prevent or limit access to needed health care services, which may increase the risk for poor health outcomes and health disparities. These include the lack of health insurance, poor access to transportation and limited health care resources. These barriers greatly impact vulnerable populations and communities.

Access as a Key Health Issue

When key informants were asked to identify the Top 5 health issues in Bristol, Access to care/uninsured was selected by 66.7% of respondents, second only to Substance abuse/alcohol abuse. An informant spoke about the general health of the community as being affected by the lack of access to care and health insurance. "It doesn't matter what the most prevalent or most pervasive health condition is in the community if a person does not have the access to care/insurance they need in order to have screening." Issues such as cost, transportation, appointment availability and barriers to resources were mentioned frequently. "The awareness of resources available to those less fortunate in our community needs to continue to be stressed including access to care, not just from a financial perspective, but also from an ability to get to a health care provider (transportation, ease of making an appointment)." A key informant recommended, "Maintaining and increasing access are key. Without that, the other issues will never be resolved. The access to care needs to be made easier and the system needs to be simplified." In addition, "Transportation for the disabled in this group is also hard to come by." Over one-third (38.6%) of key informants perceive the lack of transportation to be a significant barrier to accessing health care.

Navigation of Health and Social Support Systems

The ability to navigate a complex health care system is difficult for many community residents and the community is said to lack case managers to assist in this process. When key informants were asked about missing health care resources, 42.6% pointed to case management/social services. “Many residents do not know how to navigate the insurance or health care systems in order to establish care.” When residents are not able to establish care, important wellness and preventive care may be neglected, leading to an urgent need for health care. Over half of key informants (56.1%) chose the inability to navigate the health care system and the availability of providers and appointments (47.4%) as a significant barrier to accessing care.

Culturally competent providers, particularly those that are multi-lingual are critical to increasing health care access in a community. In Bristol, 21.3% of residents speak a language other than English and 37.1% speak English “less than very well”. In addition to English, the primary language spoken is Spanish (11.4%) and 39.6% speak English “less than very well.” Although only 2.9% speak Asian and Pacific Islander languages in Bristol, 36.9% of these speak English “less than very well”. A sizable portion (42.6%) of key informants found multicultural/bilingual health care providers to be lacking in the community. “Language and cultural barriers are also major barriers to accessing equitable care.”

Also impacting access and care coordination is an individual’s living situation. Individuals may be isolated and have difficulty obtaining health care due to the lack of a social support system. In Bristol, a lower percentage of individuals are married (44.4%) in comparison to the state (47.6%) and the nation (47.9%). Percentages of widowed are similar throughout, but Bristol demonstrates the highest percentage of divorced (12.3%) compared to the state and nation. A total of 920 grandparents in Bristol are estimated to live with their grandchildren and of those, 20.0% are responsible for them. Also, there is a higher percentage of female householders with no spouse present than male householders with no spouse present. Both data points are higher in Bristol than in Connecticut and the U.S. For householders 65+, 11.0% live alone. These groups, living alone or as sole providers in a household may be foregoing needed health care and social support. When living alone, transportation becomes an issue, particularly for someone with health issues. Unfortunately, transportation as a health care resource is perceived to be lacking in Bristol by 46.3% of key informants. Positively, the number of social associations per 10,000 is also higher (9.8) than the state (8.9) and nation. (9.1).

Health Insurance Coverage

Critical to accessing health care is the ability to pay for it, typically through health insurance coverage. Positively, a higher percentage of the population has health insurance coverage in Bristol (96.0%) than in Connecticut and the U.S, however the percentage of public coverage is also higher (38.3%). Yet, older adults in Bristol are more likely to be uninsured (1.8%) when compared to older adults in the state (0.8%) and the nation (0.8%). About one fifth of older adults have Medicaid, or some other means tested public coverage either alone or in combination with another plan. Some may have difficulty finding providers that accept Medicaid coverage.

Medical Provider Density

There appears to be a disparity in the availability of medical providers in Bristol when compared to Hartford County. According to County Health Rankings, provider density (the ratio of individuals to one

medical provider) in Hartford County appears to be better than in Central Bristol. In Hartford County, provider density is good with there being substantially fewer individuals per primary care provider, dentist and mental health provider than in the state or nation. However, Central Bristol has been designated by the U.S. Health Resources and Services Administration as a Medically Underserved area. The designation takes into consideration providers per 1,000 population, the percent of individuals at 100% of the federal poverty level, the population ages 65 and over and the infant mortality rate.

When assessing Bristol, less than a majority of key informants (45.6%) “Strongly Agree or Agree” that there are a sufficient number of dentists and specialists as well as providers who accept Medicaid/medical assistance (35.1%). Primary care seems to be somewhat more accessible in Bristol with 61.4% of key informants agreeing that there are sufficient primary care providers in the community. This was also the case in the 2022 study. “Most individuals have the ability to make an appointment with a Primary Care Physician when needed.” The perception that there are a sufficient number of dentists and specialists and Medicaid providers has slipped below the majority since the last study. This points to an increasing problem of access when it comes to finding providers other than primary care or for those who are uninsured or rely on Medicaid.

Key informants were able to comment on the availability of specialists. “Access to certain specialists is easier than others. Dermatology is very difficult for folks with Medicaid to access timely. Neurology and psychiatric medication management is also a specialty where people may wait quite some time before an open appointment. People needing cardiology, pulmonary, or orthopedic appointments generally have shorter wait times to access care.” Also, “Specialty Care, however, can be difficult for many in the community when making an appointment, and the earliest possible date available is months out in the future. This is contributed by the shortage of specialists in some specialties, such as Cardiology, Dermatology.” One key informant noted that there are challenges with primary care physician recruitment as well as for dermatologists and ear, nose and throat specialists.

The use of emergency services may also point to an access issue. For various reasons, individuals may delay treatment (including cost, fear, distrust, lack of transportation and lack of access to prevention services and providers). Delaying treatment may result in seeking care only when in a crisis, creating a more serious or complicated medical condition. This may lead to inappropriate use of the emergency room and increased need for hospitalization. The number of preventable hospital stays per 1,000 Medicare enrollee is 2,739 for Hartford County, but somewhat less in Connecticut (2,651) and in the U.S. (2,681). Positively, a large majority of respondents (75.9%) identified emergency care as the top “Need being met”. 54.7% said that primary care services are a need that is being met.

Affordable Housing, Income and Poverty:

Quality of Life

Adequate housing, income, education and recreation in a community can ensure positive health outcomes through proper nutrition, safe neighborhoods, full employment and a generally good standard of living. Poor health outcomes are more likely when these elements are missing in a community. Poverty, substandard housing including overcrowding, limited educational opportunities and unsafe neighborhoods may lead to increases in chronic diseases such as heart disease, hypertension, stroke, obesity, certain

cancers, injury, infectious diseases and even a shorter life expectancy. The impact of the pandemic is still being felt in the community. According to a key informant, "Covid 19 hurt everyone but low income people disproportionately." As it relates to the environment and the quality of life in Hartford County, air pollution (measure in particulate matter) is slightly worse than in the state and nation and drinking violations have been cited. As it relates to crime, rates for burglary and motor vehicle theft are highest in Bristol when compared to the state and nation.

Affordable Housing

Bristol has more owner-occupied housing units with mortgages (70.3%) than in the state or nation. The median value of the housing units in Bristol is \$252,300, lower than in Connecticut and the U.S. Housing cost burden is defined as households paying 30% or more of their income on housing costs (rent/mortgage and utilities). More than half of renters (52.4%) in Bristol experience a housing cost burden. For Bristol residents 65 years and older, 30.8% of owners and a much higher 67.5% of renters are housing cost burdened. Adversely, 42.6% of key informants replied that they "Don't Know" about sufficiency of housing assistance in Bristol.

Income and Poverty

Median family income is substantially less in Bristol than Connecticut and the nation. Median household income is also less in Bristol compared to the state and nation. 6.7% of Bristol residents earn \$15,000 to \$24,999, slightly higher than the U.S., but much higher than CT. Nearly 40% of the labor force in Bristol is employed in management, business, science and arts, somewhat less than the state and nation. Additionally, the percentage of the unemployed civilian labor force is somewhat higher in Bristol (4.9%) than in the state (3.7%) or nation (3.3%). Covid-19 is also reported to have had a negative impact on family income. "Covid-19 had detrimental impacts to the community. The cost of living has gone up dramatically, food costs substantially increased, cost of transportation, etc."

Fewer households in Bristol (9.5%) live below the poverty level compared to the state and the nation. Of those, 15.3% received food stamps/SNAP benefits in the past 12 months. However, percentages of households with supplemental security income and cash public assistance income are highest in Bristol. For families under the age of 18, 21.5% live in poverty. Far fewer married couples live below the poverty level than do female-headed households with no spouse present. In Bristol, this is 2.0% in comparison to 16.1% respectively.

Cost of Health Care

The "inability to pay out of pocket expenses" was identified as the most significant barrier to accessing health care by 64.9% of key informants. The same percentage also selected the "lack of health insurance coverage" as a key barrier. Almost one-third chose "basic needs not being met" as another barrier. Challenges to seeking medical treatment include high deductibles and a lack of financial resources. One key informant noted "Many offices do not offer sliding scale prices." Over half of key informants identified free/low cost medical and dental care as a "Missing" health care resources in the Bristol community. Another took the perspective of the provider and the hospital, saying that even when these resources exist, they have a negative impact on providers and may not last long. "With respect to low cost/free health care, there does exist options, however the current environment on reimbursing hospitals/physicians in CT is not a sustainable model with respect to both promoting the long term viability

of those offering such services.”

Vulnerable Populations

Vulnerable populations often have trouble with navigating insurance, getting approvals, paying copays and remembering appointments. Populations such as those with limited/low incomes, disabled or elderly or those without adequate housing are typically underserved as it relates to obtaining needed health care. “People of color and low income families cannot always find care.” Key informants were asked to identify underserved populations in the community. Homeless was selected by the highest percentage of participants (63.3%). This is followed by the uninsured/underinsured (60.0%) and low-income/poor (53.3%). Both of these categories were selected by a greater percentage of key informants than in the previous study. One key informant also identified veterans as underserved. “Bristol has the 2nd largest veteran population in the state of Connecticut, mental health and suicide are a large problem in this population and needs more support from Bristol Health.”

Seniors/aging/elderly and the disabled were also selected by many. The percentage of disabled seniors in Bristol is 77.3%, which is considerably higher than the state (70.5%) and the nation (62.5 %). Compared to the Connecticut and the United States, Bristol demonstrates higher percentages for each of the disabilities including hearing, vision, cognitive, ambulatory, self-care and independent living.

Social vulnerability as defined by the Federal Emergency Management Association (FEMA) refers to the potential negative effects on communities caused by external stresses on human health and life such as natural or human-caused disasters or disease outbreaks. The Social Vulnerability Index describes the susceptibility of social groups to the adverse impacts of natural hazards, including disproportionate death, injury, loss, or disruption of livelihood. Hartford County has been determined to have “moderate vulnerability” on the Social Vulnerability Index. This may have negative effects on human health. These effects may be compounded when the condition of housing is poor and people have few resources to come back from the effects of a disaster. Favorably, FEMA also describes Hartford County as having “relatively high” community resilience when dealing with stresses on human health and life.

Morbidity and Mortality:

Chronic Disease

Chronic conditions including arthritis, asthma, diabetes, cardiac disease including stroke, heart failure and chronic obstructive pulmonary disease are substantially higher in terms of a rate per 1,000 adults when Bristol is compared to Connecticut. 49.1% of key informants selected heart disease among the Top 5 Key Health Issues facing the community. In the previous CHNA (2022), this was chosen by fewer respondents (32.4%). The informants noted that heart patients should be outside walking (although the cold winters may hinder this) and they should be receiving education for eating healthily. Diabetes was chosen as 8th among key health issues by 33.3% of informants. Obesity/overweight was also selected in 2025 and may go hand in hand with cardiac and diabetes concerns. One informant commented, “I believe that overweight and obesity problems, if not addressed, can lead to heart disease, diabetes, mental health issues and certain cancers.” Management of chronic health problems can also be time consuming; something many Bristol residents grapple with due to “multiple or frequent appointments.” “Time management to prioritize exercise and cook healthy food when working full time or multiple jobs could be a factor in management conditions.” Lack of

providers comes into play again. "There is only 1 endocrinologist in Bristol so getting an appointment for diabetics is not always easy to come by either."

As it relates to communicable diseases, although the rate of HIV/AIDS and tuberculosis are lower in Hartford County, the incident rate per 100,000 individuals for chlamydia in Hartford County is higher than in Connecticut and the U.S. Rates for gonorrhea and syphilis are lower than the nation but higher than the state.

Death Rates

The crude death rate per 100,000 in Hartford County (991.7) is higher than in Connecticut (952.2) but lower than the U.S. (1,043.8). Also, the White and Hispanic or Latino population have higher crude death rates compared to the state and the nation. Higher crude death rates in Hartford County are found for accidents and nephritis, nephrotic syndrome, and nephrosis as compared to the state and nation. County Health Rankings found more injury deaths per 100,000 in Hartford County. Years of potential life lost chronicles death before the age of 75. This is sometimes referred to as premature death. In Hartford County, 6,900 years were lost compared to 6,500 in Connecticut. This is a significant number of county residents that are dying earlier than expected. However, in the U.S., the number is 8,000.

Maternal/child Health

The live birth rate per 1,000 is relatively similar throughout the county, state, and nation. Of those births however, the percentage of low and very low birthweight infants (defined as under 2,500 grams and under 1,500 grams respectively) in Hartford County is higher than the state and the nation at 8.7%. The teen birth rate (7.9 per 1,000) for mothers ages 15 to 19 is much higher than CT (3.5).

Healthy People 2030 has set an objective of reducing the rate of infant deaths (5.0). Positively, Bristol and Connecticut met the objective in 2021 at 4.8 and 4.7 respectively. However, the rate of post-neonatal (28 days to 1 year) mortality is much higher in Bristol than in Connecticut and the U.S.

Maternal and infant health was among the issues selected by key informants. 17.5% identified it as key health issue, an increase from 12.2% in the previous CHNA. Fortunately, one key informant stated that there are "plenty of pediatricians" in the area to address childhood health and illness, yet 13.3% identified children/youth as an underserved population.

Cancer

Although not in the Top 5 key health issues selected by key informants, 42.1% chose cancer as a key health issue facing the Bristol community. In Hartford County, cancer incidence rates are somewhat higher than in Connecticut and the United States. Overall, for the 5-year average 2017 to 2021, the rate was 468.8. The Hartford County age-adjusted cancer incidence rates per 100,000 for breast (female), lung and bronchus and prostate are higher than the incidence rates in Connecticut and the U.S. Colon and rectum cancer in the county is higher than in Connecticut. For the population 65+ in the county, breast and lung and bronchus and prostate continue to be higher than the nation. One key informant expressed concern about cancer care on the local level. "Bristol Health has a tremendous team of doctors and nurses to help patients navigate cancer care along with some technology to help find and diagnosis cancer, however the ability to

treat cancer with surgery is limited at Bristol Hospital. Traveling takes time and it would be great if all resources for treating cancer could be at Bristol Hospital, which would be more convenient and less time consuming.”

Cancer mortality rates (per 100,000) for colon and rectum, lung and bronchus and prostate fall short of meeting objectives set by Healthy People 2030 and are higher than the national mortality rate. Positively, the breast cancer mortality rate in the county meets the objective. This coincides with the fact that 46% of female Medicare enrollees ages 65 to 74 received mammography screenings as compared to 43% in the U.S. For all sites, the cancer mortality rate is 135.2 in Hartford County, lower than the U.S (146.0) and similar to Connecticut (135.6).

Physical/Mental Health and Well-Being

In general, key informants point out that having a community hospital like Bristol Health with “well-qualified” primary care physicians and specialists who can treat emergencies, diagnose conditions and provide inpatient care regardless of income is very valuable.

The health and well-being of Hartford County is assessed by County Health Rankings. Hartford County is slightly worse than the state average in Connecticut for Health Outcomes, but better than the average county in the nation. Health Outcomes describe how long people live on average within a community and how much physical and mental health people experience while they are alive. Health Factors represent those things that can be improved to live longer and healthier lives. They are indicators of the future health of a community. For Health Factors, Hartford County is slightly worse than the state average, but better than the average county in the nation. As it pertains to Health Outcomes, the number of poor physical health days in the past month (3.3) was similar to the U.S. and better than Connecticut. Hartford County is somewhat worse than Connecticut in terms of poor mental health days (5.0) in the month than Connecticut (4.4) and the U.S. (4.8).

Mental Health and Substance Abuse/Risk Behaviors

The Healthy People 2030 Objective related to mental health is suicide. Bristol and Connecticut meet and exceed the objective (12.8 per 100,000) and are 10.3 and 11.1 respectively. The rate remains high in the U.S. (14.5). However, according to SAMHSA, in the North Central region which includes Bristol, almost 4% of adults ages 18 or older had thoughts of suicide in 2016 to 2018. In comparison to other regions in CT, this appears slightly lower.

Mental health/suicide was selected by key informants among the Top 5 key health issues and of all issues selected, it was selected as the most significant. Importantly, 52.8% of key informants identified mental health services as “Lacking” in the community and 38.6% “Strongly disagreed or disagreed” with the statement that there are sufficient mental/behavioral health providers in the Bristol community. Favorably however, County Health Rankings finds that there are far less individuals for each mental health provider to treat in Hartford County than in the state and the nation. Mental health services for children appear to be badly needed according to one. “Mental health in children has declined precipitously since the COVID-19 pandemic. The stress, negative coping skills and instability children may have witnessed from those around them may have impacted this.” Another recognized the efforts of the education system. “Bristol's education

system did very well at minimizing the mental/social impact of all students in their care and oversight.”

Substance Abuse

As it relates to substances, cocaine use in the past year among individuals ages 12 or older in the North Central Region is similar to other regions in the state and is 2.27%. Heroin use is 0.67% for the same age group, similar to use in most other regions in the state. Data for opioid use was not reported by SAMHSA. Overall, the number of drug overdose deaths in Bristol from 2015 to 2025 is 332. In 2023, the rate per 100,000 population for suspected opioid overdoses was collected for Bristol-Burlington and was 166.

According to County Health Rankings, the percentage of adults reporting excessive drinking (16%) is less than in the state (17%) and the nation. (18%). However, the percentage of alcohol-impaired driving deaths is somewhat higher in the county. Most telling perhaps is the fact that 73.7% of key informants selected substance abuse/alcohol use as the top key health issue facing the community. In the 2022 CHNA, the percentage was even higher with 82.4% identifying as the number one key health issue.

Fortunately, in Bristol in 2023, 1,559 clients received substance abuse services while 529 received Mental Health services. 106 clients were provided a combination of mental health and substance abuse services. Coordination between the city police, the Bristol Burlington Health District and Bristol Health is reported to be strong, helping to address health concerns such as access to care, vulnerable populations and those with substance abuse issues. Another partnership between Bristol Health and the city of Bristol's COBRA program is touted as helping treat those in need without being arrested. Several informants also sang the praises of the Wheeler Health Clinic. "Wheeler Clinic opened their new headquarters in Bristol which is helping to address mental health and substance use concerns. Fatal opioid overdoses have decreased." "With the addition of Wheeler Health in downtown Bristol offering services under one roof in their building on Hope Street, I feel this has made a difference in that gap/barriers (in health care services)." Key informants have also noted an increased usage of mental/behavioral health and substance use services as well as a "strong mental/behavioral health emergency care infrastructure at Bristol Health." Follow up upon discharge, including contact by a peer support navigator or community health worker to assure that a connection to care was made was suggested to benefit the patient as well as decreasing readmission rates and repeat Emergency Department use.

Physical Health

Poor physical health in the past 30 days (3.3 days) was similar to the U.S. and better than Connecticut. Individual in Hartford County may practice more preventative health measures. For example, 55% of the population received a flu vaccination as compared to 54% in the state and only 46% in the nation.

The food environment index is a measurement of the availability and quality of food options in a specific area. A scale of 1 to 10 (with 10 being the best) is used to compare areas. Hartford County has a similar food environment index score (8.2) as Connecticut (8.3) and better than the United States (7.7) which is positive. Reportedly, the availability of fresh produce at the seasonal Bristol Farmers Market and the Foodshare's partnership with United Way and other entities as well as double snap benefits in 2024 helped families stretch their food budget. However, key informants note that vulnerable populations in Bristol struggle to eat healthily and may lack the knowledge as to how to prepare healthy foods. "The low income, homeless and poor do not have many healthy options at the food pantries as most of that food is donated."

14.8% of key informants ranked healthy food options as a health resource that is “Not Affordable” and noted that people in Bristol face challenges to maintaining a healthy lifestyle as a result. Children may be disproportionately affected. “Many are overweight/obese including our children, more access to healthy affordable food would help.”

Hartford County adults age 20 years and older are somewhat less physically active despite having a high percentage of access to exercise opportunities in comparison to the state and nation. 24% of these adults report being physically inactive. The cost of a gym membership is mentioned by a key informant to be prohibitive to many. According to a key informant, for those who work, running or walking after dark it is not always safe in Bristol and frequently the cold weather in New England is a factor. A Body Mass Index (BMI) of greater or equal to 30 indicates adult obesity. In Hartford County, 33% are determined to be obese, while in Connecticut, the percentage is 31%. Positively, one key informant reported, “Bristol has many green spaces and recreational activities that benefit residents that use them. Bristol has adequate grocery stores that provide healthy food, although this may be unaffordable to some.”

A higher percentage of adults in the county are smokers (13%) than in CT (12%). This is less than in the U.S. (15%). However, 14.0% of key informants identified tobacco as one of the Top Key Health Issues facing the community.

Prevention and Improved Priorities

Key preventative services (dentists, primary care providers, mammography screenings, pre-natal care and flu vaccinations) are necessary to keep a community healthy. Knowledge of their existence, the ability to afford them and transportation to access them is also critical. A key informant reported that “the availability of free flu shots and other vaccines in the area” is something that is being done well in the Bristol community.” Another mentioned that the dissemination of information about immunizations and other material that can help prevent disease is being done well. A recommendation was made that “there can be more group discussions at the hospital or senior center that discusses nutrition, disease prevention, exercise programs etc.” One key informant advocated for prevention services. “Our health infrastructure is not in place. We need to make health care more accessible and affordable and concentrated on prevention and chronic disease treatment.”

When assessing improvements to priority health issues, key informants were pleased to mention that there has been a big push on mental health education, increased usage of mental health and substance abuse services including for seniors and increased visibility of Bristol Health primary and specialty care. There is also more senior housing openings, an outstanding and inclusive Senior Center and the use of mid-level professionals to ensure patients are educated and to increase efficiency in care coordination.

Key informants offered some suggestions to improve the health of the population and access to health care resources and services in the Bristol community. These included increasing the communication between and interaction with faith-based and other community services to coordinate care, the improvement of walking and bicycle friendly access to shopping and recreation, educating the public about how to navigate the health care system, insurance and social services, and more partnerships between Bristol Health, the city of Bristol and the Bristol-Burlington Health District. Many comments focused on improving health literacy in

the community. “Implementing care coordination, peer support navigators or community health workers that can help community members understand instructions, access resources and follow up to assure connection to care and resources would have a tremendous benefit. Assuring social determinants of health are comprehensively addressed will help residents access care and better manage their health.”

COMMUNITY HEALTH REPORT CARDS

This Community Health Report Card highlights statistics that vary between Bristol Health’s service area (Bristol), Hartford County, Connecticut and the United States. To be classified as an area of strength, the local figure (either county or service area) must exceed the state and national figure. To be classified as an area of need, the local figure must be unfavorable compared to the state and national statistic. Depending on the database, a factor may only have a county-level comparison. Not all figures on the Community Health Report Card will have accompanying state and national comparisons. Some questions were only asked of the local key informants. When a comparison is unavailable the cell is omitted.

BRISTOL HEALTH

2025 Community Health Needs Assessment



DOMAIN	INDICATOR	MEASURE	U.S.	CONNEC-TICUT	HARTFORD COUNTY	BRISTOL
SOCIAL DETERMINANTS OF HEALTH	LANGUAGE	Population 5 Years and Older who speak English less than "very well"	38.2%	37.3%		37.1%
	INCOME	Population below 100% of the poverty level	12.4%	10.0%		8.4%
		Households with Food Stamp/SNAP benefits	11.8%	11.7%		15.3%
		% of unemployed civilian labor force	3.3%	3.7%		4.9%
		Selected by most key informants as "missing" health care resource/service: Free/low cost dental care				15.1%
	EDUCATION	% of bachelor's degree or higher	35.0%	41.9%		30.5%
	AFFORDABLE HOUSING	Renter households spending more than 30% of their income on housing	50.4%	51.3%		52.4%
		Owner households spending more than 30% of their income on housing	27.6%	29.8%		25.0%
		Selected the most by key informants as an underserved population: Homeless				63.3%
	SOCIAL SUPPORT	Nonfamily households	55.1%	54.8%		57.4%
		Householders living alone and 65 years and over	11.6%	12.7%		11.0%
		Percent of grandparents responsible for grandchildren	32.0%	28.2%		20.0%
	HEALTH CARE ACCESS	% of population without health insurance coverage	8.6%	5.3%		4.0%
		Population to Primary care physicians ratio	1,330:1	1,210:1	1,050:1	
		Population to Mental health providers ratio	320:1	220:1	170:1	
		Dentist to population ratio	1,360:1	1,150:1	930:1	
		Most prevalent barrier to accessing care cited by key informants: Inability to pay out of pocket expenses				64.9%
		Most significant barriers among those selected: Inability to navigate the health care system				26.0%
		Percentage of key informants who Strongly disagree or disagree that there are sufficient transportation services available				48.2%
		Most "lacking" healthcare service in the community cited by key informants: Mental health services				52.8%
		Most unaffordable health care resource/service in the community cited by key informants: Healthy food options				14.8%
	BUILT ENVIRONMENT	Food environment index = food access and insecurity (ranking from 1 = worst to 10 = best)	7.7	8.3	8.2	
		Access to exercise opportunities	84%	93%	96%	

● = Areas of Greatest Strength
 ● = Areas of Moderate Need
 ● = Areas of Greatest Need

BRISTOL HEALTH

2025 Community Health Needs Assessment



DOMAIN	INDICATOR	MEASURE	U.S.	CONNEC-TICUT	HARTFORD COUNTY	BRISTOL
HEALTH BEHAVIORS	PHYSICAL AND MENTAL HEALTH	Population reporting "fair" or "poor" overall health	14%	12%	13%	
		Poor physical health (average within past 30 days)	3.3	2.9	3.3	
		Poor mental health (average within past 30 days)	4.8	4.4	5.0	
		% of population with adult obesity (BMI ≥ 30)	34%	31%	33%	
		Top key health issue identified by key informants: Substance abuse/alcohol abuse				73.7%
	TOBACCO AND ALCOHOL USE	Adults who are current smokers	15%	12%	13%	
		Excessive drinking in adults	18%	17%	16%	
	PREVENTATIVE SCREENINGS	Mammography screening among female Medicare enrollees, ages 65 to 74	43%	47%	46%	
		Preventable hospital stays per 1,000 Medicare enrollees	2,681	2,651	2,739	
HEALTH OUTCOMES	CHRONIC CONDITIONS AND INFECTIOUS DISEASES	Overall cancer incidence rates per 100,000 in adults	444.4	467.4	468.8	
		Incidence of Chlamydia per 100,000	495.5	409.1	509.4	
		Incidence of Gonorrhea per 100,000	214.0	149.9	210.8	
		Incidence of HIV per 100,000	12.7	7.4	6.1	
		Incidence of tuberculosis per 100,000	2.7	1.7	1.5	
	PREMATURE DEATH	Years of potential life lost (death before age 75) per 100,000 people	6,900	6,500	8,000	
	DEATH RATES	Overall cancer mortality rates per 100,000 (HP 2030 – 122.7)	146.0	135.6	135.2	
		Crude Death Rate due to suicide per 100,000	14.5	11.1	10.3	
		Death by accidents (unintentional injury) per 100,000 (Age-adjusted)	67.8	73.3	80.3	
		Infant mortality rate per 1,000 live births (HP 2030 – 5.0)	5.44	4.7		4.8

● = Areas of Greatest Strength
 ● = Areas of Moderate Need
 ● = Areas of Greatest Need

DEMOGRAPHIC STATISTICS

A. Population Statistics

According to the U.S. Census Bureau, Bristol had 61,129 residents in 2023, with a slightly higher percentage of males than females, which is dissimilar to Connecticut and the U.S. which had a slightly higher female population. The median age in Bristol is 38.2 years, which is similar to the nation (38.7) but lower than the state (41.2).

Table A1. Overall Population (2010; 2019-2023)

	U.S.	Connecticut	Bristol
Population	332, 387,540	3,598,348	61,129
Population Change from 2010	9.4%	1.5%	1.1%
Male population	49.5%	49.1%	50.1%
Female population	50.5%	50.9%	49.9%

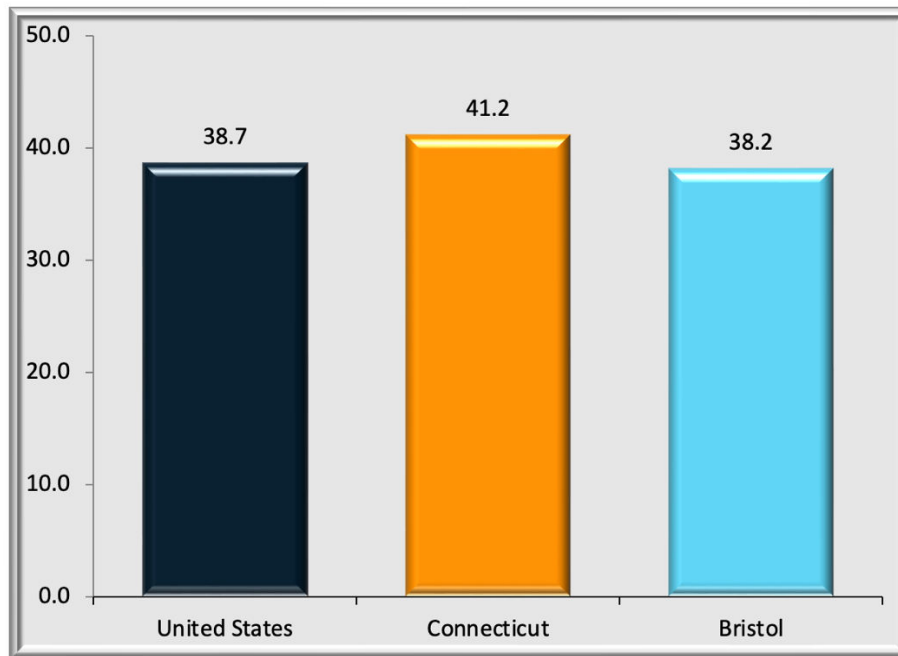
Source: U.S. Census Bureau

Table A2. Population by Age (2019 – 2023)

	U.S.	Connecticut	Bristol
Under 5 years	5.7%	5.0%	4.6%
5 to 14 years	12.5%	11.4%	11.1%
15 to 24 years	13.1%	13.1%	13.3%
25 to 44 years	26.8%	25.0%	29.7%
45 to 59 years	18.7%	20.1%	19.6%
60 to 74 years	16.4%	17.6%	15.1%
75 to 84 years	4.9%	5.2%	4.5%
85 years and over	1.9%	2.4%	2.1%
Median Age (Years)	38.7	41.2	38.2

Source: U.S. Census Bureau

Figure A1. Median age (2019 – 2023)



The population in Bristol is largely White (81.1%), higher than Connecticut (76.2%) and the U.S. (73.4%). The percentage of Hispanic or Latino (of any race) is highest in the U.S. in comparison to Bristol which has the lowest of the geographies (12.2%). 21.3% of Bristol residents speak a language other than English and 37.1% speak English “less than very well. .” In addition to English, the primary language spoken is Spanish (11.4%) which is somewhat similar to the state (12.6%) and the nation (13.4%).

Table A3. Race Alone or in Combination with One or More Other Races (Ethnicity) (2019 – 2023)

	U.S.	Connecticut	Bristol
White	73.4%	76.2%	81.1%
Black/African American	14.4%	13.6%	12.2%
American Indian/Alaska Native	2.2%	1.2%	2.2%
Asian	7.2%	5.8%	6.1%
Native Hawaiian and Pacific Islander	0.5%	0.2%	0.1%
Some Other Race	13.9%	13.5%	13.6%
Hispanic or Latino (of any race) ^a	19.0%	17.8%	18.6%

Source: U.S. Census Bureau

^a Hispanic/Latino residents can be of any race, for example, White Hispanic or Black/African American Hispanic

Figure A2. Racial breakdown of the three major races (2019 – 2023)

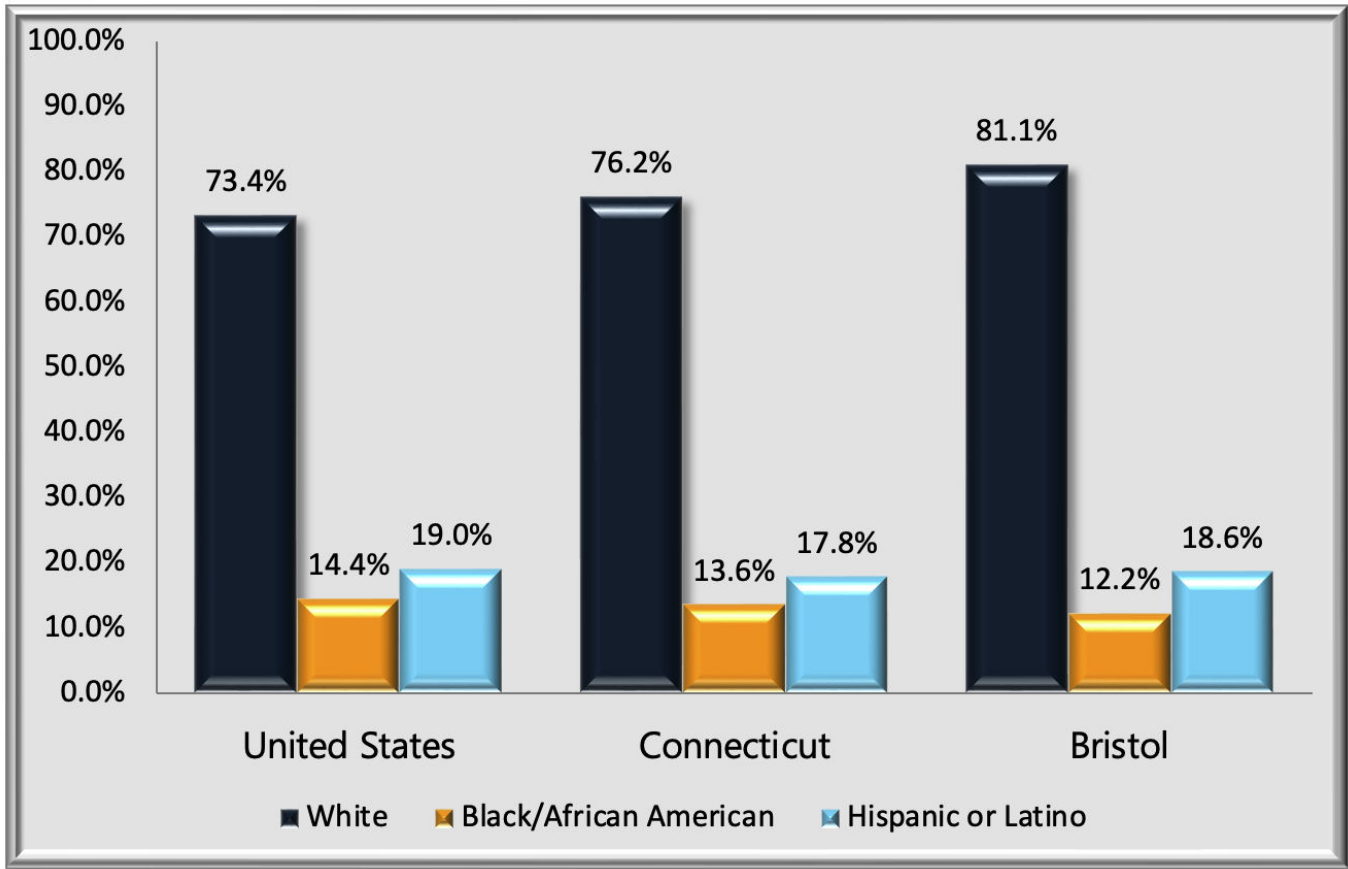


Table A4. Race and Hispanic or Latino Origin, Population Aged 65 Years and Over (2019 – 2023)

	United States	Connecticut	Bristol
White	76.9%	83.6%	90.3%
Black or African American	9.2%	6.8%	1.2%
American Indian and Alaska Native	0.5%	0.1%	0.0%
Asian	4.8%	2.7%	1.8%
Native Hawaiian and Other Pacific Islander	0.1%	0.0%	0.0%
Some Other Race	3.3%	3.0%	3.0%
Hispanic or Latino ^a (of any race)	9.0%	7.0%	5.6%

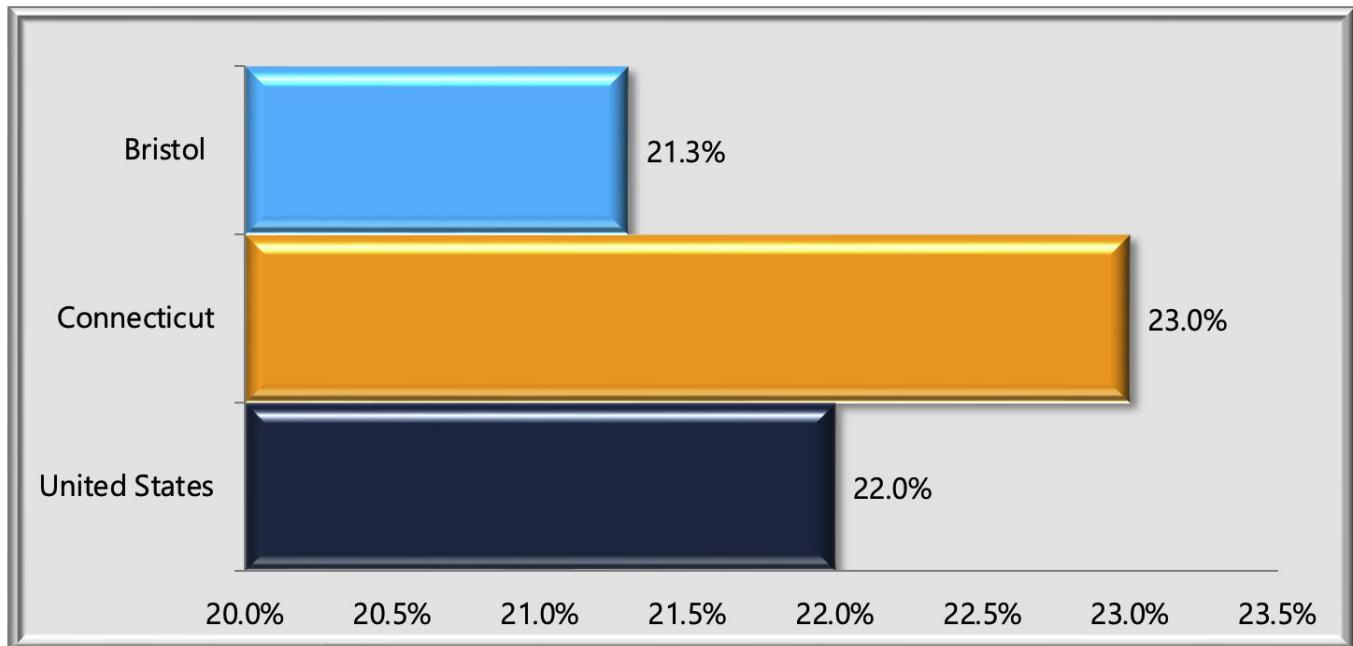
Source: U.S. Census Bureau

Table A5. Language Spoken at Home, 5 Years Old and Older (2019 – 2023)

	U.S.	Connecticut	Bristol
English only	78.0%	77.0%	78.7%
Language other than English	22.0%	23.0%	21.3%
Speak English less than "very well"	38.2%	37.3%	37.1%
Spanish	13.4%	12.6%	11.4%
Speak English less than "very well"	39.6%	40.2%	39.6%
Other Indo-European languages	3.8%	6.9%	6.2%
Speak English less than "very well"	30.6%	32.8%	34.9%
Asian and Pacific Islander languages	3.5%	2.5%	2.9%
Speak English less than "very well"	44.1%	40.0%	36.9%
Other languages	1.2%	1.0%	0.8%
Speak English less than "very well"	29.6%	25.3%	19.5%

Source: U.S. Census Bureau

Figure A3. Percentage of population speaking a language other than English at home (2019 – 2023)



Just over 13% of older adults in Bristol are veterans, which is slightly higher than Connecticut.

Table A6. Veteran Population, Population 65 Years and Over (2019-2023)

United States	Connecticut	Bristol
14.6%	12.4%	13.3%

Source: U.S. Census Bureau

B. Household Statistics

A lower percentage of individuals in Bristol are married (44.4%) in comparison to the state (47.6%) and the nation (47.9%). Percentages of widowed are similar throughout, but Bristol demonstrates the highest percentage of divorced (12.3%) compared to the state and nation.

Table B1. Marital Status, 15 Years and Over (2019 – 2023)

	U.S.	Connecticut	Bristol
Never married	34.1%	35.4%	36.7%
Now married, except separated	47.9%	47.6%	44.4%
Divorced	10.7%	10.4%	12.3%
Separated	1.7%	1.2%	1.1%
Widowed	5.6%	5.4%	5.5%

Source: U.S. Census Bureau

There are fewer married couple households in Bristol. Bristol also has the smallest average household and family size. However, Bristol slightly fewer householders living alone. There is a higher percentage of female householders with no spouse present than male householders with no spouse present. Both data points are higher in Bristol than in Connecticut and the U.S. For householders 65+, 11.0% live alone.

Table B2. Households by Type (2019– 2023)

	U.S.	Connecticut	Bristol
Total Households	127,482,865	1,420,170	24,737
Average household size	2.54	2.47	2.44
Average family size	3.15	3.05	3.01
Family households:	64.5%	64.6%	63.5%
Married-couple family:	73.2%	73.0%	67.7%
Male householder, no spouse present, family:	7.8%	7.5%	10.8%
Female householder, no spouse present family:	19.0%	19.5%	21.5%
Nonfamily households	55.1%	54.8%	57.4%
Householders living alone	28.5%	28.7%	28.4%
65 years and over	11.6%	12.7%	11.0%

Source: U.S. Census Bureau

Figure B1. Family households by householder(s) present

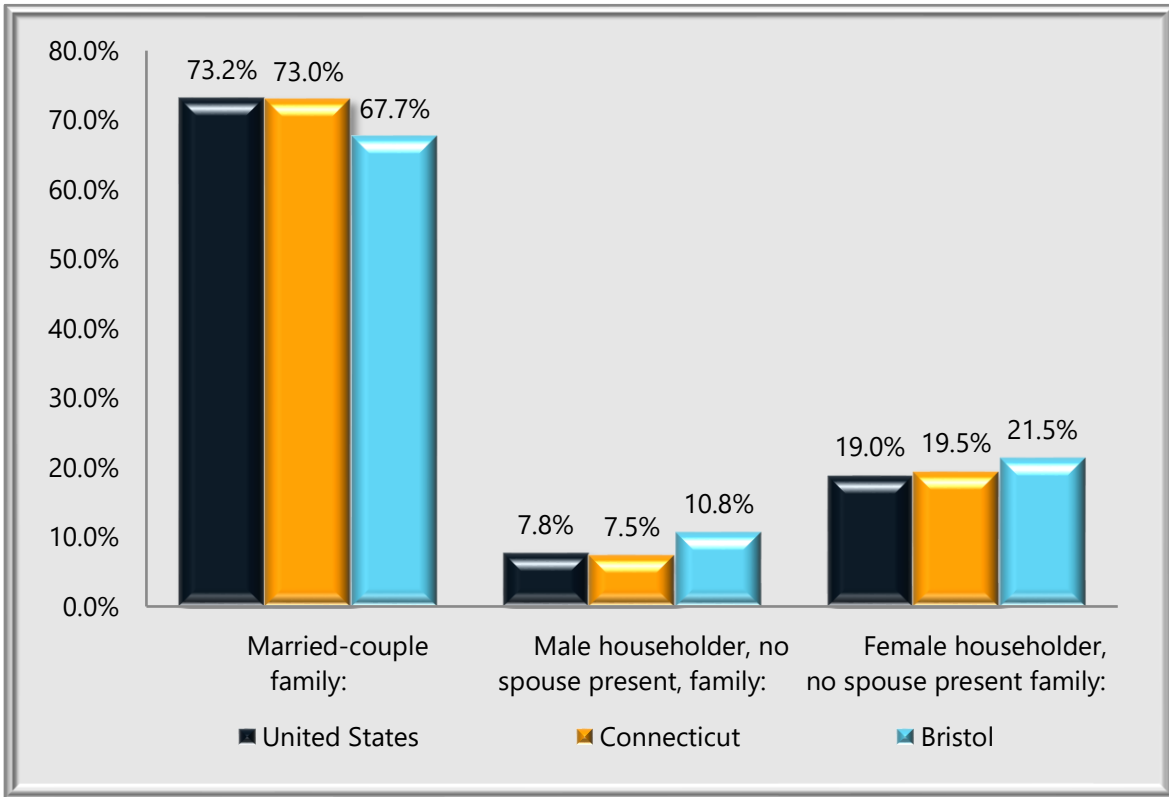
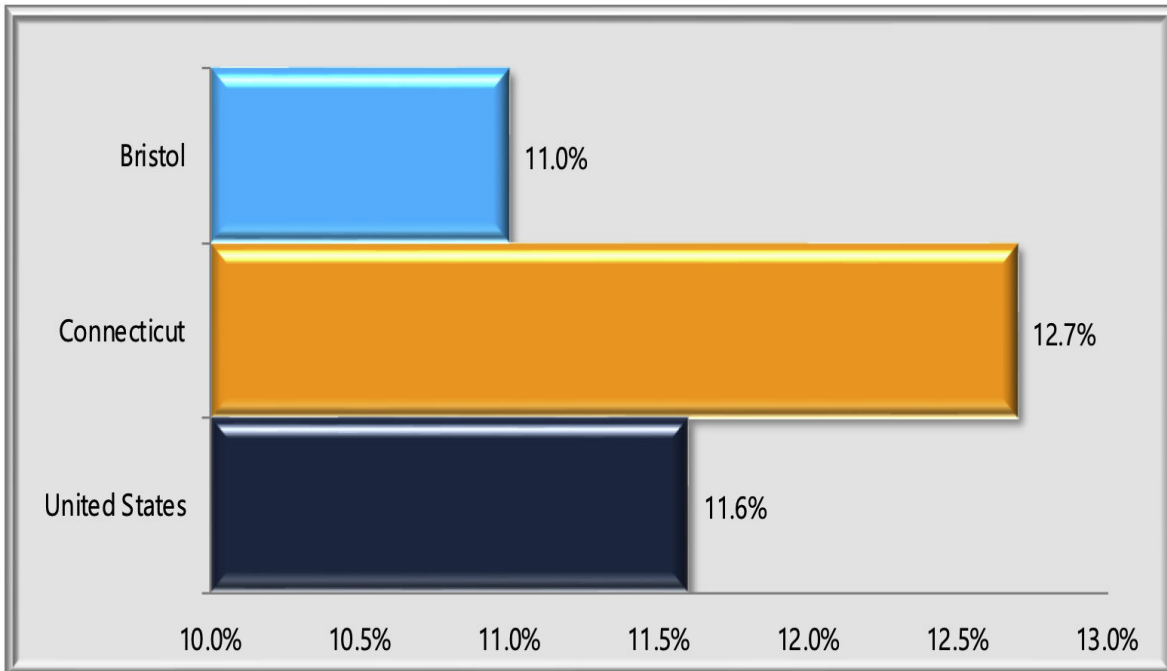


Figure B2. Householder living alone, 65 years and over (2019 – 2023)



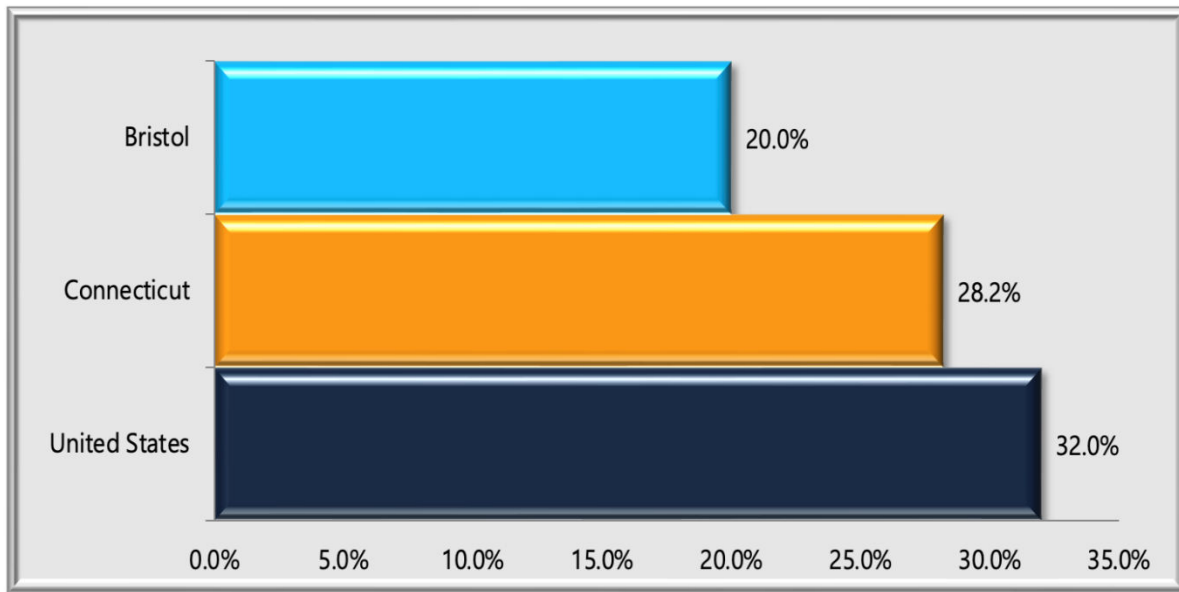
A total of 920 grandparents in Bristol are estimated to live with their grandchildren and of those, 20.0% are responsible for them. This percentage is substantially lower than Connecticut and the nation.

Table B3. Grandparents Responsible for Grandchildren (2019 – 2023)

	U.S.	Connecticut	Bristol
Number of grandparents living with own grandchildren under 18 years	6,844,458	58,297	920
% of grandparents responsible for grandchildren	32.0%	28.2%	20.0%

Source: U.S. Census Bureau

Figure B3. Percentage of grandparents responsible for grandchildren (2019 – 2023)



Households living in owner-occupied homes number 16,015 while renter occupied homes are lightly over half of that (8,722). There are estimated to be 2,007 vacant housing units in Bristol.

Table B4. Households by Occupancy (2019 – 2023)

	U.S.	Connecticut	Bristol
Total housing units	142,332,876	1,536,049	26,744
Occupied housing units	127,482,865	1,420,170	24,737
Owner-occupied	82,892,037	939,912	16,015
Renter-occupied	44,590,828	480,258	8,722
Vacant units	14,850,011	115,879	2,007

Source: U.S. Census Bureau

Data from the U.S. Census is presented for households rather than for population (individuals) when income and other values are considered. Bristol has more owner-occupied housing units with mortgages (70.3%) than in the state or nation. The median value of the housing units in Bristol is \$252,300, lower than in Connecticut and the U.S. The median monthly rent is also lower at \$1,305.

Housing cost burden is defined as households paying 30% or more of their income on housing costs (rent/mortgage and utilities).

For owners and renters, a smaller percentage in Bristol pay 30% or more of their gross household income for a mortgage or rent (and associated expenses) in comparison to the state and nation. Yet, more than half of renters (52.4%) in Bristol experience a housing cost burden. For Bristol residents 65 years and older, 30.8% of owners and a much higher 67.5% of renters are housing cost burdened.

Table B5. Housing Characteristics (2019– 2023)

	U.S.	Connecticut	Bristol
Owner-Occupied Housing			
Housing units with a mortgage	61.2%	65.4%	70.3%
Housing units without a mortgage	38.8%	34.6%	29.7%
Median value	\$303,400	\$343,200	\$252,300
Households spending 30% or more income on mortgage/Owner costs	27.6%	29.8%	25.0%
Renter-Occupied Housing			
Occupied units paying rent	42,439,779	461,855	8,427
Median (dollars per month)	\$1,348	\$1,431	\$1,305
Households spending 30% or more of income on rent	50.4%	51.3%	52.4%

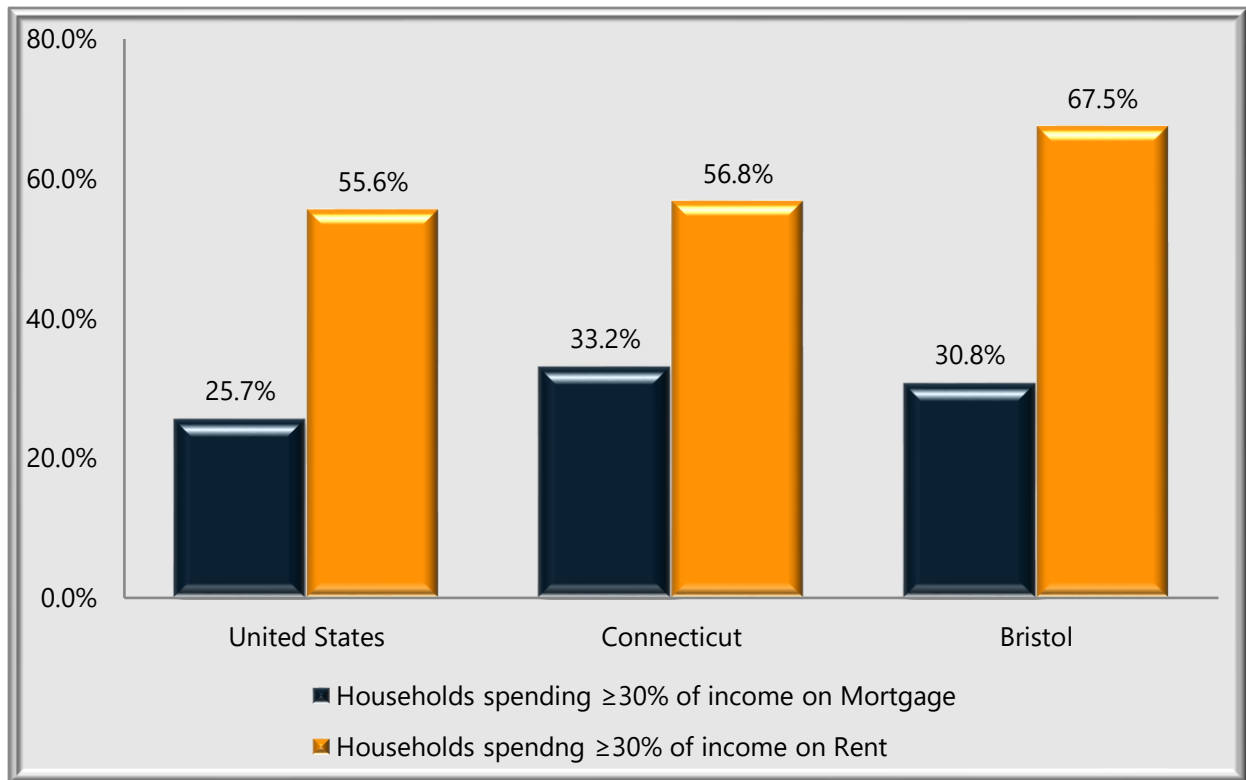
Source: U.S. Census Bureau

Table B6. Housing Value and Costs, Population 65 Years and Over (2019 - 2023)

	United States	Connecticut	Bristol
Median Home Value	\$282,800	\$331,800	\$249,700
Median Monthly Owner Costs With a Mortgage	\$1,648	\$2,131	\$1,689
Median Monthly Owner Costs Without a Mortgage	\$603	\$1,038	\$842
Median Rent	\$1,069	\$1,117	\$1,146
Older adults spending 30% or more of income on mortgage/owner costs	25.7%	33.2%	30.8%
Older adults spending 30% or more of income on rent	55.6%	56.8%	67.5%

Source: U.S. Census Bureau

Figure B4. Households spending more than 30% of income on housing – all ages (2019 – 2023)



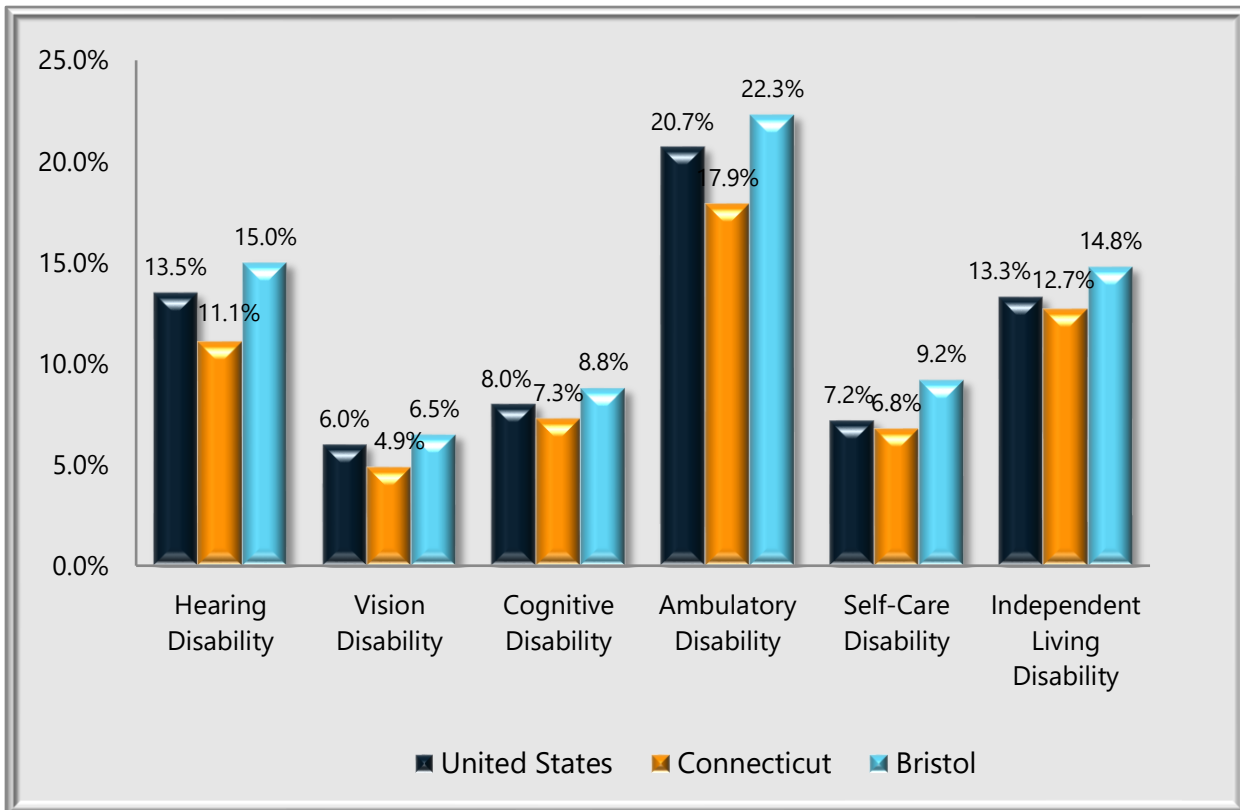
The percentage of disabled older adults in Bristol is 77.3%, which is considerably higher than the state (70.5%) and the nation (62.5 %). Older adults in Bristol are most affected by hearing, ambulatory and living independently disabilities. Compared to the Connecticut and the United States, Bristol demonstrates higher percentages for each of the disabilities including hearing, vision, cognitive, ambulatory, self-care, and independent living.

Table B7. Disabled Population, Population 65 Years and Over (2019 – 2023)

	United States	Connecticut	Bristol
Population with a Disability	70.5%	62.5%	77.3%
Hearing Disability	13.5%	11.1%	15.0%
Vision Disability	6.0%	4.9%	6.5%
Cognitive Disability	8.0%	7.3%	8.8%
Ambulatory Disability	20.7%	17.9%	22.3%
Self-Care Disability	7.2%	6.8%	9.2%
Independent Living	13.3%	12.7%	14.8%

Source: U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates

Figure B5. Disabilities by Type, Population 65 Years and Over (2019- 2023)



C. Income Statistics

Overall, mean, and median household income is somewhat less than mean and median family income. Median family income is substantially less in Bristol than Connecticut and the U.S. Median household income is also less in Bristol compared to the state and nation . Bristol individual median earnings are \$50,262 with 21.5% earning \$100,000 to \$149,999 and 16.3% earning \$50,000 to \$74,999.

Table C1. Household and Family Income (2019 – 2023)

	U.S.	Connecticut	Bristol
Household Income			
Less than \$15,000	8.5%	7.6%	6.8%
\$15,000 to \$24,999	6.6%	5.6%	6.7%
\$25,000 to \$34,999	6.8%	5.6%	5.8%
\$35,000 to \$49,999	10.4%	8.6%	9.6%
\$50,000 to \$74,999	15.7%	13.4%	16.3%
\$75,000 to \$99,999	12.7%	12.0%	12.7%
\$100,000 to \$ 149,999	17.4%	17.8%	21.5%
\$150,000 to \$199,999	9.3%	11.2%	11.1%
\$200,000 or more	12.6%	18.2%	9.5%
Median household income	\$78,538	\$93,760	\$83,458
Mean household income	\$110,491	\$135,332	\$99,677
Family Income			
Median family income	\$96,922	\$52,961	\$47,010
Mean family income	\$130,215	\$76,969	\$59,776
Individual Median Earnings			
Median earnings for workers	\$44,587	\$51,475	\$50,262

Source: U.S. Census Bureau

Figure C1. Median household income (2019 – 2023)



Figure C2. Median family income (2019 – 2023)

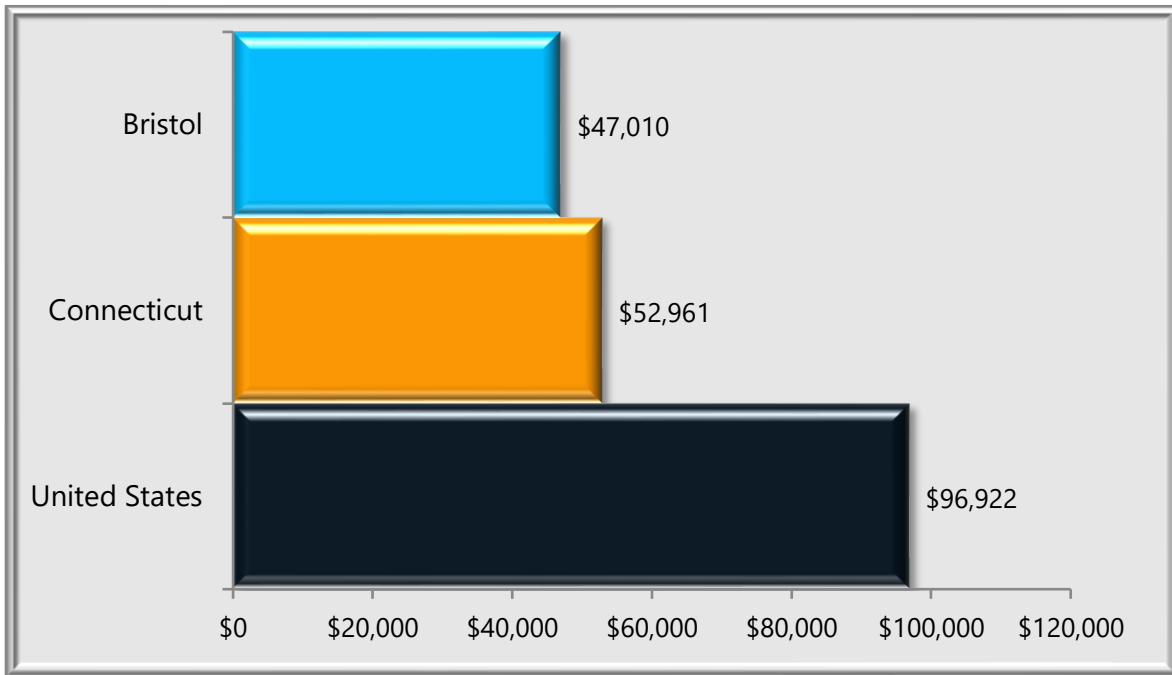


Table C2. Health and Human Services Poverty Guidelines (2025)

Size of Family/ Household	48 Contiguous States and the District of Columbia 100% of Poverty Level
1	\$15,650
2	\$21,150
3	\$26,650
4	\$32,150
5	\$37,650
6	\$43,150
7	\$48,650
8	\$54,150
For each additional person after 8, add: \$5,500	

Source: U.S. Department of Health and Human Services

*Data reflects 2025 poverty guidelines

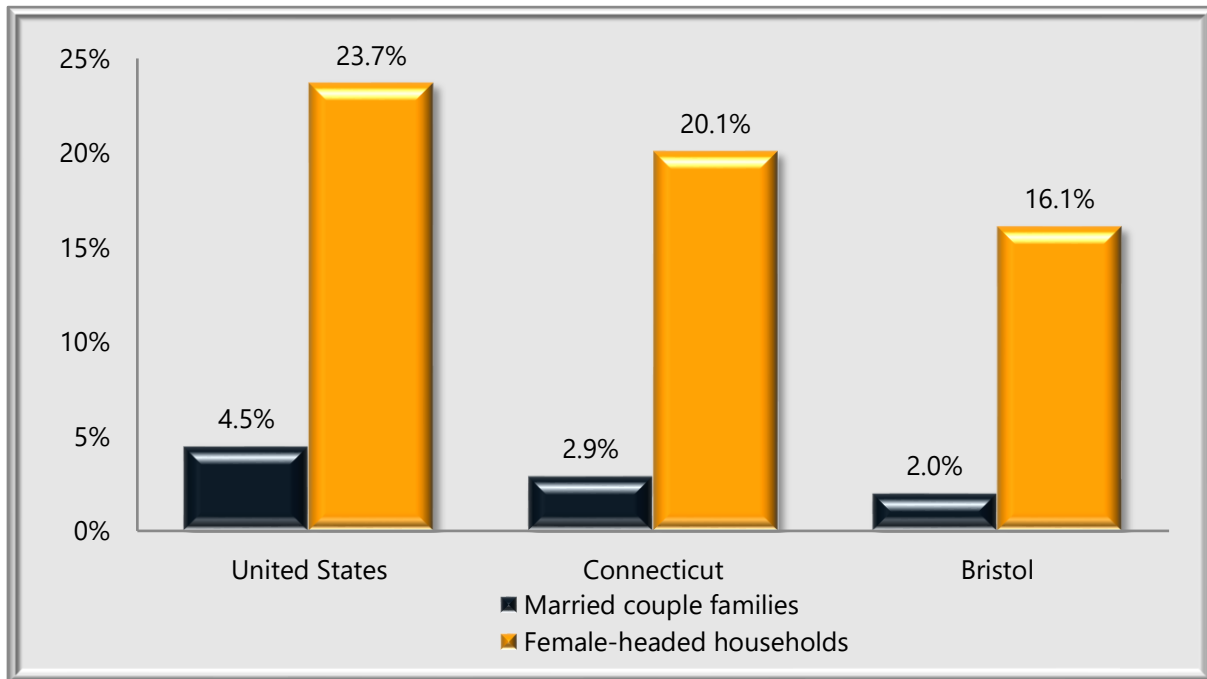
As it relates to families, 5.0% in Bristol live below the federal poverty level, however, those with related children under the age of 18, 21.5% live in poverty.

Table C3. Poverty Status of Families and People in the Past 12 Months (2019 – 2023)

	U.S.	Connecticut	Bristol
All families	8.7%	6.8%	5.0%
With related children under 18 years	13.5%	11.1%	7.3%
With related children under 6 years	12.4%	8.1%	2.2%
Married couple families	4.5%	2.9%	2.0%
With related children under 18 years	5.8%	3.8%	1.7%
With related children under 6 years	4.4%	2.2%	0.0%
Female-headed households, no husband present	23.7%	20.1%	16.1%
With related children under 18 years	32.6%	28.6%	21.5%
With related children under 6 years	36.8%	27.2%	2.9%
All people	12.4%	10.0%	8.4%
Under 18 years	16.3%	13.1%	10.7%
18 years to 64 years	11.6%	9.5%	7.9%
65 years and over	10.4%	8.3%	7.8%

Source: U.S. Census Bureau

Figure C3. Percentage of families below the poverty level by household type (2019 – 2023)



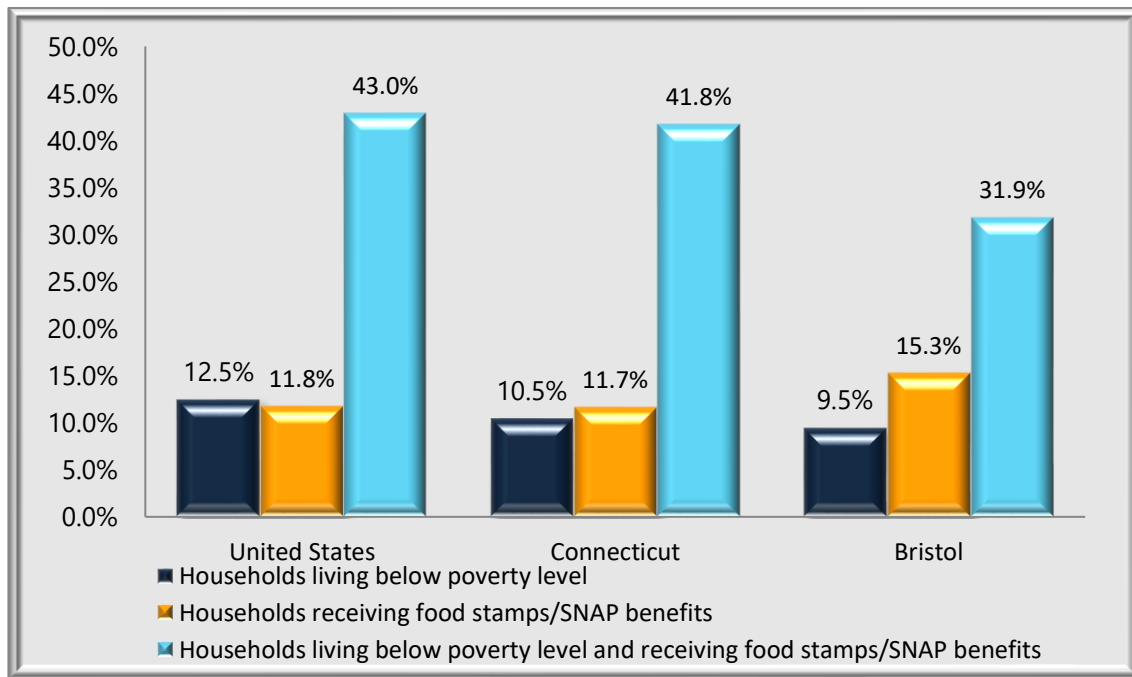
Fewer households in Bristol (9.5%) live below the poverty level compared to the state and the nation. Of those, 15.3% received food stamps/SNAP benefits in the past 12 months. However, percentages of households with supplemental security income and cash public assistance income are highest in Bristol.

Table C4. Households with Supplemental Benefits in the Past 12 Months (2019 – 2023)

	U.S.	Connecticut	Bristol
Households below poverty level	12.5%	10.5%	9.5%
Households with supplemental security income	5.1%	4.7%	5.3%
Mean supplemental security income	\$11,361	\$11,555	\$9,868
Households with cash public assistance income	2.7%	2.9%	3.7%
Mean cash public assistance income	\$4,420	\$4,734	\$5,430
Households with food stamps/SNAP benefits in the past 12 months	11.8%	11.7%	15.3%
Households below poverty level and receiving food stamps	43.0%	41.8%	31.9%
Households with one or more people 60 years and over receiving food stamps	38.8%	43.4%	38.8%
Households with children under 18 years receiving food stamps	47.2%	40.2%	46.4%

Source: U.S. Census Bureau

Figure C4. Households below poverty level and receiving food stamps (2019 – 2023)



D. Employment Statistics

In Bristol, a larger percentage of the population is in the labor force (70.5%) than in Connecticut (66.1%) and in the U.S. (63.5%). Most of the Bristol employed workforce (77.4%) drive alone to work while 9.8% work from home and a higher percentage than in the state and nation, carpool (9.8%). Nearly forty percent of the labor force in Bristol is employed in management, business, science, and arts, somewhat less than the state and nation and 4.8% of county workers are self-employed. However, the percentage of the unemployed civilian labor force is somewhat higher in Bristol than in the state or nation.

Table D1. Employment Status, 16 Years Old and Older (2019 – 2023)

	U.S.	Connecticut	Bristol
Population in labor force	169,855,626	1,953,702	35,721
% of population in labor force	63.5%	66.1%	70.5%
Civilian labor force	168,567,852	1,945,293	35,645
Armed Forces	1,287,774	8,409	76
% of population not in labor force	36.5%	33.9%	29.5%
Unemployed civilian labor force	3.3%	3.7%	4.9%

Sources: Bureau of Labor Statistics & U.S. Census Bureau

Figure D1. Unemployed civilian labor force (2019-2023)

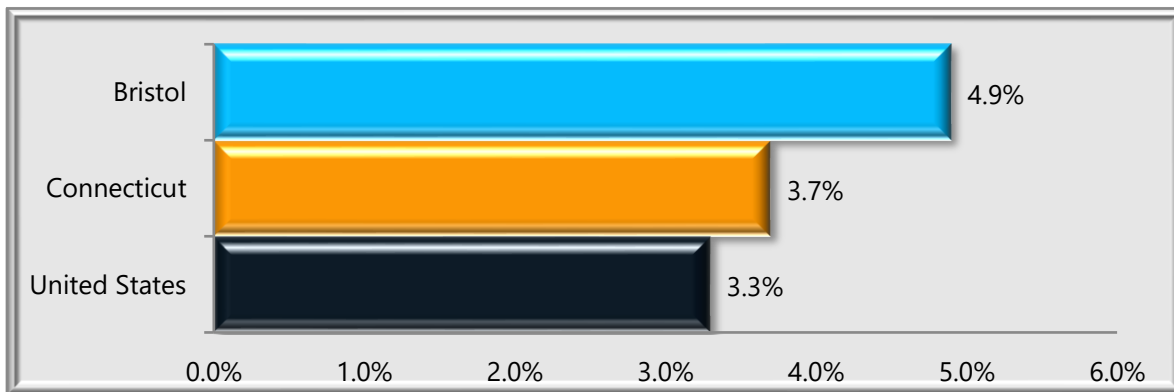


Table D2. Commuting To Work Status (2019 – 2023)

	U.S.	Connecticut	Bristol
Workers who drive alone to work	70.2%	70.6%	77.4%
Car, truck, or van -- carpooled	8.5%	7.7%	9.8%
Workers commuting by public transportation (excluding taxicab)	3.5%	3.4%	0.5%
Walked	2.4%	2.5%	1.8%
Other means	1.9%	1.5%	0.7%
Worked at home	13.5%	14.4%	9.8%
Mean travel time to work (minutes)	26.6	26.6	24.5

Source: U.S. Census Bureau

Table D3. Estimated Major Occupational Groups (2019 – 2023)

	U.S.	Connecticut	Bristol
Management, business, science, and arts	42.0%	46.6%	38.6%
Service	16.5%	16.3%	19.0%
Sales and office	19.9%	19.4%	20.6%
Natural resources, construction, and maintenance	8.6%	7.1%	8.1%
Production, transportation, and material moving	13.0%	10.6%	13.7%

Source: U.S. Census Bureau

Table D4. Class of Worker (2019 – 2023)

	U.S.	Connecticut	Bristol
Private wage and salary workers	79.4%	80.5%	79.5%
Government workers	14.4%	13.2%	15.7%
Self-employed in own not incorporated business	6.0%	6.2%	4.8%
Unpaid family workers	0.2%	0.2%	0.1%

Source: U.S. Census Bureau

Table D5. Estimated Major Industrial Group Percentages (2019 – 2023)

	U.S.	Connecticut	Bristol
Agriculture, forestry, fishing, hunting, mining	1.6%	0.4%	0.1%
Construction	6.9%	6.1%	6.9%
Manufacturing	10.0%	10.6%	11.7%
Wholesale trade	2.3%	2.0%	1.7%
Retail trade	10.9%	10.5%	11.0%
Transportation and warehousing, and utilities	5.9%	4.6%	5.1%
Information	1.9%	2.0%	2.9%
Finance, insurance, real estate, rental, and leasing	6.7%	8.9%	8.9%
Professional, scientific, management, administrative and waste management services	12.4%	12.2%	9.5%
Educational services, health care, social assistance	23.4%	26.7%	25.3%
Arts, entertainment, recreation, accommodation, and food	8.8%	7.9%	8.0%
Other services, except public administration	4.7%	4.3%	4.6%

Source: U.S. Census Bureau

E. Education Statistics

A slightly higher percentage of individuals 25 years and over graduated from high school in Bristol (93.4%) than in Connecticut (91.3%) and the U.S. (89.4%). More individuals have some college education than in the state or the nation. However, a substantially smaller percentage (30.5%) than Connecticut (41.9%) and the U.S. (35.0%) have completed a bachelor’s degree or higher or have a graduate or professional degree.

Table E1. Educational Attainment, Population 25 Years and Over (2019 – 2023)

	U.S.	Connecticut	Bristol
Less than high school diploma	11.6%	9.3%	12.4%
High school graduate (includes equivalency)	34.6%	31.1%	42.0%
Some college, no degree	19.4%	16.2%	20.6%
Associate’s degree	8.8%	7.6%	11.6%
Bachelor’s degree	21.3%	23.0%	18.7%
Graduate or professional degree	13.7%	19.0%	11.7%
Percent high school graduate or higher	89.4%	91.3%	93.4%
Percent bachelor’s degree or higher	35.0%	41.9%	30.5%

Source: U.S. Census Bureau

Figure E1. Population with a high school diploma or bachelor’s degree or higher (2019 – 2023)

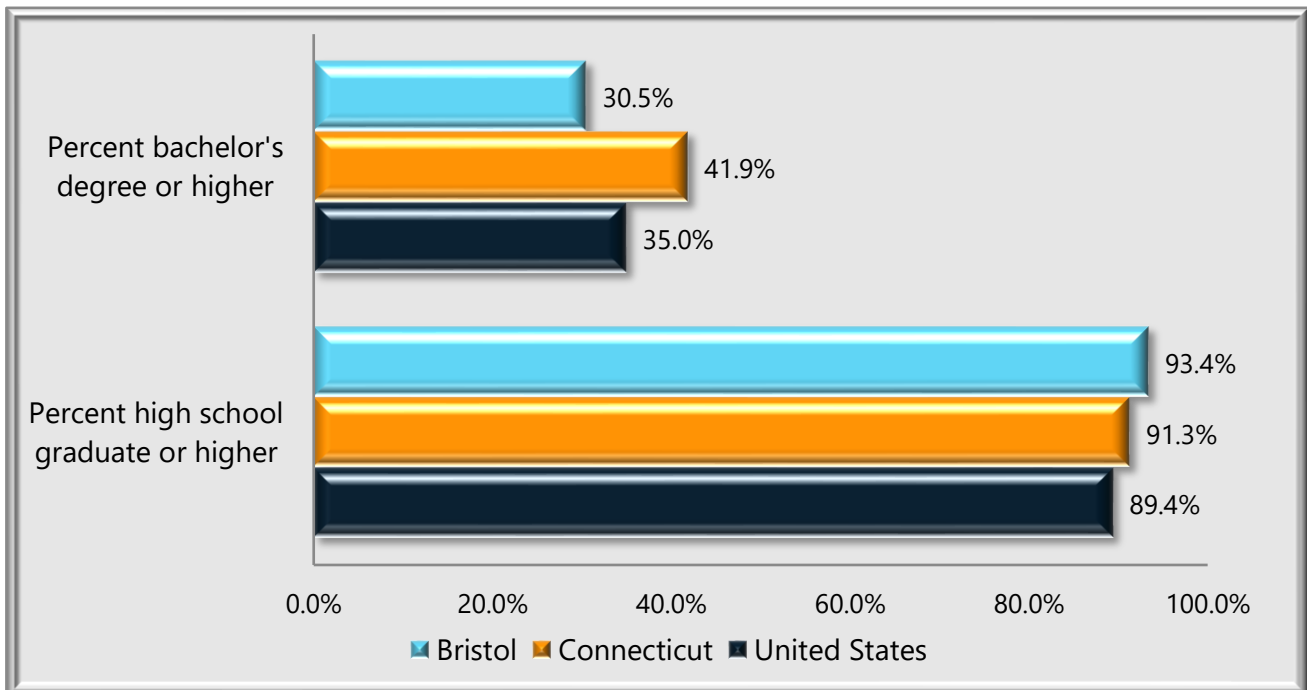


Table E2. Public School Enrollment, Population Three Years and Over (2019 – 2023)

	U.S.	Connecticut	Bristol
Nursery school, preschool	5.8%	5.8%	5.2%
Kindergarten	5.1%	4.5%	4.6%
Elementary school (grades 1- 8)	40.8%	38%	38.6%
High school (grades 9 -12)	21.6%	22.3%	24.4%
College or graduate school	26.7%	29.4%	27.2%

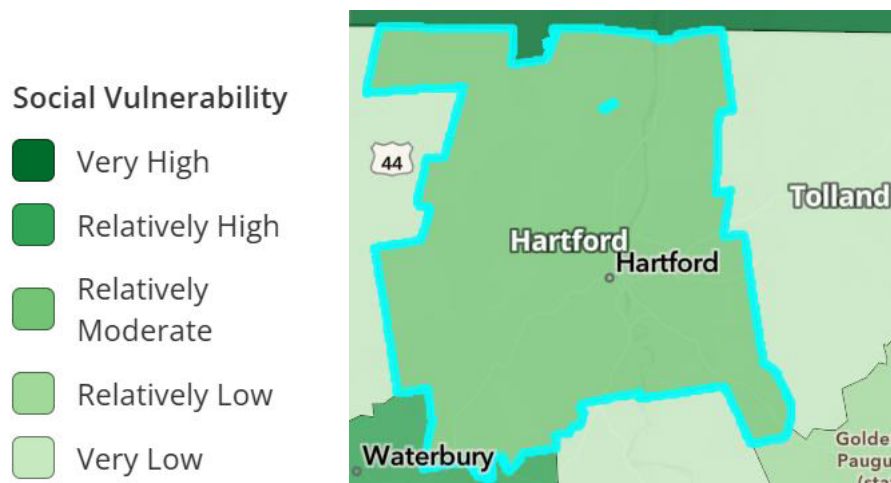
Source: U.S. Census Bureau

Social Vulnerability Index

Social vulnerability as defined by the Federal Emergency Management Association (FEMA) refers to the potential negative effects on communities caused by external stresses on human health and life. It is the susceptibility of social groups to the adverse impacts of natural hazards, including disproportionate death, injury, loss, or disruption of livelihood. Such stresses include natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss. The Social Vulnerability Index (SVI) percentile ranking values are ranked from 0 to 1 in quartiles as low (0.0-0.2500), mid-low (0.2501-0.5000), mid-high (0.5001-0.7500), and high (0.7501-1.0). Higher SVI ranking values correspond to higher vulnerability. The SVI evaluates census tracts on 15 social factors, including unemployment, household composition and disability, minority status and language, and housing and transportation.

According to the map, Connecticut has moderate to low areas of high social vulnerability. Hartford County appears to have “moderate vulnerability..” FEMA also describes Hartford County as having “relatively high” community resilience when dealing with stresses on human health and life.

Figure E2. Social Determinant of Health Measure: Social Vulnerability Index (2025)



Source: Social Vulnerability Index, United States, 2017 to 2021

HEALTH STATISTICS

F. Health Care Access Statistics

A higher percentage of population has health insurance coverage in Bristol (96.0%) than in Connecticut and the U.S, however the percentage of public coverage is also higher. Both Bristol and Connecticut show similar percentages for private insurance which is higher than the nation.

Table F1. Health Insurance Coverage (2019 – 2023)

	U.S.	Connecticut	Bristol
With health insurance coverage	299,424,402	3,367,143	58,146
% of population with health insurance coverage	91.4%	94.7%	96.0%
With private health insurance	67.3%	69.4%	69.2%
With public coverage	36.3%	37.2%	38.3%
% of population without health insurance	8.6%	5.3%	4.0%

Source: U.S. Census Bureau

Table F2. Type of Health Insurance Coverage (2019 – 2023)

	U.S.	Connecticut	Bristol
Public health insurance alone	21.3%	22.4%	23.3%
Medicare coverage alone	6.1%	6.3%	5.7%
Medicaid/means tested coverage alone	15.0%	15.9%	17.4%
VA health care coverage alone	0.3%	0.1%	0.2%

Source: U.S. Census Bureau

Figure F1. Civilian non-institutionalized population without health insurance (2019– 2023)

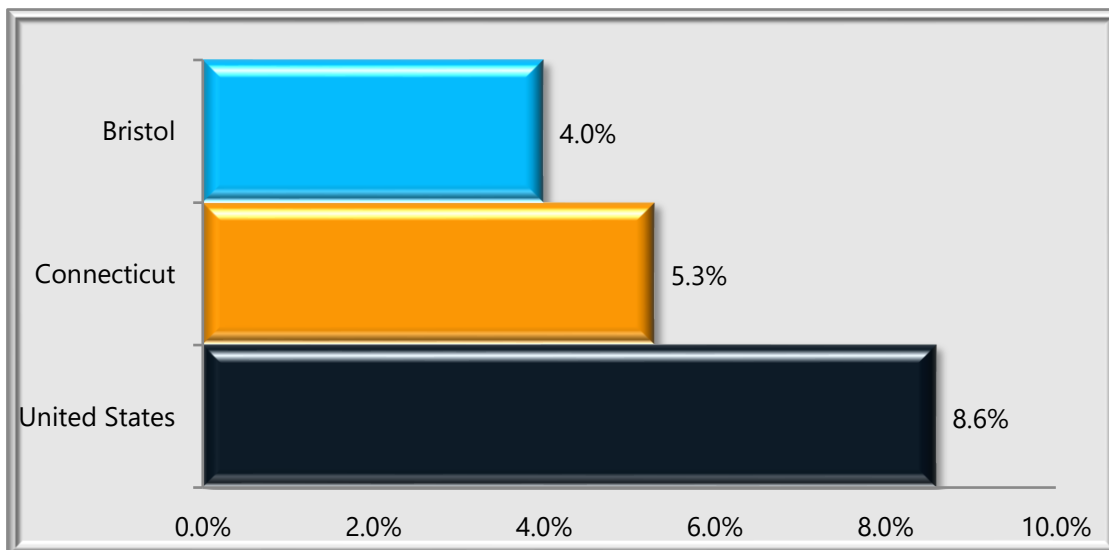
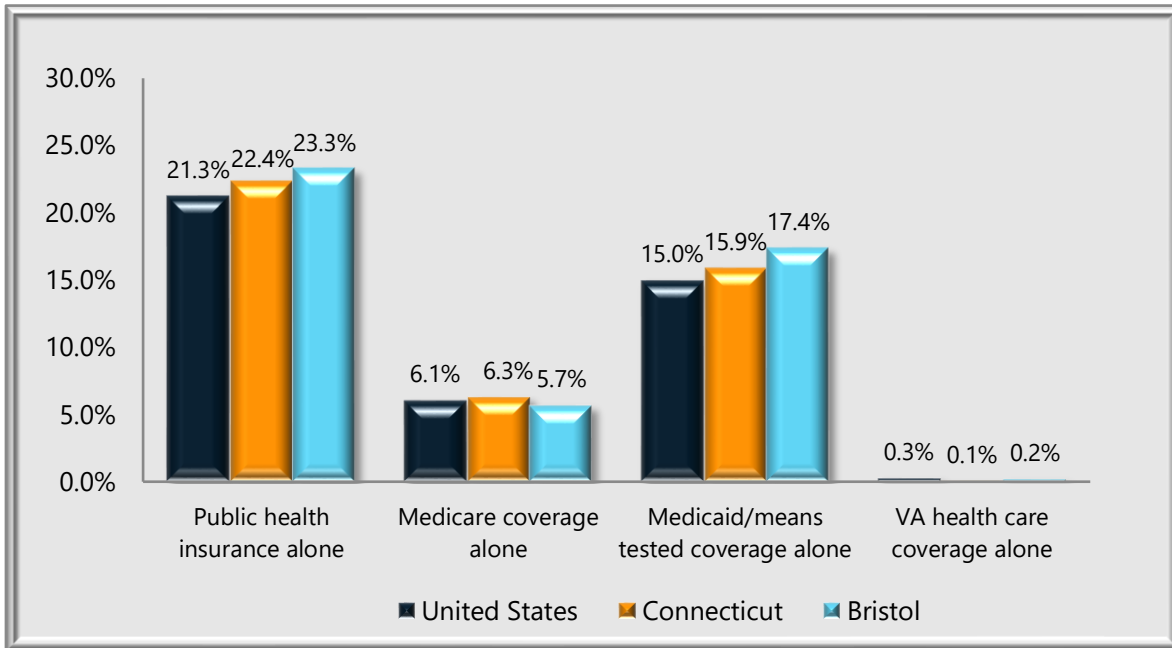


Figure 2. Percentage of public health insurance coverage



According to the Kaiser Family Foundation, adults aged 65 and older, who are eligible for health care coverage through Medicare, are much less likely than younger age groups to say they have not gotten a test or treatment because of cost. However, a substantial portion of these older adults report difficulty paying for various aspects of health care, especially services not covered by Medicare, such as hearing services, dental and prescription drug costs. Medicare provides near universal coverage to seniors, but it has gaps that can leave beneficiaries with substantial out-of-pocket costs.

Older adults in Bristol are more likely to be uninsured (1.8%) when compared to older adults in the state (0.8%) and the nation (0.8%). A large majority (92.7%) of the city’s population 65+ have Medicare coverage alone or in combination with another insurance plan. About a fifth of older adults have Medicaid, or some other means tested public coverage either alone or in combination with another plan.

Table F3. Uninsured Population Aged 65 Years and Over (2019 - 2023)

United States	Connecticut	Bristol
0.8%	0.8%	1.8%

Source: U.S. Census Bureau, 2019-20231 American Community Survey 5-Year Estimates

Table F4. Public Health Insurance Coverage Alone or in Combination, Population 65 Years and Over (2019 - 2023)

	United States	Connecticut	Bristol
Medicare coverage alone or in combination	95.4%	94.3%	92.7%
Medicaid/means-tested public coverage alone or in combination	13.8%	16.1%	20.3%
VA health care coverage alone or in combination	6.8%	4.9%	5.9%

Source: U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates

Medically Underserved Areas (MUAs), designated by the U.S. Health Resources Services Administration, detect geographic areas with a lack of access to primary care services. There is a shortage of primary care health services for residents within the specific geographic area. The designations are based on the Index of Medical Underservice (IMU), which is calculated based on four demographic and health indicators:

- Provider per 1,000 population ratio
- Percent of the population below the federal poverty level
- Percent of the population over age 65
- Infant mortality rate

The IMU scale can range from 0 to 100, where 0 represents the completely underserved. To qualify for a designation, the IMU score must be less than or equal to 62.0. The score for Central Bristol is 56.8.

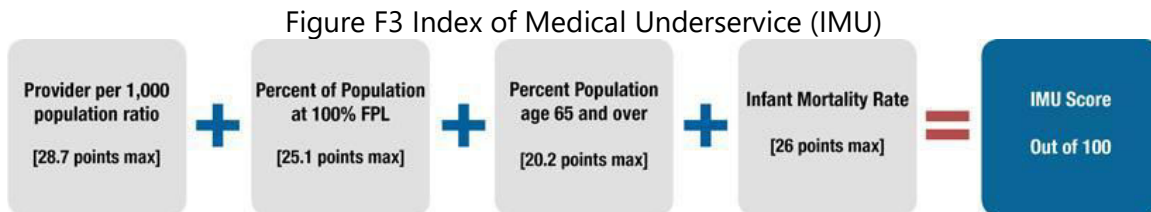


Table F5. Medically Underserved Areas (2023)

	Designation Type	Index of Medical Underservice Score*	Rural Status
Central Bristol	MUA	56.8	Non-Rural

Source: Health Resources and Services Administration

*To qualify for a designation, the IMU score must be less than or equal to 62.0.

G. Maternal & Child Health Statistics

The live birth rate per 1,000 is relatively similar throughout the county, state, and nation. Of those births however, the percentage of low and very low birthweight infants (defined as under 2,500 grams and under 1,500 grams respectively) in Hartford County is higher than the state and the nation at 8.7%.. The teen birth rate (7.9 per 1,000) for mothers ages 15 to 19 is much higher than CT (3.5).

Table G1. Live Birth Rate per 1,000 by Age of the Mother (2021)

	U.S.	Connecticut	Bristol
Number of live births	3,596,017	36,932	583
Birth Rate	10.7	10.1	10.3
15-19	13.9	3.5	7.9*
20-24	61.5	16.3	--
25-29	93.0	36.5	--
30-34	97.6	58.3	--
35-39	53.7	33.9	--
40-44	12.0	6.8	--
45-49	0.9	0.6	--

Sources: Centers for Disease Control and Prevention and National Vital Statistics Reports (U.S.) & Connecticut Department of Public Health/CT Registration Report 2021 Table 11b (CT & Bristol) *Local level rates only offered in aggregated 2017-2021 data (--) Data Unavailable

Figure G1. Live birth rate per 1,000 for mothers 15-19 years of age (2021)

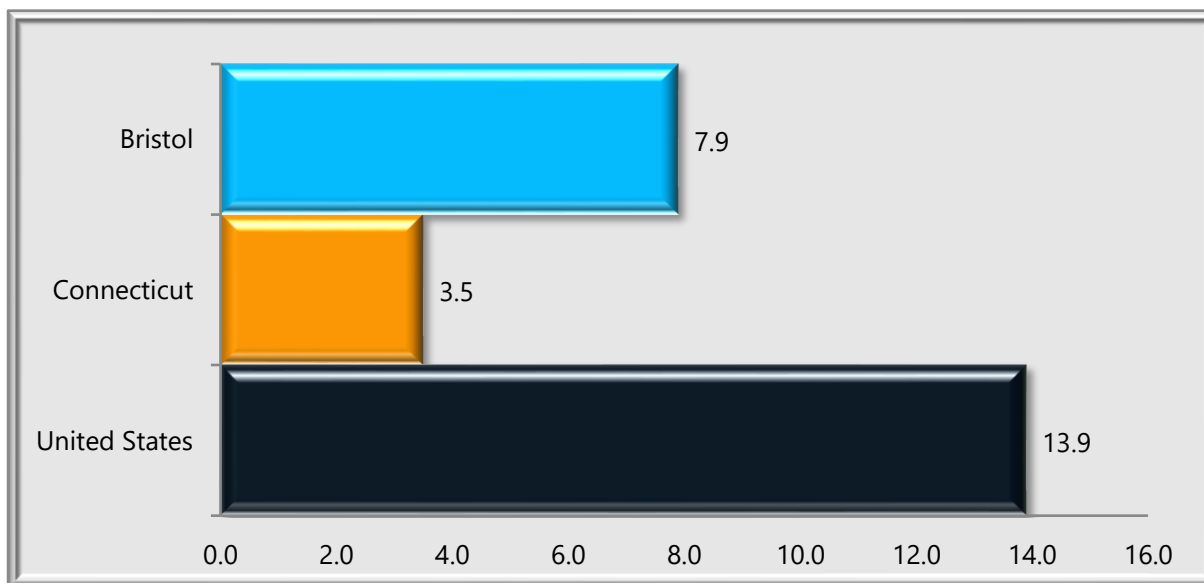
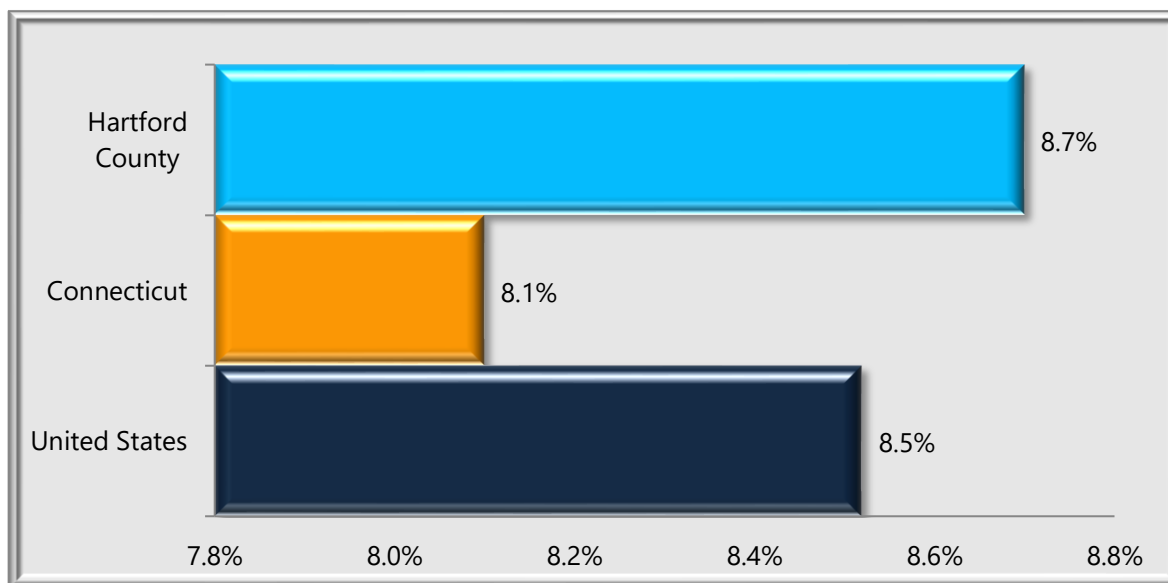


Table G2. Low Birth Weight and Very Low Birth Weight Births (2021)

	U.S.	Connecticut	Hartford County
Low birth weight	8.5%	8.1%	8.7%
Very low birth weight	1.4%	1.4%	1.7%

Sources: National Vital Statistics Report (U.S.) and Connecticut Department of Public Health/CT Registration Report 2021 Table 14 (CT & Bristol)

Figure G2. Percentage of infants with low birthweight (2021)



Healthy People 2030: Maternal, Infant, and Child Health (Morbidity and Mortality)

Healthy People 2030 tracks 355 measurable public health objectives that have 10-year targets and are associated with evidence-based interventions. Each measurable objective has a reliable data source, baseline measure, and a target for specific improvements to be achieved by the year 2030. In 2030, there is one Maternal, Infant, and Child Health Leading Health objective which is:

- Reduce the rate of infant deaths – MICH-02

In comparison to HP 2030, Bristol and Connecticut met the objective in 2021 at 4.8 and 4.7 respectively. The rate of post-neonatal mortality is much higher in Bristol than in Connecticut and the U.S.

Table G3. Infant Mortality Rate per 1,000 Live Births (2021)

	HP 2030	U.S.	Connecticut	Bristol
Infant	5.0	5.44	4.7	4.8
Neonatal	--	3.49	3.1	1.6
Post-neonatal	--	1.9	1.6	3.2

Sources: CDC Wonder (U.S.) & Connecticut Department of Public Health, Connecticut Registration Table 7 (CT & Bristol) and Healthy People 2030.

H. Communicable Diseases Statistics

The incident rate per 100,000 individuals for chlamydia in Hartford County is higher than in Connecticut and the U.S. Rates for gonorrhea and syphilis are lower than the nation but higher than the state. Rates for other communicable diseases include HIV diagnoses for which Bristol is much lower. Bristol is also lower than the other geographies for tuberculosis.

Table H1. Sexually Transmitted Illness Incidence Rates per 100,000 (2021)

	U.S.	Connecticut	Hartford County
Chlamydia	495.5	409.1	509.4
Gonorrhea	214.0	149.9	210.8
Syphilis (primary and secondary)	16.2	9.1	14.5

Sources: Centers for Disease Control & Prevention AtlasPlus. Data for Bristol no longer collected.

Figure H1. Chlamydia, Gonorrhea and Syphilis incidence rate per 100,000 (2021)

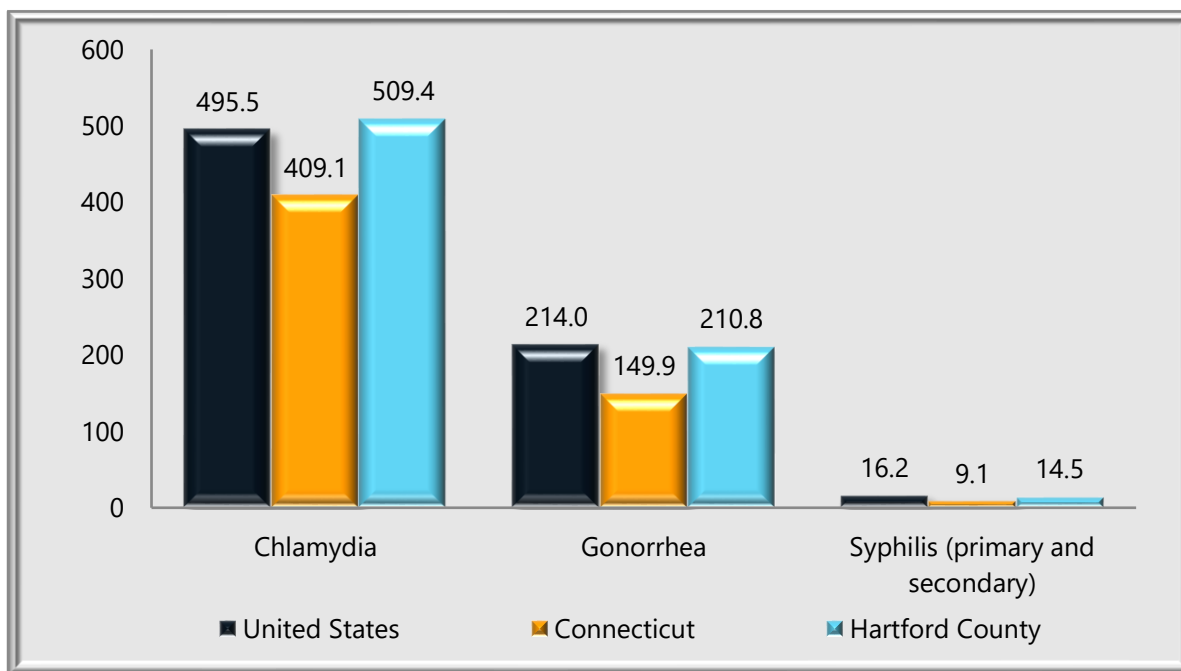


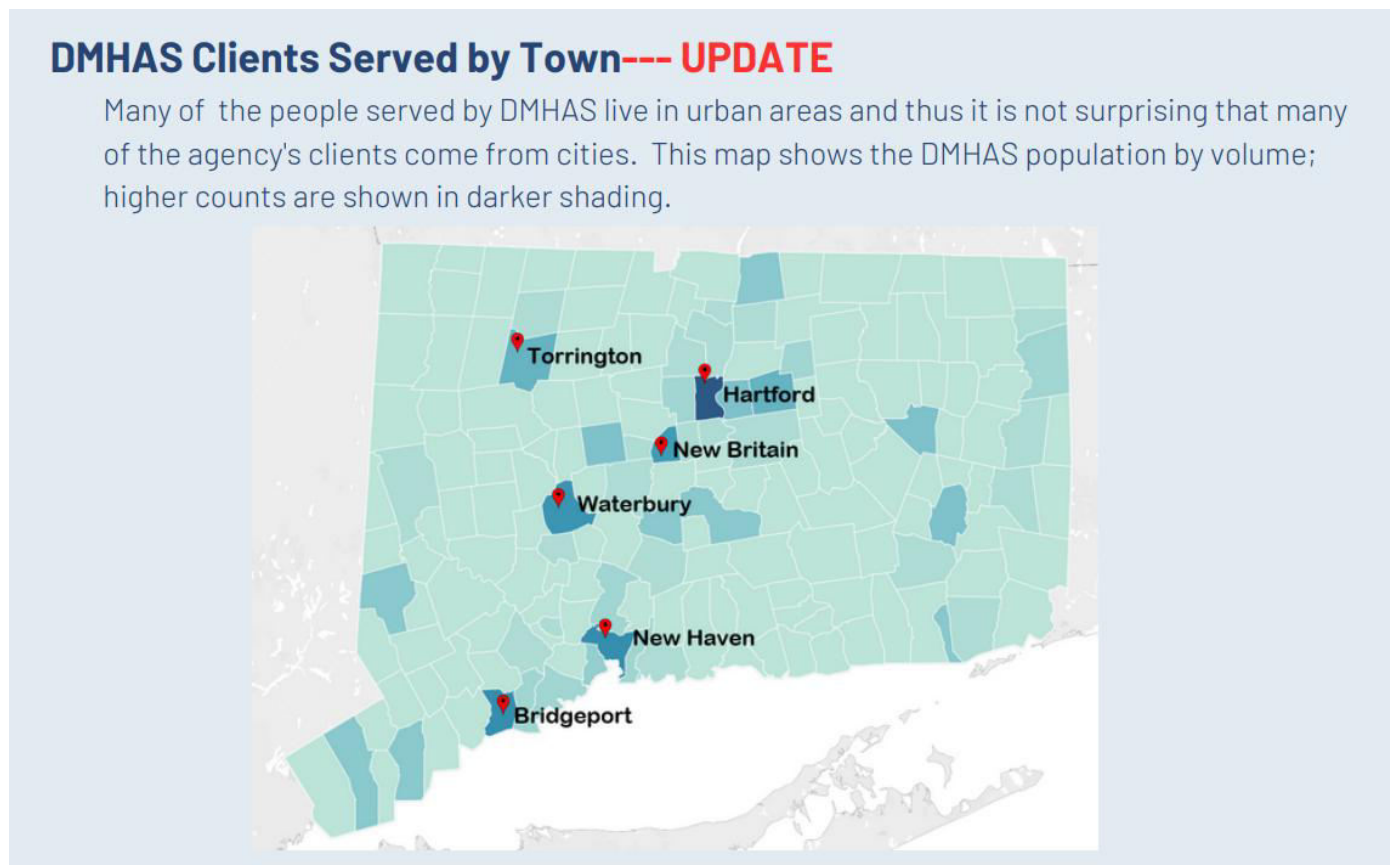
Table H2. HIV/AIDS and Tuberculosis Incidence Rates per 100,000 (2021)

	U.S.	Connecticut	Hartford County
HIV Diagnoses	12.7	7.4	6.1
Tuberculosis	2.7	1.7	1.5

Source: Centers for Disease Control and Prevention AtlasPlus. Connecticut State Department of Public Health. Data for Bristol no longer collected.

I. Mental Health and Substance Abuse Statistics

The Connecticut Department of Mental Health and Substance Abuse provides a description of towns and cities in which it provides the greatest number of services. In the map below, higher counts of services provided are indicated by darker shading. Areas including the city of Hartford in Hartford County are receiving a substantial amount of services. In Bristol in 2023, 1,559 clients received substance abuse services while 529 received Mental Health services. 106 clients were provided a combination of mental health and substance abuse services (totaling 2,194 clients).



Source: CT DMHSA 2023 Annual Statistical Report

The Healthy People 2030 Objective related to mental health is related to suicide. Bristol and Connecticut meet and exceed the objective (12.8 per 100,000) and are 10.3 and 11.1 respectively. The rate remains high in the U.S. (14.5).

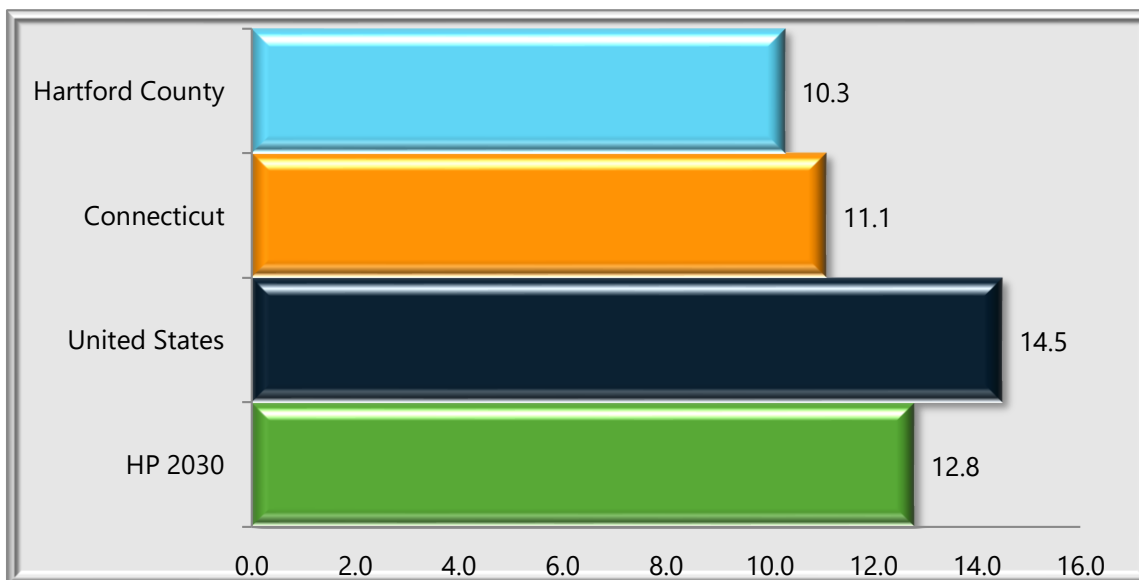
➤ Healthy People 2030 Objective MHMD – 01 – Reduce the Suicide Rate 2030

Table I1. Crude Death Rate Due to Suicide per 100,000 (2021)

	HP 2030	U.S.	Connecticut	Hartford County
Total suicide	12.8	14.5	11.1	10.3

Sources: Centers for Disease Control and Prevention (U.S.) & Connecticut Department of Public Health (CT & Hartford). Data for Bristol no longer collected.

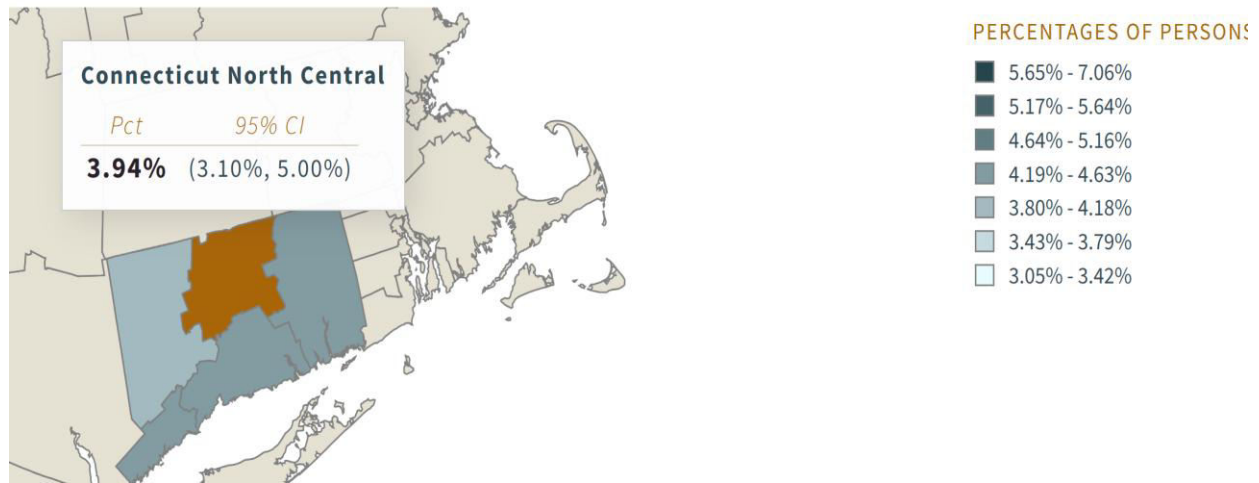
Figure I1. Crude Death Rate Due to Suicide per 100,000 (2021)



The Substance Use and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services (HHS) that leads public health efforts to advance the behavioral health of the nation and to improve the lives of individuals living with mental and substance use disorders, and their families. Services within Connecticut and data collected are based on location within 5 Regions (Eastern, North Central, Northwestern, South Central and Southwest). Bristol and Hartford County (most portions) lie within the North Central region. Data from 2016 – 2018 is the most recent data available by substate region.

In the North Central region, almost 4% of adults ages 18 or older had thoughts of suicide from 2016 to 2018. In comparison to other regions in CT, this appears slightly lower.

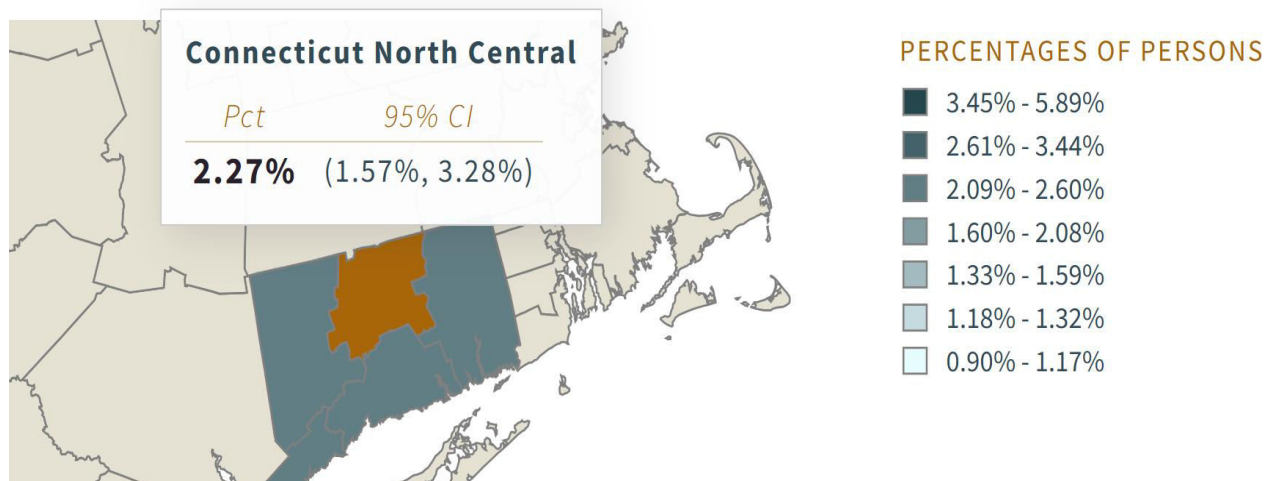
Figure I2. Had Serious Thoughts of Suicide in the Past Year Among Adults 18 or Older 2016 - 2018



Source: SAMHSA Interactive NSDUH Substate Estimates

As it relates to substance abuse, cocaine use in the past year among individuals ages 12 or older (2016 to 2018) in the North Central Region is similar to other regions in the state and is 2.27%. Heroin use is 0.67% of the same age group, similar to use in most other regions in the state. Data for opioid use is not reported by SAMHSA during this time period. Overall, the number of drug overdose deaths in Bristol from 2015 to 2025 is 332. In 2023, the rate per 100,000 population for suspected opioid overdoses was collected for Bristol-Burlington and was 166.

Figure I3. Cocaine Use in the Past Year Among Individuals Aged 12 or Older 2016 - 2018



Source: SAMHSA Interactive NSDUH Substate Estimates

Figure I4. Heroin Use in the Past Year Among Individuals Aged 12 or Older 2016 - 2018

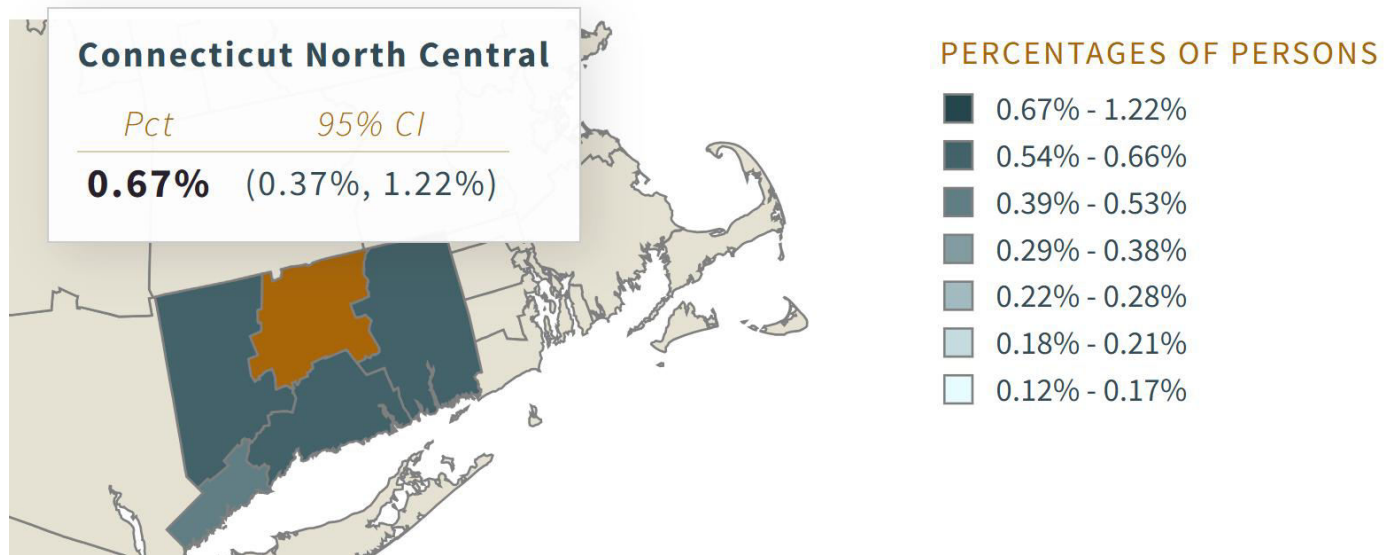
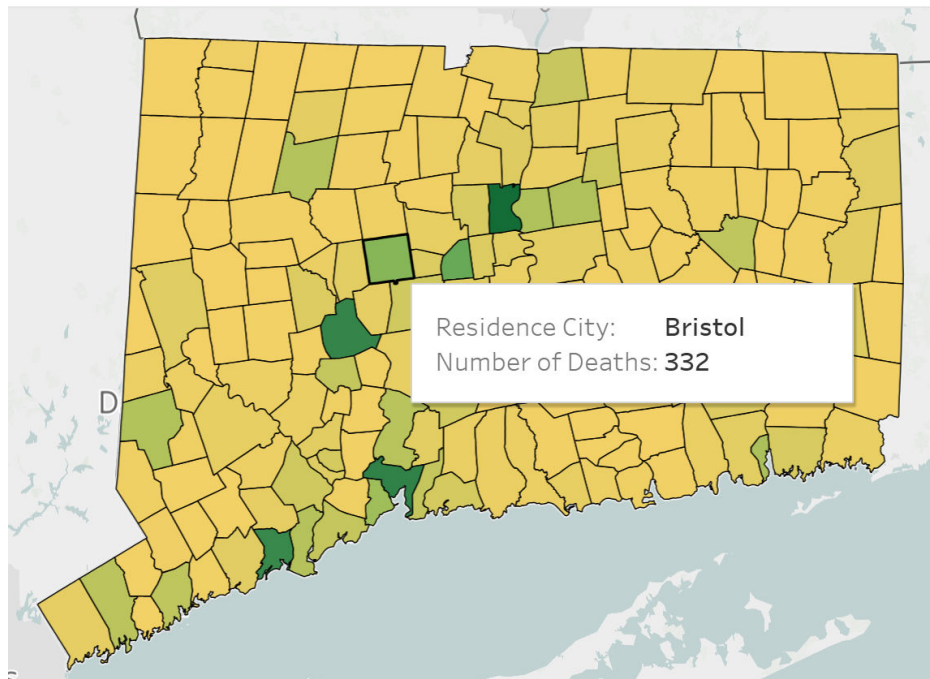
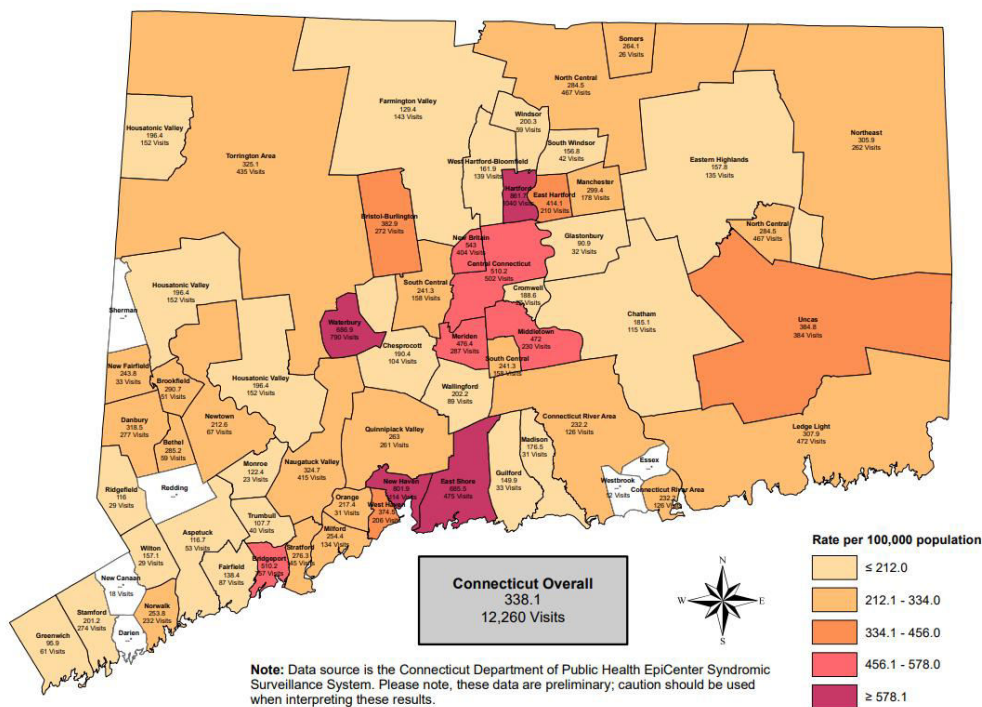


Figure I5. Drug Overdose Deaths in Connecticut Data Dashboard, 2015 to 2025



Source: CT Department of Public Health – Injury and Violence Surveillance

Figure I6. Rate per 100,000 Population and County of Emergency Department and Urgent Care Visits for Suspected Opioid Overdoses Among CT Residents by Local Health Department/District 2023



Note: Data source is the Connecticut Department of Public Health EpiCenter Syndromic Surveillance System. Please note, these data are preliminary; caution should be used when interpreting these results.

Source: CT Department of Public Health – Injury and Violence Surveillance

J. Chronic Conditions

The Connecticut Hospital Association provided Bristol Health with Key Health Indicator data including Age-adjusted Principal Diagnosis Rate for chronic conditions per 1,000 adults. The geographies compared in the data table include the CHNA area¹, the major population center of Bristol and the state of Connecticut. With the exception of high blood pressure, stroke and arthritis, Bristol has the highest rate per 1,000 adults for all diagnoses when compared to the CHNA and Connecticut. U.S. data is not displayed and is typically reported by prevalence rate in a percentage. When known, the prevalence rate by chronic condition is noted in the text but does not appear in the table because it cannot be directly compared to the age-adjusted rates per 1,000 adults supplied for Bristol and Connecticut.

¹ Includes Bristol, Burlington, Farmington, Harwinton, Plainville, Plymouth, Southington, Thomaston and Wolcott.
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Figure J1. Age adjusted Principal Diagnosis Rate per 1,000 adults.

CHNA Rank	Health Indicator	Age-Adjusted Principal Diagnosis Rate per 1,000 Adults		
		CHNA Area	Major Population Center	State of CT
1	Mental Health Composite	45.7	59.6	10.4
2	Sepsis	36.6	39.3	8.4
3	Substance-Related Disorders (SRD)	30.7	38.7	8.1
4	Community Acquired (CommAcq) Pneumonia	22.6	28.5	4.3
5	Heart Failure (HF)	20.5	22.8	4.3
6	High Blood Pressure (HBP)	16.4	15.2	4.5
7	Chronic Obstructive Pulmonary Disease (COPD)	13.5	19.8	2.2
8	Stroke	10.7	10.0	2.5
9	Diabetes - Uncontrolled/Short Term Complications (Unc-STC)	9.9	14.9	2.7
10	Asthma	8.7	11.6	2.8
11	Acute Myocardial Infarction (AMI)	8.1	9.0	1.8
12	Arthritis	5.7	5.7	1.8
13	Coronary Artery Disease (CAD)	4.5	6.0	1.0
14	Diabetes - Long Term Complications (LTC)	4.5	5.5	1.3
15	Overweight/Obesity	3.5	6.1	1.0

The following data is condition specific.

Arthritis

Arthritis is defined as inflammation of the joints. The percentage of individuals diagnosed with arthritis is higher in Bristol than in Connecticut. The prevalence of arthritis in the U.S. is 27.7% of the population in 2022.

Table J1. Age-adjusted Population 18 and over, rate per 1,000 (2024)

Connecticut	Bristol
1.5	5.7

Source: CT Hospital Association

Arthritis diagnoses includes: rheumatism, polymyalgia rheumatica; osteoarthritis (not osteoporosis); tendonitis, bursitis, bunion, tennis elbow; carpal tunnel syndrome, tarsal tunnel syndrome; joint infection, etc.

Asthma

Asthma is defined as a chronic condition that inflames and narrows the airways in the lungs. In the data, asthma is reported as the percentage of individuals who currently have asthma. Bristol (13.9) has a substantially higher age-adjusted rate than the state (3.5). The prevalence of asthma in the U.S. was 27.7% in 2021.

Table J2. Age-adjusted Population 18 and over, Rate per 1,000 (2024)

Connecticut	Bristol
3.5	13.9

Source: CT Hospital Association

Cancer

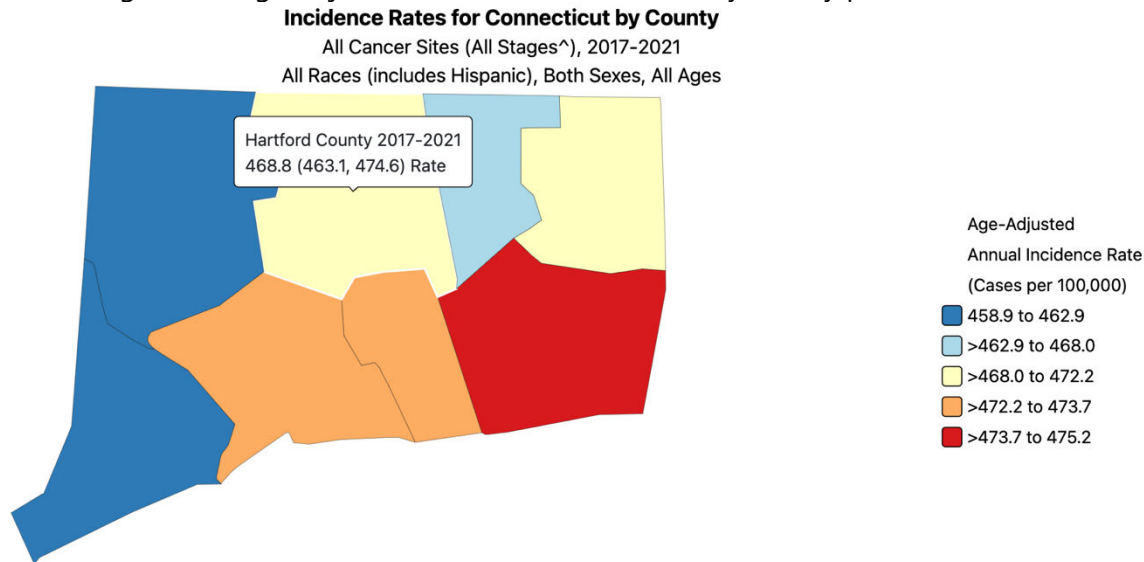
The Hartford County age-adjusted cancer incidence rates per 100,000 for breast (female), lung and bronchus, and prostate are higher than the incidence rates in Connecticut and the U.S. The incidence rate of colon and rectum cancer in the county is similar to the nation, but higher than the state. For the population 65+ in the county, breast, lung, bronchus, and prostate continue to be higher than the nation. Overall, for the 5-year average 2017 to 2021, the rate was 468.8 which is higher than the state and nation.

Table J3. Age-adjusted Cancer Incidence by Site, per 100,000 (2017-2021)

	U.S.	Connecticut	Hartford County
Breast (female)	129.8	143.1	145.6
Colon and Rectum	36.4	33.9	36.1
Lung and Bronchus	53.1	55.3	56.3
Prostate	113.2	130.0	131.8
All sites	444.4	467.4	468.8

Sources: National Cancer Institute SEER & Connecticut Department of Public Health. Data no longer collected for Bristol. *Rates based on 2010 population counts

Figure J2. Age-adjusted cancer incidence rates by county per 100,000



Source: National Cancer Institute, State Cancer Profiles.

Figure J3. Cancer incidence for all sites per 100,000 (2017-2021)

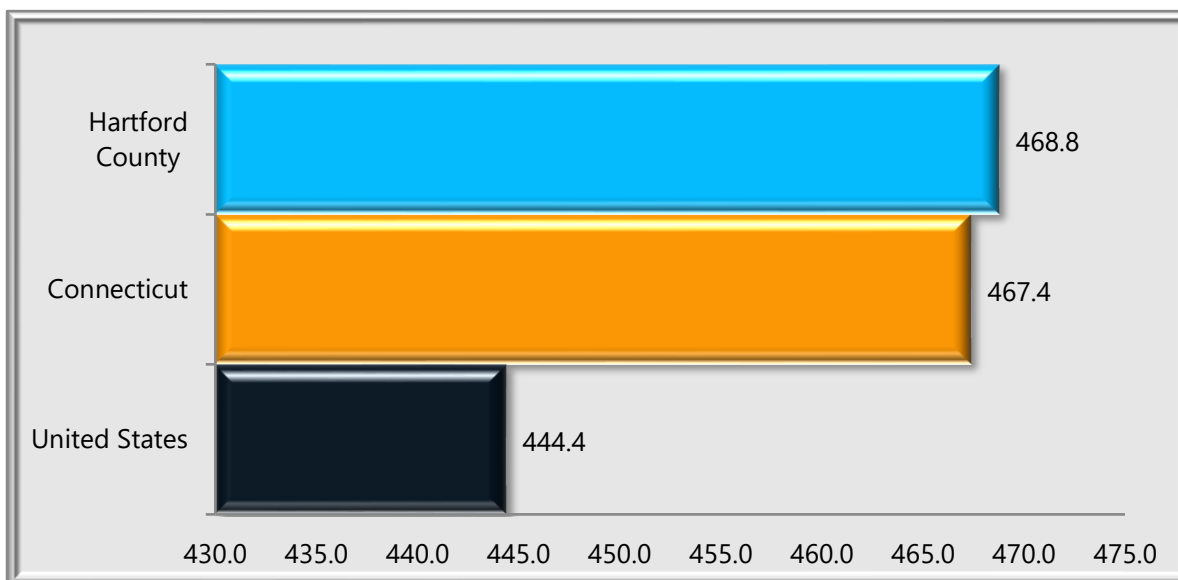


Table J4: Cancer Incidence Rates for Population 65+ per Age-Adjusted 100,000 by Site (2017-2021)

	United States	Connecticut	Hartford County
Breast, Female	435.5	476.0	490.0
Colon and Rectum	155.6	144.1	151.6
Lung and Bronchus	305.9	330.8	333.0
Prostate	598.1	691.7	664.3
Total Cancer Incidence	1,975.2	2,128.1	2,123.8

Source: National Cancer Institute

*Data has been suppressed to ensure confidentiality and stability of rate estimates.

Diabetes

Diabetes is caused either by the body’s inability to produce insulin or effectively use the insulin that is produced. Bristol’s diabetes rate is somewhat higher than Connecticut. The prevalence rate in the U.S. is 10.0% of the population in 2024.

Table J5. Age-adjusted Population 18 and over, Rate per 1,000 (2024)

Connecticut	Bristol
1.3	5.5

Source: CT Hospital Association

Cardiac Disease

Cardiac disease, also known as cardiovascular disease (CVD), refers to a group of conditions that affect the heart and blood vessels. For coronary artery disease, heart failure and stroke, Bristol has a higher rate than the state. It is substantially higher for heart failure. The prevalence of coronary artery disease in the U.C. in 2022 was 4.4% in the general population.

Table J6. Age-adjusted Population 18 and over, Rate per 1,000 (2024)

	Connecticut	Bristol
Coronary Artery Disease	1.0	6.0
Heart Failure	4.3	22.8
Stroke	2.0	10.0

Source: CT Hospital Association

Respiratory Disease

Chronic Obstructive Pulmonary Disease (COPD) is an ongoing lung condition caused by damage to the lungs, making it difficult to breathe. The rate in Bristol for COPD is higher than for the state. Air pollution is often associated with higher rates of respiratory diseases like asthma and COPD. Fine particulate matter is a form of air pollution and is a measure of the overall outdoor air quality. It is measured as an average daily amount in micrograms per cubic meter. The particulate matter is higher in Hartford County than in the state.

Table J7. Age-adjusted population 18 and over, Rate per 1,000 (2024)

	Connecticut	Bristol
COPD	2.2	19.8

Source: CT Hospital Association

Table J8. Particulate Matter (2024)

	Connecticut	Hartford County
Particulate Matter	7.4	7.7

Source: County Health Rankings

K. Mortality Statistics

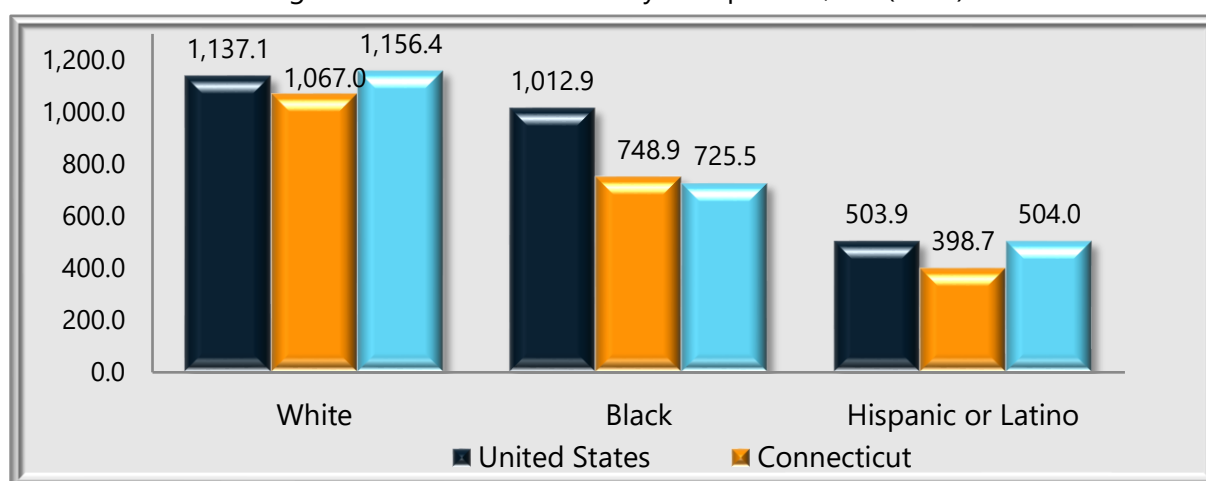
The crude death rate per 100,000 in Hartford County (991.7) is higher than in Connecticut (952.2) but lower than the U.S. (1,043.8). The White and Hispanic or Latino population have higher crude death rates compared to the state and the nation.

Table K1. Crude Death Rates per 100,000 (2021)

	U.S.	Connecticut	Hartford County
Number of Deaths	3,464,231	34,333	8,894
Overall Death Rate	1,043.8	952.2	991.7
Death Rate by Race			
White	1,137.1	1,067.0	1,156.4
Black	1,012.9	748.9	725.5
Hispanic or Latino	503.9	398.7	504.0

Source: Centers for Disease Control and Prevention Wonder (U.S. and Hartford County) & Connecticut Department of Public Health (CT). Data for Bristol no longer collected.

Figure K1. Crude death rate by race per 100,000 (2021)



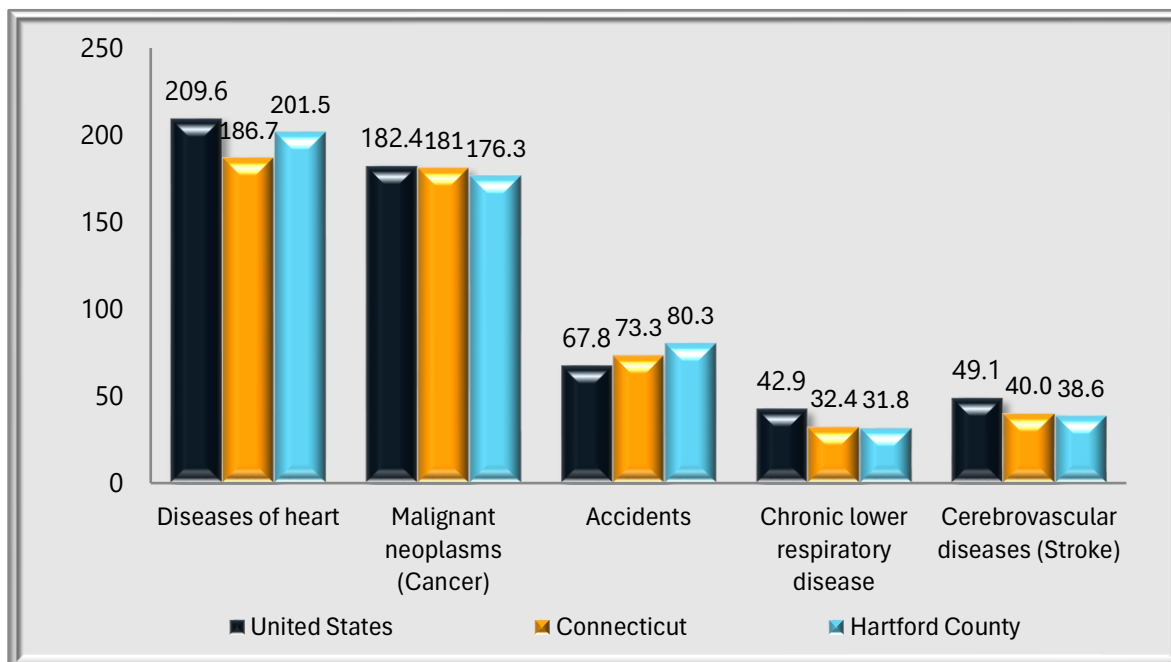
Higher crude death rates in Hartford County are found for accidents and nephritis, nephrotic syndrome, and nephrosis as compared to the state and nation. Positively, all other causes for all ages are lower than in Connecticut and the U.S.

Table K2. Crude Death Rates by Leading Causes of Mortality, All Ages per 100,000 (2021)

	U.S.	Connecticut	Hartford County
Diseases of heart	209.6	186.7	201.5
Malignant neoplasms (Cancer)	182.4	181.0	176.3
Accidents	67.8	73.3	80.3
Chronic lower respiratory disease	42.9	32.4	31.8
Cerebrovascular diseases (Stroke)	49.1	40.0	38.6
Alzheimer’s Disease	36.0	29.1	25.6
Diabetes mellitus	31.1	21.4	23.7
Influenza and pneumonia	12.6	11.3	9.8
Nephritis, nephrotic syndrome, and nephrosis	16.4	17.7	19.0

Source: Centers for Disease Control and Prevention (U.S. and Hartford) & Connecticut

Figure K2. Crude death rates for the top five leading causes of death per 100,000 (2021)



Cancer Mortality

Specific mortality data is displayed in this section for cancer. This data is age-adjusted and therefore differs from the crude death rate for neoplasm supplied in the general mortality data. The following Healthy People 2030 objectives have been established for cancer.

- Reduce the overall cancer death rate – C-01
- Reduce the female breast cancer death rate – C-04
- Reduce the colorectal cancer death rate – C-06
- Reduce the lung cancer death rate – C-02
- Reduce the prostate cancer death rate – C-08

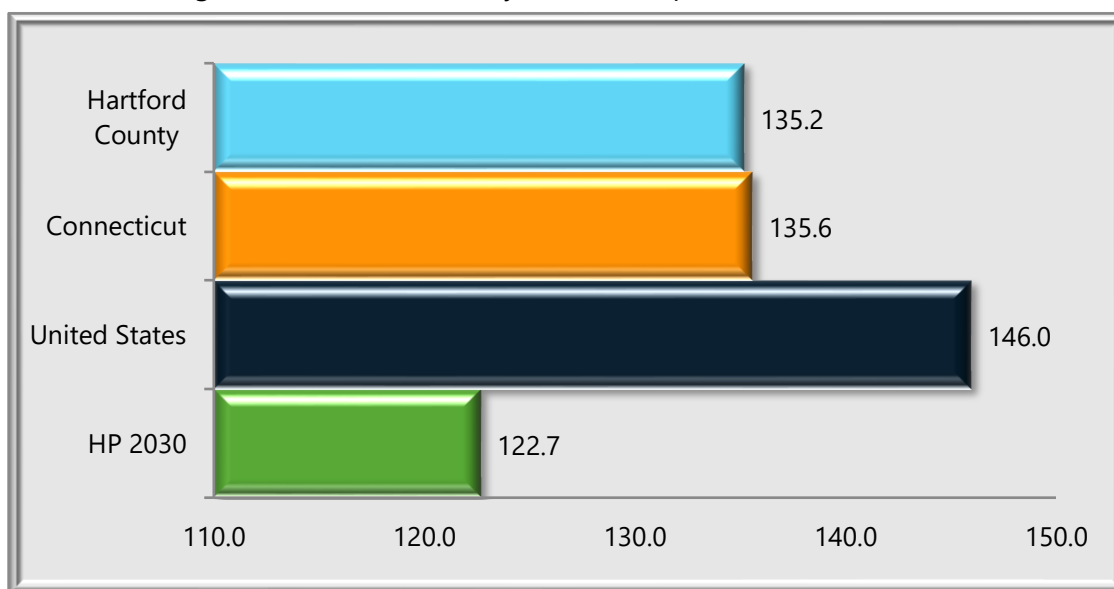
For all sites, the age-adjusted cancer mortality rate is 135.2 in Hartford County, lower than the U.S (146.0) and similar to Connecticut (135.6). Specifically, the county mortality rate per 100,000 for breast (female) cancer meets the Healthy People 2030 objective. Colon and rectum, lung and bronchus and prostate fall short of meeting the objective and are higher than the national mortality rate.

Table K3. Age-adjusted Cancer Mortality Rates by Cancer Site, All Stages, per 100,000 (2018-2022)

	HP 2030	U.S.	Connecticut	Hartford County
Breast (female)	15.3	19.3	16.8	15.3
Colon and Rectum	8.9	12.9	10.4	10.8
Lung and Bronchus	25.1	32.4	28.3	27.4
Prostate	16.9	19.0	19.0	20.3
All sites	122.7	146.0	135.6	135.2

Sources: CDC State Cancer Profiles and Healthy People 2030. Data for Bristol no longer collected.

Figure K3. Cancer mortality for all sites per 100,000 (2018-2022)



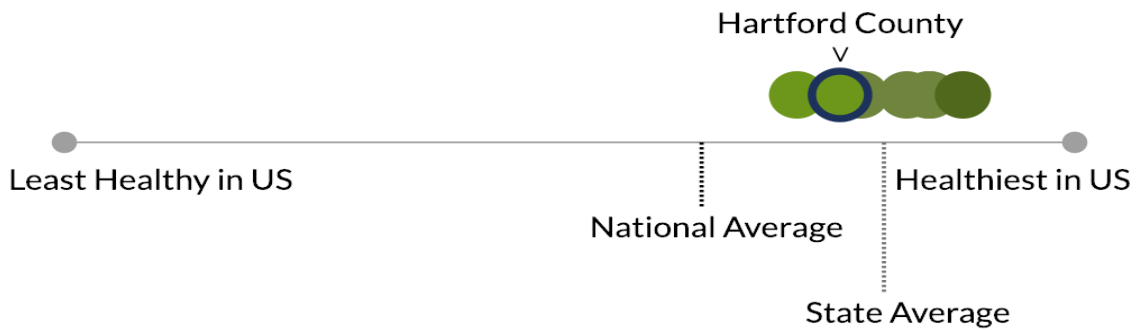
L. County Health Rankings²

Health Outcomes describe how long people live on average within a community and how much physical and mental health people experience while they are alive.

- Hartford County is slightly worse than the state average in Connecticut for Health Outcomes, but better than the average county in the nation.

² The County Health Rankings 2025 report representation of county health has changed significantly from the report used in the Bristol Health 2022 CHNA. Rather than a numerical ranking, each county in a state is represented by a dot, shaded a certain color and placed on a scale from least healthy to healthiest in the nation. The new visual tool then shows where one county falls on a "continuum" of health nationally, compared to the least healthy and most healthy counties, which are unnamed in the visualization. Also, the data tables provide a percentage for the United States, rather than a National Benchmark which was used in previous reports.

Figure L1. Health Outcomes Comparison for Hartford County, CT



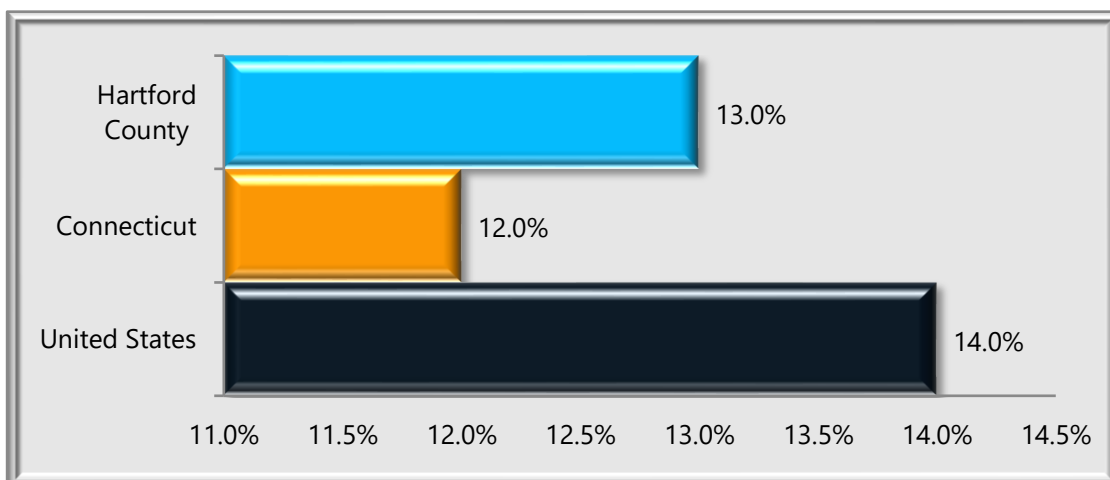
As it pertains to Health Outcomes, Hartford County is somewhat higher (5.0 days) for poor mental health in the past 30 days than Connecticut (4.4) and the U.S. (4.8). Poor physical health in the past 30 days (3.3 days) was similar to the U.S. and better than Connecticut.

Table L1. Health Outcome (2024)

	United States	Connecticut	Hartford County
Premature death (Years of potential life lost before age 75 per age-adjusted 100,000)	8,000	6,500	6,900
Poor or fair health	14%	12%	13%
Poor physical health in past 30 days (Average number of days)	3.3	2.9	3.3
Poor mental health in past 30 days (Average number of days)	4.8	4.4	5.0

Source: County Health Rankings

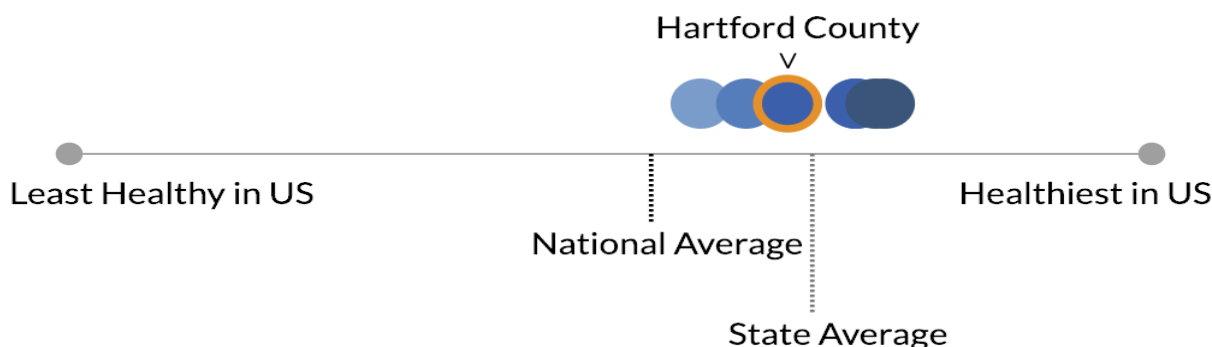
Figure L2. Percent of adult population with poor or fair health (2024)



Health Factors represent those things that can be improved to live longer and healthier lives. They are indicators of the future health of a community.

According to County Health Rankings, for Health Factors, Hartford County is slightly worse than the state average, but better than the average county in the nation.

Figure L3. Health Factors Comparison Hartford County, CT



Specifically, Hartford County adults are somewhat less physically active despite having a high percentage of access to exercise opportunities in comparison to the state and nation. There is a substantial percentage of alcohol-impaired driving deaths in comparison as well. Clinically, provider density is good with there being substantially fewer individuals for each primary care provider, dentist, and mental health provider to treat.

Table L2. Health Factors (2024)

	United States	Connecticut	Hartford County
Adult smoking	15%	12%	13%
Adult obesity (BMI ≥ 30)	34%	31%	33%
Food environment index	7.7	8.3	8.2
Physical inactivity (Adults aged 20 years+)	23%	22%	24%
Access to exercise opportunities	84%	93%	96%
Excessive drinking	18%	17%	16%
Alcohol-impaired driving deaths	26%	32%	34%

Source: County Health Rankings

Table L3. Clinical Care (2024)

	United States	Connecticut	Hartford County
Uninsured (Population <65 years)	10%	6%	6%
Primary care physician density	1,330:1	1,210:1	1,050:1
Dentist density	1,360:1	1,150:1	930:1
Mental health provider density	320:1	220:1	170:1
Preventable hospital stays per 1,000 Medicare enrollees	2,681	2,651	2,739
Years of potential life lost (death before age 75) per 100,000	6,900	6,500	8,000
Flu Vaccinations	46%	54%	55%
Mammography screening among female Medicare enrollees ages 65 - 74	43%	47%	46%

Source: County Health Rankings

Social and Economic Factors are also examined. In the county, there is a somewhat higher percentage of children living in households with a single parent (28%) and there are more injury deaths per 100,000. Positively, the number of social associations per 10,000 is also higher (9.8) than the state (8.9) and nation. (9.1).

Table L4. Social and Economic Factors (2024)

	United States	Connecticut	Hartford County
Children in poverty	16%	13%	14%
Income inequality (Ratio of household income at the 80 th percentile to income at the 20 th percentile)	4.9	5.1	5.1
Children in single-parent households	25%	25%	28%
Social associations per 10,000	9.1	8.9	9.8
Injury deaths per 100,000	80	80	84

Source: County Health Rankings

In Hartford County, air pollution (measure in particulate matter) is slightly worse than in the state and nation and drinking violations have been cited.

Table L5. Physical Environment (2024)

	United States	Connecticut	Hartford County
Air pollution – particulate matter	7.4	7.4	7.7
Drinking water violations	N/A	N/A	Yes
Severe housing problems	17%	17%	16%
Long commute – driving alone	36%	35%	29%

Source: County Health Rankings

M. Crime Statistics

Rates for burglary and motor vehicle theft are highest in Bristol when compared to the state and nation.

Table M1. Reported Offenses per 100,000 Population (2023)

	U.S.	Connecticut	Bristol
Violent crime	1,201,857	5,452	Not available
Homicides	.42	.19	0
Rape*	2.69	1.44	0
Burglary	20.08	9.34	11.36
Aggravated assault	19.8	6.8	1.62
Property crime	6,119,495	6,814	Not available
Breaking or entering	5.56	3.35	0
Larceny	106.83	94.47	35.71
Motor vehicle theft	26.64	23.64	50.32

Source: Federal Bureau of Investigation, Uniform Crime Reporting and Crime Data Explorer

* U.S. figure estimated using the legacy UCR definition of rape.

KEY INFORMANT SURVEY RESULTS

Methodology

A key informant survey was conducted with a total of 52 key informants between April 17 and May 12, 2025. Key informants are defined as community stakeholders with expert knowledge, including public health and health care professionals, social service providers, non-profit leaders, business leaders, faith-based organizations, and other community leaders. Participants in this key informant survey included health care and public health professionals, business leaders, government housing/transportation agencies, non-profit/social service providers, foundation, and community members. Questions focused on health issues and barriers for people in the community, health care access, underserved populations, and how to increase the overall health of the service areas. The online Key Informant survey is found in Appendix C.

KEY INFORMANT INTERVIEWS

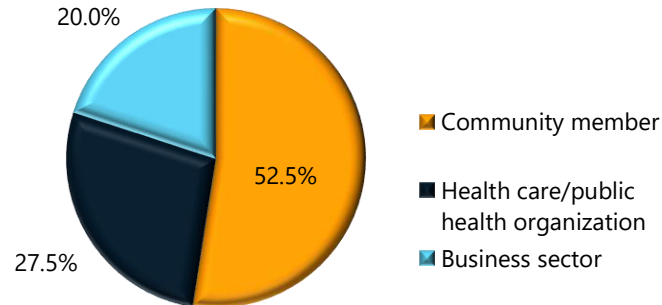
Holleran staff worked with Bristol Health to identify key informant contact information. 318 key informants were asked to participate in an online survey. A total of 52 key informants completed the survey between April and May 2025 for a completion rate of 16.4%. The largest percentage of informants identified as community members (52.5%), health care/public health organizations (27.5%), and business leaders (17.0%). Others participating included government/housing and transportation leaders (6.4%), non-profit/social service/aging services (4.3%) and other (4.3%). Other included a key informant affiliated with a Community Foundation and another retired from a career in social service.

A list of key informants and their organizations can be found in Appendix D. It is important to note that the results reflect the perceptions of some community leaders but may not represent all community perspectives.

Table 1. Number and Percentage of Respondents by Community Affiliation

Community Affiliation	Count	Percentage of respondents
Health care/public health organization	11	23.4%
Business sector	8	17.0%
Government/housing/transportation sector	3	6.4%
Non-profit/social services/aging services	2	4.3%
Education/youth services	0	0.0%
Faith-Based/cultural organization	0	0.0%
Mental/behavioral health organization	0	0.0%
Other (specify)	2	4.3%

Figure 1. Top 3 participant community affiliations



Key Health Issues

A. Identified Health Issues

Key informants were asked to determine the top five health issues in their community from a list of 14 focus areas identified in the survey. The majority of respondents stated that Substance abuse/alcohol abuse (73.7%) was the top health issue. This is similar to the CHNA conducted in 2022. However, in this study, Access to care/uninsured, selected by 66.7%, surpassed Mental health/suicide (63.2%). Following this, 61.4% chose Overweight/obesity, followed by heart disease (49.1%). Heart disease outranks cancer as the fifth key health issue in 2025. In this study, Other is identified as Government health care reimbursements.

Figure A1. Ranking of key health issues in the community

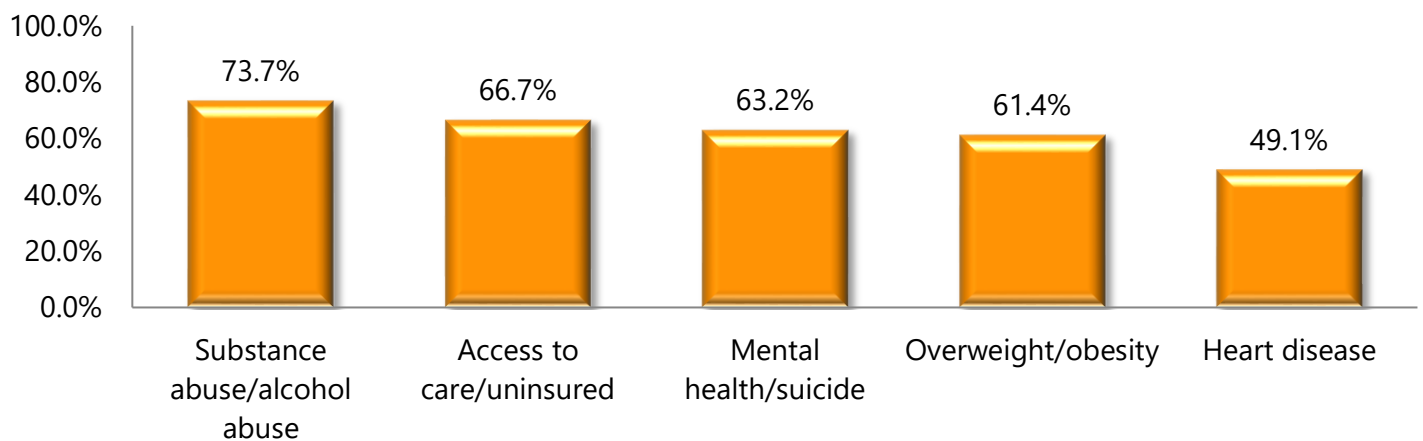


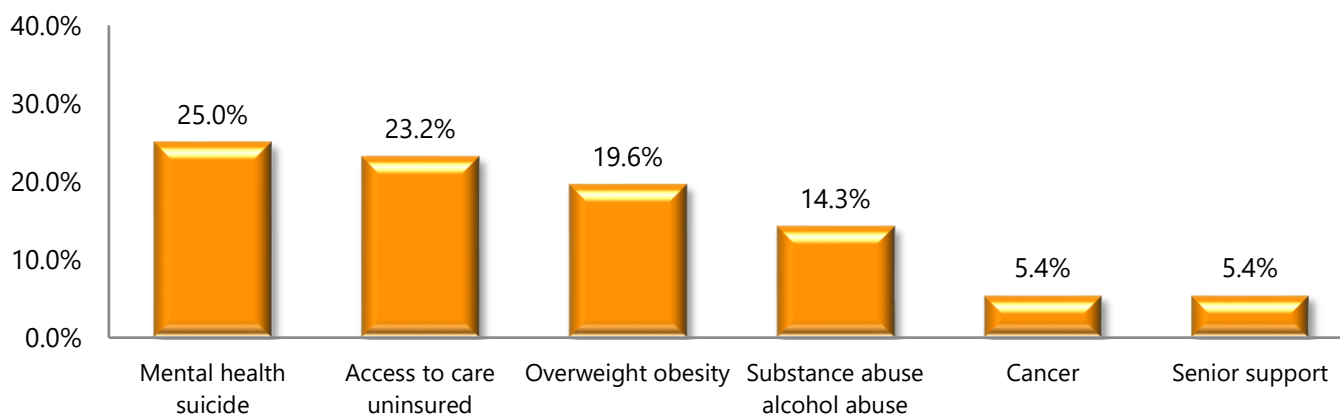
Table A1: Comparison ranking of Key Health Issues (2025 and 2022)

Key Health Issue	Count	2025 Percent of respondents who selected the issue*	Count	2022 Percent of respondents who selected the issue*
Substance abuse/alcohol abuse	42	73.7%	61	82.4%
Access to care/uninsured	38	66.7%	40	54.1%
Mental health/suicide	36	63.2%	58	78.4%
Overweight/obesity	35	61.4%	40	54.1%
Heart disease	28	49.1%	24	32.4%
Senior support	27	47.4%	32	43.2%
Cancer	24	42.1%	33	44.6%
Diabetes	19	33.3%	29	39.2%
Maternal/infant health	10	17.5%	9	12.2%
Tobacco	8	14.0%	8	10.8%
Dental health	3	5.3%	8	10.85
Stroke	3	5.3%	4	5.4%
Sexually transmitted diseases	0	0.0%	1	1.4%
Other (specify)	1	1.8%	5	6.8%

*Respondents could select more than one option therefore the percentages may sum to more than 100.0%.

When asked to determine which health issue is the most significant, the highest percentage of key informants selected Mental health/suicide (25.0%). About 14% of respondents selected Substance abuse/alcohol abuse. Access to care/uninsured was selected as the second most significant with 23.2% of key informants selecting it. Access to care/uninsured has moved up in importance since the last study as has Overweight/obesity. As in 2022, Substance abuse/alcohol abuse, although identified as the Top Key Health Issue, is perceived to be less significant than these other issues.

Figure A2. Ranking of most significant health issues in the community



Respondents were asked to share information regarding these key health issues and their reasons for ranking them this way. Participants focused on issues of access, mental health and substance abuse issues and obesity.

Select Comments Regarding Key Health Issues:

- Bristol Health has a tremendous team of doctors and nurses to help patients navigate cancer care along with some technology to help find and diagnosis cancer, however the ability to treat cancer with surgery is limited at Bristol Hospital. Traveling takes time and it would be great if all resources for treating cancer could be at Bristol Hospital, which would be more convenient and less time consuming.
- Without insurance, one cannot get help with any of the health issues.
- I believe that overweight and obesity problems, if not addressed, can lead to heart disease, diabetes, mental health issues and certain cancers.
- There is a high rate of substance abuse in the community causing increased crime and repeat ED visits.
- It doesn't matter what the most prevalent or most pervasive health condition is in the community if a person does not have the access to care/insurance they need in order to have screening, diagnosis, preventative care, or treatment of a specific condition.
- Bristol has the 2nd largest veteran population in the state of Connecticut, Mental health and suicide are a large problem in this population and needs more support from Bristol Health.
- Poor nutrition and healthy living choices.
- The awareness of resources available to those less fortunate in our community needs to continue to be stressed including access to care, not just from a financial perspective, but also from an ability to get to a health care provider (transportation, ease of making an appointment).
- Maintaining and increasing access are key. Without that, the other issues will never be resolved. The access to care needs to be made easier and the system needs to be simplified. Hiring and retaining staff are key.
- Many residents do not know how to navigate the insurance or health care systems in order to establish care. Access to detox is not easily available in our community. Many are overweight/obese including our children more access to healthy affordable food would help. Substance use and homelessness is disregarded or ignored or viewed as a problem, support and access to help needs to be more available.

B. Access to Care & Barriers

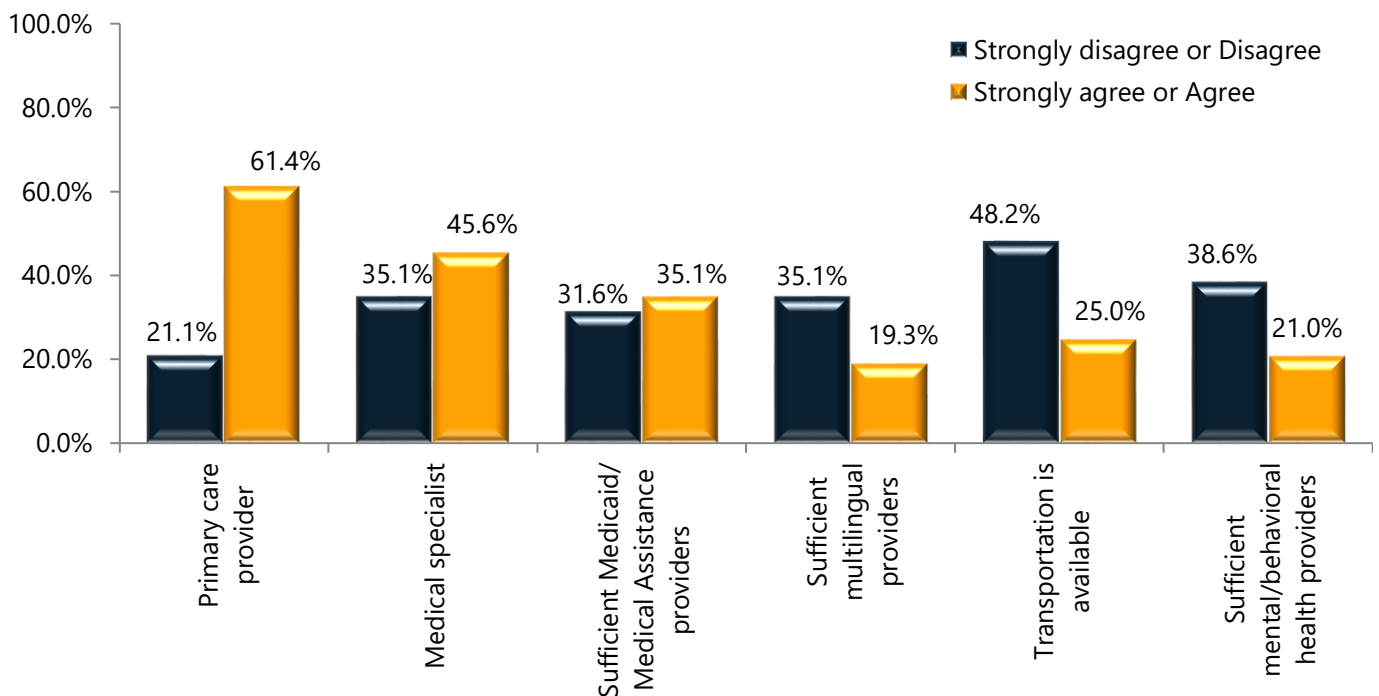
The next set of questions relates to Health Care Access, already mentioned as a key health issue to many participants. Key informants were asked to rate specific statements regarding access to care on a five-point scale of Strongly Disagree to Strongly Agree. The statements were phrased positively, for example, "Residents in the area are able to access a primary care provider when needed ."

The majority of key informants Strongly agree or agree that there are sufficient primary care providers (61.4%). This was also the case in the 2022 study. However, less than a majority Strongly agree or agree that there are a sufficient number of dentists and specialists (45.6%) as well as providers who accept Medicaid/medical assistance (35.1%). The perception that there are a sufficient number of dentists and specialists and Medicaid providers has slipped below the majority

since the last study. This points to an increasing problem of access when it comes to finding providers other than primary care or for those who are uninsured or rely on Medicaid.

However, consistent with the Top key health issues findings, over one-third of respondents (38.6%) Strongly disagree or disagree that there are sufficient mental/behavioral health providers, enough transportation (48.2%) or bilingual providers (35.1%). These perceptions have not changed since the previous study and even persist in the community, identified in the 2019 CHNA report as well.

Figure B1. Percentage of respondents who selected “Strongly agree” or “Agree” as compared to those who selected “Strongly disagree” or “Disagree” with the Health Care Access factors. *



*See Appendix A: Key Informant Survey Tool for full factor phrasing.

Respondents were also asked to share information regarding access to care issues in the community. As in 2022, access issues appear to be preventing the community from getting needed care. This includes the lack of doctor’s appointments or long waiting lists, particularly specialists, due to long waiting times, insurance coverage issues or trouble navigating the system. Reimbursement rates were also discussed, which have an impact on the hospital. Select responses are listed below.

Select Comments Regarding Access to Care Issues:

- More mental health providers are needed as well as transportation options.
- Access to certain specialists is easier than others. Dermatology is very difficult for folks with Medicaid to access timely. Neurology and psychiatric medication management is also a specialty

where people may wait quite some time before an open appointment. People needing cardiology, pulmonary, or orthopedic appointments generally have shorter wait times to access care.

- There are plenty of primary care/pediatricians in the area however many do not know how to navigate the system. Specialist appointments have to be made way in advance. Mental health providers are booking way out. Many patients cannot take the bus to appointments and Veyo is not always reliable.
- Overall, the Bristol Health System continually seeks ways to improve upon and offer access to low cost, quality health care. While additional Primary Care Physicians is certainly welcomed and needed, most individuals have the ability to make an appointment with a Primary Care Physician when needed. Specialty Care, however, can be difficult for many in the community when making an appointment, and the earliest possible date available is months out in the future. This is contributed by the shortage of specialists in some specialties, such as Cardiology, Dermatology, Rheumatology to name a few, which is more the result of a shortage of specialists in the industry.
- The payor mix within the community (Government pay vs. Commercial), places an enormous strain on the financial health of hospitals, particularly community hospitals, as the reimbursement rates for Government pay (Medicaid, Medicare) do not come close to adequately paying health care service providers in CT, particularly for those surgical services considered 'elective'.
- Care is available, people are not always proactive in accessing the care they need.
- There are challenges with PCP recruitment and specialty access such as dermatology and ENT.
- The hospital serves many towns, neighborhoods, and individuals that have very different demographic factors from one another. What is sufficient in care/providers for one town, neighborhood, group, or individual might be substandard for others. However, I do believe that mental health care and timely access to quality primary care physician practices are issues of concern across all demographics.
- Many offices do not offer sliding scale prices. Transportation is always an issue.

Key informants were asked to select the most significant barriers that keep people from accessing care in the community. Similar to 2022, they selected the inability to pay out of pocket expenses and the lack of health insurance coverage as the top barrier (both 64.9%). This is followed by the inability to navigate the health care system, the availability of providers/appointments and the lack of transportation. In this case, Other is noted to be "Those on Medicaid not keeping/cancelling appointments leading to inefficiencies, Lack of desire to seek care and No knowledge."

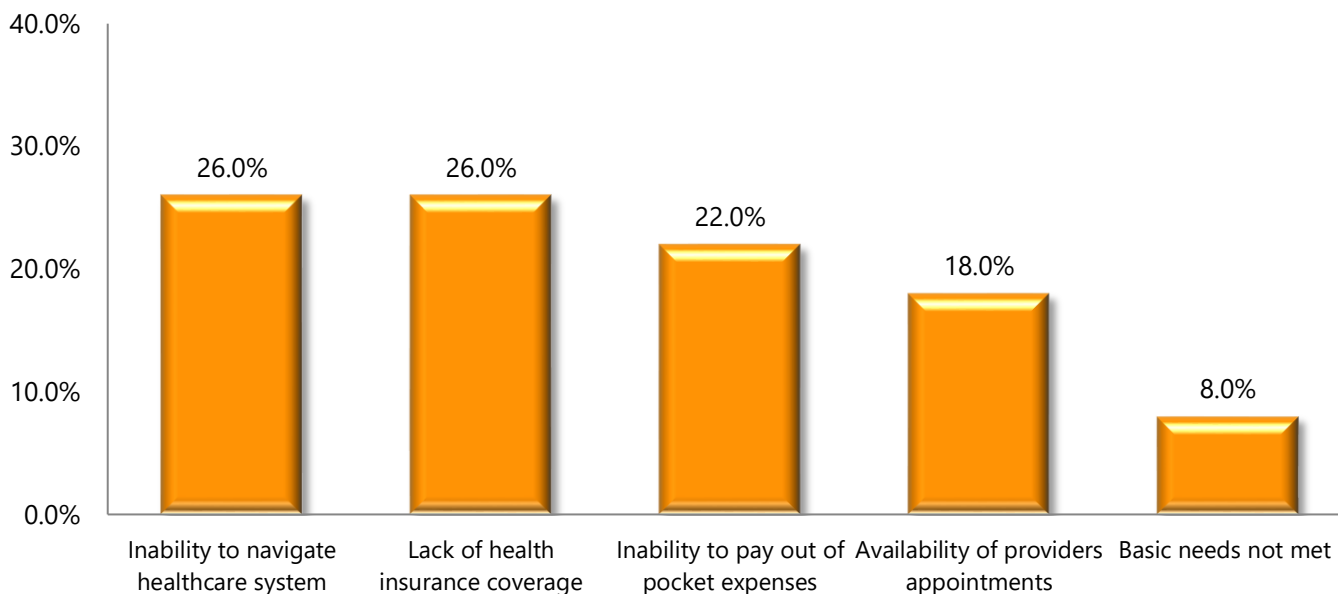
The barrier that is perceived to be the most significant, however, is the inability to navigate the health care system (26.0%). Lack of health insurance coverage was also chosen as being as significant. This has become more significant since the previous study. The availability of providers/appointments is found to be a significant barrier by 18.0% of respondents. Basic needs not being met was selected as most significant by fewer respondents (8.0%).

Table B1: Most Significant Barriers

Key Health Barrier	Percent of respondents who selected the issue*	Percent of respondents who selected the issue as the most
Inability to pay out of pocket expenses	64.9%	22.0%
Lack of health insurance coverage	64.9%	26.0%
Inability to navigate health care system	56.1%	26.0%
Availability of providers/appointments	47.4%	18.0%
Lack of transportation	38.6%	0.0%
Basic needs not met	31.6%	8.0%
Time limitations	31.6%	0.0%
Language/cultural barriers	24.6%	0.0%
Lack of trust	14.0%	0.0%
Lack of childcare	8.8%	0.0%
None/no barriers	5.3%	0.0%
Other (specify)	5.3%	0.0%

*Respondents could select more than one option therefore the percentages may sum to more than 100.0%.

Figure B2. Most significant barriers keeping people in the community from accessing healthcare



Additionally, respondents were asked to share information regarding these barriers to health care. Three recurring themes are noted. These include difficulty navigating the health care system, lack of providers and cost and basic needs. Select responses are listed below.

Select Comments Regarding Barriers to Health Care:

- Too long a wait for an appointment.

- It can be difficult for some people, particularly those with mental health issues or the elderly to navigate insurance, approvals, when there is a copay, remembering appointments.
- The people with whom I usually come in contact with would say that availability is the issue they most often encounter.
- Navigating the health care system can be difficult...and fully understanding and navigating any further continued care.
- The difficulty many people experience when trying to navigate the medical or psychiatric care systems is the biggest barrier to good care. Language and cultural barriers are also major barriers to accessing equitable care.
- If a person's basic needs are not met, it is unlikely they have insurance and likely that all of the other issues on this list are also barriers to health care.
- Without providers, again, the other issues are mute.

C. Underserved Populations

Key informants were asked about the existence of underserved populations and subsequently to identify them in the service area. About 59% of respondents said that there are underserved populations. This is less than in 2022 when more than 65% of key informants stated there are specific underserved populations in the community. Once again, homeless people was selected by the highest percentage of participants (63.3%). This is followed by the uninsured/underinsured (60.0%) and low-income/poor (53.3%) as underserved. Both of these categories were selected by a greater percentage of key informants than in the previous study. Seniors/aging/elderly and people with disabilities were also selected by many.

Figure C1. Responses to the question, "Are there specific populations in this community that you think are not being adequately served by local health services?"

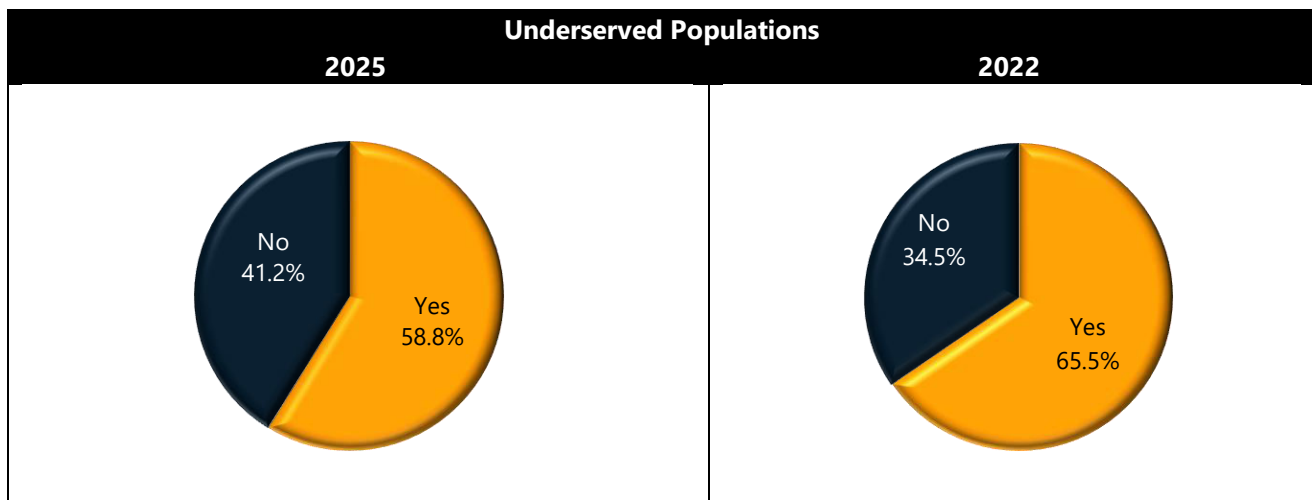


Table C2. Underserved Populations Ranked by Key Informants Who Answered "Yes"*

UNDERSERVED POPULATIONS	Count	Row N %
Homeless	25	69.4%
Uninsured/underinsured	19	52.8%

Low-income/poor	17	47.2%
Seniors/aging/elderly	13	36.1%
Hispanic/Latino	10	27.8%
Disabled	9	25.0%
Black/African-American	8	22.2%
Children/youth	7	19.4%
Immigrant/refugee	7	19.4%
Young adults	5	13.9%
None	0	0.0%
Other	0	0.0%

*Respondents could select more than one option; therefore, the percentages may sum to more than 100.0%.

Respondents were also asked to share additional information regarding the underserved populations. Low income individuals and families were discussed the most as being particularly vulnerable. Select responses are listed below.

Select Comments Regarding Access to Care Issues:

- I suspect that those with lower incomes and lower education would be more at risk because they don't seek help because of the cost and they do not understand how the health system works.
- People of color and low income families cannot always find care.
- The low income, homeless and poor do not have many healthy options at the food pantries as most of that food is donated. This demographic also needs help navigating the health and social service system. Transportation for the disabled in this group is also hard to come by.

Health Care Resources/Services

Key informants frequently interact with individuals and families who are seeking resources to improve their health and quality of life and are therefore knowledgeable about the availability and sufficiency of health and social service resources. They were asked to identify key health care services in the community as “Missing”, “Lacking”, “Not affordable”, “Need being met”, or “Don’t know”. The list of health care resources and services that key informants responded to includes 24 items. A number of resources and services were selected frequently by participants as “Missing” or “Lacking” as noted in the following sections.

D. Health Care Resources/Services Meeting the Need

A large majority of respondents (75.9%) identified emergency care as the top “Need being met”. This is similar to the result in 2019 and 2022. A majority also perceive that the need for primary care services is being met. This coincides with the percentage of key informants that Strongly agree or Agree that there are a sufficient number of primary care providers in the community. The need for home health care and senior supports are also said to be met by over 40%. The need for specialists is perceived to be met by about 39%, slightly less than those who agreed that there are sufficient specialists in the community.

Table D1. Top 5 Health Care Resources/Services “Being Met” in the community

Health Care Resource/Service	Percentage of respondents that selected service as “Need being met”
Emergency care	75.9%
Primary care services	54.7%
Home health care services	50.0%
Senior support	40.7%
Specialty care services	39.6%

E. Lacking Health Care Resources/Services

Mental health services were selected by over half as a resource that is lacking. In both 2022 and 2019, Mental health services were the second most often selected service that is lacking. This has now moved to the top of the list. This is followed by Transportation (46.3%). The selection of Case management/social services and Multicultural/bilingual services points to issues of access discussed earlier. Substance abuse services were chosen as lacking by a smaller percentage of informants (37.0%). The same percentage who chose Specialty care services as a Need being met, also said that it was Lacking.

Table E1. Top 5 Health Care Resources/Services “Lacking” in the community

Health Care Resource/Service	Percentage of respondents that selected service as “Lacking”
Mental health services	52.8%
Transportation	46.3%
Case management/social services	42.6%
Multicultural/bilingual healthcare providers	42.6%
Specialty care services	39.6%

F. Unknown Areas of Health Care Resources/Services

A majority of respondents (66.7%) are unaware or “Don’t know” about the existence of sexual health care in the community. Fewer respondents do not know about the availability of free/low-cost dental care, Federally Qualified Health Centers, bilingual services, and housing assistance. This remains the same as reported in the 2022 study.

Table F2. Top 5 Health Care Resources/Services “Don’t Know” in the community

Health Care Resource/Service	Percentage of respondents that selected service as “Don’t know”
Sexual health care	66.7%
Free/low cost dental care	50.9%
Federally qualified health centers	50.0%
Housing assistance	42.6%
Bilingual services	37.7%

G. Unaffordable Health Care Resources/Services

A smaller percentage of key informants identified health care resources and services in the community as being unaffordable. Healthy food options were selected by the highest percentage of key informants (14.8%) as unaffordable. Home health care and emergency care were chosen as well, similar to 2022. Other responses were dissimilar to the previous study which identified free/low cost medical care, free/low cost dental care and specialty care services were chosen. In 2025, key informants identified advocacy for social needs and prescription services. Advocacy may be tied to the need for assistance navigating the health care system and case management services. This may be a resource that is unavailable in the community.

Table G1. Top 5 Health Care Resources/Services “Not Affordable” in the community

Health Care Resource/Service	Percentage of respondents that selected service as “Not affordable”
Healthy food options	14.8%
Advocacy for social needs	13.0%
Prescription assistance	11.3%
Home health care services	11.1%
Emergency care	11.1%

H. Missing Health Care Resources/Services

Finally, more respondents are likely to identify a resource or service as “Lackin” rather than “Missing.” Here, free/low cost dental and medical care top the list. Not only is it identified as unaffordable, it is perceived to be Missing by 15.1% and 9.3% of respondents respectively. Transportation was chosen as Missing by 7.4% While substance abuse services were selected by 5.6%, mental health services were only selected as Missing by 1.9%.

Table H1. Top 5 Health Care Resources/Services “Missing” in the community

Health Care Resource/Service	Percentage of respondents that selected service as “Missing”
Free/low cost dental care	15.1%
Free/low cost medical care	9.3%
Transportation	7.4%
Substance abuse services	5.6%
Support group services	5.6%

Respondents were asked to share additional information regarding the need and accessibility of health care resources and services in the community. Transportation, low cost health care, counseling and access issues including cost and reimbursement are prevalent among the comments. These responses are provided below.

Select Comments Regarding the Need and Accessibility of Healthcare Resources:

- Dial a ride inadequate. Public buses only go to certain places and are not on a frequent schedule.
- There are many mental health providers, however the need is too big that they are booking months out. When searching for grief counselors recently I only came across 2 in Bristol. There are plenty of healthy food options for those that can afford it, but not for those that cannot.
- All of these can be moving targets...depending on the demographics of any town. Hospitals are at the mercy of town leadership to determine demographics /federal and state aid/housing needs, etc. The above needs continue to be part of hospital Board discussions.
- With respect to low cost/free health care, there does exist options, however the current environment on reimbursing hospitals/physicians in CT is not a sustainable model with respect to both promoting the long term viability of those offering such services.
- So many people are struggling with the issues this survey has presented. Some due to lack of access, others due to lack of knowledge and understanding of available resources, others make a choice not to seek care even if the care they need is available (i.e. some people who struggle with addiction or obesity, for example).

Open-Ended Comments

Finally, key informants were given the opportunity to provide additional feedback in the form of open- ended comment fields. Key informants were asked, “What challenges do people in the community face in trying to maintain healthy lifestyles like exercising, eating healthy and/or trying to manage chronic conditions like diabetes or heart disease?” Almost all who responded addressed the issue of access to healthy food, the lack of knowledge, time and resources related to eating healthy and the cost-prohibitive nature of gym memberships.

Select Comments regarding Community Challenges to Trying to

Maintain a Healthy Lifestyle:

- People in Bristol face challenges in maintaining a healthy lifestyle when they are homeless or are low-income and are unable to afford health food.
- Affordability and safe access.
- Access to healthy foods is limited, lack of knowledge about how to prepare/eat healthy foods, healthy foods are more expensive, cost of a gym or exercise class, time to manage chronic conditions (i.e. multiple or frequent appointments).
- Lack of financial resources. Lack of support for disease management . Lack of knowledge on disease management.
- High deductibles discourage some from seeking medical treatment. Time management to prioritize exercise and cook healthy food when working full time or multiple jobs could be a factor in managing conditions. Fast food is easier.
- People need accurate and easily understood information on a regular basis as well as easy and inexpensive access to gyms and parks and safe areas to walk etc. They need the good food to be cheaper than the fast food and easier to access than the fast foods This requires changing what we feed our children in schools and beginning the education of our children about living a healthy lifestyle.
- Transportation and cost for low income people to access good nutrition Walking and biking friendly neighborhoods. Exercise options for people who don't/can't join gym or club. Daycare.
- Social determinants of health greatly impact the ability of Bristol residents to maintain healthy lifestyles, eat a healthy diet, and manage chronic illnesses. Bristol residents need stronger social services/supports in order to address these issues.
- Many in Bristol that do work full time may not be able to afford going to the gym and running/jogging/walking after dark is not always safe. Education for healthy eating needs to be reinforced to avoid heart disease and diabetes as well as after diagnosis. There is only 1 endocrinologist in Bristol so getting an appointment for diabetics is not always easy to come by either.
- Affordability and access. There are not enough places for community members to gather safely. People who care for older adults and family members are not adequately prepared to take care of their loved ones.
- Here in New England, the cold winter weather is a factor. Heart patients should be outside walking but it's tough to walk outside when it is cold. The cost of healthy eating definitely affects the ability to maintain healthy eating. We are lucky to have Family Roots in our community. They offer a wide variety of fruits and vegetables that are less expensive than the traditional grocery stores.
- Lack of affordable service and transportation and lack of education.

Next, key informants were asked, "In your opinion, what is being done well in the community in terms of health and quality of life?" Many respondents pointed to existing programs as well as collaborations between valued organizations (including Bristol Health) such as the education system, the senior center, and the police department. Issues of food and nutrition, exercise, physical health and mental health and disease prevention are being addressed.

Select Comments regarding What is Being Done Well in the Community:

- Access to fresh produce at the seasonal Bristol Farmers Market - offering double SNAP benefits last year helped those who were eligible stretch their benefits to feed themselves and/or their families. Wheeler Health Family Wellness Center on Hope Street has many services all under one roof. The partnership between Bristol Health and the City of Bristol COBRA program that helps those with substance abuse issues get treatment without being arrested. Foodshare's partnership with United Way and other entities (churches, nonprofit orgs.) to bring food to Bristol every other week gives those that need access to food.
- Collaboration with Senior Center for Senior Health.
- Plenty of parks and outdoor community spaces, access to walking trails, cultural resources available, recreational activities abundant, availability of free flu shots and other vaccines in area, availability of health and mental health directories of service providers, free health educational trainings like Dementia Friends, QPR training, CPR. and First aid, etc.
- Having a community hospital which can treat emergencies, has a great diagnostics team and great inpatient care.
- Community hospital is a great resource regardless of income. School system is strong and addresses the needs of most students.
- Expansion of primary care access is helping. Ample use of mid-level providers to ensure that patients are fully educated about their diseases and healthy life-styles.
- Bristol has many green spaces and recreational activities that benefit residents that use them. Bristol has adequate grocery stores that provide healthy food, although this may be unaffordable to some. Bristol has great pediatricians with good access to care. The Bristol Senior Center provides a plethora of services that benefit seniors immensely.
- The schools offer unified sports which includes fun and exercise for the children that may not be able to join a team. Places like Agape House, Brian's Angels and SVDP are there for our homeless population.
- Coordination and alignment between the city (Police Department and Bristol Burlington Health District) and Bristol Health to address health concerns (access to care, reaching out to those less fortunate, and compassionate options for those suffering from substance abuse), and promoting access to care.
- City Parks Department, Public Library and Senior Community Center have increased their programming and outreach to the community and its neighborhoods.
- Having a community hospital. The existence of some well qualified primary care physicians and specialists. Health and safety education initiatives.
- Providing information about immunizations and things that can help prevent disease.

Key informants were then asked, "What recommendations or suggestions do you have to improve health and quality of life in the community?" An overwhelming number of comments made indicate that many respondents are interested in more education about health related issues as about the programming that is available.

Select Comments regarding Recommendations and Suggestions:

- Improve collaboration with other CT Health Systems.
- More medical and social services outreach to the community.
- Bristol Health needs more communication and interaction with the faith based and other community services to coordinate and improve the mental and physical health of the community.
- Transportation is an issue for many low income families as well as seniors.
- Walking and bike friendly access to shopping and recreation. Better public transportation. More arts, culture venues. Public garden plots to grow food. Daycare for young working people to exercise and have relaxation time.
- Implementing care coordination, peer support navigators or community health workers that can help community members understand instructions, access resources and follow up to assure connection to care and resources would have a tremendous benefit. Assuring social determinants of health are comprehensively addressed will help residents access care and better manage their health.
- Even more outreach and education. More visibility.
- Nutrition and parenting education for families. More access to healthy food for the low income. More community social workers available the need is huge in Bristol. Education on how to navigate social services and the medical system. Maybe some classes at the library on this or at a school after hours. Having a detox center would be great. Having a job fair at Rockwell Park for those that need to work could be helpful as well.
- With all the technology that exists, I do not receive any health information from Bristol Health despite having been to the ER and having my primary care physician within the medical group. It is a missed opportunity.
- More communication to the elderly and disadvantaged population on the services offered in our community. Many are not reading newspapers anymore so perhaps a city-wide community mailing to highlight all of the options for healthcare and healthy living options.
- Better access to free transportation.
- More collaboration and partnerships between Bristol Health, City of Bristol, and the Bristol Burlington Health District.
- Medical professionals being involved in the community.
- More needs to be done to support low income families with housing.
- I think there can be more group discussions at the hospital or senior center that discusses nutrition, disease prevention, exercise programs etc. This might help the community know what doctors or programs they have access to. There are a lot of older people who do not understand Medicare and Medicare Advantage coverage.

A question was repeated from the 202 study in this CHNA about the effect COVID-19 had on the health needs of the community. "Did COVID-19 highlight any specific gaps/barriers in community health services?" Three years later, the answers reflect the effects on health care including provider availability, loss of community services and the increase in mental health issues including for young people.

Select Comments regarding the impact of COVID-19 on community health

needs:

- COVID-19 brought to light the need for mental health care in this community. With the addition of Wheeler Health in downtown Bristol offering services under one roof in their building on Hope Street, I feel this has made a difference in that gap/barriers.
- We now know that we are not prepared for a pandemic and we need to figure out how to get prepared. Our health infrastructure is not in place. We need to make health care more accessible and affordable and concentrated on prevention and chronic disease treatment. We need better communication between the established medical community and the local community services and schools.
- Decreased number of providers.
- Covid 19 hurt everyone but low income people disproportionately.
- Covid 19 propelled disinformation and diminished trust in institutions, science and healthcare. Mental health service needs were not being met.
- Mental health in children has declined precipitously since the COVID-19 pandemic. The stress, negative coping skills and instability children may have witnessed from those around them may have impacted this.
- Virtual appointments have increased access to some groups - it has also made it more difficult for others.
- I think people are still afraid to go to the hospital and to their doctor for help.
- More awareness of the value of social interactions.
- Covid-19 had detrimental impacts to the community. The cost of living has gone up dramatically, food costs substantially increased, cost of transportation, etc. Mental health and substance abuse has increased. The community is lacking support services for mental health, and substance abuse.

Next, key informants were asked to comment on any improvements they have seen in the priority health issues identified in 2022. These are

- Mental/Behavioral Health & Substance Misuse
- Chronic Disease Management
- Access to Care & Care Coordination
- Seniors Health & Services

As in 2022, some respondents noted improvement in some of the areas including expansion of mental health programs, access and coordination, and senior services including housing and dementia. However, others perceive there to be little improvement since these priorities were established.

Select Comments regarding Improvements in Priority Health Issues:

- Big push on mental health education, but not treatment.
- Increased usage of Mental/Behavioral Health and Substance Misuse services.
- Demand for mental health services is finally stabilizing. More attention being paid to services for seniors with the aging of baby boomers.
- Still the same areas needing assistance.
- I feel there's been greater awareness and improvement in all these areas.
- Access and coordination has improved within the expanded Bristol Health Medical Group and new office structure on Main Street. The EMR has helped with coordination also.

- The leadership at Bristol Hospital as well as the Board members continue to make all of the above a priority.
- Bristol Health primary and specialty care are more visible in the community. Wheeler Clinic opened their new headquarters in Bristol which is helping to address mental health and substance use concerns. Fatal opioid overdoses have decreased.
- More senior housing has opened up. The Community Health Center now has a van that goes to the local homeless day centers which helps with access to care for that population.
- Bristol has an outstanding Senior Center that offers an environment of inclusion, socializing and acceptance, as well as support services for health care, financial assistance. Strong mental/behavior health emergency care infrastructure at Bristol Health, coupled with a strong partnership between the city and the hospital.
- Increased services to our geriatric community through inpatient senior behavioral health, increased geriatric providers.
- There has been an increase in support for dementia patients and caregivers for dementia patients which is appreciated.
- Access to care and coordination has definitely improved and become more efficient.

Finally, key informants were asked to provide any additional feedback that might be helpful to Bristol Health in their ongoing efforts to improve the health of the community. Some systems issues were noted with specific departments/processes such as the emergency room, billing, and mental health patient follow-up. Select responses are provided here.

Select General Feedback for Bristol Health:

- Patients who visit the Emergency Department with mental health/substance use concerns are often discharged with referrals to outpatient care. It would improve services significantly if these patients were contacted by a peer support navigator or community health worker who could assure connection to care and address any unmet resource needs. This would not only benefit the patient, but also help manage repeated emergency department use and decrease readmission rates.
- I have heard several people say they aren't happy with the services from Bristol Health. Billing issues, lack of empathy from providers, appointments seem like they are only a conversation with the doctor, which people view as just an appointment so the provider can charge a fee, long wait times in the ER when there doesn't appear to be many people there and most importantly it seems like you have to be your own advocate and question tests or the care being provided.
- Slow the focus on expansion and bring the focus back to what they used to be good at.
- Appreciate the expansion into Southington. Continuing to recruit primary care is vital and creating pipelines for APRNs.

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APPENDIX B: DEFINITIONS

Age-Adjusted Rate: Age-adjustment is a statistical process applied to rates of disease, death, injuries, or other health outcomes, which allows populations with different age structures to be compared.

Behavioral Risk Factor Surveillance System (BRFSS): Ongoing surveillance system with the objective to collect uniform, state-specific data from surveys on adults' health-related risk behaviors, chronic health conditions, and use of preventive services.

Crude Rate: Expresses the frequency in which a disease or condition occurs in a defined population in a specified period of time, without regard to age or sex.

Determinants of Health: The personal, social, cultural, economic, and environmental factors that influence the health status of individuals or populations.

Family: Defined as a householder and one or more other people living in the same household who are related to the householder by birth, marriage, or adoption.

Frequency: Often denoted by the symbol "n," and referred to the number of occurrences of an event.

Health: A state of complete physical, mental, and social well-being and not just the absence of disease or infirmity.

Health Disparities: Indicate the difference in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups.

Health Outcomes: A medical condition or health status that directly affects the length or quality of a person's life. These are indicators of health status, risk reduction, and quality of life enhancement.

Housing Unit: A house, an apartment, a mobile home, a group of rooms, or a single room occupied (or if vacant, intended for occupancy) as separate living quarters.

Household: All the people who occupy a housing unit, including related family members and all the unrelated people who may be residing there. Examples include college students sharing an apartment or a single male living alone.

Householder: One person in each household is designated as the householder. In most cases, the householder is the person, or one of the people, in whose name the housing unit is owned or rented (maintained). The two major categories of householders are "family" and "nonfamily."

Incidence: Refers to the number of individuals who develop a specific disease or experience a specific health-related event during a particular time period.

Infant Mortality Rate: Number of live-born infants who die before their first birthday per 1,000 live births in a given year.

Low Birth Weight (LBW): A birthweight less than 2,500 grams (5 pounds, 8 ounces).

Morbidity: Refers to the state of being diseased or unhealthy within a population.

Mortality: Number of deaths occurring in a given period in a specified population.

Neonatal Mortality Rate: Defined as the number of infant deaths from birth up to but not including 28 days of age per 1,000 live births per year.

Post-Neonatal Mortality Rate: Defined as the number of infant deaths occurring from 28 days up to but not including 1 years of age per 1,000 live births per year.

Poverty: When a person or group of individuals lack human needs because they cannot afford them. Human needs include clean water, nutrition, health care, education, clothing, and shelter.

Preterm: Births delivered less than 37 completed weeks of gestation based on obstetric estimate of gestation.

Prevalence: The total number of individuals in a population who have a disease or health condition at a specific period of time, usually expressed as a percentage of the population.

Quality of Life: Degree to which individuals perceive themselves as able to function physically, emotionally, and socially.

Rate: A measure of the intensity of the occurrence or frequency with which an event occurs in a defined population. Rates are generally expressed using a standard denominator such as per populations of 1,000, 10,000 or 100,000.

Size of Household: Includes all the people occupying a housing unit.

Size of Family: Includes the family householder and all other people in the living quarters that are related to the householder by birth, marriage, or adoption.

Socioeconomic Status (SES): A composite measure that typically incorporates economic, social, and work status. Examinations of socioeconomic status often reveal inequalities in access to resources.

Very Low Birth Weight (VLBW): Indicates a birth weight less than 1,500 grams (3 pounds, 5 ounces).

Vital Statistics: Systematically tabulated data derived from certificates and reports of births, deaths, fetal deaths, marriages, and divorces, based on the registration of these vital events.

Years of Potential Life Lost (YPLL): A measure of premature mortality or death on a population, calculated as deaths that occur before some predetermined minimum or desired life span (usually age 75, which is the average life span).

APPENDIX C: KEY INFORMANT SURVEY

Community Health Needs Assessment Key Informant Online Questionnaire

INTRODUCTION

As part of its ongoing commitment to improving the health of the communities it serves, Bristol Health is spearheading a comprehensive Community Health Needs Assessment.

You have been identified as an individual with valuable knowledge and opinions regarding community health needs, and we appreciate your willingness to participate in this survey.

The survey should take about 10 to 15 minutes to complete. Please be assured that all of your responses will go directly to our research consultant, Holleran Consulting, and will be kept strictly confidential. Please note that while your responses, including specific quotations, may be included in a report of this study, your identity will not be directly associated with any quotations.

When answering the questions, please consider the community and area of interest to be the City of Bristol.

KEY HEALTH ISSUES

1. What are the top **5** health issues you see in the community? (Choose 5)

<input type="checkbox"/> Access to care/uninsured	<input type="checkbox"/> Overweight/obesity
<input type="checkbox"/> Cancer	<input type="checkbox"/> Senior support
<input type="checkbox"/> Dental health	<input type="checkbox"/> Sexually transmitted diseases
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Substance abuse/alcohol abuse
<input type="checkbox"/> Maternal/infant health	<input type="checkbox"/> Tobacco
<input type="checkbox"/> Mental health/suicide	<input type="checkbox"/> Other (specify):

2. Of those health issues mentioned, which **1** is the most significant? (Choose 1)

<input type="checkbox"/> Access to care/uninsured	<input type="checkbox"/> Overweight/obesity
<input type="checkbox"/> Cancer	<input type="checkbox"/> Senior support
<input type="checkbox"/> Dental health	<input type="checkbox"/> Sexually transmitted diseases
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Substance abuse/alcohol abuse
<input type="checkbox"/> Maternal/infant health	<input type="checkbox"/> Tobacco
<input type="checkbox"/> Mental health/suicide	<input type="checkbox"/> Other (specify):

3. Please share any additional information regarding these health issues and your reasons for ranking them this way in the box below:

ACCESS TO CARE

4. On a scale of strongly disagree through strongly agree, please rate each of the following statements about **Health Care Access** in the area.

Strongly disagree ← → Strongly agree

Residents in the area are able to access a primary care provider when needed. (Family Doctor, Pediatrician, General Practitioner)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Residents in the area are able to access a medical specialist when needed. (Cardiologist, Dermatologist, Neurologist, etc.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
There are a sufficient number of providers accepting Medicaid and Medical Assistance in the area.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
There are a sufficient number of multilingual providers in the area.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
There are a sufficient number of mental/behavioral health providers in the area.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Transportation for medical appointments is available to area residents when needed.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

5. Please share any additional information regarding access to care issues in your community in the box below:

6. What are the most significant barriers that keep people in the community from accessing health care when they need it? (Select all that apply)

<input type="checkbox"/> Availability of providers/appointments
<input type="checkbox"/> Basic needs not met (food/shelter)
<input type="checkbox"/> Inability to navigate health care system
<input type="checkbox"/> Inability to pay out of pocket expenses (co-pays, prescriptions, etc.)
<input type="checkbox"/> Lack of child care
<input type="checkbox"/> Lack of health insurance coverage
<input type="checkbox"/> Lack of transportation
<input type="checkbox"/> Lack of trust

<input type="checkbox"/>	Language/cultural barriers
<input type="checkbox"/>	Time limitations (long wait times, limited office hours, time off work)
<input type="checkbox"/>	None/no barriers
<input type="checkbox"/>	Other (specify):

7. Of those barriers mentioned, which **1** is the most significant? (Choose 1)

<input type="checkbox"/>	Availability of providers/appointments
<input type="checkbox"/>	Basic needs not met (food/shelter)
<input type="checkbox"/>	Inability to navigate health care system
<input type="checkbox"/>	Inability to pay out of pocket expenses (co-pays, prescriptions, etc.)
<input type="checkbox"/>	Lack of child care
<input type="checkbox"/>	Lack of health insurance coverage
<input type="checkbox"/>	Lack of transportation
<input type="checkbox"/>	Lack of trust
<input type="checkbox"/>	Language/cultural barriers
<input type="checkbox"/>	Time limitations (long wait times, limited office hours, time off work)
<input type="checkbox"/>	None/no barriers
<input type="checkbox"/>	Other (specify):

8. Please share any additional information regarding barriers to health care in the box below:

9. For each **Healthcare Resource/Service** listed, please select whether you think it is missing (not available), lacking (available but not enough to meet needs) or not affordable (price may be a barrier in accessing service) within the community. If you think the service is available and affordable, please select the need as being met.

Healthcare Resources/Services	Missing	Lacking	Not Affordable	Need Being Met	Don't Know
Advocacy for social needs (food security, housing, education, employment, etc.)					
Bilingual services					
Case management/social services					
Corporate health screenings/education programs (on-site for employees)					
Emergency care					
Federally qualified health centers (FQHCs)					
Food distribution					
Free/low cost dental care					
Free/low cost medical care					
Health education/information/outreach					
Healthy food options					
Home health care services					
Housing assistance					
Prescription assistance					
Mental health services					
Multicultural/bilingual healthcare providers					
Preventive health screenings (blood pressure, diabetes, stroke, etc.)					
Primary care services					
Specialty care services (cardiologist, neurologists, etc.)					
Substance abuse services					
Support group services					
Senior support					
Sexual health care					
Transportation					

10. Please share any additional information regarding the need for and accessibility of healthcare resources and/or services for individuals living in the community in the box below:

11. Are there specific populations in this community that you think are not being adequately served by local health services?

Yes

No

12. **If yes**, Which populations are underserved? (Select all that apply)

<input type="checkbox"/>	Black/African-American
<input type="checkbox"/>	Children/youth
<input type="checkbox"/>	Disabled
<input type="checkbox"/>	Hispanic/Latino
<input type="checkbox"/>	Homeless
<input type="checkbox"/>	Immigrant/refugee
<input type="checkbox"/>	Low-income/poor
<input type="checkbox"/>	Seniors/aging/elderly
<input type="checkbox"/>	Uninsured/underinsured
<input type="checkbox"/>	Young adults
<input type="checkbox"/>	None
<input type="checkbox"/>	Other (specify):

13. Please share any additional information regarding underserved populations in the box below:

CHALLENGES & SOLUTIONS

14. What challenges do people in the community face in trying to maintain healthy lifestyles like exercising and eating healthy and/or trying to manage chronic conditions like diabetes or heart disease?

15. What effect has COVID-19 had on the health needs of the community? Did COVID-19 highlight any specific gaps/barriers in community health services?

16. In your opinion, what is being done **well** in the community in terms of health and quality of life? (Community Assets/Strengths/Successes)

17. What recommendations or suggestions do you have to improve health and quality of life in the community?

18. In 2022, Bristol Health and its partners identified the following areas as priorities:

-Mental/Behavioral Health & Substance Misuse

- Chronic Disease Management
- Access to Care & Care Coordination
- Seniors Health & Services

In your community, what changes have you seen in these areas since 2019?

DEMOGRAPHICS

19. Which one of these categories would you say **BEST** represents your community affiliation? (Choose 1)

<input type="checkbox"/> Business sector
<input type="checkbox"/> Community member
<input type="checkbox"/> Education/youth services
<input type="checkbox"/> Faith-based/cultural organization
<input type="checkbox"/> Government/housing/transportation sector
<input type="checkbox"/> Health care/public health organization
<input type="checkbox"/> Mental/behavioral health organization
<input type="checkbox"/> Non-profit/social services/aging services
<input type="checkbox"/> Other (specify):

CLOSING

20. Bristol Health and its partners will use the information gathered through this survey in guiding their community health improvement activities. Please share any other feedback you may have for them below:

Thank you! That concludes the survey.

APPENDIX C: KEY INFORMANT PARTICIPANTS AND VERBATIM COMMENTS

First Name	Last Name	Organization
Michael	Heimbach	Bristol Health Board of Directors, Bristol Health Corporator
Jason	Kruger	Bristol Senior Center
Dawn	Nielson	City of Bristol
Gregory	Hahn	Bristol Health Corporator
Sandra M.	Leone, Jr.	Bristol Health Corporator
Anthony	D'Amato	Bristol Health Corporator
Anthony M.	Mattioli	Bristol Health Corporator
Kate	Kerchaert	Main Street Community Foundation
William A.	Petit, Sr.	Bristol Health Corporator
Jeanne	Radcliff	Bristol Health Corporator
Harland S.	Graime, Ph.D.	Bristol Health Corporator
Mary Ann	Cordeau	Bristol Health Corporator
Jerald A.	Rafaniello	Bristol Health Corporator
Leslie S.	Kish	Bristol Health Corporator
Leonard	Banco	Bristol Health Corporator
Eileen	Adams	Bristol Health Corporator
Phyllis	Guida	Bristol Health Corporator
Dennis D.	Ferguson, M.D.	Bristol Health Corporator
Thomas H.	Morrow	Bristol Health Corporator
Fonda	Green	Bristol Health Corporator
Nancy	Brault	Bristol Health Corporator
Kristina	Tanguay	Bristol/Burlington Health District
Louis	Auletta	Bristol Health Board of Directors
Ryan	Allaire	Central Connecticut Chambers of Commerce
Christie	Ganavage	Bristol/Burlington Health District
Wanita A.	Parenti	Bristol Health Corporator
Sarah	Mitchell	United Way
John	Lodovico	Tunxis Community College/Bristol BOD
Glenn	Heiser	Bristol Health Corporator
Mr. Brian K.	Dehm	Bristol Health Corporator
Mark	Morello	Police Chief
Donna	Osuch	Bristol Health Corporator
Gary	Sassu	Bristol Health Corporator
Donald	D'Alesio	Bristol Health Corporator

First Name	Last Name	Organization
Mark	Zammett	Bristol Health Corporator
Mary Lynn	Gagnon	Bristol Health Corporator
Albert	Peguero	Bristol Health
Stephanie	Allaire	Bristol Health Corporator
Jennifer	Feda	Bristol Health
Thomas	Barnes	Bristol Health Board of Directors
Lisa	Coates	Bristol Health
Chris Ann	Meaney	Bristol Health
Marie V.	O'Brien	Bristol Health Corporator
S. Douglas	Devnew, Jr.	Bristol Health Corporator
Patrick R.	Nelligan	Bristol Health Corporator
Kimberly	Lewis	Bristol Health Corporator
Thomas P.	O'Brien	Bristol Health Corporator
William A.	Hamzy, Esq.	Bristol Health Corporator
Mark	Watson, MD	Bristol Health Corporator
Christine	Laprise	Bristol Health
Lea	Mola	Bristol Health Corporator
Susan Heiser	Heiser	Bristol Health Corporator

VERBATIM COMMENTS
Please share any additional information regarding these health issues.
Bristol Health has a tremendous team of doctors and nurses to help patients navigate cancer care along with some technology to help find and diagnosis cancer, however the ability to treat cancer with surgery is limited at Bristol Hospital and cancer patients have to utilize the better technology and surgery options at other hospitals outside of Bristol. Traveling takes time and it would be great if all resources for treating cancer could be at Bristol Hospital which would be more convenient and less time consuming.
Without insurance, one cannot get help with any of the health issues
Access to good mental health diagnosis and treatment. Along with drug counseling and treatment are sorely needed and will intensify as our state has legalized recreational marijuana. Long term exposure to high levels of THC have been proven to exacerbate mental health issues.
Access to care would seem to be the easiest to fix and would improve preventative and treatment of the other 4 issues. The other four issues are very close in significance. We need to do more preventative care and follow up care for the chronic disease issues.
Many people in Bristol do not have adequate health coverage.

VERBATIM COMMENTS
Many of the medical issues such as diabetes, heart disease, cancer, and mental health are significantly impacted by obesity, poor nutrition and poor health habits.
Access to care for ALL individuals is important...not just for uninsured. Access to GOOD care ...as close to home as possible. Being in an environment...a culture...where 'you', the individual really matters.
Poor mental health is a serious issue for many Bristol residents. While there are many services available to address this concern, there seems to be a disconnect between having services available and people using these services as often as they are needed. I believe addressing mental health concerns is the lynchpin to help unlock people's ability to care for their physical health, provide stable, healthy environments for their families, and increase their socioeconomic wellbeing over time. This also applies to substance use and to a lesser degree, obesity, and diabetes.
Many residents do not know how to navigate the insurance or health care systems in order to establish care. Access to detox is not easily available in our community Many are overweight/obese including our children more access to healthy affordable food would help Substance use and homelessness is disregarded or ignored or viewed as a problem, support and access to help needs to be more available.
Maintaining and increasing access are key. Without that, the other issues will never be resolved. The access to care needs to be made easier and the system needs to be simplified. Hiring and retaining staff are key.
While Bristol Health, along with the Bristol, Burlington Health District provide excellent services to our community and outreach programs in coordination with the Bristol Police Department for those afflicted with Substance Abuse, we need to continue to find alternative ways and new approaches to those who, while reluctant and/or afraid to seek help from our local resources, that benefit not only the patient, but the families and communities impacted by the affects of Substance/alcohol abuse. The awareness of resources available to those less fortunate in our community needs to continue to be stressed including access to care, not just from a financial perspective, but also from an ability to get to a health care provider (transportation, ease of making an appointment).
Seeing a lot of overweight people and not eating healthy at restaurants
When people are overweight or obese, they often have many additional health problems.
Poor nutrition and healthy living choices.
Bristol has the 2nd largest veteran population in the state of Connecticut, Mental health and suicide are a large problem in this population and needs more support from Bristol Health
So many in the community that have mental health and they are unable to have access to the care they need

VERBATIM COMMENTS
It doesn't matter what the most prevalent or most pervasive health condition is in the community if a person does not have the access to care/insurance they need in order to have screening, diagnosis, preventative care, or treatment of a specific condition.
There is a high rate of substance abuse in the community causing increased crime and repeat ED visits.
There are no successful programs in the area. Places get funding and do nothing with it
I believe that overweight and obesity problems, if not addressed, can lead to heart disease, diabetes, mental health issues and certain cancers.
Please share any additional information regarding access to care issues in your community .
More mental health providers are needed as well as transportation options.
The previous neutral answers are because they are unknown to me. There are specialties we don't have such as allergists and ENT's.
Even with insurance coverage I cannot get a timely appointment with certain specialists and this is an issue for other people with insurance as well. People complain that they cannot get to see primary care physicians in a timely manner.
The 'Neutral' responses are based on my personal experience of not needing those needs. As for my comments below - regarding barriers: I believe individuals want care when they need care. Many individuals don't fully understand how a hospital/physicians work. They don't understand the insurance piece. They only know they have health insurance - pay the premiums - get upset about the balance (co-pay) A hospital has so many facets. A community needs health care...but a hospital NEEDS a community to help support that asset.
Access to certain specialists is easier than others. Dermatology is very difficult for folks with Medicaid to access timely. Neurology and psychiatric medication management is also a specialty where people may wait quite some time before an open appointment. People needing cardiology, pulmonary, or orthopedic appointments generally have shorter wait times to access care.
There are plenty of primary care/pediatricians in the area however many do not know how to navigate the system Specialist appointments have to made way in advance Mental health providers are booking way out Many patients can not take the bus to appointments and Veyo is not always reliable
With doctors retiring, there are not enough people to replace them. Also the amount of time doctors spend with patients is lessening and more self advocacy is taking. I

VERBATIM COMMENTS
<p>speak from personal experience. I was admitted to the Bristol Health ER, prior to having a scheduled surgery at a different hospital, and when I went in for my annual, my primary care physician did not care about the ER visit in 'her' hospital or that I had an organ removed. This has led me to look for another doctor in an entirely different health group.</p>
<p>Overall, the Bristol Health System continually seeks ways to improve upon and offer access to low cost, quality health care. While additional Primary Care Physicians is certainly welcomed and needed, most individuals have the ability to make and appointment with a Primary Care Physician when needed. Specialty Care, however, can be difficult for many in the community when making an appointment, and the earliest possible date available is months out in the future. This is contributed by the shortage of specialists in some specialties, such as Cardiology, Dermatology, Rheumatology to name a few, which is more the result of a shortage of specialists in the industry. Additionally, the payor mix within the community (Government pay vs. Commercial), places and enormous strain on the financial health of hospitals, particularly community hospitals, as the reimbursement rates for Government pay (Medicaid, Medicare) do not come close to adequately paying health care service providers in CT, particularly for those surgical services considered 'elective'.</p>
<p>The questions I answered neutral to I am unsure of. I'm not sure there are sufficient number of providers accepting Medicaid and Medical Assistance. I am also unsure about multilingual providers in the area, and transportation.</p>
<p>Care is available, people are not always proactive in accessing the care they need</p>
<p>There are challenges with PCP recruitment and specialty access such as dermatology and ENT.</p>
<p>Our hospital's service 'area' is diverse in demographic factors. I cannot give a blanket response of 'strongly agree' or 'strongly disagree' for any of the questions you asked. The hospital serves many towns, neighborhoods, and individuals that have very different demographic factors from one another. What is sufficient in care/providers for one town, neighborhood, group, or individual might be substandard for others. However, I do believe that mental health care and timely access to quality primary care physician practices are issues of concern across all demographics.</p>
<p>Many offices do not offer sliding scale prices. Transportation is always an issue</p>
<p>Please share any additional information regarding barriers to health care.</p>
<p>They are all of concern.</p>
<p>Too long a wait for an appointment.</p>

VERBATIM COMMENTS
It can be difficult for some people, particularly those with mental health issues or the elderly to navigate insurance, approvals, when there is a copay, remembering appointments.
I am not sure which is the most significant. The people with whom I usually come in contact with would say that availability is the issue they most often encounter
Navigating the health care system can be difficult...and fully understanding and navigating any further continued care.
The difficulty many people experience when trying to navigate the medical or psychiatric care systems is the biggest barrier to good care. One solution is offering increased care coordination or peer support navigators in primary care offices. This can also help build confidence and trust. Language and cultural barriers are also major barriers to accessing equitable care. Having access to qualified medical interpreters or bilingual peer support navigators for anyone with difficulty understanding English is very important.
Without providers, again, the other issues are mute.
It was difficult to pick one.
People do not want to put in the effort or do not care about their health so they do not seek the care they need. They also come to the ED for everything. If people could be filtered to outpt. clinics better than the ED would not be cluttered with folks who do not need ED care.
If a person's basic needs are not met, it is unlikely they have insurance an likely that all of the other issues on this list are also barriers to health care.

VERBATIM COMMENTS
Please share any additional information regarding the need and accessibility of healthcare resources and/or services for individuals living in the community.
Most needs are lacking but being worked on
Dial a ride inadequate. Public buses only go to certain places and are not on a frequent schedule.
All of these can be moving targets...depending on the demographics of any town. Hospitals are at the mercy of town leadership to determine demographics /federal and state aid/housing needs, etc. The above needs continue to be part of hospital Board discussions.
There are many mental health providers, however the need is too big that they are booking months out. When searching for grief counselors recently I only came across 2 in Bristol There are plenty of healthy food options for those that can afford it, but not for those that cannot.
While I am not aware of all services provided, I do know that between Bristol Health and Bristol Burlington Health District that are considerable opportunities for individuals and families to receive most basic essential health care needs. With respect to low cost/free health care, there does exist options, however the current environment on reimbursing hospitals/physicians in CT is not a sustainable model with respect to both promoting the long term viability of those offering such services
I cannot speak for others. I am fortunate to have health insurance and adequate health care. I cannot make a blanket statement regarding the needs of people who are not in my situation. So many people are struggling with the issues this survey has presented. Some due to lack of access, others due to lack of knowledge and understanding of available resources, others make a choice not to seek care even if the care they need is available (i.e. some people who struggle with addiction or obesity, for example).
What challenges do people in the community face in trying to maintain healthy lifestyles like exercising and eating healthy and/or trying to manage chronic conditions like diabetes or heart disease?
American food is not the healthiest.
People in Bristol face challenges in maintaining a healthy lifestyle when they are homeless or are low-income and are unable to afford health food.
Affordability and safe access.
Older population, fixed income.

VERBATIM COMMENTS
Self-motivation and discipline.
Access to healthy foods is limited lack of knowledge about how to prepare/eat healthy foods healthy foods are more expensive cost of a gym or exercise class time to manage chronic conditions (i.e. multiple or frequent appointments)
Poor food choices SNAP benefits being used for wrong foods Homeless population is in dire need of affordable/free healthcare.
Lack of financial resources Lack of support for disease management Lack of knowledge on disease management.
High deductibles discourage some from seeking medical treatment. Time management to prioritize exercise and cook healthy food when working full time or multiple jobs could be a factor in managing conditions. Fast food is easier
People need accurate and easily understood information on a regular basis as well as easy and inexpensive access to gyms and parks and safe areas to walk etc. they need the good food to be cheaper than the fast food and easier to access than the fast foods This requires changing what we feed our children in schools and beginning the education of our children about living a healthy lifestyle. We have lowered the use of tobacco and we need to do the same or better when dealing with drugs and alcohol and unhealthy eating habits.
Lack of income may interfere with healthy diets and appropriate medical care.
Transportation and cost for low income people to access good nutrition Walking and biking friendly neighborhoods. Exercise options for people who don't/can't join gym or club . Daycare.
First...in all of society...not just our community: Individuals need to take responsibility for their part of the solution. In conjunction with working with health care providers -
Social determinants of health greatly impact the ability of Bristol residents to maintain healthy lifestyles, eat a healthy diet, and manage chronic illnesses. Bristol residents need stronger social services/supports in order to address these issues.
Education and support
I think for most people in the area it's a combination of costs and available time.

VERBATIM COMMENTS
<p>Many in Bristol that do work full time may not be able to afford going to the gym and running/jogging/walking after dark is not always safe. Education for healthy eating needs to be reinforced to avoid heart disease and diabetes as well as after diagnosis. There is only 1 endocrinologist in Bristol so getting an appointment for diabetics is not always easy to come by either.</p>
<p>Affordability and access. There are not enough places for community members to gather safely. We as a society are teaching/showing young people that older populations are throw-a-ways. People who care for older adults and family members are not adequately prepared to take care of their loved ones. Culturally as a people we need to find the value of humans and treat them with dignity. If they feel valued, they will ask for assistance.</p>
<p>EDUCATION</p>
<p>Access to low cost healthy food options Continuing Education on health eating habits. Recipes for success Cost of health care to some, who do not properly utilize Affordable care solutions, as well as having a champion to encourage them to seek assessments/diagnosis and/or regular checkups.</p>
<p>Lack of focus and energy to exercise</p>
<p>access to healthy choices of food</p>
<p>I don't think folks seek out the services that are available, some free, i.e. Silver Sneakers</p>
<p>Here in New England, the cold winter weather is a factor. Heart patients should be outside walking but it's tough to walk outside when it is cold. Our local senior center has options, but not sure many people take advantage of their services. The cost of healthy eating definitely affects the ability to maintain healthy eating. We are lucky to have Family Roots in our community. They offer a wide variety of fruits and vegetables that are less expensive than the traditional grocery stores.</p>
<p>Don't eat healthy</p>
<p>Finding the time to balance a healthy lifestyle, the finances to do so, the access to proper care.</p>
<p>The time commitment is difficult due to work, school, child care, etc How do we make it easier for employees and community members?</p>
<p>Not enough no cost or low cost opportunities for exercising or being outdoors.</p>

VERBATIM COMMENTS
Unhealthy restaurant selection
Lack of affordable service and transportation and lack of education
Lack of a sense of community. Not prioritizing healthy habits due to stressors, lack of education, lack of peer/colleague family support or group commitment to prioritizing health. Physicians prescribing drugs right away for a condition rather than truly addressing diet/exercise/stress/environmental factors first with a patient. PATIENTS expecting a magic pill and being unwilling to make lifestyle changes that would positively impact their health.
Discipline
Transportation challenges and cost to maintain a healthy lifestyle.
Too many affordable fast food chains. Healthy food is expensive and hard to buy on a consistent basis for low income or people on a fixed budget. Prices for gym memberships have risen.
What effect has COVID-19 had on the health needs of the community? Did COVID-19 highlight any specific gaps/barriers in community health services?
Huge impact on social skills and hypochondria.
COVID-19 brought to light the need for mental health care in this community. With the addition of Wheeler Health in downtown Bristol offering services under one roof in their building on Hope Street, I feel this has made a difference in that gap/barriers.
Decreased number of providers.
Covid made community less able to access healthcare, seems to have changed attitudes of people getting out and getting service.
Insignificant although the pandemic was leveraged by the community as an excuse for certain behaviors and we are suffering the consequences (children education disaster, workers compensation abuse, lack of productivity etc.).
Inadequate mental health services/providers.
COVID-19 separation meant people were not able to access healthcare facilities. They were afraid of contact.
Probably the after effects of social isolation on mental health. The Bristol Health

VERBATIM COMMENTS
system did a good job with COVID 19 at the time of the pandemic
We now know that we are not prepared for a pandemic and we need to figure out how to get prepared. Our health infrastructure is not in place and needs improvement on a national level. We need to make health care more accessible and affordable and concentrated on prevention and chronic disease treatment. We need better communication between the established medical community and the local community services and schools.
Covid 19 hurt everyone but low income people disproportionately.
Covid 19 propelled disinformation and diminished trust in institutions, science and healthcare Low income workers where forced onto the frontlines while high income workers had alternatives More public education and community outreach helps. Mental health service needs were not being met.
One major effect - was individuals not being able to go visit their loved ones...and those in a hospital could not interact. Bristol Hospital was very pro-active with setting up clinics to receive the vaccine...and being very pro-active to follow protocol and help people. The most troubling barrier - is looking back. We only knew what we were being told.
Mental health in children has declined precipitously since the COVID-19 pandemic. The stress, negative coping skills and instability children may have witnessed from those around them may have impacted this. If we can help adults address their own mental health struggles and provide strong social/community supports, this will likely have an impact on improving children's mental health as well.
None
The timeline to see a doctor seems like it has increased since COVID. It seems like you have to wait 3-6 months to see a provider now and the appointments seem rushed. It also seems like you now have to question the care and recommendations from your provider. This may just be a coincidence and not have anything to do with COVID though.
During COVID an appointment at primary care was impossible to get. Video appointments do not capture the whole picture.

VERBATIM COMMENTS
Virtual appointments have increased access to some groups - it has also made it more difficult for others. With so much technology, to ease the loss of staff and speed up the check-in process, there are some folks who are not familiar with new-to-them technology. These folks are left to struggle through the navigation or they stop going because they are looking/needing human interactions.
I believe that the community of Bristol navigated and afforded access to Covid vaccines exceptionally well during that period of time. Additionally, as the Education system played a major role during the covid period and subsequent period coming out of covid, Bristol's Education system did very well at minimizing the mental/social impact of all students in their care and oversight.
It's over... 5 years ago
I'm sure the seclusion we felt during COVID-19 affected the health needs of the community. At Bristol Health we were busy offering COVID shots set up outside where people could drive in and get their test done while they sat in their cars.
I think people are still afraid to go to the hospital and to their doctor for help.
More awareness of the value of social interactions.
Increased mental health and addition issues. COVID 19 also highlighted some individuals' and groups' inability to think critically to identify misinformation and their rejection of research based science that does not fit whatever narrative they have constructed in their minds, which ultimately impacts whether or not they will seek access to community health services in the community, or support our evolving healthcare initiatives.
Impact on younger members of the community has been dramatic
Covid-19 had detrimental impacts to the community. The cost of living has gone up dramatically, food costs substantially increased, cost of transportation, etc. Mental health and substance abuse has increased. The community is lacking support services for mental health, and substance abuse.
The realization that the community health services can become very overwhelmed during a pandemic.
In your opinion, what is being done <i>well</i> in the community in terms of health and quality of life? (Community Assets/Strengths/Successes).
Education

VERBATIM COMMENTS
<p>Access to fresh produce at the seasonal Bristol Farmers Market - offering double SNAP benefits last year helped those who were eligible stretch their benefits to feed themselves and/or their families. Wheeler Health Family Wellness Center on Hope Street has many services all under one roof. The partnership between Bristol Health and the City of Bristol COBRA program that helps those with substance abuse issues get treatment without being arrested. Foodshare's partnership with United Way and other entities (churches, nonprofit orgs.) to bring food to Bristol every other week gives those that need access to food.</p>
<p>Collaboration with Senior Center for Senior Health.</p>
<p>Bristol hospital seems to have done a good job serving our community, and the addition of wheeler clinic helped to provide mental health and addiction services.</p>
<p>Plenty of parks and outdoor community spaces. access to walking trails. cultural resources available. recreational activities abundant. availability of free flu shots and other vaccines in area. availability of health and mental health directories of service providers. free health educational trainings like Dementia friends, QPR training, CPR. and First aid, etc.</p>
<p>We have a good hospital and medical staff in the city but people with limited fund are not able to access it. Language barriers may be a factor.</p>
<p>Having a community hospital which can treat emergencies, has a great diagnostics team and great inpatient care.</p>
<p>Mental health.</p>
<p>I believe that the emergency department at the hospital is a definite success and provides excellent care.</p>
<p>Community hospital is a great resource regardless of income. School system is strong and addresses the needs of most students.</p>
<p>Expansion of primary care access is helping. Ample use of mid-level providers to ensure that patients are fully educated about their diseases and healthy life-styles. There is full complement of qualified specialists though access can be a problem at times.</p>

VERBATIM COMMENTS
I believe Bristol Hospital has excellent, above average leadership throughout the organization. The hospital is not just another business in town....it is one of our best assets. Because of the current leadership, it has truly become more visible, more respected. It is one of the few 'stand alone' hospitals...just received exemplary recognition...above average nursing care - Magnant Status! We are not the biggest.....WE ARE THE BEST! More people need to walk through our doors...they will see and feel a difference.
Bristol has many green spaces and recreational activities that benefit residents that use them. Bristol has adequate grocery stores that provide healthy food, although this may be unaffordable to some. Bristol has great pediatricians with good access to care. The Bristol Senior Center provides a plethora of services that benefit seniors immensely.
Bristol Health outreach and community involvement is essential and being done well.
We have a lot of providers in the area.
Bristol offers a lot of walking trails and parks for children and adults to use during the day to help with exercise. The farmer's market is access to fruits and vegetables, however one needs money for this. The schools offer unified sports which includes fun and exercise for the children that may not be able to join a team. Places like Agape House, Brian's Angels and SVDP are there for our homeless population.
It is sufficient.
Community awareness
Coordination and alignment between the city (Police Department and Bristol Burlington Health District) and Bristol Health to address health concerns (access to care, reaching out to those less fortunate, and compassionate options for those suffering from substance abuse), and promoting access to care.
Bristol Hospital has done a great job educating the community on health and quality of life.. Still has a long way to go..
Senior services, health fairs
Our greatest asset in our community is Bristol Health. They have a wide variety of physicians and medical staff at the hospital and the Medical Care Center.
Emergency services

VERBATIM COMMENTS
Food banks, pantries, kitchens
Bristol Health and Wheeler behavioral health access
City Parks Department, Public Library and Senior Community Center have increased their programming and outreach to the community and its neighborhoods.
City of Bristol involvement.
Having a community hospital. The existence of some well qualified primary care physicians and specialists. Health and safety education initiatives.
Emergency Care.
While personal transportation is likely an issue, the community has several bus lines. Many Bristol Health services, including the hospital, sit on the bus line.
Providing information about immunizations and things that can help prevent disease.
What recommendations or suggestions do you have to improve health and quality of life in the community?
Lower health costs. Medicare should provide for hearing, sight and dental as well.
I feel the City of Bristol is doing the best they can with the resources they have to provide health care, healthy food options, mental health, and addiction services, along with services for the homeless. As with anything there is always room for improvement.
Improve collaboration with other CT Health Systems
More medical and social services outreach to the community.
I'm not knowledgeable enough about the tangled web of the health care system to be able to answer that question.
Bristol health needs more communication and interaction with the faith based and other community services to coordinate and improve the mental and physical health of the community. Working together to improve all of the social and health care issues is essential.
Transportation is a issue for many low income families as well as seniors.
Walking and bike friendly access to shopping and recreation. Better public transportation More arts, culture venues. Public garden plots to grow food Daycare

VERBATIM COMMENTS
for young working people to exercise and have relaxation time.
I have stated above...first, we have to take on our own responsibility. A community is made up of people...I hope more individuals become more a part of an overall solution - get involved...give back. While every community has people in need of something...I can only hope there will always be more in line to give back.
Implementing care coordination, peer support navigators or community health workers that can help community members understand instructions, access resources and follow up to assure connection to care and resources would have a tremendous benefit. Assuring social determinants of health are comprehensively addressed will help residents access care and better manage their health.
Even more outreach and education. More visibility.
Helping people understand the cost for services and how much they will be responsible for paying out of pocket would be a benefit.
Nutrition and parenting education for families. More access to healthy food for the low income. More community social workers available the need is huge in Bristol. Having an actual social services department in the city. Education on how to navigate husky, social services, and the medical system, maybe some classes at the library on this or at a school after hours. Having a detox center would be great. Having a job fair at Rockwell park for those that need to work could be helpful as well.
For current patients providing materials - either paper or digitally - of things to be aware of from a health perspective would be appreciated. I currently receive communications from Hartford HealthCare because I use services at one of their walk-in clinics. While not all the content applies, I am constantly being communicated with about current topics. My bank does the same thing. With all the technology that exists, I do not receive any health information from Bristol Health despite having been to the ER and having my primary care physician within the medical group. It is a missed opportunity.
More community awareness
Need to get the public outside and just walk to start the process of quality of life.
More education and awareness.

VERBATIM COMMENTS
More communication to the elderly and disadvantaged population on the services offered in our community. Many are not reading newspapers anymore so perhaps a city-wide community mailing to highlight all of the options for healthcare and healthy living options.
More stability in the primary care area.
Better access to free transportation.
More health related education where the people are (churches, coffee shops, etc) Rotating Farmers market.
More collaboration and partnerships between Bristol Health, City of Bristol, and the Bristol Burlington Health District.
Better understand the demographics of the city
Education and a availability
This is the trillion dollar question, isn't it? What can we do to bring the community together across demographic and ideological differences? What can we do to make insurance companies and the federal government champions of healthcare initiatives instead of barriers to healthcare? How can we recruit and retain quality physicians, nurses, lab technicians, researchers, and support staff? How can we encourage, support, convince others to make their own health (and the health of the people their choices and actions impact) a priority over everything else, and then to support others in doing the same?
Medical professionals being involved in the community
More needs to be done to support low income families with housing.
I think there can be more group discussions at the hospital or senior center that discusses nutrition, disease prevention, exercise programs etc. This might help the community know what doctors or programs they have access to. There are a lot of older people who do not understand Medicare and Medicare advantage coverage.
<p>In 2022, Bristol Health and its partners identified the following areas as priorities:</p> <ul style="list-style-type: none"> -Mental/Behavioral Health & Substance Misuse -Chronic Disease Management -Access to Care & Care Coordination -Seniors Health & Services <p>In your community, what changes have you seen in these areas since 2019?</p>

VERBATIM COMMENTS
Big push on mental health education, but not treatment
Increased usage of Mental/Behavioral Health and Substance Misuse services.
None noted.
Senior health service
Access to care is available although requiring diligence in some cases. Personal behavior and responsibility have always been and continues to be a significant obstacle. Childcare issues (cost, availability) significantly contribute to many challenges in the community.
Demand for mental health services is finally stabilizing more attention being paid to services for seniors with the aging of baby boomers not sure if access to care has improved or not.
Still the same areas needing assistance.
Don't know.
I am not in the main stream of things therefore cannot answer your questions honestly.
Still feel many of these issues exist.
I do not have much specific knowledge other than personal experience. Access and coordination has improved within the expanded Bristol Health Medical Group and new office structure on Main Street. The EMR has helped with coordination also.
The leadership at Bristol Hospital as well as the Board members continue to make all of the above a priority.
Bristol Health primary and specialty care are more visible in the community. Wheeler clinic opened their new headquarters in Bristol which is helping to address mental health and substance use concerns. Fatal opioid overdoses have decreased.
I feel there's been greater awareness and improvement in all these areas.
Wheeler Health opened in downtown Bristol which I think is a huge benefit for our population.
More senior housing has opened up. The Community Health Center now has a van that goes to the local homeless day centers which helps with access to care for that population. Wheeler has one site now which is better for the community.
None.
Access to care & coordination
Senior Health - Bristol has an outstanding Senior Center that offers an environment of inclusion, socializing and acceptance, as well as support services for health care, financial assistance. Strong mental/behavior health emergency care infrastructure at Bristol Health, coupled with a strong partnership between the city and the hospital Still need for additional specialists in certain areas of specialty care, to reduce the

VERBATIM COMMENTS
length of time to receive an appointment, however this will only succeed with a greater pool of specialists in the field, and a more financially feasible government pay model in the state of CT.
Increase in substance abuse and homelessness, mental health issues.
Senior Health and services has been a focus, many more programs for seniors have been but in place.
Chronic Disease Management.
I think progress has been made on all of these areas.
Increased services to our geriatric community through inpt senior behavioral health, increased geriatric providers.
Improvements have been made in all four areas across the board. As needs continue to diversify in terms of management of specific conditions and disease patterns, better attention to implementation may be needed.
There has been an increase in support for dementia patients and caregivers for dementia patients which is appreciated.
Still valid
New addition of a larger wheeler clinic for one stop to care
All of the above, based on the programs and the facilities the hospital has invested in, created and maintained since 2019. However, these needs are so great that I feel like we are just treading water in some areas, especially in the mental/behavioral health and substance misuse category. Access to care and coordination has definitely improved and become more efficient, but there are still some specialties that have long wait times (i.e., dermatology). I worry about our senior population because they can't or won't advocate for themselves sometimes, and may not have someone in their lives who will. I worry that some are invisible and quietly suffering.
Cost of all services has risen dramatically
I believe senior health and services has improved. The others are still barriers.
There seems to be more access to some of these services.
Bristol Health and its partners will use the information gathered through this survey in guiding their community health improvement activities. Please share any other feedback you may have for them.
Applaud the efforts of Bristol health in identifying health needs despite an environment of insufficient reimbursements and poor government support.
The Administration has done an outstanding job to keep Bristol Hospital solvent in a very challenging environment

VERBATIM COMMENTS
<p>To the leadership of Bristol Hospital: You have been a shining star for our community. Your knowledge, your leadership, your true heart and soul have been dedicated to our community. THANK YOU!</p>
<p>Patients who visit the Emergency Department with mental health/substance use concerns are often discharged with referrals to outpatient care. It would improve services significantly if these patients were contacted by a peer support navigator or community health worker who could assure connection to care and address any unmet resource needs. This would not only benefit the patient, but also help manage repeated emergency department use and decrease readmission rates.</p>
<p>I have heard several people say they aren't happy with the services from Bristol Health. Billing issues, lack of empathy from providers, appointments seem like they are only a conversation with the doctor, which people view as just an appointment so the provider can charge a fee, long wait times in the ER when there doesn't appear to be many people there and most importantly it seems like you have to be your own advocate and question tests or the care being provided.</p>
<p>They need to do better. Slow the focus on expansion and bring the focus back to what they used to be good at. I have had to battle with the billing department to come to payment agreements because they would not work with my budget. I have a co-worker who continually receives calls with test results for other patients simply because they have the same name. My elderly parents are having trouble keeping specialty doctors because they leave Bristol Health because those doctors are unhappy and work for another medical group. They too have had issues with their primary care, billing, and being treated with dignity. Essentially, I feel management needs to humble themselves and understand real people are suffering because they want to expand their kingdom instead of providing a wholeistic, comprehensive experience. This is why I won't use Bristol Health for any medical procedures.</p>
<p>Bristol has great support groups and Health Care</p>
<p>Appreciate the expansion in to Southington. Continuing to recruit primary care is vital and creating pipelines for APRNs.</p>
<p>The billing system at the hospital is broken. fix it</p>

APPENDIX E: 2022 CHNA KEY HEALTH PRIORITIES AND IMPLEMENTATION STRATEGY OUTCOMES

2022 IMPLEMENTATION STRATEGY OUTCOMES

Mental and Behavioral Health and Substance Misuse

As an initial effort to promote early recognition of mental health and substance use concerns, the Bristol-Burlington Health District conducted 392 mental health screenings. These screenings served as a vital outreach and education initiative, helping to identify individuals in need and connect them to appropriate services.

Building on this foundation, the organization prioritized increasing access to care by decentralizing behavioral health services and integrating them into Bristol Health's primary care settings. As a result, the number of behavioral health access points expanded from one in 2019 to five by July 2024. This model has improved accessibility, reduced stigma, and supported earlier intervention through community-based care.

In August 2024, Bristol Health began offering lab services at Wheeler Clinic to enhance care for behavioral health patients. At launch, the clinic served approximately 90 patients per month; by December 2024, that number had more than doubled to 188 patients per month, demonstrating increased utilization and improved access.

Additionally, patients seen in the emergency department are provided with behavioral health resources to ensure timely support at critical points of care. A Referral Coordinator role was also added to the organization to strengthen follow-up efforts. The coordinator contacts patients within 48 hours of a referral to confirm appointments and help address any barriers to care.

Between July 16 and December 10, 2024, Community Mental Health Affiliates clinicians conducted 22 visits at the counseling center, serving an average of two patients per month. Together, these efforts reflect a comprehensive, coordinated approach to outreach, early identification, and expanded access to behavioral health services throughout the community.

Furthermore, we continue to support the COBRA program which provides individuals struggling with substance misuse a pathway to treatment while reducing barriers such as transportation and lack of awareness. Through this initiative, BPD officers and EMS personnel engage individuals in crisis, offering treatment options rather than punitive actions.

Bristol Health facilitates referrals through its Emergency Care Center and Behavioral Health services, ensuring that individuals receive timely and comprehensive support. Launched in 2019, the program has continued to grow and serve as a vital component of the community's response to substance misuse.

Currently, 83 EMS personnel and 125 Emergency Department employees support the COBRA program, highlighting the collaborative effort across public safety and healthcare providers to address behavioral health crises with compassion and connection to care.

Chronic Disease Management

The Bristol Community has focused on increasing early detection of chronic diseases and providing ongoing education, with a particular emphasis on hypertension management. Community events offering blood pressure screenings have been a key outreach strategy, with screenings held at nine events in FY 2022, 14 events in FY 2023, and four in FY 2024.

These efforts have contributed to year-over-year improvements in the management of blood pressure among patients diagnosed with hypertension. The percentage of patients meeting blood pressure control goals increased from 72.17% in calendar year 2022 to 76.00% in 2023, and further to 77.06% in 2024. This trend demonstrates progress in managing chronic conditions through early detection and community education initiatives.

In addition, the organization participates in Accountable Care Organizations (ACOs), which emphasize preventive screenings and proactive care management. Through this model, the organization works to close gaps in care related to key preventive clinical health metrics, further supporting early intervention and chronic disease prevention.

Access to Care and Care Coordination

Bristol Health is committed to improving access to care and strengthening care coordination through a wide range of initiatives that address both clinical and non-clinical barriers. Outreach to the community has remained a central strategy, with the Healthy Living column in *The Bristol Press* providing consistent health education on topics such as breast cancer risk, smoking cessation, mental health and aging, sun safety, and foot health. The column published 14 articles in FY22, 25 in FY23, and 17 in FY24. In addition, Bristol Health produced 17 educational segments on Nutmeg TV in FY23 and 19 in FY24 to highlight the expertise of its specialists and promote awareness of available services. Educational efforts were further supported by 35 health-focused social media posts over the past year.

Care coordination has been enhanced through programs like the Better Breathers Group, which meets monthly and is open to the public. This group supports patients with respiratory conditions such as asthma, pneumonia, pulmonary fibrosis, emphysema, COPD, chronic bronchitis, and chronic respiratory failure. Upon discharge, patients with related diagnoses are informed about the group, where specialists present on relevant topics and answer participant questions, promoting continuity of care and patient empowerment.

To ensure sufficient access to specialty care, Bristol Health is actively addressing provider availability. A provider survey was conducted to assess future retirements and departures, and a physician-to-population analysis is underway to inform recruitment strategies. Urology was identified as a corporate recruitment goal for FY2024, illustrating the organization's

proactive approach to maintaining access across service lines.

Recognizing that transportation is a significant barrier to care, Bristol Health collaborated with graduate students from the University of New Haven to analyze payer mix and no-show rates by geographic and socioeconomic factors. This research is intended to uncover gaps in service coverage and identify causes for missed appointments, particularly in primary and specialty care. To support patients with immediate transportation needs, a Lyft ride program is available for those who cannot arrange transportation following appointments or after discharge when no caretaker is present.

These combined efforts reflect Bristol Health’s strategic and patient-centered approach to improving access, coordinating care, and addressing the social determinants that impact health outcomes throughout the community.

Seniors’ Health and Services

Bristol Health remains committed to supporting the health and quality of life of older adults through targeted outreach, specialized care, and community education. Over the past two fiscal years, the organization hosted a total of 27 educational seminars at the Bristol Senior Center—17 in FY23 and 10 in FY24, covering a range of health topics relevant to seniors and their caregivers. These sessions serve as important opportunities to provide practical information, answer questions, and connect residents with local resources.

A key ongoing initiative is the monthly *Dementia Friends* program, which is open to anyone interested in learning what it’s like to live with dementia. The goal of the program is to change the way people think, act, and talk about dementia through education and awareness, empowering the community to better support individuals and families touched by the condition. Another important offering is the Bristol Health Memory Café, launched in January 2020 and held monthly at the Bristol Senior Center. This free, relaxed social gathering is open to individuals experiencing memory loss or cognitive changes, along with their care partners. The Memory Café is designed to create a welcoming environment where individuals living with dementia can feel comfortable and engaged. For caregivers, it offers a valuable opportunity to relax and enjoy time with their loved ones in a supportive, stigma-free setting, focusing on connection rather than the condition.

In addition to educational efforts, Bristol Health has expanded its clinical footprint to meet the growing needs of the senior population. From FY22 to FY24, providers delivered care to over 1,500 patients at Ingraham Manor, offering services that include primary care, psychiatry, pulmonary care, orthopedics, geriatrics, and cardiology. In FY24, services were also extended to Kind Care, where 179 patients were treated, further broadening access to high-quality care for seniors in long-term care settings. We continue to expand our reach with our geriatrician now providing care to the Livewell Alliance residents.

Together, these efforts demonstrate a strong and ongoing commitment to addressing the unique health needs of the senior community through compassionate care, education, and service expansion.

APPENDIX F. 2019 IMPLEMENTATION STRATEGY OUTCOMES

2019 Implementation Strategy Outcomes

Mental Health

Bristol Health has continued work on its 2019 goal of improving mental health to protect the health, safety, and quality of life of Bristol residents. The Bristol Health Counseling Center partnered with Bristol Health Primary Care Physicians to ensure they uphold the expectation that depression screenings are done at least annually on their patients. Kate Maldonado, Bristol Health Medical Group Director of Quality, reports a snapshot of the data received through these depression screenings as part of Bristol Health's Patient-Centered Medical Home (PCMH) applications. Integrated therapy professionals are also embedded in some Bristol Health Primary Care practices. Bristol Health has also launched telehealth services through The Counseling Center to increase access to care for this service line.

Substance Abuse/Alcohol Abuse

The leadership of the Bristol Health Counseling Center serve on and lead numerous committees that address mental health and substance misuse issues in the Bristol community. These include:

- The Mayor's Opioid Task Force
- The Community Care Team which addresses issues and options for patients who frequent the Emergency Department at Bristol Hospital.
- City of Bristol's Recovery Alliance (COBRA) which is a collaboration between Bristol Health, the Bristol/Burlington Health District, and numerous local agencies.

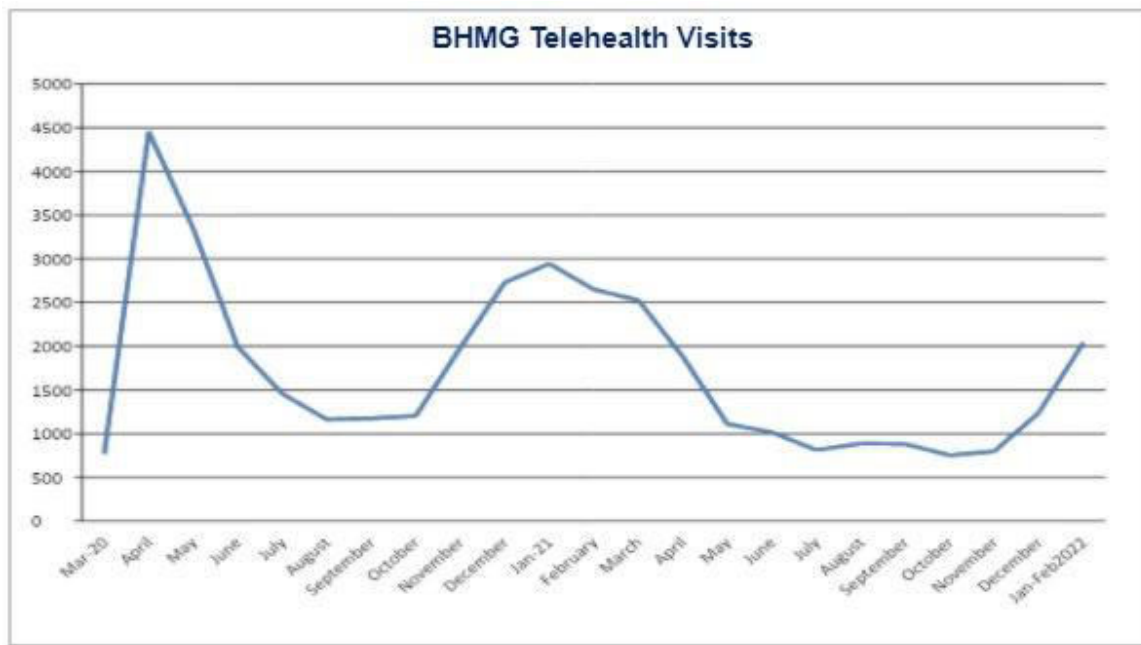
Since 2019, COBRA has added multiple access points for referral to services including Bristol Health Emergency Medical Services (EMS), Bristol Police Department, Bristol Fire Department, and community locations. Bristol Health Primary Care Physicians also perform substance/alcohol screenings on their patients.

Crisis evaluations performed in Bristol Hospital's Brault Emergency Department are not separated by substance/psych. Most pertinent would be crisis data which shows some increase from 2019-2021 but not supported by overall Emergency Department visits for substance/psych reasons.

Access to Care

Bristol Health adopted numerous approaches to increase access to care for the community. Bristol Health was one of the first healthcare organizations in the nation to adopt telehealth services in the Emergency Department. Since adoption, the ED has seen over 1,200 patients virtually from over 60 towns in Connecticut. In 2021, Bristol Health opened the first half of the Brault Emergency Care Center, which features a 12,500-square-foot state-of-the-art addition. The new Emergency Care Center will be completely finalized in 2022 and will include a more comfortable setting for young patients with a dedicated pediatric and behavioral health area.

Bristol Health also leveraged telemedicine through the Bristol Health Medical Group, with nearly 40,000 telehealth appointments completed. The top five telehealth visits included behavioral health, primary care, neurology, pulmonology, and geriatrics.



Since 2019, Bristol Health has intentionally focused on making virtual seminars available to the community. This strategic initiative allowed access to care during the COVID-19 pandemic when live in-person gatherings were not an option. This included bariatric informational seminars, orthopedic surgery classes, COVID vaccine town halls, COVID vaccine registration events, and more. Through this innovative approach, Bristol Health was able to reach over 1,500 community residents per event.

Bristol Health has also consolidated primary care physician offices into a centrally located 60,000-square-foot medical office building in downtown Bristol. This allows patients to have access to primary and specialty care in one convenient location. Since 2019, over 20 providers have joined the medical staff of the Bristol Health Medical Group.

Bristol Health further expanded access to care in our secondary service area, including opening a state-of-the-art medical office building in Southington, Connecticut, that offers primary and specialty care services.

Bristol Health also approached patient barriers for access to care with innovative solutions. For example, the Bariatrics Department created ease of access to care by offering Lyft rides for patients with transportation barriers, the organization provided free valet parking service outside of medical offices, and created templated office schedules that allow for greater flexibility to fill vacant appointment slots and work with the patients on their convenience for visits.

Bristol Health further supported efforts in increasing the proportion of persons with health insurance, including an update of our Financial Assistance Policy. Since 2019, we have worked closely with patients to offer financial counseling. We have seen an increase of 4.04% of patients between 2019 and 2021 who have managed Medicare insurance and a rise of 2.06% of patients who have Medicaid insurance.

Overweight/ Obesity

The Bristol Hospital Weight Loss Surgery Program offers numerous support groups for its patients on such subjects as portion control, getting through the holidays, and making good eating choices. During difficult times of quarantining during the COVID-19 pandemic, the Weight Loss Surgery Team offered telehealth visits for nutrition counseling, behavioral health screenings, and bariatric office visits.

As a result, surgical case volume increased since elective surgeries were paused in 2020, and program intake volume saw a dramatic increase of 127 patients since 2020. Bariatric Surgery maintained quality care to offer patients this positive lifestyle healthcare service.

Initiatives since 2019 include the addition of a virtual pre-operative patient education class, virtual support groups, and the addition of a 1-week post-operation appointment with a provider.

In 2020, Bristol Health developed a Bariatric Surgery Exercise Program on our campus in our Bernie Guida Cardiac Rehab facility. This program offers patients the chance to participate in an evidence-based bariatric exercise class.

Additionally, many strategies have been implemented by our Clinical Nutrition team. Despite a national decrease in volumes of patients seeking this type of care, our Clinical Nutrition Department met the community in outpatient settings and was able to keep volumes above 1,000 visits annually, in addition to virtual telephone and telehealth encounters. Since 2019, bariatric and outpatient nutrition materials have been updated and distributed to patients, offering up-to-date nutritional information and guidance.

During this time, the Bristol Health Public Relations Department, in partnership with Clinical Nutrition, published over 40 articles in local media newspapers to support ongoing community education.

APPENDIX G. 2016 IMPLEMENTATION STRATEGY OUTCOMES

Mental Health and Substance/Alcohol Misuse

Bristol Hospital opened a new Senior Behavioral Health Unit in 2018. The 6,150-square-foot, 15-bed inpatient unit—which includes private and semi-private rooms—is built on Level F of the hospital. The new unit includes a team of behavioral health professionals who assess, diagnose, and treat adults aged 65 and older with acute psychiatric and behavioral disorders. Inpatient care for this population is provided on a 24/7 basis in a safe, comfortable, and secure environment. The team treats patients suffering from such conditions as dementia, depression, severe anxiety, bipolar disorder, and psychosis. The team also addresses medications, dietary needs, family issues and social concerns.

The Bristol Health Counseling Center hosted a free monthly mental health and substance recovery educational series for the community from August 2017 to February 2018. Each session covered a particular subject ranging from depression and anxiety to substance misuse and LGBTQ issues. Additionally, the Counseling Center social worker who coordinated the series previewed each session in a live, in-studio interview on the local FOX affiliate morning show each month.

The leadership of the Bristol Health Counseling Center—Systems Director of Behavioral Health Rebecca Colasanto, LCSW and Operations Manager Lisa Coates, LCSW—are being called upon by the Mayor’s office and other local officials to serve on and lead numerous committees that address mental health and substance misuse issues. These include:

- The Mayor’s Opioid Task Force
- The Community Care Team which addresses issues and options for patients who frequent the Emergency Center of Bristol Hospital
- The newly formed COBRA (City of Bristol’s Recovery Alliance), which is a collaboration between Bristol Health, the Bristol/Burlington Health District and numerous local agencies including the Bristol Police Department. The concept of COBRA is to offer treatment options for those struggling with substance misuse as an alternative to arrest and incarceration.

The Counseling Center staff also received a grant for free community programs that address suicide prevention and Narcan training. Since 2018, the Counseling Center team has coordinated a QPR Suicide training for the community and Bristol Health employees.

In 2019, Rebecca Colasanto, LCSW, was appointed to serve on the State of Connecticut Behavioral Health Partnership Oversight Council. The council is led by the Connecticut General Assembly Speaker House Joe Aresimowicz.

Access to Care

Bristol Health opened a new 60,000-square-foot medical office building at 15 Riverside Ave in downtown Bristol. The building houses an array of medical sub-specialties of the Bristol Health Medical Group including cardiology, endocrinology, neurology, orthopedics, rheumatology, and urology. Additionally, there is dedicated space for laboratory, and physical and occupational therapy services

Since 2016, 66 new providers have joined the medical staff of the Bristol Health Medical Group.

From 2016 – 2019, the Bristol Health Public Relations Department has tripled the number of community events and seminars which offer numerous screenings and educational outreach to the Greater Bristol Community. More than 25,000 local residents have attended these events which include screenings for blood pressure, pulse oxygen, blood sugar, smoking cessation and foot and ankle pain.

Senior Support

In addition to the new Senior Behavioral Health Unit, the Bristol Health Medical Group's Center for Geriatric and Palliative Care —led by Dr. Margarita Reyes—has offered a highly-successful dementia free education series to the community. The monthly six-part series takes place in the summer and fall. Additionally, Dr. Reyes has appeared in a monthly live in-studio interview on the local FOX affiliate in which she previews each session.

To keep pace with a very busy patient roster, the Center for Geriatric and Palliative Care has added geriatric two nurse practitioners.

Dr. Reyes has formed a palliative care program and team with the ability to see patients across health care setting including the hospital, office, home, assisted living and nursing homes. The Bristol home care palliative "special touch" program and hospice team continues to grow in number of patients, social workers, and nurses.

Overweight/Obesity

The Bristol Hospital Weight Loss Surgery Program offers numerous support groups for its patients on such subjects as portion control, getting through the holidays and making good eating choices. The Weight Loss Surgery team also produced and distributed a cookbook that featured dozens of healthy recipes.

As part of a mandatory information session for all patients considering weight loss surgery, a video was produced that educates patients about the program and the surgery options. The video serves as an alternative to the in-person information session and has been tremendously successful. Patients can view the video in their home and at their own convenience.

The Bristol Hospital Parent and Child Center continues to have had great success with its obesity prevention efforts through its set of Family Wellness Programs. The Family Wellness Program's goal is to prevent childhood obesity by promoting family nutrition and healthy physical activity for low-income families with such programs as "Gardening for Health," and "Cooking Matters in the Store." The Parent and Child Center also offers free Zumba and exercise programs for parents and children. Since 2015, more than 500 low-income families have participated in these programs.

APPENDIX H. 2013 IMPLEMENTATION STRATEGY OUTCOMES

Mental Health and Substance/Alcohol Misuse

The Behavioral Health Team at Bristol Hospital hosted a roundtable discussion in January 2014 with approximately 30 community leaders and stakeholders to discuss the issue of mental health and substance/alcohol misuse and how Bristol Hospital can better serve the community. Also in 2014, Bristol Hospital hosted another meeting with numerous stakeholders to address the growing concern of the lack of response, care and resources, and the difficulties associated with getting hospital patients to the lead mental health authority in the area, which is located in New Britain, Connecticut.

In 2015, Bristol Hospital and Wheeler Clinic reached an agreement to further improve behavioral health crisis services for children, adults, and families in the Greater Bristol region. Under the agreement, Wheeler will assume responsibility for Bristol Hospital's Emergency Department Crisis Service from 8 a.m. to midnight, seven days a week, and provide immediate intervention and facilitated connections to community services and resources, including primary and behavioral health care. The Bristol Hospital/Wheeler Clinic partnership continued in 2016 with a community forum on the opioid epidemic in which approximately 75 members of the community attended. Bristol Hospital and Wheeler Clinic also hosted two successful Mental Health First Aid presentations. The eight-hour certification course is designed to help individuals better understand mental health challenges and recovery, and to help respond in appropriate ways to provide help and support. Bristol Hospital also hosted a community event with the Connecticut Department of Mental Health and Addiction Services on the subject of Naloxone.

Access to Care

Since 2013, Bristol Hospital and the Bristol Hospital Multi-Specialty Group have added 74 new medical staff and added 16 new medical offices throughout the community. New service lines have been cultivated to address medical needs within the community, including vascular surgery, wound care, rheumatology, cardiology, orthopedics, spine surgery and sports medicine, and neurology.

Senior Support

Bristol Hospital has increased the number of free screenings offered throughout the community (including the senior center). Free screenings include blood pressure clinics, balance screenings, blood sugar screening, foot screening and nail clinics. The hospital also provides free educational seminars at senior centers on topics such as dementia, living with diabetes, and nutrition and wellness.

Overweight/Obesity

The Bristol Hospital Weight Loss Surgery Program offers numerous support groups for its patients on such subjects as portion control, getting through the holidays and making good eating choices. In 2014, the Weight Loss Surgery program launched its own Facebook page within the Bristol Hospital main Facebook page. This is a members-only page for patients who can share stories, recipes, and advice to their fellow patients, but in a private setting.

The Bristol Hospital Parent and Child Center has had great success since 2013 in its obesity prevention efforts through its set of Family Wellness Programs. The Family Wellness Program's goal is to prevent childhood obesity by promoting family nutrition and healthy physical activity for low-income families with such programs as "Gardening for Health," and "Cooking Matters in the Store." The Parent and Child Center also offers free Zumba and exercise programs for parents and children. Since 2015, approximately 330 low-income families have participated in these programs.

The hospital's actions in support of its heart health implementation strategy:				
	Action	Action Goal	Timeline	Measure
1	Improve Community Access to Heart Health Care	Launch heart-healthy outreach campaigns using social media	Annual Outcome	# of posts about heart health
2	Increase Provider Capacity and Care Delivery	Add new service line locations to expand reach	End of FY2028	Number of locations or departments offering the service line
		Increase providers recruitment based on need from provider succession plan	End of FY2028	Increase # of new providers hired
		Increasing new patient volume and appointment availability	Annual Outcome	# of new patients introduced to the practice
		Increase referrals from other community channels	Annual Outcome	# of referrals received
		Promote Cardiac Rehab through lunch & learns	End of FY2027	Increase use of cardiac rehab
3	Increasing Community Awareness/Engagement	Increase Preventative Health Education (i.e. senior centers, community centers, schools, etc)	End of FY2028	# of senior centers participated
		Partner with Nutmeg TV and clinicians to air educational segments regarding heart health	End of FY2028	# of segments completed on heart health
		Partner with Wheeler Clinic for community screenings and educational programs	End of FY2028	# of participants attending screenings/educational sessions
4	Increase Population Knowledge and Education about Resources Available, Symptoms, etc	Host heart-healthy activities and education material at Bristol Public Schools	End of FY2028	# of heart-healthy activities provided in Bristol Schools
		Host virtual webinars to educate the community on preventative care, how to identify symptoms, etc.	End of FY2028	# of webinars hosted
5	Increase Knowledge of Food Nutrition and Diet on the Population's Overall Health	Increase real time education about healthy foods	End of FY2028	% increase in participants' knowledge of healthy foods (pre/post questions or quick surveys).
		Host Teaching Kitchens by Bristol Health staff to inform community about healthy and affordable recipes	End of FY2028	# of teaching kitchens hosted
		Create resource packets (Diets, guidance, recipes) given at discharge	End of FY2028	# of packets handed out to patients

The hospital's actions in support of its stroke care implementation strategy:

	Action	Action Goal	Timeline	Measure
1	Achieve Stroke-Ready Designation	Stroke Ready Hospital Certification (quality metrics)	End of FY2026	Get Stroke Ready Certified
2	Increase Provider Capacity	Increase Providers Recruitment based on need in provider succession plan	End of FY2028	Increase # of new providers hired for neurology
		Use marketing tools to educate community on resources BH has for stroke care	End of FY2027	# of stroke-related posts
3	Strengthen Stroke Prevention and Early Identification through Community Outreach	Use marketing tools to interact with community and test knowledge of stroke symptoms	End of FY2028	# of tools created
		Host stroke-prevention talks at senior centers and community spaces.	End of FY2028	# of talks completed / # of attendees
		Work with Nutmeg TV to run stroke awareness segments.	End of FY2028	# of segments completed on stroke care
		Run stroke-awareness events during Stroke Awareness Month (May) and World Stroke Day (Oct 29).	Annual Outcome	# of touch points in the community and at BH
4	Improve Stroke Response and Treatment Access	Provide staff training on early recognition	End of FY2028	# of training sessions hosted / Pre/post quiz score improvement
		Increase responses and treat number of stroke calls from EMS	End of FY2028	EMS Data Tx - number of stroke calls came to BH or bypass BH

The hospital's actions in support of its pulmonary services implementation strategy:

	Action	Action Goal	Timeline	Measure
1	Increase Identification of Pulmonary Disease by Clinicians	Increase the number of of patients receiving Pulmonary Function Test	End of FY2028	Increased code/procedure being completed and comparing # to previous years
		Provide education to current and newly hired clinicians on primary care test order and referrals.	End of FY2028	# of providers educated during onboarding
2	Increase Pulmonary Health of Current Patients	Improve discharge care plans for patients with proper instruction, warnings, education	End of FY2028	Decreased # of readmissions
		Increase capture rate for Transitional Care Management	Annual Outcome	Increased capture rate
		Increase awareness and attendance of Better Breathers (Support) Group	Annual Outcome	# of messages sent through ECW
3	Increase Smoking Cessation Programs for the Community	Use social media and marketing to define what smoke is and what is included in the products	End of FY2028	# of social media posts
		Provide pulmonary health education in local schools about marijuana/vaping/smoking	End of FY2028	# of lessons taught / Pre/post quiz score improvement
		Run smoking cessation events during National Smoking Cessation Month (November)	Annual Outcome	# of touch points hosted in the community and at BH
4	Increase Community Education on Pulmonary Health	Conduct medication education for adults and children on inhaler use at medical visits	Annual Outcome	# of educational pamphlets handed out / # of pts receiving education re: med usage
		Partner with Nutmeg TV and clinicians to air educational segments regarding pulmonary health	End of FY2028	# of segments completed on pulmonary health

The hospital's actions in support of its care coordination/ health literacy implementation strategy:

	Action	Action Goal	Timeline	Measure
1	Reduce High-Risk Adolescents Behaviors and Increase Education on Decision-Making and Preventative Care	Host activities and provide education material at Bristol Public Schools on decision-making, substance use, and mental health awareness	End of FY2028	# of decision-making activities hosted at Bristol Public Schools
		Use digital media to post youth-focused communication materials and available services	End of FY2028	# of posts made
	Expand Transitional Care Management Program	Increased patient education on TCM	End of FY2028	Increase # of pts to see provider within 14 days
3	Optimize Referral Process and Specialist Coordination	Conduct meetings and review data with specialty partners biannually to discuss workflow gaps and barriers	Annual outcome	# of meetings completed
		Use EMR capabilities to ensure care coordination between primary care and specialty care	End of FY2028	# of in-process and completed referrals using EMR monitoring
4	Increase communication to external partners	Standardized biannual communication briefs with new updates and recruitment	Annual outcome	# of emails sent
5	Increase Knowledge of Chronic Conditions	Use EMR to reach out to patients on diagnosed conditions	Annual outcome	Trackable data on campaign engagement
		Work with Nutmeg TV to run health literacy segments.	End of FY2028	# of segments completed on health literacy
6	Annual Wellness Visit Campaign	Send messages through EMR to remind eligible patients to schedule appointments	Annual outcome	# of recurrent patients scheduled
		Complete front-end staff training for scheduling optimization	End of FY2028	# of trainings completed
7	Advanced Care Planning and Patient Insurance Education Initiative	Integrate advanced care planning discussions into annual wellness visits	Annual outcome	# of provider advanced care planning trainings completed
8	Medication Therapy Management Program	Offer consultation with pharmacist to have patients review and discuss medications	Annual outcome	# of patients participating in the program