About the 2022 CHNA and Partners

The Health Improvement Alliance together with Bridgeport Hospital, St. Vincent’s Medical Center, and their community partners conduct a Community Health Needs Assessment (CHNA) every three years. The 2022 CHNA was a community-wide undertaking with extensive data collection and input from community residents, health and social services experts, and people who serve our community every day.

The 2022 CHNA was conducted in collaboration with the Health Improvement Alliance, a coalition of community based organizations that serve the Greater Bridgeport region of Connecticut and are committed to broad collaboration and meaningful community engagement to improve the health and wellbeing of residents across Greater Bridgeport. A list of the member organizations is included on page 38.

The CHNA tracks the health and wellbeing of our community and monitors the social and environmental factors that influence health outcomes. These data illuminate health disparities across population groups and geographies and help us direct resources to advance health equity. Through the CHNA, we confirmed our understanding of community health priorities, and gathered new insights toward collaborative solutions.

Conducting the CHNA during the COVID-19 pandemic offered a unique view of our community’s resources and needs. We saw the strength of our community come together to help one another. We witnessed innovative and swift responses to a health and economic crisis. We also documented gaps in our service delivery systems that reflect longstanding inequities in our society.

The triennial CHNA presents an opportunity to measure our progress toward equity, and to foster new partnerships and opportunities for collaboration. The information learned from the CHNA guides our collective work toward improving health and wellbeing, and advancing health equity so that all residents can benefit from the resources in our community.

We must work together as a community to develop collaborative solutions for these complex challenges. Making measurable progress will take time, but we continue to make significant strides every day.

Our CHNA research included:

- **Analysis of Health and Socioeconomic Data**
  Public health statistics, demographic and social measures, and healthcare utilization data were collected and analyzed to develop a comprehensive community profile.

- **Community Survey of Lived Experiences**
  As part of the DataHaven Community Wellbeing Survey across Connecticut, a telephone survey was conducted with community residents to document lived experiences and personal perspectives of health and wellbeing.

- **Key Informant Survey and Interviews**
  Surveys and interviews were conducted with key informants to better understand the impact of COVID-19 on the community and diverse populations.

- **Input on Priority Health Needs from Community Representatives**
  We asked residents from diverse communities what they saw as priority health needs, and how those issues impact their day-to-day lives.

- **Input from Experts and Key Stakeholders**
  Health and social service providers, public health experts, and representatives from a wide range of community-based organizations participated in the CHNA to guide the process and provide their expertise on community health needs.

The 2022 CHNA was conducted from March 2021 to June 2022 and aligned with IRS Code 501(r) requirements for not-for-profit hospitals to conduct a CHNA every three years as well as Connecticut state requirements for hospital community benefit reporting.
Creating a world of difference in the healthcare we provide today and our support of the community.

About the Health Improvement Alliance (HIA)

The Health Improvement Alliance (HIA) established in 2003, works to address the health needs of the Greater Bridgeport community, which includes Bridgeport, Easton, Fairfield, Milford, Monroe, Stratford, and Trumbull. HIA is a coalition of two neighboring hospitals, Bridgeport Hospital and St. Vincent’s Medical Center, along with the seven departments of health, federally qualified health centers, and about 50 community and non-profit organizations all serving the Greater Bridgeport Region.

HIA partner organizations work together to identify, prioritize, and measurably improve the health of the community through prevention, education, and services. HIA has a steering committee and four task forces that collaborate to address the health priorities identified through the Community Health Needs Assessment (CHNA). These task forces consist of representatives from partner organizations and those interested in improving the health of the community through collaboration.
Greater Bridgeport Area of Connecticut consists of the towns of:

<table>
<thead>
<tr>
<th>Town</th>
<th>Life Expectancy in Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgeport</td>
<td>77.6</td>
</tr>
<tr>
<td>Easton</td>
<td>83.4</td>
</tr>
<tr>
<td>Fairfield</td>
<td>82.3</td>
</tr>
<tr>
<td>Milford</td>
<td>80.1</td>
</tr>
<tr>
<td>Monroe</td>
<td>81.6</td>
</tr>
<tr>
<td>Stratford</td>
<td>79.6</td>
</tr>
<tr>
<td>Trumbull</td>
<td>82.4</td>
</tr>
</tbody>
</table>

Population by Race and Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>Bridgeport</th>
<th>Greater Bridgeport</th>
<th>Connecticut</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>56%</td>
<td>56%</td>
<td>68%</td>
</tr>
<tr>
<td>Black</td>
<td>16%</td>
<td>16%</td>
<td>5%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>21%</td>
<td>7%</td>
<td>10%</td>
</tr>
<tr>
<td>Other</td>
<td>7%</td>
<td>7%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Percentages of Population by Age Groups

- **Under 5**: Bridgeport: 6%, Greater Bridgeport: 6%, Connecticut: 6%
- **5 to 19**: Bridgeport: 21%, Greater Bridgeport: 20%, Connecticut: 19%
- **20 to 44**: Bridgeport: 41%, Greater Bridgeport: 38%, Connecticut: 31%
- **45 to 64**: Bridgeport: 31%, Greater Bridgeport: 31%, Connecticut: 28%
- **65 and older**: Bridgeport: 31%, Greater Bridgeport: 28%, Connecticut: 17%
Food Insecurity

- 17% Received food from emergency services during COVID-19 Pandemic
- 29% Low availability of affordable high-quality fruits and vegetables

Housing

- Renters cost-burdened household 58%
- Home ownership 59%

Economic Stability

- 11.5% People below poverty level
- 15% No reliable transportation
- 32% Financially difficult or just getting by
- 15% Still be in debt if sold all major possessions and turned them into cash to pay off debts

<table>
<thead>
<tr>
<th>Town</th>
<th>Median Household Income $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easton</td>
<td>157,448</td>
</tr>
<tr>
<td>Fairfield</td>
<td>139,122</td>
</tr>
<tr>
<td>Trumbull</td>
<td>122,451</td>
</tr>
<tr>
<td>Monroe</td>
<td>118,669</td>
</tr>
<tr>
<td>Milford</td>
<td>91,799</td>
</tr>
<tr>
<td>Stratford</td>
<td>79,430</td>
</tr>
<tr>
<td>Connecticut</td>
<td>78,444</td>
</tr>
<tr>
<td>Bridgeport</td>
<td>46,662</td>
</tr>
</tbody>
</table>
A profile of the health and social factors that impact health and wellbeing in the Greater Bridgeport Community.

**Educational Attainment**

<table>
<thead>
<tr>
<th></th>
<th>Bridgeport</th>
<th>Greater Bridgeport</th>
<th>Connecticut</th>
</tr>
</thead>
<tbody>
<tr>
<td>No High School Diploma</td>
<td>24%</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>High School or Some College</td>
<td>58%</td>
<td>50%</td>
<td>51%</td>
</tr>
<tr>
<td>Bachelor’s Degree or More</td>
<td>19%</td>
<td>38%</td>
<td>39%</td>
</tr>
</tbody>
</table>

**COMMUNITY WELLBEING**

Community Perspective of Living in Greater Bridgeport

- **84%**: Satisfied with their city or area
- **65%**: Think it is a good place to raise kids
- **66%**: Report it is safe to walk at night

**Self-Reported Health, Life Satisfaction, and Happiness**

- Good Health: Bridgeport 42%, Greater Bridgeport 55%, Connecticut 58%
- Life Satisfaction: Bridgeport 48%, Greater Bridgeport 61%, Connecticut 66%
- Happiness: Bridgeport 60%, Greater Bridgeport 66%, Connecticut 68%

Sources: DataHaven Community Wellbeing Survey 2021; Centers for Disease Control and Prevention 2019; American Community Survey 2015-2019
Health Risk Factors

Adults never exercise
- Bridgeport: 26%
- Greater Bridgeport: 19%
- Connecticut: 19%

Adults experiencing obesity
- Bridgeport: 44%
- Greater Bridgeport: 32%
- Connecticut: 30%

Self-Reported Chronic Diseases

- Diabetes
  - Bridgeport: 13%
  - Greater Bridgeport: 10%
  - Connecticut: 10%

- Hypertension
  - Bridgeport: 34%
  - Greater Bridgeport: 31%
  - Connecticut: 31%

- Heart Diseases
  - Bridgeport: 6%
  - Greater Bridgeport: 5%
  - Connecticut: 6%

- Asthma
  - Bridgeport: 25%
  - Greater Bridgeport: 20%
  - Connecticut: 17%

- Depression
  - Bridgeport: 34%
  - Greater Bridgeport: 31%
  - Connecticut: 34%
A profile of the health and social factors that impact health and wellbeing in the Greater Bridgeport Community.

Sources: DataHaven Community Wellbeing Survey 2021; Centers for Disease Control and Prevention 2019; American Community Survey 2015-2019

**Healthy Lifestyles**

- **Greater Bridgeport Overall**
  - Obesity: 32%
  - Hypertension / High Blood Pressure: 31%
  - Diabetes: 10%

- **Black / African Americans**
  - Obesity: 48%
  - Hypertension / High Blood Pressure: 42%
  - Diabetes: 14%

- **Hispanics**
  - Obesity: 39%
  - Hypertension / High Blood Pressure: 26%
  - Diabetes: 8%

- **Whites**
  - Obesity: 26%
  - Hypertension / High Blood Pressure: 30%
  - Diabetes: 10%

**Access to Care**

- **Didn't Get Needed Medical Care**
  - Whites: 12%
  - Hispanics: 13%
  - Black/African Americans: 10%
  - Greater Bridgeport Overall: 11%

- **No One Person or Place as Primary Care Practitioner**
  - Wizards: 19%
  - Hispanics: 11%
  - Black/African Americans: 14%
  - Greater Bridgeport Overall: 10%

- **No Annual Dental Visit**
  - Whites: 26%
  - Hispanics: 33%
  - Black/African Americans: 37%
  - Greater Bridgeport Overall: 30%
### Behavioral Health

**Graph:***
- Not Received Needed Emotional/Social Support:
  - Whites: 7%
  - Hispanics: 17%
  - Black/African Americans: 25%
  - Greater Bridgeport Overall: 14%
- Feel Mostly or Completely Anxious:
  - Whites: 11%
  - Hispanics: 25%
  - Black/African Americans: 20%
  - Greater Bridgeport Overall: 16%
- Report Being Depressed or Hopeless:
  - Whites: 33%
  - Hispanics: 46%
  - Black/African Americans: 33%
  - Greater Bridgeport Overall: 34%

### Drug Overdose Death Rate Per 100,000 People
- Bridgeport: **46.0**
- Greater Bridgeport: **31.6**
- Connecticut: **35.2**

### Child Wellbeing

- **74%** pregnant women accessing prenatal care in the 1st trimester
- **65%** adults reporting they think their neighborhood is a good place to raise children

### Percentage of Infants and Toddlers Enrolled in High Quality Early Care and Education:

**27.2%**
A closer look at the factors that influence health in our community.

Social Drivers of Health

Social drivers of health (SDoH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.¹

SDoH are grouped into five domains that include factors like receiving timely healthcare; living in safe neighborhoods with transportation options; having nutritious food to eat; feeling valued and treated with respect; and having access to quality learning opportunities. The quality and availability of these “place-based” inputs directly contribute to health outcomes that can be measured in higher rates of disease and years of life lost.

By addressing each of these domains, we can dismantle longstanding inequities in our society and rebuild a healthier community for all people.

1 World Health Organization who.int

What is Health Equity?

Health equity means everyone has a fair and just opportunity to be as healthy as possible.

To achieve health equity we need to focus efforts on the “upstream” factors like social drivers of health, and we need to acknowledge racism and discrimination as root causes of inequity.
Socioeconomic and Health Disparities by Race and Ethnicity

The impact of social drivers of health and underlying inequities can be seen in health disparities experienced within population groups and in neighborhoods. These disparities are often the result of historical structural barriers that have prevented equal access to opportunity through racism and discrimination.

Using tools like the Community Needs Index (right), supports place-based investments in people and neighborhoods to reduce disparities and advance health equity.

Describe your community:
“A very ethnically, socio-economically and religiously diverse community that is very divided by geographical sub-areas within the town.” —Community Member

Diversity enriches communities.

Communities benefit from embracing diversity of race, language, culture, identity, and perspectives. Different backgrounds and lived experiences contribute new ideas for solving longstanding challenges. In conducting the CHNA, significant efforts were made to collect input from people from all walks of life across our community and representatives of organizations that serve distinct populations.

Inviting diverse input from community stakeholders, we heard that we need more healthcare and social service providers who reflect the different cultural backgrounds, perspectives, and values of residents. Our community health improvement plan outlines ways we are pursuing strategies to advance Diversity, Equity, Inclusion, and Belonging (DEIB) across our organizations and within our community.
Healthcare Access and Quality

Availability of high quality healthcare, receiving services when you need them, and being able to afford care are some of the key factors associated with this social driver of health domain.

As shown in the Provider Availability chart below, the Greater Bridgeport community is generally well served by healthcare providers, but not all residents are benefiting from these resources. In the Greater Bridgeport community, Hispanic residents are most likely to report not receiving care when they need it.

Lack of health insurance is one barrier that keeps people from accessing healthcare. Without health insurance residents are less likely to receive preventive care like health screenings and may postpone treatment.

About 16% of Hispanic residents in the Greater Bridgeport area report not having health insurance, approximately 2-3 times higher than their White and Black/African American neighbors.

Lack of Health Insurance vs. Access to Care (didn’t get needed healthcare)

Source: DataHaven Community Wellbeing Survey 2021

Social Drivers of Health: Health and Healthcare
COVID-19 Impact in Our Community

The 2022 CHNA was conducted during the COVID-19 pandemic, which created unprecedented health and socioeconomic challenges for people across the Greater Bridgeport community, and the world. COVID-19 demanded equal measure in response from healthcare, social services, government, businesses, families, and individuals.

**COVID-19 exacerbated existing disparities within the health and social service systems and exposed long-standing inequities in power and socioeconomic opportunities within our society.**

COVID-19 did not impact all people equally. The graph below shows that Hispanic, Black/African American, Indigenous, and other People of Color (BIPOC) experienced disproportionately higher deaths due to COVID-19 relative to their overall population distribution. That means even though more White people died from COVID-19, a larger proportion of BIPOC populations died from COVID-19 than did White people.

This trend illuminated wider disparities in health outcomes for these populations and reflects structural factors like racism, lower wages, limited educational opportunities, inadequate housing, and unsafe working conditions, among other factors that contribute to higher rates of COVID-19 and poorer health outcomes from other diseases.

The dual impact of the COVID-19 pandemic and social justice movement helped shine a light on these disparities and the underlying inequities within our communities. Data tools like the COVID-19 Community Vulnerability Index (CCVI) were used to predict what communities could be most at-risk for high COVID-19 spread and infection.

### 2019-2022 Population Distributed COVID-19 Deaths by Race, Ethnicity in Connecticut

*Source: Centers for Disease Control and Prevention*

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>% of Population Distributed</th>
<th>% of Populations Classified as Very High or High Vulnerability for COVID-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>-12.9%</td>
<td>43%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>-4%</td>
<td>40%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>7.8%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Asian</td>
<td>-12%</td>
<td>12%</td>
</tr>
</tbody>
</table>

*Source: Sergo Ventures, https://www.precisionforcoviddata.org*
Social Drivers of Health: Economic Stability

Economic Stability

Having enough money to afford food, housing, healthcare, and daily needs is essential to wellbeing. Community representatives and individual residents alike told us that economic security was among the top needs in our community.

“All the prices went up, but my income is not going up.” – Community Member

Meet ALICE (Asset Limited, Income Constrained, Employed)
The ALICE Index represents the working poor, based on local cost of living. ALICE households have income above the poverty level, but not enough to meet all their basic needs.

Families and individuals whose economic means are just above the poverty level struggle to keep afloat. These individuals are Asset Limited, Income Constrained, Employed or ALICE. They make too much money to receive significant social assistance, but are one financial crisis away from falling into poverty. ALICE households were some of the most economically impacted by the COVID-19 pandemic.

Shown in this graphic, life expectancy is lower in communities with higher household economic instability. Bridgeport has the lowest life expectancy and the highest populations in poverty and ALICE households.

Percent of Population Below 100% Poverty, ALICE Households and Life Expectancy by Geography

Source: American Community Survey 2015-2019; United for ALICE

Key measures of economic stability are:
+ Home ownership
+ Housing cost burden
+ Food security
Survey respondents who perceived that they will “be in debt” if they were to sell all of their assets, and turned them into cash to pay off all of their debts.

Source: DataHaven Community Wellbeing Survey 2021

“My pay has not grown with the cost of living, every month I dive deeper into savings.” – Community Member

Homeownership, Cost-burdened Renters and Children in Poverty by Geography

Source: American Community Survey 2015-2019

In Greater Bridgeport communities with a higher percentage of homeownership, there is a lower percentage of children in poverty.

“We need to keep people in their homes and the utilities on.” – Community Resident

*Cost-burdened is defined as spending 30% or more of income on housing.*
Social Drivers of Health: Economic Stability

Home Ownership, Housing Cost Burden

Owning a home is an investment. For many families, their home is their largest asset. People need to have resources to purchase and maintain a home, so it’s not surprising that people with less household income are less likely to own their home. However, clear disparities among racial and ethnic groups point at inequities that go beyond income. Only one third of Black/African American residents and less than one half of Hispanic residents own their home—compared to nearly three fourths of White residents.

Practices like red-lining allowed, and enforced, community segregation and created economic inequities that can be seen today in disproportional homeownership among communities of color.

Equitable homeownership is important to building healthy communities. Having safe and appropriate housing is a key factor in one’s health. Neighborhood stability influences investments in community infrastructure, such as schools, roads, public transportation, and green spaces, creating a healthier environment for everyone.

Survey respondents who stated that they own their own home.
Source: DataHaven Community Wellbeing Survey 2021

Housing Insecurity vs. Prevalence of Asthma

Source: DataHaven Community Wellbeing Survey 2021

Our home environments impact our health. The graphics below show the relationship between inadequate housing and asthma. Lower income households, Hispanic residents, and Black residents are more likely to have inadequate housing and experience higher rates of asthma.
Food Security

Food security depends on many factors including the type of food that is available in neighborhoods, the local cost of food, and the amount of household resources available to spend on food. Easy access to fresh foods is an important component of healthy living. In the Greater Bridgeport area, there are wide disparities by race, education and income among households who needed food assistance. More than 1 in 4 households in the city of Bridgeport reported food security problems.

Survey respondents who stated that they had times in the past 12 months when they did not have enough money to buy food that they or their family needed.

Source: DataHaven Community Wellbeing Survey 2021

Food Insecurity vs. Diabetes

The inability to afford healthy food impacts health. The graph below shows the relationship between food affordability and prevalence of diabetes. People who are more likely to report struggling with diabetes are also more likely to report struggling to afford healthy food.

Survey respondents who stated that they or any other adult in their household received groceries or meals from a food pantry, food bank, soup, kitchen, or other emergency food service since February 2020.

Source: DataHaven Community Wellbeing Survey 2021

“It’s difficult to have healthy food when there isn’t enough money. Sometimes it’s cheaper to buy unhealthy food.” – Community Member
In addition to the resources available in communities, the physical environment and infrastructure of neighborhoods impact health. The availability of good schools, well-maintained roads, public transportation, green spaces, healthy environments, technology, and public safety promotes or hinders good health.

COVID-19 brought issues like access to high speed internet to the forefront as people needed reliable technology for school, work, health, and social connections.

Public transportation is essential to ensuring people can get to work, and the services that are available in their community. Safe neighborhoods and having access to free or low-cost recreational activities promotes physical activity and social engagement, which contribute to healthy bodies and minds.

In the Greater Bridgeport community, residents in the city of Bridgeport report the most needs for infrastructure investments.

### The Digital Divide
Source: American Community Survey 2015-2019

During COVID-19 we were able to use technology to bring services to people in their homes, but we need to bridge the wide digital divide within our communities to effectively reach all residents.

<table>
<thead>
<tr>
<th>Internet Access by Location</th>
<th>Internet Subscription (any)</th>
<th>Broadband Subscription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgeport (lowest)</td>
<td>79.0%</td>
<td>78.7%</td>
</tr>
<tr>
<td>Easton (highest)</td>
<td>95.7%</td>
<td>95.7%</td>
</tr>
<tr>
<td>Greater Bridgeport</td>
<td>85.2%</td>
<td>84.9%</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>88.8%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>85.9%</td>
<td>85.5%</td>
</tr>
<tr>
<td>US</td>
<td>83.0%</td>
<td>82.7%</td>
</tr>
</tbody>
</table>

### Built Environment vs. Physical Activity
Source: DataHaven Community Wellbeing Survey 2021

Households with higher income levels are more likely to have affordable recreation options and be more physically active. Hispanic and Black households have less access to available recreation options and report less physical activity than White households.
Survey respondents who perceived that the condition of public parks and other public recreational facilities was “good” or “excellent”

Source: DataHaven Community Wellbeing Survey 2021

Survey respondents who stated that there have been times in the past 12 months when they stayed home when they needed to go someplace because they had no access to reliable transportation.

Source: DataHaven Community Wellbeing Survey 2021

Survey respondents who stated that they “very often” or “fairly often” have access to a car when they need it

Source: DataHaven Community Wellbeing Survey 2021

Survey respondents who perceived that the availability of affordable, high-quality fruits and vegetables was “good” or “excellent”

Source: DataHaven Community Wellbeing Survey 2021
Education Access and Quality

Education is one of the best predictors of good health and long life.

Throughout most of the Greater Bridgeport area, nearly all teens graduate from high school on time, exceeding the statewide average. However, recent graduation rates for the Bridgeport School District continue to be much lower than surrounding communities. This measure, combined with lower post-secondary education attainment for Black and Hispanic adults, points to systemic barriers that contribute to a cycle of inequity.

Did you know: Higher levels of education create access to a wider range of employment opportunities, leading to increased access to healthy living resources, including health insurance and transportation.

High School Graduation Rate, Greater Bridgeport Area School Districts 2020-2021 School Year
Source: CT State Department of Education (SDE), 2020-2021

*Easton is part of Regional School District 09 (ER9) that includes both Easton and Redding students.

Equity in Education

Availability of accessible, well-funded, and well-resourced public education opportunities and exposure to diverse employment pathways, such as in the healthcare and social services fields, increase the opportunity for upward mobility, economic security, and better health outcomes.

% of Population Age 25+ with Bachelor’s Degree or Higher by Race/Ethnicity
Source: American Community Survey 2015-2019

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
<th>Asian</th>
<th>Two or more Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgeport</td>
<td>22.2%</td>
<td>17.5%</td>
<td>8.0%</td>
<td>42.6%</td>
<td>19.0%</td>
</tr>
<tr>
<td>Easton</td>
<td>63.9%</td>
<td>0.0%</td>
<td>55.7%</td>
<td>59.5%</td>
<td>96.8%</td>
</tr>
<tr>
<td>Fairfield</td>
<td>67.7%</td>
<td>40.7%</td>
<td>47.3%</td>
<td>62.6%</td>
<td>51.1%</td>
</tr>
<tr>
<td>Milford</td>
<td>41.6%</td>
<td>31.6%</td>
<td>46.8%</td>
<td>64.6%</td>
<td>49.4%</td>
</tr>
<tr>
<td>Monroe</td>
<td>49.5%</td>
<td>60.7%</td>
<td>23.4%</td>
<td>56.5%</td>
<td>38.9%</td>
</tr>
<tr>
<td>Stratford</td>
<td>34.6%</td>
<td>26.8%</td>
<td>20.4%</td>
<td>58.6%</td>
<td>36.0%</td>
</tr>
<tr>
<td>Trumbull</td>
<td>55.4%</td>
<td>47.5%</td>
<td>38.9%</td>
<td>67.6%</td>
<td>40.9%</td>
</tr>
<tr>
<td>Greater Bridgeport</td>
<td>44.1%</td>
<td>20.6%</td>
<td>14.3%</td>
<td>57.0%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>53.1%</td>
<td>23.1%</td>
<td>18.6%</td>
<td>69.2%</td>
<td>37.1%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>41.9%</td>
<td>21.3%</td>
<td>17.3%</td>
<td>65.8%</td>
<td>31.0%</td>
</tr>
<tr>
<td>US</td>
<td>33.5%</td>
<td>21.6%</td>
<td>16.4%</td>
<td>54.3%</td>
<td>31.9%</td>
</tr>
</tbody>
</table>
Diversity of race, language, culture, and perspective enriches communities.

As much as communities are shaped by those who live there, people are impacted by the social context of the places where they live. Social context includes family, neighborhoods, school and work environments, political or religious systems, and other interpersonal infrastructures within a community. People’s lived experiences within their social context play a significant role in good health and wellbeing.

Feeling like you belong, are appreciated, and are valued in your community reinforces protective health factors that help people and communities overcome adversity. Poverty, violence, poor housing, racism, and discrimination create Adverse Community Environments that perpetuate trauma and increase Adverse Childhood Experiences (ACEs) that have lasting impact on people and their communities.

Across the Greater Bridgeport area, people identifying as Black/African American or Hispanic were more likely to feel they were treated with less respect than others when seeking healthcare, but residents of all races reported similar experiences of unfair treatment at work.

Survey respondents who perceived that at any time in their life, they have been unfairly fired, unfairly denied a promotion, or raise, or not hired for a job for unfair reasons.

Survey respondents who perceived that, when seeking healthcare, they have been treated with less respect or received services that were not as good as what other people get.*
Determining Priority Health Needs

To determine community health priorities, we must consider what the data show, and more importantly, what our community sees as the most pressing health concerns.

Community engagement was a central part of the CHNA. We invited wide participation from community members and organizations, including experts in health, social service representatives, advocates, community champions, policy makers, and lay community residents. These stakeholders were asked to weigh in on data findings, share their perspectives on challenges facing our community, and provide input on collaborative solutions.

The CHNA data and stakeholder input reinforced that the areas we’ve been focused on are still the most pressing needs in our community. Through community conversations, we asked how residents experience these issues in their day to day lives, and how we could do a better job helping them to live a healthier life.

Residents shared their attitudes and experiences about community needs most important to them through a telephone survey of 400 households and community surveys with 131 diverse community residents across Greater Bridgeport.
## Determining Priority Health Needs

### What you told us:

+ We need to help all people benefit from our community’s robust health and social services. Many people are not aware of these resources or cannot access them.
+ We need to increase opportunities for community members to share lived experiences and participate in collaborative solutions to community challenges.
+ We need to grow trust in the healthcare system and that starts with honoring diversity and ensuring equitable delivery of services.

### How we will respond:

We developed a Community Health Improvement Plan (CHIP) to guide our efforts in responding to our community’s needs. Using recommendations from the people who deliver and use these services, we will foster collaboration to better coordinate our community resources. We will seek to better connect people to the services they need and reduce disparities in health and socioeconomic measures that stem from underlying inequities in our society.

The following pages highlight key findings from the CHNA that support community health priorities and how we are addressing these concerns.

---

### In your words

**The top issues impacting our community are:**

+ Affording food
+ Affording medical care, prescriptions, and supplies
+ Education
+ Financial security (paying bills, etc.)
+ Mental health
+ Drugs and Alcohol

These needs are in line with requests for services to the 211 referral system.

---

### Top Requested Services* to 211 Referral System

<table>
<thead>
<tr>
<th>Need Category</th>
<th># of times requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Housing &amp; Shelter</td>
<td>15,615</td>
</tr>
<tr>
<td>2 Mental Health &amp; Addictions</td>
<td>4,801</td>
</tr>
<tr>
<td>3 Utilities</td>
<td>2,738</td>
</tr>
<tr>
<td>4 Employment &amp; Income</td>
<td>2,659</td>
</tr>
<tr>
<td>5 Food</td>
<td>1,943</td>
</tr>
<tr>
<td>6 Government &amp; Legal</td>
<td>1,776</td>
</tr>
<tr>
<td>7 Clothing &amp; Household Goods</td>
<td>331</td>
</tr>
<tr>
<td>8 Transportation Assistance</td>
<td>281</td>
</tr>
<tr>
<td>9 Disaster</td>
<td>243</td>
</tr>
<tr>
<td>10 Child Care &amp; Parenting</td>
<td>103</td>
</tr>
</tbody>
</table>

*This list excludes requests for other healthcare services.*

---

Did you know you can dial “2-1-1” on any phone or visit uwc.211ct.org to connect to all kinds of services across our community?
Access to Care

The Greater Bridgeport area has robust, engaged, and high quality healthcare and social services that are essential components to ensuring health and wellbeing in our community.

However, not all of our residents benefit from these community resources. The data show wide disparities among communities of color and those with lower incomes in receiving the services they need, when they need them. We need to address social drivers of health as the root causes of these disparities and a reflection of the underlying inequities within our society.

As health and social service providers we are doing this by bringing care to people in their neighborhoods through the use of community health workers and technology. We continue to provide free and low cost services regardless of ability to pay. We are working to better reflect the populations we serve through staffing, language capabilities, and honoring diverse people and cultures.

We asked healthcare and social service providers about how COVID-19 will continue to impact our communities. This is what they told us:

+ Postponed care during the pandemic has led to greater acuity in need or disease
+ Providers are experiencing a backlog of patients, higher acuity, and longer wait times
+ Staff shortages are reducing capacity of health and human services, childcare, and education institutions
+ Loss of trust in healthcare and government are keeping people from proactively seeking services
+ We need to re-establish positive relationships among residents of all ages

Survey respondents who stated that they do not have one person or place they think of as their personal doctor or healthcare provider

Source: DataHaven Community Wellbeing Survey 2021

<table>
<thead>
<tr>
<th>By Income</th>
<th>By Race/Ethnicity</th>
<th>By Education</th>
<th>By Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$30K</td>
<td>44%</td>
<td>18%</td>
<td>23%</td>
</tr>
<tr>
<td>$30K - $100K</td>
<td>27%</td>
<td>24%</td>
<td>18%</td>
</tr>
<tr>
<td>&gt;$100K</td>
<td>6%</td>
<td>17%</td>
<td>17%</td>
</tr>
<tr>
<td>Black/African American</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some College or Associate’s</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bachelor’s or Higher</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-34</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35-49</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50-64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65+</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Having a trusted provider and medical home promotes positive health behaviors like receiving health screenings and ensures access to medical care when needed. Availability of providers and capacity of current services ensure timely care. Community members and key stakeholders alike agreed that wait times for essential services like affordable housing and behavioral healthcare are longer than ever before.
COVID-19 showed that we can achieve wide access to services across our community.

COVID-19 testing and vaccination sites were erected in days. Food distribution channels multiplied across the community. Virtual meetings, telehealth, mass text messaging, and online information allowed for safe interaction and continuation of services during the periods of isolation and community quarantine.

How we are improving access to care

+ In collaboration with partners, HIA works to raise awareness of existing health services and deliver accurate health information into the hands of the community.

+ Pandemic response included creating a website with up-to-date information on COVID-19 vaccines and testing, food assistance, and more.

+ Through the coalition website and social media outlets, HIA shares current information to the community and other organizations about how to access healthcare and other local resources.
Behavioral Health

Behavioral health encompasses mental health conditions, substance use disorders, and one’s overall sense of wellbeing. Nationwide, there has been an increase in demand for behavioral health services, a trend we have seen in Greater Bridgeport communities too.

Referrals for mental health and addictions were the second most common request to the 211 referral system.

Feedback from community service providers and residents confirmed that, like most communities, demand for behavioral health services are outpacing our delivery system capacity. This challenge compels us to leverage our community assets in new ways, and rethink how we can create environments that reduce trauma and foster community connections.

Mental Health and Substance Use Disorders as Percentage of Total Visits

The graph below shows the increase in visits (in any setting) for mental health and substance use disorders as a percentage of total visits during 2015-2020 for Bridgeport Hospital and St. Vincent’s Medical Center, two hospitals that serve Greater Bridgeport.

Suicide Death Rate Per Age-Adjusted 100,000

Overdose Death Rate per 100,000 (2020)

Greater Bridgeport 31.6
Bridgeport 46.0
Milford 35.0
Stratford 34.5
Fairfield 16.2
Trumbull 13.9
Monroe 10.2
Easton N/A
Fairfield County 23.9
Connecticut 35.2
How we are responding to behavioral health needs

Many people throughout Greater Bridgeport experienced increased stress or trauma in their daily lives and since the onset of the COVID-19 pandemic. Nearly half of all adults ages 18-34 throughout the community reported feeling down.

Survey respondents who have been bothered by feeling down, depressed, or hopeless “several days”, “more than half the days”, or “nearly every day” over the past 2 weeks

Survey respondents who stated that they personally know anyone who has struggled with an addiction to heroin or other opiates such as prescription painkillers at any point during the last three years

Member organizations of HIA actively participate in weekly regional Community Care Team (CCT) meetings. The CCT works together to support the care of patients with chronic physical and mental health needs to reduce emergency department visits.

A community resource page was developed on the HIA website to serve as a centralized channel to share information on available services and resources with partners and the community.

Survey respondents who stated that they personally know anyone who has struggled with an addiction to heroin or other opiates such as prescription painkillers at any point during the last three years

Many people throughout Greater Bridgeport experienced increased stress or trauma in their daily lives and since the onset of the COVID-19 pandemic. Nearly half of all adults ages 18-34 throughout the community reported feeling down.

Roughly 1 in 3 adults across all demographic groups within the Greater Bridgeport area personally know someone struggling with opiate addiction.
Child Wellbeing

Traumatic or stressful events in childhood are called Adverse Childhood Experiences or ACEs. ACEs have been shown to have lifelong impacts on the economic, educational, and mental and physical health outcomes for individuals, and are associated with decreased life expectancy.

ACEs grow from Adverse Community Environments. By taking an upstream approach to emphasize interventions that address adverse community environments such as promoting "trauma informed care," we can prevent, identify, and offset life's negative events.

Focusing community health interventions on underlying social drivers of health, such as poverty and discrimination, can yield more effective and impactful treatment of downstream disease conditions, and pave the way for equitable health outcomes. The following diagram from the CDC illustrates the connection between environment and experiences.

How we are building resiliency among youth

Recognizing a need for further supporting the youth, HIA formed a child wellbeing task force in January 2021 with an overall goal of promoting healthy child development.

HIA partners collaborated to address COVID-19 vaccine hesitancy among breastfeeding mothers by hosting two focus groups and developing Trusted Voices video series featuring local mothers speaking about why they chose to be vaccinated.

The Pair of ACEs
Source: Centers for Disease Control and Prevention

Adverse Childhood Experiences
+ Maternal Depression
+ Emotional & Sexual Abuse
+ Substance Abuse
+ Domestic Violence
+ Physical & Emotional Neglect
+ Divorce
+ Mental Illness
+ Incarceration
+ Homelessness

Adverse Community Environments
+ Poverty
+ Discrimination
+ Community Disruption
+ Lack of Opportunity, Economic Mobility, & Social Capital
+ Poor Housing Quality & Affordability
+ Violence
Trauma, isolation, and lack of socialization during COVID-19 created environments that can have long lasting impact on youth.

Youth Measures of Mental Health and Substance Use, 9th-12th Graders

Source: Centers for Disease Control and Prevention, Youth Risk Behavior Survey 2019
Connecticut Department of Public Health

<table>
<thead>
<tr>
<th></th>
<th>Feel Consistently Sad or Depressed</th>
<th>Attempted Suicide</th>
<th>E-cigarette Use (last 30 days)</th>
<th>Alcohol Use (last 30 days)</th>
<th>Marijuana Use (last 30 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>30.6%</td>
<td>6.7%</td>
<td>27%</td>
<td>25.9%</td>
<td>21.7%</td>
</tr>
<tr>
<td>US</td>
<td>36.7%</td>
<td>8.9%</td>
<td>32.7%</td>
<td>29.1%</td>
<td>21.7%</td>
</tr>
</tbody>
</table>

Starting Out Strong

Ensuring pregnant people have the support they need to help each baby start life as healthy as possible is important. The data show that most pregnant people in the Greater Bridgeport area are able to access early prenatal care, which is the best way to promote a healthy pregnancy and delivery.

Infant Mortality

Infant mortality (death of a child before age 1) is used as an international measure of overall community health. This is because the death of babies is impacted by social and economic factors and quality of life conditions for mothers.

Disparities in infant mortality are measures of structural socioeconomic inequities that happen long before pregnancy or birth. Upstream strategies that address the root causes of inequities can have far reaching impact on infant mortality, child wellbeing, reducing family trauma, and increasing life expectancy for all people.

Maternal and Child Health, 2019 Data

Source: Connecticut Department of Public Health Registration Report Births, Deaths, Fetal Deaths, and Marriages

As shown in this table, Bridgeport has lower rates of early prenatal care and higher infant mortality rates than the region and the state.

<table>
<thead>
<tr>
<th></th>
<th>% First Trimester Prenatal Care</th>
<th>% Low Birth Weight</th>
<th>Infant Death Rate per 1,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgeport</td>
<td>74.5</td>
<td>10.1</td>
<td>7.3</td>
</tr>
<tr>
<td>Easton</td>
<td>98.3</td>
<td>NA</td>
<td>0.0</td>
</tr>
<tr>
<td>Fairfield</td>
<td>89.2</td>
<td>5.6</td>
<td>1.9</td>
</tr>
<tr>
<td>Milford</td>
<td>91.4</td>
<td>7.6</td>
<td>2.2</td>
</tr>
<tr>
<td>Monroe</td>
<td>91.6</td>
<td>6.4</td>
<td>0.0</td>
</tr>
<tr>
<td>Stratford</td>
<td>85.3</td>
<td>6.5</td>
<td>6.5</td>
</tr>
<tr>
<td>Trumbull</td>
<td>87.4</td>
<td>8.4</td>
<td>0.0</td>
</tr>
<tr>
<td>Greater Bridgeport</td>
<td>80.9</td>
<td>NA</td>
<td>4.8</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>81.5</td>
<td>7.5</td>
<td>4.0</td>
</tr>
<tr>
<td>Connecticut</td>
<td>84.7</td>
<td>7.8</td>
<td>4.5</td>
</tr>
<tr>
<td>US</td>
<td>77.6</td>
<td>8.3</td>
<td>5.6</td>
</tr>
</tbody>
</table>
Priority Health Needs

Healthy Lifestyles

Disparities, Impact of Social Drivers of Health

Prior to COVID-19, the top leading causes of death among all populations in the US were chronic diseases. Across Greater Bridgeport communities, it is clear that preventive care, early diagnosis, and comprehensive treatment are high quality and effective. However, wide health disparities exist between those that benefit from these lifesaving services and those that die prematurely. The data reinforce that social drivers of health directly impact health outcomes for chronic disease, resulting in inequities in life expectancy by race and neighborhood.

Adult Health Indicators, Age Adjusted, 2019 BRFSS

Source: Centers for Disease Control and Prevention 2019

<table>
<thead>
<tr>
<th></th>
<th>Asian</th>
<th>Black</th>
<th>Hispanic</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairfield County</td>
<td>94.2</td>
<td>80.8</td>
<td>87.7</td>
<td>82.8</td>
</tr>
<tr>
<td>Connecticut</td>
<td>92.9</td>
<td>79.0</td>
<td>84.7</td>
<td>80.6</td>
</tr>
</tbody>
</table>

Key informants were asked what factors most impacted residents’ good health. Their responses below reinforce that healthy lifestyles start with healthy environments.

1. Housing
2. Medical insurance
3. Employment
4. Healthy food
5. Adequate transportation
6. Open space
Self-Reported Chronic Diseases

Source: DataHaven Community Wellbeing Survey 2021

- Since 2014, HIA has provided free Know Your Numbers health screenings in Bridgeport area food pantries. Screenings also connect people to healthcare resources for follow-up care when needed.

- In September 2021, HIA hosted Walk ‘n Talk for Essential Workers featuring local healthcare professionals who walked with community members while providing health and wellness tips.

Populations who experience unfavorable social drivers of health, such as lack of access to quality education and employment, are also at greater risk for disease. In Greater Bridgeport, Hispanic and Black residents report chronic disease diagnoses more frequently than their White neighbors.
Community Health Improvement Plan 2022-2025
Our continuing efforts to improve community health

What is a Community Health Improvement Plan (CHIP)?

A CHIP helps organizations move from data to action by addressing priority health and wellbeing needs identified in the CHNA. The CHIP serves as a guide for strategic planning and a tool by which to measure impact by detailing goals, strategies, and initiatives over the three-year reporting timeframe.

The CHIP aligns unmet community needs with high-level strategies and corresponding health system and hospital initiatives. The CHIP measures the impact of collective action initiatives and tracks progress over time. CHIP strategies focus on improving the health and wellbeing of our community and achieving health equity for all by addressing health disparities identified in the CHNA. CHIP initiatives reflect community focused initiatives, programs, and services planned for the next three years.

Alignment with Healthy Connecticut 2025

Healthy Connecticut 2025 State Health Improvement Plan (SHIP) is the five-year state health strategic plan for improving the health of Connecticut residents. Representatives from HIA and other community organizations participated in creating Healthy Connecticut 2025 and serve on ongoing action teams. Connecticut Department of Public Health oversees the development of the SHIP, in collaboration with multi-sector partners from across the state.

The Healthy Connecticut 2025 State Health Improvement Plan is aligned with the National Prevention Strategy, Healthy People 2030 objectives, the Centers for Disease Control and Prevention, and with other existing local and State of Connecticut plans.

In addition to the SHIP, the 2022 hospital CHNA was aligned with IRS Code 501(r) requirements for not-for-profit hospitals as well as Connecticut state requirements for hospital community benefit reporting. Hospital CHIP goals align with SHIP goals to establish support for statewide initiatives at the local level.

Approach to Community Health Improvement

Like the CHNA, the HIA CHIP reflects input from many stakeholders. It acknowledges existing work, community assets and gaps in resources. The success of the CHIP requires ongoing collaboration with community partners and input from local residents to address social drivers of health (SDoH) and advance initiatives toward health and wellbeing. Developed by HIA task forces comprised of representatives from our partner organizations throughout the Greater Bridgeport area, the CHIP provides direction for addressing the health and wellbeing needs of the community over the next three years. The four priority areas identified by the CHNA process include Access to Care, Behavioral Health, Child Wellbeing, and Healthy Lifestyles. These priority areas reflect the greatest needs in the community and align with statewide efforts in the SHIP.
Access to Care

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

**Healthy CT 2025 Goal:** Ensure all Connecticut residents have knowledge of, and suitable access to, affordable, comprehensive, appropriate, quality health care.

**OBJECTIVE:** Improve health outcomes across the region, focusing on at risk and vulnerable populations with high rates of chronic disease.

**Strategy:** Increase enrollment in safety net programs that provide access to medical and dental services for those insured and uninsured.

**Strategy:** Increase number of community members that receive services when they need them.

**Strategy:** Increase participation in preventive screening services.

**Strategy:** Provide simple, consistent health messaging in multiple languages using technology and other communication strategies.

**Strategy:** Empower the community to prioritize health and wellness by fostering existing and creating new partnerships.

**OBJECTIVE:** Increase the percent of community members who report having a primary care provider.

**OBJECTIVE:** Expand access to specialty care services to ensure people can receive care when they need it.

**Strategy:** Examine processes and policies that may be limiting access to services.

**Strategy:** Reduce no show rates for medical appointments.

**Strategy:** Increase access to telehealth, mobile, school-based and community services.

**Strategy:** Increase healthcare worker support to increase staff satisfaction and retention.

**Strategy:** Improve coordination of primary and specialty care.

**OBJECTIVE:** Reduce the percentage of people who report being treated with less respect or received services that were not as good as others in the community.

**Strategy:** Increase utilization of Culturally and Linguistically Appropriate Services (CLAS) standards in healthcare and other settings.

**Strategy:** Create welcoming health care and community services settings that honor diversity and reflect the community served.
**Behavioral Health**

**HIA Goal:**
Every resident in Greater Bridgeport has equitable access to behavioral health services and resources available to build resiliency.

**Healthy CT 2025 Goal:**
Ensure community strength, safety, and resiliency by providing equitable and sustainable access to community resources to address the unique physical, social, and behavioral health needs of all Connecticut residents.

---

**OBJECTIVE:** Increase the percentage of adults and youth who report feeling satisfied with life and their community.

**Strategy:** Increase the number of ways to connect residents to their community.

**Strategy:** Normalize the discussion of behavioral health in clinical and social settings

**Strategy:** Ensure residents can benefit from existing services.

---

**OBJECTIVE:** Increase behavioral health workforce and development.

**Strategy:** Increase availability and utilization of community health workers and peer support specialists whose lived experience reflects the communities they serve.

**Strategy:** Retain and recruit staff that reflect the communities we serve.

---

**OBJECTIVE:** Increase the number of people who receive behavioral health care in the appropriate setting.

**Strategy:** Continue to improve the coordination of care for frequent use of ED for behavioral health.

**Strategy:** Involve/educate community police (presenting symptoms, best methods of interventions, etc.).

**Strategy:** Create a welcoming service delivery setting that honors diversity and reflects the community we serve.

**Strategy:** Identify new partners within underserved communities and populations to assist as liaisons for services and care.

---

**OBJECTIVE:** Expand the use of additional sites for behavioral health care, including community, schools, home health, and telehealth.

**Strategy:** Link clinical and non-clinical settings and services.

**Strategy:** Identify ways to reduce barriers to seeking care.

**Strategy:** Increase access to telehealth, mobile, and community-based services; ensure cultural competency and health literacy.

**Strategy:** Identify interim solutions for those who are waitlisted/waiting for services.
Child Wellbeing

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

**Healthy CT 2025 Goal:**
Ensure community strength, safety, and resiliency by providing equitable and sustainable access to community resources to address the unique physical, social and behavioral health needs of all Connecticut residents.

**OBJECTIVE:** Increase positive childhood experiences through youth engagement in social athletic, civic, cultural, recreational, and educational activities.

**Strategy:** Increase participation in extracurricular programming by addressing awareness, safety, affordability, and access/transportation.

**Strategy:** Increase participation in STEM programming.

**Strategy:** Promote the benefits of youth-driven community programming to improve positive youth development and outcomes.

**OBJECTIVE:** Build community capacity by increasing awareness and prevention of Adverse Childhood Experiences (ACES).

**Strategy:** Increase knowledge of parenting and childhood development.

**Strategy:** Increase the use of developmental and ACES screenings across multiple settings.

**OBJECTIVE:** Increase access to services offered by community-based organizations.

**Strategy:** Create and continue partnerships to increase access to services for prenatal, neonatal, and postpartum care through doula care, education and access, and home visiting programs.

**Strategy:** Increase engagement of community health workers and community messengers whose lived experiences reflect the communities they serve — across multiple settings.
Healthy Lifestyles

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

**Healthy CT 2025 Goals:**
Ensure all Connecticut residents have knowledge of, and suitable access to, affordable, comprehensive, appropriate, quality health care.
Ensure that all Connecticut residents have equitable access to safe and affordable nutritious and culturally appropriate food.

**OBJECTIVE:** Improve health outcomes across the region, focusing on at-risk and vulnerable populations with high rates of chronic disease.

**Strategy:** Reduce disparities in chronic disease and life expectancy by addressing social drivers of health (SDOH).
**Strategy:** Empower the community to prioritize health and wellness.
**Strategy:** Increase number of residents who receive services when they need them.
**Strategy:** Increase availability and use of free community-based recreation for all ages.
**Strategy:** Increase participation in preventive screening services.
**Strategy:** Leverage existing and foster new partnerships in underserved communities.
**Strategy:** Provide consistent health messaging in plain language using technology and social media.

**OBJECTIVE:** Increase the utilization of available food programs by eligible residents.

**Strategy:** Increase the awareness of access points where community members can obtain affordable, healthy, and nutritious food.
**Strategy:** Evaluate and seek to coordinate new and existing programs that address access to healthy food.
**Strategy:** Enhance awareness and provision of nutrition assistance services and nutrition education.

**OBJECTIVE:** Reduce the percentage of people who report being treated with less respect or received services that were not as good as others in the community.

**Strategy:** Increase utilization of Culturally and Linguistically Appropriate Services (CLAS).
**Strategy:** Strengthen community trust in health care providers.
**Strategy:** Increase community connections.
**Strategy:** Create welcoming care setting that honors diversity and reflects the community.

**OBJECTIVE:** Increase the percent of community members who report having a primary care provider.

**Strategy:** Increase awareness of available medical services and community resources.
**Strategy:** Expand use of non-traditional sites for care including community, schools, home health, and telehealth.
**Strategy:** Promote and support utilization of community health workers (CHWs)/community messengers whose lived experience reflects the communities they serve.
Community Partners:
Thank you to our community partners that provide guidance, expertise, and ongoing collaboration to foster collective impact in improving the health and wellbeing of the Greater Bridgeport community.

Greater Bridgeport / Health Improvement Alliance (HIA)
- Access Health CT
- Alliance for Community Empowerment
- American Heart & Stroke Association
- Americas Free Clinic of Bridgeport
- Aspetuck Health District
- Beacon Health Options
- Bridgeport Alliance for Young Children
- Bridgeport Child Advocacy Coalition
- Bridgeport Farmers Market Collaborative
- Bridgeport Hospital
- Bridgeport Regional Business Council
- Bridgeport Rescue Mission
- Building Neighborhoods Together
- Catholic Charities
- Central CT Coast YMCA
- City of Bridgeport
- City of Bridgeport Department of Health and Social Services
- City of Milford
- Community Health Network of Connecticut, Inc.
- Continuum of Care, LLC
- Council of Churches of Greater Bridgeport
- CT Dental Health Partnership
- CT State Department of Public Health
- CT State Department of Social Services
- CT State Dept. of Mental Health/ Greater Bridgeport Community Mental Health Center (GBCMHC)
- Fairfield Health Department
- Fairfield University School of Nursing
- Greater Bridgeport Medical Association
- Hartford HealthCare Medical Group
- Hispanic Health Council
- Hope Dispensary of Greater Bridgeport
- Housatonic Community College
- Interdenominational Ministerial Alliance
- Liberation Programs
- LifeBridge Community Services
- Milford Health Department
- MOMS Partnership
- Monroe Health Department
- National Association of Hispanic Nurses-CT Chapter
- Northeast Medical Group
- Optimus Healthcare
- Park City Communities
- Pediatric Healthcare Associates
- Recovery Network of Programs, Inc.
- Sacred Heart University, Colleges of Nursing and Health Professions
- Salvation Army
- Shiloh Baptist Church
- Southern Connecticut State University
- Southwest Community Health Center
- Southwestern CT Area Health Education Center, Inc.
- St. Vincent’s Medical Center
- Stratford Health Department
- Supportive Housing Works
- The Connection, Inc.
- The Hub, a division of Regional Youth Adult Social Action Partnership (RYASAP)
- The Kennedy Center
- Town of Easton
- Town of Fairfield
- Town of Monroe
- Town of Stratford
- Town of Trumbull
- Trumbull Health Department
- United Way of Coastal Fairfield County
- University of Bridgeport
- Visiting Nurse Services of CT

Research Partners:
Thank you to our research partners for their essential role in completing the 2022 CHNA.

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

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

Community Research Consulting | buildcommunity.com
CRC correlated data across all research efforts and facilitated multiple meetings with community partners and stakeholders. Applying insights from these sessions, CRC developed the CHNA report and led strategic planning in creation of the Community Health Improvement Plan (CHIP).

A woman-owned business based in Lancaster, Pennsylvania, Community Research Consulting (CRC) partners with our clients to build vibrant, healthier, sustainable communities. Our approach emphasizes wide participation in dynamic dialogue to both define and solve challenges with the people who experience them. Using quantitative and qualitative research methods, we conduct studies and develop solutions for community health, housing, socioeconomic disparities, capacity-building, population health management, and similar challenges. We specialize in transforming research into action through strategic planning, policy change, and collective impact.

Community Wisdom/NRC Health | nrchealth.com
Community Wisdom/NRC Health conducted community conversations through a series of interviews and surveys of 142 diverse community residents during March and April 2022 to collect feedback on community health priorities.

NRC Health helps partners know each person they serve—behaviors, preferences, wants, and needs—not as point-in-time insights, but as an ongoing relationship. Our approach to content development is guided by a single objective: information that will help our clients tangibly improve the experiences of the people they serve. We examine a broad variety of topics and share our point of view across formats, including the Community Wisdom Survey.
APPENDIX A:
Health Improvement Alliance Progress Report 2019-2022 CHIP

Health Improvement Alliance (HIA)
HIA is comprised of almost 100 individuals representing Bridgeport Hospital, St. Vincent’s Medical Center, seven local health departments, federally qualified health centers (FQHCs), community agencies, faith-based organizations, universities, town and city agencies, and residents from Bridgeport, Easton, Fairfield, Milford, Monroe, Stratford, and Trumbull. In 2019, HIA completed a Community Health Needs Assessment (CHNA) and prioritization process to identify priority health issues. Priority health needs were grouped into three overarching focus areas: access to care, behavioral health, and healthy lifestyles. Individual task forces, comprised of HIA members, work together on each focus area. In October 2019, HIA launched the 2019-2022 Community Health Implementation Plans (CHIPs) for the three focus areas mentioned above. Just six short months later, responding to the COVID-19 pandemic became the focus for all HIA partner organizations, shifting the focus of the work outlined in the 2019-2022 CHIPs. Each task force adapted and collaborated to respond to community needs that were a result of or exacerbated by the pandemic. The HIA steering committee and task forces all continued to meet on a monthly basis, with one new task force, Child Wellbeing, added in January 2020. In December 2020, the partnership decided that further collaboration was needed and convened a weekly regional COVID-19 coordination meeting with representatives from the hospitals, FQHCs and all of the local departments of health. At each phase of the pandemic, from education around masking, to COVID-19 testing and vaccinations, partners found it invaluable to come together to discuss challenges, share resources and coordinate a regional, cohesive response.

Since completing its last CHNA in 2019, the partnership took multiple steps to align its work, deepen relationships and serve the community, especially in regard to the COVID-19 pandemic.

Highlights of HIA accomplishments since 2019 include:

- Launched HIA website and Facebook in Spring 2020 to address the need for partners to share COVID-19 information with the community.
- Developed the online resource page on the HIA website that is regularly updated.
- Developed the Trusted Voices COVID-19 vaccine video series featuring HIA partners talking about their reasons for getting vaccinated.
- In Summer 2021, expanded HIA social media to include LinkedIn and Instagram as a way to reach a broader audience and promote our work in the communities we serve.
- Monthly HIA meetings have included presentations about emerging issues including a housing forum, 2-1-1, The Hub mental health resources, MOMS partnership, and Access Health CT.
- Participated in DASH LAPP grant with other HECs from around CT.
- Partnership expanded to include 32 new members representing 15 new organizations.

From 2019-2022, BH and SVMC, along with the four HIA task forces, made significant progress towards CHIP goals in the Greater Bridgeport region. In 2019, the priority areas for Greater Bridgeport were identified as Access to Care, Healthy Lifestyles, and Behavioral Health. The 2019-2022 CHIPs for both BH and SVMC mirrored those for HIA and included initiatives addressing those same priority areas.
**Access to Care Accomplishments**

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

**Goal:** By February 2022, only 13% of adults in Greater Bridgeport will report not having a medical home and 74% will report visiting a dentist at least once in the past year.

- **Indicator:** Percentage of people in Greater Bridgeport that indicate they do not have a medical home [2015-N/A, 2018-19%, 2021-14%]
- **Indicator:** Percentage of people in Greater Bridgeport that have indicate they have been to the dentist in the last year [2015-74%, 2018-72%, 2021-68%]

**HIA Partnership Initiatives**

- Dental handout with COVID-19 guidelines that were developed by this team were leveraged by DPH and COHI to create branded communication.
- Developed the “Your Health Can’t Wait” messaging in response to COVID-19 and posted the images on a new page on the HIA website.
- Redesigned and launched CLAS Assessment with 11 partner organizations completing the assessment in Summer 2020. Hosted two health literacy workshops as a direct result of needs identified by the CLAS assessment, attended by over 65 local partners.
- Weekly calls took place from mid-December 2020 through June 2021, as a way for HIA partners to coordinate COVID-19 response activities related to testing, vaccination and sharing information.
- Partners worked on how to design mobile vaccination clinics for those who were falling behind with flu and routine childhood vaccinations.
- Communications Committee launched website and Facebook page, improving the ability to share information across HIA organizations.
- Developed the online resources page as a centralized channel to share information with the public on how to access healthcare and other resources.
- Designed and implemented a COVID-19 Activities Assessment of HIA partner organizations to capture regional efforts related to the pandemic that took the focus off our 2019 CHIP goals. From March 2020-December 2021:
  - Ten HIA partner organization launched telehealth services due to the pandemic.
  - HIA partner organizations reported more than 356,628 combined staff hours were spent on COVID-19 related efforts. This total does not include staff hours from BH or SVMC.

**Behavioral Health Accomplishments**

The Behavioral Health Task Force worked together on multiple initiatives with the goal of increasing social and emotional support for adults in the region. Work throughout the region is supported by the efforts of HIA and both Bridgeport Hospital and St. Vincent’s Medical Center.

**Goal:** By February 2022, the Health Improvement Alliance (HIA) efforts will result in a 2% increase in social and emotional support for adults in the Greater Bridgeport area.

- **Indicator:** Percentage of people in the Greater Bridgeport region who indicate they receive the social and emotional support they need [DHWS, 2018 Baseline: 66% Always/Usually, 2021-62%]

**HIA Partnership Initiatives**

- Development of a community resources page on HIA website as a way to share information with partners and the community.
- Distributed regularly scheduled emails to a dedicated distribution list to ensure resources are shared across HIA partners.
- Created and distributed a toolkit focused on the resource available from local partner, The Hub, as a way to share their comprehensive mental health and peer supports resource guides widely across the region.
- In response to a need identified in the community, created a flyer and resource card featuring information on available warm lines and crisis support hotlines.
- The Community Care Team (CCT) was reactivated in September 2020 and meets via Zoom. The CCT focuses on identifying and working with high utilizers of the ED. In 2019, the CCT appointed new Co-Chairs and the group met 68 times from October 2019-August 2021.
Child Wellbeing Accomplishments
The Child Wellbeing Task Force formed in January 2021 with an overall goal of promoting healthy child development from birth to 8 years with a specific focus on Adverse Childhood Experiences (ACES). The early work of this task force has been supported by HIA partners, including Bridgeport Hospital and St. Vincent’s Medical Center. The initiation of this task force arose from HIA’s involvement in the state Health Enhancement Community (HEC) grant, which was awarded after the 2019-2022 CHIPS were already in progress. The HEC work focuses on increasing healthy weight and physical fitness (aligned with the HIA Healthy Lifestyles priority area), and improving child wellbeing. The HIA Child Wellbeing task force was created to align with the HEC work. Bridgeport Hospital and St. Vincent’s Medical Center have been actively involved in the early work of this task force, helping to recruit members and support initiatives.

Goal: Our Baby Bundle strategies will serve at least 1,050 infants and toddlers (25%) in years 1-3 and 2,100 (50%) over years 5-7.

+ Indicator: Percent of children developmentally ready at age three; (15% by Year 3; 25% by year 5).

HIA Partnership Initiatives
+ Representatives from Bridgeport Hospital and St. Vincent’s Medical Center participate and help facilitate the Child Wellbeing Task Force.
+ Hosted HIA screening and discussion of the film Resilience to build awareness of ACEs and recruit task force members.
+ First task force meetings focused education and raising awareness of relevant work and topics. Presentations including:
  • The Bridgeport Basics
  • An overview of HIA
  • CT state doula legislation
  • American Heart Association legislative efforts for water-filling stations in Bridgeport schools
  • Local vaccine efforts
  • Community Resiliency Model
  • Universal Home Visiting model and the inclusion of Community Health Workers (CHW) and doulas into that model
+ Collaborated with the Healthy Lifestyles Task Force, emme (empowerment, mindfulness, motivation, education) coalition, Bridgeport Prospers, and the United Way of Coastal Fairfield County to address vaccination hesitancy among breastfeeding moms. Those efforts included:
  • Hosted two focus groups with new mothers to gather information on COVID-19 vaccination safety concerns, as part of CDC Foundation funding for vaccine hesitancy. A report of findings was shared with HIA partners.
  • Developed several videos for the Trusted Voices video series featuring local mothers speaking about why they chose to get vaccinated against COVID-19.

Healthy Lifestyles Accomplishments
The Healthy Lifestyles Task Force organized and conducted multiple programs with the goal of decreasing chronic disease through the promotion of lifestyles changes. Work throughout the region is supported by the efforts of HIA and both Bridgeport Hospital and St. Vincent’s Medical Center.

Goal: By February 2022, promote healthy lifestyles in the Greater Bridgeport region to reduce diagnosed hypertension and diabetes in adults by 3%.

+ Indicator: % of people in Greater Bridgeport who have been told they have high blood pressure [2015-28%, 2018-29%, 2021-31%], diabetes [2015-9%, 2018-11%, 2021-10%] or heart disease [2015-5%, 2018-5%, 2021-5%]

HIA Partnership Initiatives
+ Developed ways to continue supporting local food pantries while they were closed due to COVID-19, including developing and providing them with mental health wellbeing materials to distribute to their clients.
+ Face-to-face Know Your Numbers health screenings were paused until spring 2021. Screened 31 individuals at 2 locations in 2021, with a total of 143 screened from early 2020-2021.
+ Continued creating and disseminating Get Healthy CT monthly resources on various health topics.
+ St. Vincent’s, Bridgeport Hospital, and Stratford Health Department continued hosting their own monthly food distributions.
+ Two HIA partners, BH and SVMC, hosted weekly farm stands and offered SNAP doubling incentives and Bridgeport Bucks through partnership with the Bridgeport Farmers Market Collaborative.
+ Hosted a Walk ‘n Talk for Essential Workers in September 2021, featuring around 15 different local healthcare professional volunteers.
+ Carried out the Healthy Communities Grant, a multi-year grant awarded to the Stratford Health Department, in partnership with other regional health departments in Bridgeport, Fairfield, Monroe, and Trumbull.
One goal of the Community Health Needs Assessment (CHNA) is to understand the strengths, needs, and challenges communities face. Needs can vary across individuals, organizations, neighborhoods and even cities. Various community-based resources including community leaders, policies, social service agencies and welcoming physical spaces help alleviate burdens and elevate the quality of life of residents. Identifying and sharing information on available, well-liked and frequently used community resources increases awareness of existing gaps and best practices.

**Methodology:**
Community assets were derived from research of the United Way 2-1-1 online database and additional internet research. The following tables list examples of community resources that are categorized into seven areas of community needs. These seven areas are:

- **Access to Care:** Resources providing various healthcare services, ranging from reproductive health, dental care, general community clinics, health screenings, etc.
- **Behavioral Health:** Resources helping to connect community members to mental health services as well as services that deal with supporting and treating those dealing with substance abuse.
- **Financial Assistance:** Resources helping to connect community members to employment opportunities and financial support programs.
- **Food Assistance:** Resources comprised of programs and initiatives that provide food and education surrounding nutrition to community members.
- **Housing & Utility Assistance:** Resources for housing including emergency services for domestic violence and homelessness; payment assistance for rent, mortgage, utilities, and other housing costs.
- **Promoting Wellness & Healthy Lifestyles:** Resources that have to do with positive and health lifestyles, such as physical activity (green space, fitness centers), youth and family enrichment, and/or community establishments that foster both connectivity and fellowship amongst members.
- **Transportation Assistance:** Resources on transportation assistance for general regional needs as well as health services and medical appointments.

The following community resources listed across each category is not an exhaustive list. To learn about or access any services within the Greater Bridgeport region, visit uwc.211ct.org or call 2-1-1 from any phone.
## APPENDIX B: Greater Bridgeport Community Resources

### Greater Bridgeport Access To Care

<table>
<thead>
<tr>
<th>Organizations</th>
<th>Contact Information</th>
<th>Key Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridges Healthcare</td>
<td>949 Bridgeport Ave, Milford, CT 06460</td>
<td>Mental Health &amp; Recovery Programs and Services. Recovery focused services to support individuals with severe and prolonged mental illness and addiction problems. Helps adults, children, and families toward healing, recovery, and renewal.</td>
</tr>
<tr>
<td>Bridgeport Hospital Milford Campus</td>
<td>300 Seaside Ave, Milford, CT 06460</td>
<td>ED and Urgent Care, Joint Replacement, Advance Wound Care Center.</td>
</tr>
<tr>
<td>GBAPP-HIV Services</td>
<td>1470 Barnum Ave, Suite 301, Bridgeport, CT 06610</td>
<td>Network of services providing clients with treatment, education, and outreach. People of all ages living with HIV/AIDS.</td>
</tr>
<tr>
<td>Onesight-Lenscrafter-Trumbull</td>
<td>5065 Main St, Trumbull, CT 06611</td>
<td>Vision Screening. Eye Care. Eyeglass Program. May only obtain services through a referral from a social service organization or church. Service prioritizes low income individuals without insurance.</td>
</tr>
<tr>
<td>Onesight-Pearle Vision-Fairfield</td>
<td>1901 Black Rock Turnpike, Fairfield, CT 06825</td>
<td>Vision Screening. Eye Care. Eyeglass Program. May only obtain services through a referral from a social service organization or church. Service prioritizes low income individuals without insurance.</td>
</tr>
<tr>
<td>Weisman Americas Free Clinic of Bridgeport</td>
<td>115 Highland Avenue, Bridgeport, CT 06604</td>
<td>Diagnosis and Treatment. Essential Medication. X-Ray and Diagnostic Services. Physical Exam. Referrals. Services only offered to those without insurance (including Medicaid, Medicare, and Veterans care). Eligible to individuals with a total household income under 250% of the Federal Poverty Level (FPL). Must bring photo ID, proof of income, and medical record/prescriptions. Appointments preferred.</td>
</tr>
<tr>
<td>Bridgeport Hospital</td>
<td>Primary Care Center 267 Grant Street, Bridgeport, CT 06610</td>
<td>Acute &amp; Chronic Pain Management, Adolescent Services, Ahlbin Rehabilitation Center, Anesthesia &amp; Pain Management, Blood Management Services, Brain Tumors, Cancer (Oncology), Children (Pediatrics), Diabetes, Ear Nose &amp; Throat (Otolaryngology), Emergency Services, Geriatric (Aging), Gynecologic Cancer, Head and Neck Cancer, Heart &amp; Vascular, Hostitalist Services, Lymphoma/Leukemia, Maternity, Neurology &amp; Neurosurgery, Occupational Medicine &amp; Wellness Services, Ophthalmology, Oral &amp; Maxillofacial Surgery, Orthopedics, Ostomy Services, Palliative Care, Plastic &amp; Reconstrucive Surgery, Podiatry, Pulmonary Medicine, Radiation Oncology, Radiology Services, Sarcoma, Sleep Disoders &amp; Sleep Medicine, Stroke, Surgery, Trauma &amp; Burn, Urology, Weight Loss (Bariatric) Surgery, Wound Care.</td>
</tr>
</tbody>
</table>

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## APPENDIX B: Greater Bridgeport Community Resources

### Greater Bridgeport Behavioral Health

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<tbody>
<tr>
<td><strong>Family Re-Entry of Bridgeport</strong></td>
<td>75 Washington Ave, Bridgeport, CT 06604 (203) 576-6924 familyreentryorg Mon-Fri 9 am-5 pm</td>
<td>Transitional Housing. Youth Mentoring. Support for Mental Health and Substance Use Issues. Fatherhood Engagement.</td>
</tr>
<tr>
<td><strong>Liberation Programs (Recovery for Life)- Multiple Locations</strong></td>
<td>399 Mill Ave, Bridgeport CT 06850 (293) 962-4516 liberationprograms.org Mon-Fri 5:30 m-1 pm, 2:30 pm-6:30 pm, Sat 6 am-10 am</td>
<td>Outpatient Services. Inpatient Services. Housing. Medication Assisted Treatment Wellness Vans. Prevention. Locations: Bridgeport, Stamford, Norwalk and Greenwich.</td>
</tr>
<tr>
<td><strong>Mobile Crisis Intervention Services</strong></td>
<td>Connecticut Dept. of Children and Families (2-1-1) mobilecrisissempct.org 24/7</td>
<td>Services are provided by teams of mental health workers (psychiatrists, RNs, MSWs, psychologists, psychiatric technicians) who intervene in situations where an individual’s mental or emotional condition results in behavior which constitutes an imminent danger to him or herself or to another. Visit people in their homes or community sites, and others meet clients in clinics or hospital emergency rooms. Psychiatric emergency rooms and mental health facilities can provide crisis services to people in crisis who can travel or get help with transportation to a facility.</td>
</tr>
<tr>
<td><strong>REACH Program: Bridgeport Hospital</strong></td>
<td>1558 Barnum Ave, Bridgeport, CT 06610 (203) 994-3377 bridgeporthospital.org/locations/bridgeport-1558-barnum-ave.aspx Mon-Thurs 8:30 am-5:30 pm, Fri 9 am-1 pm</td>
<td>Intake Assessments. Medication Management. Group Therapy. Case Management. After Care Planning.</td>
</tr>
</tbody>
</table>

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## Greater Bridgeport Community Resources

### Greater Bridgeport Food Assistance

<table>
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<tr>
<th>Organizations</th>
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</table>
| Bishop Jean Williams Food Pantry | 4 Worth St, Bridgeport, CT 06604  
(203) 873-0260  
parkcityinitiative.org  
Tues 10:00 am-2:00 pm, Wed 12:00 pm-4:00 pm, Thurs 1:00 pm-6:00 pm | Provides emergency meals to low-to-moderate families that are food insecure. Families are able to shop on a weekly basis. Provides groceries for families to prepare balanced meals for their families. By appointment due to COVID-19. |
| Bridgeport Farmer’s Market Collaborative- Multiple Locations | bridgeportfarmersmarkets.org | Various locations are: Alliance Farmers Market, St Vincent’s Farm Stand Health & Wellness, East Side Market, Farmers Market of Black Rock, Downtown at McLevy Green, Bridgeport Hospital, Stratfield Market, Reservoir Community Farm Stand, East End NRZ Market & Cafe. All accept Senior and WIC FMNP checks and double SNAP payments. |
| Bridgeport Nutrition Program: Meals on Wheels | 215 Warren St, Bridgeport, CT 06604  
(203) 332-3264  
https://www.cwresources.org/lines-of-business/food-services/call for more information | Provides two meals per day by way of delivery. |
| Bridgeport Rescue Mission | 1088 Fairfield Ave, Bridgeport, CT 06605  
(203) 333-4087  
bridgeportrescuemission.org  
Daily 6:45-7:15 am, 12:30-1:00 pm, 5:30-6:00 pm | Food Distribution. Clothing Distribution. Addiction Recovery. Emergency Housing. Women & Children’s Housing. |
| Connecticut Department of Agriculture | 450 Columbus Blvd, Suite 701 Hartford, CT 06103  
(860) 713-2503  
www.CTGrown.gov  
portal.ct.gov/DOAG/ADaRC/Publications/Farmers-Markets | Connecticut has nearly 100 farmers’ markets and can be found in virtually any town, seven days a week. The popularity of the markets mirrors the benefits - fresh, local products, friendly farmers that are the face behind the food you’re buying, and a community gathering place for everyone to enjoy. Nearly all farmers’ markets in Connecticut are affiliated with the Farmers’ Market Nutrition Program (FMNP) which serves participants of Women, Infant, and Children (WIC) and the Senior Farmers’ Market Nutritional Program (SFMNP) for seniors who are over the age of 60 and meet income eligibility guidelines with checks to purchase fresh fruits, vegetables, cut herbs and honey. USDA Supplemental Nutrition Assistance Program (SNAP) benefits are also available to improve access to fresh fruits and vegetables to low-income Americans and are issued on electronic benefits transfer or EBT cards that are used like debit cards. For more information, please visit the FMNP page: Farmers’ Market Nutrition Programs. |
| Connecticut Foodshare | 2 Research Pkwy, Wallingford, CT 06492  
(203) 469-5000  
https://www.ctfoodshare.org/ | Mobile Foodshare pantry on wheels. Food pantries can be found by searching 2-1-1 of CT, a United Way program. |
| Council of Churches of Greater Bridgeport | 1718 Capitol Ave, Bridgeport, CT 06604  
(203) 334-1121  
https://www.ccgb.org/  
Mon-Fri 8:30 am-4:00 pm | FEED Center - free culinary courses for low income residents. Oversees the mobile marketplace, serve as incubator kitchens for new food businesses and oversees a network of 40 food pantries. |
| First Baptist Church of Stratford Agape Food Pantry | 105 Hamilton Ave, Stratford, CT 06615  
(203) 377-1441  
https://fbcstratford.org/  
2nd, 3rd, 4th Sat of every month 10:00 am-12:00 pm | Offers emergency food assistance to anyone in need. Pantry is open on the 2nd, 3rd and 4th Saturday of every month from 10:00 am-12:00 noon. Pantry is closed the 1st Saturday of every month. |
| nOURish Bridgeport, Inc. | 2200 North Ave, Bridgeport, CT 06604  
(203) 335-3107  
https://www.nourishbpt.org/super-food-pantry  
Mon, Wed 2:00-6:00 pm | Super Food Pantry and Baby Center serving neighbors in the South and West End of Bridgeport. By appointment only during COVID-19. Photo ID required. |
| The Thomas Merton Center | 43 Madison Ave, Bridgeport, CT 06604  
(203) 367-9036  
https://www.themertoncenter.org/  
Mon-Fri 7:30 am-3:00 pm | Breakfast (9:00 am-10:00 am) & Lunch (11:30 am-12:30 pm), Eat Smart Marketplace (Mon, Wed & Fri 10:00 am-11:00 am by appointment only), Shower (Mon & Tues appointment required), Warm Project, Other Services: Mail Program, Case Management, Support Groups, Referrals to other services, Title V training program. |

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## APPENDIX B: Greater Bridgeport Community Resources

### Greater Bridgeport Housing & Utility Assistance

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| Bridgeport Rescue Mission | 1088 Fairfield Ave, Bridgeport, CT 06605  
(203) 333-4087  
bridgeportrescuemission.org  
| Building Neighborhoods Together | 570 State St, Bridgeport, CT 06604  
(203) 290-4255  
bntweb.org  
Mon- Fri 9 am-5 pm | All our classes and counseling sessions are free. Pre-Purchase Counseling and Education. Rental Assistance thru Unitect. Rental Counseling and Education. Eviction Prevention Counseling. Foreclosure Prevention Counseling and Education. Reverse Mortgage Counseling. Financial Literacy Counseling & Education. Credit Counseling and Coaching. Budget Counseling and Coaching. Fair Housing Discrimination Counseling & Education Benefits. Resident Engagement and Empowerment. |
| Cassie’s Cottage | Address Upon Inquiry  
(203) 224-8818  
cassiecottage.net  
Hours Upon Inquiry | A private women’s sober living home in Fairfield County. To be a safe, recovery-focused home where women ages 20+ learn how to stay sober through accountability, self-efficacy, honesty, and connection to recover from the disease of addiction. Stay at least 3 months. |
| Clifford House | 1450 Main St, Bridgeport, CT 06604  
(203) 367-0808  
N/A  
Hours Upon Inquiry | 100 apartment mid-rise building with 5 apartments specially equipped to accommodate residents confined to wheelchairs. The Project Based, Section 8 facility accommodates low-income one or two person households where the head of household is at least 52 years of age or older, unless disabled/handicapped. Smoke-Free Facility. |
| Emerge Inc. | 89 Colony St, Stratford, CT 06615  
(203) 375-8610  
emerge-inc.org  
Hours Upon Inquiry | Offers transitional shelter for up to one year or longer, and permanent supportive housing options for female survivors of domestic violence and their children. Most services are provided in-house including rehabilitation programs, counseling, parenting skills, employment assistance and money management. |
| Greater Bridgeport Community Mental Health Center | 1635 Central Ave, Bridgeport, CT 06610  
(203) 551-7400  
portal.ct.gov/DMHAS/SWCMHS/Agency-Files/GBCMHC  
| Housing Development Fund Bridgeport Office | 1111 Main St, Bridgeport, CT 06604  
(203) 969-1830  
hdfconnects.org  
| Isaiah House II | 120 Clinton Ave, Bridgeport, CT 06605  
(203) 676-0616  
N/A  
Hours Upon Inquiry | Halfway House. |
| Liberation Programs (Recovery for life) | 399 Mill Hill Ave, Bridgeport, CT 06610  
(203) 399-3136  
liberationprograms.org  
Mon-Fri 9 am-1 pm, 2:30 pm-6:30 pm, Sat 6 am-10 am | Liberation provides 18 units of permanent supportive housing for families who are homeless or at risk of homelessness and in need of help maintaining their mental health and/or recovery at Gini’s House in Norwalk. Outpatient Service. Inpatient Service. Prevention. Medical Assistance Treatment Wellness Van. |
| Milford Redevelopment and Housing Partnership | 75 Demaio Dr, Milford, CT 06460  
(203) 877-3233  
ic.milford.ct.us/milford-redevelopment-housing-partnership-mrhp  
24/7 | Milford Redevelopment and Housing Partnership is a housing authority that participates in the Section 8 Housing Choice Voucher (HCV) and Public Housing programs. |
| Park City Communities | 150 Highland Ave, Bridgeport, CT 06604  
(203) 337-8900  
parkcitycommunities.org  
Mon, Tues, Thur & Fri 8:30 am-3:45 pm, Wed 8:30 am-11:45 am | Park City Communities is committed to providing quality housing of choice, empowering residents to their highest level of self-sufficiency, and forming public and private partnerships to help revitalize our neighborhoods. |

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<tr>
<td>Bridgeport Caribe Youth Leaders</td>
<td>1067 Park Ave, Bridgeport, CT 06604&lt;br&gt;(203) 913-0073&lt;br&gt;bcl.org&lt;br&gt;Mon-Fri 9 am-4 pm</td>
<td>To provide youth with sports, educational and civic direction helping them build the character and self-esteem they need to reach their full potential and value in society.</td>
</tr>
<tr>
<td>Bridgeport Public Library North Branch</td>
<td>3455 Madison Ave, Bridgeport, CT 06606&lt;br&gt;(203) 276-7003&lt;br&gt;bplnorthbridgeport.org&lt;br&gt;Mon &amp; Wed 10 am-6 pm, Tues &amp; Thurs 12 pm-8 pm, Fri &amp; Sat 10 am-5 pm</td>
<td>Books, Computers, Programs (all ages).</td>
</tr>
<tr>
<td>Edith Wheeler Memorial Library</td>
<td>733 Monroe Tpke, Monroe CT, 06688&lt;br&gt;(203) 452-2850&lt;br&gt;ewml.org&lt;br&gt;Mon-Wed 9 am-7 pm, Thurs 9 am-3 pm, Fri &amp; Sat 9 am-2 pm</td>
<td>Books, Computers, Programs (all ages).</td>
</tr>
<tr>
<td>Fairfield Public Library - Main Library</td>
<td>1080 Old Post Rd, Fairfield CT, 06824&lt;br&gt;(203) 276-3155&lt;br&gt;fairfieldpubliclibrary.org&lt;br&gt;Mon &amp; Wed &amp; Fri 9 am-5 pm, Tues &amp; Thurs 9 am-7 pm, Sat 1 pm-5 pm</td>
<td>Books, Computers, Programs (all ages).</td>
</tr>
<tr>
<td>Lighthouse Afterschool Program</td>
<td>45 Lyon Terr, #301, Bridgeport, CT 06604&lt;br&gt;(203) 576 7252&lt;br&gt;bpebridgeport.gov&lt;br&gt;Mon-Fri 3 pm-5 pm</td>
<td>Register online. School/community program which provides educational, cultural, and recreational programs. Summer program 5 days a week from 8:30 am-5:30 pm which include academics support as well as athletics and recreational activities designed to motivate participants.</td>
</tr>
<tr>
<td>Milford Public Library</td>
<td>67 New Haven Ave, Milford, CT 06460&lt;br&gt;(203) 783-3290&lt;br&gt;ci.milford.ct.us&lt;br&gt;Mon 10 am-5 pm, Tues-Thurs 10 am-8:30 pm, Fri 1-5 pm, Sat 10 am-5 pm</td>
<td>Books, Computers, Programs (all ages).</td>
</tr>
<tr>
<td>Neighborhood Studios of Fairfield County</td>
<td>510 Barnum Ave, Bridgeport, CT 06608&lt;br&gt;(203) 386-3300&lt;br&gt;nstudies.org&lt;br&gt;Mon &amp; Thurs 10 am-8 pm, Wed 9 am-7 pm</td>
<td>Neighborhood Studios believes art education enhances cognitive and social development in children, thereby increasing their chances for success in all areas of learning. Afterschool programming. Partnerships. Performance Opportunities. Transportation &amp; Financial Assistance.</td>
</tr>
<tr>
<td>Sterling House Community Center</td>
<td>2283 Main St, Stratford, CT 06615&lt;br&gt;(203) 378-2606&lt;br&gt;sterlinghousecc.org&lt;br&gt;Mon-Thurs 9 am-6 pm, Fri 9 am-5 pm, Sat 9 am-3 pm</td>
<td>Summer Camp. Active Afternoons. SHCC Athletics. Sterling Down &amp; Dirty 5K. Service Saturdays. Sponsor an Event. Delivery Services. Food Pantry.</td>
</tr>
<tr>
<td>YMCA-Stratford</td>
<td>3045 Main St, Stratford, CT 06614&lt;br&gt;(203) 375-5644&lt;br&gt;Mon-Thur 5:30 am-8 pm, Fri 5:30 am-7 pm, Sat 7 am-5 pm, Sun 8 am-2 pm</td>
<td>From exceptional fitness facilities including our indoor pool, Life Fitness circuit, Lifecycles, Elliptical Cross trainers, treadmills, recumbent bikes and upright bikes to our child watch and child care services for preschoolers, before and after-school child care and summer day camp.</td>
</tr>
</tbody>
</table>

*These resource lists were compiled in summer 2021 and are not meant to be exhaustive. For additional resources, and the most up-to-date contact information, please visit 211ct.org.*
### APPENDIX B: Greater Bridgeport Community Resources

#### Greater Bridgeport Financial Assistance

<table>
<thead>
<tr>
<th>Organizations</th>
<th>Contact Information</th>
<th>Key Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALS Association-Connecticut Chapter</td>
<td>4 Oxford Rd, Milford, CT 06460 (203) 874-5050 webct.alsa.org Mon-Thurs 8:30 am-4:30 pm, Fri 8:30 am-2:30 pm</td>
<td>Research. Public Policy. Care Services. Public Education &amp; Awareness.</td>
</tr>
<tr>
<td>American Legion</td>
<td>752 East Main St, Bridgeport, CT 06608 (203) 332-6646 alctssmf.org Mon, Wed &amp; Thurs 8 am-5 pm</td>
<td>The Connecticut Soldiers, Sailors, and Marines Fund was established in 1919 to assist needy wartime veterans and their families. It is administered by the American Legion in accordance with the provisions of the Connecticut General Statutes, Sections 27-136 and 27-140, and is governed under the Bylaws of the American Legion Department of Connecticut.</td>
</tr>
<tr>
<td>Bridgeport Department of Social Services</td>
<td>925 Housatonic Ave, Bridgeport, CT 06606 (203) 576-7416 portal.ct.gov/dss Mon, Tues, Thurs &amp; Fri 8 am-4:30 pm</td>
<td>Provides federal/state food and economic aid, health care coverage, independent living and home care, social work, child support, home-heating aid, protective services for older adults, and more vital service areas.</td>
</tr>
<tr>
<td>Emerge Connecticut Inc.</td>
<td>830 Grand Ave, New Haven, CT 06511 (203) 562-0171 emergect.net Mon- Fri 9 am-4 pm</td>
<td>Self-sufficient social enterprise committed to assisting formerly incarcerated people successfully integrate back into their families and communities.</td>
</tr>
<tr>
<td>LifeBridge Community Services</td>
<td>475 Clinton Ave, Bridgeport, CT 06605 (203) 368-4291 lifebridge.org Mon-Thurs. 9 am-8 pm, Fri 8 am-5 pm</td>
<td>The lives of the youth and families served by LifeBridge have been deeply impacted by trauma, poverty, and a lack of educational opportunity. Domestic Violence. Family Therapy. Adolescent Wellness. Community Support Program. Substance Abuse. General Counseling. Urban Scholars Program. Community Closet. Work Skills Program.</td>
</tr>
<tr>
<td>PeopleReady</td>
<td>755 Boston Post Rd, Milford, CT 06460 (203) 776-2265 peopleready.com Mon-Fri 5:30 am-6 pm, Sat 7 am-11 am</td>
<td>PeopleReady specializes in quick and reliable on-demand labor and highly skilled workers. PeopleReady supports a wide range of blue-collar industries, including construction, manufacturing and logistics, waste and recycling, and hospitality.</td>
</tr>
<tr>
<td>Small Business Administration</td>
<td>1000 Lafayette Cir, Bridgeport, CT 06604 (203) 457-6654 sba.gov Mon-Sat 9 am-5 pm</td>
<td>Independent agency of the federal government to aid, counsel, assist and protect the interests of small business concerns, to preserve free competitive enterprise and to maintain and strengthen the overall economy of our nation.</td>
</tr>
<tr>
<td>Youth Works</td>
<td>350 Fairfield Ave, Bridgeport, CT 06604 (203) 416-8487 ajczywct.com Mon-Fri 8:30 am-4:30 pm</td>
<td>Works with Connecticut Department of Labor. The Workplace. Career Resources.</td>
</tr>
</tbody>
</table>

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# Greater Bridgeport Transportation Assistance

<table>
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<tr>
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<tbody>
<tr>
<td>ALS Association - Connecticut Chapter</td>
<td>4 Oxford Rd, Milford, CT 06460 (203) 874-5050 webct.alsa.org Mon-Thurs 8:30 am-4:30 pm Fri 8:30 am-2:30 pm</td>
<td>Van rides to ALS Clinics and/or neurology offices in Connecticut only. Must schedule 7 days in advance. Services only offered to ALS patients with or without a wheelchair who are registered with ALSA CT and live in CT. Must have no other transportation service and limited to four round trips per year.</td>
</tr>
<tr>
<td>Coordinated Transportation Solution</td>
<td>35 Nutmeg Dr, #120 Trumbull, CT 06611 (203) 736-8810 ctstransit.com Mon-Fri 8 am-5 pm</td>
<td>Non-emergency medical transportation services, transportation consulting, workers’ compensation transportation, special education transportation and mobility management services.</td>
</tr>
<tr>
<td>Greater Bridgeport Transport Authority</td>
<td>Multiple Locations (203) 336-7070 Ext. 131 gogbt.com/how-to-ride/for-riders-with-a-disability/ Mon-Fri 9 am-4 pm</td>
<td>Alternative bus transportation for individuals with mental or physical disabilities. Reservations can be made as early as five days in advance of your travel date, but no later than 4:30 pm the day prior to your trip.</td>
</tr>
<tr>
<td>Kennedy Center</td>
<td>2440 Reservoir Ave, Trumbull, CT 06611 (203) 365-8522 ctada.com Mon-Fri 8 am-5 pm</td>
<td>ADA Paratransit is a shared ride, advanced reservation, origin-to-destination service for persons with disabilities who are unable to use the public bus service because of their disability.</td>
</tr>
<tr>
<td>M7</td>
<td>65 Industry Dr, West Haven, CT 06516 (203) 777-7777 icabb.com By Appointment</td>
<td>Encompass Program. Traditional Service. Wheelchair-Accessible/Paratransit Transportation. Medical and Student Transportation.</td>
</tr>
<tr>
<td>Veteran’s Affairs- Shuttle Bus Program</td>
<td>752 East Main Street, 1st Floor, Bridgeport CT 06608 (203) 576-8348 va.gov/healthbenefits/vtp Mon-Fri 9 am-4:30 pm</td>
<td>Beneficiary Travel (BT). Veterans Transportation Service (VTS). Highly Rural Transportation Grants (HRTG).</td>
</tr>
</tbody>
</table>

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Partnering to build healthier communities since 2003.

www.hia-ct.org