Yale
NewHaven
Health

Lawrence + Memorial
Hospital

2025

Community Health Needs Assessment

Greater New London

crescendo | cg
Prepared by Crescendo Consulting Group

September 2025

Yale NewHaven Health
Lawrence + Memorial Hospital

Dear Community Member,

As the president of Lawrence + Memorial Hospital (L+M), I have the privilege to share our 2025 Community Health Need Assessment (CHNA) with you. The history of L+M Hospital, which officially opened in 1912, is very much tied to the history of New London, where, like its hospital, the community and surrounding towns have always strived to enhance the quality of life. The hospital employs more than 2,500 people, most of whom live in the region and are proud to be part of a dynamic community hospital that offers world-class care.

This comprehensive assessment, conducted by the Yale New Haven Health Office of Health Equity & Community Impact, identified obstacles faced by many individuals in the New London area when it comes to health and wellbeing. The assessment also incorporated valuable input and insight from new and existing regional partners to enhance our understanding of the community we have the privilege to serve.

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

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

Sincerely,

Richard Lisitano

President, Lawrence + Memorial Hospital
Executive Vice President, Yale New Haven Health

MISSION, VISION AND VALUES

MISSION

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

VISION

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

VALUES

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

YaleNewHavenHealth

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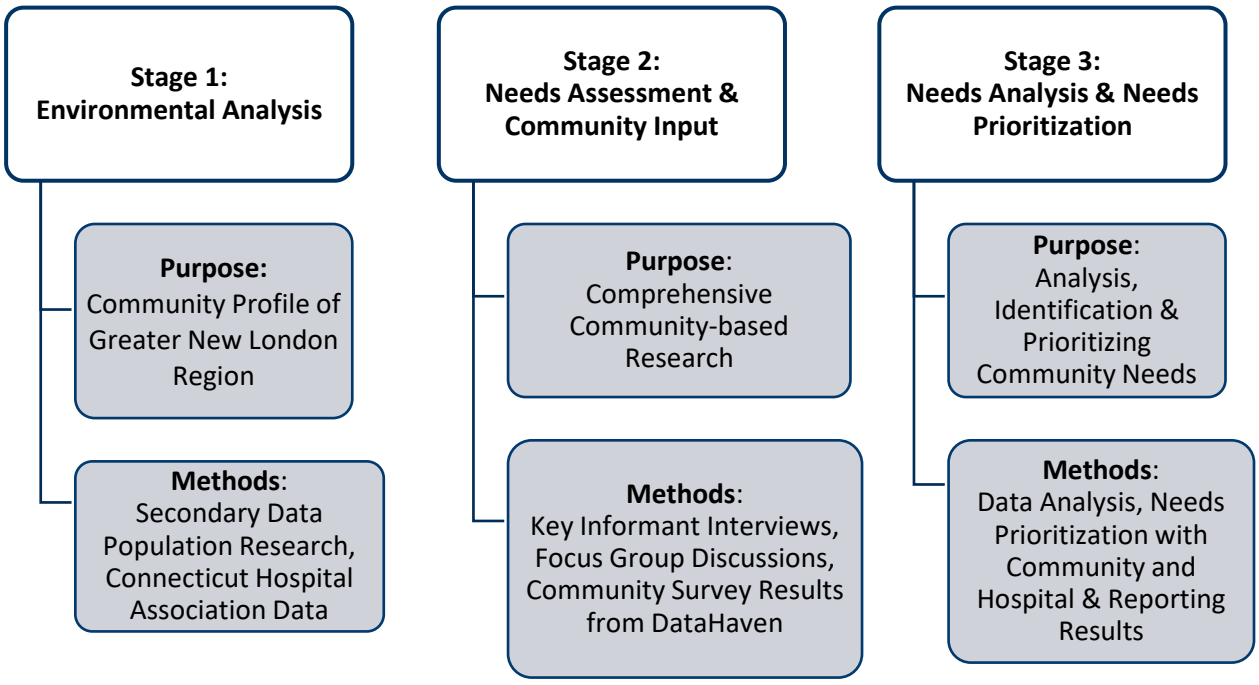
EXECUTIVE SUMMARY

Lawrence + Memorial Hospital (L+M) is committed to improving the health and well-being of residents in Greater New London, Connecticut. As a not-for-profit hospital, L+M conducts a Community Health Needs Assessment (CHNA) every three years, as required by Section 501(r)(3) of the Internal Revenue Code. This assessment identifies the most pressing health needs in the community and helps guide the hospital's efforts to address them.

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

CHNA Methodology and Data Gathering

The CHNA methodology involved a 3-stage process which included an environmental analysis, community input, and prioritization as outlined below.



<table>
<tr><td colspan="2">Data Collection Our robust data collection process included qualitative and quantitative data collection which provided critical insights into demographics of the region, access and experience of care and services and how social drivers impact health outcomes.</td></tr>
<tr><td>  Environmental Analysis & Collection of Secondary Data Secondary data was collected from numerous sources including the US Census American Community Survey (ACS), United Way (ALICE and 211), CDC (Wonder, PLACES, BRFSS), Connecticut Hospital Association (CHA) ChimeData.</td><td>  DataHaven Community Wellbeing Survey 499 telephonic surveys completed by Greater New London community members in English and Spanish as part of the probability sampling process conducted by DataHaven during the spring and summer 2024. The survey is used to evaluate local health and wellbeing opportunities spanning health care, housing, employment, and community needs, gaps and resources.</td></tr>
<tr><td>  Interviews: 21 one-on-one interviews with key informants from health and social service organizations between late summer through early fall.</td><td>  DataHaven Community Based Assets and Needs Survey (CBANS) 185 electronic surveys using convenience sampling were completed by Greater New London residents in English, Spanish and Haitian Creole during the summer 2024.</td></tr>
<tr><td>  Focus Groups 18 focus groups were conducted in English and Spanish in partnership with the Health Improvement Collaborative of Southeastern Connecticut (HIC) and the Eastern Connecticut Health Collaborative (ECHC), which includes Hartford Healthcare and Backus Hospital.</td><td>  Access Audit Mystery shopper calls to evaluate how easily community members can access health care, social services, and resources in Greater New London.</td></tr>
</table>

Data Analysis and Community Health Prioritization

A two-part structured needs prioritization process was conducted, integrating community feedback and evidence-based decision-making. This included Health Improvement Collaborative (HIC) of Southeastern Connecticut members, regional community partners and community members.

Session 1: reviewed 2022 CHNA report data and the updated 2025 CHNA data and findings

Session 2: participants identified the most pressing health needs based on a structured scoring method

After completing this process, the top six health priority areas were identified:

1. **Food Insecurity**
2. **Overdose**
3. **Health Insurance and Healthcare Navigation**
4. **Behavioral Health**
5. **Chronic Disease**
6. **Prenatal and Maternal Care**

- **Lawrence + Memorial Hospital prioritization session** – hospital leaders considered the regional prioritization findings to select organizational priorities for the Implementation Strategy Plan.

Hospital Priority Areas

The community priorities identified were presented to the Lawrence + Memorial Hospital leadership who agreed to adopt three community identified priorities:

Health System Priority Area

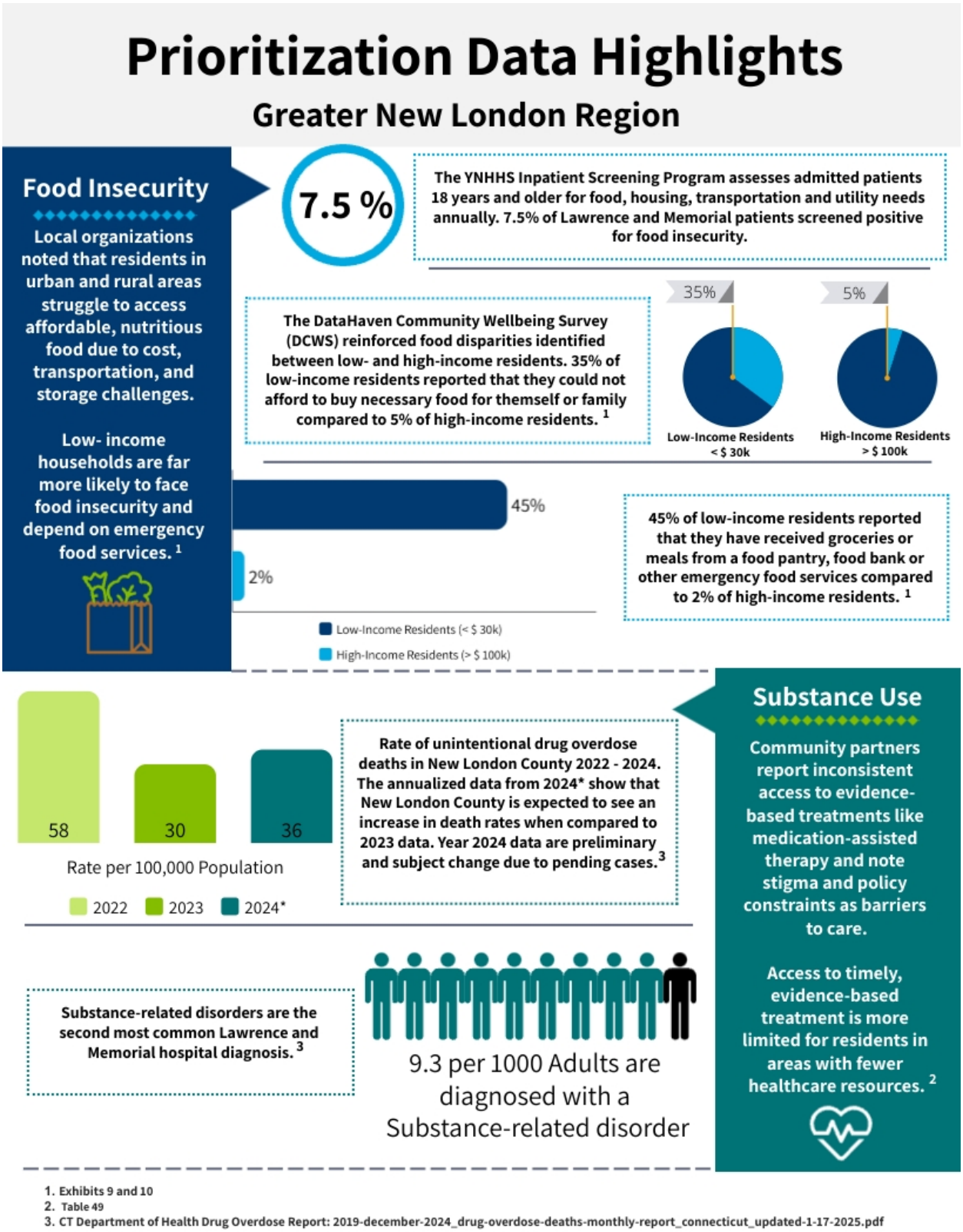
Community members, from across our hospital regions, identified cultural competency as a need during the 2025 CHNA process. This valuable feedback revealed opportunities to improve patient care by expanding language access and cultural sensitivity training and education for staff.

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

Next Steps: From Analysis to Action

The CHNA findings and selected priority areas were used to inform our 2025-2028 Implementation Strategy Plan. This document can be found online at https://www.lmhospital.org/about/community-involvement/community-partnerships/Community-Health-Needs-Assessment.

Prioritized Needs Executive Summary



1. Exhibits 9 and 10
2. Table 49
3. CT Department of Health Drug Overdose Report: 2019-december-2024_drug-overdose-deaths-monthly-report_connecticut_updated-1-17-2025.pdf

Prioritization Data Highlights

Greater New London Region

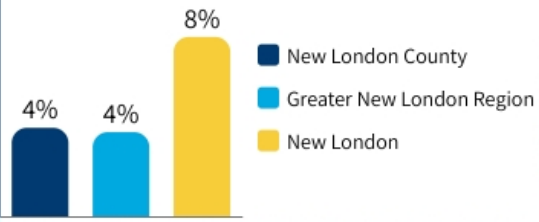
Healthcare Navigation

Key Informants described challenges navigating health systems, including difficulties finding providers who accept public insurance, which leads to delays in getting appointments.

Lower-income residents are less likely to have employer insurance and more likely to delay or forego needed care due to cost and systemic complexity.

DataHaven Community Based Assets and Needs Survey (CBANS) revealed only 16% of residents earning <$30k had employer-sponsored insurance, compared to 71% of residents earning >$100k. Employer insurance often offers broader provider access and lower out-of-pocket costs than other coverage options. [5]

14% of adults reported not receiving needed care; 32% postponed it due to cost, insurance barriers, or long wait times. [6]



Uninsured rate exceeds 5% in some towns, with coverage gaps concentrated in New London. [4]

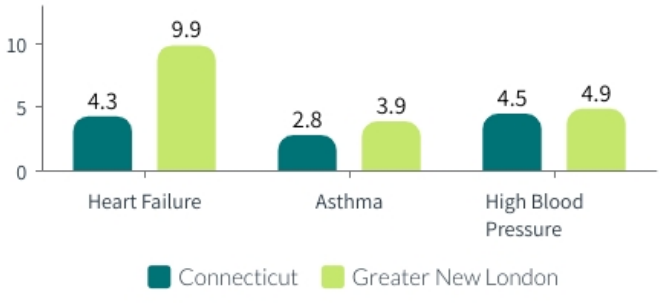
DCWS revealed residents earning under $30,000 were more than twice as likely to report asthma compared to those earning over $100,000. Asthma is a common chronic respiratory disease that can be worsened by poor housing conditions and limited access to preventive care. [7]

x2

Chronic Disease

Key Informants shared that residents with chronic conditions struggle to manage their health due to high costs, transportation barriers, and a shortage of local specialists.

Asthma and other chronic diseases are more common among low-income residents, reflecting broader challenges in managing long-term health conditions.[7]



Hospitalization rates for asthma, heart failure, and high blood pressure exceed state averages. [8]

4. Exhibit 29
5. Exhibit 30
6. Exhibit 33
7. Exhibit 45
8. Exhibit 44

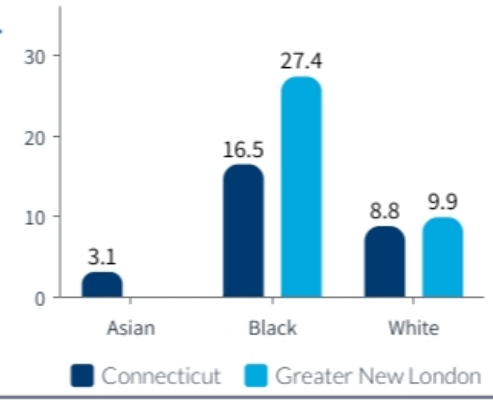
Prioritization Data Highlights

Greater New London Region

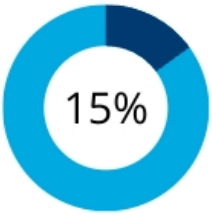
Behavioral Health

Key Informants shared that a shortage of providers, long waitlists, and limited availability of crisis services make it difficult for residents to access timely mental health care.

Mental health disorders are the leading cause of hospitalization at L+M, with a rate of 11.2 per 1,000 adults, higher than the state average. [10]

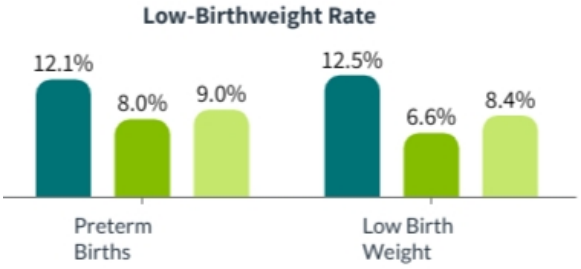


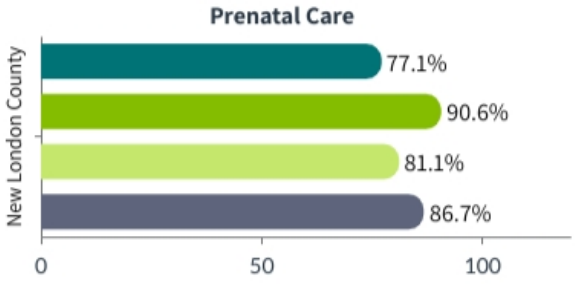
In the Greater New London Region Black adults had a hospitalization rate for mental health of 27 per 1,000, more than twice the state average of 10.4 per 1,000. [9]



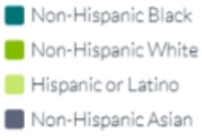
The DCWS noted that 15% of residents screened at risk for depression; anxiety rates higher among those with lower income.[11]

Maternal & Prenatal Care





Black mothers are less likely to receive early prenatal care and are nearly twice as likely to have low birthweight infants compared to White mothers. Low birthweight increases risks for health complications during infancy and later life. [12]



Community partners noted challenges accessing consistent OB/GYN care, particularly for residents in rural areas or those who lose insurance coverage during pregnancy.

9. Exhibit 40
10. Table 49
11. Exhibit 25 & 39
12. Exhibit 42 & 43

INTRODUCTION

Lawrence + Memorial Hospital (L+M) is committed to improving the health and well-being of residents in Greater New London, Connecticut. As a not-for-profit hospital, L+M conducts a Community Health Needs Assessment (CHNA) every three years, as required by Section 501(r)(3) of the Internal Revenue Code. This assessment identifies the most pressing health needs in the community and helps guide the hospital's efforts to address them.

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

The CHNA report was approved by the Lawrence + Memorial Hospital Board of Trustees on September 26, 2025. The findings in this report informed a separate Implementation Strategy Plan (ISP) that outlines specific actions Lawrence + Memorial Hospital will take to address identified health needs, which will receive Board of Trustee approval in Fiscal Year 2026. The documents will be made publicly available, to ensure transparency and accountability.

This report presents the findings of the most recent CHNA, conducted in collaboration with our community partners. It provides an overview of the health status of Greater New London residents, identifies key health challenges, and highlights L+M's commitment to addressing these issues. By working with community key informants, L+M aims to build a healthier future for all residents of Greater New London.

Community input is essential to ensuring that the Community Health Needs Assessment (CHNA) reflects the priorities and experiences of those who live and work in the region.

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

ABOUT OUR HOSPITAL

L+M is a not-for-profit, acute care hospital serving southeastern Connecticut (CT) and southwestern Rhode Island. Located in New London, CT, the hospital is part of Yale New Haven Health (YNHHS) and provides comprehensive medical, surgical, and specialty services to the community.

L+M offers emergency care, maternity services, advanced cardiac care, cancer treatment, orthopedics, and behavioral health services. It is a designated stroke center and has a Level III Trauma Center. The hospital is known for its commitment to quality, patient-centered care, and expanding access to healthcare through partnerships with local organizations.

As a community-focused hospital, L+M works to address regional health needs through outreach programs, preventive care, and collaborations.

For more information, visit www.lmhospital.org.

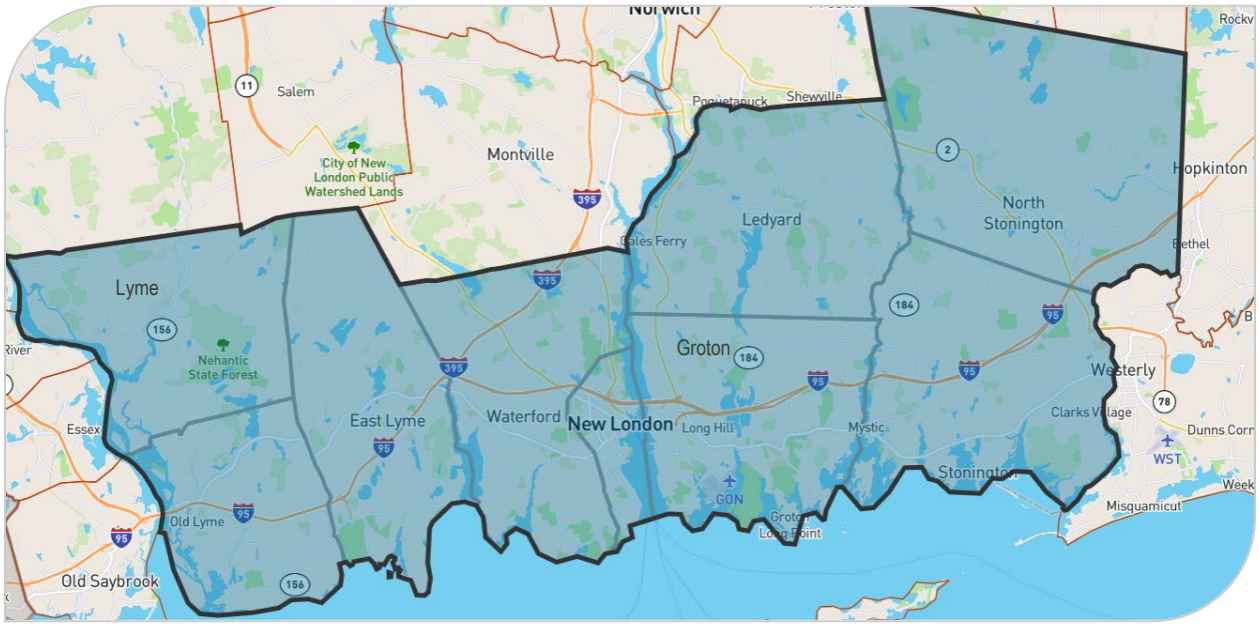
ABOUT OUR PARTNERS

The 2025 CHNA for the Greater New London, Connecticut region was collaboratively conducted with the Health Improvement Collaborative of Southeastern Connecticut (HIC), which includes L+M Hospital, and the Eastern Connecticut Health Collaborative (ECHC), which includes Hartford Healthcare and Backus Hospital.

These partnerships bring together diverse organizations, healthcare providers, and community key informants, fostering collaboration to address the unique needs of the region. This collective effort reflects a shared commitment to understanding and addressing the health and well-being of residents across Greater New London, Connecticut. A list of partners involved in the process can be found in Appendix D.

OUR REGION

The municipalities in the Greater New London region service area include the city of New London and the towns of East Lyme, Groton, Ledyard, Lyme, North Stonington, Old Lyme, Stonington, and Waterford. These municipalities are located in New London County, Connecticut.



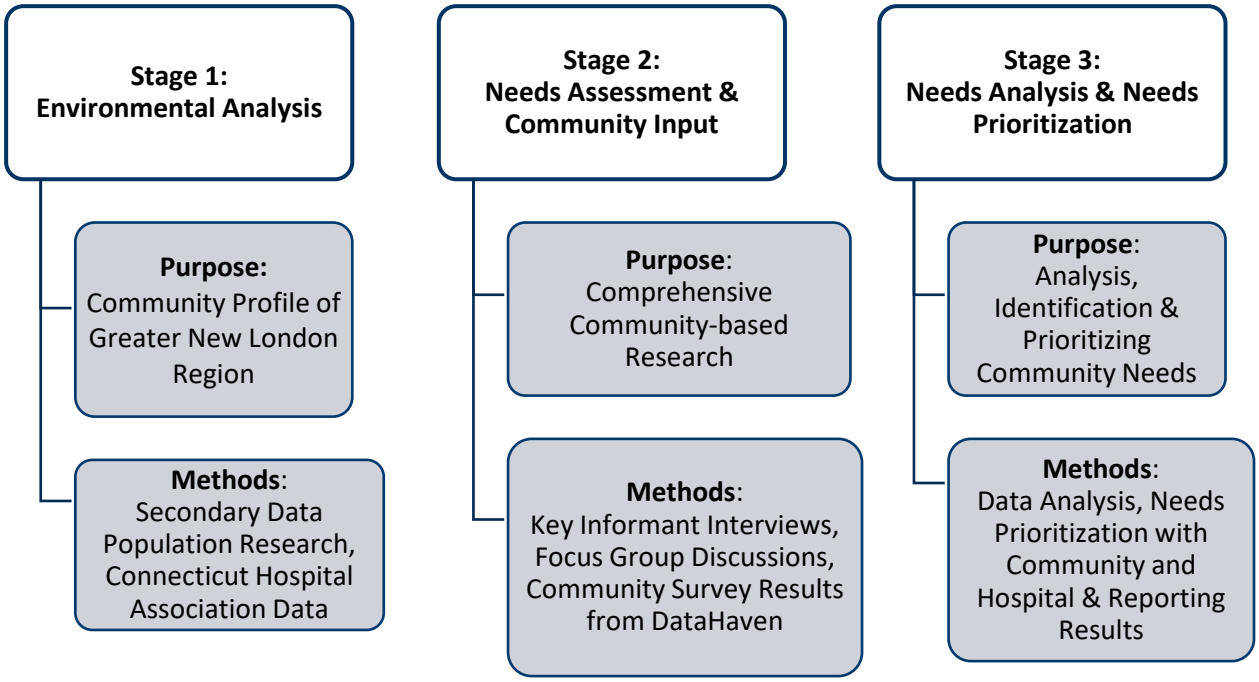
Service Area Zip Codes

Zip Code	Town	County	Market	State
06320	New London	New London	New London	CT
06333	East Lyme	New London	East Lyme	CT
06335	Ledyard	New London	Gales Ferry	CT
06338	Ledyard	New London	Mashantucket	CT
06339	Ledyard	New London	Ledyard	CT
06340	Groton	New London	Groton	CT
06349	Groton	New London	Groton	CT
06355	Stonington	New London	Mystic	CT
06357	Waterford	New London	Niantic	CT

Zip Code	Town	County	Market	State
06359	North Stonington	New London	North Stonington	CT
06371	Old Lyme	New London	Old Lyme	CT
06372	Stonington	New London	Old Mystic	CT
06375	Waterford	New London	Quaker Hill	CT
06376	Old Lyme	New London	South Lyme	CT
06378	Stonington	New London	Stonington	CT
06379	Stonington	New London	Pawcatuck	CT
06385	Waterford	New London	Waterford	CT
06388	Stonington	New London	West Mystic	CT
06439	Lyme	New London	Hadlyme	CT

CHNA METHODOLOGY

Results of the major research activities employed in this Community Health Needs Assessment include secondary data research, reviewing results of DataHaven Community Well-Being Survey efforts, conducting primary qualitative interviews with key informants and in focus groups, and conducting a needs prioritization process, all of which are explained in more detail below.



Data Sources

Stage 1: Environmental Analysis

Secondary Data and Internal Data Analysis provided a critical insight into demographics of the Greater New London region, social determinants of health, and behavioral health-related measures, among many others.

Stage 2: Needs Assessment & Community Input

Qualitative Research included 21 one-on-one key informant interviews and 18 focus groups in collaboration with the HIC and ECHC.

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

- **DataHaven Community Well-Being Survey (DCWS)** a statewide survey that utilizes probability sampling to collect localized data. This randomized telephonic survey, offered in English and Spanish, included 499 responses from residents across the Greater New London region.
- **Community Based Assets and Needs Survey (CBANS)** was administered utilizing conscience sampling. This electronic survey, available in English, Spanish and Haitian Creole, included a subset of questions from DCWS, Greater New London region received 185 responses to the CBANS.

Stage 3: Needs Analysis & Needs Prioritization

A **Needs Prioritization Process** was conducted with the Health Improvement Collaborative (HIC), regional partners, and community members, who used data review and scoring methods to identify key health needs. Lawrence + Memorial Hospital leadership reviewed the regional findings and selected hospital priorities based on community-identified needs and the hospital's ability to affect change.

Data Limitations

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

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

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

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

DataHaven Community Wellbeing Survey (DCWS) and Community-Based Assets and Needs Survey (CBANS): While the **DCWS** aims for broad representation, participation is voluntary, which can introduce nonresponse bias and limit its ability to fully reflect certain populations, including Black/African American residents. **CBANS** helps address this gap by amplifying the voices of groups who have been marginalized, though it is not statistically representative. Together, these surveys provide a more inclusive picture of community needs, but their findings should be interpreted with an awareness of these limitations.

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

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

How to Read This Report

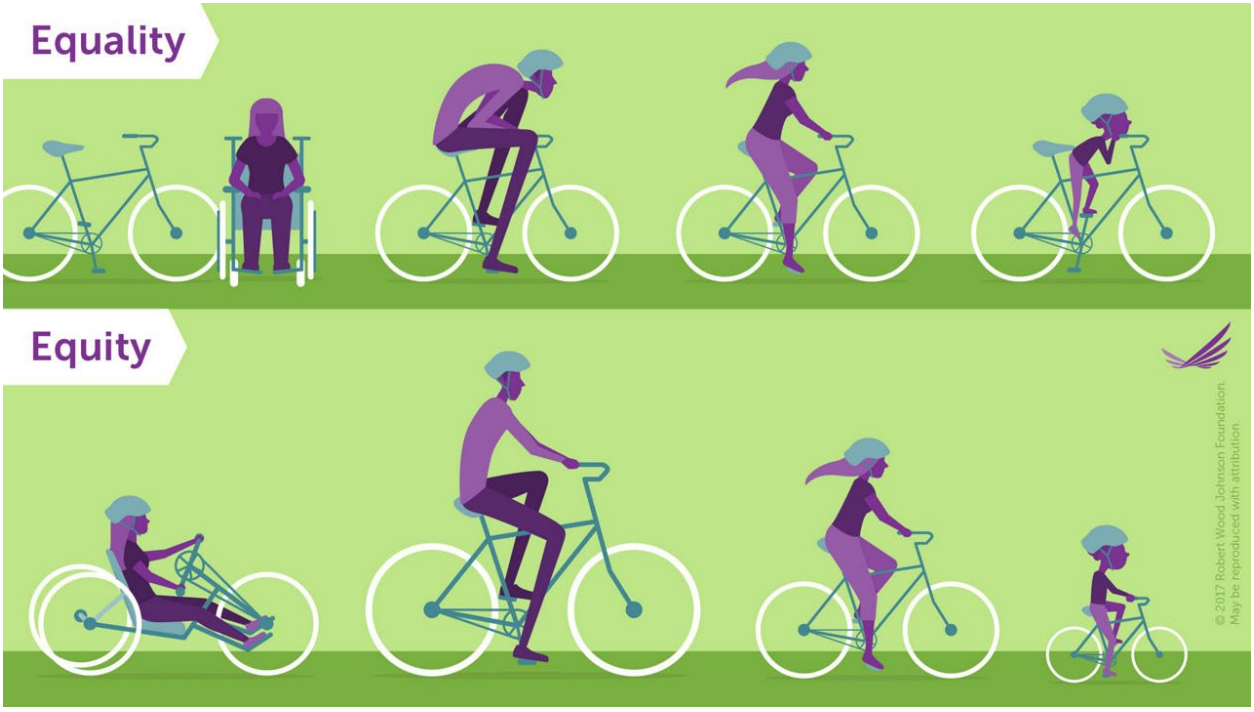
This CHNA aims to give a holistic depiction of the health and well-being of the hospital region. The report is organized by the five Social Drivers of Health domains: Health Care Access and Quality, Education Access and Quality, Economic Stability, Neighborhood and Built Environment and Social and Community Context. Each section includes summary data from the primary and secondary quantitative and qualitative data. Additional data is located in Appendix E. While the report aims to be comprehensive, it is not an exhaustive list of all the challenges and data for the region.

Report Terms and Definitions

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

Health Equity Lens

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



Source: Visualizing Health Equity: One Size Does Not Fit All Infographic – RWJF Alignment. Reproduced with permission of the Robert Wood Johnson Foundation, Princeton, N.J.

Health Equality: Providing everyone with the same resources or services. However, because people have different needs, equal treatment does not always lead to fair health outcomes.

Health Equity: Ensuring that individuals receive the support necessary for their specific circumstances. Some people may need additional resources, such as more healthcare access, affordable medications, or transportation assistance, to achieve the same level of health as others.

Many factors influence health, including income, neighborhood conditions, healthcare availability, and reliable transportation. Some communities experience greater challenges due to systemic barriers and fewer resources. L+M is committed to identifying these gaps and addressing disparities to promote fair access to healthcare.

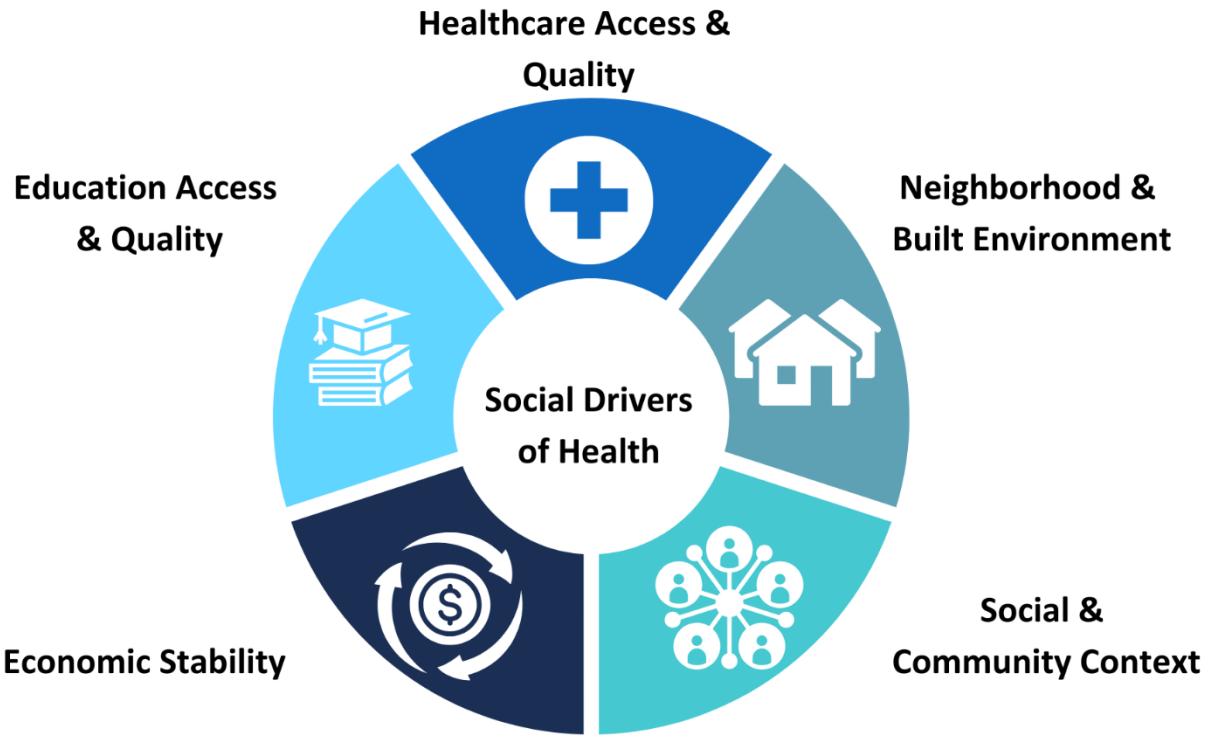
Where possible and relevant, this report presents data by race, ethnicity, education, and income to show differences in health outcomes and identify where disparities exist. Breaking down the data in this way helps highlight gaps in access to care and can inform strategies to improve health for all.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

Social Drivers of Health Framework

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. They also contribute to wide health disparities and inequities.

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

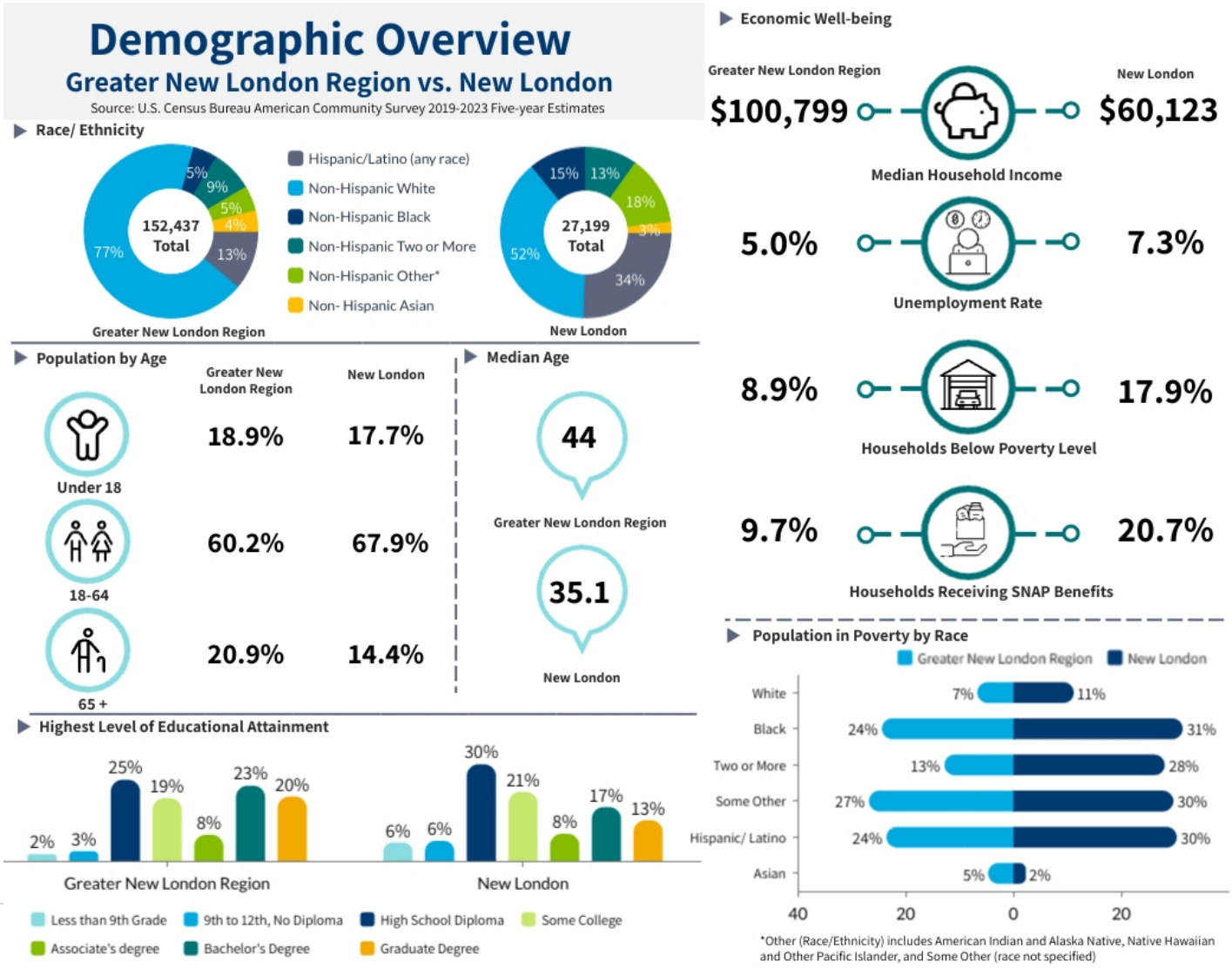
Social Drivers are also known as social determinants. “Determinants” suggest that nothing can be done to change our health fate. By using the term “drivers,” we can reframe the conversation that social factors don’t force health to be fated or destined, but rather something that people and communities can change.



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

COMMUNITY PROFILE

Demographics



Qualitative Key Findings

To understand how people interact with their communities, systems, and services, we must first build relationships grounded in mutual trust and benefit. Listening to people's stories and lived experiences helps reveal the root causes behind health behaviors and outcomes, not just the outcomes themselves.

Qualitative data, resulting from community engagement, provides an important context for the health and well-being outcomes and trends contained in the numbers underlying the environmental analysis. In combination, qualitative and quantitative data produce a broader picture of what a community is experiencing and enable a more thorough and well-rounded approach to program and policy development.

The Greater New London region's overall community engagement for the 2025 CHNA included qualitative research consisting of focus groups and key informant interviews.

Populations Engaged

This effort engaged individuals across the region with special intention to include those who have been historically underrepresented. Strategic outreach included social service and health organizations, healthcare providers, seniors, parents, educators, individuals with lower socioeconomic status, those who identify as BIPOC (Black, Indigenous and People of Color) and Native American, primary Spanish-speakers, veterans, and concerned community members across the service area towns, among others.

In total, input was collected from 21 key informants and 18 focus groups conducted in and around the Greater New London region. Focus groups were conducted in both English, Spanish, and Haitian Creole.

Themes

The themes below reflect key issues and dynamics that emerged consistently across focus groups and key informant interviews. While individual community members may not use terms like "health equity" explicitly, these themes represent shared experiences, concerns, and values discussed in relation to health and well-being in the Greater New London region.

These concepts are not mutually exclusive, they often overlap and influence one another. Together, they help illustrate the broader context in which residents live, access services, and make decisions about their health. The four themes are:

Throughout the interviews and focus groups, community members identified increasing **health equity** as an ever-present goal for the community. Many participants expressed concern that citizenship status, socioeconomic status, racial and ethnic identity, and age have a significant impact on the Greater New London region residents' ability to maintain their health and wellbeing.

Healthcare access in the Greater New London region is affected by a number of factors including insurance status and provider availability, patient primary language, and financial resources. High quality, accessible healthcare was noted as especially difficult to obtain for the immigrant community.

Participants emphasized the importance of **trust** both between healthcare providers, community organizations, and residents. By establishing a relationship built on trust, individuals are often more likely to seek care and follow recommendations.[3] Community members involved in the interviews and focus groups shared ideas shared ideas for building trust in the community including incorporating cultural considerations into treatment, building relationships between the health system and community members, and recruiting diverse providers and staff.

Community members shared that **diversity** is a strength in Greater New London. They also said it's important to consider this diversity when identifying needs and creating solutions. Community members involved in the interviews and focus groups emphasized the value of services that reflect the different cultures and languages in the community, and the need for providers who understand and represent the people they serve. Participants also voiced the importance of having input in the CHNA process from a diverse group of individuals, especially those that have historically been marginalized.

These themes are not mutually exclusive and often have compounding impacts on individuals. The interconnectedness of these themes highlights the need for a holistic approach to improve the wellbeing of its residents.

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

Community Strengths

The Greater New London region has many great assets and strengths. While the bulk of this assessment focuses on the opportunities for improvement in health and social drivers of health, there are robust community assets across the region that help to strengthen health and wellbeing in the region. Many are included in the Asset Inventory (Appendix G).

Additionally, participants identified a number of community strengths, including a diverse and welcoming community, strong social connections, and collaborative community organizations.

Economic Stability

Economic Stability is one of the five social drivers of health. It includes key issues, such as income, poverty, employment, food security, and housing stability. People living in poverty are more likely to experience food insecurity, housing instability or poor housing conditions, and limited access to healthcare services, which can all contribute to poor health outcomes.

(U.S. Department of Health and Human Services, Healthy People 2030)

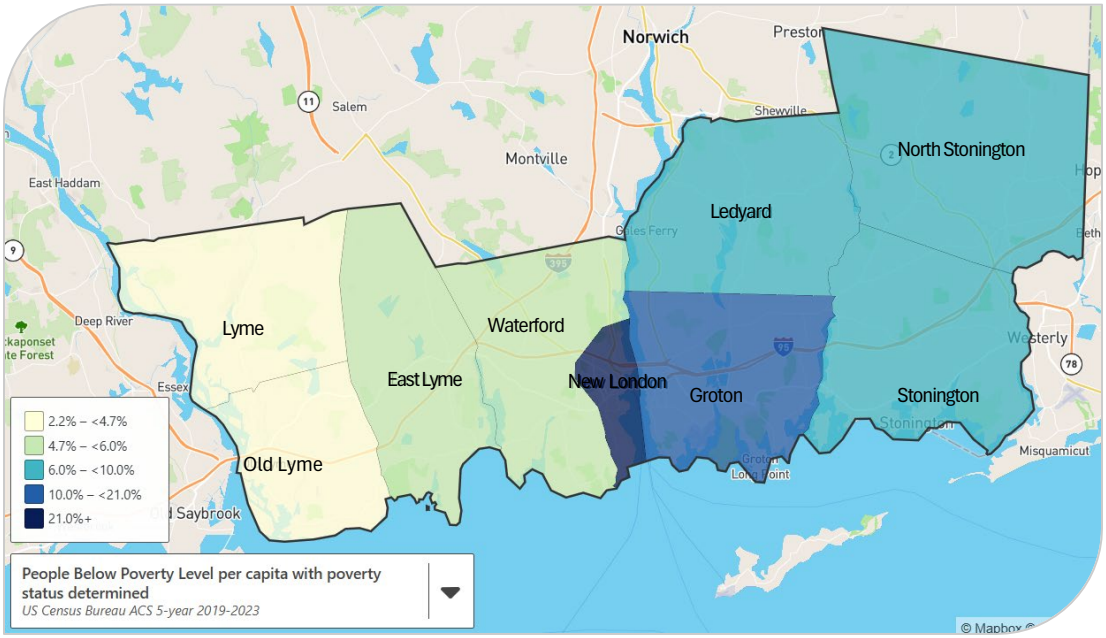
Income and Poverty

The Greater New London region experiences a higher than state average median income. While some areas, such as Lyme and Old Lyme, report incomes well above the state average, other municipalities, particularly Groton and New London, have significantly lower median incomes (Table 27).

EXHIBIT 1: MEDIAN HOUSEHOLD INCOME

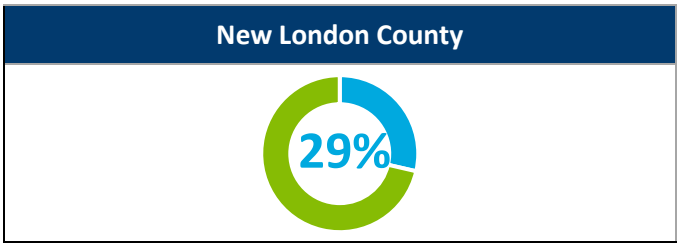
Geography	Income
Lyme	$139,000
Old Lyme	$126,904
North Stonington	$115,069
Waterford	$75,968
Stonington	$108,922
Ledyard	$107,774
East Lyme	$107,667
Greater New London Region	**$100,799**
CT	**$93,760**
Groton	$69,811
New London	$60,123

EXHIBIT 2: PERCENT OF POPULATION LIVING IN POVERTY



Nearly one in three households in New London County qualifies as Asset Limited, Income Constrained, Employed (ALICE), meaning they earn above the poverty level but still struggle to afford basic needs (Table 26). These are often working individuals and families who do not qualify for public assistance but may have difficulty affording essentials like housing, childcare, healthcare, transportation, or food.

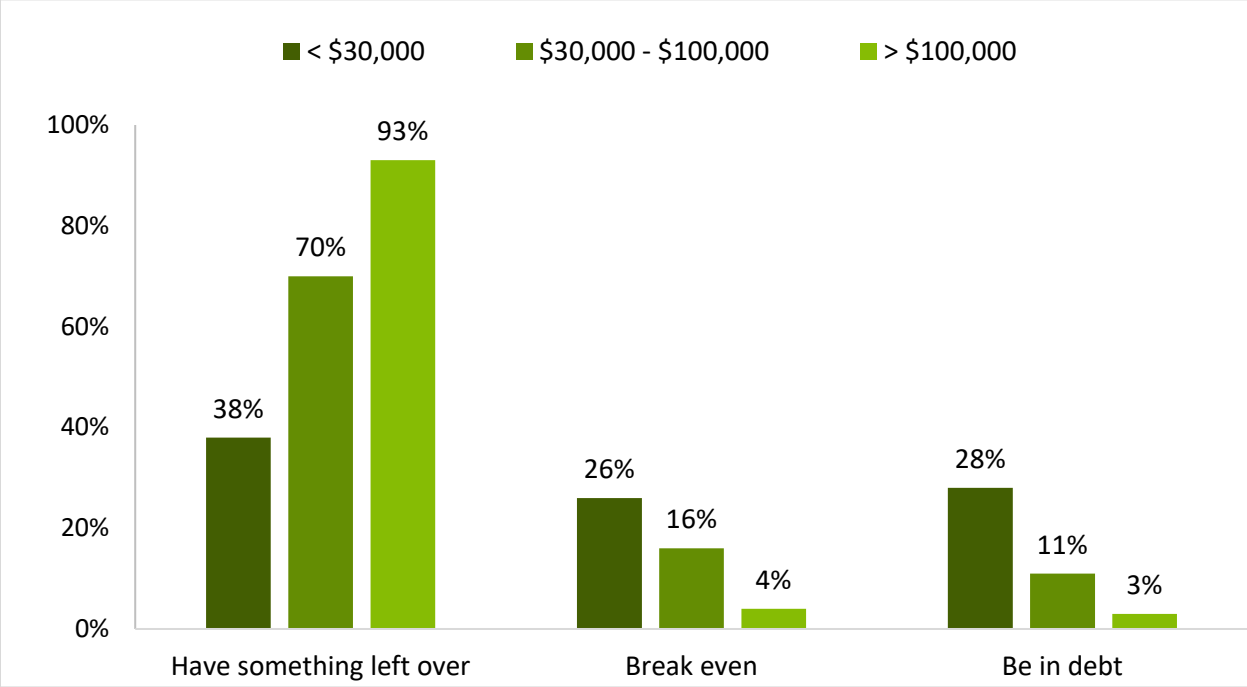
EXHIBIT 3: UNITED WAY ASSET LIMITED INCOME-CONSTRAINED EMPLOYED (ALICE) POPULATION



Source: United Way United for ALICE Research Center, Connecticut, 2022. Table 26

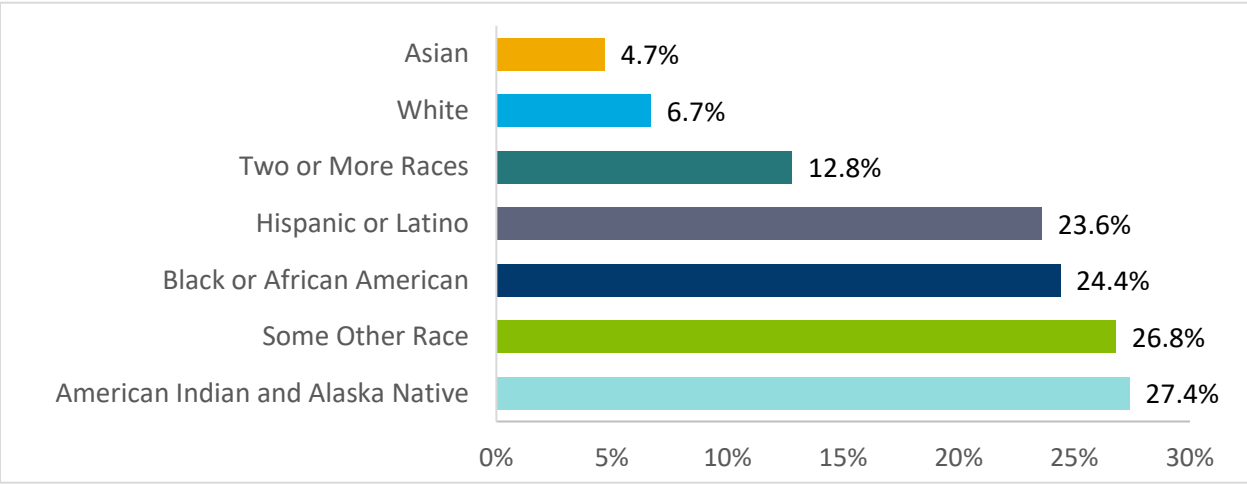
In Greater New London, over one-quarter of survey respondents in households earning less than $30,000 said they would still be in debt even after selling all major possessions, investments, and assets and paying off all debts, showing how hard it is for some families to get ahead.

EXHIBIT 4: DCWS QUESTION – FINANCIAL STATUS OF RESPONDENTS' HOUSEHOLDS AFTER SELLING ALL MAJOR POSSESSIONS, INVESTMENTS, ASSETS, AND PAYING OFF ALL DEBTS, BY INCOME (GREATER NEW LONDON REGION)



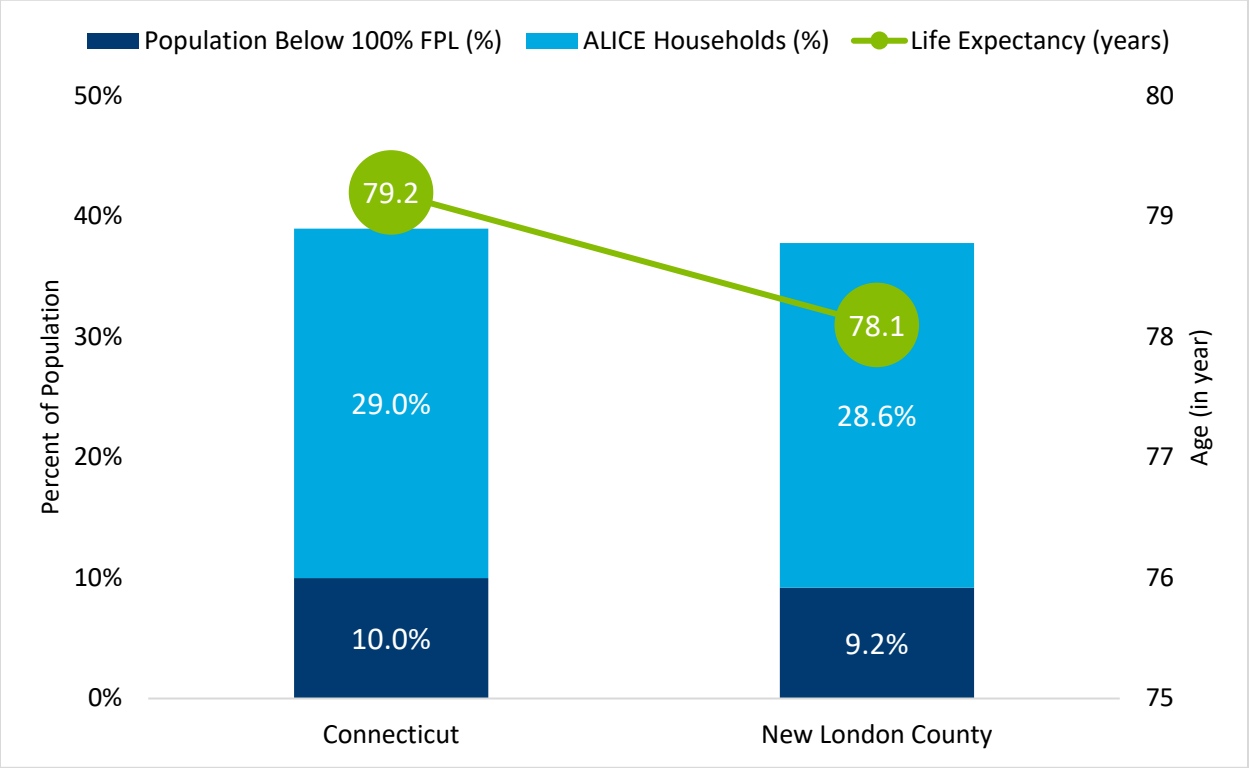
Poverty rates also reveal significant racial disparities. Black, Hispanic, and Native American residents are more than three times as likely as White residents to live below the poverty level, reflecting broader systemic inequities in economic opportunity (Table 25). These disparities in income and financial stability contribute to health inequities, as financial constraints limit access to healthcare, healthy food, and stable housing.

EXHIBIT 5: PERCENT OF POPULATION LIVING IN POVERTY, BY RACE/ETHNICITY



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 25

EXHIBIT 6: POPULATION LIVING IN POVERTY, ALICE HOUSEHOLDS, AND LIFE EXPECTANCY



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 25| UnitedWay United for ALICE Research Center, Connecticut, 2022. Table 26 | County Health Rankings 2020-2022 Table 45

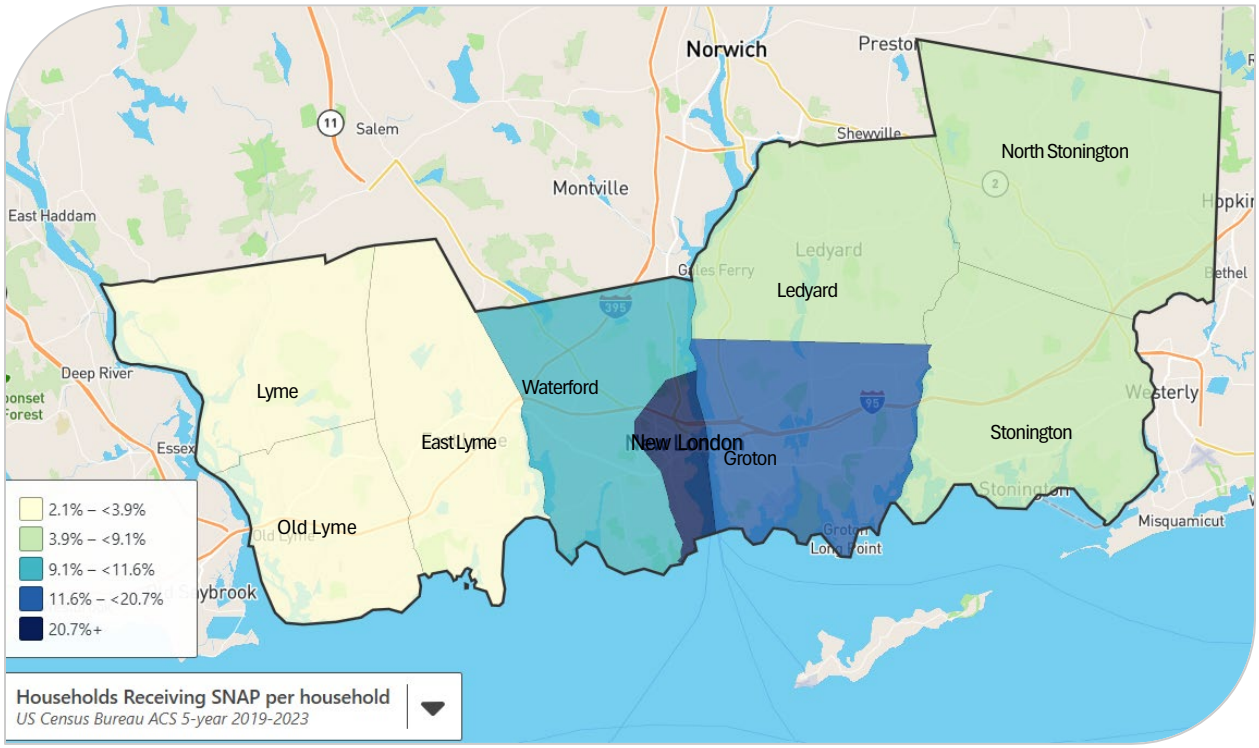
Yale New Haven Health's Community Health Workers provide assistance and referrals to community resources to address the social drivers of health needs of patients.

Food Insecurity

> **"It is challenging to get healthier foods with everything being so expensive. This causes children to not eat healthy meals. Children then begin to gain weight, become obese and their asthma worsens." - Key Informant**

Food insecurity is a persistent issue in the Greater New London region, with urban areas facing greater barriers to accessing healthy, affordable food. Greater New London key informants described the region as a "food apartheid area," emphasizing that low-income residents without reliable transportation struggle to reach grocery stores that offer fresh, nutritious options. Those experiencing both food and housing insecurity face additional barriers, as they may receive food assistance but lack a stable place to store or prepare meals.

EXHIBIT 7: PERCENT OF HOUSEHOLDS RECEIVING SNAP BENEFITS



DCWS data reinforces these disparities. Food insecurity was much more common among lower-income residents, with 35% of those earning under $30,000 reporting they did not have enough money to buy food in the past year, compared to just 5% of those earning $100,000 or more. Households earning less than $30,000 were over 22 times more likely to rely on food assistance compared to those earning over $100,000 (45% vs. 2%)

EXHIBIT 8: DCWS QUESTION – RESPONDENTS WHO DID NOT HAVE ENOUGH MONEY TO BUY NECESSARY FOOD FOR SELF OR FAMILY IN THE PAST 12 MONTHS, BY INCOME (GREATER NEW LONDON)

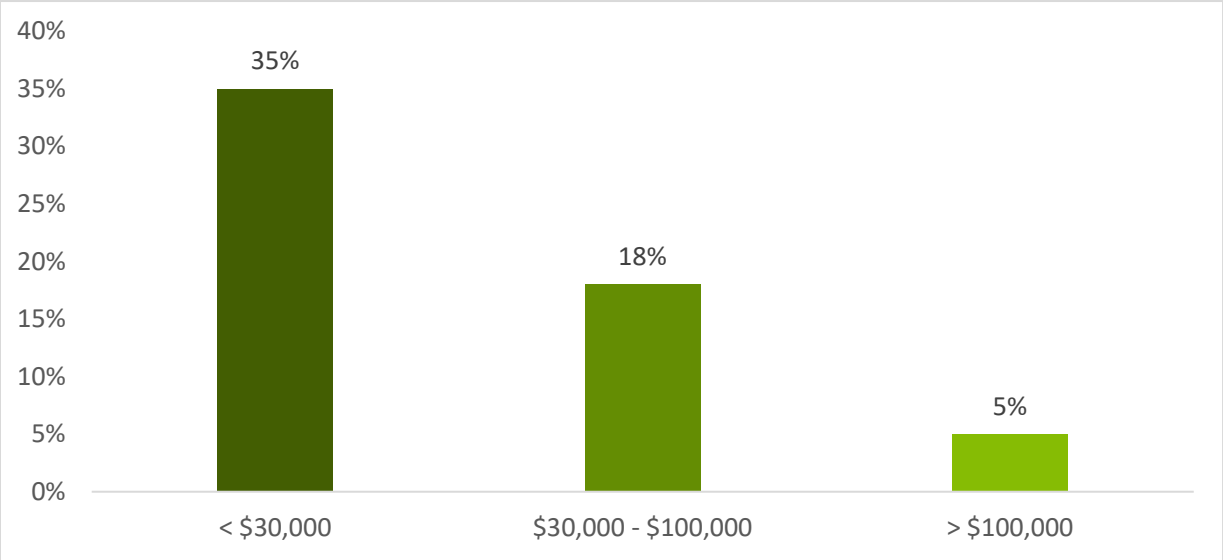
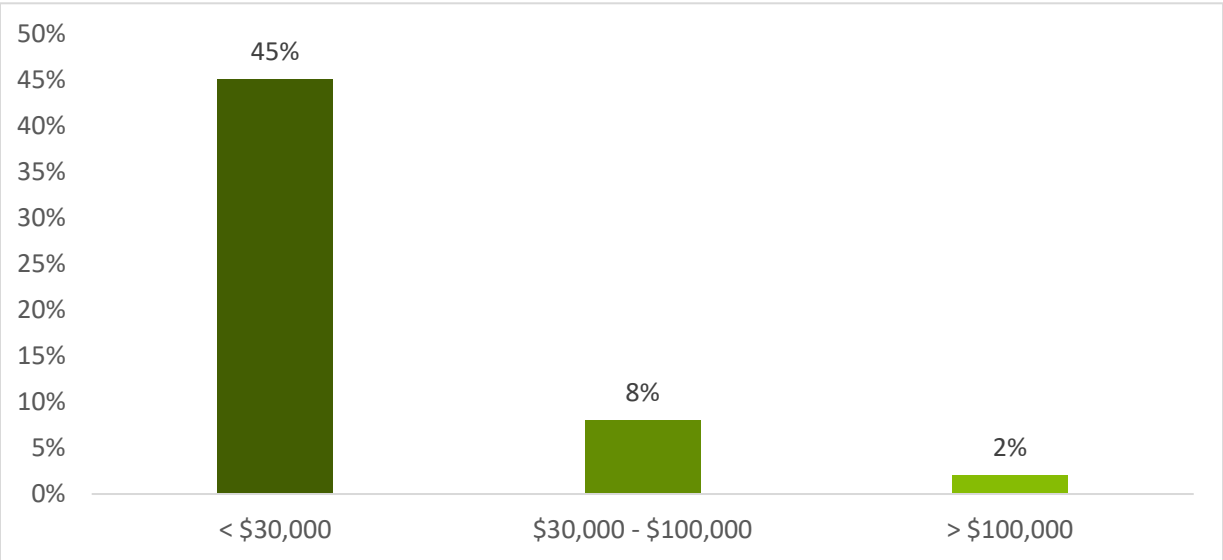


EXHIBIT 9: DCWS QUESTION – RESPONDENTS WHO RECEIVED GROCERIES OR MEALS FROM A FOOD PANTRY, FOOD BANK, SOUP KITCHEN, OR OTHER EMERGENCY FOOD SERVICES IN THE PAST 12 MONTHS, BY INCOME (GREATER NEW LONDON)



Percent of Students Eligible for Free/Reduced Lunch in New London County

41%

Children in the region are also affected, with 41% of students in New London County eligible for free or reduced-price lunch, highlighting the economic challenges many families face.

7.5%

of 8,895 L+M patients screened reported **food insecurity.**

Source: Yale New Haven Health's SDoH screening initiative (10/01/23- 09/30/24)

Lawrence and Memorial Hospital supports and collaborates with many food pantries and food assistance programs across the region through volunteer time and donations.

Housing

Housing affordability is a major challenge in the Greater New London region. According to Greater New London key informants, rising costs burden both renters and prospective homeowners, with out-of-state investors driving up prices. Many residents experience overcrowding due to high costs and housing shortages, impacting physical and behavioral health.

Affording a home remains out of reach for many. A worker in New London County would need to earn nearly $30 per hour to afford a fair-market rent two-bedroom apartment—far exceeding the wages of many residents. Key informants emphasize the urgent need for affordable housing options and stronger renter protections to prevent worsening instability and poor health outcomes.

Hourly Wage Necessary to Afford a 2-Bedroom Apartment at Fair Market Rent:

$29.92

in New London County-Norwich-New London HUD Metro Area

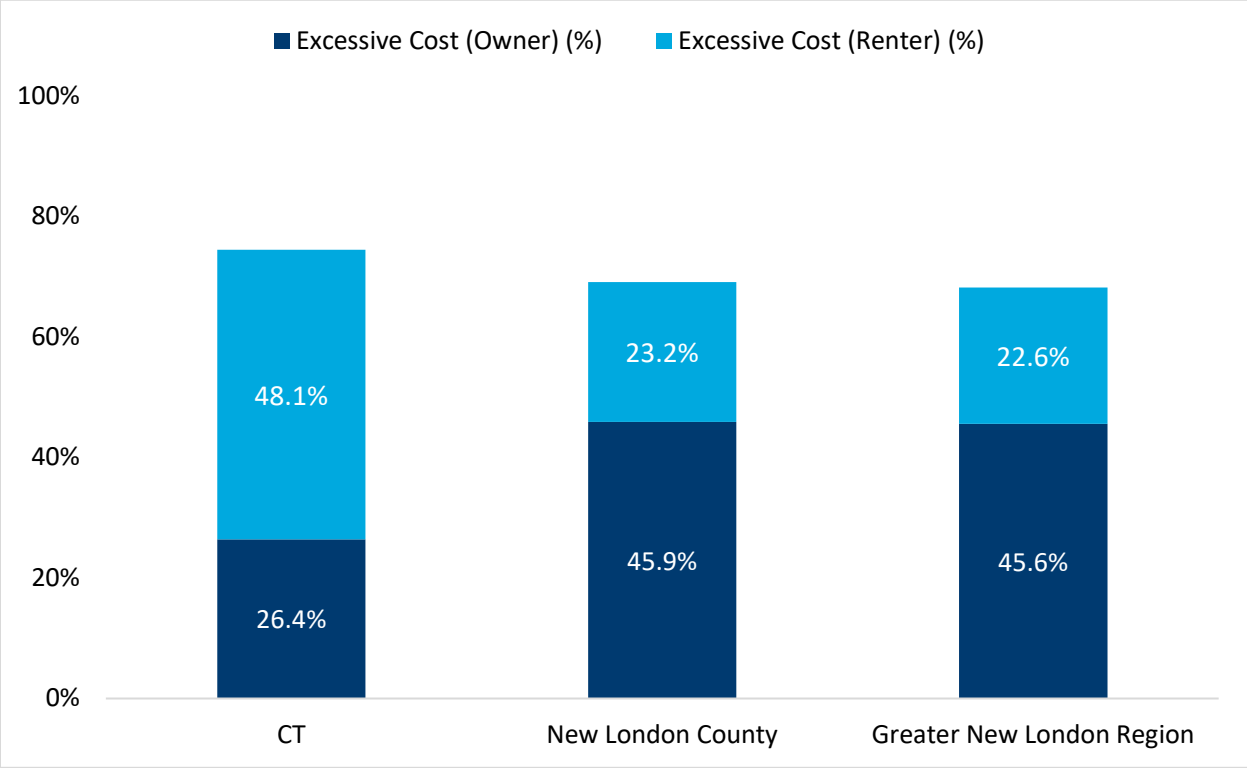
National Low Income Housing Coalition (2023)

"Housing is healthcare. When someone has stable affordable housing, their medical conditions can drastically change for the better."

- Key Informant

Lawrence and Memorial Hospital supports and collaborates with local housing initiatives.

EXHIBIT 10: OWNER AND RENTER EXCESSIVE COSTS[4]



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 34

3.6%

Of 9,298 L+M patients screened reported **housing insecurity.**

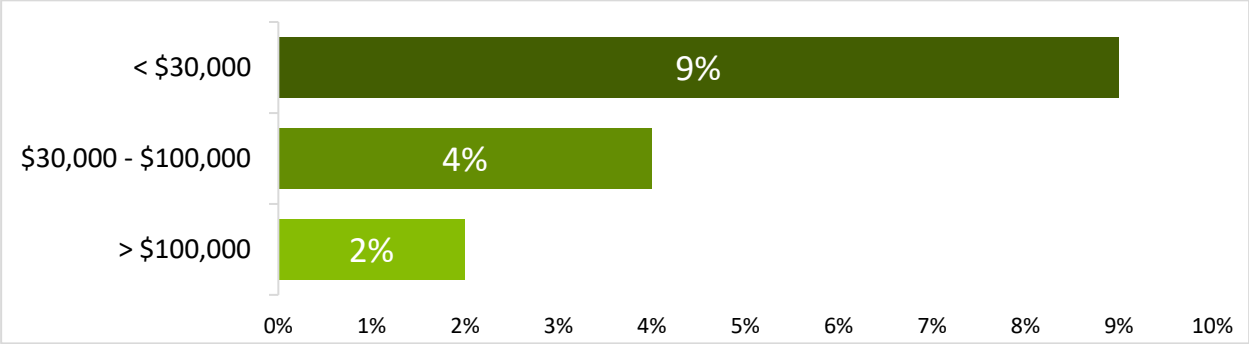
Source: Yale New Haven Health's SDoH screening initiative (10/01/23- 09/30/24)

[4] Excessive housing costs are defined by the U.S. Department of Housing and Urban Development (HUD) as spending more than 30% of household income on housing expenses, including rent or mortgage, utilities, and insurance.
Source: U.S. Department of Housing and Urban Development. "Affordable Housing."

Employment

Employment plays a crucial role in financial stability and access to healthcare, yet some Greater New London residents face barriers to securing jobs. According to DCWS, 4% of survey respondents reported being unemployed in the past 30 days but wanting to work.

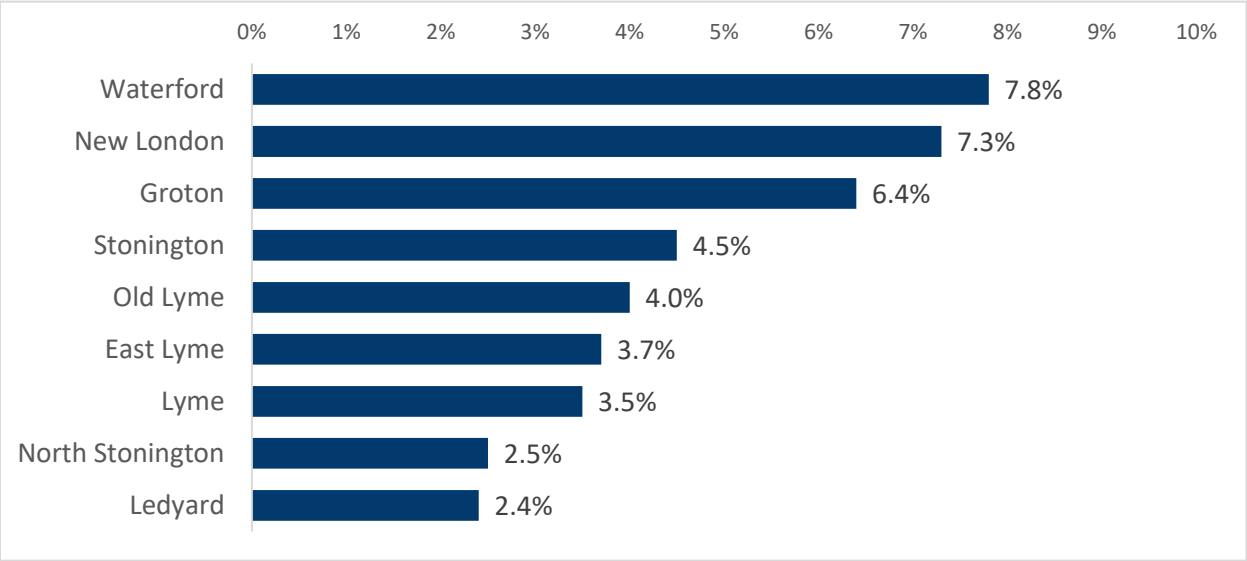
EXHIBIT 11: DCWS QUESTION – PARTICIPANTS WHO HAVE NOT HAD A JOB IN THE PAST 30 DAYS, BUT WOULD LIKE TO WORK, BY INCOME (GREATER NEW LONDON REGION)



Without stable employment and adequate wages, individuals may struggle to afford healthcare, leading to delayed medical care and worsening health outcomes.

Unemployment rates vary widely across the Greater New London region. Waterford and New London had the highest rates at 7.8% and 7.3%, respectively—nearly three times higher than towns like Ledyard (2.4%) and North Stonington (2.5%). These geographic differences suggest that residents in some communities may face more limited access to stable employment, which can have downstream effects on housing stability, healthcare access, and overall well-being.

EXHIBIT 12: UNEMPLOYMENT RATES BY TOWN



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

Neighborhood and Built Environment

Neighborhood and Built Environment is one of the five social drivers of health. It includes key issues such as quality of housing, access to transportation, and neighborhood crime and violence. The environment, such as air pollution, unsafe drinking water, and climate change can also impact the health of an individual person and the community as a whole.

(U.S. Department of Health and Human Services, Healthy People 2030)

The communities we live in and where we live in them, can have a major impact on our health and well-being. Many people within the United States live in neighborhoods without sidewalks, and high rates of violence, unsafe air or water, and other health and safety risks. Persons of color and households of lower income disproportionately live in neighborhoods with these health risks.[5]

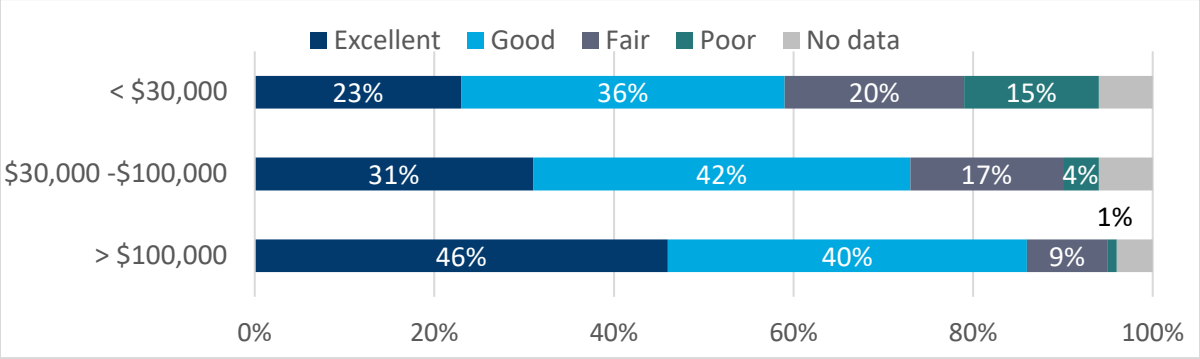
Neighborhood Livability

Community environment plays a critical role in overall well-being, shaping access to safe spaces for recreation, social engagement, and child development.

[5] Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services. Healthy People 2030, Neighborhood and Built Environment. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment

According to DCWS, 76% of survey respondents rated their neighborhood as an 'excellent' or 'good' place to raise children. However, disparities exist across racial and income groups. White respondents were more likely than Latino respondents to rate their community favorably. Similarly, higher-income residents were more likely to report a positive perception of their neighborhood, while those with lower incomes were more likely to rate their community as only 'fair' or 'poor'.

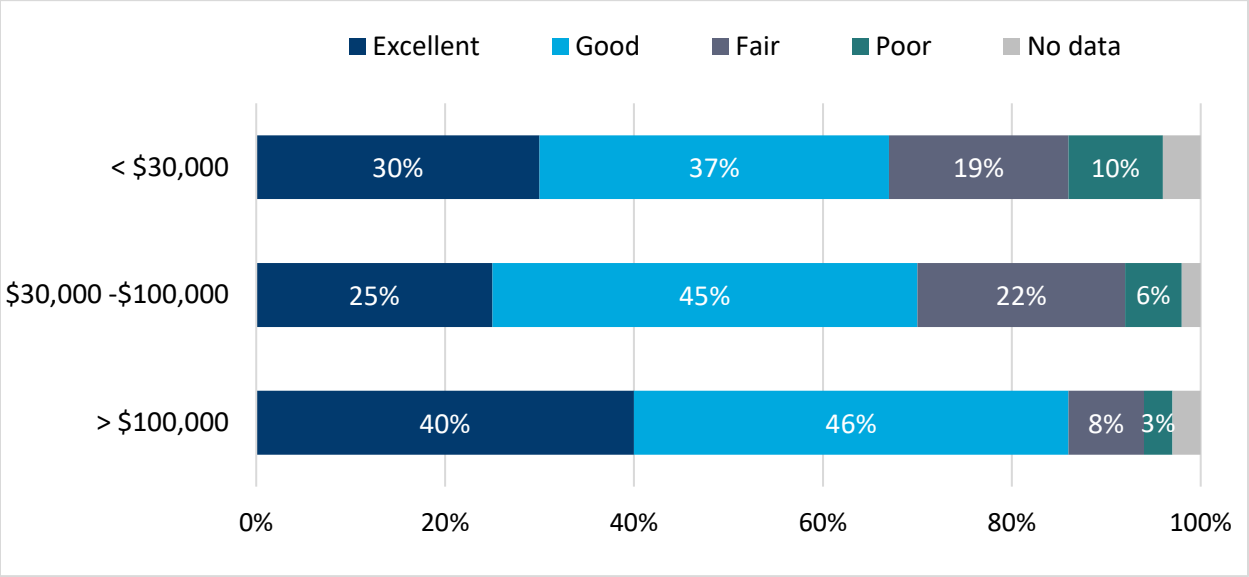
EXHIBIT 13: DCWS QUESTION – HOW RESPONDENTS RATE LOCAL AREA AS A PLACE TO RAISE CHILDREN, BY INCOME (GREATER NEW LONDON)



Public parks and recreational spaces are important for fostering physical activity, social connection, and overall health.

Overall, three out of four DCWS respondents (76%) rated the condition of local parks and recreational facilities as 'excellent' or 'good', but satisfaction varies based on income. Higher-income individuals were more likely to give favorable ratings, while lower-income respondents were more likely to rate park conditions as only 'fair' or 'poor'.

EXHIBIT 14: DCWS QUESTION – HOW RESPONDENTS RATE THE CONDITION OF LOCAL PUBLIC PARKS AND RECREATIONAL FACILITIES, BY INCOME (GREATER NEW LONDON)

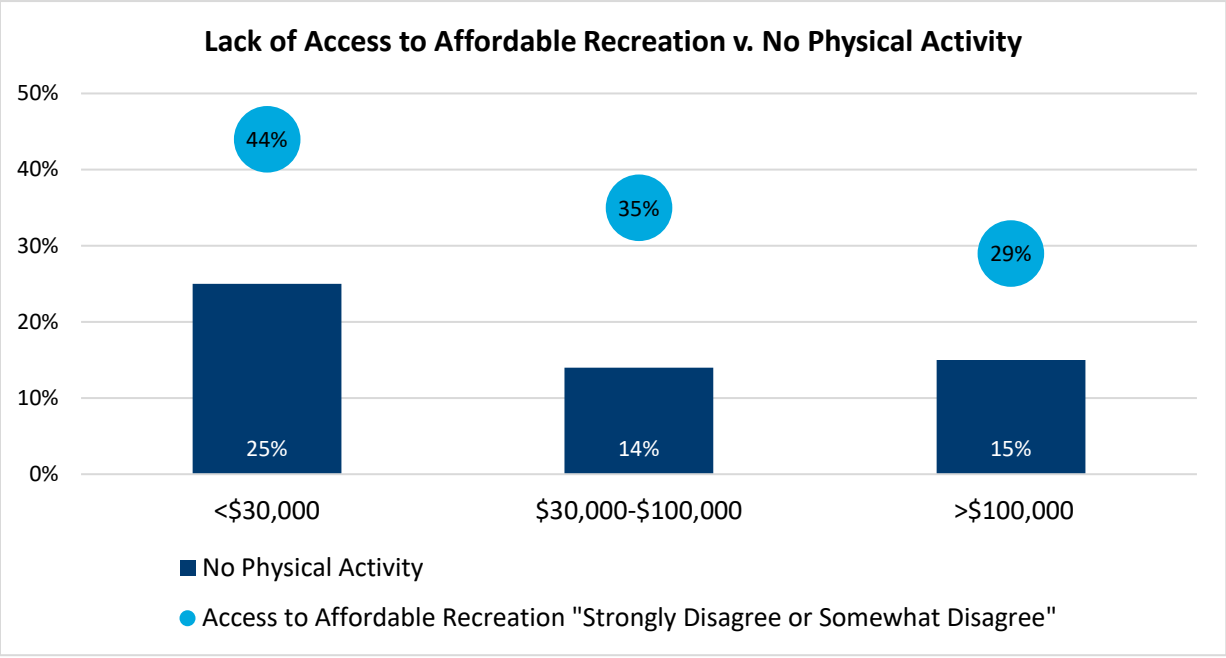


Ensuring equitable access to well-maintained parks and safe community spaces is essential for supporting positive health outcomes. Residents in lower-income neighborhoods may face greater barriers to accessing quality outdoor environments, which can limit opportunities for recreation and social engagement. Investing in neighborhood infrastructure, improving public spaces, and addressing disparities in community resources can help promote health and well-being for all residents of the Greater New London region.

These barriers are reflected in survey findings, which show a connection between income level, and access to affordable recreation, and physical activity in the Greater New London region.

Survey data shows that Greater New London residents with lower incomes are more likely to report both a lack of access to affordable recreation and no weekly physical activity. Among those earning less than $30,000, 44% said they lack access to affordable recreational opportunities, and 25% reported they were not exercising at all during the week. In comparison, just 15% of respondents earning more than $100,000 reported no weekly physical activity. These findings suggest that access and affordability may be important factors influencing health behaviors like physical activity.

EXHIBIT 15: DCWS QUESTIONS - ACCESS TO AFFORDABLE RECREATION IN COMMUNITY (STRONGLY DISAGREE AND SOMEWHAT DISAGREE) VS. HOW MANY DAYS PER WEEK DO YOU EXERCISE (NONE), BY INCOME (GREATER NEW LONDON)



Transportation

Access to reliable transportation is a significant challenge in the Greater New London region, particularly for medical appointments.

Greater New London key informants and community members reported that existing medical transportation services require advance scheduling, are unreliable, and often come at a cost. The free transportation services provided during the COVID-19 pandemic were discontinued, leaving many residents with limited options. As a result, some individuals opt for virtual healthcare visits, even when it may compromise their quality of care.

Households Without a Vehicle in Greater New London Region

6.8%

Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 3

Transportation barriers disproportionately affect certain populations, including older adults and tribal community members. Older adults relying on transit services report frequent delays, no-shows, and restricted service areas, making it difficult to access essential care. Additionally, public transportation does not serve all areas equally— key informants highlighted that routes do not run through the reservation, further limiting access to healthcare and other critical services.

> **"The elderly are alone in their homes with no access to social media, they lost their transportation. They have to rely on others, especially in the rural areas."**
>
> **- Key Informant**

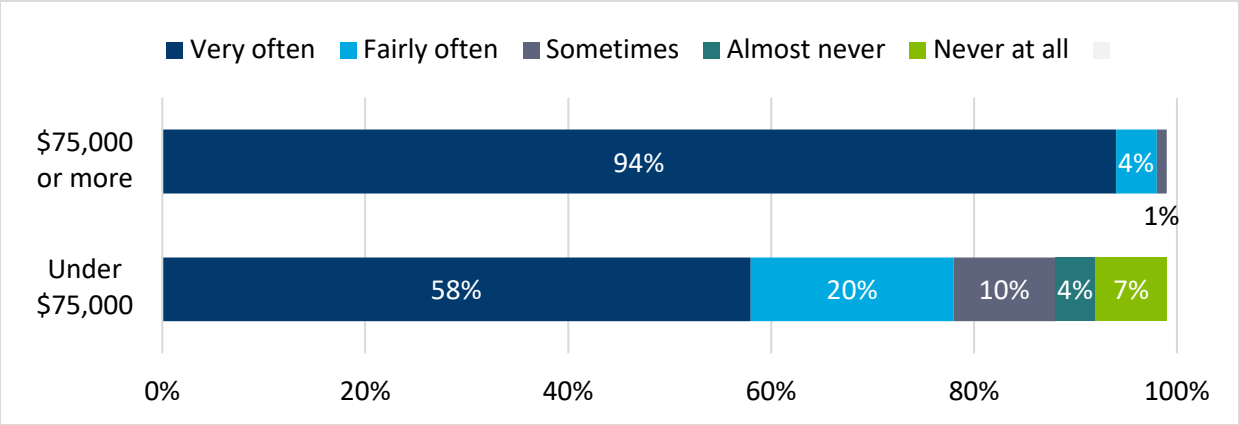
3.7%

of 8,931 L+M patients screened reported **transportation insecurity.**

Source: Yale New Haven Health's SDoH screening initiative (10/01/23- 09/30/24)

Survey data reinforces these challenges. Overall, 13% of CBANS respondents reported limited or no access to a car when needed. Access varies by income, with 58% of respondents earning less than $75,000 reporting frequent car access, compared to 94% of those earning $75,000 or more.

EXHIBIT 16: CBANS QUESTION – HOW OFTEN RESPONDENTS HAVE ACCESS TO A CAR WHEN NEEDED, BY INCOME (GREATER NEW LONDON)



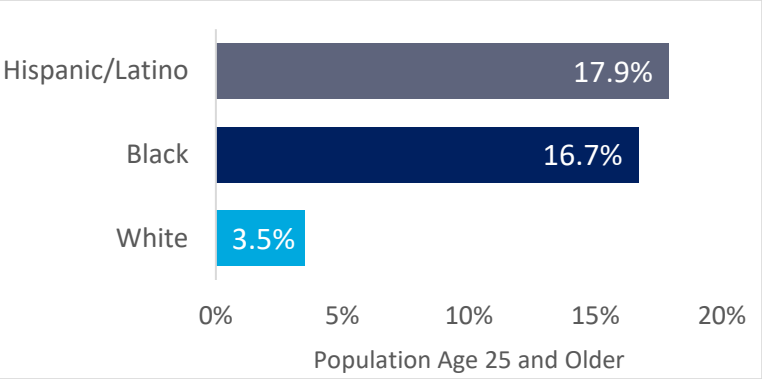
Education Access and Quality

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

(U.S. Department of Health and Human Services, Healthy People 2030)

The Greater New London region shows disparities in educational attainment by race and ethnicity. Nearly one in six Hispanic/Latino adults (17.9%) and Black adults (16.7%) in the region do not have a high school diploma, compared to just 3.5% of White adults (Table 19). These disparities highlight challenges in accessing educational resources and the long-term impact of systemic barriers on economic mobility and health outcomes.

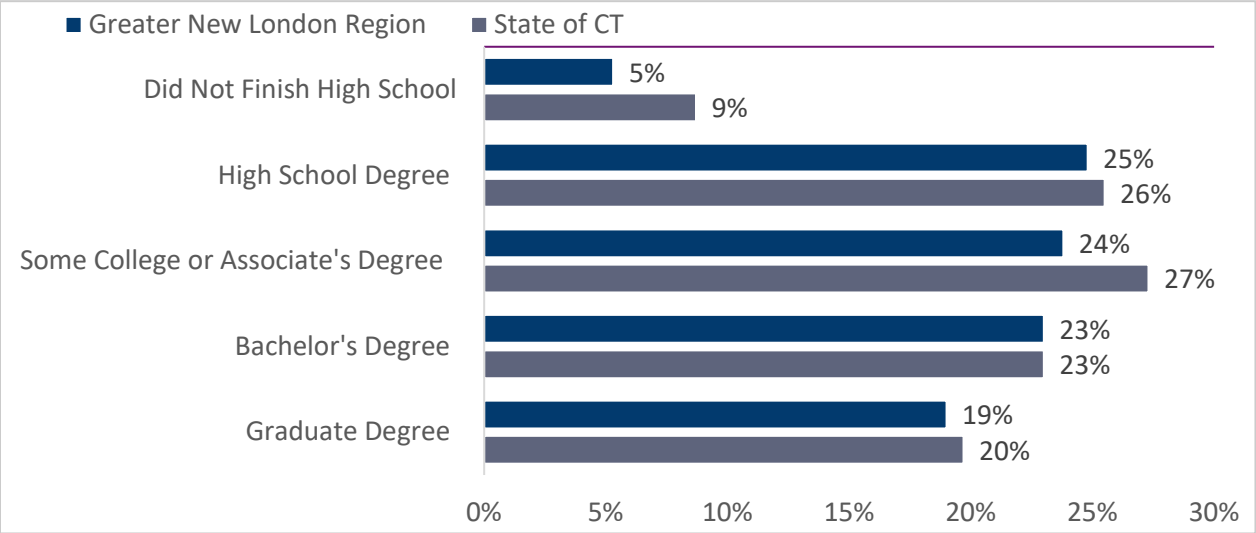
EXHIBIT 17: ADULTS WITHOUT A HIGH SCHOOL DIPLOMA (AGE 25+), AS A SHARE OF THEIR RACIAL/ETHNIC GROUP IN GREATER NEW LONDON REGION



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

While overall educational attainment in the region closely mirrors state trends, a lower percentage of Greater New London residents have not finished high school (5% vs. 9% statewide). However, the percentage of residents with bachelor's and graduate degrees is nearly the same as the state average, reflecting educational opportunities for some, despite challenges for others (Table 18).

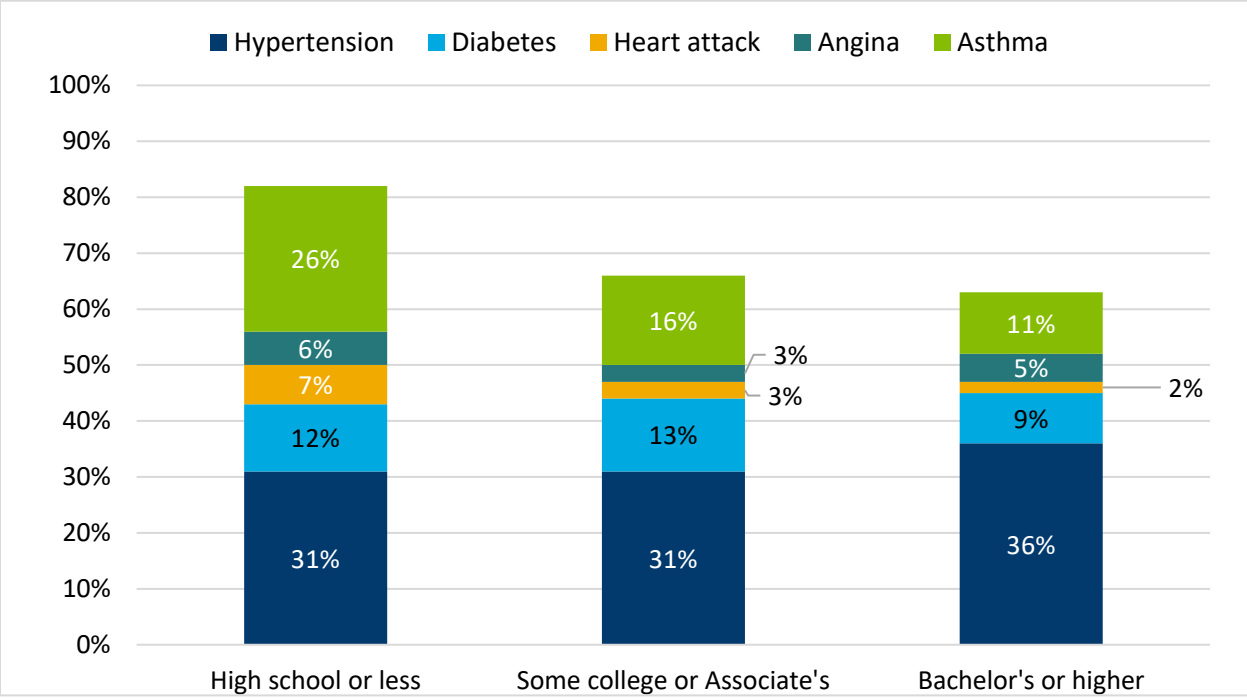
EXHIBIT 18: HIGHEST LEVEL OF EDUCATIONAL ATTAINMENT, 25 YEARS AND OLDER



Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates. Table 18

Survey data from the Greater New London region shows that residents with lower levels of education are more likely to report having chronic conditions like asthma, heart attack, angina, and diabetes. Adults with a high school diploma or less reported the highest overall burden of these conditions, especially asthma. While hypertension rates remained high across all education levels, people with a bachelor's degree or higher were less likely to report multiple chronic conditions, highlighting the connection between education and long-term health.

EXHIBIT 19: DCWS QUESTIONS - PREVALENCE OF CHRONIC CONDITIONS, BY EDUCATION LEVEL (GREATER NEW LONDON)



Social and Community Context

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

(U.S. Department of Health and Human Services. Healthy People 2030)

Language and Cultural Barriers

A Harvard T.H. Chan School of Public Health study[6] found that 51% of Black Americans say they have personally experienced people using racial slurs against them and 35% of Asian Americans reported personally experiencing people making offensive comments about their race or ethnicity.

Greater New London community members and key informants highlighted significant challenges as a result of race, ethnicity, language and immigration status. There was a consistent theme from Black and Latino individuals concerning ways that their race and ethnicity may cause inferior healthcare treatment.

In 2023, Yale New Haven Hospital developed a 'We Ask Because We Care' campaign to help identify and address health disparities due to race, ethnicity and language.

[6] Harvard T.H. Chan School of Public Health. Discrimination in America. https://hsph.harvard.edu/news/discrimination-in-america/#:~:text=Workplace,hiring%2C%20promotion%2C%20and%20compensation.&text=%E2%80%94Robert%20Blendon%2C%20Richard%20L.,who%20co%2Ddirected%20the%20surveys.

In addition, language barriers remain a persistent issue, limiting individuals' ability to navigate healthcare, education, and social support systems.

Many residents struggle to advocate for their needs due to the lack of translated materials, interpreters, and multilingual staff at service agencies. Despite the presence of large immigrant communities, service providers often lack the capacity to serve them effectively, making it difficult for individuals to access essential services.

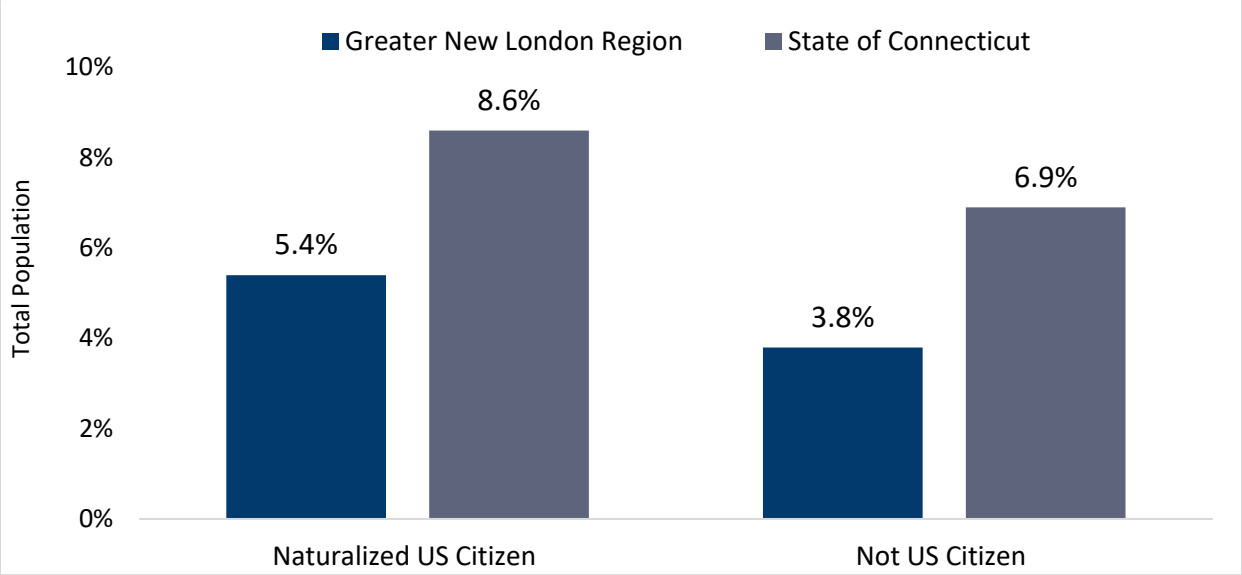
Beyond language barriers, cultural misunderstandings contribute to social isolation. Some community members shared that immigrants feel disconnected due to systemic barriers, such as restricted access to key programs and services. Financial stability can help mitigate some of these challenges, but those without economic security or strong social networks face greater difficulties.

Without culturally competent services and broader community awareness, many non-English speakers remain isolated from the resources and relationships that foster overall well-being.

According to the most recent census data, 9% of the Greater New London region's population is foreign-born.

EXHIBIT 20: FOREIGN-BORN POPULATION

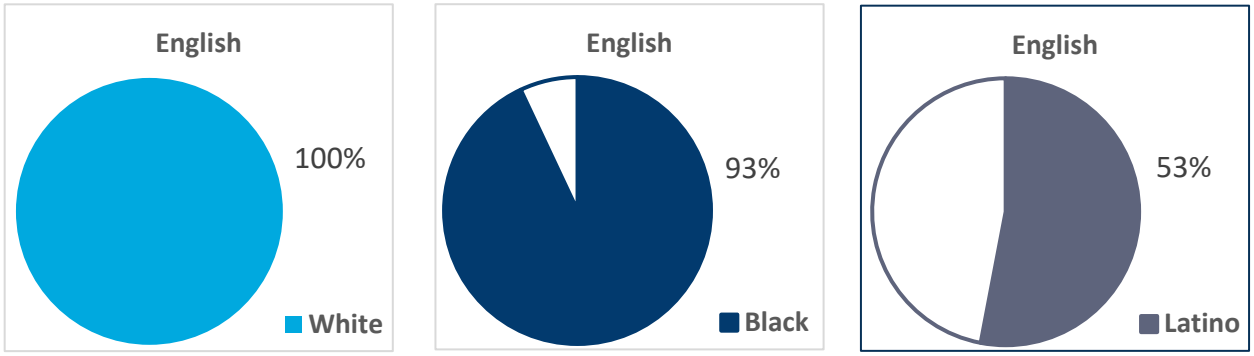
Source: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates



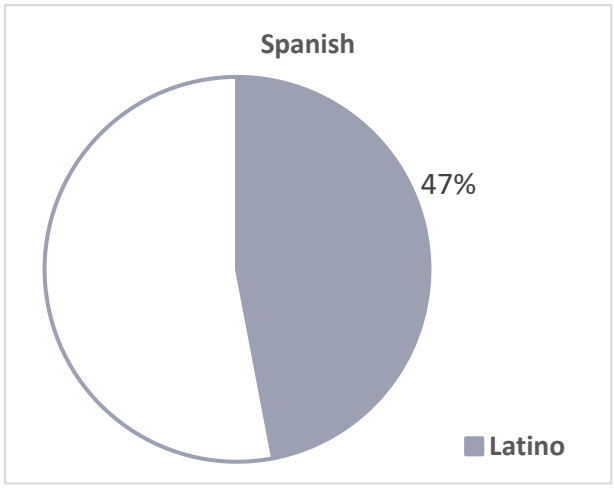
The CBANS survey further highlights the linguistic diversity of the region, with 89% of respondents speaking English at home and 8% speaking Spanish.

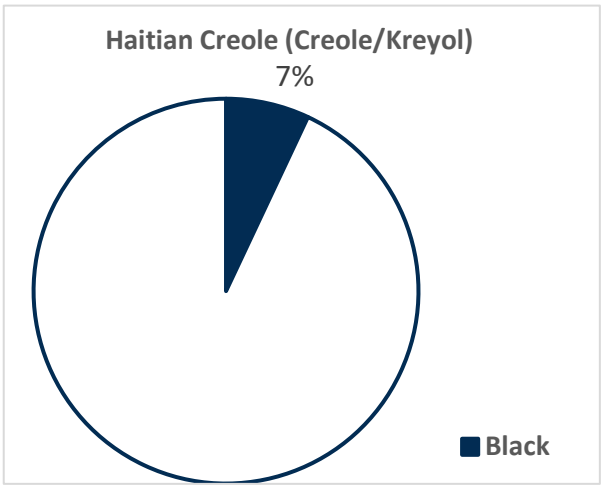
Among racial groups, 47% of Latino CBANS respondents reported speaking Spanish at home, while 7% of Black respondents reported speaking Haitian Creole.

EXHIBIT 21: CBANS QUESTION – PRIMARY LANGUAGE SPOKEN AT HOME, BY RACE/ETHNICITY



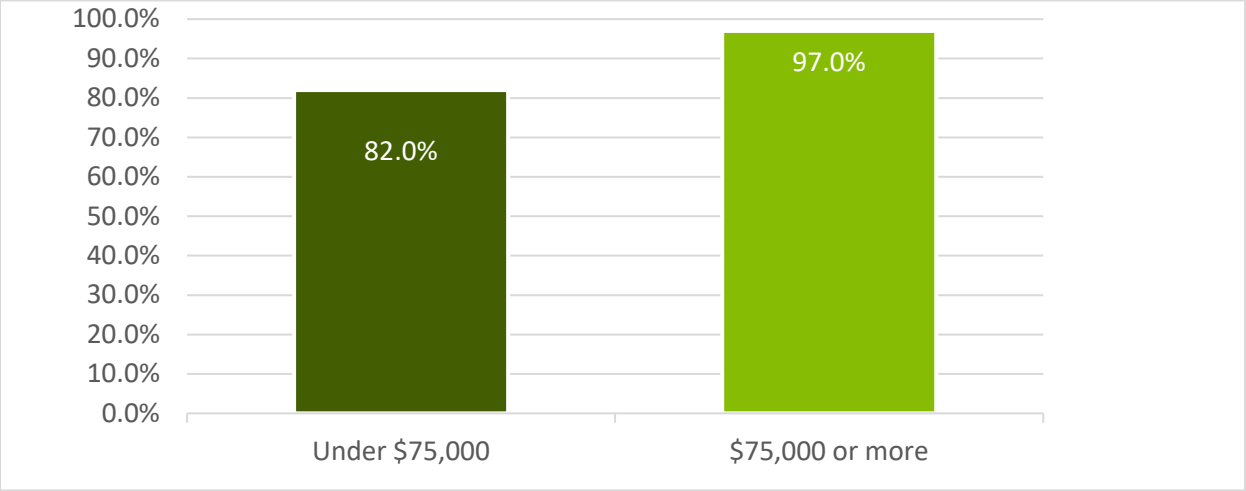
(GREATER NEW LONDON)





Lower-income CBANS respondents in Greater New London are more likely to speak a language other than English at home, with 14% of those earning less than $75,000 speaking Spanish compared to 0% of those earning more than $75,000. The 3% of those who speak languages other than English that earn more than $75,000 speak languages other than Spanish. When language barriers intersect with financial instability, navigating essential services such as healthcare, education, and employment becomes even more challenging, further limiting opportunities for economic and social mobility. Language barriers and cultural divides not only impact social integration but also limit access to necessary services, creating disparities in healthcare, education, and economic opportunities.

EXHIBIT 22: CBANS QUESTION – PRIMARY LANGUAGE SPOKEN AT HOME (ENGLISH), BY INCOME (GREATER NEW LONDON)



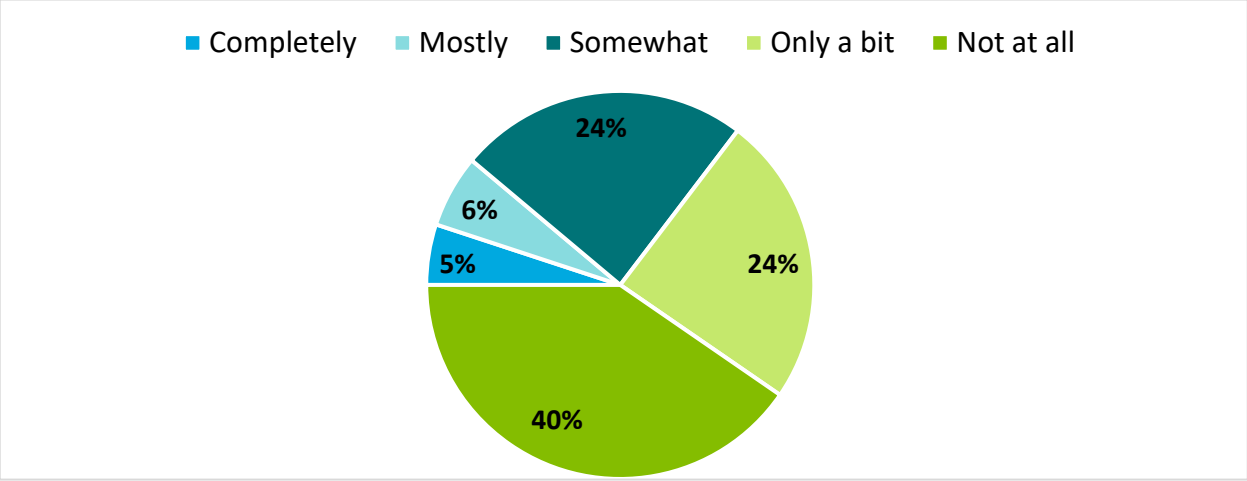
Social Connection

Social connectedness plays a vital role in overall well-being, influencing behavioral health, resilience, and access to support systems. According to the U.S. Surgeon General, the health risks associated with prolonged social isolation are comparable to smoking 15 cigarettes a day.[7]

Social connection supports behavioral health, resilience, and a sense of belonging. Key informants in the Greater New London region described a strong sense of community as a local asset. Events, school programs, and outreach efforts help bring people together and reduce isolation, particularly for families and older adults.

Still, survey data suggests that some residents experience mental and emotional strain. While the majority reported feeling little or no anxiety the previous day, nearly one in three reported feeling "somewhat," "mostly," or "completely" anxious.

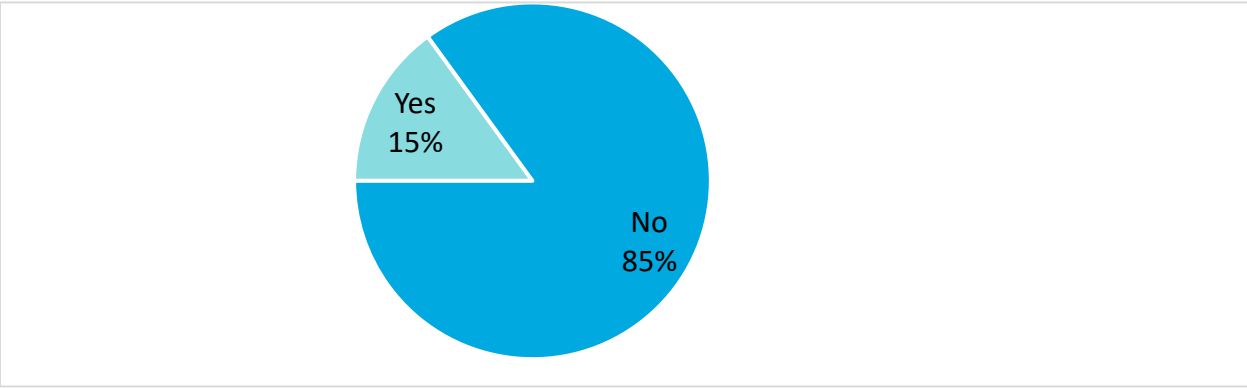
EXHIBIT 23: DCWS QUESTION – HOW ANXIOUS DID YOU FEEL YESTERDAY? (GREATER NEW LONDON)



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

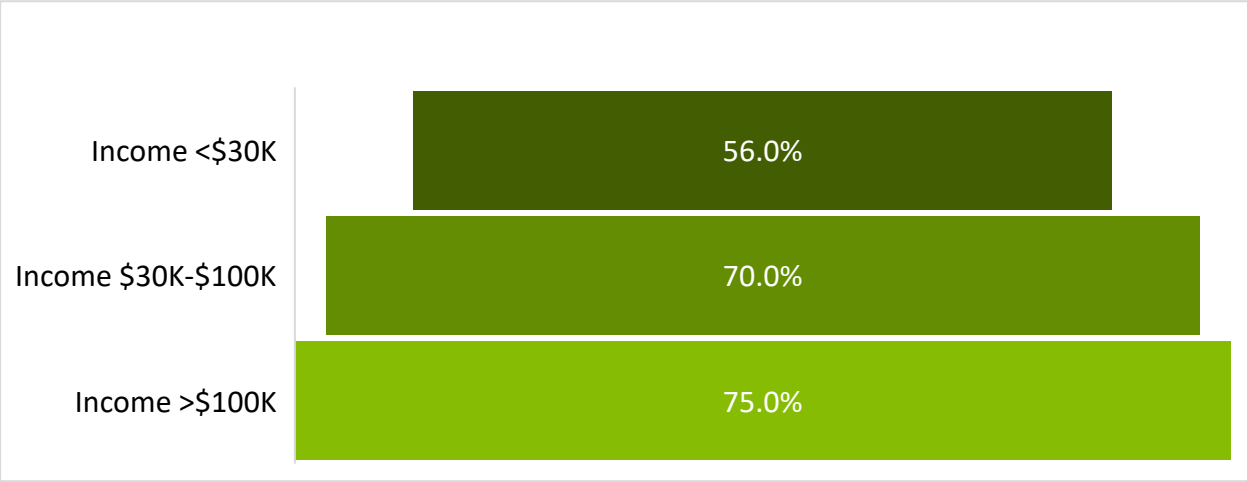
In addition, **15% of respondents screened at risk for a major depressive episode** using a standardized tool.

EXHIBIT 24: DCWS QUESTION – PHQ-2 GREATER THAN OR EQUAL TO 3 INDICATING RISK OF MAJOR DEPRESSIVE EPISODE[8] (GREATER NEW LONDON)



Support from friends, family, and the community can help ease these burdens—but not all residents have consistent access to that support. Survey data shows that emotional support increases with income: while 75% of higher-income respondents say they “always” or “usually” feel supported, only 56% lower-income respondents said the same.
These findings highlight the importance of building inclusive, connected communities and ensuring everyone has access to the relationships and resources that support well-being.

EXHIBIT 25: DCWS QUESTION - SURVEY RESPONDENTS WHO PERCEIVE THEY "ALWAYS OR USUALLY" GET THE SOCIAL AND EMOTIONAL SUPPORT THEY NEED (GREATER NEW LONDON)



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

Health Care Access and Quality

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

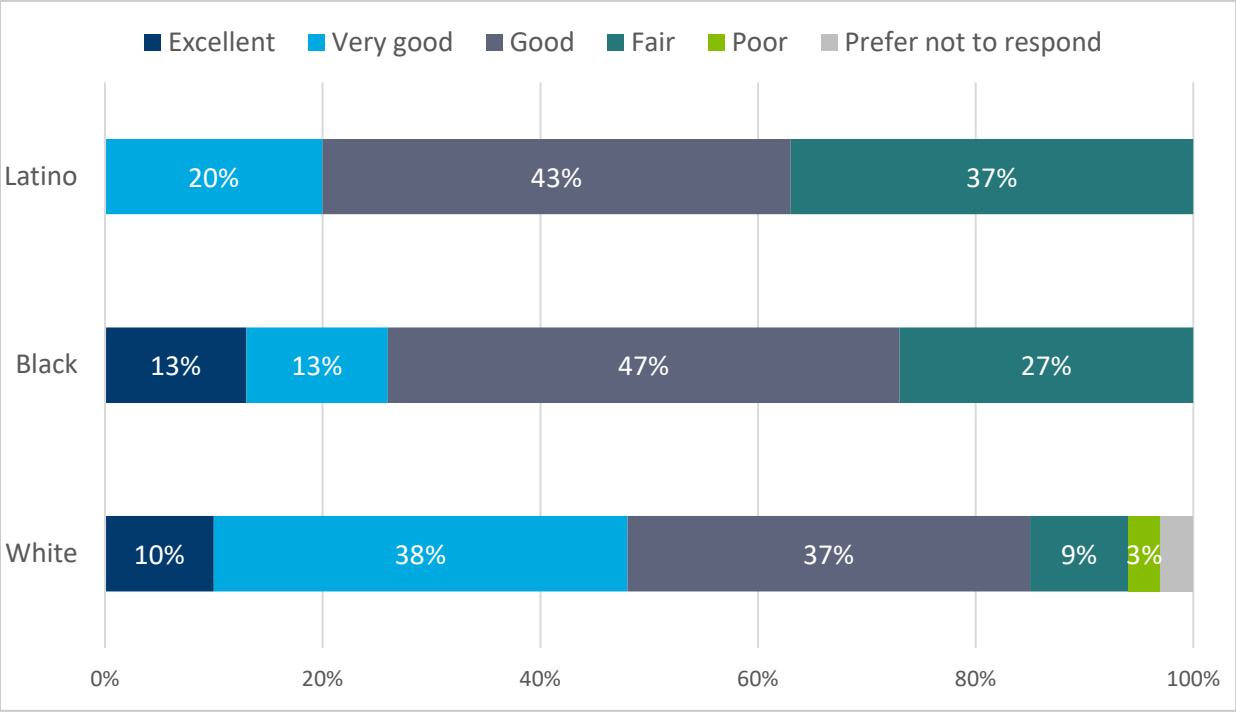
(U.S. Department of Health and Human Services, Healthy People 2030)

Health Status

Overall health is shaped by access to quality healthcare, economic stability, and social conditions. While some residents in the Greater New London region report good or excellent health, disparities exist, particularly by race and income.

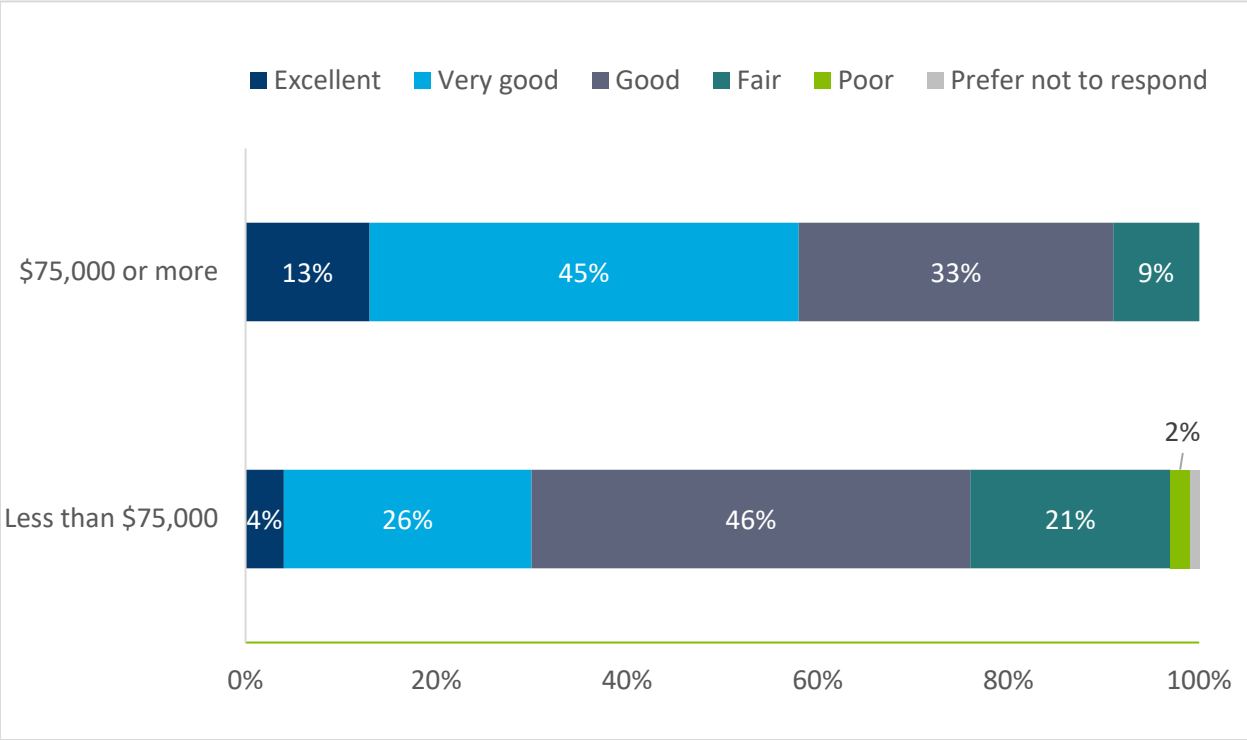
According to CBANS survey data, 42% of respondents rated their health as "Excellent" or "Very good." Among respondents, 37% of Latino participants, 27% of Black participants, and 12% of White participants rated their health as fair or poor.

EXHIBIT 26: CBANS QUESTION – HOW RESPONDENTS RATE THEIR OVERALL HEALTH, BY RACE (GREATER NEW LONDON)



Health ratings also varied by income. Among respondents earning less than $75,000, 23% reported fair or poor health, compared to 9% of those earning $75,000 or more.

EXHIBIT 27: CBANS QUESTION – HOW RESPONDENTS RATE THEIR OVERALL HEALTH, BY INCOME (GREATER NEW LONDON)



Access to Care Barriers

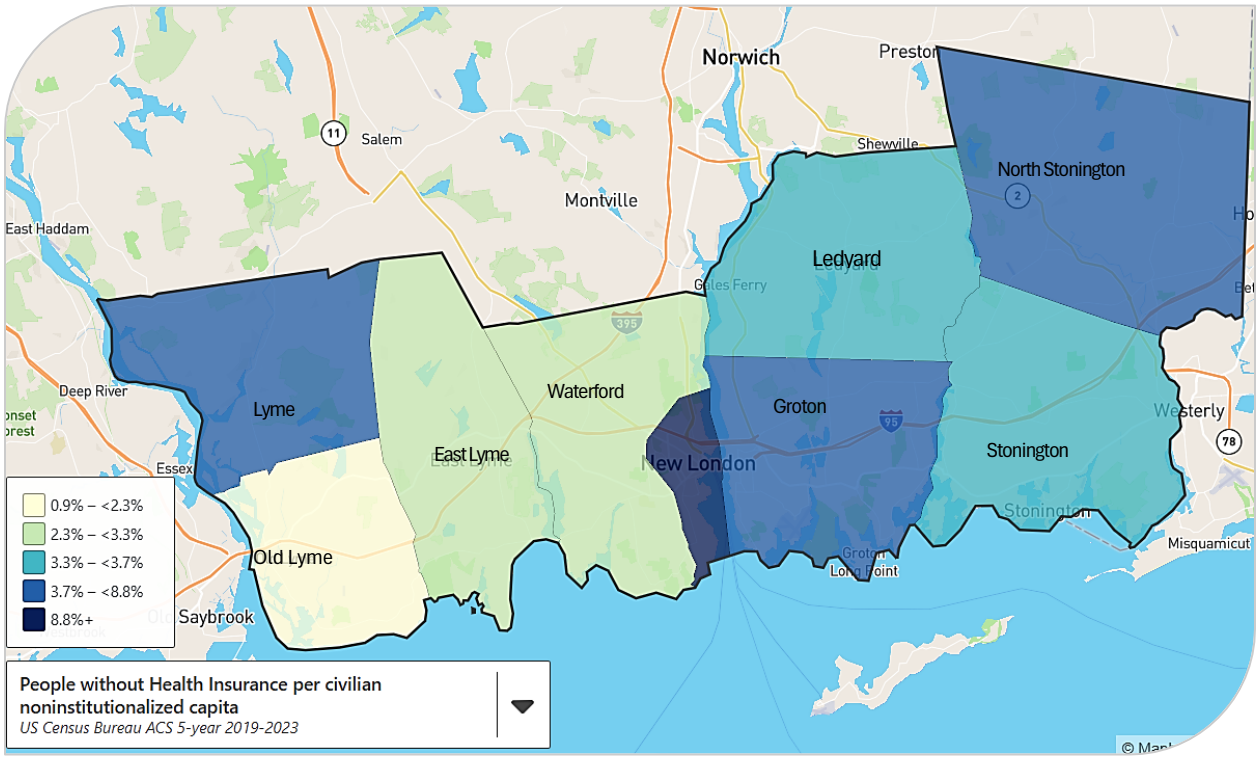
Navigating the healthcare system in the Greater New London region presents challenges, particularly for residents with limited resources. Greater New London key informants and community members report confusion about when to seek primary care versus emergency care, leaving many unsure of how to access timely medical treatment.

Even insured individuals face obstacles, as fewer providers accept insurance, and insurance benefits are often unclear. High-deductible plans and costly copays prevent some from seeking care, even when employed full-time. Delays in care are exacerbated by long wait times and the need for multiple visits to complete routine testing, which adds financial and emotional strain.

Insurance Coverage

While the population of uninsured residents in the Greater New London region towns varies, there are pockets where more than 5% of the population is without insurance coverage (Table 1), leading to challenges in those areas.

EXHIBIT 28: UNINSURED POPULATION, BY TOWN



Many residents rely on government assistance programs like Medicare and Medicaid, but access remains limited due to provider restrictions. Survey data from DCWS indicates that 28% of respondents have Medicare, and 18% have Medicaid. While these programs offer coverage, they do not guarantee access to care, as some providers do not accept these plans.

Medicare: 28%
Medicaid: 18%

Disparities in insurance coverage connected to employment are evident across income brackets. CBANS survey data reveals only 16% of those earning less than $30,000 have employer-sponsored insurance, compared to 53% of those earning $30,000–$100,000 and 71% of those earning over $100,000.

EXHIBIT 29: CBANS QUESTION – RESPONDENTS' TYPE OF INSURANCE, BY INCOME (GREATER NEW LONDON)

Type of Insurance	Less than $75,000	$75,000 or more
State Health Insurance Exchange such as Access Health CT or NY State of Health	5%	0%
Insurance obtained through a current or former employer or union	45%	83%
Insurance purchased directly from an insurance company	5%	3%
Medicare	28%	12%
Medicaid, Medical Assistance, HUSKY or any kind of government-assistance plan	36%	2%
Any other type of health insurance plan	3%	6%

LEGEND

Less — More

While insurance coverage is an important step, it does not always translate to accessible care. Residents with lower incomes are not only less likely to have employer-sponsored insurance—they also face more challenges getting the care they need when they need it.

Some of these challenges may be connected to trust in the healthcare system. Data from the DCWS survey shows that Greater New London residents with lower incomes are more likely to report difficulty accessing medical care and more likely to say they don't trust local health officials or healthcare workers very much.

EXHIBIT 30: DCWS SURVEY QUESTIONS: UNINSURED POPULATION VS. THOSE WITH LOW TRUST IN LOCAL HEALTH OFFICIALS AND HEALTH CARE WORKERS, BY INCOME (GREATER NEW LONDON)

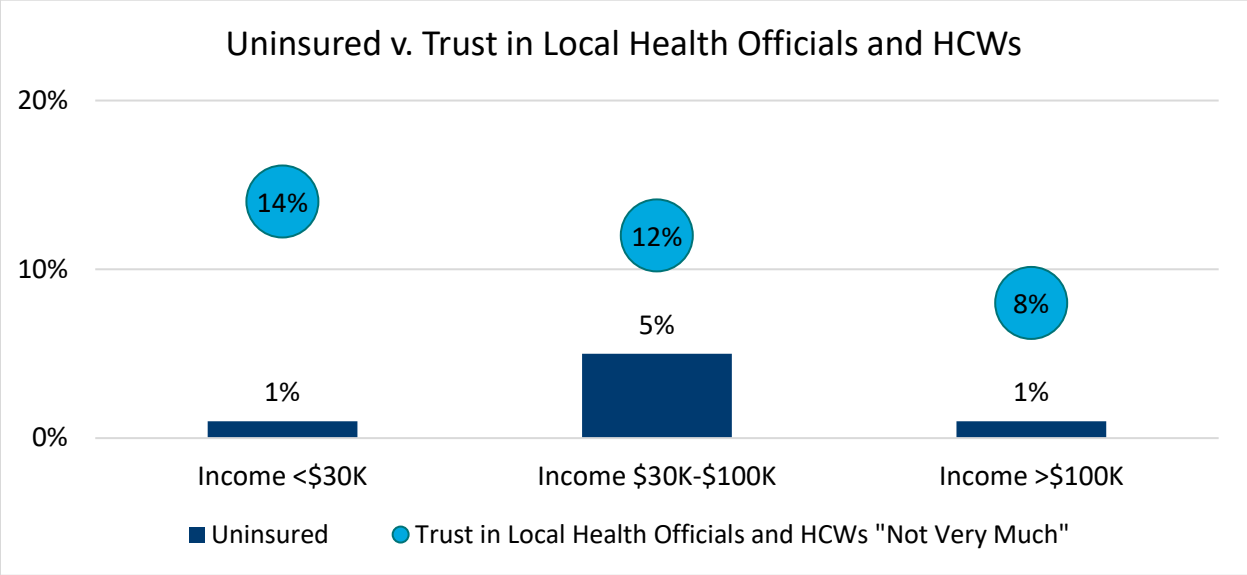
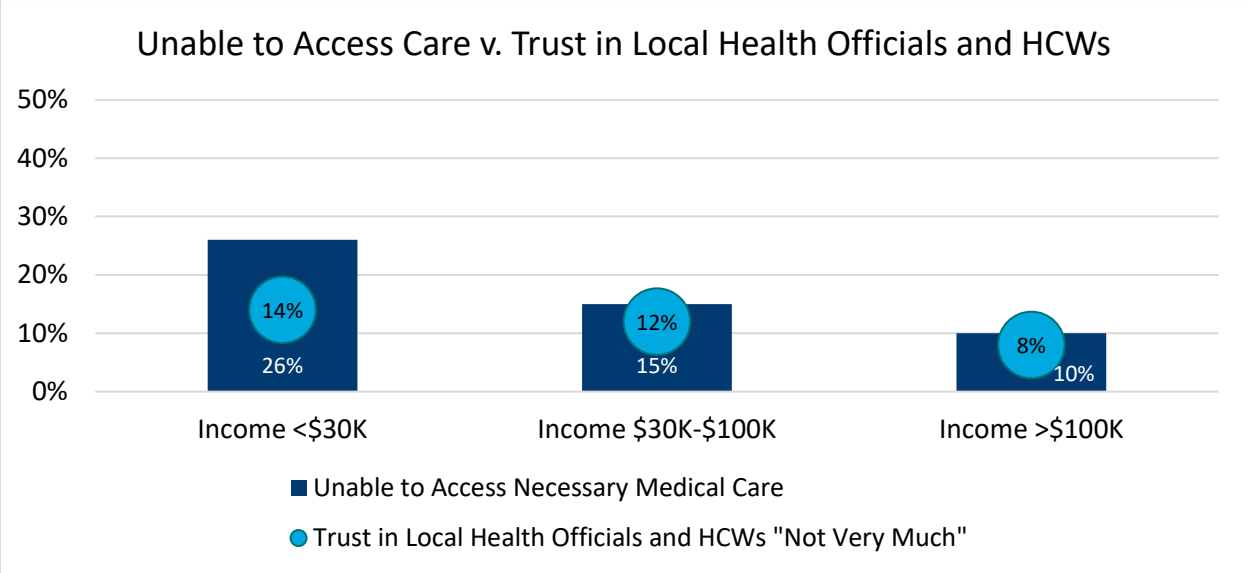
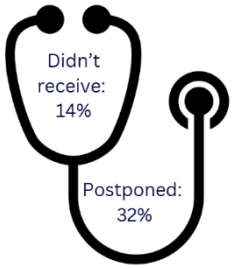


EXHIBIT 31: DCWS SURVEY QUESTIONS: THOSE UNABLE TO ACCESS NECESSARY MEDICAL CARE VS. THOSE WITH LOW TRUST IN LOCAL HEALTH OFFICIALS AND HEALTH CARE WORKERS, BY INCOME (GREATER NEW LONDON)



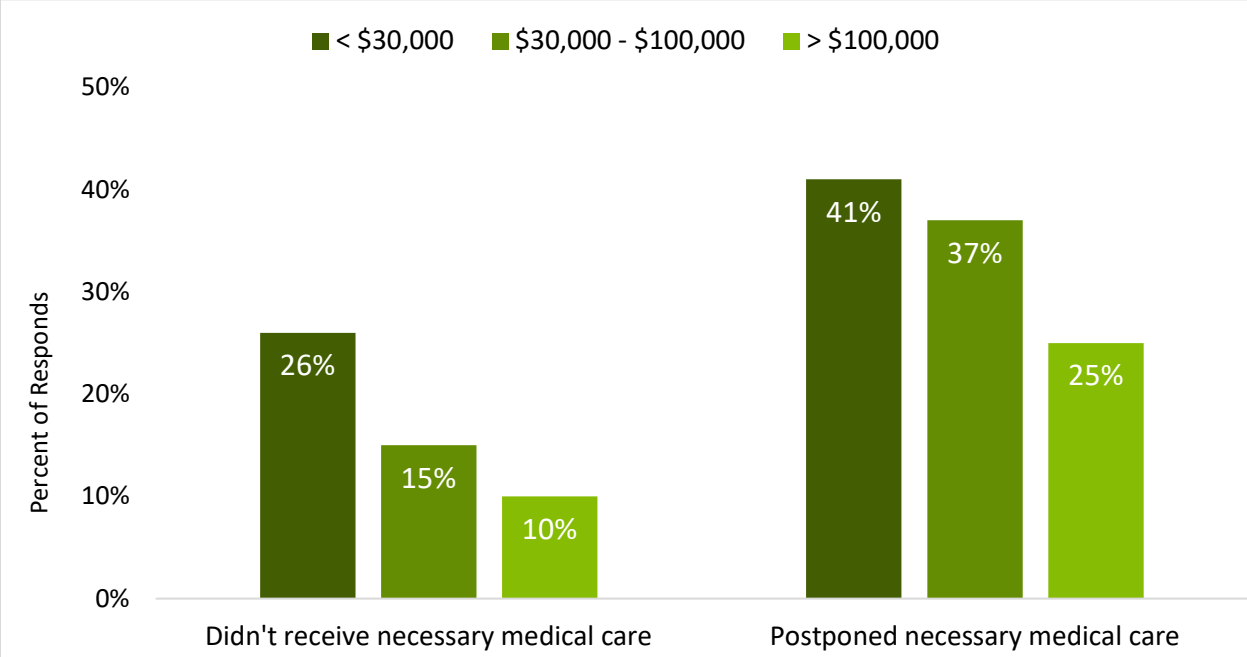
Delayed Medical Care



Some Greater New London residents report either postponing or not receiving necessary medical care. DCWS survey data shows that 14% of respondents did not receive the necessary care they needed, while 32% postponed it. The most frequently cited reasons include high costs, provider shortages, and long wait times.

Significant income disparities exist in accessing timely medical care. 26% of DCWS respondents earning less than $30,000 reported not receiving necessary care, compared to only 10% of those earning $100,000.

EXHIBIT 32: DCWS QUESTION –RESPONDENTS WHO WERE UNABLE TO RECEIVE TIMELY MEDICAL CARE IN THE PAST 12 MONTHS DUE TO NOT RECEIVING IT AT ALL OR POSTPONING CARE, BY INCOME (GREATER NEW LONDON)



Additionally, some individuals could not access care because their doctor or hospital would not accept their insurance. CBANS survey data reveals that, of respondents who could not receive timely medical care, 16% attributed this to the doctor or hospital not accepting their insurance.

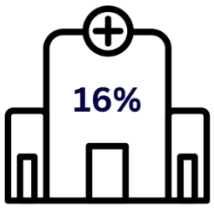
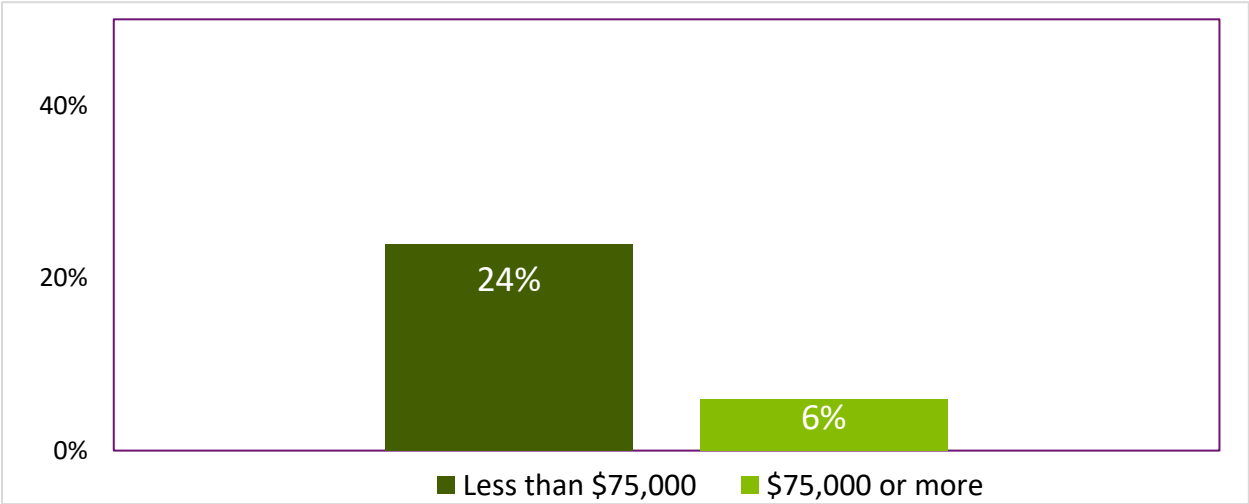


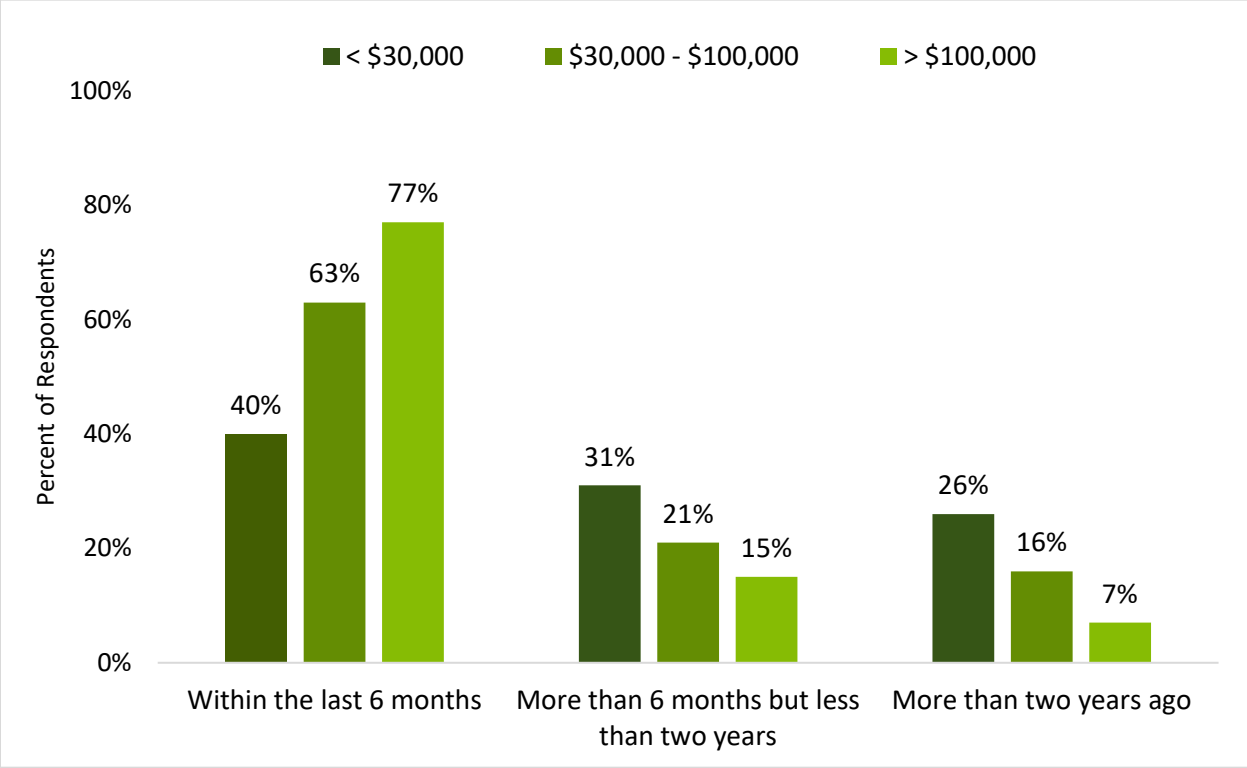
EXHIBIT 33: CBANS QUESTION – AMONG RESPONDENTS WHO WERE UNABLE TO RECEIVE TIMELY MEDICAL CARE, THE PERCENTAGE WHO SAID IT WAS BECAUSE A DOCTOR OR HOSPITAL WOULD NOT ACCEPT THEIR INSURANCE, BY INCOME (GREATER NEW LONDON)



Many older adults face barriers to accessing the care they need. For example, those living in rural areas often have to travel longer distances to see providers, including specialists. And transitioning from employer-sponsored health insurance plans to Medicare can complicate coverage and require people to switch providers.[9] Key informants shared that many seniors must prioritize certain expenses over their health, leading to worsening conditions. For example, the lack of dental coverage under Medicare makes it difficult for older adults to maintain good nutrition, contributing to poor overall health. Dental access is an issue for all ages, as it can lead to extreme pain, other systemic issues and preventable emergency room visits.

[9] U.S. Department of Health and Human Services, Social Determinants of Health and Older Adults. https://odphp.health.gov/our-work/national-health-initiatives/healthy-aging/social-determinants-health-and-older-adults#health

EXHIBIT 34: DCWS QUESTION – LAST TIME PARTICIPANTS SAW A DENTIST, BY INCOME (GREATER NEW LONDON)



Provider Shortages

The region's provider shortages significantly limit access to healthcare, with long wait times for primary, pediatric, and women's health care. Greater New London key informants and community members report that wait times for a primary care appointment can be as long as six months.

The provider-to-population ratios (Table 41) for New London County are significantly worse than state averages, particularly for primary care physicians (1,284:1 vs. 835:1), pediatricians (991:1 vs. 618:1), and women's health providers (4,772:1 vs. 2,576:1). These shortages leave residents with fewer options, often leading them to emergency departments for non-emergency care.

EXHIBIT 35: HEALTH CARE PROVIDER RATIOS

HEALTH CARE PROVIDER RATIOS, PEOPLE PER PROVIDER — NEW LONDON COUNTY VS. CT STATE		
Primary Care Physicians (PCP)	**Pediatricians**	**Women's Health (Ob/Gyn)**
1,284 : 1	**991 : 1**	**4,772 : 1**
CT State Ratio 834 : 1	CT State Ratio 618 : 1	CT State Ratio 2,576 : 1
Higher ratios indicate fewer providers per person, suggesting a provider shortage.		

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

Health Equity

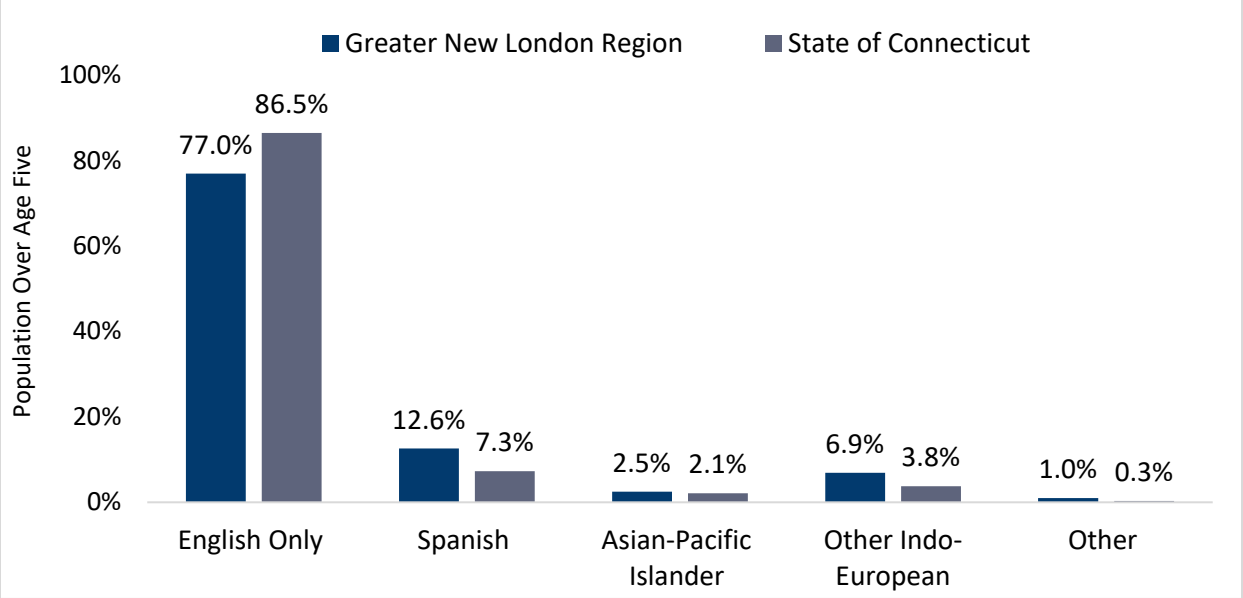
Greater New London key informants and community members report that new immigrants face major healthcare access challenges due to language barriers and citizenship status. Undocumented individuals are ineligible for most health assistance programs, limiting their ability to seek care. Those who arrived in the U.S. within the last five years do not qualify for HUSKY/Medicaid services, further restricting access. Limited job opportunities and lack of insurance make affording healthcare even more difficult.

"If I go with my mom to a medical appointment who doesn't speak English, she's treated better. Language is huge." - Key Informant

Many minority groups often feel "othered" in healthcare settings due to language barriers, race/ethnicity, and insurance status. A shortage of diverse healthcare professionals exacerbates the issue. Key informants emphasize the need for stronger efforts in recruiting and retaining providers from diverse backgrounds, particularly those who understand the unique challenges faced by immigrant and under-resourced populations. Incentives to encourage providers to

train and stay in the region could help improve long-term retention. Language barriers are a persistent challenge. Interpreters are limited, and English class waitlists are long, particularly for Haitian-Creole speakers. Miscommunication leads to untreated conditions and discourages follow-up care, creating further health risks. Additionally, members of the Mashantucket Pequot Tribal Nation face healthcare inequities, with insurance status affecting provider availability. Key informants note that some providers hold biases or assumptions about tribal affiliation, creating additional barriers to care.

EXHIBIT 36: LANGUAGE SPOKEN AT HOME



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

According to key informants, behavioral health care in the region also lacks a patient-centered approach. Key informants report that non-medical interventions are often overlooked, while providers prioritize costly treatments over addressing root causes. This contributes to unnecessary charges and leaves community members without appropriate, culturally competent care.

Systemic Mistrust

Key informants and focus group participants emphasized the importance of trust between community members and organizations providing essential services. They identified a particular need to build trust with minoritized populations, including LGBTQIA+, undocumented, Black/African American, and Indigenous communities.

Fear of discrimination and unclear policies can fuel systemic mistrust and discourage individuals from engaging with healthcare providers and community resources. To overcome these

challenges, participants stressed the need for consistency and transparency. They noted that including community voices in decision-making builds strong partnerships and strengthens trust. Participants also highlighted several tangible suggestions for fostering trust, such as offering services in multiple languages, incorporating traditional health practices when able, and training staff in culturally competent care.

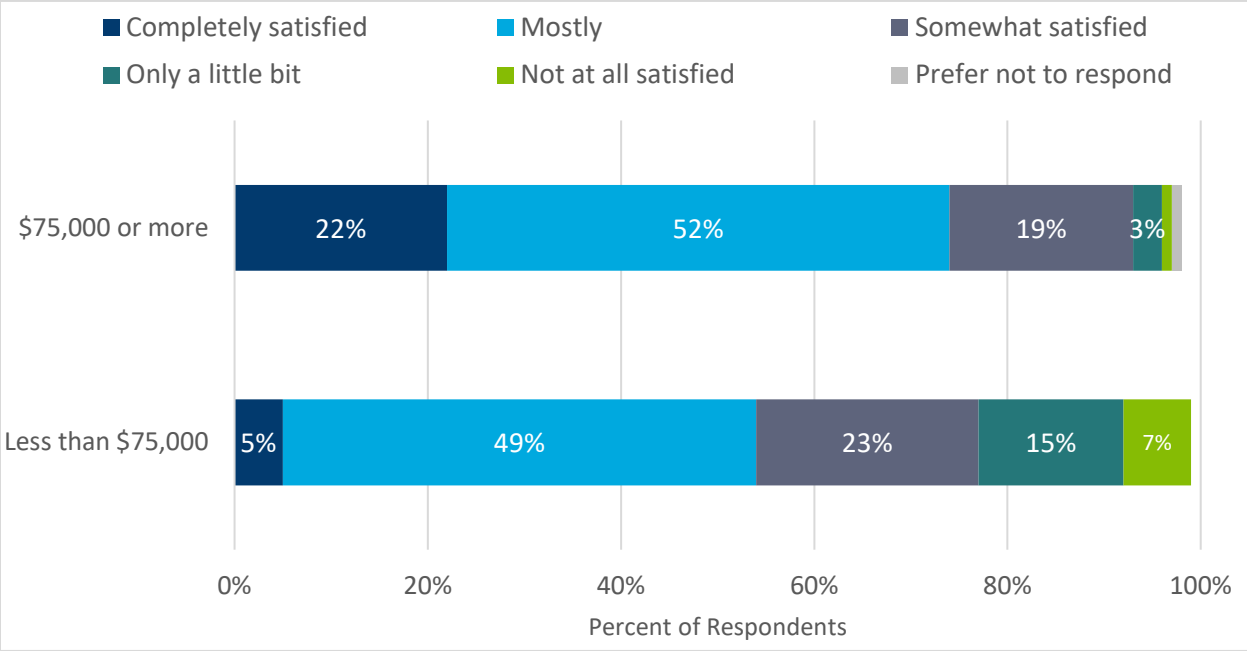
Behavioral Health

Greater New London key informants report a "complete lack" of behavioral health services for both children and adults, affecting people across all socioeconomic backgrounds. The behavioral health system is described as complex and difficult to navigate, with only those who persistently advocate for themselves gaining access to care. Those with the greatest need, particularly individuals in crisis, often struggle the most to find timely support.

> **"There is a complete lack of mental health services for children and adults both poor and not poor. We don't even have a child psychiatrist in New London**
>
> **- Key Informant**

Survey data highlights disparities in behavioral health and well-being across racial and income groups. Overall, 63% of CBANS respondents reported being "completely" or "mostly" satisfied with their life, but satisfaction levels varied. Greater New London respondents with higher incomes were more likely to report being satisfied with their lives, while those earning less than $75,000 were more likely to feel only somewhat satisfied—or not satisfied at all.

EXHIBIT 37: CBANS QUESTION –OVERALL, HOW SATISFIED ARE YOU WITH YOUR LIFE NOWADAYS? BY INCOME



Anxiety and depression remain widespread concerns. Among DCWS respondents, 11% reported feeling "completely" or "mostly" anxious the day before the survey, and 6% reported feeling down, depressed, or hopeless nearly every day. Those with lower incomes were more likely to report anxiety and depression, indicating financial strain as a contributing factor to behavioral health challenges.

EXHIBIT 38: DCWS QUESTION –OVERALL, HOW ANXIOUS DID YOU FEEL YESTERDAY? BY INCOME (GREATER NEW LONDON)

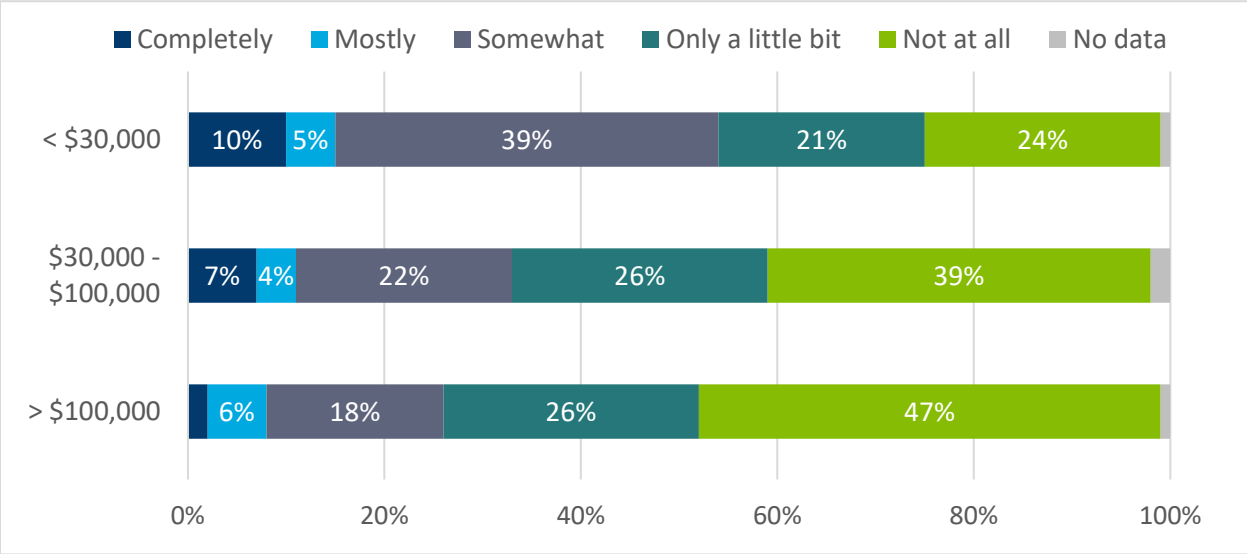
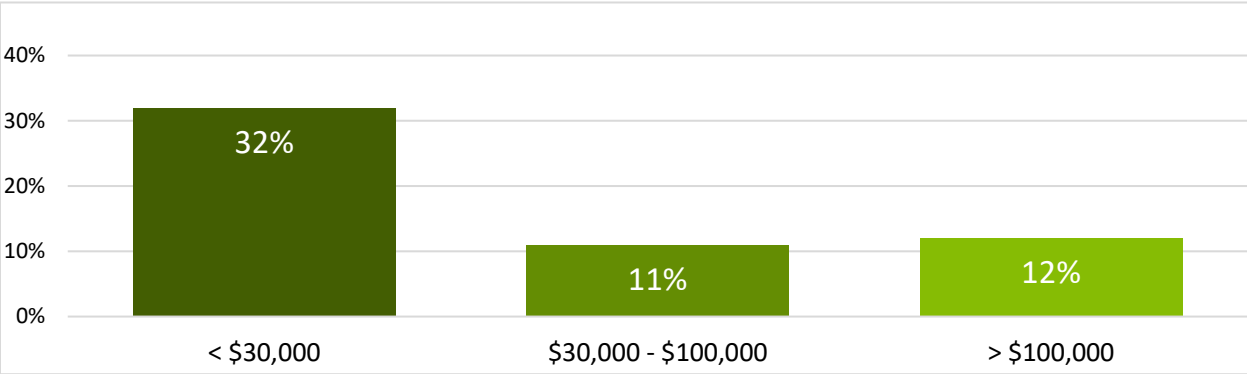


EXHIBIT 39: DCWS QUESTION – PARTICIPANTS AT RISK OF MAJOR DEPRESSIVE EPISODE[10] (GREATER NEW LONDON)



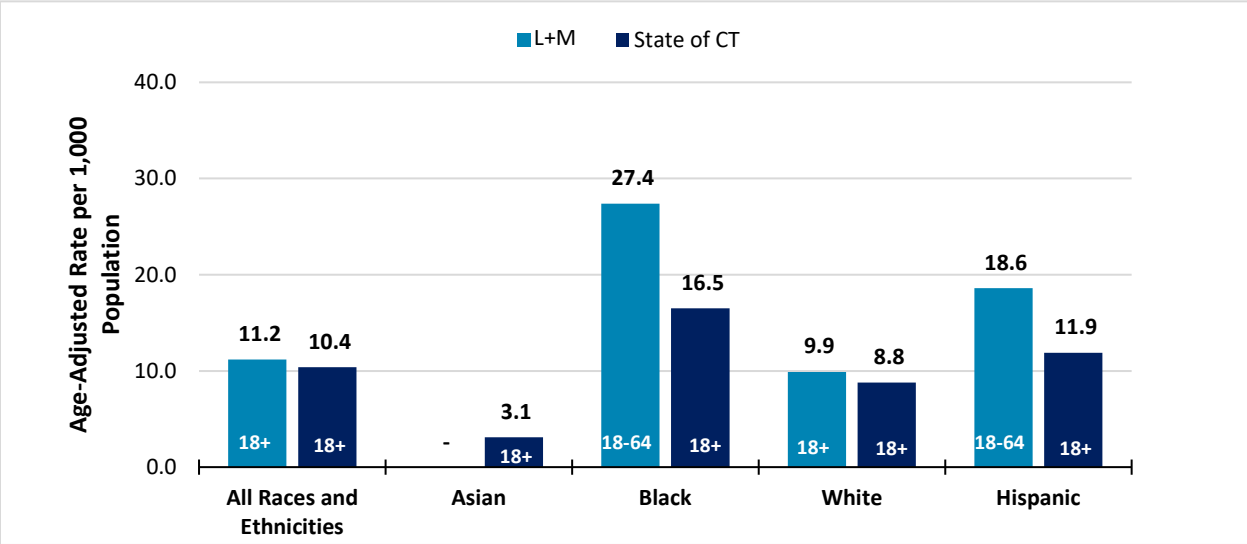
10 *PHQ-2 score greater than or equal to 3.

The high rate of hospitalizations for behavioral health conditions at Lawrence + Memorial Hospital—11.2 per 1,000 adults in the Greater New London region compared to 10.4 per 1,000 statewide—reflects the gap in community-based behavioral health services (Table 50). Without sufficient access to preventive and outpatient care, more individuals end up seeking treatment in emergency settings, exacerbating strain on the healthcare system and leaving many without long-term support.

Behavioral health disorders were the **most** common hospital diagnosis at Lawrence + Memorial Hospital, with a rate of **11.2 per 1,000** adults, compared to a rate of 10.4 in the State of CT.

Behavioral health visits to Lawrence + Memorial Hospital are not the same for everyone. Black adults ages 18 to 64 had the highest rate of behavioral health-related hospital visits—27 out of every 1,000 people—more than twice the state average. Hispanic adults also had a higher rate (19 per 1,000) compared to White adults (10 per 1,000). These differences show that some groups may face more behavioral health challenges or have fewer options for getting care early, before problems become more serious. This highlights the importance of making behavioral health care easier to access and more welcoming for all communities.

EXHIBIT 40: PATIENTS WITH A LAWRENCE + MEMORIAL HOSPITAL ENCOUNTER FOR BEHAVIORAL HEALTH BY RACE/ETHNICITY



Source: Connecticut Hospital Association, CHIME Data

Substance Use

Greater New London key informants expressed concerns about limited access to evidence-based substance use treatment. Many treatment centers still prioritize traditional abstinence-based programs over medication-assisted treatment (MAT), which has been shown to improve outcomes. The Substance Abuse and Mental Health Services Administration (SAMHSA) highlights research indicating that a combination of medication and therapy can successfully treat substance use disorders, and for some medications, can help sustain recovery. The MAT approach has been shown to improve patient survival, increase retention in treatment, decrease criminal activity among people with substance use disorders, increase the ability to gain and maintain employment, improve birth outcomes among women who have substance use disorders and are pregnant, as well as contribute to lowering a person's risk of contracting HIV or hepatitis C by reducing the potential for relapse.[11]

"We don't have enough Narcan. We had boxes we had to remove due to unwise legislation. One of our homeless people in the community died less than 24 hours after being released. We need more easy access to it in the community, or a way to give it out to people in the community. Now people who don't use substances are asking for it for their neighbors/friends, etc. People need access to free Narcan when they need it."

- Key Informant

Visible substance use in the community is another concern. Parents reported that they worry about children being exposed to substance use and witnessing traumatic events, which can have long-term effects on behavioral health. Additionally, the perception of harm surrounding marijuana use has shifted, with some community members noting that its increasing normalization has led to higher usage rates, particularly among youth.

[11] SAMHSA, Substance Use Disorder Treatment Options. https://www.samhsa.gov/substance-use/treatment/options

Substance-use related disorders were the **second** most common hospital diagnosis at Lawrence + Memorial Hospital, with a rate of **9.3 per 1,000** adults.

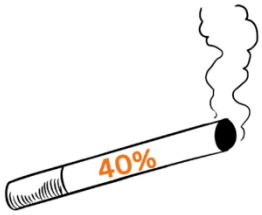
Sub-conditions:

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

Source: Connecticut Hospital Association, CHIME data

After behavioral health disorders, substance-use related disorders were the **second most common** hospital diagnosis at Lawrence + Memorial Hospital, with a rate of **9.3 per 1,000 adults**, highlighting the significant burden of substance use on the healthcare system (Table 50). Alcohol-related disorders were the most frequent sub-condition, followed by non-opioid and opioid-related disorders, emphasizing the need for accessible and effective treatment options to address these issues.

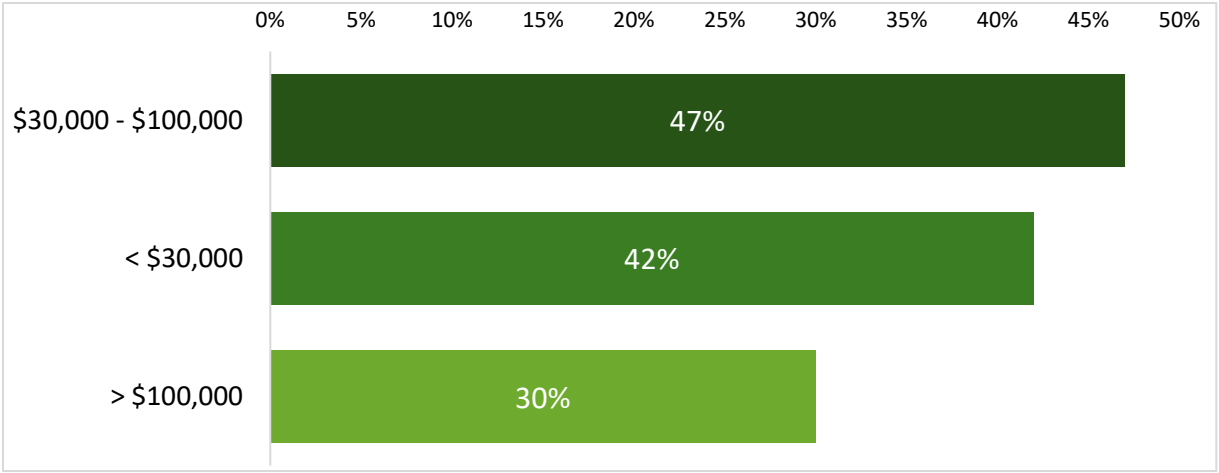
Tobacco Use



Survey data from DCWS shows that 40% of respondents reported smoking at least 100 cigarettes in their lifetime.

Rates were highest among those with moderate incomes ($30,000–$100,000), highlighting income-related differences in smoking history. Understanding these patterns is critical for shaping prevention and cessation programs that address disparities and reduce the long-term health consequences of smoking.

EXHIBIT 41: DCWS QUESTION – PARTICIPANTS WHO HAVE SMOKED AT LEAST 100 CIGARETTES IN THEIR LIFE, BY INCOME (GREATER NEW LONDON)



Maternal Health

Greater New London key informants and community members highlighted significant challenges for families with children, particularly single mothers balancing multiple jobs. Many struggle to find time for self-care and medical appointments, while single mothers of children with disabilities face even greater difficulties in accessing necessary support.

Access to prenatal and maternal care is also impacted by the consolidation of healthcare networks, which has shifted specialized care away from rural areas. In some areas of the region, fewer providers offer women's health services, making it difficult for expectant mothers to receive consistent prenatal care. Insurance coverage remains a barrier for some working mothers, as they earn just enough to lose eligibility for benefits. As one single mother shared, “I came here to make my life better... but they took my kid’s insurance because I get paid too much.” Without affordable healthcare, even basic services become financially burdensome.

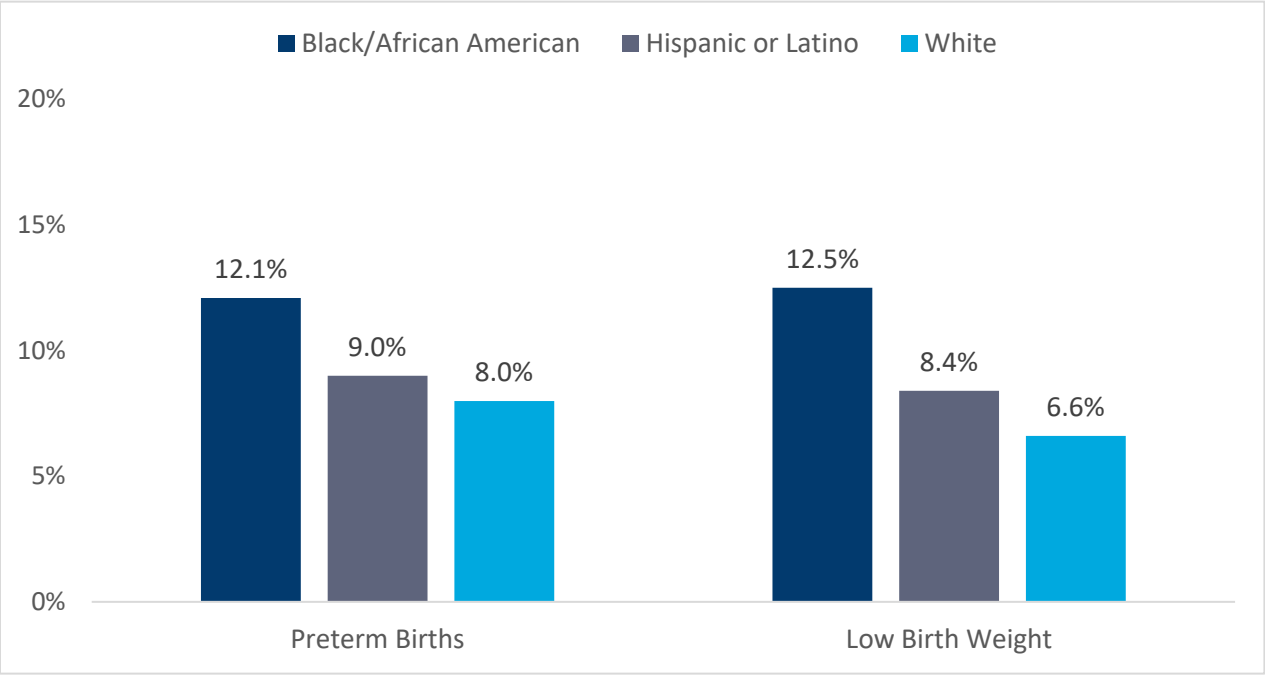
Low birthweight, defined as infants born weighing less than 5.5 pounds, is a significant indicator of maternal and prenatal health. In New London County, 8.7% of total births are classified as low birthweight, a rate higher than both Connecticut's 8.0% and the U.S. average of 7.1%. Low birthweight is associated with increased risks of infant mortality, developmental delays, and long-term health complications such as respiratory issues and chronic diseases.[12] Ensuring access to comprehensive prenatal care—including proper nutrition, regular screenings, and management of maternal health conditions—plays a crucial role in reducing the prevalence of low birthweight and improving birth outcomes.[13]

There are racial disparities in both preterm births and low birth weight in New London County.

- Preterm birth rates are highest among Black mothers (12.1%), followed by Hispanic mothers (9.0%) and White mothers (8.0%). Black infants are 1.5 times more likely to be born preterm compared to White infants.
- Low birth weight rates show a similar pattern, with Black mothers having the highest rate (12.5%), followed by Hispanic mothers (8.4%) and White mothers (6.6%). Black infants are nearly twice as likely to be born at a low birth weight compared to White infants.

[12] March of Dimes. (2022). *Low Birthweight*. Retrieved from https://www.marchofdimes.org/find-support/topics/birth/low-birthweight
[13] Centers for Disease Control and Prevention. (2021). *Birthweight and Gestation*. Retrieved from https://www.cdc.gov/nchs/fastats/birthweight.htm

EXHIBIT 42: PRETERM BIRTHS AND LOW BIRTH WEIGHT IN NEW LONDON COUNTY, BY RACE/ETHNICITY



Source: CDC WONDER Natality 2019-2023. Table 59 | County Health Rankings, Health Data – Teen Births & Infant Mortality, 2021. Table 57

Prenatal Care in First Trimester in New London County

77.1%
Black/African American Mothers

81.1%
Hispanic/Latino Mothers

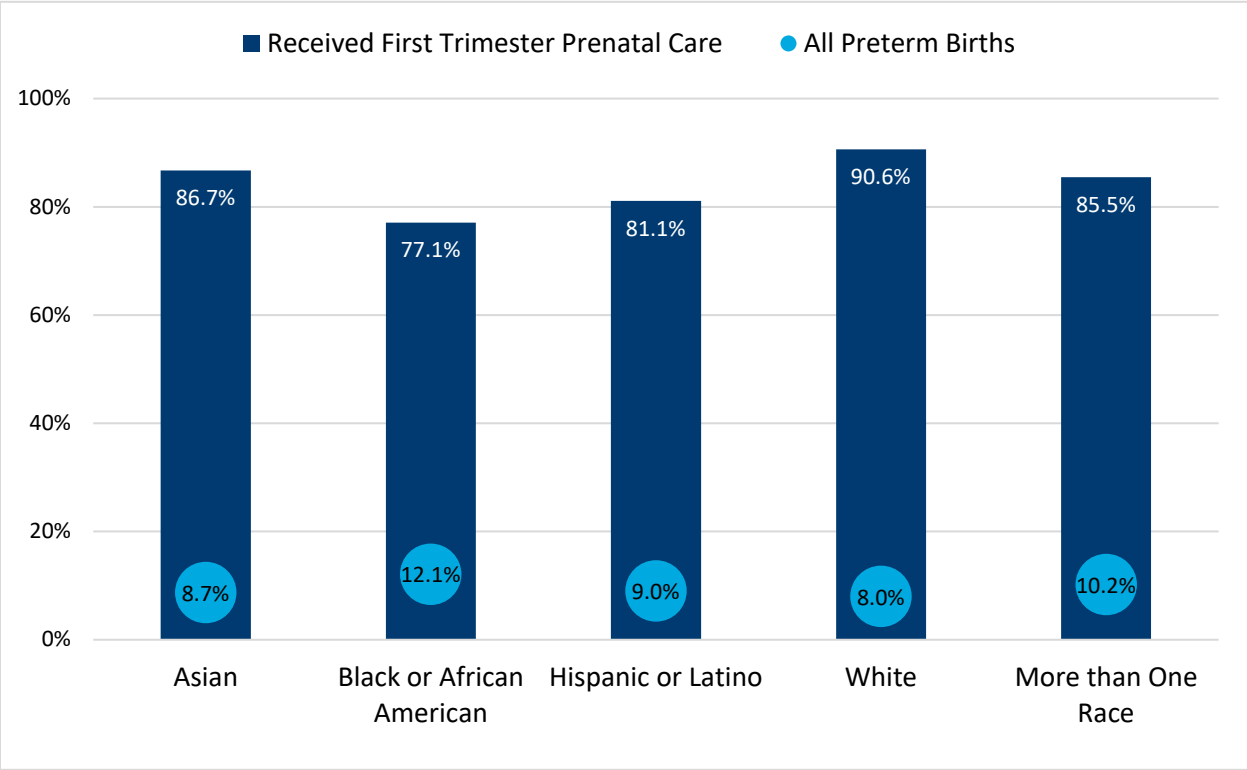
90.6%
White Mothers

Source: CDC WONDER Natality 2019-2023. Table 60

These disparities indicate unequal access to prenatal care, systemic barriers to maternal health services, and social determinants of health that disproportionately affect Black and Hispanic mothers. Preterm birth and low birth weight are linked to higher infant mortality rates, developmental delays, and long-term health challenges, underscoring the need for targeted interventions to improve birth outcomes for mothers of color in New London County.

Disparities also exist in prenatal care access. Black women in New London County are 1.2 times less likely than White women to receive first-trimester prenatal care (77.1% vs. 90.6%), while Hispanic women are 1.1 times less likely (81.1% vs. 90.6%). These gaps highlight inequities in access to early prenatal care, which is critical for identifying and managing health risks during pregnancy.

EXHIBIT 43: FIRST TRIMESTER PRENATAL CARE V. PRETERM BIRTHS



Source: CDC WONDER Natality 2019-2023. Table 59 | CDC WONDER Natality 2019-2023. Table 60

Lawrence + Memorial Hospital partners with Nurturing Families to provide in home visiting and support for new moms in the region.

Health Outcomes

Hospitalizations for chronic diseases in the Greater New London region exceed state averages, highlighting gaps in preventive care and disease management. Conditions such as heart failure, high blood pressure, asthma, chronic obstructive pulmonary disease (COPD), and diabetes complications occur at higher rates compared to the state

> **"The elderly are on more medications and experience more health issues. Medicare doesn't cover dental, for example, so they can't eat well, so they are sicker. It's a vicious circle. They're making choices about what care to receive and what medication to take based on income, or special diets are ignored because they must be."**
>
> **- Key Informant**

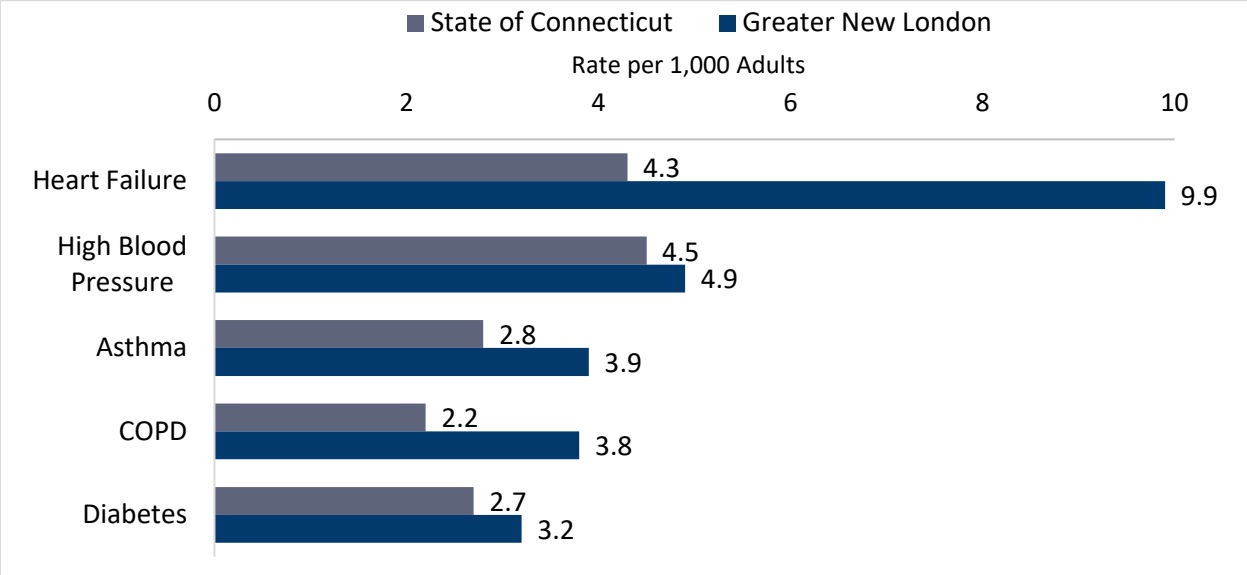
Greater New London community members and key informants noted that managing chronic diseases is especially difficult for people with multiple conditions, as they may need to coordinate care across several providers or begin complex treatment plans at a younger age.

Barriers such as financial constraints and limited provider access make it difficult for residents to manage conditions like diabetes and cardiovascular disease effectively. Additionally, the high cost of healthy food contributes to childhood obesity and worsens respiratory conditions like asthma.

Chronic Disease Hospitalizations

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

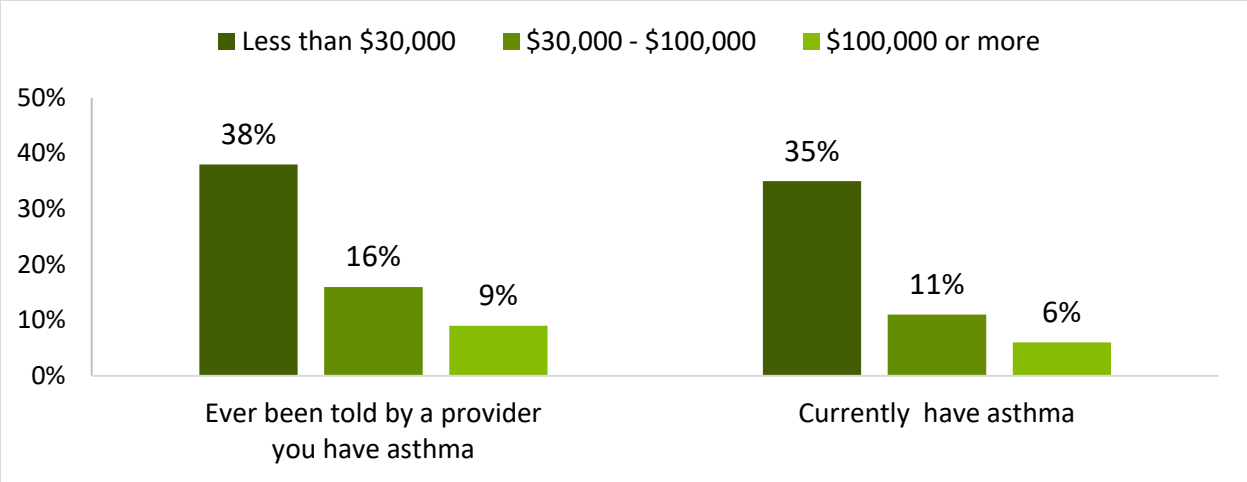
EXHIBIT 44: CHRONIC DISEASE HOSPITALIZATION RATES PER 1,000 ADULTS BY PRINCIPAL DIAGNOSIS (CHRONIC CONDITIONS)



Source: Community Health Profiles, Hospital utilization rates for key health indicators. Provided by Connecticut Hospital Association. Table 50

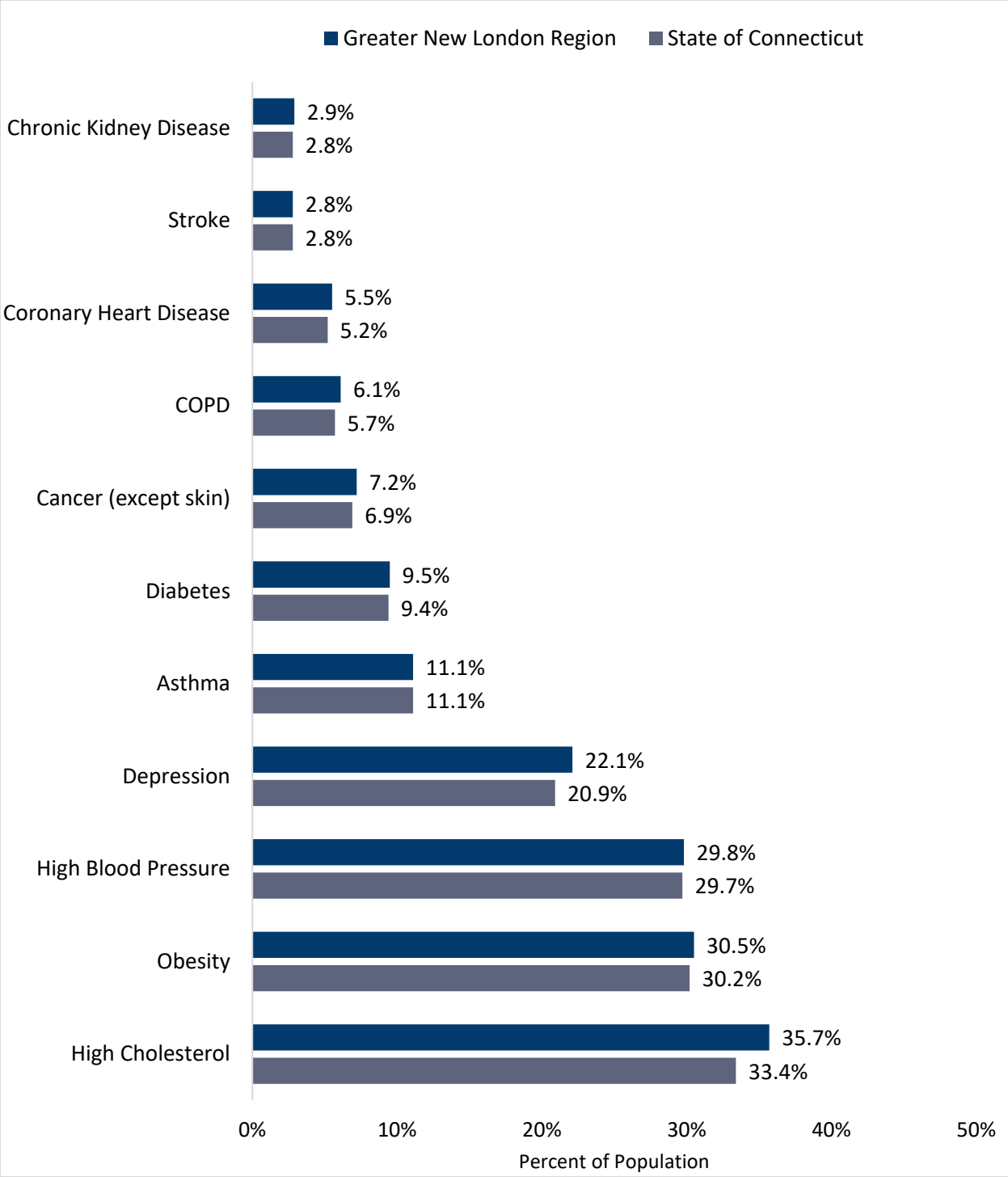
DCWS Survey data reinforces community concerns about chronic conditions, with 16% of respondents reporting they have been told they had asthma, while 12% currently have asthma. This is a concern, particularly among low-income residents. Survey data shows that DCWS respondents with incomes below $30,000 are more than twice as likely to report being diagnosed with asthma compared to those with incomes above $100,000.

EXHIBIT 45: DCWS QUESTION – ASTHMA DIAGNOSIS AND CURRENT STATUS, BY INCOME (GREATER NEW LONDON)



Adults who have self-reported conditions in the Greater New London region report higher rates of high cholesterol, obesity, and depression compared to the state average, further emphasizing the need for targeted chronic disease prevention and management strategies.

EXHIBIT 46: CHRONIC CONDITIONS SELF-REPORTED BY ADULTS



Source: CDC PLACES (2020-2021). Provided by Connecticut Hospital Association. Table 42

NEEDS PRIORITIZATION

Regional Community Prioritization

A two part in-person prioritization session was conducted with members of the Health Improvement Collaborative of Greater New London (HIC), regional community partners, and community members. The first session reviewed information from past CHNAs well as updated data from the 2025 CHNA. The second session focused on identifying the most pressing health needs based on a structured scoring method.

Participants evaluated health indicators using a grid system designed for different groups:

- HIC members used a grid to rate needs based on Relevance, Impact, and Feasibility.
- Community members were able to vote on the top health priorities at the Place for Community Wellbeing in New London to identify the top health priorities.

After completing this process, the top six health priority areas were identified:

1. **Food Insecurity**
2. **Overdose**
3. **Health Insurance and Healthcare Navigation**
4. **Behavioral Health**
5. **Chronic Disease**
6. **Prenatal and Maternal Care**

These priorities reflect both data-driven insights and community perspectives.

Internal Hospital Prioritization

Following the Regional Community Prioritization Session, Lawrence + Memorial Hospital leadership reviewed the identified priorities and selected areas of focus that align with the hospital's capacity to address community health needs.

The hospital selected the following three priority areas for the next three years:

1. **Behavioral Health**
2. **Chronic Disease**
3. **Prenatal and Maternal Care**

These priorities ensure a targeted approach to improving health outcomes while leveraging hospital resources and expertise. Collaboration with community organizations will be essential in addressing these key areas effectively.

APPENDICES

Appendix A: 2022-2025 Lawrence + Memorial Hospital Implementation Strategy Plan Update

Appendix B: 2022-2025 Yale New Haven Health Implementation Strategy Plan Update

Appendix C: 2025 List of Identified Community Health Needs

Appendix D: Community Partners

Appendix E: Secondary Data Tables

Appendix F: Access Audit

Appendix G: Asset Map and Community Resources

Appendix H: DataHaven Respondent Demographics

Appendix I: Key Informant Interview

Appendix J: Focus Group Guide

Lawrence + Memorial Hospital contributes to an annual toy drive for families in Greater New London.

Appendix A: 2022-2025 Lawrence + Memorial Hospital Implementation Strategy Plan Update

Goal 1 Community Health and Wellbeing **Improve the health and wellbeing of the community with a focus on social drivers of health and health equity.**	
Strategy 1 **Support local community organizations and events that help alleviate SDoH.**	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Proactively target organizations/initiatives that align with our four priority areas to support via monetary contributions and/or employee volunteerism.	The initiative is ongoing and will achieve 150 approved local sponsorships by the end of FY 2025.
Strategy 2 Raise awareness about community programs and efforts done by hospital departments.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Develop and implement a CHIP internal communication plan to educate employees about our community-based work. Examples include management council presentations, and internal communications (emails, intranet, & newsletters).	Internal communication plan developed and implemented to raise awareness about community programs. This included press releases, media stories, and newsletters, reaching 48,978 print copies and 78,048 email copies.
Strategy 3 Screen for socioeconomic needs and provide resources for support.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Provide transportation to patients receiving oncology treatment to ensure that care is not limited by access.	3,487 taxi, Uber, or medical transportation rides were provided with in-kind staff support coordinating them.
Strategy 4 Pursue increased trust and buy-in with our community members by listening, learning and improving health equity for our patients and the community with a focus on Black/African American residents.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Engage local Black/African American community leaders through listening sessions around health equity and social drivers of health.	14 focus groups were held, completing the initiative in FY 2023.
b. Identify areas of need through use of listening session feedback, CHNA data and information from community engaged strategies.	Seven areas of need were identified. These included access to care, advocacy to address service desert, continued outreach and presence, invest in community resources and enhance STEM and Health Professions opportunities.

Goal 2 Access to Care **Ensure access to quality health care and wellbeing services for all community members.**	
Strategy 1 Ensure all patients have quality information during their communication with healthcare providers regardless of their background or their literacy level.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Conduct quality improvement checks during patient rounding to address miscommunication and misunderstandings.	Quality improvement checks were conducted during patient rounding to address miscommunication and misunderstandings. The initiative focused on improving the likelihood of "Recommending the Hospital". The initiative is ongoing, with a target to achieve an 85.24% positive patient perception score by FY 2025.
b. Provide translations for multiple languages of patient materials and client satisfaction surveys in multiple languages.	40% of after visit summaries translated into the primary language for Limited English Proficiency patients in FY 2024.
c. Disseminate patient experience feedback with other departments in the hospital.	100% of feedback shared with departments in various forums.
Strategy 2 Develop cancer prevention and screening programs in New London and Washington County.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. In collaboration with Yale Medicine (YM), conduct skin screening programs at Electric Boat (EB), Mohegan Sun and Foxwoods resorts and, provide education and sunscreen to participants.	The goal was to conduct one community screening event per year, tracking the number of individuals screened. This initiative was paused due to COVID-19 restrictions, resumed in FY 2023. A skin screening event was held on May 1, 2023, with 92 individuals screened.
b. Provide education to pediatricians, school nurses and PTA with respect to Gardasil vaccination by Yale Medicine (YM) screening and prevention team.	This initiative is currently on hold due to a lack of YM providers to support the program. It is expected to be revisited in FY 2025.
Strategy 3 Increase community outreach for CT lung screening program and enhance the local community resources for smoking cessation.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Obtain smoking cessation certification and offer onsite program for community and participants in the lung screening program.	Six completed tobacco cessation training in FY 2023, marking the successful launch of this new program. The initiative was completed in FY 2023, with a target of certifying five individuals by 2025.
Strategy 4 Provide access to health care and services and support under-resourced populations	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Continue to provide free care services to those eligible.	Financial Assistance at cost (free / charity care) provided 21,219 encounters / $42,211,594
b. Continue to provide Medicaid services to those eligible.	Medicaid Under Reimbursement at cost provided 135,712 encounters / $58,493,804

c. Provide awareness of public/government health insurance options to patients and offer support, assistance and continual follow-up throughout the enrollment process.	679 applications for public/government health insurance were initiated, with 509 staff hours dedicated to enrollment assistance.
d. Provide access to prescription and medication assistance programs.	Cost savings for patients totaled $288,537 through prescription and medication assistance programs (FY 2023).

Goal 3 Behavioral Health **Increase capacity and equitable availability of behavioral health services and support resources.**	
Strategy 1 Support Zero Suicide implementation in healthcare organizations.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Provide training to healthcare and other providers to prevent suicide.	77 suicide prevention training sessions (QPR classes) were conducted by Dr. Robert Harrison. The training courses were attended by 778 staff members.
Strategy 2 Promote access to comprehensive behavioral health services to address the needs of our patients and community members.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Establish a Behavioral Health Community Fund to support training and education for community and providers	The Behavioral Health Community Fund was successfully established one collaborative community-based training session, "Speaking Safety."
b. Provide EPIC access to collaborative community Behavioral Health partners.	Completed, EPIC access is now available to key community partners.
c. Resource sharing and education to align resources within the hospital setting.	Efforts to align resources within the hospital setting included a two-day "Seeking Safety" training session in July 2024. Approximately 40 participants attended each day. This initiative is ongoing.

Goal 4 Healthy Living **Achieve equitable life expectancy for community members through availability and coordination of healthy living services and resources.**	
Strategy 1 Commit to support food services offered in the community to address food insecurity and to provide healthier food options.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Continue to support FRESH New London, a community grassroots organization that addresses food needs in New London.	A $150,000 donation was provided to FRESH programs.
b. Continue to participate in the food pantry in New London to fill the gap in food services.	Community Health Workers (CHWs) from Lawrence + Memorial Healthcare volunteered for 747 hours at Food for the People Pantry in New London. This initiative is ongoing.
c. Donate unused/unsold food to food programs.	Discussions about donating food on a regular basis were started. A large, one-time donation was made to the Salvation Army on January 29, 2024. Over the past two years the primary focus of this work has been to develop a food composting effort. Since March 2024, 77,100 pounds of food has been composted with Blue Earth.
d. Conduct healthy food drives to support local food programs.	2,629 pounds of food were donated through healthy food drives. The initiative is ongoing.
e. Offer healthy food options in the cafeteria for patients, staff and visitors.	Over 2,500 mindful items offered.
Strategy 2 Connect food-insecure diabetic patients and pre-diabetic people with healthy food and education as a way to help improve their health.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Provide nutritional counseling and education by a Bilingual Diabetes Community Health Worker (CHW), about access to healthy food and other needed support in New London.	Nine community nutritional education sessions were conducted, with 221 participants, 75 diabetic patients were enrolled in the program, and community outreach reached 330 individuals. The initiative is ongoing.
Strategy 3 Support asthma patients by providing education and services in community settings to address patients' needs to improve their health and wellbeing.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Increase reach and utilization of Breathe Well – Respira Bien, a community-based asthma intervention/management program, among LatinX populations in the Greater New London area.	21 program awareness events/ vendor tables, 178 school children with Asthma enrolled in the program and 168 adult patients with asthma enrolled in the program. The initiative is ongoing.

Strategy 4 Design community-based programs to educate community members about nutrition and physical activity and their relationship to cancer.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Provide nutrition education focused on obesity awareness and its relationship to cancer.	5 nutrition education programs were conducted, with a total of 127 participants. The first program for FY 2025 is scheduled for the second quarter, with ongoing efforts to continue providing education on nutrition and cancer prevention.
Strategy 5 Provide social services to children with SDoH high needs.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
Continue to implement the intensive in-home program for children in the Nurturing Families program.	The intensive in-home program for children in the Nurturing Families program continues to support families, with 108 families enrolled. The initiative is ongoing.
Strategy 6 Develop community engagement activities and events to raise awareness about Heart and Vascular health conditions.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Organize and conduct the Annual Heart Walk by LMH.	The Annual Heart Walk was successfully organized in FY 2023, with 67 walkers from the hospital and $4,763 was raised. In FY2024, the event saw 52 participants and $4,763 was raised. The initiative is ongoing.
b. Host community educational sessions about variety of diseases and health conditions by our team of healthcare providers.	Three educational sessions were held, with 68 attendees. Topics included heart health, cholesterol, and men's urology. Additional sessions are ongoing. The initiative is complete.

Appendix B: 2022-2025 Yale New Haven Health Implementation Strategy Plan Update

Goal 1 Community Health & Wellbeing **Improve the health and wellbeing of the community with a focus on social drivers of health and health equity.**	
Strategy 1 **Align our everyday business activities in a way that improves living conditions in our communities and addresses health equity.**	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. i) Meet or exceed MBE (minority business enterprise) and WBE (women owned business enterprise) spend targets for defined construction projects. ii) Increase spend on local and diverse organizations to at least 5% of adjusted spend over a 5-year period (FY23-27).	i) YNHHS was able to meet and exceed MBE and WBE spend going from 3.4% and 15% in 2022 to 5.4% and 14.4% in 2024 respectively. ii) Local spend and diverse spend goals were met and exceeded.
b. Utilizing services from banks that participate in efforts to invest in or provide services and products to (e.g., loans, mortgages, etc.) communities to whom Yale New Haven Health is also providing care.	YNHHS has had $2 Million in banking assets in local banks from FY22 to the present day. Major banking partners have significant impact investment throughout Connecticut.
c. Place members of the management team on local organization boards to support the community.	As of FY23, YNHHS has 5 board placements (2 in Bridgeport, 3 in New Haven). 41 employees on community boards from Bridgeport Hospital. 6 senior leaders on 24 boards from Greenwich Hospital.
d. Implement initiatives to reduce emissions from the Center for Sustainability strategic plan and track process.	• Tracking energy consumption and purchasing electricity and food using digitized platforms. • Implementing a system wide food waste reduction plan. Data from Lean Path, Foods waste tracking platform to minimize food waste. Staff training and data collection on food waste reduction and composting in progress.
Strategy 2 Develop strategies to address disparities by race and ethnicity to drive equitable care and outcomes.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Develop and implement strategies to address disparities by race and ethnicity based on root cause analyses.	Two root cause analysis conducted, and strategies implemented to address disparities.

b. Identify and decrease variation in clinical care (testing, referral, and treatment patterns) by race and ethnicity.	Developed systems to build analytics around readmissions outcomes for nine conditions with process measures ongoing.
c. Identify and decrease variation in clinical outcomes by race and ethnicity.	Completed for all inpatient and outpatient areas.
Strategy 3 Support a healthcare environment that honors and reflects the communities we serve.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. i) Seek input from the community and provide feedback on health equity in order to inform future strategy (number of focus groups). ii) Seek input from the community and provide feedback on health equity in order to inform future strategy (produce community health needs assessments).	i) 27 focus groups held across all delivery networks in effort to implement the We Ask Because We Care campaign. ii) Assessment produced with 4 of 5 collective impact partnerships in 2022. CHNA evaluation and redesign conducted and formed new governance structure with collective partnership participation for FY25 CHNA process.
Strategy 4 Engage patients, families, physicians, and staff to increase YNHHS presence in the community to build stronger relationships.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Increase awareness and education about health equity, health disparities and cultural competence.	5 sessions offered including Cultural Intelligence and Critical Consciousness: A Strategic Praxis Framework for Inclusive excellence, Barriers and Opportunities to LGBTQIA+ Healthcare Equity and Inclusion Excellence, and The Traumatic Impact of Structural Racism.
b. Support community relationships through volunteerism, and presence in the community to increase community trust and engagement.	2 per hospital conducted (details on length of program-help quantify dollar value, prep time of DEIB staff, how many participants at DN level), 10 total for FY 23 and 24.
c. Provide DEIB education and resources.	201 total courses were for various departments reaching 1824 employees and 9 E-learnings reaching 7,332 employees.
d. Establish Employee Resource Groups/Affinity Groups to assist in identifying the varied needs of the community and support the community through volunteer work.	N/A Affinity Group launched 1/24/2025

Strategy 5 Embed health equity within YNHHS and its hospitals.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Build infrastructure to support health equity.	4 delivery network health equity structures established at all hospital locations (not NEMG). Office of Health Equity and Community Impact Established.
b. Expand ethnicity categories in electronic medical records patient demographics.	REAL data capture went from 90% in 2022 to 99.3% in 2024.
c. Redesign process and staff training to increase collection and use of Racial, Equity and Language (REaL) information in patient care.	Redesigned staff training is available to all delivery networks across the Health System.
Strategy 6 Enhance the patient experience to reflect the community and patient population.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Improve the diversity of Patient Family Advisors to reflect community and patient population.	YNHHS has established PFACS in all hospitals across the Health System.
b. Partner with DEIB, Press Ganey, Office of Health Equity and Community Impact, and Patient Family Advisors to enhance health equity of patient survey questions and use results to increase patient experience.	In FY 24- we started to provide data by race for system objectives to all DNs. In order to capture more meaningful data for DEI questions we transitioned survey questions. This change has provided more actionable detail.
Strategy 7 Screen for socioeconomic needs and provide resources for support.	
Initiatives	**Summary Results (10/1/2022 through 12/31/2024)**
a. Adopt a common set of SDoH questions across all care settings.	140,292 inpatient total screened from 2022 to 2024, and 143,487 NEMG total screened from 2022 to 2024.
b. Develop strategies to support patients with identified needs through referrals and interventions in alignment with The Joint Commission (TJC) requirements.	7,306 referred cases using the Unite Us system. Implemented automated Resource list process. Renewed partnership with Unite Us. Enhanced Dashboard and implement pulse reporting. Expanded screening to include all inpatient, and children hospital inpatient units, and impatient Psych. 90% of NEMG sites implemented screening.

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

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

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

Appendix C: List of Identified Community Health Needs

The following list highlights the community needs identified through the 2025 Community Health Needs Assessment for the Greater New London region. These needs are categorized into high-level focus areas and are presented without prioritization.

Healthcare Needs

- Better chronic disease management programs.
- Culturally appropriate healthcare for tribal populations.
- Enhanced prenatal and maternal care for under-resourced communities.
- Expanded dental care for Medicaid and uninsured populations.
- Improved access to specialty care services.
- Increased telehealth services for remote areas.
- More primary care providers to reduce wait times.
- Support for navigating healthcare and insurance options.

Behavioral Health Care Needs

- Crisis intervention for immediate behavioral health needs.
- Expanded behavioral health services to meet demand.
- Increased substance use treatment and recovery programs.
- Integrated behavioral and primary care services.
- Trauma-informed care to address generational and historical trauma.
- Youth-focused behavioral health services.

Diversity and Equity Needs

- Cultural competence and implicit bias training for providers.
- Equitable resources for tribal communities.
- Improved language access through interpreters and translators.
- LGBTQ+ affirming and inclusive healthcare.
- More providers of color in the healthcare workforce.

Social Drivers of Health

- Affordable childcare for low-income families.
- Affordable housing to address homelessness and overcrowding.
- Better public transportation to access services.
- Education and job training for groups who have been marginalized.
- Environmental health programs to address pollution and exposure risks.
- Programs to improve food security and nutrition access.

Appendix D: Community Partners

- *Health Improvement Collaborative of Southeastern Connecticut*
- *City of New London*
- *Community Health Center, Inc.*
- *FRESH New London*
- *Hispanic Alliance of Southeastern Connecticut*
- *Ledge Light Health District*
- *United Way of Southeastern Connecticut*
- *Community Members*
- *Mujeres Entre Culturas*
- *Eastern Connecticut Health Collaborative*
- *Hartford Healthcare*
- *New London Public Schools*
- *New London Senior Center*
- *Church of the City*
- *Eastern Pequot Tribal Nation*
- *Mashantucket Pequot Tribal Nation*
- *Southeast Connecticut Ministerial Alliance*
- *Madonna Place*

Appendix E: Secondary Data Tables

TABLE 1: CDC SOCIAL VULNERABILITY INDEX DATA - SOCIOECONOMIC STATUS

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Total Population	3,598,348	267,707	152,437	18,638	9,343	15,394	2,356	2,7199	5,154	7,644	18,381	3,496
Population Below Poverty Level	10%	9.2%	9.1%	4.9%	19.5%	7.5%	2.2%	21.0%	6.0%	2.3%	6.0%	6.7%
Unemployment Rate	5.6%	5.0%	5.0%	3.7%	6.4%	2.4%	3.5%	7.3%	2.5%	4.0%	4.5%	7.8%
Median Household Income	$93,760	$94,432	$100,799	$107,667	$69,811	$107,774	$139,000	$60,123	$115,069	$126,904	$108,922	$75,968
Low Income Households Severely Cost Burdened	35.0%	29.1%	31.8%	33.9%	27.6%	23.8%	40.0%	32.0%	22.7%	28.7%	31.5%	49.9%
No High School Diploma	8.7%	6.5%	5.3%	3.2%	8.7%	3.3%	1.4%	12.0%	4.3%	2.1%	2.8%	4.5%
Uninsured Population	5.2%	4.1%	3.9%	2.6%	6.8%	3.3%	3.9%	8.3%	3.6%	0.9%	3.2%	1.3%

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

TABLE 2: CDC SOCIAL VULNERABILITY INDEX DATA - HOUSEHOLD CHARACTERISTICS & MINORITY STATUS[14]

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Population Under Age 18	20.4%	19.6%	18.9%	17.2%	15.5%	26.7%	15.6%	17.7%	17.4%	19.6%	17.9%	15.8%
Population Age 65 and Over	18.1%	19.7%	20.9%	25.8%	15.6%	15.4%	29.5%	14.4%	23.9%	25.9%	28.1%	23.4%
Living with a Disability	11.9%	13.4%	13.0%	12.2%	19.0%	11.8%	9.7%	16.4%	9.6%	8.5%	12.2%	17.4%
English Language Proficiency	8.6%	5.4%	5.1%	3.1%	4.5%	3.0%	0.5%	16.1%	1.1%	2.4%	1.6%	2.1%
Racial & Ethnic Minority	37.0%	26.1%	27.1%	19.4%	37.8%	22.5%	7.3%	55.2%	13.6%	12.0%	14.6%	24.8%

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

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

TABLE 3: CDC SOCIAL VULNERABILITY INDEX DATA - HOUSING TYPE & TRANSPORTATION[15]

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Mobile Homes	0.7%	2.3%	1.7%	0.0%	0.3%	1.6%	1.0%	0.4%	3.2%	2.0%	2.0%	14.4%
No Vehicle	8.6%	6.9%	6.8%	2.5%	13.2%	3.4%	1.5%	15.8%	4.5%	0.6%	4.6%	16.7%
Overcrowded Housing Units	2.0%	0.9%	0.7%	0.2%	0.4%	0.7%	0.0%	1.9%	0.0%	0.3%	0.3%	0.0%
Group Quarters	2.7%	3.3%	4.5%	5.2%	0.1%	0.3%	0.4%	12.1%	0.2%	0.3%	1.7%	3.0%

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

TABLE 4: PROJECTED PERCENT CHANGE IN POPULATION, 2010 TO 2032

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Total Population (2010)	3,574,097	274,061	155,269	19,159	10,365	15,051	2,406	27,620	5,297	7,603	18,509	2,874
Total Population (2023)	3,598,348	267,707	152,437	18,638	9,343	15,394	2,356	27,199	5,154	7,644	18,381	3,496
Percent Change (2010-2023)	+0.7%	-2.3%	-1.8%	-2.7%	-9.9%	+2.3%	-2.1%	-1.5%	-2.7%	+0.5%	-0.7%	+21.6%
Total Population (2032)	3,749,919	276,489	155,289	19,898	9,356	15,731	2,597	27,726.9	5,296	8,070	18,977	3,361
Percent Change (2023-2032)	+4.2%	+3.3%	+1.9%	+6.8%	+0.1%	+2.2%	+10.2%	+1.9%	+2.8%	+5.6%	+3.2%	-3.8%

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

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

TABLE 5: MEDIAN AGE PERCENT CHANGE, 2010 TO 2023

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Median Age (2010)	39.5	39.8	ND	43.6	33.5	37.1	48.5	29.6	43.9	47.9	44.8	45.9
Median Age (2023)	41.2	42.7	44	49.5	38.6	37.4	54.4	35.1	49.4	50.9	51.5	45.7
Percent Change (2010-2023)	+4.3%	+7.3%	ND	+13.5%	+15.2%	+0.8%	+12.2%	+18.6%	+12.5%	+6.3%	15.0%	-0.4%

Sources: U.S. Census Bureau American Community Survey 2006-2010 Five-year Estimates | U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

TABLE 6: POPULATION BY AGE GROUP

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Under Age 18	20.4%	19.6%	18.9%	17.2%	15.5%	26.7%	15.6%	17.7%	17.4%	19.6%	17.9%	15.8%
Age 18 to 64	61.5%	60.7%	60.2%	57.0%	68.9%	57.8%	54.9%	67.9%	58.7%	54.5%	54.0%	60.8%
Age 65 and Over	18.1%	19.7%	20.9%	25.8%	15.6%	15.4%	29.5%	14.4%	23.9%	25.9%	28.1%	23.4%
Age Under 5	5.0%	4.9%	4.8%	3.0%	3.3%	5.7%	2.9%	5.0%	4.2%	5.1%	4.4%	1.3%
Age 5 to 9	5.4%	4.9%	4.8%	4.4%	4.6%	7.6%	3.9%	4.2%	4.7%	4.3%	4.7%	3.2%
Age 10 to 14	6.0%	6.1%	6.1%	6.1%	5.6%	9.5%	5.7%	6.5%	4.3%	6.3%	5.7%	8.2%
Age 15 to 19	6.6%	6.1%	6.0%	4.8%	3.6%	5.8%	4.0%	8.3%	8.1%	5.9%	4.2%	3.9%
Age 20 to 24	6.5%	6.4%	6.9%	4.6%	9.9%	4.1%	4.3%	11.6%	4.6%	4.2%	3.4%	5.0%
Age 25 to 34	12.5%	12.8%	13.0%	10.0%	19.6%	13.9%	8.6%	14.2%	5.6%	6.0%	9.6%	14.6%
Age 35 to 44	12.5%	11.9%	11.2%	11.1%	9.7%	13.1%	12.3%	13.7%	12.7%	9.8%	10.4%	13.3%
Age 45 to 54	12.9%	12.3%	12.1%	13.2%	8.7%	12.8%	9.4%	9.5%	15.4%	15.5%	13.6%	12.7%
Age 55 to 59	7.2%	7.7%	7.2%	8.6%	9.2%	6.0%	8.9%	7.1%	6.7%	8.1%	7.9%	6.8%
Age 60 to 64	7.2%	7.3%	7.0%	8.3%	10.2%	5.8%	10.6%	5.5%	9.8%	8.9%	7.9%	7.7%
Age 65 to 74	10.4%	11.6%	11.9%	14.6%	8.8%	9.4%	19.2%	8.9%	17.4%	17.4%	15.5%	13.0%
Age 75 to 84	5.2%	5.7%	6.1%	7.8%	3.8%	4.7%	9.0%	4.0%	4.0%	5.8%	9.2%	8.1%
Age Over 85	2.4%	2.4%	2.8%	3.4%	2.9%	1.3%	1.4%	1.5%	2.6%	2.6%	3.4%	2.3%

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

TABLE 7: POPULATION BY RACE (ALONE)

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
White	67.6%	77.6%	76.7%	81.5%	69.5%	82.3%	93.8%	51.8%	91.5%	88.7%	86.5%	76.9%
Two or More Races	9.5%	8.5%	8.7%	5.3%	10.6%	8.1%	4.6%	13.4%	6.4%	6.4%	8.0%	9.2%
Black or African American	10.7%	5.3%	5.1%	2.2%	9.1%	3.0%	0.0%	14.5%	0.0%	0.4%	2.2%	8.2%
Some Other	7.1%	4.2%	4.9%	4.2%	5.2%	2.8%	0.9%	17.4%	0.0%	1.3%	1.1%	1.9%
Asian	4.8%	3.9%	4.2%	6.7%	5.4%	2.9%	0.6%	2.6%	2.0%	3.2%	1.8%	3.1%
American Indian and Alaska Native	0.3%	0.5%	0.4%	0.1%	0.2%	0.9%	0.0%	0.3%	0.1%	0.0%	0.4%	0.8%
Native Hawaiian and Other Pacific Islander	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

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

TABLE 8: POPULATION BY ETHNICITY

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Hispanic or Latino	17.8%	11.9%	12.5%	5.9%	16.0%	8.9%	1.5%	34.4%	9.8%	4.3%	3.1%	8.2%

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

TABLE 9: BLACK, INDIGENOUS, PEOPLE OF COLOR (BIPOC) POPULATION

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
BIPOC Population	37.0%	26.1%	27.1%	19.4%	29.7%	22.5%	7.3%	55.2%	13.6%	12.0%	14.6%	17.1%

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

TABLE 10: POPULATION BY SEX

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Females	50.9%	49.7%	49.8%	54.6%	47.8%	48%	47.4%	52.5%	48.3%	50.5%	50.1%	53.3%
Males	49.1%	50.3%	50.2%	45.4%	52.2%	52%	52.6%	47.5%	51.7%	49.5%	49.9%	46.7%

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

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

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
English Only	77.0%	87.1%	86.5%	87.2%	89.2%	92.3%	96.2%	66.9%	93.4%	89.9%	94.0%	93.0%
Spanish	12.6%	6.6%	7.3%	2.1%	4.9%	3.8%	0.7%	27.1%	3.0%	2.3%	1.4%	2.8%
Asian-Pacific Islander	2.5%	2.3%	2.1%	3.7%	2.4%	2.0%	0.7%	1.5%	0.0%	0.5%	0.4%	1.0%
Other Indo-European	6.9%	3.8%	3.8%	6.7%	3.4%	1.9%	2.4%	3.8%	3.7%	7.2%	3.9%	2.8%
Other	1.0%	0.2%	0.3%	0.4%	0.0%	0.0%	0.0%	0.7%	0.0%	0.1%	0.3%	0.4%

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

TABLE 12: FOREIGN-BORN POPULATION

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Naturalized US Citizen	8.6%	5.3%	5.4%	7.5%	4.8%	3.7%	3.2%	8.4%	4.0%	4.8%	3.2%	2.7%
Not US Citizen	6.9%	3.5%	3.8%	2.0%	5.4%	1.0%	0.3%	10.8%	1.0%	3.7%	1.8%	1.4%

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

TABLE 13: POPULATION LIVING WITH DISABILITY BY AGE

	CT	New London County	Greater New London Service Area	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Age Under 5	0.7%	0.6%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%	0.0%
Age 5 to 17	6.3%	8.5%	8.4%	4.4%	15.1%	8.9%	1.3%	12.1%	4.3%	5.0%	11.4%	1.4%
Age 18 to 34	7.5%	9.5%	11.2%	12.4%	19.4%	10.1%	4.0%	14.2%	5.4%	2.2%	5.7%	5.9%
Age 35 to 64	10.7%	11.5%	10.6%	10.7%	16.3%	9.4%	4.3%	15.7%	7.4%	5.4%	7.0%	24.6%
Age 65 to 74	19.4%	21.5%	18.2%	12%	24.1%	17.9%	12.8%	35.4%	15.0%	12.8%	9.8%	21.1%
Age 75 and Over	43.1%	44.1%	41.8%	37.2%	47.9%	47.4%	46.3%	45.6%	38.2%	34.7%	46.5%	41.3%

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

TABLE 14: POPULATION LIVING WITH DISABILITY BY TYPE

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Ambulatory Difficulty	5.5%	6.2%	5.6%	5.1%	6.5%	3.7%	4.3%	7.0%	4.8%	3.6%	4.5%	9.4%
Cognitive Difficulty	4.9%	5.7%	5.4%	4.5%	9.4%	5.7%	3.3%	7.9%	1.6%	2.8%	4.4%	8.2%
Independent Living Difficulty	4.4%	4.7%	4.8%	3.7%	5.8%	3.4%	3.0%	6.7%	2.7%	2.2%	4.0%	9.2%
Hearing Difficulty	3.1%	3.7%	3.9%	4.7%	5.4%	4.4%	4.2%	2.8%	3.9%	3.5%	4.6%	1.5%
Vision Difficulty	2.1%	2.1%	2.3%	2.3%	2.0%	3.0%	1.4%	1.3%	4.4%	1.7%	0.7%	2.6%

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

TABLE 15: POPULATION LIVING WITH DISABILITY BY RACE

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
American Indian and Alaska Native	14.9%	15.3%	17.7%	0.0%	0.0%	2.1%	ND	0.0%	28.6%	ND	0.0%	0.0%
Black or African American	12.6%	12.7%	14.9%	0.0%	14.1%	8.2%	ND	20.0%	0.0%	3.2%	10.1%	16.9%
White	12.5%	14.4%	13.9%	14.5%	22.3%	13.0%	9.0%	17.3%	9.9%	9.0%	12.1%	20.7%
Two or More Races	11.2%	11.0%	12.4%	7.5%	14.4%	5.8%	7.4%	19.6%	10.0%	1.8%	12.1%	7.6%
Asian	6.3%	11.2%	11.8%	5.9%	5.4%	10.3%	26.7%	20.8%	0.0%	11.5%	47.8%	0.0%
Some Other Race	12.5%	13.4%	11.7%	2.4%	14.1%	9.6%	90.9%	13.5%	ND	0.0%	8.6%	0.0%
Native Hawaiian and Other Pacific Islander	15.3%	91.3%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND

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

TABLE 16: POPULATION LIVING WITH DISABILITY BY ETHNICITY

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Hispanic or Latino	12.2%	12.7%	12.9%	5.5%	18.1%	12.7%	16.7%	15.2%	0.0%	2.7%	8.3%	23.6%

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

TABLE 17: POPULATION WITH A BACHELOR'S DEGREE OR HIGHER, PERCENT CHANGE

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Population with a Bachelor's Degree or Higher Attainment (2010)	35.7%	30.9%	35.9%	37.7%	26.8%	36.1%	61.4%	22.2%	43.3%	54.7%	44.8%	23.4%
Population with a Bachelor's Degree or Higher Attainment (2023)	41.9%	36.4%	42.7%	50.3%	34.7%	39.7%	63.3%	28.9%	40.9%	53.6%	51.7%	25.5%
Percent Change (2010-2023)	+17.5%	+17.8%	+19.0%	+33.5%	+29.4%	+9.8%	+3.0%	+30.6%	-5.6%	-2.1%	+15.4%	+8.8%

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

TABLE 18: HIGHEST LEVEL OF EDUCATIONAL ATTAINMENT

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Less than 9th Grade	4.0%	2.4%	2.2%	1.0%	3.1%	1.2%	0.3%	5.7%	1.4%	0.4%	1.0%	2.0%
9th to 12th Grade, No Diploma	4.7%	4.0%	3.1%	2.1%	5.6%	2.1%	1.1%	6.3%	3.0%	1.8%	1.8%	2.5%
High School Degree	25.5%	28.2%	24.8%	22.2%	26.1%	27.3%	12.5%	29.5%	28%	17.4%	20.5%	38.3%
Some College No Degree	16.2%	20.2%	19.2%	15.7%	23.6%	21.5%	16.3%	21.1%	17.3%	17.5%	16.9%	22.9%
Associates Degree	7.6%	8.7%	8.1%	8.6%	7.0%	8.2%	6.5%	8.4%	9.4%	9.5%	8.1%	8.8%
Bachelor's Degree	23.0%	20.0%	23.0%	27.0%	24.4%	20.2%	34.3%	16.5%	20.3%	22.3%	28.0%	10.8%
Graduate Degree	19.0%	16.4%	19.7%	23.3%	10.3%	19.5%	29.0%	12.5%	20.6%	31.2%	23.7%	14.7%

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

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

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
White	5.5%	4.6%	3.5%	1.9%	3.6%	3.4%	1.4%	7.4%	4.7%	2.1%	2.2%	3.8%
Black/African American	12.3%	13.2%	16.7%	10.4%	14.4%	13.3%	ND	20.0%	100.0%	9.1%	8.9%	15.6%
Hispanic/Latino	25.0%	21.0%	17.9%	14.3%	21.1%	0.0%	3.6%	22.6%	0.0%	0.0%	14.6%	8.0%

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

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

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Asian	66.2%	47.5%	58.1%	70.9%	72.9%	30.1%	45.5%	47.2%	100.0%	46.4%	58.5%	88.2%
White	45.9%	38.1%	45.1%	50.5%	36.5%	40.3%	62.0%	36.7%	40.0%	54.6%	52.2%	26.2%
Two or More Races	31.9%	32.4%	34.9%	45.3%	19.0%	36.5%	95.2%	25.1%	29.8%	50.6%	59.6%	27.5%
Some Other Race	17.4%	19.4%	20.7%	30.6%	48.3%	40.7%	47.6%	9.7%	ND	15.2%	61.0.%	0.0%
Black or African American	26.3%	20.1%	18.9%	18.0%	6.4%	53.1%	ND	17.9%	0.0%	0.0%	11.3%	2.3%
American Indian and Alaska Native	20.7%	14.2%	14.2%	75.0%	29.4%	13.6%	ND	51.9%	0.0%	ND	2.6%	0.0%
Native Hawaiian and Other Pacific Islander	22.0%	0.0%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND

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

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

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Hispanic or Latino	20.0%	19.3%	22.1%	44.6%	20.9%	27.5%	75.0%	15.7%	29.8%	42.7%	53.3%	16.4%

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

TABLE 22: CHILD CARE CENTERS

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Child Care Centers	900	54	21	ND	ND	ND	ND	ND	ND	ND	ND	ND

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

TABLE 23: POVERTY PERCENT CHANGE

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Households Below Poverty Level (2010)	9.4%	7.9%	7.4%	3.6%	12.8%	3.0%	4.3%	16.5%	5.4%	2.4%	5.8%	8.6%
Households Below Poverty Level (2023)	10.5%	9.3%	8.9%	5.4%	16.6%	8.0%	2.4%	17.9%	5.0%	2.7%	7.4%	10.4%
Percent Change (2010-2023)	+12.7%	+17.4%	+20.2%	+49.2%	+29.4%	+163.7%	-44.3%	+8.3%	-8.1%	+15%	+27.4%	+21.4%

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

TABLE 24: INCOME TO POVERTY RATIOS

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
100% -124% FPL	2.8%	2.9%	2.6%	2.1%	2.0%	1.4%	0.3%	5.7%	0.0%	1.9%	1.4%	6.4%
125% - 149% FPL	3.0%	3.1%	3.0%	0.8%	3.3%	1.5%	1.9%	5.6%	3.7%	0.9%	2.4%	2.1%
150% - 184% FPL	4.3%	4.6%	4.2%	2.8%	5.4%	3.1%	1.2%	4.5%	5.1%	1.8%	4.1%	9.3%
185% - 199% FPL	2.0%	1.6%	1.5%	0.7%	2.8%	1.5%	1.4%	1.4%	1.7%	0.3%	1.5%	0.0%
200% and Over FPL	77.9%	78.6%	79.6%	88.8%	67.1%	85.1%	93.0%	61.9%	83.5%	92.8%	84.6%	75.5%

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

TABLE 25: PERCENT OF POPULATION LIVING IN POVERTY

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
People Below Poverty Level	10.0%	9.2%	9.1%	4.9%	19.5%	7.5%	2.2%	21.0%	6.0%	2.3%	6.0%	6.7%
American Indian and Alaska Native	22.2%	25.1%	27.4%	0.0%	0.0%	0.0%	ND	12.3%	14.3%	ND	39.0%	0.0%
Asian	8.8%	7.7%	4.7%	2.5%	1.4%	8.8%	0.0%	2.3%	0.0%	10.6%	0.0%	0.0%
Black or African American	17.1%	16.8%	24.4%	0.0%	44.1%	15.8%	ND	31.4%	0.0%	6.5%	2.7%	4.1%
Native Hawaiian and Other Pacific Islander	29.8%	91.3%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND
Some Other Race	22.1%	23.9%	26.8%	23%	19.2%	0.0%	0.0%	35.4%	ND	0.0%	0.0%	0.0%
Two or More Races	13.2%	14.8%	12.8%	0.0%	25.6%	0.2%	0.0%	28.1%	0.0%	0.0%	7.6%	9.2%
White	7.2%	7.3%	6.7%	4.6%	16.8%	8.2%	2.3%	11.2%	6.6%	2.3%	6.0%	7.1%
Hispanic or Latino	20.3%	23.2%	23.6%	0.6%	42.1%	13.7%	0.0%	30.3%	34.8%	0.0%	12.4%	10.5%

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Age Under 5	13.4%	12.3%	13.6%	3.2%	43.7%	18.3%	0.0%	32.3%	0.0%	2.4%	13.8%	0.0%
Age Under 18	13.1%	13.1%	13.5%	4.4%	40.6%	12.2%	5.7%	34.5%	8.4%	1.1%	9.5%	0.0%
Age 18 to 64	9.5%	8.8%	8.7%	4.1%	17.6%	5.4%	1.3%	19.9%	7.8%	0.8%	4.9%	6.3%
Age 65 and Over	8.3%	6.5%	6.1%	6.8%	7.0%	7.0%	1.9%	8.9%	0.0%	6.4%	5.8%	12.6%

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

TABLE 26: UNITEDWAY ALICE

	U.S.	CT	New London County
Households Below ALICE Threshold	29.0%	29.0%	28.6%

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

TABLE 27: MEDIAN HOUSEHOLD INCOME PERCENT CHANGE

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Median Household Income (2010)	$69,243	$70,323	$71,549	$82,824	$57,225	$88,663	$91,726	$47,168	$83,007	$97,884	$76,943	$56,895
Median Household Income (2023)	$93,760	$94,432	$100,799	$107,667	$69,811	$107,774	$139,000	$60,123	$115,069	$126,904	$108,922	$75,968
Percent Change (2010-2023)	+35.4%	+34.3%	+40.9%	+30.0%	+22.0%	+21.6%	+51.5%	+27.5%	+38.6%	+29.6%	+41.6%	+33.5%

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

TABLE 28: MEDIAN HOUSEHOLD INCOME BY RACE

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Asian	$126,722	$120,996	$124,331	$181,033	$89,978	$79,464	ND	$53,009	ND	$84,643	$111,111	ND
Two or More Races	$76,435	$101,724	$103,607	$167,563	$71,250	$104,583	ND	$65,890	$131,840	ND	ND	$70,625
White	$103,032	$94,678	$99,285	$103,816	$72,083	$111,279	$141,875	$72,252	$115,208	$127,788	$108,956	$77,440
Other Race	$56,744	$93,372	$91,685	$200,117	$61,538	$93,750	ND	$47,300	ND	ND	$200,313	ND
Black or African American	$62,712	$86,603	$79,483	ND	$45,661	$138,750	ND	$44,476	ND	ND	$35,750	$46,233
American Indian and Alaska Native	$52,152	$87,865	$43,523	ND	ND	$43,523	ND	ND	ND	ND	ND	ND
Native Hawaiian and Other Pacific Islander	$41,573	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND

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

TABLE 29: MEDIAN HOUSEHOLD INCOME BY ETHNICITY

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Hispanic or Latino	$60,136	$87,819	$84,320	$152,857	$36,703	$78,500	ND	$49,390	$131,840	$205,481	$43,929	ND

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

TABLE 30: EMPLOYMENT BY INDUSTRY

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Management	11.6%	10.5%	11.3%	11.9%	8.8%	9.5%	16.5%	5.8%	11.0%	15.9%	17.2%	10.9%
Office and Administrative Support	9.3%	8.7%	8.3%	8.5%	7.3%	7.2%	10.7%	9.4%	3.2%	7.1%	8.9%	8.8%
Sales	9.0%	7.8%	8.2%	8.4%	10.4%	4.4%	6.6%	9.8%	6.2%	10.0%	8.0%	10.3%
Education, Training and Library	7.1%	6.9%	7.5%	9.2%	8.3%	7.3%	10.4%	6.0%	8.9%	7.6%	8.1%	7.0%
Food Preparation and Serving	4.3%	5.5%	5.4%	2.6%	5.1%	5.4%	0.6%	6.7%	12.7%	6.3%	5.7%	4.2%
Architecture and Engineering	2.5%	4.6%	5.3%	6.1%	6.2%	7.9%	5.3%	4.6%	0.7%	4.1%	3.3%	5.1%
Business and Finance	6.5%	5.0%	5.0%	8.6%	2.0%	5.7%	7.1%	2.1%	3.1%	5.2%	5.2%	7.2%
Production	4.5%	4.9%	4.8%	3.3%	4.4%	5.4%	2.2%	7.9%	2.3%	3.5%	5.0%	2.9%
Construction and Extraction	4.2%	4.9%	4.4%	3.0%	5.0%	6.0%	11.2%	4.2%	8.0%	3.4%	6.4%	0.6%
Health Diagnosis and Treating Practitioners	4.4%	3.9%	4.3%	4.8%	5.1%	3.3%	4.2%	2.2%	7.4%	4.7%	3.5%	2.9%
Building, Grounds Cleaning, and Maintenance	3.3%	3.7%	3.6%	2.6%	3.8%	3.8%	1.2%	7.1%	1.8%	5.3%	2.0%	1.4%
Personal Care and Service	2.7%	4.5%	3.6%	4.0%	2.7%	5.9%	0.0%	3.1%	5.9%	3.9%	3.9%	2.8%
Computer and Mathematical	3.3%	2.7%	3.2%	4.5%	5.0%	3.3%	0.6%	2.2%	2.6%	2.7%	1.7%	0.4%
Healthcare Support	3.4%	3.1%	2.7%	2.1%	6.5%	3.4%	0.6%	4.7%	2.6%	0.7%	1.8%	2.8%
Community and Social Service	1.9%	2.1%	2.6%	1.6%	1.2%	3.6%	3.4%	3.4%	2.2%	1.1%	3.7%	0.0%

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Arts, Design, Entertainment, Sports and Media	2.1%	2.1%	2.3%	2.9%	2.7%	1.6%	9.5%	2.6%	2.0%	2.3%	1.5%	1.5%
Life, Physical, and Social Science	1.2%	1.7%	2.1%	2.5%	0.8%	1.3%	0.9%	1.5%	3.4%	2.5%	3.1%	2.0%
Transportation	2.9%	2.5%	2.0%	1.2%	1.9%	1.1%	1.4%	2.4%	1.6%	1.4%	1.3%	4.7%
Material Moving	2.6%	2.4%	1.9%	1.5%	1.2%	2.4%	1.0%	2.7%	2.4%	1.2%	1.2%	4.6%
Installation, Maintenance, and Repair	2.3%	2.5%	1.8%	1.5%	0.9%	3.1%	0.5%	1.2%	2.8%	3.6%	1.1%	6.6%
Health Technologist and Technicians	2.0%	1.9%	1.6%	0.6%	2.0%	2.1%	0.9%	1.2%	4.9%	1.0%	0.8%	3.9%
Fire Fighting and Prevention	1.1%	1.6%	1.2%	2.3%	2.2%	2.3%	0.1%	0.4%	0.0%	0.8%	1.1%	1.7%
Legal	1.3%	1.0%	1.1%	1.1%	0.2%	0.7%	1.0%	0.5%	0.5%	1.8%	0.6%	0.0%
Law Enforcement	0.7%	0.8%	0.9%	1.2%	0.1%	0.8%	0.6%	1.0%	1.3%	0.0%	0.4%	0.0%
Farming, Fishing and Forestry	0.2%	0.1%	0.1%	0.3%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%

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

TABLE 31: HOUSEHOLDS RECEIVING SNAP

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Households Receiving Food Stamps/SNAP	11.7%	10.6%	9.7%	3.0%	18.9%	5.3%	2.4%	20.7%	3.9%	2.1%	5.3%	17.1%

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

TABLE 32: FOOD INSECURITY AMONG ADULTS

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Food Insecurity Rate	14.8%	ND	12.1%	8.3%	12.6%	9.8%	5.7%	22.8%	6.9%	6.8%	7.5%	10.1%

Source: BRFSS PLACES 2022

TABLE 33: CHILDREN ELIGIBLE FOR FREE OR REDUCED PRICE LUNCH

	United States	CT	New London County
Percent of Children	51%	40%	41%

Source: National Center for Education Statistics, 2021-2022

TABLE 34: HOUSING COSTS & HOME VALUE

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Median Household Income	$69,243	$70,323	$71,549	$82,824	$57,225	$88,663	$91,726	$47,168	$83,007	$97,884	$76,943	$56,895
Renter Excessive Housing Costs	48.1%	45.9%	45.6%	49.8%	47.3%	25.1%	15.0%	52.9%	43.2%	53.7%	35.7%	45.5%
Owner Excessive Housing Costs	26.4%	23.2%	22.6%	23.2%	18.0%	25.5%	21.4%	25.3%	23.0%	20.6%	23.4%	30.4%
Renter Housing Mobile Homes	0.4%	1.5%	0.7%	0.0%	0.0%	1.5%	0.0%	0.0%	0.6%	0.0%	0.0%	23.0%
Owner Housing Mobile Homes	0.8%	2.6%	1.9%	0.0%	0.8%	1.5%	0.0%	0.0%	3.5%	1.1%	3.0%	11.2%
Homeowner Vacancy Rate	0.9%	0.9%	0.9%	0.4%	3.5%	2.2%	0.0%	1.1%	0.0%	0.0%	1.1%	0.8%

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

TABLE 35: FAIR MARKET RENT (FMR)

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
0 Bedrooms	ND	$976	ND	$970	ND	$970	$970	ND	$970	$970	$970	ND
1 Bedrooms	ND	$1,177	ND	$1,177	ND	$1,177	$1,177	ND	$1,177	$1,177	$1,177	ND
2 Bedrooms	ND	$1,459	ND	$1,450	ND	$1,450	$1,450	ND	$1,450	$1,450	$1,450	ND
3 Bedrooms	ND	$1,900	ND	$1,878	ND	$1,878	$1,878	ND	$1,878	$1,878	$1,878	ND
4 Bedrooms	ND	$2,486	ND	$2,470	ND	$2,470	$2,470	ND	$2,470	$2,470	$2,470	ND

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

TABLE 36: HOUSING WAGE

	U.S.	CT	New London County – Norwich-New London HMFA
Hourly Wage Necessary to Afford a 2-Bedroom Apartment at Fair Market Rent (FMR)	$32.11	$34.54	$29.92

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

TABLE 37: MEDIAN HOME RENT

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Median Home Rent	$1,431	$1,389	$1,549	$1,568	$1,493	$1,547	$1,524	$1,303	$1,224	$2,012	$1,416	$1,561

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

TABLE 38: HOUSEHOLD COMPOSITION

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Households with Children	28.7%	26.6%	26.4%	24.1%	20.5%	34.7%	25.1%	25.5%	27.2%	29.7%	23.6%	22.9%
Households with Grandparents Responsible for Grandchildren	0.9%	0.6%	0.5%	0.3%	1.4%	0.9%	0.0%	0.1%	0.0%	0.3%	0.3%	0.6%

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

TABLE 39: TRANSPORTATION

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Mean Travel Time to Work (in minutes)	26.6	24.2	22.3	26.0	17.7	23.4	33.8	20.1	28.0	24.7	23.5	30.1
Commute by Public Transit	3.4%	1.2%	1.5%	0.8%	2.6%	0.4%	3.5%	4.7%	0.0%	1.7%	0.8%	0.9%
Commute by Drive Alone	70.6%	76.2%	74.5%	69.2%	71.0%	83.6%	65.0%	67.7%	90.8%	71.8%	74.5%	82.0%
Walkability	ND	ND	ND	3	58	48	0	91	19	2	47	25

Sources: U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates | Walk Score, walkscore.com, 2024

TABLE 40: BROADBAND

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Households Without Internet Access	6.5%	7.0%	6.8%	4.0%	11.9%	4.3%	1.3%	9.4%	13.0%	2.1%	5.0%	7.3%
Number of Internet Providers (2024)	16	10	ND	9	9	9	8	9	8	8	9	8

Sources: Federal Communications Commission Fixed Broadband Deployment Data 2024 | U.S. Census Bureau American Community Survey 2019-2023 Five-year Estimates

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

	CT	New London County	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Primary Care Physician	835:1	1284:1	1329:1	347:1	2566:1	ND	468:1	1720:1	1275:1	1150:1	252:1
Primary Care Nurse Practitioner	1033:1	1260:1	2067:1	347:1	5131:1	ND	484:1	1032:1	1275:1	1840:1	655:1
Dentist	1398:1	1647:1	1431:1	246:1	5131:1	ND	952:1	2580:1	1093:1	2300:1	252:1
Mental Health Provider	520:1	617:1	979:1	151:1	3849:1	2390:1	226:1	5160:1	850:1	876:1	131:1
Pediatrician	618:1	991:1	463:1	181:1	407:1	ND	414:1	947:1	ND	1663:1	ND

	CT	New London County	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Obstetrics Gynecology (OBGYN)	2576:1	4772:1	3371:1	544:1	ND	ND	1186:1	ND	ND	ND	ND
Midwife and Doula	15745:1	11135:1	10112:1	2175:1	7457:1	ND	4746:1	ND	ND	9254:1	ND

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

TABLE 42: SELF-REPORTED CHRONIC CONDITIONS AMONG ADULTS

	Greater New London Region	CT
High cholesterol	35.7%	33.4%
Obesity among adults	30.5%	30.2%
High blood pressure	29.8%	29.7%
Depression	22.1%	20.9%
Asthma	11.1%	11.1%
Diagnosed diabetes	9.5%	9.4%
Cancer (excluding skin cancer)	7.2%	6.9%
Chronic obstructive pulmonary disease (COPD)	6.1%	5.7%
Coronary heart disease	5.5%	5.2%
Chronic kidney disease	2.9%	2.8%
Stroke	2.8%	2.8%

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

TABLE 43: SELF-REPORTED GENERAL WELL-BEING AMONG ADULTS

	Greater New London Region	CT
Mental health not good for two weeks or more[16]	15.0%	14.6%
Fair or poor self-rated health status	12.3%	13.3%

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

	Greater New London Region	CT
Physical health not good for two weeks or more[17]	9.8%	10.0%

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

TABLE 44: HEALTH RISK BEHAVIORS AMONG ADULTS

	Greater New London Region	CT
Binge or heavy drinking	16.2%	15.5%
Current adult smokers	14.0%	13.9%
No leisure time physical activity (% of adults)	20.1%	22.7%

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

TABLE 45: LIFE EXPECTANCY

	New London County	CT
Life Expectancy (in years)	78.1	79.2

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

TABLE 46: UNINSURED POPULATION

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
Uninsured Age Under 6	2.4%	2.1%	1.8%	0.0%	2.9%	0.0%	0.0%	3.9%	0.0%	0.0%	8.5%	0.0%
Uninsured Age 6 to 18	3.1%	2.0%	1.3%	2.9%	3.1%	0.6%	0.0%	2.1%	1.8%	0.0%	0.0%	0.0%
Uninsured Age 19 to 64	7.5%	6.2%	6.4%	3.8%	9.1%	5.7%	7.2%	12.2%	6%	1.7%	5.5%	2.3%
Uninsured Age 65 and Over	0.8%	0.6%	0.7%	1.0%	2.1%	0.0%	0.0%	3.2%	0.0%	0.0%	0.0%	0.0%

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

	CT	New London County	Greater New London Region	East Lyme	Groton	Ledyard	Lyme	New London	North Stonington	Old Lyme	Stonington	Waterford
People with Private Health Insurance	73.3%	74.2%	75.4%	80.2%	66.3%	82.6%	74.7%	55.6%	82.2%	79.7%	80.8%	68.5%
People with Public Health Insurance	39.3%	41.4%	41.4%	40.0%	45.5%	32.8%	39.8%	55.3%	38.7%	35.1%	40.8%	50.0%
Uninsured Age 18 and Under with a Disability	1.7%	1.7%	0.6%	0.0%	0.0%	0.0%	0.0%	2.5%	0.0%	0.0%	0.0%	0.0%
Uninsured Age 19 to 64 with a Disability	5.5%	6.5%	9.3%	14.7%	12%	10.4%	0.0%	12.8%	0.0%	0.0%	7.1%	4.2%
Uninsured People in Labor Force	7.2%	6.1%	6.0%	3.4%	7.2%	5.1%	8.3%	12.3%	4.9%	2.0%	5.5%	2.8%

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

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

	CT	New London County
Birth Rate	9.9	9.4

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

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

	CT	New London County
Death Rate	9.5	11.0

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

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

	CT	New London County
Accidental Injuries	73.3	87.8
Alzheimer's Disease	29.1	24.2
Birth Defects	2.2	ND
Cancer	181.0	211.7
Chronic Liver Disease	15.3	17.5
Chronic Lower Respiratory Disease	32.4	40.9
Birth-related Conditions	2.5	ND
Diabetes	21.4	20.5
Heart Disease	186.7	220.6
High Blood Pressure	9.1	11.2

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

TABLE 50: RANKED LIST OF SELECT HEALTH INDICATOR HOSPITAL UTILIZATION RATES FOR ADULTS IN CONNECTICUT

		Age-Adjusted Principal Diagnosis Rate per 1,000 Adults	
Rank	Health Indicator	Lawrence + Memorial Hospital	State of CT
1	Mental Health Composite	16.6	10.4
2	Substance-Related Disorders (SRD)	13.0	8.1
3	Sepsis	12.2	8.4
4	Heart Failure (HF)	9.9	4.3
5	Community Acquired (CommAcq) Pneumonia	7.9	4.3
6	High Blood Pressure (HBP)	4.9	4.5
7	Asthma	3.9	2.8

		Age-Adjusted Principal Diagnosis Rate per 1,000 Adults	
Rank	**Health Indicator**	Lawrence + Memorial Hospital	**State of CT**
8	Stroke	3.9	2.5
9	Chronic Obstructive Pulmonary Disease (COPD)	3.8	2.2
10	Acute Myocardial Infarction (AMI)	3.7	1.8
11	Arthritis	3.7	1.8
12	Diabetes - Uncontrolled/Short Term Complications (Unc-STC)	3.2	2.7
13	Coronary Artery Disease (CAD)	3.1	1.0
14	Diabetes - Long Term Complications (LTC)	2.1	1.3
15	Overweight/Obesity	1.4	1.0

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

TABLE 51: OBESITY (ADULTS)

	U.S.	CT	New London County
Obesity (Adults)	34.0%	31.0%	31.0%

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

TABLE 52: SMOKING STATUS

	U.S.	CT	New London County
Current Smokers (Adults)	15.0%	12.0%	15.0%

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

TABLE 53: INFECTIOUS DISEASE

	U.S.	CT	New London County
Hepatitis B	3,544	15	0
Hepatitis A	18,846	0	3
HIV/AIDS	1,107,597[18]	171	10
Influenza	35,000,000	98	10
Lyme Disease	34,945	400	86
Tuberculosis	8,916	54	1

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

TABLE 54: SEXUALLY TRANSMITTED DISEASES

	U.S.	CT	New London County
Syphilis	129,813	280	6
Chlamydia	1,808,703	12,716	749
Gonorrhea	616,392	4,604	174
Chancroid	8	0	0

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

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

TABLE 55: MENTAL HEALTH AND BEHAVIORAL HEALTH STATUS

	U.S.	CT	New London County
Percent of Frequent Mental Distress	15.0%	13.0%	15.0%
Poor Mental Health Days	4.8	4.4	5.0
Poor Physical Health Day	3.3	2.9	3.2
Drug Overdose Death Rate (per 100,000)	32.0	42.0	47.0

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

TABLE 56: SUICIDE

	U.S.	CT	New London County
Suicide Rate	14.0	10.0	13.0

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

TABLE 57: MATERNAL AND CHILD HEALTH

	U.S.	CT	New London County
Birth Rate (per 1,000)	11.0	9.9	9.4
Teen Birth Rate (per 1,000)	17.0	8.0	8.0
Low Birthweight	7.1%	8.0%	8.7%
Infant Mortality	6.0	5.0	4.0

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

TABLE 58: LOW BIRTH WEIGHT, BY RACE/ETHNICITY OF MOTHER[19]

	CT	New London County
American Indian or Alaska Native (not Hispanic or Latino)	9.6%	ND
Asian (not Hispanic or Latino)	9.0%	9.6%
Black or African American (not Hispanic or Latino)	13.0%	12.5%
Native Hawaiian or Other Pacific Islander (not Hispanic or Latino)	ND	ND
Hispanic or Latino	8.5%	8.4%
White (not Hispanic or Latino)	6.3%	6.6%
More than One Race (not Hispanic or Latino)	9.3%	9.8%

Source: CDC WONDER Natality 2019-2023

TABLE 59: PRETERM BIRTHS, BY RACE/ETHNICITY OF MOTHER[20]

	CT	New London County
American Indian or Alaska Native (not Hispanic or Latino)	10.9%	ND
Asian (not Hispanic or Latino)	8.0%	8.7%
Black or African American (not Hispanic or Latino)	13.2%	12.1%
Native Hawaiian or Other Pacific Islander (not Hispanic or Latino)	ND	ND
Hispanic or Latino	10.1%	9.0%
White (not Hispanic or Latino)	8.2%	8.0%
More than One Race (not Hispanic or Latino)	10.0%	10.2%

Source: CDC WONDER Natality 2019-2023

[19] This dataset represents low birth weight births by race/ethnicity. Low birth weight is defined as a baby weighing less than 2,500 grams when born.
[20] This dataset represents preterm births by race/ethnicity. Preterm is defined as a birth occurring before 37 weeks.

TABLE 60: FIRST TRIMESTER PRENATAL CARE, BY RACE/ETHNICITY OF MOTHER[21]

	CT	New London County
American Indian or Alaska Native (not Hispanic or Latino)	80.8%	85.4%
Asian (not Hispanic or Latino)	84.0%	86.7%
Black or African American (not Hispanic or Latino)	76.7%	77.1%
Native Hawaiian or Other Pacific Islander (not Hispanic or Latino)	78.9%	ND
Hispanic or Latino	77.7%	81.1%
White (not Hispanic or Latino)	88.2%	90.6%
More than One Race (not Hispanic or Latino)	80.2%	85.5%

Source: CDC WONDER Natality 2019-2023

TABLE 61: YOUTH SUBSTANCE ABUSE

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

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

[21] This dataset represents the percent of births in which the mother received prenatal care in the first trimester by race/ethnicity.

Appendix F: Access Audit

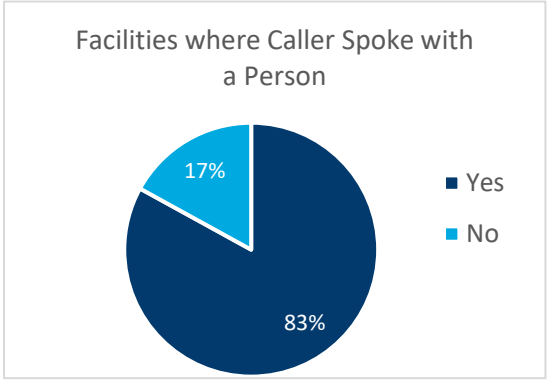
Yale New Haven Health Access Audit – Greater New London

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

The audit involved calls to six facilities within New London's service area, providing diverse services such primary care, behavioral health, outpatient rehabilitation, and pediatric care. The facilities included in the audit are:

Health System Facilities Included in Access Audit

1. Federally Qualified Health Center (Independent FQHC)
2. Community Behavioral Health Provider
3. Federally Qualified Health Center (Multi-Service Human Services FQHC)
4. YNHHS Ambulatory Site – Walk-in/Primary Care Clinic
5. YNHHS Ambulatory Site – Primary Care Practice
6. YNHHS Ambulatory Site - Multi-Specialty & Emergency Care



Phone calls were conducted at various times during the standard business hours in early December. Out of the six calls placed, the caller spoke with a staff member at five facilities. Staff members immediately answered calls at five of the six facilities with which the caller spoke with a person. At the facilities where the caller did not speak with a staff member, there was an automated answer that required the caller to leave their contact information. The caller was able to collect

helpful information at five of the six (83%) facilities. Though one facility's phone tree directed the caller to another number to schedule an appointment. The number was provided too quickly and not repeated, making it difficult for someone without a pen or paper to capture it, potentially requiring them to call back and navigate the phone tree again.

Ability of facilities to accept new patients

The ability to accept new patients varied significantly across the facilities assessed. While most facilities confirmed they were accepting new patients, one said they were not. The wait times for appointments ranged from the following month to delays of several months. One facility stated they were unable to schedule new patients until nearly four months away, while another reported the earliest availability was more than six months away due to a limited provider schedule. In one case, the facility referred callers to two alternative clinics that were accepting new patients, though they did not provide specific availability information. Another facility required patients to register before any scheduling information could be provided, creating an additional barrier for prospective patients.

Ability of facilities to answer questions and refer the caller elsewhere when the desired services are unavailable

The ability to answer questions and provide referrals when services were unavailable varied widely among the facilities. One facility demonstrated a proactive approach by offering alternative options, such as contact information for other clinics in the area. For example, one facility provided the names and numbers of nearby locations in Mystic and Groton that were accepting new patients. Other facilities, however, offered limited guidance, requiring callers to independently navigate their options. One facility relied on an automated system that directed callers to leave a voicemail with no immediate support or referrals provided.

How staff inquiries help to determine prospective patient's needs

The extent to which staff inquired about the caller's needs varied across the facilities. Some staff members asked for basic information, such as insurance details, demographic information, and specific healthcare needs, ensuring a tailored response. For example, one facility requested details about previous medical visits and medication lists, reflecting a thorough approach to understanding the patient's needs. Conversely, other facilities focused primarily on administrative steps, such as account setup or insurance verification, without asking follow-up questions to fully assess the caller's healthcare requirements.

Of the six facilities where the caller spoke with a staff member, staff at three of the facilities asked questions to determine prospective client needs and other information. Staff at the other two facilities did not ask any questions, though they were helpful.

Ease of speaking with a person

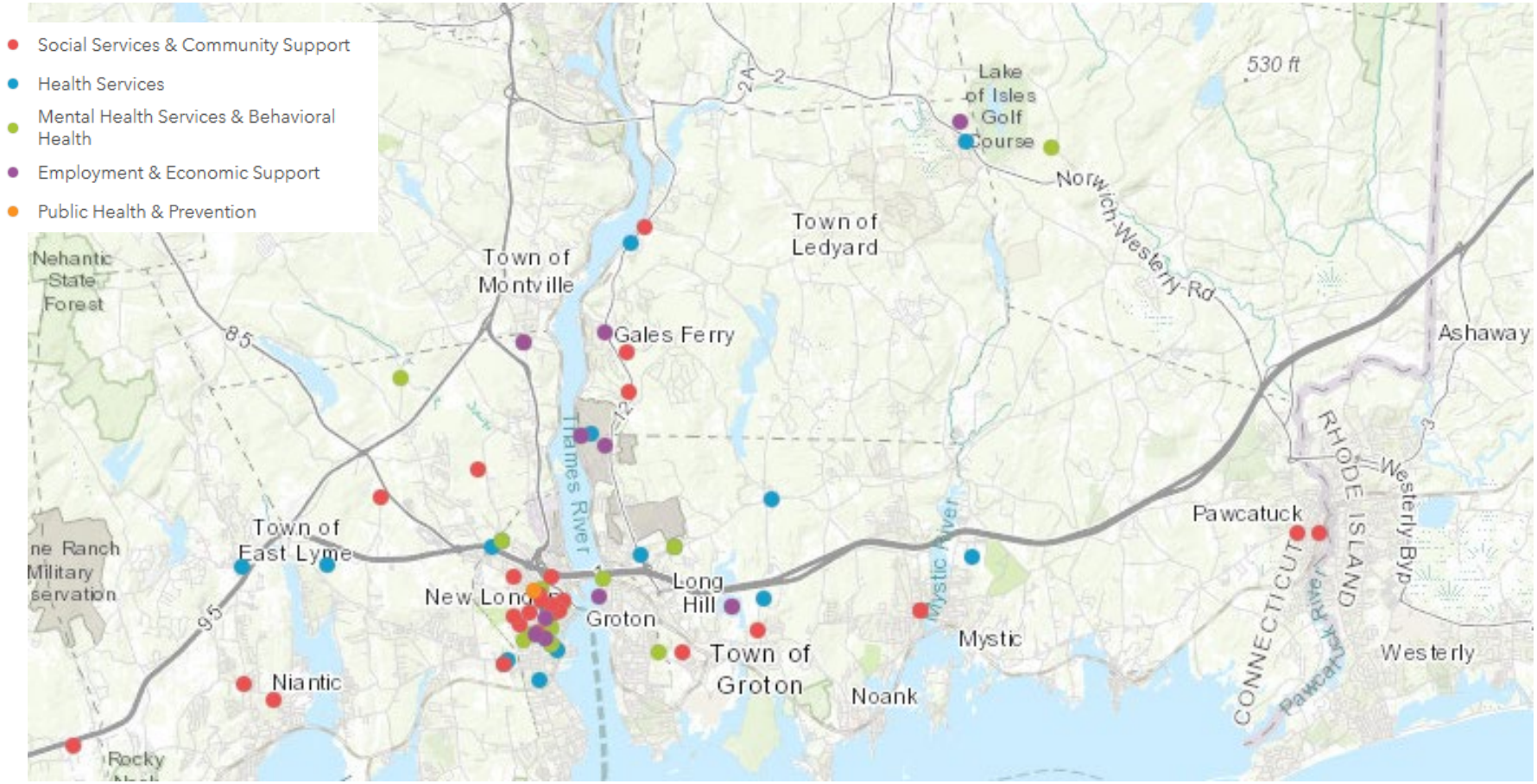
The ease of speaking with a staff member varied among the facilities. At some locations, callers were able to connect with a staff member quickly and efficiently through straightforward phone systems. For example, one facility's phone tree required only two steps, enabling the caller to speak with a helpful representative in under two minutes. However, other facilities presented challenges. One facility's automated system required the caller to navigate multiple steps, while another provided a callback number too quickly for the caller to write down, resulting in delays

Language Offerings

Language accessibility was limited across the facilities audited. While Spanish was offered as an alternative language option in the phone tree at one facility, others lacked such options entirely. One facility noted that Spanish translation services could be arranged during appointments, but no other languages were explicitly supported within the phone systems. Expanding language offerings to include additional commonly spoken languages in the area would improve accessibility for non-English-speaking populations and reduce barriers to care.

Appendix G: Asset Map and Community Resources

ASSET MAP OF GREATER NEW LONDON SERVICE AREA



Link to Interactive Map: https://arcg.is/15rOqe2

Greater New London Service Area Resource Table

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
EMPLOYMENT & ECONOMIC SUPPORT			
Connecticut Indian Council, Stonington	82 Norwich-Westerly Road 06359 and North Stonington, CT, United States, Connecticut	Job Training, Employee Assistance	bwaldron@rhodeislandindiancouncil.org
CW Resources, Groton	460 Thresher Ave, Groton, CT 06340	Job Training, Employee Assistance	cwresources.org
Navy Fleet and Family Support Center, Groton	Building 83, Grenadier Ave, Groton, CT 06340	Employee. Assistance, Counseling. Wellness Programs, Financial Programs, Child and Family Services	(860) 694-3383
Navy-Marine Corps Relief Society, Groton	83 Grayling Ave, Groton, CT 06349	Job Training, Employee Assistance, Financial Support Services	nmcrs.org
New London Public Schools, Adult and Continuing Education, New London	3 Shaws Cove 1st floor, New London, CT 06320	Job Training, Employee Assistance	newlondonadulted.org
Opportunities Industrialization Center of New London County (OIC), New London	106 Truman St New London, CT 06320	Job Training, Employee Assistance	oicnlc.org
Seabird Enterprises, Groton	169 Thames St Groton, CT 06340	On-The-Job The Job Training to Individuals with Developmental Disabilities	seabirdenterprises.org
Sound Community Services, New London	21 Montauk Ave New London, CT 06320	Behavioral Health, Substance Abuse Treatment, Education, Case Management, Social	soundcommunityservices.org

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
		Support, Homelessness Support, Counseling, Employment Services.	
United Cerebral Palsy Association of Eastern Connecticut - Quaker Hill	42 Norwich Rd Quaker Hill, CT 06375	Housing- Assistance. Education, Counseling, Child and Family Services, Employment Assistance.	ucpect.org
Veterans Affairs, United States Department of - Groton Submarine Base Itinerant Office	NAVSUBASE NL Box 00 Groton, CT 06349-5000	Financial Support Services	https://www.cnic.navy.mil/regions/cnrma/installations/navsubbase_new_london.html
Viability, Inc., Gales Ferry	1649 CT-12 Gales Ferry, CT 06335	Job Training, Employee Assistance	viability.org
HEALTHCARE SERVICES			
Careco Medical / Careco Shoreline, Waterford CT	398 Willetts Ave #3013, Waterford, CT 06385	Home Healthcare Services	carecohomecare.com
Community Health Center, Groton	481 Gold Star Hwy #100, Groton, CT 06340	Community Health Center, Mental Health Provider, Substance Use Treatment. Counseling	chc1.com
Community Health Center, New London	1 Shaws Cove New London, CT 06320	Community Health Center, Mental Health Provider, Substance Use Treatment. Counseling	chc1.com
Lawrence & Memorial Hospital - Yale New Haven Health, New London	365 Montauk Ave New London, CT 06320	Hospital	https://www.lmhospital.org/

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
Northeast Medical Group	194 Howard Street New London, CT 06320	Primary Care, Specialty Care	https://www.northeastmedicalgroup.org/find-a-location#sort=relevancy&numberOfResults=25 (*multiple locations)
Yale Haven Health Children's Hospital - Pediatric Specialty Center	3 Shaws Cove Suite 205 New London, CT 06320	Hospital	https://www.ynhhs.org/locations/new-london-3-shaws-cove-psc
Lawrence+Memorial Waterford Cancer Care Center (Smilow Cancer Hospital – Waterford)	230 Waterford Parkway South Waterford, CT 06385	Hospital	https://www.ynhh.org/smilow
Pequot Health Center	52 Hazelnut Hill Rd, Groton, CT 06340	Emergency Care, Laboratory Services, Diagnostic Imaging, Rehabilitation Services. Occupational Health Services.	https://www.lmhospital.org/locations/groton-52-hazelnut-hill-road
Yale New Haven Health Urgent Care - Groton	220 Rt 12 Groton, CT 06340	Urgent Care	https://www.ynhhs.org/locations/groton-220-route-12-urgent-care
Yale New Haven Health - Location Information		Primary Care, Specialty Care.	https://www.ynhhs.org/find-a-location/
Yale New Haven Health - Physician Information		Primary Care, Specialty Care.	ynhhs.org/physician-referral-info
Hartford Health Care New London Urgent Care	351 N Frontage Rd New London, CT 06320	Urgent Care	Urgent Care in New London, CT | Hartford Healthcare - GoHealth Urgent Care
Natchaug Hospital (HHC Behavioral Health Services)	1353 Gold Star Highway Groton, CT 06360	Hospital, Behavioral Health Services	https://natchaug.org/locations/care-plus

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
Backus Hospital - Physician Information		Hospital	https://backushospital.org/find-a-doctor
Flanders Health Center – East Lyme	339 Flanders Road, East Lyme CT 06333	Outpatient Healthcare Services	https://www.ynhhs.org/locations/east-lyme-339-flanders-road
Waterford Outpatient Rehabilitation Services	40 Boston Post Road, Waterford CT 06385	Outpatient Rehabilitation Services	https://www.lmhospital.org/locations/waterford-40-boston-post-road.aspx
Mashantucket Pequot Tribal Nation, Mashantucket	2 Matts Path Mashantucket, CT 06338	Primary Care Services, Diabetes Education and Management, Prevention Initiatives, Behavioral Health, Counseling. Crisis Management.	https://www.mptn-nsn.gov/
Masonicare Home Health & Hospice, Mystic	45 Clara Dr Mystic, CT 06355	Specialty, Hospice	masonicare.org
Overeaters Anonymous	1830 Rte 12 Gales Ferry, CT 06335	Wellness Programs	https://oa.org/find-a-meeting/?type=0&country=United%20States&order=distance&sort=ASC&distance=25&lat=41.4077855&longit=-72.1119925&zip=06375&limit=20&paged=1&submit=true
Planned Parenthood of Southern New England, New London	45 Franklin St New London, CT 06320	Specialty Clinic, Reproductive Health Services, Sexual Health Services, Advocacy, Education.	(860) 443-5820
Tri-Service Warrior Care Clinic, Groton	1 Wahoo Ave Groton, CT 06349	Specialty Clinic (Cardiology, GI, Etc.)	(860) 694-7508

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
Visiting Nurse Association of Southeastern Connecticut, Waterford	403 N Frontage Rd Waterford, CT 06385	Senior Resources, Physical and Mental Health Services	vnasc.org
Mental Health Services & Behavioral Health			
Alliance For Living, New London	154 Broad St New London, CT 06320	Substance Use Treatment, Counseling, Counselling, Basic Needs Assistance. Food Security Services.	allianceforliving.org
Child & Family Agency of Southeastern Connecticut, New London	75 Granite St New London, CT 06320	Mental Health Provider	childandfamilyagency.org
Child & Family Agency of Southeastern Connecticut, Groton	591 Poquonnock Rd Groton, CT 06340	Mental Health Provider	childandfamilyagency.org
Community Health Center, Groton	481 Gold Star Hwy #100, Groton, CT 06340	Community Health Center, Mental Health Provider, Substance Use Treatment. Counseling	chc1.com
Community Health Center, New London	1 Shaws Cove New London, CT 06320	Community Health Center, Mental Health Provider, Substance Use Treatment. Counseling	chc1.com
Safe Futures, New London	16 Jay St New London, CT 06320	Counselling, Prevention Education & Awareness Programs, Shelter	safefuturesct.org
Salvation Army - New London Corps Community Center, New London	11 Governor Winthrop Blvd New London, CT 06320	Counseling, Wellness Program.	(860) 443-6409

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
Sexual Assault Crisis Center of Eastern Connecticut Inc., New London	78 Howard St New London, CT 06320	Counseling, Prevention and Community Education	saccec.org
Sound Community Services, New London	21 Montauk Ave New London, CT 06320	Behavioral Health, Substance Abuse Treatment, Education, Case Management, Social Support, Homelessness Support, Counseling, Employment Services.	soundcommunityservices.org
United Community and Family Services, New London	351 N Frontage Rd #24 New London, CT 06320	Adult And Pediatric Primary Medical Care, Women's Health Services, Outpatient Behavioral Health Services, Community Based Behavioral Health Services, Community Outreach Services, Eldercare Services	(860) 442-4319
Waterford Country School, Quaker Hill	78 Hunts Brook Rd Quaker Hill, CT 06375	Counseling, Child and Family Services	(860) 442-9454
A-Cure LLC, New London	851 Bank St New London, CT 06320	Counseling	acure411.com
Catholic Charities - Diocese of New London and Norwich	28 Huntington St New London, CT 06320	Counseling - Case Management	(860) 443-5328
Community Speaks Out, Groton	214B Thames St Groton, CT 06340	Counseling, Financial Support Services, Education	communityspeaksout.org
Roost Recovery Center, New London	931 Bank St, New London, CT 06320	Substance Abuse Rehab	(860) 447-2233
Southeastern Council on Alcoholism and Drug	62 Coit St New London, CT 06320	Substance Use Treatment, Counseling	scadd.org

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
Dependence (Scadd), New London			
Stonington Institute, North Stonington	75 Swantown Hill Rd North Stonington, CT 06359	Behavioral Healthcare Services	stoningtoninstitute.com
Public Health & Prevention			
Ledge Light Health District, New London	216 Broad St New London, CT 06320	Public Health Department, Wellness Programs, Food Banks	llhd.org
Social Services & Community Support			
Groton, Town of - Senior Center, Groton	102 Newtown Rd Groton, CT 06340	Senior Services, Wellness Programs	groton-ct.gov/depts/parksrec/seniors/
New London, City of - Senior Center, New London	120 Broad St New London, CT 06320	Senior Services, Wellness Programs	ci.new-london.ct.us/content/7429/7431/12924/default.aspx
Always Home, Mystic	119 High St Mystic, CT 06355	Homelessness Prevention and Emerging Shelter and Rapid Re-Housing	alwayshome.org
Carabetta Management, New London	71 Redden Ave New London, CT 06320	Housing - Affordable Housing	carabetta.com
Covenant Shelter of New London, New London	42 Jay St New London, CT 06320	Shelter - Emergency	covenantshelterofnewlondon.org
New London Homeless Hospitality Center, New London	730 State Pier Rd, New London, CT 06320	Shelter	nlhhc.org
Groton Housing Authority, Groton	770 Poquonnock Rd Groton, CT 06340	Housing - Affordable Housing, Housing Assistance	grotonhousingauthority.org

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
Ledyard Housing Authority / Kings Corner Manor, Gales Ferry	60 Kings Hwy Gales Ferry, CT 06335	Housing - Affordable Housing, Housing Assistance	ledyardct.org/689/Ledyard-Housing-Authority-Kings-Corner-M
New London Housing Authority, New London	78 Walden Ave New London, CT 06320	Housing - Affordable Housing, Housing Assistance	newlondonhousing.org
Stonington Housing Authority, Pawcatuck	45 Sisk Dr Pawcatuck, CT 06379	Housing - Affordable Housing, Housing Assistance	stoningtonhousingauthority.org
Habitat for Humanity of Eastern Connecticut	377 Broad St. New London, CT 06320	Housing - Affordable Housing	habitatect.org
United Cerebral Palsy Association of Eastern Connecticut - Quaker Hill	42 Norwich Rd Quaker Hill, CT 06375	Housing Assistance, Education, Counseling, Child and Family Services, Employment Assistance.	ucpect.org
Navy Fleet and Family Support Center, Groton	Building 83, Grenadier Ave, Groton, CT 06340	Employee. Assistance, Counseling. Wellness Programs, Financial Programs, Child and Family Services	(860) 694-3383
Safe Futures, New London	16 Jay St New London, CT 06320	Counselling, Prevention Education & Awareness Programs, Shelter	safefuturesct.org
Thames Valley Council for Community Action, New London	83 Huntington St New London, CT 06320	Housing Assistance, Education, Counseling, Child and Family Services, Job Training, Employee Assistance, Utilities Assistance.	tvcca.org
United Way of Southeastern Connecticut- Gales Ferry	283 Stoddards Wharf Rd, Gales Ferry, CT 06335	Basic Needs Assistance, Education, Food Security Services, Wellness Programs	uwsect.org

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
New London, City of - Office of Youth Affairs, New London	111 Union St New London, CT 06320	Youth Services	newlondonyouthaffairs.org
Pawcatuck Neighborhood Center, Pawcatuck	27 Chase St Pawcatuck, CT 06379	Senior Services, Community Services, Recreational Activities	pawcatuckneighborhoodcenter.org
Adventist Community Services of Connecticut, Waterford	152 Bloomingdale Rd Quaker Hill, CT 06375	Basic Needs Assistance. Food Security Services.	waterfordsdachurch.com
Alliance for Living, New London	154 Broad St, New London, CT 06320	Substance Use Treatment, Counseling, Counselling, Basic Needs Assistance. Food Security Services.	allianceforliving.org
Careco Medical / Careco Shoreline, Waterford	398 Willetts Ave #3013, Waterford, CT 06385	Home Healthcare Services	carecohomecare.com
Church of the City of New London,	250 State St New London, CT 06320	Faith, Food Security Services - Meals	cotcnl.org
Care and Share of East Lyme-Niantic	12 Roxbury Rd Niantic, CT 06357	Food Assistance, Emergency Support, Youth Programs, Financial Assistance.	careandshareofel.org
Groton Community Meals, Mystic	119 High St Mystic, CT 06355	Food Security Service - Meals	grotonmeals.org
New London Community Meal Center, New London	12 Montauk Ave New London, CT 06320	Food Security Service - Meals	http://nlcommunitymealcenter.org
Niantic Community Church Food Pantry, Niantic	170 Pennsylvania Ave Niantic, CT 06357	Food Pantry	(860) 739-6208
Outreach for the Unreached Ministry, Gales Ferry	12 Inchcliffe Dr Gales Ferry, CT 06335	Food Pantry	(860) 464-6222

Name of Resource / Facility	Address	Sub-Sector / Services Provided	Contact Information (Website or Phone #)
Food to the People	74 Garfield Ave. New London, CT 06320	Food Pantry	860-448-4882
FRESH New London	26 Broad St. New London, CT 06320	Food Security Service and Access	https://freshnewlondon.org/
Curtin Transportation Group, Waterford	176 Cross Rd Waterford, CT 06385	Transportation - School	curtinlivery.com
Southeast Connecticut Community Center of the Blind, New London	120 Broad St # 132 New London, CT 06320	Assistance And Programs for Individuals Who Are Blind or Visually Impaired	centeroftheblind.com
LEARN, Old Lyme	44 Hatchetts Hill Rd, Old Lyme, CT 06371	Educational Service Center	learn.k12.ct.us
Rotary Club of Groton		Basic Needs Assistance, Youth, Education, Job Training, Recreational Activities	grotonrotary.org
211 Connecticut	N/A		*This resource list was compiled in winter 2025 and is not meant to be exhaustive. For additional resources, and the most up-to-date contact information, please visit 211ct.org

Appendix H: DataHaven Respondent Demographics

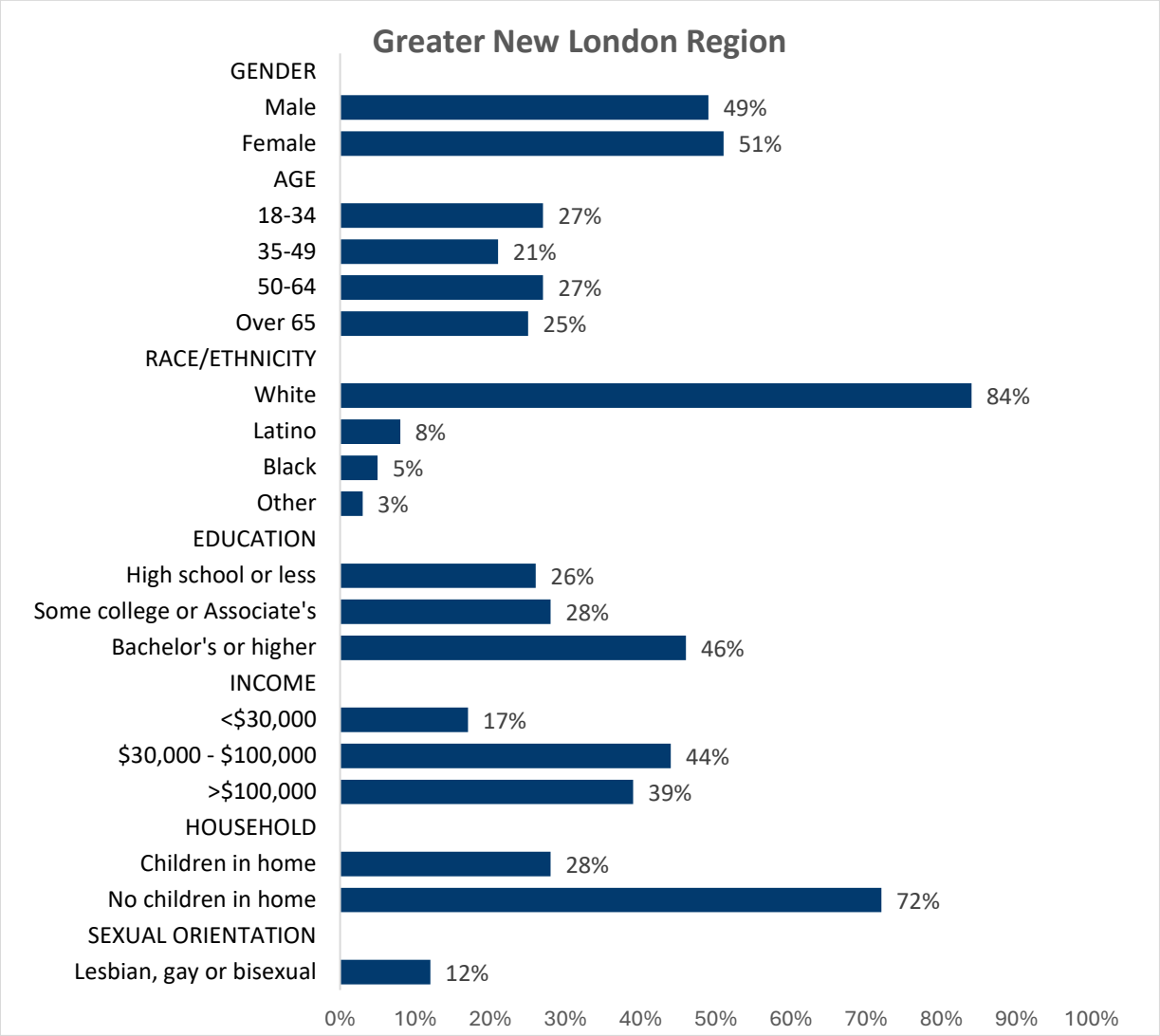
Additional information and data can be found online at the CT DataHaven website: www.ctdatahaven.org

DataHaven Community Wellbeing Survey (DCWS)

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

In the Greater New London region in 2024, DataHaven conducted in-depth interviews with 499 randomly-selected adults on the DCWS.

DCWS Respondent Demographics

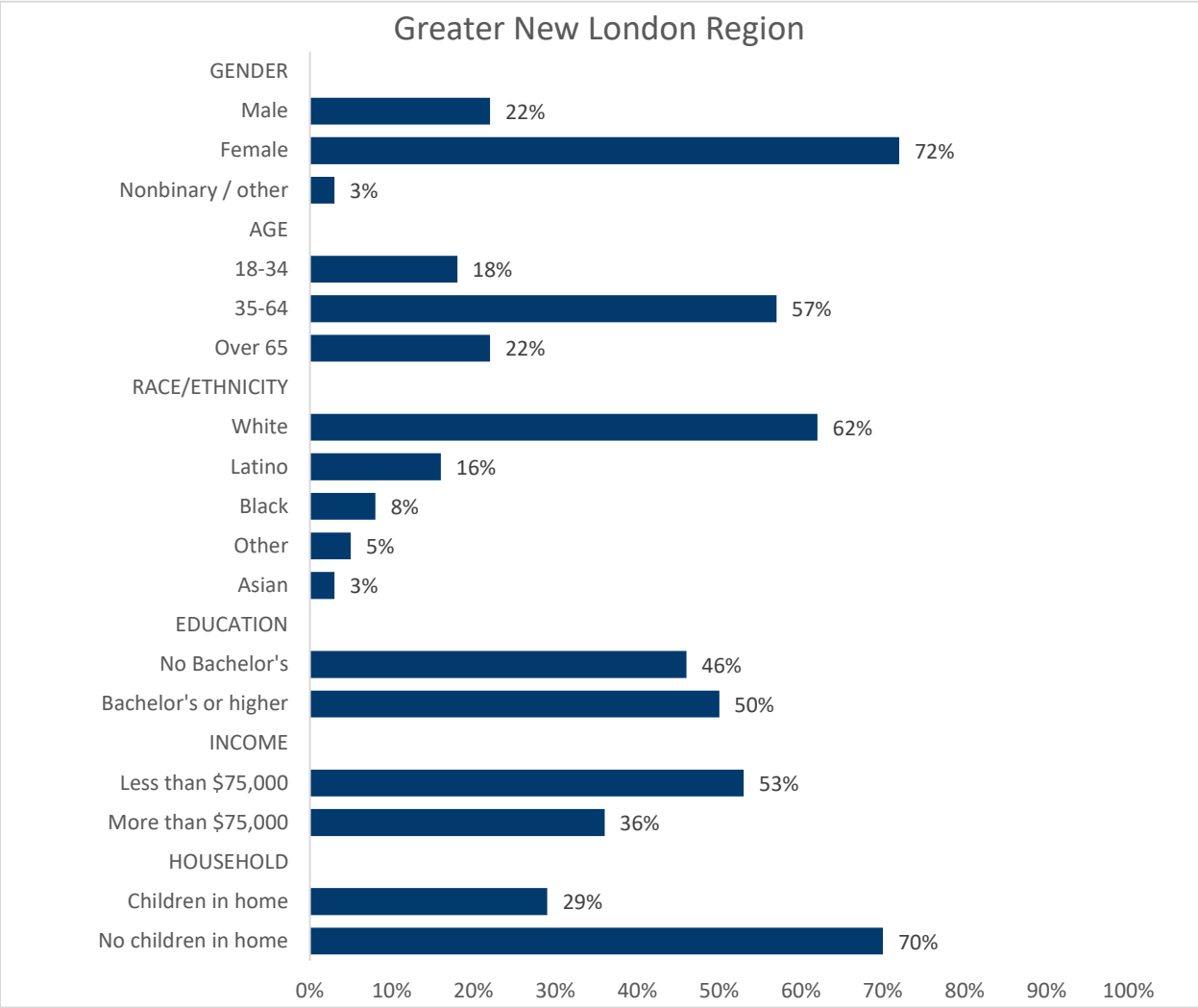


Community-Based Assets and Needs Survey (CBANS)

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

In the Greater New London region, 185 respondents participated in the survey, offering valuable insights into the priorities and needs of this area.

CBANS Respondent Demographics



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

Appendix I: Key Informant Interview Guide

Introductory Questions

1. Please tell me a little about yourself and how you interact with the local community (i.e., what does your organization do?)

2. When you think of good things about living and/or working in the community, what are the first things that come to mind?

3. If you had to pick the top two or three challenges or things people struggle with most in your community, what comes to mind?

Access to Care and Delivery of Services

4. What, if any, health care services are difficult to find and/or access? And why?

5. What are some health-related resources available in the community that are working well and why?

Behavioral Health

6. What, if any, behavioral health care services (including mental health and substance use) are difficult to find and/or access? Why?

7. What behavioral-health resources are available in the community?

8. What types of stigma, if any, are around seeking treatment for mental health and/or substance use disorders?

Health Equity, Groups Experiencing Disadvantage, Barriers

9. Do you think people in the community are generally **HEALTHY**? Please explain why you think people are healthy or not healthy in your community?

10. How can we improve the overall health of our community?

11. Would you say health care services are equally available to everyone in the community regardless of gender, race, age, or socioeconomics? What populations are especially disadvantaged and/or under-resourced in your community?

12. What barriers to services exist, if any?

13. Do community health care providers care for patients in a culturally sensitive manner?

14. What would you say are the two or three most urgent needs for the groups experiencing the most disadvantage??

Social Determinants, Neighborhood & Physical Environment

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

16. What are the top three non-health related assets and why?

Enhancing Outreach & Disseminating Information

17. How do individuals generally learn about access to and availability of services in the area?

18. What do you think are some challenges to spreading awareness and understanding of the availability of services and ways to access them? What might help overcome the challenges?

Magic Wand

19. From your perspective what are the 2 -3 most important health issues/concerns in the community?

20. Based on the health issues you selected/identified… if you had a Magic Wand that you personally could improve the health of the community, what interventions or resources (programs, services etc.) would you implement?

Appendix J: Focus Group Guide

Introductory Questions

1. To start, please briefly introduce yourself and share something you like about your community.
2. What is your definition of "community"?
3. What does a "healthy" community look like to you?
4. What are the two or three most important health needs in your community?

Access to Care and Delivery of Services

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

Social Determinants, Neighborhood & Physical Environment

8. What are the top three social or environmental health needs or challenges in the community? Why?
9. What resources and services are available and/or missing in your community to help people with [needs or challenges identified in Question 8]?

Health Equity and Groups Experiencing Disadvantage

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

Protective and Risk Factors

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

Magic Wand

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