Health Indicators and Risk Behaviors in Connecticut

Results of the 2017 Connecticut Behavioral Risk Factor Surveillance Survey

FEBRUARY, 2020

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ACKNOWLEDGMENTS

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The CT BRFSS team acknowledges with gratitude the time contributed by over 10,588 citizen volunteers within the State of Connecticut who responded anonymously to the 2017 BRFSS. The results presented in this report would not be possible without their participation.

ADDITIONAL RESOURCES

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Health Statistics and Surveillance Section, Survey Unit, Connecticut Behavioral Risk Factor Surveillance System, February, 2020

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SUMMARY

The Connecticut Behavioral Risk Factor Surveillance System (CT BRFSS) is an ongoing statewide voluntary phone survey of Connecticut citizen volunteers aged 18 and over. The CT BRFSS questionnaire (http://www.ct.gov/dph/BRFSS) changes somewhat from year to year to provide information on emerging health issues in the state and to address state-specific priorities.

Data from the CT BRFSS have been used to inform the development of state health plans, such as the State Health Improvement Plan,[1] the Connecticut coordinated chronic disease plan;[2] and to track online adult and child state health priorities[3,4] and chronic disease dashboards.[5] Data are also being used to inform action plans for the population health component of the State Innovations Model (SIM) grant,[6] a grant from the U.S. Center for Medicare and Medicaid Service to transform healthcare in the state. Data from this survey are also used to monitor the activity of the grant.[7] In addition, understanding factors that affect vulnerable populations in Connecticut is important for identifying and addressing health disparities. The CT BRFSS continues to have a significant role in the CT State Health Assessment process, by providing health indicators specific to race, disability status, health insurance status, and other factors. Data from the CT BRFSS also inform health programs for their work to improve and promote the health of all Connecticut residents.

In this report, a section named State of the State compares selected adult health indicators in Connecticut during calendar year 2017, with median results from 2017 for the United States and its territories. In addition, 38 selected health indicators are discussed in six chapters: 1) health status indicators, 2) risk behavior indicators, 3) clinical preventive practices, 4) chronic conditions, 5) environmental health indicators, and 6) child health.

METHODOLOGY

The population for the Connecticut Behavioral Risk Factor Surveillance System (CT BRFSS) consists of the total non-institutionalized English and Spanish-speaking adult population. In 2017, the CT BRFSS collected 5,528 landline interviews and 5,060 cell phone interviews, totaling 10,588 interviews. If any children lived in the same household as the respondent, one child was randomly selected, and the adult respondent provided information about that child. A total of 2,067 interviews about children were completed. The landline sample was a disproportionate stratified random digit dial (RDD) sample, stratified by geography and listed status. Within each contacted household, one adult was selected at random to be interviewed. The cell phone sample was an unstratified RDD sample drawn from dedicated cellular telephone banks with equal probability. An adult contacted by cell phone was eligible to complete the survey if he or she lived in a private residence or college housing.

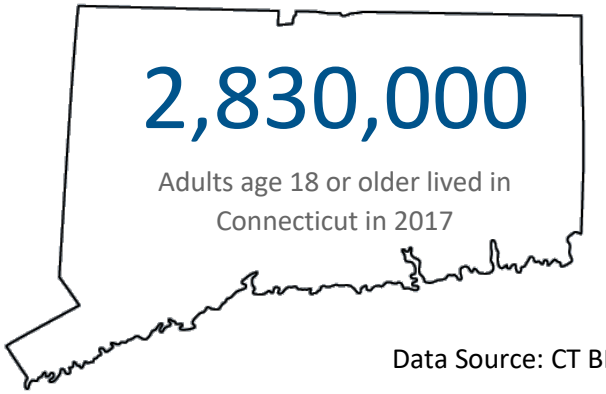
Landline and cell phone data were combined and weighted by the Centers for Disease Control and Prevention (CDC) to adjust for differential selection probabilities. The weighted data were then adjusted to the distribution of the Connecticut adult population using iterative proportional fitting or raking. Raking adjustments were made by telephone type, race/ethnicity, education, marital status, age by gender, gender by race/ethnicity, age by race/ethnicity, and renter/owner status. This weighting methodology was adopted by CDC in 2011 to accommodate the inclusion of cell phone interviews and to allow for adjustments to more demographics. As a result of these methodological changes, BRFSS data for 2011 and forward are not comparable to BRFSS data prior to 2011.

Prevalence estimates and 95% confidence intervals were computed using SAS PROC SURVEYFREQ, which can properly compute variances for complex sampling plans. Any responses of "Not known/Not sure" or "Refused" were classified as missing. The coefficients of variation (CV) were used to assess the validity of each estimate. Prevalence estimates with a CV of between 15.0% and 20.0%, inclusive, are marked with a "†"; prevalence estimates with a CV greater than 30.0% are suppressed due to poor validity. Prevalence estimates with a CV between 20.1% and 30.0%, inclusive, are marked with "††", to indicate caution should be exercised when interpreting these estimates. The exact values were not disclosed in this report, but can be located in the 2017 Summary Tables available online.

Each health indicator was analyzed at the statewide level, and was evaluated by age, gender, race/ethnicity, household income, whether the adult had health care coverage, whether the adult had a disability, and the adult's educational attainment. Race and ethnicity were defined by three categories: non-Hispanic White, non-Hispanic Black or African American, and Hispanic or Latino/a. A fourth category, non-Hispanic respondents of other or multiple races, was excluded from analysis because the CV was too large for most estimates in this category to allow reporting. Indicators concerning children were analyzed by the age of the child, gender of the child, race/ethnicity of the child, household income, and the adult proxy's health insurance status and educational attainment.

Significant increases or decreases compared to the United States were evaluated by a one-population two-tailed binomial test at the 0.05(*), 0.01(**) and 0.001(***) levels. Changes in prevalences of selected health indicators from years 2012 to 2017 were evaluated using a two population two-tailed chi-squared test for significant increase or decrease at the 0.1(‡), 0.05(‡‡), and 0.01(‡‡‡) levels. Statistical significant testing was only conducted among prevalence estimates with a CV less than 0.15. Significance testing by demographic characteristic was evaluated using a two population two-tailed chi-squared test for significant increase or decrease in risk/protection or prevalence (alpha=0.05); only statistically significant results are discussed in this report.

ADULT DEMOGRAPHICS IN CONNECTICUT



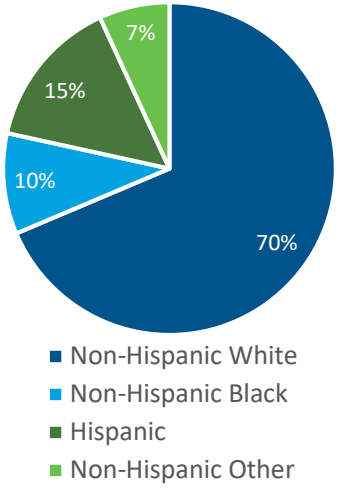
2,830,000

Adults age 18 or older lived in Connecticut in 2017

Data Source: CT BRFSS, 2017

Race & Ethnicity

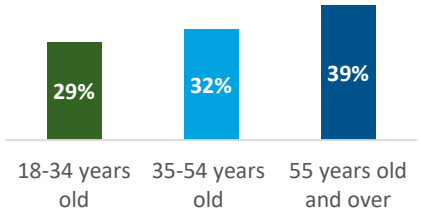
1 in **5** adults were non-Hispanic White.
1 in **12** adults were Hispanic.
1 in **15** adults were non-Hispanic Black.



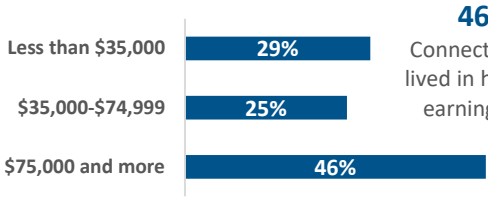
Gender

Male and female adults were equally distributed.

Age



Household Income



46.4% Connecticut adults lived in households earning at least

92.1% Connecticut adults who had insurance coverage

One in five Connecticut Adults had a disability

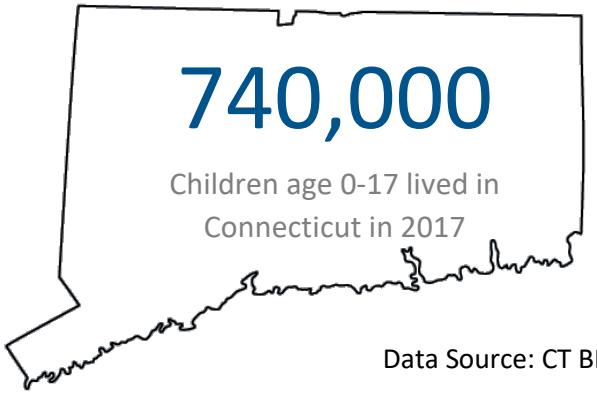
61.5% Connecticut adults who had at least a college degree

Note: all the demographic data above are estimated weighted population based on CT BRFSS 2017.

TABLE 1: ADULTS LIVING IN CONNECTICUT, CT 2017

Demographic Characteristics	Survey Respondents	Estimated Weighted Population	Estimated % of Population
Total	10,588	2,830,000	**100.0%**
Age			
18-34 years old	1,271	790,000	**28.5%**
35-54 years old	2,885	900,000	**32.3%**
55 years old and over	6,188	1,090,000	**39.2%**
Gender			
Male	4,610	1,360,000	**48.2%**
Female	5,961	1,470,000	**51.8%**
Race/Ethnicity			
Non-Hispanic White	8,267	1,900,000	**69.1%**
Non-Hispanic Black	681	270,000	**9.7%**
Hispanic	835	400,000	**14.6%**
Other	568	180,000	**6.6%**
Income			
Less than $35,000	2,235	640,000	**28.6%**
$35,000-$74,999	2,127	560,000	**25.0%**
$75,000 and more	4,106	1,040,000	**46.4%**
Health Insurance Status			
Insured	10,021	2,590,000	**92.1%**
Not Insured	526	220,000	**7.9%**
Disability			
Yes	2,459	600,000	**22.5%**
No	7,643	2,070,000	**77.5%**
Education			
HS graduate or less	3,013	1,080,000	**38.5%**
More than HS education	7,518	1,730,000	**61.5%**

CHILD DEMOGRAPHICS IN CONNECTICUT



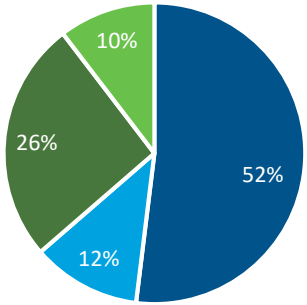
740,000

Children age 0-17 lived in Connecticut in 2017

Data Source: CT BRFSS, 2017

Race & Ethnicity

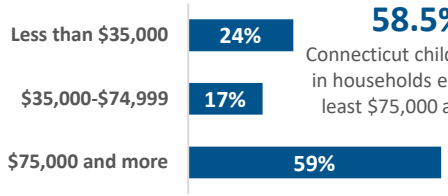
1 in **2** children were non-Hispanic White.
1 in **4** children were Hispanic.
1 in **10** children were non-Hispanic Black.



Gender

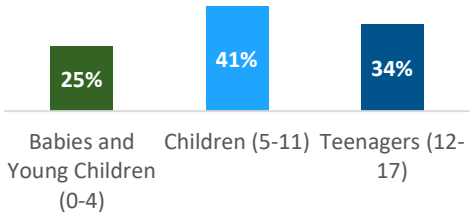
Male and female children were equally distributed.

Household Income



58.5%
Connecticut children lived in households earning at least $75,000 annually

Age



92.6%

Connecticut children had an insured adult caregiver

74.4%

Connecticut children had an adult caregiver with at least a college degree

Note: all the demographic data above are estimated weighted population based on CT BRFSS 2017.

TABLE 2: CHILDREN LIVING IN CONNECTICUT, CT 2017

Demographic Characteristics	Survey Respondents	Estimated Weighted Population	Estimated % of Population
Total	2,067	740,000	**100.0%**
Age			
0-4 years old	332	160,000	**25.4%**
5-11 years old	593	260,000	**40.8%**
12-17 years old	812	210,000	**33.8%**
Gender			
Male	1,008	360,000	**50.4%**
Female	943	350,000	**49.6%**
Race/Ethnicity			
Non-Hispanic White	1,258	360,000	**52.0%**
Non-Hispanic Black	154	80,000	**11.7%**
Hispanic	347	180,000	**26.0%**
Other	165	70,000	**10.4%**
Household Income			
Less than $35,000	365	160,000	**24.3%**
$35,000-$74,999	338	110,000	**17.2%**
$75,000 and more	1,098	380,000	**58.5%**
Caregiver's Health Insurance Status			
Insured	1,918	680,000	**92.6%**
Not Insured	140	50,000	**7.4%**
Caregiver's Education Attainment			
HS graduate or less	1,567	190,000	**25.6%**
More than HS education	491	500,000	**74.4%**

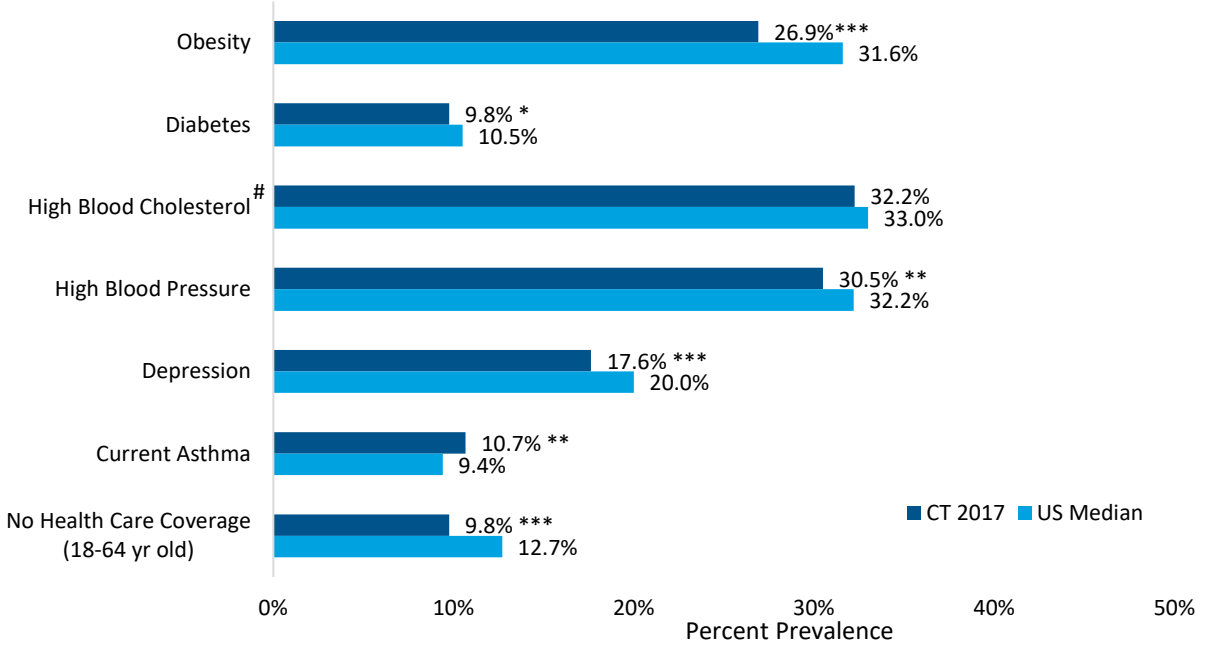
1. STATE OF THE STATE

Connecticut Comparison to the United States in 2017

Sixteen selected health indicators and modifiable risk factors were compared to estimates for the United States and its territories during 2017 (Figures 1 and 2 and Tables 3 and 4). More information about these statewide indicators can be found throughout this report.

Figure 1 and Table 3 highlight selected adult health indicators in Connecticut during calendar year 2017, compared to median results from 2017 for the United States and its territories.

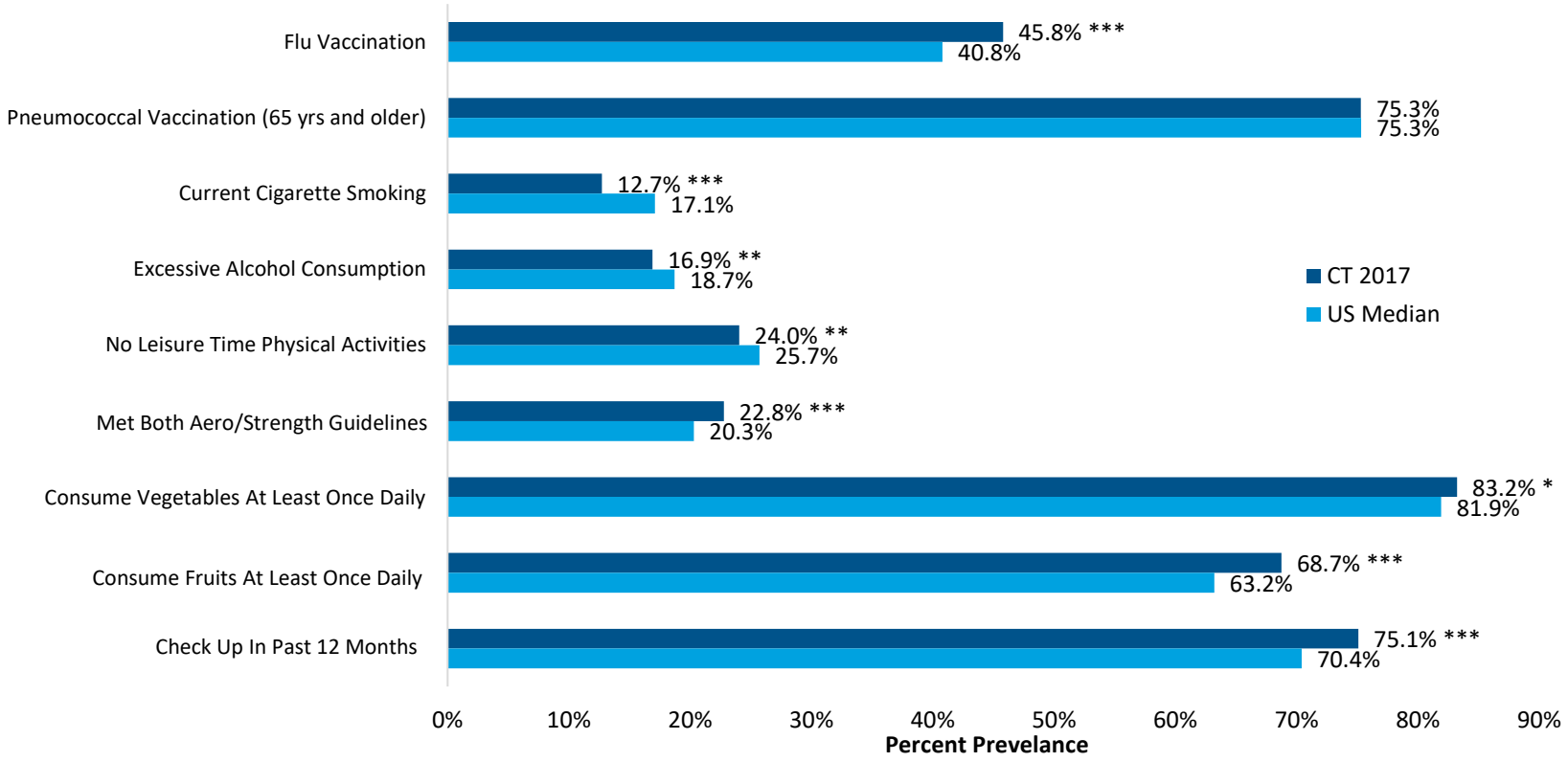
FIGURE 1: SELECTED ADULT HEALTH INDICATORS IN CONNECTICUT VERSUS THE UNITED STATES AND TERRITORIES, 2017



 # Adults who have had their blood cholesterol checked and have been told it was high.
*Statistical significance is indicated with the following: * - significance < 0.05; ** - significance < 0.01; *** - significance < 0.001*

Figure 2 and Table 4 highlight selected adult modifiable risk factors in Connecticut during 2017, compared to median results from 2017 for the U.S. and its territories. More information on these indicators is located within this report.

FIGURE 2: SELECTED ADULT MODIFIABLE RISK FACTORS IN CONNECTICUT VERSUS THE U.S. AND TERRITORIES, 2017



*Statistical significance is indicated with the following: * - significance < 0.05; ** - significance < 0.01; *** - significance < 0.001*

TABLE 3: SELECTED ADULT HEALTH INDICATORS IN CONNECTICUT VERSUS THE UNITED STATES AND TERRITORIES, CT 2017

Health Indicator	CT 2017	U.S. Median	Risk Difference	Significantly Greater or Less Risk/Protection
Obesity	26.9%	31.6%	**-4.6%**	Less Risk ***
Diabetes	9.8%	10.5%	**-0.7%**	Less Risk *
High Blood Cholesterol	32.2%	33.0%	**-0.8%**	NS
High Blood Pressure	30.5%	32.2%	**-1.7%**	Less Risk **
Depression	17.6%	20.0%	**-2.4%**	Less Risk ***
Current Asthma	10.7%	9.4%	**1.3%**	More Risk **
No Health Care Coverage (18-64 yr old)	9.8%	12.7%	**-2.9%**	Less Risk ***

Note: Prevalence in 2017 of selected adult health indicators were obtained from the Behavioral Risk Factor Surveillance System for Connecticut (www.ct.gov/dph/brfss) and the United States and its territories (www.cdc.gov/brfss). Risk differences for Connecticut versus the United States and its territories were tested for significantly greater or lesser risk using two-tailed one sample z-test against the U.S. median.

Statistical significance is indicated with the following: * - significance < 0.05; ** - significance < 0.01; * - significance < 0.001; NS - not significantly different. Text in green indicates less risk/more protection and red indicates higher risk/less protection**

TABLE 4: SELECTED ADULT MODIFIABLE RISK FACTORS IN CONNECTICUT VERSUS THE UNITED STATES AND TERRITORIES, CT 2017

Health Indicator	CT 2017	U.S. Median	Risk Difference	Significantly Greater or Less Risk/Protection
Flu Vaccination	45.8%	40.8%	**5.0%**	More Protection ***
Pneumococcal Vaccination (65 yrs and older)	75.3%	75.3%	**0.0%**	NS
Current Cigarette Smoking	12.7%	17.1%	**-4.4%**	Less Risk ***
Excessive Alcohol Consumption	16.9%	18.7%	**-1.8%**	Less Risk **
No Leisure Time Physical Activities	24.0%	25.7%	**-1.7%**	Less Risk **
Met Both Aero/Strength Guidelines	22.8%	20.3%	**2.5%**	More Protection ***
Consume Vegetables At Least Once Daily	83.2%	81.9%	**1.3%**	More Protection *
Consume Fruits At Least Once Daily	68.7%	63.2%	**5.5%**	More Protection ***
Check Up In Past 12 Months	75.1%	70.4%	**4.7%**	More Protection ***

Note: Prevalence in 2017 of selected modifiable risk factors were obtained from the Behavioral Risk Factor Surveillance System for Connecticut (www.ct.gov/dph/brfss) and the United States and its territories (www.cdc.gov/brfss). Risk differences for Connecticut versus the United States and its territories were tested for significantly greater or lesser risk using two-tailed one sample z-test against the U.S. Median.

Statistical significance is indicated with the following: * - significance < 0.05; ** - significance < 0.01; * - significance < 0.001; NS - not significantly different. Text in green indicates less risk/more protection and red indicates higher risk/less protection**

Compared to the United States and its territories, Connecticut adult risk was significantly less, and prevalence significantly better, for 13 of the 16 health indicators:

- Obesity (<0.001)
- Diabetes (<0.05)
- High Blood Pressure (<0.01)
- Depression (<0.001)
- No Health Care Coverage (18-64 years old) (<0.001)
- Flu Vaccination (<0.001)
- Current Cigarette Smoking (<0.001)
- Excessive Alcohol Consumption (<0.01)
- No Leisure Time Physical Activities (<0.01)
- Met both Aerobic/Strength Guidelines (<0.001)
- Consume Vegetables at least once a day (<0.05)
- Consume fruits at least once daily (<0.001)
- Check up in past 12 months (<0.001)

Compared to the United States and its territories, Connecticut adult risk was significantly more, and prevalence significantly worse, for only one health indicator:

- Current Asthma (<0.01)

Adult risk in Connecticut for the remaining two health indicators was not significantly different from the United States:

- High Blood Cholesterol
- Pneumococcal Vaccination (65 years old and older)

Connecticut Comparison to Other States in 2017

Connecticut's ranking compared to other states and U.S. territories for selected health indicators is shown in Figure 3.

For 23 selected health indicators, Connecticut was compared to all states in the United States and its territories, and was ranked among the best 10 states in the country for 8 indicators (marked as **green circles** in Figure 3):

- Self -Reported Good or Better Health
- At Least One Primary Care Provider
- Check Up in the Past 12 Months
- Flu Vaccination
- Seatbelt Use
- Consume fruit at least once a day
- Current Cigarette Use
- Obesity

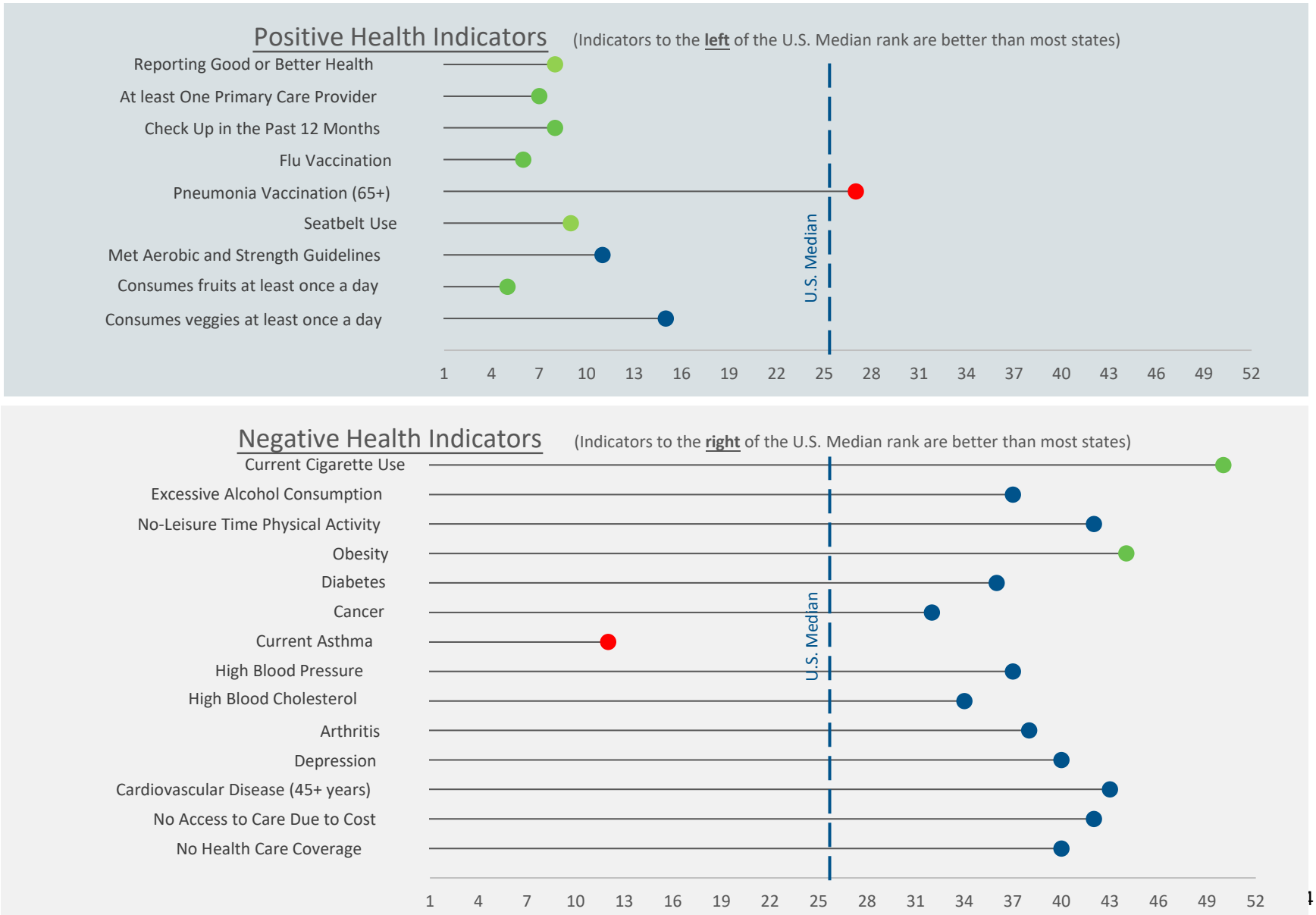
Among all 23 selected health indicators, Connecticut ranked better than half than all states in the United States and its territories for all except two indicators (marked as **blue circles** in Figure 3):

- Met Aerobic and Strength Guidelines
- Consume Vegetables at least once a day
- Excessive Alcohol Consumption
- No Leisure Time Physical Activity
- Diabetes
- Cancer
- High Blood Pressure
- High Blood Cholesterol
- Arthritis
- Depression
- Cardiovascular Disease (45+ years)
- No Access to Care Due to Cost
- No Health Care Coverage

For two indicators, Connecticut ranked worse than most states and territories (marked as **red circles** in Figure 3):

- Current Asthma
- Pneumonia Vaccination (65+)

FIGURE 3: CONNECTICUT STATE RANKING FOR SELECTED ADULT HEALTH INDICATORS, BRFSS, 2017



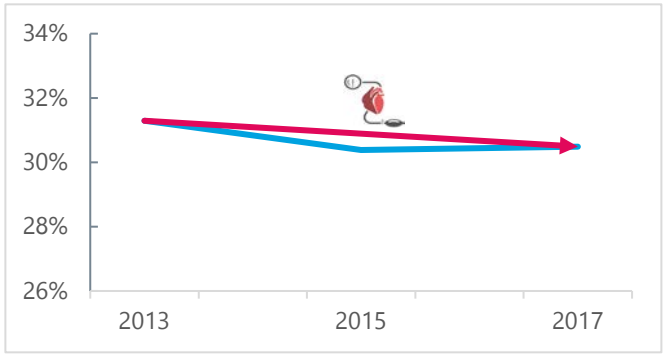
Change in Selected Connecticut Health Indicators (2012–2017)

Figure 4, Figure 5, and Table 5 show change from 2013 through 2017 among Connecticut adults for selected indicators. Figure 4 highlights biennial health indicators, and Figure 5 highlights annual health indicators. Estimates in Figure 4A show four-year change from 2013 to 2017; and estimates in Figures 4B show biennial change for individual years, from 2013 to 2015 and from 2015 to 2017. **Red lines** indicate presence of a 4-year change (Figure 4A) or biennial change (Figure 4B).

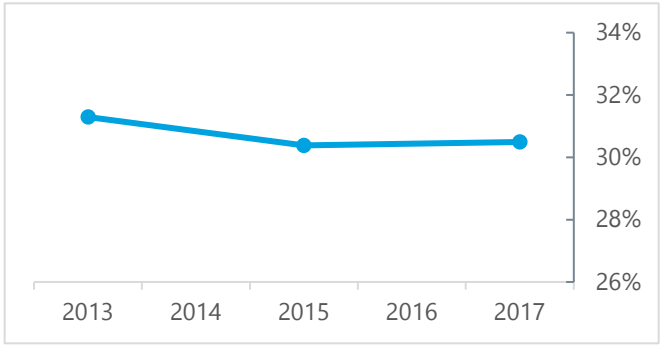
FIGURE 4: CHANGE IN SELECTED BIENNIAL HEALTH INDICATORS, CT BRFSS 2013–2017

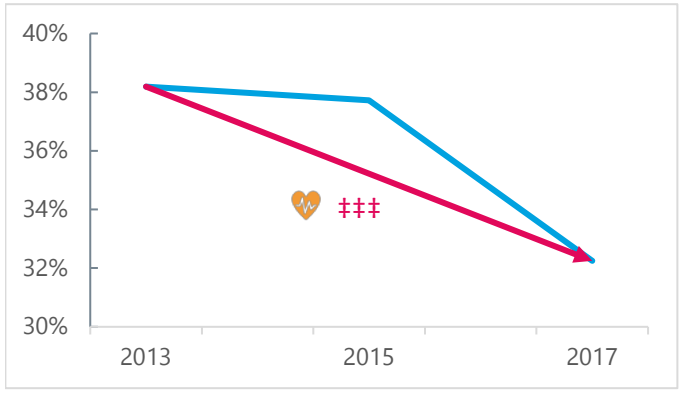
Figures 4A: Four-Year Increase/Decrease

Figure 4B: Yearly Increase/Decrease

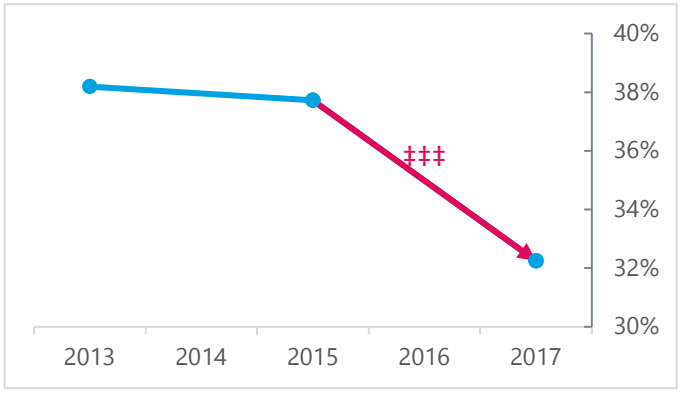


High Blood Pressure



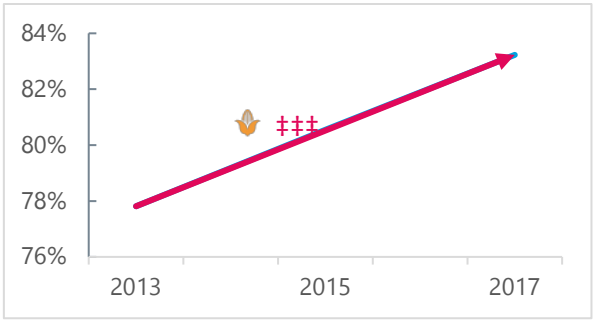


High Blood Cholesterol

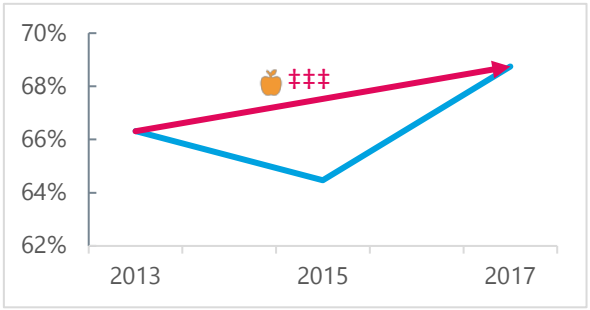


‡= significance <0.10; ‡‡=significance <0.05; ‡‡‡=significance <0.01

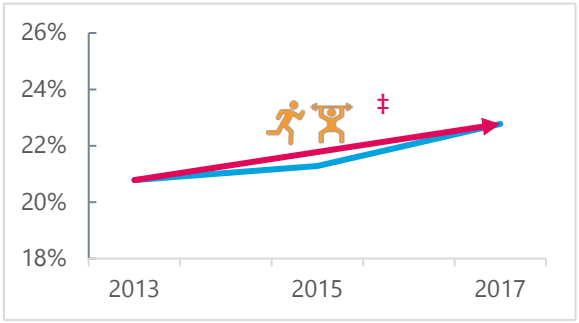
Figures 4A: Four-Year Increase/Decrease Cont.



Consume Vegetables at Least Once Daily

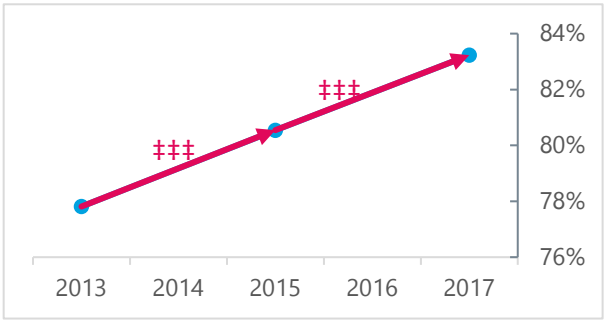


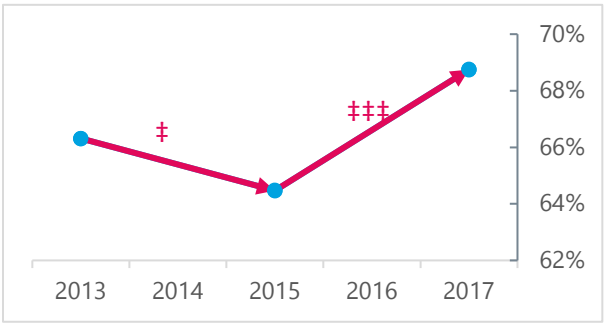
Consume Fruits at Least Once Daily

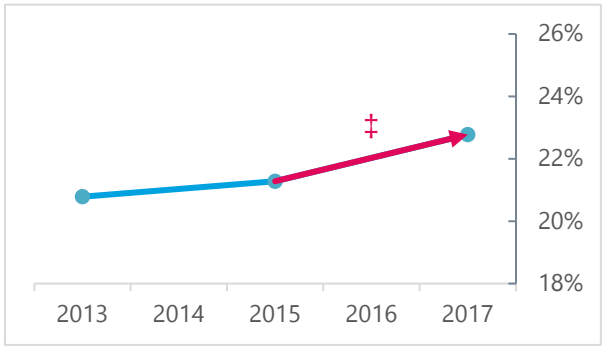


Meet Both Aerobic & Strengthening Guidelines

Figure 4B: Yearly Increase/Decrease Cont.







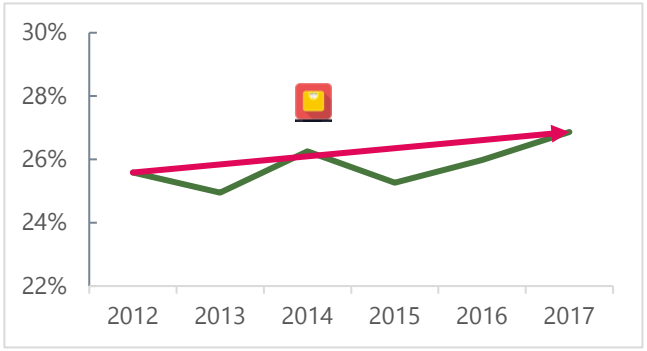
‡= significance <0.10; ‡‡=significance <0.05; ‡‡‡=significance <0.01

Estimated percent prevalence values for selected health indicators are shown for years 2012-2017 (Figure 5A); and for individual years 2012, 2013, 2014, 2015, 2016, and 2017 (Figure 5B), these values are shown with circles. Five-year changes from 2012 to 2017 (Figure 5A) and annual changes from years 2012 to 2013, 2013 to 2014, 2014 to 2015, 2015 to 2016, and 2016 to 2017 (Figure 5B) are shown with **red lines**.

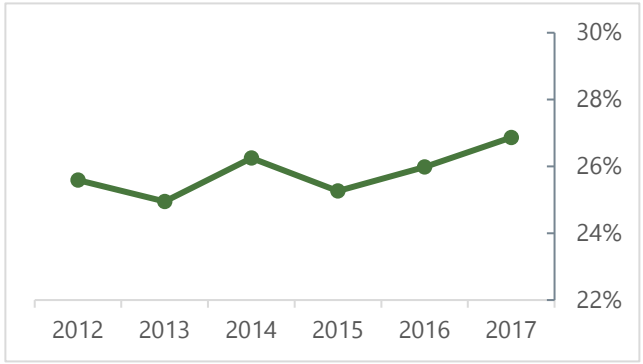
FIGURE 5: CHANGE IN SELECTED ANNUAL HEALTH INDICATORS, CT BRFSS 2012–2017

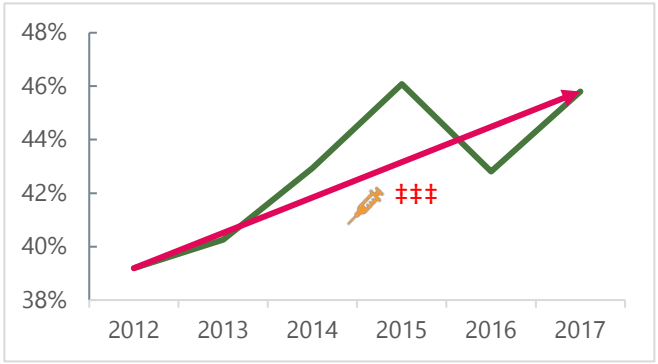
Figure 5A: Five Year Increase/Decrease

Figure 5B: Yearly Increase/Decrease

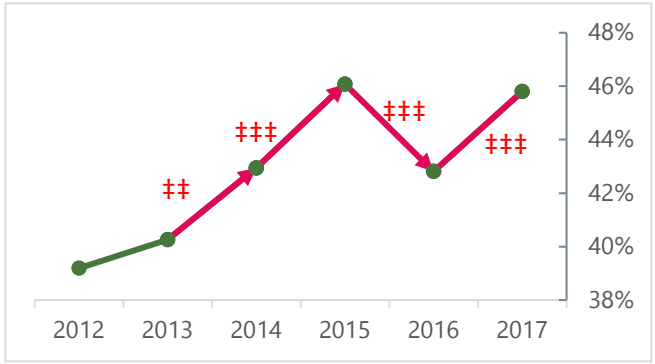


Adult Obesity





Flu Vaccination

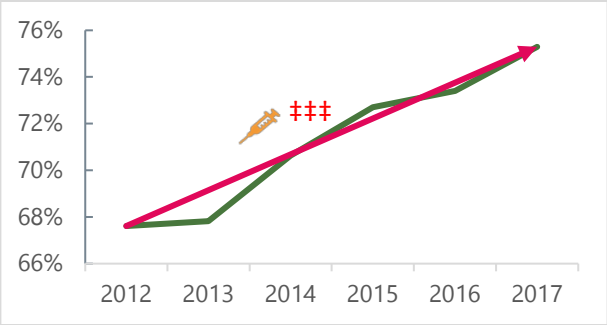


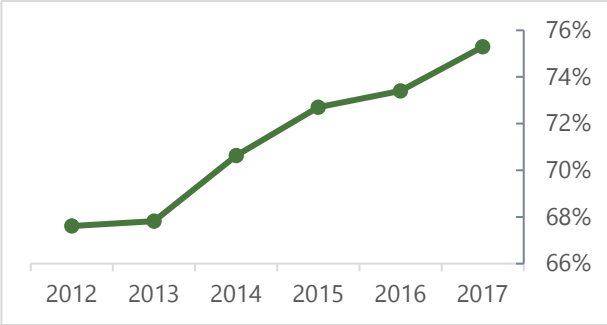
‡= significance <0.10; ‡‡=significance <0.05; ‡‡‡=significance <0.01

Figure 5A: Five Year Increase/Decrease (Cont.)

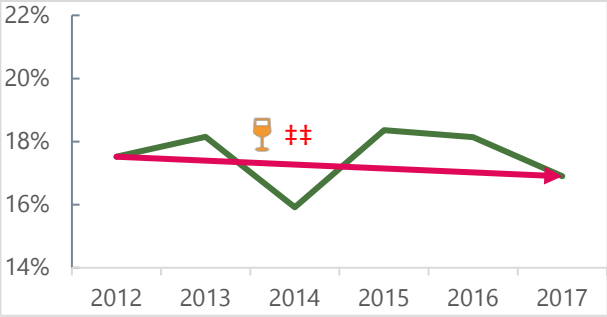
Figure 5B: Yearly Increase/Decrease (Cont.)

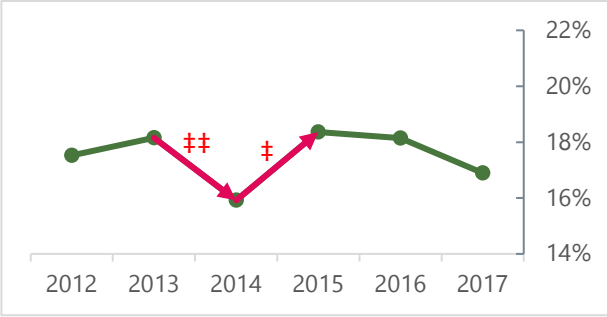
Pneumococcal Vaccination (65 years & Older)



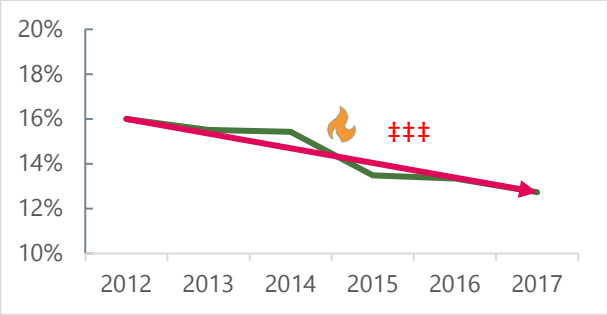


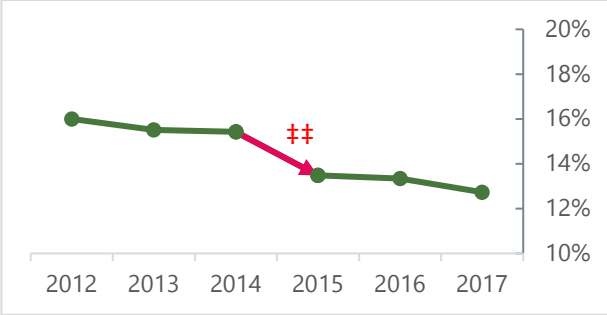
Excessive Alcohol Consumption





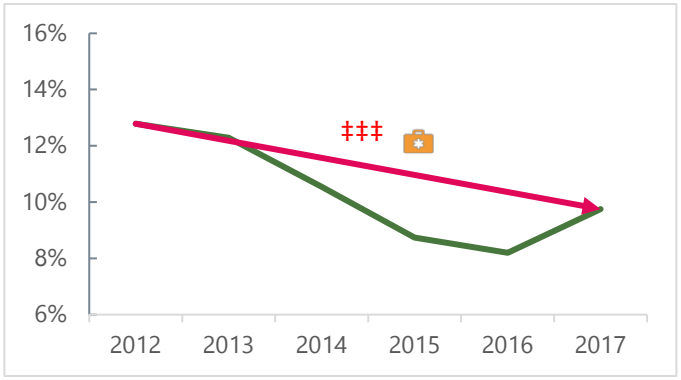
Current Cigarette Use



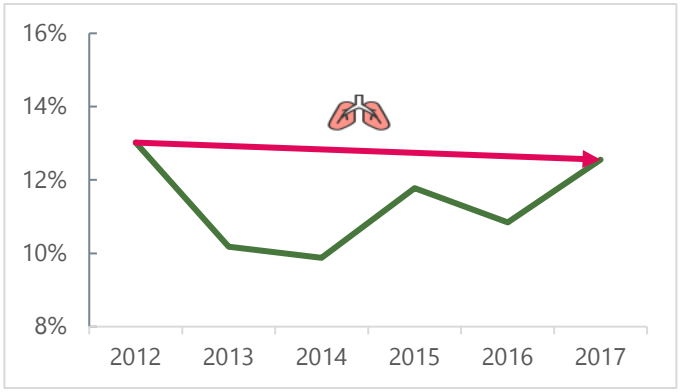


‡= significance <0.10; ‡‡=significance <0.05; ‡‡‡=significance <0.01

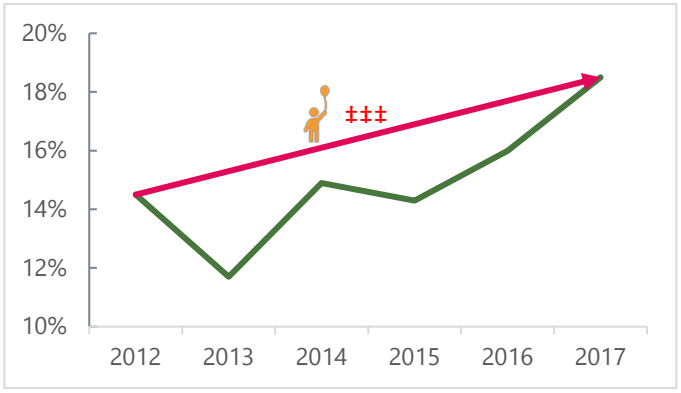
Figure 5A: Five Year Increase/Decrease (Cont.)



No Health Care Coverage (18–64 years old)

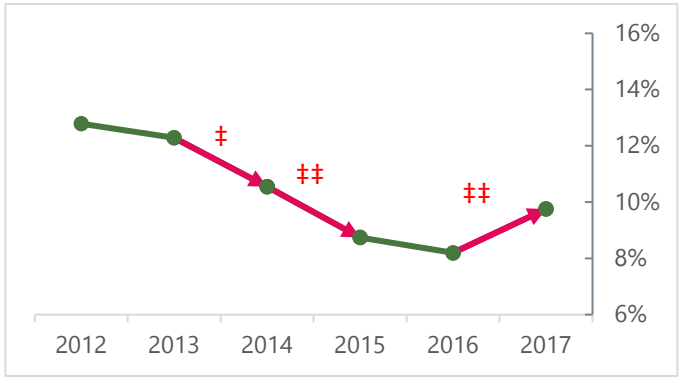


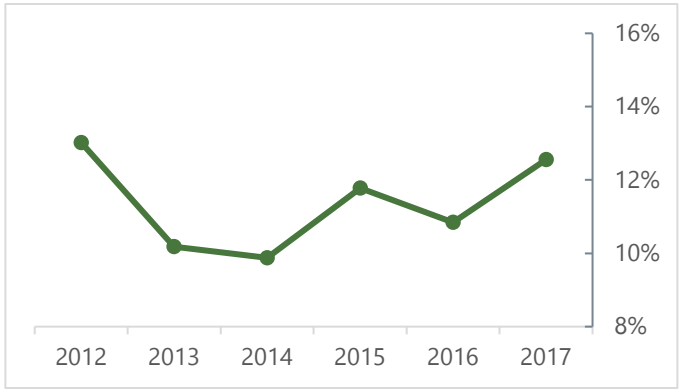
Child Asthma (0–17 years old)

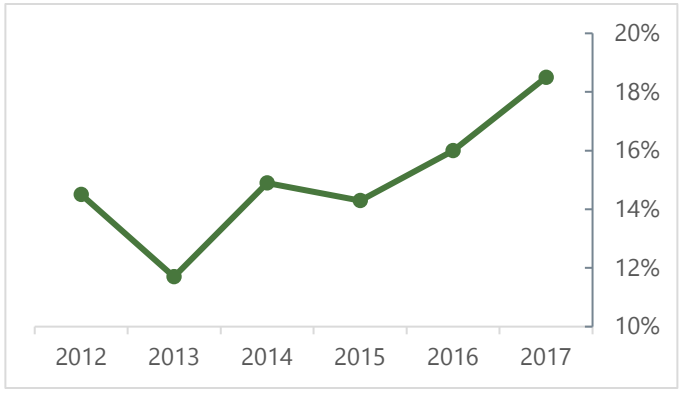


Child Obesity (5–17 years old)

Figure 5B: Yearly Increase/Decrease (Cont.)







‡= significance <0.10; ‡‡=significance <0.05; ‡‡‡=significance <0.01

TABLE 5: TREND IN PERCENT PREVALENCE OF SELECTED HEALTH INDICATORS, CT 2012–2017

Health Indicators	2012	2013	2014	2015	2016	2017
High Blood Pressure[#]		31.3		30.4		30.5
High Blood Cholesterol[#]		38.2		37.7		32.2
Consume Vegetables at Least Once Daily[#]		77.8		80.5		83.2
Consume Fruit at Least Once Daily[#]		66.3		64.5		68.7
Meet Both Aerobic & Strengthening Guidelines[#]		20.8		21.3		22.8
Adult Obesity	25.6	25.0	26.3	25.3	26.0	26.9
Flu Vaccination	39.2	40.3	42.9	46.1	42.8	45.8
Pneumococcal Vaccination (65 years & older)	67.6	67.8	70.6	72.7	73.4	75.3
Excessive Alcohol Consumption	17.5	18.2	15.9	18.4	18.1	16.9
Current Cigarette Use	16.0	15.5	15.4	13.5	13.3	12.7
No Health Care Coverage (18–64 years old)	12.8	12.3	10.6	8.7	8.2	9.8
Child Asthma (0–17 years old)	13.0	10.2	9.9	11.8	10.8	12.6
Child Obesity (5–17 years old)	13.6	11.3	13.6	13.4	16.0	18.9

[#] Health indicators offered in the BRFSS every other year.

Significant decreases from 2012 to 2017 in Connecticut (Figure 4A and Figure 5A) were observed for the following indicators:

- High blood cholesterol ($p<0.01$) fell 5.6 percentage points from 2013 to 2017, representing about 80,000 fewer adults with high blood cholesterol by 2017 (Figure 4A). There was a 5.1% reduction between 2015 and 2017 (Figure 4B).
- Excessive alcohol consumption decreased by 0.6% from 2012 to 2017 overall ($p<0.05$), representing about 34,000 adults. From 2013 to 2014 there was a significant decrease to 15.9% ($p<0.05$). Between 2014 and 2015 there was an increase to 18.4% ($p<0.10$) (Figure 5B).
- Current cigarette use decreased by 3.3% from 2012 to 2017 (<0.01), which represents approximately 97,000 Connecticut adults. Between 2014 and 2015, current cigarette use encountered a significant drop of 1.9 percentage points ($p<0.01$).
- From 2012 to 2017, having no health care coverage among adults 18–64 years old decreased by 3.0% ($p<0.01$), which represents about 71,000 Connecticut adults. There was a steady decline between 2013 and 2014 of 1.7% ($p<0.10$), and a 1.8% decline between 2014 and 2015 ($p<0.05$).

Significant increases from 2012 to 2017 in Connecticut (Figure 4A and Figure 5A) were observed for the following indicators:

- Consumption of vegetables at least once daily increased from 2013 to 2017 by 5.4%, indicating that approximately 65,000 Connecticut adults have increased their daily vegetable intake ($p<0.01$) (Figure 4A). Between 2013 and 2015, consumption of vegetables increased by 2.7% ($p<0.01$) (Figure 4B). Again, a 2.7%increase occurred between 2015 and 2017 ($p<0.01$), accounting for an increase in 74,000 Connecticut adults (Figure 4B).
- Between 2013 and 2017, consuming fruit at least once daily increased overall by 2.4% ($p<0.01$), representing approximately 18,000 Connecticut adults (4A). There was a significant increase annually occurring between 2015 and 2017 ($p<0.01$), representing an increase of about 124,000 Connecticut adults consuming fruit at least once daily (Figure 4B).
- From 2013 to 2017, adults who met aerobic and strengthening guidelines increased by 1.9% ($p<0.10$), representing 25,000 adults (Figure 4A). There was a 1.9% increase between 2015 and 2017
  ($p<0.10$), which represents 40,000 Connecticut adults (Figure 4B).
- Flu vaccination increased by 6.6% from 2012 to 2017 ($p<0.01$), which represents an increase of about 63,000 Connecticut adults getting a flu vaccination (Figure 5A). There were annual increases of 3% between 2013 and 2014, 2014 and 2015, and again 2016 and 2017 (Figure 5B).
- Between 2012 and 2017 Connecticut adults receiving the pneumococcal vaccination (ages 65 and older) increased 7.7% ($p<0.01$) (Figure 5A) but no annual significant changes were observed (Figure 5B). This overall change accounts for approximately 51,000 Connecticut adults above the age of 64 reporting that they received a pneumococcal vaccination between 2012 and 2017.
- From 2012 to 2017, child obesity for 5- to 17-year olds increased ($p<0.01$) by 5.3%, representing approximately an increase in obesity of 13,000 Connecticut youth (Figure 5A). While there was an initial decrease between 2012 and 2013, every year thereafter, child obesity either remained about the same or increased. No yearly significant findings in either direction (increases or decreases) were observed (Figure 5B).

No significant changes were observed from 2012 to 2017 in Connecticut for high blood pressure, adult obesity, and child asthma.

2. VULNERABLE POPULATIONS IN CONNECTICUT

Connecticut is one of the healthiest states in the nation and is ranked well for most selected health indicators in this report compared to other states; however, health disparities were found by further adjustments for social determinants of health (e.g., age, sex, race/ethnicity, income, disability status, and education level). In 2017, certain groups had significantly higher prevalence of poor health outcomes:

Non-Hispanic Black (compared to NH White)	**Hispanic** (compared to NH White)
• Fair/poor health • Obesity • Limited health care coverage due to costs • No leisure time physical activity • Low vegetable consumption • No tetanus shot • Arthritis • Diabetes • High blood pressure • Child consumption of fast food • Child dentist visit	• Fair/poor health • Disability • Poor physical health • Obesity • Limited health care coverage due to costs • No insurance • No leisure time physical activity • Low vegetable consumption • Cigarette smoking • No blood cholesterol test • No flu vaccine • No tetanus shot • Asthma • Child obesity • Child never breastfed • Child asthma • Child screen time • Child consumption of fast food • Child consumption of sugar-sweetened beverages • Child dental decay

Annual Income Less than $35,000 (compared to higher incomes)	Adults Without Health Insurance
• Fair/poor health • Poor mental health • Poor physical health • Disability • Obesity • Limited health care coverage due to costs • No insurance • No leisure time physical activity • Did not meet aerobic/strength guidelines • Low fruit and vegetable consumption • Cigarette, vapor, vape pen, or e-cigarette use • Blood cholesterol test • Flu vaccine • No tetanus shot • Asthma • COPD • Arthritis • Cardiovascular disease • Prediabetes and diabetes • High blood cholesterol • High blood pressure • Kidney disease • Depression	• Fair/poor health • Obesity • Limited health care coverage due to costs • No leisure time physical activity • Did not meet aerobic/strength guidelines • Low vegetable consumption • Cigarette, vapor, vape pen, or e-cigarette use • Binge drinking • No blood cholesterol test • No flu vaccine • No tetanus shot

Disabled Adults	Less Than High School Education
• Fair/poor health • Poor mental health • Poor physical health • Obesity • Limited health care coverage due to costs • No insurance • No leisure time physical activity • Did not meet aerobic/strength guidelines • Low fruit and vegetable consumption • Cigarette smoking • Vapor, vape pen, or e-cigarette use • Tetanus shot • COPD • Arthritis • Cardiovascular disease • Cancer • Prediabetes and diabetes • High blood cholesterol • High blood pressure • Kidney disease • Depression	• Fair/poor health • Disability • Poor physical health • Obesity • Limited health care coverage due to costs • No insurance • No leisure time physical activity • Did not meet aerobic/strength guidelines • Low fruit and vegetable consumption • Cigarette smoking • Vapor, vape pen, or e-cigarette use • No blood cholesterol test • No flu vaccine • Pneumococcal vaccination • No tetanus shot • Asthma • COPD • Arthritis • Cardiovascular disease • Cancer • Diabetes • High blood pressure • Kidney disease

3. Health Status Indicators

General Health Status

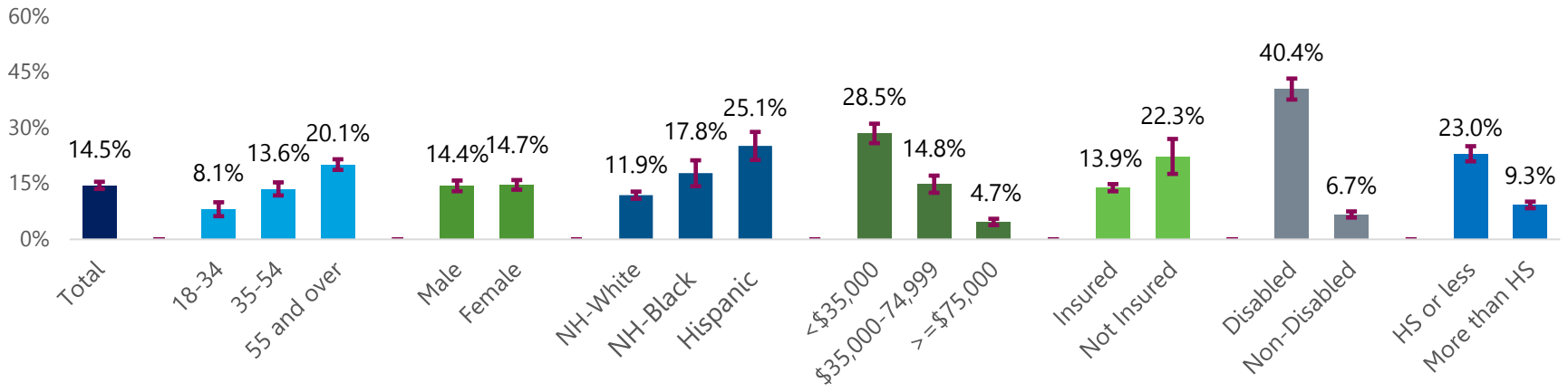
General self-rated health status is a valuable measure to collect alongside more objective health measures because it has strong predictive properties for health outcomes; specifically, self-reports of poor health are strongly associated with mortality.[8] CT BRFSS respondents were asked to rate their general health as excellent, very good, good, fair, or poor.

One in seven Connecticut adults rated their health as either fair or poor in 2017. The prevalence of adults who reported fair or poor health is shown in Figure 6.

Compared to their counterparts in the state, the prevalence of having **fair or poor health** among adults in Connecticut was significantly greater for:

- Adults 55 years and older (20.1%) and adults 35–54 years old (13.6%);
- Hispanic (25.1%) and non-Hispanic Black (17.8%) adults;
- Adults from households earning less than $35,000 (28.5%) and $35,000–$74,999 (14.8%);
- Adults without health insurance (22.3%);
- Disabled adults (40.4%); and
- Adults with no more than a high school education (23.0%).

Figure 6: Percentage of CT Residents Reporting Poor of Fair Overall Health, CT 2017



Disability

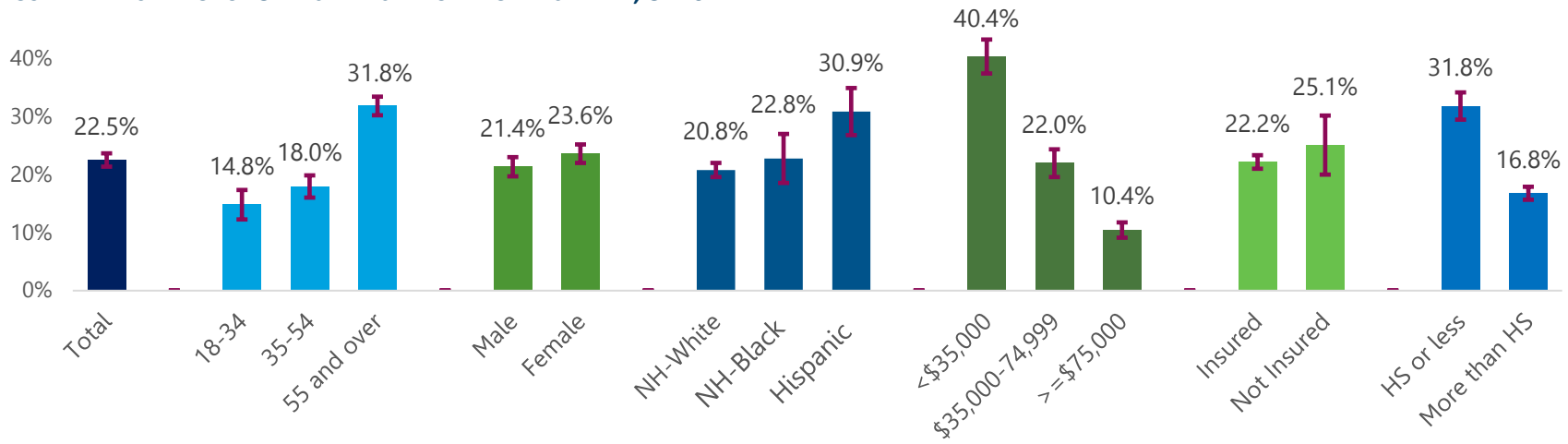
The Americans with Disabilities Act (ADA) defines an individual with a disability as "a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment."[9] Respondents were classified as having a disability if they answered "yes" to any of the following five questions: 1) Are you blind or do you have serious difficulty seeing, even when wearing glasses? 2) Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering or making decisions? 3) Do you have serious difficulty walking or climbing stairs? 4) Do you have difficulty dressing or bathing? 5) Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?
6) Are you deaf or do you have serious difficulty hearing?

One in five adults in Connecticut reported that they have a disability in 2017. Results are shown in Figure 7.

Compared to their counterparts in the state, the prevalence of **being disabled** among adults in Connecticut was significantly greater for:

- Adults 55 years and older (31.8%) and adults 35–54 years old (18.0%);
- Hispanic adults (30.9%);
- Adults from households earning less than $35,000 (40.4%) and $35,000–$74,999 (22.0%); and
- Adults with no more than a high school education (31.8%).

FIGURE 7: PERCENTAGE OF CT RESIDENTS REPORTING A DISABILITY, CT 2017



Health-Related Quality of Life (Poor Mental Health)

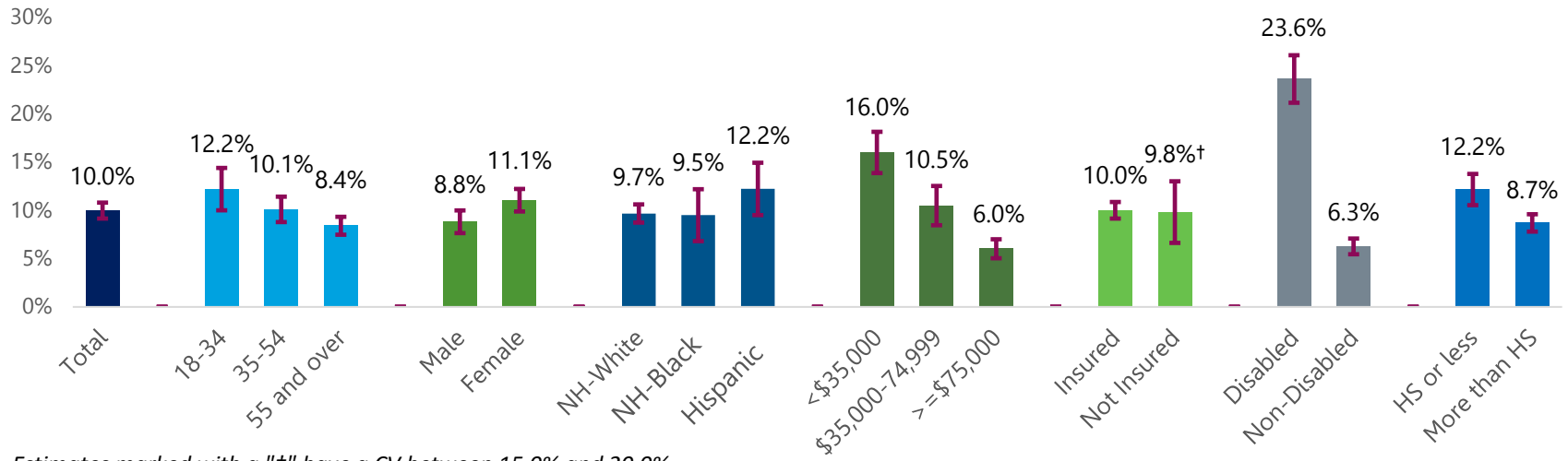
The BRFSS uses the Healthy Days Measure to assess health-related quality of life. The Healthy Days Measure has been useful for identifying health disparities and tracking population trends.[10] This measure defines adults as being in poor physical or mental health if they reported 14 or more days (within the past 30 days) for which their physical or mental health was "not good."

One in ten Connecticut adults reported poor mental health. The prevalence of adults who had poor mental health is reported in Figure 8.

Compared to their counterparts in the state, the prevalence of **poor mental health** among adults in Connecticut was significantly greater for:

- Adults 18-34 years of age (12.2%) and adults 35–54 years old (10.1%);
- Females (11.1%);
- Adults from households earning less than $35,000 (16.0%) and $35,000–$74,999 (10.5%); and
- Adults with a disability (23.6%); and
- Adults with no more than a high school education (12.2%).

FIGURE 8: PERCENTAGE OF CT RESIDENTS REPORTING POOR OR FAIR MENTAL HEALTH, CT 2017



Estimates marked with a "†" have a CV between 15.0% and 20.0%

Health-Related Quality of Life (Poor Physical Health)

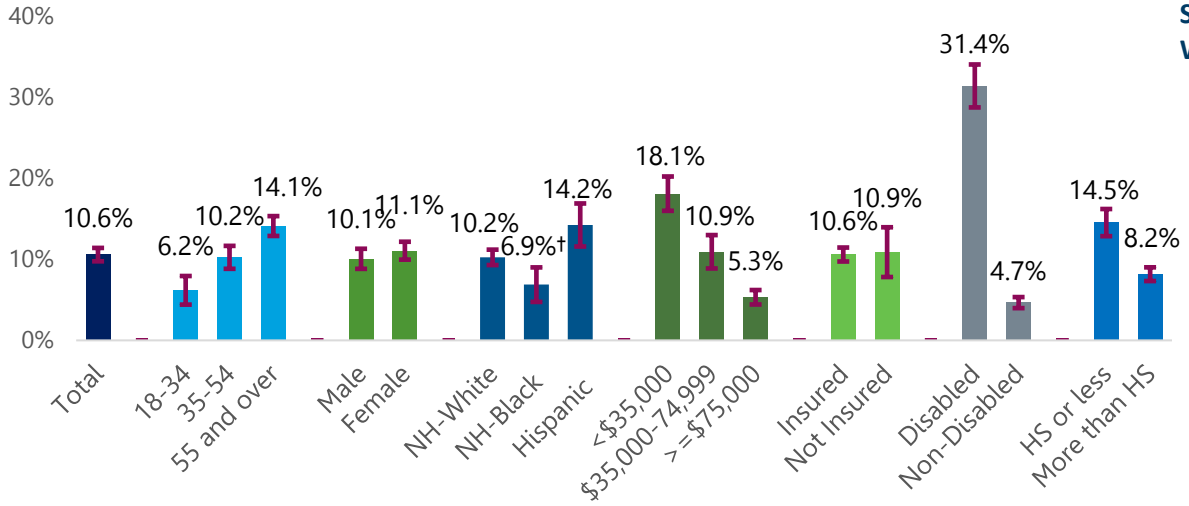
The BRFSS uses the Healthy Days Measure to assess health-related quality of life. The Healthy Days Measure has been useful for identifying health disparities and tracking population trends.[10] This measure defines adults as being in poor physical or mental health if they reported 14 or more days (within the past 30 days) for which their physical or mental health was "not good."

One in nine Connecticut adults reported poor physical health. The prevalence of adults who had poor physical health is reported in Figure 9. Adults were also asked if their poor physical or mental health was a barrier to life's activities, see Figure 10.

Compared to their counterparts in the state, the prevalence of **poor physical health** among adults in Connecticut was significantly greater for:

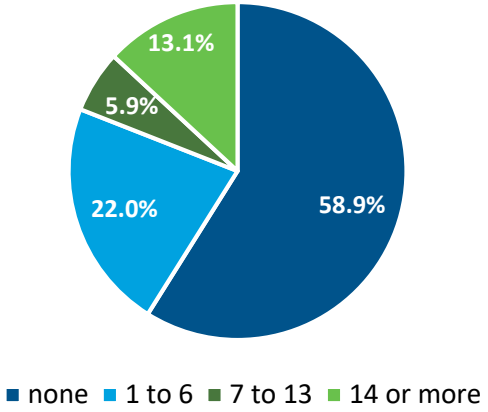
- Adults 55 years and older (14.1%) and adults 35–54 years old (10.2%);
- Hispanic adults (14.2%) compared to non-Hispanic White adults (10.2%);
- Adults from households earning less than $35,000 (18.1%) and $35,000–$74,999 (10.9%);
- Adults with a disability (31.4%); and
- Adults with no more than a high school education (14.5%).

FIGURE 9: PERCENTAGE OF CT RESIDENTS REPORTING POOR PHYSICAL HEALTH, CT 2017



Estimates marked with a "†" have a CV between 15.0% and 20.0%

FIGURE 10: PERCENTAGE OF CT RESIDENTS WHO SAID THEIR POOR PHYSICAL OR MENTAL HEALTH WAS A BARRIER TO LIFE'S ACTIVITIES, CT 2017



Adult Weight Status

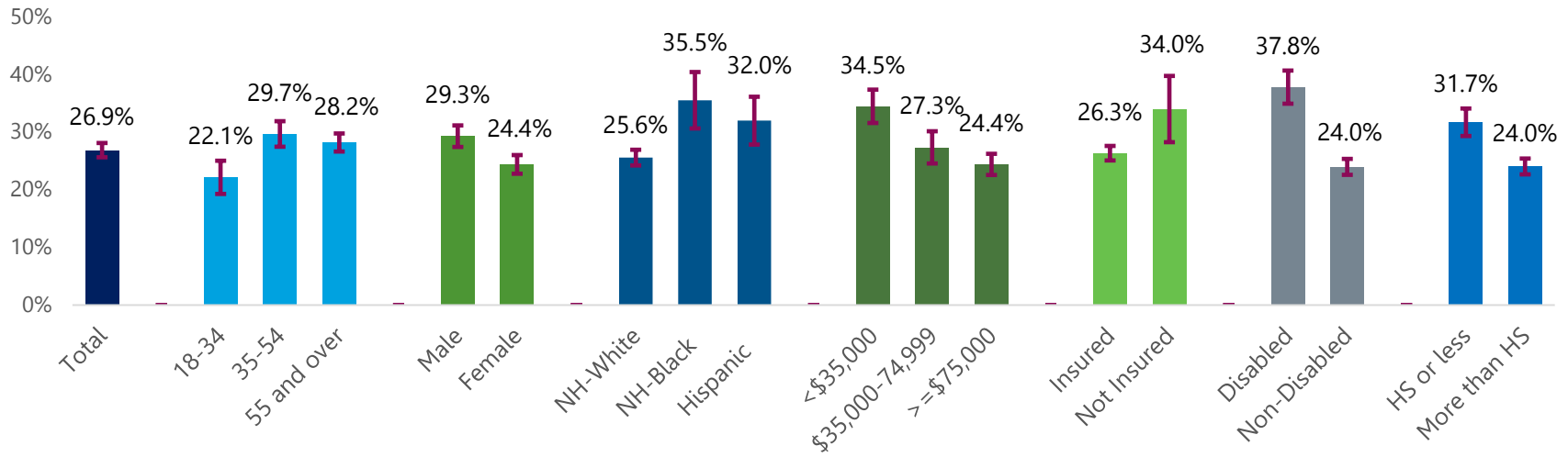
The BRFSS survey asks respondents to provide their height and weight without shoes. A body mass index (BMI) is calculated by dividing their weight in kilograms by the squared value of their height in meters. An adult with a BMI between 25.0 and 29.9 is considered overweight, while an adult with a BMI of 30 or above is considered obese. The prevalence of obese adults is of particular interest because obesity has been shown to be a major cause of preventable morbidity and mortality in the United States.[11] Overweight and obese adults are at risk for developing a wide range of health problems, including high blood pressure, type 2 diabetes, coronary heart disease, certain cancers, strokes, and other diseases.[12] Results are shown in Figure 11 for obesity.

One in four Connecticut adults were obese in 2017.

Compared with their counterparts in the state, the prevalence of being **obese** among Connecticut residents was significantly greater for:

- Adults 35–54 years old (29.7%) and 55 years and older (28.2%);
- Males (29.3%);
- Non-Hispanic Black (35.5%) and Hispanic (32.0%) adults;
- Adults from households earning less than $35,000 (34.5%);
- Adults without health insurance (34.0%);
- Adults with a disability (37.8%); and
- Adults with no more than a high school education (31.7%).

FIGURE 11: PREVALENCE OF OBESITY AMONG CT ADULTS, CT 2017



Health Care Coverage

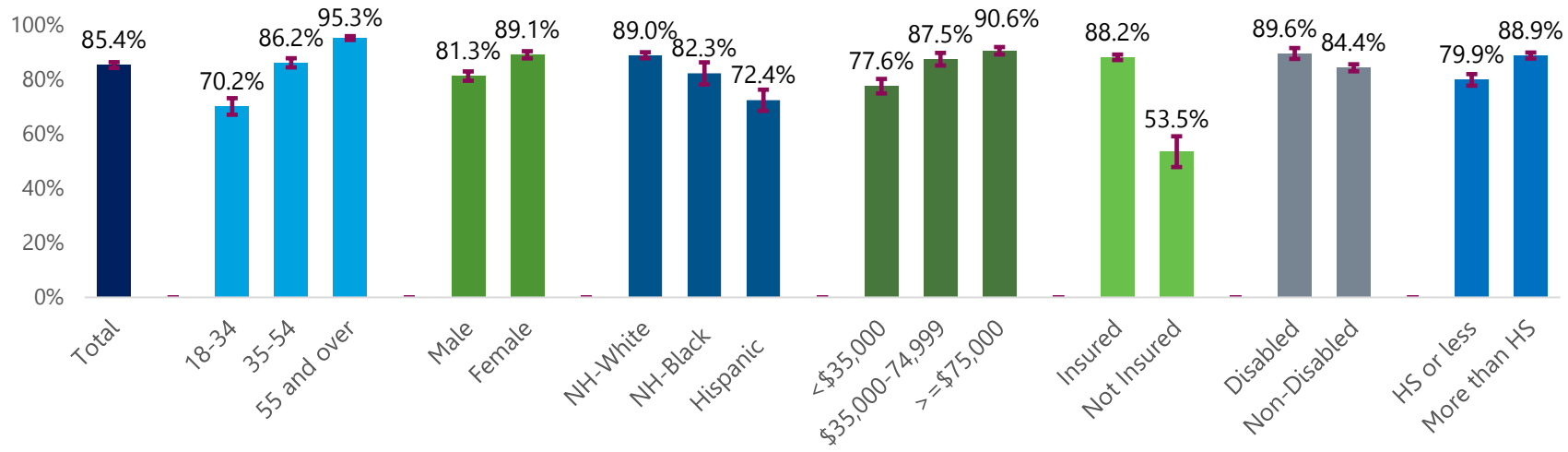
People who have access to a personal health care provider or a regular health care setting have better health outcomes.[13] Generally, an effective primary health care system is associated with better health outcomes. Limited health care coverage is a barrier to access to care that adversely impacts health outcomes. "Limited" health care coverage includes adults who do not have a primary care provider, which is a personal doctor or health care provider; or adults who needed to see a doctor in the past year but could not because of cost. In this report, the results of adults having at least one primary health care provider and having limited health care access due to cost in 2017 are shown in Figures 12 and 13.

Eight in ten Connecticut adults reported they had at least one primary health care provider in 2017.

Compared to their counterparts in the state, the prevalence of having **at least one primary health care provider** was significantly greater for:

- Adults 55 years and older (95.3%) and adults 35–54 years old (86.2%);
- Females (89.1%);
- Non-Hispanic White adults (89.0%) and Non-Hispanic Black adults (82.3%);
- Adults from households earning at least $75,000 (90.6%) and $35,000–$74,999 (87.5%);
- Adults with health insurance (88.2%);
- Adults with a disability (89.6%); and
- Adults with more than a high school education (88.9%).

FIGURE 12: AT LEAST ONE PRIMARY HEALTH CARE PROVIDER, CT 2017

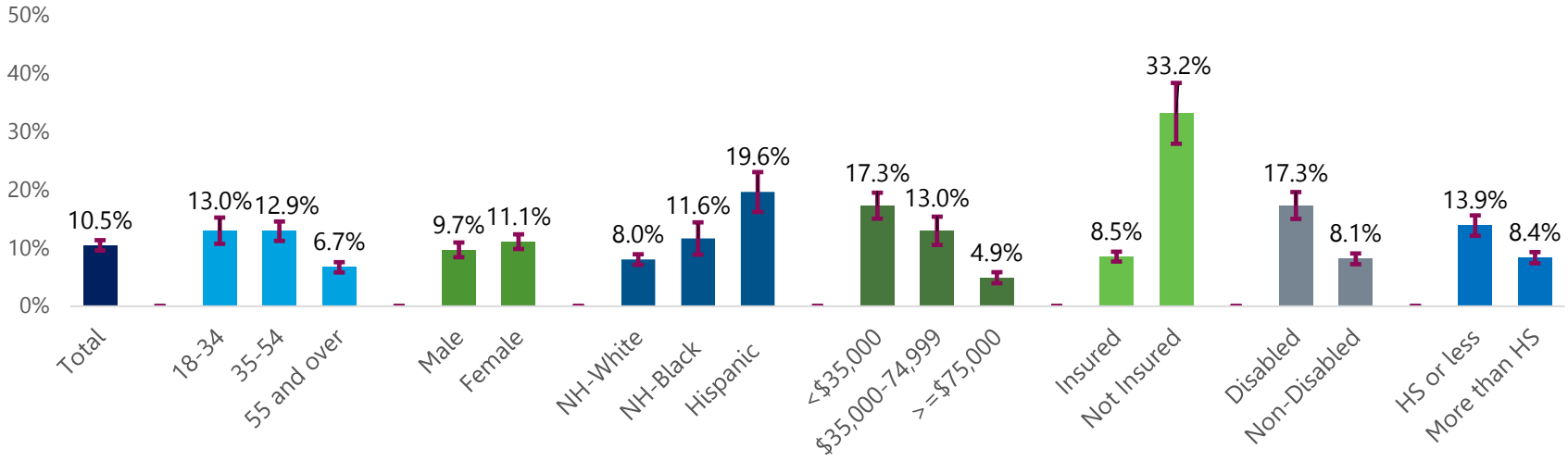


One in ten Connecticut adults reported that they had no health care due to costs.

Compared to their counterparts in the state, the prevalence of having **limited health care coverage** due to cost among adults in Connecticut was significantly greater for:

- Adults 18–34 years old (13.0%) and 35–54 years old (12.9%);
- Hispanic (19.6%) and Non-Hispanic Black adults (11.6%);
- Adults from households earning less than $35,000 (17.3%) and $35,000–$74,999 (13.0%);
- Adults without health insurance (33.2%);
- Adults with a disability (17.3%); and
- Adults with no more than a high school education (13.9%).

FIGURE 13: NO HEALTH CARE ACCESS DUE TO COST, CT 2017



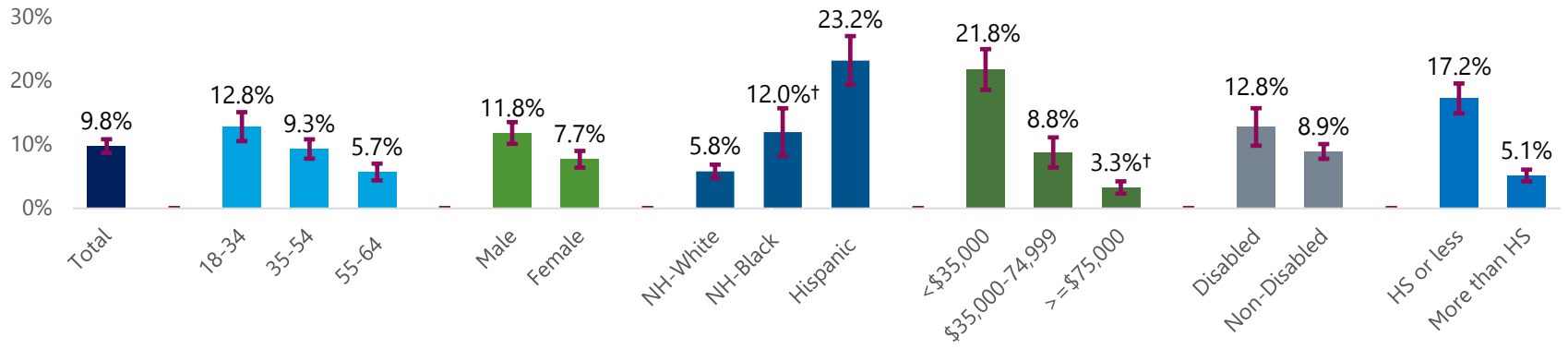
Health Insurance Coverage

Health insurance coverage includes private insurance and plans such as health maintenance organizations (HMOs) or government plans such as Medicare or the Indian Health Service. Adults without health care coverage have higher mortality rates for a range of health conditions, compared to insured adults.[14] Adults without health care coverage are less likely to get needed care and screenings, and they have poorer health outcomes.[15] Medicaid is a public health insurance program for low-income Americans and other target groups, including pregnant women and people with disabilities. An expansion of Medicaid coverage under the Affordable Care Act went into effect in 2014. The prevalence of adults aged 18-64 years old in 2017 who reported having no health care coverage, private insurance, Medicaid, or Medicare coverage are broken down by demographic characteristics in the figures below. Adults who obtained coverage via Tricare, Veterans Affairs. (VA), military services, Indian Health Service or tribal health services, or an unknown source are not shown in the Figure 14-17. One in ten Connecticut adults reported that they had no health insurance coverage in 2017.

Compared to their counterparts in the state, the prevalence of having **no health insurance coverage** among adults aged 18–64 years old was significantly greater for:

- Adults 18–34 years old (12.8%) and 35–54 years old (9.3%);
- Males (11.8%);
- Hispanic (23.2%) compared to non-Hispanic White adults (5.8%);
- Adults from households earning less than $35,000 (21.8%) compared to $35,000–$74,999 (8.8%);
- Adults with a disability (12.8%); and
- Adults with no more than a high school education (17.2%).

FIGURE 14: NO INSURANCE COVERAGE, ADULTS 18-64 YEARS OLD, CT 2017



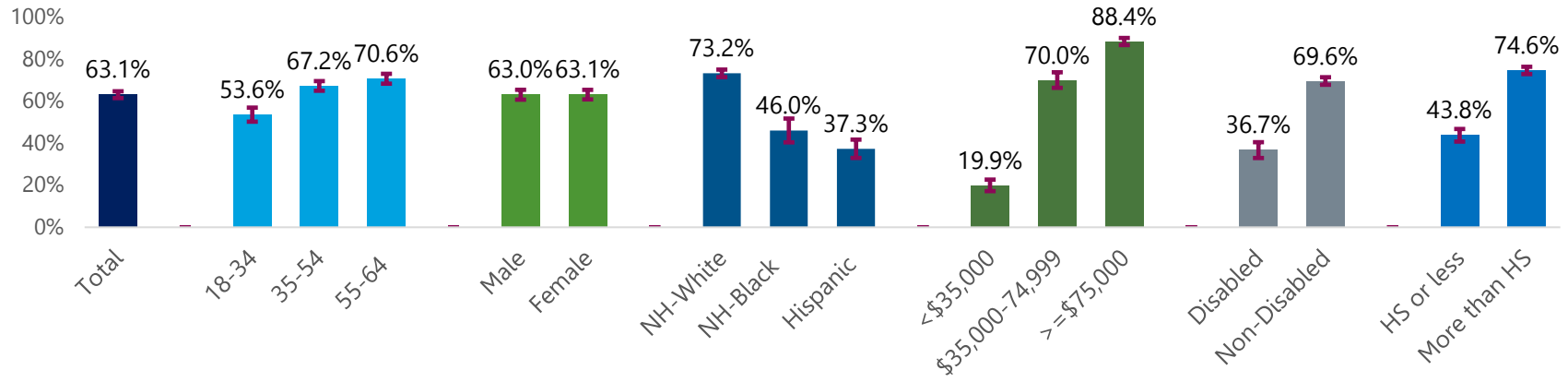
Estimates marked with a "†" have a CV between 15.0% and 20.0%.

Six in ten Connecticut adults reported that they had private health insurance coverage in 2017.

Compared to their counterparts in the state, the prevalence of adults with **private health insurance coverage** among adults aged 18–64 years old was significantly greater for:

- Adults 55 -64 years old (70.6%) and 35–54 years old (67.2%);
- Non-Hispanic White adults (73.2%);
- Adults from households earning at least $75,000 (88.4%) and $35,000–$74,999 (70.0%);
- Adults with a disability (69.6%); and
- Adults with more than a high school education (74.6%).

FIGURE 15:PRIVATE INSURANCE, ADULTS 18-64 YEARS OLD, CT 2017

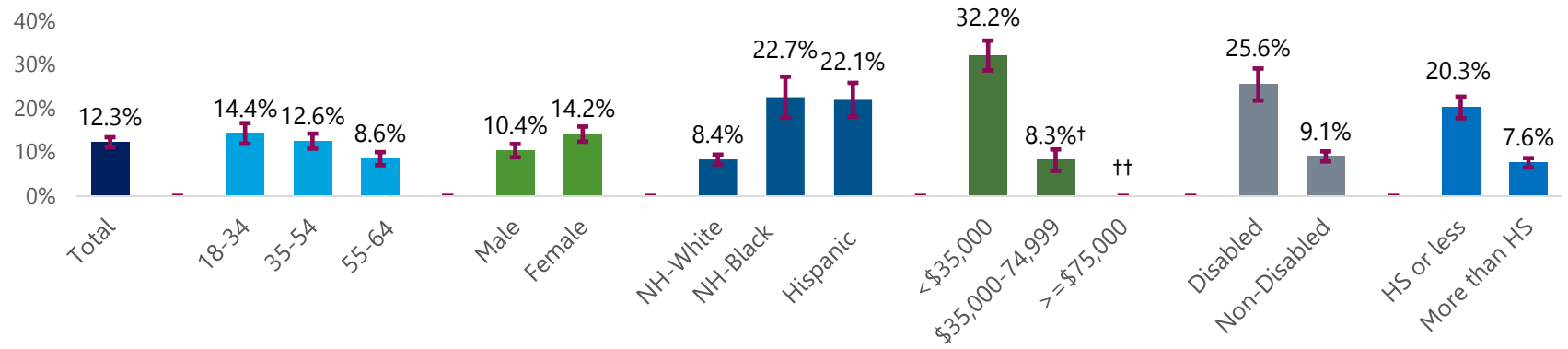


One in eight Connecticut adults had Medicaid coverage in 2017.

Compared to their counterparts in the state, the prevalence of adults who had **Medicaid coverage** among adults aged 18–64 years old was significantly greater for:

- Adults 18–34 years old (14.4%) and 35–54 years old (12.6%);
- Females (14.2%);
- Non-Hispanic Black adults (22.7%) and Hispanic adults (22.1%);
- Adults with a disability (25.6%); and
- Adults with no more than a high school education (20.3%).

FIGURE 16: MEDICAID COVERAGE, ADULTS 18-64 YEARS OLD, CT 2017

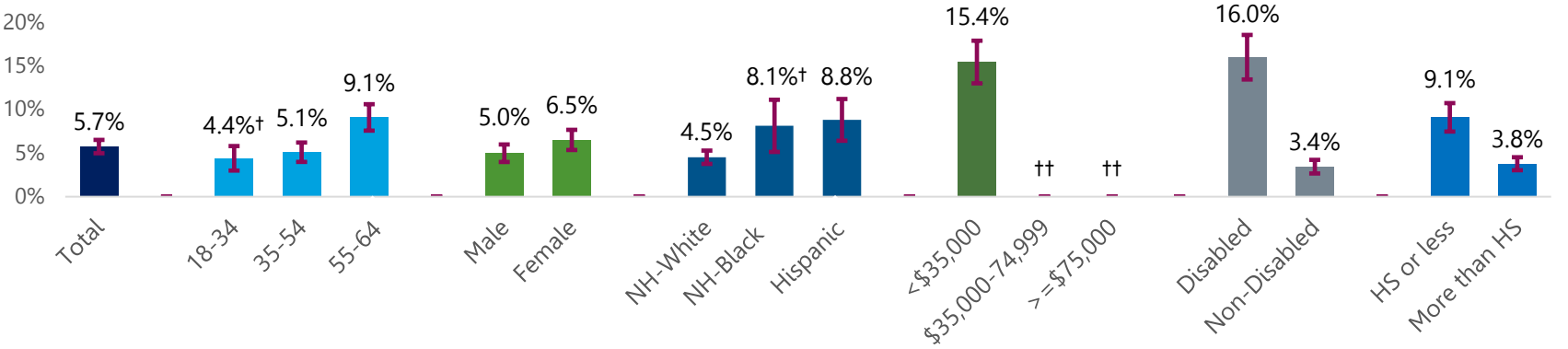


One in 20 Connecticut adults had Medicare coverage in 2017.

Compared to their counterparts in the state, the prevalence of adults who had **Medicare coverage** among adults aged 18–64 years old was significantly greater for:

- Adults 55-64 years old (9.1%);
- Hispanic adults (8.8%) compared to non-Hispanic White adults (4.5%);
- Adults with a disability (16.0%); and
- Adults with no more than a high school education (9.1%).

FIGURE 17: MEDICARE COVERAGE, ADULTS 18-64 YEARS OLD, CT 2017



Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%.

4. Risk Behavior Indicators

Motor Vehicle Safety

Seatbelt use is the most effective way to reduce the number of injuries and deaths in motor vehicle crashes.[16] Respondents to the BRFSS were asked how often they wore seatbelts when they drove or rode in a car. The prevalence of adults who said they always wore a seatbelt is shown in Figure 18.

Over 90% of Connecticut adults in 2017 reported using a seatbelt all the time.

Compared to their counterparts in the state, the prevalence of **always wearing a seatbelt** was significantly greater for:

- Adults 55 years and older (93.5%) and adults 35–54 years old (92.5%);
- Females (93.3%);
- Adults from households earning at least $75,000 (94.2%);
- Adults without a disability (92.3%); and
- Adults with more than a high school education (93.5%).

Figure 18: Seatbelt Use, CT 2017

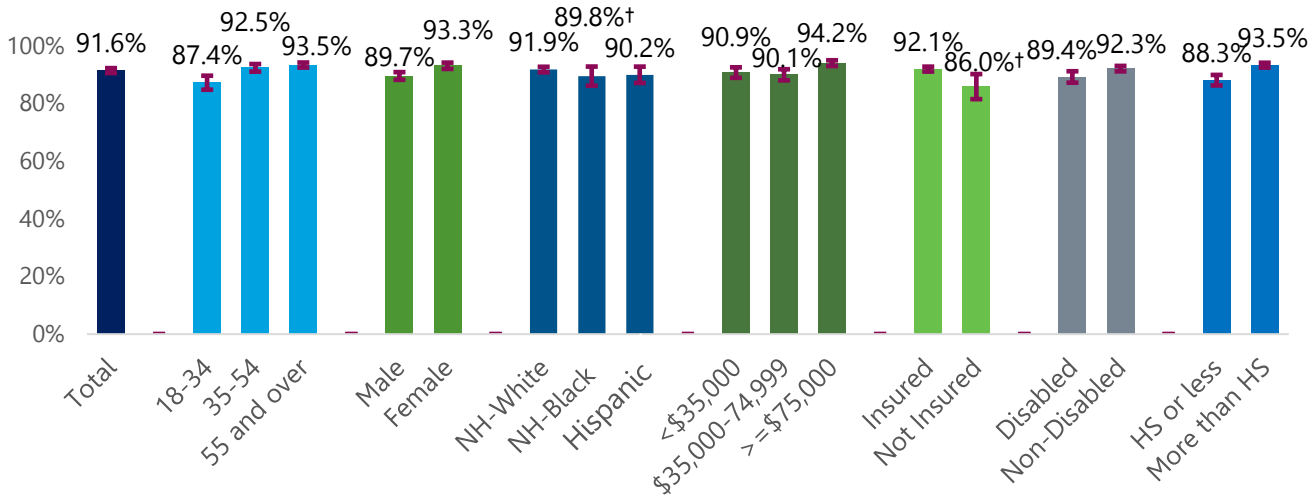
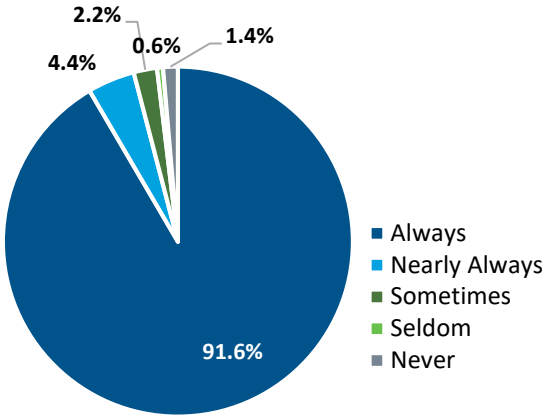


Figure 19: Frequency of Seatbelt Use, CT 2017



Adult Physical Activity

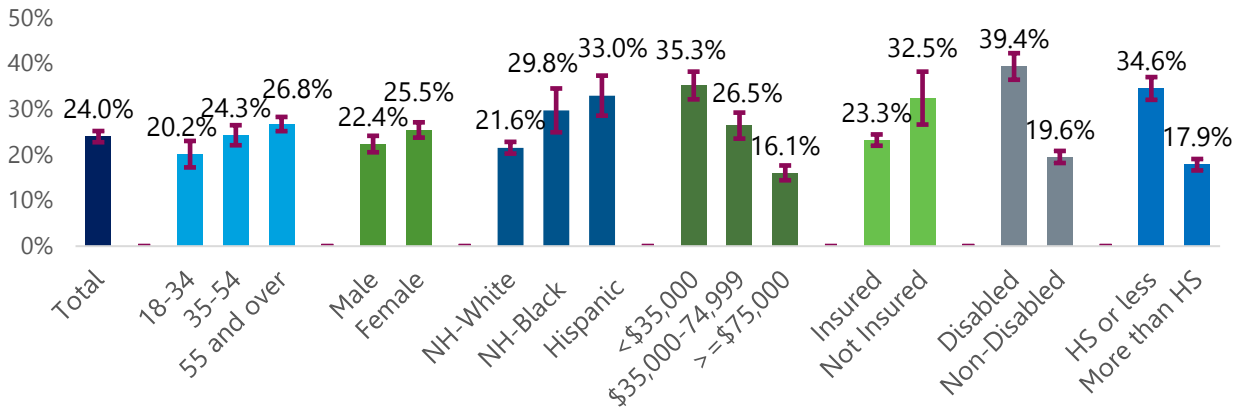
Regular physical exercise has been shown to prevent certain chronic diseases. A sedentary lifestyle is a risk factor for obesity, bone and joint diseases, depression, and chronic diseases.[17] Adults were asked to report whether they had participated in any physical activities or exercises in the past 30 days, such as running, calisthenics, golf, gardening, or walking, other than for their job. Figure 20 shows the prevalence of adults who did not engage in leisure or recreational physical activity.

Nearly one in four Connecticut adults in 2017 did not engage in any recreational physical activity outside of work.

Compared to their counterparts in the state, the prevalence of **no leisure-time activity** among adults in Connecticut was significantly greater for:

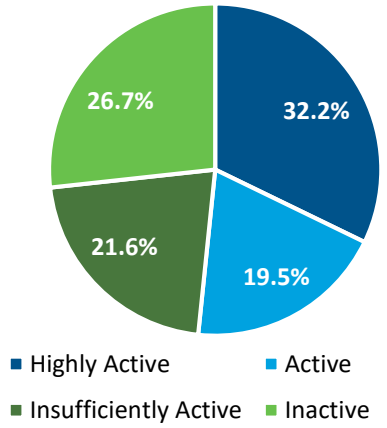
- Adults 55 years and older (26.8%) and adults 35–54 years old (24.3%);
- Females (25.5%);
- Hispanic (33.0%) and non-Hispanic Black (29.8%) adults;
- Adults from households earning less than $35,000 (35.3%) and $35,000–$74,999 (26.5%);
- Adults without health insurance (32.5%);
- Adults with a disability (39.4%); and
- Adults with no more than a high school education (34.6%).

FIGURE 20: DID NOT ENGAGE IN LEISURE OR RECREATIONAL PHYSICAL ACTIVITY, CT 2017



Estimates marked with a "†" have a CV between 15.0% and 20.0.

FIGURE 21: CATEGORIES OF PHYSICAL ACTIVITY, CT 2017



Aerobic and Strengthening Guidelines

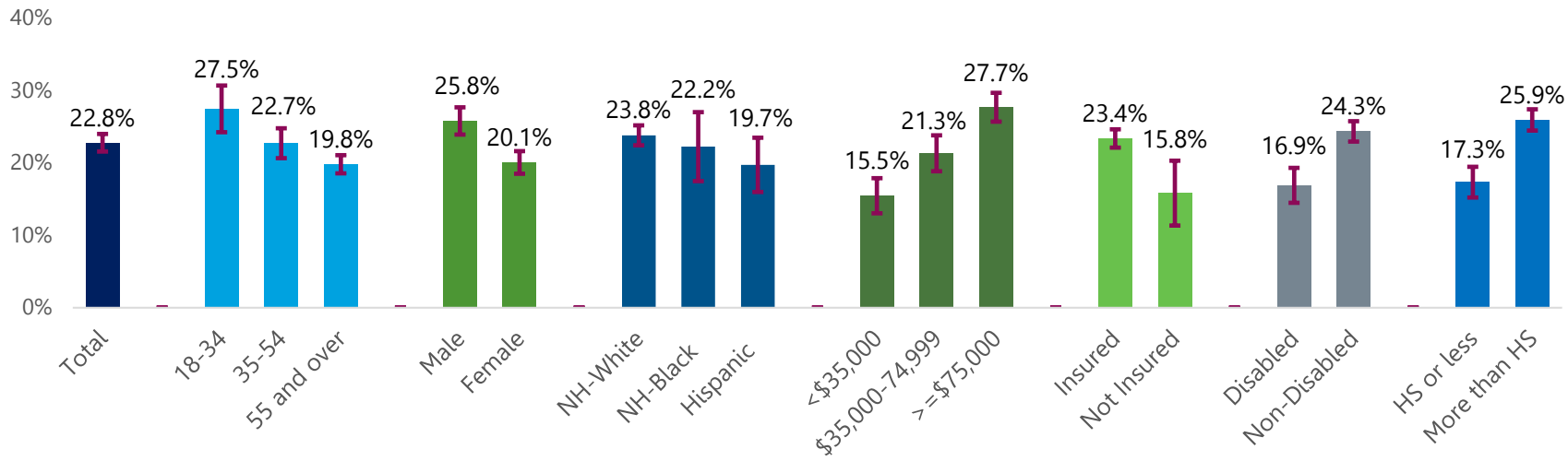
The 2008 Physical Activity Guidelines for Americans recommends that adults participate in at least 150 minutes a week of moderate-intensity aerobic physical activity and at least two or more times a week of muscle-strengthening activities for health benefits.[18] People who are physically active generally live longer and have a lower risk for heart disease, stroke, type 2 diabetes, depression, and some cancers.[19] The 2017 BRFSS asked respondents the frequency of their physical activities. Figure 22 shows the proportion of adults who met the aerobic and/or muscle strengthening exercise guidelines.

One in five of Connecticut adults met the aerobic and/or muscle strengthening exercise guidelines in 2017

Compared to their counterparts in the state, the prevalence of adults who **met aerobic and muscle strengthening guidelines** was significantly greater for:

- Adults 18–34 years old (27.5%) and 35–54 years old (22.7%);
- Males (25.8%);
- Adults from households earning at least $75,000 (27.7%) and $35,000–$74,999 (21.3%);
- Adults with health insurance (23.4%);
- Adults without a disability (24.3%); and
- Adults with more than a high school education (25.9%)

FIGURE 22: MET BOTH AEROBIC AND STRENGTHENING GUIDELINES, CT 2017



Fruit and Vegetable Consumption

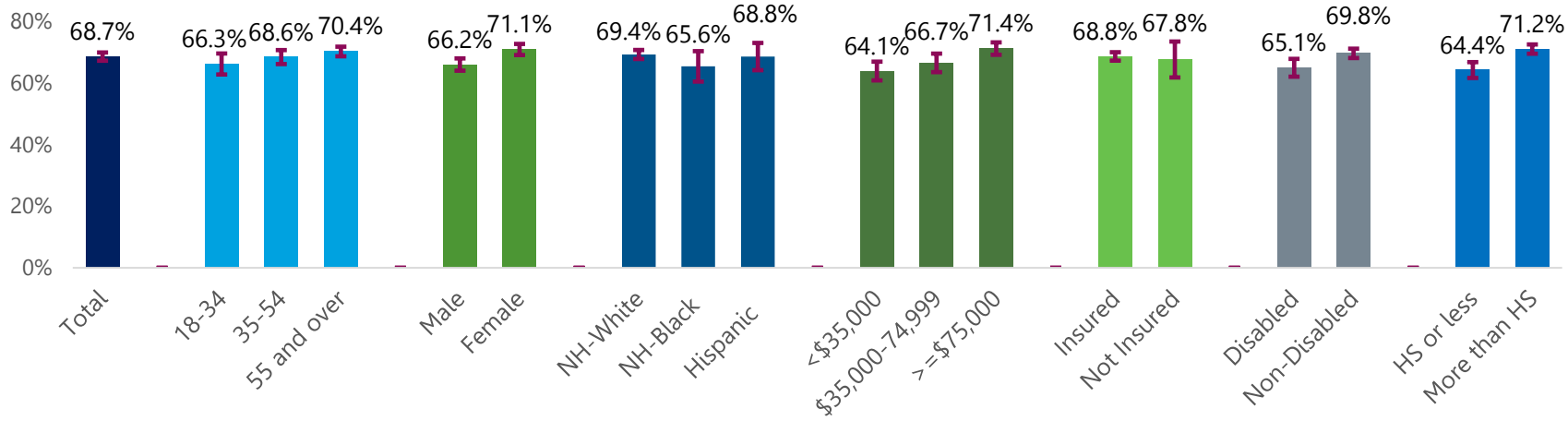
The Dietary Guidelines for Americans recommend that people consume five to thirteen servings of fruits and vegetables, with different amounts based on total calorie intake. The average American, however, only eats about three servings of fruits and vegetables each day. The benefits of fruits and vegetables are numerous. They can improve vision, lower blood pressure, prevent some types of cancer, and reduce the risk of heart disease and stroke. Fruits and vegetables are also low in fat and calories and contain many vital minerals and vitamins that maintain blood sugar and keep appetite in check. The 2017 BRFSS asked respondents how often they ate fruits and vegetables, including servings of 100% fruit juice. Figure 23 and Figure 24 shows the proportion of adults in 2017 consuming fruits or vegetables at least once daily, separately.

In 2017, nearly 7 in 10 Connecticut adults reported that they consumed fruits at least once daily.

Compared to their counterparts in the state, the prevalence of adults **consuming fruits at least once daily** was significantly greater for:

- Adults 55 years and older (70.4%);
- Females (71.1%);
- Adults from households earning at least $75,000 (71.4%);
- Adults without a disability (69.8%); and
- Adults with more than a high school education (71.2%)

FIGURE 23: CONSUME FRUITS AT LEAST ONCE DAILY, CT 2017

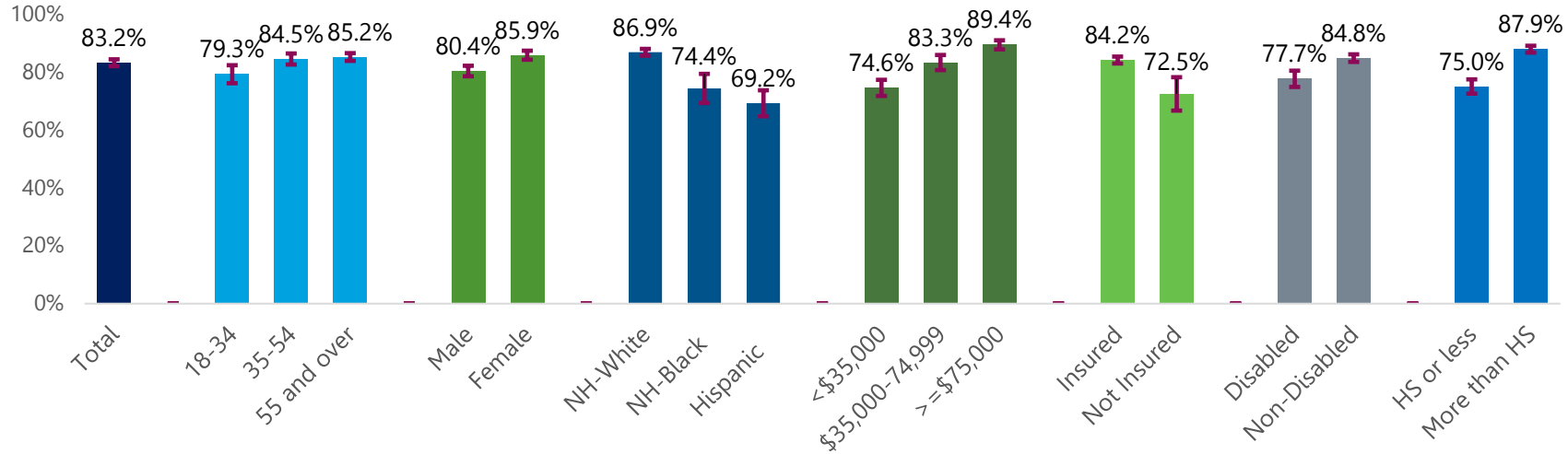


In 2017, eight in ten Connecticut adults reported that they consumed vegetables at least once daily.

Compared to their counterparts in the state, the prevalence of adults in 2017 **consuming vegetables at least once daily** was significantly greater for:

- Adults 55 years and older (85.2%) and adult 35-54 years old (84.5%);
- Females (85.9%);
- Non-Hispanic White adults (86.9%);
- Adults from households earning at least $75,000 (89.4%) and $35,000–$74,999 (83.3%);
- Adults with health insurance (84.2%);
- Adults without a disability (84.8%); and
- Adults with more than a high school education (87.9%).

FIGURE 24: CONSUME VEGETABLES AT LEAST ONCE DAILY, CT 2017



Current Cigarette Smoking

According to the U.S. Surgeon General, smoking is the number one preventable cause of death.[20] It is detrimental to nearly every organ in the body and causes poorer overall health. Smokers are more likely to develop lung cancer, stroke, and heart disease when compared to non-smokers. Smoking is associated with numerous other cancers and diseases. Nearly half a million Americans die every year in the United States as a result of cigarette smoking, meaning that one in five deaths nationwide can be linked to smoking. The prevalence of current cigarette smoking is shown in Figure 25.

One in eight Connecticut adults in 2017 were current smokers, smoked cigarettes "every day" or "some days" in the past month.

Compared to their counterparts in the state, the prevalence of **current cigarette smoking** was significantly greater for:

- Adults 18–34 years old (15.1%) and 35–54 years old (14.7%);
- Males (14.1%);
- Hispanic (16.3%) compared to non-Hispanic White (12.0%) adults;
- Adults from households earning less than $35,000 (19.9%) and $35,000–$74,999 (14.2%);
- Adults without health insurance (21.0%);
- Adults with a disability (20.6%); and
- Adults with no more than a high school education (19.6%).

FIGURE 25: CURRENT CIGARETTE SMOKING, CT 2017

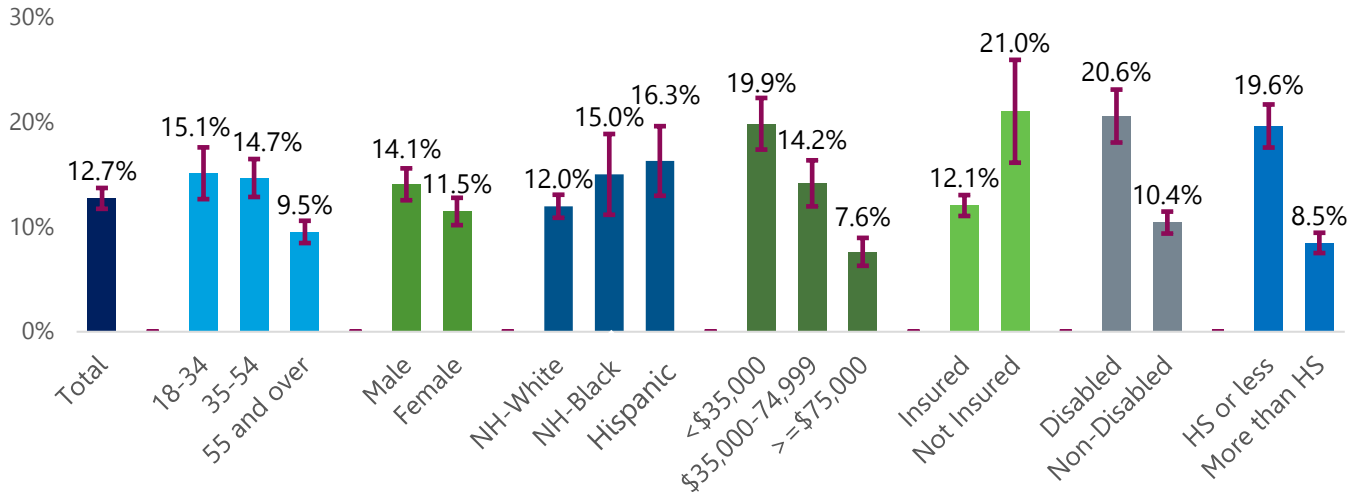
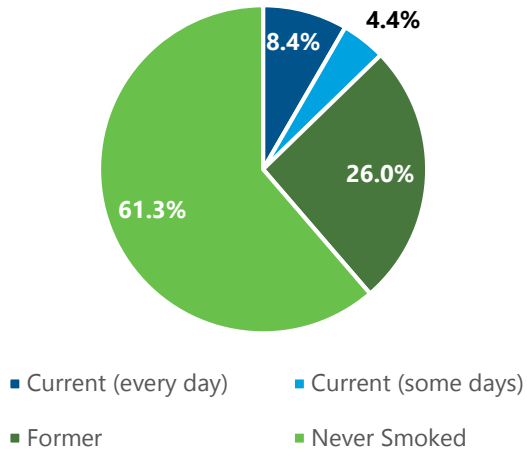


FIGURE 26: SMOKING STATUS, CT 2017



Other Tobacco Products

Although cigarette smoking in the United States has been steadily declining, use of alternative tobacco products has become more prevalent over the past several decades.[21] The health effects of non-cigarette tobacco use are often perceived as less harmful than traditional cigarettes, particularly in younger age groups. Yet nicotine exposure during adolescence may have long-lasting adverse effects on the developing adolescent brain.[17] In addition, nearly all first-time tobacco use, and much of the subsequent addiction, occurs during adolescence and young adulthood. The negative health risks associated with hookahs are well-established, and preliminary studies on e-cigarettes identify harmful effects as well.[22, 23] The BRFSS survey asks respondents to report their use of four types of tobacco products. Electronic cigarettes, commonly called e-cigarettes, contain cartridges of nicotine and other chemicals. The nicotine is vaporized and inhaled through a battery-powered device that resembles a traditional cigarette. Hookahs, also known as water pipes, deliver a small mixture of shredded tobacco (often flavored) through a mouthpiece attached to a rubber hose. Most cigars are composed primarily of a single type of tobacco (air-cured and fermented), and they have a tobacco wrapper.[24] The use of these alternative tobacco products among Connecticut adults in 2017 are shown in Figure 27, 29-30.

In 2017, one in six CT adults in 2017 had tried vapor, vape pen or e-cigarettes.

Compared to their counterparts in the state, the prevalence of **using vapor, vape pens, or e-cigarettes** was significantly greater for:

- Adults 18–34 years old (31.4%) and 35–54 years old (13.2%);
- Males (18.0%);
- Adults from households earning less than $35,000 (18.2%) and $35,000–$74,999 (17.4%);
- Adults with a disability (20.5%); and
- Adults with no more than a high school education (18.7%).

FIGURE 27: EVER TRIED VAPOR OR VAPE PEN OR E-CIGARETTES, CT 2017

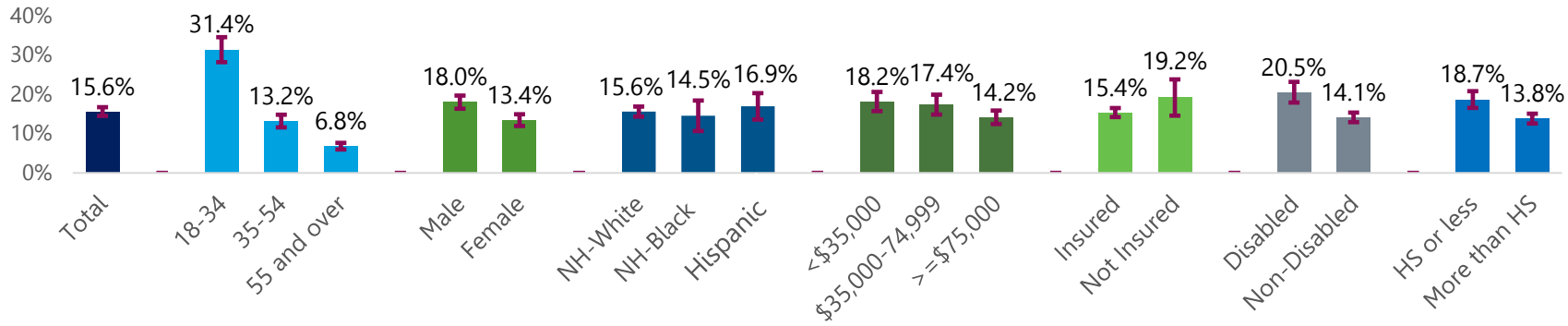
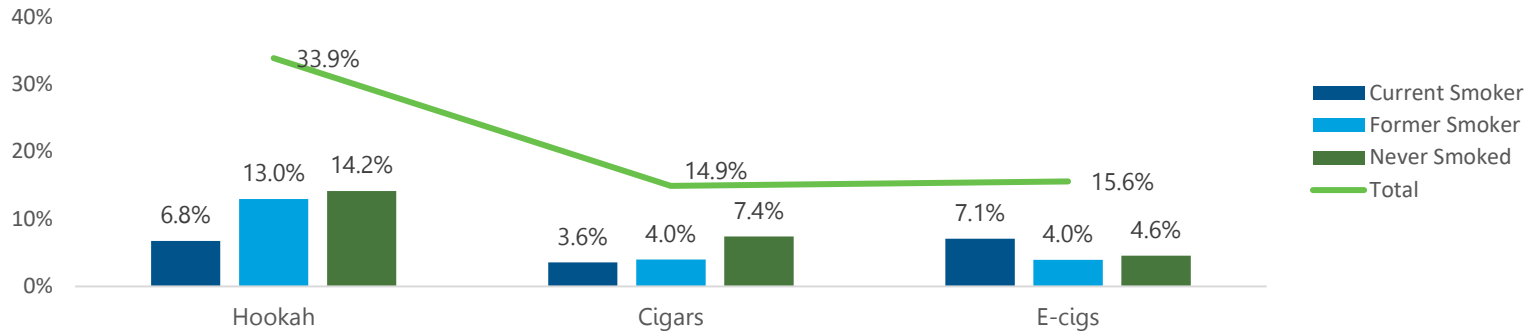


FIGURE 28: EVER TRIED E-CIGARETTES OR VAPING PRODUCTS, BY SMOKING (CIGARETTE) STATUS, CT 2017

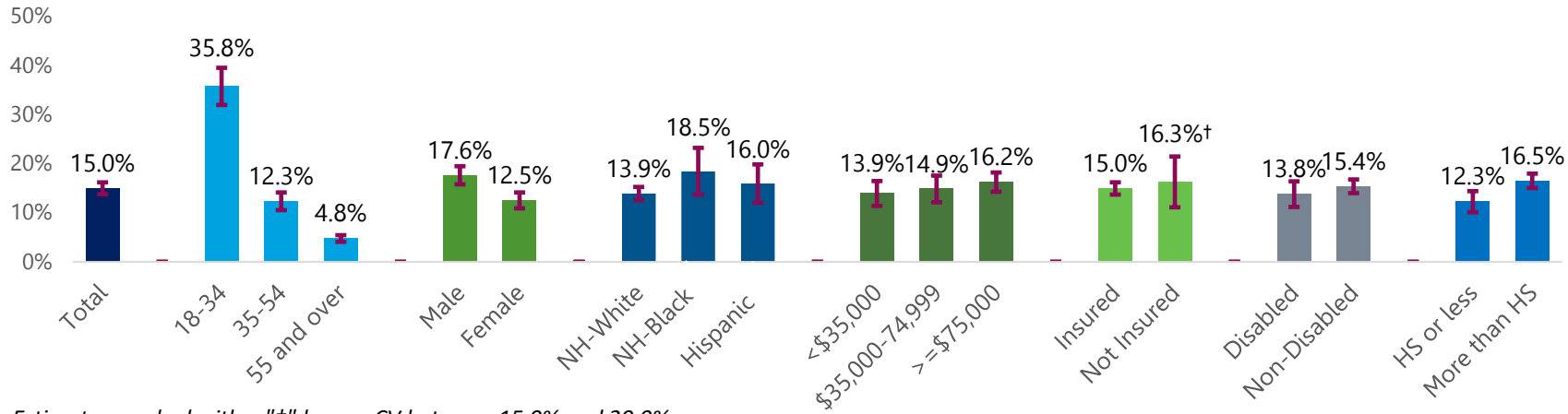


One in seven CT adults in 2017 had tried smoking hookah.

Compared to their counterparts in the state, the prevalence of **ever using hookah** was significantly greater for:

- Adults 18–34 years old (35.8%) and 35–54 years old (12.3%);
- Males (17.6%);
- Non-Hispanic Black (35.5%) and Hispanic (32%) adults; and
- Adults with more than a high school education (16.5%).

FIGURE 29: EVER TRIED SMOKING HOOKAH, CT 2017

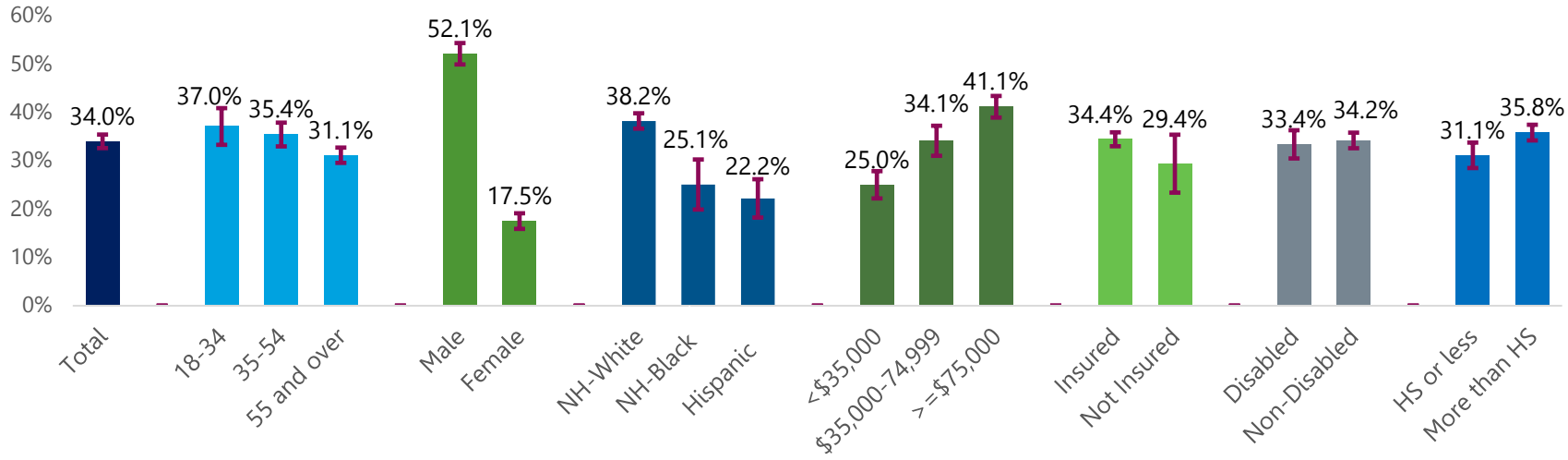


Estimates marked with a "†" have a CV between 15.0% and 20.0%.

One in three CT adults had tried smoking cigars, cigarillos, or flavored little cigars. Compared to their counterparts in the state, the risk of **ever using cigars, cigarillos, or flavored little cigars** was significantly greater for:

- Adults 18–34 years old (37.0%) and 35–54 years old (35.4%);
- Males (52.1%);
- Non-Hispanic White adults (38.2%);
- Adults from households earning at least $75,000 (41.1%) and $35,000–$74,999 (34.1%); and
- Adults with more than a high school education (35.8%).

FIGURE 30: EVER TRIED CIGARS, CIGARILLOS, OR FLAVORED LITTLE CIGARS, CT 2017



Alcohol Consumption

Excessive alcohol consumption, such as binge drinking or heavy drinking, is associated with numerous health problems, including chronic diseases, unintentional injuries, neurological impairments, and social problems.[25] A person binge drinks when they drink enough within a two-hour period that their blood alcohol concentration reaches 0.08 grams/deciliter. For men, this usually means consuming more than five drinks during one occasion. For women, it's more than four drinks.[26] Binge drinking is linked to a variety of health problems, such as liver disease, neurological damage, and alcohol poisoning, and can lead individuals to engage in risky and violent behaviors.[27] Heavy drinking is defined as consuming an average of more than two drinks per day for men, and more than one drink per day for women.[28] Excessive drinking is defined as either heavy drinking or binge drinking.

The BRFSS questionnaire ask respondents to report the number of days they consumed at least one drink of alcohol in the past 30 days, and for those who did drink, how many times they drank more than these thresholds.

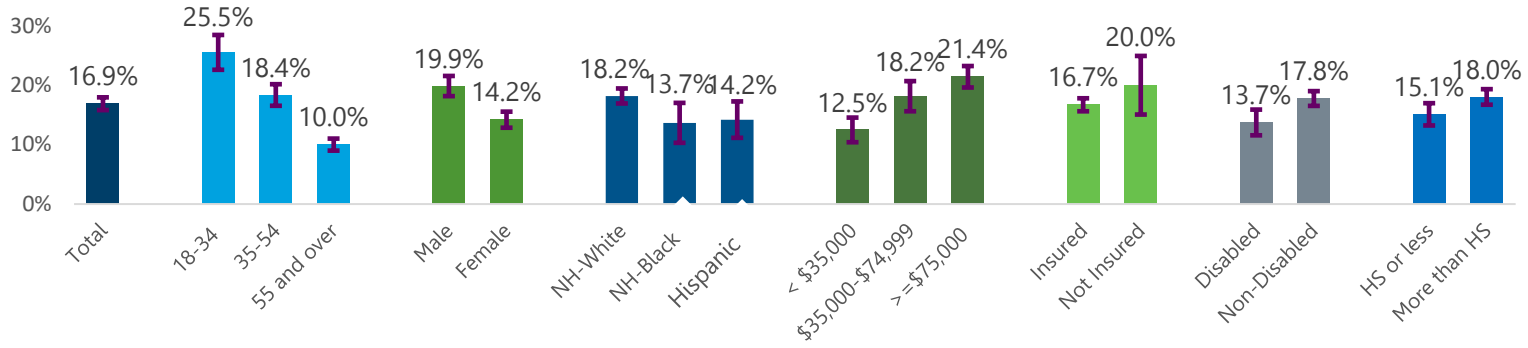
The prevalence of adults in 2017 who engaged in binge drinking, heavy drinking, or excessive drinking over the previous 30 days is shown below (Figure 31-33).

One in six CT adults report excessive alcohol consumption in 2017. Approximately one in six CT adults engaged in binge drinking, while one in 19 engaged in heavy drinking.

Compared to their counterparts in the state, the prevalence of **excessive alcohol consumption** was significantly greater for:

- Adults 18–34 years old (25.5%) and 35–54 years old (18.4%);
- Males (19.9%);
- Non-Hispanic White adults (18.2%);
- Adults from households earning at least $75,000 (21.4%) and $35,000–$74,999 (18.2%);
- Adults without a disability (17.8%); and
- Adults with more than a high school education (18.0%).

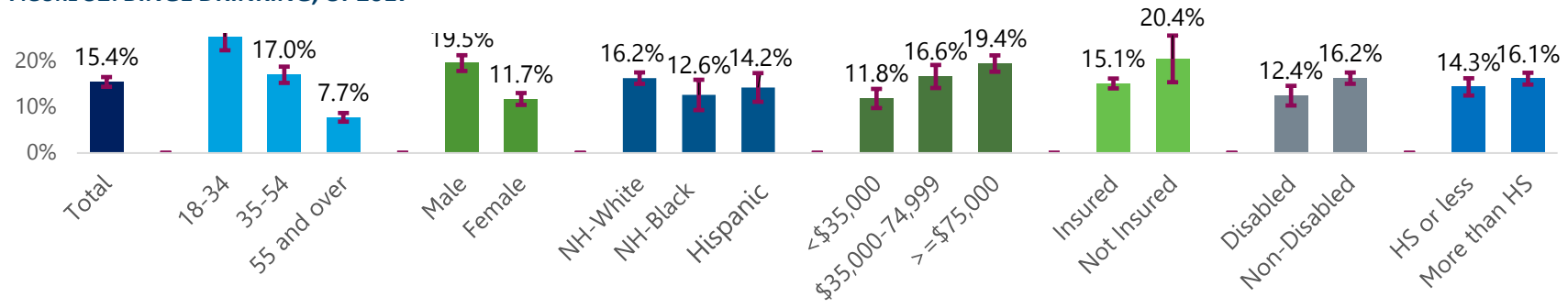
FIGURE 31: EXCESSIVE ALCOHOL CONSUMPTION, CT 2017



Compared to their counterparts in the state, the prevalence of **binge drinking** was significantly greater for:

- Adults 18–34 years old (25.2%) and 35–54 years old (17.0%);
- Males (19.5%);
- Adults from households earning at least $75,000 (19.4%) compared to less than $35,000 (11.8%);
- Adults without health insurance (20.4%); and
- Adults without a disability (16.2%).

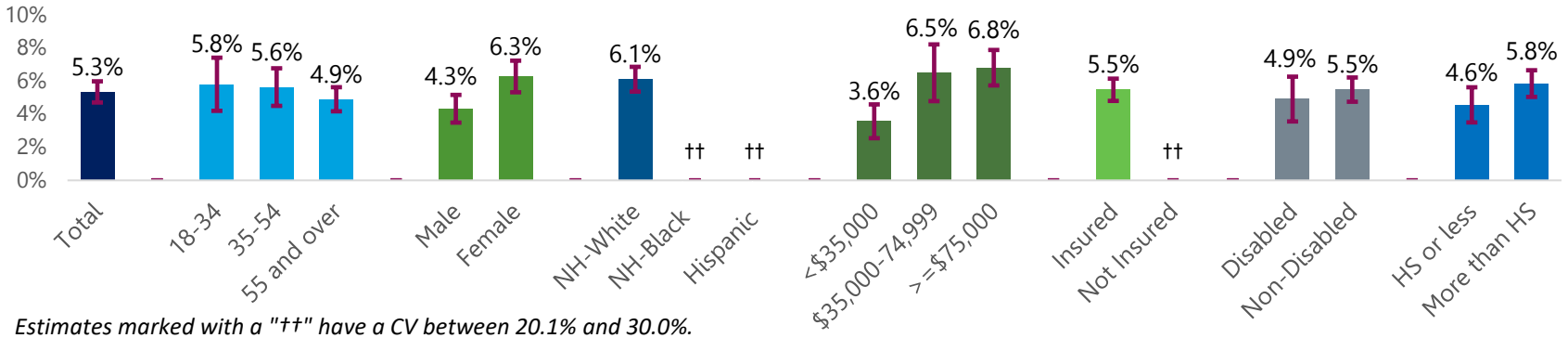
FIGURE 32: BINGE DRINKING, CT 2017



Compared to their counterparts in the state, the prevalence of **heavy drinking** was significantly greater for:

- Females (6.3%);
- Adults from households earning at least $75,000 (6.8%) and $35,000-$74,999 (6.5%).

FIGURE 33: HEAVY DRINKING, CT 2017



Estimates marked with a "††" have a CV between 20.1% and 30.0%.

5. Clinical Preventive Practices

Routine Check-Up

CDC stresses the importance of routine check-ups for disease prevention and screening.[29] Respondents in the BRFSS are asked how long it has been since they last visited a doctor for a routine check-up. The prevalence of adults in 2017 who had a check-up in the previous year is shown in Figure 34.

Three-fourths of Connecticut adults in 2017 had a routine check-up in the previous year.

Compared to their counterparts in the state, the prevalence of having a routine check-up within the past year was significantly greater for:

- Adults 55 years and older (85.5%) and adults 35–54 years old (70.5%);
- Females (77.2%);
- Non-Hispanic Black adults (85.6%);
- Adults from households earning less than $35,000 (77.5%);
- Adults with health insurance (76.5%);
- Adults with a disability (83.2%); and
- Adults with no more than a high school education (77.2%).

Figure 34: Routine Check-Up in the Past Year, CT 2017

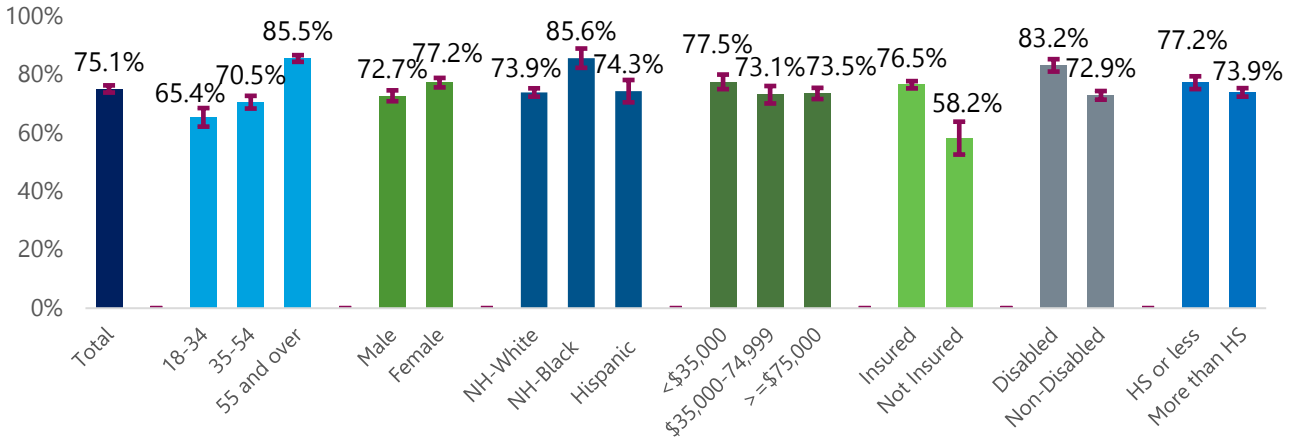
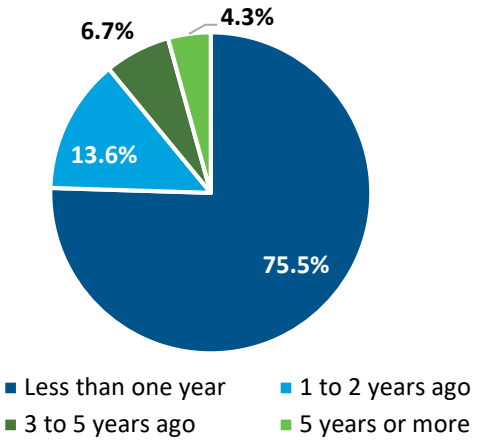


FIGURE 35: TIME SINCE LAST ROUTINE CHECK-UP, CT 2017



Cholesterol Screening

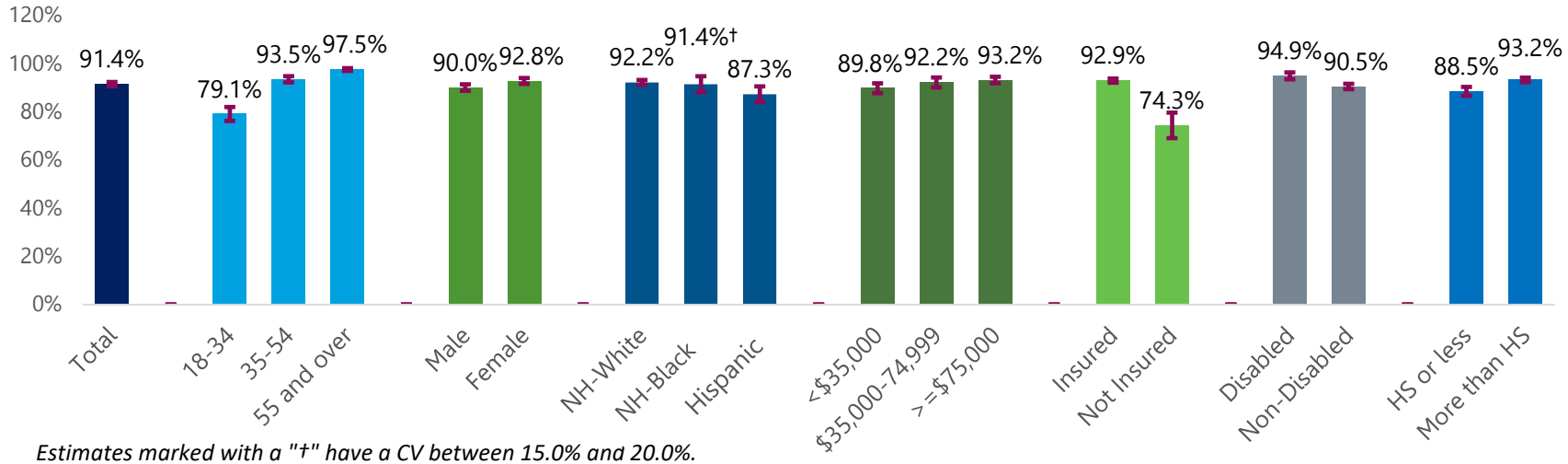
Cholesterol is a lipid that is produced in the liver and kidneys and ingested from food. Some cholesterol is necessary, but too much cholesterol can lead to clogging of the arteries. High cholesterol is one of the risk factors associated with heart attack, heart disease, and stroke.[30] Blood testing is the only way to determine how much cholesterol is in the body.[31] Patients are encouraged to talk to their primary care provider about cholesterol testing. The 2017 BRFSS asked respondents if they had ever had their cholesterol checked, and if their cholesterol was checked in the past five years (Figure 36).

Ninety-five percent of Connecticut adults in 2017 reported having had their blood cholesterol checked, while 91.4% of those had their blood cholesterol checked in the past five years.

Compared to their counterparts in the state, the prevalence of having **blood cholesterol checked in past 5 years** was significantly greater for:

- Adults 55 years and older (97.5%) and adults 35–54 years old (93.5%);
- Females (92.8%);
- Non-Hispanic White (92.2%) compared to Hispanic (87.3%) adults;
- Adults from households earning at least $75,000 (93.2%) compared to less than $35,000 (89.8%);
- Adults with health insurance (92.9%);
- Adults with a disability (94.9%); and
- Adults with more than a high school education (93.2%).

FIGURE 36: CHECKED BLOOD CHOLESTEROL IN PAST FIVE YEARS, CT 2017



Estimates marked with a "†" have a CV between 15.0% and 20.0%.

Adult Influenza

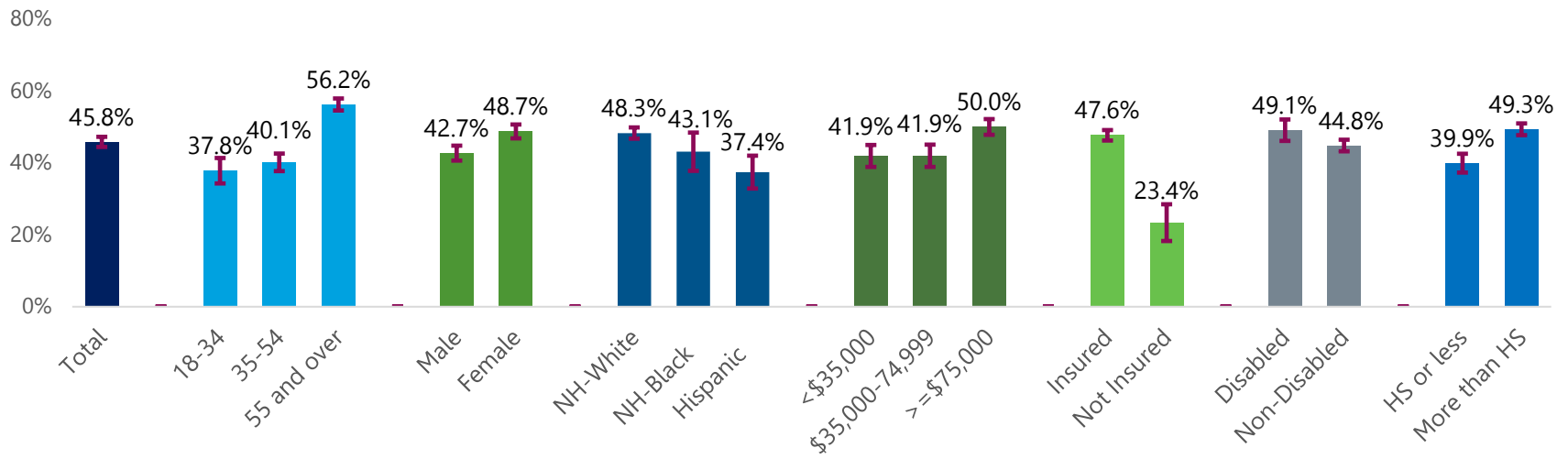
The influenza (flu) virus can cause serious infections, hospitalizations, and even death in some susceptible individuals. Seasonal flu vaccines are recommended for everyone over six months of age.[32] Respondents to the BRFSS were asked if they had received the seasonal flu vaccine, either as a shot or nasal spray mist. All respondents were asked if they had received the flu vaccine in the past 12 months. Results are shown in Figure 37.

In 2017, 45.8% of CT adults in 2017 had a flu vaccine within the past year.

Compared to their counterparts in the state, the prevalence of having an **influenza vaccination in the past year** among Connecticut adults was significantly greater for:

- Adults 55 years and older (56.2%);
- Females (48.7%);
- Non-Hispanic White (48.3%) compared to Hispanic (37.4%) adults;
- Adults from households earning at least $75,000 (50.0%);
- Adults with health insurance (47.6%);
- Adults with a disability (49.1%); and
- Adults with more than a high school education (49.3%).

FIGURE 37: FLU VACCINE IN THE PAST YEAR, CT 2017



Pneumococcal Vaccinations

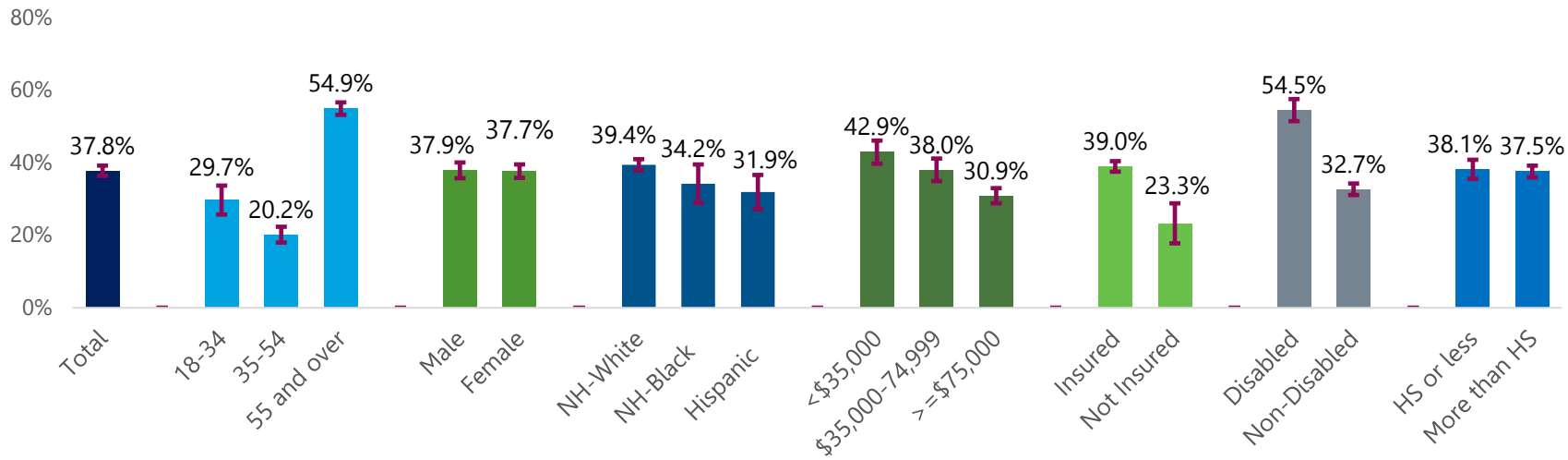
Pneumonia is a lung infection that can be caused by viruses, bacteria, or fungi. In the United States, pneumococcal disease causes 4 million illness, 445,000 hospitalizations, and 22,000 deaths annually.[33] Infection caused by some types of pneumococcal bacteria can be prevented by a pneumococcal or "pneumonia" vaccine.[34] Respondents to the BRFSS were asked if they have ever received the pneumococcal vaccine, which is recommended for children under five years old, adults over 65 years old, and adults at high risk for disease (HIV infection, organ transplantation, leukemia, and severe kidney disease). Results are shown in Figure 38.

In 2017, thirty-eight percent of CT adults reported that they ever had pneumococcal vaccination.

Compared to their counterparts in the state, the prevalence of ever having a **pneumococcal vaccination** among Connecticut adults was significantly greater for:

- Adults 55 and over (54.9%) and 18-34 years old (29.7%);
- Non-Hispanic White (39.4%) compared to Hispanic (31.9%) adults;
- Adults from households earning less than $35,000 (42.9%) compared to at least $75,000 (30.9%);
- Adults with health insurance (39.0%); and
- Adults with a disability (54.5%).

FIGURE 38: EVER HAD PNEUMOCOCCAL VACCINATION, CT 2017



Human Immunodeficiency Virus (HIV) Screening

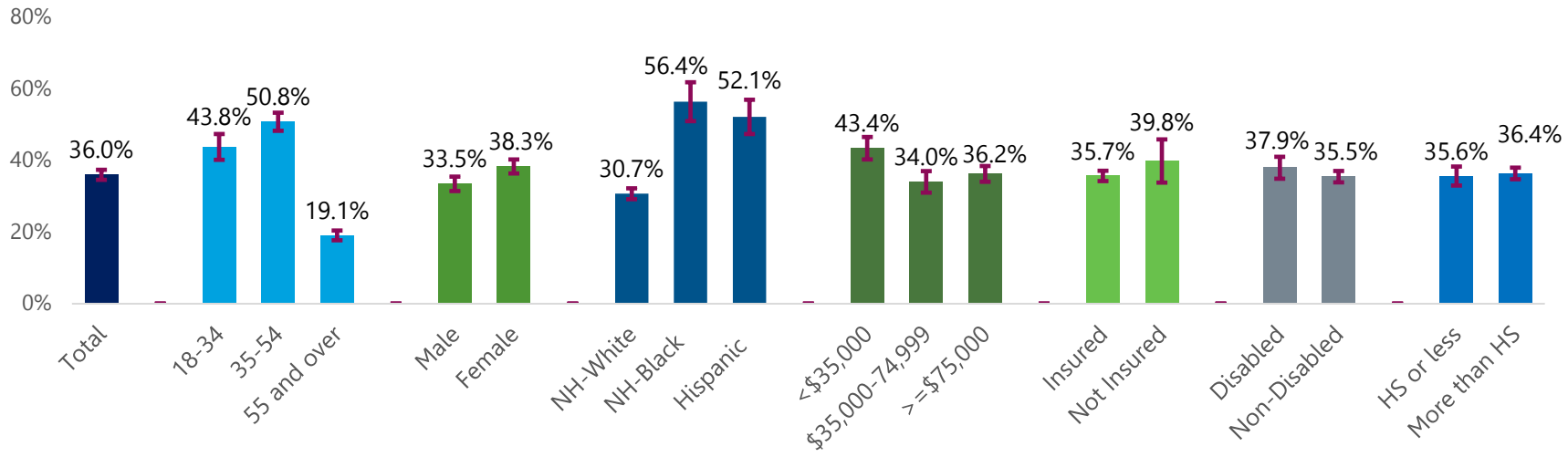
Over one million Americans are living with the human immunodeficiency virus (HIV), and of these, about one in six are not aware they are infected. The group most affected by HIV is men who have sex with men, although heterosexuals and drug users can also be affected. African Americans and Hispanics are over-represented in new HIV infections.[35] Individuals can be tested for the virus by testing blood or oral fluid. Respondents to the CT BRFSS were asked if they have ever been tested for HIV, not including testing while donating blood. Results are shown in Figure 39.

More than one-third of Connecticut adults in 2017 reported having been tested for HIV.

Compared with their counterparts in the state, the prevalence of being **tested for HIV** was significantly greater for:

- Adults 35–54 years old (50.8%) and adults 18–34 years old (43.8%);
- Females (38.3%);
- Non-Hispanic Black (56.4%) and Hispanic adults (52.1%); and
- Adults from households earning less than $35,000 (43.4%).

FIGURE 39: EVER TESTED FOR HIV, CT 2017



Adult TDAP Vaccination

The Adult Tdap vaccine immunizes against tetanus, diphtheria, and pertussis, three bacterial diseases that were once common in the United States. Tetanus enters the body through cuts and scratches that have come into contact with the bacteria, usually through dirt or soil. Diphtheria and pertussis are spread by respiratory droplets, such as coughing and sneezing.[36] Vaccines have been instrumental in decreasing the incidence of these diseases.[37]
In 2005, the Advisory Committee on Immunization Practices recommended the use of a new vaccine, Tdap, that immunizes against all three diseases, rather than just tetanus and diphtheria (Td). They also recommended that adults between the ages of 19 and 64 receive one shot of Tdap instead of a booster dose of Td.[38]
The 2017 BRFSS asked respondents whether they had received a tetanus vaccination since 2005.

In 2017, fifty-nine percent of CT adults reported they had received the Tdap vaccine.

Compared with their counterparts in the state, the prevalence of having a **tetanus shot since 2005** was significantly greater for:

- Adults 18–34 years old (66.3%) and adults 35–54 years old (59.4%);
- Non-Hispanic White adults (62.3%);
- Adults from households earning at least $75,000 (65.7%) and $35,000–$74,999 (59.3%);
- Adults with health insurance (59.8%); and
- Adults with more than a high school education (63.9%).

FIGURE 40: TETANUS VACCINATION, CT 2017

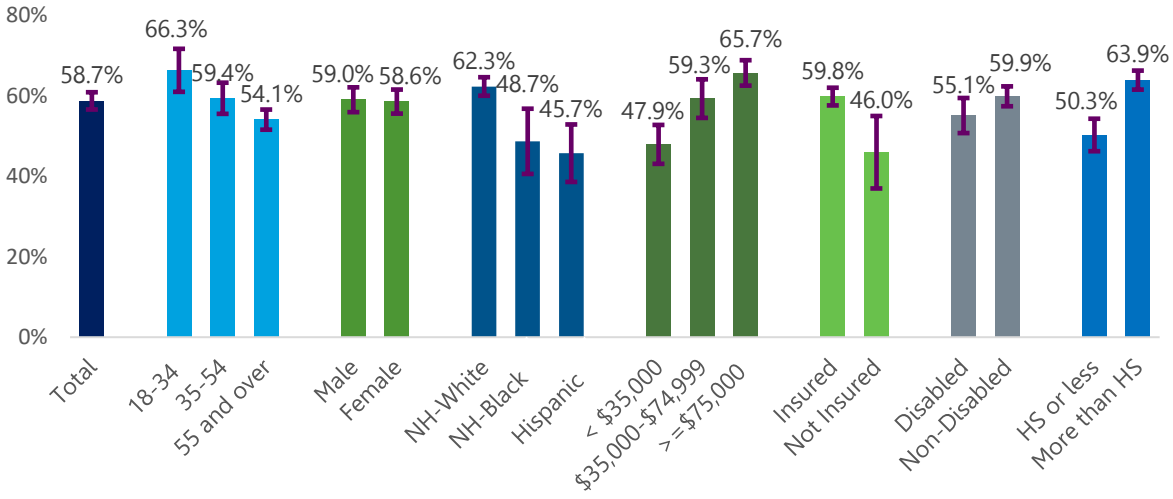
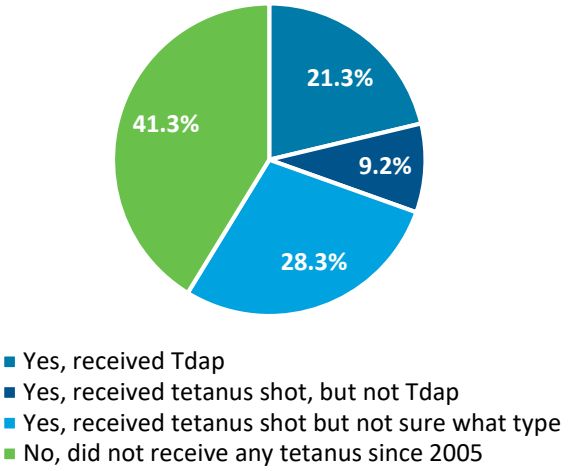


FIGURE 41: TDAP AND TETANUS VACCINATIONS AMONG ADULTS, CT 2017



6. Chronic Conditions

Asthma

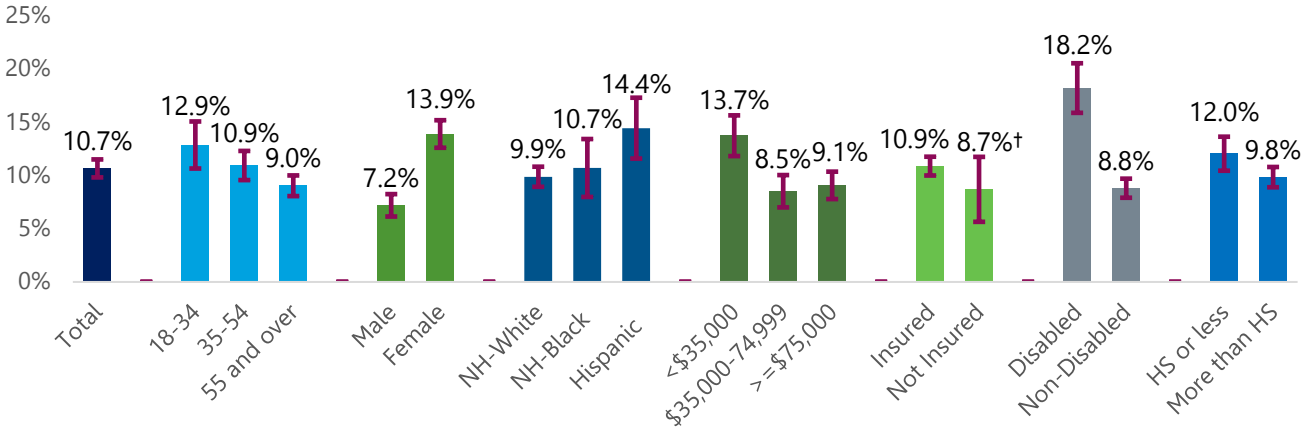
Asthma is a chronic lung disease that causes the airways to become inflamed or swollen. Symptoms of asthma include shortness of breath, coughing, and wheezing.[39] Four thousand people die in the United States each year due to asthma-related causes. These deaths are preventable with proper treatment.[40] Overall, asthma rates have been increasing in adults in the United States.[41] Respondents were asked if, among those who indicated a doctor or health professional had ever told them they had asthma, whether they still had asthma. Results in 2017 are shown in Figure 42.

One in ten Connecticut adults (10.7%) reported having current asthma in 2017.

Compared to their counterparts in the state, the risk of having **current asthma** was significantly greater for:

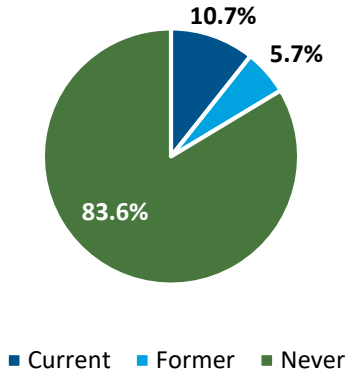
- Adults 18–34 years old (12.9%) and adults 35–54 years old (10.9%);
- Females (13.9%);
- Hispanic adults (14.4%) compared to non-Hispanic White adults (9.9%);
- Adults from households earning less than $35,000 (13.7%);
- Adults with a disability (18.2%); and
- Adults with no more than a high school education (12.0%).

Figure 42: Adult Current Asthma, CT 2017



Estimates marked with a "†" have a CV between 15.0% and 20.0%.

Figure 43: Adult Asthma Status, CT



Chronic Obstructive Pulmonary Disease

Chronic obstructive pulmonary disease (COPD) is a lung disease that includes two main conditions: emphysema and chronic bronchitis. The term COPD is used because most sufferers have many conditions. COPD is characterized by damage to the lungs and airways, which causes less air to flow into the lungs. Symptoms include heavy coughing, wheezing, and shortness of breath. Cigarette smoking is the primary cause of COPD, although other lung irritants such as air pollution, chemical fumes, and dust may also contribute.[42] Genetic factors may also contribute to COPD.

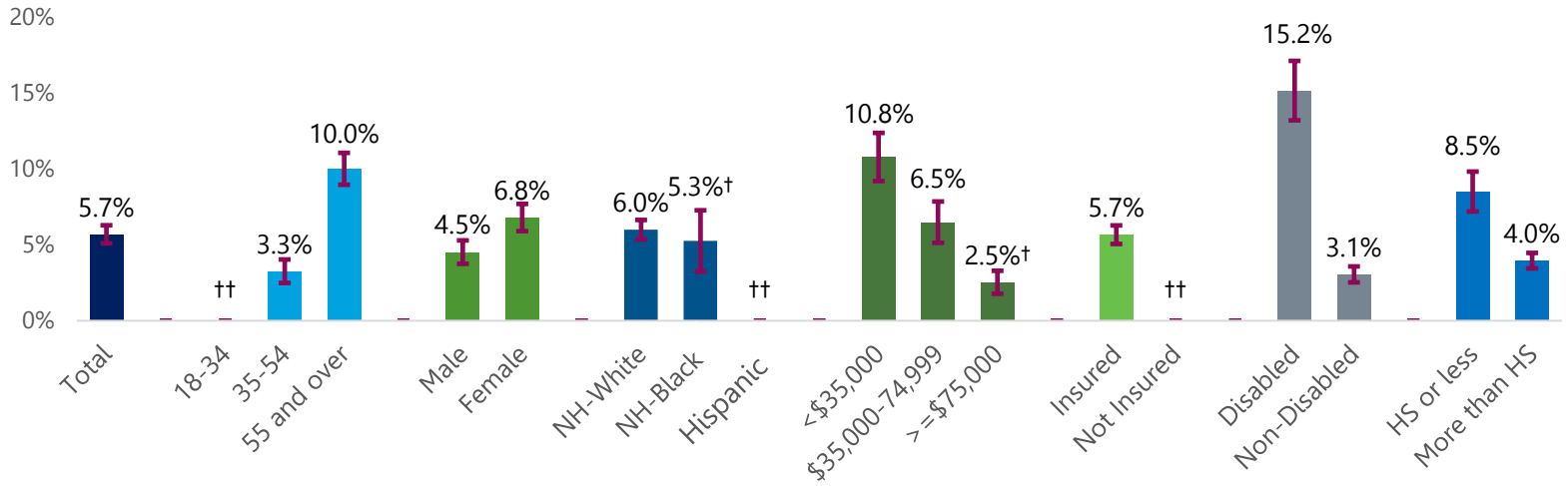
Respondents to the BRFSS were asked if they were ever told they had COPD, emphysema, or chronic bronchitis, and results in 2017 are shown in Figure 44.

In 2017, six percent CT adults reported they had COPD.

Compared to their counterparts in the state, the prevalence of **COPD** was significantly greater for:

- Adults 55 years and older (10.0%) compared to adults 35-54 years old (3.3%);
- Females (6.8%);
- Adults from households earning less than $35,000 (10.8%) compared to $35,000–$74,999 (6.5%);
- Adults with a disability (15.2%); and
- Adults with no more than a high school education (8.5%).

FIGURE 44: CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CT 2017



Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%.

Arthritis

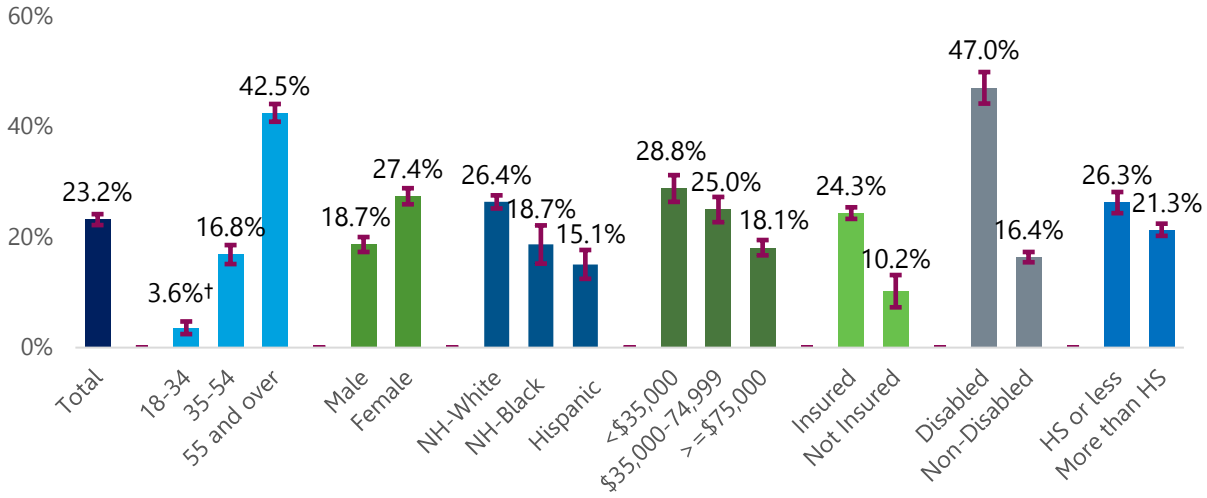
Arthritis covers over 100 rheumatic conditions that affect the joints and connective tissues. It is the most common cause of disability in the United States, and it affects one in five American adults. Arthritis is more common among women, and the risk of developing arthritis symptoms increases with age. In addition, there is some evidence that having arthritis can increase the risk of falls and associated injuries.

One in four Connecticut adults in 2017 had been diagnosed with arthritis.

Compared to their counterparts in the state, the prevalence of arthritis was significantly greater for:

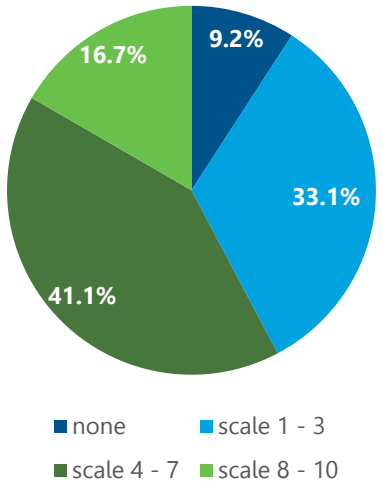
- Adults 55 years and older (42.5%) compared to adults 35–54 years old (16.8%);
- Females (27.4%);
- Non-Hispanic White adults (26.4%);
- Adults from households earning less than $35,000 (28.8%) and $35,000–$74,999 (25.0%);
- Adults with health insurance (24.3%);
- Adults with a disability (47.0%); and
- Adults with no more than a high school education (26.3%).

FIGURE 45: ARTHRITIS, CT 2017



Estimates marked with a "†" have a CV between 15.0% and 20.0%.

FIGURE 46: ARTHRITIS PAIN LEVEL, CT 2017



Arthritis Burden

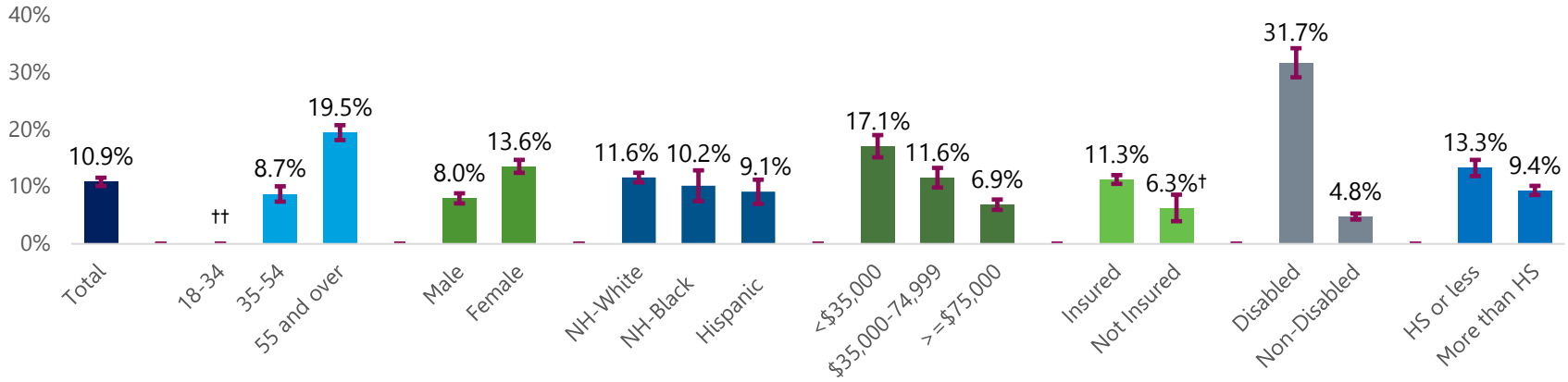
Adults with arthritis commonly experience functional limitations in carrying out daily activities. The most common limitations include problems stooping, bending, kneeling, standing for more than two hours, walking for more than one-fourth of a mile, pushing a heavy object, and climbing a flight of stairs. Arthritis-related work limitations affect at least one in every 25 working-age adults in every U.S. state, and arthritis-attributable limitations are highest among obese adults.[43] In 2015, a series of questions asked respondents who reported an arthritis diagnosis if they were limited in any way in any of their usual activities because of arthritis or joint symptoms. These respondents were also asked whether arthritis affected their work and their social activities, including going shopping, going to the movies, or attending religious or social gatherings. The results of adults in 2017 who reported that arthritis impacted their daily life are shown in Figures 47-49.

One in ten CT adults in 2017 reported that arthritis limited their daily activities because of arthritis of joint symptoms while one in 24 reported arthritis limited their social activities "a lot" and one in 15 reported arthritis limited their work.

Compared to their counterparts in the state, the prevalence of arthritis with **limited usual activities in some way** was significantly greater for:

- Adults 55 years old and over (19.5%) compared to 35-54 years old (8.7%);
- Females (13.6%);
- Adults from households earning less than $35,000 (17.1%) and $35,000–$74,999 (11.6%);
- Adults with a disability (31.7%); and
- Adults with no more than a high school education (13.3%).

FIGURE 47: ARTHRITIS LIMITED DAILY LIFE, CT 2017

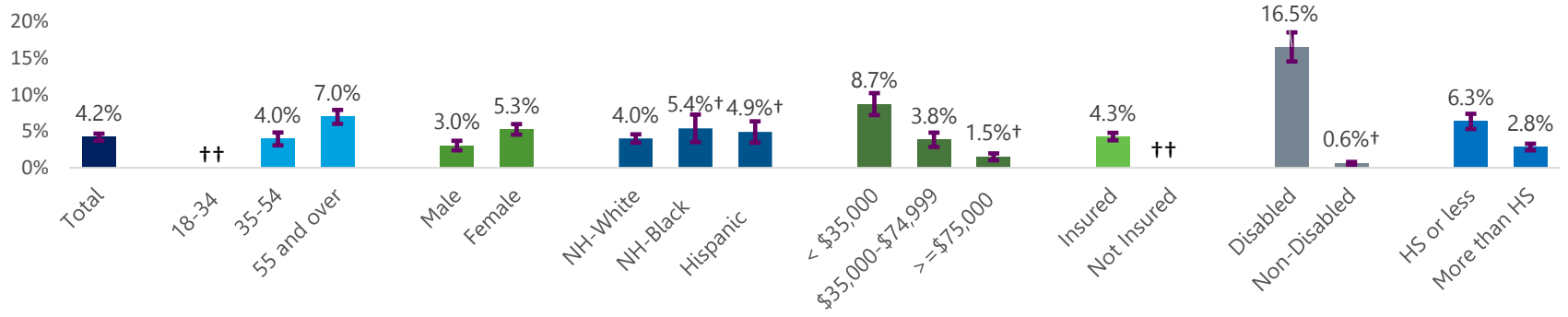


Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%.

Compared to their counterparts in the state, the prevalence of arthritis that **limited social activities "a lot"** was significantly greater for:

- Adults 55 and over (7.0%) compared to adults 35-54 (4.0%) years old;
- Females (5.3%);
- Adults from households earning less than $35,000 (8.7%) compared to $35,000-74,999 (3.8%); and
- Adults with no more than a high school education (6.3%).

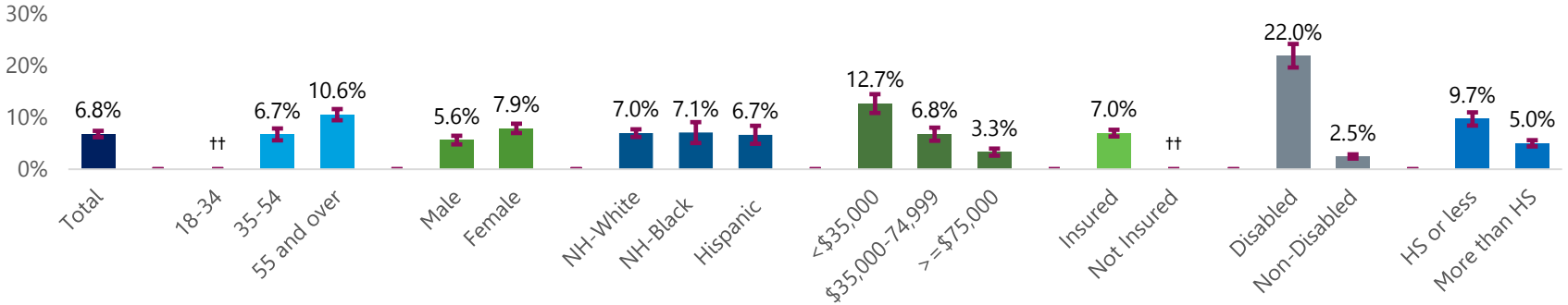
FIGURE 48: ARTHRITIS OFTEN LIMITED SOCIAL ACTIVITIES, CT 2017



Compared to their counterparts in the state, the prevalence of arthritis that **limited work** was significantly greater for:

- Adults 55 years old and over (10.6%) compared to adults 35-54 (6.7%) years old;
- Females (7.9%);
- Adults from households earning less than $35,000 (12.7%) and $35,000–$74,999 (6.8%);
- Adults with a disability (22.0%); and
- Adults with no more than a high school education (9.7%).

FIGURE 49: ARTHRITIS LIMITED WORK ACTIVITIES, CT 2017



Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%; estimates with CV greater than 30.0% were suppressed.

Cardiovascular Disease and Stroke

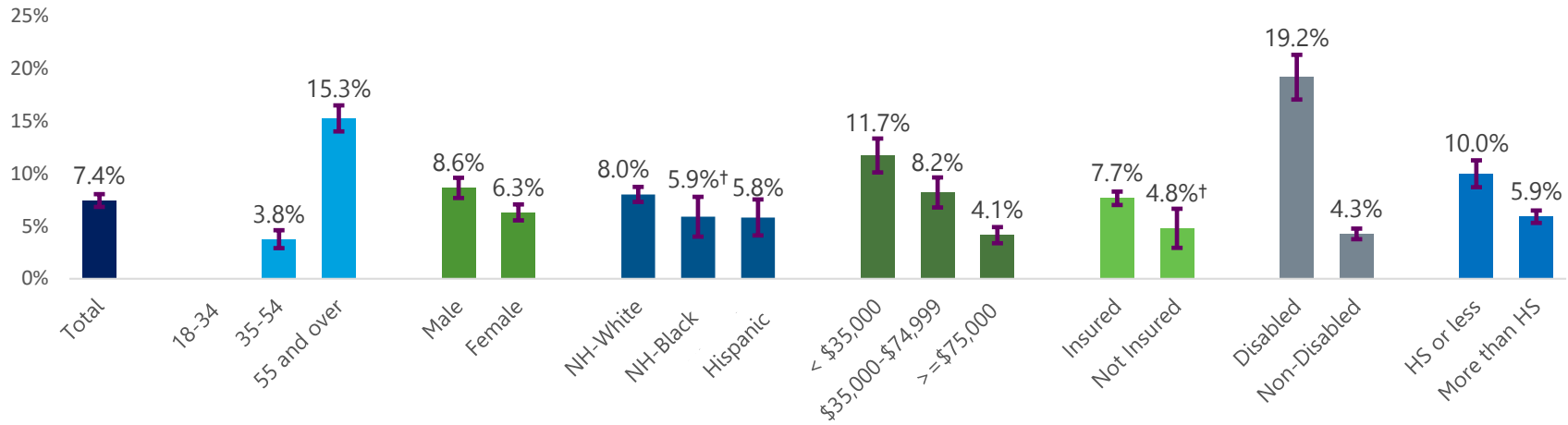
Cardiovascular disease (CVD) encompasses several heart conditions. It is the leading cause of death in the United States. The most common type of heart disease is coronary heart disease.[44] Adults who suffer from coronary heart disease have plaque build-up in their coronary arteries, which reduces the flow of oxygen to the heart. This can lead to angina, characterized by chest pain or pressure, as well as heart attacks.[45] Cardiovascular disease and stroke can be prevented by remaining physically active and eating a healthy and well-balanced diet and managing risk factors such as high blood pressure and cholesterol.[46] Respondents are asked if they were ever told they had any of the following: a heart attack, also called a myocardial infarction; angina or coronary heart disease; or a stroke, a disease caused by a blocked blood vessel or bleeding in the brain. Results in 2017 for those who responded to all three questions were combined and are presented in Figure 50.

In 2017, seven percent of CT adults reported they had cardiovascular disease.

Compared with their counterparts in the state, the risk of **cardiovascular disease** was significantly greater for:

- Adults 55 years and older (15.3%);
- Males (8.6%);
- Adults from households earning less than $35,000 (11.7%) and $35,000–$74,999 (8.2%);
- Adults with a disability (19.2%); and
- Adults with no more than a high school education (10.0%).

FIGURE 50: CARDIOVASCULAR DISEASE, CT 2017



Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates with CV greater than 30.0% were suppressed.

Pre-Diabetes

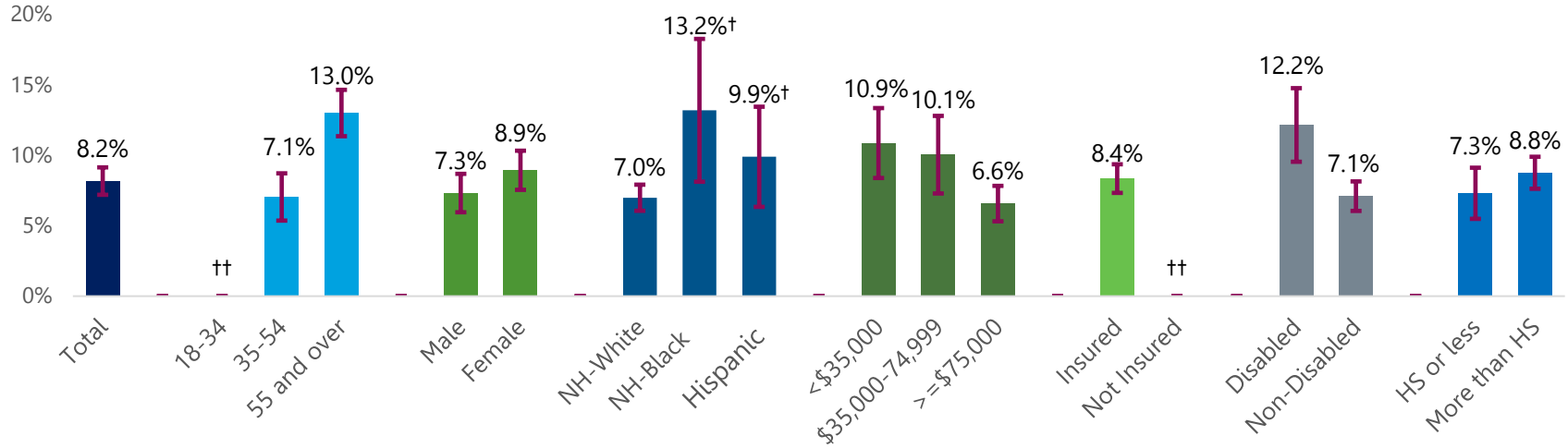
Pre-diabetes refers to blood sugar levels that are higher than normal but not high enough to be diagnosed with diabetes. The American Diabetes Association (ADA) recommends that testing to detect pre-diabetes be considered in adults who are overweight or obese and have one or more additional risk factors for diabetes.[47] Respondents to the BRFSS were asked if they had ever been told they had pre-diabetes or borderline diabetes. Women with pre-diabetes only during pregnancy are not considered to have had pre-diabetes. Results are shown in Figure 51.

In 2017, one in 12 Connecticut adults reported that they had been diagnosed with pre-diabetes.

Compared with their counterparts in the state, the prevalence of **pre-diabetes** among Connecticut adults was significantly greater for:

- Adults 55 years and older (13.0%) compared to adults 35-54 years old (7.1%);
- Adults from households earning less than $35,000 (10.9%) compared to $75,000 or more (6.6%); and
- Adults with a disability (12.2%).

FIGURE 51: PRE-DIABETES, CT 2017



Estimates marked with a "†" have a CV betwen 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%.

Diabetes

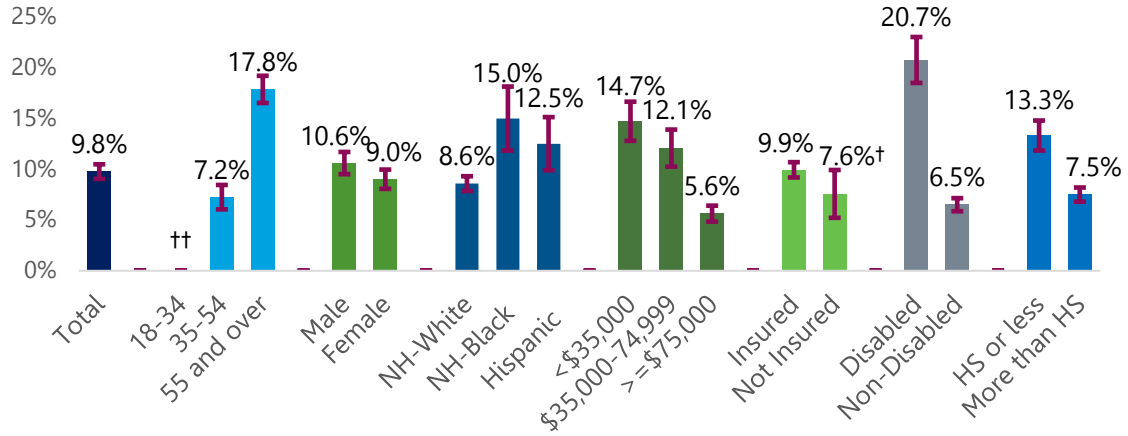
Diabetes is a disease characterized by high levels of blood sugar. It can lead to serious health problems, such as heart disease, stroke, blindness and lower-extremity amputation.[48] Diabetes affects over 29 million people in the U.S. Those over 60 years of age, African Americans and Hispanics, and groups of low socioeconomic status are at higher risk for diabetes.[49] Respondents to the BRFSS were asked if they have ever been told they have diabetes. Women with diabetes only during pregnancy are not classified as having diabetes. Results in 2017 are shown in Figure 52.

One in 10 Connecticut adults reported in 2017 that they had ever been diagnosed with diabetes.

Compared with their counterparts in the state, the prevalence of **diabetes** among adults in Connecticut was significantly greater for:

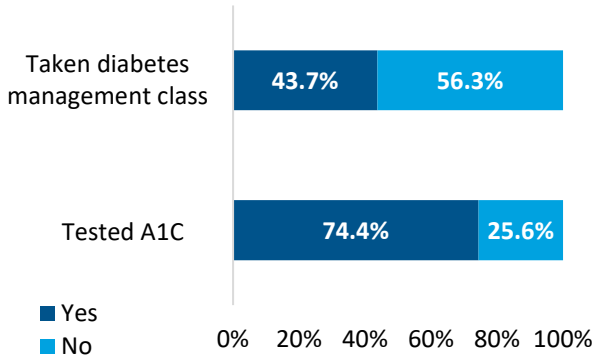
- Adults 55 or over (17.8%) compared to adults 35–54 years old (7.2%);
- Non-Hispanic Black (15.0%) and Hispanic (12.5) adults;
- Adults from households earning less than $35,000 (14.7%) and $35,000-$74,999 (12.1%);
- Adults with a disability (20.7%); and
- Adults with no more than a high school education (13.3%).

FIGURE 52: DIABETES, CT 2017



Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%.

FIGURE 53: DIABETES MANAGEMENT: TESTED A1C (>=2 TIMES), TAKEN DIABETES MANAGMENT CLASS



Cholesterol Awareness

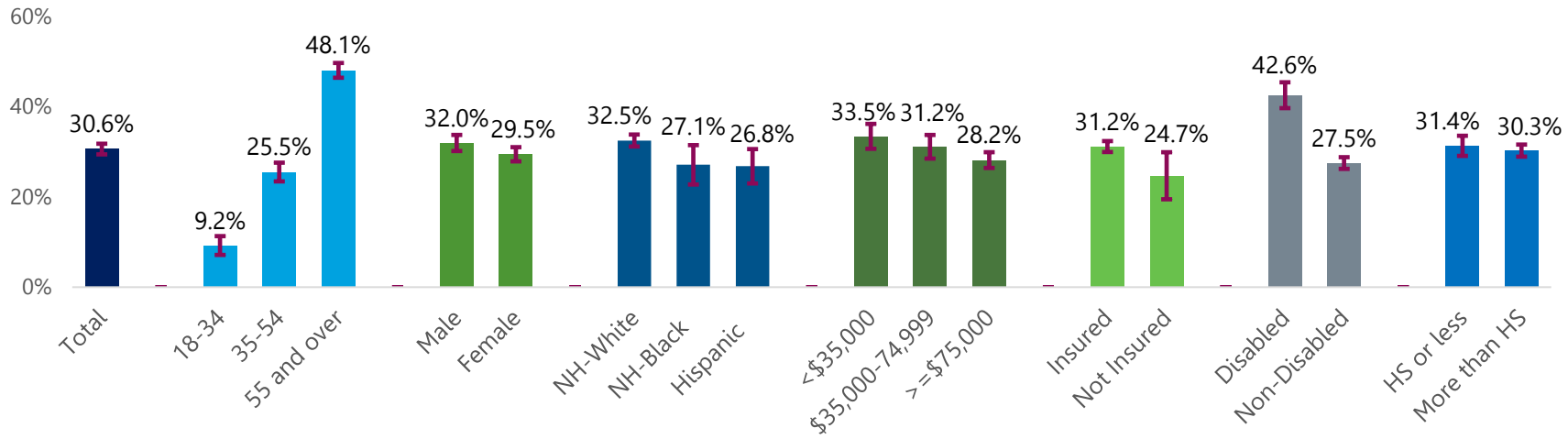
It is estimated that more than 73 million American adults suffer from high cholesterol, but less than one in three of these adults has their high cholesterol under control.[50] People with high cholesterol have twice the risk of heart disease as people with lower levels of cholesterol.[51] Cholesterol can be controlled by making lifestyle and dietary changes. Depending on overall risk of cardiovascular disease, medication may be necessary.[52] The 2017 BRFSS asked respondents if they had ever been told they had high blood cholesterol levels. Results in 2017 are shown by demographics in Figure 54.

One in three Connecticut adults in 2017 had ever been told their blood cholesterol was high.

Compared to their counterparts in the state, the risk of ever having **high blood cholesterol** among adults in Connecticut was significantly greater for:

- Adults 55 years and older (48.1%) and adults 35-54 years old (25.5%);
- Non-Hispanic White adults (32.5%);
- Adults from household earning less than $35,000 (33.5%) and $35,000-$74,999 (31.2%);
- Adults with health insurance (31.2%); and
- Adults with a disability (42.6%).

FIGURE 54: EVER TOLD BLOOD CHOLESTEROL WAS HIGH, CT 2017



Hypertension Awareness

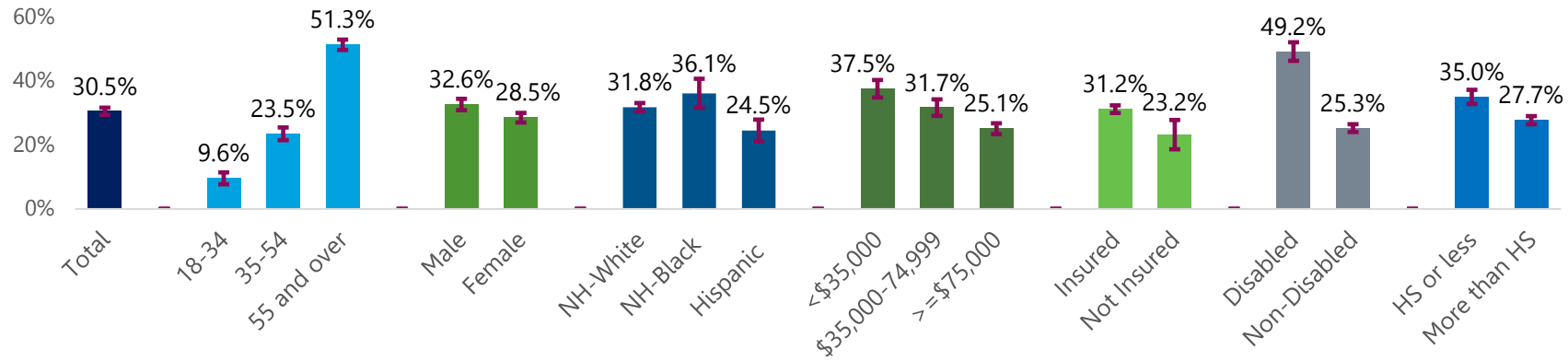
Hypertension is the medical term for high blood pressure, a condition that impacts one in three adults in America (approximately 70 million people). It estimated that only 50% of these adults have their high blood pressure under control.[53] Medication and lifestyle changes are often enough to control high blood pressure, but if it is not controlled, it can result in heart problems, kidney disease, and stroke.[54] Consuming more than the recommended amount of sodium, smoking, drinking too much alcohol, and family history of high blood pressure can all contribute to the development of high blood pressure. African Americans are more likely to develop high blood pressure than other groups.[52] Hypertension can be prevented by eating a healthy diet low in sodium and high in fruits and vegetables, being active, and not smoking.[55] BRFSS respondents were asked if they had ever been told they had high blood pressure and, among those with diagnosed hypertension, whether they were currently taking medication for the condition. Results in 2017 are shown in Figures 55-56.

One in three Connecticut adults in 2017 have been diagnosed with hypertension, while three in four were taking medicine for their high blood pressure among those diagnosed with hypertension.

Compared to their counterparts in the state, the risk of **ever having high blood pressure** among adults in Connecticut was significantly greater for:

- Adults 55 years and older (51.3%) and adults 35–54 years old (23.5%);
- Males (32.6%);
- Non-Hispanic Black (36.1%) and non-Hispanic White (31.8%) adults;
- Adults from households earning less than $35,000 (37.5%) and $35,000–$74,999 (31.7%);
- Adults with health insurance (31.2%);
- Adults with a disability (49.2%); and
- Adults with no more than a high school education (35.0%).

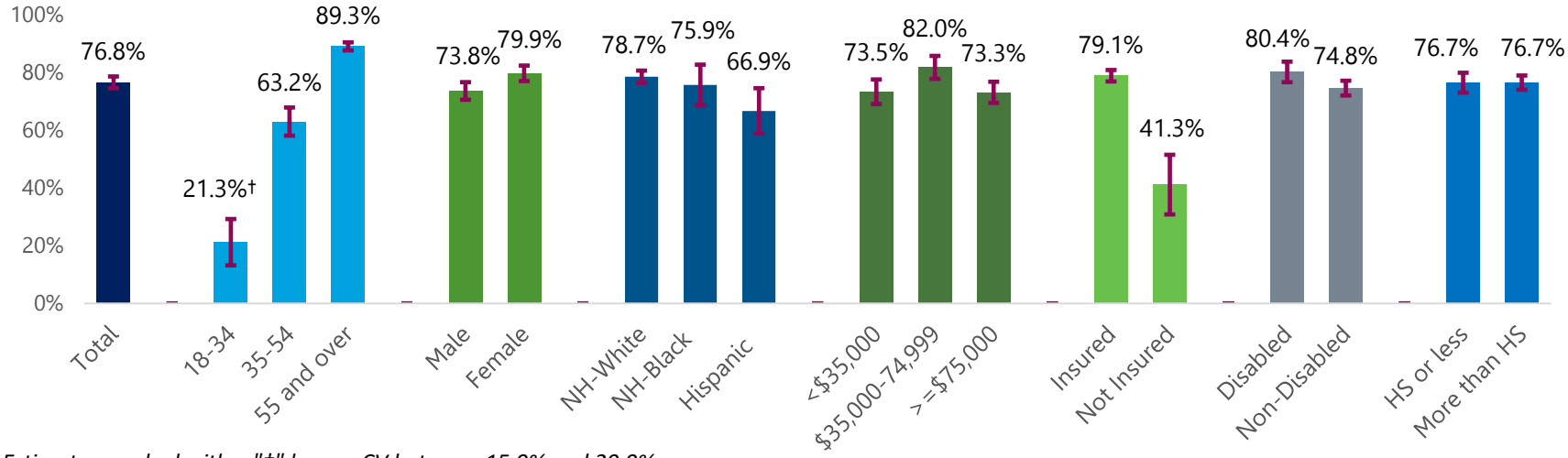
FIGURE 55: EVER TOLD HAD HIGH BLOOD PRESSURE, CT 2017



Compared to their counterparts in the state, the prevalence of **taking medicine for high blood pressure** among adults diagnosed with hypertension was significantly greater for:

- Adults 55 years and older (89.3%) compared to adults 35–54 years old (63.2%);
- Females (79.9%);
- Non-Hispanic Whites (78.7%) compared to Hispanic adults (66.9%);
- Adults from households earning $35,000–$74,999 (82.0%);
- Adults with health insurance (79.1%); and
- Adults with a disability (80.4%).

FIGURE 56: CURRENTLY TAKING MEDICINE FOR HIGH BLOOD PRESSURE, CT 2017



Estimates marked with a "†" have a CV between 15.0% and 20.0%.

Kidney Disease

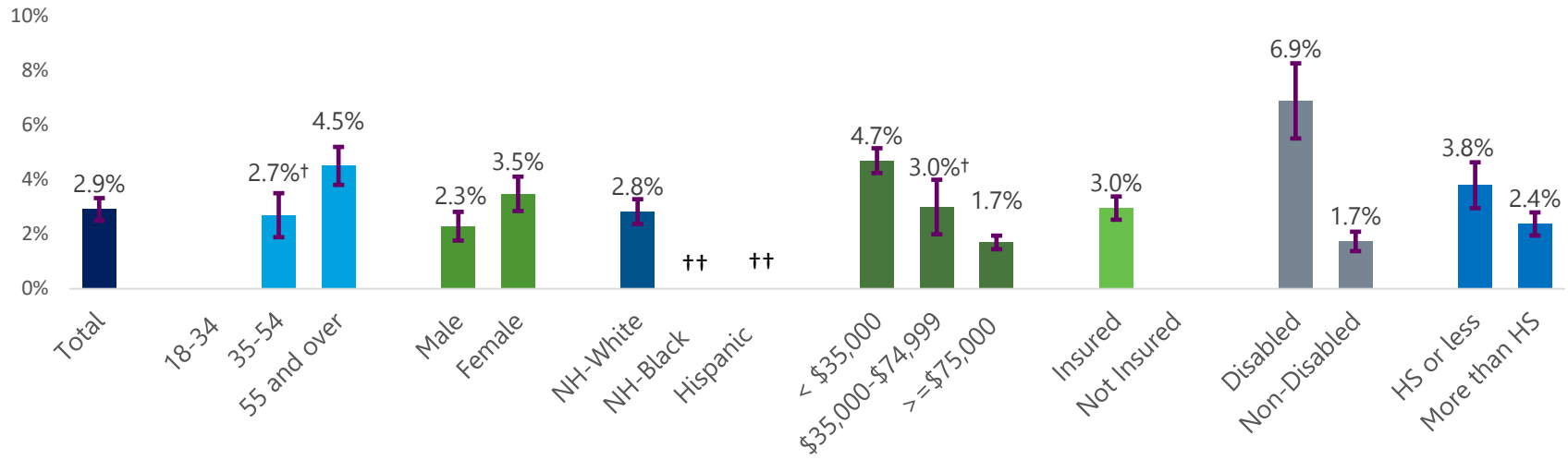
Chronic kidney disease is a condition in which the kidneys cannot filter blood as well as they should, and waste is not properly filtered. A person with kidney disease is more likely to develop heart disease and other health problems. Adults with diabetes or high blood pressure are at higher risk of developing chronic kidney disease.[56] Chronic kidney disease can be detected early with blood tests. If it is detected, medication can reduce the damage to the kidneys by 50%. Kidney disease often runs in families, and family medical history can often identify people at risk for chronic kidney disease.[57] Respondents are asked if they were ever told they had kidney disease. Results in 2017 are shown in Figure 57.

One in 35 Connecticut adults in 2017 had been diagnosed with kidney disease.

Compared to their counterparts in the state, the risk of **kidney disease** among adults in Connecticut was significantly greater for:

- Females (3.5%);
- Adults from households earning less than $35,000 (4.7%) compared to $75,000 or more (1.7%);
- Adults with a disability (6.9%); and
- Adults with no more than a high school education (3.8%).

FIGURE 57: KIDNEY DISEASE, CT 2017



Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%; estimates with CV greater than 30.0% were suppressed.

Depression

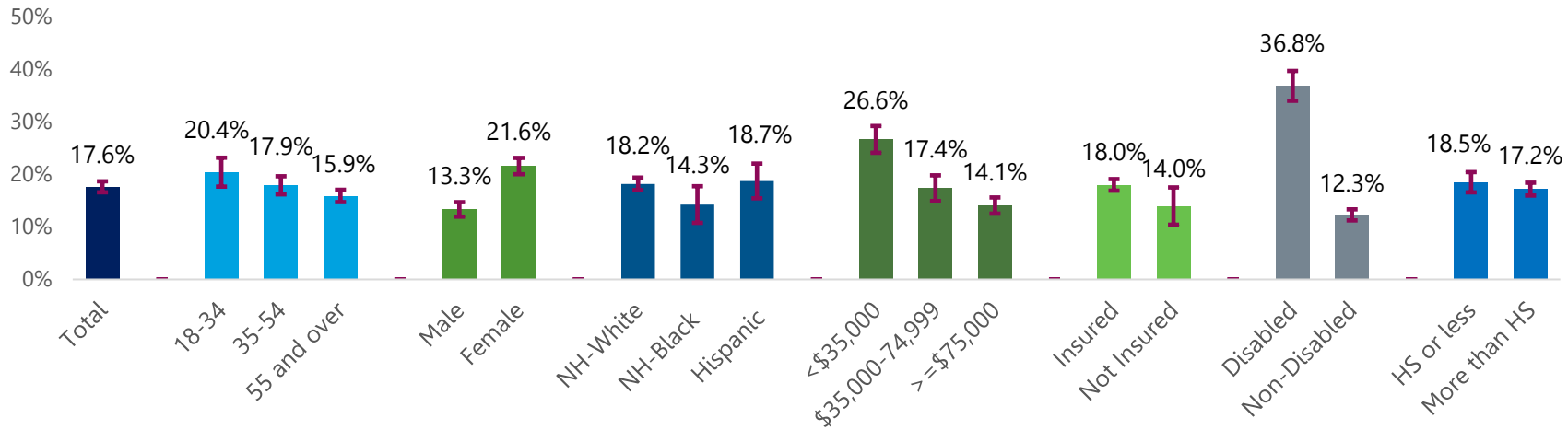
Depression is a common and serious illness that can take several forms. Symptoms include persistent feelings of sadness, anxiety, emptiness, hopelessness, as well as fatigue, irritability, and restlessness. Depressive disorders may interfere with a person's work and daily activities and prevent them from functioning normally. Some forms of depression develop under unique circumstances; others occur in episodes or may be longer-term.[58] Depression is often misconstrued as a sign of weakness, and if left untreated, can have tragic consequences, including suicide. Medication and therapy have been proven effective in treating major depression.[59] Respondents are asked if they were ever told they had a depressive disorder, including depression, major depression, dysthymia, or minor depression. Results in 2017 are shown in Figure 58.

One in six Connecticut adults in 2017 had been diagnosed with depression (17.6%).

Compared to their counterparts in the state, the risk of having **depression** among Connecticut adults was significantly greater for:

- Adults 18–34 years old (20.4%) compared to adults 55 and over (15.9%);
- Females (21.6%);
- Adults from households earning less than $35,000 (26.6%) and $35,000–$74,999 (17.4%); and
- Adults with a disability (36.8%).

FIGURE 58: DEPRESSION, CT 2017



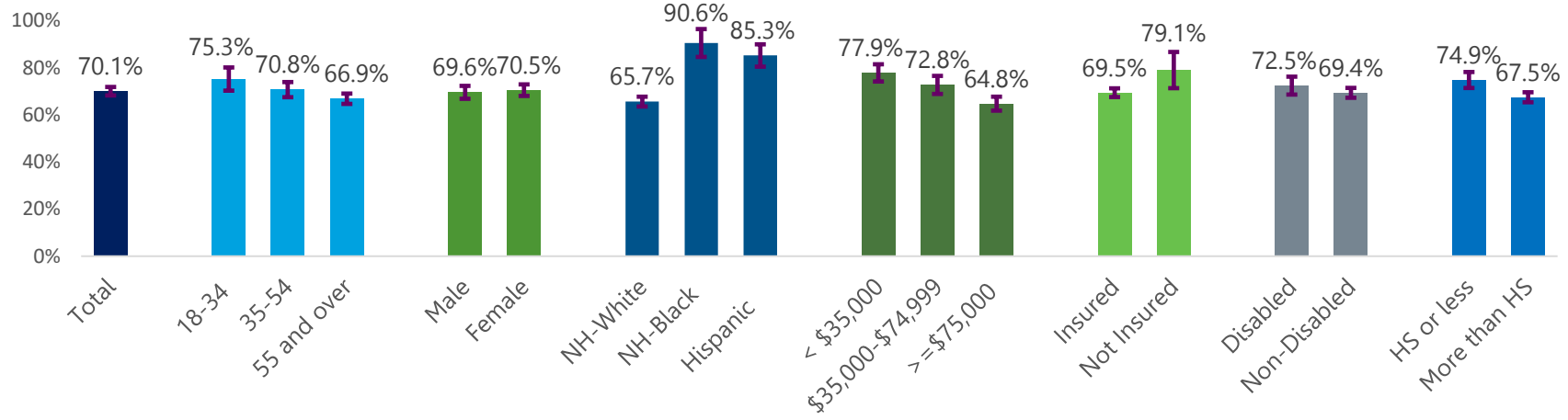
7. Environmental Health

Water Sources

Drinking water comes from a variety of sources, including public water systems, private wells, or bottled water.[60] It is important to know where drinking water comes from, how it's been tested, and if it's safe to drink. According to the United States Environmental Protecting Agency (EPA), public drinking water systems consist of community and non-community systems. Eight percent of U.S. community water systems provide water to 82% of the U.S. population through large municipal water systems.[61] Private water systems are composed of private groundwater residential wells, cisterns, and large private water systems that serve more than one residence.[62] Many people in the United States receive their water from private groundwater wells. The presence of contaminants in sources of drinking water can lead to adverse health effects, including gastrointestinal illness, reproductive problems, and neurological disorders.[63] In 2017, BRFSS respondents were asked to report their main source of water supply. The prevalence of adults in 2017 who reported having public or private well water supply in their residence is broken down by demographic characteristics in Figures 59-60.

In 2017, seventy percent of CT adults had a public water supply, while one in three adults reported having private well as their main water source.

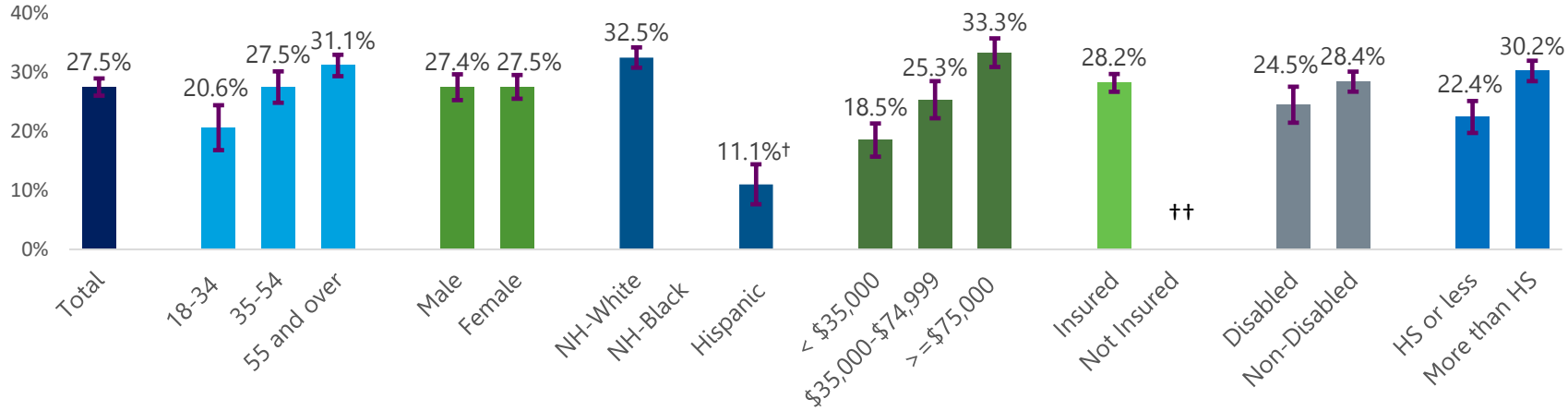
Figure 59: Public Water Supply, CT 2017



Compared to their counterparts in the state, the prevalence of having **public water supply** among Connecticut adults was significantly greater for:

- Adults 18–34 years old (75.3%) compared to adults 55 and over (66.9%);
- Non-Hispanic Blacks (90.6%) and Hispanics (85.3%);
- Adults from households earning less than $35,000 (77.9%) compare to at least $75,000 (64.8%);
- Adults without health insurance (79.1%); and
- Adults with no more than a high school education (74.9%).

FIGURE 60: PRIVATE WELL WATER SUPPLY, CT 2017



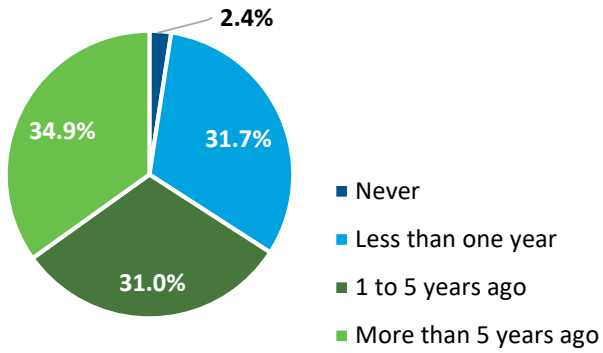
Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%; estimates with CV greater than 30.0% was suppressed.

Compared to their counterparts in the state, the prevalence of having **private water supply** among Connecticut adults was significantly greater for:

- Adults 55 and older (31.1%) compared to adults 18-34 years old (20.6%);
- Adults from households earning at least $75,000 (33.3%) and $35,000-$74,999 (25.3%);
- Adults with more than a high school education (30.2%).

The E.P.A recommends that homeowners have their well water tested annually. Testing is also recommended for water that develops a noticeable change in color, odor, or taste. Connecticut DPH water testing guidelines are also available on the www.ct.gov/DPH website. Figure 61 shows the frequency of well water testing in Connecticut.

FIGURE 61: TIME SINCE LAST WELL WATER TEST, CT 2017



8. CHILD HEALTH

Child Weight Status

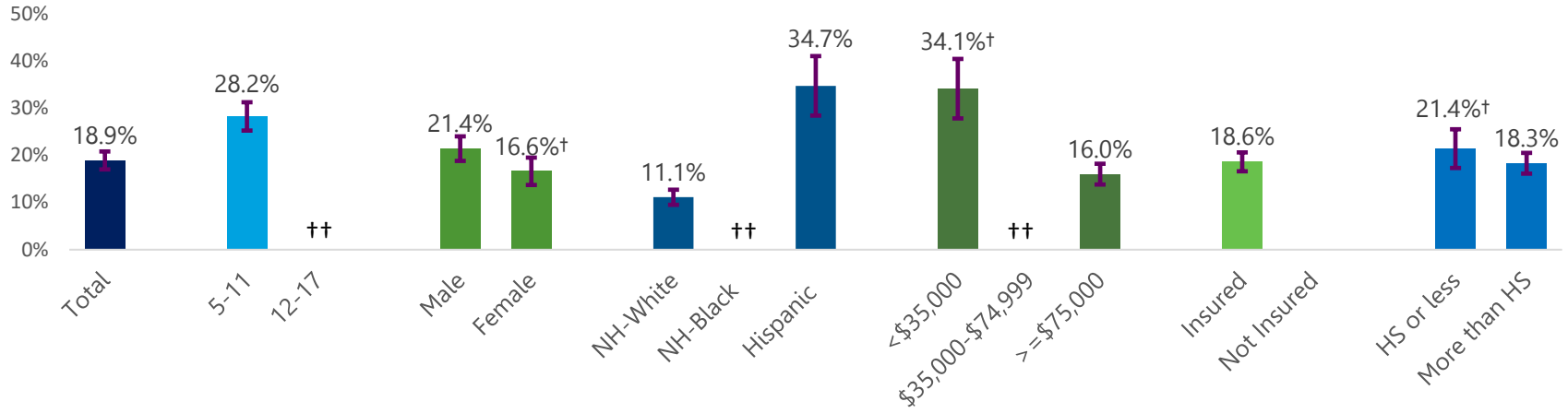
As part of a state-specific module in the BRFSS, a child is randomly selected in the household and the adult respondent is asked to provide the height and weight of that child. As with adults, BMI was calculated for these randomly selected children; however, child weight status is calculated differently than that for adults.[64] For children, weight status is determined comparatively based on age and sex. An overweight child has a BMI between the 85th and 95th percentile for children of the same age and sex, while an obese child has a BMI at or above the 95th percentile for children of the same age and sex. Obese children face a variety of health and social problems and are more likely to be obese adults.[65] Results for 2017 are shown in Figure 62.

In 2017, one in five children in CT were obese among child 5-17 years old.

Compared to their counterparts in the state, the prevalence of obesity among Connecticut children was significantly greater for:

- Hispanic (34.7%) compared to non-Hispanic White (11.1%) children.

FIGURE 62: CHILD OBESITY (5-17 YEARS OLD), CT 2017



Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%; estimates with CV greater than30.0% were suppressed.

Breastfeeding

The American Academy of Pediatrics recommends that mothers breastfeed infants exclusively for six months and continue to breastfeed for at least six more months after introducing solid foods.[66, 67] Breastfeeding provides a host of health benefits for nursing mothers and babies. Nursing infants receive natural protection against common illnesses and infections due to the immunologic properties of breast milk. There is also some evidence that breastfeeding can prevent the development of allergies, auto-immune disorders, and even chronic disease later in life.[68] In the BRFSS, an adult proxy is asked whether the selected child was ever breastfed. Results in 2017 are shown in Figure 63 and 64.

In 2017 in Connecticut, four out of every five children have been breastfed.

Compared to their counterparts in the state, the prevalence of **ever being breastfed** among children was significantly greater for:

- Non-Hispanic White children (84.4%) compared to Hispanic children (76.8%);
- Children living in households with annual incomes at least $75,000 (85.3%); and
- Children living with an adult proxy who had more than a high school education (84.1%).

FIGURE 64: LENGTH OF BREASTFEEDING PERIOD (MONTHS), CT 2017

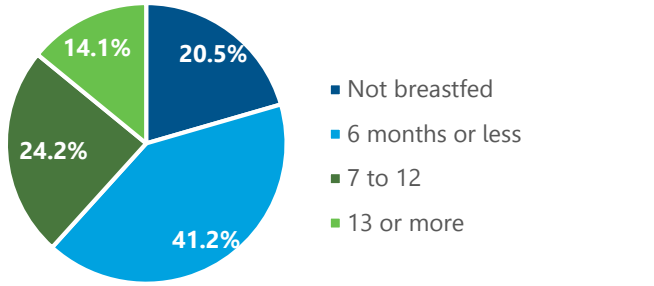
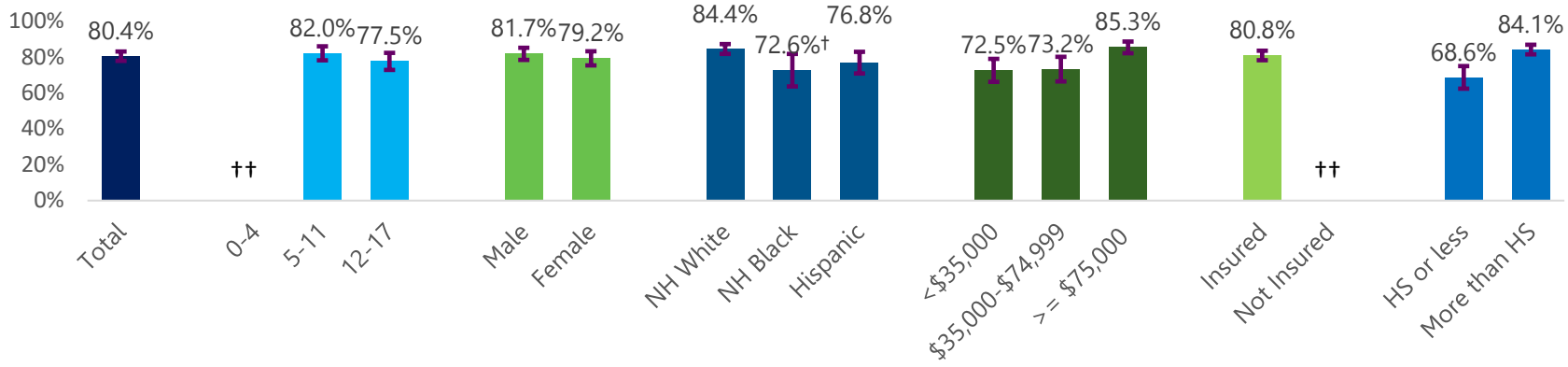


FIGURE 63: BREASTFEEDING, CT 2017



Estimates marked with a "†" have a CV between 15.0% and 20.0%: estimates marked with a "††" have a CV between 20.1% and 30.0%.

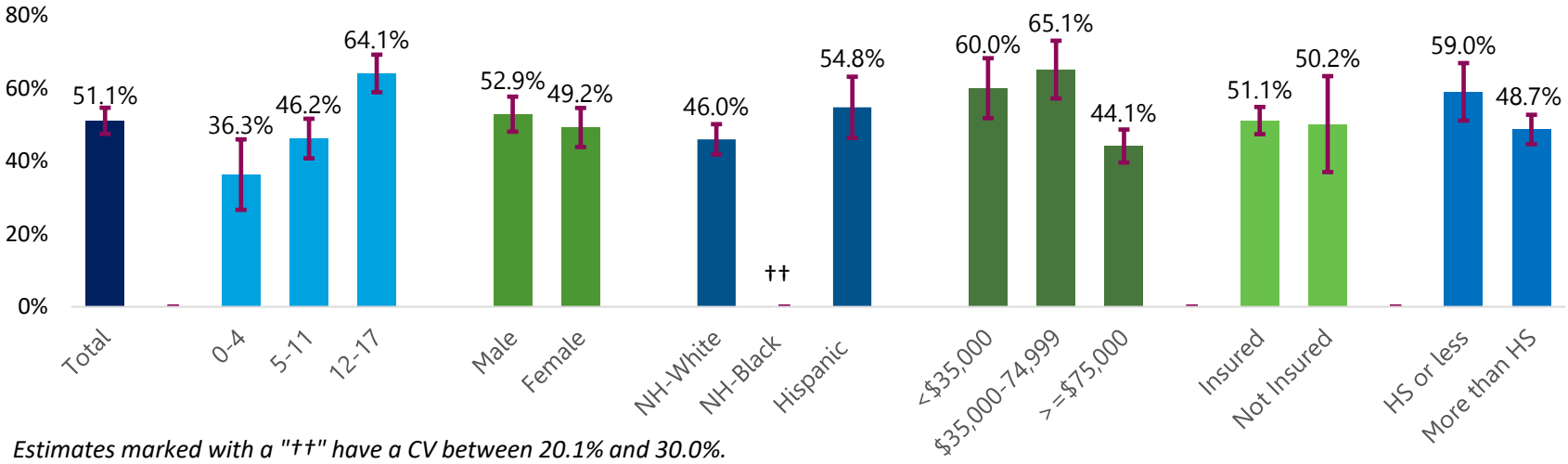
Child Screen Time

The American Academy of Family Physicians (AAFP) and American Academy of Pediatrics recommends that screen time is limited to no screen time before 2 years of age, and no more than two hours a day for children 2 and older.[69] U.S. children 8–18 years old are exposed to 7 hours and 38 minutes of entertainment screen time daily.[70] This indicator is of interest because sedentary behaviors, such as sitting in front of the television for long periods, may contribute to weight gain or obesity. Additionally, television or computer exposure may negatively affect child development or perspective in other ways.[71] The BRFSS survey asks the adult proxy respondent how much time the selected child spent watching programs, movies, videos or playing video games on television. Another question asks how much time the child spent using a computer tablet, or handheld device for playing video games or for something that is not schoolwork. The data from both questions were combined to calculate total screen time exposure for children ages 2–17. Results in 2017 are reported in Figure 65.

Half of Connecticut children in 2017 had excessive screen time (more than 2 hours daily). Compared to their counterparts in the state, the risk of **excessive screen time** among children in Connecticut was significantly greater for:

- Children 12–17 years old (64.1%);
- Children living in a household with annual earnings of less than $35,000 (60.0%) and $35,000-74,999 (65.1%); and
- Children with an adult proxy who had no more than a high school education (59.0%).

FIGURE 65: CHILD SCREEN TIME, CT 2017



Estimates marked with a "††" have a CV between 20.1% and 30.0%.

Child Soda/Fast Food Consumption

Consumption of soda and other sugar-sweetened beverages (SSBs) is associated with obesity in children.[72] Children who eat at fast-food and full-service restaurants eat more and have poorer diets compared to children who eat at home.[73]

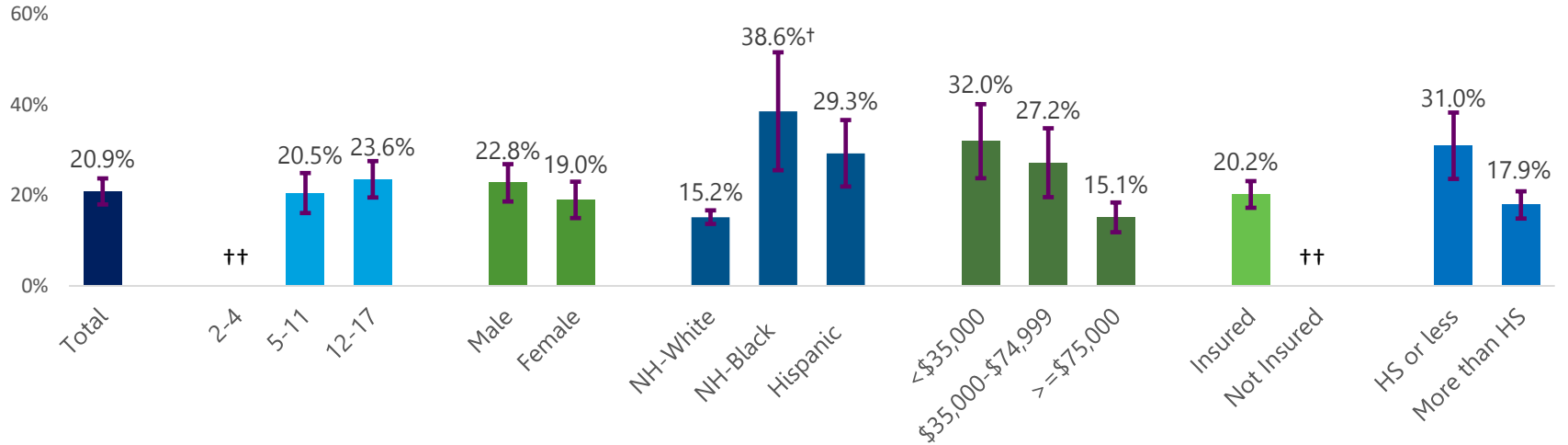
Adult proxy respondents report how many glasses, bottles, or cans of soda or other SSBs the randomly selected child drinks on an average day. They are also asked how many times in the past week the child ate fast food or pizza at school, at home, or at a fast-food restaurant. Results in 2017 for children two years old and over are reported in Figure 66-67.

One in five Connecticut children drank SSBs at least once daily in 2017, while one in three ate fast food two or more times weekly.

Compared to their counterparts in the state, the risk of **drinking SSBs at least once daily** among children in Connecticut was significantly greater for:

- Hispanic children (29.3%) compared non-Hispanic White children (15.2%);
- Children living in a household with annual earnings of less than $35,000 (32.0%) and $35,000-74,999 (27.2%); and
- Children living with an adult proxy who had no more than a high school education (31.0%).

FIGURE 66: DRANK SUGAR SWEETENED BEVERAGES AT LEAST ONCE DAILY, CT 2017

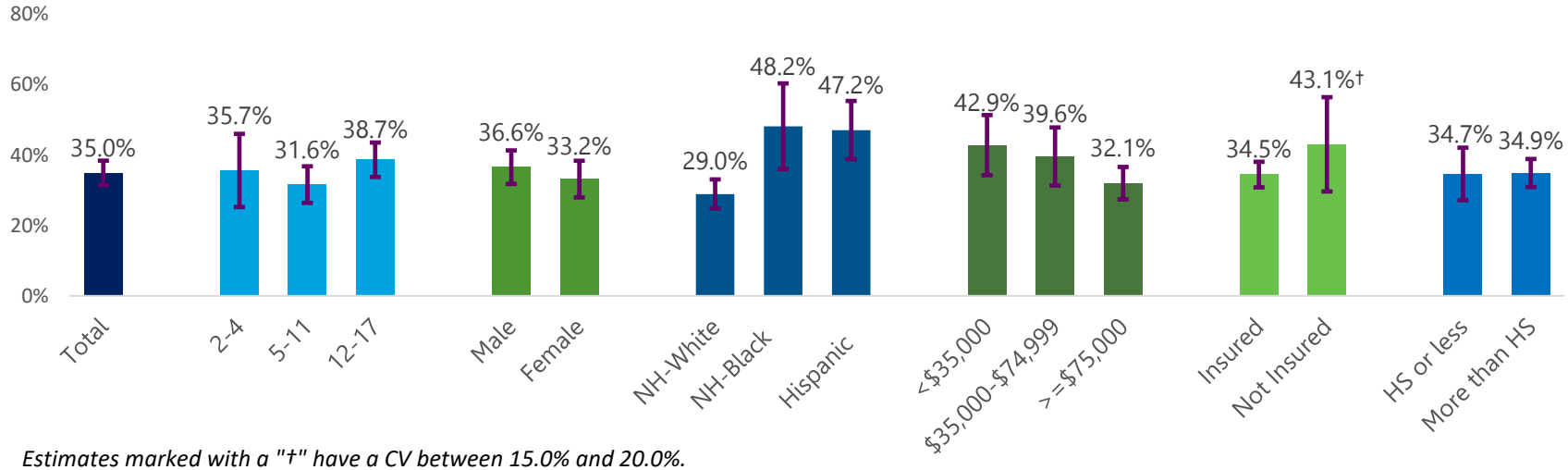


Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%.

Compared to their counterparts in the state, the risk of **eating fast food two or more times weekly** among children in Connecticut was significantly greater for:

- Non-Hispanic Black children (48.2%) and Hispanic children (47.2%); and
- Children living in a household with earnings of less than $35,000 (42.9%) compared to at least $75,000 (32.1%).

FIGURE 67: ATE FAST FOOD TWO OR MORE TIMES WEEKLY, CT 2017



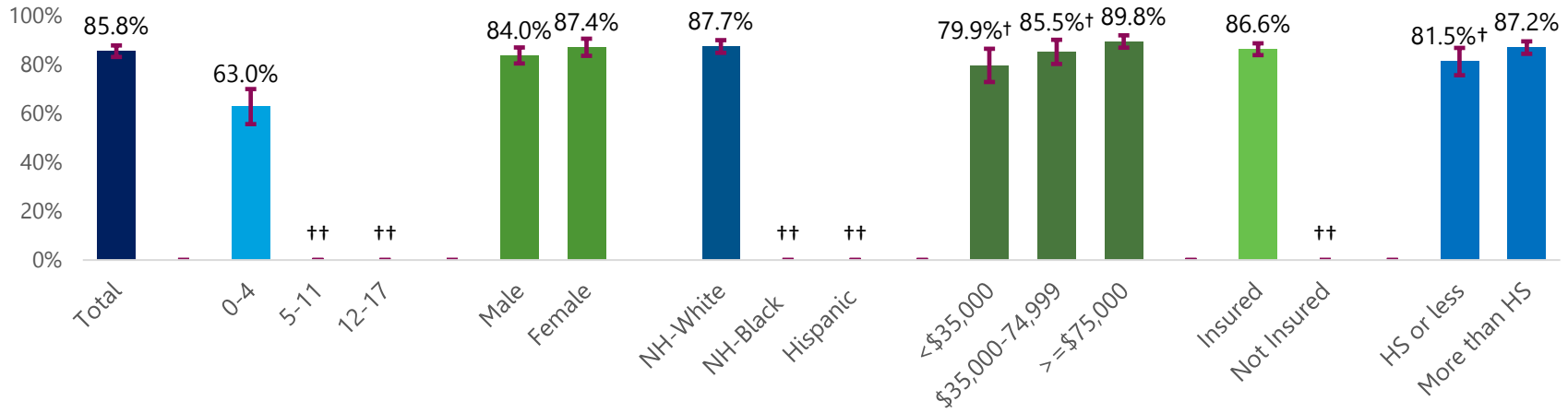
Estimates marked with a "†" have a CV between 15.0% and 20.0%.

Child Oral Health

Although it is largely preventable, tooth decay is the most common chronic condition among children in the United States.[74] Dental caries (cavities) can cause pain and infection, and if left untreated they can lead to malnourishment and serious medical complications.[75] The American Academy of Pediatric Dentistry recommends that children see a pediatric dentist when their first tooth appears, and no later than their first birthday.[76] Dental sealants can also prevent tooth decay.[77] Sealants are thin, plastic coatings that are painted on the back teeth, protecting the grooves from getting germs and food particles lodged in them. It is recommended that sealants are applied soon after the permanent tooth has come in. Adult respondents are asked if the randomly selected child had seen a dental provider in the previous year, and if so, whether they had ever had dental sealants. For the purposes of this analysis, we examined dental sealants only in children 5-17 years old. Results in 2017 are shown in Figure 68-70.

Eighty-six percent of Connecticut children in 2017 had a dental visit in the previous year, in which half of them had dental sealants applied to their teeth at some time. One in six had been told they have dental decay (cavities).

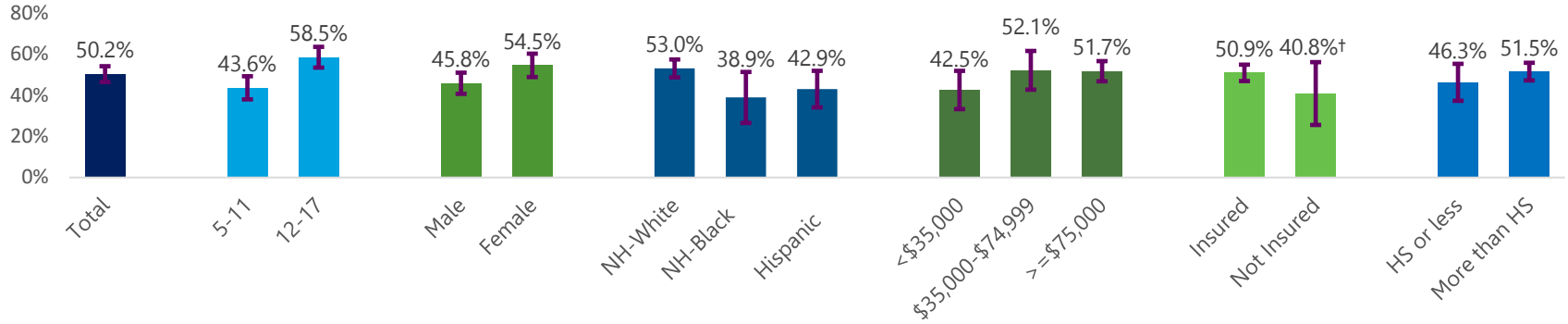
FIGURE 68: DENTIST VISIT IN PAST YEAR, CT 2017



Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%.

Compared to their counterparts in the state, the prevalence of having **dental sealants** was significantly greater for children 12–17 years old (58.5%) compare to children 5-11 years old (43.6%).

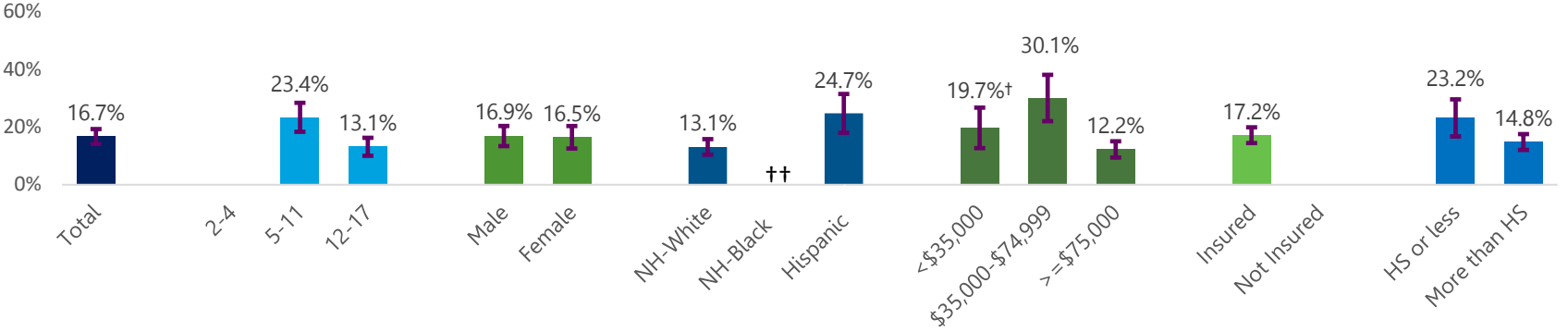
FIGURE 69: RECEIVED DENTAL SEALANT (CHILDREN 5-17 YEARS OLD), CT 2017



Compared to their counterparts in the state, the prevalence of children with **cavities in the past 12 months** was significantly greater for:

- Children ages 5–11 (23.4%) compared to children 12-17 years old (13.1%);
- Hispanic children (24.7%) compared to non-Hispanic White children (13.1%);
- children living in households earning of $35,000-$74,999 (30.1%) compared to at least $75,000 (12.2%); and
- Children living with an adult proxy with no more than a high school education (23.2%).

FIGURE 70: CHILD DENTAL DECAY (CAVITIES IN PAST 12 MONTHS), CT 2017



Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%; estimates with CV greater than 30.0% were suppressed.

Child Asthma

While asthma can affect people of all ages, it usually begins during childhood. Of the 25 million Americans who suffer from asthma, 6.2 million are children.[78] Asthma is the third most common cause of hospitalizations in children and accounts for 13.8 million missed days of school each year.[79] Respondents are asked if the randomly selected child in the household had ever been diagnosed with asthma and if the child still had asthma.

One in eight Connecticut children in 2017 had had current asthma. An additional six percent had been diagnosed with asthma in the past but no longer had the condition.

FIGURE 71: CURRENT CHILD ASTHMA STATUS, CT 2017

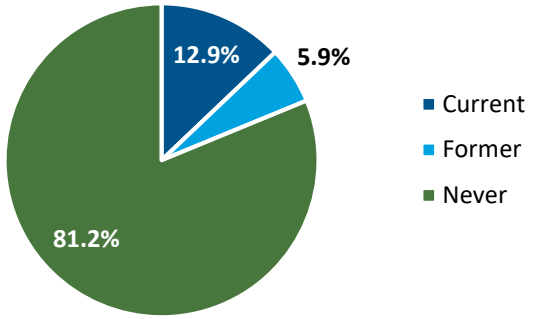
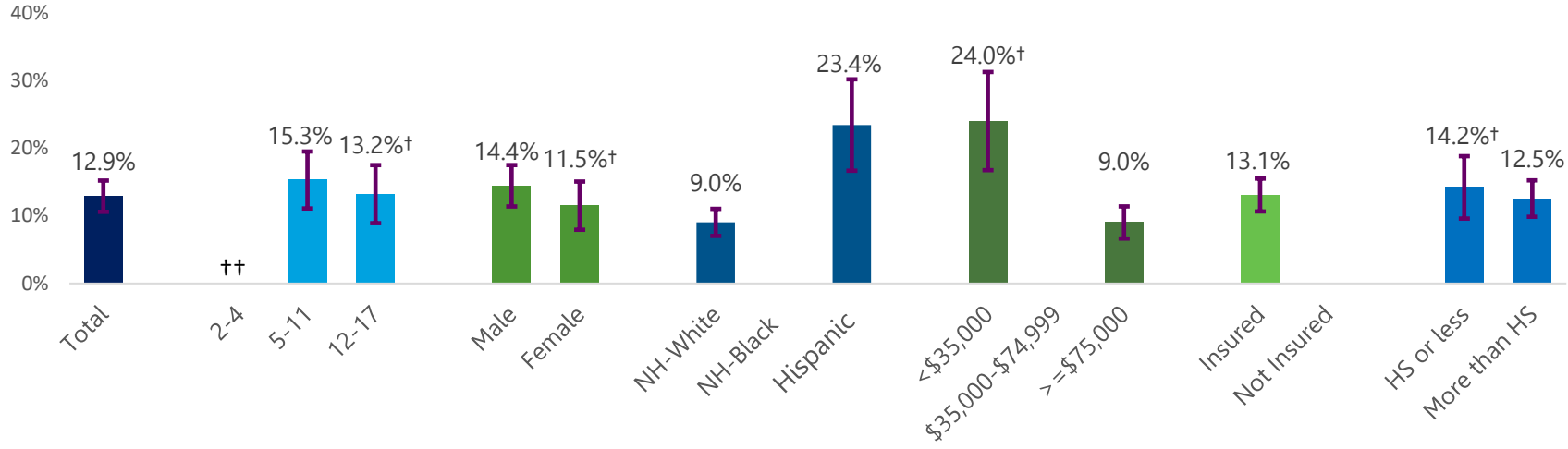


FIGURE 72: CHILD ASTHMA, CT 2017



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9. End Notes

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