Healthy Connecticut 2000

Final Report

Connecticut Department of Public Health

June 2005

ACKNOWLEDGMENTS

Prepared by:

Carol E. Bower
Meg A. Hooper
Pam Daniels
Angela Jimenez
MaryBeth C. Serdechny

We gratefully acknowledge the contributions of our many colleagues--past and present--at the Connecticut Department of Public Health, who helped formulate and revise objectives and targets, provided surveillance data and advice on data interpretation, and critically reviewed the manuscript.

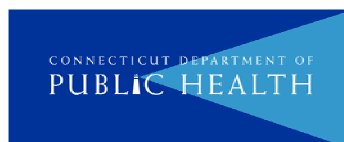
Suggested citation:

Bower, C.E., M.A. Hooper, P. Daniels, A. Jimenez, and M.B.C. Serdechny. 2005. *Healthy Connecticut 2000 Final Report.* Hartford, CT: Connecticut Department of Public Health.

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH
Planning Branch
State Health Planning Section

410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134-0308

http://www.dph.state.ct.us



CONTENTS

INTRODUCTION 1

Background 1

Technical Considerations 2

Modification of Original Objectives 2

Treatment of "Sub-objectives" 2

Data Sources and Availability 2

Coding for Causes of Death 2

Rate Calculations 2

Evaluation of Progress Made and Targets Met 2

OUTCOMES 5

Outcomes by Priority Area 5

Progress 5

Targets 6

Outcomes by Indicator Category 6

Mortality 7

Morbidity 7

Risk Factors 7

Prevention and Health Services 7

Outcomes for Special Population Groups 8

Children 9

Adolescents 9

Older Adults 9

Minorities 9

Women 10

STATISTICAL ANALYSIS OF PROGRESS 1

Outcome Ratios 11

Target Ratios 11

DISCUSSION 12

Looking Toward 2010 16

Tobacco Use 17

Diet, Physical Activity, and Overweight 18

Infectious and Vaccine-Preventable Diseases 19

Pregnancy and Childbirth (Low Birthweight) 19

Environmental Health 19

APPENDICES 21

1 Revised Objectives and Sub-objectives 22

2 Tracking Data 31

3 Summary Analyses of Progress 46

INTRODUCTION

Background

In 1990, the U.S. Department of Health and Human Services published *Healthy People 2000*,[1] a national strategy for reaching disease prevention and health promotion targets by 2000. It included 319 unduplicated objectives in 22 priority areas, representing a model of performance measurements for both population-based and individual health status and health services.

The Healthy Connecticut Project, launched in 1994 by the Connecticut Department of Public Health (DPH), applied national goals and objectives at the state level. The *Healthy Connecticut 2000 Baseline Assessment Report*[2] contained more than 100 objectives in 17 priority areas, focusing on health status and risk reduction. A 1997 supplement, *Healthy Connecticut 2000 Replacements and Additions,*[3] added two "services and protection" priority areas (Education & Community-Based Programs, and Food & Drug Safety), with objectives aimed at increasing the accessibility and quality of preventive care services. The 19 priority areas[4] currently addressed in the *Healthy Connecticut 2000 Final Report* are shown in Table 1. A listing of individual objectives is given in Appendix 1.

Table 1
HEALTHY CONNECTICUT 2000
PRIORITY AREAS*

HEALTH PROMOTION	
1	Physical Activity & Fitness
2	Nutrition
3	Tobacco
5	Family Planning
7	Violent & Abusive Behaviors
8	Educational & Community-Based Programs
HEALTH PROTECTION	
9	Unintentional Injuries
10	Occupational Safety & Health
11	Environmental Health
12	Food & Drug Safety
13	Oral Health
PREVENTIVE SERVICES	
14	Maternal & Infant Health
15	Heart Disease & Stroke
16	Cancer
17	Diabetes & Chronic Disabling Conditions
18	HIV Infection
19	Sexually Transmitted Diseases
20	Immunization & Infectious Diseases
SURVEILLANCE & DATA SYSTEMS	
22	Surveillance & Data Systems

* Priority area numbering corresponds to Healthy People 2000 priority areas. National priority areas 4 (Alcohol & Other Drugs), 6 (Mental Health & Mental Disorders), and 21 (Clinical Preventive Services) were not addressed in the *Healthy Connecticut 2000 Baseline Assessment Report.*

The *Healthy Connecticut 2000 Final Report* is an evaluation of the state's progress toward and success in achieving Connecticut's year 2000 objectives. It is intended to be a tool for policy makers, health planners, and program staff, offering both current and historical views of health status and health services, and highlighting both successes and challenges.

---

[1] U.S. Department of Health and Human Services. 1990. *Healthy People 2000.* Hyattsville, MD: Public Health Service. DHHS Publication No. (PHS) 91-50213.

[2] Connecticut Department of Public Health. 1994. *Healthy Connecticut 2000 Baseline Assessment Report.* Hartford, CT: Connecticut Department of Public Health.

[3] Connecticut Department of Public Health. 1997. *Healthy Connecticut 2000 Replacements and Additions.* Hartford, CT: Connecticut Department of Public Health.

[4] Priority area numbering corresponds with *Healthy People 2000* priority areas and chapter numbers. *Healthy Connecticut 2000* encompasses 19 of the 22 national priority areas.

Technical Considerations

This report is an assessment of progress toward Connecticut's year 2000 objectives, as presented in the *Healthy Connecticut 2000 Baseline Assessment Report* and amended subsequently.

The *Final Report* contains surveillance data only for the 219 objectives and sub-objectives for which progress could be tracked and/or target achievement could be assessed. Objectives for which no surveillance data were available are not included. There are 104 main objectives (95 of which are unduplicated) and 115 sub-objectives (98 of which are unduplicated). Counts and percentages in summary tabulations presented in the narrative of this report include duplicates. Annual data, targets, data sources, and commentary for each objective and sub-objective are given in Appendix 2.

Modification of Original Objectives

Some of the objectives discussed here differ from those originally published in the *Healthy Connecticut 2000 Baseline Assessment Report* and *Replacements and Additions*. They were modified for several reasons: 1) language was changed to make the objectives easier to understand; 2) target populations (e.g., age groups, racial and ethnic groups) or units of measurement were revised to reflect data availability; 3) proxy measures were substituted based on data availability, while retaining the intent of the original objectives; 4) baseline values or baseline years were changed when the values in the *Baseline Assessment Report* could not be substantiated; and 5) objectives were deleted when there were no available tracking data.

Treatment of "Sub-objectives"

The 115 "sub-objectives" considered in this report were taken from the *Baseline Assessment Report*. Some were part of the wording of the actual numbered objectives; some were itemized in tables below the written objectives and assigned their own baseline and/or target values; and some were listed only as "special target populations" without reference to baseline or target values. In the narrative and in Appendices 2 and 3 of this report, "overall" or "total population" values refer to the main objective, and all others are considered sub-objectives.

Data Sources and Availability

Data sources for the tracked objectives are identified in Appendix 2. They were provided by program staff at DPH or other state agencies, reproduced from published reports, or calculated using raw data from the previously mentioned sources. The DPH program names used in the Appendix reflect the most recent (2005) agency organization. Because of differences in reporting by various programs, database technicalities, and variation in survey years, it was not possible to include data for all objectives for the same years. When more complete data were not available, data from limited surveys and anecdotal information were used and are noted as such.

Coding for Causes of Death

Underlying causes of death were coded using the Ninth Revision of the *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death* (ICD-9), and the *Addendum to the ICD-9* for the classification of HIV infection. The ICD-9 codes used in this report are the same as those published in the final national progress report, *Healthy People 2000 Final Review*.[5] Codes for four of the causes of death differ from those used to report deaths in the Connecticut *Registration Report*[6] and other mortality reports issued by the CT Department of Public Health (Table 2).

Table 2
COMPARISON OF ICD-9 CODES USED FOR REPORTING CERTAIN CAUSES OF DEATH
IN *HEALTHY PEOPLE 2000* AND DPH MORTALITY REPORTS

Objective Numbers	*Healthy People 2000*		DPH Mortality Reports	
	Cause of death	ICD-9 code(s)	Cause of death	ICD-9 code(s)
1.1, 3.1, 15.1	Coronary heart disease	402, 410-414 429.2	Diseases of the heart	390-398, 402, 404-429
3.2	Lung cancer	162.2-162.9	Malignant neoplasms of the trachea, bronchus, and lung	162
7.1	Homicide	E960-969	Homicide and legal intervention	E960-978
9.6	Residential fires	E890-899	Residential fires	E890

The classification system used to code underlying cause of death changed in 1999 from the ICD-9 to the Tenth Revision of the *International Statistical Classification of Diseases and Related Health* (ICD-10). Differences between the two coding systems caused a discontinuity in reporting of death data because there is no direct code-to-code translation. For this reason, death data for 1999 and 2000 were not included in the present report.

Rate Calculations

Rates of incidence, prevalence, mortality, etc. were calculated using standard methods. Age-adjusted mortality rates were calculated by the direct method, using the 1940 U.S. standard million population. The denominators used for population-based rates varied with the reporting program or data provider. Sources of denominators are specified in the footnotes to Appendix 2.

Evaluation of Progress Made and Targets Met

Because the *Healthy Connecticut 2000 Baseline Assessment Report* was largely descriptive, progress was gauged mainly as qualitative or quantitative improvement over time and in relation to target values. Where possible, two simple analytical measures were used: 1) the ratio between the

[5] U.S. Department of Health and Human Services, National Center for Health Statistics. 2001. *Healthy People 2000 Final Review*. Hyattsville, MD: Public Health Service.

[6] Bower, C.E., F.A. Amadeo, and L.M. Mueller. 2002. *One Hundred Fifty-First Connecticut Registration Report*. Hartford, CT: Connecticut Department of Public Health. 178 pp.

baseline and most recent values (progress over time); and 2) the ratio between the most recent and target values (targets met). Some objectives were expressed as adverse conditions or events (e.g., disease incidence) for which a decrease over time was desired, whereas others were expressed as favorable conditions or events to be increased (e.g., healthy behaviors). Any movement *away from* the target value (regardless of whether it was an increase or decrease) produced a negative ratio and was considered a worsening for the objective. Any movement *toward* the target was produced a positive ratio, indicating improvement. This method was similar to the one used to report national progress in the *Healthy People 2000 Final Review.*[5]

For some objectives, progress made or targets met could not be evaluated by the above methods for one or more reasons: 1) baseline and/or target values were non-numeric; 2) no targets were specified in the objectives; 3) final-year values could not be compared to target values, because of inconsistencies in units of measurement, operational definitions, or methods of calculation. Consequently, the total number of objectives in each analysis sometimes differed. The detailed methodologies and results for the analyses are given in Appendix 3.

Of 219 total objectives and sub-objectives, 214 had quantitative or qualitative progress measures, and 208 had appropriate targets. Targets met and progress made were considered separately, because for any given grouping of objectives, the percentage with targets met was not always related to the percentage that showed improvement. In Priority Area 15, for example (Heart Disease and Stroke), improvement occurred for 92% of objectives, while only 50% of targets were met.

The purpose of these analyses was mainly to show progress over time and relative to targets; however, there are some important limitations to the interpretation of these statistics. Progress was measured as the difference between the baseline and most recent values only. Variations that occurred between the baseline and final years were not taken into account, though they are included in the tracking data in Appendix 2. AIDS incidence (Objective 18.2), for example, decreased by 11.2% between the baseline year (1990) and 2000; whereas relative to its peak rate of 49.0 in 1993 (not shown in Appendix 2), the decrease was 66.1%. Baseline and most recent years varied from one objective to another, so progress ratios were based on different time periods. Finally, even very small changes that may have been within the limits of random variation were viewed as "improvements" or "worsenings." The latter is particularly important to consider when interpreting data for small subgroups or samples. Conclusions reached in this report about improvement or worsening for some objectives therefore may differ from results obtained by using other methods of analysis or significance testing.[7]

---

[7] See, for example, the DPH report, *Mortality and Its Risk Factors in Connecticut, 1989-1998*, for significance testing of death rates. http://www.dph.state.ct.us/OPPE/Mortality/mortalityriskfactors.htm

OUTCOMES

Outcomes by Priority Area

Progress

Relative to baseline values, there was improvement for 65.4% of all objectives and sub-objectives, worsening for 24.8%, and no change for 9.8% (Table 3). Improvement occurred for 50% or more of measurable objectives in 17 of the 19 priority areas, with the highest percentages in the areas of Surveillance & Data Systems (2 objectives, 100%), Heart Disease and Stroke (11 objectives, 91.7%), and Sexually Transmitted Diseases (7 objectives, 87.5%).

Table 3

SUMMARY OF PROGRESS MADE AND TARGETS MET
FOR OBJECTIVES IN THE 19 *HEALTHY CONNECTICUT 2000* PRIORITY AREAS[a]

PRIORITY AREA[c]	PROGRESS FOR MEASURABLE OBJECTIVES[b]							TARGETS MET		
	Improved		Worsened		No Change		TOTAL			TOTAL
	No.	%	No.	%	No.	%	OBJ'S	No.	%	TARGETS
All Areas and Measurable Objectives	140	65.4	53	24.8	21	9.8	214	103	49.5	208
1 Physical Activity & Fitness	10	62.5	6	37.5	0	0	16	7	43.8	16
2 Nutrition	2	15.4	11	84.6	0	0	13	2	15.4	13
3 Tobacco	10	66.7	4	26.7	1	6.7	15	8	61.5	13
5 Family Planning	4	50.0	0	0.0	4	50.0	8	6	75.0	8
7 Violent & Abusive Behaviors	14	77.8	4	22.2	0	0.0	18	4	25.0	16
8 Education & Community Programs	5	71.4	2	28.6	0	0.0	7	6	85.7	7
9 Unintentional Injuries	16	76.2	3	14.3	2	9.5	21	13	56.5	23
10 Occupational Safety & Health	1	50.0	1	50.0	0	0.0	2	1	50.0	2
11 Environmental Health	9	69.2	3	23.1	1	7.7	13	2	20.0	10
12 Food & Drug Safety	5	83.3	1	16.7	0	0.0	6	6	100.0	6
13 Oral Health	1	50.0	1	50.0	0	0.0	2	0	0.0	4
14 Maternal & Child Health	9	50.0	5	27.8	4	22.2	18	7	36.8	19
15 Heart Disease & Stroke	11	91.7	1	8.3	0	0.0	12	6	50.0	12
16 Cancer	15	78.9	3	15.8	1	5.3	19	9	50.0	18
17 Diabetes & Chronic Disabling Conditions	0	0.0	2	100.0	0	0.0	2	0	0.0	2
18 HIV Infection	4	57.1	1	14.3	2	28.6	7	4	66.7	6
19 STDs	7	87.5	1	12.5	0	0.0	8	7	87.5	8
20 Immunization & Infectious Diseases	15	60.0	4	16.0	6	24.0	25	13	56.5	23
22 Surveillance & Data Systems	2	100.0	0	0.0	0	0.0	2	2	100.0	2

[a] Of 219 total objectives, data could be tracked for 214 and target achievement could be assessed for 208.

[b] Change from baseline to final year.

[c] *Healthy People 2000* priority areas 4 (Substance Abuse), 6 (Mental Health), and 21 (Clinical Preventive Services) were not included in *Healthy Connecticut 2000.*

Worsening occurred for 50% or more of objectives in four priority areas, with the greatest proportions in the areas of Nutrition and Diabetes & Chronic Disabling Conditions. In Family Planning, there was no change for 50% of the objectives; however, the baseline values for these objectives were the same as the target values (100%), leaving no opportunity for further improvement.

Targets

Targets were met for half of all measurable objectives in *Healthy Connecticut 2000*.[8] In 12 of the 19 priority areas, targets were met for at least 50% of objectives, and more than 70% of objectives were met in five priority areas (Family Planning, Educational & Community-based Programs, Food & Drug Safety, Sexually Transmitted Diseases, and Surveillance & Data Systems). The lowest proportions of targets were met in the areas of Oral Health, Diabetes & Chronic Disabling Conditions, Nutrition, and Environmental Health (Table 3).

Outcomes by Indicator Category

Every objective was classified into one of four categories -- Morbidity, Mortality, Risk Factors, or Prevention and Health Services -- and progress and target achievement were assessed for each (Table 4).

Table 4

SUMMARY OF PROGRESS MADE AND TARGETS MET FOR INDICATORS OF MORTALITY, MORBIDITY, RISK FACTORS, AND PREVENTION AND HEALTH SERVICES

INDICATOR CATEGORY[a]	PROGRESS FOR MEASURABLE OBJECTIVES[b]							TARGETS MET		
	TOTAL OBJS	Improved No.	Improved %	Worsened No.	Worsened %	No Change No.	No Change %	TOTAL TARGETS	No.	%
All categories[c]	214	140	65.4	53	24.8	21	9.8	208	103	49.5
Mortality	52	38	73.1	12	23.1	2	3.8	52	27	51.9
Morbidity	61	39	63.9	17	27.9	5	8.2	57	28	49.1
Risk Factors	64	48	75.0	16	25.0	0	0	62	27	43.5
Prevention & Health Services	37	15	40.5	8	21.6	14	37.8	37	21	56.8

[a] *Mortality* means deaths. *Morbidity* refers to injury and disease. *Risk factors* are behaviors and exposures that may lead to illness. *Prevention and health services* refers to public responsibility for assuring the population's health and safety.

[b] Change from baseline to final year.

[c] Of 219 total objectives, data could be tracked for 214 and target achievement could be assessed for 208.

Of the four indicator categories, the most improvement but the smallest proportion of targets met occurred among objectives for Risk Factors. The least improvement but the greatest proportion of targets met occurred among objectives for Prevention and Health Services.

---

[8] When interpreting percentages of target achievement, the total number of objectives in each priority area is an important consideration. For example, 6 targets met represented 50%, 75%, 85.7%, or 100% of total targets, depending on the priority area (see Table 3).

Mortality

Improvements occurred for nearly three-fourths of mortality-related objectives, including marked decreases in infant mortality and overall death rates for heart disease and stroke, unintentional injuries (especially drownings), and cancer (Appendix 3). In contrast, worsening occurred for sub-objectives for certain population groups, such as lung cancer deaths among females, suicides among adolescents, cervical cancer deaths among black women, and deaths among the elderly due to motor vehicle crashes and pneumonia and influenza. More than half of mortality targets were met or surpassed.

Morbidity

Nearly two-thirds of objectives related to morbidity were characterized by improvement, notably those related to asthma hospitalizations, childhood lead poisoning, and infectious disease incidence, including most sexually transmitted diseases, hepatitis B, tuberculosis, and most foodborne infections (Appendices 2 and 3). Worsening occurred for more than one in four morbidity objectives, including those for growth retardation among low-income children, infections with *E. coli* and *Chlamydia*, low birthweight, and diabetes. About half of morbidity targets were met or surpassed.

Risk Factors

Improvement occurred for three-fourths of objectives pertaining to risk factors, including: physical activity among adults; smoking, violence, sexual abstinence, and pregnancy among teens; and screenings for breast cancer, blood pressure, and cholesterol (Appendices 2 and 3). Worsening occurred for one-fourth of the objectives, such as those for overweight among adults, fruit and vegetable consumption, adult use of seat belts, and exposure to air pollutants. Less than half of targets for risk factors were achieved.

Prevention and Health Services

Improvement occurred for about 40% of objectives related to prevention and health services. Progress was made in the areas of newborn screening for genetic disorders, drinking water safety and fluoridation, radon testing, influenza and pneumococcal vaccination, and monitoring, analysis, and publication of health status indicators (Appendices 2 and 3). Worsening occurred for more than one in five objectives, notably injury and violence prevention programs, and completion of tuberculosis treatment. No change occurred for more than one-third of prevention and health services objectives, in large part because many were maintained at baseline values that were already in compliance with the terms of contracts between DPH and service providers. More than half of targets were met or surpassed.

Outcomes for Special Population Groups

Of total objectives and sub-objectives, 134 of those for which progress could be measured and 132 of those for which target achievement could be assessed pertained to special populations for which health disparities have been reported.[9, 10, 11] These groups were Children, Adolescents, Older Adults, Women (including those of childbearing age), and Minorities (those of African American/Black, American Indian, and Asian American/Pacific Islander race, and Hispanic ethnicity).

Table 5

SUMMARY OF PROGRESS MADE AND TARGETS MET FOR OBJECTIVES PERTAINING TO SPECIAL POPULATION GROUPS

POPULATION GROUP	PROGRESS FOR MEASURABLE OBJECTIVES[a]							TARGETS MET		
	TOTAL OBJS	Improved No.	Improved %	Worsened No.	Worsened %	No Change No.	No Change %	TOTAL TARGETS	No.	%
All ages[b]	214	140	65.4	53	24.8	21	9.8	208	103	49.5
Children[c]	34	22	64.7	11	32.4	1	2.9	34	14	41.2
Adolescents[d]	25	18	72.0	6	24.0	1	4.0	24	16	66.7
Older adults[e]	7	5	71.4	2	28.6	0	0.0	6	0	0
Racial and ethnic minorities[f]	30	18	60.0	12	40.0	0	0.0	31	12	38.7
African American/Black	19	12	63.2	7	36.8	0	0.0	20	9	45.0
Hispanic	8	4	50.0	4	50.0	0	0.0	8	1	12.5
Asian/Pacific Islander	2	2	100.0	0	0.0	0	0.0	2	1	50.0
American Indian	1	0	0.0	1	100.0	0	0.0	1	1	100.0
Women[g]	38	26	68.4	8	21.1	4	10.5	37	19	51.4

[a] Change from baseline to final year.

[b] Of 219 total objectives, data could be tracked for 214 and target achievement could be assessed for 208.

[c] Depending on the specific objective, "children" may refer to the following groups: ages <1, <2, <5, <6, 0-5, 0-14, 1-2, 3-4, and 5-14 years; children in day care; and children in schools.

[d] Depending on the specific objective, "adolescents" refers to the following groups: ages 10-19, 15-17, 15-19, and 15-24 years; students in grades 4-12; students in grades 9-12.

[e] Refers to persons 55+, 65+, or 70+ years of age, depending on the objective.

[f] Includes objectives for persons of African American/Black, Asian American/Pacific Islander, or American Indian race, and those of Hispanic ethnicity.

[g] Includes females of all ages, including "childbearing age" (15-44 yrs).

There was improvement in at least half of the health measures for each of the special population groups (Table 5). The greatest proportion of improvements occurred among objectives for Asian Americans and Pacific Islanders, Adolescents, Older Adults, and Women, whereas the most worsening occurred among objectives for Hispanics. More than half of targets were met for Adolescents and Women, whereas only one target (12.5%) was met for Hispanics.

---

[9] Hynes, M.M., L.M. Mueller, C.E. Bower, and M.J. Hofmann. 1999. *Multicultural Health: The Health Status of Minority Groups in Connecticut*. Hartford, CT: Connecticut Department of Public Health. 82 pp.

[10] Connecticut Department of Public Health. 1999. *Looking Toward 2000: An Assessment of Health Status and Health Services*. Hartford, CT: Connecticut Department of Public Health. 378 pp.

[11] Connecticut Department of Public Health. 2001. *Connecticut Women's Health*. Hartford, CT: Connecticut Department of Public Health. 201 pp.

Children

Nearly two-thirds of the 34 measurable objectives pertaining to children showed improvement (Table 5). Notable decreases occurred in rates of homicide, drowning, and residential fire deaths, asthma hospitalizations, iron deficiency in children 1-2 years of age, and fetal alcohol syndrome. Growth retardation among low-income children, low birthweight overall and among whites, and very low birthweight increased, however (Appendices 2 and 3).

Less than half of total targets for children were achieved, yet targets were met or surpassed for homicides, child maltreatment, and unintentional injury deaths. Although targets were met for most objectives pertaining to vaccine-preventable childhood diseases, in 2000 only 85% of children 2 years of age had received the basic immunization series, and cases of pertussis rose to more than five times the target value.

Adolescents

Of the 25 objectives targeting adolescents, 72% showed improvement and 67% of targets were met or surpassed (Table 5). Twenty-one objectives for adolescents (84%) focused on reducing risky behaviors. Notable decreases occurred in smoking, physical fighting, weapon carrying, and dropping out of high school (overall and for certain racial and ethnic groups), whereas physical activity worsened. Although teen pregnancies and gonorrhea incidence declined, fewer sexually active students reported using condoms (Appendices 2 and 3). Motor vehicle related deaths decreased, while suicides and suicide attempts increased.

Older Adults

Improvements occurred for five out of seven objectives for older adults, but no targets were met (Table 5). Death rates for suicide among white males, cervical cancer, and residential fires declined, whereas the death rate for motor vehicle crashes increased (Appendices 2 and 3). Despite improvements in pneumococcal and influenza vaccination rates among older adults, the mortality rate for pneumonia and influenza also rose.

Minorities

Healthy Connecticut 2000 contained 30 measurable objectives for racial and ethnic minority groups; 60% showed improvement relative to baseline values, and targets were reached for nearly 40% (Table 5).

Among objectives for African Americans/Blacks, 12 of 19 (63.2%) showed improvement, including those for: homicide deaths among young males; deaths due to lung cancer, drowning, and stroke; asthma hospitalizations; infant mortality; low birthweight; and the incidence of tuberculosis, gonorrhea, and syphilis (Table 5, Appendices 2 and 3). Worsening occurred for homicide deaths among females, deaths

from heart disease and cervical cancer, lower extremity amputations among diabetics, and growth retardation among low-income children under 1 year of age. Less than half of targets for African Americans/Blacks were achieved.

Of the eight objectives for Hispanics, half showed improvement relative to baseline values (homicide deaths among young males, asthma hospitalizations, low birthweight, and tuberculosis incidence). The infant death rate for Hispanics rose, whereas it fell for other population groups. The percentages of high school drop-outs and growth retardation among low-income Hispanic children 1 year of age and younger also worsened. Only one target was met.

Improvements occurred for both objectives for Asian Americans/Pacific Islanders (high school drop-out rate and tuberculosis incidence), while the drop-out rate for American Indians (the only objective for this group) worsened.

Women

Of the 38 objectives for women, two-thirds showed favorable changes, and just over half of targets were met (Table 5). Objectives involving violent and abusive behaviors against women showed improvements, evidenced by declines in the incidence of reported female victims of rape and family violence (Appendices 2 and 3). Among women of childbearing age, notable declines (improvements) occurred for teen pregnancy, smoking during pregnancy, and gonorrhea incidence.

Worsening occurred for about one-fifth of objectives for women, including lung cancer deaths, overweight prevalence, and breastfeeding. Although smoking prevalence among Connecticut women declined, one out of five adult women and one out of four women of childbearing age still smoked regularly in 2000, and 8.5% of women who gave birth smoked during pregnancy. Between 1990 and 1998, the lung cancer death rate for women increased by 5.8%, whereas it decreased by 10.1% among men (Appendix 2).

Overweight prevalence increased by 70% among Connecticut women, compared to a 43% increase among men. Although diet and exercise habits improved, in 2000 more than one in four women reported they did not engage in any leisure time physical activity (Appendix 2).

STATISTICAL ANALYSIS OF PROGRESS

Outcome Ratios

Outcome ratios (the ratios between the baseline and most recent values) could be calculated for 204 of the 214 objectives with tracking data (Appendix 3). Ratios were greater than 1 (signifying improvement) for 133 objectives (65.2%), equal to 1 (signifying no change) for 18 objectives (8.8%), and less than 1 (signifying worsening) for 53 objectives (26.0%). Some of the largest outcome ratios, signifying the greatest improvements, occurred for infectious diseases, including primary and secondary syphilis, congenital syphilis, gonorrhea, and mumps. The smallest ratios (poorest outcomes) occurred for occupational skin disorders/diseases, and breastfeeding through 5-6 months postpartum.

Target Ratios

Target ratios (the ratios between the most recent values and the target values) were available for 189 objectives and sub-objectives (Appendix 3). Targets were surpassed (ratio >1) for 70 objectives or 37.0%; targets were met (ratio = 1) for 21 objectives (11.1%); and targets failed to be met (ratio <1) for 98 objectives (51.9%). Objectives with the largest target ratios included: motor-vehicle-related deaths among children, pedestrians, and motorcyclists; homicides among children <5 years of age; assault injuries; and the incidence of primary and secondary syphilis, especially among African Americans. Target ratios were lowest for cases of pertussis, breastfeeding through 5-6 months postpartum, residential fire deaths among the elderly and African Americans, and homicide deaths among young Hispanic males and both male and female African Americans.

DISCUSSION

Progress toward achieving the measurable objectives of *Healthy Connecticut 2000* was assessed as changes in values from the baseline year to the final year, and as targets met. Because failure to meet targets may have resulted from unrealistic target setting at the outset, changes over time is probably the better measure of overall progress for any given priority area, indicator type, or special population, given the limitations of the evaluation methods (see *Introduction*). Types of objectives for which there was improvement, no change, or worsening overall during the 1990's and for various population groups are summarized in Tables 6 through 8.

Table 6

HEALTHY CONNECTICUT 2000

AREAS IN WHICH IMPROVEMENT OCCURRED DURING THE 1990's

	OVERALL OR TOTAL POPULATION	SPECIAL POPULATIONS [a]						
		Age Group			Racial/Ethnic Group			
TYPE OF OBJECTIVE		Child	Adol	OAd	AA/Bl	Hsp	Asn Am	Women
MORTALITY								
Heart disease	✓							
Stroke	✓				✓			
Cancer, all sites:	✓							
Lung cancer	✓				✓			
Female breast cancer	✓							✓
Cervical cancer	✓			✓				✓
Intentional injuries:								
Homicide	✓	✓			✓ [b]	✓ [b]		
Suicide	✓			✓ [b]				
Unintentional injuries:								
Motor vehicle related	✓	✓	✓					
Motorcyclists & pedestrians	✓							
Drowning	✓	✓			✓			
Residential fires	✓	✓		✓				
Infant mortality	✓	✓			✓			
MORBIDITY								
Violence:								
Family violence								✓
Rape								✓
Child maltreatment		✓						
Assault	✓							
Physical fighting			✓					
Weapon carrying			✓					
Non-fatal head injuries	✓							
Blood lead levels	✓	✓						
Asthma	✓	✓			✓	✓		
Foodborne infections:								
Salmonella infections and outbreaks	✓							
Campylobacter jejuni infections	✓							
Listeria monocytogenes infections	✓							
Maternal & infant health:								
Fetal alcohol syndrome		✓						
Low birthweight					✓	✓		

(Table 6 continues)

Table 6 (Continued)

HEALTHY CONNECTICUT 2000

AREAS IN WHICH IMPROVEMENT OCCURRED DURING THE 1990's

TYPE OF OBJECTIVE	OVERALL OR TOTAL POPULATION	SPECIAL POPULATIONS [a]						
		Age Group			Racial/Ethnic Group			Women
		Child	Adol	OAd	AA/Bl	Hsp	Asn Am	
MORBIDITY (CONTINUED)								
Sexually transmitted diseases:								
Gonorrhea	✓		✓		✓			✓
Primary & secondary syphilis	✓				✓			
Congenital syphilis		✓						
Vaccine preventable diseases:								
Measles	✓							
Rubella	✓							
Mumps	✓							
Other infectious diseases:								
Hepatitis B	✓	✓						
Tuberculosis	✓				✓	✓	✓	
Bacterial meningitis	✓							
AIDS incidence	✓							
Iron deficiency, 1-2 yrs and women		✓						✓
RISK FACTORS								
Overweight and exercise:								
Physical activity	✓[c]							✓[c]
Overweight w/ sound diet and activity	✓[c]							✓[c]
Cigarette smoking	✓[c]		✓					✓[c]
Sexual intercourse			✓					✓
Dropping out of high school			✓		✓		✓	
Safety seat and safety belt usage		✓	✓					
Bicycle helmets		✓	✓					
Pregnancy related:								
Teen pregnancy			✓					
Tobacco abstinence during pregnancy								✓
Alcohol abstinence during pregnancy								✓
Screenings:								
Blood pressure checked in last 2 yrs	✓[c]							
Cholesterol checked in last 6 yrs	✓[c]							
Clinical breast exam & mammogram				✓				✓
PREVENTION & HEALTH SERVICES								
Local health core functions	✓							
Hospitals w/ protocols for spousal abuse								
Environment related:								
Radon testing and remediation	✓							
Inspections for lead-based paint	✓							
Drinking water safety and fluoridation	✓							
Immunizations:								
Basic, children in licensed daycare		✓						
Basic, children in K thru post-secondary		✓						
Hepatitis B vaccine, high-risk infants		✓						
Influenza vaccine				✓				
Pneumococcal vaccine				✓				
Newborns screened for genetic disorders		✓						
Review & update of *Public Health Code*	✓							

[a] Child = children; Adol = adolescents; OAd = older adults; AA/Bl = African American/Black; Asn Am = Asian American; Hsp = Hispanic.

[b] The homicide death rate improved for males only among people of African American/Black race. Among the elderly, the suicide rate improved for white males.

[c] Adults 18+ years of age.

Table 7
HEALTHY CONNECTICUT 2000
AREAS IN WHICH THERE WAS NO CHANGE [a] DURING THE 1990's

TYPE OF OBJECTIVE	OVERALL OR TOTAL POPULATION	SPECIAL POPULATIONS [b]						
		Age Groups			Racial/Ethnic Groups			
		Child	Adol	OAd	AA/Bl	Hsp	Am Ind	Women
MORTALITY								
Falls and fall-related	✓							
Female breast cancer, 50+ yrs				✓				✓
MORBIDITY								
Waterborne disease outbreaks	✓							
Diphtheria cases		✓						
Tetanus cases		✓						
Polio cases		✓						
Congenital rubella cases		✓						
PREVENTION AND HEALTH SERVICES								
Tobacco use prevention plan	✓							
Prenatal care referrals								✓
Referral to family planning services								✓
Family planning outreach			✓		✓	✓	✓	
Prenatal care provided in first trimester								✓
Preconception care and counseling								✓
Screening/counseling on prenatal abnormalities								✓
Newborns treated for genetic disorders		✓						
Bicycle helmet laws through age 15 yrs		✓						
STD counseling, screening, and referral								✓
HIV education curricula in Grades 4-12		✓	✓					
HIV outreach to drug abusers in cities	✓							
Immunization financing and delivery	✓							
Childhood immunization laws		✓						

[a] "No change" may signify that both the baseline and final values were at the lowest or highest attainable values, that the desired result had already been achieved in the baseline year, or that data were available for one year only.

[b] Child = children; Adol = adolescents; OAd = older adults; AA/Bl = African American/Black; Am Ind = American Indian; Hsp = Hispanic.

Table 8

HEALTHY CONNECTICUT 2000

AREAS IN WHICH WORSENING OCCURRED DURING THE 1990's

TYPE OF OBJECTIVE	OVERALL OR TOTAL POPULATION	SPECIAL POPULATIONS [a]						
		Age Groups			Racial/Ethnic Groups			Women
		Child	Adol	OAd	AA/Bl	Hsp	Am Ind	
MORTALITY								
Heart disease					✓			
Lung cancer								✓
Cervical cancer					✓			✓
Chronic obstructive pulmonary disease	✓							
Pneumonia & influenza, 65+ yrs				✓				
Homicide					✓ [b]			
Suicide			✓					
Motor-vehicle related				✓				
Infant mortality						✓		
MORBIDITY								
Low birthweight	✓							
Very low birthweight	✓							
Severe complications of pregnancy								✓
Breastfeeding								✓
Diabetes w/ lower extremity amputation	✓				✓			
Chlamydia infections	✓							
E. coli 0157:H7 infections	✓							
Occupational skin disorders & diseases	✓							
Pertussis		✓						
Growth retardation, low income children		✓			✓	✓		
Iron deficiency, 3-4 yrs		✓						
Attempted suicide			✓					
RISK FACTORS								
Overweight	✓ [c]							✓
Fruit & vegetable consumption	✓ [c]							
Smoking cessation	✓ [c]							
Seatbelt usage	✓ [c]							
Exposure to criteria air pollutants	✓							
Dropping out of high school			✓			✓	✓	
Physical activity, regular and vigorous			✓					
Condom usage			✓					
PREVENTION & HEALTH SERVICES								
Basic immunization series, <2 yrs		✓						
Completion of preventive TB therapy	✓							
Cleft lips/palate reporting & referral		✓						
Local health programs and activities:								
Physical fitness activities	✓							
Injury prevention programs	✓							
Violence prevention programs	✓							
Radon-resistant building methods	✓							

[a] Child = children; Adol = adolescents; OAd = older adults; AA/Bl = African American/Black; Am Ind = American Indian; Hsp = Hispanic.

[b] Worsening occurred among African American/Black females only.

[c] Adults 18+ years of age.

It is important to look behind the data when interpreting outcomes. When there was no apparent change in value for a specific objective, for example, it is helpful to ask certain questions. Was the lack of change an artifact of there being data for a single year only? Was the objective a *process* objective (to develop, review, maintain, etc.), for which the result had already been accomplished at the start? Were both the baseline and final values the lowest or highest attainable values (e.g., 0 cases or 100%)?

The number of objectives in each category is also an important consideration for interpreting the data in this report. Some categories included 50 or more objectives (i.e., Risk Factors, Mortality, Morbidity), whereas others contained fewer than 10 (i.e., Older Adults, Hispanics, and nine Priority Areas). Because of such variability, high percentages of improvement sometimes were based on few objectives (e.g., Priority Area 22--Surveillance & Data Systems, 2 objectives, 100%), whereas lower percentages of improvement could be based on many objectives (e.g., Morbidity, 39 objectives, 64%).

Looking Toward 2010

Despite improvement in many priority areas, numerous risk factors for death and disease were still prevalent among Connecticut residents in 2000. Moreover, certain racial and ethnic groups, women, children, and older adults often had a disproportionate burden of injury, disease, and death.

Health disparities can shorten life expectancies and decrease quality of life and economic opportunities, leading to decreased productivity and increased healthcare costs. The reasons behind health disparities are complex and may be related to behavioral factors such as smoking, diet, and obesity, and to socioeconomic factors like income, education, health insurance status, and level of access to primary and preventive care.

Connecticut's population is older, on average, than the U.S. population, and older adults--the fastest growing age group--represented 14% of the state population in 2000. Racial and ethnic minorities are projected to constitute half of the U.S. population by 2050, and they already account for up to 72% of the population of Connecticut's largest cities. Although population diversity is one of our greatest assets, it also presents myriad health challenges requiring creative interventions for reaching high-risk and underserved groups.

In January 2000, the U.S. Department of Health and Human Services launched *Healthy People 2010,*[12] a comprehensive national agenda for health promotion and disease prevention. Its two overarching goals--to increase quality and years of healthy life, and to eliminate health disparities--guided the development of 467 evidence-based objectives in 28 focus areas. In addition, a set of 10 *Leading Health Indicators* were chosen to track progress toward meeting the initiative's goals. These indicators(Table 9), each of which is

---

[12] U.S. Department of Health and Human Services. 2000. *Healthy People 2010*, 2nd ed. Washington, DC: U.S. Government Printing Office.

associated with one or more objectives from *Healthy People 2010*, were selected because they represent the nation's major health concerns; data are available for tracking progress, and they have the ability to motivate individuals and communities to take action to improve health.

Table 9

HEALTHY PEOPLE 2010
LEADING HEALTH INDICATORS

	Indicators
1	Physical Activity
2	Overweight and Obesity
3	Tobacco Use
4	Substance Abuse
5	Responsible Sexual Behavior
6	Mental Health
7	Injury and Violence
8	Environmental Quality
9	Immunization
10	Access to Health Care

In developing *Healthy Connecticut 2010,* the state health agenda for the first decade of the new century, the Connecticut Department of Public Health is tailoring the national objectives of *Healthy People 2010* to Connecticut's specific health status and health services needs. Based on the findings of the *Healthy Connecticut 2000* initiative, future public health efforts in Connecticut will be particularly important in the areas discussed below.

Tobacco Use

Smoking is the single most preventable cause of death in Connecticut and the U.S., and it is the most important public health issue facing our society. It is a major risk factor for lung cancer and other respiratory cancers, cardiovascular disease, chronic obstructive pulmonary disease (COPD), and low birthweight.

Rates of death and premature death from lung cancer in Connecticut are significantly greater in men than in women, and black males have the highest death rate among racial and ethnic subgroups.[13] While incidence and death rates for lung cancer among Connecticut males decreased during the 1990's, those for females increased.[13, 14] COPD, comprising chronic airways obstruction, chronic bronchitis, emphysema, and other lung conditions, is the fourth leading cause of death among Connecticut residents.[6] About 80-90% of COPD is attributable to cigarette smoking.[12] COPD death rates are higher among whites than among African-Americans/Blacks and Hispanics.[13]

---

[13] Connecticut Department of Public Health. 2004. *Mortality and Its Risk Factors in Connecticut, 1989 to 1998*. Hartford, CT: Connecticut Department of Public Health. http://www.dph.state.ct.us/OPPE/Mortality/mortalityriskfactors.htm.

[14] Connecticut Tumor Registry. 2004. *Connecticut Cancer Surveillance, 1990-2000*. Hartford, CT: Connecticut Department of Public Health. http://www.dph.state.ct.us/OPPE/pdfs/CONNECTICUT%20CANCER%20SURVEILLANCE%20.pdf.

Maternal smoking during pregnancy is harmful to both mother and child, increasing the risk of low birthweight and other adverse maternal events and poor pregnancy outcomes (stillbirth, preterm delivery, neonatal mortality, sudden infant death syndrome).[15] In the 1980's, up to one-fourth of low birthweight among American infants was due, at least in part, to maternal smoking during pregnancy. Low birthweight infants are more susceptible to respiratory infections and other illnesses, and are more likely than normal birthweight infants to be admitted to neonatal intensive care units.[16]

Although smoking prevalence declined overall and for all population groups in Connecticut, at the end of the last decade one in five adults, one in four women of childbearing age, and nearly one in three high school students reported they smoked regularly.

Diet, Physical Activity, and Overweight

Overweight and obesity--which result from a combination of biological factors (e.g., genetics and metabolism) and behavioral factors (e.g., physical inactivity and poor diet)--are associated with four of the top ten leading causes of death: heart disease, certain cancers, stroke, and type 2 diabetes. They also raise the risk of illness from high cholesterol, high blood pressure, arthritis, gallbladder disease, sleep disturbances, and breathing problems.[12] In persons with diabetes, obesity increases the risk for cardiovascular and microvascular disease; the prevalence of obesity among adults with diabetes in the U.S. is nearly double that of the general population.[17]

Overweight among Connecticut adults increased by 55% during the 1990's (Appendix 2). At the end of the last decade, nearly 30% of Connecticut adults were overweight, 70% ate less than five fruits or vegetables daily, and 25% had no leisure time physical activity. Numerous disparities exist in diet, obesity, and physical activity among different population groups in Connecticut. African Americans/Blacks, males, and younger adults have the lowest rates of fruit and vegetable consumption; Hispanic and African American/Black adults are more likely than white non-Hispanics to be obese, and older adults, lower-income persons, African Americans/Blacks, and Hispanics have the highest prevalence of physical inactivity.[18]

Many opportunities exist for promoting healthful diet and exercise, beginning in childhood and continuing through adulthood, by increasing nutrition education and counseling, linking diet and exercise in health promotion programs, and emphasizing prevention of chronic diseases associated with poor diet and overweight.

---

[15] Pollack, H., P.M. Lantz, and J.G. Frohna. 2000. Maternal smoking and adverse birth outcomes among singletons and twins. *American Journal of Public Health* 90(3):395-400.

[16] Lightwood, J.M., C.S. Phibbs, and S.A. Glantz. 1999. Short-term health and benefits of smoking cessation: Low birth weight. *Pediatrics* 104(6):1312-1320.

[17] Eberhardt, M.S., C. Ogden, M. Engelgau, et al. 2004. Prevalence of overweight and obesity among adults with diagnosed diabetes - United States, 1988-1994 and 1999-2002. *Morbidity and Mortality Weekly Report* 53:1063-1066.

[18] Adams, M.A. 2000. *Connecticut Behavioral Health Risks: Factors Related to Cancer.* Hartford, CT: Connecticut Department of Public Health.

Infectious and Vaccine-Preventable Diseases

Infectious diseases, including those preventable by vaccination, still represent a major cause of disability and death. Great strides were made in Connecticut during the 1990's in reducing the incidence of many infectious and vaccine-preventable diseases. Problems still remain, however, for influenza and pneumococcal disease among the elderly, and pertussis among children.

Sexually transmitted diseases are one class of infectious diseases that remains an important public health concern in Connecticut. Despite dramatic decreases in gonorrhea infections among all populations during the 1990's, incidence rates were still in the triple digits for certain subgroups. The incidence rate for chlamydia increased, however, and the death rate for cervical cancer, which is strongly associated with human papillomavirus (HPV) infection, rose among African American/Black women. Although the transmission of HPV and the bacteria that cause chlamydia may be reduced by following safe sex practices, the proportion of sexually active students using condoms declined during the 1990's. Among Connecticut adults in 1998 (the only year for which data are available), only 16% of adults with one sex partner and 39% of adults with multiple sex partners (the higher risk group) said they used a condom every time they had intercourse.[19]

Pregnancy and Childbirth (Low Birthweight)

Low birthweight contributes more than any other risk factor to infant deaths, and newborns with the lowest birthweight have the greatest risk of dying. Furthermore, low birthweight infants that survive longer than one year are more likely than those of normal birthweight to experience subsequent developmental and neurological disabilities.[12]

Percentages of both low birthweight and very low birthweight among infants delivered to Connecticut residents increased during the 1990's, and in 2000 Connecticut had the highest percentage of low birthweight in New England.[20] About 90% of the increase in low birthweight in Connecticut from 1990 to 1998 was attributable to preterm delivery related to multiple pregnancies.[21] It has been estimated that smoking causes 20-30% of all low birthweight deliveries in the U.S.[12] Poor nutrition before and during pregnancy, infections of the genital tract, drug abuse, stress, and environmental exposures to toxic substances also have been associated with preterm deliveries and low birthweight.

Environmental Health

Environmental quality is a major public health concern in Connecticut, with outdoor air pollution and childhood lead poisoning being key issues. The Clean Air Act identified six "criteria air pollutants,"[22] chronic exposure to which is associated with increased respiratory symptoms and exacerbated asthma and emphysema, sometimes leading to hospitalizations and even premature death.

---

[19] Connecticut Department of Public Health. 1998. *Behavioral Risk Factor Surveillance System.* (State-specific questions.)

[20] Martin, J.A., B.E. Hamilton, S.J. Ventura, et al. 2002. Births: Final data for 2000. *National Vital Statistics Reports* 50(5): 1-104.

[21] Mueller, L. 2001. Pregnancy and birth. Pages 26-17 in: *Connecticut Women's Health.* Hartford: Connecticut Department of Public Health.

[22] *Criteria air pollutants* are those causing adverse health effects at current or historic ambient concentrations. They are: particulate matter, ozone, nitrogen dioxide, sulfur dioxide, carbon monoxide, and lead.

In Connecticut in 2000, criteria air pollutants exceeded EPA standards on 99% of days. About 30,000 Connecticut residents are hospitalized each year for respiratory problems,[23] but the proportion related to air pollution is not known.

Childhood lead poisoning is a preventable environmental health problem. Although lead is harmful to people of all ages, it is particularly toxic to children, whose growing bodies absorb more of it and whose nervous systems are more sensitive to its damaging effects. If not detected and treated early, high concentrations of lead can cause neurological damage, impaired growth, and learning, behavioral, and hearing problems.

Exposure to lead can occur both indoors and outdoors. The main source of indoor lead exposure for children is dust contaminated by lead-based paint, which was banned from residential use in 1978. Outdoor lead exposure occurs mainly via soil contaminated by leaded paint and lead from motor vehicle emissions and industrial wastes.

Although numbers of Connecticut children with lead poisoning declined substantially during the late 1990's, more than 2,200 children under 6 years of age were identified with elevated blood lead levels in 2000. Childhood lead poisoning is found in all populations, but children in low-income families living in older housing have the greatest risk. Although several hundred Connecticut residential dwellings are inspected each year for lead-based paint, only about 5,100 out of 1.1 million at-risk homes--less than one-half of one percent--had been inspected as of 2000.

[23] Connecticut Department of Public Health, Health Information Systems and Reporting Section, Hospital Discharge and Billing Data Base, 2000.

Appendices

1 Revised Objectives and Sub-objectives

2 Tracking Data

3 Summary Analyses of Progress

APPENDIX 1

HEALTHY CONNECTICUT 2000 FINAL REPORT
REVISED OBJECTIVES AND SUB-OBJECTIVES

1 PHYSICAL ACTIVITY AND FITNESS

1.1 Reduce coronary heart disease deaths to no more than 84 per 100,000 people
Total population
African-American/Black (no more than 115 per 100,000)

1.2 Reduce overweight to a prevalence of no more than 20% among adults 18 years of age and older
Adults, 18+ years
Males
Females

1.3 Increase to at least 30% the proportion of people 18 years of age and older who engage in regular and sustained physical activity

1.4 Increase to at least 20% the proportion of people who engage in regular and vigorous physical activity
Adults, 18+ years
Students in grades 9-12

1.5 Reduce to no more than 15% the proportion of people who engage in no leisure time physical activity
Adults, 18+ years
Males
Females

1.6 Increase to at least 40% the proportion of students in grades 9-12 who regularly perform physical activities that enhance and maintain muscular strength, muscular endurance, and flexibility

1.7 Increase to at least 35% the proportion of overweight adults who have adopted sound dietary practice combined with regular physical activity to attain an appropriate body weight
Adults, 18+ years
Males
Females

1.11 Increase the proportion of local health departments/agencies funded by block grants that offer fitness activities for their service areas

2 NUTRITION

2.3 Reduce overweight to a prevalence of no more than 20% among adults 18 years of age and older
Adults 18+ years
Males
Females

2.4 Reduce growth retardation among low-income children to less than 7%
Children < 5 years
African-American/Black children < 1 year
Hispanic children < 1 year
Hispanic children 1 year

2.6 Increase the proportion of adults 18+ years of age who consume five or more daily servings of fruits and vegetables

2.10 Reduce iron deficiency to less than 10% among low-income children and less than 3% among low-income women of childbearing age
Children, 1-2 years
Children, 3-4 years
Females, 18-44 years

2.11 Increase to at least 75% the proportion of mothers who breastfeed their babies in the early postpartum period, and to at least 50% the proportion who continue breastfeeding until their babies are 5 to 6 months old
Early postpartum period
Through 5 to 6 months postpartum

APPENDIX 1
HEALTHY CONNECTICUT 2000 FINAL REPORT
REVISED OBJECTIVES AND SUB-OBJECTIVES

3 TOBACCO

3.1 Reduce coronary heart disease deaths to no more than 84 per 100,000 people

- Total population
  - African-American/Black (115 per 100,000)

3.2 Slow the rise in lung cancer deaths to achieve a rate of no more than 42 per 100,000 people overall, 55 per 100,000 males, and 34 per 100,000 females

- Total population
  - Males
  - Females
  - African-American/Black

3.3 Slow the rise in deaths from chronic obstructive pulmonary disease to achieve a rate of no more than 20 per 100,000 people

3.4 Reduce cigarette smoking to a prevalence of no more than 15% among adults 18+ years of age

- Adults 18+ years
  - Males
  - Females
    - Females, 18-44 years
    - Females who gave birth

3.5 Reduce the initiation of cigarette smoking by children and adolescents so that no more than 15% of students in grades 9-12 are current smokers

3.6 Increase to at least 60% the proportion of cigarette smokers 18+ years of age who stopped smoking cigarettes for at least one day during the preceding year

3.14 Develop and maintain a Tobacco Use Prevention and Control Plan

5 FAMILY PLANNING

5.1 Reduce pregnancies among females 15 to 17 years of age to no more than 50 per 1,000

5.4 Reduce to no more than 40% the proportion of students in grades 9-12 who have ever engaged in sexual intercourse

- All students
  - Males
  - Females

5.9 Increase to 100% the number of prenatal care referrals made for women seeking such care after receiving positive pregnancy test results and options counseling at Department of Public Health funded Family Planning clinics

5.10 Increase to 100% the number of Department of Public Health funded Primary Health Care settings that provide or refer to Family Planning services

5.11a Increase to 100% the proportion of Department of Public Health funded Family Planning contractors that provide education and outreach activities to males, minorities of any age, and all persons 10-18 years of age

5.11b Increase to 100% the proportion of women in Department of Public Health funded Family Planning clinics who are counseled, and when counseled, elect to receive screening for sexually transmitted diseases, including HIV where appropriate, as part of a reproductive health care visit

APPENDIX 1

HEALTHY CONNECTICUT 2000 FINAL REPORT

REVISED OBJECTIVES AND SUB-OBJECTIVES

7 VIOLENT AND ABUSIVE BEHAVIORS

7.1 Reduce homicides to no more than 5.0 per 100,000 people.

- Total population
  - Children, <5 years
  - African-American/Black males, 15-34 years
  - African-American/Black females, 15-34 years
  - Hispanic males, 15-34 years

7.2 Reduce suicides to no more than 6.7 per 100,000 people

- Total population
  - Adolescents, 15 19 years
  - Males, 20-34 years
  - While males, 65+ years

7.4 Reverse to less than 25.2 per 1,000 children the rising incidence of maltreatment of children 18 years of age and younger

7.5 Reduce female victims of family violence, 16+ years of age to no more than 27 per 1,000 population

7.6 Reduce assault injuries to no more than 8 per 1,000 people

7.7 Reduce rape of females 12 years of age and older to no more than 108 per 100,000

7.8 Reduce the incidence of injurious suicide attempts among students in grades 9-12 to no more than 3 per 100,000

7.9 Reduce to 32% the incidence of physical fighting among students in grades 9-12

7.10 Reduce to 17.6% the incidence of weapon carrying by students in grades 9-12

7.12 Extend protocols for routinely identifying, treating, and properly referring victims of spouse abuse to at least 90% of hospital-based emergency departments and primary care departments

7.17 Extend coordinated violence prevention programs facilitated by local health departments to 75% of communities in the state with populations over 40,000

8 EDUCATIONAL AND COMMUNITY-BASED PROGRAMS

8.2 Decrease the high school drop-out rate to 10% or less, thereby reducing risks for multiple problem behaviors and poor mental and physical health

- Total student population
  - White
  - African-American/Black
  - Hispanic
  - American Indian
  - Asian American/Pacific Islander

8.14 Increase to 100% the proportion of people who are served by a local health department that is effectively carrying out the assessment, assurance, and policy development core functions of public health

APPENDIX 1

HEALTHY CONNECTICUT 2000 FINAL REPORT

REVISED OBJECTIVES AND SUB-OBJECTIVES

9 UNINTENTIONAL INJURIES

9.3 Reduce deaths caused by motor vehicle crashes to no more than 10.8 per 100,000 people

- Total population
  - Children, 0-14 years
  - Adolescents, 15-24 years
  - Adults, 70+ years
- Motorcyclists
- Pedestrians

9.4 Reduce deaths from falls and fall-related injuries to no more than 2.3 per 100,000 people

9.5 Reduce drowning deaths to no more than 1.0 per 100,000 people

- Total population
  - Children, <5 years
  - Males, 15-34 years
  - African-American/Black

9.6 Reduce residential fire deaths to no more than 0.5 per 100,000 people

- Total population
  - Children, <5 years
  - Adults, 65+ years
  - African-American/Black males
  - African-American/Black females

9.9 Reduce non-fatal head injuries so that hospitalizations for this condition are no more than 106 per 100,000 people

9.12 Increase the use of occupant protection systems, such as seat belts and child safety seats, to at least 85% of motor vehicle occupants

- Seat belts, adults, 18+ years
- Seat belts, children, 5-14 years
- Safety seats, children, 0-5 years

9.13 Increase use of helmets to at least 50% of child and adolescent bicyclists

9.14 Extend the law requiring bicycle helmet use to include children up to and including 15 years of age

9.21 Increase the number of local health departments that routinely provide age-appropriate counseling on injury prevention or have incorporated injury prevention into their programs

10 OCCUPATIONAL SAFETY AND HEALTH

10.4 Reduce the incidence of occupational skin disorders or diseases to no more than 55 per 100,000 full-time workers

10.8 Eliminate exposures that result in workers having blood lead concentrations >25 μg/dL of whole blood

APPENDIX 1

HEALTHY CONNECTICUT 2000 FINAL REPORT

REVISED OBJECTIVES AND SUB-OBJECTIVES

11 ENVIRONMENTAL HEALTH

11.1 Reduce asthma morbidity, as measured by a reduction in asthma hospitalizations, to no more than 160 per 100,000 people

Total population

Children, 0-14 years

African-American/Black, non-Hispanic

Hispanic

11.3 Eliminate outbreaks of waterborne disease from infectious agents and chemical poisoning

11.4 Reduce to no more than 13,000 the number of children aged 6 months through 5 years with blood lead levels exceeding 10 µg/dL

Children, <6 yrs with 10+ µg/dL

Children, <6 yrs with 20+ µg/dL

11.5 Reduce human exposure to criteria air pollutants, as measured by an increase to at least 85% in the proportion of people who live in counties that have not exceeded any Environmental Protection Agency standard for air quality in the previous 12 months

11.6 Increase to at least 50% the proportion of homes tested for radon concentrations and that have either been found to pose minimal risk or have been modified to reduce the risk to health

11.9 Increase to 100% the proportion of people who receive a supply of public drinking water that meets the safe drinking water standard established by the Environmental Protection Agency

11.11 Perform testing for lead-based paint in at least 50% of homes built before 1978

11.12 Expand and promote the use of radon resistant building techniques in new construction for high radon potential areas through mailings and presentations

12 FOOD AND DRUG SAFETY

12.1 Reduce infections caused by key foodborne pathogens to incidences of no more than: *Salmonella* species, 16 per 100,000 people; *Campylobacter jejuni,* 25 per 100,000; *Escherichia coli* O157:H7, 4 per 100,000; and *Listeria monocytogenes* , 0.5 per 100,000

Salmonella species

Campylobacter jejuni

Escherechia coli O157:H7

Listeria monocytogenes

12.2 Reduce outbreaks of infections due to *Salmonella enteritidis* to fewer than 2 per year

12.4 By the year 2000, the Department of Public Health will review the Public Health Code regulations pertaining to food establishments and promulgate regulations

APPENDIX 1

HEALTHY CONNECTICUT 2000 FINAL REPORT

REVISED OBJECTIVES AND SUB-OBJECTIVES

13 ORAL HEALTH

13.1 Reduce dental caries (cavities) so that the proportion of children 7 to 9 years of age with untreated dental diseases is no greater than 20%, and those with a history of treated or untreated decayed, missing, or filled surfaces (DMFS) is no greater than 35%

Children with untreated dental caries

Children with history of treated or untreated DMFS

13.9 Increase to 100% the proportion of people served by community water systems providing optimal levels of fluoride

13.15 Establish and maintain an effective system for recording and referring infants with cleft lips and/or palates to craniofacial anomaly teams

14 MATERNAL AND INFANT HEALTH

14.1 Reduce the overall infant mortality rate to no more than 5.5 per 1,000 live births

Total population (5.5 per 1,000)

White

African-American/Black (11.0 per 1,000)

Hispanic (8.0 per 1,000)

14.3 Reduce the maternal mortality rate to no more than 5.3 per 100,000 live births

14.4 Reduce the incidence of fetal alcohol syndrome to no more than 0.12 per 1,000 live births

14.5 Reduce low birthweight to an incidence of no more than 5% of live births and very low birthweight to no more than 1% of live births

Low birthweight, all races

White

African-American/Black

Hispanic

Very low birthweight, all races

14.7 Reduce severe complications of pregnancy to no more than 150 per 1,000 live births

14.10 Increase abstinence from tobacco use by pregnant women to at least 90%, and increase abstinence from alcohol use by pregnant women to 100%

Abstinence from tobacco use

Abstinence from alcohol use

14.11 Increase to 90% the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy in Connecticut DPH-funded programs

14.12 Increase to 100% the proportion of primary care providers in DPH-funded programs who provide age-appropriate preconception care and counseling

14.13 Increase to 90% the proportion of DPH-funded prenatal care programs that offer screening and counseling on the prenatal detection of fetal abnormalities

14.15 Increase to 100% the proportion of newborns screened for genetic disorders, and maintain at 100% the proportion of newborns testing positive for disease who receive appropriate treatment

Screened

Treated

APPENDIX 1

HEALTHY CONNECTICUT 2000 FINAL REPORT

REVISED OBJECTIVES AND SUB-OBJECTIVES

15 HEART DISEASE AND STROKE

15.1 Reduce coronary heart disease deaths to no more than 84 per 100,000 people

- Total population
  - African-American/Black (no more than 115 per 100,000 people)

15.2 Reduce stroke deaths to no more than 16.8 per 100,000 people

- Total population
  - African-American/Black (no more than 27 per 100,000 people)

15.11 Increase to at least 30% the proportion of adults 18+ years of age who engage in regular and sustained physical activity of 30 minutes per session five or more sessions per week regardless of intensity

15.12 Reduce cigarette smoking to a prevalence of no more than 15% among adults 18+ years of age

- Adults, 18+ years
  - Males
  - Females
    - Females, 18-44 years
    - Females who gave birth

15.13 Increase to at least 95% the proportion of adults 18+ years of age who have had their blood pressure measured within the preceding 2 years

15.14 Increase to at least 75% the proportion of adults 18+ years of age who have had their blood cholesterol checked within the preceding 5 years

16 CANCER

16.1 Reverse the rise in cancer deaths to achieve a rate of no more than 120 per 100,000 people

16.2 Slow the rise in lung cancer deaths to achieve a rate of no more than 42 per 100,000 people overall, 55 per 100,000 males, and 34 per 100,000 females

- Total population
  - Males
  - Females
  - African-American/Black

16.3 Reduce the mortality rate for female breast cancer to no more than 23.1 per 100,000 women

- All females
  - Females, 50+ years

16.4 Reduce deaths from cancer of the uterine cervix to no more than 1.1 per 100,000 women

- All females
  - White females
  - African-American/Black females
  - Females, 55+ years

16.6 Reduce cigarette smoking to a prevalence of no more than 15% among adults 18+ years of age

- Adults, 18+ years
  - Males
  - Females
    - Females, 18-44 years
    - Females who gave birth

16.8 Increase the proportion of adults 18+ years of age who consume five or more daily servings of fruits and vegetables

16.11 Increase to at least 85% the proportion of women 40 years of age and over who have ever received a clinical breast examination and a mammogram, and to at least 75% the proportion of women 50 years of age and over who received a clinical breast examination and mammogram within the last 2 years

- Women, 40+ years, CBE and mammogram, ever had
- Women, 50+ years, CBE and mammogram in preceding 2 years

APPENDIX 1

HEALTHY CONNECTICUT 2000 FINAL REPORT

REVISED OBJECTIVES AND SUB-OBJECTIVES

17 DIABETES AND CHRONIC DISABLING CONDITIONS

17.10 Reduce the rate of lower extremity amputation among people with diabetes to 4.9 per 1,000 overall and 6.1 per 1,000 among African-American/Blacks

Total population
African-American/Black

18 HIV INFECTION

18.2. Confine the annual incidence of diagnosed AIDS cases to no more than 1,100 per 100,000 people

18.3 Reduce to no more than 40% the proportion of students in grades 9-12 who have ever engaged in sexual intercourse

Both sexes
Females
Males

18.4 Increase to at least 50% the proportion of sexually active students in grades 9-12 who used a condom at last sexual intercourse

18.10 Maintain at 100% the proportion of schools that have age-appropriate HIV education curricula for students in grades 4 through 12, preferably as part of quality school health education

18.12 Maintain at 100% the proportion of cities with populations over 100,000 that have outreach programs to contact drug abusers (particularly intravenous drug abusers) to deliver HIV risk reduction messages

19 SEXUALLY TRANSMITTED DISEASES

19.1 Reduce gonorrhea to an incidence of no more than 120 cases per 100,000 people overall, 1,150 per 100,000 among African-American/Blacks, 206 per 100,000 among females 15-44 years of age, and 450 per 100,000 among adolescents 10-19 years of age

Total population
African-American/Black
Females, 15-44 years
Adolescents, 10-19 years

19.2 Reduce the incidence of *Chlamydia trachomatis* infections to no more than 170 cases per 100,000 people

19.3 Reduce the incidence of primary and secondary syphilis to no more than 4 cases per 100,000 people overall, and no more than 30 cases per 100,000 among African-Americans/Blacks

Total population
African-American/Black

19.4 Reduce the incidence of congenital syphilis to no more than 20 cases per 100,000 live births

APPENDIX 1

HEALTHY CONNECTICUT 2000 FINAL REPORT

REVISED OBJECTIVES AND SUB-OBJECTIVES

20 IMMUNIZATION AND INFECTIOUS DISEASES

20.1 Reduce indigenous cases of vaccine-preventable disease as follows:

- Diphtheria, persons ≤ 25 years (0 cases)
- Tetanus, persons ≤ 25 years (0 cases)
- Polio, wild type virus (0 cases)
- Measles, indigenous (0 cases)
- Rubella (0 cases)
- Congenital rubella (0 cases)
- Mumps (≤ 5 cases)
- Pertussis (≤ 10 cases)

20.2 Reduce pneumonia and influenza deaths among people 65+ years of age to no more than 7.3 per 100,000

20.3 Reduce hepatitis B to an incidence of no more than 40 cases per 100,000 people overall, and no more than 5 cases among children <2 years of age.

- Total population
  - Children, <2 years

20.4 Reduce tuberculosis to an incidence of no more than 2.8 cases per 100,000 people overall; 12.0 per 100,000 among Asian Americans/ Pacific Islanders; 9.0 per 100,000 among African Americans/Blacks; and 5.0 per 100,000 among Hispanics.

- Total population
  - Asian American/Pacific Islander
  - African American/Black
  - Hispanic

20.7 Reduce the incidence of bacterial meningitis to no more than 0.8 cases per 100,000 people

20.11 Increase immunization levels as follow:

- Basic immunization series, children <2 years of age (at least 90%)
- Basic immunization series, children in licensed child care facilities (at least 98%)
- Basic immunization series, children in kindergarten through post-secondary education institutions (at least 98%)
- Hepatitis B immunization, high-risk infants of hepatitis B surface antigen-positive mothers (at least 90%)
- Influenza vaccination in preceding year, adults 65+ years of age (at least 80%)
- Pneumococcal vaccination, ever, adults 65+ years of age (at least 80%)

20.13 Maintain immunization laws for 100% of schools, pre-schools, and all day care settings for all antigens

20.15 Maintain financing and delivery of immunizations for children and adults so that 100% of Connecticut residents have no financial barriers to receiving recommended immunizations

20.18 Increase to at least 85% the proportion of people found to have tuberculosis infection who completed courses of preventive therapy

22 SURVEILLANCE AND DATA SYSTEMS

22.1 Develop and establish use of a set of health status indicators appropriate for state and local health agencies

22.5 Implement periodic analysis and publication of data needed to measure progress toward Connecticut's health objectives for each racial or ethnic group that makes up at least 10% of the population

Appendix 2

HEALTHY CONNECTICUT 2000 FINAL REPORT

TRACKING DATA

Obj. No. [Duplicate]	Objective Description[a]	ICD-9 Code(s)	Baseline Data		Tracking Data[b]							Year 2000 Target[c]	Data Source	Comments
			Year	Value	1994	1995	1996	1997	1998	1999	2000			
1. PHYSICAL ACTIVITY AND FITNESS														
1.1	**Coronary heart disease deaths (per 100,000)**	**402, 410-414, 429.2**												
[3.1, 15.1]	Total population		1990	97.7		88.9	87.2	85.7	80.7			84	DPH *Registration Reports* and provisional data.	See Footnote "e"
	African-American/Black		1990	114.1		124.6	110.6	112.1	115.2			115		
1.2	**Overweight prevalence (%)**													
[2.3]	Adults 18+ yrs		1989	18.4	24.0	24.7	25.7	29.1	27.4	28.6	DNA	20	DPH, Behavioral Risk Factor Surveillance System (BRFSS)	From 1994-1999, overweight was defined as Body Mass Index >27.8 (males) and >27.3 (females). Definition changed in 1998 for both sexes to: BMI 25.0 to 29.9 = overweight, and BMI >29.9 = obese. Year 2000 data reflect new definition.
	Males		1989	21.1	29.2	27.8	31.9	32.1	30.2	30.2	DNA		DPH, BRFSS	
	Females		1989	16.0	19.2	21.9	20.1	26.0	24.7	27.2	DNA		DPH, BRFSS	
1.3 [15.11]	**Regular and sustained physical activity, adults 18+ yrs (%)**		1989	20.3	26.9	QNA	21.4	QNA	20.4	QNA	23.7	30	DPH, BRFSS	Regular and sustained physical activity of 30 minutes per session, five or more sessions per week regardless of intensity.
1.4	**Regular and vigorous physical activity (%)**													
	Adults 18+ yrs		1994	16.9	16.9	QNA	14.3	QNA	14.1	QNA	17.0	20	DPH, BRFSS	Regular and vigorous physical activity of 3+ sessions per week, 20+ minutes per session, at 50% or more of capacity.
	Students in Grades 9-12		1995	67.0		67.0	QNA	66.3	QNA	62.3	QNA		CT Dept. of Education, Youth Risk Behavioral Surveillance (DOE, YRBS)[d]	Activities that caused sweating and hard breathing for at least 20 minutes on at least 3 of the previous 7 days.
1.5	**No leisure time physical activity (%)**													
	Adults 18+ yrs		1989	32.3	21.9	QNA	25.6	QNA	27.1	QNA	25.2	15		
	Males		1989	30.0	17.0	QNA	23.8	QNA	24.1	QNA	22.5	15	DPH, BRFSS	Reported as no leisure time physical activity in last month.
	Females		1989	34.3	26.4	QNA	27.2	QNA	29.8	QNA	27.7	15		
1.6	**Regular activity for strength, endurance, flexibility, students in Grades 9-12 (%)**		1995	46.0		46.0	QNA	46.7	QNA	47.4	QNA	40	DOE, YRBS[d]	Activities such as push-ups, sit-ups, or weightlifting on at least three of the days preceding the survey.
1.7	**Overweight adults with sound diet & regular physical activity (%)**													
	Adults 18+ yrs		1994	22.5	QNA	QNA	46.2	QNA	53.9	QNA	49.5	35		
	Males		1994	24.6	QNA	QNA	50.0	QNA	55.8	QNA	46.9	35	DPH, BRFSS	Reported as eating fewer calories and exercising to lose weight.
	Females		1994	19.6	QNA	QNA	43.6	QNA	51.7	QNA	52.9	35		
1.11	**Local health departments offering physical fitness activities (%)**		1997	28.3	DNA	DNA	DNA	28.3	22.0	31.8	20.2	Increase	DPH, Office of Local Health, *per capita* grant applications, 1997 - 2000.	Proportion of local health *per capita* grant applicants that offer fitness activities as an essential service. This does not include other contractual programs that may offer physical fitness programs.

Appendix 2

HEALTHY CONNECTICUT 2000 FINAL REPORT

TRACKING DATA

Obj. No. [Duplicate]	Objective Description[a]	ICD-9 Code(s)	Baseline Data		Tracking Data[b]							Year 2000 Target[c]	Data Source	Comments
			Year	Value	1994	1995	1996	1997	1998	1999	2000			
2. NUTRITION														
2.3	**Overweight prevalence (%)**													
[1.2]	Adults 18+ yrs		1989	18.4	24.0	24.7	25.7	29.1	27.4	28.6	DNA	20	DPH, BRFSS	From 1994-1999, overweight was defined as Body Mass Index >27.8 (males) and >27.3 (females). Definition changed in 1998 for both sexes to: BMI 25.0 to 29.9 = overweight, and BMI >29.9 = obese. Year 2000 data reflect new definition.
	Males		1989	21.1	29.2	27.8	31.9	32.1	30.2	30.2	DNA			
	Females		1989	16.0	19.2	21.9	20.1	26.0	24.7	27.2	DNA			
2.4	**Growth retardation among low-income children (%)**												DPH, WIC Program	Growth retardation is defined as height-for-age below the 5th percentile of children in the National Center for Health Statistics reference population. Data were collected from local WIC programs participating in CDC's Pediatric Nutrition Surveillance System (4 participants in 1991 and 21 in 1998). CT WIC did not participate in the survey during 1999 and 2000.
	Children <5 yrs		1991	6.9					12.8			<7		
	African-American/Black children <1yr		1991	11.6					14.3			<7		
	Hispanic children <1 yr		1991	7.8					12.3			<7		
	Hispanic children 1 yr		1991	10.9					11.0			<7		
2.6 [16.8]	**Daily intake of 5+ fruits & vegetables, adults 18+ yrs (%)**		1994	33.5	33.5	QNA	27.2	32.7	27.9	QNA	29.3	Increase	DPH, BRFSS	
2.10	**Iron deficiency (%)**													Tracked as anemia. Data from local WIC programs participating in the CDC's Pediatric Nutrition Surveillance System (4 programs in 1991 and 21 in 1998). CT WIC did not participate in the survey during 1999 and 2000.
	Children 1-2 yrs		1991	11.5					1.0			<10	DPH, WIC Program	
	Children 3-4 yrs		1991	11.5					12.1			<10	DPH, WIC Program	
	Females 18-44 yrs		1990	0.9	0.9	0.9	0.8	0.7	0.7	0.8	0.7	<3	DPH Birth Registry	Percent of women who had live births and were anemic.
2.11	**Breastfeeding (%)**												DPH, WIC Program	1990 and 1997 data from the Ross Products Division Mothers' Survey; 1998 and 2001 data from the 21 local WIC programs.
	Early postpartum period		1990	53.1				65.5	43.3		46.1	75		
	Through 5-6 months postpartum		1990	20.7				30.9	21.6		7.8	50		
3. TOBACCO														
3.1	**Coronary heart disease deaths (per 100,000)**	**402, 410-414, 429.2**											DPH *Registration Reports* and provisional data.	See Footnote "e"
[1.1, 15.1]	Total population		1990	97.7		88.9	87.2	85.7	80.7			84		
	African-American/Black		1990	114.1		124.6	110.6	112.1	115.2			115		
3.2	**Lung cancer deaths (per 100,000)**												DPH *Registration Reports* and provisional data.	See Footnote "e"
[16.2]	Total population	**162.2-162.9**	1990	33.8		33.2	33.8	33.2	32.8			42		
	Males		1990	46.7		43.4	43.4	41.0	42.0			55		
	Females		1990	24.3		25.6	26.6	27.3	25.7			34		
	African-American/Black		1990	39.3		35.3	33.6	40.3	39.0					
3.3	**Chronic obstructive pulmonary disease deaths (per 100,000)**	**490-496**	1990	15.3	16.0	15.5	15.8	16.5	15.4			20	DPH *Registration Reports* and provisional data.	See Footnote "e"

Appendix 2

HEALTHY CONNECTICUT 2000 FINAL REPORT

TRACKING DATA

Obj. No. [Duplicate]	Objective Description[a]	ICD-9 Code(s)	Baseline Data		Tracking Data[b]							Year 2000 Target[c]	Data Source	Comments
			Year	Value	1994	1995	1996	1997	1998	1999	2000			
3.4	**Cigarette smoking prevalence (%)**													
[15.12, 16.6]	Adults 18+ yrs		1989	26.6	19.8	20.8	21.7	21.6	20.9	22.8	19.9	15	DPH, BRFSS	
	Males		1989	26.3	20.5	21.0	22.6	21.3	22.1	25.3	20.4		DPH, BRFSS	BRFSS data reported as current smokers who smoke every day or some days.
	Females		1989	26.8	19.1	20.6	20.9	21.9	20.4	20.6	19.4		DPH, BRFSS	
	Females 18-44 yrs		1989	30.2	21.0	23.5	27.3	26.6	27.7	25.5	24.6		DPH, BRFSS	
	Females who gave birth		1990	13.4	10.8	10.5	10.0	9.7	9.3	8.3	8.5		DPH Birth Registry	
3.5	**Current smoking by students, Grades 9-12 (%)**		1995	39.0	QNA	39.0	QNA	35.2	QNA	31.2	QNA	15*	DOE, YRBS[d]	*Original objective was to reduce initiation of cigarette smoking so 15% or less would be regular smokers by age 20. Reported data are for students who smoked 1 or more cigarettes in prior 30 days.
3.6	**Smokers who stopped smoking, adults 18+ yrs (%)**		1991	53.7	45.6	48.4	43.5	45.6	DNA	50	DNA	60	DPH, BRFSS	Quit smoking for one day or more during the preceding year.
3.14	**Tobacco use prevention plan**		1996	Plan			Plan		Plan		In progress	Develop and maintain	DPH, Tobacco Prevention Program and CT Dept. of Mental Health and Addiction Services	*Connecticut Tobacco Control Plan* published in 1996 and 1998, and *Connecticut Tobacco Use Prevention and Control Plan* published in 2002.
5. FAMILY PLANNING														
5.1	**Teen pregnancy rate, 15-17 yrs (per 1,000)**		1991	55.6	52.8	45.2	46.9	43.1	40.3	37.3	33.7	50	DPH *Registration Reports* and provisional data.	
5.4	**Ever had sexual intercourse, students in Grades 9-12 (%)**													
[18.3]	All students		1995	50.0	QNA	50.0	QNA	43.5	QNA	44.3	QNA	40		
	Females		1995	46.0	QNA	46.0	QNA	42.3	QNA	39.3	QNA	40	DOE, YRBS[d]	
	Males		1995	53.0	QNA	53.0	QNA	44.4	QNA	49.1	QNA	40		
5.9a	**DPH-funded clinics providing prenatal care referrals for pregnant women (%)**		1996	100			100	100	100	100	100	100	DPH, Family Health Section	Measures reflect contract requirements for all pregnant women in DPH-funded family planning clinics, school-based health centers, and community health centers to receive or be referred to prenatal care services.
5.10	**DPH-funded primary health care settings that provide or refer to family planning services (%)**		1996	100			100	100	100	100	100	100	DPH, Family Health Section	Measures reflect contract requirements for all clients in DPH-funded family planning clinics, school-based health centers, and community health centers to receive or be referred for family planning services.
5.11a	**DPH-funded family planning contractors that provide outreach to males, minorities, and persons 10-18 yrs of age (%)**		1996	100			100	100	100	100	100	100	DPH, Family Health Section	Measures reflect policy and protocol for all DPH-funded family planning clinics, school-based health centers, and community health centers to provide outreach to the target populations.
5.11b	**Women in DPH family planning clinics who receive STD counseling, screening, and referrals (%)**		1996	100			100	100	100	100	100	100	DPH, Family Health Section	Measures reflect contract requirements that all clients are assessed for STD/HIV risk factors, those with identified risks are screened, and all clients receive disease prevention counseling.

Appendix 2

HEALTHY CONNECTICUT 2000 FINAL REPORT

TRACKING DATA

Obj. No. [Duplicate]	Objective Description[a]	ICD-9 Code(s)	Baseline Data		Tracking Data[b]							Year 2000 Target[c]	Data Source	Comments
			Year	Value	1994	1995	1996	1997	1998	1999	2000			
7. VIOLENT AND ABUSIVE BEHAVIORS														
7.1	**Homicide deaths (per 100,000)**	**E960-969**												
	Total population		1990	5.5	7.5	5.4	5.9	4.8	5.2			5		
	Children <5 yrs		1995	2.7		2.7	2.3	2.3	1.4				DPH *Registration Reports* and provisional data.	See Footnote "e"
	African-American/Black males 15-34 yrs		1990	85.0		92.4	99.5	95.3	75.0					
	African-American/Black females 15-34 yrs		1990	23.5		17.5	NC	NC	23.7					
	Hispanic males 15-34 yrs		1990	53.3		30.6	46.9	29.3	28.4					
7.2	**Suicide deaths (per 100,000)**	**E950-E959**												
	Total population		1990	7.9	9.1	9.2	8.4	7.6	7.5			6.7		
	Adolescents 15-19 yrs		1990	9.0	9.9	5.6	6.1	4.5	9.3				DPH *Registration Reports* and provisional data.	See Footnote "e"
	Males 20-34 yrs		1990	17.7		19.3	21	16.6	16.3					
	White males 65+ yrs		1990	26.7		29.1	18.9	22.8	18.3					
7.4	**Maltreatment of children <18 yrs (per 1,000)**		1997	21.1				21.1		16.2		<25.2	CT Department of Children and Families, *Town Page Annual Report, SFY98,* 1/99 and *SFY00*, 7/00.	Children (0-18 yrs) identified as "abused/neglected/uncared for" is the unduplicated count of children involved in the substantiated reports received during the year. Population denominator from USBOC.
7.5	**Female victims of family violence, 16+ years (per 1,000)**		1993	9.5	8.9	9.2	8.7	9.2	8.5	8.5	8.3	27*	Connecticut Dept. of Public Safety, Div. of State Police. *Uniform Crime Reports, Crime in Connecticut, Annual Reports*, 1993-1999.	*Original objective and target were for physical abuse of women by male partners. Reported data are for female victims of family violence 16+ yrs of age.
7.6	**Assault injuries (per 1,000)**		1991	2.8	2.4	2.1	2.1	2.1	2.1	2.0	2.0	8	Connecticut Dept. of Public Safety, Div. of State Police. *Uniform Crime Reports, Crime in Connecticut, Annual Reports*, 1993-1999.	Original target was set for 12+ years of age. Data are for reported aggravated assaults, all ages.
7.7	**Rape, females 12+ yrs (per 100,000)**		1996	90.2			90.2	76.2	61	50.6	59.7	108*	DPH, Rape Crisis Prevention Program.	*Original objective was for rape and attempted rape. Tracking data do not include attempted rape.
7.8	**Injurious suicide attempts, students Grades 9-12 (%)**		1995	3.0	QNA	3.0	QNA	3.0	QNA	3.6	QNA	3	DOE, YRBS[d]	Suicide attempt in last 12 months that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse.
7.9	**Physical fighting, students Grades 9-12 (%)**		1995	38	QNA	38	QNA	33.8	QNA	32.5	QNA	32	DOE, YRBS[d]	Participated in a physical fight on school property at least once in the past year.
7.10	**Weapon carrying, students Grades 9-12 (%)**		1995	22.0	QNA	22.0	QNA	17.0	QNA	15.5	QNA	17.6	DOE, YRBS[d]	Carried a weapon (gun, knife, or club) on school property in past 30 days.
7.12	**Hospital emergency departments and primary care centers with protocols for spousal abuse victims (%)**		1995	62.0		62.0	80.0	84.0	DNA	DNA	DNA	90	DPH, Preventive Health Services Block Grant, annual reports, 1994 - 1998.	Data are for emergency departments only and were from the Intimate Partner Violence Contract with the Domestic Violence Training Project. This information has not been tracked since the contract ended.

Appendix 2

HEALTHY CONNECTICUT 2000 FINAL REPORT

TRACKING DATA

Obj. No. [Duplicate]	Objective Description[a]	ICD-9 Code(s)	Baseline Data		Tracking Data[b]							Year 2000 Target[c]	Data Source	Comments
			Year	Value	1994	1995	1996	1997	1998	1999	2000			
7.17	**Municipalities with populations >40,000 having violence-prevention programs facilitated by local health departments (%)**		1997	32.6	DNA	DNA	DNA	32.6	36.6	29.5	20.2	75	DPH, Local Health Administration	Proportion of local health *per capita* grant applicants that offer violence prevention activities as an essential service. Does not include other contractual programs that may offer violence prevention programs.
8. EDUCATIONAL AND COMMUNITY-BASED PROGRAMS														
8.2	**High-school drop-outs (%)**													
	Total student population		1992	4.7	4.6	4.8	4.6	3.9	3.5	3.3	3.1	10		
	White		1997	2.8				2.7	2.5	2.2	2.1		CT Department of Education, "High School Dropout Rates in Connecticut." *Data Bulletin,* July, 2001.	Original objective called for increasing the graduation rate to 90% or greater. Because graduation data were not available, drop-out percentage was used instead, and target was adjusted accordingly to 10%.
	African-American/Black		1997	6.6				6.5	5.5	5.6	4.7			
	Hispanic		1997	7.8				7.8	8.8	8.3	8.0			
	American Indian		1997	3.7				3.7	2.3	2.8	5.1			
	Asian American/Pacific Islander		1997	2.3				2.3	2.6	2.7	2.0			
8.14	**Population served by local health departments providing assessment, policy development, and assurance core functions of public health (%)**		1994	77.2	77.2	79.1	78.1	80.1	82.1	81.5	82.8	100	DPH, Local Health Administration	Population served by a full-time local health department.
9. UNINTENTIONAL INJURIES														
9.3	**Motor vehicle related deaths (per 100,000)**	**E810-825**												
	Total population		1990	12.2	10.1	10.8	9.9	10.6	10.0			10.8		See Footnote "e."
	Children 0-14 yrs		1990	2.8		1.8	3.0	2.8	1.7				DPH, *Registration Reports* and provisional data	See Footnote "e."
	Adolescents 15-24 yrs		1990	26.8	22.1	22.5	19.8	20.7	18.0					See Footnote "e."
	Adults 70+ yrs		1990	18.0	16.8	16.6	15.3	18.3	20.0					See Footnote "e."
	Motorcyclists		1994	1.0	1.0	1.0	1.0	1.2	0.8				National Highway Traffic Safety Administration. *Traffic Safety Facts.* 1994-1998.	Data for motorcyclists and pedestrians are from NHTSA's Fatal Accident Reporting System (FARS) and General Estimates System, rather than the specified ICD-9 codes, for comparability with national rates. Rates are crude rates based on occurrence.
	Pedestrians		1994	1.9	1.9	1.5	1.5	1.6	1.5				National Highway Traffic Safety Administration. *Traffic Safety Facts. 1994-1998.*	
9.4	**Fall and fall-related deaths (per 100,000)**	**E880-888**	1990	2.4	2.5	2.2	2.8	2.3	2.4			2.3	DPH *Registration Reports* and provisional data.	See Footnote "e"
9.5	**Drowning deaths (per 100,000)**													
	Total population	**E830, E832, E910**	1990	1.4	1.2	1.2	1.1	0.9	0.8			1.0		
	Children <5 yrs		1990	1.7		1.3	1.8	1.8	0.9				DPH *Registration Report*s and provisional data.	See Footnote "e." Crude rate was used for 1998 for African American/Black.
	Males 15-34 yrs		1990	2.7		2.8	1.8	2.0	1.9					
	African-American/Black		1990	1.9		NC	2.2	NC	0.7					

Appendix 2

HEALTHY CONNECTICUT 2000 FINAL REPORT

TRACKING DATA

Obj. No. [Duplicate]	Objective Description[a]	ICD-9 Code(s)	Baseline Data		Tracking Data[b]							Year 2000 Target[c]	Data Source	Comments
			Year	Value	1994	1995	1996	1997	1998	1999	2000			
9.6	**Residential fire deaths (per 100,000)**	**E890-899**												
	Total population		1990	1.0		0.9	1.1	0.6	0.9			0.5		
	Children <5 yrs		1990	2.1		1.8	2.3	0.9	0				DPH, Registration Reports and provisional data	See Footnote "e." Crude rate was used for 1998 for African American/Black males and females.
	Adults 65+ yrs		1990	2.7		2.8	2.3	1.7	2.3					
	African-American/Black males		1990	NC		NC	NC	NC	1.4					
	African-American/Black females		1990	NC		NC	NC	NC	3.8					
9.9	**Hospitalizations for non-fatal head injuries (per 100,000)**	**E800-801, 803-804, 850-854, 870-873, 925**	1993	71.9	65.1	70.5	68.8	69.8	59.5	60.4	58.2	106	DPH, Hospital Discharge and Billing Data Base	See Footnote "f"
9.12	**Use of safety devices by motor vehicle occupants (%)**													
	Seat belts, adults 18+ yrs		1989	75.3	QNA	69.2	QNA	69.3	QNA	DNA	QNA	85		Always use safety belt.
	Seat belts, children 5-14 yrs		1995	83.4	QNA	83.4	QNA	88.1	QNA	DNA	QNA	85	DPH, BRFSS	Use of child safety belt (persons with a child 5-15 yrs surveyed).
	Safety seats, children 0-5 yrs		1995	90.9	QNA	90.9	QNA	96.3	QNA	DNA	QNA	85		Use of child safety seat (persons with a child 0-5 yrs surveyed).
9.13	**Bicycle helmet use by adolescents (%)**		1995	52.5	QNA	52.5	QNA	59.1	QNA	59.2	QNA	50	DPH, BRFSS	Surveyed adults with children age 5-15 yrs (for oldest child) who "always wear" helmets. State law requires protective head-gear for children <16 years of age (see Objective 9.14).
9.14	**Bicycle helmet laws (through age 15 years)**		1993	12 yrs	12 yrs	12 yrs	12 yrs	15 yrs	15 yrs	15 yrs	15 yrs	15 yrs	C.G.S., Section 14-286d	According to the statute, no child 15 years of age or under shall operate a bicycle without protective headgear. Law changed from 12 years of age by P.A. 97-46 in 1997.
9.21	**Local health departments offering injury prevention counseling or programs (%)**		1997	56.5	DNA	DNA	DNA	56.5	65.9	63.6	46.7	Increase	DPH, Local Health Department *per capita* grant applications, 1997 - 2000	Proportion of local health *per capita* grant applicants that offer injury prevention activities as an essential service. Does not include other contractual programs that may offer injury prevention programs.
10. OCCUPATIONAL SAFETY AND HEALTH														
10.4	**Occupational skin disorders or diseases (per 100,000)**		1992	7.7	7.5	13.4	21.0	28.2	31.4	35.7	49.8	55	DPH, "Physicians Report of Occupational Disease." Occupational Disease Surveillance System.	Includes all workers (full- and part-time) with known or suspected occupational disease. Incidence is considered under-reported, and is lower than figures from the U.S. Dept. of Labor Statistics. Original objective for full-time workers only.
10.8	**Adults with blood lead concentrations >25µg/dL (# new cases)**		1993	202	226	99	108	79	39	59	45	0	DPH, Adult Lead Epidemiology and Surveillance System	Includes new cases among all adults. New cases are used to identify exposure, not continuing prevalence. Original objective targeted workers only.

Appendix 2

HEALTHY CONNECTICUT 2000 FINAL REPORT

TRACKING DATA

Obj. No. [Duplicate]	Objective Description[a]	ICD-9 Code(s)	Baseline Data		Tracking Data[b]							Year 2000 Target[c]	Data Source	Comments
			Year	Value	1994	1995	1996	1997	1998	1999	2000			
11. ENVIRONMENTAL HEALTH														
11.1	**Asthma hospitalizations (per 100,000)**	**493**												
	Total population		1993	146.3	135.7	137.7	135.9	128.6	113.6	125.3	114.9	160		See Footnote "f"
	Children 0-14 yrs		1993	232.5	200.1	209.9	222.7	233.7	157.6	207.2	174.6		DPH, Hospital Discharge and Billing Data Base	Includes children <14 years of age with unknown date of birth.
	African-American/Black, non-Hispanic		1993	367.6	333.1	381.0	381.2	344.3	287.7	310.0	248.1			
	Hispanic		1993	420.4	427.0	411.8	411.9	382.4	326.1	300.9	259.0			
11.3	**Outbreaks of waterborne disease (#)**		1990	0	0	0	0	0	0	0	0	0	DPH, Water Supplies Section	Waterborne disease does not exist in Connecticut's public water supplies; however, approximately 500,000 CT residents are still dependent on private wells not regulated for waterborne disease.
11.4	**Elevated blood lead levels (# cases)**													
	Children <6 yrs with 10+ μg/dL		1996	3,122			3,122	2,795	2,483	2,017	2,233	13,000*	DPH, Childhood Lead Poisoning Prevention Program (CLPPP)	*Target was based on CDC estimates for all children <6 years of age. Tracking data are for screened children only. Values cannot be extrapolated to the whole population of children <6 years of age, as only high-risk children are tested.
	Children <6 yrs with 20+ μg/dL		1996	773			773	690	589	460	418			
11.5	**Exposure to criteria air pollutants (% of days)**		1990	96.4	97.6	96.7	99.0	96.8	98.6	97.0	99.2	85*	CT Dept Environmental Protection, Bureau of Air Management	*Original objective was for percentage of CT population exposed to EPA standard air quality. Tracking data represent number of days when air quality in Connecticut was below EPA standard.
11.6	**Homes tested for radon and found or made low-risk (% of total homes tested)**		1992	18.0	23.0		30.0					50	Survey Communications Inc. Conference of Radiation Control Program Directors. *Radon Risk Communication and Results Study*, 1996.	Data are from a sample survey of homeowners reporting their homes had been tested for radon. No new data since 1996.
11.9	**People who receive public drinking water that meets US EPA safety standards (%)**		1991	73.0				90.0	90.0	90.0	90.0	100	DPH, Water Supplies Section	Safe drinking water means community water supplies are in compliance with federal and state standards and are without quality violations.
11.11	**Homes built before 1978 that were tested for lead-based paint (cumulative % tested)**		1995	0.10		0.10	0.19	0.27	0.36	0.41	0.45	50*	DPH, Lead Program	*Original objective was for pre-1950 structures and included public buildings. Lead inspections of public buildings are not reported, nor are pre-1950 residential units reported separately. Reported data are from local health department quarterly reports, submitted by 65-87% of health departments for state fiscal years 1995-96 to 2000-01, and representing cumulative percentages of homes built before 1978 and inspected since 7/01/1995. Percentages are based on a Census 2000 estimate of 1,083,491 pre-1980 dwelling units. Inspections to identify dwellings with toxic levels of lead have been mandated since 1987 (P.A. 87-394), but numbers of tests done before 1995 are not available. Percentages given here are thus underestimated.

Appendix 2

HEALTHY CONNECTICUT 2000 FINAL REPORT

TRACKING DATA

Obj. No. [Duplicate]	Objective Description[a]	ICD-9 Code(s)	Baseline Data Year	Baseline Data Value	Tracking Data[b] 1994	1995	1996	1997	1998	1999	2000	Year 2000 Target[c]	Data Source	Comments
11.12	**Promote radon resistant building techniques**													
	Information packets (#)		1995	3,000		3,000	3,200	1,725	2,235	2,547	2,396	5,000	DPH, Radon Program	Numbers for 1997-2000 represent radon packages distributed. Numbers for 1995-96 represent individual leaflets distributed, and may be overestimated.
	Presentations (#)		1995	25		25		10	6	6	8	25		
12. FOOD AND DRUG SAFETY														
12.1	**Infections caused by foodborne pathogens (per 100,000)**													
	Salmonella species		1993	24.7	20.1	24.4	18.0	16.7	15.5	16.2	12.3	16.0	DPH, Epidemiology & Emerging Infections Program	
	Campylobacter jejuni		1992	31.9	NR	NR	NR	18.7	18.4	17.2	17.2	25.0		
	Escherichia coli 0157:H7		1993	1.6	2.0	1.1	2.1	1.3	1.8	2.9	2.6	4.0		
	Listeria monocytogenes		1993	0.8	0.5	0.5	0.7	0.5	0.9	0.8	0.5	0.5		
12.2	**Outbreaks of *Salmonella enteritidis* infections (per year)**		1993	5.0		5.0	0.0	1.0	2.0	1.0	1.0	2.0	DPH, Epidemiology & Emerging Infections Program	
12.4	**Review Public Health Code pertaining to food establishments and promulgate regulations**								Review in progress	Review in progress	Code Revised	Review Completed	DPH, Office of Government Relations	C.G.S. 19a-36 authorizes the Commissioner of Public Health to establish and occasionally amend the Public Health Code. C.G.S. 19a-36a authorizes regulation of food service establishments and their employees.
13. ORAL HEALTH														
13.1	**Dental caries, children 7-9 yrs (%)**												DPH, Oral Health Program, *Oral Health Survey and Needs Assessment,* 1998	Original objective targeted children 6-8 years of age and adolescents 15 years of age. Data are from survey of second grade children 7-9 years of age.
	Untreated		1997	40.0				40.0				20.0		
	History of untreated or treated decayed, missing or filled surfaces		1997	57.0				57.0				35.0		
13.9	**People served by community water systems providing optimal levels of fluoride (%)**		1990	87.2	87.5	89.0	89.0	89.0	89.0	89.0	89.0	100	DPH, Water Supplies Section	
13.15	**System for recording and referring infants with cleft lips and/or palates to craniofacial anomaly (CFA) teams**		1989	Yes	No	No	No	Yes	Yes	Yes	No	CFA Registry	DPH, Oral Health Program	Objective is to re-establish a system that existed in 1989. As of 2000, the UConn Health Center no longer records and refers Connecticut infants.
14. MATERNAL AND INFANT HEALTH														
14.1	**Infant mortality (deaths per 1,000 live births)**												DPH *Registration Reports* and provisional data.	
	Total population		1990	7.9	7.9	7.3	6.4	7.2	7.0	6.1	6.6	5.5		The 1999 infant death rate of 6.1 per 1,000 live births was the lowest in Connecticut history.
	White		1990	6.4	6.7	6.7	5.3	6.4	5.6	5.7	5.7			
	African-American/Black		1990	17.8	18.9	13.6	15.3	14.9	17.7	10.6	14.7	11.0		
	Hispanic		1995	7.6		7.6	6.8	7.9	9.4	7.7	8.3	8.0		Hispanic ethnicity is considerably under-reported on infant death certificates.

Appendix 2

HEALTHY CONNECTICUT 2000 FINAL REPORT

TRACKING DATA

Obj. No. [Duplicate]	Objective Description[a]	ICD-9 Code(s)	Baseline Data		Tracking Data[b]							Year 2000 Target[c]	Data Source	Comments
			Year	Value	1994	1995	1996	1997	1998	1999	2000			
14.3	**Maternal mortality (deaths per 100,000 live births)**	**630-676**	1987-1996	5.3	<----------------5.3---------|							5.3	National Center for Health Statistics. 1999. State-specific maternal mortality among black and white women, United States, 1987-1996. *MMWR* 48 (23) 492-496.	Data pooled for 1987-1996 because of small numbers.
14.4	**Fetal alcohol syndrome (per 1,000 live births)**	**760.71**	1993	0.93	0.61	0.33	0.28	0.24	0.33	0.24	0.22	0.12	DPH Hospital Discharge and Billing Data Base	Does not include resident births that occurred out of state. For 1993-1999, 5% of FAS hospitalizations in newborns were not assigned V codes, resulting in lower apparent rates.
14.5	**Low and very low birthweight (% of live births)**													
	Low birthweight, all races		1990	6.6	6.9	7.1	7.3	7.3	7.8	7.6	7.5	5.0		Low birthweight is defined as <2,500 grams.
	White		1990	5.6	5.5	5.7	5.9	6.2	6.5	6.2	6.4		DPH *Registration Reports* and provisional data. http://www.dph.state.ct.us/oppe/annualregreports.htm	
	African-American/Black		1990	13.1	12.6	12.7	13.1	12.2	13.2	13.5	12.1			
	Hispanic		1990	8.9	9.0	8.9	8.8	8.3	9.7	9.1	8.7			
	Very low birthweight, all races		1990	1.3	1.3	1.5	1.5	1.6	1.7	1.6	1.6	1.0		Very low birthweight is defined as <1,500 grams.
14.7	**Severe complications of pregnancy (per 1,000 live births)**	**640-648**	1993	138.1	140.3	162.4	154.4	157.1	164.3	177.4	192.1	150	DPH, Hospital Discharge and Billing Data Base	
14.10	**Tobacco and alcohol abstinence during pregnancy (%)**													
	Tobacco abstinence		1990	86.6	89.2	89.5	90.0	90.3	90.6	91.7	91.5	90	DPH, Birth Registry	
	Alcohol abstinence		1990	97.6	98.7	98.7	99.0	98.9	99.0	99.3	99.3	100		
14.11	**Pregnant women who receive prenatal care in the first trimester in DPH-funded programs (%)**		1995	100		100	100	100	100	100	100	90	DPH, Family Health Section	DPH-funded family planning clinics and school-based and community health centers have contractual requirements for prenatal care.
14.12	**DPH-funded providers with age-appropriate preconception care/counseling (%)**		1995	100		100	100	100	100	100	100	100	DPH, Family Health Section	DPH-funded family planning clinics, school-based and community health centers have contractual requirements for prenatal counseling and referrals to family planning services.
14.13	**DPH-funded programs with screening/counseling on fetal abnormality prenatal detection (%)**		1995	100		100	100	100	100	100	100	90	DPH, Family Health Section	Data are not available, but contractees adhere to ACOG standards, and screening for genetic disorders is an integral part of obstetric care. DPH supports Pregnancy Exposure and Information Services at UConn, which provides information and referral services.
14.15	**Newborns screened and treated for genetic disorders (%)**												DPH, Family Health Section	State law requires that all newborns are screened for 8 genetic disorders. Data are from a 3-month review for first specimen screening. Data limitations: 1) may include second specimens; 2) excludes exemptions due to conflict with religious tenets and practice. All screened infants found positive receive follow-up and treatment.
	Screened		1996	98.1			98.1	DNA	99.9	DNA	100	100		
	Treated		1990	100	100	100	100	100	100	100	100	100		

Appendix 2
HEALTHY CONNECTICUT 2000 FINAL REPORT
TRACKING DATA

Obj. No. [Duplicate]	Objective Description[a]	ICD-9 Code(s)	Baseline Data		Tracking Data[b]							Year 2000 Target[c]	Data Source	Comments
			Year	Value	1994	1995	1996	1997	1998	1999	2000			
15. HEART DISEASE AND STROKE														
15.1	**Coronary heart disease deaths (per 100,000)**	**402, 410-414, 429.2**											DPH *Registration Reports* and provisional data.	See Footnote "e"
[1.1, 3.1]	Total population		1990	97.7		88.9	87.2	85.7	80.7			84		
	African-American/Black		1990	114.1		124.6	110.6	112.1	115.2			115		
15.2	**Stroke deaths (per 100,000)**	**430-438**											DPH *Registration Reports* and provisional data.	See Footnote "e"
	Total population		1989	22.3	21.4	20.7	21.1	20.0	20.1			16.8		
	African-American/Black		1990	28.9		31.1	30.6	30.0	26.9			27		
15.11 [1.3]	**Regular and sustained physical activity, adults 18+ yrs (%)**		1989	20.3	26.9	QNA	21.4	QNA	20.4	QNA	23.7	30	DPH, BRFSS	Regular and sustained physical activity of 30 minutes per session, five or more sessions per week, regardless of intensity.
15.12	**Cigarette smoking prevalence (%)**													
[3.4, 16.6]	Adults 18+ yrs		1989	26.6	19.8	20.8	21.7	21.6	20.9	22.8	19.9	15	DPH, BRFSS	Current smokers who smoke every day or some days.
	Males		1989	26.3	20.5	21.0	22.6	21.3	22.1	25.3	20.4		DPH, BRFSS	
	Females		1989	26.8	19.1	20.6	20.9	21.9	20.4	20.6	19.4		DPH, BRFSS	
	Females 18-44 yrs		1989	30.2	21.0	23.5	27.3	26.6	27.7	25.5	24.6		DPH, BRFSS	Target set for "women of reproductive age."
	Females who gave birth		1990	13.4	10.8	10.5	10.0	9.7	9.3	8.3	8.5		DPH Birth Registry	
15.13	**Blood pressure checked in last 2 yrs, adults 18+ yrs (%)**		1993	94.2	QNA	94.7	QNA	95.1	QNA	95.2	QNA	95	DPH, BRFSS	Had blood pressure checked, and could state whether it was normal or high.
15.14	**Blood cholesterol checked in past 5 yrs, adults 18+ yrs (%)**		1989	62.0	67.6	70.2	QNA	73.3	QNA	75.2	QNA	75	DPH, BRFSS	
16. CANCER														
16.1	**Cancer deaths (per 100,000)**	**140-208**	1990	123.3	124.3	120.7	121.0	117.6	116.8			120	DPH *Registration Reports* and provisional data.	
16.2	**Lung cancer deaths (per 100,000)**	**162.2-162.9**												See Footnote "e"
[3.2]	Total population		1990	33.8		33.2	33.8	33.2	32.8			42		
	Males		1990	46.7		43.4	43.4	41.0	42.0			55		
	Females		1990	24.3		25.6	26.6	27.3	25.7			34		
	African-American/Black		1990	39.3		35.3	33.6	40.3	39.0					
16.3	**Female breast cancer deaths (per 100,000)**	**174**												See Footnote "e"
	All females		1990	21.4	21.1	21.4	21.0	19.6	19.7			23.1		
	Females 50+ yrs		1990	101.8		105.6	102.4	97.7	101.8					

Appendix 2

HEALTHY CONNECTICUT 2000 FINAL REPORT

TRACKING DATA

Obj. No. [Duplicate]	Objective Description[a]	ICD-9 Code(s)	Baseline Data		Tracking Data[b]							Year 2000 Target[c]	Data Source	Comments
			Year	Value	1994	1995	1996	1997	1998	1999	2000			
16.4	**Cervical cancer deaths (per 100,000)**	**180**												
	All females		1990	1.7	2.1	1.5	2.2	1.5	1.4			1.1	DPH *Registration Reports* and provisional data.	See Footnote "e"
	White females		1990	1.5		1.5	1.8	1.4	1.2					See Footnote "e"
	African-American/Black females		1990	4.2		NC	6.3	3.1	4.4					Crude rate calculated for 1998 .
	Females 55+ yrs		1990	5.7		5.5	8.1	3.8	5.4					See Footnote "e"
16.6	**Cigarette smoking prevalence (%)**													
[3.4, 15.12]	Adults 18+ yrs		1989	26.6	19.8	20.8	21.7	21.6	20.9	22.8	19.9	15	DPH, BRFSS	
	Males		1989	26.3	20.5	21.0	22.6	21.3	22.1	25.3	20.4		DPH, BRFSS	BRFSS data are for current smokers who smoke every day or some days.
	Females		1989	26.8	19.1	20.6	20.9	21.9	20.4	20.6	19.4		DPH, BRFSS	
	Females 18-44 yrs		1989	30.2	21.0	23.5	27.3	26.6	27.7	25.5	24.6		DPH, BRFSS	
	Females who gave birth		1990	13.4	10.8	10.5	10.0	9.7	9.3	8.3	8.5		DPH *Registration Reports* and provisional data	
16.8 [2.6]	**Daily intake of 5+ fruits & vegetables, adults 18+ yrs (%)**		1994	33.5	33.5	QNA	27.2	32.7	27.9	QNA	29.3	Increase	DPH, BRFSS	Eat 5 or more daily servings of fruits and vegetables.
16.11	**Clinical breast exam & mammogram (%)**													
	Females 40+ yrs, ever had		1994	78.3	78.3	79.3	80.6	78.6	79.6	83.3	86.6	85	DPH, BRFSS	Ever had mammogram and clinical breast exam, 40+ yrs
	Females 50+ yrs, had in last 2 yrs		1994	63.3	63.3	67.6	65.7	67.0	69.4	77.8	78.6	75	DPH, BRFSS	Had mammogram and CBE within last 2 yrs, 50+ yrs
17. DIABETES & CHRONIC DISABLING CONDITIONS														
17.10	**Diabetes with lower extremity amputation (per 1,000)**	**Diagnosis Code 250 plus Procedure Code 84.1, w/o a code of 895-897**											DPH, BRFSS (diabetes prevalence); DPH, Hospital Discharge and Billing Data Base (lower extremity amputations)	Rates were calculated using as denominators the estimated numbers of CT residents 18+ years of age with diabetes. For total population, estimates were calculated as single year BRFSS prevalence rates multiplied by the 2000 Census population 18+ years of age (2,563,877). Because single-year prevalence rates among black non-Hispanics are unstable, a 3-year (1998-2000) BRFSS average prevalence rate (7.75%) was applied to the 2000 Census population of single-race black, non-Hispanic adults (202,510) to estimate the number of diabetics.
	Total population		1993	7.2	9.0	9.9	9.9	8.7	10	10.9	8.0	4.9		
	African-American/Black (non-Hispanic)		1993	9.2	10.4	10.2	10.5	8.6	11.4	12.6	11.8	6.1		

Appendix 2
HEALTHY CONNECTICUT 2000 FINAL REPORT
TRACKING DATA

Obj. No. [Duplicate]	Objective Description[a]	ICD-9 Code(s)	Baseline Data		Tracking Data[b]							Year 2000 Target[c]	Data Source	Comments
			Year	Value	1994	1995	1996	1997	1998	1999	2000			
18. HIV INFECTION														
18.2	**AIDS incidence (diagnosed cases per 100,000)**		1990	18.7	34.2	37.5	34.0	25.2	18.5	17.6	16.6	1,100*	DPH, HIV/AIDS Epidemiology Program, "Numbers of CT AIDS cases reported, diagnosed, deaths, and prevalent cases through December 31, 2004."	* The target of 1,100 per 100,000 was set as a prevalence rate for HIV infection. The corresponding *Healthy People 2000* objective and target were changed to "an annual incidence of diagnosed AIDS cases of no more than 43 per 100,000." For Connecticut, the objective was changed for consistency, but the target value was not.
18.3	**Ever had sexual intercourse, students in Grades 9-12, (%)**													
[5.4]	Both sexes		1995	50.0	QNA	50.0	QNA	43.5	QNA	44.3	QNA	40		
	Females		1995	46.0	QNA	46.0	QNA	42.3	QNA	39.3	QNA	40	DOE, YRBS[d]	
	Males		1995	53.0	QNA	53.0	QNA	44.4	QNA	49.1	QNA	40		
18.4	**Condom use, sexually active students in Grades 9-12 (%)**		1995	56.0	QNA	56.0	QNA	57.3	QNA	54.7	QNA	50	DOE, YRBS[d]	Condom was used during last sexual intercourse.
18.10	**Schools with HIV education curricula in Grades 4-12 (%)**		1995	100	DNA	100	100	100	100	100	100	100	DPH, AIDS and Chronic Disease Section	According to C.G.S. 10-19(b), each local and regional board of education must offer instruction on AIDS. Content and scheduling are at the discretion of the local board of education.
18.12	**Cities (population >100,000) with HIV outreach to drug abusers (%)**		1995	100		100	100	100	100	100	100	100	DPH, AIDS and Chronic Disease Section	Includes Bridgeport, Hartford, New Haven, Stamford, and Waterbury.
19. SEXUALLY TRANSMITTED DISEASES														
19.1	**Gonorrhea incidence (per 100,000)**													
	Total population		1989	315.0	145.0	124.0	103.0	96.0	104.7	101.0	85.5	120		Targets for gonorrhea incidence rates for racial and ethnic groups are probably high, because the large numbers of cases with unknown race/ethnicity were assumed to be distributed in the same percentages as those of known race/ethnicity.
	African-American/Black		1993	803.0	770.0	705.0	577.0	549.0	882.0	792.6	638.7	1,150	DPH, STD Control Program	
	Females 15-44 yrs		1989	526.0		251.0	219.0	199.0	193.0	182.0	154.5	206		
	Adolescents 10-19 yrs		1990	487.0	335.0	308.0	260.0	223.0	212.0	217.0	193.0	450		Original objective and target were for adolescents 15-19 years of age.
19.2	***Chlamydia trachomatous* incidence (per 100,000)**		1990	195.0	218.0	197.0	191.0	195.0	229.0	227.0	232.0	170	DPH, STD Control Program	About 80% of Connecticut's Chlamydia cases are found in women, and more than two-thirds occur among people 15-24 years of age.
19.3	**Primary and secondary syphilis incidence (per 100,000)**													
	Total population		1990	26.6	3.2	2.6	3.1	1.9	0.76	0.48	0.44	4	DPH, STD Control Program	
	African-American/Black		1990	236.3	32.4	18.6	25.9	11.7	6.1	2.8	2.6	30		
19.4	**Congenital syphilis incidence (per 100,000 live births)**		1990	53.9	13.1	15.8	4.5	7.0	6.9	6.3	6.3	20	DPH, STD Control Program	

Appendix 2

HEALTHY CONNECTICUT 2000 FINAL REPORT

TRACKING DATA

Obj. No. [Duplicate]	Objective Description[a]	ICD-9 Code(s)	Baseline Data		Tracking Data[b]							Year 2000 Target[c]	Data Source	Comments
			Year	Value	1994	1995	1996	1997	1998	1999	2000			
20. IMMUNIZATION AND INFECTIOUS DISEASES														
20.1	**Indigenous vaccine preventable diseases (# cases)**													"Indigenous vaccine preventable diseases" excludes those acquired outside the U.S.
	Diphtheria (≤25 yrs)		1990	0	0	0	0	0	0	0	0	0		Last reported case of diphtheria was in 1962.
	Tetanus (≤25 yrs)		1990	0	0	0	0	0	0	0	0	0		
	Polio		1990	0	0	0	0	0	0	0	0	0		
	Measles		1990	28	4	1	2	0	0	2	0	0	DPH, Immunizations Program	
	Rubella		1990	3	3	45	4	5	28	0	1	0		One additional case of rubella was reported in 1998, but place of origin was unknown.
	Congenital rubella		1990	0	0	0	0	0	0	0	0	0		
	Mumps		1990	17	12	4	1	1	3	0	3	5		
	Pertussis		1990	31	44	34	49	36	45	35	54	10		
20.2	**Pneumonia & influenza deaths, adults 65+ yrs (per 100,000)**	**480-487**	1990	236.9	228.1	215.7	223.8	239.1	246.2			7.3*	DPH *Registration Reports* and provisional data.	*Original objective was for epidemic-related pneumonia and influenza deaths. Tracking data are for all pneumonia and influenza deaths. Objective was changed, but target value was not reset.
20.3	**Hepatitis B incidence**													
	Total population (per 100,000)		1990	7.4	2.9	2.7	2.5	1.7	1.0	1.5	1.4	40*	DPH HIV/AIDS Surveillance & Viral Hepatitis Prevention Program	*Original objective for total population was based on national estimates that included undetected cases, whereas tracking data are for reported acute cases. Objective was changed, but target value was not reset.
	Children <2 yrs (# acute cases)		1989	1	0	1	0	0	0	0	0	5		
20.4	**Tuberculosis incidence (per 100,000)**	**010-018.9**												
	Total population		1990	5.0	4.5	4.2	4.2	3.9	3.9	3.7	3.1	2.8	DPH, Tuberculosis Control Program	
	Asian American & Pacific Islander		1989	29.6	44.8	50.9	67.2	50.9	28.6	37.3	20.7	12		
	African-American/Black		1989	21.9	17.6	15.0	13.4	15.0	16.5	12.4	10.0	9		
	Hispanic		1989	8.9	16.0	14.5	15.5	15.0	9.7	10.7	5.6	5		
20.7	**Bacterial meningitis incidence (per 100,000)**		1991	0.57	0.46	0.58	0.49	0.73	0.37	0.15	0.15	0.8	DPH, Epidemiology & Emerging Infections Program	Bacterial meningitis is not reportable in CT. Data represent invasive infections with *Neisseria meningitidis* and *Haemophilus influenzae*.

Appendix 2

HEALTHY CONNECTICUT 2000 FINAL REPORT

TRACKING DATA

Obj. No. [Duplicate]	Objective Description[a]	ICD-9 Code(s)	Baseline Data		Tracking Data[b]							Year 2000 Target[c]	Data Source	Comments
			Year	Value	1994	1995	1996	1997	1998	1999	2000			
20.11	**Immunizations (%)**													
	Basic immunization series, children 2 yrs		1994	86.0	86.0	85.0	88.0	87.0	90.0	87.0	85.0	90	CDC, National Immunization Survey	Basic series comprises 4 DPT, 3 Polio, and 1 MMR.
	Basic immunization series, children in licensed day care		1993	96.0	96.0	97.0	97.0	98.0	97.2	98.0	97.9	98	CDC, National Immunization Survey (1993-1997 data); DPH, Immunization Program (1998-2000 data)	DPH data are from annual surveys of all licensed daycare centers in CT.
	Basic immunization series, children in schools, grades pre-K through 12		1991	98.0	98.0	98.0	98.0	98.0	98.4	97.5	98.5	98	DPH Immunization Program	Based on annual surveys of new entrants to all Connecticut schools (grades pre-K to 12).
	Hepatitis B immunization, high risk infants		1995	94.0		94.0	97.8	99.1	99.0	96.7	97.4	90	DPH, HIV/AIDS Surveillance & Viral Hepatitis Prevention Program	Original objective targeted all high risk populations. Tracking data are for infants of surface-antigen-positive mothers who received HBIG plus 3 doses of HBV by age 12 months.
	Influenza vaccination in last 12 months, adults 65+ yrs		1995	62.5	QNA	62.5	QNA	67.2	QNA	64.8	QNA	80	DPH, BRFSS	Original objective targeted institutionalized chronically ill or older people. Tracking data are for surveyed CT residents 65+ years of age who have telephones in their homes.
	Pneumococcal vaccination, ever had, adults 65+ yrs		1995	38.3	QNA	38.3	QNA	43.0	QNA	49.0	QNA	80	DPH, BRFSS	Original objective targeted institutionalized chronically ill or older people. Tracking data are for surveyed CT residents 65+ years of age who have telephones in their homes.
20.13	**Maintain immunization laws for schools, pre-schools, & day care settings (%)**		1994	100	100	100	100	100	100	100	100	100	DPH Immunization Program	Mandated by: C.G.S. 19a-87b-10 (daycare); C.G.S. 19a-7f (school entry); C.G.S 19a-7f and 10-204a (schools). Statutory change of 1999 added Varicella to the list of required immunizations.
20.15	**Maintain financing & delivery of immunizations (%)**		1994	100	100	100	100	100	100	100	100	100	DPH Immunization Program	Mandated by C.G.S 19a-7f.
20.18	**People with tuberculosis infections who completed preventive therapy (%)**		1991	82.2	82.9	75.5	63.0	63.6	59.0	59.9	64.8	85	DPH, Tuberculosis Control Program	Rates are for people with latent tuberculosis infection, not active cases.

Appendix 2

HEALTHY CONNECTICUT 2000 FINAL REPORT

TRACKING DATA

Obj. No. [Duplicate]	Objective Description[a]	ICD-9 Code(s)	Baseline Data		Tracking Data[b]							Year 2000 Target[c]	Data Source	Comments
			Year	Value	1994	1995	1996	1997	1998	1999	2000			
22. SURVEILLANCE AND DATA SYSTEMS														
22.1	**Develop and establish use of a set of health status indicators**		1994	Done	Done	Done	Done	Done	Done	Done	Done	Data set	DPH, State Health Planning Section	DPH contributes data for tracking 18 Health Status or Consensus Indicators from *Healthy People 2000* and 21 Leading Health Indicators from *Healthy People 2010*.
22.5	**Periodic (at least once every 3 years) analysis and publication of data for measuring progress toward objectives for each racial or ethnic group representing 10% or more of the population**		1994	No report	No report	No report	No report	No report	No report	Done	No report	Reports	DPH, State Health Planning Section	According to the 2000 Census, no racial or ethnic group except "white race" constitutes 10% or more of the Connecticut population; however, persons of African American/black race and Hispanic ethnicity each represent >10% of the population of some counties and more than one-third of the population of some towns. A comprehensive report, *Multicultural Health: The Health Status of Minority Groups in Connecticut,* was published by DPH in 1999. All major DPH reports on natality, morbidity, and mortality contain data broken out by race and ethnicity.

NOTES:

[a] Main objectives are shown in boldface; sub-objectives are in normal type.

[b] Blank spaces indicate that data either were not collected or were not available for that year. DNA = data not analyzed. NC = mortality rates not calculated for less than 5 events. NR = not a reportable disease in the given year. QNA = question not asked (BRFSS) or survey not conducted (YRBS) in the given year. Rates were calculated using US Census Bureau population estimates as denominators.

[c] An asterisk (*) beside a target value indicates that tracking data could not be evaluated relative to the target, because of differences in operational definition, units of measurement, or method of calculation. See *Comments* column for specific reasons.

[d] Connecticut YRBS data cannot be compared over time, because the 1995 and 1999 data were unweighted, whereas the 1997 data were weighted.

[e] Unless otherwise noted, mortality rates for all ages, total population, and by sex, race, and ethnicity were age-adjusted to the 1940 U.S. standard million population. Rates for particular age cohorts are age-specific.

[f] Hospitalization rates were calculated as crude rates for ease of comparison with national rates. When age-adjusted to the 1940 or 2000 U.S. standard million population, absolute values change, but patterns of hospitalization rates remain the same.

APPENDIX 3

HEALTHY CONNECTICUT 2000 FINAL REPORT
SUMMARY ANALYSES OF PROGRESS

Relationship Between Baseline and Most Recent Values

When improvement for an objective was evidenced by a *decrease* from the baseline value (e.g., mortality or incidence rates), the *outcome ratio* between the baseline and final values for a given objective was determined by using the equation:

(a) Outcome Ratio = Baseline Value / Final Value

When improvement for an objective was evidenced by an *increase* from the baseline value (e.g., healthful behaviors or health service delivery), the *outcome ratio* between the baseline and final values was determined by using the equation:

(b) Outcome Ratio = Final Value / Baseline Value

A ratio of 1 thus signifies no change, a ratio >1 indicates improvement, and a ratio <1 indicates worsening, relative to the baseline value.

Relationship Between Target and Most Recent Values

When improvement for an objective was evidenced by a *decrease* toward a target value (e.g., mortality or incidence rates), the *target ratio* between the target and final values was determined by using the equation:

(c) Target Ratio = Target Value / Final Value

When improvement for an objective was evidenced by an *increase* toward a target value (e.g., healthful behaviors or health service delivery), the *target ratio* between the target and final values was determined by using the equation:

(d) Target Ratio = Final Value / Target Value

A ratio of 1 thus signifies the target was met, a ratio >1 indicates the target was surpassed, and a ratio <1 indicates the target was not met.

The outcome and target ratios and the qualitative progress outcomes (better, worse, no change), along with targets met, are given in the accompanying table. The qualitative determinations were based on these ratios rather than the values in Appendix 2.

APPENDIX 3

HEALTHY CONNECTICUT 2000 FINAL REPORT
SUMMARY ANALYSES OF PROGRESS

Objective No.	Objective Description	Outcome[a]	Target Met[b]	Outcome Ratio	Target Ratio
1	**PHYSICAL ACTIVITY AND FITNESS**				
1.1	**Coronary heart disease deaths (per 100,000)**				
	Total population	B	Yes	1.21	1.04
	African-American/Black	W	Yes	0.99	1.00
1.2	**Overweight prevalence (%)**				
	Adults 18+ yrs	W	No	0.64	0.70
	Males	W	No	0.70	0.66
	Females	W	No	0.59	0.74
1.3	**Regular and sustained physical activity, adults 18+ yrs (%)**	B	No	1.17	0.79
1.4	**Regular and vigorous physical activity (%)**				
	Adults 18+ yrs	B	No	1.01	0.85
	Students in grades 9-12	W	Yes	0.93	3.12
1.5	**No leisure time physical activity (%)**				
	Adults 18+ yrs	B	No	1.28	0.60
	Males	B	No	1.33	0.67
	Females	B	No	1.24	0.54
1.6	**Regular activity for strength, endurance, flexibility, students in grades 9-12 (%)**	B	Yes	1.03	1.19
1.7	**Overweight adults with sound diet & regular physical activity (%)**				
	Adults 18+ yrs	B	Yes	2.20	1.41
	Males	B	Yes	1.91	1.34
	Females	B	Yes	2.70	1.51
1.11	**Local health departments offering physical fitness activities (%)**	W	No	0.71	(c)
2	**NUTRITION**				
2.3	**Overweight prevalence (%)**				
	Adults 18+ yrs	W	No	0.64	0.70
	Males	W	No	0.70	0.66
	Females	W	No	0.59	0.74
2.4	**Growth retardation among low-income children (%)**				
	Children <5 yrs	W	No	0.54	0.55
	African-American/Black children <1yr	W	No	0.81	0.49
	Hispanic children <1 yr	W	No	0.63	0.57
	Hispanic children 1 yr	W	No	0.99	0.64
2.6	**Daily intake of 5 fruits & vegetables, adults 18+ yrs (%)**	W	No	0.87	(c)
2.10	**Iron deficiency (%)**				
	Children 1-2 yrs	B	Yes	11.50	10.00
	Children 3-4 yrs	W	No	0.95	0.83
	Females 18-44 yrs	B	Yes	1.30	4.29
2.11	**Breastfeeding (%)**				
	Early postpartum period	W	No	0.87	0.61
	Through 5-6 months postpartum	W	No	0.38	0.16

APPENDIX 3

HEALTHY CONNECTICUT 2000 FINAL REPORT
SUMMARY ANALYSES OF PROGRESS

Objective No.	Objective Description	Outcome[a]	Target Met[b]	Outcome Ratio	Target Ratio
3	**TOBACCO**				
3.1	**Coronary heart disease deaths (per 100,000)**				
	Total population	B	Yes	1.21	1.04
	African-American/Black	W	Yes	0.99	1.00
3.2	**Lung cancer deaths (per 100,000)**				
	Total population	B	Yes	1.03	1.28
	Males	B	Yes	1.11	1.31
	Females	W	Yes	0.95	1.32
	African-American/Black	B	N/A[1]	1.01	(c)
3.3	**COPD deaths, total population (per 100,000)**	W	Yes	0.99	1.30
3.4	**Cigarette smoking prevalence (%)**				
	Adults 18+ yrs	B	No	1.34	0.75
	Males	B	No	1.29	0.74
	Females	B	No	1.38	0.77
	Females 18-44 yrs	B	No	1.23	0.61
	Females who gave birth	B	Yes	1.58	1.76
3.5	**Current smoking by students, Grades 9-12 (%)**	B	N/A[2]	1.25	(c)
3.6	**Smokers who stopped smoking, adults 18+ yrs (%)**	W	No	0.93	0.83
3.14	**Tobacco use prevention plan**	NC	Yes	(c)	(c)
5	**FAMILY PLANNING**				
5.1	**Teen pregnancy rate, 15-17 yrs (per 1,000)**	B	Yes	1.65	1.48
5.4	**Students in Grades 9-12 who ever had sexual intercourse (%)**				
	All students	B	No	1.13	0.90
	Females	B	Yes	1.17	1.02
	Males	B	No	1.08	0.81
5.9	**DPH-funded clinics providing prenatal care referrals for pregnant women (%)**	NC	Yes	1.00	1.00
5.10	**DPH-funded primary health care settings that provide or refer to family planning services (%)**	NC	Yes	1.00	1.00
5.11a	**DPH-funded family planning contractors that provide outreach to males, minorities, and persons 10-18 yrs of age (%)**	NC	Yes	1.00	1.00
5.11b	**Women in DPH family planning clinics who receive STD counseling, screening, and referrals (%)**	NC	Yes	1.00	1.00
7	**VIOLENT AND ABUSIVE BEHAVIORS**				
7.1	**Homicide deaths (per 100,000)**				
	Total population	B	No	1.06	0.96
	Children <5 yrs	B	Yes	1.93	3.57
	African-American/Black males 15-34 yrs	B	No	1.13	0.07
	African-American/Black females 15-34 yrs	W	No	0.99	0.21
	Hispanic males 15-34 yrs	B	No	1.88	0.18
7.2	**Suicide deaths (per 100,000)**				
	Total population	B	No	1.05	0.89
	Adolescents 15-19 yrs	W	No	0.97	0.72
	Males 20-34 yrs	B	No	1.09	0.41
	White males 65+ yrs	B	No	1.46	0.37

APPENDIX 3

HEALTHY CONNECTICUT 2000 FINAL REPORT
SUMMARY ANALYSES OF PROGRESS

Objective No.	Objective Description	Outcome[a]	Target Met[b]	Outcome Ratio	Target Ratio
7.4	**Maltreatment of children < 18 yrs (per 1,000)**	B	Yes	1.30	1.56
7.5	**Female victims of family violence, 16+ years (per 1,000)**	B	N/A[2]	1.14	(c)
7.6	**Assault injuries (per 1,000)**	B	Yes	1.40	4.00
7.7	**Rape, females 12+ yrs (per 100,000)**	B	N/A[2]	1.51	(c)
7.8	**Injurious suicide attempts, students Grades 9-12 (%)**	W	No	0.83	0.83
7.9	**Physical fighting, students Grades 9-12 (%)**	B	No	1.17	0.98
7.10	**Weapon-carrying, students Grades 9-12 (%)**	B	Yes	1.42	1.14
7.12	**Hospital emergency departments and primary care centers with protocols for spousal abuse victims (%)**	B	No	1.35	0.93
7.17	**Municipalities with populations >40,000 having violence-prevention programs facilitated by local health departments(%)**	W	No	0.62	0.27
8	**EDUCATIONAL AND COMMUNITY-BASED PROGRAMS**				
8.2	**High-school drop-outs (%)**				
	Total student population	B	Yes	1.52	3.23
	White	B	Yes	1.33	4.76
	African-American/Black	B	Yes	1.40	2.13
	Hispanic	W	Yes	0.98	1.25
	American Indian	W	Yes	0.73	1.96
	Asian American/Pacific Islander	B	Yes	1.15	5.00
8.14	**Population served by local health departments providing assessment, policy development, and assurance core functions of public health (%)**	B	No	1.07	0.83
9	**UNINTENTIONAL INJURIES**				
9.3	**Motor vehicle related deaths (per 100,000)**				
	Total population	B	Yes	1.22	1.08
	Children 0-14 yrs	B	Yes	1.65	6.35
	Adolescents 15-24 yrs	B	No	1.49	0.60
	Adults 70+ yrs	W	No	0.90	0.54
	Motorcyclists	B	Yes	1.25	13.50
	Pedestrians	B	Yes	1.27	7.20
9.4	**Fall and fall-related deaths (per 100,000)**	NC	No	1.00	0.96
9.5	**Drowning deaths (per 100,000)**				
	Total population	B	Yes	1.75	1.25
	Children <5 yrs	B	Yes	1.89	1.11
	Males 15-34 yrs	B	No	1.42	0.53
	African-American/Black	B	Yes	2.71	1.43
9.6	**Residential fire deaths (per 100,000)**				
	Total population	B	No	1.11	0.56
	Children <5 yrs	B	Yes	(c)	(c)
	Adults 65+ yrs	B	No	1.17	0.22
	African-American/Black males	N/M	No	(c)	0.36
	African-American/Black females	N/M	No	(c)	0.13
9.9	**Hospitalizations for non-fatal head injuries (per 100,000)**	B	Yes	1.24	1.82
9.12	**MV occupant use of safety devices (%)**				
	Seat belts, adults 18+ yrs	W	No	0.92	0.82
	Seat belts, children 5-14 yrs	B	Yes	1.06	1.04
	Safety seats, children 0-5 yrs	B	Yes	1.06	1.13

APPENDIX 3

HEALTHY CONNECTICUT 2000 FINAL REPORT
SUMMARY ANALYSES OF PROGRESS

Objective No.	Objective Description	Outcome[a]	Target Met[b]	Outcome Ratio	Target Ratio
9.13	**Bicycle helmet use by children and adolescents (%)**	B	Yes	1.13	1.18
9.14	**Bicycle helmet laws through age 15 yrs**	NC	Yes	(c)	(c)
9.21	**Local health departments offering injury prevention programs (%)**	W	No	0.83	(c)
10	**OCCUPATIONAL SAFETY AND HEALTH**				
10.4	**Occupational skin disorders or diseases (per 100,000)**	W	Yes	0.15	1.10
10.8	**Adults with blood lead concentrations >25 ug/dL (# new cases)**	B	No	4.49	(c)
11	**ENVIRONMENTAL HEALTH**				
11.1	**Asthma hospitalizations (per 100,000)**				
	Total population	B	Yes	1.27	1.39
	Children 0-14 yrs	B	No	1.33	0.92
	African-American/Black, non-Hispanic	B	No	1.48	0.64
	Hispanic	B	No	1.62	0.62
11.3	**Outbreaks of waterborne disease (#)**	NC	Yes	1.00	1.00
11.4	**Elevated blood lead levels (# cases)**				
	Children <6 yrs with 10+ ug/dL	B	N/A[2]	1.40	(c)
	Children <6 yrs with 20+ ug/dL	B	N/A[1]	1.85	(c)
11.5	**Exposure to criteria air pollutants (% of days)**	W	N/A[2]	0.97	(c)
11.6	**Homes tested for radon and found or made low-risk (% of total homes tested)**	B	No	1.67	0.60
11.9	**People receiving public drinking water that meets US EPA safety standards (%)**	B	No	1.23	0.90
11.11	**Homes inspected for lead-based paint (cumulative %)**	B	No	0.52	0.28
11.12	**Promote radon resistant building techniques**				
	Information packets (#)	W	No	0.80	0.48
	Presentations (#)	W	No	0.32	0.32
12	**FOOD AND DRUG SAFETY**				
12.1	**Infections caused by foodborne pathogens (per 100,000)**				
	Salmonella species	B	Yes	2.01	1.30
	Campylobacter jejuni	B	Yes	1.85	1.45
	Escherichia coli 0157:H7	W	Yes	0.62	1.54
	Listeria monocytogenes	B	Yes	1.60	1.00
12.2	**Outbreaks of *Salmonella enteritides* infections (per year)**	B	Yes	5.00	2.00
12.4	**Review Public Health Code pertaining to food establishments and promulgate regulations**	B	Yes	(c)	(c)
13	**ORAL HEALTH**				
13.1	**Dental caries, children 7-9 yrs (%)**				
	Untreated	N/A	No	1.00	0.50
	History of untreated or treated decayed, missing or filled surfaces	N/A	No	1.00	0.61
13.9	**People served by community water systems providing optimal levels of fluoride (%)**	B	No	1.02	0.89
13.15a	**System for recording and referring infants with cleft lips and/or palates to craniofacial teams (Yes/No)**	W	No	(c)	(c)

APPENDIX 3

HEALTHY CONNECTICUT 2000 FINAL REPORT
SUMMARY ANALYSES OF PROGRESS

Objective No.	Objective Description	Outcome[a]	Target Met[b]	Outcome Ratio	Target Ratio
14	**MATERNAL AND INFANT HEALTH**				
14.1	**Infant mortality (per 1,000 live births)**				
	Total population	B	No	1.20	0.83
	White	B	No	1.12	0.96
	African-American/Black	B	No	1.21	0.75
	Hispanic	W	No	0.92	0.96
14.3	**Maternal mortality (deaths per 100,000 live births)**	N/A	Yes	1.00	1.00
14.4	**Fetal alcohol syndrome (per 1,000 live births)**	B	No	4.23	0.55
14.5	**Low and very low birthweight (% of live births)**				
	Low birthweight, all races	W	No	0.88	0.67
	White	W	No	0.88	0.78
	African-American/Black	B	No	1.08	0.41
	Hispanic	B	No	1.02	0.57
	Very low birthweight, all races	W	No	0.81	0.63
14.7	**Severe complications of pregnancy (per 1,000 live births)**	W	No	0.72	0.78
14.10	**Tobacco and alcohol abstinence during pregnancy (%)**				
	Tobacco abstinence	B	Yes	1.06	1.02
	Alcohol abstinence	B	No	1.02	0.99
14.11	**Pregnant women who receive prenatal care in the first trimester in DPH-funded programs (%)**	NC	Yes	1.00	1.11
14.12	**DPH-funded providers with age-appropriate preconception care/counseling (%)**	NC	Yes	1.00	1.00
14.13	**DPH-funded programs with screening/counseling on fetal abnormality prenatal detection (%)**	NC	Yes	1.00	1.11
14.15	**Newborns screened and treated for genetic disorders (%)**				
	Screened	B	Yes	1.02	1.00
	Treated	NC	Yes	1.00	1.00
15	**HEART DISEASE AND STROKE**				
15.1	**Coronary heart disease deaths (per 100,000)**				
	Total population	B	Yes	1.21	1.04
	African-American/Black	W	Yes	0.99	1.00
15.2	**Stroke deaths (per 100,000)**				
	Total population	B	No	1.11	0.84
	African-American/Black	B	Yes	1.07	1.00
15.11	**Regular and sustained physical activity, adults 18+ yrs (%)**	B	No	1.17	0.79
15.12	**Cigarette smoking prevalence (%)**				
	Adults 18+ yrs	B	No	1.34	0.75
	Males	B	No	1.29	0.74
	Females	B	No	1.38	0.77
	Females 18-44 yrs	B	No	1.23	0.61
	Females who gave birth	B	Yes	1.58	1.76
15.13	**Blood pressure checked in last 2 yrs, adults 18+ yrs (%)**	B	Yes	1.01	1.00
15.14	**Blood cholesterol checked in past 5 yrs, adults 18+ yrs (%)**	B	Yes	1.21	1.00

APPENDIX 3

HEALTHY CONNECTICUT 2000 FINAL REPORT
SUMMARY ANALYSES OF PROGRESS

Objective No.	Objective Description	Outcome[a]	Target Met[b]	Outcome Ratio	Target Ratio
16	**CANCER**				
16.1	**Cancer deaths (per 100,000)**	B	Yes	1.06	1.03
16.2	**Lung cancer deaths (per 100,000)**				
	Total population	B	Yes	1.03	1.28
	Males	B	Yes	1.11	1.31
	Females	W	Yes	0.95	1.32
	African-American/Black	B	Yes	1.01	1.08
16.3	**Female breast cancer deaths (per 100,000)**				
	All females	B	Yes	1.09	1.17
	Females 50+ yrs	NC	N/A[1]	1.00	(c)
16.4	**Cervical cancer deaths (per 100,000)**				
	All females	B	No	1.21	0.79
	White females	B	No	1.25	0.92
	African-American/Black females	W	No	0.95	0.25
	Females 55+ yrs	B	No	1.06	0.20
16.6	**Cigarette smoking prevalence (%)**				
	Adults 18+ yrs	B	No	1.34	0.75
	Males	B	No	1.29	0.74
	Females	B	No	1.38	0.77
	Females 18-44 yrs	B	No	1.23	0.61
	Females who gave birth	B	Yes	1.58	1.76
16.8	**Daily intake of 5 fruits & vegetables, adults 18+ yrs (%)**	W	No	0.87	(c)
16.11	**Clinical breast exam & mammogram (%)**				
	Females 40+ yrs, ever had	B	Yes	1.11	1.02
	Females 50+ yrs, had in last 2 yrs	B	Yes	1.24	1.05
17	**DIABETES AND CHRONIC DISABLING CONDITIONS**				
17.10	**Diabetes with lower extremity amputation (per 1,000)**				
	Total population	W	No	0.90	0.61
	African-American/Black	W	No	0.78	0.52
18	**HIV INFECTION**				
18.2	**AIDS incidence (diagnosed cases per 100,000)**	B	N/A[2]	1.13	(c)
18.3	**Ever had sexual intercourse, students in Grades 9-12, (%)**				
	Both sexes	B	No	1.13	0.90
	Females	B	Yes	1.17	1.02
	Males	B	No	1.08	0.81
18.4	**Condom use by sexually active students, Grades 9-12 (%)**	W	Yes	0.98	1.09
18.10	**Schools with HIV education curricula in grades 4-12 (%)**	NC	Yes	1.00	1.00
18.12	**Cities (pop. >100,000) with HIV outreach to drug abusers (%)**	NC	Yes	1.00	1.00
19	**SEXUALLY TRANSMITTED DISEASES**				
19.1	**Gonorrhea incidence (per 100,000)**				
	Total population	B	Yes	3.68	1.40
	African-American/Black	B	Yes	1.26	1.80
	Females 15-44 yrs	B	Yes	3.41	1.33
	Adolescents 10-19 yrs	B	Yes	2.52	2.33
19.2	**Chlamydia trachomatous incidence (per 100,000)**	W	No	0.84	0.73

APPENDIX 3

HEALTHY CONNECTICUT 2000 FINAL REPORT
SUMMARY ANALYSES OF PROGRESS

Objective No.	Objective Description	Outcome[a]	Target Met[b]	Outcome Ratio	Target Ratio
19.3	**Primary and secondary syphilis incidence (per 100,000)**				
	Total population	B	Yes	60.45	9.09
	African-American/Black	B	Yes	91.59	11.63
19.4	**Congenital syphilis (per 100,000 live births)**	B	Yes	8.56	3.17
20	**IMMUNIZATION AND INFECTIOUS DISEASES**				
20.1	**Indigenous vaccine preventable diseases (# of cases)**				
	Diphtheria (≤25 yrs)	NC	Yes	(c)	(c)
	Tetanus (≤25 yrs)	NC	Yes	(c)	(c)
	Polio	NC	Yes	(c)	(c)
	Measles	B	Yes	(c)	(c)
	Rubella	B	No	3.00	(c)
	Congenital rubella	NC	Yes	(c)	(c)
	Mumps	B	Yes	5.67	1.67
	Pertussis	W	No	0.57	0.19
20.2	**Pneumonia & influenza deaths, adults 65+ yrs (per 100,000)**	W	N/A[2]	0.96	(c)
20.3	**Hepatitis B incidence**				
	Total population (per 100,000)	B	N/A[2]	5.17	(c)
	Children <2 yrs (# cases)	B	Yes	(c)	(c)
20.4	**Tuberculosis incidence (per 100,000)**				
	Total population (per 100,000)	B	No	1.61	0.90
	Asian American & Pacific Islander	B	No	1.43	0.58
	African-American/Black	B	No	2.19	0.90
	Hispanic	B	No	1.59	0.89
20.7	**Bacterial meningitis incidence (per 100,000)**	B	Yes	3.07	5.33
20.11	**Immunizations (%)**				
	Basic immunization series				
	Children <2 yrs	W	No	0.99	0.94
	Children in licensed day care facilities	B	Yes	1.02	1.00
	Children in K through post-secondary schools	B	Yes	1.01	1.01
	Hepatitis B immunization, high risk infants	B	Yes	1.04	1.08
	Influenza vaccination in last year, adults 65+ yrs	B	No	1.04	0.81
	Pneumococcal vaccination, ever, adults 65+ yrs	B	No	1.28	0.61
20.13	**Maintain immunization laws for schools, pre-schools, & day care settings (%)**	NC	Yes	1.00	1.00
20.15	**Maintain financing & delivery of immunizations (%)**	NC	Yes	1.00	1.00
20.18	**People with tuberculosis infections who completed preventive therapy (%)**	W	No	0.79	0.76
22	**SURVEILLANCE AND DATA SYSTEMS**				
22.1	**Develop and establish set of health status indicators**	B	Yes	-	-
22.5	**Periodic analysis and publication of state progress toward objectives for each racial or ethnic group**	B	Yes	-	-

[a] B = Better; W = Worse; NC = No change; N/A = Not applicable (no values available other than baseline); N/M = Not measurable.

[b] Yes = Target met; No = Target not met; N/A[1] = Not applicable (target not specified); N/A[2] = Not applicable (different measures used for objective and target). See "Notes" column on data table for objective-specific details

[c] Calculations not performed because original and final measures differed, there was no target specified, target was non-numeric, there was no baseline value, one or both values equalled zero, or there were less than 5 events. See "Comments" column on data table for objective-specific details

[d] Calculations could not be performed with less than 3 data points, or when the value for year 1 or 2 was zero.