Health Indicators and Risk Behaviors in Connecticut: 2019 Results of the Connecticut Behavioral Risk Factor Surveillance Survey (BRFSS)

APRIL 2022

Keeping Connecticut Healthy

DPH
Connecticut Department
of Public Health

ACCREDITED HEALTH DEPARTMENT

PHAB

Advancing public health performance

PUBLIC HEALTH ACCREDITATION BOARD

Manisha Juthani, MD, Commissioner, Connecticut Department of Public Health

410 Capitol Avenue
Hartford, CT 06134
www.ct.gov/dph

ACKNOWLEDGMENTS

Manisha Juthani, MD
Commissioner,
Connecticut Department of Public Health

This report was prepared by:
Xi Zheng, M.P.H., M.S.
Epidemiologist
Health Statistics and Surveillance Section
Connecticut Department of Public Health

ADDITIONAL RESOURCES

For questions or comments about this report, please contact:

Celeste Jorge, M.P.H.
Epidemiologist
Health Statistics and Surveillance Section
Connecticut Department of Public Health
410 Capitol Ave.,
Hartford, CT 06134
Phone: (860) 509-7695
Celeste.Jorge@ct.gov

Xi Zheng, M.P.H., M.S.
BRFSS Epidemiologist
Health Statistics and Surveillance Section
Connecticut Department of Public Health
410 Capitol Ave.
Hartford, CT 06134
Phone: (860) 509-7670
Xi.Zheng@ct.gov

Find more BRFSS fact sheets, reports, and publications at the Connecticut Department of Public Health BRFSS website:
www.ct.gov/dph/BRFSS

Health Statistics and Surveillance Section, Survey Unit, Connecticut Behavioral Risk Factor Surveillance System, April 2022

CONTENTS

LIST OF FIGURES

LIST OF TABLES

SUMMARY

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

Data from the CT BRFSS have been used to inform the development of state health plans, such as the State Health Improvement Plan,[1] the Connecticut coordinated chronic disease plan;[2] to track online adult and child state health priorities[3,4] and included in chronic disease dashboards.[5] Data were also being used to inform action plans for the population health component of the State Innovations Model (SIM) grant,[6] a grant from the U.S. Center for Medicare and Medicaid Service to transform healthcare in the state. In addition, understand factors that affect vulnerable populations in

Connecticut is important for identifying and addressing health disparities. The CT BRFSS continues to have a significant role in the CT State Health Assessment process, by providing health indicators specific to race, disability status, health insurance status, and other factors. Data from the CT BRFSS also inform health programs for their work to improve and promote the health of all Connecticut residents.

In this report, a section named State of the State compares selected adult health indicators in Connecticut during calendar year 2019, with median results from 2019 for the United States and its territories. In addition, 35 selected health indicators are discussed in six chapters: 1) health status indicators, 2) risk behavior indicators, 3) clinical preventive practices, 4) chronic conditions, 5) child health, and 6) environmental health indicators.

METHODOLOGY

The population for the Connecticut Behavioral Risk Factor Surveillance System (CT BRFSS) consists of the total non-institutionalized English and Spanish-speaking adult population. In 2019, the CT BRFSS collected 4,284 landline interviews and 4,879 cell phone interviews, totaling 9,163 interviews. If any children lived in the same household as the respondent, one child was randomly selected, and the adult respondent provided information about that child. A total of 1,567 interviews about children were completed. The landline sample was a disproportionate stratified random digit dial (RDD) sample, stratified by geography and listed status. Within each contacted household, one adult was selected at random to be interviewed. The cell phone sample was an unstratified RDD sample drawn from dedicated cellular telephone banks with equal probability. An adult contacted by cell phone was eligible to complete the survey if he or she lived in a private residence or college housing.

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

Prevalence estimates and 95% confidence intervals were computed using SAS PROC SURVEYFREQ, which can properly compute variances for complex sampling plans. Any responses of "Not known/Not sure" or "Refused" were classified as missing. The coefficients of variation (CV) were used to assess the validity of each estimate. Prevalence estimates with a CV of between 15.0% and 20.0%, inclusive, are marked with a "†"; prevalence estimates with a CV greater than 30.0% are suppressed due to poor validity. Prevalence estimates with a CV between 20.1% and 30.0%, inclusive, are marked with "††", to indicate caution should be exercised when interpreting these estimates. The exact values were not disclosed in this report but are available in the 2019 Summary Tables posted online.

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

Significant increases or decreases compared to the United States were evaluated by a one-population two-tailed binomial test. Change in the prevalence of selected health indicators from years 2015 to 2019 was evaluated using a two population two-tailed chi-squared test for significant increase or decrease. Statistical significance testing was only conducted in prevalence estimates with a CV less than 0.15. Significance testing by demographic characteristic was evaluated using a two population two-tailed chi-squared test for significant increase or decrease in risk/protection or prevalence (alpha=0.05); only significant results are discussed in this report.

ADULT DEMOGRAPHICS IN CONNECTICUT

2,790,000
Adults 18 or older lived in Connecticut in 2019
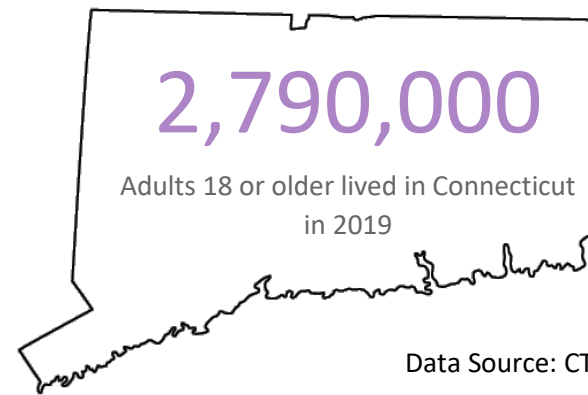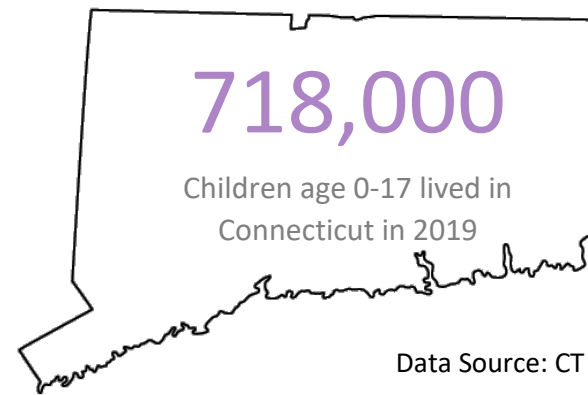
Data Source: CT BRFSS, 2019

Race & Ethnicity
7 in **10** adults were non-Hispanic White.
1 in **6** adults were Hispanic.
1 in **10** adults were non-Hispanic Black.
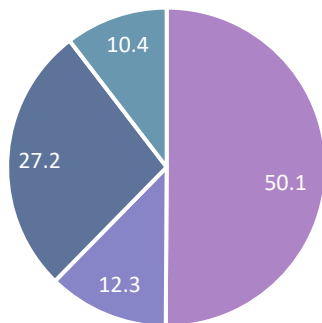
Pie chart values: 6.7, 15.5, 9.9, 67.8
- Non-Hispanic White
- Non-Hispanic Black
- Hispanic
- Non-Hispanic Other

Gender
Male and female adults were equally distributed.

Household Income
$75,000 and more	47.0
$35,000-$74,999	25.6
Less than $35,000	27.4
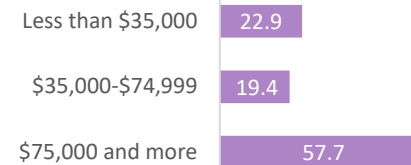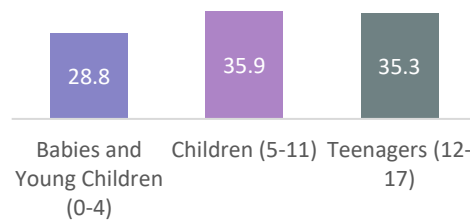
Age
- 18-34 years old: 28.3
- 35-54 years old: 31.1
- 55 and over: 40.6

91.7% Connecticut adults had health insurance coverage

One in four Connecticut adults had a disability

62.1% Connecticut adults had more than high school education

Note: all the demographic data above are estimated weighted population based on CT BRFSS 2019.

TABLE 1: ADULTS LIVING IN CONNECTICUT, CT 2019

Demographic Characteristics	Survey Respondents	Estimated Weighted Population	Estimated % of Population
Total	8,958	2,790,000	100.0
Age			
18-34 years old	1,119	789,000	28.3
35-54 years old	2,176	869,000	31.1
55 and over	5,663	1,135,000	40.6
Gender			
Male	4,196	1,374,000	48.2
Female	4,967	1,474,000	51.8
Race/Ethnicity			
Non-Hispanic White	7,069	1,884,000	67.8
Non-Hispanic Black	633	275,000	9.9
Hispanic	722	431,000	15.5
Other	508	187,000	6.7
Income			
Less than $35,000	1,845	605,000	27.4
$35,000-$74,999	1,915	564,000	25.6
$75,000 and more	3,431	1,037,000	47.0
Health Insurance Status			
Insured	8,626	2,594,000	91.7
Not Insured	494	235,000	8.3
Disability Status			
Disabled	2,203	614,000	22.9
Non-disabled	6,503	2,064,000	77.1
Education			
HS graduate or less	2,533	1,073,000	37.9
More than HS education	6,577	1,755,000	62.1

Demographic Characteristics	Survey Respondents	Estimated Weighted Population	Estimated % of Population
Total	1,567	718,000	**100**
Age			
0-4 years old	251	182,000	28.8
5-11 years old	434	227,000	35.9
12-17 years old	649	223,000	35.3
Gender			
Male	786	356,000	50.9
Female	721	344,000	49.1
Race/Ethnicity			
Non-Hispanic White	884	341,000	50.1
Non-Hispanic Black	155	83,000	12.3
Hispanic	291	185,000	27.2
Other	138	71,000	10.4
Household Income			
Less than $35,000	280	142,000	22.9
$35,000-$74,999	260	120,000	19.4
$75,000 and more	810	358,000	57.7
Caregiver's Health Insurance Status			
Insured	1,448	653,000	91.0
Not Insured	113	65,000	9.0
Caregiver's Education Attainment			
HS graduate or less	388	195,000	27.3
More than HS education	1,171	520,000	72.7

1. STATE OF THE STATE

CONNECTICUT COMPARISON TO THE U.S. IN 2019

Figure 1 and Table 3 highlight selected adult health indicators in Connecticut during calendar year 2019, compared to median results

from 2019 for the United States and its territories.

FIGURE 1: SELECTED ADULT HEALTH INDICATORS IN CONNECTICUT VERSUS THE UNITED STATES AND TERRITORIES, 2019

Indicator	CT 2019	US Median
No Health Care Coverage (18-64 yr old)	10.0	13.6
Current Asthma	10.5	9.7
High Blood Pressure	30.9	32.2
High Blood Cholesterol	32.2	30.6
Depression	14.4	19.7
Diabetes	9.6	10.8
Obesity	29.1	32.4

Percent Prevalence (%)
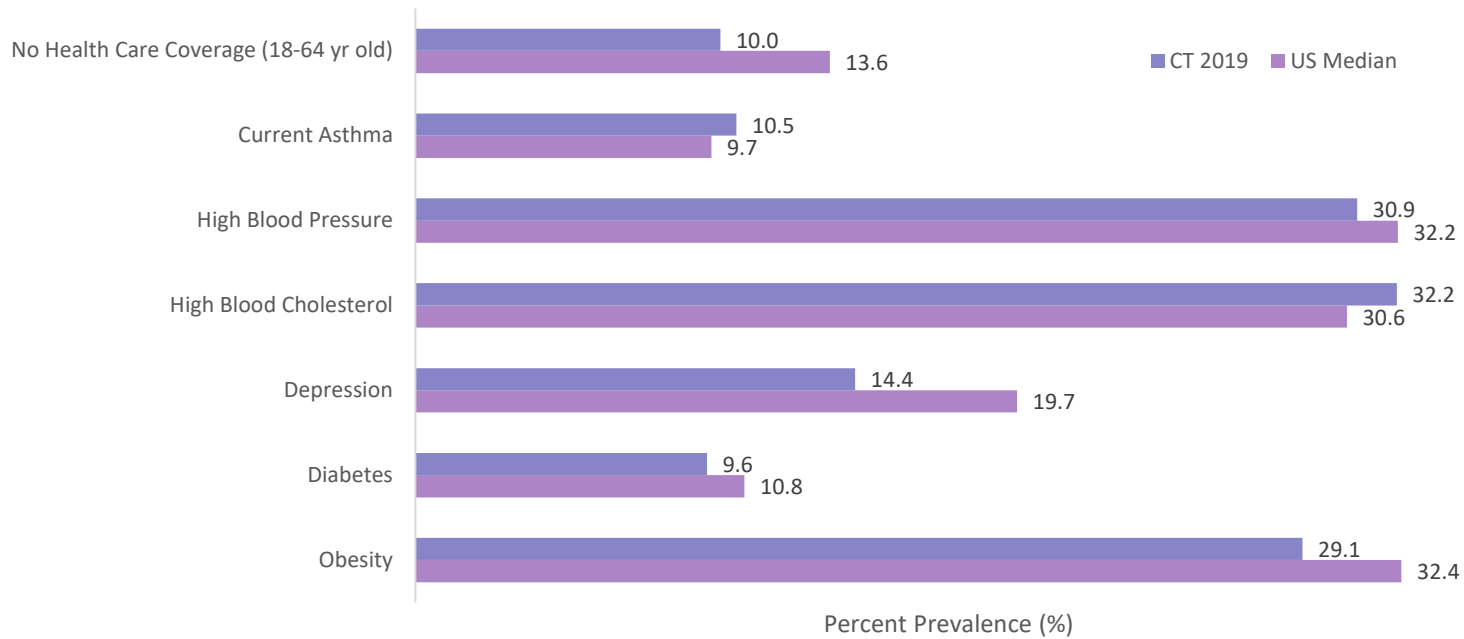
*= significance < 0.05

Figure 2 and Table 4 highlight selected adult modifiable risk factors in Connecticut during 2019, compared to median results from 2019 for the U.S. and its territories. More information on these indicators is located within this report.

Risk Factor	CT 2019	US Median
Check-up Within Past Year	80.5	77.6
Consume Fruits At Least Once Daily	66.1	54.0
Consume Vegetables At Least Once Daily	80.4	69.0
Met Both Aero/ Strength Guidelines	33.3	22.8
No Leisure Time Physical Activities	23.5	26.4
Excessive Alcohol Consumption	17.6	18.4
Current Cigarette Smoking	12.1	16.0
Pneumococcal Vaccination (65 years and older)	74.5	73.1
Flu Vaccination	49.7	43.4

Percent Prevalence (%)
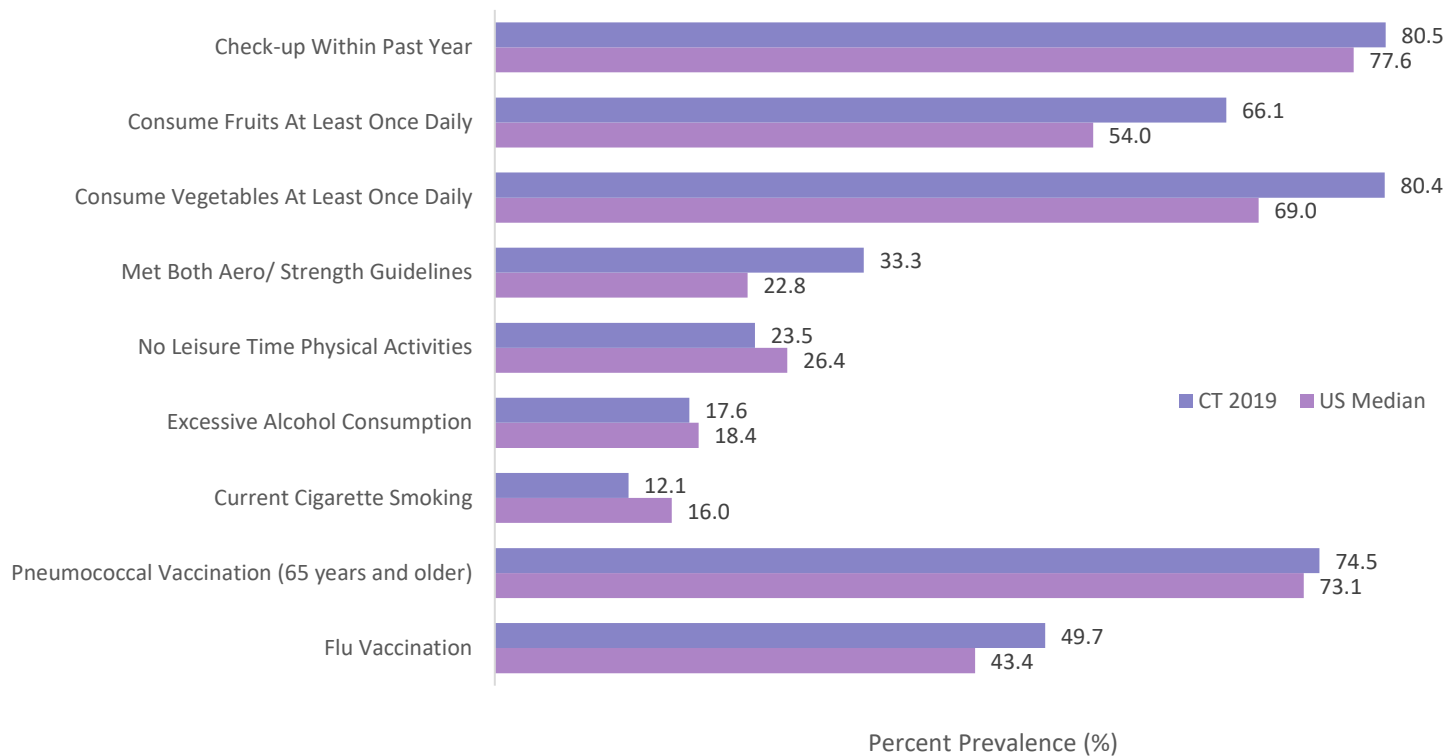
*= significance < 0.05

TABLE 3: SELECTED ADULT HEALTH INDICATORS IN CONNECTICUT VERSUS THE UNITED STATES AND TERRITORIES, CT 2019

Health Indicator	CT 2019	U.S. Median	Risk Difference	Significantly Greater or Less Risk/Protection
Adult Obesity	29.1%	32.4%	-3.3%	Less Risk
Diabetes	9.6%	10.8%	-1.2%	Less Risk
Depression	14.4%	19.7%	-5.3%	Less Risk
High Blood Cholesterol	32.2%	30.6%	1.6%	NS
High Blood Pressure	30.9%	32.2%	-1.3%	Less Risk
Current Asthma	10.5%	9.7%	0.8%	NS
No Health Care Coverage (18-64 yr old)	10.0%	13.6%	-3.6%	Less Risk

Note: Prevalence in 2019 of selected adult health indicators were obtained from the Behavioral Risk Factor Surveillance System for Connecticut (www.ct.gov/dph/brfss) and the United States and its territories (www.cdc.gov/brfss). Risk differences for Connecticut versus the United States and its territories were tested for significantly greater or lesser risk using two-tailed one sample z-test against the U.S. median.

TABLE 4: SELECTED ADULT MODIFIABLE RISK FACTORS IN CONNECTICUT VERSUS THE UNITED STATES AND TERRITORIES, CT 2019

Health Indicator	CT 2019	U.S. Median	Risk Difference	Significantly Greater or Less Risk/Protection
Flu Vaccination	49.7%	43.4%	6.3%	More Protection
Pneumococcal Vaccination (65 years and older)	74.5%	73.1%	1.4%	NS
Current Cigarette Smoking	12.1%	16.0%	-3.9%	Less Risk
Excessive Alcohol Consumption	17.6%	18.4%	-0.8%	NS
No Leisure Time Physical Activities	23.5%	26.4%	-2.9%	Less Risk
Met Both Aero/ Strength Guidelines	33.3%	22.8%	10.5%	More Protection
Consume Vegetables At Least Once Daily	80.4%	69.0%	11.4%	More Protection
Consume Fruits At Least Once Daily	66.1%	54.0%	12.0%	More Protection
Check-up Within Past Year	80.5%	77.6%	2.9%	More Protection

Note: Prevalence in 2019 of selected modifiable risk factors were obtained from the Behavioral Risk Factor Surveillance System for Connecticut (www.ct.gov/dph/brfss) and the United States and its territories (www.cdc.gov/brfss). Risk differences for Connecticut versus the United States and its territories were tested for significantly greater or lesser risk using two-tailed one sample z-test against the U.S. Median.

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

Sixteen selected health indicators and modifiable risk factors were compared to estimates for the United States and its territories during 2019 (Figures 1 and 2 and Tables 3 and 4). More information about these statewide indicators can be found elsewhere in this report.

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

- Obesity
- Diabetes
- Depression
- No Health Care Coverage (18-64 years old)
- High Blood Pressure
- Check-up within past year
- Current cigarette smoking
- Flu vaccination

- Pneumococcal vaccination (65+ years old)
- No leisure time physical activities
- Met both aero/ strengthen guidelines
- Consume vegetables at least once daily
- Consume fruits at least once daily

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

- High Blood Cholesterol

- Current Asthma

- Excessive alcohol consumption

CONNECTICUT COMPARISON TO OTHER STATES IN 2019

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

For 21 selected health indicators, and compared to all states in the United States and its territories, Connecticut ranked among the best 10 states in the country for 10 indicators (marked as **turquoise circles** in Figure 3):

- Health Care Coverage (18-64)
- Had Flu Vaccine
- Consume Fruit At Least Once Daily
- Met Aerobic and Strengthening Guidelines
- At Least One Primary Care Provider
- Flu Vaccination In The Past Year
- Depression
- No Access to Care Due to Cost
- Current Cigarette Use
- Cardiovascular Diseases (45+)

Among all 21 selected health indicators, Connecticut ranked better than half among all states in the United States and its territories for all except three indicators (marked as **purple circles** in Figure 3):

- Excessive Alcohol Consumption
- No-Leisure Time Physical Activity
- Obesity
- Diabetes
- Arthritis
- High Blood Pressure
- Reporting Good Or Better Health
- Pneumonia Vaccination (65+)

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

- Current Asthma
- High Blood Cholesterol
- Consume Vegetables At Least Once Daily

U.S. Rank

Positive Health Indicators

(Indicators to the **left** of the U.S. rank are better than most states)

Health Care Coverage (18-64)
Met Aerobic & Strengthening Guidelines
Pneumonia Vaccination (65+)
Flu Vaccination In The Past Year
Check Up In The Past 12 Months
At Least One Primary Care Provider
Reporting Good Or Better Health
Consume Vegetables At Least Once Daily
Consume Fruit At Least Once Daily

U.S. Median

Negative Health Indicators

(Indicators to the **right** of the U.S. rank are better than most states)

High Blood Pressure
High Blood Cholesterol
Cardiovascular Diseases (45+)
Arthritis
Depression
Current Asthma
Diabetes
Obesity
No Access to Care Due to Cost
No-Leisure Time Physical Activity
Excessive Alcohol Consumption
Current Cigarette Use

U.S. Median

Connecticut State Ranking
(50 States, District of Columbia, Guam, and Puerto Rico)
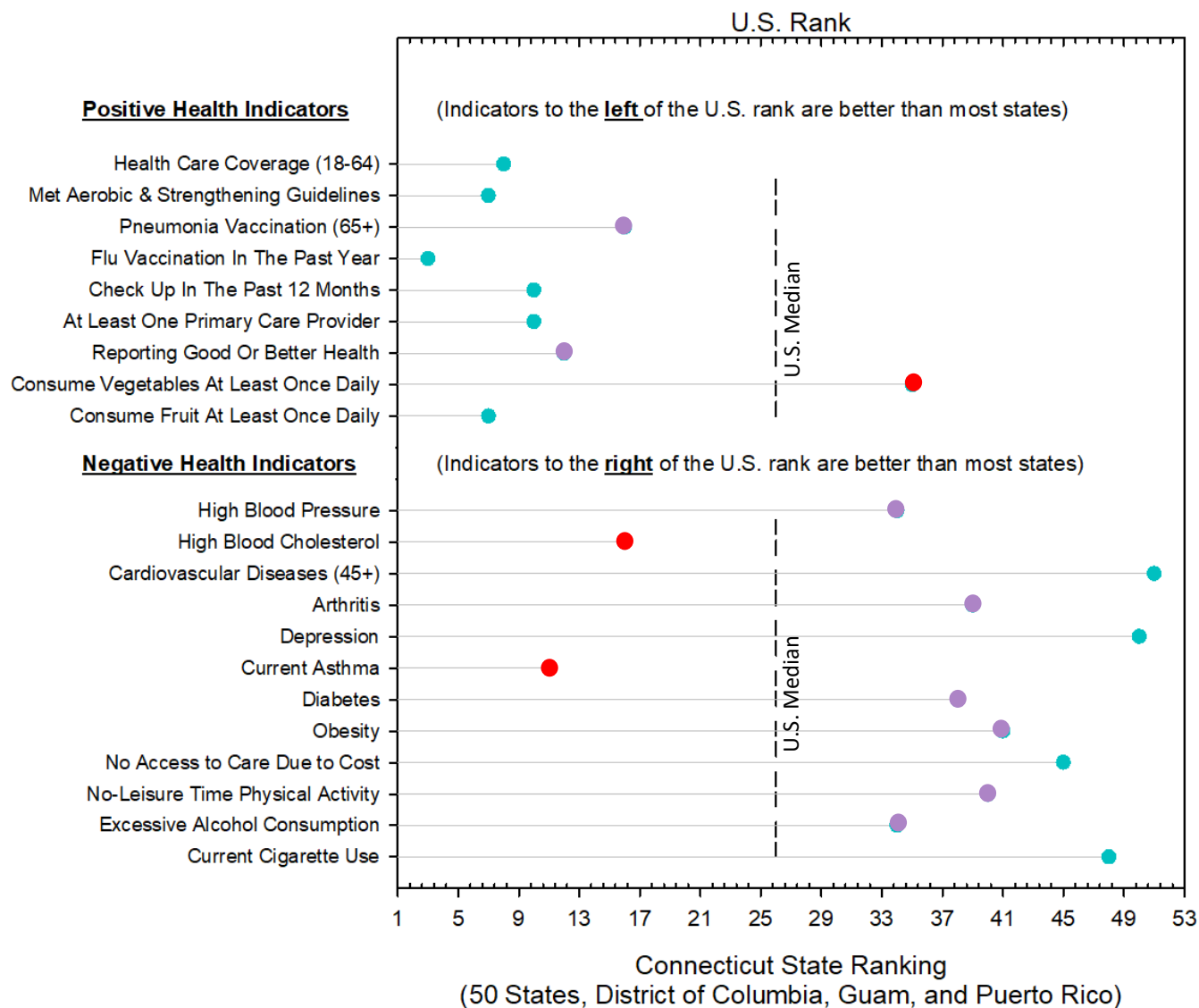
CHANGE IN SELECTED CONNECTICUT HEALTH INDICATORS (2015–2019)

Figure 4, Figure 5, and Table 5 show the change from 2015 through 2019 among Connecticut adults for selected biennial (Figure 4) and annual (Figure 5) health indicators. Estimated percent prevalence value for selected health indicators are shown for years 2015, 2017, and 2019 (Figure 4A); and for individual years 2015, 2017, 2019 (Figure 4B), these values are shown with circles. Four-year change from 2015 to 2019(Figure 4A) and biennial change from 2015 to 2017 and 2017 to 2019 (Figure 4 B) are shown with **purple** lines.

FIGURE 4: CHANGE IN SELECTED BIENNIAL HEALTH INDICATORS, CT BRFSS 2015–2019

Figure 4A: Four-Year Increase/Decrease   **Figure 4B: Yearly Increase/Decrease**
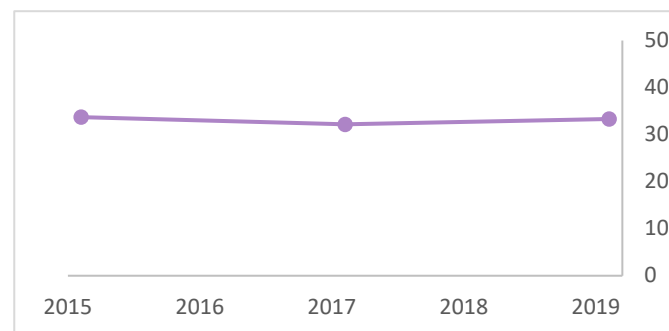
Met Aerobic/ Strengthening Guidlines
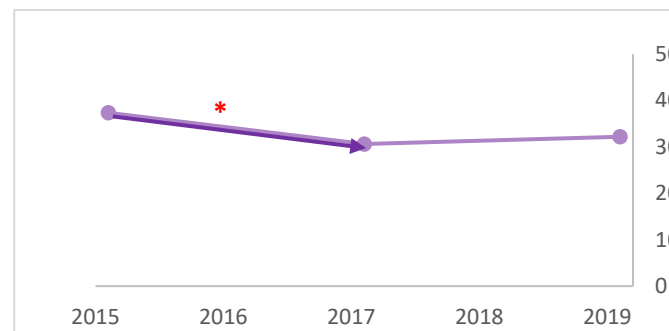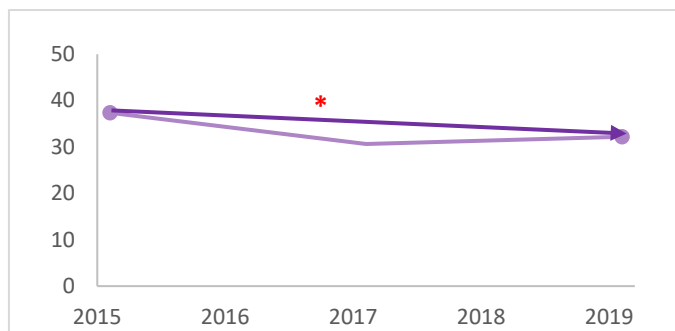
High Blood Cholesterol

*=significance<0.05

Figure 4A: Four-Year Increase/Decrease Cont.   **Figure 4B: Yearly Increase/Decrease Cont.**
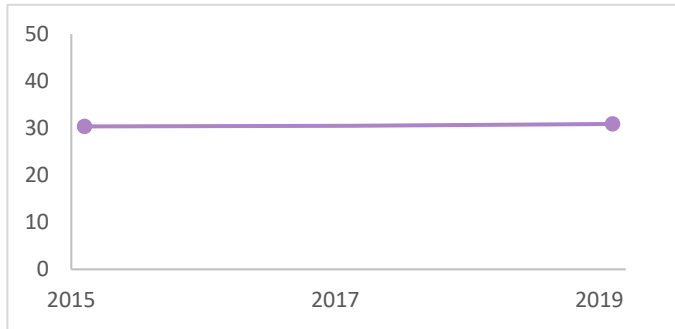
High Blood Pressure
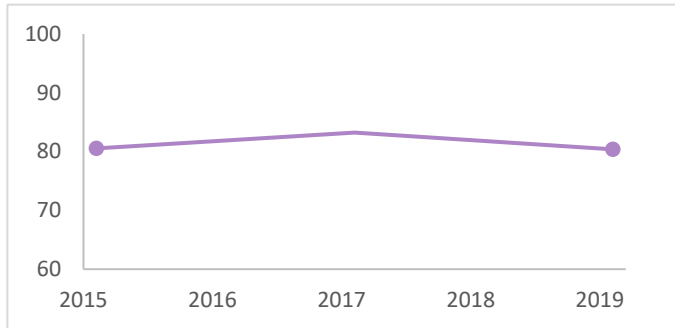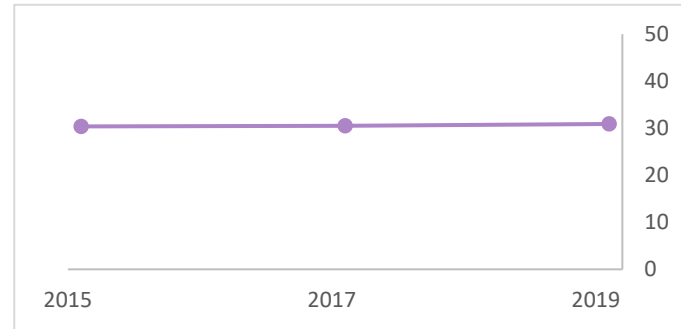
Consume Vegetables At Least Once Daily
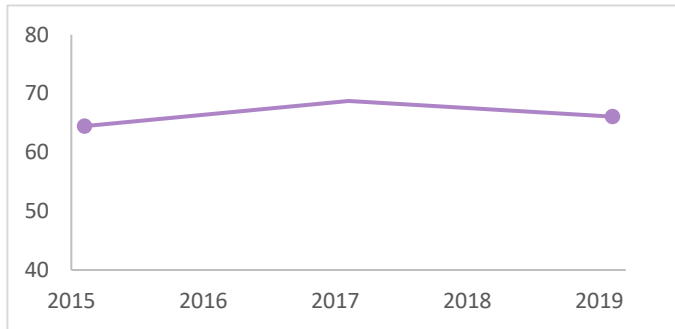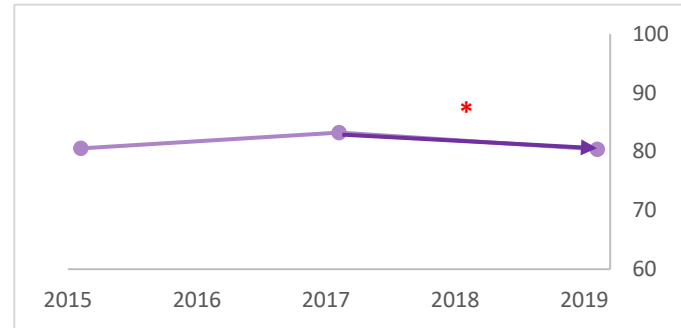
Consume Fruits At Least Once Daily
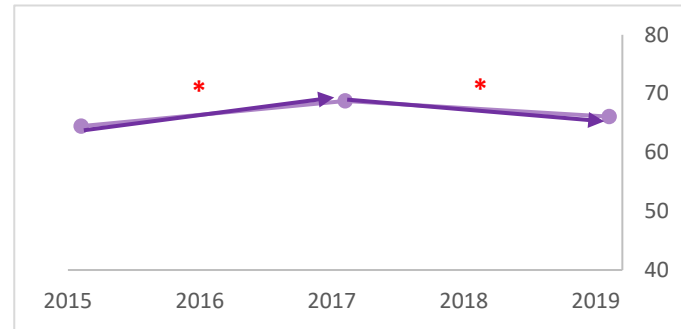
*= significance < 0.05

Estimated percent prevalence values for selected health indicators are shown for years 2015-2019 (Figure 5A); and for individual years 2015, 2016, 2017, 2018, and 2019 (Figure 5B), these values are shown with circles. Five-year changes from 2015 to 2019 (Figure 5A) and annual changes from years 2015 to 2016, 2016 to 2017, 2017 to 2018, and 2018 to 2019 (Figure 5B) are shown with **purple** lines.

FIGURE 5: CHANGE IN SELECTED ANNUAL HEALTH INDICATORS, CT BRFSS 2015–2019

Figure 5A: Five Year Increase/Decrease   **Figure 5B: Yearly Increase/Decrease**
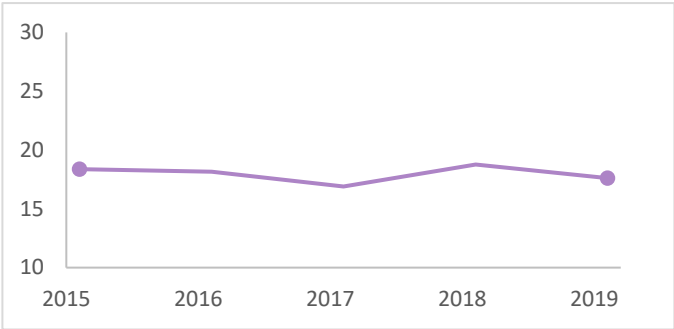
Excessive Alcohol Consumption
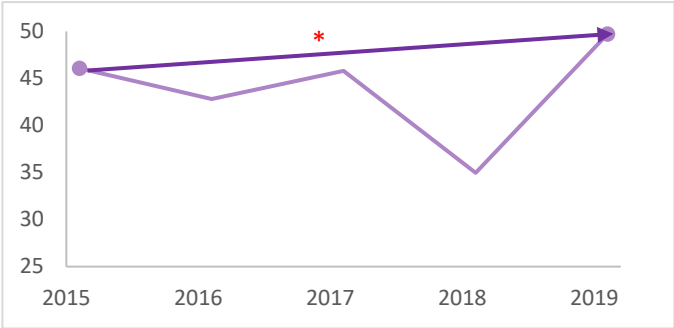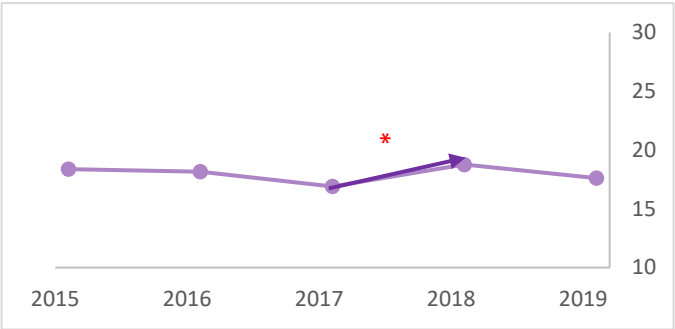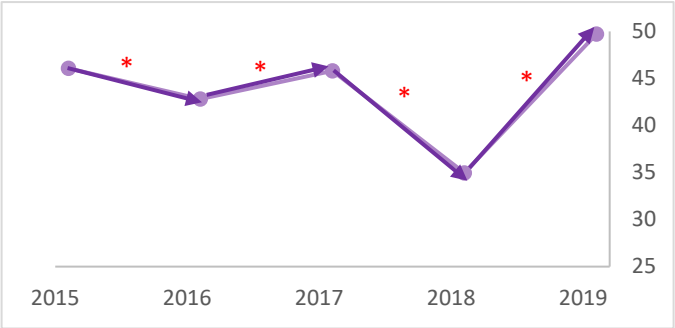
Flu Vaccination

*=significance< 0.05
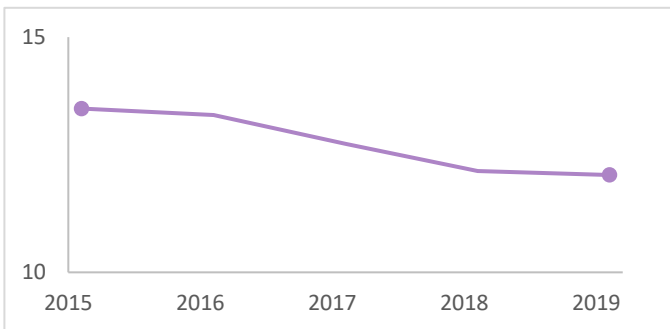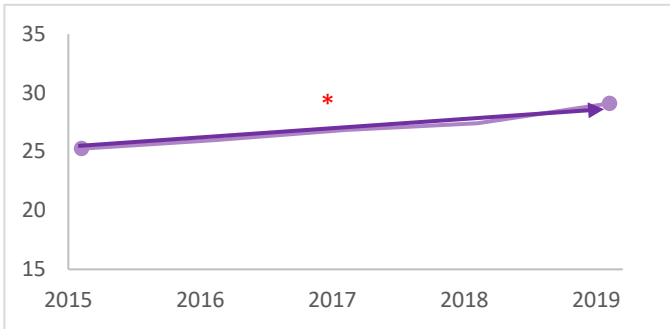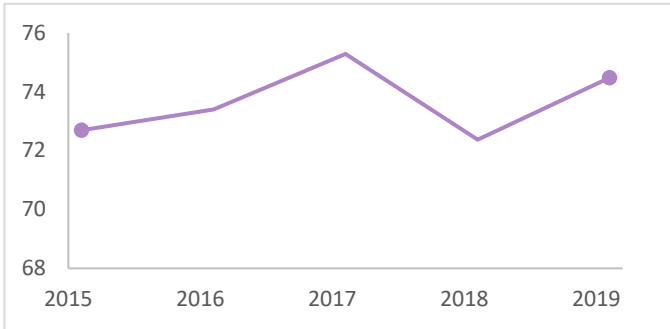
Figure 5A: Five Year Increase/Decrease (Cont.)

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

Pneumococcal Vaccination (65 years & Older)

Adult Obesity

Current Cigarette Use
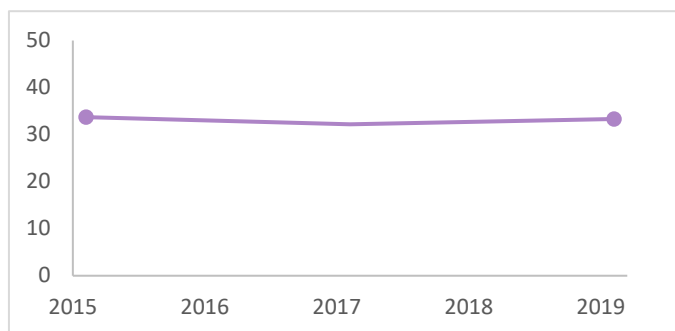
*= significance <0.05
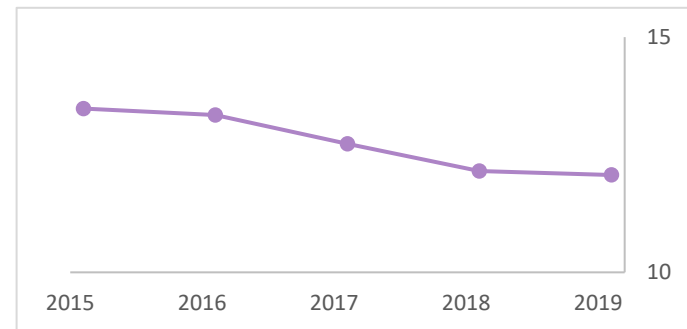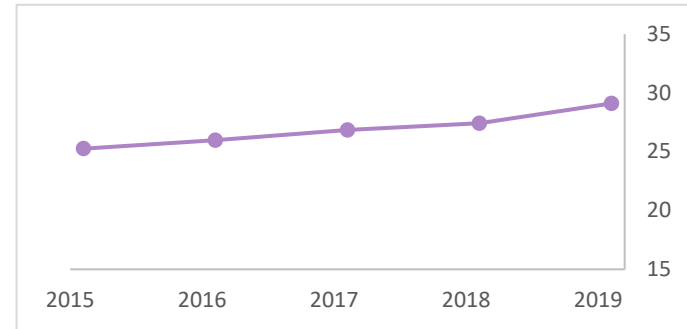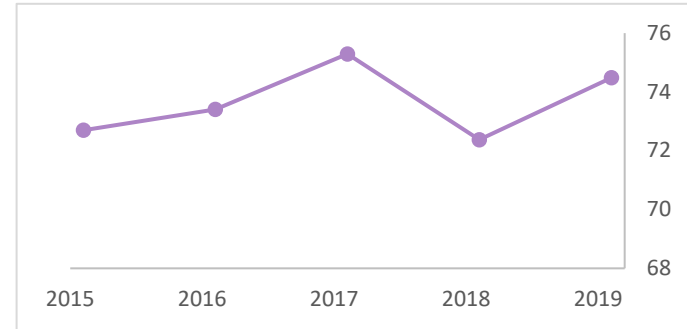
Figure 5A: Five Year Increase/Decrease (Cont.)   **Figure 5B: Yearly Increase/Decrease (Cont.)**
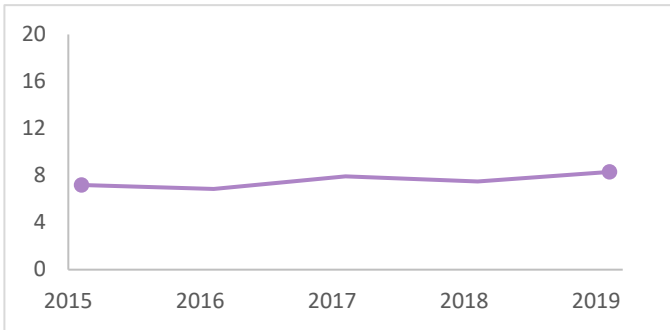
No Health Care Coverage (18–64 years old)
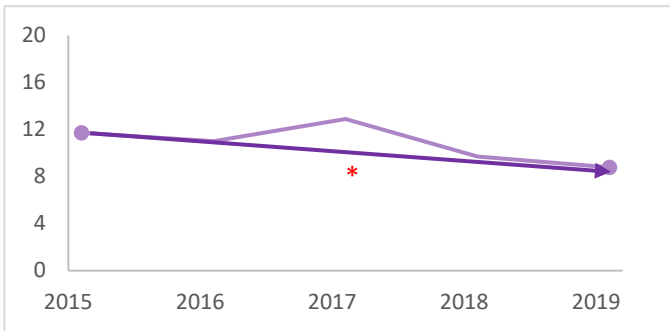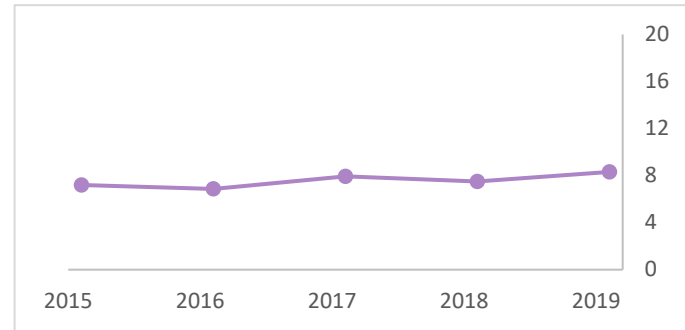
Child Asthma (0–17 years old)
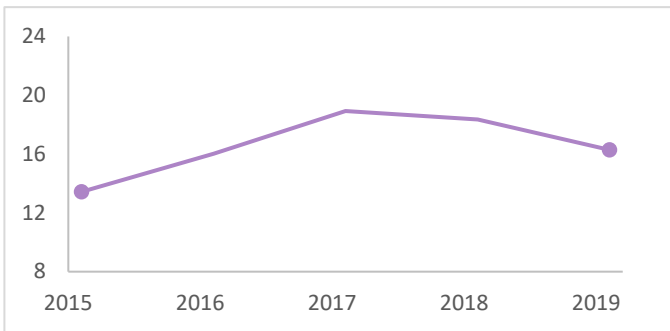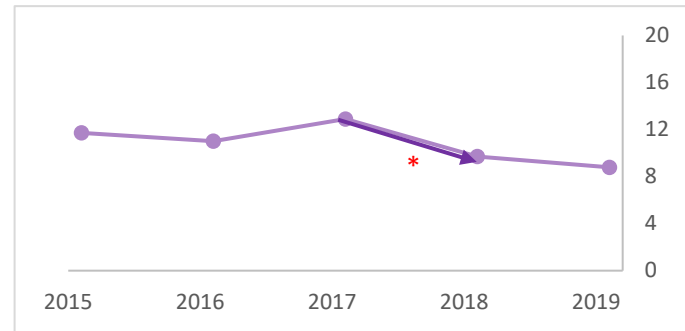
Child Obesity (5–17 years old)
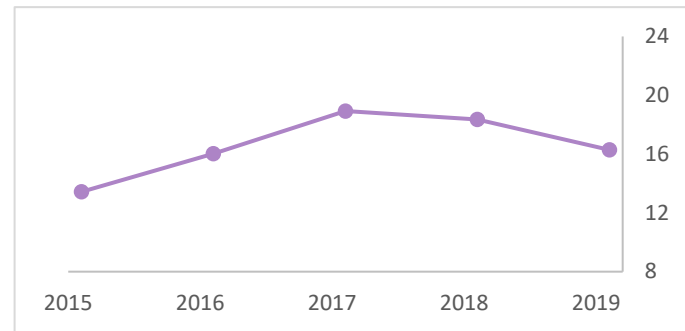
*= significance <0.05

TABLE 5: TREND IN PERCENT PREVALENCE OF SELECTED HEALTH INDICATORS, CT 2015–2019

Health Indicators	2015	2016	2017	2018	2019
Met Aerobic/ Strengthening Guidelines #	33.7		32.2		33.3
High Blood Pressure #	30.4		30.5		30.9
High Blood Cholesterol#	37.4		30.6		32.2
Consume Vegetables At Least Once Daily#	80.5		83.2		80.4
Consume Fruits At Least Once Daily#	64.5		68.7		66.1
Excessive Alcohol Consumption	18.4	18.1	16.9	18.8	15.6
Flu Vaccination	46.1	42.8	45.8	35.0	49.7
Pneumococcal Vaccination (65 years & older)	72.7	73.4	75.3	72.4	74.5
Adult Obesity	25.3	26.0	26.9	27.4	29.1
Current Cigarette Use	13.5	13.3	12.7	12.2	12.1
No Health Care Coverage (18-64 years old)	7.2	6.9	7.9	7.5	8.3
Child Asthma (0-17 years old)	11.7	11.0	12.9	9.7	8.8
Child Obesity (5-17 years old)	13.4	16.0	18.9	18.4	16.3

Health indicators offered in the BRFSS every other year.

2. VULNERABLE POPULATIONS IN CONNECTICUT

Connecticut is one of the healthiest states in the nation and is ranked well for most selected health indicators in this report compared to other states; however, health disparities were found by further adjustments for social determinants of health (e.g., age, sex, race/ethnicity, income, disability status, and education level). In 2019, certain groups had significantly higher prevalence of poor health outcomes:

Non-Hispanic Black (compared to NH White)	Hispanic (compared to NH White)
• Fair/poor health • Obesity • No insurance (18-64 years old) • No leisure time physical activity • No dental visit in past year • No flu vaccine • Current asthma • Diabetes • Child consumption of sugar-sweetened beverages	• Fair/poor health • Disability • Poor physical health • House insecurity • Obesity • No primary doctor • No access to care due to cost • No insurance (18-64 years old) • No leisure time physical activity • No dental visit in past year • No flu vaccine • Current asthma • Child consumption of sugar-sweetened beverages

Annual Income Less than $35,000 (compared to higher incomes)	Adults Without Health Insurance
• Fair/poor health • Poor mental health • Poor physical health • House insecurity • Disability • Obesity • No primary doctor • No access to care due to cost • No insurance (18-64 years old) • No leisure time physical activity • Current cigarette smoking • Ever use e-cigarette • No dental visit in past year • Current asthma • COPD • Arthritis • Cardiovascular disease • Prediabetes and diabetes • Kidney disease • Depression • Child consumption of sugar-sweetened beverages	• Fair/poor health • House insecurity • No primary doctor • No access to care due to cost • No leisure time physical activity • Binge drinking • No dental visit in past year • No flu vaccine

Disabled Adults	Adults With Less Than High School Education
• Fair/poor health • Poor mental health • Poor physical health • House insecurity • Obesity • No access to care due to cost • No leisure time physical activity • Current cigarette smoking • Ever use e-cigarette • Excessive alcohol consumption	• Fair/poor health • Disability • Poor mental health • Poor physical health • House insecurity • Obesity • No primary doctor • No access to care due to cost • No insurance (18-64 years old) • No leisure time physical activity • Current cigarette smoking • Ever use e-cigarette

3. HEALTH STATUS INDICATORS

GENERAL HEALTH STATUS

Self-rated general health status is a valuable measure to collect alongside more objective health measures because it has strong predictive properties for health outcomes; specifically, self-reports of poor health are strongly associated with mortality.[7] CT BRFSS respondents were asked to rate their general health as excellent, very good, good, fair, or poor.

One in seven Connecticut adults rated their health as either fair or poor in 2019. The prevalence of adults who reported fair or poor health is shown in Figure 6.

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

- Adults 55 years and older (18.6%) and adults 35–54 years old (14.5%);
- Hispanic (24.2%) and non-Hispanic Black (20.6%) adults;
- Adults from households earning less than $35,000 (30.8%) and $35,000–$74,999 (13.5%);
- Adults without health insurance (21.2%);
- Disabled adults (39.5%); and
- Adults with no more than a high school education (24.0%).

FIGURE 6: PERCENTAGE OF CT RESIDENTS REPORTING POOR OR FAIR OVERALL HEALTH, CT 2019
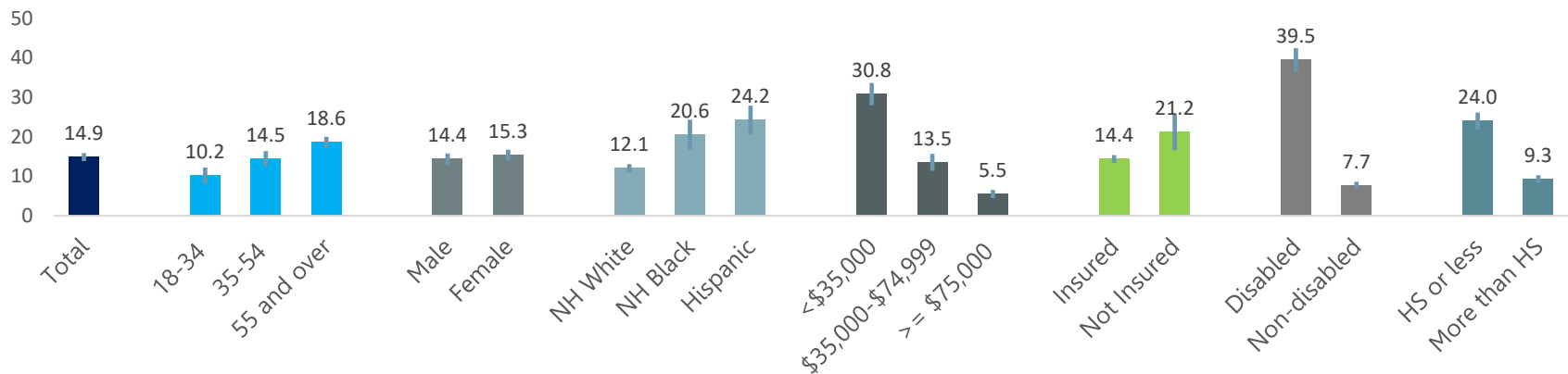
DISABILITY

The Americans with Disabilities Act (ADA) defines an individual with a disability as "a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment."[8] Respondents were classified as having a disability if they answered "yes" to any of the following five questions: 1) Are you blind or do you have serious difficulty seeing, even when wearing glasses? 2) Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering or making decisions? 3) Do you have serious difficulty walking or climbing stairs? 4) Do you have difficulty dressing or bathing? 5) Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? 6) Are you deaf or do you have serious difficulty hearing?

Nearly one in four adults in Connecticut reported that they have a disability in 2019. Results are shown in Figure 7.

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

- Adults 55 years and older (30.6%);
- Hispanic adults (29.0%) compared to non-Hispanic White adults (21.4%);
- Adults from households earning less than $35,000 (41.8%) and $35,000–$74,999 (21.7%); and
- Adults with no more than a high school education (33.7%).

FIGURE 7: PERCENTAGE OF CT RESIDENTS REPORTING A DISABILITY, CT 2019
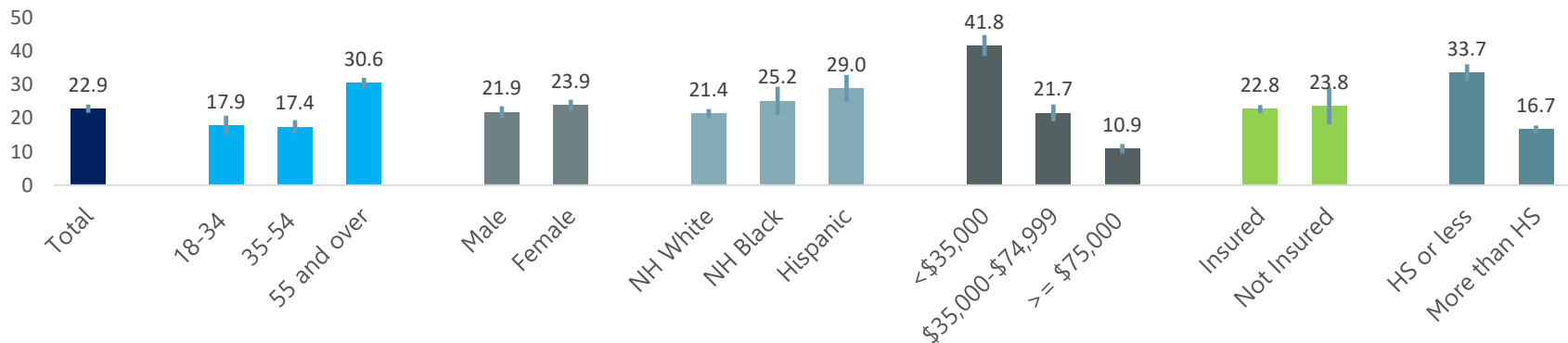
HEALTH-RELATED QUALITY OF LIFE (POOR MENTAL HEALTH)

The BRFSS uses the Healthy Days Measure to assess health-related quality of life. The Healthy Days Measure has been useful for identifying health disparities and tracking population trends.[9] This measure defines adults as being in poor mental health if they reported 14 or more days (within the past 30 days) for which their mental health was "not good."

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

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

- Adults 18-34 years of age (15.6%);
- Adults from households earning less than $35,000 (18.4%) and $35,000-$74,999 (10.9%);
- Adults with a disability (28.7%); and
- Adults with no more than a high school education (14.5%).
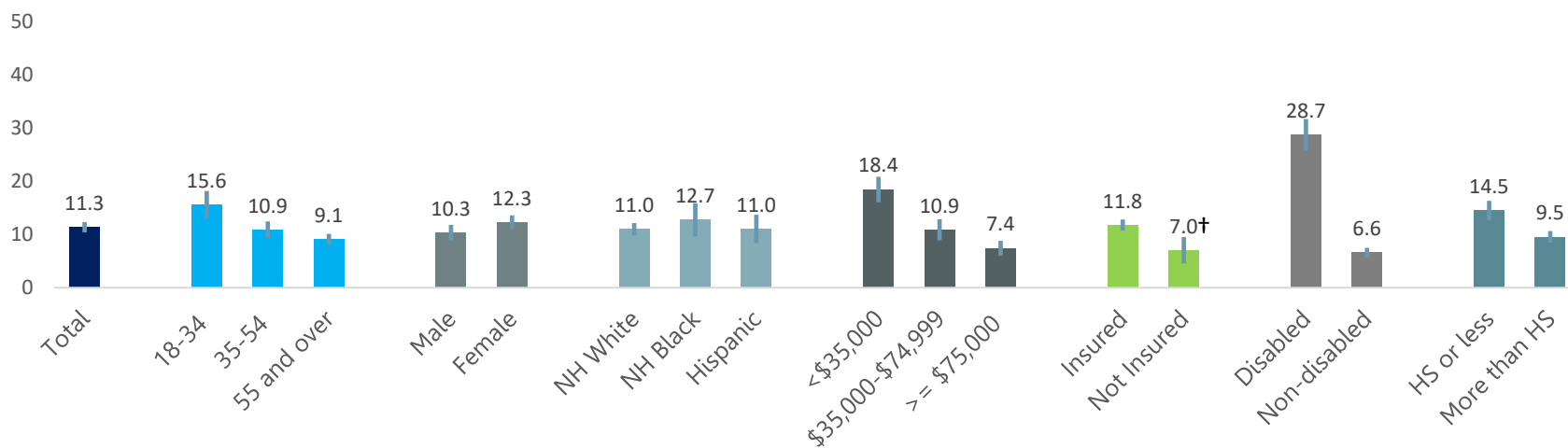
Estimates marked with a "†" have a CV between 15.0% and 20.0%.

HEALTH-RELATED QUALITY OF LIFE (POOR PHYSICAL HEALTH)

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

One in nine Connecticut adults reported poor physical health. The prevalence of adults who had poor physical health is reported in Figure 9.

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

- Adults 55 years and older (14.3%);
- Hispanics (13.3%) compared to non-Hispanic Whites (9.6%);
- Adults from households earning less than $35,000 (18.8%) and $35,000–$74,999 (9.4%);
- Adults with a disability (31.0%); and
- Adults with no more than a high school education (14.6%).

FIGURE 9: PERCENTAGE OF CT RESIDENTS REPORTING POOR PHYSICAL HEALTH, CT 2019
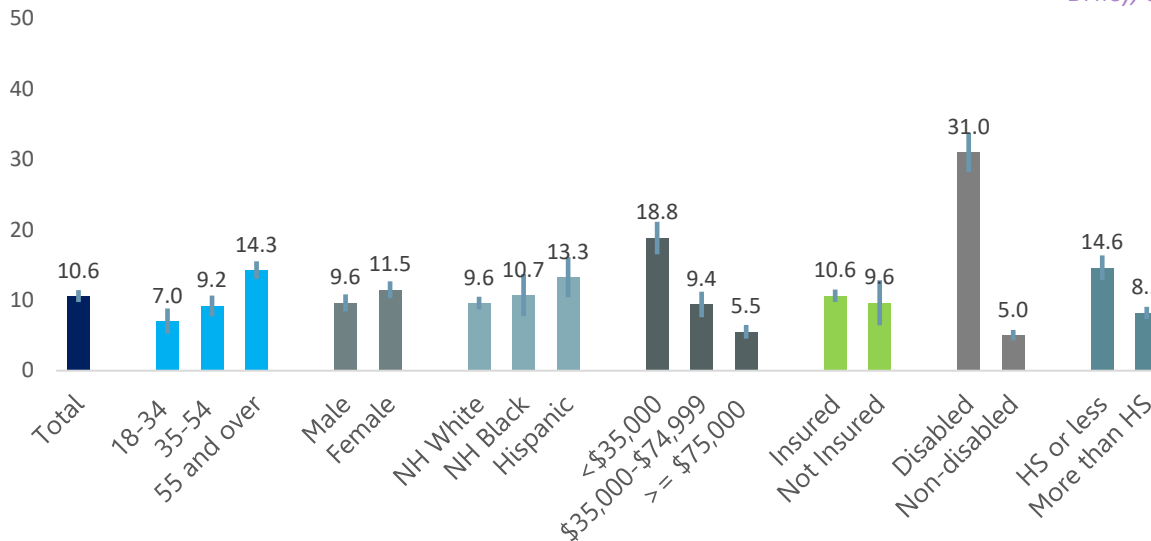
FIGURE 10: POOR PHYSICAL OR MENTAL HEALTH AS A BARRIER TO LIFE'S ACTIVITIES (IN DAYS), CT 2019
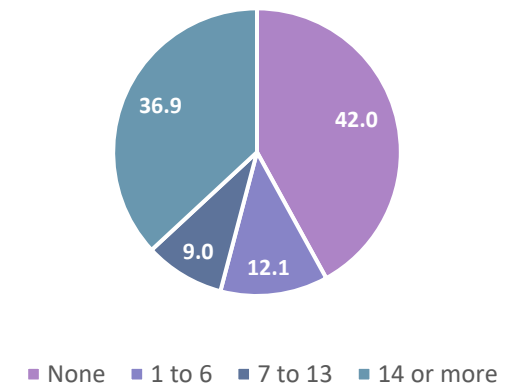
FINANCIAL STRESS

Financial stress can negatively impact a person's health. Previous BRFSS data have shown that adults experiencing housing instability or food insecurity are significantly more likely to suffer from insufficient sleep and mental distress.[10] Different forms of housing instability, including difficulty paying rent or living in overcrowded conditions, can be risk factors for homelessness.[11] Food insecurity affects people who face limited or uncertain availability of nutritionally adequate meals or limited ability to buy nutritious foods.[12] Among low-income adults, food insecurity is associated with chronic disease, such as diabetes or hypertension.[13] Respondents were asked to report how often in the past 12 months they felt worried or stressed about having enough money to pay for housing. They were also asked how often in that period they felt worried or stressed about having enough money to buy nutritious meals. The proportion of adults who felt worried or stressed "always" or "usually" is reported.

One in eight Connecticut residents in 2019 felt stressed or worried about paying for housing in the previous year, while one in 13 felt stress about paying for nutritious food.

Compared to their counterparts in the state, the prevalence of **always or usually feeling stress about having enough money for housing** among adults in Connecticut was significantly greater for:

- Adults 18-34 (17.9%) and 35-54 (15.9%) years old;
- Non-Hispanic Blacks (16.6%) and Hispanics (21.1%);
- Adults from households earning less than $35,000 (29.1%) and $35,000–$74,999 (14.7%);
- Adults without health insurance (22.7%);
- Adults with a disability (26.8%); and
- Adults with no more than a high school education (19.9%).

FIGURE 11: PREVALENCE OF ALWAYS OR USUALLY FEELING STRESS ABOUT HAVING ENOUGH MONDEY FOR HOUSING, CT 2019.
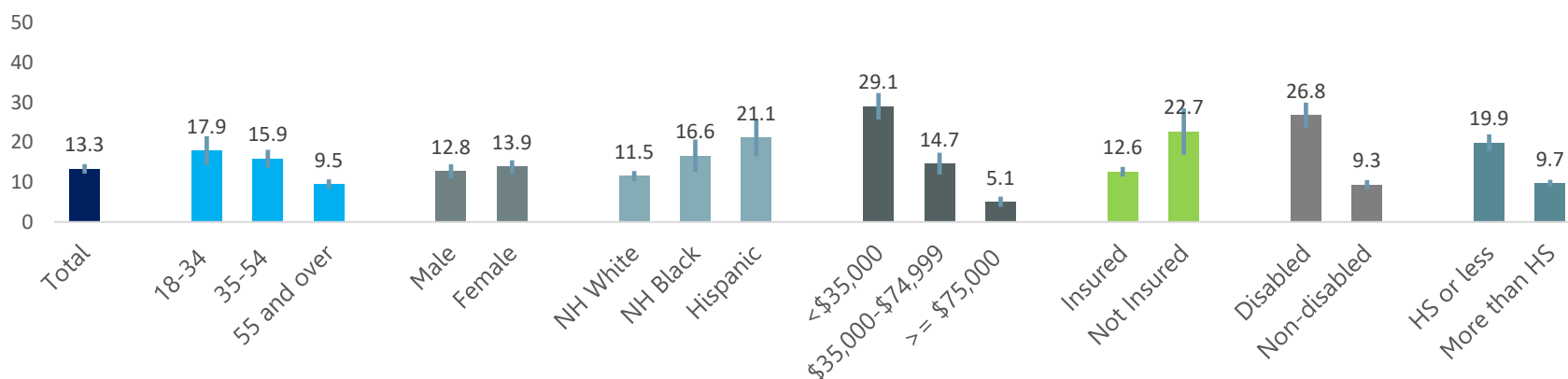
One in 13 Connecticut residents in 2019 felt stress about paying for nutritious food. Compared to their counterparts in the state, the prevalence of **always or usually feeling stress about having enough money paying for nutritious food** among adults in Connecticut was significantly greater for:

- Adults 18-34 (13.3%) and 35-54 (9.0%) years old;
- Hispanics (13.6%) compared to non-Hispanic Whites (6.4%); and
- Adults from households earning less than $35,000 (18.3%) compared to $35,000–$74,999 (9.5%);

- Adults with a disability (17.8%); and
- Adults with no more than a high school education (11.6%).

FIGURE 12: PREVALENCE OF ALWAYS OR USUALLY FEELING STRESS ABOUT HAVING ENOUGH MONEY FOR FOOD, CT 2019
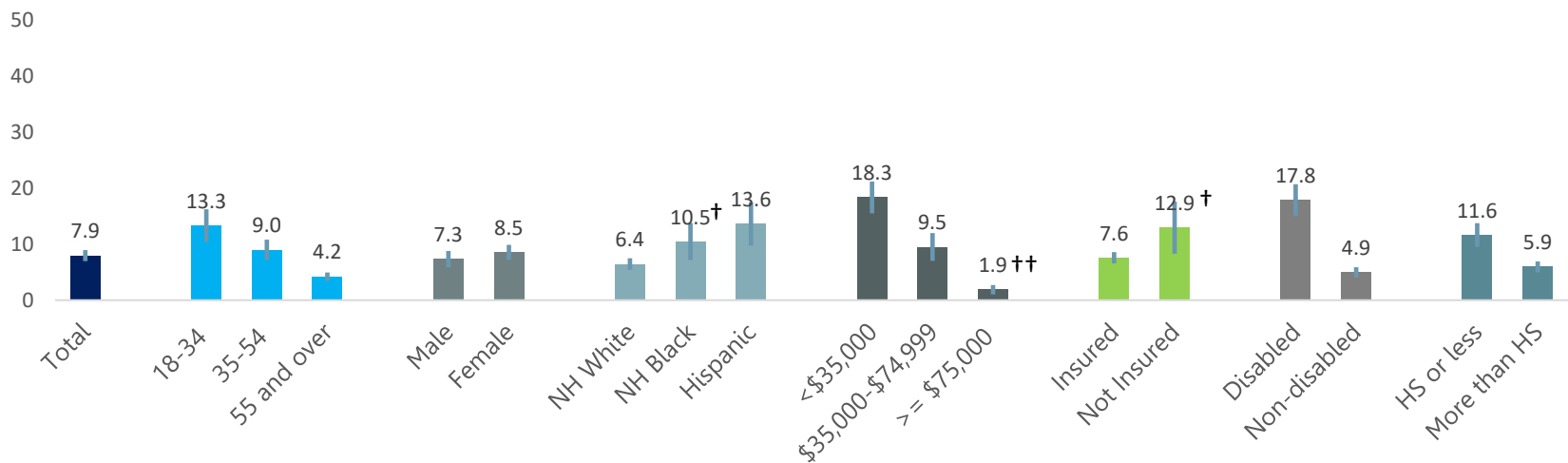
Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%.

ADULT WEIGHT STATUS

The BRFSS survey asks respondents to provide their height and weight without shoes. A body mass index (BMI) is calculated by dividing their weight in kilograms by the squared value of their height in meters. An adult with a BMI between 25.0 and 29.9 is considered overweight, while an adult with a BMI of 30 or above is considered obese. The prevalence of obese adults is of particular interest because obesity has been shown to be a major cause of preventable morbidity and mortality in the United States.[14] Overweight and obese adults are at risk for developing a wide range of health problems, including high blood pressure, type 2 diabetes, coronary heart disease, certain cancers, strokes, and other diseases.[15] Results for obesity are shown in Figure 13.

In Connecticut, one in three CT adults were overweight, and one in four CT adults were obese in 2019.

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

- Adults 35–54 years old (32.7%) and 55 years and older (30.3%);
- Non-Hispanic Black (44.0%) and Hispanic (35.5%) adults;
- Adults from households earning less than $35,000 (37.0%) compared at least $75,000 (25.0%);
- Adults with a disability (38.3%); and
- Adults with no more than a high school education (33.1%).

FIGURE 13: PREVALENCE OF OBESITY AMONG CT ADULTS, CT 2019
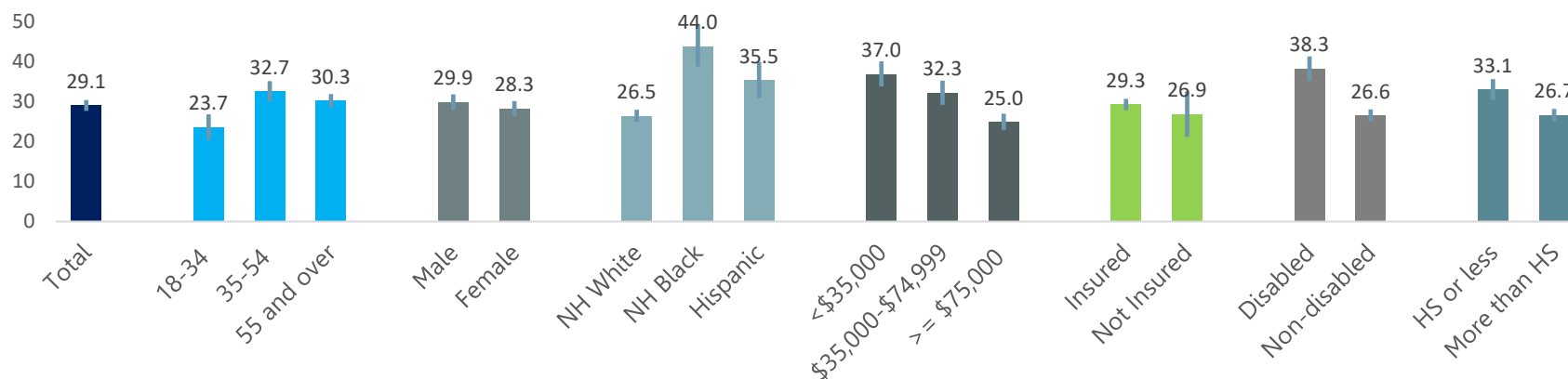
HEALTH CARE ACCESS

People who have access to a personal health care provider or a regular health care setting have better health outcomes.[16] Generally, an effective primary health care system is associated with better health outcomes. Limited health care coverage is a barrier to access to care that adversely impacts health outcomes. "Limited" health care coverage includes adults who do not have a primary care provider, which is a personal doctor or health care provider; or adults who needed to see a doctor in the past year but could not because of cost, or adults who did not take medication as prescribed because of cost. Results are shown in Figures 14-15. In 2019, eight in ten CT adults reported they had at least one primary health care provider, one in ten CT adults reported that they had no health care due to costs, and one in 10 CT adults reported they did not take their medication as prescribed because of cost.

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

- Adults 55 years and older (93.8%) and adults 35–54 years old (82.1%);
- Females (87.0%);
- Non-Hispanic White adults (87.7%) and Non-Hispanic Black adults (83.6%);
- Adults from households earning at least $75,000 (90.1%) and $35,000–$74,999 (83.8%);
- Adults with health insurance (87.0%); and
- Adults with more than a high school education (88.0%).

FIGURE 14: AT LEAST ONE PRIMARY HEALTH CARE PROVIDER, CT 2019
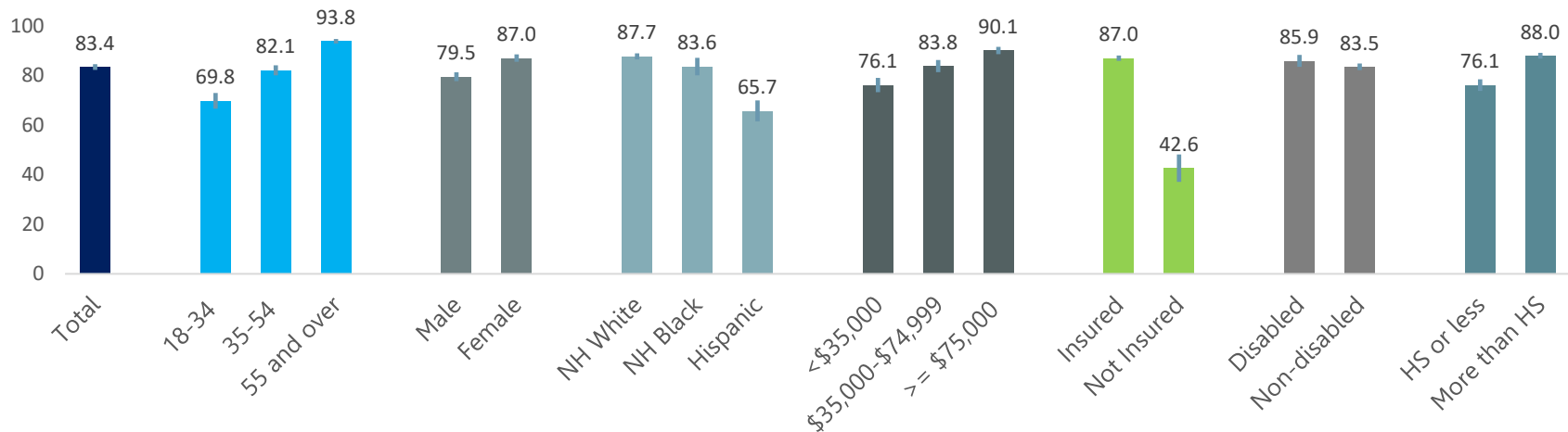
Compared to their counterparts in the state, the prevalence of having **no access to care due to cost** among adults in Connecticut was significantly greater for:

- Adults 18–34 years old (14.0%) compared to 55 and over (6.4%);
- Hispanic (19.1%) compared to non-Hispanic White adults (7.7%);
- Adults from households earning less than $35,000 (15.7%) and $35,000–$74,999 (13.0%);

- Adults without health insurance (32.1%);
- Adults with a disability (16.7%); and
- Adults with no more than a high school education (11.7%).

FIGURE 15: NO HEALTH CARE ACCESS DUE TO COST, CT 2019
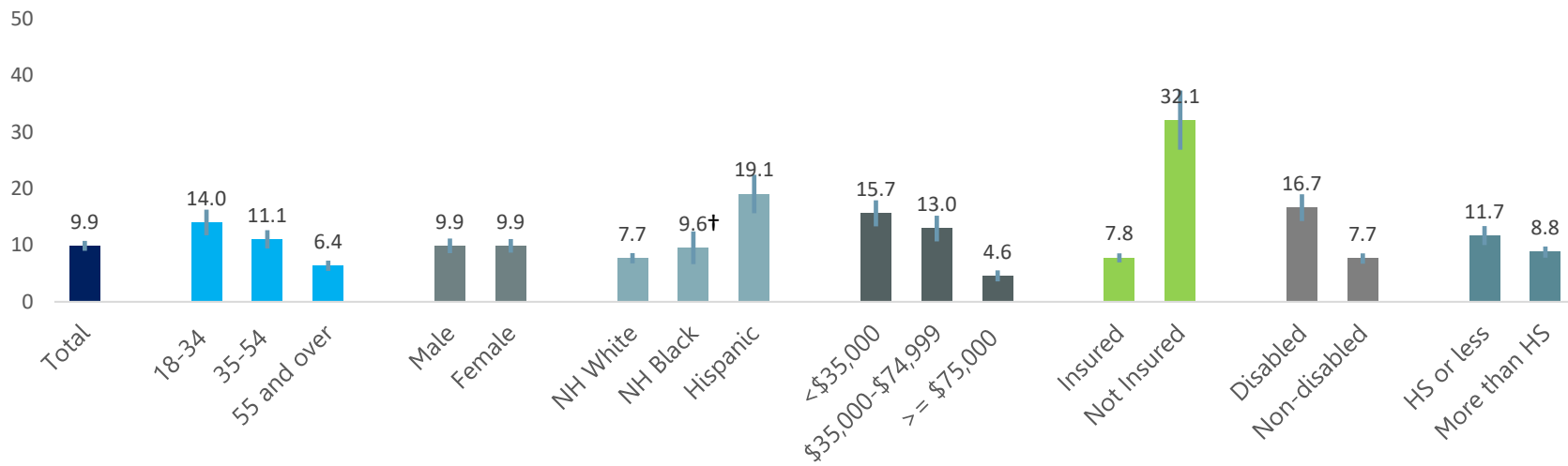
Estimates marked with a "†" have a CV between 15.0% and 20.0%.

HEALTH INSURANCE COVERAGE (18-64 YEARS OLD)

Health insurance coverage includes private insurance and plans such as health maintenance organizations (HMOs) or government plans such as Medicare or the Indian Health Service. Adults without health care coverage have higher mortality rates for a range of health conditions, compared to insured adults.[17] Adults without health care coverage are less likely to get needed care and screenings, and they have poorer health outcomes.[18] Medicaid is a public health insurance program for low-income Americans and other target groups, including pregnant women and people with disabilities. An expansion of Medicaid coverage under the Affordable Care Act went into effect in 2014.

The prevalence of adults aged 18-64 years old in 2019 who reported having no health care coverage, private insurance, Medicaid, or Medicare coverage are broken down by demographic characteristics in Figures 16 to 19 below.

In 2019, one in 11 CT adults 18-64 years old reported that they had no health insurance coverage, six in ten reported that they had private health insurance coverage, one in eight had Medicaid coverage, and one in 20 had Medicare coverage.

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

- Adults 18–34 years old (12.7%) compared to adults 55-64 years old (6.1%);
- Hispanic (26.7%) adults compared to non-Hispanic White adults (4.9%);
- Adults from households earning less than $35,000 (20.6%) compared to $35,000–$74,999 (11.0%); and
- Adults with no more than a high school education (17.9%).

FIGURE 16: NO INSURANCE COVERAGE, ADULTS 18-64 YEARS OLD, CT 2019
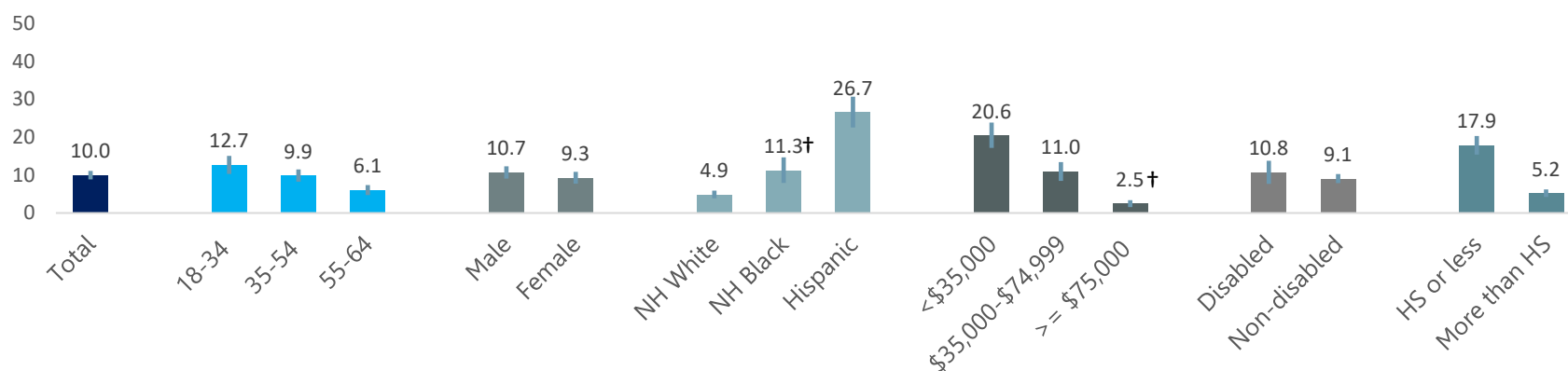
Estimates marked with a "†" have a CV between 15.0% and 20.0%.

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

- Adults 55-64 (68.3%) and 35–54 years old (67.4%);
- Non-Hispanic White (71.8%) and non-Hispanic Black (52.0%) adults;

- Adults from households earning at least $75,000 (87.0%) and $35,000–$74,999 (66.0%);
- Adults with a disability (69.5%); and
- Adults with more than a high school education (73.1%).

FIGURE 17: PRIVATE INSURANCE, ADULTS 18-64 YEARS OLD, CT 2019
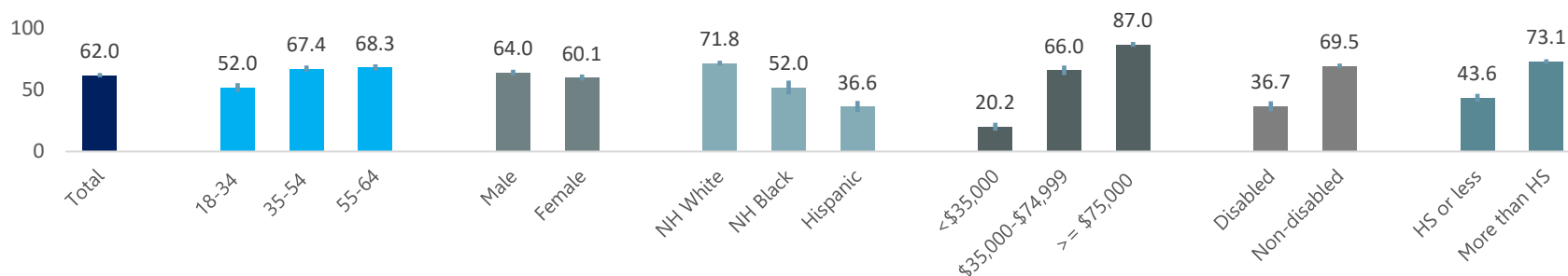
Compared to their counterparts in the state, the prevalence of adults who had **Medicaid coverage** among adults aged 18–64 years old was significantly greater for:

- Adults 18–34 years old (15.1%) compared to adults 55-64 years old (7.8%);
- Females (13.6%);
- Non-Hispanic Black adults (16.4%) and Hispanic adults (15.7%);

- Adults from households earning less than $35,000 (28.8%) compared to from $35,000–$74,999 (7.6%);
- Adults with a disability (20.5%); and
- Adults with no more than a high school education (15.1%).

FIGURE 18: MEDICAID COVERAGE, ADULTS 18-64 YEARS OLD, CT 2019
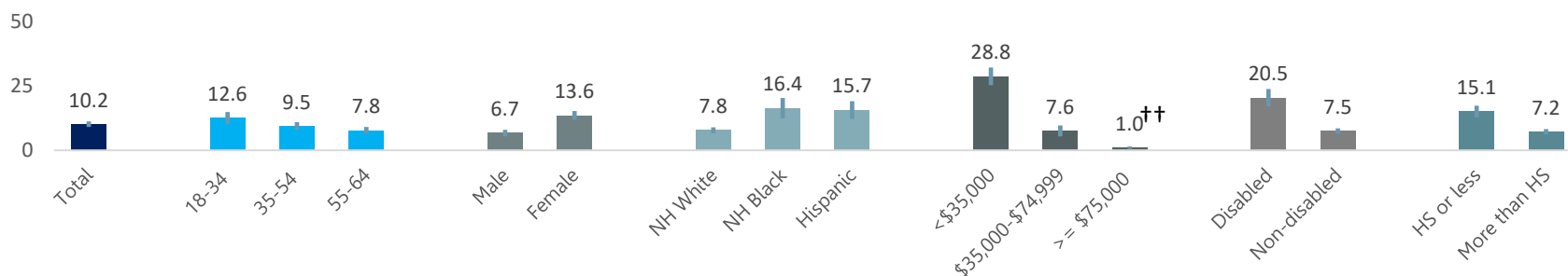
Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%; estimates with CV greater than 30.0% were suppressed.

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

- Adults 55-64 years old (9.3%);
- Adults with a disability (17.0%); and
- Adults with no more than a high school education (9.8%).

FIGURE 19: MEDICARE COVERAGE, ADULTS 18-64 YEARS OLD, CT 2019
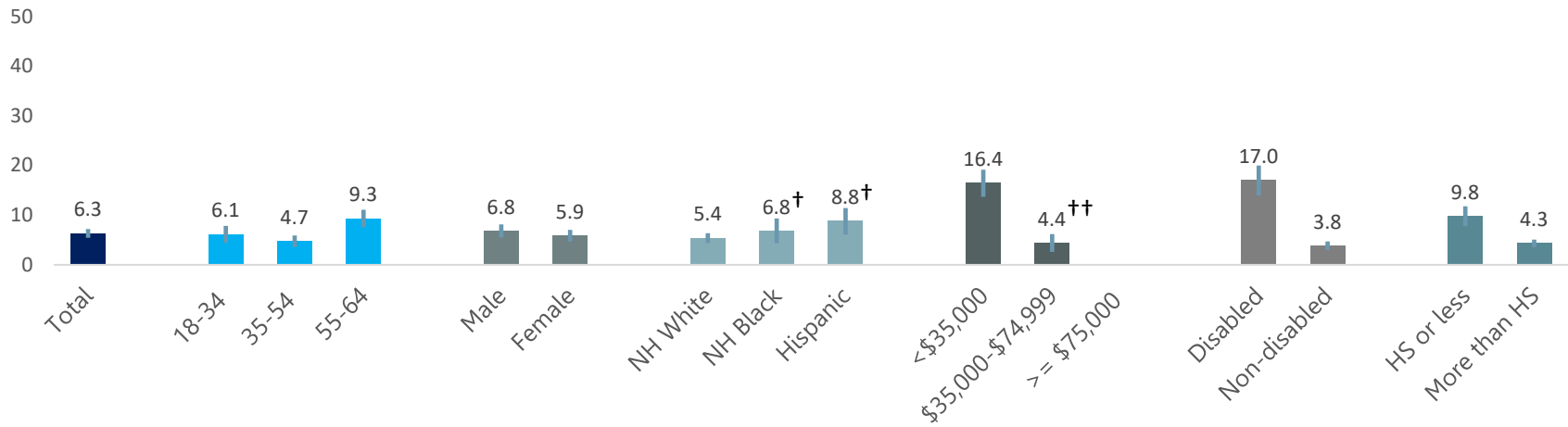
Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%.

Note: Generally, Medicare is available for people age 65 or older, younger people with disabilities and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

4. RISK BEHAVIOR INDICATORS

ADULT PHYSICAL ACTIVITY

Regular physical exercise has been shown to prevent certain chronic diseases. A sedentary lifestyle is a risk factor for obesity, bone and joint diseases, depression, and chronic diseases.[19] Adults were asked to report whether they had participated in any physical activities or exercises in the past 30 days, such as running, calisthenics, golf, gardening, or walking, other than for their job. Figure 20 shows the prevalence of adults who did not engage in leisure or recreational physical activity.

Nearly one in four Connecticut adults in 2019 did not engage in any recreational physical activity outside of work.

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

- Females (25.3%);
- Hispanic (30.4%) and non-Hispanic Black (30.4%) adults;
- Adults from households earning less than $35,000 (36.2%) and $35,000–$74,999 (24.0%);
- Adults without health insurance (37.2%);
- Adults with a disability (40.3%); and
- Adults with no more than a high school education (34.0%).

FIGURE 20: DID NOT ENGAGE IN LEISURE OR RECREATIONAL PHYSICAL ACTIVITY, CT 2019
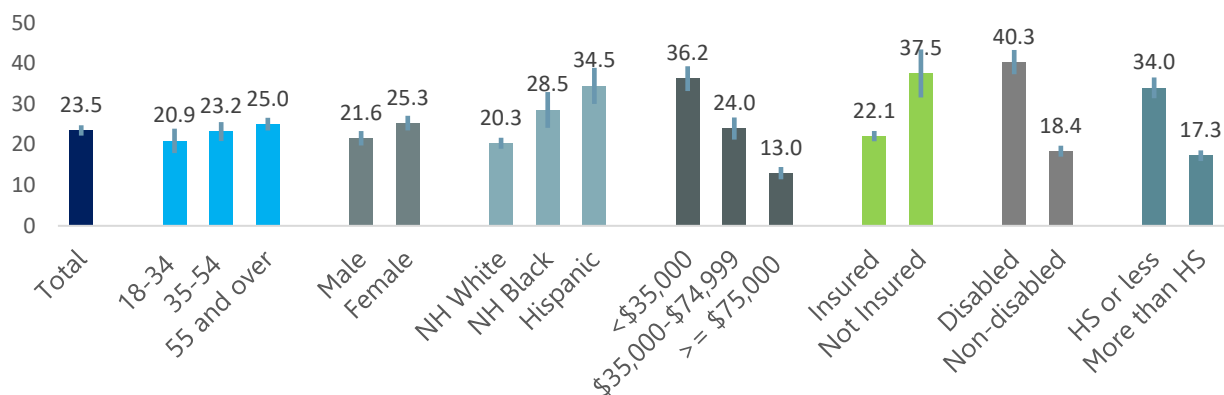
FIGURE 21: PHYSICAL ACTIVITY CATEGORIES, CT 2019
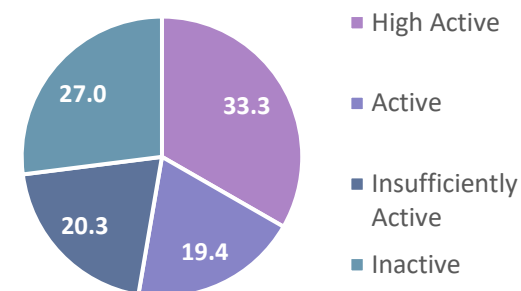
CURRENT CIGARETTE SMOKING

According to the U.S. Surgeon General, smoking is the number one preventable cause of death.[20] It is detrimental to nearly every organ in the body and causes poorer overall health. Smokers are more likely to develop lung cancer, stroke, and heart disease when compared to non-smokers. Smoking is associated with numerous other cancers and diseases. Nearly half a million Americans die every year in the United States as a result of cigarette smoking, meaning that one in five deaths nationwide can be linked to smoking. The prevalence of current cigarette smoking is shown in Figure 23.

One in eight Connecticut adults in 2019 were current smokers, smoked cigarettes "every day" or "some days" in the past month.

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

- Adults 18–34 years old (13.0%) and 35–54 years old (14.7%);
- Males (13.7%);
- Adults from households earning less than $35,000 (22.1%) and $35,000–$74,999 (13.0%);
- Adults with a disability (21.6%); and
- Adults with no more than a high school education (17.4%).

Figure 22: SMOKING STATUS, CT 2019.

- Current (every day) 3.5
- Current (some days) 8.6
- Former 25.2
- Never Smoked 62.7
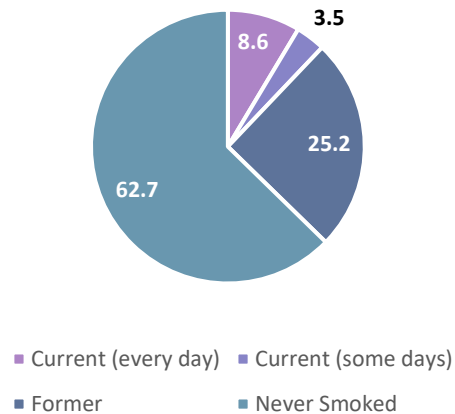
Figure 23: CURRENT CIGARETTE SMOKING, CT 2019.

Total: 12.1; 18-34: 13.0; 35-54: 14.7; 55 and over: 9.7; Male: 13.7; Female: 10.6; NH White: 12.3; NH Black: 14.2; Hispanic: 10.9; <$35,000: 22.1; $35,000-$74,999: 13.0; >= $75,000: 7.4; Insured: 11.8; Not Insured: 16.1†; Disabled: 21.6; Non-disabled: 9.3; HS or less: 17.4; More than HS: 9.0
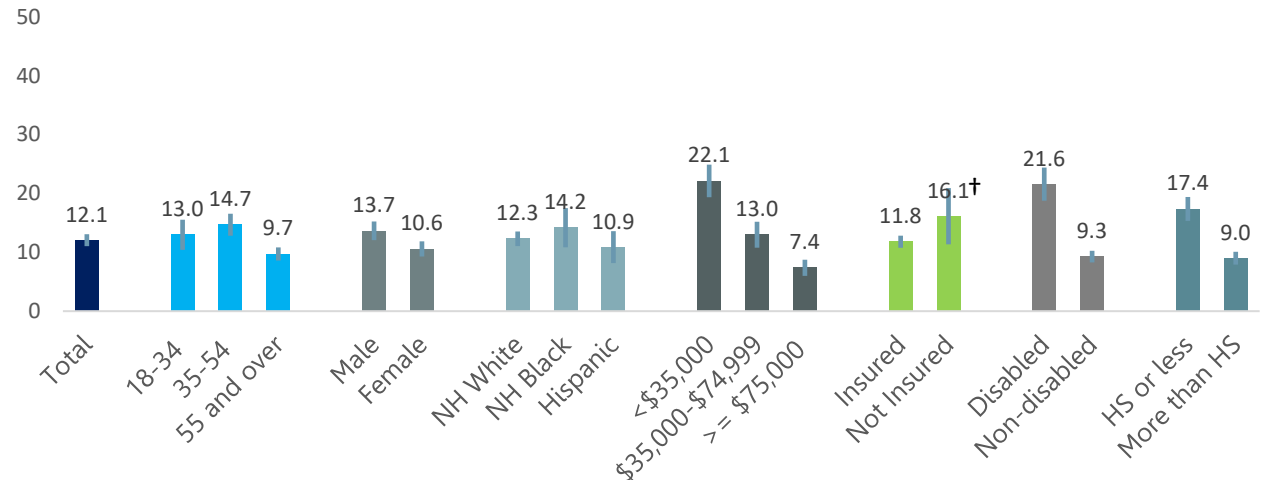
Estimates marked with a "†" have a CV between 15.0% and 20.0%.

E-CIGARETTE AND HOOKAH USE

Although cigarette smoking in the United States has been steadily declining, use of alternative tobacco products has become more prevalent over the past several decades.[21] The health effects of non-cigarette tobacco use are often perceived as less harmful than traditional cigarettes, particularly in younger age groups. Yet nicotine exposure during adolescence may have long-lasting adverse effects on the developing adolescent brain. In addition, nearly all first-time tobacco use, and much of the subsequent addiction, occurs during adolescence and young adulthood. The negative health risks associated with hookahs are well-established, and preliminary studies on e-cigarettes identify harmful effects as well.[22, 23]

The BRFSS survey asks respondents to report their use of electronic cigarettes. Electronic cigarettes, commonly called e-cigarettes, contain cartridges of nicotine and other chemicals. The nicotine is vaporized and inhaled through a battery-powered device that resembles a traditional cigarette. The use of electronic cigarettes and Hookah among Connecticut adults in 2019 is shown in Figure 25-26.

One in five CT adults in 2019 had tried vapor, vape pen or e-cigarettes. Compared to their counterparts in the state, the prevalence of **using vapor, vape pens, or e-cigarettes** was significantly greater for:

- Adults 18–34 years old (42.2%) and 35–54 years old (17.9%);
- Males (23.1%);
- Adults from households earning less than $35,000 (23.7%) and $35,000-$74,999 (22.0%); and
- Adults with a disability (25.3%); and
- Adults with no more than a high school education (23.7%).

FIGURE 24: E-CIGARETTE USE, CT 2019

Legend: Current (every day), Current (some days), Former, Never Used
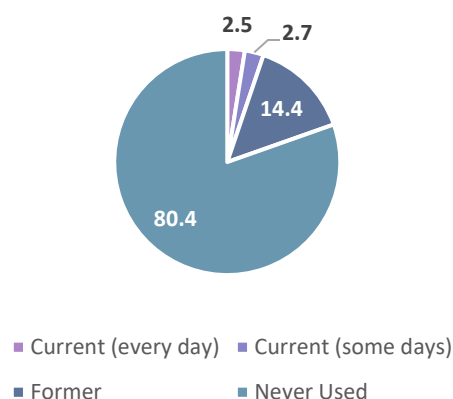
FIGURE 25: EVER TRIED VAPOR OR VAPE PEN OR E-CIGARETTES, CT 2019

43
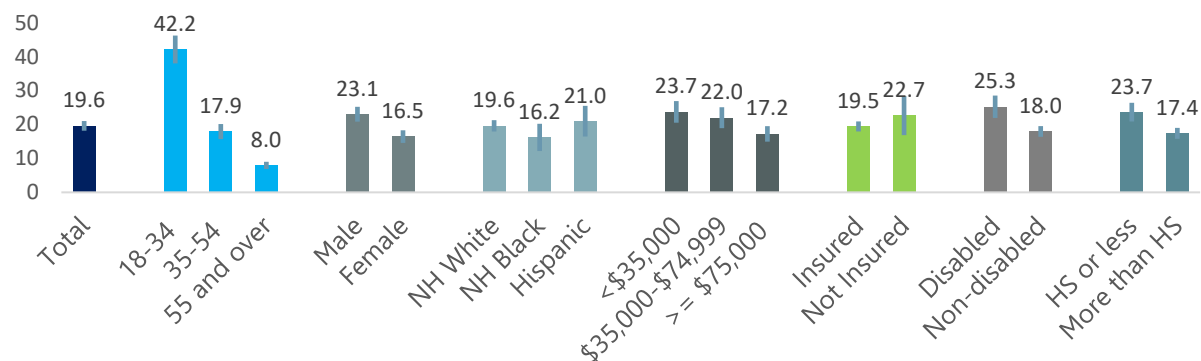
One in six CT adults in 2019 had tried smoking hookah. Compared to their counterparts in the state, the prevalence of **ever using hookah** among CT adults was significantly greater for:

- Adults 18–34 years old (36.9%) and 35–54 years old (14.1%);
- Males (19.9%); and
- Hispanic (20.8%) adults.

FIGURE 26: EVER TRIED SMOKING HOOKAH, CT 2019.
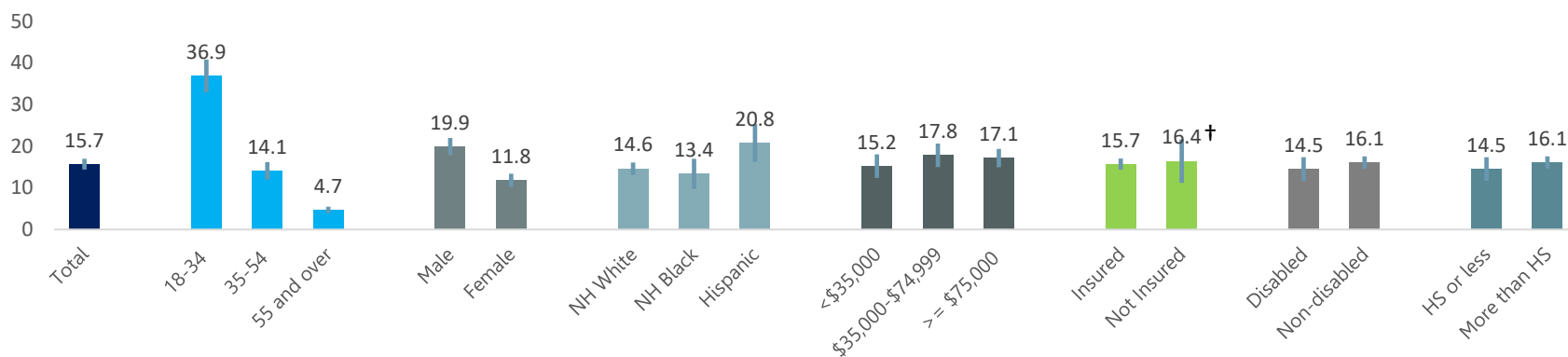
Estimates marked with a "†" have a CV between 15.0% and 20.0%.

ALCOHOL CONSUMPTION

Excessive alcohol consumption, such as binge drinking or heavy drinking, is associated with numerous health problems, including chronic diseases, unintentional injuries, neurological impairments, and social problems.[24] A person binge drinks when they drink enough within a two-hour period that their blood alcohol concentration reaches 0.08 grams/deciliter. For men, this usually means consuming more than five drinks during one occasion. For women, it is more than four drinks.[25] Binge drinking is linked to a variety of health problems, such as liver disease, neurological damage, and alcohol poisoning, and can lead individuals to engage in risky and violent behaviors.[26] Heavy drinking is defined as consuming an average of more than two drinks per day for men, and more than one drink per day for women.[27] Excessive drinking is defined as either heavy drinking or binge drinking.

The BRFSS questionnaire ask respondents to report the number of days they consumed at least one drink of alcohol in the past 30

days, and for those who did drink, how many times they drank more than these thresholds. The prevalence of adults in 2019 who engaged in binge drinking, heavy drinking, or excessive drinking over the previous 30 days is shown below (Figure 27-29).

One in six CT adults report excessive alcohol consumption in 2019. Approximately one in six CT adults engaged in binge drinking, while one in 16 engaged in heavy drinking.

Compared to their counterparts in the state, the prevalence of **excessive alcohol consumption** was significantly greater for:
- Adults 18–34 years old (26.3%) and 35–54 years old (19.5%);
- Males (20.7%);
- Non-Hispanic White (18.6%) and Hispanic (20.0%) adults;
- Adults from households earning at least $75,000 (21.6%) compared to less than $35,000 (15.1%); and
- Adults without a disability (18.3%).

FIGURE 27: EXCESSIVE ALCOHOL CONSUMPTION, CT 2019
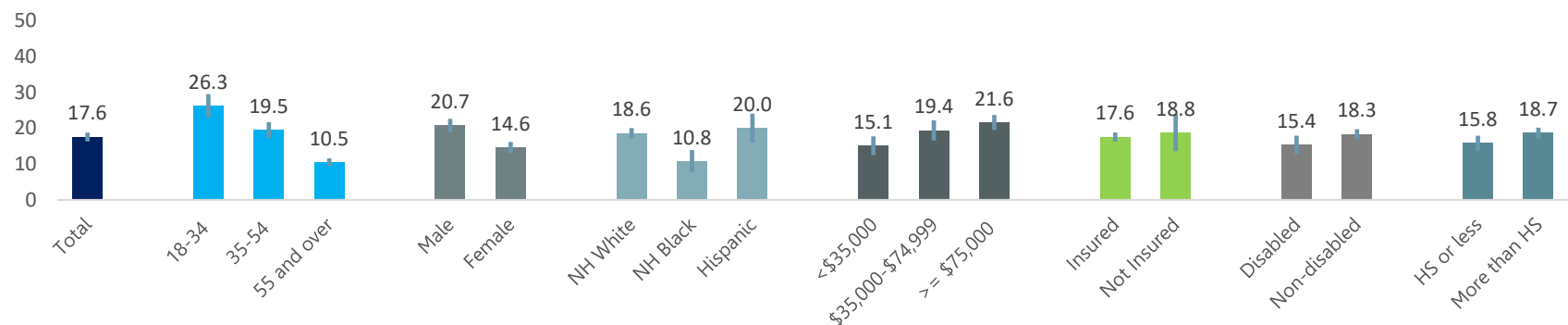
Compared to their counterparts in the state, the prevalence of **binge drinking** was significantly greater for:

- Adults 18–34 years old (25.0%) and 35–54 years old (18.3%);
- Males (19.6%);
- Non-Hispanic White (16.4%) and Hispanic (19.2%) adults;
- Adults from households earning at least $75,000 (19.3%) compared to less than $35,000 (13.5%); and
- Adults without a disability (16.5%).

FIGURE 28: BINGE DRINKING, CT 2019
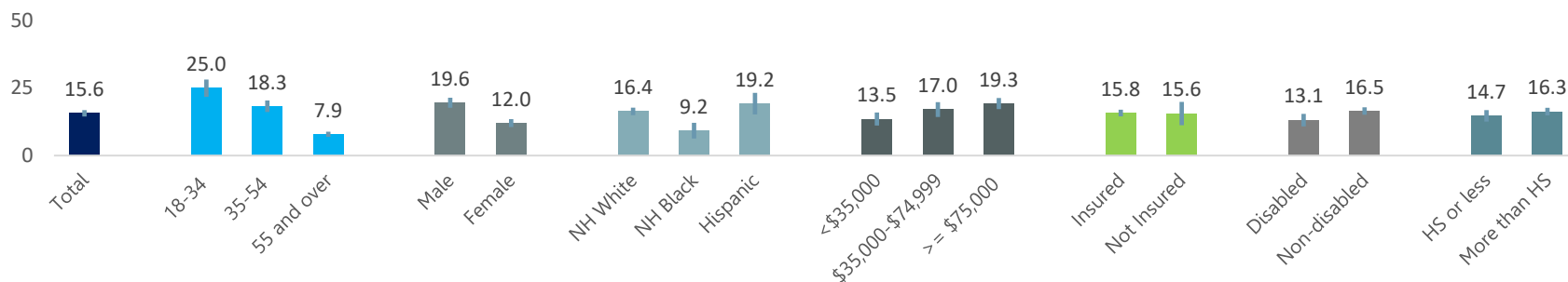
Compared to their counterparts in the state, the prevalence of **heavy drinking** was not differences among demographics.

FIGURE 29: HEAVY DRINKING, CT 2019
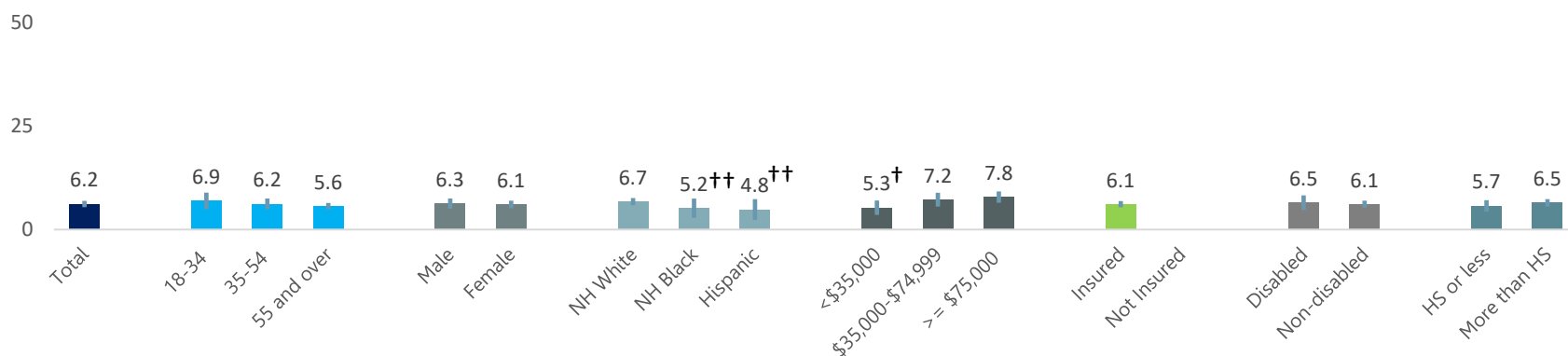
Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%; estimates with CV greater than 30.0% were suppressed.

5. CLINICAL PREVENTIVE PRACTICES

ROUTINE CHECK-UP

The CDC stresses the importance of routine check-ups for disease prevention and screening.[28] Respondents in the BRFSS are asked how long it had been since they last visited a doctor for a routine check-up. The prevalence of adults in 2019 who had a check-up in the previous year is shown in Figure 30-31.

Four-fifths of Connecticut adults in 2019 had a routine check-up in the previous year.
Compared to their counterparts in the state, the prevalence of

having a **routine check-up within the past year** was significantly greater for:

- Adults 55 years and older (88.9%) and 35-54 years old (77.2%);
- Females (83.6%);
- Non-Hispanic White (80.6%) and non-Hispanic Black (88.3%) adults;
- Adults with health insurance (82.4%); and
- Adults with a disability (86.1%).

FIGURE 31: ROUTINE CHECK-UP IN THE PAST YEAR, CT 2019
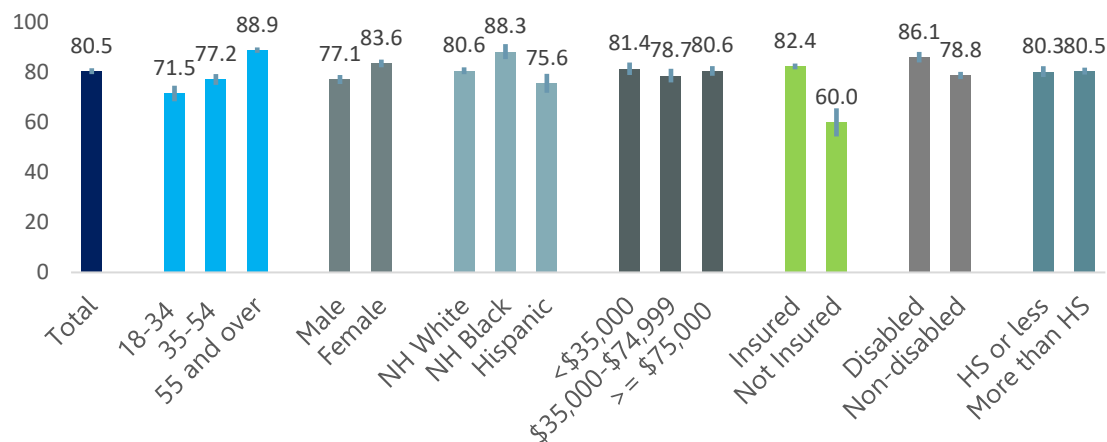
FIGURE 30: TIME SINCE LAST ROUTINE CHECK-UP, CT 2019
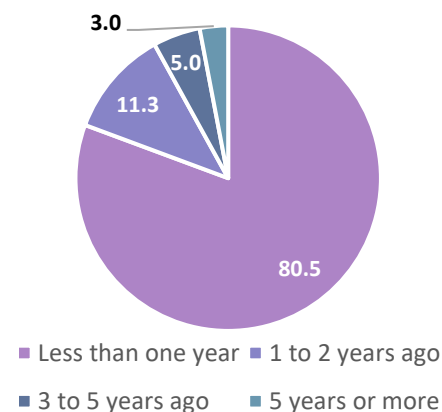
CHOLESTEROL SCREENING

Cholesterol is a lipid that is produced in the liver and kidneys and ingested from food. Some cholesterol is necessary, but too much cholesterol can lead to clogging of the arteries. High cholesterol is one of the risk factors associated with heart attack, heart disease, and stroke.[29] Blood testing is the only way to determine how much cholesterol is in the body.[30] Patients are encouraged to talk to their primary care provider about cholesterol testing. The 2019 BRFSS asked respondents if they had ever had their cholesterol checked, and if their cholesterol was checked in the past five years (Figure 32).

Ninety percent of Connecticut adults in 2019 had their blood cholesterol checked in the past five years. Compared to their counterparts in the state, the prevalence of having **blood cholesterol checked in past 5 years** was significantly greater for:

- Adults 55 years and older (96.6%) and adults 35–54 years old (92.1%);
- Non-Hispanic White (91.3%) compared to Hispanic (85.6%) adults;
- Adults from households earning at least $75,000 (93.1%) compared to less than $35,000 (87.8%);
- Adults with health insurance (91.8%); and
- Adults with more than a high school education (92.6%).

FIGURE 32: HAD BLOOD CHOLESTEROL CHECKED IN PAST 5 YEARS, CT 2019.
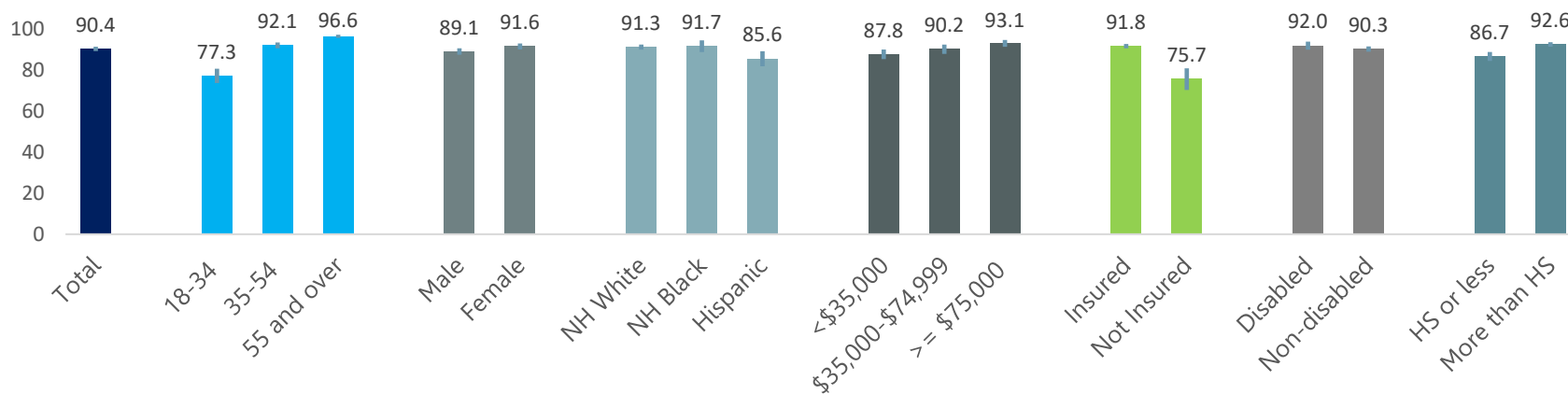
HUMAN IMMUNODEFICIENCY VIRUS (HIV) SCREENING

Over one million Americans are living with human immunodeficiency virus (HIV), and of these, about one in six are not aware they are infected. The group most affected by HIV is men who have sex with men, although heterosexuals and drug users can also be affected. African Americans and Hispanics are over-represented in new HIV infections.[31] Individuals can be tested for the virus by testing blood or oral fluid.

Respondents to the CT BRFSS were asked if they have ever been tested for HIV, not including testing while donating blood. Results are shown in Figure 33.

Two-fifth of Connecticut adults in 2019 reported having been tested for HIV.

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

- Adults 35–54 years old (60.0%) and adults 18–34 years old (46.3%);
- Non-Hispanic Black (66.9%) and Hispanic (59.4%) adults;
- Adults from household earning less than $35,000 (49.8%);
- Adults without health insurance (48.9%); and
- Adults with disability (44.1%).

FIGURE 33: EVER TESTED FOR HIV, CT 2019
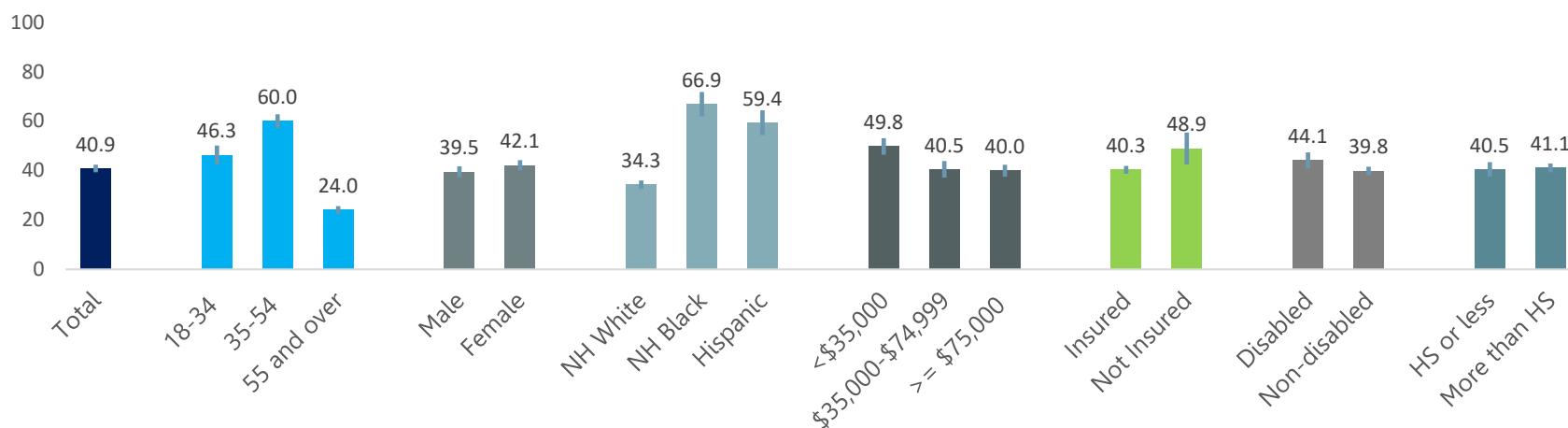
ADULT INFLUENZA VACCINATION

The influenza (flu) virus can cause serious infections, hospitalizations, and even death in some susceptible individuals. Seasonal flu vaccines are recommended for everyone over six months of age.[32] Respondents to the BRFSS were asked if they had received the seasonal flu vaccine, either as a shot or nasal spray mist. All respondents were asked if they had received the flu vaccine in the past 12 months. Results are shown in Figure 34.

In 2019, half of CT adults in 2019 had a flu vaccine in the past year, and seven in 10 CT adults aged 65 and over had a flu vaccine in the past year.

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

- Adults 55 years and older (62.9%);
- Females (53.3%);
- Non-Hispanic White adults (54.6%) and non-Hispanic Black adults (45.2%);
- Adults from household earning at least $75,000 (54.9%);
- Adults with health insurance (51.6%); and
- Adults with more than a high school education (53.5%).

FIGURE 34: FLU VACCINE IN THE PAST YEAR, CT 2019
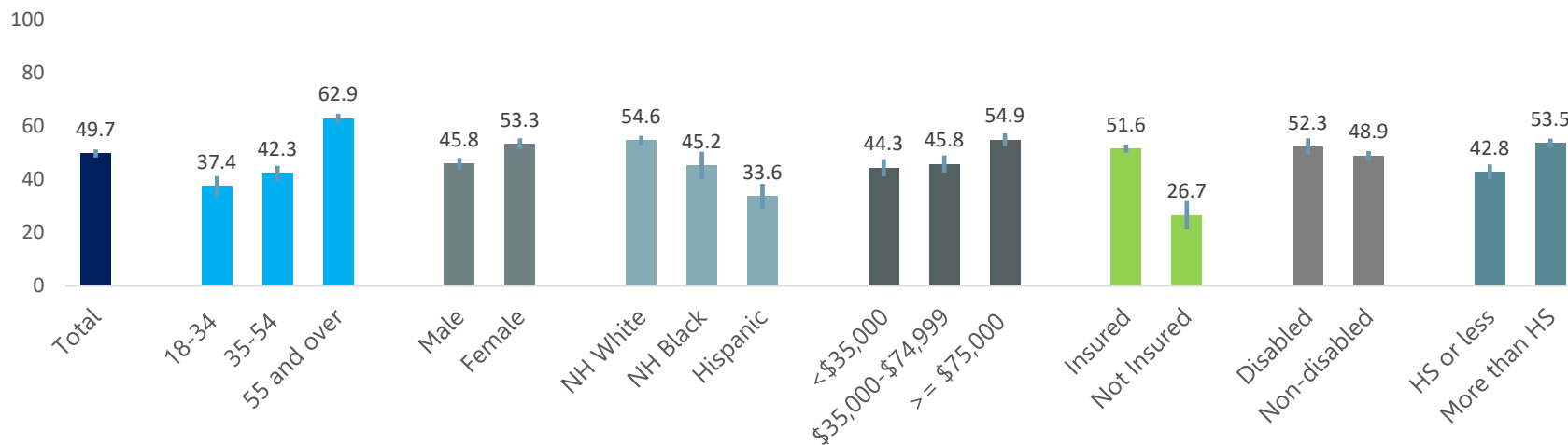
PNEUMOCOCCAL VACCINATION (65+)

Pneumococcal disease, or pneumonia, is a lung infection that can be caused by viruses, bacteria, or fungi. In the United States, pneumococcal disease causes 4 million illness, 445,000 hospitalizations, and 22,000 deaths annually.[33] Infection caused by some types of pneumococcal bacteria can be prevented by a pneumococcal or "pneumonia" vaccine.[34] Respondents to the BRFSS were asked if they have ever received the pneumococcal vaccine, which is recommended for children under five years old, adults over

65 years old, and adults at high risk for disease (e.g., HIV infection, organ transplantation, leukemia, and severe kidney disease). Results are shown in Figure 35.

In 2019, nearly three-fourth CT adults reported that they ever had pneumococcal vaccination.

Compared to their counterparts in the state, the prevalence of ever having a **pneumococcal vaccination** among Connecticut adults 65 and older was significantly greater for:

- Adults with a disability (78.2%).

FIGURE 35: EVER HAD PNEUMOCOCCAL VACCINATION (65+), CT 2019
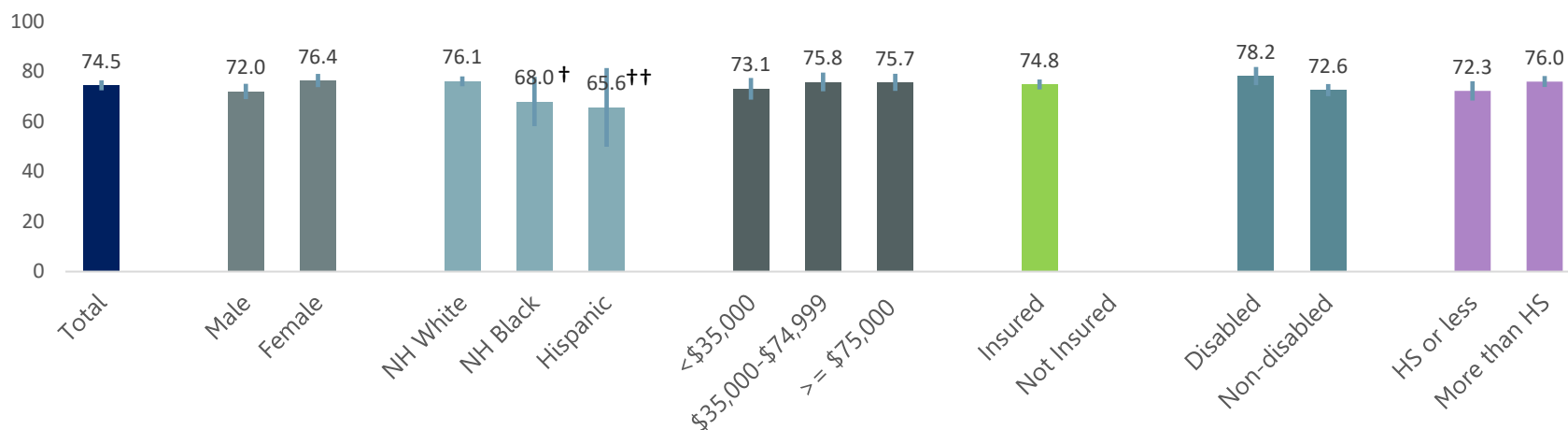
Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%; estimates with CV greater than 30.0% were suppressed.

ADULT TDAP VACCINATION

The Adult Tdap vaccine immunizes against tetanus, diphtheria, and pertussis, three bacterial diseases that were once common in the United States. Tetanus enters the body through cuts and scratches that have come into contact with the bacteria, usually through dirt or soil. Diphtheria and pertussis are spread by respiratory droplets, such as coughing and sneezing.[35] Vaccines have been instrumental in decreasing the incidence of these diseases.[36]

In 2005, the Advisory Committee on Immunization Practices recommended the use of a new vaccine, Tdap, that immunizes against all three diseases, rather than just tetanus and diphtheria (Td). They also recommended that adults between the ages of 19 and 64 receive one shot of Tdap instead of a booster dose of Td.[37]

The 2019 BRFSS asked respondents whether they had received a tetanus vaccination since 2005. In 2019, seventy percent of CT adults reported they had received the Tdap vaccine.

Compared with their counterparts in the state, the prevalence of having a **tetanus shot since 2005** was significantly greater for:
- Adults 18–34 years old (75.5%) and adults 35–54 years old (70.0%);
- Non-Hispanic White adults (72.4%);
- Adults from households earning at least $75,000 (73.9%) and $35,000–$74,999 (69.3%);
- Adults with health insurance (70.5%);
- Adults with disability (70.6%); and
- Adults with more than a high school education (71.9%).

FIGURE 36: HAD TDAP VACCINATION, CT 2019.
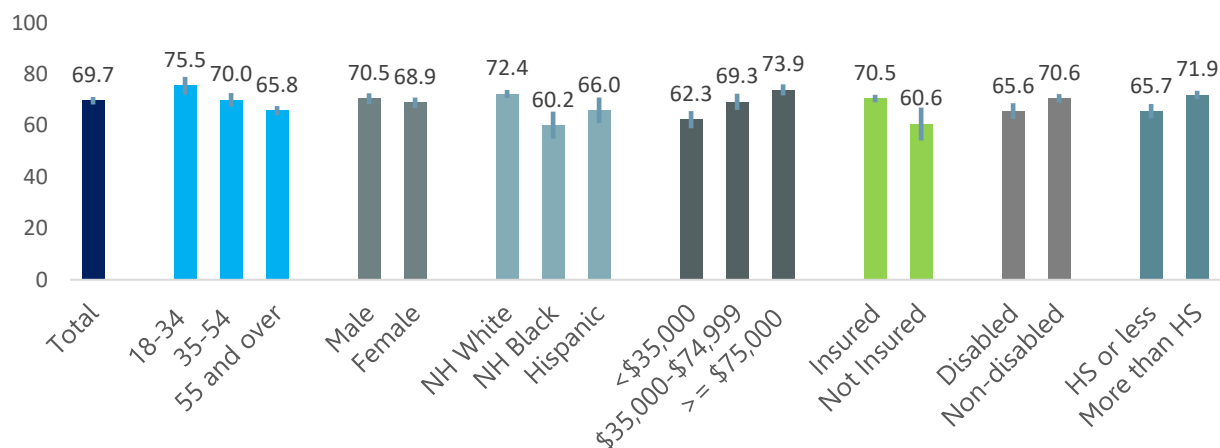
FIGURE 37: TDAP AND TETANUS VACCINATIONS, CT 2019.

52
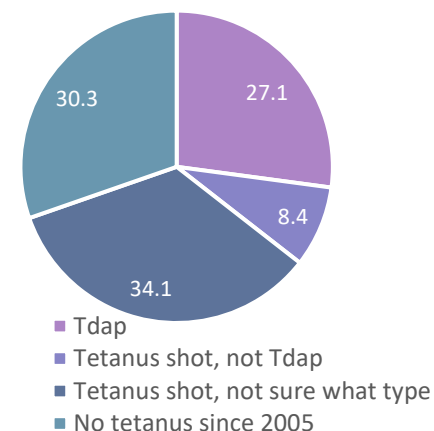
SHINGLES VACCINATION

Shingles is caused by the same virus that causes chicken pox. Symptoms of shingles include a painful skin rash. The CDC recommends the shingles vaccine, known as Zostavax®, to adults over 60 years of age.[38] Respondents aged 50 and over were asked if they have had the shingles vaccine since it became available in 2006 (see Figure 38).

In 2019, one in three CT adults 50 and over ever had the shingles or zoster vaccine. Compared with their counterparts in the state, the prevalence of having a **shingle shot among adults 50 and over** was significantly greater for:

- Non-Hispanic White adults (34.2%) compared to non-Hispanic Black adults (22.5%); and
- Adults with more than a high school education (33.1%).

FIGURE 38: HAD SHINGLES VACCINATION AMONG ADULTS 50 AND OVER, CT 2019.
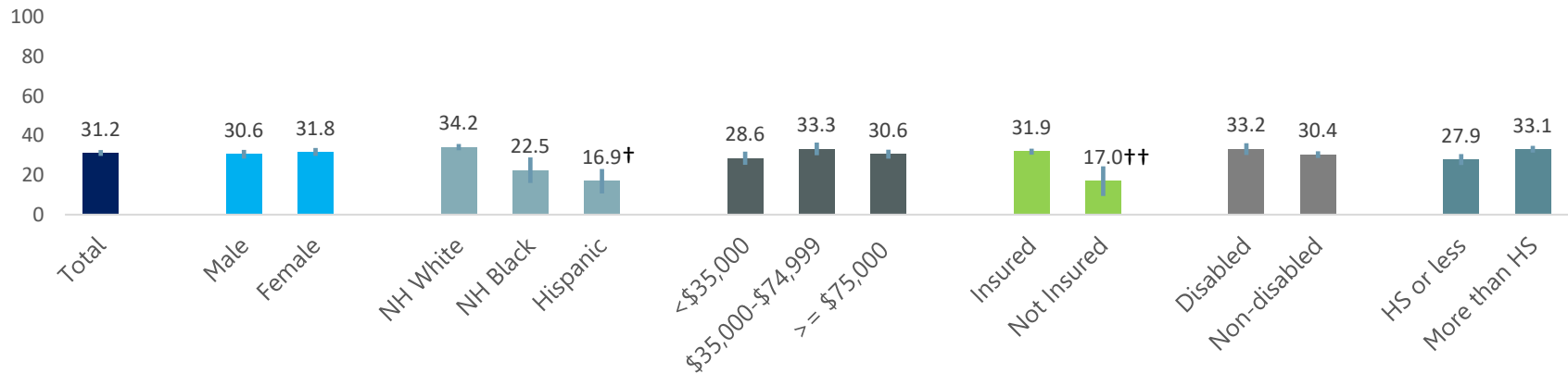
Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%.

6. CHRONIC CONDITIONS

ASTHMA

Asthma is a chronic lung disease that causes the airways to become inflamed or swollen. Symptoms of asthma include shortness of breath, coughing, and wheezing.[39] Four thousand people die in the United States each year due to asthma-related causes. These deaths are preventable with proper treatment.[40] Overall, asthma rates have been increasing in adults in the United States.[41] Respondents were asked if, among those who indicated a doctor or health professional had ever told them they had asthma, whether they still had asthma. Results in 2019 are shown in Figures 39 and 40.

One in ten Connecticut adults (10.3%) reported having current asthma in 2019.

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

- Adults 35–54 years old (12.4%) compared to adults 50 years old and over (9.2%);
- Females (13.6%);
- Adults from households earning less than $35,000 (13.6%); and
- Adults with a disability (18.7%).

FIGURE 39: ADULT ASTHMA STATUS, CT 2019

Current: 10.5
Former: 5.8
Never: 83.7

- Current ■ Former ■ Never

FIGURE 40: ADULT CURRENT ASTHMA, CT 2019

Total: 10.5; 18-34: 12.4; 35-54: 10.9; 55 and over: 9.2; Male: 7.3; Female: 13.6; NH White: 10.1; NH Black: 12.7; Hispanic: 12.2; <$35,000: 13.6; $35,000-$74,999: 10.0; >= $75,000: 9.7; Insured: 10.8; Not Insured: 7.6††; Disabled: 18.7; Non-disabled: 8.1; HS or less: 11.9; More than HS: 9.7

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

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

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

Respondents to the BRFSS were asked if they were ever told they had COPD, emphysema, or chronic bronchitis, and results in 2019 are shown in Figure 41.

In 2019, one in 20 CT adults reported they had COPD.

Compared to their counterparts in the state, the prevalence of **COPD** was significantly greater for:
- Adults 55 years and older (9.2%) compared to adults 35-54 years old (3.3%);
- Adults from households earning less than $35,000 (9.4%) and $35,000-$75,000 (5.2%);
- Adults with a disability (13.7%); and
- Adults with no more than a high school education (7.5%).

FIGURE 41: CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CT 2019
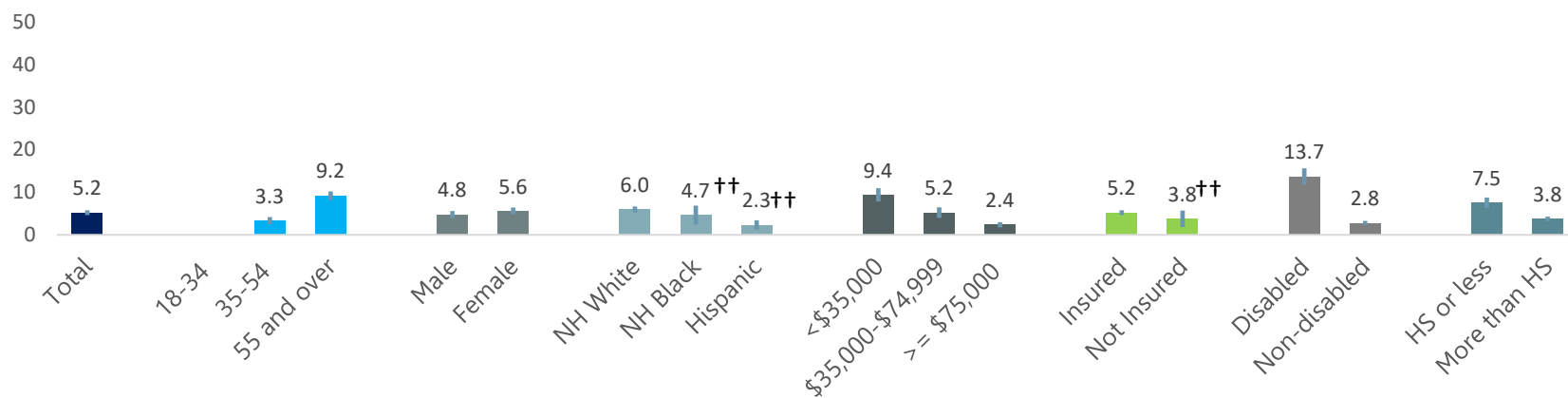
Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%; estimates with CV greater than 30.0% were suppressed.

ARTHRITIS

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

Respondents to the BRFSS were asked if they were ever told they had arthritis, and results in 2019 are shown in Figure 42.

One in four Connecticut adults in 2019 had been diagnosed with arthritis.

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

- Adults 55 years and older (42.9%) and adults 35–54 years old (15.4%);
- Females (27.5%);
- Non-Hispanic White (27.0%) and non-Hispanic Black (23.2%) adults;
- Adults from households earning less than $35,000 (29.7%) and $35,000-$74,999 (25.1%);
- Adults with health insurance (24.8%);
- Adults with a disability (45.0%); and
- Adults with no more than a high school education (26.7%).

FIGURE 42: ARTHRITIS, CT 2019
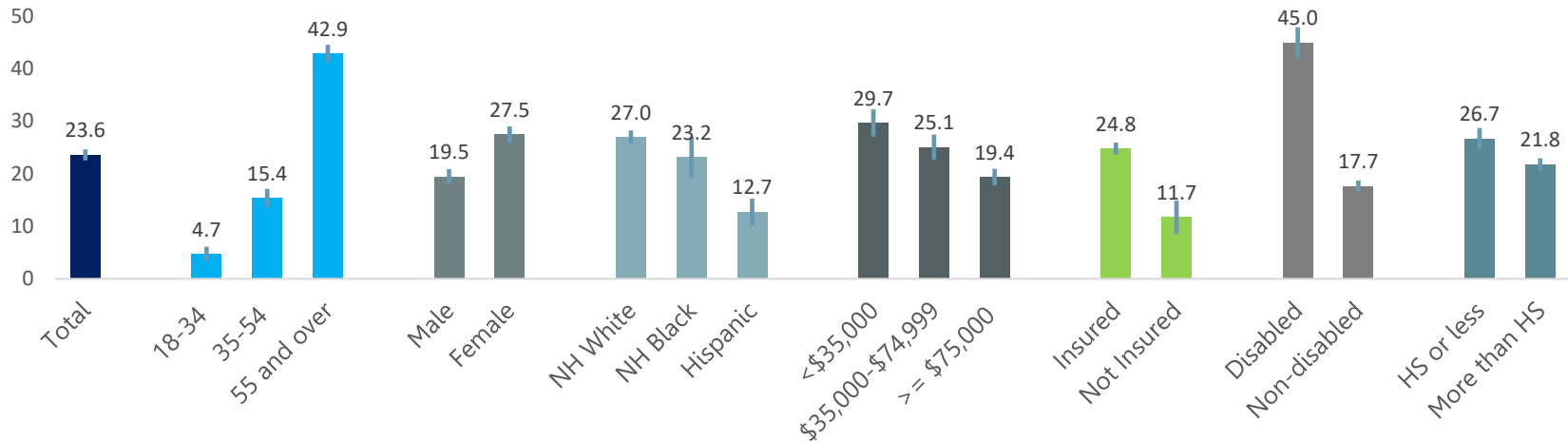
CARDIOVASCULAR DISEASE AND STROKE

Cardiovascular disease (CVD) encompasses several heart conditions. It is the leading cause of death in the United States. The most common type of heart disease is coronary heart disease.[43] Adults who suffer from coronary heart disease have plaque build-up in their coronary arteries, which reduces the flow of oxygen to the heart. This can lead to angina, characterized by chest pain or pressure, as well as heart attacks.[44] Cardiovascular disease and stroke can be prevented by remaining physically active and eating a healthy and well-balanced diet and managing risk factors such as high blood pressure and cholesterol.[45] Respondents are asked if they were ever told they had any of the following: a heart attack, also called a myocardial infarction; angina or coronary heart disease; or a stroke, a disease caused by a blocked blood vessel or bleeding in the brain. Results in 2019 for those who responded to all three questions were combined and are presented in Figure 43.

In 2019, one in 15 CT adults reported they had cardiovascular disease.

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

- Adults 55 years and older (12.9%) compared to adults 35-54 years old (3.0%);
- Non-Hispanic Black adults (9.5%) compared to non-Hispanic White adults (6.6%);
- Adults from households earning less than $35,000 (11.5%) and $35,000-$74,999 (7.2%);
- Adults with a disability (17.1%); and
- Adults with no more than a high school education (8.6%).

FIGURE 43: CARDIOVASCULAR DISEASE OR STROKE, CT 2019
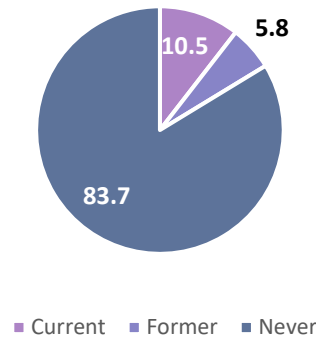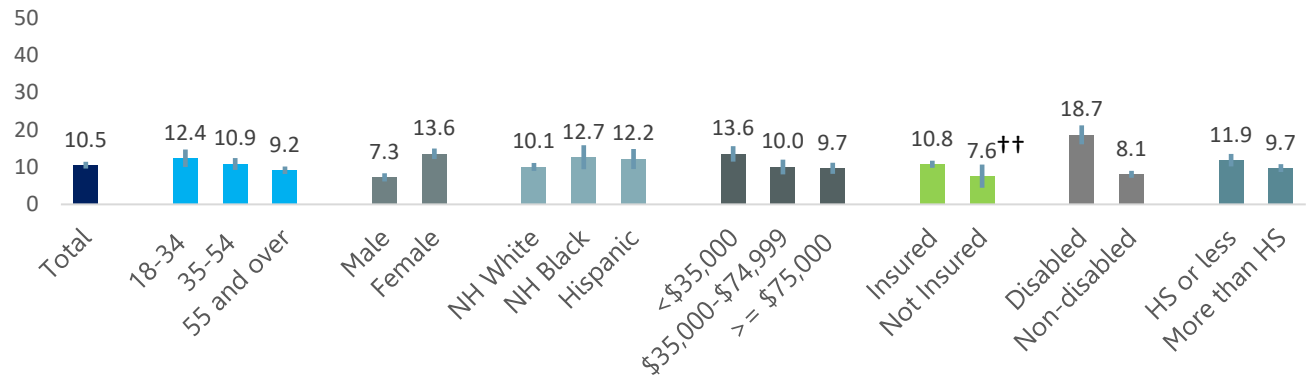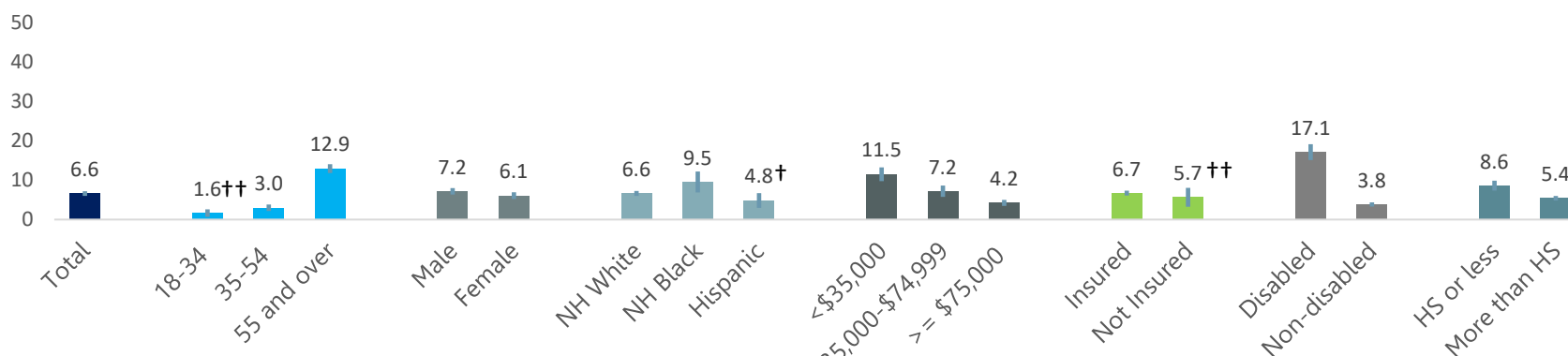

Estimates marked with a "†" have a CV between 15.0% and 20.0%[; estimates marked with a "††" have a CV between 20.1% and 30.0%.

CHOLESTEROL AWARENESS

It is estimated that more than 73 million American adults suffer from high cholesterol, but less than one in three of these adults has their high cholesterol under control.[46] People with high cholesterol have twice the risk of heart disease as people with lower levels of cholesterol.[47] Cholesterol can be controlled by making lifestyle and dietary changes. Depending on overall risk of cardiovascular disease, medication may be necessary.[48]
 The 2019 BRFSS asked respondents if they had ever been told they had high blood cholesterol levels. Results in 2019 are shown by demographics in Figure 44.

One in three Connecticut adults in 2019 had ever been told their blood cholesterol was high. Compared to their counterparts in the state, the risk of ever having **high blood cholesterol** among adults in Connecticut was significantly greater for:

- Adults 55 years and older (45.7%) and adults 35-54 years old (28.8%);
- Non-Hispanic White adults (34.2%) compared to Hispanic adults (26.9%);
- Adults with health insurance (32.9%); and
- Adults with a disability (45.0%).

FIGURE 44: HIGH BLOOD CHOLESTEROL, CT 2019.
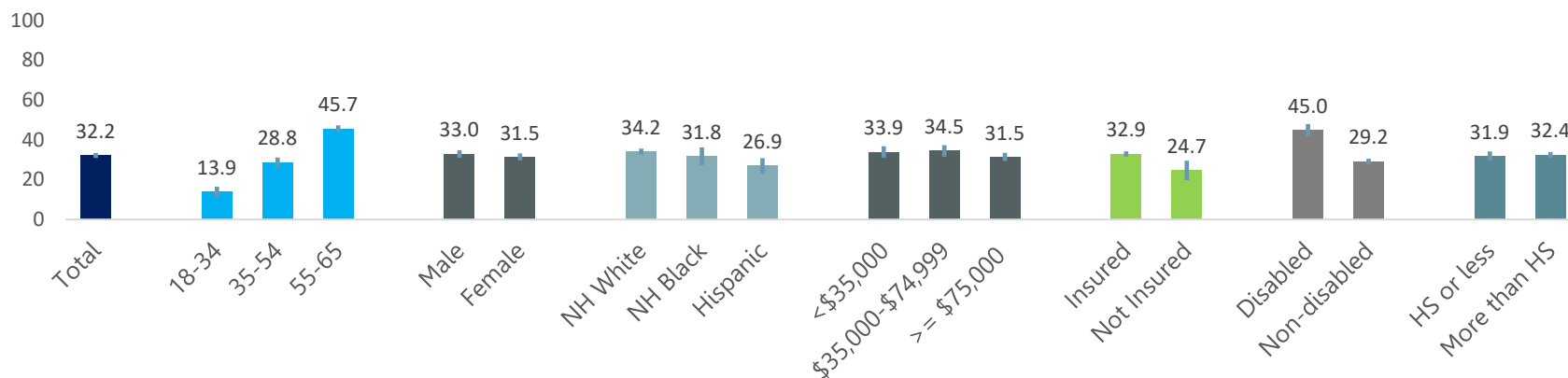
HYPERTENSION AWARENESS

Hypertension is the medical term for high blood pressure, a condition that impacts one in three adults in America (approximately 70 million people). It estimated that only 50% of these adults have their high blood pressure under control.[49] Medication and lifestyle changes are often enough to control high blood pressure, but if it is not controlled, it can result in heart problems, kidney disease, and stroke.[50] Consuming more than the recommended amount of sodium, smoking, drinking too much alcohol, and family history of high blood pressure can all contribute to the development of high blood pressure. African Americans are more likely to develop high blood pressure than other groups.[48] Hypertension can be prevented by eating a healthy diet low in sodium and high in fruits and vegetables, being active, and not smoking.[51] BRFSS respondents were asked if they had ever been told they had high blood pressure and, among those with diagnosed hypertension, whether they were currently taking medication for the condition. Results in 2019 are shown in Figures 45.

Nearly one in three Connecticut adults in 2019 have been diagnosed with hypertension, while three in four were taking medicine for their high blood pressure among those diagnosed with hypertension (77.7%).

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

- Adults 55 years and older (50.7%) and adults 35–54 years old (25.0%);
- Males (33.0%);
- Non-Hispanic Black (43.1%) and non-Hispanic White (31.8%) adults;
- Adults from households earning less than $35,000 (39.1%) and $35,000–$74,999 (32.7%);
- Adults with health insurance (32.0%);
- Adults with a disability (46.8%); and
- Adults with no more than a high school education (35.9%).

FIGURE 45: HIGH BLOOD PRESSURE, CT 2019.

59
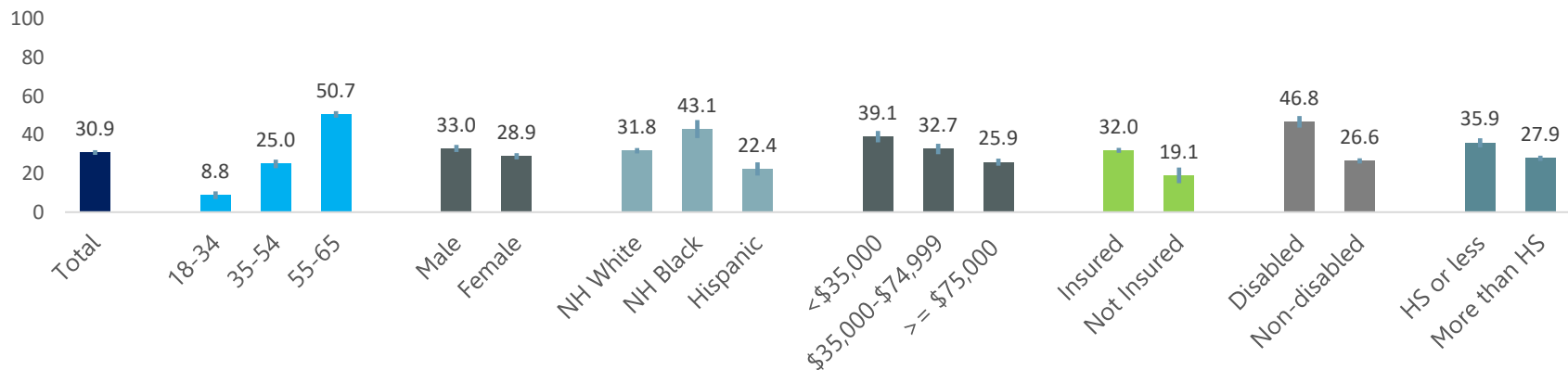
DIABETES

Diabetes is a disease characterized by high levels of blood sugar. It can lead to serious health problems, such as heart disease, stroke, blindness and lower-extremity amputation.[52] Diabetes affects over 29 million people in the U.S. Those over 60 years of age, African Americans and Hispanics, and groups of low socioeconomic status are at higher risk for diabetes.[53] Respondents to the BRFSS were asked if they have ever been told they have diabetes. Women with diabetes only during pregnancy are not classified as having diabetes.

One in 10 Connecticut adults reported in 2019 that they had ever been diagnosed with diabetes. Among them, three in four tested A

one C in the past three months, and two in five had taken diabetes management class (Figure 46).

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

- Adults 55 or over (16.8%) compared to adults 35–54 years old (6.9%);
- Non-Hispanic Black (15.5%) compared to non-Hispanic White adults (8.4%);
- Adults from households earning less than $35,000 (14.8%) and $35,000-$74,999 (9.8%);
- Adults with a disability (19.9%); and
- Adults with no more than a high school education (12.9%).

FIGURE 46: DIABETES MANAGEMENT AMONG ADULTS WITH DIABETES, CT 2019.

FIGURE 47: DIABETES, CT 2019.

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

KIDNEY DISEASE

Chronic kidney disease is a condition in which the kidneys cannot filter blood as well as they should, and waste is not properly filtered. A person with kidney disease is more likely to develop heart disease and other health problems. Adults with diabetes or high blood pressure are at higher risk of developing chronic kidney disease.[54] Chronic kidney disease can be detected early with blood tests. If it is detected, medication can reduce the damage to the kidneys by 50%. Kidney disease often runs in families, and family medical history can often identify people at risk for chronic kidney disease.[55] Respondents are asked if they were ever told they had kidney disease. Results in 2019 are shown in Figure 48.

One in 42 Connecticut adults in 2019 had been diagnosed with kidney disease.

Compared to their counterparts in the state, the risk of **kidney disease** among adults in Connecticut was significantly greater for:
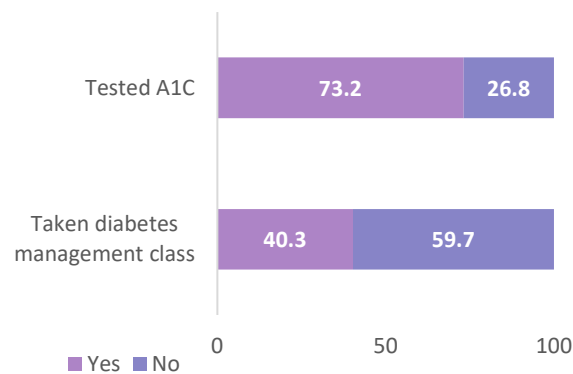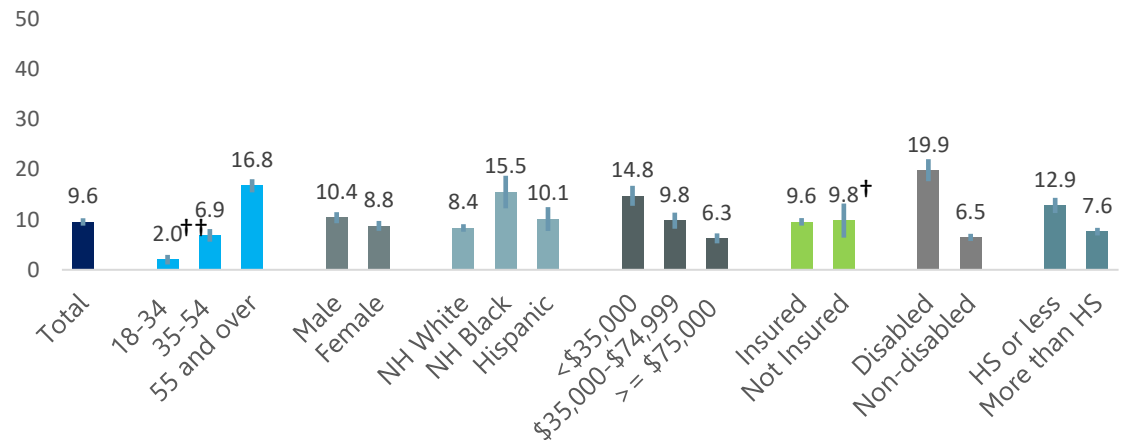
- Adults with a disability (5.7%).

FIGURE 48: KIDNEY DISEASE, CT 2019

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

DEPRESSION

Depression is a common and serious illness that can take several forms. Symptoms include persistent feelings of sadness, anxiety, emptiness, and hopelessness, as well as fatigue, irritability, and restlessness. Depressive disorders may interfere with a person's work and daily activities and prevent them from functioning normally. Some forms of depression develop under unique circumstances; others occur in episodes or may be longer-term.[56] Depression is often misconstrued as a sign of weakness, and if left untreated, can have tragic consequences, including suicide. Medication and therapy have been proven effective in treating major depression.[57] Respondents are asked if they were ever told they had a depressive disorder, including depression, major depression, dysthymia, or minor depression. Results in 2019 are shown in Figure 49.

One in seven Connecticut adults in 2019 had been diagnosed with depression.

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

- Adults 18–34 years old (18.1%);
- Females (17.8%);
- Non-Hispanic White adults (16.2%);
- Adults from households earning less than $35,000 (22.4%); and
- Adults with a disability (33.0%).

FIGURE 49: DEPRESSION, CT 2019
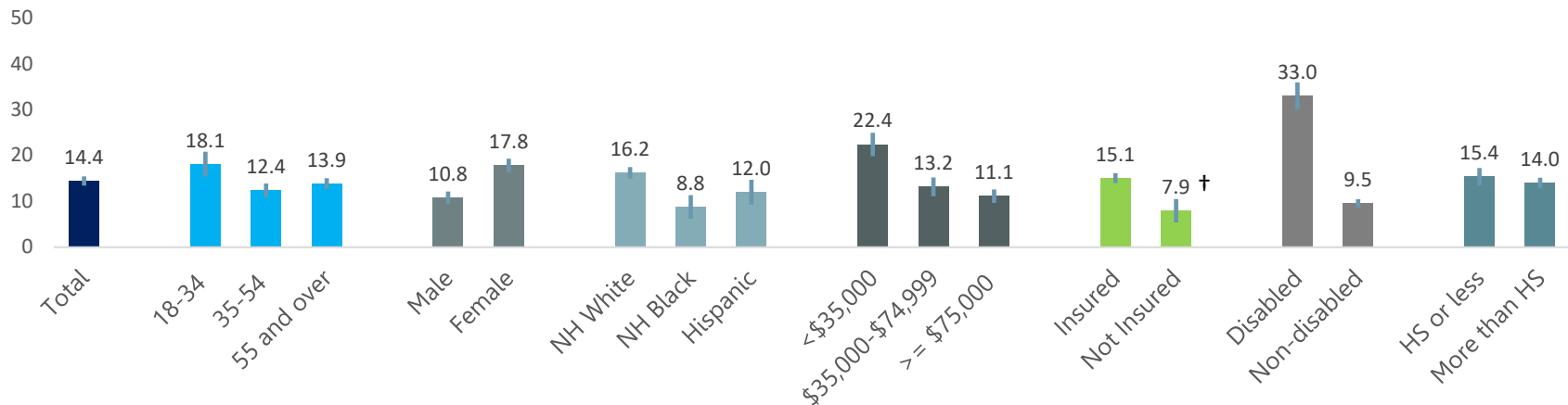
Estimates marked with a "†" have a CV between 15.0% and 20.0%.

7. CHILD HEALTH

CHILD WEIGHT STATUS

As part of a state-specific module in the BRFSS, a child is randomly selected in the household and the adult respondent is asked several health-related questions about that child, including the child's height and weight. As with adults, BMI was calculated for these randomly selected children; however, child weight status is calculated differently than that for adults.[58] For children, weight status is determined comparatively based on age and sex. An overweight child has a BMI between the 85th and 95th percentile

for children of the same age and sex, while an obese child has a BMI at or above the 95th percentile for children of the same age and sex. Obese children face a variety of health and social problems and are more likely to be obese adults.[59] Results for 2019 are shown in Figure 50.

In 2019, one in seven children 5-17 years old were **overweight**, and one in six children 5-17 years old were **obese**.

FIGURE 50: CHILD OBESITY (5-17 YEARS OLD), CT 2019

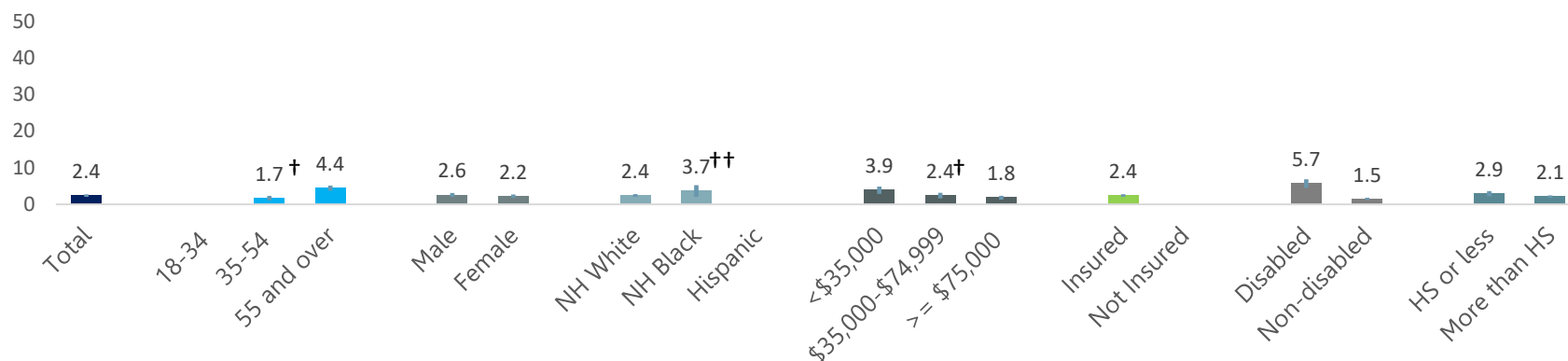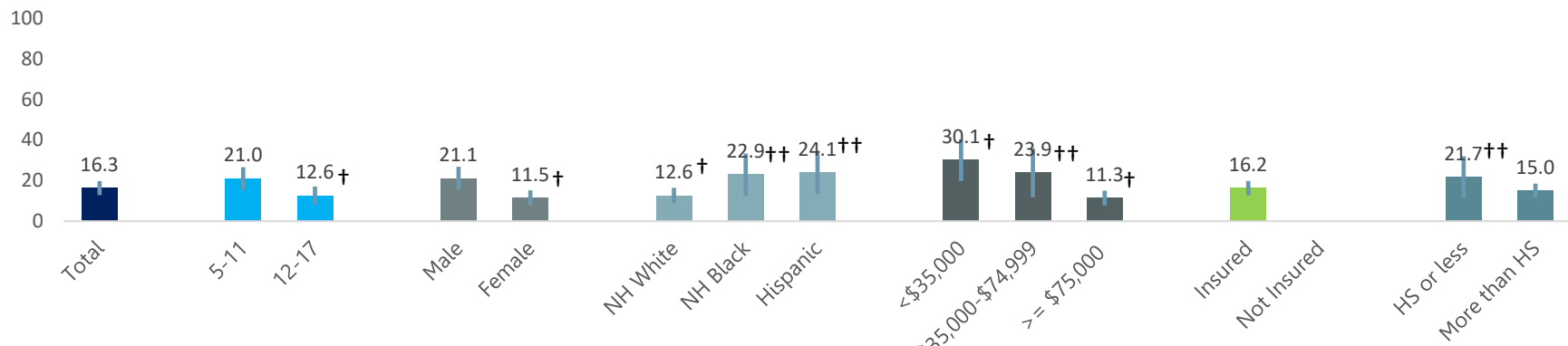*Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%; estimates with CV greater than 30.0% were suppressed.*

BREASTFEEDING

The American Academy of Pediatrics recommends that mothers breastfeed infants exclusively for six months and continue to breastfeed for at least six more months after introducing solid foods.[60, 61] Breastfeeding provides a host of health benefits for nursing mothers and babies. Nursing infants receive natural protection against common illnesses and infections due to the immunologic properties of breast milk. There is also some evidence that breastfeeding can prevent the development of allergies, auto-immune disorders, and even chronic disease later in life.[62] In the BRFSS, an adult proxy is asked whether the selected child was ever breastfed, and how long the child was breastfed and exclusively breastfed. Results in 2019 are shown in Figures 51 and 52.

In 2019, four out of every five Connecticut children have been breastfed, and among them three in five have been exclusively breastfed for at least 3 months.

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

- Children 5-11 (87.1%) compared to 12-17 (78.1%) years old;
- Non-Hispanic White (86.9%) compared to Hispanic (77.1%) children;
- Children from household with annual incomes at least $75,000 (89.8%) compared to less than $35,000 (72.3%); and
- Children living with an adult caregiver who had more than a high school education (86.2%).

FIGURE 51: LENGTH OF BREASTFEEDING PERIOD (MONTHS), CT 2019.

Not breastfed
6 months or less
7-12 months
13-60 months
Unknown

FIGURE 52: CHILD EVER BREASTFED, CT 2019

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

CHILD SCREEN TIME

The American Academy of Family Physicians (AAFP) and American Academy of Pediatrics recommends that screen time is limited, with no screen time before 2 years of age, and no more than two hours a day for children 2 and older.[63] U.S. children 8–18 years old are exposed to about 7 hours and 38 minutes of entertainment screen time daily.[64] This indicator is of interest because sedentary behaviors, such as sitting in front of the television for long periods, may contribute to weight gain or obesity. Additionally, television or computer exposure may negatively affect child development or perspective in other ways.[65] The BRFSS survey asks the adult proxy respondent how much time the selected child spent watching programs, movies, videos or playing video games on television. Another question asks how much time the child spent using a computer, tablet, or handheld device for playing video games or for something that is not schoolwork. The data from both questions

were combined to calculate total screen time exposure for children ages 2–17. Results in 2019 are reported in Figure 53.

Three in five Connecticut children in 2019 had excessive screen time (more than 2 hours daily). Compared to their counterparts in the state, the risk of **excessive screen time** among children in Connecticut was significantly greater for:

- Children 12–17 years old (73.8%);
- Boys (66.6%);
- Hispanic (67.5%) compared to non-Hispanic White (51.6%) children; and
- Children living with an adult caregiver who had more than a high school education (69.1%).
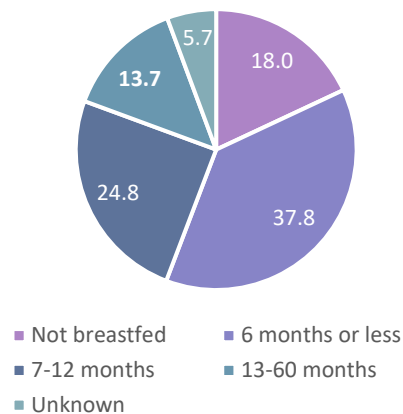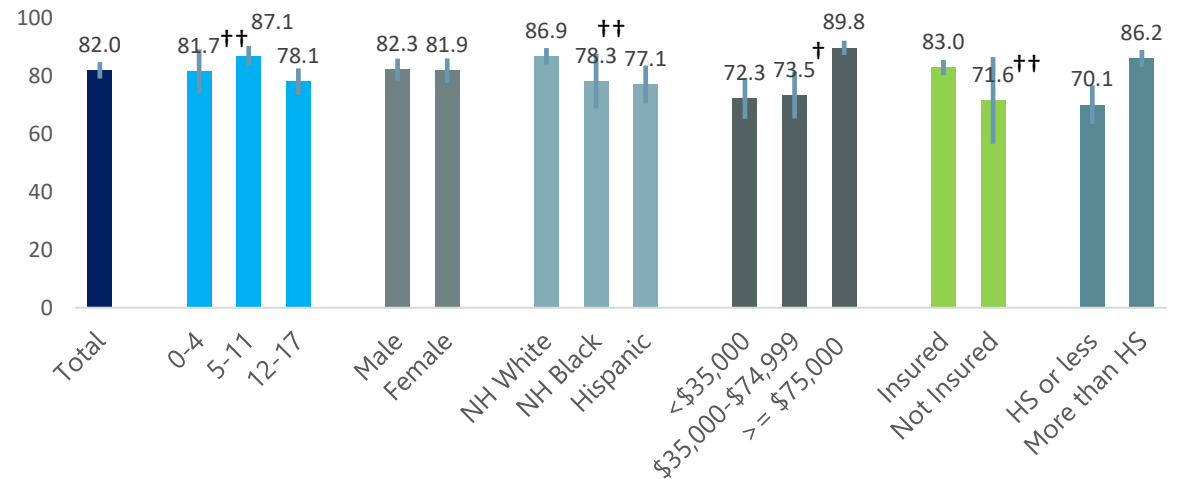
FIGURE 53: CHILD EXCESSIVE SCREEN TIME, CT 2019
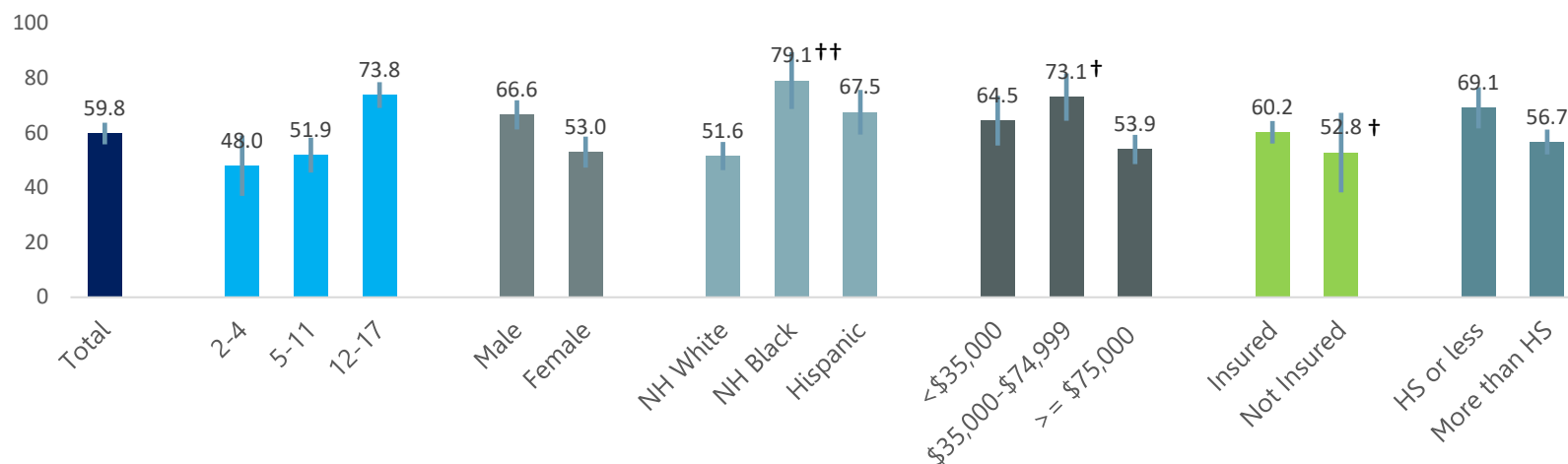
Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%.

CHILD SODA AND FAST FOOD CONSUMPTION

Consumption of soda and other sugar-sweetened beverages (SSBs) is associated with obesity in children.[66] Children who eat at fast-food and full-service restaurants eat more and have poorer diets compared to children who eat at home.[67]

Adult proxy respondents report how many glasses, bottles, or cans of soda or other SSBs the randomly selected child drinks on an average day. They are also asked how many times in the past week the child ate fast food or pizza at school, at home, or at a fast-food restaurant. Results in 2019 for children two years old and over are reported in Figures 54 and 55.

One in four Connecticut children drank SSBs at least once daily in 2019, while two in five ate fast food two or more times weekly.

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

- Non-Hispanic Black (41.0%) compared to non-Hispanic White children (21.3%);
- Children living in a household with annual earnings of less than $35,000-$74,999 (36.1%) compared to at least $75,000 (20.7%); and
- Children living with an adult proxy who had no more than a high school education (38.4%).

FIGURE 54: DRANK SUGAR SWEETENED BEVERAGES AT LEAST ONCE DAILY, CT 2019
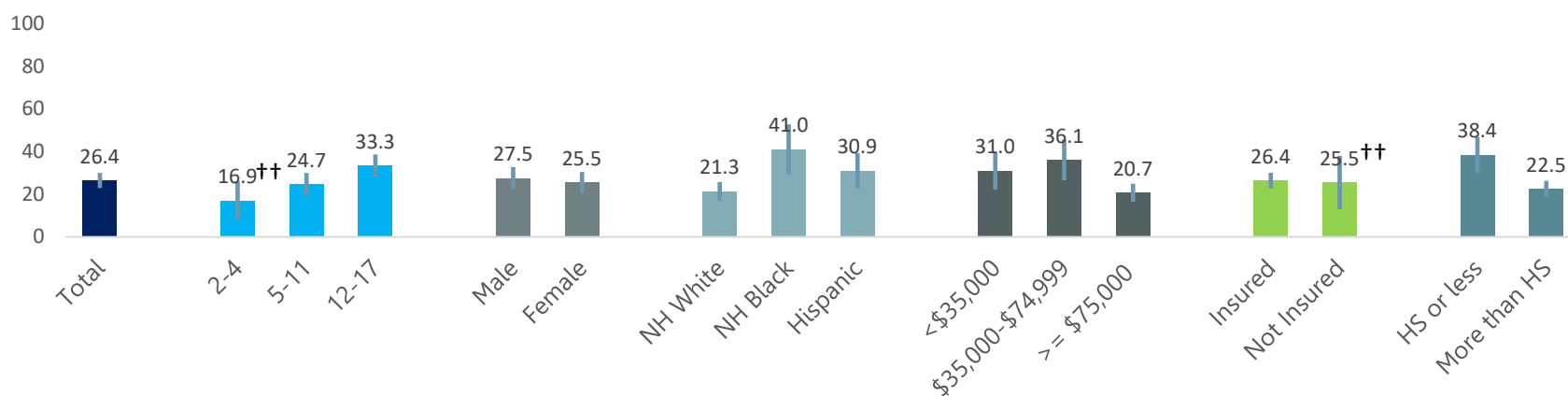
Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%.

Compared to their counterparts in the state, the prevalence of **eating fast food two or more times weekly** among children in Connecticut, no difference was found.

FIGURE 55: ATE FAST FOOD TWO OR MORE TIMES WEEKLY, CT 2019
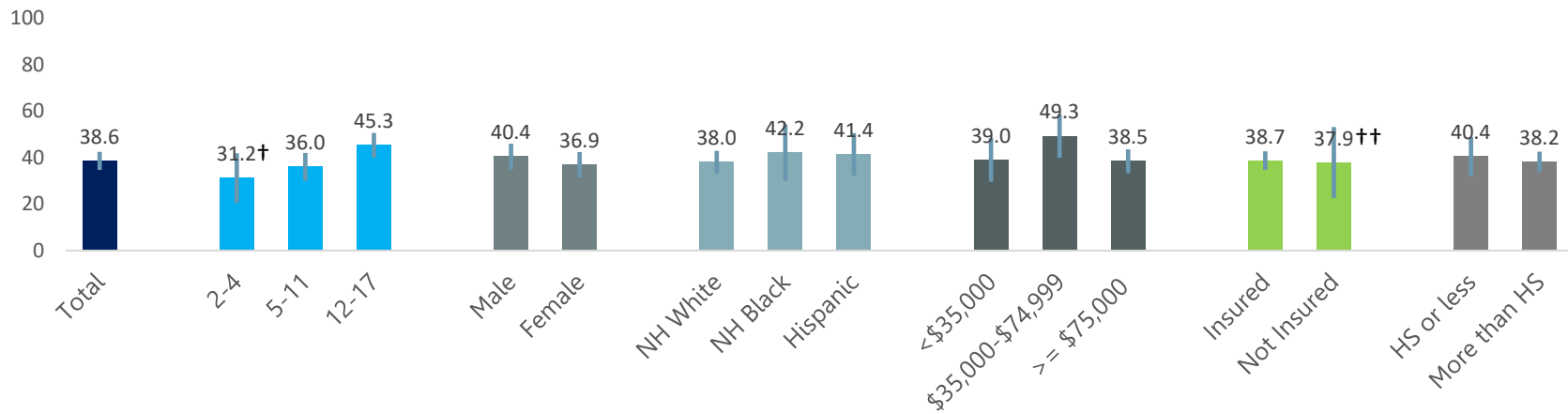
Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%.

CHILD ORAL HEALTH

Although it is largely preventable, tooth decay is the most common chronic condition among children in the United States.[68] Dental caries (cavities) can cause pain and infection, and if left untreated they can lead to malnourishment and serious medical complications.[69] The American Academy of Pediatric Dentistry recommends that children see a pediatric dentist when their first tooth appears, and no later than their first birthday.[70] Dental sealants can also prevent tooth decay.[71] Sealants are thin, plastic coatings that are painted on the back teeth, protecting the grooves from getting germs and food particles lodged in them. It is recommended that sealants are applied soon after the permanent tooth has come in. Adult respondents are asked if the randomly selected child had seen a dental provider in the previous year, and if so, whether they had ever had dental sealants. For the purposes of this analysis, we examined dental sealants only in children 5-17 years old. Results in 2019 are shown in Figures 56-58. Eighty-six percent of Connecticut children in 2019 had a dental visit in the previous year, in which half of them had dental sealants applied to their teeth at some time. One in six had been told they have dental decay (cavities).

Compared to their counterparts in the state, the prevalence of having **dental visit in the previous year,** no difference was found.

FIGURE 56: CHILD DENTIST VISIT IN PAST YEAR, CT 2019
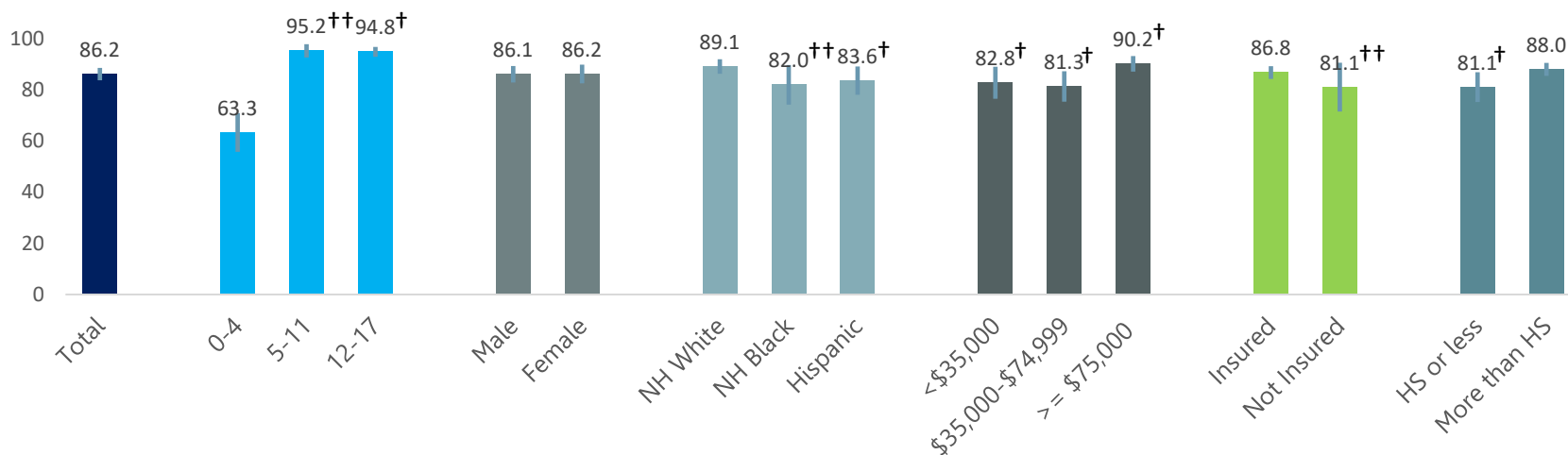
Estimates marked with a "†" have a CV between 15.0% and 20.0%, estimates marked with a "††" have a CV between 20.1% and 30.0%.

68

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

- Children 12–17 years old (58.0%) compared to children 5-11 years old (38.8%);
- Children from household with annual household incomes at least $75,000 (54.3%) compared to those with less than $35,000 (38.9%); and

- Children living with an adult proxy who had more than a high school education (53.0%).

FIGURE 57: RECEIVED DENTAL SEALANT (CHILDREN 5-17 YEARS OLD), CT 2019

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

- Children 5-11 years old (22.5%) compared to children 12-17 years old (12.9%).

FIGURE 58: CHILD DENTAL DECAY (CAVITIES IN PAST 12 MONTHS), CT 2019
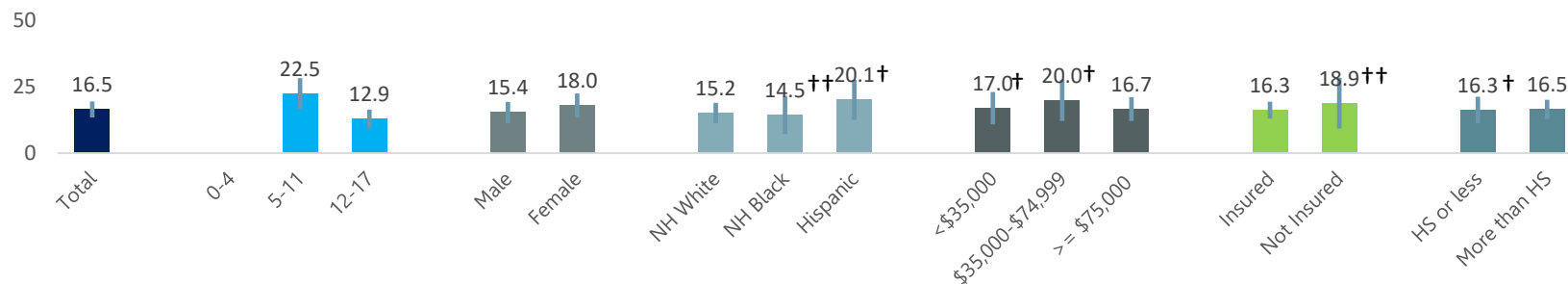
Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%; estimates with CV greater than 30.0% were suppressed.

CHILD ASTHMA

While asthma can affect people of all ages, it usually begins during childhood. Of the 25 million Americans who suffer from asthma, 6.2 million are children.[72] Asthma is the third most common cause of hospitalizations in children and accounts for 13.8 million missed days of school each year.[73] Respondents are asked if the randomly selected child in the household had ever been diagnosed with

asthma and if the child still had asthma. Results in 2019 are shown in Figures 59-60.

One in eleven Connecticut children in 2019 had current asthma. An additional five percent had been diagnosed with asthma in the past but no longer had the condition.

Compared to their counterparts in the state, the prevalence of child **currently having asthma**, no difference was found.

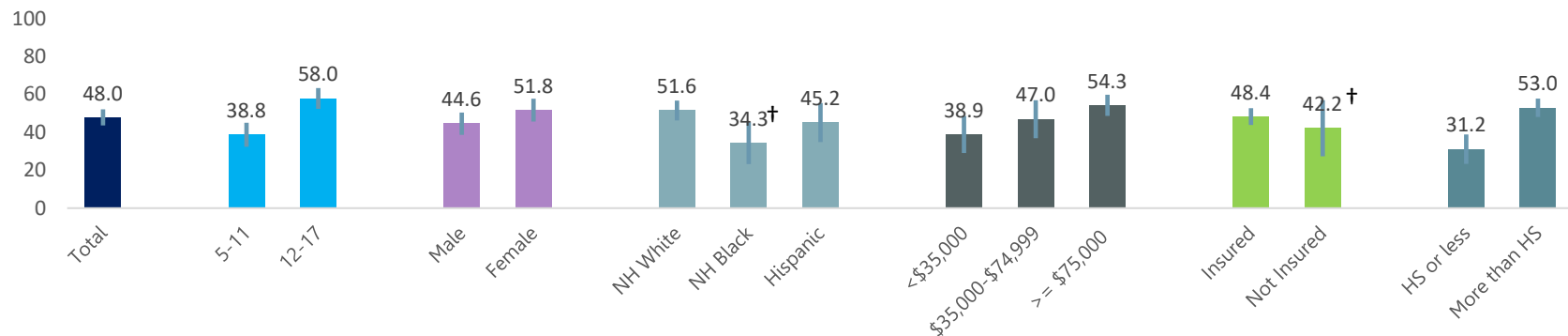*FIGURE 59: CURRENT CHILD ASTHMA STATUS, CT 2019*
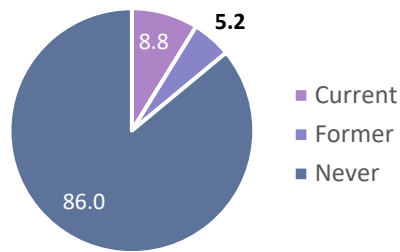
FIGURE 60: CHILD ASTHMA, CT 2019
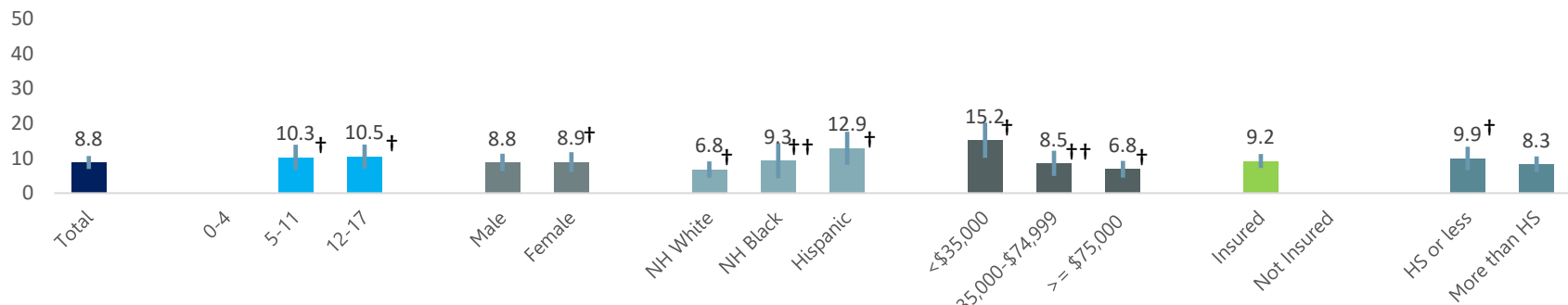
Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%; estimates with CV greater than 30.0% were suppressed.

8. ENVIRONMENTAL HEALTH

RADON

Radon is a naturally occurring, radioactive gas released in rock, soil, and water formed from the breakdown of uranium. Levels in outdoor air pose a low threat to human health. However, radon can enter homes from surrounding soil and become a health hazard inside buildings. Radon does not cause symptoms. You can't see it or smell it, but an elevated radon level in your home may be affecting the health of your family. Breathing radon over prolonged periods may damage lung tissue. Exposure to radon is the leading cause of lung cancer in nonsmokers in the United States. The U.S. Environmental Protection Agency (EPA) estimates that radon causes more than 20,000 lung cancer deaths in the country each year. In 2019, CT BRFSS respondents were asked if their household air been tested for the presence of radon gas.

Nearly half of Connecticut adults tested their household air for the presence of radon gas in 2019. Compared to their counterparts in the state, the prevalence of Connecticut adults **tested their household air for the presence of radon gas** was significantly greater for:

- Adults 35-54 years old (57.2%) and 55 and over (46.0%);
- Non-Hispanic White adults (54.5%);
- Adults from households earning $35,000-$74,999 (41.8%) and at least $75,000 (64.1%);
- Adults with health insurance (49.8%);
- Disabled adults (51.2%); and
- Adults with more than a high school education (56.0%).

FIGURE 61: ADULTS EVER TESTED FOR RANDON GAS IN THEIR HOUSEHOLD, CT 2019.
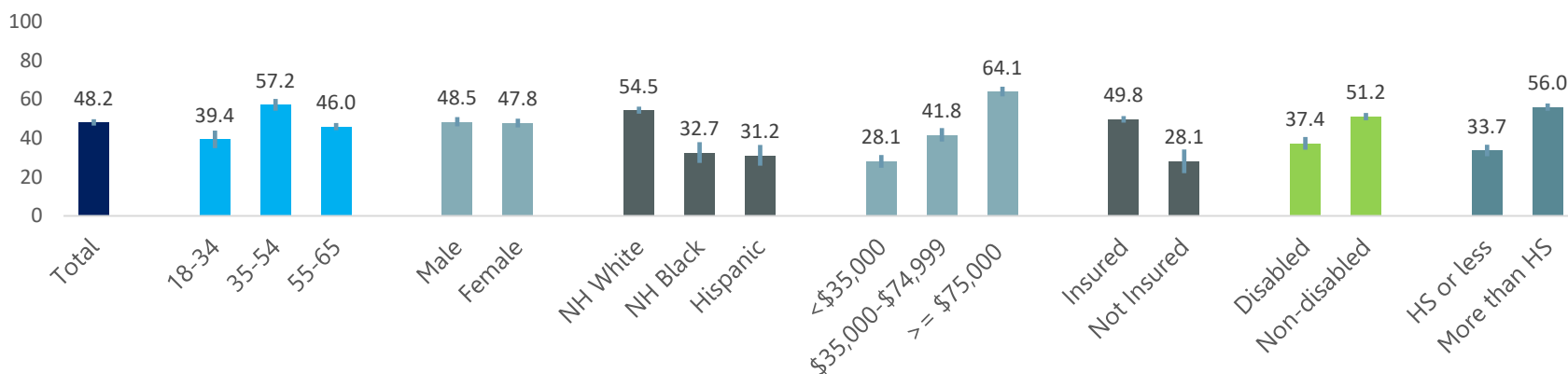
9. END NOTES

[1] Connecticut Department of Public Health. (2014). Healthy Connecticut 2020. 2: State Health Improvement Plan, Connecticut Department of Public Health, Hartford, Connecticut. http://www.ct.gov/dph/lib/dph/state_health_planning/sha-ship/hct2020/hct2020_state_hlth_impv_032514.pdf

[2] Connecticut Department of Public Health. (2014). Live Health Connecticut, A Coordinated Chronic Disease Prevention and Health Promotion Plan, Connecticut Department of Public Health, Hartford, Connecticut. http://www.ct.gov/dph/lib/dph/state_health_planning/dphplans/chron_dis_coord_plan__april_2014.pdf

[3] Connecticut Department of Public Health: Healthy Connecticut 2020 Performance Dashboard. http://www.ct.gov/dph/cwp/view.asp?a=3130&q=553676

[4] Committee on Children: RBA Children's Report Card, Connecticut General Assembly, Hartford, Connecticut. https://www.cga.ct.gov/kid/rba/results.asp

[5] Connecticut Department of Public Health: Chronic Disease Prevention and Health Promotion, Live Healthy Connecticut Indicators. http://www.ct.gov/dph/cwp/view.asp?a=3137&Q=547826&PM=1

[6] Healthcare Innovation Central: State Innovation Model (SIM) Initiative, Connecticut Office of the Healthcare Advocate, Hartford, CT. http://www.healthreform.ct.gov/ohri/site/default.asp

[7] DeSalvo, Karen B, Bloser, N, Reynolds, K, He, Jiang, Muntner, P. (2006). Mortality Prediction with a Single General Self-Rated Health Question. Journal of General Internal Medicine, 21(3):267-275.

[8] U.S. Department of Justice: A Guide to Disability Rights Laws, July 2009. http://www.ada.gov/cguide.htm

[9] Centers for Disease Control and Prevention. (2000). Measuring Healthy Days: Population Assessment of Health-Related Quality of Life, Atlanta, Georgia. http://www.cdc.gov/hrqol/pdfs/mhd.pdf

[10] 1 Liu, Yong, et al. "Relationships between Housing and Good Insecurity, Frequent Mental Distress, and Insufficient Sleep among Adults in 12 US States, 2009." Preventing Chronic Disease. 11.1 (March 2014). http://www.cdc.gov/pcd/issues/2014/13_0334.htm

[11] Kushel, Margot B., Reena Gupta, Lauren Gee, and Jennifer S. Haas. "Housing Instability and Food Insecurity as Barriers to Health Care Among Low-Income Americans." Journal of General Internal Medicine. 21.2 (January 2006): 71-77. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1484604/

[12] United States Department of Agriculture Economic Research Center. "Food Security in the U.S: Measurement." October 2017. https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-theus/measurement.aspx

[13] Seligman, Hilary K., Barbara A. Laraia, and Margot B. Kushel. "Food Insecurity Is Associated with Chronic Disease among Low-Income NHANES Participants." The Journal of Nutrition. 140.2. (February 2010): 304-310. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2806885/

[14] National Heart, Blood and Lung Institute (1998). Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. Obesity Education Initiative. NIH Publication No. 98-4083. http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf

[15] Centers for Disease Control and Prevention: Adult Overweight and Obesity: Causes and Consequences. https://www.cdc.gov/obesity/adult/causes.html

[16] Kushel, Margot B., Reena Gupta, Lauren Gee, and Jennifer S. Haas. (2006). Housing Instability and Food Insecurity as Barriers to Health Care among Low-Income Americans. Journal of General Internal Medicine, 21(1): 71-77. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1484604

[17] Cheung, MR (2013). Lack of Health Insurance Increases All Cause and All Cancer Mortality in Adults: An Analysis of National Health and Nutrition Examination Survey (NHANES III) Data. Asian Pac J Cancer Prev, 14(4):2259-2263.

[18] Marwick, C (2002). For the Uninsured, Health Problems Are More Serious. Journal of the National Cancer Institute, 94(13):967-968.

[19] Warburton, DE, Nichol, CW, Bredlin, SSD (2006) Health Benefits of Physical Activity: The Evidence. Canadian Medical Association Journal, 174(6):801-809.

[20] U.S. Public Health Service (2014): The Health Consequences of Smoking – 50 Years of Progress: A Report of the Surgeon General. http://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf

[21] Shivo, M, Advalovic, MV, Murin, S (2014). Non-cigarette Tobacco and the Lung. Clin Rev Allergy Imun, 46(1):3453.

[22] American Cancer Society: Health Risks of Smokeless Tobacco. http://www.cancer.org/cancer/cancercauses/tobaccocancer/smokeless-tobacco

[23] American Lung Association (2007): An Emerging Deadly Trend: Waterpipe Tobacco Use. http://www.lungusa2.org/embargo/slati/Trendalert_Waterpipes.pdf

[24] Centers for Disease Control and Prevention: Alcohol and Public Health, Frequently Asked Questions. http://www.cdc.gov/alcohol/faqs.htm

[25] National Institute on Alcohol Abuse and Alcoholism: Drinking Levels Defined. http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking

[26] Centers for Disease Control and Prevention: Fact Sheets- Binge Drinking. http://www.cdc.gov/alcohol/fact-sheets/binge-drinking.htm

[27] Centers for Disease Control and Prevention: Fact Sheets- Alcohol Use and Health. http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm

[28] Centers for Disease Control and Prevention: Regular Check-Ups are Important. http://www.cdc.gov/family/checkup/

[29] American Heart Association (2019): HDL (Good), LDL (Bad) Cholesterol and Triglycerides. https://www.heart.org/en/health-topics/cholesterol/hdl-good-ldl-bad-cholesterol-and-triglycerides

[30] American Heart Association (2019): How to Get Your Cholesterol Tested. https://www.heart.org/en/health-topics/cholesterol/how-to-get-your-cholesterol-tested

[31] AIDS.gov: HIV In the United States: At A Glance. http://aids.gov/hiv-aids-basics/hiv-aids-101/statistics/#ref2

[32] Centers for Disease Control and Prevention: Key facts about seasonal flu vaccine. http://www.cdc.gov/flu/protect/keyfacts.htm

[33] Centers for Disease Control and Prevention: Pneumonia, Common Causes of Pneumonia. http://www.cdc.gov/pneumonia/index.html

[34] Centers for Disease Control and Prevention: Pneumococcal Disease, Pneumococcal Vaccination. http://www.cdc.gov/pneumococcal/vaccination.html

[35] Centers for Disease Control and Prevention: Diphtheria Causes and Transmission (2019) https://www.cdc.gov/diphtheria/about/causes-transmission.html

[36] Centers for Disease Control and Prevention: Diphtheria Vaccination (2019) https://www.cdc.gov/diphtheria/vaccination.html

[37] Centers for Disease Control and Prevention: Pertussis: Summary of Vaccine Recommendations (2019) https://www.cdc.gov/vaccines/vpd/pertussis/recs-summary.html

[38] Centers for Disease Control and Prevention. "Vaccines and Preventable Diseases: Shingles Vaccination: What You Need To Know". 8 November 2013. http://www.cdc.gov/vaccines/vpd-vac/shingles/vacc-need-know.htm

[39] National Institutes of Health: National Heart, Lung and Blood Institute: What Is Asthma? http://www.nhlbi.nih.gov/health/health-topics/topics/asthma/

[40] Centers for Disease Control and Prevention. Breathing Easier. http://www.cdc.gov/asthma/pdfs/breathing_easier_brochure.pdf

[41] Agency for Toxic Substances and Disease Registry: Environmental Health and Medicine Education, Environmental Triggers of Asthma. http://www.atsdr.cdc.gov/csem/csem.asp?csem=32&po=0

[42] National Institutes of Health: National Heart, Lung and Blood Institute: What Is COPD? http://www.nhlbi.nih.gov/health/health-topics/topics/copd/

[43] Centers for Disease Control and Prevention: Heart Disease Fact Sheet. https://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_heart_disease.htm

[44] National Institutes of Health: National Heart, Lung and Blood Institute: What Is Coronary Heart Disease? http://www.nhlbi.nih.gov/health/health-topics/topics/cad/

[45] American Heart Association: How to Help Prevent Heart Disease – At Any Age. http://www.heart.org/HEARTORG/HealthyLiving/How-to-Help-Prevent-Heart-Disease---At-AnyAge_UCM_442925_Article.jsp#.VtSuDXnSlmM

[46] Centers for Disease Control and Prevention. (2015). High Cholesterol Facts. http://www.cdc.gov/cholesterol/facts.htm

[47] Centers for Disease Control and Prevention. (2015). Division for Heart Disease and Stroke Prevention: Cholesterol Fact Sheet. http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_cholesterol.htm

[48] American Heart Association. (2015). Prevention and Treatment of High Cholesterol. http://www.heart.org/HEARTORG/Conditions/Cholesterol/PreventionTreatmentofHighCholesterol/Prevention-andTreatment-of-High-Cholesterol_UCM_001215_Article.jsp

[49] Nwankwo T, Yoon SS, Burt V, Gu Q. (2013). Hypertension among adults in the US: National Health and Nutrition Examination Survey, 2011-2012. NCHS Data Brief, No. 133. http://www.cdc.gov/nchs/data/databriefs/db133.htm

[50] National Institutes of Health. (2015). High Blood Pressure. http://www.nlm.nih.gov/medlineplus/ency/article/000468.htm

[51] Centers for Disease Control and Prevention. (2014) Controlling Blood Pressure. http://www.cdc.gov/bloodpressure/control.htm

[52] Centers for Disease Control and Prevention: Putting the Brakes on Diabetes Complications (2019). https://www.cdc.gov/features/preventing-diabetes-complications/index.html

[53] Centers for Disease Control and Prevention: The National Program to Eliminate Diabetes-Related Disparities in Vulnerable Populations. http://www.cdc.gov/diabetes/prevention/pdf/vulnerablepopulationsfactsheet.pdf

[54] Centers for Disease Control and Prevention: National Chronic Kidney Disease Fact Sheet, 2014. http://www.cdc.gov/diabetes/pubs/pdf/kidney_factsheet.pdf

[55] National Institutes of Health: Chronic Kidney Disease and Kidney Failure. https://report.nih.gov/nihfactsheets/ViewFactSheet.aspx?csid=34

[56] National Institutes of Health: National Institute of Mental Health: Depression, What is Depression? http://www.nimh.nih.gov/health/topics/depression/index.shtml

[57] Centers for Disease Control and Prevention: Mental Health Conditions: Depression and Anxiety (2019). https://www.cdc.gov/tobacco/campaign/tips/diseases/depression-anxiety.html

[58] Centers for Disease Control and Prevention: Growth Chart Training. http://www.cdc.gov/nccdphp/dnpao/growthcharts/resources/sas.htm

[59] Freedman DS, Dietz WH, Srinivasan SR, Berenson GS. (2009) Risk factors and adult body mass index among overweight children: the Bogalusa Heart Study. Pediatrics, 123:750-57.

[60] American Academy of Pediatrics: Breastfeeding (Policy Statement). https://www.aafp.org/about/policies/all/breastfeeding.html

[61] Centers for Disease Control and Prevention. (2016). U.S. Breastfeeding Report Card. https://www.cdc.gov/breastfeeding/data/reportcard.htm

[62] Jackson, Kelly M and Nazar, Andrea M. (2006). Breastfeeding, the Immune Response, and Long-term Health. Journal of the American Osteopathic Association, 106(4):203-207.

[63] AAFP (2015): Put the iPad Down: Find Ways to Cut Back on Screen Time
https://www.aafp.org/news/blogs/freshperspectives/entry/put_the_ipad_down_find.html

[64] Rideout VJ, Foehr UG, Roberts DF (2010). Generation M2: Media in the Lives of 8- to 18-Year-Olds. https://www.kff.org/other/event/generation-m2-media-in-the-lives-of/

[65] Moreno, MA. (2011). Reducing Screen Time for Children. Arch Pediatr Adolesc Med, 165(11):1056.

[66] Ludwig, DS, Peterson, KE, Gortmaker, SL (2001) Relation Between Consumption of Sugar-sweetened Drinks and Childhood Obesity: A Prospective, Observational Analysis. Lancet, 357(9255):505-508.

[67] Powell, LM, Nguyen, BT. (2013). Fast-food and Full-service Restaurant Consumption among Children and Adolescents: Effect on Energy, Beverage and Nutrient Intake. J American Medical Association Pediatrics, 167(1):1420.

[68] Centers for Disease Control and Prevention: Division of Oral Health, Children's Oral Health. http://www.cdc.gov/OralHealth/children_adults/child.htm

[69] Connecticut Department of Public Health, Office of Oral Health (2013): Oral Health in Connecticut.
http://www.ct.gov/dph/lib/dph/oral_health/pdf/final_oral_health_burden_report_2013.pdf

[70] American Academy of Pediatric Dentistry: Frequently asked questions. http://www.aapd.org/resources/frequently_asked_questions/#36

[71] Centers for Disease Control and Prevention, Division of Oral Health: Dental Sealants. https://www.cdc.gov/vitalsigns/dental-sealants/index.html

[72] Centers for Disease Control and Prevention, National Center for Health Statistics, Asthma (2019) https://www.cdc.gov/nchs/fastats/asthma.htm

[73] Centers for Disease Control and Prevention, Asthma-related Missed School Days among Children aged 5–17 Years (2013)
https://www.cdc.gov/asthma/asthma_stats/missing_days.htm