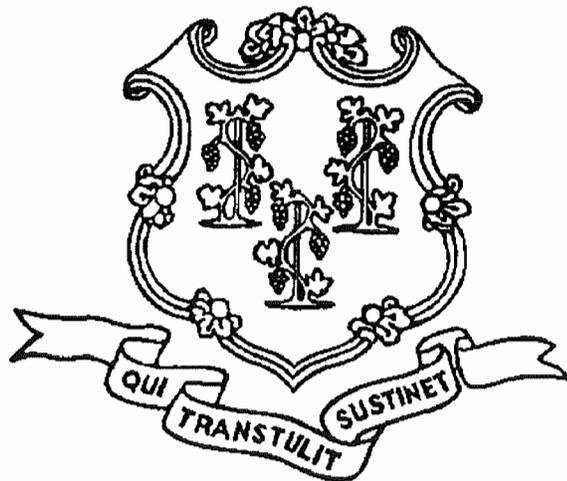


HEALTHY CONNECTICUT

2000

Baseline Assessment Report



Connecticut Department of Public Health
and Addiction Services

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

INTRODUCTION

The State of Connecticut Department of Public Health and Addiction Services (DPHAS) is charged with the responsibility of protecting the health of Connecticut's residents. The department's activities include: health promotion and disease prevention; identification, monitoring and control of infectious diseases, environmental and occupational hazards; licensure and regulation of health agencies and health providers; and the collection and analysis of health data for determining health policy for the state. The department is working in consort with federal and local authorities to maximize the quality and quantity of available health services.

The publication 'Healthy Connecticut 2000' is the outgrowth of the department's coordinated response to the national initiative which produced the document 'Healthy People 2000' (1990).

Healthy People 2000, published by the U.S. Surgeon General in 1989, is a national initiative to improve the health of all Americans through prevention. It is driven by 300 specific national health promotion and disease prevention objectives targeted for achievement by the year 2000. Healthy People 2000's overall goals are to: increase the span of healthy life

Introduction

p. I-2

for Americans, reduce health disparities among Americans, and achieve access to preventive services for all Americans.

With input from its many units, a cross-agency committee was organized in December 1992. One of the committee's major responsibilities was to review the federal directives and identify the state's status in addressing health status and risk reduction objectives. This initial process determined that the state was demonstrating progress in addressing areas such as cardiovascular disease, infant mortality, cancer, AIDS and other infectious diseases. Further refinement of the process identified areas of need which the state must address. The review process also indicated that because of important differences in denominator data used by the Federal government, it was not always possible to determine if Connecticut was precisely meeting particular health objectives.

Additionally the process assisted the agency in identifying its health-related data needs, particularly in relationship to 112 of the 388 national objectives the department identified as targets for this effort. Each objective is individually described by available data. It should also be noted that certain objectives are highlighted in multiple chapters.

The purpose of the above process was that it would: 1) provide the framework for a Connecticut Public Health Agenda for the 1990's; 2) assist DPHAS in setting specific program

Introduction

p. I-3

priorities that would guide department policy and programs to direct limited resources in specific identified areas; 3) serve as a basis for the DPHAS Strategic Plan; 4) assist in the implementation of DPHAS reorganization activities; and 5) the application of Healthy People 2000 health objectives (the federal initiative) would enable Connecticut to remain competitive in attracting needed federal funds.

The objectives contained in this report were selected from Chapters one through 22 in the Healthy People 2000 report. Objectives from Chapters 4, 6, 8, 13, and 21 are not included in this report at this time but will most likely be part of a later revision of this report.

Connecticut's demographics reflect the diversity of the state's population. This diversity, coupled with a changing economy, is further reflected in the ever-increasing numbers of unemployed individuals/families who now qualify and are now dependent upon public programs to assist in meeting their basic health care needs.*

With this as a background, DPHAS as the lead public health agency is challenged as it plans to meet its responsibilities in the twenty-first century. In the 1990 census, the population of Connecticut was determined to be 3,287,116, of whom 87 percent

* 1990 Connecticut Census: There are approximately 68,092 households that receive some form of public assistance.

Introduction

p. I-4

were white, 8.3 percent were black, 1.5 percent were Asian or Pacific Islander, 0.2 percent were American Indian, Eskimo, or Aleut. Of the above 6.2 percent were of Hispanic origin. All other races accounted for the remaining 2.9 percent.

Further analysis indicates that 22.8 percent were children under the age of 18, 13.5 percent were individuals age 65 and over and 23.6 percent were women of child-bearing age (15-44 years)*.

Fairfield County, determined to have the highest per-capita income in the United States, has many communities with families living well below the poverty level. New Haven County harbors the state's largest number of persons with HIV/AIDS.

The number of deaths among Connecticut residents for 1990 was 27,545. Of these 13,619 were males, 13,925 were females, and one unknown. In 1990, the five leading causes of death, in the order of their proportional share of the total number of deaths, were: 1) diseases of the heart; 2) malignant neoplasms, 3); cerebrovascular diseases; 4) influenza and pneumonia; and 5) chronic obstructive pulmonary diseases.

The department has previously identified a number of health priorities. One of its priorities is reducing the mortality rate due to cardiovascular disease. Cardiovascular disease claims the lives of more state residents than any other single disease entity. Areas in which the state has demonstrated

* 1990 Connecticut Census: There are approximately 68,092 households that receive some form of public assistance.

Introduction

p. I-5

progress include smoking cessation, decrease in highway fatalities and increase in the purity of its water supply.

Although proud of these accomplishments, the department is challenged in many areas, including the area of needed health related data.

The agency is charged with resolving issues such as unavailability or questioned reliability of specific data sets and nonexistent or incompatible computer resources to effect linkage of data programs. With this as a backdrop, the need to define a department-wide infrastructure with supporting personnel must be addressed.

Graphs for each objective were devised to compare U.S. Baseline, U.S. Year 2000 Target, Connecticut Baseline and Connecticut Year 2000 Target. For those objectives for which Connecticut data are either nonexistent or inadequate due to inconsistent reporting procedures, Connecticut goals were based upon those goals detailed in the federal Healthy People 2000 document.

NOTE REGARDING FORMAT:

The Connecticut baseline and Connecticut 2000 goals are defined in both the graphic display and table. Source means the programmatic responsibility for data.

Introduction

p. I-6

All mortality data is age-adjusted to the 1940 population unless otherwise indicated.

The resulting document serves to provide a framework for program planning, evaluation and policy development.

This is a working document and provides information on our progress in achieving Connecticut's health care objectives. The intent is to update this document periodically when new data are generated.

NOTE: It should be noted that this document highlights only a portion of the programs and objectives for Connecticut. If you require further information on programs and/or objectives not highlighted, please contact the program person listed in the acknowledgment section for the area of interest.

ACKNOWLEDGEMENTS

We wish to express our sincere appreciation to all those who participated in the preparation of this report and thank them for their diligence, patience and support.

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TABLE OF CONTENTS

Reference Guide

Note: Numbers in parentheses () indicate duplicate objectives.

1. PHYSICAL ACTIVITY AND FITNESS

Health Status Objectives

- 1.1 Coronary Heart Disease Deaths (3.1, 15.1)
- 1.2 Overweight Prevalence (2.3)

Risk Reduction Objectives

- 1.3 Physical Activity, Light to Moderate (15.11)
- 1.4 Physical Activity, Vigorous
- 1.5 No Physical Activity
- 1.6 Physical Activity--Muscle Strength, Endurance,
Flexibility
- 1.7 Appropriate Body Weight

2. NUTRITION

Health Status Objectives

- 2.3 Overweight Prevalence (1.2)
- 2.4 Growth Retardation

Risk Reduction Objectives

- 2.5 Dietary Fat Intake (15.9, 16.7)
- 2.6 Complex Carbohydrates and Fiber-containing Foods
(16.8)
- 2.10 Iron Deficiency
- 2.11 Breastfeeding

3. TOBACCO

Health Status Objectives

- 3.1 Coronary Heart Disease Deaths (1.1, 15.1)
- 3.2 Lung Cancer Deaths (16.2)
- 3.3 Chronic Obstructive Pulmonary Disease Deaths

Risk Reduction Objectives

- 3.4 Cigarette Smoking (15.12, 16.6)
- 3.5 Cigarette Smoking--Children and Youth
- 3.6 Smoking Cessation
- 3.7 Smoking Cessation during Pregnancy
- 3.8 Exposure to Tobacco Smoke at Home

5. FAMILY PLANNING

Health Status Objectives

- 5.1 Teen Pregnancies
- 5.2 Unintended Pregnancies

Risk Reduction Objectives

- 5.4 Adolescent Sexual Intercourse (18.3)
- 5.6 Contraceptive Use

7. VIOLENT AND ABUSIVE BEHAVIOR

Health Status Objectives

- 7.1 Homicides
- 7.2 Suicides
- 7.4 Maltreatment of Children
- 7.5 Physical Abuse of Women by Male Partners
- 7.6 Assault Injuries
- 7.7 Rape and Attempted Rape
- 7.8 Injurious Adolescent Suicide Attempts

Risk Reduction Objectives

- 7.9 Physical Fighting among Adolescents
- 7.10 Weapon Carrying by Adolescents

9. UNINTENTIONAL INJURIES

Health Status Objectives

- 9.3 Deaths from Motor Vehicle Crashes
- 9.4 Deaths from Falls and Fall-related Injuries
- 9.5 Drowning Deaths
- 9.6 Residential Fire Deaths
- 9.9 Nonfatal Head Injuries

Risk Reduction Objectives

- 9.12 Occupant Protection Systems
- 9.13 Helmet Use

10. OCCUPATIONAL SAFETY AND HEALTH

Health Status Objectives

10.4 Occupational Skin Disorders or Diseases

Risk Reduction Objectives

10.8 Blood Lead Concentrations

11. ENVIRONMENTAL HEALTH

Health Status Objectives

11.1 Asthma Morbidity

11.3 Waterborne Disease

11.4 Blood Lead Levels

Risk Reduction Objectives

11.5 Exposure to Air Pollutants

11.6 Residential Radon Concentrations

11.9 Safe Drinking Water

*13.9 Water Systems with Fluoride Treatment

12. FOOD AND DRUG SAFETY

Health Status Objectives

12.1 Foodborne Infections

12.2 Salmonella Enteritis Outbreaks

Risk Reduction Objectives

12.3 Food Preparation Practices

14. MATERNAL AND INFANT HEALTH

Health Status Objectives

14.1 Infant Mortality

14.3 Maternal Mortality

14.4 Fetal Alcohol Syndrome

*This objective is from Chapter 13 in the Healthy People 2000 report.

14. MATERNAL AND INFANT HEALTH (Cont.)

Risk Reduction Objectives

- 14.5 Low Birth Weight
- 14.6 Weight Gain in Pregnancy
- 14.7 Complications of Pregnancy
- 14.10 Tobacco, Alcohol, Marijuana, Cocaine Use During Pregnancy

15. HEART DISEASE AND STROKE

Health Status Objectives

- 15.1 Coronary Heart Disease Deaths (1.1, 3.1)
- 15.2 Stroke Deaths

Risk Reduction Objectives

- 15.4 High Blood Pressure Control
- 15.5 High Blood Pressure Control Action
- 15.6 Adult Mean Serum Cholesterol
- 15.8 Blood Cholesterol Reduction Action
- 15.9 Dietary Fat Intake (2.5, 16.7)
- 15.11 Physical Activity--Light to Moderate (1.3)
- 15.12 Cigarette Smoking (3.4, 16.6)

16. CANCER

Health Status Objectives

- 16.1 Cancer Deaths
- 16.2 Lung Cancer Deaths (3.2, 22.1e)
- 16.3 Breast Cancer Deaths
- 16.4 Cervical Cancer Deaths

Risk Reduction Objectives

- 16.6 Cigarette Smoking (3.4, 15.12)
- 16.7 Dietary Fat Intake (2.5, 15.9)
- 16.8 Dietary Carbohydrates and Fiber (2.6)

17. DIABETES AND CHRONIC DISABLING CONDITIONS

Health Status Objectives

- 17.10 Severe Complications of Diabetes

18. HIV INFECTION

Health Status Objectives

18.2 HIV Infection

Risk Reduction Objectives

18.3 Adolescent Sexual Activity (5.4)

18.4 Condom Use

18.6 Uncontaminated Drug Paraphernalia Use

19. SEXUALLY TRANSMITTED DISEASES

Health Status Objectives

19.1 Gonorrhea

19.2 Chlamydia trachomatis

19.3 Syphilis (22.1n)

19.4 Congenital Syphilis

20. IMMUNIZATION AND INFECTIOUS DISEASES

Health Status Objectives

20.1 Vaccine-preventable Diseases

20.2 Pneumonia and Influenza Deaths

20.3 Viral Hepatitis

20.4 Tuberculosis

20.7 Bacterial Meningitis

Risk Reduction Objectives

20.11 Immunization Levels

20.12 Post-exposure Rabies Treatments

22. SURVEILLANCE AND DATA SYSTEMS

22.1 Develop a set of health status indicators appropriate for Federal, State, and local health agencies, and to establish use of the in at least 40 states

22.1(a) Reduce Infant Mortality

22.1(b) Reduce Deaths Caused by Motor Vehicle Crashes

22.1(c) Reduce Work-related Injuries

22.1(d) Reduce Suicides

22.1(e) Lung Cancer Deaths

22.1(f) Female Breast Cancer Deaths

22.1(g) Cardiovascular Disease Deaths

22.1(h) Homicides

22.1(i) All Causes of Death

22. SURVEILLANCE AND DATA SYSTEMS

- 22.1(j) Incidence of AIDS
 - 22.1(k) Measles Incidence
 - 22.1(l) Tuberculosis Incidence
 - 22.1(m) Syphilis Incidence
 - 22.1(n) Low Birth Weight Prevalence
 - 22.1(o) Births to Adolescents
 - 22.1(p) Reduce Mothers Delivering Babies with Late or No Prenatal Care
 - 22.1(q) Percentage of Persons in Counties Exceeding the U.S. E.P.A. Air Quality Standards
-
- 22.5 Periodic Analysis and Publication of State Progress towards the National Objective for Each Racial or Ethnic Group That Makes Up at Least 10 Percent of the State Population
-
- 22.6 Expand in All State Systems for the Transfer of Health Information Related to the National Health Objectives among Federal, State and Local Agencies

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 1 - PHYSICAL ACTIVITY AND FITNESS

Connecticut's citizens are becoming increasingly aware of the benefits of a healthy lifestyle. Some are changing their habits in order to live a more productive, longer and healthy life. However, in a survey of state residents, completed in 1992, it was found that over half of Connecticut's adults were considered to be sedentary or irregular exercisers. During the year 1989, 44 percent of Connecticut deaths were caused by coronary heart disease and stroke. These deaths may have been attributed to diets high in fat and cholesterol, the absence of regular physical activity and fitness, high blood pressure, obesity, and diabetes.

Because heart disease is one of the leading causes of death and disability in Connecticut, the potential role of physical activity in preventing coronary heart disease is of particular importance. On average, physically active people reduce their chances of early death compared to those who are physically inactive*. It has been shown in recent studies that the addition of exercise has favorable effects on both blood pressure and blood cholesterol, reducing stress, and lowering the risk for certain chronic diseases.

* Report - Presidents Council of Physical Fitness and Sports
Series 1, No. 1, Feb. 1993

Chapt. 1 - Physical Activity and Fitness

p. 1-2

Functional independence of older adults may be maintained and the quality of life enhanced by the addition of regular physical activity.

Data from proceedings of the Workshop on Physical Activity and Public Health states that physical activity appears to provide some protection against several other chronic diseases such as adult-onset diabetes, hypertension, certain cancers, osteoporosis and depression. Even the addition of moderate-intensity physical activity can have health-promoting effects.

While vigorous exercise has been emphasized in the past, it is now recognized that even moderate physical activity produces measurable health benefits and in some ways is preferable to more vigorous forms of exercise that may cause injuries and require more of a commitment of time, money and effort.

The Department of Public Health and Addiction Services proposes a goal that all Connecticut residents incorporate physical activity and fitness regimes into their lifestyles.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 1 - PHYSICAL ACTIVITY AND FITNESS

Selected Objectives

OBJ.# OBJECTIVE DESCRIPTION

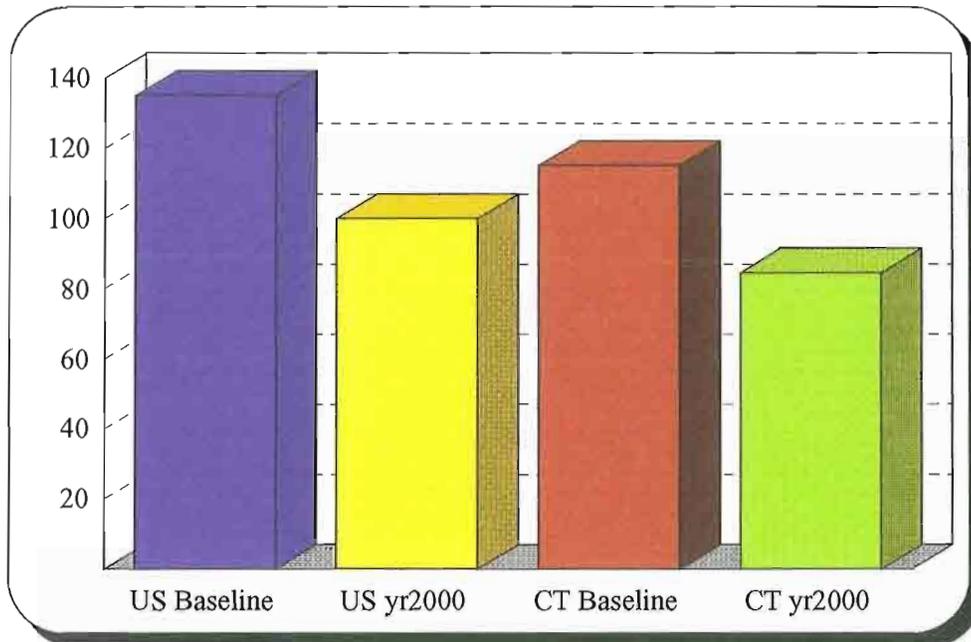
Health Status Objective

- 1.1 Reduce coronary heart disease deaths to no more than 84.4 per 100,000 people
- 1.2 Reduce overweight to a prevalence of not more than 20 percent among people aged 20 and older and no more than 15 percent among adolescents aged 12 through 19

Risk Reduction Objectives

- 1.3 Increase to at least 30 percent the proportion of people aged six and older who engage regularly, (preferably daily) in light to moderate physical activity for at least 30 minutes per day
- 1.4 Increase to at least 20 percent the proportion of people aged 18 and older and to at least 75 percent the proportion of children and adolescents aged 6-17 who engage in vigorous physical activity that promotes the development and maintenance of cardiorespiratory fitness three or more days per week for 20 or more minutes per occasion
- 1.5 Reduce to no more than 15 percent the proportion of people aged six and older who engage in no leisure time physical activity
- 1.6 Increase to at least 40 percent the proportion of people aged six and older who regularly perform physical activities that enhance and maintain muscular strength, muscular endurance, and flexibility
- 1.7 Increase to at least 35 percent the proportion of overweight people aged 12 and older who have adopted sound dietary practice combined with regular physical activity to attain an appropriate body weight

Objective 1.1: Reduce coronary heart disease deaths to no more than 84.4 per 100,000 people



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------------|---------------------|-----------------------|---------------------|
| 135 per 100,000 | 100 per 100,000 | 115 per 100,000(1989) | 84.4 per 100,000 |

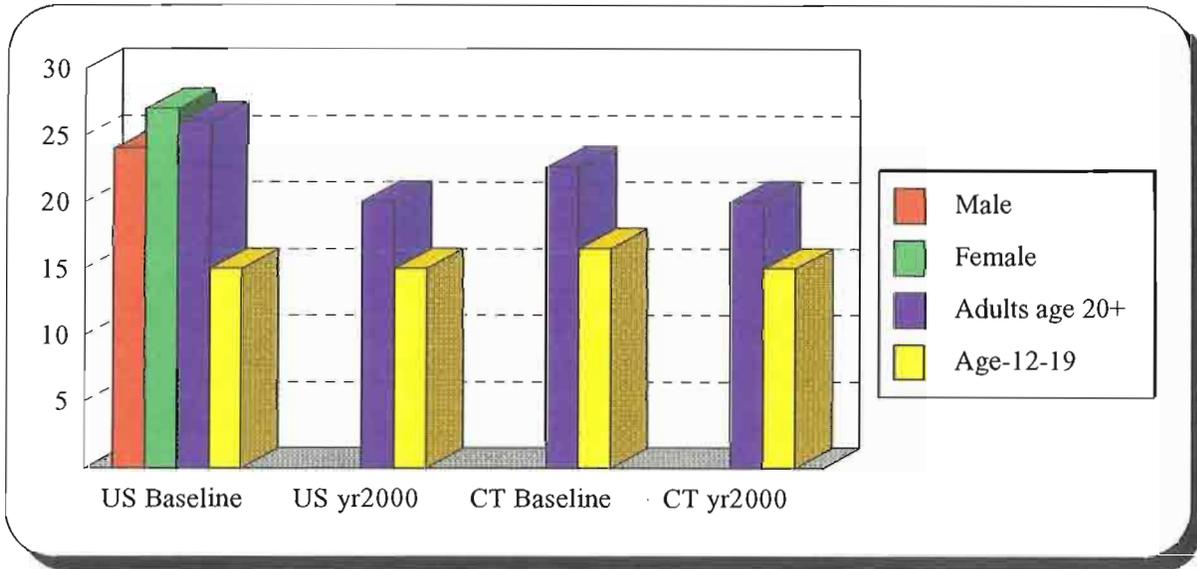
Source: Division of Chronic Disease and Injury Prevention, Health Surveillance and Planning, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: In 1989, 44 percent of all deaths in Connecticut were from heart disease and stroke. Mortality from these diseases is potentially preventable by modification of risk factors such as smoking, exercise, high blood pressure, and obesity. It is estimated that control of these risk factors could prevent between 40 percent and 70 percent of all related premature deaths.

Objective 1.2: Reduce overweight to a prevalence of no more than 20 percent among people aged 20 years and older and no more than 15 percent among adolescents aged 12 through 19



| Age/Sex | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|----------------|-------------|---------------------|-------------|---------------------|
| Adults age 20+ | 26% | 20% | 22.6%* | 20% |
| Age 12-19 | 15% | 15% | 16.5%* | 15% |
| Male | 24% | | | |
| Female | 27% | | | |

Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

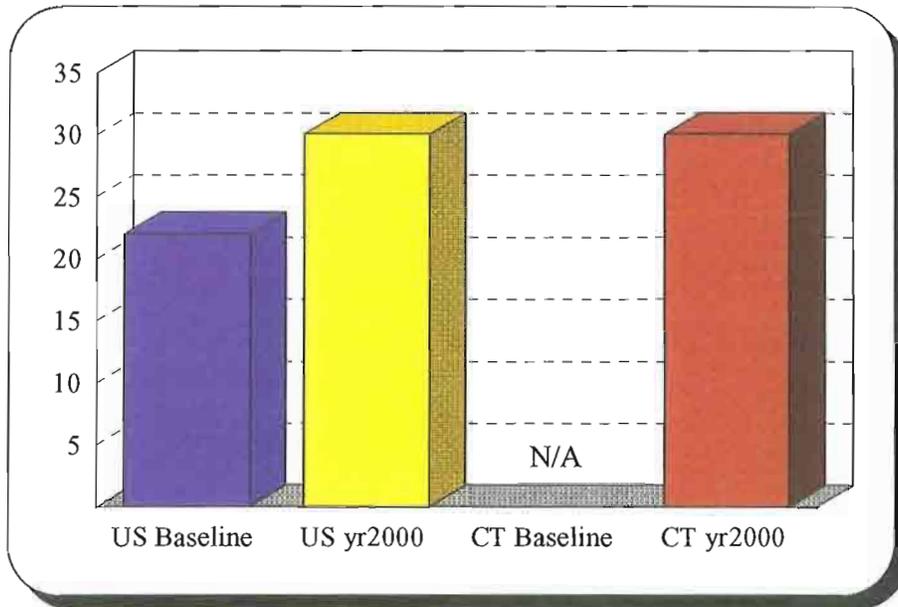
Data

Limitations: BRFSS is ages 18+ (not 20+). The Youth Health Check is not a representative sample; it is done in self-selected schools.

Rationale: Overweight is associated with elevated serum cholesterol levels, elevated blood pressure, some types of cancer, non-insulin-dependent diabetes, and is an independent risk factor for coronary heart disease. Overweight acquired during childhood or adolescence may persist into adulthood and increase risk for some chronic diseases later in life.

*1990 Behavioral Risk Factor Surveillance Survey (BRFSS), 1990 Youth Health Check

Objective 1.3: Increase to at least 30 percent the proportion of people aged six and older who engage regularly, preferably daily, in light to moderate physical activity for at least 30 minutes per day.



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|-------------|---------------------|
| 22% | 30% | N/A | 30% |

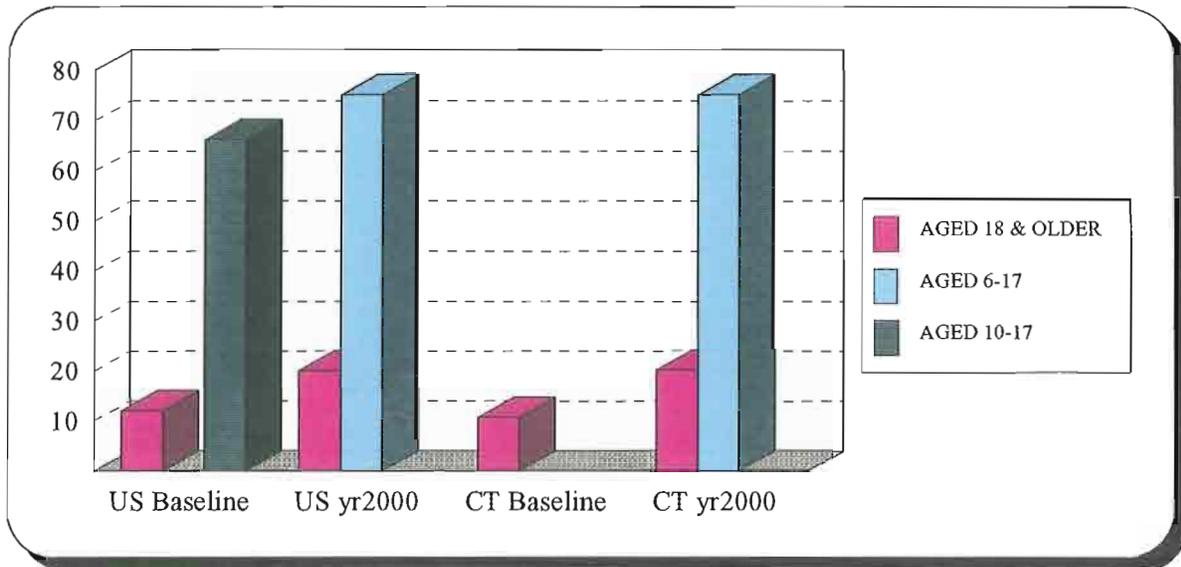
Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

Data

Limitations: Connecticut does not have data for residents 6 years old and younger thus the Federal Year 2000 Target has been used.

Rationale: In 1992, 57 percent of Connecticut adults were at risk of developing several chronic health problems as a result of not engaging in adequate exercise. Changes in lifestyle, which include programs of moderate, regular exercise for 30 minutes a day, three times a week markedly lower death rates from all causes, specifically from cancer and cardiovascular disease.

Objective 1.4: Increase to at least 20 percent the proportion of people aged 18 and older and to at least 75 percent the proportion of children and adolescents aged 6 through 17 who engage in vigorous physical activity that promotes the development and maintenance of cardiorespiratory fitness three or more days per week for 20 or more minutes per occasion



| Age | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------|-------------|---------------------|--------------|---------------------|
| 18+ | 12% | 20% | 10.6% (1990) | 20% |
| 6-17 | | 75% | | 75% |
| 10-17 | 66% | | | |

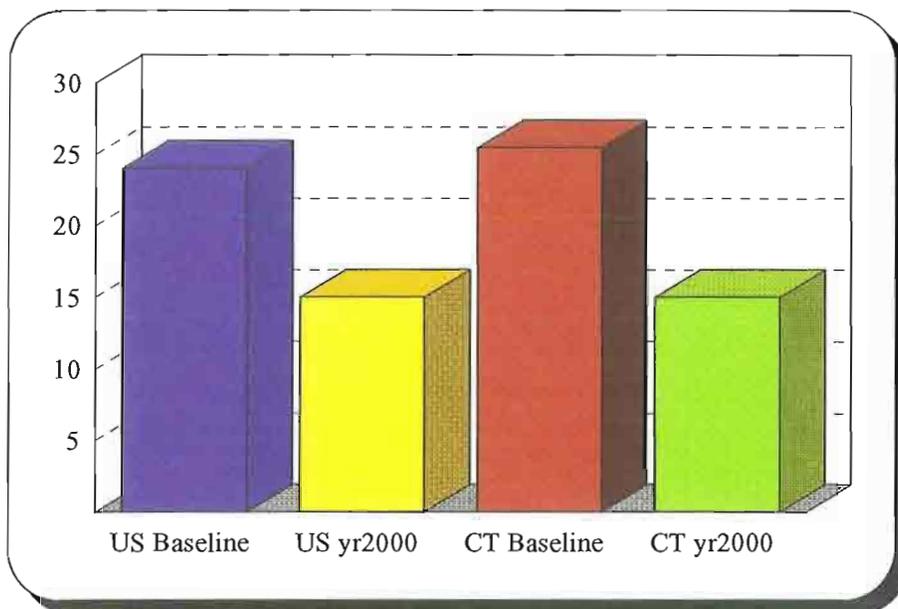
Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

Data

Limitations: No Connecticut baseline data exist for children and adolescents aged 6 through 17.

Rationale: Persons of all ages should include physical activity in a comprehensive health program, and should increase their daily physical activity to a level appropriate to their capabilities, needs, and interest. Although evidence supports the fact that low-level intensity activities performed daily have long-term benefits, dynamic exercise (high level intensity activity) for extended periods of time (30-60 minutes, 3 to 4 times weekly) is recommended and encouraged.

Objective 1.5: Reduce to no more than 15 percent the proportion of people aged six and older who engage in no leisure-time physical activity



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|--------------|---------------------|
| 24% | 15% | 25.4% (1990) | 15% |

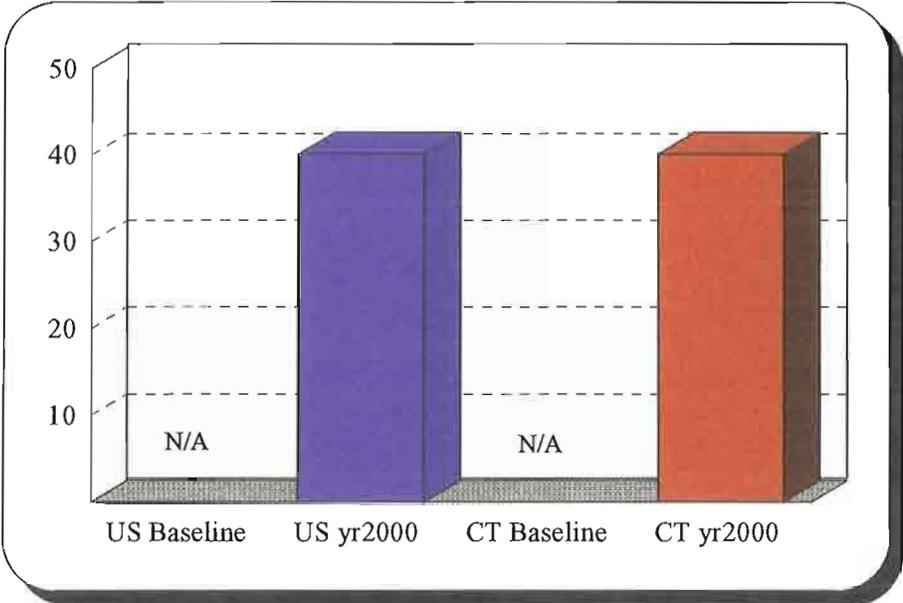
Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: The American Heart Association has recently classified sedentary lifestyles as a primary risk factor for heart disease comparable to high blood pressure, elevated blood cholesterol and cigarette smoking. Stroke and peripheral vascular disease have been shown to be associated with sedentary living and no physical activity. Over 25 percent of Connecticut residents have been identified as living sedentary lifestyles (perform no leisure time physical activity).

Objective 1.6: Increase to at least 40 percent the proportion of people aged six and older who regularly perform physical activities that enhance and maintain muscular strength, muscular endurance, and flexibility.



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------------------------------|---------------------|--------------------------------|---------------------|
| No data available at this time | 40% | No data available at this time | 40% |

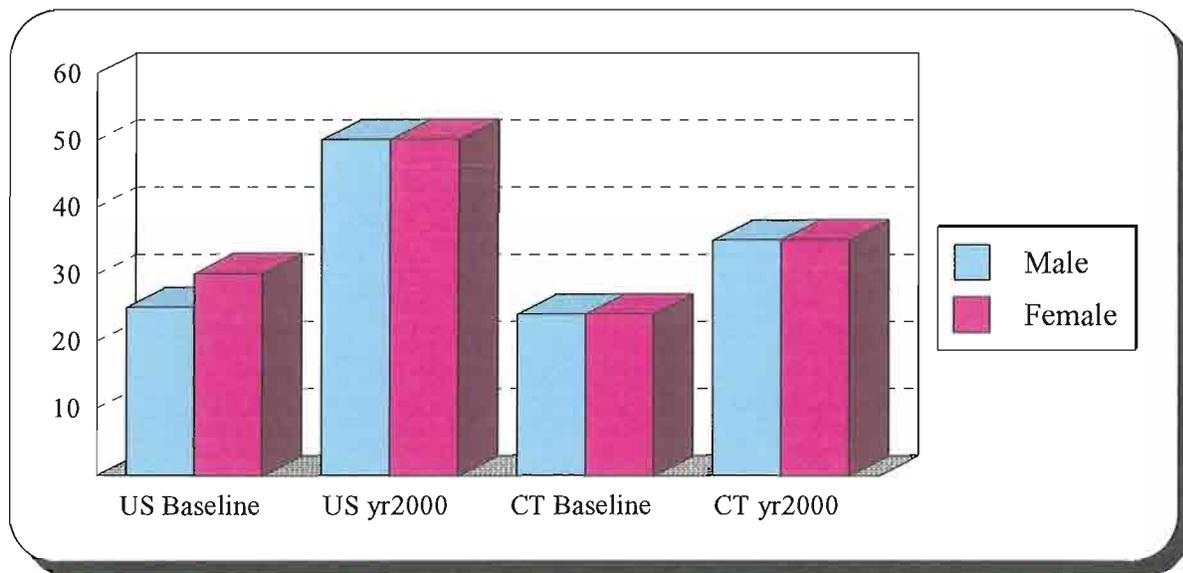
Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

Data

Limitations: Connecticut does not have baseline data for those residents six years old and older. The Federal Year 2000 Target is used.

Rationale: Regular vigorous physical activity helps achieve and maintain higher levels of cardiorespiratory fitness. Daily light to moderate physical activity can help attain weight control and achieve the physiologic benefits that many of Connecticut's residents desire. Physical activities include brisk walking, jogging/running, lap swimming, cycling, dancing, skating, rowing, jumping rope, cross country skiing, hiking/backpacking, racquet sports, and competitive group sports.

Objective 1.7: Increase to at least 35 percent the proportion of overweight people aged 12 and older who have adopted sound dietary practice combined with regular physical activity to attain an appropriate body weight



| Sex | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------|-------------|---------------------|-------------|---------------------|
| Female | 30% | 50% | 24% | 35% |
| Male | 25% | 50 % | 24% | 35% |

Source: Division of Community Health Promotion, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: The adoption of low fat and low salt dietary patterns is important for Connecticut residents in the prevention of coronary heart disease, high blood pressure, and certain cancers. Further, the adoption of dietary and physical activity habits that will reduce the onset of obesity will help reduce the likelihood of coronary heart disease. It is especially important for all residents of Connecticut to learn the importance of daily regular physical activity in the prevention of weight gain.

Chapter 2 - NUTRITION

Growing public awareness about diet and health, as well as increasing scientific evidence linking diet to disease prevention and/or treatment, have made nutrition a public health priority. Implementation of recommendations* for nutrition policy and programming can best occur through state-level coordination of nutrition programs and services.

In Connecticut, as in the rest of the nation, nutrition is associated with three of the five leading causes of death, including coronary heart disease, some types of cancer, and stroke. Once prevalent, nutritional deficiencies have generally been replaced by problems related to dietary excesses and imbalances. However, available data collected indicate that undernourishment still exists in some groups such as those of low socioeconomic status, children, the homeless, and many elderly individuals in Connecticut.

* Healthy People 2000 National Health Promotion and Disease Prevention Objectives; the Surgeon General's Report on Nutrition and Health, 1988; National Research Council's Diet and Health 1989; and Dietary Guidelines for Americans, 1990

Chapt. 2 - Nutrition

p. 2-2

Optimal nutrition promotes health, prevents disease, and thereby reduces health care costs**; additionally, it promotes good work and school performance and enhances the quality of life. Nutrition is one of the most important aspects of public health.

The Department of Public Health and Addiction Services commits to providing the leadership to advance and coordinate nutrition programs and services to meet the needs of the public and to achieve national nutrition objectives. The State's nutrition agenda should incorporate the following strategies:

- o improve public access to nutrition information and education
- o establish a state nutrition data tracking system
- o secure resources for nutrition systems development
- o assure nutrition components in the Department's programs
- o assure standards and monitoring of nutrition programs and services
- o provide guidance to programs, officials, and legislators on nutrition policy
- o assist communities in developing nutrition plans
- o promote access to healthy foods for all population groups
- o foster personal responsibility for enhanced health through optimal nutrition.

** "Position Statement," The Coalition for Nutrition Services in Health Care Reform, 1993

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 2 - Nutrition

Selected Objectives

OBJ. 1 OBJECTIVE DESCRIPTION

Health Status Objective

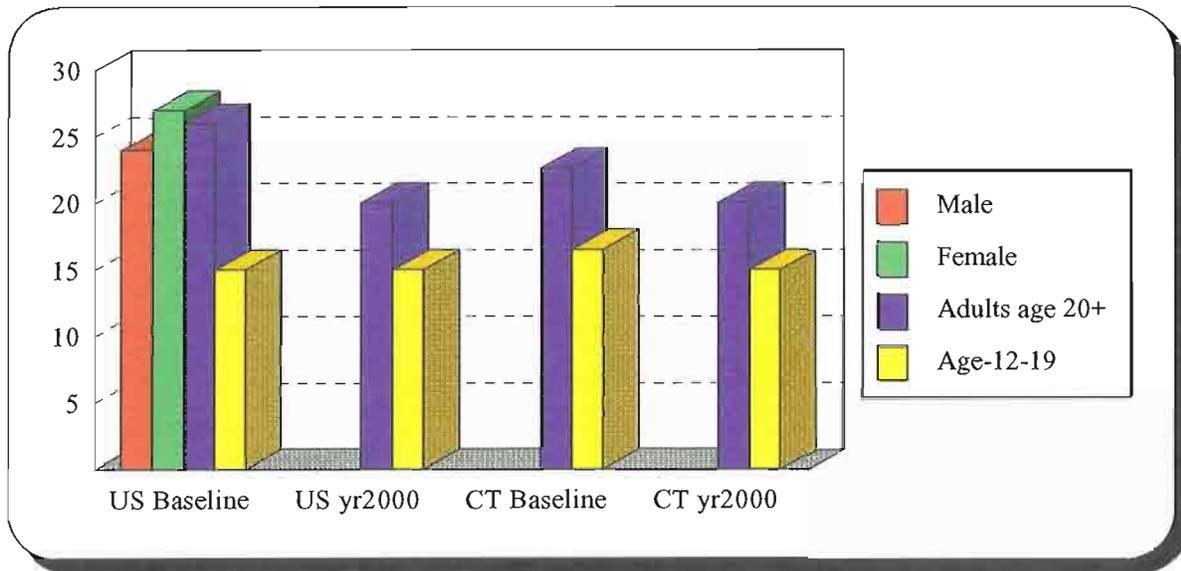
- 2.3 Reduce overweight to a prevalence of no more than 20 percent among people aged 20 and older and no more than 15 percent among adolescents aged 12 through 19
- 2.4 Reduce growth retardation among low income children under five years of age to less than seven percent

Risk Reduction Objectives

- 2.5 Reduce dietary fat intake to an average of 30 percent of calories or less and average saturated fat to less than ten percent among people aged two and older
- 2.6 Increase complex carbohydrate and fiber-containing foods in diets of adults to five or more servings for vegetables (including legumes) and fruit and six or more daily servings for grain products
- 2.10 Reduce iron deficiency to less than ten percent among children aged one through four and less than three percent for women of childbearing age
- 2.11 Increase to at least 75 percent the proportion of mothers who breastfeed their babies in the early postpartum period and to at least 50 percent the proportion who continue to breastfeed until their babies are five to six months old

Note: Cholesterol Reduction Objective appears in Heart Disease Section 15.6.

Objective 2.3: Reduce overweight to a prevalence of no more than 20 percent among people aged 20 years and older and no more than 15 percent among adolescents aged 12 through 19



| Age/Sex | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|----------------|-------------|---------------------|-------------|---------------------|
| Adults age 20+ | 26% | 20% | 22.6% * | 20% |
| Age 12-19 | 15% | 15% | 16.5% ** | 15% |
| Male | 24% | | | |
| Female | 27% | | | |

Source: Division of Community Health Services, Department of Public Health and Addiction Services

Data

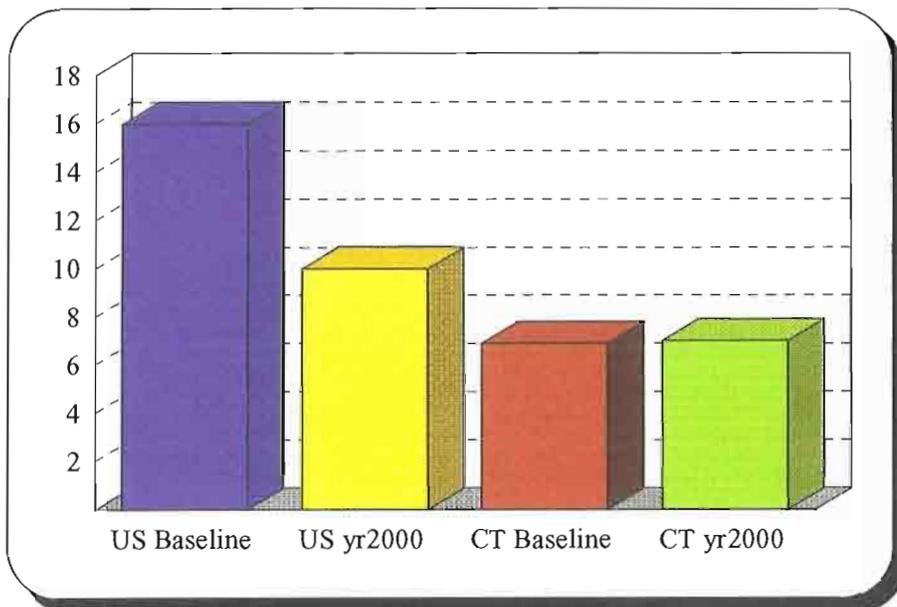
Limitations:

Rationale: Overweight is associated with elevated serum cholesterol levels, elevated blood pressure, some types of cancer, non-insulin-dependent diabetes, and is an independent risk factor for coronary heart disease. Overweight acquired during childhood or adolescence may persist into adulthood and increase risk for some chronic diseases later in life. The prevalence of overweight has not declined in the last two decades.

* BRFSS (Behavioral Risk Factor Surveillance Survey) 1990

**Youth Health Check 1990

Objective 2.4: Reduce growth retardation among low income children under five years of age to less than seven percent



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|-------------|---------------------|
| 16% (1988) | Under 10% | 6.9% (1991) | Under 7% |

Source: Child and Adolescent Health Division, Department of Public Health and Addiction Services

Special Population Targets

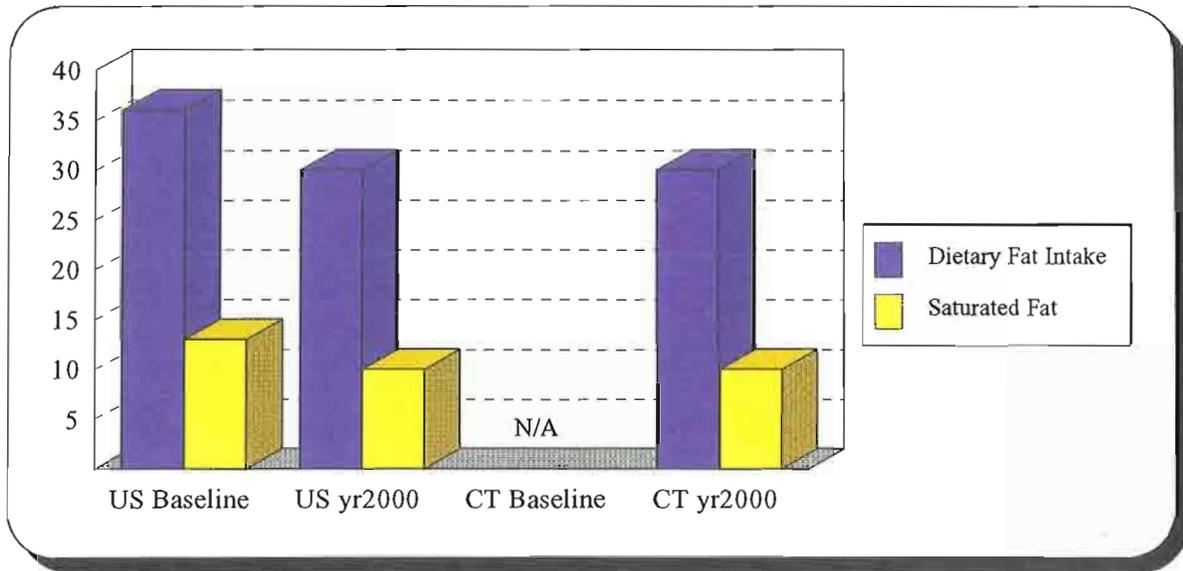
| Low income children | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|---|-------------|---------------------|-------------|---------------------|
| Black Children less than 1 year old | 15% | 10% | 11.6% | 7% |
| Hispanic Children less than 1 year of age | 13% | 10% | 7.8% | 7% |
| Hispanic Children 1 year of age | 16% | 10% | 10.9% | 7% |

Data

Limitations: The data are based on data from four local WIC Programs participating in CDC's Pediatric Nutrition Surveillance System (PedNSS) during 1991.

Rationale: Growth retardation is a good indicator of overall nutritional status, so it is important to monitor and address. It will show us to some degree the success of nutrition programs at preventing growth retardation related to long term health problems and/or poor nutrition.

Objective 2.5: Reduce dietary fat intake to an average of 30 percent of calories or less and average saturated fat to less than ten percent among people aged two and older



| Fat Intake | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|---------------|-------------|---------------------|-------------------|---------------------|
| Dietary Fat | 36% | 30% | No data available | 30% |
| Saturated Fat | 13% | 10% | No data available | 10% |

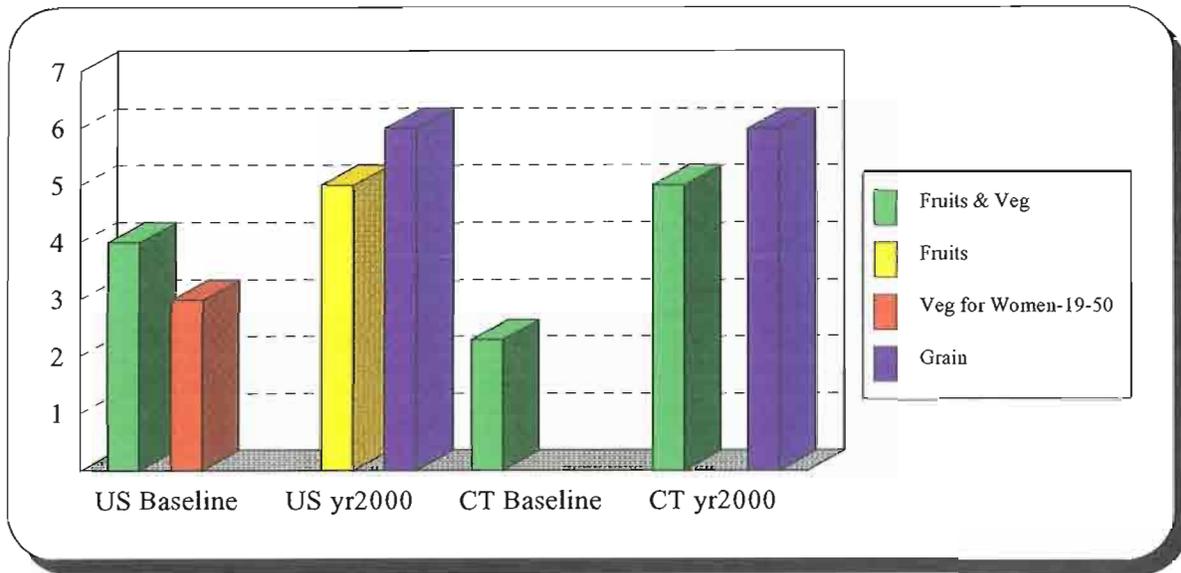
Source: Child and Adolescent Health Division, Department of Public Health and Addiction Services

Data

Limitations: Connecticut data are not available at this time; thus, the Federal Year 2000 Target is used. Connecticut baseline data will be available in the 1994 Behavioral Health Risk Factor Surveillance Survey (BRFSS).

Rationale: Evidence associates diets high in fat with increased risk of obesity, some types of cancer and heart disease. The targets of 30 percent of calories or less from fat and less than ten percent of calories from saturated fat are consistent with established recommendations.

Objective 2.6: Increase complex carbohydrate and fiber-containing foods in the diets of adults to five or more daily servings for vegetables (including legumes) and fruits, and to six or more daily servings for grain products



| Food Products-Servings | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------------------|-------------|---------------------|-------------|---------------------|
| Fruits & Vegetables | 4.0 | 5+ | 2.28 | 5+ |
| Fruits | | 5+ | | |
| Veg.-Women 19-50 | 3.0 | | | |
| Grain | | 6+ | | 6+ |

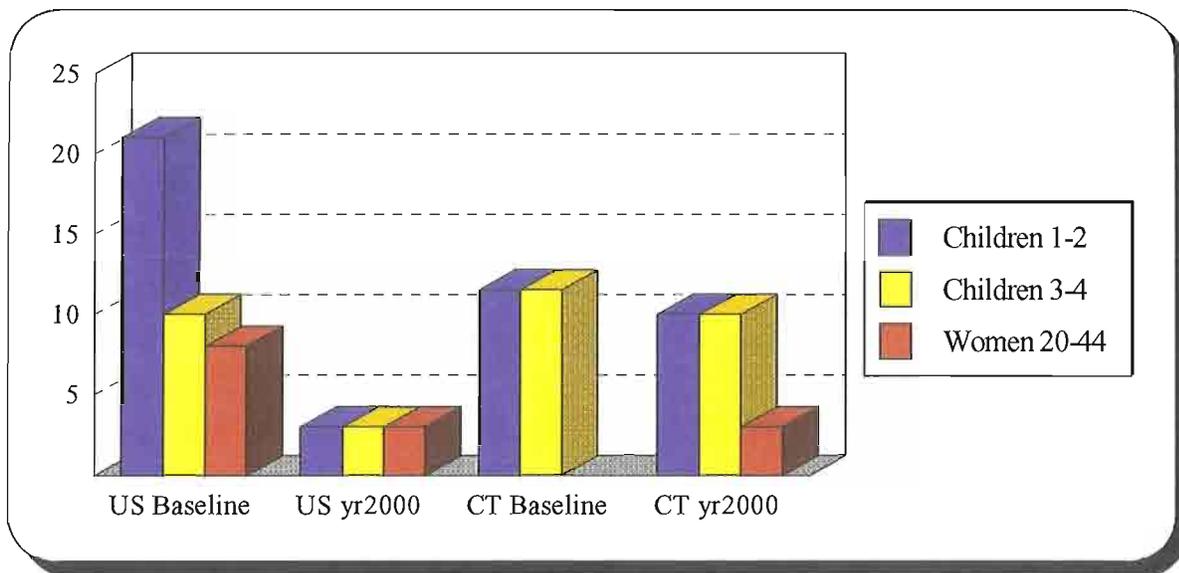
Source: Child and Adolescent Health Division, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Vegetables, fruits and grains are good sources of complex carbohydrates and dietary fiber, vitamins and minerals. Dietary patterns with higher fruits, vegetables and grains are associated with a variety of health benefits, including a decreased risk for heart disease and some types of cancers. In the Connecticut baseline only 5.6 percent ate five or more servings of fruits and vegetables. 1990 Behavioral Risk Factor Surveillance Survey (BRFSS)

Objective 2.10: Reduce iron deficiency to less than ten percent among children aged one through four and less than three percent among women of childbearing age



| Population | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------------|-------------|---------------------|-------------|---------------------|
| Children age 1-2 | 21% | 3% | 11.5% | 10% |
| Children age 3-4 | 10% | 3% | 11.5% | 10% |
| Women age 20-44 | 5% | 3% | No data | 3% |

Source: Child and Adolescent Health Division, Department of Public Health and Addiction Services

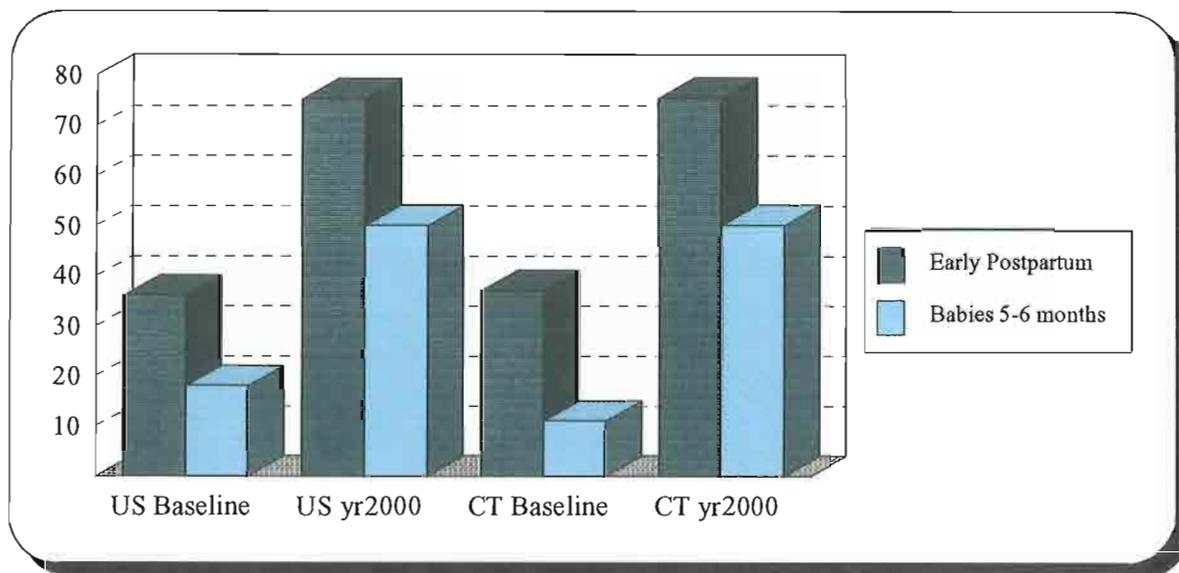
Data

Limitations: Connecticut Baseline is derived from data of four local WIC (Women and Infant-Children) programs. No data are available for Women 20-44. Due to this lack of baseline data, the Federal Year 2000 Target is used.

Rationale: The most common cause of anemia in late infancy and early childhood is iron deficiency, which can impair growth and development. Using data from the Pediatric Nutritional Surveillance Survey (PedNSS) 1991, the data are as follows:

| Condition | US Baseline | CT Baseline |
|----------------|-------------|-------------|
| Low Hemoglobin | 21.3% | 11.5% |
| Low Hematocrit | 15.8% | 19% |

Objective 2.11: Increase to at least 75 percent the proportion of mothers who breastfeed their babies in the early postpartum period and to at least 50 percent the proportion who continue to breastfeed until their babies are five to six months old



| Population | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------------|-------------|---------------------|-------------|---------------------|
| Early Postpartum | 36% | 75% | 37% | 75% |
| Babies 5-6 months | 18% | 50% | 11% | 50% |

Source: Child and Adolescent Health Division, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Breastfeeding provides both nutritional and immunologic benefits to infants. These benefits include protection from infection, diarrhea and respiratory illnesses, which account for the majority of sick-child care visits. Mothers' benefits include more rapid postpartum recovery, increased self-esteem, enhanced mother-child bonding and decreased risk of breast cancer, as well as cost savings over infant formula. All these benefits make breastfeeding the optimal and preferred method to nurture infants, especially for the socioeconomically disadvantaged.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 3 - TOBACCO

Cigarette smoking is the major preventable cause of death in the United States and in Connecticut. In Connecticut an estimated 5,446 people died in 1989 from smoking-related causes, including about 1,900 from cardiovascular disease and 1,443 from cancer. If smoking were listed separately, it would be the third leading cause of death.

The Behavioral Risk Factor Surveillance Survey (BRFSS) estimates a smoking prevalence rate of 22.4 percent for adults over age 18. Every day in Connecticut nearly eleven million cigarettes are smoked - four billion every year.

Smoking is also a major problem among our youth. According to a recent statewide survey conducted by the Connecticut Alcohol and Drug Abuse Commission, nearly one third of students in grades 9-12 and 13 percent of students in grades 6-8 reported smoking in the previous 30 days. For seniors, the rate of cigarette use in the past 30 days was 35.5 percent.

The 1989 Current Population Survey conducted by the U.S. Bureau of Census shows that the prevalence of smoking among Connecticut men aged 35-64 was 35.3 percent, while for women of

the same age it was 33.2 percent. The rate for Connecticut women was among the worst in the U.S.

Smoking cost the state over 900 million dollars in direct and indirect costs in 1989 - close to \$300 for every man, woman and child in our state. In contrast, the total tax revenue in 1989 from cigarettes purchased was estimated at approximately \$120 million.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 3 - TOBACCO

Selected Objectives

OBJ. 1 OBJECTIVE DESCRIPTION

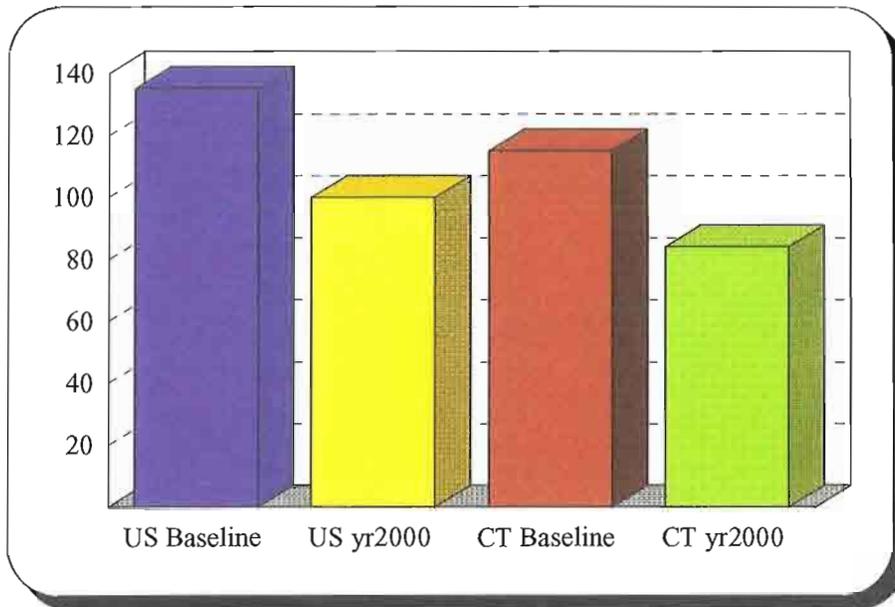
Health Status Objectives

- 3.1 Reduce coronary heart disease deaths to no more than 84 per 100,000 people
- 3.2 Slow the rise in lung cancer deaths to achieve a rate of no more than 42.1 per 100,000 people
- 3.3 Slow the rise in deaths from chronic obstructive pulmonary disease to achieve a rate of no more than 26 per 100,000 people

Risk Reduction Objectives

- 3.4 Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 20 and older
- 3.5 Reduce the initiation of cigarette smoking by children and youth so that no more than 15 percent have become regular cigarette smokers by age 20
- 3.6 Increase to at least 60 percent the proportion of cigarette smokers aged 18 or older who stopped smoking cigarettes for at least one day during the preceding year
- 3.7 Increase smoking cessation during pregnancy so that at least 60 percent of women who are cigarette smokers at the time they become pregnant quit smoking early in pregnancy and maintain abstinence for the remainder of their pregnancy
- 3.8 Reduce to no more than 20 percent the proportion of children aged six and younger who are regularly exposed to tobacco smoke at home

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



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------------|---------------------|------------------------|---------------------|
| 135 per 100,000 | 100 per 100,000 | 115 per 100,000 (1989) | 84 per 100,000 |

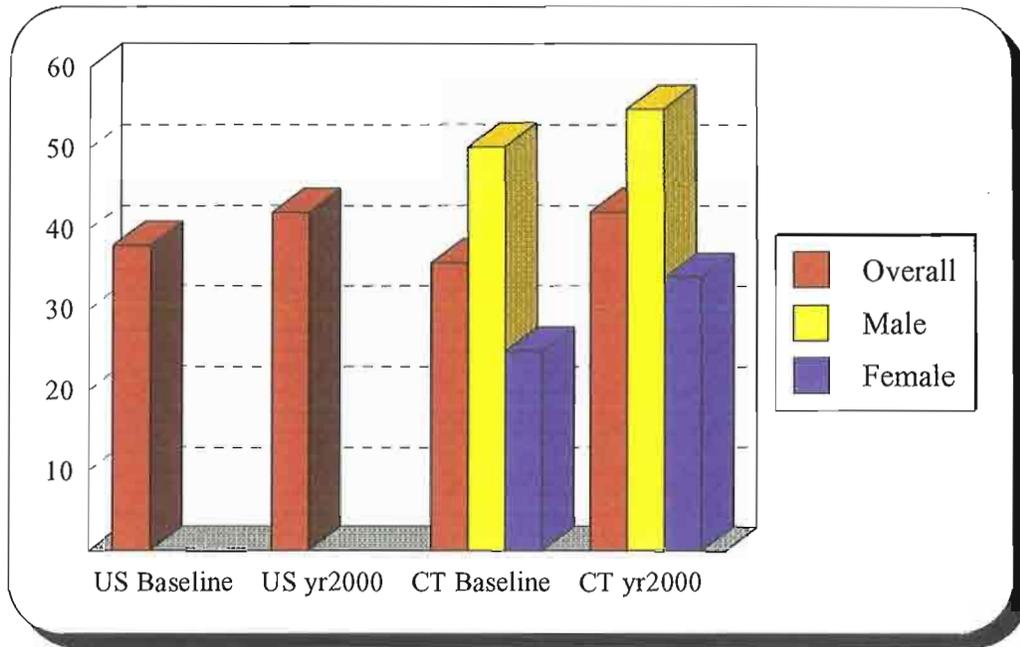
Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: In 1989, 44 percent of all deaths in Connecticut were from heart disease and stroke. Mortality from these diseases is potentially preventable by modification of risk factors such as smoking, exercise, high blood pressure and obesity. It is estimated that control of these risk factors could prevent between 40 percent and 70 percent percent of all related premature deaths.

Objective 3.2: Slow the rise in lung cancer deaths to achieve a rate of no more than 42 per 100,000 people



| Sex | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|---------|------------------|---------------------|------------------|---------------------|
| Overall | 37.9 per 100,000 | 42.0 per 100,000 | 35.8 per 100,000 | 42.0 per 100,000 |
| Male | - | - | 24.8 per 100,000 | 54.8 per 100,000 |
| Female | - | - | 50.1 per 100,000 | 34.0 per 100,000 |
| | (1987) | | (1989) | |

Source: Division of Chronic Disease and Injury Prevention, Health Surveillance and Planning, Department of Public Health and Addiction Services

Data

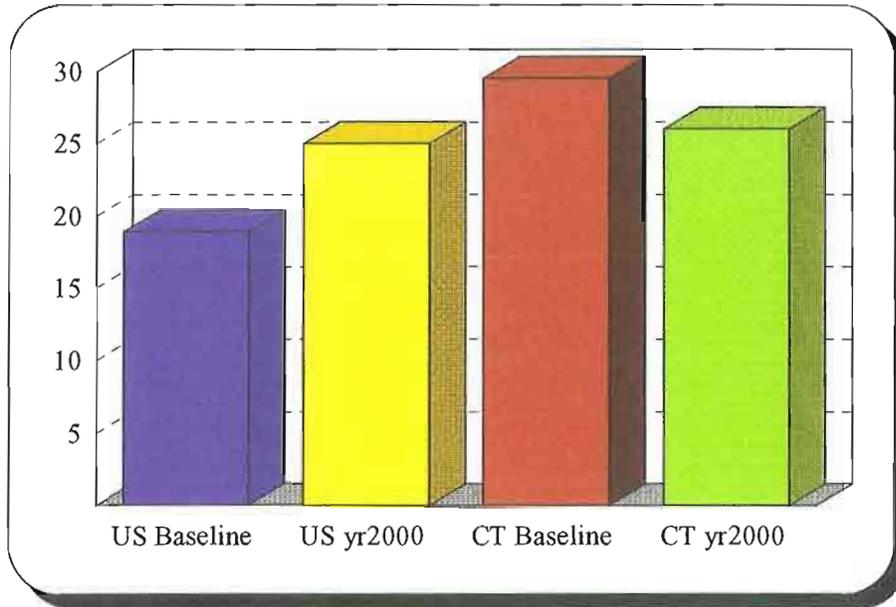
Limitations: The consensus indicator is for both sexes; however due to the substantial differences in mortality rates and the associated trends for men and women, separate objectives will be tracked for each sex.

Rationale: Of the 7,082 cancer deaths in 1989, 1,443 (20.4%) were attributable to smoking. Lung cancer is associated with smoking and exposure to secondhand smoke. Both primary and secondary smoke exposure are preventable. The incidence of lung cancer in women in Connecticut rose tenfold between 1935-39 and 1988.

Special Target Populations:

- Women
- Blacks

Objective 3.3: Slow the rise in deaths from chronic obstructive pulmonary disease to achieve a rate of no more than 26 per 100,000 people



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------------------|---------------------|-----------------------|---------------------|
| 18.9 per100,000(1987) | 25 per 100,000 | 29.5 per100,000(1989) | 26 per 100,000 |

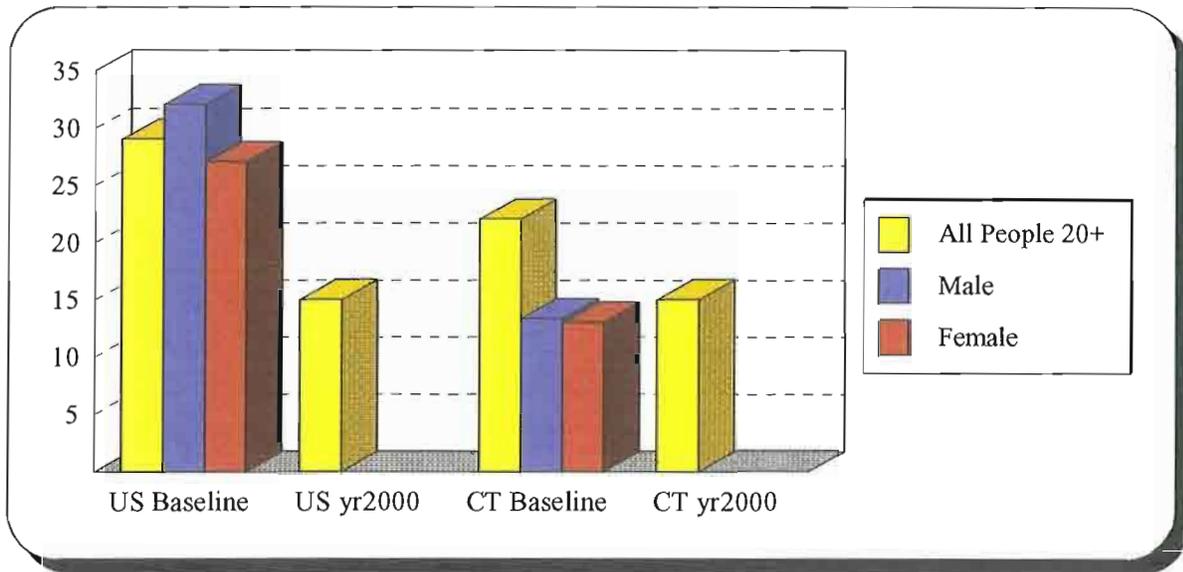
Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: There has been a significant increase in chronic obstructive pulmonary disease (COPD) mortality for both sexes of all ages between 1979 and 1989. The average increase in COPD crude mortality rates for both sexes was 9.74 per 100,000 population. Females showed a significant increase in mortality of 1.20 deaths per 100,000. In the 65+ population, there was also a significant increasing trend in COPD mortality. The average increase was 3.49 deaths per 100,000. Females in this population had an increasing trend of 6.06 deaths per 100,000 while males showed a decreasing trend of 0.51 deaths per 100,000.

Objective 3.4: Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 20 and older



| Sex | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------|-------------|---------------------|--------------|---------------------|
| All People | 29% | 15% | 22% aged 18+ | 15% |
| Male | 32% | | 13.3% | |
| Female | 27% | | 13.0% | |

Source: Division of Chronic Disease and Injury Prevention, 1990 Behavioral Risk Factor Surveillance Survey (BRFSS), Department of Public Health and Addiction Services

Data

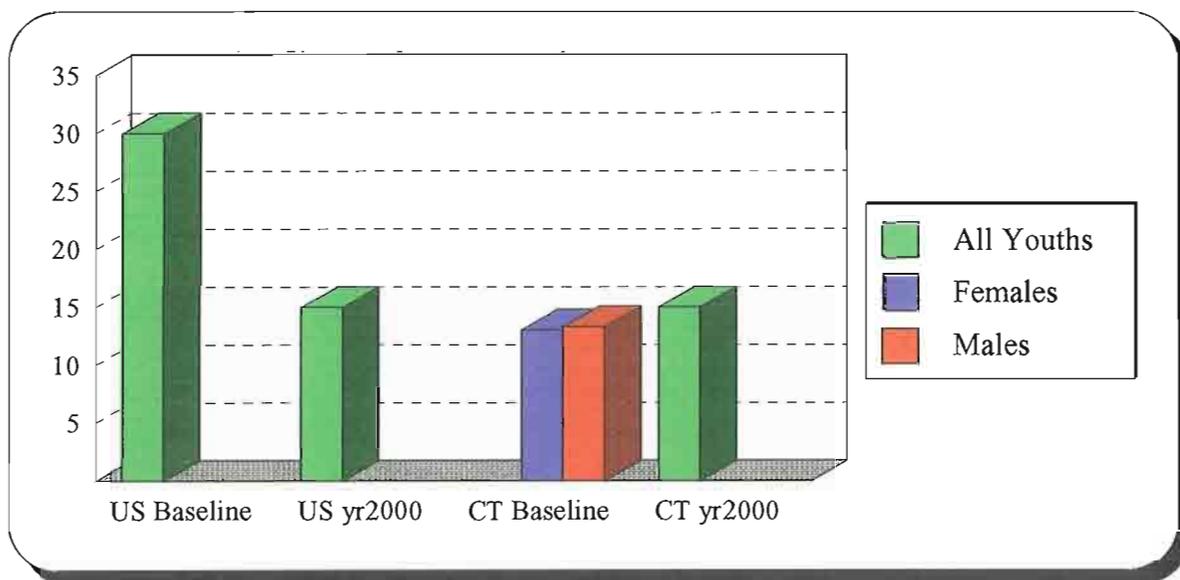
Limitations: Connecticut Baseline is based on all persons aged 18 and older.

Rationale: Cigarette smoking is the most important preventable cause of death and disability in the United States, estimated to cause at least 400,000 deaths per year. Smoking has been shown to increase the risk of death due to heart disease, lung and other cancers, and chronic obstructive pulmonary diseases. In addition, exposure to secondhand smoke may contribute to up to 50,000 deaths per year.

Special Targets

- Women of Reproductive Age
- Pregnant Women

Objective 3.5: Reduce the initiation of cigarette smoking by children and youth so that no more than 15 percent have become regular cigarette smokers by age 20



| Sex | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------|-------------|---------------------|-------------|---------------------|
| All Youths | 30% | 15% | | 15% |
| Females | | | 13%* | |
| Males | | | 13.3%* | |

Source: Division of Chronic Disease and Injury Prevention, 1990 Behavioral Risk Factor Surveillance Survey (BRFSS), Department of Public Health and Addiction Services

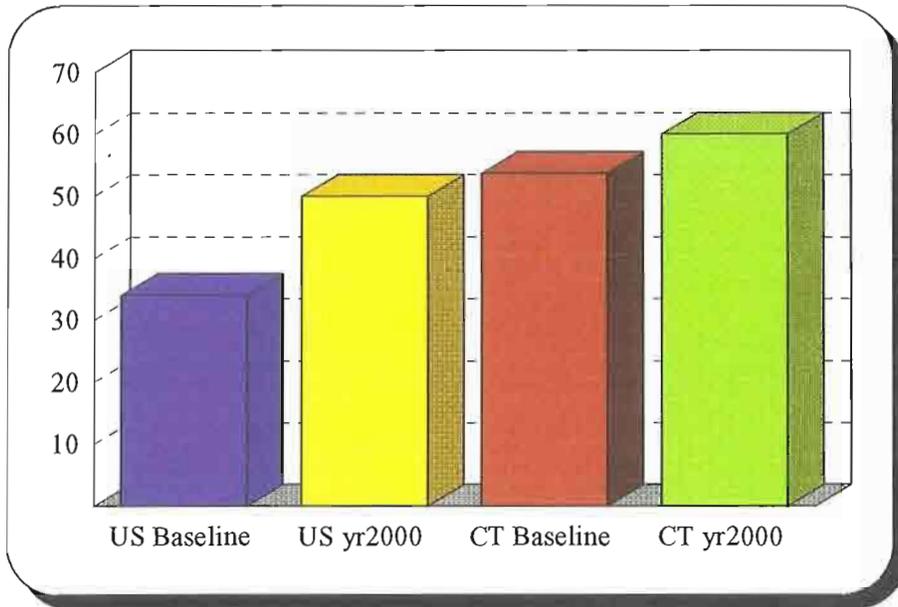
Data

Limitations:

Rationale: Use and access to tobacco by youth have negative future effects on their health. In addition, the Surgeon General has stated that 90 percent of smokers begin smoking before age 21. The prevalence of smoking by those under 20 in Connecticut is higher than that of the adult population.

*Grades 9-12

Objective 3.6: Increase to at least 60 percent the proportion of cigarette smokers aged 18 or older who stopped smoking cigarettes for at least one day during the preceding year



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|-------------|---------------------|
| 34% (1986) | 50% | 53.7% | 60% |

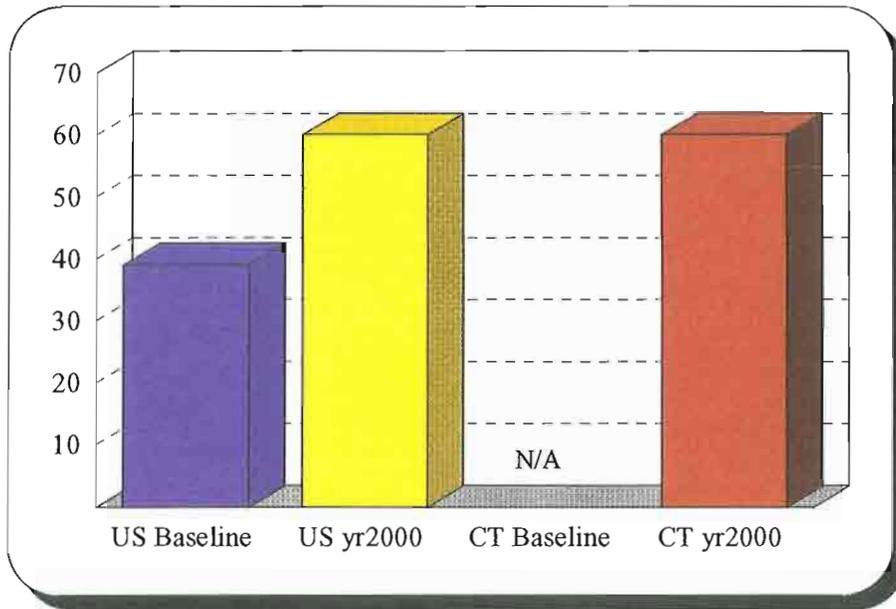
Source: Division of Chronic Disease and Injury Prevention, 1990 Behavioral Risk Factor Surveillance Survey (BRFSS), Department of Public Health and Addiction Services

Data

Limitations:

Rationale: The more times an individual attempts to quit smoking, the greater his/her chances of eventual success.

Objective 3.7: Increase smoking cessation during pregnancy so that at least 60 percent of women who are cigarette smokers at the time they become pregnant quit smoking early in pregnancy and maintain abstinence for the remainder of their pregnancy



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|-------------------|---------------------|
| 39% | 60% | No data available | 60% |

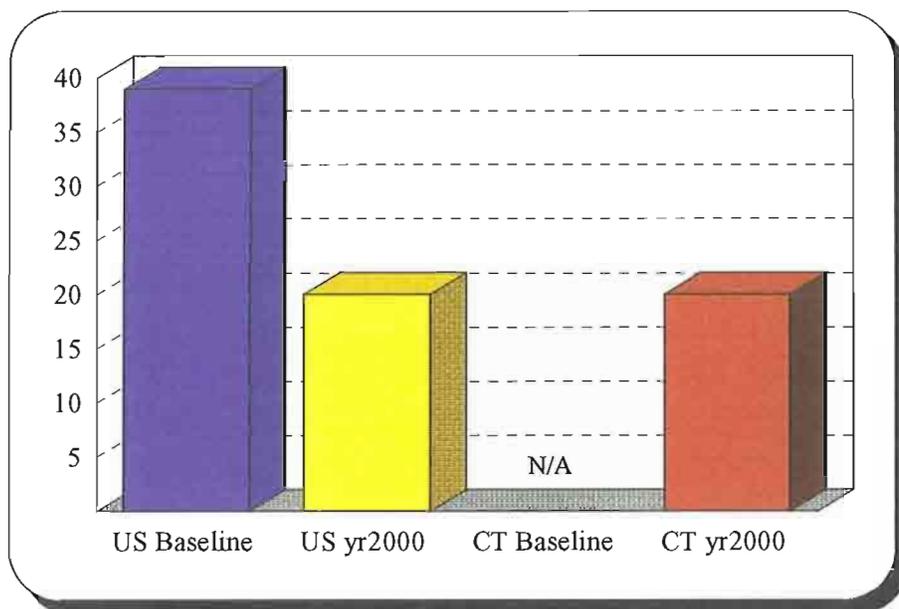
Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Smoking during pregnancy is associated with low birthweight babies, Sudden Infant Death Syndrome (SIDS) and other conditions which contribute to increased infant mortality. In addition, children in smoking households experience negative health consequences. While we do not have specific data on pregnant women we do know that the rate of smoking for girls grades 9-12 is 35 percent (1990-reported smoking in the last month). This is the beginning of their childbearing years.

Objective 3.8: Reduce to no more than 20 percent the proportion of children aged six and younger who are regularly exposed to tobacco smoke at home



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|-------------------|---------------------|
| 39% | 20% | No data available | 20% |

Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

Data

Limitations: Connecticut data are nonexistent; thus, the Federal Year 2000 Target is used.

Rationale: The Environmental Protection Agency report, "Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders" classifies environmental tobacco smoke (ETS) as a known human carcinogen. In children, ETS is causally associated with an increased risk of lower respiratory tract infections such as bronchitis and pneumonia. EPA estimates that 150,000 to 300,000 cases per year in infants and young children up to 18 months are attributable to environmental tobacco smoke. In addition, ETS exposure is causally associated with increased prevalence of fluid in the middle ear, symptoms of upper respiratory tract irritation, and a small but significant reduction in lung function in children. ETS exposure is causally associated with additional episodes and increased severity of symptoms in children with asthma. This report estimates that 200,000 to 1,000,000 asthmatic children have their conditions worsened by exposure to ETS. Finally, ETS exposure is a risk factor for new cases of asthma in children who have not previously displayed symptoms.

Chapter 5 - FAMILY PLANNING

Family planning has become a subject of much concern in this state. The increase in the initiation of teenage sexual activity and subsequent increase in teenage pregnancies has caused ripples throughout all social programs. Not only do they have implications for the present, but also for the future. The children born to many teenage parents today must be cared for, both by the parent or parents of the teenager and in some instances by the state. Social programs must be available to take care of children whose parents cannot provide for them and their children's progress must be closely monitored.

In order to accomplish a lower rate of teenage pregnancy, a multi-dimensional approach that will help teens focus on the future in addition to their present circumstances is needed. Successful family planning can also help lower the incidence of low-birth-weight babies, infant mortality and maternal morbidity.

Children should be brought into a world ready for them and their needs. The Department of Public Health and Addiction Services wants to ensure that those children born in this state have a fair chance at life. They should not only have the basic necessities such as food and a place to stay, but also that they have parents with the ability to give them the love and

Chapt. 5 - Family Planning

p. 5-2

attention that they, as children, need to grow up happy and healthy. Additionally, through effective barrier contraception, the department wants to prevent transmission of sexually transmitted diseases, in both women and men, which contributes to increased infertility. Also, the department wants to assure that help with effective contraception is available, and that couples know how to use contraception effectively for maximal protection. For those who are infertile and who want children, the Department can assist them by identifying resources and offering referrals for infertility treatment.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 5 - FAMILY PLANNING

Selected Objectives

OBJ. 1 OBJECTIVE DESCRIPTION

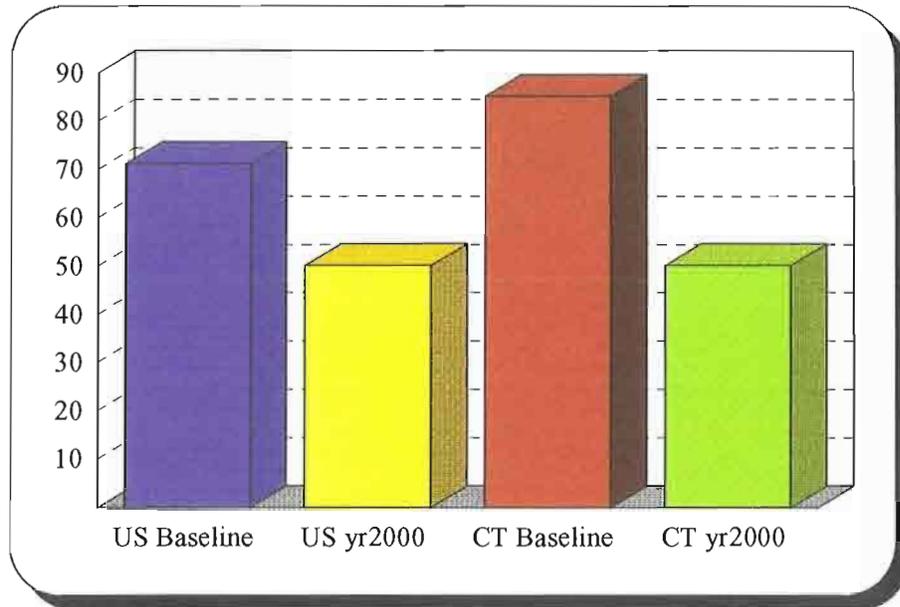
Health Status Objectives

- 5.1 Reduce pregnancies among girls aged 17 and younger to no more than 50 per 1,000
- 5.3 Reduce the prevalence of infertility to no more than 6.5 percent

Risk Reduction Objectives

- 5.4 Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15% by age 15 and no more than 40 percent by age 17
- 5.6 Increase to at least 90 percent the proportion of sexually active, unmarried people aged 19 and younger who use contraception, especially combined contraception methods that both effectively prevent pregnancy and provide barrier protection against disease

Objective 5.1: Reduce pregnancy among girls aged 17 and younger to no more than 50 per 1,000 adolescents



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|----------------|---------------------|------------------------|---------------------|
| 71.1 per 1,000 | 50 per 1,000 | 85 per 1,000 (1989) | 50 per 1,000 |

Source: Community Health Services/Maternal and Infant Health Division, Department of Public Health and Addiction Services

Data

Limitations: The potential for baseline data exists with the Connecticut Adolescent Health Survey project development at the time of these writings.

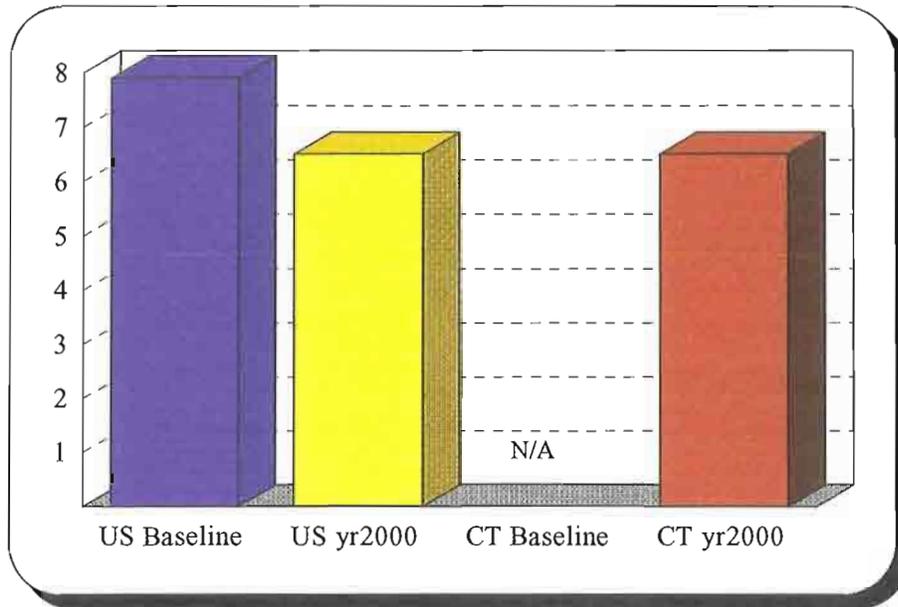
Rationale: This objective and its special population targets are particularly challenging. Pregnancy rates among young women aged 15-17 showed virtually no change between 1979 and 1985, hovering around 70 per 1,000 women. The effectiveness of various efforts to reduce rates of adolescent pregnancy will vary depending on the type of community involved. Programs should be tailored to local standards and values. No simple, one-dimensional approach is likely to succeed, given the complexity of the issue and the number of factors influencing an individual's decision to become sexually active. A successful approach is one that promotes development of mature, responsible individuals who understand the consequences of their actions, and who are goal-oriented and self-disciplined. Mature teens understand that their actions today have consequences for tomorrow and that the choices they make today will be with them for the rest of their lives.

Special Population Targets

Black adolescent girls

Hispanic adolescent girls

Objective 5.3: Reduce the prevalence of infertility to no more than 6.5 percent



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|----------------------|----------------------|-------------------|----------------------|
| 7.9% married couples | 6.5% married couples | No data available | 6.5% married couples |

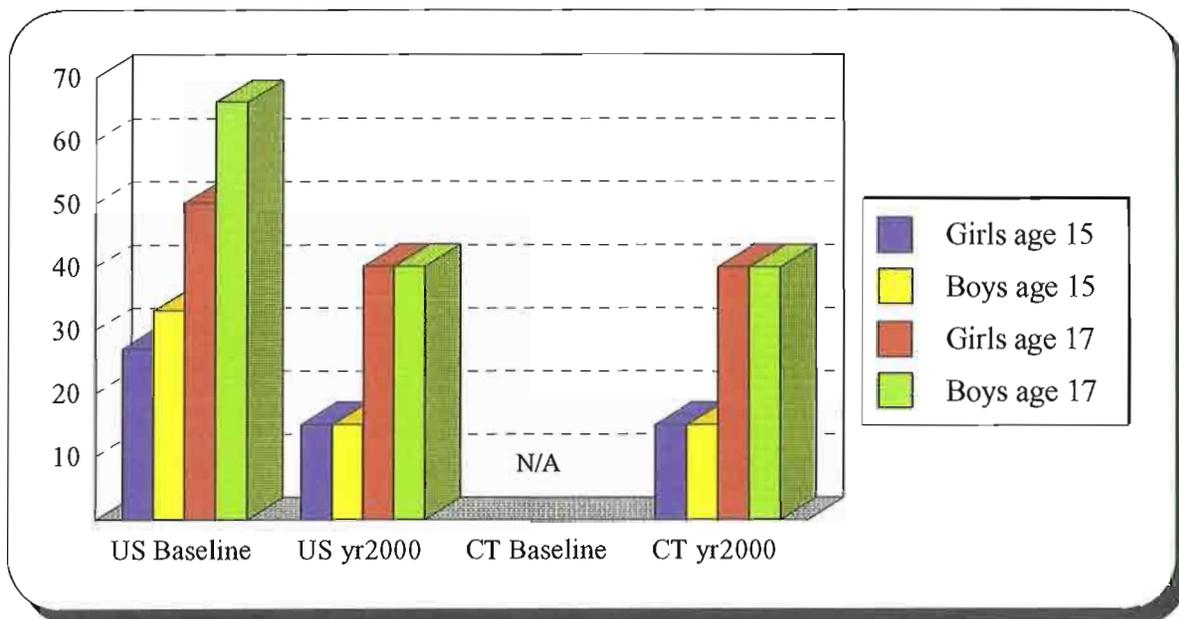
Source: Community Health Services/Maternal and Infant Health Division, Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Reductions in infertility are possible through improved preconception counseling (especially related to prevention of STDs), increased fertility awareness and fertility monitoring. Other treatment interventions such as medical induction of ovulation, surgical procedures to correct blocked fallopian tubes, artificial insemination and *in vitro* fertilization require appropriate referral.

Objective 5.4: Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17



| Sex | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------------|-------------|---------------------|-------------------|---------------------|
| Girls age 15 | 27% | 15% | No data available | 15% |
| Boys age 15 | 33% | 15% | | 15% |
| Girls age 17 | 50% | 40% | | 40% |
| Boys age 17 | 66% | 40% | | 40% |

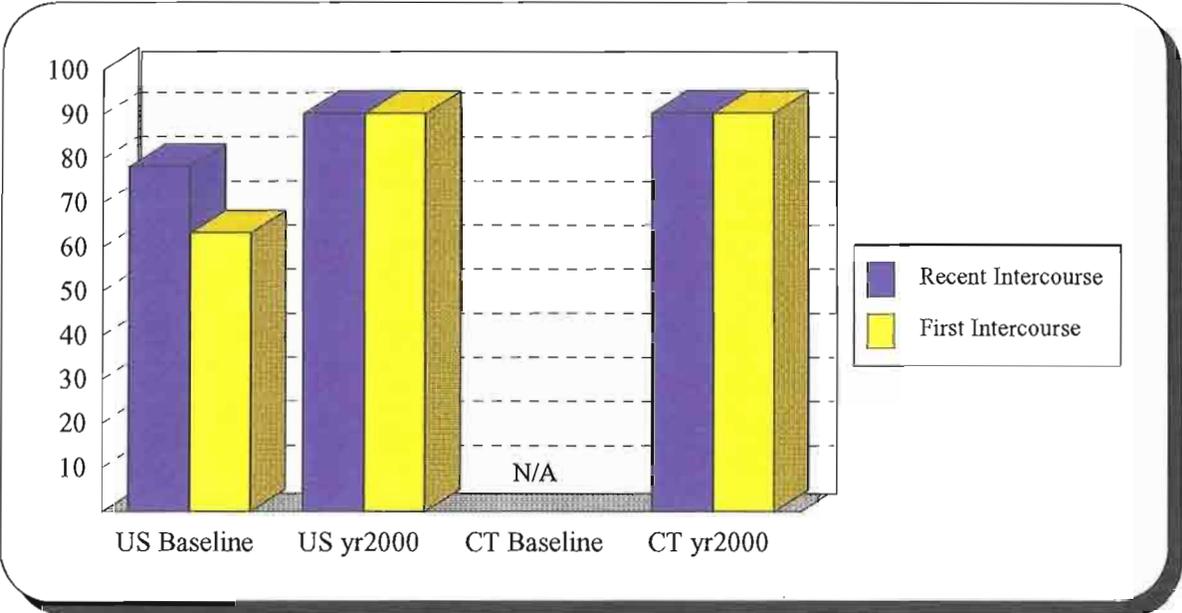
Source: Community Health Services/Maternal and Infant Health Division, AIDS program, Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Initiation of sexual activity at a younger age is a primary risk factor for unintended pregnancy. Because only some teenagers are sexually active, this amounts to a rate of at least 25 percent among those who are sexually active. Teenagers report that social pressure is the chief reason why their peers do not wait until they are older to have sexual intercourse. Sexual activity at young ages is more common among young people from low socioeconomic status families, and among adolescents who smoke, use alcohol or other drugs, or have evidence of delinquency. Research supports widely held beliefs that adolescents can respond positively to directive counseling from adults about sexuality. Some successful programs have taken a community approach involving parents, the media, the schools, and the clergy in preventing teen pregnancy. One study found that such an approach was successful in reducing teen sexual activity and improving contraceptive use among teens who were sexually active.

Objective 5.6: Increase to at least 90 percent the proportion of sexually active, unmarried people aged 19 and younger who use contraception, especially combined contraception methods that both effectively prevent pregnancy and provide barrier protection against disease



| Time | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|----------------------------|-------------|---------------------|-------------------|---------------------|
| At Most Recent Intercourse | 78% | 90% | No data available | 90% |
| First Intercourse | 63% | 90% | | 90% |

Source: Community Health Services/Maternal and Infant Health Division, Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Targeting adolescent sexual behaviors can help reduce rates of adolescent pregnancy, Sexually Transmitted Disease (STD) and HIV infection. Only one third of teenagers who have had sexual intercourse admit they use contraceptives all the time. Low-income teenagers are the least likely to use contraceptives consistently. Sexually active teenagers who have talked about sex, pregnancy, and contraception with their parents or who have a strong appreciation of the consequences if they or their partners become pregnant are the most likely to use contraception consistently. For sexually active teenagers who will not postpone sexual activity, consistent use of dual methods of contraception is the most effective means of reducing rates of pregnancy and sexually transmitted diseases.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 7 - VIOLENT AND ABUSIVE BEHAVIORS

Injuries related to violence are a major health problem for Connecticut's children, youth and young adults, and women, causing death and disability. Violence-related injuries are among the leading causes of death for Connecticut residents between the ages of 1 and 24 years. Domestic violence is the leading cause of injury to all women. Suicide is the third leading cause of death for Connecticut residents 15-19 years old.

During 1989, violence-related injuries were responsible for 22 percent of all deaths. Approximately 35 percent of all homicide victims in Connecticut are between 15 to 24 years of age, yet this age group represents only 15 percent of Connecticut's total population. Homicide is the leading cause of death in Connecticut for minority youth between 15 and 24 years of age.

Previously, violent and abusive behavior has been thought to be in the domain of law enforcement, social services and mental health professionals. Violence in the home has long been considered a matter to be settled in private.

Violence is now recognized by the U.S. Public Health Service and the Department of Public Health and Addiction Services as an urgent public health problem. In many Connecticut cities, there has been an epidemic of violent behavior, especially homicide, and the incidences of injuries and deaths from violence are increasing. Between 1985 and 1990, the homicide rate in Connecticut increased by 38 percent, and the assault rate increased 55 percent. Nationally, reports of rape have risen ten times faster than the overall crime rate.

Homicide is not just associated with criminal behavior. The FBI Uniform Crime Reports indicate that the majority of homicides occur during the course of arguments or fights, not during the commission of another crime. Increasing criminal penalties may do little to prevent these homicides. Additionally, studies show that crimes that are committed between acquaintances are not responded to as seriously as those that occur between strangers.

Violent behavior invariably brings both the perpetrator and the victim in contact with the public health system. There is growing evidence that children who witness or experience violence in the home or their community are at much greater risk of becoming a victim or perpetrator of violence as an adolescent or adult. In addition, there has been a greater emphasis on the

Chapt. 7 - Violent and Abusive Behaviors

p. 7-3

potential for injuries due to the presence of firearms in the home. Of children involved in The Connecticut Health Check*, 35 percent reported they had access to a gun in their homes. A coordinated approach among law enforcement, public health, health care, educational, and social service agencies and communities is needed to begin to make an impact on the problem of violence and abusive behavior.

Violence is a multifaceted problem closely interrelated with a variety of major social and economic problems for which there are no easy solutions. However, it is clear that the social and economic problems must be addressed for there to be substantial reductions in the incidence of violent injuries and deaths.

*The Connecticut Health Check is a computerized health risk appraisal for youth. Data are from self-selected schools; therefore, data do not represent all school children in the state.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 7 - VIOLENT AND ABUSIVE BEHAVIORS

Selected Objectives

OBJ. 1 OBJECTIVE DESCRIPTION

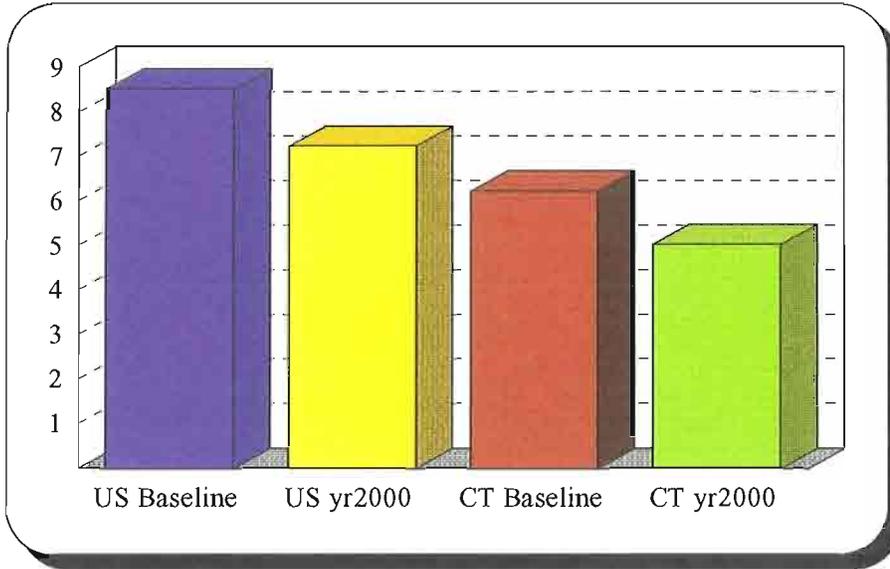
Health Status Objectives

- 7.1 Reduce homicides to no more than 5.0 per 100,000 people
- 7.2 Reduce suicides to no more than 6.7 per 100,000 people
- 7.4 Reverse to less than 25.2 per 1,000 children the rising incidence of maltreatment of children younger than age 18
- 7.5 Reduce physical abuse directed at women by male partners to no more than 27 per 1,000 couples
- 7.6 Reduce assault injuries among people aged 12 and older to no more than ten per 1,000
- 7.7 Reduce rape and attempted rape of women aged 12 and older to no more than 108 per 100,000 women
- 7.8 Reduce by 15 percent the incidence of injurious suicide attempts among adolescents aged 14 through 17

Risk Reduction Objectives

- 7.9 Reduce by 20 percent the incidence of physical fighting among adolescents aged 14 through 17
- 7.10 Reduce by 20 percent the incidence of weapon-carrying by adolescents aged 14 through 17

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



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------------------|---------------------|------------------------|---------------------|
| 8.5 per 100,000 (1989) | 7.2 per 100,000 | 6.2 per 100,000 (1989) | 5.0 per 100,000 |

Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

Data

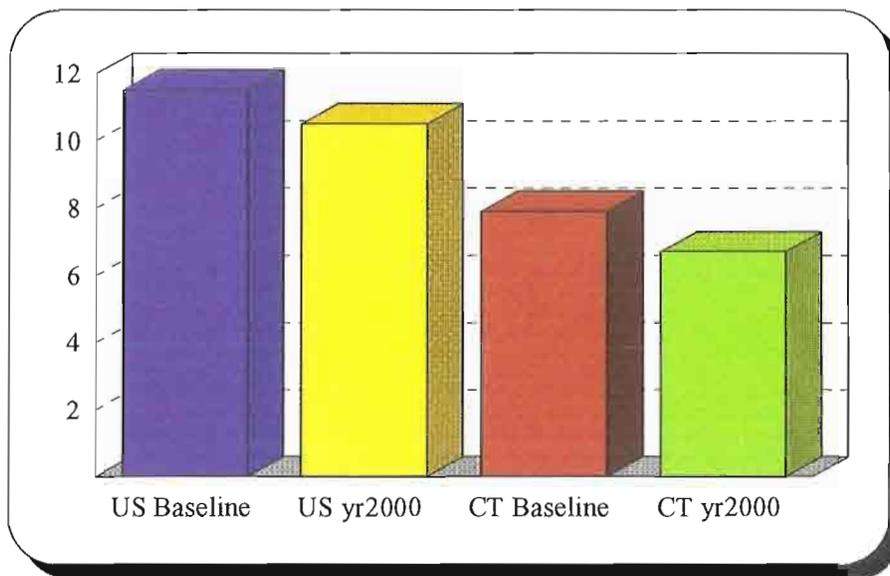
Limitations:

Rationale: Homicide is one of the leading causes of death for Connecticut residents under the age of 35 years. It is the leading cause of death for minority youth and young adults in Connecticut.

Special Target Populations

- Children aged 3 and younger
- Spouses aged 15-34
- Black Men aged 15-34
- Hispanic Men aged 15-34
- Black Women aged 15-34

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



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------------------|---------------------|------------------------|---------------------|
| 11.5 per 100,000 (1990) | 10.5 per 100,000 | 7.9 per 100,000 (1990) | 6.7 per 100,000 |

Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Suicide is one of the leading causes of death for Connecticut youth and young adults aged 15 to 35 years. Men over the age of 65 have a higher suicide rate than any other population group.

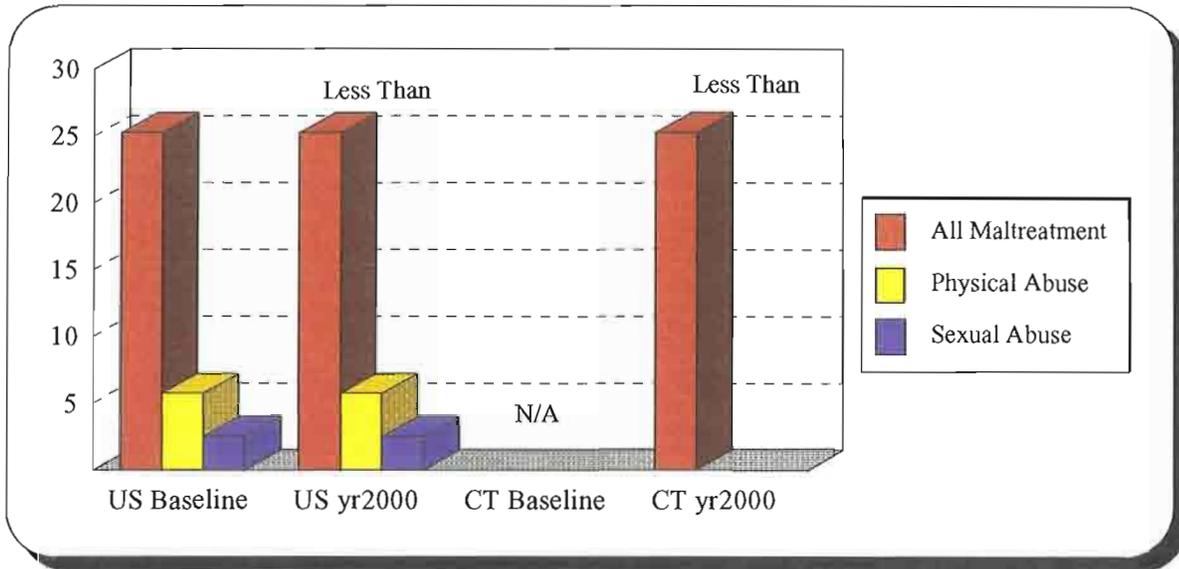
Special Target Populations

Youth aged 15-19

Men aged 20-34

White men aged 65+

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



| Maltreatment | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------------|----------------|--------------------------|-------------------|--------------------------|
| All Maltreatment | 25.2 per 1,000 | Less than 25.2 per 1,000 | No data available | Less than 25.2 per 1,000 |
| Physical Abuse | 5.7 per 1,000 | Less than 5.7 per 1,000 | | |
| Sexual Abuse | 2.5 per 1,000 | Less than 2.5 per 1,000 | | |

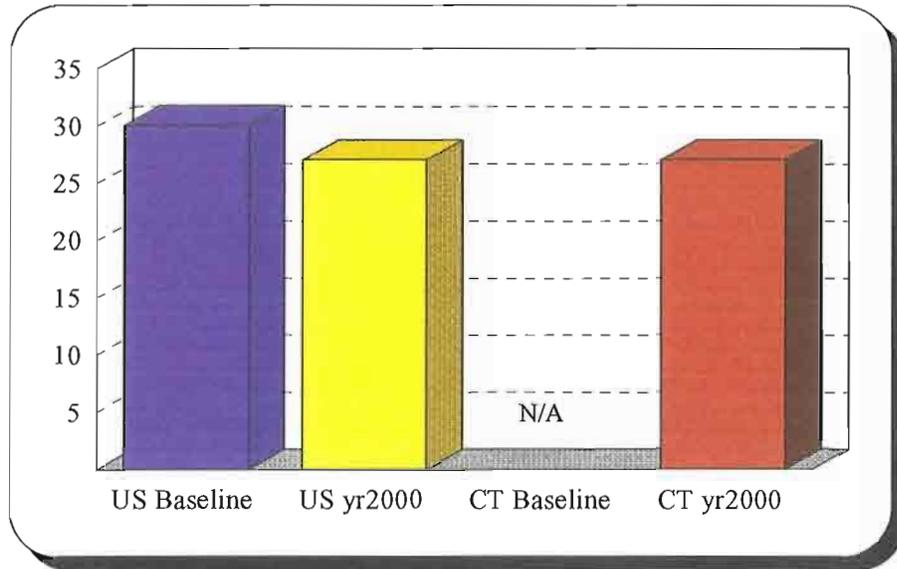
Source: Community Health Services, Department of Public Health and Addiction Services, Department of Children and Families

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: It is estimated that 1.5 million children nationwide experience child abuse and neglect each year. More than 20,000 children are reported to be abused or neglected annually in Connecticut. The Connecticut Department of Children and Families confirmed 1,412 victims of child sexual abuse in 1990-1991 and 1,641 victims of child sexual abuse in 1991-1992.

Objective 7.5: Reduce physical abuse directed at women by male partners to no more than 27 per 1,000 couples



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------------|---------------------|-------------------|---------------------|
| 30 per 1,000 | 27 per 1,000 | No data available | 27 per 1,000 |

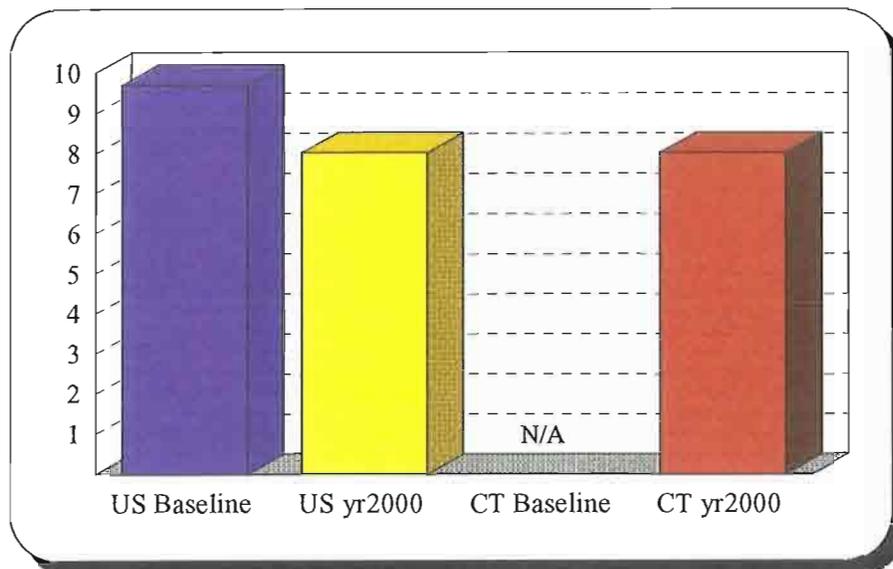
Source: Bureau of Health Promotion, Department of Public Health and Addiction Services

Data

Limitations: Connecticut data include reported incidents only. Unreported incidents are estimated to be at least three times the reported incidents. Due to the lack of reliable data, the Federal Year 2000 Target is used.

Rationale: Over six million women are beaten by male partners in the United States every year. Abuse is the most common cause of serious injury for women. Studies have indicated that more than 20 percent of women using emergency rooms are abused. In 1991, there were 21,520 incidents of violent crimes committed against women by male partners in Connecticut. Domestic violence projects responded to 40,000 calls from battered women and other primary victims and received over 30,000 case referrals from the courts. It is estimated that as many as 200,000 to 300,000 adult women face some form of abuse or violence from a male partner each year.

Objective 7.6: Reduce assault injuries among people aged 12 and older to no more than eight per 1,000



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|---------------|---------------------|--------------------------|---------------------|
| 9.7 per 1,000 | 8.0 per 1,000 | Available in 1994 CHIME* | 8.0 per 1,000 |

Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

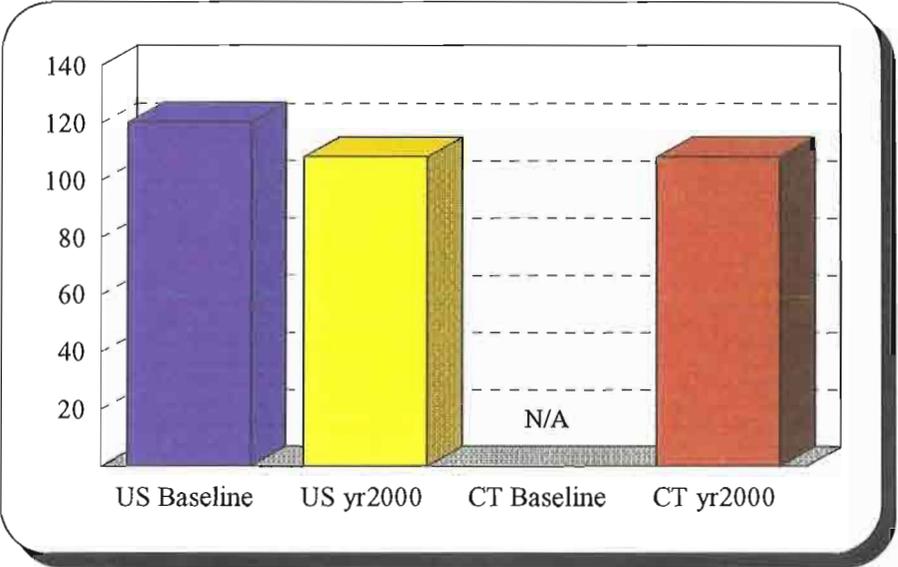
Data

Limitations: The baseline data for this objective will be available from the CHIME* report of 1994. Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: According to the Uniform Crime Report Program maintained by the Connecticut State Police, the rate of assaults for Connecticut residents (all ages) has increased from 163.3 per 100,000 in 1980 to 286.0 per 100,000 in 1990. It is not known from this reporting system how many of these assaults resulted in injuries requiring hospitalization or medical attention.

* CHIME is the Connecticut Health Information Management and Exchange.

Objective 7.7: Reduce rape and attempted rape of women aged 12 and older to no more than 108 per 100,000 women



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------------|---------------------|-------------------|---------------------|
| 120 per 100,000 | 108 per 100,000 | No data available | 108 per 100,000 |

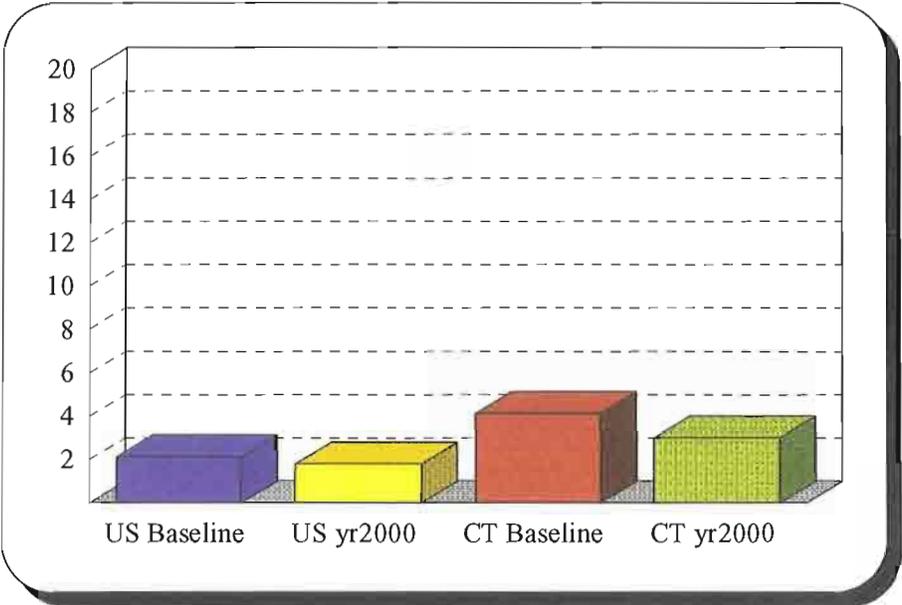
Source: Bureau of Health Promotion, Department of Public Health and Addiction Services

Data

Limitations: Approximately only one in ten rapes is reported to the police. Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: One in five women will be sexually assaulted in her lifetime. It is estimated that 27,000 women are sexually assaulted annually in Connecticut.

Objective 7.8: Reduce by 15 percent the incidence of injurious suicide attempts among adolescents aged 14 through 17



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|--------------|---------------------|
| 2.1 (1987) | 1.8 | 4.1 * (1989) | 3 |

Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

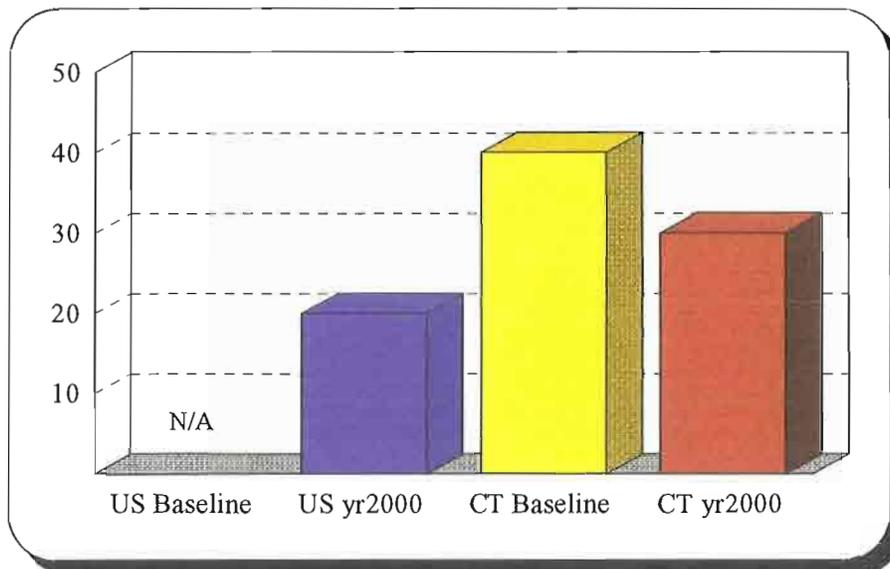
Data

Limitations:

Rationale: For each completed suicide it is estimated that there are between 100-200 suicide attempts among young people. Attempted suicide is a potentially lethal health event, a risk factor for future completed suicide and an indicator for other serious health problems.

* Ages 10-17

Objective 7.9: Reduce by 20 percent the incidence of physical fighting among adolescents aged 14 through 17



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------------|---------------------|-------------------|---------------------|
| No data available | Reduce by 20% | Approximately 40% | 32% |

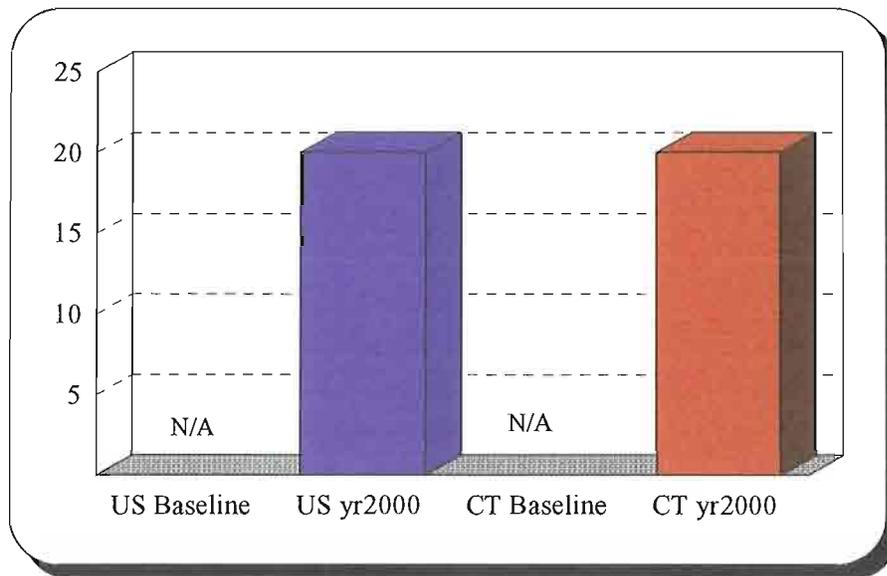
Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Physical fighting is the major factor leading up to many of the homicides among adolescents and also causes many serious injuries. Approximately 40 percent of the 7000 students grades 7 - 12, participating in the Connecticut Health Check, reported that they had been in a fight involving physical violence during the past year.

Objective 7.10: Reduce by 20 percent the incidence of weapon-carrying by adolescents aged 14 through 17



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------------------------------|---------------------|---|---------------------|
| No data available at this time | Reduce by 20% | Data available from YRBS (Youth Risk Behavioral Survey) in 1995 | Reduce by 20% |

Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Firearms were responsible for 81 percent of all homicides and 71 percent of all suicides among 15-19 year olds in Connecticut during 1988. Approximately 20 percent of all deaths from all causes in this age group are due to guns. Firearm-related deaths are second only to motor vehicles as a cause of death for youth. They outnumber all disease-related causes of death for this age group. A national survey of high school students found that one out of twenty students reported carrying a gun to school during the preceding month.

Chapter 9 - UNINTENTIONAL INJURIES

In 1990 the United States had 91,983 deaths due to unintentional injuries. They are the single greatest cause of mortality for individuals aged 1-44 years and cost the nation approximately \$133.2 billion each year. In the State of Connecticut, unintentional injuries are among the leading causes of death of individuals aged 1 to 34 years. Most of the deaths are associated with motor vehicle crashes, involving motor vehicle occupants, motorcyclists, bicyclists and pedestrians.

Unintentional injuries also cause disability, which leads to losses in productivity and higher medical care and rehabilitation treatment costs. These costs reflect the tip of a large iceberg. The ultimate costs of injuries are not known. Lost productivity and the costs of pain and suffering that the individual, family and friends incur are immeasurable. In the United States on an average day, more than 170,000 men, women and children are injured seriously enough to need medical care. Non-fatal injuries account for one in every six hospital days and one in every ten hospital discharges.

Alcohol and other drugs play a role in nearly half of all deaths related to motor vehicle injuries, and are a contributing

Chapt. 9 - Unintentional Injuries

p. 9-2

factor in many other types of injuries including drowning, fires, and falls. Social attitudes and the manner in which some media portray drugs and alcohol are major contributors to the problem; changing these attitudes of how society views the use of alcohol and drugs is a challenge for all sectors of society. Progress in prevention will depend on continuing and increasing public education and awareness.

In Connecticut, a number of laws have been designed to protect individuals from injury. A new law that applies to bicyclists has been passed, which states that any child under the age of 12 must wear an approved bicycle helmet while riding on any public street. The state has legislation in place requiring the use of seat belts and child safety seats. Other legislation aimed at decreasing motor vehicle related injuries includes a legal age of 21 years for alcohol consumption and laws designed to decrease driving under the influence and restricting youth access to alcohol.

The Connecticut Health Information Management and Exchange (CHIME) database, maintained by the Connecticut Hospital Association, is being used by DPHAS to determine cause of injury, costs of hospitalization from trauma and injury, and hospital utilization due to injury. CHIME is also

Chapt. 9 - Unintentional Injuries

continued - p. 9-3

used to access and collect other data about injuries which occur in the state.

The Department of Public Health and Addiction Services is utilizing the continuing efforts of researchers, educators, practitioners in public health, law enforcement officers, behavioral scientists, engineers and others to treat injuries more effectively and to prevent them from happening.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 9 - UNINTENTIONAL INJURIES

Selected Objectives

OBJ 1 OBJECTIVE DESCRIPTION

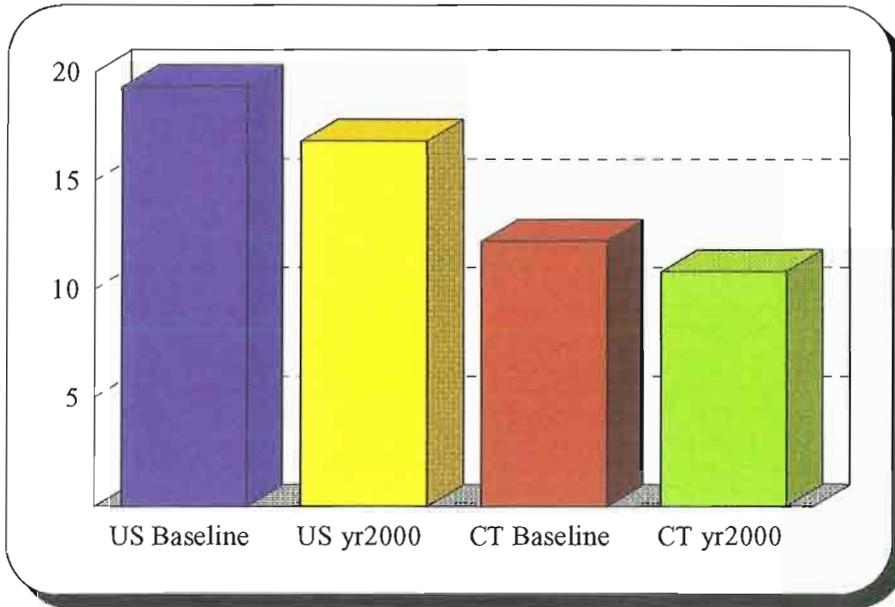
Health Status Objectives

- 9.3 Reduce deaths caused by motor vehicle crashes to no more than 10.8 per 100,000 people
- 9.4 Reduce deaths from falls and fall-related injuries to no more than 2.3 per 100,000 persons
- 9.5 Reduce drowning deaths to no more than 1.0 per 100,000 persons
- 9.6 Reduce residential fire deaths to no more than 0.5 per 100,000 people
- 9.9 Reduce non-fatal head injuries so that hospitalizations from these injuries are no more than 106 per 100,000 persons

Risk Reduction Objectives

- 9.12 Increase the use of occupant protection systems, such as seatbelts, inflatable safety restraints, and child safety seats, to at least 85 percent of motor vehicle occupants
- 9.13 Increase use of helmets to at least 80 percent of motorcyclists and 50 percent of bicyclists

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



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------------------|---------------------|-------------------------|---------------------|
| 19.2 per 100,000 (1990) | 16.8 per 100,000 | 12.2 per 100,000 (1990) | 10.8 per 100,000 |

Source: Division of Chronic Disease and Injury Prevention, Health Surveillance and Planning, Department of Public Health and Addiction Services

Data

Limitations: Local figures will reflect place of deceased's residence, not the place of the accident.

Rationale: Motor vehicle crashes (including motor vehicle occupants, motorcyclists, bicyclists and pedestrians) are the leading cause of death overall for Connecticut residents, one to 34 years of age. They are also a leading cause of hospitalization. Alcohol plays a major role in motor vehicle crashes; in Connecticut during 1990, over 40 percent of drivers involved in fatal crashes were intoxicated. This percentage is even higher for young drivers.

Special Population Targets

Children 14 years and younger

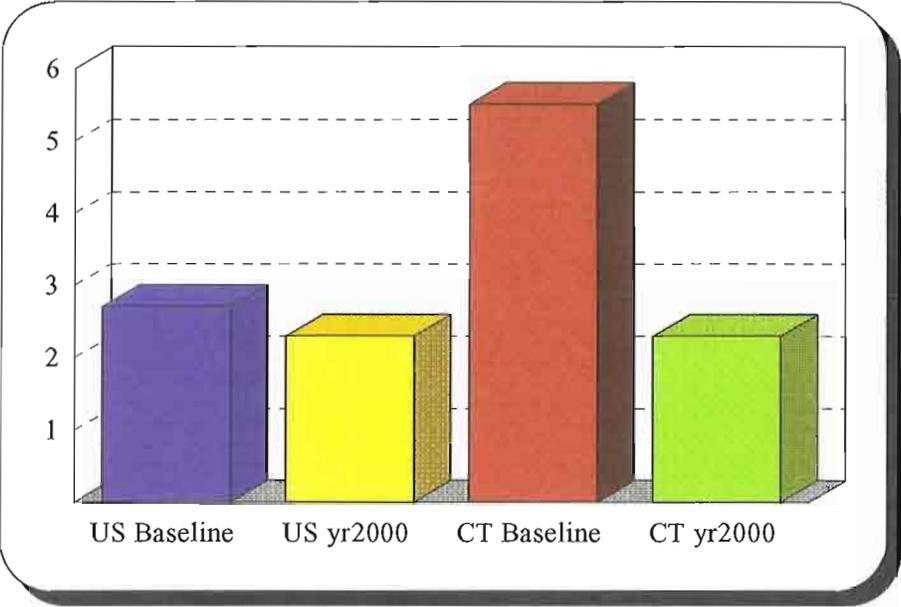
Youth aged 15-24

People aged 70+

Motorcyclists

Pedestrians

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



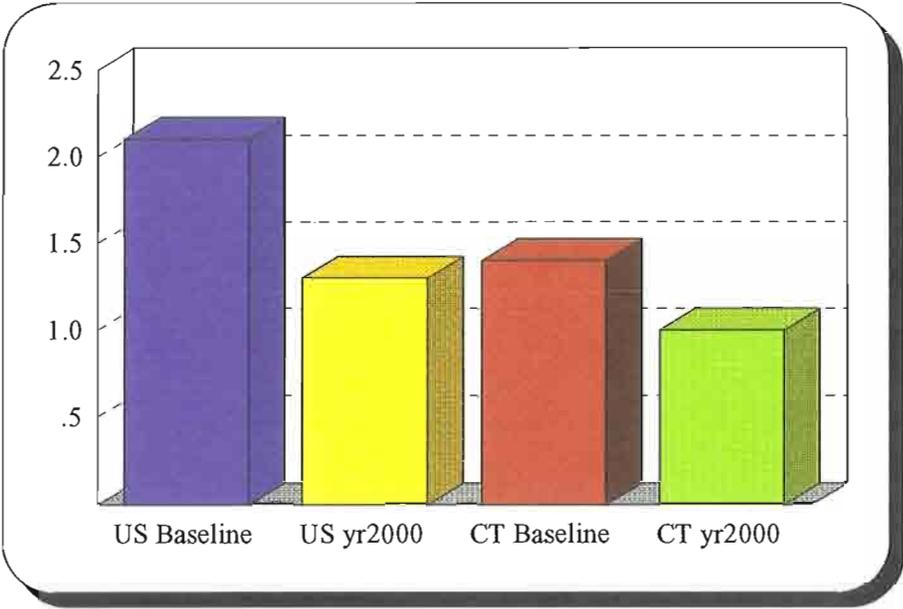
| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------------|---------------------|------------------------|---------------------|
| 2.7 per 100,000 | 2.3 per 100,000 | 5.5 per 100,000 (1990) | 2.3 per 100,000 |

Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

Data Limitations:

Rationale: Falls are the leading cause of injury-related hospitalization in Connecticut for children under the age of 15 and the second leading cause for 15 to 19 year olds. The highest death rates from falls are among Connecticut residents over the age of 70.

Objective 9.5: Reduce drowning deaths to no more than 1.0 per 100,000 persons



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------------|---------------------|------------------------|---------------------|
| 2.1 per 100,000 | 1.3 per 100,000 | 1.4 per 100,000 (1989) | 1.0 per 100,000 |

Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

Data

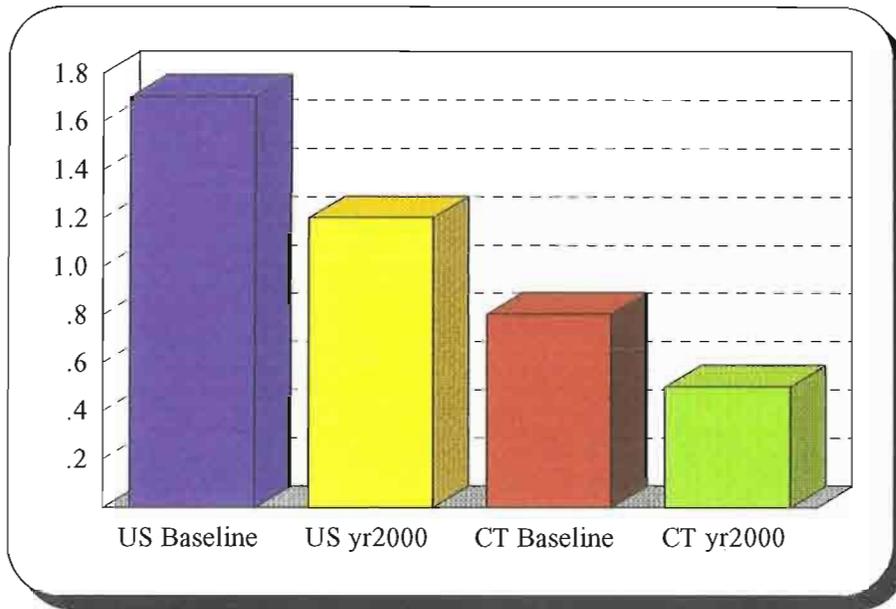
Limitations:

Rationale: Drowning is one of the leading causes of injury-related death for children, adolescents and young adults in Connecticut. Approximately 86 percent are males and 20 percent are minority males.

Special Target Populations

- Children aged 4 and younger
- Men aged 15-34
- Black Males

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



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------------|---------------------|-----------------|---------------------|
| 1.7 per 100,000 | 1.2 per 100,000 | 0.8 per 100,000 | 0.5 per 100,000 |

Source: Division of Chronic Disease and Injury Prevention, Health Surveillance and Planning, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Fire and burn-related injuries are one of the leading causes of injury-related death in Connecticut among children less than ten years old. Older persons also have higher death rates. The poor, urban residents, and minorities are at increased risk. Cigarettes are the major cause of fatal residential fires.

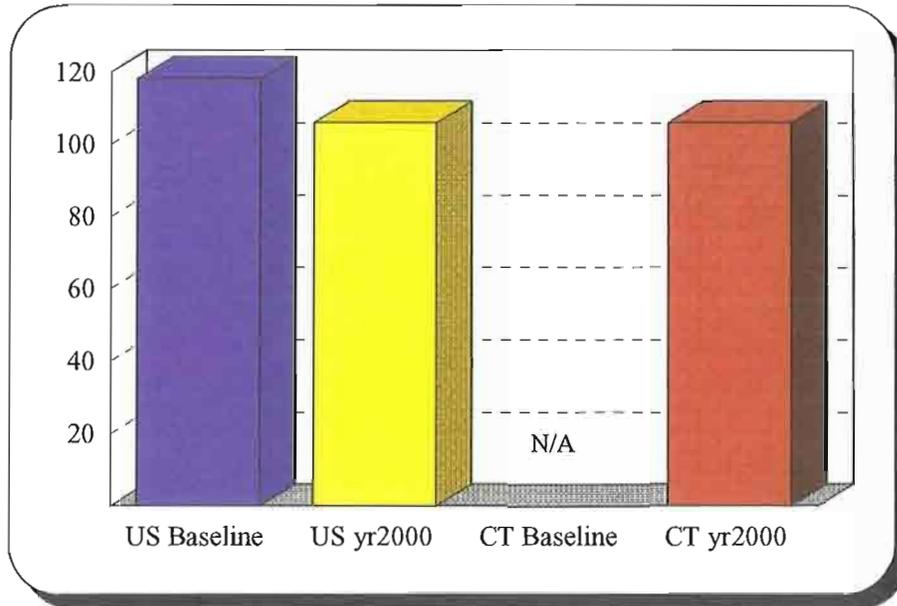
Special Target Populations

- Children aged 4 and younger
- People aged 65+
- Black Males
- Black Females

Type-Specific Targets

- Residential fires caused by smoking

Objective 9.9: Reduce non-fatal head injuries so that hospitalizations from these injuries are no more than 106 per 100,000 persons



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------------------|-------------------------|------------------------------|-------------------------|
| 118 per 100,000 persons | 106 per 100,000 persons | Available from CHIME in 1994 | 106 per 100,000 persons |

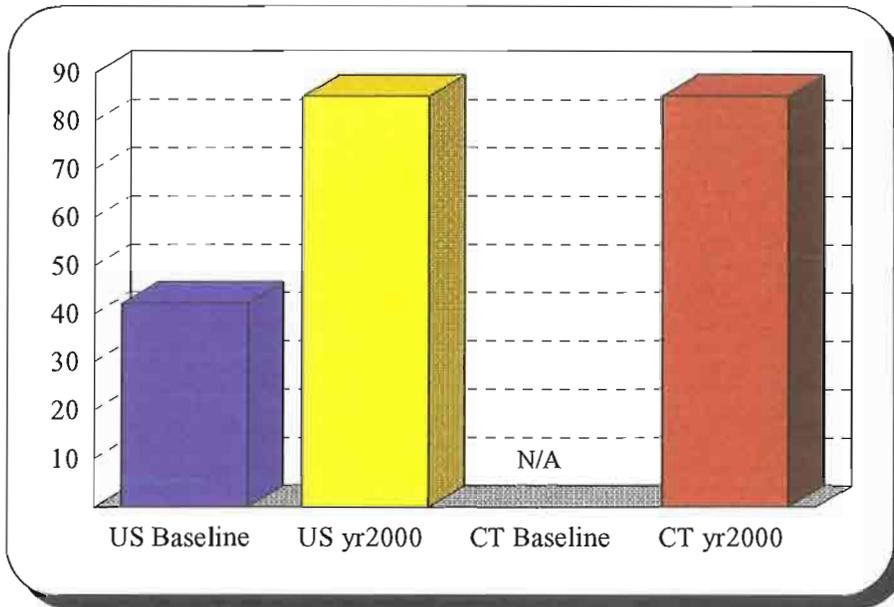
Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

Data

Limitations: Baseline data will not be available until the Connecticut Health Information Management Exchange (CHIME) report in 1994. Due to the lack of baseline data, the Federal Year 2000 Target is being used.

Rationale: Head injuries are the most common severe disabling injuries in the United States. The most common underlying causes include motor vehicle, motorcycle, bicycle, recreational and violence-related.

Objective 9.12: Increase the use of occupant protection systems, such as seatbelts, inflatable safety restraints, and child safety seats, to at least 85 percent of motor vehicle occupants



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|-------------------|---------------------|
| 42% in 1988 | 85% | No data available | 85% |

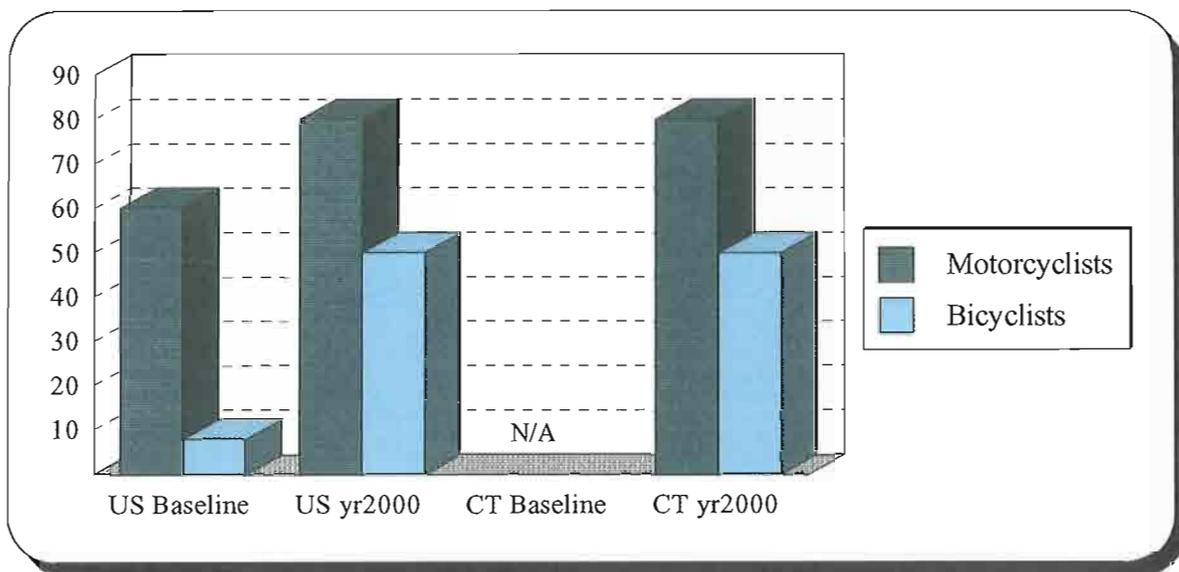
Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Approximately half of all fatalities and serious injuries in motor vehicles could be prevented by correct use of lap/shoulder safety belts. A safety belt used in conjunction with an air bag provides even greater protection. Correctly used child safety seats are 71 percent effective in preventing fatalities to young children and 67 percent effective in reducing the need for hospitalization.

Objective 9.13: Increase the use of helmets to at least 80 percent of motorcyclists and 50 percent of bicyclists



| Type of Transportation | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------------------|-------------|---------------------|-------------------|---------------------|
| Motorcyclists | 60% | 80% | No data available | 80% |
| Bicyclists | 8% | 50% | No data available | 50% |

Source: Division of Chronic Disease and Injury Prevention, Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Head injury is the leading cause of death in both bicycle and motorcycle crashes. Bicycle injuries are a major cause of injury-related hospitalizations for five to fourteen year olds in Connecticut. Bicycle helmets can prevent 85 percent of serious head injuries. Unhelmeted motorcyclists are twice as more likely than helmeted riders to incur a fatal head injury and three times more likely to receive a nonfatal head injury. In the State of Connecticut, since October 1, 1993, children under the age of 12 years are required to wear an approved bicycle helmet while riding their bicycles on any street in the state.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 10 - OCCUPATIONAL SAFETY AND HEALTH

There are approximately 1.3 million workers in Connecticut. The Environmental Epidemiology and Occupational Health Division (EEOH) of DPHAS is concerned with the evaluation of potential exposures in occupational settings. The EEOH has continued to develop its capacity to monitor occupational health, such as adult lead poisoning. In 1992, 2,409 occupational diseases of all types were reported. The "Occupational Health Clinics Bill" has provided money to EEOH to help set up a state program for occupational disease surveillance that was enhanced with a grant from the National Institute of Occupational Safety and Health. EEOH continued its research into lead exposure in bridge construction workers in conjunction with a five year grant obtained from Yale University. EEOH will place an emphasis on conducting educational workshops and follow-up on clusters of occupational disease in the workplace.

Chapter 10 - OCCUPATIONAL SAFETY AND HEALTH

Selected Objectives

OBJ. 1 OBJECTIVE DESCRIPTION

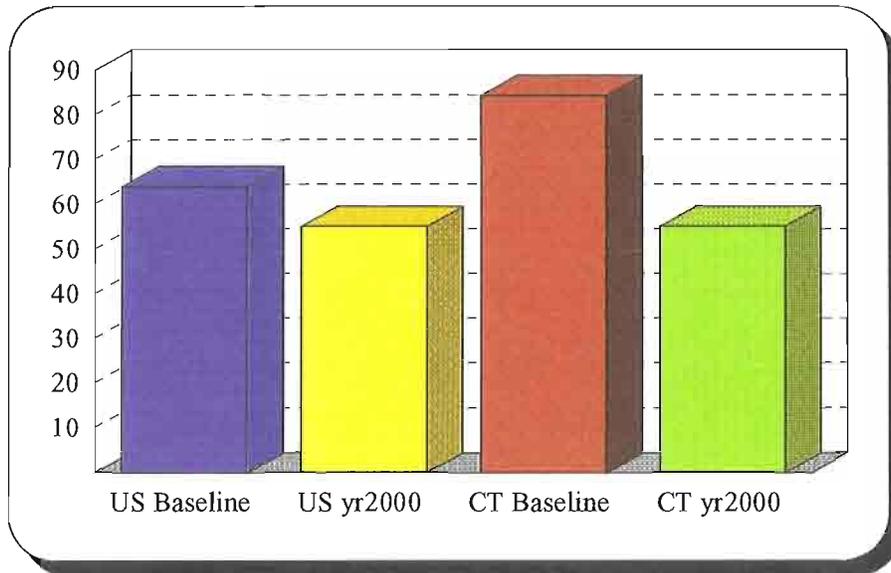
Health Status Objectives

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

Risk Reduction Objectives

- 10.8 Eliminate exposures which result in workers having blood lead concentrations greater than 25µg/dl of whole blood

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



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------------------|---------------------|--------------------------|---------------------|
| 64 per 100,000 (1990) | 55 per 100,000 | 84.3 per 100,000 (1990)* | 55 per 100,000 |

Source: Environmental Epidemiology and Occupational Health Division, Department of Public Health and Addiction Services

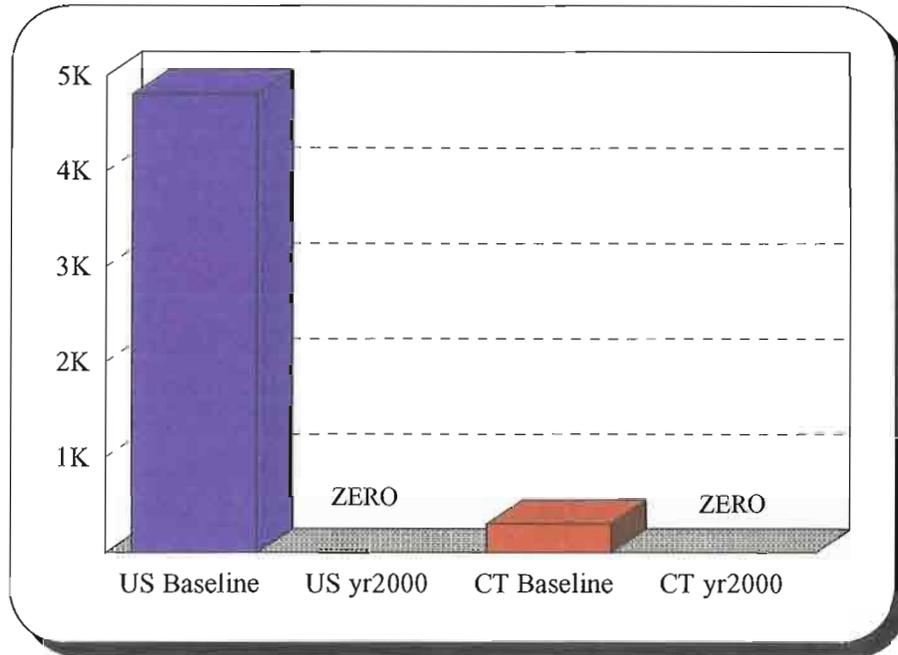
Data

Limitations:

Rationale: Skin diseases are not the most common and preventable occupational diseases. Proper surveillance and intervention can reduce these diseases.

*Based on survey and estimate in 1990 Occupational Diseases in Connecticut report and Bureau of Labor Statistics. U.S. Government Accounting Office, Human Resource Div. "Assuring Accuracy in Employer Injury and Illness", B-232872.

Objective 10.8: Eliminate exposures which result in workers having blood lead concentrations greater than 25µg/dl of whole blood



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|---------------|---------------------|-------------|---------------------|
| 4,804 workers | 0 | 300* | 0 |

Source: Environmental Epidemiology and Occupational Health Division, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Adult lead poisoning is one of the most widespread occupational diseases in Connecticut. Proper surveillance and intervention can eliminate this risk. This objective may be difficult to measure due to present standards on reporting lead exposures.

*This figure is based upon 4,804 workers with blood lead levels above 25µg/dl in seven states, 1988 (Healthy People 2000, 1990; Occupational Diseases in Connecticut, 1990).

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 11 - ENVIRONMENTAL HEALTH

The environment plays a large role in the health and well-being of Connecticut's residents. Some areas of concern are water safety, air pollution, blood lead levels, and radon.

The State's effort to protect its water supply has paid off by a lack of outbreak of waterborne diseases caused by infectious agents. Connecticut is also above the national average for fluoridation of its water supplies.

In the area of air pollution, Connecticut lacks the data on the relationship between asthma morbidity and air quality. Air pollution in Connecticut is partially affected by air pollution drifting from neighboring states.

Because of a change in the reporting requirements for high blood lead levels the total number of reports with people having high blood lead levels, has increased. The criteria for reporting lead exposure in children and adults have also changed. Any child with a lead blood level of 10 μ g/dl or above must be reported to the state, and subsequently, the child's housing situation must be evaluated for lead. Any adult with a blood lead level of 25 μ g/dl or above must also be reported to the state.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 11 - ENVIRONMENTAL HEALTH

Selected Objectives

OBJ. 1 OBJECTIVE DESCRIPTION

Health Status Objectives

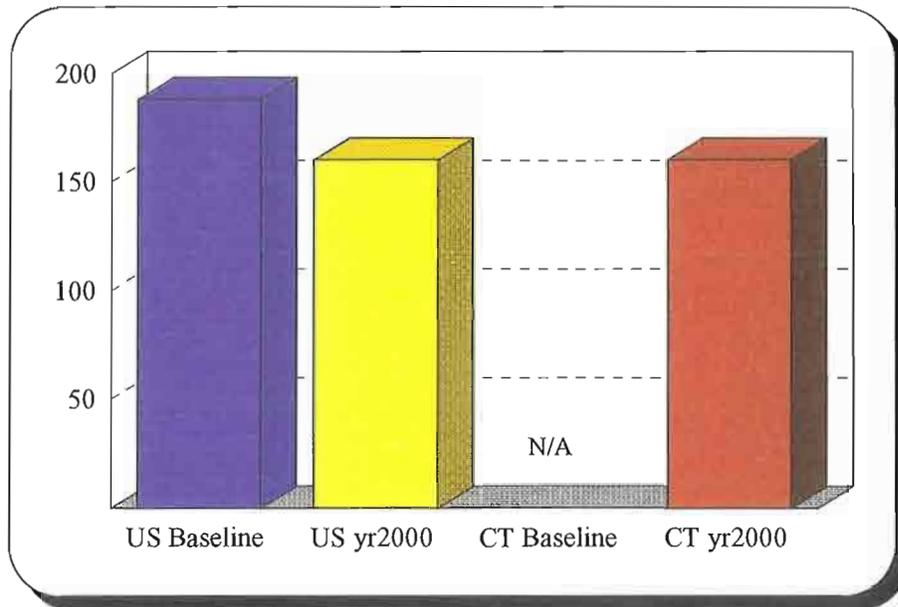
- 11.1 Reduce asthma morbidity, as measured by a reduction in asthma hospitalizations, to no more than 160 per 100,000 people
- 11.3 Eliminate outbreaks of waterborne disease from infectious agents and chemical poisoning
- 11.4 Reduce prevalence of blood lead levels exceeding 10µg/dl among children aged six months through five years to no more than 13,000

Risk Reduction Objectives

- 11.5 Reduce the human exposure to criteria air pollutants, as measured by an increase to at least 85 percent in the proportion of people who live in counties that have not exceeded any Environmental Protection Agency standard for air quality in the previous 12 months
- 11.6 Increase to at least 50 percent the proportion of homes in which homeowners and to at least 75 percent the proportion of homes in which occupants have tested for radon concentrations and that have either been found to pose minimal risk or have been modified to reduce the risk to health
- 11.9 Increase to 100 percent the proportion of people who receive a supply of public drinking water that meets the safe drinking water standards established by the Environmental Protection Agency
- 13.9* Increase to 100 percent the proportion of people served by community water systems providing optimal levels of fluoride

* This is an environmental health objective from chapter 13 in the Healthy People 2000 report.

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



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------------|---------------------|-------------------|---------------------|
| 188 per 100,000 | 160 per 100,000 | No data available | 160 per 100,000 |

Source: Environmental Epidemiology and Occupational Health Division, Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

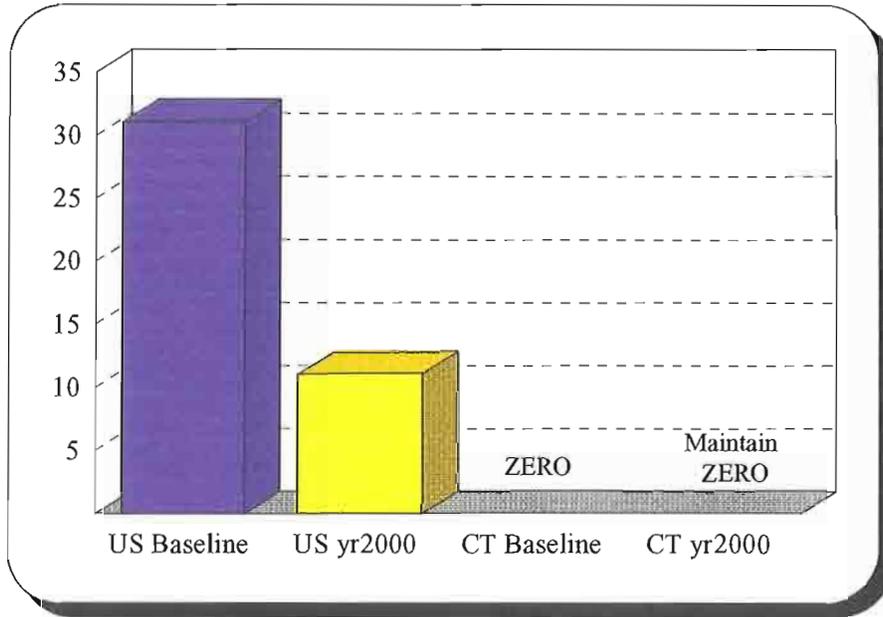
Rationale: Asthma is known to be highly influenced by environmental factors especially ambient air pollution.

Special Population Target

Children (aged 14 and younger)

Minorities

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



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------------------|---------------------|-------------|----------------------|
| 31 outbreaks (1981-88) | 11 per year | 0 | maintain 0 outbreaks |

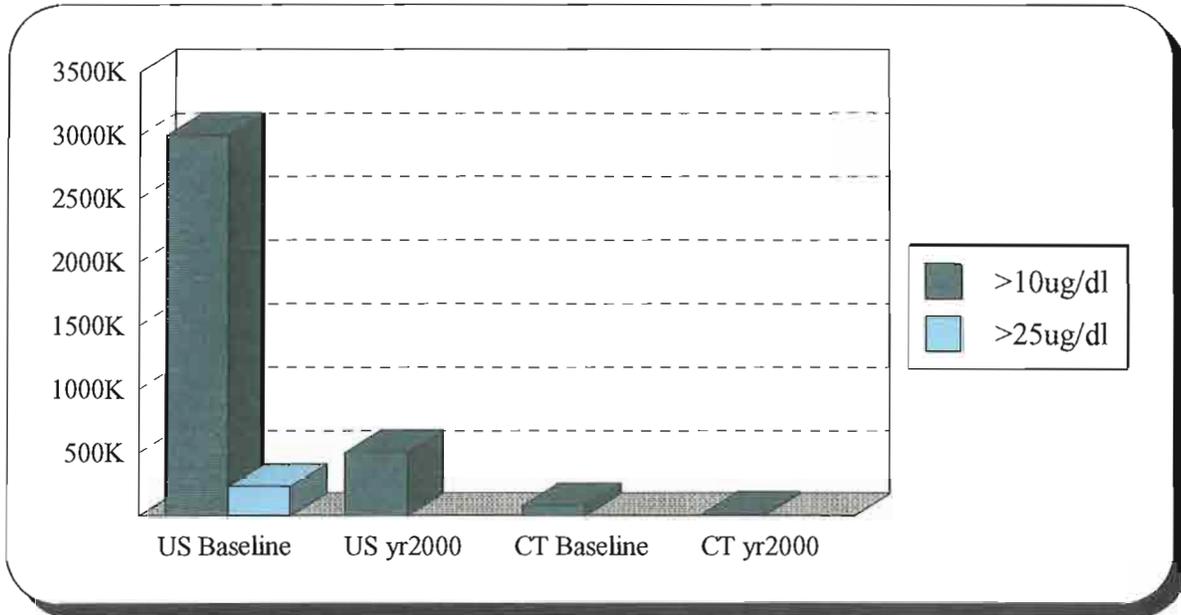
Source: Water Supply Section, Environmental Health Division, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: This objective is related to the public water supply program. Connecticut is ahead of the nation and most other states. The preventive/enforcement activities of the program must be maintained to assure a safe adequate supply of drinking water to the residents of Connecticut.

Objective 11.4: Reduce the prevalence of blood lead levels exceeding 10µg/dl among children aged six months through five years to no more than 13,000



| Concentration | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|---------------|-------------|---------------------|-------------|--------------------------------------|
| >10µg/dl | 3,000,000 | 500,000 | 80,000* | 13,000 children with BLL of >10µg/dl |
| >25µg/dl | 234,000 | 0 | | |

Source: Environmental Health Division, Department of Public Health and Addiction Services

Data

Limitations:

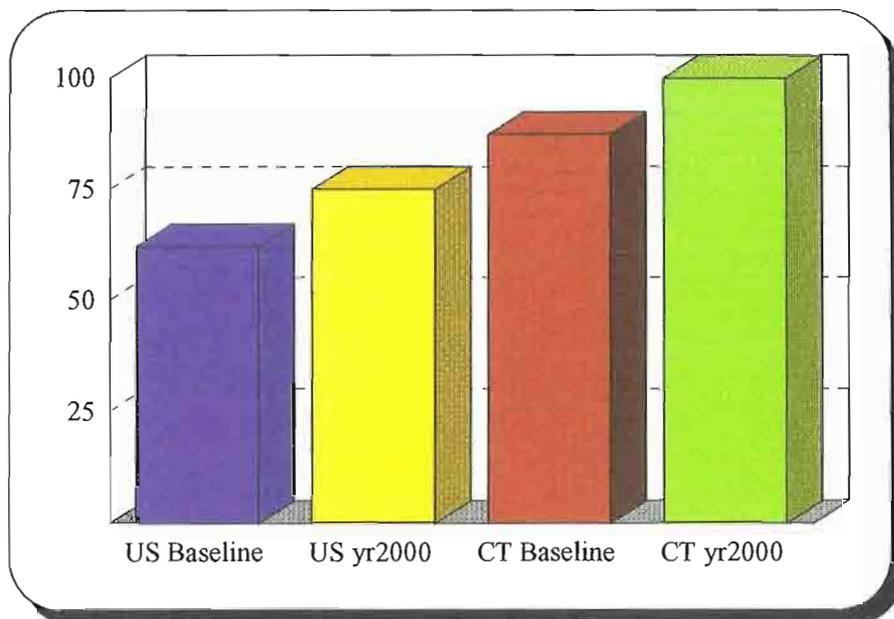
Rationale: Reducing elevated blood lead levels improves children's health, cognitive development, IQ, hearing and kidney function.

*CDC (Centers for Disease Control) statement, Preventing Lead Poisoning in Young Children, Oct. 1991

Special Target Population

Inner-city low income black children

Objective *13.9: Increase to 100 percent the proportion of people served by community water systems providing optimal levels of fluoride



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|-------------|---------------------|
| 62% | 75% | 87.2% | 100% |

Source: Environmental Epidemiology and Occupational Health Division, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: This objective is related to the public water supply program. Connecticut is ahead of the nation and most other states. The preventive/enforcement activities of the program must be maintained to assure a safe, adequate supply of drinking water to the residents of Connecticut. Fluoridation available to a larger percentage of the population can be accomplished by modifying current legislation.

*This objective is from Chapter 13 in the Healthy People 2000 report.

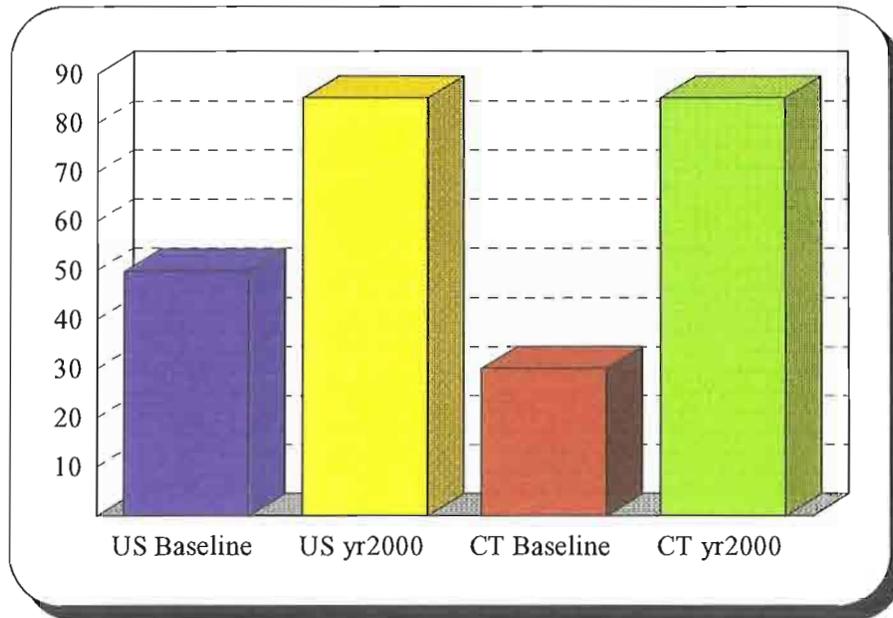
Chapter 12 - FOOD AND DRUG SAFETY

Although Connecticut and the United States have strict food and drug laws to protect the public, there are still daily outbreaks of foodborne illness. In rare cases these illnesses can sometimes take lives.

The Department of Public Health and Addiction Services seeks to reduce the public health risk of foodborne illness by ensuring reasonable protection from contaminated food and by improving the sanitary conditions of food-handling operations.

In Connecticut, the local health departments have the authority and the responsibility for providing direct services in the form of regulatory oversight for food service establishments, e.g., inspection and outbreak investigations. The primary role of the Department of Public Health and Addiction Services is to promulgate regulations, provide regulatory interpretations, train, certify and recertify local food inspectors at local health departments, and serve as consultants to local health officials on a wide range of retail food issues. The Food Protection Program's approach to food safety (i.e., foodborne disease prevention) is to target the key risk factors that cause foodborne illness.

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



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------------|---------------------|--------------------|---------------------|
| 49.7% (1988) | 85% | Approx. 30% (1989) | 85% |

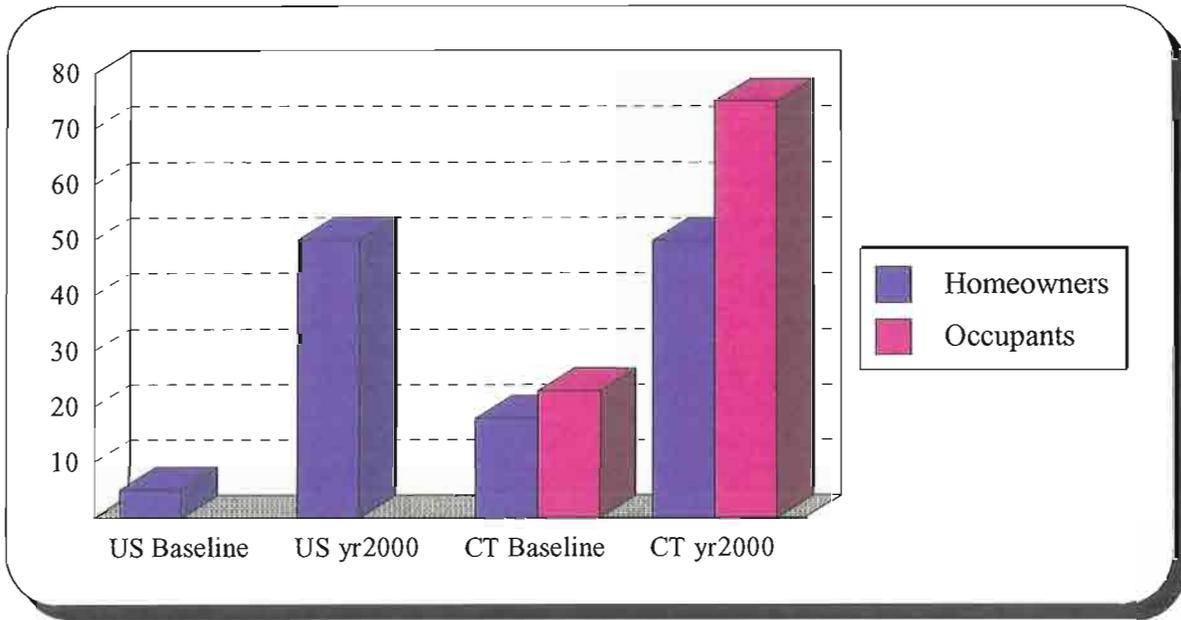
Source: Environmental Epidemiology and Occupational Health Division, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Connecticut has some of the worst ambient air pollution problems in the country, especially for ozone. Much of this pollution is from out of state. Reduction will result in health improvements, especially for asthmatics. This objective primarily relates to one of the primary missions of the Connecticut Department of Environmental Protection which has linkages to the Department of Public Health and Addiction Services, Bureaus of Health Promotion and Laboratory.

Objective 11.6: Increase to at least 50 percent the proportion of homes in which homeowners and at least 75 percent the proportion of homes in which occupants have tested for radon concentrations and that have either been found to pose minimal risk or have been modified to reduce the risk to health



| People | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------|-------------|---------------------|-------------|---------------------|
| Homes | <5% | 50% | 18%* | 50% |
| Occupants | | | 23%* | 75% |

Source: Environmental Epidemiology and Occupational Health Division, Department of Public Health and Addiction Services

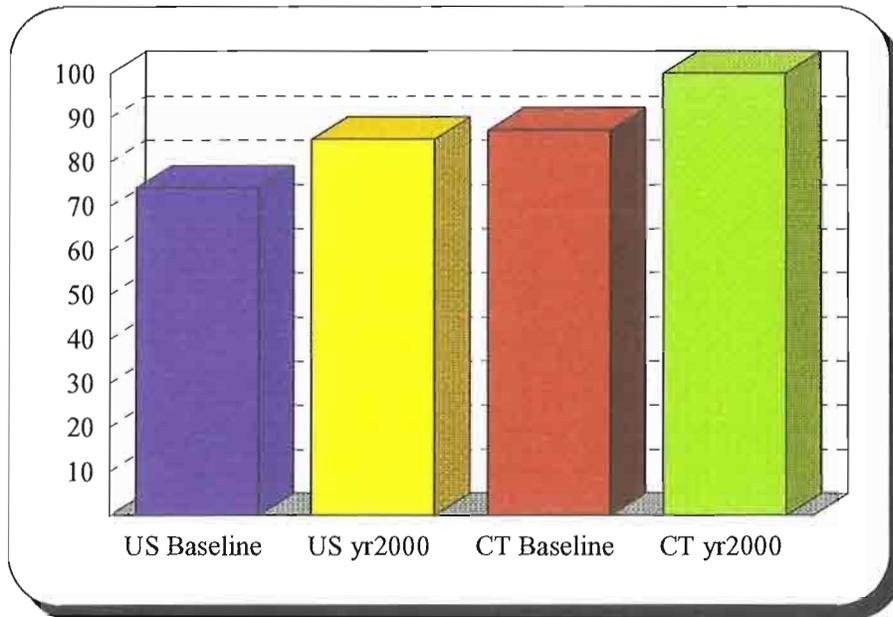
Data

Limitations:

Rationale: Radon is an odorless, colorless, naturally occurring gas that can enter a building through the air or water. It is a known human lung carcinogen and evidence is building about its role in the development of gastrointestinal cancer. Reducing radon exposure through testing, mitigation, education and construction standards could reduce lung cancer cases in Connecticut by 300 per year.

*Conference of Radiation Control Program Direction, Inc. (CRCPD) 1993 Survey

Objective 11.9: Increase to 100 percent the proportion of people who receive a supply of public drinking water that meets the safe drinking water standards established by the Environmental Protection Agency



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|-------------|---------------------|
| 74% | 85% | 87% | 100% |

Source: Environmental Epidemiology and Occupational Health Division, Connecticut Department of Public Health and Addiction Services

Data

Limitations:

Rationale: This objective is related to the public water supply program. Connecticut is ahead of the nation and most other states. The preventive/enforcement activities of the program must be maintained to assure a safe, adequate supply of drinking water to the residents of Connecticut.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 12 - FOOD AND DRUG SAFETY
Selected Objectives

OBJ. 1 OBJECTIVE DESCRIPTION

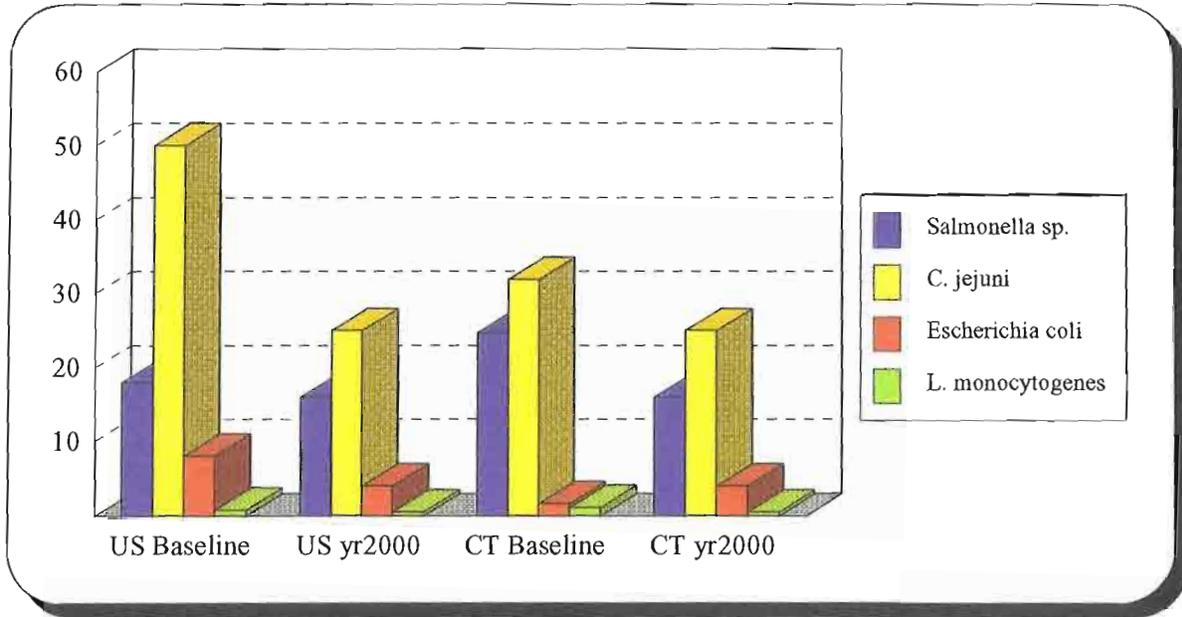
Health Status Objectives

- 12.1 Reduce infections caused by key foodborne pathogens to incidences of no more than:
 Salmonella species 16 per 100,000
 Campylobacter jejune 25 per 100,000
 Escherichia coli 0157:H7 4 per 100,000
 Listeria monocytogenes 0.5 per 100,000
- 12.2 Reduce outbreaks of infections due to *Salmonella enteritidis* to fewer than two outbreaks yearly

Risk Reduction Objectives

- 12.3 Increase to at least 75 percent the proportion of households in which principal food preparers routinely refrain from leaving perishable food out of the refrigerator for over two hours and wash cutting boards and utensils with soap after contact with raw meat and poultry

Objective 12.1: Reduce incidences of infections caused by key foodborne pathogens (see table below for specific CT targets) per 100,000 people



| Pathogen | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|---------------------------------|-------------|---------------------|-------------|---------------------|
| <i>Salmonella species</i> | 18 | 16 | 24.7 (1993) | 16 |
| <i>Campylobacter jejuni</i> | 50 | 25 | 31.9 (1992) | 25 |
| <i>Escherichia coli</i> 0157:H7 | 8 | 4 | 1.6 (1993) | 4 |
| <i>Listeria monocytogenes</i> | 0.7 | 0.5 | 1.1 (1993) | 0.5 |

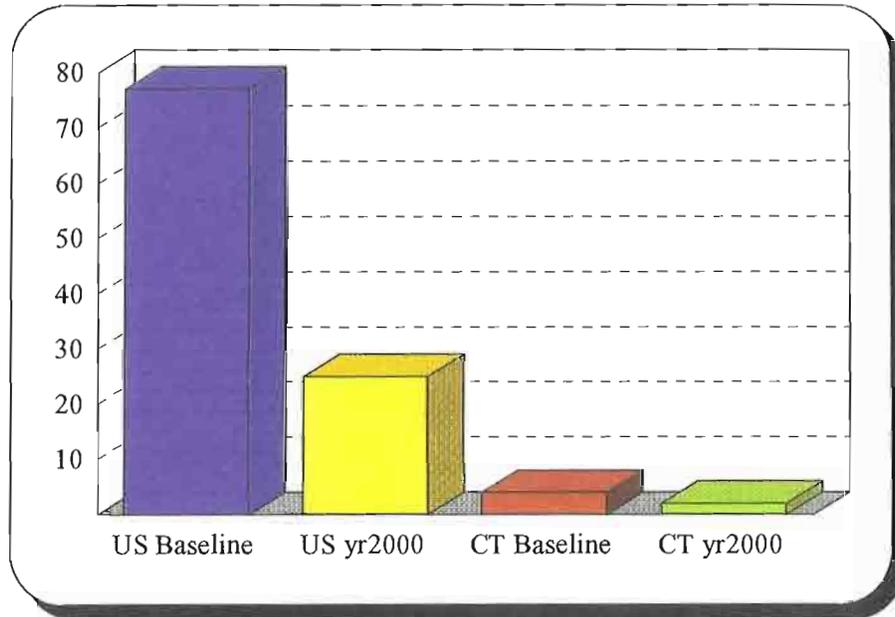
Source: Environmental Health Services Division, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Foodborne disease adversely affects the young, the elderly and the immunocompromised population. Because of improved reporting procedures, more cases are being identified, which will be reflected in the overall goal. Reducing foodborne diseases will reduce disease and unnecessary deaths, and reduce health care costs.

Objective 12.2: Reduce outbreaks of infections due to *Salmonella enteritidis* to fewer than two outbreaks yearly



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|-------------|---------------------|
| 77 | 25 | 4 | 2 |

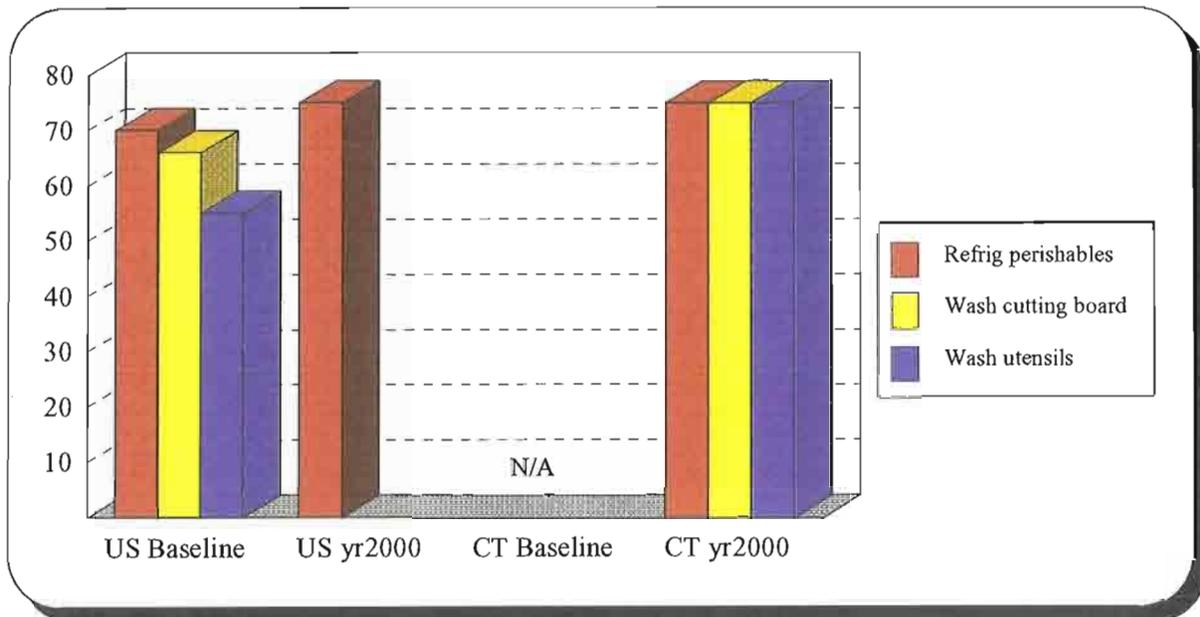
Source: Environmental Health Services Division, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Foodborne disease adversely impacts the young, elderly and the immunocompromised populations. Because of improved reporting procedures, more cases are being identified, which will be reflected in the overall goal. Reducing foodborne disease will reduce disease and unnecessary deaths, and reduce health care costs.

Objective 12.3: Increase to at least 75 percent the proportion of households in which principal food preparers routinely refrain from leaving perishable food out of the refrigerator for over two hours and wash cutting boards and utensils with soap after contact with raw meat and poultry



| Actions | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------------------|-------------|---------------------|-------------|---------------------|
| Refrig. of perishables | 70% | 75% | No data | 75% |
| Wash cutting board | 66% | | " | 75% |
| Wash utensils w/soap | 55% | | " | 75% |

Source: Environmental Health Services Division, Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Most food-borne infections are transmitted because of inadequate refrigeration of food and failure to clean cutting boards and utensils properly.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 14 - MATERNAL AND INFANT HEALTH

Improving the health of Connecticut's mothers and infants falls within the scope of the Department of Public Health and Addiction Service's maternal/infant health programs. Pregnancy-related health issues such as inadequate or no prenatal care, poor nutrition, inadequate weight gain, substance abuse (use of tobacco, alcohol, and other drugs), age at first pregnancy, and interval between pregnancies, can contribute to perinatal morbidity, low birth weight and infant mortality. These problems are even more pronounced in the State's minority population, in which low birth weight and infant mortality rates exceed those of many third-world countries. Health status is also affected by social/environmental problems such as undocumented aliens, homelessness, and violence.

The Department is committed to addressing these issues through its programs that target pregnant women and infants, with particular emphasis on teens, minorities, uninsured women and children in areas of high unemployment and poverty in Connecticut. Our goal is to develop strategies to assure basic services and access to care for these target groups. To meet this goal we have developed linkages with other state agencies, and with our local constituents.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 14 - MATERNAL AND INFANT HEALTH

Selected Objectives

OBJ. 1 OBJECTIVE DESCRIPTION

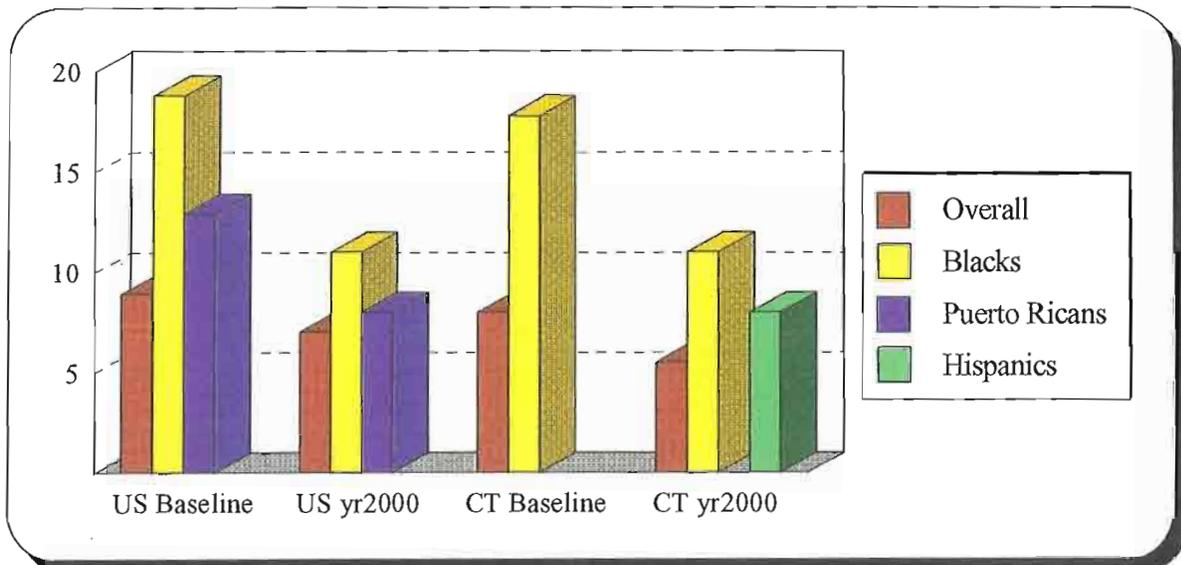
Health Status Objectives

- 14.1 Reduce the overall infant mortality rate to no more than 5.5 per 1,000 live births
- 14.3 Reduce the maternal mortality rate to no more than 5.3 per 100,000 live births
- 14.4 Reduce fetal alcohol syndrome to no more than 0.12 per 1,000 live births

Risk Reduction Objectives

- 14.5 Reduce low birth weight to an incidence of no more than 5 percent of live births and very low birth weight to no more than 1 percent of live births
- 14.6 Increase to at least 85 percent the proportion of mothers who achieve the minimum recommended weight gain during their pregnancies
- 14.7 Reduce severe complications of pregnancy to no more than 15 per 100 deliveries
- 14.10 Increase abstinence from tobacco use by pregnant women by at least 90 percent and increase abstinence from alcohol, cocaine, and marijuana by pregnant women by at least 20 percent

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



| Race/Ethnicity | US Baseline | US 2000 Target | CT Baseline | CT 2000 Target |
|----------------|----------------|----------------|------------------|----------------|
| Overall | 8.9 per 1,000 | 7 per 1,000 | 7.9 per 1,000** | 5.5 per 1,000 |
| Blacks | 17.9 per 1,000 | 11 per 1,000 | 17.8 per 1,000** | 11 per 1,000 |
| Puerto Ricans | 12.9 per 1,000 | 8 per 1,000 | N/A | N/A |
| Hispanics* | N/A | N/A | N/A | 8 per 1,000 |

Source: Community Health Services/Maternal and Infant Health, Department of Public Health and Addiction Services

Data

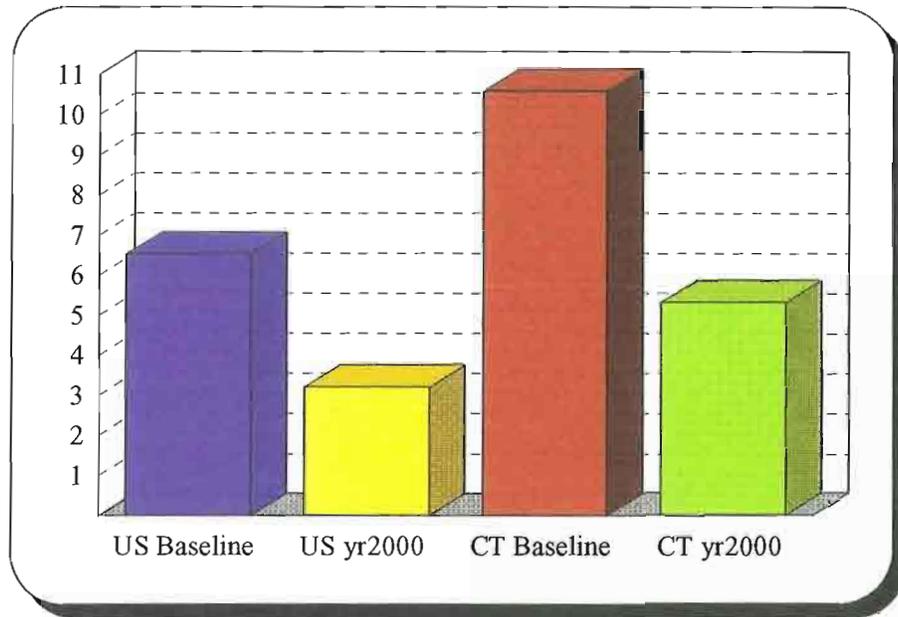
Limitations:

Rationale: Infant mortality rate is widely used to measure and compare the health of communities, states and nations. In Connecticut, some cities have an infant mortality rate more than twice the state average; Connecticut ranked 5th highest out of the six New England states and 17th for all states in 1989; and the U.S. ranks 21st out of 28 countries with an infant mortality rate of less than 15. Historically, Blacks have had infant mortality rates about double those of Whites. Recent trends do not show the Black-White gap narrowing. Indeed the gap may be widening. Therefore, the stated objectives for Blacks may be overly optimistic for both Connecticut and the nation.

*1990

**Mothers of Hispanic ethnicity are identified based on information from linked birth-infant death files. Although the Healthy People 2000 objective 13.1c identifies "Puerto Rican" ethnicity, the more general classification "Hispanic," is used here because it is used in standard NCHS tabulations.

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



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------------|---------------------|----------------------------|---------------------|
| 6.6 per 100,000 | 3.3 per 100,000 | 10.5 per 100,000 (1992) | 5.3 per 100,000 |

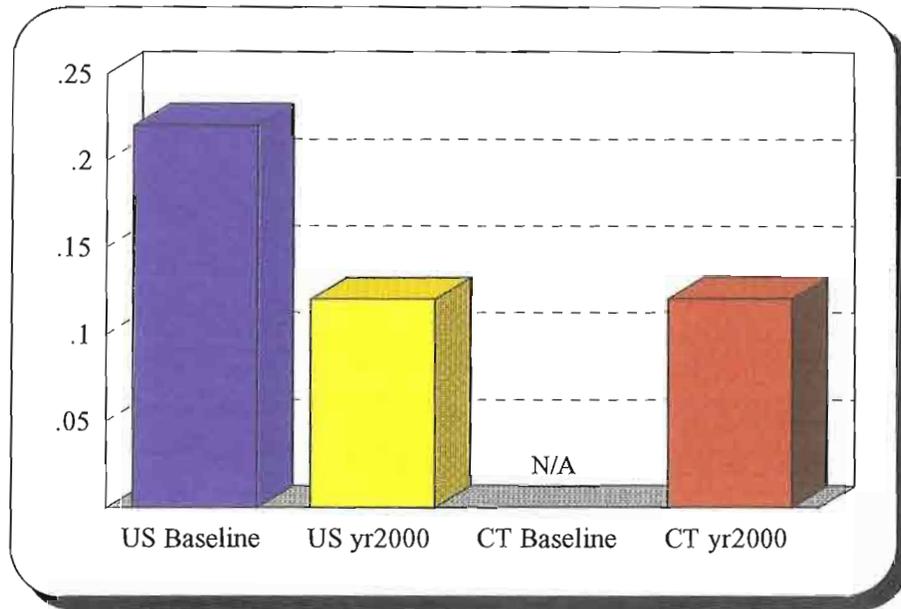
Source: Community Health Services/Maternal and Infant Health, Department of Public Health and Addiction Services

Data

Limitations: As in other states, Connecticut's maternal mortality cases may be significantly underreported.

Rationale: Nationally, a high proportion of maternal deaths are considered preventable. Maternal death reviews contribute to an understanding of risk factors of maternal death and evaluation as well as improvement in the quality of care.

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



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------------------|---------------------|-------------------|---------------------|
| 0.22 per 1,000 (1987) | 0.12 per 1,000 | No data available | 0.12 per 1,000 |

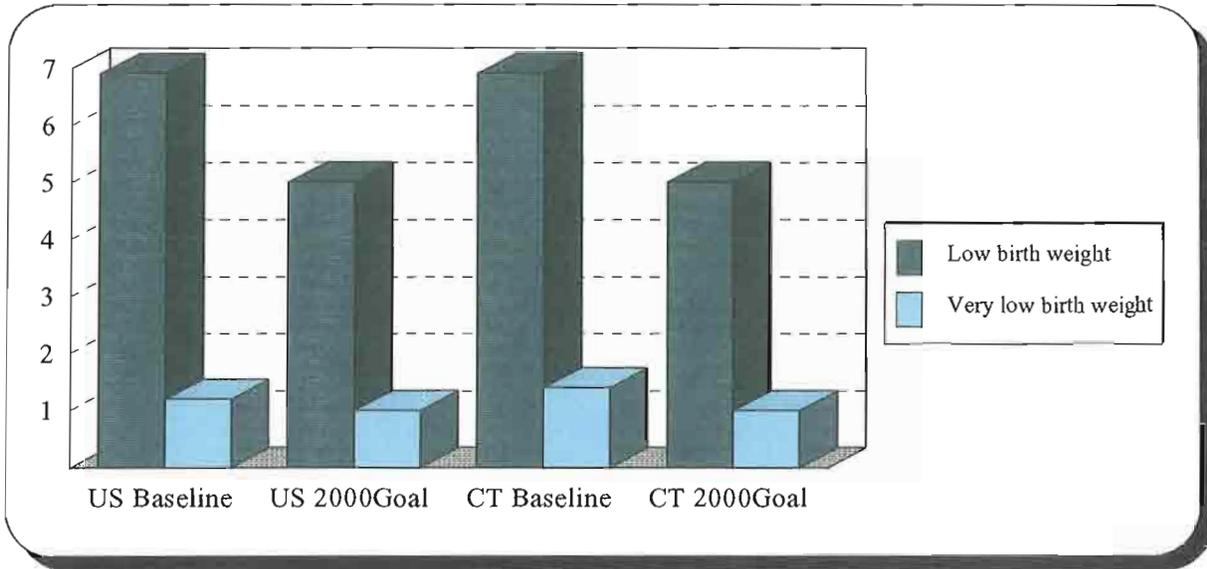
Source: Community Health Services/Maternal and Infant Health, Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Fetal Alcohol Syndrome (FAS) is the leading cause of preventable birth defects in the US today. Approximately 5,000 babies born in the US have FAS, another 50,000 have fetal alcohol effects (FAE), and cost of caring for these infants is nearly a billion dollars a year. Children born with FAS usually suffer alcohol withdrawal, central nervous system damage, growth deficiencies, facial and skeletal malformations and learning and behavioral problems. FAE children have milder versions of the same problems as FAS children and often go unrecognized and do not get the services they need.

Objective 14.5: Reduce low birth weight to an incidence of no more than five percent of live births and very low birth weight to no more than one percent of live births



| Birth weight | US Baseline | US 2000 Target | CT Baseline | CT 2000 Target |
|-----------------------|-------------|----------------|-------------|----------------|
| Low Birth Weight | 6.9% (1987) | 5% | 6.9% (1991) | 5% |
| Very Low Birth Weight | 1.2% | 1% | 1.4% (1989) | 1% |

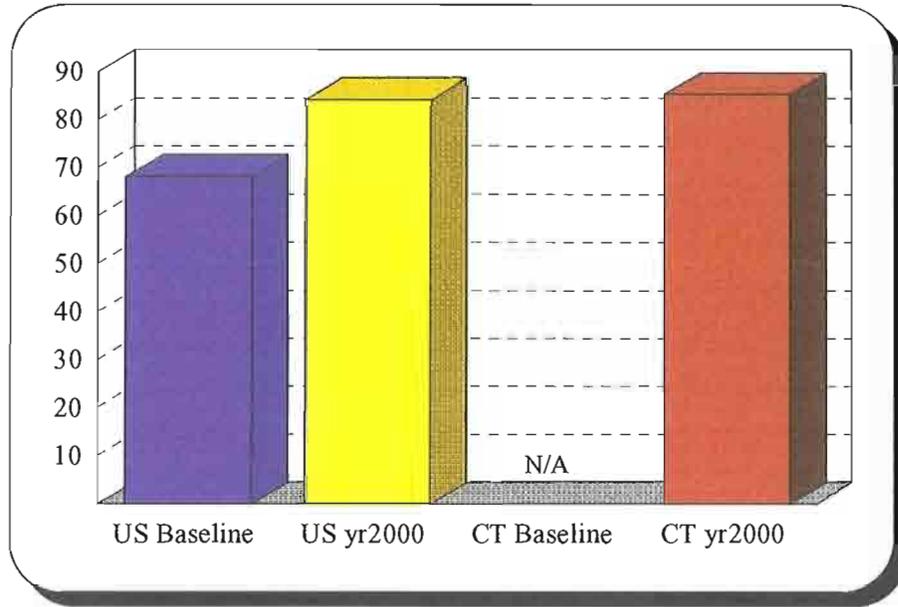
Source: Community Health Services/Maternal and Infant Health, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Low birth weight is defined as infants weighing <2,500 grams at birth, and very low birth weight is defined as infants who weigh <1,500 grams at birth. Medical care costs for low birthweight infants can average \$30,000. Low birthweight infants are at greater risk for death, health problems, developmental disorders and other handicapping conditions. Prevention of low birth weight can be achieved through a number of strategies, such as improving access to family planning and prenatal care, preterm birth prevention programs, smoking cessation, substance abuse programs, nutrition programs (e.g., WIC), etc.

Objective 14.6: Increase to at least 85 percent the proportion of mothers who achieve the minimum recommended weight gain during their pregnancies



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|-------------------|---------------------|
| 68% (1980) | 85% | No data available | 85% |

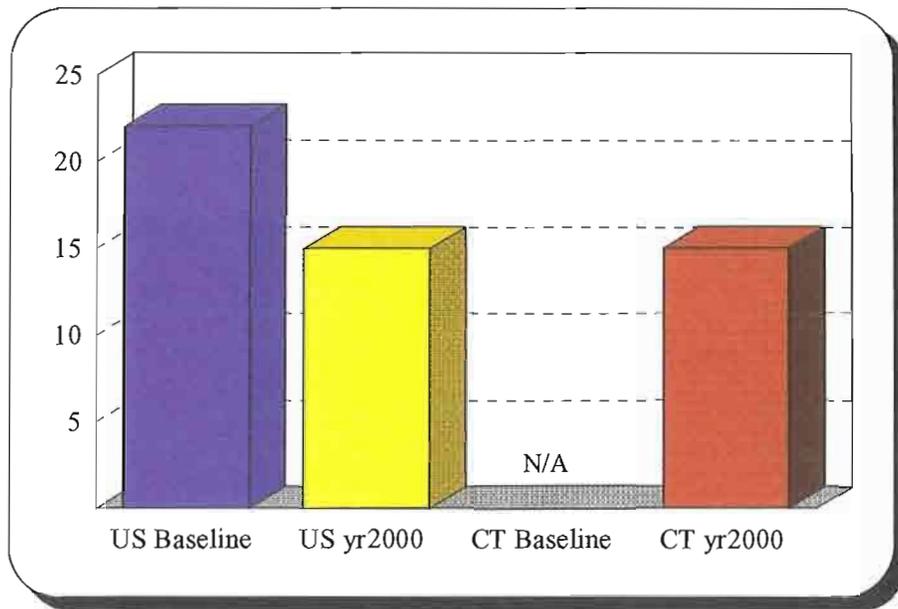
Source: Community Health Services/Maternal and Infant Health, Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Good nutrition during pregnancy promotes maternal weight gain, which helps reduce low birth weight and its resulting complications.

Objective 14.7: Reduce severe complications of pregnancy to no more than 15 per 100 deliveries



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------------|---------------------|-------------------|---------------------|
| 22/100 deliveries | 15 per 100 | No data available | 15 per 100 |

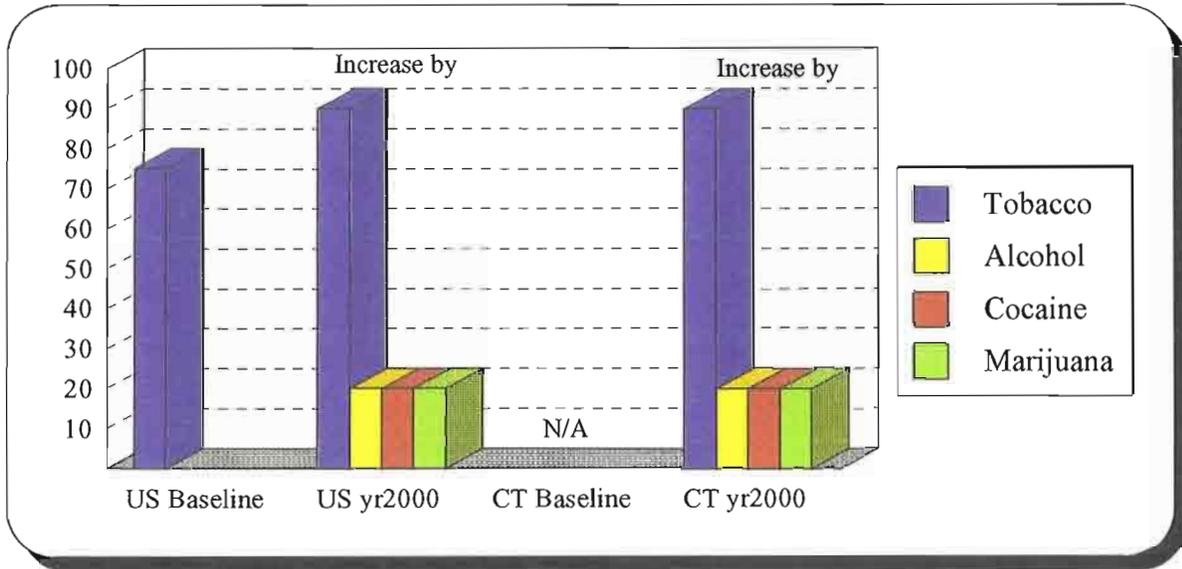
Source: Community Health Services/Maternal and Infant Health, Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Adequate protein intake during pregnancy can help prevent toxemia; impact of gestational diabetes is reduced through optimal nutrition. This objective will be measured using hospitalizations due to pregnancy-related complications.

Objective 14.10: Increase abstinence from tobacco use by pregnant women to 90 percent and increase abstinence from alcohol, cocaine and marijuana use by pregnant women to 20 percent



| Drug | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------|-------------|---------------------|-------------------|---------------------|
| Tobacco | 75% | 90% | No data available | 90% |
| Alcohol | | 20% | | 20% |
| Cocaine | | 20% | | 20% |
| Marijuana | | 20% | | 20% |

Source: Community Health Services/Maternal and Infant Health, Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Tobacco, alcohol, cocaine and marijuana are toxic to the fetus and can reduce food intake by the mother leading to such problems as fetal alcohol syndrome, low birth weight, and a variety of other poor outcomes.

Chapter 15 - HEART DISEASE AND STROKE

Cardiovascular disease (CVD) is among the leading causes of death in Connecticut. A total of 12,252 state residents died from CVD in 1989, about 1.7 times the number who died from cancer. The broad category of CVD includes coronary heart disease, cerebrovascular disease (stroke), hypertension, atherosclerosis, and peripheral vascular disease.

Mortality rates for CVD vary by a number of factors including race and geographic area of the state. Compared with whites, mortality rates for blacks are 80 percent higher for stroke and 40 percent higher for heart disease. According to the most current data, 21 towns (including the three largest cities) had mortality rates for heart disease that were significantly higher than the state rate. Most of these towns and cities had lower *per capita* incomes than the state as a whole.

Based on national figures, an estimated 800,000 state residents - or about one in four - have some form of CVD. This figure includes people with various forms of heart disease, hypertension, varicose veins, atherosclerosis, and cerebrovascular disease. From U.S. data, the cost of CVD in the state is estimated to be \$1.3 billion or about \$400 per person, about one third of total adult health care expenditures.

Several factors increase the risk of developing cardiovascular disease. Modifiable risk factors are smoking, high blood pressure, elevated blood cholesterol, physical inactivity, obesity, diabetes, and poor response to stress. There are also non-modifiable risk factors such as increasing age, male sex, black race, and a family history of heart disease. In addition, the more risk factors a person has, the higher the risk. For example, a person who smokes and has high blood pressure and high cholesterol increases his/her risk 8-10 times.

An estimated 390,000 Americans die each year from diseases which may be related to smoking, including 115,000 from heart disease and 27,500 from stroke. An additional 37,000 non-smokers are estimated to die of heart disease each year from the effects of passive smoking. In Connecticut, an estimated 4,200 die each year from all smoking related causes, including 1,900 from CVD. Smokers have a 70 percent greater risk than non-smokers of dying from heart disease and twice the risk of stroke. Non-smokers living with smokers have been shown in a number of studies to have a 30 percent increased risk of death from ischemic heart disease or myocardial infarction compared with other non-smokers.

Evidence indicates that smokers of all ages can reap immediate and significant health benefits by quitting smoking. Even among smokers who already have heart disease, smoking cessation can reduce the risk of recurrent heart attack and cardiovascular death. Smoking cessation represents the single most important step that smokers can take to improve the length and quality of their lives.

Approximately one in every three adults in the U.S. is estimated to have high blood pressure or hypertension. Hypertension is the most important risk factor for stroke and a major risk factor for heart disease. According to results from the Framingham Heart Study, the risk of stroke is up to seven times greater for those with uncontrolled high blood pressure measurements and the risk of coronary heart disease is 3-4 times greater. Since hypertension usually produces no clear symptoms, periodic blood pressure measurements are essential for detection and control. While there is no cure for hypertension, treatment with either medication or behavior modification can often prevent related health problems and prolong life.

Obesity is usually defined as having weight 20 percent or more above desirable weight as obtained from life insurance tables of height and weight. Obesity is not only a risk factor for CVD, but it also increases the risk of hypertension and elevated blood cholesterol. People who are 10 percent over

Chapt. 15 - Heart Disease and Stroke

p. 15-4

their ideal weight are more likely to develop heart disease and stroke even if they have no other risk factors. Weight loss is one of the chief methods one can use to reduce CVD risk.

Elevated levels of cholesterol can accelerate development of fatty deposits on arteries, which may eventually block blood flow and lead to a heart attack or stroke. High blood cholesterol has been shown in a number of studies to be related to an increased risk of coronary heart disease and has been called a major cause of coronary heart disease. Evidence is also accumulating to demonstrate that individuals with high cholesterol levels can reduce their risk of heart disease by lowering the level and that a 1 percent decline in serum cholesterol level results in a 2 percent decline in risk.

Blood cholesterol levels are influenced by diet. In addition to reduction of cholesterol intake, reduction of total fat and saturated fat consumption are important. Obesity, physical inactivity, and genetic factors also affect cholesterol levels.

Physical inactivity is often defined as exercising less than three times a week and/or for less than 20 minutes at a time. Physically inactive individuals are about twice as likely to develop CVD as those who are active. This increased risk is similar to the amount of increase in CVD risk due to hypertension, elevated cholesterol levels, and smoking.

Physical activity may have beneficial effects on hypertension, cholesterol, weight control and anxiety, which may also affect CVD risk.

Patterns of physical activity should be established in childhood and adolescence. Results from the Connecticut Health Check indicate that 56 percent of high school students and 42 percent of junior high students participated in aerobic exercise less than three times per week. Over 39 percent of elementary school students in grades 4 and 5 were exercising less than four times per week. These results indicate that programs to promote physical activity should not be limited to adults but should include elementary, junior, and senior high school students.

Diabetes is a disease that results either when insulin is not produced by the body or the insulin which is made cannot metabolize glucose. As a result, glucose accumulates in the blood and may eventually damage the major blood vessels. People with diabetes are 2 to 4 times as likely to have heart disease as those without diabetes and 2 to 6 times as likely to have a stroke. Over 75 percent of people with diabetes will die of some form of CVD.

Stress is difficult to define and measure and affects people differently. Some studies have shown a higher incidence of coronary heart disease in individuals in high stress job

categories. Other researchers have found negative correlations between job satisfaction and heart disease mortality rates. Stress also increases the prevalence of other risk factors; for example, people may attempt to relieve stress by smoking or overeating.

Much of the burden of heart disease and stroke is preventable by lifestyle modification. Over half of all CVD deaths in Connecticut are estimated to be attributed to the four risk factors of smoking, high blood pressure, obesity, and physical inactivity. Many of these unhealthy behaviors may be established in childhood. State data for 1989-90 suggest that 45 percent of boys and 58 percent of girls in grades 7-12 were either overweight, smoked, or exercised less than three times per week. At a minimum, programs should focus on the primary modifiable risk factors for cardiovascular disease, which are high blood pressure, high blood cholesterol, smoking, and physical inactivity.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 15 - HEART DISEASE AND STROKE

Selected Objectives

OBJ. 1 OBJECTIVE DESCRIPTION

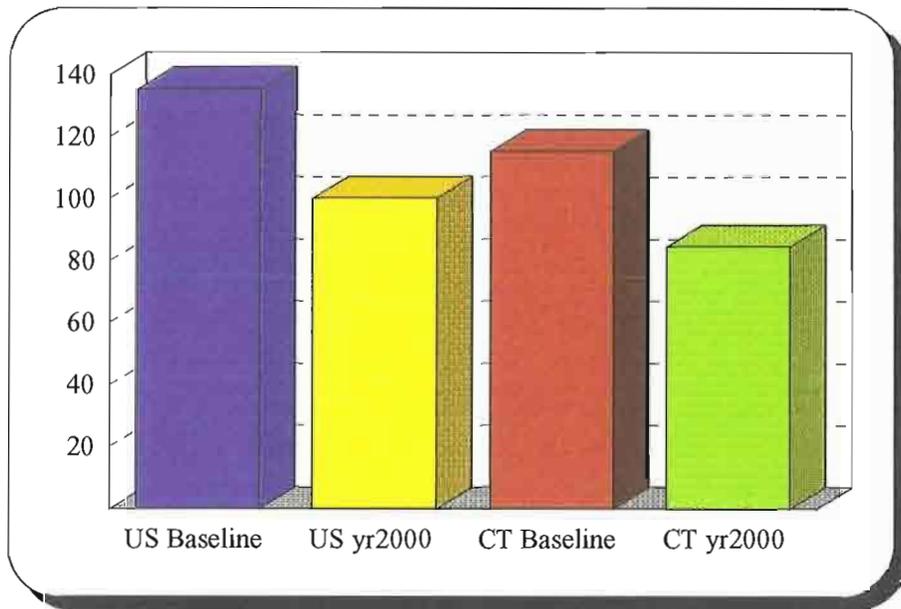
Health Status Objectives

- 15.1 Reduce coronary heart disease deaths to no more than 84.4 per 100,000 people
- 15.2 Reduce stroke deaths to no more than 16.8 per 100,000 people

Risk Reduction Objectives

- 15.4 Increase to at least 50 percent the proportion of people with high blood pressure whose blood pressure is under control
- 15.5 Increase to at least 85 percent the proportion of people with blood pressure who are taking action to help control their blood pressure
- 15.6 Reduce the mean serum cholesterol level among adults to no more than 200 mg/dl
- 15.8 Increase to at least 55 percent the proportion of adults with high blood cholesterol who are aware of their condition and are taking action to reduce their cholesterol to recommended levels
- 15.9 Reduce dietary fat intake to an average of 30 percent of calories or less and average saturated fat to less than 10 percent among people aged two and older
- 15.11 Increase to at least 30 percent the proportion of people aged six and older who engage regularly, preferably daily, in light to moderate physical activity for at least 30 minutes per day
- 15.12 Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 20 and older

Objective 15.1: Reduce coronary heart disease deaths to no more than 84.4 per 100,000 people



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------------|---------------------|-----------------|---------------------|
| 135 per 100,000 | 100 per 100,000 | 115 per 100,000 | 84.4 per 100,000 |

Source: Division of Chronic Disease and Injury Prevention, Health Surveillance and Planning, Connecticut Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Heart disease is the leading cause of death in Connecticut, causing a total of 9,809 deaths in 1989. About half of these deaths are preventable, linked to risk factors that are modifiable. Attributable causes of these deaths are smoking (987), obesity (1980), sedentary lifestyle (853), high blood pressure (1614) and elevated cholesterol. In addition, exposure to second hand smoke has been identified by the American Heart Association as responsible for up to 35,000 heart disease deaths per year in the United States.

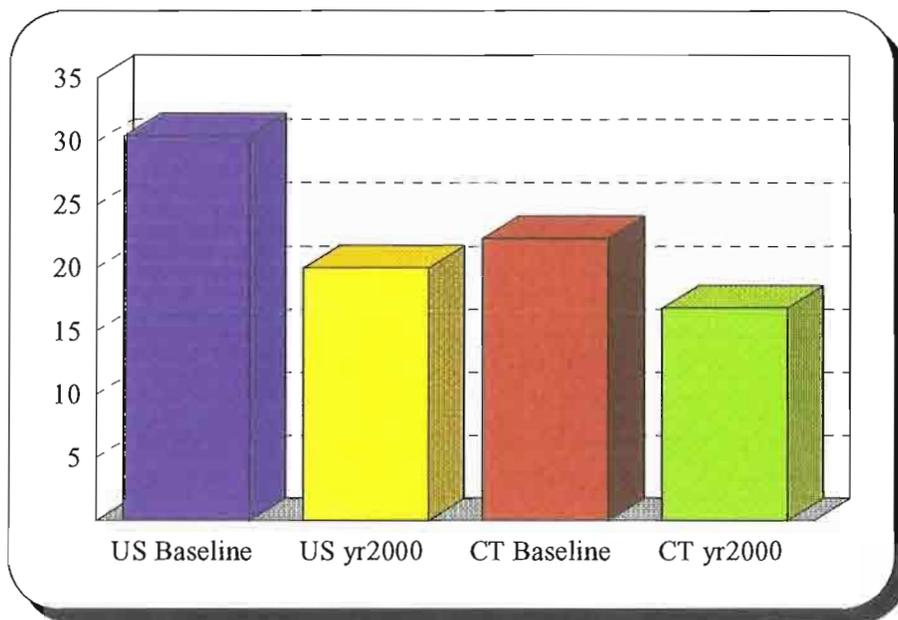
Special Population Target

Blacks

| US Baseline | US Year 2000 Goal | CT Baseline* | CT Year 2000 Goal |
|-----------------|-------------------|-------------------|-------------------|
| 163 per 100,000 | 115 per 100,000 | No data available | 115 per 100,000 |

* Due to lack of baseline data, the Federal Year 2000 Target is used.

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



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------------|---------------------|------------------|---------------------|
| 30.3 per 100,000 | 20 per 100,000 | 22.3 per 100,000 | 16.8 per 100,000 |

Source: Division of Chronic Disease and Injury Prevention, Health Surveillance and Planning, Connecticut Department of Public Health and Addiction Services

Data

Limitations:

Rationale: In Connecticut, about 66 percent of stroke deaths are attributable to hypertension, being at least 10 percent above ideal weight and smoking. These are potentially preventable deaths since these are modifiable risk factors.

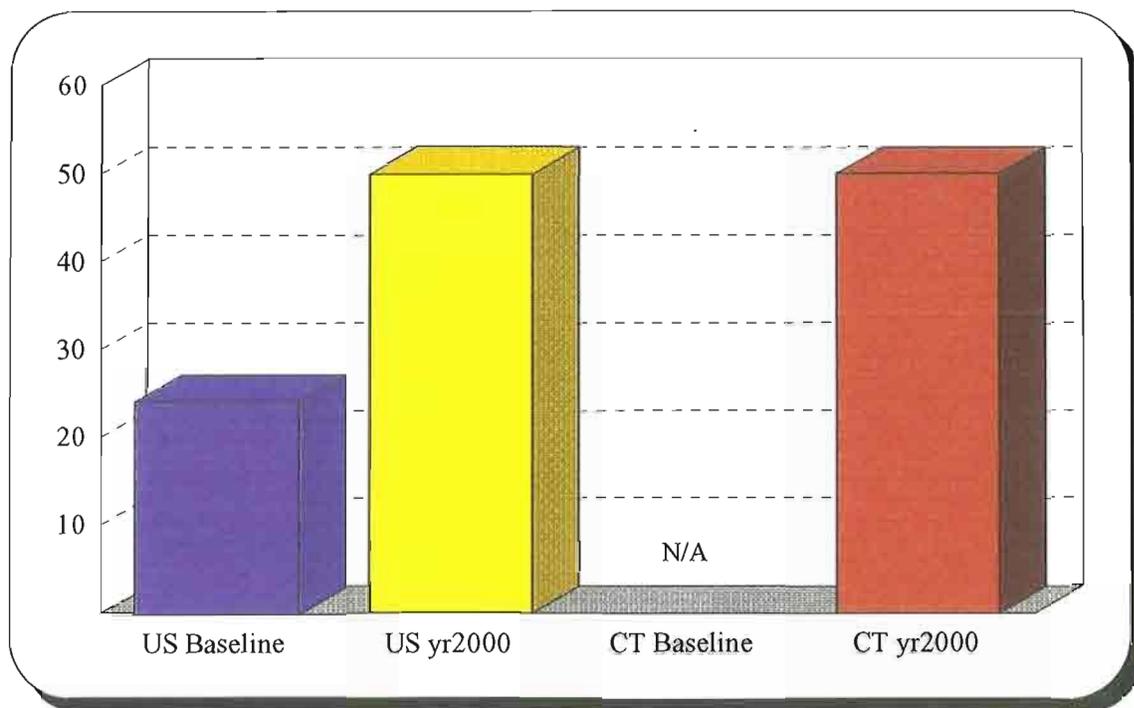
Special Population Target

Blacks

| US Baseline | US Year 2000 Target | CT Baseline* | CT Year 2000 Target |
|------------------|---------------------|-------------------|---------------------|
| 51.2 per 100,000 | 27 per 100,000 | No data available | 27 per 100,000 |

*Due to the lack of baseline data, the Federal Year 2000 Target is used for.

Objective 15.4: Increase to at least 50 percent the proportion of people with high blood pressure whose blood pressure is under control



| Years | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|---------|-------------|---------------------|-------------------|---------------------|
| 1982-84 | 24% | 50% | No data available | 50% |

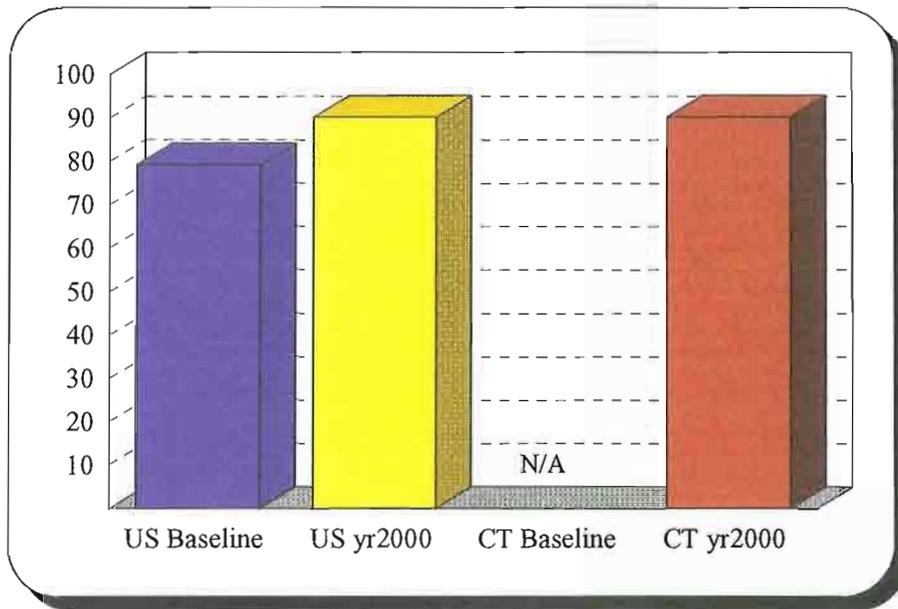
Source: Division of Chronic Disease and Injury Prevention, Connecticut Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Blood pressure control is defined as maintaining a blood pressure less than 140 mm Hg systolic and 90 mm Hg diastolic.

Objective 15.5: Increase to at least 90 percent the proportion of people with high blood pressure who are taking action to help control their blood pressure



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|-------------------|---------------------|
| 79% | 90% | No data available | 90% |

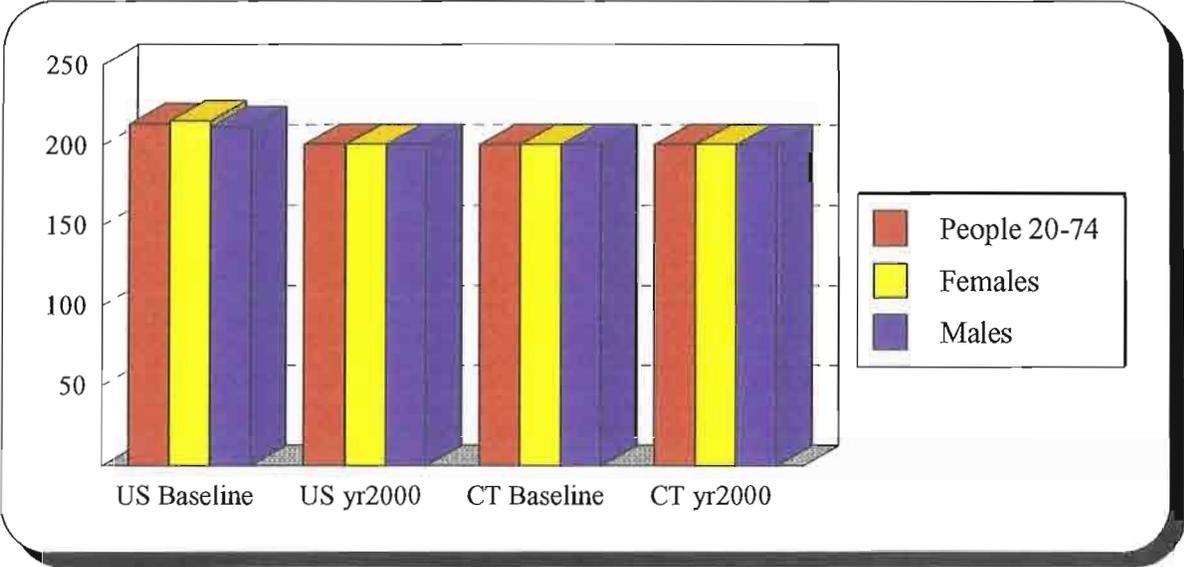
Source: Division of Chronic Diseases and Injury Prevention, Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Actions to control blood pressure include taking medication, losing weight, cutting down on salt and exercising.

Objective 15.6: Maintain the mean serum cholesterol level among adults at no more than 200 mg/dl or less



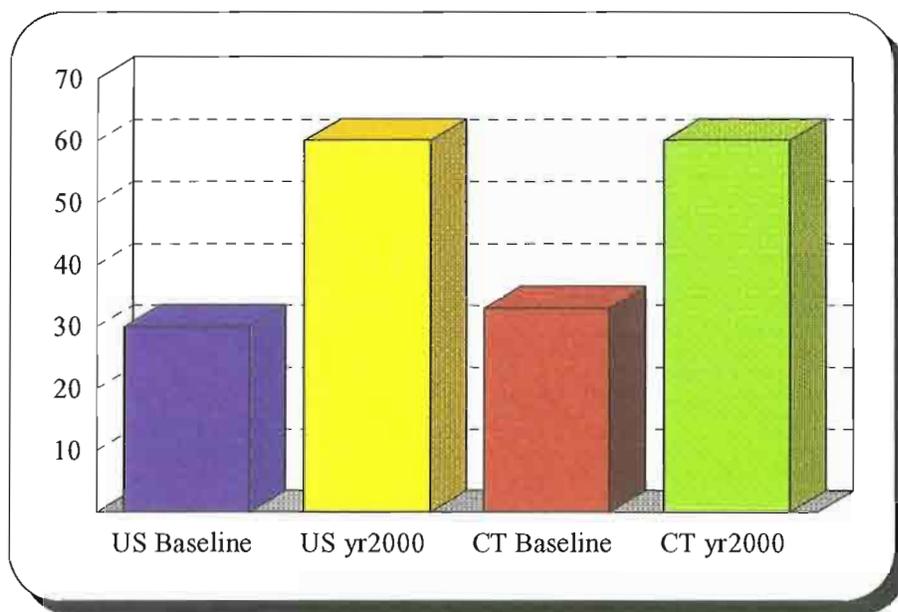
| Populations | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------------|-------------|---------------------|---------------------------|---------------------|
| People 20-74 | 213 mg/dl | 200 mg/dl | 200 mg/dl | 200 mg/dl |
| Females | 215 mg/dl | 200 mg/dl | average of those surveyed | 200 mg/dl |
| Males | 211 mg/dl | 200 mg/dl | 200 mg/dl | 200 mg/dl |

Source: Division of Chronic Disease, Connecticut Department of Public Health and Addiction Services

Data Limitations:

Rationale: This objective addresses the detection of high blood cholesterol and its reduction through diet and if necessary drug treatment. Blood cholesterol levels greater than or equal to 240 mg/dl are associated with a substantially higher incidence of coronary heart disease. Reducing the prevalence of high blood cholesterol among adults will help decrease the risk for coronary heart disease.

Objective 15.8: Increase to at least 55 percent the proportion of adults with high blood pressure who are aware of their condition and are taking action to reduce their cholesterol to recommended levels



| Population | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------------------------|-------------|---------------------|-------------|---------------------|
| People with high cholesterol | 30% | 60% | 33% | 60% |

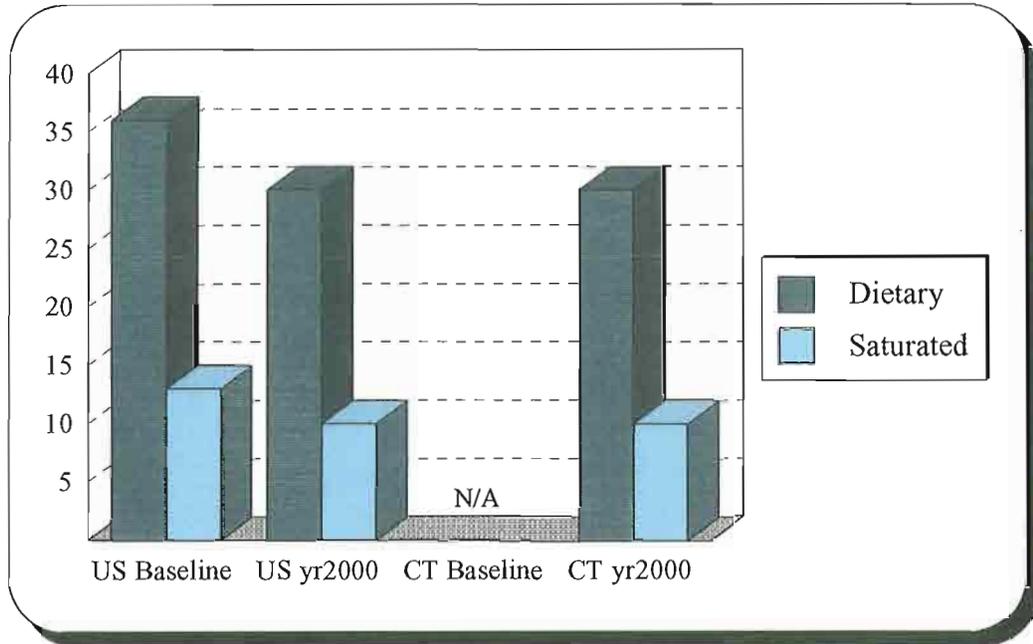
Source: Division of Chronic Disease and Injury Prevention, Connecticut Department of Public Health and Addiction Services

Data

Limitations:

Rationale: In 1988, an estimated 33 percent of people with high blood cholesterol were aware that their blood cholesterol was high. High blood cholesterol as used here means a level that requires diet and/or drug treatment. Actions to control high blood cholesterol include keeping medical appointments, making recommended dietary changes (e.g., reducing saturated fat, total fat, and dietary cholesterol), and, if necessary, taking prescribed medication.

Objective 15.9: Reduce dietary fat intake to an average of 30 percent of calories or less and average saturated fat intake to less than 10 percent among people aged two and older



| Fat Intake | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|---------------|-------------|---------------------|-------------------|---------------------|
| Dietary Fat | 36% | 30% | No data available | 30% |
| Saturated Fat | 13% | 10% | | 10% |

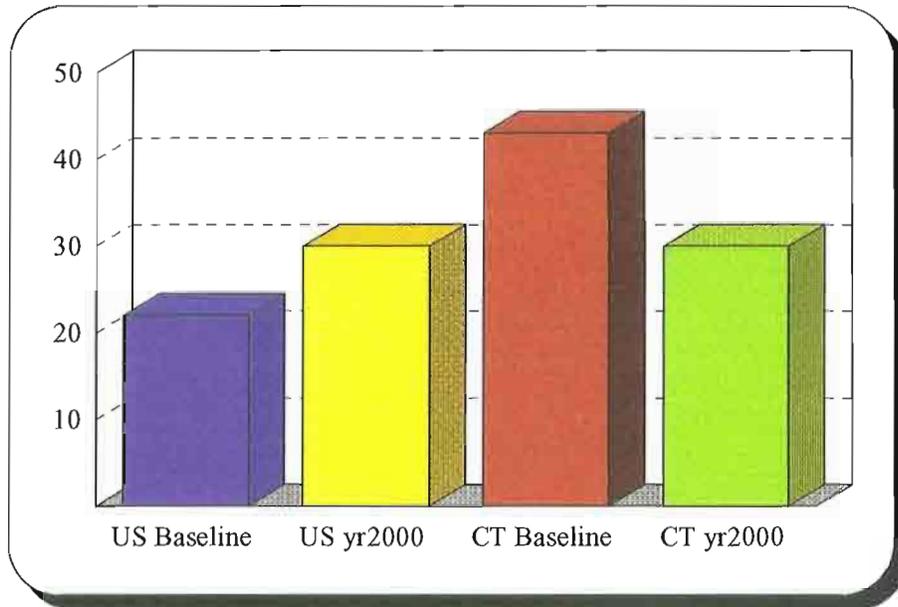
Source: Child and Adolescent Health Division, Connecticut Department of Public Health and Addiction Services

Data

Limitations: Due to lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Evidence associates diets high in fat with increased risk of obesity, some types of cancer and heart disease. The targets of 30 percent or less of calories from fat and less than 10 percent of calories from saturated fat are consistent with established recommendations.

Objective 15.11: Increase to at least 30 percent the proportion of people aged six and older who engage regularly, preferably daily, in light to moderate physical activity for at least 30 minutes per day



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|-------------|---------------------|
| 22% | 30% | 43% | 30% |

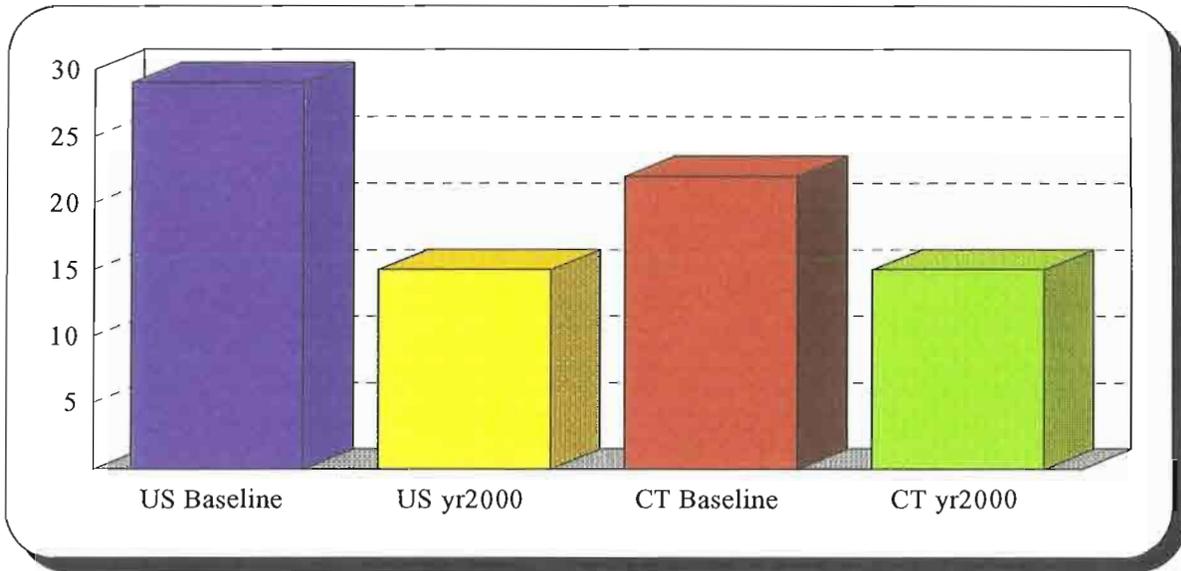
Source: Division of Chronic Disease and Injury Prevention, Connecticut Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Currently, approximately 57 percent of Connecticut residents are at risk of developing several chronic health problems as a result of their not engaging in adequate exercise. Changes in lifestyles, which include programs of moderate, regular exercise for 30 minutes a day, three times a week markedly lower death rates from many causes.

Objective 15.12: Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 20 and older



| Sex/Age | US Baseline | US Year 2000 Target | CT Baseline* | CT Year 2000 Target |
|------------|-------------|---------------------|----------------|---------------------|
| All People | 29% | 15% | 22% (aged 18+) | 15% (aged 18+) |

Source: Division of Chronic Disease, Connecticut Department of Public Health and Addiction Services

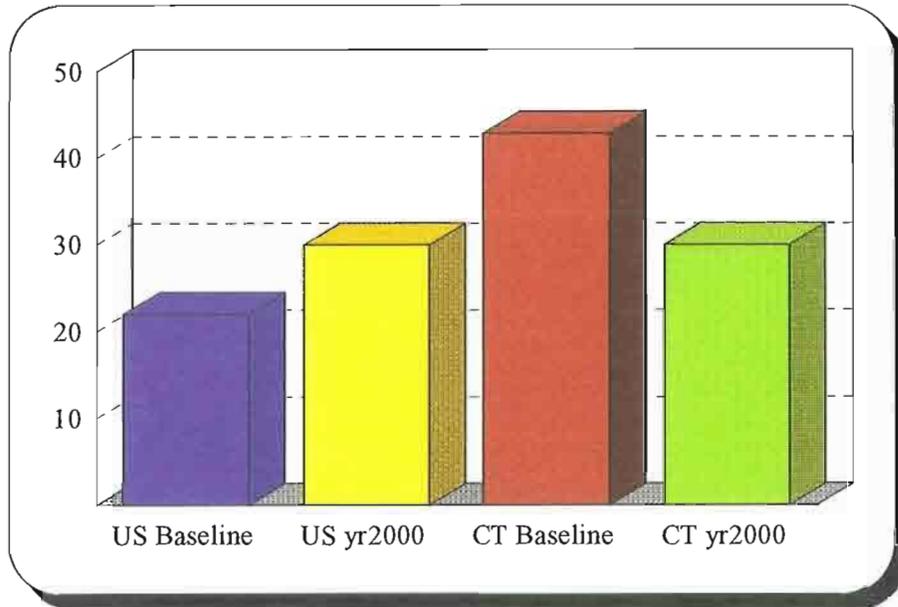
Data

Limitations:

Rationale: Use and access to tobacco have negative future effects on health. In addition, the Surgeon General has stated that 90 percent of smokers begin before age 21.

* 1990 Behavioral Risk Factor Surveillance Survey (BRFSS)

Objective 15.11: Increase to at least 30 percent the proportion of people aged six and older who engage regularly, preferably daily, in light to moderate physical activity for at least 30 minutes per day



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|-------------|---------------------|
| 22% | 30% | 43% | 30% |

Source: Division of Chronic Disease and Injury Prevention, Connecticut Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Currently, 57 percent of Connecticut residents are at risk of developing several chronic health problems as a result of their not engaging in adequate exercise. Changes in lifestyles, which include programs of moderate, regular exercise for 30 minutes a day, three times a week markedly lower death rates from many causes.

Chapter 16 - CANCER

According to current estimates, one in every eight women can expect to develop breast cancer sometime in her lifetime. Diagnosis at an early stage improves the chances for survival. While cervical cancer is less common, deaths from this cancer should be totally preventable with proper screening and treatment.

The burden of breast and cervical cancer in Connecticut is considerable. Female breast cancer (invasive) accounted for 15.4 percent of all cancer - or one in every six - diagnosed in 1990-91 in the state, and 31 percent of all cancers in women. The incidence of breast cancer doubled for Connecticut women between 1935-39 and 1990-91, and was at an age-adjusted annual rate of 114.5 per 100,000 women in 1990-91. About 2,500 new invasive breast cancer cases are expected in the state in 1994.

In 1989, 669 Connecticut women died from breast cancer; this represents 9.4 percent of all cancer deaths that year. Breast cancer mortality rates in the state are higher than in other parts of the country; our state ranked 8th in the nation in age-adjusted mortality rates for this cancer in 1986. Data for 1986-1990 indicate that the average age-adjusted mortality rate for Connecticut was 28.4 per 100,000 and ranked 14th among the 50 states plus the District of Columbia (27.4 per 100,000 for total U.S.). The data also show that 11 of

the 13 states in the highest quartile for breast cancer mortality rates are located in the Northeast. Reasons for this regional elevation in rates are unclear, but the rates indicate the need for a coalition of statewide efforts in the Northeast to reduce this burden. Following a national trend, breast cancer mortality rates in Connecticut have been stable since the early 1970s.

Breast cancer incidence rates are higher among white women, yet age-adjusted mortality for breast cancer is about 12 percent greater among black women. In Connecticut, five-year survival rates for early stage breast cancer are greater than 90 percent, but rates for black women are significantly lower than for white women. Some of this gap is due to differences in the stage of diagnosis, with blacks obtaining treatment at later stages. Farley & Flannery (Late-Stage Diagnosis of Breast Cancer in Women of Lower Socioeconomic Status: Public Health Implications) found that in Connecticut, black women were diagnosed with metastatic breast cancer approximately twice as often as white women.

Incidence rates for breast cancer increase with age, and the incidence rate for late stage (i.e. regional or metastatic) shows no decline at older ages. Thus older women (age 65+) warrant special attention in targeting interventions aimed at increasing screening rates and thus reducing the proportion of late-stage breast cancers

Both incidence and mortality rates for invasive cervical cancer have been declining since the late 1930s, with these improvements attributed at least in part to increased use of the Pap test. Invasive cervical cancer was diagnosed in 3,342 women in the state between 1985 and 1988 and more than 50 women died from this cancer in 1989. All such deaths are considered potentially preventable with proper screening and treatment. The overall mortality rate for cervical cancer in Connecticut in 1986-90 was a relatively low 2.21 per 100,000 or 44th among the 51 states, but the mortality rate for black women in the state was nearly three times as high.

Screening by Pap test affects mortality by shifting the stage at diagnosis to pre-invasive (including) *in situ* cervical lesions. In Connecticut, there has been only a slight decline in the ratio of *in situ* to invasive cervical cancer cases in recent years. The proportion of cervical cancer cases diagnosed at the invasive (U.S., *in situ*) stage is about 45 percent higher among women 65 years and older compared with those younger than 65. This finding is consistent with the literature and reflects lower screening rates among older women.

The age-adjusted annual death rates from lung cancer in Connecticut in 1986-90 was 43.7 per 100,000 or slightly lower than that for the entire U.S. (48.7), and Connecticut ranked 38th. There are no effective screening tests for lung cancer.

Chapt. 16 - Cancer

p. 16-4

Therefore, reduction of lung cancer death rates can be achieved only by reducing the incidence rates through effective smoking prevention and cessation programs. In Connecticut lung cancer incidence rates continue to increase in women, and although age-adjusted incidence rates lower in women than in men for all ages combined, rates in young adults (20-44 years old) were about equal in the two sexes in 1990-91.

Chapter 16 - CANCER

Selected Objectives

OBJ. 1 OBJECTIVE DESCRIPTION

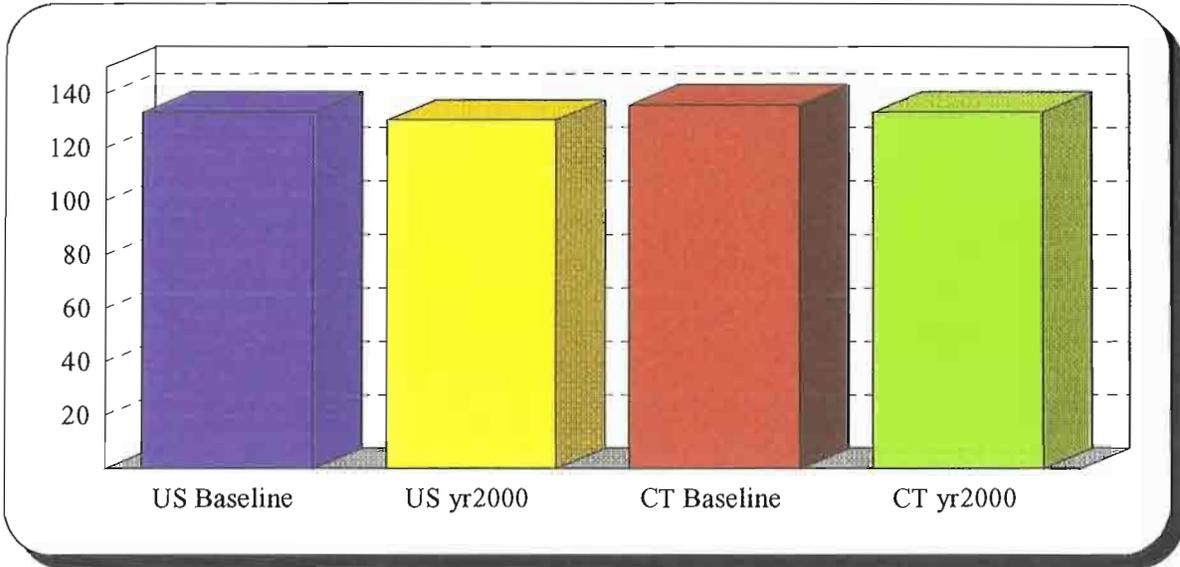
Health Status Objectives

- 16.1 Reverse the rise in cancer deaths to achieve a rate of no more than 133 per 100,000 people
- 16.2 Slow the rise in lung cancer deaths to achieve a rate of no more than 42.1 per 100,000 people
- 16.3 Reduce breast cancer mortality rate to no more than 23.1 per 100,000 women
- 16.4 Reduce deaths from cancer of the uterine cervix to no more than 1.1 per 100,000 women

Risk Reduction Objectives

- 16.6 Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 20 and older
- 16.7 Reduce dietary fat intake to an average of 30 percent of calories or less and average saturated fat intake to less than 10 percent of calories among people aged two or older
- 16.8 Increase complex carbohydrate and fiber-containing foods in the diets of adults to five or more daily servings for vegetables (including legumes) and fruits, and to six or more daily servings of grain products

Objective 16.1: Reverse the rise in cancer deaths to achieve a rate of no more than 133 per 100,000 people



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------------|---------------------|-------------------|---------------------|
| 133.0 per 100,000 | 130.0 per 100,000 | 135.6 per 100,000 | 133.0 per 100,000 |

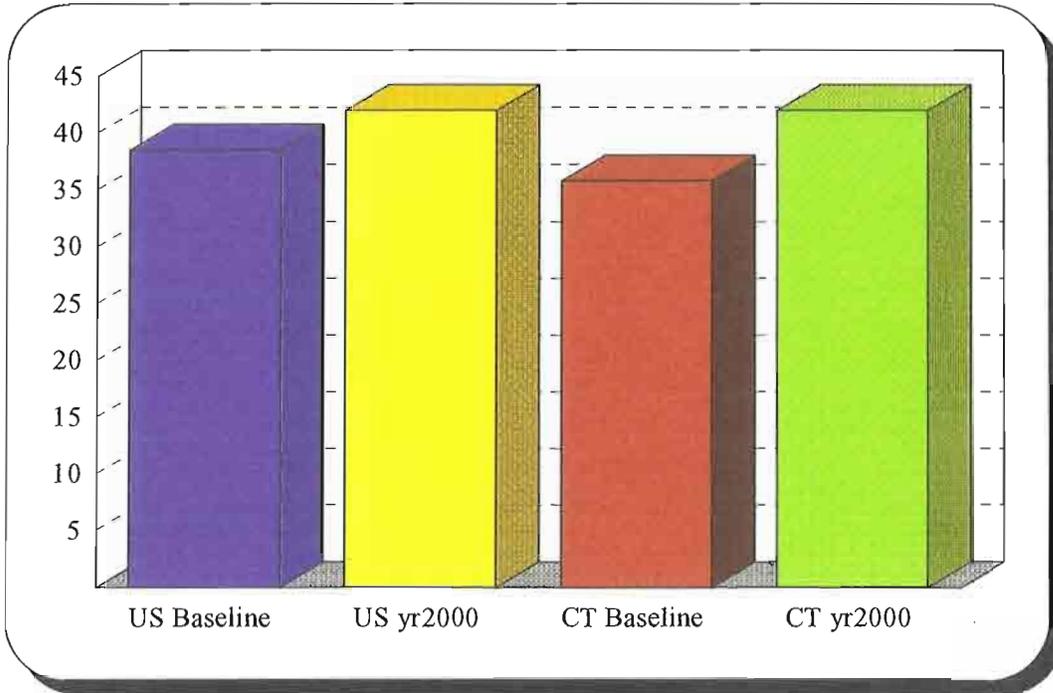
Source: Division of Chronic Diseases and Injury Prevention, Connecticut Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Cancer is the second leading cause of death in Connecticut accounting for 25 percent of the total number of deaths. Many of these deaths are preventable. Modifiable risk factors associated with cancer include smoking, exposure to secondhand smoke and diet. Early detection and treatment of many cancers may also increase survival rate and decrease deaths.

Objective 16.2: Slow the rise in lung cancer deaths to achieve a rate of no more than 42 per 100,000 people



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------------|---------------------|------------------|---------------------|
| 38.5 per 100,000 | 42 per 100,000 | 35.8 per 100,000 | 42 per 100,000 |

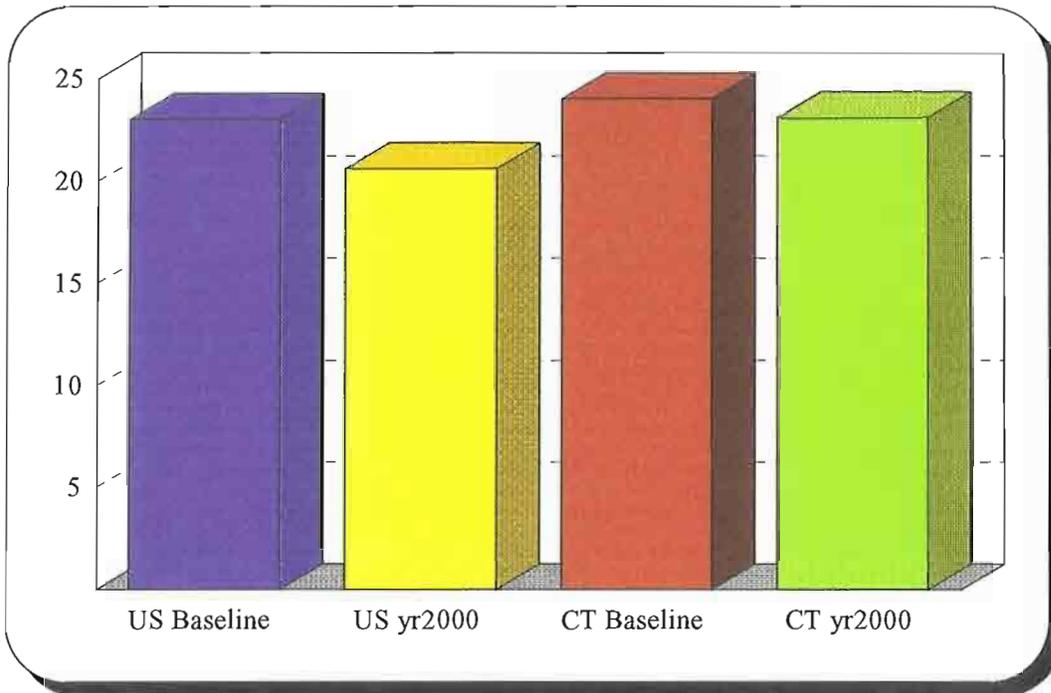
Source: Division of Chronic Diseases and Injury Prevention, Connecticut Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Cancer is the second leading cause of death in Connecticut accounting for 25 percent of the total number of deaths. Many of these deaths are preventable. Modifiable risk factors associated with cancer include smoking, exposure to secondhand smoke and diet. Early detection and treatment of many cancers may also increase survival rate and decrease deaths.

Objective 16.3: Reduce breast cancer mortality rate to no more than 23.1 per 100,000 women



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------------|---------------------|------------------|---------------------|
| 23.0 per 100,000 | 20.6 per 100,000 | 24.0 per 100,000 | 23.1 per 100,000 |

Source: Division of Chronic Diseases and Injury Prevention, Connecticut Department of Public Health and Addiction Services

Data

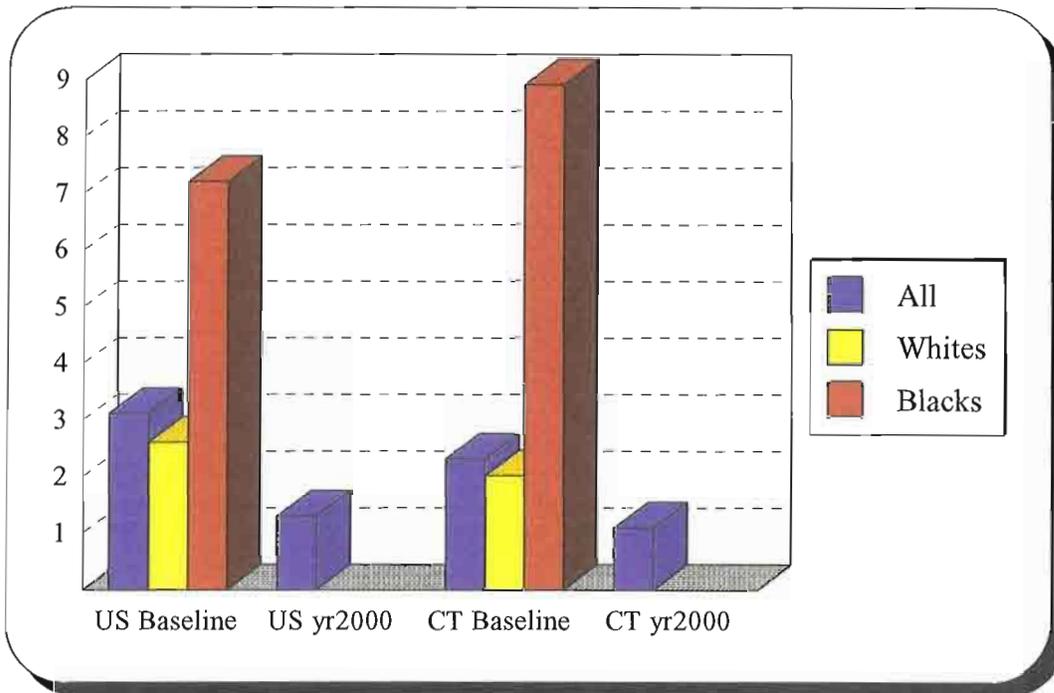
Limitations:

Rationale: In the United States, one in eight women will develop breast cancer in her lifetime. Breast cancer deaths can be decreased by early detection and treatment. The National Cancer Institute and the American Cancer Society recommend mammograms every two years for women 40-50 years old and every year for women 50 and older. Self exams and a yearly exam by a physician are also recommended. Those individuals with a family history of breast cancer are encouraged to have more frequent exams and screenings. The Tumor Connecticut Registry indicates later-stage diagnosis in certain population groups. Earlier detection would have reduced death rates. There may also be a link between breast cancer and fat in the diet, a potentially modifiable behavior.

Target Population:

Women over 50

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



| Race | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------|-----------------|---------------------|-----------------|---------------------|
| All | 3.1 per 100,000 | 1.3 per 100,000 | 2.3 per 100,000 | 1.1 per 100,000 |
| Whites | 2.6 per 100,000 | | 2.0 per 100,000 | |
| Blacks | 7.2 per 100,000 | | 8.9 per 100,000 | |

Source: Division of Chronic Diseases and Injury Prevention, Connecticut Department of Public Health and Addiction Services

Data

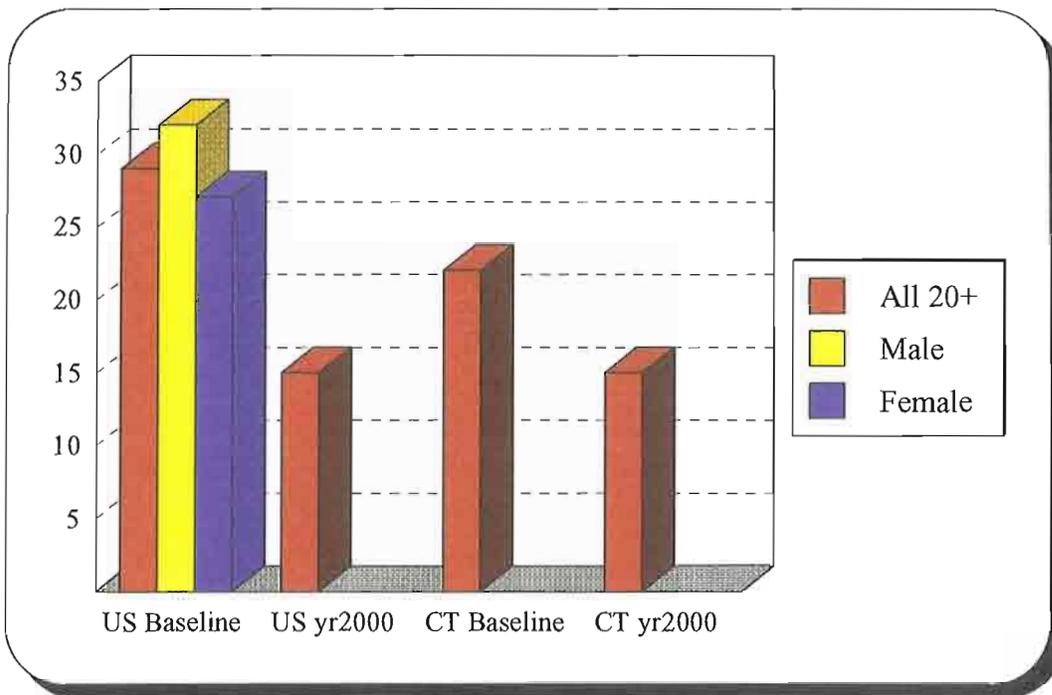
Limitations:

Rationale: With intervention and screening, cervical cancer mortality is preventable. Connecticut data suggest that we should target high risk women, black women and women over age 55.

Special Target Population:

- Black women
- High risk women
- Women over age 55

Objective 16.6: Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 20 and older



| Sex | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------|---------------|---------------------|---------------|---------------------|
| All | 29% (20+ yrs) | 15% (20+ yrs) | 22% (18+ yrs) | 15% (20+ yrs) |
| Male | 32% | | | |
| Female | 27% | | | |

Source: Division of Chronic Diseases and Injury Prevention, Connecticut Department of Public Health and Addiction Services

Data

Limitations: Connecticut Baseline is for all persons aged 18 and older.

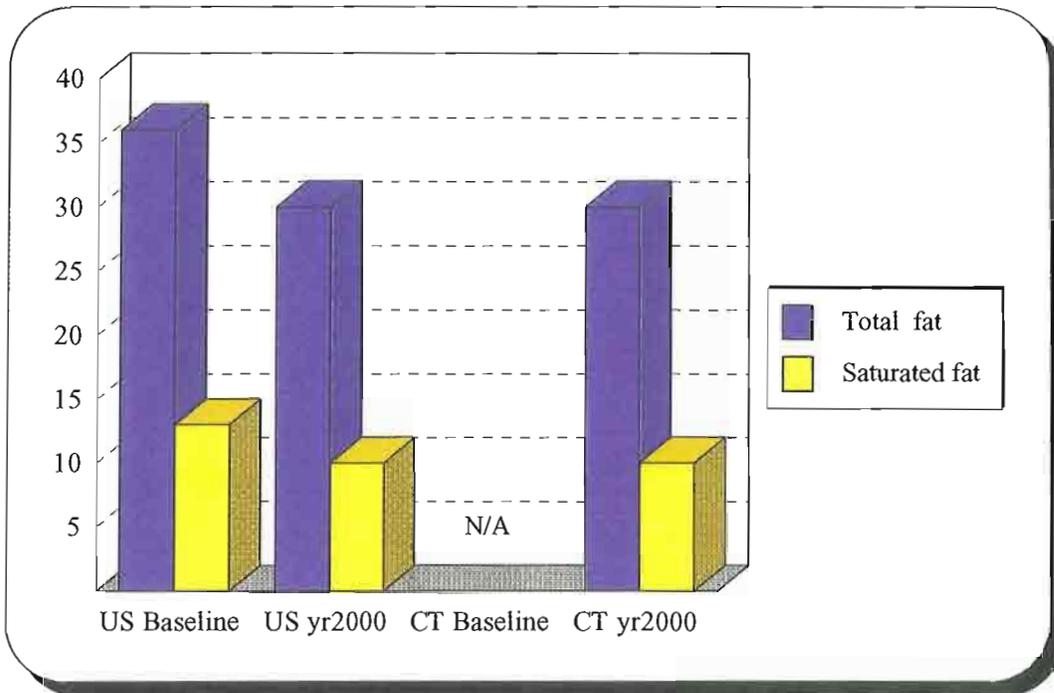
Rationale: Cigarette smoking is a preventable cause of death in the United States, estimated to cause at least 400,000 deaths per year. Smoking has been shown to increase the risk of death due to heart disease, lung and other cancers, and chronic obstructive pulmonary diseases. In addition, exposure to secondhand smoke may contribute up to 50,000 deaths per year.

Special Target Population:

Women of reproductive age

Pregnant women

Objective 16.7: Reduce dietary fat intake to an average of 30 percent of calories or less and average saturated fat intake to less than 10 percent of calories among people aged two and older



| Fat Intake | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|---------------|-------------|---------------------|-------------------|---------------------|
| Dietary fat | 36% | 30% | No data available | 30% |
| Saturated fat | 13% | 10% | No data available | 10% |

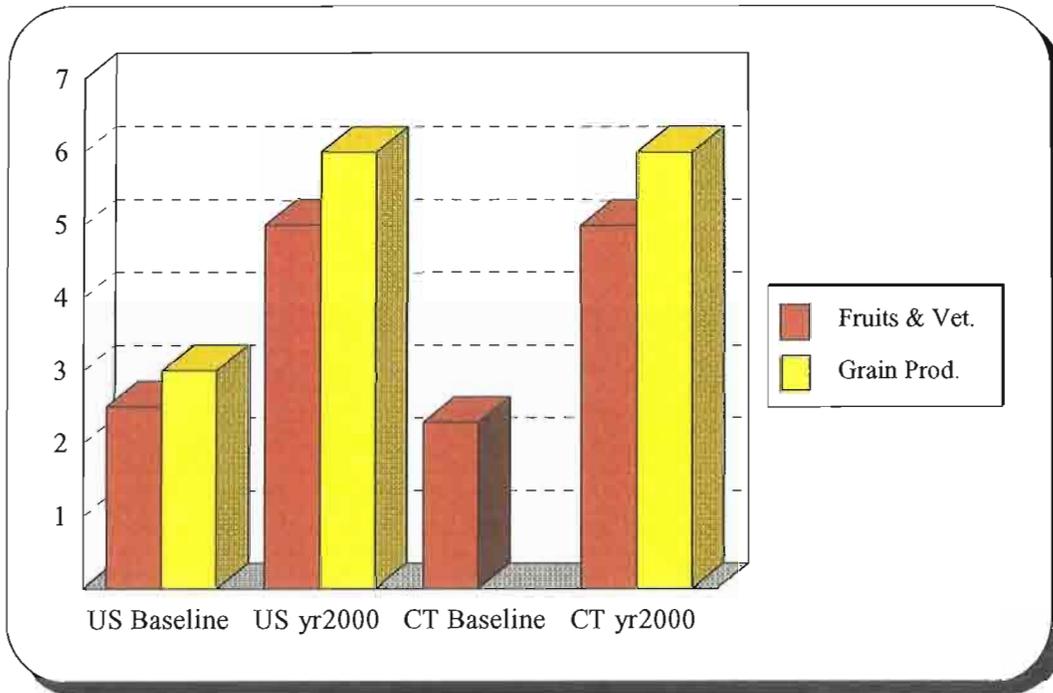
Source: Division of Chronic Diseases and Injury Prevention, Child and Adolescent Health, Connecticut Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Evidence associates diets high in fat with some types of cancer. The targets of 30 percent or less of calories from fat and less than 10 percent of calories from saturated fat are consistent with established recommendations.

Objective 16.8: Increase complex carbohydrate-and fiber-containing foods in the diets of adults to five or more daily servings for vegetables (including legumes) and fruits, and to six or more daily servings of grain products



| Servings of Food | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------------------|--------------|---------------------|-------------|---------------------|
| Fruits and Vegetables | 2.5 Servings | 5+ Servings | 2.28 | 5+ Servings |
| Grain Products | 3 Servings | 6+ Servings | Servings* | 6+ Servings |

Source: Child and Adolescent Health Division, Connecticut Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Vegetables, fruits, and grains are good sources of complex carbohydrates and dietary fiber, vitamins and minerals. Dietary patterns with higher fruits, vegetables and grains are associated with a variety of health benefits including a decreased risk for heart disease and some cancers (e.g., colon cancer).

*1990 BRFSS (Behavioral Risk Factor Surveillance Survey)

Chapter 17 - DIABETES AND CHRONIC DISABLING CONDITIONS

Diabetes, a chronic metabolic disease, affects approximately 185,000 Connecticut residents, but only about 93,000 of these cases are diagnosed. Approximately 7 million people in the United States have been diagnosed with diabetes, but approximately 3.5 million unknowingly have the disease. The Behavioral Risk Factor Surveillance Survey (BRFSS), 1988-1989, from the Connecticut Department of Public Health and Addiction Services, indicates a known prevalence rate of 4.5%, but if this represents only half of the people with the disease, the prevalence rate would be approximately 9%. The BRFSS for 1989 also indicates that those individuals who are 20% over ideal weight are three times more likely to have diabetes, individuals with high blood pressure have four times the risk, and individuals who reported being inactive have three times the risk.

State mortality data from 1990 places diabetes as the seventh leading cause of death in Connecticut, responsible for 493, deaths, giving Connecticut a mortality rate of 619/100,000. When diabetes is considered as an underlying or contributing cause of death, the CDC estimates over 2,400 Connecticut residents die each year from diabetes. This would

Chapt. 17 - Diabetes and Chronic Disabling Conditions

p. 17-2

place the diabetes death rate per 100,000 population at 11.2, the sixth highest among the 50 states and the District of Columbia.

Approximately 90% of Connecticut's residents with diabetes have Type II diabetes, non-insulin dependent diabetes mellitus. Diabetes is generally more prevalent in women than men and more common with increasing age, particularly after age 40. Diabetes is significantly more prevalent in the black, American Indian, and Hispanic (particularly Puerto Rican) populations. Mortality rates are also higher in the black and Hispanic populations than in the white population.

Diabetes has a significant impact on the daily lives of all in the state and the nation. The annual cost to the nation is estimated at \$20.4 billion, and it costs Connecticut \$277 million in direct (medical care) and indirect costs (lost productivity). Approximately 39,000 hospitalizations in Connecticut each year are diabetes-related. It is estimated that over 1,100* Connecticut residents suffer significant diabetes-related complications each year including:

- * Over 795 lower-extremity amputations
- * Over 120 new cases of end-stage renal disease
- * Over 190 new cases of blindness

Chapt. 17 - Diabetes and Chronic Disabling Conditions

p. 17-3

Type II diabetes can be controlled by diet and hypoglycemic medications for, therefore, self-care programs focused on diet control can be effective. The Connecticut Department of Public Health and Addiction Services is particularly dedicated to identifying and referring individuals diagnosed with diabetes to self-care programs .

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 17 - DIABETES AND CHRONIC DISABLING
CONDITIONS

Selected Objectives

OBJ. 1 OBJECTIVE DESCRIPTION

Health Status Objectives

17.10 Reduce the most severe complications of diabetes as follows:

 Lower extremity amputation to 4.9 per 1,000

 Lower blindness to 1.4 per 1,000

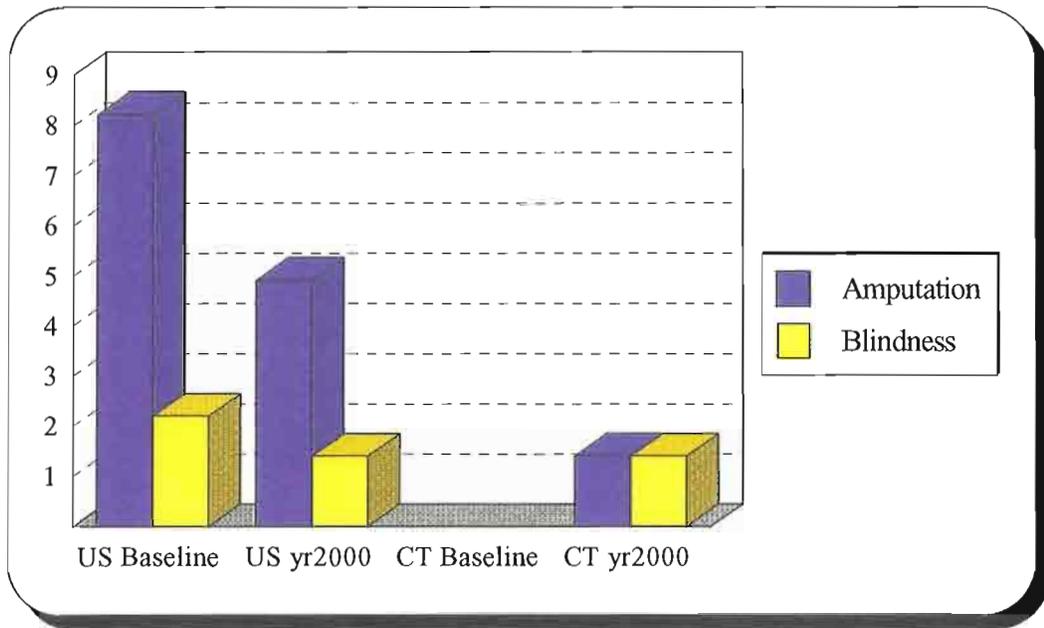
Special Target Populations:

 Hispanics

 Blacks

 Elderly

**Objective 17.10: Reduce the most severe complications of diabetes as follows:
 Lower extremity amputation to 4.9 per 1,000 people with diabetes
 Blindness to 1.4 per 1,000 people with people**



| Condition | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|----------------------------|---------------|---------------------|-------------------|---------------------|
| Lower extremity amputation | 8.2 per 1,000 | 4.9 per 1,000 | No data available | 4.9 per 1,000 |
| Blindness | 2.2 per 1,000 | 1.4 per 1,000 | | 1.4 per 1,000 |

Source: Division of Chronic Disease and Injury Prevention, Connecticut Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: CDC (Center for Disease Control) estimated over 1,100 Connecticut residents suffer significant diabetes-related complications annually including over 795 lower-extremity amputations, and 190 new cases of blindness. It is estimated that at least half of these complications are preventable. Because many people have diabetes and do not know it, these numbers are expected to be highly underreported.

Special Population Target

- Hispanics
- Blacks
- Elderly

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 18 - HIV INFECTION

In Connecticut, as in other states, Acquired Immunodeficiency Syndrome (AIDS) is a significant problem. As of September 30, 1993, 4,503 AIDS cases were reported in Connecticut. The Centers for Disease Control and Prevention have received reports of over 339,000 cases of AIDS in the United States. From October 1992 to September 1993, Connecticut ranked fifth among States for newly reported cases with an incidence rate of 51 per 100,000 people. Nearly two-thirds of all persons reported with AIDS have died.

AIDS cases provide a measure of severe morbidity due to infection with Human Immunodeficiency Virus (HIV). Serious opportunistic infection, conditions, and malignancies, as well as severe damage to the immune system signal the onset of AIDS. For some people, these illnesses may develop within a year or two after infection with HIV. Most HIV-infected persons stay healthy for up to ten years or longer before severe symptoms appear. Persons with HIV can transmit the virus to others even if they have no symptoms of AIDS. The CDC estimates that as many as one million Americans are currently infected with HIV, and as many as 20,000 Connecticut residents may be infected.

The epidemiology of AIDS in Connecticut continues to differ dramatically from national patterns. Half of all Connecticut cases reported in 1992 were intravenous drug users (IDUs) and 60 percent of all cases were related to injection drug use. Sixty-one percent of reported Connecticut AIDS cases have died. Connecticut's profile has remained stable over the last three years. In 1992, men who have sex with men accounted for 52 percent of the cases reported nationally, but only 27 percent were reported in Connecticut. AIDS disproportionately affects minority populations. Blacks and Hispanics constitute 15 percent of the Connecticut population but represent 58 percent of Connecticut's (but not) all AIDS cases. Non-whites with AIDS are more likely than whites to report injection drug use and heterosexual contact while 59 percent of the white cases were among men who reported homosexual or bisexual activity.

Female AIDS cases in Connecticut represent 21 percent of the cumulative caseload, nearly twice the U.S. figure of 12 percent. In 1992, 23 percent of the cases reported were women. While 56 percent of all Connecticut cases were non-white, 73 percent of all female cases are non-white. Fifty-seven percent of adult cases in women reported injection drug use, and an additional 35 percent (211) acquired AIDS through heterosexual contact. Of these 211 cases, 73 percent became infected through sexual

Chapt. 18 - HIV Infection

p. 18-3

contact with an injection drug user (IDU). Female heterosexual contact cases were more likely to be black (50 percent) or Hispanic (27 percent) than white (21 percent).

To slow the epidemic of HIV disease, DPHAS employs strategies aimed at education and risk reduction, HIV counseling and testing, and early identification and treatment of HIV-infected persons. Such approaches can keep the uninfected from becoming infected and provide HIV-infected persons with medical services to keep them healthier longer and the skills necessary to decrease the potential of HIV transmission to others.

Adolescents and young adults are particularly vulnerable individuals. As of fall 1993, more than 60,000 persons between the ages of 20 and 29 were diagnosed with AIDS; 1 in every 5 cases in adults. Many of them were probably infected as teenagers. A teen in the U.S. gets pregnant every 30 seconds. Every 13 seconds a teen in the U.S. gets a sexually transmitted disease, such as chlamydia or gonorrhea. The average age of first intercourse for girls in the U.S. is 16 and for boys is 15.5 years. DPHAS would like to provide education and risk education skills to teens. The lessons of postponing sexual intercourse, or if postponement of sexual activity is not

Chapt. 18 - HIV Infection

p. 18-4

possible, the use of condoms are needed ones. Use of condoms for all sexually active persons, both married and unmarried must be emphasized.

Reports of women with no identifiable risk factors have increased from 3% in 1986 to 9% in 1992. Most Connecticut women with AIDS (88%) are diagnosed in the age range 21-29 years. This means Connecticut women with AIDS are diagnosed in their childbearing years (15-44); this has major implications for the potential prenatal transmission of HIV to infants. The 1991 incidence rate for black women (36.5/100,000) was 14 times higher than that of white women (2.6/100,000), and for Hispanic women it was 10 times higher. In two of Connecticut's major cities, Stamford and New Haven, AIDS was the leading killer of women in their childbearing years in 1990.

The Department of Public Health and Addiction Services would like to slow the spread of HIV infection through education, testing, counseling and treatment, and bring infected people into care sooner and preventing the further spread of AIDS to others. The Department would also like to provide education to the most vulnerable individuals and teenagers to prevent their becoming infected and spreading this very lethal infection.

Chapt. 18 - HIV Infection

p. 18-5

Injection drug use is responsible for a large proportion of AIDS and HIV infection in Connecticut. It is estimated that over 11,000 IDUs are already infected with HIV. In July 1991, the National Commission on AIDS recommended removing legal barriers to the purchase and possession of needles and syringes, as part of a strategy for reducing the spread of HIV among IDUs. To help reduce use of contaminated needles and syringes, Connecticut enacted laws effective July 1st, 1993. The laws that allow the purchase without a prescription of up to 10 needles and syringes at one time in pharmacies and the possession of up to 10 needles and syringes. (Connecticut General Statutes, Sections 21a-65, 21a-240, 21a-267, 1992). Under these new laws, pharmacies are permitted, but not required, to sell needles and syringes without a prescription. Connecticut legislators also approved and funded additional needle-exchange programs (NEPs) in Hartford and Bridgeport, and allowed the Department to authorize three additional unfunded NEPs.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 18 - HIV INFECTION

Selected Objectives

OBJ. 1 OBJECTIVE DESCRIPTION

Health Status Objectives

18.2 Confine the prevalence of HIV infection to no more than 1,100 per 100,000 people

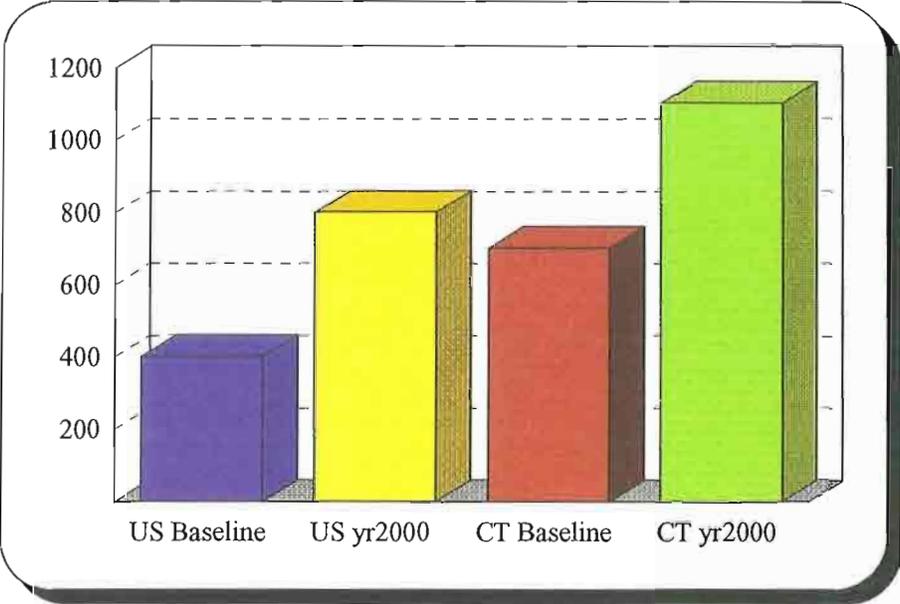
Risk Reduction Objectives

18.3 Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17

18.4 Increase to at least 50 percent the proportion of sexually active, people with multiple sex partners who used a condom at last sexual intercourse

18.6 Increase to at least 50 percent the estimated proportion of intravenous drug abusers not in treatment who use only uncontaminated drug paraphernalia ("works")

Objective 18.2: Confine the prevalence of HIV infection to no more than 1,100 per 100,000 people



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------------|---------------------|------------------------|---------------------|
| 400 per 100,000 | 800 per 100,000 | 700 per 100,000 (1992) | 1,100 per 100,000 |

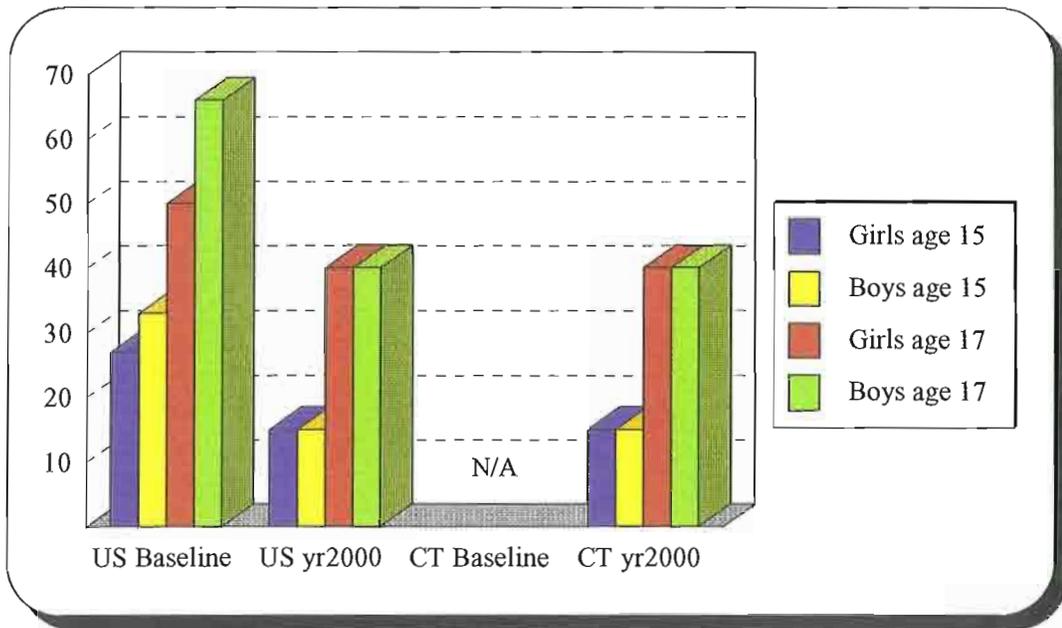
Source: AIDS Program, Connecticut Department of Public Health and Addiction Services

Data

Limitations: HIV infection is not monitored (i.e., is not reportable). It must be estimated from AIDS case data and HIV seroprevalence studies.

Rationale: This is an overall measure of the burden of HIV infection in the community. HIV is a long term infection; the average incubation period is approximately 10 years. That is why the numbers shown above are increasing instead of decreasing.

Objective 18.3: Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17



| Sex and Age | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------------|-------------|---------------------|-------------------|---------------------|
| Girls age 15 | 27% | 15% | No data available | 15% |
| Boys age 15 | 33% | 15% | No data available | 15% |
| Girls age 17 | 50% | 40% | | 40% |
| Boys age 17 | 66% | 40% | | 40% |

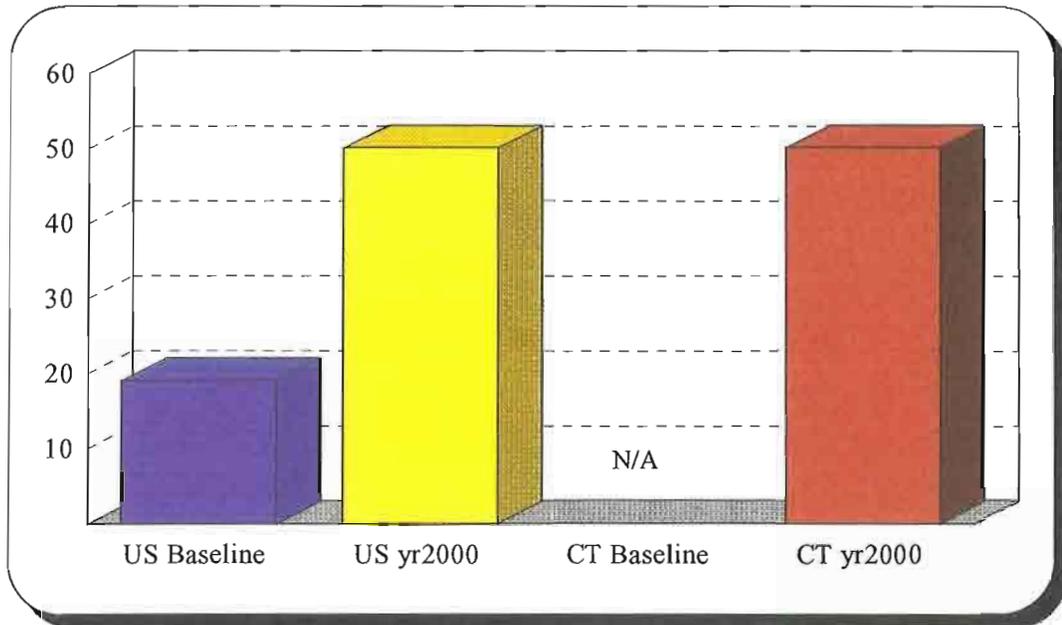
Source: Community Health Services/Maternal and Infant Health Division, AIDS Programs, Connecticut Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Initiation of sexual activity at a younger age is a primary risk factor for unintended pregnancy. Because only some teenagers are sexually active, this amounts to a rate of at least 25 percent among those who are sexually active. Teenagers report that social pressure is the chief reason why their peers do not wait until they are older to have sexual intercourse. Sexual activity at young ages is more common among young people from low socioeconomic status families, and among adolescents who smoke, use alcohol or other drugs, or have evidence of delinquency. Research supports widely held beliefs that adolescents can respond positively to directive counseling from adults about sexuality. Some successful programs have taken a community approach involving parents, the media, the schools, and the clergy in preventing teen pregnancy. One study found that such an approach was successful in reducing teen sexual activity and improving contraceptive use among teens who were sexually active.

Objective 18.4: Increase to at least 50 percent the proportion of sexually active people with multiple partners who used a condom at last sexual intercourse



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|-------------------|---------------------|
| 19% | 50% | No data available | 50% |

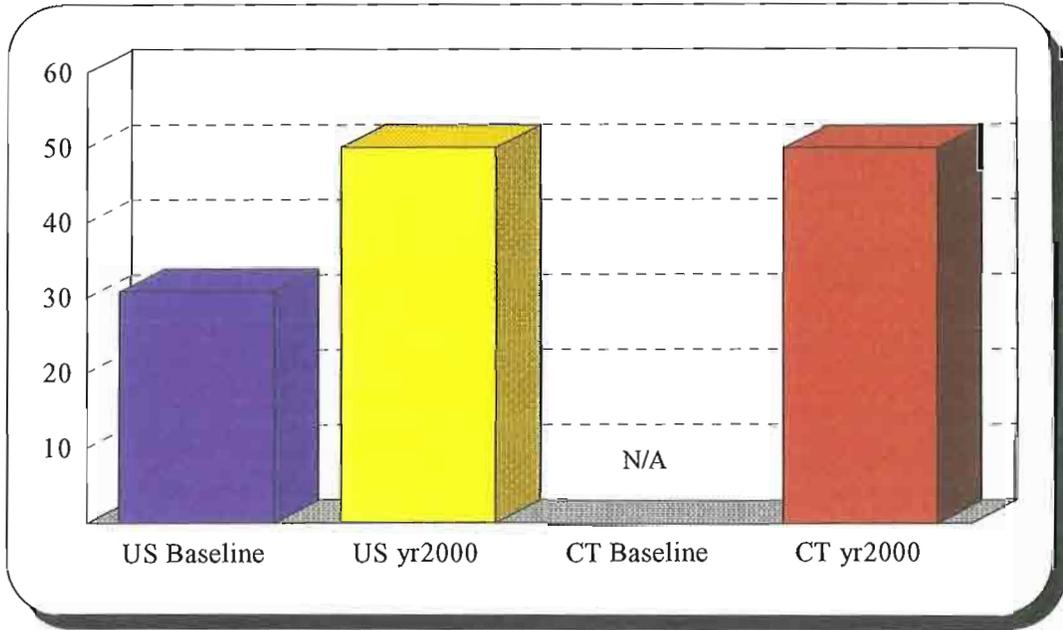
Source: AIDS Programs, Connecticut Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Attaining this target would substantially reduce sexually transmitted HIV infection. About 40% of all persons with AIDS in Connecticut were infected through sexual intercourse. Data from the national 1991 Youth Risk Behavior Survey (YRBS) show that young women report that 38% of their partners used condoms, whereas 54% of young men report condom use.

Objective 18.6: Increase to at least 50 percent the estimated proportion of intravenous drug abusers not in treatment who use only uncontaminated drug paraphernalia (works)



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|-------------------|---------------------|
| 30.8% | 50.0% | No data available | 50.0% |

Source: AIDS Programs, Connecticut Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Achievement of this target would substantially reduce the most common source of HIV transmission in the state. Almost half of all persons with AIDS in Connecticut are IDUs (Intravenous Drug Users). According to 1992 data from the National Institute on Drug Abuse, about 57% of IDUs were using uncontaminated drug paraphernalia nationally.

Chapter 19 - SEXUALLY TRANSMITTED DISEASES

Sexually transmitted diseases (STDs) continue to be among the most frequently reported communicable diseases in Connecticut. In recent years, however, they have declined dramatically. The 5,669 cases of gonorrhea reported in 1992 are 48% less than the record total of 11,004 cases seen in 1988, and 14% less than 1991's total. Similarly, the incidence of newly acquired syphilis, which reached a record high of 1,836 cases in 1989, fell 67% to 597 cases in 1992. The 1992 case total is 42% under 1991's total. Of the reportable STDs, only chlamydia increased over its 1991 total, from 7,840 cases in 1991 to 8,748 in 1992; however, the increase is likely the result of an expanding chlamydia screening program.

Left untreated, STDs can lead to devastating consequences, which can be life threatening. Women and children are particularly vulnerable to the serious outcomes of these infections. Chlamydia and gonorrhea are leading causes of pelvic inflammatory disease and ectopic pregnancy in women. Newborns are frequently infected with chlamydia, resulting in eye infections and pneumonia. Chlamydia may also be one of the causes of low birth weight, a leading cause of infant mortality. Untreated gonorrhea and chlamydia commonly result in involuntary infertility in women and men. A pregnant woman infected with

Chapt. 19 - Sexually Transmitted Diseases

p. 19-2

syphilis can pass the infection to her unborn child, which can result in stillbirth. A surviving child may suffer lifelong physiological and neurological disorders.

Perhaps the greatest concern over STDs is the role they play in the transmission of HIV infection. The presence of gonorrhea, chlamydia, syphilis, *Herpes simplex* and chancroid, substantially increases the chances that HIV will be transmitted on a single sexual exposure. This will result in a corresponding increase in AIDS cases, particularly among heterosexual groups having high incidence rates of STDs.

The Connecticut Department of Public Health and Addiction Services is committed to reducing these STDs among Connecticut's residents through its support of gonorrhea and chlamydia screening services, partner notification services, STD clinic services, and professional and public education programs.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 19 - SEXUALLY TRANSMITTED DISEASES

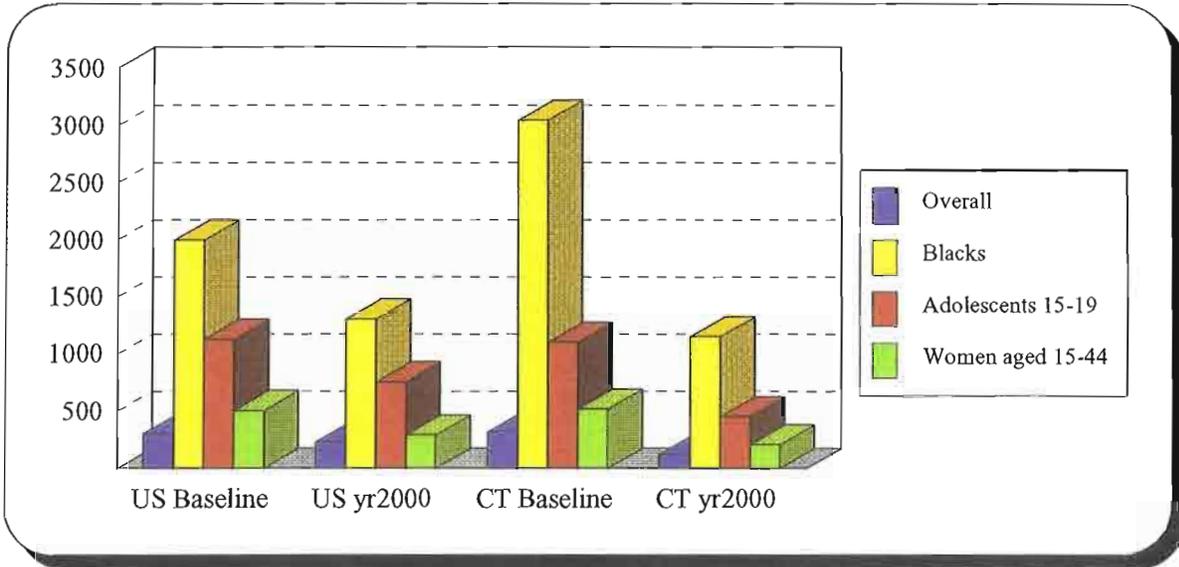
Selected Objectives

OBJ. 1 OBJECTIVE DESCRIPTION

Health Status Objectives

- 19.1 Reduce gonorrhea incidence to no more than 120 cases per 100,000 people overall, in blacks to no more than 1,150 per 100,000, in adolescents to no more than 450 per 100,000 and to no more than 206 per 100,000 in women
- 19.2 Reduce Chlamydia trachomatis infection, as measured by a decrease in the incidence of nongonococcal urethritis, to no more than 170 cases per 100,000 people
- 19.3 Reduce primary and secondary syphilis to an incidence of no more than four cases per 100,000 people, and to no more than 30 cases per 100,000 blacks
- 19.4 Reduce congenital syphilis to an incidence of no more than 20 cases per 100,000 live births

Objective 19.1: Reduce gonorrhea to an incidence of no more than 120 cases per 100,000 people



| Population | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------------------------|-------------|---------------------|--------------|---------------------|
| Overall | 300 | 225 | 315 (1989) | 120 |
| Blacks | 1,990 | 1,300 | 3,033 (1989) | 1,150 |
| Adolescents 15-19 yrs | 1,123 | 750 | 1,097 (1989) | 450 |
| Women 15-44 yrs | 501 | 290 | 515 (1989) | 206 |

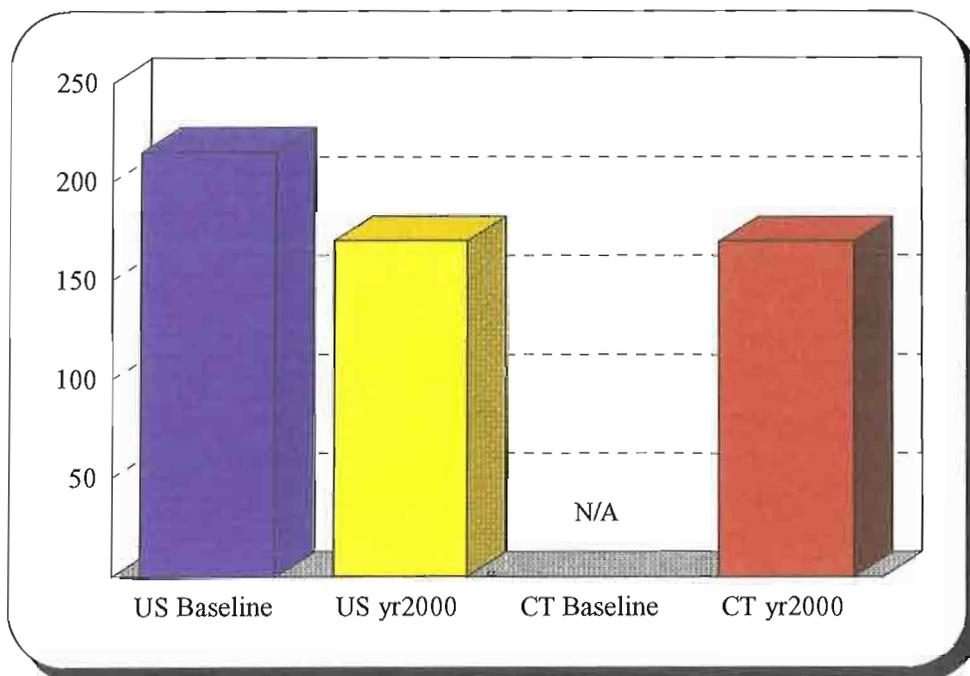
Source: Epidemiology Section, Connecticut Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Gonorrhea remains one of the most commonly reported communicable diseases in Connecticut. Left untreated, gonorrhea can also cause pelvic inflammatory disease, ectopic pregnancy, arthritis and prostatitis. Gonorrhea can also facilitate the sexual transmission of HIV infection. Screening of selected groups and treatment of contacts can prevent the occurrence of gonorrhea.

Objective 19.2: Reduce *Chlamydia trachomatis* infections, as measured by a decrease in the incidence of nongonococcal urethritis, to no more than 170 cases per 100,000 people



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------------|---------------------|-------------------|---------------------|
| 215 per 100,000 | 170 per 100,000 | No data available | 170 per 100,000 |

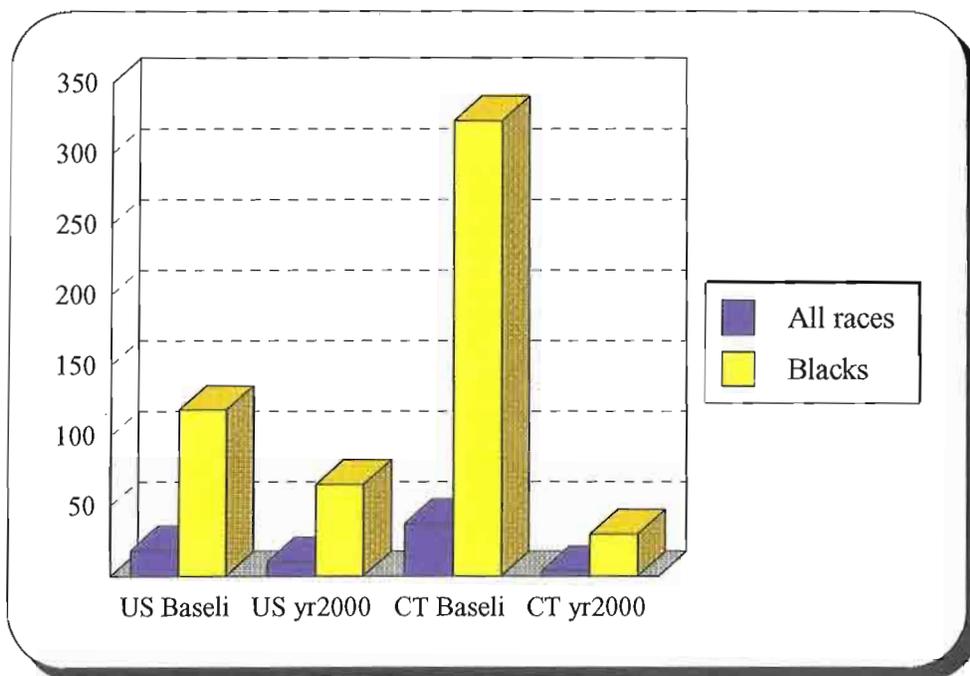
Source: Epidemiology Section, Connecticut Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal Year 2000 Target is used.

Rationale: The consequences of untreated chlamydia include pelvic inflammatory disease and ectopic pregnancy in women, infertility in both women and in men, and eye infections and pneumonia in infants. Chlamydia also facilitates the sexual transmission of HIV infection. Screening of women and early treatment can prevent chlamydia infection and its consequences.

Objective 19.3: Reduce primary and secondary syphilis to an incidence of no more than four cases per 100,000 people overall, and no more than 30 cases per 100,000 in blacks



| Population | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------|-----------------|---------------------|---------------------------|---------------------|
| All races | 18 per 100,000 | 10 per 100,000 | 37 per 100,000 | 4 per 100,000 |
| Blacks | 118 per 100,000 | 65 per 100,000 | 323 per 100,000 (1989) | 30 per 100,000 |

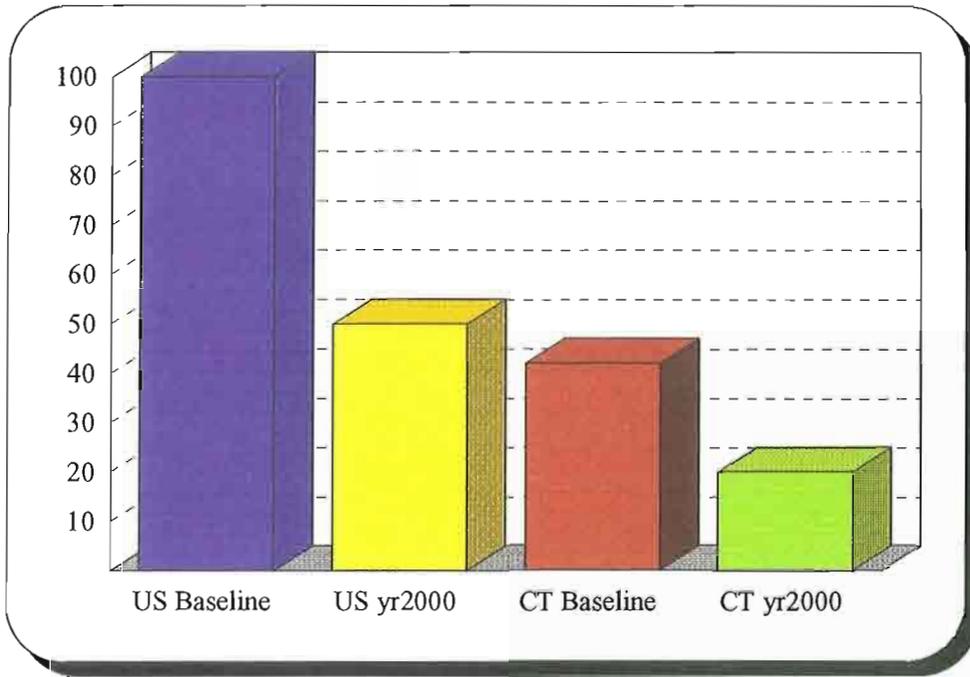
Source: Epidemiology Section, Connecticut Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Syphilis continues to affect mostly minority, inner city populations. The medical and economic consequences of untreated syphilis are often serious and may be life threatening. Syphilis is known to facilitate sexual transmission of HIV on a single exposure to it. Selected screening and treatment of contacts can prevent progression of syphilis and its consequences.

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



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------------------|---------------------|-----------------------|---------------------|
| 100 per 100,000 (1989) | 50 per 100,000 | 42 per 100,000 (1989) | 20 per 100,000 |

Source: Epidemiology Section, Connecticut Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Congenital syphilis can result in stillbirth or a variety of manifestations of disseminated syphilis including skeletal deformities and mental retardation. It can be prevented by prenatal screening, screening programs targeted at high risk women, and more general syphilis prevention efforts.

Chapter 20 - IMMUNIZATION AND INFECTIOUS DISEASES

Infectious diseases have historically been a major source of preventable morbidity and mortality. As recently as 1989, more than 200 measles cases occurred in Connecticut, with more than 10% of them requiring hospitalization and one resulting death. An average of 30 cases of pertussis with several subsequent deaths still occur annually. Immunization is one of the most effective and cost-effective public health interventions. All vaccine-preventable diseases have the potential to be eliminated with increased emphasis on vaccination.

Tuberculosis has recently re-emerged as a preventable disease needing more attention. The HIV epidemic has resulted in increases in TB and mortality in urban areas and among groups with a high prevalence of HIV infection. Other infectious diseases are also increasing. In 1992, annual rabies cases in wildlife increased 57 percent to 831 reported cases. Lyme disease increased 68 percent to 1,821 cases.

A wide range of disease control initiatives are in place to attempt to contain infectious diseases. A total of 711,022

Chapt. 20 - Immunization and Infectious Diseases

p. 20-3

doses of publicly supplied vaccine were purchased for distribution to health care providers in the state. Surveys showed that immunization levels in 2- year-olds in urban areas are 15-20 percent lower than their counterparts in other areas of the state. A State Immunization Action Plan was developed, and \$388,000 in federal funding was obtained to attempt to address this difference. Special efforts have begun to contain HIV-related TB, as it may occur in drug treatment programs, prisons and the community. During the year 1989, 20,963 cases of communicable diseases were reported and evaluated. In addition, 271 outbreaks of illness (22 community, 249 in-hospital/nursing home) were investigated. The Department of Public Health and Addiction Services will continue to identify susceptible populations and prevent illness through vaccination, education and preventive treatment, so the potential for continued spread of infectious diseases can be minimized.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 20 - IMMUNIZATION AND INFECTIOUS DISEASES

Selected Objectives

OBJ. 1 OBJECTIVE DESCRIPTION

Health Status Objectives

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

| |
|---|
| diphtheria in people aged less than 25 years to zero cases tetanus in people aged less than 25 years to zero cases polio (wild type virus) to zero cases measles, rubella and congenital rubella to zero cases mumps and pertussis to less than five and ten cases respectively |
|---|

20.2 Reduce epidemic-related pneumonia and influenza deaths among people aged 65 and older to no more than 7.3 per 100,000

20.3 Reduce Hepatitis B to an overall incidence of 40 cases per 100,000 and to no more than five cases per 100,000 in infants

20.4 Reduce tuberculosis to an overall incidence of no more than 2.8 cases per 100,000 people; in Asian Pacific Islander to no more than 12.0 cases per 100,000; in Blacks to no more than 9.0 cases per 100,000; and in Hispanics to no more than 5.0 cases per 100,000

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

Risk Reduction Objectives

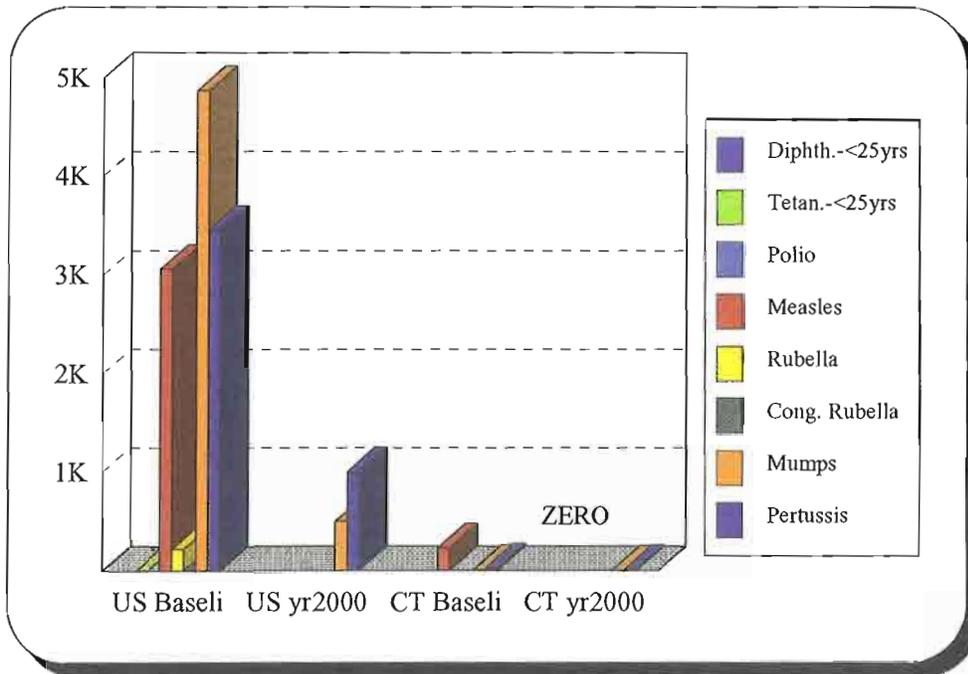
20.11 Increase immunization levels as follows:

- . Basic immunization series among children under age two to at least 90 percent
- . Basic immunization series among children in licensed child care facilities and kindergarten through post-secondary education institutions to 98 percent
- . Pneumococcal pneumonia and influenza immunizations among institutionalized chronically ill or older people to at least 80 percent
- . Hepatitis B immunization among high risk populations, including infants of surface antigen-positive mothers, to at least 90 percent

20.12 Reduce post-exposure rabies treatment by at least 50 percent per year

Objective 20.1: Reduce indigenous cases of vaccine preventable diseases as follows:

| | |
|--|----------------------------------|
| Diphtheria in people aged less than 25 years to zero | Rubella to zero |
| Tetanus in people aged less than 25 years to zero | Congenital rubella to zero |
| Polio (wild type virus) to zero | Mumps to less than five cases |
| Measles to zero | Pertussis to less than ten cases |



| Disease | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------------------|-------------|---------------------|-------------|---------------------|
| Diphtheria* | 1 | 0 | 0 | 0 |
| Tetanus* | 3 | 0 | 0 | 0 |
| Polio | 0 | 0 | 0 | 0 |
| Measles | 3,058 | 0 | 229 (1991) | 0 |
| Rubella | 225 | 0 | 1 (1991) | 0 |
| Congenital rubella | 6 | 0 | 0 | 0 |
| Mumps | 4,866 | 500 | 11 (1991) | 5 |
| Pertussis | 3,450 | 1,000 | 24 (1991) | 10 |

Source: Epidemiology Section, Connecticut Department of Public Health and Addiction Services

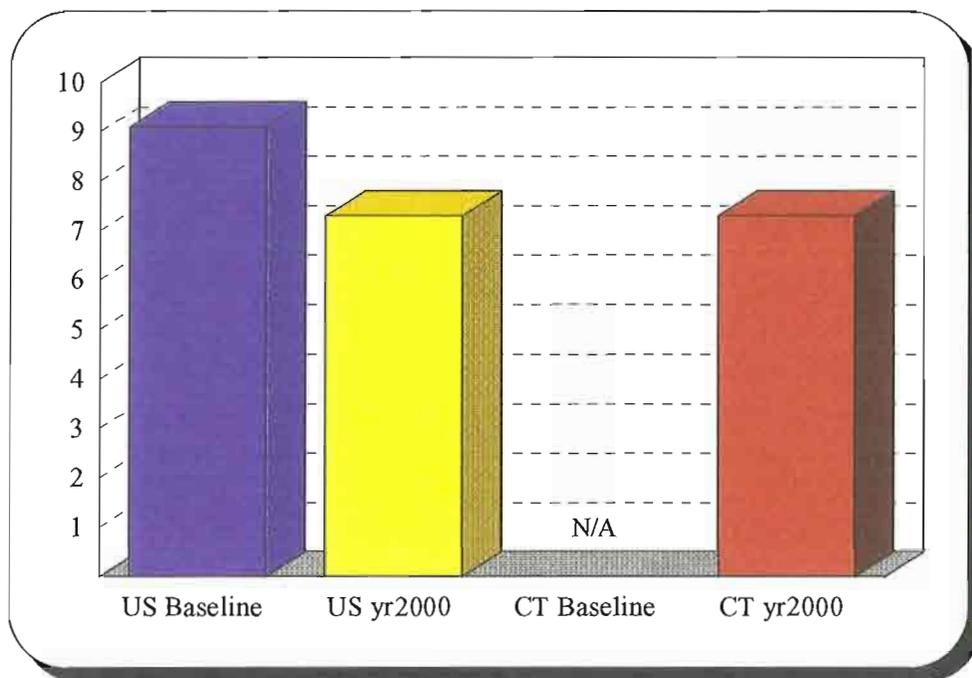
Data

Limitations:

Rationale: Vaccination is currently the most cost-effective of all specific disease control strategies. Each of the above diseases has the potential to be eradicated with fully successful early childhood immunization programs.

*In people less than 25 years of age.

Objective 20.2: Reduce epidemic-related pneumonia and influenza death among people aged 65 and older to no more than 7.3 per 100,000



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------------|---------------------|-------------------|---------------------|
| 9.1 per 100,000 | 7.3 per 100,000 | No data available | 7.3 |

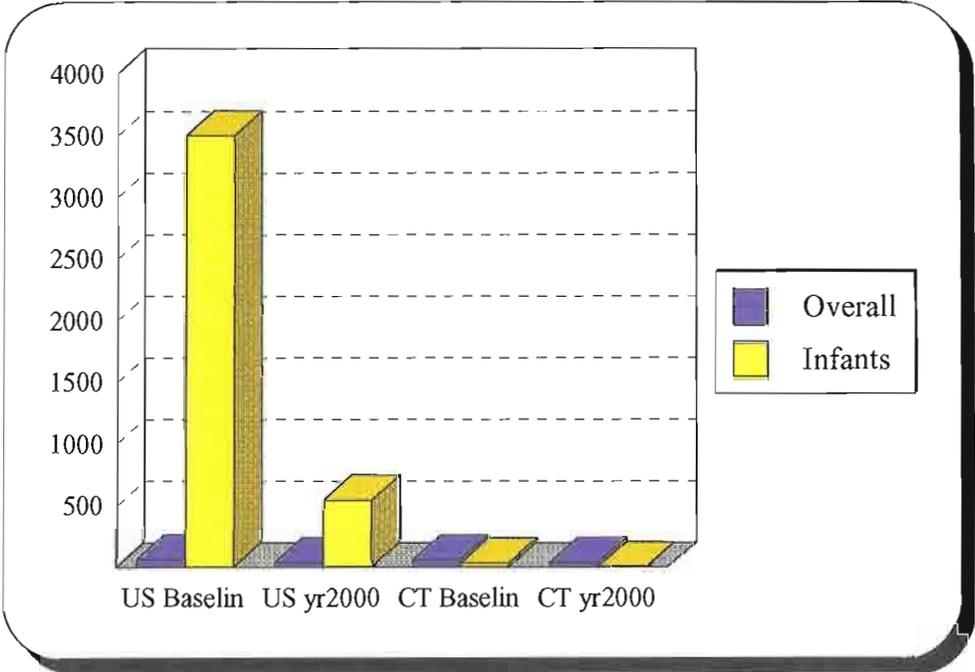
Source: Epidemiology Section, Connecticut Department of Public Health and Addiction Services

Data

Limitations: Due to lack of baseline data, the Federal Year 2000 Target is used.

Rationale: Influenza and pneumonia are major causes of mortality among the elderly. Successful immunization efforts with influenza and pneumococcal vaccines can prevent much of the excess mortality associated with influenza epidemics.

Objective 20.3: Reduce Hepatitis B to an incidence of no more than 40 cases per 100,000 people and no more than five cases in infants



| Population | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------|-------------------|---------------------|-----------------------|---------------------|
| Overall | 63 per 100,000 | 40 per 100,000 | 59 per 100,000 | 40 per 100,000 |
| Infants | 3,500 per 100,000 | 550 per 100,000 | 35 per 100,000 (1989) | 5 per 100,000 |

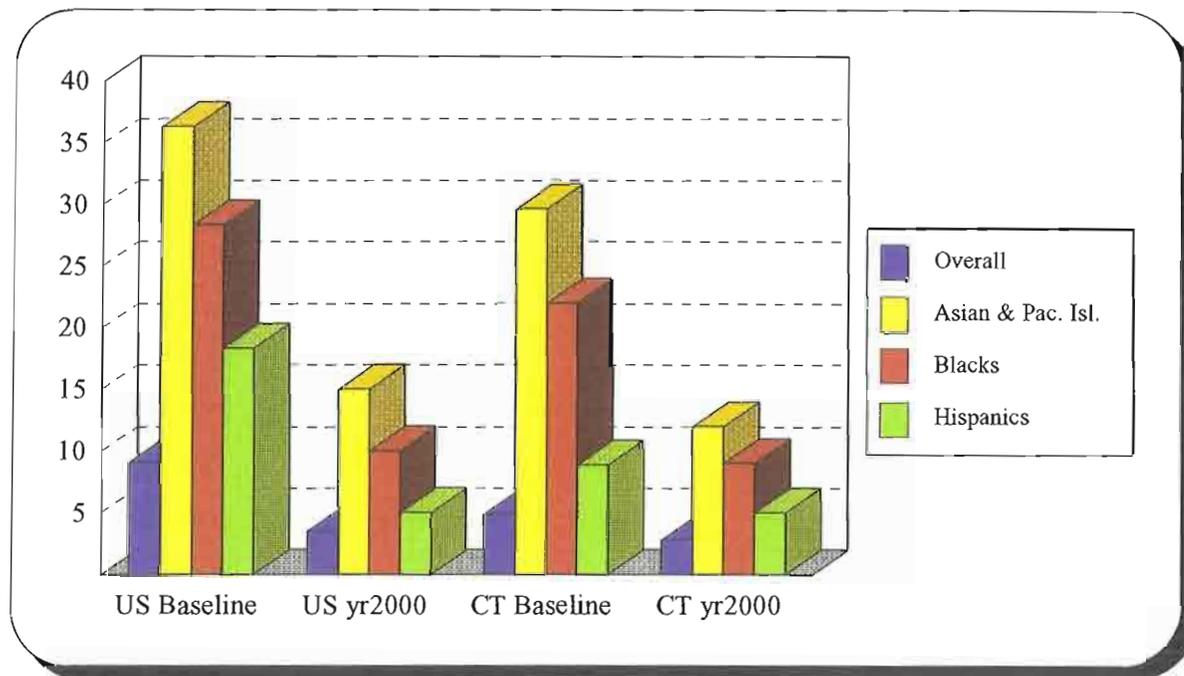
Source: Epidemiology Section, Connecticut Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Hepatitis B is a major cause of acute hepatitis, liver cancer and cirrhosis. Hepatitis B virus infection and its consequences can be prevented with vaccination, now recommended for all infants beginning shortly after birth.

Objective 20.4: Reduce tuberculosis to an incidence of no more than 2.8 cases per 100,000 people; in Asian Pacific Islander to no more than 12.0 cases per 100,000; in blacks to no more than 9.0 cases per 100,000; and in Hispanics to no more than 5.0 cases per 100,000



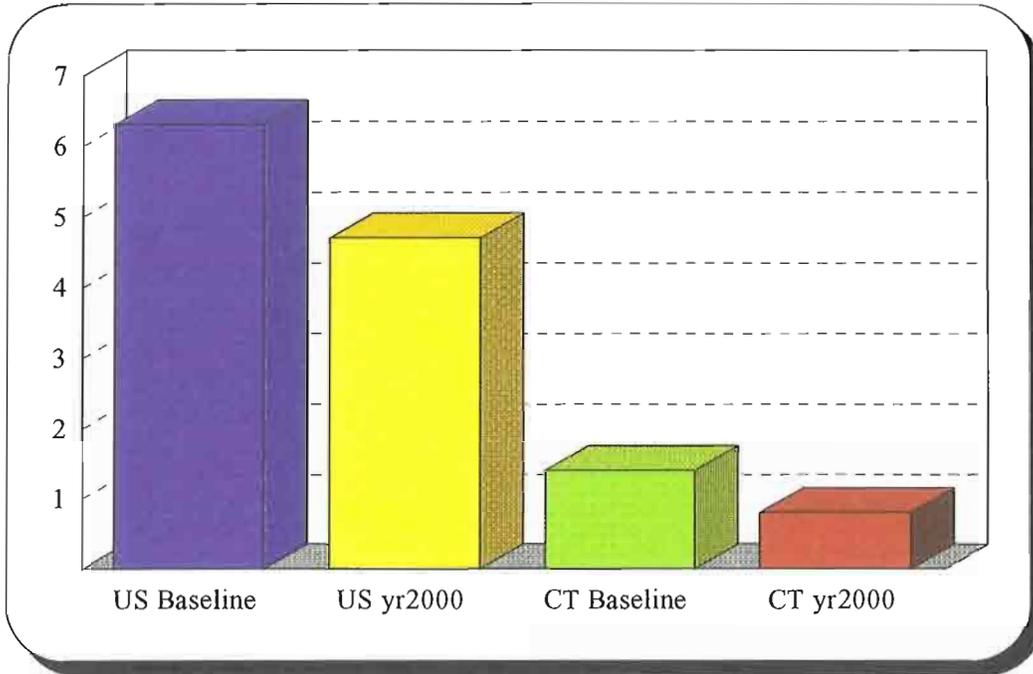
| Population | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------------------------|-------------------------|---------------------|------------------------|---------------------|
| Overall incidence | 3.5 per 100,000 | 3.5 per 100,000 | 4.9 per 100,000 (1989) | 2.8 per 100,000 |
| Asian & Pacific Islander | 15.0 per 100,000 | 15.0 per 100,000 | 29.6 per 100,000 | 12.0 per 100,000 |
| Blacks | 28.3 per 100,000 | 10.0 per 100,000 | 21.9 per 100,000 | 9.0 per 100,000 |
| Hispanics | 18.3 per 100,000 (1987) | 5.0 per 100,000 | 8.9 per 100,000 (1989) | 5.0 per 100,000 |

Source: Epidemiology Section, Connecticut Department of Public Health and Addiction Services

Data
Limitations: The U.S. Year 2000 Target is a short term goal set in the United States Tuberculosis elimination plan.

Rationale: Tuberculosis remains a leading cause of death worldwide and is a substantial cause of preventable morbidity in minority groups in the U.S. and in Connecticut.

Objective 20.7: Reduce bacterial meningitis to no more than 0.8 cases per 100,000 people



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-----------------|---------------------|------------------------|---------------------|
| 6.3 per 100,000 | 4.7 per 100,000 | 1.4 per 100,000 (1989) | 0.8 per 100,000 |

Source: Epidemiology Section, Connecticut Department of Public Health and Addiction Services

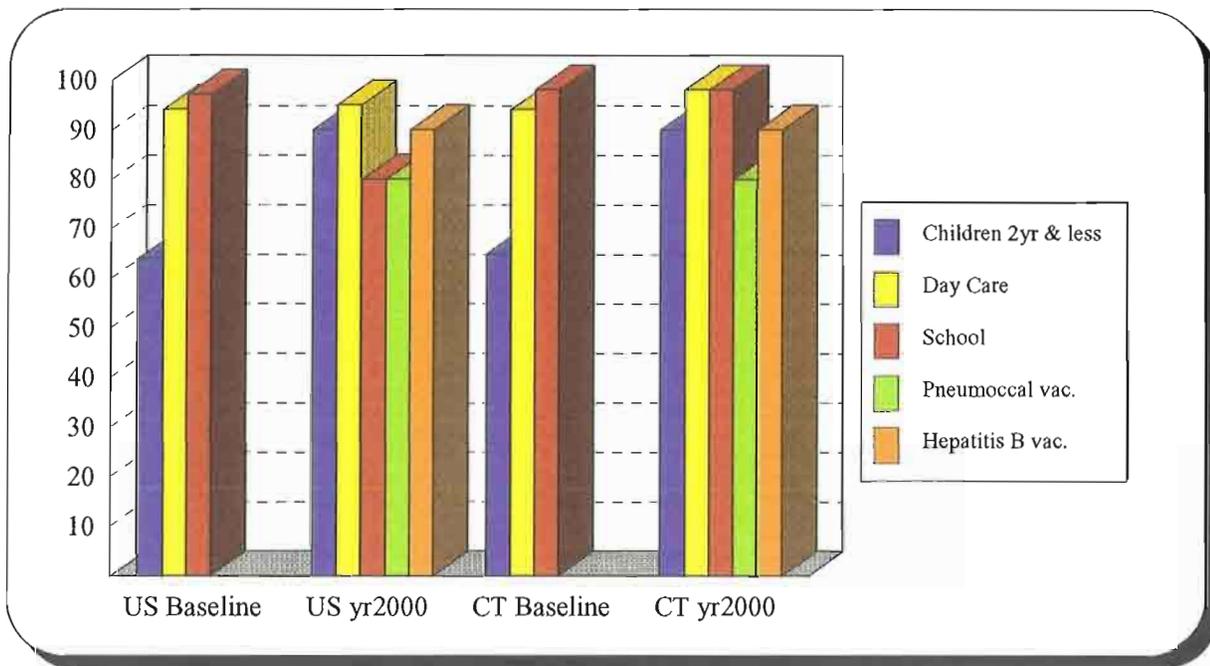
Data

Limitations:

Rationale: Bacterial meningitis is characterized by high death and permanent disability rates. Some forms (e.g., Hib, meningococcal) are preventable with immunization and administration of antibiotics to close contacts.

Objective 20.11: Increase immunization levels as follow:

- **Basic immunization series among children under age two to at least 90 percent**
- **Basic immunization series among children in licensed child care facilities and kindergarten through post-secondary education institutions to 98 Percent**
- **Pneumococcal pneumonia and influenza immunization among institutionalized chronically ill or older people to at least 80 percent**
- **Hepatitis B immunization among high risk populations, including infants of surface antigen-positive mothers, to at least 90 percent**



| Population | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|----------------------------------|-------------|---------------------|-------------|---------------------|
| Children 2 yrs & Less | 54-64% | 90% | 65% (1991) | 90% |
| Day Care | 94-95% | 95% | 94% (1991) | 98% |
| School | 97-98% | 80% | 98% (1991) | 98% |
| Pneumococcal & Influenza Vaccine | No data | 80% | No data | 80% |
| Hepatitis B Vaccine | No data | 90% | No data | 90% |

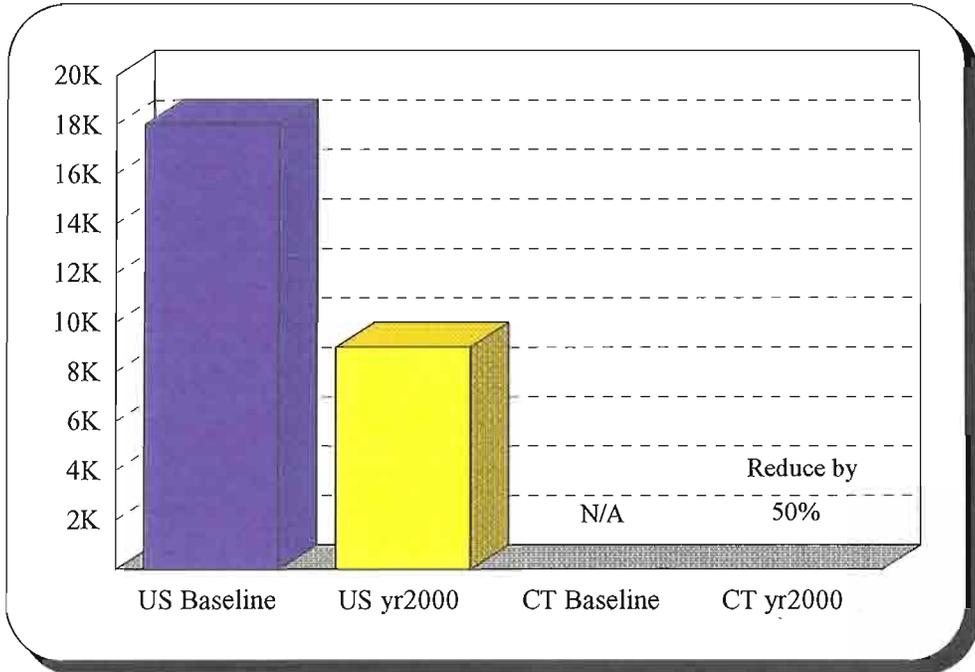
Source: Epidemiology Section, Connecticut Department of Public Health and Addiction Services

Data

Limitations: Where baseline data are lacking, the Federal Year 2000 Target is used.

Rationale: Vaccination is currently the most cost-efficient of all specific disease control strategies.

Objective 20.12: Reduce post-exposure rabies treatment by at least 50 percent



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|-------------------|---------------------|
| 18,000 | 9,000 | No data available | Reduce by 50% |

Source: Epidemiology Section, Connecticut Department of Public Health and Addiction Services

Data

Limitations: Due to the lack of baseline data, the Federal 2000 Target is used. It is hoped that there will be a 50 percent reduction in the actual number of cases of rabies exposures with increased educational efforts and increased animal vaccination.

Rationale: The raccoon rabies epizootic has caused a dramatic increase in the number of persons receiving post exposure treatment in Connecticut. With effective public education and animal vaccination programs, it should be possible to reduce the frequency of unnecessary and costly treatment.

HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 22 - SURVEILLANCE AND DATA SYSTEMS

Adequate surveillance, data collection, and analysis are necessary to achieve the objectives outlined in *Healthy People 2000*. Currently these capacities need to be further developed and integrated within the Department.

Unlike other sections of *Healthy People 2000*, Chapter 22 is focused on public health data systems capacity, which may relate to any of the other content areas. These objectives are intended to improve the coverage, detail and usefulness of public health data systems and guide public health into the 21st century.

Several of the objectives are focused on activities at the national level, and are therefore not included in this Connecticut report. Objective 22.1 called for the development of "a set of health status indicators appropriate for Federal, State and local health agencies, and to establish use of the set in at least 40 States." The first part of this objective was completed when the consensus set of 18 indicators was published in July 1991*. This chapter provides the baseline Connecticut figures which can be used to monitor progress made in each of these 18 areas. The reader will note that the 18

* Centers for disease control and Prevention. Consensus set of health indicators for general assessment of community health status, United States. MMWR 40 (27): 449-51. 1991.

Chapter 22 - SURVEILLANCE AND DATA SYSTEMS

p. 22-2

health indicators presented under objective 22.1 are not all comparable to similar indicators presented in the balance of *Healthy People 2000*. In several cases slightly different measures have been chosen to assure that the consensus indicators can be measured and monitored at all levels, i.e., at the national, state and local levels. In addition to monitoring the consensus indicators identified under objective 22.1, some discussion of objectives 22.5 and 22.6 is also highlighted in this chapter.

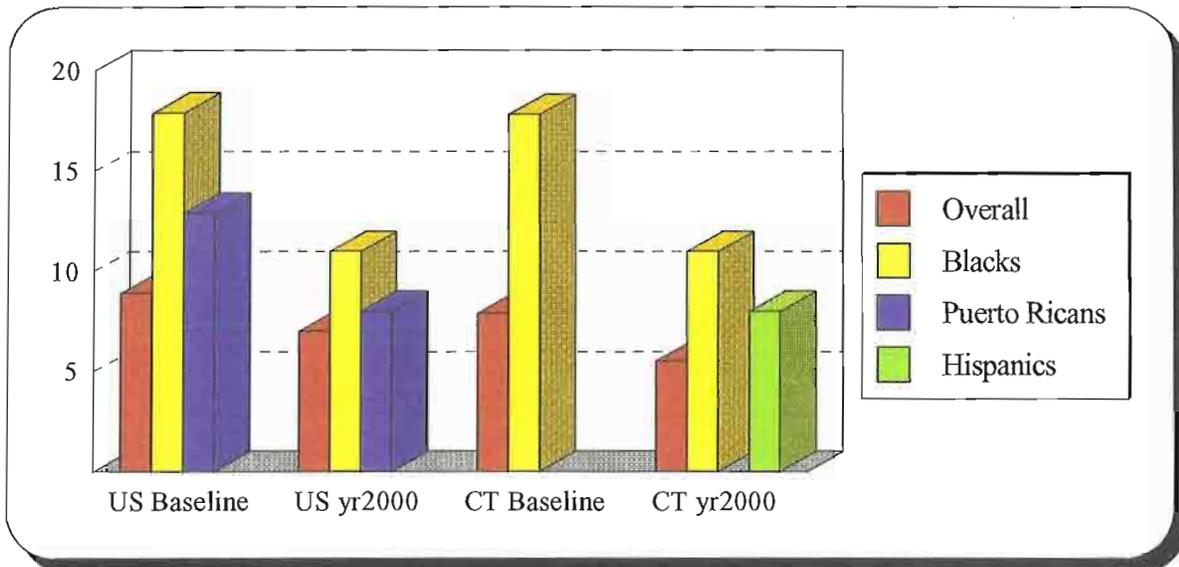
HEALTHY CONNECTICUT 2000 BASELINE ASSESSMENT REPORT

Chapter 22 - SURVEILLANCE AND DATA SYSTEMS

Selected Objectives

| <u>OBJ. 1</u> | <u>OBJECTIVE DESCRIPTION</u> |
|---------------|--|
| 22.1 | Develop a set of health status indicators appropriate for Federal, State and local health agencies, and to establish use of the set in at least 40 States |
| 22.1(a) | Reduce the infant mortality rate to no more than 5.5 per 1,000 live births: Black infants rate to no more than 11 per 1,000 live births and Hispanic infants rate to no more than eight per 1,000 live births |
| 22.1(b) | Reduce deaths caused by motor vehicle crashes to no more than 10.8 per 100,000 people |
| 22.1(c) | Reduce deaths from work-related injuries to no more than 4.0 per 100,000 full-time workers |
| 22.1(d) | Reduce suicides to no more than 6.7 per 100,000 |
| 22.1(e) | Slow the rise in lung cancer deaths to a rate of no more than 42.1 per 100,000 people; rate in females to no more than 34.0 per 100,000; and rate in males to no more than 54.8 per 100,000 |
| 22.1(f) | Reduce breast cancer mortality rate to no more than 23.1 per 100,000 women |
| 22.1(g) | Reduce cardiovascular disease deaths to no more than 118.7 per 100,000 people |
| 22.1(h) | Reduce homicides to no more than 5.0 per 100,000 people |
| 22.1(i) | Reduce deaths from all causes to no more than 328.4 per 100,000 people |
| 22.1(j) | Confine the incidence of diagnosed AIDS to no more than 32.9 per 100,000 cases |
| 22.1(k) | Reduce measles incidence to zero |
| 22.1(l) | Reduce tuberculosis to an incidence of no more than 2.8 cases per 100,000 people: Asian Pacific Islander incidence to no more than 12.0 per 100,000, Blacks incidence to no more than 9.0 per 100,000 and Hispanic incidence to no more than 5.0 per 100,000 |

Objective 22.1 (a): Reduce the infant mortality rate to no more than 5.5 per 1,000 live births



| Race/Ethnicity | US Baseline | US 2000 Target | CT Baseline | CT 2000 Target |
|----------------|----------------|----------------|----------------|----------------|
| Overall | 8.9 per 1,000 | 7.0 per 1,000 | 8.9 per 1,000 | 5.5 per 1,000 |
| Blacks | 17.9 per 1,000 | 11.0 per 1,000 | 17.8 per 1,000 | 11.0 per 1,000 |
| Puerto Ricans | 12.9 per 1,000 | 8.0 per 1,000 | - | - |
| Hispanics* | - | - | - (1990) | 8.0 per 1,000 |

Source: Community Health Services/Maternal and Infant Health Division, Health Surveillance and Planning, Connecticut Department of Public Health and Addiction Services

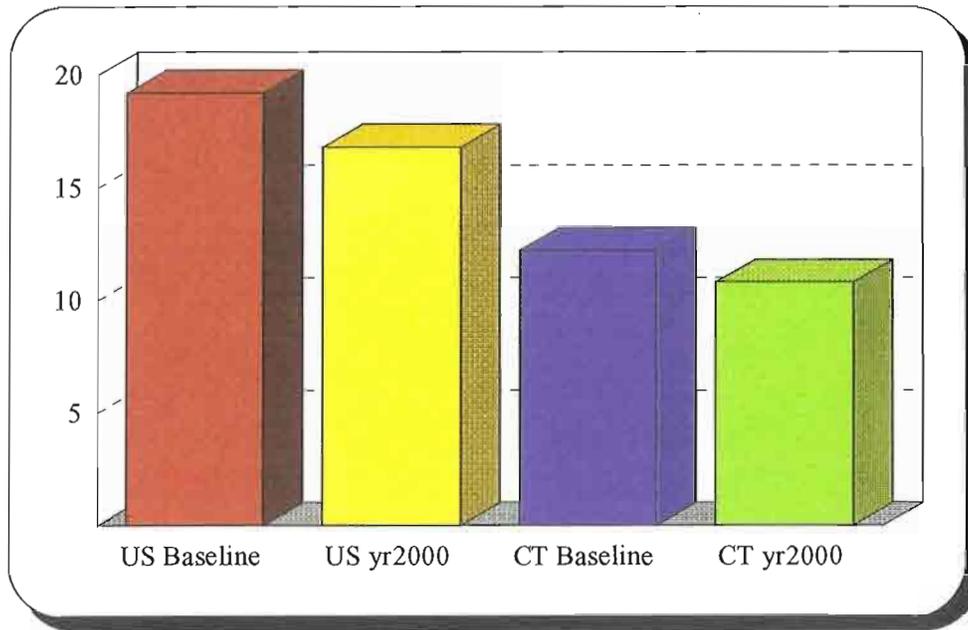
Data

Limitations:

Rationale: Infant mortality rate is widely used to measure and compare the health of communities, states, nations. Some Connecticut cities have an infant mortality rate more than twice the state average; Connecticut ranked 5th out of the six New England states and 17th for all states in 1989; and the U.S. ranks 21st out of 28 countries with Infant Mortality Rate of less than 15. Historically, blacks have had infant mortality rates about double those of whites. Recent trends do not show the black-white gap narrowing. Indeed the gap may be widening. Therefore, the stated objectives for Blacks may be overly optimistic for both Connecticut and the nation.

*Mothers of Hispanic ethnicity are identified based on information from linked birth-infant death files. Although the *Healthy People 2000* objective 13.1c identifies "Puerto Rican" ethnicity, the more general classification "Hispanic," is used here because it is used in standard NCHS (National Center for Health Statistics) tabulations.

Objective 22.1 (b): Reduce deaths caused by motor vehicle crashes to no more than 10.8 per 100,000 people



| US Baseline | US 2000 Target | CT Baseline | CT 2000 Target |
|-------------------------|------------------|-------------------------|------------------|
| 19.2 per 100,000 (1990) | 16.8 per 100,000 | 12.2 per 100,000 (1990) | 10.8 per 100,000 |

Source: Division of Chronic Disease and Injury Prevention, Health Surveillance and Planning, Connecticut Department of Public Health and Addiction Services

Data

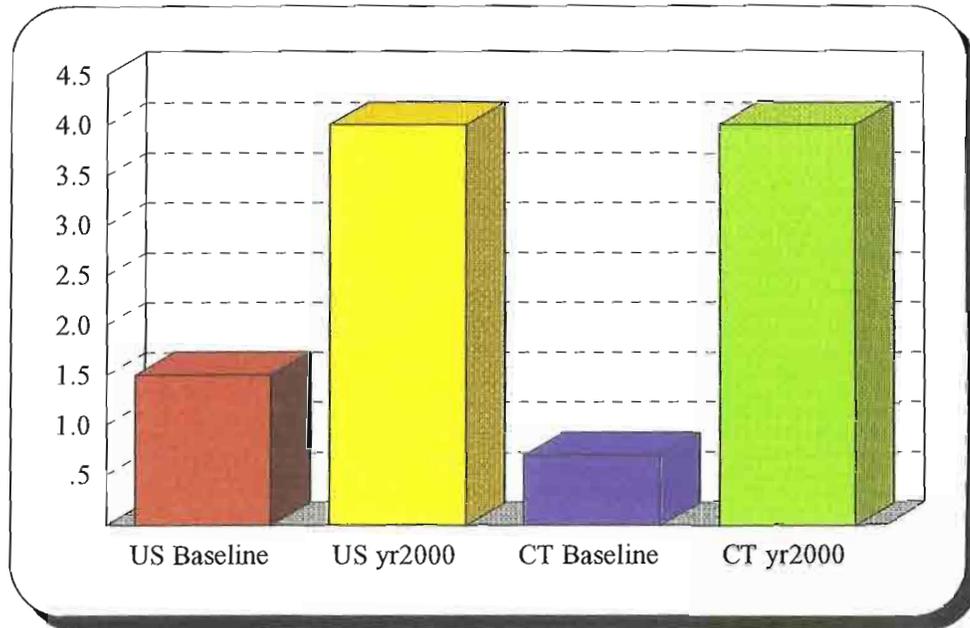
Limitations: Local figures will reflect place of decreased's residents, not the place of the accident.

Rationale: Motor vehicle crashes (including motor vehicle occupants, motorcyclists, bicyclists and pedestrians) are the leading cause of death overall for Connecticut residents, one to 34 years of age. They are also a leading cause of hospitalization. Alcohol plays a major role in motor vehicle crashes; in Connecticut during 1990 over 40 percent of drivers involved in fatal crashes were intoxicated. This percentage is even higher for young drivers.

Special Population Targets

- Children aged 14 years and younger
- Youth aged 15-24 years
- People aged 70 and older
- Motorcyclists
- Pedestrians
- Alcohol-related motor vehicle crash deaths

Objective 22.1 (c): Reduce deaths from work related injuries to no more than four per 100,000 full-time workers



| US Baseline | US 2000 Target | CT Baseline | CT 2000 Target |
|------------------------|-----------------|--------------------------------|-----------------|
| 1.5 per 100,000 (1990) | 4.0 per 100,000 | approx. 0.7 per 100,000 (1990) | 4.0 per 100,000 |

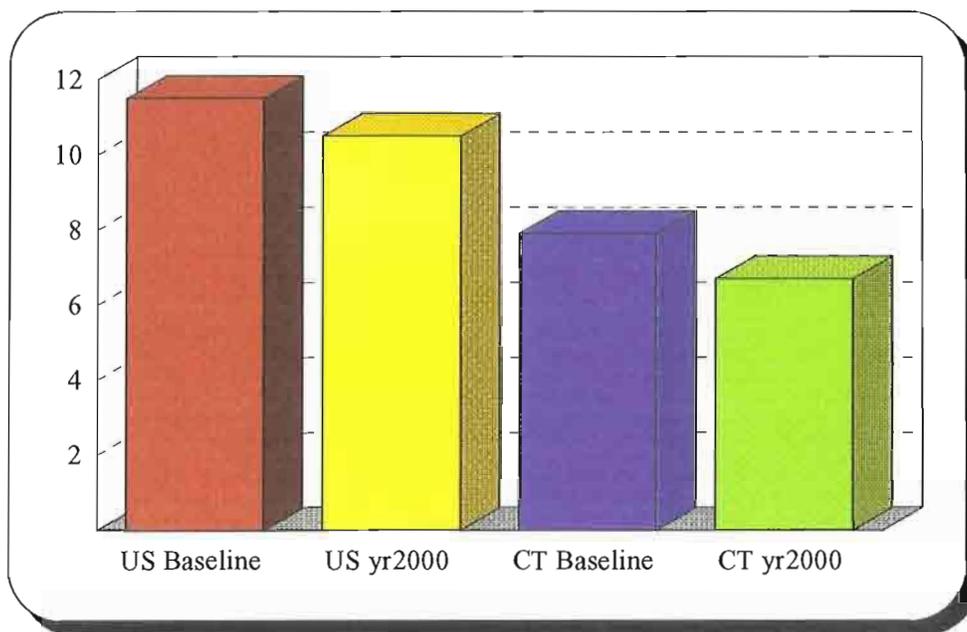
Source: Environmental Epidemiology and Occupational Health Division Health Surveillance and Planning, Connecticut Department of Public Health and Addiction Services

Data

Limitations: Due to uncertainties in the completeness of the reporting for "work related" deaths which relies on information obtained from the Medical Examiner's office, our counts are probably under-reported due to the data collection procedures used. In the absence of a definite Connecticut baseline figure, the U.S. year 2000 target was adopted for Connecticut.

Rationale: Work related injuries are preventable through programs focused on education and work environment surveillance.

Objective 22.1 (d): Reduce suicides to no more 6.7 per 100,000 people



| US Baseline | US 2000 Target | CT Baseline | CT 2000 Target |
|-------------------------|------------------|------------------------|-----------------|
| 11.5 per 100,000 (1990) | 10.5 per 100,000 | 7.9 per 100,000 (1990) | 6.7 per 100,000 |

Source: Division of Chronic Disease and Injury Prevention, Connecticut Department of Public Health and Addiction Services

Data

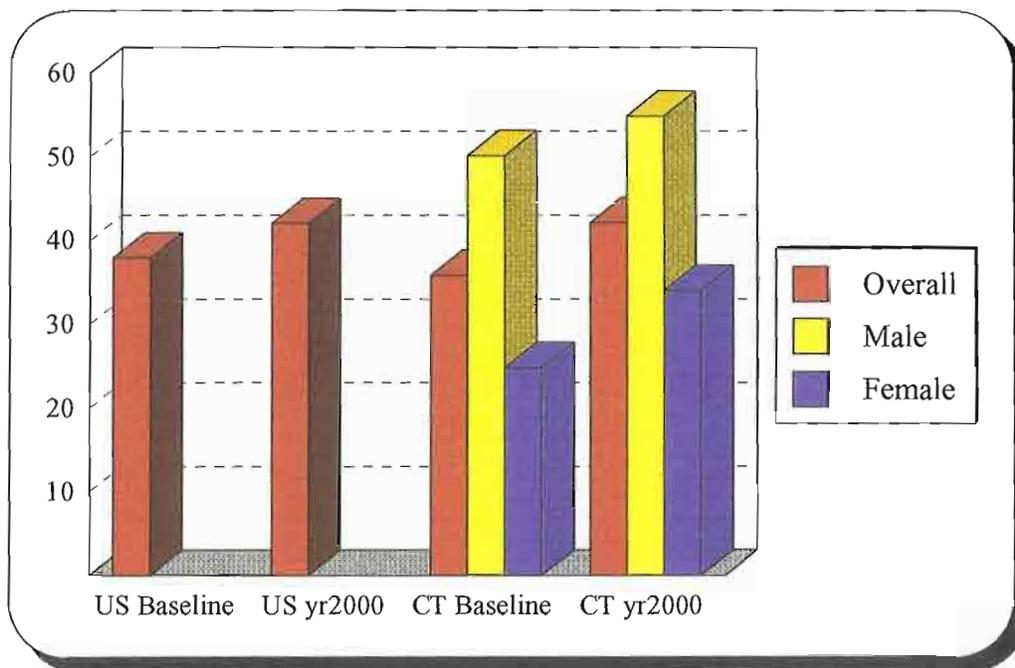
Limitations:

Rationale: Suicide is one of the leading causes of death for Connecticut youth and young adults aged 15 to 35 years old. Men over the age of 65 have a higher suicide rate than any other population group. When high-risk behaviors are identified, suicide can be prevented.

Special Target Populations

- Youth aged 15-19 years
- Men aged 20-34 years
- White men aged 65 years and older

Objective 22.1(e): Slow the rise in lung cancer deaths to a rate of no more than 42.0 per 100,000 people



| Sex | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|---------|------------------|---------------------|------------------|---------------------|
| Overall | 37.9 per 100,000 | 42.0 per 100,000 | 35.8 per 100,000 | 42.0 per 100,000 |
| Male | - | - | 50.1 per 100,000 | 54.8 per 100,000 |
| Female | - | - | 24.8 per 100,000 | 34.0 per 100,000 |
| | (1987) | | (1989) | |

Source: Division of Chronic Disease and Injury Prevention, Health Surveillance and Planning, Department of Public Health and Addiction Services

Data

Limitations: The consensus indicator is for both sexes; however due to the substantial differences in mortality rates and the associated trends for men and women, separate objectives will be tracked for each sex.

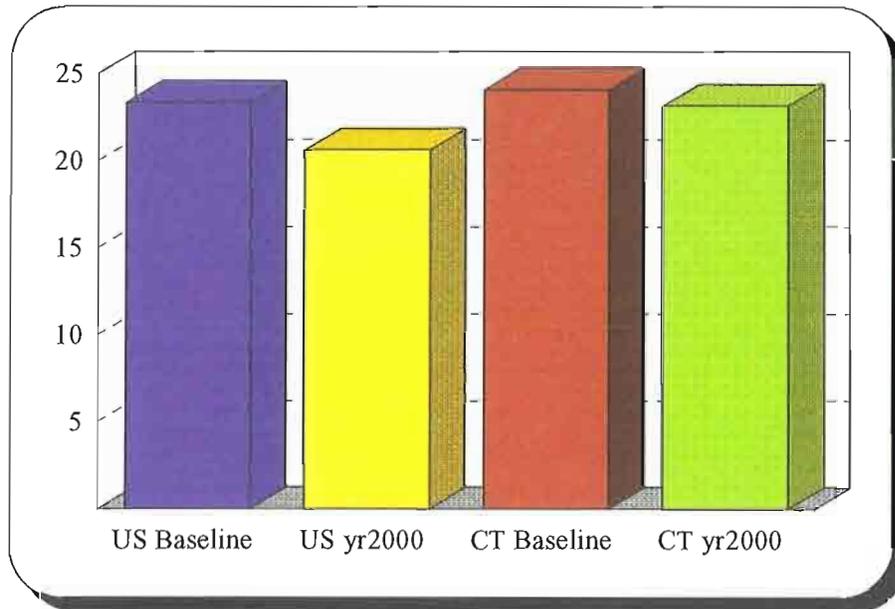
Rationale: Of the 7,082 cancer deaths in 1989, 1,443 (20.4%) were attributable to smoking. Lung cancer is associated with smoking and exposure to secondhand smoke. Both primary and secondary smoke exposure are preventable. The incidence of lung cancer in women in Connecticut rose tenfold between 1935-39 and 1988.

Special Target Populations:

Women

Blacks

Objective 22.1(f): Reduce breast cancer mortality rate to no more than 23.1 per 100,000 women



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------------------|---------------------|-------------------------|---------------------|
| 23.3 per 100,000 (1988) | 20.6 per 100,000 | 24.0 per 100,000 (1989) | 23.1 per 100,000 |

Source: Division of Chronic Diseases and Injury Prevention, Department of Public Health and Addiction Services

Data

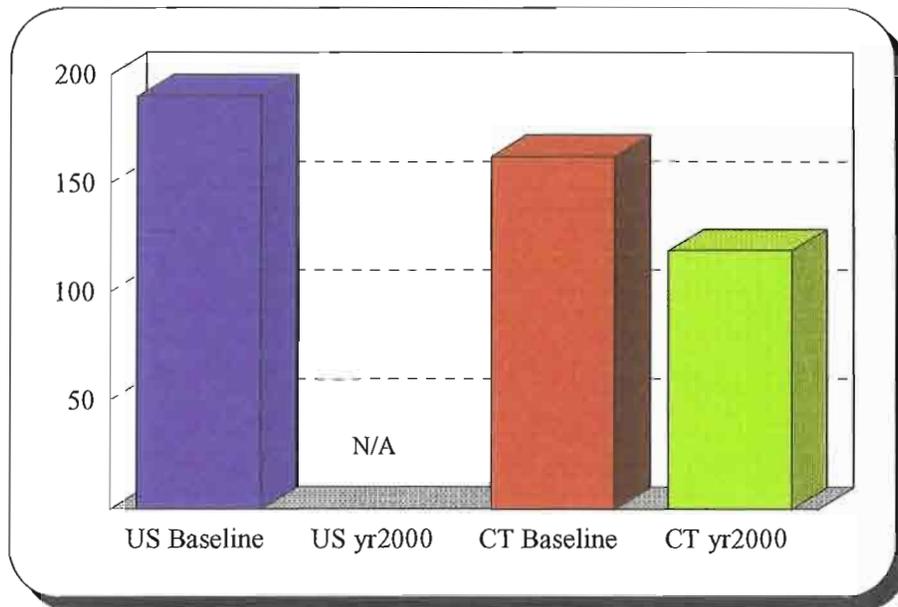
Limitations:

Rationale: In the United States, one in eight women will develop breast cancer in her lifetime. Breast cancer deaths can be decreased by early detection and treatment. The National Cancer Institute and the American Cancer Society recommend mammograms every two years for women 40-50 years old and every year for women 50 and older. Self exams and a yearly exam by a physician are also recommended. Those individuals with a family history of breast cancer family are encouraged to have more frequent exams and screenings. The Connecticut Tumor Registry data indicates that certain population groups tend to be diagnosed with more advanced disease. Earlier detection would have reduced death rates in these groups. There may also be a link between breast cancer and fat in the diet, a potentially modifiable behavior.

Target Population

Women over 50

Objective 22.1(g): Reduce Cardiovascular disease deaths to no more than 84.4 per 100,000 people



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------------------------|---------------------|--------------------------|---------------------|
| 189.9 per 100,000 (1990) | Not Applicable | 161.8 per 100,000 (1990) | 161.8 per 100,000 |

Source: Division of Chronic Diseases and Injury Prevention, Department of Public Health and Addiction Services

Data

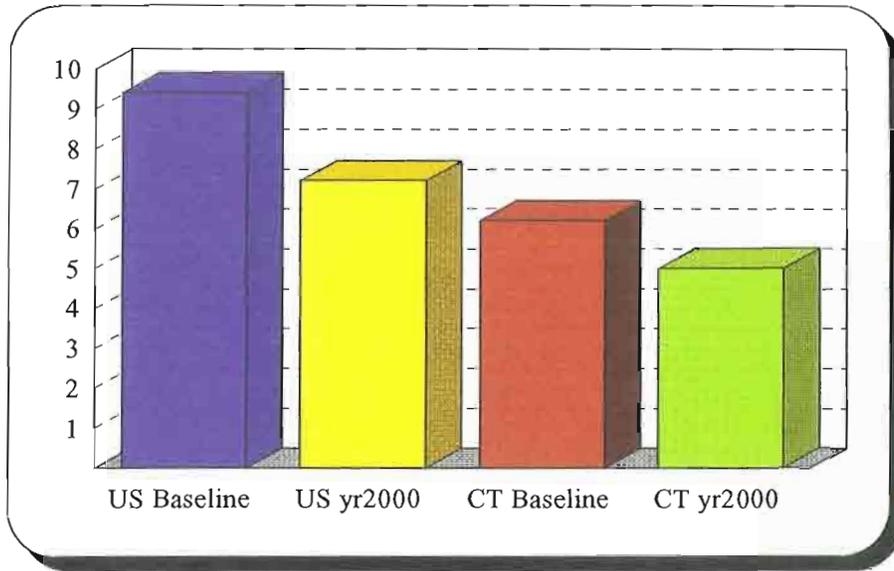
Limitations:

Rationale: Heart disease is the major component of cardiovascular disease and is the leading cause of death in Connecticut, causing a total of 9,810 deaths in 1989. About half of these deaths are preventable, linked to risk factors that are modifiable. Attributable causes of these deaths are smoking (987), obesity (1980), sedentary lifestyle (853), high blood pressure (1,614) and elevated cholesterol (330). In addition, exposure to secondhand smoke has been identified by the American Heart Association as responsible for up to 35,000 heart disease deaths per year in the United States.

Special Population Target

Blacks

Objective 22.1(h): Reduce homicides to no more than 5.0 per 100,000 people



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------------------|---------------------|------------------------|---------------------|
| 9.4 per 100,000 (1989) | 7.2 per 100,000 | 6.2 per 100,000 (1989) | 5.0 per 100,000 |

Source: Health Surveillance and Planning, Department of Public Health and Addiction Services

Data

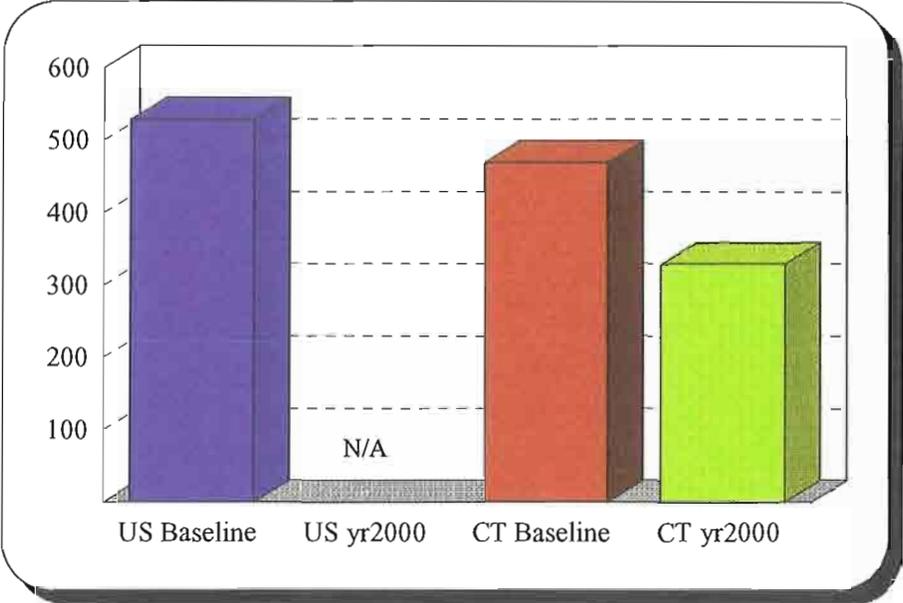
Limitations:

Rationale: Homicide is one of the leading causes of death for Connecticut residents under the age of 35 years. It is the leading cause of death for minority youth and young adults in Connecticut. Deaths due to homicide are all preventable.

Special Target Populations

- Children aged 3 and younger
- Spouses aged 15-34
- Black men aged 15-34
- Hispanic men aged 15-34
- Black women aged 15-34

Objective 22.1(i): Reduce all causes of death to no more than 328.4 per 100,000 people



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------------------------|---------------------|--------------------------|---------------------|
| 528.0 per 100,000 (1989) | Not Applicable | 467.9 per 100,000 (1989) | 328.4 per 100,000 |

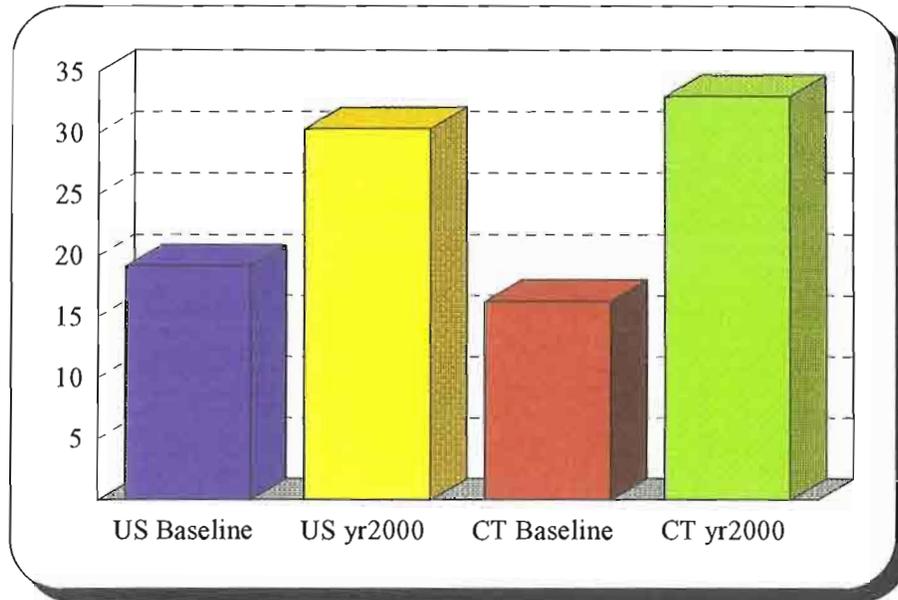
Source: Health Surveillance and Planning, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Reduction of all causes of death can be effected through education, prevention and intervention efforts. This is a comprehensive measure which provides a meaningful indicator for assessing demographic and geographic group differences. This measure can be contrasted with other summary measures such as life expectancy and potential life years lost.

Objective 22.1(j): Confine the incidence of AIDS to no more than 32.9 per 100,000 people



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------------------------|---------------------|-------------------------|---------------------|
| 19.1 per 100,000 (1991)* | 30.3 per 100,000 | 16.2 per 100,000 (1991) | 32.9 per 100,000 |

Source: AIDS Division, Connecticut Department of Public Health and Addiction Services

Data

Limitations: The Connecticut Year 2000 Target is based on the current trend for 1981-1991.

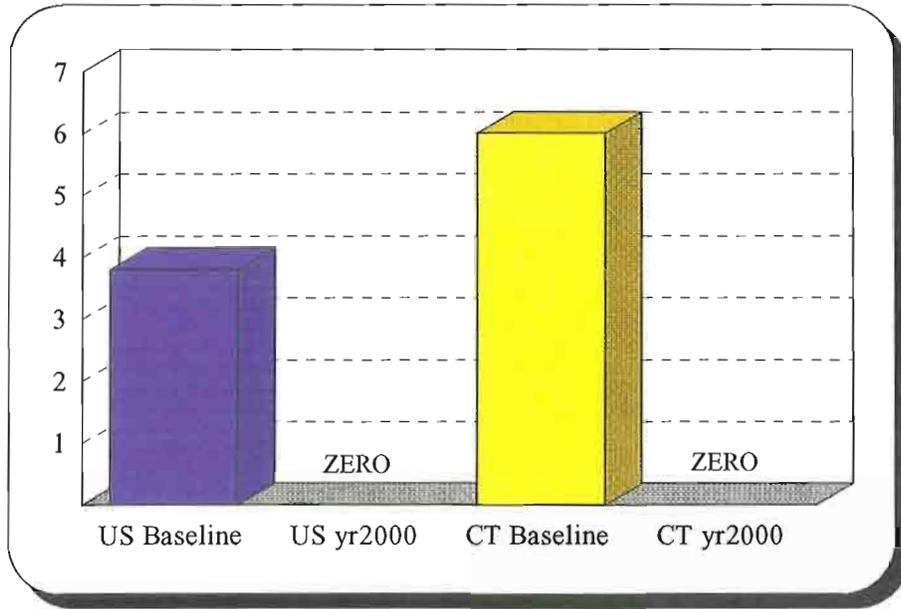
Rationale: This is one of eighteen consensus health indicators we are required to collect.

**Healthy People 2000* Statistical Notes, Spring 1992 Vol. 1, No. 3, p. 4, NCHS, CDC.

Healthy People 2000 says to limit to 98,000 cases. Since this figure, 98,000 was adjusted for under-reporting, we use the original figure 83,300 (85% of 98,000). [1] Although the the U.S. baseline is higher than Connecticut's, the U.S. year 2000 target is lower. This discrepancy is due to the differing methods used to derive U.S. and Connecticut target figures. [1] The year 2000 US target of 98,000 cases was the product of an AIDS experts conference in 1989. The Connecticut target is based on a linear projection of 1981-91 rates. The National Center for Infectious Diseases has published estimated by year of diagnosis US AIDS incidence rates, rates for 1981-91 (see * above). Using these data in a linear trend projection to 2000 yields a projected US incidence figure of 38.9/100,000. Use of the same method produces consistent estimates.

[1] To calculate the U.S. 2000 rate=30.3/100,000 ($10^5 \times 83,300/274,815,000$).

Objective 22.1(k): Reduce measles incidence to zero cases per 100,000 people



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------------------|---------------------|------------------------|---------------------|
| 3.8 per 100,000 (1991) | 0.0 per 100,000 | 6.0 per 100,000 (1991) | 0.0 per 100,000 |

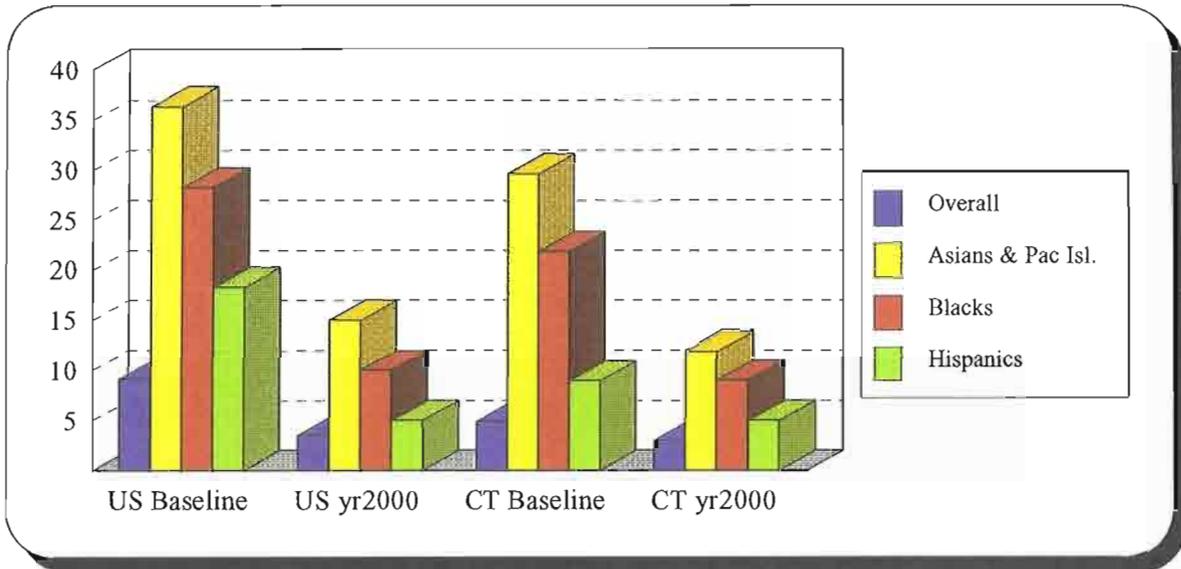
Source: Epidemiology Section, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Vaccination is currently the most cost-effective of all specific disease control strategies. Measles has the potential to be eradicated with fully successful early childhood immunization programs.

Objective 22.1(l): Reduce tuberculosis to an incidence of no more than 2.8 cases per 100,000 people



| Population | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------------------------|-------------------------|---------------------|------------------------|---------------------|
| Overall incidence | 9.1 per 100,000 | 3.5 per 100,000 | 4.9 per 100,000 | 2.8 per 100,000 |
| Asian & Pacific Islander | 36.3 per 100,000 | 15.0 per 100,000 | 29.6 per 100,000 | 12.0 per 100,000 |
| Blacks | 28.3 per 100,000 | 10.0 per 100,000 | 21.9 per 100,000 | 9.0 per 100,000 |
| Hispanics | 18.3 per 100,000 (1987) | 5.0 per 100,000 | 8.9 per 100,000 (1989) | 5.0 per 100,000 |

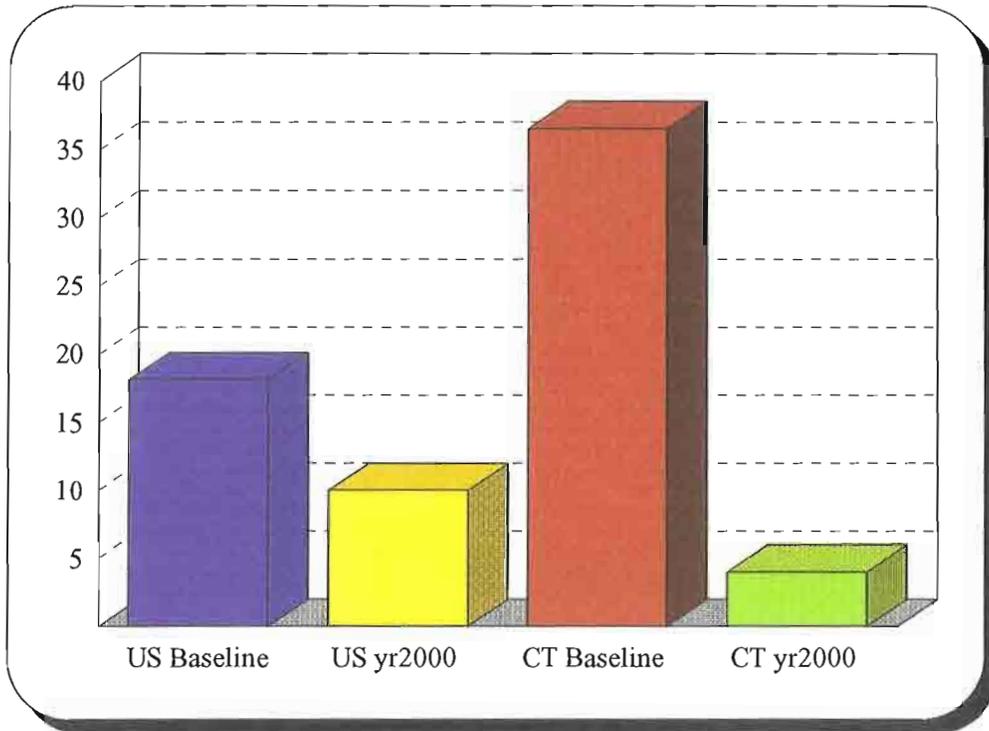
Source: Epidemiology Section, Department of Public Health and Addiction Services

Data

Limitations: The U.S. Year 2000 Target is a short term goal set in the United States Tuberculosis elimination plan.

Rationale: Tuberculosis remains a leading cause of death worldwide and is a substantial cause of preventable morbidity in minority groups in the U.S. and in Connecticut. The incidence of tuberculosis has been increasing as a result of a drug resistant strain particularly in high risk "immunocompromised" populations. Increased surveillance will assist in earlier identification to eventually reduce transmission rates.

Objective 22.1(m): Reduce primary and secondary syphilis to an incidence of no more than 4.0 cases per 100,000 people



| Population | US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|------------|-------------------------|---------------------|-------------------------|---------------------|
| Overall | 18.1 per 100,000 (1989) | 10.0 per 100,000 | 36.5 per 100,000 (1989) | 4.0 per 100,000 |

Source: Epidemiology Section, Department of Public Health and Addiction Services

Data

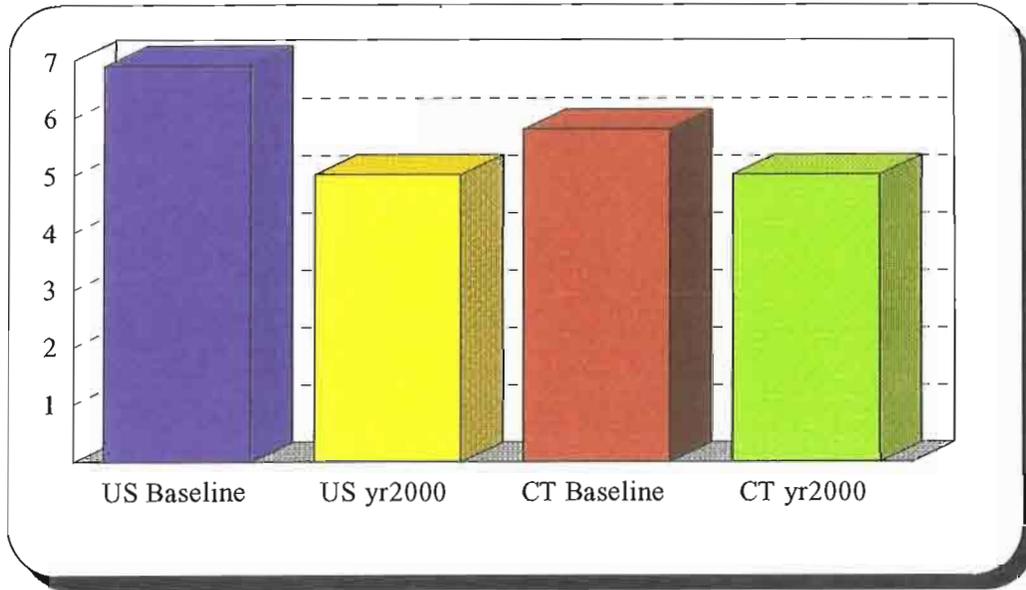
Limitations:

Rationale: Syphilis continues to affect mostly minority, inner city populations. The medical and economic consequences of untreated syphilis are often serious and may be life threatening. Syphilis is known to facilitate sexual transmission of HIV after a single exposure to it. Selected screening and empiric treatment of contacts can prevent progression of syphilis and its consequences.

Special Population Target

Black men and women

Objective 22.1(n): Reduce low birth weight to an incidence of no more than five percent of live births



| Birth weight | US Baseline | US 2000 Target | CT Baseline | CT 2000 Target |
|------------------|-------------|----------------|-------------|----------------|
| Low birth weight | 6.9% (1987) | 5% | 6.9% (1991) | 5% |

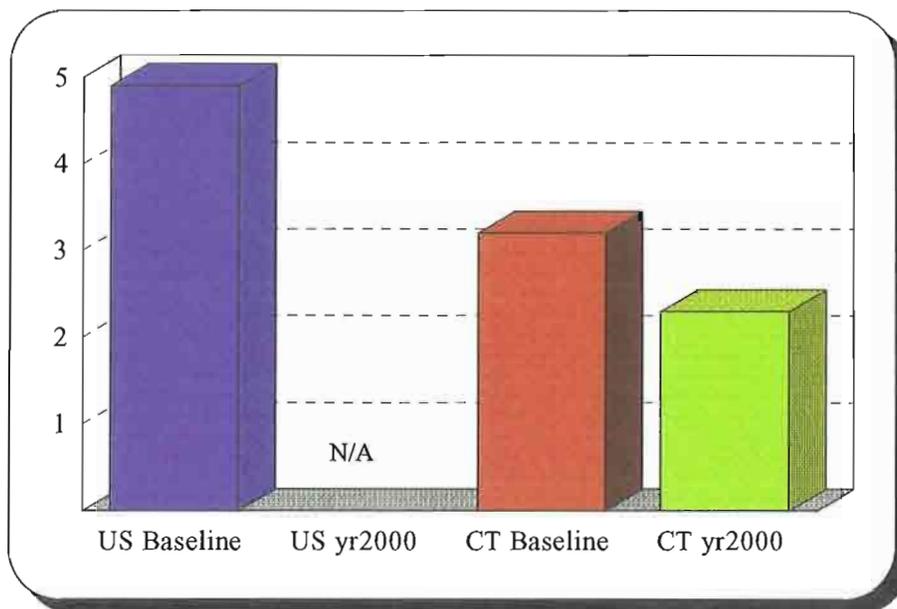
Source: Community Health Services/Maternal and Infant Health, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Medical care costs for low-birth-weight infants can average \$30,000. Low-birth-weight infants are at greater risk for death, health problems, developmental disorders and other handicapping conditions. Prevention of low birth weight can be achieved through a number of strategies, such as improving access to family planning and prenatal care, preterm birth prevention programs, smoking cessation, substance abuse programs, and nutrition programs (e.g., WIC).

Objective 22.1(o): Reduce births to adolescents (ages 10-17) as a percentage of total live births to 5.9 percent



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|-------------|---------------------|--------------|---------------------|
| 4.9% (1991) | Not Applicable | 3.2 % (1991) | 2.3% |

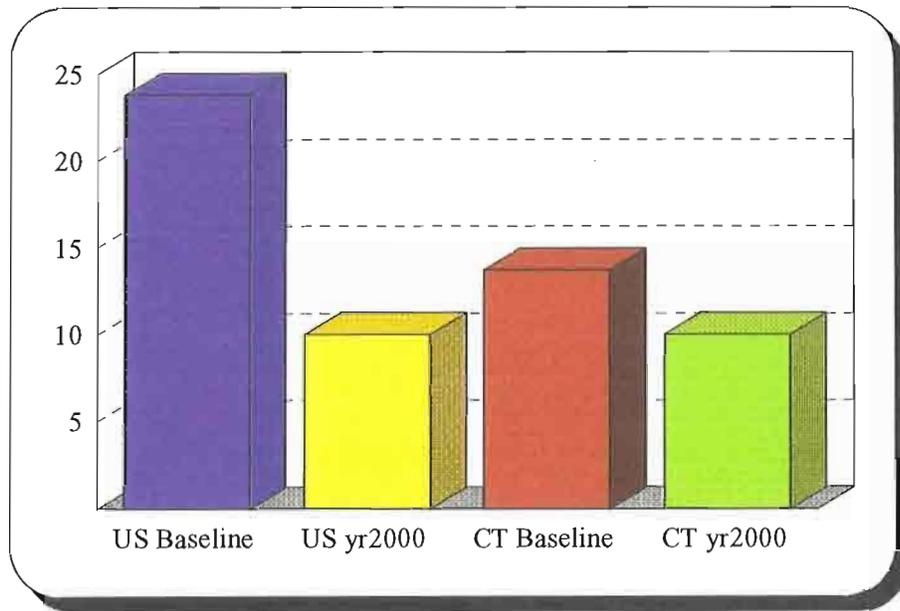
Source: Community Health Services/Maternal and Infant Health, Department of Public Health and Addiction Services

Data

Limitations: The lack of age-specific population figures led to the adoption of this indicator rather than using adolescent birth rates per 100,000 girls aged 10-17 years.

Rationale: This indicator may identify social and behavioral risk factors, and limited access to health care.

Objective 22.1(p): Reduce the percentage of mothers delivering babies with late or no prenatal care to no more than ten percent



| US Baseline | US Year 2000 Target | CT Baseline | CT Year 2000 Target |
|--------------|---------------------|--------------|---------------------|
| 23.8% (1991) | 10% | 13.7% (1991) | 10% |

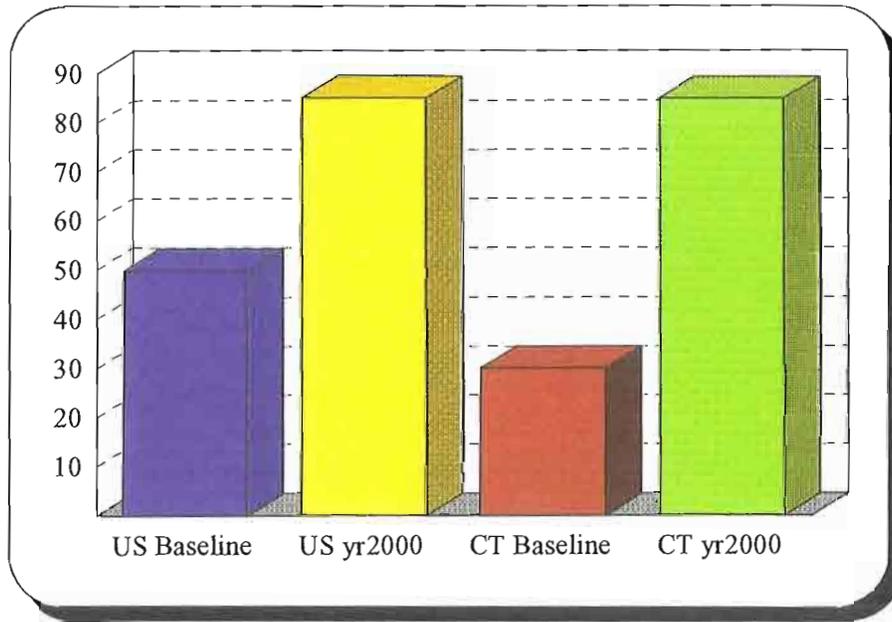
Source: Maternal and Child Health Division, Health Surveillance and Planning, Department of Public Health and Addiction Services

Data

Limitations: The historic trend for late/no prenatal care is increasing, with a project year 2000 value of 16.6 percent. The trend is too unreliable to be considered accurate. Due to the lack of prenatal data prior to 1981, the data include only 1981-1991 figures.

Rationale: Based on strong programmatic efforts to increase the use of early prenatal care, the CT Year 2000 Target was set at ten percent, equal to the U.S. Target.

Objective 22.1(q): Reduce human exposure to criteria air pollutants, as measured by an increase to at least 85 percent in the proportion of people who live in counties that have not exceeded any Environmental Protection Agency standard for air quality in the previous 12 months



| US Baseline | US Year 2000 Goal | CT Baseline | CT Year 2000 Goal |
|--------------|-------------------|--------------------|-------------------|
| 49.7% (1988) | 85% | Approx. 30% (1989) | 85% |

Source: Environmental Epidemiology and Occupational Health Division, Department of Public Health and Addiction Services

Data

Limitations:

Rationale: Connecticut has some of the worst ambient air pollution problems in the country, especially for ozone. Much of this pollution is from out of state. Reduction will result in health improvements, especially for asthmatics. This objective primarily relates to one of the primary missions of the Connecticut Department of Environmental Protection, which has linkages to the Department of Public Health and Addiction Services, Bureaus of Health Promotion and Laboratory.

Objective 22.5: Periodic analysis and publication of State progress toward the national objectives for each racial or ethnic group that makes up at least 10 percent of the State population

Source: Office of Health Policy Development, Department of Public Health and Addiction Services

Data

Limitations: There are currently no data available at the state level. For the first time this year, U.S. data have been provided for tracking objectives and sub-objectives in 22 priority areas in *Health United States 1992*, August 1993, DHHS Pub. No. (PHS) 93-1232.

Rationale: Statewide, in 1990, neither the Black nor the Hispanic groups accounted for 10 percent or more of the state population (Blacks constituted 8.3 percent, and Hispanics 6.5 percent of the 1990 population). There are 14 towns in Connecticut (1990) with populations that were about 10 percent or more Hispanic or Black. These town-level subgroups are not always included in our major surveillance reports. Analyzing and disseminating consensus indicator information at this level of detail will require new data and reporting infrastructure. Nevertheless, this effort is warranted because racial and ethnic minorities have historically had the greatest health care needs and may benefit from new systematic efforts to track their health status.

Objective 22.6: Expand all State systems for the transfer of health information related to the national health objectives among Federal, State and local agencies

Source: Office of Health Policy Development, Department of Public Health and Addiction Services

**Data
Limitations:**

Rationale: In Connecticut, our ability to transfer health information is uneven, and is limited by infrastructure limitations at the state and local level. The identification in this document of health indicators that can also be tracked at a local level provides the core contents around which an initial system may be designed.