Health Indicators and Risk Behaviors in Connecticut: Results of the 2018 Connecticut Behavioral Risk Factor Surveillance Survey (BRFSS)

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The CT BRFSS team acknowledges with gratitude the time contributed by over 10,709 citizen volunteers within the State of Connecticut who responded anonymously to the 2018 BRFSS. The results presented in this report would not be possible without their participation.

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SUMMARY

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

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

In this report, a section named State of the State compares selected adult health indicators in Connecticut during calendar year 2018, with median results from 2018 for the United States and its territories. In addition, 38 selected health indicators are discussed in six chapters: 1) health status indicators, 2) risk behavior indicators, 3) clinical preventive practices, 4) chronic conditions, 5) environmental health indicators, and 6) child health.

METHODOLOGY

The population for the Connecticut Behavioral Risk Factor Surveillance System (CT BRFSS) consists of the total non-institutionalized English and Spanish-speaking adult population. In 2018, the CT BRFSS collected 5,195 landline interviews and 5,514 cell phone interviews, totaling 10,709 interviews. If any children lived in the same household as the respondent, one child was randomly selected, and the adult respondent provided information about that child. A total of 2,407 interviews about children were completed. The landline sample was a disproportionate stratified random digit dial (RDD) sample, stratified by geography and listed status. Within each contacted household, one adult was selected at random to be interviewed. The cell phone sample was an unstratified RDD sample drawn from dedicated cellular telephone banks with equal probability. An adult contacted by cell phone was eligible to complete the survey if he or she lived in a private residence or college housing and did not have a landline at these residences.

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

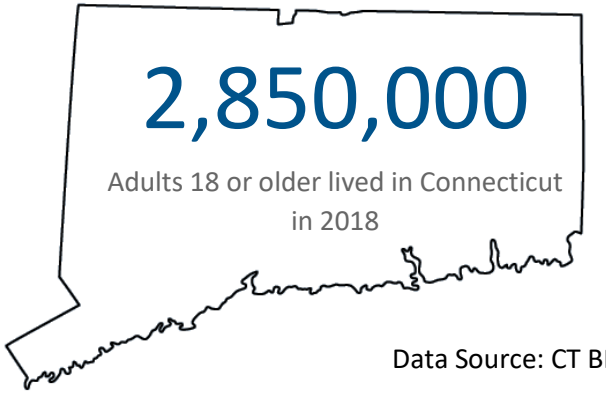
Prevalence estimates and 95% confidence intervals were computed using SAS PROC SURVEYFREQ, which can properly compute variances for complex sampling plans. Any responses of "Not known/Not sure" or "Refused" were classified as missing. The coefficients of variation (CV) were used to assess the validity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

not disclosed in this report, but are available in the 2018 Summary Tables posted online.

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

Significant increases or decreases compared to the United States were evaluated by a one-population two-tailed binomial test. Change in the prevalence of selected health indicators from years 2014 to 2018 was evaluated using a two population two-tailed chi-squared test for significant increase or decrease. Statistical significance testing was only conducted in prevalence estimates with a CV less than 0.15. Significance testing by demographic characteristic was evaluated using a two population two-tailed chi-squared test for significant increase or decrease in risk/protection or prevalence (alpha=0.05); only significant results are discussed in this report.

ADULT DEMOGRAPHICS IN CONNECTICUT



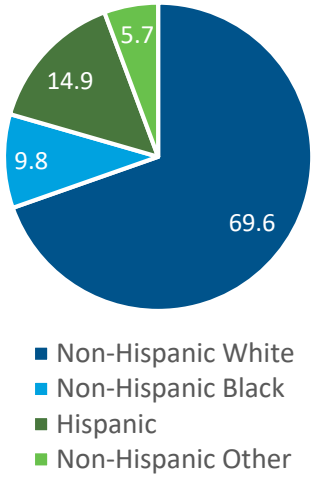
2,850,000

Adults 18 or older lived in Connecticut in 2018

Data Source: CT BRFSS, 2018

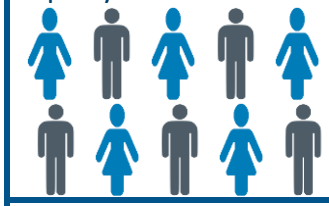
Race & Ethnicity

7 in **10** adults were non-Hispanic White.
1 in **7** adults were Hispanic.
1 in **10** adults were non-Hispanic Black.

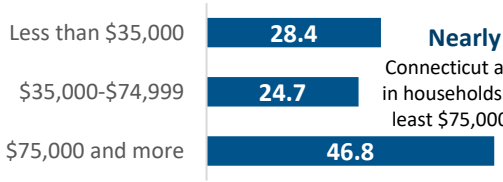


Gender

Male and female adults were equally distributed.

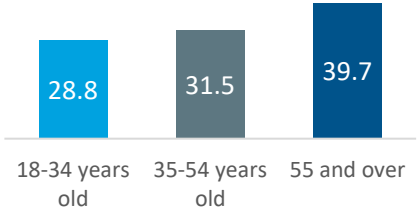


Household Income



Nearly half Connecticut adults lived in households earning at least $75,000 annually

Age



92.5% Connecticut adults who had health insurance coverage

One in four Connecticut adults had a disability

61.9% Connecticut adults who had more than high school education

Note: all the demographic data above are estimated weighted population based on CT BRFSS 2018.

TABLE 1: ADULTS LIVING IN CONNECTICUT, CT 2018

Demographic Characteristics	Survey Respondents	Estimated Weighted Population	Estimated % of Population
Total	10,709	2,850,000	**100**
Age			
18-34 years old	1,320	796,000	28.8
35-54 years old	2,744	872,000	31.5
55 and over	6,239	1,096,000	39.7
Gender			
Male	4,718	1,372,000	48.2
Female	5,973	1,476,000	51.8
Race/Ethnicity			
Non-Hispanic White	8,336	1,940,000	69.6
Non-Hispanic Black	770	274,000	9.8
Hispanic	796	414,000	14.9
Other	564	158,000	5.7
Income			
Less than $35,000	2,239	639,000	28.4
$35,000-$74,999	2,247	557,000	24.7
$75,000 and more	4,124	1,054,000	46.8
Health Insurance Status			
Insured	10,159	2,617,000	92.5
Not Insured	503	212,000	7.5
Disability Status			
Disabled	2,618	631,000	23.2
Non-disabled	7,698	2,095,000	76.8
Education			
HS graduate or less	3,045	1,083,000	38.1
More than HS education	7,617	1,756,000	61.9

CHILD DEMOGRAPHICS IN CONNECTICUT

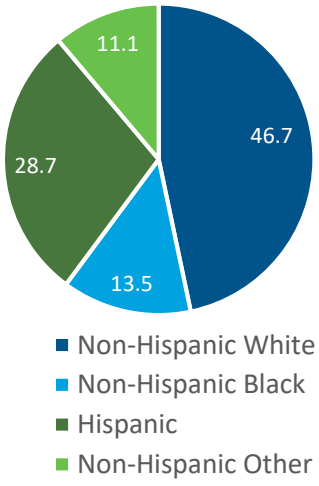
730,000

Children 0-17 lived in Connecticut in 2018

Data Source: CT BRFSS, 2018

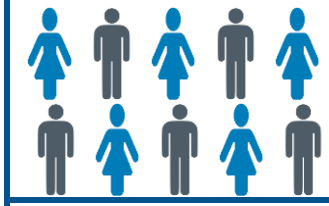
Race & Ethnicity

1 in **2** children were non-Hispanic White.
1 in **4** children were Hispanic.
1 in **7** children were non-Hispanic Black.

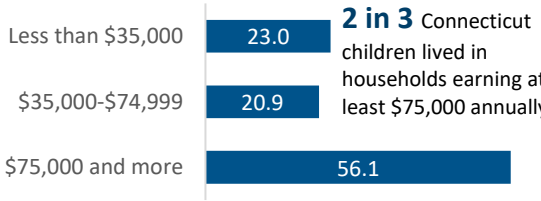


Gender

Male and female children were equally distributed.

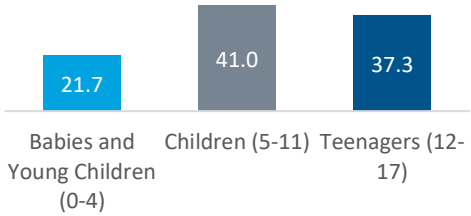


Household Income



2 in 3 Connecticut children lived in households earning at least $75,000 annually

Age



92.4%

Connecticut children who had an insured adult caregiver

75.5%

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

Note: all the demographic data above are estimated weighted population based on CT BRFSS 2018.

TABLE 2: CHILDREN LIVING IN CONNECTICUT, CT 2018

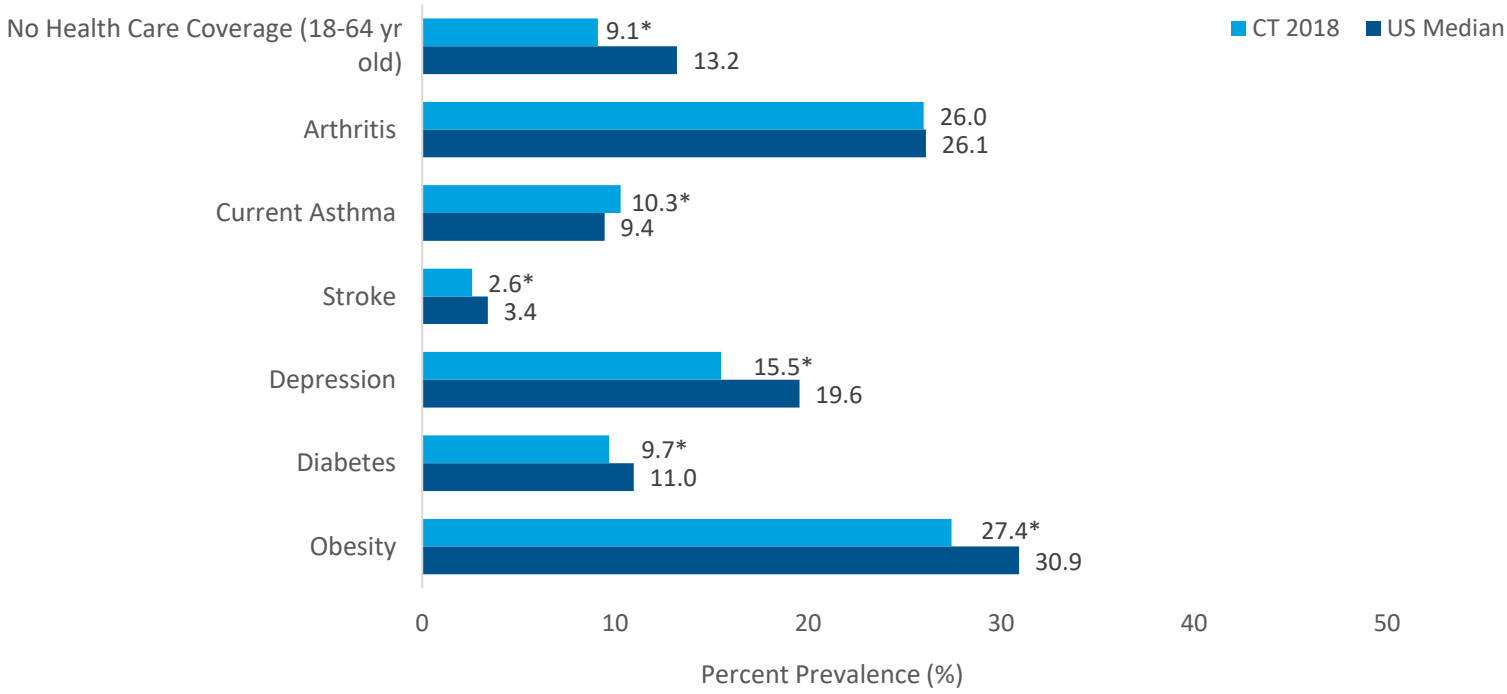
Demographic Characteristics	Survey Respondents	Estimated Weighted Population	Estimated % of Population
Total	2,407	733,000	**100**
Age			
0-4 years old	340	125,277	21.7
5-11 years old	568	237,218	41.0
12-17 years old	843	215,690	37.3
Gender			
Male	988	337,596	52.2
Female	989	309,563	47.8
Race/Ethnicity			
Non-Hispanic White	1,237	299,052	46.7
Non-Hispanic Black	190	86,216	13.5
Hispanic	356	183,848	28.7
Other	177	71,384	11.1
Household Income			
Less than $35,000	447	144,915	23.0
$35,000-$74,999	400	131,517	20.9
$75,000 and more	1,176	353,106	56.1
Caregiver's Health Insurance Status			
Insured	2,220	673,732	92.4
Not Insured	176	55,620	7.6
Caregiver's Education Attainment			
HS graduate or less	612	179,110	24.5
More than HS education	1,788	552,068	75.5

1. STATE OF THE STATE

CONNECTICUT COMPARISON TO THE UNITED STATES IN 2018

Figure 1 and Table 3 highlight selected adult health indicators in Connecticut during calendar year 2018, compared to median results from 2018 for the United States and its territories.

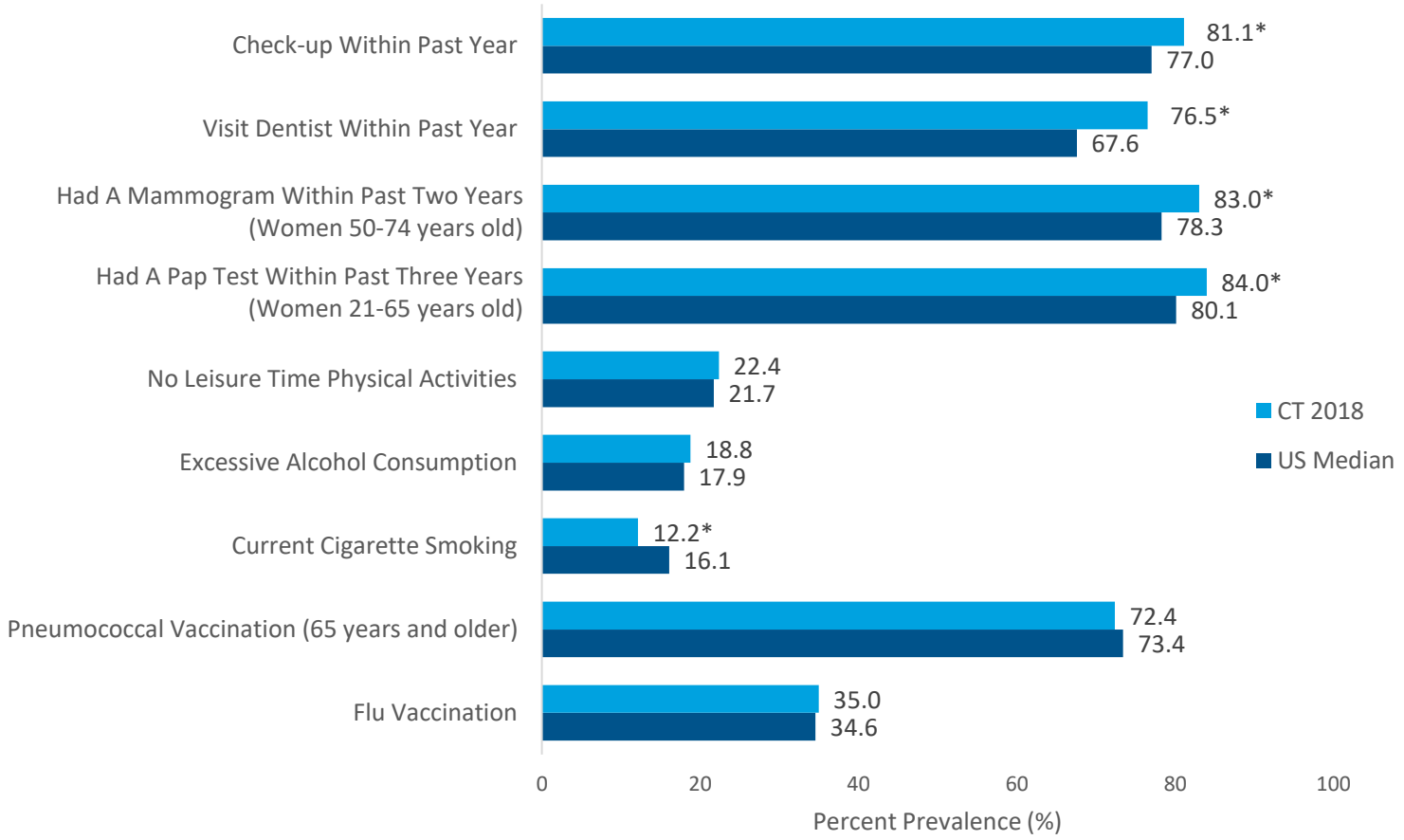
FIGURE 1: SELECTED ADULT HEALTH INDICATORS IN CONNECTICUT VERSUS THE UNITED STATES AND TERRITORIES, 2018



*= significance < 0.05

Figure 2 and Table 4 highlight selected adult modifiable risk factors in Connecticut during 2018, compared to median results from 2018 for the U.S. and its territories. More information on these indicators is located within this report.

FIGURE 2: SELECTED ADULT MODIFIABLE RISK FACTORS IN CONNECTICUT VERSUS THE U.S. AND TERRITORIES, 2018



*= significance < 0.05

TABLE 3: SELECTED ADULT HEALTH INDICATORS IN CONNECTICUT VERSUS THE UNITED STATES AND TERRITORIES, CT 2018

Health Indicator	CT 2018	U.S. Median	Risk Difference	Significantly Greater or Less Risk/Protection
Adult Obesity	27.4%	30.9%	-3.5%	Less Risk
Diabetes	9.7%	11.0%	-1.3%	Less Risk
Depression	15.5%	19.6%	-4.1%	Less Risk
Stroke	2.6%	3.4%	-0.8%	Less Risk
Current Asthma	10.3%	9.4%	0.8%	More Risk
Arthritis	26.0%	26.1%	0.1%	NS
No Health Care Coverage (18-64 years old)	9.1%	13.2%	4.1%	More Protection

Note: Prevalence in 2018 of selected adult health indicators were obtained from the Behavioral Risk Factor Surveillance System for Connecticut (www.ct.gov/dph/brfss) and the United States and its territories (www.cdc.gov/brfss). Risk differences for Connecticut versus the United States and its territories were tested for significantly greater or lesser risk using two-tailed one sample z-test against the U.S. median.

TABLE 4: SELECTED ADULT MODIFIABLE RISK FACTORS IN CONNECTICUT VERSUS THE UNITED STATES AND TERRITORIES, CT 2018

Health Indicator	CT 2018	U.S. Median	Risk Difference	Significantly Greater or Less Risk/Protection
Flu Vaccination	35.0%	34.6%	0.4%	NS
Pneumococcal Vaccination (65 years and older)	72.4%	73.4%	-1.0%	NS
Current Cigarette Smoking	12.2%	16.1%	-3.9%	Less risk
Excessive Alcohol Consumption	18.8%	17.9%	0.8%	NS
No Leisure Time Physical Activities	77.6%	78.3%	-0.7%	NS
Had A Pap Test Within Past Three Years (Women 21-65 years old)	84.0%	80.1%	3.9%	More Protection
Had A Mammogram Within Past Two Years (Women 50-74 years old)	83.0%	78.3%	4.7%	More Protection
Visit Dentist Within Past Year	76.5%	67.6%	9.0%	More Protection
Check-up Within Past Year	81.1%	77.0%	4.1%	More Protection

Note: Prevalence in 2018 of selected modifiable risk factors were obtained from the Behavioral Risk Factor Surveillance System for Connecticut (www.ct.gov/dph/brfss) and the United States and its territories (www.cdc.gov/brfss). Risk differences for Connecticut versus the United States and its territories were tested for significantly greater or lesser risk using two-tailed one sample z-test against the U.S. Median.

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

Sixteen selected health indicators and modifiable risk factors were compared to estimates for the United States and its territories during 2018 (Figures 1 and 2 and Tables 3 and 4). More information about these statewide indicators can be found elsewhere in this report.

Compared to the United States and its territories, Connecticut adult risk was significantly less, and prevalence significantly better, for 9 of the 16 health indicators:

- Obesity
- Diabetes
- Depression
- No Health Care Coverage (18-64 years old)
- Stroke
- Women who had a mammogram within past two years (50-74 years old)
- Women who had a Pap test within past three years (21-65 years old)
- Visit dentist within past year
- Check-up within past year
- Current cigarette smoking

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

- Current Asthma

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

- Arthritis
- Pneumococcal Vaccination (65 years old and older)
- Flu vaccination
- Excessive alcohol consumption
- No leisure time physical activities

CONNECTICUT COMPARISON TO OTHER STATES IN 2018

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

For 21 selected health indicators, and compared to all states in the United States and its territories, Connecticut ranked among the best 13 states in the country for 10 indicators (marked as **turquoise circles** in Figure 3):

- Reporting Good or Better Health
- At Least One Primary Care Provider
- Check Up in the Past 12 Months
- Fall in Past Year
- Cardiovascular Diseases (45+)
- Dentist Visit in Past Year
- Women had Mammogram Within Past 2 Years (50-74 years old)
- Current Cigarette Use
- Obesity
- Women 40+ Years Old Had PAP Test Within Past 3 Years
- Healthcare coverage
- Healthcare Access
- Depression

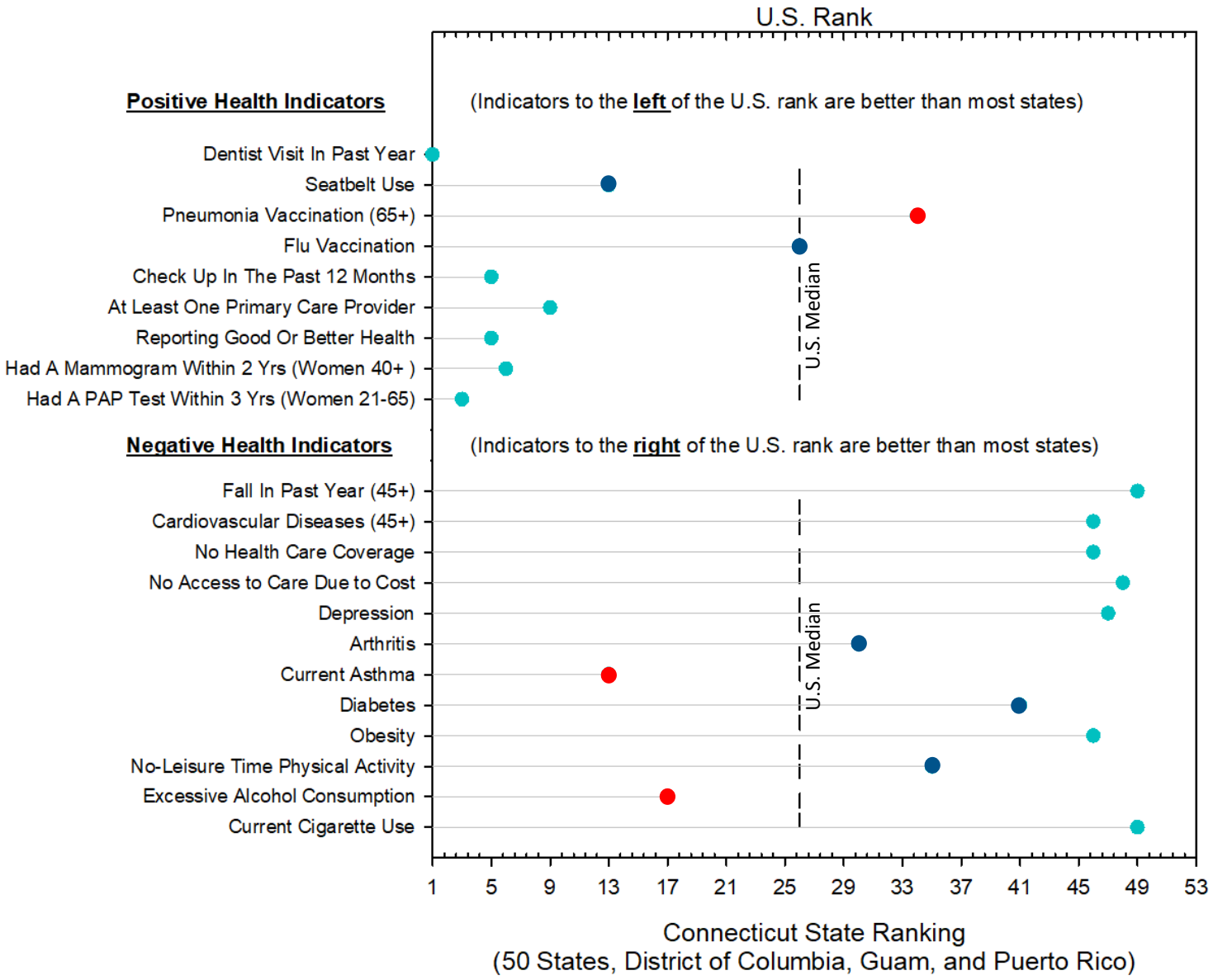
Among all 21 selected health indicators, Connecticut ranked better than half among all states in the United States and its territories for all except three indicators (marked as **blue circles** in Figure 3):

- Seatbelt Use
- Flu Vaccination
- Arthritis
- Diabetes
- No Leisure Time Physical Activity

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

- Current Asthma
- Pneumonia Vaccination (65+)
- Excessive Alcohol Consumption

FIGURE 3: CONNECTICUT STATE RANKING FOR SELECTED ADULT HEALTH INDICATORS, BRFSS, 2018



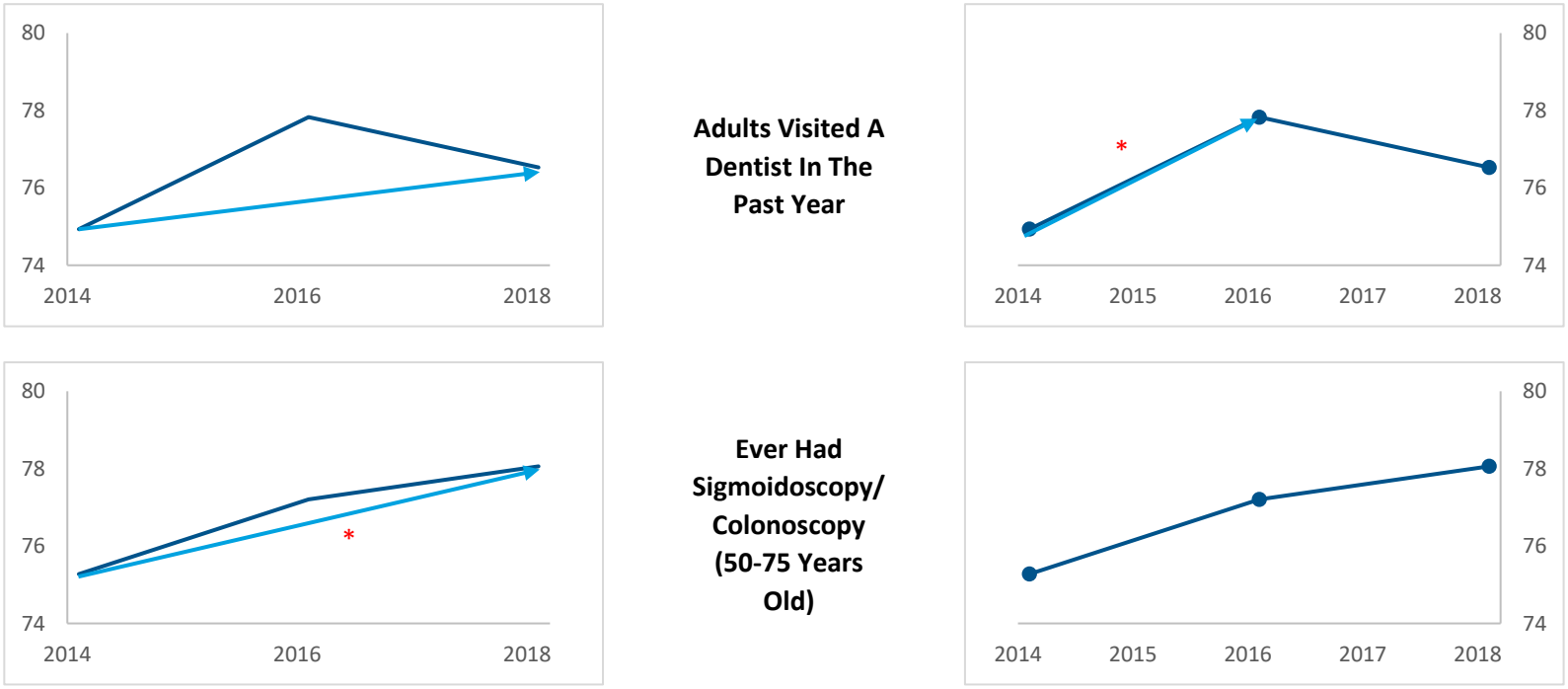
CHANGE IN SELECTED CONNECTICUT HEALTH INDICATORS (2014–2018)

Figure 4, Figure 5, and Table 5 show the change from 2014 through 2018 among Connecticut adults for selected biennial (Figure 4) and annual (Figure 5) health indicators. Estimated percent prevalence value for selected health indicators are shown for years 2014, 2016, and 2018 (Figure 4A); and for individual years 2014, 2016, 2018 (Figure 4B), these values are shown with circles. Four-year change from 2014 to 2018(Figure 4A) and biennial change from 2014 to 2016 and 2016 to 2018 (Figure 4 B) are shown with **light blue** lines.

FIGURE 4: CHANGE IN SELECTED BIENNIAL HEALTH INDICATORS, CT BRFSS 2014–2018

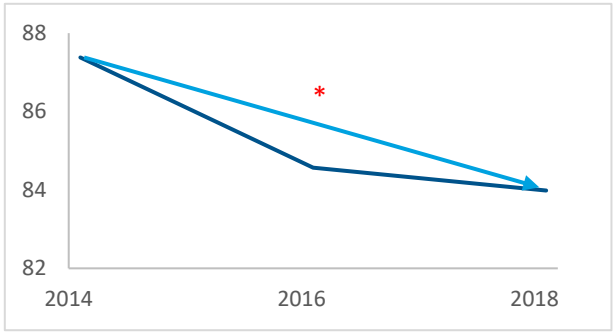
Figure 4A: Four-Year Increase/Decrease

Figure 4B: Yearly Increase/Decrease

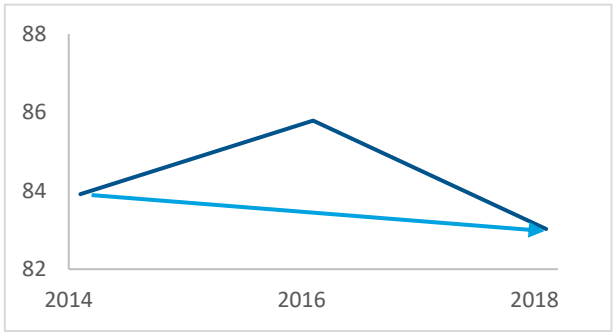


*=significance<0.05

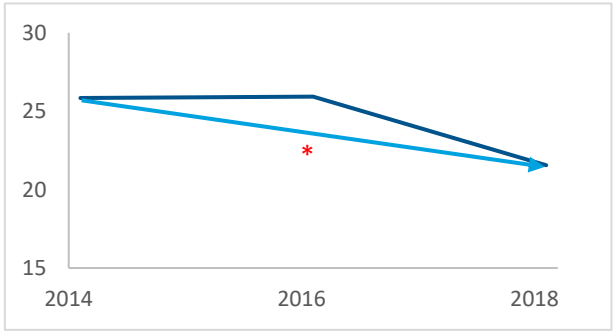
Figure 4A: Four-Year Increase/Decrease Cont.



Pap Test In The Past 3 Years (Women 21-65 years old)

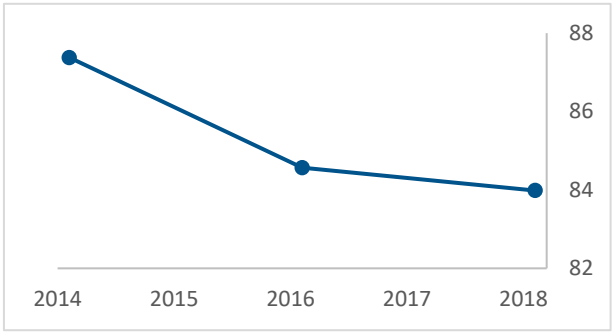


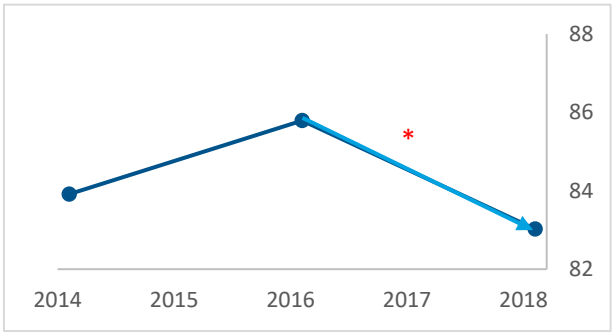
Mammogram In The Past 2 Years (Women 50-74 Years Old)

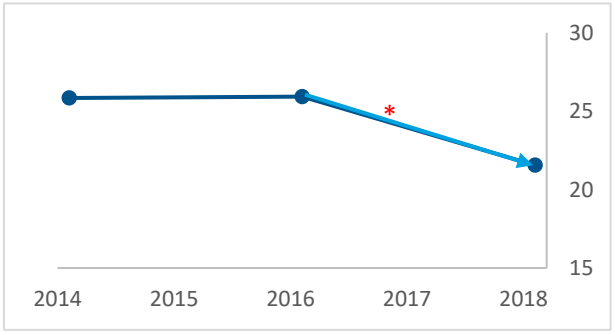


Fall In The Past Year (50 and Older)

Figure 4B: Yearly Increase/Decrease Cont.







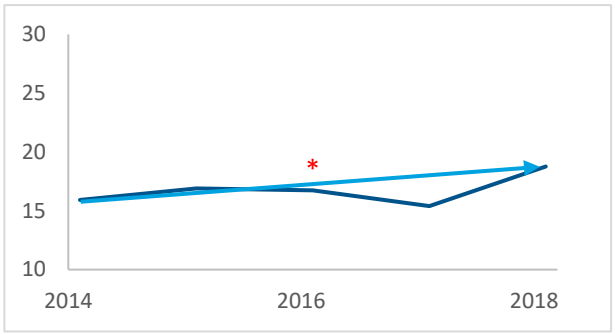
*= significance < 0.05

Estimated percent prevalence values for selected health indicators are shown for years 2014-2018 (Figure 5A); and for individual years 2014, 2015, 2016, 2017, and 2018 (Figure 5B), these values are shown with circles. Five-year changes from 2014 to 2018 (Figure 5A) and annual changes from years 2014 to 2015, 2015 to 2016, 2016 to 2017, and 2017 to 2018 (Figure 5B) are shown with **blue** lines.

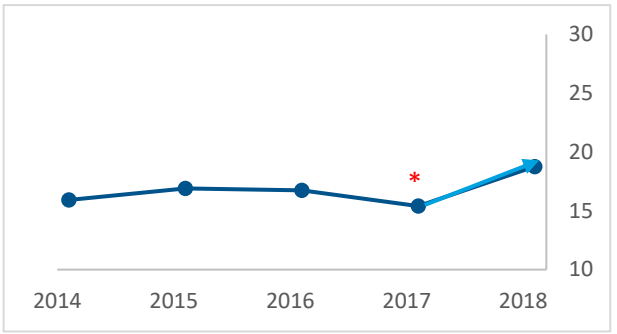
FIGURE 5: CHANGE IN SELECTED ANNUAL HEALTH INDICATORS, CT BRFSS 2014–2018

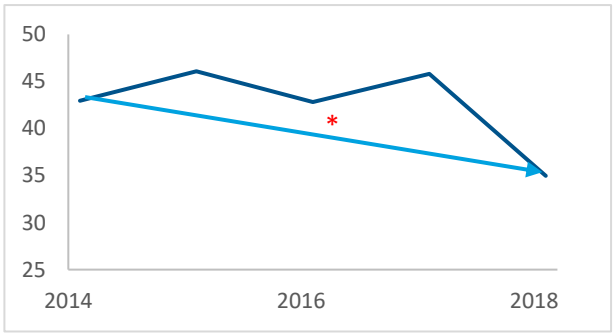
Figure 5A: Five Year Increase/Decrease

Figure 5B: Yearly Increase/Decrease

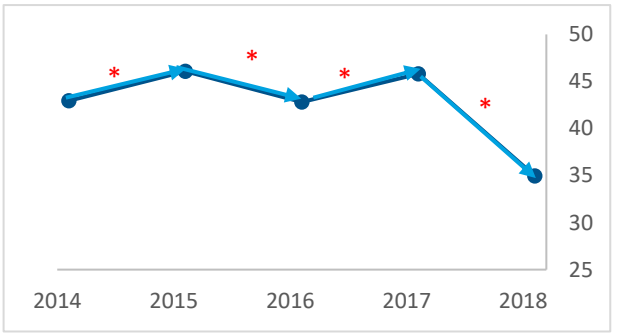


Excessive Alcohol Consumption



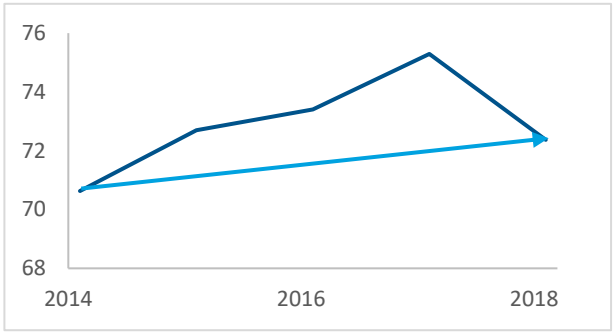


Flu Vaccination

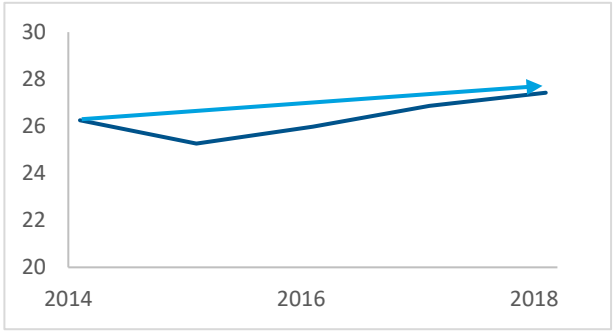


*=significance< 0.05

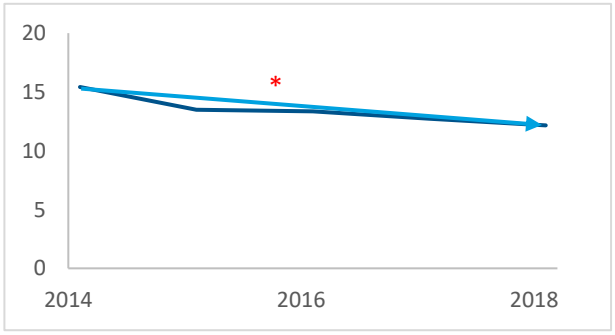
Figure 5A: Five Year Increase/Decrease (Cont.)



Pneumococcal Vaccination (65 years & Older)



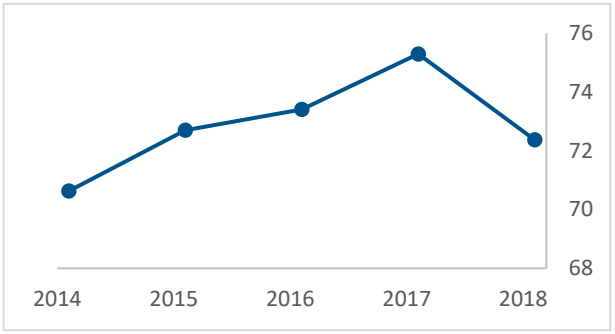
Adult Obesity

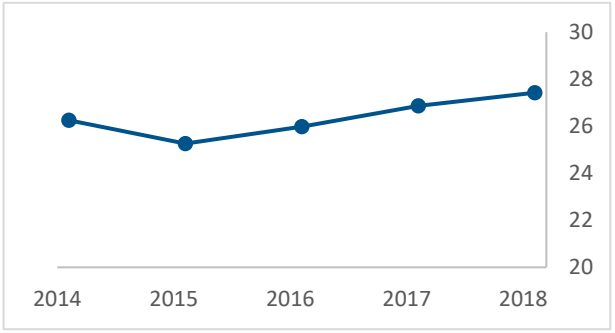


Current Cigarette Use

*= significance <0.05

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





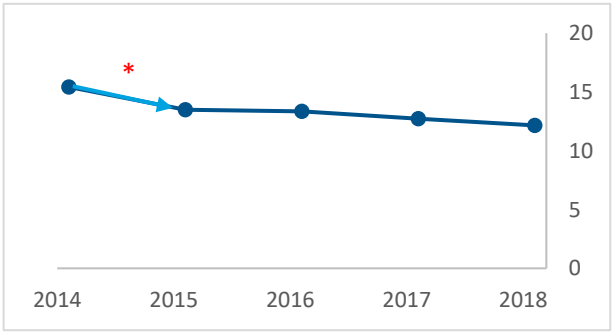
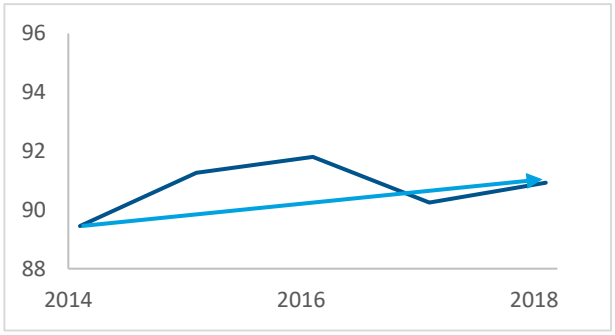
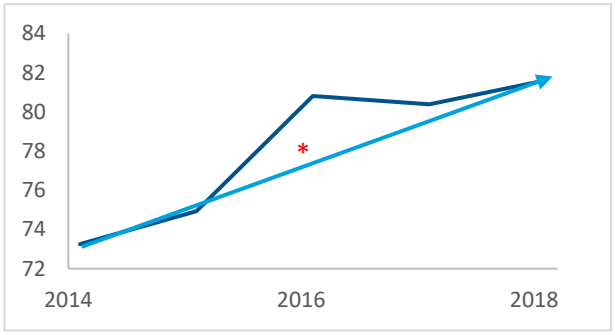


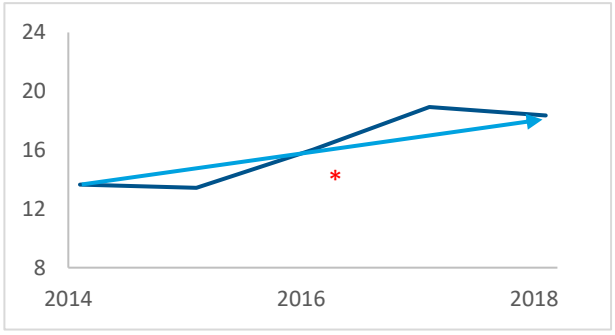
Figure 5A: Five Year Increase/Decrease (Cont.)



Health Care Coverage (18–64 years old)



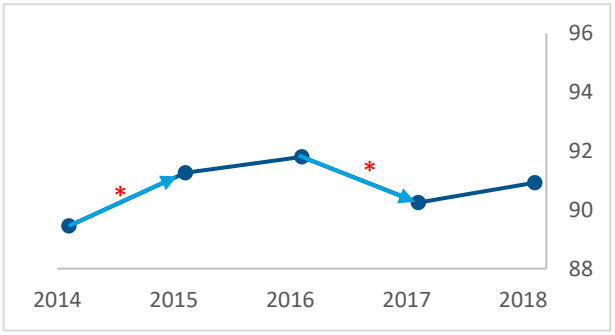
Child Ever Breastfed (0–17 years old)

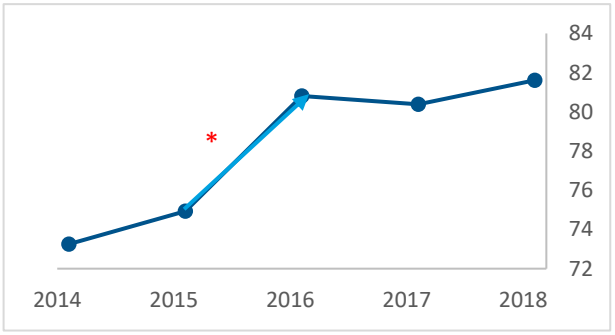


Child Obesity (5–17 years old)

*= significance <0.05

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





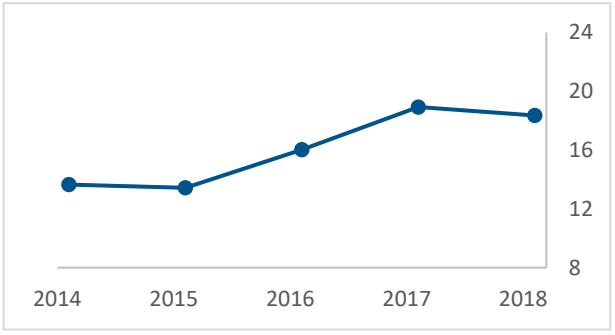


TABLE 5: TREND IN PERCENT PREVALENCE OF SELECTED HEALTH INDICATORS, CT 2014–2018

Health Indicators	2014	2015	2016	2017	2018
Visited A Dentist In The Past Year[#]	74.9		77.8		76.5
Ever Had Sigmoidoscopy/ Colonoscopy (50-75 years old)[#]	75.3		77.2		78.1
Pap Test In The Past 3 Years (Women 21-65 years old)[#]	87.4		84.6		84.0
Mammogram In The Past 2 Years (Women 50-74 years old)[#]	83.9		85.8		83.0
Fall In The Past Year (50 and older)[#]	25.8		25.9		21.6
Excessive Alcohol Consumption	15.9	16.9	16.7	15.4	18.8
Flu Vaccination	42.9	46.1	42.8	45.8	35.0
Pneumococcal Vaccination (65 years & older)	70.6	72.7	73.4	75.3	72.4
Adult Obesity	26.3	25.3	26.0	26.9	27.4
Current Cigarette Use	15.4	13.5	13.3	12.7	12.2
Health Care Coverage (18-64 years old)	89.4	91.3	91.8	90.2	90.9
Child Ever Breastfed (0-17 years old)	73.3	74.9	80.8	80.4	81.6
Child Obesity (5-17 years old)	13.6	13.4	16.0	18.9	18.4

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

2. VULNERABLE POPULATIONS IN CONNECTICUT

Connecticut is one of the healthiest states in the nation and is ranked well for most selected health indicators in this report compared to other states; however, health disparities were found by further adjustments for social determinants of health (e.g., age, sex, race/ethnicity, income, disability status, and education level). In 2018, certain groups had significantly higher prevalence of poor health outcomes:

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

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

Disabled Adults	Less Than High School Education
• Fair/poor health • Poor mental health • Poor physical health • Obesity • No access to care due to cost • No access to prescription drug due to cost • No insurance (18-64 years old) • No leisure time physical activity • Fall in past year • Current cigarette smoking • Ever use E-cigarette • Periodontal disease • No breast cancer screening (Women 50-74 years old) • Current asthma • COPD • Arthritis • Cardiovascular disease • Prediabetes and diabetes • Kidney disease • Depression	• Fair/poor health • Disability • Poor mental health • Poor physical health • Obesity • No access to care due to cost • No access to prescription drug due to cost • No insurance (18-64 years old) • No leisure time physical activity • Current cigarette smoking • No dentist visit in past year • No flu vaccine • No cervical cancer screening (Women 21-65) • No prostate cancer screening (Men 40+) • No colorectal cancer screening (50-75 years old) • Current asthma • COPD • Arthritis • Cardiovascular disease • Diabetes • Kidney disease • Child consumption of sugar-sweetened beverages

3. HEALTH STATUS INDICATORS

GENERAL HEALTH STATUS

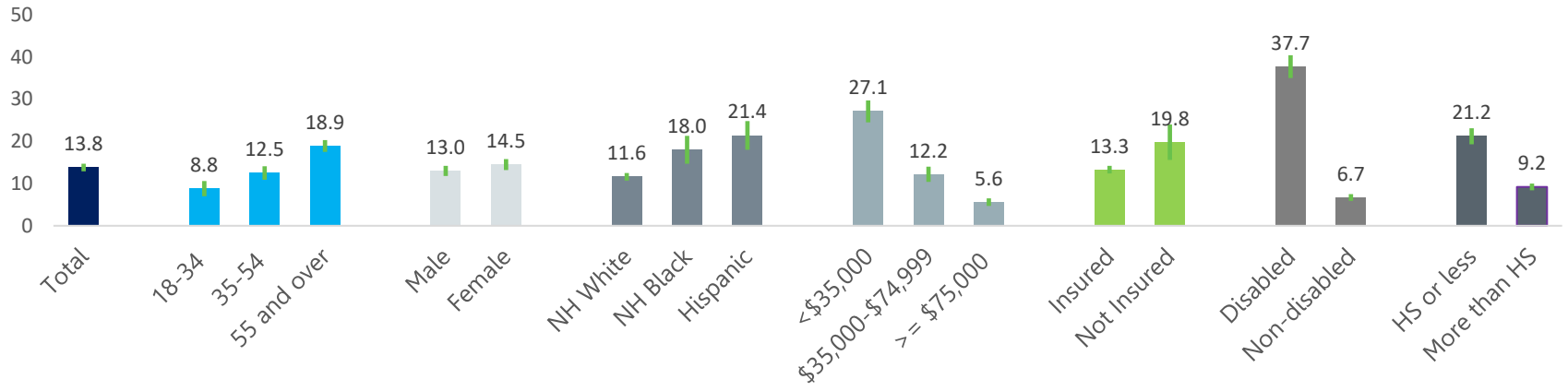
Self-rated general health status is a valuable measure to collect alongside more objective health measures because it has strong predictive properties for health outcomes; specifically, self-reports of poor health are strongly associated with mortality.[8] CT BRFSS respondents were asked to rate their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

One in seven Connecticut adults rated their health as either fair or poor in 2018. The prevalence of adults who reported fair or poor health is shown in Figure 6.

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

- Adults 55 years and older (18.9%) and adults 35–54 years old (12.5%);
- Hispanic (21.4%) and non-Hispanic Black (18.0%) adults;
- Adults from households earning less than $35,000 (27.1%) and $35,000–$74,999 (12.2%);
- Adults without health insurance (19.8%);
- Disabled adults (37.3%); and
- Adults with no more than a high school education (21.2%).

FIGURE 6: PERCENTAGE OF CT RESIDENTS REPORTING POOR OF FAIR OVERALL HEALTH, CT 2018



DISABILITY

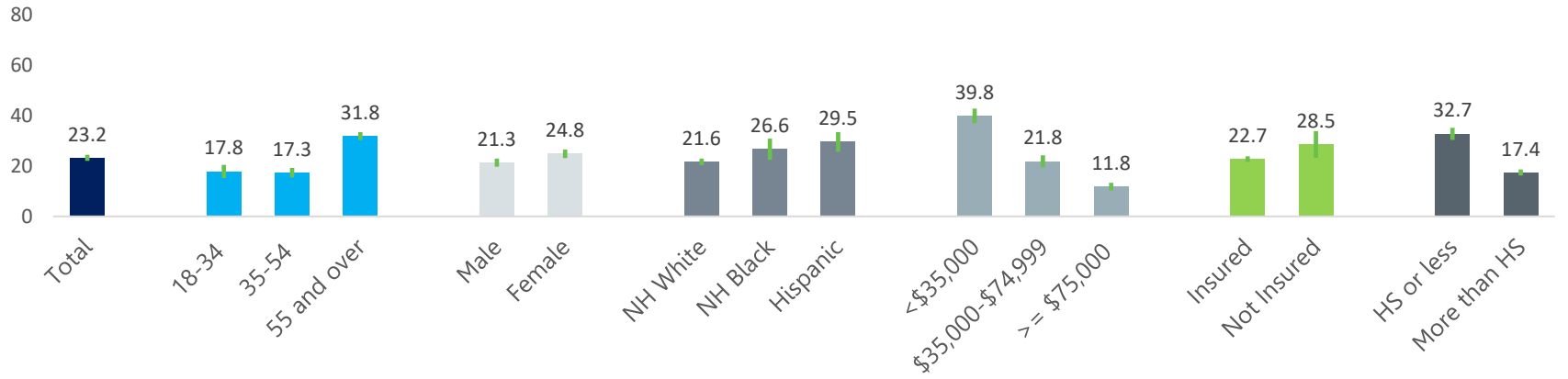
The Americans with Disabilities Act (ADA) defines an individual with a disability as "a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having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

Nearly one in four adults in Connecticut reported that they have a disability in 2018. Results are shown in Figure 7.

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

- Adults 55 years and older (31.8%);
- Females (24.8%);
- Hispanic adults (29.5%) and non-Hispanic Black (26.6%);
- Adults from households earning less than $35,000 (39.8%) and $35,000–$74,999 (21.8%); and
- Adults with no more than a high school education (32.7%).

FIGURE 7: PERCENTAGE OF CT RESIDENTS REPORTING A DISABILITY, CT 2018



HEALTH-RELATED QUALITY OF LIFE (POOR MENTAL HEALTH)

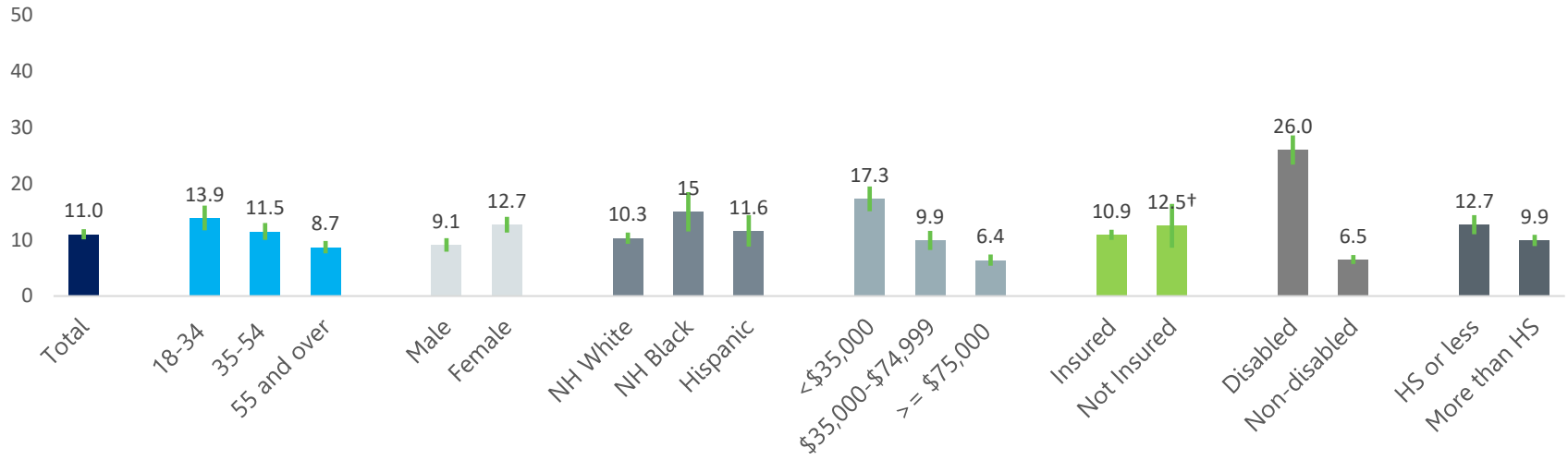
The BRFSS uses the Healthy Days Measure to assess health-related quality of life. The Healthy Days Measure has been useful for identifying health disparities and tracking population trends.[10] This measure defines adults as being in poor mental health if they reported 14 or more days (within the past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

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

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

- Adults 18-34 years of age (13.9%) and adults 35–54 years old (11.5%);
- Females (12.7%);
- Non-Hispanic Black adults (15.0%) compared to non-Hispanic White adults (10.3%);
- Adults from households earning less than $35,000 (17.3%);
- Adults with a disability (26.0%); and
- Adults with no more than a high school education (12.7%).

FIGURE 8: PERCENTAGE OF CT RESIDENTS REPORTING POOR OR FAIR MENTAL HEALTH, CT 2018



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

HEALTH-RELATED QUALITY OF LIFE (POOR PHYSICAL HEALTH)

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

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

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

- Adults 55 years and older (14.4%) and adults 35–54 years old (9.7%);
- Adults from households earning less than $35,000 (18.0%) and $35,000–$74,999 (10.4%);
- Adults with a disability (29.3%); and
- Adults with no more than a high school education (14.0%).

FIGURE 9: PERCENTAGE OF CT RESIDENTS REPORTING POOR PHYSICAL HEALTH, CT 2018

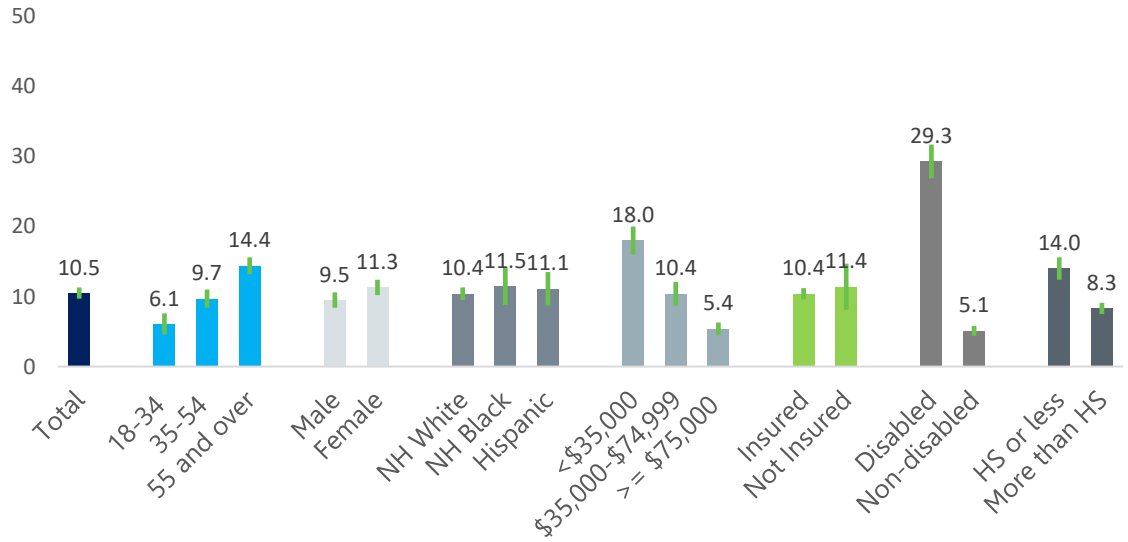
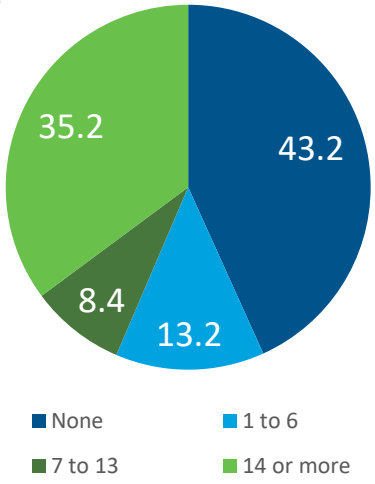


FIGURE 10: POOR PHYSICA OR MENTAL HEALTH AS A BARRIER TO LIFE'S ACTIVITIES, CT 2018



ADULT WEIGHT STATUS

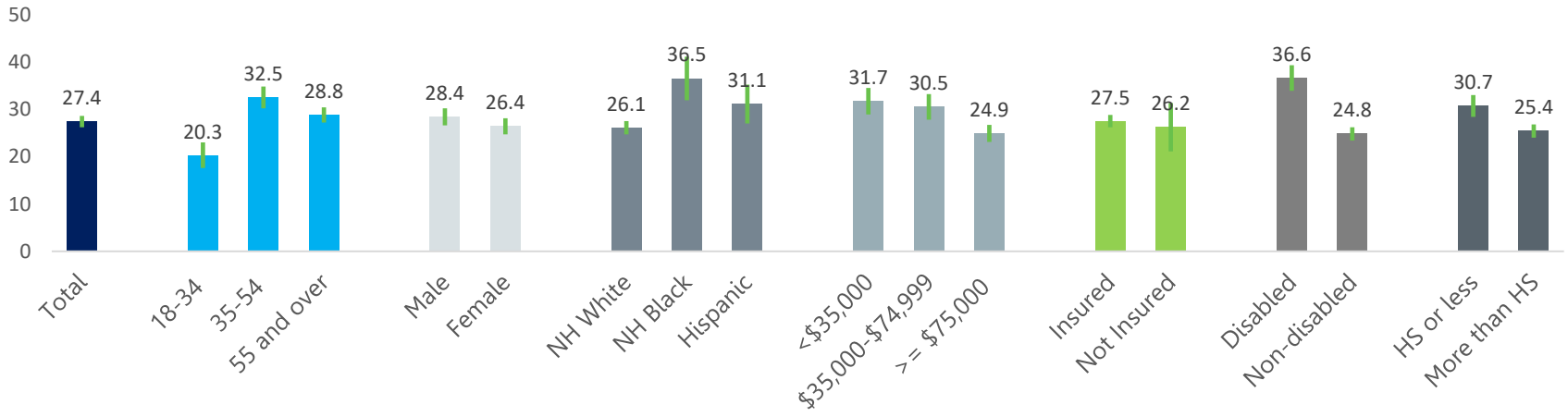
The BRFSS survey asks respondents to provide their height and weight without shoes. A body mass index (BMI) is calculated by dividing their weight in kilograms by the squared value of their height in meters. An adult with a BMI between 25.0 and 29.9 is considered overweight, while an adult with a BMI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

In Connecticut, one in three CT adults were overweight, and one in four CT adults were obese in 2018.

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

- Adults 35–54 years old (32.5%) and 55 years and older (28.8%);
- Non-Hispanic Black (36.5%) and Hispanic (31.1%) adults;
- Adults from households earning less than $35,000 (31.7%) and $35,000-$74,999 (30.5%);
- Adults with a disability (36.6%); and
- Adults with no more than a high school education (30.7%).

FIGURE 11: PREVALENCE OF OBESITY AMONG CT ADULTS, CT 2018



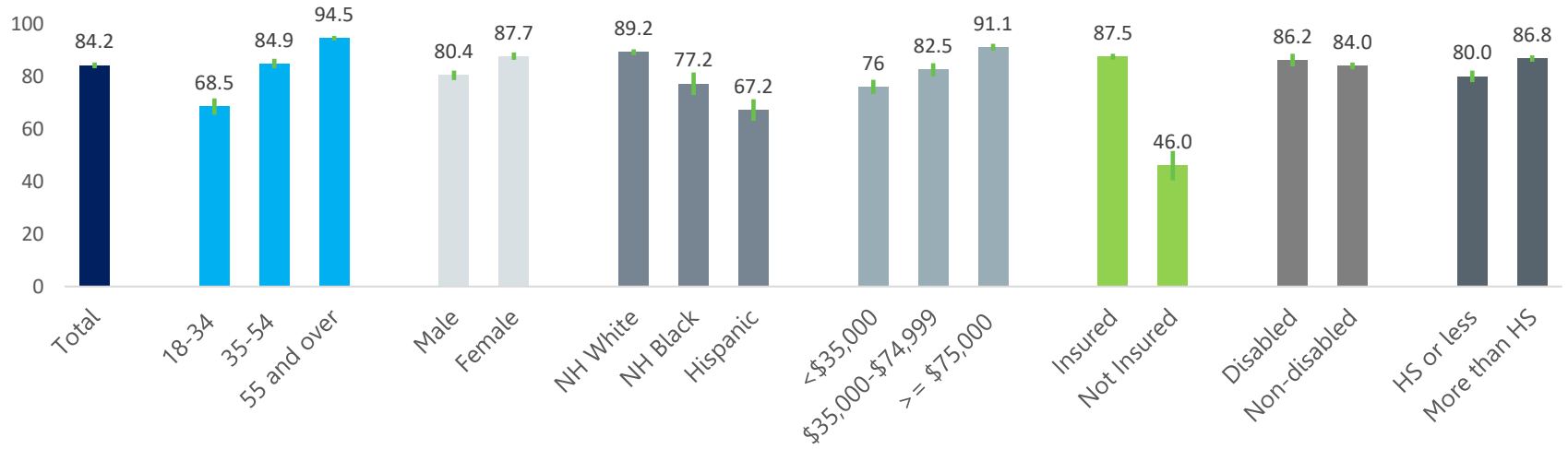
HEALTH CARE ACCESS

People who have access to a personal health care provider or a regular health care setting have better health outcomes.[13] Generally, an effective primary health care system is associated with better health outcomes. Limited health care coverage is a barrier to access to care that adversely impacts health outcomes. "Limited" health care coverage includes adults who do not have a primary care provider, which is a personal doctor or health care provider; or adults who needed to see a doctor in the past year but could not because of cost, or adults who did not take medication as prescribed because of cost. Results are shown in Figures 12-14.
In 2018, eight in ten CT adults reported they had at least one primary health care provider, one in ten CT adults reported that they had no health care due to costs, and one in 13 CT adults reported they did not take their medication as prescribed because of cost.

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

- Adults 55 years and older (94.5%) and adults 35–54 years old (84.9%);
- Females (87.7%);
- Non-Hispanic White adults (89.2%) and Non-Hispanic Black adults (77.2%);
- Adults from households earning at least $75,000 (91.1%) and $35,000–$74,999 (82.5%);
- Adults with health insurance (87.5%); and
- Adults with more than a high school education (86.8%).

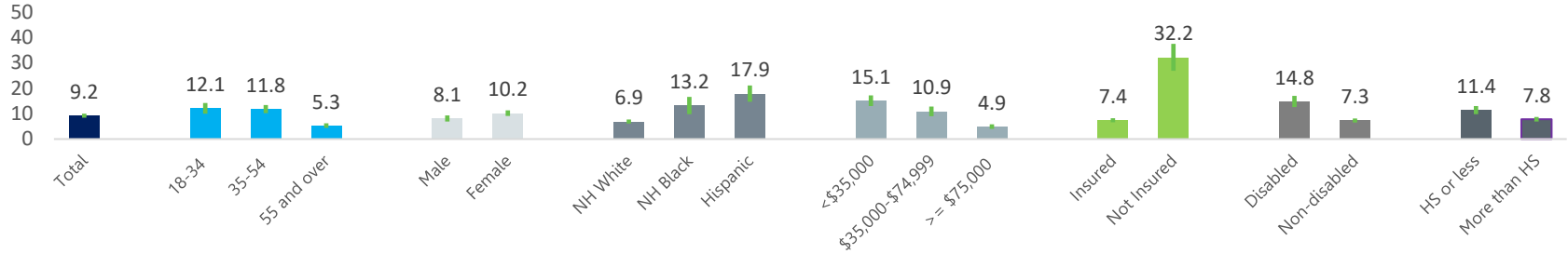
FIGURE 12: AT LEAST ONE PRIMARY HEALTH CARE PROVIDER, CT 2018



Compared to their counterparts in the state, the prevalence of having **no access to care due to cost** among adults in Connecticut was significantly greater for:

- Adults 18–34 years old (12.1%) and 35–54 years old (11.8%);
- Females (10.2%);
- Hispanic (17.9%) and non-Hispanic Black adults (13.2%);
- Adults from households earning less than $35,000 (15.1%) and $35,000–$74,999 (10.9%);
- Adults without health insurance (32.2%);
- Adults with a disability (14.8%); and
- Adults with no more than a high school education (11.4%).

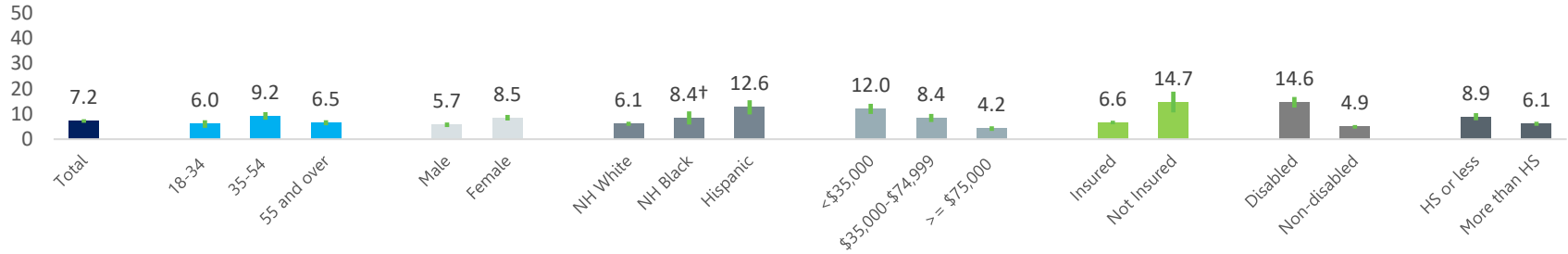
FIGURE 13: NO HEALTH CARE ACCESS DUE TO COST, CT 2018



Compared to their counterparts in the state, the prevalence of having **not taking medication as prescribed due to cost** among adults in Connecticut was significantly greater for:

- Adults 35–54 years old (9.2%);
- Females (8.5%);
- Hispanic (12.6%) compared to non-Hispanic White adults (6.1%);
- Adults from households earning less than $35,000 (12.0%) and $35,000–$74,999 (8.4%);
- Adults without health insurance (14.7%);
- Adults with a disability (14.6%); and
- Adults with no more than a high school education (8.9%).

FIGURE 14: NO ACCESS TO PRESCRIPTION DRUG DUE TO COST, CT 2018



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

HEALTH INSURANCE COVERAGE (18-64 YEARS OLD)

Health insurance coverage includes private insurance and plans such as health maintenance organizations (HMOs) or government plans such as Medicare or the Indian Health Service. Adults without health care coverage have higher mortality rates for a range of health conditions, compared to insured adults.[14] Adults without health care coverage are less likely to get needed care and screenings, and they have poorer health outcomes.[15] Medicaid is a public health insurance program for low-income Americans and other target groups, including pregnant women and people with disabilities. An expansion of Medicaid coverage under the Affordable Care Act went into effect in 2014.

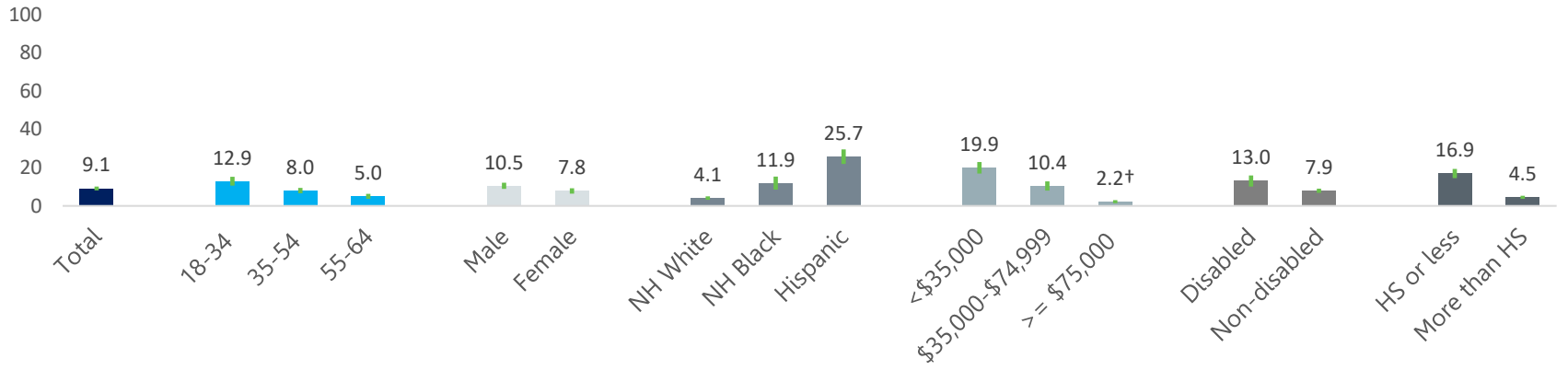
The prevalence of adults aged 18-64 years old in 2018 who reported having no health care coverage, private insurance, Medicaid, or Medicare coverage are broken down by demographic characteristics in Figures 15 to 18 below.

In 2018, one in 11 CT adults 18-64 years old reported that they had no health insurance coverage, six in ten reported that they had private health insurance coverage, one in eight had Medicaid coverage, and one in 20 had Medicare coverage.

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

- Adults 18–34 years old (12.9%) and 35–54 years old (8.0%);
- Males (10.5%);
- Hispanic (25.7%) and non-Hispanic Black (11.9%) adults;
- Adults from households earning less than $35,000 (19.9%) compared to $35,000–$74,999 (10.4%);
- Adults with a disability (13.0%); and
- Adults with no more than a high school education (16.9%).

FIGURE 15: NO INSURANCE COVERAGE, ADULTS 18-64 YEARS OLD, CT 2018

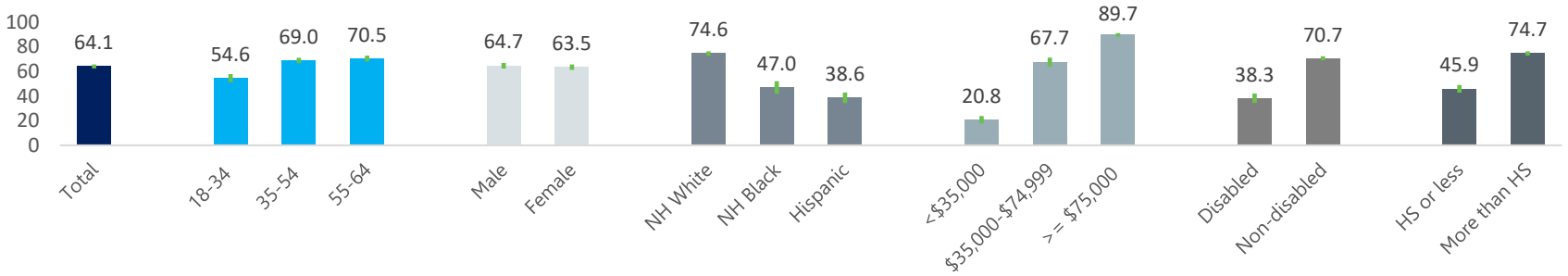


Estimates marked with a "†" have a CV between 15.0% and 20.0%.

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

- Adults 55-64 (70.5%) and 35–54 years old (69.0%);
- Non-Hispanic White adults (74.6%);
- Adults from households earning at least $75,000 (89.7%) and $35,000–$74,999 (67.7%);
- Adults with a disability (70.7%); and
- Adults with more than a high school education (74.7%).

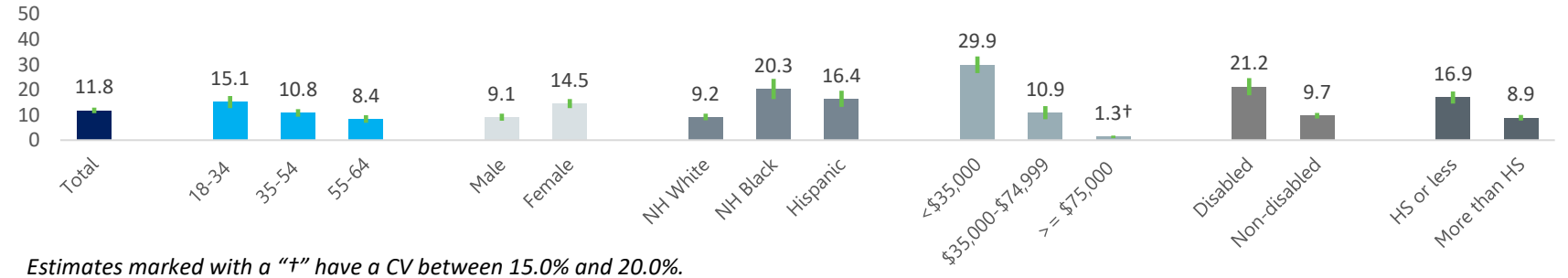
FIGURE 16: PRIVATE INSURANCE, ADULTS 18-64 YEARS OLD, CT 2018



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

- Adults 18–34 years old (15.1%);
- Females (14.5%);
- Non-Hispanic Black adults (20.3%) and Hispanic adults (16.4%);
- Adults from households earning less than $35,000 (29.9%) compared to from $35,000–$74,999 (10.9%);
- Adults with a disability (21.2%); and
- Adults with no more than a high school education (16.9%).

FIGURE *17: MEDICAID COVERAGE, ADULTS 18-64 YEARS OLD, CT 2018*

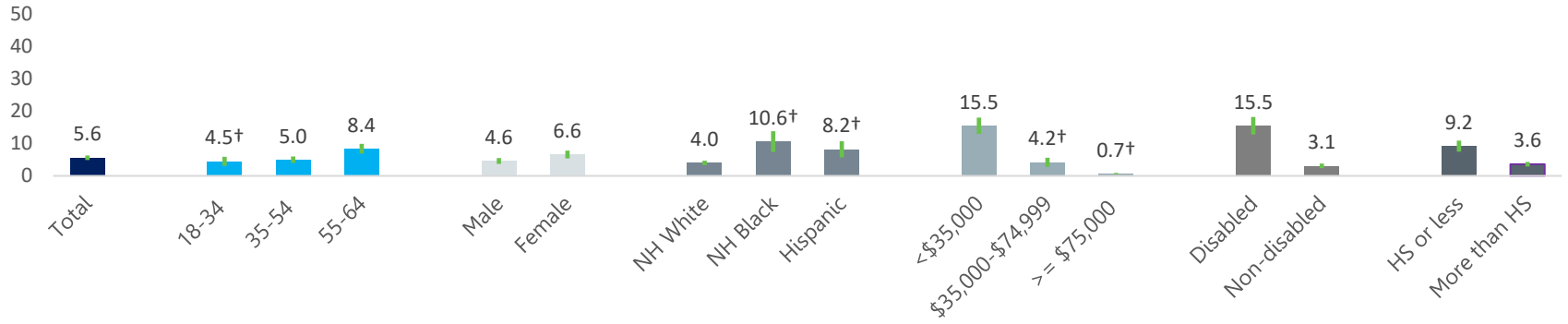


Estimates marked with a "†" have a CV between 15.0% and 20.0%.

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

- Adults 55-64 years old (8.4%) compared to 35-54 years old (5.0%);
- Females (6.6%);
- Adults with a disability (15.5%); and
- Adults with no more than a high school education (9.2%).

FIGURE 18: MEDICARE COVERAGE, ADULTS 18-64 YEARS OLD, CT 2018



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

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

4. RISK BEHAVIOR INDICATORS

ADULT PHYSICAL ACTIVITY

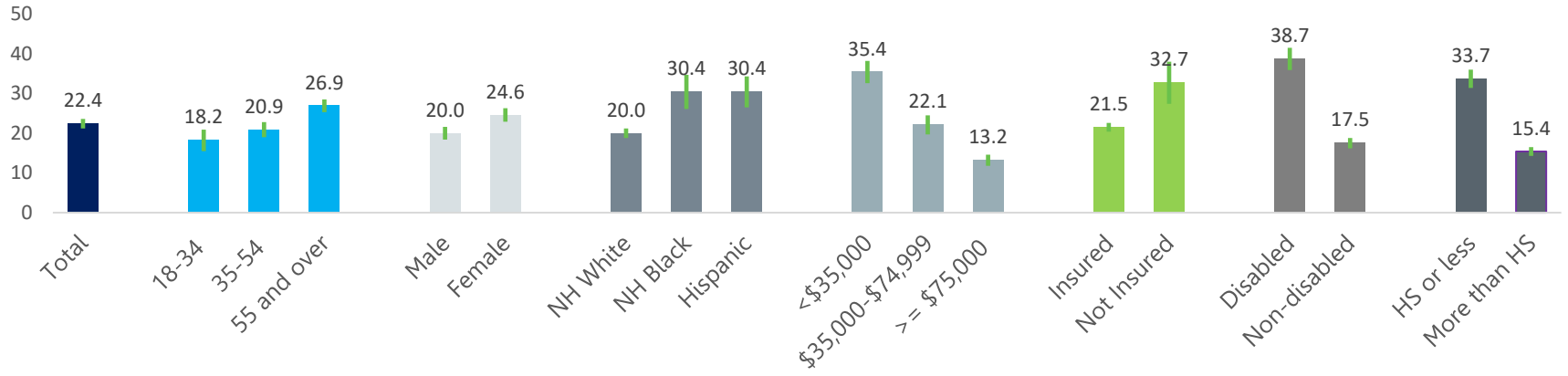
Regular physical exercise has been shown to prevent certain chronic diseases. A sedentary lifestyle is a risk factor for obesity, bone and joint diseases, depression, and chronic diseases.[16] Adults were asked to report whether they had participated in any physical activities or exercises in the past 30 days, such as running, calisthenics, golf, gardening, or walking, other than for their job. Figure 19 shows the prevalence of adults who did not engage in leisure or recreational physical activity.

Nearly one in four Connecticut adults in 2018 did not engage in any recreational physical activity outside of work.

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

- Adults 55 years and older (26.9%);
- Females (24.6%);
- Hispanic (30.4%) and non-Hispanic Black (30.4%) adults;
- Adults from households earning less than $35,000 (35.4%) and $35,000–$74,999 (22.1%);
- Adults without health insurance (32.7%);
- Adults with a disability (38.7%); and
- Adults with no more than a high school education (33.7%).

FIGURE 19: DID NOT ENGAGE IN LEISURE OR RECREATIONAL PHYSICAL ACTIVITY, CT 2018



MOTOR VEHICLE SAFETY

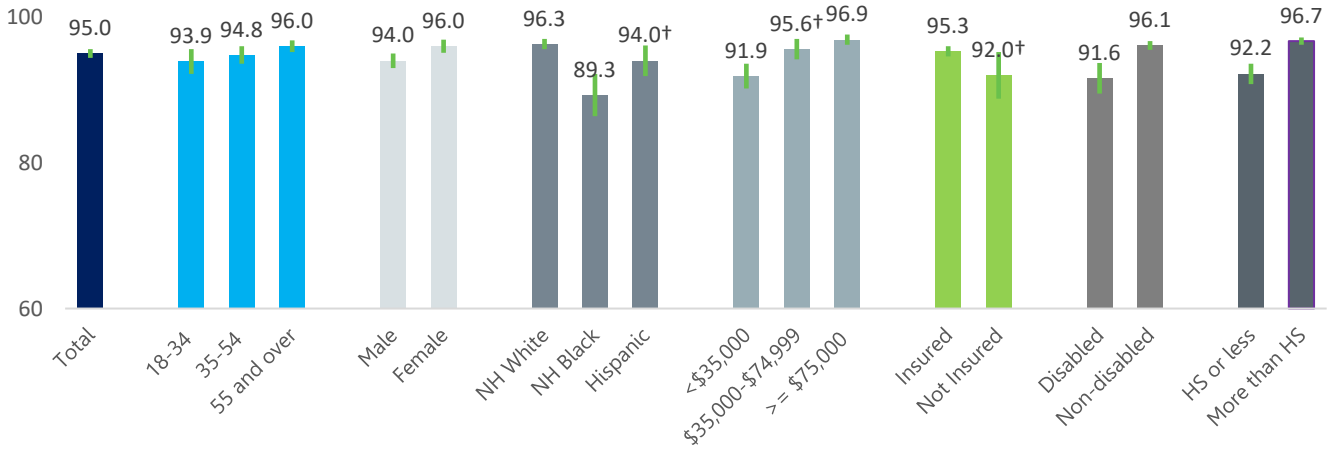
Seatbelt use is the most effective way to reduce the number of injuries and deaths in motor vehicle crashes.[17]. The prevalence of adults who said they always wore a seatbelt is shown in Figure 20. Respondents to the BRFSS were asked how often they wore seatbelts when they drove or rode in a car Figure 21.

In 2018, ninety-five percent of Connecticut adults reported using a seatbelt all the time. Approximately 3% of Connecticut adults reported having driven at least once when perhaps had too much to drink.

Compared to their counterparts in the state, the prevalence of **always or nearly always wearing a seatbelt** when they drove or rode in a car was significantly greater for:

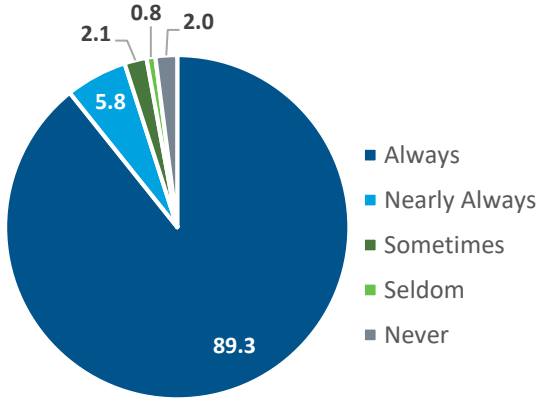
- Females (96.0%);
- Non-Hispanic White adults (96.3%) compared to non-Hispanic Black adults (89.3%);
- Adults from households earning at least $75,000 (96.9%) compared to less than $35,000 (91.9%);
- Adults without a disability (96.1%); and
- Adults with more than a high school education (96.7%).

FIGURE 20: ALWAYS OR NEARLY ALWAYS USED A SEATBELT, CT 2018



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

FIGURE 21: FREQUENCY OF SEATBELT USE, CT 2018



INADEQUATE SLEEP

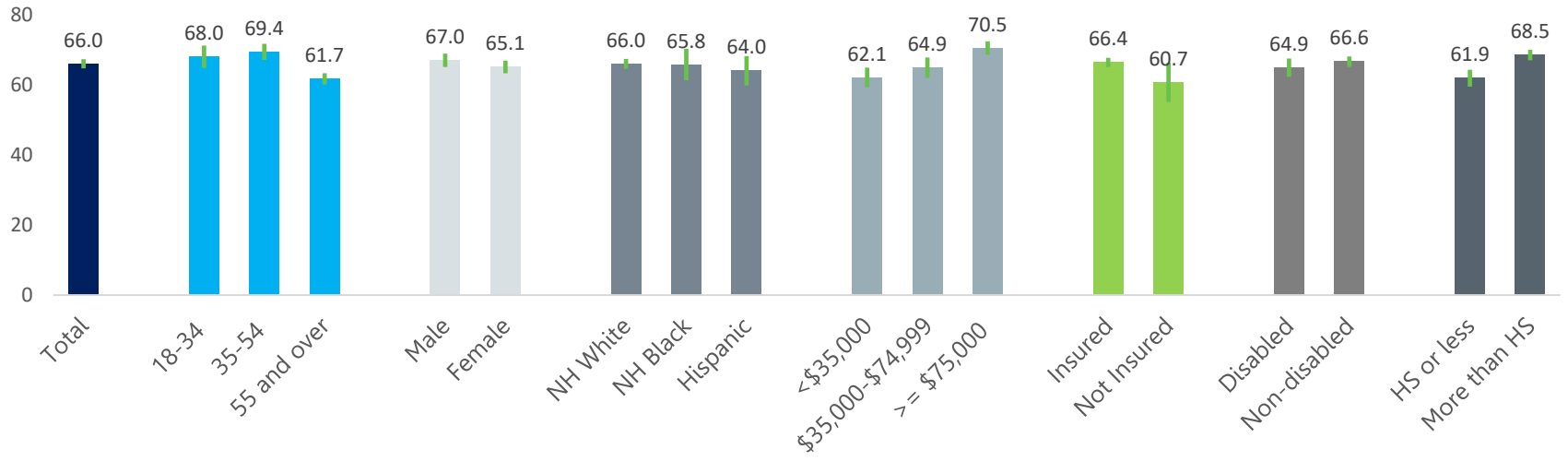
The recommended amount of sleep varies by age group, with school-age children recommended to have at least ten hours of sleep each night and teenagers recommended to get 9-10 hours each night. Adults should get 7 to 8 hours of nightly sleep.[18] Lack of sleep can have a substantial impact on health. Studies have found that short sleep duration is associated with an increased risk of cardiovascular disease, diabetes, and obesity.[19] Sleep loss can also impact daily function, with inadequate sleep increasing the risk of drowsy driving and crashes. Figure 22 shows the proportion of adults who slept less than eight hours of sleep per night.

Two-thirds of Connecticut adults got less than eight hours of sleep per night in 2018.

Compared to their counterparts in the state, the prevalence of adults who **had inadequate sleep** was significantly greater for:

- Adults 18–34 years old (68.0%) and 35–54 years old 69.4%);
- Adults from households earning at least $75,000 (70.5%); and
- Adults with more than a high school education (68.5%).

FIGURE 22: INADEQUATE SLEEP, CT 2018



FALLS

Each year, one in three Americans over 65 years old suffers a fall. Falls can cause fractures, trauma, and a resulting fear of falling that can push older Americans to limit their activities. However, falls are often highly preventable.[20]

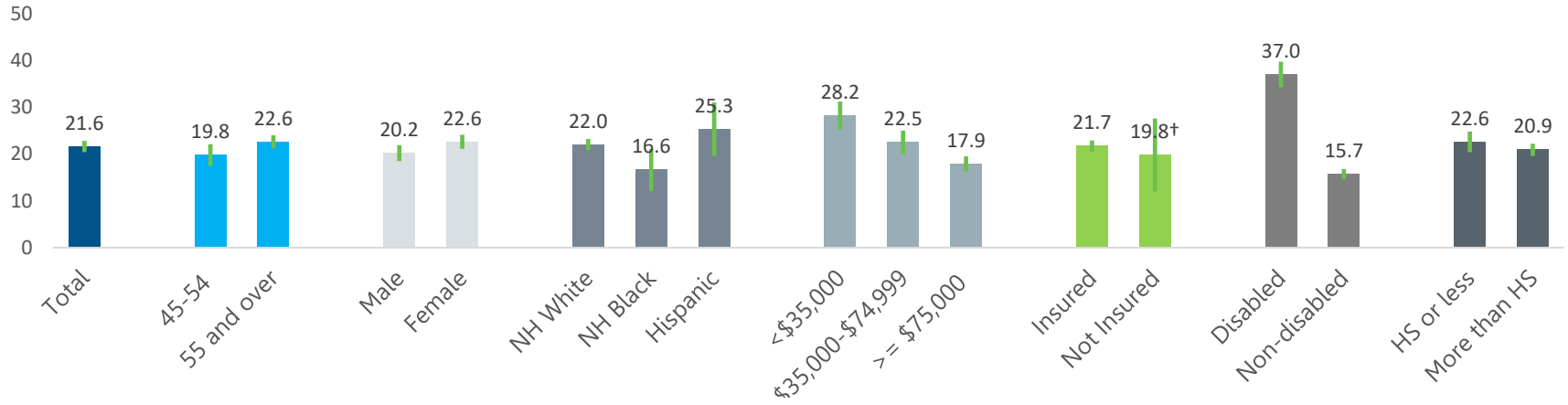
Respondents aged 45 and older were asked how many times they had fallen in the past 12 months, and how many of the falls resulted in injury.

In 2018, one in five Connecticut adults aged 45 years and older, and one in four CT adults 65 and over reported had a fall in the past 12 months. Of those who had fallen at least once in the past 12 months, two in five suffered an injury.

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

- Non-Hispanic White (22.0%) and Hispanic (25.3%) adults;
- Adults from households earning less than $35,000 (28.2%) and $35,000-$74,999 (22.5%); and
- Adults without a disability (37.0%).

FIGURE 23: FALL IN PAST YEAR (45 AND OLDER), CT 2018



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

CURRENT CIGARETTE SMOKING

According to the U.S. Surgeon General, smoking is the number one preventable cause of death.[21] It is detrimental to nearly every organ in the body and causes poorer overall health. Smokers are more likely to develop lung cancer, stroke, and heart disease when compared to non-smokers. Smoking is associated with numerous other cancers and diseases. Nearly half a million Americans die every year in the United States as a result of cigarette smoking, meaning that one in five deaths nationwide can be linked to smoking. The prevalence of current cigarette smoking is shown in Figure 24.

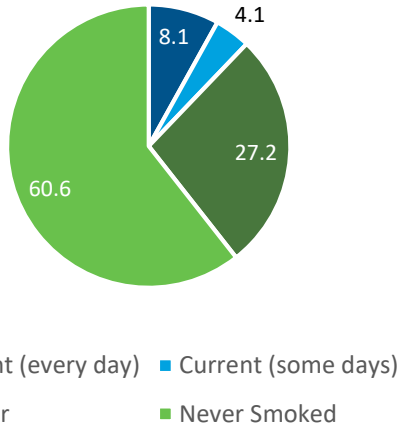
One in eight Connecticut adults in 2018 were current smokers, smoked cigarettes "every day" or "some days" in the past month.

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

- Adults 18–34 years old (14.1%) and 35–54 years old (13.7%);
- Males (13.6%);
- Non-Hispanic Black (18.2%) and Hispanic (16.5%) adults;
- Adults from households earning less than $35,000 (21.2%) and $35,000–$74,999 (12.2%);
- Adults without health insurance (19.7%);
- Adults with a disability (18.2%); and
- Adults with no more than a high school education (19.0%).

Figure 24: CURRENT CIGARETTE SMOKING, CT 2018.

Figure 25: SMOKING STATUS, CT 2018.



E-CIGARETTE USE

Although cigarette smoking in the United States has been steadily declining, use of alternative tobacco products has become more prevalent over the past several decades.[22] The health effects of non-cigarette tobacco use are often perceived as less harmful than traditional cigarettes, particularly in younger age groups. Yet nicotine exposure during adolescence may have long-lasting adverse effects on the developing adolescent brain. In addition, nearly all first-time tobacco use, and much of the subsequent addiction, occurs during adolescence and young adulthood. The negative health risks associated with hookahs are well-established, and preliminary studies on e-cigarettes identify harmful effects as well.[23, 24]

The BRFSS survey asks respondents to report their use of electronic cigarettes. Electronic cigarettes, commonly called e-cigarettes, contain cartridges of nicotine and other chemicals. The nicotine is vaporized and inhaled through a battery-powered device that resembles a traditional cigarette. The use of electronic cigarettes among Connecticut adults in 2018 is shown in Figure 26.

One in five CT adults in 2018 had tried vapor, vape pen or e-cigarettes. Compared to their counterparts in the state, the prevalence of **using vapor, vape pens, or e-cigarettes** was significantly greater for:

- Adults 18–34 years old (38.1%) and 35–54 years old (18.9%);
- Males (23.0%);
- Adults from households earning less than $35,000 (18.9%) compared to at least $75,000 (23.0%); and
- Adults with a disability (22.2%).

FIGURE 26: EVER TRIED VAPOR OR VAPE PEN OR E-CIGARETTES, CT 2018

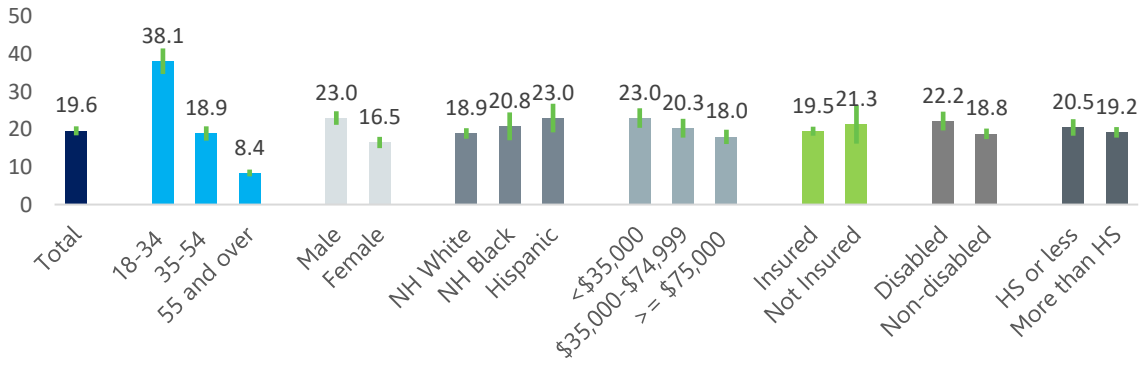
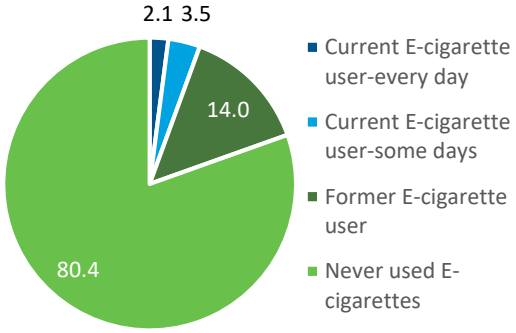


FIGURE 27: E-CIGARETTE USE STATUS, CT 2018



ALCOHOL CONSUMPTION

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

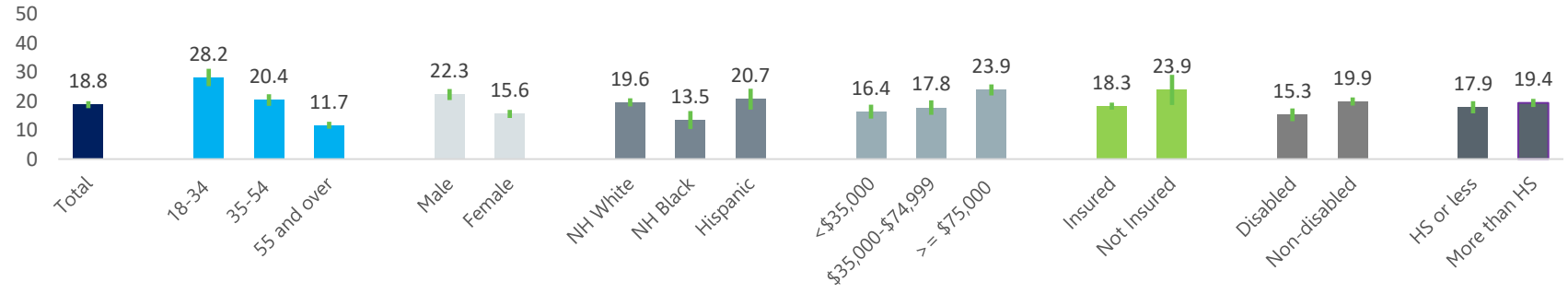
The BRFSS questionnaire ask respondents to report the number of days they consumed at least one drink of alcohol in the past 30 days, and for those who did drink, how many times they drank more than these thresholds. The prevalence of adults in 2018 who engaged in binge drinking, heavy drinking, or excessive drinking over the previous 30 days is shown below (Figure 28-30).

One in five CT adults report excessive alcohol consumption in 2018. Approximately one in six CT adults engaged in binge drinking, while one in 17 engaged in heavy drinking.

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

- Adults 18–34 years old (28.2%) and 35–54 years old (20.4%);
- Males (22.3%);
- Non-Hispanic White (19.6%) and Hispanic (20.7%) adults;
- Adults from households earning at least $75,000 (23.9%);
- Adults without health insurance (23.9%); and
- Adults without a disability (19.9%).

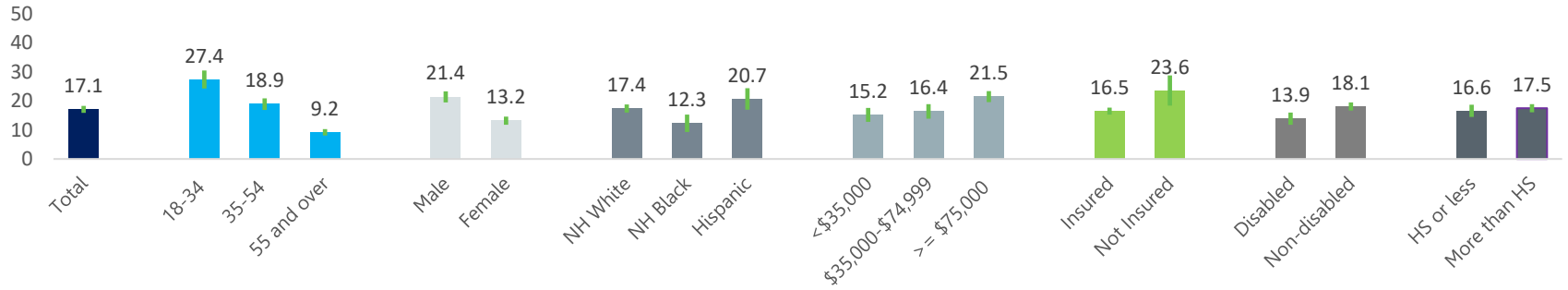
FIGURE 28: EXCESSIVE ALCOHOL CONSUMPTION, CT 2018



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

- Adults 18–34 years old (27.4%) and 35–54 years old (18.9%);
- Males (21.4%);
- Non-Hispanic White (17.4%) and Hispanic (20.7%) adults;
- Adults from households earning at least $75,000 (21.5%);
- Adults without health insurance (23.6%); and
- Adults without a disability (18.1%).

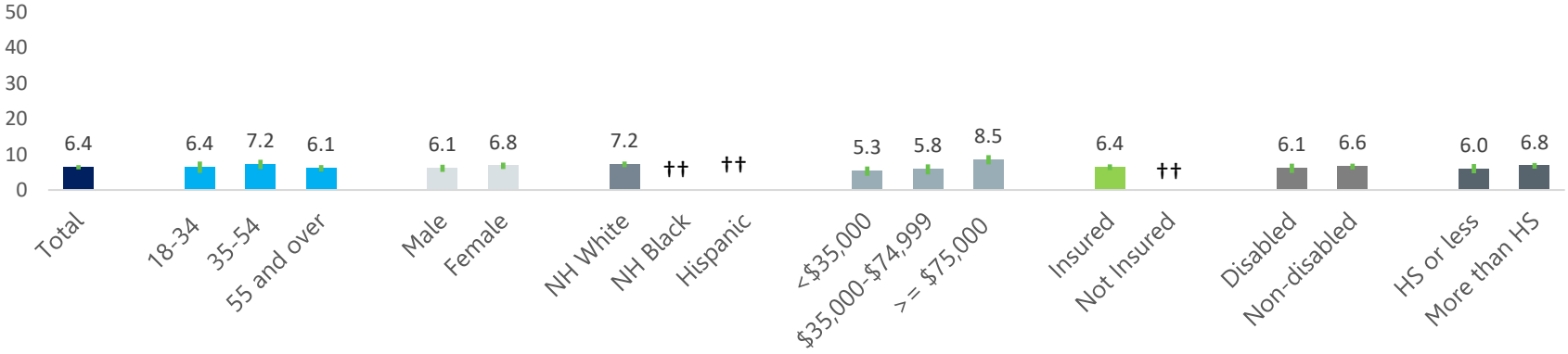
FIGURE 29: BINGE DRINKING, CT 2018



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

- Adults from households earning at least $75,000 (8.5%).

FIGURE 30: HEAVY DRINKING, CT 2018



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

5. CLINICAL PREVENTIVE PRACTICES

ROUTINE CHECK-UP

The CDC stresses the importance of routine check-ups for disease prevention and screening.[29] Respondents in the BRFSS are asked how long it had been since they last visited a doctor for a routine check-up. The prevalence of adults in 2018 who had a check-up in the previous year is shown in Figure 31.

Four-fifths of Connecticut adults in 2018 had a routine check-up in the previous year.

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

- Adults 55 years and older (89.2%);
- Females (83.3%);
- Non-Hispanic White (82.0%) and non-Hispanic Black (83.9%) adults;
- Adults from households at least $75,000 (82.2%) compared to $35,000-$74,999 (77.1%);
- Adults with health insurance (83.0%); and
- Adults with a disability (84.6%).

FIGURE 31: ROUTINE CHECK-UP IN THE PAST YEAR, CT 2018

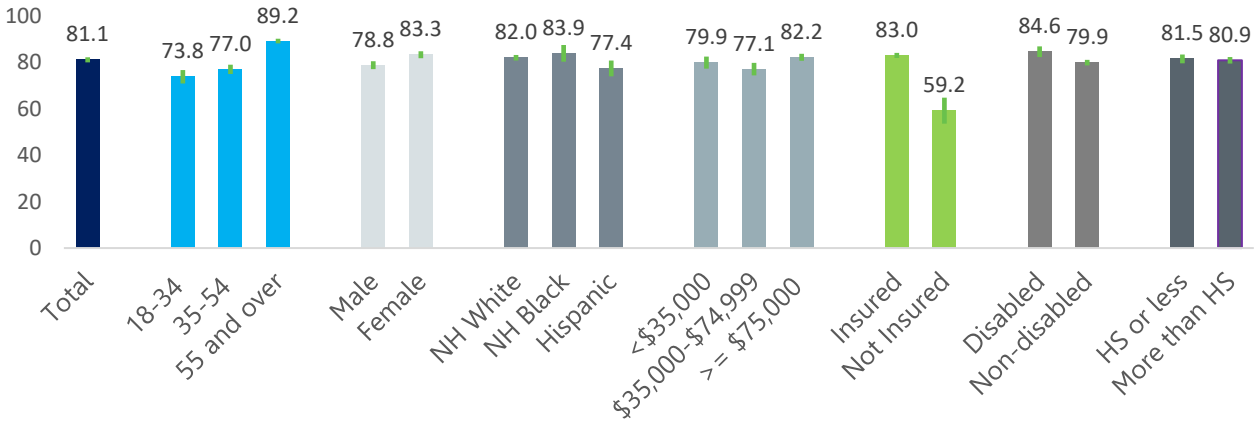
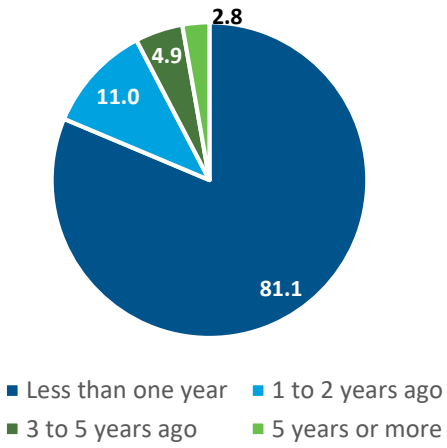


FIGURE 32: TIME SINCE LAST ROUTINE CHECK-UP, CT 2018



ADULT ORAL HEALTH

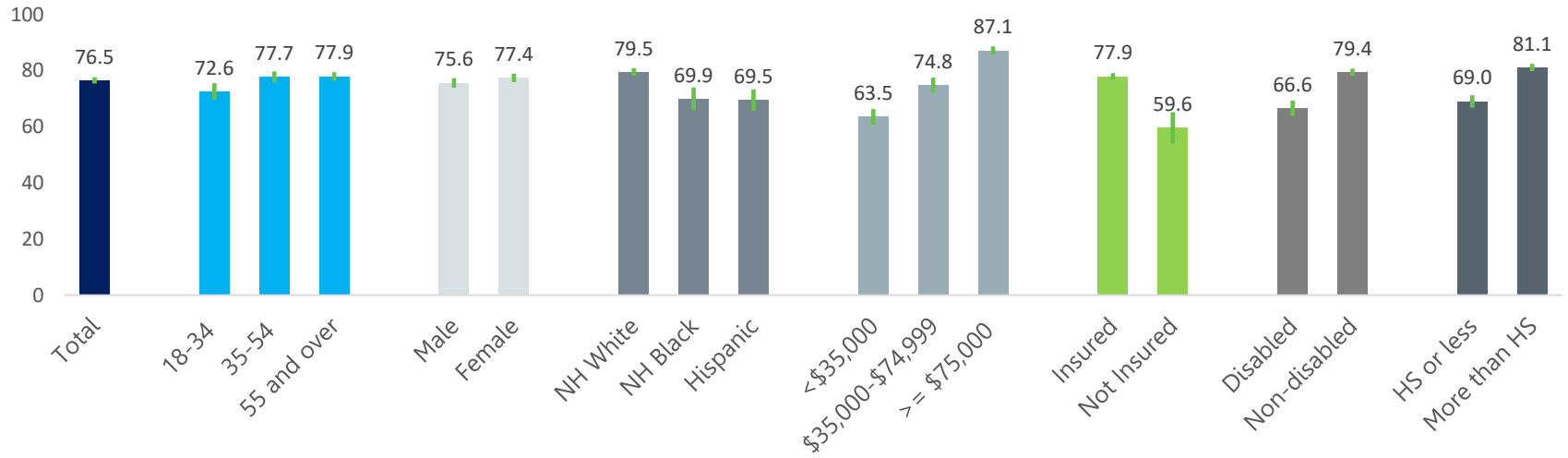
Untreated tooth decay (cavities) and periodontal (gum) disease can affect an individual's ability to eat, speak, and manage other chronic diseases such as diabetes and heart disease. Water fluoridation, considered one of the top ten great public health achievements of the 20th century, has greatly contributed to the decline of dental caries over the past 70 years.[30] Regular dental visits also contribute to good oral health. Respondents to the BRFSS were asked how long it had been since they last visited a dentist or dental clinic for any reason. They were also asked how many of their permanent teeth had been removed because of tooth decay, gum disease or infection, and if they had ever been told they had bone loss around their teeth. Results are shown in Figures 33-34.

Three-fourths of Connecticut adults in 2018 had visited the dentist in the past year. One in three had at least one permanent tooth extracted sometime in the past.

Compared to their counterparts in the state, the prevalence of having had a **dental visit in the previou**s year among Connecticut adults was significantly greater for:

- Adults 55 years and older (77.9%) and adults 35–54 years old (77.7%);
- Non-Hispanic White adults (79.5%);
- Adults from households earning at least $75,000 (87.1%) and from $35,000-$74,999 (74.8%);
- Adults with health insurance (77.9%);
- Adults with a disability (79.4%); and
- Adults with more than a high school education (81.1%).

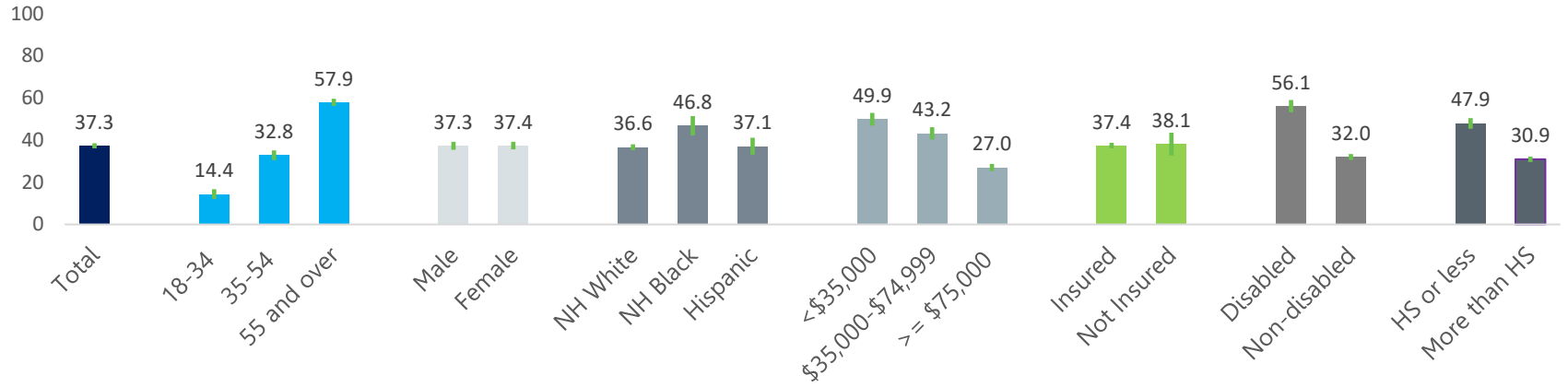
FIGURE 33: VISITED DENTIST IN THE PAST YEAR, CT 2018



Compared to their counterparts in the state, the prevalence of having **had any permanent teeth extract** among Connecticut adults was significantly greater for:

- Adults 55 years and older (57.9%) and adults 35–54 years old (32.8%);
- Non-Hispanic Black adults (46.8%);
- Adults from households earning less than $35,000 (49.9%) and $35,000-$74,999 (46.8%);
- Adults with a disability (56.1%); and
- Adults with less than a high school education (47.9%).

FIGURE 34: ADULTS HAD ANY PERMANENT TEETH EXTRACTED, CT 2018



PERIODONTAL DISEASE

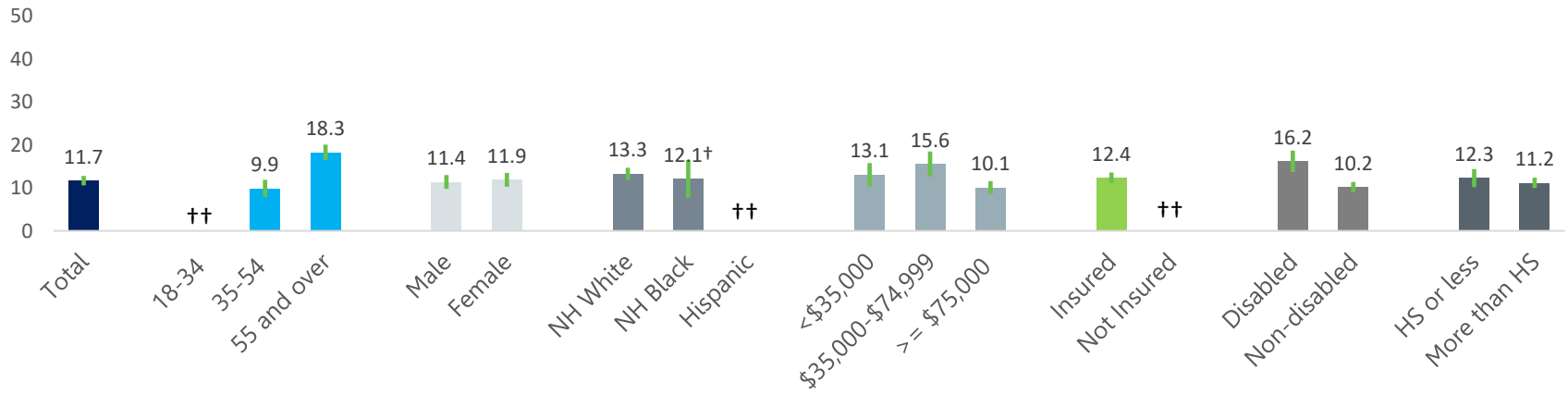
Periodontal disease, also known as gum disease, is most prevalent in the U.S. among adults and is an important dental public health problem.[31] Nearly half of all adults at least 30 years old in the U.S.[32] show signs of gum disease. Severe gum disease affects about 9% of adults in the U.S. overall. Periodontal disease starts with plaque (bacteria) accumulating on teeth and below the gums causing inflammation and bleeding that leads to tissue damage and bone loss. Bone loss around the teeth can lead to loose teeth and eventually loss of teeth.[33,34] Early stage periodontal disease is not painful and many people are not aware they have it.[34] Results for Connecticut adults are shown in Figure 35.

One in nine of Connecticut adults in 2018 reported having ever been told they had periodontal disease, and one in six Connecticut adult residents had received treatment for their periodontal disease.

Compared to their counterparts in the state, the prevalence of **ever being told they have periodontal disease** was significantly greater for:

- Adults 55 years and older (18.3%) compared to adults 35–54 years old (9.9%);
- Adults from households earning $35,000-$74,999 (15.6%) compared to at least $75,000 (10.1%); and
  Adults with a disability (16.2%).

FIGURE 35: EVER BEING TOLD HAVE PERIODONTAL DISEASE, CT 2018



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

ADULT INFLUENZA

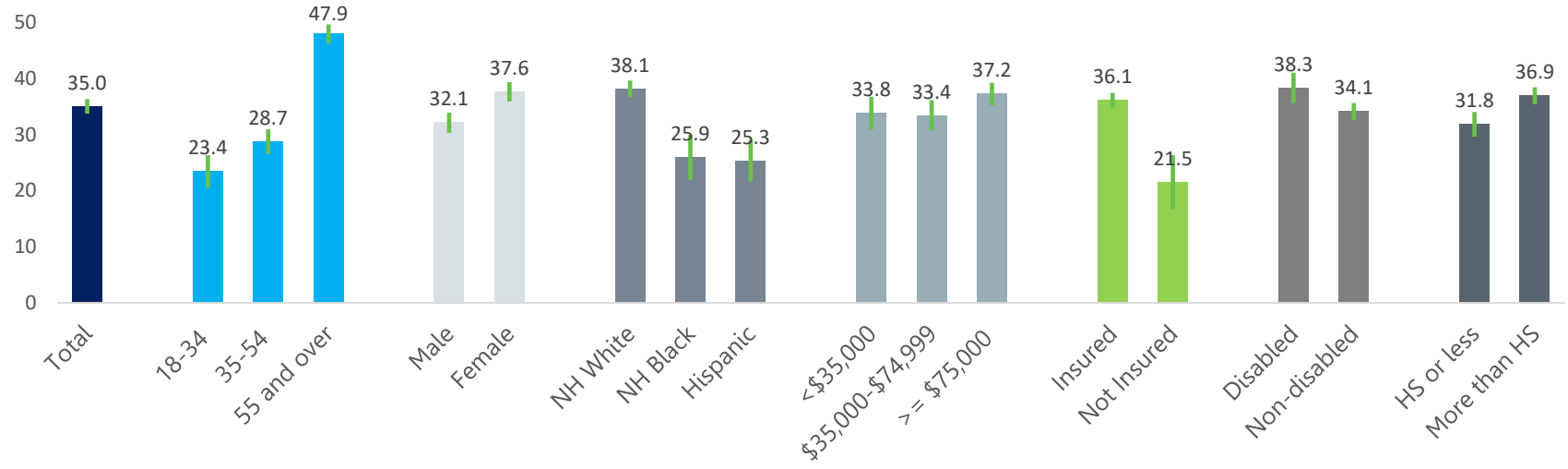
The influenza (flu) virus can cause serious infections, hospitalizations, and even death in some susceptible individuals. Seasonal flu vaccines are recommended for everyone over six months of age.[35] Respondents to the BRFSS were asked if they had received the seasonal flu vaccine, either as a shot or nasal spray mist. All respondents were asked if they had received the flu vaccine in the past 12 months. Results are shown in Figure 36.

In 2018, one in three CT adults in 2018 had a flu vaccine in the past year, and over half of CT adults aged 65 and over had a flu vaccine in the past year (55.3%).

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

- Adults 55 years and older (47.9%) and adults 35-54 years old (28.7%);
- Females (37.6%);
- Non-Hispanic White adults (38.1%);
- Adults with health insurance (36.1%);
- Adults with a disability (38.3%); and
- Adults with more than a high school education (36.9%).

FIGURE 36: FLU VACCINE IN THE PAST YEAR, CT 2018



PNEUMOCOCCAL VACCINATIONS (65+)

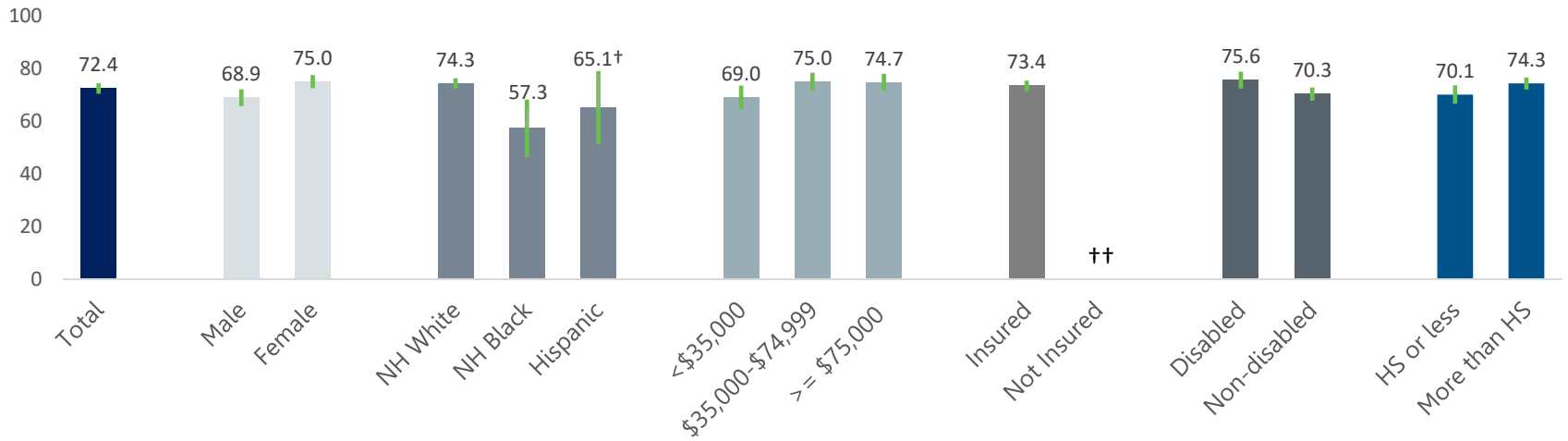
Pneumococcal disease, or pneumonia, is a lung infection that can be caused by viruses, bacteria, or fungi. In the United States, pneumococcal disease causes 4 million illness, 445,000 hospitalizations, and 22,000 deaths annually.[36] Infection caused by some types of pneumococcal bacteria can be prevented by a pneumococcal or "pneumonia" vaccine.[37] Respondents to the BRFSS were asked if they have ever received the pneumococcal vaccine, which is recommended for children under five years old, adults over 65 years old, and adults at high risk for disease (e.g., HIV infection, organ transplantation, leukemia, and severe kidney disease). Results are shown in Figure 37.

In 2018, nearly three-fourth CT adults reported that they ever had pneumococcal vaccination.

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

- Females (75.0%);
- Non-Hispanic White (74.3%) compared to non-Hispanic Black (57.3%) adults; and
- Adults with a disability (75.6%).

FIGURE 37: EVER HAD PNEUMOCOCCAL VACCINATION (65+), CT 2018



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

HUMAN IMMUNODEFICIENCY VIRUS (HIV) SCREENING

Over one million Americans are living with human immunodeficiency virus (HIV), and of these, about one in six are not aware they are infected. The group most affected by HIV is men who have sex with men, although heterosexuals and drug users can also be affected. African Americans and Hispanics are over-represented in new HIV infections.[38] Individuals can be tested for the virus by testing blood or oral fluid.

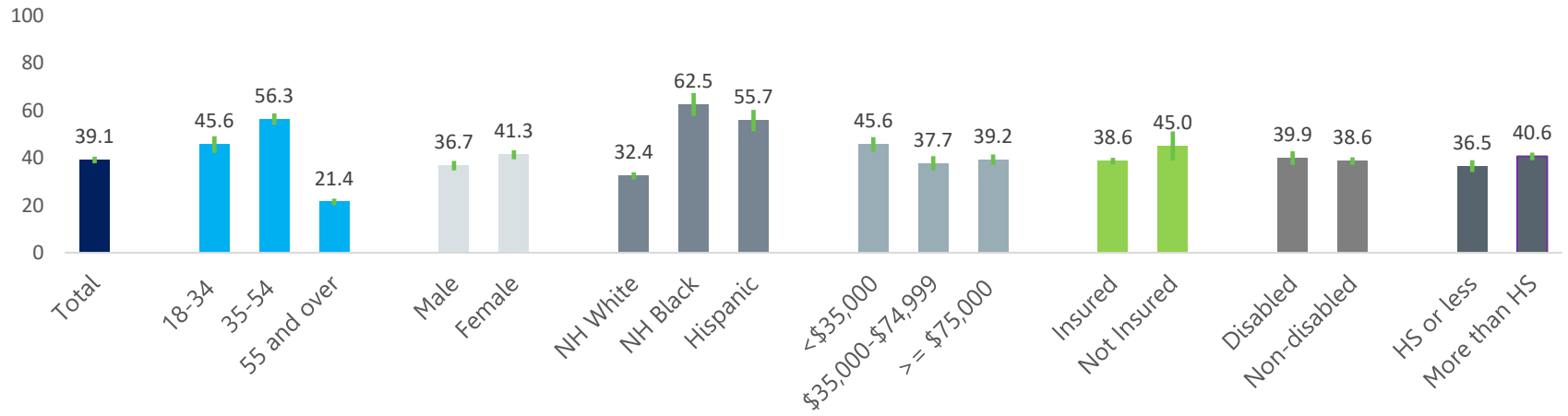
Respondents to the CT BRFSS were asked if they have ever been tested for HIV, not including testing while donating blood. Results are shown in Figure 38.

Two-fifth of Connecticut adults in 2018 reported having been tested for HIV.

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

- Adults 35–54 years old (56.3%) and adults 18–34 years old (45.6%);
- Females (41.3%);
- Non-Hispanic Black (62.5%) and Hispanic (55.7%) adults;
- Adults from household earning less than $35,000 (45.6%);
- Adults without health insurance (45.0%); and
- Adults with more than a high school education (40.6%).

FIGURE 38: EVER TESTED FOR HIV, CT 2018



CERVICAL CANCER SCREENING FOR WOMEN 21-65 YEARS

The main cause of cervical cancer is the human papillomavirus (HPV), a common sexually-transmitted virus.[39] In 2006, a vaccine to prevent HPV infection became available for use in the United States. In addition, highly reliable and effective screening tests (Pap test, or Pap smear) can find changes in the cervix that may become cancer if left untreated. These prevention tools make cervical cancer a highly preventable disease.[40] The most current screening guidelines set by the U.S. Preventative Services Task Force (USPSTF) in 2012 recommends that women aged 21 to 29 get a Pap smear every three years, and that women aged 30 to 65 get a Pap smear in combination with HPV testing every 5 years.[41]

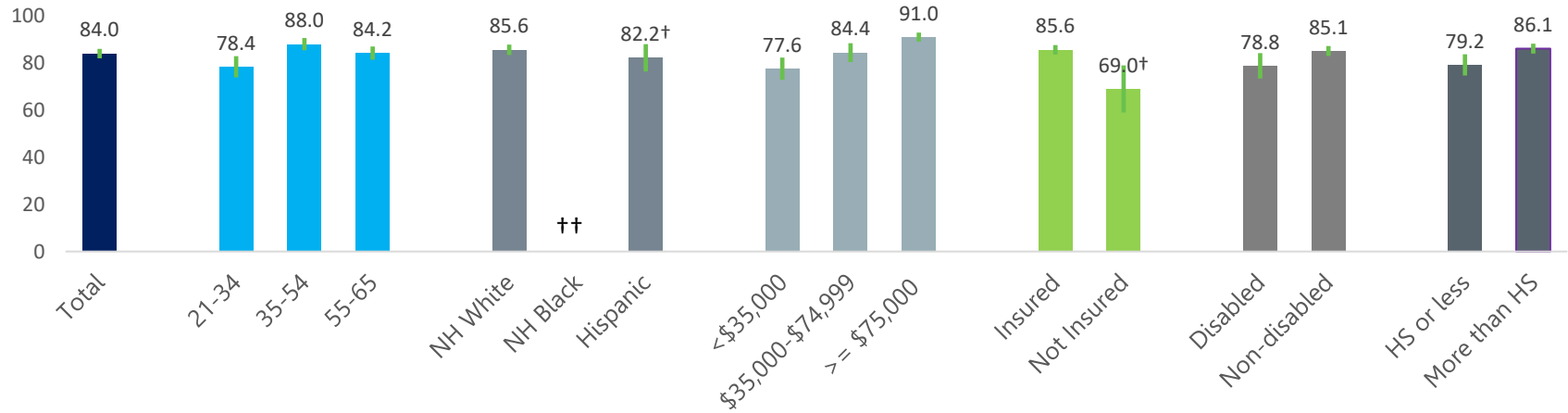
Female respondents in the BRFSS were asked if they had ever had a Pap test, and how long it had been since their last Pap test. Results for women aged 21 and older are shown in Figure 39.

In 2018, eighty-four percent of women 21-65 years old in Connecticut had a Pap test in the last three years.

Compare to their counterparts in the state, the prevalence of Connecticut adults 21-65 years old having an appropriately times **(within past three years) Pap test** was significantly greater for:

- Adults 35-54 years old (88.0%) compared to adults 21-34 years old (78.4%);
- Adults from household earning at least $75,000 (91.0%); and
- Adults with more than a high school education (86.1%).

FIGURE 39: CERVICAL CANCER SCREENING (WOMEN 21-65), CT 2018



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

HUMAN PAPILLOMA VIRUS (HPV) TEST

HPV is the most common sexually transmitted disease (STD), with millions of Americans currently infected. HPV can infect both men and women. Most people with HPV don't know they have it and never get any symptoms or health problems. The test is used to check for the types of HPV that can lead to cervical cancer. It is often done at the same time as a pap smear, a procedure that checks for abnormal cells that can also lead to cervical cancer. When an HPV test and a pap smear are done at the same time, it called co-testing. The American Cancer Society recommends women woman aged 30-65 years old have co-testing every five years, or woman of any age that gets an abnormal result on a pap smear.

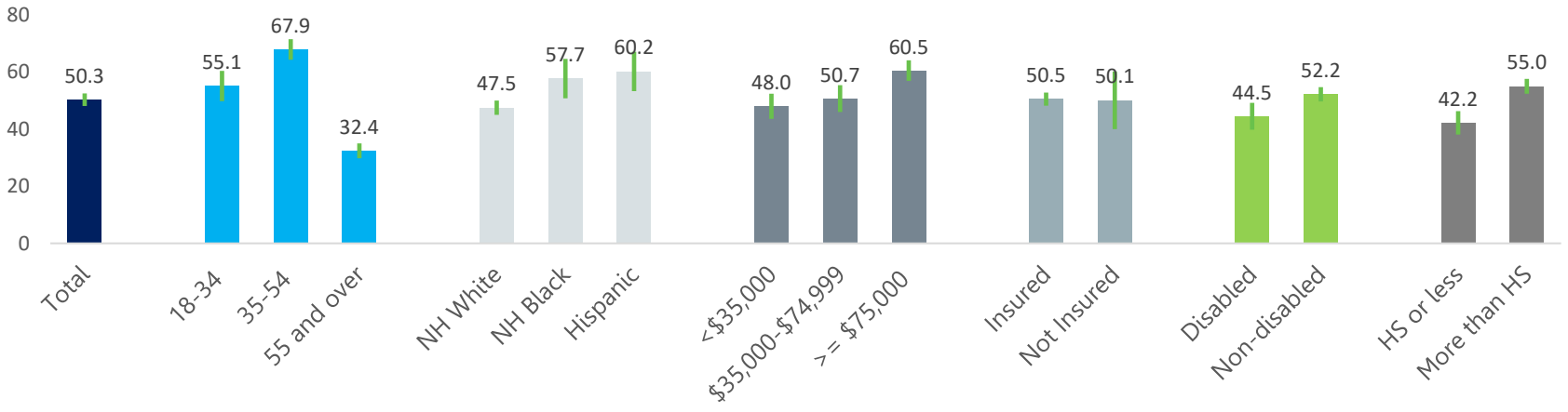
Female respondents in the BRFSS were asked if they had ever had a HPV test, and how long it had been since their last HPV test. Results are shown in Figure 40.

Half of Connecticut women reported they ever had an HPV test in 2018.

Compared with their counterparts in the state, the prevalence of women who reported that they **ever had an HPV test** was significantly greater for:

- Women 18-34 (55.1%) and 35-54 (67.9%);
- Non-Hispanic Black (57.7%) and Hispanic (60.2%) women;
- Women from household earning at least $75,000 (60.5%);
- Women with disability (52.2%); and
- Women with more than a high school education (55.0%).

FIGURE 40: WOMEN WHO EVER RECEIVED AN HPV TEST, CT 2018



BREAST CANCER SCREENING FOR WOMEN, 50-74 YEARS

Breast cancer is the second leading cause of death from cancer in women.[42] The purpose of breast cancer screening is to look for cancer before there are signs or symptoms of the disease. When abnormal tissue or cancer is detected earlier, it may be more easily treated. Regular mammograms can lower the risk of dying from breast cancer.[43] The most recent guidelines by the U.S. Preventive Services Task Force in 2016 recommends biennial screening mammography for women aged 50 to 74 years old.[44]

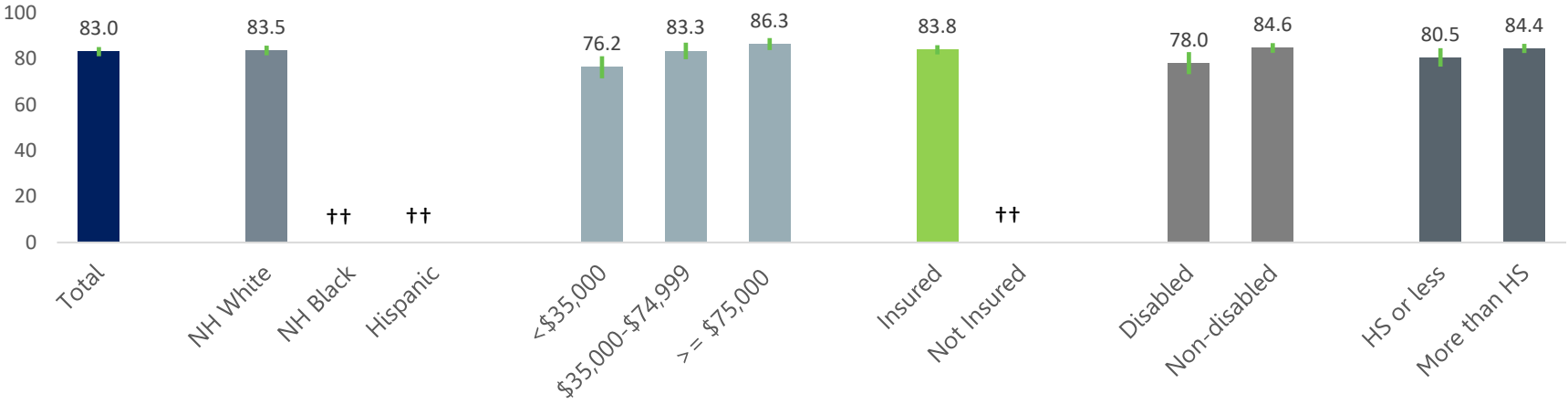
Female respondents were asked if they had ever received a mammogram, and for those who had, how long it had been since their last one. . Results are shown in Figure 41.

In 2018, eighty-three percent of Connecticut women aged 50-74 years old had a mammogram in the past two years.

Compared with their counterparts in the state, the prevalence of having a **mammogram in the past two years** among CT women was significantly greater for:

- Women living in household with annual income $35,000-$74,999 (83.3%) and at least $75,000 (86.3%); and
- Women without a disability (84.6%).

FIGURE 41: BREAST CANCER SCREENING (WOMEN 50-74), CT 2018



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

PROSTATE CANCER SCREENING FOR MEN 40 AND OVER

Prostate-specific antigen (PSA) is a protein produced by the prostate, and elevated levels of PSA in the blood are correlated with a higher risk for prostate cancer.[45] A PSA test has regularly been used in prostate cancer screening, however medical professionals have started to caution against the test because some men with elevated PSA levels are later found to not have prostate cancer. While there is disagreement over whether PSA tests should be recommended as a screening tool, there is agreement that a man considering a PSA test should be given all possible information about the benefits and harms of the test.[46]

Men aged 40 and older were asked if their healthcare provider had ever spoken with them about the advantages and disadvantages of a PSA test. They were also asked if they had ever had a PSA test, when it happened, and their main reason for having it. Results are shown in Figures 42 and 43.

In 2018, one in three Connecticut men aged 40 years and older reported had PSA test within past 2 years.

Compared with their counterparts in the state, the prevalence of having a **PSA test in the past two years** among men 40 and over was significantly greater for:

- Men 55 and over (46.3%) compared to men 40-54 years old (15.9%);
- Adults from households earning at least $75,000 (37.0%) compared to from less than $35,000 (26.1%); and
- Adults with more than a high school education (38.6%).

FIGURE 42: PROSTATE CANCER SCREENING (MEN 40+), CT 2018

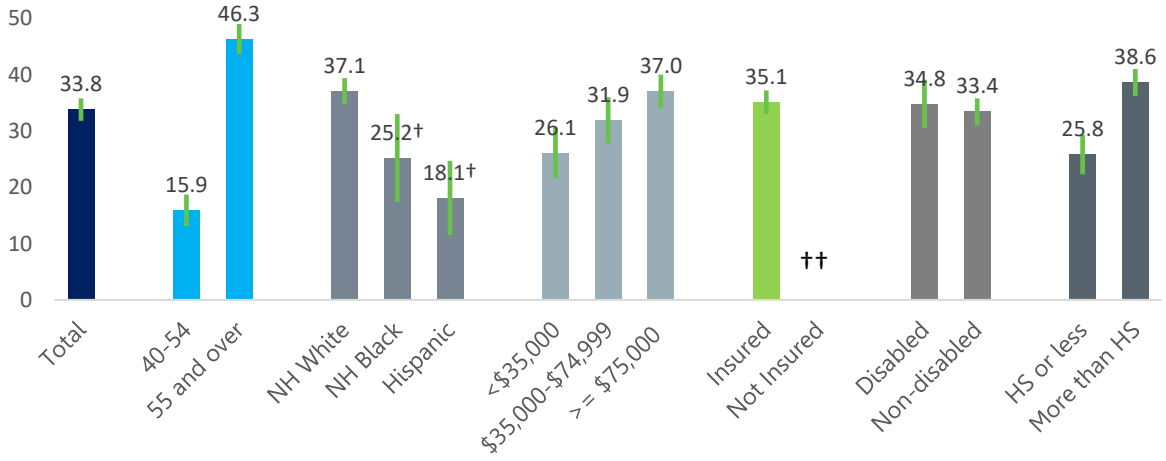
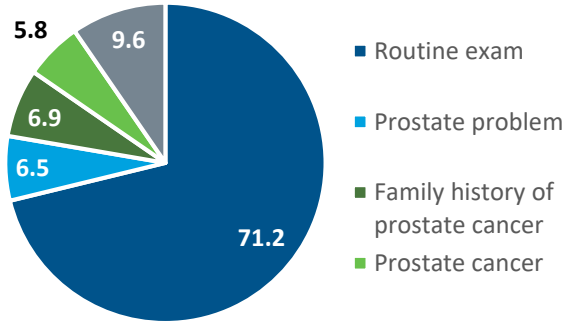


FIGURE 43: MAIN REASON FOR PSA TEST, CT 2018



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

COLORECTAL CANCER SCREENING 50-75 YEARS

Colorectal Cancer (CRC) is the fourth most common cancer, and although it is preventable, it is the fourth leading cause of cancer-related death in the U.S. CRC usually develops from precancerous polyps (growths). Screening for CRC using fecal occult blood testing, sigmoidoscopy or colonoscopy offers a clear benefit for adults 50 to 75 years old.[47] Detection and removal of these polyps during sigmoidoscopy or colonoscopy screening can prevent cancer. It is estimated that proper screening could prevent more than half of the 51,000 deaths from CRC each year.[48]

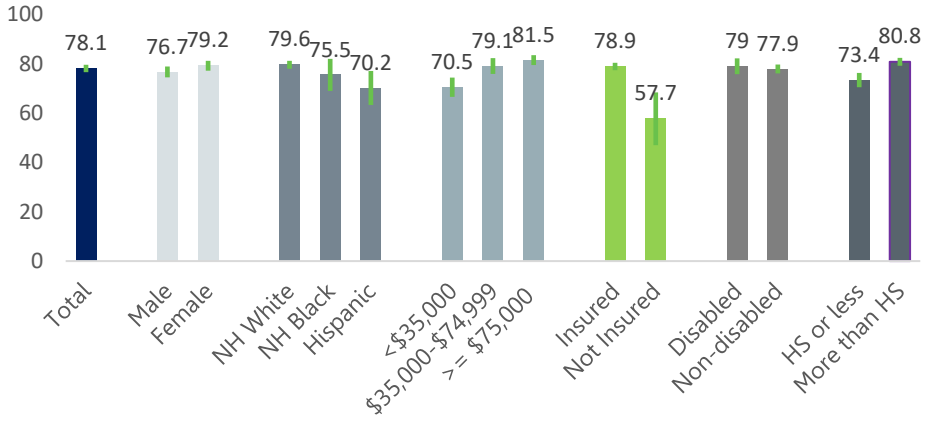
Respondents 50 years old and older were asked if they had ever had a blood stool test using a home kit, sigmoidoscopy or colonoscopy, and if so, when they had the test. Results are shown in Figures 44 and 45.

In 2018, seventy-eight percent of CT adults 50-75 years old reported they ever had a sigmoidoscopy or colonoscopy, and one in seven reported they had a blood stool test within the past 3 years.

Compared with their counterparts in the state, the prevalence of **ever having a sigmoidoscopy or colonoscopy** among adults 50-75 years old was significantly greater for:

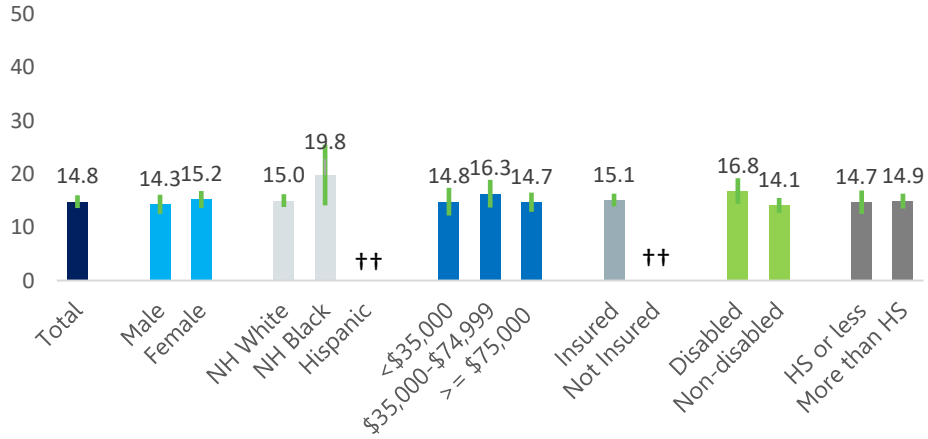
- Non-Hispanic White (79.6%) compared to Hispanic (70.2%) adults;
- Adults from households earning at least $75,000 (81.5%) and $35,000–$74,999 (79.1%);
- Adults with insurance (78.9%); and
- Adults with more than a high school education (80.8%).

FIGURE 44: EVER HAD SIGMOIDOSCOPY/ COLONOSCOPY (50-75) SCREENING, CT 2018



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

FIGURE 45: ADULTS 50-75 YEARS OLD REPORTED HAD A BLOOD STOOL TEST WITHIN THE PAST 3 YEARS, CT 2018



6. CHRONIC CONDITIONS

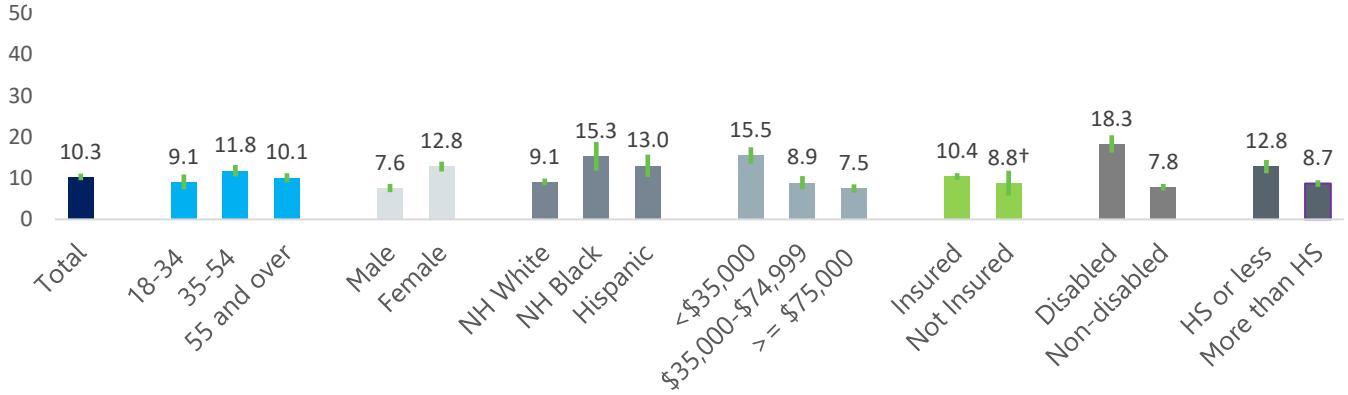
ASTHMA

Asthma is a chronic lung disease that causes the airways to become inflamed or swollen. Symptoms of asthma include shortness of breath, coughing, and wheezing.[49] Four thousand people die in the United States each year due to asthma-related causes. These deaths are preventable with proper treatment.[50] Overall, asthma rates have been increasing in adults in the United States.[51] Respondents were asked if, among those who indicated a doctor or health professional had ever told them they had asthma, whether they still had asthma. Results in 2018 are shown in Figures 46 and 47.
One in ten Connecticut adults (10.3%) reported having current asthma in 2018.

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

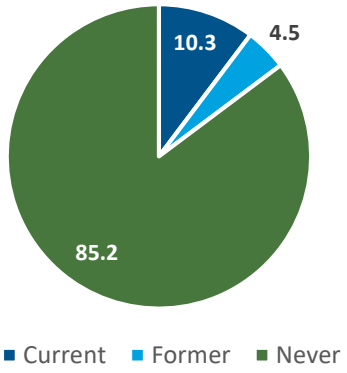
- Adults 35–54 years old (11.8%) compared to adults 18-34 years old (9.1%);
- Females (12.8%);
- Hispanic adults (13.0%) and non-Hispanic Black adults (15.3%);
- Adults from households earning less than $35,000 (15.5%);
- Adults with a disability (18.3%); and
- Adults with no more than a high school education (12.8%).

FIGURE 46: ADULT CURRENT ASTHMA, CT 2018



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

FIGURE 47: ADULT ASTHMA STATUS, CT 2018



CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Chronic obstructive pulmonary disease (COPD) is a lung disease that includes two main conditions: emphysema and chronic bronchitis. The term COPD is used because most sufferers have many conditions. COPD is characterized by damage to the lungs and airways, which causes less air to flow into the lungs. Symptoms include heavy coughing, wheezing, and shortness of breath. Cigarette smoking is the primary cause of COPD, although other lung irritants such as air pollution, chemical fumes, and dust may also contribute.[52] Genetic factors may also contribute to COPD.

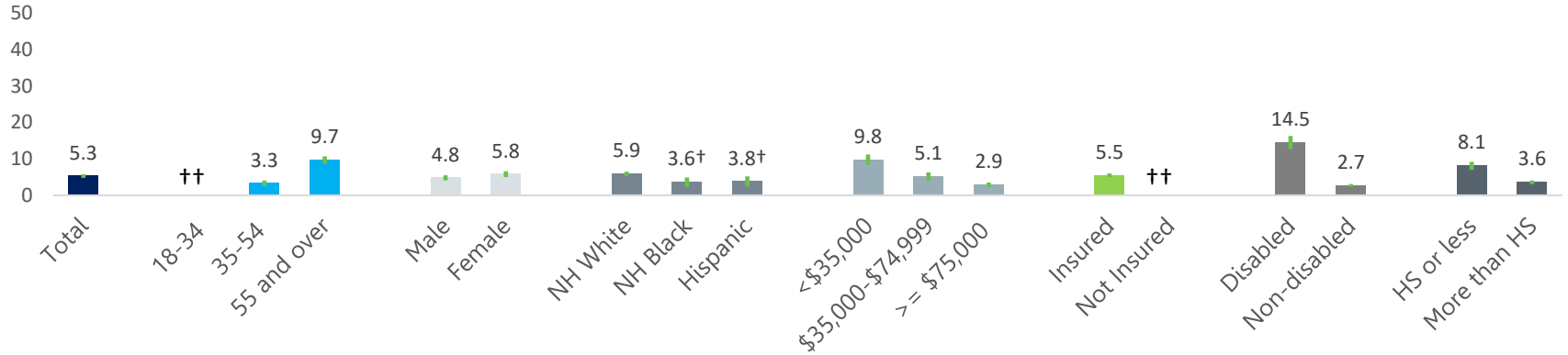
Respondents to the BRFSS were asked if they were ever told they had COPD, emphysema, or chronic bronchitis, and results in 2018 are shown in Figure 48.

In 2018, one in 20 CT adults reported they had COPD.

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

- Adults 55 years and older (9.7%) compared to adults 35-54 years old (3.3%);
- Adults from households earning less than $35,000 (9.8%) and $35,000-$75,000 (5.1%);
- Adults with a disability (14.5%); and
- Adults with no more than a high school education (8.1%).

FIGURE 48: CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CT 2018



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

ARTHRITIS

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

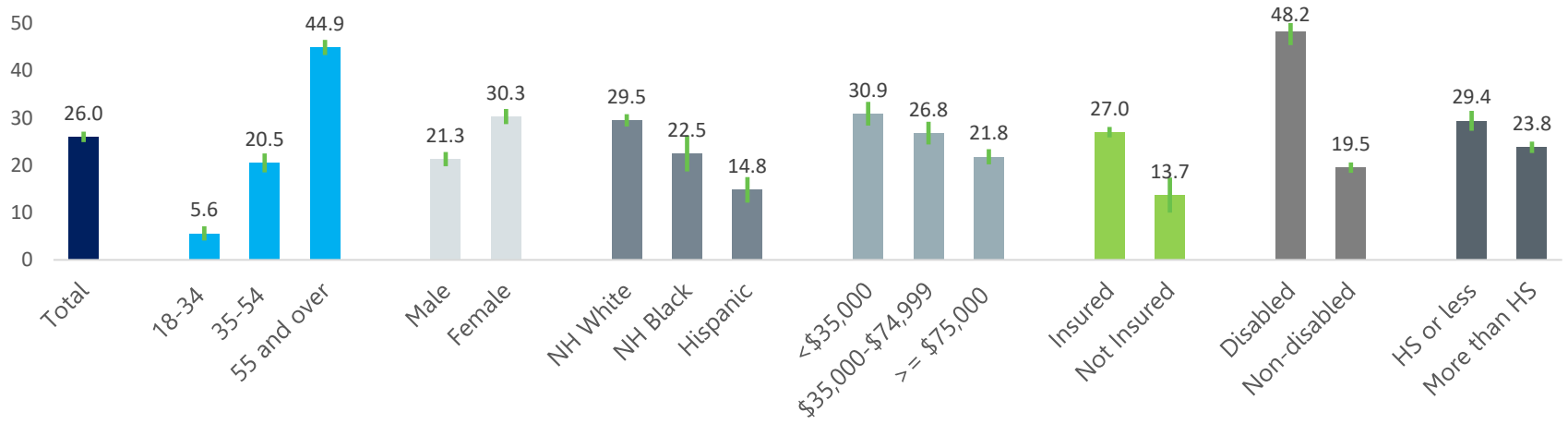
Respondents to the BRFSS were asked if they were ever told they had arthritis, and results in 2018 are shown in Figure 49.

One in four Connecticut adults in 2018 had been diagnosed with arthritis.

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

- Adults 55 years and older (44.9%) and adults 35–54 years old (20.5%);
- Females (30.3%);
- Non-Hispanic White (29.5%) and non-Hispanic Black (22.5%) adults;
- Adults from households earning less than $35,000 (30.9%) and $35,000-$74,999 (26.8%);
- Adults with health insurance (27.0%);
- Adults with a disability (48.2%); and
- Adults with no more than a high school education (29.4%).

FIGURE 49: ARTHRITIS, CT 2018



CARDIOVASCULAR DISEASE AND STROKE

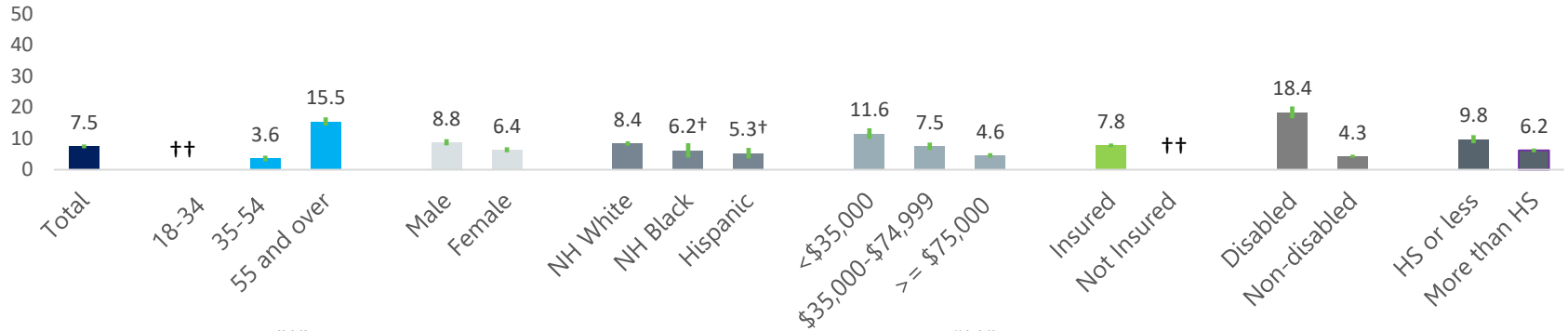
Cardiovascular disease (CVD) encompasses several heart conditions. It is the leading cause of death in the United States. The most common type of heart disease is coronary heart disease.[53] Adults who suffer from coronary heart disease have plaque build-up in their coronary arteries, which reduces the flow of oxygen to the heart. This can lead to angina, characterized by chest pain or pressure, as well as heart attacks.[54] Cardiovascular disease and stroke can be prevented by remaining physically active and eating a healthy and well-balanced diet and managing risk factors such as high blood pressure and cholesterol.[55] Respondents are asked if they were ever told they had any of the following: a heart attack, also called a myocardial infarction; angina or coronary heart disease; or a stroke, a disease caused by a blocked blood vessel or bleeding in the brain. Results in 2018 for those who responded to all three questions were combined and are presented in Figure 50.

In 2018, one in 13 CT adults reported they had cardiovascular disease.

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

- Adults 55 years and older (15.5%) compared to adults 35-54 years old (3.6%);
- Males (8.8%);
- Adults from households earning less than $35,000 (11.6%) and $35,000-$74,999 (7.5%);
- Adults with a disability (18.4%); and
- Adults with no more than a high school education (9.8%).

FIGURE 50: CARDIOVASCULAR DISEASE, CT 2018



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

PRE-DIABETES

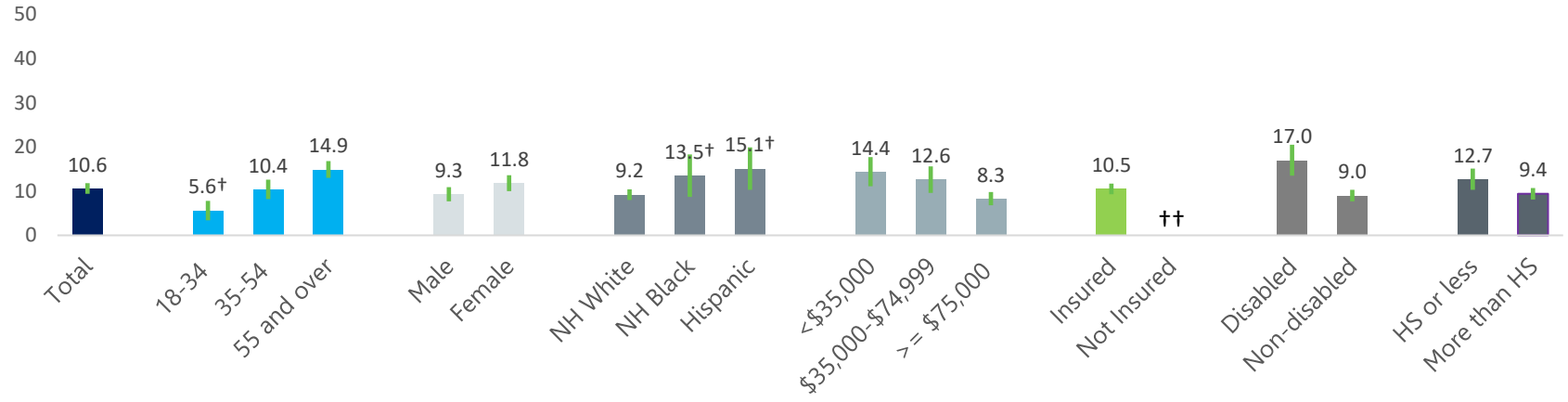
Pre-diabetes refers to blood sugar levels that are higher than normal but not high enough to be diagnosed with diabetes. The American Diabetes Association (ADA) recommends that testing to detect pre-diabetes be considered in adults who are overweight or obese and have one or more additional risk factors for diabetes.[56] Respondents to the BRFSS were asked if they had ever been told they had pre-diabetes or borderline diabetes. Women with pre-diabetes only during pregnancy are not considered to have had pre-diabetes. Results are shown in Figure 51.

In 2018, one in nine Connecticut adults reported that they had been diagnosed with pre-diabetes. More than half of CT adults (56.6%) reported had a test for high blood sugar in past three years.

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

- Adults 55 years and older (14.9%) compared to adults 35-54 years old (10.4%);
- Adults from households earning less than $35,000 (14.4%) compared to at least $75,000 (8.3%);
- Adults with a disability (17.0%); and
- Adults with more than a high school education (12.7%).

FIGURE 51: PRE-DIABETES, CT 2018



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

DIABETES

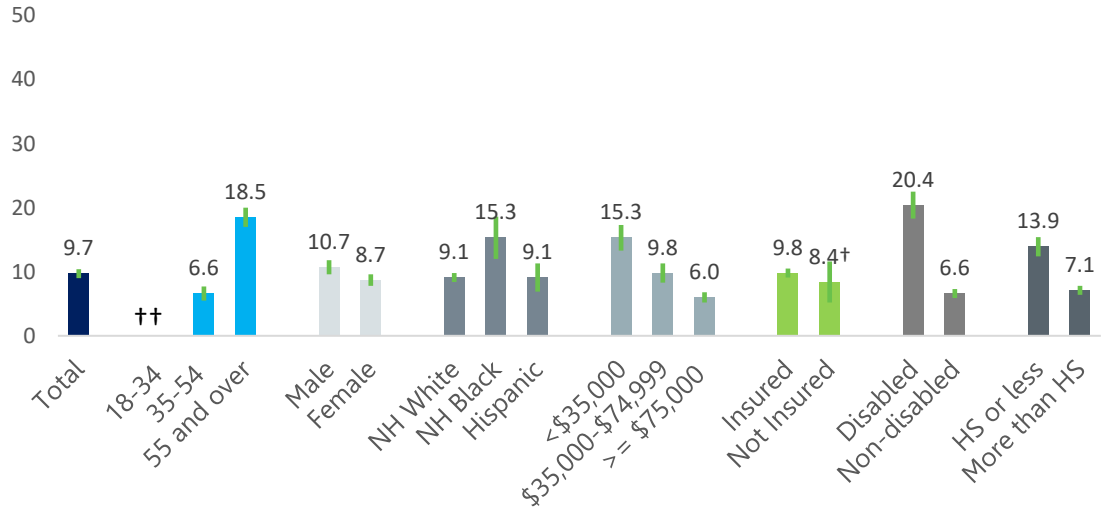
Diabetes is a disease characterized by high levels of blood sugar. It can lead to serious health problems, such as heart disease, stroke, blindness and lower-extremity amputation.[57] Diabetes affects over 29 million people in the U.S. Those over 60 years of age, African Americans and Hispanics, and groups of low socioeconomic status are at higher risk for diabetes.[58] Respondents to the BRFSS were asked if they have ever been told they have diabetes. Women with diabetes only during pregnancy are not classified as having diabetes. Results in 2018 are shown in Figure 52.

One in 10 Connecticut adults reported in 2018 that they had ever been diagnosed with diabetes.

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

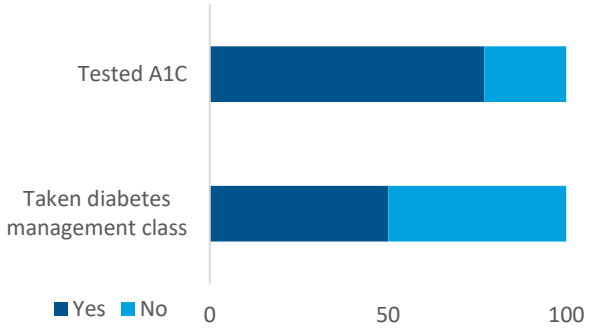
- Adults 55 or over (18.5%) compared to adults 35–54 years old (6.6%);
- Males (10.7%);
- Non-Hispanic Black (15.3%);
- Adults from households earning less than $35,000 (15.3%) and $35,000-$74,999 (9.8%);
- Adults with a disability (20.4%); and
- Adults with no more than a high school education (13.9%).

FIGURE 52: DIABETES, CT 2018



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

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



KIDNEY DISEASE

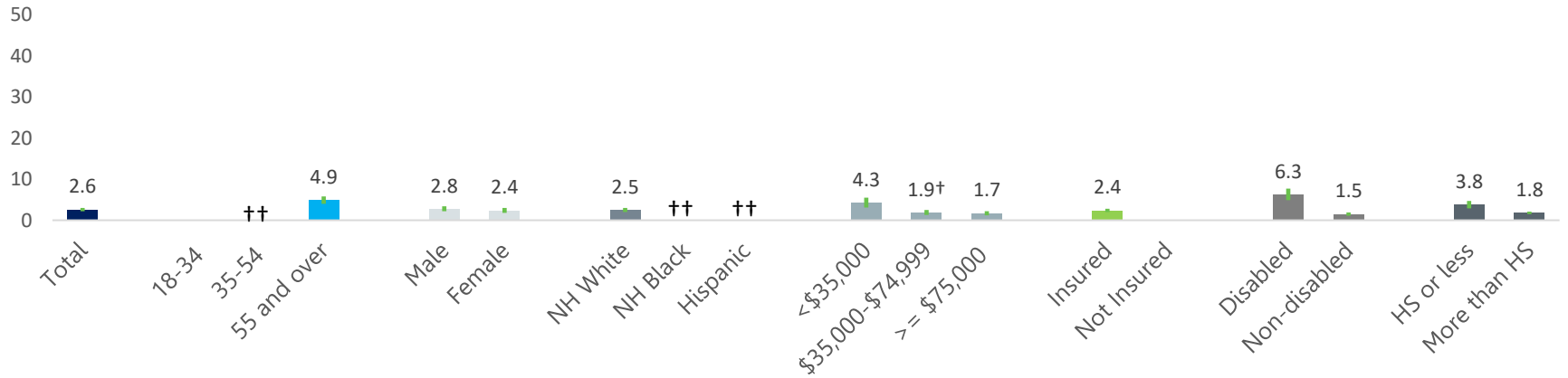
Chronic kidney disease is a condition in which the kidneys cannot filter blood as well as they should, and waste is not properly filtered. A person with kidney disease is more likely to develop heart disease and other health problems. Adults with diabetes or high blood pressure are at higher risk of developing chronic kidney disease.[59] Chronic kidney disease can be detected early with blood tests. If it is detected, medication can reduce the damage to the kidneys by 50%. Kidney disease often runs in families, and family medical history can often identify people at risk for chronic kidney disease.[60] Respondents are asked if they were ever told they had kidney disease. Results in 2018 are shown in Figure 54.

One in 38 Connecticut adults in 2018 had been diagnosed with kidney disease.

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

- Adults from households earning less than $35,000 (4.3%) compared to $75,000 or more (1.7%);
- Adults with a disability (6.3%); and
- Adults with no more than a high school education (3.8%).

FIGURE 54: KIDNEY DISEASE, CT 2018



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

DEPRESSION

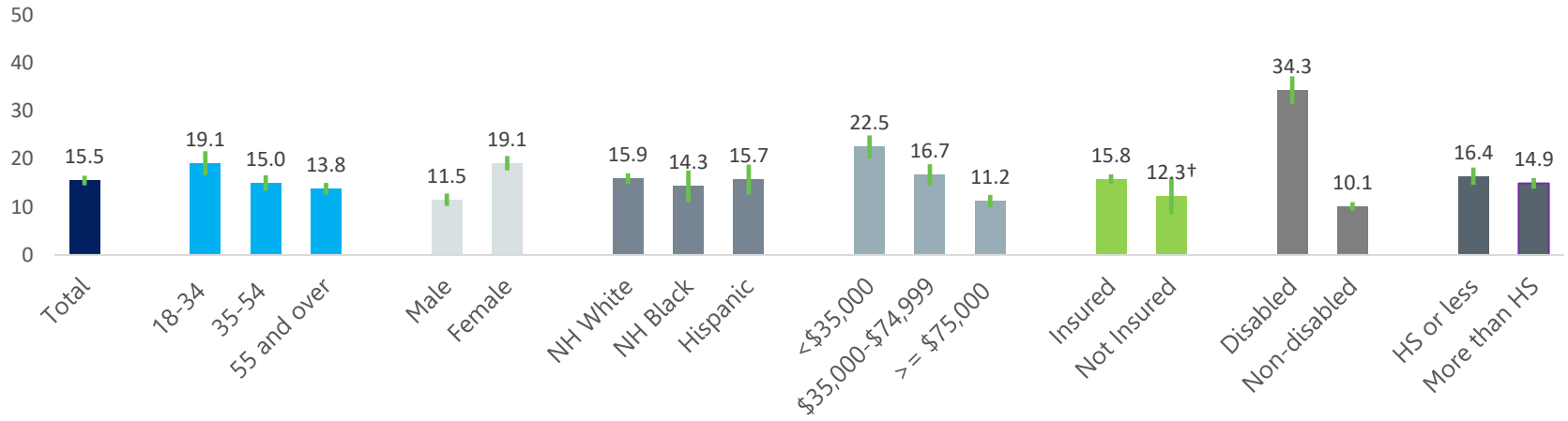
Depression is a common and serious illness that can take several forms. Symptoms include persistent feelings of sadness, anxiety, emptiness, and hopelessness, as well as fatigue, irritability, and restlessness. Depressive disorders may interfere with a person's work and daily activities and prevent them from functioning normally. Some forms of depression develop under unique circumstances; others occur in episodes or may be longer-term.[61] Depression is often misconstrued as a sign of weakness, and if left untreated, can have tragic consequences, including suicide. Medication and therapy have been proven effective in treating major depression.[62] Respondents are asked if they were ever told they had a depressive disorder, including depression, major depression, dysthymia, or minor depression. Results in 2018 are shown in Figure 55.

One in six Connecticut adults in 2018 had been diagnosed with depression (15.5%).

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

- Adults 18–34 years old (19.1%);
- Females (19.1%);
- Adults from households earning less than $35,000 (22.5%) and $35,000–$74,999 (16.7%); and
- Adults with a disability (34.3%).

FIGURE 55: DEPRESSION, CT 2018



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

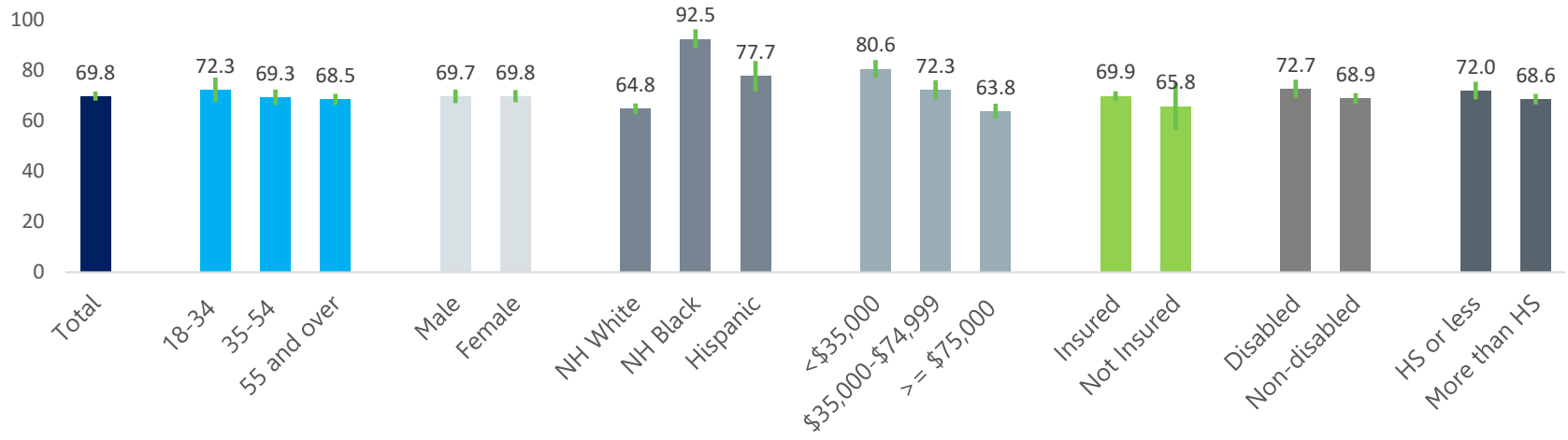
7. ENVIRONMENTAL HEALTH

WATER SOURCES

Drinking water comes from a variety of sources, including public water systems, private wells, or bottled water.[63] It is important to know where drinking water comes from, how it's been tested, and if it's safe to drink. According to the United States Environmental Protecting Agency (EPA), public drinking water systems consist of community and non-community systems. Eight percent of U.S. community water systems provide water to 82% of the U.S. population through large municipal water systems.[64] Private water systems are composed of private groundwater residential wells, cisterns, and large private water systems that serve more than one residence.[65] Many people in the United States receive their water from private groundwater wells. The presence of contaminants in sources of drinking water can lead to adverse health effects, including gastrointestinal illness, reproductive problems, and neurological disorders.[66] In 2018, BRFSS respondents were asked to report their main source of water supply. The prevalence of adults in 2018 who reported having public or private well water supply in their residence is broken down by demographic characteristics in Figures 56 and 57.

In 2018, seven in ten CT adults had a public water supply, while one in four adults reported having private well as their main water source.

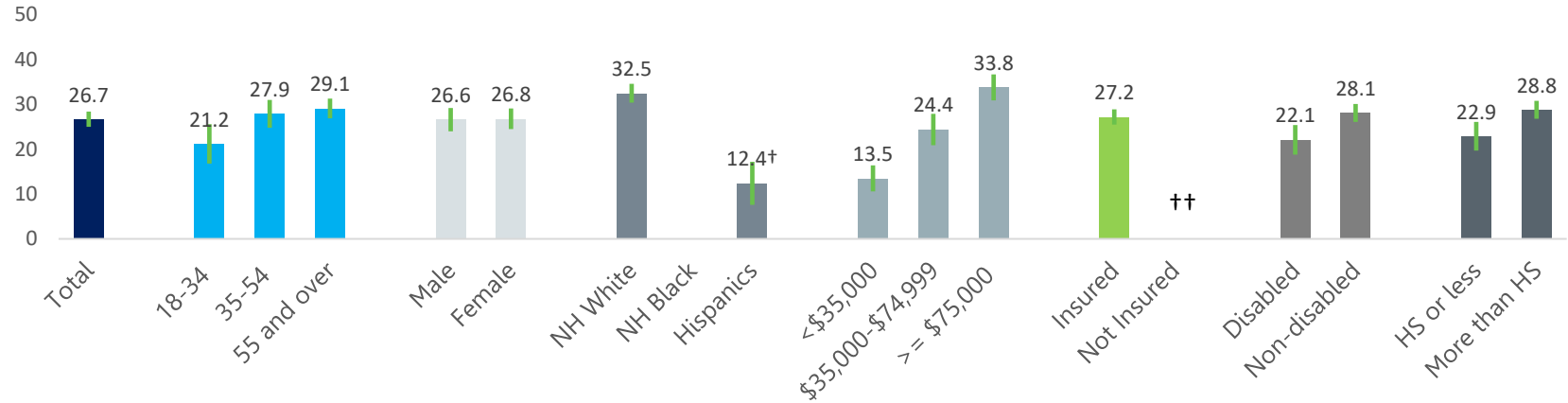
FIGURE 56: PUBLIC WATER SUPPLY, CT 2018



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

- Non-Hispanic Blacks (92.5%) and Hispanics (77.7%); and
- Adults from households earning less than $35,000 (80.6%) and $35,000-$74,999 (72.3%).

FIGURE 57: PRIVATE WELL WATER SUPPLY, CT 2018



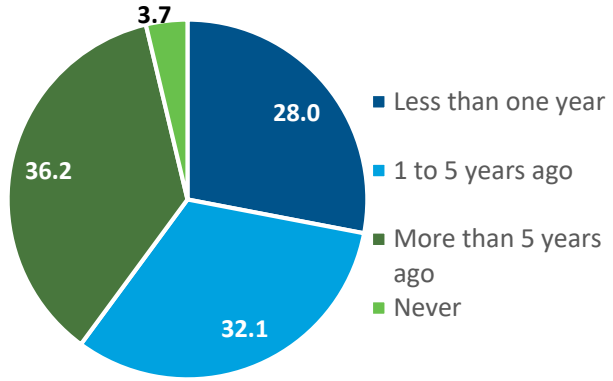
Estimates marked with a "†" have a CV between 15.0% and 20.0%; estimates marked with a "††" have a CV between 20.1% and 30.0%; estimates with CV greater than 30.0% was suppressed.

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

- Adults 55 and older (29.1%) and adults 35-54 years old (27.9%);
- Adults from households earning at least $75,000 (33.8%) and $35,000-$74,999 (24.4%); and
- Adults with a disability (28.1%).

The E.P.A recommends that homeowners have their well water tested annually. Testing is also recommended for water that develops a noticeable change in color, odor, or taste. CT DPH water testing guideline is also available on the www.ct.gov/DPH website. Figure 58 shows the frequency of well water testing for Connecticut residents.

FIGURE 58: TIME SINCE LAST WELL WATER TEST, CT 2018



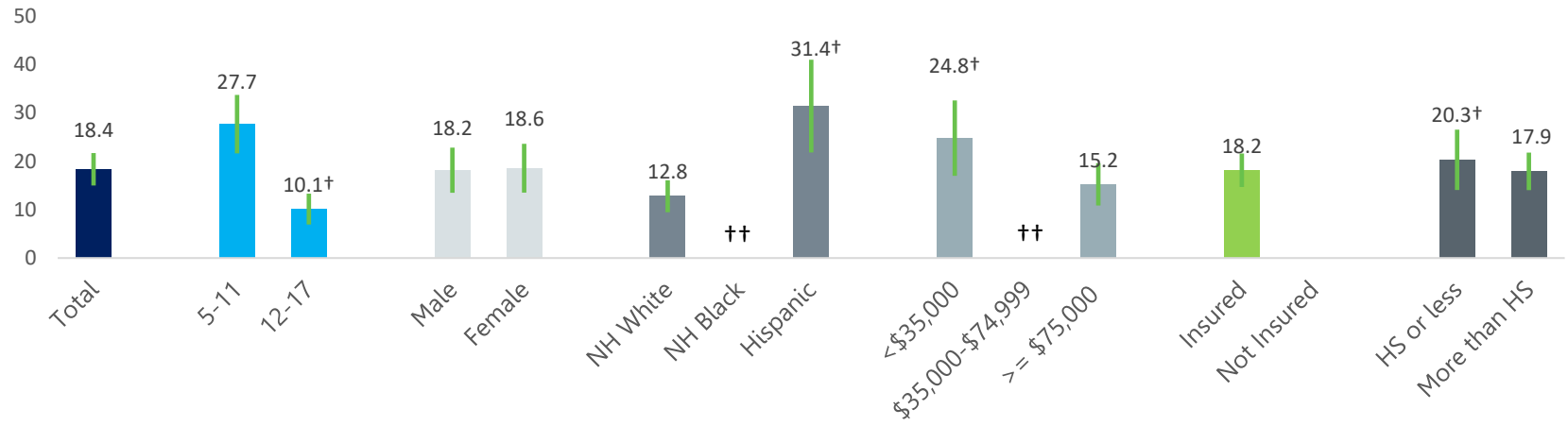
8. CHILD HEALTH

CHILD WEIGHT STATUS

As part of a state-specific module in the BRFSS, a child is randomly selected in the household and the adult respondent is asked several health-related questions about that child, including the child's height and weight. As with adults, BMI was calculated for these randomly selected children; however, child weight status is calculated differently than that for adults.[67] For children, weight status is determined comparatively based on age and sex. An overweight child has a BMI between the 85th and 95th percentile for children of the same age and sex, while an obese child has a BMI at or above the 95th percentile for children of the same age and sex. Obese children face a variety of health and social problems and are more likely to be obese adults.[68] Results for 2018 are shown in Figure 59.

In 2018, one in six children 5-17 years old were **overweight**, and one in five children 5-17 years old were **obese**.

FIGURE 59: CHILD OBESITY (5-17 YEARS OLD), CT 2018



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

BREASTFEEDING

The American Academy of Pediatrics recommends that mothers breastfeed infants exclusively for six months and continue to breastfeed for at least six more months after introducing solid foods.[69, 70] Breastfeeding provides a host of health benefits for nursing mothers and babies. Nursing infants receive natural protection against common illnesses and infections due to the immunologic properties of breast milk. There is also some evidence that breastfeeding can prevent the development of allergies, auto-immune disorders, and even chronic disease later in life.[71] In the BRFSS, an adult proxy is asked whether the selected child was ever breastfed, and how long the child was breastfed and exclusively breastfed. Results in 2018 are shown in Figures 60 and 61.

In 2018, four out of every five Connecticut children have been breastfed, and among them three in five have been exclusively breastfed for at least 3 months.

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

- Children from household with annual incomes at least $75,000 (87.3%); and
- Children living with an adult caregiver who had more than a high school education (84.9%).

FIGURE 60: CHILD EVER BREASTFED, CT 2018

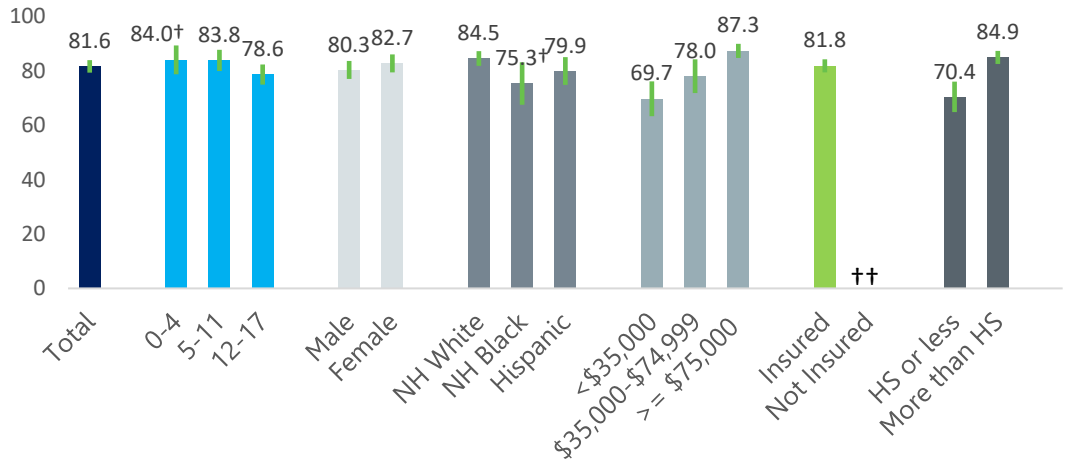
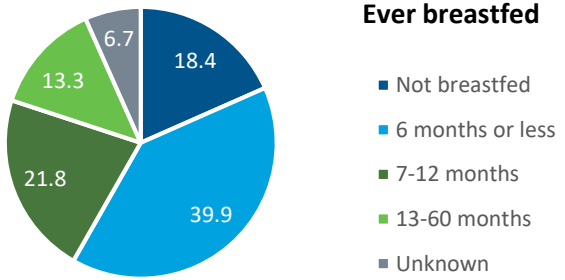


FIGURE 61: LENGTH OF BREASTFEEDING BREASTFEEDING PERIOD (MONTH), CT 2018



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

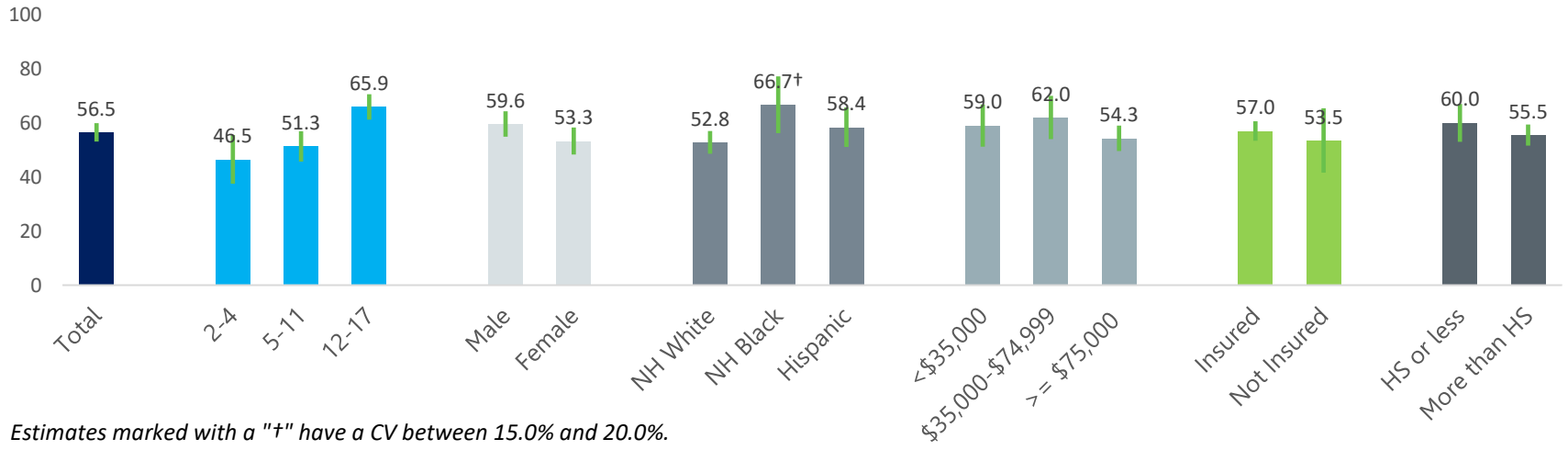
CHILD SCREEN TIME

The American Academy of Family Physicians (AAFP) and American Academy of Pediatrics recommends that screen time is limited, with no screen time before 2 years of age, and no more than two hours a day for children 2 and older.[72] U.S. children 8–18 years old are exposed to about 7 hours and 38 minutes of entertainment screen time daily.[73] This indicator is of interest because sedentary behaviors, such as sitting in front of the television for long periods, may contribute to weight gain or obesity. Additionally, television or computer exposure may negatively affect child development or perspective in other ways.[74] The BRFSS survey asks the adult proxy respondent how much time the selected child spent watching programs, movies, videos or playing video games on television. Another question asks how much time the child spent using a computer, tablet, or handheld device for playing video games or for something that is not schoolwork. The data from both questions were combined to calculate total screen time exposure for children ages 2–17. Results in 2018 are reported in Figure 62.

More than half of Connecticut children in 2018 had excessive screen time (more than 2 hours daily). Compared to their counterparts in the state, the risk of **excessive screen time** among children in Connecticut was significantly greater for:

- Children 12–17 years old (65.9%).

FIGURE 62: CHILD EXCESSIVE SCREEN TIME, CT 2018



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

CHILD SODA AND FAST FOOD CONSUMPTION

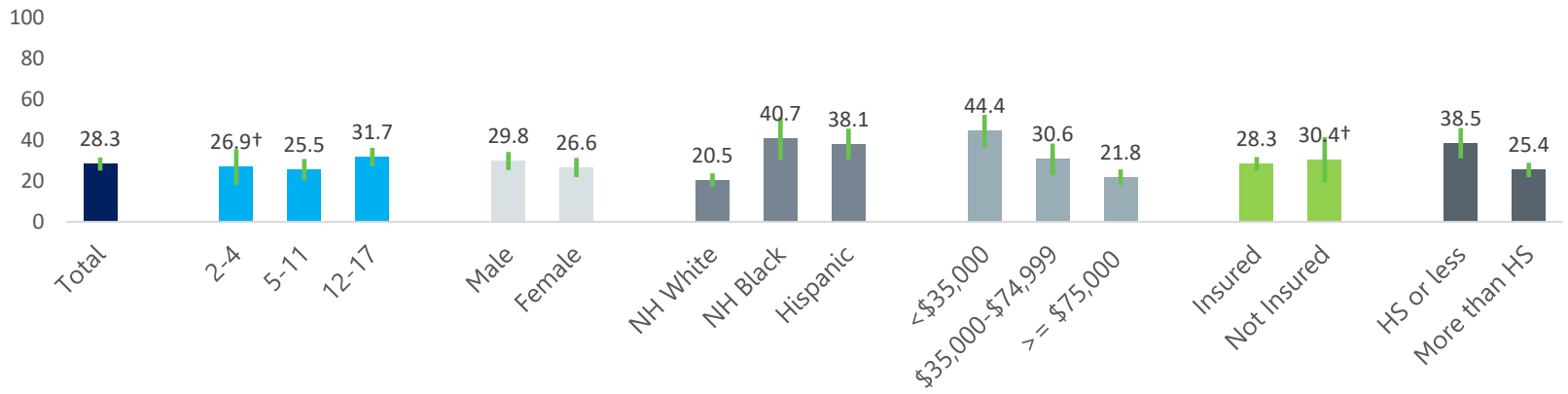
Consumption of soda and other sugar-sweetened beverages (SSBs) is associated with obesity in children.[75] Children who eat at fast-food and full-service restaurants eat more and have poorer diets compared to children who eat at home.[76]
Adult proxy respondents report how many glasses, bottles, or cans of soda or other SSBs the randomly selected child drinks on an average day. They are also asked how many times in the past week the child ate fast food or pizza at school, at home, or at a fast-food restaurant. Results in 2018 for children two years old and over are reported in Figures 63 and 64.

One in four Connecticut children drank SSBs at least once daily in 2018, while two in five ate fast food two or more times weekly.

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

- Hispanic children (38.1%) and non-Hispanic Black children (40.7%);
- Children living in a household with annual earnings of less than $35,000 (44.4%) and $35,000-$74,999 (30.6%); and
- Children living with an adult proxy who had no more than a high school education (38.5%).

FIGURE 63: DRANK SUGAR SWEETENED BEVERAGES AT LEAST ONCE DAILY, CT 2018

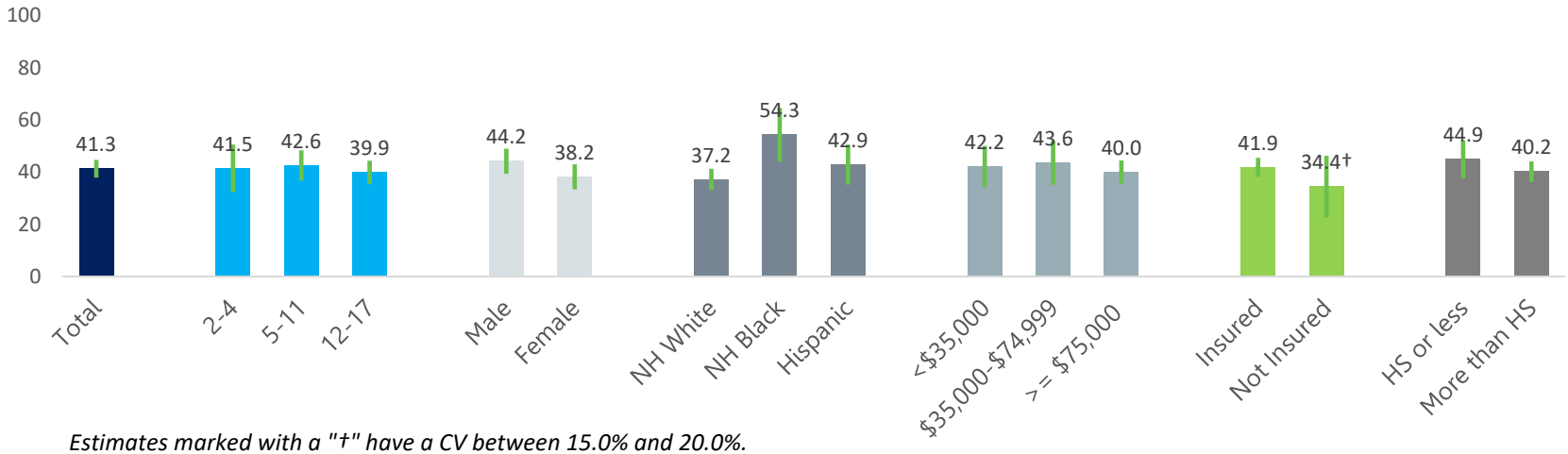


Estimates marked with a "†" have a CV between 15.0% and 20.0%.

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

- Non-Hispanic Black children (54.3%) compared to non-Hispanic White children (37.2%).

FIGURE 64: ATE FAST FOOD TWO OR MORE TIMES WEEKLY, CT 2018



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

CHILD ORAL HEALTH

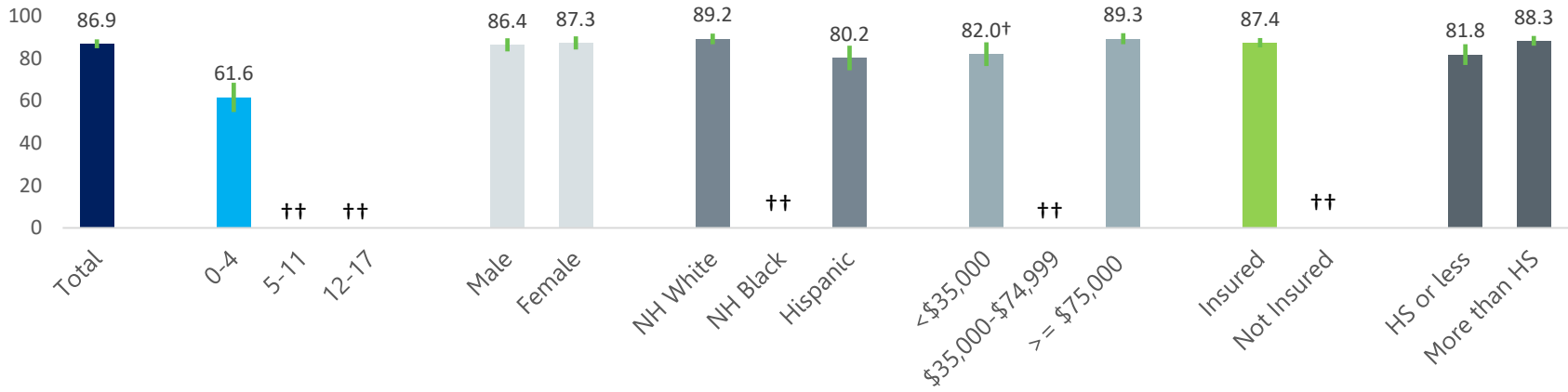
Although it is largely preventable, tooth decay is the most common chronic condition among children in the United States.[77] Dental caries (cavities) can cause pain and infection, and if left untreated they can lead to malnourishment and serious medical complications.[78] The American Academy of Pediatric Dentistry recommends that children see a pediatric dentist when their first tooth appears, and no later than their first birthday.[79] Dental sealants can also prevent tooth decay.[80] Sealants are thin, plastic coatings that are painted on the back teeth, protecting the grooves from getting germs and food particles lodged in them. It is recommended that sealants are applied soon after the permanent tooth has come in. Adult respondents are asked if the randomly selected child had seen a dental provider in the previous year, and if so, whether they had ever had dental sealants. For the purposes of this analysis, we examined dental sealants only in children 5-17 years old. Results in 2018 are shown in Figures 65-67.

Eighty-seven percent of Connecticut children in 2018 had a dental visit in the previous year, in which half of them had dental sealants applied to their teeth at some time. One in seven had been told they have dental decay (cavities).

Compared to their counterparts in the state, the prevalence of having **visited a dentist last year** was significantly greater for:

- Non-Hispanic White children (89.2%) compare to Hispanic children (80.2%); and
- Child living with an adult proxy with more than a high school education (88.3%).

FIGURE 65: CHILD DENTIST VISIT IN PAST YEAR, CT 2018

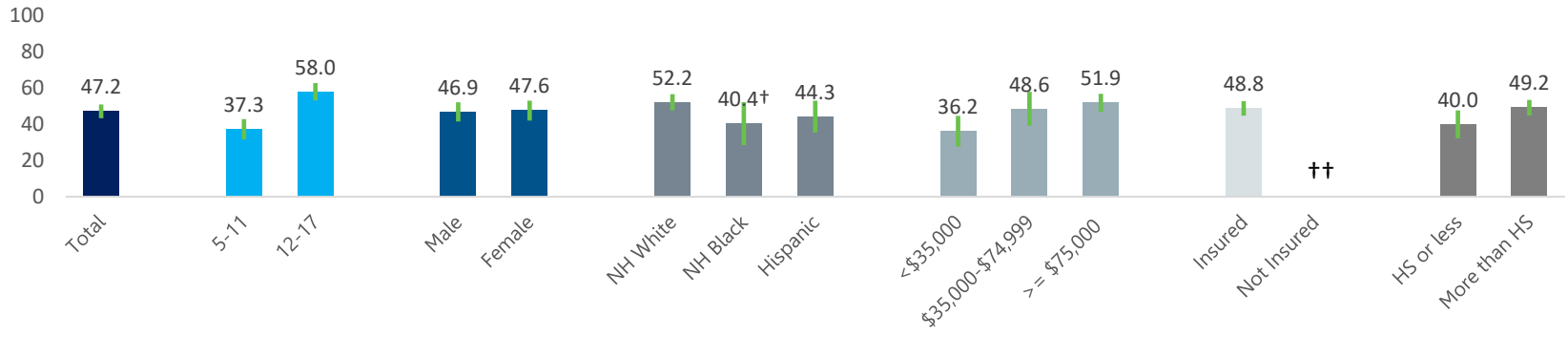


Estimates marked with a "†" have a CV between 15.0% and 20.0%, estimates marked with a "††" have a CV between 20.1% and 30.0%.

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

- Children 12–17 years old (58.0%) compared to children 5-11 years old (37.3%); and
- Children from household with annual household incomes at least $75,000 (51.9%) compared to those with less than $35,000 (36.2%).

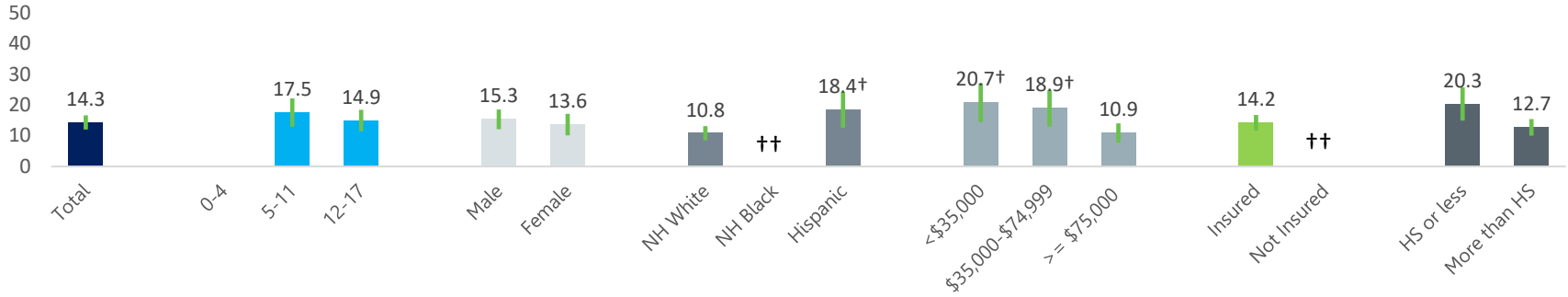
FIGURE 66: RECEIVED DENTAL SEALANT (CHILDREN 5-17 YEARS OLD), CT 2018



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

- Hispanic children (18.4%) compared to non-Hispanic White children (10.8%);
- Children living with an adult proxy with no more than a high school education (20.3%).

FIGURE 67: CHILD DENTAL DECAY (CAVITIES IN PAST 12 MONTHS), CT 2018



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

CHILD ASTHMA

While asthma can affect people of all ages, it usually begins during childhood. Of the 25 million Americans who suffer from asthma, 6.2 million are children.[81] Asthma is the third most common cause of hospitalizations in children and accounts for 13.8 million missed days of school each year.[82] Respondents are asked if the randomly selected child in the household had ever been diagnosed with asthma and if the child still had asthma. Results in 2018 are shown in Figures 68-69.

One in ten Connecticut children in 2018 had current asthma. An additional five percent had been diagnosed with asthma in the past but no longer had the condition.

FIGURE 68: CURRENT CHILD ASTHMA STATUS, CT 2018

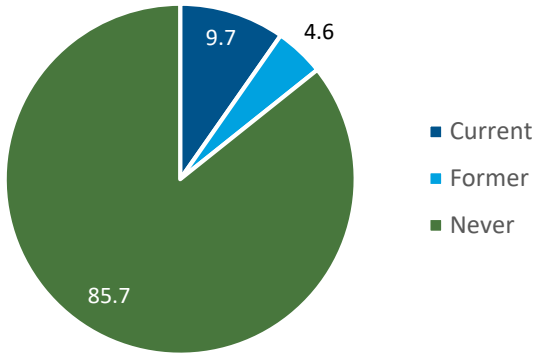
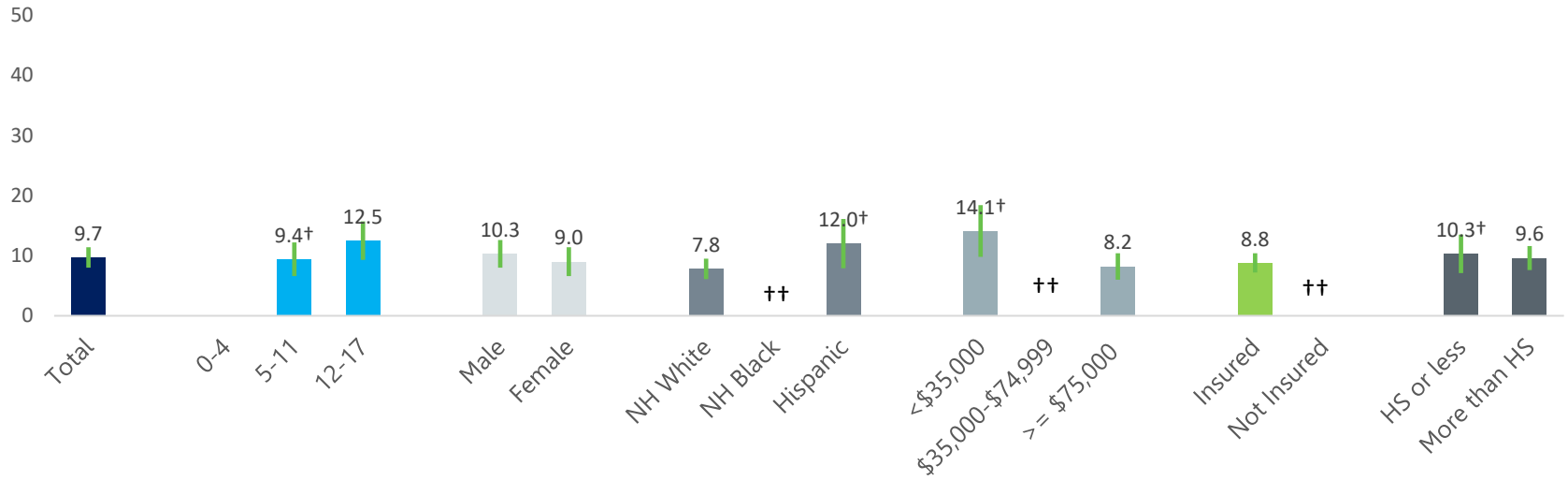


FIGURE 69: CHILD ASTHMA, CT 2018



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

9. END NOTES

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

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

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

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

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

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

[7] University of Connecticut Health Center, Center for Public Health and Health Policy: Connecticut State Innovation Model (CT SIM) Test Grant, Farmington, CT. http://www.publichealth.uconn.edu/sim_dash.html?ohriNav=%7C

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

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

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

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

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

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

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

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

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

[17] Centers for Disease Control and Prevention: Injury Prevention and Control, Motor Vehicle Safety, Seat Belts: Get the Facts. http://www.cdc.gov/motorvehiclesafety/seatbelts/facts.html

[18] Centers for Disease Control and Prevention. Sleep and sleep disorders. March 2017. https://www.cdc.gov/sleep/about_sleep/how_much_sleep.html

[19] Shankar A, Sya mala S, Kalidindi S (2010) Insufficient Rest or Sleep and Its Relation to Cardiovascular Disease, Diabetes and Obesity in a National,Multiethnic Sample. PLoS ONE 5(11): e14189. *https://www.researchgate.net/publication/49677758_Insufficient_Rest_or_Sleep_and_Its_Relation_to_Cardiovascular_Disease_Diabetes_and_Obesity_in_a_National_Multiethnic_Sample*

[20] Centers for Disease Control and Prevention: Home and Recreational Safety, Important Facts about Falls. *http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html*

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

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

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

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

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

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

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

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

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

[30] Centers for Disease Control and Prevention (1999) Achievements in Public Health, 1900–1999: Fluoridation of Drinking Water to Prevent Dental Caries. *MMWR 48(41):933–940*.

[31] Eke PI, Dye BA, Wei L, Thornton-Evans GO, Genco RJ. Prevalence of periodontitis in adults in the United States: 2009 and 2010. J Dent Res. 2012;91:914–920.

[32] Centers for Disease Control and Prevention: Adult Oral Health. https://www.cdc.gov/oralhealth/basics/adult-oral-health/index.html

[33] Center for Disease Control and Prevention. Periodontal Disease. https://www.cdc.gov/oralhealth/periodontal_disease/index.htm

[34] Erickson, L.E., (2016). The mouth-body connection. *Journal of the America Society on Aging.* 40, 25-31.

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

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

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

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

[39] Centers for Disease Control and Prevention: Cervical Cancer. *http://www.cdc.gov/cancer/cervical/*

[40] Centers for Disease Control and Prevention: Gynecologic Cancer, What Should I Know About Screening? *http://www.cdc.gov/cancer/cervical/basic_info/screening.htm*

[41] U.S. Preventive Services Task Force: Final Recommendation Statement, Cerivcal Cancer: Screening, March 2012. *http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/cervical-cancer-screening*

[42] Centers for Disease Control and Prevention: Breast Cancer, Basic Information about Breast Cancer. *http://www.cdc.gov/cancer/breast/basic_info/*

[43] National Institutes of Health: National Cancer Institute: Breast Cancer Screening (PDQ®). *http://www.cancer.gov/types/breast/patient/breast-screening-pdq*

[44] U.S. Preventive Services Task Force: Breast Cancer Screening. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-screening1?ds=1&s=breast%20cancer

[45] Centers for Disease Control and Prevention: Prostate Cancer, What Screening Tests Are There? *http://www.cdc.gov/cancer/prostate/basic_info/screening.htm*

[46] National Institutes of Health, National Cancer Institute: Prostate-Specific Antigen (PSA) Test. http://www.cancer.gov/cancertopics/factsheet/detection/PSA

[47] U.S. Preventive Services Task Force: Colorectal Cancer: Screening. *http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening*

[48] Centers for Disease Control and Prevention: Colorectal Cancer Screening: It's The Right Choice. *http://www.cdc.gov/cancer/colorectal/basic_info/screening/infographic.htm*

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

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

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

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

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

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

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

[56] Mayo Clinic: Prediabetes, Diagnosis (2019). https://www.mayoclinic.org/diseases-conditions/prediabetes/diagnosis-treatment/drc-20355284

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

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

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

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

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

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

[63] Centers for Disease Control and Prevention: Drinking Water. http://www.cdc.gov/healthywater/drinking/index.html

[64] Centers for Disease Control and Prevention: Public Water Systems. http://www.cdc.gov/healthywater/drinking/public/index.html

[65] Centers for Disease Control and Prevention: Private Water Systems. http://www.cdc.gov/healthywater/drinking/private/index.html

[66] Centers for Disease Control and Prevention: Drinking Water: Water-related Diseases and Contaminants in Public Water Systems. http://www.cdc.gov/healthywater/drinking/public/water_diseases.html

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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