Healthy Connecticut 2010

FINAL REPORT

Connecticut Department of Public Health
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FINAL REPORT

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DPH Keeping Connecticut Healthy

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INTRODUCTION

Healthy People 2010

Healthy People 2010 is a comprehensive set of disease prevention and health promotion goals and objectives for the first decade of the new century. It identifies a wide range of public health priorities and specific, measurable objectives in 28 focus areas. The overarching goals are to increase quality and years of healthy life, and to eliminate health disparities.

Healthy Connecticut 2010 Final Report

The *Healthy Connecticut 2010 Final Report* is a summary of progress made during the past decade to improve the health of Connecticut residents and to eliminate health disparities. It is based on the ten Leading Health Indicators identified in *Healthy People 2010*: 1) Physical Activity; 2) Overweight and Obesity; 3) Tobacco Use; 4) Substance Abuse; 5) Responsible Sexual Behavior; 6) Mental Health; 7) Injury and Violence; 8) Environmental Quality; 9) Immunization; and 10) Access to Health Care.

The Leading Health Indicators are the major behavioral risk factors, social and physical environmental factors, and other health system factors that are instrumental in shaping the health of both individuals and communities; socioeconomic factors—notably education and income—underlie each indicator and can profoundly affect outcomes.

Healthy People 2010 contains specific objectives and indicators to be used for tracking progress for each Leading Health Indicator. For Connecticut, the suggested objectives and indicators were used whenever possible. Additional or alternative objectives and indicators were used or substituted when data were not available or when the national objectives were not germane to Connecticut's population. Together, they provide an overview of the health status of Connecticut residents that will be useful for setting goals and objectives for the next decade.

Data, Sources, Trends, and Statistical Analysis

The Connecticut data used in this report were those released to the public through June, 2010. Three or more data points are included for each objective. The presence or absence of data for any given year reflects the periodicity of surveys or completeness of databases. Annual data are depicted in graphs, and tables containing the data and their sources are identified in the section entitled *Tracking Data and Data Sources* at the end of the report.

This report is intended to be descriptive, not analytical. With few exceptions, trend analyses of the data to identify statistically significant changes over time were not performed, nor were differences between the oldest and most recent data points or between outcomes for population groups assessed for significant differences. Data and graphs are thus presented for general

reference and the stories they tell. Researchers are encouraged, however, to analyze the raw data by their preferred methods.

Analyses of statistical significance are included for certain indicators and are noted in the narrative accompanying the related graphs. Trend analysis (logistic regression analysis) was provided by the Centers for Disease Control and Prevention for Connecticut data from the Youth Risk Behavior Survey (YRBS); these analyses identify whether behaviors of high school students increased or decreased significantly over time.[1] Significant trends also were identified in the report on the 2009 Connecticut Youth Tobacco Survey.[2]

In addition, for objectives based on data from the 2009 Behavioral Risk Factor Surveillance System (BRFSS), the statistical significance of changes over time were estimated by comparing confidence intervals of the oldest and most recent data points. Significant disparities between population groups (by sex and race/ethnicity) from the 2009 BRFSS and 2009 YRBS, and significant differences between Connecticut and the United States for 2009 BRFSS indicators also were assessed by comparing confidence intervals of point estimates.

A statistically significant change or difference is one that is unlikely to have occurred by chance. A lack of statistical significance does not always mean that a difference does not have practical or meaningful importance, and may be the result of a sample size that was too small, or limitations in the accuracy of the data or in the relationship of the measure (e.g. hospitalization) to the real event of importance (e.g. serious illness). If a difference is too small to be detected, it may, however, not be a meaningful difference.

[1] Centers for Disease Control and Prevention. 2010. *2009 Connecticut Youth Risk Behavior Survey Trend Analysis Report*.

[2] Connecticut Department of Public Health, Tobacco Use Prevention and Control Program. 2010. *Connecticut Youth Tobacco Survey, 2009*. In preparation.

OBJECTIVES TRACKED FOR LEADING HEALTH INDICATORS

The suggested objectives for measuring progress for the Leading Health Indicators in *Healthy People 2010* are shown below. Modifications, substitutions or additions for Connecticut, based on data availability or relevance, are noted as "actual".

1. Physical Activity

22-7. Suggested: Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardio-respiratory fitness 3 or more days per week for 20 or more minutes per occasion.

> ***Actual:*** Increase the proportion of students in grades 9-12 who participated in at least 20 minutes of exercise or physical activity that made them sweat and breathe hard on 3 or more of the past 7 days, or who were physically active doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes per day on 5 or more of the past 7 days.

22-2. Suggested: Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.

> ***Actual***: Increase the proportion of adults with 30+ minutes of any physical activity 5 or more days per week, or adults with 30 or more minutes of moderate physical activity 5 or more days per week, or vigorous physical activity for 20 or more minutes 3 or more days per week.

2. Overweight and Obesity

19-3c. Suggested: Reduce the proportion of children and adolescents who are overweight or obese.

> ***Actual:*** Reduce the proportions of students in grades 9-12 who are overweight or obese.
>
> ***Actual:*** Reduce the proportions of children 10-17 years of age who are overweight or obese.

19-2. Suggested: Reduce the proportion of adults who are obese.

> ***Actual:*** Reduce the proportions of adults who are overweight or obese.

3. Tobacco Use

27-2b. Suggested: Reduce cigarette smoking by adolescents.

> ***Actual*:** Decrease the proportion of students in grades 9-12 who currently smoke cigarettes.

27-1a. Suggested: Reduce cigarette smoking by adults.

> ***Actual:*** Decrease the proportion of adults 18 years of age and older who currently smoke cigarettes.

4. Alcohol and Substance Abuse

26-10a. Suggested: Increase the proportion of adolescents not using alcohol or any illicit drugs during the past 30 days.

Actual: Decrease the proportion of students in grades 9-12 who currently drink alcohol.

Actual: Decrease the proportion of students in grades 9-12 who binge drink (drink 5 or more drinks in a row in the past 30 days.

Actual: Decrease the proportion of persons 12 years of age and older who used illicit drugs during the past month.

26-10c. Suggested and Actual: Reduce the proportion of adults using any illicit drug during the past 30 days.

26-11c. Suggested and Actual: Reduce the proportion of adults engaging in binge drinking of alcoholic beverages during the past month.

5. Responsible Sexual Behavior

13-6. Suggested: Increase the proportion of sexually active persons who use condoms.

Actual: Decrease the proportion of students in grades 9-12 who ever had sexual intercourse.

Actual: Of students in grades 9-12 who had sexual intercourse in the last 3 months, increase the proportion who used a condom during their last sexual intercourse.

6. Mental Health

18-9b. Suggested: Increase the proportion of adults with recognized depression who receive treatment.

Actual: Decrease the proportion of adults 18 years of age and older who have serious psychological distress.

Actual: Decrease the proportion of children 12-17 years of age and adults 18 years of age and older who have a major depressive episode.

Actual: Decrease the rate of suicide overall and among males in high-risk age groups.

Actual: Decrease the proportion of students in grades 9-12 who attempted suicide in the past 12 months.

7. Injury and Violence

15-5a. Suggested and Actual: Reduce deaths caused by motor vehicle crashes.

15-32. Suggested and Actual: Reduce homicides.

Connecticut-Added Objectives:

Reduce deaths caused by accidental poisoning.

Reduce deaths caused by falls.

Reduce hospitalizations for hip fractures.

Reduce suicides and attempted suicides.

8. Environmental Quality

8-1a. Suggested: Reduce the proportion of persons exposed to air that does not meet the U.S. Environmental Protection Agency's health-based standards for ozone.

> ***Actual:*** Reduce the number of days that air quality does not meet the U.S. Environmental Protection Agency's health-based standards for ozone.

27-10. Suggested and Actual: Reduce the proportion of nonsmokers exposed to environmental tobacco smoke.

Connecticut-Added Objective:

> Reduce asthma hospitalizations.

9. Immunization

14-24a. Suggested: Increase the proportion of young children who receive all vaccines that have been recommended for universal administration for at least 5 years.

> ***Actual:*** Increase the proportion of children 19-35 months of age who receive all vaccines that have been recommended for universal administration.

14-29 a & b. Suggested: Increase the proportion of non-institutionalized adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease.

> ***Actual:*** Increase the proportion of adults 65 years of age and older who are vaccinated annually against influenza.
>
> ***Actual:*** Increase the proportion of adults 65 years of age and older who have ever been vaccinated against pneumococcal disease.

10. Access to Health Care

1-1. Suggested and Actual: Increase the proportion of persons with health insurance.

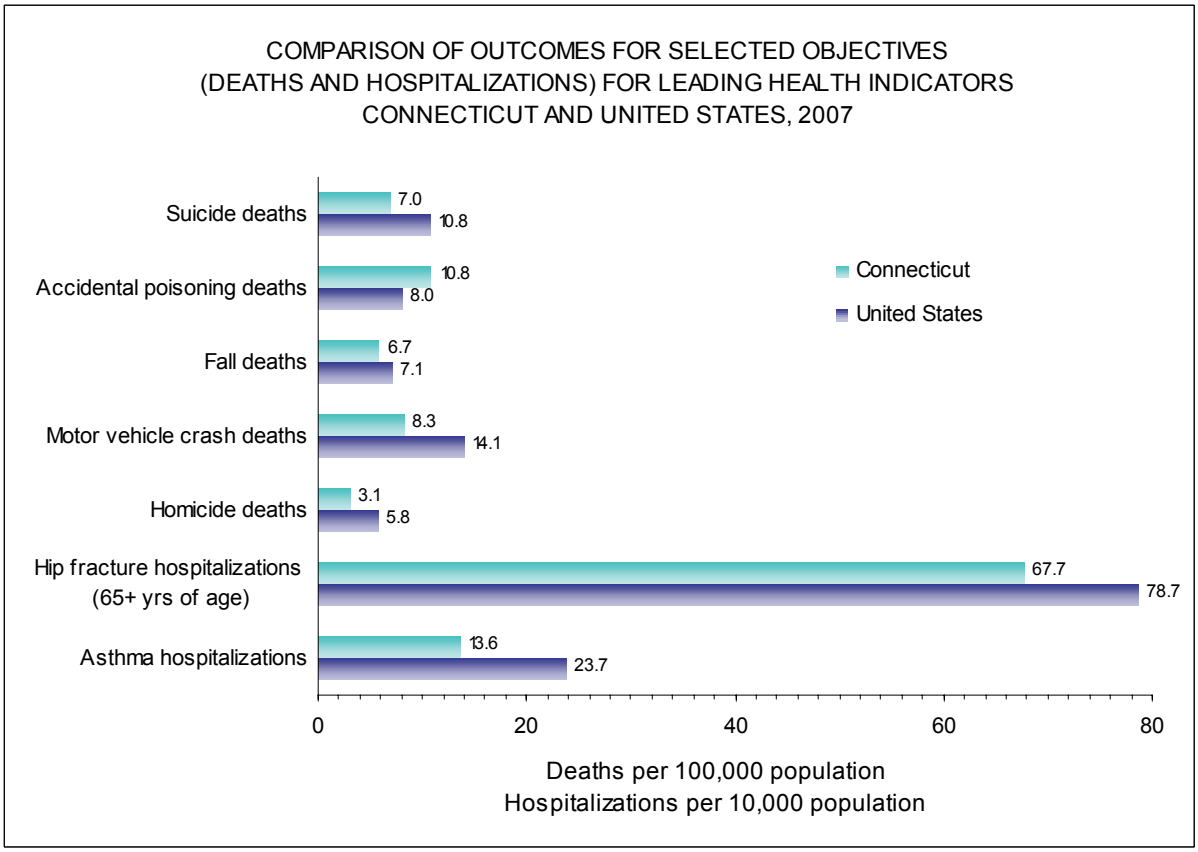
1-4a. Suggested and Actual: Increase the proportion of persons who have a specific source of ongoing care.

16-6a. Suggested and Actual: Increase the proportion of pregnant women who begin prenatal care in the first trimester of pregnancy.

HOW ARE WE DOING? CONNECTICUT vs. UNITED STATES

Various indicators of health for Connecticut residents compared to the United States population as a whole are shown in the graphs below.

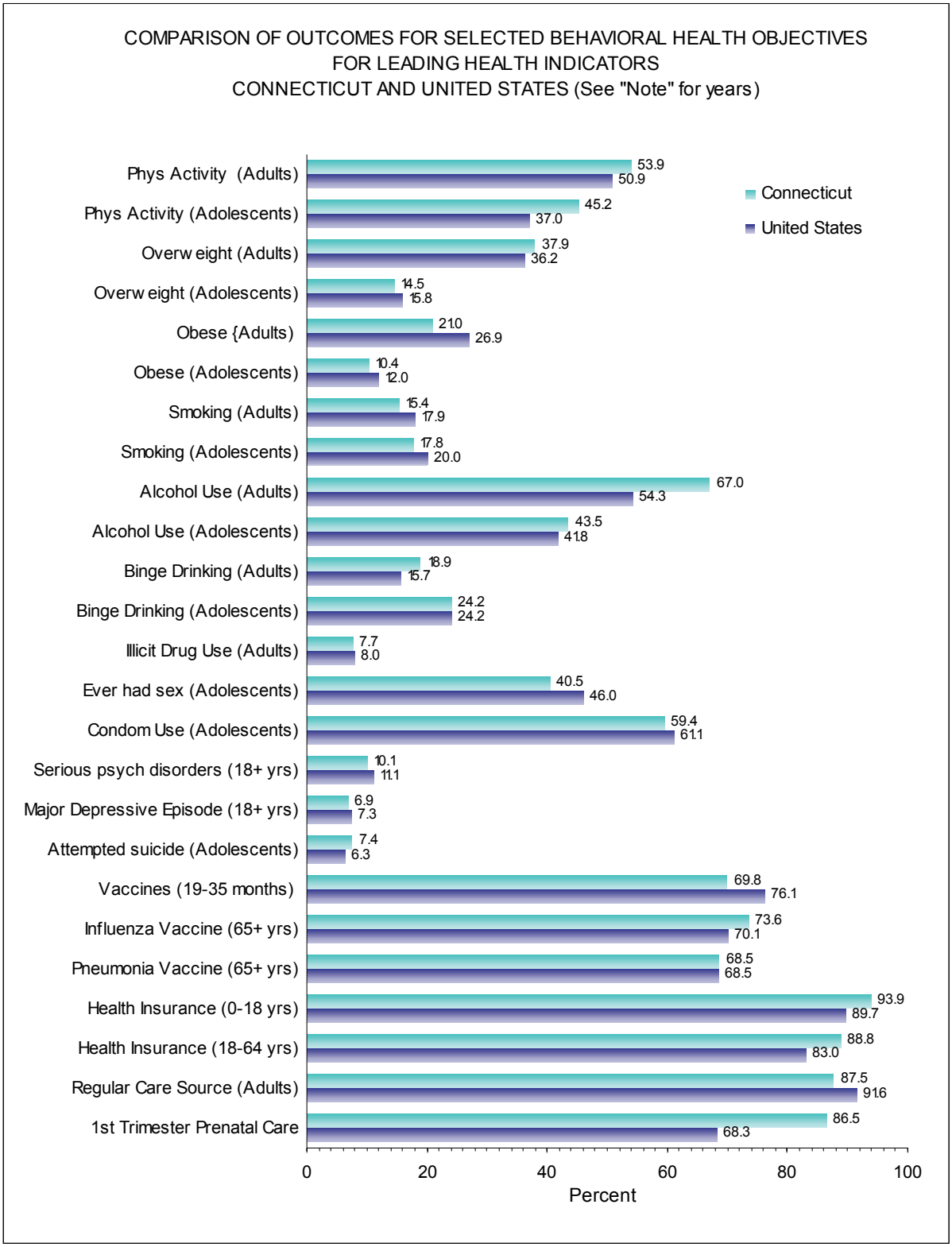
Connecticut death rates for selected unintentional and intentional injuries, hospitalization rates for hip fractures among the elderly, and hospitalization rates for asthma (an indicator of environmental quality) were lower than national rates, whereas the state's death rate for accidental poisoning was 35% greater.



Sources: Connecticut Death Registry, Connecticut Hospital Discharge Database, National Vital Statistics System, and National Hospital Discharge Survey.

Note: Death rates were age-adjusted to the U.S. 2000 standard population.

Compared to the U.S., Connecticut had lower prevalence of most risk factors, serious psychological disorders, and major depressive episodes. Connecticut residents under 65 years of age were more likely to have health insurance, adults were more likely to have a regular source of health care, pregnant women were more likely to begin prenatal care during the first trimester of pregnancy, and teens were more likely to get the recommended amount of physical activity. Connecticut adults, however, had higher prevalence of alcohol use and binge drinking. Connecticut was poorer than the nation for one of the three immunization indicators--children 19-35 months who received the recommended vaccinations.



Sources: Behavioral Risk Factor Surveillance System, Connecticut School Health Survey, Youth Risk Behavior Survey, National Immunization Survey, National Survey on Drug Use and Health.

Notes: Data years: Physical Activity, Overweight, Obese, Smoking, Alcohol Use, Binge Drinking (Adults 2009, Adolescents 2009); Illicit Drug Use, Serious Psychological Disorders, Major Depressive Episode (2006-2007); Sex, Condom Use (during last sexual intercourse), Attempted Suicide (2009); Vaccines (2009); Health Insurance (Children 2007-2008, Adults 18-64 yrs 2009).

LEADING HEALTH INDICATORS











1 PHYSICAL ACTIVITY

Background

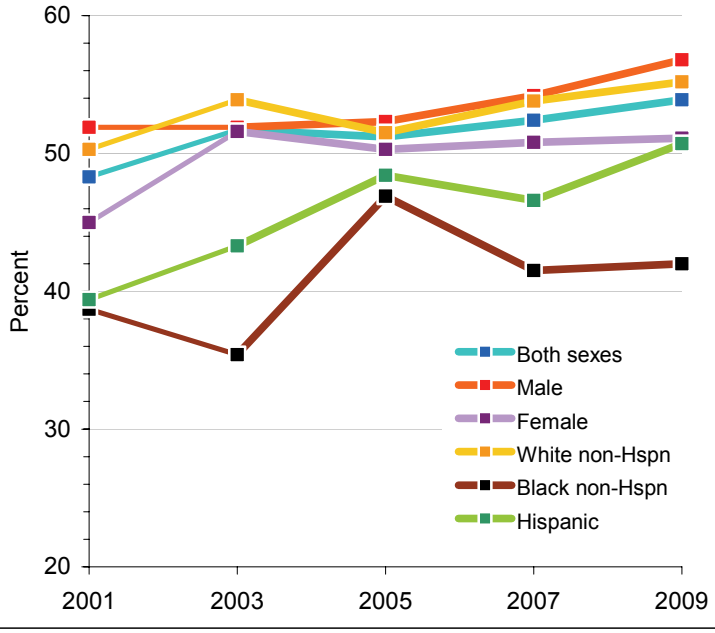
Physical activity is one of the most important methods of improving overall health. The benefits of regular physical activity include decreased risk of heart disease and stroke, colorectal and breast cancers, type 2 diabetes and metabolic syndrome, high cholesterol, and high blood pressure. It also strengthens bones and muscles, reduces the risk of osteoporosis and falls, improves mental health and mood, and lowers the overall risk of premature death.

In 2000, the Behavioral Risk Factor Surveillance System surveyed adults for any physical activity for at least 30 minutes 5 or more times per week. In 2001 it was changed to 30 or more minutes of moderate physical activity 5 or more days per week, or vigorous physical activity for 20 or more minutes 3 or more days per week. Similarly, the original objective for adolescents (vigorous physical activity that made them sweat or breathe hard, for at least 20 minutes on 3 or more days a week) was revised to include any vigorous physical activity for a total of at least 60 minutes per day on 5 or more days a week.

Findings

Adults. From 2001 to 2009, physical activity among all groups of Connecticut adults increased, with the greatest improvement occurring among Hispanics (Fig. 1-1). These changes were statistically significant overall, and for women and white non-Hispanics. Significant disparity persisted throughout the period, however for black non-Hispanics compared to white non-Hispanics.

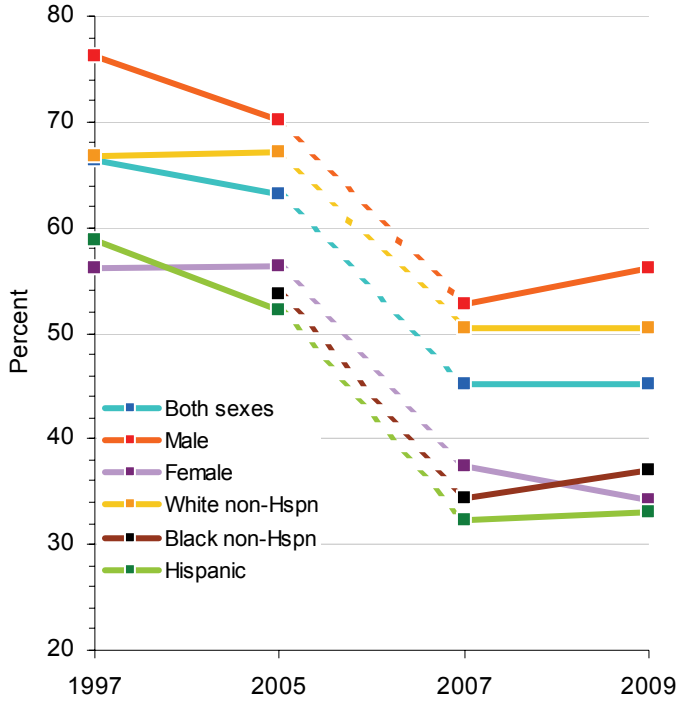
FIGURE 1-1
REGULAR OR VIGOROUS PHYSICAL ACTIVITY
ADULTS 18+ YEARS OF AGE BY SEX, RACE & ETHNICITY
CONNECTICUT, 2001-2009



Source: Behavioral Risk Factor Surveillance System

Adolescents. In contrast, from 1997 to 2005, the proportion of adolescents who engaged in regular physical activity decreased overall, with the lowest proportions reported among Hispanics, black non-Hispanics, and females (Fig. 1-2). In 2009, females were significantly more likely than males to engage in regular physical activity. After 2007, when the definition of regular physical activity became more stringent, there was improvement among males, black non-Hispanics, and Hispanics, whereas physical activity among females declined; there was no change for white non-Hispanics, but none of these changes was statistically significant.

FIGURE 1-2
REGULAR PHYSICAL ACTIVITY
STUDENTS IN GRADES 9-12 BY SEX
CONNECTICUT, 1997-2009



Source: Youth Risk Behavior Survey

Note: Broken lines between the 2005 and 2007 data points denotes definition change in 2007.

2 OVERWEIGHT AND OBESITY

Background

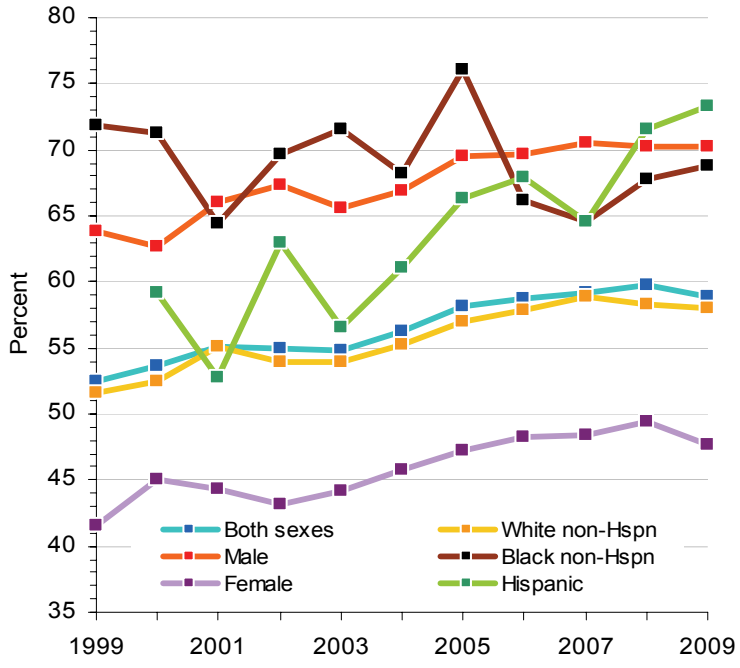
Obesity is at the forefront of public health issues in Connecticut. Overweight and obesity are defined by a person's body mass index (BMI), which takes into account weight and height;[1] a BMI of 25 to 25.9 is considered overweight, and a BMI of 30 or greater is considered obese.

Overweight and obesity increase the risk of developing many chronic diseases and conditions, including heart disease and stroke; type 2 diabetes; breast, endometrial, and colon cancers; high blood pressure; high cholesterol; liver and gallbladder disease; osteoarthritis; asthma and other respiratory problems; and infertility. Obese children tend to carry their weight problem into adulthood, because behavioral and clinical anti-obesity programs often are not covered by insurance.[2] In 2008 in Connecticut, an estimated $735 million in direct medical costs were attributed to obesity, and costs are projected to increase to $2.9 billion in 2018.[3]

Findings

Adults (Overweight or Obese). Connecticut historically has had one of the lowest prevalence rates for overweight and obesity in the U.S. (7th lowest in 2009). Still, from 1999 to 2009, the prevalence of

FIGURE 2-1
OVERWEIGHT OR OBESE
ADULTS 18+ YEARS OF AGE
BY SEX, RACE & ETHNICITY
CONNECTICUT, 1999-2009



Source: Behavioral Risk Factor Surveillance System

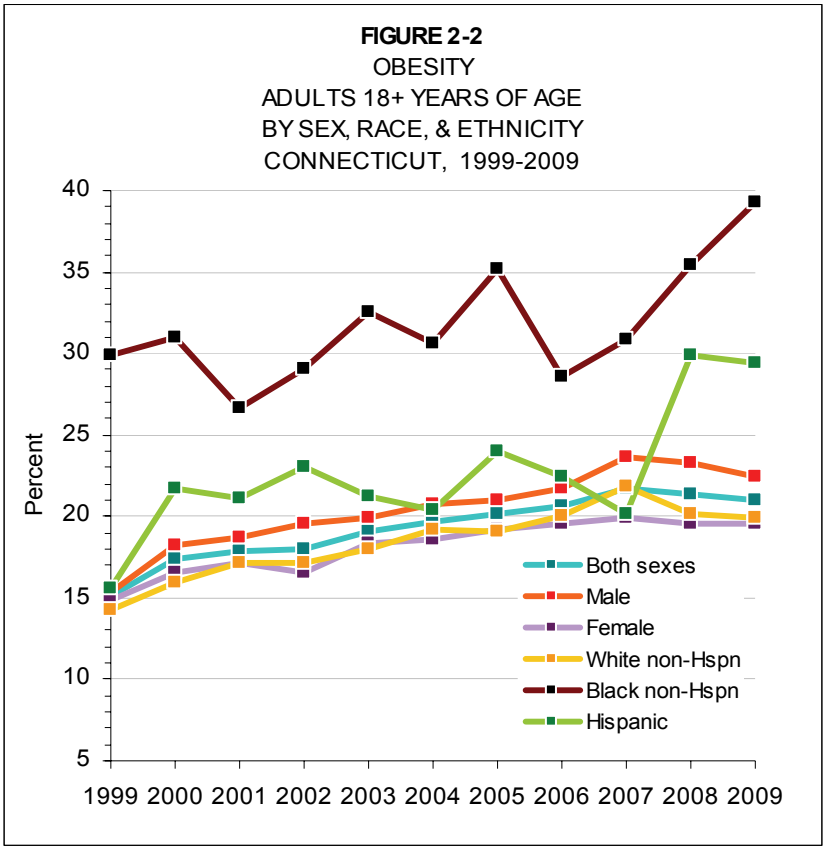
[1] BMI = (weight in pounds x 703) / (height in inches x height in inches)

[2] Skelton, J.A. et al. 2009. Prevalence and trends of severe obesity among U.S. children and adolescents. *Academic Pediatrics* 9(5):322-329.

[3] United Health Foundation, American Public Health Association, and Partnership for Prevention. 2009. *The Future Costs of Obesity: National and State Estimates of the Impact of Obesity on Direct Health Care Expenses*. (Based on research by K.E. Thorpe.) http://www.americashealthrankings.org/2009/report/Cost%20Obesity%20Report-final.pdf

overweight or obesity appeared to increase among all groups except black non-Hispanics, and rates for males, Hispanics, and non-Hispanic blacks were consistently greater than those for non-Hispanic whites and females (Fig. 2-1). In 2009, three out of five Connecticut adults (59%) were overweight or obese.

Adults (Obesity). The prevalence of obesity, alone, increased overall and for all population groups during the same period (Fig. 2-2), and these changes were statistically significant for all groups except black non-Hispanics; from 1999 to 2009, obesity among Hispanics nearly doubled. In 2009, obesity prevalence was significantly higher among Hispanics and black non-Hispanics compared to white non-Hispanics, and greater for males than for females, though not significantly so. Females and non-Hispanic whites consistently had the lowest obesity rates, whereas black non-Hispanics had the highest rates.

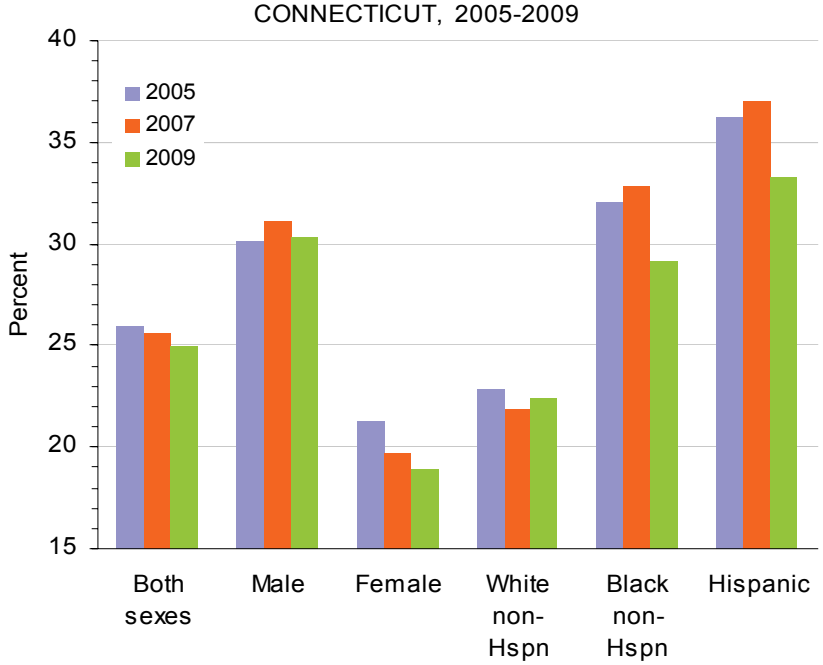


Source: Behavioral Risk Factor Surveillance System

Adolescents (Overweight or Obese). Data on overweight and obesity among Connecticut adolescents (high school students in grades 9-12) are available only for 2005, 2007, and 2009. The prevalence of overweight or obesity decreased for all groups except males from 2005 to 2009 (Fig. 2-3), but none of the changes was statistically significant. Rates were highest among Hispanics and lowest among females for all 3 years. In 2009, males were significantly more likely than females to be overweight or obese.

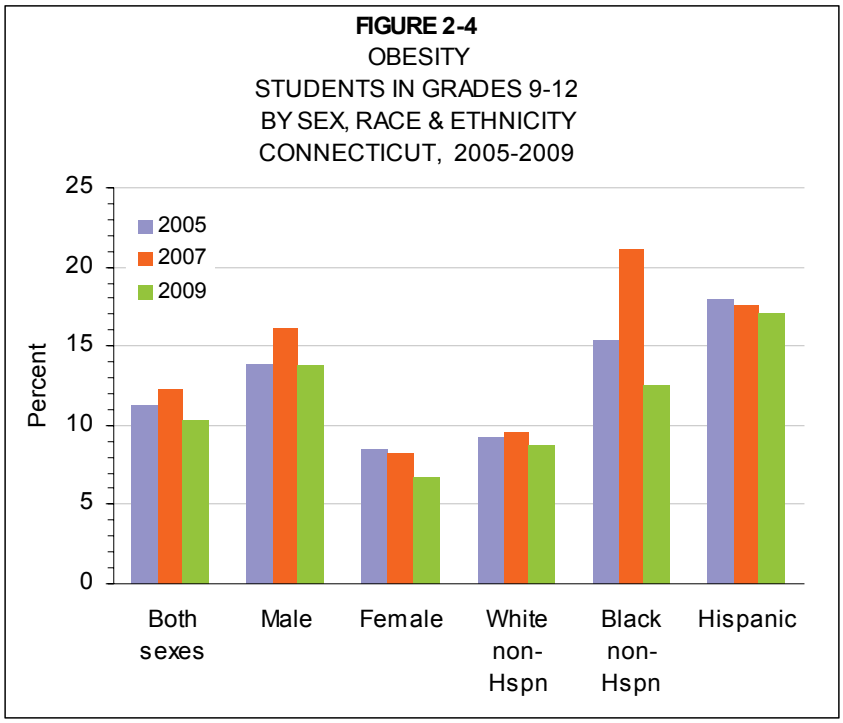
Adolescents (Obesity). Obesity among Connecticut youths decreased overall and for all population groups during the 3-year period, with transient increases in obesity in some groups in 2007 (Fig. 2-4); none of the changes was statistically significant. Female and white non-Hispanic high school students consistently had the lowest obesity rates, whereas Hispanics, black non-Hispanics, and males had the highest rates. In 2009, obesity prevalence was 48% greater among Hispanics than among white non-Hispanics.

FIGURE 2-3
OVERWEIGHT OR OBESE
STUDENTS IN GRADES 9-12
BY SEX, RACE & ETHNICITY
CONNECTICUT, 2005-2009



Source: Youth Risk Behavior Survey

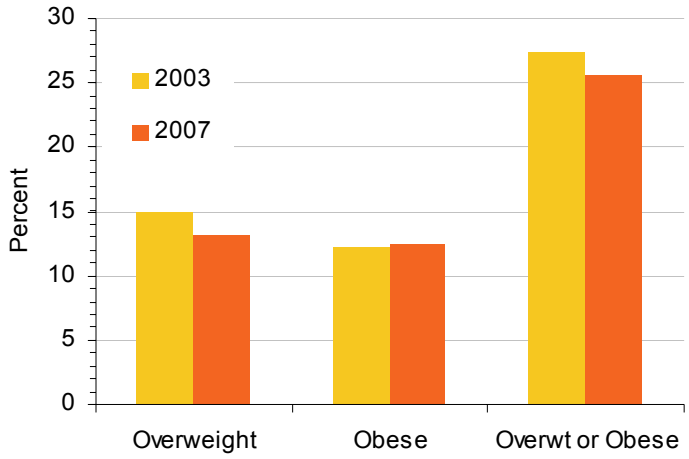
FIGURE 2-4
OBESITY
STUDENTS IN GRADES 9-12
BY SEX, RACE & ETHNICITY
CONNECTICUT, 2005-2009



Source: Youth Risk Behavior Survey

Children. The proportion of overweight and obese Connecticut children 10-17 years of age decreased from 27.3% in 2003 to 25.7% in 2007 (Fig. 2-5).[4]

FIGURE 2-5
OVERWEIGHT AND OBESITY
CHILDREN 10-17 YRS
CONNECTICUT, 2003 AND 2007



Source: National Survey of Children's Health

Based on new evidence that obesity among children and adolescents can be treated successfully, the U.S. Preventive Services Task Force recommended in January, 2010 that clinicians screen children 6 to 18 years of age for obesity and offer or refer them for comprehensive, intensive, behavioral interventions to improve their weight status.[5]

[4] Child and Adolescent Health Measurement Initiative, Data Resource Center. National Survey of Children's Health 2003 and 2007. Data Query: Weight status of children based on BMI for age. http://www.nschdata.org. Accessed 28 January 2010.

[5] U.S. Preventive Services Task Force. .*Screening for Obesity in Children and Adolescents*, Topic Page. January 2010. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/uspstf/uspschobes.htm. Accessed 02 February 2010.

3 TOBACCO USE

Background

Tobacco use is the single most avoidable cause of death and the most important public health issue of our time. It increases the risk of lung cancer and other cancers, heart disease, stroke, and chronic lung diseases, and maternal smoking contributes to premature and low-birthweight births. More than 4,700 Connecticut adults die each year as a consequence of their own smoking,[1] and 440 more die from exposure to secondhand smoke.[2] Although the effects of smoking on health are well documented and publicized, more than 4,000 Connecticut children still become regular smokers each year.

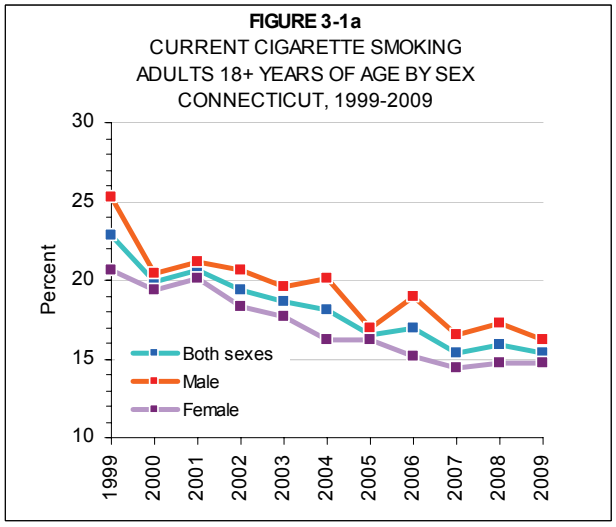
Tobacco use also has enormous economic costs, with estimated expenditures attributable to the consequences of tobacco use in Connecticut totaling $1.63 billion per year.[1]

Among nonsmokers, exposure to "secondhand" or environmental tobacco smoke (ETS) is especially harmful to the unborn fetus, infants, young children, and those with preexisting heart or lung disease.

Findings

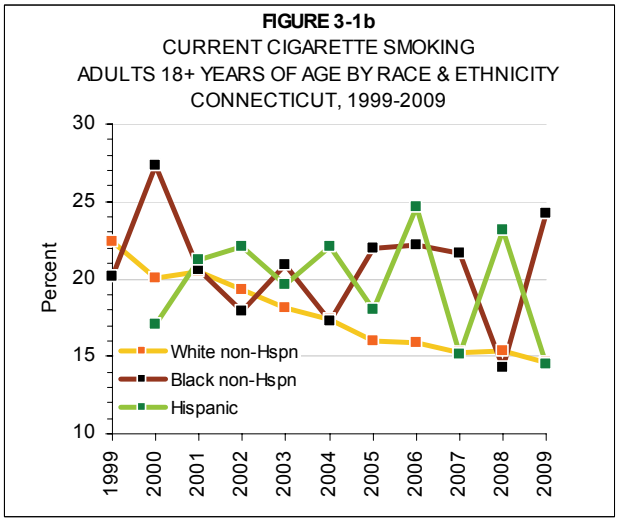
Adults. Connecticut has one of the lowest rates of current smoking in the nation, and in 2009, it ranked 8th lowest among the states (15.4% compared to 17.9% nationally).[3] Smoking among Connecticut adults has declined by 40% during the past 20 years, with the greatest decrease--by one-third--occurring during the last decade. Smoking prevalence decreased for all groups but black non-Hispanics since 1999 (Figs. 3-1a and 3-1b), and were statistically significant overall, for males, females, and non-Hispanic whites. Smoking among non-Hispanic blacks increased by 20% between 1999 and 2009, but this increase was not statistically significant.

FIGURE 3-1a
CURRENT CIGARETTE SMOKING
ADULTS 18+ YEARS OF AGE BY SEX
CONNECTICUT, 1999-2009



Source: Behavioral Risk Factor Surveillance System

FIGURE 3-1b
CURRENT CIGARETTE SMOKING
ADULTS 18+ YEARS OF AGE BY RACE & ETHNICITY
CONNECTICUT, 1999-2009



Source: Behavioral Risk Factor Surveillance System

[1] CDC. "Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses -- United States 2000-2004," *MMWR* 57(45), November 14, 2008 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5745a3.htm.

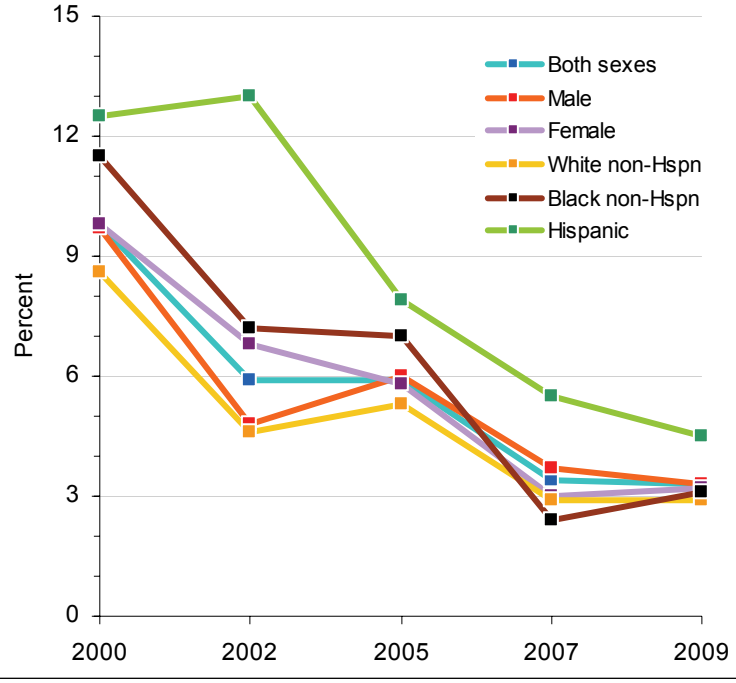
[2] CDC. "Cigarette Smoking-Attributable Morbidity – United States, 2000" *MMWR* 52(35): 842-844, September 5, 2003. http://www.cdc.gov/mmwr/PDF/wk/mm5235.pdf.

[3] CDC. Behavioral Risk Factor Surveillance System. Prevalence and Trends Data: Tobacco Use 2009, All States and Nationwide. http://apps.nccd.cdc.gov/BRFSS

Adolescents. The prevalence of cigarette smoking among adolescents historically has been greater than that for adults, and this pattern persisted during the first decade of the twenty-first century.

Middle School Students. Between 2000 and 2009, cigarette smoking among middle school students decreased 66%, and statistically significant decreases occurred overall, for boys, girls, white non-Hispanics, and Hispanics (Fig. 3-2). Although the rate among black non-Hispanic students decreased, the change was not significant. Hispanic students consistently had the highest smoking rates, whereas white non-Hispanics had the lowest rates.

FIGURE 3-2
CURRENT CIGARETTE SMOKING
MIDDLE SCHOOL STUDENTS BY SEX, RACE & ETHNICITY
CONNECTICUT, 2000-2009

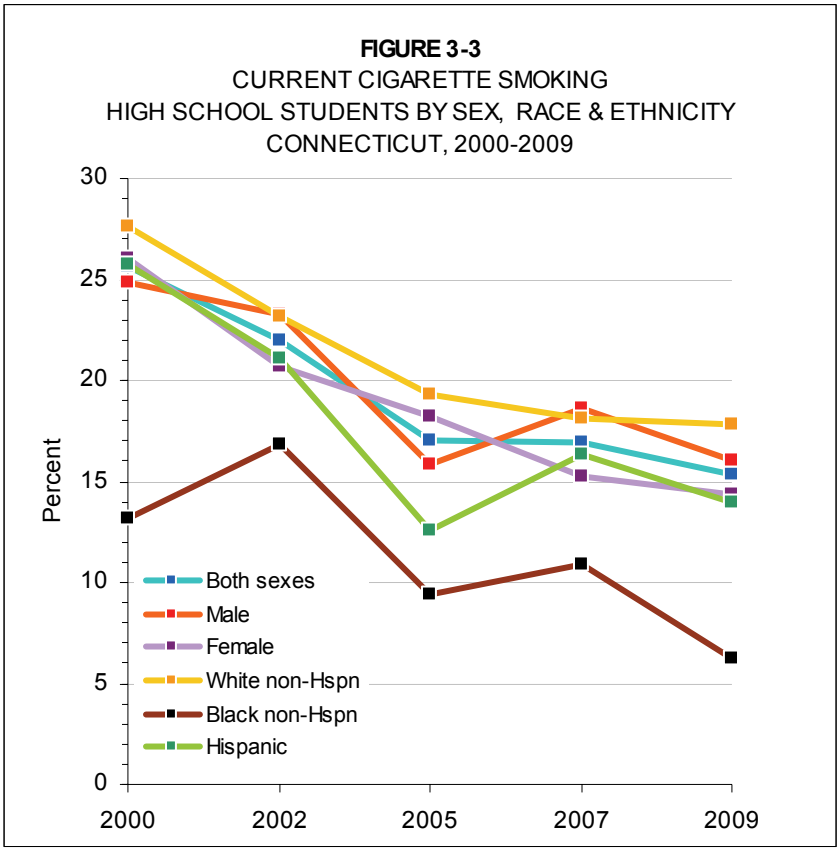


Source: Connecticut Youth Tobacco Survey

High School Students. From 2000 to 2009, cigarette smoking decreased by 40% among high school students, and statistically significant changes occurred overall and among boys, girls, and white non-Hispanics. Decreases in smoking also occurred among Hispanic and black non-Hispanic students; however, these changes were not statistically significant (Fig. 3-3).

White non-Hispanic students generally had the highest smoking rates, and black non-Hispanic students had the lowest rates, and in 2009, white non-Hispanic and Hispanic students were significantly more likely than black non-Hispanic students to be current cigarette smokers.

FIGURE 3-3
CURRENT CIGARETTE SMOKING
HIGH SCHOOL STUDENTS BY SEX, RACE & ETHNICITY
CONNECTICUT, 2000-2009



Source: Connecticut Youth Tobacco Survey

[4] Centers for Disease Control and Prevention. 2007. *Best Practices for Comprehensive Tobacco Control Programs--2007*. http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices/pdfs/2007/BestPractices_Complete.pdf

[5] Centers for Disease Control and Prevention. 2010. State cigarette excise taxes - United States, 2009. *MMWR Morbidity and Mortality Weekly Report*. 59(13):385-388.

4 ALCOHOL AND SUBSTANCE ABUSE

Background

Alcohol, marijuana, tobacco, cocaine, heroin, and misused prescription drugs are the priority substances targeted for prevention efforts in Connecticut.[1] The use of alcohol and illicit drugs is associated with injury, illness, disability, lost productivity, death, and crime--including domestic violence, and it also can lead to serious chronic mental health problems.

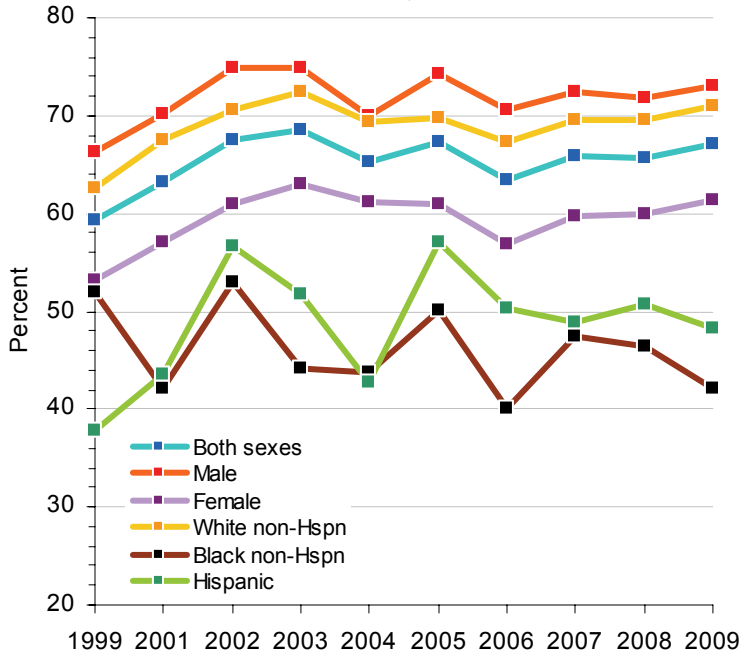
Together, alcohol and drug abuse account for about 650 deaths and 5,000 hospitalizations among Connecticut residents each year.[2] In 2008, 40% of motor-vehicle-related fatalities were alcohol-related (BAC≥0.01%), and 33% involved alcohol-impaired drivers (BAC≥0.08%), and these percentages were about the same since 1998.[3] Inpatient hospitalizations for alcohol and drug abuse accounted for $77 million in hospital charges in 2007,[4] and underage drinking cost the state an estimated $621 million in 2005.[1]

Findings

Alcohol Use

Adults. Between 2001 and 2009, current alcohol use (at least one drink in past 30 days) increased among adults in all population groups except black non-Hispanics (Fig. 4-1). These changes were statistically

FIGURE 4-1
CURRENT ALCOHOL USE
ADULTS 18+ YEARS OF AGE BY SEX, RACE & ETHNICITY
CONNECTICUT, 1999-2009



Source: Behavioral Risk Factor Surveillance System

[1] Connecticut Department of Mental Health and Addiction Services. *2009 Connecticut Strategic Prevention Framework State Epidemiological Profiles*. http://www.ct.gov/dmhas/lib/dmhas/prevention/ctspf/SEWprofiles09.pdf. Accessed 01 Feb. 2010.

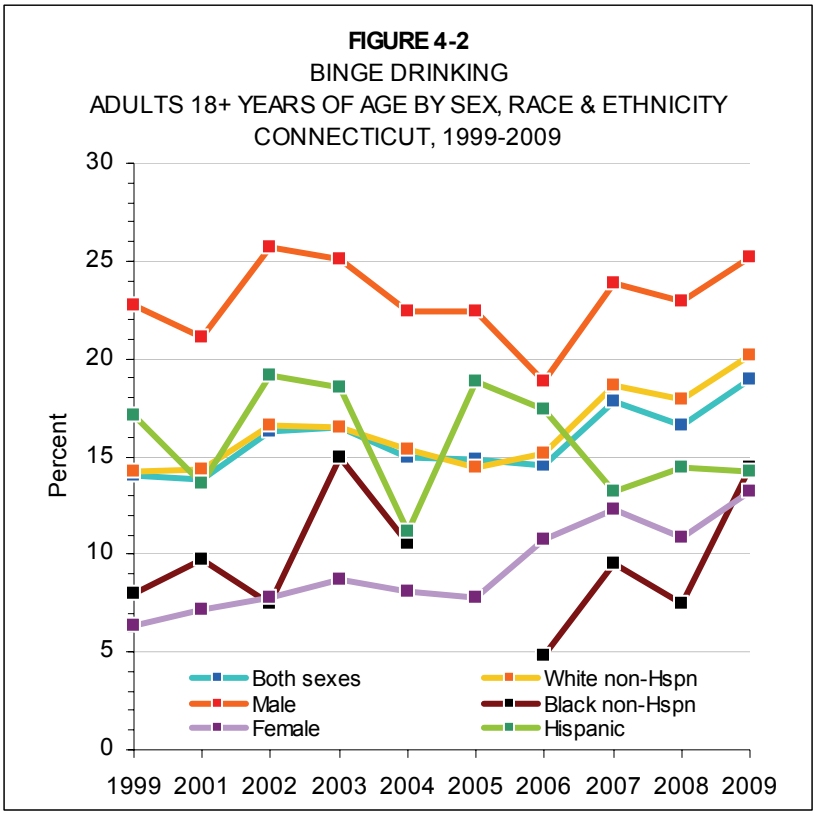
[2] Connecticut Department of Public Health. *2007 Registration Report*, Table 9 (provisional). Accessed 02 Feb. 2010.

[3] National Highway Traffic Safety Administration, National Center for Statistics and Analysis. Fatal Analysis Reporting System (FARS) Web-Based Encyclopedia. http://www-fars.nhtsa.dot.gov/States/StatesAlcohol.aspx. Accessed 05 Feb. 2010.

[4] Connecticut Department of Public Health. *2007 Hospitalization Report*, Table H-1AA. http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397512&dphPNavCtr=%7C. Accessed 02 Feb. 2010.

significant overall, for females, and for white non-Hispanics. In 2009, Hispanics and black non-Hispanics were significantly less likely than white non-Hispanics to drink alcoholic beverages, and women were significantly less likely to drink, compared to men. The proportion of white non-Hispanics who drank alcohol was nearly 70% greater than that of black non-Hispanics.

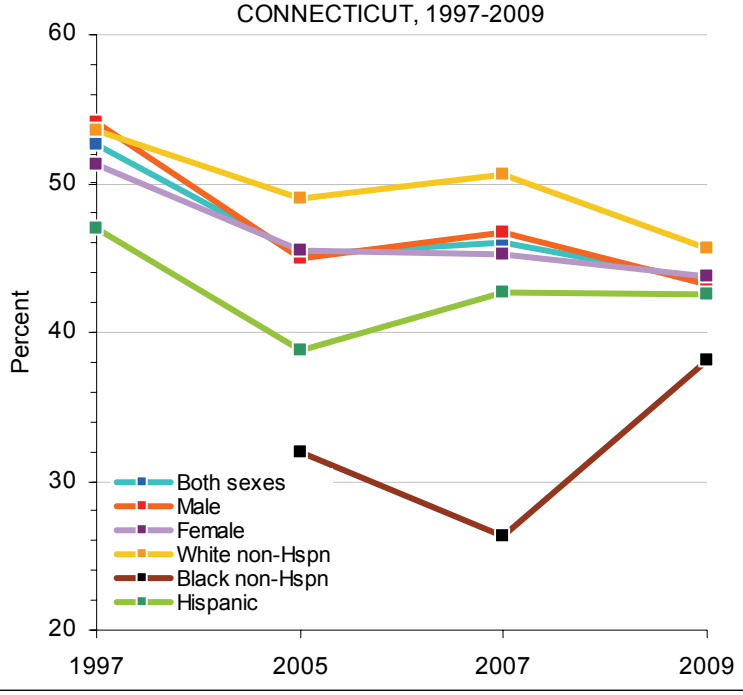
The definition of binge drinking changed in 2006, from five or more drinks on one or more occasions during the past month to five or more for men and four or more for women, so annual data are comparable from 1999-2005 and from 2006-2009, but not across the two intervals. During the most recent 4 years, binge drinking increased overall and among men and white non-Hispanics. Binge drinking decreased by 3.2 percentage points among Hispanics and increased by 9.6 percentage points among black non-Hispanics, but these changes were not statistically significant.(Fig. 4-2). In 2009, the prevalence of binge drinking was higher among white non-Hispanics compared to black non-Hispanics and Hispanics, but these differences were not significant. Men were significantly more likely than women to binge drink (91% greater prevalence).



Source: Behavioral Risk Factor Surveillance System
Note: Data not available for black non-Hispanics in 2005.

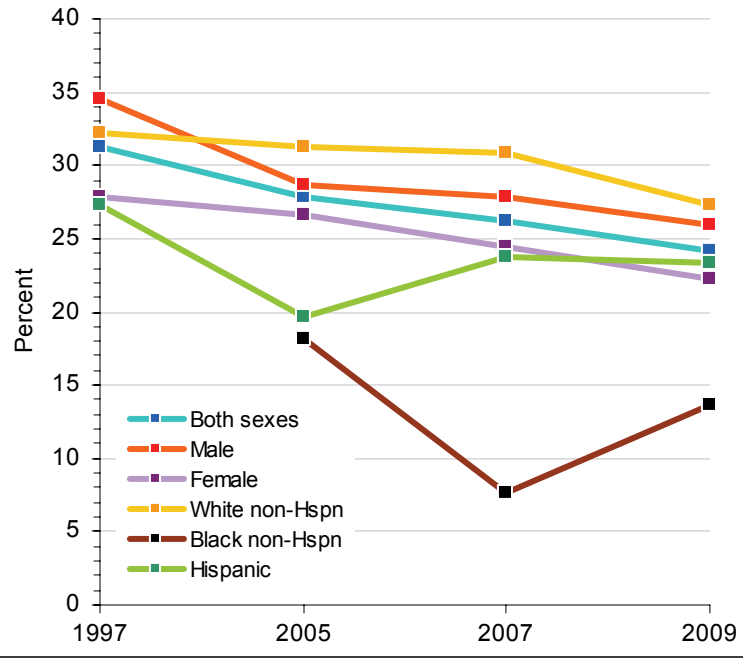
Adolescents. From 1997 to 2009, statistically significant decreases in alcohol use occurred overall and among male, female, and white non-Hispanic high school students (Fig. 4-3). In 2009, nearly half of all high school students reported drinking alcohol in the past 30 days. Binge drinking declined significantly for high school students overall, for males, and for white non-Hispanics since 1997 (Fig. 4-4). Differences in drinking and binge drinking by males and females were not statistically significant.

FIGURE 4-3
CURRENT ALCOHOL USE
STUDENTS IN GRADES 9-12 BY SEX, RACE & ETHNICITY
CONNECTICUT, 1997-2009



Source: Behavioral Risk Factor Surveillance System
Note: Data for black non-Hispanics not available in 1997.

FIGURE 4-4
BINGE DRINKING
STUDENTS IN GRADES 9-12 BY SEX, RACE & ETHNICITY
CONNECTICUT, 1997-2009

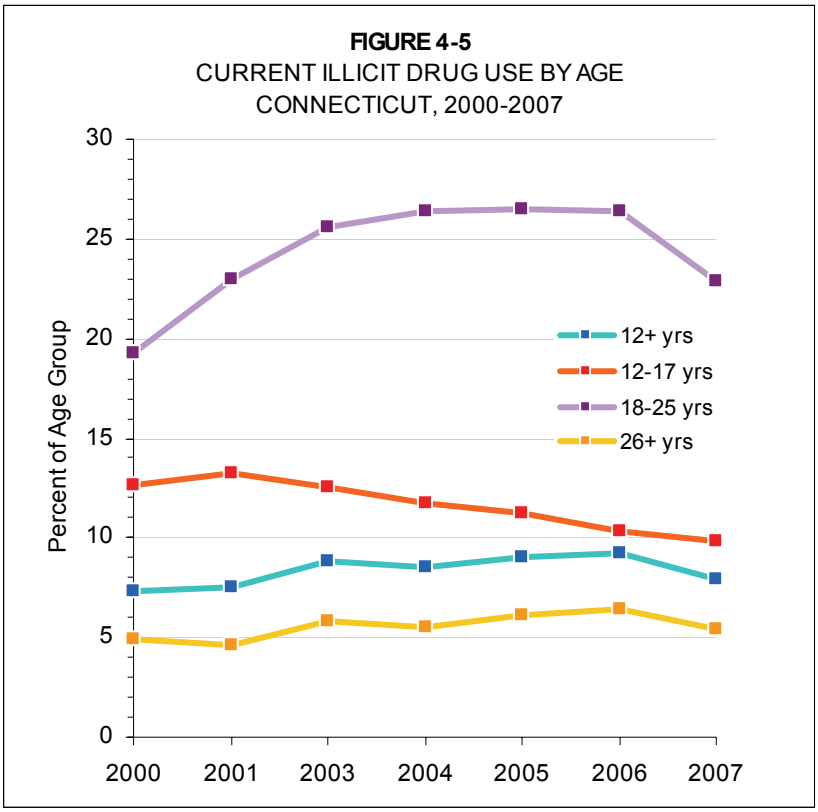


Source: Behavioral Risk Factor Surveillance System
Note: Data for black non-Hispanics not available in 1997.

Illicit Drug Use

Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. In 2007, 8% of the Connecticut population 12 years of age and older reported using one or more illicit drugs in the past 30 days. This proportion is the same as it was in 2000. Past-30-day illicit drug use among adolescents 12-17 years of age apparently has been declining. Young adults 18-25 years of age consistently had the highest rates of illicit drug use, and persons 26 years of age and older had the lowest rates (Fig. 4-5).[5]

FIGURE 4-5
CURRENT ILLICIT DRUG USE BY AGE
CONNECTICUT, 2000-2007



Source: SAMHSA National Survey on Drug Use and Health

Accidental poisoning is the leading cause of unintentional injury death in Connecticut (see *Injury and Violence*). In 2005-2007, 754 Connecticut resident deaths, including 681 accidental poisoning deaths, had narcotics listed as a secondary cause of death. Cocaine, heroin, and methadone accounted for 75% of these deaths.[6]

[5] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Office of Applied Statistics. National Surveys on Drug Use and Health. *State Estimates of Substance Use and Mental Health: Connecticut*. http://www.oas.samhsa.gov/nsduh.htm. All data points in the graphs and in the discussion are two-year annual averages of the stated year and the prior year.

[6] Amadeo, F. 2010. Unpublished analysis of 2005-2007 Connecticut resident deaths with opioid narcotic poisoning listed as a secondary cause of death (ICD-10 codes T40.0 to T40.6). Connecticut Department of Public Health, Health Information Systems & Reporting.

5 RESPONSIBLE SEXUAL BEHAVIOR

Background

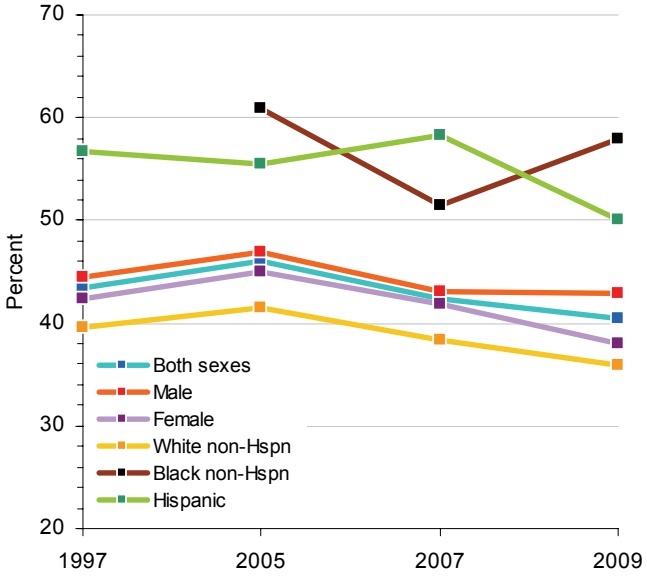
Risky sexual behavior refers to unprotected sexual intercourse, multiple sex partners, young age at first intercourse, and use of drugs and alcohol before intercourse. It is responsible for unwanted pregnancies and accounts for the majority HIV and sexually transmitted infections (STIs), including human papillomavirus (the cause of most cervical cancers), chlamydia, gonorrhea, and syphilis. Abstinence is the only way to achieve full protection, but condom use and delaying sexual activity can reduce risk substantially.

Teen births are a particular problem because of their numerous health, social, and economic consequences. Birth and pregnancy rates among Connecticut teens have been declining since the early 1990's. In 2007, the number of births to Connecticut teens 15-19 years of age was the lowest since 1954, and the number of abortions was 50% lower than its high two decades earlier.[1] The number of HIV/AIDS cases diagnosed annually in Connecticut has decreased 43%--from 851 in 2002 to 482 in 2007.[2] Numbers of all three reportable sexually transmitted infections have been increasing. In 2008 there were 12,522 cases of chlamydia and 2,801 cases of gonorrhea. In 2009 65 cases of infectious syphilis were reported, 31% of which were co-infected with HIV.[3]

Findings

Multi-year tracking data are available for Connecticut students but not for adults. Overall, in 2009, 41% of Connecticut high school students reported they ever had sexual intercourse (Fig. 5-1), and 30% reported

FIGURE 5-1
EVER HAD SEX
STUDENTS GRADES 9-12 BY SEX, RACE & ETHNICITY
CONNECTICUT, 1997-2009



Source: Youth Risk Behavior Survey
Note: Data for black non-Hispanic students not available for 1997.

[1] Connecticut Department of Public Health, Health Information Systems and Reporting Section. Birth and Pregnancy Rates. Females 15-19 Years of Age, Connecticut 1980-2007. Pre-1980 data from Connecticut Registration Reports, 1950 to 1979.

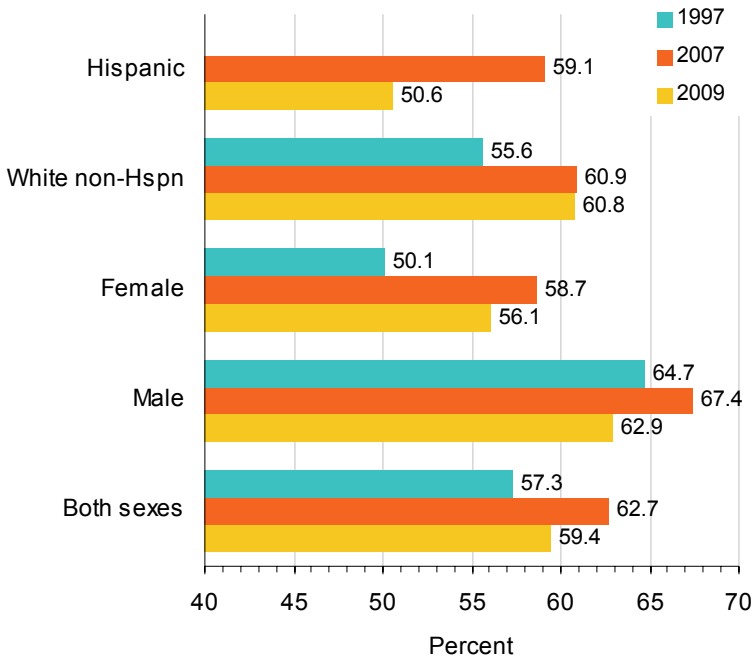
[2] Connecticut Department of Public Health, HIV/AIDS Surveillance Program. Trends in HIV/AIDS Cases by Year of Report, Diagnosis, Death, and Prevalence 1980 to December 31, 2009.

[3] Connecticut Department of Public Health, Infectious Disease Section. Sexually Transmitted Diseases, Connecticut, 2008. 2009 syphilis data: P. Lane, personal communication.

having sexual intercourse during the last 3 months. From 1997 to 2009, the percentage who ever had sex decreased for all population groups (Fig. 5-1), but the changes were statistically significant only overall and for females. Compared to white non-Hispanic students, black non-Hispanic and Hispanic students were about 60% and 40% more likely, respectively, to have had sex.

Overall, in 2009 59% of high school students who had sexual intercourse during the last 3 months reported they used a condom during their last sexual intercourse (Fig. 5-2). Since 1997, condom use by sexually active students increased overall, but the increase was not statistically significant. Differences between condom use by males and females in 2009 also was not significant.

FIGURE 5-2
USED CONDOM DURING LAST SEXUAL INTERCOURSE
STUDENTS GRADES 9-12 BY SEX, RACE & ETHNICITY
CONNECTICUT, 1997-2009



Source: Youth Risk Behavior Survey

Note: Data not available for Hispanic students in 1997, for black non-Hispanics in 1997, 2007, or 2009, or for any Connecticut students in 2005.

In addition to condom use, other sexual risk behaviors contribute to disease and unintended pregnancies. In 2009, 5% of high school students reported they had sexual intercourse before the age of 13 years; 11% had sexual intercourse with four or more people during their life; and 25% drank alcohol or used drugs before their last sexual intercourse. For pregnancy prevention, 26% of female students reported they used birth control pills.[4]

[4] Connecticut Department of Public Health, Health Information Systems and Reporting Section. *2009 Connecticut Youth Risk Behavior Survey*.

6 MENTAL HEALTH

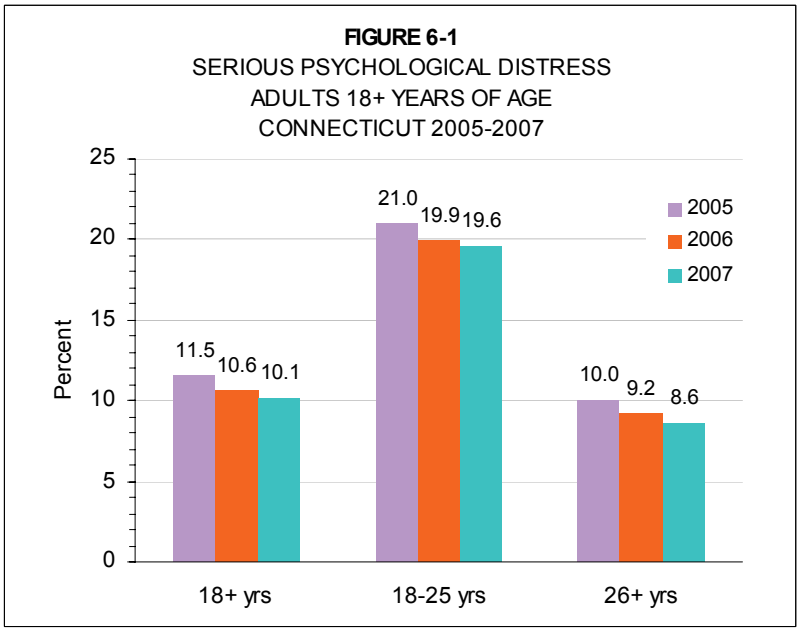
Background

In 2007, one in three Americans 18 years of age and older had a diagnosable mental disorder.[1] The estimated lifetime prevalence was 57% for all mental disorders, 35% for substance use/abuse disorders, 31% for anxiety disorders, 25% for impulse-control disorders (e.g., attention deficit/hyperactivity disorder), and 21% for mood disorders (e.g., major depressive disorder, bipolar disorder).[2] These mental disorders account for more disability than any other diseases, including heart disease and cancer.[3] Major depression is the leading cause of disability and is responsible for more than two-thirds of suicides.[4]

In Connecticut in 2007, mental disorders, excluding alcohol and drug psychoses, accounted for 17,344 hospitalizations (488 per 100,000 population), with $332 million in total hospital charges. Adults 25-44 years of age accounted for 39% of these hospitalizations.[5]

Findings.

Serious Psychological Distress. Serious psychological distress (see *Tracking Data* for definition) is assessed only for persons over 17 years of age. From 2005 to 2007 (data from earlier years not comparable), serious psychological distress declined slightly among all age groups but was more than twice as common among young adults 18-25 years of age than among persons 26 years of age and older (Fig 6-1).



Source: SAMHSA National Survey on Drug Use and Health

[1] Harvard School of Medicine. *National Comorbidity Survey Replication.* Table 2. 12-month prevalence of DSM-IV/WMH-CIDI disorders by sex and cohort. http://www.hcp.med.harvard.edu/ncs/ftpdir/table_ncsr_12monthprevgenderxage.pdf. Accessed 2 February 2010. Diagnosable mental health disorders, as used here, include anxiety, mood, and impulse control disorders, and substance abuse, including tobacco disorders.

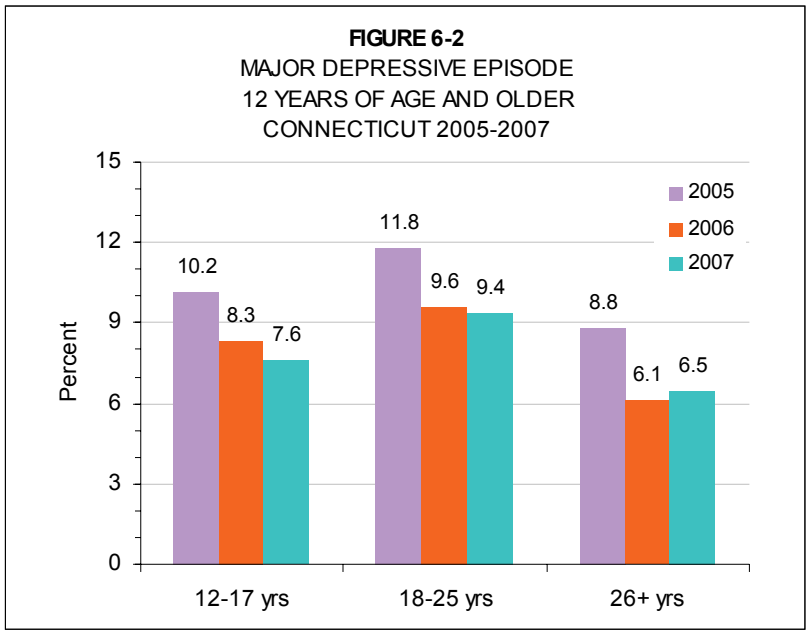
[2] Harvard School of Medicine. *National Comorbidity Survey Replication.* Table 1. Lifetime prevalence of DSM-IV/WMH-CIDI disorders by sex and cohort. http://www.hcp.med.harvard.edu/ncs/ftpdir/table_ncsr_LTprevgenderxage.pdf. Accessed 2 February 2010.

[3] World Health Organization. 2005. *Promoting Mental Health: Concepts, Emerging Evidence, Practice*. Geneva: World Health Organization. http://www.who.int/mental_health/evidence/MH_Promotion_Book.pdf. Accessed 5 February 2010.

[4] U.S. Department of Health and Human Service, *Healthy People 2010*. Vol. 1, p. 36. http://www.healthypeople.gov/Document/pdf/uih/uih.pdf.

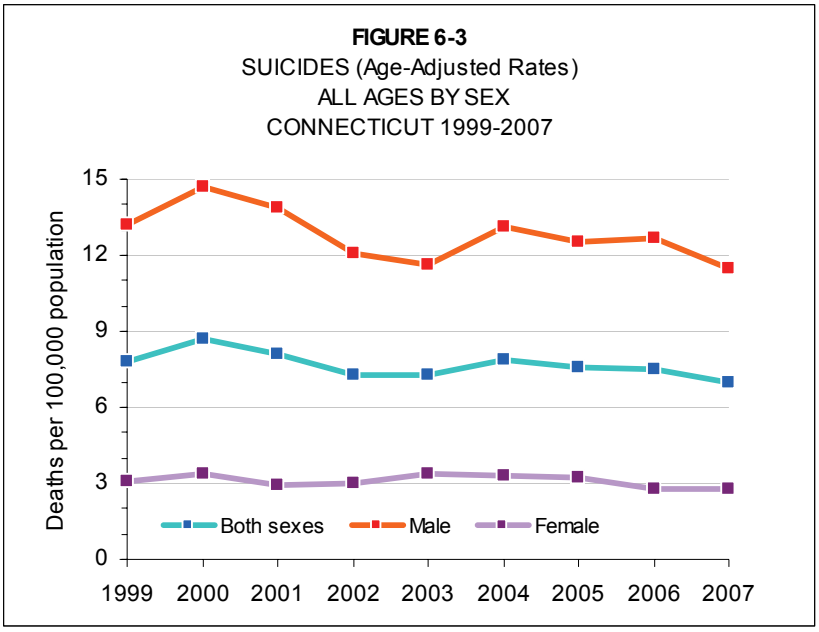
[5] Connecticut Department of Public Health. Connecticut Resident Hospitalizations, 2007. Table H-1AA. http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397512. Accessed 8 February 2010.

Major Depressive Episodes. From 2005 to 2007, major depressive episodes declined among all age groups. Young adults 18-25 years of age and children 0-17 years of age consistently were more likely than adults 26 years of age and older to have a major depressive episode (Fig. 6-2).



Source: SAMHSA National Survey on Drug Use and Health

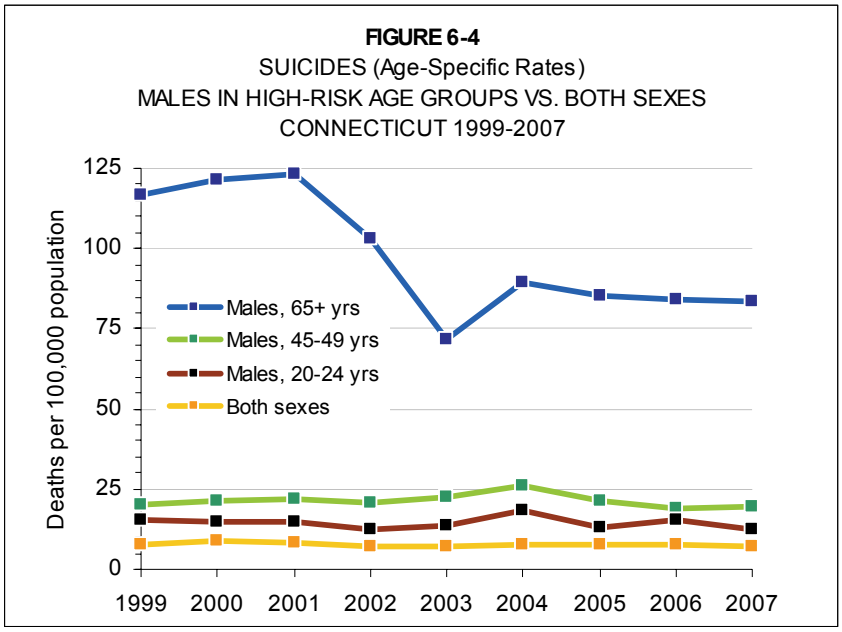
Suicide. Each year, 250 to 300 Connecticut residents take their own lives. In 2007, suicide was the second leading cause of death for males 15-19 and 25-34 years of age, the third for males 20-24 years of age, and ranked fourth for males 35-44 and 45-55 years of age.[6] Suicide also is often among the top five leading causes of death for children 10-14 years of age. From 1999 to 2007, the Connecticut suicide rate decreased overall and for both sexes (Fig. 6-3). Suicide rates for males consistently were about 4 times greater than those for females.



Source: Connecticut Death Registry (Registration Reports)

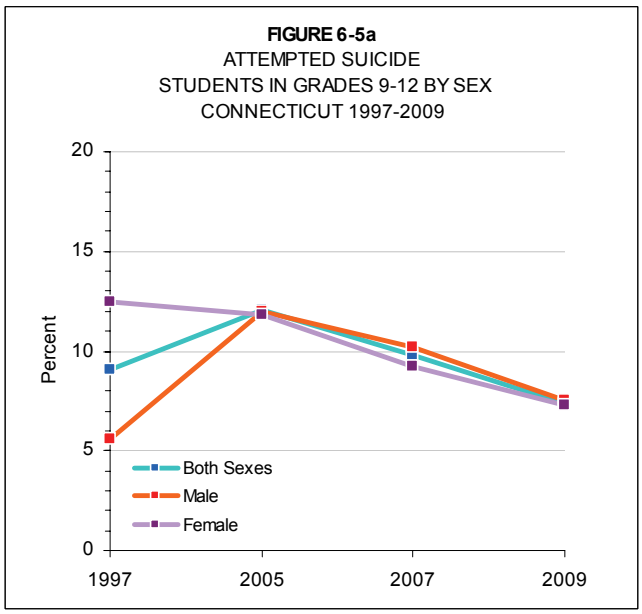
[6] Connecticut Department of Public Health, Health Information Systems and Reporting Section. 2007 Registration Report, Table 10. http://www.ct.gov/dph/cwp/view.asp?a=3132&q=394598.

Suicide rates for males 65 years of age and older were 10 to 15 times greater than those for the overall population, and those for males 45-49 years of age were 2.5 to 3 times greater (Fig. 6-4).

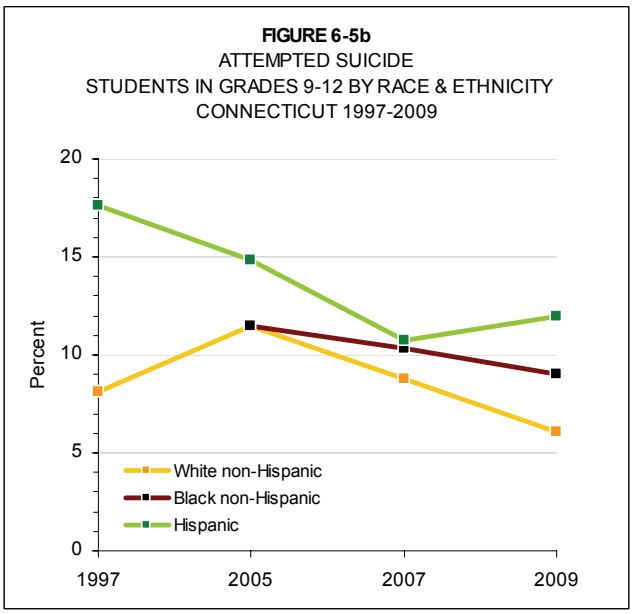


Source: Connecticut Death Registry (Registration Reports)

Attempted Suicide. As noted above, suicide is a leading cause of death for adolescents. From 1997 to 2009, the percentage of high school students who said they attempted suicide in the past 12 months decreased overall and for all groups except males (Figs. 6-5a and 6-5b); however, only the decrease among female students was statistically significant. By 2009 the initial gap between rates for males and females had disappeared and was not significant (Fig. 6-5a).



Source: Youth Risk Behavior Survey



Source: Youth Risk Behavior Survey
Note: Data for black non-Hispanics not available in 1997.

7 INJURY AND VIOLENCE

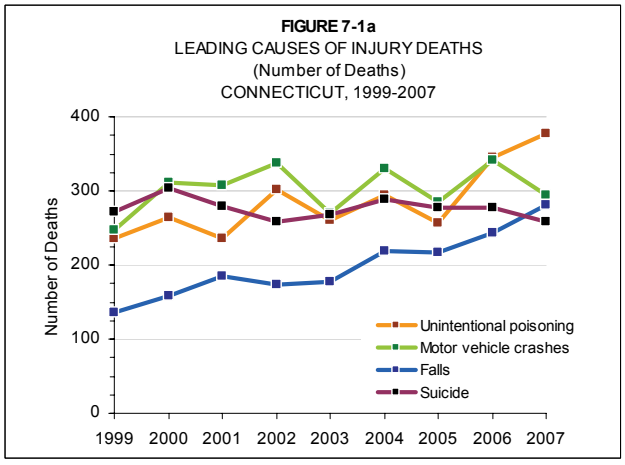
Background

Injury is the leading cause of death for Connecticut residents between the ages of 1 and 44 years[1] and the fourth leading cause of death and hospitalization for all ages combined.[1,2] Each year in Connecticut, about 1,700 resident deaths and about 19,000 hospitalizations result from injuries, with unintentional injuries accounting for 78% of the deaths and 84% of the hospitalizations. In 2007, the most common causes of unintentional injury death were unintentional poisoning (29%), motor vehicle crashes (22%), and falls (21%); Of intentional injury deaths, 71% were self-inflicted (suicide).[1] More than half (58%) of unintentional injury hospitalizations were for falls, whereas about two-thirds (65%) of intentional injury hospitalizations were for self-inflicted injuries. The 2007 hospitalization rate for assault injuries was nearly 9 times greater for black non-Hispanics and 5 times greater for Hispanics, compared to white non-Hispanics, whereas hospitalization rates for self-inflicted injuries were about the same for all three groups.[3]

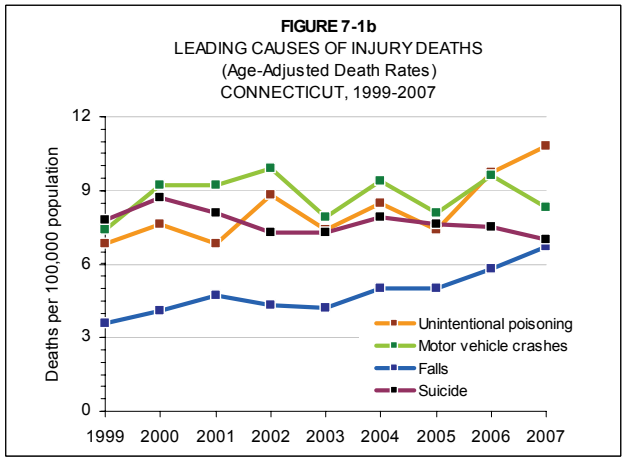
In the U.S. in 2002, $73.4 billion were spent on medical care for injury-related conditions, including $27.1 billion for inpatient hospitalizations, $7 billion for home healthcare, and $4.7 billion for prescription medicines.[4] In Connecticut in 2007, more than $593 million were spent on inpatient hospitalizations and more than $492 million were spent on hospital emergency department visits.[5]

Findings

Based on number of deaths, from 1999 to 2005, "motor vehicle traffic crashes" was the leading cause of injury-related death in Connecticut, and "suicide" or "unintentional poisoning" were second or third. In 2006, however, "unintentional poisoning" replaced "motor vehicle traffic crashes" as the leading cause of injury-related death, and in 2007, "falls" replaced "suicide" as the third leading cause (Fig. 7-1a). The age-adjusted death rate for suicide was still higher than that for falls, however (Fig. 7-1b).



Source: Connecticut Death Registry (Registration Reports)



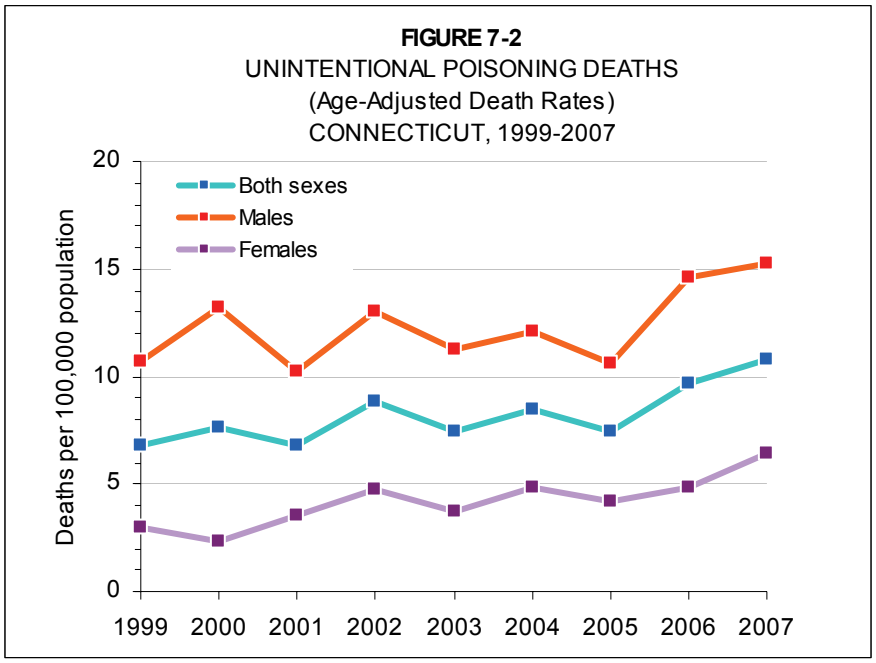
Source: Connecticut Death Registry (Registration Reports)

[1] Connecticut Department of Public Health. Health Information Systems and Reporting Section. Registration Report for 2007. Tables 9 and 10.
[2] Connecticut Department of Public Health. Health Information Systems and Reporting Section. Hospitalization Report for 2007. Table H-5.
[3] Connecticut Department of Public Health. Health Information Systems and Reporting Section. Hospitalization Report for 2007. Table H-7.
[4] Machlin, S. 2005. *Health Care Expenditures for Injury-Related Conditions, 2002.* Statistical Brief #93. Agency for Healthcare Research and Quality, Rockville, MD. http://meps.ahrq.gov/mepsweb/data_files/publications/st93/stat93shtml.
[5] Mohammed, M. 2010. Unpublished analysis of Connecticut CHIME data, 2007. Connecticut Department of Public Health, Injury Program.

Nationally, "motor vehicle traffic crashes" remained the leading cause of injury-related death, despite a significant decrease in the number and rate of deaths during the same period.[6]

Unintentional Injuries

Unintentional Poisoning Deaths. From 1999 to 2007, the annual number of unintentional poisoning deaths climbed from 235 to 378, a 61% increase (Fig. 7-1a). Age-adjusted death rates for unintentional poisoning increased by 59% overall, 43% among males and 113% among females (Fig. 7-2). In 2007, males were 2.4 times more likely than females to die from unintentional poisoning, and males accounted for 70% of the deaths. Of the 980 unintentional poisoning deaths that occurred in 2005-2007, nearly half (48%) were persons 35 to 49 years of age, and 681 (69%) were related to narcotics, chiefly heroin, cocaine, and methadone.[7]



Source: Connecticut Death Registry (Registration Reports)

Deaths Related to Motor Vehicle Traffic Crashes. In 2006, Connecticut had the sixth lowest rate in the U.S. for deaths related to motor vehicle traffic crashes.[5] From 1999 to 2007 in Connecticut, the number of such deaths increased by 19% (Fig. 7-1a), and the age-adjusted death rate increased by 12% overall, 11% among males and 12% among females (Fig. 7-3). In 2007, males were 1.7 times more likely than females to die as the result of a motor vehicle traffic crash, and males accounted for 205 (70%) of the 294 deaths. Teens and young adults 15-24 years of age accounted for 27% of the deaths in 2005-2007. "Motor vehicle traffic crashes" is the leading cause of death for this age group.

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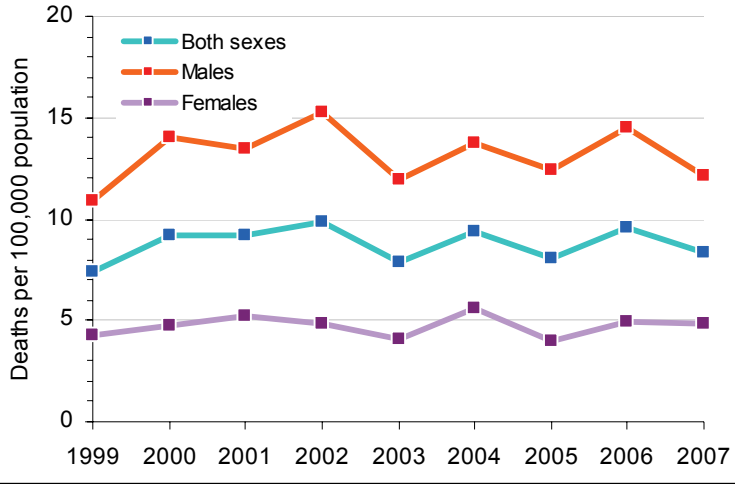
[6] Heron, M. et al. 2009. *Deaths: Final Data for 2006*. National Vital Statistics Report, Vol. 57, No. 14. 136 pp.

[7] Amadeo, F. 2010. Unpublished analysis of 2005-2007 Connecticut resident deaths with opioid narcotic poisoning listed as a secondary cause of death (ICD-10 codes T40.0 to T40.6). Connecticut Department of Public Health, Health Information Systems and Reporting.

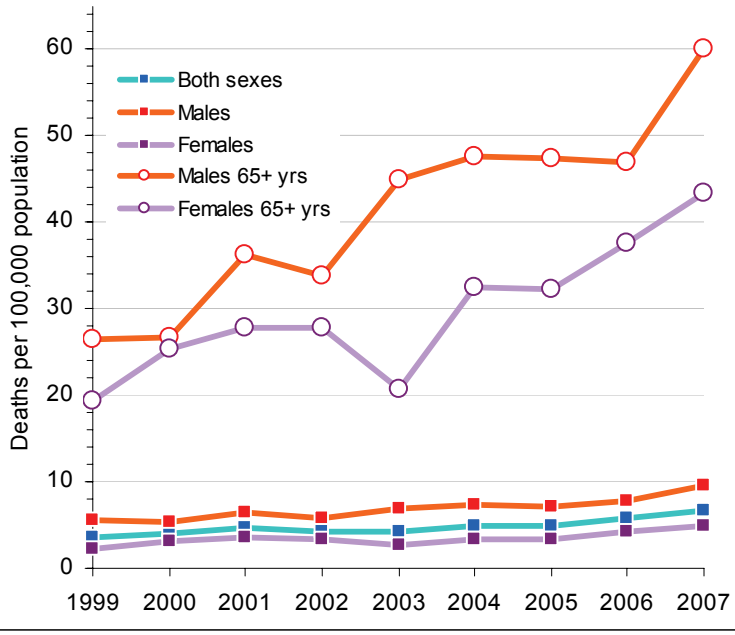
FIGURE 7-3
MOTOR VEHICLE CRASH DEATHS
(Age-Adjusted Death Rates)
CONNECTICUT, 1999-2007



Source: Connecticut Death Registry (Registration Reports)

Fall Deaths. From 1999 to 2007, the number of deaths from falls more than doubled (107% increase), and the age-adjusted death rate increased by 86% overall, 73% among males and 118% among females (Fig. 7-4). The age-specific death rate from falls also more than doubled for people 65 years of age and older (Fig. 7-4). This increase may be related to increased life expectancy.[8] In 2007, persons 65+ years of age were 7.5 times more likely than the overall Connecticut population to die from a fall.

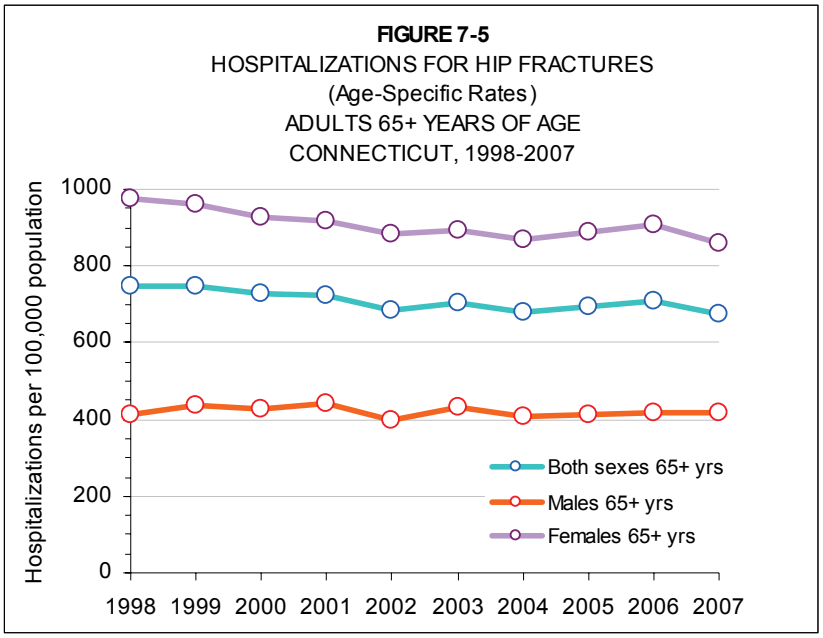
FIGURE 7-4
FALL DEATHS
(Age-Adjusted and Age-Specific Death Rates)
CONNECTICUT, 1999-2007



Source: Connecticut Death Registry (Registration Reports)

[8] According to the CDC, overall U.S. life expectancy increased from 76.7 in 1999 to77.9 in 2007. http://www.cdc.gov/nchs/products/life_tables.htm.

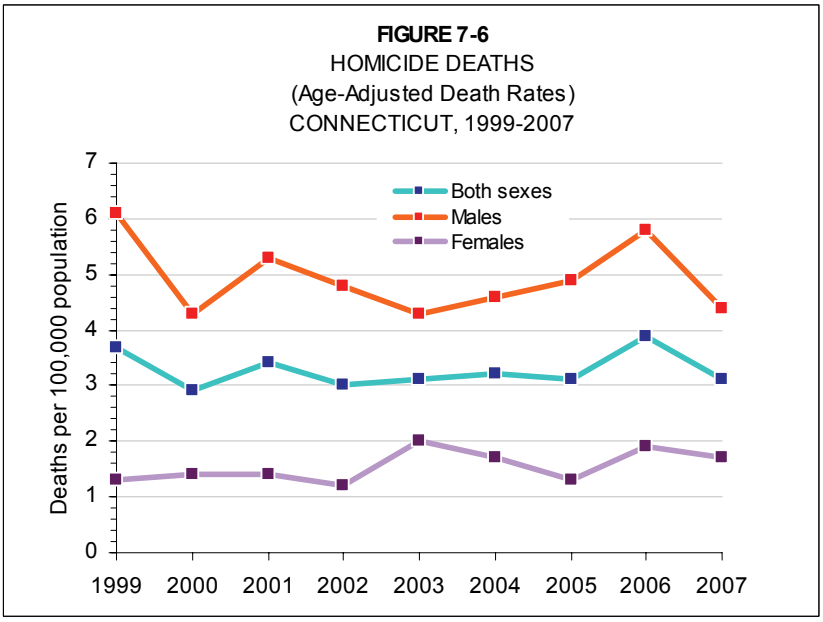
Hospitalizations for Hip Fractures. More than 90% of hip fractures among the elderly result from falls.[9] In Connecticut in 2007, there were 3,600 hospitalizations for hip fractures, 89% of which were people 65+ years of age, with total hospital charges of $121 million. From 1998 to 2007, the hospitalization rate for Connecticut residents 65+ years of age declined by 10% (Fig. 7-5). Women were twice as likely as men to be hospitalized for a hip fracture.



Source: Connecticut Hospital Discharge and Billing Data Base (Hospitalization Reports)

Intentional Injuries (See *Mental Health* for a discussion of Suicide)

Homicides. From 1999 to 2007, the Connecticut homicide rate decreased by 20% overall and 30% among males, but increased by 31% among females (Fig. 7-6).

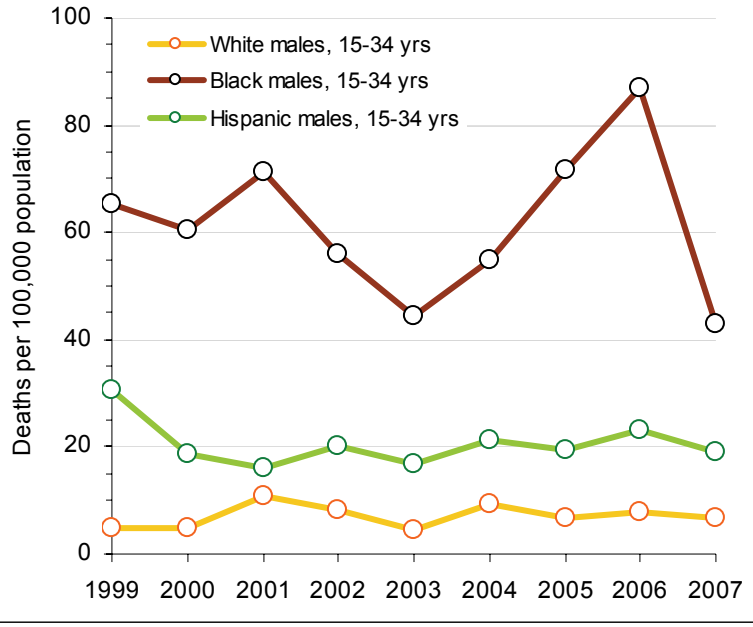


Source: Connecticut Death Registry (Registration Reports)

[9] Grisso, J.A. et al. 1991. Risk factors for falls as a cause of hip fracture in women. The Northeast Hip Fracture Study Group. *New England Journal of Medicine* 324(19):1326–1331.

Males 15-34 years of age are at particularly high risk of death from homicide (Fig. 7-7). From 1999 to 2007, the homicide rate for white males in this age group increased by 36%, while the rate for black males decreased by 30%, and the rate for Hispanic males decreased by 40%. Despite these decreases, compared to rates for white males 15 to 34 years of age, the 2007 homicide rates were more than 6 times higher for black males and nearly 3 times higher for Hispanic males (6.8, 42.9, and 18.9 deaths per 100,000 population, respectively) (Fig. 7-7). The homicide rate for black females 15-34 years of age fell by 50% from 1999 to 2007, but still was more than twice as high as the overall rate for Connecticut females of all ages in 2007 (3.7 and 1.7 deaths per 100,000 population, respectively; not shown).

FIGURE 7-7
HOMICIDE DEATHS
(Age-Adjusted Death Rates)
MALES 15-34 YEARS OF AGE BY RACE & ETHNICITY
CONNECTICUT, 1999-2007



Source: Connecticut Death Registry (Registration Reports)

Homicide commonly appears among the top three leading causes of death for young Connecticut residents--especially males--10 to 14 and 15 to 19 years of age. The total numbers of annual deaths in these age group are small, however (<5 for 10-14 years and <20 for 15-19 years), [10] so age-specific mortality rates tend to be unstable.

[10] Connecticut Department of Public Health. Health Information Systems and Reporting Section. Registration Reports for 1999-2007. Table 10. http://www.ct.gov/dph/cwp/view.asp?a=3132&q=394598

8 ENVIRONMENTAL QUALITY

Background

Poor environmental quality is responsible for about 25% of preventable illnesses, and air pollution alone causes an estimated 2 million premature deaths worldwide each year.[1] Chronic exposure to indoor and outdoor air pollutants increases the risk of developing cardiovascular and respiratory diseases.

Ozone, a major component of smog, is formed when certain industrial and motor vehicle emissions react with sunlight. In the upper atmosphere, ozone shields the earth from ultraviolet radiation, but at ground level, inhalation of ozone can damage lung tissue, impair lung function, and sensitize lungs to irritation by other environmental contaminants. While no one is immune to the harmful effects of ozone, groups at highest risk are children, the elderly, and people with chronic conditions such as asthma, chronic bronchitis, emphysema, cardiovascular disease, and diabetes.

Environmental tobacco smoke (ETS, "secondhand smoke") can be found in any indoor environment where people smoke--in homes, workplaces, public places, and cars. ETS has both immediate and long-term effects on the health of non-smokers, including heart disease, lung cancer, and increased risk of tuberculosis in adults, and lower respiratory infections, ear infections, and asthma in children.[2] In the U.S., exposure of nonsmokers to secondhand smoke causes an estimated 46,000 heart disease deaths, 3,400 lung cancer deaths, up to 300,000 lung infections, and more than 750,000 middle ear infections in children.[3] In 2008 in Connecticut, more than one in ten (11.4%) nonsmoking adults reported exposure to ETS inside their homes or workplaces.[4]

Secondhand smoke irritates the chronically inflamed bronchial passages of people with asthma, can trigger asthma attacks and increase their severity, and is an established risk factor for asthma in preschoolers with no prior history of asthma. Exposure to high concentrations of ozone can have similar effects. Because asthma is closely associated with environmental irritants and triggers, asthma hospitalizations and emergency department visits are useful indicators of environmental quality.

Asthma prevalence is greater in Connecticut than in the U.S. as a whole and appears to be rising. In 2006, an estimated 248,000 adults and 86,000 children--about 10% of the Connecticut population--had asthma.[5] Based on asthma prevalence, hospitalizations, emergency department visits, and deaths, the following population subgroups have been identified as a priority for asthma intervention in Connecticut: 1) children; 2) women; 3) older adults (65 years of age and older); 4) Hispanics of any race; 5) non-Hispanic blacks; 6) residents of low socioeconomic status; and 7) residents of urban areas.[6]

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1 World Health Organization. Air Quality and Health. Fact Sheet No. 313. http://www.who.int/mediacentre/factsheets/fs313/en/index.html. Accessed 11 Feb. 2010.

2 Benowitz, N.L. 2010. Secondhand smoke and infectious disease in adults. *Archives of Internal Medicine*. 170:292-293.

3 American Cancer Society. Prevention and Early Detection: Secondhand Smoke. http://www.cancer.org/docroot/PED/content/PED_10_2X_Secondhand_Smoke-Clean_Indoor_Air.asp . Accessed 16 Feb. 2010.

4 Centers for Disease Control and Prevention. 2009. State-specific secondhand smoke exposure and current cigarette smoking among adults—United States, 2008. *MMWR* 58(44): 1232-1235.

5 Peng, J, R. Rodriguez, and S. Hewes. 2008. *Asthma in Connecticut 2008: A Surveillance Report. Hartford*, CT: Connecticut Department of Public Health, Health Education, Management and Surveillance Section.

6 Connecticut Asthma Advisory Council Plan Revision Workgroups. 2009. A Collaborative Effort for Addressing Asthma in Connecticut 2009-2014. Hartford, CT: Connecticut Department of Public Health, Asthma Program. http://www.ct.gov/dph/lib/dph/hems/asthma/pdf/final_state_asthma_plan_4-30-09.pdf

Findings

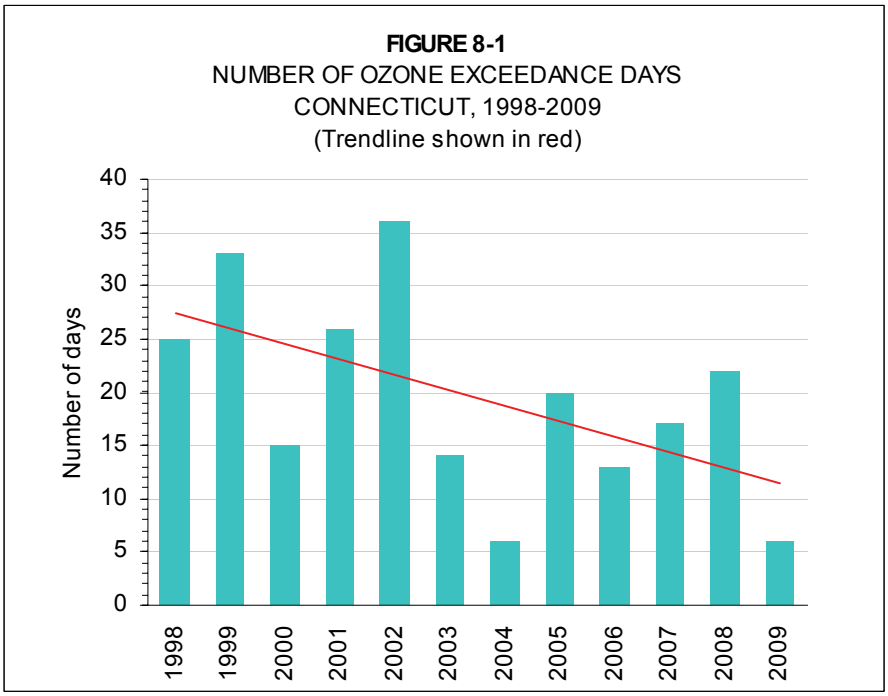
Ozone

The Connecticut Department of Environmental Protection has been monitoring ambient ozone levels throughout the state since the early 1970's. The current network consists of the 11 sites, with one or more sites in every county except Windham.

The air quality parameter for ozone is expressed as *ozone exceedance days*. An ozone exceedance day is defined as a day, measured from midnight to midnight, on which any one or more monitors in the state record an 8-hour ozone concentration greater than or equal to the National Ambient Air Quality Standard (currently 75 parts per billion), which is considered detrimental to health. In Connecticut, the total number of annual days that ozone exceeded national standards decreased from a high of 36 in 2002 to 6 in 2009 (Fig. 8-1). Even more dramatic improvement has occurred since the 1980's, during which time there were as many as 84 ozone exceedance days in one year (1983).

Air quality in Connecticut has improved substantially over the past four decades; however, standards have become more stringent as more information about adverse health effects of pollutants over time has become available. In 2008, for example, the standard was lowered from 84 to 75 parts per billion.

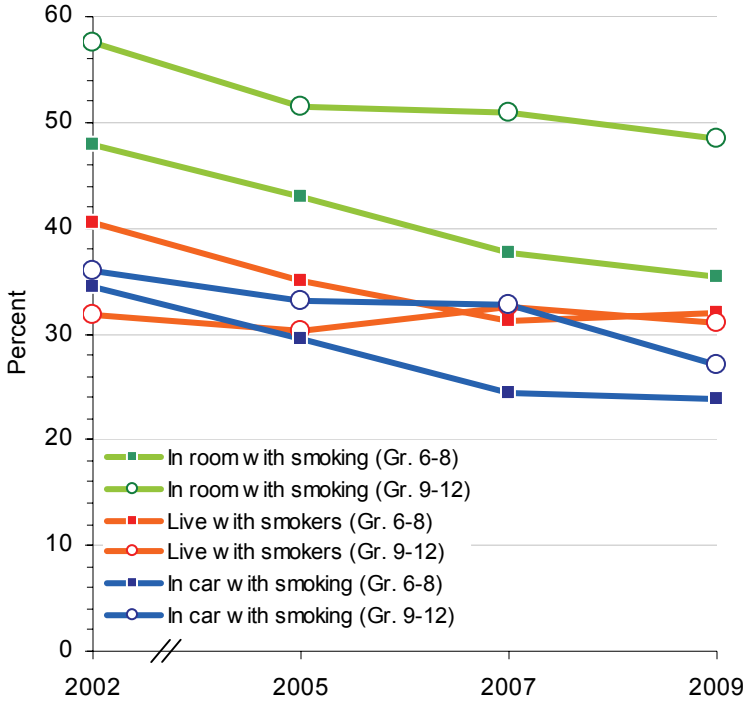
FIGURE 8-1
NUMBER OF OZONE EXCEEDANCE DAYS
CONNECTICUT, 1998-2009
(Trendline shown in red)



Source: Department of Environmental Protection

Environmental Tobacco Smoke. Multi-year data on ETS exposure are available for Connecticut adolescents but not for adults. From 2002 to 2009, the proportions of non-smoking students who lived with smokers or were exposed to secondhand smoke at home or in cars decreased to various degrees (Fig. 8-2). Although only 3% of middle school students and 15% of high school students were current smokers in 2009 (see *Tobacco Use*), nearly one-third of all non-smoking students lived with a smoker, more than one-quarter of students were recently in a car with someone smoking, and about one-third of middle school students and one-half of high school students reported they were recently in the same room as someone who was smoking.

FIGURE 8-2
RECENT EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE
BY PLACE OF EXPOSURE
NON-SMOKING STUDENTS IN GRADES 6-8 AND 9-12
CONNECTICUT, 2002-2009



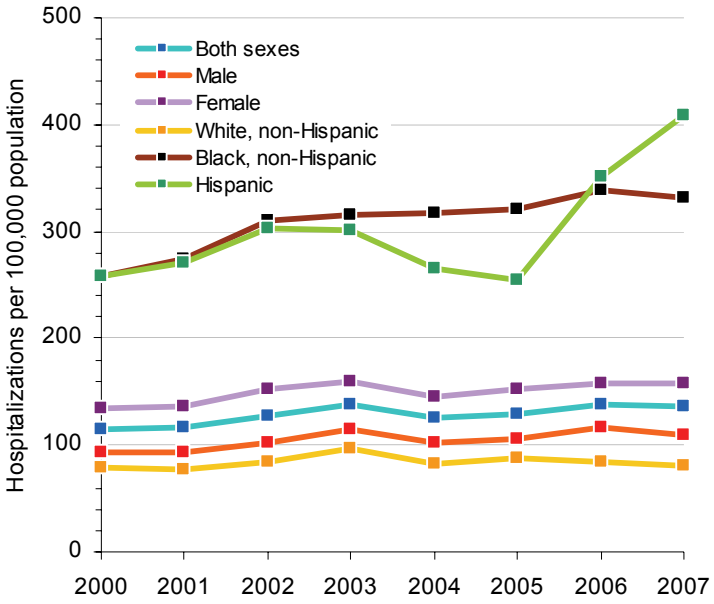
Source: Connecticut Youth Tobacco Survey

Asthma Emergency Department Visits. From 1996 to 2004, the rate of hospital emergency department (ED) visits with a primary diagnosis of asthma was stable (average of 585 visits by adults 18+ years of age and 859 visits by children 0-17 years of age per 100,000 population); however, during the same period, the rates of ED visits with a secondary diagnosis of asthma increased from 194 to 756 per 100,000 among adults and from 325 to 911 per 100,000 among children (data not shown).[7] Female adults and male children had substantially higher rates of ED visits compared to the opposite sex. In 2004, the rate of ED visits was 5 times higher for Hispanics and 4 times higher for black non-Hispanics, compared to white non-Hispanics (1,468, 1,215, and 296 visits per 100,000 population, respectively).

Asthma Inpatient Hospitalizations. Compared to 2000, in 2007 inpatient hospitalizations for asthma increased by 19% overall and by 3% among white non-Hispanics, 28% among black non-Hispanics, 58% among Hispanics, and 65% among persons 65 years of age and older (Figs. 8-3 and 8-4). Hospitalization rates for females were about 43% greater than those for males. Compared to white non-Hispanics, black non-Hispanics were 4 times more likely and Hispanics were 5 times more likely to be hospitalized with a primary diagnosis of asthma (Fig. 8-3).

[7] Peng, J, R. Rodriguez, and S. Hewes. 2008. *Asthma in Connecticut 2008: A Surveillance Report.* Hartford, CT: Connecticut Department of Public Health, Health Education, Management and Surveillance Section.

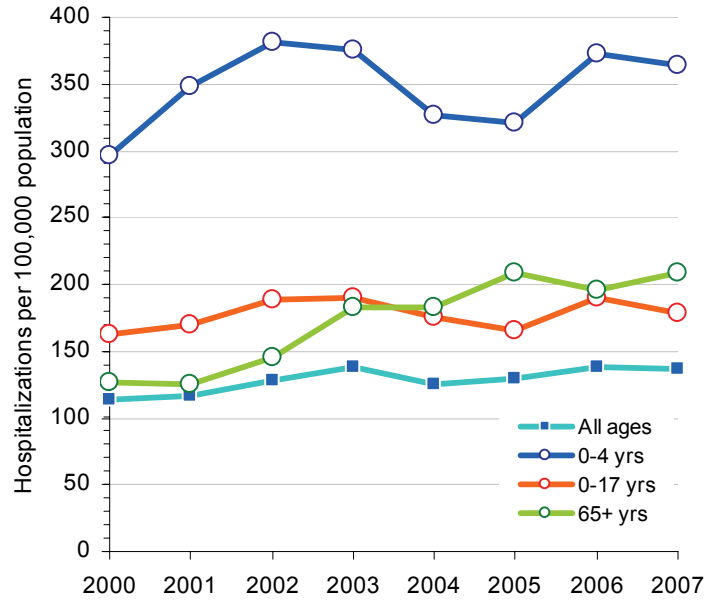
FIGURE 8-3
AGE-ADJUSTED ASTHMA HOSPITALIZATION RATES
BY SEX, RACE & ETHNICITY
CONNECTICUT, 2000-2007



Source: Connecticut Hospital Discharge and Billing Data Base
Note: Hospitalization rates age-adjusted to 2000 U.S. standard population.

Children less than 18 years of age--especially those under 5 years--and adults 65 years of age and older also had higher hospitalization rates compared to the overall Connecticut population (Fig. 8-4).

FIGURE 8-4
ASTHMA HOSPITALIZATIONS FOR HIGH-RISK AGE GROUPS
CONNECTICUT, 2000-2007



Source: Connecticut Hospital Discharge and Billing Data Base
Note: Hospitalization rate for "all ages" age-adjusted to the 2000 standard U.S. population.
Other rates are age-specific.

9 IMMUNIZATION

Background

Vaccines prevent disease in those who receive them and protect individuals who come in contact with unvaccinated people. Vaccination has a huge economic impact in addition to its health impact, reducing the costs of office visits, hospitalizations, disability, lost productivity, and premature death.

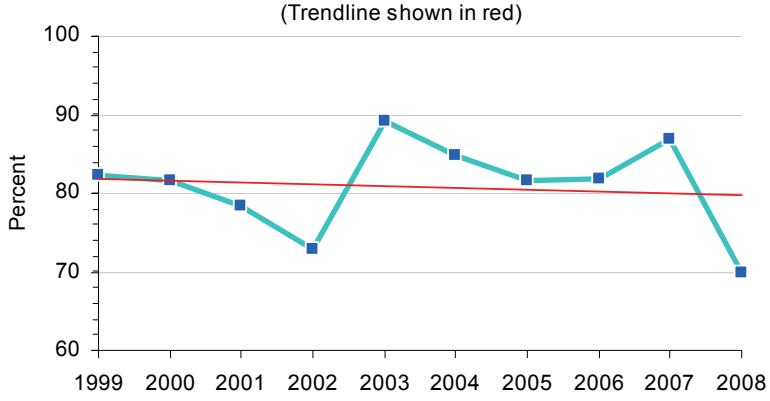
Eleven individual or combination vaccines are recommended by the CDC for universal administration to children.[1] For children 19 to 35 months of age the recommended vaccines and number of dosages are: 4 DTaP--a combined vaccine that protects against diphtheria, tetanus, and pertussis (whooping cough); 3 HepB--protects against hepatitis B; 1 MMR--protects against measles, mumps, and rubella (German measles); 3 Hib-- protects against *Haemophilus influenzae* Type b; and 3 Polio-- protects against poliovirus; and 1 varicella vaccine—protects against chicken pox (included after 2001).

Annual vaccination for seasonal influenza and a pneumococcal (pneumonia) vaccine every 10 years are recommended for people 65 years of age and older. "Pneumonia and influenza" is the fifth leading cause of death among Connecticut residents 75 to 84 years of age and men 85+ years of age.

Findings

Children. From 1999 to 2008, the percentage of children 19-35 months of age who received the recommended vaccines trended downward slightly, and a 10-year low occurred in 2008.[2]

FIGURE 9-1
RECEIVED RECOMMENDED VACCINES
CHILDREN 19-35 MONTHS OF AGE
(4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hep B; 1 Varicella after 2001)
CONNECTICUT, 1999-2008
(Trendline shown in red)



Source: CDC, National Immunization Survey

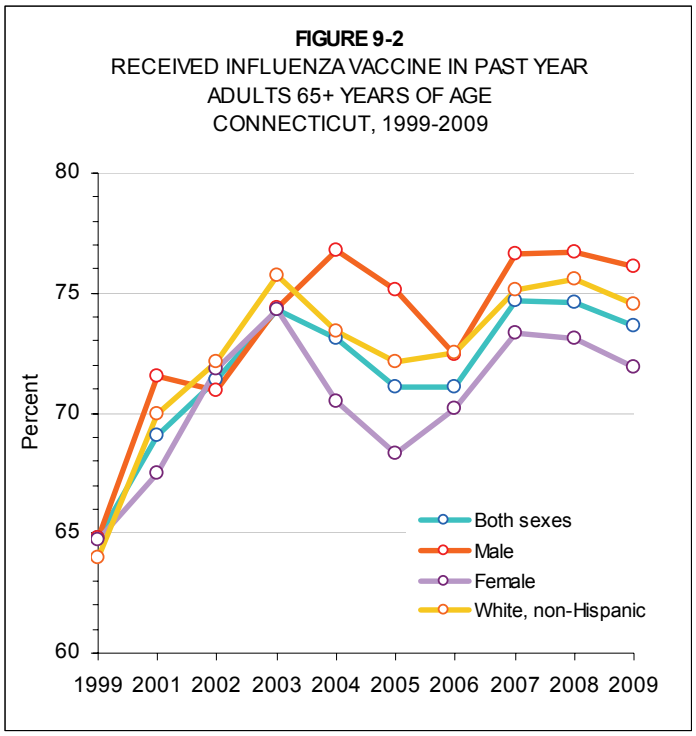
Adults. From 1999 to 2009, the percentage of adults 65 years of age and older who received a yearly influenza vaccine increased significantly overall and for white non-Hispanics (Fig. 9-2). Other increases were not significant, and data were not available for black non-Hispanics and Hispanics because of small numbers of survey respondents; however, unweighted survey data suggest that they are less likely to get flu shots[3]

[1] Centers for Disease Control and Prevention. Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States 2010. http://www.cdc.gov/vaccines/recs/schedules/downloads/child/2010/10_0-6yrs-schedule-bw.pdf . Accessed 17 Feb. 2010.

A large drop in the 3-dose Hib vaccine series coverage rate was largely responsible for the overall immunization coverage rate decrease in 2008. This drop resulted from the national Hib vaccine shortage that occurred from November, 2007 to June, 2009.

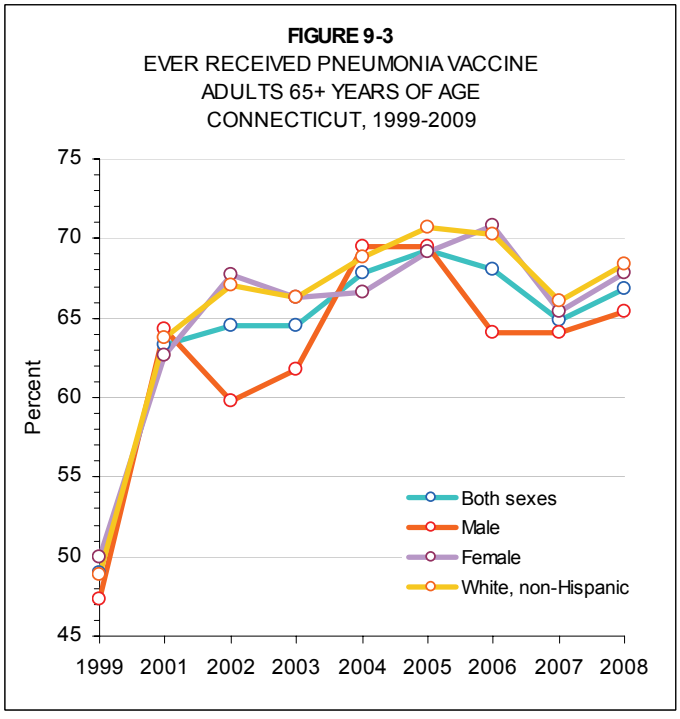
[2] Centers for Disease Control and Prevention. Immunization Coverage in the U.S. National Immunization Survey, Children 19-35 Months. http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#chart . Accessed 17 Feb. 2010.

[3] D. Rosen, DPH Immunization Program, personal communication.



Source: Behavioral Risk Factor Surveillance System

During the same period, the proportion of older adults who received pneumococcal (pneumonia) vaccine improved significantly for all groups (Fig. 9-3). Females were more likely than males to receive a pneumococcal vaccine, whereas males were more likely than females to get annual influenza vaccines, though these differences were not statistically significant. Unweighted survey data for black non-Hispanics and Hispanics suggest that these groups may be less likely than white non-Hispanics to get the pneumococcal vaccine.[4]



Source: Behavioral Risk Factor Surveillance System

[4] D. Rosen, DPH Immunization Program, personal communication.

10 ACCESS TO HEALTH CARE

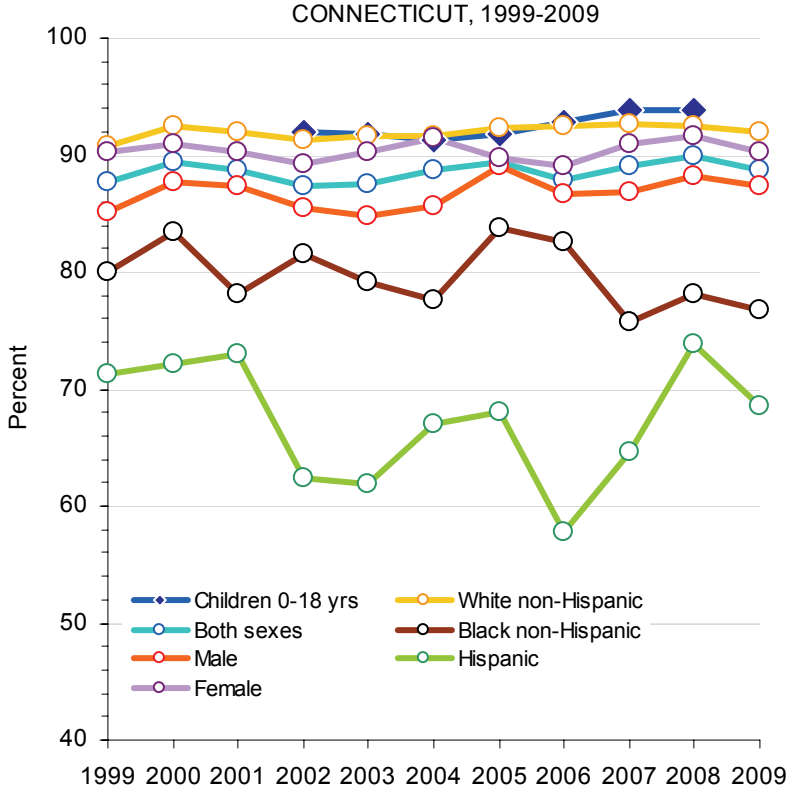
Background

Access to quality health care across the continuum of care--from prevention, screening, and diagnosis to treatment and end-of-life care--is key to eliminating health disparities and improving quality of life. Health insurance status and type, income, English proficiency, having a regular primary care provider or place of care, and availability of facilities and transportation are important predictors of access to health care. Indicators of access include utilization of clinical preventive services (such as cancer, blood pressure, and cholesterol screening, and prenatal care), emergency medical services, long-term care and rehabilitation services; effective management of chronic disease; and education about modifiable risk factors.

Findings

Health Insurance. Of the Connecticut population under 65 years of age, children were the most likely to have health insurance coverage; females were somewhat more likely than males, and white non-Hispanics were significantly more likely than non-Hispanic blacks and Hispanics to be insured (Fig. 10-1). In 2009, 92% of white non-Hispanics had health insurance, compared to 80% of black

FIGURE 10-1
PERSONS WITH HEALTH INSURANCE
CHILDREN 0-18 YRS OF AGE AND
ADULTS 18-64 YRS OF AGE BY SEX, RACE & ETHNICITY
CONNECTICUT, 1999-2009

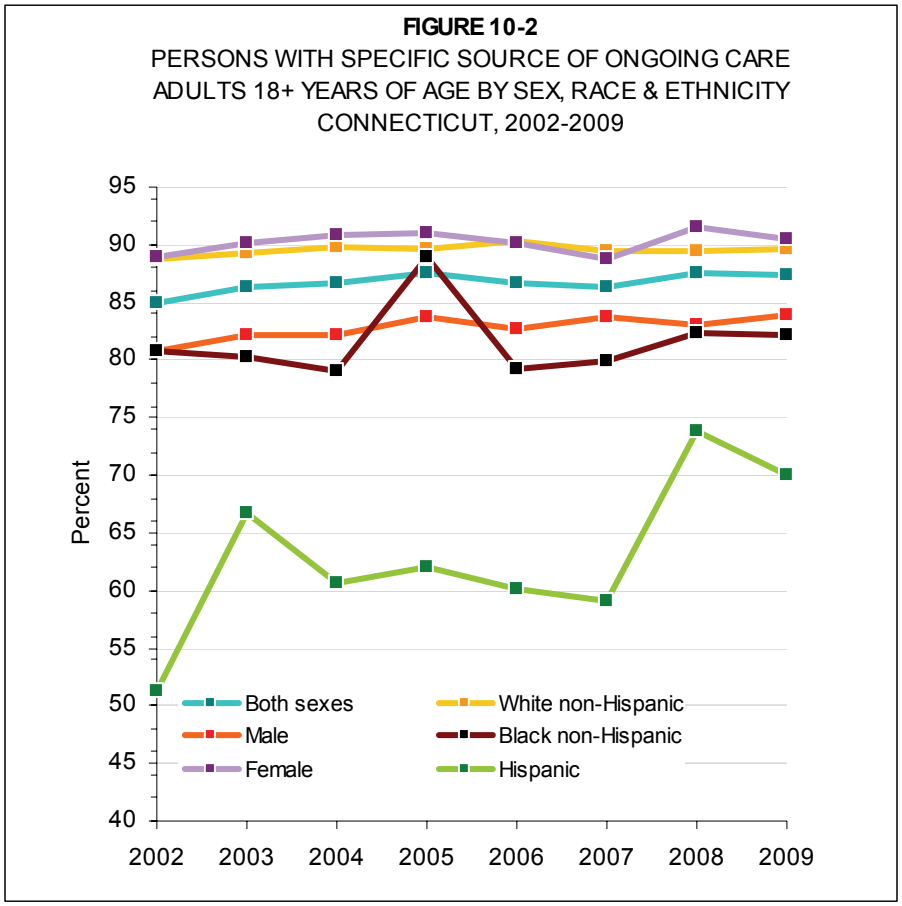


Source: Behavioral Risk Factor Surveillance System
Note: Data for children 0-18 years of age not available until 2002.

non-Hispanics and 71% of Hispanics. There were no statistically significant changes in health insurance coverage for any population between 1999 and 2009.

Specific Source of Ongoing Care. From 2002 to 2009, the proportion of Connecticut adults 18 years of age and older with a specific source of ongoing health care was about the same except for Hispanics (19 percentage point improvement) (Fig. 10-2). In 2009, women and non-Hispanic whites were the most likely to have ongoing care, men and Hispanics were the least likely (Fig. 10-2), but the differences were not statistically significant. The gap between non-Hispanic whites and Hispanics narrowed considerably, however, from 37 percentage points in 2002 to 20 in 2009.

FIGURE 10-2
PERSONS WITH SPECIFIC SOURCE OF ONGOING CARE
ADULTS 18+ YEARS OF AGE BY SEX, RACE & ETHNICITY
CONNECTICUT, 2002-2009

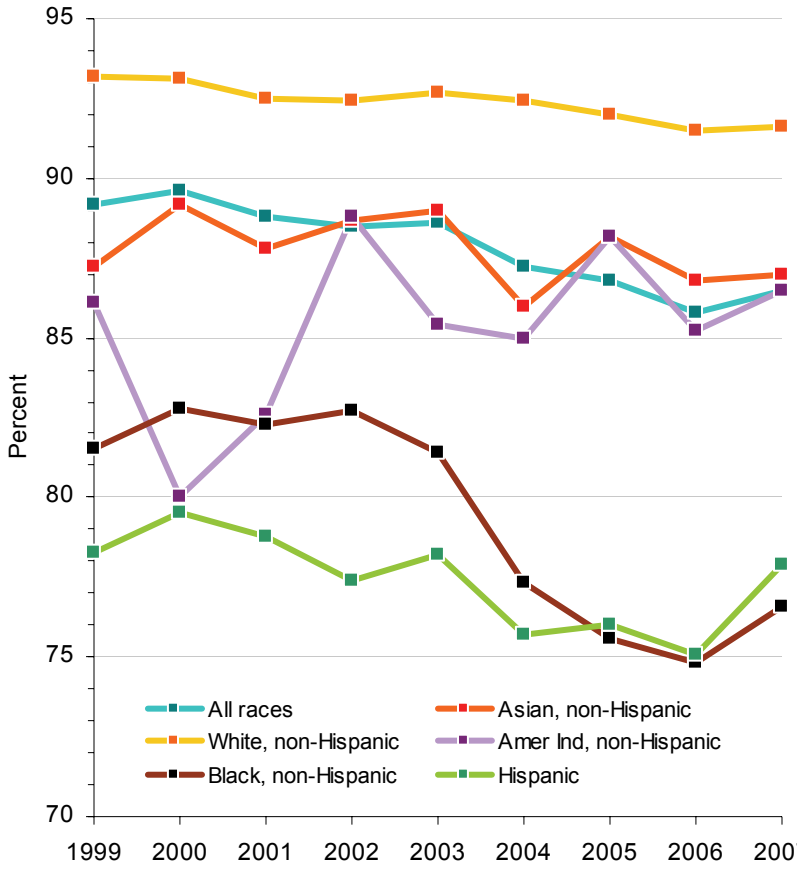


Source: Behavioral Risk Factor Surveillance System

Prenatal Care. From 1999 to 2007, the percentage of pregnant women who began prenatal care during the first trimester of pregnancy decreased overall (from 89.2% to 86.5%) and in all racial and ethnic population groups except American Indians (0.4% increase) (Fig. 10-3). The greatest decrease (5 percentage points) occurred among non-Hispanic blacks. Non-Hispanic whites were the most likely to

begin prenatal care early, followed by non-Hispanic Asians and American Indians (all >86% in 2007). Black non-Hispanics and Hispanics were the least likely (<78%).

FIGURE 10-3
BEGAN PRENATAL CARE IN FIRST TRIMESTER OF PREGNANCY
BY RACE & ETHNICITY
CONNECTICUT, 1999-2007



Source: Connecticut Birth Registry (Registration Reports)

TRACKING DATA AND SOURCES

	1997	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Data Source	Comments
1 PHYSICAL ACTIVITY													
Recommended activity (%) **(Objective 22-2)**													
Adults 18+ yrs													
Both sexes	-	23.7	48.3	-	51.7	-	51.2	-	52.4	-	53.9		2000: Adults with 30+ minutes of any physical activity five or more days per week. 2001-2007: Adults with 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week.
Male	-	24.9	51.9	-	51.9	-	52.3	-	54.2	-	56.8		
Female	-	22.5	45.0	-	51.6	-	50.3	-	50.8	-	51.1	CDC, BRFSS Prevalence and Trends http://apps.nccd.cdc.gov/BRFSS	
White non-Hispanic	-	24.3	50.3	-	53.9	-	51.5	-	53.8	-	55.2		
Black non-Hispanic	-	23.8	38.7	-	35.4	-	46.9	-	41.5	-	42.0		
Hispanic	-	20.7	39.4	-	43.3	-	48.4	-	46.6	-	50.7		
Recommended activity (%) **(Objective 22-7)**													
Students, Grades 9-12													
Both sexes	66.3	-	-	-	-	-	63.1	-	45.1	-	45.2	2009 YRBSS Trend Analysis Report	1997 & 2005: Participated in at least 20 min. of exercise or physical activity that made them sweat and breathe hard on 3 or more of the past 7 days. 2007 & 2009: Physically active doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 min. per day on 5 or more of the past 7 days.
Male	76.2	-	-	-	-	-	70.2	-	52.7	-	56.1		
Female	56.2	-	-	-	-	-	56.3	-	37.4	-	34.2		
White non-Hispanic	66.7	-	-	-	-	-	67.2	-	50.5	-	50.5		
Black non-Hispanic	-	-	-	-	-	-	53.6	-	34.4	-	37.1		
Hispanic	58.8	-	-	-	-	-	52.1	-	32.3	-	33.1		

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Data Source	Comments
2 OVERWEIGHT AND OBESITY													
Overweight (%)													
(Objective 19-2)													
Adults 18+ yrs													
Both sexes	37.4	36.3	37.2	37.0	35.7	36.5	38.1	38.2	37.5	38.3	37.9	CDC, BRFSS Prevalence and Trends http://apps.nccd.cdc.gov/BRFSS	Based on body mass index (BMI). For adults, BMI 25.0-29.9 = overweight and BMI 30+ = obese.
Male	48.5	44.4	47.3	47.7	45.7	46.1	48.5	47.9	46.8	47.0	47.8		
Female	26.7	28.5	27.2	26.6	25.9	27.2	28.1	28.7	28.5	29.8	28.1		
White non-Hispanic	37.3	36.5	38.0	36.9	35.9	36.1	37.9	37.8	37.1	38.1	38.1		
Black non-Hispanic	41.9	40.2	37.8	40.6	39.1	37.6	40.8	37.5	33.6	32.3	29.5		
Hispanic	-	37.5	31.7	40.0	35.3	40.7	42.3	45.5	44.4	41.7	43.9		
(Objective 19-3)													
Students, Grades 9-12													
Both sexes	-	-	-	-	-	-	14.7	-	13.3	-	14.5	2009 YRBS Trend Analysis Report	
Male	-	-	-	-	-	-	16.3	-	14.9	-	16.6		
Female	-	-	-	-	-	-	12.9	-	11.5	-	12.2		
White non-Hispanic	-	-	-	-	-	-	13.7	-	12.3	-	13.7		
Black non-Hispanic	-	-	-	-	-	-	16.6	-	11.7	-	16.7		
Hispanic	-	-	-	-	-	-	18.4	-	19.5	-	16.3		
Obese (%)													
(Objective 19-2)													
Adults 18+ yrs													
Both sexes	15.1	17.4	17.9	18.0	19.1	19.7	20.1	20.6	21.7	21.4	21.0	CDC, BRFSS Prevalence and Trends http://apps.nccd.cdc.gov/BRFSS	Based on body mass index (BMI). For adults, BMI 25.0-29.9 = overweight and BMI 30+ = obese.
Male	15.4	18.2	18.7	19.6	19.9	20.8	21.0	21.7	23.7	23.3	22.4		
Female	14.9	16.6	17.1	16.5	18.3	18.6	19.2	19.5	19.9	19.6	19.6		
White non-Hispanic	14.3	16.0	17.1	17.1	18.0	19.2	19.1	20.0	21.8	20.2	19.9		
Black non-Hispanic	29.9	31.0	26.6	29.0	32.5	30.6	35.2	28.6	30.9	35.4	39.3		
Hispanic	15.6	21.7	21.1	23.0	21.2	20.4	24.0	22.4	20.2	29.9	29.4		
(Objective 19-3)													
Students, Grades 9-12													
Both sexes	-	-	-	-	-	-	11.2	-	12.3	-	10.4	2009 YRBS Trend Analysis Report	
Male	-	-	-	-	-	-	13.9	-	16.2	-	13.8		
Female	-	-	-	-	-	-	8.4	-	8.2	-	6.7		
White non-Hispanic	-	-	-	-	-	-	9.2	-	9.6	-	8.7		
Black non-Hispanic	-	-	-	-	-	-	15.4	-	21.1	-	12.5		
Hispanic	-	-	-	-	-	-	17.9	-	17.5	-	17.0		

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Data Source	Comments
Overweight or Obese (%)													
(Objective 19-2)													
Adults 18+ yrs													
Both sexes	52.5	53.7	55.1	55.0	54.8	56.2	58.2	58.8	59.2	59.7	58.9	CDC, BRFSS Prevalence and	Overweight or obese = BMI 25 and over.
Male	63.9	62.6	66.0	67.3	65.6	66.9	69.5	69.6	70.5	70.3	70.2	Trends	
Female	41.6	45.1	44.3	43.1	44.2	45.8	47.3	48.2	48.4	49.4	47.7	http://apps.nccd.cdc.gov/BRFSS	
White non-Hispanic	51.6	52.5	55.1	54.0	53.9	55.3	57.0	57.8	58.9	58.3	58.0		
Black non-Hispanic	71.8	71.2	64.4	69.6	71.6	68.2	76.0	66.1	64.5	67.7	68.8		
Hispanic	-	59.2	52.8	63.0	56.5	61.1	66.3	67.9	64.6	71.6	73.3		
(Objective 19-3)													
Students, Grades 9-12													
Both sexes	-	-	-	-	-	-	25.9	-	25.6	-	24.9	2009 YRBS Trend Analysis	
Male	-	-	-	-	-	-	30.2	-	31.1	-	30.4	Report	
Female	-	-	-	-	-	-	21.3	-	19.7	-	18.9		
White non-Hispanic	-	-	-	-	-	-	22.9	-	21.9	-	22.4		
Black non-Hispanic	-	-	-	-	-	-	32.0	-	32.8	-	29.2		
Hispanic	-	-	-	-	-	-	36.3	-	37.0	-	33.3		
Children 10-17 yrs													
(Objective 19-3)													
Overweight (%)	-	-	-	-	15.0	-	-	-	13.2	-	-	National Survey of Children's	
Obese (%)	-	-	-	-	12.3	-	-	-	12.5	-	-	Health. www.nschdata.org	
Overweight or Obese (%)	-	-	-	-	27.3	-	-	-	25.7	-	-		

	1997	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Data Source	Comments
3 TOBACCO USE														
Current cigarette smoking (%)														
(Objective 27-1a)														
Adults 18+ yrs														
Both sexes	-	22.8	19.9	20.6	19.4	18.6	18.1	16.5	17.0	15.4	15.9	15.4		
Male	-	25.3	20.4	21.2	20.6	19.6	20.1	17.0	18.9	16.5	17.3	16.2	CDC, BRFSS Prevalence and Trends	"Current smokers." Smoke every day or some days.
Female	-	20.6	19.4	20.1	18.3	17.7	16.2	16.2	15.2	14.4	14.7	14.7	http://apps.nccd.cdc.gov/BRFSS	
White, non-Hispanic	-	22.4	20.1	20.5	19.3	18.1	17.4	16.0	15.9	15.2	15.3	14.6		
Black, non-Hispanic	-	20.2	27.3	20.6	17.9	20.9	17.3	22.0	22.2	21.7	14.3	24.2		
Hispanic	-	-	17.1	21.2	22.1	19.6	22.1	18.0	24.6	15.1	23.2	14.5		
(Objective 27-2b)														
Students, Middle School														
Both sexes			9.8	-	5.9	-	-	5.9	-	3.4	-	3.3	Connecticut Youth Tobacco Surveys	Smoked cigarettes on one or more of the past 30 days.
Male			9.7	-	4.8	-	-	6.0	-	3.7	-	3.3		
Female			9.8	-	6.8	-	-	5.8	-	3.0	-	3.2		
White, non-Hispanic			8.6	-	4.6	-	-	5.3	-	2.9	-	2.9		
Black, non-Hispanic			11.5	-	7.2	-	-	7.0	-	2.4	-	3.1		
			12.5	-	13.0	-	-	7.9	-	5.5	-	4.5		
Students, High School														
Both sexes			25.6	-	22.0	-	-	17.0	-	16.9	-	15.3	Connecticut Youth Tobacco Surveys	Smoked cigarettes on one or more of the past 30 days.
Male			24.9	-	23.3	-	-	15.8	-	18.6	-	16.0		
Female			26.0	-	20.7	-	-	18.2	-	15.2	-	14.4		
White, non-Hispanic			27.6	-	23.2	-	-	19.3	-	18.1	-	17.8		
Black, non-Hispanic			13.2	-	16.8	-	-	9.4	-	10.9	-	6.23		
Hispanic			25.7	-	21.1	-	-	12.6	-	16.3	-	14.0		

	1997	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Data Source	Comments
4 ALCOHOL AND SUBSTANCE ABUSE														
Current alcohol use (%)														
(Objective 26-10)														
Adults 18+ yrs														
Both sexes	-	59.4	-	63.3	67.6	68.6	65.3	67.3	63.4	65.8	65.7	67.0	CDC, BRFSS Prevalence and Trends http://apps.nccd.cdc.gov/BRFS	1999: At least one drink of any alcoholic beverage during the past month. 2001-2008: At least one drink of alcohol in the past 30 days.
Male	-	66.3	-	70.2	74.9	74.8	69.9	74.2	70.5	72.4	71.9	73.0		
Female	-	53.2	-	57.1	61.0	63.0	61.2	61.0	56.9	59.7	60.0	61.4		
White non-Hispanic	-	62.5	-	67.6	70.6	72.4	69.4	69.7	67.3	69.6	69.5	71.0		
Black non-Hispanic	-	51.9	-	42.2	53.0	44.2	43.7	50.2	40.0	47.4	46.4	42.1		
Hispanic	-	37.9	-	43.6	56.6	51.8	42.8	57.0	50.3	48.9	50.7	48.3		
Adults, 18+ yrs	-	-	-	-	-	-	-	65.9	65.4	67.0	-	-	SAMHSA, National Surveys on Drug Use & Health	
(Objective 26-10a)														
Students, Grades 9-12														
Both sexes	52.6	-	-	-	-	-	-	45.3	-	46.0	-	43.5	2009 YRBS Trend Analysis Report	Students in Grades 9-12 At least one drink in past 30 days.
Male	54.1	-	-	-	-	-	-	45.0	-	46.7	-	43.2		
Female	51.3	-	-	-	-	-	-	45.5	-	45.3	-	43.8		
White non-Hispanic	53.5	-	-	-	-	-	-	49.0	-	50.6	-	45.6		
Black non-Hispanic	-	-	-	-	-	-	-	31.9	-	26.3	-	38.1		
Hispanic	47.0	-	-	-	-	-	-	38.8	-	42.7	-	42.5		
12-17 yrs	-	-	-	-	-	18.9	20.9	20.9	20.2	19.6	-	-	SAMHSA, National Surveys on Drug Use & Health	
18-25 yrs	-	-	-	-	-	72.3	73.8	71.4	71.8	71.9	-	-		
Binge drinking (%)														
(Objective 26-11)														
Adults 18+ yrs														
Both sexes	-	14.0	-	13.8	16.3	16.5	14.9	14.8	14.5	17.8	16.6	18.9	CDC, BRFSS Prevalence and Trends http://apps.nccd.cdc.gov/BRFS	Adults 18+ yrs of age. 1999-2005: 5 or more drinks on one occasion. 2006-2009: Males 5 or more drinks, females 4 or more drinks on one occasion.
Male	-	22.7	-	21.1	25.7	25.1	22.4	22.4	18.8	23.9	22.9	25.2		
Female	-	6.3	-	7.2	7.8	8.7	8.1	7.8	10.7	12.3	10.9	13.2		
White non-Hispanic	-	14.2	-	14.3	16.6	16.5	15.4	14.4	15.2	18.6	17.9	20.2		
Black non-Hispanic	-	8.0	-	9.7	7.5	15.0	10.5	-	4.8	9.5	7.5	14.4		
Hispanic	-	17.1	-	13.6	19.1	18.5	11.2	18.8	17.4	13.2	14.4	14.2		
Adults, 18+ yrs	-	-	-	-	-	-	-	27.4	26.7	26.5	-	-	SAMHSA, National Surveys on Drug Use & Health	Five or more drinks on one occasion

Note: SAMHSA data on alcohol use included for comparison purposes only.

	1997	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Data Source	Comments
Binge drinking (%)														
Students, Grades 9-12														
Both sexes	31.2	-	-	-	-	-	-	27.8	-	26.2	-	24.2	2009 YRBS Trend Analysis	Five or more drinks in a row in
Male	34.5	-	-	-	-	-	-	28.7	-	27.8	-	26.0	Report	the past 30 days.
Female	27.9	-	-	-	-	-	-	26.6	-	24.5	-	22.5		
White non-Hispanic	32.2	-	-	-	-	-	-	31.2	-	30.8	-	27.3		
Black non-Hispanic	-	-	-	-	-	-	-	18.2	-	7.7	-	13.7		
Hispanic	27.3	-	-	-	-	-	-	19.6	-	23.8	-	23.4		
12-17 yrs	-	-	-	-	-	-	12.4	12.1	11.9	13.2	-	-	SAMHSA, National Survey on	
18-25 yrs	-	-	-	-	-	-	48.6	48.7	49.8	49.9	-	-	Drug Use & Health	
Current illicit drug use (%) **(Objective 26-10c)**														Use of illicit drugs in past month. Includes marijuana, hashish, cocaine/crack, heroin hallucinogens, inhalants, and prescription-type psychotherapeutics used nonmedically. Each single year figure is an annual average of the indicated year and prior year.
12+ yrs	-	-	7.3	7.5	-	8.8	8.5	9.0	9.2	7.9	-	-	SAMHSA, National Surveys on	
12-17 yrs	-	-	12.6	13.2	-	12.5	11.7	11.2	10.3	9.8	-	-	Drug Use & Health	
18-25 yrs	-	-	19.3	23.0	-	25.6	26.4	26.5	26.4	22.9	-	-		
26+ yrs	-	-	4.9	4.6	-	5.8	5.5	6.1	6.4	5.4	-	-		
18+ yrs	-	-	-	-	-	-	-	8.8	9.1	7.7	-	-		

Note: SAMHSA data on alcohol use included for comparison purposes only.

	1997	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Data Source	Comments
5 RESPONSIBLE SEXUAL BEHAVIOR														
Ever had sex (%) (Objective 25-11)														
Students, Grades 9-12														
Both sexes	43.5	-	-	-	-	-	-	46.0	-	42.4	-	40.5	2009 YRBS Trend	Ever had sexual intercourse.
Male	44.4	-	-	-	-	-	-	47.0	-	43.1	-	42.9	Analysis Report	
Female	42.3	-	-	-	-	-	-	45.0	-	41.8	-	38.0		
White non-Hispanic	39.6	-	-	-	-	-	-	41.5	-	38.3	-	35.9		
Black non-Hispanic	-	-	-	-	-	-	-	60.9	-	51.4	-	57.9		
Hispanic	56.7	-	-	-	-	-	-	55.5	-	58.2	-	50.0		
Condom use during last sexual intercourse (%) Objective 13-6a														
Students, Grades 9-12														
Both sexes	57.3	-	-	-	-	-	-	-	-	62.7	-	59.4	2009 YRBS Trend	Of students who had sexual intercourse during past 3 months, percentage who used a condom during last intercourse.
Male	64.7	-	-	-	-	-	-	-	-	67.4	-	62.9	Analysis Report	
Female	50.1	-	-	-	-	-	-	-	-	58.7	-	56.1		
White non-Hispanic	55.6	-	-	-	-	-	-	-	-	60.9	-	60.8		
Hispanic	-	-	-	-	-	-	-	-	-	59.1	-	50.6		

Note: Prevalance not calculated for African Americans due to small number of respondents.

	1997	1999	2000	2001	2002	2003	2004	2005	2006	2007	2009	Data Source	Comments
6 MENTAL HEALTH													
Serious psychological distress (%)												SAMHSA, National Survey on Drug Use & Health	Serious psychological distress (SPD) is defined as having a score of 13 or higher on the K6 scale, which takes into account feeling nervous, hopeless, restless or fidgety, sad or depressed, worthless, and that everything is an effort. Because of questionnaire changes, these estimates are not comparable with estimates from earlier reports. Data for SPD are not defined for 12 to 17 year olds.
18+ yrs	-	-	-	-	-	-	-	11.5	10.6	10.1	-		
18-25 yrs	-	-	-	-	-	-	-	21.0	19.9	19.6	-		
26+ yrs	-	-	-	-	-	-	-	10.0	9.2	8.6	-		
Major depressive episode (%)												SAMHSA, National Survey on Drug Use & Health	According to DSM-IV, lifetime major depressive episode = five or more of the following symptoms nearly every day in the same 2-wk period (where at least one of the symptoms is a depressed mood or loss of interest or pleasure in daily activities): (1) depressed mood most of the day; (2) markedly diminished interest or pleasure in all or almost all activities most of the day; (3) significant weight loss when not sick or dieting, or weight gain when not pregnant or growing, or decrease or increase in appetite; (4) insomnia or hypersomnia; (5) psychomotor agitation or retardation; (6) fatigue or loss of energy; (7) feelings of worthlessness; (8) diminished ability to think or concentrate or indecisiveness; and (9) recurrent thoughts of death or suicidal ideation.
12-17 yrs	-	-	-	-	-	-	-	10.2	8.3	7.6	-		
18+ yrs	-	-	-	-	-	-	-	9.2	6.6	6.9	-		
18-25 yrs	-	-	-	-	-	-	-	11.8	9.6	9.4	-		
26+ yrs	-	-	-	-	-	-	-	8.8	6.1	6.5	-		
Suicides (Deaths per 100,000 population) **(Objective 18-1)**													
Both sexes	-	7.8	8.7	8.1	7.3	7.3	7.9	7.6	7.5	7.0	-		All death rates except those for specific age groups were age-adjusted to the U.S. 2000 standard population.
Male	-	13.2	14.7	13.9	12.1	11.6	13.1	12.5	12.7	11.5	-	DPH, Health Information Systems & Reporting, Annual AAMR and Age-specific Mortality Reports	
Female	-	3.1	3.4	2.9	3.0	3.4	3.3	3.2	2.8	2.8	-		
Males, 15-19 yrs	-	7.3	10.7	16.6	7.6	3.3	4.0	6.3	11.0	10.9	-		
Males, 20-24 yrs	-	15.5	15.1	15.1	12.5	13.9	18.1	13.0	15.3	12.3	-		
Males, 45-49 yrs	-	19.9	21.6	21.9	20.6	22.4	26.2	21.6	18.8	19.5	-		
Males, 65+ yrs	-	116.6	121.7	123.5	103.3	71.9	89.4	85.1	84.4	83.6	-		
Males, white	-	14.6	16.3	14.9	13.5	12.7	14.2	13.6	13.7	12.5	-		
Attempted suicide (%) **(Objective 18-2)**													
Students, Grades 9-12													
Both Sexes	9.1	-	-	-	-	-	-	12.1	-	9.8	7.4	2009 YRBS Trend Analysis Report	Attempted suicide one or more times during the past 12 months.
Male	5.6	-	-	-	-	-	-	12.0	-	10.2	7.5		
Female	12.5	-	-	-	-	-	-	11.8	-	9.2	7.3		
White non-Hispanic	8.1	-	-	-	-	-	-	11.5	-	8.8	6.1		
Black non-Hispanic	-	-	-	-	-	-	-	11.5	-	10.3	9.0		
Hispanic	17.6	-	-	-	-	-	-	14.8	-	10.7	12.0		

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2009	Data Source	Comments
7 INJURY AND VIOLENCE														
Unintentional Injuries:														
Deaths caused by accidental poisoning (Per 100,000 population)														
(Objective 15-8)														
Both sexes	-	-	6.8	7.6	6.8	8.8	7.4	8.5	7.4	9.7	10.8		DPH, Health Information Systems & Reporting, Annual AAMR Reports	All death rates except those for specific age groups were age-adjusted to the 2000 U.S. standard population.
Males	-	-	10.7	13.2	10.2	13.0	11.3	12.1	10.6	14.6	15.3			
Females	-	-	3.0	2.3	3.5	4.7	3.7	4.8	4.2	4.8	6.4			
Deaths caused by motor vehicle traffic crashes (Per 100,000 population)														
(Objective 15-15a)														
Both sexes	-	-	7.4	9.2	9.2	9.9	7.9	9.4	8.1	9.6	8.3		DPH, Health Information Systems & Reporting, Annual AAMR Reports	All death rates except those for specific age groups were age-adjusted to the 2000 U.S. standard population.
Males	-	-	10.9	14.0	13.5	15.3	11.9	13.7	12.4	14.5	12.1			
Females	-	-	4.3	4.7	5.2	4.8	4.1	5.6	4.0	4.9	4.8			
Deaths caused by falls (Per 100,000 population)														
(Objective 15-27)														
Both sexes	-	-	3.6	4.1	4.7	4.3	4.2	5.0	5.0	5.8	6.7		DPH, Health Information Systems & Reporting, Annual AAMR Reports and Age-specific Mortality Reports	All death rates except those for specific age groups were age-adjusted to the 2000 U.S. standard population.
Males	-	-	5.5	5.3	6.4	5.7	6.9	7.4	7.2	7.8	9.5			
Females	-	-	2.2	3.1	3.5	3.3	2.6	3.4	3.4	4.3	4.8			
Adults 65+ yrs														
Both sexes	-	-	22.2	25.9	31.3	30.3	30.6	38.6	38.4	41.1	50.4			
Males	-	-	26.5	26.8	36.2	33.8	44.9	47.6	47.4	46.9	60.2			
Females	-	-	19.3	25.3	27.9	27.9	20.8	32.6	32.2	37.6	43.5			
Hospitalizations for hip fractures (Per 100,000 population)														
(Objective 15-28)														
Adults, 65+ yrs														
Both sexes	-	747.2	748.9	726.2	722.2	686.4	704.7	681.5	694.9	706.6	677.1		DPH, Health Information Systems & Reporting, Hospital Discharge Data	The number of discharges in 2007 was 3,198 (814 males and 2,384 females).
Males	-	410.8	435.7	428.6	439.6	396.9	429.9	405.4	411.8	418.8	419.1			
Females	-	977.3	962.6	928.3	915.2	885.1	893.1	868.2	887.4	908.3	857.3			

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2009	Data Source	Comments
Intentional Injuries														
Homicides (Deaths per 100,000 population)														
(Objective 15-32)														
Both sexes	-	-	3.7	2.9	3.4	3.0	3.1	3.2	3.1	3.9	3.1		DPH, Health Information Systems & Reporting, Annual AAMR Reports and Age-specific Mortality Reports	All death rates except those for specific age groups were age-adjusted to the 2000 U.S. standard population.
Males	-	-	6.1	4.3	5.3	4.8	4.3	4.6	4.9	5.8	4.4			
Females	-	-	1.3	1.4	1.4	1.2	2.0	1.7	1.3	1.9	1.7			
Children 0-4 yrs	-	-	2.2	0.9	1.8	0.9	2.4	2.8	2.4	1.0	2.4			
Black males, 15-34 yrs	-	-	65.2	60.6	71.3	55.8	44.5	54.9	71.8	86.9	42.9			
Black females, 15-34 yrs	-	-	8.0	8.0	4.0	3.9	7.8	11.6	1.9	7.5	3.7			
Hispanic males, 15-34 yrs	-	-	30.6	18.5	16.0	20.1	16.7	21.3	19.5	23.1	18.9			
White males, 15-34 yrs	-	-	5.0	4.7	10.8	8.2	4.4	9.2	6.6	7.9	6.8			
Suicides (Deaths per 100,000 population)														
(Objective 18-1)														
Both sexes	-	-	7.8	8.7	8.1	7.3	7.3	7.9	7.6	7.5	7.0		DPH, Health Information Systems & Reporting, Annual AAMR Reports and Age-specific Mortality Reports	All death rates except those for specific age groups were age-adjusted to the 2000 U.S. standard population.
Male	-	-	13.2	14.7	13.9	12.1	11.6	13.1	12.5	12.7	11.5			
Female	-	-	3.1	3.4	2.9	3.0	3.4	3.3	3.2	2.8	2.8			
Males, 15-19 yrs	-	-	7.3	10.7	16.6	7.6	3.3	4.0	6.3	11.0	10.9			
Males, 20-24 yrs	-	-	15.5	15.1	15.1	12.5	13.9	18.1	13.0	15.3	12.3			
Males, 65+ yrs	-	-	116.6	121.7	123.5	103.3	71.9	89.4	85.1	84.4	83.6			
Attempted suicide (%)														
(Objective 18-2)														
Students, Grades 9-12														
Both sexes	9.1	-	-	-	-	-	-	-	12.1	-	9.8	7.4	2009 YRBS Trend Analysis Report	Attempted suicide one or more times during the past 12 months.
Males	5.6	-	-	-	-	-	-	-	12.0	-	10.2	7.5		
Females	12.5	-	-	-	-	-	-	-	11.8	-	9.2	7.3		
White non-Hispanic	8.1	-	-	-	-	-	-	-	11.5	-	8.8	6.1		
Black non-Hispanic	-	-	-	-	-	-	-	-	11.5	-	10.3	9		
Hispanic	17.6	-	-	-	-	-	-	-	14.8	-	10.7	12		
LEADING CAUSES OF UNINTENTIONAL INJURY														
(Deaths per 100,000 population)														
Accidental poisoning	-	-	6.8	7.6	6.8	8.8	7.4	8.5	7.4	9.7	10.8		DPH, Health Information Systems & Reporting, Annual AAMR Reports	All death rates were age-adjusted to the 2000 U.S. standard population.
Motor vehicle crashes	-	-	7.4	9.2	9.2	9.9	7.9	9.4	8.1	9.6	8.3			
Falls	-	-	3.6	4.1	4.7	4.3	4.2	5.0	5.0	5.8	6.7			
Suicide	-	-	7.8	8.7	8.1	7.3	7.3	7.9	7.6	7.5	7.0			
(Number of Deaths)														
Unintentional poisoning	-	-	235	264	235	302	261	294	256	346	378		DPH, Health Information Systems & Reporting, Annual Registration Reports	
Motor vehicle crashes	-	-	248	311	307	338	270	330	285	342	294			
Falls	-	-	136	158	184	173	177	219	217	243	281			
Suicide	-	-	271	303	280	258	267	288	277	277	259			

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Data Source	Comments
8 ENVIRONMENTAL QUALITY														
Exposure to second-hand smoke (%) **(Objective 27-10)**														
Adults 18+ yrs														
Indoor workplace exposure	-	-	-	-	-	-	-	-	-	-	6.4	-	2008 Connecticut Behavioral Risk	
Home exposure	-	-	-	-	-	-	-	-	-	-	5.0	-	Factor Surveillance System	
Non-smoking Students, Grades 6-8														
Live with smokers (Gr. 6-8)	-	-	-	-	40.5	-	-	35.1	-	31.3	-	31.9	DPH Tobacco Program, Connecticut	"In room..." and "In car..." refer
In room with smoking (Gr. 6-8)	-	-	-	-	47.9	-	-	42.9	-	37.7	-	35.3	Youth Tobacco Surveys, 2002-2009	to recent exposures, on 1 or
In car with smoking (Gr. 6-8)	-	-	-	-	34.5	-	-	29.5	-	24.4	-	23.9		more of past 7 days.
Non-smoking Students, Grades 9-12														Data for non-smoking students only.
Live with smokers (Gr. 9-12)	-	-	-	-	31.8	-	-	30.3	-	32.6	-	31.0		
In room with smoking (Gr. 9-12)	-	-	-	-	57.6	-	-	51.4	-	50.9	-	48.4		
In car with smoking (Gr. 9-12)	-	-	-	-	35.9	-	-	33.2	-	32.8	-	27.1		
Asthma hospitalizations (Per 100,000 population) **(Objective 24-2)**														
Both sexes	-	-	114	116	128	138	125	129	138	136	-	-	DPH, Health Information Systems &	for all but specific age groups
Male	-	-	93	94	103	115	103	105	116	110	-	-	Reporting, Hospitalization Statistics,	were age-adjusted to the U.S.
Female	-	-	134	137	152	160	145	153	158	157	-	-	Tables H-1, H-1AA, and H-2; DPH,	2000 standard million
0-4 yrs	-	-	297	348	382	376	327	321	373	364	-	-	Health Education, Management, and	population.
0-17 yrs	-	-	163	170	188	190	175	165	190	178	-	-	Surveillance, *Asthma in*	
65+ yrs	-	-	127	125	145	183	183	208	196	209	-	-	*Connecticut, 2008: A Surveillance*	
White, non-Hispanic	-	-	78	77	85	96	83	88	85	80	-	-	*Report.* 2006 and 2007 rates for	
Black, non-Hispanic	-	-	258	275	310	316	317	320	338	331	-	-	age 0-17 provided by J. Olson	
Hispanic	-	-	258	271	302	301	266	255	352	408	-	-	(personal communication).	
Ozone Exceedance Days (Objective 8-1a)														
Number of days	25	33	15	26	36	14	6	20	13	17	22	6	Connecticut Department of Environmental Protection, Bureau of Air Quality Management. Annual Summary Information for Ozone. www.ct.gov/dep/air	Ozone Exceedance Days = Number of days that the 8-hr average concentration of ozone in the air in Connecticut exceeded the federal standard (84 ppb through 2007 and 75 ppb from 2008 forward).

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Data Source	Comments
9 IMMUNIZATION													
4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 HepB Vaccines (%) **(Objective 14-24a)**													
Children 19-35 months	82.3	81.6	78.4	72.8	89.1	84.8	81.5	81.8	86.8	69.8	-	CDC, National Immunization Survey. Estimated vaccination coverage with individual vaccines and selected vaccination series among children 19-35 months of age by state. http://www.cdc.gov/vaccines	Received recommended number of vaccines for: diphtheria, tetanus toxoids, and acellular pertussis; poliovirus; measles-mumps-rubella; Haemophilus influenzae type b; and hepatitis B. Varicella vaccine added after 2001.
Influenza Vaccine (%) **(Objective 14-29a)**													
Adults 65+ yrs													
Both sexes	64.8	-	69.1	71.4	74.3	73.1	71.1	71.1	74.7	74.6	73.6	CDC, BRFSS Prevalence and Trends http://apps.nccd.cdc.gov/BRFSS/	Adults 65+ yrs of age who had a flu shot in past year.
Male	64.8	-	71.5	70.9	74.4	76.8	75.1	72.4	76.6	76.7	76.1		
Female	64.7	-	67.5	71.8	74.3	70.5	68.3	70.2	73.3	73.1	71.9		
White, non-Hispanic	64.0	-	70.0	72.1	75.7	73.4	72.1	72.5	75.1	75.6	74.5		Percentages could not be calculated for black non-Hispanic and Hispanic respondents because of small sample sizes.
Black, non-Hispanic	-	-	-	-	-	-	-	-	-	-	-		
Hispanic	-	-	-	-	-	-	-	-	-	-	-		
Pneumoccal Disease Vaccine (%) **(Objective 14-29b)**													
Adults 65+ yrs													
Both sexes	49.0	-	63.3	64.5	64.5	67.8	69.3	68.1	64.9	66.8	68.5	CDC, BRFSS Prevalence and Trends http://apps.nccd.cdc.gov/BRFSS/	Adults 65+ yrs of age who ever had a pneumonia vaccination.
Male	47.3	-	64.3	59.8	61.8	69.5	69.5	64.1	64.1	65.4	66.7		
Female	50.0	-	62.6	67.7	66.3	66.6	69.1	70.8	65.4	67.8	69.7		
White, non-Hispanic	48.9	-	63.8	67.1	66.3	68.8	70.7	70.3	66.1	68.4	69.3		Percentages could not be calculated for black and Hispanic respondents because of small sample sizes.
Black, non-Hispanic	-	-	-	-	-	-	-	-	-	-	-		
Hispanic	-	-	-	-	-	-	-	-	-	-	-		

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Data Source	Comments
10 ACCESS TO HEALTH CARE													
Persons with health insurance (%) **(Objective 1-1)**													
Children 0-18 yrs	-	-	-	92.0	91.8	91.3	91.8	92.9	93.9	93.9	-	U.S. Census Bureau, American Community Survey. Trend data provided by Lindsay Donaldson, Kaiser Family Foundation.	Estimates of uninsured children are based on pooled date from the indicated and prior years (i.e., 2001-2002 to 2007-2008).
Adults 18-64 yrs													
Both sexes	87.7	89.4	-	-	87.5	88.7	89.4	87.9	89.0	90.0	88.8	CDC, BRFSS Prevalence and Trends http://apps.nccd.cdc.gov/BRFSS/	Any kind of health care coverage.
Male	85.2	87.7	-	-	84.8	85.7	89.0	86.7	86.9	88.2	87.3		
Female	90.3	91.0	-	-	90.2	91.5	89.8	89.1	90.9	91.7	90.3		
White, non-Hispanic	90.7	92.5	-	-	91.7	91.7	92.3	92.5	92.6	92.4	91.9		
Black, non-Hispanic	80.0	83.4	-	-	79.2	77.6	83.7	82.6	75.8	78.1	76.8		
Hispanic	71.2	72.2	-	-	61.8	67.0	68.1	57.8	64.7	73.9	68.5		
Persons with a specific source of ongoing care (%) **(Objective 1-4)**													
Adults 18+ yrs													
Both sexes	-	-	-	85.0	86.3	86.6	87.5	86.6	86.3	87.5	87.3	BRFSS, Connecticut Core Questions Data Reports, 2002-2009	Adults with one or more personal doctors or health care providers. Hispanics consistently had lower percentages, compared to other racial/ethnic and sociodemographic groups.
Male	-	-	-	80.7	82.2	82.1	83.7	82.7	83.7	83.1	83.9		
Female	-	-	-	88.9	90.1	90.8	91.0	90.1	88.7	91.6	90.5		
White, non-Hispanic	-	-	-	88.8	89.3	89.8	89.6	90.3	89.5	89.4	89.6		
Black, non-Hispanic	-	-	-	80.7	80.2	79.0	89.0	79.2	79.9	82.3	82.2		
Hispanic	-	-	-	51.3	66.7	60.6	62.1	60.2	59.0	73.9	70.1		
Prenatal care beginning in first trimester of pregnancy (%) **(Objective 16-6a)**													
All races	89.2	89.6	88.8	88.5	88.6	87.2	86.8	85.8	86.5	-	-	DPH, Health Information Systems & Reporting Section. Analysis of Initiation of Prenatal Care (unpublished).	Data based on women who delivered live births.
Non-Hispanic													
White	93.2	93.1	92.5	92.4	92.7	92.4	92.0	91.5	91.6	-	-		
Black	81.5	82.8	82.3	82.7	81.4	77.3	75.6	74.8	76.6	-	-		
American Indian	86.1	80.0	82.6	88.8	85.4	85.0	88.2	85.2	86.5	-	-		
Asian	87.2	89.2	87.8	88.7	89.0	86.0	88.2	86.8	87.0	-	-		
Hispanic	78.3	79.5	78.8	77.4	78.2	75.7	76.0	75.1	77.9	-	-		