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Introduction

The first release of the *Community Report Card for Western Connecticut* in 2009 established a baseline profile of community health in the Housatonic Valley Region (HVR) by assessing key demographic, socioeconomic, and health status indicators. The HVR is comprised of ten distinct municipalities (herein referred to as the "community") including: Bethel, Bridgewater, Brookfield, Danbury, New Fairfield, New Milford, Newtown, Redding, Ridgefield and Sherman. The *2009 Community Report Card* focused on indicators in the following areas:

- *Economic Stability*
- *Education*
- *Health Status*
- *Health and Lifestyle Behaviors and Risk Factors*
- *Diseases*

The *2012 Community Report Card for Western Connecticut* contains an update of the original key indicators, and integrates relevant findings from selected national and state health assessments and surveys, and the U.S. Census. Comparison of trends for the same indicators over time permits health, human services, and community leaders to measure improvements, identify disparities, and establish priorities to improve the health-related quality of life and well-being of residents throughout the region. This includes collaboration among health and community leaders to identify opportunities to improve access to health-related services, cost-effectiveness of services, and service quality.

This report was commissioned by the City of Danbury Health and Human Services Department, Western CT Health Network/ Danbury Hospital-New Milford Hospital, United Way of Western Connecticut, and Western Connecticut State University (WCSU). The collective thoughts, opinions, and expertise of a regional Steering Committee – including health care providers, educational institutions, community-based providers, and local government agencies – guided the development of this report. The Community Report Card represents a collaborative effort of community members, leaders, and organizations whose mission is to identify priority health needs in the region and mobilize resources to address those needs.

Objectives

The major objectives of the *2012 Community Report Card for Western Connecticut* are to:

1. Provide a narrative and statistical update of key indicators in the areas of economic stability, education, health status, behavioral risk factors, and diseases for HVR residents.

2. Provide current recommendations on how provider and community partnerships could improve the health and well-being of HVR residents.

3. Provide more in-depth insight on the health and social needs of older adults living in our community.

Methods

The *Report Card* combines narrative information and statistical data (tables, charts, and graphs) drawn from local, state, and federal sources. The report is intended to be descriptive and not analytical; therefore data is presented for general reference and, in most instances, has not been analyzed for statistical significance. Whenever possible, indicators are presented at the municipal (town or city) level. In the case of certain indicators, the statistical data is not available for lesser populated towns. In addition, health data is not published at the town level when there are a very small number of events, due to validity and confidentiality concerns. State and federal statistics are also included for certain indicators to provide a perspective on how the Housatonic Valley Region compares to the state and nation. The process of how the indicators were selected is described in the initial version of the Report Card (2009). For this Report, the data was obtained from the original sources when available. If the data was no longer available from the original source then searches were conducted and the new source is noted. There are some indicators where the data was collected in a different manner; in these instances an explanation is included to describe the changes and any implications.

With the growth in the population ages 65 and over in the region, the 2012 version of the Community Report Card contains a section specifically dedicated to the health of older adults. "Seniors in our communities are healthy and thrive" is the vision statement crafted by the Steering Committee for the older adult component of the *2012 Community Report Card*. Four topics were identified to enable public health, hospitals, human service providers, and the general public to better assess if older adults in the region exemplify this vision statement:

➢ *Housing.* This includes availability of housing options, skilled nursing, assisted living, and hospice facilities.

➢ *Support Services.* This includes services which promote access to health care and human services, such as public transportation, fuel assistance, Meals on Wheels, senior centers, etc.

➢ *Quality of Life.* This includes demographics, socioeconomic status, social supports, recreation, and spirituality.

➢ *Physical and Mental Health*. This includes risk factors, disease (morbidity) and death (mortality) rates.

Methods, cont'd.

The survey design team at WCSU reviewed published senior health report cards to select indicators for an Older Adult Health Survey. These included the Naugatuck Valley 2007 *Senior Needs Assessment* http://www.valleyunitedway.org/2007/SeniorNeedsExecutive Summary.pdf, *Seniors in Canada 2006 Report Card* http://dsp-psd.pwgsc.gc.ca/Collection/HP30-1-2006E.pdf, and *Improving Health Literary for Older Adults*, *2009* http://www.cdc.gov/healthmarketing/healthliteracy/reports/olderadults.pdf.

After selection of relevant indicators, Senior Center and Social Services Directors from HVR municipalities reviewed both the topics and the indicators and commented on the usefulness of compiling information on these indicators. Feedback confirmed that the needs of older adults are covered by the four topics and the indicators were then finalized.

Older Adult Health surveys were developed by the project team at WCSU from validated survey instruments for completion by older adults throughout the region. Long and short versions were developed for a general health and a general health plus dental survey. An effort was made to distribute surveys equally across all 10 HVR municipalities based on the population ages 65 and older. The target population was older adults who had the ability to complete the survey and also had an understanding of the needs in their community. Ninety-one sites were identified for survey administration. Although many sites were interested in receiving the results of the survey, permission to conduct the surveys was obtained from only 20 of these sites and completed surveys were received from only 10 sites. A total of 123 surveys were received. The majority of these surveys were collected at a regional volunteer recognition luncheon. Although this is not a representative sample of the older adult population in the HVR, as community volunteers, survey respondents are potentially more aware of available services and service gaps. Survey results are presented in The Older Adult Health Survey and Focus Group Summary section of this report.

Health: A Definition

The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."
(http://www.who.int/governance/eb/who_constitution_en.pdf)

The phrase "health status" refers to the current condition of wellness and illness in our community, which is defined by measures of both positive and harmful behaviors, the existence of symptoms and conditions of illness and wellness, and the prevalence of specific diseases.

Findings and Recommendations

The findings and recommendations presented in this report are designed to promote discussion among all stakeholders on the health and well-being of the community as well as access and quality of health delivery systems in the region. The overarching intent is to identify priority needs for health improvement within the Housatonic Valley Region and provide a starting point for a more comprehensive health assessment in the future.

Looking Back

In April 2011, health care provider agencies and community members were asked to participate in a brief questionnaire as past recipients of the *2009 Community Report Card for Western Connecticut*. This survey was designed to capture perspectives on the value of the Report Card, i.e., how its content was used to support grant requests and funding, foster alignment of programs and services and partnerships, and advance a particular community health improvement initiative. Assessment of progress towards the five key consensus recommendations of community stakeholders presented in the *2009 Community Report Card* was also part of the survey. A 29% response rate was achieved (133 distributed surveys with 38 completed) and respondents included health care providers, community agencies, and community members.

The majority of respondents (63%; 24 individuals) indicated that they had received a copy of the *2009 Community Report Card for Western Connecticut*. Of the individuals who indicated they did not receive a copy, nearly half noted they had heard of the Report Card. An overwhelming majority (97%) indicated they would like to receive a future version of the Report Card. A summary of all survey respondent findings, including reported progress towards the 2009 Report Card's consensus recommendations, follows.

1. Use of the Community Report Card

More than half of the respondents (54%) indicated they had utilized information provided in the Report Card during the past two years. The primary use was for discussion purposes, followed by facilitation of program development/ implementation and funding requests, and education about community needs.

2. Five Key Recommendations

Recommendation # 1 - The community should capitalize on existing collaborations, initiatives, partnerships and programs to develop and embrace educational strategies across a broad continuum of providers that will expand and strengthen the focus on prevention, particularly targeting childhood obesity, heart disease, cancer, diabetes, and tick-borne illness.

Twenty-two (22) respondents indicated they had developed or partnered with another entity to address one of the recommended programs: Childhood Obesity (18), Diabetes (9), Heart Disease (8), Tick-borne Illness (8) and Cancer (7).

Highlights of programs and/or partnerships cited include the United Way Obesity initiative; HVCEO Tick Illness Prevention Task Force; Ridgefield BLAST Lyme program; WCSU Health Service "biggest loser" program; Connecticut Institute for Communities, Inc. colorectal cancer screening and establishment of a

Looking Back, cont'd.

Federally Qualified Community Health Center; Danbury Public Schools School-Based Health Centers and American Heart Association and American Cancer Society's awareness activities targeting the school age population; Ann's Place partnership with the Hispanic Center to address the needs of Hispanic/Latino cancer survivors; Americas Free Clinic emphasis on outreach and care for uninsured diabetics; Town of New Milford Walking Project; Town of Bethel 2-1-1 referral program; Regional YMCA of Western Connecticut Coalition for Healthy Kids and Diabetes Self-Management Education program with Danbury Hospital; and Danbury Hospital's Healthy Heart screening and education initiatives.

Recommendation # 2 – Data indicates the Greater Danbury area generally is very healthy across many indicators, including the 10 leading causes of death. Public health, hospitals and human services providers should be recognized for their efforts toward preventive, interceptive and ongoing care and supports for our community. They should also continue to strive for ways to maintain existing and pertinent programs and to find new and creative solutions to address emerging needs.

Nearly two-thirds (65%) of respondents indicated they implemented ways to maintain existing and pertinent programs. Seventeen (17) individuals indicated they found solutions to address emerging needs.

Recommendation # 3 – While indicators show the community has fairly substantial access to care in our region, lacking health insurance should not be a barrier to receiving care. The community should continue to work toward ensuring access to quality,

affordable care for residents. The community should make the public better aware of state health insurance initiatives such as HUSKY and Charter Oak in a continuing effort to bridge barriers to care.

The majority of respondents (72%) indicated they have undertaken efforts to make the community more aware of health insurance initiatives.

Activities identified include evaluating clients for eligibility for public assistance and increasing awareness of state insurance initiatives. Specifics cited include Newtown's parent awareness of HUSKY programs as part of Free and Reduced Lunch programs; Danbury Department of Health and Human Services TB clinic referrals to Danbury Hospital's Financial Counseling; Danbury Housing Partnership educating the public on housing and homeless issues; the 3Rs collaborative and Danbury Children First's dissemination of information about HUSKY and pediatric clinics at events and through their Parent to Parent Newsletter; Women's Center of Greater Danbury referrals for resources; Boys & Girls Club of Ridgefield newsletter link to the no-cost and anonymous screener: www.qualify4care.com; Town of Bethel referral to 2-1-1 if the health department does not have the specific referral information sought; and Danbury Hospital's Families Network at Children's Day.

Recommendation # 4 - The community should develop a plan to better promote 2-1-1 (United Way Info Line) as a source for available services for the general provider populations.

Approximately 75% of respondents have not yet developed a plan to promote Info Line. Ten (10) individuals noted they provided

Looking Back, cont'd.

specific presentations at networking meetings, written identification in communications such as program directories, workplace campaigns, electronic communication, newsletters and annual reports, Development of referral procedures for handling information requests and a reference directory of current health information, subject matter experts and agency information to provide residents/others to assure they receive the information they need to help themselves was also noted.

> **Recommendation # 5 - The Community Report Card for Western Connecticut should be used as a source of information and a forum for education that spurs discussion and moves all stakeholders into action, and it should be revised biennially.**

An overwhelming majority indicated support for ALL of the initiatives for helping the community prepare for future reports. These include collecting community-specific data where there is none; determining "target" populations and collecting relevant data for these populations; conducting focus groups with target populations; prioritizing needs; conducting a Resource Assessment (scan of what resources are available) and identifying unmet needs and creating a plan to address them; identifying evidence-based strategies/programs to meet the needs and evaluating programs and monitoring indicators.

Respondents noted that while all of the activities are possible and desirable, sufficient human and financial resources and the right leadership are needed to implement and sustain these activities. Highlights include:

- *Success is dependent on key stakeholders being on board and adequate resources being available.*

- *This requires organization, motivation and support.*

- *Collaborative, facilitated community conversations can lead to prioritization of needs, joint data gathering exercises, and resource assessments.*

- *There are many services in our area but there are many who are not aware of them. Efforts should be made to broaden awareness and utilize many of the individual agency efforts as a starting point.*

- *The community should and can prepare for future reports, by expanding the Steering Committee (in numbers and scope) and build on the foundation of the first Community Report Card.*

- *To improve health disparities, it is important to collect more in-depth data especially through focus groups to better align community resources with gaps identified by the community.*

- *The Community Health Committee representing the towns and cities should use a community health linkages model to obtain data and support to refine what the area health problems are and the priority list with a targeted plan of action.*

Moving Forward

Connecticut Health Rankings

According to the United Health Foundation, in 2011 Connecticut ranks third in health status in the country overall, a continued positive trend from the 2009 seventh rank and 2010 fourth rank. Strengths include low rates of smoking, a lower prevalence of obesity when compared to other states in the nation, a low percentage of children in poverty, a low rate of uninsured population, high immunization coverage, and relatively high proportion of primary care physicians. Areas where improvement is needed include a high prevalence of binge drinking and moderate levels of air pollution. The report indicates that Connecticut has demonstrated success in reducing deaths from cardiovascular disease and cancer and, in the past ten years, smoking prevalence has decreased dramatically. Although Connecticut has a relatively low rate of uninsured, the percent uninsured has increased from 9.7% in 2009 to 11.1% in 2011. Highlights include:

- While Connecticut has one of the lowest obesity rates in the U.S., 634,000 adults in Connecticut are obese, an increase of 188,000 individuals in the past 10 years.

- In the past year, smoking decreased from 15.4 percent to 13.2 percent of adults. There are 364,000 adults in Connecticut who still smoke.

- In the past year, diabetes increased from 6.6 percent to 7.3 percent of adults. There are 201,000 adults in Connecticut who have diabetes.

- Compared to other health measures, the rate of preventable hospitalizations remains high in Connecticut at 63.1 discharges per 1,000 Medicare enrollees.

- Health Disparities - In Connecticut, obesity is more prevalent among non-Hispanic blacks at 39.5 % than non-Hispanic whites at 20.8 %. Diabetes also varies by race and ethnicity in the state; 11.5 % of non-Hispanic blacks have diabetes compared to 6.7 % of non-Hispanic whites.

Source: United Health Foundation (2011) *"America's Health Rankings®: A Call to Action for Individuals and Their Communities" 22nd edition* http://www.americashealthrankings.org/CT/2011, *accessed 1/12/12).*

Healthy People 2010 and 2020

Any report of community health indicators should include *Healthy People 2010* and *Healthy People 2020*. This comprehensive set of national disease prevention and health promotion goals for the nation targets measureable health objectives in 28 focus areas. The final Healthy People 2010 report and the newly released objectives for Healthy People 2020 can be accessed at http://www.healthypeople.gov.

The overarching goal of *Healthy People 2020* is to increase both the quality and years of healthy life, and eliminate health disparities. A report on statewide progress towards achievement of *Healthy People 2010* targets was compiled by the CT Department of Public Health in June 2010. Findings from this report, *Healthy Connecticut 2010*, are incorporated into the Report Card sections as relevant. The entire report is available at: http://www.ct.gov/dph/lib/dph/state_health_planning/healthy_people/hct2010_final_rep_jun2010.pdf.

Our Community
Population

The Housatonic Valley Region (HVR) comprises ten municipalities in western Connecticut in close proximity to the New York metropolitan area.

Data from the United States Census Bureau shows that as of 2010, the population of this region was 224,616, an increase of 12,368 since Census 2000. The HVR has grown at a faster rate than any other region in Connecticut. In the 1950s these 10 communities represented only 2.9% of Connecticut's population; in 2000 they represented 6.2% of the state population. This growth trend continued through 2010 at which time they represented 6.6% of the state population. By 2030, the HVR is projected to be at 7.1% of the state population. Table 1 outlines projections to the year 2030 compiled by the Connecticut State Data Center. It is important to note that these projected population numbers are derived from historical patterns of population change and that there is no guarantee that past patterns will hold constant in the future.

Table 1: Population Projections for HVR Municipalities, 2015-2030					
Town	Census 2010 Population	2015	2020	2025	2030
Bethel	18,584	22,486	24,223	25,779	26,878
Bridgewater	1,727	2,057	2,134	2,216	2,271
Brookfield	16,452	17,756	18,424	19,065	19,644
Danbury	80,893	79,403	81,665	83,813	85,754
New Fairfield	13,881	15,196	15,624	16,012	16,249
New Milford	28,142	31,156	32,562	33,953	35,173
Newtown	27,560	30,147	32,242	34,242	36,161
Redding	9,158	8,092	7,721	7,436	7,225
Ridgefield	24,638	25,676	26,483	27,142	27,729
Sherman	3,581	4,430	4,586	4,724	4,823
HVR Totals	224,616	236,399	245,664	254,382	261,907
Connecticut	3,408,029	3,573,885	3,622,774	3,669,990	3,702,400

Source: Connecticut State Data Center, University of Connecticut, http://ctsdc.uconn.edu/projections/ct_towns.html, accessed 5/28/2011

Our Community cont'd.

Demographic Profile
Ethnicity and Race

The Housatonic Valley Region has become much more ethnically diverse in recent years. From 2000 to 2010, the Black/African American population in the region increased from 6,527 to 7,671, or 17.5% of the total population. In 2010, 75.6% of the region's Black/African American population resided in Danbury. The Hispanic/Latino population in the region nearly doubled from 2000 to 2010, and currently comprises 12% of the region's population. Three-fourths of the Hispanic/Latino population in the region resides in Danbury. In 2000, Hispanic/Latino residents in the region represented many nationalities; the groups with the largest populations in the region are Puerto Rican (19% of the total Hispanic/Latino population), Ecuadorian (15%), Dominican (14%), and Mexican (12%). The region also had a substantial population of residents of Irish, Italian, German, and Polish ancestry in 2000 – 23%, 20%, 17%, and 6% respectively. (Source: Housatonic Valley Council of Elected Officials, http://hvceo.org/tables/TABLE_P18.php http://hvceo.org/tables/TABLE_P20.php Accessed 8/7/11.)

Note: At the time of publication, Census 2010 data on ancestry was not yet available, so no comparisons of growth in specific nationalities are available.

Age

The population distribution among age groups in the region is similar to the distribution in the state and in the nation. However, four communities in our region have a larger percentage of adults in the 50 and over range than either the state (34.4%) or the nation (33.3%). Bridgewater has the highest percentage of adults over the age of 50 with 49.1% of the population in this category, followed by Sherman (39.4%), Redding (36.8%), and Brookfield (35.3%). As expected, the median age in these communities is also higher than the state average. Communities with older populations usually have a greater demand for health care services, in the present and in the future. The proportion of each HVR municipality population by age range in 2010 is shown graphically below:

Figure 1: HVR Municipality Population by Age, 2010

Source: Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 4/11/2011
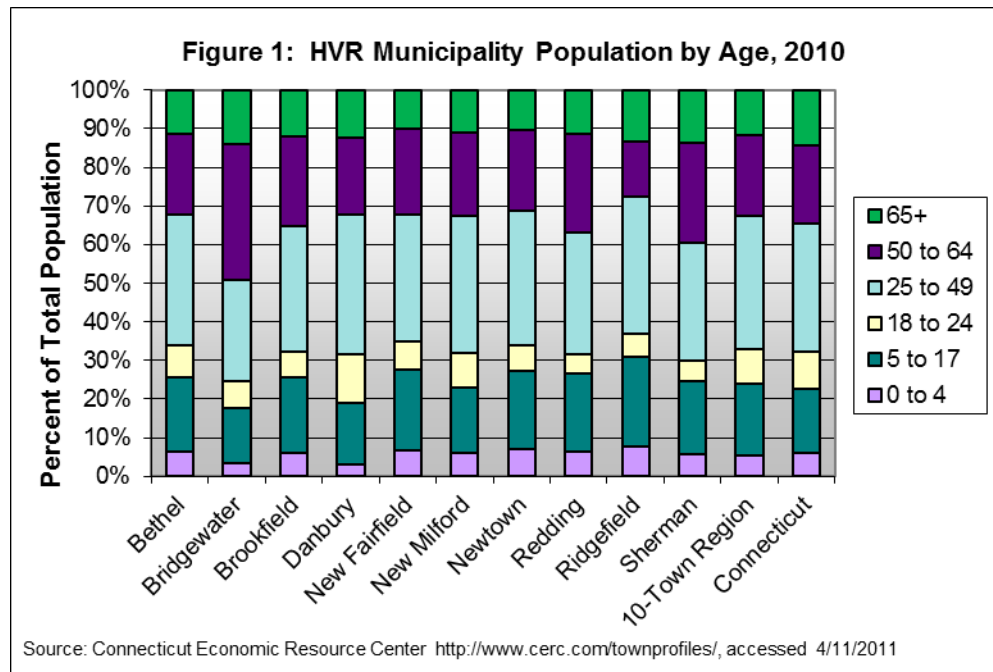
Our Community cont'd.

Age, cont'd.

Median age projections for the HVR as compiled by the CT Data Center for 2000-2030 show an overall increasing trend through 2015, influenced by factors such as aging in the "baby boomer" generation and the state's declining birth rate.

Figure 2: Area Median Age 2000 to 2030
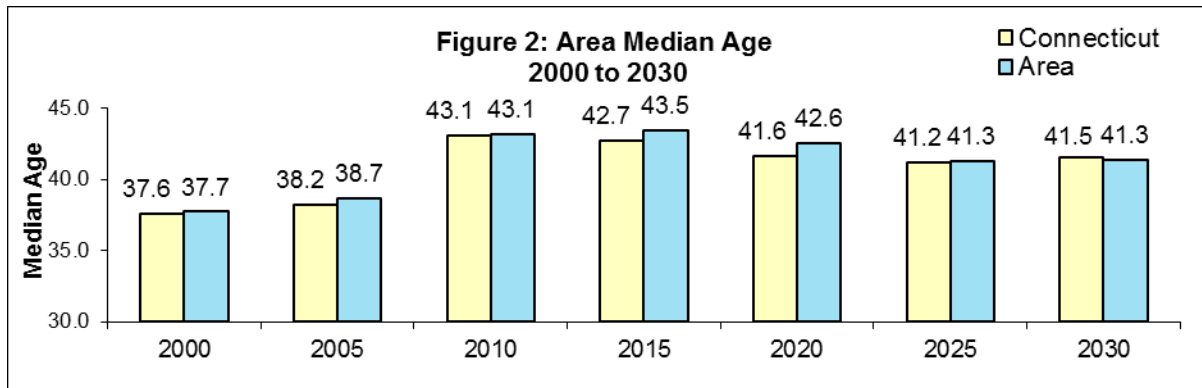
Population Trends

Careful examination of changes in population statistics over time, or temporal trends, is an important component of community health assessment and planning. A summary of population trends in HVR municipalities over the past decade by race/ethnicity follows.

Municipality	Total Census Population*		White Population		Black/African American Population		Asian Population		Hispanic/Latino Population	
	2000	2010	2000	2010	2000	2010	2000	2010	2000	2010
Bethel	18,067	18,584	16,692	16,504	228	343	641	833	669	1,419
Brookfield	15,664	16,452	14,926	15,285	119	177	388	598	372	710
Danbury	74,848	80,893	56,853	55,202	5,060	5,803	4,082	5,474	11,791	20,185
New Fairfield	13,953	13,881	13,511	13,161	54	149	177	232	393	611
Newtown	25,031	27,560	23,815	25,914	437	444	351	648	590	1,033
Redding	8,270	9,158	7,952	8,693	62	63	147	200	122	237
Ridgefield	23,643	24,683	22,726	23,147	146	179	492	788	465	941
Sherman	3,827	3,581	3,726	3,469	21	15	26	35	66	76
Bridgewater	1,824	1,727	1,779	1,681	17	14	13	16	9	26
New Milford	27,121	28,142	25,583	25,809	383	484	518	779	751	1,693
HVR Total	212,248	224,661	187,563	188,865	6,527	7,671	6,835	9,603	14,477	26,931

Table 2: HVR Municipality Census 2000 and 2010 Population Counts by Race/Ethnicity

Source: CT State Data Center, University of Connecticut, http:// ctsdc.uconn.edu/.../2010_2000_PL_Census_data_comparison_towns, accessed 1/12/12

* Note - subgroup population numbers do not equal the total population numbers as ethnic/racial subgroups with fewer than 10 residents for one or more municipalities and "other" were not included.

Our Community, cont'd.

Population Trends, cont'd.

In interpreting the significance of the percentage change in population by racial/ethnic subgroup, it is important to also reference the absolute change in population numbers from 2000 to 2010 to gain perspective. Even small numeric changes in events with fewer occurrences may result in large percentage changes. This is referred to as small numbers effect or phenomenon. For example, a numeric increase of 10 from 10 to 20 represents a 100% increase, as does a numeric increase of 1,000 from 1,000 to 2,000.

Table 3: HVR Municipality Census 2000 and 2010 Number and Percentage Population Change										
Municipality	**Total Population**		**White Population**		**Black/African American Population**		**Asian Population**		**Hispanic/ Latino Population**	
	Number Change	**% Change**	**Number Change**	**% Change**	**Number Change**	**% Change**	**Number Change**	**% Change**	**Number Change**	**% Change**
Bethel	517	2.9	-188	-1.1	115	50.4	192	30.0	750	112.1
Brookfield	788	5.0	359	2.4	58	48.7	210	54.1	338	90.9
Danbury	6,045	8.1	-1,651	-2.9	743	14.7	1,392	34.1	8,394	71.2
New Fairfield	-72	-0.5	-35	-2.6	95	175.9	55	31.1	218	55.5
Newtown	2,529	10.1	2,099	8.8	7	1.6	297	84.6	443	75.1
Redding	888	10.7	741	9.3	1	1.6	53	36.1	115	94.3
Ridgefield	995	4.2	421	1.9	33	22.6	296	60.2	476	102.4
Sherman	-246	-6.4	-257	-6.9	-6	-28.6	9	34.6	10	15.2
Bridgewater	-97	-5.3	-98	-5.5	-3	-17.7	3	23.1	17	188.9
New Milford	1,021	3.8	226	0.9	101	26.7	261	50.4	942	125.4
HVR Total	12,413	5.9	1,302	0.7	1,144	17.5	2,768	40.5	12,454	86.0

Source: CT State Data Center, University of Connecticut, http://ctsdc.uconn.edu/.../2010_2000_PL_Census_data_comparison_towns, accessed 1/12/12

Overall, review of population changes from 2000 to 2010 indicate that there is considerable variation in population growth rates among HVR municipalities as well as increasing ethnic and racial diversity throughout the region. The most consistent population growth in the region has occurred in Asian and Hispanic/Latino subgroups. In addition, the population growth rate for the region has slowed over the past decade at 5.8% compared with 13% from 1990 to 2000. Additional population statistics for the region are available at http://www.hvceo.org/areainfo.php.

Economic Stability: Indicators and Findings

It is well documented that persons of higher socioeconomic status are more likely to have health insurance, participate in health screenings and regular health care, obtain a higher level of education, reside in safer neighborhoods, and exhibit healthier personal lifestyle habits. In sharp contrast, persons living in poverty tend to have fragmented health care; low educational attainment; live in substandard housing and unsafe neighborhoods; and experience higher rates of unemployment, crime, tobacco use, substance abuse, mental illness, and certain chronic health conditions such as obesity and diabetes. *Healthy People 2010 and 2020* both emphasize the inseparable connections among individual health status and the social factors and physical conditions in the environment in which people are born, live, learn, play, work, and age.

Income and Poverty

The median household income in the region varies widely. In 2010, the annual household median income in HVR municipalities ranged from a low of $62,582 in Danbury to a high of $131,677 in Ridgefield. All municipalities except Danbury have median household incomes well above the state and national average. As indicated in Figure 3, since 2009 there has been a decline in the median household income in all HVR communities with the exception of Bridgewater. Danbury and New Milford experienced the smallest decline.

Figure 3: Median Household Income, 2007 - 2010

Source: Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 3/23/2011 + e-mail communication from Dale Shannon, Senior Economist CERC 6/6/2011
* United States Census Bureau Median Household Income 1-year Estimates http://www.census.gov/did/www/saipe/county.html accessed 6/9/2011
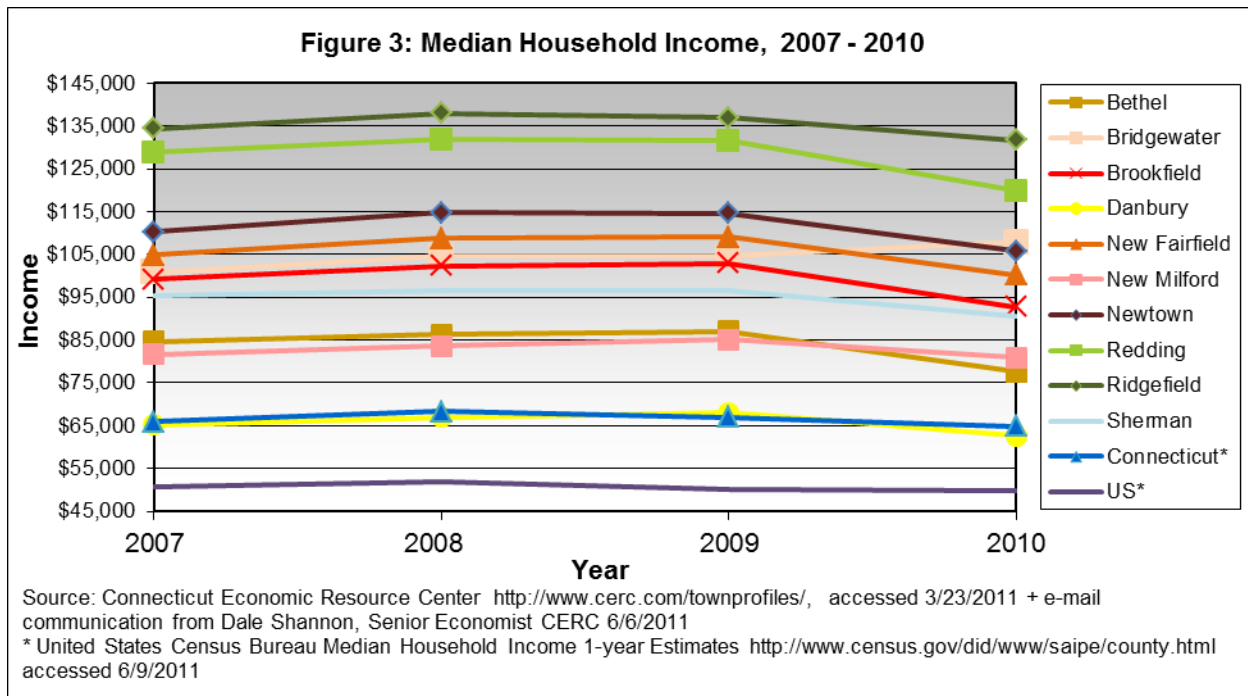
Economic Stability: Indicators and Findings, cont'd.

Income and Poverty, cont'd.

In 2012, the official U.S. federal poverty level for a family of four was set at an annual income of $23,050 or less. (Source: US Department of Health and Human Services http://aspe.hhs.gov/ poverty/ 12poverty.shtml, accessed 1/27/2012). In geographic areas with a high cost of living such as our region, even persons living above 200% of the poverty level struggle to make ends meet. The federal poverty guidelines, or percentage multiples of them (such as 130 percent, 150 percent, or 185 percent), are used to determine eligibility for a number of federal and state assistance programs, including the National School Lunch Program, Supplemental Nutrition Assistance Program (formerly the Food Stamp Program), the Temporary Assistance for Needy Families Program, and the WIC Program.

With the current economic downturn, a growing number of individuals and families in the region are entering the ranks of the "working poor." These individuals, underemployed and/or employed in low wage jobs, earn too much money to qualify for federal or state assistance programs, but not enough money to experience a decent quality of life or meet many of their basic needs. The working poor are also more likely to not receive health insurance benefits through their employers.

According to the U.S. Census Bureau, 42.9 million Americans (14.3% of the US population) lived in poverty in 2009 (Source: US Census Bureau, "Poverty: 2008 and 2009, American Community Survey Briefs" http://www.census.gov/ prod/ 2010pubs/acsbr09-1.pdf accessed 8/12/2011). The proportion of Americans living in poverty has increased over the past decade. Table 4 shows that our community poverty rates fall below both the state and national rates. Danbury's level of poverty is considerably higher than the other municipalities in the region and comparable to the state. It should be noted that throughout the state and region, significant disparities exist with minority populations disproportionately living in poverty.

Table 4: Economic Characteristics of HVR Municipalities		
Town	Median Household Income in 2010 ($)	Poverty Rate in 2009 (percent)
Bethel	$77,625	4.8%
Bridgewater	$107,934	2.9%
Brookfield	$92,731	2.4%
Danbury	$62,582	8.5%
New Fairfield	$100,202	2.9%
New Milford	$80,887	2.1%
Newtown	$105,744	2.2%
Redding	$119,788	1.6%
Ridgefield	$131,677	1.8%
Sherman	$90,638	2.2%
Connecticut*	$64,851	8.7%
United States*	$49,777	14.3%
Source: Connecticut Economic Resource Center, Inc. Town Profiles 2011 www.cerc.org accessed 8/17/2011 * United States Census Bureau Median Household Income 1-year Estimates http://www.census.gov/did/www/saipe/county.html accessed 6/9/2011		

Economic Stability: Indicators and Findings, cont'd.

Employment Status

According to State Department of Labor data reports, Connecticut and the HVR municipalities have recently experienced a decline in the unemployment rate. The state's unemployment rate in July 2011 was 9.1%, and as of December 2011 this had declined to 7.6%, below the national unemployment rate of 8.5%. In December 2011, unemployment rates in the region ranged from a low of 4.4% in Bridgewater to a high of 6.4% in Sherman. (Source: Connecticut Department of Labor, http://www.ctdol.state.ct.us/ accessed 8/18/2011 & 1/27/12).

Free and Reduced Price School Meals

Free or reduced price school meals are available for all children attending public schools whose families are income eligible. The income eligibility for free meals is 130% or below the federal poverty level; for reduced meals it is more than 130% up to 185% of the federal poverty level. The percentage of children receiving free or reduced price school meals is a highly useful indicator of the extent of poverty and economic stability in our community.

Since 2000, data indicate that the region tends to fall below the statewide average for free or reduced price meal eligibility. This is consistent with the region's overall higher average median household income. Danbury is the exception with the percentage of students eligible for free/reduced price meals generally exceeding the state average. In 2009-2010, one out of every three Danbury children was eligible to receive free/reduced price meals. The Danbury Promise for Children Partnership's *2011 Community Report Card on Danbury's Young Children* states this had increased to 46% in 2010-2011. It is notable that over the past two years, there has been an increase in the number of eligible children in all HVR communities.

Figure 4: Percent of Students Eligible for Free/Reduced Price Meals, 2001-2010
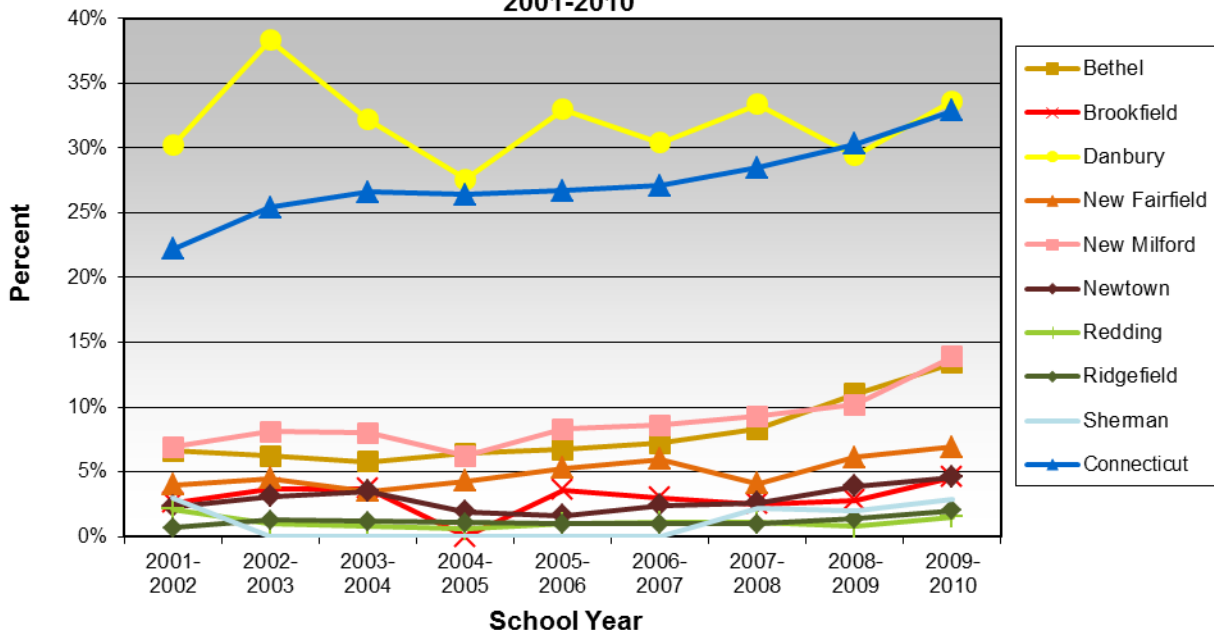
Source: Connecticut State Department of Education, Student Need Data
http://sdeportal.ct.gov/Cedar/WEB/ct_report/StudentNeedDT.aspx accessed 3/23/2011

Economic Stability: Indicators and Findings, cont'd.

Homelessness

The National Alliance to End Homelessness defines homelessness as a complex problem with a simple solution - housing. People become homeless when they cannot find housing that they can afford. It is estimated that there are 643,067 people experiencing homelessness on any given night in the United States with 238,110 people in families, and 404,957 individuals. These numbers are from point-in-time counts conducted in communities throughout the country on a single night in January every other year. (Source: The National Alliance to End Homelessness, Snapshot of Homelessness, http://www.endhomelessness.org/section/about_homelessness/snapshot_of_homelessness accessed 8/29/2011).

Homelessness results from many factors. Economics is a major driver of homelessness across the nation. In Connecticut, the economic pressures are particularly acute with the relatively high cost of living and scarcity of low cost housing. In the Danbury metropolitan area, the estimated 2011 living wage to afford a one bedroom apartment was $24.27 per hour; the minimum wage in 2012 is only $8.25 per hour. (Source: Fiscal Year 2011 Final Fair Market Rents for Existing Housing, http://www.universallivingwage.org, accessed 1/30/12).

The data in Table 5 indicates that 4,451 people were homeless in Connecticut on January 27, 2011. Table 5 shows the Point-in-Time Count of homeless in the Greater Danbury area and Connecticut from January 2008 through January 2011.

Table 5: Homelessness Point-in-Time Counts for Connecticut and Greater Danbury, 2008-2011

		January 30, 2008		January 30, 2009		January 27, 2010		January 27, 2011		Total Percent Change from 2008 to 2011	
		Greater Danbury Area	Statewide	Greater Danbury Area	Statewide	Greater Danbury Area	Statewide	Greater Danbury Area	Statewide	Greater Danbury Area	Statewide
Total	Total	123	3,444	103	2,824	127	3,829	158	4,451	28.5%	29.2%
	Single Adults	115	2,847	91	2,414	96	2,508	130	3,064		
	Families	10	482	12	423	11	521	11	533		
	Unaccompanied Youth	0	119	0	17	0	18	0	0		
	Children in Families	16	873	23	793	20	782	17	854		

Note: an unsheltered homeless person resides in a place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, or on the street, and a sheltered homeless person resides in an emergency shelter or transitional housing for homeless persons who originally came from the streets or emergency shelters.

Source: CT Coalition to End Homelessness http://www.cceh.org/publications/, 2010-2011 data update accessed 1/27/12.

Economic Stability: Indicators and Findings, cont'd.

Homelessness, cont'd.

In 2005 Danbury Mayor Mark D. Boughton commissioned a Task Force to develop a comprehensive and detailed plan to end homelessness in Danbury within 10 years. The plan was unveiled in February 2006 with four objectives:

1. Increase the supply of permanent housing units to meet the projected need of homeless persons.

2. Keep people housed and reduce the number of people becoming homeless and specifically reduce the number of people being discharged into homelessness by state and local institutions and agencies.

3. Ensure that there are adequate, appropriate and sufficient services to assist homeless or at-risk persons in accessing and retaining housing.

4. Develop a strategy to ensure that the plan is both implemented and monitored to completion.

The Task Force's report stresses urgency in ending homelessness. The cost of long-term homelessness is "most acutely felt by the health and mental health systems. A recent study found that hospitalized homeless people stay an average of more than four days longer than other inpatients and that almost half of medical hospitalizations of homeless people were directly attributable to their homeless condition and therefore preventable." Homeless individuals "are three times more likely to use hospital emergency rooms than the general population, and are at higher risk for emergency department services because of their poor health." The American Academy of Pediatrics has found that homeless children are more likely than other children to experience trauma-related injuries, developmental delays, chronic disease, and poor academic achievement. (Source: The Mayor's Task Force to End Homelessness, www.ci.danbury.ct.us, accessed 11/9/08.)

The Greater Danbury Continuum of Care and the Danbury Housing Partnership are working with a broad range of partners throughout the region to address the multifaceted needs of the homeless population. The Partnership website can be accessed at: www.danbury housing partnership.org.

Education: Indicators and Findings

According to the National Center for Education Statistics (NCES), an individual's level of education is highly correlated with specific socioeconomic outcomes. For example, a high school graduate tends to achieve more stable employment and a higher income level than a high school dropout. According to the NCES, students who do not graduate from high school are more likely to rely on public assistance and have poorer physical health than individuals who completed graduation requirements. Data also indicates that the socioeconomic and quality of life benefits of education continue with further advances in educational attainment. Higher education is strongly associated with improved health status, access to health care, increased income, and job opportunities. Persons with higher educational attainment are more likely to live in safe neighborhoods, be employed in higher paying jobs with health benefits, and practice healthy lifestyle habits.

The Connecticut State Department of Education has established three priorities in their 2006 – 2011 Comprehensive Plan for Education to address gaps in educational achievement.

1. High-quality preschool education for all students.
2. High academic achievement for all students in reading, writing, mathematics and science.
3. High school reform so that all students graduate and are prepared for lifelong learning and careers in a competitive global economy.

The ability to achieve these priorities within our local schools will have a direct impact on the future quality-of-life for our students and the economic well-being of our communities.

Figure 5: High School Graduation Rate, 2004-2008

Source: Connecticut State Department of Education, CEDAR ,
http://sdeportal.ct.gov/Cedar/WEB/ct_report/GraduationDT.aspx accessed 3/24/2011
Note: Bridgewater, Redding, and Sherman are excluded as their students attend high schools located in other towns.
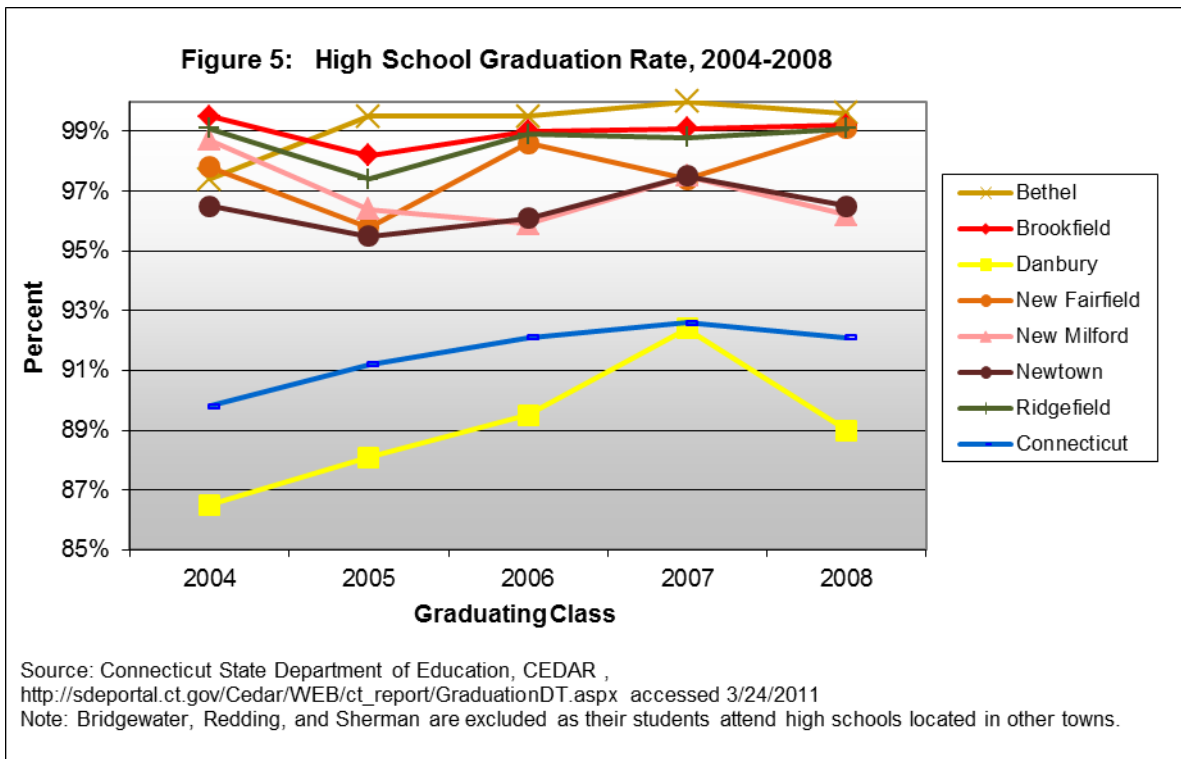
Education: Indicators and Findings

High School Graduation and Higher Educational Attainment

As indicated in Figure 5, the graduation rate for most HVR municipalities is well above the state rate. Danbury, a priority school district, is the exception with a graduation rate consistently below the state average. According to the NCES, the national graduation rate in 2008-2009 was 75.5%, compared with Connecticut's rate of 92%. This rate varies greatly by race/ethnicity and was highest for Asian/Pacific Islanders at 91.8%, followed by White students at 82%, Hispanic students at 65.9%, Native American students at 64.8% and African-American students at 63.5%. (Source: National Center for Education Statistics, www.nces.ed.gov, accessed 8/16/2011).

Four-year cumulative data for the 2009 cohort of high school students in Connecticut shows an overall decline in graduation rates and considerable disparities in these rates by socio-demographic group: Hispanic/Latino (58.1%), African American/Black (66.2%), low income (59.9%), limited English proficiency (53.4%), and special education students (53.4%) compared with (86.8%) for White students. (Source: Connecticut Department of Education. Commissioner Calls for Action. *"New Formula, Unique Student Data Produce More Accurate State Graduation Rates"*, Press Release. March 23, 2010).

Table 6 summarizes existing data relating to the level of educational attainment by HVR residents age 25 and over in the last decade. During this period of time, the overall level of education has consistently increased. With the exception of Danbury, residents ages 25 and over throughout the region were more likely to graduate from high school and to receive advanced degrees than the average Connecticut resident. Residents in eight out of ten HVR municipalities exceeded the state average for attainment of a bachelor's degree or higher.

Municipality	High School Graduate or Higher		Bachelor's Degree or Higher	
	Census 2000	Census 2010	Census 2000	Census 2010
Bethel	89%	91%	37%	40%
Bridgewater	93%	96%	48%	52%
Brookfield	93%	94%	44%	46%
Danbury	77%	84%	27%	33%
New Fairfield	94%	96%	41%	44%
New Milford	91%	95%	31%	35%
Newtown	93%	95%	50%	53%
Redding	97%	98%	63%	65%
Ridgefield	96%	97%	66%	67%
Sherman	94%	95%	42%	45%
State (CT)	84%	89%	31%	35%

Table 6: Educational Attainment in HVR Residents Ages 25 and Over, Census 2000 and 2010

Sources: CERC 2011 Town Profiles and Census 2000: Summary Social, Economic and Housing Characteristics (Table 4).

Education: Indicators and Findings, cont'd.

High School Graduation and Higher Educational Attainment, cont'd.

Among the public school districts in our region, in 2009-2010 Danbury had the highest concentration of racial/ethnic diversity with over half of the students enrolled being minority (52%), followed by Bethel at 19.7%. Figure 6 shows the percentage of minority students from 2001-2002 through the 2009–2010 school years. This growth trend in the proportion of minority students in public schools is consistent across all HVR municipalities.

Figure 6: Percent of Minority Students Enrolled, 2001-2010

Source: Connecticut State Department of Education, Strategic School Profiles,
http://sdeportal.ct.gov/Cedar/WEB/ResearchandReports/SSPReports.aspx   accessed 5/31/2011
Note: Bridgewater is included in the Region 12 School District.
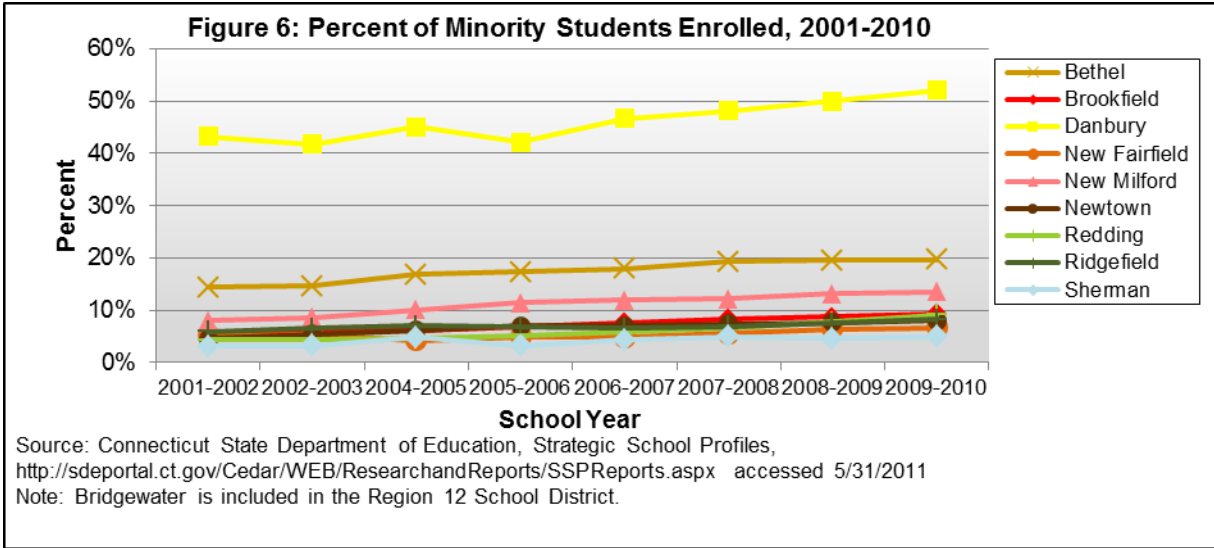
High School Dropout Rate

As shown in Figure 7, many municipalities in the region have on average maintained a low dropout rate with the exception of Brookfield, Danbury, and New Milford where the dropout rates remain above the regional average (and exceed the state average in the case of Danbury).

Figure 7: High School Dropout Rate, Grades 9 - 12, 2003-2010

Source: Connecticut State Department of Education, Dropout Rate
http://sdeportal.ct.gov/Cedar/WEB/ct_report/DropoutDT.aspx accessed 3/24/2011
Note: Bridgewater is included in the Region 12 District
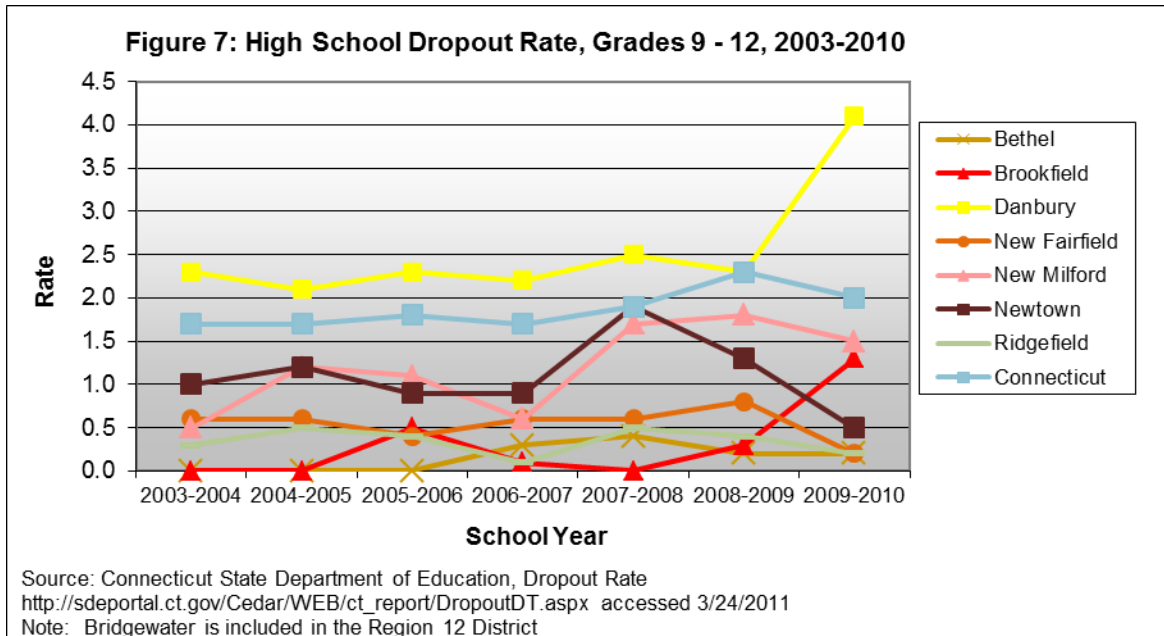
Education: Indicators and Findings, cont'd.

Special Education and Students with Disabilities

Special education involves the provision of individualized educational services for students with a wide range of disabilities. Special education is provided to a child with an identified disability who needs specially designed instruction to meet his/her unique needs and to enable the child to access the general curriculum of the school district. A child who is eligible for special education services is entitled by federal law to receive a free appropriate public education (FAPE). FAPE ensures that all students with disabilities

receive an appropriate public education at no cost to the family.

The percentage of K-12 students with disabilities by HVR municipality is presented in Figure 8. This percentage has held fairly constant for many municipalities over the past four years. Sherman has experienced a steady decline in the percent of students with disabilities and there has been an overall increase in the percent of students with disabilities in New Milford, Danbury, and Redding.

Figure 8: Prevalence Rate Students with Disabilities*, 2006-2010

Source: Connecticut State Department of Education, Students for Whom District is Fiscally Responsible, http://sdeportal.ct.gov/Cedar/WEB/ct_report/SpecialEducationResourseDT.aspx   Accessed 3/23/2011
* Past reports used title "Percent of Students with Disabilities for Whom the District is Fiscally Responsible"
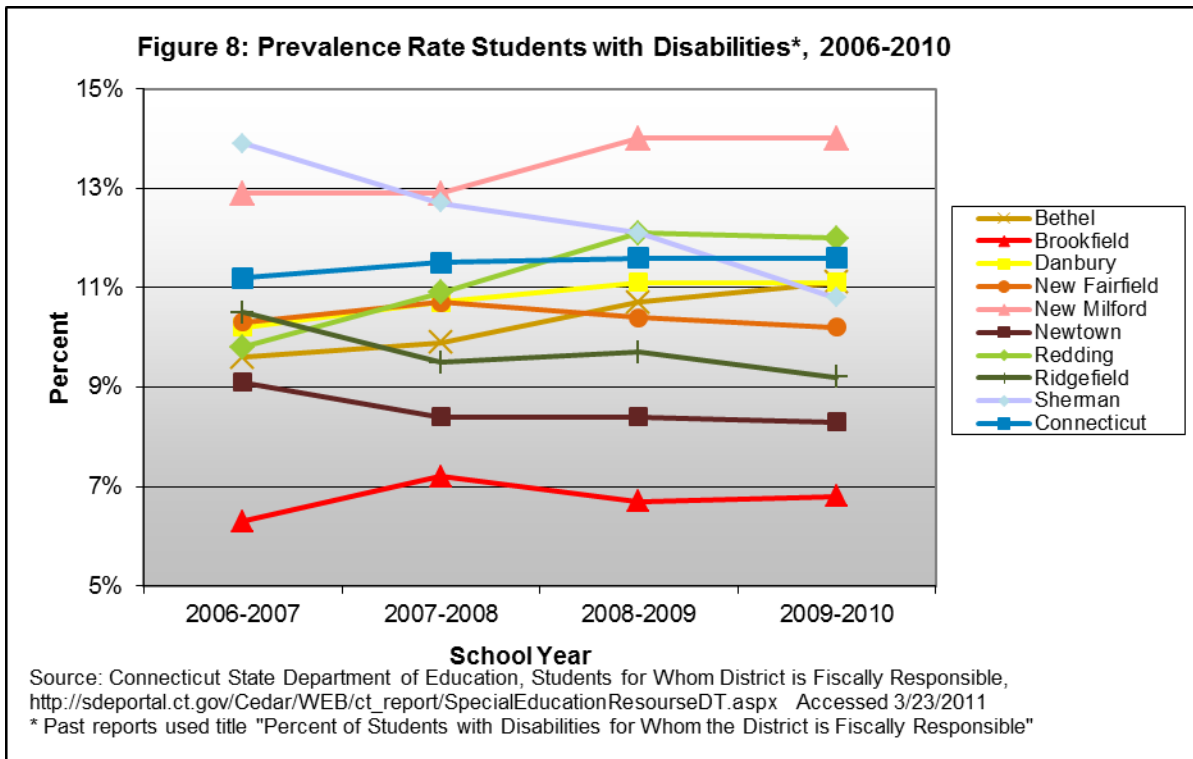
Education: Indicators and Findings, cont'd.

English as a Second Language (ESL)

There are frequently socioeconomic disparities between ESL residents and residents whose primary language is English. Disparities are seen in both children and adults and are reflected in many of the other issues examined within this report.

Students with limited English proficiency, or English Language Learners, tend to have poorer academic performance than children who are fluent in English. Children residing in ESL homes are also less likely to have health insurance and more likely to be living in poverty.

Although the percent of students with a non-English home language is increasing in the majority of municipalities in our region, it is clearly impacting Danbury to a far greater degree. As presented in Figure 9, Danbury's level is considerably higher than the state, while all other municipalities fall below the state percentage.

Figure 9: K-12 Students with a Non-English Home Language, 2004-2010

Source: Connecticut State Department of Education, Students for Whom District is Fiscally Responsible, http://sdeportal.ct.gov/Cedar/WEB/ct_report/SpecialEducationResourseDT.aspx   Accessed 3/23/2011
* Past reports used title "Percent of Students with Disabilities for Whom the District is Fiscally Responsible"
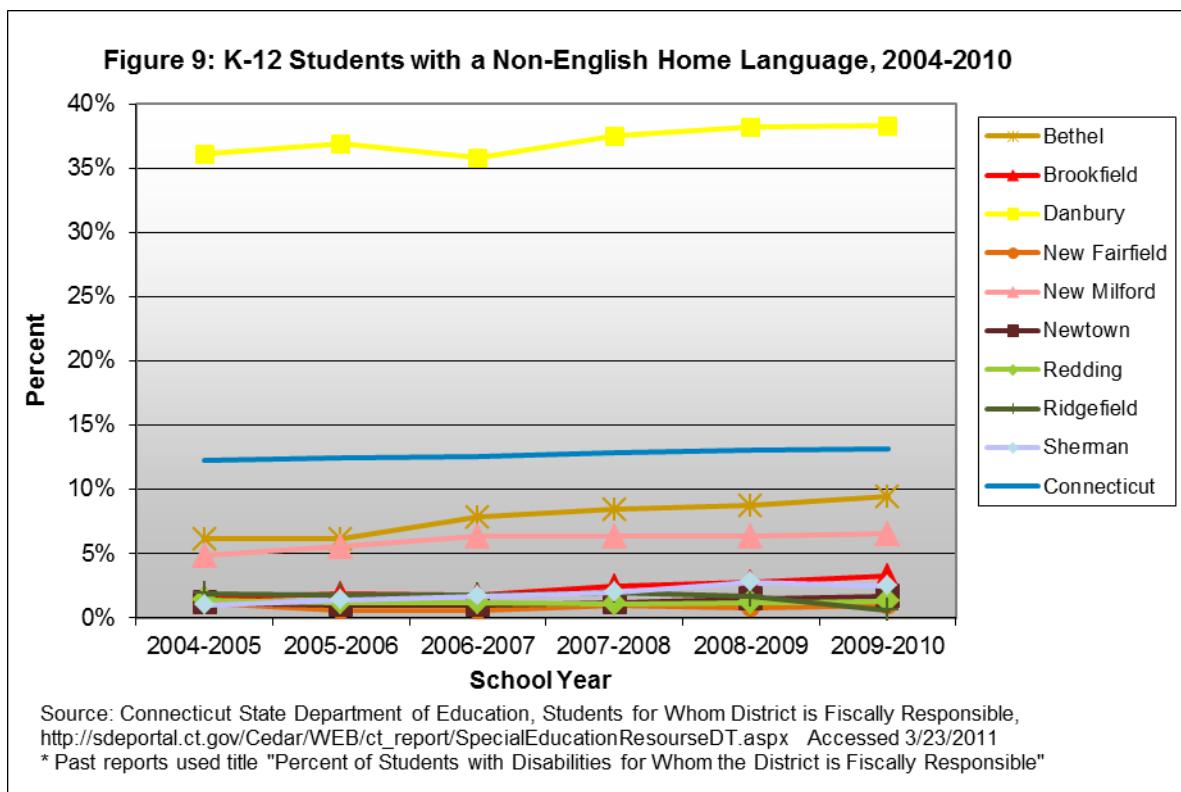
Health Status: Indicators and Findings

Health Insurance Coverage

Having public or private health insurance coverage is a potent predictor of both access to and regular use of all types of health care services - preventive, screening, and diagnostic and treatment.

Studies demonstrate that individuals without health insurance are far more likely to receive fragmented health care and experience delayed access to health screenings and treatment for disease. In addition to the negative impact of delayed access to care on individual health, the economic costs to society are high. Research has shown that delayed access to care results in overuse of costly emergency department services and premature death and disability. As shown in Figure 10, Connecticut falls well below the national average in the percentage of residents who are uninsured. During the past few years, however, this percentage has been increasing at a faster rate in CT than in the U.S. as a whole.

Figure 10: CT and U.S. Percent Uninsured Population, 1999-2009
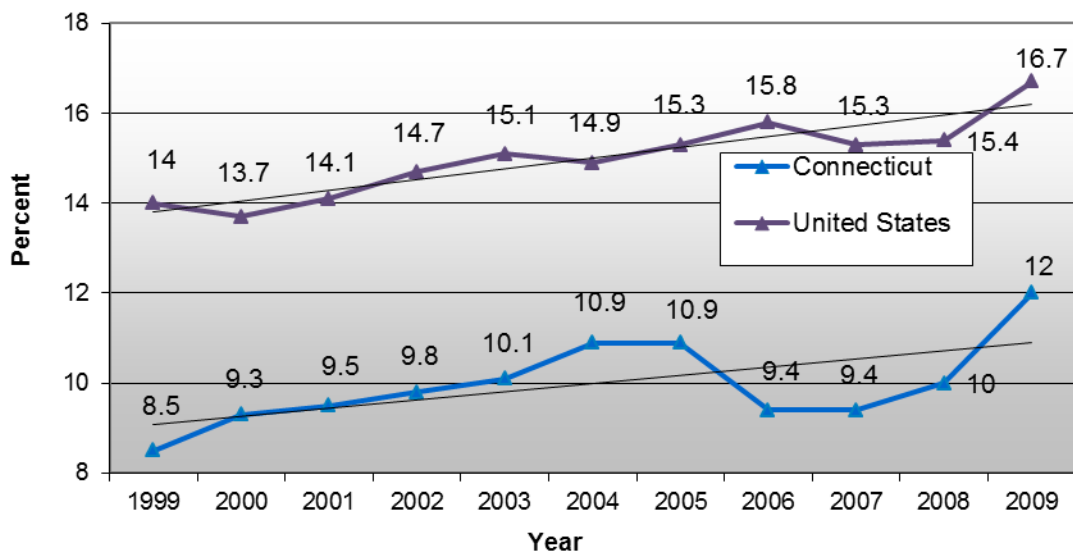
Source: US Census Bureau, Historical Health Insurance Data,
http://www.census.gov/hhes/www/hlthins/data/historical/index.html, accessed 3/24/2011
Note: Population as of March of the following year.

Health Status: Indicators and Findings, cont'd.

Health Insurance Coverage, cont'd.

According to the CT Department of Public Health's report, *Healthy Connecticut 2010*, the likelihood of being insured in our state varies considerably for different population subgroups. As shown in Figure 11, children in Connecticut are more likely than adults to have health insurance, females are more likely than males, and white non-Hispanic residents are significantly more likely than non-Hispanic Black and Hispanic residents to have health insurance coverage.

FIGURE 11
PERSONS WITH HEALTH INSURANCE
CHILDREN 0-18 YRS OF AGE AND
ADULTS 18-64 YRS OF AGE BY SEX, RACE & ETHNICITY
CONNECTICUT, 1999-2009
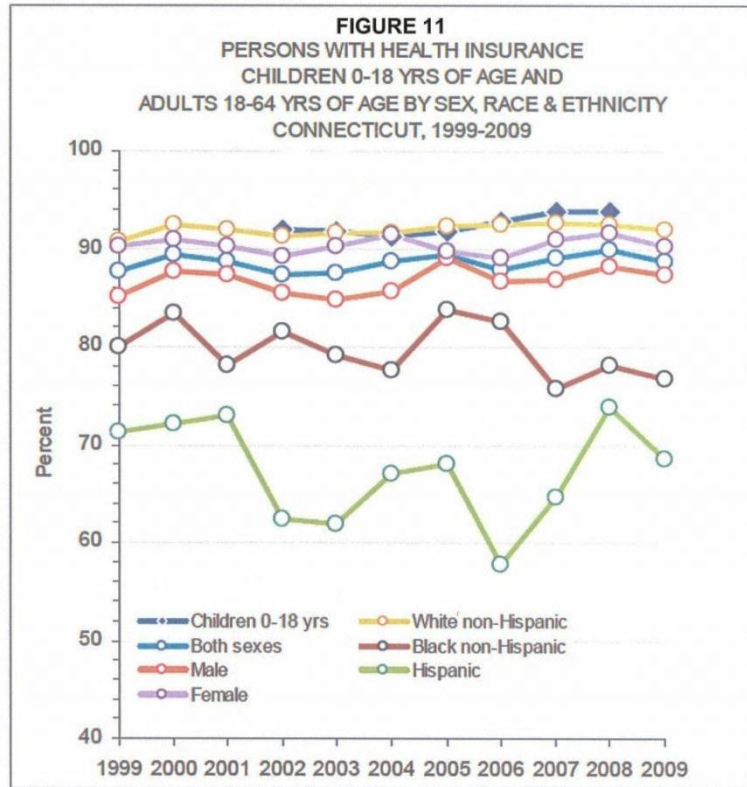
Source: Behavioral Risk Factor Surveillance System as cited in *Healthy Connecticut 2010*
Note: Data for children 0-18 years of age not available until 2002.

Factors Influencing Insurance Status

There are several key reasons why individuals and families may or may not be insured, most notably employment status and availability of employer-sponsored health insurance, eligibility for public health insurance, and affordability of insurance for persons who are self-insured.

HUSKY Health is Connecticut's comprehensive public health insurance program for children, parents, relative caregivers, senior citizens, individuals with disabilities, adults without children and pregnant women who meet income and citizenship eligibility guidelines. HUSKY Health is designed to reduce the number of uninsured families in Connecticut and increase access to preventive care and diagnostic and treatment services. It is important to note that our region has a growing number of undocumented residents. These individuals are categorically ineligible for public health insurance programs, such as Medicaid, which require proof of citizenship (natural-born citizen,

Health Status: Indicators and Findings, cont'd.

Factors Influencing Insurance Status, cont'd.

naturalized citizen, or U.S. national). HUSKY A (Medicaid) provides benefits to CT children under the age of 19 and their parents or a relative caregiver with incomes at or below 185% of the federal poverty level and low income pregnant women. HUSKY B, also known as the Children's Health Insurance Program or CHIP, provides benefits to children under the age of 19 who are not eligible for HUSKY A and live in households with incomes between 185-300% of the poverty level. HUSKY A provides free health care coverage for children under the age of 19 and parents or relative caregivers who live with a child under the age of 19. HUSKY B plans include co-payments and/or premiums based on family composition and income.

Both plans cover comprehensive preventive and illness-related health care, including physician visits, emergency and hospital care, immunizations, prescriptions, and vision care. Dental care is provided through the Dental Health Partnership. Children with mental health and substance abuse concerns are served through the Connecticut Behavioral Health Partnership. For children with special physical health needs, the program provides coverage for additional services.

HUSKY C, formerly known as Title 19, or Medicaid for the for the Aged/Disabled, provides coverage to income-eligible CT residents ages 65 or older, and ages 18 to 64 who are blind or have another qualifying disability. HUSKY D, formerly known as Medicaid for Low Income Adults, provides coverage for persons ages 19-64 who do not qualify for HUSKY A and do not receive Supplemental Security Income or Medicare. (Sources: United Way of CT 2-1-1 HUSKY Health Plans, http://infoline.org, and www.huskyhealth.com, accessed 1/31/12).

In 2009, 10% of Connecticut's population was uninsured, which is considerably below the U.S. average at 16.7%. Data for individual municipalities in the HVR region are not available, however according to the U.S. Census Bureau, Fairfield County's uninsured population was 10.8% in 2007 for persons under the age of 65 (Source: U.S. Census Bureau, Small Area Health Insurance Estimates, http://www.census.gov/did/www/sahie/index.html accessed 7/7/2011). Interestingly, from 2008-2009 there was a reported decrease in the percent of persons covered by public insurance in the state in contrast to an increase in the country.

Table 7: Health Insurance Coverage by Type, Percent of Total Population, 2007 - 2009

Type	Connecticut			United States		
	2007	2008	2009	2007	2008	2009
Covered by Private or Government	90.6%	90.0%	88.0%	84.7%	84.6%	83.3%
Private	76.3%	74.9%	75.3%	67.5%	66.7%	63.9%
Employment-based	68.0%	65.7%	66.3%	59.3%	58.5%	55.8%
Direct Purchase	9.4%	9.4%	9.6%	8.9%	8.9%	8.9%
Government	25.8%	27.0%	24.7%	27.8%	29.0%	30.6%
Medicaid	11.2%	11.8%	9.6%	13.2%	14.1%	15.7%
Medicare	14.3%	14.9%	14.7%	13.8%	14.3%	14.3%
Military Health Care	1.9%	2.1%	2.2%	3.7%	3.8%	4.1%

Source: US Census Bureau, Historical Health Insurance Data, http://www.census.gov/hhes/www/hlthins/data/historical/index.html, accessed 3/24/2011

Note: Population as of March of the following year.

Health Status: Indicators and Findings, cont'd.

Factors Influencing Insurance Status, cont'd.

Overall enrollment of CT children in the HUSKY A and B Plans has increased from 2010 to 2011, holding relatively constant during 2011. The data in Table 8 shows the number of children enrolled in the region and in the state for January 2009, January 2010 and for January and December 2011. Seven of the ten HVR municipalities experienced an increase in HUSKY A child enrollment in 2011; five experienced an increase in HUSKY B enrollment.

Table 8: Number of Children Enrolled in HUSKY A and B Comparison, 2009 - 2011								
	January 1, 2009		January 1, 2010		January 1, 2011		December 1, 2011	
	Husky A	Husky B	Husky A	Husky B	Husky A	Husky B	Husky A	Husky B
Bethel	584	120	695	127	777	130	792	123
Bridgewater	27	<5	32	6	35	*	30	*
Brookfield	277	52	295	93	395	61	400	70
Danbury	5,620	542	6,348	561	7,174	499	7,426	518
New Fairfield	266	73	354	63	397	63	408	67
New Milford	915	167	1,121	188	1,237	181	1,220	182
Newtown	383	81	494	154	619	93	604	99
Redding	80	18	99	42	130	27	139	22
Ridgefield	37	31	203	36	224	39	242	32
Sherman	76	17	97	19	112	24	115	18
Connecticut	331,519	13,654	239,531	15,657	256,808	14,874	256,052	14,874

Source: State of Connecticut Department of Social Services, Healthcare for UninSured Kids and Youth (HUSKY), http://www.ct.gov/hh/ and http://www.huskyhealth.com/hh/lib/hh/pdf/Reports/HUSKYBEnrollment0110.pdf, accessed 3/24/2011 and 1/31/12
* indicates < 5

Findings: Although publicly-funded insurance programs are in place in the region and state to serve low income children and adults, they are not available for persons who do not meet income or citizenship eligibility requirements. Income thresholds for HUSKY are also more stringent for non-pregnant adults without children, and access to providers is limited in some areas.

In addition, the enrollment process may be challenging for those with language and/or literacy barriers. Ongoing enrollment assistance at such sites as community and faith-based organizations, social and human services offices, community health centers, hospitals, and WIC offices would help encourage enrollment by eligible adults and children.

Emergency Department Visits

When individuals have health insurance they are more likely to access either a private health provider's office or a primary care clinic when they or their children are ill. Without insurance, the alternatives are community-based health centers with a sliding fee schedule for self-pay patients based on income, and hospital emergency departments. Tracking the frequency of emergency department visits for non-emergent conditions is one way to evaluate if hospitals are inappropriately being used for primary care. Frequent use of the emergency department services for primary care indicates that a community may have an insufficient quantity of primary care providers or health providers serving the uninsured population

Health Status: Indicators and Findings, cont'd.

Emergency Department Visits, cont'd.

such as Federally Qualified Community Health Centers.

Table 9 provides the number of emergency department visits for community residents at Western CT Health System's Danbury and New Milford Hospitals and emergency department visits at all Connecticut hospitals for Connecticut residents only. The number of emergency department visits as a percent of the total population (2010 Census data) for each municipality was calculated for comparative purposes. It should be noted these percentages are a rough approximation, as the visit counts are not unduplicated, i.e., one individual may have multiple visits,

and the percentages do not capture hospital visits occurring outside of the state. The proportion of emergency visits by resident population varies greatly across the region, and is highest in Danbury (41.7%) and lowest in Ridgefield at 14.2%. In 2007, all HVR municipalities were below the state percentage (41.5%). Some factors that may explain the variance include: resident geographic proximity to the hospital (percentages are highest in Danbury and New Milford where the hospitals are physically located), the proportion of residents who are uninsured, and the proportion of residents seeking care outside CT.

Table 9: Emergency Visits by Municipality[1] compared to statewide data (2007) [3], FY 2010					
	Inpatient (Admitted from Emergency Department)	Outpatient (Discharged from Emergency Department)	Total	Population Census 2010[2]	Emergency Department visits as % of population
Bethel	1,046	4,705	5,751	18,584	30.9%
Bridgewater	78	425	503	1,727	29.1%
Brookfield	725	3,345	4,070	16,452	24.7%
Danbury	4,652	29,069	33,721	80,893	41.7%
New Fairfield	545	2,768	3,313	13,881	23.9%
New Milford	1,149	9,936	11,085	28,142	39.4%
Newtown	1,108	3,654	4,762	27,560	17.3%
Redding	316	1,067	1,383	9,158	15.1%
Ridgefield	857	2,643	3,500	24,638	14.2%
Sherman	102	870	972	3,581	27.1%
HVR Total	10,578	58,482	69,060	224,616	30.7%
Connecticut[3]	1,223,641	230,244	1,453,885	3,502,309	41.5%

Sources:
[1] Danbury and New Milford Hospital, data received July 31, 2008 and August 26, 2008
[2] Connecticut State Data Center, University of Connecticut, http://ctsdc.uconn.edu/projections/ct_towns.html, accessed 5/28/2011.
[3] CHIME (Connecticut Health Information and Management Exchange) data received from Danbury Hospital 1/8/2009

Health Status: Indicators and Findings, cont'd.

Emergency Department Visits, cont'd.

The trend data in Figure 12 show the rate of emergency room visits per 1,000 population (based on 2010 Census data) from 2004 to 2010. Local trends have remained fairly constant. Danbury has the highest rate, followed by New Milford.

Figure 12: Emergency Visits per 1,000 population*, FY 2004-2010

Sources: Source: Danbury and New Milford Hospital, data received July 31, 2008, August 26, 2008, March 23, 2011, March 28, 2011, and March 29, 2011
* Rate based on 2010 population - Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 4/11/2011. Data for CT available only through 2007.

FIGURE 13
LEADING CAUSES OF INJURY DEATHS
(Number of Deaths)
CONNECTICUT, 1999-2007

Source: Connecticut Death Registry (Registration Reports) as cited in *Healthy Connecticut 2010*

Emergency department visits for intentional and unintentional injuries are additional important indicators of community health. The most prevalent unintentional injuries vary by age group and include: accidental poisonings in infants and children, motor vehicle accidents in adolescents and young adults (many of which are alcohol-related), and falls in the elderly. Intentional injuries include those that are self-inflicted such as suicide attempts. As shown in Figure 13, the leading causes of injury-related deaths in the state include unintentional poisoning, motor vehicle accidents, falls, and suicide.

Health Status: Indicators and Findings, cont'd.

Mental or Behavioral Health

The World Health Organization (WHO) defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal st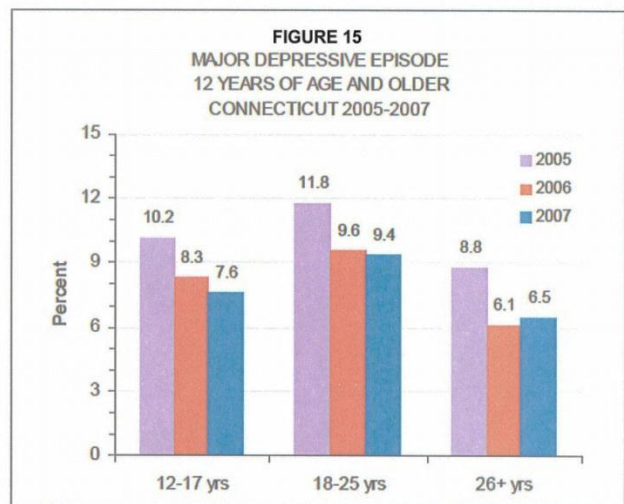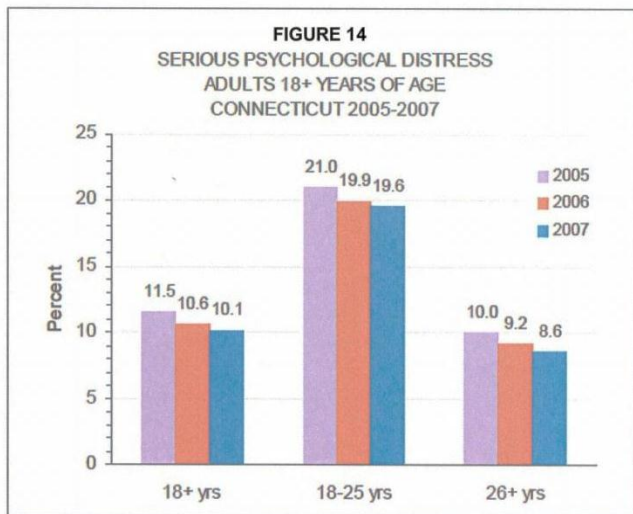resses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." Furthermore, as noted in *Healthy Connecticut 2010*, WHO reports that mental health disorders, including substance use/abuse, anxiety disorders, impulse-control disorders, and mood disorders account for more disability than other chronic diseases, such as heart disease and cancer.

Access to appropriate counseling and treatment for mental health concerns and disorders is critical to a community's overall well-being. High rates of crime, homelessness, suicide, and substance abuse are all distress signals. Behavioral health is often overlooked as a priority community health issue and there is a lack of current and comprehensive community level assessment data in this area. Figures 14 and 15 provide insight on the prevalence of two mental health disorders - serious psychological distress in CT adults and major depressive episodes in CT residents ages 12 and older - from 2005-2007, respectively.

Serious psychological distress is defined by mental health experts as having a score of 13 or higher on The Kessler 6 (K6) screening scale. Major depressive episode is defined as a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of symptoms for depression as described in the DSM-IV. Overall, there has been a downward trend in the prevalence of these disorders in CT adolescents and adults for the three year period shown. More recent data was not available for inclusion in this report.

FIGURE 14
SERIOUS PSYCHOLOGICAL DISTRESS
ADULTS 18+ YEARS OF AGE
CONNECTICUT 2005-2007

FIGURE 15
MAJOR DEPRESSIVE EPISODE
12 YEARS OF AGE AND OLDER
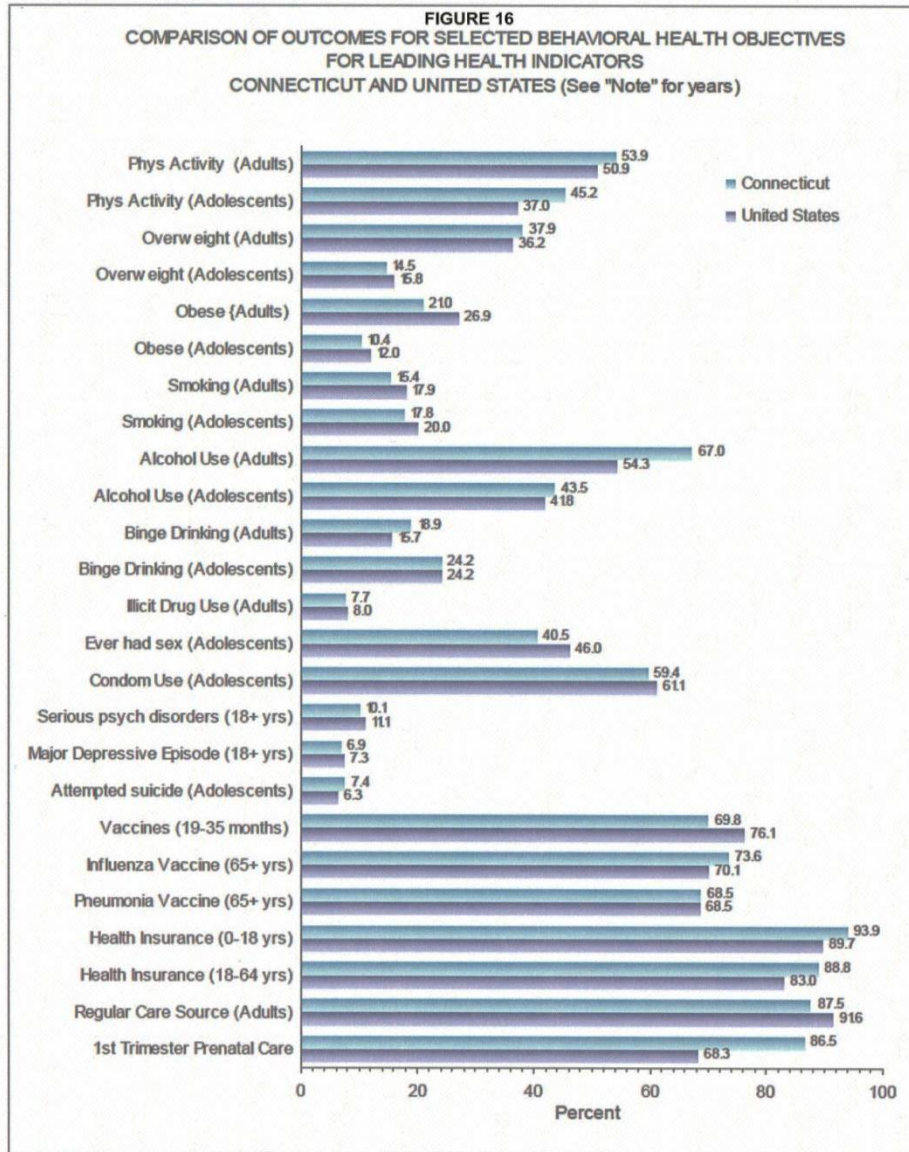CONNECTICUT 2005-2007

Source: SAMHSA National Survey on Drug Use and Health as cited in *Healthy Connecticut 2010*

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings

Leading Health Indicator Behavioral Risk Overview

A comparison of outcomes in U.S. and CT residents for selected behavioral health objectives related to the *Healthy People 2010* leading health indicators – physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care – are presented in Figure 16. Behavioral risk factor data is only available at the state level, due to the sampling framework used for the Behavioral Risk Factor Surveillance Survey, or BRFSS.

FIGURE 16
COMPARISON OF OUTCOMES FOR SELECTED BEHAVIORAL HEALTH OBJECTIVES
FOR LEADING HEALTH INDICATORS
CONNECTICUT AND UNITED STATES (See "Note" for years)

Indicator	Connecticut	United States
Phys Activity (Adults)	53.9	50.9
Phys Activity (Adolescents)	45.2	37.0
Overweight (Adults)	37.9	36.2
Overweight (Adolescents)	14.5	15.8
Obese (Adults)	21.0	26.9
Obese (Adolescents)	10.4	12.0
Smoking (Adults)	15.4	17.9
Smoking (Adolescents)	17.8	20.0
Alcohol Use (Adults)	67.0	54.3
Alcohol Use (Adolescents)	43.5	41.8
Binge Drinking (Adults)	18.9	15.7
Binge Drinking (Adolescents)	24.2	24.2
Illicit Drug Use (Adults)	7.7	8.0
Ever had sex (Adolescents)	40.5	46.0
Condom Use (Adolescents)	59.4	61.1
Serious psych disorders (18+ yrs)	10.1	11.1
Major Depressive Episode (18+ yrs)	6.9	7.3
Attempted suicide (Adolescents)	7.4	6.3
Vaccines (19-35 months)	69.8	76.1
Influenza Vaccine (65+ yrs)	73.6	70.1
Pneumonia Vaccine (65+ yrs)	68.5	68.5
Health Insurance (0-18 yrs)	93.9	89.7
Health Insurance (18-64 yrs)	88.8	83.0
Regular Care Source (Adults)	87.5	91.6
1st Trimester Prenatal Care	86.5	68.3

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).

Source: Healthy Connecticut 2010

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Leading Health Indicator Behavioral Risk Overview, cont'd.

As shown in Figure 16, compared to the U.S. as a whole, Connecticut had a lower prevalence of most risk factors. CT residents under the age of 65 were more likely to have health insurance coverage and have a regular source of health care; pregnant women were more likely to receive early prenatal care; adults and teens were more likely to be physically active, not be obese, and not smoke. Negative findings include the higher prevalence of alcohol use in CT adults and teens and binge drinking in CT adults than in the U.S. as a whole.

Childhood and Adolescent Obesity

According to the Centers for Disease Control and Prevention, the prevalence of childhood obesity has more than tripled in the past 30 years. The percentage of children aged 6–11 years in the United States who were obese increased from 7% in 1980 to nearly 20% in 2008. Over this same time period, the percentage of adolescents aged 12–19 years who were obese increased from 5% to 18%. In 2008, more than one-third of children and adolescents were overweight or obese. (Source: Centers for Disease Control and Prevention, Adolescent and School Health, http://www.cdc.gov/healthyyouth/obesity/ facts.htm, accessed 2/20/12).

Although not representative of the general pediatric population, the 2010 Pediatric Nutrition Surveillance System (PedNSS) assesses weight status of children from low-income families participating in the Special Supplemental Food Program for Women, Infants and Children (WIC). PedNSS reports that 30.5% of low-income children ages 2 to 5 years are overweight or obese nationwide.
(Source: Centers for Disease Control and Prevention, Pediatric Nutrition Surveillance System, http://www.cdc.gov/pednss/ accessed 8/9/2011).

The long-term health implications of childhood and adolescent obesity are serious. Youth who are obese are more likely to experience social and psychological problems due to poor self-esteem. They are more likely to be overweight adults, and consequently at a greater risk for developing heart disease, hypertension, type 2 diabetes, stroke, osteoarthritis, and certain types of cancer. (Source: Centers for Disease Control and Prevention, Adolescent and School Health, http://www.cdc.gov/ healthyyouth/obesity/facts.htm, accessed 2/20/12).

According to the National Survey of Children's Health:

- Approximately 95,000 Connecticut children ages 10-17 years (25.7%) are considered overweight or obese according to Body Mass Index (BMI) for age standards.

- Hispanic/Latino (40.4%) and Black/African American (38.1%) children in Connecticut are almost two times more likely than white children (21.8%) to be overweight or obese.

- CT children are more likely than their counterparts nationwide to be physically active for at least four days per week (36.2% versus 34.4%), and less likely to spend one hour or more a day in front of a television or computer screen (42.7% versus 50.1%).

More information on obesity and other health issues for CT children are available at: www.nschdata.org.

Lack of physical activity is a major contributing factor to overweight and obesity. Figure 17 provides information about the percentage of school age children in our community who have passed the state physical fitness test. Students are tested according to the standards presented in Figure 18. In the past, students were tested in

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Childhood and Adolescent Obesity, cont'd.

all four areas of fitness: aerobic endurance, flexibility, muscular strength and endurance, and body composition. In the 2009-2010 school year, the requirement for

testing body composition was removed. This has likely resulted in a falsely elevated number of students meeting the requirements.
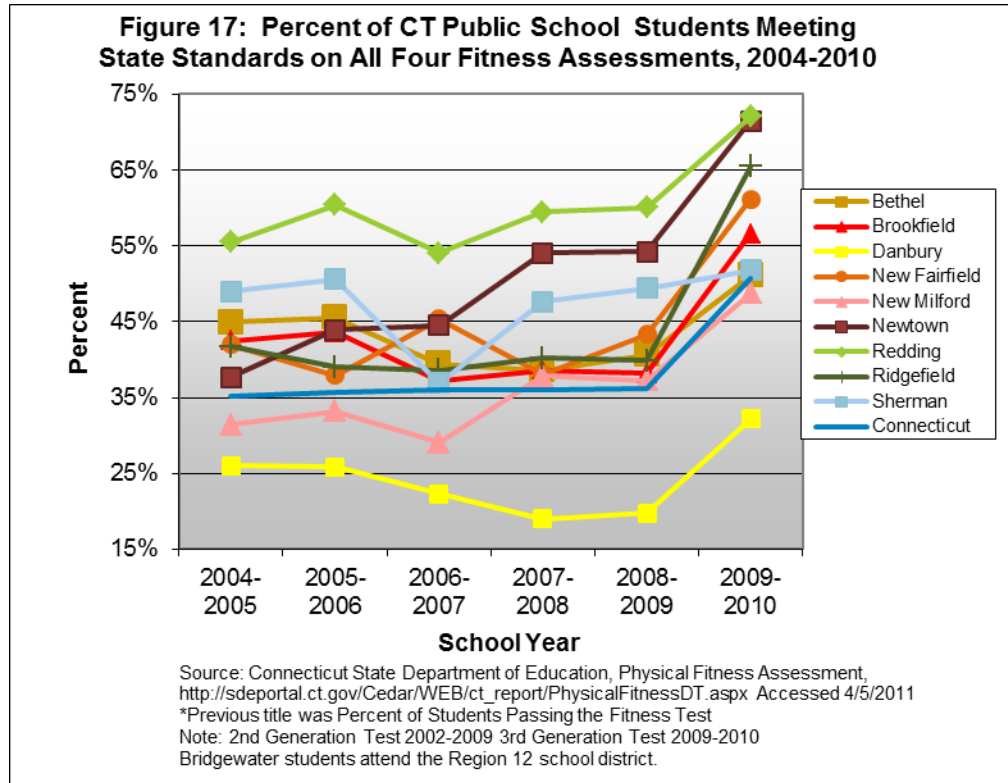

Figure 17: Percent of CT Public School Students Meeting State Standards on All Four Fitness Assessments, 2004-2010

Source: Connecticut State Department of Education, Physical Fitness Assessment, http://sdeportal.ct.gov/Cedar/WEB/ct_report/PhysicalFitnessDT.aspx Accessed 4/5/2011
*Previous title was Percent of Students Passing the Fitness Test
Note: 2nd Generation Test 2002-2009 3rd Generation Test 2009-2010
Bridgewater students attend the Region 12 school district.

Figure 18: Physical Fitness Assessment Guidelines

Health-related Component	2nd Generation (1999)	3rd Generation (2009)	Change
• Flexibility	• Back-saver sit-and-reach	• Back-saver sit-and-reach (improved version) • Shoulder stretch (optional)	• Adjusted for lower back • Addition of shoulder flexibility check
• Upper body muscle • Strength and endurance	• Right-angle push-up	• 90° push-up	• None • Name changed for consistency with research and literature
• Abdominal muscle strength and endurance	• Curl-up	• Curl-up • (improved version)	• Adjusted for limb length and neck comfort
• Aerobic endurance	• Mile run	• Mile run or P.A.C.E.R.	• District option, focus on vO$_2$max
• Body composition	• BMI		• BMI not included

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Childhood and Adolescent Obesity, cont'd.

Figure 19 provides information on the weight status of children in CT and the U.S. for 2003 and 2007. Children are classified as underweight, normal weight, at-risk for overweight or overweight based on the Body Mass Index (BMI) for their age. BMI is a proxy measure for body composition that is calculated based on the child's height and weight. Overall, more children in CT were reported to be of a healthy weight than the national average.
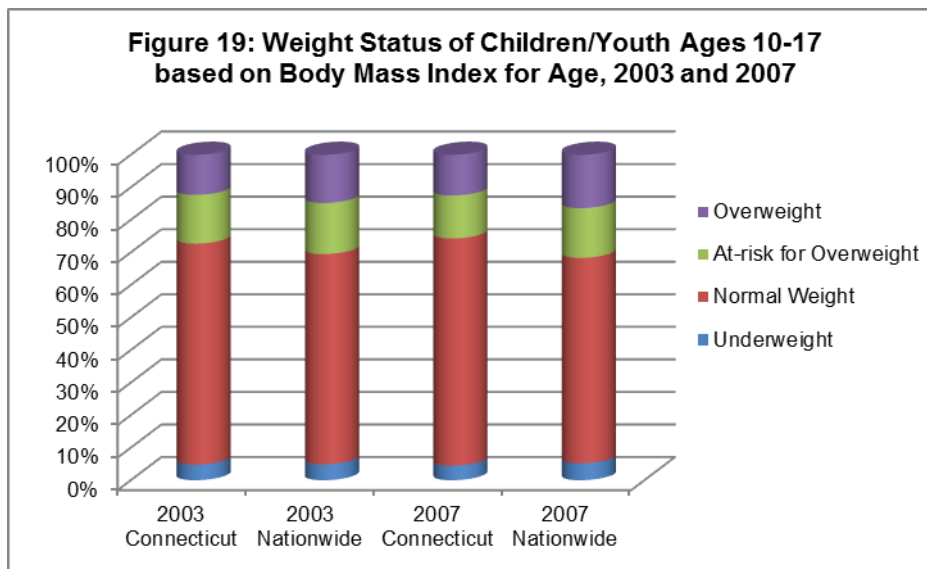
Figure 19: Weight Status of Children/Youth Ages 10-17 based on Body Mass Index for Age, 2003 and 2007

Source: Child and Adolescent Health Measurement Initiative. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. http://www.nschdata.org/Content/07ObesityReportCards.aspx Accessed 1/19/2010.

According to the 2007 National Survey of Children's Health, Connecticut ranks fifth in the nation for overweight or obese children (first is best). This is an improvement from the 2003 rank of 17th. This report indicates only 58.3% of Connecticut children ages 6-17 engage in 4 or more days of vigorous activity per week. This percentage is slightly lower than the national average of 64.3%. However, Connecticut children engage in less screen time (includes TV, video games, etc.) per week when compared to the national average. Overall, 10.7% of children ages 1 to 5 and 8.5% of children ages 6 to 17 engage in 4 or more hours per weekday compared to the national averages of 12.8% and 10.8%, respectively. It is interesting to note that children with public health insurance were considerably more likely to be overweight or obese than children with private health insurance at both the state and national level (Connecticut: 35.1% versus 21.9%; U.S.: 43.2% versus 27.3%). (Source: 2007 National Survey of Children's Health. Data analysis provided by the Child and Adolescent Health Measurement Initiative, Data Resource Center. http://www.childhealthdata.org/, accessed 1/19/2010).

As reported in *Healthy Connecticut 2010*, adolescent obesity prevalence data for 2005-2009 from the Youth Risk Behavior Survey also show a favorable decline in obesity for teens in grades 9-12. Analysis of 2009 data shows a higher prevalence of obesity in males and in Hispanic/Latino teens.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Childhood and Adolescent Obesity, cont'd.

Findings: As shown in Figure 19, the prevalence of overweight and obesity increased across the U.S. from 2003-2007. It is notable that, during this same period of time, the prevalence of overweight _decreased_ in CT. Specifically, the proportion of overweight and obese children 10-17 years of age in CT decreased from 27.3% in 2003 to 25.7% in 2007. Unfortunately, there is no representative data on weight status of children or adolescents at the municipal level. As noted previously, BMI is no longer included in the standard physical fitness assessment measures for public school children in CT, and there is no BMI surveillance system in place in CT. Three potential BMI surveillance methods include school-based, registry-based, and hybrid (de-identified extraction of height and weight measurements from school health record forms). (Source: Altarum Institute, Registry-Based BMI Surveillance: A Guide to System Preparation, Design, and Implementation, http://www.altarum.org, accessed 2/14/12) BMI surveillance methodologies should be further evaluated to advance the quality and representativeness of overweight and obesity prevalence data available in CT.

Preventive Dental Care

The Pew Charitable Trusts issued a report in 2011 which assessed each state's ability to serve insured children. In this report, states were graded on eight benchmarks assessing dental health policies. The report states that tooth decay is the most common disease of childhood; it is five times more common than asthma. In spite of this, most children do not have dental insurance. There are three times as many children without dental insurance compared to those without medical insurance. (Source: Pew Charitable Trusts, The State of Children's Dental Health http://www.pewcenteronthestates.org/initiatives_detail.aspx?initiativeID=85899359680 accessed 8/25/2011).
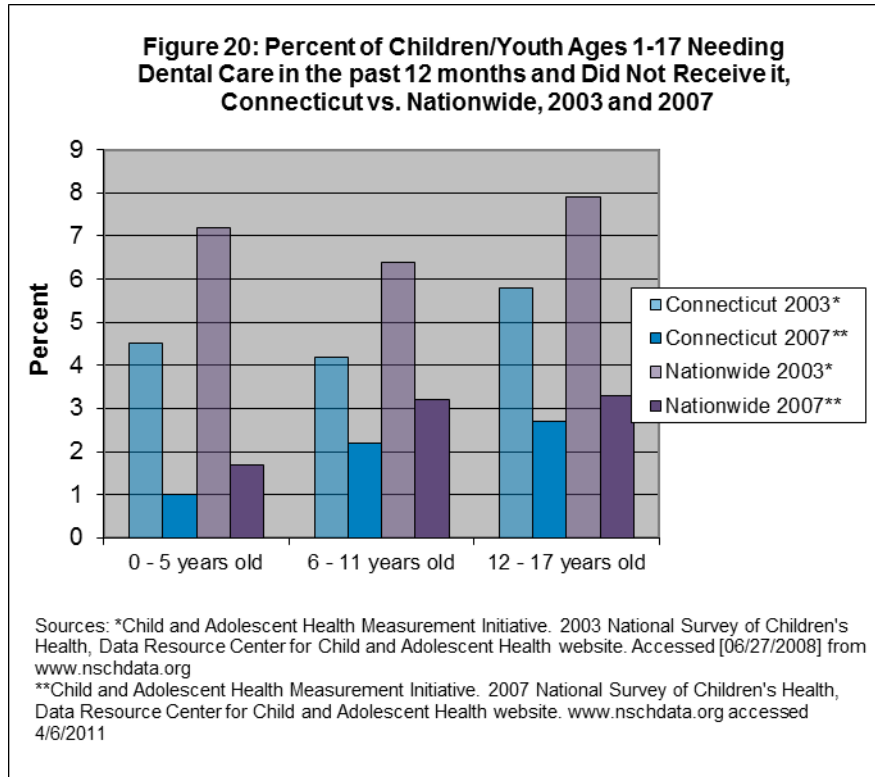
Connecticut is one of seven states that received an "A" in 2011 by meeting six of the eight policy benchmarks for strengthening children's dental health. This is the result of a concerted, joint effort of a number of entities to improve the status of dental care in Connecticut and increase access to oral health care services. The full report can be accessed on the Pew website listed above; the Connecticut Fact Sheet can be accessed at: http://www.pewcenteronthestates.org/uploadedFiles/wwwpewcenteronthestatesorg/Initiatives/Childrens_Dental_Health/048_11_DENT_50_State_Factsheets_Connecticut_052311_web.pdf.

Figure 20 shows state and national levels of children by age group who did not receive needed preventive dental care during the past 12 months in 2003 and 2007. Data are not available at the community level. Overall, children in Connecticut are more likely to receive dental care than the general U.S. population.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Preventive Dental Care, cont'd.

Figure 20: Percent of Children/Youth Ages 1-17 Needing Dental Care in the past 12 months and Did Not Receive it, Connecticut vs. Nationwide, 2003 and 2007

Sources: *Child and Adolescent Health Measurement Initiative. 2003 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. Accessed [06/27/2008] from www.nschdata.org
**Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website. www.nschdata.org accessed 4/6/2011

Findings: There has been a marked improvement in Connecticut and the nation in the proportion of children who received required dental care in 2003 and 2007. Connecticut has experienced a 50% or more reduction in those who needed care but did not receive it across all age groups. These findings provide support for the effectiveness of statewide initiatives to improve children's access to and utilization of dental health services.

Teen Births

The teen birth rate is an important health indicator as teen mothers are more likely to have poor birth outcomes such as low birth weight and prematurity. Infants of teen mothers are also at risk of be raised in an economically unstable environment, since teen mothers have a greater likelihood of being a single parent and not completing high school. Their children tend to exhibit poorer health, are more likely to be abused, and more likely to become single parents themselves. Often the infant is born into poverty and from that stems a cycle of dependence for both mother and child in addition to many other socioeconomic challenges. (Source: March of Dimes Medical Resources - Teenage Pregnancy. http://www.marchofdimes.com/professionals/medicalresources_teenpregnancy.html accessed 2/20/12.)

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Teen Births, cont'd.

Table 10: Teen Births Ages 15 -17, 2004, 2006, and 2008						
	2004		2006		2008	
	Number	Rate	Number	Rate	Number	Rate
Bethel	3	LNE	14	6.7	13	6.8
Bridgewater	0	0	0	0	0	0
Brookfield	1	LNE	12	7.3	13	9.4
Danbury	18	14.4	78	6.6	77	6.3
New Fairfield	2	LNE	5	3.9	7	5.7
New Milford	3	LNE	20	6.2	22	7.1
Newtown	0	0.1	11	4.6	9	4.5
Redding	0	0.1	0	0	3	*
Ridgefield	0	0.1	18	7.7	7	3.8
Sherman	0	0.1	6	18.2	0	0
Connecticut	917	13.8	3,389	8.1	3,004	8.1
United States[+]	133,980	22.0	133,943	22.0	135,664	22.0

Sources: Connecticut Association for Human Services Connecticut Kids Count
http://www.cahs.org/publications-kidscount.asp accessed 5/30/2011
[+]National KIDCOUNTS Data Center
http://datacenter.kidscount.org/data/acrossstates/NationalProfile.aspx accessed 5/31/2011

Rate is number of births to females ages 15-17 per 1,000 females for that age group in a town
* Percentages for towns in which fewer than five incidents occurred during the reported time period are not calculated because of the unreliability of small numbers.

Births to teen mothers and teen pregnancy also create serious financial consequences. Statistics compiled from the National Campaign to Prevent Teen Pregnancy show that teen pregnancy cost Connecticut taxpayers about $137 million in 2008 up from $98 million in 2004. This number covers public health costs, public welfare, loss of income, and incarceration. On a positive note, the teen birth rate in Connecticut has declined 43% between 1991 and 2008, a savings to Connecticut taxpayers of approximately of $162 million in 2008. (Source: The National Campaign to Prevent Teen Pregnancy, http://www.thenationalcampaign.org/, accessed 8/19/2011).

Findings: The teen birth rates in our region are well below the national rate. In 2008 Brookfield's teen birth rate was above the state rate; rates for all other HVR municipalities fell below the state level.

Prenatal Care

Adequate and timely prenatal care can significantly impact the quality of a woman's pregnancy and birth outcomes. The detrimental effects of late or no prenatal care to both maternal and infant health are well documented. Table 11 indicates that the rates of late or no prenatal care in most HVR municipalities are lower than the state average but higher than the national average. As reported in *Healthy Connecticut 2010*, statewide, non-Hispanic white females are most likely to begin prenatal care early; Black non-Hispanic and Hispanic females were the least likely.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Prenatal Care, cont'd.

Findings: The rates for delayed or lack of prenatal care in Danbury for 2008 are higher than in other HVR communities however, Danbury rates have shown a favorable decline from those in 2004 and 2006. Danbury is considerably more ethnically diverse than the other communities, with the highest proportion of undocumented immigrants who may not receive timely prenatal care due to cultural, health insurance, and deportation issues.

Table 11: Late Or No Prenatal Care, 2004, 2006, and 2008						
	2004		2006		2008	
	Number	Percent	Number	Percent	Number	Percent
Bethel	12	6.2%	25	11.9%	18	9.5%
Bridgewater	2	LNE	0	0.0%	0	0.0%
Brookfield	17	9.6%	19	11.6%	8	5.8%
Danbury	193	19.0%	233	19.6%	182	14.8%
New Fairfield	10	6.1%	5	3.9%	6	5.0%
New Milford	24	6.6%	22	6.8%	24	7.8%
Newtown	14	5.1%	17	7.1%	20	10.0%
Redding	3	LNE	2	*	7	11.1%
Ridgefield	20	7.8%	18	7.7%	12	6.6%
Sherman	1	LNE	4	*	1	*
Connecticut	5,301	12.8%	5,858	14.0%	4,947	12.4%
United States	114,916	3.6%	97,420	4.0%	51,889	4.0%

Source: Connecticut Association for Human Services Connecticut Kids Count
http://www.cahs.org/publications-kidscount.asp accessed 5/30/2011
[+]National KIDCOUNTS Data Center
http://datacenter.kidscount.org/data/acrossstates/NationalProfile.aspx accessed 5/31/2011
Percent of All Live Births
* Percentages for towns in which fewer than five incidents occurred during the reported time period are not calculated because of the unreliability of small numbers

Low Birth Weight

Low birth weight is a term used for infants who are born weighing less than 2,500 grams or 5½ pounds. Low birth weight is a major risk factor for infant mortality and long term disability. Prevention of low birth weight is a major focus of public health and prenatal care programs. As defined in the Institute of Medicine's report, *Preventing Low Birthweight*, risk factors for LBW include: low socioeconomic status, low education level, non-white race (particularly Black/African American), childbearing at extremes of age, inadequate weight gain, smoking, substance abuse, absent or inadequate prenatal care, and preterm delivery or multiple pregnancies. Low birth weight infants are at increased risk for complications and related health care costs are escalated due to the need for highly specialized care, including neonatal intensive care units. The rates of low birth weight for HVR municipalities are presented in Table 12.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Low Birth Weight, cont'd.

Table 12: Low Birth Weight, 2004, 2006, and 2008						
	2004		2006		2008	
	Number	Percent	Number	Percent	Number	Percent
Bethel	9	4.6%	14	6.7%	13	6.8%
Bridgewater	2	LNE	0	0%	0	0%
Brookfield	7	3.9%	12	7.3%	13	9.4%
Danbury	69	6.8%	78	6.6%	77	6.3%
New Fairfield	8	4.9%	5	3.9%	7	5.7%
New Milford	21	5.8%	20	6.2%	22	7.1%
Newtown	10	3.6%	11	4.6%	9	4.5%
Redding	5	5.9%	0	0%	3	*
Ridgefield	13	5.1%	18	7.7%	7	3.8%
Sherman	1	LNE	6	18.2%	0	0%
Connecticut	3,076	8.0%	3,389	8.1%	3,004	8.1%
United States	331,772	8.1%	351,974	8.3%	347,209	8.2%

Source: Connecticut Association for Human Services Connecticut Kid Count
http://www.cahs.org/publications-kidscount.asp accessed 5/30/2011
Percent of All Live Births
* Percentages for towns in which fewer than five incidents occurred during the reported time period are not calculated because of the unreliability of small numbers
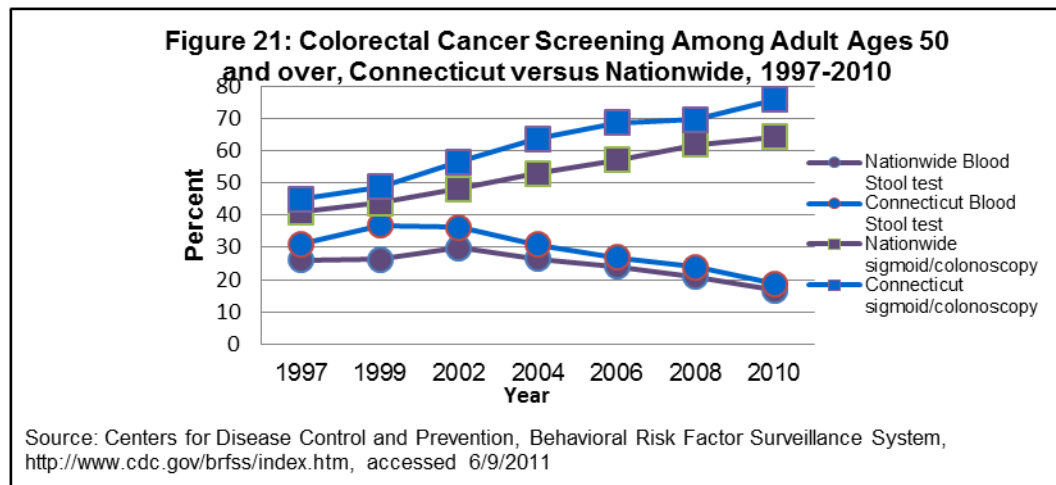
Findings: The data for 2004-2008 in Table 9 shows the rates for low birth weight in all HVR municipalities except Danbury remained lower than the state and national rates.

Colorectal Cancer Screening

Colorectal cancer occurs most frequently in men and women over the age of 50. It is the third leading cause of cancer death among both genders. Early detection is the best defense in overcoming this disease. The American Cancer Society (http://www.cancer.org) and National Cancer Institute (http://cancer.gov) recommend first screening at age 50 if there are no risk factors other than age; an individual with family history of colorectal cancer, polyps or other risk factors should begin screening at an earlier age.

Figure 21: Colorectal Cancer Screening Among Adult Ages 50 and over, Connecticut versus Nationwide, 1997-2010

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, http://www.cdc.gov/brfss/index.htm, accessed 6/9/2011

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Colorectal Cancer Screening, cont'd.

Findings: Early detection and treatment are key to reducing deaths from colorectal cancer. The data in Figure 21 indicates that Connecticut has been consistently above the national average in the rate of colorectal screening for adults age 50 and older across all testing method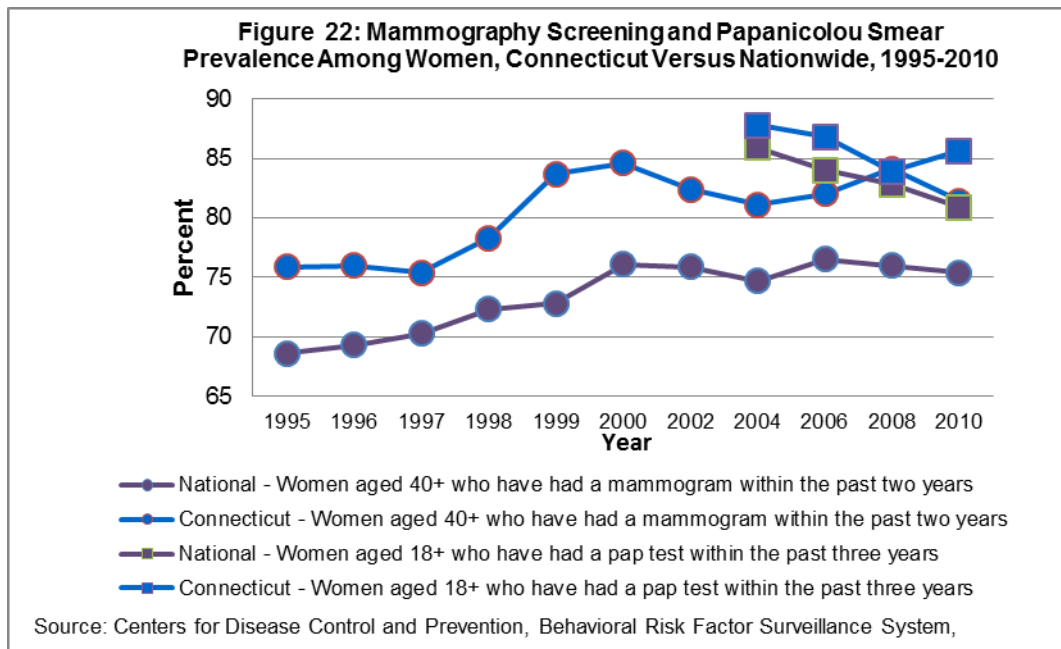s. There has been a positive upward trend in the sigmoid/colonoscopy screening rate, and the *Healthy People 2020* goal of 70.5% was achieved in 2010. The steady decline in reported blood stool test screening is likely due to many physicians now using colonoscopy/sigmoidoscopy as the primary screening method for colorectal cancer.

Mammography Screening and Papanicolaou Smear

Early detection of breast and cervical cancer improves the likelihood that these cancers are diagnosed at an early stage and treated successfully. The American Cancer Society and National Cancer Institute recommend routine mammography screening for early detection of breast cancer among women ages 40 and over. One of the risk factors for cervical cancer is the Human Papilloma Virus (HPV), which can be detected with a Papanicolaou Smear (Pap test). Recent data show a highly favorable decrease in both incidence (declined from 146.7 cases per 100,000 residents in 1998 to 136.5 cases per 100,000 residents in 2008) and mortality (declined from 29 deaths per 100,000 residents in 1997 to 21.7 deaths per 100,000 residents in 2007) for breast cancer in Connecticut. Similar trends are seen for cervical cancer and both are in line with national trends. (Source: National Cancer Institute, State Cancer Profiles Historical Trend Data, http://statecancerprofiles.cancer. gov/ accessed 8/5/2011).

Findings: Figure 22 shows that Connecticut exceeds the national average for participation in each of these cancer screening procedures. It is noteworthy that there has been a consistent downward trend in the percent of women reporting they had a Pap test in the past three years. This may be related to changes in the routine screening periodicity recommendations to every two to three years.

Figure 22: Mammography Screening and Papanicolou Smear Prevalence Among Women, Connecticut Versus Nationwide, 1995-2010

Legend:
- National - Women aged 40+ who have had a mammogram within the past two years
- Connecticut - Women aged 40+ who have had a mammogram within the past two years
- National - Women aged 18+ who have had a pap test within the past three years
- Connecticut - Women aged 18+ who have had a pap test within the past three years

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System,

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Tobacco, Alcohol and Drugs

Cardiovascular disease, cancer and diseases of the lung are among the most common causes of death and can be directly attributed to unhealthy behaviors, most notably tobacco use. Alcohol and drug abuse are major factors in premature death and disability. While drug abuse often receives a great deal of media attention, the impact of alcohol and tobacco on morbidity and mortality far exceed all other drugs and accidents combined. Other chronic conditions such as diseases of the lungs, liver and kidneys, as well as intentional and unintentional injuries, are related to tobacco, alcohol and/or drug abuse.

Tobacco Use

Figure 23: Current Smokers, CT Adults (ages 18 and over), 1995-2010

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, Prevalence and Trends Data, http://apps.nccd.cdc.gov/BRFSS/index.asp, accessed 4/6/2011
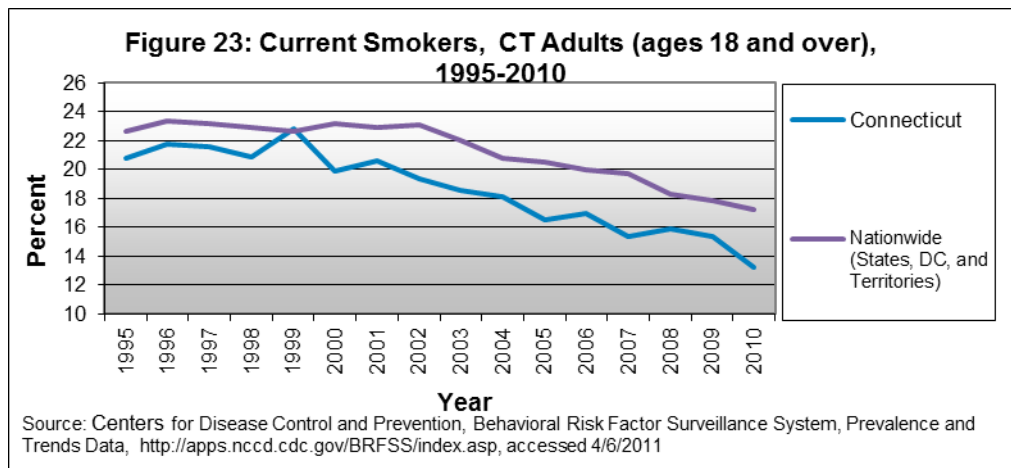
Figure 23 shows that adult tobacco use has been declining in Connecticut and nationwide; Figure 24 indicates a slight decrease in smoking among youth. In 2010, the prevalence of use among adults was much lower in Connecticut (13.2%) when compared to the national average (17.2%). Highlights from the 2010 Behavioral Risk Factor Surveillance System (BRFSS) and the 2009 Youth Risk Behavior Survey (YRBS) for Connecticut include:

- Men are slightly more likely to smoke than women (15.4% versus 11.1%).

- Younger adults, age 18-24 (20.4%), are much more likely to smoke than older adults (25-34 years: 18.5%, 35-44 years: 13.0%, 45-54 years: 12.5%, 55-64 years: 13.2%, and 65+ years: 5.0%).

- Hispanic/Latinos (14.0%) are more likely to smoke than whites or Black/African-
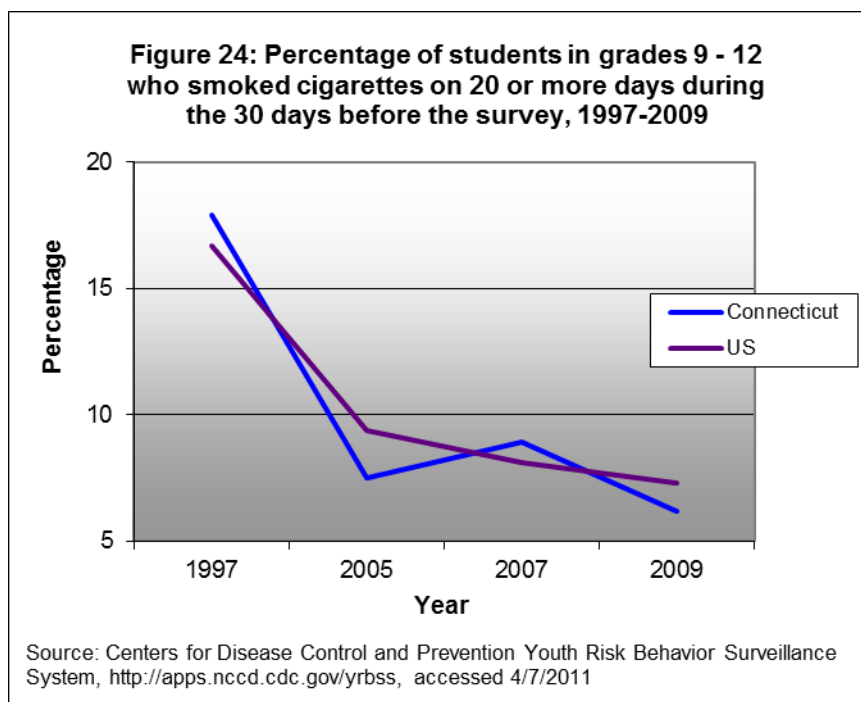
Americans (13.4% and 9.9% respectively). The percent of Black/African-American smokers decreased dramatically from 21.7% in 2007 to 9.9% in 2010.

- People with lower incomes are much more likely to smoke than those with higher incomes (< $15,000: 23.7%, $15,000-24,999: 24.2%, $25,000-34,999: 17.8%, $35,000-49,999: 20.5%, and >$50,000: 9.4%).

- Adults with a lower education are much more likely to smoke than those with more education (< high school: 24.2%, high school or GED: 19.3%, some post high school: 16.6%, and college graduate: 6.9%).

- Among female high school students in the 12th grade, whites are more likely to smoke.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Tobacco, Alcohol and Drugs, cont'd.

Tobacco Use, cont'd.

Figure 24: Percentage of students in grades 9 - 12 who smoked cigarettes on 20 or more days during the 30 days before the survey, 1997-2009

Source: Centers for Disease Control and Prevention Youth Risk Behavior Surveillance System, http://apps.nccd.cdc.gov/yrbss, accessed 4/7/2011

Findings: Although tobacco use has been declining in Connecticut, use among youth is just slightly below the national average. Data indicate a need for interventions targeted toward younger, less-educated, and lower-income adult audiences and teenage girls.

Alcohol Use

A major issue with alcohol use is binge drinking. Binge drinking — drinking to get drunk — is defined as consuming five or more drinks in a row for males and four or more drinks in a row for females. Binge drinking is especially a problem for young drinkers and can result in unintentional injuries and death. The drinker may be unable to make rational decisions, may be more likely to engage in acts of violence or be a victim, and more likely to be in a motor vehicle accident.
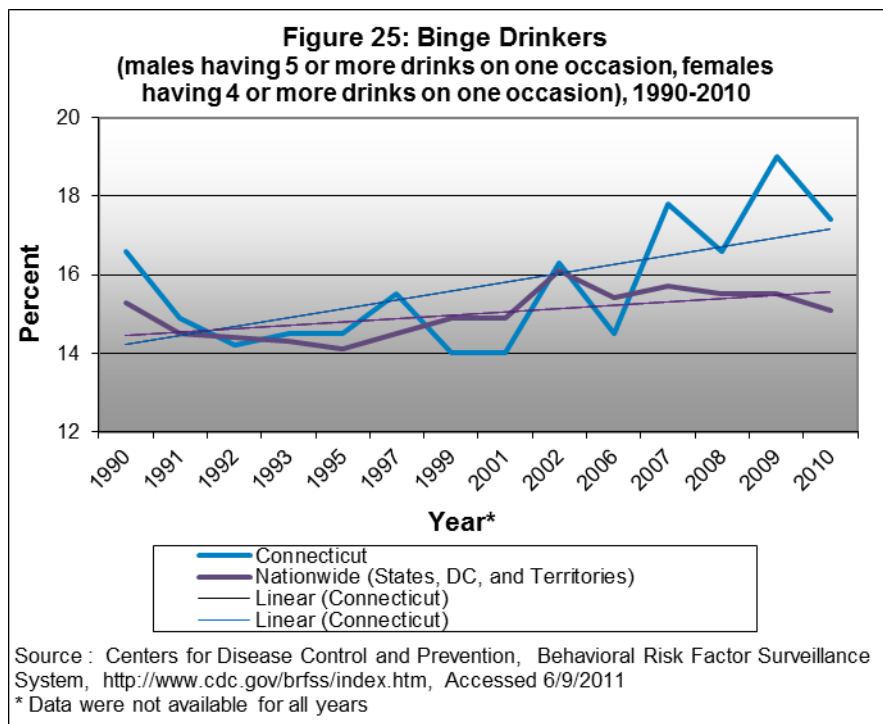
Although alcohol use is decreasing, binge drinking is increasing. The rate of binge drinking spiked in 2002 and in 2007, and reached almost 20% in 2009. The Connecticut Legislature changed the underage drinking laws in 2006 to include prosecution for underage drinking on private property in addition to public places specifically to address this problem. When compared with the nation, Connecticut has been close to the national average. In 2007, the percentage of binge drinking increased in Connecticut, surpassing the national average and it has since continued to be above the national average. People with an income of $30,000 or more and those with a high school degree or some college are likely to participate in binge drinking. Males are twice as likely as females (23.9% versus 11.5%); young adults (age 18-24) are twice as likely as 25-34 year olds and 9 times more likely than those over age 65; and Hispanic/Latinos are more likely to binge drink. Binge drinking interventions should focus on college students and younger adults in the work force.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Tobacco, Alcohol and Drugs, cont'd.

Alcohol Use, cont'd.

Figure 25: Binge Drinkers
(males having 5 or more drinks on one occasion, females having 4 or more drinks on one occasion), 1990-2010

Source : Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, http://www.cdc.gov/brfss/index.htm, Accessed 6/9/2011
* Data were not available for all years

Alcohol-related hospitalizations, whether into the emergency department for acute intoxication or into the inpatient unit for alcohol withdrawal and alcohol-related consequences, have risen slightly or are leveling off in most communities as Figure 26 illustrates. The exception to this is the rise in alcohol-related hospitalizations in Danbury in 2008 and in Bethel in 2010. The Danbury numbers remained high for 2009 and 2010.

Missing from alcohol-related hospitalizations is data on the lengths of stay and readmission rates, which would reveal a more important story regarding both the severity of those with alcohol-related problems and the success or lack thereof regarding access and response to treatment for those problems upon discharge.

Findings: Certain community characteristics could help to explain the higher rates of alcohol-related hospitalizations in Danbury and Bethel. When compared to the other towns, Danbury and Bethel have the lowest median incomes,

have school districts in lower District Reference Groups (DRGs), and, in 2006, had higher numbers of liquor permits per square mile. (Sources: Connecticut State Department of Education, http://www.sde.ct.gov/sde/LIB/sde/PDF/dgm/report1/cpse2006/appndxa.pdf and University of Connecticut Health Center, Department of Mental Health and Addiction Services, http://www.commed.uchc.edu/healthservices/sew/files/SI_MAP_Compendium.pdf accessed 9/2/2011).

Changes in the underage drinking laws could be a catalyst for increased use of emergency department services for intoxication. In addition, Danbury Hospital closed its detoxification center in 2008 and Midwestern Connecticut Council on Alcoholism (MCCA) opened an outpatient center in Danbury and transitional centers (one in Bethel and one in Danbury). The increased use of the hospital emergency department could potentially be a result of transports from the MCCA facilities to the hospital. (Source: Sharon Guck, Director CHOICES Program, WCSU, personal communication 9/1/2011).

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Tobacco, Alcohol and Drugs, cont'd.

Alcohol Use, cont'd.

Figure 26: Alcohol-related Hospitalizations per 1,000 population*, FY 2004-2010
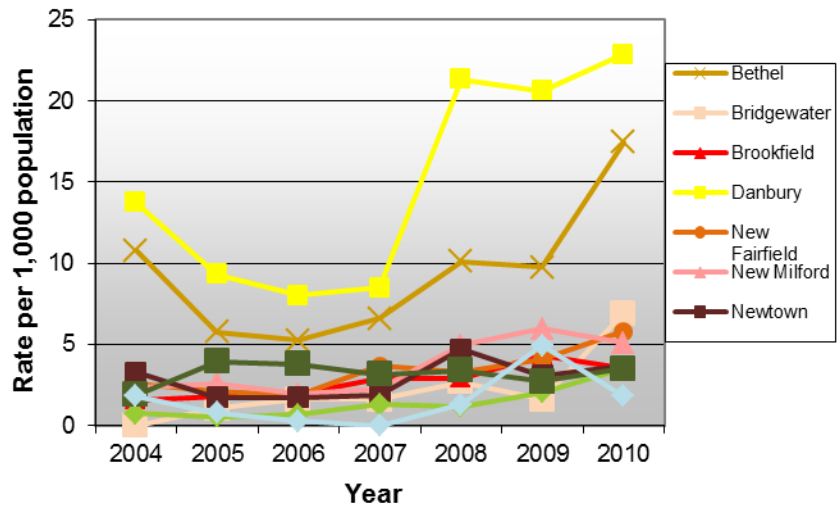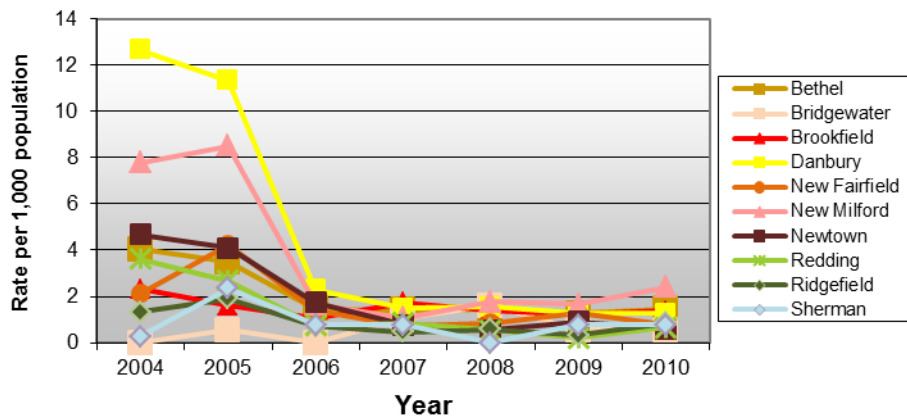
Sources: Source: Danbury and New Milford Hospital, data received July 31, 2008, August 26, 2008, March 23, 2011, March 28, 2011, and March 29, 2011
* Rate based on 2010 population Connecticut Economic Resource Center
http://www.cerc.com/townprofiles/, accessed 4/11/2011

Drug Use

Figure 27 indicates a decline in drug-related hospitalizations for Danbury residents and a slight decline or leveling for the other HVR communities.

Figure 27: Drug-Related Hospitalizations per 1,000 Population*, FY 2004-2010

Sources: Source: Danbury and New Milford Hospital, data received July 31, 2008, August 26, 2008, March 23, 2011, March 28, 2011, and March 29, 2011
* Rate based on 2010 population Connecticut Economic Resource Center
http://www.cerc.com/townprofiles/, accessed 4/11/2011

Findings: As Figure 27 demonstrates, overall there has been a substantial decline in drug-related hospitalizations for residents in the region from 2004-2006; with trends remaining relatively stable since 2007.

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Child Abuse

Although child abuse is not a lifestyle behavior or risk, it may be the outcome of other health and lifestyle factors, such as substance abuse. The term "child abuse" encompasses definitions categorized by two headings: abuse and neglect. The Connecticut Department of Children and Families (DCF) defines abuse as a non-accidental injury to a child that, regardless of motive, is inflicted or allowed to be inflicted by the person responsible for the child's care. This abuse primarily includes physical and sexual abuse. Neglect is the failure, whether intentional or not, of the person responsible for the child's care to provide and maintain adequate food, clothing, medical care, supervision, and/or education. A child is defined as anyone younger than 18. Table 13 presents the 2010 Census tally of children aged 18 and under in each town, the state of Connecticut, and the nation.

| Table 13: Percent of Total Population Aged 18 and Under, 2010			
Town	Percentage	Town	Percentage
Bethel	25.70%	New Milford	23.07%
Bridgewater	17.83%	Newtown	27.28%
Brookfield	25.47%	Redding	26.52%
Danbury	19.09%	Ridgefield	30.93%
New Fairfield	27.65%	Sherman	24.68%
Connecticut	22.74%	U.S.	23.69%
Source: Calculated based on data retrieved from Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 4/11/2011			

Figure 28 shows statewide data on child abuse for 2008 through 2010 and presents the number of substantiated child abuse allegations per type of abuse for the state.

Figure 28: Number of Statewide Allegations to DCF, 2008-2010
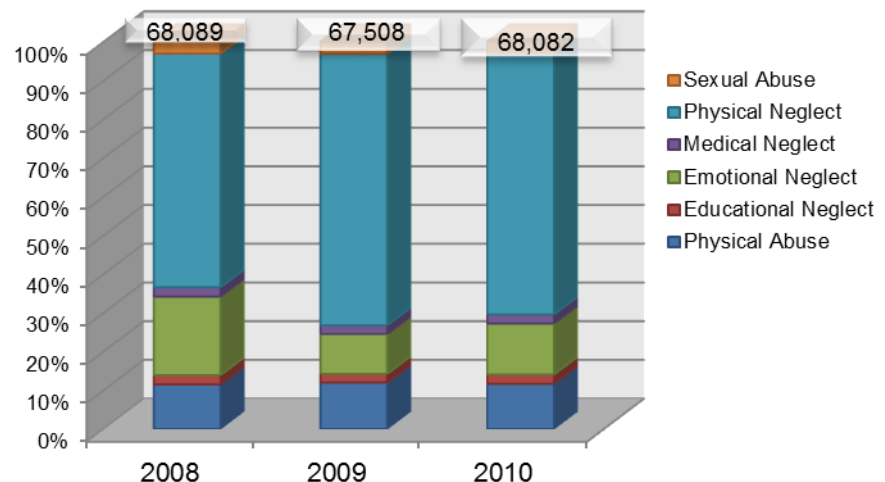
Source: State of Connecticut Department of Children and Families, http://www.ct.gov/dcf/lib/dcf/agency/pdf/tp_2010.pdf accessed 4/3/2011

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Child Abuse, cont'd.

Our community's statistics indicate that, for the most part, HVR municipalities fall below the state's average for the percent of children with substantiated allegations of child abuse. According to Childhelp®, the national average on a yearly basis of substantiated child abuse reports is 12.3 per thousand children. This mirrors the child abuse rates in our community. It is important to note that both local and national statistics reflect only child abuse cases that are reported. Experts estimate that the actual number of child abuse cases is three times higher than those reported. (Source: ChildHelp®, National Child Abuse Statistics, http://www.childhelp.org/pages/statistics accessed 8/6/2011).

Table 14 provides local data for child abuse claims for the community for 2009-2010. The table indicates the total child abuse allegations, the substantiated allegations, and the substantiation rate for the entire state. This data is not available for all towns each year.

Table 14: Child Abuse Cases Reported to Department of Children and Families, 2009 - 2010					
Community	Total	Substantiated	Number of Children Substantiated	Substantiation Rate	Percent of Children[1]
2009					
Bethel	146	26	19	18.0%	0.10%
Bridgewater					0.00%
Brookfield	77	22	13	29.0%	0.08%
Danbury	1,134	262	180	23.0%	0.23%
New Fairfield	81	20	12	25.0%	0.09%
New Milford	358	80	44	22.0%	0.15%
Newtown	117	20	14	17.0%	0.05%
Redding					0.00%
Ridgefield	104	24	16	23.0%	0.07%
Sherman	9	--	--	--	--
Connecticut	67,508	19,495	9,828	29%	0.28%
2010					
Bethel	183	56	40	31.0%	0.22%
Bridgewater					0.00%
Brookfield	89	16	11	18.0%	0.07%
Danbury	1,038	291	197	28.0%	0.25%
New Fairfield	98	35	23	36.0%	0.16%
New Milford	344	77	42	22.0%	0.15%
Newtown	125	34	21	27.0%	0.08%
Redding					0.00%
Ridgefield	120	18	14	15.0%	0.06%
Sherman					0.00%
Connecticut	68,082	19,315	9,873	28%	0.28%

Source: CT Department of Children and Families town pages,
http://www.ct.gov/dcf/lib/dcf/agency/pdf/tp_2010.pdf accessed 4/3/2011
Notes: For confidentiality reasons, data for towns with 10 or less Children Substantiated as Abuse/Neglect/Uncared For will not be reported as an individual town
Data are reported for Department of Children and Family's Fiscal Year (July 1 - June 30)
[1]Based on 2007 population estimates from Connecticut State Data Center, University of Connecticut, http://ctsdc.uconn.edu/Projections.html, accessed 1/9/2009

Health and Lifestyle Behaviors and Risk Factors: Indicators and Findings, cont'd.

Child Abuse, cont'd.

Findings: While there should be zero tolerance for any incident of child abuse, the data indicates that local substantiation rates (the number of reported incidents substantiated) are in line or better and the rate of substantiated is lower for our region than for Connecticut as a whole.

Diseases: Indicators and Findings

The incidence and prevalence of infectious and chronic diseases are major indicators of personal and community health. The 2009 Community Report Card for Western CT identified selected infectious diseases of high interest in our region including: Tuberculosis (TB), HIV/AIDS, Sexually Transmitted Diseases (STDs), and tick-borne illnesses. Chronic diseases identified as high interest include: asthma, diabetes, cancer, and cardiovascular disease. Although this is not an exhaustive list of diseases of concern to our community, it represents selected conditions of high interest to monitor improvements in health over time.

The data and narrative which follow provide an update of the impact of these diseases in the community – including such factors as hospitalization rates, incidence, prevalence, and mortality (death) rates. The results of disease-specific surveillance reports for the state and municipalities in our region are also included as relevant to these selected diseases. Examination of the diseases most impacting health is important to determining methods to minimize premature illness and death by enhancing primary, secondary, and tertiary prevention efforts targeted to priority health concerns.

Chronic Diseases

Cardiovascular Disease, Cancer, and Diabetes

These three chronic diseases are leading causes of death in the country, state, and region. Risk for developing these diseases can be greatly reduced through healthy lifestyle choices.

Table 15: Number of Deaths per 100,000 Population, 2005-2007									
	2005			2006			2007		
	Diabetes[1]	Heart Disease[2]	Cancer[3]	Diabetes[1]	Heart Disease[2]	Cancer[3]	Diabetes[1]	Heart Disease[2]	Cancer[3]
Connecticut	20	173	179	19.2	177.3	177.8	15.8	171	170.7
United States	25	211	184	23.3	200.2	180.7	22.5	190.9	178.4

Source: Data were retrieved from : http://statehealthfacts.org/ accessed 4/1/2011, the following were the primary sources for these data:
[1] Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Compressed Mortality File (CMF) compiled from 2005, Series 20 No. 2K, 2008.
[2] Source: The Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, Division of Vital Statistics, National Vital Statistics Report Volume 56, Number 10, April 24, 2008, Table 29. Available at http://www.cdc.gov/nchs/pro Note: Cerebrovascular disease or stroke deaths are not included in Heart Disease rates.
[3] Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Compressed Mortality File (CMF) compiled from 1999-2005, CDC WONDER On-line Database

Diseases: Indicators and Findings, cont'd.

Chronic Diseases, cont'd.

Cardiovascular Disease, Cancer, and Diabetes, cont'd.

Cardiovascular diseases (CVD) are the leading cause of death in the United States and world-wide. Cardiovascular diseases include coronary heart disease (CHD), cerebrovascular disease (stroke), and heart failure. CVD is the leading cause of death in Connecticut, accounting for about one-third of all Connecticut resident deaths. More than half (55%) of these deaths are among females. Risk factors for CVD may be modifiable or non-modifiable. Modifiable risk factors include high blood pressure, high blood cholesterol, smoking, diabetes, obesity, and physical inactivity. Non-modifiable risk factors include increasing age and family history of heart disease and stroke. The age adjusted mortality rates for CVD declined significantly for CT residents from 1999-2008. There are considerable disparities in mortality from CVD, with Black/African American residents having the highest age-adjusted mortality rates. (Source: State of Connecticut, Department of Public Health, the Burden of Cardiovascular Disease in Connecticut, 2010 Surveillance Report, http://www.ct.gov/dph/lib/dph/hisr/pdf/2010cvd_burdendoc_final.pdf accessed 8/21/2011).

The second leading cause of death in the United States and Connecticut is cancer. The death rate and the annual rate of new cancer cases have been decreasing. This is the result of increased primary prevention efforts, earlier detection (secondary prevention) and improved treatment options. (Source: State of Connecticut, Department of Public Health, Connecticut Comprehensive Cancer Control Program, Connecticut Cancer Plan 2009-2013, http://www.ct.gov/dph/lib/dph/comp_cancer/pdf_files/ctcancerplan_2009_2013_cdversion.pdf accessed 8/21/2011).

In 2008, the age-adjusted cancer incidence rate in Connecticut was estimated at 499.8 per 100,000 people, a decrease from the 2007 rate of 502.5 per 100,000 people. (Source: National Cancer Institute, State Cancer Profiles, http://statecancerprofiles.

cancer.gov/ accessed 8/21/2011). As noted in the CT DPH *2009 Connecticut Health Disparities Report*, Black/African American residents have the highest cancer mortality rate, followed by white residents. Hispanic/Latino and Asian/Pacific Islander residents have the lowest cancer mortality rates.

In 2008, diabetes was the eighth leading cause of death in Connecticut. In Connecticut (2007-2009 data), an estimated 6.9% or approximately 186,000 adults aged 18 and older reported being diagnosed with diabetes. An additional 93,000 adults are estimated to have undiagnosed diabetes. The prevalence of type 2 diabetes in Connecticut and in the nation has increased significantly. This is the most common form of diabetes and was previously known as adult onset diabetes. Type 2 diabetes typically develops later in life and is strongly linked to overweight and obesity. In type 2 diabetes, either the body does not produce enough insulin or the cells ignore the insulin. In contrast, type 1 diabetes is usually diagnosed in children and young adults, and was previously known as juvenile onset diabetes. Type 1 diabetes, the body does not produce insulin.

Risk factors for diabetes are both modifiable with primary prevention (physical activity and healthy eating) and non-modifiable (genetic). In addition to practicing healthy lifestyle behaviors, persons with insulin-dependent diabetes must control their diabetes with medication. The impact of diabetes on a person's health can be minimized with regular medical care and self-monitoring of blood glucose levels. (Source: State of Connecticut, Department of Public Health, the Burden of Diabetes in Connecticut, 2010 Surveillance Report, http://ct.gov/dph/lib/dph/hisr/pdf/2010diabetesburden_final.pdf accessed 8/21/2011).

Diseases: Indicators and Findings, cont'd.

Chronic Diseases, cont'd.

Cardiovascular Disease, Cancer, and Diabetes, cont'd.

As stated in the *2009 Connecticut Health Disparities Report*, lower income and Hispanic/Latino and Black/African American residents have a higher prevalence of diabetes and a higher mortality rate from this disease.

Findings: CT age-adjusted rates for Heart Disease, Cancer, and Diabetes compare favorably with those for the U.S. as a whole, however the rates for Cancer and

Heart Disease remain above *Healthy People 2020* targets. Due to their prevalence, these conditions are major causes of premature disability and death, and result in significant health care costs. Disparities in disease prevalence and mortality rates by racial/ethnic group and socioeconomic status are also evident.
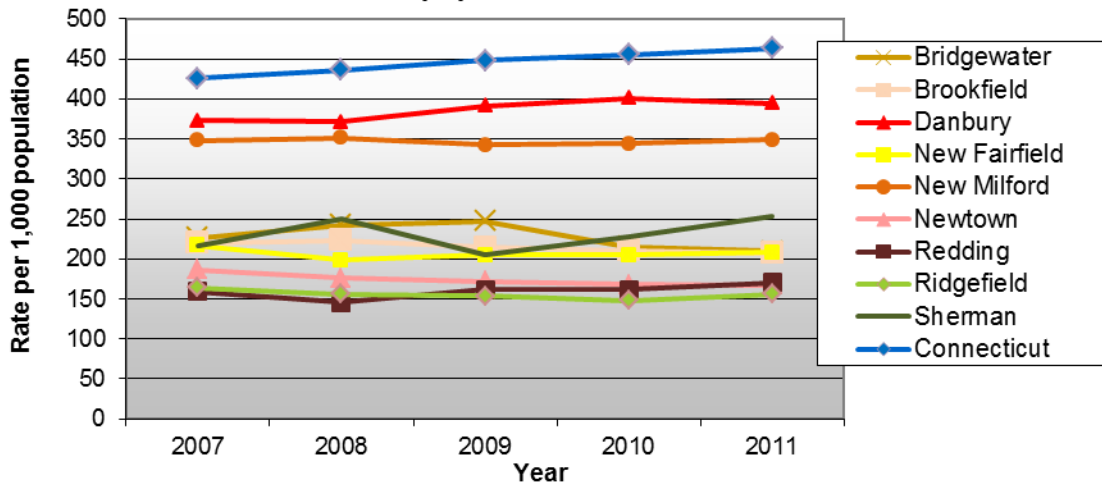
Asthma

Asthma is a chronic respiratory condition that inflames the airways which restricts the flow of air in and out of the lungs. Asthma is one of the most common chronic diseases in children, and a major cause of school absenteeism. Asthma is associated with exposure to allergens, indoor pollutants (such as tobacco smoke), and ambient air pollutants. Asthma is more common in persons living in poverty. These individuals are generally less likely to receive regular or specialized medical care, and are more likely to smoke and

live in substandard housing, therefore experiencing greater exposure to asthma irritants. (Source: American Lung Association. http://www.lung.org/lung-disease/asthma/, accessed 2/20/12).

Figure 29 provides local data for asthma-related hospital emergency department visit rates for the years 2007 to 2011. The rates have remained relatively consistent over time. The rates in Danbury and New Milford are higher than those for other HVR municipalities, however all HVR rates fall below those for the state.

Figure 29: Asthma-Related Emergency Department Visits per 1,000 population*, 2007-2011

Source: CT Hospital Association, CHIME PCR Reports
* Rate based on 2010 population Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 4/11/2011

Diseases: Indicators and Findings, cont'd.

Chronic Diseases, cont'd.

Asthma, cont'd.

As reported by CT DPH in the *Connecticut School-based Asthma Surveillance Report for 2010*, asthma prevalence rates among Connecticut public school students have remained fairly constant since 2006, measured most recently at 13.1% for school year 2008-2009. Asthma prevalence rates during this time were higher among students in grade PK or K than for students in either grades 6-7 or grades 9-11 and higher among male students than female students. For example, during the school year 2008-2009, the asthma rates were 14.5% among male students and 11.6% among female students.

Students from racial and ethnic subgroups experienced different rates of asthma during this same time period. Hispanic/Latino students had the highest rates of asthma followed by Black/African American students, other race/ethnicity students, and white students. Specifically, during 2008-2009, the asthma rates were 16.9% among Hispanic/Latino students, 14.8% among Black/African American students, 12.2% among students of other race/ethnicity, and 10.6% among white students. In general, asthma rates increased with decreasing socioeconomic status as measured by school District Reference Group or DRG. Asthma prevalence rates by public school district for HVR communities are provided in Table 16.

Table 16: Asthma Prevalence Rates by School District, 2006-2009 Average			
Town	Percentage	Town	Percentage
Bethel	12.4%	Newtown	10.4%
Brookfield	9.7%	Redding	8.5%
Danbury	11.2%	Ridgefield	6.8%
New Fairfield	9.4%	Sherman	13.5%
New Milford	15.2%	Connecticut	13.2%
Source: CT DPH Connecticut School-based Asthma Surveillance Report 2010 http://www.ct.gov/dph/lib/dph/hems/asthma/pdf/schoo_base_asthma_surveillance_report_2010.pdf, assessed 2/20/12 Note: Bridgewater is included in Region 12.			

Findings: Asthma tends to be more prevalent in urban areas, so it is expected that Danbury and New Milford would have the highest emergency department visit rate in our region. The rates for all HVR municipalities are consistently lower than the rate for the state.

Asthma prevalence in school children is higher than the state three year average in two HVR communities – New Milford and Sherman. As Sherman is a rural and relatively affluent K-8 district, this higher rate may reflect the younger age distribution of students in the district.

Diseases: Indicators and Findings, cont'd.

Infectious Diseases

Tuberculosis

Tuberculosis (TB) is a disease caused by a bacterium called *Mycobacterium tuberculosis*. The bacteria usually attack the lungs, however TB bacteria can attack any part of the body. Tuberculosis remerged as a public health issue in the 1980's, peaking in 1992. In 2010, 60% of reported TB cases in the United States occurred in foreign-born persons. There are a number of foreign countries which are endemic for Tuberculosis, most notably in sub-Saharan Africa and Asia. The case rate among foreign-born persons (18.1 cases per 100,000) in 2010 was approximately 11 times higher than among U.S.-born persons (1.6 cases per 100,000). In 2010, both the number of TB cases reported and the case rate decreased compared to 2009. In 2010, the number of reported TB cases in 2010 was the lowest recorded since national reporting began in 1953. CT's TB case rate ranked 24th out of the 50 states in 2010. (Sources: Centers for Disease Control and Prevention. Reported Tuberculosis in the United States, 2010 http://www.cdc.gov/tb/statistics/reports/210/table20.htm and Trends in Tuberculosis, 2010 http://wwwcdc.gov/tb/publications/factsheets/statistics/TBTrends.htm, accessed 2/21/12.)

Tuberculosis is associated with poverty and substandard, crowded living conditions. The bacteria are released into the air when a person with active TB coughs or sneezes. Co-infection in persons with human immunodeficiency virus (HIV) infection is also a concern as the condition thrives in individuals with compromised immune systems.

Table 17: Annual TB Incidence by City and Year, 2005 - 2010						
	2005	2006	2007	2008	2009	2010*
Bethel	0	0	0	0	1	1
Bridgewater	0	0	0	0	0	0
Brookfield	0	0	0	0	0	0
Danbury	6	6	11	4	4	7
New Fairfield	0	0	1	0	0	0
New Milford	0	0	1	0	0	0
Newtown	0	0	0	0	1	0
Redding	0	0	0	0	0	0
Ridgefield	0	0	0	0	0	0
Sherman	0	0	0	0	0	0
State	95	89	108	98	95	85

Sources: Connecticut Department of Public Health. http://www.ct.gov/dph/lib/dph/CityByYear2000_2009.pdf. accessed 4/3/2011 and CDC Reported Tuberculosis in the United States, 2010 http://www.cdc.gov/tb/statistics/reports/2010/tablre20.htm, accessed 12/20/12

 * Local TB clinic data received from Maureen Singer, R.N., City of Danbury TB Clinic. Personal communication with Andrea Rynn 5/11/2011

Diseases: Indicators and Findings, cont'd.

Infectious Diseases, cont'd.

Tuberculosis, cont'd.

Findings: It appears that tuberculosis is not a major health issue in the HVR except in Danbury. "Danbury continues to have a higher incidence of tuberculosis than either the state as a whole or the nation at large. Most of the Danbury cases have occurred in persons born in Latin America or Asia who acquired a latent infection while resident in their home country which then reactivated some time after arrival in the U.S. Because there are large populations in Danbury from Brazil, Ecuador and Indochina at risk of reactivation TB as they age, the community is likely to continue to experience TB cases well into the future. This problem may well be augmented by travel and visitation to the home countries where the disease remains prevalent." (Source: Scott LeRoy, Director of Health, Danbury Health and Human Services Department, email communication received August 16, 2011).

Tick-Borne Illness

Our region has a higher rate of tick-borne illness than most other geographic areas in the nation. There are also extremely high rates reported in neighboring Hudson Valley New York counties. There are many varieties of tick-borne diseases but this report will focus on three: Lyme disease, Ehrlichiosis, and Babesiosis. The positive news is that effective precautions can significantly reduce the risk of contracting these illnesses.

According to CDC, Lyme disease is caused by the bacterium *Borrelia burgdorferi* and is transmitted to humans through the bite of infected blacklegged ticks. In Ehrlichiosis is also transmitted to humans by the bite of an infected tick. The lone star tick (Amblyomma americanum) is the primary vector of both *Ehrlichia chaffeensis* and *Ehrlichia ewingii* in the United States. Babesiosis is carried by blacklegged ticks infected with the *Babesia* parasite.

Figure 30: Lyme Disease Rates per 100,000 Population, 2003-2010
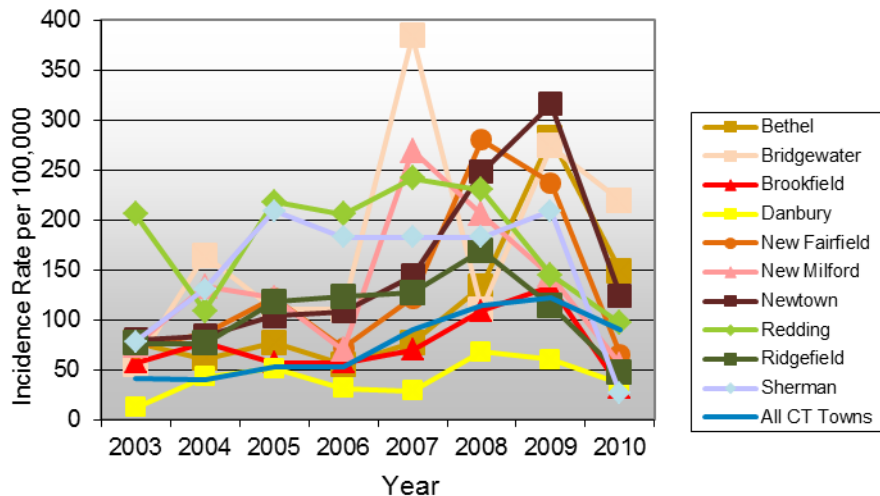
Source Connecticut Department of Public Health
http://www.ct.gov/dph/cwp/view.asp?a=3136&Q=399694&dphPNavCtr=|46973|#46999 Accessed 4/3/2011

Diseases: Indicators and Findings, cont'd.

Infectious Diseases, cont'd.

Tick-Borne Illness, cont'd.

Untreated Lyme disease can potentially result in extremely serious health consequences. Some people infected with Ehrlichiosis may have symptoms so mild that they never seek medical attention, and the body fights off the illness on its own. But untreated Ehrlichiosis with persistent symptoms can result in serious illness as well. Most patients recover from Babesiosis with few, if any, lasting effects.

The Housatonic Valley Council of Elected Officials (HVCEO) has endorsed the tick-borne disease prevention program called "BLAST" in all 10 HVCEO municipalities. The Ridgefield Health Department received a grant from the Connecticut Department of Public Health to create this unique health education program in 2008. BLAST stands for the five most important things families can do to stay safe from tick-borne illness (Bathe within two hours of outdoor activity, Look for ticks and rashes daily, Apply repellents to skin and clothing, Spray the yard perimeter for ticks, and Treat pets with veterinarian recommended products). The BLAST Program includes printed materials, age-appropriate power point presentations and health fair display materials in both English and Spanish. Trained community volunteers are available year round to staff community and corporate wellness events. Complete information about the program is available on the Town of Ridgefield website: www.ridgefieldct.org.

In addition, Western Connecticut State University is the setting for an annual Spring Lyme disease patient seminar and health fair coordinated by area task forces and Rotary Clubs. The event recognizes May as Lyme Awareness month and features practitioners and resources that may be helpful to this patient population. Lyme patients are also served by the Ridgefield Visiting Nurse Association's Lyme, Chronic Fatigue and Fibromyalgia Support Group. This free drop-in group, which is open to all area residents, meets at noon on the second Thursday of each month. Details can be found at www.ridgefieldvna.org under Community Wellness. A complete listing of local tick-borne disease related events, support services and resources can be found on the HVCEO Tick-Borne Illness Prevention Center website at www.hvceo.org/lymemain.php. (Source: Jennifer Reid, BLAST Program Coordinator, e-mail communication received 8/31/2011).
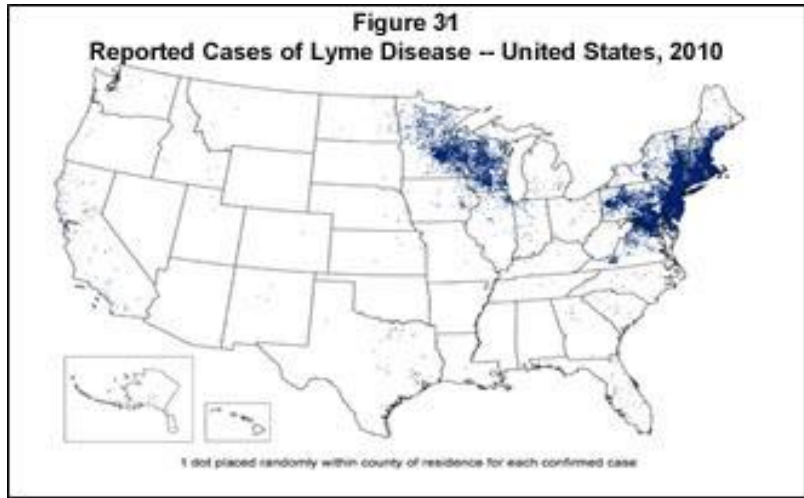
The Western Connecticut Health Network's Biomedical Research Institute currently operates the state's only Lyme Disease Registry. The purpose of the Registry is to create a comprehensive database of Lyme disease patients to support multidisciplinary research leading to a better understanding of: 1) the course of disease and how people are affected; 2) causes of persistent symptoms; and 3) improved diagnosis and treatment. The Registry is seeking persons ages 5 and older who have been diagnosed with Lyme by a health care provider. Participants are asked to answer questions about their symptoms and treatment and provide a blood sample. Participation is free, voluntary, and strictly confidential. Only one visit is required; all follow-up is conducted by mail or email. For more information or to participate, contact the Registry at 203-739-8383 or by mail: lymeregistry@danhosp.org.

Findings: The data in Figure 30 show that Lyme disease is a prevalent health concern in the region; preventive health education initiatives are underway. Figure 31 graphically depicts the number of new Lyme disease cases reported across the country. It is evident that Lyme disease remains a priority health issue in our region.

Diseases: Indicators and Findings, cont'd.

Infectious Diseases, cont'd.

Tick-Borne Illness, cont'd.

Figure 31
Reported Cases of Lyme Disease -- United States, 2010

1 dot placed randomly within county of residence for each confirmed case

Human Immunodeficiency Virus (HIV) and Sexually Transmitted Diseases (STDs)

These conditions are preventable through education and safe sex practices. Injection drug use and risky sexual practices, including prostitution, are contributing factors in many HIV and STD cases. STD cases are on the rise nationally among high school students.

At a national level, the estimated number of HIV cases in 2009 as reported in 40 states with confidential name-based HIV infection reporting was 42,011 (rate of 17.4 per 100,000 population).

This represents a slight increase from 2008 (42,005 cases). During the same year, the estimated number of cases of AIDS in the United States and dependent areas was 34,247 (rate of 11.2 per 100,000 population), a decrease from 2008 (34,755 cases). (Source: Centers for Disease Control and Prevention, HIV/AIDS Statistics and Surveillance, http://www.cdc.gov/hiv/topics/surveillance/index.htm accessed 8/13/2011). As shown in Table 18, Danbury has the largest number of residents living with HIV/AIDS in the region.

Table 18: HIV/AIDS Surveillance Program HIV and AIDS Cases Reported by City/Town of Residence 2009 and cumulative from 1980 through December 31, 2009*

	HIV/AIDS			
	Incidence[1] 2009	1980-2009	Living with 2009 [2]	Living with 2008 [2]
Bethel	1	29	21	20
Bridgewater	0	2	1	1
Brookfield	1	21	11	10
Danbury	9	407	215	224
New Fairfield	1	13	4	6
New Milford	0	54	24	29
Newtown	0	4	3	12
Redding	1	19	8	10
Ridgefield	0	22	13	13
Sherman	0	6	1	1
ALL CT Towns	538	19,473	10,574	10,860

*HIV and AIDS data are combined for 2009. The data were reported separately in previous years
[1]Current year data are new cases for the year.
[2]This number includes all cases from 1980 to current year still living.
Source: Connecticut Department of Public Health.
http://www.ct.gov/dph/lib/dph/aids_and_chronic/surveillance/city_and_county/ct_hivaids_town_currentyear_table_new.pdf, Accessed 4/3/2011

Diseases: Indicators and Findings, cont'd.

Infectious Diseases, cont'd.

Human Immunodeficiency Virus (HIV) and Sexually Transmitted Diseases (STDs), cont'd.

According to CDC, Chlamydia is the most commonly reported sexually transmitted disease in the United States with 1,244,180 cases in 2009 (409.2 per 100,000 people), increased 3% from 2008 and 19% from 2006. Gonorrhea is the second-most commonly reported STD with 301,174 cases in 2009 (99.1 cases per 100,000 people). Nationally, Gonorrhea rates declined 10% since 2008 and are at the lowest level since tracking began in 1941. Although the number of cases of primary and secondary syphilis is much lower (13,997 in 2009), the rate has been increasing. The national rate per 100,000 people is 4.6 for

2009, an increase of 5% from 2008 and 39% since 2006. (Source: Centers for Disease Control and Prevention, STD Surveillance, 2009 http://www.cdc.gov/std/stats09/default.htm accessed 8/13/2011).

Table 19 shows the cases of Chlamydia, Gonorrhea, and Syphilis as reported by the Connecticut STD Control Program for 2007 and 2009. The largest increase in the number of Chlamydia cases was reported in Danbury residents; the largest increase in Gonorrhea cases was reported in Bethel residents. Fortunately, there were no Syphilis cases reported in the region in 2009.

Table 19: Chlamydia, Gonorrhea, and Primary and Secondary Syphilis Cases by HVR Municipality and CT, 2007 and 2009

	2007				2009			
	Chlamydia cases	Gonorrhea cases	Syphilis cases	Total Cases	Chlamydia cases	Gonorrhea cases	Syphilis cases	Total Cases
Bethel	22	0	0	22	19	20	0	39
Bridgewater	0	0	0	0	0	0	0	0
Brookfield	10	1	0	11	8	1	0	9
Danbury	131	17	0	148	197	9	0	206
New Fairfield	10	0	1	11	11	2	0	13
New Milford	20	1	0	21	37	3	0	40
Newtown	6	3	1	10	17	1	0	20
Redding	4	0	0	4	6	0	0	6
Ridgefield	9	1	0	10	9	1	0	10
Sherman	0	0	0	0	3	3	0	6
State Total	11,512	2,332	39	13,883	12,136	2,554	65	14,755

Source: CT Department of Public Health. http://www.ct.gov/dph/lib/dph/infectious_diseases/std/std_city.pdf, Accessed 4/1/2011

Findings: Six of the 10 HVR municipalities have experienced an increase in the number of STD cases; Danbury has seen the largest increase in absolute numbers.

## Diseases: Indicators and Findings, cont'd.

Leading Causes of Death and Mortality Rates

Examination of the leading causes of death and other mortality data is essential to assessing and monitoring the health of a community. This information is also critical to identify priority needs for programs and services to prevent or reduce premature death and disability from chronic diseases and injury.

Figure 32 presents the leading causes of death in the United States and Connecticut for 2007. Table 20 shows the leading causes of death in our community and Connecticut for 2005-2009.

Although the 10 causes of death are not in the same rank order for each community, the underlying causes of death are chronic conditions which are related to behavioral risk factors. Efforts should be focused on supporting health-promoting behaviors along with awareness education and skill-building. This is especially true of physical activity; healthy eating; avoiding tobacco use, alcohol abuse, and illicit drugs; managing stress; and other preventive lifestyle behaviors.

Figure 32: Leading Causes of Death United States and Connecticut, 2007
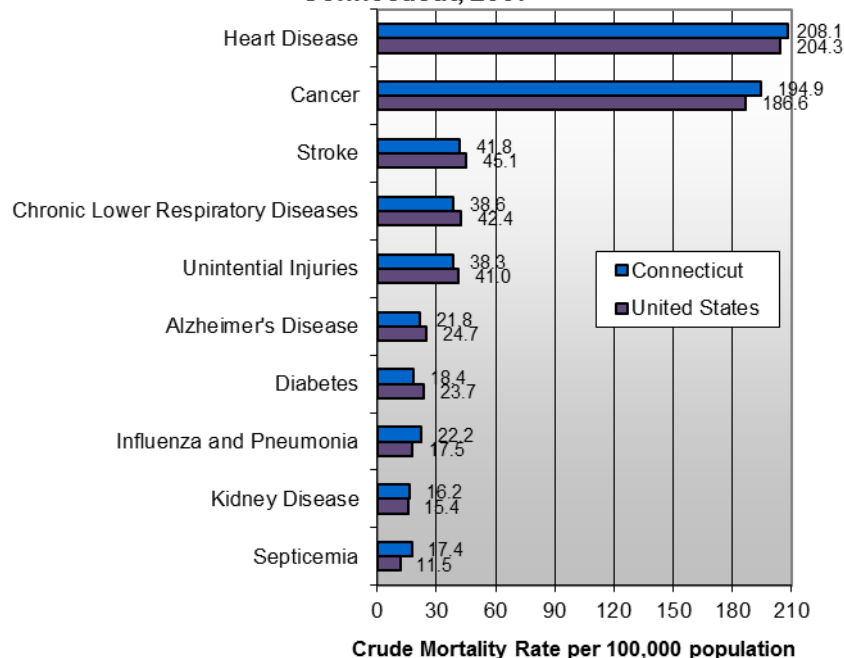
Source: Centers for Disease Control and Prevention, National Center for Health Statistics
http://www.cdc.gov/nchs/data/dvs/LCWK9_2007.pdf, accessed 4/3/2011

Updated data from the National Center for Health Statistics for the 10 leading causes of death in CT residents reveal that the rank order (from first to last) in 2009 was the same as that shown in Figure 32 with the exception of kidney disease now ranked as the 9th leading cause and septicemia as the 10th leading cause. It is noteworthy that there

are differences in the rank order of the leading causes of death by gender and race/ethnicity. For example, the leading cause of death for males of all races/ethnicities in CT is cancer and for females it is heart disease. For both White males and females, the leading cause of death in 2009 was heart disease, followed by cancer. For

Diseases: Indicators and Findings, cont'd.

Leading Causes of Death and Mortality Rates, cont'd.

Black/African American and Hispanic/Latinos residents, the leading cause of death was cancer for both genders, followed by heart disease. (Source: National Center for

Injury Prevention and Control, Centers for Disease Control and Prevention, WISQARS Leading Causes of Death Reports, 1999-2009, http://ebappa.cdc.gov/cgi-bin/broker.exe, accessed 2/23/12.)

Community	Heart Disease	Cancer	Stroke	Chronic Lower Respiratory Diseases	Unintentional Injuries	Alzheimer's Disease	Diabetes	Influenza and Pneumonia	Kidney Disease	Septicemia	Suicide	Chronic Liver Disease and Cirrhosis
Bethel	169.2	158.3	28.2	45.6	29.3	9.8	13.0	17.4	9.8	14.1	7.6	4.3
Bridgewater	157.8	218.4	12.1	36.4	-	12.1	48.5	-	36.4	24.3	-	24.3
Brookfield	162.5	163.7	25.7	36.6	22.0	15.9	14.7	8.6	9.8	13.4	7.3	7.3
Danbury	166.7	154.0	24.6	32.3	26.4	13.0	16.8	12.5	9.1	14.5	8.6	7.6
New Fairfield	121.1	122.5	18.5	21.4	31.3	17.1	11.2	15.7	4.3	19.6	8.5	7.1
New Milford	235.6	156.8	28.8	37.3	30.9	28.1	11.3	19.0	8.4	16.2	7.7	10.5
Newtown	141.7	165.7	28.5	29.2	28.5	12.0	9.0	13.5	11.2	10.5	7.5	1.5
Redding	210.1	210.1	59.4	34.3	36.5	36.5	2.3	20.6	9.1	18.3	11.4	9.1
Ridgefield	134.7	135.5	29.3	23.4	20.9	14.2	10.9	12.5	10.9	9.2	5.0	2.5
Sherman	107.7	142.0	29.4	14.7	14.7	19.6	9.8	4.9	4.9	9.8	14.7	9.8
Connecticut	209.0	195.7	42.0	41.1	36.0	22.1	19.8	22.2	16.3	16.8	8.1	8.1

Table 20: Leading Causes of Death, 2005-2009 Average Crude Rate[1]

Source: Connecticut Department of Public Health Epidemiology Program, email communication 2/24/12
[2] Crude mortality rates were used for this table since the age-adjusted mortality rates were not available for all causes of death

It is important to note that Figure 32 and Table 20 reflect crude mortality rates, which have not been age-adjusted. Crude mortality rates are useful to assess the magnitude of the number of deaths in a community, however they do not account for differences in rates that are attributable to differences in the age composition of the resident population. For example, communities with a higher proportion of older residents, such as Bridgewater, would be expected to have higher mortality rates from chronic diseases, as the incidence and prevalence of these diseases increase with age. Age-adjusted mortality rates (AAMR) correct for differences in age distribution of communities, and therefore give an accurate representation of excess disease mortality. In 2008, CTDPH published two reports of age-adjusted town-state comparisons

for the ten leading causes of death in CT residents for the time period 2002-2006. These reports can be accessed at www.ct.gov/dph/lib/dph/hisr/hcqsar/mortality/pdf/aamr_comparisons_2002_2006.pdf and www.ct.gov/dph/lib/dph/hisr/hcqsar/mortality/pdf/lcod_2002-2006_aamr.pdf.

Statistically significant findings from 2002-2006 of relevance to HVR municipalities include:

- Bethel, Brookfield, New Milford, and Newtown had a *higher AAMR from all causes* for both genders combined compared with the state as a whole.

- Bethel and Newtown had a *higher AAMR for all causes for males* compared with males in the state as a whole.

Diseases: Indicators and Findings, cont'd.

Leading Causes of Death and Mortality Rates, cont'd.

- Bethel had a *higher AAMR for Major Cardiovascular Diseases and Diseases of the Heart for males* compared with males in the state as a whole.

- Danbury had a *higher AAMR for Coronary Heart Disease for both genders* combined compared with the state as a whole.

- Danbury had a *lower AAMR for Congestive Heart Failure for both genders* combined and for females compared with the state as a whole.

- New Milford had a *lower AAMR for Diseases of the Heart for both genders* combined compared with the state as a whole.

Updated age-adjusted mortality data provided by CTDPH for all causes of death by municipality for the five-year period 2005-2009 shows that the overall AAMR is *lower* than the state AAMR for the majority of HVR communities. The AAMR for all causes of death was lower than the state rate at statistically significant levels in Bethel, Bridgewater, Danbury, New Fairfield, Redding, and Ridgefield,

and statistically higher than the state rate in New Milford.

Findings: When examining the leading causes of death in Connecticut and the U.S., data show HVR municipalities overall compare favorably, with some exceptions. Since 2000-2004, there has been a decline in the mortality rates for many the leading causes of death in the nation, state, and our region. However, the high prevalence of these conditions in the population warrants ongoing prevention efforts. Table 20 reflects crude death rates, which are statistically invalid for comparisons across communities. However, it is interesting to note that, based on crude mortality rates, Sherman, which has the second highest proportion of persons ages 50 and over in the region, had the lowest rates for heart disease, chronic lower respiratory diseases, unintentional injuries, and influenza/pneumonia. Data for 2005-2009 provided by CT DPH reflect a lower AAMR from all causes of death compared with the state in the majority of HVR municipalities.

Infant Mortality

Infant mortality is commonly used as an indicator of a community's health. The infant mortality rate typically varies from year to year in communities such as the HVR where there are a small number of

infant deaths per year. Table 21 shows the number of infant deaths and rate of infant mortality in HVR communities from 2004 to 2006 and 2006 to 2008.

Diseases: Indicators and Findings, cont'd.

Infant Mortality, cont'd.

Table 21: Infant Mortality Rates in HVR Municipalities, 2004-2008				
	2004-2006		2006-2008	
	Number	Rate	Number	Rate
Bethel	4	*	5	8.0
Bridgewater	0	0.0	0	0.0
Brookfield	1	*	1	*
Danbury	15	4.4	19	5.2
New Fairfield	2	*	2	*
New Milford	7	6.7	5	5.3
Newtown	0	0.0	0	0.0
Redding	0	0.0	0	0.0
Ridgefield	1	*	1	*
Sherman	2	*	0	0.0
Connecticut	717	5.7	753	6.2
United States (2006 & 2007)	28,527	6.7	29,138	6.8

Source: Connecticut Association for Human Services Connecticut Kid Count http://www.cahs.org/publications-kidscount.asp accessed 5/30/2011
 +National KIDCOUNTS Data Center http://datacenter.kidscount.org/data/acrossstates/NationalProfile.aspx accessed 5/31/2011
Rate is per 1,000 live births
* Rates are not calculated for cases of less than 5 events

Findings: In general, the infant mortality rate in Connecticut has increased but is still lower than the national average. With the small number of events in our communities, the rates vary considerably, with no consistent trend.

Suicide Mortality

Suicide can have a profound effect on a community. At times, especially in the suicide of a young person, an entire community suffers from feelings of guilt over what might have been done to prevent it. The sense of community is equally jarred when an adult commits suicide. A community's behavioral health resources should be fully engaged in the healing and recovery process and in ongoing prevention efforts.

Key findings from a special report issued by CT DPH and previously summarized in the *2009 Community Report Card* are provided for reference.

- Suicide was the second leading cause of injury death in Connecticut accounting for 18.1% of all injury-related deaths between 2000–2004, with 1,396 suicide deaths, for an average of 279 suicides a year.

- The cities and towns with the highest number of suicide deaths among residents were Hartford (60), New Haven (51), Bridgeport (45), Waterbury (40), Meriden (34), New Britain (34), Bristol (31), Stamford (29), East Hartford (28), Danbury (27), and Fairfield (25).

- Overall, males completed suicide at a rate of four times

Diseases: Indicators and Findings, cont'd.

Suicide Mortality, cont'd.

higher than females and up to 11 times higher among the 65–69 age group reaching a peak rate of 30.2 per 100,000 males 85 years or older. Females experienced their highest suicide death rate between 45–49 years.

- Suicide rates were roughly twice as high among non-Hispanic Whites (8.7 per 100,000 population) as compared to either Hispanics (4.6 per 100,000 population) or non-Hispanic Blacks (3.9 per 100,000 population).

Prevention of suicide in youth and young adults remains a key health priority in CT. As stated in a 2009 CT Department of Mental Health and Addiction Services Report, *Youth Suicide: A Public Health Problem in CT*, suicide was the second leading cause of death for ages 10-14 and the third among people aged 15 to 24; however, it ranks second for college students. The 2007 CT Youth Risk Behavior Survey found that 15.1% (U.S =16.9%) of students seriously

considered attempting suicide during the past 12 months; 13.8 % (U.S.=13.0%) of students made a plan about how they would attempt suicide during the past 12 months; and 12.1 % (U.S.=8.4%; statistically significant difference) of students actually attempted suicide one or more times during the past 12 months. (Source: Youth Suicide: A Public Health Problem in CT, http://www.ct.gov/dmhas/lib/dmhas/prevention/cyspi/YouthSuicideCT.pdf, assessed 2/23/12).

More recent mortality data from the National Center for Injury Prevention and Control indicate that in 2009, suicide was the second leading cause of death both in youth ages 15-19 (15 deaths; 16%) and in young adults ages 20-24 (27 deaths; 15.7%). (Source: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, WISQARS Leading Causes of Death Reports, 1999-2009, http://ebappa.cdc.gov/cgi-bin/broker.exe, accessed 2/23/12.)

Older Adult Health: Survey and Focus Group Findings

As previously noted in the Introduction Section, a key objective of the 2012 Report Card was to provide more in-depth insight on the health and social needs of older adult residents in our region. The Report Card Steering Committee identified four broad topics to enable public health, hospitals, human service providers, and the general public to better assess how older adults in the region exemplify the vision statement "Seniors in our communities are healthy and thrive".

- *Housing.* This includes availability of housing options, skilled nursing, assisted living, and hospice facilities.

- *Support Services.* This includes services which promote access to health care and human services, such as public transportation, fuel assistance, meals on wheels, senior centers, etc.

- *Quality of Life.* This includes demographics, socioeconomic status, social supports, recreation, and spirituality.

- *Physical and Mental Health*. This includes risk factors, disease (morbidity) and death (mortality) rates.

Assessment of older adult health and social needs in the region was accomplished through three methods – health surveys administered to senior volunteers, focus groups with older adults conducted at area senior centers, and a focus group with providers of services to older adults in the region. Key focus group questions were developed by Mhora Lorentson, Ph.D., and Mary Bevan, M.P.H, of *The Center for Healthy Schools and Communities at EDUCATION CONNECTION*, in consultation with Steering Committee leadership. The consumer and provider focus group sessions were professionally facilitated by Dr. Lorentson.

Older Adult Health Surveys

The health survey design team at WCSU reviewed published senior health report cards to select indicators for an Older Adult Health Survey. As previously mentioned, these included the Naugatuck Valley 2007 *Senior Needs Assessment*, *Seniors in Canada 2006 Report Card* and *Improving Health Literary for Older Adults, 2009*.

After selection of relevant indicators, Senior Center and Social Services Directors from HVR municipalities reviewed both the topics and the indicators. Feedback confirmed that key needs of older adults were covered satisfactorily

within the four topic areas and the indicators were then finalized.

During the spring of 2011, the Older Adult Health Survey was administered to senior volunteers in the region to gain insight on current health needs and the availability of local services to meet these needs. Dr. Lorentson completed the analysis of survey data. Survey questions targeted key indicators of older adult health-related needs in each topic area. Four surveys were developed and administered and included both long and short versions, with and without questions relating to dental health. All questions on the short survey

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Health Surveys, cont'd.

versions were included on the long versions.

Survey administration occurred through a comprehensive process in which 91 locations for survey distribution were identified across the region. Twenty of these identified sites provided permission to administer the survey and completed surveys were received from only 10 sites. A total of 123 surveys were received with the majority of these surveys being completed by participants at a regional volunteer recognition luncheon. Although this is not a representative sample of the older adult population in the HVR, as community volunteers, survey respondents are potentially more aware of available services and service gaps.

Key Findings

Overall, data suggest that survey respondents are experiencing a variety of successes, needs and challenges related to their existing housing, support services, quality of life and physical and mental health. It is noted that, due to the limited and relatively homogenous sample, data cannot be assumed to be representative of older adults in the region. However, data provide a good understanding of the experiences of the 123 respondents and can serve as a baseline from which to further explore and examine the health-related needs of our older adult population, design and administer more representative health surveys and, in conjunction with other data summarized in the Community Report Card for Western CT, to further develop strategies to identify and address the priority health needs of our community.

Housing

Data suggest that the majority of respondents live alone or with a spouse or partner. The majority of respondents own their home, pay no mortgage payments, perceive their financial resources to be sufficient to pay for housing and living expenses all or most of the time, and feel very safe in their communities. It is noted that, due to the small and relatively homogeneous sample, these results are skewed in the direction of highly active, non-minority older adults who are involved in their communities. It is of particular note that, even given this homogeneous sample, there was a subgroup of respondents who still pay a mortgage or rent and experience financial challenges most or some of the time. Additionally, of the sample, almost one-third expressed that they feel only somewhat safe in their communities.

Older Adult Health: Survey and Focus Group Findings, cont'd.

Key Findings, cont'd.

Support Services

The majority of respondents appeared to have a social support network in place to at least some extent. Overall, participants were most likely to report the availability of emotional support and less likely to express the availability of physical support in the sense of the presence of a person who could help them to do things they could not do for themselves. Individuals generally perceived their neighborhood to be a positive and friendly place to live. It is noted however, that even in the small sample expected to be healthier and more active than the majority of the community, there are generally eight to sixteen percent of individuals who do not perceive their neighborhoods to be a highly positive place to live.

The majority of respondents owned a car and drive themselves when necessary. Very few were dependent on others or on public transportation.

Quality of Life

As expected given the relatively small, homogeneous sample, survey results indicate that the majority of respondents are at least somewhat active in their communities with attendance at religious services being the most common activity reported. One-third of respondents attended religious services more than twice to six times per month. Respondents were less likely to have friends over to their home and more likely to attend clubs or organizational meetings or to volunteer.

Respondents were most likely to communicate using a cellular phone for voice applications or to use a computer for e-mail and communication and generally less likely to text for communication or to use computers to pay bills or manage money.

Even with the considerable bias of the sample toward healthier, active older adults in the community, respondents reported a range of physical and emotional health limitations with almost half expressing limitations in the area of moderate daily activities. Results indicate that respondents also experience challenges in the area of mental health with half or more of respondents expressing issues with anxiety and frequently not feeling happy.

Physical and Mental Health

When asked to complete a rating scale, the majority of respondents self-reported good to excellent mental and physical health and relatively healthy nutritional habits. However, it is noted that the majority of individuals also report not participating in any physical activity during the past month and 8% have only two meals a day on most days of the week. In addition, the majority of respondents consume less than the recommended number of servings of fruits and vegetables per day.

Chronic health conditions including diabetes, cancer, and angina were reported by 2 to 21% of respondents. Cancer was the chronic health condition most commonly faced by both respondents (21%) and their families (45%).

The majority of respondents stated that they understood their medications and were under the care of at least one health provider. Use of prescription medications was common (87% of respondents). A considerable proportion of respondents had never participated in recommended health screenings. Compliance was lowest for mammograms by women and for sigmoid/colonoscopy by both genders.

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Focus Groups

Dr. Lorentson completed five focus group interviews with older adults and one focus group interview with providers of services to older adults in the region. Older adult focus group interviews were hosted by senior centers within the region. The focus group with providers of services to older adults was held at the Danbury City Hall. A total of 42 seniors participated in focus groups. Participants represented primarily the towns of Bethel, Brookfield, Danbury and New Milford with a few individuals attending from other area towns. The majority of respondents were women. Additionally, four providers of services to seniors participated in the provider focus group. These individuals worked in New Milford and Danbury and included

representatives from a hospital, a visiting nurse association, a specialized care settings and an organization targeting the medical and non-medical needs of seniors.

Focus group interview questions were developed to identify key indicators within each topic area and were designed to assess current health needs, satisfaction with current health-related services and to identify recommendations for service improvement as appropriate.

Conceptual analysis of responses was used to analyze focus group interview results. Overall, the results of focus group interviews suggest a number of key themes.

Overall Perceptions

Participants are generally satisfied with the level of services provided for older adults in the ten town region. Most individuals "*love it*" and state that they "*get all kinds of help*". Participants expressed enthusiasm in a number of areas including the availability of senior centers and high quality healthcare. Participants describe available programs and services as providing motivation and support to keep moving forward.

Participants expressed satisfaction with the existence of SweetHART buses; opportunities for socialization provided by senior centers and area religious organizations; availability of a variety of high-quality medical services; support provided by area social services and hospitals; available living opportunities for low-income and high-income senior adults; and the interpersonal support provided to each other by senior adults. Respondents were particularly enthusiastic about the interest shown in the welfare of seniors as evidenced by the

inclusion of focus groups and surveys to collect supplementary information related to Older Adult health needs as a component of the Community Report Card.

Participants expressed concerns related to the lack of transportation and limited availability of SweetHART buses; lack of sidewalks and places for seniors to walk; shortage of low-income and medium-income housing, in particular a lack of availability of housing on one floor; the need for opportunities for socialization and interpersonal interaction of homebound seniors; the need for increased availability of delivery services for food and pharmaceuticals; the need for dental services that accept Medicaid; the need for behavioral health services and support for seniors and their caregivers; the need for inexpensive in-home non-medical support for seniors; and the need for support for the "*very old*". All participants emphasized the importance of education for seniors to help them understand how to

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Focus Groups, cont'd.

Overall Perceptions, cont'd.

take care of themselves medically and to increase their utilization of available services. All participants expressed interest in continuing to strengthen and expand senior center activities and the availability of services for older adults in the ten town region.

Housing and Living Environment

Respondents described the living situations of older adults as generally safe and comfortable with older adults described as living in condominiums or low-income/medium-income housing or with family or friends. Housing was typically considered to be relatively safe and comfortable with adequate availability of low-income housing throughout the ten town region. Service providers however emphasized that the safety and security of individuals varies by income level. These individuals described some of the seniors they interacted with as living "*in extremely poor conditions*". A number of participants emphasized that the availability of low-income housing varies by town with shortages described as existing in some towns. A number of participants also described shortages of medium-income housing throughout the area.

Although generally satisfied with the overall living conditions in the region, participants expressed a number of concerns. Specifically, large gaps were identified in the availability of housing with only one floor, suitable for individuals with mobility concerns and in the availability of housing in which one senior can live with another senior to share costs and support personal safety. Participants stated that many seniors live alone and that living alone is often a risk itself for personal safety. Senior participants stated that a number of housing situations prohibit non-family members from living together.

Additionally, participants identified a number of safety issues for individuals living alone. Specifically, the high cost of "*safety buttons*" such as Life Alert was described as a barrier for many senior adults who were unable to purchase security systems. A number of individuals discussed the importance of "*senior-to-senior*" or other networks to just "*check in*" and make sure someone who is living alone is "*okay*".

Participants expressed significant concerns related to the isolation of individuals with medical issues living alone in any type of housing situation and emphasized that, in the current culture and work setting, many seniors do not live close to either family or friends. It was also emphasized that, when older adults do live in proximity to family, family members are often described as "*busy with their own lives*" and not easily available to address the needs of their senior relatives. Lastly, a number of participants expressed a need for support in cleaning and maintaining a household. Participants described situations in which isolation and medical limitations make it difficult for some seniors to clean their own homes and maintain a safe and sanitary living environment. These individuals described a service that used to be, but is no longer, available in which social service representatives went to senior households to help to clean and

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Focus Groups, cont'd.

Housing and Living Environment, cont'd.

organize the house. This service was described as very important to seniors facing physical or emotional limitations that make it difficult to maintain a safe and sanitary household.

The majority of participants expressed that the financial impact of housing varies by individual. Participants generally described Connecticut as a very expensive state to live in for seniors. However, many of the towns in the region were described as providing a number of options for low-income seniors to support the cost of housing, including tax breaks and vouchers. Senior centers and social service agencies were identified as providing seniors with educational opportunities to learn about available financial assistance.

Quality of Life

Respondents identified a number of key indicators of quality of life for seniors including the need for socialization and communication on a consistent basis. Respondents were generally very satisfied with the number of opportunities available for socialization in the region and identified the senior centers as the hub for most social activities. Senior centers were described as critical to seniors to find support from their peers; participate in clubs and activities such as dancing, singing and yoga; to receive educational guidance related to issues of importance to seniors such as use of technology, financial planning and support services available, including tax services. In addition to senior centers, area religious and social service organizations were identified as sources of socialization and support for many seniors.

Challenges cited by participants include ongoing difficulties with transportation due to a lack of adequate availability of SweetHART buses, a lack of sidewalks or other venues seniors can use to walk to social events, a lack of opportunities to provide social activities for homebound seniors, and a lack of services to address the needs of "the oldest of the old." Additionally, the majority of participants described a lack of adequate funding for senior centers in recent years has resulted in decreased space for participants, decreased availability of "day trips" and decreased opportunities for a variety of activities.

Respondents described a wide variety of use of technology by seniors to support quality of life. Specifically, the majority of senior participants described themselves as using cell phones and computers for communication on a consistent basis. Approximately half of participants also used computers for games, to track finances, and to conduct Internet searches on topics of interest.

Participants described quality of life as dependent on the availability of support services to help older adults to cope with existing physical limitations. Participants described needs such as *how to fix a light bulb*", "*cook dinner*", "*get groceries*", "*clean the house*" and "*obtain medications*" as issues commonly faced by the senior population. This area was described for many as a "*tough*" area with the majority of participants being "*unsatisfied*" with support available in this area. A number of participants stated a belief that senior citizens often get "*taken advantage of*" when these needs have to be addressed. Seniors described a situation in which individuals with close and supportive family and neighbors were able to address many of these needs. However, for individuals

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Focus Groups, cont'd.

Quality of Life, cont'd.

without close family, support in these areas was described as typically coming *"at a cost"* and requiring consistent efforts to find and identify trustworthy individuals to help.

Similarly, participants described a need for increased availability of support for emotional or mental health challenges faced by seniors. Senior participants emphasized a need for free or low-cost counseling services, increased support for seniors within the home setting, and support groups to provide emotional and interpersonal support.

Social Support

The majority of participants described social support as critical to the emotional and physical health of seniors. As one individual stated, *"We need laughter to keep moving forward...that is what we need."* Social support was generally described as being provided by family members who live in the area and the senior centers. Additionally, individuals residing in condominiums or other shared living situations often described a positive network of support within these communities.

As in other areas, transportation was described as a significantly limiting factor to obtaining social support. Some seniors stated that they still *"drove themselves"* or *"were picked up by other seniors"* to attend events. The need for increased availability of SweetHART buses, or similar door-to-door transportation services, was emphasized by participants throughout all focus groups. Participants described some availability of volunteer drivers for senior adults through local religious organizations.

Physical and Mental Health

All participants perceived the availability of high-quality medical care to be excellent within the area. However, large gaps in ability of individuals to access this care were identified. Specifically, participants emphasized that medical care for low-income individuals was generally highly supported through social services and high-income individuals could pay for care that was necessary. However, the middle-income population was consistently described as not having the ability to support the continuum of care required and, particularly, the long-term expense of home care when that became necessary. Additionally, access to dental care, behavioral healthcare and vision and hearing support were described as minimal due to lack of insurance coverage. Older adults from New Milford expressed concerns that the recent merger of Danbury and New Milford Hospitals might lead to a shortage of medical services in the New Milford area.

Individuals described challenges faced by older adults in practicing good health habits such as being physically active, eating nutritious meals, drinking plenty of water, participating in health screenings, not smoking and not drinking alcohol in excess. Seniors described a low degree of motivation for individuals living by themselves to cook nutritious meals or to *"get out and move."* Although all participants described a high availability of fitness centers and sports clubs with sliding fee scales or low-cost opportunities for seniors, transportation difficulties were described as making it challenging for seniors to use these services. Additionally, the physical layout of many of the ten

Older Adult Health: Survey and Focus Group Findings, cont'd.

Older Adult Focus Groups, cont'd.

Physical and Mental Health, cont'd.

municipalities in the region was described as having few sidewalks or walking paths and therefore creating a challenge for seniors to experience ongoing physical activities.

All participants described the ability to understand and have the energy to follow-up and practice medical recommendations as a challenge for seniors with stamina or cognitive issues. Participants expressed a need for ongoing education and follow-up support to assist seniors to follow medical recommendations and practice good health habits. This need was described as particularly acute for seniors with chronic health conditions such as asthma, high blood pressure, or heart disease as these individuals need to be especially diligent in practicing positive health habits.

Representative Focus Group Quotes

Older Adults

"Transportation is a big issue…many of us don't drive. There aren't enough SweetHART buses. And…for those with physical limitations, the buses only pick you up at the bottom of the driveway—you have to get there. Often there are hills, or slippery, it is tough."

"We have great healthcare resources out there—a lot of them and they are qualified. But, to use them you need Medicare plus supplemental— then you are fine."

"Senior centers are so important for seniors. Many senior volunteer services have often been cut back. It would be nice if the towns could do more—not depend so much on the senior centers."

"We have physical limitations…not at all satisfied with the support provided by communities to address these. A lot of people can't get out—there are no structures in place for friendly visits to the home, support for home-bound people. There are often no more neighborhoods so neighbors aren't there—have to go to the senior centers and that is often not possible."

"The gaps we face? We really need transportation, help for the "oldest of the old", and support for socialization needs—especially of home-bound adults. The senior centers are critical—we need a comfortable place to go."

"There is often not enough low or middle income housing—some towns have them but generally not enough. There are huge waiting lists. Especially, you need to have housing all on one floor—we need a lot more of that. And…many places don't let non-relatives live together, so you can't share expenses"

"Great housing options for the lower and high income brackets—very little middle income housing."

Older Adult Health: Survey and Focus Group Findings, cont'd.

Representative Focus Group Quotes, cont'd.

Health Care Providers

"How do older adults get support to meet their day-to-day needs? This is a huge portion of healthcare. Wealthy people can pay for it, there are a lot of options for low income people. Middle of the road people have nothing—they try to pull in family and friends to do this...a huge issue. There is very little support out there for caregivers either."

"The three major priorities we see to improve the health services for older adults are: 1) education—help them see and understand what they need to do to take care of themselves; 2) Transportation to get them out and where they need to go; and 3) Address the needs of middle-income older adults. They are hurting the most."

The complete Older Adult Health Survey and Focus Group Reports can be accessed at the United Way of Western CT website: http://www.uwwesternct.org.

Conclusions

Overall, survey and focus group data indicates that the region continues to be relatively successful at meeting a number of health and social needs of senior adults. The region was generally described as having high quality medical care, excellent housing options for low and high income seniors, and active and supportive senior centers. However, focus group data indicates that a number of gaps in service and opportunities for improvement also exist. Specifically, data suggests significant improvements are needed in the areas of health education for older adults, financial and social support for middle-income senior adults, and in the availability of more flexible housing and transportation options.

Recommendations for Future Data Collection

- Future older adult health surveys should be developed to be less complex and be validated prior to administration.

- Future data collection efforts should consider the use of a random sample for survey distribution or the use of targeted survey distribution directed toward key informants to increase the generalizability of findings. An individual trained in survey administration should be present to review surveys for completion and obvious errors prior to collection.

- It is highly recommended that future assessments include strategies to assess the needs of less active, less mobile, less affluent and minority senior adults who were not well-represented in the current survey and focus group information.

- Future provider focus groups should include broader representation of health and social service providers, both geographically and by area of specialty.

Conclusions and Recommendations

The leading health concerns in our community, as in the state and the nation, result from a number of interconnected factors, many of which can be controlled or modified. Harmful lifestyle behaviors such as smoking, overeating, poor nutrition, lack of physical activity, tobacco use, substance abuse, and unsafe sexual practices have major impacts on individual health. Lack of health insurance, limited English proficiency, and cultural factors present barriers to access and utilization of medical care and preventive health services. Income, employment status, educational attainment, housing, and transportation are social factors which impact health or access to care. Uncontrollable factors, including inherited health conditions or increased susceptibility to disease, also significantly influence health.

In spite of the favorable health status enjoyed by most HVR residents, health disparities exist and are concentrated in the uninsured and low income population groups. Families and individuals who live in poverty or are uninsured are more likely to have poor health status. Poverty underlies many of the social factors that contribute to poor health. Differences for many health indicators are also apparent by gender, race/ethnicity, age, and place of residence. This information should be used to determine subgroups in the population in need of further assessment, as well as to guide the development of programs and services to meet identified health needs. Expanded joint planning and coordination of programs and services among health partners in the community can reduce health disparities and improve the health of all area residents.

Effective strategies to improve community health involve active collaboration and commitment among providers, health agencies, educators, and community-based organizations and groups, and the public they serve. Developing a plan for health improvement in the community involves collective action and sharing of expertise and resources across agencies and organizations in both the public and private sectors.

With this in mind, the following key recommendations are proposed by the Community Report Card Steering Committee Leadership to guide future Community Report Card health assessment activities:

- *Broaden the CRC Steering Committee membership to assure active participation by community agencies providing services to and community groups most affected by health disparities in the region.*

- *Use a strategic health planning process to identify gaps in qualitative and quantitative data needed to determine priority health needs, and to begin to develop a comprehensive action plan for community health improvement.*

- *Collect more in-depth data, through surveys, focus groups, and key informant interviews, to better inform the determination of priority health needs and to better align community resources with these needs.*

- *Conduct a scan of available health-related data and assessments to refine the key health indicators for the region for inclusion in future editions of the Community Report Card.*