Community Report Card for Western Connecticut

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Introduction

This Community Report Card of Western Connecticut establishes a comprehensive baseline profile of our community's health status by assessing several key quality-of-life factors in the Housatonic Valley region. We can proceed from this baseline to identify areas where public intervention may improve the quality of services, cost effectiveness of services, and access to services for priority health needs.

The Report Card focuses on the following areas:

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

Within each of these areas, there are indicators, which will provide consistent measurement for comparison among other communities, the state, and the nation. With regular monitoring, we can identify disparities, establish priorities, measure improvement, and facilitate direction in improving the quality of life for all citizens throughout the region.

The Danbury Health, Housing, and Welfare Department, Danbury Hospital, United Way of Western Connecticut, and Western Connecticut State University (WCSU) commissioned this Report Card. A steering committee of community leaders from throughout the region called upon WCSU to provide the data-gathering and writing team. Dr. Robyn Housemann of WCSU's Department of Health Promotion & Exercise Sciences compiled this report's statistical data and provided consultation for the content of the text. Don Lowe, an MFA graduate of WCSU's Professional Writing Program and Dr. Brian Clements, Coordinator of the WCSU Writing Program wrote the text; consultant Debbie McCuin-Channing, M.S., edited the text.

The ten towns (herein referred to as the "community") that comprise the Housatonic Valley Region are Bethel, Bridgewater, Brookfield, Danbury, New Fairfield, New Milford, Newtown, Redding, Ridgefield, and Sherman. The collective thoughts, opinions, and expertise from a broad representation of the community—health care providers, educational institutions, community based providers, and local government agencies—have shaped the content of this report.

Funding for this report was provided by Boehringer Ingelheim, Danbury Hospital, Fairfield County Bank, Fairfield County Community Foundation, Poland Spring Natural Spring Water, Savings Bank of Danbury, Union Savings Bank, United Way of Western Connecticut, and Western Connecticut State University.

Objectives

The major objectives of the Report Card are to:

1. Develop a comprehensive profile of the education, economic situation, risk factors, health and lifestyle behaviors, and diseases of residents in the Housatonic Valley region by focusing on a broad array of specific indicators in each category.
2. Provide recommendations on how partnerships among providers and the community could improve the health and wellbeing of residents

Methods

The Report Card combines textual explanation and statistical data (tables, charts, and graphs) drawn from local, state, and federal sources. Whenever possible the authors have tried to illustrate each indicator on a town-by-town basis. In the case of certain indicators, the statistical data are not available from lesser populated towns. When this occurs, the available data are used. Whenever possible, links to other data sources are included to access more in-depth information.

The indicators chosen for the Report Card were based on input from several sources. The steering committee met several times to discuss and select a list of potential indicators. The committee discussed health issues that were relevant to the community and created a long list of potential indicators. They discussed the feasibility of gathering these data from reliable sources and narrowed down the indicators based on this assessment.

The indicators were further refined based on reviewing report cards and community assessments that were conducted by other communities in our state and across the country. For the purpose of this report card, five community health assessments were examined for content and format. A list of these assessments is found on page 46.

Involving members of the larger community was the last step in finalizing the indicator list. Focus groups were conducted with representation from numerous community organizations. Input from participants was integrated where feasible and the final list of indicators was created.

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 wellbeing of the community as well as the health delivery systems with the intent to improve health within the Housatonic Valley region and set the stage for a more comprehensive assessment in the future.

Our Community

Population

The Housatonic Valley region comprises ten municipalities in western Connecticut in close proximity to the New York metropolitan area.

Data from the Housatonic Valley Council of Elected Officials (HVCEO) show that as of July 1, 2007 the population of this region is 222,188. This region has grown faster than any other part of Connecticut. In the 1950's these ten communities represented only 2.9% of Connecticut's population; in 2000 they represented 6.2% of the state population, and it is projected to be at 6.9% by 2020. The table below outlines projections to the year 2030

2010-2030 Population Projections for Connecticut Towns, Total Population

Town	Census 2000 Household Population	2007 Population Estimates[1]	Projected Household Population					
			2005	2010	2015	2020	2025	2030
Bethel	18,067	18,514	19,078	20,749	22,601	24,338	25,894	26,993
Bridgewater	1,824	1,884	1,909	2,001	2,090	2,167	2,249	2,304
Brookfield	15,664	16,413	16,390	17,121	17,834	18,502	19,143	19,722
Danbury	75,568	79,226	78,556	80,958	83,251	85,513	87,661	89,602
New Fairfield*	13,964	14,100	14,381	14,764	15,207	15,635	16,023	16,260
New Milford	27,134	28,439	28,621	30,029	31,429	32,835	34,226	35,446
Newtown	25,031	26,790	26,979	28,971	31,041	33,136	35,136	37,055
Redding*	8,560	8,840	8,801	8,723	8,388	8,017	7,732	7,521
Ridgefield	23,706	23,872	24,520	25,169	25,921	26,728	27,387	27,974
Sherman*	3,827	4,110	4,126	4,269	4,430	4,586	4,724	4,823
10 Town Totals	213,345	222,188	223,361	232,754	242,192	251,457	260,175	267,700
Connecticut	3,408,029	3,502,309	3,494,925	3,534,086	3,573,885	3,622,774	3,669,990	3,702,400

* Preliminary Data

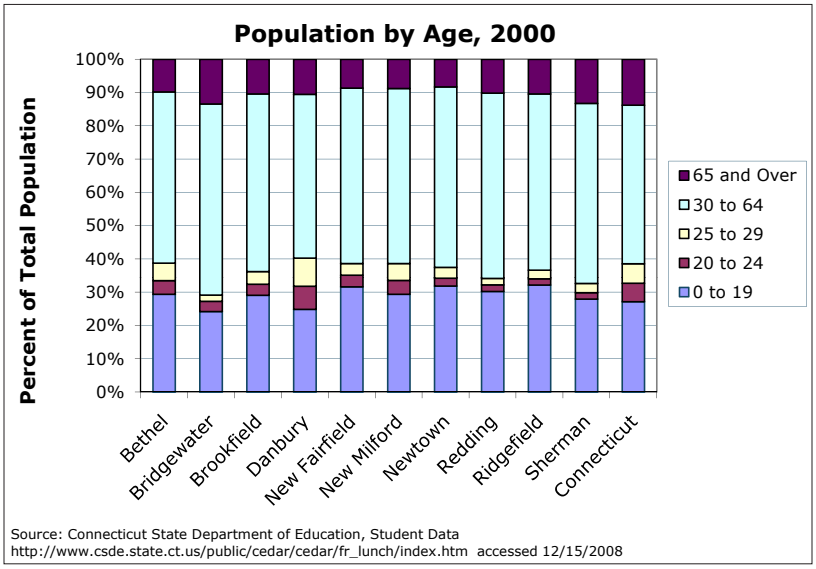
Source: Connecticut State Data Center, University of Connecticut, http://ctsdc.uconn.edu/Projections.html, accessed 12/14/2008

Ethnic Profile

The Housatonic Valley region has become much more ethnically diverse. Between 1990 and 2000, the African-American population in the region increased from 5,538 to 6,527. In 2000, 78% of the region's African-American population lived in Danbury. The Hispanic population in the region more than doubled from 6,629 in 1990 to 15,228 in 2000. Hispanics in the region represent many nationalities; the groups with the largest populations in the region are Puerto Rican (19% of the total Hispanic population), Ecuadorian (15%), Dominican (14%), and Mexican (12%). The region also has a substantial population of Irish, Italian, German, and Polish ancestry – 23%, 20%, 17%, and 6% respectively. *(Source: Housatonic Valley Council of Elected Officials, Accessed 11/9/08.)*

Our Community, cont'd.

Age Profile



Source: Connecticut State Department of Education, Student Data
http://www.csde.state.ct.us/public/cedar/cedar/fr_lunch/index.htm accessed 12/15/2008

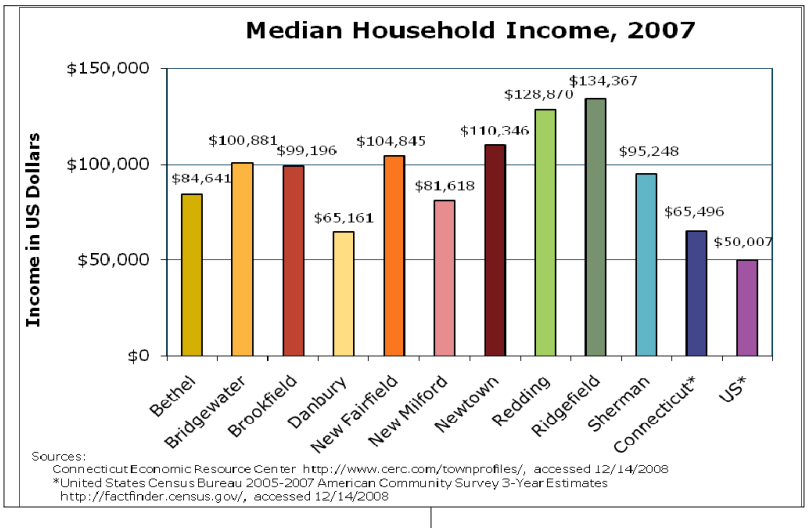
The population distribution among age groups in the region is similar to the distribution in the state and in the nation. However, our region has a larger percentage of adults in the 45–64 range than either the state or the nation. Communities with older populations usually have a greater demand for health care services, in the present and in the future.

Economic Stability: Indicators and Findings

It is well documented that a person's socioeconomic status has a direct correlation to their ability to have adequate health care and their ability to maintain a healthy diet and lifestyle. Research confirms that individuals living below the poverty line tend to be less physically healthy, tend to have a higher risk of obesity and diabetes, and face greater challenges in achieving higher levels of education.

Income and Poverty Level

Our region ranges widely in median household income, and all towns in the region except Danbury are well above the state average in median household income; however, a higher cost of living in our region may absorb that income.



Sources:
Connecticut Economic Resource Center http://www.cerc.com/townprofiles/, accessed 12/14/2008
*United States Census Bureau 2005-2007 American Community Survey 3-Year Estimates
http://factfinder.census.gov/, accessed 12/14/2008

The federal government established the poverty line in 2008 for a family of four at an annual income of $21,200. While this serves value statistically, it doesn't tell the complete story.

In higher income locations like our region, it is customary to set the poverty threshold at 200% of the federal guideline, or $42,400. A growing number of middle-class families in our community have moved into that pool of "working poor." These individuals, considered middle-class, make too much

Economic Stability: Indicators and Findings, cont'd.

Income and Poverty Level, cont'd.

money to qualify for state and federal aid but not enough to pay for health insurance that could assure the health and wellbeing of the family unit, hence they frequently lack health insurance.

According to the U.S. Census Bureau, 37 million Americans (about one in eight) live in poverty as of 2004. The number has been increasing every year. The U.S. Census Bureau does make a distinction that the poor in America are not necessarily indigent or destitute, but rather, they fall under our economic guidelines of poverty. The table below shows that our community poverty rates are below both the state and national rates. Danbury's level of poverty is statistically much higher than the other towns within the community.

Among children under the age of 18, our community is below state and national levels of poverty at 100% of the national standard. However, Danbury is above the statewide poverty level among children under 18 at 200% of the national standard.

It is important to note that these data are based upon the 2000 Census. The 2008 economic landscape has seen tremendous changes at local, state, and national levels.

According to the State Department of Labor, Connecticut has experienced a 54% increase in unemployment claims since January 2008. As of November 2008, the unemployment rate was 6.6%, up 1.7% from November 2007. The state reports that there were 2,752 business closures in the first quarter of 2008. This is a national trend. "Through August 2008, total nonfarm employment decreased by 525,000 (-0.5%). There were 304,000 mortgages in default and 91,000 families lost their homes. Housing starts were down 31% from a year ago. The U.S. stock market lost 37% of its value. Financial markets from London to Tokyo lost significant value. The U.S. Congress passed a Rescue Plan TARP at a potential cost of $750 billion to U.S. taxpayers." *(Connecticut Department of Labor)*

At the time of this writing, the U.S. economy is in a recession that will surely take its toll in our community.

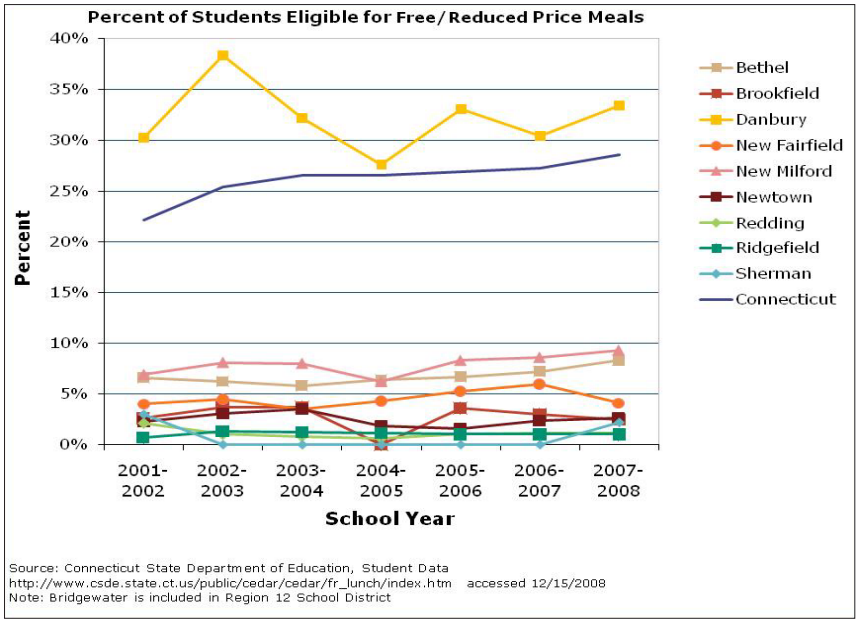
Economic Characteristics, 2000

Town	Median Household Income in 1999 ($)	Families Below the Poverty Level		Persons Aged 65 and Older Below the Poverty level	
		Number	Percent	Number	Percent
Bethel	$68,891	56	1.20%	97	5.50%
Bridgewater	$80,420	12	2.30%	2	0.80%
Brookfield	$82,706	52	1.20%	39	2.30%
Danbury	$53,664	1079	5.90%	638	8.30%
New Fairfield	$84,375	38	1.00%	57	1.70%
New Milford	$65,354	154	2.40%	131	5.50%
Newtown	$90,193	151	2.20%	77	3.90%
Redding	$104,137	29	1.20%	31	3.50%
Ridgefield	$107,351	87	1.30%	128	5.30%
Sherman	$76,202	28	2.60%	30	5.90%
Connecticut	$53,935	49983	5.60%	30818	7.00%
United States	$41,994	6,620,945	9.20%	3,287,774	9.90%

Source: U.S. Census Bureau, Census 2000 Profile of Selected Economic Characteristics 2000, Summary File 3 http://factfinder.census.gov accessed 12/15/2008

Economic Stability: Indicators and Findings, cont'd.

Free and Reduced Price School Lunches



Free school lunches are available for children within public school systems whose families qualify as having insufficient means to pay. The percentage of children receiving free/reduced price school lunches is another indicator of how much poverty exists in our community.

Findings: Since 2000, statistics demonstrate that our community tends to fall below the statewide frequency for free/reduced rate lunches. The exception to this is in Danbury where the frequency of free/reduced price school lunches exceeds the state average. On average, depending upon the year, roughly 1 out of every 3 Danbury children receives free/reduced price school lunches. For academic year 2008-09, a family of four must earn less than $27,560 for a child to receive free meals and less than $39,220 to receive reduced price meals. The Connecticut State Department of Education uses eligibility for free or reduced price meals as its poverty indicator.

Homelessness

Currently 1 in 400 Americans are homeless. In Connecticut, one of the wealthiest states in the country, the homeless rate exceeds 33,000 annually. Homelessness results from many factors. Economics is a major driver. One has to earn at least $19.30/hour to be able to afford an apartment in Connecticut. Minimum wage as of January 1, 2009 is only $8.00 per hour. Connecticut Counts 2008 reported that on January 30, 2008, 3,444 households were experiencing homelessness. In a report by the Connecticut Department of Economic and Community Development, it is estimated that there are between 3,000 and 5,000 homeless individuals on any given night. *(Source: http://www.ct.gov/ecd/cwp/view.asp?A=1105&Q=250564 accessed 6/30/2008).*

The table shows the Point in Time Count for January 2007 and 2008. According to Scott LeRoy, Director of Danbury's Health, Housing and Welfare Department, "this is the first count conducted in this manner required by U. S. Department of Housing and Urban Development." The study shows that total chronic homelessness in the greater Danbury area decreased slightly from 2007 to 2008.

In 2005 Danbury Mayor Mark D. Boughton commissioned a task force to develop a comprehensive and detailed plan to end homelessness in Danbury within ten years.

Economic Stability: Indicators and Findings, cont'd.

Homelessness, cont'd.

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 makes the case for 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. *(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. *(www.danburyhousingpartnership.org.)*

Findings: A great deal of work needs to continue on this indicator. Initial trends look positive however in the short term data do not allow for conclusive findings.

Homelessness: Point-in-Time Counts 2007 and 2008

		30-Jan-07		30-Jan-08		Percent Change from 2007 to 2008	
		Greater Danbury Area	Statewide	Greater Danbury Area	Statewide	Greater Danbury Area	Statewide
Sheltered	Total	111	2565	116	2846	4.50%	10.96%
	Single Adults	99	2138	108	2257		
	Families	10	392	10	474		
	Unaccompanied Youth	2	35	0	119		
	Children in Families	15	728	16	861		
Unsheltered	Total	25	760	7	598	-72.00%	-21.32%
	Single Adults	25	707	7	590		
	Families	0	38	0	8		
	Unaccompanied Youth	0	15	0	0		
	Children in Families	0	69	0	12		
Total	Total	136	3325	123	3444	-9.56%	3.58%
	Single Adults	124	2845	115	2847		
	Families	10	430	10	482		
	Unaccompanied Youth	2	50	0	119		
	Children in Families	15	797	16	873		

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: Connecticut Coalition to End Homelessness, Connecticut Counts 2007 and 2008, http://www.cceh.org/pdf/2007_pit_report.pdf and http://www.cceh.org/pdf/2008_pit_report.pdf accessed 12/11/2008

Education: Indicators and Findings

According to the National Center for Education Statistics (NCES) an individual's level of education points directly to specific socio-economic outcomes. For example, a high school graduate tends to achieve a far more desirable employment status and a higher income level than a high school dropout. The graduate is more apt to have health insurance and has a lower chance of exposure to crime, homelessness, and mental illness. According to the NCES, students who do not graduate from high school are more likely to rely on public assistance and more likely to have poorer diets and poorer physical health.

The Connecticut State Department of Education has established three priorities in their 2006 – 2011 Comprehensive Plan for Education to address the significant implications of insufficient education.

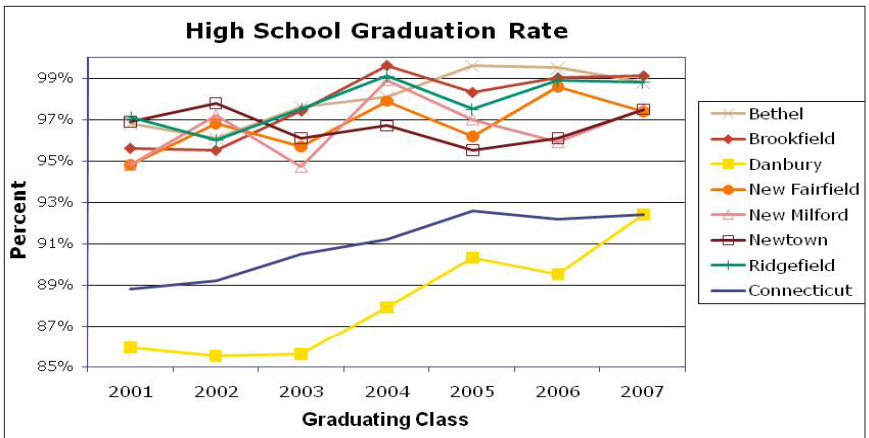
1. High-quality preschool education for all students.
2. High academic achievement for all students in reading, writing, mathematics and science.
3. High school reform so all students graduate and are prepared for lifelong learning and careers in a competitive, global economy.

Our region's ability to meet these goals within our local schools will have a direct correlation to the quality-of-life for its citizens. The high school dropout/graduation rate is a principle tool for predicting how a community's young adult population will fare in the world.

High School Graduation

Our community's graduation rate is well above the state rate, with the exception of Danbury.

According to the Manhattan Institute, the national graduation rate in 1998 was 71 %. But the rate varies greatly by race. The national graduation rate for white students was 78 %; African-American students 56%; and Latino students 54%.



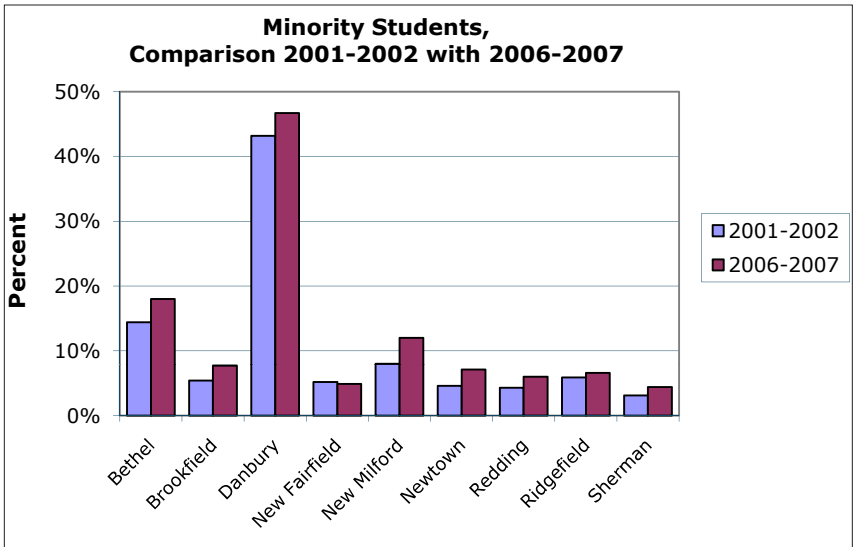
Source: Connecticut State Department of Education, Student Data, http://www.csde.state.ct.us/public/cedar/cedar/grads/index.htm accessed 12/15/2008
Note: Bridgewater is included in the Region 12 School District, Redding students attend Joel Barlow High school, Sherman students attend a local high school of their choice.

According to the U. S. Census Bureau, 85% of adults age 25 and older in 2003 had high school diplomas. The differences in rates with regard to race had subsided since 1998 with 80% of African-American adults 25 years and older holding high school diplomas. Through any type of comparison, our community's high school graduation rate appears to be well above the national average. *(Source: www.manhattan-institute.org/html/cr_baeo.htm accessed 7/22/2008).*

Among the towns in our community, Danbury has the highest concentration of ethnic diversity. The chart shows the percentage of minority students for the 2001-2002 and 2006–2007 school years.

Education: Indicators and Findings, cont'd.

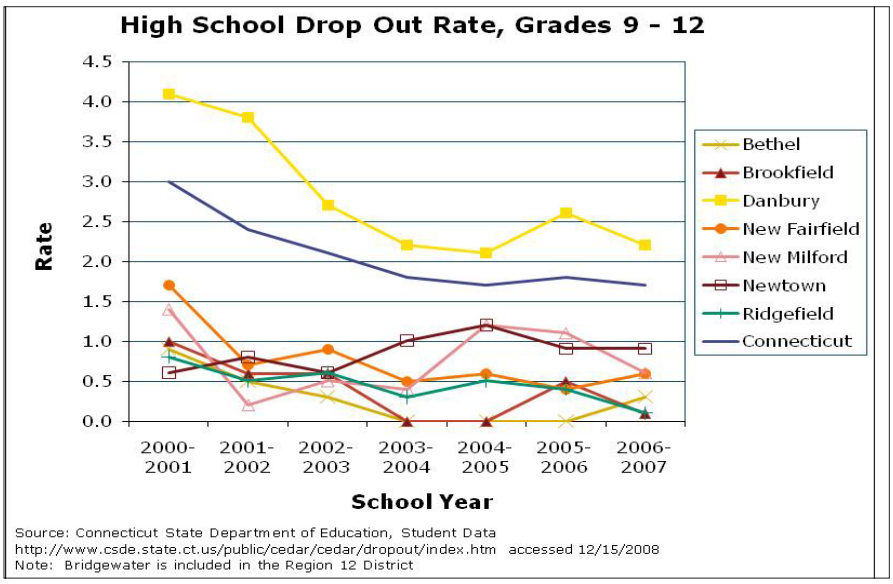
High School Graduation, cont'd.



Source: Connecticut State Department of Education, Strategic School Profiles, http://www.csde.state.ct.us/public/cedar/profiles/index.htm accessed 12/15/2008

High School Drop Out Rate

While the dropout rate among high school students in our community has declined since 2000, Danbury remains above the state average. The other towns in the region have on average held a steadily low rate of dropout.



Source: Connecticut State Department of Education, Student Data
http://www.csde.state.ct.us/public/cedar/cedar/dropout/index.htm accessed 12/15/2008
Note: Bridgewater is included in the Region 12 District

Education: Indicators and Findings, cont'd.

Special Education

Although it is primarily associated with students who have mental and physical challenges, special education is a modified education tool for a wide range of students, including individuals with learning disabilities and behavioral issues. Special education services also branch out to the gifted. The number of students in a community receiving special education services indicates how well a community responds to the multidimensional needs of its student population.

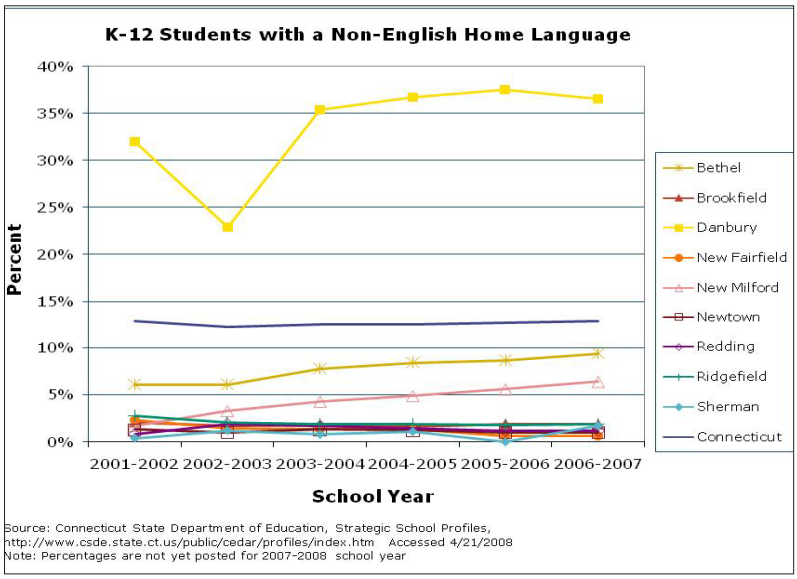
Students with Disabilities

An assessment of the special education system in each of the community's school systems must take into account individual student needs. Considering all special education students as a single group may ignore larger issues. If many of a district's students are mentally or physically impaired, it could mean that the community may have need for outside resources and the community might examine the reasons why so many of its students are impaired. If the issues are behavioral, a community may want to examine some of the outside influences that exacerbate the sitiation.

Findings: The percent of K-12 students with disabilities has held fairly steady since 2001, with the exception of Sherman. National and statewide comparisons for this indicator are difficult as data have not been identified.

English as a Second Language (ESL)

There are frequently socio-economic disparities between ESL residents and residents born into English-first environs. Disparities are seen in both children and adults and are reflected in many of the other socio-economic issues examined within this report.



Children from ESL homes tend to earn poorer grades in our public school systems than English-first speaking children, thus requiring added resources to meet state requirements. Children from ESL homes often are less likely to have health insurance and more likely to be raised in poverty.

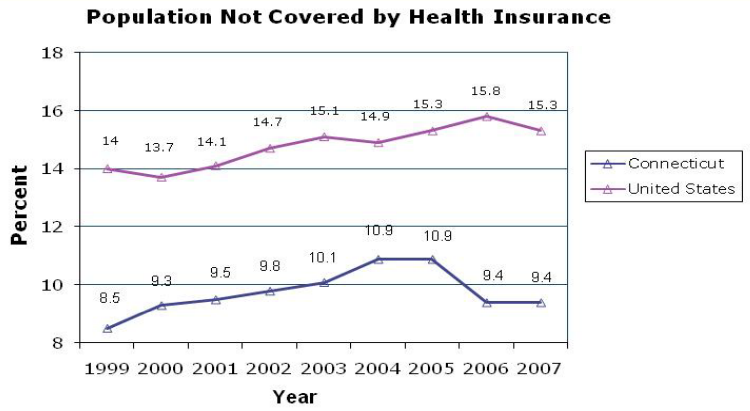
Findings: Although the percent of students with a non-English home language is increasing in the majority of towns in our community, it is clearly impacting Danbury at a far greater degree. Danbury's level is significantly higher than the state, while all other towns fall below the state percentage.

Health Status: Indicators and Findings

Health Insurance

Studies demonstrate that individuals without health insurance are far more apt to experience declining health. This occurs because the uninsured do not likely have sufficient resources for wellness and routine doctor visits.

Consequently, the possibility of catastrophic medical conditions rise and these life-threatening illnesses are often expensive to treat. When they go unpaid, the difference is made up through public spending (taxes), an increase in medical costs and a corresponding increase in health insurance premiums. The overall health of a community can be at risk when there are a high percentage of uninsured citizens. Connecticut is below the national average in population not covered by health insurance.



Source: US Census Bureau, Historical Health Insurance Data, http://www.census.gov/hhes/www/hlthins/historic/index.html, accessed 12/16/2008
NOTE: Numbers in thousands. People as of March of the following year.

Why are so many adults uninsured?

There are many reasons a person may or may not be insured, including financial, cultural and level of education, among others. In addition, health insurance premiums and costs have increased.

Additionally, our community has a growing population of undocumented citizens. For these residents, health insurance may be beyond reach. These residents account for a significant portion of the emergency room visits for non-emergency medical needs.

According to the Urban Institute, the percentage of employed adults nationally (ages 18 to 64) that lacked health coverage climbed from 19.7% in 2005 to 20.2% in 2006. Nearly 1.3 million full-time workers lost their health insurance in 2006. Nearly 47 million Americans (16% of the total population, including children) were without health insurance in 2005. Nearly 90 million people — about one-third of the population below the age of 65 — spent a portion of either 2006 or 2007 without health coverage. Nearly 40% of the uninsured population resides in households that earn $50,000 or less.

Health Insurance Coverage by Type, 2007

Type	Connecticut Number	Connecticut Percent	United States Number	United States Percent
Covered by Private or Government	3,150	90.6%	253,449	84.7%
Private	2,652	76.3%	201,991	67.5%
Employment-based	2,365	68.0%	177,446	59.3%
Direct Purchase	326	9.4%	27,673	9.3%
Government	896	25.8%	83,031	27.8%
Medicaid	391	11.2%	39,554	13.2%
Medicare	498	14.3%	41,375	13.8%
Military Health Care	57	1.6%	10,955	3.7%

Source: US Census Bureau, Historical Health Insurance Data, http://www.census.gov/hhes/www/hlthins/historic/index.html, accessed 12/16/2008

Health Status: Indicators and Findings, cont'd.

Why are so many adults uninsured?, cont'd.

As of the 2000 census, Connecticut's population of uninsured was 10.3%. Data for individual towns are not available, but Fairfield County's uninsured population was 7.9% in 2000. Our community, most of which is located in Fairfield County, appears to be in slightly better shape than the state or national average.

Connecticut has a health insurance program for children and teenagers from financially qualifying families up to the age of 19 called The HUSKY (Healthcare for Uninsured Kids and Youth) Plan. HUSKY Plan B provides benefits to children who are not eligible for HUSKY Plan A (existing full Medicaid program) and includes doctor visits, prescriptions, vision and dental care. For children with special physical health care needs, the program offers additional services. Children with mental health and substance abuse issues are served through the Connecticut Behavioral Health Partnership. HUSKY reduces the number of uninsured families in Connecticut and increases access to preventive services. (*Connecticut Voices for Children, http://www.ctkidslink.org/publications/CB08keepingkidshealthy.pdf, accessed 12/30/2008)* Overall, enrollment in the HUSKY Plan is increasing. State enrollment was 312,675 in January 2008 and 329,267 in December 2008. This number has greatly increased since the start of the program in July 1998 (220,000). The data in the table indicate the number of children enrolled in our community in December 2008.

Findings: Based on data shown, which is on a state level, Connecticut is trending in a positive way as compared to the national data. In looking at the last two years, the number of Connecticut residents not covered by health insurance is 40% lower than the national rate.

Number of Children Enrolled in Husky, 12/01/2008

	Husky A	Husky B
Bethel	895	129
Bridgewater	37	*
Brookfield	414	41
Danbury	7,480	555
New Fairfield	404	77
New Milford	1,407	180
Newtown	570	96
Redding	110	21
Ridgefield	244	41
Sherman	136	19
Connecticut	329,267	13,959

Source: State of Connecticut Department of Social Services, Healthcare for UninSured Kids and Youth (HUSKY), http://www.huskyhealth.com/pubs.htm, accessed 12/16/2008

* indicates < 5

Husky A: State-sponsored health care insurance for children under age 19 and their caregivers, Eligililty is based on familiy income and number of children in family

Husky B: Provides coverage for those not covered under Husky A, co-pays and premiums are based on family income and number of children

Health Status: Indicators and Findings, cont'd.

Emergency Room Visits

When individuals have insurance they are more likely to visit a doctor's office or a clinic when they or their children are not feeling well. Without insurance, the alternatives are community-based clinics and the emergency room. The emergency department is often the primary care site for the uninsured. Tracking emergency room utilization can tell us the frequency by which people who have no health insurance use it for primary care. It also tells us about the availability of a community's primary care physicians, as many physician offices are no longer manned on weekends in order to cut costs.

The following table provides the number of emergency department visits for community residents at local community 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 (2007 population estimates) for each town was calculated for comparative purposes. This number varies greatly across the region. It is highest in Danbury (39.8%) and lowest for Redding at 14.9%. All towns are below the state percentage (41.5%). Some of the factors that explain the variance include: community environment (urban, suburban, rural), type of hospital (acute care, tertiary care), lack of health insurance coverage and immigrant or undocumented population.

Three types of emergency room visits are important sub-indicators of community health: unintentional injury, intentional violence; and emergency room use for primary health care. With regard to unintentional injuries, those involving alcohol are a primary concern. A greater-than-average use of the emergency room for primary care indicates that a community may have a large population of uninsured citizens and/or a high population of undocumented non-residents living within it.

The trend data in the following graph show the rate of emergency room visits per 1,000 population (based on 2007 population estimates) from 2004 to 2007. Local trends have remained fairly constant. Danbury has the highest rate, followed by New Milford. The statewide data show a decrease in 2006 followed by an increase in 2007 to surpass Danbury.

Emergency Room Visits by Community[1] compared to statewide data[3], FY 2007

	Inpatient (Admitted from Emergency Department)	Outpatient (Discharged from Emergency Department)	Total	Population Estimates 2007[2]	Emergency Room visits as % of population
Bethel	924	4,842	5,766	18,514	31.1%
Bridgewater	61	413	474	1,884	25.2%
Brookfield	682	3,466	4,148	16,413	25.3%
Danbury	4,659	26,885	31,544	79,226	39.8%
New Fairfield	488	2,908	3,396	14,100	24.1%
New Milford	1,052	9,462	10,514	28,439	37.0%
Newtown	932	4,126	5,058	26,790	18.9%
Redding	277	1,044	1,321	8,840	14.9%
Ridgefield	823	2,931	3,754	23,872	15.7%
Sherman	78	780	858	4,110	20.9%
Regional TOTAL	9,976	56,857	66,833	222,188	30.1%
Connecticut[3]	1,223,641	230,244	1,453,885	3,502,309	41.5%

Sources:

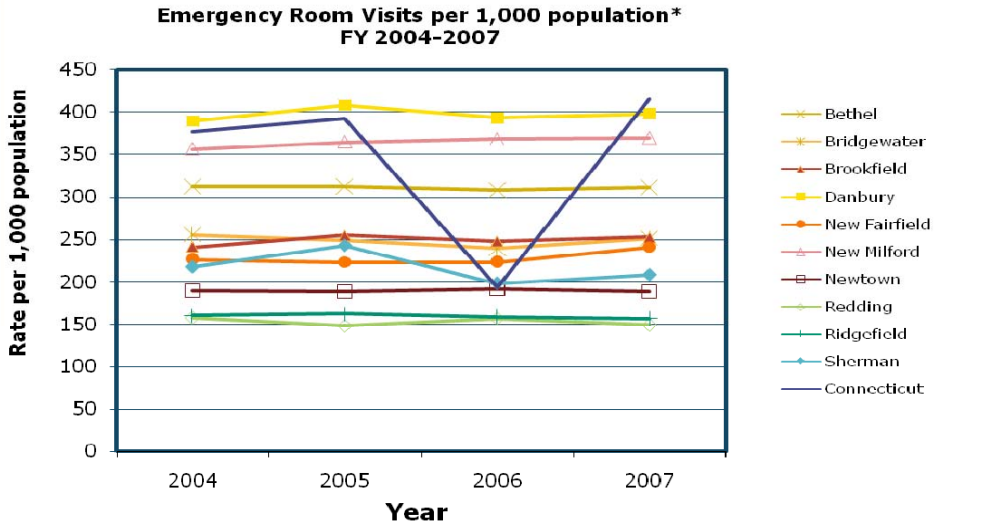
[1] Danbury and New Milford Hospital, data received July 31, 2008 and August 26, 2008

[2] Connecticut State Data Center, University of Connecticut, http://ctsdc.uconn.edu/EstimatesCensus/2007data/PR_CtSDC_Estimates2007_WebTowns.xls, accessed 1/9/2009

[3] CHIME (Connecticut Health Information and Management Exchange) data received from Danbury Hospital 1/8/2009

Health Status: Indicators and Findings, cont'd.

Emergency Room Visits, cont'd.



Sources: Danbury and New Milford Hospital, data received July 31, 2008 and August 26, 2008 and CHIME (Connecticut Health Information and Management Exchange) data received from Danbury Hospital 1/8/2009
* Rate based on 2007 population estimates Connecticut State Data Center, University of Connecticut, http://ctsdc.uconn.edu/EstimatesCensus/2007data/PR_CtSDC_Estimates2007_WebTowns.xls, accessed 1/9/2009

Findings: The data show that emergency room visits from residents of the 10-town region has remained fairly constant. It also shows that emergency room visits as a percent of population is well below the rate in Connecticut overall. This demonstrates a good safety net of community preventive and clinic programs, and an understanding generally by the community about appropriate emergency department usage and access.

Mental Health

The World Health Organization defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."

Connecticut: Serious Psychological Distress and Depression in Past Year, Age 18 and Older: Annual Averages

	2004-2005		2005-2006	
	Estimated Numbers (in thousands)	Percentage of population	Estimated Numbers (in thousands)	Percentage of population
Serious Psychological Distress[1]	2,999	11.5%	2,789	10.6%
Having at Least One Major Depressive Episode[2]	23,910	9.2%	17,310	6.6%

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004-2006

NOTE: Estimates are based on a survey-weighted hierarchical Bayes estimation approach.

[1] Serious psychological distress (SPD) is defined as having a score of 13 or higher on the K6 scale. Because of questionnaire changes, these estimates are not comparable with estimates from the 2002-2003 and 2003-2004 State reports, the 2002-2004 substate report, and the 2004 and earlier national results reports. For details, see Section A.8 in Appendix A of the report on State estimates of substance use from the 2005-2006 NSDUHs. Data for SPD are not defined for 12 to 17 year olds; therefore, the "Total" estimate reflects those aged 18 or older.

[2] Major Depressive Episode (MDE) 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 the symptoms for depression as described in the DSM-IV. Due to minor wording differences in the questions in the adult and adolescent MDE modules, data from youths aged 12 to 17 were not combined with data from persons aged 18 or older to get an overall estimate (i.e., for those aged 12 or older). Therefore, the "Total" estimate reflects those aged 18 or older.

Note: Data for the above indicators are not available at the national or community level.

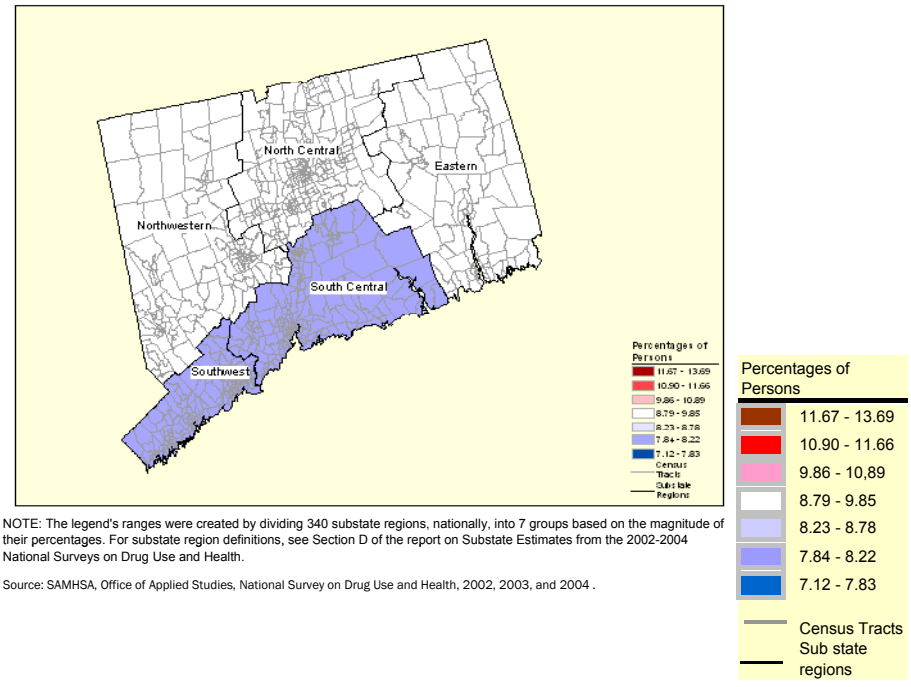
Health Status: Indicators and Findings, cont'd.

Mental Health, cont'd.

Appropriate attention and response to mental health issues are critical for a community's overall well-being. Inattention to community mental health may result in a wave of socio-economic ills. Crime, homelessness, suicide, child abuse, substance abuse, truancy and economic problems are all distress signals. Clinical mental illness, learning disabilities, behavior disabilities, general stress and post-traumatic stress disorder (PTSD) are some of the conditions that challenge people, many of whom are children, on a day-to-day basis. When these conditions go untreated, a community is faced with social problems left in their wake.

Findings: While these tables are age-and geography-specific, efforts should be made to investigate subsets that would identify and expand the community's emerging needs, for example, mental health issues in school-age children.

Serious Psychological Distress In Past Year Among Persons Aged 18 Or Older in Connecticut, by Substate Region:



NOTE: The legend's ranges were created by dividing 340 substate regions, nationally, into 7 groups based on the magnitude of their percentages. For substate region definitions, see Section D of the report on Substate Estimates from the 2002-2004 National Surveys on Drug Use and Health.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004 .

Risk Factors: Indicators and Findings

When there is a high prevalence of unhealthy behaviors within a community, it sets the stage for a variety of health risks. An analysis of the statistics that follow shows encouraging trends and indicates where attention should be focused for more improvement.

Forty percent of the deaths worldwide are due to 10 risk factors, some of which we look at here. The world's healthy life expectancy could be increased by 5-10 years if health-promotion decisions were made by individuals and communities to reduce these risks. Two major risk factors involve nutrition: being overweight and underweight.

Statistics on child obesity, children's fitness and children's oral health suggest further directions in those areas. Difficulty in any of these three areas during early and adolescent development foretells problems in adulthood.

Child 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.

Percent of Total Population Aged 18 and Under, 2000

Town	Percentage	Town	Percentage
Bethel	27.30%	New Milford	24.40%
Bridgewater	22.10%	Newtown	29.10%
Brookfield	27.40%	Redding	29.10%
Danbury	21.70%	Ridgefield	26.90%
New Fairfield	30.00%	Sherman	26.70%
Connecticut	24.70%	US	25.70%

Source: 2000 US Census data http://factfinder.census.gov/servlet/GCTTable?_bm=y&-geo_id=04000US09&-_box_head_nbr=GCT-P5&-ds_name=DEC_2000_SF1_U&-format=ST-7, accessed 4/21/2008

The table presents the most recent census tally of children aged 18 and under in each town, the state of Connecticut, and the nation.

The pie chart and table show statewide data on child abuse for the 2006 fiscal year. The chart indicates the number of substantiated child abuse allegations per type of abuse.

The table indicates the total child abuse allegations, the substantiated allegations, and the substantiation rate for the entire state for 2006.

Risk Factors: Indicators and Findings, cont'd.

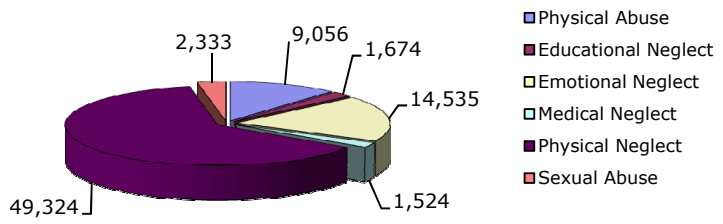
Child Abuse, cont'd.

According to the nonprofit organization Childhelp, which is committed to the prevention and treatment of child abuse *(www.childhelp.org)*, there are more than 3 million reports of child abuse every year in the United States. Experts estimate that the actual number of child abuse reports is probably three times higher. Of our adult prison population, 36.7% of women and 14.4% of men were abused as children. Their report goes on to highlight that children who have been sexually abused are 2.5 times more likely to abuse alcohol and 3.8 times more likely to become addicted to drugs. One third of abused children will later abuse their children. Abused children have a 25% higher-than-average rate of teenage pregnancy. Our community's statistics indicate that, for the most part, we are lower than the state's average for 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. Again, it is important to note that these statistics reflect only child abuse cases that are reported.

The table on the next page provides local data for child abuse claims for the community for 2003-2008. Data for towns with 10 or less children substantiated are not reported. For comparative purposes, number of children substantiated as a percent of the total population of children in a given community is calculated. Our communities are below the state percentage for most years.

Findings: While there should be zero tolerance for any incident of child abuse, the data indicate that our region's providers are addressing this issue well. The 10-town rates are substantially better than other parts of Connecticut and the state as a whole. Local substantiation rates (the number of reported incidents substantiated) are in line or better and the rate of substantiated lower for our region than for Connecticut as a whole.

Number of Allegations to DCF, Statewide, Fiscal Year 2006



Source: State of Connecticut Department of Children and Families, http://www.ct.gov/dcf/lib/dcf/agency/pdf/tp_2006.pdf accessed 12/16/2008

2006 Total Statewide Allegations by Type of Abuse

Allegations	Total	Substantiated	Substantiation Rate
Physical Abuse	9,056	667	7%
Educational Neglect	1,674	879	53%
Emotional Neglect	14,535	3546	24%
High Risk Newborn	-	-	-
Medical Neglect	1,524	500	33%
At Risk	-	-	-
Physical Neglect	49,324	13339	27%
Sexual Abuse	2,333	574	25%
Total Allegations	81,277	19903	24%

Source: State of Connecticut Department of Children and Families, http://www.ct.gov/dcf/lib/dcf/agency/pdf/tp_2006.pdf accessed 12/16/2008

Risk Factors: Indicators and Findings, cont'd.

Child Abuse, cont'd.

Child Abuse Cases Reported to Department of Children and Families, 2003 – 2008

Community	total	substantiated	number of children substantiated	substantiation rate	Percent of children[1]
2003					
Bethel	282	63	32	22.0%	0.17%
Bridgewater	--	--	--	--	0.00%
Brookfield	129	21	14	16.0%	0.09%
Danbury	1707	397	215	23.0%	0.27%
New Fairfield	137	42	22	31.0%	0.16%
New Milford	613	141	77	23.0%	0.27%
Newtown	180	53	30	29.0%	0.11%
Redding	64	31	22	48.0%	0.25%
Ridgefield	103	24	11	23.0%	0.05%
Sherman	--	--	--	--	0.00%
Connecticut	95214	20322	11471	21.0%	0.33%
2004					
Bethel	237	67	32	0.28	0.17%
Bridgewater	--	--	--	--	0.00%
Brookfield	--	--	--	--	0.00%
Danbury	1575	447	226	0.28	0.29%
New Fairfield	113	29	18	0.26	0.13%
New Milford	552	145	75	0.26	0.26%
Newtown	205	57	28	0.28	0.10%
Redding	55	14	12	0.25	0.14%
Ridgefield	142	41	23	0.29	0.10%
Sherman	42	35	12	0.83	0.29%
Connecticut	91890	25313	12770	0.28	0.36%
2005					
Bethel	224	28	28	13.0%	0.15%
Bridgewater	--	--	--	--	0.00%
Brookfield	--	--	--	--	0.00%
Danbury	1,515	291	172	19.0%	0.22%
New Fairfield	109	15	13	14.0%	0.09%
New Milford	398	78	45	20.0%	0.16%
Newtown	142	26	16	18.0%	0.06%
Redding	47	14	11	30.0%	0.12%
Ridgefield	--	--	--	--	0.00%
Sherman	--	--	--	--	0.00%
Connecticut	86,416	21745	11226	25.0%	0.32%
2006					
Bethel	--	--	--	--	0.00%
Bridgewater	--	--	--	--	0.00%
Brookfield	--	--	--	--	0.00%
Danbury	1,364	214	133	16.0%	0.17%
New Fairfield	--	--	--	--	0.00%
New Milford	452	91	50	20.0%	0.18%
Newtown	182	22	13	12.0%	0.05%
Redding	--	--	--	--	0.00%
Ridgefield	--	--	--	--	0.00%
Sherman	--	--	--	--	0.00%
Connecticut	81,277	19903	9977	24.0%	0.28%

Risk Factors: Indicators and Findings, cont'd.

Child Abuse Cases Reported to Department of Children and Families, 2003 – 2008

2007					
Bethel	236	30	18	13.0%	0.10%
Bridgewater	--	--	--	--	0.00%
Brookfield	120	27	16	23.0%	0.10%
Danbury	1,334	224	131	17.0%	0.17%
New Fairfield	160	28	17	18.0%	0.12%
New Milford	460	81	48	18.0%	0.17%
Newtown	--	--	--	--	0.00%
Redding	--	--	--	--	0.00%
Ridgefield	--	--	--	--	0.00%
Sherman	--	--	--	--	0.00%
Connecticut	78,150	20,174	9,422	26.0%	0.27%
2008					
Bethel	185	25	20	14.0%	0.11%
Bridgewater	9	2	1	22.0%	0.05%
Brookfield	102	4	4	4.0%	0.02%
Danbury	1,142	174	116	15.0%	0.15%
New Fairfield	98	32	13	33.0%	0.09%
New Milford	372	59	34	16.0%	0.12%
Newtown	127	29	13	23.0%	0.05%
Redding	26	2	2	8.0%	0.02%
Ridgefield	11	20	8	18.0%	0.03%
Sherman	9	--	--	--	0.00%
Connecticut	--	--	--	--	

Source: CT Department of Children and Families, accessed 4/21/2008, updated 1/9/2009
http://www.ct.gov/dcf/cwp/view.asp?a=2565&q=317652
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 Famiily's fiscal year (July 1 - June 30)
Based on 2007 population estimates from Connecticut State Data Center, University of Connecticut, http://ctsdc.uconn.edu/Projections.html, accessed 1/9/2009

Childhood Obesity

According to the Centers for Disease Control, "the prevalence of obesity among children aged 6 to 11 more than doubled in the past 20 years, going from 6.5% in 1980 to 17% in 2006. The rate among adolescents ages 12 to 19 more than tripled, increasing from 5% to 17.6%." The long-term health implications are serious. Children who are obese are more likely to experience social and psychological problems due to poor self-esteem. They are likely to be overweight adults, and consequently at a greater risk for heart disease, type 2 diabetes, stroke, osteoarthritis and cancer. Children become overweight when they have poor eating habits and little or no physical activity.

According to the National Survey of Children's Health:

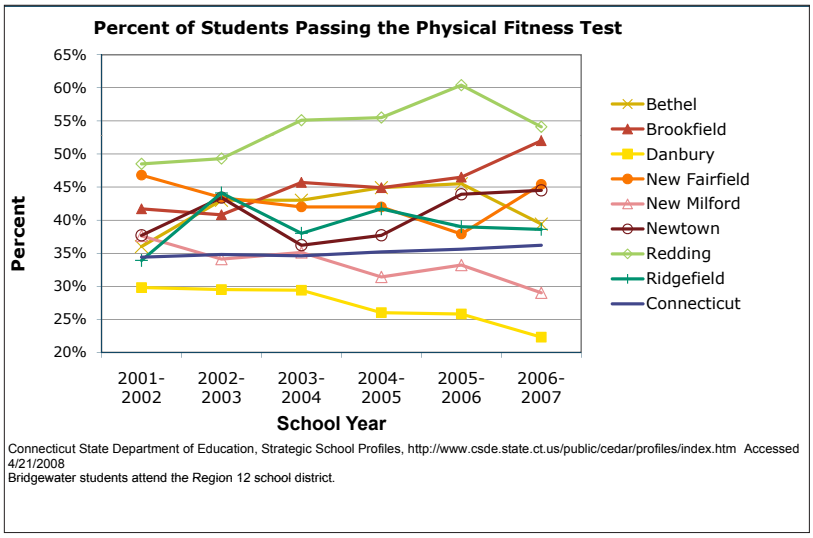
- Approximately 98,000 of 357,000 Connecticut children ages 10 to17 years (27.3%) are considered overweight or obese according to Body Mass Index (BMI) for age standards.
- African-American children in Connecticut are almost two times more likely than white children to be overweight or obese (44.9% to 23.2%).
- Almost one in three (32.4%) Hispanic children in Connecticut are obese or overweight.

Risk Factors: Indicators and Findings, cont'd.

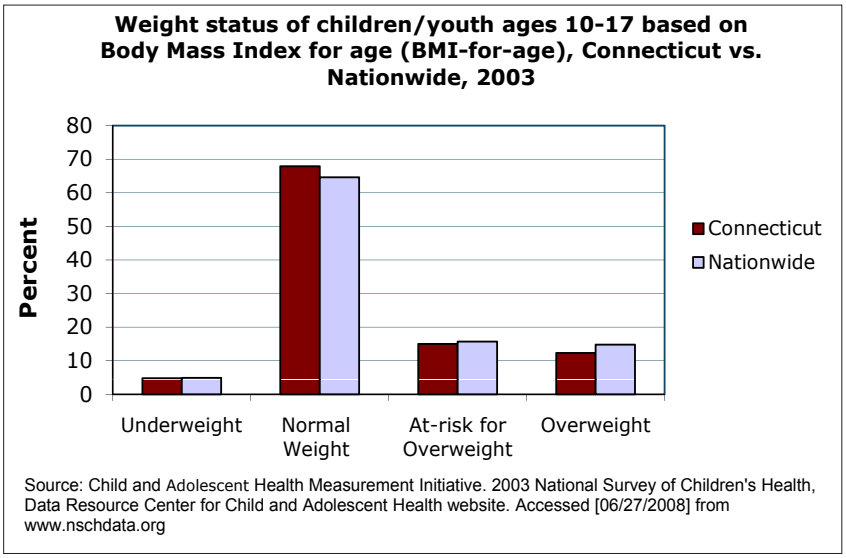
Childhood Obesity, cont'd.

- Connecticut children are less likely than their counterparts nationwide to be physically active for at least four days per week, and more likely to spend two hours or more a day in front of a television or computer screen.
- According to the 2006 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families participating in Women, Infants and Children Program (WIC), 32.7% of low-income children ages 2 to 5 years in Connecticut are overweight or obese.

For more information on obesity and children in Connecticut go to *www.nschdata.org.*



Connecticut State Department of Education, Strategic School Profiles, http://www.csde.state.ct.us/public/cedar/profiles/index.htm Accessed 4/21/2008
Bridgewater students attend the Region 12 school district.



Source: 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

The graph provides information about the percentage of children in our community who have passed the physical fitness test. The students are tested in three areas of fitness: cardio-respiratory, muscular strength and endurance, and flexibility. Standards are based on age/grade level. The students need to be able to run a mile in a specified time period, properly execute a specified amount of sit-ups and push-ups, and be able to reach forward while in a seated position. While some communities exceed the state levels, the percentages show that there is room for improvement.

The bar chart provides information comparing Body Mass Index for children in Connecticut and nationwide. Body Mass Index is a proxy measure for overweight obesity, which is calculated based on the child's height and weight as reported by a parent or guardian. Children in Connecticut are slightly healthier than the national average.

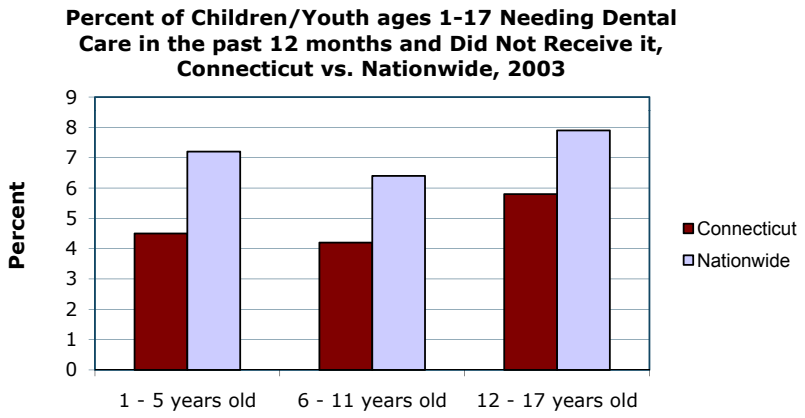
Findings: Both graphs indicate that childhood obesity is growing across the U.S. and in our region. We may trend ahead of Connecticut regarding the percent of students passing the Physical Fitness Test, but a large percentage of students are failing. Additionally, the second graph shows a lower percentage of Connecticut children are overweight or at risk. Children in Connecticut are slightly healthier than the national average and less inclined to be overweight, at-risk or obese generally.

Risk Factors: Indicators and Findings, cont'd.

Preventive Dental Care

This bar chart shows state and national levels of children by age group who did not receive needed preventive dental care during the past 12 months. Data are not available in this area for our community.

Findings: This is an important issue for children in our community to ensure health and general success but the data are not available for our community. The bar chart shows that Connecticut children are faring substantially better than those nationwide.



Source: 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

Teen Births

The teen pregnancy rate is an important indicator because these births are more likely to bring newborns into an unstable household. Frequently, the mother is not married. Teen mothers have a greater likelihood to drop out of school. Their children tend to exhibit poorer health, are more likely to be abused, and more likely to become single parents themselves. Often the child is born below the poverty line and from that stems a cycle of dependence for both mother and child in addition to many other socio-economic difficulties. Communities with high teen birth rates are most likely to have higher-than-average exposure to dispiriting social conditions in the realm of health, education and crime.

Teen pregnancy also creates serious financial consequences. Statistics compiled from the National Campaign to Prevent Teen Pregnancy show that teen pregnancy cost Connecticut taxpayers about $98 million in 2004. This number covers public

Teen Births Age 15 -17

	2001		2004	
	Number	Rate	Number	Rate
Bethel	1	LNE	3	LNE
Bridgewater	0	0	0	0
Brookfield	1	LNE	1	LNE
Danbury	21	17.6	18	14.4
New Fairfield	0	0	2	LNE
New Milford	2	LNE	3	LNE
Newtown	0	0	0	0.1
Redding	0	0	0	0.1
Ridgefield	0	0	0	0.1
Sherman	0	0	0	0.1
Connecticut	1006	15.5	917	13.8
United States	145324	25	133980	22

Source: Kids Count: Community Level Information on Kids, http://www.kidscount.org/cgi-bin/cliks.cgi?action=profile Accessed 4/21/2008

Rate is number of births to females ages 15-17 per 1,000 females for that age group in a town

LNE = Low Number Event, rates are not calculated for cases of less than 5 events

Risk Factors: Indicators and Findings, cont'd.

Teen Births, cont'd.

health costs, public welfare, loss of income and incarceration. According to the same source, the average annual cost associated with a mother younger than 17 having a child is $6,850.

According to extensive research on teen birth rates over the last 30 years compiled by the Guttmacher Institute, the teen birth rate nationally in 2002 was about 43 births per 1,000. (Note: The statistic cites "births" and not pregnancies.) The national teen birth rate has been on the decrease and this is the lowest number in 30 years. (The peak was seen in 1991 at 61.8.) From 1991 to 2004, the teen birth rate overall within the state has been decreasing. According to the Guttmacher Institute, one-third of all American teenage pregnancies end in abortion.

Our community appears to be well below the national average for teen birth rates in 2001 and 2004.

Findings: This community compares favorably to Connecticut and U.S. comparative data. The Danbury rate is slightly higher, but it is trending in a positive way as a percent of population compared with 2001 population data.

Low Birth Weight

Low birth weight is a term used for babies who are born weighing less than 5½ pounds. Low birth weight is often associated with alcohol, tobacco or drug use during pregnancy. Other causes include lack of or no prenatal care, improper nutrition, premature delivery or multiple-birth babies. A baby with a low birth weight may be at increased risk for complications and the health care costs escalate due to the need for specialized care, usually in neonatal intensive care units. In our community, the rates for low birth weight for 2004 are lower than the state and national rates.

Findings: While the data shows that there have been some changes in percentages since 2001, providers are taking good care of our expectant mothers. In our community, the rates for low birth weight for 2004 are lower than both the state and national rates.

Low Birth Weight

	2001		2004	
	Number	Percent	Number	Percent
Bethel	13	6.10%	9	4.60%
Bridgewater	2	LNE	2	LNE
Brookfield	15	7.70%	7	3.90%
Danbury	51	4.70%	69	6.80%
New Fairfield	10	5.50%	8	4.90%
New Milford	19	5.60%	21	5.80%
Newtown	10	5.50%	10	3.60%
Redding	11	10.90%	5	5.90%
Ridgefield	8	3.20%	13	5.10%
Sherman	4	LNE	1	LNE
Connecticut	2939	6.90%	3076	8.00%
United States	308747	7.70%	331772	8.10%

Source: Kids Count: Community Level Information on Kids, http://www.kidscount.org/cgi-bin/cliks.cgi?action=profile Accessed 4/21/2008

Percent of All Live Births

LNE = Low Number Event, rates are not calculated for cases of less than 5 events

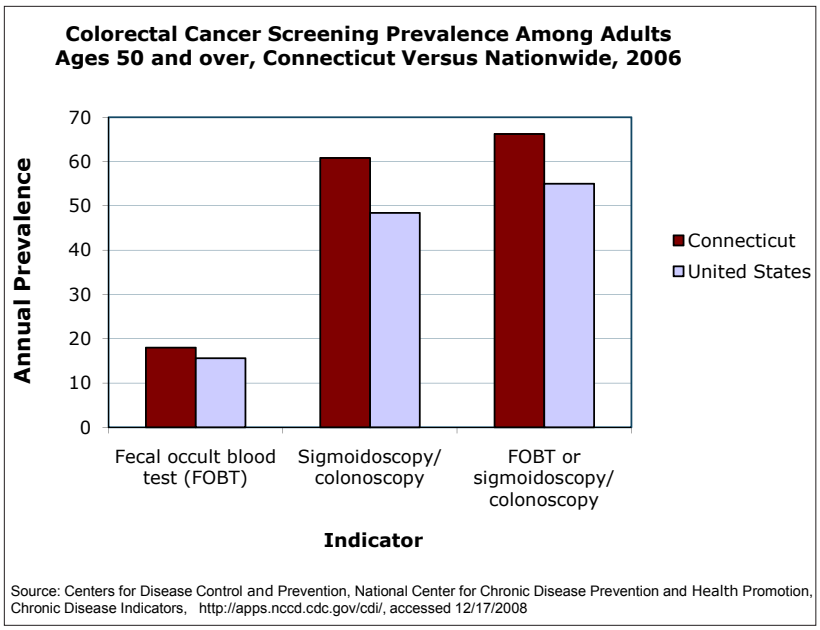
Health and Lifestyle Behaviors: Indicators and Findings

Human behavior is a key factor in determining a state of health and wellness. When there is a high prevalence of unhealthy behaviors within a community, it sets the stage for a variety of health risks.

Good showings of preventive health measures such as mammograms and colorectal cancer screenings indicate that we might look to a future decline in breast and colon cancers. The outcome of statistics on tobacco, alcohol and drug use is a possible predictor of the number of hospitalizations and deaths (car accidents, overdoses, lung cancer) related to tobacco, alcohol and drugs and should drive decision-making on programs in those areas. An analysis of the statistics that follow shows encouraging trends and indicates where attention should be focused for more improvement.

Colorectal Cancer Screening

Colorectal cancer develops in the colon or the rectum and occurs most frequently in men and women over the age of 50. It is the third leading cause of cancer death among both genders. Because this cancer starts with a growth (polyp) that may not be cancerous, early detection is the best defense in overcoming this disease. If polyps are detected, they are removed to prevent later stages of cancer development. The American Cancer Society *(www.cancer.org)* recommends first screening at age 50 if there are no risk factors other than age; an individual with family history of colorectal cancer or polyps or other risk factors should begin screening at an earlier age.

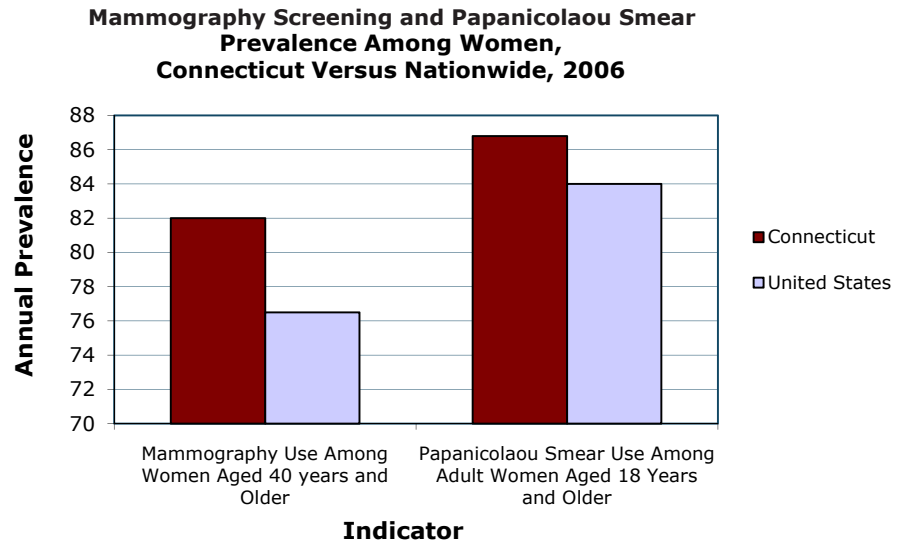


Finding: Prevention is key to reducing deaths from colorectal cancer. The data in the graph demonstrate that prevention efforts in Connecticut are in place as Connecticut is above the national average for colorectal screening for adults age 50 and older across all testing methods.

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

Mammography Screening and Papanicolaou Smear.

Early detection of breast and cervical cancer improves the chance that these cancers can be diagnosed at an early stage and treated successfully. According to the American Cancer Society, one of the best methods for early detection of breast cancer among women age 40 and over is the mammogram. One of the risk factors for cervical cancer is the Human Papilloma Virus (HPV), which can be detected with a Papanicolaou Smear (Pap test).



Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Chronic Disease Indicators, http://apps.nccd.cdc.gov/cdi/, accessed 12/17/2008

Connecticut is currently recognized for having the fourth-best mammography rates of screening nationwide. Additionally, recent data show a decrease in both incidence and mortality for breast cancer in Connecticut.

Findings: The graph shows that Connecticut is above the national average for participation in each of these cancer screening techniques. The graph also shows that women in Connecticut are seeking cervical cancer screening (Papanicolaou testing) at a higher rate than nationally.

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.

Obesity, poor nutrition and lack of physical activity are also major risk factors for premature death. 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 exceeds 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 drug abuse.

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

Tobacco, Alcohol, and Drugs

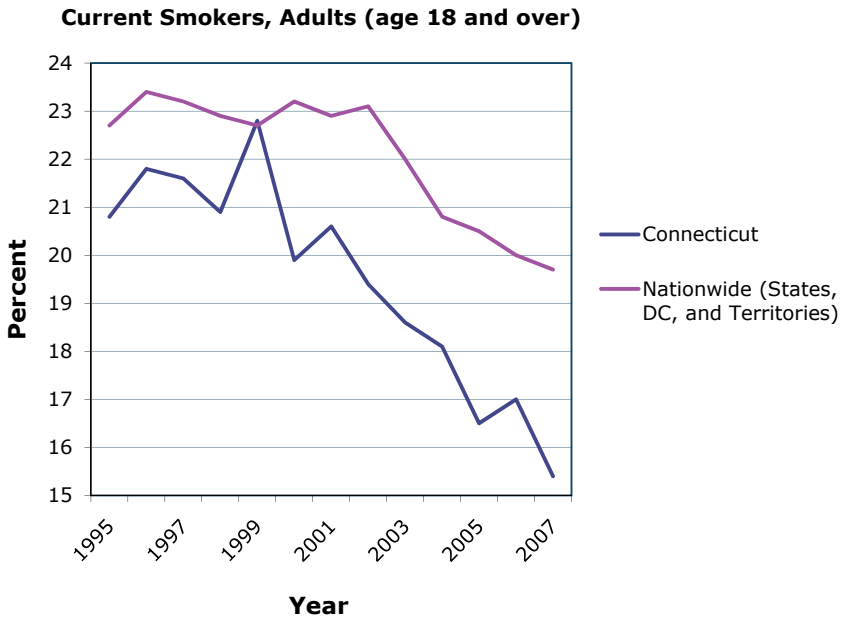
Tobacco Use

Adult tobacco use has been declining in Connecticut and nationwide. In 2007 the prevalence of use among adults was much lower in Connecticut (15.4%) when compared to the national average (19.7%). Data from the 2007 Behavioral Risk Factor Surveillance System (BRFSS) include the following:

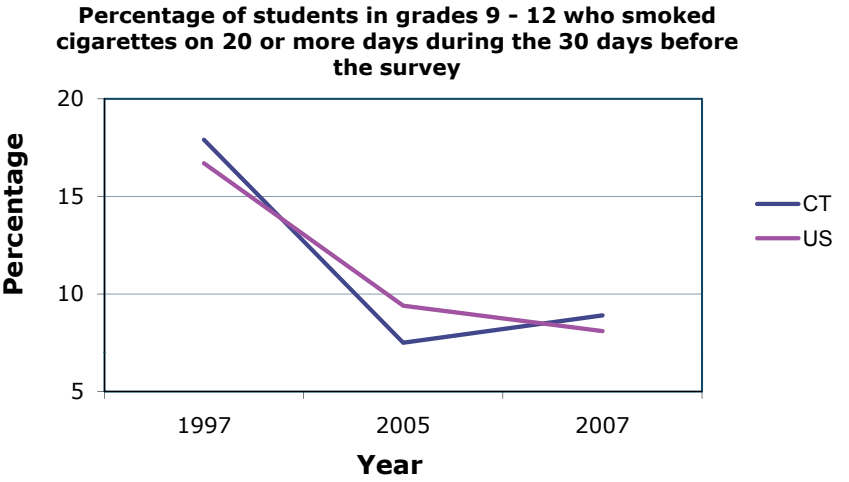
- Men are slightly more likely to smoke than woman (16.5% versus 14.4%).
- Younger adults, age 18-24 (22.7%), are much more likely to smoke than older adults (25-34 years: 18.8%, 35-44 years: 15.8%, 45-54 years: 17.9%, 55-64 years: 13.9%, and 65+ years: 6.5%).
- African-Americans (21.7%) are more likely to smoke than whites or Hispanics (15.2% and 15.1% respectively).
- People with lower incomes are much more likely to smoke than those with higher incomes (< $15,000: 28.0%, $15,000-24,999: 24.5%, $25,000-34,999: 22.7%, $35,000-49,999: 16.9%, and >$50,000: 12.5%).
- Adults with a lower education are much more likely to smoke than those with more education (< high school: 28.4%, high school or GED: 24.3%, some post high school: 17.8%, and college graduate: 7.9%).
- Among female high school students in the 12th grade, whites and Hispanics are more likely to smoke.

The data for our state indicate an increase in tobacco use among youth that is above the national average.

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



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 12/17/2008



Source: Centers for Disease Control and Prevention Youth Risk Behavior Survey, http://apps.nccd.cdc.gov/yrbss, accessed 6/27/2008

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

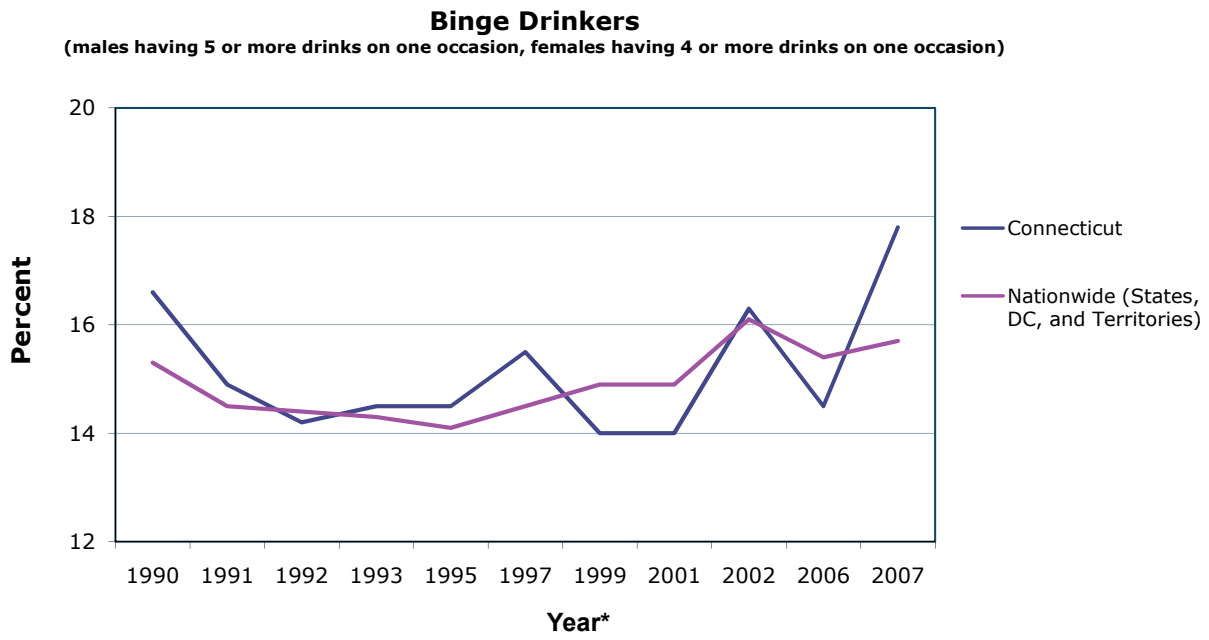
Tobacco, Alcohol, and Drugs, cont'd.

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, 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 again in 2007. 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. People with an income of $50,000 or more and those with a high school degree or more are likely to participate in binge drinking. Males are twice as likely as females, young adults (age 18-24) are twice as likely as 25-34 year olds and 15 times more likely than those over age 65, and whites are more likely than other races to binge drink.

On a regional level, the data in the table to the right indicate the rate for alcohol use in the southwest region to be slightly higher than the state rate and the rate for binge drinking to be slightly lower than the state rate.



Source : Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, http://www.cdc.gov/brfss/index.htm, Accessed 6/27/2006
* Data were not availble for all years

Tobacco, Alcohol, and Drugs, cont'd.

Alcohol Use cont'd.

Alcohol Use in Past Month and Binge Alcohol Use in Past Month in Connecticut among Persons Aged 12 or Older, by Substate Region: Percentages, Annual Averages Based on 1999, 2000, and 2001 NSDUHs

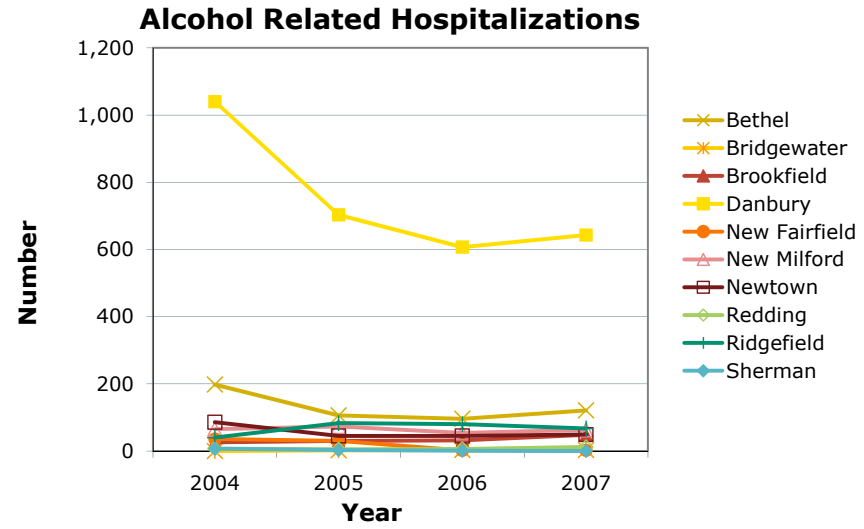
State/Substate Region	Alcohol Use in Past Month (estimated %)	Binge Alcohol Use in Past Month[1] (estimated %)
Connecticut	56.62	21.4
Eastern	58.65	23.94
North Central	57.23	21.76
Northwestern	55.2	19.87
South Central	55.58	21.39
Southwest	57	20.65

[1] Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 1999, 2000, and 2001. http://oas.samhsa.gov/subStateTABS/CT.htm, Accessed 6/30/2008

Alcohol-related hospitalizations, whether into the emergency department for acute intoxication or into the inpatient unit for alcohol withdrawal and alcohol-related consequences, appear also to be on the decline. On a local level, prevalence and hospitalization rates for alcohol use, recently on decline, appear to be leveling off in the past few years as the graph illustrates.

Findings: Binge-drinking interventions should focus on the college crowd and younger adults in the work force. Missing from alcohol-related hospitalizations are 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.



Source: Danbury Hospital, data received July 31, 2008; New Milford Hospital, data received 8/26/2008

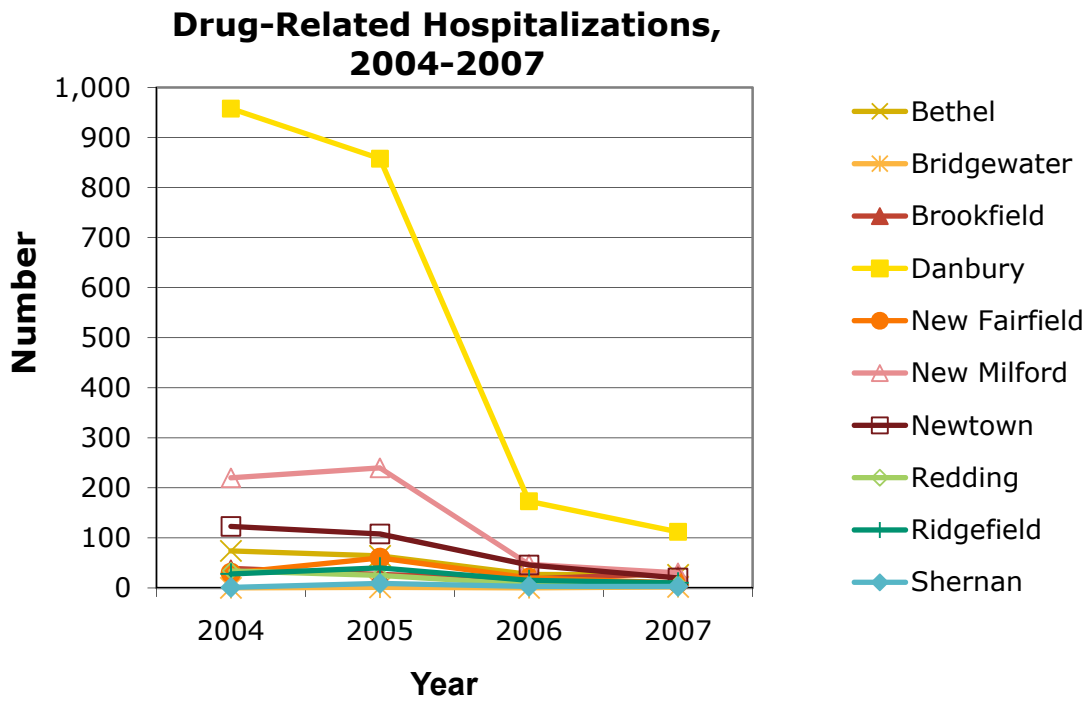
Health and Lifestyle Behaviors: Indicators and Findings, cont'd.

Tobacco, Alcohol, and Drugs, cont'd.

Drug Use

The table below indicates a decline in drug-related hospitalizations for Danbury residents and a slight decline or leveling for the other communities.

Findings: Health and human service providers are fully engaged on this issue as the graph demonstrates a substantial decline in drug-related hospitalizations for greater Danbury-area residents.



Source: Danbury Hospital, data received July 31, 2008; New Milford Hospital, data received 8/26/2008

Diseases: Indicators and Findings

The following data examine hospitalizations from, incidence of, and death rates due to significant chronic and infectious diseases within our community.

The data take into account hospitalizations from asthma for both children and adults; the percentages of infection for HIV, sexually transmitted diseases (STDs), tick-borne illnesses, and tuberculosis; and death rates for diabetes, cancer, and cardiovascular disease.

A higher-than-average incidence of any of these diseases indicates health areas that a community might consider improving upon. Many of these conditions are preventable. Others can be made less prevalent.

Asthma

Asthma is a chronic condition that inflames the airways that allow the passage of air in and out of the lungs. Although there is no cure, the symptoms of asthma are exacerbated by poor air quality and are often associated with poverty. People in poverty tend to smoke more and/or live in housing with inadequate ventilation allowing contact with asthma irritants. Dust mites, symptomatic of poor living conditions, can also be an irritant for asthma patients. Industrial and automobile emissions are linked to creating asthmatic symptoms. By looking at our community's hospitalization rate from asthma, we in turn get a clearer picture of the community's poverty, access to health care, and air quality both indoors and outdoors.

The following table provides local data for asthma hospitalizations and hospitalization rates compared to statewide data for the years 2001 to 2005.

Findings: The hospitalization rates in all communities are below the state rates for children and adults with a primary diagnosis of asthma. Danbury is highest among our communities but is still below the state rate.

Asthma Hospitalizations by Town, 2001-2005

	Adults 18+ years old		Children 0 - 17 years old		Total Population	
Town	# Hospitalizations	Rate (per 10,000)	# Hospitalizations	Rate (per 10,000)	# Hospitalizations	Rate (per 10,000)
Bethel	45	6.8	18	7.3	63	7.0
Bridgewater	*	*	*	*	*	*
Brookfield	15	2.6	11	5.1	26	3.3
Danbury	252	8.6	101	12.4	353	9.4
New Fairfield	19	3.9	12	5.7	31	4.4
New Milford	41	4.2	35	9.4	76	5.6
Newtown	37	4.2	16	4.4	53	4.2
Redding	6	2	7	5.8	13	3.1
Ridgefield	35	4.3	16	4.4	51	4.3
Shernan	*	*	*	*	7	3.7
Connecticut	2900	11.1	1500	17.8	4400	12.7

* In keeping with confidentiality regulations, numbers and rates are suppressed when the number is less than 6

Note: The information presented is for hospitalizations with asthma coded as the primary diagnosis

Source: Peng, J., Rodriguez, R., & Heyes, S. (2008). Asthma in Connecticut 2008: A Surveillance Report. Connecticut Depertment of Public Health, Health Education, Management and Surveillance Section, Hartford, CT.

Diseases: Indicators and Findings, cont'd.

Tuberculosis

Once considered extinct, tuberculosis is now on the rise nationally, but the rise is deceptive as more than 80% of American tuberculosis (TB) cases are brought into the United States by immigrants. Tuberculosis is associated with poverty and poor living conditions. The bacteria are released into the air when a person with active TB coughs or sneezes. Human immunodeficiency virus (HIV) infection has also been a factor for its resurgence as the condition thrives best in individuals whose immune systems have been compromised. Most American cases of TB are the result of patients with weak immune systems existing in combination with poor living conditions that originate in another country.

Tuberculosis in the United States resurged from 1985 until 1992, after which it began a decline in every year thereafter. In 2005, there were 14,000 reported cases of TB in the United States. The number of new cases in 2006 was 13,767, which represents a 3.2% decline from 2005. It is important to note that a high percentage of the TB cases in our community occurred in residents who were foreign-born. Most of the cases have occurred in individuals from Brazil, India, and Ecuador, which accounts for why Danbury has the most cases of the towns within our community. Cases in people who are foreign-born, African-American, Asian, and Hispanic are 9.5, 8.4, 21.2, and 7.6 times higher than rates among whites, respectively. The incidence rate for the United States in 2006 was 4.6 per 100,000. In Connecticut, the rate was 2.5 per 100,000. *(Source: Centers for Disease Control and Prevention, accessed 8/09/2008 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5611a2.htm)*

Findings: It appears that tuberculosis is not a health issue for our community except for the population of Danbury.

Annual TB Incidence by City and Year, 1998 to 2007

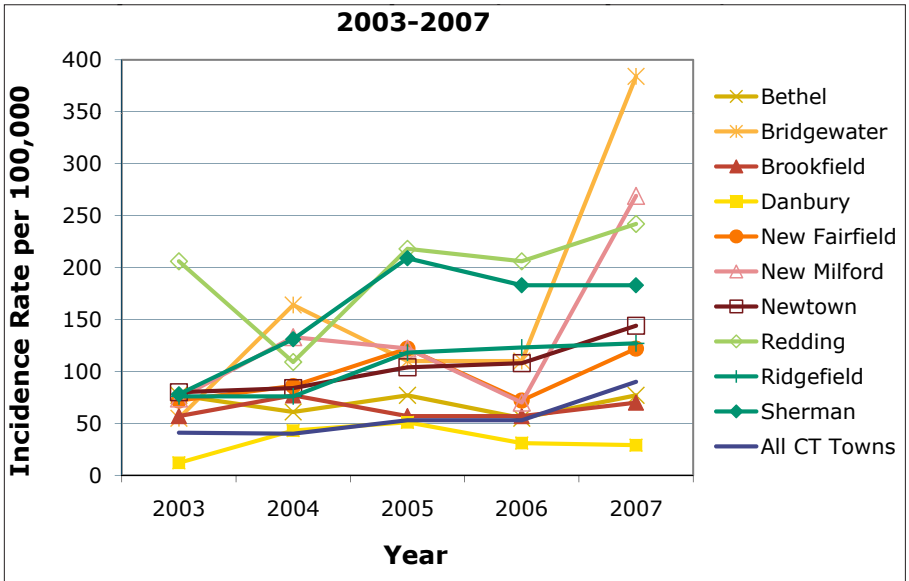
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Bethel	0	0	0	0	0	0	0	0	0	0
Bridgewater	0	0	0	0	0	0	0	0	0	0
Brookfield	1	0	0	0	1	1	0	0	0	0
Danbury	7	9	6	5	4	5	13	6	6	11
New Fairfield	0	0	0	0	0	0	0	0	0	1
New Milford	1	0	1	0	0	1	2	0	0	1
Newtown	0	0	0	0	0	0	0	0	0	0
Redding	1	0	0	0	0	0	0	0	0	0
Ridgefield	0	0	1	0	0	0	2	0	0	0
Sherman	0	1	0	0	0	0	0	0	0	0
All CT Towns	127	121	105	121	105	111	101	95	89	108

Source: Connecticut Department of Public Health. http://www.CT.gov/DPH/lib/DPH/City_By_Year_Report.pdf, Accessed April 23, 2008

Diseases: Indicators and Findings, cont'd.

Tick-Borne Illness

Our community has an unusually high rate of tick-borne illness as compared to nearly any other community in the nation. Statistics show higher rates in certain neighboring communities, particularly in the state of New York, but in light of how difficult accurate statistics for tick-borne illnesses are to compile, it is still accurate to say that our community has one of the highest rates of infection. There are many varieties of tick-borne diseases but this report will focus on three: Lyme disease, ehrlichiosis, and babesiosis. The good news is that precautions can be taken that can significantly lower the chance of contracting these illnesses.



Source Connecticut Department of Public Health
http://www.ct.gov/dph/cwp/view.asp?a=3136&Q=399694&dphPNavCtr=|46973|#46999 Accessed

The culprit in Lyme disease is the deer tick, which bites through the skin as it uses humans and other animals as a host. Ehrlichiosis is thought to be spread by the bite of the Lone Star tick, according to the Mayo Clinic. Babesiosis is carried by deer ticks infected with the Babesia parasite. As seen with Lyme disease and ehrlichiosis, it is transmitted to people through the bite of the tick. Babesiosis is the rarest of the three, but it has been seen most often in Rhode Island and health experts have noticed its prevalence in other East Coast states. Some health experts fear that babesiosis is the next tick-borne epidemic.

Untreated Lyme disease can result in extremely serious health consequences: paralysis, meningitis, neurological difficulties, joint swelling, arthritis and loss of hearing or sight. 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 an illness serious enough for hospitalization. Most patients recover from babesiosis with few, if any, lasting effects. The most serious and sometimes fatal cases are found in elderly people, in pregnant women, in people who have had their spleens removed, or in people with immune deficiencies.

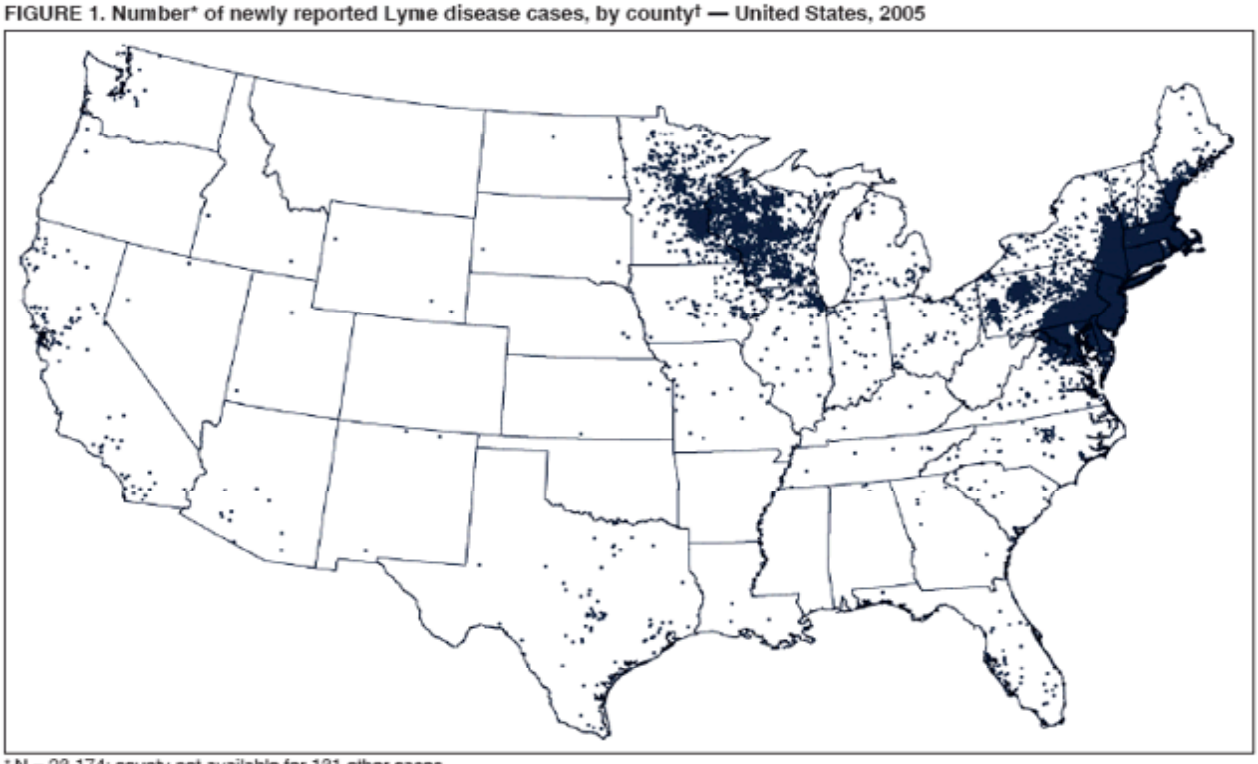
Diseases: Indicators and Findings, cont'd.

Tick-Borne Illness, cont'd.

To help prevent the uncontrolled spread of tick-borne illness, the region's elected officials at the Housatonic Valley Council of Elected Officials (HVCEO) voted in June 2008 to endorse the use of a public health education program called "BLAST" in all 10 HVCEO towns. Ridgefield received a grant of $50,000 from the Connecticut Department of Public Health to create this unique public health education program. BLAST stands for the five most important things families can do to stay safe from tick-borne illness (Bathe, Look for ticks, Apply repellant, Spray yard, Treat pets). The BLAST Program is to be shared with all Fairfield County communities. A regional BLAST workshop was held in Ridgefield on Nov. 5, 2008, so all Fairfield County municipalities could learn how to properly use the BLAST program. *(http://www.ridgefield.org/content/46/6311/6347/default.aspx)*

Finding: The data show that this issue requires attention in the region and a plan is in place to do this. Prevention is key to improving local rates.

FIGURE 1. Number* of newly reported Lyme disease cases, by county† — United States, 2005



* N = 23,174; county not available for 131 other cases.
† One dot was placed randomly within the county of patient residence for each reported case.

Source: Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5623a1.htm?s_cid=mm5623a1_e, accessed 8/9/2008

Diseases: Indicators and Findings, cont'd.

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

These conditions are preventable through proper care and education. Drug abuse is a contributing factor for many HIV and STD cases. There is a trend among high school students nationally toward an increase in STD cases.

At a national level, the estimated number of HIV cases in 2006 as reported in 33 states and five dependent areas was 36,817. During the same year, the estimated number of cases of AIDS in the United States and dependent areas was 37,852. *(Source: Centers for Disease Control and Prevention, accessed 8/9/2008, http://www.cdc.gov/hiv/topics/surveillance/basic.htm).*

Danbury has seen a spike in STD cases in recent years, and this could be for two reasons: It is possible that Danbury is following an epidemic-like trend of STDs in major urban areas. It could also be that an organization did an awareness drive, and consequently, more people were tested, offering better documentation of STDs. If the latter is true, then it may also be true that the other towns in the community are not reporting accurately and the incidence is much higher. The increase statewide in STD and the decrease in HIV cases over the past three years appears to follow a national trend.

According to the Centers for Disease Control (CDC), chlamydia is the most commonly reported infectious disease in the United States with 1,030,911 cases in 2006, up from 976,445 in 2005. Gonorrhea is the second-most commonly reported disease with 388,366 cases in 2006. Although the number of cases of primary and secondary syphilis is much lower (9,756 in 2006), the rate has been increasing. The national rate increased 13.8% between 2005 and 2006. *(Source: Centers for Disease Control and Prevention, accessed 8/9/2008 http://www.cdc.gov/std/stats/pdf/trends2006.pdf).*

Connecticut Department of Public Health HIV/AIDS Surveillance Program HIV* and AIDS Cases Reported by City/Town of Residence 2008 and cumulative from 1980 through June 30, 2008

	HIV			AIDS		
	Incidence[1] 2008	1980-2008	Living with [2]	Incidence[1] 2008	1980-2008	Living with [2]
Bethel	3	6	5	1	21	14
Bridgewater	0	0	0	0	1	0
Brookfield	1	4	4	0	15	6
Danbury	12	77	76	9	316	145
New Fairfield	0	1	1	0	12	4
New Milford	2	7	7	1	47	20
Newtown	1	4	4	2	34	7
Redding	2	5	5	0	14	5
Ridgefield	0	4	4	0	18	9
Sherman	0	0	0	0	5	0
ALL CT Towns	855	3388	3,278	445	15,325	7,453

*A person with HIV infection who has not developed AIDS

[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_current year_table.pdf, Accessed 12/17/2008

Diseases: Indicators and Findings, cont'd.

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

The following table shows the cases of chlamydia, gonorrhea, and syphilis as reported by the Connecticut STD Control Program for 2007.

Findings: Danbury has seen an increase in STD cases in recent years. The increase statewide in STD and the decrease in HIV cases over the past three years appears to follow a national trend.

Chlamydia, Gonorrhea, and Primary and Secondary Syphilis Cases Reported by City, Connecticut 2007

	Syphilis cases	Disease Gonorrhea cases	Chlamydia cases	Total Cases
Bethel	0	0	22	22
Bridgewater	0	0	0	0
Brookfield	0	1	10	11
Danbury	0	17	131	148
New Fairfield	1	0	10	11
New Milford	0	1	20	21
Newtown	1	3	6	10
Redding	0	0	4	4
Ridgefield	0	1	9	10
Sherman	0	0	0	0
Total all CT Cities	39	2332	11512	13883

Source: CT Department of Public Health. http://www.ct.gov/dph/lib/dph/std_city.pdf, Accessed 4/21/2008

Diseases: Indicators and Findings, cont'd.

Diabetes, Cancer, and Heart Disease

All three of these are leading causes of death in this country. Each is extremely expensive to treat. Health experts maintain that one-third of all deaths from these three conditions are preventable through behavioral changes.

In Connecticut (2003-2005 data), an estimated 6.2% or approximately 168,000 adults aged 18 and older reported being diagnosed with diabetes, compared with about 7% of the U.S. population. An additional 70,000 adults are estimated to have undiagnosed diabetes. This falls right in line with the national diabetes rates, 7.8% of both diagnosed and undiagnosed diabetes. The prevalence of diabetes in Connecticut has been gradually on the rise. *(http://www.ct.gov/dph/LIB/dph/hisr/pdf/Diabetes_surveillance_2006CT.pdf)*

Heart disease is the leading cause of death in the United States. It is also the leading cause of death in Connecticut. Heart disease accounted for 29% of the state's deaths in 2001. The second leading cause of death in the United States and Connecticut is cancer. According to comparative statistics provided by the Centers for Disease Control (CDC) in the years 1995 and 2001, Connecticut's heart disease and cancer rates are both slightly higher than the national average.

In 2003, the age-adjusted cancer incidence rate in Connecticut was 489.4 per 100,000 people and in the United States was 459.9 per 100,000 people. Our community is in step with the rest of the nation.

Number of Deaths per 100,000 Population

	Diabetes[1] (2005)	Heart Disease[2] (2005)	Cancer[3] (2005)
Connecticut	20	173	179
United States	25	211	184

Note: Age-adjusted rates per 100,000 U.S. standard population. Populations used for computing death rates are post-censal estimates based on the 2000 census. Since death rates are affected by the population composition of a given area, age-adjusted death

Source: Data were retrieved from : http://statehealthfacts.org/ accessed 12/17/2008, 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. Accessed

[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

[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

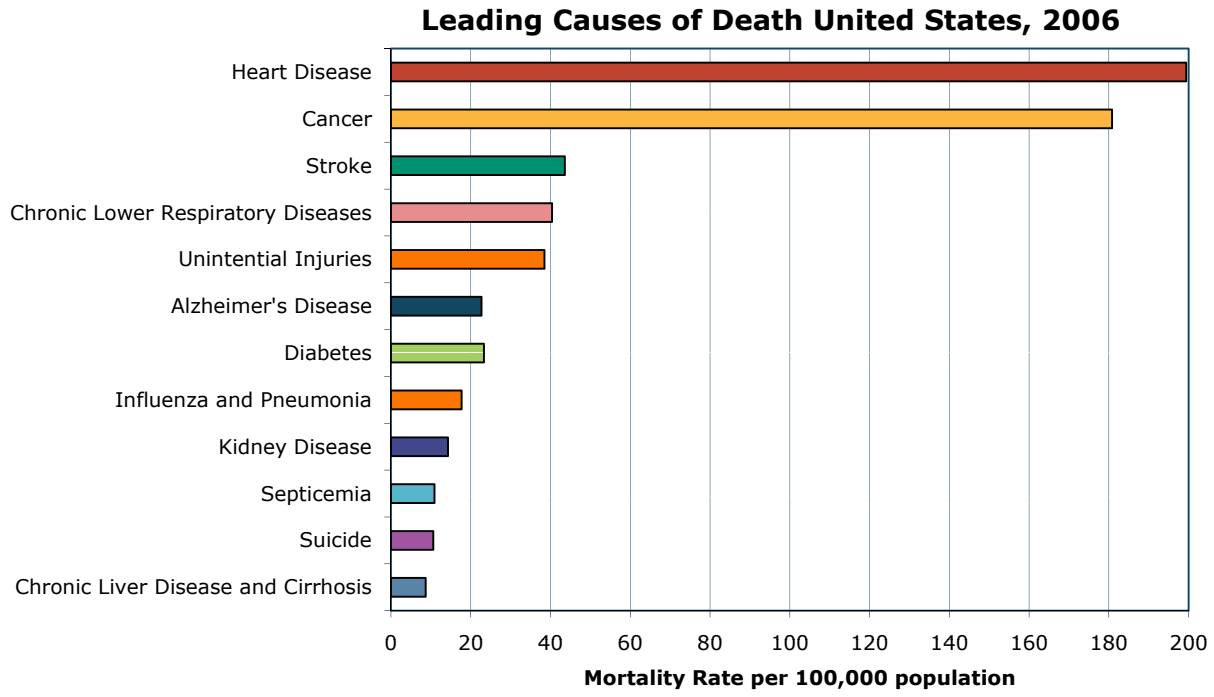
Diseases: Indicators and Findings, cont'd.

Mortality Rates

Mortality data is a valuable measure for assessing the health status of a community. This data is integral in developing health promotion programs to prevent or reduce premature mortality.

The following graph presents the leading causes of death in the United States for 2006. This is followed by a table with the leading causes of death in our community and Connecticut for 2002-2006. Although the 10 causes of death for each community are not in the same rank order for each community, the 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, alcohol, and drugs, managing stress, and other preventative behaviors.

Findings: When examining the leading causes of death across Connecticut and the U.S., data show the Greater Danbury area ranks quite well against all U.S. comparisons and in most cases is well below every Connecticut indicator comparison.



ource: Centers for Disease Control and Prevention, National Vital Statistics Report, Preliminary Data 2006.
ttp://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_16.pdf, accessed 11/30/2006

Diseases: Indicators and Findings, cont'd.

Mortality Rates, cont'd.

Leading Causes of Death, 2002-2006, Crude Rate[2]

Community	Heart Disease	Cancer	Stroke	Chronic Lower Respiratory Diseases	Unintentional Injuries	Alzheimer's Disease
Bethel	**247.4**	**184.4**	**39.8**	**47.5**	**25.4**	**11.0**
Bridgewater	**185.8**	**207.7**	**32.8**	**32.8**	**43.7**	**10.9**
Brookfield	**248.2**	**185.9**	**34.4**	**43.3**	**31.8**	**15.3**
Danbury	**224.9**	**159.4**	**33.3**	**33.5**	**31.4**	**16.2**
New Fairfield	**168.7**	**135.9**	**18.6**	**11.4**	**34.3**	**11.4**
New Milford	**206.8**	**145.0**	**36.8**	**33.8**	**26.5**	**20.6**
Newtown	**213.3**	**171.9**	**30.2**	**23.9**	**33.4**	**21.5**
Redding	**214.2**	**187.7**	**28.9**	**31.3**	**21.7**	**16.8**
Ridgefield	**191.5**	**158.6**	**29.7**	**27.8**	**16.0**	**12.7**
Sherman	**161.2**	**166.4**	**46.8**	**10.4**	**15.6**	**26.0**
Connecticut	**297.5**	**202.0**	**47.8**	**35.2**	**33.5**	**19.3**
US (2006)[1]	**210.2**	**187.1**	**45.8**	**40.4**	**41.6**	**24.4**

Leading Causes of Death, 2002-2006, Crude Rate[2]

Community	Diabetes	Influenza and Pneumonia	Kidney Disease	Septicemia	Suicide	Chronic Liver Disease and Cirrhosis
Bethel	**9.9**	**15.5**	**12.1**	**8.8**	**6.6**	**6.6**
Bridgewater	**21.9**	**10.9**	**10.9**	**10.9**	**0.0**	**21.9**
Brookfield	**11.5**	**17.8**	**3.8**	**11.5**	**3.8**	**6.4**
Danbury	**18.4**	**14.4**	**9.8**	**13.6**	**9.3**	**7.2**
New Fairfield	**5.7**	**12.9**	**7.2**	**12.9**	**7.2**	**7.2**
New Milford	**14.7**	**30.9**	**8.1**	**16.9**	**6.6**	**9.6**
Newtown	**8.0**	**19.1**	**10.3**	**8.0**	**9.6**	**2.4**
Redding	**16.8**	**19.3**	**4.8**	**21.7**	**1.5**	**7.2**
Ridgefield	**9.3**	**13.5**	**10.1**	**16.0**	**8.4**	**2.5**
Sherman	**20.8**	**5.2**	**5.2**	**10.4**	**0.0**	**5.2**
Connecticut	**21.0**	**24.9**	**16.3**	**16.4**	**7.8**	**8.4**
US (2006)[1]	**24.2**	**18.8**	**15.0**	**11.4**	**10.7**	**9.1**

Source: Connecticut Department of Public Health, Age-Adjusted Mortality Rates, Town Comparisons, http://www.ct.gov/dph/lib/dph/hisr/hcqsar/mortality/xls/aamr_towns_aggregate_2002-2006.xls, accessed 1/9/2009

[1] Centers for Disease Control and Prevention, National Vital Statistics Report, Preliminary Data 2006. http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_16.pdf, accessed 11/30/2006

[2] Crude mortality rates were used for this table since the age-adjusted mortality rates were not available for all causes of death

Diseases: Indicators and Findings, cont'd.

Infant Mortality

Infant mortality is commonly used as an indicator of a community's health. The infant mortality rate is often difficult to calculate in communities where there are a small number of infant deaths. The table below shows the number and rate of infant mortality in our communities from 2001 to 2004.

Findings: In general, the infant mortality rate in Connecticut is lower than the national average and, with the small number of cases in our communities, we can assume that our infant mortality rate is below the national average. In 2005, the infant mortality rate for the United States was 6.87 infant deaths per 1,000 live births. For Connecticut, it was 5.8.

Infant Mortality

	2001		2002		2003		2004	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Bethel	-	-	4	LNE	-	-	-	-
Bridgewater	-	-	-	-	-	-	-	-
Brookfield	-	-	1	LNE	-	-	-	-
Danbury	6	5.5	4	LNE	1	LNE	3	LNE
New Fairfield	-	-	-	-	3	LNE	-	-
New Milford	2	LNE	1	LNE	1	LNE	3	LNE
Newtown	1	LNE	-	-	1	LNE	-	-
Redding	-	-	-	-	-	-	-	-
Ridgefield	1	LNE	-	-	1	LNE	1	LNE
Sherman	1	LNE	1	LNE	1	LNE	-	-
Connecticut	258	6	273	6.5	230	5.4	232	5.5
United States	27568	6.8	28034	7	28025	6.9	27936	6.8

Source: Kids Count: Community Level Information on Kids. http://www.kidscount.org/cgi-bin/cliks.cgi?action=profile Accessed 4/21/2008

Rate is per 1000 live births

LNE = Low Number Event, rates are not calculated for cases of less than 5 events

Suicide

Suicide can have a profound effect on a community. Anguish over guilt and unanswered questions and a lingering sense that more could have been done to help will frequently remain with friends and relatives after someone takes his/her own life. At times, especially in the suicide of a young person, an entire community suffers from feelings of indictment over what might have been done to prevent it. In extreme cases, a suicide involving a young person signals the potential for an epidemic of copycat suicides. The sense of community is equally jarred when an adult commits suicide. It can indicate that a community's social health services need to be examined.

The following data was retrieved through the Connecticut Department of Public Health.

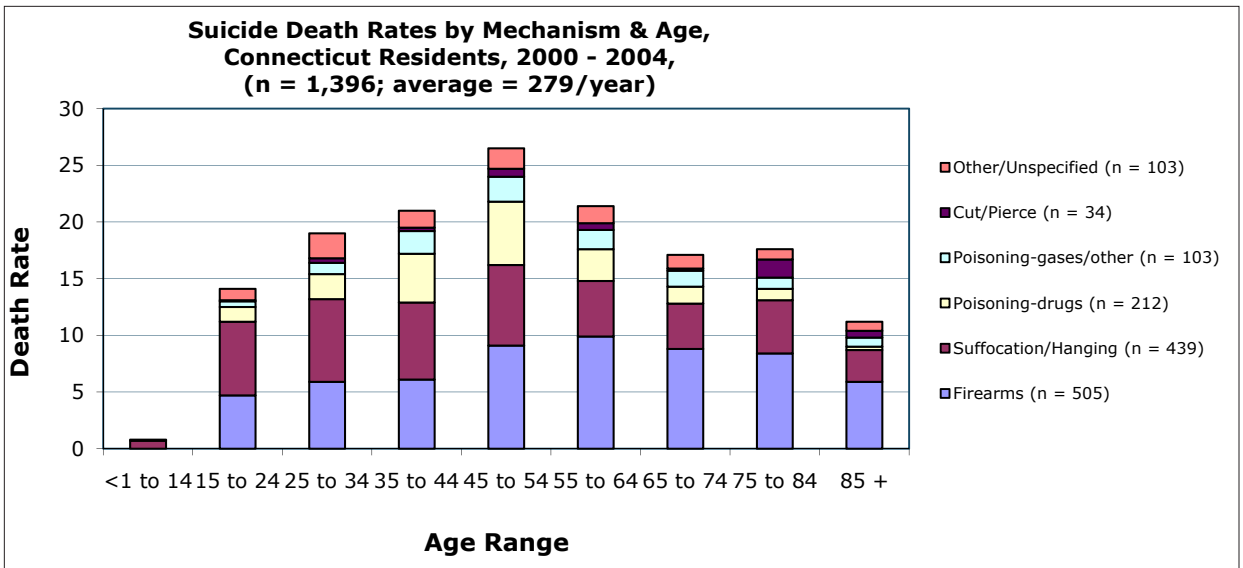
- Suicide was the second leading cause of injury death in Connecticut accounting for 18.1% of all injury-related deaths between 2000-2004, with 1,396 suicide deaths, for an average of 279 suicides a year.

Diseases: Indicators and Findings, cont'd.

Suicide, cont'd.

- Firearms accounted for more than one-third (36.2%) of all suicide deaths, followed by suffocation, hanging or strangulation (31.5%), and poisoning by drugs or other substances (22.8%).
- 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 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.
- More than one-fourth of all suicides occurred between 40-49 years of age, while more than 60% happened between the ages of 30-59 years.
- Males were almost 3.5 times more likely to use firearms, while females were nearly four times more likely to use drugs in completing suicide.
- Hanging/suffocation was the second-leading mechanism of suicide death for both males (32.2%) and females (28.7%).
- 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

Findings: Data show the majority of our communities has a lower rate of suicide than Connecticut and all communities have a lower rate than the national rate. This data can be found in the Leading Causes of Death table on page xxx..



Source: Connecticut Department of Public Health, Injury in Connecticut: Deaths and Hospitalizations. http://www.ct.gov/dph/lib/dph/hems/injury/databook/dph_injury_databook_final.pdf, accessed 8/8/2008

Recommendations

The recommendations presented in this document are not intended to put the burden of solution on a particular provider, local health care agency, or community. Any solution will require partnerships among public and private providers in health care, education, social services and government. Based upon the findings presented in the *Community Report Card of Western Connecticut*, we recommend the following:

A. 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.

B. 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 service providers should be recognized for their efforts toward preventative, interventive and on-going 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.

C. 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.

D. The community should develop a plan to better promote 2-1-1 (Infoline) as a source for available services for the general and provider populations.

Recommendations, cont'd.

E. *The Community Report Card of 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. In preparation for future reports, the community should:

1. Collect community-specific data where there are none.
2. Determine "target" populations, such as those most in need or those most impacted, and collect relevant data for these populations.
3. Conduct focus groups with target populations to find out their needs/wants, barriers, facilitators, etc.
4. Prioritize needs.
5. Conduct resource assessment — what resources are available to meet identified needs and determine if these resources are currently meeting the needs. Identify unmet needs and create a plan to address them.
6. Identify evidence-based strategies/programs to meet the needs: such as *http://thecommunityguide.org/ and http://cancercontrolplanet.cancer.gov/*
7. Evaluate programs and monitor indicators..

List of Comparison Assessments

Cayuga County, New York Community Report Card
http://www.co.cayuga.ny.us/hhs/doh/reportcard/index.htm

Clark County, Washington, Community Report Card 2007
http://www.clarkcommunitychoices.org/docs/annual_report/Community_Choices_2007_Annual_Report.pdf

New London, Connecticut Community Health Assessment
http://www.ledgelighthd.org/programs/pdfs/NLC_final_Brochure_20070423.pdf

Norwalk, Connecticut Community Report Card
http://www.communityplanning.org/hsc/images/Indicators%205-15-07.pdf

San Mateo County, California, Children in Our Community:
A Report on Their Health and Well-Being
http://www.co.sanmateo.ca.us/Attachments/SMC/pdfs/Articles/Reports/Children%20In%20our%20Community.pdf

Focus Group Participants

November 2007

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Focus Group Participants

November 2007

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