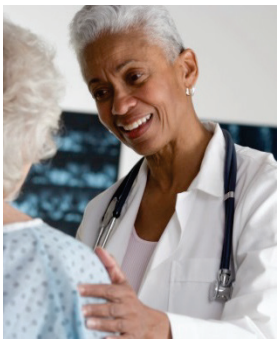
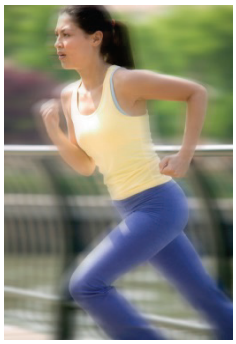
HEALTH RISK BEHAVIORS IN CONNECTICUT

Results of the 2012 Behavioral Risk Factor Surveillance Survey

April, 2014



Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Connecticut Department of Public Health
410 Capitol Avenue,
PO Box 340308, Hartford, CT 06134
www.ct.gov/dph/BRFSS

Jewel Mullen, MD, MPH, MPA
Commissioner

Acknowledgements

Jewel Mullen, MD, MPH, MPA
Commissioner
Connecticut Department of Public Health

Lisa Davis, MBA, BS, RN
Deputy Commissioner
Connecticut Department of Public Health

Diane Aye, MPH, PhD
CT BRFSS Coordinator
Section Chief, Health Statistics and Surveillance
Connecticut Department of Public Health

Carol L. Stone, PhD, MPH, MAS, MA
CT BRFSS Project Director/Principal Investigator
Health Statistics and Surveillance Section
Connecticut Department of Public Health

The CT BRFSS team acknowledges with gratitude the time contributed by over 8,000 citizen volunteers within the State of Connecticut who responded anonymously to the survey during the 2012 calendar year. The results presented in this report would not be possible without their participation.

Feedback from the following staff within the Connecticut Department of Public Health is gratefully acknowledged: Olga Armah, Marianne Buchelli, Linda Ferraro, William Gerrish, Lisa McCooey, Justin Peng, Stephanie Poulin, Patricia Przysiecki, Vincent Sacco, Ramon Sanchez, Brian Toal, Susan Yurasevecz.

This document was prepared by ICF International, 126 College Street, Burlington, VT 05401. Kristie Healey and Olivia Saucier coauthored the report, with contributions from Jennifer Goldberg, Elizabeth Hall and Mirna Moloney, and supervision from Naomi Freedner-Maguire and Kisha Bailly.

Portions of this report were modelled on the *2012 Behavioral Risk Factor Survey Report,* by the Michigan Department of Community Health (Chris Fussman, MS, Michigan BRFSS Coordinator).

This report was supported by Cooperative Agreement Number 5U58SO000003 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

Additional Resources

For questions or comments about this report, please contact:

Carol L. Stone, PhD, MPH, MA, MAS
Supervising Epidemiologist
Health Statistics and Surveillance Section
Connecticut Department of Public Health
Hartford, Connecticut, 06106

Carol.Stone@ct.gov (860-509-7147)

Find more BRFSS factsheets, reports and publications at the Connecticut Department of Public Health BRFSS website: *http://www.ct.gov/dph/BRFSS*.

Suggested citation:

Connecticut Department of Public Health (2014) Health Risk Behaviors in Connecticut: Results of the 2012 Connecticut Behavioral Risk Factor Surveillance Survey, Connecticut Department of Public Health, Hartford, Connecticut (*http://www.ct.gov/dph/BRFSS*).

Health and Surveillance Section, Survey and Research Unit, Connecticut Behavioral Risk Factor Surveillance System, New, 3-27-14

Table of Contents

List of Figures

List of Tables

Summary

The Connecticut Behavioral Risk Factor Surveillance System (CT BRFSS) is an ongoing statewide voluntary phone survey of Connecticut adult citizen volunteers aged 18 and over. It is funded by the Centers of Disease Control and Prevention (CDC) in 50 states, and has been offered within Connecticut since 1989. Households are randomly selected and contacted by a contractor who conducts most interviews in the evenings and on weekends. Once an interviewer reaches a household, a random selection of adult household members is made to choose one person to participate in the survey. Listed and unlisted residential telephone numbers are included in the sample, but not business, Fax, or modem phone lines. Cell phones were recently added to the methodology.

The CT BRFSS questionnaire changes somewhat from year to year to provide information on emerging health issues in the state and to address state-specific priorities. The survey originally collected data on health behaviors related to the leading causes of death, but has since been expanded to include issues related to health care access, utilization of preventive health services, and to address emerging issues such as alternative tobacco use or shingles vaccinations. Results of the survey are used to inform public health programs across the agency about progress toward meeting health objectives, and are also used to help identify emerging public health needs in the state.

Each month, survey data from Connecticut are sent to the CDC for editing and checking. At the end of each year, data are compiled and weighted to be representative of all adults in the state, and returned to states for analysis and use in planning and monitoring health programs. Summary data for all states are available via the CDC BRFSS website and date back to 1995.

In calendar year 2012, the CT BRFSS survey gathered survey data from citizen volunteers in Connecticut on a range of health-related risk factors and behaviors. Each section in this report presents summary results for 2012 of a risk behavior or condition, broken down by demographic subgroups that include age, gender, race/ethnicity, income, insurance status, disability status, and education level.

Details of the summary information below can be found in the body of this report, as well as from *Figure 1*, which highlights selected findings of the 2012 survey in Connecticut, compared to survey results in Connecticut during the previous year, and compared to the U.S. Median results from 2012.

While significance tests between U.S. median values and Connecticut data were not performed, two state-level indicators improved significantly from 2011 to 2012. The proportion of Connecticut adults without health coverage decreased significantly, from 14.8% in 2011 to 12.8% in 2012, and the proportion of Connecticut adults who have no leisure-time physical activity decreased significantly from 25.5% in 2011 to 22.1% in 2012.

Figure 1: Risk Factors in Connecticut, 2011 and 2012, *versus* the U.S., 2012

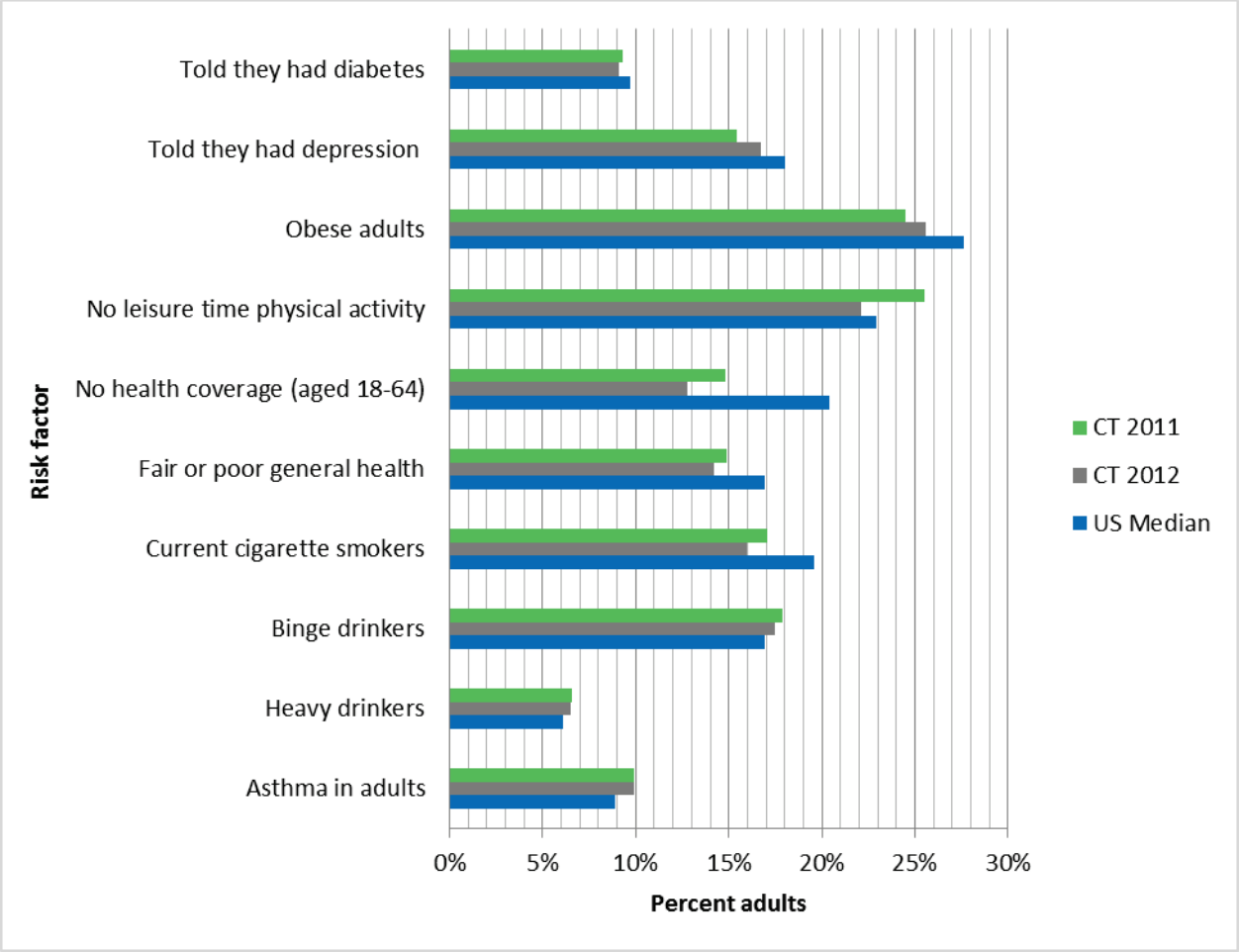


Table 1: Risk Factors in Connecticut, 2011 and 2012, *versus* the U.S., 2012

Risk factor	CT 2011	CT 2012	US Median (2012)
Asthma in adults	9.9%	9.9%	8.9%
Heavy drinkers	6.6%	6.5%	6.1%
Binge drinkers	17.9%	17.5%	16.9%
Current cigarette smokers	17.1%	16.0%	19.6%
Fair or poor general health	14.9%	14.2%	16.9%
No health coverage (aged 18-64 years old)	14.8%	12.8%*	20.4%
No leisure time physical activity	25.5%	22.1%*	22.9%
Obese adults	24.5%	25.6%	27.6%
Told they had depression	15.4%	16.7%	18.0%
Told they had diabetes	9.3%	9.1%	9.7%

In the table above, significant changes are noted with an "".*

Encouraging signs

- Compared to the U.S., Connecticut adult residents in 2012 appeared less likely to report poor health, to be uninsured, to have been diagnosed with depression, or to have obesity or diabetes.
- Less than one in six Connecticut adults (16%) were current smokers in 2012, an apparent decrease from 17.1% in 2011, and lower than the U.S. median of 19.6%. Of the other tobacco products reported, hookah was the most common, with 11.5% of adults having tried it, followed by e-cigarettes, which nearly 1 in 10 adults had tried (9.1%).
- The proportion of Connecticut adults with no leisure time for physical activity decreased significantly from 25.5% in 2011 to 22.1% in 2012, below the U.S. Median. As noted above, significance tests between Connecticut state values and U.S. median values were not performed.

Trends to watch

- Connecticut adult residents in 2012 appeared more likely to have been diagnosed with asthma (9.9%), compared to the U.S. median (8.9%).
- Levels of binge drinking did not change significantly from 2011 (18.0%) to 2012 (17.5%) and were slightly higher than the national median (16.9%). Men were significantly more likely to engage in binge drinking, compared to women.
- While obesity levels in Connecticut were still lower than national levels, there was an apparent increase in the prevalence of overweight and obese adults in 2012 compared to 2011. Taken together, 62.3% of Connecticut adults were either overweight or obese in 2012, apparently higher than the 59.7% Connecticut rate in 2011, but lower than 2012 U.S. median of 63.9%. Separately, just over one-fourth of Connecticut adults were obese (25.6%) in 2012, while another 36.7% were overweight.
- While obesity levels showed an apparent increase, diabetes levels were stable; 9.1% of Connecticut adults were told they had diabetes in 2012, compared to 9.3% in 2011.
- The proportion of Connecticut adults with asthma remained stable at about 10% of the adult population in both 2011 and 2012. About 12% of Connecticut children had asthma in 2012, up slightly from 11% in 2011; this increase was not, however, significant.

Vulnerable populations

- Connecticut adults who were uninsured, disabled, low-income, or with a high school degree or less were significantly more likely to experience poor health outcomes.
- Relative to adults with health coverage, **uninsured** adults were significantly more likely to rate their health as fair or poor, to have poor mental health, to be disabled, to live sedentary lifestyles, to be cigarette smokers, or to binge drink. They were also significantly less likely to receive certain important health screenings, routine check-ups or dentist visits.

- Negative health outcomes were significantly higher for **disabled** adults compared to non-disabled adults. Adults characterized as having a disability were significantly more likely to be obese, to rate their health as fair or poor, to have poor mental and physical health, to face barriers to healthcare, to sustain falls, to have vision or cognitive impairments, or to lead sedentary lifestyles. They were also more likely to have asthma, chronic obstructive pulmonary disease, arthritis, cardiovascular disease, cancer, diabetes and pre-diabetes, kidney disease or depression.
- Compared to higher income adults, **low-income** adults in Connecticut were significantly more likely to experience poor mental or physical health, to be disabled, obese, uninsured or sedentary. They were significantly more likely to experience barriers to care, to sustain falls, to have vision or cognitive impairments, or to be cigarette or e-cigarette smokers. These disparities were also seen in access to clinical preventive practices. Compared to their counterparts of higher income, low-income women were significantly less likely to have appropriately timed pap tests, and low-income men were significantly less likely to discuss PSA tests with their doctors. Finally, the poorest Connecticut adults were significantly more likely to have asthma, chronic obstructive pulmonary disease, arthritis, diabetes or prediabetes, or depression.
- Adults with a **high school degree or less** were significantly more likely to report poor health, to be disabled, obese, uninsured, or sedentary compared to adults with at least some post-high school education. They were more likely to experience barriers to care, as well as vision or cognitive impairments. Relative to adults with higher levels of education, these adults were significantly more likely to smoke cigarettes and e-cigarettes, and were significantly less likely to have proper health screenings or to receive recommended immunizations. They were significantly more likely to have asthma, chronic obstructive pulmonary disease, arthritis and cardiovascular disease.
- The racial/ethnic background of Connecticut adults was significantly associated with certain poorer health outcomes. Relative to non-Hispanic Whites, Hispanics and non-Hispanic Blacks were more likely to be obese, to lack a personal healthcare provider, to have foregone needed care because of cost, or to lead sedentary lifestyles. Compared to adults of other ethnic backgrounds, Hispanics were significantly more likely to experience poor physical health, be uninsured, and have depression.

Methodology

The population for the Connecticut Behavioral Risk Factor Surveillance System (CT BRFSS) consists of the total non-institutionalized English and Spanish-speaking adult population residing in telephone-equipped dwelling units. In 2012, the CT BRFSS collected 7,158 landline interviews and 1,623 cell phone interviews. If any children lived in the same household as the respondent, one child was randomly selected and the adult respondent provided information about that child. A total of 2,176 interviews about children were completed: 1,685 by landline and 491 by cell phone. The landline sample was a disproportionate stratified random digit dial (RDD) sample, stratified by geography and listed status. Listed phone numbers were oversampled relative to unlisted numbers at a rate of 1.5 to 1. Within each contacted household, one adult was selected at random to be interviewed. The cell phone sample was an unstratified RDD sample drawn from dedicated cellular telephone banks with equal probability. An adult contacted by cell phone was eligible to complete the survey if he or she lived in a private residence or college housing either without a landline present, or with a landline but with at least 90 percent of all calls received by cell phone.

Landline and cell phone data were combined and weighted by CDC to adjust for differential selection probabilities. The weighted data were then adjusted to the distribution of the Connecticut adult population using iterative proportional fitting, or raking. Raking adjustments were made by telephone type, race/ethnicity, education, marital status, age by gender, gender by race/ethnicity, age by race/ethnicity, and renter/owner status. This weighting methodology was adopted by CDC in 2011 to accommodate the inclusion of cell phone interviews and to allow for adjustments to more demographics. As a result of these methodological changes, BRFSS data for 2011 and 2012 are not comparable to BRFSS data prior to 2011.

Prevalence estimates and confidence intervals were computed using SAS Proc SurveyMeans, which can properly compute variances for complex sampling plans. Respondents who answered that they did not know or refused to answer were treated as missing in the calculation of prevalence estimates. The coefficient of variation (CV), computed as the standard error divided by the mean, was used to assess the reliability of each estimate. If the CV for any estimate was greater than 15%, the estimate was not reported and is shown in the tables with an asterisk (*).

Each health indicator was analyzed at the statewide level, and was evaluated by age, gender, race/ethnicity, household income, whether or not the adult had health care coverage, whether or not the adult had a disability, and the adult's educational attainment. Race and Ethnicity was defined by three categories: non-Hispanic White, non-Hispanic Black, and Hispanic. A fourth category, non-Hispanic respondents of other or multiple races, was excluded from analysis because the CV was too large for most estimates in this category to allow reporting. Indicators concerning children were analyzed by the age of the child, gender of the child, race/ethnicity of the child, household income, and the adult proxy's educational attainment.

Overall significance testing by demographics was evaluated by Chi-Square tests in Proc SurveyFreq to correctly compute variances. If a Chi-Square test detected a significant difference, pairwise tests for significant differences were conducted among each combination of categories. Each pairwise test was conducted by computing the confidence interval of the difference between the two estimates, using a pooled standard error, and when significant, is indicated in the report as "significant." Chi-squared testing of any two dichotomous indicators results in a crude odds ratio, and when significant, is indicated in the report using the term "likelihood." All tests were conducted at the 95% significance level.

1. Health Status Indicators

General Health Status

General self-rated health status is a valuable measure to collect alongside more objective health measures because it has strong predictive properties for health outcomes; specifically, self-reports of poor health are strongly associated with mortality and morbidity. [1]

BRFSS respondents were asked to rate their general health as excellent, very good, good, fair or poor. The proportion of adults who reported that their health was fair or poor is shown in *Table 2*.

- About 1 in 7 Connecticut adults (14.2%) rated their health as either fair or poor, with similar results among men and women.
- Adults aged 55 and older were significantly more likely to report fair or poor health (19.2%), compared to adults aged 35-54 (12.4%) and adults aged 18-34 (10%).
- Hispanics were significantly more likely to report fair or poor health (28.9%) compared to non-Hispanic Whites (11.4%) and non-Hispanic Blacks (18.1%), who were also significantly more likely than non-Hispanic Whites to have fair or poor health.
- Self-reported health status improved as incomes rose. All relationships between income categories were significant.
- Adults without health insurance coverage were significantly more likely to report fair or poor health (23.1%) compared to covered adults (13.1%).
- Adults with a disability (as defined on p. 16) were significantly more likely to rate their health as fair or poor (42.3%) compared to adults who do not report a disability (6.7%).
- Self-reported poor health was correlated with lower education levels: Connecticut adults with a high school diploma or less were significantly more likely to report that their general health was fair or poor (22.5%), compared to adults with more than a high school education (8.6%).

Table 2: Health Status Indicators

	General Health, Fair or Poor	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**14.2%**	**(13.2%-15.2%)**
Age		
18-34 years old	10.0%	(7.7%-12.3%)
35-54 years old	12.4%	(10.7%-14.1%)
55 and over years old	19.2%	(17.7%-20.8%)
Gender		
Male	13.5%	(11.9%-15.1%)
Female	14.8%	(13.4%-16.2%)
Race/Ethnicity		
non-Hispanic White	11.4%	(10.4%-12.4%)
non-Hispanic Black/African Am	18.1%	(14.0%-22.1%)
Hispanic/Latino	28.9%	(24.2%-33.7%)
Income		
Less than $35,000	28.8%	(26.1%-31.6%)
$35,000-$74,999	10.9%	(9.2%-12.6%)
$75,000 and more	4.4%	(3.4%-5.4%)
Health Insurance Status		
Insured	13.1%	(12.1%-14.1%)
Not Insured	23.1%	(18.7%-27.5%)
Disability		
Yes	42.3%	(39.3%-45.4%)
No	6.7%	(5.8%-7.6%)
Education		
High School Graduate or Less	22.5%	(20.4%-24.6%)
More Than High School	8.6%	(7.6%-9.5%)

Health-Related Quality of Life

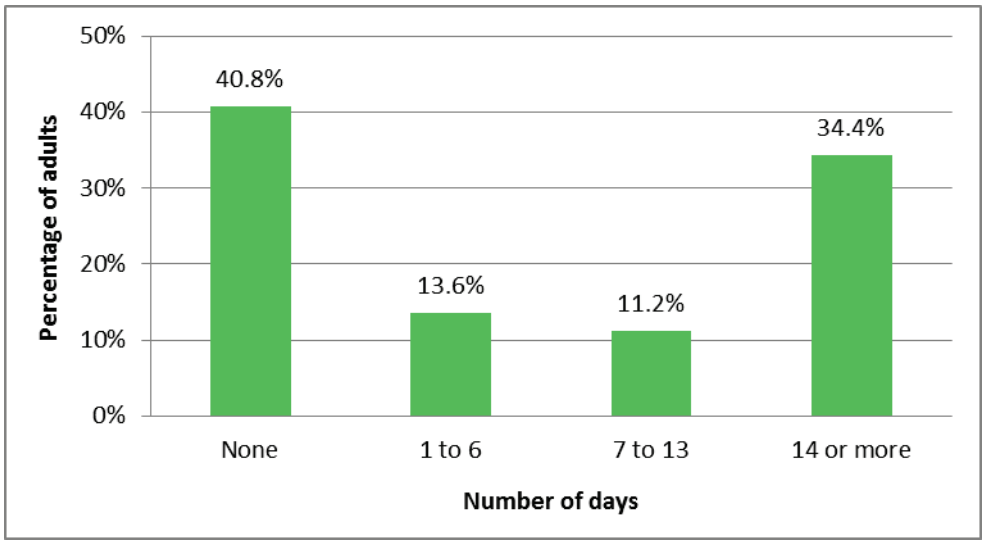
Adults in poor physical or mental health are defined as having reported 14 or more days for which their mental or physical health was "not good," within the past 30 days. The Healthy Days measure has been useful for identifying health disparities and tracking population trends.[2] The proportion of adults who reported physical and mental unhealthy days is reported in *Table 3*.

Table 3: Health-related Quality of Life

	Poor Physical Health		Poor Mental Health	
Demographic Characteristics	%	95% Confidence Interval	%	95% Confidence Interval
Total	**11.0%**	**(10.1%-11.9%)**	**10.5%**	**(9.6%-11.3%)**
Age				
18-34 years old	5.6%	(3.9%-7.2%)	12.5%	(10.3%-14.7%)
35-54 years old	11.1%	(9.6%-12.6%)	11.0%	(9.6%-12.5%)
55 and over years old	15.1%	(13.6%-16.5%)	8.4%	(7.3%-9.4%)
Gender				
Male	10.1%	(8.8%-11.4%)	9.2%	(7.9%-10.6%)
Female	11.8%	(10.6%-13.0%)	11.6%	(10.4%-12.8%)
Race/Ethnicity				
non-Hispanic White	10.6%	(9.6%-11.5%)	9.8%	(8.8%-10.8%)
non-Hispanic Black/African Am	10.7%	(7.8%-13.6%)	10.4%	(7.7%-13.1%)
Hispanic/Latino	15.3%	(11.7%-18.9%)	13.9%	(10.3%-17.4%)
Income				
Less than $35,000	18.6%	(16.4%-20.7%)	16.6%	(14.4%-18.8%)
$35,000-$74,999	10.2%	(8.5%-11.8%)	10.5%	(8.6%-12.4%)
$75,000 and more	5.6%	(4.5%-6.6%)	5.8%	(4.8%-6.8%)
Health Insurance Status				
Insured	10.8%	(9.8%-11.7%)	9.7%	(8.8%-10.6%)
Not Insured	12.6%	(9.7%-15.6%)	16.4%	(12.9%-19.8%)
Disability				
Yes	34.7%	(31.8%-37.7%)	24.3%	(21.6%-27.0%)
No	4.7%	(4.0%-5.4%)	6.7%	(5.9%-7.5%)
Education				
High School Graduate or Less	15.4%	(13.6%-17.1%)	13.4%	(11.7%-15.1%)
More Than High School	8.2%	(7.3%-9.1%)	8.6%	(7.7%-9.5%)

- Overall, the proportion of Connecticut adults who experienced poor physical health (11%) was similar to the proportion that experienced poor mental health (10.5%).
- Physical health worsened with age, with significantly higher proportions of adults reporting poor physical health as age increased. The opposite trend was observed with mental health: rates of poor mental health decreased with age, but the only significant change between adults aged 55 and older was in comparison to both of the younger age categories.
- Women were significantly more likely to report poor mental health compared to men (11.6% vs 9.2%).
- Hispanics were significantly more likely than non-Hispanic Whites to experience poor mental health, and were significantly more likely than non-Hispanic Whites and non-Hispanic Blacks to experience poor physical health.
- The quality of both mental and physical health significantly increased with income. Adults in the poorest income category were more than three times as likely to experience poor mental and physical health compared to adults in the highest income category.
- Uninsured adults were significantly more likely to report poor mental health (16.4%) compared to insured adults. (9.7%).
- Adults with a disability were significantly more likely to have experienced poor physical (34.7%) and mental (24.3%) health in the past 30 days compared to non-disabled adults (4.7% of whom experienced poor physical health and 6.7% of whom experienced poor mental health).
- Adults with a high school education or less were significantly more likely to report poor physical (15.4%) and mental (13.4%) health, compared to adults with more than a high school education, 8.2% of whom reported poor physical health and 8.6% of whom reported poor mental health.
- Respondents who reported at least 14 days of poor physical or mental health during the previous month were asked for how many days this kept them from doing usual activities, such as self-care, work, or recreation. Results are reported in *Figure 2* below. Over a third of adults (34.4%) said that their poor health hampered their activities for 14 days or more during the previous month.

Figure 2: Poor Physical or Mental Health as a Barrier to Life's Activities, Connecticut 2012



Disability

The Americans with Disabilities Act (ADA) defines an individual with a disability as "a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment."[3] In this report, respondents were categorized as having a disability if they answered two questions and said yes to at least one of the two questions (*Table 4*). These questions asked if:

a) They were limited in any way in any activities because of physical, mental or emotional problems; or.
b) They had any health problem that required special equipment, such as a cane, a wheelchair, a special bed, or a special telephone.

Figure 3: Characteristics of Disabled Adults, Connecticut 2012

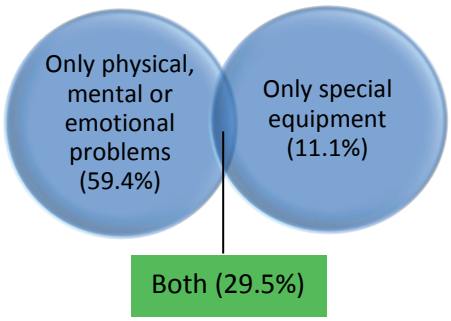


Table 4: Disability among Adults

Demographic Characteristics	Disability %	Disability 95% Confidence Interval
Total	**21.1%**	**(19.9%-22.2%)**
Age		
18-34 years old	11.5%	(9.1%-13.8%)
35-54 years old	18.0%	(16.1%-20.0%)
55 and over years old	31.5%	(29.7%-33.3%)
Gender		
Male	20.9%	(19.1%-22.7%)
Female	21.2%	(19.7%-22.7%)
Race/Ethnicity		
non-Hispanic White	21.6%	(20.3%-22.9%)
non-Hispanic Black/African Am	17.8%	(13.7%-21.9%)
Hispanic/Latino	22.3%	(17.9%-26.8%)
Income		
Less than $35,000	32.1%	(29.3%-34.8%)
$35,000-$74,999	20.8%	(18.5%-23.1%)
$75,000 and more	12.7%	(11.1%-14.3%)
Health Insurance Status		
Insured	21.6%	(20.4%-22.9%)
Not Insured	16.6%	(13.2%-20.0%)
Education		
High School Graduate or Less	25.4%	(23.2%-27.6%)
More Than High School	18.1%	(16.8%-19.4%)

- Over one-fifth (21.1%) of Connecticut adults said yes to either of the two questions.
- Rates of disability increased with age. The youngest adults were significantly less likely to report a disability compared to adults in higher age categories. All the differences in disability status between ages were significant.
- Disability levels were similar for men and women.
- Percent of disability decreased with income. Adults living in households making less than $35,000 were significantly more likely to report a disability (32.1%) compared to adults in higher income brackets. Conversely, adults living in households making more than $75,000 were significantly less likely to report a disability (12.7%).
- Rates of disability were significantly higher for adults with health care coverage (21.6%) compared to uninsured adults (16.6%).
- Adults with a high school education or less were significantly more likely to report a disability (25.4%), while those with more than a high school education were less likely (18.1%).

Adult Weight Status

The BRFSS survey asked respondents to provide their height and weight without shoes. A body mass index (BMI) was calculated by dividing their weight in kilograms by the squared value of their height in meters. An adult who has a BMI between 25.0 and 29.9 is considered overweight, while an adult with a BMI of 30 or above is considered obese. The proportion of obese adults is of particular interest because obesity has been shown to be a major cause of preventable morbidity and mortality in the United States.[4] Overweight and obese adults are at risk for developing a wide range of health problems, including high blood pressure, Type 2 diabetes, coronary heart disease, certain cancers, strokes and other diseases.[5]

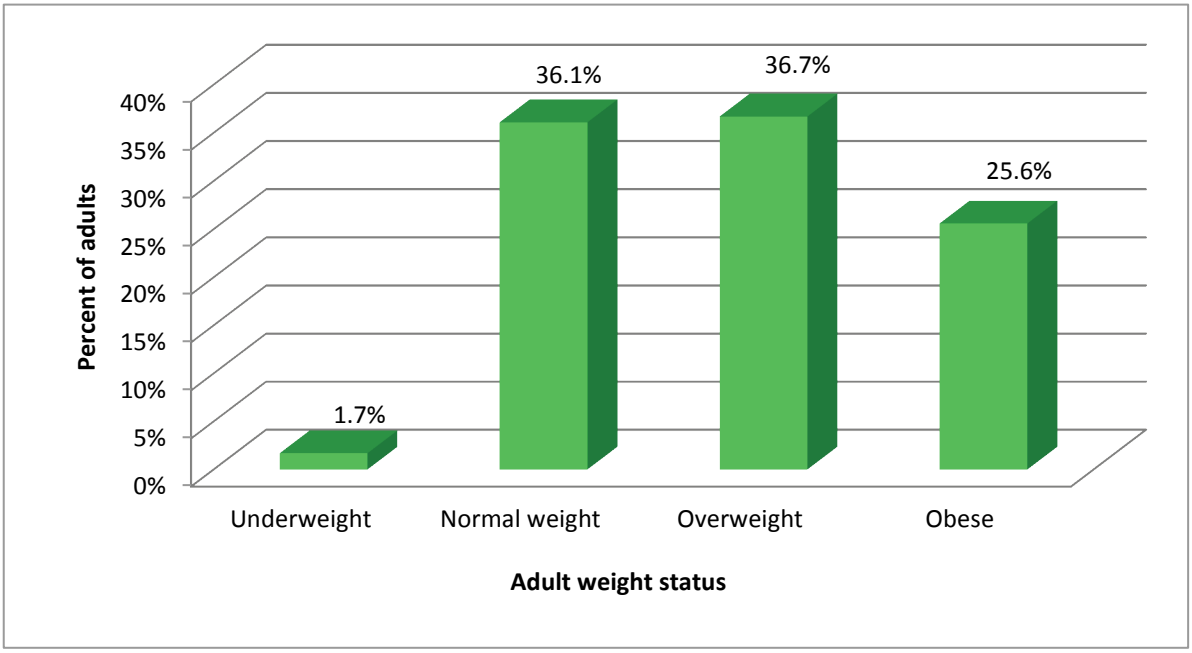
Table 5 shows the proportion of obese adults in Connecticut by demographic subgroups.

Table 5: Adult Weight Status by Demographics

	Adult Overweight		Adult Obese	
Demographic Characteristics	%	95% Confidence Interval	%	95% Confidence Interval
Total	**36.7%**	**(35.2%-38.2%)**	**25.6%**	**(24.3%-26.9%)**
Age				
18-34 years old	31.5%	(28.0%-35.1%)	19.9%	(17.0%-22.8%)
35-54 years old	37.4%	(35.0%-39.8%)	28.4%	(26.2%-30.6%)
55 and over years old	39.9%	(38.0%-41.8%)	27.2%	(25.3%-29.0%)
Gender				
Male	44.2%	(41.9%-46.5%)	27.1%	(25.1%-29.1%)
Female	29.2%	(27.4%-31.1%)	24.1%	(22.4%-25.7%)
Race/Ethnicity				
non-Hispanic White	36.3%	(34.7%-37.9%)	24.1%	(22.7%-25.6%)
non-Hispanic Black/African Am	39.1%	(33.5%-44.6%)	34.3%	(29.1%-39.5%)
Hispanic/Latino	38.5%	(33.1%-44.0%)	32.2%	(27.2%-37.1%)
Income				
Less than $35,000	35.8%	(32.8%-38.7%)	32.1%	(29.3%-34.9%)
$35,000-$74,999	38.1%	(35.2%-41.0%)	28.1%	(25.4%-30.8%)
$75,000 and more	39.3%	(36.8%-41.7%)	21.4%	(19.3%-23.4%)
Health Insurance Status				
Insured	36.3%	(34.7%-37.8%)	25.6%	(24.2%-26.9%)
Not Insured	40.0%	(35.0%-45.1%)	26.7%	(22.4%-31.0%)
Disability				
Yes	30.8%	(28.0%-33.7%)	39.3%	(36.2%-42.4%)
No	38.1%	(36.4%-39.9%)	22.1%	(20.7%-23.5%)
Education				
High School Graduate or Less	36.9%	(34.3%-39.5%)	30.3%	(27.8%-32.7%)
More Than High School	36.6%	(34.9%-38.3%)	22.5%	(21.1%-24.0%)

- In 2012, one quarter (25.6%) of CT adults were obese while over one third were overweight (36.7%).
- Adults aged 18-34 were significantly less likely to be overweight or obese compared to adults in older age groups.
- A significantly higher proportion of adult males were overweight (44.2%) or obese (27.1%), compared to females (29.2% and 24.1%).
- Non-Hispanic Blacks and Hispanics were both significantly more likely to be obese (34.3% and 32.2%, respectively), compared to non-Hispanic whites (24.1%).
- The rate of obesity decreased as household income rose and the relationship between obesity and income categories was significant.
- Adults with a disability were significantly less likely to be overweight (30.8%) compared to non-disabled adults (38.1%) but were significantly more likely to be obese (39.3%), compared to adults without a disability (22.1%).
- Adults with a high school degree or less (30.3%) were significantly more likely to be obese compared to adults with more than a high school education (22.5%).
- *Figure 4* below shows the distribution of weight status among Connecticut Adults.

Figure 4: Adult Weight Status, Connecticut 2012



Child Weight Status

As part of a state-specific module in the BRFSS, a child was randomly selected in the household and the adult respondent was asked to provide the height and weight of that child. As with adults, BMI was calculated for these randomly selected children; however child weight status is calculated differently than for adults.[6] For children, weight status is determined comparatively based on age and sex. An overweight child has a BMI between the 85th and 95th percentile for children of the same age and sex, while an obese child has a BMI at or above the 95th percentile for children of the same age and sex.[7] Obese children face a variety of health and social problems, and are more likely to be obese adults.[8]

Table 6: Child Weight Status by Demographics

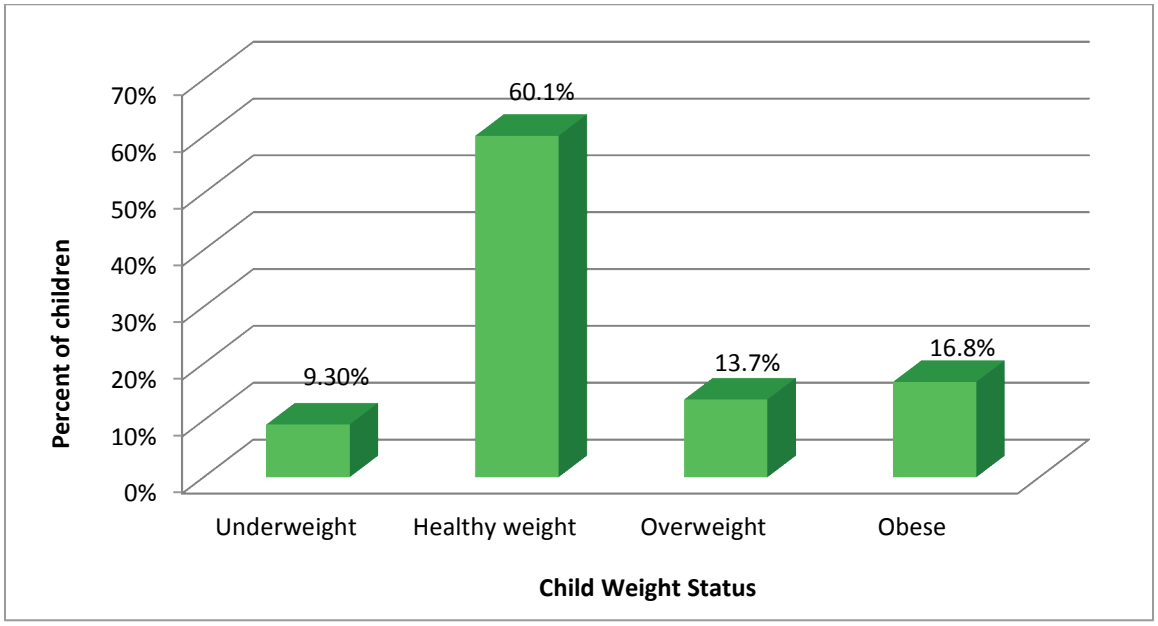
	Child Overweight		Child Obesity	
Demographic Characteristics	**%**	**95% Confidence Interval**	**%**	**95% Confidence Interval**
Total	**13.7%**	**(11.5%-15.9%)**	**16.8%**	**(14.2%-19.5%)**
Child Age				
0-4 years old	*	*	38.6%^	(28.3%-48.9%)
5-11 years old	17.0%	(13.2%-20.7%)	19.7%	(15.2%-24.1%)
12-17 years old	11.8%	(8.8%-14.8%)	8.7%	(6.2%-11.2%)
Child Gender				
Male	14.7%	(11.6%-17.8%)	20.2%	(16.2%-24.3%)
Female	12.8%	(9.7%-15.8%)	13.4%	(10.0%-16.8%)
Child Race/Ethnicity				
Non-Hispanic White	13.3%	(10.8%-15.8%)	13.8%	(11.3%-16.3%)
Non-Hispanic Black	*	*	*	*
Hispanic/Latino	*	*	*	*
Adult Proxy Income				
Less than $35,000	*	*	28.7%	(20.4%-37.0%)
$35,000-$74,999	18.0%	(12.9%-23.2%)	19.7%	(14.2%-25.3%)
$75,000 and more	10.7%	(8.1%-13.3%)	12.7%	(9.7%-15.7%)
Adult Proxy Education				
High School Graduate or Less	*	*	26.6%	(19.4%-33.8%)
More Than High School	13.1%	(10.7%-15.5%)	13.9%	(11.4%-16.5%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

^ Small fluctuations in adult proxy reporting of weight and height for young children can have a large impact on BMI calculations and the percentiles used to determine overweight and obesity. These results may, therefore. be skewed.

- In 2012, one in every six CT children was obese (16.8%) and nearly 1 in 7 was overweight (13.7%)
- Likelihood of obesity decreased significantly with age: 38.6% of children 4 years old or younger were obese, compared to 19.7% of children aged 5-11 and 8.7% of children aged 12-17.
- Similarly, children aged 12-17 were significantly less likely to be overweight (11.8%) compared to children aged 5-11 (17%).
- Boys were significantly more likely to be obese (20.2%) than girls (13.4%).
- Children living in households with an income of at least $75,000 were significantly less likely to be obese (12.7%) than those with household incomes of $35,000-$74,999 (19.7%) or less than $35,000 (28.7%). Similarly, children in the highest earning households were significantly less likely to be overweight (10.7%) compared to children in middle-income households (18%).
- Children whose adult proxy had more than a high school education were significantly less likely to be obese (13.9%) than children whose proxy had a high school diploma or less (26.6%).
- *Figure 5* below shows the distribution of weight status among Connecticut children, a majority of whom (60.1%) had a healthy weight.

Figure 5: Child Weight Status, Connecticut 2012



No Health Care Coverage (Uninsured)

Health care, or insurance coverage, includes private insurance and plans such as Health Maintenance Organizations (HMOs), or government plans such as Medicare or the Indian Health Service. Adults without health care coverage have higher mortality rates for a range of health conditions compared to insured adults. They are less likely to get needed care and screenings, and have poorer health outcomes.[9] The proportion of adults aged 18-64 who reported having no health care coverage and their demographic characteristics is shown in *Table 7*.

- In 2012, 12.8% of CT adults aged 18-64 were reportedly uninsured.
- The proportion of uninsured adults decreased significantly with age. Younger adults aged 18-34 were nearly twice as likely to be uninsured (17.1%) as adults aged 55-64 (8.8%).
- Men were significantly more likely to be uninsured (15.9%) compared to women (9.7%).
- Hispanics were significantly more likely to be uninsured (30.3%) compared to non-Hispanic Whites (8.4%) and non-Hispanic Blacks (17.6%)
- Adults in the lowest household income category were significantly more likely to be uninsured (27%) compared to adults in households earning between $35,000 and $74,999 (12.4%).
- Adults with lower education levels were significantly more likely to be uninsured (20.9%) compared to adults who had more than a high school education (7.9%).

Table 7: Uninsured Adults by Demographics

	No Health Care Coverage Among Adults 18-64 Years	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**12.8%**	**(11.6%-14.0%)**
Age		
18-34 years old	17.1%	(14.4%-19.8%)
35-54 years old	11.3%	(9.8%-12.9%)
55-64 years old	8.8%	(7.1%-10.5%)
Gender		
Male	15.9%	(13.9%-17.9%)
Female	9.7%	(8.4%-11.1%)
Race/Ethnicity		
non-Hispanic White	8.4%	(7.3%-9.5%)
non-Hispanic Black/African Am	17.6%	(13.2%-22.0%)
Hispanic/Latino	30.3%	(25.3%-35.3%)
Income		
Less than $35,000	27.0%	(23.7%-30.4%)
$35,000-$74,999	12.4%	(10.1%-14.7%)
$75,000 and more	*	*
Disability		
Yes	11.1%	(8.6%-13.5%)
No	12.7%	(11.3%-14.1%)
Education		
High School Graduate or Less	20.9%	(18.3%-23.5%)
More Than High School	7.9%	(6.9%-9.0%)

Limited Health Care Coverage

In this report, "limited" health care coverage includes adults who:

a) Do not have a primary care provider, which is a personal doctor or health care provider; and
b) Needed to see a doctor in the past year but could not because of cost. People who have access to a personal health care provider or a regular health care setting have better health outcomes.[10] Generally, an effective primary health care system is associated with better health outcomes. Limited health insurance coverage is a barrier to access to care that adversely impact health outcomes.

Table 8: Limited Healthcare by Demographics

	No Personal Health Care Provider		No Health Care Access Due to Cost	
Demographic Characteristics	%	95% Confidence Interval	%	95% Confidence Interval
Total	**13.8%**	**(12.7%-14.8%)**	**12.1%**	**(11.2%-13.1%)**
Age				
18-34 years old	26.1%	(23.0%-29.1%)	15.9%	(13.5%-18.4%)
35-54 years old	13.1%	(11.5%-14.7%)	13.8%	(12.1%-15.5%)
55 and over years old	5.5%	(4.6%-6.4%)	7.5%	(6.4%-8.6%)
Gender				
Male	17.4%	(15.6%-19.1%)	12.4%	(10.8%-13.9%)
Female	10.5%	(9.2%-11.7%)	11.9%	(10.7%-13.1%)
Race/Ethnicity				
non-Hispanic White	10.1%	(9.1%-11.1%)	9.2%	(8.2%-10.1%)
non-Hispanic Black/African Am	22.3%	(17.3%-27.3%)	20.0%	(15.4%-24.7%)
Hispanic/Latino	27.0%	(22.5%-31.4%)	23.0%	(19.0%-27.1%)
Income				
Less than $35,000	22.4%	(19.9%-24.9%)	23.9%	(21.4%-26.4%)
$35,000-$74,999	12.7%	(10.7%-14.6%)	12.5%	(10.5%-14.6%)
$75,000 and more	6.4%	(5.1%-7.6%)	3.5%	(2.6%-4.4%)
Health Insurance Status				
Insured	8.8%	(8.0%-9.7%)	8.1%	(7.2%-9.0%)
Not Insured	54.5%	(49.6%-59.3%)	45.3%	(40.5%-50.2%)
Disability				
Yes	9.7%	(7.9%-11.6%)	19.3%	(16.8%-21.9%)
No	14.6%	(13.4%-15.8%)	9.9%	(8.9%-10.9%)
Education				
High School Graduate or Less	19.1%	(16.9%-21.2%)	16.4%	(14.5%-18.3%)
More Than High School	10.3%	(9.3%-11.4%)	9.4%	(8.3%-10.4%)

- Nearly 14% of Connecticut adults reported not having a personal doctor, while about 12% could not get needed care in the previous year because of cost.
- Likelihood of having a personal health care provider increased significantly with age. Younger adults were 5 times less likely to have a personal health care provider compared to adults aged 55 and older (26.1% vs 5.5%).
- Similarly, adults aged 55 and older were significantly less likely to have foregone needed care because of cost (7.5%) compared to younger adults.
- Men were significantly less likely to have a personal health care provider (17.4%) compared to women (10.5%).
- Non-Hispanic Blacks (22.3%) and Hispanics (27%) were significantly less likely to have a personal health care provider compared to non-Hispanic Whites (10.1%).
- Non-Hispanic Whites were significantly less likely to have foregone needed care because of cost (9.2%) compared to non-Hispanic Blacks (20%) and Hispanics (23%).
- Income was correlated significantly with lack of a personal health care provider and inability to get care because of cost. Adults in households earning less than $35,000 experienced more barriers to health care than adults in higher income groups.
- Uninsured adults were significantly more likely to face both types of barriers to care, compared to covered adults. The same was true for disabled adults, and adults with a high school degree or less.

Falls, Adults over 45 years old

Each year, 1 in 3 Americans over 65 years old suffers a fall. While falls can cause fractures and trauma, and a resulting fear of falling that can push older Americans to limit their activities, falls are often highly preventable.[11]

Respondents aged 45 and older were asked how many times they had fallen in the past 12 months, and how many of these falls resulted in injury. Results are shown in *Table 9*.

Table 9: Experience with Falls by Demographics

	At least one Fall in the past 12 months		Injured during Fall	
Demographic Characteristics	%	95% Confidence Interval	%	95% Confidence Interval
Total	**24.4%**	**(23.0%-25.8%)**	**40.9%**	**(37.7%-44.2%)**
Age				
45-54 years old	23.0%	(20.3%-25.6%)	42.1%	(35.7%-48.4%)
55 and over years old	25.2%	(23.6%-26.9%)	40.3%	(36.6%-44.1%)
Gender				
Male	21.3%	(19.2%-23.3%)	37.1%	(31.9%-42.4%)
Female	27.1%	(25.1%-29.0%)	43.5%	(39.3%-47.6%)
Race/Ethnicity				
non-Hispanic White	25.3%	(23.7%-26.8%)	39.0%	(35.6%-42.5%)
non-Hispanic Black/African Am	22.6%	(17.2%-28.0%)	48.1%	(34.8%-61.4%)
Hispanic/Latino	*	*	*	*
Income				
Less than $35,000	28.2%	(25.2%-31.2%)	54.4%	(48.3%-60.6%)
$35,000-$74,999	23.8%	(21.0%-26.5%)	37.6%	(31.2%-43.9%)
$75,000 and more	22.7%	(20.3%-25.1%)	30.7%	(25.2%-36.2%)
Health Insurance Status				
Insured	24.2%	(22.8%-25.7%)	40.8%	(37.4%-44.2%)
Not Insured	26.7%	(20.7%-32.7%)	42.8%	(30.3%-55.3%)
Disability				
Yes	39.4%	(36.2%-42.5%)	52.5%	(47.5%-57.4%)
No	18.5%	(17.0%-20.0%)	31.1%	(27.1%-35.2%)
Education				
High School Graduate or Less	23.8%	(21.4%-26.3%)	46.8%	(41.0%-52.6%)
More Than High School	24.8%	(23.1%-26.5%)	37.1%	(33.3%-40.9%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

- Nearly a quarter of adults aged 45 and older had fallen in the past 12 months (24.4%). For those who had fallen at least once, 40.9% suffered an injury.
- Women were significantly more likely than men to sustain a fall (27.1% *versus* 21.3%), but while the injury rate for women was higher (43.5% *versus* 37.1%), this difference was not significant.
- Adults living in the lowest income households were significantly more likely to sustain a fall (28.2%) and to be injured during falls (54.4%), compared to adults in the higher-income categories.
- Disabled adults were significantly more likely to fall (39.4%) and be injured during a fall (52.5%) compared to non-disabled adults (18.5% and 31.1%).
- While adults with a high school degree or less were not more likely to sustain a fall; they were significantly more likely to be injured during a fall (51.5%) compared to adults with more than a high school education (38.5%).

Vision Impairment

While vision disability is one of the top 10 disabilities in adults, early detection and treatment of the conditions causing vision loss, such as diabetes and chronic diseases, can be effective at reducing the social and economic impact of vision loss. At the same time, most American adults do not seek eye care because of cost or lack of awareness.[12]

Respondents were asked if they have any trouble seeing, even when wearing glasses or contacts. The proportion of adults who reported having trouble seeing or reported being blind is reported in *Table 10*.

- About 1 in 7 adults (14.3%) reported having trouble seeing. These rates were lowest for younger adults and increased with age. Adults aged 55 and over (16.8%) and adults aged 36-54 (14.6%) were significantly more likely than adults aged 18-34 (10.4%) to report having trouble seeing.
- Women were significantly more likely to report vision impairment (16.1%) compared to men (12.3%).
- Hispanics had significantly higher levels of reported vision impairment compared to non-Hispanic Whites (12.6%) and non-Hispanic Blacks (15.2%). Adults with the lowest incomes were significantly more likely to report vision problems (22.3%) compared to adults in higher income categories. The rate of vision impairment decreased as income increased, and the difference between each category was significant.
- Adults with a disability (30.6%) were significantly more likely to report vision impairment than adults without a disability (9.9%).
- Finally, adults with a high school degree or less (17%) were significantly more likely to report that they had trouble seeing compared to adults with more than a high school education (12.3%).

Table 10: Vision Impairment by Demographics

	Trouble Seeing	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**14.3%**	**(13.2%-15.3%)**
Age		
18-34 years old	10.4%	(8.2%-12.6%)
35-54 years old	14.6%	(12.8%-16.4%)
55 and over years old	16.8%	(15.3%-18.2%)
Gender		
Male	12.3%	(10.8%-13.8%)
Female	16.1%	(14.7%-17.5%)
Race/Ethnicity		
non-Hispanic White	12.6%	(11.6%-13.6%)
non-Hispanic Black/African Am	15.2%	(11.5%-18.9%)
Hispanic/Latino	24.2%	(19.6%-28.9%)
Income		
Less than $35,000	22.3%	(19.9%-24.7%)
$35,000-$74,999	14.6%	(12.4%-16.7%)
$75,000 and more	8.9%	(7.4%-10.3%)
Health Insurance Status		
Insured	13.8%	(12.7%-14.9%)
Not Insured	17.9%	(14.5%-21.3%)
Disability		
Yes	30.6%	(27.7%-33.5%)
No	9.9%	(8.9%-11.0%)
Education		
High School Graduate or Less	17.0%	(15.1%-18.9%)
More Than High School	12.3%	(11.2%-13.5%)

Cognitive Disorders

Cognitive impairment refers to an individual's difficulty remembering, concentrating, understanding and making decisions that affect their daily life. It is not caused by a specific disease and is not limited to a particular age group, though age is the main risk factor. Cognitive impairment may be caused by Alzheimer's disease, other dementias, stroke, brain injuries and development disabilities, and can range from mild to severe.[13]

A state-added section of the BRFSS questionnaire asked respondents about their experience with confusion and memory loss. Interviewers specified that this did not refer to occasionally forgetting keys or forgetting a recent acquaintance's name, but rather to confusion or memory loss that was happening more frequently or getting worse. Results are shown in *Table 11*.

- About 1 in 13 adults (7.6%) reported experiencing confusion and/or memory loss in the past year.
- The prevalence of cognitive disorders decreased as incomes rose. The differences in cognitive disorders between the income categories were all significant.
- Adults with a disability were significantly more likely to report cognitive problems (19.2%) compared to non-disabled adults (4.3%).
- As with vision loss, adults with a high school degree or less were significantly more likely to experience cognitive disorders (9.2%) compared to adults with more than a high school education (6.3%).

Table 11: Cognitive Disorders by Demographics

	Confusion/Memory Loss in Past Year	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**7.6%**	**(6.8%-8.3%)**
Age		
18-34 years old	*	*
35-54 years old	8.2%	(6.7%-9.7%)
55 and over years old	9.0%	(7.9%-10.1%)
Gender		
Male	6.9%	(5.8%-8.0%)
Female	8.2%	(7.1%-9.3%)
Race/Ethnicity		
non-Hispanic White	7.3%	(6.4%-8.1%)
non-Hispanic Black/African Am	*	*
Hispanic/Latino	*	*
Income		
Less than $35,000	11.8%	(9.8%-13.8%)
$35,000-$74,999	7.0%	(5.6%-8.3%)
$75,000 and more	4.5%	(3.5%-5.5%)
Health Insurance Status		
Insured	7.3%	(6.5%-8.1%)
Not Insured	*	*
Disability		
Yes	19.2%	(16.6%-21.7%)
No	4.3%	(3.7%-5.0%)
Education		
High School Graduate or Less	9.2%	(7.8%-10.7%)
More Than High School	6.3%	(5.5%-7.1%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

2. Risk Behavior Indicators

Adult Physical Activity

Regular physical exercise has been shown to prevent certain chronic diseases, just as a sedentary lifestyle is a risk factor for a variety of chronic diseases, obesity, bone and joint diseases, and depression.[14] Adults were asked to report whether they had participated in any physical activities or exercises other than for their job, such as running, calisthenics, golf, gardening or walking, other than for their job. *Table 12* shows the proportion of adults who did not engage in any leisure-time physical activity.

- Just over one-fifth (22.1%) of Connecticut adults did not engage in any physical activity outside of work in 2012.
- Rates of physical activity were significant with regard to age: there were greater levels of physical inactivity as age increases. Only 16.2% of adults aged 18-34 did not engage in leisure-time physical activity, compared to 20.9% of adults aged 35-54 and 27.9% of adults aged 55 and older.
- Non-Hispanic Blacks and Hispanics were both significantly more likely to not engage in physical activity relative to non-Hispanic Whites and non-Hispanic adults of other races.
- Participation in physical activity was significant with regard to income: Adults making less money were significantly less likely to engage in physical activity compared to adults in higher income categories. The rate of inactivity amongst the poorest adults (34.3%) was three times the rate for adults in households earning $75,000 or more (11.2%).
- There were significant differences in inactivity rates based on insurance status and disability: adults without health care coverage were significantly more likely to not engage in physical activity compared to adults with insurance; similarly, disabled adults were more than twice as likely (40%) to be inactive compared to non-disabled adults (16.9%).
- Adults with a high school education or less were significantly more likely to be inactive (33.8%) compared to adults with more than a high school education (14.3%).

Table 12: No Leisure-Time Physical Activity by Demographics

	No Leisure Time Physical Activity	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**22.1%**	**(20.9%-23.4%)**
Age		
18-34 years old	16.2%	(13.4%-18.9%)
35-54 years old	20.9%	(18.8%-22.9%)
55 and over years old	27.9%	(26.1%-29.6%)
Gender		
Male	20.8%	(18.9%-22.8%)
Female	23.3%	(21.7%-24.9%)
Race/Ethnicity		
non-Hispanic White	19.3%	(18.0%-20.6%)
non-Hispanic Black/African Am	29.0%	(24.1%-33.9%)
Hispanic/Latino	34.4%	(29.5%-39.4%)
Income		
Less than $35,000	34.3%	(31.5%-37.1%)
$35,000-$74,999	23.3%	(20.8%-25.8%)
$75,000 and more	11.2%	(9.6%-12.8%)
Health Insurance Status		
Insured	21.2%	(20.0%-22.5%)
Not Insured	29.5%	(25.0%-34.1%)
Disability		
Yes	40.0%	(37.0%-43.1%)
No	16.9%	(15.6%-18.3%)
Education		
High School Graduate or Less	33.8%	(31.3%-36.3%)
More Than High School	14.3%	(13.1%-15.5%)

Child TV/Video Time

Despite the American Academy of Pediatrics' recommendation that children aged two and older be exposed to no more than two hours a day of screen time, U.S. children currently watch an average of four hours of entertainment media per day. This indicator is of interest because sedentary behaviors such as sitting in front of the television for long periods may contribute to weight gain or obesity. Additionally, television or computer exposure may negatively affect a child's development or perspective in other ways.[15]

The BRFSS survey asked the adult proxy respondent how much time the selected child spent watching television videos or DVDs on an average day. A subsequent question asked how much time the child spent playing computer games each day. Results for children at least two years old are reported in *Table 13.*

Table 13: Child Screen Time by Demographics, at least two years old

	More than Two Hours TV Daily		More than Two Hours Video Games Daily	
Demographic Characteristics	%	95% Confidence Interval	%	95% Confidence Interval
Total	**24.6%**	**(21.9%-27.3%)**	**9.9%**	**(8.2%-11.6%)**
Child Age				
2-4 years old	*	(13.2%-23.6%)	*	*
5-11 years old	19.1%	(15.0%-23.1%)	*	*
12-17 years old	30.8%	(26.6%-34.9%)	18.5%	(15.1%-21.9%)
Child Gender				
Male	26.8%	(22.8%-30.7%)	13.0%	(10.2%-15.8%)
Female	22.6%	(18.9%-26.4%)	6.7%	(4.8%-8.6%)
Child Race/Ethnicity				
Non-Hispanic White	17.5%	(15.0%-20.0%)	7.3%	(5.8%-8.8%)
Non-Hispanic Black	44.3%	(34.6%-54.1%)	*	*
Hispanic/Latino	35.8%	(27.6%-44.0%)	*	*
Adult Proxy Income				
Less than $35,000	36.9%	(30.0%-43.7%)	*	*
$35,000-$74,999	30.0%	(23.9%-36.2%)	*	*
$75,000 and more	15.2%	(12.4%-18.0%)	*	*
Adult Proxy Education				
High School Graduate or Less	40.1%	(33.6%-46.7%)	*	*
More Than High School	18.4%	(16.0%-20.9%)	8.2%	(6.5%-9.9%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

- In 2012, almost one quarter of Connecticut children (24.6%) watched over two hours of television each day, while about 10% spent over two hours playing computer games.
- Children aged 12-17 were significantly more likely to watch over two hours of TV (30.8%) compared to children aged 5-11 (19.1%).
- Non-Hispanic Black children were significantly more likely to watch at over two hours of TV each day (44.3%) compared to non-Hispanic Whites (17.5%). Hispanics (33.9%) were significantly more likely than non-Hispanic Whites to watch this amount of television.
- Children in higher-income households were significantly less likely to watch over two hours of TV each day (15.2%) compared to children in both lower household income categories.

Child Soda/Fast Food Consumption

Consumption of soda and other sugar-sweetened beverages (SSBs) is associated with obesity in children.[16] At the same time, children who eat at fast-food and full service restaurants eat more and have poorer diets compared to children who eat at home.[17]

Adult proxy respondents reported how many glasses, bottles, or cans of soda or other sugar-sweetened drinks the randomly-selected child drank on an average day. They were also asked how many times in the past week the child ate fast food or pizza at school, at home or at a fast-food restaurant, carryout or drive-thru. Results for children aged 2 and over are reported in *Table 14*.

- Almost one-third (32.3%) of Connecticut children drank at least one SSB per day in 2012, while 14.1% ate fast food at least twice per week.
- Children aged 12-17 were significantly more likely to drink at least one SSB per day (39.7%) compared to younger children.
- Boys were significantly more likely to consume at least one sugary drink per day (36.4%), compared to girls (28.2%).
- Non-Hispanic White children were significantly less likely to consume at least one sugary drink per day (26.1%) compared to non-Hispanic Black children (49.7%) and Hispanic children (38.5%).
- The likelihood of drinking at least one SSB per day decreased significantly as income rose. For fast food consumption, children in the poorest households were twice as likely to consume fast food at least twice per week (19.8%), compared to children in the wealthiest households (10.8%), a significant difference.
- Children whose adult proxy had more than a high school education were significantly less likely to drink at least one SSB per day (27.7%) than children whose proxy had a high school degree or less (43.9%).

Table 14: Child Soda and Fast Food Consumption, at least two years old

	Drank Soda or Sugary Drink At Least Once Per Day		Ate Fast Food At Least Twice Per Week	
Demographic Characteristics	%	95% Confidence Interval	%	95% Confidence Interval
Total	**32.3%**	**(29.5%-35.2%)**	**31.0%**	**(28.2%-33.8%)**
Child Age				
2-4 years old	23.5%	(16.7%-30.4%)	30.6%	(22.8%-38.3%)
5-11 years old	29.2%	(24.8%-33.6%)	27.0%	(23.0%-31.1%)
12-17 years old	39.7%	(35.4%-44.1%)	35.5%	(31.2%-39.7%)
Child Gender				
Male	36.4%	(32.2%-40.5%)	31.5%	(27.6%-35.4%)
Female	28.2%	(24.4%-32.1%)	30.5%	(26.5%-34.6%)
Child Race/Ethnicity				
Non-Hispanic White	26.1%	(23.2%-29.0%)	28.4%	(25.3%-31.5%)
Non-Hispanic Black	49.7%	(39.9%-59.6%)	34.9%	(25.7%-44.0%)
Hispanic/Latino	38.2%	(30.3%-46.1%)	34.3%	(26.5%-42.0%)
Adult Proxy Income				
Less than $35,000	46.4%	(39.4%-53.5%)	38.4%	(31.4%-45.3%)
$35,000-$74,999	34.8%	(28.9%-40.8%)	31.4%	(25.6%-37.2%)
$75,000 and more	24.2%	(20.7%-27.7%)	27.7%	(24.1%-31.3%)
Adult Proxy Education				
High School Graduate or Less	43.9%	(37.5%-50.3%)	37.6%	(31.2%-43.9%)
More Than High School	27.7%	(24.7%-30.6%)	28.5%	(25.6%-31.5%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

Cigarette Smoking

Smoking is the number one preventable cause of death in the U.S. It is detrimental to nearly every organ in the body and causes poorer overall health. Smokers are more likely to develop lung cancer, stroke and heart disease when compared to non-smokers. Nearly half a million Americans die every year in the United States as a result of cigarette smoking; meaning that 1 in 5 deaths nationwide can be linked to smoking.[18]

- About 1 in 6 Connecticut adults (16%) said they smoke cigarettes "every day" or "some days."
- Cigarette smoking levels decreased significantly with age. Among younger adults, 22.4% were self-reported smokers, while 17.7% of adults aged 35-54 were smokers and only 9.6% of adults aged 55 and over were smokers.
- Men were significantly more likely to be smokers (18.5%) compared to women (13.7%).
- Cigarette smoking decreased significantly as incomes rose. Over a quarter of adults in households earning under $35,000 were smokers, compared to 16.5% of adults in middle-income households, and less than 10% of adults in the highest income households.
- Uninsured adults were more likely to be smokers (28.6%) compared to insured adults (14.6%), as were disabled adults (22.4% *versus* 14.2% of non-disabled adults).
- Finally, adults with a high school degree or less were significantly more likely to be smokers compared to adults with more than a high school education.

Figure 6: Smoking Status of Adults, Connecticut 2012

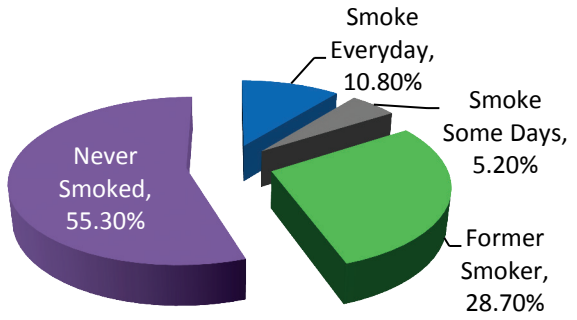


Table 15: Cigarette Smoking by Demographics

	Current Smoking	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**16.0%**	**(14.9%-17.2%)**
Age		
18-34 years old	22.4%	(19.3%-25.5%)
35-54 years old	17.7%	(15.8%-19.6%)
55 and over years old	9.6%	(8.5%-10.7%)
Gender		
Male	18.5%	(16.7%-20.3%)
Female	13.7%	(12.3%-15.1%)
Race/Ethnicity		
non-Hispanic White	15.4%	(14.1%-16.7%)
non-Hispanic Black/African Am	17.3%	(13.1%-21.5%)
Hispanic/Latino	19.0%	(14.8%-23.3%)
Income		
Less than $35,000	25.7%	(23.1%-28.4%)
$35,000-$74,999	16.5%	(14.3%-18.7%)
$75,000 and more	9.2%	(7.7%-10.8%)
Health Insurance Status		
Insured	14.6%	(13.4%-15.7%)
Not Insured	28.6%	(24.1%-33.1%)
Disability		
Yes	22.4%	(19.7%-25.2%)
No	14.2%	(13.0%-15.5%)
Education		
High School Graduate or Less	22.3%	(20.1%-24.5%)
More Than High School	12.0%	(10.8%-13.3%)

Hookah, E-cigarette and Smokeless Tobacco Use

Although cigarette smoking in the United States has been steadily declining, use of alternative tobacco products has become more prevalent over the past several decades. The health effects of non-cigarette tobacco are often perceived as less harmful than traditional cigarettes, particularly in younger age groups. [19]

The BRFSS survey asked respondents to report their use of the following tobacco products:

- Electronic cigarettes, commonly called e-cigarettes, contain cartridges of nicotine and other chemicals. The nicotine is vaporized and inhaled through a battery-powered device that resembles a traditional cigarette.
- A hookah, also known as a water pipe, delivers a small mixture of shredded tobacco (often flavored) through a mouth piece attached to a rubber hose.
- Snus was described to respondents as a moist, smokeless tobacco that is usually sold in individual or pre-packaged pouches. These are placed under the lip against the gum.
- Dissolvable tobacco products are made of powdered tobacco that has been compressed and resembles a piece of hard candy. The product dissolves entirely, and the user does not need to spit out or throw away any substance.[20] Estimates for dissolvable tobacco are not reported because the coefficient of variation is above 15%.

The prevalence of these other tobacco products amongst CT adults is shown in *Table 16*.

Table 16: Use of Tobacco Products by Demographics

	Ever Tried E-Cigarettes		Ever Tried Smoking in Hookah		Ever tried Snus	
Demographic Characteristics	**%**	**95% Confidence Interval**	**%**	**95% Confidence Interval**	**%**	**95% Confidence Interval**
Total	**9.1%**	**(8.1%-10.2%)**	**11.5%**	**(10.4%-12.6%)**	**6.9%**	**(6.0%-7.8%)**
Age						
18-34 years old	19.5%	(16.3%-22.7%)	28.3%	(24.8%-31.8%)	12.4%	(9.8%-15.0%)
35-54 years old	7.5%	(6.2%-8.8%)	7.3%	(6.0%-8.6%)	7.9%	(6.5%-9.4%)
55 and over years old	3.3%	(2.5%-4.0%)	3.6%	(2.9%-4.4%)	*	*
Gender						
Male	11.4%	(9.6%-13.1%)	15.6%	(13.7%-17.4%)	12.8%	(11.1%-14.6%)
Female	7.1%	(5.9%-8.3%)	7.8%	(6.5%-9.1%)	*	*
Race/Ethnicity						
non-Hispanic White	9.6%	(8.4%-10.9%)	12.0%	(10.7%-13.3%)	8.0%	(6.9%-9.1%)
non-Hispanic Black/African Am	*	*	*	*	*	*
Hispanic/Latino	*	*	*	*	*	*

	Ever Tried E-Cigarettes		Ever Tried Smoking in Hookah		Ever tried Snus	
Demographic Characteristics	**%**	**95% Confidence Interval**	**%**	**95% Confidence Interval**	**%**	**95% Confidence Interval**
Income						
Less than $35,000	13.2%	(10.8%-15.7%)	11.5%	(9.3%-13.7%)	6.5%	(4.7%-8.3%)
$35,000-$74,999	9.2%	(7.2%-11.1%)	9.3%	(7.4%-11.1%)	6.8%	(5.2%-8.4%)
$75,000 and more	6.5%	(5.2%-7.9%)	12.7%	(10.8%-14.7%)	7.3%	(5.7%-8.9%)
Health Insurance Status						
Insured	8.2%	(7.1%-9.2%)	11.0%	(9.9%-12.2%)	6.4%	(5.5%-7.3%)
Not Insured	17.8%	(13.4%-22.2%)	15.3%	(11.3%-19.3%)	*	*
Disability						
Yes	11.3%	(8.9%-13.6%)	9.7%	(7.6%-11.7%)	5.8%	(4.2%-7.4%)
No	8.6%	(7.4%-9.7%)	12.0%	(10.7%-13.3%)	7.1%	(6.1%-8.2%)
Education						
High School Graduate or Less	12.9%	(10.8%-15.1%)	8.4%	(6.7%-10.1%)	7.3%	(5.7%-9.0%)
More Than High School	6.6%	(5.6%-7.6%)	13.4%	(12.0%-14.9%)	6.5%	(5.5%-7.5%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

- In 2012, 11.5% of adults had tried smoking hookah, 9.1% had tried e-cigarettes and 6.9% had tried snus.
- Likelihood of having tried these products was significant in regards to age for all the age categories shown. Younger adults aged 18-34 were more likely to have tried all the products, though the difference was most stark for hookah (younger adults were almost eight times more likely to have tried hookah compared to adults aged 55 and older) and e-cigarettes (younger adults were almost six times more likely to have tried them compared to adults aged 55 and older).
- Men were significantly more likely to have tried hookah (15.6%) and e-cigarettes (11.4%) compared to women (7.8% and 7.1%).
- E-cigarette use was significant in regards to income across all categories, with poorer adults more likely to have tried e-cigarettes compared to higher income categories. With hookah, the adults in the highest household income category were more likely to have tried it, however this was not significant.
- Adults without health insurance were significantly more likely to have tried hookah (15.3%) and e-cigarettes (17.8%), compared to adults with health coverage (11% and 8.2%).
- Adults with a high school degree or less were significantly more likely to have tried e-cigarettes, but significantly less likely to have tried smoking hookah compared to adults with more than a high school education.

Alcohol Consumption

Excessive alcohol consumption, such as binge drinking and heavy drinking, is associated with numerous health problems, including chronic diseases, unintentional injuries, neurological impairments and social problems.[21]

A person binge drinks when they drink so much within a two-hour period that their blood alcohol concentration reaches 0.08g/dL. For men, this means consuming more than five drinks during one occasion. For women, it's more than four drinks.[22] Binge drinking is linked to a variety of health problems such as liver disease, neurological damage and alcohol poisoning, and can lead individuals to engage in risky and violent behaviors.[23]

Heavy drinking is defined as consuming an average of more than two drinks per day for men, and more than one drink per day for women.[24]

The BRFSS questionnaire asked respondents to report the number of days they had consumed at least one drink of alcohol in the past 30 days, and for those who did drink, how many times they drank more than these thresholds. The proportion of adults who engaged in binge drinking and heavy drinking over the previous 30 days is shown in *Table 17*.

Table 17: Excessive Alcohol Consumption by Demographics

	Binge Drinking		Heavy Drinking	
Demographic Characteristics	%	95% Confidence Interval	%	95% Confidence Interval
Total	**17.5%**	**(16.3%-18.7%)**	**6.5%**	**(5.8%-7.2%)**
Age				
18-34 years old	28.2%	(24.9%-31.4%)	6.9%	(5.1%-8.8%)
35-54 years old	19.1%	(17.1%-21.0%)	7.3%	(6.1%-8.6%)
55 and over years old	8.2%	(7.1%-9.3%)	5.4%	(4.6%-6.3%)
Gender				
Male	22.9%	(20.9%-24.9%)	6.5%	(5.4%-7.7%)
Female	12.6%	(11.1%-14.0%)	6.4%	(5.5%-7.4%)
Race/Ethnicity				
non-Hispanic White	18.9%	(17.5%-20.3%)	7.6%	(6.7%-8.5%)
non-Hispanic Black/African Am	*	*	*	*
Hispanic/Latino	16.4%	(12.4%-20.5%)	*	*
Income				
Less than $35,000	16.1%	(13.6%-18.6%)	5.1%	(3.9%-6.4%)
$35,000-$74,999	15.7%	(13.5%-17.9%)	6.1%	(4.9%-7.4%)
$75,000 and more	21.2%	(19.1%-23.2%)	8.5%	(7.1%-9.9%)

Demographic Characteristics	Binge Drinking		Heavy Drinking	
	%	95% Confidence Interval	%	95% Confidence Interval
Health Insurance Status				
Insured	16.8%	(15.5%-18.0%)	6.5%	(5.7%-7.3%)
Not Insured	23.1%	(18.5%-27.7%)	*	*
Disability				
Yes	13.3%	(10.9%-15.7%)	5.3%	(3.9%-6.7%)
No	18.7%	(17.3%-20.1%)	6.8%	(6.0%-7.7%)
Education				
High School Graduate or Less	15.9%	(13.9%-17.9%)	6.3%	(5.1%-7.5%)
More Than High School	18.7%	(17.2%-20.2%)	6.7%	(5.7%-7.6%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

- Over 1 in 6 Connecticut adults (17.5%) engaged in binge drinking in 2012, while 6.5% engaged in heavy drinking.
- Likelihood of binge drinking was significantly correlated with age. Adults aged 18-34 were over three times more likely to binge drink (28.2%) compared to adults aged 55 and older (8.2%).
- Men were significantly more likely to binge-drink (22.9%) compared to women (12.6%).
- Adults in households earning at least $75,000 were significantly more likely to engage in binge-drinking compared to adults in either of the lower-income categories. The same significant relationship is seen with heavy drinking: adults in the highest income category were significantly more likely to engage in heavy drinking relative to adults in either of the lower-income categories.
- Uninsured adults were significantly more likely to binge drink (23.1%) compared to adults with health insurance (16.8%).
- Disabled adults were significantly less likely to binge drink (13.3%) compared to non-disabled adults (18.7%).
- Adults with a high school degree or less were significantly less likely to binge drink (15.9%) compared to adults with more than a high school education (18.7%).

Motor Vehicle Safety

Seat belt use is the most effective way to reduce the number of injuries and deaths in motor vehicle crashes.[25] BRFSS respondents were asked how often they wore seatbelts when they drove or rode in a car. The proportion of adults who said they always wore a seatbelt is shown in *Table 18*.

- In 2012, nearly 90% of CT adults always wore a seatbelt.
- Likelihood of always wearing a seatbelt was significant in regards to age: younger adults were less likely to always wear a seatbelt compared to older adults.
- Women were significantly more likely to always wear a seatbelt (91.5%) compared to men (83.3%).
- Non-Hispanic Whites were significantly more likely to always wear a seatbelt (88.5%) compared to non-Hispanic Blacks (81.8%).
- Adults in the highest income category were significantly more likely to always wear a seatbelt (89.5%) compared to adults in both lower-income categories (86.2% for middle-income earners and 85.7% for lower income adults).
- Adults with more than a high school education were significantly more likely to always wear a seatbelt (89%) compared to adults with a high school degree or less (85.4%).
- In a subsequent question, 2.1% of adults reported that they had been drinking and driving in the past month. None of the demographic subgroups were reportable due to high coefficients of variation.

Figure 7: How Often Adults Wear a Seatbelt in the Car, Connecticut 2012

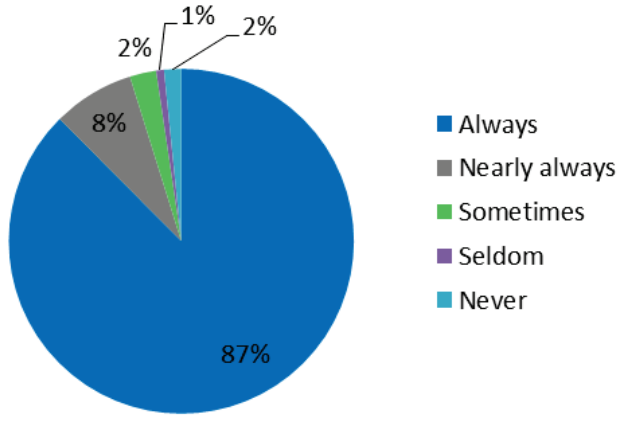


Table 18: Seatbelt Use by Demographics

Demographic Characteristics	Always Uses a Seatbelt	
	%	95% Confidence Interval
Total	**87.6%**	**(86.5%-88.6%)**
Age		
18-34 years old	82.3%	(79.5%-85.2%)
35-54 years old	88.4%	(86.9%-89.9%)
55 and over years old	90.4%	(89.2%-91.6%)
Gender		
Male	83.3%	(81.5%-85.0%)
Female	91.5%	(90.3%-92.6%)
Race/Ethnicity		
non-Hispanic White	88.5%	(87.4%-89.6%)
non-Hispanic Black/African Am	81.8%	(76.7%-86.9%)
Hispanic/Latino	86.8%	(83.5%-90.0%)
Income		
Less than $35,000	85.7%	(83.6%-87.9%)
$35,000-$74,999	86.2%	(84.1%-88.3%)
$75,000 and more	89.5%	(87.9%-91.2%)
Health Insurance Status		
Insured	88.4%	(87.3%-89.4%)
Not Insured	80.8%	(76.8%-84.8%)
Disability		
Yes	85.9%	(83.6%-88.2%)
No	88.1%	(86.9%-89.2%)
Education		
High School Graduate or Less	85.4%	(83.5%-87.4%)
More Than High School	89.0%	(87.8%-90.1%)

Environmental Health and Behaviors

In a state-added series of BRFSS questions, respondents were asked about different behaviors related to their home and environment.

Fish Advisories

The Connecticut Department of Public Health has issued consumption guidelines for fish caught in Connecticut waters. These materials, published in both English and Spanish, give anglers and consumers advice on safe eating levels for different species of fish.[26] The warnings concern mercury and polychlorinated biphenyls, which can accumulate in fish as a result of mercury in the air and from chemical spills.

Respondents were asked if they had read, seen or heard any official advice about eating fish, and for those who had, if they have followed that advice. Results are shown in *Table 19*.

Table 19: Fish Advisories by Demographics

	Seen or Heard Advice About Fish		Follow Advice About Fish	
Demographic Characteristics	**%**	**95% Confidence Interval**	**%**	**95% Confidence Interval**
Total	**33.0%**	**(31.6%-34.4%)**	**84.8%**	**(82.9%-86.8%)**
Age				
18-34 years old	24.3%	(21.0%-27.6%)	84.7%	(79.2%-90.3%)
35-54 years old	36.7%	(34.3%-39.1%)	84.9%	(81.5%-88.2%)
55 and over years old	35.6%	(33.8%-37.5%)	85.0%	(82.7%-87.4%)
Gender				
Male	31.9%	(29.8%-34.1%)	83.0%	(79.6%-86.4%)
Female	33.9%	(32.1%-35.8%)	86.4%	(84.2%-88.6%)
Race/Ethnicity				
non-Hispanic White	37.2%	(35.6%-38.8%)	86.3%	(84.4%-88.3%)
non-Hispanic Black/African Am	18.2%	(13.9%-22.6%)	83.1%	(74.2%-92.0%)
Hispanic/Latino	19.0%	(14.5%-23.5%)	73.6%	(61.2%-86.0%)
Income				
Less than $35,000	23.4%	(21.0%-25.8%)	84.8%	(80.7%-88.8%)
$35,000-$74,999	36.0%	(33.1%-38.9%)	86.9%	(83.6%-90.2%)
$75,000 and more	40.3%	(37.8%-42.8%)	83.8%	(80.4%-87.1%)
Health Insurance Status				
Insured	34.3%	(32.8%-35.8%)	85.0%	(83.0%-87.1%)
Not Insured	21.7%	(17.7%-25.7%)	81.3%	(73.4%-89.2%)

Demographic Characteristics	Seen or Heard Advice About Fish		Follow Advice About Fish	
	%	95% Confidence Interval	%	95% Confidence Interval
Disability				
Yes	33.5%	(30.6%-36.5%)	85.4%	(81.9%-88.9%)
No	32.9%	(31.3%-34.5%)	84.7%	(82.3%-87.0%)
Education				
High School Graduate or Less	23.9%	(21.6%-26.2%)	85.3%	(81.3%-89.4%)
More Than High School	39.1%	(37.3%-40.8%)	84.6%	(82.4%-86.9%)

- One third of CT adults (33%) had seen or heard official advice about eating sport-caught or store-bought fish. Of those who had seen or heard advice, nearly 85% followed the advice.
- Younger adults were significantly less likely to have heard the fish advisories (24.3%) compared to older adults; though they were not less likely to heed the advice if they heard it.
- Non-Hispanic Blacks (18.2%) and Hispanics (19%) were significantly less likely to have heard the advisories, compared to non-Hispanic Whites (37.2%).
- Non-Hispanic Whites were significantly more likely than Hispanics to follow the advice (86.3% *versus* 73.6%).
- Awareness of the advisories was significantly correlated with income. Poorer adults were significantly less likely to have heard the official advice relative to adults in higher income categories. Similarly, adults in the highest income households were significantly more likely to have heard the warnings (40.3%) relative to adults in either of the two lower household income categories (23.4% and 36%).
- Adults with healthcare insurance were significantly more likely to have heard the advisory (34.3% *versus* 21.7% for uninsured adults) as were adults with more than a high school education (39.1% *versus* 23.9% for adults with a high school degree or less).

Carbon Monoxide Detector Use

Carbon Monoxide (CO) is a poisonous, colorless, odorless gas that is a byproduct of the incomplete burning of fuels such as coal, wood, charcoal, oil, kerosene, propane and natural gas.[27] Poor functioning fuel-burning appliances can emit deadly CO gas, as do cars running in closed garages. Known as the "invisible killer," CO can result in poisoning and death of people and animals who breathe it. The Consumer Product Safety Commission and the CDC recommend installing battery-operated CO alarms near a home's sleeping areas.[28]

Unusual weather in the state during 2011 prompted a set of questions about the use of generators and concern about carbon monoxide poisoning. BRFSS respondents were asked if they had a carbon monoxide detector in their home (*Table 20*).

- Almost 70% of Connecticut adults reported having a CO detector in their home.
- Adults aged 55 and older were significantly less likely to have a CO detector, compared to both categories of younger adults.
- Non-Hispanic Whites were significantly more likely to have a detector (72.8%) compared to non-Hispanic Blacks (60.9%) and Hispanics (55.8%).
- Ownership of a CO detector was significant in regards to income: adults in the lowest household income category were significantly less likely to have a detector in their home (57.1%) compared to adults from either of the two higher household income categories (68.5% and 79.7%). Adults in the highest household income category were significantly more likely to have had a detector compared to adults from either of the two lower household income categories.
- The following groups were significantly less likely to have a CO detector in their home: uninsured adults (compared to insured adults), disabled adults (compared to non-disabled adults), and adults with a high school degree or less (compared to adults with more than a high school education).

Table 20: CO Detector Use by Demographics

	Have Carbon Monoxide Detector	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**69.7%**	**(68.3%-71.1%)**
Age		
18-34 years old	71.4%	(67.9%-75.0%)
35-54 years old	72.6%	(70.4%-74.9%)
55 and over years old	65.6%	(63.7%-67.5%)
Gender		
Male	70.8%	(68.7%-72.9%)
Female	68.7%	(66.8%-70.5%)
Race/Ethnicity		
non-Hispanic White	72.8%	(71.3%-74.2%)
non-Hispanic Black/African Am	60.9%	(55.3%-66.5%)
Hispanic/Latino	55.8%	(49.9%-61.6%)
Income		
Less than $35,000	57.1%	(53.9%-60.3%)
$35,000-$74,999	68.5%	(65.8%-71.3%)
$75,000 and more	79.7%	(77.7%-81.6%)
Health Insurance Status		
Insured	71.0%	(69.5%-72.5%)
Not Insured	57.7%	(52.5%-62.9%)
Disability		
Yes	64.2%	(61.1%-67.3%)
No	71.3%	(69.7%-72.9%)
Education		
High School Graduate or Less	64.5%	(61.8%-67.2%)
More Than High School	73.2%	(71.7%-74.8%)

GENERATOR USE

Portable generators are often used to generate electricity during clean-up and recovery following a natural disaster. To avoid CO poisoning, portable gas-powered generators should be located further than 20 feet from the home, with the exhaust pointing away from the home.[29] Respondents were asked if they used a gasoline or diesel-powered generator to provide electricity in their home during a power outage, and for those who did, where the generator was placed.

- Nearly a quarter (23.5%) of Connecticut adults used a generator in the previous year.
- Adults aged 35-54 were significantly more likely to use a generator compared to other age categories.
- Men were significantly more likely to use generators (25.6%) compared to women (21.6%).
- A much higher proportion of adults owned or rented a generator (82.3%), rather than borrowed one (17.7%), as shown in *Figure 8*.
- For the generator location, there were no significant differences between groups.

Figure 8: Generator Use among Adults, Connecticut 2012

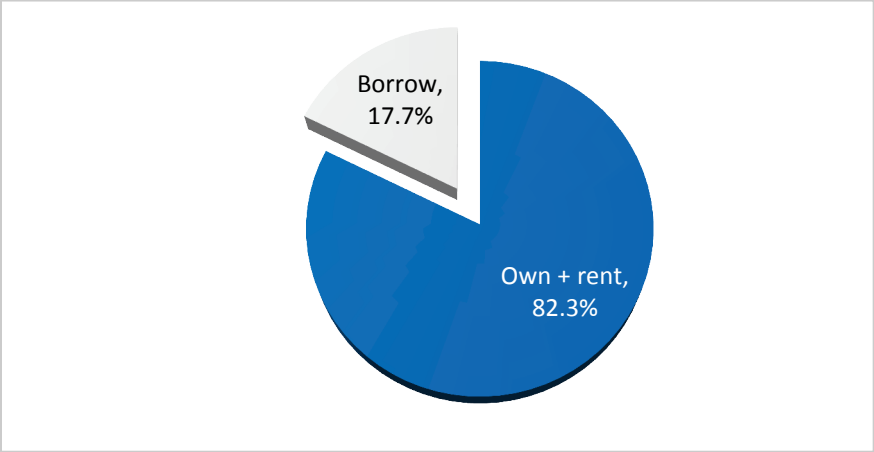
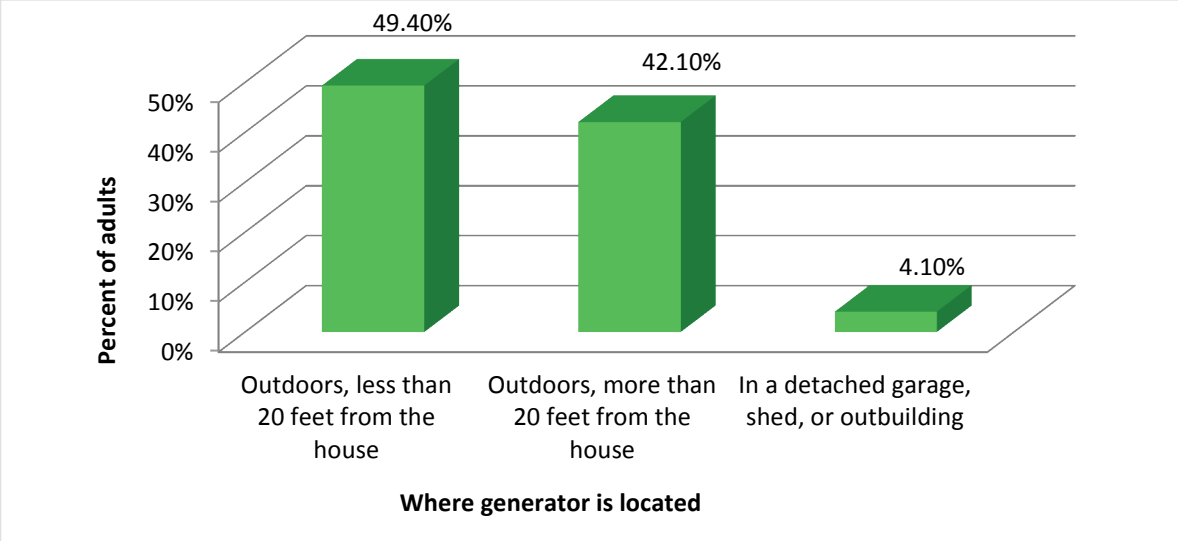


Figure 9: Generator Placement, Connecticut 2012



3. Clinical Preventive Practices

Routine Check-up in Past Year

The CDC stresses the importance of routine check-ups for disease prevention and screening.[30] Respondents were asked how long it had been since they last visited a doctor for a routine checkup. The proportion of adults who had a check-up in the previous year is shown in *Table 21*.

- Overall, just over 70% of Connecticut adults had received a check-up in the previous year.
- Adults aged 55 and older were significantly more likely to have had a routine check-up (83.3%) in the past year, compared to either of the two younger adult categories (64.1% and 65.6%).
- Women were significantly more likely to have had a check-up (75.4%) compared to men (67.6%).
- Non-Hispanic Black adults were significantly more likely to have had a check-up (78.8%) compared to each of the other racial/ethnic groups.
- Adults with healthcare coverage were significantly more likely to have had a check-up (75.2%), compared to uninsured adults (41.6%).
- Adults with a disability were significantly more likely to have had a check-up (75.2%) compared to non-disabled adults (69.4%).

Figure 10: Length of Time since Last Routine Check-up, Connecticut 2012

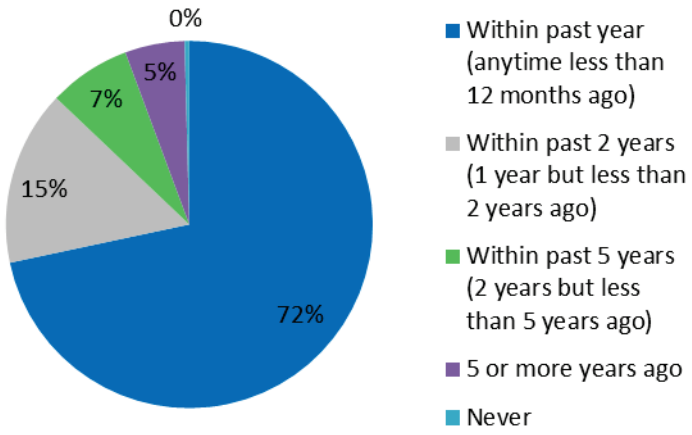


Table 21: Routine Check-ups by Demographics

	Routine Checkup in Past Year	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**71.7%**	**(70.3%-73.0%)**
Age		
18-34 years old	64.1%	(60.7%-67.6%)
35-54 years old	65.6%	(63.3%-67.9%)
55 and over years old	83.3%	(81.9%-84.7%)
Gender		
Male	67.6%	(65.5%-69.8%)
Female	75.4%	(73.7%-77.0%)
Race/Ethnicity		
non-Hispanic White	71.7%	(70.2%-73.2%)
non-Hispanic Black/African Am	78.8%	(74.6%-83.0%)
Hispanic/Latino	66.7%	(61.7%-71.7%)
Income		
Less than $35,000	70.2%	(67.5%-72.9%)
$35,000-$74,999	71.4%	(68.8%-74.1%)
$75,000 and more	72.0%	(69.8%-74.2%)
Health Insurance Status		
Insured	75.2%	(73.9%-76.6%)
Not Insured	41.6%	(36.8%-46.3%)
Disability		
Yes	79.8%	(77.4%-82.2%)
No	69.4%	(67.8%-71.0%)
Education		
High School Graduate or Less	71.5%	(69.1%-74.0%)
More Than High School	71.7%	(70.1%-73.3%)

Breast Cancer Screening for Females over 40

Breast cancer is the second leading cause of cancer death in women.[31] While breast cancer can occur in men, this is typically considered a woman's disease, and so only women were asked questions about breast cancer screening. Female respondents were asked if they had ever received a mammogram, and for those who had, how long it had been since their last one. Women were also asked if they had ever had a clinical breast exam (CBE), and when the last one occurred.

These results in *Table 22* are only shown for women over 40, because mammography is generatlly not recommended for use in younger women.[32]

Table 22: Breast Cancer Screening by Demographics

	40+ Had Mammogram in Past Two Years		40+ Had Clinical Breast Exam and Mammogram	
Demographic Characteristics	%	95% Confidence Interval	%	95% Confidence Interval
Total	**79.8%**	**(78.0%-81.5%)**	**74.2%**	**(72.4%-76.1%)**
Age				
40-54 years old	78.1%	(75.1%-81.2%)	75.7%	(72.6%-78.9%)
55 and over years old	81.0%	(79.0%-83.0%)	73.1%	(70.8%-75.3%)
Race/Ethnicity				
non-Hispanic White	80.1%	(78.3%-81.9%)	75.3%	(73.3%-77.2%)
non-Hispanic Black/African Am	80.3%	(73.6%-87.0%)	75.8%	(68.8%-82.9%)
Hispanic/Latino	76.4%	(66.9%-85.8%)	64.8%	(55.1%-74.6%)
Income				
Less than $35,000	73.3%	(69.3%-77.3%)	63.8%	(59.7%-68.0%)
$35,000-$74,999	81.3%	(77.9%-84.6%)	75.2%	(71.6%-78.9%)
$75,000 and more	85.2%	(82.7%-87.7%)	83.5%	(80.9%-86.2%)
Health Insurance Status				
Insured	81.3%	(79.5%-83.1%)	75.9%	(74.0%-77.7%)
Not Insured	57.4%	(48.6%-66.2%)	48.5%	(39.6%-57.5%)
Disability				
Yes	74.4%	(70.6%-78.2%)	65.5%	(61.5%-69.5%)
No	81.5%	(79.6%-83.5%)	77.2%	(75.1%-79.3%)
Education				
High School Graduate or Less	76.9%	(73.8%-80.0%)	69.1%	(65.8%-72.4%)
More Than High School	82.1%	(80.1%-84.0%)	78.0%	(76.0%-80.1%)

- Almost 80% of Connecticut women aged 40 and older had a mammogram in the past two years, and slightly fewer had the recommended combination of mammogram and CBE.
- Women in households earning less than $35,000 were significantly less likely to have had a mammogram (73.5%) compared to women in both higher income categories.
- The likelihood of having a CBE and a mammogram in the past two years rose significantly with income.
- Women with health coverage were significantly more likely to have had a mammogram (81.3%), as well as a mammogram and CBE (75.9%), in the past two years, compared to uninsured women (57.4% and 48.5%).
- The same relationship was seen among non-disabled women, who were significantly more likely to have had these screenings relative to disabled women; and among women with higher education levels, who were more likely to get screened, relative to women with a high school degree or less.

Cervical Cancer Screening

Cervical cancer is the easiest female cancer to prevent. The Pap test, or Pap smear, is a highly reliable and effective screening tool.[33] The main cause of cervical cancer is the human papillomavirus (HPV), a common sexually-transmitted virus.[34] In 2012, new screening guidelines recommended that women aged 21 to 65 get a Pap smear every three years.[35] Female respondents were asked if they had ever had a Pap test, and how long it had been since their last Pap test. Results for women aged 21 and older are shown in *Table 23*.

Table 23: Cervical Cancer Screening by Demographics

	Age 21+ Ever Had Pap Test		Age 21+ Had Appropriately Timed Pap Test	
Demographic Characteristics	**%**	**95% Confidence Interval**	**%**	**95% Confidence Interval**
Total	**95.3%**	**(94.3%-96.2%)**	**83.5%**	**(81.9%-85.1%)**
Age				
21-34 years old	89.6%	(86.1%-93.1%)	85.2%	(81.2%-89.1%)
35-54 years old	98.0%	(97.2%-98.8%)	90.3%	(88.3%-92.4%)
55 and over years old	95.7%	(94.5%-96.8%)	74.2%	(71.5%-76.9%)
Race/Ethnicity				
non-Hispanic White	96.9%	(96.0%-97.9%)	83.8%	(82.0%-85.6%)
non-Hispanic Black/African Am	92.7%	(88.9%-96.5%)	84.7%	(79.0%-90.3%)
Hispanic/Latino	90.0%	(86.2%-93.7%)	83.7%	(78.7%-88.8%)
Income				
Less than $35,000	93.0%	(91.0%-95.0%)	76.3%	(72.8%-79.9%)
$35,000-$74,999	95.6%	(93.1%-98.1%)	84.2%	(80.5%-87.8%)
$75,000 and more	98.8%	(98.1%-99.5%)	92.5%	(90.7%-94.3%)
Health Insurance Status				
Insured	95.9%	(94.9%-96.8%)	85.0%	(83.3%-86.6%)
Not Insured	88.1%	(83.4%-92.9%)	67.5%	(60.3%-74.7%)
Disability				
Yes	92.5%	(89.8%-95.3%)	74.3%	(69.7%-78.8%)
No	96.1%	(95.1%-97.0%)	85.7%	(84.1%-87.4%)
Education				
High School Graduate or Less	91.7%	(89.6%-93.8%)	74.3%	(70.7%-77.9%)
More Than High School	97.4%	(96.5%-98.2%)	88.2%	(86.7%-89.8%)

- In 2012, over 95% of women had had a Pap in their lives, and 83.5% had had one in the recommended time frame (in the last three years).
- Likelihood of having ever had a Pap test increased significantly with age.
- Non-Hispanic White women were significantly more likely to have had a Pap test at some point, relative to women in other racial/ethnic categories.
- Likelihood of having an appropriately timed Pap increased significantly with income.
- Disabled women and uninsured women were significantly less likely to have had a Pap test, whether in the past three years or in their life, compared to non-disabled women and insured women, respectively.
- Women with a high school degree or less were significantly less likely to have had a Pap test at any point or within the recommended interval, relative to women with more than a high school education.

Prostate Cancer Screening

Prostate-specific antigen (PSA) is a protein produced by the prostate, and elevated levels of PSA in the blood are correlated with a higher risk for prostate cancer.[36] A PSA test has regularly been used in prostate cancer screening, however medical professionals have started to caution against the test because some men with elevated PSA levels are later found to not have prostate cancer.

While there is disagreement over whether PSA tests should be recommended as a screening tool, there is agreement that a man considering a PSA test should be given all possible information about the benefits and harms of the test.[37]

Men aged 40 and older were asked if their health care provider had ever spoken with them about the advantages and disadvantages of a PSA test. They were also asked if they ever had a PSA test, when it happened, and their main reason for having it. Results are shown in *Table 24*.

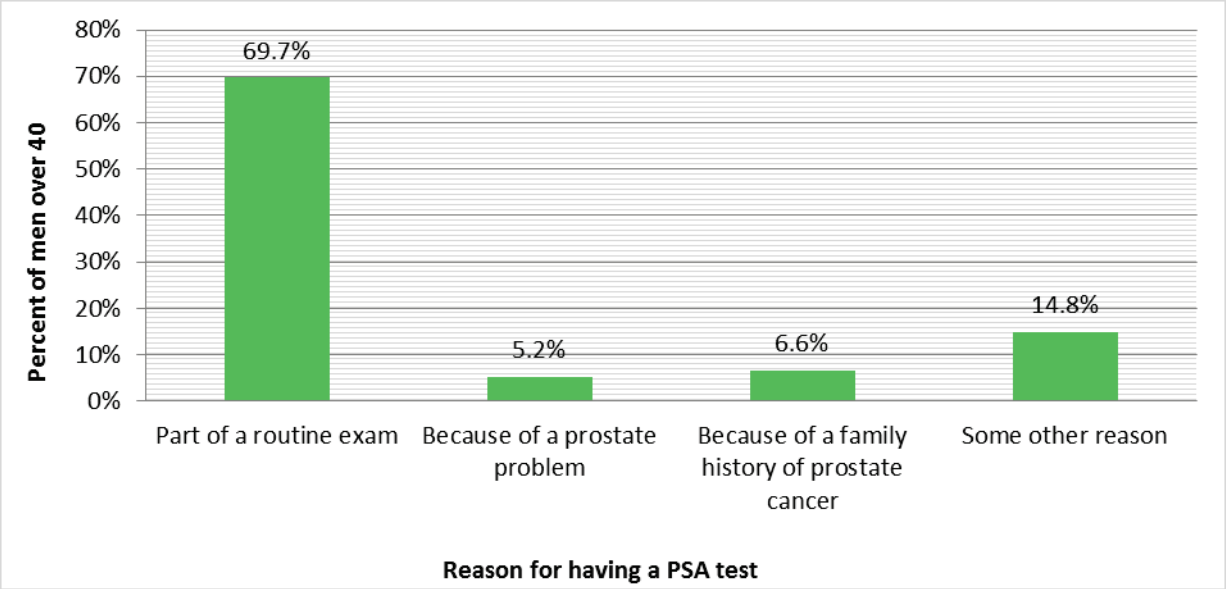
Table 24: Prostate Cancer Screening by Demographics

	Ever Discussed Advantages of PSA Test With Doctor		Had PSA Test in Past Two Years	
Demographic Characteristics	%	95% Confidence Interval	%	95% Confidence Interval
Total	**61.7%**	**(59.2%-64.3%)**	**47.6%**	**(45.0%-50.2%)**
Age				
40-54 years old	46.5%	(42.2%-50.7%)	27.6%	(23.7%-31.6%)
55 and over years old	74.9%	(72.1%-77.7%)	65.4%	(62.4%-68.5%)
Race/Ethnicity				
non-Hispanic White	64.6%	(61.9%-67.3%)	50.2%	(47.4%-53.0%)
non-Hispanic Black/African Am	58.1%	(47.2%-69.0%)	44.7%	(34.2%-55.2%)
Hispanic/Latino	45.8%	(34.9%-56.6%)	*	*
Income				
Less than $35,000	53.5%	(47.7%-59.3%)	37.2%	(31.6%-42.9%)
$35,000-$74,999	63.6%	(58.6%-68.6%)	48.6%	(43.4%-53.7%)
$75,000 and more	66.7%	(63.0%-70.4%)	52.9%	(49.0%-56.9%)
Health Insurance Status				
Insured	64.6%	(62.0%-67.3%)	50.6%	(47.9%-53.4%)
Not Insured	34.9%	(26.5%-43.2%)	*	*
Disability				
Yes	62.4%	(57.1%-67.8%)	48.1%	(42.7%-53.5%)
No	61.5%	(58.6%-64.5%)	47.4%	(44.4%-50.5%)
Education				
High School Graduate or Less	55.4%	(50.8%-60.0%)	41.8%	(37.1%-46.5%)
More Than High School	65.9%	(63.0%-68.9%)	51.5%	(48.4%-54.6%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

- Almost two-thirds of men aged 40 and older had discussed the advantage of a PSA test with their doctor, and nearly half had a PSA test in the previous two years.
- Men aged 55 and older were significantly more likely to have discussed a test with their doctors (74.9% *versus* 46.5%) and to have had a PSA test in the past two years (65.4% *versus* 27.6%).
- Non-Hispanic White men were significantly more likely to have discussed the benefits and dangers of a PSA test (64.6%), compared to Hispanic men (45.8%), just as they were more likely to have undergone a PSA test (50.2%) relative to Hispanic men (44.7%) but the latter difference in the percentages was not significant.
- Men in lower-income households were significantly less likely to have discussed the test, and also to have had the test, compared to men in either of the two higher household income categories.
- Men with health insurance were significantly more likely to have discussed the test (64.6%), compared to uninsured men (34.9%).
- Men with a high school diploma or less were significantly less likely to have discussed the test (55.4%), compared to men with more than a high school education (65.9%). They were also significantly less likely to have had the test (51.5% vs 41.8%).
- Men who had had the PSA test were asked to provide their reasons for having it. These reasons are shown in *Figure 11*.

Figure 11: Reason for Having PSA Test, Connecticut 2012



Colorectal Cancer Screening

Colorectal Cancer (CRC) is the fourth most common cancer, and although preventable, it is the fourth leading cause of cancer-related death in the U.S. CRC usually develops from precancerous polyps (growths). Detection and removal of these polyps during sigmoidoscopy or colonoscopy screening can actually prevent cancer. Screening for CRC using fecal occult blood testing, sigmoidoscopy and colonoscopy offer a clear benefit for adults aged 50 to 75. [38] It is estimated that proper screening could prevent more than half of the 51,000 deaths from CRC each year.[39] Respondents aged 50 and older were asked if they had ever had a blood stool test using a home kit, and whether they had ever had a sigmoidoscopy or colonoscopy. Results are shown in *Table 25*.

- About 1 in 6 adults aged 50 and older (16.4%) had had a blood stool test in the previous two years, while nearly three-quarters had had a sigmoidoscopy or colonoscopy at some point (74.5%).
- Non-Hispanic White adults were significantly more likely to have had a sigmoidoscopy or colonoscopy (75.9%) compared to non-Hispanic Blacks (66.1%).
- Likelihood to have ever undergone a sigmoidoscopy or colonoscopy increased significantly with income.
- Adults without health insurance were significantly less likely to have undergone a sigmoidoscopy or colonoscopy (41.6%) relative to covered adults (76.9%).
- Disabled adults were significantly less likely to have had a blood stool test in the past two years (15.3%) relative to non-disabled adults (18.8%).
- Adults with more than a high school education were significantly more likely to have undergone a sigmoidoscopy or colonoscopy (78.6%) relative to adults with a high school degree or less (68.8%).

Table 25: Colorectal Cancer Screening by Demographics

	Age 50+ Had Blood Stool Test in Past Two Years		Age 50+ Ever Had Sigmoidoscopy or Colonoscoy	
Demographic Characteristics	%	95% Confidence Interval	%	95% Confidence Interval
Total	**16.4%**	**(15.0%-17.7%)**	**74.5%**	**(72.8%-76.2%)**
Age				
50-54 years old	11.0%	(8.2%-13.7%)	55.0%	(50.6%-59.4%)
55 and over years old	18.1%	(16.5%-19.6%)	80.5%	(79.0%-82.1%)
Gender				
Male	16.8%	(14.7%-19.0%)	74.6%	(71.9%-77.2%)
Female	15.9%	(14.3%-17.6%)	74.4%	(72.3%-76.6%)
Race/Ethnicity				
non-Hispanic White	16.5%	(15.1%-18.0%)	75.9%	(74.2%-77.6%)
non-Hispanic Black/African Am	20.3%	(14.5%-26.1%)	66.1%	(58.1%-74.1%)
Hispanic/Latino	*	*	69.5%	(61.1%-77.9%)
Income				
Less than $35,000	16.6%	(14.0%-19.3%)	68.0%	(64.5%-71.5%)
$35,000-$74,999	15.8%	(13.3%-18.3%)	75.3%	(71.9%-78.6%)
$75,000 and more	16.2%	(13.8%-18.5%)	79.9%	(77.3%-82.5%)
Health Insurance Status				
Insured	17.0%	(15.6%-18.4%)	76.9%	(75.2%-78.5%)
Not Insured	*	*	41.6%	(33.8%-49.4%)
Disability				
Yes	18.8%	(16.2%-21.4%)	74.0%	(70.9%-77.1%)
No	15.3%	(13.7%-16.8%)	74.9%	(73.0%-76.9%)
Education				
High School Graduate or Less	15.8%	(13.6%-18.1%)	68.8%	(65.8%-71.7%)
More Than High School	16.8%	(15.1%-18.4%)	78.6%	(76.7%-80.5%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

Adult Oral Health

Oral health is essential to the general health and well-being of all.[40]

Respondents to the BRFSS were asked how long it had been since they last visited a dentist or dental clinic for any reason, and also how many of their permanent teeth had been removed because of tooth decay, gum disease or infection. Results are shown in *Table 26*.

Table 26: Adult Oral Health by Demographics

	Visited dentist in past year		Had any permanent teeth extracted	
Demographic Characteristics	%	95% Confidence Interval	%	95% Confidence Interval
Total	**76.1%**	**(74.8%-77.4%)**	**41.7%**	**(40.2%-43.1%)**
Age				
18-34 years old	71.7%	(68.4%-75.1%)	18.5%	(15.7%-21.3%)
35-54 years old	77.5%	(75.4%-79.6%)	37.0%	(34.7%-39.3%)
55 and over years old	78.0%	(76.4%-79.7%)	64.8%	(62.9%-66.6%)
Gender				
Male	73.1%	(71.0%-75.2%)	40.6%	(38.4%-42.8%)
Female	78.9%	(77.2%-80.6%)	42.7%	(40.7%-44.6%)
Race/Ethnicity				
non-Hispanic White	79.5%	(78.2%-80.9%)	40.0%	(38.5%-41.6%)
non-Hispanic Black/African Am	67.6%	(62.4%-72.7%)	51.8%	(46.2%-57.5%)
Hispanic/Latino	66.4%	(61.4%-71.4%)	43.0%	(37.8%-48.1%)
Income				
Less than $35,000	60.8%	(57.9%-63.8%)	56.5%	(53.4%-59.5%)
$35,000-$74,999	76.3%	(73.6%-78.9%)	46.1%	(43.1%-49.1%)
$75,000 and more	88.6%	(87.0%-90.2%)	27.5%	(25.4%-29.5%)
Health Insurance Status				
Insured	79.3%	(78.0%-80.6%)	41.4%	(39.9%-43.0%)
Not Insured	51.6%	(46.6%-56.5%)	44.7%	(39.8%-49.6%)
Disability				
Yes	67.7%	(64.7%-70.7%)	59.3%	(56.1%-62.5%)
No	78.4%	(77.0%-79.9%)	36.8%	(35.2%-38.4%)
Education				
High School Graduate or Less	67.9%	(65.4%-70.4%)	53.0%	(50.2%-55.7%)
More Than High School	81.7%	(80.3%-83.1%)	34.2%	(32.6%-35.8%)

- Just over three-quarters (76.1%) of Connecticut adults saw a dentist at least once in the past year, while 41.7% of adults had at least one permanent tooth extracted.
- Adults aged 18-34 were significantly less likely to have visited a dentist (71.7%) relative to both categories of older adults. Additionally, likelihood of having teeth removed because of specific problems increased significantly with age.
- Women were significantly more likely to have seen a dentist (78.9%) relative to men (73.1%).
- Non-Hispanic Whites were significantly more likely to have visited a dentist, and non-Hispanic Blacks were significantly more likely to have had teeth extracted, relative to other racial/ethnic groups.
- Likelihood of having seen a dentist increased significantly with higher incomes, while likelihood of having permanent teeth extracted decreased significantly with income.
- Adults with health coverage were significantly more likely to visit a dentist (79.3%) relative to uninsured adults (51.6%).
- Disabled adults were significantly less likely to have seen a dentist (67.7% *versus* 78.4% for non-disabled adults) and were significantly more likely to have had permanent teeth extracted (59.3% *versus* 36.8% for non-disabled adults).
- Adults with higher levels of education were significantly more likely to have visited a dentist, while adults with a high school degree or less were significantly more likely to have had permanent teeth extracted.

Child Oral Health

Although it is largely preventable, tooth decay is the most common chronic disease among children in the United States.[41] Dental caries (cavities) can cause pain and infection, and if left untreated they can lead to malnourishment and serious medical complications.[42] Dental disease has also been linked with other chronic conditions, such as diabetes, heart disease and stroke.[43] The American Academy of Pediatric Dentistry recommends that children see a pediatric dentist when their first tooth appears, and no later than their first birthday.[44]

Adult respondents were asked if the randomly-selected child had seen a dental provider in the previous year. Results are shown in *Table 27*.

- In 2012, 85% of Connecticut children had seen a dentist in the prior year.
- The youngest children, aged 0-4, were significantly less likely to have seen a dentist, relative to either of the two older children categories.
- Non-Hispanic White children were more likely to have seen a dentist (86.7%), relative to non-Hispanic Blacks (81.8%) and Hispanics (82.7%), but these differences were not significant.
- Children in the highest household income category were significantly more likely to have visited a dentist (88.2%) relative to children in the poorest households (79.5%).
- Children whose adult proxy had a high school degree or less were significantly less likely to have visited a dentist (81%) than children whose proxy had more than a high school education (86.7%).

Table 27: Child Oral Health by Demographics

	Child Visited Dentist in Past Year	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**85.0%**	**(83.0%-86.9%)**
Child Age		
0-4 years old	60.0%	(54.3%-65.7%)
5-11 years old	94.3%	(91.5%-97.0%)
12-17 years old	92.6%	(90.3%-95.0%)
Child Gender		
Male	84.4%	(81.4%-87.4%)
Female	85.7%	(83.1%-88.3%)
Child Race/Ethnicity		
Non-Hispanic White	86.7%	(84.6%-88.7%)
Non-Hispanic Black	81.8%	(75.5%-88.2%)
Hispanic/Latino	83.4%	(77.5%-89.2%)
Adult Proxy Income		
Less than $35,000	79.5%	(74.5%-84.5%)
$35,000-$74,999	84.9%	(80.8%-89.0%)
$75,000+	88.2%	(85.9%-90.5%)
Adult Proxy Education		
High School Graduate or Less	81.0%	(76.4%-85.6%)
More Than High School	86.7%	(84.6%-88.7%)

Adult Flu and Pneumonia Vaccinations

The influenza (flu) virus can cause serious infections, hospitalizations and even death in some susceptible individuals. Seasonal flu vaccines are recommended for everyone over six months of age.[45] Respondents were asked if they had received the seasonal flu vaccine, either as a shot or nasal spray mist. All respondents were also asked if they had ever received the pneumonia vaccine, which is given once or twice in a person's lifetime: generally to children under five years old and to adults at high risk for disease.[46] Results are shown in *Table 28*.

Table 28: Adult Vaccinations by Demographics

	Had a Flu Vaccine in Past Year		Ever Had Pneumonia Shot	
Demographic Characteristics	%	95% Confidence Interval	%	95% Confidence Interval
Total	**39.2%**	**(37.8%-40.6%)**	**29.7%**	**(28.3%-31.1%)**
Age				
18-34 years old	26.4%	(23.0%-29.8%)	17.0%	(13.5%-20.5%)
35-54 years old	34.9%	(32.6%-37.2%)	15.9%	(13.9%-17.8%)
55 and over years old	53.1%	(51.1%-55.0%)	50.2%	(48.2%-52.2%)
Gender				
Male	36.1%	(33.9%-38.3%)	29.5%	(27.3%-31.8%)
Female	42.0%	(40.1%-43.9%)	29.8%	(28.0%-31.5%)
Race/Ethnicity				
non-Hispanic White	43.0%	(41.3%-44.6%)	31.3%	(29.7%-32.8%)
non-Hispanic Black/African Am	25.8%	(21.5%-30.1%)	26.2%	(21.2%-31.1%)
Hispanic/Latino	29.6%	(24.6%-34.5%)	23.5%	(17.9%-29.0%)
Income				
Less than $35,000	33.7%	(31.0%-36.5%)	35.6%	(32.7%-38.5%)
$35,000-$74,999	38.4%	(35.6%-41.2%)	30.8%	(28.0%-33.6%)
$75,000 and more	42.8%	(40.4%-45.2%)	22.7%	(20.4%-25.0%)
Health Insurance Status				
Insured	42.0%	(40.5%-43.5%)	31.4%	(29.9%-32.9%)
Not Insured	15.7%	(11.9%-19.5%)	15.1%	(11.6%-18.5%)
Disability				
Yes	47.2%	(44.1%-50.3%)	48.9%	(45.6%-52.2%)
No	37.0%	(35.4%-38.6%)	24.1%	(22.6%-25.6%)
Education				
High School Graduate or Less	35.8%	(33.3%-38.3%)	32.0%	(29.5%-34.5%)
More Than High School	41.6%	(39.8%-43.3%)	28.2%	(26.5%-29.8%)

- Almost 40% of Connecticut adults had had a flu vaccine in the previous year and almost 30% had had a pneumonia shot.
- Adults aged 55 and over were significantly more likely to have gotten a flu vaccine in the past year and were more likely to have ever gotten a pneumonia shot (53.1% and 50.2% respectively) in comparison with either of the two younger adult categories.
- Females were significantly more likely to have received a flu vaccine (42%) compared to males (36.1%).
- Non-Hispanic Whites were significantly more likely to have received a flu vaccine (43%) compared to any of the other racial/ethnic groups. Non-Hispanic Whites were significantly more likely to have ever had a pneumonia shot (31.3%) compared to Hispanics (23.5%).
- Adults with health coverage were significantly more likely to have received either vaccine compared to uninsured adults. The same was true for disabled adults relative to non-disabled adults.
- Adults with a high school degree or less were significantly less likely to have received a flu vaccine (35.8%) compared to adults with more than a high school education (41.6%).

Shingles Vaccination

Shingles is caused by the same virus that causes chicken pox. Symptoms of shingles include a painful skin rash. The CDC recommends the shingles vaccine, known as Zostavax®, to adults over 60 years of age.[47]

Respondents aged 50 and over were asked if they have had the shingles vaccine since it became available in 2006 (see *Table 29*).

- In 2012, 12% of adults aged 50 and older had received the shingles vaccine.
- Similar proportions of men (11.5%) and women (12.5%) had received the vaccine.
- Adults in lower-income households were significantly less likely to have gotten the vaccine (8.3%), compared to adults in the higher-income categories.
- Adults with a high school degree or less were significantly less likely to have received the shingles vaccine (8.3%), compared to adults with more than a high school education (14.6%).

Table 29: Shingles Vaccination by Demographics

	Ever Had Shingles Vaccination	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**12.0%**	**(11.0%-13.1%)**
Age		
50-54 years old	*	*
55 and over years old	15.2%	(13.8%-16.5%)
Gender		
Male	11.5%	(9.7%-13.3%)
Female	12.5%	(11.1%-13.8%)
Race/Ethnicity		
non-Hispanic White	13.2%	(12.0%-14.4%)
non-Hispanic Black/African Am	*	*
Hispanic/Latino	*	*
Income		
Less than $35,000	8.3%	(6.1%-10.4%)
$35,000-$74,999	13.2%	(11.2%-15.3%)
$75,000 and more	12.7%	(10.8%-14.6%)
Health Insurance Status		
Insured	12.6%	(11.4%-13.7%)
Not Insured	*	*
Disability		
Yes	12.0%	(10.0%-13.9%)
No	12.0%	(10.7%-13.4%)
Education		
High School Graduate or Less	8.3%	(6.6%-10.0%)
More Than High School	14.6%	(13.2%-16.1%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

Child Flu Vaccination

Children are at a higher risk for developing the flu, and so a preventative vaccine is especially recommended for children under five and their caregivers. The vaccine is currently approved for children as young as six months old. Children, especially infants and those who are immune-compromised, are also more likely to develop complications from the flu, including pneumonia.[48]

The proxy adult was asked whether the selected child had received the seasonal flu vaccination, as either a shot or nasal spray. Results are shown in *Table 30*.

- Just under 60% of children received a flu vaccine in the previous year.
- The youngest children were the most likely to get the vaccine (79.2%), followed by children aged 5-11 (62.4%) and the oldest children (45.6%). Likelihood of receiving the flu vaccine between any two of these three age groups were significantly different.
- Children in the highest-income households were significantly more likely to receive the flu shot (63.6%), relative to children in middle-income households (51.4%).

Table 30: Child Flu Vaccination by Demographics

	Child Had Flu Shot in Past Year	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**59.9%**	**(57.2%-62.6%)**
Child Age		
0-4 years old	79.2%	(74.4%-83.9%)
5-11 years old	62.4%	(57.8%-67.0%)
12-17 years old	45.6%	(41.2%-50.0%)
Child Gender		
Male	61.2%	(57.3%-65.0%)
Female	58.6%	(54.7%-62.5%)
Child Race/Ethnicity		
Non-Hispanic White	58.6%	(55.5%-61.8%)
Non-Hispanic Black	56.9%	(47.9%-65.9%)
Hispanic/Latino	64.0%	(56.8%-71.2%)
Adult Proxy Income		
Less than $35,000	59.8%	(53.5%-66.1%)
$35,000-$74,999	51.4%	(45.4%-57.5%)
$75,000+	63.6%	(59.9%-67.2%)
Adult Proxy Education		
High School Graduate or Less	56.6%	(50.8%-62.5%)
More Than High School	61.1%	(58.1%-64.1%)

Human Papilloma Virus (HPV) Vaccination

Human Papilloma Virus (HPV) is the most common sexually transmitted infection. The virus is extremely common, and in most cases, it goes away on its own without symptoms. However, in some cases, it can lead to genital warts and cervical cancer.[49] The CDC recommends that preteen girls and boys get the HPV vaccine to protect against genital warts, rare cancers that can affect both sexes, and cervical cancers that can affect females.[50]

Respondents aged 18 to 49 were asked if they had ever had an HPV vaccination. The first HPV vaccine, Gardasil®, was approved in 2006 for females and males aged 9 to 26. A second vaccine, Cervarix®, was approved in 2009 for females aged 10 to 25.[51] These age and sex restrictions on the vaccine explain why data for older adults, as well as males, are not reportable (see *Table 31*).

- In 2012, 11.4% of Connecticut adults had received the HPV vaccination.
- Over 1 in 5 adults aged 18-34 (21.1%) had received the vaccine.
- Nearly 1 in 5 females (19.4%) had received the vaccine.
- The rate of HPV vaccination for adults in the lowest income category (13.2%) was higher than for adults overall (11.4%).
- Though the data is not shown in the table, adults without health insurance were significantly more likely to NOT have received the HPV vaccination (94.6%), relative to adults with health insurance (87.6%).

Table 31: HPV Vaccination by Demographics

	Ever Had HPV vaccination?	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**11.4%**	**(9.6%-13.2%)**
Age		
18-34 years old	21.1%	(17.8%-24.5%)
35-49 years old	*	*
Gender		
Male	*	*
Female	19.4%	(16.3%-22.4%)
Race/Ethnicity		
non-Hispanic White	12.0%	(9.7%-14.4%)
non-Hispanic Black/African Am	*	*
Hispanic/Latino	*	*
Income		
Less than $35,000	13.2%	(10.0%-16.5%)
$35,000-$74,999	*	*
$75,000 and more	*	*
Health Insurance Status		
Insured	12.4%	(10.4%-14.5%)
Not Insured	*	*
Disability		
Yes	*	*
No	11.5%	(9.6%-13.4%)
Education		
High School Graduate or Less	*	*
More Than High School	11.9%	(9.8%-14.0%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

Human Immunodeficiency Virus (HIV) Testing

Over one million Americans are living with the Human Immunodeficiency Virus (HIV), and of these, about 1 in 6 are not aware they are infected. The group most affected by HIV is men who have sex with men, though heterosexuals and drug users can also be affected. African Americans are over-represented in new HIV infections, as are Hispanics.[52] Individuals can be tested for the virus by testing blood or oral fluid. BRFSS respondents were asked if they had ever been tested for HIV, not counting testing while giving blood (*Table 32*).

- In 2012, over one-third (34%) of Connecticut adults had been tested for HIV.
- Adults aged 55 and over were significantly less likely to have been tested for HIV (16%), compared to adults aged 18-34 (43.7%) and 35-54 (44.5%).
- Women were significantly more likely to have been tested for HIV (35.9%) compared to men (32%).
- Non-Hispanic Blacks and Hispanics were significantly more likely to be screened for HIV (55.6% and 56.2%, respectively), compared to non-Hispanic Whites (27.3%) and non-Hispanic adults of other/multiple races (40.5%).
- Adults in lower-income households were significantly more likely to have been tested (40.2%) compared to adults in both higher-income categories.
- Adults without healthcare coverage were significantly more likely to have been tested (41.3%), compared to covered adults (33.2%).
- Adults with at least some post-high school education were significantly more likely to have been tested compared to adults with a high school degree or less (36.3% *versus* 30.4%).

Figure 12: Location of Last HIV Test, Connecticut 2012

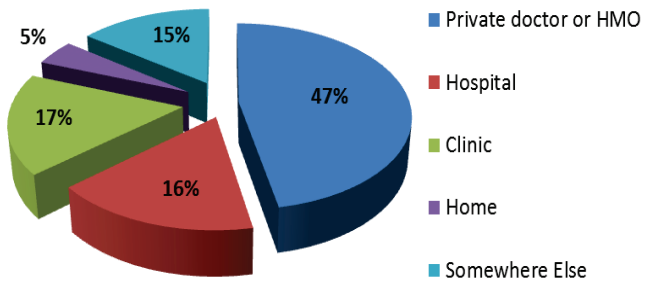


Table 32: HIV Testing by Demographics

Demographic Characteristics	Ever tested for HIV	
	%	95% Confidence Interval
Total	**34.0%**	**(32.6%-35.5%)**
Age		
18-34 years old	43.7%	(40.0%-47.3%)
35-54 years old	44.5%	(42.0%-46.9%)
55 and over years old	16.0%	(14.6%-17.5%)
Gender		
Male	32.0%	(29.8%-34.2%)
Female	35.9%	(34.0%-37.9%)
Race/Ethnicity		
non-Hispanic White	27.3%	(25.8%-28.8%)
non-Hispanic Black/African Am	55.6%	(49.8%-61.4%)
Hispanic/Latino	56.2%	(50.7%-61.7%)
Income		
Less than $35,000	40.2%	(37.1%-43.3%)
$35,000-$74,999	30.5%	(27.7%-33.2%)
$75,000 and more	34.5%	(32.1%-36.9%)
Health Insurance Status		
Insured	33.2%	(31.7%-34.7%)
Not Insured	41.3%	(36.3%-46.2%)
Disability		
Yes	34.3%	(31.1%-37.5%)
No	34.0%	(32.4%-35.6%)
Education		
High School Graduate or Less	30.4%	(27.9%-32.9%)
More Than High School	36.3%	(34.6%-38.1%)

4. Chronic Conditions

Asthma in Adults

Asthma is a chronic lung disease that causes the airways to become inflamed or swollen. Symptoms of asthma include shortness of breath, coughing, and wheezing.[53]

Respondents were asked if a doctor or health professional had ever told them they had asthma, and whether they still had asthma. Results are shown in *Table 33*.

- About 1 in 10 Connecticut adults (9.9%) reported that they currently had asthma.
- Females were significantly more likely to have had asthma (12.6%), compared to males (7%).
- Hispanics were significantly more likely to report that they currently had asthma (14.6%), compared to non-Hispanic Whites (8.9%).
- Adults in the lowest-income category were significantly more likely to report having asthma (16.4%), compared to adults in higher-income categories.
- Over 1 in 6 disabled adults reported having asthma (17.1%), which was significantly higher than the percent for non-disabled adults (8.1%).
- Adults with a high school degree or less were significantly more likely to have had asthma (11.3%), compared to adults with more than a high school education (9.1%).

Table 33: Asthma in Adults by Demographics

	Adults Currently Have Asthma	
Demographic Characteristics	%	95% Confidence Interval
Total	**9.9%**	**(9.0%-10.9%)**
Age		
18-34 years old	11.1%	(8.6%-13.5%)
35-54 years old	10.2%	(8.8%-11.7%)
55 and over years old	8.8%	(7.7%-9.9%)
Gender		
Male	7.0%	(5.8%-8.2%)
Female	12.6%	(11.2%-14.0%)
Race/Ethnicity		
non-Hispanic White	8.9%	(7.9%-9.9%)
non-Hispanic Black/African Am	12.0%	(9.0%-14.9%)
Hispanic/Latino	14.6%	(11.0%-18.2%)
Income		
Less than $35,000	16.4%	(14.1%-18.8%)
$35,000-$74,999	7.6%	(6.2%-8.9%)
$75,000 and more	7.5%	(6.1%-8.9%)
Health Insurance Status		
Insured	10.1%	(9.1%-11.1%)
Not Insured	9.0%	(6.4%-11.6%)
Disability		
Yes	17.1%	(14.8%-19.5%)
No	8.1%	(7.1%-9.1%)
Education		
High School Graduate or Less	11.3%	(9.6%-13.0%)
More Than High School	9.1%	(8.0%-10.1%)

Asthma in Children

While asthma can affect people of all ages, it usually starts during childhood. Of the 25 million Americans who suffer from asthma, 7 million of these are children.[54]

Respondents were asked if the randomly-selected child in the household had ever been diagnosed with asthma and if the child still had asthma. Results are shown in *Table 34*.

- In 2012, 12.1% of Connecticut children had asthma, a higher rate than Connecticut adults (*see page 58*).
- Children aged 12-17 were significantly more likely to be asthmatic (14.7%), relative to children aged 5-11 (12.7%).
- Unlike adults, there were no significant differences in the rates of asthma between males and females.
- Children in the poorest households were significantly more likely to be asthmatic (16.2%), relative to children in the highest income households (9.2%).

Table 34: Asthma in Children by Demographics

	Children Currently Have Asthma	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**12.1%**	**(10.3%-13.9%)**
Child Age		
0-4 years old	*	*
5-11 years old	12.7%	(9.7%-15.7%)
12-17 years old	14.7%	(11.6%-17.7%)
Child Gender		
Male	13.5%	(10.7%-16.2%)
Female	10.8%	(8.6%-13.0%)
Child Race/Ethnicity		
Non-Hispanic White	11.3%	(9.4%-13.3%)
Non-Hispanic Black	*	*
Hispanic/Latino	*	*
Adult Proxy Income		
Less than $35,000	16.2%	(11.7%-20.7%)
$35,000-$74,999	*	*
$75,000+	9.2%	(7.1%-11.3%)
Adult Proxy Education		
High School Graduate or Less	13.9%	(10.1%-17.8%)
More Than High School	11.0%	(9.1%-12.8%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

Chronic Obstructive Pulmonary Disease (COPD)

Chronic Obstructive Pulmonary Disease (COPD) is a lung disease that includes two main conditions: emphysema and chronic bronchitis. The term COPD is used because most sufferers have both conditions. COPD causes irreversible damage to the lungs and airways, which causes less air to flow to the lungs. Symptoms include mucus-heavy coughing, wheezing and shortness of breath. Cigarette smoking is the primary cause of COPD, though other pollutants in the air may also contribute.[55]

Respondents were asked if they were ever told they had COPD, emphysema or chronic bronchitis, and results are shown in *Table 35*.

- In 2012, about 5% of Connecticut adults had been told they had COPD.
- Adults aged 55 and older were significantly more likely to report having been told they had COPD, emphysema or chronic bronchitis (9%), *versus* adults aged 35-54 (4.4%).
- Likelihood of having COPD decreased significantly as incomes rose: adults with incomes less than $35,000 were significantly more likely to have had COPD, emphysema or chronic bronchitis compared to higher-income adults.
- Disabled adults were significantly more likely to have had COPD, emphysema or chronic bronchitis (15.5%) relative to non-disabled adults (2.8%).
- Adults with a high school degree or less were significantly more likely to have had COPD (7.5%), compared to adults with more than a high school education (4.1%).

Table 35: Adults with COPD by Demographics

	Ever Told Had COPD	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**5.4%**	**(4.8%-6.1%)**
Age		
18-34 years old	*	*
35-54 years old	4.4%	(3.5%-5.4%)
55 and over years old	9.0%	(7.9%-10.1%)
Gender		
Male	5.6%	(4.6%-6.5%)
Female	5.3%	(4.6%-6.1%)
Race/Ethnicity		
non-Hispanic White	5.5%	(4.8%-6.2%)
non-Hispanic Black/African Am	*	*
Hispanic/Latino	*	*
Income		
Less than $35,000	9.8%	(8.1%-11.5%)
$35,000-$74,999	5.8%	(4.6%-7.0%)
$75,000 and more	2.2%	(1.6%-2.9%)
Health Insurance Status		
Insured	5.5%	(4.8%-6.1%)
Not Insured	*	*
Disability		
Yes	15.5%	(13.4%-17.7%)
No	2.8%	(2.3%-3.3%)
Education		
High School Graduate or Less	7.5%	(6.3%-8.6%)
More Than High School	4.1%	(3.5%-4.8%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

Arthritis

Arthritis covers over 100 rheumatic conditions that affect the joints and the connective tissues.[56] It is the most common cause of disability in the U.S, and affects 1 in 5 American adults. Arthritis is more common among women, and the risk of developing arthritis symptoms increases with age.[57]

Respondents were asked if they were ever told they had some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia. Results are shown in *Table 36*.

- Almost 1 in 4 Connecticut adults reported being diagnosed with arthritis (24.3%).
- Adults aged 55 and older reported a significantly higher percentage of being diagnosed with arthritis (46.5%) *versus* those aged 35-54 (17.4%).
- Females had a significantly higher frequency of being diagnosed with arthritis (27.3%) *versus* males (21.0%).
- Non-Hispanic white adults had a significantly higher reportage of being diagnosed with arthritis (26.8%) *versus* non-Hispanic Black adults (19.1%), Hispanic adults (17.8%).
- Arthritis levels decreased significantly as incomes rose: adults with incomes less than $35,000 were significantly more likely to report arthritis (31.0%), compared to adults with higher incomes.
- Adults with health care coverage were significantly more likely to have arthritis (25.5%), compared to adults without health insurance (14.3%).
- Disabled adults were significantly more likely to report having arthritis (57.7%) *versus* those who did not report a disability (15.5%). More than half of all disabled adults had arthritis.
- Adults with a high school diploma or less were significantly more likely to have arthritis (28.5%) *versus* adults with more than a high school education (21.3%).

Table 36: Adults with Arthritis by Demographics

	Diagnosed with Arthritis	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**24.3%**	**(23.1%-25.4%)**
Age		
18-34 years old	*	*
35-54 years old	17.4%	(15.6%-19.2%)
55 and over years old	46.5%	(44.6%-48.4%)
Gender		
Male	21.0%	(19.3%-22.6%)
Female	27.3%	(25.7%-28.9%)
Race/Ethnicity		
non-Hispanic White	26.8%	(25.5%-28.1%)
non-Hispanic Black/African Am	19.1%	(15.4%-22.7%)
Hispanic/Latino	17.8%	(14.1%-21.5%)
Income		
Less than $35,000	31.0%	(28.5%-33.6%)
$35,000-$74,999	27.1%	(24.7%-29.5%)
$75,000 and more	17.5%	(15.8%-19.1%)
Health Insurance Status		
Insured	25.5%	(24.3%-26.7%)
Not Insured	14.3%	(11.4%-17.2%)
Disability		
Yes	57.7%	(54.6%-60.8%)
No	15.5%	(14.5%-16.5%)
Education		
High School Graduate or Less	28.5%	(26.4%-30.7%)
More Than High School	21.3%	(20.1%-22.6%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

Cardiovascular Disease

Cardiovascular disease (CVD), commonly known as heart disease, encompasses several heart conditions. It is the leading cause of death for men and women and for people of most racial/ethnic groups in the United States. The most common heart disease is coronary heart disease.[58] Adults who suffer from coronary heart disease have plaque build-up in their coronary arteries, which reduces the flow of oxygen to the heart. This can lead to angina, characterized by chest pain or pressure, as well as heart attacks.[59]

Respondents were asked if they were ever told they had the following: a heart attack, also called a myocardial infarction; angina or coronary heart disease; a stroke. Results were combined and are presented in *Table 37* among those who responded to all three questions.

- In 2012, 7.1% of Connecticut adults had ever been told they had a heart attack, coronary heart disease, or stroke.
- Adults aged 55 and over were significantly more likely to have CVD (15.2%), compared to adults aged 35-54 (3.6%).
- Men were significantly more likely to be told they had CVD (9%) compared to women (5.3%).
- Adults with incomes of $75,000 or more were significantly less likely to have been told they had CVD (4.3%) than those with incomes between $35,000 and $74,999 (7.7%) or those with incomes less than $35,000 (9.3%).
- Adults who reported having a disability were significantly more likely to report having had a form of CVD (17.7%) compared to non-disabled adults (4.3%).
- Adults with a high school diploma or less were significantly more likely to report having CVD than those with more than a high school education (8.8% *versus* 6%).

Table 37: Adults with any Type of Cardiovascular Disease by Demographics

	At least one of Heart Attack, Coronary Heart Disease, Stroke	
Demographic Characteristics	%	95% Confidence Interval
Total	**7.1%**	**(6.4%-7.7%)**
Age		
18-34 years old	*	*
35-54 years old	3.6%	(2.7%-4.5%)
55 and over years old	15.2%	(13.8%-16.5%)
Gender		
Male	9.0%	(7.9%-10.1%)
Female	5.3%	(4.6%-6.0%)
Race/Ethnicity		
non-Hispanic White	7.6%	(6.8%-8.3%)
non-Hispanic Black/African Am	*	*
Hispanic/Latino	*	*
Income		
Less than $35,000	9.3%	(8.0%-10.6%)
$35,000-$74,999	7.7%	(6.4%-9.0%)
$75,000 and more	4.3%	(3.4%-5.2%)
Health Insurance Status		
Insured	7.5%	(6.8%-8.2%)
Not Insured	*	*
Disability		
Yes	17.7%	(15.5%-19.8%)
No	4.3%	(3.7%-4.8%)
Education		
High School Graduate or Less	8.8%	(7.6%-10.0%)
More Than High School	6.0%	(5.3%-6.7%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

Cancer

After heart disease, cancer is the second leading cause of death among Americans. More than 500,000 Americans die every year from cancer.[60] Skin cancer is the most common cancer in the U.S.; its deadliest form, melanoma, can be caused by exposure to ultraviolet light.[61]

BRFSS respondents were asked if they were ever told they had skin cancer or any other type of cancer.

- In 2012, 11.3% of Connecticut adults had ever been told they had any type of cancer.
- Adults aged 55 and older were significantly more likely to have been told they had cancer (23.3%) than adults aged 35-54 (7.3%).
- Women were significantly more likely to have been told they had cancer (12.3%) compared to men (10.3%).
- Adults with incomes of at least $75,000 were significantly less likely to have been told they had cancer (9.9%) than adults with incomes between $35,000 and $74,999 (12.6%) or less than $35,000 (12.1%).
- Adults who reported having a disability were significantly more likely to have been told they have cancer (18.9%) relative to adults without disabilities (9.4%).
- Among adults who had been told they had cancer, almost 2 in 5 had skin cancer only (39.1%), half had another cancer only (50.5%), and 1 in 10 had both skin cancer and another cancer (10.4%).

Figure 13: Prevalence of Skin and Other Cancers, Connecticut 2012

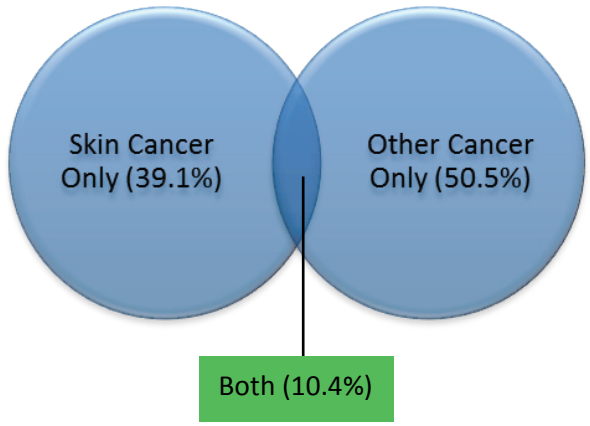


Table 38: Adults with Cancer by Demographics

	Ever Told Had Cancer	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**11.3%**	**(10.6%-12.1%)**
Age		
18-34 years old	*	*
35-54 years old	7.3%	(6.1%-8.5%)
55 and over years old	23.3%	(21.7%-24.9%)
Gender		
Male	10.3%	(9.1%-11.4%)
Female	12.3%	(11.3%-13.4%)
Race/Ethnicity		
non-Hispanic White	13.7%	(12.8%-14.7%)
non-Hispanic Black/African Am	*	*
Hispanic/Latino	*	*
Income		
Less than $35,000	12.1%	(10.5%-13.7%)
$35,000-$74,999	12.6%	(10.9%-14.3%)
$75,000 and more	9.9%	(8.7%-11.1%)
Health Insurance Status		
Insured	12.3%	(11.5%-13.2%)
Not Insured	*	*
Disability		
Yes	18.9%	(16.8%-21.1%)
No	9.4%	(8.6%-10.2%)
Education		
High School Graduate or Less	11.0%	(9.7%-12.4%)
More Than High School	11.6%	(10.7%-12.5%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

Pre-diabetes

Pre-diabetes refers to blood sugar levels that are higher than normal but not high enough to be diagnosed with diabetes. Adults with pre-diabetes are at-risk for developing Type 2 diabetes, heart disease and stroke.[62] Respondents were asked if they had ever been told they had pre-diabetes or borderline diabetes. Women with pre-diabetes only during pregnancy were not considered to have had pre-diabetes. Results are shown in *Table 39*.

- In 2012, 7.2% of Connecticut adults reported having been diagnosed with pre-diabetes.
- Adults aged 55 and over were significantly more likely (12.4%) than adults aged 35-54 (5.5%) to have been told they had pre-diabetes.
- Adults with incomes below $35,000 were significantly more likely (8.9%) to have been told they had pre-diabetes than adults with incomes of $75,000 or more (6.2%).
- Adults who reported having a disability were significantly more likely to have been diagnosed with pre-diabetes (12.7%) than adults without disabilities (5.8%).

Table 39: Adults with Prediabetes by Demographics

	Ever Told Had Pre-diabetes	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**7.2%**	**(6.4%-7.9%)**
Age		
18-34 years old	*	*
35-54 years old	5.5%	(4.4%-6.6%)
55 and over years old	12.4%	(11.0%-13.8%)
Gender		
Male	7.0%	(5.8%-8.1%)
Female	7.3%	(6.4%-8.3%)
Race/Ethnicity		
non-Hispanic White	7.0%	(6.2%-7.7%)
non-Hispanic Black/African Am	*	*
Hispanic/Latino	*	*
Income		
Less than $35,000	8.9%	(7.1%-10.8%)
$35,000-$74,999	7.8%	(6.1%-9.5%)
$75,000 and more	6.2%	(5.2%-7.3%)
Health Insurance Status		
Insured	7.4%	(6.6%-8.2%)
Not Insured	*	*
Disability		
Yes	12.7%	(10.5%-14.9%)
No	5.8%	(5.1%-6.6%)
Education		
High School Graduate or Less	8.3%	(6.8%-9.8%)
More Than High School	6.4%	(5.6%-7.3%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

Diabetes

Diabetes is a disease characterized by high levels of blood sugar. It can lead to serious health problems, such as heart disease and stroke.[63] BRFSS respondents were asked if they had ever been told they had diabetes. Women with diabetes only during pregnancy were not considered to have had pre-diabetes. Results are shown in *Table 40*.

- In 2012, 9.1% of Connecticut adults had been diagnosed with diabetes.
- Adults aged 55 and over were significantly more likely to have been diagnosed with diabetes (17.1%) than adults aged 35-54 (6.7%).
- Men were significantly more likely to have been diagnosed with diabetes (10.8%) than women (7.6%).
- Adults with incomes of at least $75,000 were significantly less likely to have been told they had diabetes (5.3%) than middle-income adults (10.6%) or low-income adults (12.6%).
- Adults with disabilities were significantly more likely to report diabetes (19.1%) than adults without disabilities (6.6%).
- Adults with a high school degree or less were significantly more likely to have been told they had diabetes (12.5%) compared to adults with more than a high school education (7.0%).
- Diabetics were asked a series of questions on how they manage their diabetes day to day. A majority of diabetics (69.2%) stated that they were currently taking insulin, while only about half of diabetics had taken a course or class on how to manage their diabetes themselves (50.4%).

Figure 14: Managing Diabetes, Connecticut 2012

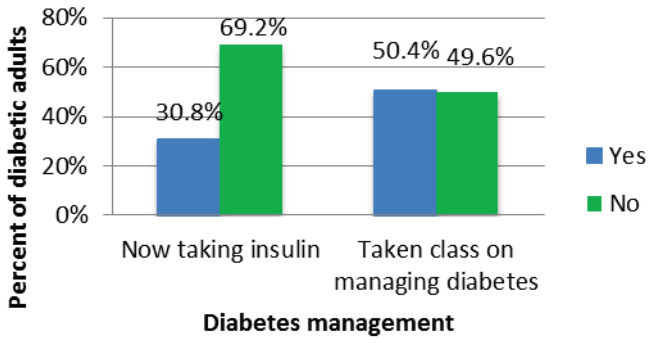


Table 40: Adults with Diabetes by Demographics

	Ever Told Had Diabetes	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**9.1%**	**(8.3%-10.0%)**
Age		
18-34 years old	*	*
35-54 years old	6.7%	(5.2%-8.1%)
55 and over years old	17.1%	(15.6%-18.6%)
Gender		
Male	10.8%	(9.3%-12.2%)
Female	7.6%	(6.8%-8.5%)
Race/Ethnicity		
non-Hispanic White	8.3%	(7.5%-9.1%)
non-Hispanic Black/African Am	*	*
Hispanic/Latino	11.5%	(8.1%-14.8%)
Income		
Less than $35,000	12.6%	(10.8%-14.3%)
$35,000-$74,999	10.6%	(8.7%-12.5%)
$75,000 and more	5.3%	(4.1%-6.4%)
Health Insurance Status		
Insured	9.4%	(8.5%-10.3%)
Not Insured	7.4%	(5.3%-9.6%)
Disability		
Yes	19.1%	(16.6%-21.5%)
No	6.6%	(5.8%-7.4%)
Education		
High School Graduate or Less	12.5%	(10.8%-14.2%)
More Than High School	7.0%	(6.1%-7.8%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

Kidney Disease

Chronic Kidney Disease (CKD) is a condition in which the kidneys cannot filter blood as well as they should, and so wastes are not properly filtered. A person with kidney disease is more likely to develop heart disease and other health problems. Adults with diabetes or high blood pressure are at higher risk of developing CKD.[64]

Respondents were asked if they were ever told they had kidney disease. Results are shown in *Table 41*.

- In 2012, 2.3% of Connecticut adults had been told they had kidney disease.
- Adults with a disability were significantly more likely to have been told they have had kidney disease (5.8%) than adults without disabilities (1.4%).
- Adults with a high school degree or less were significantly more likely to have been told they had kidney disease (3.1%) compared to adults with more than a high school education (1.8%).

Figure 15: Prevalence of Kidney Disease, Connecticut 2012

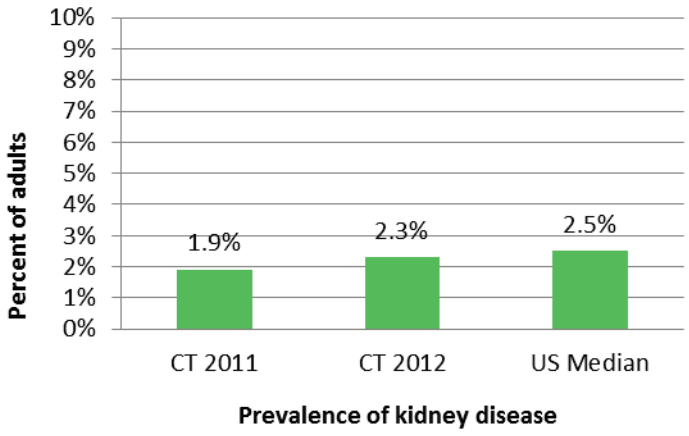


Table 41: Adults with Kidney Disease by Demographics

	Ever Told Had Kidney Disease	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**2.3%**	**(1.9%-2.7%)**
Age		
18-34 years old	*	*
35-54 years old	*	*
55 and over years old	4.1%	(3.3%-4.9%)
Gender		
Male	2.3%	(1.7%-2.9%)
Female	2.2%	(1.7%-2.7%)
Race/Ethnicity		
non-Hispanic White	2.4%	(1.9%-2.8%)
non-Hispanic Black/African Am	*	*
Hispanic/Latino	*	*
Income		
Less than $35,000	3.7%	(2.7%-4.7%)
$35,000-$74,999	*	*
$75,000 and more	*	*
Health Insurance Status		
Insured	2.3%	(1.9%-2.7%)
Not Insured	*	*
Disability		
Yes	5.8%	(4.4%-7.1%)
No	1.4%	(1.0%-1.7%)
Education		
High School Graduate or Less	3.1%	(2.3%-3.8%)
More Than High School	1.8%	(1.4%-2.2%)

Estimates marked with a "" are not reported because their coefficients of variation are greater than 15%.*

Depression

Depression is a common and serious illness that can take several forms. Symptoms include persistent feelings of sadness, anxiety, "emptiness," hopelessness as well as fatigue, irritability and restlessness. Depressive disorders may interfere with a person's work and daily activities and prevent them from functioning normally. Some forms of depression develop under unique circumstances; others occur in episodes or may be longer-term.[65]

Respondents were asked if they were ever told they had a depressive disorder, including depression, major depression, dysthymia, or minor depression. Results are shown in *Table 42*.

- In 2012, 1 in 6 Connecticut adults (16.7%) reported having been told they had a depressive disorder.
- Women were significantly more likely to have been told they had a depressive disorder (19.0%) compared to men (14.2%).
- Hispanic adults (23.8%) were significantly more likely than either non-Hispanic White adults (16.5%) or non-Hispanic Black adults (12.5%) to have been told they had a depressive disorder. Non-Hispanic White adults were also significantly more likely than non-Hispanic Black adults to have been told they had a depressive disorder.
- The likelihood of having been diagnosed with a depressive disorder decreased significantly for each increase in income range.
- Adults with a disability were significantly more likely to have been diagnosed with a depressive order (34.2%) than adults without a disability (12.0%).

Table 42: Adults with Depression by Demographics

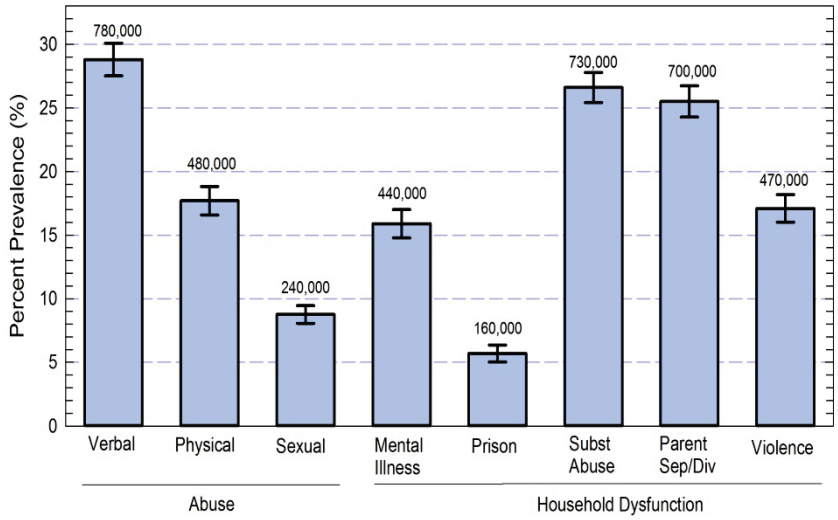
	Ever Told Had Depressive Disorder	
Demographic Characteristics	**%**	**95% Confidence Interval**
Total	**16.7%**	**(15.6%-17.8%)**
Age		
18-34 years old	16.8%	(14.0%-19.6%)
35-54 years old	18.0%	(16.3%-19.8%)
55 and over years old	15.5%	(14.1%-16.8%)
Gender		
Male	14.2%	(12.6%-15.9%)
Female	19.0%	(17.5%-20.4%)
Race/Ethnicity		
non-Hispanic White	16.5%	(15.3%-17.7%)
non-Hispanic Black/African Am	12.5%	(9.1%-15.9%)
Hispanic/Latino	23.8%	(19.3%-28.3%)
Income		
Less than $35,000	22.9%	(20.5%-25.3%)
$35,000-$74,999	17.0%	(14.8%-19.3%)
$75,000 and more	12.3%	(10.7%-13.9%)
Health Insurance Status		
Insured	16.7%	(15.5%-17.8%)
Not Insured	17.4%	(14.1%-20.7%)
Disability		
Yes	34.2%	(31.2%-37.2%)
No	12.0%	(10.9%-13.1%)
Education		
High School Graduate or Less	18.1%	(16.2%-20.0%)
More Than High School	15.8%	(14.5%-17.1%)

5. Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are experiences typically reported among adults when they were children less than 18 years of age.[66] There are a total of eight ACEs grouped into two types: Abuse, which includes verbal, physical, and sexual abuse; and Household Dysfunction, which is witnessed as a child and includes mental illness, incarceration, substance abuse, parental separation/divorce, and domestic violence.

Estimates of ACEs in Connecticut were obtained using previously published methods.[67] A total of 2,481 responses from the 2012 BRFSS were recorded to the ACEs questions.

Figure 16: Types of Adverse Childhood Experience (ACE), Connecticut 2012



Weighted frequency of each type of ACE in the population of adult Connecticut residents is shown above the bars, assuming a statewide adult population of 2.8 million.

Types of ACEs in Connecticut

The percent prevalence of the most commonly reported ACEs were:

- Verbal abuse (28.8%) affecting 780,000 residents;
- Substance abuse in the household (26.6%), affecting 730,000 residents;
- Parental separation/divorce (25.5%), affecting 700,000 residents; and
- Physical abuse (17.7%), affecting 480,000 residents.

The percent prevalence of household dysfunction during childhood was 52.6%, affecting 1.4 million adult residents. The percent prevalence of abuse during childhood was 36.6%, affecting nearly one million adult residents.

Table 43: Characteristics of at Least One Adverse Childhood Experience by Demographics

	Percent Prevalence			Percent Prevalence			Percent Prevalence	
Characteristic	**(%)**	**95% Confidence Interval**	**Characteristic**	**(%)**	**95% Confidence Interval**	**Characteristic**	**(%)**	**95% Confidence Interval**
Housing Arrangement			Sex			Age Group		
Own	56.9	53.7-60.1	Male	63.0	58.8-67.1	18-24 years old	61.8	49.3-74.4
Rent	73.2	68.3-78.2	Female	59.3	55.8-62.7	25-34 years old	72.0	64.4-79.5
						35-54 years old	67.3	63.2-71.4
Education			Race /Ethnicity			55 and over years old	51.6	48.1-55.0
Less than HS degree	72.1	62.7-81.6	Non-Hispanic White/Caucasian	58.8	55.9-61-7			
HS Degree	60.5	54.9-66.1	Non-Hisp Black/Afr Am/Other/Multi	72.3	62.1-82.5			
More than HS	59.6	56.4-62.8	Hispanic/Latino	74.8	66.0-83.7			

Among adults in Connecticut with at least one ACE, the percent prevalence was significantly higher among those who: 1) Lived in rental housing or other housing situations, compared to those who own their owned homes; 2) Were 25-34 years of age, compared to those who were at least 55 years of age; and 3) Were of minority race/ethnicity, compared to those who were non-Hispanic White/Caucasian.

Adults in Connecticut who during childhood experienced verbal abuse were more likely to have also experienced:

- Substance abuse in the household (13.5%);
- Physical abuse (13.4%);
- Household domestic violence (11.0%);
- Divorce/separation in the household (10.3%);
- Mental illness in the household (10.0%).

The percent prevalence of adults in Connecticut who experienced 5-8 ACEs in childhood is highest among those who experienced incarceration (40.2%) or domestic violence (35.0%) in the household, or who experienced sexual abuse (34.8%).

Number of ACEs in Connecticut

The percent prevalence of at least one ACE during childhood among adults in Connecticut, whether abuse or household dysfunction, was 61%, affecting 1.6 million residents.

Among adults in Connecticut, 7.6% had at least five of eight ACEs during childhood, affecting 200,000 adult residents. In *Figure 17*, weighted frequency estimates among adults in CT are shown in parentheses.

Figure 17: Prevalence of at Least one ACE, Connecticut 2012

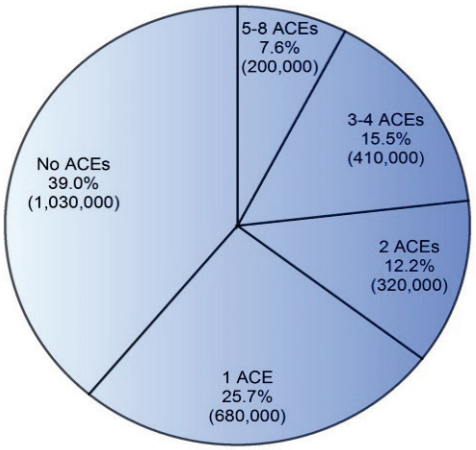
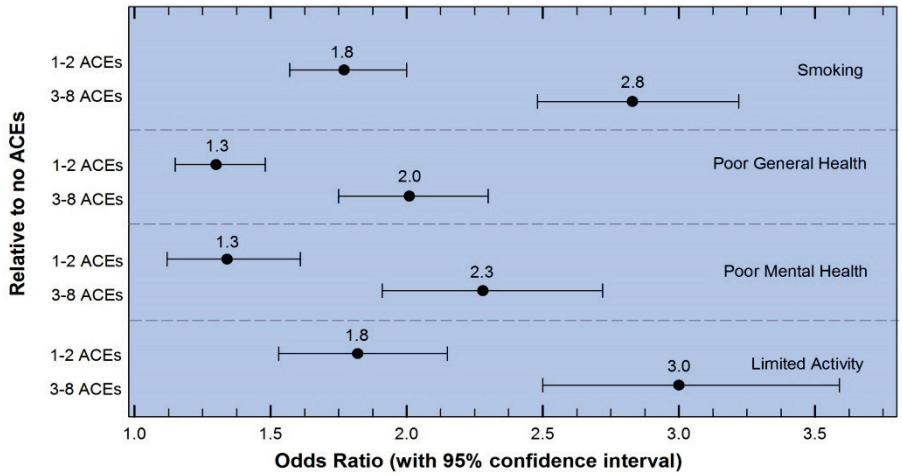


Figure 18: Number of ACEs and Health Outcomes/Risk Behaviors, Connecticut 2012



Association between Number of ACEs and Adult Health Outcomes

In an analysis of ACE data from six states including Connecticut, adverse childhood experiences (ACEs) were associated with risk behaviors and poor health outcomes in adulthood.[68] The strongest correlation between ACEs and adverse events in adulthood were smoking behavior and poor general health, poor mental health, and limited activity that results from poor mental or physical health. Smoking behavior, which is also a risk factor for poor health outcomes, was a controlled covariate in the analysis of poor health outcomes. The data indicate that, whereas 1-2 ACEs was associated with a mild yet significant increased likelihood of adult risk behaviors and poor health outcomes, a larger number of ACEs was associated with a stronger risk of both smoking behavior and poor health outcomes.

Compared to no ACEs, adults with 3-8 ACEs in Connecticut and five other states combined were:

- 3.0 (95% CI: 2.5, 3.6) times more likely to report limited activity, such as self-care, work, or recreation, due to poor health;
- 2.8 (95% CI: 2.5, 3.2) times more likely to smoke;
- 2.3 (95% CI: 1.9, 2.7) times more likely to report poor mental health; and
- 2.0 (95% CI: 1.7, 2.3) times more likely to report poor general health.

These risks for adults with 3-8 ACES were also significantly higher compared to adults with 1-2 ACEs ($p < 0.05$).

These findings have implications for state and local programs that serve adults and children. The demographic of families at risk for poor outcomes includes those whose adults and children have a high number of ACEs. Indicators of poor family outcomes and ACEs were similar, and include families of low income, families with a high school education or less, and families of minority race/ethnicity.

Endnotes

[1] DeSalvo, Karen B. MD, MPH, MSc., et al. "Mortality Prediction with a Single General Self-Rated Health Question". *Journal of General Internal Medicine.* 21.3. (March 2006): 267-75. http://onlinelibrary.wiley.com/doi/10.1111/j.1525-1497.2005.00291.x/full

[2] Centers for Disease Control and Prevention. "Measuring Healthy Days: Population Assessment of Health-Related Quality of Life". November 2000. http://www.cdc.gov/hrqol/pdfs/mhd.pdf

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

[4] National Heart, Blood and Lung Institute. "Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report." *Obesity Education Initiative*. NIH Publication No. 98-4083. (September, 2008). http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf

[5] Centers for Disease Control and Prevention. "Adult Overweight and Obesity: Causes and Consequences". 27 April 2012. http://www.cdc.gov/obesity/adult/causes/index.html; NHLBI, "Clinical Guidelines."

[6] Child BMI were compared against CDC growth charts. For overview of SAS code used to compute child weight status, see: http://www.cdc.gov/nccdphp/dnpao/growthcharts/resources/sas.htm

[7] Centers for Disease Control and Prevention. "Basics About Childhood Obesity." 27 Apr. 2012. http://www.cdc.gov/obesity/childhood/basics.html; Barlow, Sarah E. "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report". *American Academy of Pediatrics.*120.S164: (2007) http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full.html

[8] CDC. "Basics About Childhood Obesity."

[9] Dorn, Stan. "Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality". *Urban Institute.* January 2008. http://www.urban.org/UploadedPDF/411588_uninsured_dying.pdf; Marwick, Charles. "For the Uninsured, Health Problems Are More Serious". *Journal of the National Cancer Institute.* 94.13. (2002): 967-968. http://jnci.oxfordjournals.org/content/94/13/967.full; Wilper, Andrew P., et al. "Health Insurance and Mortality in US Adults". *American Journal of Public Health.* 99.12. (December 2009): 2289-2295. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2775760/

[10] Gutkin, Cal. "Outliers: extended families, better health outcomes. Why everyone should have a family doctor". *Canadian Family Physician.* 55.7. 768: (July 2009). http://www.cfp.ca/content/55/7/768.full

[11] Centers for Disease Control and Prevention. "Falls Among Older Adults: An Overview". 20 September 2013. http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html

[12] Centers for Disease Control and Prevention. "Vision Health Initiative (VHI): Fast Facts". 5 November 2009. http://www.cdc.gov/visionhealth/basic_information/fast_facts.htm

[13] Centers for Disease Control and Prevention. "Cognitive Impairment: A Call for Action, Now!" February 2011. http://www.cdc.gov/aging/pdf/cognitive_impairment/cogimp_poilicy_final.pdf

[14] Warburton, Darren E., Crystal Whitney Nichol, Shannon S.D. Bredin. "Health benefits of physical activity: the evidence". *Canadian Medical Association Journal.*174.6. 801-809: (14 March 2006). http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1402378/

[15] Moreno, Megan A. MD, MSEd, MPH, et al. "Reducing Screen Time for Children". *Journal of the American Medical Association: Pediatrics.* 165.11. (November 2011) http://archpedi.jamanetwork.com/article.aspx?articleid=1107620; American Academy of Pediatrics. "Media and Children." http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/pages/media-and-children.aspx

[16] Ludwig, David S., Karen E. Peterson, Steven L. Gortmaker. "Relation between consumption of sugar-sweetened drinks and childhood obesity: a prospective, observational analysis". *Lancet.* 357. 505-8.: (2001) http://www.commercialalert.org/candp/lancet.pdf

[17] Powell, LM, BT Nguyen. "Fast-food and full-service restaurant consumption among children and adolescents: effect on energy, beverage and nutrient intake". *Journal of the American Medical Association: Pediatrics.* 167.1. 14-20: (January 2013) http://www.ncbi.nlm.nih.gov/pubmed/23128151

[18] Centers for Disease Control and Prevention. "Health Effects of Cigarette Smoking". 6 February 2014. http://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/

[19] Schivo, M., MV Advalovic, S. Murin. "Non-cigarette tobacco and the lung". *The Journal of Allergy and Clinical Immunology.* 46.1. 34-53: (February 2014). http://www.ncbi.nlm.nih.gov/pubmed/23673789

[20] American Society of Clinical Oncology. "Health Risks of Waterpipes, Smokeless Tobacco, and E-cigarettes". http://www.cancer.net/navigating-cancer-care/prevention-and-healthy-living/tobacco-use/health-risks-waterpipes-smokeless-tobacco-and-e-cigarettes

[21] Centers for Disease Control and Prevention. "Alcohol and Public Health: Frequently Asked Questions". 31 July 2013. http://www.cdc.gov/alcohol/faqs.htm

[22] National Institute on Alcohol Abuse and Alcoholism. "Moderate & Binge Drinking". http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking

[23] Centers for Disease Control and Prevention. "Fact Sheets- Binge Drinking". 7 Nov. 2012. http://www.cdc.gov/alcohol/fact-sheets/binge-drinking.htm

[24] Centers for Disease Control and Prevention. "Fact Sheets- Alcohol Use and Health". 26 December 2013. http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm

[25] Centers for Disease Control and Prevention. "Seat Belts Fact Sheet". 4 January 2011. http://www.cdc.gov/motorvehiclesafety/seatbelts/facts.html#howbig

[26] Connecticut Department of Public Health. "If I Catch It, Can I Eat It? A Guide to Eating Fish Safely". 2013. http://www.ct.gov/dph/lib/dph/environmental_health/eoha/pdf/ificatchit_2012_english.pdf

[27] Consumer Product Safety Commission. "Carbon Monoxide Questions and Answers". http://www.cpsc.gov/en/Safety-Education/Safety-Education-Centers/Carbon-Monoxide-Information-Center/Carbon-Monoxide-Questions-and-Answers-/

[28] Centers for Disease Control and Prevention. "Carbon Monoxide Poisoning". http://www.cdc.gov/co/pdfs/flyer_danger.pdf; CPSC, "Carbon Monoxide Questions and Answers".

[29] Centers for Disease Control and Prevention. "When The Power Goes Out, Keep Your Generator Outside". http://www.cdc.gov/co/pdfs/generators.pdf ; Wang, Liangzhu, Steven J. Emmerich, Ryan Powell. "Modeling the Effects of Outdoor Gasoline Powered Generator Use on Indoor Carbon Monoxide Exposures – Phase II". *National Institute of Standards and Technology*. NIST Technical Note 1666. http://www.cdc.gov/co/pdfs/cdc_phaseii_tn1666.pdf

[30] Centers for Disease Control and Prevention, "Regular Check-Ups are Important". 2 Feb. 2014. http://www.cdc.gov/family/checkup/

[31] Centers for Disease Control and Prevention, "General Information About Breast Cancer." 3 Dec. 2013. http://www.cancer.gov/cancertopics/pdq/screening/breast/Patient/page2

[32] National Cancer Institute. "Mammograms Fact Sheet". 24 July 2012. http://www.cancer.gov/cancertopics/factsheet/Detection/mammograms#r1

[33] Centers for Disease Control and Prevention. "Cervical Cancer Screening". 28 January 2014. http://www.cdc.gov/cancer/cervical/basic_info/screening.htm

[34] Centers for Disease Control and Prevention. "Cervical Cancer". 28 January 2014. http://www.cdc.gov/cancer/cervical/

[35] Moyer, Virginia A., MD, MPH. "Screening for Cervical Cancer: U.S. Preventive Services Task Force Recommendation Statement". *Annals of Internal Medicine.* 156.12. 880-891: (19 June 2012). http://annals.org/article.aspx?articleid=1183214

[36] Centers for Disease Control and Prevention. "Prostate Cancer: What Screening Tests Are There?" 4 December 2013. http://www.cdc.gov/cancer/prostate/basic_info/screening.htm

[37] National Cancer Institute. "Prostate-Specific Antigen (PSA) Test". 24 July 2012. http://www.cancer.gov/cancertopics/factsheet/detection/PSA

[38] U.S. Preventive Services Task Force. "Screening for Colorectal Cancer: Recommendation Statement". October 2008. http://www.uspreventiveservicestaskforce.org/uspstf08/colocancer/colors.htm

[39] Centers for Disease Control and Prevention. "'Colorectal Cancer Screening: It's The Right Choice' Infographic". 3 December 2013. http://www.cdc.gov/cancer/colorectal/basic_info/screening/infographic.htm

[40] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*, Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

[41] Centers for Disease Control and Prevention. "Children's Oral Health". 10 September 2013. http://www.cdc.gov/OralHealth/children_adults/child.htm

[42] Mullen, Jewel, M.D., M.P.H., M.P.A. "Oral Health in Connecticut", *Connecticut Department of Public Health.* December 2013. http://www.ct.gov/dph/lib/dph/oral_health/pdf/final_oral_health_burden_report_2013.pdf

[43] National Children's Oral Health Foundation. "Facts About Tooth Decay". http://www.ncohf.org/resources/tooth-decay-facts

[44] American Academy of Pediatric Dentistry. "Frequently Asked Questions". http://www.aapd.org/resources/frequently_asked_questions/#36

[45] Centers for Disease Control and Prevention. "Key Facts About Seasonal Flu Vaccine". 7 November 2013. http://www.cdc.gov/flu/protect/keyfacts.htm

[46] Centers for Disease Control and Prevention. "Vaccines and Preventable Diseases: Pneumococcal Vaccination". 7 June 2013. http://www.cdc.gov/VACCINES/vpd-vac/pneumo/default.htm#vacc

[47] Centers for Disease Control and Prevention. "Vaccines and Preventable Diseases: Shingles Vaccination: What You Need To Know". 8 November 2013. http://www.cdc.gov/vaccines/vpd-vac/shingles/vacc-need-know.htm

[48] U.S. Department of Health and Human Services. "Who's At Risk: Children and Infants". http://www.flu.gov/at-risk/children/

[49] Centers for Disease Control and Prevention. "Genital HPV Infection –Fact Sheet". 14 February 2013. http://www.cdc.gov/std/hpv/stdfact-hpv.htm

[50] Centers for Disease Control and Prevention. "HPV Vaccines". 5 February 2013. http://www.cdc.gov/hpv/vaccine.html

[51] Centers for Disease Control and Prevention. "Human Papillomavirus. Epidemiology and Prevention of Vaccine-Preventable Diseases". *The Pink Book: Course Textbook – 12th Edition Second Printing. (*May 2012).http://www.cdc.gov/vaccines/pubs/pinkbook/hpv.html

[52] U.S. Department of Health and Human Services. "HIV In the United States: At A Glance." 6 June 2012. http://aids.gov/hiv-aids-basics/hiv-aids-101/statistics/#ref2

[53] National Heart, Lung and Blood Institute. "What Is Asthma?" 5 June 2012. http://www.nhlbi.nih.gov/health/health-topics/topics/asthma/

[54]National Heart, Lung and Blood Institute. "What Is Asthma?" 5 June 2012. http://www.nhlbi.nih.gov/health/health-topics/topics/asthma/

[55]National Heart, Lung and Blood Institute. "What Is COPD?" 5 June 2012. http://www.nhlbi.nih.gov/health/health-topics/topics/copd/

[56] Centers for Disease Control and Prevention.
Arthritis Basics". 1 August 2011. http://www.cdc.gov/arthritis/basics.htm

[57] Centers for Disease Control and Prevention. "Quick Stats on Arthritis". 1 August 2011. http://www.cdc.gov/arthritis/media/quickstats.htm

[58] Centers for Disease Control and Prevention. "Heart Disease Fact Sheet". http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/docs/fs_heart_disease.pdf

[59] National Heart, Lung and Blood Institute. "What Is Coronary Heart Disease?" 31 August 2012. http://www.nhlbi.nih.gov/health/health-topics/topics/cad/

[60] Centers for Disease Control and Prevention. "Cancer Statistics by Cancer Type". 25 September 2013. http://www.cdc.gov/cancer/dcpc/data/types.htm

[61] Centers for Disease Control and Prevention. "What Is Skin Cancer?" 19 February 2014. http://www.cdc.gov/cancer/skin/basic_info/what-is-skin-cancer.htm

[62] National Diabetes Information Clearinghouse. "Prediabetes: What You Need to Know". 24 July 2013. http://diabetes.niddk.nih.gov/dm/pubs/prediabetes_ES/

[63] Centers for Disease Control and Prevention. "Diabetes Report Card 2012: National and State Profile of Diabetes and Its Complications". 13 February 2014. http://www.cdc.gov/diabetes/pubs/reportcard/diabetes-overview.htm

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

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

[66] Connecticut Department of Public Health. "Adverse Childhood Experiences in Connecticut." Spring 2013. http://www.ct.gov/dph/lib/dph/hisr/pdf/ACEs_Factsheet_CTBRFSS_July_2013.pdf

[67] Bynum, L, et al. "Adverse childhood experiences reported by adults—Five states, 2009". *Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report 59(49):1609-1613*. (December 17 2010). http://www.cdc.gov/mmwr/pdf/wk/mm5949.pdf

[68] Stone, C (2013) Association Between Number of Adverse Events in Childhood and Adult Risk Behaviors and Poor Health Outcomes, Connecticut Department of Public Health, Hartford, Connecticut. http://www.ct.gov/dph/lib/dph/hisr/pdf/ACEs_Risk_Outcomes_BRFSS_July_2013.pdf

Connecticut Department of Public Health
410 Capitol Avenue,
PO Box 340308, Hartford, CT 06134
www.ct.gov/dph/BRFSS