Greater Bridgeport, CT Community Health Assessment

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Submitted to:

The Primary Care Action Group

Health Resources in Action
Advancing Public Health and Medical Research

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OVERVIEW AND ACKNOWLEDGEMENTS

Over an eight month period from June 2012 to February 2013, the Primary Care Action Group (membership list on next page) led a process to assess the health needs of the greater Bridgeport community. The towns included in the assessment included Bridgeport, Easton, Fairfield, Monroe, Trumbull, and Stratford. The overall goal of the initiative was to conduct a comprehensive health planning effort to measurably improve the health of Greater Bridgeport, CT residents.

The Healthy People 2020 indicators were used as the framework of our work. The planning began in June, and over the summer of 2012, with the help of three dedicated student interns: Kelly Foss, Yale School of Public Health), Thomas Gaudett (Harvard University), and Carolyn Addorisio (Southern Connecticut State University), secondary data for the 26 Healthy People 2020 goals were collected and analyzed for each of the towns and compared to state and national benchmarks. A demographic profile was also developed for each town, and a list of community assets was compiled for use in asset mapping.

In September 2012, Health Resources in Action (HRiA), a non-profit public health consulting organization from Boston, MA, was engaged by the Primary Care Action Group to assist with additional quantitative and qualitative research to enhance the data and collect input from key stakeholders in the community. A quantitative survey that explored key health concerns, behaviors, and priorities for services and programming was developed and administered to 1,302 individuals throughout the six towns, and over 200 key stakeholders were surveyed through either one on-one interviews or focus groups.

The results of this research were reviewed publicly on February 26, 2013, and based on input from the Primary Care Action Group members and the community at large, four key health priorities were selected for action planning at a regional level. These issues are:

- Obesity (healthy eating and physical activity)
- Heart Disease and Diabetes
- Mental Health/Substance Abuse
- Access to Health Care

Additional action planning may occur at a city/town level on other health priorities that were identified through this work.

This report has been produced for the benefit of the greater Bridgeport community for use in health and social planning. Next steps for this work include the development of a Community Health Improvement Plan (CHIP), which is occurring during March and April 2013. That plan will be developed by the community and will be available to the public in the summer of 2013.

Primary Care Action Group members:

- St. Vincent's Medical Center
- Bridgeport Hospital
- Optimus Healthcare
- Southwest Community Health Center
- City of Bridgeport Department of Health and Social Services
- Stratford Health Department
- Fairfield Health Department
- Trumbull/Monroe Health District
- Easton Health Department
- AmeriCares Free Clinic of Bridgeport, LLC

- Connecticut Department of Social Services
- Connecticut Department of Mental Health and Addiction Services
- Greater Bridgeport Medical Association
- Southwestern Area Health Education Center
- Bridgeport Child Advocacy Coalition

EXECUTIVE SUMMARY

Introduction

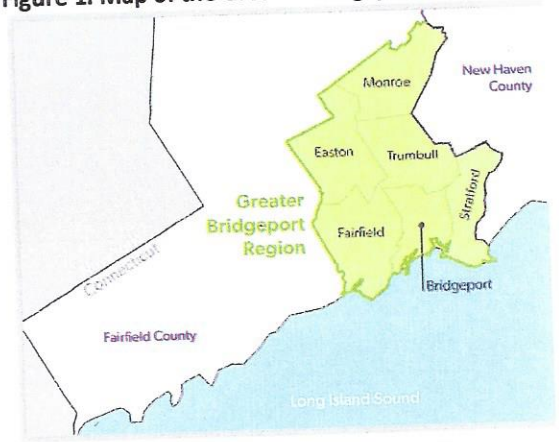
Understanding the current health status of the community is important in order to identify priorities for future planning and funding, the existing strengths and assets on which to build upon, and areas for further collaboration and coordination across organizations, institutions, and community groups. To this end, the Primary Care Action Group (PCAG)—a coalition of hospitals, departments of public health, federally qualified health centers, and numerous community and not-profit organizations serving the Greater Bridgeport, CT area—is leading a comprehensive regional health planning effort comprised of two phases:

- Community Health Assessment (CHA) – identifies the health-related needs and community strengths in the Greater Bridgeport area (Figure 1)
- Community Health Improvement Plan (CHIP) – determines the key health priorities, overarching goals, and specific strategies to implement across the service area

This report details the findings of the community health assessment conducted from September 2012 – January 2013 to achieve the following goals:

1. To examine the current health status of the Greater Bridgeport region (comprised of Bridgeport, Stratford, Fairfield, Trumbull, Monroe, and Easton) and compare these rates to state indicators as well as to national goals;
2. To explore the current health priorities—as well as new and emerging health concerns—among residents within the social context of their communities; and
3. To identify community strengths, resources, and gaps in services in order to help the PCAG and community members set programming, funding, and policy priorities.

Figure 1: Map of the Greater Bridgeport Region, CT



Methods

This CHA aims to identify the health-related needs and strengths of the Greater Bridgeport area through a social determinants of health framework, which defines health in the broadest sense and recognizes numerous factors at multiple levels— from lifestyle behaviors (e.g., healthy eating and active living) to clinical care (e.g., access to medical services) to social and economic factors (e.g., poverty) to the physical environment (e.g., air quality)—which have an impact on the community's health. Existing social, economic, and health data were drawn from national, state, county, and local sources, such as the U.S. Census and CT State Department of Health, which include self-report, public health surveillance, and vital statistics data. Over 200 individuals from multi-sector organizations, community stakeholders, and residents were engaged in focus groups and interviews to gather their feedback on priority health concerns, community challenges to addressing these concerns, current strengths of the area, and opportunities for the future. Additionally, 1,302 respondents from the six PCAG communities completed a brief 30-item community survey that was developed and administered online or in-person to gather quantitative data that were not provided by secondary sources and to understand public perceptions around health issues.

Key Findings

The following section provides a brief overview of the key findings from this community health assessment.

Demographics

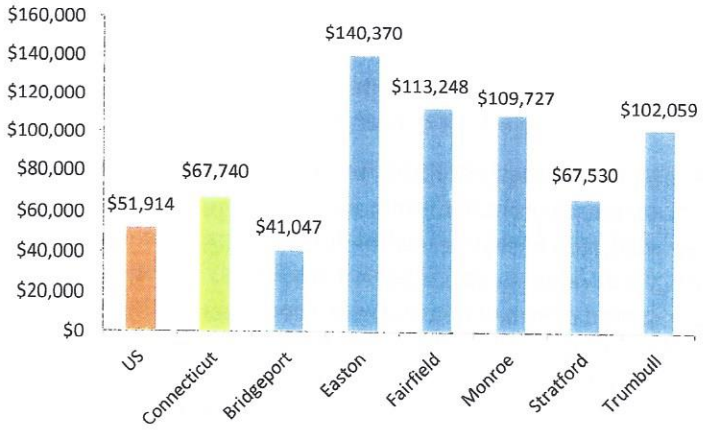
- **Population.** The Greater Bridgeport area has a population of 318,217, which has grown over the past decade but at a smaller rate than the state overall. Bridgeport, Connecticut's largest city and the fifth largest city in New England, comprises 45% of the region's population. Fairfield and Stratford each make up less than 20% of the total population of the region.
- **Age Distribution.** While residents describe their communities as multi-generational, the median age of the population of each town in the area except Bridgeport and Fairfield is higher than for the state as a whole. The proportion of residents over the age of 65 in the region is expected to increase to over 20% by 2025. Concerns about the implications of an aging population for the region's health and social service infrastructure were a common theme across focus groups and interviews.
- **Racial and Ethnic Diversity.** The towns in the region vary dramatically in terms of their racial and ethnic composition. The communities of Easton, Fairfield, Trumbull, and Monroe are over 90% White and Stratford's population is over three-quarters White. By contrast, more than 75% of Bridgeport's population is non-White; Hispanics and African-Americans each comprise over one third of Bridgeport's residents.

> *"Here in the suburbs, there is not a real mix in terms of racial background in our town."* –Focus group participant, Fairfield
>
> *"Bridgeport is very diverse. There are a lot of different people here, from different cultures."* –Focus group participant, Bridgeport

Social and Physical Environment

- **Income and Poverty.** According to the 2011 American Community Survey, the Greater Bridgeport region has the widest gap between rich and poor of all 516 metropolitan and micropolitan areas included in the survey. The towns of Fairfield, Trumbull, and Monroe are affluent with median incomes substantially higher than national and state averages. Stratford, which has a long history as an industrial town, was described by residents as blue collar and middle class. Bridgeport has a higher poverty rate and a lower median income than both state and national averages; it is among one of the poorest cities in the country.

Figure 2: Median Household Income, US, CT, and Towns, 2006-2010



DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2006-2010 American Community Survey.

- **Employment.** As elsewhere, the economic downturn has been felt in the Greater Bridgeport area. The lack of job growth was cited as a concern by many residents. Regional unemployment data indicate that both Bridgeport and Stratford experienced higher unemployment during 2012 (12% and 9-10%, respectively) than the state or the rest of the region's communities. According to residents, a substantial challenge is bringing new business into the region.

- **Educational Attainment.** The school systems in several towns were enthusiastically described as *"excellent"*; the region also has numerous universities and community colleges. The proportion of residents with a college degree or higher in Easton, Monroe, Fairfield, and Trumbull is greater than that of the state overall (35.2%). Only 15% of Bridgeport adults have a college degree or higher, less than half the rate for the state overall. Bridgeport's school system was described by one interviewee as *"one of the poorest educational systems in the country"* characterized by overcrowding, few resources, high dropout rates, and poor educational achievement.

> *"Our school system is very good. It makes it attractive for young families to move in."* –Interviewee, Trumbull/Monroe

- **Urbanicity.** The towns comprising the Greater Bridgeport area were described by residents as a mix of small towns, suburban areas, and urban centers. Residents from more affluent parts of the region appreciated the shoreline, beautiful parks and walking trails, as well as libraries and downtown shopping areas and restaurants. As a large urban center, Bridgeport was noted for the convenience of transportation, retail shopping, parks, and health facilities.

- **Housing.** Housing is expensive in many areas of Greater Bridgeport and taxes are high. Although housing is more reasonably priced in Bridgeport, social service providers reported high eviction rates and concerns about housing safety. Median monthly housing costs with a mortgage or monthly rental costs are higher for most towns in the region than for the state and the nation.

- **Transportation.** Transportation is a concern for many parts of the region, especially for seniors, youth, and low income individuals. In surrounding communities, amenities such as shopping, entertainment, and health services are spread out, with few public transportation options for easy access.

- **Crime and Violence.** Residents saw surrounding communities as relatively safe but reported substantial crime and violence in Bridgeport. The rates of violent and property crime in Bridgeport and Stratford are higher than those for the state. For example, the homicide rate in Bridgeport (14 per 100,000 population) is substantially higher than that of other communities in the region, the state overall (0.04 per 100,000 population) and the U.S. (4.2 per 100,000 population).

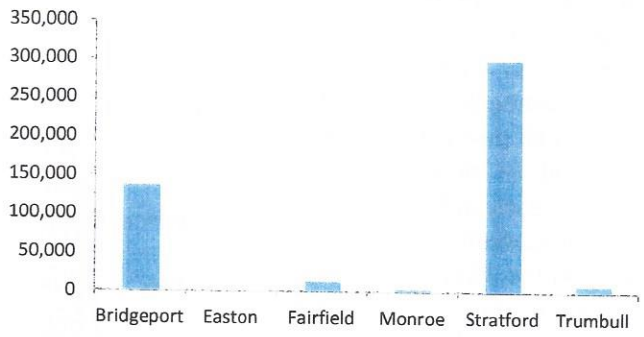
> *"Gangs- that's a big concern. There's a lot of that around Bridgeport and in some parts of Stratford."* –Focus group participant, Bridgeport
>
> *"I have lived in other areas where I waved to my neighbors and that's it. But here, the neighbors really care."* –Focus group participant, Stratford

- **Social Support and Cohesion.** Residents' perceptions of the social climates in their communities were mixed. Many residents, particularly in the surrounding communities, cited strong social relationships. Some residents observed that the undercurrent of competitiveness and affluence in the area has led to a tendency to ignore concerns or problems.

- **Access to Healthy Foods and Recreation.** Concerns about obesity, healthy eating, and physical activity were common themes across focus groups and interviews. Those in the suburban areas reported easy access to healthy food. By contrast, Bridgeport was described as a *"food desert."* Stratford residents also reported challenges to obtaining fresh, healthy food. While many focus group members and interviewees reported that the region has many opportunities for physical activity, they acknowledged that these are not available in all communities and, in some cases, are cost prohibitive. Emphasis on academics in school has led to reductions in time for recess and physical activity. In Bridgeport, safety concerns prevent residents from using parks and playgrounds.

- **Environmental Quality.** The region's long industrial history has had environmental repercussions, according to residents, who spoke about the region's brownfield areas. This not only leaves substantial land unusable for business development but is also linked to health concerns. The level of environmental waste in Stratford is over twice as high as in Bridgeport (Figure 3). Recent natural disasters, including Hurricane Sandy, have led to concerns about economic development in low lying areas and the capacity of towns to respond to such emergencies.

Figure 3: Federal Toxic Release Inventory Environmental Waste (Including air, water, and solid), Towns, 2008



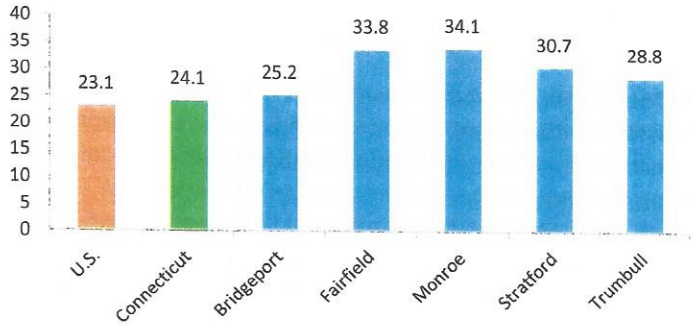
DATA SOURCE: Healthy Equity Index, Toxics Release Inventory Program Data and Tools, 2008.

Health Behaviors

- **Healthy Eating, Physical Activity, and Overweight/Obesity.** Greater Bridgeport region focus group participants and interviewees reported that obesity is emerging as a serious community issue, and with it, rising cases of chronic diseases. Survey data indicate that 57% of adults in the region are either overweight or obese. In addition to time constraints, the infrastructure itself – having the healthy choice be the easy choice – was discussed among many assessment participants.

- **Substance Use and Abuse.** Although several residents reported that substance use is declining in the region overall, they reported a rise in the use of alcohol and prescription drugs. According to the Behavioral Risk Factor Surveillance System (BRFSS), in 2010 the proportion of adults reporting binge drinking in the county is higher than for the state and has been increasing. Quantitative data indicate that across almost all key measures for substance use among youth, Bridgeport youth are substantially lower than surrounding towns such as Fairfield and Monroe (Figure 4). Residents attributed the use of substances among youth to several factors including academic stress and the lack of other activities.

Figure 4: Proportion of Youth Grades 9-12 Having Used Marijuana Once or More in the Last 12 Months, U.S., Connecticut, and Towns, 2011

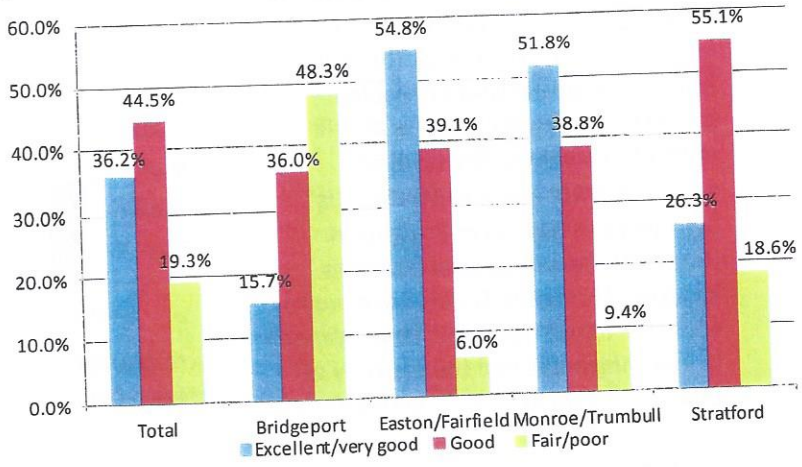


DATA SOURCE: Youth Risk Behavior Surveillance System, 2011 **Data for Easton not available.

Health Outcomes

- **Perceived Community and Individual Health Status**. BRFSS data from 2010 show that in Fairfield County, 90.6% of adults perceive their own personal health to be "good" or "excellent". However, nearly half of community survey respondents from Bridgeport (48.3%) reported that their community's health was fair or poor, compared to 18.6% of respondents from Stratford, and under 10% of respondents from Monroe/Trumbull or Easton/Fairfield.

Figure 5: Perceived Community Health Status, CHA Survey Respondents



DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012

- **Leading Causes of Death and Hospitalization.** Quantitative data indicate that the top three causes of death in each of the city/towns in the region are heart disease , cancer and injuries (with the exception of Monroe where the third leading cause of death is chronic lower respiratory disease). Data from two hospitals show that the leading causes of emergency department (ED) admissions are heart disease (20.3%), digestive disease (12.7%), and mental illness (12.4%). Over ten percent of ED admissions were for respiratory diseases and for injury and poisoning.

- **Chronic Disease.** When asked about health concerns in their communities, focus group and interview participants mentioned chronic diseases such as cardiovascular disease and diabetes which they saw as closely related to obesity. Several also mentioned cancer-related illnesses which they attributed in part to toxic aspects of the region's environment and infrastructure. A number of participants also reported that asthma rates were high in the region, especially in Bridgeport.

- **Mental Health.** Assessment participants reported rising rates of depression and mental health issues in the region connected to substance use, the economic downturn, and the region's achievement culture. Residents expressed particular concern about rising rates of mental illness among children and teens. The attempted suicide rate among high schoolers in Bridgeport (16.9%) and Stratford (14.6%) is over twice as high as those in the state (6.7%) and nation (7.8%). Respondents reported that the region lacks mental health providers to address the need; as a result, a growing number of people with mental health issues are appearing at the emergency department for services.

> *"Mental health – that is one of the most unaddressed issues here in Bridgeport."* –Focus group participant, Regional
>
> *"It's very hard to get psychiatric services for students in the area."* – Focus group participant, Fairfield

- **Oral Health.** Several assessment participants also reported that oral health was a concern, particularly for low-income children, youth, and seniors.

- **Maternal and Child Health.** Births to teens between the ages of 15-17 are substantially higher in Bridgeport (38 per 1,000 live births) and slightly higher in Stratford (15 per 1,000 live births) than the state average (13 per 1,000 live births). Both towns also experience higher rates of infant mortality and pre-term births than other communities and the state as a whole.

- **Communicable Diseases.** Data show that all Greater Bridgeport towns except Bridgeport have lower rates of sexually transmitted infections than the state overall. Bridgeport's rates are substantially higher: rates of Syphilis infection in Bridgeport are over three times as high as for the state, and rates of Chlamydia and Gonorrhea are over twice as high.

Health Care Access and Utilization

- **Resources and Use of Health Care Services.** The region is seen as having substantial health resources including two hospitals, two community health centers, and an AmeriCares free clinic. In addition, Bridgeport and Stratford have school-based health centers, community centers and health departments throughout the region that play an important role in advancing public health. Residents expressed concerns about the supply of medical providers, specifically noting a need for more mental health and dental providers, especially for low-income populations. They also reported substantial social services in the region although these have experienced budget cuts in recent years.

> *"I think Stratford has an excellent health care system, but it's not accessible to everyone."* – Focus group participant, Stratford
>
> *"I think we lack a lot of information about how to navigate the ever-changing medical system."* –Focus group participant, Monroe

- **Challenges to Accessing Health Care Services.** While the region has many medical services, residents acknowledged that barriers exist and services are not available equally to everyone. Access to care was described as a challenge particularly in Bridgeport where there is a higher proportion of low income and uninsured patients. Barriers include lack of insurance coverage, a growing number of providers unwilling to accept Medicare and Medicaid, long wait times and lack of after-hour health services, and the cost of health care. Lack of transportation, awareness of services and how to negotiate the health care system were also identified as barriers, especially for low income, cultural and language minority populations, and senior residents, thus, causing a growing number of people to seek care at emergency departments.
- **Quality of Care.** In describing their interactions with the health care system and providers, several respondents spoke about health care quality. Many respondents expressed concerns about the short amount of time doctors often spend with patients, leaving patients perhaps not fully aware of their health issues or how to take care of them. ED focus group members reported that a lack of follow-up care after a hospital stay has resulted in patients returning to the ED unnecessarily.

Community Strengths and Challenges

- **Health Care Services and Providers.** The Greater Bridgeport region has a number of prestigious healthcare institutions as well as excellent community health centers, according to residents. Many of these also support community programs. Residents also pointed to excellent services provided by health departments and, in Bridgeport, school-based health centers.
- **Recreational Facilities.** According to focus group participants and interviewees, the region has a geography and infrastructure that supports health, although accessibility is an issue for some. Safety concerns constrain physical activity in Bridgeport which has a large number of parks.
- **Strong Social Services and Organizations.** Respondents identified their communities as having good social services, including senior services, libraries, and public health services; although in recent years, budget cuts have resulted in fewer services being available.
- **Growing Collaboration and Emerging Leadership.** Residents provided varying perspectives on the extent to which services were coordinated and social service resources were efficiently used. Some respondents reported strong collaboration. Others in the region, however, pointed to a culture of *"home rule"* that led to competition among agencies and duplication of services.

- **Larger Economic Forces.** Like elsewhere in this country, the Greater Bridgeport region is affected by larger shifts in the nation. Respondents expressed concern about unemployment, declining income and rising taxes, and the stress associated with this. They also noted the implications of reduced public sector investment and cuts to social services on the health and well-being of the community.
- **Demographic Shifts.** The region has a high proportion of seniors which is projected to grow. Residents noted that the aging population will bring challenges to the health and social service infrastructure.
- **Natural Environment.** Several focus group respondents and interviewees reported that larger issues of the environment can threaten future progress. Recent local disasters, including Hurricane Sandy, have demonstrated the vulnerability of the local infrastructure.

Vision for the Future

- **Perceived Priority Areas:** When survey respondents were asked about areas for future priority, they focused on seniors, services related to mental health/substance abuse, chronic disease prevention, and increasing access to medical care.
- **More Marketing of Existing Services.** Respondents reported that more needs to be done to market existing services in the region, and perhaps change when they are offered. As one focus group participant stated, *"we get to a stronger community by being an informed community. To identify what are the existing services, and where are the needs. To be more informed and more aware."*
- **More Health Education.** Residents reported that more health education for the public was needed overall and specifically on obesity, asthma, substance abuse, and sexually transmitted infections. Education about accessing and using health services was also identified as critically important, especially as more people become insured under health care reform.
- **Support Services for Youth, Elderly and Other Vulnerable Populations.** A vision for more youth engagement emerged including education for youth around substance use, opportunities to be physically active, mentoring, parent involvement, and social workers in schools. More recreational opportunities for seniors was also identified as a vision for the future. Increased cultural competency and bi-lingual providers were needed for the non-English speaking residents.
- **More Mental Health Services.** Residents reported that more mental health services were needed across the region and across age groups, including community-based mental health services, mental health providers with geriatric and pediatric expertise, psychiatric housing units, and transitional housing for mental health patients.
- **Enhanced Environment to Support Health.** While specific suggestions differed by community, residents overall would like to see more support for healthy eating and physical activity. Those in the outlying communities would like to see greater attention to walkability and more sidewalks.
- **Focus on Prevention.** Residents envisioned a greater emphasis on prevention—they would like to see more prevention programs and screenings in locations accessible to community members—the corner store, faith institutions, and schools.
- **Greater Collaboration between Hospitals and Community Care.** Although respondents differed in their perspectives of collaboration across agencies in the region, nearly all shared a vision for greater collaboration to be effective and efficient with resources.
- **More Community-Based Delivery of Programs and Greater Involvement of Community Institutions.** Focus group respondents and interviewees felt that local institutions can play a key role in providing services and in connecting local residents to services. Garnering the support of community leaders and institutions was seen as a critical step for greater collaboration and effective delivery of health and other services. Faith-based organizations were identified as key allies.

- **More Communication around Patients.** Medical and mental health providers reported that greater communication across the health system would be important for enhanced quality of care. Mental health providers requested accessible information on a patient's medical status, while providers would like information about patients' prescriptions for a more holistic approach to treatment.
- **Enhanced Involvement of the Public.** Several residents shared the vision of a leadership that is informed by and knowledgeable of the situation in communities. This requires that community members become more involved and advocate for themselves.
- **Improvements in the Economy.** Residents recognized that an improved economy was critical for the future health of the region to address unemployment, increase incomes, and restore funding to social and health services. Residents noted some progress in economic development and redevelopment and cleanup of polluted sites.

Key Themes and Conclusions

- **There is wide variation between the city of Bridgeport and surrounding communities in terms of population composition, socioeconomic levels, and needs.** The region has one of the widest gaps between rich and poor in the country and clearly demonstrates the social and economic patterning of health behaviors and outcomes.
- **Environmental quality and local infrastructure issues were identified as concerns for the region which residents see as constraining economic growth and negatively affecting public health.** The industrial legacy of the area, existing septic infrastructure, and recent Hurricane Sandy aftermath were all themes that emerged in the assessment.
- **The aging of the region's population was noted by many, and concerns about seniors were prominent.** As Baby Boomers age, seniors are expected to comprise an ever increasing proportion of the population in the region which is expected to put great demands on the health and social service infrastructure.
- **Mental health was identified as a pressing need by assessment participants, and current services were largely seen as inadequate.** According to residents, the region needs more mental health providers especially those skilled at addressing the needs of children and teens, education and prevention programs and community-based care and treatment options, especially to provide services after an emergency visit.
- **Obesity and access to physical activity and healthy food were concerns identified by focus group participants and interviewees.** Walkability of communities, nutritious school lunches, and accessible and affordable recreational areas were all issues identified as important for changing the environmental landscape to support obesity prevention.
- **The region is seen as having a strong health care infrastructure, but there are concerns about access.** While the region has many health assets including hospitals, community health centers, school-based health centers, and public health departments, residents expressed concerns about access to health care, including primary care as well as dental and mental health care.
- **As the health system increasingly faces challenges and health reform is implemented, residents saw the great need for increased efforts focusing on prevention.** A focus on prevention and better lifestyle behaviors were seen as essential to improving the health of the region. More education relative to health, a stronger infrastructure that supports health (e.g., sidewalks, safe green space), and changes in how to navigate the health system were all seen as important. Future collaboration and coordination of efforts were also viewed as critical, and an area in which the region currently has a strong foundation.

INTRODUCTION

OVERVIEW

Improving the health of a community is critical to ensuring the quality of life of its residents and fostering sustainability and future prosperity. Health is intertwined with the multiple facets of our lives, and yet, where we work, live, learn, and play all have an impact on our health. Understanding the current health status of a community—and the multitude of factors that influence health—is important in order to identify priorities for future planning and funding, the existing strengths and assets on which to build upon, and areas for further collaboration and coordination across organizations, institutions, and community groups.

To this end, the Primary Care Action Group (PCAG)—a coalition of two community hospitals, five departments of public health, federally qualified health centers, and numerous community and non-profit organizations serving the Greater Bridgeport, CT area—is leading a comprehensive regional health planning effort. This effort is comprised of two major phases:

- Community Health Assessment (CHA) – identifies the health-related needs and community strengths in the Greater Bridgeport Area
- Community Health Improvement Plan (CHIP) – determines the key health priorities, overarching goals, and specific strategies to implement across the service area

This report details the findings of the community health assessment conducted from September 2012 – January 2013. To ensure a data-driven process, these findings will be the foundation for the participatory community health improvement planning process, scheduled to take place February – May 2013.

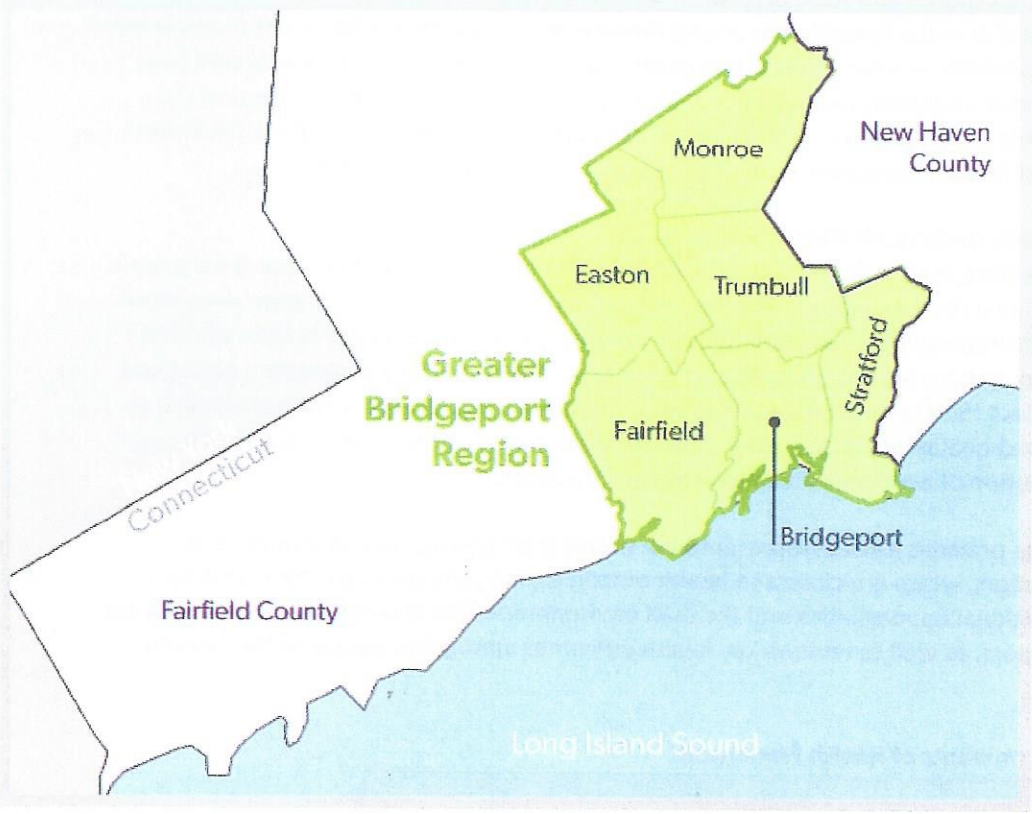
PURPOSE AND GEOGRAPHIC SCOPE

The Greater Bridgeport community health assessment was conducted to meet several overarching goals:

1. To examine the current health status of the Greater Bridgeport area (comprised of Bridgeport, Stratford, Fairfield, Trumbull, Monroe, and Easton)
2. To explore current health priorities—as well as new and emerging health concerns—among residents within the social context of their communities; and
3. To identify community strengths, resources, and gaps in services in order to help the PCAG members set programming, funding, and policy priorities.

This Greater Bridgeport community health assessment focuses on six communities within Fairfield County, CT: Bridgeport, Fairfield, Stratford, Trumbull, Monroe and Easton (Figure 2).

Figure 2: Map of the Greater Bridgeport Area, Connecticut



ADVISORY STRUCTURE AND PROCESS

The CHA-CHIP process was spearheaded, funded, and managed by the Primary Care Action Group (see Appendix A for a list of organizational PCAG members). The Primary Care Action Group was founded in 2004 with the mission to improve the health of the community. PCAG's vision is work together as a coalition to identify, prioritize, and measurably improve the health of their community through health care prevention, education, and services. To develop a shared vision and plan for the community and help sustain lasting change, the PCAG assessment and planning process aims to engage agencies, organizations, and residents in the area through participatory and collaborative approaches.

In September 2012, PCAG hired Health Resources in Action (HRiA), a non-profit public health organization, as a consultant partner to provide strategic guidance and facilitation of the CHA-CHIP process, collect and analyze data, and develop the report deliverables.

PCAG has been reaching out to the larger community through communications and meetings to discuss the importance of this planning process. Additionally, the community has been engaged in focus groups and interviews during the comprehensive data collection effort of the community health assessment. Public awareness and dissemination of the CHA findings and subsequent CHIP priorities and strategies will continue to be conducted via media and public events.

METHODS

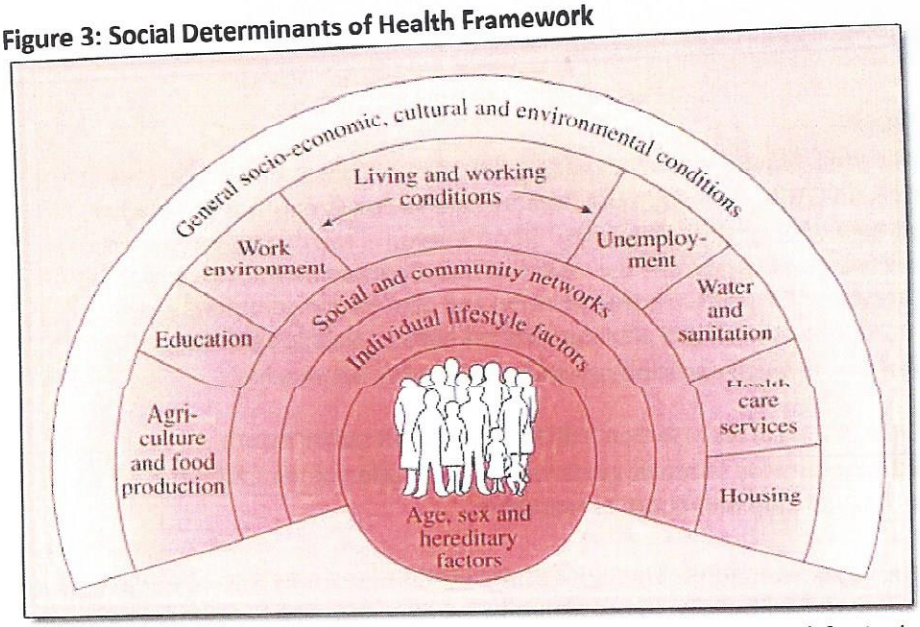
The following section describes how the data for the community health assessment was compiled and analyzed, as well as the broader lens used to guide this process. Specifically, the community health assessment defines health in the broadest sense and recognizes that numerous factors at multiple levels impact a community's health — from lifestyle behaviors (e.g., diet and exercise) to clinical care (e.g. access to medical services) to social and economic factors (e.g., employment opportunities) to the physical environment (e.g., air quality). The beginning discussion of this section discusses the larger social determinants of health framework which helped guide this overarching process.

SOCIAL DETERMINANTS OF HEALTH FRAMEWORK

It is important to recognize that multiple factors have an impact on health and that there is a dynamic relationship between real people and their lived environments. Where we are born, grow, live, work, and age—from the environment in the womb to our community environment later in life—and the interconnections among these factors are critical to consider. That is, not only do people's genes and lifestyle behaviors affect their health, but health is also influenced by more upstream factors such as employment status and quality of housing stock. The social determinants of health framework addresses the distribution of wellness and illness among a population.

The following diagram provides a visual representation of this relationship, demonstrating how individual lifestyle factors, which are closest to health outcomes, are influenced by more upstream factors such as educational opportunities and the built environment. This report provides information on many of these factors, as well as reviews key health outcomes among the people of the Greater Bridgeport area.

Figure 3: Social Determinants of Health Framework



DATA SOURCE: World Health Organization, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health: Discussion paper for the Commission on the Social Determinants of Health, 2005.

DATA COLLECTION METHODS

Quantitative Data: Reviewing Existing Secondary Data

The Greater Bridgeport community health assessment builds off of previous efforts in the Greater Bridgeport region. Specifically, in Summer 2012, PCAG member agencies with significant help from summer interns compiled data from secondary sources on key social, economic, and health indicators for the region and specifically for Bridgeport, Stratford, Fairfield, Trumbull, Monroe, and Easton. Existing data were drawn from state, county, and local sources. Sources of data included, but were not limited to, the U.S. Census, U.S. Bureau of Labor Statistics, Centers for Disease Control and Prevention, CT State Department of Health, as well as local organizations and agencies. Types of data included self-report of health behaviors from large, population-based surveys such as the Behavioral Risk Factor Surveillance System (BRFSS), as well as vital statistics based on birth and death records. It should be noted that other than population counts and racial/ethnic distribution, other data from the U.S. Census derive from the American Community Survey which includes data from a sample of the geographic area.

Community Survey

In order to gather quantitative data that were not provided by secondary sources and to understand public perceptions around health issues, a brief 30-item community survey was developed and administered online or in-person to residents within the six PCAG communities. The survey explored key health concerns of community residents as well as their primary priorities for services and programming. The PCAG partners reviewed and provided feedback on the survey and also assisted with disseminating the survey link via their networks (e.g., sending an email announcement out to their contacts) and providing hard copies of the surveys to local organizations. The in-person survey was administered by trained graduate students from the Yale School of Public Health who attended a two-hour training on survey administration.

During five weeks from early December 2012 – early January 2013, the community survey was administered via three dissemination methods: online sent via email, the media, and local networks; in-person administered by Yale School of Public Health students at local sites such as grocery stores and health clinics; and by hard copy available in foyers and waiting rooms of local organizations such as libraries, senior centers, community centers, and health centers. Through all dissemination methods, the surveys were available in both English and Spanish. The survey used a convenience sample for gathering information but strong efforts were made to disseminate the survey through multiple venues and media to yield a broad cross-section of respondents from the region.

A total of 1,302 respondents completed the survey from the six communities that were the focus of this assessment. (An additional 113 respondents from other towns in the region completed the survey, but were not included in the survey analyses.)

Figure 4 shows the distribution of survey respondents by the six towns in the region. Due to small sample sizes of responses in some communities, analyses by town throughout this report groups some communities together. Survey analyses focus on four town groupings: Bridgeport, Easton/Fairfield, Monroe/Trumbull, and Stratford. Table 1 provides a breakdown of demographic characteristics of the survey respondents overall and by these town groupings.

Figure 4: Number of Survey Respondents by Town, n=1,302

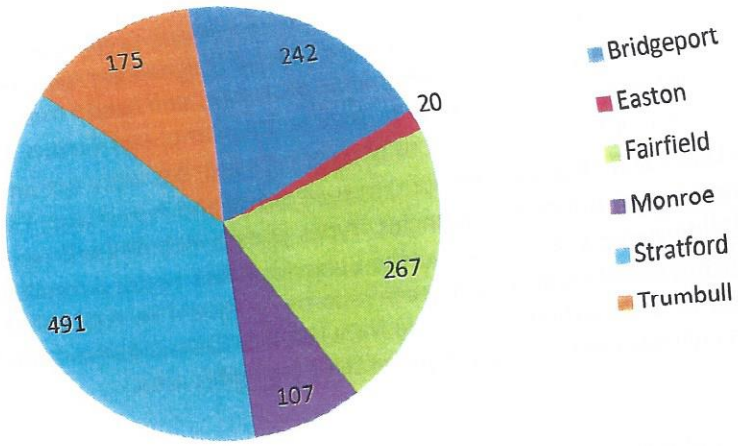


Table 1: Survey Respondent Characteristics, by Town

	Total N=1,302	Bridgeport N=242	Easton/ Fairfield N=287	Monroe/ Trumbull N=282	Stratford N=491
Age					
Under 18 years old	4.1%	6.1%	0.3%	1.4%	6.8%
18-34 years old	11.3%	23.7%	10.5%	7.5%	8.2%
35-64 years old	65.7%	62.3%	71.0%	65.6%	64.2%
65 years or older	18.9%	7.9%	18.2%	25.4%	20.8%
Gender					
Male	28.9%	39.5%	18.4%	25.4%	32.2%
Female	71.1%	60.5%	81.6%	74.6%	67.8%
Race/Ethnicity					
White, non-Hispanic	79.3%	34.5%	95.5%	93.1%	82.6%
Black, non-Hispanic	8.5%	30.5%	0.3%	0.7%	7.7%
Hispanic	8.3%	27.8%	1.7%	2.5%	6.4%
Asian, non-Hispanic	1.3%	1.3%	1.7%	1.4%	0.8%
Other race, non-Hispanic	1.8%	4.0%	0.7%	1.4%	0.7%
2 or more	0.8%	1.8%	0.0%	0.7%	0.8%
Educational Attainment					
HS Diploma or Less	17.8%	39.2%	7.0%	9.3%	19.3%
Some College	23.5%	32.4%	16.4%	19.9%	25.7%
College graduate or more	58.7%	28.4%	76.7%	70.8%	54.9%
Caregiver role (respondents may select more than one):					
Children under age 6	13.1%	19.0%	12.2%	11.3%	11.6%
Children aged 6-12	19.7%	19.4%	16.4%	25.2%	18.5%
Children aged 13-18	21.5%	22.7%	17.4%	25.9%	20.8%
Seniors (aged 65+)	21.2%	14.0%	18.8%	25.9%	23.4%

Qualitative Data: Focus Groups and Interviews

During December 2012, 22 focus groups and 15 key informant interviews were conducted in the region to gather feedback on people's priority health concerns, community challenges to addressing these concerns, current strengths of the area, and opportunities for the future. Ultimately, the qualitative discussions engaged over 200 individuals.

The focus groups spanned across age groups, geography, and role in the community. Groups represented a range of populations, including seniors, youth, parents, Spanish-speaking residents, low income residents, and social and health service professionals. Interviews were with organizational and governmental leaders within the Greater Bridgeport area and represented the public health, health care, social service, business, education, government, emergency management, and faith communities.

A semi-structured interview guide was used across all interviews and focus groups to ensure consistency in the topics covered. Each focus group and interview was facilitated by a trained moderator, and detailed notes were taken during conversations. On average, focus groups lasted 90 minutes and included 6-12 participants, while interviews lasted approximately 30-60 minutes. Participants for the focus groups and interviews were recruited by the PCAG partners with the goal of engaging a cross-section of residents and leaders.

Analyses

The secondary data, qualitative data from interviews and focus groups, and survey data were synthesized and integrated into this community health assessment report. The collected qualitative information was manually coded and then analyzed thematically for main categories and sub-themes. Data analysts identified key themes that emerged across all groups and interviews as well as the unique issues that were noted for specific populations. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. While city/town differences are noted where appropriate, analyses emphasized findings common across the Greater Bridgeport Area. Selected paraphrased quotes – without personal identifying information – are presented in the narrative of this report to further illustrate points within topic areas.

For the survey data, frequencies and cross-tabulations by town grouping and by other characteristics (e.g., race/ethnicity, insurance status) were conducted using SPSS statistical software, Version 21. In most instances, response options from the survey were collapsed for ease of interpretation. Many questions on the CHA survey were from existing national surveys (e.g., Behavioral Risk Factor Surveillance Survey), and analyses conducted were consistent with these measures.

Limitations

As with all research efforts, there are several limitations related to the assessment's research methods that should be acknowledged. It should be noted that for the secondary data analyses, in several instances, county-level data could not be disaggregated into municipalities. Additionally, secondary data sources are not consistent with each other in the most recent year that data are available. Furthermore, data based on self-reports should be interpreted with particular caution. In some instances, respondents may over- or underreport behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked. In addition, respondents may be prone to recall bias—that is, they may attempt to answer accurately but remember incorrectly. In some surveys, reporting and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys here benefit from large sample sizes and repeated administrations, enabling comparison over time. However, the Greater Bridgeport community health assessment survey, also self-reported data, used a non-random sampling method, and therefore its findings may not be representative of the larger population.

While the focus groups and interviews conducted for this assessment provide valuable insights, results are not statistically representative of a larger population due to non-random recruiting techniques and a small sample size. Recruitment for focus groups was conducted by community organizations, and participants were those individuals already involved in community programming. Due to this, it is possible that the responses received only provide one perspective of the issues discussed. While efforts were made to talk to a diverse cross-section of individuals, demographic characteristics were not collected from the focus group and interview participants, so it is not possible to confirm whether they reflect the composition of the region. In addition, organizations did not exclude participants if they did not live in one of six communities that were the focus of this assessment, therefore participants in a specific community's focus group might not necessarily live in that area, although they did spend time there through the organization. Lastly, it is important to note that data were collected at one point in time, so findings, while directional and descriptive, should not be interpreted as definitive.

FINDINGS

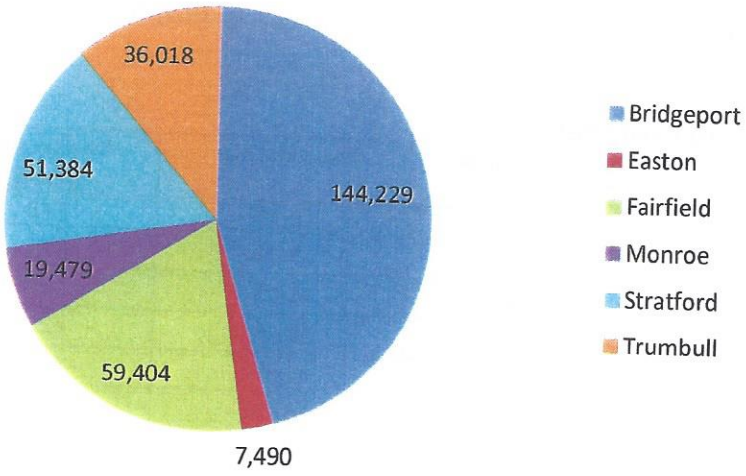
DEMOGRAPHICS

This section describes the population of the Greater Bridgeport region. Numerous factors are associated with the health of a community including what resources and services are available (for example, safe green space, access to healthy foods, transportation options) as well as who lives in the community. While individual characteristics such as age, gender, race, and ethnicity have an impact on people's health, the distribution of these characteristics across a community is also critically important and can affect the number and type of services and resources available.

Population

In 2010, the total population of the Greater Bridgeport region was estimated to be 318,004, up 3.3% from 2000 (307,607). The region is located in Fairfield County, the state's largest county; however, the towns within it vary by size, growth patterns, wealth, and diversity of residents. Bridgeport, Connecticut's largest city and the fifth largest city in New England, comprised 45% of the region's population in 2010 (Figure 5). The next largest towns in the area, Fairfield and Stratford, each comprised less than 20% of the total population of the region. The smallest community, Easton, with a population of 7,490 in 2010, comprised about 2% of the region's population in 2010.

Figure 5: Population in Towns, 2010



DATA SOURCE: US Department of Commerce, Bureau of the Census, 2010.

As seen in Table 2, all towns in the region experienced population growth between 2000 and 2010. With the exception of Trumbull which grew by 4.9% residents over the decade, the towns in the region experienced a smaller rate of increase than the state as a whole (4.7%). Monroe, which grew at 1.2% between 2000 and 2010, experienced the slowest rate of population growth.

Table 2: Population Change in Connecticut, Greater Bridgeport Region, and Towns, 2000 and 2010

	2000 Population	2010 Population	% Change 2000 to 2010
Bridgeport	139,529	144,229	3.3%
Easton	7,272	7,490	2.9%
Fairfield	57,340	59,404	3.5%
Monroe	19,247	19,479	1.2%
Stratford	49,976	51,384	2.7%
Trumbull	34,243	36,018	4.9%
Greater Bridgeport Region	307,607	318,004	3.3%
Connecticut	3,405,565	3,574,097	4.7%

DATA SOURCE: US Department of Commerce, Bureau of the Census, 2000 and 2010.

Age Distribution

> *"There is a mix of everyone here—babies, youth, adults, and the elderly."*–Focus group participant, Stratford

Focus group participants and interviewees described their communities as comprising people of all ages. Several residents noted that Connecticut has a higher proportion of elderly residents than many other states (14.3%) and the Greater Bridgeport region is consistent with this observation (Table 3). The proportion of residents age 65 and over is substantially higher in Stratford (17.5%) and Trumbull (18.2%). The median age across towns ranges from 32.6 years in Bridgeport to 45.1 years in Easton. Of all the towns in the region, Bridgeport (7.4%) and Fairfield (5.9%) have the highest proportions of children under age 5. These proportions are also higher than the state average (5.7%). The proportion of residents over the age of 65 in the Greater Bridgeport region is expected to increase over the coming years. The Connecticut State Data Center at the University of Connecticut estimates that the region's senior population (65+) will increase to 16% of the total population by 2015, to 18.1% by 2020, and to 20.9% by 2025.

Table 3: Age Distribution, Connecticut and Towns, 2010

Geography	Under 5 yrs	Under 20 years	65 and over	Median Age (years)
Bridgeport	7.4%	28.5%	10.1%	32.6
Easton	4.9%	29.9%	15.0%	45.1
Fairfield	5.9%	29.9%	15.1%	40.0
Monroe	4.8%	28.5%	13.3%	42.7
Stratford	5.4%	24.3%	17.5%	42.2
Trumbull	5.2%	27.3%	18.2%	43.9
Connecticut	5.7%	25.6%	14.3%	40.0

DATA SOURCE: US Department of Commerce, Bureau of the Census, 2010.

The implications of an aging population for the region were a common theme across focus groups and interviews. The needs of seniors arose frequently in conversations as residents expressed concerns about isolation among seniors who are not mobile, elderly without family nearby, and the demands that an aging population will have on the local social service and health infrastructure. Isolation was a common theme, especially among senior focus group members. As one Stratford senior focus group participant noted, *"There are seniors who don't leave their houses; it's very concerning."*

Among health and social service providers, seniors' access to services was a concern. As one Trumbull EMS focus group member explained, *"we see a lot of elderly by themselves...sometimes we take them to*

the hospital, but they really shouldn't be there. They should be getting help from social services." While residents reported that senior centers play a critical role in promoting social connections and connecting older residents to needed services, they also expressed concern about the ability of these centers and the social service and health infrastructure to meet the demands of the region's elderly and rapidly aging population.

Racial and Ethnic Diversity

> *"Here in the suburbs, there is not a real mix in terms of racial background in our town."* –Focus group participant, Fairfield
>
> *"Bridgeport is very diverse. There are a lot of different people here, from different cultures."* – Focus group participant, Bridgeport

The communities of the Greater Bridgeport region vary in their levels and types of diversity, according to respondents. When asked to describe their communities, focus group and interview respondents from Fairfield, Trumbull, and Monroe responded that their communities were primarily upper middle class and white. Those from Stratford frequently described their community as a *"blue collar town"* with cultural, racial, and ethnic diversity. One focus group member described the community as *"a multicultural melting pot that is growing."* Bridgeport was universally described as a blue collar and middle class community with wide racial and ethnic diversity, including a large immigrant and undocumented population.

Table 4 confirms substantial variation in the levels of racial, ethnic, and linguistic diversity across Greater Bridgeport's municipalities. The communities of Easton, Fairfield, Trumbull, and Monroe are over 85% non-Hispanic White. Hispanics and Asians comprise the largest proportion of the non-White population in these communities. By contrast, more than three-quarters of Bridgeport's population is non-White, with Hispanics comprising 38.2% and non-Hispanic Blacks comprising 32.2% of the population. Stratford's non-White population is also equally divided between Hispanics and Blacks, each making up slightly less than 14% of Stratford's population.

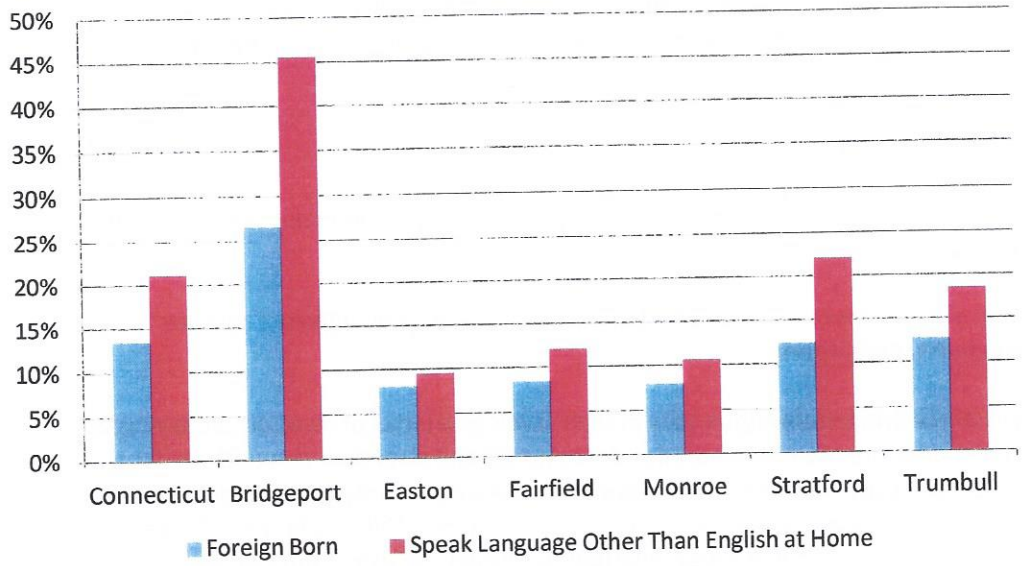
Table 4: Racial/Ethnic Composition, Connecticut and Towns, 2010

	White, non-Hispanic	Black, non-Hispanic	Asian, non-Hispanic	Other Race, non-Hispanic	2 or More Races, non-Hispanic	Hispanic/Latino
Bridgeport	22.7%	32.2%	3.3%	1.6%	1.9%	38.2%
Easton	92.0%	0.6%	3.2%	0.2%	1.0%	2.9%
Fairfield	88.0%	1.7%	3.7%	0.3%	1.2%	5.0%
Monroe	90.6%	1.3%	2.1%	0.2%	1.1%	4.7%
Stratford	68.2%	13.6%	2.3%	0.5%	1.6%	13.8%
Trumbull	85.7%	3.0%	4.3%	0.2%	1.0%	5.7%
Connecticut	71.2%	9.4%	3.8%	0.6%	1.7%	13.4%

DATA SOURCE: US Department of Commerce, Bureau of the Census, 2010.

Over one quarter of Bridgeport's population is foreign-born and nearly one half speaks a language other than English at home, a proportion far higher than other towns in the region and the state as a whole (Figure 6). According to the U.S. Census, the most commonly spoken non-English language in the city is Spanish, with over 30% of the population reporting speaking Spanish at home.

Figure 6: Percent Population Who are Foreign Born or Who Speak Language Other Than English at Home, Connecticut and Towns, 2006-2010



DATA SOURCE: US Department of Commerce, Bureau of the Census, 2006-2010 American Community Survey.

SOCIAL AND PHYSICAL ENVIRONMENT

Income and poverty are closely connected to health outcomes. A higher income makes it easier to live in a safe neighborhood with good schools and many recreational opportunities. Higher wage earners are better able to buy medical insurance and medical care, purchase nutritious foods, and obtain quality child care than those earning lower wages. Lower income communities have shown higher rates of asthma, obesity, diabetes, heart disease, and child poverty. Those with lower incomes also experience lower life expectancies.

Income and Poverty

> *"We are right smack in the middle of Fairfield County, a very rich county, so the disparities really stand out between Bridgeport and the rest of the county, and are large."* –Focus group participant, Greater Bridgeport Region

> *"We feel like a small town. There is a real cross section of affluence and middle America. People are generally doing well. Yet, there are pockets of poverty."* –Interviewee, Trumbull/Monroe

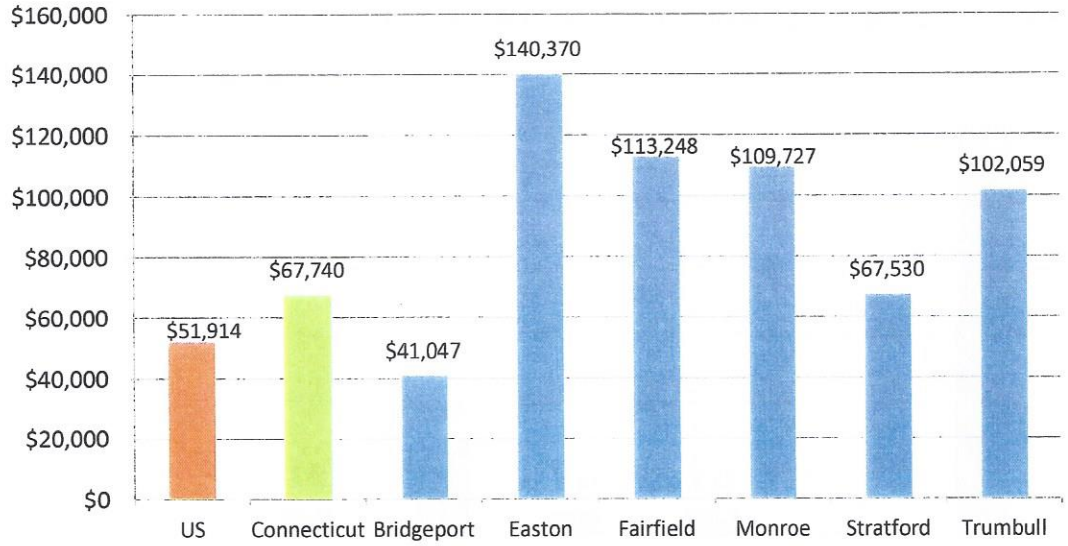
The Greater Bridgeport region has substantial differences in income and poverty levels although residents struggling during the economic recession can be found throughout the area. According to the U.S. Census American Community Survey, the region has the widest gap between rich and poor of all 516 metropolitan and micropolitan areas included in the survey. Residents confirmed the substantial income disparity in the region. Focus group members and interviewees described the towns of Fairfield, Trumbull, and Monroe as affluent. They pointed to expensive homes and a large number of local amenities including upscale shopping, restaurants, and entertainment. However, while these communities were singled out for their affluence, respondents noted that not all community members in these towns have high incomes. Seniors, in particular, were described by several respondents as struggling to stay in the community as the cost of living in the region increases. One older member of a

focus group in Monroe shared, *"A lot of people I talk to are concerned about whether they will be able to afford to live in the homes they have lived in for years."*

Stratford, which has a long history as an industrial town, was described as more blue collar and middle class. Bridgeport was characterized by residents as having high poverty and many single parent households. Residents pointed to substantial challenges including high unemployment and few low-skilled job opportunities. As one Bridgeport focus group member described, *"Most of this community is poor. We all live on coupons and disability."* As a whole, the city was seen as lacking the amenities of the surrounding communities, including green space where residents felt safe and access to affordable, healthy food.

According to the 2010 American Community Survey, household median income in all but two Greater Bridgeport communities was higher than that for Connecticut as a whole (Figure 7). All communities except Bridgeport had a median household income higher than that for the nation. Four communities had a median household income of greater than $100,000, with the highest in Easton ($140,370). The town of Stratford had a median houseful income close to the state average. Bridgeport's median household income in 2010 was $41,047, far lower than that of the state and the country.

Figure 7: Median Household Income, U.S., Connecticut, and Towns, 2006-2010

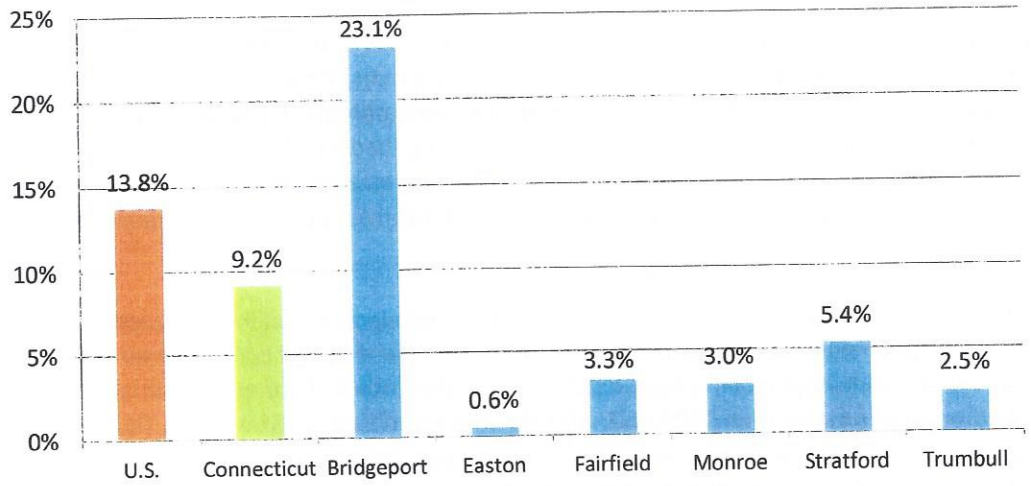


DATA SOURCE: US Department of Commerce, Bureau of the Census, 2006-2010 American Community Survey.

Poverty rates across much of the region vary (Figure 8). While the percentage of individuals in poverty in most of the region's communities is lower than that of the state (9.2%) and nation (13.8%), almost one quarter of Bridgeport's individuals had incomes below the federal poverty line (23.1%).[1] Stratford has a poverty rate closer to the state average. Reliance on food stamps is another measure of poverty. Quantitative data reveal that Bridgeport's food stamp cases (306 per 1,000 population) is nearly three times higher than the state rate (117 per 1,000 population) and many more times higher than rates in the other towns (Figure 9).

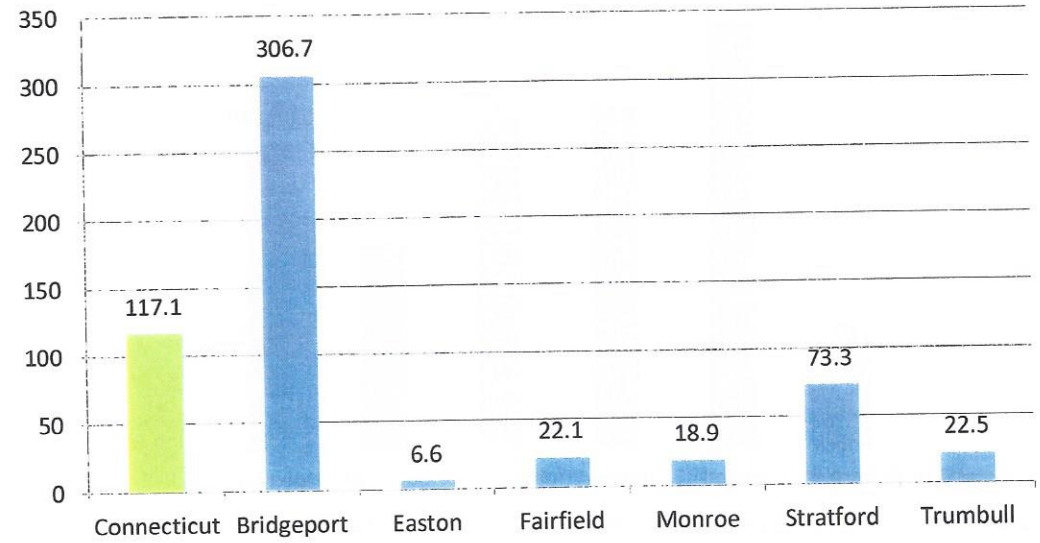
[1] These data discuss the percentage of individuals whose income in the past 12 months fell below the federal poverty level, which is adjusted for family size. For example, in 2010, the federal poverty level was $14,570 for a family of two and $22,050 for a family of four.

Figure 8: Percent of Individuals Below 100% of Poverty Level, U.S., Connecticut, and Towns, 2006-2010



DATA SOURCE: US Department of Commerce, Bureau of the Census, 2006-2010 American Community Survey.

Figure 9: Food Stamp Cases per 1,000 Population, Connecticut and Towns, 2010



DATA SOURCE: Connecticut Data Collaborative, 2010.

As elsewhere, the economic downturn has been felt in the Greater Bridgeport region. One local Fairfield leader stated, *"The economy seems to be all that we talk about."* Several respondents reported that families in the region have experienced a decline in their standards of living as a result of economic downturn and rising costs. They pointed to job loss, foreclosures, rising levels of stress, and people being forced to move from the region. An increase in the number of intergenerational households was also observed as adult children have been forced to move back into their parents' homes. As one Bridgeport social service provider shared, *"We are seeing people who have lost jobs and lost all they have."* According to others, even residents in affluent areas have experienced a decline in standards of living. A Trumbull/Monroe community leader explained, *"We have a lot of 'maintain appearances.' They need to go to the food pantry clandestinely."*

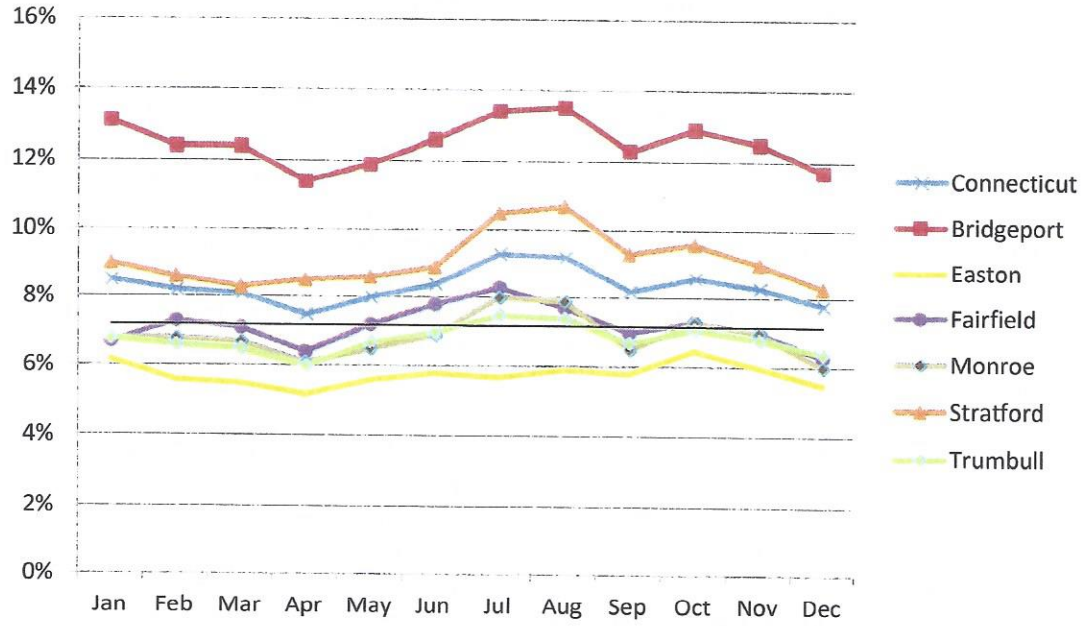
Employment

> *"The economy and jobs is something that is on everyone's minds. It looms large."* –Focus group participant, Stratford

The lack of job growth was cited as a concern by many residents. Stagnant growth was a concern by residents and leaders alike. Among all the day-to-day challenges participants mentioned in focus group discussions, "*Jobs are the biggest concern*" was a recurring theme, particularly in the lower income communities. Social service and health care providers serving vulnerable populations expressed concern about the employment prospects of these groups who generally have fewer skills, poor work histories, and may have language barriers, all of which create significant employment challenges in today's economy.

Monthly unemployment data from 2012 indicate that both Bridgeport and Stratford experienced higher unemployment during 2012 than the state or the rest of the Greater Bridgeport communities (Figure 10). Bridgeport consistently experienced over 12% unemployment over the year while Stratford's rate has been between 9-10%. Easton, by contrast, has experienced the lowest rate among the towns, less than 6%.

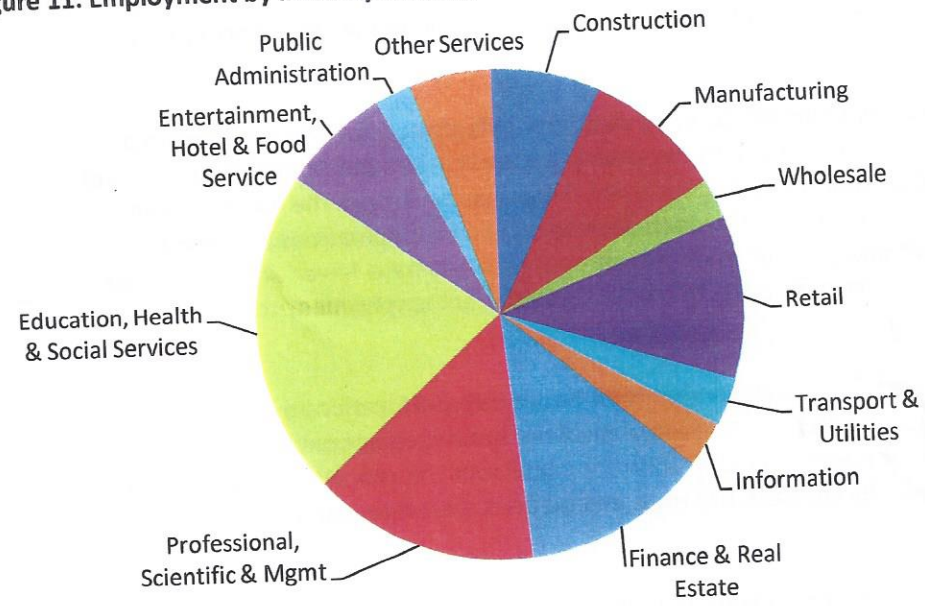
Figure 10: Monthly Unemployment, Connecticut and Towns, 2012



DATA SOURCE: Connecticut Department of Labor, Local Area Unemployment Statistics (LAUS).

Figure 11 presents information about the sectors in which Fairfield County residents are employed. (Data specifically for the Greater Bridgeport region and individual towns were not available.) The sectors with the highest proportion of the County's workers are Education, Health, and Social Services (21.4%), Professional, Scientific and Management (15.0%), and Finance and Real Estate (12.3%). The fewest people are employed in Public Administration (2.4%) and Wholesale (2.6%).

Figure 11: Employment by Industry Sectors, Fairfield County, 2007-2011



DATA SOURCE: SOURCE: U.S Department of Commerce, Bureau of the Census, 2007-2011 American Community Survey 5-Year Estimates, 2012.

One of the most substantial employment challenges, according to residents, is the difficulty of bringing new business into the region. While a sluggish economy has played a role in slow economic growth, residents also pointed to some weaknesses in the local infrastructure. While the region was described by respondents as having excellent access to highways, regional cities, and rail and air transportation, the septic system infrastructure has prevented existing businesses from expanding and new businesses from moving to the region. As one Fairfield leader explained, *"We have high water usage businesses that can't expand. The current septic systems can't deal with enlarging businesses. We have limited growth."* In addition, according to some residents, recent storms, including Hurricane Sandy, have highlighted concerns about the viability of locating businesses so close to the shoreline.

A common theme among residents of the Greater Bridgeport region was the high rate of property taxes. Residents reported substantial economic strain due to the high tax burden and the stresses of a slow economy. As one Trumbull resident explained, *"The budget and taxes are a real point of contention."* Another from Stratford observed that, *"People who are able to are leaving Stratford to escape the tax burden."* Concern about what taxpayers received for their money was also expressed by some residents. As one person from Trumbull/Monroe remarked, *"we pay a lot more but we seem to get a lot less."* Another Trumbull/Monroe resident held a similar view, stating, *"We are nickel and dimed for everything. We were charged $6-$12 for playing on public tennis courts."*

Educational Attainment

> *"In Bridgeport, even when we do have our kids graduate and go to college, they end up having to spend their first year in remedial classes."* –Focus group participant, Bridgeport

> *"Our school systems around here are very good. It makes it attractive for young families to move in."* –Interviewee, Trumbull/Monroe

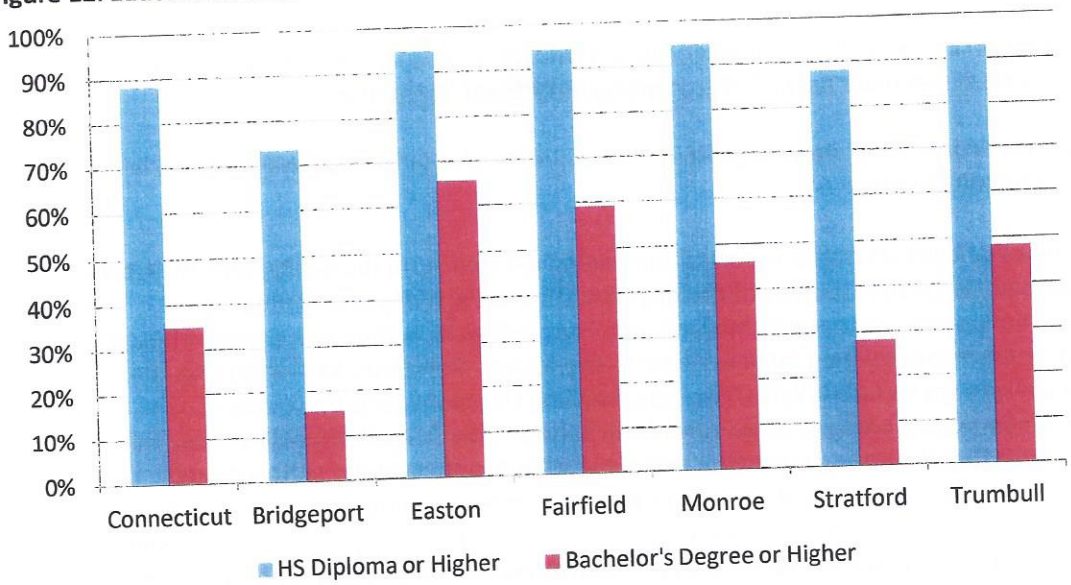
Residents of the Greater Bridgeport region reported substantial differences in the quality and availability of educational opportunities for the students of Bridgeport compared to those in surrounding communities. The school systems of Fairfield, Monroe, and Trumbull were enthusiastically described as "excellent" and one of the reasons young families move to the region. Residents also noted that the area has numerous universities including Yale University, Fairfield University, and University of Bridgeport, as well as community colleges which contribute substantially to intellectual life. However, some residents observed that the strong education and achievement culture of the region creates significant stress for families and students. As one Trumbull focus group member explained, *"in those school systems where academic achievement is expected, it's not OK to be average."* Students as well as social service providers attributed use of substances and mental health issues such as depression among the region's youth in part to the need for youth to keep up with academic expectations.

In contrast to the educational opportunities provided in surrounding communities, Bridgeport's school system was described by one Bridgeport interviewee as *"one of the poorest educational systems in the country."* Residents pointed to overcrowded schools, few resources, high dropout rates, and poor educational achievement. Although several magnet schools exist in the city, enrollment is limited and selected through a competitive lottery system. As one resident stated, *"if your name isn't picked in the lottery, you're condemned by your zip code."* However, despite the challenges Bridgeport's school system faces, several focus group and interview participants reported seeing recent positive changes. Residents shared that the Mayor has been leading an initiative to improve the school system. As one social service provider explained, *"We have a team leading the school system which includes strong leaders with a vision who are currently doing a much needed revamping of the system."* Another resident agreed, stating, *"Now, even parents want to get more involved [in the school system]. We didn't see that before."*

Quantitative results show high educational attainment among many of the area's communities (Figure 12). The proportion of residents with a college degree or higher in Easton, Monroe, Fairfield, and Trumbull is higher than for the state overall (35.2%). The proportion of adults with less than a high school diploma is very low in these towns as well. Stratford is just below the state average for both of these indicators. Bridgeport, however, has lower levels of educational attainment. Only 15% of Bridgeport adults have a college degree or higher, less than half the rate for the state overall, and over a quarter of adults have less than a high school diploma.

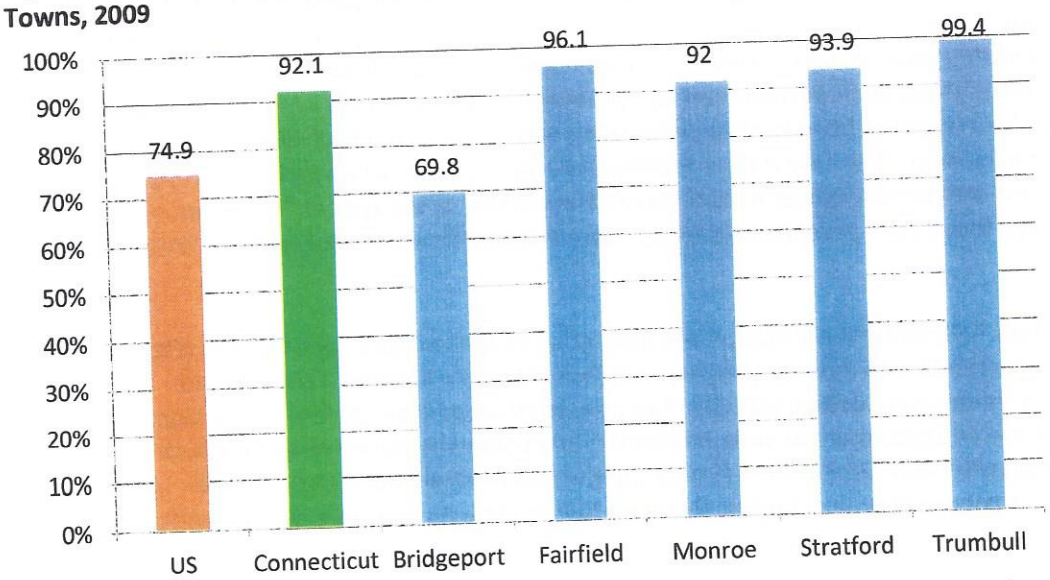
The proportion of high school students graduating with a diploma on time is the same as or higher for several Greater Bridgeport communities than for the state as a whole (92.1%) (Figure 13). However, in Bridgeport (69.8%), the rate of completion is lower than all communities, the state, and the U.S. (74.9%).

Figure 12: Educational Attainment of Persons Over Age 25, Connecticut and Towns, 2006-2010



DATA SOURCE: US Department of Commerce, Bureau of the Census, 2006-2010 American Community Survey.

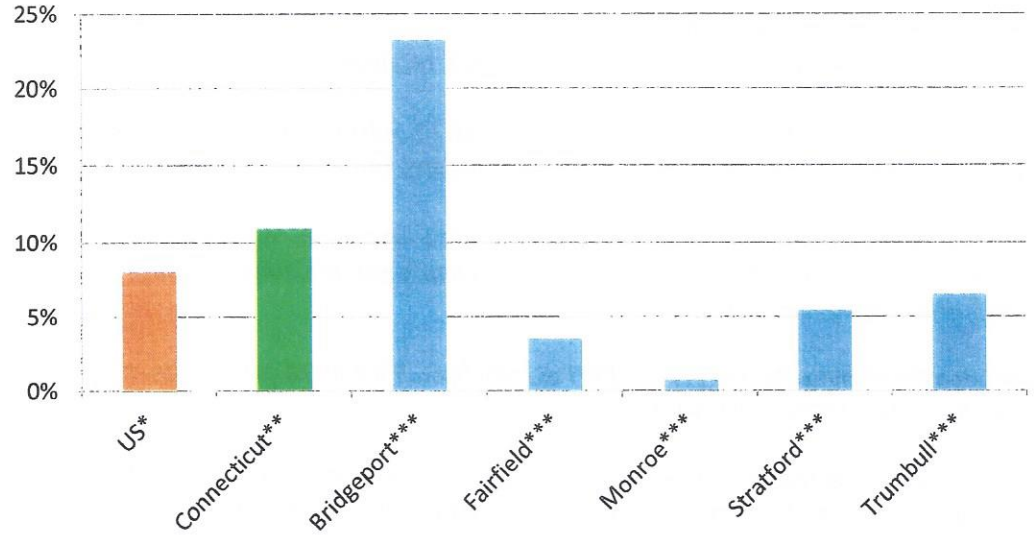
Figure 13: Students Who Graduate with a Diploma 4 Years after 9th Grade, U.S., Connecticut, and Towns, 2009



DATA SOURCE: State data: Connecticut State Department of Education, Connecticut Education Data and Research, Connecticut Graduation Rates, 2009
DATA SOURCE: Town level data: Connecticut Department of Education School Profiles, Action for Bridgeport Community Development, Head Start/Early Head Start, Community Assessment, 2009
NOTE: Data for Easton not available.

According to quantitative data, the high school drop-out rate in Bridgeport is 23.3%, many times higher than other communities and twice as high as the state (11%) (Figure 14). The lowest drop-out rate is in Monroe (0.8%).

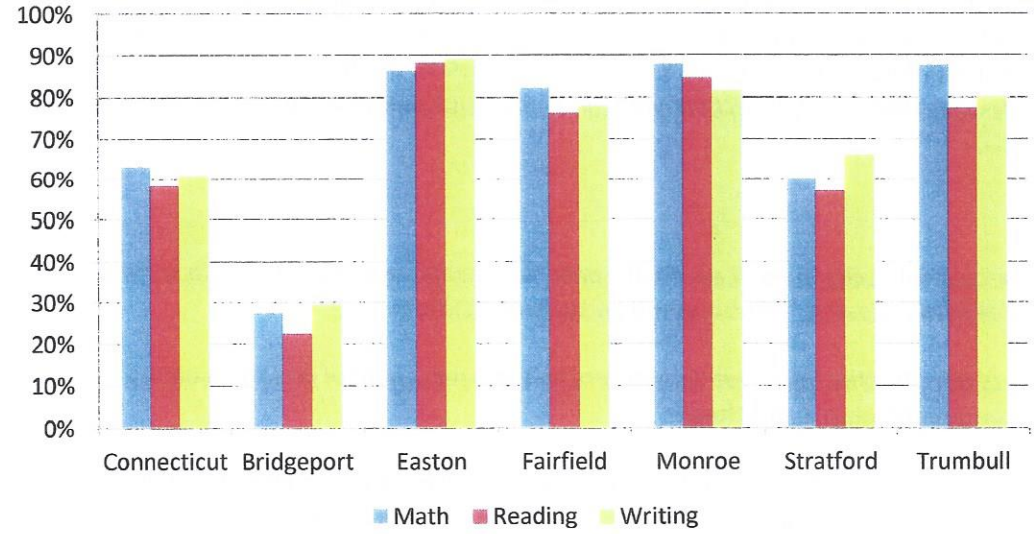
Figure 14: Cumulative High School Drop-Out Rate, U.S., Connecticut, and Towns, 2009-2010



*DATA SOURCE: National Center for Education Statistics, Fast Facts, Drop Out Rates, 2010.
**DATA SOURCE: Connecticut State Department of Education, Connecticut Education Data and Research, Cumulative High School Dropout Rate, 2010.
***DATA SOURCE: Connecticut Department of Education School Profiles, Action for Bridgeport Community Development, Head Start/Early Head Start, Community Assessment, 2009.
NOTE: Data for Easton not available.

Test scores from the Connecticut Mastery Test (CMT) show that student in the surrounding communities score well on the standardized tests, in general scoring higher than students in the state overall (Figure 15). However, scores for students in Bridgeport are far lower, with barely one quarter of third grade students scoring at the level goal or higher in each of the three subjects.

Figure 15: Proportion of Grade 3 Students Meeting Level Goal or Above in Connecticut Mastery Test (CMT) in Connecticut and Towns, 2009-2010



DATA SOURCE: Connecticut Data Collaborative, 2011.

Figure 17: Percent of Residents Whose Housing Costs are 35% or More of Household Income, U.S., Connecticut, and Towns, 2007-2011

DATA SOURCE: US Department of Commerce, Bureau of the Census, 2007-2011 American Community Survey 5-Year Estimates, 201.

Transportation

> *"As an older person, public transportation can be difficult. I see bus stops, but I don't know if we can use them- if they are going where I need. That information is not there."* –Focus group participant, Stratford

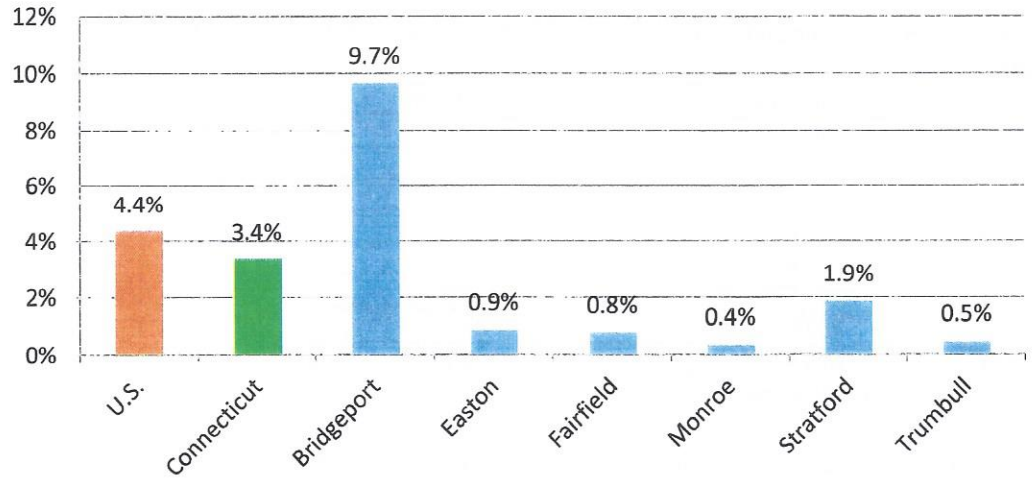
> *"Out here in the outlying areas of Trumbull and Monroe, we have a lot of land and no bus routes, so we have transportation issues for seniors."* –Focus group participant, Monroe

> *"Many families don't have personal transportation and rely on public transportation, particularly low-income people."* –Focus group participant, Bridgeport

Transportation emerged as a key concern for many parts of the region, especially for seniors, youth, and low-income individuals. In surrounding communities, amenities such as shopping, entertainment, and health services are spread apart and there are few public transportation options, making it difficult for those without cars to access them. Transportation was cited as a particular concern for seniors. As one interviewee from Monroe stated, *"A lot of seniors cannot go to senior centers because they do not have transportation."* Residents reported that even where bus service exists, for example in Stratford, it is difficult for seniors to walk to bus stops and make transfers. While Bridgeport was reported to have more transportation options, residents reported that these can be expensive for those with little income.

Quantitative data indicated that many residents of the Greater Bridgeport area do have access to a vehicle. However, at nearly 10%, residents in Bridgeport are less likely to have a car than those in the other surrounding communities (Figure 18).

Figure 18: Percent of Households with No Vehicle Available, U.S., Connecticut, and Towns, 2007-2011



DATA SOURCE: US Department of Commerce, Bureau of the Census, American Community Survey 5-Year Estimates, 2007-2011.

Crime and Violence

> *"Gangs- that's a big concern. There's a lot of that around Bridgeport and in some parts of Stratford."* –Focus group participant, Bridgeport
>
> *"What we see at our organization is that the number one thing the community is concerned about in Bridgeport in terms of youth is probably youth violence."* –Focus group participant, Regional
>
> *"If it happens in Bridgeport, you hear about it, but in the other towns, they sweep it under the carpet."* –Focus group participant, Bridgeport
>
> *"Here in the suburbs, I feel very safe. Violence or crime is not something that is generally top of mind."* –Focus group participant, Fairfield

For the most part, residents saw surrounding communities as relatively safe but reported substantial crime and violence in Bridgeport. However, several observed that crime, such as robberies, has increased in recent years in suburban areas. Growing gang violence in the region was mentioned by several focus group respondents and interviewees. One Stratford first responder explained, *"There are gangs in very poor areas, in low income parts, and in middle income neighborhoods. They don't have a preference. They are all over. They are prevalent everywhere."* Some residents reported that the lack of activities for youth has contributed to rising rates of gang activity, crime, and substance use among youth.

Residents of Bridgeport frequently reported concerns about personal safety. As one focus group member from the community reported, *"People are always worried about having a safe space for their kids to go."* Those from neighboring Stratford reported spill-over crime and drug trade from the city.

Quantitative data show substantial variation in crime rates across the Greater Bridgeport municipalities (Table 5). Rates of both violent and property crime are lowest in Easton and highest in Bridgeport and

Stratford. The rate of violent crime in Bridgeport is over three times higher than that for the state and the rate in Stratford slightly exceeds the state rate. The rates of property crime in both urban areas are also higher than for the state.

Table 5: Violent and Property Offenses Known to Law Enforcement, Rate per 100,000 Population, U.S., Connecticut, and Towns, 2009

	Violent Crime	Property Crime
Bridgeport	1085.1	4042.3
Easton	27.5	866.3
Fairfield	64.5	1941.1
Monroe	36.4	883.3
Stratford	322.2	2913.4
Trumbull	67.2	2336.2
Connecticut	307.5	2428.7
US	403.6	2941.9

DATA SOURCE: Connecticut Data Collaborative, 2009.

Table 6 shows fatal injuries and homicides in the Greater Bridgeport region. The homicide rate in Bridgeport (14 per 100,000 population) is substantially higher than that of other communities in the region, the state overall (0.04 per 100,000 population) and the U.S. (4.2 per 100,000 population). The rate of fatal injuries in the city (58 per 100,000 population) is similar to that for the U.S. (59.2 per 100,000 population) but higher than that for Connecticut (49.8 per 100,000 population) and other communities in the region.

Table 6: Fatal Injuries and Homicides per 100,000 Population, U.S., Connecticut, and Towns, 2005-2009

	Fatal Injuries	Homicides
Bridgeport*	58	14
Easton*	32	0
Fairfield*	27	1
Monroe*	24	0
Stratford*	53	5
Trumbull*	28	0
Connecticut**	49.8	.04
US**	59.2	4.2

*DATA SOURCE: National Center for Injury Prevention and Control 2009; Rates standardized to US Department of Commerce, Bureau of the Census, 2000 Population estimates.

** DATA SOURCE: U.S. Department of Justice, Federal Bureau of Investigation, Crime in the United States, Total Murder Victims, 2010; Rates standardized to US Department of Commerce, Bureau of the Census, 2010 Population estimates.

Rising rates of domestic violence, including elder abuse and dating violence, were also reported by residents throughout the region. Several praised the efforts of the Center for Women and Families to address this issue and serve victims. Recently, the Center, which is based in Bridgeport, has added branches in the surrounding communities. Several interviewees underscored that these office openings emphasize that the issue of domestic violence is pervasive among all communities and is not relegated to only low income neighborhoods.

Youth and those who work with youth reported that bullying has increased. As one adult from a Stratford focus group shared, *"At school, the children do not feel safe because of bullying."* Student focus group members from Bridgeport shared this view, reporting a rise in student-on-student violence; as one stated, *"I'm not used to the fights here. Big fights breaking out in school. We just had a lock-down*

yesterday." Those who mentioned bullying also reported that they believed not much is being done to address this issue. As one focus group member from Stratford stated, *"We talk about bullying a lot but there is no active education."*

Social Support and Cohesion

> *"I have lived in other areas where I wave to my neighbors and that's it. But here, the neighbors really care."* –Focus group participant, Stratford
>
> *"This town cares a lot about itself, and the people around it. Volunteerism is high, participation is high."* –Focus group participant, Stratford
>
> *"We are into a new way of looking generationally, where everyone is like, you are on your own. As an older person, it's tough to see how things are changing, and people don't interact with each other as much anymore."* –Focus group participant, Monroe

Perceptions of the social climates in the region's communities were mixed. Many residents, particularly in the surrounding communities, cited strong social relationships. As parent focus group member from Trumbull shared, *"It's a familiar community. I go to the grocery store and see the same people."* However, others reported less social cohesion. As one Bridgeport resident observed, *"When I was younger, I could just sit outside and know everyone. Now people just don't know each other."* The elderly were singled out as being more socially isolated, especially those who do not have family living locally. Senior respondents valued the role of senior centers in creating social connections while at the same time noting that not all seniors have the transportation or physical ability to get to these places.

However, many residents discussed the response to the recent Hurricane Sandy in November 2012 as a testament to community connectedness. Many focus group and interview participants cited how neighbors looked out for each other during the storm, particularly keeping watch on elderly or frail individuals, helped with clean-up in their community, and were quick to provide donated food and goods to those hit hardest by the storm. They noted that in times of crisis, the communities across the region came together.

Regarding the overall social climate of the region, some residents observed that the undercurrent of competitiveness and affluence in the more upscale areas has led to a tendency to ignore concerns or problems. As one Trumbull focus group member stated, *"People don't know about problems because everything is hidden. No one wants to share with their neighbors when things are going wrong."*

Another concern expressed by a number of respondents related to the increasing breakdown of families and rising parent stress. As one Fairfield school nurse stated, *"The high rate of divorce and separation really is affecting students."* Others reported that parents' employment commitments have meant that more children are left on their own for long periods of time. As one Trumbull social service provider explained, *"We have the two extremes, the helicopter parent and the parent who drops off their kids and expects you to raise them."*

Access to Healthy Foods and Recreation

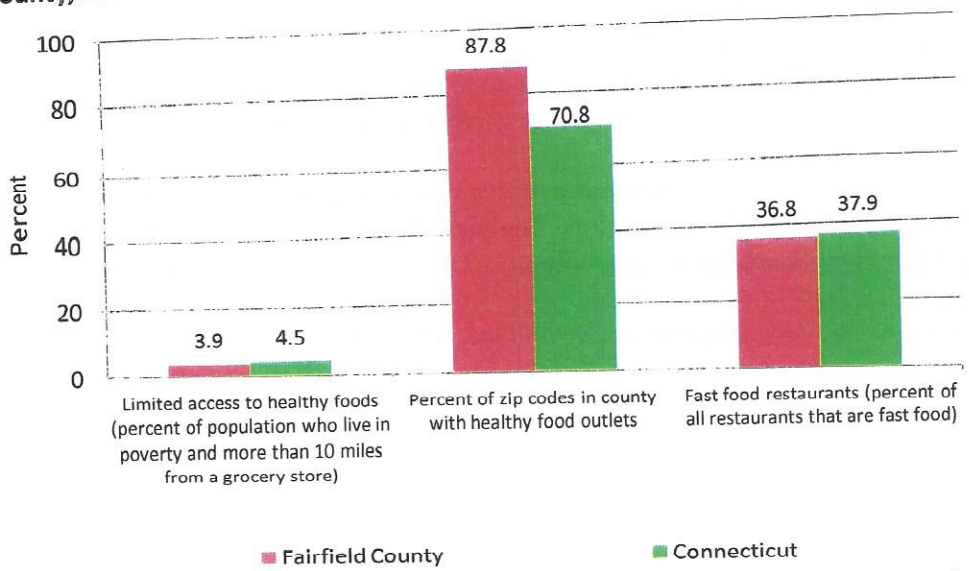
"Access can be a real issue, especially in low income areas. You are looking at no recess, no health education in the schools. There's limited access to fruits and vegetables when you don't have a lot of money." –Focus group participant, Bridgeport

"We have a lot of nice grocery stores in the area. We have a lot of access—but people can also afford it."–Focus group participant, Trumbull

Similar to trends nationwide, concerns about obesity, healthy eating, and physical activity were common themes across focus groups and interviews. According to respondents, access varied substantially across the region. Those in the suburban areas of Fairfield, Trumbull, and Monroe reported easy access to healthy food: the availability of grocery stores that carry fresh items and the ability of residents to pay for these. By contrast, Bridgeport was described as a *"food desert."* Residents stated that the city lacks a grocery store on the east side and that recently, the Stop and Shop in the north end closed. This has resulted in some residents now needing to rely on public transportation to get to a grocery store or, alternatively, shop at convenience stores which offer fewer healthy options. As one Bridgeport focus group member explained, *"If you wanted to go to a supermarket to get fresh foods, you have to get on a bus with your three kids, pay $1.25 and trek across town."* In Stratford as well, residents reported that healthy food is not available south of Post Road. As a result, many residents of the town also shop at convenience stores. Focus group members and interviewees throughout the region expressed concerns about the cost of healthy food; while some can afford more expensive fresh foods, others cannot. As one social service provider who serves the entire region stated, in some communities, *"The cost of food and convenience is prohibitive to eating healthy."* Fast food outlets are prevalent throughout the region, according to residents.

As Figure 19 below shows, 87.8% of zip codes in Fairfield County have healthy food outlets, higher than the rate for Connecticut as a whole (70.8%). However, the proportion of restaurants in Fairfield County that are fast food establishments (36.8%) is similar to that of the state (37.9%).

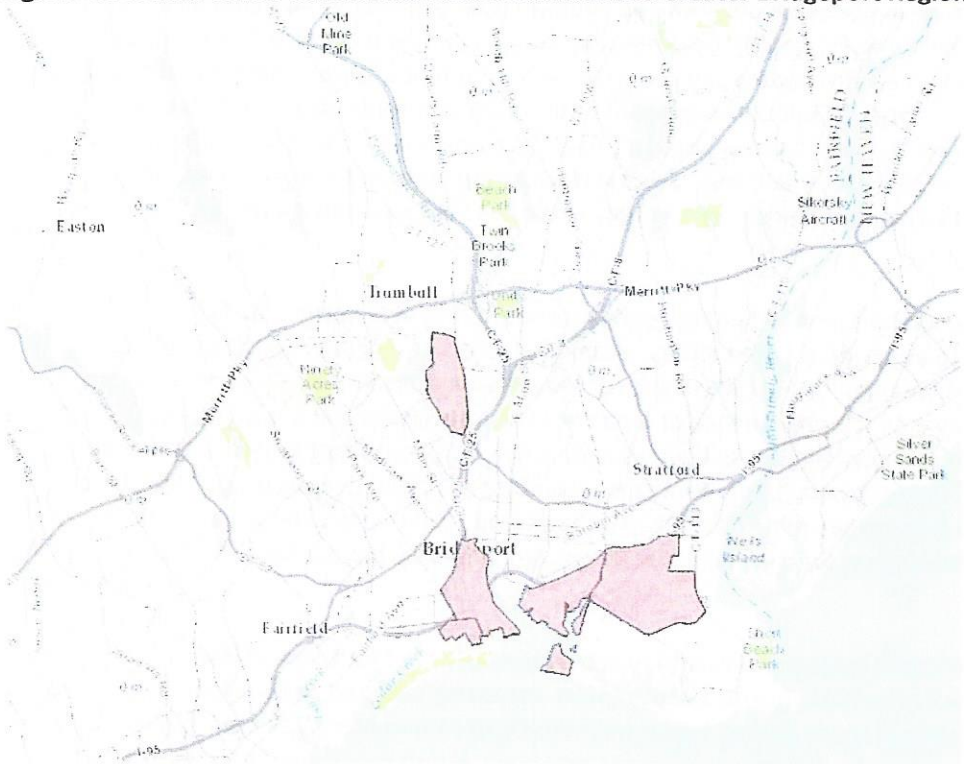
Figure 19: Percent of People with Access to Healthy Foods, Connecticut and Fairfield County, 2009



DATA SOURCE: Census Zipcode Business Patterns, 2009 used in United States Department of Agriculture (USDA) *Food Environment Atlas, analysis by County Health Rankings and Roadmaps, 2009.*

Figure 20 presents a map with the census tracts in the region (in red) identified as food deserts. The U.S. Department of Agriculture defines these as low-income neighborhoods (poverty rate at least 20%) where a substantial number of residents do not have easy access to a supermarket or large grocery store (typically within 1 mile for an urban area). As the map shows, several areas in and around Bridgeport are considered food deserts by the USDA's definition.

Figure 20: Census Tracts Considered Food Deserts in the Greater Bridgeport Region



DATA SOURCE: United States Department of Agriculture (USDA), Economic Research Service, Food Desert Locator, using 2009 data, at http://www.ers.usda.gov/data-products/food-desert-locator/go-to-the-locator.aspx

One area in which residents reported substantial change was in the area of school nutrition. They noted that state and local agencies appear to be working on addressing childhood obesity by changing portion sizes, replacing less healthy with more healthy options, and increasing the availability of fruits and vegetables. However, not all have been happy with these changes. Students reported that decreased portion sizes have led students to fill up with less healthy snacks. As one Bridgeport teen explained, *"What they did for our lunches, they just cut everything down. They just gave us a quarter size sub."* Others reported a lack of freshness: *"The salad in here is packaged, and they look so lifeless."* Both students and adults expressed concerns that the new healthy food is being thrown away rather than eaten. As one teen observed, *"You just have to take it, but you don't have to eat it. You can just throw it out."* An adult focus group member from Stratford argued, *"There is a balancing point between healthy food and appetizing food."* Consumption of fast food is still prevalent among teens as it is less expensive and more convenient than healthier options, as one Bridgeport teen focus group member remarked, *"My friend comes in every morning with McDonald's."*

In addition to access to healthy foods, having safe spaces to be active was also considered important to addressing rising obesity rates. Data from the County Health Rankings indicate Fairfield County has more

recreational facilities than compared to the rest of the state (20 per 100,000 compared to 14 per 100,000 population). While many focus group members and interviewees spoke positively about their surroundings, citing the large number of parks, walking trails, athletic facilities, and beaches, they also acknowledged that facilities are not available in all communities and in some cases, are cost prohibitive. As one teen from Bridgeport reported, *"We don't really have that many basketball courts in general, and they closed some of them off to youth because of fights."*

Residents from surrounding communities generally reported the availability of a number of enclosed sports facilities, yet these are fee-based and often require a car to access. A Monroe parent focus group respondent reported a decrease in places for children and youth to play, explaining, *"We eliminated 90% of the places they can play. We turned a football field into a parking lot and a lot of yards I used to play in are getting bought up and turned into houses."* In surrounding communities, it was noted that the lack of sidewalks make it difficult to walk. As one focus group member from Stratford explained, *"It's a difficult town to be a pedestrian in."* Another concurred stating, *"The way the cars go whizzing by you, it's unsafe. There really should be a sidewalk there."* Several focus group members and interviewees reported that a Bike/Walk initiative was currently underway in the Fairfield area and expressed hope that this could be expanded.

While residents reported increased access to healthy foods in schools, they also noted that the emphasis on academics in schools has led to reductions in time for recess and physical activity. As one Bridgeport social service provider stated, *"We've cut a lot of the physical exercise programs in our schools."* This, in combination with the prominence of organized team sports, has meant that those students not on teams have few opportunities to be physically active. As one Bridgeport teen remarked, *"We don't go outside a lot."* In Bridgeport, safety concerns were cited as preventing residents from using parks and playgrounds. As a focus group member from the city shared, *"I live across the street from a park. It's a beautiful park and I love it. But I would never let my daughter play there…there's just too much violence."*

Concerns for seniors also emerged in discussions around access to nutritious foods and health-promoting activities. Several expressed concerns about seniors not eating well and healthy food being out of economic reach for many of them. As one senior from Stratford commented *"The seniors need to have access to more nutritional foods. The farmer's market was good, but so expensive. There should be discounts for senior citizens to shop there."* The lack of sidewalks was noted as a particular constraint for seniors who also shared concerns about the lack of accessible facilities to walk indoors in bad and wintry weather. When discussing the built environment, seniors also mentioned their concerns about outdoor spaces in general—such as sidewalks—being accessible to them to engage in daily activities such as taking out the garbage or walking the dog without prompting falls.

Environmental Quality

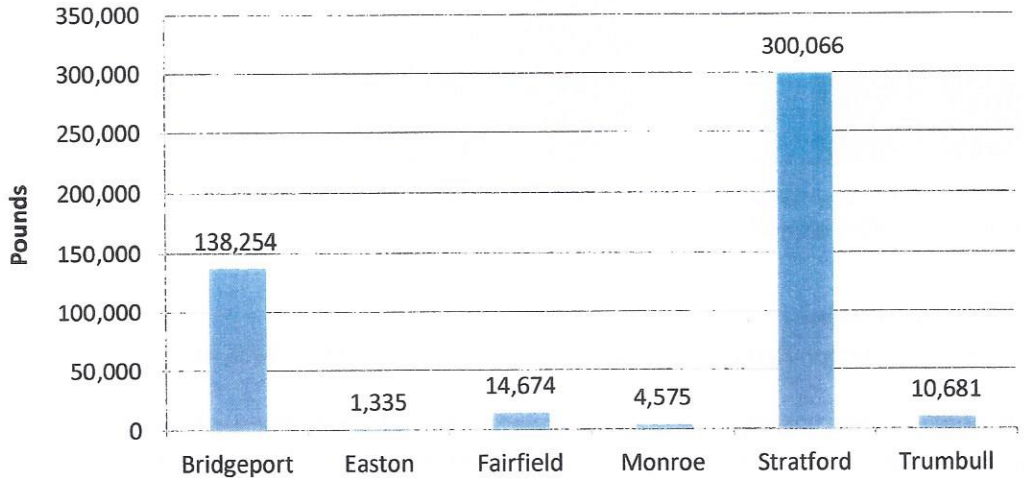
> *"I fear that we have toxic clouds buried beneath us."* –Focus group member, Stratford

Concerns about the impact of environmental change and an aging infrastructure were mentioned by numerous Greater Bridgeport residents. The region's long industrial history has had environmental repercussions, according to residents, who spoke extensively about the region's brownfield areas. Residents discussed asbestos and lead concerns at the Raymark Industries site in Stratford (a SuperFund site), thorium issues at the Stratford Army Engine Plant, and abandoned industrial warehouses and coal plants in Bridgeport. These sites not only leave substantial land unusable for business development but many residents were also concerned about them being linked to health issues. As one interviewee from

Trumbull/Monroe stated, *"A lot of our homes are built on filled wetlands. We see young mothers succumbing to breast cancer. I don't know if there is a real link, but it makes us nervous."*

Quantitative data confirm the perceptions of focus group members and interviewees. According to the EPA's Toxic Release Inventory Program, environmental waste in Stratford (300,066 pounds) is over twice as high as in Bridgeport (138,254 pounds) (Figure 21).

Figure 21: Federal Toxic Release Inventory Environmental Waste (Including air, water, and solid), Towns, 2008

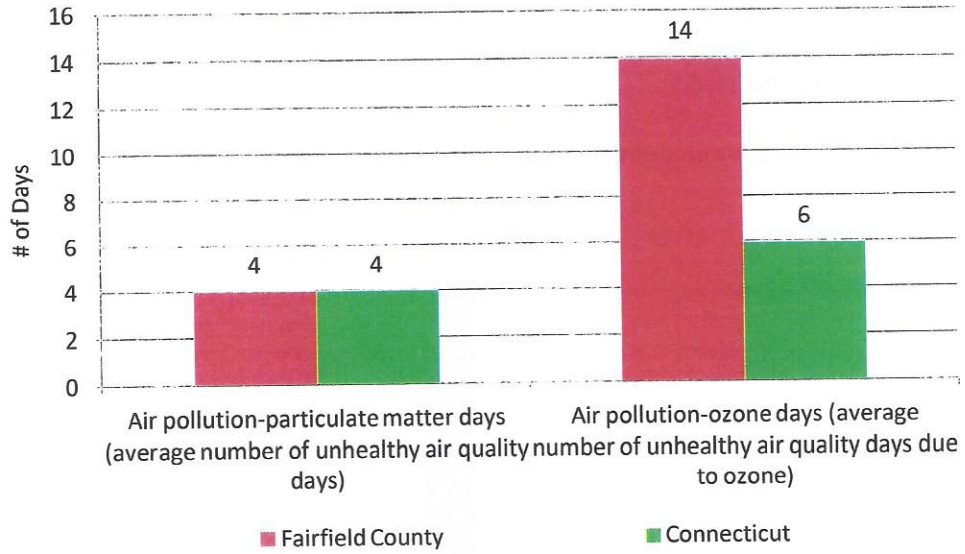


DATA SOURCE: Healthy Equity Index, Toxics Release Inventory Program Data and Tools, 2008.

Residents reported some changes, however, and pointed to work the Mayor of Bridgeport has been doing to make the city the greenest in New England by bringing in transit and green jobs. Redevelopment and clean-up work has been underway, and some residents were hopeful about the future changes.

Air quality is also an issue of concern, particularly as a trigger for asthma which is disproportionately experienced by low-income children. County Health Rankings data show that in 2007, Fairfield County had the same annual number of unhealthy air quality days (4) due to fine particulate matter as the state (Figure 22). However, the County had far more (14) ozone days that year (days when air quality was unhealthy for sensitive populations due to ozone levels) than the state as a whole (6).

Figure 22: Air Pollution, Connecticut and Fairfield County, 2007



DATA SOURCE: US Environmental Protection Agency (EPA), 2007 as cited by the County Health Rankings, 2012.

The consequences of natural disasters, including recent Hurricane Sandy, were also discussed by several focus group participants and interviewees who expressed concerns about economic development in low lying areas and the capacity of towns to respond to such emergencies. As one person from Stratford explained, *"there are several areas where whenever there is heavy rain, that area gets flooded considerably. A lot of businesses are moving out of that area because it's not sustainable to keep rebuilding there."* Respondents who spoke about this issue reported that the region is relatively well prepared for these types of challenges due to substantial training and preparedness drills. A related concern pertains to the region's old septic infrastructure which can and has backed up in bad weather. The lack of a sewer system was reported to be a substantial constraint to local development.

However, some Stratford first responders expressed concerns about readiness to help populations with special needs such as those in extended care or requiring oxygen. As one first responder shared, *"Those give me anxiety. This is something we really need to get our arms around and explore options about what we can do, although we are very good at adjusting each time we face one of those experiences."*

HEALTH BEHAVIORS

This section describes lifestyle behaviors among the residents of the Greater Bridgeport region that support or hinder health. These include individuals' behaviors and risk factors such as physical activity, nutrition, and alcohol and substance use that contribute substantially to morbidity and mortality. Where available, this analysis includes measures that are tracked as part of the Healthy People 2020 (HP2020) Initiative, a 10-year agenda focused on improving the Nation's health. Due to data constraints, some health behavior measures are available only for Fairfield County as a whole, and not individual towns.

Healthy Eating, Physical Activity, and Overweight/Obesity

> *"We are a vigorous, health-minded community."* –Interviewee, Trumbull/Monroe

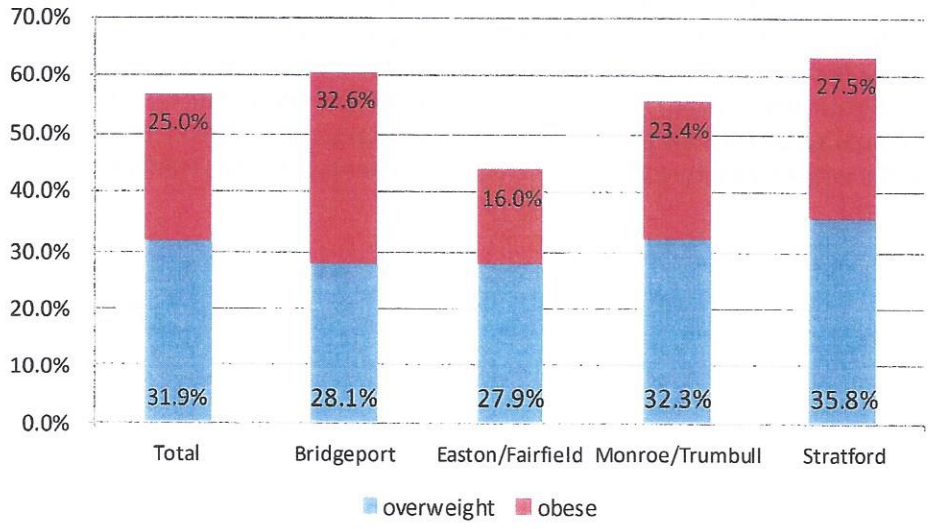
> *"Parents don't recognize themselves or their children as being obese."*—Focus group participant, Regional

Similar to trends nationwide, Greater Bridgeport region focus group participants and interviewees reported that obesity is emerging as a community issue, and with it, rising cases of chronic diseases.

Adult Obesity

As seen nationally, obesity is a growing concern. The majority of Greater Bridgeport survey respondents in the community health assessment survey (56.9%) were considered either overweight (31.9% at body mass index between 25.0-29.9) or obese (25.0% at body mass index greater or equal to 30). However, rates varied across communities. Looking just at obesity, 32.6% of Bridgeport survey respondents and 27.5% of those from Stratford were considered obese, whereas only 16.0% of Easton and Fairfield survey respondents were considered obese. County-wide, the 2010 Behavioral Risk Factor Surveillance Survey indicates that the prevalence of adult obesity in Fairfield County is 16.6% compared with 23.0% in the state and 27.5% in the country.

Figure 23: Percent Overweight or Obese, Greater Bridgeport CHA Survey, 2012

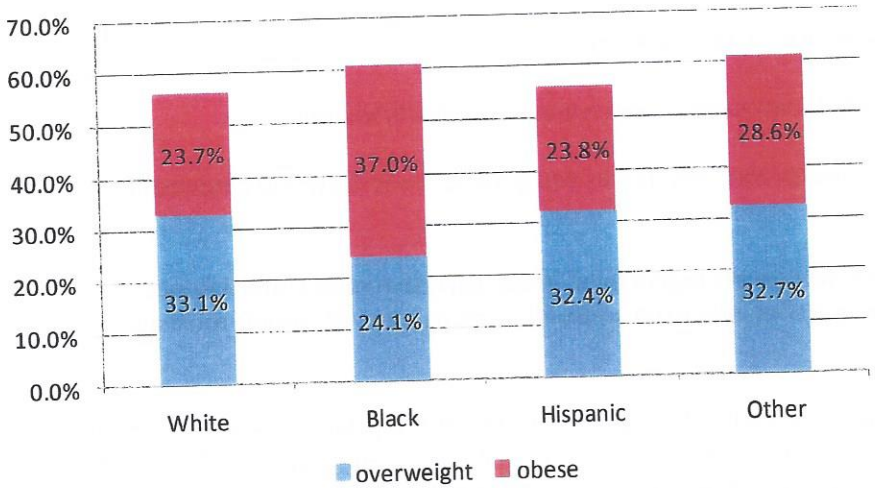


DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

Respondents self-reported their height and weight. Body mass index was calculated and then categorized as overweight (BMI: 25.0-29.9) or obese (BMI: ≥30.0).

Survey respondents also differed in overweight and obesity rates by race/ethnicity, with the starkest contrast specifically in obesity rates. Among respondents of the community health assessment survey, 37.0% of non-Hispanic Black respondents were considered obese, compared to 28.6% of those of Other race (which included respondents identified as Asian, Other race, or two or more races), 23.8% of Hispanic respondents, and 23.7% of non-Hispanic White respondents.

Figure 24: Percent Overweight or Obese, by Race/Ethnicity, Greater Bridgeport CHA Survey, 2012

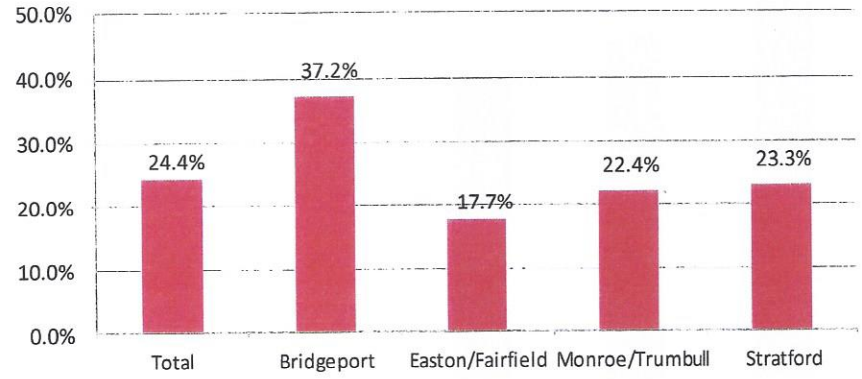


DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

Although fruit and vegetable consumption data are not available for the specific Greater Bridgeport region, Fairfield County data from the 2010 Behavioral Risk Factor Surveillance Survey indicate that only 30.2% of Fairfield County adults consume at least five or more servings of fruits and vegetables daily. However, this is higher than residents across the state, at 28.3%.

In discussions with focus group and interview participants, physical activity was considered an important aspect of good health, but residents reported numerous challenges to being physically active. Barriers discussed ranged from lack of time to community infrastructure not encouraging physical activity (e.g., lack of sidewalks, concerns for safety in urban parks) for adults or children. When survey respondents were asked about their physical activity, 24.4% indicated that they had participated in no leisure time physical activity in the past month, with ranges from 17.7% of survey respondents in Easton/Fairfield to 37.2% in Bridgeport (Figure 25).

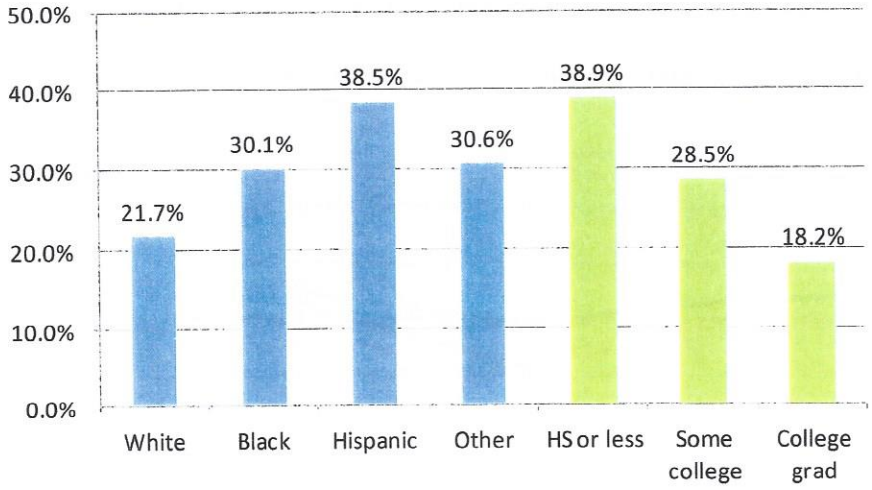
Figure 25: Percent of Respondents Reporting No Leisure Time Physical Activity in Past Month, Greater Bridgeport CHA Survey, 2012



DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

As seen statewide and nationally, there are patterns in physical activity responses by race/ethnicity and educational level among survey respondents. At 38.5%, Hispanic respondents were most likely to report having no leisure time physical activity (Figure 26). There was also a strong educational gradient in physical activity responses, with those with a high school education or less being most likely to report no leisure time physical activity compared those with some college or a college degree.

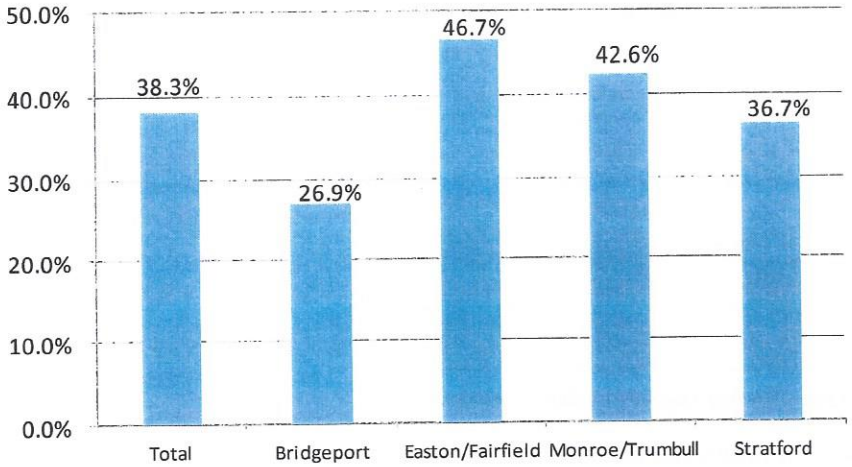
Figure 26: Percent of Respondents Repoting No Leisure Time Physical Activity in Past Month, by Race/Ethnicity and Education Level, Greater Bridgeport CHA Survey, 2012



DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

Greater Bridgeport community health assessment survey respondents were asked about their participation in moderate and vigorous physical activities. Based on their self-reports of physical activity time and frequency, 38.3% of survey respondents meet the government's physical activity guidelines (Figure 27). Respondents from Easton/Fairfield were most likely to meet these physical activity guidelines, while those from Bridgeport were least likely. The Healthy People 2020 target for this behavior is 47.9%.

Figure 27: Percent of Respondents Reporting Meeting Physical Activity Recommendations, Greater Bridgeport CHA Survey, 2012

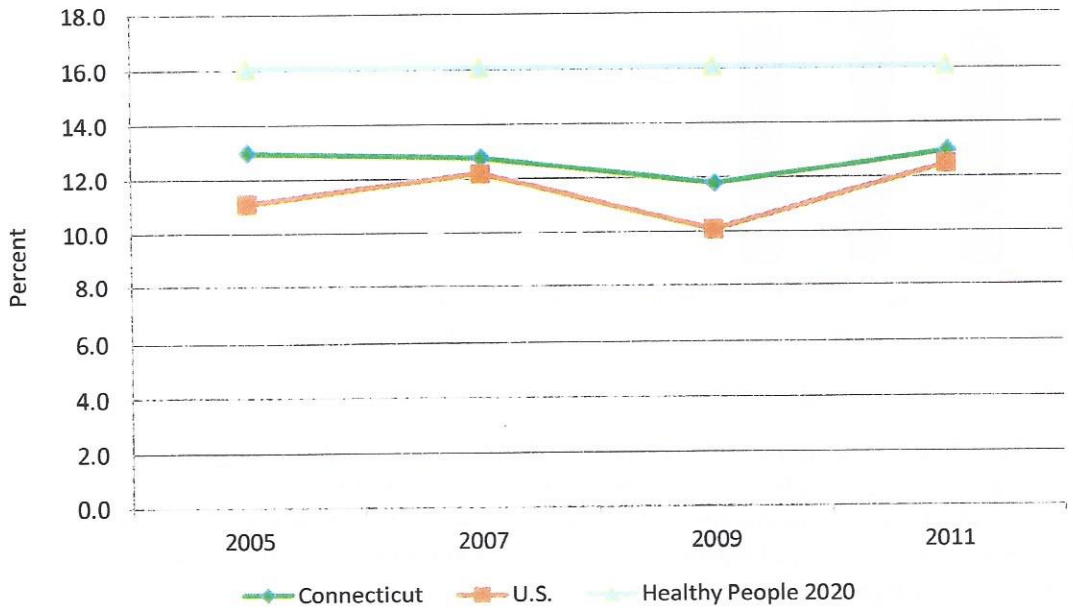


DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.
Note: Physical activity recommendations are at least 150 minutes of light or moderate activity per week, 75 minutes of vigorous activity, or 150 minutes per week of an equivalent combination of activity.

Child and Youth Obesity

The obesity rate among high school students in Connecticut has changed little between 2005 and 2011 (Figure 28). In 2011, the rate of youth obesity in Connecticut (13.0%) was similar to that of the nation (12.5%) and lower than the Healthy People 2020 target (16.1%). Although child and youth obesity rates are not available for most Greater Bridgeport towns, according to Bridgeport CARES 2011, the city of Bridgeport has a 25% child and youth obesity rate, far higher than that for the state or the nation.

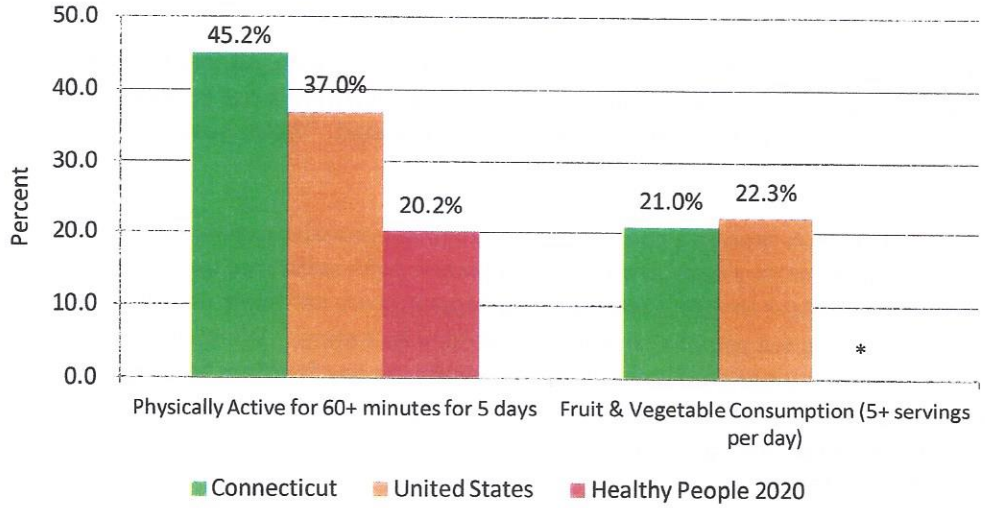
Figure 28 : Percent of Obese Youth, 9th-12th Grades, U.S. and Connecticut, 2005 – 2011



DATA SOURCE: Youth Risk Behavior Survey (YRBS), 2005, 2007, 2009, 2011 **relevant Fairfield County data not available. Data for Fairfield County or specific towns not available.

Quantitative data from the Youth Risk Behavioral Survey show that less than half of Connecticut youth were getting the recommended level of exercise per week in 2009, although this rate is higher than for the nation (37.0%) and higher than the Healthy People 2020 target of 20.2% (Figure 29). The proportion of Connecticut youth eating the recommended number of fruits and vegetables per day—one quarter—is the same as for U.S. youth as a whole.

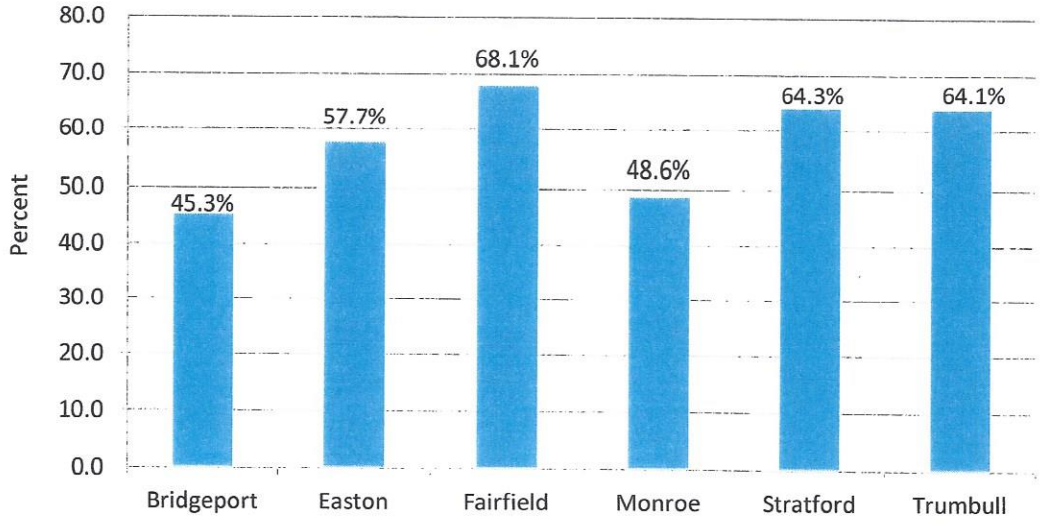
Figure 29: Physical Activity and Fruit and Vegetable Consumption among Youth, U.S. and Connecticut, 2009



DATA SOURCE: Youth Risk Behavior Survey (YRBS), 2009 *relevant Healthy People 2020 target, not available
Data for Fairfield County or specific towns not available.

Physical activity data among youth indicate that less than half of fourth graders in Bridgeport and Monroe meet physical fitness standards. Approximately 58% of youth meet these standards in Easton as do over two-thirds of youth in Fairfield, Stratford and Trumbull (Figure 30).

Figure 30: Percent of Students Meeting the Standard on All Four Physical Fitness Tests, Grade 4, Towns, 2010



DATA SOURCE: Connecticut Data Collaborative, 2010.

Substance Use and Abuse (Alcohol, Tobacco, and Illegal Drugs)

> *"Because of our affluence or perceived affluence, we don't talk about our problems in public. Something like drugs has been allowed to thrive in our community because we don't want to talk about it publicly and admit that we—or our children—have these problems too."* –Interviewee, Trumbull/Monroe

> *"We have a couple of hot spots in town, drugs, that kind of thing."* –Focus group participant, Stratford

Substance use was mentioned as an area of concern by respondents across the region. Although several residents believed that substance use is declining overall in the region, they reported a rise in the use of alcohol and prescription drugs. As one focus group member from Monroe stated, *"We've got a population that self-medicates."*

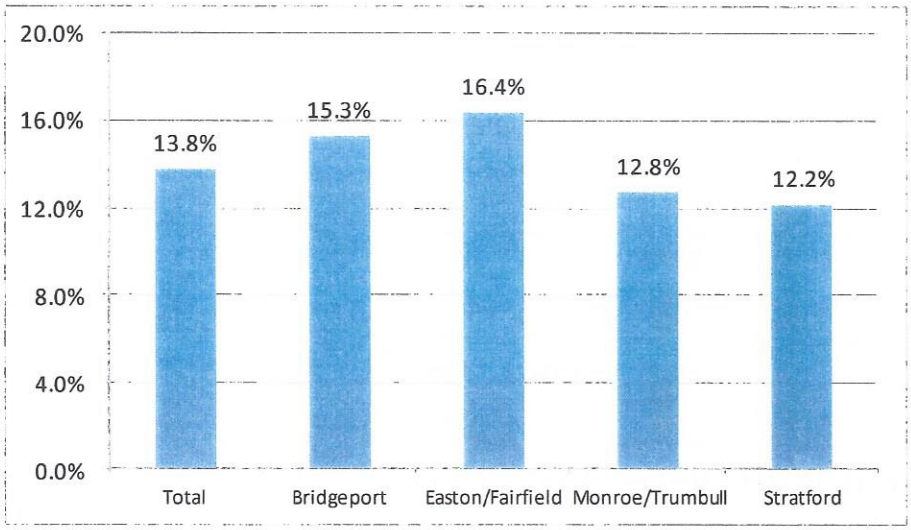
The lack of substance abuse services was cited as a concern. As one regional provider explained, *"The tools are not there for people to do what they need to do to help someone [with substance use issues]. It really just comes down to the money. If the money is not there, the resources are not there...and that's the sad part. You want to do something but you can't because the money isn't there."* While the region has a methadone clinic, some residents wondered about its effectiveness. As one Stratford focus group member stated, *"You quit a drug, and they give you pills. The pills have side effects."* Additionally, social service providers reported that reduced funding has led to cuts in substance education programs for young people, which has contributed to the problem.

<u>Adult Substance Use</u>

Among respondents of the Greater Bridgeport community health assessment survey, 66.3% reported having had at least one alcoholic drink in the past 30 days. However, 13.8% reported binge drinking behavior in the past month (on one occasion in the past month, having five or more drinks for men and four or more drinks for women) (Figure 31). Responses were slightly different by community, with a higher percentage of respondents from Easton/Fairfield and Bridgeport reporting binge drinking behaviors in the past month than respondents from the other communities.

According to the 2010 Behavioral Risk Factor Surveillance Survey, the percentage of adult binge drinking in the county overall is slightly higher, at 20.5% than what is seen in the state (17.4%) and nation (15.1%).

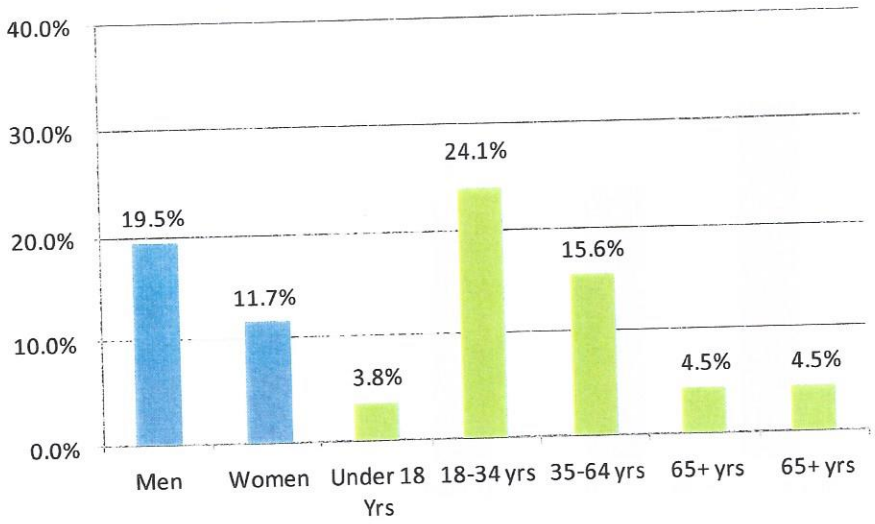
Figure 31: Percent Survey Respondents Reporting Binge Drinking, Greater Bridgeport CHA Survey, 2012



DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

Figure 32 shows the survey responses on binge drinking by gender and age group. Among men who completed the Greater Bridgeport community health assessment survey, 19.5% reported that they participated in binge drinking behavior in the past 30 days, compared to 11.7% of women. The 18-34 year old group had the highest binge drinking rates at 24.1%, followed 35-64 year olds.

Figure 32: Percent Survey Respondents Reporting Binge Drinking, by Gender and Age Group, Greater Bridgeport CHA Survey, 2012

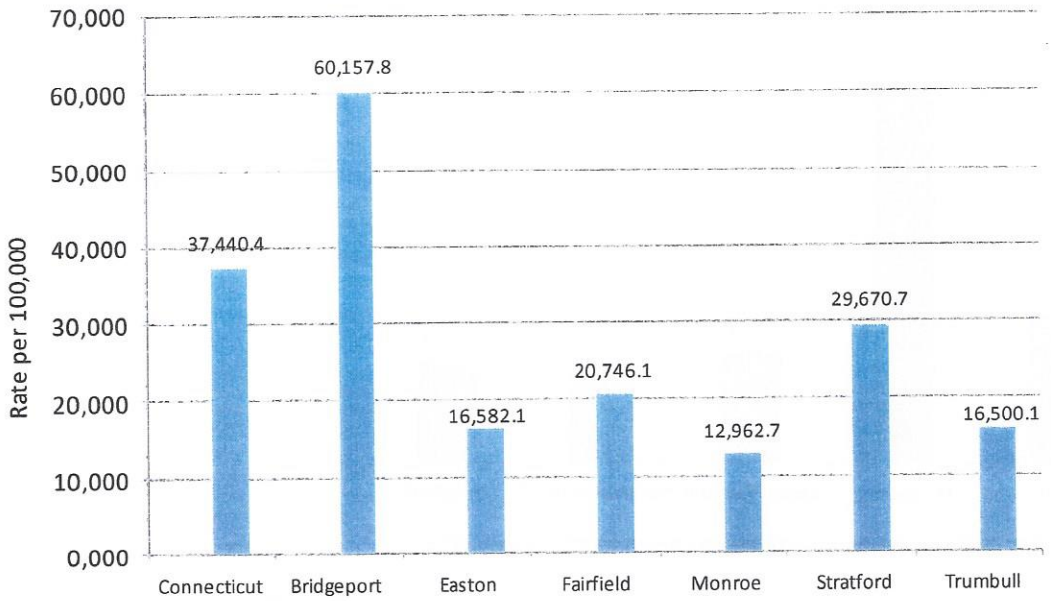


DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

While little reliable data on drug use among adults in the region were available, there is some information on drug and alcohol-induced deaths. Drug-induced deaths in Bridgeport were 16.2 per 100,000 population and 15.8 per 100,000 population in Stratford, higher than the state rate of 11.1 per 100,000 population, according to the CT Department of Public Health Average Annual Mortality Rate, 2004-2008 data. Fairfield's rate of 6.2 per 100,000 population was lower than the state average.

Emergency room department visits with substance abuse as the primary diagnosis show a similar pattern with Bridgeport and Stratford having the highest rate per 100,000, at 60,158 per 100,000 and 29,670, respectively (Figure 33). Fairfield has a higher rate of substance abuse-related ED visits than the remaining communities of Easton, Monroe, and Trumbull.

Figure 33: Emergency Department Non-Admission Visions with Substance Abuse as Principle Diagnosis



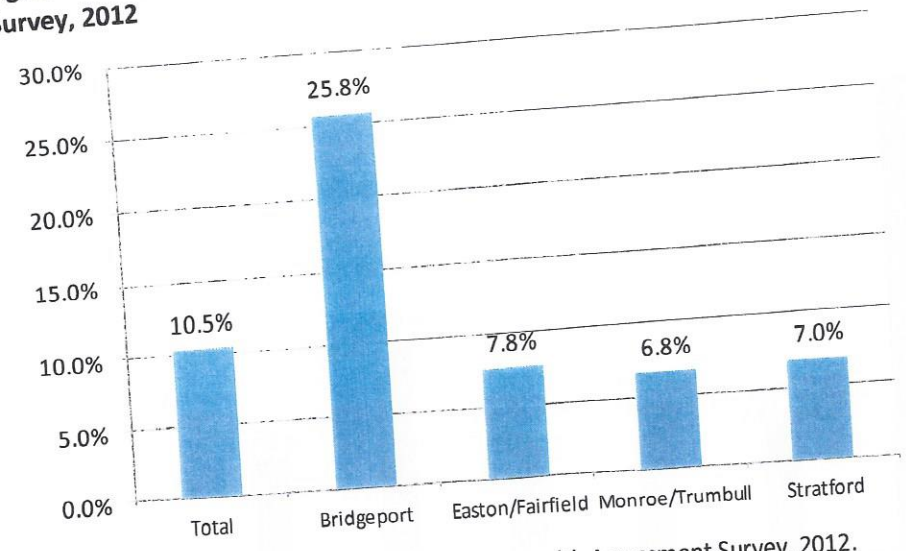
DATA SOURCE: CHIME Hospital Discharge Data, 2010.

The smoking rate among community health assessment survey respondents (10.5%) is similar to what has been reported in Fairfield County (10.0%) in the 2010 Behavioral Risk Factor Surveillance Survey and lower than what is seen across the state (13.2%) and the target for Healthy People 2020 (12.0%). However, demonstrated in Figure 34, the percentage of survey respondents who reported being a current smoker as defined by smoking every day or some days is much higher in Bridgeport (25.8%) compared to the other communities in the region (6.8%-7.8%).

There were disproportionate smoking rates by race/ethnicity and educational level among survey respondents (Figure 35). At 22.3%, Hispanics were the most likely to be current smokers followed by Blacks at 17.3%. As with many other risk-related behaviors, there is also an educational gradient in smoking, with those with lower education being more likely to be a current smoker than those with higher levels of education.

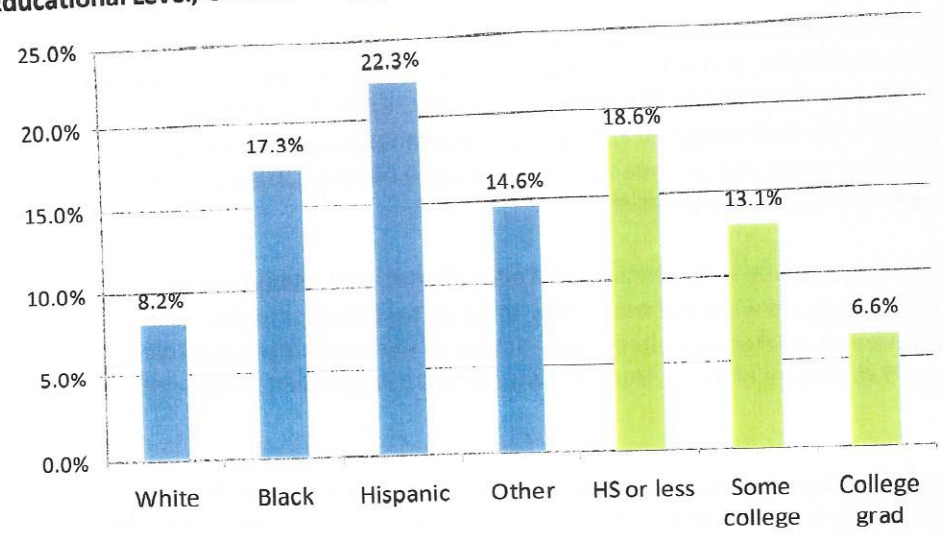
Of the 133 survey respondents who were smokers, 59 (41.8%) indicated that they smoke at home. Among these individuals who smoke at home, 11 of these smokers reported that they were a caretaker for a child 12 years old or younger.

Figure 34: Percent Survey Respondents Reporting Being a Current Smoker, Greater Bridgeport CHA Survey, 2012



DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

Figure 35: Percent Survey Respondents Reporting Being a Current Smoker, by Race/Ethnicity and Educational Level, Greater Bridgeport CHA Survey, 2012



DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

Among the 141 survey respondents in the region who indicated that they were current smokers, nearly half (47.5%) indicated that they have tried to quit in the past year. This ranged from 36.8% of smokers in Monroe/Trumbull to 56.5% of smokers in Easton/Fairfield who indicated they had tried to quit in the past year.

Youth Substance Use

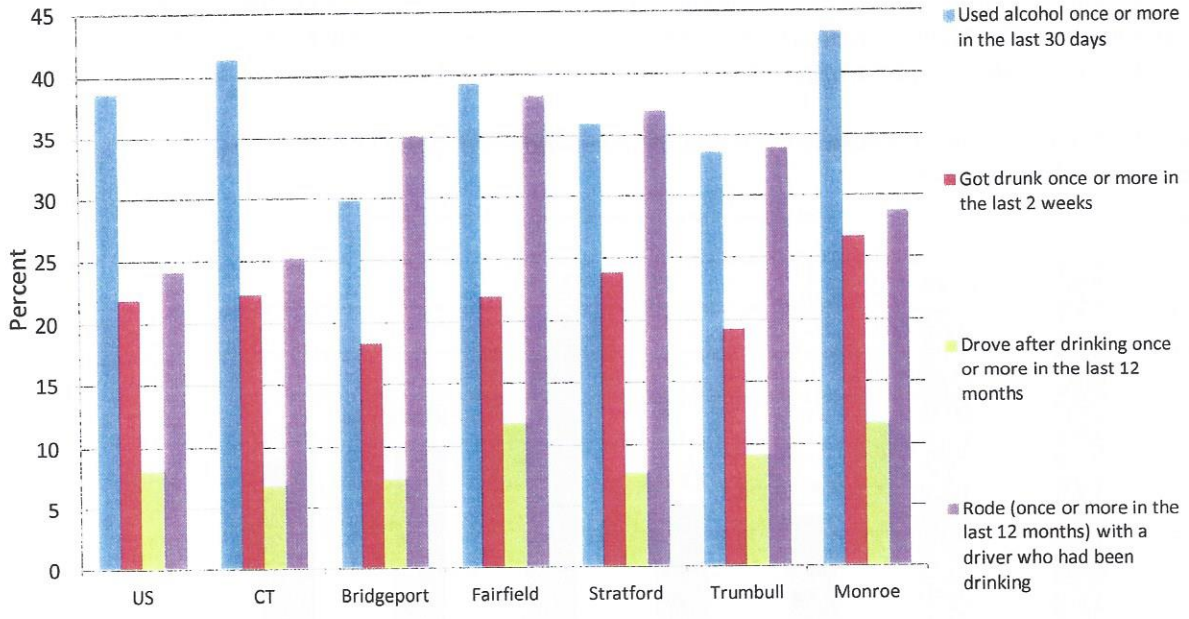
Among teens, smoking cigarettes, using prescription drugs, and drinking at younger ages were issues that were reported by several focus group participants. As one parent focus group member stated, *"I'm really concerned with the kids in Monroe and Trumbull; they go to parties, and the drinking is happening*

at people's houses." Several residents noted a rise in the use of prescription drugs among teens. One teen focus group member from Bridgeport shared that *"Popping pills is becoming very popular."* Ease of access to substances was reported by some residents as one of the reasons for their increased use. As one Bridgeport teen explained, *"Some stores just sell cigarettes, it doesn't matter how old you are."* Relative to prescription drugs, one Trumbull/Monroe interviewee remarked, *"The trade in prescription drugs among teens horrifies me, because it's accessible—the parents and grandparents need it. The young people know there is a thriving trade."*

Residents attributed the use of substances among youth to several factors. Some reported that academic stress has contributed to substance use, especially alcohol and prescription drugs. Others reported that the lack of activities for youth is a factor. As one Bridgeport youth focus group member stated, *"That's why a lot of kids are stuck on drugs and alcohol, because what is there to do otherwise?"* Many adults held the same view. One Trumbull/Monroe parent explained, *"There isn't stuff for [teens] to do. They hang out at people's houses and are bored."* Another agreed, stating, *"If you're not into sports, there isn't anything."*

Quantitative data from the Search Institute Survey on Developmental Assets indicate that across almost all key measures for substance use among youth, Bridgeport youth report lower substance use than in the surrounding towns (Figure 36). The proportion of Monroe youth reporting having used alcohol once or more in the 30 days prior to the survey or getting drunk in the past two weeks was the highest among the communities surveyed in 2011. Across all the communities from which data were collected, a higher proportion of youth in Greater Bridgeport communities reported driving after drinking or riding in a car with a driver who had been drinking than youth in CT or the U.S. overall.

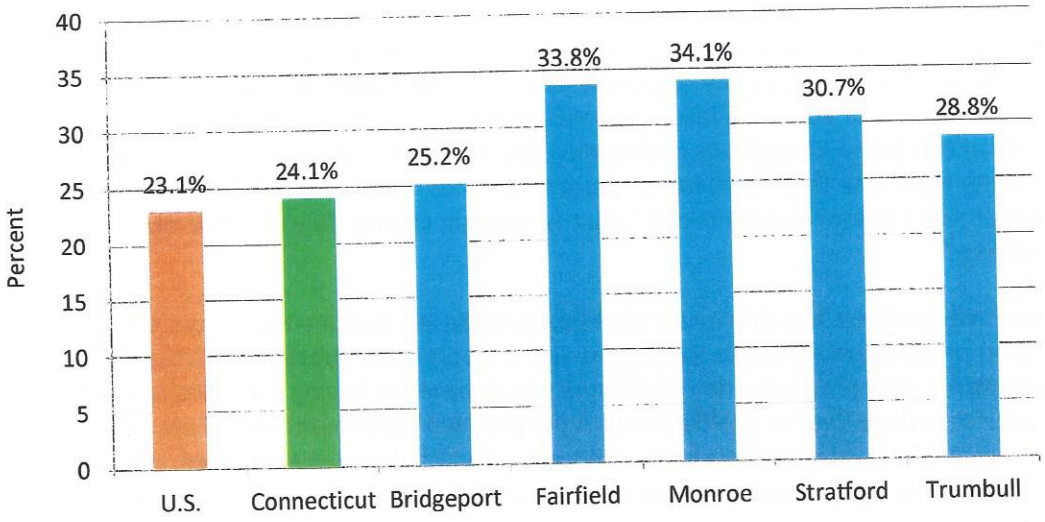
Figure 36: Alcohol Utilization Rates and Risks, Grades 9-12, U.S., Connecticut, and Towns, 2011



DATA SOURCE for town level data: RYASAP Report 2011, Search Institute Survey, Developmental Assets, 2011. Data for Easton not available.
NOTE: Data for U.S. and CT are from the Youth Risk Behavioral Survey. Data for US and CT on the "got drunk" indicator relates to binge drinking and asked participants if they had had five or more drinks of alcohol in a row within a couple of hours on at least 1 day (during the 30 days before the survey).

Overall, youth from the Greater Bridgeport region were more likely to report having used marijuana in the past year than youth state or nationwide. Town-level data indicate that nearly one third of Monroe and Fairfield youth in grades 9-12 have used marijuana in the past 12 months, while Bridgeport youth were the least likely to report usage of marijuana (Figure 37).

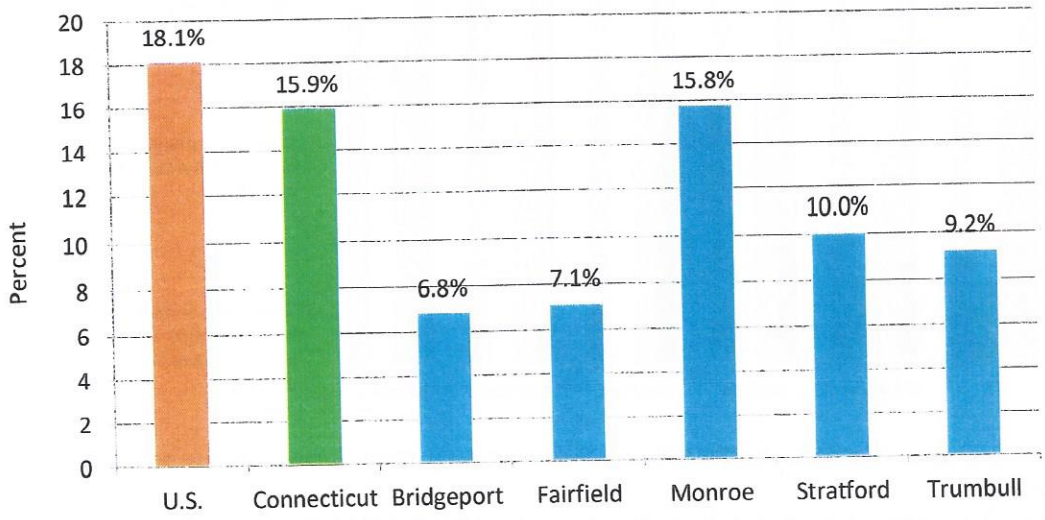
Figure 37: Proportion of Youth Grades 9-12 Having Used Marijuana Once or More in the Last 12 Months, U.S., Connecticut, and Towns, 2011



DATA SOURCE for town level data: RYASAP Report 2011, Search Institute Survey, Developmental Assets, 2011. Data for Easton not available.
NOTE: Data for US. and CT are from the Youth Risk Behavioral Survey, 2011.

Cigarette use among youth in the Greater Bridgeport region is substantially lower than that for the state (15.9%) and the U.S. (18.1%) in all communities except Monroe (Figure 38). Among all the communities surveyed, the lowest rate of reported cigarette use was among youth in Bridgeport (6.8%).

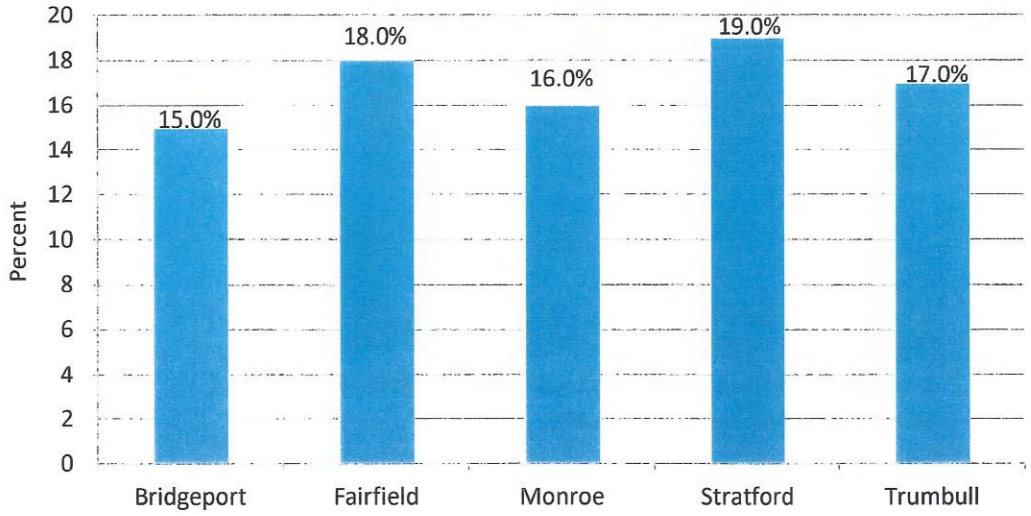
Figure 38: Proportion of Youth Grades 9-12 Having Smoked Cigarettes in the Past 30 Days, U.S., Connecticut, and Towns, 2011



DATA SOURCE for town level data: RYASAP Report 2011, Search Institute Survey, Developmental Assets, 2011. Data for Easton not available.
NOTE: Data for U.S. and CT are from the Youth Risk Behavioral Survey, 2011.

Use of illicit drugs among youth in Greater Bridgeport towns was highest in Stratford (19%). Bridgeport had the lowest rate of the communities from which data were collected (15%) (Figure 39).

Figure 39: Used Illicit Drugs Multiple Times in the Last 12 Months, Grades 6-12, Towns, 2011



DATA SOURCE for town level data: RYASAP Report 2011, Search Institute Survey, Developmental Assets, 2011. Data for Easton not available.
NOTE: Data for U.S. and CT are from the Youth Risk Behavioral Survey, 2011.
Illicit drug use defined as one or more of the following yearly drug use rates: 3 or more uses of marijuana, 2 or more uses of LSD, 2 or more uses of heroin, 2 or more uses of amphetamines.

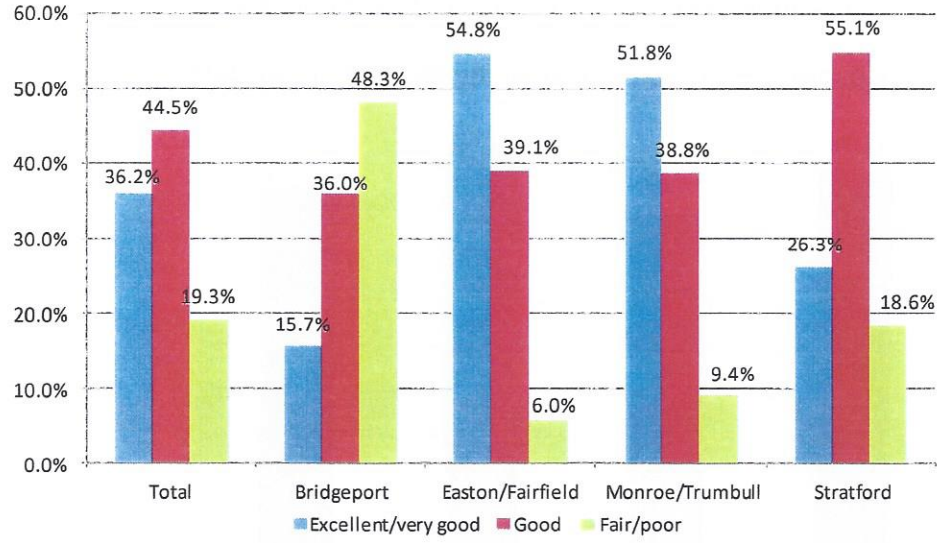
HEALTH OUTCOMES

This section of the report provides an overview of leading health conditions in the Greater Bridgeport region by examining incidence, hospitalization, and mortality data in addition to discussing the pressing concerns that residents and leaders identified during focus groups and interviews.

Perceived Community and Individual Health Status

In the survey, respondents were asked to describe the health of their overall community. Among respondents across the six communities, 80.7% described their community's health as good (44.5%) or excellent/very good (36.2%), while 19.3% said their community's health was fair or poor (Figure 40). However, responses varied by town. Nearly half of respondents from Bridgeport (48.3%) reported that their community's health was fair or poor, compared to 18.6% of respondents from Stratford, and fewer 10% of respondents from Monroe/Trumbull or Easton/Fairfield.

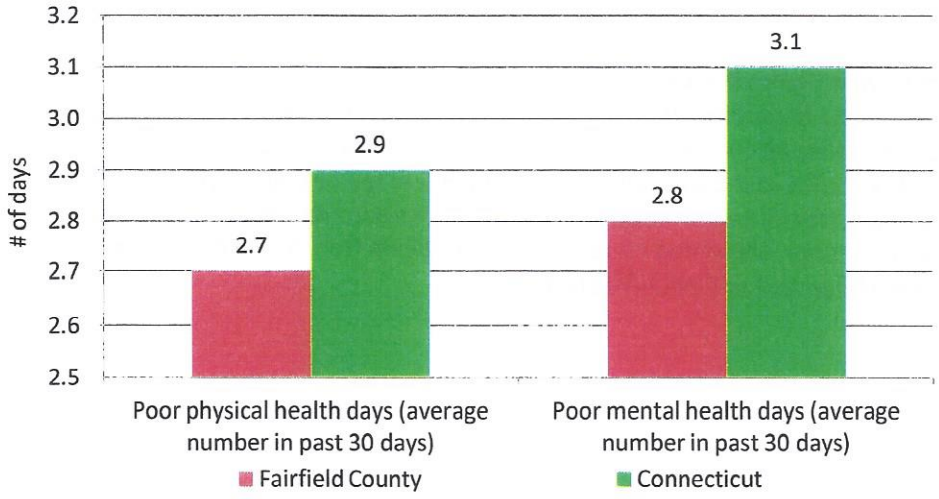
Figure 40: Perceived Community Health Status, CHA Survey Respondents, 2012



DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

Data on perceptions of individual level health are only available at the County level. When asked to describe their own health, 9.4% of Fairfield County residents who responded to the 2010 Behavioral Risk Factor Surveillance Survey indicated that they considered their own personal health as fair or poor. When the survey further asked about physical vs. mental health, approximately 2.7% of Fairfield adult respondents reported having poor physical health days and 2.8% reported poor mental health days in the 30 days prior to the survey (Figure 41). This compares to 2.9% and 3.1%, respectively, among adults in the state overall.

Figure 41: Perceived Health Status, Adults, Connecticut and Fairfield County, 2010

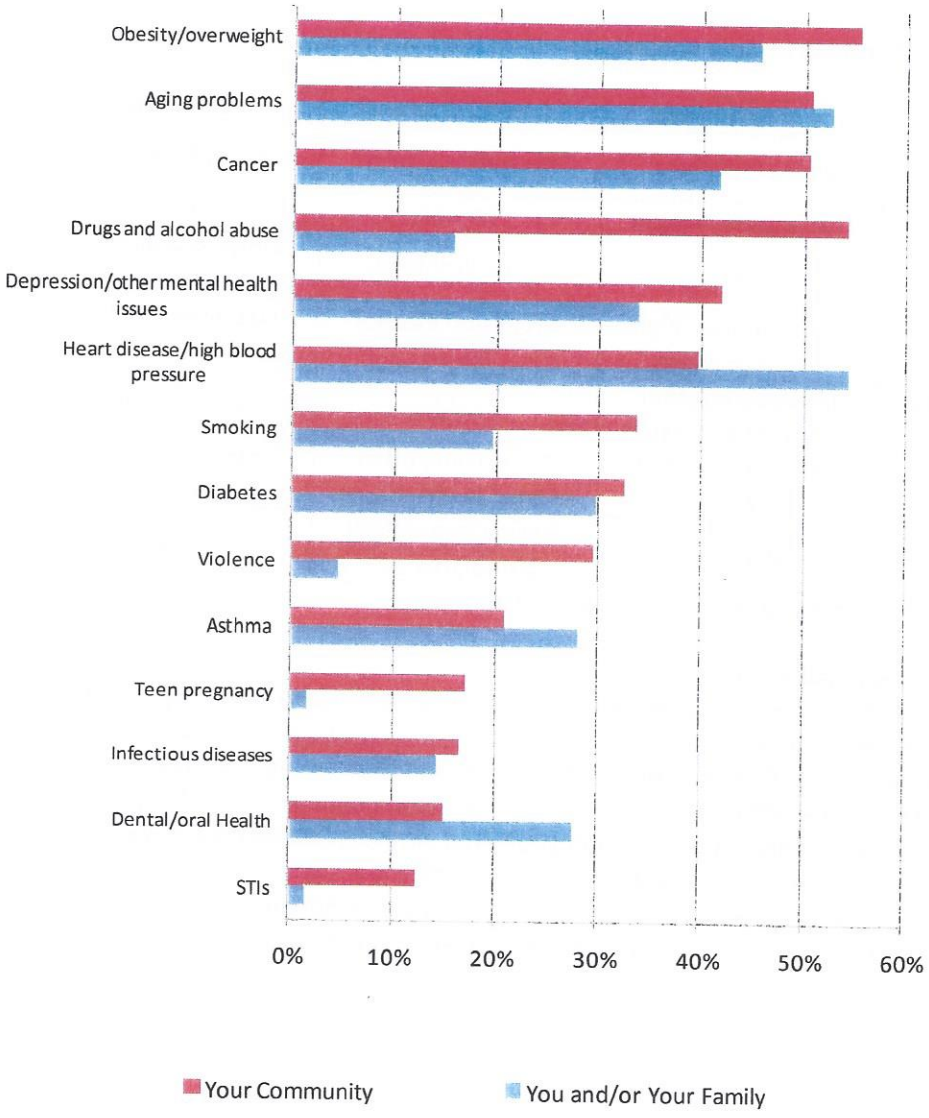


DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2010.

Survey respondents were asked about their primary issues that have the largest impact on their community and themselves/their family (Figure 42). There were some differences between respondents' personal health issues and perceived community health issues. While some topics such as

drug and alcohol abuse were key concerns at the community level, other health issues—such as aging, heart disease, asthma, and dental/oral issues—were more likely to be personal concerns. Overall, top community health concerns across the region for survey respondents were obesity, aging issues, cancer, and drugs and alcohol abuse.

Figure 42: Top Health Issues with the Largest Impact on the Community and for the Respondent/Family, CHA Survey Respondents, 2012



DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

Top community health concerns differed slightly by specific town. Appendix B provides the detailed breakdown of percentage of survey respondents by town selecting which issues were perceived to affect their community and them personally. As seen in Table 7, Easton/Fairfield, Monroe/Trumbull, and Stratford survey respondents noted aging problems and cancer within their top three community health concerns, with obesity being in the top two for Easton/Fairfield and Monroe/Trumbull survey respondents. While obesity was also in the top three community health concerns for Bridgeport survey respondents, drugs/alcohol abuse and violence were the health concerns perceived as having the largest impact on the community in Bridgeport.

Table 7: Top Health Concerns Perceived to Have Largest Impact on the Community, by Town, CHA Survey Respondents, 2012

Rank	Bridgeport	Easton/Fairfield	Monroe/Trumbull	Stratford
1	Drugs and alcohol abuse	Aging Problems	Obesity/overweight	Aging Problems
2	Violence	Obesity/overweight	Cancer	Cancer
3	Obesity/overweight	Cancer	Aging Problems	Drugs and alcohol abuse
4	Depression/other mental health issues	Heart disease/high blood pressure	Drugs and alcohol abuse	Depression/other mental health issues
5	Heart disease/high blood pressure	Depression/other mental health issues	Smoking	Obesity/overweight
6	Diabetes	Drugs and alcohol abuse	Depression/other mental health issues	Heart disease/high blood pressure
7	Smoking	Diabetes	Heart disease/high blood pressure	Smoking

DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

Leading Causes of Death and Hospitalization

Quantitative data indicate that the top two causes of death in each of the city/towns in the region are heart disease, cancer, and injuries (with the exception of Monroe where the third leading cause of death is chronic lower respiratory disease) (Table 8). For all communities except Monroe, injuries was the third leading cause of death. There are some differences in mortality rates across municipalities. Bridgeport experiences a substantially higher mortality rate due to infectious and parasitic diseases (43.0 deaths per 100,000 population) than other towns. Fairfield has a lower mortality rate than most other towns in the region for almost all diseases, with the exception of Alzheimer's diseases where its rate of mortality (26.9 deaths per 100,000 population) is the highest among the Greater Bridgeport communities.

Table 8: Age-Adjusted Mortality Rate per 100,000, U.S., Connecticut, and Towns, 2004-2008

	Bridgeport	Easton	Fairfield	Monroe	Stratford	Trumbull
Major Cardiovascular Diseases	276.1	212.9	201.1	278.0	262.0	262.3
Malignant Neoplasms (Cancer)	167.1	197.8	154.9	204.1	184.1	163.9
All injuries	57.2	48.7	28.0	26.8	51.6	35.0
Chronic lower respiratory diseases	31.9	-	25.7	40.1	33.1	25.8
Infectious and parasitic diseases	43.0	-	15.4	-	24.5	22.4
Accidents	37.7	-	20.9	22.4	39.0	31.0
Diabetes	28.6	-	14.9	22.2	21.3	13.6
Alzheimer's disease	14.8	-	26.9	23.4	18.5	22.1
Pneumonia and Influenza	14.8	-	17.6	-	20.3	10.5
Chronic liver disease and cirrhosis	11.5	-	5.9	-	7.3	-
Nephritis, nephrotic syndrome, nephrosis	16.2	-	4.5	-	12.9	13.7
Suicide	6.2	-	5.8	26.8	7.8	-
Homicide & legal intervention	11.9	0	-	-	-	-
Alcohol-induced	9.2	0	-	-	-	-
Drug-induced	16.2	-	6.2	-	15.8	-

DATA SOURCE: Connecticut Department of Public Health, 2005-2009.
- Data not provided due to small sample.

Table 9 and Table 10 provide information on emergency department (ED) visits and admissions for two of the region's hospitals, Bridgeport Hospital and St. Vincent's Medical Center. These data show that the leading causes of ED visits are injury and poisoning (23.1%), while leading causes for admissions are heart disease (20.3%), digestive disease (12.7%), and mental illness (12.4%). Among Medicaid patients, the highest proportion of ED admissions were for mental illness (23.9%); almost twice as many Medicaid patients were admitted for mental illness than for digestive disease (12.1%), the second leading cause for ED admissions among this population. Among Medicare patients, nearly twice as many patients were admitted for heart disease (25.1%) than for respiratory diseases (13.8%), the second leading cause of admissions among this population.

Table 9: Leading Reasons for Emergency Department Visits by Principal Diagnosis and Insurance Status, Bridgeport Hospital and St. Vincent's Medical Center, 2012

	Total	Medicare	Medicaid	Private	Uninsured
Injury and poisoning	23.1%	21.2%	20.0%	27.5%	22.8%
Symptoms; signs; and ill-defined conditions and factors influencing health status	13.5%	13.0%	14.0%	14.5%	12.4%
Diseases of the respiratory system	12.9%	10.3%	14.8%	13.1%	10.9%
Diseases of the nervous system and sense organs	8.7%	8.1%	9.4%	8.4%	8.3%
Diseases of the musculoskeletal system and connective tissue	8.6%	10.5%	8.7%	7.1%	8.3%
Diseases of the digestive system	6.2%	6.1%	6.5%	5.5%	6.9%
Diseases of the GI system	5.5%	6.4%	5.0%	5.3%	7.1%
Mental illness	5.3%	5.9%	5.7%	3.5%	6.5%

DATA SOURCE: St. Vincent's Hospital and Bridgeport Hospital.

Table 10: Leading Reasons for Emergency Department Admission by Principal Diagnosis and Insurance Status, Bridgeport Hospital and St. Vincent's Medical Center, 2012

	Total	Medicare	Medicaid	Private	Uninsured
Diseases of the circulatory system	20.3%	25.1%	11.3%	18.2%	16.7%
Diseases of the digestive system	12.7%	11.1%	12.1%	17.2%	15.3%
Mental illness	12.4%	6.5%	23.9%	12.7%	21.1%
Diseases of the respiratory system	11.8%	13.8%	10.7%	9.5%	5.9%
Injury and poisoning	10.7%	9.8%	10.3%	12.4%	11.8%
Diseases of the genitourinary system	6.6%	8.0%	4.9%	5.2%	6.1%
Endocrine; nutritional; and metabolic diseases and immunity disorders	4.9%	4.9%	5.3%	4.2%	4.8%
01 Infectious and parasitic diseases	4.2%	5.1%	3.6%	3.0%	2.2%

DATA SOURCE: St. Vincent's Medical Center and Bridgeport Hospital.

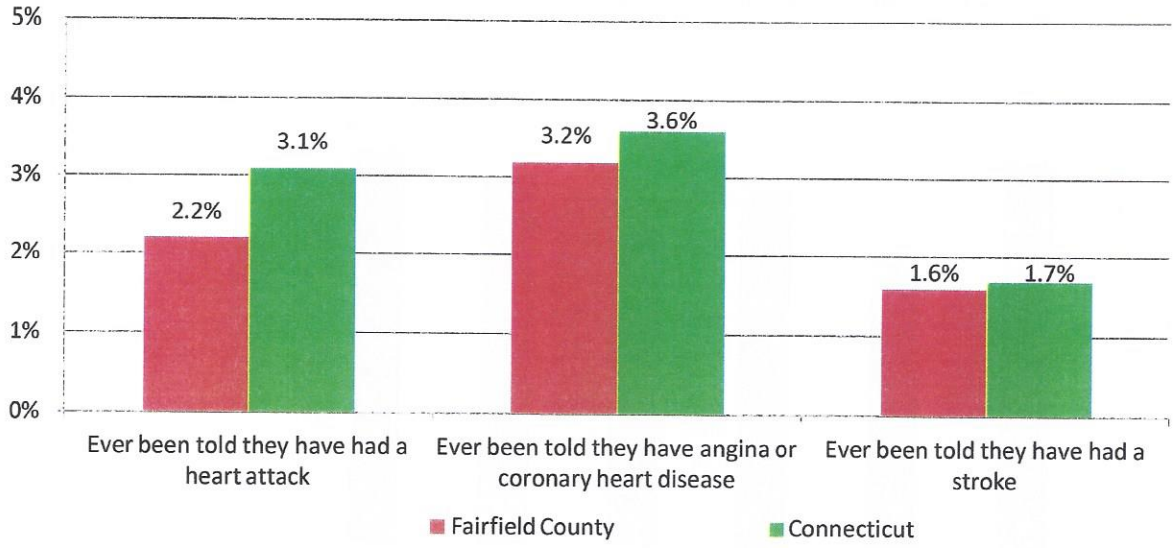
Chronic Disease

"A lot of us have diabetes. It really seems to be increasing." –Focus group participant, Bridgeport

When asked about health concerns in their communities, focus group respondents and interviewees mentioned chronic diseases such as cardiovascular disease and diabetes which they saw as being closely related to obesity. Several also mentioned cancer-related illnesses which they attributed in part to toxic aspects of the region's environment and infrastructure. Differences in chronic disease rates across racial and ethnic groups (health disparities) were mentioned by several residents and social service providers.

Quantitative data show that the proportion of Fairfield County adults ever told they have heart disease (3.2%) or have experienced a heart attack (2.2%) is lower than for the state overall (Figure 43). Less than 2% of adult residents reported ever having been told they had a stroke, also lower than for adults in the state as a whole.

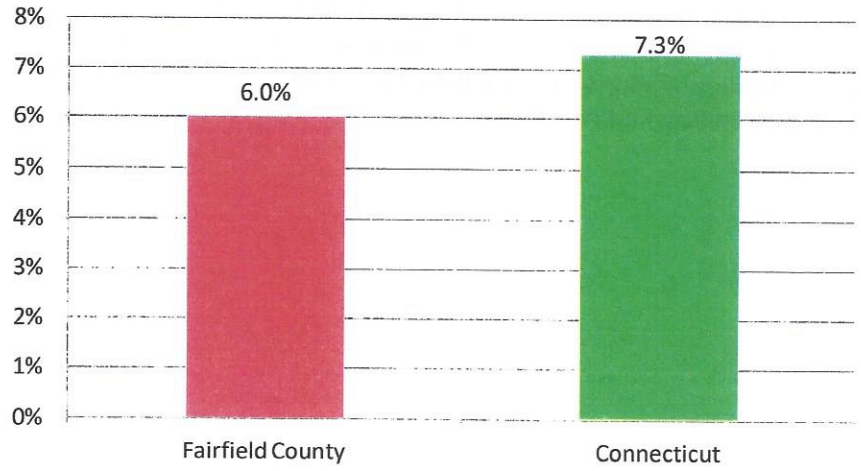
Figure 43: Percent of Adults Who Have Been Told They Have Heart-Related Report Chronic Condition, Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2010.

The proportion of adults who have ever been told they have diabetes is lower for Fairfield County (6.0%) than for the state overall (7.3%) (Figure 44). According to 2010 Behavioral Risk Factor Surveillance data, fewer Fairfield County adults with diabetes (80.4%) than Connecticut adults with diabetes (83.0%), however, received an HbA1c screening in 2009.

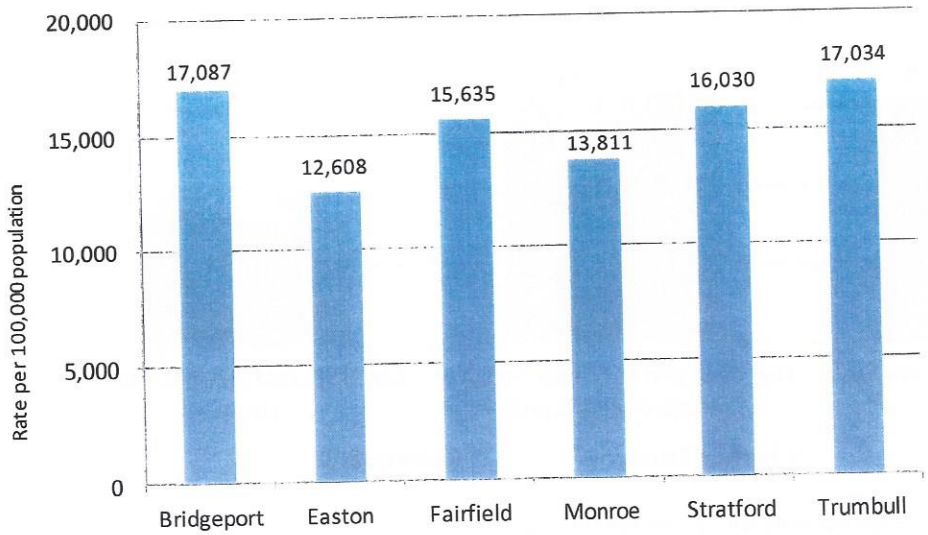
Figure 44: Percent of Adults Who Have Ever Been Told They Have Diabetes, Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2010.

Figure 45 indicates the rate per 100,000 of hospitalizations for ambulatory care sensitive (ACS) conditions. This is the acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital. These conditions include angina, asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart failure and pulmonary edema, and hypertension. In the region, residents from Bridgeport and Trumbull have the highest hospitalization rate for ACS conditions, while Easton and Monroe have the lowest rates.

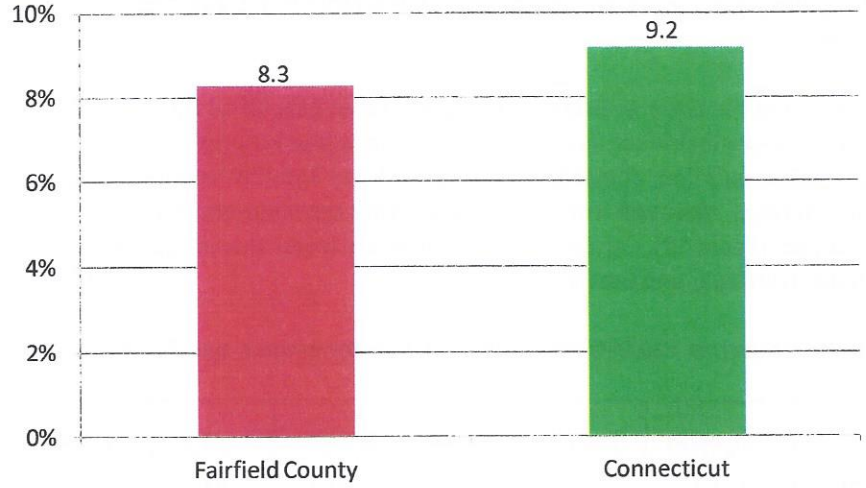
Figure 45: Hospitalizations for Ambulatory Care Sensitive Conditions per 100,000 Population, 2005-2010



DATA SOURCE: Health Equity Index; Source: CHIME Hospital Discharge Data 2005-2010, Connecticut Hospital Association.

While asthma rates among Fairfield County adults (8.3%) are slightly lower than for the state as a whole (9.2%), a number of focus group members and interviewees saw asthma as significant health concern, particularly in Bridgeport (Figure 46). As one Stratford resident stated, *"I'm concerned about air quality. It does seem to me like there are a lot of children with asthma."* While some school nurses reported high rates of asthma, others thought the rates were lower than they were several decades ago. The availability of care for asthma was a concern among providers and social service agencies. As one Bridgeport social service agency member stated, *"A lot of people don't have access to health care they need to treat their asthma."* In Bridgeport the age of housing stock was also a concern as an asthma trigger. According to the U.S. Census 2011 American Community Survey, 60% of Bridgeport's housing stock was built before 1960.

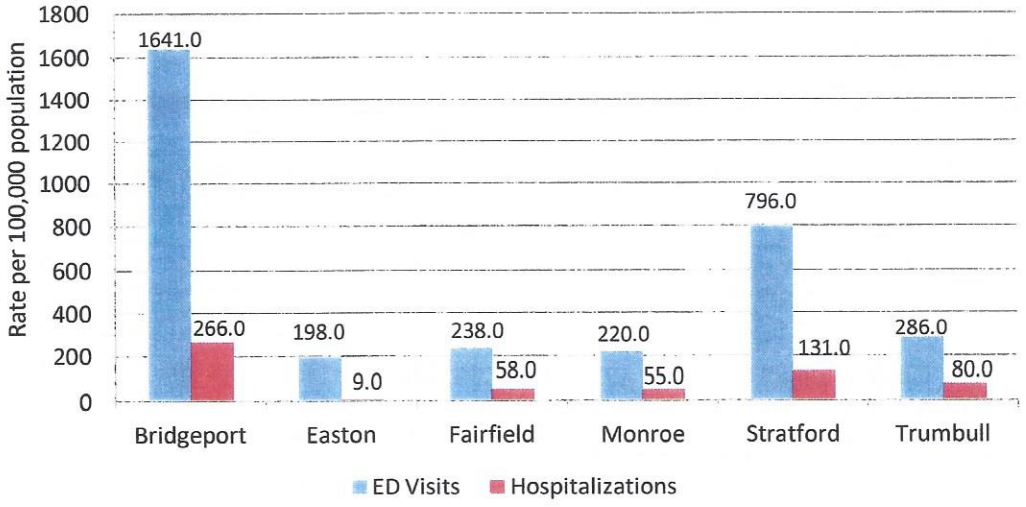
Figure 46: Percent of Adults Who Currently Have Asthma, Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS).

Quantitative data confirm concerns about high rates of asthma among children in both Bridgeport and Stratford (Figure 47). The rate of asthma-related ED visits among children in Bridgeport (1,641 per 100,000 population) is nearly seven times higher than that most of the surrounding communities while the rate in Stratford (796 per 100,000 population) is nearly three times as high. Asthma hospitalization rates for Bridgeport (266 per 100,000 population) and Stratford (131 per 100,000 population) children were also substantially higher than other communities in the region.

Figure 47: Asthma-Related Emergency Department Visits and Hospitalizations among Children Age 0-18 per 100,000, FY2005-2010



DATA SOURCE: Health Equity Index; Connecticut Hospital Association, CHIME Hospital Discharge Data by zip code, FY2005-2010.

Cancer

> "Cancer is one of those health issues where you seem to know a lot of people it has affected."—Focus group participant, Monroe

Cancer is the second leading cause of death in the Greater Bridgeport region (Table 11). Of all the Greater Bridgeport communities, rates of cancer incidence and mortality are highest in Monroe. Monroe's mortality rate is 204 per 100,000 population, above both state (176.9 per 100,000 population) and national (181 per 100,000 population) rates, although it should be noted that the state and town level figures are from slightly different years (Table 12). Cancer mortality rates are lower than state and national averages in Bridgeport, Fairfield, Trumbull, and Easton.

Table 11: Age-Adjusted Cancer Mortality Rates per 100,000 Population, U.S., Connecticut, and Towns, 2006-2008

	US	CT	Bridgeport	Easton	Fairfield	Monroe	Stratford	Trumbull
All Cancers	181.3	176.9	167.1	197.8	154.9	204.1	184.1	163.9
Female Breast Cancer	23.5	23.2	14.5	-	9.3	18.2	13.8	10.4
Cervical Cancer	2.4	1.7	2.9	-	-	-	-	-
Colorectal Cancer	17.0	15.6	11.2	-	12.2	21.1	13.4	12.6
Lung Cancer	51.6	46.9	43.3	-	39.9	50.4	44.3	35.3
Melanoma	2.7	2.8	-	-	-	-	-	-
Oropharyngeal Cancer	2.5	2.1	-	-	-	-	-	-
Prostate Cancer	24.4	25.7	7.2	-	7.5	-	7.0	11.1

DATA SOURCE: CDC, 2004-2008.
- Data not provided due to small sample.

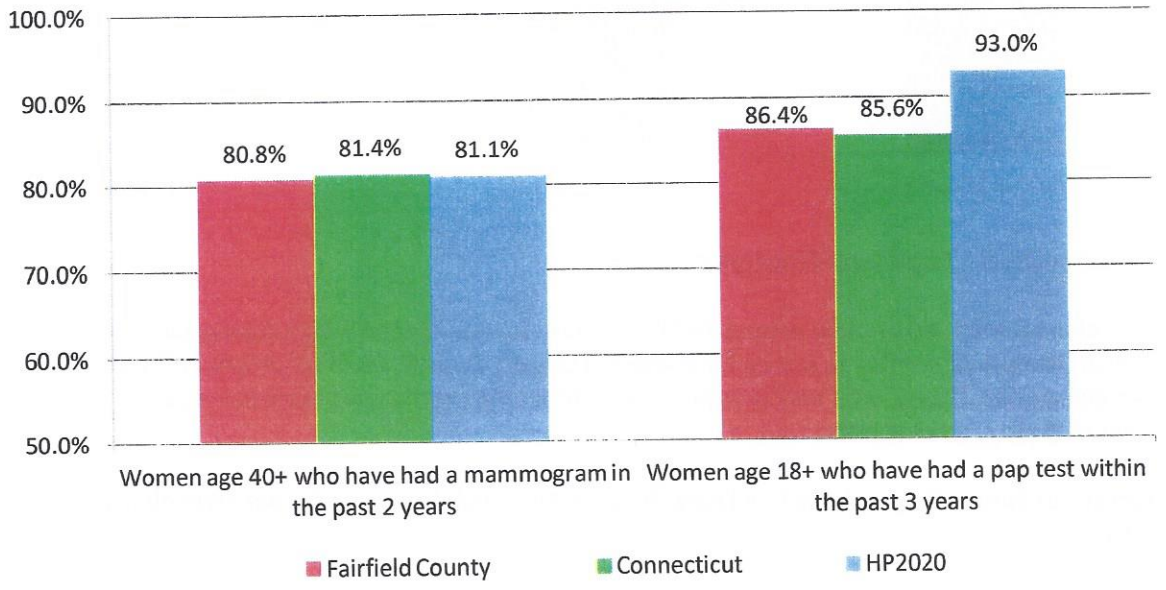
Table 12: Age-Adjusted Cancer Incidence Rates per 100,000 Population, U.S., Connecticut, and Towns, 2006-2008

	US	CT	Bridgeport	Easton	Fairfield	Monroe	Stratford	Trumbull
All Cancers	465.0	504.4	481	713	628	635	612	618
Cervical Cancer	8.1	6.3	50	103	58	47	64	60
Colorectal Cancer	47.6	49.2	53	45	48	47	56	51
Female Breast Cancer	121.0	136.2	152	194	226	251	201	218
Lung Cancer	67.9	68.1	59	52	61	58	70	53
Non-Hodgkins Lymphoma			40	62	41	46	33	60
Pancreatic Cancer			0	0	0	0	0	0
Prostate Cancer	152.7	162.1	155	213	195	168	197	185
Skin Cancer			13	91	79	52	35	62

DATA SOURCE: CDC, 2004-2008 (Connecticut Data). Health Equity Index; Connecticut Department of Health Tumor Registry. Population estimates come from the Nielsen Claritas Pop-Facts Demographics Report for 2007. Date: 2006-2008. (Town Data).

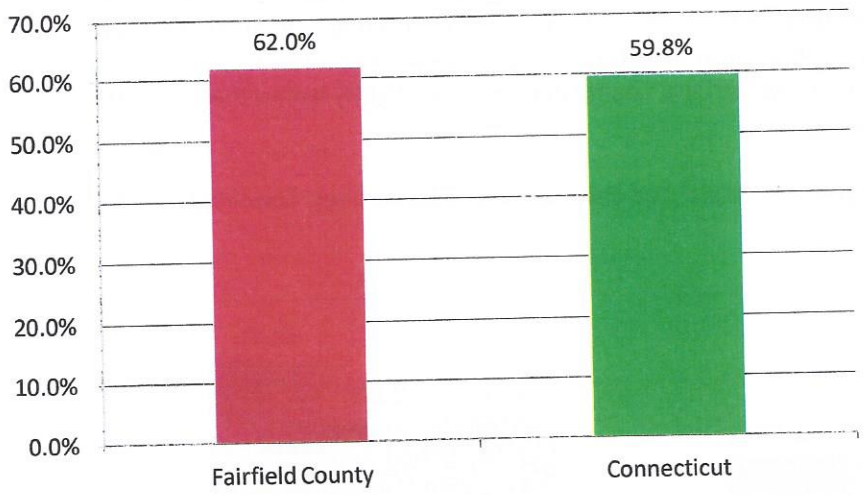
Data about cancer screenings indicate that a similar proportion of Fairfield County adults as well as adults across the state receive regular screenings (Figure 48 and Figure 49). Approximately 81% of women over the age of 40 in Fairfield County have received a mammogram in the past two years, nearly meeting the HP2020 target of 81.1%. However, the proportion of Fairfield County women over the age of 18 who have had a pap test is about 86%, lower than the HP2020 target of 93%. This is similar to the state rate. The rate of PSA screening among Fairfield County men (62%) is slightly higher than for males in the state overall (59.8%) (Figure 49).

Figure 48: Percent of Women in Engaged in Breast and Cervical Cancer Screenings, Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), 2010.

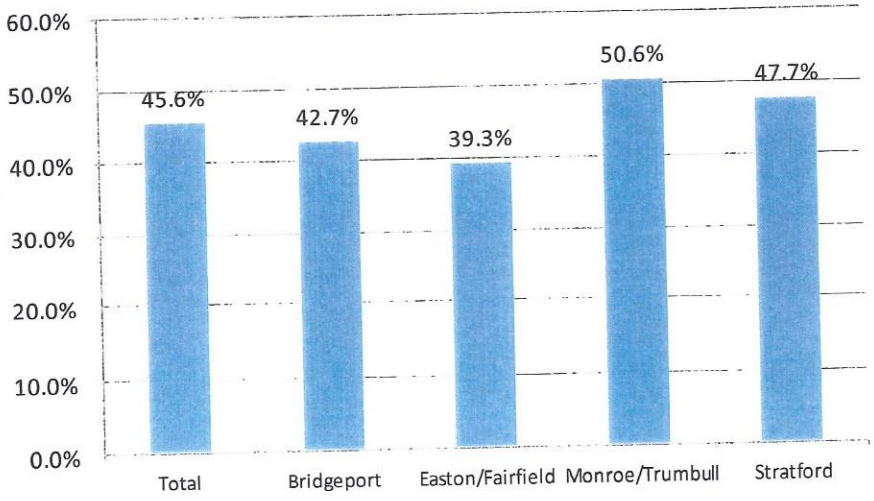
Figure 49: Percent of Men Age 40+ Who Have Screened for Prostate Cancer (via a PSA Test) in the Past 2 Years, Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS).

Survey respondents 50 years old or older were asked if they have been screened with a colonoscopy or sigmoidoscopy in the past 12 months to screen for colorectal cancer. Overall, 45.6% of respondents 50+ years old responded affirmatively, with residents in Easton/Fairfield being the least likely to indicate receiving either of these screening tests.

Figure 50: Percent of Survey Respondents 50+ Years Old Who Received Colorectal Cancer Screening in Past 12 Months



DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

Mental Health

> *"The mental health issue has been tremendous, especially when you're in an affluent community where it's all about keeping up with the Joneses."*–Interviewee, Fairfield

> *"Mental health – that is one of the most unaddressed issues here in Bridgeport."*–Focus group participant, Regional

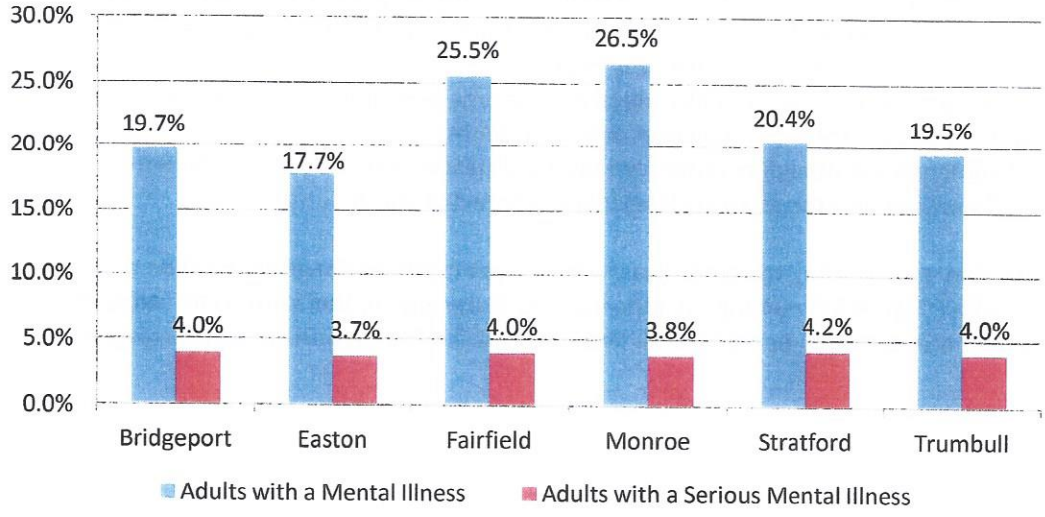
> *"It's very hard to get psychiatric services for youth in the area."*–Focus group participant, Fairfield

> *"Before they [people with substance abuse and mental health issues] were inpatients. There were beds and these people were taken care of. There were coaches to help them take their medications, and get them in a routine, like a halfway house. Whereas now, they are more likely to end up on the street, and then in the ED."*–Focus group participant, Bridgeport

A frequently mentioned health concern for residents of the Greater Bridgeport region was mental health. Focus group respondents and interviewees reported rising rates of depression and mental health issues among people in the region and connected these to substance use, the economic downturn, and the region's achievement culture. As one interviewee observed of the region, *"Serious mental illness seems to have increased."* Medical providers reported a rise in mental health issues presented in hospital emergency departments (ED).

Quantitative data provide a picture of mental illness prevalence in the region (Figure 51). According to data collected by the Southwest Regional Mental Health Board, Monroe (26.5%) and Fairfield (25.5%) have the highest proportion of adults with a mental health illness of the communities in the region. Easton (17.7%) has the lowest rate. The proportion of adults with a serious mental illness is more similar across the communities in the region, roughly 4%. While death by suicide in the region is not as high as the national rate of 11.3 or the state rate of 8.9 per 100,000 population, it does occur. Figure 52 shows the suicide rate standardized per 100,000 population for 2009 for several communities for which data were available.

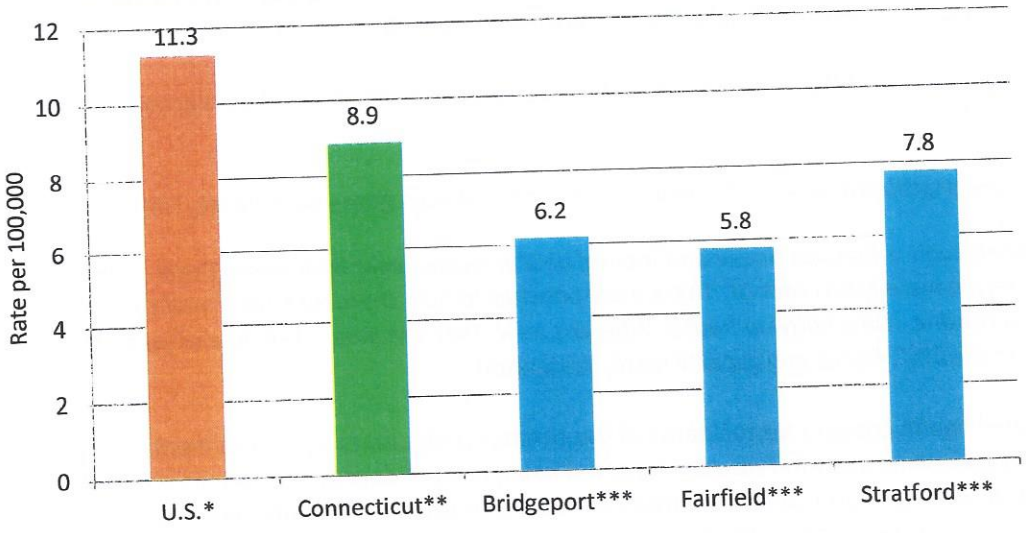
Figure 51: Prevalence of Mental Health Illness, Towns, 2012



DATA SOURCE: Southwest Regional Mental Health Board, Strategic Planning Retreat 2012 Presentation.

Note: A serious mental illness is defined a diagnosable mental disorder that substantially interferes with or limited one or more major life activities.

Figure 52: Suicides per 100,000 Population, U.S., Connecticut, and Towns, 2009

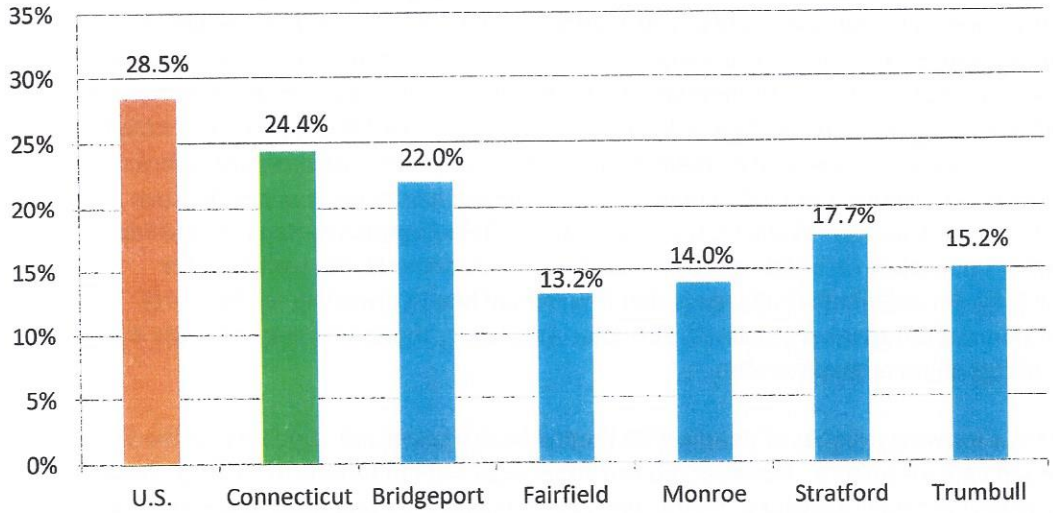


*DATA SOURCE: Healthy People 2020.
**DATA SOURCE: Connecticut Department of Public Health 2009 | National Center for Injury Prevention and Control, 2009.
***DATA SOURCE: Connecticut Department of Public Health.
NOTE: AAMR not reported for towns<15 suicides therefore data for Easton, Monroe, and Trumbull are not available.

Residents expressed particular concern about rising rates of mental illness among children and teens. As one Stratford social service provider reported, *"Younger children are presenting with more severe behavioral health needs."* School nurses in Fairfield echoed this, reporting growing rates of psychiatric issues related to anxiety and depression as well as rising rates of suicide ideation among students. Mental health issues were attributed to the stresses of school and home life. As one Bridgeport teen focus group member stated, *"People are always stressed out about either schoolwork or home stuff."* A Fairfield school nurse concurred, stating, *"This go-go society can be stress-inducing on the kids."* Social service providers report that high rates of divorce and separation are also negatively affecting children's mental health and a growing number of children are dealing with trauma. As one first responder from Stratford stated, *"With a lot of these kids, they come from broken homes and there is an emotional component that isn't being addressed."* Additionally, social service providers discussed the mental health effects of living in the poorer areas of Bridgeport, where residents see more pervasive community violence. Finally, several providers observed that the displacement associated with the aftermath of Hurricane Sandy has also raised stress levels for children and youth.

Quantitative data show that, overall, the region has lower rates of youth depression than the state (24.4%) and the U.S. (28.5%) (Figure 53). Among the communities in the region, there are higher rates of depression among high schoolers in Bridgeport (22.0%) and Stratford (17.7%) than in the surrounding communities.

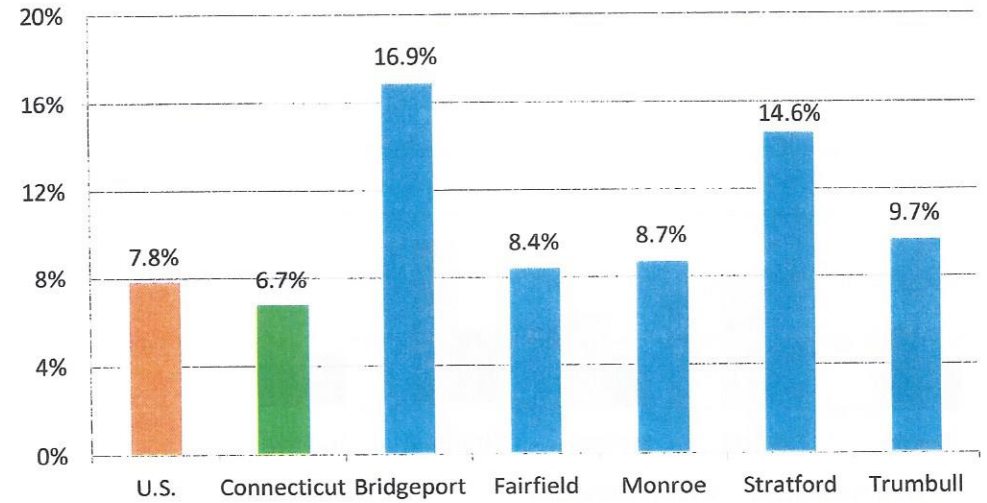
Figure 53: Percentage of High School Youth Reporting Feeling Sad or Depressed Most of the Time in the Last Month, U.S., Connecticut, and Towns, 2011



DATA SOURCE for town level data: RYASAP Report 2011, Search Institute Survey, Developmental Assets, 2011. Data for Easton not available.
NOTE: Data for US and CT are from the Youth Risk Behavioral Survey.

The attempted suicide rate among high schoolers in Bridgeport (16.9%) and Stratford (14.6%) are much higher than for other towns in the region and over twice as high as those in the state (6.7%) and nation (7.8%) (Figure 54).

Figure 54: Percentage of High School Youth Reporting Having Attempted Suicide One or More Times, U.S., Connecticut, and Towns, 2011



DATA SOURCE for town level data: RYASAP Report 2011, Search Institute Survey, Developmental Assets, 2011. Data for Easton not available.
NOTE: Data for US and CT are from the Youth Risk Behavioral Survey.

A substantial challenge to the health and social service delivery systems, according to mental health workers as well as medical providers, is the growing number of patients who have both health and mental health issues. As one Bridgeport mental health provider explained, *"Clients have 5-10 problems*

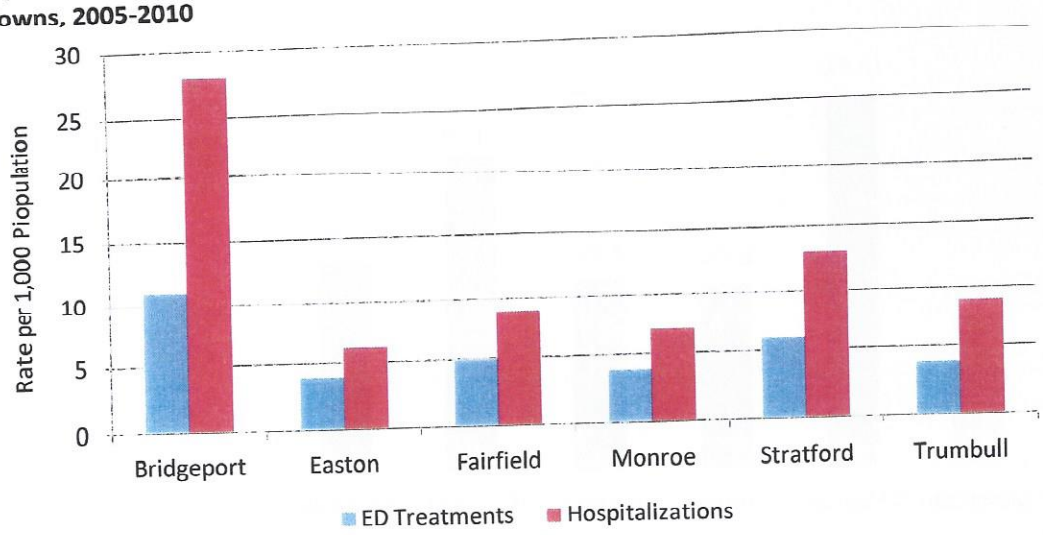
and so they all need a lot of support." A social service provider working in Bridgeport reported the same challenge: *"Sometimes people come in for housing but I know their issues are mental health or health."*

Focus group and interview participants reported that the region lacks enough mental health providers of all kinds to address the need including psychiatrists, psychiatric in-patient beds, and those skilled at addressing the needs of children and teens. As a Bridgeport emergency department provider explained, *"Mental health is a huge unmet need."* A staff member of a Bridgeport community mental health center agreed, stating, *"Beds are full and people waiting to fill them all the time."* In addition, residents stated that Medicaid and Medicare are not accepted by many mental health providers. As one parent focus group member from Trumbull/Monroe shared, *"I think there are mental health services but they are private pay. They don't take insurance."* While local services like Fairfield Community Services provide psychologists and family counselors on a sliding scale, according to respondents, the wait time for appointments can be long. An additional challenge is that few mental health providers are bilingual, making it difficult for non-English speakers to access services. As a result, those who need services must wait long periods to access them or go untreated.

According to providers, a growing number of people with mental health issues are appearing at the ED because they cannot get care elsewhere. However, ED providers reported limitations to treating these patients. As one Bridgeport provider explained, *"Here, with psych patients, we just treat acute episodes, which can only go so far when this is a chronic illness."* Additional concerns are lack of patient compliance with medication and lack of follow up care. According to one Bridgeport ED provider, *"Uninsured psych patients will sit in the ER for days, there is a huge lack of care for them."*

Hospital data indicate that rates of mental health ED visits and hospitalizations in the Greater Bridgeport region are highest in Bridgeport (11 per 1,000 population and 28 per 1,000 population), far higher than other towns in the region (Figure 55).

Figure 55: Mental Health Emergency Department Visits and Hospitalizations, per 1,000 Population, Towns, 2005-2010



DATA SOURCE: Connecticut Hospital Association, CHIME Hospital Discharge Data; analysis conducted by CT Association of Directors of Health, 2005-2010.

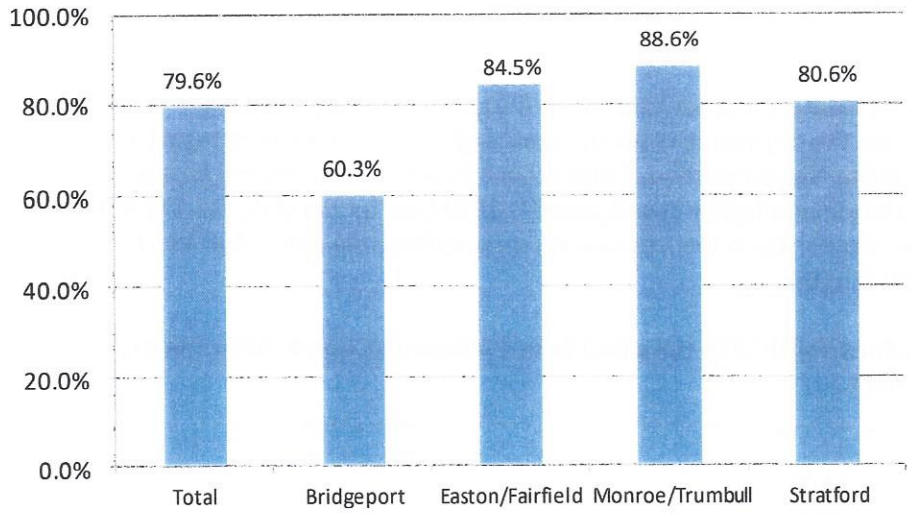
Oral Health

> *"You can line up kids and ask them to smile, and they all have cavities."* –Focus group participant, Stratford

Several focus group respondents and interviewees reported that oral health was a concern in the region, particularly for low-income children, youth, and seniors. The cost of dental care was a substantial issue of concern, especially for seniors. As one Stratford resident shared, *"I have some dental issues that I've been trying to get fixed and so I went to check out options to get it fixed. And the highest quote I got was $11,000 and the lowest quote was $7,000."*

Data from the Greater Bridgeport CHA survey indicates that nearly 80% of survey respondents reported visiting a dentist in the past year, although rates were lower in Bridgeport (60.3%) (Figure 56). Results from the CHA survey were similar to data from the 2010 Behavioral Risk Factor Surveillance Survey, which showed that 83.1% of adults in Fairfield County reported visiting the dentist in the past year, a figure that was higher than for the state (81.6%).

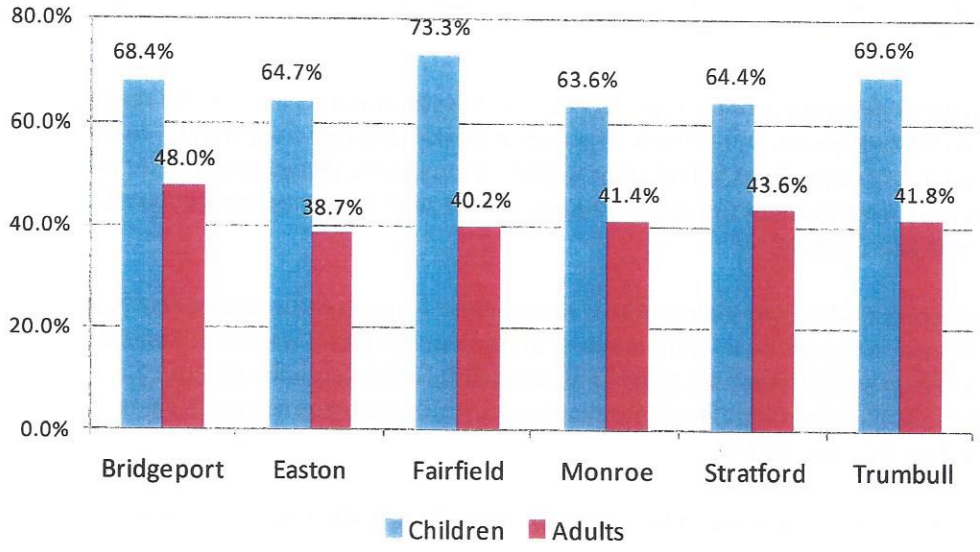
Figure 56: Percent Survey Respondents who Visited a Dentist/Dental Clinic in the Past Year, Greater Bridgeport CHA Survey, 2012



DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

Dental care usage may be slightly lower among Medicaid recipients. Figure 57 shows use of the oral health system in the past year among child and adult Medicaid enrollees. Overall, 63-73% of child Medicaid enrollees in the six Greater Bridgeport communities had used oral health services in the past year, while rates were closer to 40% for adults.

Figure 57: Proportion of Individuals Continuously Enrolled in Medicaid Who Used the Oral Healthcare System in the Past 12 Months, Towns, 2011

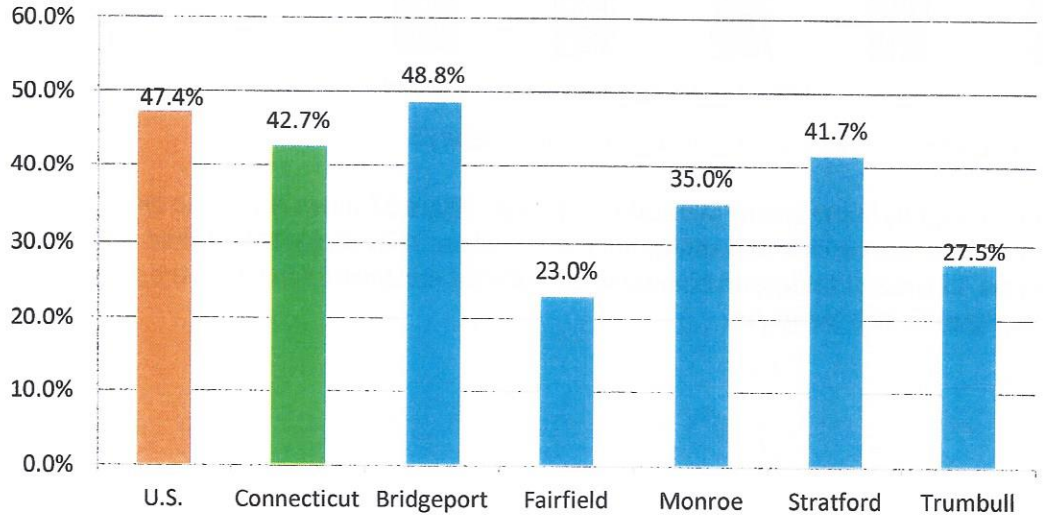


DATA SOURCE: CT Department of Public Health, 2012.

Maternal and Child Health

Although the health of infants and mothers was not extensively discussed in focus groups and interviews, a few respondents from the city shared concerns about high school students engaging in sexual behavior and getting pregnant. The proportion of high school students who reported having ever had sexual intercourse in their lifetime was higher in Bridgeport (48.8%) than for the state (42.7%) or the nation (47.4%) (Figure 58). Rates were lower in the surrounding communities; the rate in Fairfield is almost half the rate in Bridgeport (23.0%).

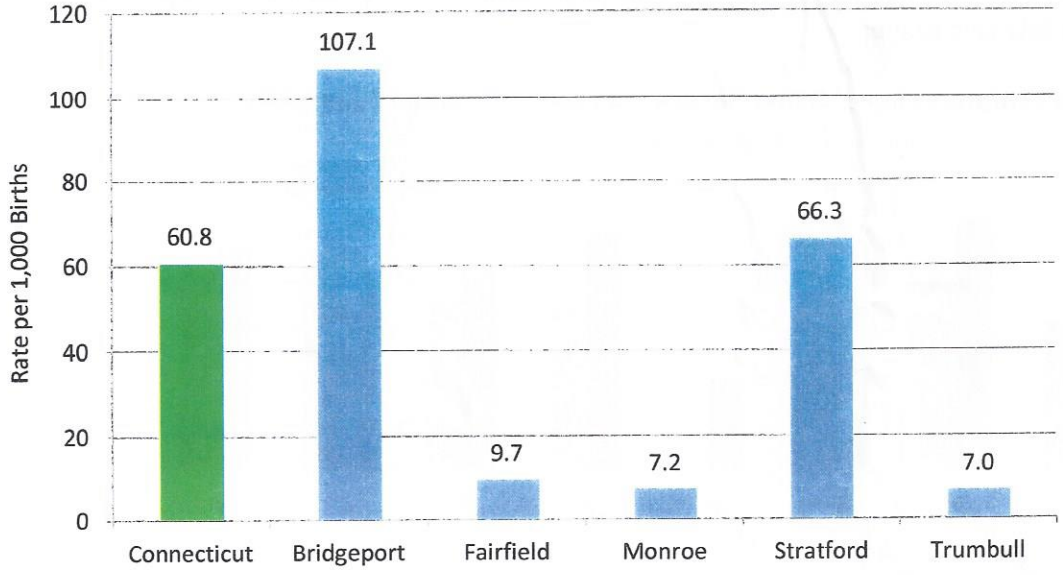
Figure 58: Proportion of High School Youth Who Have Had Sexual Intercourse One or More Times, U.S., Connecticut, and Towns, 2011



DATA SOURCE: CDC, Youth Risk Behavior Surveillance System (YRBSS), High School YRBS, CT, 2011; Development Assets: A Profile of Your Youth; Public schools 2011; Grades 9-12 **Data for Easton not available.

Births among teenagers—mothers under the age of 20 years old—are substantially higher in Bridgeport (107.1 births per 1,000 births) as compared to the rate in the state overall (60.8 per 1,000 births) and the rates in the surrounding towns.

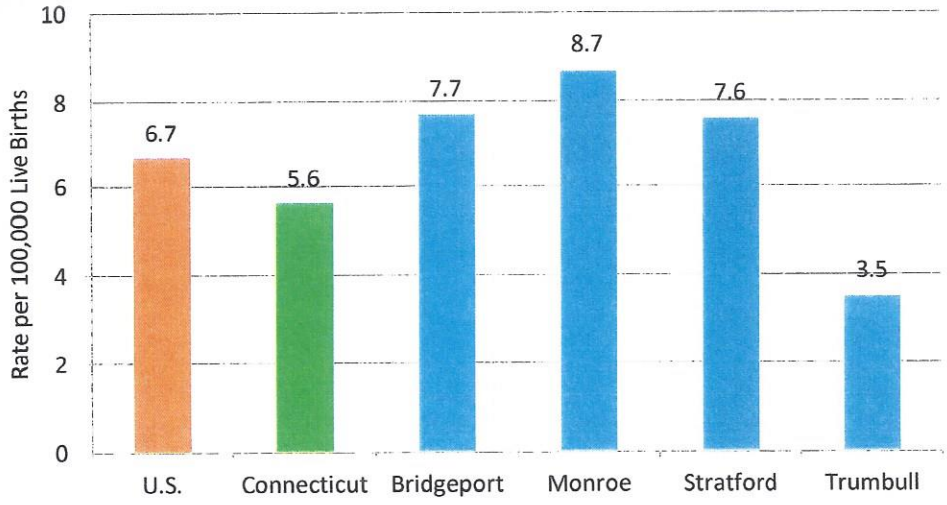
Figure 59: Teen Birth Rate per 1,000 Births, Among Mothers Under Age 20, 2010



DATA SOURCE: Connecticut Department of Public Health, Vital Statistics Report, 2010, Table 4.
NOTE: There are no data for Easton as fewer than five events were not calculated.

Quantitative data indicate that birth outcomes vary across the region. The infant mortality rate in Monroe (8.7 per 1,000 live births) and Bridgeport (7.7 per 1,000 live births) are higher than the rate for Connecticut as a whole (5.6 per 1,000 live births) (Figure 60). Fifteen percent of births in Bridgeport and 8.2% of births in Stratford are from mothers who received no prenatal care in the first trimester, a far higher rate than the other communities in the region.

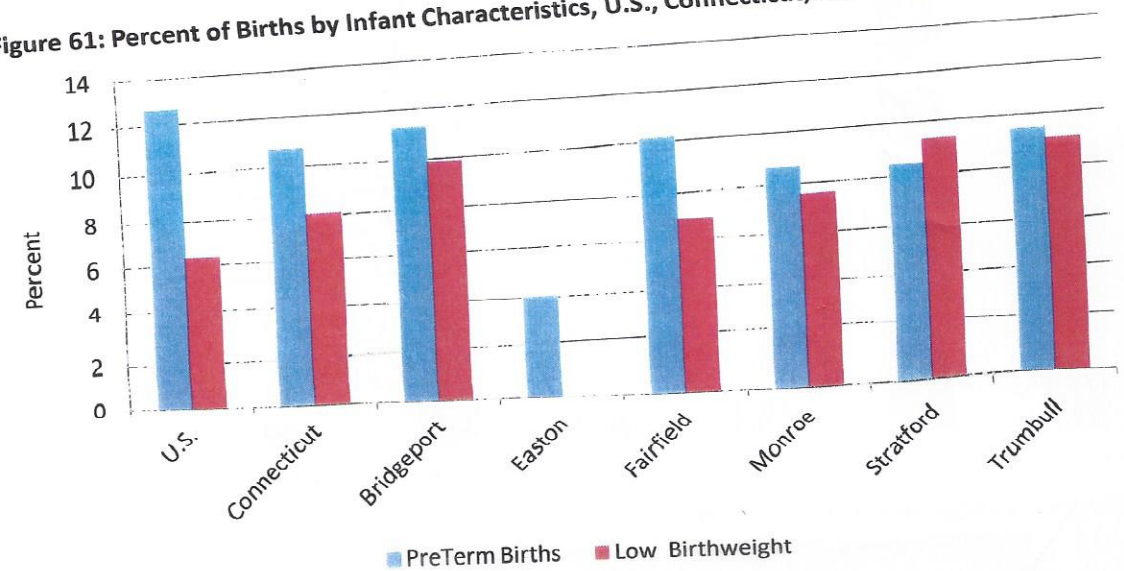
Figure 60: Infant Death Rate per 100,000 Live Births, U.S., Connecticut, and Towns, 2008



DATA SOURCE: Connecticut Data Collaborative 2008 **Rates for Fairfield and Easton were 0.

Risky birth outcomes of preterm birth (before 37 weeks gestation) and low birth weight (less than 2,500 grams) vary across the region (Figure 61). While the percentage of infants born preterm to mothers in Connecticut overall is approximately 10.8%, the rate is higher in Bridgeport (11.3%) and much lower in Easton (4.18%). A higher percentage of low birthweight babies are born in Bridgeport (9.9%), Stratford (9.4%), and Trumbull (9.1%) than in other communities or the state as a whole (8.1%). However, it should be noted that the total number of births for some municipalities may be small, so it is important to interpret these data with caution.

Figure 61: Percent of Births by Infant Characteristics, U.S., Connecticut, and Towns, 2008

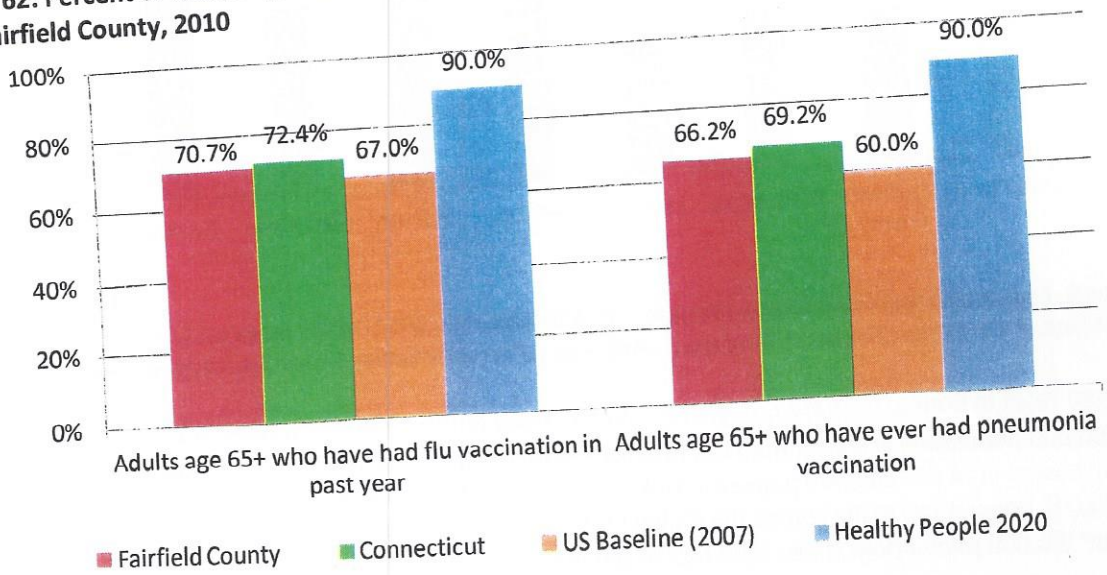


DATA SOURCE: Connecticut Data Collaborative 2008 Low Birthweight: under 2500 grams. U.S. data are from the Centers for Disease Control and Prevention National Center for Health Statistics.

Infectious Diseases

Focus group and interview participants did not mention communicable or infectious diseases during discussions, but some did comment on the importance of older adults receiving preventive care such as getting a flu shot. The proportion of adults aged 65 years and older who reported receiving the influenza and pneumococcal vaccines in 2010 was lower in Fairfield County than in the state as a whole, and both rates were lower than the HP2020 target (Figure 62).

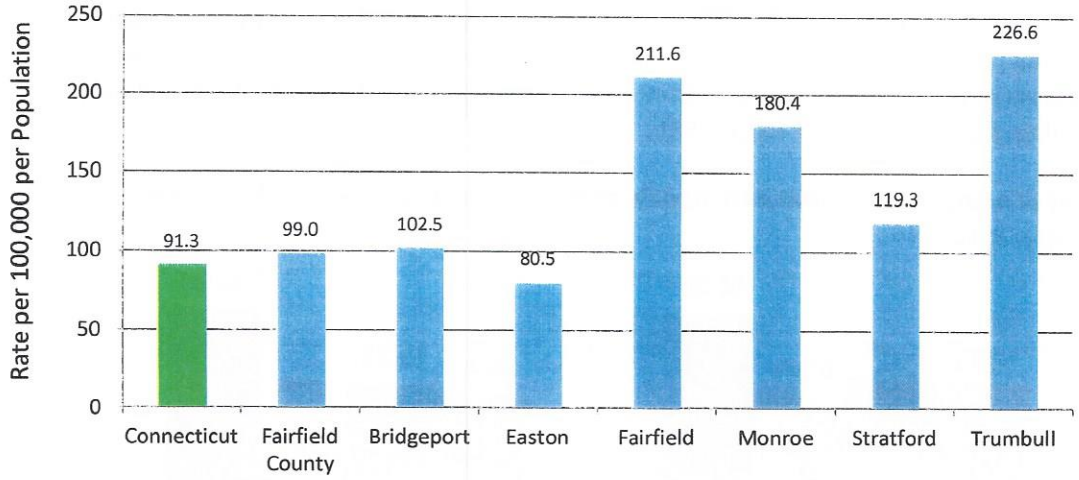
Figure 62: Percent of Adults Age 65+ who have had Flu and Pneumonia Vaccination, U.S., Connecticut and Fairfield County, 2010



DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS).

Compared to the state as a whole, the rate of influenza per 100,000 population was higher in most Greater Bridgeport communities with the exception of Easton (Figure 63). The rates in Trumbull (226 per 100,000 population) and Fairfield (211 per 100,000 population) were over twice as high as the state average.

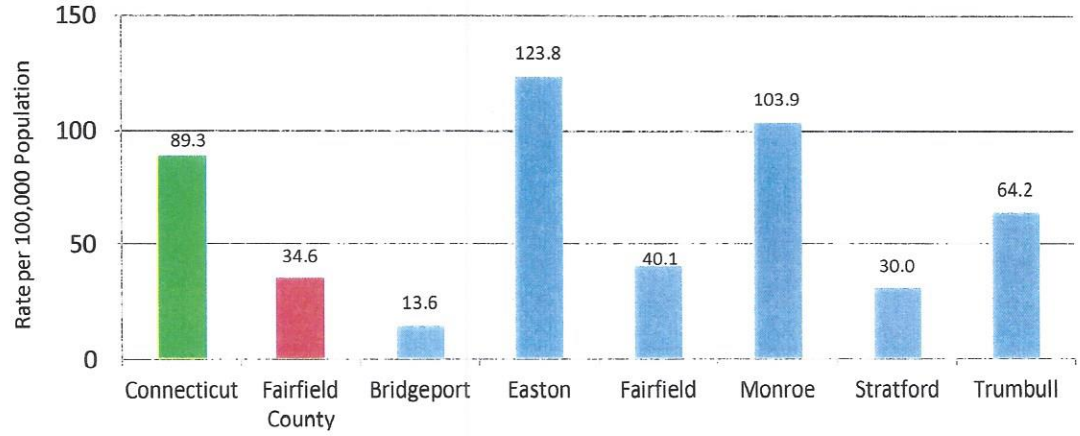
Figure 63: Rate of Influenza per 100,000 Population in Connecticut, Fairfield County, and Towns, 2012-2013 Season



DATA SOURCE: Connecticut Department of Public Health, Disease Statistics, 2013. NOTE: Rates calculated based on U.S. Department of Commerce, Bureau of the Census, American Community Survey 5-Year Estimates, 2007-2011.

Lyme disease rates in Connecticut are notably high and in many of the towns of Greater Bridgeport, the rate per 100,000 population is higher than the rate for Fairfield County (89 per 100,000 population) (Figure 64). Easton (124 per 100,000 population), Monroe (104 per 100,000 population), and Trumbull (64 per 100,000 population) experienced the highest rates of Lyme disease in the region. Bridgeport's rate (35 per 100,000 population) is less than half of the state rate.

Figure 64: Rate of Lyme Disease* per 100,000 Population in Connecticut, Fairfield County, and Towns, 2011



DATA SOURCE: Connecticut Department of Public Health, Disease Statistics, 2011. *Rates comprised of both confirmed and probably cases of Lyme disease.

Table 13 shows that all Greater Bridgeport towns with the exception of Bridgeport have lower rates of sexually transmitted infections than the state overall. Bridgeport's rates are substantially higher: rates of syphilis, gonorrhea and Chlamydia in Bridgeport are at least twice as high as the state. In CT, the majority of cases of gonorrhea and Chlamydia are found among individuals who are less than 25 years old (60.1% for gonorrhea and 71.0% for Chlamydia). It should be noted that some towns' populations

skew younger. For example, almost 38% of Bridgeport's population is 24 years old or younger, which may partially contribute to its higher STI rate.

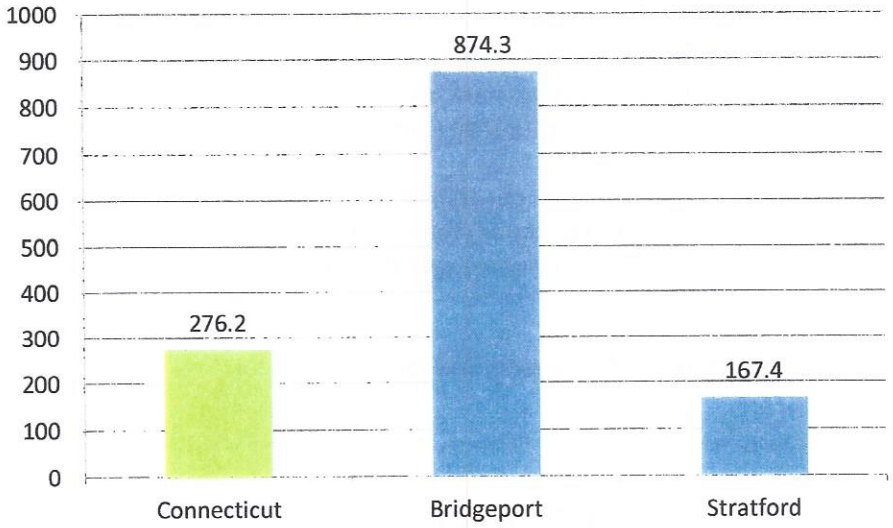
Table 13: Rate of Sexually Transmitted Infections per 100,000 Population, 2009

	Chlamydia	Gonorrhea	Syphilis
Bridgeport	4,308	1,071	28
Easton	320	27	13
Fairfield	434	54	13
Monroe	318	31	10
Stratford	1,421	307	14
Trumbull	453	56	6
Connecticut	1748	355	14

DATA SOURCE: CT Department of Public Health, 2009.

Quantitative data indicate that in 2007, the rate of HIV in Bridgeport was substantially higher (874.3 per 100,000 population) than the state (276.2 per 100,000 population) (Figure 65).

Figure 65: HIV Rate per 100,000 Population, Connecticut, Bridgeport, and Stratford, 2007



DATA SOURCE: Connecticut Department of Public Health, AIDS and Chronic Disease Section, Epidemiologic Profile of HIV/AIDS in Connecticut, 200.7
NOTE: Data cited only for cities with greater than 50 cases, therefore data not available for Fairfield, Trumbull, Monroe, Easton, or Westport.

HEALTHCARE ACCESS AND UTILIZATION

Resources and Use of Health Care Services

"You can get good quality healthcare care in Bridgeport."–Focus group participant, Bridgeport

"We are rich in terms of health services across this region."–Interviewee , Trumbull/Monroe

"I think there is access to care but I don't think people are taking advantage of it."–Interviewee, Fairfield

"There are services the poorer communities need that they don't have."– Focus group participant, Bridgeport

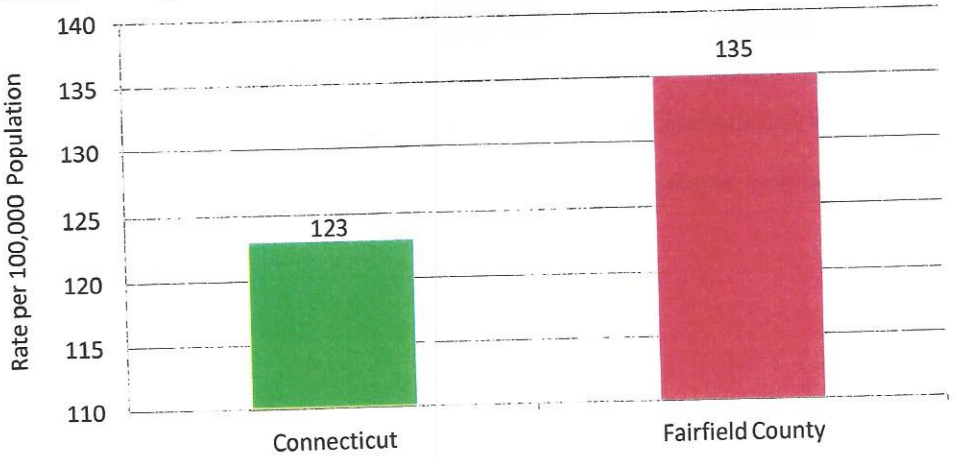
"The health services are excellent in this community."– Focus group participant, Fairfield

Health Resources

Greater Bridgeport focus group respondents and interviewees reported that the region has substantial health resources. St. Vincent's Medical Center and Bridgeport Hospital in particular were repeatedly cited as important assets that provide both health and ancillary services to the communities of the region. Additional resources mentioned by residents included the two community health centers, Southwest and Optimus, and the AmeriCares free clinic. Health departments were also mentioned as a source for immunizations and screenings. Residents of Bridgeport reported that health centers located in the city's schools provide important medical and dental care for many adolescents the city.

Quantitative data show that the ratio of primary care physicians per 100,000 population is higher in Fairfield County (135 primary care physicians per 100,000 population) than in the state (123 primary care physicians per 100,000 population) (Figure 66). This is consistent with the national benchmark of 135 primary care physicians per 100,000 population.

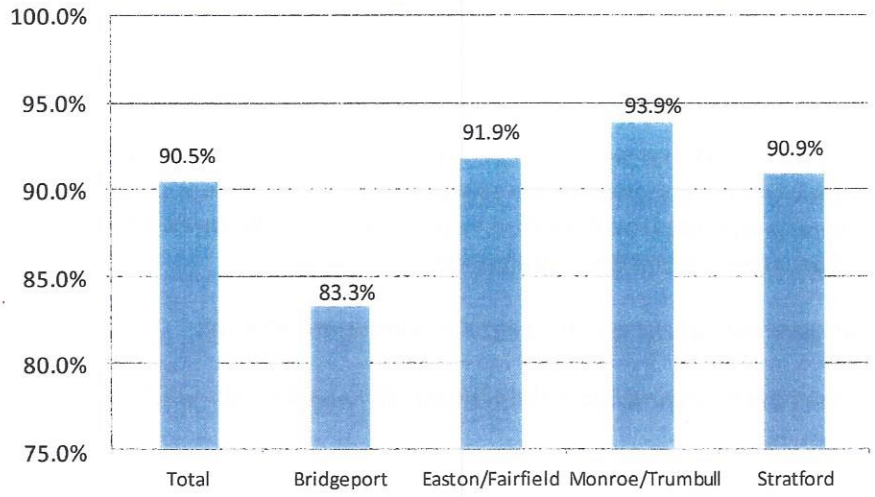
Figure 66: Rate of Primary Care Physicians per 100,000 Population, Connecticut and Fairfield County, 2009



DATA SOURCE: Health Resources and Services Administration, Area Resource File (ARF), analysis by County Health Rankings, 2009.

Among community health assessment survey respondents, 90.5% indicated that they have at least one person or facility that they consider as their personal health care provider (Figure 67). Furthermore, most respondents (84.9%) indicated that they went to a private doctor's office for their primary source of care. However, one-third of Bridgeport residents reported that they typically go to a community- or hospital-based health center for their care.

Figure 67: Percent Having One Person/Facility as Their Personal Health Care Provider, Greater Bridgeport Community Health Assessment Survey, 2012



DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

Table 14: Primary Medical Care Facilities among Survey Respondents, Greater Bridgeport Community Health Assessment Survey, 2012

	Total	Bridgeport	Easton/ Fairfield	Monroe/ Trumbull	Stratford
Private doctor's office	84.9%	54.2%	92.1%	95.0%	88.5%
Community/hospital health center	8.5%	32.2%	2.5%	1.4%	5.4%
Walk-in clinic	5.8%	10.3%	5.4%	3.6%	5.2%
Emergency room	0.9%	3.3%	0.0%	0.0%	0.8%

DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

Focus group respondents and interviewees also noted that there are substantial social services in the region, including Catholic Charities, senior centers, YMCAs, 211, and programs such as Operation HOPE in Fairfield that helps the homeless and the most at-risk populations. They also noted several regional collaborative efforts such as the Bridgeport Child Advocacy Coalition, Alliance for Young Children, Drug Prevention Council, Get Healthy Connecticut, the Stratford Youth and Family Advisory Board. However, funding of services and nonprofits has been a tremendous challenge, especially in these economic times. Residents mentioned several programs that used to provide important services but now do not exist, including My HealthDirect which helped connect ED patients to primary care providers for follow-up visits and the People to Places bus service in Bridgeport.

Several focus group members and interviewees spoke about the sweeping changes occurring in the health care arena, including those yet to come as a result of health reform. Medical providers reported

on the growing trend among for-profit institutions to purchase nonprofit institutions and among hospitals to purchase practices, resulting in fewer independent physician practices which can affect cost and care. Both medical providers and residents described the growth of "concierge" medical services in the region that work outside the traditional health insurance system and require out-of-pocket health expenditures from patients. Finally, residents and providers expressed concern about the ability of the existing health care system to absorb the growing number of patients who will seek health care as a result of the Affordable Care Act.

While some residents reported that the region has many specialists, others disagreed. For example, one ED medical provider in Bridgeport observed, *"There is a growing need and a shrinking pool of specialists."* As a result, providers report that patients with specialized needs increasingly get sent to the ED.

Challenges to Accessing Health Care Services

> *"I know people who [because local providers do not take Medicare] have PCPs halfway across the state and that's not fair. Because then you are not practicing preventive medicine because you don't have someone to go to, and you have to wait until you have that heart attack or stroke, and then go to the ER and get taken care of."*–Focus group participant, Bridgeport
>
> *"Finding a GP that will take a new Medicaid patient is a challenge."* –Interviewee, Monroe
>
> *"I think we lack a lot of information about how to navigate the ever-changing medical system."*– Focus group participant, Monroe
>
> *"I think Stratford has an excellent health care system, but it's not accessible to everyone."*–Focus group participant, Stratford
>
> *"The truth of the matter is, we cannot expect a person to take care of themselves, medically, physically, mentally, until they have a roof over their heads."* – Focus group participant, Regional

When asked about access to health care services, focus group and interview participants acknowledged that while the region has many medical services, barriers exist and services are not available equally to everyone. Access to care was described as a challenge particularly in Bridgeport where economic challenges are greater, and there is a higher proportion of low-income and uninsured patients. Those working with more vulnerable populations reported that their constituencies face substantial challenges to accessing quality health care.

Survey respondents also noted their barriers to care. Table 15 reveals that survey respondents were most likely to note long waits for appointments, lack of evening/weekend services, and cost of care as the top three challenges they have experienced. However, responses did differ by town. Not surprisingly, those without insurance also were more likely to cite having experienced many of these barriers. In particular, 60.6% of respondents without insurance indicated that cost of care was a barrier to accessing health care. Differences also emerged by race/ethnicity. In particularly, Blacks and Hispanics were more likely than Whites to cite lack of transportation, discrimination/unfriendliness of staff, and language issues (among Hispanics) as barriers to care.

Table 15: Percent Survey Respondents who Have Experienced Barrier to Health Care, Greater Bridgeport Community Health Assessment Survey, 2012

	Total	Bridgeport	Easton/ Fairfield	Monroe/ Trumbull	Stratford
Long waits for appointments	20.8%	29.8%	20.6%	18.1%	18.1%
Lack of evening/weekend services	20.4%	20.7%	26.5%	17.7%	18.1%
Cost of care	19.0%	25.2%	17.1%	13.8%	20.2%
Lack of insurance	17.1%	21.9%	18.8%	11.0%	17.1%
Afraid to have a check-up	6.4%	13.6%	4.2%	4.3%	5.3%
Lack of transportation	6.5%	19.8%	2.1%	0.7%	5.7%
Discrimination/unfriendliness of staff	4.6%	9.1%	3.5%	3.2%	3.9%
No regular source of healthcare	2.7%	8.3%	2.1%	0.7%	1.4%
Don't know about services available	2.6%	4.5%	1.7%	1.4%	2.9%
Language problems	1.2%	3.3%	0.7%	0.4%	0.8%
No available provider near me	1.7%	2.5%	2.1%	0.4%	1.8%
Never experienced difficulties	40.0%	24.0%	39.0%	49.6%	43.0%

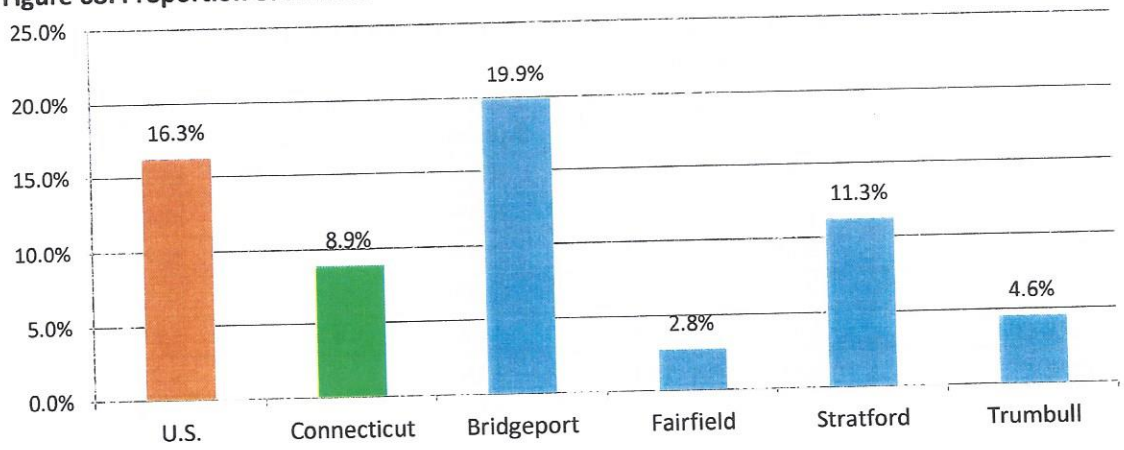
DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

Lack of Insurance Coverage

In focus groups and interviews, lack of insurance and underinsurance was frequently cited as a barrier to accessing health care. While the poor have always struggled to obtain health care coverage, according to respondents, the recent economic changes have meant more middle class families have lost insurance or had their coverage reduced. As one Monroe focus group member stated, *"That's a problem—how to get people like us who fall into this no-man's land of not being poor enough to get subsidized help but not rich enough to afford it, the proper coverage."* Residents reported that people increasingly obtain catastrophic health insurance which does not provide for preventive services.

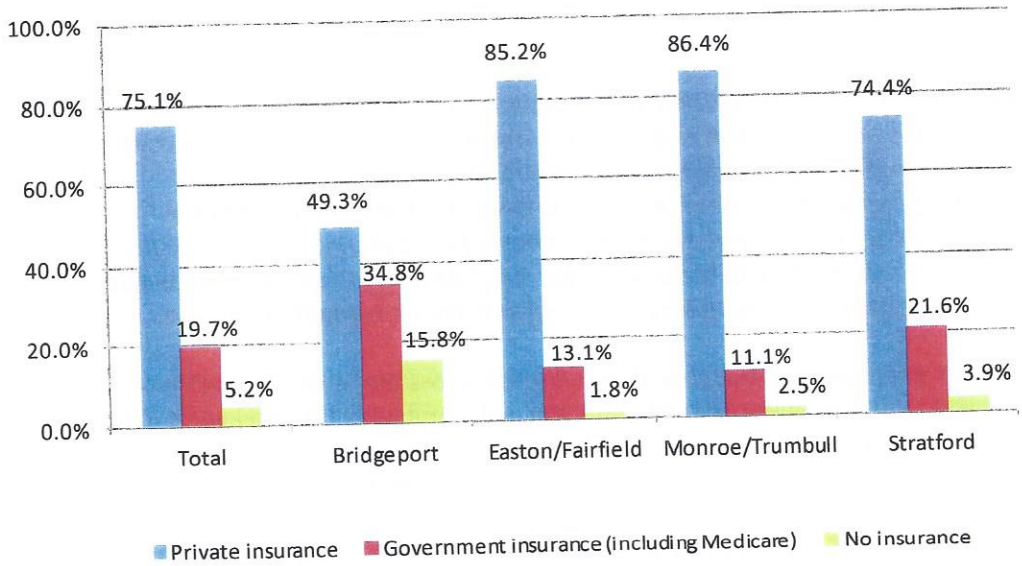
Quantitative data show wide differences in the rates of uninsurance across the towns in the Greater Bridgeport region (Figure 68). While the rates in Fairfield (2.8%) and Trumbull (4.6%) are lowest in the region and lower than for the state as a whole (8.9%), the proportion of uninsured is much higher in Stratford (11.3%). In Bridgeport, nearly 20% of residents are uninsured. Community health assessment survey respondents had slightly lower rates of uninsurance than national datasets show. However, overall, 5.2% of Greater Bridgeport survey respondents were uninsured, 75.1% had private insurance, and 19.7% had some type of government insurance, including Medicare or Medicaid (Figure 69). Yet, this distribution varied by town.

Figure 68: Proportion of Persons without Medical Insurance, U.S., Connecticut, and Towns, 2010



DATA SOURCE: U.S. Department of Commerce, Bureau of the Census, 2010. American Community Survey 2008-2010. **Data not available for Monroe or Easton.

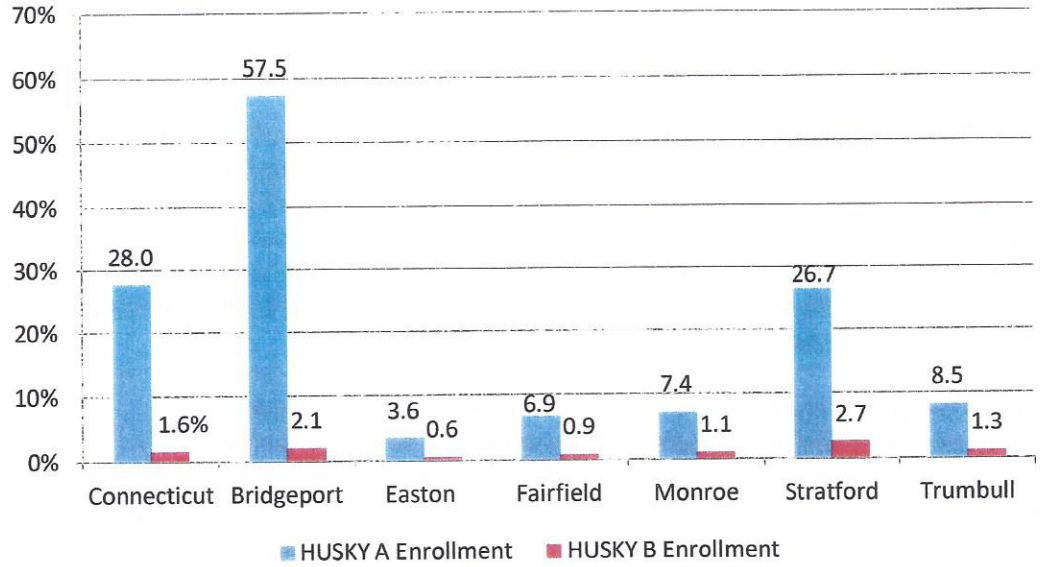
Figure 69: Health Insurance Coverage among Survey Respondents, Greater Bridgeport Community Health Assessment Survey, 2012



DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

Several social service providers in focus groups and interviews expressed concerns about low rates of HUSKY/Medicaid insurance enrollment for children, attributed in part to the fact that families must reapply each year. This has meant that some children do not have a regular pediatrician. Quantitative data on child and youth enrollment in HUSKY shows that more than half of Bridgeport children (57.5%) and 26.7% of Stratford children are enrolled in HUSKY A, while the rate is 28.0% statewide (Figure 70). Percentages are much lower in the other communities in the region.

Figure 70: HUSKY A and B Enrollment, Children and Youth Under Age 19, Connecticut and Towns, 2011



DATA SOURCE: Connecticut Voices for Children, DSS, 2011.

Provider Availability and Service Coverage

Finding physicians willing to take some insurances has also become a challenge according the residents. Focus group members and interviewees expressed concern about the growing number of physicians as well as mental health providers unwilling to accept Medicare and Medicaid. As one Bridgeport provider explained, *"Doctors are refusing to see Medicaid clients. Even on call doctors try to reduce seeing Medicaid."* A Monroe senior shared, *"There's a huge problem around getting a PCP, because when you say that you are on Medicare, doctors are saying they aren't taking it anymore."* Finding a doctor is not just a problem for seniors on Medicare. As one community member from Bridgeport stated, *"With HUSKY, it's gotten really hard to get treatment for our kids. We had to go all the way to Hartford to see a nutritionist after a referral."* Providers report that low reimbursement has been the primary reason that practices are closing to Medicare and Medicaid patients. As one Stratford senior focus group member stated, *"The reimbursements are so horrific that I ask myself 'how do [the doctors] stay in business?'"* For some services, such as mental health, insurance coverage can run out. The result, according to one Bridgeport mental health worker, is that *"The client is sent to the mental health center during a time of need."*

The number and availability of health access points was also cited as a concern among some focus group members and interviewees. Long wait times for appointments and lack of after-hour health services were also reported. Family health centers report constraints in providing specialty care and, for example, may provide specialty clinics only 2-3 times a month, resulting in a substantial wait for appointments and little capacity for follow-up care. The hours during which health care facilities are open present a challenge to some populations. As one Bridgeport provider explained, *"We have people working in Bridgeport from 7am to 3 pm which doesn't coincide with hours of operation for physician's offices."* Several respondents expressed concerns about access points once health reform is more fully implemented in 2014, especially given the aging of the population. As one elderly Monroe focus group member stated, *"With the baby boomers taking over, it's really overwhelming to the system."*

Lack of Specialty and Behavioral Health Services

Residents consistently reported a shortage of mental health services. As one Bridgeport focus group member stated, *"Sometimes you have better access to those [mental health services] once you have been arrested for something than before."* The result, according to respondents, is increased use of the ED for these needs.

Several respondents also cited lack of dental care as a concern for the region. They noted that many do not have dental insurance and those who do often find that their insurances provide only limited coverage for oral health services beyond cleanings. According to respondents, free or discounted dental care is unavailable and school nurses reported a shortage of dentists willing to accept HUSKY. Cost of oral health care was cited by several residents, especially seniors. As one Stratford focus group member stated, *"You could go in there [dentist's office] and walk out with a bill of $5,000. And you can't pay that out of pocket, and most people don't have dental insurance."*

A prevailing theme across focus group respondents and interviewees was the lack of prevention programs. Additionally, the economic decline has meant substantial cuts to educational programs, screening, and early intervention services in recent years according to respondents. A leader from Fairfield explained, *"We don't do a good enough job educating about prevention."* An ED focus group member in Bridgeport saw this as a phenomenon buoyed by the health care system, stating, *"I think there is this social phenomenon where EDs have influenced this acute approach to care, and you really have to break that and flip that."*

Cost of Health Care

Affordability of health care is also of significant concern to many residents in the Greater Bridgeport region. Health insurance is generally expensive and more so when purchased outside of an employer-based plan. As one interviewee from Trumbull/Monroe stated, *"so many people are paying through their nose for health. They have enough means to protect against catastrophic loss. But they are enslaved by their insurance."* Paying for health care is very expensive according to some residents. One Bridgeport focus group member shared, *"I went to the hospital twice and both times I went it cost a total of almost $3,000 for basically nothing."* The ability to pay co-pays was also reported to be a growing issue. ED providers reported seeing patients readmitted to the hospital because they don't have money for co-pays. A physician from Trumbull/Monroe explained, *"People aren't going to their physicians because they can't afford the co-pays. People are not being as aggressive health wise as they would have been in the past."*

Lack of Awareness of Services

> *"There are a lot of things here, resources, not that they are consistent or reliable, but if you keep looking, you can find it."* –Focus group participant, Bridgeport
>
> *"I don't think there is enough marketing or advertising of health services that are available."*–Focus group participant, Stratford

While many respondents described the region as relatively rich in health and social services, several also reported that people are not accessing them because they don't know about them. As one Bridgeport focus group member explained, *"We have two world-class clinics in this community. But there are still tons of people who don't know about them. Don't know how to get to them. Don't know how much they provide at a very low cost."* Residents cited several examples of programs that exist but are not well attended. One was the program *Are You Okay?* in which the police department contacts home-bound

seniors daily to check on them. But, as one Monroe senior noted, *"out of this whole town, it seemed only 4 people know about it and that's who signed up."* A focus group member from Stratford mentioned a free program called Silver Sneaker which encourages seniors to engage in physical activity. According to this individual, *"Senior citizens don't know about it, so people don't go to it."*

Lack of knowledge about how to navigate the health system was also cited as a barrier to care by focus group respondents and interviewees. As one Bridgeport health provider explained, *"Navigating the health care system is incredibly complex."* Another focus group member from Stratford concurred, stating, *"I often get overwhelmed by how to work the [health] system and how to advocate and I'm pretty good at it. So, I can only imagine how someone who does not have my skill, experience, and confidence would do it."*

Transportation

> *"We have the health clinic here, but you have to walk at least two blocks to a bus stop. My primary doctor is on the Trumbull Stratford line. Some of the transportation they offer you, you have to put in a weeklong notice. And you can only put in 18 times, and that's for a year."* (Southend CC) –Focus group participant, Stratford

> *"The hospitals say that a person is going to speak but at Trumbull Hotel. How am I going to get there?"* –Focus group participant, Stratford

As previously mentioned in the survey findings, lack of transportation is a significant barrier. Focus group and interview participants noted that limited transportation is an issue particularly challenging for low income residents and seniors. Several focus group members mentioned that the health care system was excellent including having health promotion programs, *"But we are missing the necessary transportation to get out there."* Transportation is also an issue for older adults to get to senior centers. As one Stratford person stated, *"We have a lot of seniors who would use the [senior center] if they knew how to use the transportation that's available."*

Stigma in Seeking Specific Services

Stigma associated with seeking treatment is a substantial barrier to accessing mental health, substance use, and social services. Respondents attributed this largely to desire to keep individual and community problems "hidden." As one Monroe provider explained, *"The shame factor is huge. We don't talk about that here, we can't talk about that."* As a result, those needing services either do not seek treatment or leave the area for treatment. This is especially the case with youth. Others observe that families of those with mental health issues don't want to be involved. As one mental health provider in Bridgeport observed, *"There is very little family support."* Several Fairfield respondents reported that among seniors, *"There is still the stigma about talking to a social worker."* Another from Stratford noted, *"There are a lot of programs but the citizens have trouble coming to terms with needing help."*

Barriers for Vulnerable Populations

In addition to the barriers described above, cultural and language minority populations face unique challenges to accessing health care according to respondents. Newcomers often take low wage jobs with no health insurance. They must negotiate a complex and unfamiliar U.S. health care system and the associated paperwork. Non-English speakers face language barriers that make it difficult to locate services and complete paperwork. As one Bridgeport medical provider explained, *"Bridgeport continues to be a safe haven to undocumented folks, access continues to be a huge issue for them."* Another provider from Bridgeport pointed to the issues faced by language minorities saying, *"We have a lot of*

people coming from Africa and Haiti for example and a lot of times they are left out because they currently can't access the referral system due to language."

Misuse of the Health Care System

According to focus group respondents and interviewees, the barriers to health care access have led to increased use of emergency departments (ED) for health issues that are not emergencies. As one Bridgeport medical provider focus group member shared, *"the ED is the safety net for the community."* Those working in mental health report that there is no community care, so patients come to the emergency room. As one provider from Bridgeport explained, *"We have clients and bouncing in and out of the hospital and they just struggle."* Finally, providers reported that challenges in identifying specialty care especially for lower-income populations has also meant that more people end up getting these services in the ED. As one Bridgeport ED provider explained, *"If they can't get a patient seen by a specialist, they will often be sent to the ED. So it really taxes all of the resources we have and they aren't being used in the most efficient way, quality wise and quantity wise."*

Additionally, a concern broadly related to access are high no-show rates, which was of particular concern to medical providers. As one Bridgeport provider explained, *"We secure an appointment, we call, and still the rate of no-shows is disturbingly significant. You have the point of access, and the challenge is still there."* Another concurred stating, *"People don't show up even though calls are made to remind of appointments."* High no-show rates not only mean that patients are not receiving services, they also contribute to inefficiencies in the entire health and social service system which increases costs.

Quality of Care

In describing their interactions with the health care system and providers, several respondents spoke about health care quality. Many respondents expressed concerns about the short amount of time doctors often spend with patients, leaving patients perhaps not fully aware of their health issues or how to take care of them. As one Fairfield senior focus group member reported, *"The doctor's care is very automated, so we don't have the more personal relationship with the doctor we once had."* Others expressed concern about the tendency to prescribe medications. A Bridgeport focus group member observed, *"You walk in and they have their pads ready to just write you a prescription and send you away without really figuring out what the problem is. You go in bad, and come out worse."* Others reported on fragmentation of care that comes especially when several specialists are involved. As one Fairfield school nurse explained, *"[Kids] will go see all the different specialists, who are more interested in their particular area of expertise, and fail to see the whole child."*

ED focus group members reported that a lack of follow-up care after a hospital stay has resulted in patients returning to the ED unnecessarily. As one medical provider from Bridgeport stated, *"Once patients have a problem and end up in the hospital, home care is a huge problem, referral to rehabs, or short-term care is an issue because of lack of payment. So patients end up in the hospital because they can't have the resources for care that would usually take place in the home."*

While residents reported concerns about quality of care, they also noted that some responsibility rests with patients. As one Bridgeport focus group participant observed, *"The problem is that we think the doctor is going to fix me, but we don't understand that it's a partnership where the doctor helps us when we present a holistic picture of what we are dealing with. Otherwise, they will treat all the different symptoms you complain about at each occasion you go to see them, instead of piecing the whole thing together and finding out exactly what is wrong."* A Fairfield interviewee concurred, stating, *"I know so many educated people who go to the doctor and don't give their doctor a history. And they say, well he didn't notice anything during the exam so...and they don't understand that there really needs to be conversation around these things in order to make sure that as partners, you and your doctor are*

ensuring that you get the best care, and stay healthy." These sentiments were reiterated in a number of conversations.

Health Information Seeking

Residents look to a variety of sources for their information on health. When survey respondents were asked the sources from which they receive the majority of their health information, they were most likely to say doctor/nurse, Internet, and TV/radio/newspapers (Figure 71). In addition to some differences by town, there were slight differences in responses by race/ethnicity although top information sources were consistent across all races/ethnicities. However, Blacks were slightly less likely to cite doctor/nurse as a primary health information source and more likely than other respondents to name family, neighbors, and the library as sources of health information.

Figure 71: Primary Health Information Sources among Survey Respondents, Greater Bridgeport CHA Survey, 2012

	Total	Bridgeport	Easton/ Fairfield	Monroe/ Trumbull	Stratford
Doctor/nurse	68.0%	56.2%	66.6%	67.7%	74.7%
Internet	57.8%	40.5%	61.3%	61.0%	62.3%
TV/radio/newspaper	44.7%	40.5%	46.3%	44.0%	46.2%
Family members	26.3%	24.8%	24.7%	24.5%	29.1%
Friends	20.2%	15.3%	20.2%	20.9%	22.2%
Pharmacy	14.8%	11.2%	15.0%	12.4%	17.9%
Employer	11.4%	12.4%	7.0%	10.3%	14.1%
Library	6.5%	7.4%	8.0%	6.0%	5.3%
Neighbors	3.4%	4.1%	2.8%	2.1%	4.1%
Government	3.4%	3.3%	3.1%	2.1%	4.3%
Church/spiritual advisor	2.1%	5.0%	0.3%	2.1%	1.6%

DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

COMMUNITY STRENGTHS

Focus group participants and interviewees were asked to identify their communities' strengths and assets. This section presents some of the overarching themes that emerged in these discussions.

Health Care Services and Providers

The Greater Bridgeport region has a number of prestigious healthcare institutions as well as excellent community health centers, according to residents. Many of these also support community programs. Residents also pointed to excellent services provided by health departments and, in Bridgeport, school-based health centers.

Recreational Facilities

According to focus group participants and interviewees, the region has a geography and infrastructure that supports health, although accessibility is an issue for some. The large number of parks, recreational facilities, and physical activity places help support the region's activity levels and recent efforts such as the Walk/Bike Initiative in Fairfield are seen as important efforts to continue to promote physical activity. Safety concerns constrain physical activity in Bridgeport even though the city has a large number of parks. Concerns about lack of sidewalks for pedestrians were expressed by some in the outlying communities.

Strong Social Services and Organizations

Respondents identified their communities as having good social services, although in recent years, budget cuts have resulted in fewer services being available. These services include senior centers, domestic violence intervention services, libraries, and services provided by local health departments.

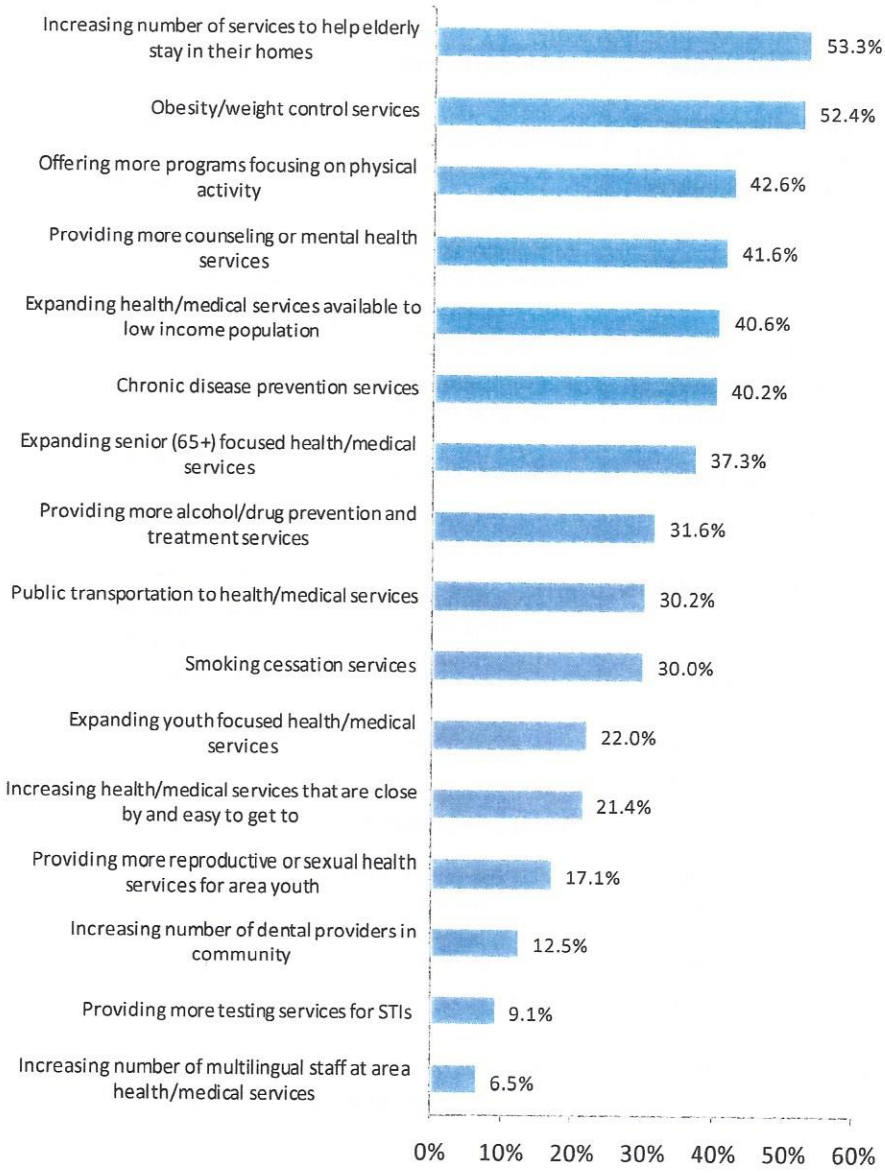
Growing Collaboration and Emerging Leadership

Residents provided varying perspectives on the extent to which services were coordinated and social service resources were efficiently used. Some respondents reported strong collaboration. For example, one focus group respondent from Stratford noted, *"I always found it very unique in how we share resources and how people working on different things get together."* Others in the region, however, pointed to a culture of "home rule" that has led to competition among agencies and duplication of services. A Trumbull/Monroe interviewee stated, *"The fragmentation of what is traditional in Connecticut, with town-rule, self-rule, without good feelings around multi-town is a hindrance to using resources efficiently and where they are really needed."* Those from Bridgeport more frequently reported collaboration; one focus group member pointed to a citywide collaborative around homelessness that was viewed as successful and resulted in a 10-year plan to address homelessness. As one regional focus group member stated, *"People are starting to realize they need partnerships to be more successful."*

VISION FOR THE FUTURE

When thinking about the future, survey respondents saw key areas for action. As shown in Figure 72, survey respondents were asked to identify the areas they considered to be priorities to be addressed in the future. Respondents were most likely to identify increasing services for elderly to stay in their homes, providing programs focusing on obesity and physical activity, and expanding counseling and mental health services as the top areas of focus. Overall, a focus on seniors, mental health/substance abuse, chronic disease prevention, and increasing access to care were some of the overarching priority areas. Table 16 presents the overarching areas identified by survey respondents by town. Specific results from the survey by town for this question can be found in Appendix C.

Figure 72: Survey Respondents' Identified Areas Considered Priority to Address in the Future, Greater Bridgeport Community Health Assessment Survey, 2012



DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

Table 16: Survey Respondents' Identified Areas Considered Priority to Address in the Future, by Town, Greater Bridgeport Community Health Assessment Survey, 2012

	Bridgeport	Easton/Fairfield	Monroe/Trumbull	Stratford
1	Expanding health/medical services available to low income population	Increasing number of services to help elderly stay in their homes	Obesity/weight control services	Increasing number of services to help elderly stay in their homes
2	Obesity/weight control services	Obesity/weight control services	Increasing number of services to help elderly stay in their homes	Providing more counseling or mental health services
3	Providing more counseling or mental health services	Offering more programs focusing on physical activity	Offering more programs focusing on physical activity	Obesity/weight control services
4	Providing more alcohol/drug prevention and treatment services	Chronic disease prevention services	Chronic disease prevention services	Offering more programs focusing on physical activity
5	Chronic disease prevention services	Expanding senior (65+) focused health/medical services	Providing more counseling or mental health services	Expanding health/medical services available to low income population
6	Public transportation to health/medical services	Providing more counseling or mental health services	Expanding health/medical services available to low income population	Expanding senior (65+) focused health/medical services
7	Offering more programs focusing on physical activity	Expanding health/medical services available to low income population	Expanding senior (65+) focused health/medical services	Chronic disease prevention services

DATA SOURCE: Greater Bridgeport Community Health Assessment Survey, 2012.

In addition to discussing areas of priority, focus group and interview participants also talked about their visions and hopes for their future community 3-5 years from now. This section discusses the themes that emerged from these conversations.

More Marketing of Existing Services

Respondents reported that more needs to be done to market the services that already exist in the region, and perhaps change when they are offered. While residents pointed out gaps in resources across the region, there was also a shared sense that there are many resources in the region, including programs offered by hospitals, social service agencies, and health departments, but that people did not always know about them. As one regional focus group participant stated, *"We become a stronger community by being an informed community. To identify what are the existing services, and where are the needs- that's what is important."* Residents expressed a desire for more marketing of local programs and services. They noted that marketing needs to be relevant to the audiences. For example, as one focus group member pointed out, while many seniors are facile with the compute, not all are, so it is important to find other ways to reach them with information. Medical providers also reported a need for information about services. As one from Bridgeport participant stated, "E*asy access to all these places for docs regarding all community services so that they can refer and help get patients into those*

services. Right now, doctors and nurses are not aware of what is available. Need something centrally located that is updated regularly."

More Health Education

Residents reported that more education was needed around health, available resources, and how to navigate the health system. However, they noted that creative ways were needed to reach populations with these messages. A consistent theme across focus groups and interviewees was the need to get more information out to the public, on a variety of issues. As one interviewee observed, *"I think in general, there are people who are very educated, but not about their health."* A social service provider working with youth commented, *"their issue with health is that they don't take it seriously or have the necessary tools."*

Education about accessing and using health services was identified as critically important, especially as more people become insured under health reform. This includes accessing appropriate health care, the importance of keeping appointments, etc. As one Bridgeport provider stated, *"A big thing we need is community education, is helping our community to learn how to access services."* However, some acknowledged that many people do not access such educational programs. As one Fairfield interviewee stated, *"..when you provide programs like [health education], you will get people who are motivated to access them. So you won't really reach the people who really need the program."* Thus identifying ways to reach people was seen as important. This included offering programs in the evenings and on weekends, soliciting the support of faith-based organizations, and enhancing community-based access points.

Support Services for Youth, Elderly, and Other Vulnerable Populations

Respondents frequently mentioned the importance of support services, especially for youth, seniors, and more vulnerable populations. Youth, parents, and those who work with youth reported the need for more places for youth to go in their spare time. As one Bridgeport focus group member stated, *"We have to get the young people to do something to get them out of the streets."* A Bridgeport student focus group member agreed, saying, *"I think if we had more activities, there would be less drama. Because if people were more preoccupied, then people would be less likely to fight."* Additional suggestions included education around substance use and opportunities to be physically active. Teens reported wanting more activities to be physically active and mentioned activities such as Zumba or other dance classes or yoga classes. Because cost of activities is a constraint for many, some students suggested events like "free nights" at local facilities such as the skating rink. Activities located near where kids live were also seen as important. As one Trumbull focus group member stated, *"kids need things within walking distance."* Mental health workers reported a need for more supports to youth such as mentoring, parent involvement, and social workers in schools. Education for parents was also identified as an important need.

As noted throughout this report, the needs of seniors – both present and future – were of substantial concern to residents of the Greater Bridgeport region. Focus group respondents and interviewees reported that they would like to see more services as well as supports that in past decades might have been handled by other family members such as such as paying bills, walking the dog, and taking out the trash. As one senior focus group member from Stratford shared, *"as we get older, little stresses become big stresses."* Senior centers were seen as a critical service. As one Stratford focus group member stated about senior centers, *"There is a lot that goes on [at the senior center], and it's a hub for information."* More recreational opportunities for seniors were also identified as a vision for the future.

Other residents reported the need for more education around concerns of older adults, such as dementia, and education for families and caregivers as well. Several noted that many families are

unprepared to care for elders and need education and support. As a Trumbull/Monroe interviewee noted, *"We're lacking in skills and information. We never thought we were going to have to deal with [illnesses associated with aging]."*

Several respondents mentioned the importance of reaching the increasingly diverse population of the region. They stressed the need for providers to be culturally competent and to be able to access language services. Having more bilingual speaking health providers was reported as a need by several Spanish-speaking focus group participants.

More Mental Health Services

Residents reported that more mental health services were needed across the region and across age groups. This includes community-based mental health services, mental health providers with geriatric and pediatric expertise, psychiatric housing units, and transitional housing for mental health patients. The ability to address the mental health needs of an aging population as well as children and youth was also seen as critical. Several respondents observed the decline in the family and noted more family support and parenting education would be helpful. As one Bridgeport medical provider stated, *"families need more support as that is where the issues stem from."* Another focus group member from Stratford concurred, saying *"parents need to be guided and taught."*

Enhanced Environment to Support Health

While specific suggestions differed by community, residents overall would like to see more support for healthy eating and physical activity. Those in the outlying communities would like to see greater attention to walkability and more sidewalks. While residents applauded efforts like the Bike/Walk initiative in Fairfield and some noted positive changes in worksites, they thought these efforts should be expanded and walking and biking facilities should be increased in other towns. Reinstating physical activity in schools and encouraging children and youth to engage in physical activity were also cited as visions for the future. As one Bridgeport youth stated, *"I want to be somewhere safe, where I can be active."*

Others reported that they would like to see fewer fast food and liquor outlets in their communities. In Bridgeport, residents shared a vision of greater availability of affordable, fresh food. Some saw a need for education about the importance of healthy eating and physical activity. As one interviewee from Bridgeport stated, *"education is important to help families understand how to make a healthy meal with inexpensive food."*

Focus on Prevention

Residents envisioned a greater emphasis on prevention—they would like to see more prevention programs and screenings in locations accessible to community members—the corner store, faith institutions, and schools. As one Bridgeport provider stated, *"I think we need these programs located in their communities and open to the communities that are affordable."* A Trumbull/Monroe interviewee agreed, saying *"you need to meet people where they are."*

Greater Collaboration between Hospitals and Community Care

As discussed earlier, providers differed in their perspectives of whether there was collaboration across agencies and between social service and health agencies in the region. However, nearly all shared a vision in which greater collaboration took place, to be both effective and efficient with resources. Some mentioned more regional collaborative efforts. Within health, some residents envisioned more coordinated care, which would require payment reform. However, some noted collaboration will be challenging. As one regional focus group member stated, *"The disparity is enormous, so it is difficult to find common ground."*

More Community-Based Delivery of Programs and Greater Involvement of Community Institutions
Focus group respondents and interviewees felt that local institutions can play a key role in providing services and in connecting local residents to services. As one Bridgeport social service provider stated, *"Because health is much more than just the doctor's. I mean including people that the community actually talks to. I mean, my barber probably knows a lot more about me than my wife."* A respondent from the Bridgeport social service provider community concurred stating, *"If it's not seen as outside, and it comes from inside the community out that's going to motivate people more."* Garnering the support of these community individuals and institutions was seen as a critical step for greater collaboration and effective delivery of health and other services. As a Fairfield focus group member stated, *"Connecticut has a great medical system, but on a more community level could be introduced to us better."*

Faith-based organizations were mentioned by several respondents as a potential key ally. As one medical provider from Bridgeport noted, *"If we could work with church leaders, they could help us extend our reach in the community."* Residents reported that religious institutions have credibility within their congregations and communities. A member of the faith community in Fairfield expressed caution, however, noting "*When it's associated with a particular faith community, people assume they're going to hear that 'slant.' If it becomes non-denominational…"*

More Communication and Coordination about Patient Care
Medical and mental health providers reported that greater communication across the health system would be important for enhanced quality of care. A Bridgeport medical provider from the ED stated, *"Right now it is difficult to follow a patient who has different places."* Mental health providers, for example, expressed a desire for better information about what is happening with patient. Others noted the need to have information about prescriptions so patients are not prescribed medications that conflict with one another. Some Bridgeport providers reported that this would enhance efficiency: *"It would be helpful to have electronic medical records so that they would not have to take all the information each time they see a new patient."* Providers also reported that having such information would help to promote a more holistic approach to caring for patients. As one Bridgeport mental health provider explained, *"For things to change we have to start looking at people as a whole."*

Enhanced Involvement of the Public
Several residents shared the vision of a leadership that is informed by and knowledgeable of the situation in communities. As one Bridgeport social service provider explained the current situation, *"There is a serious lack in Bridgeport of policymakers coming out of this city that are informed."* A Trumbull/Monroe community leader interviewee agreed, saying, *"There is a real disconnect with policymakers/decision makers in the understanding of the health care needs of the economically disadvantaged."*

Respondents reported that residents play a key role in this, yet it requires that community members become more involved and advocate for themselves. As one Fairfield interviewee stated, *"I think there needs to be more of an investment in really educating key elected leaders on the importance of these issues."* A senior focus group member from Fairfield concurred, saying, *"Legislators in our community don't know all the answers and so they really need to listen to the community."* A social service provider working across the region reported, *"It would be nice if residents could learn to advocate for themselves and be empowered. Because people who are in power to affect policy, and bring in the resources, are tired of hearing providers all the time. More patient navigators can help patients be more empowered within the healthcare system."*

Improvements in the Economy

Residents recognized that an improved economy was critical for the future health of the region and the residents within it. Interviewees and focus group participants agreed that improvements in the economy were needed to address unemployment, increase incomes, and restore funding to social and health services. More affordable housing and improvements in transportation options were mentioned as hopes for the region. However, these are dependent on improvements in the economy. Residents pointed to some hopeful signs, including economic development and redevelopment and some positive movement in the cleanup of polluted sites. Those in surrounding communities noted, however, that a critical barrier to economic growth and investment in the region is resolution of sewer system issues.

KEY THEMES AND CONCLUSIONS

Integrating secondary data in the region, community resident surveys, and discussions with community residents and leaders, this report provides an overview of the social and economic environment of the Greater Bridgeport region, the health conditions and behaviors that affect its residents, and perceptions of strengths and challenges in the current public health and health care systems. Several overarching themes emerged from this analysis:

- **There is wide variation between the city of Bridgeport and surrounding communities in terms of population composition, socioeconomic levels, and needs.** The region has one of the widest gaps between rich and poor in the country. Bridgeport comprises nearly half the region's population and is characterized by low median income, high rates of poverty and unemployment, higher levels of crime and violence, and substantially lower levels of education. Surrounding communities are more affluent, with far lower rates of crime and violence and higher education levels. This difference affects residents' access to healthy food, the availability of safe green and recreational space, as well as access to and use of health care and prevention services. By most measures, residents in Bridgeport as well as Stratford experience poorer overall health than those in the region's other communities. While the economic decline has been felt throughout the region, already poor areas were harder hit. Residents reported concerns about slow job growth, high taxes, and the affordability of the region. Some community leaders also noted that the wide variation in the region in communities may also be a challenge to future collaborative, regional efforts due to the unique needs of some communities.

- **Environmental quality and local infrastructure issues were identified as concerns for the region which residents see as constraining economic growth and negatively affecting public health.** Overall, the region experiences more high ozone days than the state overall and in Stratford and Bridgeport, the industrial legacy has led to brownfields concerns that constrain development and negatively affect health. In addition, residents reported that the existing septic infrastructure constrains business expansion in the region and discourages new businesses from establishing there. Finally, recent severe weather events have demonstrated both the challenges for and vulnerability of the region's infrastructure, further discouraging business investment.

- **The aging of the region's population was noted by many, and concerns about seniors were prominent.** With the exception of the city of Bridgeport, the Greater Bridgeport region communities have a high median age. As Baby Boomers age, seniors are expected to comprise an ever increasing proportion of the population in the region. Concerns about the aging population were prominent in focus groups and interviews. Residents noted concerns about the isolation of seniors especially as increasingly fewer have family close by. Likewise, residents expect that demands on the health and social service infrastructure will rise. While services such as senior centers will play an important role, there will be a need to ensure that seniors can access them.

- **Mental health was identified as a pressing need by assessment participants, and current services were largely seen as inadequate.** Mental health concerns in the region were a top-of-mind issue for residents who perceive a rise in the number of people with mental health issues. A closely-related issue is the growing use of substances, especially alcohol and prescription drugs. Among youth in the region, alcohol and marijuana use was high. Hospital providers reported high use of the emergency department for mental health issues and data indicate that among the region's youth, rates of suicide attempts are higher than for the state and nation. According to residents, the region needs more mental health providers especially those skills at addressing the needs of children and teens, education and prevention programs, and community-based care and treatment options, especially to provide services after an emergency visit.

- **Obesity and access to physical activity and healthy food were concerns identified by focus group participants and interviewees.** Similar to trends nationally, high obesity rates in the region are concerning, and heart disease was identified as leading cause of death. Those in the more affluent communities reported access to many grocery stores, parks, and recreational facilities, but, for some participants, accessibility and affordability were concerns. Similarly, some residents expressed concerns about walkability in the surrounding communities, although a few noted that recent initiatives are addressing some of these challenges. Healthy food options were reported to be more difficult to obtain in Bridgeport and in some parts of Stratford. Cuts to physical activity programs in schools have further contributed to concerns about overweight and obesity among youth in the region. While progress to enhance healthy food options in schools were noted, residents, including youth, reported that these efforts have not necessarily translated into increased consumption of these foods.

- **The region is seen as having a strong health care infrastructure, but there are concerns about access.** The region has many health assets including hospitals, community health centers, school-based health centers, and public health departments. Residents across the region expressed concerns about access to health care, although specific barriers to access varied across the region. Lack of insurance was cited as a common concern, but more frequently in Bridgeport where nearly 20% of residents do not have insurance. Additional barriers include the cost of health care, finding providers willing to accept public insurance, lack of transportation, and stigma related to accessing certain services such as mental health care. Dental and mental health service access is a concern, especially for lower-income populations. Residents also identified lack of awareness of services or how to navigate the health care system as challenges for the region's residents. Residents noted that substantial and fundamental shifts in the health care infrastructure are occurring, including a rise in concierge health services, the purchase of small practices by large health care systems, and health reform. Quality of care, notably the little time that providers now spend with patients and inadequate follow up care after hospital stays, were also identified as concerns. Some approaches to address these challenges included more public awareness and health education as well as greater coordination across health care settings.

- **As the health system increasingly faces challenges and health reform is implemented, residents saw the great need for increased efforts focusing on prevention.** A focus on prevention and better lifestyle behaviors were seen as essential to improving the health of the region. More education relative to health, a stronger infrastructure that supports health (e.g., sidewalks, safe green space), and changes in how to navigate the health system were also seen as an important need. However, assessment participants noted that creative ways were needed to reach populations with these messages. Future collaboration and coordination of efforts were viewed as critical, and an area in which the region currently has a strong foundation.

Appendix A: Primary Care Action Group Members

Health Departments
City of Bridgeport Department of Health and Social Services
Stratford Health Department
Fairfield Health Department
Trumbull/Monroe Health District
Easton Health Department

Hospitals
Bridgeport Hospital
St. Vincent's Medical Center

Other Community Partners
Optimus Health Care
Southwest Community Health Center
Department of Mental Health & Addiction Services
AmeriCares Free Clinic of Bridgeport, LLC
Connecticut Department of Social Services
Connecticut Department of Mental Health and Addiction Services
Greater Bridgeport Medical Association
Southwestern Area Health Education Center
Bridgeport Child Advocacy Coalition

Appendix B: Survey Results by Town for Top Personal and Community Health Concerns

Issue:	Concern for:	Total N=1,302	Bridgeport N=242	Easton/ Fairfield N=287	Monroe/ Trumbull N=282	Stratford N=491
Obesity/overweight	You and/or Your Family	45.4%	45.0%	40.1%	45.0%	48.9%
	Your community	55.5%	44.6%	47.7%	59.9%	62.9%
Aging Problems	You and/or Your Family	52.6%	31.0%	58.5%	62.4%	54.2%
	Your community	50.8%	33.1%	57.5%	61.3%	49.7%
Cancer	You and/or Your Family	41.6%	36.0%	47.4%	44.0%	39.7%
	Your community	50.6%	35.1%	54.7%	56.0%	52.7%
Drugs and alcohol abuse	You and/or Your Family	15.6%	24.0%	14.6%	11.3%	14.5%
	Your community	48.2%	56.2%	49.8%	42.6%	46.6%
Depression/other mental health issues	You and/or Your Family	33.6%	34.3%	40.8%	33.3%	29.3%
	Your community	41.9%	41.7%	48.1%	43.3%	37.7%
Heart disease/heart attacks/high blood pressure	You and/or Your Family	54.3%	42.6%	53.0%	63.1%	55.8%
	Your community	39.6%	38.4%	39.0%	47.9%	35.8%
Smoking	You and/or Your Family	19.5%	30.2%	16.0%	13.1%	20.0%
	Your community	33.7%	37.2%	26.5%	28.0%	39.5%
Diabetes	You and/or Your Family	29.7%	40.1%	20.6%	25.9%	32.2%
	Your community	32.6%	38.4%	26.1%	39.4%	29.7%
Violence	You and/or Your Family	4.5%	10.7%	1.4%	2.1%	4.5%
	Your community	29.6%	54.5%	13.6%	17.4%	33.8%
Asthma	You and/or Your Family	28.1%	36.8%	26.8%	23.0%	27.5%
	Your community	20.8%	28.9%	20.6%	16.0%	19.8%
Teen pregnancy	You and/or Your Family	1.5%	2.5%	1.4%	0.7%	1.6%
	Your community	17.1%	37.2%	8.0%	5.7%	18.9%
Infection/contagious diseases	You and/or Your Family	14.4%	10.3%	17.1%	15.6%	14.3%
	Your community	16.6%	18.6%	17.1%	12.8%	17.5%
Dental/Oral Health	You and/or Your Family	27.6%	31.4%	25.4%	27.7%	26.9%
	Your community	15.0%	22.7%	10.8%	9.9%	16.5%
STIs	You and/or Your Family	1.6%	4.1%	0.3%	1.4%	1.2%
	Your community	12.4%	26.4%	8.0%	8.9%	10.0%

Appendix C: Survey Results by Town for Top Priority Areas

	Total N=1,302	Bridgeport N=242	Easton/ Fairfield N=287	Monroe/ Trumbull N=282	Stratford N=491
Increasing number of services to help elderly stay in their homes	53.3%	34.7%	61.3%	66.3%	50.3%
Obesity/weight control services	52.4%	46.3%	44.6%	57.1%	57.2%
Offering more programs focusing on physical activity	42.6%	35.5%	42.9%	47.5%	43.2%
Providing more counseling or mental health services	41.6%	43.8%	49.1%	39.4%	37.3%
Expanding health/medical services available to low income population	4.1%	57.0%	39.7%	33.3%	37.3%
Chronic disease prevention services	40.2%	40.1%	37.3%	44.7%	39.3%
Expanding senior (65+) focused health/medical services	37.3%	32.2%	38.0%	41.5%	36.9%
Providing more alcohol/drug prevention and treatment services	31.6%	41.7%	32.1%	29.4%	27.5%
Public transportation to health/medical services	30.2%	36.8%	23.3%	29.4%	31.4%
Smoking cessation services	30.0%	34.4%	22.0%	28.7%	33.2%
Expanding youth focused health/medical services	22.0%	21.5%	21.3%	22.3%	22.6%
Increasing health/medical services that are close by and easy to get to	21.4%	22.7%	22.3%	17.7%	22.4%
Providing more reproductive or sexual health services for area youth	17.1%	24.8%	14.6%	10.3%	18.5%
Increasing number of dental providers in community	12.5%	20.2%	8.4%	8.5%	13.4%
Providing more testing services for STIs	9.1%	21.5%	3.5%	4.6%	8.6%
Increasing number of multilingual staff at area health/medical services	6.5%	13.6%	4.9%	4.6%	4.9%