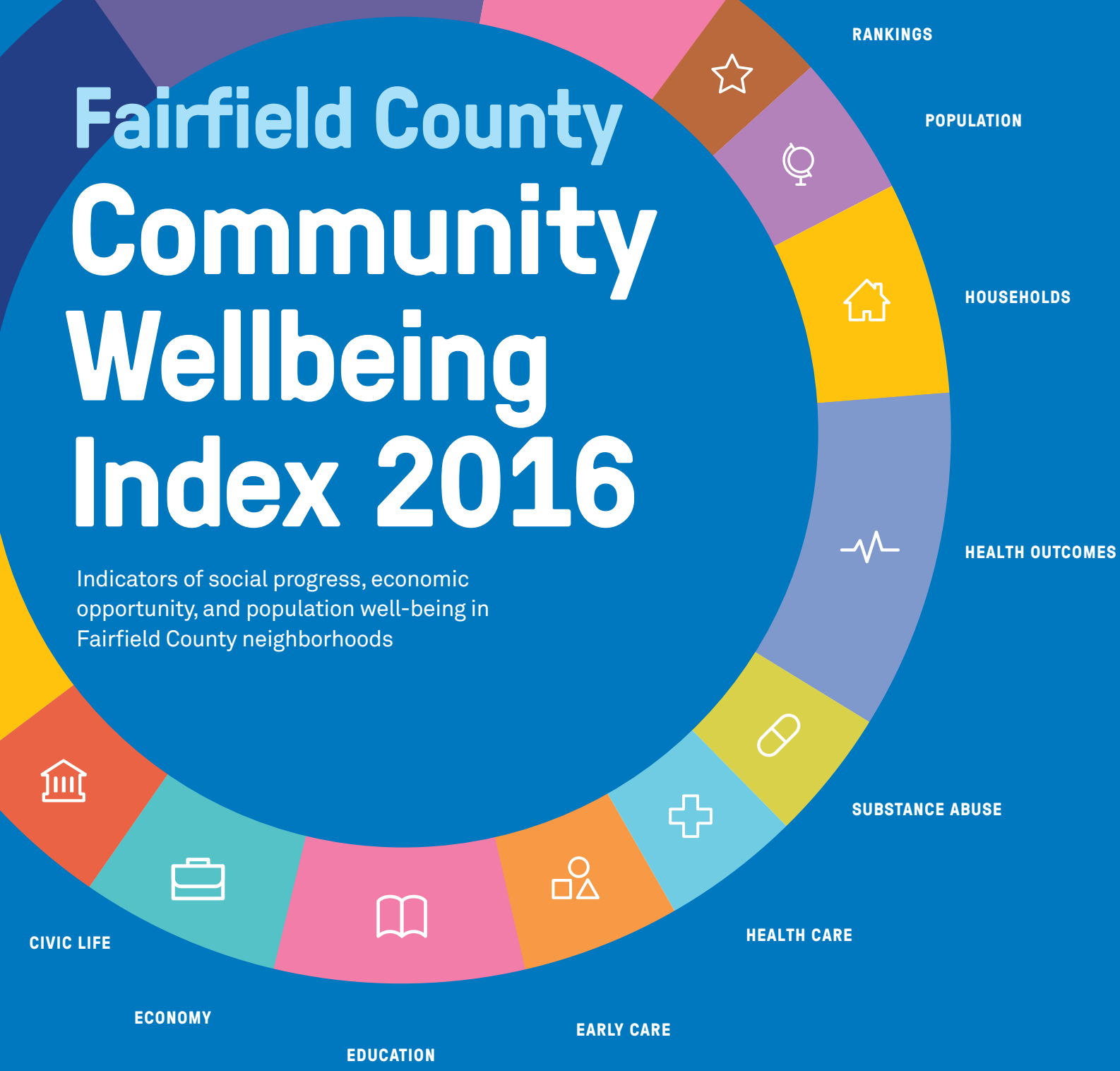
Fairfield County Community Wellbeing Index 2016

Indicators of social progress, economic opportunity, and population well-being in Fairfield County neighborhoods



A CORE PROGRAM OF
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In partnership with **Fairfield County's Community Foundation** and a **Community Health Needs Assessment** for the towns served by Bridgeport Hospital, Danbury Hospital, Greenwich Hospital, Norwalk Hospital, St. Vincent's Medical Center, and Stamford Hospital

Fairfield County's Community Foundation — TOGETHER WE THRIVE
Norwalk Hospital — Western Connecticut Health Network
Stamford Health — Healing. Reimagined.
Yale NewHaven Health — Bridgeport Hospital
Greenwich Hospital — Yale New Haven Health
St. Vincent's Medical Center
Danbury Hospital — Western Connecticut Health Network

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Major Funders

DataHaven

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TOGETHER WE THRIVE

Norwalk Hospital
Western Connecticut Health Network

Danbury Hospital
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Stamford Health
Healing. Reimagined.

Greenwich Hospital
Yale New Haven Health

St.Vincent's Medical Center

Yale NewHaven Health
Bridgeport Hospital

2015 DataHaven Community Wellbeing Survey Funders

The Fairfield County Community Wellbeing Index makes extensive use of the DataHaven Community Wellbeing Survey, which completed in-depth interviews with 16,219 randomly-selected adults in Connecticut last year. In addition to the major funders listed above, supporters of the survey's interviews with 4,962 adults in Fairfield County included the Greater Bridgeport Primary Care Action Group, United Way of Coastal Fairfield County, City of Norwalk Health Department, Connecticut Health Foundation, Connecticut Housing Finance Authority, and Valley Community Foundation, among others. Please see ctdatahaven.org for a complete list of statewide partners and funders.

Lead Authors

Mark Abraham, Executive Director, DataHaven
Mary Buchanan, Project Manager, DataHaven

Co-authors and Contributors

Ari Anisfeld, Aparna Nathan, Camille Seaberry, and Emma Zehner, DataHaven
Amanda Durante and Fawatih Mohamed, University of Connecticut Health Center
Linda F Cantley, Deron Galusha, and Baylah Tessier-Sherman, Yale Occupational and Environmental Medicine Program, Yale School of Medicine
Don Levy and Meghann Crawford, Siena College Research Institute
Connecticut Hospital Association ChimeData
Cyd Oppenheimer, Consultant
Brian Slattery, Consultant
Jeannette Ickovics, Yale School of Public Health
Nancy Von Euler, January Reissman, and Karen Brown, Fairfield County's Community Foundation
Design by KUDOS Design Collaboratory™: John Kudos, Creative Direction, Ashley Wu, Production Design

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CHAPTER 1

Introduction

What does it mean to have a healthy economy? How do we know if people are doing better than they were ten years ago? How do we measure growth meaningfully—in terms of not only dollars and cents, but also the quality of people's lives?

Good data and thoughtful measurements can capture our attention, highlight areas for direct action, and focus efforts to create change. The gross domestic product (GDP), which measures the value of all goods and services a country produces, has become a primary gauge of the health of our economy. Its measure guides major decisions for policymakers, journalists, and residents alike. The raw numbers of the value of economic activity, however, do not capture how well people are doing in a common-sense, day-to-day way — how much they experience prosperity when (and if) it comes, and how much it hurts when the economy slows down. In recent decades, alternative indicators have been proposed as a way to capture the experiences and situations of individuals, neighborhoods, and regions. These more sensitive and nuanced measures of well-being include how people are doing on a daily basis, how they function in the world, and how they generally perceive their lives and their communities.

Alongside standard economic indicators, these measures of experienced and evaluative well-being can offer further insight to inform policy. Attention to well-being is particularly useful when analyzing and prioritizing qualitative aspects of a community, such as perceptions of safety, certain environmental factors, access to community resources, and general optimism about the future.

At DataHaven, we believe that good data can propel community action. We look for numbers that can inform policy and stay relevant to the general public. More public data are available now than ever before, and in this report, our goal is to distill those figures and put them in context to provide a first-order approximation of how Fairfield County is doing. We've included a broad range of information, with input from our gracious partners in local hospitals, foundations, and city agencies. Their assistance throughout the process has helped us hone in on the multi-dimensional well-being of the diverse communities in Fairfield County. No indicator is perfect, and ours are no exception. We expect that feedback from community members will challenge our choices and help strengthen future reports. But we hope that the research here — much of it published for the first time — enables us, as a community, to see things that we might not otherwise see, so that we solve problems that might otherwise go unrecognized.

To return to our original claim, measurements have power — but only when people care. We hope you dig into the analyses and find trends that speak to you, share your stories with neighbors, start a dialogue about how our communities can be improved, and take action for the common good. We invite you to engage.

Mark Abraham, Executive Director, DataHaven

About the Document

We do not claim that this first edition of the Fairfield County Community Wellbeing Index is comprehensive; it is a work in progress that we intend to add to over time based on input from readers and regional partners. While some of the topics here have been the subject of other studies, we believe that there has never been a program that attempted to synthesize all of them into a single report on the interrelationship of quality of life, health, and economic competitiveness of Fairfield County and its individual towns and neighborhoods. Modeled after our Greater New Haven Community Index 2013, we believe that this single-source approach is effective because it creates an inclusive, approachable product and allows readers and partners to see how the work they do across different sectors contributes to a broader whole.

We developed this report based on an extensive

analysis of information gathered directly from local residents in 2015 and 2016. Data collection included in-depth, live cell phone and landline interviews with randomly-selected adults (4,962 living in Fairfield County and 16,219 living statewide) during the landmark **DataHaven Community Wellbeing Survey**, supplemented by focus groups and interviews. The Index also draws upon secondary data produced by dozens of agencies and organizations, including the U.S. Census Bureau, Connecticut state agencies, and the Connecticut Hospital Association. Care was taken to ensure that all persons living in Fairfield County, regardless of age, gender, race, ethnicity, national origin, or other demographic characteristics, would be represented within these sources of information. All data sources are documented in Chapter 5.

This report is designed to meet Greenwich Hospital's, Stamford Hospital's, Norwalk Hospital's, Danbury Hospital's, St. Vincent's Medical Center's, and Bridgeport Hospital's individual IRS requirements in Form 990 Schedule H and Notice 2011-52 that discuss the creation of a **Community Health Needs Assessment (CHNA)**, as well as to meet the similar needs of local health departments as part of a national accreditation process. This report's **health chapter (Chapter 3)** is intended to document key health needs in the communities served by all of the hospitals, while using a unified approach to reach the broadest possible audience. **Additional CHNA chapters (see below)** have been created separately based on the work of the multi-agency community-hospital coalition that exists within each hospital's primary service area. These additional chapters contain detail on community needs that were identified within each town and selected adjacent areas, and document the process used to conduct the community health needs assessments within each area including the production of the main Fairfield County Community Wellbeing Index. The chapters discuss the **Community Health Improvement Plan** being developed and updated within each hospital service area. Like the main report, the chapters have benefited from input from dozens of local public health experts. They may be found on the individual hospital or DataHaven websites when they are finalized.

DOCUMENT	TOWNS INCLUDED
Fairfield County Community Wellbeing Index	**All 23 towns in Fairfield County**
Additional CHNA Chapters and Hospital Service Area	
Greater Greenwich (Greenwich Hospital)	**Greenwich**, plus selected adjacent sections of New York State
Greater Stamford (Stamford Hospital)	**Darien, Stamford**
Greater Norwalk (Norwalk Hospital)	**New Canaan, Norwalk, Weston, Westport, Wilton**
Greater Danbury (Danbury Hospital)	**Bethel, Brookfield, Danbury, New Fairfield, Newtown, Redding, Ridgefield, Sherman**, plus selected adjacent sections of Litchfield and New Haven Counties
Greater Bridgeport (Bridgeport Hospital and St. Vincent's Medical Center)	**Bridgeport, Easton, Fairfield, Monroe, Trumbull, Stratford**
2016 Valley Community Index separately-produced; CHNA for Griffin Hospital	**Shelton**, plus other towns in the Lower Naugatuck Valley region

Measuring How Communities Shape Well-Being

Using our unprecedented statewide survey plus U.S. Census Bureau data, DataHaven constructed concise indicators to illustrate the connection between communities and individuals. More than 16,000 randomly-selected adults living throughout Connecticut participated in the 2015 DataHaven Community Wellbeing Survey (CWS). The survey's questions on health, happiness, and quality of life help us create an understanding of how people evaluate and experience day-to-day life.

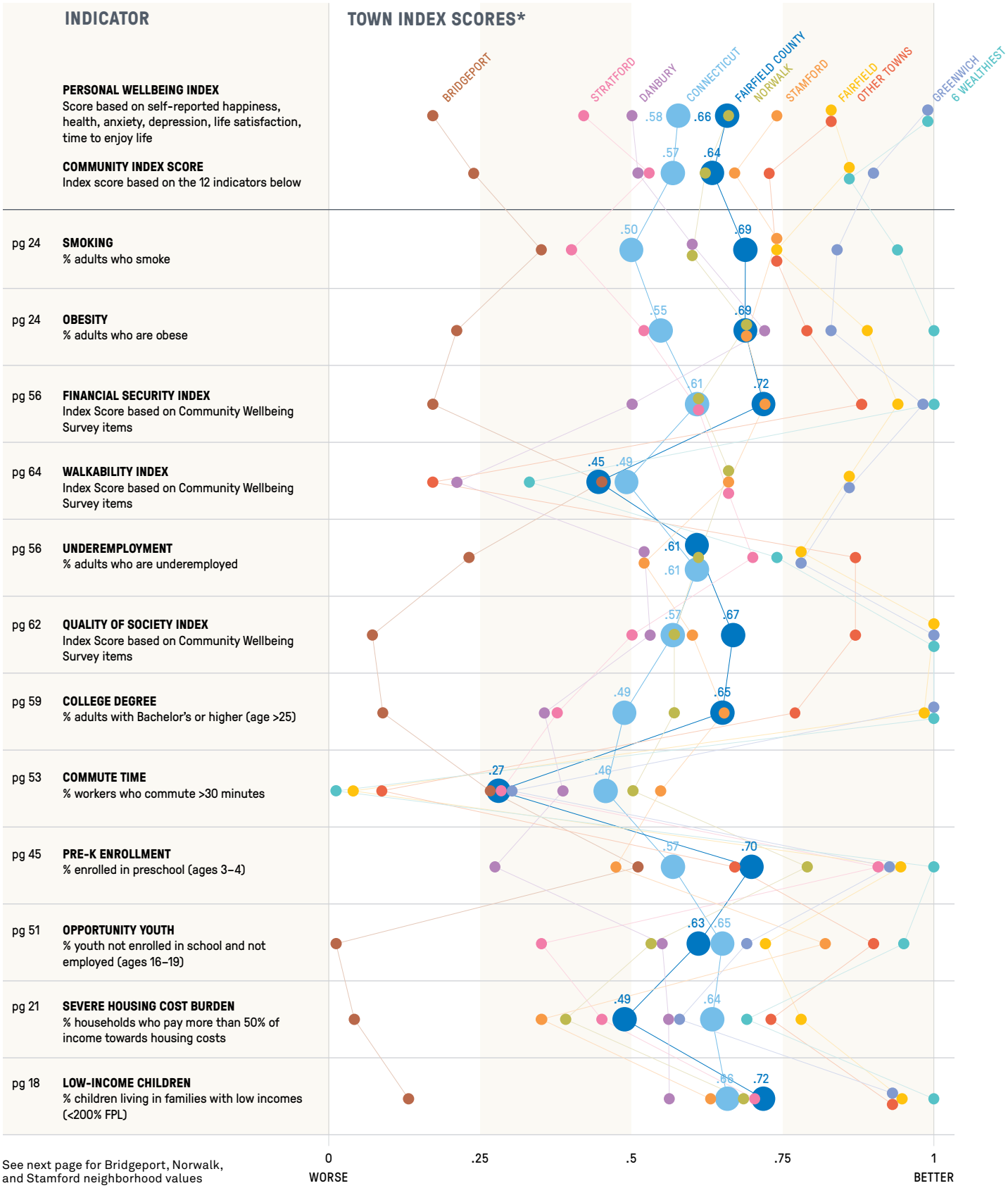
Designed by a panel of local and national experts and drawn from well-known surveys in the United States and United Kingdom, the CWS included a series of questions that are regularly used to evaluate personal well-being and that together make up our personal well-being index:

- How would you rate your overall health?
- How satisfied are you with your life nowadays?
- How happy did you feel yesterday?
- How anxious did you feel yesterday?
- Overall, to what extent do you have the time you need to do things that you really enjoy?
- During the last month, how often have you been bothered by feeling down, depressed, or hopeless?
- Do you have relatives or friends who you can count on to help you when you need them?

Meanwhile, we developed a broader Community Index that blends Census data and survey participants' perceptions of what life is like in their communities. These indicators seek to capture the physical and social environments that people live in — including measures of community-wide health, infrastructure, education, and economics.

1.1

Personal Wellbeing Index and Community Index



* See next page for Bridgeport, Norwalk, and Stamford neighborhood values

ABOUT THE INDICES

Community well-being — a neighborhood's shared assets and strengths, and the feeling of trust and cohesiveness between its residents — impacts the personal well-being of residents. We approach well-being from both the individual and community angles. Healthy communities are made up of individuals who feel safe and included, have access to goods and opportunities, and are civically engaged.[1] In return, such communities foster healthier, happier residents, propelling a virtuous cycle. To highlight this relationship, we used residents' evaluations of their own physical and mental health, happiness, personal relationships, and life satisfaction to create a Personal Wellbeing Index. We also identified 12 key indicators of community well-being, which collectively form our Community Index.

The chart gives a visual overview of index scores by indicator. Higher scores are better, and are based on how each geographic area compares to a wide distribution of neighborhoods throughout Connecticut. The table below provides the actual data values for comparison. Page numbers link to additional analysis of each indicator.

Index scores are normalized so that all range from 0 to 1, with 1 representing the preferred (better) outcome. Each town or neighborhood is compared to a large sample of Connecticut zip codes. A town with a score of 1 for an indicator means it performed as well as the top 95th percentile of the zip codes, while a score of 0 indicates the town fits in the bottom 5th percentile for that indicator. Actual values for individual community indicators (described in more detail on the previous page) are shown in the table.

Certain indicators in the community index appear personal but have social components. Obesity is a prime example. To the extent obesity is under individuals' control, public health research suggests it can spread through a social network.[2,3]

Fairfield County's extensive economic, educational, cultural, and health-related assets could translate into a high quality of life for all residents. Yet, levels of well-being are not evenly distributed across communities or neighborhoods, even within the same town. We often find correlations between community well-being and personal well-being. Studying both these measures together allows us to better understand the interplay between community strength and individual health and happiness.

The aspiration of this report is that data will reveal the assets and challenges of our communities and provide a starting point for action by community leaders and policymakers. The indices shown here preview what follows.

1.2

Community Index Components Data Values

	PERSONAL WELL-BEING INDEX	COMM-UNITY INDEX	SMOKING	OBESITY	FINANCIAL SECURITY INDEX	WALKA-BILITY INDEX	UNDER EMPLOY-MENT	QUALITY OF SOCIETY INDEX	COLLEGE DEGREE	COM-MUTE TIME	PRE-K ENROLL-MENT	OPPOR-TUNITY YOUTH	SEVERE HOUSING COST BURDEN	LOW INCOME CHILDREN
Connecticut	**0.58**	**0.57**	15%	26%	0.61	0.49	14%	0.57	37%	34%	64%	6%	18%	30%
Fairfield County	**0.66**	**0.64**	11%	22%	0.72	0.45	14%	0.67	45%	38%	69%	6%	20%	26%
Bridgeport	**0.17**	**0.24**	18%	36%	0.17	0.45	23%	0.07	16%	38%	62%	14%	29%	65%
East End	**0.09**	**0.08**	23%	44%	0.06	0.21	26%	0.01	7%	34%	61%	30%	38%	80%
Central	**0.17**	**0.23**	19%	35%	0.11	0.49	24%	0.10	18%	37%	56%	10%	27%	67%
Other	**0.26**	**0.33**	13%	35%	0.28	0.45	20%	0.13	17%	40%	76%	11%	28%	52%
Danbury	**0.50**	**0.51**	13%	21%	0.50	0.21	16%	0.53	30%	35%	53%	7%	19%	36%
Fairfield	**0.83**	**0.86**	8%	18%	0.94	0.86	10%	1.00	66%	37%	77%	5%	19%	12%
Greenwich	**0.99**	**0.90**	10%	16%	0.99	0.86	10%	1.00	62%	44%	78%	5%	15%	10%
Norwalk	**0.66**	**0.63**	13%	22%	0.61	0.66	14%	0.57	41%	32%	72%	7%	22%	28%
Central	**0.58**	**0.55**	16%	25%	0.50	0.62	16%	0.57	37%	29%	64%	5%	24%	35%
Other	**0.74**	**0.73**	11%	18%	0.77	0.74	11%	0.57	46%	34%	80%	10%	20%	20%
Stamford	**0.74**	**0.67**	10%	22%	0.72	0.66	16%	0.60	46%	31%	60%	3%	23%	32%
Central	**0.74**	**0.64**	11%	22%	0.55	0.82	18%	0.57	40%	30%	53%	5%	26%	43%
Other	**0.74**	**0.71**	8%	22%	0.94	0.41	13%	0.67	57%	31%	77%	1%	18%	10%
Stratford	**0.42**	**0.54**	17%	27%	0.61	0.66	12%	0.50	31%	38%	75%	9%	21%	27%
6 Wealthiest	**0.99**	**0.86**	6%	10%	1.00	0.33	11%	1.00	76%	48%	83%	2%	17%	7%
Other Towns	**0.83**	**0.73**	10%	19%	0.88	0.17	8%	0.87	51%	42%	68%	2%	16%	12%

See Figure 1.1 for a definition of each component.

State Rankings

Connecticut compares well to other states on well-established national rankings of community well-being and economic opportunity. When created by respected organizations in a valid way, these types of rankings can help bring context to any discussion of regional issues. However, regional or citywide trends can be misleading, because even as a city improves, conditions within its most disadvantaged neighborhoods may be getting worse. Throughout this report, we have drilled down into the statewide and region-wide data by town, neighborhood, and demographic group to assess the performance of specific communities. DH

1.3

State Rankings

NEIGHBORING STATE RANKINGS FOR COMPARISON

REPORT (YEAR) — PUBLISHER	CT	MA	RI	NY	NJ
Measure of America (2013–2014) — Social Science Research Council Composite ranking of life expectancy, education and median earnings	1	2	14	8	3
State Equality Index (2015) — Human Rights Campaign Places states in one of four categories based on their LGBT-related legislation and policies (From best to worst: Working Toward Innovative Equality (WTIE), Solidifying Equality (SE), Building Equality (BE), and High Priority to Achieve Basic Equality (HPABE)	1	8	14	8	8
State Integrity Investigation (2015) — The Center for Public Integrity Grading based on the laws and systems states have in place to deter corruption	3	11	5	31	19
Opportunity Index (2015) — Measure of America and Opportunity Nation Composite measure of economic, educational, and civic factors that expand opportunity	3	2	25	15	6
Bloomberg State Innovation Index (2016) — Bloomberg Scored states on R&D intensity, productivity, high-tech density, concentration STEM employment, science and engineering degree holders, and patent activity	5	1	14	17	4
Quality Counts (2016) — Education Week Ranks states on three indices developed by the Education Week Research Center, including factors such as the role education plays in career outcomes, academic performance, and school finances	5	1	13	9	2
America's Health Rankings (2015) — United Health Foundation Study of health behaviors, environmental and social barriers to health, health care and disease risk	6	3	14	13	11
State Energy Efficiency Scorecard (2015) — ACEEE Assessment of policies and programs that promote energy efficiency	6	1	4	9	21
Kids Count (2015) — Annie E. Casey Foundation Composite index of children's economic security, education and health	6	3	31	28	8
New Economy Index (2014) — Information Tech & Innovation Fdn (ITIF) Index of digital economy, economic dynamism and global integration	8	1	19	12	10
State Technology and Science Index (2014) — Milken Institute Study of economic performance in technology and science	9	1	13	11	16
State Long-Term Services and Supports Scorecard (2014) — AARP Measures systems that help older people and adults with disabilities	12	18	38	25	26
State of American Wellbeing (2015) — Gallup Composite score based on happiness, emotional health, economic wellbeing and other topics	18	30	26	40	32
Volunteer Rate Rankings (2014) — Corporation for National & Community Service Ranking based on average volunteer rates	20	33	38	50	45
Assets & Opportunity Scorecard (2016) — Corporation for Enterprise Development Ranking based on 67 outcome measures to assess the financial security and economic opportunity of U.S. households, including categories such as financial assets and income, business and jobs, housing and homeownership, healthcare, and education	23	14	35	32	25
Average ranking among all 50 U.S. states	**8**	**9**	**20**	**21**	**16**

CHAPTER 2

A Changing Region

Residential divisions by race and income are particularly apparent among children. In Fairfield County, 36 percent of African-American children and 30 percent of Latino children live in poor neighborhoods—those where the average family income (AFI) is less than half the state AFI. Just 1 percent of white children live in poor neighborhoods.

From 2005 to 2014, the number of severely cost-burdened renters (those paying more than half of their total income towards housing costs) increased by 51 percent in Fairfield County.

THE FAIRFIELD COUNTY POPULATION

Population and Growth

In 2014, Fairfield County had a total population of 934,200. The largest towns in the region are also the most population dense, and are considered to be the county's major cities: Bridgeport, Stamford, Norwalk, and Danbury.[4]

Since 1990, the county population increased by 13 percent, at a rate faster than Connecticut's population overall (up 9 percent). Every town in the region grew in population; Danbury and Stamford grew the most, each adding more than 17,000 people. As a whole, the suburban towns grew faster than the cities from 1990 to 2014.[5]

Recently, however, some cities have experienced rapid growth; Danbury had the largest population increase of any town in Connecticut from 2000 to 2010; Stamford led the state in population growth from 2010 to 2014.[6]

Age Groups and Aging

In the county between 1990 and 2014, the number of young adults (ages 18–34) decreased by 15 percent, or 32,900. Meanwhile, the population of middle-aged adults (ages 35–64) grew the fastest, at a rate of 26 percent (+81,100 people). Over the next decade, older adults (ages 65 and over) are projected to be the only group to increase significantly in size. From 2014 to 2025, the older adult population will grow by 37 percent, or 47,700.[7]

Fewer young people and more aging adults have made the total county population older in general, trends that mirror the statewide changes. The growth in older adults is due to Baby Boomers, who began turning 65 in 2011, and is occurring nationally and internationally.[8]

The wealthiest towns and other suburbs saw dramatic change in age structure, with the number of middle-aged and older adults increasing much more rapidly than in the city centers. In general, these towns lost large numbers of young adults but gained many middle-aged and older adults. The number of children also grew, fastest in the wealthiest towns.[9] (FIG 2.2)

2.1

Population and Growth in Fairfield County

POPULATION IN FAIRFIELD COUNTY AND TOWNS, 1990–2014

	TOTAL POPULATION, 1990	TOTAL POPULATION, 2014	PERCENT CHANGE 1990–2014	DENSITY, 2014 POP. PER SQUARE MILE	MEDIAN AGE, 2000	MEDIAN AGE, 2014
United States	248,709,873	**314,107,084**	26%	91	35	**37**
Connecticut	3,287,116	**3,592,053**	9%	742	37	**40**
Fairfield County	827,645	**934,215**	13%	1,495	37	**40**
Bethel	17,541	**19,078**	9%	1,130	37	**42**
Bridgeport	141,686	**146,680**	4%	9,185	31	**32**
Brookfield	14,113	**16,774**	19%	848	39	**45**
Danbury	65,585	**82,781**	26%	1,976	35	**37**
Darien	18,196	**21,190**	16%	1,674	38	**39**
Easton	6,303	**7,593**	20%	277	40	**47**
Fairfield	53,418	**60,678**	14%	2,029	39	**41**
Greenwich	58,441	**62,141**	6%	1,305	40	**42**
Monroe	16,896	**19,744**	17%	757	38	**43**
New Canaan	17,864	**20,073**	12%	905	40	**43**
New Fairfield	12,911	**14,079**	9%	689	37	**44**
Newtown	20,779	**27,960**	35%	485	38	**44**
Norwalk	78,331	**87,214**	11%	3,815	37	**41**
Redding	7,927	**9,267**	17%	294	41	**49**
Ridgefield	20,919	**25,025**	20%	725	39	**43**
Shelton	35,418	**40,472**	14%	1,321	40	**46**
Sherman	2,809	**3,636**	29%	166	42	**48**
Stamford	108,056	**125,401**	16%	3,332	36	**36**
Stratford	49,389	**52,092**	5%	2,980	40	**43**
Trumbull	32,016	**36,444**	14%	1,563	40	**43**
Weston	8,648	**10,319**	19%	521	40	**43**
Westport	24,410	**27,055**	11%	1,355	41	**45**
Wilton	15,989	**18,519**	16%	691	40	**42**

2.2

The Changing Age Structure of Fairfield County

POPULATION AND CHANGE BY AGE GROUP, 1990–2025

	1990	2000	2014	2025 PROJECTION	1990–2014	2014–2025 PROJECTION
AGE 0–4	56,957	64,005	55,160	49,085	-3% 1,797 PEOPLE	-11% 6,075 PEOPLE
AGE 5–17	130,168	162,209	170,155	139,693	+31% 39,987 PEOPLE	-18% 30,462 PEOPLE
AGE 18–34	220,281	179,417	187,341	194,872	-15% 32,940 PEOPLE	+4% 7,531 PEOPLE
AGE 35–64	310,171	359,773	391,284	385,728	+26% 81,113 PEOPLE	-1% 5,556 PEOPLE
AGE 65–79	85,195	84,123	90,275	133,253	+6% 5,080 PEOPLE	+48% 42,978 PEOPLE
AGE 80+	24,873	33,040	40,000	44,720	+61% 15,127 PEOPLE	+12% 4,720 PEOPLE
TOTAL POPULATION	827,645	882,567	934,215	947,351	+13% 106,570 PEOPLE	+1% 13,136 PEOPLE

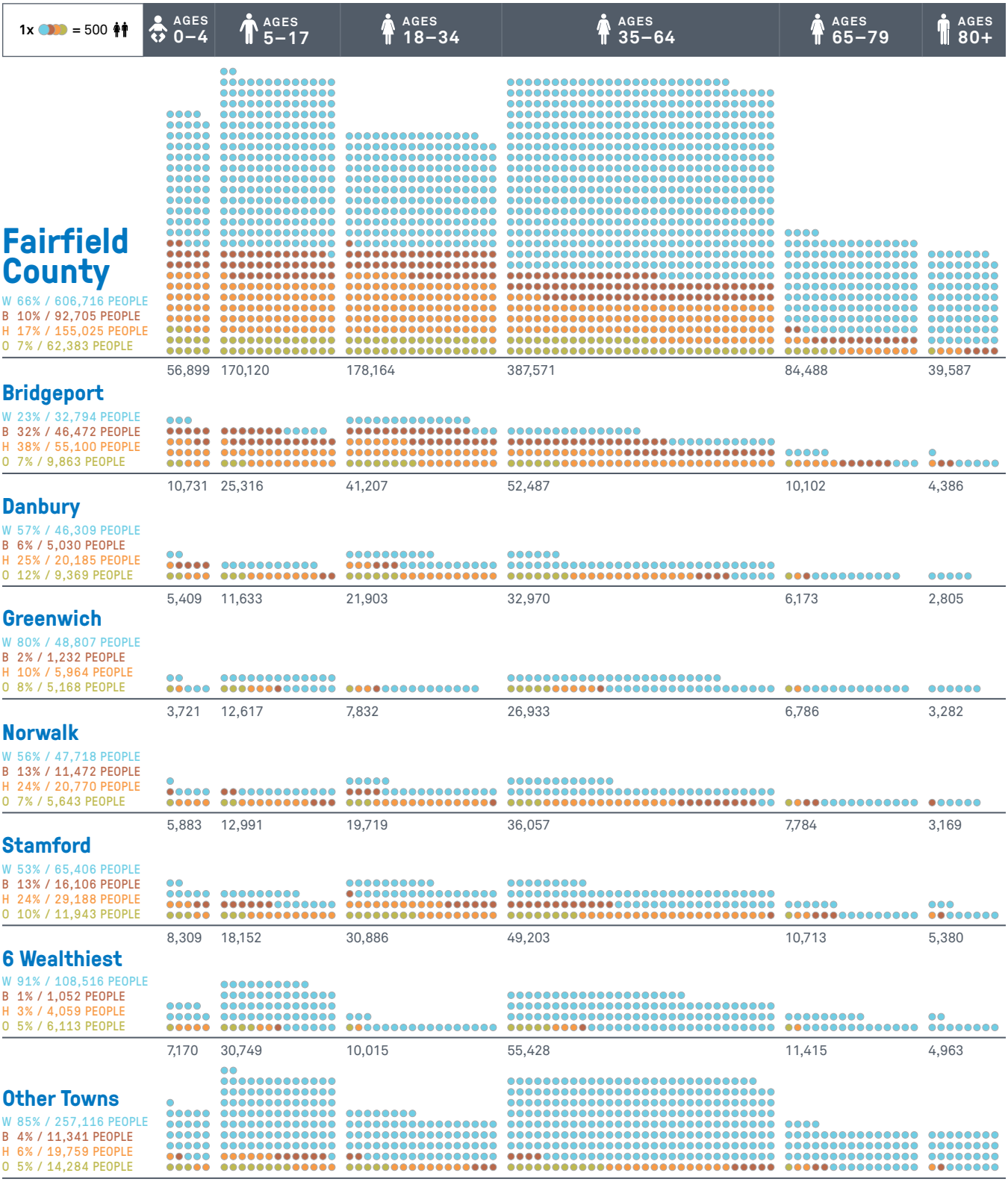
2.3

Race and Ethnicity in Fairfield County

POPULATION BY RACE/ETHNICITY AND AGE, 2010

US
WHITE 64% / 196,817,552 PEOPLE
BLACK 12% / 37,685,848 PEOPLE
HISPANIC 16% / 50,477,594 PEOPLE
OTHER 8% / 23,764,544 PEOPLE

CT
WHITE 71% / 2,546,262 PEOPLE
BLACK 9% / 335,119 PEOPLE
HISPANIC 13% / 479,087 PEOPLE
OTHER 6% / 213,629 PEOPLE



* Other towns include Fairfield and Stratford

Racial/Ethnic Groups and Increasing Diversity

In 2014, 35 percent of Fairfield County residents identified as racial or ethnic minorities (not non-Hispanic white) compared to 20 percent in 1990. Over this period, the minority population doubled, an increase of 162,600 individuals, while the size of the self-identified white population decreased by 55,200 people (-8 percent).[10] Population projections show that continuing over the next 30 years, all of Fairfield County's net population growth will come from people of color, preventing population loss even as the number of white people will continue to decline.[11]

Racial and ethnic diversity is highest among the youngest Fairfield County residents, supporting the prediction that the diversity of the region's population will continue to increase in the future.[12] Similarly, the median age of racial and ethnic groups varies dramatically by racial/ethnic group: it is 45 years among non-Hispanic whites, 35 years among Asians, 34 years among African Americans and 30 years among Hispanic or Latinos.[13] It is important to take age into account when describing differences between groups, particularly when it comes to health outcomes.

In this report, we will refer to racial or ethnic minorities, or people of color, as people who do not identify as non-Hispanic white. This group includes people who do not identify racially as white, as well as all people who identify ethnically as Hispanic, regardless of their race. For a variety of historical reasons, race is closely related to geography, income, and other social factors.

As of 2014, a majority of Fairfield County residents are white non-Hispanic (65 percent); 10 percent identify as Black or African American, 7 percent as some other race but not ethnically Hispanic, and 18 percent as Hispanic. Compared to other counties, the region has the largest Hispanic population in Connecticut and the 59th largest in the U.S.[14] Within Fairfield County, the four largest cities have the most racially and ethnically diverse populations of the region's towns. In Bridgeport, 77 percent of residents are people of color. Approximately 12 percent of the combined populations of the wealthy and suburban towns are people of color.[15]

The "majority minority" racial/ethnic composition of the cities' populations, in contrast to the predominantly white suburbs, indicates that racial residential segregation exists in Fairfield County. In other words, regional diversity is not indicative of the community-level; neighborhoods tend to be either mostly people of color or mostly white people. The neighborhood-level racial segregation is linked to high economic segregation as well in the community (see Income Inequality section on page 18).[16]

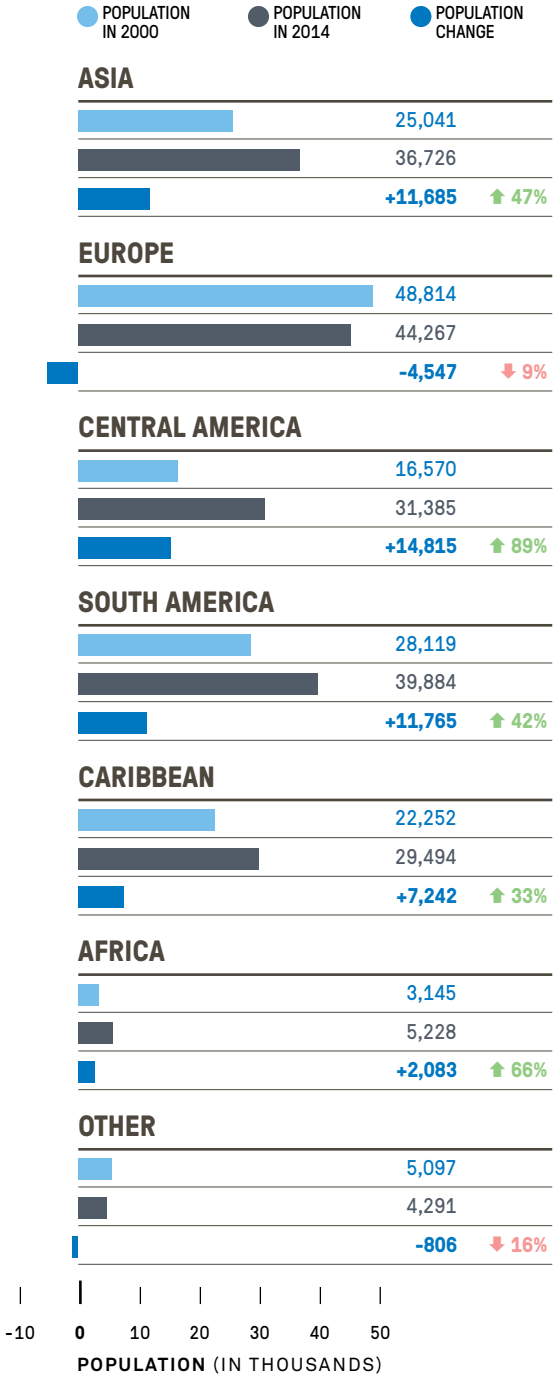
Residential divisions by race and income are particularly apparent among children. Among the population ages 0–17 in Fairfield County, 36 percent of all African-Americans and 30 percent of all Latinos live in "poor" neighborhoods, where the average family income (AFI) is less than half the state AFI. Just 1 percent of white and 4 percent of Asian children live in poor neighborhoods (see page 19 for more information on neighborhood income levels). The average white student in Fairfield County attends a primary school (grades K–8) with a school poverty rate of 18 percent, compared to school poverty rates of 66 percent and 74 percent for the schools attended by the average Hispanic and African-American students, respectively.[17]

2.4

Fairfield County's Foreign-Born Population

CHANGES IN IMMIGRANT POPULATION FROM 2000 THROUGH 2014, BY COUNTRY OF BIRTH

Fairfield County attracts immigrants from many countries throughout the world.* From 2000 to 2014, 100 percent of net population growth in Fairfield County could be attributed to the increase in the foreign-born population. The number of immigrants born in Guatemala, India, Ecuador, or Mexico, but residing in Fairfield County, grew the most. Populations from Guyana, Bangladesh, Guatemala, Venezuela, Honduras, and Dominican Republic grew the fastest, more than doubling in size.



* Countries or regions of origin are only identified in this graphic if the population born there that lives in Fairfield County was estimated to be at least 700 persons.

CENTRAL AMERICA

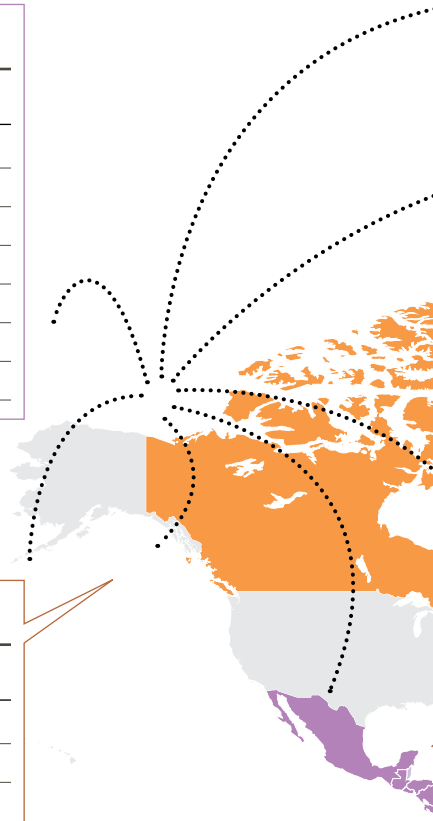
		2000	2014	NUMBER CHANGE	PERCENT CHANGE
1	**Guatemala**	5,095	11,619	6,524	128%
2	**Mexico**	6,270	10,898	4,628	74%
3	**Honduras**	1,786	3,670	1,884	105%
4	**El Salvador**	1,449	2,876	1,427	98%
5	**Costa Rica**	1,097	1,300	203	19%
6	**Nicaragua**	613	776	163	27%
	Remainder	260	246	-14	-5%

CARIBBEAN

		2000	2014	NUMBER CHANGE	PERCENT CHANGE
1	**Jamaica**	9,093	10,966	1,873	21%
2	**Haiti**	6,138	7,993	1,855	30%
4	**Dominican Republic**	3,671	7,341	3,670	100%
3	**Cuba**	1,785	1,096	-689	-39%
	Remainder	1,565	2,098	533	34%

SOUTH AMERICA

		2000	2014	NUMBER CHANGE	PERCENT CHANGE
1	**Ecuador**	6,091	11,001	4,910	81%
2	**Brazil**	7,926	10,737	2,811	35%
3	**Colombia**	7,727	7,911	184	2%
4	**Peru**	3,170	5,342	2,172	69%
5	**Argentina**	773	1,373	600	78%
6	**Venezuela**	492	1,054	562	114%
7	**Guyana**	297	864	567	191%
8	**Chile**	728	723	-5	-1%
	Remainder	915	879	-36	-4%

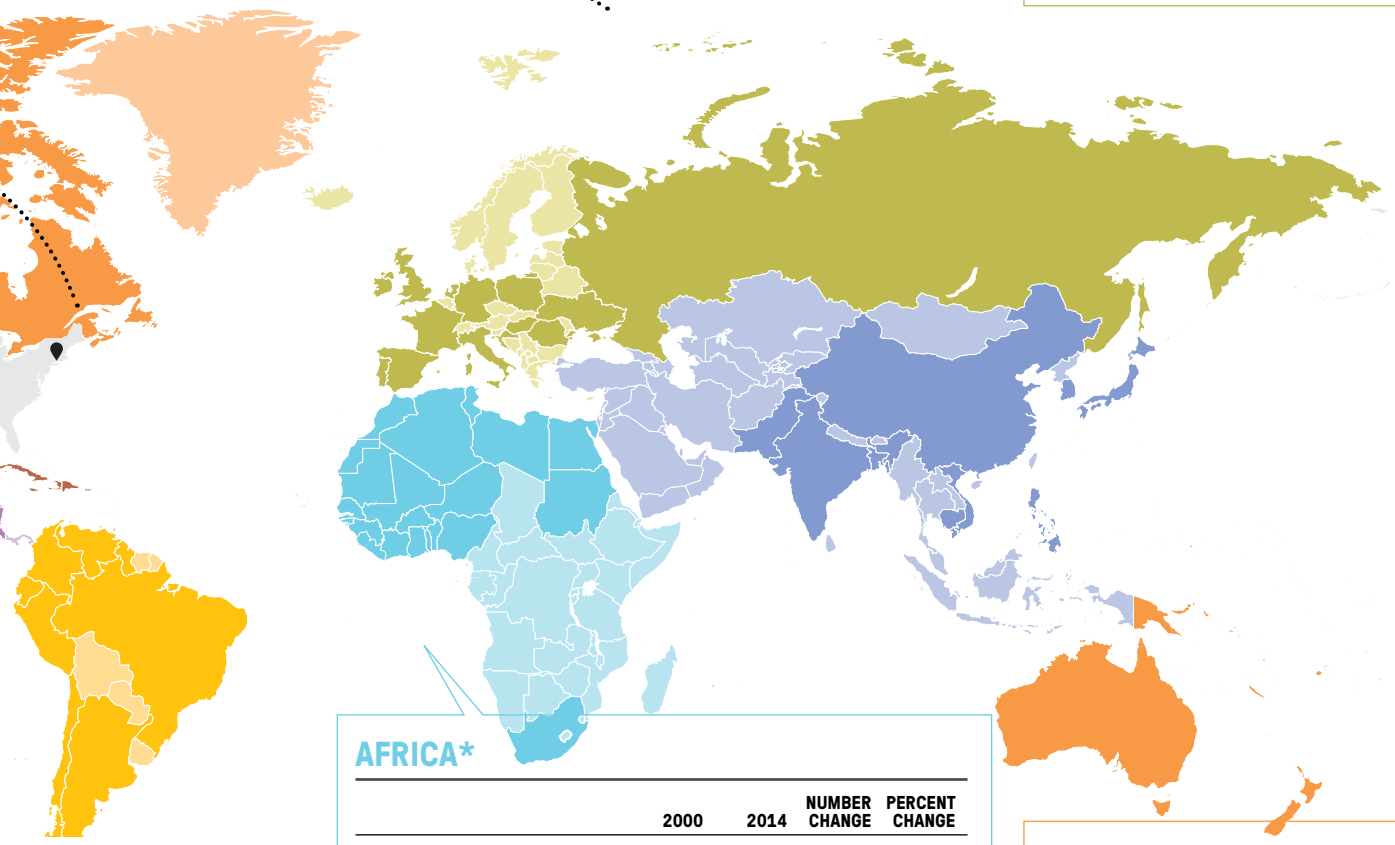


ASIA

	2000	2014	NUMBER CHANGE	PERCENT CHANGE
① **India**	5,581	10,651	5,070	91%
② **China**	3,696	6,515	2,819	76%
③ **Philippines**	2,050	2,849	799	39%
④ **Vietnam**	2,081	2,249	168	8%
⑤ **Korea**	1,715	2,247	532	31%
⑥ **Pakistan**	962	1,772	810	84%
⑦ **Bangladesh**	673	1,589	916	136%
⑧ **Japan**	2,049	1,530	-519	-25%
⑨ **Cambodia**	1,034	1,040	6	1%
Remainder	5,200	6,284	1,084	21%

EUROPE

	2000	2014	NUMBER CHANGE	PERCENT CHANGE
① **Poland**	5,558	6,033	475	9%
② **United Kingdom**	6,796	5,894	-902	-13%
③ **Italy**	7,983	5,700	-2,283	-29%
④ **Portugal**	5,477	3,974	-1,503	-27%
⑤ **Germany**	3,853	3,086	-767	-20%
⑥ **Russia**	1,947	2,225	278	14%
⑦ **Greece**	2,361	2,028	-333	-14%
⑧ **Ireland**	1,778	1,925	147	8%
⑨ **Ukraine**	887	1,338	451	51%
⑩ **Romania**	911	1,262	351	39%
⑪ **France**	1,365	1,212	-153	-11%
⑫ **Hungary**	1,343	997	-346	-26%
⑬ **Netherlands**	586	775	189	32%
⑭ **Spain**	489	728	239	49%
Remainder	7,480	7,090	-390	-5%



AFRICA*

	2000	2014	NUMBER CHANGE	PERCENT CHANGE
① **West African countries**†	1,059	1,586	527	50%
② **North African countries**‡	688	1,272	584	85%
③ **South Africa**	574	1,047	473	82%
Remainder	824	1,323	499	61%

* Countries listed were the place of birth of at least 700 residents in 2014.

† West Africa includes Benin, Burkina Faso, Cape Verde, Gambia, Ghana, Guinea, Guinea-Bissau, Ivory Coast, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, St Helena, and Togo.

‡ North Africa includes Algeria, Egypt, Libya, Morocco, Sudan, Tunisia, and Western Sahara.

OTHER

	2000	2014	NUMBER CHANGE	PERCENT CHANGE
① **Canada**	4,284	3,456	-828	-19%
② **Oceania**	751	751	0	0%

Immigration in Fairfield County

From 1990 to 2014, the number of foreign-born people living in Fairfield County increased by 90,300, or 89 percent, and reflected a recent uptick in immigration nationwide.[18] By 2014, one-fifth of the county-wide population, or 191,300 individuals, were immigrants. Much of the county's immigrant population resides in one of the four major cities, where between one-quarter of the population (in Norwalk) and one-third (in Stamford) are foreign-born people.[19]

Immigrants bring to Fairfield County the cultural perspectives of their more than 130 home countries from every region around the world.[20] In general, they increase the economic resilience of the county: four-fifths of immigrants are of working age, and a majority of working-age immigrants (71 percent statewide) are employed and pay taxes.[21]

In total, 43 percent of immigrants living in Fairfield County are naturalized U.S. citizens. Of the county's 109,300 non-citizen residents, more than half are legal U.S. residents, while an estimated 47,400 are undocumented immigrants.[22] Forty-one percent of foreign-born residents of Fairfield County entered the U.S. recently, at some time since 2000. These immigrants are more likely to be of working age (18-64) and less likely to be naturalized U.S. citizens.[23]

Within Fairfield County, differences exist between groups of immigrants. Twenty-five percent of foreign-born people living in the largest four cities hold at least a bachelor's degree, compared to two-thirds of immigrants living in the wealthiest towns.[24] Urban-dwelling immigrants are more likely to have recently arrived in the U.S. or to be of working age, and less likely to be naturalized citizens — compared to foreign-born residents of suburban towns.[25]

MIGRATION TO FAIRFIELD COUNTY

In 2014, 12 percent of all Fairfield County residents moved to a new home, including 5 percent of all residents who moved from outside the county. Residential mobility rates are generally higher among city residents. Over 9,100 people, or approximately one-tenth of all people who moved, relocated to Fairfield County from a foreign country.[26]

Analysis of tax records suggest that in 2014, Fairfield County had net out-migration, with more people leaving the county than moving to it from somewhere else. The largest numbers of in-migrating Fairfield County residents lived previously in New York City or Westchester County, New York. Those areas had net "in-migration populations" to Fairfield County — meaning that there were more people who moved from New York City or Westchester to the region, than Fairfield County residents who moved to those locations.[27] Florida and New Haven County were the most popular destinations for former Fairfield County residents who moved away; both areas attracted more residents from Fairfield County than vice versa.

2.5

Characteristics of Immigrants in Fairfield County

FOREIGN-BORN RESIDENTS OF FAIRFIELD COUNTY, 2014

	TOTAL POPULATION	PERCENT FOREIGN-BORN	TOTAL FOREIGN-BORN POPULATION	NATURALIZED CITIZENS	AGE 18–64	ENTERED US 2000–14	BA OR HIGHER ED	1990–2014 CHANGE POPULATION FOREIGN-BORN
United States	314,107,084	13%	41,056,885	46%	80%	38%	28%	108%
Connecticut	3,592,053	14%	490,460	48%	79%	40%	33%	76%
Fairfield County	934,215	20%	191,275	43%	81%	41%	33%	89%
Bridgeport	146,680	28%	40,638	34%	86%	46%	15%	96%
Danbury	82,781	32%	26,492	34%	83%	47%	18%	169%
Fairfield	60,678	11%	6,410	57%	74%	30%	49%	52%
Greenwich	62,141	22%	13,636	48%	74%	41%	60%	35%
Norwalk	87,214	24%	21,298	43%	83%	44%	32%	105%
Stamford	125,401	34%	43,126	36%	83%	46%	35%	114%
Stratford	52,092	13%	6,922	57%	79%	26%	26%	128%
6 Wealthiest Towns	122,181	11%	13,510	58%	71%	33%	67%	34%
Other Towns	195,047	10%	19,243	64%	74%	24%	46%	54%

HOUSEHOLDS & INCOME IN FAIRFIELD COUNTY

Households and the Homes Where They Live

Of the 333,500 households in Fairfield County, more are single adults living alone, non-related adults living together, or single adults with children, compared to past decades. Meanwhile, from 1990 to 2014 the numbers of "traditional households" — married couples and married couples with children — hardly grew.[28] This restructuring of households is occurring across the nation and is projected to continue. The changes are due to people marrying and having children later in life, higher divorce rates, and more and longer-living older adults (40 percent of adults living alone in Fairfield County are 65 years or older).[29]

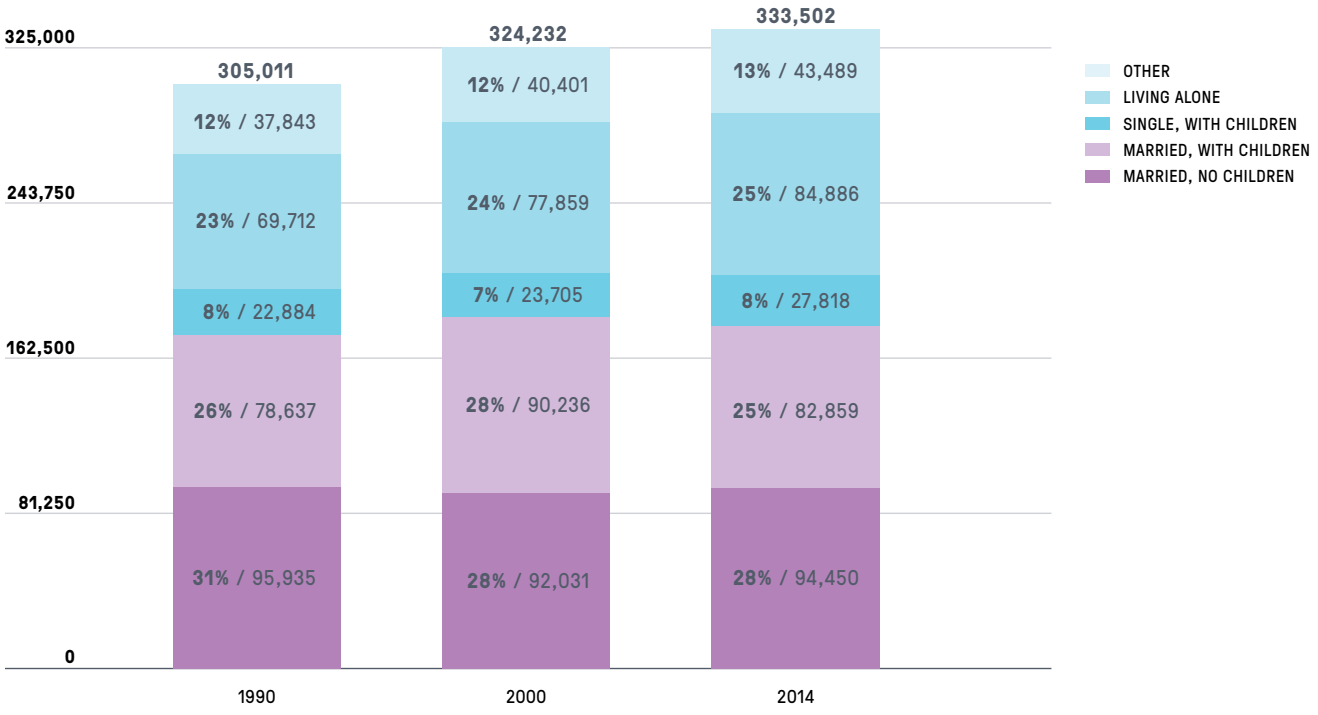
A majority of existing houses in the region (65 percent) are single-family homes, while multi-family apartments or condominiums are concentrated in the cities and neighboring suburbs.[30] Multi-family units tend to be rental or affordable, attracting young workers, single adults, or households that otherwise do not want, or cannot afford, to own their home. The increase in "non-traditional" households and those households' preference for smaller units in urban settings have helped to shift regional housing demand towards multi-family units in cities.[31] Fifty-seven percent of homes built in Fairfield County from 2010 to 2014 were multi-family, compared to 25 percent built from 2000–04.[32]

County-wide, the homeownership rate is 68 percent: this represents an overall increase in homeownership since 2000, but it is still below the pre-Recession peak of 72 percent in 2007.[33] Homeownership is significantly lower in cities (40–60 percent) compared to suburbs (approximately 80 percent), in part because the urban areas offer more rental or affordable housing options.[34] Refer to page 21 for homeownership rates.

2.6

The Changing Household Structure of Fairfield County

HOUSEHOLDS IN FAIRFIELD COUNTY, 1990–2014



2.7

Income and Income Inequality in Fairfield County

MEDIAN, BOTTOM, AND TOP HOUSEHOLD INCOMES IN FAIRFIELD COUNTY TOWNS, 2014

UNITED STATES

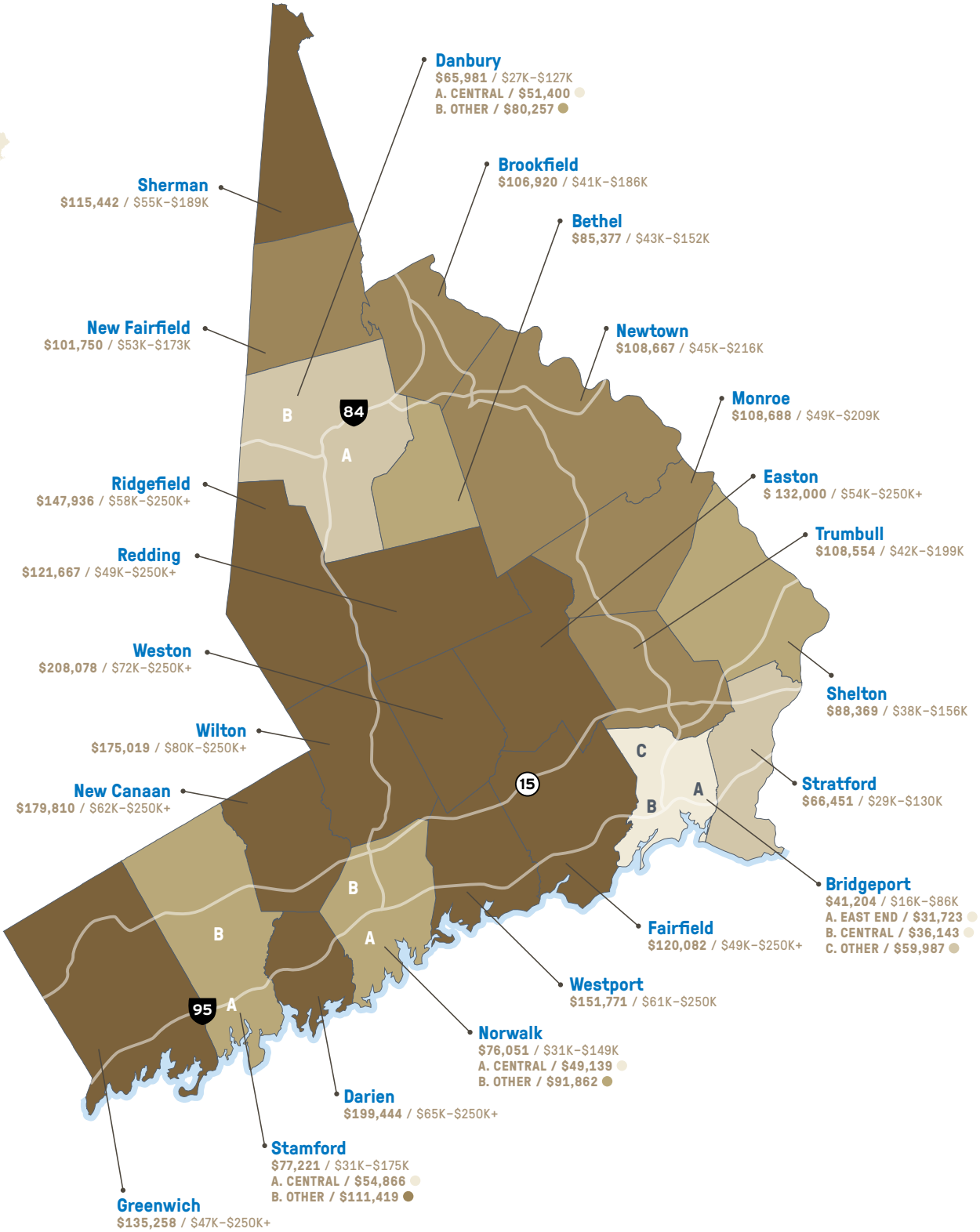
$53,482 MEDIAN INCOME
$22K BOTTOM 20% INCOME
$108K TOP 20% INCOME

CONNECTICUT

$69,899 MEDIAN INCOME
$27K BOTTOM 20% INCOME
$139K TOP 20% INCOME

FAIRFIELD COUNTY

$83,163 MEDIAN INCOME
$31K BOTTOM 20% INCOME
$184K TOP 20% INCOME



- $30,000 TO $54,999
- $55,000 TO $74,999
- $75,000 TO $94,999
- $95,000 TO $114,999
- $115,000 OR MORE

Income Inequality in Fairfield County

Households in Fairfield County have a median income of $83,163 — around $13,000 higher than the state and $30,000 higher than the nation.[35] However income is not evenly distributed between Fairfield County households. The region's income inequality ranks first of the 100 largest U.S. metro areas when comparing incomes of top and bottom earners: the richest households (top 5 percent of earners) made $558,970 per year, nearly 18 times the $31,330 that poorest (bottom 20 percent) earned.[36]

Neighborhood income segregation occurs when people with extreme incomes — who are very rich or very poor — mostly live in neighborhoods where other residents have similar levels of income. Fairfield County's "most affluent" neighborhoods, home to 95,049 people, have an average family income (AFI) of $293,900, more than 2.5 times the statewide average. Meanwhile, 93,106 people now live in "poor" neighborhoods, where the AFI is $46,000, less than half the statewide average. Since 1980, the populations of these neighborhoods have more than tripled.[37]

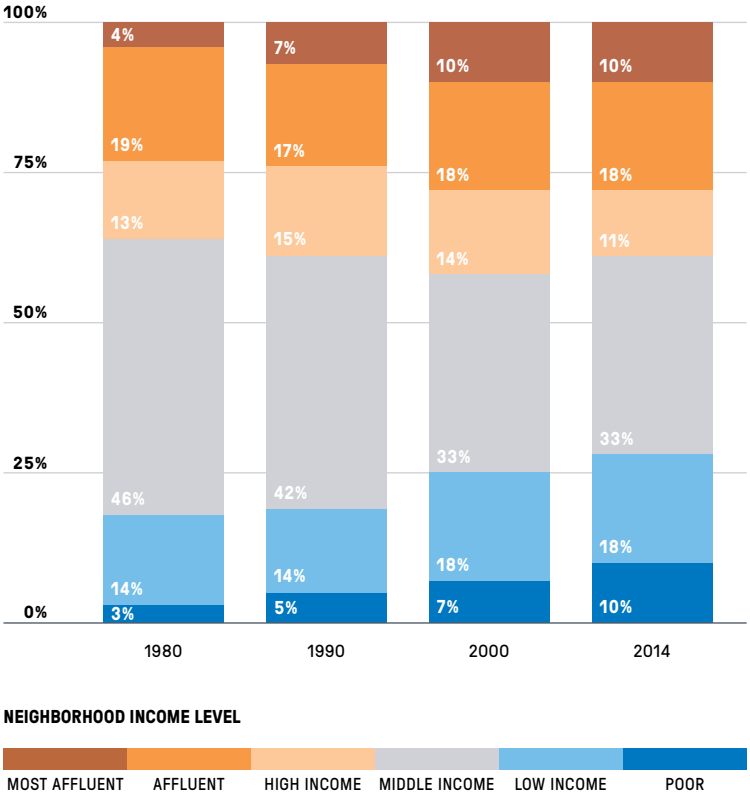
The county population living in an extreme-income neighborhood has steadily increased, at the expense of "middle-income" neighborhoods — those with AFI between 75 and 125 percent of the statewide average. Thirty-three percent of Fairfield County residents lived in middle-income neighborhoods in 2014, down from 46 percent in 1980. Twenty-nine percent of the county's children lived in these middle-income neighborhoods.[38]

Income segregation results in unequal access to community resources. Through taxes, charitable giving, and other spending, high-earning households help communities support resources such as well-funded schools, parks in good condition, and maintained roads and infrastructure. In general, residents of poor neighborhoods themselves have low incomes and are less able to support their communities financially.[39]

2.8

Growing Neighborhood Income Inequality in Fairfield County

DISTRIBUTION OF POPULATION BY NEIGHBORHOOD INCOME LEVEL, FAIRFIELD COUNTY, 1980–2014



	DEFINITION BASED ON AVERAGE FAMILY INCOME	1980 POPULATION	2014 POPULATION	1980–2014 CHANGE IN TOTAL POPULATION
Most Affluent	> 2.5x State AFI	31,722	95,049	↑ 200%
Affluent	1.5–2.49x State AFI	154,381	168,144	↑ 9%
High Income	1.25–1.49x State AFI	108,261	100,158	↓ 7%
Middle Income	0.75–1.24x State AFI	369,057	308,357	↓ 16%
Low Income	0.5–0.74x State AFI	116,945	169,401	↑ 45%
Poor	< 0.5x State AFI	26,778	93,106	↑ 248%

Living in Economic Hardship

In 2014, 9 percent of the total Fairfield County population lived in poverty, meaning they were in households with annual incomes below the federal poverty line (or FPL, equivalent to $15,730 per year for a family of two, $23,850 for a family of four). Meanwhile, 21 percent of residents were low-income, living in households with annual incomes of less than two times the FPL (low-income status includes people living in poverty).[40]

The low-income rate in Fairfield County overall is slightly lower than statewide. However, certain towns and neighborhoods have much higher rates than the county or state average. In general, children are also more likely to live in low-income households than the population as a whole; in Fairfield County, the low-income rate is 26 percent among the population ages 0–17 (and it is even

higher, at 29 percent, among the population ages 0–5).[41] (FIG 2.9)

This report uses the low-income threshold to identify individuals and households living in severe economic hardship; however, this definition does not capture everyone who faces financial stress. On the 2015 DataHaven Community Wellbeing Survey, 31 percent of adults in Fairfield County said they were just getting by financially or finding it difficult to manage.[42]

2.9

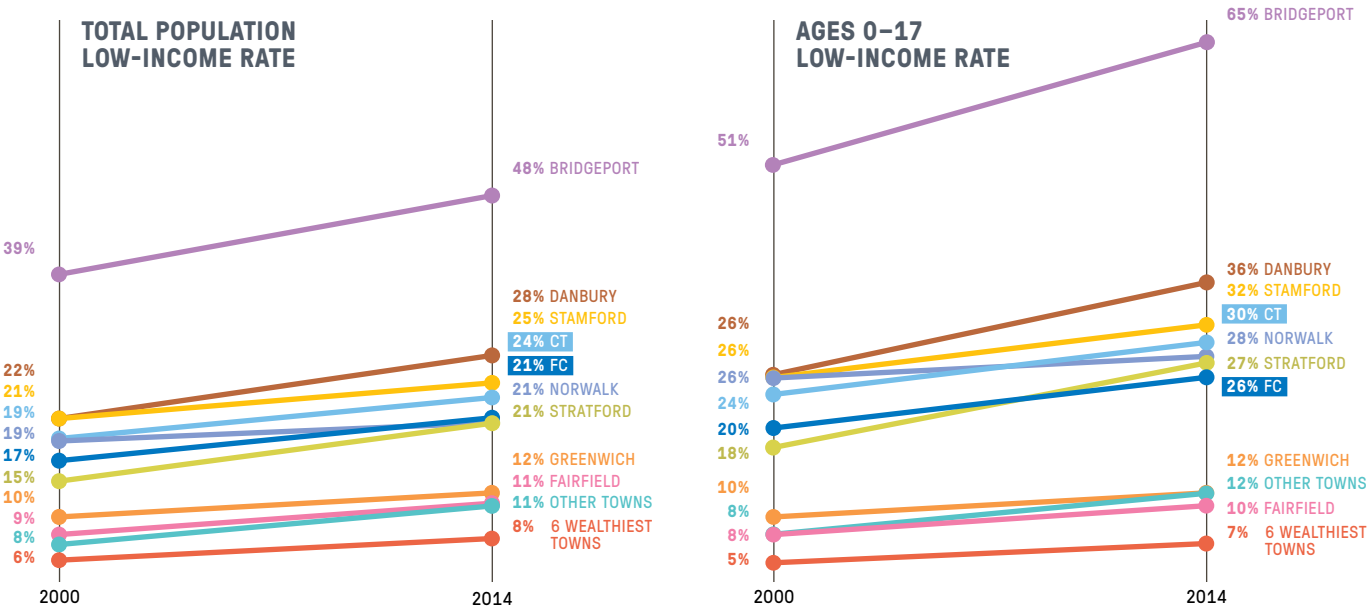
The Low-Income Population in Fairfield County

LOW-INCOME POPULATION BY AGE GROUP, FAIRFIELD COUNTY, 2000–2014

	POPULATION, INCOME STATUS KNOWN*	POPULATION, LOW-INCOME	POPULATION, LOW-INCOME RATE	AGE 0–17, INCOME STATUS KNOWN	AGE 0–17, LOW-INCOME	AGE 0–17, LOW-INCOME RATE	AGE 0–5, INCOME STATUS KNOWN	AGE 0–5, LOW-INCOME	AGE 0–5, LOW-INCOME RATE
United States	306,226,394	105,773,407	35%	72,637,885	32,116,429	44%	23,709,036	11,329,330	48%
Connecticut	3,481,115	823,045	24%	785,691	233,352	30%	232,654	78,316	34%
Fairfield County	916,013	196,548	21%	222,636	57,049	26%	66,282	18,894	29%
Bridgeport	142,212	68,052	48%	36,201	23,526	65%	12,898	8,808	68%
Danbury	79,427	22,322	28%	17,322	6,291	36%	5,922	2,502	42%
Fairfield	55,947	6,408	11%	15,217	1,594	10%	4,442	347	8%
Greenwich	61,612	7,691	12%	16,436	1,913	12%	5,352	623	12%
Norwalk	86,601	18,556	21%	16,552	4,593	28%	5,646	1,290	23%
Stamford	124,235	31,516	25%	26,803	8,481	32%	9,853	3,083	31%
Stratford	51,677	10,932	21%	10,214	2,765	27%	2,874	729	25%
6 Wealthiest	121,459	9,289	8%	37,957	2,485	7%	8,452	304	4%
Other Towns	192,843	21,782	11%	45,934	5,401	12%	10,843	1,208	11%

* The US Census Bureau can identify poverty status — or if people live above or below the poverty threshold — for people who are not: inmates in institutions; in college dorms; or under age 15 and not related by birth, marriage, or adoption to a reference person. The same definition applies for other "poverty income known" populations.

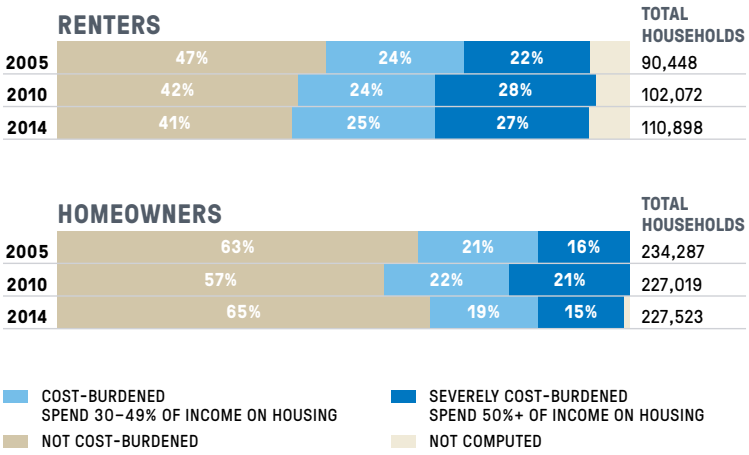
THE GROWING LOW-INCOME POPULATION IN FAIRFIELD COUNTY, 2000–2014



2.10

Housing Cost Burden in Fairfield County

HOUSEHOLDS PAYING MORE THAN 30 PERCENT OF INCOME ON HOUSING COSTS, 2005–2014*



* Percentages do not add up to 100% because households for whom cost-burden is not computed are not included

2.11

Characteristics of Fairfield County Households

HOUSEHOLDS BY HOMEOWNERSHIP AND SEVERE COST-BURDEN RATES, 2014

	HOUSEHOLDS	HOMEOWNERS	HOME OWNERSHIP RATE	SEVERELY COST BURDENED OWNER+RENTER	SEVERE COST BURDEN RATE
United States	116,211,092	74,787,460	64%	18,552,117	16%
Connecticut	1,356,206	913,043	67%	239,454	18%
Fairfield County	333,502	228,331	68%	67,978	20%
Bridgeport	50,034	20,574	41%	14,559	29%
Danbury	29,046	17,504	60%	5,557	19%
Fairfield	20,194	16,687	83%	3,007	15%
Greenwich	21,994	15,196	69%	4,130	19%
Norwalk	35,450	22,010	62%	7,928	22%
Stamford	46,418	25,435	55%	10,720	23%
Stratford	20,330	16,384	81%	4,317	21%
6 Wealthiest	40,996	34,948	85%	6,804	17%
Other Towns	69,040	59,593	86%	10,956	16%

For many, the costs of certain basic needs constitute an unaffordable share of their household budget. For example, in Fairfield County in 2012, a typical family of four needed $64,775 to cover all living costs, according to the United Way. Based on this cost of living estimate, 28 percent of households earned less than what they needed to pay for food, housing, transportation, childcare, healthcare, and other necessary expenses.[43] Inability to pay for these necessities can create harmful outcomes on individual physical and economic well-being, such as food insecurity (see page 30), lack of child care (see page 42), limited access to cars or reliable transportation (see page 53), or housing cost-burden.

Housing Affordability

Six percent of Fairfield County adults reported not having enough money for housing or shelter, indicating that they faced housing insecurity.[44] Many more Fairfield County residents — 42 percent — are housing cost burdened, spending more than the federally-recommended 30 percent of total income on housing costs. Twenty percent were severely cost-burdened, putting more than half of their budget towards mortgage and ownership costs or rent.[45] While housing cost-burden does not always result in housing insecurity, it does limit money available for other basic necessities, leaving households to choose which bills to pay.[46] For example, a national survey found that of the 21 percent of Americans who reported struggling to pay their rent or mortgage this year, 57 percent said they made cuts to their spending on groceries.[47]

The housing cost-burden rate is slightly higher in Fairfield County than statewide, in part due to higher housing costs: at minimum, a single adult pays $998 per month in housing costs, compared to the $786 state average.[48] Housing cost-burden is even more prevalent in some towns and neighborhoods: for example, 38 percent of households in the East End of Bridgeport pay more than fifty percent of income on housing. The problem is also more serious among renters compared to homeowners.[49] Further, the rates of housing cost burden have increased over the past decade, as household incomes have grown slower than the average cost to rent or own a home in the county.[50] From 2005 to 2014, the number of households that were severely cost-burdened increased by 10 percent — the number of severely cost-burdened renting households increased by 51 percent.[51]

CHAPTER 3

A Healthy Region

Health is fundamental to prosperity and quality of life in Fairfield County. The typical resident reports levels of health and personal well-being that are better than those of the typical US or Connecticut resident. Similarly, death rates—compared either in terms of all-cause mortality rates or by measuring the impact of premature deaths—are lower than national averages.

Social determinants of health, such as access to health insurance, safe neighborhoods, economically-secure families, and school systems with high graduation rates, also shape the lives of Fairfield County residents in generally positive ways. The Federal Government's Healthy People 2020 initiative includes social determinants like these among their "Leading Health Indicators" because of their ability to predict and support the health of children and adults.[52]

The high health status of Fairfield County overall can be traced back to its historical economic advantages, infrastructure investments, and social policies, as well as to the health of the places its people arrived from throughout recent decades. Health may also be a predictor of the region's future success, as healthy communities are more likely to retain productive businesses and individuals.[53]

Differences by Place and Race

The high health status of the population as a whole hides vast differences across all measures of well-being. Towns and neighborhoods differ by age structure, race, and economic status. These factors greatly affect the burden and types of health conditions that are of concern in each community.

Economically-distressed neighborhoods see the effects of their residents having lower socio-economic status as well as being significantly younger in average age. These two factors result in a more concentrated burden of conditions such as adverse birth outcomes, childhood asthma, lead poisoning, violence, and sexually transmitted diseases. In addition, chronic diseases—especially heart disease and diabetes—begin to impact populations living in distressed neighborhoods at a younger age.

Meanwhile, areas that are older have a greater burden of age-related illnesses, such as cancer. Issues such as dementia will continue to grow as a concern in all towns as the older population grows in both cities and suburban areas (see Chapter 2).

Health inequities are a particular concern within minority communities that have faced longstanding social and legal barriers to achieving a high health status. For communities of color in particular, barriers to achieving a high health status often overlay specific places, and are linked to the differential government policies that have impacted racially-segregated neighborhoods currently and throughout every century of American history.

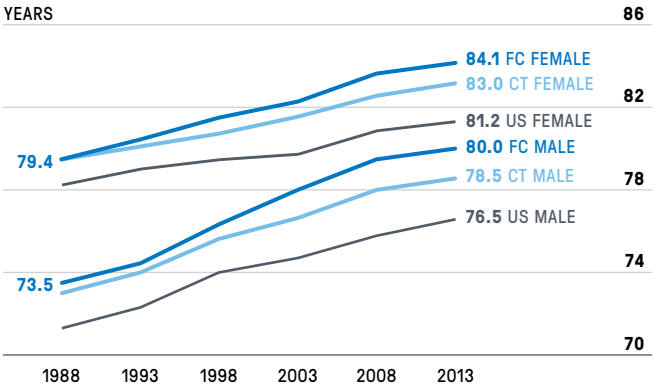
This document focuses on broadly reporting disparities by place, and in doing so, it reveals the differences in health status between zip codes where people of color are currently concentrated and zip codes that are almost-exclusively white.

The **Community Health Needs Assessment** process (see Chapter 1 and conclusion of this chapter) creates a platform for residents and multi-sector leaders to provide input on and understand how the distribution of the region's assets can create barriers that prevent some groups from achieving an optimal health status.

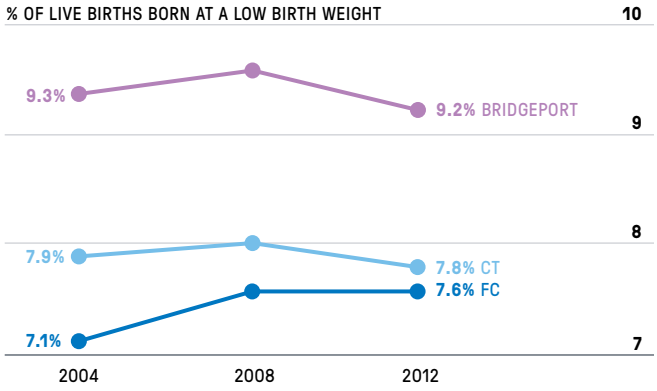
3.1

Fairfield County Trends

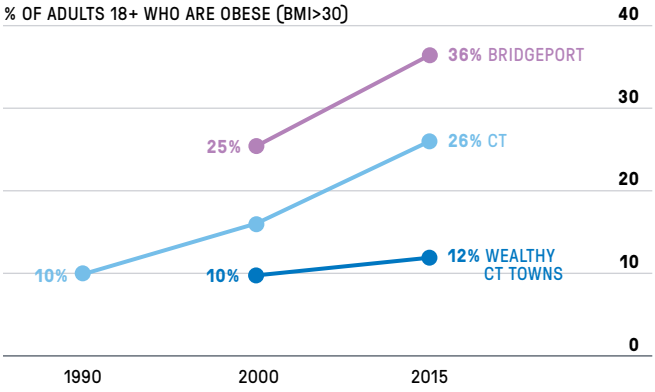
LIFE EXPECTANCY IN FAIRFIELD COUNTY (FC) EXCEEDS US AND CT AVERAGES



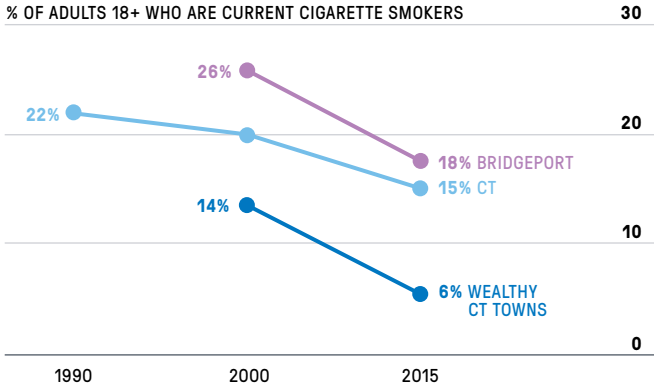
RATES OF LOW BIRTH WEIGHT HAVE BEEN STABLE



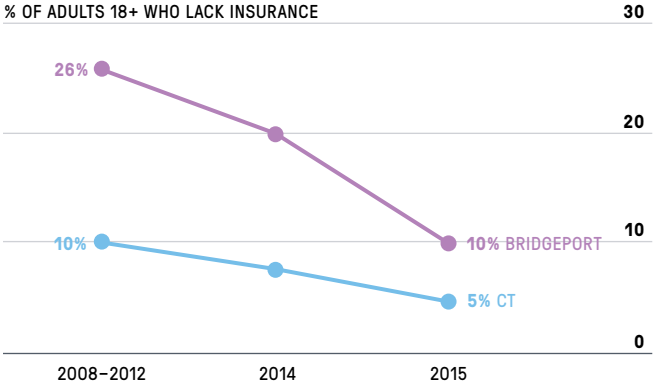
THE DISPARITY IN ADULT OBESITY RATES IS GROWING



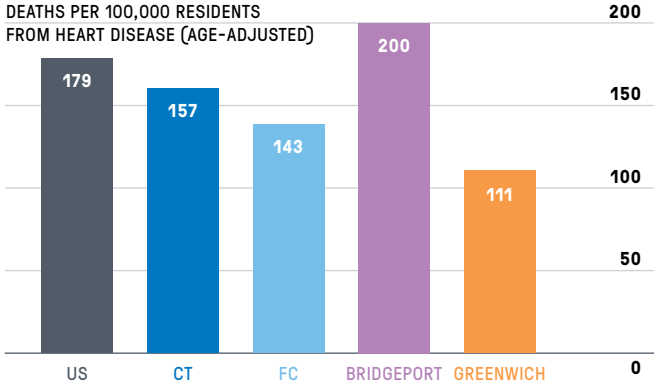
ADULT SMOKING RATES ARE DECLINING



HEALTH INSURANCE COVERAGE HAS IMPROVED DRAMATICALLY



MORTALITY RATES FROM HEART DISEASE ARE MUCH LOWER IN WEALTHY TOWNS



3.2

Well-Being and Chronic Disease Risk Factors

2015 COMMUNITY WELLBEING SURVEY, PERCENT OF FAIRFIELD COUNTY ADULTS AGE 18+

	SELF-RATED HEALTH GOOD/EXCELLENT	ANXIETY	DEPRESSION	DIABETES	OBESITY	FOOD INSECURITY	SMOKING	ASTHMA	NO HEALTH INSURANCE	DENTIST VISIT IN PAST YEAR
Connecticut	63	11	9	9	26	12	15	13	4.9	77
Fairfield County	67	11	7	7	22	10	12	11	6.1	79
Bridgeport	51	17	12	12	36	25	18	15	9.8	67
Danbury	59	14	8	8	21	11	13	11	7.2	73
Fairfield	72	6	5	7	16	3	10	7	5.0	83
Greenwich	75	7	4	7	19	6	8	8	5.2	83
Norwalk	68	13	6	7	22	10	13	13	9.1	77
Stamford	67	11	6	8	23	10	10	9	9.3	80
Stratford	60	14	9	8	27	16	17	17	4.3	80

BETTER WORSE

HEALTH OUTCOMES

Self-Rated Health and Well-being

Self-rated health is a uniquely strong predictor of future health outcomes, such as premature mortality and health care costs.[54] Because of this, it is widely used to assess the overall health of an entire population. Self-rated health, as well as anxiety, depression, and personal well-being more broadly, varies widely within the region (see also Personal Well-being Index in Chapter 1). Concerns that tend to lessen self-related health—such as premature chronic diseases—can directly impact how people evaluate their life satisfaction and experience happiness in their day-to-day lives.[55]

Infant Health

Because of its relationship to complex issues such as maternal health care access, smoking, nutrition, and stress, infant health and birth outcomes are considered to be key indicators of overall community-wide health. Birth outcome indicators in Fairfield County are consistent with state rates, but large disparities are evident by town. From 2008 to 2013 each year, on average, 7.6 percent of all babies born in the area had a low birth weight (weighing less than 5.5 pounds (2,500 grams)). Over the same period, 1.3 percent of all babies born had very low birth weights (less than 3.3 pounds or 1,500 grams). Low birth weight increases the risk of more serious health concerns, such as fetal and infant mortality or long-term health conditions. On average, the rate of infant mortality was 5.5 per 1,000 live births in the County, and the rate of fetal plus infant mortality was 10.9 per 1,000 live births. While these rates of mortality and other health issues involving mothers and infant children have dramatically improved during the past century, geographic disparities remain high and further improvements are a national health goal.

3.3

Infant Health Indicators

BIRTH OUTCOMES, 2008–2013

	TOTAL BIRTHS ANNUALIZED	FETAL AND INFANT DEATHS ANNUALIZED	IMR (INFANT DEATHS PER 1,000 LIVE BIRTHS)	FIMR (FETAL AND INFANT DEATHS PER 1,000 LIVE BIRTHS)	PERCENT LOW BIRTH WEIGHT	PERCENT VERY LOW BIRTH WEIGHT
Connecticut	38,007	401	5.3	10.5	7.9%	1.5%
Fairfield County	10,549	115	5.5	10.9	7.6%	1.3%
Bridgeport	2,236	38	8.6	17.1	9.3%	1.9%
Danbury	1,143	11	5.0	9.9	7.1%	1.3%
Fairfield	531	3	2.5	5.0	6.6%	1.1%
Greenwich	632	3	2.6	5.3	6.7%	1.1%
Norwalk	1,217	14	5.8	11.5	7.4%	1.3%
Stamford	1,863	18	4.9	9.8	7.9%	1.1%
Stratford	539	6	5.9	11.8	7.6%	1.5%

Mortality Rates and Premature Death

Knowing what people die of is important to understanding the health of a population. Leading causes of death are the causes that result in the greatest number of deaths in a community. The crude mortality rate is the number of deaths adjusted for the population size. (FIG 3.4) But it is also useful to consider the extent to which these causes result in premature death, typically done by measuring the total number of life years lost before age 75 (years of potential life lost to 75, or YPLL). In areas where YPLL is significantly higher, this reflects that the burden of deaths on young people is higher, and that there is a substantial loss of human potential.

The community-wide conditions and health behaviors that are linked to premature death are often considered preventable. For example, it is likely that preventing young people from smoking cigarettes would reduce lung cancer deaths, and policy changes that limited crash severity or reduced the amount of vehicle miles driven annually would have a direct relationship to the number of young adults killed in motor vehicle crashes.

Data on death indicate that chronic diseases are a major concern in towns throughout the region. Cancer and heart disease, and conditions such as stroke and diabetes, are leading causes of death and premature death. Injuries—consisting of suicides, homicides, and accidents, including drug overdoses—are also major concerns to the region. Many injuries are associated with the availability of drugs and firearms, and often impact much younger residents. This is shown by the higher average number of years lost per death from these conditions. (FIG 3.5)

Additionally, fetal and infant deaths result in a great loss of human potential, ranking among the leading causes of years of potential life lost. This loss is felt most acutely by the African-American population in Fairfield County, as it is in the nation overall.[56] Infant mortality has complex roots, and may relate to other burdens of illness in the population such as financial stress, trauma, chronic disease, and environments that lead to low birth weight.

Although people are living longer lives than they were in recent decades, objective measures like premature death and mortality rates provide an incomplete picture of chronic diseases, mental health, infectious diseases, and other issues that relate to day-to-day quality of life. Many adults are living with disabilities, chronic diseases, or mental health concerns that can begin at an early age. Mental health and addiction impact the general well-being of individuals and communities, and may be underlying causes of many of the other health needs identified here.

3.4

Leading Causes of Death

AGE-ADJUSTED MORTALITY RATES AND TRENDS, 2008–2012

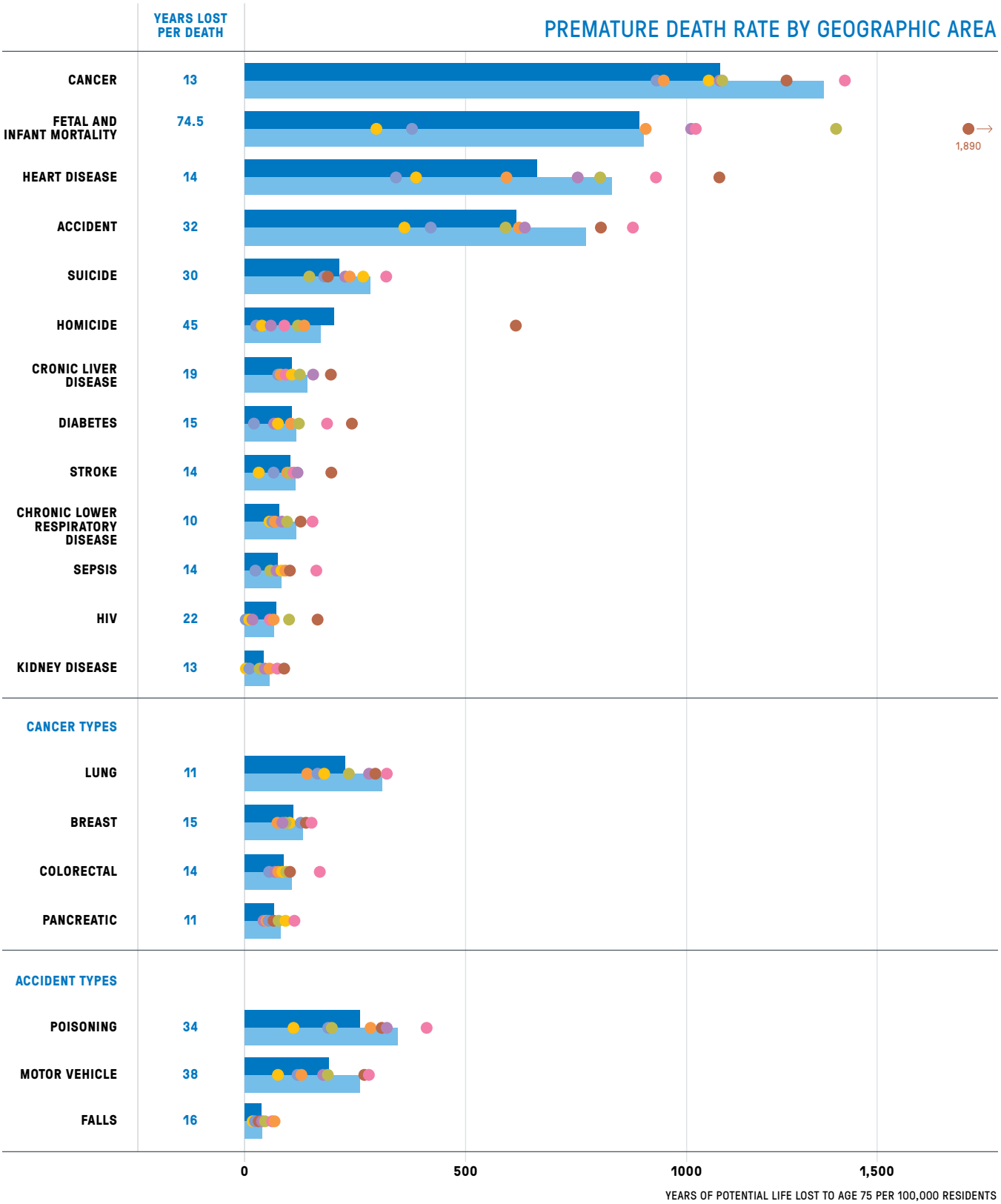
		TOTAL DEATHS 2008–2012	DEATHS PER YEAR 2008–2012	2008–2012 CRUDE MORTALITY RATE (DEATHS PER 100,000)	AGE-ADJUSTED MORTALITY RATE (AAMR) PER 100,000	TREND FROM 2003–2007 TO 2008–2012	HIGHER OR LOWER RATE THAN CT?
All Causes	**Connecticut**	144,577	28,915	809	660	↑ Improving	
	Fairfield County	31,904	6,381	696	584	↑ Improving	Lower
	Bridgeport	4,778	956	662	732	↑ Improving	Higher
	Danbury	2,472	494	610	610		Lower
	Fairfield	2,457	491	826	565		Lower
	Greenwich	2,173	435	709	482	↑ Improving	Lower
	Norwalk	2,679	536	625	581	↑ Improving	Lower
	Stamford	4,014	803	654	554	↑ Improving	Lower
	Stratford	2,647	529	1,029	672	↑ Improving	
Heart Disease	**Connecticut**	35,765	7,153	200	157	↑ Improving	
	Fairfield County	8,088	1,618	176	143	↑ Improving	Lower
	Bridgeport	1,293	259	179	200	↑ Improving	Higher
	Danbury	641	128	158	156		
	Fairfield	665	133	224	139		Lower
	Greenwich	534	107	174	111	↑ Improving	Lower
	Norwalk	634	127	148	136	↑ Improving	Lower
	Stamford	933	187	152	124	↑ Improving	Lower
	Stratford	713	143	277	168	↑ Improving	Likely Higher
Cancer	**Connecticut**	33,775	6,755	189	160	↑ Improving	
	Fairfield County	7,536	1,507	164	144	↑ Improving	Lower
	Bridgeport	1,004	201	139	159	↑ Improving	
	Danbury	578	116	143	147		Lower
	Fairfield	522	104	176	137		Lower
	Greenwich	536	107	175	127		Lower
	Norwalk	674	135	157	148		Lower
	Stamford	986	197	161	143		Lower
	Stratford	606	121	236	163	↑ Improving	
All Injuries	**Connecticut**	9,037	1,807	51	47	↓ Worsening	
	Fairfield County	1,953	391	43	40		Lower
	Bridgeport	384	77	53	54		Higher
	Danbury	155	31	38	37		Lower
	Fairfield	116	23	39	36		Lower
	Greenwich	104	21	34	29		Lower
	Norwalk	154	31	36	34		Lower
	Stamford	245	49	40	37		Lower
	Stratford	148	30	58	49		

* Trends or differences in rates are only noted if they are considered to be statistically significant.

3.5

Causes of Premature Death

YEARS OF POTENTIAL LIFE LOST PRIOR TO AGE 75, 2008–2012



3.6

Heart Disease, Hospital Inpatient Encounters

AGE-ADJUSTED ANNUALIZED ENCOUNTER RATE PER 10,000 RESIDENTS, 2012–2014

9 WEALTHIEST TOWNS IN CT

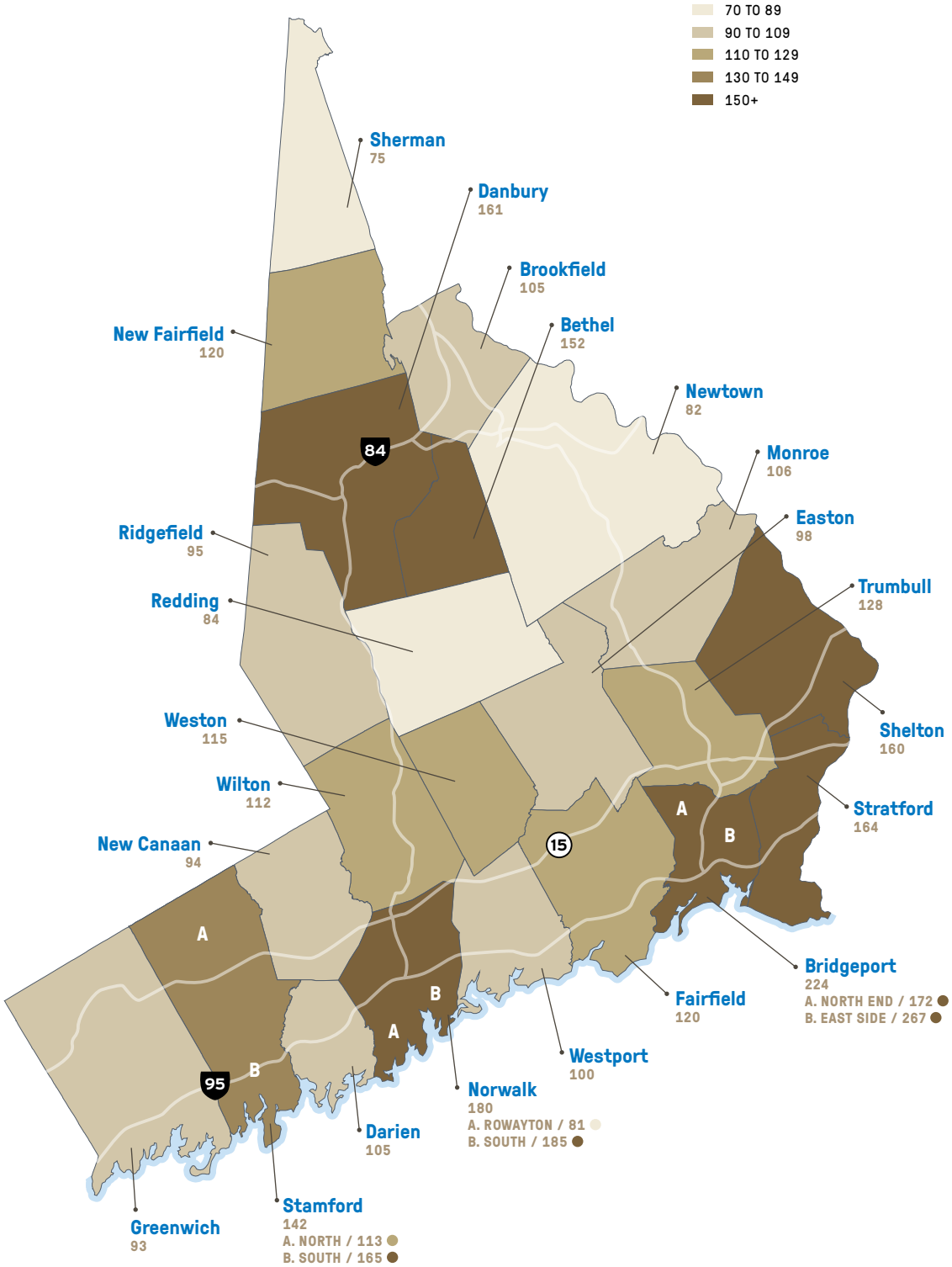
100 ENCOUNTER RATE

4 LARGEST CITY CENTERS IN CT

235 ENCOUNTER RATE

FAIRFIELD COUNTY

145 ENCOUNTER RATE



Early Chronic Diseases

Preventing the early onset of chronic diseases such as cancer, heart disease, and diabetes, in the areas where it occurs most, could bring major social and economic benefits to the region. In the previous few pages, data on mortality and premature death rates reveal very large disparities in well-being within the region.

Because mortality data only tell us about people who die, they do not allow a complete picture of the true quality of life impacts of common chronic diseases. By allowing public health officials to look at the conditions that people of all ages experience by neighborhood and other characteristics, our analyses of the DataHaven Community Wellbeing Survey combined with hospital records creates a clearer picture. Only a few of our analyses can be included within this document; others are available through our website or will inform further work. Results show that in some parts of the region, adults are much more likely to be hospitalized for severe conditions such as heart disease and lung cancer at an early age. For example, in the nine wealthiest towns in Connecticut, the annual rate of hospitalization for heart disease among middle-age adults age 45-64 was 32 per 10,000 residents from 2012 to 2014, whereas in the state's four largest urban core towns (Bridgeport, New Haven, Hartford, Waterbury), it was 266 per 10,000 residents. Middle-age adults in many urban neighborhoods were more likely to be admitted to the hospital for this condition than were seniors age 65-74 in wealthy communities. Adults impacted by early chronic disease often live with a need for special medical treatment or experience lower overall levels of well-being, regardless of whether or not they may be at a particularly higher risk of premature death. Results from the Community Wellbeing Survey also reveal large health disparities by income, wealth, neighborhood, and race/ethnicity in the rates of high blood pressure, smoking, poor nutrition, and poor mental health, which are risk factors for chronic diseases.

The prevention of early chronic disease is an area where cross-sector leaders from public and private sectors can play a larger role. For example, in focus groups, healthy food is deemed more accessible in wealthier towns. Even in these towns, some residents report the need to travel a significant distance to buy healthy food, which may be an issue if they lack access to transportation. Access to unhealthy foods and substances can be restricted through public policies that impact the cost or availability of such items. Addressing other community concerns, such as stress, employment, education, and community safety, may also help people across the lifespan maintain an optimal health status.

3.7

Heart Disease & Lung Cancer Inpatient Encounters by Age

AGE-ADJUSTED ANNUALIZED ENCOUNTER RATE PER 10,000 RESIDENTS, 2012–2014

	HEART DISEASE INPATIENT ENCOUNTER RATES			LUNG CANCER INPATIENT ENCOUNTER RATES		
	ALL AGES, AGE-ADJUSTED*	AGES 45–64	AGES 65–74	ALL AGES, AGE-ADJUSTED	AGES 45–64	AGES 65–74
Fairfield County	145	93	368	12	12	56
Bridgeport	224	256	703	15	23	62
Danbury	161	109	481	15	16	67
Fairfield	136	49	332	13	10	68
Greenwich	93	36	234	8	6	32
Norwalk	180	124	465	13	15	59
Stamford	142	92	350	11	11	47
Stratford	164	130	424	16	17	79
9 Wealthiest CT Towns	100	32	216	8	4	36
4 Largest CT Urban Core Towns	235	266	730	16	18	70

* See map on previous page

Nutrition, Obesity, and Diabetes

The American Medical Association recognizes obesity as a chronic disease. Being obese can contribute to other health conditions such as cancer, depression, diabetes, heart disease, high blood pressure, stroke, and other conditions that can reduce life expectancy and quality of life.

In 2015, the rate of obesity in Fairfield County (22 percent) was below the national and state average (35 percent and 26 percent, respectively), and better than the Federal Government's Healthy People 2020 objective of 30.5 percent. These rates are calculated based on self-reported height and weight. Within the region, substantial differences exist by income group, age, and town of residence.

Across the nation and within Connecticut, obesity rates have increased dramatically. In Connecticut, rates have increased from 16 percent in 2000 to 26 percent in 2015. Precise historical data by town is not available for most of Fairfield County, but all available sources suggest that most towns in Connecticut have been following the same trend.[57] In Fairfield County's wealthiest towns, however, obesity rates are significantly lower than they are elsewhere: only about 1 in 10 adults are obese. These towns also have very low rates of poverty and food insecurity. The fact that obesity rates in the wealthiest neighborhoods appear to have remained fairly stable over the past decade suggests that economic and neighborhood factors are important to obesity prevention.

Obesity, physical inactivity, advanced age, and poor diet are risk factors for Type 2 diabetes, a chronic condition that often leads to other severe long-term health problems. In 2015, the prevalence of diabetes in Fairfield County (7 percent) was below the rates in the state (9 percent) and nation (10 percent).[58] The dramatic geographic disparities in the rates of hospital visits for diabetes-related illnesses, particularly when comparing younger adults across towns, is a proxy for the impact that this disease has on quality of life in communities with lower income levels.

Food insecurity and a lack of physical activity are associated with the risk of overweight and obesity. Psychological stress, the habits of overeating when food is available, and the inability to consume higher-quality foods that cost more money or take more time to prepare, are associated with food insecurity.[59] In Fairfield County in 2015, 10 percent of adults said that they did not have enough money to buy food at some point in the last year. This figure was 6 percent among residents who identified as white, compared to 23 percent among residents who identified as black or Latino. Research shows that people who live in safe and walkable communities are more likely to be active. While many neighborhoods have assets that can increase physical activity, concerns about physical safety, the safety of bicycling in traffic, and the quality of recreational facilities are major concerns in central city neighborhoods in Fairfield County (see Chapter 4 for more information on walkability).

3.8

Nutrition, Obesity, and Diabetes

2015 COMMUNITY WELLBEING SURVEY, PERCENT OF FAIRFIELD COUNTY ADULTS AGE 18+

		% FOOD INSECURE	% OBESE	% WITH DIABETES
Race/ Ethnicity	Caucasian/White	6	18	7
	African American/Black	23	37	12
	Hispanic/Latino	22	29	9
Age Group	18–34	14	17	3
	35–64	11	25	7
	65–79	5	23	19
	80–94	2	14	18
Income	Under $30,000	33	33	15
	$30,000–$100,000	10	27	8
	Over $100,000	2	16	4

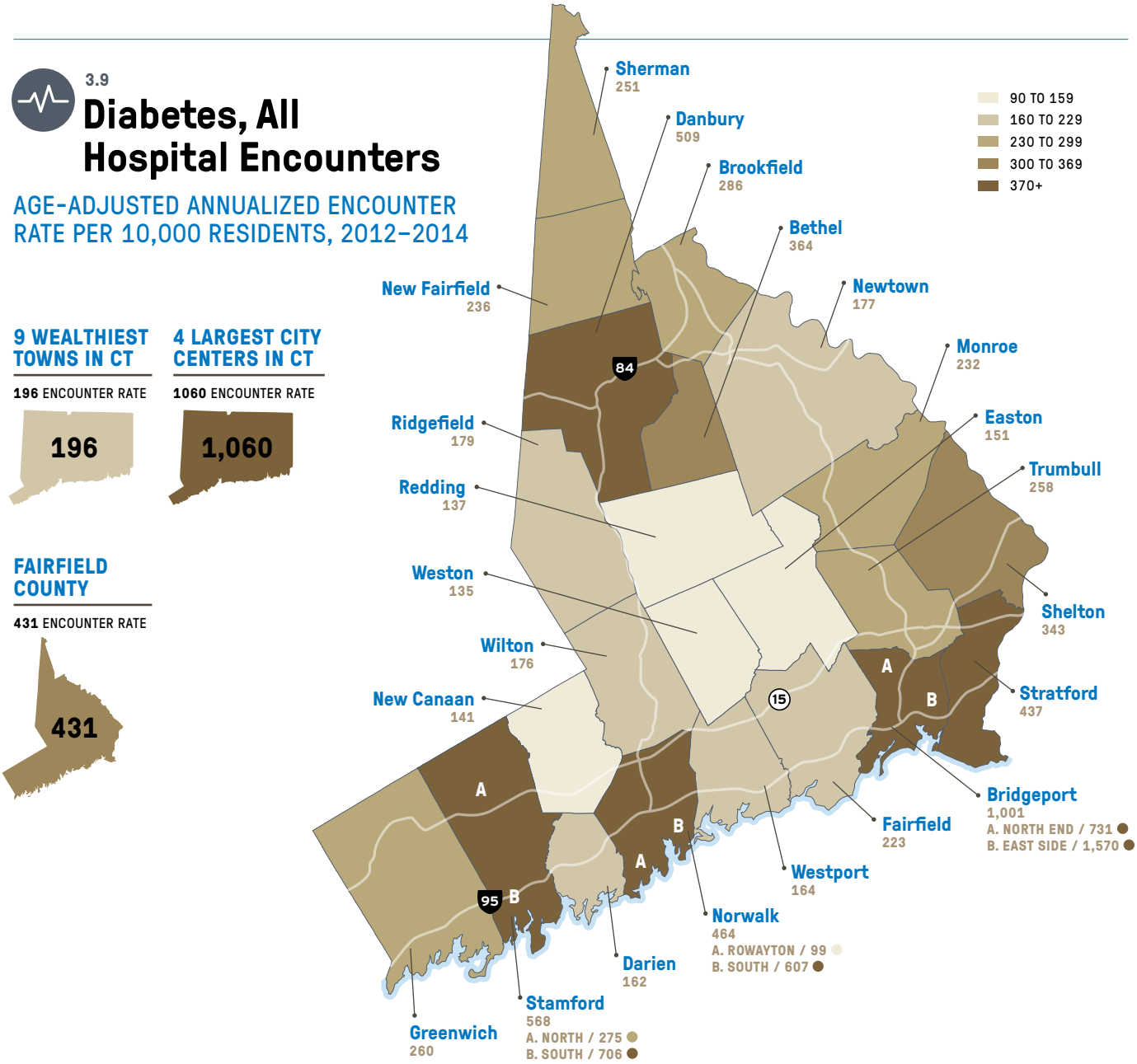
* See page 24 for rates by region and town

BETTER WORSE

3.9

Diabetes, All Hospital Encounters

AGE-ADJUSTED ANNUALIZED ENCOUNTER RATE PER 10,000 RESIDENTS, 2012–2014



	DIABETES, ALL HOSPITAL ENCOUNTER RATES PER 10,000 RESIDENTS						
	ALL AGES, AGE-ADJUSTED*	AGES 20–44	AGES 45–64	AGES 65–74	AGES 75–84	DIABETES-RELATED AMPUTATION	UNCONTROLLED DIABETES
Fairfield County	431	144	582	1,333	1,695	0.8	10
Bridgeport	1,001	352	1,775	2,798	2,713	1.8	23
Danbury	509	95	667	1,813	2,203	0.7	17
Fairfield	223	44	224	754	1,219	0.7	5
Greenwich	260	68	278	965	1,174	0.2	2
Norwalk	464	119	622	1,457	2,027	1.0	13
Stamford	568	156	794	1,811	2,232	1.3	11
Stratford	437	163	643	1,288	1,481	1.2	9
9 Wealthiest CT Towns	196	45	172	672	1,070	0.3	3
4 Largest CT Urban Core Towns	1,060	365	1,859	2,993	2,942	2.5	26

* See map above

Injury and Violence

Injury is among the leading causes of death, particularly among younger adults. Injuries include both unintentional injuries such as falls, crashes, and accidental drug overdose, as well suicide and homicide.

In most of the region, mortality rates from injury are similar to or in many cases significantly lower than state and national averages. However, several issues are of concern to the region. Rates of death from accidental poisoning or suicide from opioid drug use are rising and are discussed to some degree in the Substance Abuse section of this report. Accidental falls impact many older adults each year, and register as a concern as this population grows quickly; many living environments could be modified to help prevent falls. While most falls are non-fatal, for every death due to falls there are many cases of permanent disability, hospitalization, or missed work. Fatal motor vehicle crash rates, while low by national standards, remain one of the major causes of premature death and a major concern, particularly within communities where several teenage drivers have been killed or where there have been calls to improve access for pedestrians, cyclists, and transit users in recent years.

Community violence, which relates to violent crime and domestic abuse as well as higher rates of premature deaths from homicide in some city center neighborhoods, is an issue that stood out as a concern due to the extent of health disparities seen by town, neighborhood, gender, and age. In addition to its role in injury, safety is an issue that can have large impacts on the physical and mental health of residents as well as their ability to enjoy parks, public spaces, sidewalks, and streets within their neighborhoods. Although reported crime rates in most towns are low and there is a widespread perception people live within safe and supportive communities, residents in some neighborhoods frequently express that safety is the most important issue that impacts their health and quality of life.

Primary data collected in some of the poorest neighborhoods of Fairfield County showed that residents overwhelmingly feel unsafe in their neighborhoods; for example, in many cases, children were not safe playing in their yards, and one participant in a community conversation even had a bullet come through her window. There is a broader lack of recreational access in these areas, since substance abuse and violence are seen to dominate parks and other public spaces. Empowering communities to revamp these public spaces and other assets, through public programs and events, can reinforce their purpose and encourage positive uses.

3.10

Injury Mortality by Type

AGE-ADJUSTED MORTALITY RATES (AAMR) PER 100,000 RESIDENTS BY INJURY CAUSE, 2008–2012

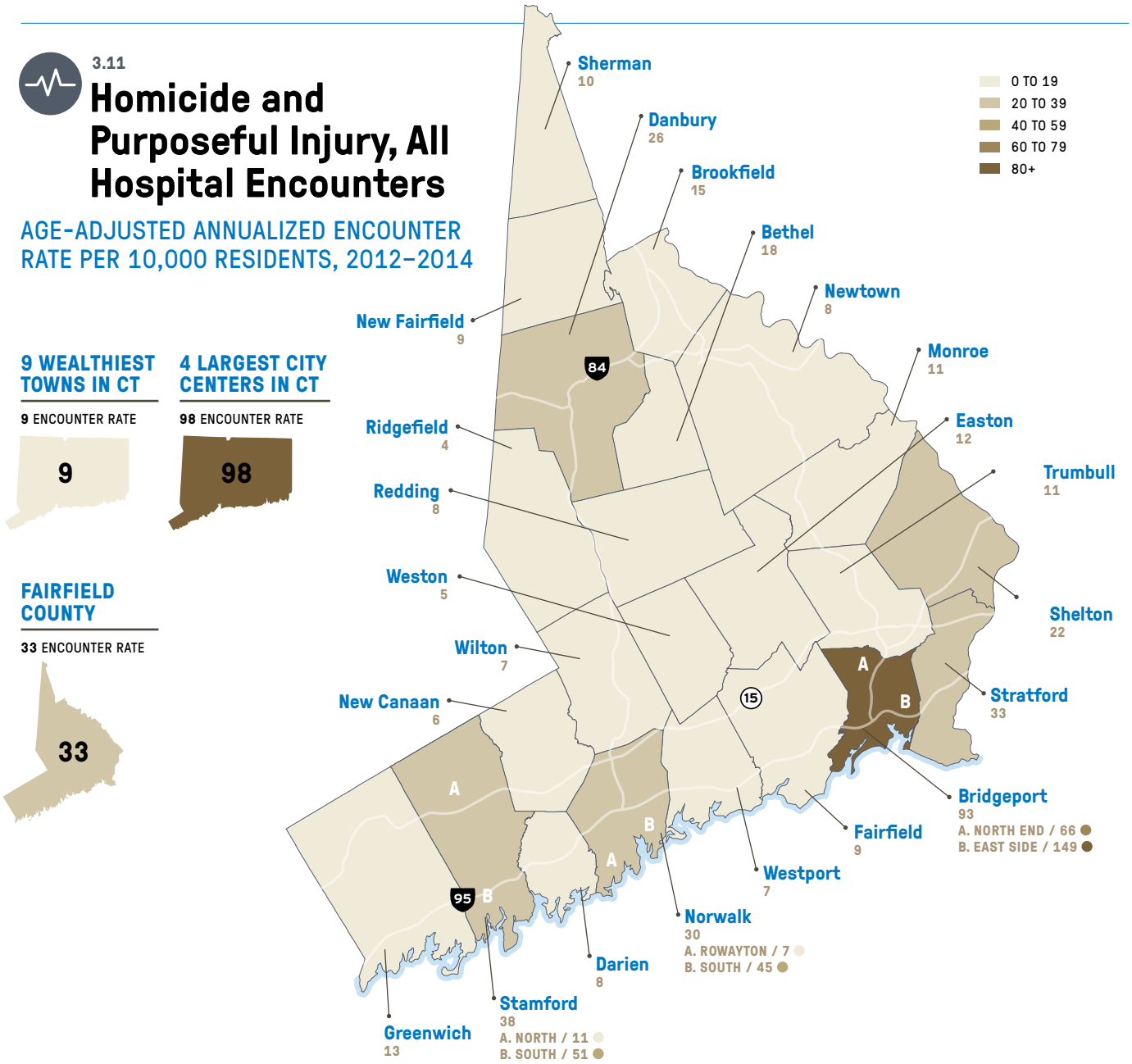
	ALL ACCIDENTS	MOTOR VEHICLE CRASHES	ACCIDENTAL POISONING	FALLS	HOMICIDE	SUICIDE
Connecticut	33	7	10	8	4	9
Fairfield County	28	6	7	8	4	7
Bridgeport	36	7	10	10	12	5
Danbury	29	4	--	9	--	7
Fairfield	24	--	--	6	--	11
Greenwich	21	--	6	6	--	7
Norwalk	24	5	5	5	--	6
Stamford	26	4	8	6	3	7
Stratford	37	7	12	8	--	10

Our analysis of hospital records on homicide and purposeful injuries (including assaults and attempted homicide), also confirm that there are large disparities in safety within the region. Because of the nuances in how this data should be interpreted across towns, neighborhoods, and city blocks, we have chosen not to present them in great detail here. However, a map and table of hospital encounter rates due to homicide and purposeful injuries illustrates that age-adjusted per capita hospital encounter rates for residents living within the state's four largest urban core towns (Bridgeport, New Haven, Hartford, and Waterbury) were more than 10 times higher than the age-adjusted rates for residents living within the state's 9 wealthiest towns. Within these towns, the disparities are even larger by neighborhood; for example, the age-adjusted rate for a hospital encounter for homicide or purposeful injury in the East Side of Bridgeport is more than twice the rate in the city's North End. Young adults age 20-44 are more likely to visit the hospital for these types of injuries than other age groups. Additionally, men are generally significantly more likely than women to report being the victim of a violent attack or crime or require hospitalization for one, according to hospital encounter records, as well as to self-reported data on victimization collected from the DataHaven Community Wellbeing Survey.

3.11

Homicide and Purposeful Injury, All Hospital Encounters

AGE-ADJUSTED ANNUALIZED ENCOUNTER RATE PER 10,000 RESIDENTS, 2012–2014



	HOMICIDE AND PURPOSEFUL INJURY, ALL HOSPITAL ENCOUNTER RATES PER 10,000 RESIDENTS						
	ALL AGES, AGE-ADJUSTED*	AGES 0–19	AGES 20–44	AGES 45–64	AGES 20–44 MALE	AGES 20–44 FEMALE	HIGH-SEVERITY CONDITIONS
Fairfield County	33	24	66	21	82	50	2.8
Bridgeport	93	69	166	73	195	137	9.0
Danbury	26	18	46	20	54	38	1.8
Fairfield	9	6	17	7	26	9	0.6
Greenwich	13	12	25	7	38	14	0.5
Norwalk	30	22	56	23	72	39	2.6
Stamford	38	34	66	25	86	44	3.1
Stratford	33	23	63	22	82	45	2.7
9 Wealthiest CT Towns	9	6	19	4	27	12	0.5
4 Largest CT Urban Core Towns	98	66	172	87	211	135	9.0

* See map above

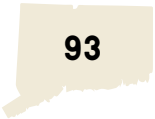
3.12

Childhood Asthma, All Hospital Encounters

AGE-SPECIFIC ANNUALIZED ENCOUNTER RATE PER 10,000 RESIDENTS AGE 0–4, 2012–2014

9 WEALTHIEST TOWNS IN CT

93 ENCOUNTER RATE

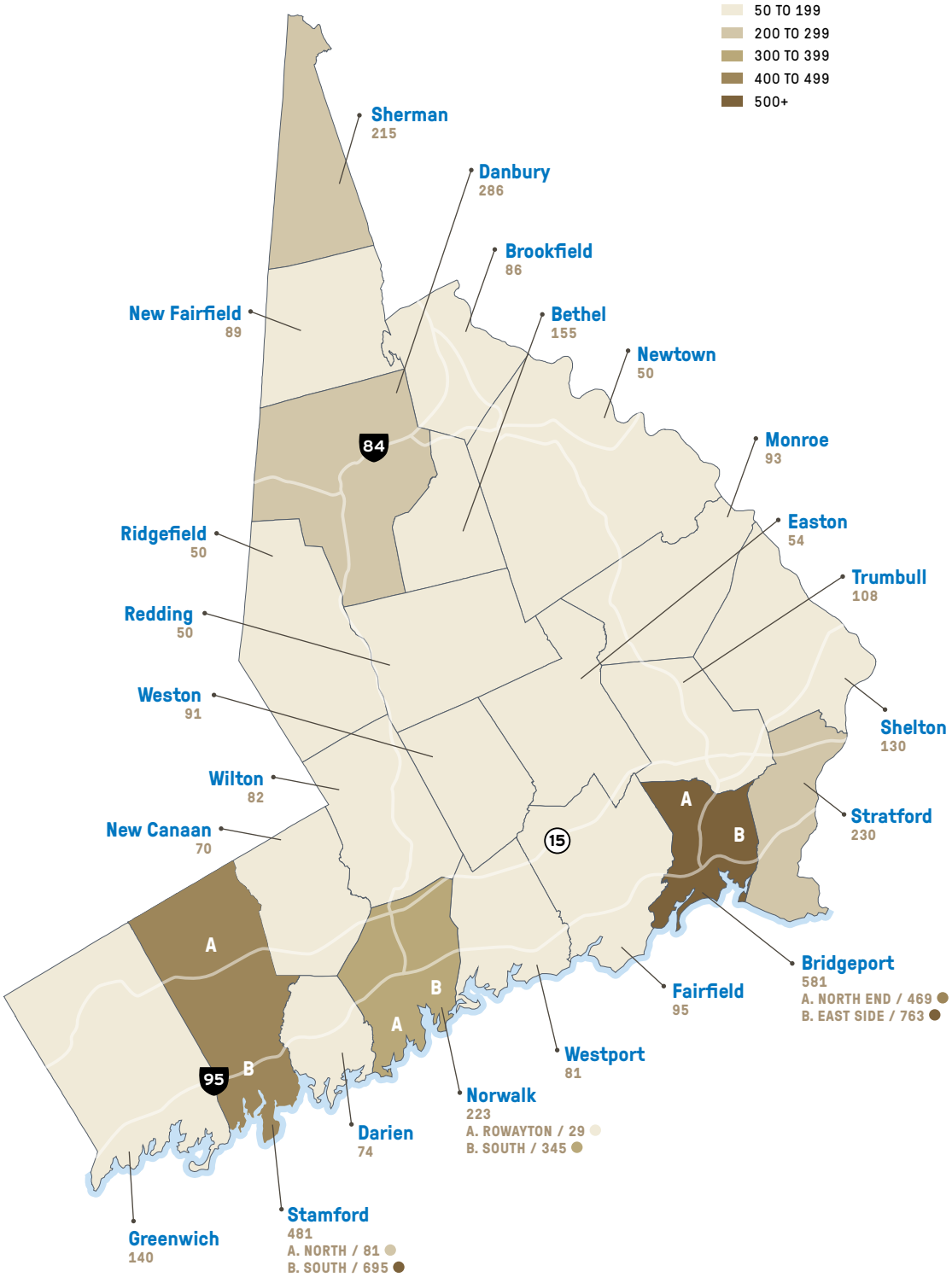


4 LARGEST CITY CENTERS IN CT

1033 ENCOUNTER RATE

FAIRFIELD COUNTY

282 ENCOUNTER RATE



Asthma

Asthma can cause a considerable burden on health and quality of life. The prevalence of asthma among all adults in Fairfield County (11 percent) is slightly below that found statewide (13 percent) and nationally (14 percent).

Asthma often develops in early childhood. By limiting a child's ability to play, learn, and sleep, asthma can also have a substantial impact on child development and educational achievement. Proper health care is important as it can reduce these impacts and also prevent dangerous asthma attacks.

From 2012 to 2014, there was a stark difference in the number of visits to an emergency room for asthma within different towns and neighborhoods across Fairfield County, particularly among children age 0-4. The higher number of severe attacks requiring hospital visits in areas such as Bridgeport and parts of Stamford is likely caused by factors such as barriers to primary care, poorer medical management of asthma, and exposure to environmental triggers.

Visits to the emergency room for asthma are considered largely avoidable if the disease is well controlled. Avoiding triggers may be more difficult in urban settings, however, where there is greater exposure to transportation-related emissions and allergens.[60]

3.13

Selected Infectious Diseases

NUMBER OF CASES (N) AND RATES PER 100,000 RESIDENTS

	HIV: NEW DIAGNOSES 2014		LIVING WITH HIV 2014		HCV (CHRONIC & RESOLVED) 2014		LYME DISEASE (CONFIRMED & PROBABLE) 2015	
	N	RATE	N	RATE	N	RATE	N	RATE
Connecticut	291	8	10,727	299	2,407	67	2,553	71
Fairfield County	102	11	2,888	315	406	44	430	47
Bridgeport	44	31	1,333	924	154	107	23	16
Danbury	8	10	233	288	32	40	36	45
Greenwich	2	3	82	134	12	20	2	3
Norwalk	9	11	333	389	32	37	17	20
Stamford	17	14	524	427	43	35	17	14
Remainder of County	22	5	383	91	133	31	335	79

BETTER WORSE

Other Health Issues

Though this chapter focuses on health issues that were most frequently prioritized in community conversations throughout the region, many other issues are of great interest to area communities. These have been documented within the Healthy Connecticut 2020 State Health Assessment and other reports, including the additional CHNA chapters referenced in Chapter 1 of this document. Additionally, many concerns that relate to health, such as a lack of transportation or quality child care, are covered in other chapters of this report.

Among these issues, childhood lead poisoning continues to be a serious pediatric health problem in the region; no amount of lead in the bloodstream is considered safe. The number of children in the city of Bridgeport under age six with elevated blood lead, using a historical standard of 10 micrograms per deciliter (10 µg), dropped from 269 (4.6 percent) to 81 (1.3 percent) between 2004 and 2013—similar to the statewide downward trend, but levels in the city were still far above 2013 levels in suburban areas (generally 0.2 percent or lower). The current, stricter standard of 5 µg, shows that 6.5 percent of children in Bridgeport had elevated blood lead in 2013, about six times higher than rates found in suburban areas. Lead exposure is generally higher in neighborhoods where many homes were built before 1950 and contain lead-based paint.

Additionally, while the reduction and prevention of infectious disease over recent decades remains one of the greatest public health achievements, infectious disease continues to be an important cause of sickness and premature death. The Selected Infectious Diseases table shows the number of cases of certain infectious disease occurring in the region in recent years. Disparities within the region illustrate the importance of reproductive health, monitoring and care for at-risk populations, and early diagnosis and treatment of infections such as Lyme disease, among other issues.[61]

SUBSTANCE ABUSE & MENTAL HEALTH

Mental health and physical health are closely connected. Poor mental health can become a disability that has significant impacts on employment, maintenance of physical health, behavioral health, and overall well-being, ultimately imposing major financial costs to individuals and society as a whole. Self-reported health and well-being in Fairfield County are similar to statewide averages (see Figure 3.2 as well as Chapter 1), though there are large differences by household income level, education level, previous exposure to trauma, and other factors that we are unable to explore here in detail.

Due to the social and mental health costs that they create, substance abuse and tobacco are of major concern to the region. Tobacco use, in particular, is considered to be of particular importance because of the high costs and premature mortality that it creates, as well the available evidence that interventions (such as delaying the age of first use) can make a difference in reducing these social burdens. Exposure to cigarette smoke is a major risk factor for chronic obstructive pulmonary disease (COPD), heart disease, and lung cancer, which are leading causes of death as well as a source of large disparities in the mortality and hospital encounter rates across Fairfield County, as shown elsewhere in this chapter.

Adults in Fairfield County are less likely to smoke cigarettes (12 percent) than are adults living in Connecticut (15 percent). Smoking rates vary by household income level in Fairfield County; 27 percent of adults earning less than $15,000 per year are current smokers, compared to 7 percent of those earning $100,000 or more. The proportion of smokers who say they have attempted to quit in the past year is 56 percent, a rate that is not statistically different from the statewide average.[62]

In addition, many residents use e-cigarettes, including some who are also current cigarette smokers. Fourteen percent of adults, including 29 percent of young adults, have tried e-cigarettes at some point in their life. About one-third of these adults report using them in the past month. Compared to adults age 35 or over, young adults are more than twice as likely to have tried or to be currently using e-cigarettes.[63]

The health impact of substance use and other behaviors are sometimes difficult to track at the population level due to the need for extensive surveying. In 2015, 8 percent of Fairfield County adults, including 14 percent of adults age 18-34, reported that they felt that they needed to cut down on their drinking or drug use at some point in the past year.[64] Additionally, surveys show that about a quarter of Connecticut high school students are offered, sold, or given illegal drugs, particularly marijuana, on school property each year. Data on hospital encounters for substance abuse, which include hospital visits for a variety of reasons not related to tobacco or alcohol, also show that young adults are particularly impacted.

Drug overdose has become a leading cause of premature death, and continues to be a rising concern in the region. In recent years, there has been an increase in the number of deaths attributable to the use of heroin as well as other narcotics such as fentanyl. The total number of drug overdose deaths in Connecticut rose from 357 in 2012 to 723 in 2015. Heroin and other opioid substances are generally encountered in about 90 percent of these drug overdose deaths. All age groups are impacted, and many deaths are linked to the abuse of prescription drugs or use of pain relievers for non-medical purposes. Given the limitations of existing data, further analysis and policy development related to this emerging issue is needed.[65]

3.14

Chronic Obstructive Pulmonary Disease (COPD)

HOSPITAL INPATIENT ENCOUNTER RATES PER 10,000 RESIDENTS PER YEAR, 2012–2014

	ALL AGES, AGE-ADJUSTED	AGES 45–64	AGES 65–74	AGES 75–84
Fairfield County	82	60	291	523
Bridgeport	121	156	461	562
Danbury	119	93	466	737
Fairfield	71	33	238	620
Greenwich	53	22	166	389
Norwalk	101	86	354	608
Stamford	66	49	228	450
Stratford	91	81	342	572
9 Wealthiest CT Towns	54	20	167	381
4 Largest CT Urban Core Towns	142	188	508	663

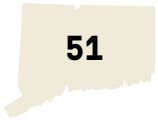
3.15

Substance Abuse, All Hospital Encounters

AGE-ADJUSTED ANNUALIZED ENCOUNTER RATE PER 10,000 RESIDENTS, 2012–2014

9 WEALTHIEST TOWNS IN CT

51 ENCOUNTER RATE

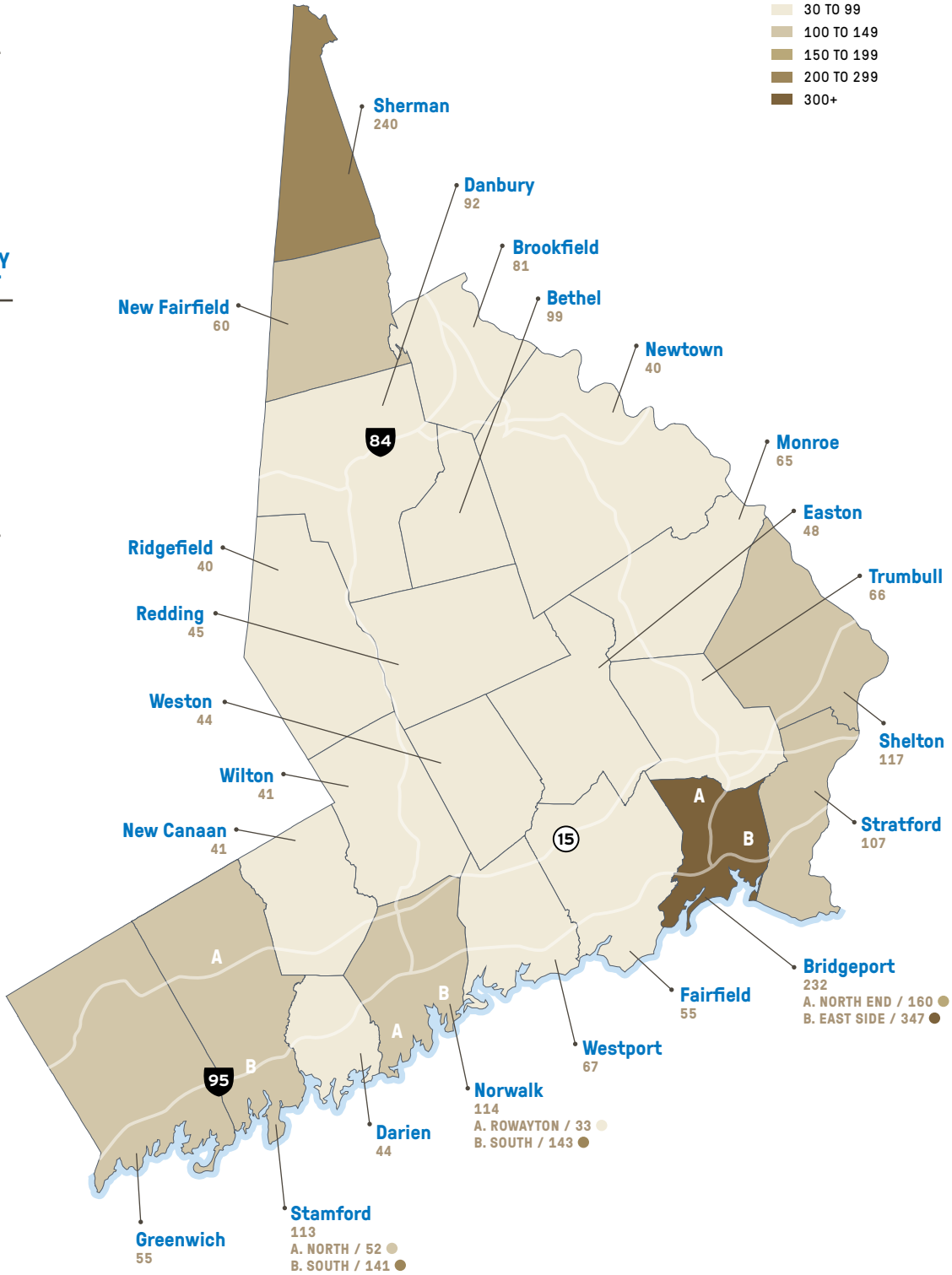


4 LARGEST CITY CENTERS IN CT

346 ENCOUNTER RATE

FAIRFIELD COUNTY

105 ENCOUNTER RATE



3.16

Preventable Dental Conditions, Hospital ED Encounters

AGE-ADJUSTED ANNUALIZED ENCOUNTER RATE PER 10,000 RESIDENTS, 2012–2014

9 WEALTHIEST TOWNS IN CT

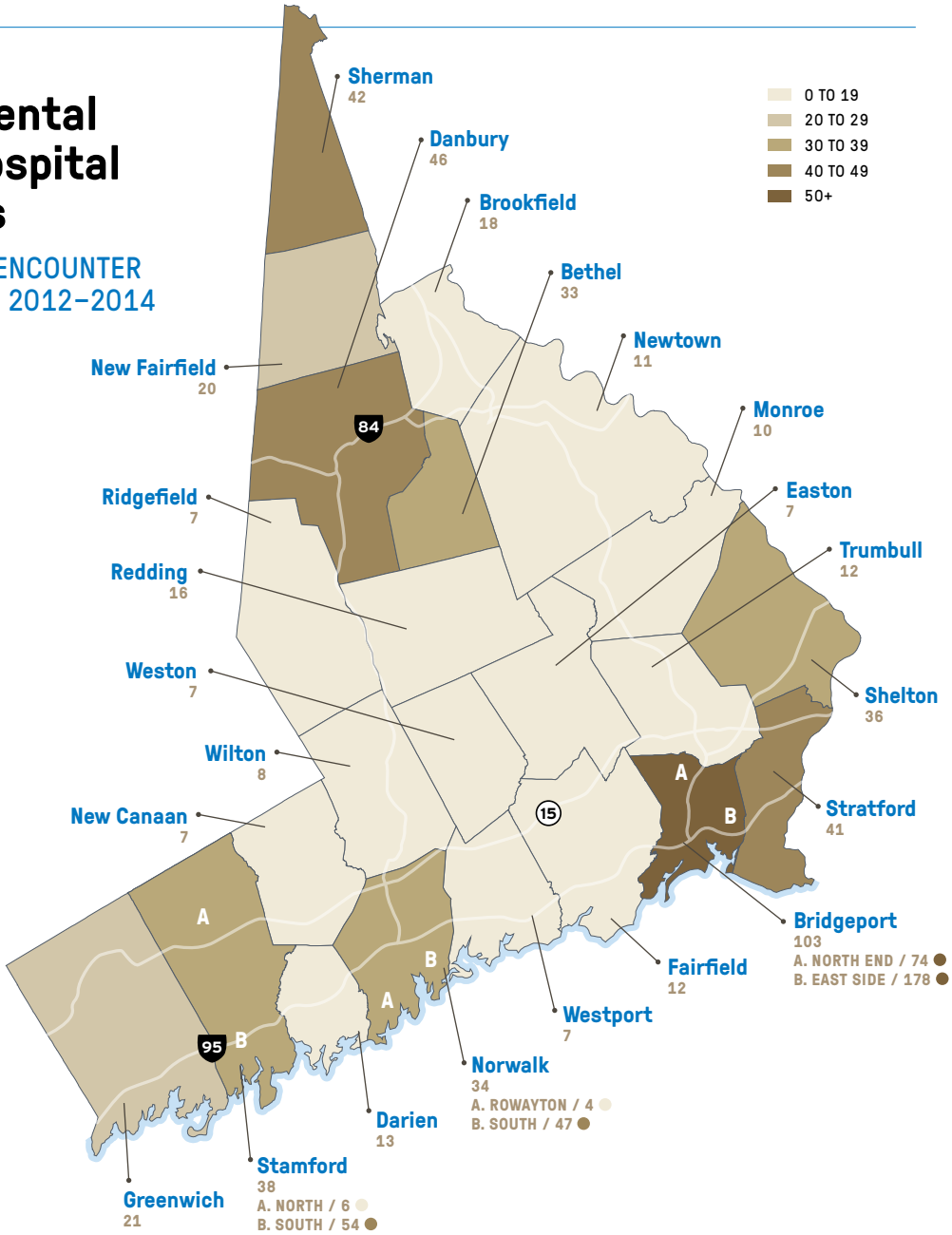
12 ENCOUNTER RATE

4 LARGEST CITY CENTERS IN CT

114 ENCOUNTER RATE

FAIRFIELD COUNTY

40 ENCOUNTER RATE



	PREVENTABLE DENTAL CONDITIONS, HOSPITAL EMERGENCY DEPARTMENT (ED) ENCOUNTER RATES PER 10,000 RESIDENTS					
	ALL AGES, AGE-ADJUSTED*	AGES 0–19	AGES 20–44	AGES 45–64	AGES 65–74	AGES 75–84
Fairfield County	40	19	78	30	13	12
Bridgeport	103	46	194	90	34	22
Danbury	46	36	74	38	15	22
Fairfield	12	4	20	13	7	3
Greenwich	21	12	31	21	13	8
Norwalk	34	20	60	28	17	13
Stamford	38	26	61	34	14	14
Stratford	41	16	87	28	12	7
9 Wealthiest CT Towns	12	6	20	10	8	8
4 Largest CT Urban Core Towns	114	53	213	105	35	21

* See map above

ACCESS TO HEALTH CARE

Access to Care

In conversations with area residents throughout Fairfield County, the ability to access quality, affordable, and convenient medical care often emerges as a major concern. In 2015, 45 percent of adults in Fairfield County earning $30,000 or less, and 29 percent earning between $30,000 and $100,000 per year, reported that they postponed or did not get the health care they needed in the past year. Additionally, nearly 1 in 10 adults said they could not get prescription medicines they needed in the past year because they could not afford it. The 2015 DataHaven Community Wellbeing Survey identifies some of the reasons why many adults may not be getting the medical care that they thought they needed. Cost is a barrier to obtaining care that impacts residents of nearly all income levels, particularly low-income adults, echoing findings from more detailed recent national studies.[66] Whether or not adults are covered by health insurance, there are frequently other barriers to obtaining care, including an inability to find time to get to the doctor's office (sometimes due to caregiving responsibilities or the need to hold multiple jobs), the fact that their health plan does not cover the cost of a procedure that they believe is needed, a lack of transportation access, or a belief that routine medical care or check-ups are not required.[67]

For a significant number of adults, a lack of health insurance is a major barrier to receiving medical care. In 2015, adults in Fairfield County were as likely as adults in Connecticut not to have health insurance—1 out of every 20 adults ages 18 and over do not have health insurance. The largest differences in health insurance access are observed by age, income level, and immigration status. The proportion of adults with a medical home (a coordinated, ongoing source of primary medical care) varies along similar lines. Additionally, about 1 in 5 residents who didn't get or postponed care in the past year report that the health insurance that they do have was not accepted.

The proportion of adults in Fairfield County who report using the emergency room as a source of medical care is similar to the statewide average. Five percent of adults in Connecticut used the emergency room three or more times in the past year. Adults with low household incomes are substantially more likely than other adults to have used the emergency room on more than one occasion in the past year. Adults may use the emergency room for severe conditions, but also to seek more routine medical treatment if they are unable to access an alternative source of care, such as a primary care provider or clinic.

Access to Oral Health

Visiting the dentist is a key factor in maintaining good oral health and is linked to other health outcomes. Connecticut has the highest percentage of any state in the United States of adults who self-report visiting a dental health professional.[68] In 2015, the rate of dental visits among adults in Fairfield County as a whole was slightly better than the statewide rate (see Figure 3.2). The percent of adults who visited a dentist in the past year varies widely by income level and neighborhood. Disparities in the rate of emergency room encounters for dental conditions, among both children and adults, indicate that there are major barriers to accessing preventive dental care in low-income neighborhoods.

3.17

Health Care Access

2015 COMMUNITY WELLBEING SURVEY, PERCENT OF FAIRFIELD COUNTY ADULTS AGE 18+

		NO HEALTH INSURANCE	DENTIST VISIT IN PAST YEAR	COULD NOT AFFORD PRESCRIPTION MEDICINES DURING PAST YEAR	DID NOT GET OR POSTPONED MEDICAL CARE DURING PAST YEAR
Race/ Ethnicity	Caucasian/White	3	83	6	24
	African American/Black	9	69	9	32
	Hispanic/Latino	15	70	10	36
Age Group	18–34	11	76	5	34
	35–64	5	80	8	29
	65–79	3	80	5	15
	80–94	1	75	4	12
Income	Under $30,000	17	63	16	45
	$30,000–$100,000	6	76	7	29
	Over $100,000	1	87	3	20

BETTER WORSE

* For insurance and dentist visits, see page 24 for rates by region and town.

Conclusion: Findings from the Community Health Needs Assessment Process in Fairfield County

As one of the healthiest metropolitan areas in the nation, Fairfield County is an excellent place to achieve one's full health potential. Relative to Connecticut, residents have higher incomes and feel more secure in accessing health care, housing, food, and transportation. They report feeling healthier in both mind and body, and they are generally part of strong communities that have the resources to support each resident's well-being.

These overarching trends do not account for the challenges faced by the county's many neighborhoods of highest need. In these areas, many families and children find it difficult to access basic needs, and often do so only while experiencing significant financial and psychological stress. Within these areas, it is no surprise that severe medical conditions begin earlier in life, even at birth, and are more likely to result in emergency hospital visits, resulting in significant long-term economic and social burdens to the region as a whole.

As part of the **Community Health Needs Assessment (CHNA)** process (see Chapter 1), DataHaven worked with directly leaders from longstanding community-hospital partnerships in the Greater Greenwich, Greater Stamford, Greater Norwalk, Greater Danbury, and Greater Bridgeport areas to develop **additional CHNA chapters** that complement the material within this report. Collectively, these chapters cover all of the towns in Fairfield County, allowing health needs to be identified in more detail, documenting the process that was used to collect data and conduct the CHNA at a local level in each area, and discussing health improvement planning efforts that are underway by collaborative partners throughout the region. You may find these chapters on the hospital or DataHaven websites when they are published this year. Additionally, health directors from throughout Fairfield County attended meetings that DataHaven convened in February and May 2016, and DataHaven was invited by community-hospital partnerships to give over a dozen presentations on community health and well-being to local public health experts and other audiences in Greenwich, Stamford, Norwalk, Danbury, Bridgeport, Stratford (detailed in the additional chapters) as well as Shelton (as part of a separate, Lower Naugatuck Valley Region needs assessment available through DataHaven).[69]

At the local level, the assessments reveal that differences in wealth are accompanied by a different experience in the health care system. For some low-income individuals, accessing quality medical care feels nearly impossible. Insurance, transportation, and related financial costs of health care appointments are the primary barriers. Even when people do go to the doctor, they feel that the quality of care varies depending on their insurance; for example, in one focus group, a woman with one insured and one uninsured child reported that she felt that the uninsured child received inferior care. Doctors are not always in easily accessible locations, and transit systems are unreliable.

In many neighborhoods, primary care medical services are plentiful. The majority of people in wealthy areas have private insurance. However, travel can be required to find specialists, especially those who accept state insurance. The additional travel and stress for individuals are a challenge to those who are trying to be frugal with medical expenses. Questions about the quality and professionalism of care, including incidents of being discriminated against based on ethnicity or medical status, also arose among residents in some areas.

It is important to understand that Fairfield County is a very heterogeneous region. While rising diversity is a key asset to the area's culture and economy, the high degree of income segregation is not, and carries with it significant costs to economic prosperity and health outcomes. Additionally, neighborhood populations vary widely by age, and the aging population will have impacts on access to services in all towns. Each community requires dignified approaches that are tailored to and likely to engage its residents in making improvements.

A positive trend in Fairfield County is the desire to make change. Civic engagement is high, and numerous health-related initiatives have been implemented by the longstanding community-hospital partnerships within each region. The community health needs assessment (CHNA) process is one tool to facilitate the cross-sector conversations about how all policies impact health and help document opportunities for community improvement. As this process is updated and expanded over the coming years, it can track the impact of these initiatives and support advocacy for the system and environmental changes that will help create a healthier region. DH

For further detail about the information in this chapter, as well as additional data specific to individual towns, please see the additional CHNA chapters referenced in Chapter 1.

CHAPTER 4

A Region of Opportunity

The county's 2,070 subsidized infant/toddler slots (including 220 free slots) could serve at most only 22 percent of the 9,450 infants and toddlers living in low-income households in Fairfield County.

Six years after high school graduation, 54 percent of all Fairfield County Class of 2008 students had earned a post-secondary degree – but enrollments and completions varied widely by town, race, gender, and economic status.

Adults who said they were seeking employment and were white have greater access to a car than those who said they were employed and were black or Latino.

Over the past decade, the health care, education, and accommodation and food service industries in Fairfield County have added about 30,000 jobs.

Fairfield County libraries have $75 on average to spend per person per year, compared to $53 statewide. Greenwich libraries have per-person operating incomes of $192 dollars per person per year, while Bridgeport libraries have $47 per person, and Danbury libraries have $25.

In Fairfield County, 4 out of 5 adults report trusting neighbors, having neighbors who could work together, and having confidence in police – all measures of community cohesion.

EARLY CARE & EDUCATION

Why Early Care and Education are Important

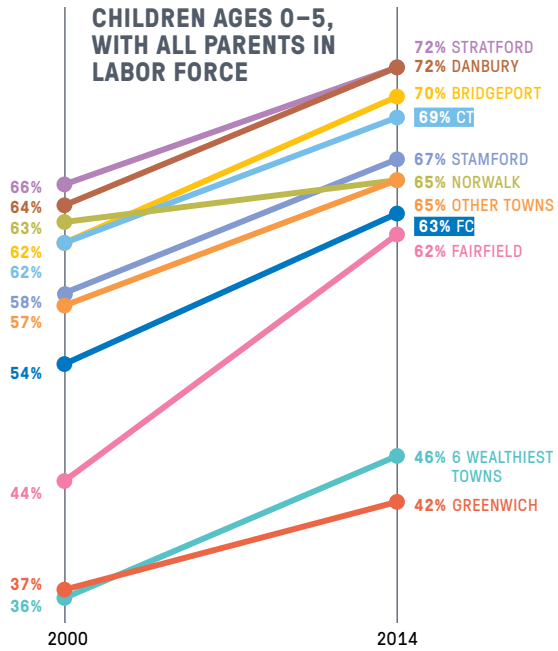
Investing in high-quality early care and education benefits young children, their parents, and the communities in which they live. Young children who participate in well-resourced and regulated early care and education programs are less likely to be retained in school or to require special education services, and more likely to graduate from high school. They are also less likely to become involved in the criminal justice or welfare systems and more likely to be productively employed.[70] Parents with access to affordable, reliable child care, are less likely to miss work and more likely to retain steady employment. These parents and their children ultimately are able to contribute more to their communities, and cost them less.

Demographics of Children and Families

In 2014, there were about 230,000 children (ages 0–17) in Fairfield County, about 55,000 of whom were under the age of 5.[71] Twenty-nine percent of young children live in low-income households,

4.1

Working Parents, 2000–2014



though this share is higher in certain towns. Overall young children are more likely to be from low-income households than the total population.[72] Low-income status indicates serious economic hardship — living in a household that earns less than $47,700 for a family of four or 200% of the Federal Poverty Line.[73] Despite the fact that the total number of young children in Fairfield County has been decreasing (down 3% since 1990), the past decade witnessed a 22 percent rise in the number of young children living in low-income families county-wide.

The number of single-parent families in Fairfield County grew by 22 percent from 1990 to 2014, four times more than the growth of married couple families with children.[74] Single-parent families are more likely to be economically-disadvantaged: in Fairfield County, single-parent families are 6 times more likely to live in poverty than married couple families living with children.[75]

In Fairfield County, the share of children ages 0–5 from families where all parents worked or were looking for work grew, from 54 percent in 2000 to 63 percent in 2014.[76] This increase may reflect the growing number of single-parent families as well as societal shifts, as more women join the workforce compared to past decades.[77] It also marks an increased need for childcare, since most working parents cannot care for their children on the job.

Access to Early Care and Education

There are many early care and education options for young children. Parents, family members, friends, or nannies look after some children at home. Center-based programs are managed by public or private schools, nursery schools, community groups, or municipalities. Family child cares are operated from a child care professional's house.

All family child care and center-based providers are "regulated," which includes licensed and license-exempt programs. Connecticut mandates the vast majority of family child care and center-based programs to be "licensed," meeting state-established minimum health and safety standards; a few center-based programs — such as those in public schools — are license-exempt.[78] To receive state subsidies for such programs as School Readiness or Smart Start, child care centers must also be accredited by the National Association for the Education of Young Children, which requires meeting an additional set of quality standards.[79] Programs that receive federal dollars, such as Head Start, must meet federal quality standards.

In 2014, there were 26,430 slots at regulated early care and education programs in Fairfield County.[80] About seven percent were in family child care homes; the rest were at centers, public schools, or nursery schools. Of these slots, 21,530 were reserved for preschool-aged children, the remainder for infants and toddlers.

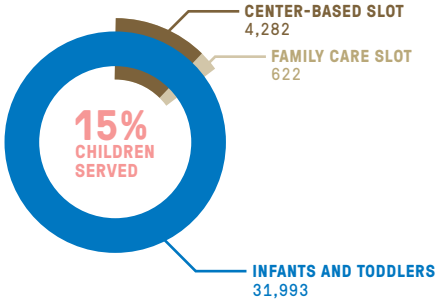
There is a serious shortage of early care and education options for infants and toddlers: there are only enough regulated infant/toddler slots in Fairfield County to serve about 15 percent of children ages 0–2.[81] Providers supply sufficient early care and education options for preschool-aged children: there are enough regulated slots for nearly all (93%) of the 3- or 4-year-olds in the county, including 87 percent in centers. (FIG 4.2)

However, the actual enrollment rate of 3- and 4-year-olds at center-based preschools is only 69 percent, suggesting that factors other

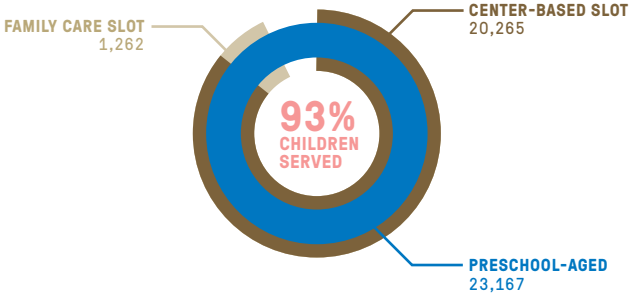
4.2

Availability of Childcare and Education in Fairfield County, 2014

REGULATED CARE AND EDUCATION SLOTS FOR INFANTS AND TODDLERS



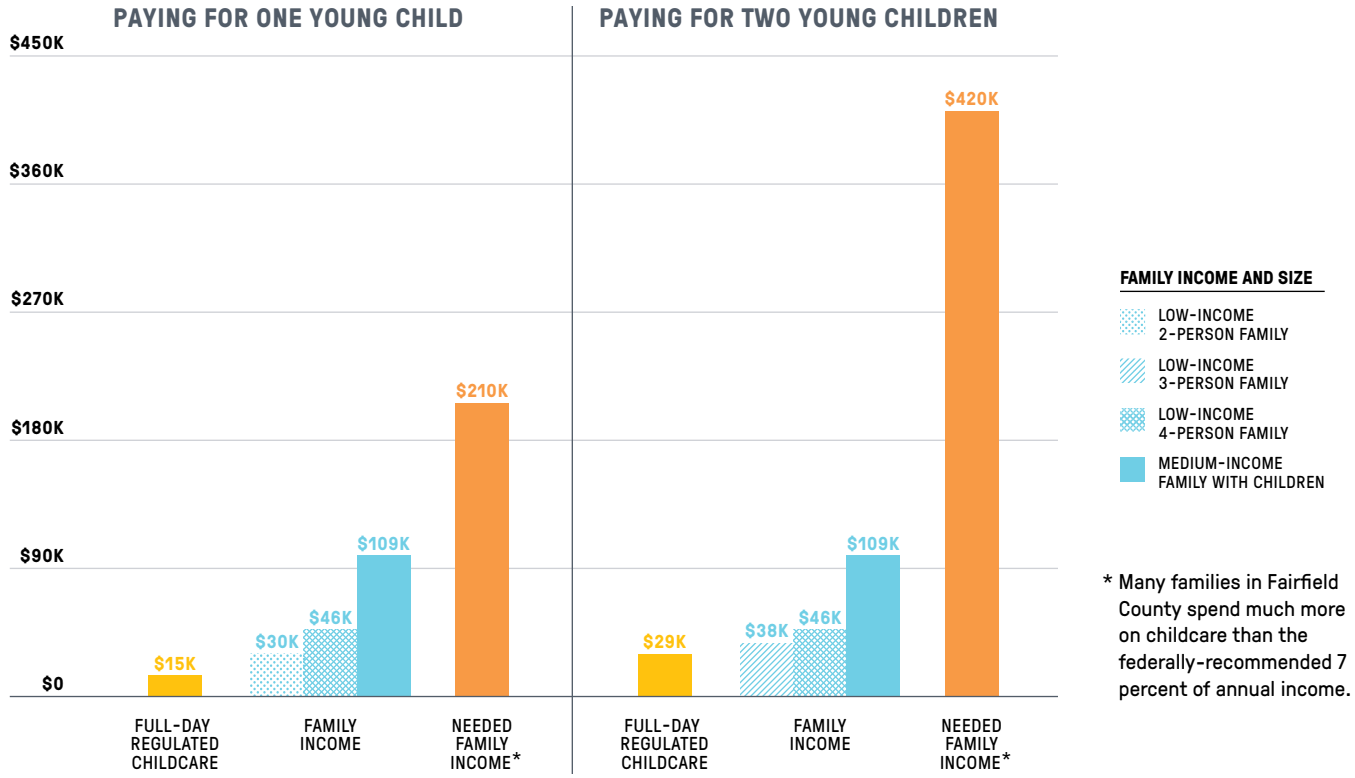
REGULATED CARE AND EDUCATION SLOTS FOR PRESCHOOL-AGED CHILDREN



4.3

Affordability of Childcare for Families

COSTS OF REGULATED, FULL-DAY CHILDCARE AND FAMILY INCOMES IN FAIRFIELD COUNTY, 2012



than availability — such as cost, location, or schedule — influence enrollment in child care and education as well.[82] For example, parents who work after normal business hours, regulated early care and education options are also limited: fewer than ten home-based providers in the county care for children between 11 p.m. and 6 a.m.[83]

Early Care and Education Cost

In 2014, costs for full-day, full-year regulated early care and education programs in Fairfield County averaged between $10,900 and $14,700 per year per child but were as much as $8,000 higher in the wealthiest towns.[84] Programs in centers and for infants and toddlers were more expensive than those in family child care homes or for preschool-aged children. Costs for early care and education are rising — the state average increased by 14 percent from 2007 to 2012.[85]

The federal government recommends that families spend at most seven percent of income on child care.[86] However in 2012, the average cost of care for one child amounted to between 10 and 14 percent of median incomes of Fairfield County families with children.[87] Some families spend even more of their income on childcare: A low-income, single-parent household (earning less than 200% FPL) would spend nearly half its budget on care for one child.[88] (FIG 4.3)

Subsidies for Costs of Early Child Care and Education

There are not enough government subsidies to assist all Fairfield County families who cannot afford early care and education. In 2014, the government funded or provided vouchers for a total of 9,290 slots, making them free or partially subsidized for eligible families: 2,070 for infants and toddlers, 7,220 for preschool-aged children.[89] Funding is extremely limited for families with

infants and toddlers: the 2,070 subsidized infant/toddler slots could serve at most only 22 percent of the 9,450 infants and toddlers living in low-income households in Fairfield County. Of these slots, only 11 percent, or 220 total slots, are free; the rest require a parent contribution.[90]

These 7,220 subsidized slots and vouchers theoretically could serve all of the 6,040 preschool-aged children from low-income households (earning less than 200% FPL) in Fairfield County.[91] A quarter (1,770) of these slots are free; the rest require families to pay some costs.[92] In reality, not all preschool-aged children from low-income families are funded, since families must apply for subsidies first, before receiving them. Further, some children use more than one form of subsidy, and families earning above the low-income threshold can also qualify for some forms of subsidies.[93] (FIG 4.4)

Preschool Enrollment

Statewide Census data suggest that a family's ability to pay impacts preschool enrollment: in 2014, 3- and 4-year-olds from low-income families (earning less than 200% FPL) were less likely to enroll in center-based preschools (54 percent) when compared to children from higher-income families earning more than twice the federal poverty line (67 percent).[94] In this same year enrollment rates of 3- and 4-year-olds were considerably lower in poorer urban towns (between 55 and 60 percent) than in the suburban and wealthy towns in the county (between 75 and 85 percent).[95] (FIG 4.5)

EDUCATIONAL OPPORTUNITIES FOR CHILDREN & YOUTH

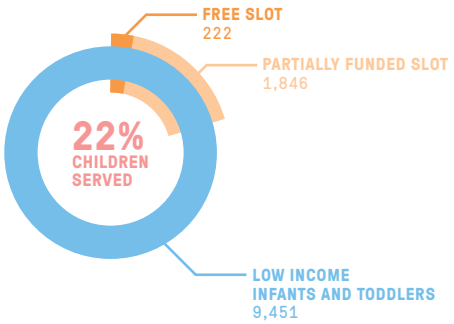
Importance of Education

Education is key for determining positive outcomes for individuals and communities. People with high school diplomas or college degrees have more employment options and higher potential earnings, on average, than people who do not finish high school.[96] In turn, individuals with good financial stability support the local economy through tax contributions and consumer purchases. As well, people with more years of education are more likely to be civically engaged and to be in good health.[97]

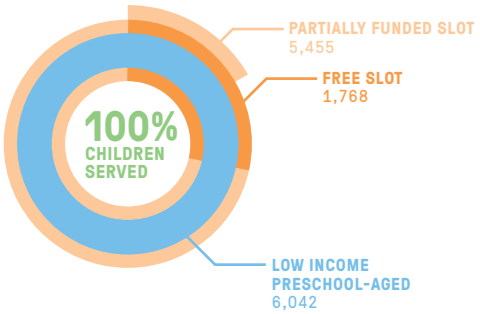
4.4

Availability of Childcare and Education Subsidies in Fairfield County, 2014

SUBSIDIZED SLOTS AND VOUCHERS FOR INFANTS AND TODDLERS



SUBSIDIZED SLOTS AND VOUCHERS FOR PRESCHOOL-AGED CHILDREN



THE CHALLENGE OF FUNDING INFANT AND TODDLER CHILDCARE

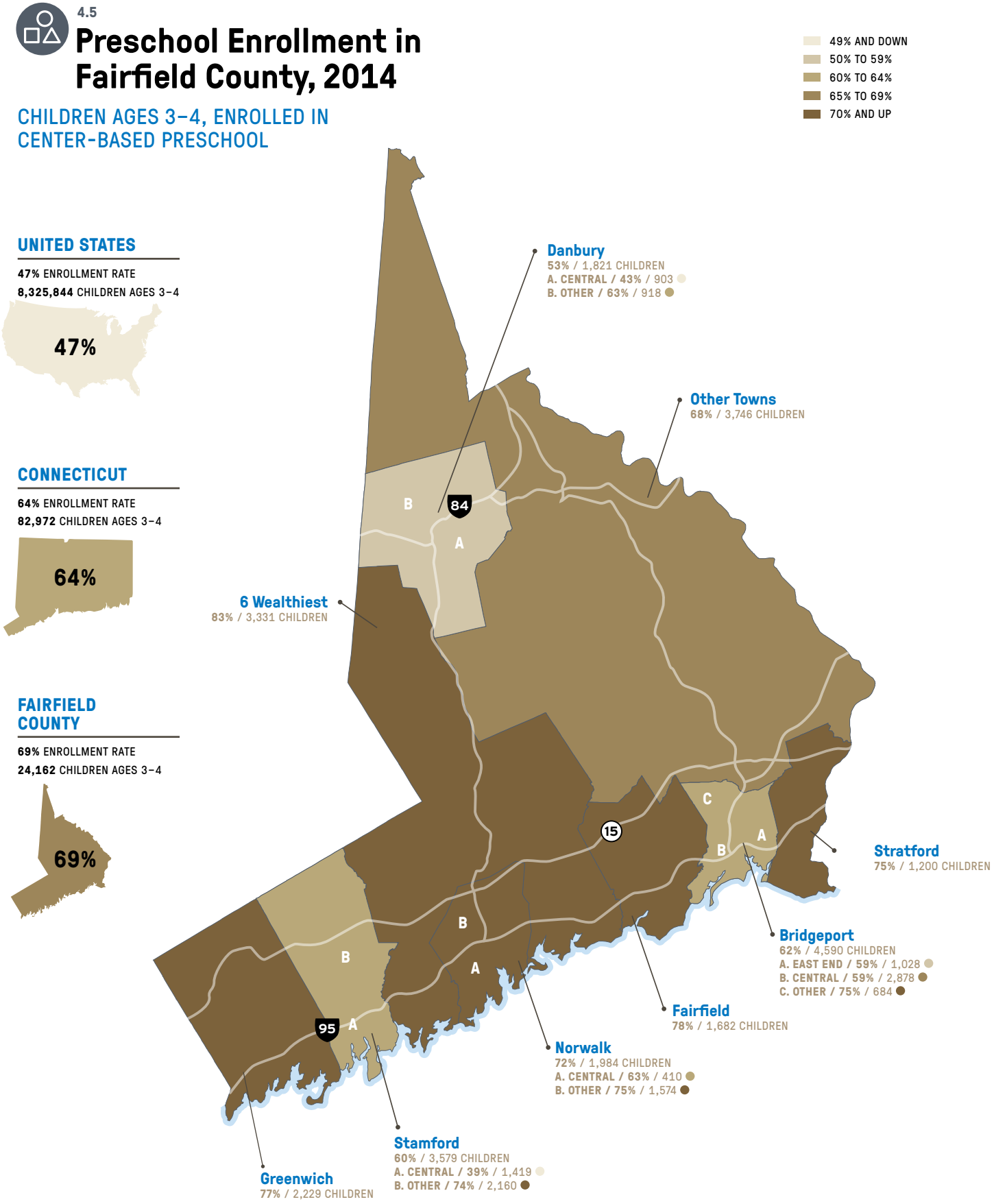
Early care and education for infants and toddlers receives significantly less funding than do preschool programs. At the same time, the costs of caring for the youngest children are significantly higher, due mainly to a higher mandated staff to children ratio.[98] Between October 2010 and October 2013, the number of infants and toddlers statewide who received some form of subsidy for early care and education fell by 5 percent, while, during that same time period, the number of preschoolers statewide who received some form of subsidy for early care and education rose by 5 percent.[99]

The government's increased investment in preschoolers may also have unintended, negative effects on the supply and price of infant-toddler care. Anecdotal evidence suggests that when the government offers free or subsidized preschool in settings that serve only preschoolers, programs that serve a range of ages may lose some preschoolers. Without that revenue stream, they may be unable to afford to offer infant/toddler care, or will only be able to offer it at higher rates.

4.5

Preschool Enrollment in Fairfield County, 2014

CHILDREN AGES 3–4, ENROLLED IN CENTER-BASED PRESCHOOL



Demographics of K–12 Students

During the 2014–15 school year, there were 136,300 students at 24 public school districts in Fairfield County.[100] About 14 percent of K–12 aged children attended private schools.[101]

Fifty-six percent of Fairfield County public school students are white, and 44 percent are children of color: 12 percent African-American, 25 percent Latino, and 7 percent some other race. A higher share of young children identify as minorities, compared to older children (see page 12) — indicating that the student body will increase in racial and ethnic diversity as older students age out of the student body. City school districts mostly enroll children of color — such as in Bridgeport, where 89 percent are children of color — compared to students at suburban and wealthy town districts, where 85 percent are white.[102]

A student who takes special education classes, who qualifies for free or reduced-price meals (FRPM) at school based on low family income (below 185% the federal poverty line), or who is an English Language Learner (ELL) is considered to be high-needs.[103] Of the 136,600 students in Fairfield County, 12 percent are special education, 35 percent are FRPM-eligible, and 8 percent are ELL; some students have more than one high-needs status.[104]

The magnitude of the high-need student populations varies widely by school district within Fairfield County. In Bridgeport, nearly 100 percent of students have at least one high-needs status, while less than 15 percent of students at the wealthiest towns' school districts are high-needs..[105]

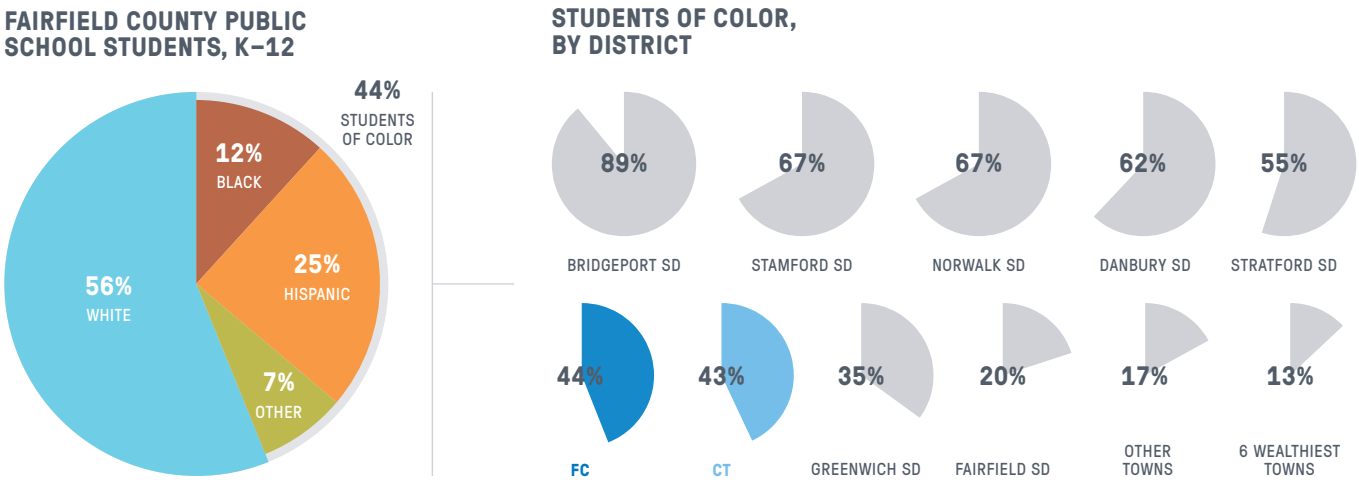
Students are considered to be transient if they change schools at least once within a school year, but counts of this population at Fairfield County schools are unreliable. Nine percent of all school-aged children (ages 5–17, attending private or public schools) living in Fairfield County move homes each year (although this overestimates the rate of transiency at public schools, since not all children who move must change schools). This rate ranges from 17 percent in Bridgeport, to five percent in the suburban towns.[106]

Skill-Building and Academic Achievement

Early school success is highly linked to later achievement. Reading and math ability in kindergarten are predictors of proficient skills in more advanced subjects.[107] A study by the Annie E. Casey Foundation found that about 16 percent of children who are not reading proficiently by the end of third grade do not graduate from high school on time, a rate four times greater than that for proficient readers.[107] Achievement in middle school is even more highly correlated with high school graduation. One study found a 30 percentage point difference in graduation rates between students who had completed algebra by the 8th grade and those who had not.[109] Math skills in eighth grade also indicate preparedness for technical classes in high school.[110]

4.6

Race and Ethnicity of Fairfield County Students, 2014–15



4.7

High-Needs Students

FAIRFIELD COUNTY PUBLIC SCHOOL STUDENTS BY HIGH-NEEDS STATUS, PREK–12, 2014–15*

	TOTAL STUDENTS	SPECIAL EDUCATION	SPEC ED PERCENTAGE	ENGLISH LANGUAGE LEARNER	ELL PERCENTAGE	FREE AND REDUCED-PRICE MEAL ELIGIBLE	FRPM ELIGIBLE PERCENTAGE
Connecticut	546,347	72,773	13%	34,919	6%	205,921	38%
Fairfield County	144,258	16,817	12%	10,920	8%	50,059	35%
Bridgeport SD	21,244	3,114	15%	2,958	14%	21,000	99%
Danbury SD	10,945	1,333	12%	2,423	22%	6,082	56%
Fairfield SD	10,213	1,146	11%	209	2%	957	9%
Greenwich SD	8,813	916	10%	571	6%	1,329	15%
Norwalk SD	11,311	1,356	12%	1,572	14%	4,955	44%
Stamford SD	16,085	1,757	11%	2,084	13%	8,341	52%
Stratford SD	7,060	813	12%	339	5%	3,272	46%
6 Wealthiest Towns	26,780	2,881	11%	216	1%	598	2%
Other Towns	28,868	3,176	11%	457	2%	2,964	10%

* Some students belong to more than one high-needs group.

According to the Connecticut State Department of Education, Fairfield County public school students perform better overall than students statewide, on standardized tests (the Smarter Balance Assessment Consortium, or SBAC). In 2015, 57 percent of county third graders passed the reading test and 48 percent of fourth graders passed the math test, demonstrating proficient skill in these areas. Fairfield County pass rates were about three percentage points higher than corresponding statewide rates. On the eighth grade math test, the Fairfield County pass rate was 43 percent, six points above the statewide rate. However, achievement differed by school district: for example, the third grade reading pass rate was 82 percent at the wealthiest towns' school districts, four times the pass rate of at Bridgeport schools.[111] (FIG 4.9)

Attendance and Academic Achievement

In Connecticut, a student is considered "truant" if he has more than four unexcused absences in any one month or more than ten in one school year, while he is considered "chronically absent" if he misses more than 10 percent of school days for any reason.[112] Absenteeism, whether excused or unexcused, has significant effects on academic achievement. Children who are chronically absent in both kindergarten and first grade are much less likely to read proficiently by the end of third grade. One Baltimore study found that sixth-graders who are chronically absent are two and a half times less likely to graduate from high-school than their non-chronically absent peers.[113]

During the 2013–14 school year, Fairfield County students had lower rates of chronic absence (8 percent of all students) than the state as a whole (11 percent). Among Fairfield County students, high school students are approximately twice as likely to be chronically absent than students in grades K–8 — a pattern that holds true within most school districts. Chronic absence rates range from below five percent for all Fairfield SD students, to more than 20 percent at Bridgeport schools.[114]

Like students who are absent, students who are suspended lose valuable class time. For students who are otherwise attending school and passing their courses, a single suspension in ninth grade is significantly correlated with later chronic absence and academic failure.[115] Being suspended once in ninth grade doubles a student's likelihood of dropping out.

Suspension rates at Fairfield County schools are below the state average. During the 2012-13 school year Fairfield County schools had an overall rate of 47 out-of-school suspensions (OSS) per 1,000 students, compared to 75 per 1,000 students

statewide.[116] However, district and state-level data reveal dramatically higher OSS suspension rates for students at poorer school districts and for non-white students. For example, the OSS suspension rate at Bridgeport schools (207 per 1,000) is four times higher than the county-wide rate.[117] Analysis of statewide data reveals that compared to white students, black students are more than six times more likely to be suspended, and Hispanic students are four times more likely.[118]

On-Time High School Graduation

Ultimately, 90 percent of Fairfield County seniors graduated on time — in 4 years — in 2014, higher than the Connecticut-wide rate of 87 percent. Corresponding with district-wide rates of skill-building and absence from school during the K–12 years, graduation rates differ by school district. At the wealthiest towns' districts, the four-year graduation rate was 97 percent, compared to 72 percent in Bridgeport.[119]

Barriers to Academic Achievement

In 2015, high-needs Fairfield County students of any grade (including FRPM-eligible, special education, and ELL students) passed the SBAC reading test at half the rate of non-high needs students.[120] Similarly, high-needs students of any grade passed the SBAC math test at about half the rate of non-high needs students. Across a majority of academic measures, large disparities in performance rates exist between groups that differ by race/ethnicity, family income, and English language proficiency.[121] Chronic absence, suspension, and transience also put students at greater risk for poor academic performance.[122] Students from groups who perform below average on earlier measures of achievement ultimately are less likely to graduate from high school on time.[123]

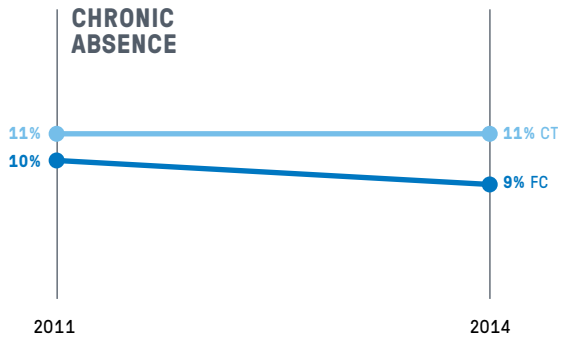
These disparities are evidence of what is commonly referred to as the "achievement gap:" the persistent difference in academic performance between two groups of students, particularly groups defined by race/ethnicity or socioeconomic status.[124] It is linked to an "opportunity gap," related to family income and resulting resources — such as access to books or educational games, nutrition, and social environment — that affect students' performance.[125] The opportunity gap begins during early childhood — by age three, children living in poverty have heard 30 million fewer words than children from high-income families[126] — and it lasts through high school graduation and beyond.[127]

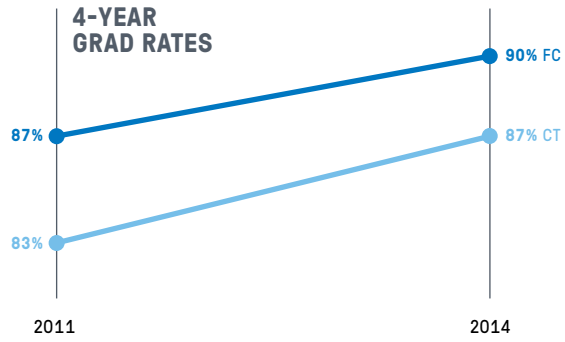
4.8

Academic Achievement in Fairfield County Schools

STUDENTS SCORING "PROFICIENT" ON STANDARDIZED TESTS (SBAC), 2015, AND 4-YEAR GRAD RATE, 2014

	3RD GRADE READING	4TH GRADE MATH	8TH GRADE MATH	4-YEAR GRAD RATE
United States	--	39%	32%	82%
Connecticut	54%	44%	37%	87%
Fairfield County	57%	48%	43%	90%
Bridgeport	21%	7%	8%	72%
Danbury	48%	42%	24%	78%
Fairfield	67%	63%	55%	94%
Greenwich	79%	67%	61%	95%
Norwalk	51%	41%	25%	84%
Stamford	45%	42%	35%	89%
Stratford	41%	22%	22%	92%
6 Wealthiest Towns	82%	72%	68%	97%
Other Towns	73%	62%	51%	95%





Higher Education

In 2013, 79 percent of Fairfield County high school graduates enrolled in college, and about four-fifths of those students started four-year programs. Between 2007 and 2013, the number of students who enrolled in any two- or four-year program grew by 9 percent. Each year about three-quarters of all former Fairfield County students continued on to a second year of college. Six years after high school graduation, 54 percent of all Fairfield County Class of 2008 students had earned a post-secondary degree, a majority emerging with four-year degrees.[128]

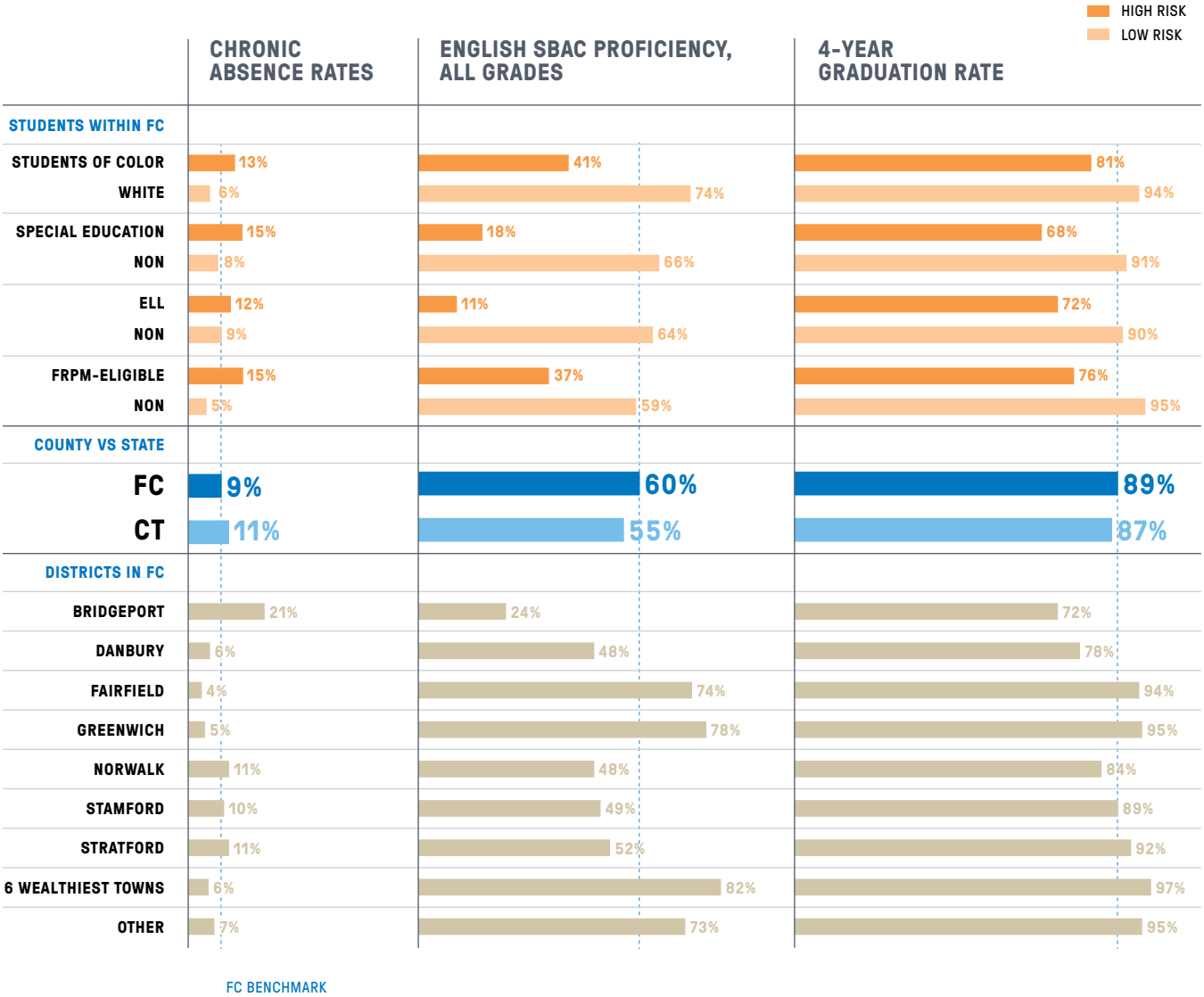
A quarter of former Fairfield County students enroll at state or community colleges, and of those students, three-quarters are placed in remedial courses to relearn high school material.[129] This signals that they are not prepared for college-level classes and ultimately results in costing them extra time and money to finish their degrees.

Further, college enrollment and completion vary

4.9

The Opportunity Gap Impacts Achievement at Fairfield County Schools

STUDENT PERFORMANCE ON ACADEMIC ACHIEVEMENT MEASURES: 2015 SBAC "PROFICIENCY" RATES, 2014 CHRONIC ABSENCE RATES, 2014 4-YEAR GRADUATION RATES



widely for graduates of different districts. In 2013, 56 percent of Bridgeport SD graduates continued on to college. Only 20 percent of the Bridgeport Class of 2008 finished a two- or four-year college degree in six years. By comparison, the wealthiest towns' districts had a collective college enrollment rate of 89 percent, and a six-year degree attainment rate of 76 percent.[130] (FIG 4.10)

Opportunities for Young People

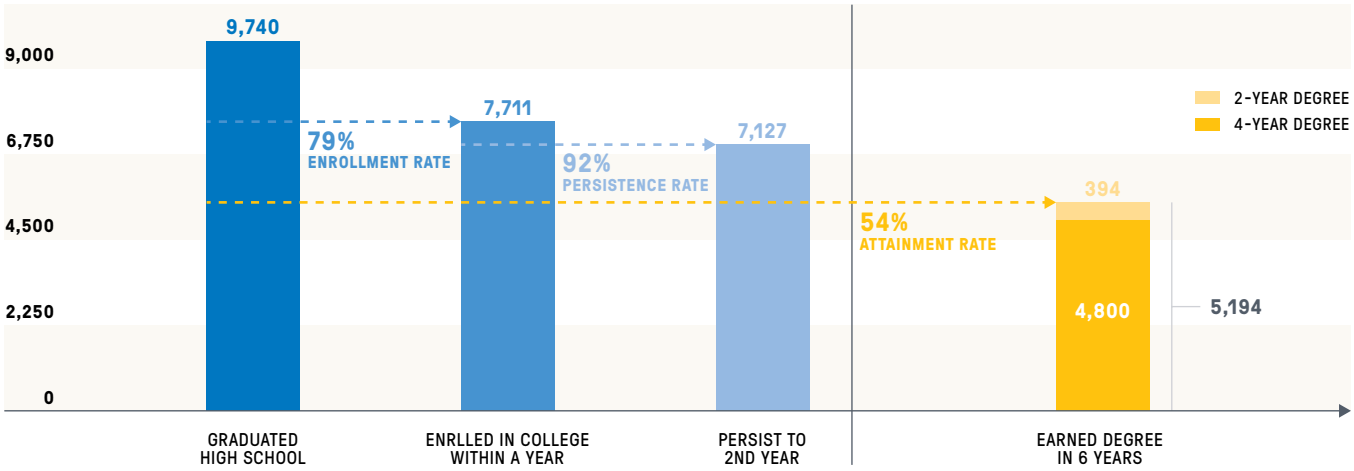
Young people need access not only to jobs, but jobs with potential for professional advancement, in order to transition from dependence on parents to self-sufficiency. Young people with stable jobs that offer future opportunity can become long-term economic contributors to the community.[131]

More than half of all Fairfield County and Connecticut youth report that they have the education and training they need to advance their careers. Compared to young people from

4.10

Higher Education of Fairfield County Students

COLLEGE ENROLLMENT, PERSISTENCE*, AND COMPLETION† OF FAIRFIELD COUNTY PUBLIC SCHOOL GRADUATES, 2008 AND 2012



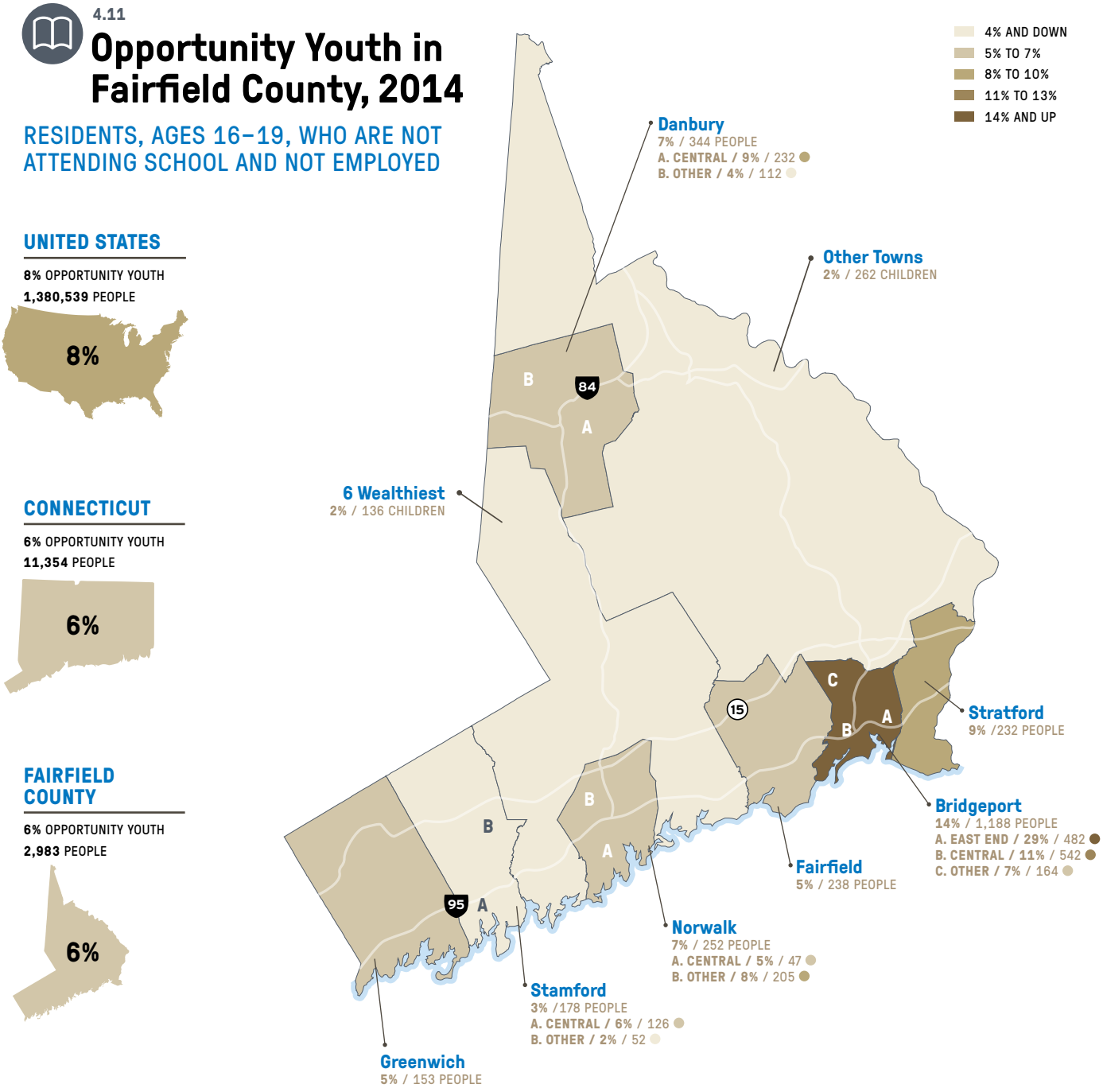
	GRADUATED HIGH SCHOOL	ENROLLED IN COLLEGE WITHIN A YEAR	ENROLLMENT RATE	PERSIST TO 2ND YEAR	PERSISTENCE RATE	EARNED DEGREE IN 6 YEARS	ATTAINMENT RATE	WITH 4-YEAR DEGREE	WITH 2-YEAR DEGREE
Connecticut	38,666	27,971	72%	24,826	89%	17,953	47%	15,740	2,213
Fairfield County	9,740	7,711	79%	7,127	92%	5,194	54%	4,800	394
Bridgeport SD	899	503	56%	434	86%	197	20%	153	44
Danbury SD	603	428	71%	370	86%	248	40%	234	14
Fairfield SD	673	570	85%	531	93%	390	64%	372	18
Greenwich SD	620	491	79%	469	96%	407	62%	392	15
Norwalk SD	762	570	75%	503	88%	308	43%	245	63
Stamford SD	1,064	811	76%	729	90%	445	43%	389	56
Stratford SD	511	373	73%	326	87%	238	41%	201	37
6 Wealthiest Towns	1,983	1,764	89%	1,700	96%	1,379	76%	1,351	28
Other Towns	2,625	2,201	84%	2,065	94%	1,582	60%	1,463	119

* Data received from Fairfield County Public School Class of 2012, most recent data available.
† Data received from Fairfield County Public School Class of 2008, most recent data available.

4.11

Opportunity Youth in Fairfield County, 2014

RESIDENTS, AGES 16–19, WHO ARE NOT ATTENDING SCHOOL AND NOT EMPLOYED



Connecticut overall, young people from Fairfield County are more likely to agree that local residents have excellent or good ability to find suitable employment, and a larger share agree that their town has positive role models for children and youth. However, young people from urban areas are less likely to describe local employment opportunities positively, or to agree that there are role models for young people in the community.[132]

Many young people still struggle to obtain employment. The official unemployment rate is 10 percent for Connecticut residents ages 16 to 24.[133] But a quarter of young residents report underemployment — either being unemployed but looking for work, or being employed part-time but preferring full-time work.[134]

4.12

Opportunities for Young People in Fairfield County

RATES AND PERCEPTIONS OF ECONOMIC AND SOCIAL OPPORTUNITIES, PEOPLE UNDER 25

	OPPORTUNITY YOUTH, AGES 16–19	UNEMPLOYMENT RATE, AGES 16–24	UNDER EMPLOYED, AGES 18–24	HAVE ENOUGH EDUCATION IN CAREER, AGES 18–24	BELIEVE JOB OPPORTUNITIES ARE GOOD, AGES 18–24	BELIEVE THERE ARE ROLE MODELS IN COMMUNITY, AGES 18–24
Connecticut	6%	10%	23%	53%	46%	71%
Fairfield County	6%	--	24%	53%	56%	75%
Bridgeport	14%	--	41%	48%	30%	50%
Stamford	3%	--	22%	59%	67%	79%
All Other Towns	4%	--	19%	53%	62%	82%
Males	7%	--	24%	47%	55%	73%
Females	5%	--	24%	59%	58%	79%

Ten percent of this age group is neither employed nor attending school (although the share is lower among 16–19 year olds).[135] These people are not connected to the social and economic opportunities that their peers can access through school or places of employment. They are more likely never to complete high school or college and to experience hardships that cost themselves and their communities, such as chronic unemployment, poverty, or involvement in the criminal justice system.[136] However, members of this group can be called "opportunity youth," because they represent great potential for the community and workforce.[137] There are high concentrations of opportunity youth in urban and periphery areas, particularly in Bridgeport and Stratford.[138] (FIG 4.11)

Depending on where they live, young people in Fairfield County have drastically different degrees of opportunity. The high neighborhood income inequality in the county (see page XX) means that many low-income people live in areas of concentrated poverty.[139] Isolated from the overall regional prosperity, youth residing in concentrated poverty areas have extremely limited access to the economic, educational, and social resources that promote upward mobility.[140] One Harvard study estimated that a low-income child growing up in Fairfield County would earn eight percent less at the age of 26, compared to a low-income child from an average place in the U.S. (where poverty is less concentrated). Conversely, Fairfield County children from high-income families have similar earnings in adulthood as their average counterparts.[141]

Opportunities for young people are also stratified based on gender. Overall, young women in Fairfield County have lower rates of unemployment and are more likely to say that they have enough training and education to advance professionally.[142] More female students complete bachelor's degrees than males at Connecticut universities.[143] These differences build from higher achievement for girls compared to boys during the K–12 education period, including a higher four-year graduation rate.[144]

However, serious disparities in salary and employment opportunities exist for young women. In 2014, about 10 percent of women graduating from four-year Connecticut universities completed STEM majors (Science, Technology, Engineering, and Math), half the share of men (20 percent).[145] In 2012, Connecticut women overall were more likely to work in industries paying low or below-average wages, such as service, arts, education, and community service. Connecticut women earn 78 cents on the dollar compared to men who held the same positions. Pay gaps are even larger for women of color: black and Hispanic women earn 60 cents and 47 cents, respectively, for every dollar that the average white man makes (the highest by median earnings).[146]

ECONOMIC OPPORTUNITY IN FAIRFIELD COUNTY

Health, well-being, and the economy are deeply intertwined. When all other conditions are the same, stronger economic opportunity supports healthier, longer lives. The converse is true as well; healthier lives allow for wealthier lives.

In this section, we examine job trends in Fairfield County, focusing attention on access to jobs that pay a high wage or "living wage"—defined here as over $3,333 per month, or $40,000 per year (though some researchers estimate the county's cost of living to be higher than this level).[147] Sixty percent of county residents earn a living wage, more than the 55 percent of earners statewide who are above this threshold.[148] Access to education, transportation, and financial services all factor into securing good jobs. Finally, we look at changes in wages and industries in the economy.

Jobs Access

Fairfield County supports a truly regional economy where people work and live in different towns, and multiple job hubs vie for workers' labor. No Fairfield town sees a majority of its jobs held by its own inhabitants. Roughly 80 percent of high-wage earners, and 75 percent of low-wage earners (people with monthly income below $3,333), work in a different town from where they live.[149]

The county is closely connected to the broader regional economy as well. Sixteen percent of working residents travel to New York state and another 16 percent work in other Connecticut counties. However, more out of state and out of county workers take jobs in Fairfield County than county residents who leave, such that the county had a net inflow of 18,000 workers in 2014 (equivalent to 5 percent of county jobs).[150] The towns of the southwest generally have more people commuting in from outside towns to work than commuting out. The opposite is true in Bridgeport and north through the lower-density towns of eastern Fairfield County, which have more working residents than they do jobs.[151]

County high-wage jobs are most concentrated in the southwest towns—such as Stamford, Greenwich, Westport, and Wilton—and many more high-wage jobs in New York City are accessible to Fairfield County residents. As a result, working residents generally commute to destinations southwest of their homes for work. This flow is more pronounced among workers earning a living wage. Of the 220,000 high-wage earning residents, 14 percent worked in Stamford and 12 percent commuted to New York City. Further, Stamford residents constitute 9 percent of higher income workers in the county.[152]

Bridgeport is home to the largest population of people working low-wage jobs. Roughly 23,000 leave the city to find work, mainly in neighboring towns. The network for low-wage jobs is more localized than the high-wage jobs network. High-wage earners typically commute farther in major flows that cross the county (e.g. see flows from Stratford to Stamford and from Danbury to Norwalk on the following map); low-wage workers commute to closer towns, generally not crossing more than two town lines. For example, notice how greater Danbury's low-wage workers pinwheel around the core city.[153]

Transportation

Transportation is a major factor in jobs access. Since the development of the Interstate highway system in the 1950s, sprawling development of suburbs and highways has resulted in jobs being physically located farther from the city centers and suburbs where many workers live. The jobs access maps illustrate this, showing that people often do not live where they work.

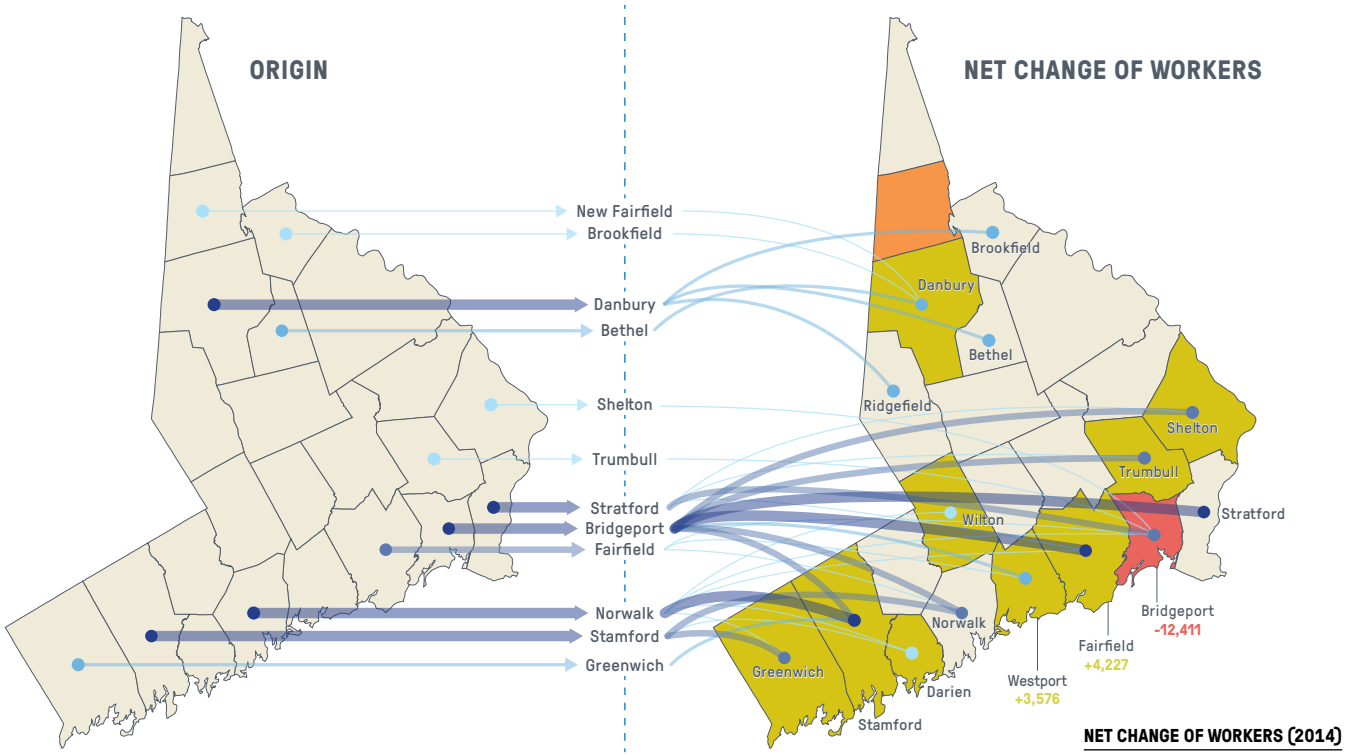
The trends indicate a mismatch between housing and job opportunities. For some, this reflects a trade-off between suburban comfort and commutes; for others, housing in job-rich areas is too expensive to afford.[154] Of note, Fairfield County has some of the lowest levels of job sprawl when measured by proportion of jobs within 3 miles from major city centers.[155]

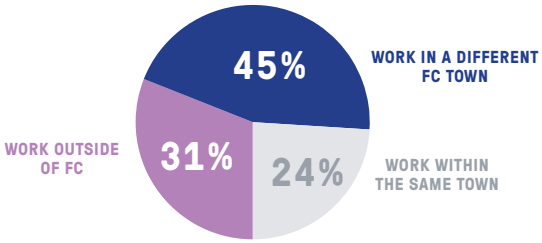
Having access to reliable transportation, whether affordable public transit or a personal vehicle, enables people to take jobs throughout the county and beyond. Access to transportation is tied to income and geography, and can perpetuate inequality. For example, coming from a family of higher earners increases access to cars, which in turn increases access to higher income jobs.

Data from the 2015 DataHaven Community Wellbeing Survey (CWS) show that both age and race are linked to car access. Younger adults tend to have less car access than older adults. More strikingly, white populations are more likely to report having access to a car "very often" or "fairly often" than black or Latino populations, even while considering employment status. Respondents who said they

4.13

Movement of Low-Income Workers (Salary < $40,000)





NET CHANGE OF WORKERS (2014)

- +10,000
- +5,000 TO +9,999
- +1,000 TO +4,999
- -999 TO +999
- -1,000 TO -4,999
- -5,000 TO -9,999
- -10,000

MOVEMENT OF COMMUTERS

- 500 TO 749 COMMUTERS
- 750 TO 999 COMMUTERS
- 1,000 TO 1,999 COMMUTERS
- 2,000 OR MORE COMMUTERS

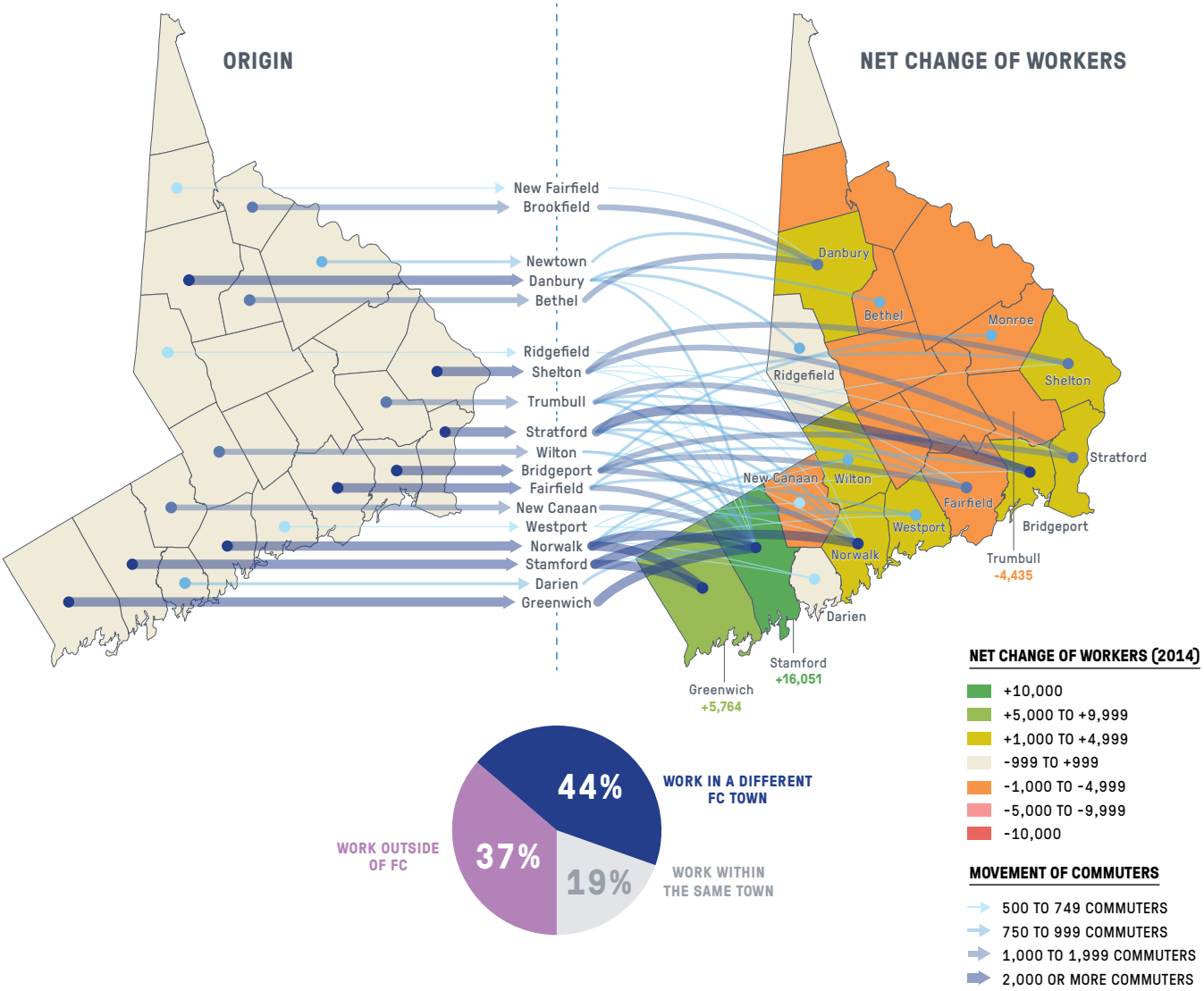
DESTINATIONS FOR WORKERS WHO WORK OUTSIDE OF FC

= 500 PEOPLE

DESTINATION	TOTAL LOW INCOME COMMUTERS	
New Haven County, CT		16,900
New York City (5 Counties)		5,000
Westchester County, NY		4,800
Litchfield County, CT		2,200
Other CT		9,600
Other NY		4,700
Other States		4,300

4.14

Movement of High-Income Workers (Salary > $40,000)



DESTINATIONS FOR WORKERS WHO WORK OUTSIDE OF FC

= 500 PEOPLE

DESTINATION	TOTAL HIGH INCOME COMMUTERS
New Haven County, CT	18,000
New York City (5 Counties)	26,000
Westchester County, NY	12,500
Litchfield County, CT	1,900
Other CT	11,300
Other NY	6,600
Other States	4,400

were seeking employment and were white had greater car access than respondents who said they were employed and were black or Latino.[156]

This is partially explained by household wealth. Compared to an unemployed person of color in Fairfield County, an unemployed white person is roughly twice as likely to live in a household with a total household income over $30,000, and three to four times as likely to live in a household with a total household income over $100,000.[157] Nationally in 2011, the typical white household owned $16 for every $1 owned by a Black household, and $13 for every $1 owned by a Latino household. White adults were also many times more likely to receive large inheritances or gifts.[158]

Limited access to transportation is compounded by limited access to financial services and other financial stressors. The less often a respondent had access to a car, the less likely they had a checking or savings account. The DataHaven Financial Security Index combines responses to eleven survey questions that include access to transportation and financial services. The index also considers whether respondents faced specific financial stressors in the previous 12 months, such as lacking money to provide adequate shelter for their families.[159]

Employed Fairfield County respondents scored 81 points on the index, above the state and overall county averages. Underemployed residents scored 68 on the index, equivalent to residents of the bottom 5th percentile of the state's zip codes in financial security. When disaggregated by race, the disparities are exacerbated.[160]

Underemployment

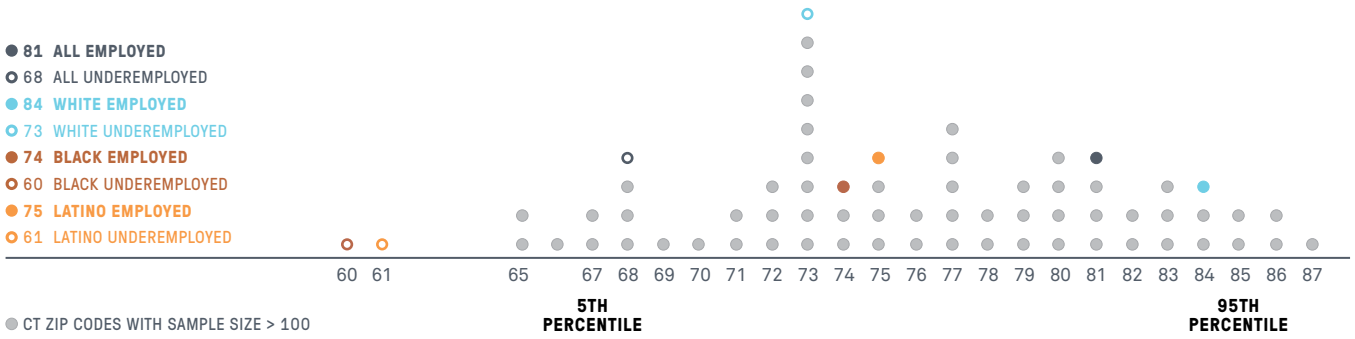
The official unemployment rate measures the proportion of people who are not working but are actively looking for work.[161] This metric excludes people who may feel "discouraged" from looking during the past few weeks, as well as "underemployed" part-time workers who would prefer to work full-time. The DataHaven Community Wellbeing Survey captures the underemployed population as well as the unemployed population of workers. The CWS underemployment rate consists

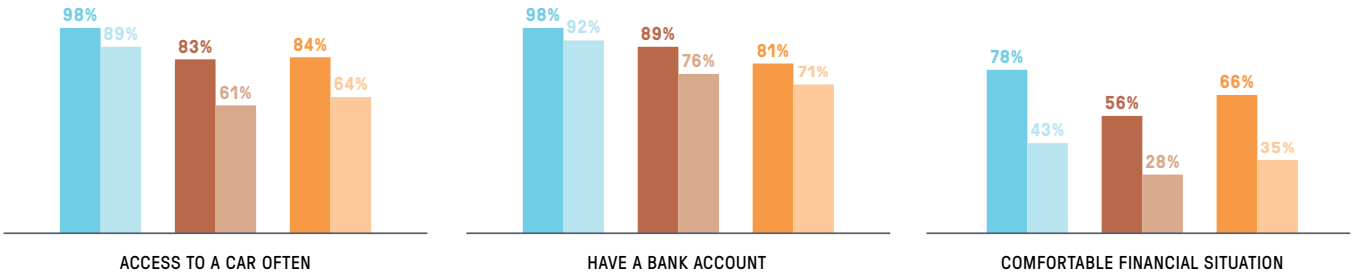
4.15

Financial Security and Underemployment

INDEX SCORE COMPARISON

Financial Security Index for workers living within Fairfield County





of the working-age population that is not employed but actively looking for work, plus those who hold a part-time job but would prefer a full-time job.[162]

In Fairfield County, underemployment stood at 14 percent in 2015,[163] compared to the official unemployment rate of 5 percent.[164] Underemployment rates in the four Fairfield core cities of Bridgeport, Stamford, Danbury, and Norwalk, were much higher than the rest of the county. Those four cities had rates ranging from 14 to 24 percent, whereas the 19 other Fairfield county towns had a combined rate of 10 percent.[165]

Underemployed workers can face some of the same health risks as unemployed individuals; in particular, workers who are employed at a lower wage or hold lower-status jobs experience symptoms of depression, low self-esteem, and low job satisfaction.[166] Underemployment can generally contribute to job-related stress, which can have numerous effects not only on an individual's health, but also on many other areas of their life.[167]

A Changing Economy

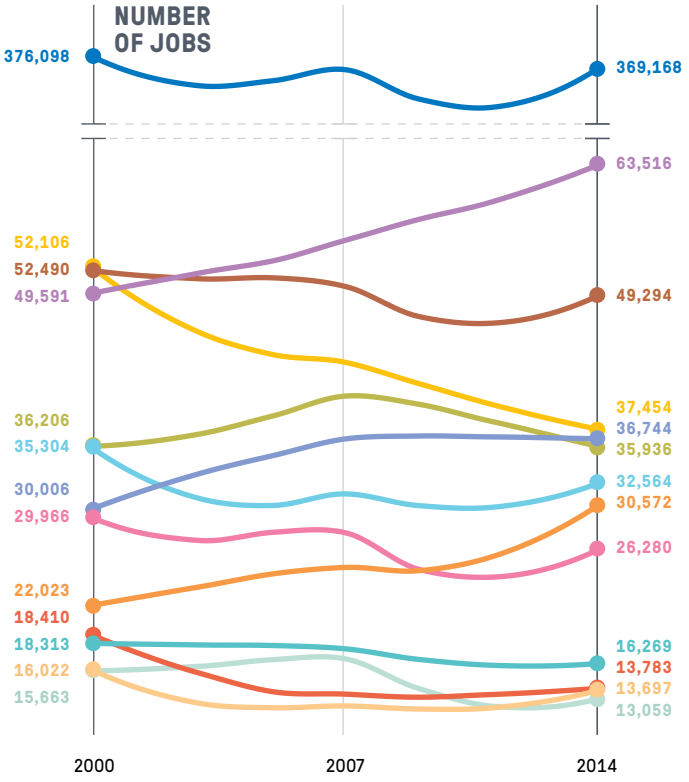
The total number of jobs in Fairfield County has not returned to its 2000 or 2007 highs. In 2014, job figures were roughly one percent below the season-adjusted peak in 2000 and in 2007, representing a net loss of 6,300 jobs since 2007. This reflects a similar pattern of job decline in Connecticut, which experienced employment peaks in 2000 and 2005. Over the past fifteen years, both economies saw two periods of economic decline and two periods of recovery.[168]

Breaking down job counts by industry sectors helps show the overall shape of the economy. In this section and the next, we will examine growth in job counts and then changes in wages.

The Health Care sector posted the strongest growth from 2000 to 2014, adding 14,000 jobs; this was the only sector that added jobs every year, even during the years of the 2008–2010 Great Recession.[169] The demand for health care work has been tied to an aging population and has seen growth throughout the nation.[170] Education

4.16

Jobs and Wage Trends by Sector, 2000–14



2000–14 CHANGE IN WAGES

	2014 WAGES	PERCENT CHANGE	DOLLAR CHANGE
All Industries	$86K	↓ 4%	-$3,854
Health Care and Social Assistance	$54K	↑ 2%	+$978
Retail Trade	$39K	↓ 33%	-$19,079
Manufacturing	$100K	↑ 10%	+$9,309
Educational Services	$58K	↓ 0%	-$155
Finance and Insurance	$258K	↑ 18%	+$38,512
Professional, Scientific, and Technical Services	$114K	↓ 5%	-$5,803
Accommodation and Food Services	$24K	↓ 10%	-$2,529
Administrative Support and Waste Management	$54K	↑ 7%	+$3,524
Wholesale Trade	$114K	↓ 6%	-$6,677
Management of Companies and Enterprises	$213K	↑ 26%	+$44,181
Information	$101K	↑ 4%	+$4,043
Construction	$65K	↓ 8%	-$5,923

and Accommodation & Food Service also added large numbers of jobs (about 7,000 and 9,000 respectively).[171]

Manufacturing declined dramatically, shedding 28 percent, or 14,500, of its jobs. Despite declines since the 1970s, Manufacturing remains one of the largest sectors. Management saw the next largest contraction decreasing by 25 percent (about 5,000 jobs). Every other sector also saw a decline in jobs relative to 2000, with sectors such as Construction taking the hardest hits during the Great Recession.[172]

While the recession clearly had a major impact on Fairfield County's economy, the major trend—a shift from a manufacturing and goods-centered economy to a service-based economy—started before the recession and has continued since. The dominant shift from Manufacturing to Health Care was not particularly impacted by the recession.

The Connecticut Department of Labor projects some of these trends will continue state-wide through 2022. They forecast Health Care will continue to be the fastest growing sector, followed by Educational Services and Professional Services. They also forecast growth in Manufacturing, bucking the 40-year contraction in that sector's employment.[173]

Wages and Payroll

Average wages in each sector help contextualize the changes in job figures. While sector-wide averages mask the wide range of wages among occupations, they provide a useful approximation of the quality of jobs within each industry sector as a whole.[173]

The average wage for jobs located in Fairfield County stood at $85,700 in 2014; this a high average wage for the US, but roughly $9,000 below the county's 2007 average, a fifteen year high (all wages are in 2014 dollars). Wages in Fairfield County's three highest-growth sectors were below average in 2014; they were particularly low—about a quarter of the average—in Food Services. More notably, these sectors' wages have hardly grown since 2000: wages in Health Care and Educational services grew slightly from 2000 to 2004 but have since declined; Food Service wages have declined by 10 percent since 2000.[175] These job counts do include both part- and full-time jobs and could reflect an increase in part-time employment. Similarly, Health Care wages likely reflect an increase in lower paid jobs within the sector such as home care workers. In many shrinking sectors, such as Manufacturing and Management, salaries were above average and have grown.

These trends support the narrative that low-wage jobs are replacing high-wage jobs but also suggest a more nuanced story. Notably, the county's payroll—the total amount in wages paid to all employees working in the county—has not fallen as quickly as one would expect given the changes in job counts. Rising wages in the Finance & Insurance, Management, Professional Services, and Manufacturing sectors help offset a shrinking workforce.[176] Since 2004, economy-wide wage growth in the top-paying sectors offset job loss-driven payroll decline by nearly $600 million.[177]

Since 2000, the Finance & Insurance sector has grown faster in terms of share of total payroll than Health Care, despite major employment growth in the latter. The Finance & Insurance sector made up roughly 10 percent of the workforce in both 2000 and 2014, but the industry share of payroll expanded from 21 percent in 2000 to 26 percent in 2014.[178]

By contrast, the quickly growing Health Care industry accounts for 15 percent of jobs, but only 9 percent of 2014 payroll. Because of this, as the

4.17

Changing Industry Footprints

SHARE OF TOTAL INDUSTRY PAYROLL, BY INDUSTRY SECTOR, IN FAIRFIELD COUNTY

	PAYROLL 2014	SHARE OF PAYROLL 2000	SHARE OF PAYROLL 2014	CHANGE IN SHARE OF TOTAL PAYROLL
Finance and Insurance	$9,300M	21.4%	25.6%	↑ 4.2%
Health Care and Social Assistance	$3,400M	7.0%	9.4%	↑ 2.4%
Educational Services	$2,100M	4.7%	5.9%	↑ 1.2%
Accommodation and Food Services	$700M	1.6%	2.0%	↑ 0.4%
Administrative and Support and Waste Management and Remediation Services	$1,400M	4.1%	3.9%	↓ 0.1%
Management of Companies and Enterprises	$2,900M	8.4%	8.1%	↓ 0.3%
Information	$1,400M	4.2%	3.8%	↓ 0.4%
Construction	$900M	3.0%	2.4%	↓ 0.6%
Wholesale Trade	$1,900M	5.9%	5.1%	↓ 0.8%
Professional, Scientific, and Technical Services	$3,700M	11.3%	10.2%	↓ 1.1%
Manufacturing	$3,700M	12.7%	10.3%	↓ 2.4%
Retail Trade	$1,900M	8.2%	5.3%	↓ 2.9%

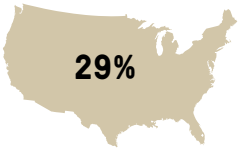
4.18

Educational Attainment

PERCENT OF ADULTS AGE 25+ WITH A BACHELOR'S DEGREE OR HIGHER, 2014

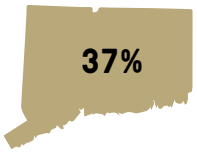
UNITED STATES

29% HAS BACHELOR'S DEGREE OR HIGHER
61,250,000 PEOPLE



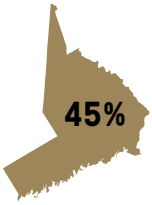
CONNECTICUT

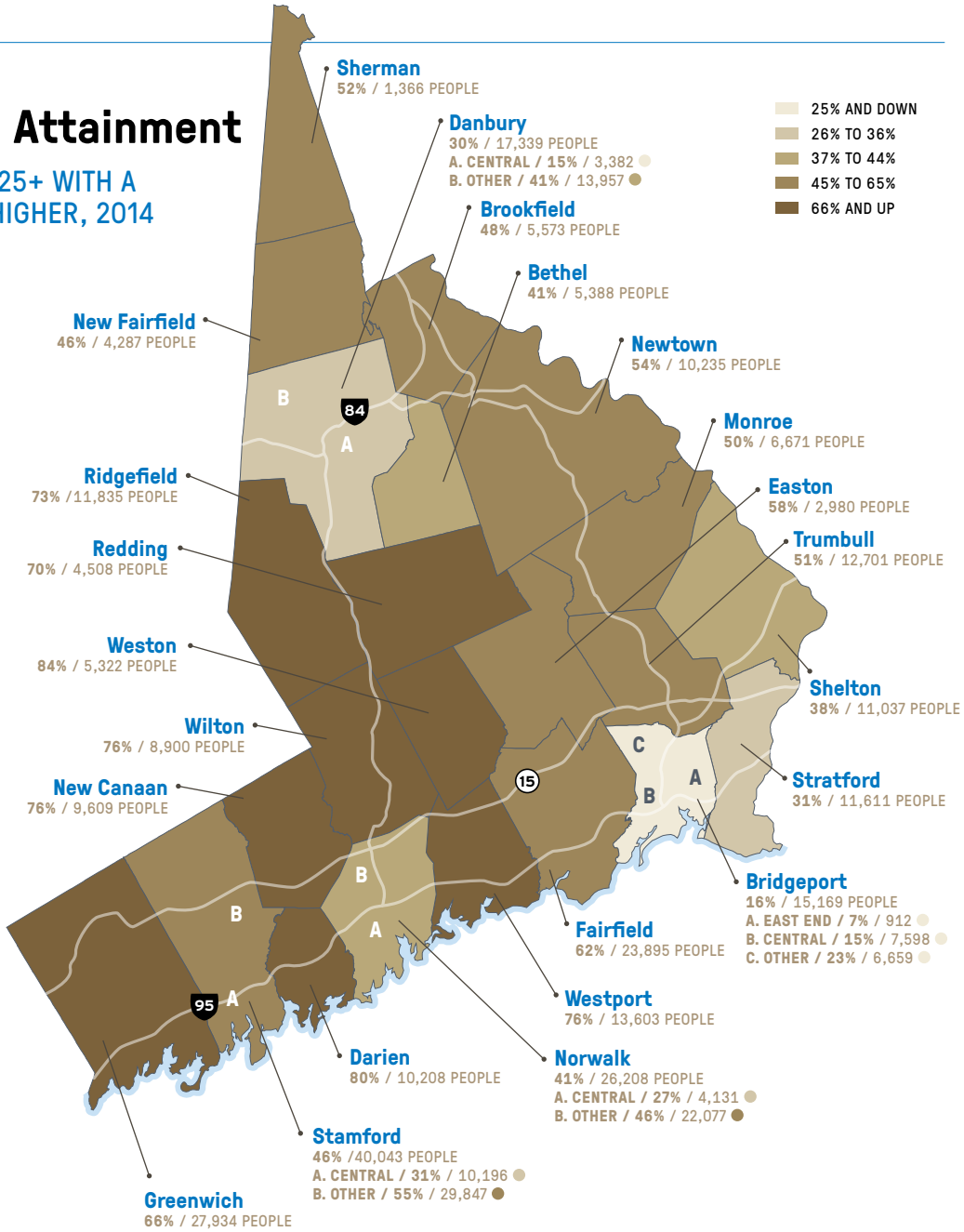
37% HAS BACHELOR'S DEGREE OR HIGHER
908,551 PEOPLE



FAIRFIELD COUNTY

45% HAS BACHELOR'S DEGREE OR HIGHER
286,422 PEOPLE





	HAS LESS THAN HIGH SCHOOL DIPLOMA	PERCENTAGE	HAS BACHELOR'S OR HIGHER	PERCENTAGE	HAS MASTER'S OR HIGHER	PERCENTAGE
United States	28,587,748	14%	61,206,147	29%	23,021,479	11%
Connecticut	257,011	10%	908,551	37%	401,889	16%
Fairfield County	68,186	11%	286,422	45%	125,850	20%
Bridgeport	23,629	26%	15,169	16%	5,732	6%
Danbury	9,962	18%	17,339	30%	7,428	13%
Fairfield	1,688	4%	23,895	62%	10,798	28%
Greenwich	1,888	4%	27,934	66%	13,791	33%
Norwalk	6,850	11%	26,208	41%	10,076	16%
Stamford	11,342	13%	40,043	46%	17,337	20%
Stratford	3,762	10%	11,611	31%	4,328	11%
6 Wealthiest Towns	1,538	2%	59,477	76%	28,525	37%
Other Towns	7,527	6%	64,746	48%	27,835	21%

county economy adds more lower-wage jobs, wage increases for higher-wage employees are expanding income inequality.[179]

Looking to the future, the Connecticut Department of Labor estimates that two of the six fastest growing occupational groups will be low-wage occupations with median wages below $25,000.[180]

Education and the Workforce

Increasing wage inequality by industry sector highlights the relationship between education and job quality. In 2016, a high-school diploma is required for most non-minimum wage jobs, and a college education is necessary for many of the high-paying occupations in Fairfield County.[181] Compared to county residents with at least bachelor's degrees, residents without high school diplomas are nearly three times more likely to be unemployed[182] and have one-quarter to one-third the average earnings.[183] Approximately 43 percent of all workers without four-year degrees report needing more education or training to advance their careers, compared to 15 percent of workers with at least bachelor's degrees.[184]

From 2000 to 2014, Fairfield County saw the proportion of adults without a high school diploma drop 5 percentage points while the proportion who hold at least a bachelor's degree increased by 6 percentage points, translating into a gain of 48,700 residents with college degrees.[185] This trend seems to be driven by a demographic shift: older residents came of age in an era when high school and college degrees were much less common.[186]

Each town within the region experienced shifts towards higher educational attainment. However, significant differences still exist within the region, by race and ethnicity, neighborhood, and income. These disparities are largely due to barriers related to family income and wealth, such as difficulty paying tuition or the K-12 opportunity gap (see the Education chapter).[187] The share of adults over 25 with bachelor's degrees ranges from 16 percent in Bridgeport to 76 percent in the six wealthiest towns.[188]

4.19

Municipal Financial Capacity in Fairfield County

MUNICIPAL TAX CAPACITY AND COST PER CAPITA, 2015, SELECTED TOWNS

	TAX CAPACITY PER CAPITA	MUNICIPAL COST PER CAPITA	MUNICIPAL SURPLUS PER CAPITA
Bridgeport	$620	$1,788	↓ $1,168
Danbury	$1,130	$1,328	↓ $198
Fairfield	$2,265	$1,381	↑ $884
Greenwich	$6,575	$1,465	↑ $5,110
Norwalk	$1,850	$1,532	↑ $318
Stamford	$2,229	$1,585	↑ $644
Stratford	$1,203	$1,502	↓ $299

COMMUNITY LIFE, LOCAL GOVERNMENT, & CIVIC ENGAGEMENT

From Greenwich's leafy estates to Bridgeport's urban center, Fairfield County has many different communities, with varying traditions, public resources, and physical spaces—leading to different perceptions of community health among its people.

What constitutes community health? For the people in it, a sense of community grows through relationships with friends and family, volunteering, and trust in others.[189] Civic engagement—the process by which people participate in community life and local affairs—improves the government's ability to solve public problems. A community that makes its members feel safe, included, and active also improves health and social connections, as public spaces and places for recreation encourage people to interact with one another and to exercise.[190]

Community resources can even mitigate economic and social inequalities by providing essential services, from schools to transportation to computers in public libraries. On the other hand, access to resources can exacerbate disparities between towns, because wealthier towns generally can support more and higher-quality resources. In Fairfield County, countywide assessments of community well-being can hide striking differences between individuals and towns.

Financial Capacity

Local government services—including education, public safety, parks, libraries, cultural events, and infrastructure maintenance—are supported by revenue from taxes and fees as well as state and federal government grants. The revenues of local governments in Fairfield County vary significantly because they rely heavily on property tax and have very different tax bases.[191]

For example, the local government in Greenwich, which has by far the most valuable property in the state, can support high-performing schools and other government services with relatively low tax rates. Property there is so valuable that if the property tax rates across Fairfield County were the same, Greenwich would still collect ten times the revenue of Bridgeport.

But tax rates are not the same; towns with less valuable property must tax each property at higher rates to support local budgets. New England Public Policy Center research shows that the per-person cost for basic quality public services is highest in urban areas. This suggests that structural costs come with providing services in cities—which already have limited taxing capacities that disadvantage local administrations regardless of their policies.[192]

Public Institutions—Libraries

Use of traditional library services has decreased in Fairfield County overall over the past decade, mirroring a downward trend statewide. The decrease occurred even though the operating incomes for libraries increased by 16 percent from 2002 to 2015. Annual visits to libraries decreased, for every system in the county except for Norwalk. Countywide, visits dropped by 13 percent, from 8 per person in 2002 to 7 per person in 2015. Similarly, annual circulation per person dropped at the county level, although the libraries in some of the larger towns — Greenwich, Danbury, Norwalk, and Fairfield — had higher rates of circulation in 2015 than in 2002.

That said, an increasing number of patrons are using libraries for services other than borrowing books. From 2002 to 2015, Fairfield County libraries doubled the number of free programs offered to patrons—classes, lectures, concerts, clubs, and other activities—and saw a 75 percent increase in attendance at such programs.

Libraries receive funding from local taxes as well as private contributions and government grants. Rates of use of library services are strongly and positively correlated with a library's operating budget; libraries in the wealthiest towns have the highest budgets and generally see more use than those in other suburbs, while major city libraries, in Bridgeport and Danbury in particular, have lower budgets and lower levels of use.[193]

Fairfield County libraries have $75 on average to spend per person per year, compared to $53 statewide. Greenwich libraries, however, have per-person operating incomes of $192 dollars per person per year, while Bridgeport libraries have $47 per person, and Danbury libraries have $25. In 2015, libraries statewide lent out (or circulated) an average of 8 items per person, compared to 10 items per person in Fairfield County that year. Greenwich libraries had a circulation rate of 24 borrowed items per resident, four times the number of items circulated per resident at libraries in the county's four major cities and eight times the number in Bridgeport.

Perceived Access to Community Resources

The 2015 DataHaven Community Wellbeing Survey (CWS) found that overall, the county's residents are satisfied with their community's resources. Eighty percent of adults rated the availability of goods and services that meet their needs as "excellent" or "good." The same percentage of adults reported that public parks and recreational facilities in their towns were in excellent or good condition. Sixty-nine percent of residents reported sometimes or often going to concerts, museums, or other cultural events, compared to 66 percent statewide. That three-quarters of Fairfield County residents believe their town is an excellent or good place to raise children—slightly above the percent of residents statewide who feel this way—further indicates overall satisfaction with communities and the resources they provide. Overall, Fairfield County

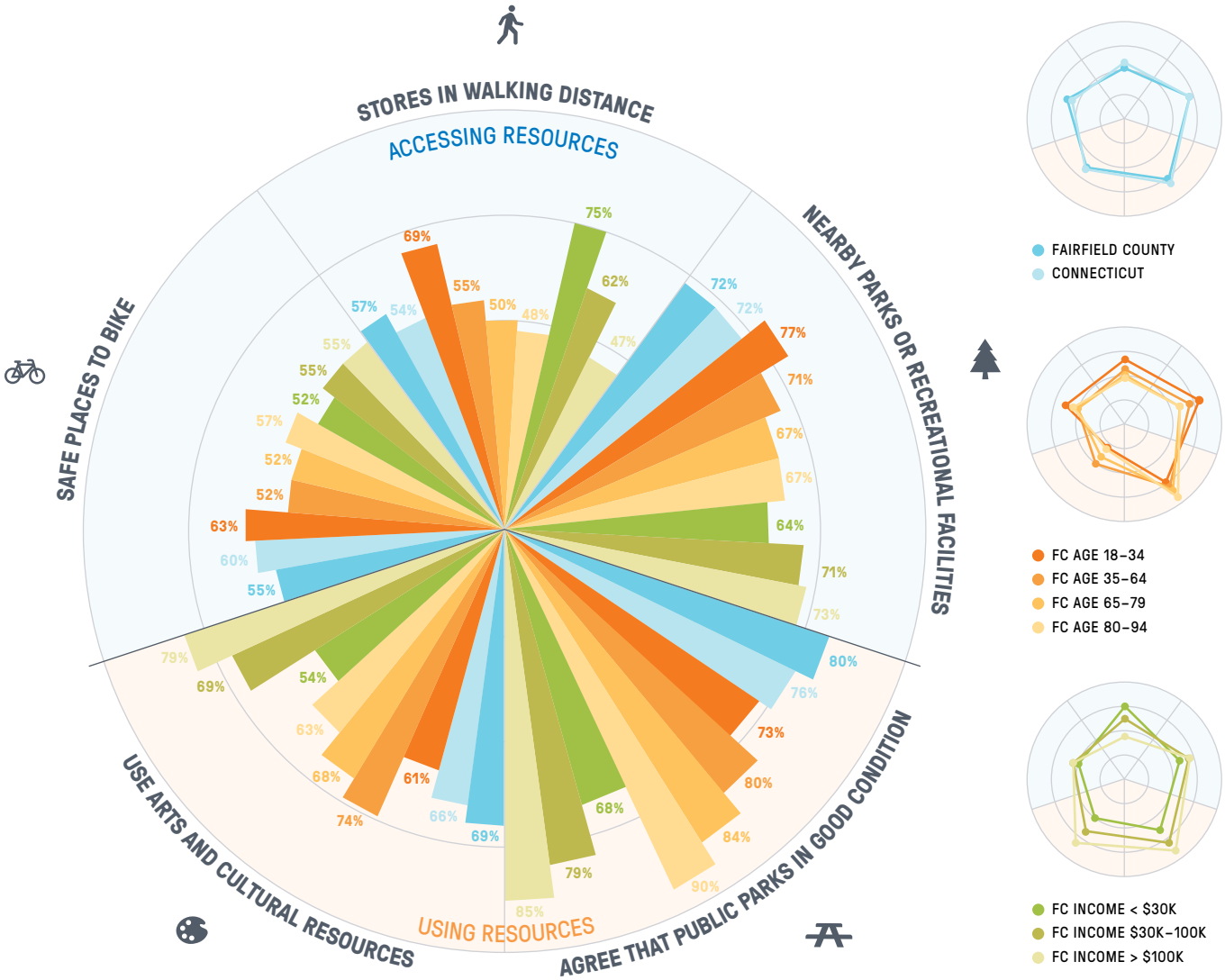
A CLOSER LOOK AT WALKABILITY

These scores can be explained by geography. Low-income respondents are more likely to live in the region's urban neighborhoods, which tend to be dense and walkable, while the wealthiest respondents are more likely to live outside of the four largest cities. Residents of the urban core are 20 percentage points more likely to say there are many places to go in easy walking distance than people living in the rest of the county. Yet, even outside of the core cities, low-income populations report better access to sidewalks and are more likely to say there are many easily walkable places in their neighborhood. At the same time, low-income city residents report much lower levels of neighborhood public safety than their wealthy suburban counterparts.

4.20

Perceived Access and Use of Community Resources

2015 COMMUNITY WELLBEING SURVEY, PERCENT OF ADULTS AGE 18+



residents scored a 67 the Quality of Society Index, which summarizes several of these factors—although results are mixed between towns. For example, residents of Greenwich scored a 78, while Bridgeport residents scored a 49.[194]

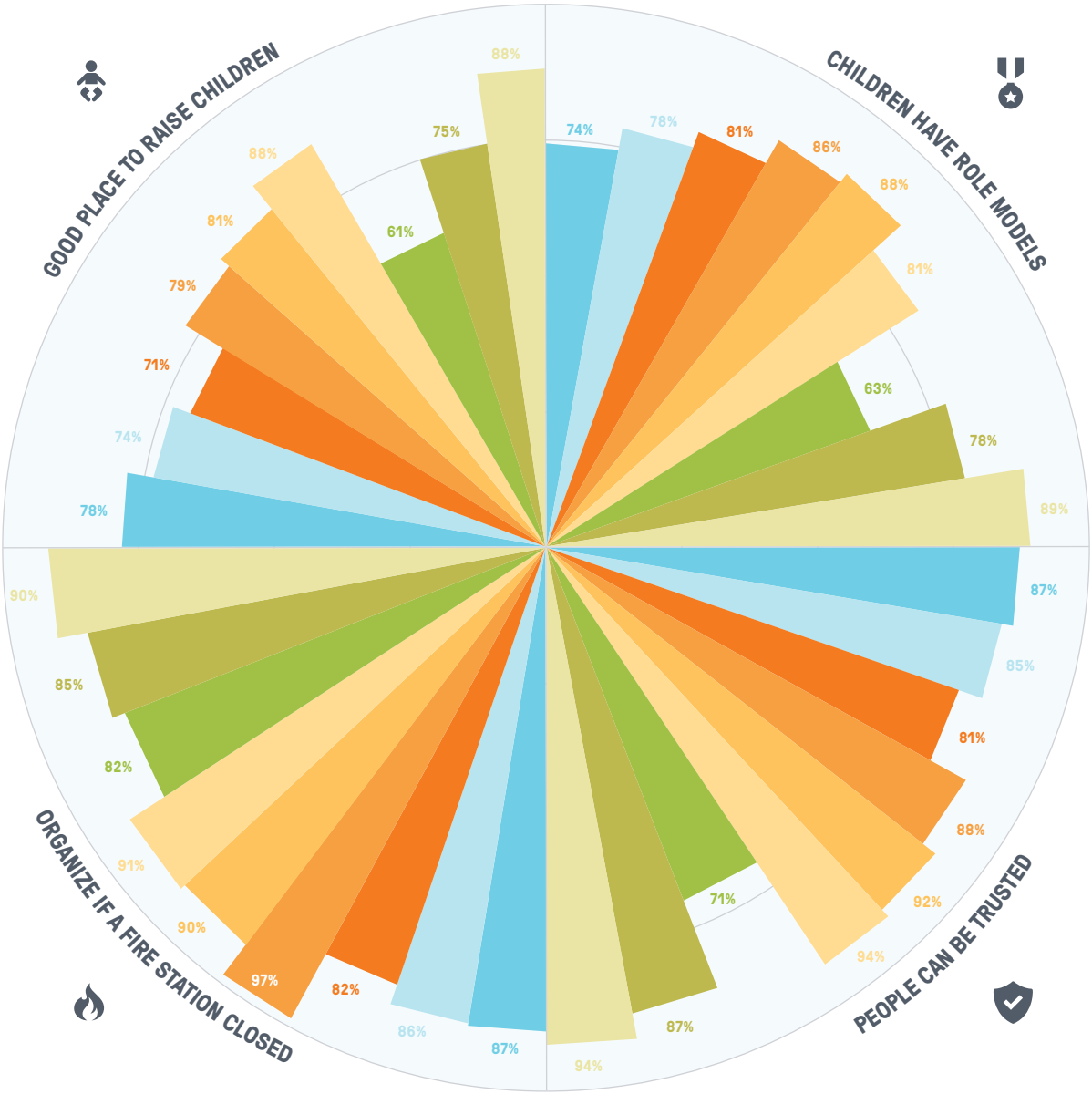
Access to community resources, however, is linked to income, with wealthier people perceiving that they enjoy greater access to goods and services, cultural events, and well-maintained recreational facilities. Fairfield County residents with household incomes over $100,000 reported enjoying these resources at rates about 15 to 35 percentage points higher than those earning less than $30,000.

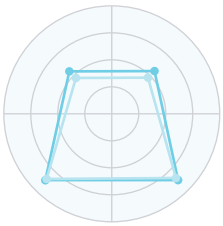
Income based-disparities are less evident when looking at measures such as "walkability." This concept includes dimensions—such as physical proximity to destinations, infrastructure for walking and biking, and perceived public safety—that have been shown to significantly influence how much people walk and exercise.[195] The DataHaven Walkability Index is calculated based on several of these factors.[196] Across all income levels, Fairfield County residents reported similar

4.21

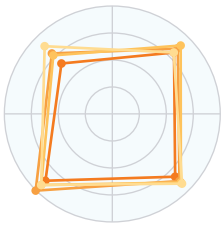
Perceived Community Cohesion

2015 COMMUNITY WELLBEING SURVEY, PERCENT OF ADULTS AGE 18+

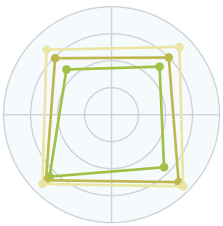




- FAIRFIELD COUNTY
- CONNECTICUT



- FC AGE 18–34
- FC AGE 35–64
- FC AGE 65–79
- FC AGE 80–94



- FC INCOME < $30K
- FC INCOME $30K–100K
- FC INCOME > $100K

levels of walkability in their neighborhoods: adults from households earning less than $30,000 had an average walkability score of 61, slightly above the score of 58 among respondents earning over $100,000.

These scores can be explained by geography. Low-income respondents are more likely to live in the region's urban neighborhoods, which tend to be dense and walkable, while the wealthiest respondents are more likely to live outside of the four largest cities. Residents of the urban core are 20 percentage points more likely to say there are many places to go in easy walking distance than people living in the rest of the county. Yet, even outside of the core cities, low-income populations report better access to sidewalks and are more likely to say there are many easily walkable places in their neighborhood. At the same time, low-income city residents report much lower levels of neighborhood public safety than their wealthy suburban counterparts.

Perceptions of Community Cohesion

Community cohesion—the degree to which residents feel connected, included, and invested in where they live—is linked to higher individual wellbeing as well as less crime and improved public health. Further, a cohesive community may fare better when facing recessions or other economic hardships.[197]

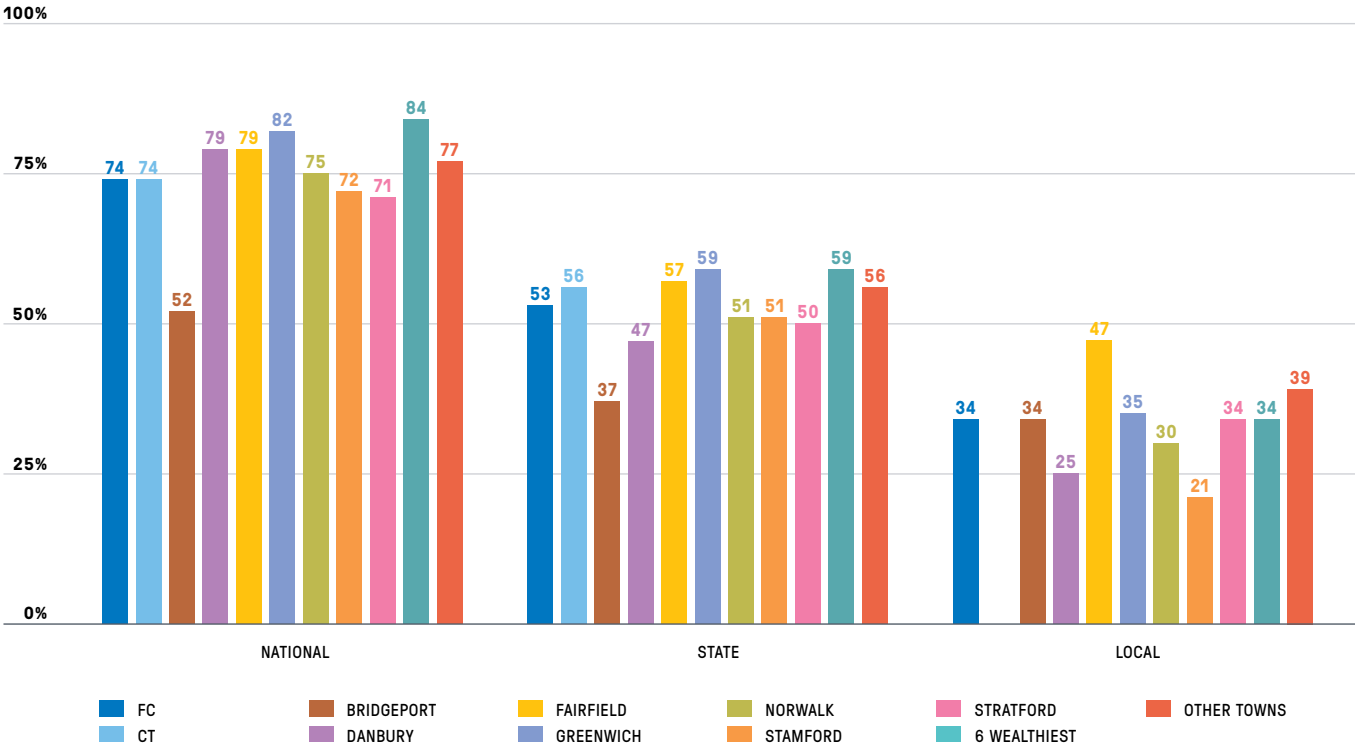
In the 2015 CWS, 94 percent of Fairfield County adults reported having relatives or friends they can count on. This figure is statistically equal across all towns, ages, races, and ethnicities, suggesting that the vast majority of area residents are at least close to one or two others in their community.

Overall, between 80 to 87 percent of adults report trusting neighbors, having neighbors who could work together, and having confidence in police—all measures of community cohesion. However, within the county, people with low household incomes were less likely than wealthier adults to report trust in neighbors and effective local government. There were similar disparities based on age, race and ethnicity, and education

4.22

Voter Turnout in Fairfield County

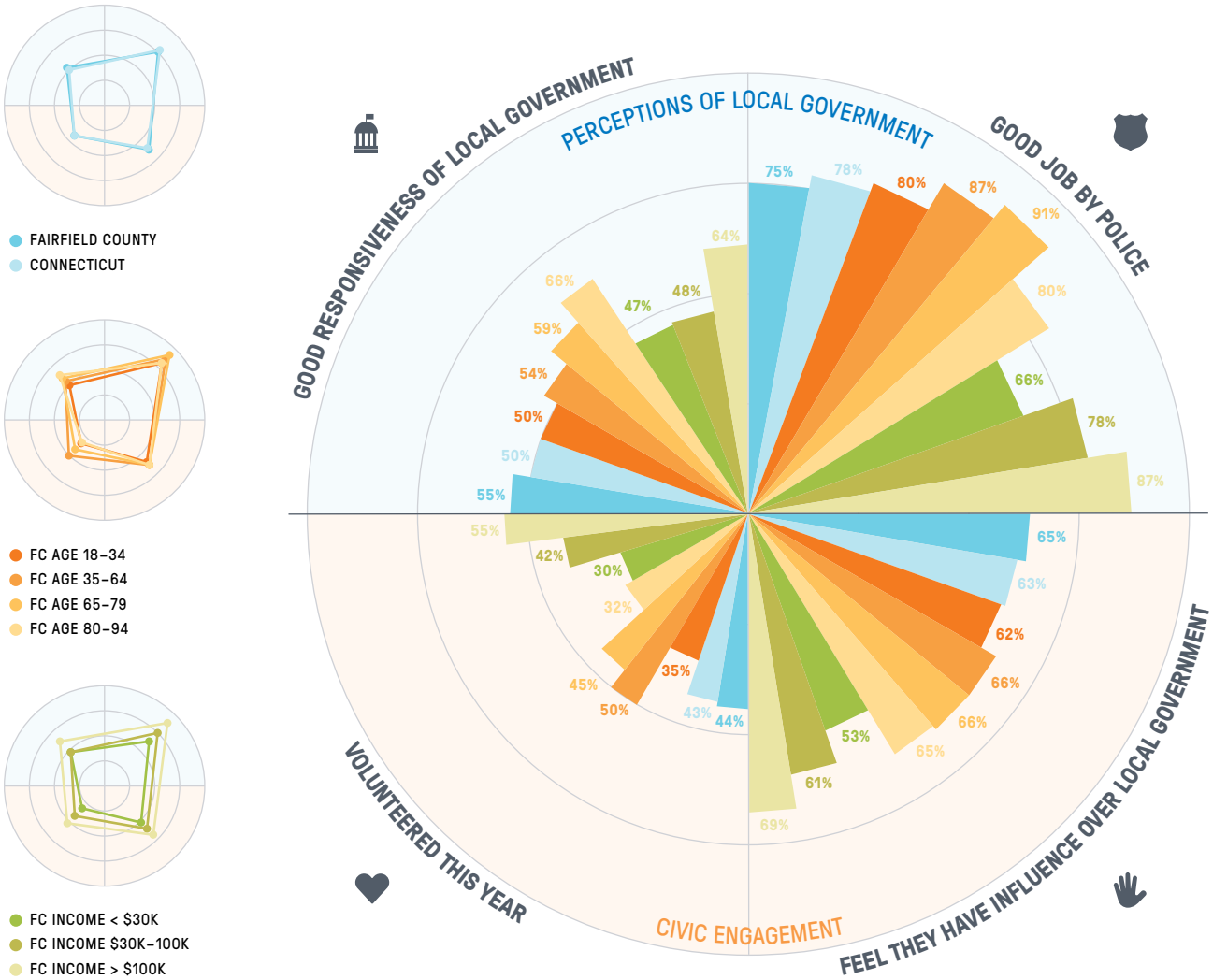
PERCENT OF REGISTERED VOTERS WHO VOTED IN VARIOUS ELECTIONS, 2012–2015, BY TOWN



4.23

Civic Engagement and Government

2015 COMMUNITY WELLBEING SURVEY, PERCENT OF ADULTS AGE 18+



levels —characteristics linked to income. On the trustworthiness of neighbors, CWS data show a 24 percentage-point gap between respondents with household incomes under $30,000 and those with over $100,000. On police efficacy, there was a 21 percent gap between these income groups.

By town, Fairfield County adults expressed different perceptions of cohesion with their neighbors and local government, even after controlling for household income. For example, of people who earned less than $30,000 and who lived in one of the four major cities, 66 percent thought their neighbors could be trusted, compared to 81 percent of people in the same income category but living in the other towns in Fairfield County. This finding suggests that characteristics of a neighborhood or town may be stronger determinants of how connected people feel to that community than personal income.

Voting and Volunteering

Fairfield County residents have similar rates of civic engagement as the state overall, and are slightly more likely to be engaged than national averages.[198] The rate of volunteerism—44 percent of county adults reported volunteering to address needs in their community in the last year—is equal to the state.[199] Also, registered county voters are equally as likely to vote in elections as voters statewide.[200]

Following national trends, among registered voters in Fairfield County, voter turnout varies significantly with the type of election: the higher the office to be elected, the higher the voter turnout. According to state voting data, 74 percent of registered county voters voted in the 2012 presidential election while 53 percent voted in the 2014 midterm gubernatorial elections. Turnout declined to 34 percent of registered voters for the most recent local elections in 2015.[201]

Statewide data indicate that civic engagement is correlated with socioeconomic status: as personal income and educational attainment increase, so do rates of volunteering, voter registration, and turnout.[202] Town-level voter turnout rates reflect this trend. They are lowest in Bridgeport, at 52 percent for the 2012 election and 37 percent for the 2014 election; they are highest in the six wealthiest towns, at 84 percent for the presidential election and 59 percent for the midterm election. Voter turnout in the 2015 local elections however, rebukes this pattern, as Bridgeport and the six wealthiest towns overall had the same turnout rates as the county average.[203] Younger adults, in addition to adults with low household incomes, were less likely to report registering to vote or volunteering,[204] which is consistent with a national pattern that younger adults are less likely to be civically engaged.[205]

Government Effectiveness and Inclusion

In Fairfield County, perceptions of government effectiveness are stratified based on age and socioeconomic status, showing the same disparities as in voting and volunteering rates.[206]

According to the CWS, 55 percent of residents overall described the local government's responsiveness to residents' needs as excellent or good. Younger adults and poorer adults reported lower levels on these metrics.[207]

Sixty-five percent of Fairfield County residents reported having at least a little influence over local government decision-making, but fewer adults with incomes below $30,000 (53 percent). Further, 59 percent of people of color responded that they had influence over local government, compared to 67 percent of white respondents.

Having elected officials whose demographics mirror the population as a whole is necessary for truly representative policies and government decision-making.[208] If people or groups have below-average perceptions of government inclusiveness and efficacy, it may reflect that they are underrepresented in government and public office. For example, 95 percent of elected officials nationally are over the age of 35.[209] In Connecticut, Hispanics are underrepresented on state boards and commissions, holding less than 4 percent of positions despite making up 13 percent of the population overall.[2010]

Women in Fairfield County are as likely as men to positively describe government effectiveness and their ability to influence government decisions. However, they are also underrepresented in local government: only 17 percent of top local officials in Fairfield County are women (even lower than 22 percent statewide). Statewide, one third of full-time government officials or administrators in local and state government are women.[211]

CHAPTER 5

Conclusion & Endnotes

Conclusion

Fairfield County performs above average on many national and state measures of quality of life and economic opportunity. Public school students have better on-time graduation and college attendance rates. Workers employed in the region have higher average wages than workers elsewhere in the country. Across all towns, residents feel connected to others in their community. As the previous chapters show, Fairfield County residents are healthy compared to other Connecticut residents or the nation as a whole, with significantly higher life expectancies and lower rates of smoking, early-onset chronic disease, and death from conditions such as heart disease and cancer.

Despite its overall affluence, Fairfield County is among the nation's most unequal metropolitan areas. Inequities in well-being appear when evidence is stratified by income, age, race, gender, and zip code. These differences are often most apparent after considering data that were collected specifically for the age groups and neighborhoods that are most impacted. The median household income in Weston is seven times higher than that of the East Side of Bridgeport. In recent years, the percentage of young children who live in low-income families has risen and wage inequality has continued to rise. Many residents of distressed neighborhoods experience risk factors, chronic diseases, and rates of premature mortality that far exceed those of the surrounding area. These differences may be viewed as opportunities to improve quality of life throughout the region as a whole.

Certain issues demand our immediate and collective attention. Neighborhood distress, poor health, and financial insecurity documented in parts of Fairfield County are disconcerting in their own right. Yet they also impact the ability of young children to grow up as healthy, happy, and productive adults, impacting the region's long-term outlook. During the first three years of life, the human brain reaches 80 percent of its full size and forms connections whose strength and number, which depend heavily on the child's environment, ultimately impact the child's learning and other cognitive abilities.[x] For example, speech sounds activate language-related parts of the brain; the more caretakers talk to or read with a child, the stronger and more numerous will be the connections formed in that child's brain. Infants and toddlers need nurturing, language-rich, and social settings, whether inside or outside their homes. For working parents, meeting these needs often requires high-quality child care and preschool programs. Such programs continue to foster children's brain development that starts at birth by developing the social-emotional skills and executive functioning necessary for success in school and in life. They also expand children's language and literacy, math, and fine-motor skills. Access to high-quality early care and education is particularly important for children exposed to adverse experiences. Young children who experience neglect or abuse, the absence of a loved one, unsafe or polluted surroundings, or exposure to "toxic neighborhoods" may not only suffer emotional instability or physical distress, but also disrupted brain development.[x] Access to high-quality early care and education settings can help children avoid these negative long-term outcomes by promoting healthy brain development.

At the other end of the age distribution, Fairfield County's large and growing population of senior citizens will present new opportunities and challenges for the region's families and communities in the coming years. With many adults living substantially longer than they are able to drive on their own, this population will need social support, civic engagement, medical care, transportation, and housing options that are tailored to their needs.

Improving the quality of transportation networks, employment prospects, civic and educational infrastructure, and fair and affordable housing choices can enhance well-being among children and adults of all ages and abilities.

A COMMUNITY INDICATORS APPROACH

One of the most effective approaches to improving communities is to build collaborative groups of citizens who seek to build consensus using a "community indicators" program. These programs can monitor progress and provide objective information about collective challenges on a continuous basis. Community indicator projects have been on the rise in the past three decades; more than ever, neighborhoods are using data to inform local policies and bring about community change.

The work of DataHaven and its multi-sector partners around the Fairfield County Community Wellbeing Index is one effort to create collaborations with local partners to allow the development of appropriate measurements for our evolving communities. Our organization also provides a platform and technical assistance resource that neighborhoods may use to decide which indicators best represent them. We hope that you will layer the information in this report with your own stories, and use it to take action in your community.

NOTES ON FIGURES

CHAPTER 1. INTRODUCTION

1.1. **Personal Wellbeing Index and Community Index.** DataHaven analysis (2016). The Personal Wellbeing Index and Community Index were both developed by DataHaven based on the 2015 DataHaven Community Wellbeing Survey (CWS) and U.S. Census Bureau American Community Survey 2014 5-Year estimate data for the individual towns of Bridgeport, Stratford, Danbury, Norwalk, Stamford, and Fairfield, plus aggregate groupings of towns that are also used elsewhere in this report: "6 Wealthiest" includes the six towns in Fairfield County with the highest median household incomes, which are Darien, New Canaan, Ridgefield, Weston, Westport, and Wilton; throughout the report, "Other Towns" include all other towns in Fairfield County that are not already listed individually. The Other Towns all share the characteristics of being relatively wealthy suburban communities such as Bethel, Monroe, New Fairfield, Newtown, Redding, Shelton, and Trumbull. Additionally, we have defined neighborhood groupings or statistical areas within the towns of Bridgeport, Norwalk, and Stamford based on the median income, density, and poverty rates of each city's Census Tracts. Within these areas, Census Tract-level Census data was used to define physical boundaries of each area and to calculate all Census-derived indicators for each aggregate statistical area. For Community Wellbeing Survey derived estimates, neighborhood areas were developed based on the large number of responses from adults living within each town, broken down by zip code of residence that most closely matched the corresponding Census Tract boundaries. These groupings were Bridgeport East End (Tracts 735, 736, 738-744; zip codes 06607 and 06608 for CWS data), Central (Tracts 702-722, 730-734, and 2572; zip codes 06604, 06605, 06610, 06650 for CWS data), and Other (701, 723-729; zip code 06606 for CWS data); Norwalk Central (Tracts 434, 437, 440, 441, 444, 445; zip codes 06850 and 06854 for CWS data) and Other (Tracts 425-433, 435, 436, 438, 439, 442, 443; zip codes 06851, 06853, and 06855 for CWS data); and Stamford Central (Tracts 201, 214, 215, 217, 218.02, 221-223, zip codes 06901, 06902, 06906, 06910 for CWS data) and Other (Tracts 202-213, 216, 218.01, 219, 220, 224; zip codes 06903, 06905, 06907 for CWS data). For Danbury, a Central and Other grouping of neighborhoods was also developed using the same method based on Census Tracts, and appears in some of the maps within this report that display Census data. However, the Danbury Central (Tracts 2101-2103, 2106, 2107.01, 2107.02) and Other (Tracts 2104, 2105, 2108-2114) areas were not scored in the Personal Wellbeing Index or Community Index because the town has only two major zip codes and the number of responses from Community Wellbeing Survey interviews of randomly-selected adults living there was relatively smaller (400 completed interviews in Danbury, versus 600 to 1,010 completed interviews in each of the three other cities shown). Due to the complexity of neighborhood data, Index scores and raw data for these neighborhood groupings are best treated as rough estimates, even though they clearly illustrate that the differences by neighborhood within a town are often greater than differences between one town and any other town. The Personal Wellbeing Index is calculated based on several survey questions regarding self-rated health, life satisfaction, mood, free time, and connection to others (see previous page of report). Similarly, the Community Index is based on 12 key indicators from survey responses and Census data, as listed in the figure. Note that several indicators of the Community Index are indices themselves—the Financial Security Index, Walkability Index, and Quality of Society Index are each calculated to summarize multiple indicators for ease of comparison. Each of these indices are normalized from 0 to 1, where 1 represents an ideal outcome. Additional detail on data and methods for the 2015 DataHaven Community Wellbeing Survey are posted at DataHaven (http://www.ctdatahaven.org/reports/datahaven-community-wellbeing-survey) and data and methods for the U.S. Census American Community Survey are posted at census.gov.

1.2. **Community Index Components Data Value.** DataHaven analysis (2016). See note for Figure 1.1 for definitions of each geographic area in the table. As described in the above note and in the report text, the raw percentages presented for college degree attainment, commute times, Pre-K enrollment, opportunity youth, severe housing cost burden, and low-income children are calculated by DataHaven directly from the U.S. Census Bureau American Community Survey 2014 5-Year estimates, whereas raw percentages presented for smoking, obesity, under-employment are directly from the 2015 DataHaven Community Wellbeing Survey's population-weighted estimates. For example, the table shows that the smoking rate among all adults in Connecticut was 15 percent in 2015. The personal well-being, financial security, walkability, and quality of society indices are derived from a larger set of responses to the Community Wellbeing Survey within each area and in this table are normalized from 0 to 1, with scores of 1 representing an ideal outcome. Further details on each of these indicators is given over the course of this report (refer to pages shown for each indicator in Figure 1.1) or are available from DataHaven upon request.

1.3. **State Rankings.** Table is compiled from the most recently-published rankings of the fifty U.S. states as of May 2016. These sources were chosen by DataHaven based on a comprehensive review of available national rankings and the author's assessment of the validity of each published source. Documents cited in the table are available online from the websites of the organizations cited, or from DataHaven.

CHAPTER 2. A CHANGING REGION

2.1. **Population and Growth in Fairfield County.** DataHaven analysis (2016). 1990 figures are from the U.S. Census Bureau Decennial Census, Table P1, Total Population. 2014 population figures are from U.S. Census Bureau American Community Survey 2014 5-year estimate, Table B01001, Sex by Age. Tables available at http://factfinder2.census.gov/. 2000 median age from Decennial Census. 2014 median age from U.S. Census Bureau American Community Survey 2014 5-year estimate, Table B01002, Median Age by Sex.

2.2. **The Changing Age Structure of Fairfield County.** DataHaven analysis (2016). 1990 and 2000 figures are from the U.S. Census Bureau Decennial Census, Table P012, Sex by Age. 2014 figures are from U.S.

Census Bureau American Community Survey 2014 5-year estimate, Table B01001, Sex by Age. Tables available at http://factfinder2.census.gov/. 2025 projections are from the Connecticut State Data Center at the University of Connecticut Libraries Map and Geographic Information Center (2012). 2015-2025 Population Projections for Connecticut at State, County, Regional Planning Organization, and Town levels—November 1, 2012 edition. Retrieved from http://ctsdc.uconn.edu/2015_2025_projections/.

2.3. **Race and Ethnicity in Fairfield County.** DataHaven analysis (2016). 2010 U.S. Census Bureau Decennial Census, Table P2, Hispanic or Latino, and Not Hispanic or Latino by Race, available at http://factfinder2.census.gov/. Geographies are defined in the note for Figure 1.1; please note that in this chart, Other Towns includes the towns of Fairfield and Stratford as well as all other towns not included in the other geographies shown. Please note that while the majority of the population-related data and text presented in this report is derived from 2014 U.S Census Bureau American Community Survey data, this chart uses 2010 Decennial Census data because of the need to present more detailed data by age and race/ethnicity.

2.4. **Fairfield County's Foreign-Born Population.** DataHaven analysis (2016). 2000 figures are from U.S. Census Bureau Decennial Census, Table PCT019, Place of Birth for the Foreign-Born Population. 2014 figures are from the U.S. Census Bureau American Community Survey 2014 5-year estimate, Table B05006, Place of Birth for the Foreign-Born Population in the United States, available at http://factfinder2.census.gov/. Please note that the concept for this graphic was initially developed as part of a 2015 report also written by the authors of this report, and published by The Community Foundation for Greater New Haven and DataHaven, entitled *Understanding the Impact of Immigration in Greater New Haven* (http://www.ctdatahaven.org/reports/understanding-impact-immigration-greater-new-haven).

2.5. **Characteristics of Immigrants in Fairfield County.** DataHaven analysis (2016). 1990 population figures from U.S. Census Bureau Decennial Census, Table P021, Place of Birth by Citizenship Status. U.S. Census Bureau American Community Survey 2014 5-year estimate, Table B05007, Place of Birth by Year of Entry by Citizenship Status for the Foreign-Born Population; Table B06009, Place of Birth by Educational Attainment in the United States; Table B05013, Sex by Age for the Foreign-Born Population; Table B05006, Place of Birth for the Foreign-Born Population in the United States. Tables available at http://factfinder2.census.gov/.

2.6. **The Changing Household Structure of Fairfield County.** DataHaven analysis (2016). 1990 and 2000 figures from U.S. Census Bureau Decennial Census, Table P015, Family Type by Presence of Own Children Under 18 Years of Age by Age of Own Children or equivalent SF1 dataset. 2014 figures from U.S. Census Bureau American Community Survey 2014 5-year estimate, Table B11003, Family Type by Presence and Age of Own Children Under 18 Years. Tables available at http://factfinder2.census.gov/.

2.7. **Income and Income Inequality in Fairfield County.** DataHaven analysis (2016). U.S. Census Bureau American Community Survey 2014 5-year estimate, Table B19080, Household Income Quintile Upper Limits and Table B19013, Median Household Income in the Past 12 Months (in 2014 Inflation-Adjusted Dollars), available at http://factfinder2.census.gov/. Differences shown are the 20th and 80th percentiles of household income for each town. For privacy, the Census suppresses data for very high incomes at the town level; as such, some towns' top incomes are only available as "$250,000+."

2.8. **Growing Neighborhood Income Inequality in Fairfield County.** DataHaven analysis (2016) of household income and population data by Census Tract. Due to changes in Census Tract boundaries over time, in order to allow comparability to current Census Tract data, the 1980, 1990, and 2000 figures from U.S. Census Bureau Decennial Census are provided by Neighborhood Change Database (NCDB) created by GeoLytics and the Urban Institute with support from the Rockefeller Foundation (2012), a dataset that is designed to hold neighborhood-level geographic boundaries constant over time. 2014 figures from U.S. Census Bureau American Community Survey 2014 5-year estimate, Tables B01003 Total Population, B17001 Poverty Status in Past 12 Months by Age, B11012 Household Type by Tenure, B19127 Aggregate Income in Past 12 Months for Families (in 2014 Inflation-Adjusted Dollars), available at http://factfinder2.census.gov/. Neighborhood income categories determined by comparing average family income by census tract to the state average family income, using ratios described in table. The percent of total population living in each neighborhood income category is compared across decades to illustrate change in neighborhood inequality.

2.9. **The Low-Income Population in Fairfield County.** DataHaven analysis (2016). 2000 figures are from U.S. Census Bureau, Ratio of Income in 1999 to Poverty Level. 2014 figures are from U.S. Census Bureau American Community Survey 2014 5-year estimate, Table B17024, Age by Ratio of Income to Poverty Level in the Past 12 Months. Tables available at http://factfinder2.census.gov/. As described in the report text, "low-income" is defined here as individuals having an annual household income less than two times (200 percent of) the federal poverty level.

2.10. **Housing Cost Burden in Fairfield County.** DataHaven analysis (2016) of data from U.S. Census Bureau American Community Survey 1-year estimates. Table B25070, Gross Rent as a Percentage of Household Income in the Past 12 Months; Table B25091, Mortgage Status by Selected Monthly Owner Costs as a Percentage of Household Income in the Past 12 Months, available at http://factfinder2.census.gov/. Households are considered cost-burdened when their monthly housing costs exceed 30 percent of their total income, and severely cost-burdened when this cost exceeds 50 percent of their total income.

2.11. **Characteristics of Fairfield County Households.** DataHaven analysis (2016). 2014 figures from U.S. Census Bureau American Community Survey 2014 5-year estimates. Table B25070, Gross Rent as a Percentage of Household Income in the Past 12 Months; Table B25091, Mortgage Status by Selected Monthly Owner Costs as a Percentage of Household Income in the Past 12 Months, available at http://factfinder2.census.gov/. Households are considered severely cost-burdened when their monthly housing costs exceed 50 percent of their total income.

CHAPTER 3. A HEALTHY REGION

3.1. **Fairfield County Trends.** DataHaven analysis (2016) of a variety of sources. For life expectancy data, online data from Institute for Health Metrics and Evaluation at the University of Washington (2015), Released April 2015 and accessed June 1, 2016 at http://vizhub.healthdata.org/us-health-map/ for Fairfield County, Connecticut, and United States. For low birth weight, Connecticut Department of Public Health Vital Statistics records from 2003 to 2013, with a 3 year centered moving average developed for each point in time shown (see note for Figure 3.3); data are presented for the city of Bridgeport, Connecticut, and Fairfield County. For obesity and smoking, DataHaven analysis (2016) of data compiled from 2015 DataHaven Community Wellbeing Survey (available at http://www.ctdatahaven.org/reports/datahaven-community-wellbeing-survey), 2007 Connecticut Health Foundation Health Data Scan (available at https://www.cthealth.org/wp-content/uploads/2011/04/health-data-scan-report.pdf), and 2011 American Lung Association Trends in Tobacco Use report (available at http://www.lung.org/assets/documents/research/tobacco-trend-report.pdf); data are presented for the city of Bridgeport, Connecticut, and for a grouping of the state's wealthiest towns. For insurance coverage rates, U.S. Census Bureau American Community Survey 2012 5-year estimates (2008-2012) and 2014 1-year estimates, Table S2701, civilian non-institutionalized population 18 years and older; and 2015 DataHaven Community Wellbeing Survey data for adults age 18 and older. Data presented for city of Bridgeport and Connecticut. For age-adjusted mortality rates from heart disease, Connecticut Department of Public Health Mortality Tables, available at http://www.ct.gov/dph/cwp/view.asp?a=3132&q=521462.

3.2. **Well-Being and Chronic Disease Risk Factors.** DataHaven analysis (2016) of questions from 2015 DataHaven Community Wellbeing Survey. Using a standard list of questions designed by a panel of local, statewide, and national experts based on major national surveys, randomly-selected adult participants were asked to rate their overall health; report recent levels of depression and anxiety; and report whether they had even been told by a doctor or medical professional that they had diabetes or asthma. Participants reported their height and weight, from which their body mass index (BMI) was calculated; obesity in adults is defined as a BMI of 30 or higher. For food insecurity, participants were asked whether there had been times in the past 12 months that they did not have enough money to provide food for their families. Smoking rates were calculated based on the number of participants who estimated having smoked at least 100 cigarettes in their entire lives; those who said they had were then asked whether they smoked every day, some days, or not at all. Smoking prevalence

for the entire population was then extrapolated from these two figures. Participants were asked to self-report whether they currently have health insurance, and whether they had seen a dentist in the past 12 months. All reported estimates from the survey are weighted in order to accurately represent the underlying adult population within each state, region, town, or neighborhood. More information on this landmark, statewide, regional, and neighborhood-level survey is available elsewhere in the report or at http://www.ctdatahaven.org/reports/datahaven-community-wellbeing-survey.

3.3. **Infant Health Indicators.** DataHaven analysis (2016) of data from Connecticut Department of Public Health Vital Statistics, available at http://www.ct.gov/dph/cwp/view.asp?a=3132&q=394598. Low and very low birth weights are defined as 2,500 grams (5.5 pounds) and 1,500 grams (3.3 pounds), respectively. Fetal mortality is defined as babies that were stillborn or otherwise not viable after 20 weeks gestation. Infant mortality is defined as children who died at less than 1 year of age. All figures are averaged over the period from 2008 to 2013 and reported as an annualized 6-year average.

3.4. **Leading Causes of Death.** Data from Connecticut Department of Public Health, available at http://www.ct.gov/dph/cwp/view.asp?a=3132&q=521462. Crude mortality rates give the number of deaths divided by the number of residents, without accounting for effects of age. Number of deaths, crude mortality rate (CMR), age-adjusted mortality rate (AAMR) and statistical significance between time periods by cause of death were created using the 2008-2012 and 2003-2007 mortality data reported for each CT town, county and the state. The 2008-2012 AAMR for each cause by town was compared to the CT statewide AAMR to identify statistically significant differences using the Standard Error of the AAMR for each town provided in the tables along with the town, county or state population from the 2010 Decennial Census (http://www.ct.gov/dph/cwp/view.asp?a=3132&q=488832) to calculate the standard deviation. For each reference area, z scores were calculated using the standard deviation, 2010 total population, and the difference between the town AAMR and reference AAMR. p values were calculated from these z scores. Statistical differences shown as "likely higher/lower" are calculated at a 90% confidence level, and those shown as "higher/lower" are calculated at a 95% confidence level. When neither difference is indicated, figures are not significantly different from those of the state. According to Mortality Technical Notes at the Connecticut Department of Public Health (http://www.ct.gov/dph/cwp/view.asp?a=3132&q=397434), "age-adjusted mortality rates are rates where the effect of differing age distributions between the groups has been removed. They are used to compare the relative mortality risk across two or more population groups at the same point in time or to compare one population at two or more points in time. Since the effect of age has been removed, these rates are called "age-adjusted" rates. This is a key difference between crude and age-adjusted rates. More specifically, the adjusted rate estimates "what the crude rate would have been in the study population if that population had the same distribution as the standard population with respect to the variable(s) for which the adjustment or standardization was carried out" (Last, 1988). Age-adjusted rates are computed by the direct method by applying age-specific rates in a population of interest to a standardized age distribution, in order to eliminate differences in observed rates that result from age differences in population composition. Age-adjusted rates presented in the CT DPH Mortality tables are consistent with the methods used by the National Center for Health Statistics/Centers for Disease Control in their tabulation of U.S. rates." AAMRs are calculated for towns and counties, but were not available for groupings of towns or neighborhoods.

3.5. **Causes of Premature Death.** Data from Connecticut Department of Public Health, available at http://www.ct.gov/dph/cwp/view.asp?a=3132&q=521462. For Years of Potential Life Lost (YPLL), we created annualized YPLL rates (or "Premature Death Rates") by cause using the 2008-2012 dataset at the individual town level; geographies presented here include the state, county, and selected individual towns. Data represent annualized averages over that five year period of time. We calculated the YPLL rate as the sum of the YPLL divided by (the total population under 75 years old*5)*100,000. The average YPLL under 75 years of age, or "Years Lost Per Death," was calculated by taking the sum of the YPLL divided by the number of deaths under 75 years of age. For YPLL due to fetal/infant deaths (summed fetal deaths plus infant deaths), we used annualized CTDPH data for 2008-2013 (see note for Figure 3.3) and used an average age at death of 0.5 years, hence the average YPLL of 74.5 years per death computed for these deaths as the basis of the comparison to standard causes of death.

3.6. Heart Disease, Hospital Inpatient Encounters, and General Notes on Analysis of Hospital Data (CHIME data). DataHaven analysis (2016) of 2012–2014 CHIME data provided by Connecticut Hospital Association upon request from and special study agreement with partner hospitals and DataHaven. The CHIME hospital encounter data extraction included de-identified information for each of 3,069,680 Connecticut hospital encounters incurred by any residents of 47 towns in CT and 15 towns in NY encompassing the service areas of several Connecticut hospitals (Bridgeport Hospital, Danbury Hospital, Greenwich Hospital, Milford Hospital, Norwalk Hospital, St. Vincent's Medical Center, Stamford Hospital, and Yale New Haven Hospital) as well as the towns of Waterbury and Hartford for use as comparisons. Any encounter incurred by any resident of these towns at any Connecticut hospital would be included in this dataset, regardless of where they received treatment. In order to develop statewide geographic benchmark comparisons within the CHIME data that could be used to provide context to any of the figures in the report that relied on CHIME data, the nine wealthiest towns in Connecticut based on household income (Darien, Easton, Greenwich, New Canaan, Ridgefield, Weston, Westport, Wilton, Woodbridge) were grouped together into a "9 Wealthiest CT Towns" figure and compared to the four largest urban centers (Bridgeport, New Haven, Hartford, Waterbury) grouped together into a "4 Largest City Centers" or "4 Largest CT Urban Core Towns" figure. In all CHIME data-based maps, a single zip code was selected to represent the neighborhood that would most closely approximate those defined by Census Tract in the other maps within this document (except for Danbury; see note for Figure 1.1). In all CHIME data-based maps (Figures 3.6, 3.9, 3.11, 3.12, 3.15, 3.16), Bridgeport "North End" is 06606, Bridgeport "East Side" is 06608, Stamford "North" is 06903, Stamford "South" is 06902, Norwalk "Rowayton" is 06853, Norwalk "South" is 06854. Each encounter observation had a unique encounter ID and was populated with one or more "indicator flags" representing a variety of conditions. Each encounter could include multiple indicator flags. Because CHIME is Connecticut-based, only hospital encounters occurring in CT were captured; therefore, encounters for individuals residing in CT towns bordering other states are more likely undercounted in some cases. Annualized encounter rates were calculated as described below for the indicator flags assigned within the dataset including Asthma, COPD, Substance Abuse, and many other conditions. Most analyses in this document describe data on "all hospital encounters" including inpatient, emergency department (ED), and observation encounters, but as noted, some look only at inpatient encounters or emergency department encounters in order to describe conditions that are considered to be of higher severity (in the case of inpatient hospitalization) or special concern (in the case of ED use for preventable conditions). Annualized encounter rates per 10,000 persons were calculated for the 3-year period 2012-2014 by zip code, town, area, region, and in aggregate by merging CHIME data with 2010 Decennial Census data by zip code, town, race, and age. For each town, our analysis included an annualized encounter rate for white non-Hispanic, total black, and total Hispanic populations in each of six age strata (0-19, 20-44, 45-64, 65-74, 75-84, and 85+ years), as well as a single age and race adjusted annualized encounter rate for each region. Additionally, an overall age-adjusted encounter rate by cause was calculated by zip code, town, area/region and aggregate. Analyses were adjusted for age by using 2010 Census population for all towns that were represented in the CHIME data, in order to remove the effect of age from the reported rates (see note for Figure 3.4 for additional rationale for using age-adjusted rates). To explore neighborhood differences in hospital encounter rates, CHIME data were merged with 2010 census data by zip code, and annualized encounter rates per 10,000 persons were calculated for each indicator flag by sex within age strata for each zip code. In addition, a single age-adjusted annualized encounter rate per 10,000 was calculated for each zip code. To enable comparison, rolled up regional encounter rates were calculated by sex within each age stratum for regions and sub-regions. Several limitations regarding this analysis deserve mention. First, it is important to note that there is no way to discern the unique number of individuals in a zip, town, area or region who experienced hospital encounters during the period under examination or the number of encounters that represented repeat encounters by the same individual for the same or different conditions. Second, the CHIME encounter dataset provides 3 diagnosis codes for each encounter. However, the indicator flags clearly use

more than 3 diagnosis fields. For example, of all asthma encounters (defined using the indicator flag for Asthma), only 25% have a primary diagnosis of asthma and only 60% have an asthma diagnosis in any of the 3 diagnostic fields provided for analysis. Consequently, there may be discrepancies when comparing the annualized CHIME encounter rates to rates calculated from DPH surveillance data, which use only the primary diagnosis field to identify an asthma hospitalization. Third, hospital encounter data may misclassify those who are ethnically Hispanic, as race is captured based on patient observation and race and ethnicity were not separately reported. Each encounter was assigned a single Race/ethnicity category with White, Black, Hispanic captured as follows: White, Black/African American, Hispanic/Latino/Spanish Origin. Consequently, an ethnically Hispanic individual may be categorized as white or black. Conversely, the 2010 census data captures race and ethnicity separately. In attempt to create appropriate denominators for the race stratified analyses, we extracted Census data on white non-Hispanic, all black, and all Hispanic populations. Because of differences in the ways race/ethnicity were captured in the CHIME data versus the 2010 census data, the race adjusted annualized encounter rates should be interpreted with significant caution, and for that reason we generally do not report them within this document even though they are important considerations in our broader view of regional health disparities. Last, encounter rate by zip code analysis includes only zip codes for which corresponding census data existed for zip code tabulation area (ZCTAs); zip codes representing P.O. boxes were not reported; zip code-based data are subject to other limitations due to the manner in which zip codes and ZCTAs are defined. To better examine encounter rates for asthma, the age-strata used to calculate asthma encounter rates differed from age groupings used for the other disease encounter types (0-4, 5-19, 20-44, 45-64, 65-74, and 75+ years). Please contact DataHaven or CHIME data for detail on diagnosis codes used to develop indicator flags, if not provided in the figure note. Data in this particular map (Figure 3.6) include age-adjusted rates only for inpatient hospital encounters for heart disease (Circulatory Diseases); inpatient encounters for this diagnosis are generally considered to be for severe conditions, and do not include emergency department or other hospital encounters.

3.7. **Heart Disease & Lung Cancer Inpatient Encounters by Age.** DataHaven analysis (2016) of 2012-2014 CHIME data provided by Connecticut Hospital Association upon request from and special study agreement with partner hospitals and DataHaven; see note for Figure 3.6 for description of the analyses shown here. Data in this particular table include age-adjusted and age-specific rates only for inpatient hospital encounters for heart disease (Circulatory Diseases) and lung cancer, which are generally considered to be severe conditions, not emergency department or other hospital encounters.

3.8. **Nutrition, Obesity, and Diabetes.** DataHaven analysis (2016) of questions from 2015 DataHaven Community Wellbeing Survey. Participants were asked to report whether they had even been told by a doctor or medical professional that they had diabetes. Participants reported their height and weight, from which their body mass index (BMI) was calculated; obesity in adults is defined as a BMI of 30 or higher. For food insecurity, participants were asked whether there had been times in the past 12 months that they did not have enough money to provide food for their families. Data are disaggregated by self-reported race and ethnicity (white non-Hispanic, black non-Hispanic, and Hispanic of any race), age group, and household income. See note for Figure 3.2 for additional detail.

3.9. **Diabetes, All Hospital Encounters.** DataHaven analysis (2016) of 2012-2014 CHIME data provided by Connecticut Hospital Association upon request from and special study agreement with partner hospitals and DataHaven; see note for Figure 3.6 for detailed description of the analyses shown here. Data in this particular table include age-adjusted and age-specific rates for any hospital encounters with Type 2 diabetes as an indicator flag (Principal or Secondary ICD-9 Diagnosis Codes 25000, 25002, 25010, 25012, 25020, 25022, 25030, 25032, 25040, 25042, 25050, 25052, 25060, 25062, 25070, 25072, 25080, 25082, 25090, 25092). Table also presents hospital encounters for conditions that are often considered to be of higher severity: diabetes-related amputation (lower-extremity amputation due to diabetes among patients with diabetes indicator, or PQI 16; please contact DataHaven or CHIME data for additional detail on this more complex diagnosis), and uncontrolled diabetes (Principal or Secondary ICD-9 Diagnosis Codes 25002, 25003).

3.10. **Injury Mortality by Type.** Data from Connecticut Department of Public Health, available at http://www.ct.gov/dph/cwp/view.asp?a=3132&q=521462. See note for Figure 3.4 for additional detail on age-adjusted mortality rates (AAMR).

3.11. **Homicide/Purposeful Injury, All Hospital Encounters.** DataHaven analysis (2016) of 2012-2014 CHIME data provided by Connecticut Hospital Association upon request from and special study agreement with partner hospitals and DataHaven; see note for Figure 3.6 for detailed description of the analyses shown here. Data in this particular table include age-adjusted and age-specific rates for any hospital encounters with "Accident/Injury-Homicide and Purposely Inflicted" as an indicator flag (Principal or Secondary ICD-9 Diagnosis Codes E9600, E9601, E961, E9620, E9621, E9622, E9629, E963, E964, E9650, E9651, E9652, E9653, E9654, E9655, E9656, E9657, E9658, E9659, E966, E9670, E9671, E9672, E9673, E9674, E9675, E9676, E9677, E9678, E9679, E9680, E9681, E9682, E9683, E9684, E9685, E9686, E9687, E9688, E9689, E969), which generally includes intentional assaults or other instances of community or domestic violence. "Suicide and Self-Inflicted" is a completely separate indicator flag in the database and does not overlap at all with this indicator. Table also presents inpatient encounters for "high severity conditions," which in this case are defined simply as inpatient encounters because of our view that assaults that require a hospitalization are more likely to involve issues such as firearm-inflicted or life-threatening injuries. In general, the majority of all encounters for this indicator are emergency department encounters; any hospital encounters due to intentional injury and assault, even those resulting in relatively minor injuries, could be considered a potential indicator of safety and is worth exploring in greater detail in future iterations of this report.

3.12. **Childhood Asthma, All Hospital Encounters.** DataHaven analysis (2016) of 2012-2014 CHIME data provided by Connecticut Hospital Association upon request from and special study agreement with partner hospitals and DataHaven; see note for Figure 3.6 for detailed description of the analyses shown here. Data in this particular map include age-specific rates among residents age 0-4 for any hospital encounters with "Asthma" as an indicator flag (Principal or Secondary ICD-9 Diagnosis Codes 49300, 49301, 49302, 49310, 49311, 49312, 49320, 49321, 49322, 49381, 49382, 49390, 49391, 49392).

3.13. **Selected Infectious Diseases.** DataHaven analysis (2016) of data obtained directly from Connecticut Department of Public Health in April 2016, including the HIV and Hepatitis Surveillance and Epidemiology and Emerging Infections Lyme Disease Surveillance programs.

3.14. **Chronic Obstructive Pulmonary Disease (COPD).** DataHaven analysis (2016) of 2012-2014 CHIME data provided by Connecticut Hospital Association upon request from and special study agreement with partner hospitals and DataHaven; see note for Figure 3.6 for detailed description of the analyses shown here. Data in this particular table include age-adjusted and age-specific rates for inpatient hospital encounters with "Chronic Obstructive Pulmonary Disease" (COPD) as an indicator flag (Principal or Secondary ICD-9 Diagnosis Codes 4910, 4911, 4912, 49120, 49121, 4918, 4919, 4920, 4928, 494, 4940, 4941, 496). Although COPD is a health outcome rather than a mental health or substance abuse issue, it is included within this section of the report because of its relationship to smoking.

3.15. **Substance Abuse, All Hospital Encounters.** DataHaven analysis (2016) of 2012-2014 CHIME data provided by Connecticut Hospital Association upon request from and special study agreement with partner hospitals and DataHaven; see note for Figure 3.6 for detailed description of the analyses shown here. Data in this particular table include age-adjusted rates for all hospital encounters with "Substance-Related Disorders" as an indicator flag (Principal or Secondary ICD-9 Diagnosis Codes 2920, 29211, 29212, 2922, 29281, 29282, 29283, 29284, 29289, 2929, 30400, 30401, 30402, 30403, 30410, 30411, 30412, 30413, 30420, 30421, 30422, 30423, 30430, 30431, 30432, 30433, 30440, 30441, 30442, 30443, 30450, 30451, 30452, 30453, 30460, 30461, 30462, 30463, 30470, 30471, 30472, 30473, 30480, 30481, 30482, 30483, 30490, 30491, 30492, 30493, 30510, 30511, 30512, 30513, 30520, 30521, 30522, 30523, 30530, 30531, 30532, 30533, 30540, 30541, 30542, 30543, 30550, 30551, 30552, 30553, 30560, 30561, 30562, 30563, 30570, 30571, 30572, 30573, 30580, 30581, 30582, 30583, 30590, 30591, 30592, 30593, 64830, 64831, 64832, 64833, 64834, 65550, 65551, 65553, 76072, 76073, 76075, 7795, 96500, 96501, 96502, 96509, V6542). These codes generally relate only to drug use and abuse, not alcohol use. In many cases, encounters flagged

for substance abuse are also flagged for various mental health-related disorders.

3.16. **Preventable Dental Conditions, Hospital ED Encounters.** DataHaven analysis (2016) of 2012-2014 CHIME data provided by Connecticut Hospital Association upon request from and special study agreement with partner hospitals and DataHaven; see note for Figure 3.6 for detailed description of the analyses shown here. Data in this particular map and table include age-adjusted and age-specific rates for emergency department hospital encounters with "Preventable Dental Conditions" as an indicator flag (Principal or Secondary ICD-9 Diagnosis Codes 521xx, 522xx, 523xx, 525xx, 528xx). Data are an indication that many residents, particularly younger or lower-income adults, may seek dental care at hospital emergency rooms for various reasons or may lack access to the preventive dental care that could allow them to avoid going to the hospital emergency room.

3.17. **Health Care Access.** DataHaven analysis (2016) of questions from 2015 DataHaven Community Wellbeing Survey. Participants were asked to report whether they had health insurance, had had a dental visit during the past 12 months, and could not afford prescription medicine during the past 12 months. Additionally, participants were asked two questions about whether they postponed or did not get the medical care that they thought they needed at any point during the past 12 months; the indicator shown here indicates the population-weighted percentage of adults in the region who answered yes to either of these two questions. Residents who answered yes to either question were also asked a series of follow-up questions that are discussed in the text. Data are disaggregated by self-reported race and ethnicity (white non-Hispanic, black non-Hispanic, and Hispanic of any race), age group, and household income. See note for Figure 3.2 for additional detail.

CHAPTER 4. A REGION OF OPPORTUNITY

4.1. **Working Parents, 2000–2014.** DataHaven analysis (2016). 2000 figures from U.S. Census Bureau Decennial Census, Table P046, Age of Own Children Under 18 Years in Families and Subfamilies by Living Arrangements by Employment Status of Parents. 2014 figures from U.S. Census Bureau American Community Survey 2014 5-year estimate, Table B23008, Age of Own Children Under 18 Years in Families and Subfamilies by Living Arrangements by Employment Status of Parents. Both available at http://factfinder2.census.gov/. See note for Figure 1.1 for additional detail on geographical areas included.

4.2. **Availability of Childcare and Education in Fairfield County, 2014.** DataHaven analysis (2016) of data from 2-1-1 Annual Child Care Capacity, Availability, and Enrollment Survey 2014, report by Connecticut 2-1-1 Childcare, available at http://www.211childcare.org/reports/ and U.S. Census Bureau American Community Survey 2014 5-Year estimate, Table B01001, Sex by Age available at http://factfinder2.census.gov/. Note that childcare provider slot capacity is calculated as enrolled slots plus vacant slots.

4.3. **Affordability of Childcare for Families.** DataHaven analysis (2016) of 2012 data from 2-1-1 Childcare Availability Affordability 2013 report, by Connecticut 2-1-1 Childcare, available at http://www.211childcare.org/reports/. Note that average child care costs are calculated using average family income from the U.S. Census Bureau American Community Survey 2012 5-year estimate, Table B19113, Median Family Income in the past 12 months (in 2012 inflation-adjusted dollars), available at http://factfinder2.census.gov

4.4. **Availability of Childcare and Education Subsidies in Fairfield County, 2014.** DataHaven analysis (2016) of data from 2-1-1 Annual Child Care Capacity, Availability, and Enrollment Survey 2014, report by Connecticut 2-1-1 Childcare, available at http://www.211childcare.org/reports/; Department of Education data on subsidized childcare and education programs, provided to DataHaven for the purposes of this report; and U.S. Census Bureau American Community Survey 2014 5-Year estimate, Table B01001, Sex by Age, and Table B17024, Age by Ratio of Income to Poverty Over Past 12 Months, available at http://factfinder2.census.gov/. Note that childcare provider slot capacity is calculated as enrolled slots plus vacant slots, and that the population of children ages 0-4 from low-income households is estimated at 83 percent of the population of children ages 0-5 from low-income households.

4.5. **Preschool Enrollment in Fairfield County, 2014.** DataHaven analysis (2016). U.S. Census Bureau American Community Survey 2014 5-year estimate, Table B14003, Sex by School Enrollment by Type of School by Age for the Population 3 Years and Over, available at http://factfinder2.census.gov/. See note for Figure 1.1 for additional detail on geographical areas included including neighborhood statistical areas listed in map within Bridgeport, Danbury, Norwalk, and Stamford.

4.6. **Race and Ethnicity of Fairfield County Students, 2014–2015.** DataHaven analysis (2016) of 2014-15 school year data from the Connecticut State Department of Education. See note for Figure 1.1 for additional detail on geographical areas included.

4.7. **High-Needs Students.** DataHaven analysis (2016) of 2014-15 school year data from the Connecticut State Department of Education. See note for Figure 1.1 for additional detail on geographical areas included.

4.8. **Academic Achievement in Fairfield County Schools.** DataHaven analysis (2016) of data from Connecticut State Department of Education. The Smarter Balance Assessment Consortium (SBAC) standardized test is the Common Core-aligned test first taken by Connecticut students in 2015. Passing scores on English/language arts (ELA) and math are those rated proficient or advanced in that subject, and students scoring at these levels are considered on track for college and career readiness. Previous standardized testing used different rubrics to determine passing; therefore, SBAC scores should not be compared with previous testing years. Graduation rates presented are four-year cohort graduation rates, giving the percentage of students who earn a high school diploma alongside the cohort with which they started 9th grade. This rate is adjusted to account for transfers in and out of each district. Chronic absenteeism is defined as a student missing at least 10 percent of the days for which they are enrolled in a year for any reason. See note for Figure 1.1 for additional detail on geographical areas included.

4.9. **The Opportunity Gap Impacts Achievement at Fairfield County Schools.** DataHaven analysis (2016) of data from Connecticut State Department of Education. The Smarter Balance Assessment Consortium (SBAC) standardized test is the Common Core-aligned test first taken by Connecticut students in 2015. Passing scores on English/language arts (ELA) and math are those rated proficient or advanced in that subject, and students scoring at these levels are considered on track for college and career readiness. Previous standardized testing used different rubrics to determine passing; therefore, SBAC scores should not be compared with previous testing years. Graduation rates presented are four-year cohort graduation rates, giving the percentage of students who earn a high school diploma alongside the cohort with which they started 9th grade. This rate is adjusted to account for transfers in and out of each district. Chronic absenteeism is defined as a student missing at least 10 percent of the days for which they are enrolled in a year for any reason. See note for Figure 1.1 for additional detail on geographical areas included.

4.10. **Higher Education of Fairfield County Students.** DataHaven analysis (2016) of data from Connecticut State Department of Education. Enrollment rates are defined as the percentage of students from a given graduating class who enroll in college within 1 year of graduation. Persistence rates are defined as the percentage of students who, after enrolling in college within 1 year of high school, continue into a second, consecutive year of college. Attainment rates are the percentage of students who earn a two- or four-year degree within 6 years of graduating high school, out of the entire high school graduating class. See note for Figure 1.1 for additional detail on geographical areas included.

4.11. **Opportunity Youth in Fairfield County, 2014.** DataHaven analysis (2016). U.S. Census Bureau American Community Survey 2014 5-year estimate, Table B14005, Sex by School Enrollment by Educational Attainment by Employment Status for the Population 16 to 19 Years, available at http://factfinder2.census.gov/. Opportunity youth (sometimes referred to as "disconnected youth") are youth ages 16 to 19 who are neither working nor currently enrolled in school. See note for Figure 1.1 for additional detail on geographical areas included including neighborhood statistical areas listed in map within Bridgeport, Danbury, Norwalk, and Stamford.

4.12. **Opportunities for Young People in Fairfield County.** DataHaven analysis (2016). U.S. Census Bureau American Community Survey 2014 5-year estimate, Table B14005, Sex by School Enrollment by Educational Attainment by Employment Status for the Population 16 to 19 Years,

available at http://factfinder2.census.gov/. Opportunity youth (sometimes referred to as "disconnected youth") are youth ages 16 to 19 who are neither working nor currently enrolled in school. Unemployment ages 16-24 data from the Bureau of Labor Statistics, available at http://www.bls.gov/web/empsit/cpseea10.htm. Other data are population-weighted estimates that come from the 2015 DataHaven Community Wellbeing Survey's in-depth interviews of randomly-selected adults age 18-24 in the region. Underemployment is defined as people who are unemployed, plus those who are working part-time but want to be working full-time.

4.13. **Movement of Low-Income Workers (Salary < $40,000).** DataHaven analysis (2016) to calculate the numbers of workers moving between pairs of towns in Fairfield County. U.S. Census Bureau Longitudinal Employer-Household Dynamics Origin-Destination Employment Statistics, available at http://lehd.ces.census.gov/data/.

4.14. **Movement of High-Income Workers (Salary > $40,000).** DataHaven analysis (2016) to calculate the numbers of workers moving between pairs of towns in Fairfield County. U.S. Census Bureau Longitudinal Employer-Household Dynamics Origin-Destination Employment Statistics, available at http://lehd.ces.census.gov/data/.

4.15. **Financial Security and Underemployment.** DataHaven analysis (2016) of 2015 DataHaven Community Wellbeing Survey. The Financial Security Index was developed by DataHaven to summarize responses to several survey questions for the sake of comparison. These questions included access to transportation, health insurance and access to health care, inability to obtain basic needs like food and shelter, and overall assessment of participants' financial situations. After calculating the index for a large sample of zip codes from around the state, scores were ranked. Several demographic groups, shown on the left, were ranked as though they were their own zip codes. As can be seen, if white working Fairfield County residents were their own zip code, their Financial Security Index would rank near the 95th percentile, while scores of Black and Latino working residents rank just above that of underemployed white residents. Underemployed Black and Latino residents lag far behind. Responses by race/ethnicity and employment status for three specific questions related to financial security are also shown; these represent the percent of all adults age 18+ within each category who answered affirmatively to the selected question.

4.16. **Jobs and Wage Trends by Sector, 2000–2014.** DataHaven analysis (2016) of U.S. Census Bureau Quarterly Workforce Indicators, available at http://qwiexplorer.ces.census.gov/, and U.S. Census Bureau Longitudinal Employer-Household Dynamics Origin-Destination Employment Statistics, available at http://lehd.ces.census.gov/data/. Average wages are given, and are calculated here as means of total annual wages over annual average employment by sector. 2000 wages are adjusted for inflation in order to accurately calculate changes in average wages over time. The chart shows that average wages in Finance grew very rapidly, while average wages in retail trade dropped precipitously. Industries are categorized based on the North American Industry Classification System; those shown are sectors in which there were at least 10,000 workers in 2014. Curves for job trends are adjusted to smooth out fluctuations over time. Data shown is for Fairfield County.

4.17. **Changing Industry Footprints.** DataHaven analysis (2016) of U.S. Census Bureau Quarterly Workforce Indicators, available at http://qwiexplorer.ces.census.gov/. Each share is given as that sector's payroll within Fairfield County divided by the county's total payroll across all sectors. This includes the seven sectors with fewer than 10,000 workers that were eliminated for Figure 4.15.

4.18. **Educational Attainment.** DataHaven analysis (2016) of U.S. Census Bureau American Community Survey 2014 5-year estimate, Table B06009, Place of Birth by Educational Attainment in the United States, available at http://factfinder2.census.gov/. On the map, the percent of all adults age 25+ with a Bachelor's Degree or higher, as well as the raw number of such adults with degrees, are given for regions as well as neighborhood areas and towns. See note for Figure 1.1 for additional detail on geographical areas included including neighborhood statistical areas listed in map within Bridgeport, Danbury, Norwalk, and Stamford.

4.19. **Municipal Financial Capacity in Fairfield County.** DataHaven analysis (2016) of data available from the New England Public Policy Center, available at https://www.bostonfed.org/publications/new-england-public-policy-center-research-report/2015/measuring-municipal-fiscal-disparities-in-connecticut.aspx. Municipal capacity refers to the amount of money from tax revenue available to a municipality. The first column shows tax capacity per capita, or the amount of revenue available per resident for each town. The second column shows the amount of money per person needed to cover that town's estimated public expenses. The third column shows the amount of surplus available per person, or the money needed subtracted from the money available. Figures are shown in green for a surplus and red for a deficit.

4.20. **Perceived Access and Use of Community Resources.** DataHaven analysis (2016) of questions from the 2015 DataHaven Community Wellbeing Survey. The indicators shown here indicate the percentage of adults in each area who answered affirmatively to the questions shown; survey respondents are weighted to be representative of the population within each area. Data are disaggregated by geographic area, self-reported age group, and household income. See note for Figure 3.2 for additional detail.

4.21. **Perceived Community Cohesion.** DataHaven analysis (2016) of questions from the 2015 DataHaven Community Wellbeing Survey. The indicators shown here indicate the percentage of adults in each area who answered affirmatively to the questions shown; survey respondents are weighted to be representative of the population within each area. Data are disaggregated by geographic area, self-reported age group, and household income. See note for Figure 3.2 for additional detail.

4.22. **Voter Turnout in Fairfield County.** DataHaven analysis (2016) of voter turnout data from the Connecticut Secretary of the State, available at http://www.ct.gov/sots/cwp/view.asp?q=401492. Voter turnout is defined as the percentage of officially registered voters who are checked as having voted. This includes overseas ballots but does not include absentee voters. Note that the years in which presidential, midterm, and local elections are held differ. Participants in the 2015 DataHaven Community Wellbeing Survey also answered a question regarding their registration to vote.

4.23. **Civic Engagement and Government.** DataHaven analysis (2016) of questions from the 2015 DataHaven Community Wellbeing Survey. The indicators shown here indicate the percentage of adults in each area who answered affirmatively to the questions shown; survey respondents are weighted to be representative of the population within each area. Data are disaggregated by geographic area, self-reported age group, and household income. See note for Figure 3.2 for additional detail.

ENDNOTES

CHAPTER 1

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Fairfield County's Community Foundation
383 Main Avenue
Norwalk, CT 06851-1543
203.750.3200
info@fccfoundation.org
fccfoundation.org

Since 1992, Fairfield County's Community Foundation has been dedicated to creating lasting change in our region and maximizing impact by combining fiscal stewardship with extensive community knowledge. As a trusted nonprofit partner and thought leader, we bring together philanthropists, nonprofits and expert resources with the goal of creating a vital and inclusive community, where every individual has the opportunity to thrive.

DataHaven
129 Church Street, Suite 605
New Haven, CT 06510
203.500.7059
info@ctdatahaven.org
ctdatahaven.org

DataHaven is a non-profit organization with a 25-year history of public service to Greater New Haven and Connecticut. Its mission is to improve quality of life by collecting, sharing, and interpreting public data for effective decision making. DataHaven is a formal partner of the National Neighborhood Indicators Partnership of the Urban Institute in Washington, DC.

Additional information related to this report is posted on our websites.