By the
Greenwich Community Health Improvement Partnership and Council of Community Services

This document is a special section of the Fairfield County Community Wellbeing Index 2019, a core program of DataHaven (ctdatahaven.org), in partnership with Fairfield County’s Community Foundation and a Community Health Needs Assessment for the towns served by all Fairfield County hospitals including Greenwich Hospital
ABOUT THIS REPORT

This document is a special section of the *Fairfield County Community Wellbeing Index 2019* (Appendix A), a comprehensive report about Fairfield County and the towns within it. The *Community Wellbeing Index* was produced by DataHaven in partnership with Fairfield County’s Community Foundation and many other regional partners, including the Greenwich Community Health Improvement Partnership and the Council of Community Services, coalitions both serving towns in the Greater Greenwich Region. This document serves as the Community Health Needs Assessment for the Greater Greenwich Region served by Greenwich Hospital (Greenwich, CT and Mamaroneck, Port Chester, Rye Brook and Rye Town, NY).

The *Community Health Needs Assessment* documents the process that GCHIP / CCS used to conduct the regional health assessment and health improvement activities. You may find the full *Community Wellbeing Index* attached to this section, or posted on the DataHaven, Fairfield County’s Community Foundation, Greenwich Hospital, or any of the town health department websites. The Community Health Needs Assessment and Community Health Improvement Plan were approved by the Greenwich Hospital Board of Trustees on June 18, 2019.
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I. EXECUTIVE SUMMARY

INTRODUCTION
Understanding the current health status of a community a necessary first step towards identifying priorities for future planning and funding, existing strengths and assets on which to build, and areas for further collaboration and coordination across organizations, institutions, and community groups. To this end, the Greenwich Community Health Improvement Partnership (GCHIP) and the Council of Community Services (CCS) – two local coalitions (‘the Coalitions’) comprised of Greenwich Hospital, local departments of public health, federally qualified health centers, and numerous community and non-profit organizations serving the Greater Greenwich region as fully set forth in Appendix B, are leading a comprehensive regional Community Health Needs Assessment (CHNA) effort. This effort is comprised of two main elements:

- Assessment – identifies the health-related needs in the Greater Greenwich area using primary and secondary data.
- Implementation Plan – determines and prioritizes the significant health needs of the community identified through the CHNA, overarching goals, and specific strategies to implement across the service area resulting in a Community Health Improvement Plan (CHIP).

This report details the findings of the CHNA conducted from January 2018 – April 2019. During this process, the following goals were achieved: the current health status of the Greater Greenwich region was examined and compared to state indicators and goals; current health priorities among residents and key stakeholders were explored; and, community strengths, resources, and gaps were identified in order to assist the coalitions and community partners in establishing top health priorities as well as programming and implementation strategies to achieve these priorities.

METHODS
The coalitions adopted the Association for Community Health Improvement’s (ACHI) Community Health Assessment Framework to guide the CHNA and to ensure that involved hospitals comply with Internal Revenue Service regulations for charitable hospitals and those of the local health departments pursuing voluntary accreditation through the Public Health Accreditation Board. Specifically, the CHNA defines health in the broadest sense and recognizes that numerous factors at multiple levels impact a community’s health – from lifestyle behaviors to clinical care to social and economic factors to the physical environment. This larger framework of the social determinants of health guided the overarching process.

Data Collection Methods
Quantitative and qualitative data were collected and reviewed throughout the CHNA process. Secondary data sources included, but were not limited to, the U.S. Census, U.S. Bureau of Labor Statistics, Centers for Disease Control and Prevention, state public health departments, Connecticut Health Information Management Exchange (CHIME), as well as local organizations and agencies. Types of data included vital statistics based on birth and death records. In addition, the Coalitions partnered with DataHaven and, in part, sponsored the 2018 DataHaven Community Wellbeing Survey (CWS), hired Health Equity Solutions to conduct community conversations in the Greater Greenwich Region, worked with the Yale School of Public Health Student Consulting Group to conduct and later analyze Key Informant Surveys, and a student Practicum Team also from the Yale School of Public Health to identify community resources.
KEY FINDINGS
The following section provides a brief overview of the key findings from the community health needs assessment for the Greater Greenwich Region. This includes overall demographics, social and physical environment, health outcomes and findings as they relate to the top three health priorities that were selected for action planning at a regional level: Healthy Lifestyles, Access to Care and Behavioral Health. These focus areas will be addressed through a Social Determinants of Health lens.

Demographics
Numerous factors are associated with the health of a community including what resources and services are available as well as who lives in the community. While individual characteristics such as age, gender, race and ethnicity have an impact on people’s health, the distribution of these characteristics across a community is also critically important and can affect the number and type of services and resources available.

- Population. The Greater Greenwich Region has a population of about 175,000.
- Age Distribution. The median age for both the population of Greenwich and all New York State areas are higher than the state of CT as a whole; however, Port Chester Village has a median age that is about four years lower than the CT state average of 40.8.
- Racial and Ethnic Diversity. The towns in the region vary dramatically in terms of their racial and ethnic composition. Greenwich and the New York State areas (excluding Port Chester Village) are close to 80% White and 10% Hispanic. By contrast, Port Chester Village is about one third White and two-thirds Hispanic.

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

- Income and Poverty. In 2014, there were wide gaps in Median Household income rates for the Greater Greenwich Region ($125,567), Fairfield County ($83,163), and Connecticut ($69,899). The widest gap is found between Greenwich ($135,528) and Port Chester Village ($60,141). The 2019 Community Index shows that income gaps have continued to widen over time.
- Educational Attainment. In 2014, the proportion of residents in the Greater Greenwich Region with a college degree or higher (60%) was greater than that of the state overall (37%) and Fairfield County (45%). Only 21% of Port Chester Village adults had a college degree or higher, compared to 66% of Greenwich adults. The educational attainment rate in 2017 is similar to what it was in 2014.
Health Outcomes
Health outcomes and risk factors related to chronic disease, mental health and substance abuse, mortality and morbidity are covered in significant detail in the Fairfield County Community Wellbeing Index 2019 as well as later in this document. These include:

- **Self-Reported Health Status.** Self-reported health status, which is a powerful predictor of future disability, hospitalization, and mortality, was higher in the Greater Greenwich Region than in Connecticut overall. Income and education levels are highly correlated to self-reported health status.

- **Neighborhood Environments.** Perceived quality of society, which relates to neighborhood trust, safety, child-friendliness, perceptions of government services and many other factors, are studied in-depth in the survey. Once again, responses from Greenwich area residents were more positive than responses statewide; however, responses appeared to be stratified by income with higher income households being more positive about quality of society than lower income households.

- **Financial Stress.** The 2018 DataHaven Community Wellbeing Survey contains many markers of financial stress, many of which are directly related to income levels. Across the board, positive levels of markers of financial stability — food security, housing security, transportation access and financial comfort — are significantly higher in wealthier areas.

- **Health Priorities**
  - **Healthy Lifestyles, including prevention and management of chronic disease.** Obesity rates are rising in Connecticut with 29% of adults classified as obese in 2018, a dramatic increase from about 11% in 1990. Port Chester adults are about as likely to be obese as Connecticut adults, but in Greenwich, the rate is just 14% (down from an estimated 19% in 2015). Additionally, smoking prevalence rates in Connecticut have decreased since 2000 and were at 14% in 2018. Rates in the Greenwich Region are lower than the state at 11% in Port Chester and 7% in Greenwich. The rate at which adults have tried e-cigarettes is also a bit lower than the statewide average (19%), at 14% in Port Chester and 16% in Greenwich. There are also concerns regarding food insecurity and financial stress among residents with limited income. Food insecurity impacts an estimated 7% of Greenwich adults and 11% of Port Chester adults, compared to 13% of all adults in the state of Connecticut.
  - **Access to Care.** Financial stress and lower socioeconomic status may also cause challenges related to access to medical care. Within Greenwich, the percent of adults who said they didn’t get the medical care they needed in the past year rose from 5% to 8% from 2015 to 2018, and the percent who postponed care they needed rose from 13% to 19%. These trends are similar to the increases seen statewide. 87% of Greenwich adults, but only 71% of Port Chester adults, report that they have visited a dentist within the past year. Although the majority of residents in the region have health insurance, it was discussed in focus groups that the type of insurance a person had was tied to issues around access to care and quality of care.
- **Behavioral Health.** Data from the DataHaven Community Wellbeing Survey, focus groups of local residents, and other sources support the inclusion of this focus area. A survey question about life chances for youth found that 19% of Greenwich adults and 35% of Port Chester adults felt that it was very likely or almost certain that young people growing up in their neighborhood would abuse drugs or alcohol. The survey also finds that a person’s reported level of happiness and anxiety are strongly correlated to income and education.

Complete findings are covered in the *Fairfield County Community Wellbeing Index 2019* (Appendix A) and additional detailed data by town are available on the DataHaven website: ctdatahaven.org.
II. INTRODUCTION

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

To this end, the Greenwich Community Health Improvement Partnership (GCHIP) and the Council of Community Services (CCS) – two local coalitions (‘the coalitions’) comprised of Greenwich Hospital, local departments of public health, federally qualified health centers, and numerous community and non-profit organizations serving the Greater Greenwich region – led a comprehensive regional Community Health Needs Assessment (CHNA) effort. This effort was comprised of two main elements:

- Assessment – identified the health-related needs in the Greater Greenwich area using primary and secondary data.
- Implementation Plan – determined and prioritized the significant health needs of the community identified through the CHNA, overarching goals, and specific strategies to implement across the service area resulting in a Community Health Improvement Plan (CHIP).

This report details the findings of the CHNA conducted from January 2018 – April 2019. The coalitions adopted the Association for Community Health Improvement’s (ACHI) Community Health Assessment Framework (Figure 1) to guide the CHNA and to ensure that it fulfills the hospitals’ Internal Revenue Service requirements and those of the local health departments pursuing voluntary accreditation through the Public Health Accreditation Board.

Figure 1: Association for Community Health Improvement Community Health Assessment Process
B. ADVISORY STRUCTURE AND PROCESS
The Community Health Needs Assessment was spearheaded, funded, and managed by GCHIP and CCS. GCHIP members include Greenwich Hospital, Greenwich Department of Health, and Optimus Healthcare; CCS partners include Greenwich Hospital, Open Door Family Medical Center, Hudson Valley Health, and the Westchester Department of Health (see Appendix B for a full list of organizational members). The organizations are representative of those in the community who serve underserved, low-income, and hard to reach populations. Representatives from these organizations provide regular input as part of the Community Health Needs Assessment and Community Health Improvement Plan implementation process by routinely attending monthly coalition meetings, providing feedback and guidance at each stage of the CHNA process, identifying specific populations for community conversations, responding to key informant surveys, attending community forums and prioritization sessions, and by being valued community partners.

GCHIP was developed in 2003 following a local community health needs assessment. The coalition envisions an accessible and seamless health care system that nurtures health improvement and wellness for all in the Greater Greenwich Region. The mission of GCHIP is to create a common ground that fosters and facilitates health improvement activities in and for the Greater Greenwich region. CCS has been bringing together community leaders to assess and meet the vital needs of the community since 1974. Their mission is accomplished by identifying and working towards solutions through mobilization, advocacy, and networking. In order to develop a shared vision and plan for the community and help sustain lasting change, both of these coalition’s assessment and planning processes aim to engage agencies, organizations, and residents in the area through participatory and collaborative approaches.

The coalitions have been reaching out to the larger community through communications and meetings to discuss the importance of this planning process. Additionally, the comprehensive data collection effort of the Community Health Needs Assessment engaged the community in community conversations, key informant surveys, and the DataHaven Community Wellbeing Survey. Dissemination of the CHNA findings and subsequent CHIP priorities and strategies, in an effort to raise public awareness, will continue to be conducted via media coverage and public events.
C. PURPOSE AND COMMUNITY SERVED
The Greater Greenwich Community Health Needs Assessment was conducted to meet several overarching goals:

1. To examine the current health status of the Greater Greenwich area; and
2. To explore current health priorities – as well as emerging health concerns – among residents within the social context of their communities;
3. To meet the legal requirements, as stipulated by the Internal Revenue Service, of Greenwich Hospital to conduct a community health needs assessment at least once every three (3) years and to adopt a written implementation strategy to meet the needs identified through the community health needs assessment; and
4. To meet voluntary health department Public Health Accreditation Board requirements.

To define community for CHNA purposes this Greater Greenwich Community Health Needs Assessment uses a geographical approach focusing on five contingent towns within Connecticut and New York: Greenwich, CT and Mamaroneck, Port Chester, Rye Brook and Rye Town, NY (Figure 2). These communities are served by Greenwich Hospital representing at least 75% of total discharges and do not overlap with CHNA areas identified by other acute care hospitals and/or collaborations. Upon defining the geographic area and population served in Greater Greenwich, the Coalitions were diligent to ensure that no groups, especially minority, low-income or medically under-served, were excluded.

Figure 2: Map of Community Served - Greater Greenwich Area, Connecticut and New York
III. METHODS

The following section describes the process and methods used to conduct the Community Health Needs Assessment, including the qualitative and quantitative data that was compiled and how it was analyzed, as well as a description of the broader lens used to guide the process. Specifically, the Community Health needs Assessment defines health in the broadest sense and recognizes that numerous factors at multiple levels impact a community’s health – from lifestyle behaviors to clinical care to social and economic factors to the physical environment. The discussion of this section discusses the larger social determinants of health framework which helped guide this overarching process.

A. SOCIAL DETERMINANTS OF HEALTH FRAMEWORK

It is important to recognize that multiple factors have an impact on health and that there is a dynamic relationship between real people and their lived environments. Where we are born, grow, live, work, and age – from the environment in the womb to our community environment later in life – and the interconnections among these factors are critical to consider when examining health status. That is to say, health outcomes are influenced by more than just an individual’s genetic code; in fact, zip code is more predictive as it is associated with lifestyle behaviors and upstream factors such as income, education, employment, and quality of housing stock. The social determinants framework addresses the distribution of wellness and illness among a population by examining factors not traditionally considered in medicine’s relatively narrow view of health.

The following diagram (Figure 3) provides a visual representation of this relationship, demonstrating how individual lifestyle factors, which are most proximate to health outcomes, are influenced by more upstream factors such as education, literacy, and physical environments. This report as well as the Fairfield County Community Wellbeing Index 2019 (Appendix A) provides information on many of these factors, as well as reviews key health outcomes.

Figure 3: Social Determinants of Health Framework
B. DATA COLLECTION METHODS – COMMUNITY INPUT

i. Quantitative Data

1. Reviewing existing secondary data
The Greater Greenwich CHNA builds off of previous efforts in the Greater Greenwich region including the 2016 CHNA and resulting CHIP which has guided the coalitions work over the past three years. In addition, the Community Health Needs Assessment utilizes secondary data from sources including, but not limited to, the U.S. Census, U.S. Bureau of Labor Statistics, Centers for Disease Control and Prevention, state public health departments, Connecticut Health Information Management Exchange (CHIME), as well as local organizations and agencies. Types of data include vital statistics based on birth and death records. Analysis of these extensive community health data sources are compiled in DataHaven’s *Fairfield County Community Wellbeing Index 2019*, which is appended to this document.

2. 2018 DataHaven Community Wellbeing Survey
The coalitions partnered with DataHaven, whose mission is to improve quality of life by collecting, interpreting, and sharing public data for effective decision-making, on the 2018 DataHaven Community Wellbeing Survey. The Community Wellbeing Survey team assisted the coalitions to gather quantitative primary data that were not provided by secondary sources and to understand public perceptions around health, including social determinants, and other issues. The Survey was conducted from March to November 2018 by the Siena College Research Institute. It was administered to randomly-selected landlines and cell phones and resulted in in-depth interviews with 16,043 adults statewide including 1,133 adults living in Greenwich, CT and Mamaroneck, Port Chester, Rye Brook and Rye Town, NY. The survey was designed by DataHaven and the Siena College Research Institute, in consultation with local, state, and national experts including members from the coalitions. Interviews were weighted to be statistically representative of adults in each city, town, or geographic region. Surveys were administered in both English and Spanish and zip codes were targeted to supplement samples of hard-to-reach populations.

The survey contains information that was previously unavailable at a local level from any other source and cross-sector analysis provides information on neighborhood quality, happiness, housing, transportation, health, economic security, workforce development, and other topics. Findings from the DataHaven Community Wellbeing Survey are primarily covered within the *Fairfield County Community Wellbeing Index 2019*. Detailed public data by town are available in crosstabs on the DataHaven website (https://ctdatahaven.org/reports/datahaven-community-wellbeing-survey).
ii. Qualitative Data

1. Community Conversations

In February 2019, five community conversations engaging a total of 127 individuals were conducted by Health Equity Solutions (HES) in the Greater Greenwich region. The Greenwich Community Health Improvement Partnership (GCHIP) organizations in Greenwich CT hosted three conversations and the Council of Community Services (CCS) organizations in Port Chester, NY hosted two conversations. The goals of the community conversations were to determine residents’ perceptions of health strengths and needs in the Greater Greenwich region; to identify gaps, challenges, and opportunities for addressing community needs more effectively; and to explore how these issues can be addressed in the future. Working with the GCHIP and CCS coalitions, groups having a disproportionate burden of health issues were identified (i.e., lower-income adults, uninsured residents, and individuals with limited English proficiency or Latino adults) as a priority to include in the community conversations. GCHIP and CCS members identified specific groups and/or organizations that fulfilled these criteria, and Health Equity Solutions organized and facilitated the following groups: low income, Hispanic parents, seniors (Port Chester and Greenwich); youth involved with a community center and low-income individuals at a soup kitchen.

Community conversations included a geographical sample of residents from both Greenwich and Port Chester.

2. Key Informant Surveys

The Community Health Needs Assessment was initiated in 2018 with the online key informant survey administered and analyzed by the Yale School of Public Health Student Consulting Group. The online survey was administered to two groups, consisting of community leaders and health and human service providers in the Greater Greenwich area using Qualtrics, an online survey tool. Members of the coalitions identified 211 (109 in Greenwich / 102 in NY) key informants between the two groups and had a 23% response rate overall (32% in Greenwich / 14% in NY). The Health and Human Services group included hospital administrators, state and local health department staff, physicians, nurses, and social service agency leaders. The Government and Community Leaders group included state and local elected officials, members of local police and fire departments, library directors, clergy, and other government agency heads. Surveys were designed to better understand the health needs of the Greater Greenwich region and included qualitative and quantitative questions on community health initiatives, health related problems, barriers to good health, health services, and current outlooks.

iii. Analyses

The secondary data and primary data from the 2018 Community Wellbeing Survey, community conversations, and key informant surveys were synthesized and integrated into this report.
iv. Limitations
As with all research efforts, there are several limitations related to the assessment’s research methods that should be acknowledged. Data based on self-reports should be interpreted with some caution. In some instances, respondents may over or underreport behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked. In addition, respondents may be prone to recall bias – that is, they may attempt to answer accurately but remember incorrectly. In some surveys recalling and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys particularly those using random sampling methods, benefit from large sample sizes and repeated administrations, enabling comparison over time.

While community conversations and key informant surveys conducted for this assessment provide valuable insights, results are not statistically representative of a larger population due to non-random recruiting techniques and a small sample size. It is also important to note that data were collected at one point in time, so findings, while directional and descriptive, should not be interpreted as definitive.
IV. FINDINGS

A. FAIRFIELD COUNTY COMMUNITY WELLBEING INDEX 2019

Overall Quality of Life and Economic Measures

From the DataHaven Community Index, which consists of a blend of indicators that illustrate the physical and social environments in which people live, overall findings include:

- Fairfield County scores well against US metros—among the top 20 percent nationally—but outcomes vary widely by race and ethnicity.
- Fairfield County ranks 15 out of 107 large US metropolitan areas, with a score of 655 out of 1,000. But the County is also home to the highest and lowest scoring geographic areas in our analysis, emphasizing its polarization on measures of well-being. For example, the towns of Greenwich and Fairfield score 745 and 720 on the Index, respectively, placing them above the best-performing metropolitan area in the nation (Madison, Wisconsin). However, the East End neighborhoods of Bridgeport have a score of just 418, which is lower than that of the lowest-performing US metro area (McAllen, Texas). These differences are largely related to income levels. The poverty rate among young children in the East End neighborhood of Bridgeport is more than 20 times greater than that of the wealthier towns.
- Asian and white residents are generally more advantaged than Black and Latino residents. The indicator with the highest degree of racial inequality is also young children in poverty. More than 1 in 4 Black children in the County live in poverty, compared to just 1 in 25 white children.
- The Community Index score predicts neighborhood-level life expectancy with a very high degree of accuracy. There is a 19-year difference in life expectancy between some neighborhoods in Fairfield County, including a 6-year difference between Bridgeport (77.7 years), the countywide average as a whole (82 years), and Greenwich (84 years).

Financial security measures also vary across the county, as shown in the table below.
### TABLE 2F

**Financial insecurity**  
SHARE OF ADULTS, FAIRFIELD COUNTY, 2018

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<th>UTILITY SHUTOFF THREAT</th>
<th>TRANSPORTATION INSECURE</th>
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**BY DEMOGRAPHIC WITHIN FAIRFIELD COUNTY**

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<td>7%</td>
<td>7%</td>
</tr>
</tbody>
</table>

**Source:** DataHaven Fairfield County Community Wellbeing Index 2019 (ctdatahaven.org)

All components of the DataHaven Community Index are shown in the table below, for areas for which it is calculated. The results show significant differences between Greenwich and other areas of Fairfield County, with Greenwich seeing lower rates of poverty and higher income levels and preschool enrollment rates. Adjacent Port Chester, NY has demographic and economic characteristics that are more similar to lower-income areas included in the table such as “Danbury central”.  

17
<table>
<thead>
<tr>
<th>LOCATION</th>
<th>OPPORTUNITY YOUTH</th>
<th>POVERTY</th>
<th>HIGH SCHOOL GRADUATES</th>
<th>YOUNG CHILD POVERTY</th>
<th>HEALTH INSURANCE COVERAGE</th>
<th>PRE-SCHOOL ENROLLMENT</th>
<th>UNEMPLOYMENT RATE</th>
<th>LIFE EXPECTANCY</th>
<th>SEVERE HOUSING COST BURDEN</th>
<th>YOUTH FULL-TIME EMPLOYMENT</th>
<th>WORKERS WITH SHORT COMMUTE</th>
<th>MEDIAN HOUSEHOLD INCOME</th>
<th>2017 COMM. INL.</th>
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<tbody>
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<td>US</td>
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<td>16%</td>
<td>24%</td>
<td>85%</td>
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<td>98%</td>
<td>2%</td>
<td>96%</td>
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<td>84.2</td>
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<td>17%</td>
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<td>70.7</td>
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<td>24%</td>
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<td><strong>INDIVIDUAL NEIGHBORHOODS</strong></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Bridgeport, central</td>
<td>14%</td>
<td>24%</td>
<td>75%</td>
<td>45%</td>
<td>82%</td>
<td>61%</td>
<td>15%</td>
<td>77.0</td>
<td>30%</td>
<td>30%</td>
<td>82%</td>
<td>$40,544</td>
<td>425</td>
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<tr>
<td>Bridgeport, East End</td>
<td>13%</td>
<td>26%</td>
<td>70%</td>
<td>34%</td>
<td>84%</td>
<td>65%</td>
<td>17%</td>
<td>76.0</td>
<td>33%</td>
<td>51%</td>
<td>82%</td>
<td>$38,573</td>
<td>418</td>
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<tr>
<td>Bridgeport, North/Black Rock</td>
<td>1%</td>
<td>11%</td>
<td>83%</td>
<td>21%</td>
<td>86%</td>
<td>77%</td>
<td>10%</td>
<td>78.7</td>
<td>22%</td>
<td>29%</td>
<td>56%</td>
<td>$66,562</td>
<td>602</td>
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<td>26%</td>
<td>70%</td>
<td>30%</td>
<td>0%</td>
<td>70.1</td>
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<td>67%</td>
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<td>82%</td>
<td>45%</td>
<td>6%</td>
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<td>26%</td>
<td>61%</td>
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<td>6%</td>
<td>92%</td>
<td>4%</td>
<td>86%</td>
<td>76%</td>
<td>7%</td>
<td>83.4</td>
<td>20%</td>
<td>26%</td>
<td>64%</td>
<td>$95,552</td>
<td>678</td>
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<tr>
<td>Norwalk, south/central</td>
<td>6%</td>
<td>18%</td>
<td>77%</td>
<td>32%</td>
<td>70%</td>
<td>74%</td>
<td>11%</td>
<td>79.3</td>
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<td>33%</td>
<td>66%</td>
<td>$85,523</td>
<td>517</td>
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<tr>
<td>Stamford, central</td>
<td>4%</td>
<td>15%</td>
<td>81%</td>
<td>17%</td>
<td>78%</td>
<td>56%</td>
<td>8%</td>
<td>80.0</td>
<td>24%</td>
<td>38%</td>
<td>67%</td>
<td>$83,307</td>
<td>580</td>
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<tr>
<td>Stamford, north</td>
<td>3%</td>
<td>5%</td>
<td>94%</td>
<td>3%</td>
<td>92%</td>
<td>69%</td>
<td>7%</td>
<td>83.1</td>
<td>20%</td>
<td>27%</td>
<td>67%</td>
<td>$115,174</td>
<td>728</td>
</tr>
</tbody>
</table>

Source: DataHaven Fairfield County Community Wellbeing Index 2019 (ctdatahaven.org)
Additional demographic and economic findings for the general area include:

- Since 2000, Fairfield County’s population has increased faster than that of Connecticut overall. Stamford has led the state in population growth from 117,083 residents in 2000 to 128,851 residents in 2017—just over a 10 percent increase.
- As of 2017, 63 percent of Fairfield County residents are white, 10 percent are Black, 19 percent are Latino, 5 percent are Asian, and 3 percent identify as another race/ethnicity. But the region is becoming more diverse: only half of young children and young adults (age 18-34) identify as non-Hispanic white.
- Fairfield County’s middle class neighborhoods have progressively shrunk in size between 1980 and 2017. While 46 percent of Fairfield County residents lived in middle-income neighborhoods in 1980, only 28 percent did in 2017.
- Between 1990 and 2017, the six wealthiest towns in the county saw over a 15 percent increase in inflation-adjusted median household income from $156,850 to $181,155. County-wide, however, inflation-adjusted median household income was stagnant during this period, decreasing by around 1 percent to $89,773 - a reflection of the wider statewide trend.
- Wages in Fairfield County overall are among the highest in the nation. However, even as average wages rose a modest one percent between 2000 and 2017 in the state as a whole, in Fairfield County they fell 4 percent. Wages for the fastest growing sectors in the region are well below the county average and have hardly grown since 2000: Health Care ($55,427 per year, +$797 since 2000), Education ($59,419, -$805) and Accommodation/Food Services ($25,274, -$2,473). While not a rapidly growing sector, retail is the second largest industry in the region with about 49,000 jobs and has an average wage of $40,271 - down 33% ($19,486) since 2000.
- There is a shortage in early care options in the county as coverage only expands to about 16 percent of infants and toddlers.
- Special education students and students eligible for free or reduced-prices meals were more than twice as likely as classmates outside of these high-needs designations to miss ten percent of school days during the 2017-18 school year.
- In Fairfield County public schools, black students are suspended or expelled at a rate 5 times greater than white students, and special education students are suspended or expelled 2.5 times as much as students who are not in special education.

Health outcomes
Prominent findings related to health outcomes in the region include:

- Overall, Fairfield County is very healthy by national and state standards. However, 76 percent of adults earning $100,000 or more per year report being in very good health, compared to just 41 percent of adults who earn less than $30,000 per year.
- While Fairfield County’s average life expectancy of 81.6 years is very high, it masks a dramatic difference in life expectancy within the region. In some neighborhoods life expectancy is as low as 70.4 years—nearly 19 years lower than that of the neighborhood with the highest life expectancy (89.1 years). Town-wide averages range from a maximum of 86.5 years in Weston to a minimum of 77.7 years in Bridgeport, a difference of nine years.
- Geographic discrepancies in the rates at which Fairfield County residents visit hospitals and emergency rooms appear to be growing. This is especially true for issues related to chronic diseases such as heart disease, diabetes, and lung disease, as well as for falls, depression, and substance use disorders.
• Variations in life expectancy may be explained by differences in the rates of premature death within the population. In Fairfield County, cancers, fetal and infant mortality, cardiovascular diseases, opioid use disorders, suicides, motor vehicle crashes, and homicides are most prominent among the causes of premature death as measured by YPLL-75. There are large differences in premature mortality by town and neighborhood. For instance:
  o “For every 100,000 residents under the age of 75, a total of 6,928 years of potential life were lost due to all premature deaths in Bridgeport each year from 2010 to 2014, compared to 2,667 in Greenwich. Heart disease, one of the leading causes of premature death, contributed 1,056 years of life lost in Bridgeport (based on 100 premature deaths each year, with an average age at death of 60) and 293 in Greenwich (16 premature deaths each year, with an average at death of 65). Homicides, a cause of premature death with some of the greatest disparities by place, race, and gender, led to the loss of 526 years of life (17 premature deaths from homicide each year, with an average age at death of 31) in Bridgeport, and nearly zero in Greenwich (fewer than one death per year).”
• The opioid overdose crisis has accelerated in recent years, with a doubling in the rate of overdose deaths in Fairfield County, peaking at 18 per 100,000 residents in 2018. The average age at death is around 40, indicating a massive loss of human potential. This crisis has hit Bridgeport particularly hard, but the number of opioid overdose deaths reported in Greenwich has remained relatively low.

Hospital encounters show concerns related to access to care, cardiovascular disease, substance use
As shown in the chart below from DataHaven’s analysis of CHIME data, rates of hospital and emergency room encounters among Greenwich residents appear to be far lower than the state (CT Aggregate) except for falls. In terms of volume, cardiovascular, mental health, and fall-related injuries are among most the common encounter conditions (note large change in scale between the two graphs below).
Annualized age-adjusted encounter rates per 10,000 residents
Greenwich and Connecticut, 2015-2017

More common encounter types
- Hypertension
- Mental disorder
- Diabetes
- Asthma, all encounters
- Falls
- Depressive disorder
- COPD
- Heart disease

Less common encounter types
- Substance abuse
- Motor vehicle accidents
- Dental
- Diabetes, uncontrolled
- Homicide & assault
- Stroke
- Lung cancer
- Suicide & self-harm

Age-adjusted encounter rate
Location: • Greenwich  ■ CT Aggregate
**Chronic disease risk factors vary within the region**
The chart below illustrates how risk factors for chronic diseases may vary widely by age, race/ethnicity, income level, and geography. Relatively speaking, greater needs are generally observed Bridgeport and Stratford. For example, smoking rates are 21% in Bridgeport and 14% in Stratford, versus just 7% in Fairfield and Greenwich.

**TABLE 29**
**Health risk factors**
**SHARE OF ADULTS WITH WELL-BEING AND CHRONIC DISEASE RISK FACTORS, FAIRFIELD COUNTY, 2018**

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>VERY GOOD SELF-RAT. HEALTH</th>
<th>ANXIETY</th>
<th>DIABETES</th>
<th>CURRENT ASTHMA</th>
<th>OBESITY</th>
<th>HAS HEALTH INSURANCE</th>
<th>DENTAL VENT PASTY</th>
<th>DEPRES.</th>
<th>SMOKING</th>
<th>FOOD INSECURITY</th>
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</thead>
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<td>78%</td>
<td>9%</td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>63%</td>
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<td>9%</td>
<td>9%</td>
<td>27%</td>
<td>64%</td>
<td>78%</td>
<td>8%</td>
<td>12%</td>
<td>11%</td>
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</table>

**BY DEMOGRAPHIC WITHIN FAIRFIELD COUNTY**

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<th>ANXIETY</th>
<th>DIABETES</th>
<th>CURRENT ASTHMA</th>
<th>OBESITY</th>
<th>HAS HEALTH INSURANCE</th>
<th>DENTAL VENT PASTY</th>
<th>DEPRES.</th>
<th>SMOKING</th>
<th>FOOD INSECURITY</th>
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<td>65%</td>
<td>78%</td>
<td>9%</td>
<td>13%</td>
<td>10%</td>
</tr>
<tr>
<td>Female</td>
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<td>11%</td>
<td>7%</td>
<td>11%</td>
<td>26%</td>
<td>65%</td>
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<td>8%</td>
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<td>70%</td>
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<td>12%</td>
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<td>10%</td>
<td>7%</td>
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<td>65%</td>
<td>71%</td>
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<td>87%</td>
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**BY GEOGRAPHY**

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<th>LOCATION</th>
<th>VERY GOOD SELF-RAT. HEALTH</th>
<th>ANXIETY</th>
<th>DIABETES</th>
<th>CURRENT ASTHMA</th>
<th>OBESITY</th>
<th>HAS HEALTH INSURANCE</th>
<th>DENTAL VENT PASTY</th>
<th>DEPRES.</th>
<th>SMOKING</th>
<th>FOOD INSECURITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgeport</td>
<td>64%</td>
<td>17%</td>
<td>13%</td>
<td>14%</td>
<td>40%</td>
<td>65%</td>
<td>62%</td>
<td>14%</td>
<td>21%</td>
<td>28%</td>
</tr>
<tr>
<td>Danbury</td>
<td>65%</td>
<td>12%</td>
<td>7%</td>
<td>9%</td>
<td>27%</td>
<td>65%</td>
<td>77%</td>
<td>7%</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Fairfield</td>
<td>65%</td>
<td>5%</td>
<td>8%</td>
<td>9%</td>
<td>26%</td>
<td>66%</td>
<td>80%</td>
<td>6%</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Greenwich</td>
<td>74%</td>
<td>10%</td>
<td>0%</td>
<td>N/A</td>
<td>14%</td>
<td>64%</td>
<td>87%</td>
<td>5%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Norwalk</td>
<td>62%</td>
<td>13%</td>
<td>9%</td>
<td>7%</td>
<td>24%</td>
<td>65%</td>
<td>78%</td>
<td>7%</td>
<td>0%</td>
<td>8%</td>
</tr>
<tr>
<td>Stamford</td>
<td>67%</td>
<td>10%</td>
<td>8%</td>
<td>8%</td>
<td>23%</td>
<td>64%</td>
<td>80%</td>
<td>7%</td>
<td>0%</td>
<td>8%</td>
</tr>
<tr>
<td>Stratford</td>
<td>51%</td>
<td>16%</td>
<td>15%</td>
<td>11%</td>
<td>37%</td>
<td>65%</td>
<td>72%</td>
<td>14%</td>
<td>16%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Source: DataHaven Fairfield County Community Wellbeing Index 2019 (ctdatahaven.org)

**Barriers in accessing care vary within the region**
The chart below illustrates how barriers to accessing health care also may vary widely by age, race/ethnicity, income level, and geography. Barriers to accessing health care are generally reported to be highest in Bridgeport, and lowest in Greenwich and similar higher-income towns. But throughout the county as a whole, many young adults (26%) lack a medical home and have not visited a dentist in the past year (30%).
# TABLE 3E

## Barriers to healthcare

SHARE OF ADULTS, FAIRFIELD COUNTY, 2018

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>DIDN'T GET CARE</th>
<th>POSTPONED CARE</th>
<th>NO MEDICAL HOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>9%</td>
<td>23%</td>
<td>12%</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>9%</td>
<td>22%</td>
<td>13%</td>
</tr>
</tbody>
</table>

### BY DEMOGRAPHIC WITHIN FAIRFIELD COUNTY

<table>
<thead>
<tr>
<th>Category</th>
<th>DIDN'T GET CARE</th>
<th>POSTPONED CARE</th>
<th>NO MEDICAL HOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>9%</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td>Female</td>
<td>9%</td>
<td>25%</td>
<td>11%</td>
</tr>
<tr>
<td>Age 18–34</td>
<td>12%</td>
<td>30%</td>
<td>26%</td>
</tr>
<tr>
<td>Age 35–49</td>
<td>8%</td>
<td>26%</td>
<td>17%</td>
</tr>
<tr>
<td>Age 50–64</td>
<td>9%</td>
<td>22%</td>
<td>7%</td>
</tr>
<tr>
<td>Age 65+</td>
<td>5%</td>
<td>10%</td>
<td>2%</td>
</tr>
<tr>
<td>White</td>
<td>7%</td>
<td>21%</td>
<td>11%</td>
</tr>
<tr>
<td>Black</td>
<td>11%</td>
<td>21%</td>
<td>17%</td>
</tr>
<tr>
<td>Latino</td>
<td>14%</td>
<td>28%</td>
<td>20%</td>
</tr>
<tr>
<td>Under $30K</td>
<td>17%</td>
<td>27%</td>
<td>16%</td>
</tr>
<tr>
<td>$30K–$100K</td>
<td>10%</td>
<td>24%</td>
<td>19%</td>
</tr>
<tr>
<td>$100K+</td>
<td>5%</td>
<td>21%</td>
<td>10%</td>
</tr>
</tbody>
</table>

### BY GEOGRAPHY

<table>
<thead>
<tr>
<th>Location</th>
<th>DIDN'T GET CARE</th>
<th>POSTPONED CARE</th>
<th>NO MEDICAL HOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgeport</td>
<td>14%</td>
<td>25%</td>
<td>19%</td>
</tr>
<tr>
<td>Danbury</td>
<td>10%</td>
<td>22%</td>
<td>15%</td>
</tr>
<tr>
<td>Fairfield</td>
<td>7%</td>
<td>22%</td>
<td>12%</td>
</tr>
<tr>
<td>Greenwich</td>
<td>8%</td>
<td>19%</td>
<td>8%</td>
</tr>
<tr>
<td>Norwalk</td>
<td>10%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Stamford</td>
<td>8%</td>
<td>21%</td>
<td>9%</td>
</tr>
<tr>
<td>Stratford</td>
<td>9%</td>
<td>25%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Source: DataHaven Fairfield County Community Wellbeing Index 2019 (ctdatahaven.org)
B. REGIONAL COMMUNITY CONVERSATIONS
Community conversations, similar to focus groups, are meant to provide the perspective of specific populations of important and otherwise potentially hard to reach community members, as part of the community health needs assessment process. Health Equity Solutions (HES), GCHIP and CCS worked collaboratively to identify host organizations for each community conversation. A total of 127 individuals participated in five community conversations during February 2019. The goals of the conversations were to determine perceptions of the community, health, and health care in the Greater Greenwich region, including community strengths, concerns, health services and service gaps, perceptions about discrimination, and health improvement priorities.

PARTICIPANT DEMOGRAPHICS
The final set of participants yielded a diverse cross-section of community members across various demographic variables: gender, age, race, ethnicity, income level, employment status, and geography. The overall demographic make-up of the groups included more females (59%) than males (41%). With regard to race, 22% were white, 14% black and 3% were American Indian/Alaska Native. Due to space constraints on the demographic survey tool, only one ethnicity was listed and 61% of participants identified their ethnicity as Hispanic. One-fourth of the participants were single, 34% were married or in a domestic partnership, 24% were widowed, and 12% divorced or separated. Thirty-one percent of the participants were employed, 31% were retired, 9% were unable to work, and 5% were homemakers. Table 1 illustrates the overall demographics of the participants in community conversations.

Table 1: Greater Greenwich Community Conversation Demographics

<table>
<thead>
<tr>
<th>Gender</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>59%</td>
</tr>
<tr>
<td>Male</td>
<td>41%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;18</td>
<td>13%</td>
</tr>
<tr>
<td>18-26</td>
<td>9%</td>
</tr>
<tr>
<td>27-34</td>
<td>1%</td>
</tr>
<tr>
<td>35-44</td>
<td>6%</td>
</tr>
<tr>
<td>45-54</td>
<td>15%</td>
</tr>
<tr>
<td>65-74</td>
<td>18%</td>
</tr>
<tr>
<td>75+</td>
<td>37%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native</td>
<td>3%</td>
</tr>
<tr>
<td>Asian</td>
<td>0%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>14%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>61%</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>0%</td>
</tr>
<tr>
<td>White</td>
<td>22%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>English as First Language</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>42%</td>
</tr>
<tr>
<td>No</td>
<td>58%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single, never married</td>
<td>29%</td>
</tr>
<tr>
<td>Married or domestic partnership</td>
<td>34%</td>
</tr>
<tr>
<td>Widowed</td>
<td>24%</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>12%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed for wages</td>
<td>31%</td>
</tr>
<tr>
<td>Self-employed</td>
<td>5%</td>
</tr>
<tr>
<td>Out of work and looking for work</td>
<td>5%</td>
</tr>
<tr>
<td>A homemaker</td>
<td>5%</td>
</tr>
<tr>
<td>A student</td>
<td>12%</td>
</tr>
<tr>
<td>Military</td>
<td>0%</td>
</tr>
<tr>
<td>Retired</td>
<td>31%</td>
</tr>
<tr>
<td>Unable to work</td>
<td>9%</td>
</tr>
<tr>
<td>Out of work and not looking for work</td>
<td>2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place of Residence</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Greenwich</td>
<td>57%</td>
</tr>
<tr>
<td>Port Chester</td>
<td>40%</td>
</tr>
<tr>
<td>Rye Brook</td>
<td>3%</td>
</tr>
</tbody>
</table>
Topics explored during the community conversations focused on the overall strengths and concerns about the community, health issues, perceptions of health care services, gaps in services, the impact of discrimination and recommended priorities to address over the next three years. All community conversations were recorded and transcribed to accurately assess emerging themes from the conversation. One community conversation included graphic recording during the meeting which captured key thoughts and themes in word artform (Figure 4).

Figure 4: Graphic Recording, Community Conversation

An analysis of themes that emerged during the conversations was organized around the Social Determinants of Health (SDOH). SDOH are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. The following are the categories from the Greater Greenwich Region:

Health and Health Care System
- Access to Care & Provider Availability
- Transportation

Neighborhood and Built Environment
- Food
- Safety

Social and Community Context
- Mental Health
- Substance Use Disorder

Key themes from the conversations included access to care and provider availability, transportation challenges, insurance, mental health access, opioid use, and the safety and affordability of healthy eating.

Health and healthcare were the most frequently discussed topics in the community conversations. Availability of providers—both primary and specialists—emerged as a common theme across all the conversations. Participants indicated that fewer doctors are accepting Medicare, more physicians are leaving general practice to pursue concierge
medicine and there are too few specialists in Greenwich. Seniors expressed the need for more information and support for end-of-life care, including hospice services.

The cost of health care was discussed at all the conversations. Greenwich youth revealed that they sometimes do not seek healthcare because of the potential financial impact on parents. Among low income and undocumented residents, the uninsured rate is higher. Some participants preferred to pay the fine associated with not having insurance rather than pay the high costs.

Insurance coverages was another area of concern. Participants voiced dissatisfaction with lack of coverage for holistic medicine. Seniors were also frustrated with Medicare drug plans. In Port Chester, there was the perception that healthcare provided at the federally qualified health center is minimal and that residents had to leave the community for hospital and emergency room services. The increase in the number of individuals diagnosed with and living with diabetes was also mentioned in most of the conversations. In Port Chester, participants expressed interest in having more educational programs from Greenwich Hospital, especially at senior centers.

Medical transportation related issues were discussed in all of the conversations except the conversation with youth. Subthemes include timing, availability, cost, and reliability of transportation. Transportation issues in Port Chester were a more significant concern than in Greenwich. Mobility and access for wheelchairs was also identified as an issue in some areas in Greenwich.

The cost of healthier eating was a theme in most of the community conversations. Although individual awareness and desire to consume healthy foods was high, participants expressed concerns about the cost and availability of healthier foods, especially in Port Chester. Food insecurity was also a concern.

In conversations, safety emerged as a theme. In Greenwich, seniors identified the need for more attention to unsafe and unmarked/lighted areas, particularly in public places, that cause falls. Given the increase in traffic, participants felt that speed enforcement is needed in areas around senior housing in light of a recent fatality. In Port Chester, participants communicated concerns about smoking around apartment buildings.

A high level of concern was expressed about mental health at all ages. In all conversations, stigma about seeking services was identified as a barrier. Youth conveyed that many young people are dealing with anxiety. Youth also indicated that more attention is needed for suicide prevention. Seniors discussed that prevalence of depression is a concern, but that many seniors do not know how to seek assistance for themselves or a spouse. In Port Chester seniors voiced a need for support for grief and grieving.

Substance abuse, including alcoholism, and its impact on families was a theme in all conversations. The rise in vaping and use of e-cigarettes was also discussed in all conversations. Although vaping was seen as tool to help individuals to stop tobacco use, participants also acknowledged that the adverse effects of vaping and its high nicotine levels are still unknown. Among youth, vaping is beginning in middle school and is being normalized in high schoolers.

Participants attending the community conversations completed a short survey at the end of the session. On the survey, participants were asked to provide demographic information, perceptions about access to healthcare and healthcare experiences, top healthcare issues and top barriers for the community.
C. KEY INFORMANT SURVEYS
CHNA related efforts were initiated in 2018 with a combination of primary data components including an online key informant survey that was administered and analyzed by the Yale School of Public Health Student Consulting Group. The online survey was developed using Qualtrics, an online survey tool, and was designed to be completed by two groups, Health and Human Services providers, and Government and Community Leaders in the Greenwich area. Members of the coalitions identified 211 (109 in Greenwich / 102 in NY) key informants between the two groups and achieved a 23% response rate overall (32% in Greenwich / 14% in NY). The Health and Human Services group included hospital administrators, state and local health department staff, physicians, nurses, and social service agency leaders. The Government and Community Leaders group included state and local elected officials, members of local police and fire departments, library directors, clergy, and other government agency heads. Within the context of survey research, key informant refers to a person with whom an interview about a particular organization, social program, problem, or interest group is conducted. In a sense, the key informant is a proxy for her or his associates at the organization or group. Key informant interviews are in-depth interviews of a select (nonrandom) group of experts who are most knowledgeable about the organization or issues. Often used as part of program evaluations and needs assessments, these targeted interviews allow us to explore and understand the current health status of the community, identify strengths upon which to build, and prioritize efforts for the future.

Greenwich

Surveys included qualitative and quantitative questions about community health initiatives, common health-related problems, barriers to good health, health services, and current outlooks. The key informant online surveys, indicated that 97% of respondents knew about the 2016 Community Health Needs Assessment and Community Health Improvement Plan compared to 80% of respondents who had known about the 2013 CHNA when a similar survey was conducted in 2015. Nearly 60% of respondents in 2018 were aware of new health initiatives in the area including Mental Health First Aid, Narcan Training, Age and Dementia friendly Greenwich initiative, information sessions about vaping and opioid use, Family Centers Health Center at Wilbur Peck introduction of interagency team.

Across survey responses, recurring themes identified the top five health issues of greatest concern to respondents: mental health and addiction; access to and use of health services; chronic disease, elderly and aging issues, and physical activity / nutrition (Figure 5). The top health issues identified by the key informants align with the health priorities confirmed through the CHNA process in 2015 / 2016 and again in 2018 / 2019 (Healthy Lifestyles, Access to Care, and Behavioral Health).
When asked to identify the most significant challenge(s) to improved health, 47 percent of respondents pointed to social barriers which they indicated impacted the awareness of health issues for adults and resulted in a lack of empathy, and language barriers. This was similar to 56% of respondents who indicated that social barriers, such as overcrowded housing, poverty, and educational gaps, were the most significant challenge for children. The top three socio-economic barriers to good health that were identified by respondents were 1) access to medical insurance, 2) access to housing, and 3) access to healthy food.

Respondents perceive limited access to mental health care, which may be contributing to rising concerns about mental health and addiction as a top health issue in the region (Figure 6). Respondent perception is shifting to uncertainty or questioning relative to whether others are treated equally compared to 2015.
Lastly, respondents felt that the top three issues for policy makers to address included: 1) reducing opioid overdoses, 2) reducing tobacco use, and 3) ensuring community safety.

New York

Surveys included qualitative and quantitative questions about community health initiatives, common health-related problems, and barriers to good health, health services, and current outlooks. The key informant online surveys indicated that 57% of respondents knew about the 2016 Community Health Needs Assessment and Community Health Improvement Plan. Twenty-one percent of respondents in 2018 were aware of new health initiatives in the region including expansion of sidewalks, Rye YMCA bilingual / Spanish programs for Diabetes Prevention Program, and Edgewood Park being more accessible including additional parking spaces.

Across the survey responses, recurring themes identified the top five health issues of greatest concern to respondents as: chronic disease; mental health and addiction, access to and use of health services; violence and safety, and physical activity / nutrition (Figure 7). The top health issues identified by the key informants align with the health priorities confirmed through the CHNA process in 2015 / 2016 and again in 2018 / 2019 (Healthy Lifestyles, Access to Care, and Behavioral Health).
When asked to identify the most significant challenge(s) to improved health, 41 percent of respondents pointed to economic barriers, which they indicated impacted adults’ and resulted in inadequate insurance coverage, lack of affordable health care, and transportation issues for disabled individuals for health-related appointments. This was similar to the 44% of respondents who indicated that economic barriers, such as lack of health insurance, high health costs, and costs of healthy foods were the most significant challenge(s) for children. The top three socio-economic barriers to good health that were identified by respondents were 1) access to medical insurance, 2) access to employment, and 3) access to healthy food.

Respondents believe there is limited access to mental health care despite rising concerns as a top health issue (Figure 8).
Lastly, respondents felt that the top three issues for policy makers to address included: 1) reducing opioid overdoses, 2) ensuring good maternal and infant health, and 3) ensuring community safety.
V. COMMUNITY ENGAGEMENT

In April 2019, an overview of the CHNA process and specific findings were disseminated at a community forum held at Greenwich Town Hall on behalf of the coalitions. On Tuesday, April 2, 2019, 42 community members attended a community forum with representation from 22 organizations and groups. At this session the group were given an overview of the Community Health Needs Assessment including a review of the purpose and scope, the 2019 primary and secondary data findings, and the 2019 focus area goals and strategies within each of the three priority areas (Healthy Lifestyles, Access to Care, and Behavioral Health). Participants were given an opportunity to confirm 2019 priorities, and draft implementation strategies. Following the presentation of the data, participants divided into three groups to provide feedback on the 2019 priorities, and draft implementation strategies.

In addition, a copy of Greenwich Hospital’s 2016 Community Health Needs Assessment and Implementation Plan was made available for public comment for a period of time throughout the 2019 assessment process. Greenwich Hospital placed a public notice in the Greenwich Time newspaper and created a dedicated email address for the receipt of written comments. No written comments were received.

This Community Health Needs Assessment document combined with the attached Fairfield County Community Wellbeing Index 2019, prepared by DataHaven, serves as the CHNA document for Greenwich Hospital along with the Greenwich Department of Health, Westchester Department of Health and other members of the coalitions. The Community Health Needs Assessment will be made widely available through individual members’ websites.
VI. PRIORITIZATION OF HEALTH ISSUES

A. 2016 COMMUNITY HEALTH IMPROVEMENT PLAN PROGRESS-TO-DATE

Greenwich Hospital Community Commitment

The Greenwich Hospital Board of Trustees is directly involved in the Community Health Needs Assessment (CHNA) and Community Health Improvement Plans (CHIP) through a subcommittee called the Community Advisory Committee (CAC). A Board of Trustees member chairs the CAC, which meets bi-annually to discuss the community benefit strategies as well as specific community outreach implementation activities based on identified health needs. The CAC includes 30 members who represent a variety of community organizations including the United Way, YMCA, YWCA, faith based organizations, local municipal health departments, Family Centers, Youth and Senior Services representatives, Mental/Behavioral Health professionals, National Association for the Advancement of Colored People, Housing Authorities of Greenwich and Port Chester, Chambers of Commerce, libraries, federally qualified health centers, Greenwich Emergency Medical Services (GEMS) and other private and corporate groups. The President and Chief Executive Officer of Greenwich Hospital, Chief Operating Officer of Greenwich Hospital and several other senior level administrators attend CAC meetings. The CAC Chairman provides updates on community benefit programs and community health improvement initiatives at Greenwich Hospital Board of Trustees meetings.

Greenwich Community Health Improvement Partnership (GCHIP)

In 2003, the CAC established the Greenwich Community Health Improvement Partnership (GCHIP) to assess and implement initiatives to support the health needs of the Greenwich community. The Greenwich Community Health Improvement Partnership (GCHIP) meets monthly and is a collaborative group composed of professionals from diverse service organizations and laypeople that have a vested interest in improving the health of their communities.

The members of the GCHIP are representatives from the Town of Greenwich Department of Health, Department of Human Services, the United Way, Board of Education, PTA, Greenwich Library, League of Women’s Voters, Housing Authority of Greenwich, Child Guidance Centers, Greenwich Police Department, Family Centers, Inc., Pathways, YMCA, YWCA, Communities 4 Action, Family Centers Health Care, Laurel House, Liberation Program, ShopRite, Health Substance Misuse Education, The HUB: Behavioral Health Actions Organization for Southwestern CT, National Alliance on Mental Illness (NAMI), Greenwich Emergency Medical Services (GEMS), Boys & Girls Club, Greenwich Adult Day Care, Greenwich Alliance for Education and numerous other interested community members. Attaining the goals of building healthy communities is possible through collaborative efforts and relationships that have been established between Greenwich Hospital and the various community groups in GCHIP. The Hospital provides staff and financial support for the Greenwich Community Health Improvement Partnership. Over the last decade, the GCHIP has implemented over 80 health initiatives that have greatly benefitted the Greenwich and lower Fairfield County communities.

The Council of Community Services (CCS)

In New York, Greenwich Hospital collaborates with The Council of Community Services (CCS) of Port Chester, Rye Brook, and Rye Town to provide community health outreach activities and support the health needs of the local communities. The Port Chester /Town of Rye Council of Community Services, Inc. was founded in 1974 by a group of concerned citizens who believed that more community awareness and participation was necessary to meets the needs of all local residents, regardless of race, age, or income. Over the past 42 years, the Council has grown and today, the Council
continues to bring together an array of community members, organizations and agencies in order to promote effective services and community integration. The CCS board members meet quarterly in Westchester, NY, and a Greenwich Hospital representative is a board member. The CCS has approximately 15 board members that meet quarterly and collaborate with other community organizations with the overall mission of bringing together community leaders and linking people with community resources to meet the vital needs of the community. Greenwich Hospital as a community partner provides staff and financial support for the CCS health and wellness initiatives.

The CCS goals are to facilitate and encourage agencies to share information to avoid duplication of services and increase community integration. CCS programs enhance and support seniors and promote positive youth development. Some initiatives include:

- Camp Scholarships – for low-income youth to attend summer camps.
- Community & School Gardens- to foster healthy eating and physical activity and to reduce obesity
- Affordable Housing Information and Advisory
- Health Information and Resources
- Drug Abuse Prevention Programs – to foster healthy drug free kids and prevent teens substance abuse and support healthy choices
- Supporting Healthy Aging – to support seniors and healthy aging in place.

The CCS collaborates with multiple organizations in Westchester County. They include Houses of Worship, Open Door Family Medical Centers, Don Bosco Community Center, Family Services of Westchester, NAACP, PCRRB Volunteer Ambulance Corps, Port Chester / Rye Brook Rotary Club, Port Chester Carver Center, Port Chester Housing Authority, Port Chester Village Board, Port Chester School District, Port Chester Police, Posillipo Senior Community Center, Port Chester Senior Center, Village of Port Chester, Village of Rye Brook, Westchester County Senior Programs and Services, Westchester County Board of Legislators, Westchester County Board of Health, Blind Brook School District, Rye YMCA and Greenwich Hospital.

The GCHIP and CCS community partnerships continue to support the Greenwich Hospital Community Health Improvement Plans (CHIP) and assists in conducting collaborative implementation strategies. The partnership CHIP model produces a collective impact that affects change by having partners share common values and goals. The GCHIP and CCS partnership members' discussions, work and actions focus on addressing local health disparities and conduct root cause prevention modalities. The GCHIP and CCS distribution group includes outreach to over 100 community representatives.

In 2016, Greenwich Hospital along with local health departments, GCHIP and CCS members completed a CHNA and a prioritization process to identify priority health issues. From this work, three areas of focus were selected including: Access to Care, Cancer, Healthy Lifestyles, and Behavioral Health. The GCHIP and CCS partnership members developed action teams or sub-committees. They collaborated to work on implementation strategies and tactics to address the identified prioritized health needs. The three action teams developed include:

- Access to Care Team
- Healthy Lifestyles Team
- Behavioral Health Team
Each Action Team meets monthly to design strategies related to their health priority area and more broadly address the Social Determinants of Health. Each Action Team also cross-pollinates ideas and activities between the Action Teams, assessing potential collaborating opportunities. Each Action Team develops programs and services and support each other’s initiatives and implementation strategies with the goal of building healthy communities.

From 2016-2019, Action Teams have made significant progress towards their CHIP goals in the greater Greenwich region including:

Access to Care Accomplishments

The Access to Care Team has developed coordinated programs to promote entry points to multiple services (insurance and enrollment, health literacy, health information/resources and health screenings) at diverse locations. This work is supported by the efforts of both partnerships’ initiatives and Greenwich Hospital. Accomplishments include:

Greenwich Hospital Initiatives

- Nurse Is In – program providing free blood pressure screenings with health education and counseling to approximately 6,000 people at health fairs and diverse community sites.
- Parish Nurse- in collaboration with the First Congregational Church of Greenwich, a registered nurse conducts screenings, coordinates support groups, conducts health education programs, provides flu shots, coordinates blood drives and serves as confidant for over 2,000 church members.
- Parent Exchange- a parent’s self-help group offering parenting classes and support groups divided according to the age of the child, from 4 months through high school.
- Consumer Health Librarian- librarian located at the hospital who encourages, enables, and supports patients, families, and the community at large to make informed decisions about their healthcare needs by providing evidence based resources.
- Teddy Bear Clinic- event held annually at Greenwich Hospital in collaboration with various healthcare professionals to promote interactive education on health and wellness to over 1,800 community residents.
- Tender Beginnings- pregnancy and parenting programs for couples and families to help them prepare for pregnancy, labor, delivery and baby care.
- Heart and Stroke Fair- event held annually to provide free screenings and resources by healthcare professionals. Over 100 community members attend.
- Survivorship Fair- event conducted annually with various healthcare professionals to celebrate cancer survivors from throughout the community.
- Free metabolic screenings-screenings conducted at hospital and other community sites to promote Knowing Your Numbers and provide to access to care.
- Greenwich Outpatient Clinic Programs- the Outpatient Center is a healthcare resource for Greenwich residents who are uninsured or under-insured. Each year, more than 5,000 adults and children visit the Outpatient Center and Pediatric Outpatient Center for medical treatment and preventive care.
- Center for Healthy Aging Programs – center for older adults and their families to access outpatient services designed to improve quality of life, including aging assessments, psychiatric screenings, programs and support groups for family and caregivers.
- Center for Behavioral and Nutritional Health- center offering scientifically and medically based services for those struggling with their health or seeking to prevent future health problems. The Center’s mission is the promotion of health and wellness as well as the management and prevention of acute and chronic medical conditions.
- Free cancer screenings and exams – Annually free Prostate, Mammograms, Head and Neck screening are conducted.
• Support Groups - Facilitated and conducted support groups (Prostate Cancer, Cancer Wellness Series, Thriving Well with Cancer, Breast Cancer Support, Diabetes Support, Stroke, Heart, Better Breathers, Parkinson’s, Multiple Sclerosis, Chronic Pain, Caregiver Support, Guillian-Barre, Bariatric Support) are offered to the community.
• Men’s Health - (Movember) program conducted to promote men’s health and wellness
• Women’s Health - programs conducted to promote women’s health and wellness
• Speakers’ Bureau/Lectures – lectures offered on Cancer Awareness and Prevention, Ban the Burn/Sun Safety, GI Health, Colon Cancer Awareness, Lung Cancer Awareness, Breast Cancer Awareness, Genetics and Cancer, Tree of Light Ceremony at Greenwich Hospital, Women’s Wellness, Chronic Pain Management, Stroke Awareness and Prevention, Advance Directives and Healthy Aging. Know Your Numbers and Know Your Meds for the community.
• Collection and distribution of Hygiene Kits for homeless at area soup kitchens.

Partnership Initiatives
• Collaborated with multiple community organizations to co-host health fairs to promote healthy lifestyles, and access to health resources and service providers.
  o Access to Care Health Fair in Mamaroneck NY
  o Honor Your Health Hispanic Health Fair in Stamford CT
  o Port Chester Fair
  o Senior Wellness Fair in Greenwich CT
  o Westchester County Senior Expo Fair in White Plains NY
  o Rye Brook Fair
  o Rye Derby Day
  o Greenwich Housing Authority Health Fair (Wilber Peck and Adam’s Garden)
  o Port Chester Housing Authority Health Fair (Drew’s Garden and Terrace)
  o Boy’s and Girl’s Club Fair in Greenwich CT
• CLAS: Conducted three Culturally and Linguistically Appropriate Services (CLAS) training programs to promote cultural diversity.
• Conducted Oral Health seminar and provided resources on regional dental health services. Seventy-five (75) participants attended.
• Developed Guide to Oral Health Brochure and distributed to over 100 community partners.
• Conducted Relay for Life with American Cancer Society (ACS). This event was attended by more than 500 community members to raise funds for the ACS.
• Annually conducted Great American Smoke-Out Program with American Cancer Society with programs held at local libraries and area schools.
• Participated in Healthier Port Chester and Mamaroneck Coalitions programs to promote schooled based edible gardens and safe routes to schools.
• Co-Sponsored Interfaith Wellness Conference in Port Chester NY that brought together 55 faiths and community leaders to share information about wellness programs.
• Participated in Westchester Aging in Place Programs to assist seniors living in their homes.
• Co-sponsored American Cancer Society & American Heart Association fund raising events.
Healthy Lifestyles Accomplishments
The Healthy Lifestyles Team organized and conducted multiple programs with the goal of promoting healthy behaviors to reduce risk factors for chronic disease. This work is supported by the efforts of both partnerships’ initiatives and Greenwich Hospital initiatives. Accomplishments include:

Greenwich Hospital Initiatives
- Facilitated support groups – The Hospital groups included Chronic Pain, Better Breather’s, Parkinson’s, Multiple Sclerosis, Heart Education, Stroke, Weigh to Be (TOPS), 12 Week Medical Weight Loss Program, Diabetes, Parent Exchange Support Group and Living Well with Cancer.
- Conducted and facilitated health and wellness programs – Greenwich Hospital collaborated with area healthcare educators and community partners to help develop wellness and health promotions programs to our diverse community members.
- Know Your Numbers – This annual event for employees conducts health screenings and provides healthy lifestyle resources.
- Fresh Start Smoking Cessation Program American Cancer Society – This free four-week smoking cessation program was conducted twice a year. This is an evidence-based approach designed to help smokers increase motivation with effective methods to stop smoking, including intervention activities, problem-solving skills, social support and medication education.
- Diabetes Self-Management Programs – Certified diabetes educators provided individual and group counseling, education and support to help understand the causes of diabetes and prediabetes, and how to self-manage Types 1 and 2 diabetes and glucose levels. Also, educates individuals on ways to reduce the risk of complications through food, physical activity and medication.
- Scout Medical Explorers – After-school program sponsored in partnership with the Greenwich Boy Scouts of America which gives an in depth view of various healthcare careers. Participants learned about numerous hospital settings and speak with healthcare professionals while touring Greenwich Hospital.
- Kids in the Kitchen – Annual program conducted at children based community centers and schools to promote health and wellness by teaching and empowering youth to make healthy lifestyle choices in order to prevent obesity and its associated health risks.
- Speaker’s Bureau/ Lectures – The Hospital lectures included Healthy Habits, Mediterranean Diet, Plant-Based Diet, Healthy Meal Planning On a Budget, Reading Food Labels, Benefits of Exercise, Benefits of Sleep and Tai Chi, Bone Health, Know Your Meds, Fall Prevention, Sun Safety, Dietary Approaches to Stop Hypertension (DASH)
- Free Screenings – The Hospital conducted free screenings including Body Mass Index, Blood Pressure, and Metabolic screening (Cholesterol, HDL, LDL, Triglycerides, and Glucose)
- Resources – The Hospital provided evidence based information and resources to the community including Life’s Simple 7, Get Healthy CT, My Plate, Stroke Awareness, Melanoma Prevention, Self-Breast Exam Shower Cards.
- Health Care Careers Programs – The four-week, after school program between Greenwich Hospital and high schools aimed to educate and inspire students to pursue fulfilling healthcare careers. Promotes healthy lifestyle education (smoking prevention and healthy diets)
- Diabetes Self-Management Education (DSME) – The Hospital offered classes to assist people living with diabetes.
- Cancer Survivorship Fair - Conducted annually with various healthcare professionals and community partners, the fair celebrated more than 100 former patients, volunteers and oncology staff as a tribute to cancer survivors from throughout the community. The celebration features information about resources available at the hospital and numerous partners in cancer care, including the Yale Cancer Genetic Counseling Program, the American Cancer Society, the Good Dog Foundation, CancerCare and Healing Touch.
Partnership Initiatives

- Co-hosted and conducted Injury Prevention programs including Bike Safety, Fall Prevention, AARP
- Co-hosted and conducted in collaboration with community partners including Oral Health Seminar, Family Night Out, Weigh to Be (TOPS), Vaping Prevention education
- “Healthy Shopping on a Budget” seminar, to teach individuals how to cost effectively eat healthy was offered and 40 people attended.
- Expanded Get Healthy CT website to include Greater Greenwich resources on Healthy Eating and Physical Activity in order to promote healthy eating and reduce obesity and chronic diseases
- A Healthy Eating seminar entitled Beyond Kale: The Superfoods, was held and 35 community members attended.
- Created and distributed a Greater Greenwich Farmers’ Market list
- Created and distributed a Greater Greenwich Diabetes Directory
- Conducted programs at various community sites with resources on sun safety and awareness of skin cancer.
- Donated 2,000 dollars to Healthier Sound Shore to purchase automated Blood Pressure equipment for low income residents with eligible medical conditions.
- Offered a seminar on Mind-Body-Mouth connection to promote oral health.

Behavioral Health Accomplishments

The Mental Health Team is a network of behavioral health service providers who educate, advocate, coordinate access to mental health services and providers. This work is supported by the efforts of both partnerships initiatives and Greenwich Hospital initiatives. Accomplishments include:

Greenwich Hospital Initiatives

- The Addiction and Recovery Center (ARC) offered many options to people seeking high-quality alcohol and substance abuse treatment. ARC’s continuum of care includes initial stabilization, early recovery skills, an intensive outpatient program, individual therapy, medication consultation, family education and counseling. Program counselors are graduate-trained and licensed in substance abuse, social work and family therapy.
- Facilitated Support groups – The Hospital groups included Alcoholics Anonymous (AA), Al-Anon, Drugs Anonymous (DA), LifeRing, Coping with Loss, Sleep Support Group, Healing Touch
- The Hospital had Diversity and Inclusion programs which promoted positive mental health
- Speakers Bureau: The Hospital offered lectures including Narcan and Opioids, Nutrition & Your Mental Health, Marijuana & Addiction, Reducing Stress
- The Hospital offered yoga programs 2-3 times per year which were open to all community members.
- The Hospital supported Tai Chi programs which were conducted throughout the community and hospital to promote physical and mental wellness.
- Mindful Meditation programs were conducted to promote physical and mental wellness.
- A program entitled Tips for Talking to Children and Teens About Mental Illness was held by the Hospital.
- Vaping and marijuana prevention informational programs were conducted through the community to promote awareness and prevention on the risks of vaping and marijuana abuse.
- A $ 5,000.00 grant was given to area first responders to purchase Naloxone for distribution.
- Provided Employee Assistance Programs related to behavioral health for employees and their family members.
Partnership Initiatives

- Conducted three Mental Health First Aid (MHFA) trainings.
- Conducted NARCAN/Opiate Epidemic trainings.
- Held Domestic Violence Awareness seminars.
- Held a community “Myth-Busters” series which focused on the dangers of Marijuana, Vape & Hookah Opiate.
- Sponsored “Chasing the Dragon” heroin/opiates awareness program with the Drug Enforcement Agency (DEA).
- Offered suicide prevention training including Question, Persuade, Refer (QPR) training for suicide prevention.
- Sponsored Mindfulness Meditation Sessions as a stress management tool.
- Co-sponsored Sensory Modulation Technique Seminar: a tool that supports initiatives to reduce seclusion and restraint use.
- Co-sponsored a film, Anonymous People. The documentary film focuses on adult’s recovery from alcohol and drug addiction.
- Co-sponsored a Community Forum on the Proposed Legalization of Recreational Marijuana to raise awareness about the pro and cons of legalizing marijuana.
- Conducted Self-Care Seminar: Sound Mediation for Relaxation. This seminar focused on relaxation and selfcare.
- Sponsored Healthy Aging seminar: Leading a Life of Legacy: What Will They Remember When You’re Gone.
- Participated in community and school Mental Health & Wellness Health Fairs.
- Conducted school-based substance abuse prevention programs- (D. A.R.E program).
B. 2019 PRIORITIZATION OF HEALTH ISSUES

As part of the CHNA engagement process, Health Equity Solutions (HES) worked with the coalitions to develop a process to prioritize health issues for the Greenwich region. Following data collection from the 2018 DataHaven Community Wellbeing Survey, key informant interviews, and community conversations, the coalitions met with Health Equity Solutions to prioritize health issues, develop measurable goals, set indicators, and identify strategies and actions for each priority. As background, GCHIP and CCS work is structured around Action Teams that reflect the three health priority areas identified during the 2013 planning cycle: Healthy Lifestyles, Access to Care, and Behavioral Health. The same priorities were confirmed during the 2016 CHNA planning process.

Health Equity Solutions (HES) facilitated a three-hour prioritization with GCHIP and CCS members and additional members from the community on March 12, 2019. Fifty individuals attended the three-hour session. HES presented highlights from the 2019 DataHaven Community Wellbeing Survey and the key informant survey as well as themes from the community conversations. The group provided feedback on the data findings and participated in interactive polling to rank goal statements and potential strategies. The top three goal areas were 1) increasing adult utilization of primary medical care by promoting access, 2) reduction in cardiovascular disease risk factors among adults in the region, and 3) decreasing the percentage of adults with food insecurity. The top ranked strategies included 1) promoting access to care, 3) promoting CLAS standards, and 3) working with providers to improve medical transportation. Based on the feedback from the prioritization session, community health improvement plans were developed for each of the priority areas within the 2019 health priority framework of Access to Care, Healthy Lifestyles, and Behavioral Health (Figure 9). These focus areas will be addressed through a Social Determinant of Health lens.

HES also facilitated a two-hour finalization session with GCHIP and CCS membership on March 19, 2019 attended by 18 GCHIP and other community members. Finally, the community health improvement plans (CHIP) and data from the 2018 DataHaven Community Wellbeing Survey, key informant survey and community conversations were presented at a public forum on April 2, 2019 and 42 people from 22 organizations attended. Following the presentation of the data, participants divided into three groups to provide feedback on the data and plans.

In March 2019, coalition members, local health departments, and community partners (including those with knowledge, information, or expertise relevant to the health needs of the community or medically underserved, low-income, and minority populations) reviewed the primary and secondary CHNA data and determined, by group consensus, that the 2016 priorities would be maintained moving forward for the 2019 CHNA. The coalitions, Greenwich Hospital and the health departments confirmed that there was a need to continue working in the 2016 focus areas as these were still the top health priority areas in the region. All primary and secondary data that was collected, analyzed and reviewed supported the continuation of 2016 priority areas: Healthy Lifestyles, Access to Care and Behavioral Health (Figure 9). These focus areas will be addressed through a Social Determinant of Health lens.
Figure 9: 2019 Priority Health Areas

2019 Health Priorities

Access To Care
Healthy Lifestyles
Behavioral Health
Social Determinants of Health
VII. COMMUNITY HEALTH IMPROVEMENT PLAN

In addition to guiding future services, programs and policies for the Coalition members and the overall area, the Community Health Needs Assessment and Community Health Improvement Plan are also prerequisites for health departments to earn voluntary accreditation, and for hospitals to maintain tax-exempt status.

The 2019 Community Health Improvement Plan was developed over the period of February through March 2019, using the key findings from the Community Health Needs Assessment, which included primary data from the 2018 DataHaven Community Wellbeing Survey, community conversations, and key informant surveys that were conducted locally, as well as quantitative data from local, state and national indicators to inform discussions and determine health priority areas.

As was the case in 2016, the Coalitions were responsible for overseeing the Community Health Needs Assessment, identifying health priorities, and overseeing the development of the Community Health Improvement Plans. A core coordinating committee was responsible for the overall management of the process, and Community Health Improvement Plan Workgroups, which represented broad and diverse sectors of the community, were continued in each health priority area. The CHIP Workgroups developed goals, objectives, strategies, and action steps for their respective components of the Health Improvement Plan.

A. OVERVIEW OF THE COMMUNITY HEALTH IMPROVEMENT PROCESS

− What is a Community Health Improvement Plan?
  A Community Health Improvement Plan or CHIP is an action-oriented strategic plan that outlines the priority health issues for a defined community, and how these issues will be addressed, including strategies and indicators for measurement, to ultimately improve the health of the community. CHIPS are created through a community-wide, collaborative planning process that engages partners and organizations to develop, support, and implement the plan. A CHIP is intended to serve as a vision for the health of the community and a framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement.

− How to use a CHIP
  A CHIP is designed to be a broad strategic framework for community health and should be modified and adjusted as conditions, resources, and external environmental factors change. It is developed and written in a way that engages multiple perspectives so that all community groups and sectors – private and nonprofit organizations, government agencies, academic institutions, community – and faith-based organizations can participate in the effort and unite to improve the health and quality of life for all people who live, work, and play in a certain region, in this case, the Greater Greenwich region.
Methods

Building upon the key findings identified in the Community Health Needs Assessment, the CHIP aims to:

- Identify priority issues for action to improve community health
- Develop and implement an improvement plan with performance measures for evaluation
- Guide future community decision-making related to community health improvement

In addition to guiding future services, programs, and policies for participating agencies and the area overall, the Community Health Improvement Plan fulfills the prerequisites for a hospital to submit to the IRS as proof of its community benefit and for a health department to earn voluntary accreditation, which indicates that the agency is meeting national standards.

To develop the Community Health Needs Assessment and the Community Health Improvement Plan, the Coalitions (which includes representatives from local public health entities) was the convening organization that brought together community residents and the area's influential leaders in healthcare, community organizations, and other key sectors, including mental health, local government, and social services. Using the guidelines of the Association for Community Health Improvement (ACHI) an improvement process was designed to incorporate the following steps:

1) Reflect and Strategize;
2) Identify and Engage Stakeholders;
3) Define the Community;
4) Collect and Analyze Data
5) Prioritize Community Health Issues;
6) Document and Communicate Results;
7) Plan Implementation Strategies;
8) Implement Strategies;
9) Evaluate Progress
B. DEVELOPMENT OF THE 2019 COMMUNITY HEALTH IMPROVEMENT PLAN STRATEGIC COMPONENTS

Coalition members convened regularly from February to March 2019 and actively used the assessment findings to review goals, objectives, and strategies to pursue for the next three-year cycle. From these meetings, groups developed a 2019 Community Health Improvement Plan document that is organized by the priority areas and includes specific goals, measurable indicators (short and long-term), strategies, action steps, and partners. These meetings were in part facilitated by Health Equity Solutions and members of the Coalitions.

C. PLANNING FOR ACTION AND MONITORING PROGRESS

Progress will be monitored at routine monthly Coalition meetings using a monitoring tool developed to track the specific goals, objectives, and strategies identified in each area. If gaps in resources are identified, the Coalitions will extend collaborative efforts to other organizations and programs that are currently providing those services as a means to foster relationships and efficiently meet the needs of the community members.

The Fairfield County Community Wellbeing Index 2019, hospital data and other resources identified in the CHIP provide common measurement indicators to monitor and evaluate progress on the implementation strategies.

D. COMMUNITY HEALTH IMPROVEMENT PLAN

Real, lasting community change stems from critical assessment of current conditions, an aspirational framing of where the Coalitions would like to be, and clear evaluation of whether the collaborative efforts are making a difference. There is also a companion plan detailing implementation strategies to be addressed by Greenwich Hospital. The following pages outline the goals, strategies, action steps, and indicators for the three health priority areas outlined in the Community Health Improvement Plan for both the coalitions and for Greenwich Hospital.
i. COMMUNITY HEALTH IMPROVEMENT PLAN:
GREENWICH COMMUNITY HEALTH IMPROVEMENT PARTNERSHIP | COUNCIL OF COMMUNITY SERVICES
2019-22 Community Health Needs Assessment
Community Health Improvement Plans
**Priority Area: Healthy Lifestyles**

**Indicator:** Percentage of people in Greater Greenwich region who indicate that they have been told by a doctor or health professional that they have hypertension. [2015-Greenwich 24% Port Chester 26%, 2018-23%; 27%]

**Indicator:** Percentage of people in Greater Greenwich region who indicate that they work out 1 or more days per week [2015-Greenwich 86% Port Chester 77%, 2018-77%; 74%]

**Indicator:** Percentage of people who did not have enough money to buy food that you or your family needed [2015-Greenwich 6% Port Chester 14%, 2018-7%; 11%]

**Goal:** By February 2022, there will be a 2% reduction in CVD risk factors among adults in the Greater Greenwich region

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Action Steps</th>
<th>Outcomes</th>
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</table>
| Implement initiatives to improve the cardiovascular health of the community and promote a culture of healthy living | • Implement collaboration among organizations to focus on decreasing hypertension rates in the community  
• Implement collaboration among organizations to focus on decreasing cardiovascular disease rates in the community  
• Collaborate with community partners to conduct & promote cardiovascular health and wellness programs and screening events  
• Provide education & promote awareness of healthy CVD lifestyles  
• Work with food pantries to have increased implementation of the SWAP  
• Provide education & awareness on the benefits of consumption of fresh fruits /vegetables/plant-based diets | # of initiatives for promoting awareness of hypertension  
# of initiatives for promoting cardiovascular health & wellness programs to reduce CVD disease  
# of health/wellness screening events  
# of initiatives to promote heart healthy lifestyles  
25% increase in food pantries adopting SWAP  
Evaluation data on satisfaction and utility of events and initiatives |
**Priority Area: Healthy Lifestyles, continued**

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<tr>
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| Implement initiatives to increase awareness of diabetes and to promote self-management for people living with diabetes | • Implement collaboration among organizations to decrease diabetes rates in the community by providing education & awareness about risk factors of diabetes and prediabetes  
• Promote and conduct healthy lifestyles & behaviors programs to improve management of prediabetes & diabetes  
• Promote & conduct diabetes health screening events  
• Implement self-management programs to decrease complications, improve medication compliance  
• Promote awareness of pharmacy options | # of health/wellness programs  
# screening events  
# of initiatives to promoting healthy lifestyles aimed at preventing and managing diabetes  
Evaluation data on satisfaction and utility of events and initiatives |
| Promote exercise and physical activity in the community | • Identify and promote existing programs and resources that are no cost, low cost options for exercise and physical activity  
• Educate the community about benefits of physical activity | # educational initiatives and programs to promote physical activity/exercise programs and resources  
# of participants who participated/attended programs  
# education materials created and/or distributed |
| Address food insecurity issues in the Greater Greenwich region | • Identify inventory/database of food resources  
• Identify contributing factors to food insecurity  
• Implement collaboration among organizations to focus and promote a culture of healthy eating  
• Develop educational programs to educate residents on how to eat healthier on a budget | # of educational program offered  
# of participants who participated/attended programs |
### Priority Area: Healthy Lifestyles

#### Partner Organizations

<table>
<thead>
<tr>
<th>Greenwich Boys and Girls Club, Greenwich Hospital, Greenwich Hospital Center for Behavioral &amp; Nutritional Health</th>
<th>Greenwich Hospital Outpatient Clinic Northeast Medical Group</th>
<th>Optimus Healthcare SNAP Eligibility &amp; Outreach Silver Hill Hospital Southwest Regional Mental Health Board (HEALTHY MINDS CT)</th>
<th>Greenwich Commission of Aging, Liberation Programs, Neighbor to Neighbor, Pathways, FQHC Wilbur Peck, Family Centers Laurel House, Inc.</th>
</tr>
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<tbody>
<tr>
<td><strong>GCHIP/CT:</strong> Greenwich Hospital, Greenwich Department of Health, River House Adult Day Center; ShopRite; YMCA of Greenwich; YWCA of Greenwich; Boys and Girls Club of Greenwich; Greenwich Emergency Management Operations, Greenwich Department of Human Services, The Nathaniel Witherell Rehabilitation and Nursing Center; Global Health Systems Consultants, LLC, The Housing Authority of Greenwich, St. Catherine’s, First Congregational Church, Greenwich Library, Byram Shubert Library, Perrot Memorial Library, Cos Cob Library, Greenwich Private Schools (Brunswick), Greenwich Board of Education, Greenwich Public Schools, Abilis, Child Guidance Center, Communities 4 Action, Get Healthy CT, League of Women Voters of Greenwich, F.S. DuBois Center, DMHAS, Community Answers, Greenwich Department of Parks and Recreation, Kids in Crisis, NAMI Stamford/Greenwich, United Way Greenwich, Greenwich Rotary Club, Greenwich Police Department, Greenwich Chamber of Commerce.</td>
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<tr>
<td><strong>CCS /NY:</strong> Greenwich Hospital, Hudson Valley Health (HRHCare Community Health - HRHCare HRHCare), FQHC Open Door Family Medical Center, Port Chester-Rye-Rye Brook EMS, Port Chester Carver Center, Rye YMCA, The Osborn, Rye Brook Seniors, Staying Put in /Rye and Environ (SPRYE) Port Chester Seniors, Rye Seniors, Westchester Department of Health, Port Chester Housing Authority, All Souls Parish, KTI Synagogue, St. Paul’s, St. Peter’s, Port Chester – Rye Brook Public Library, Rye Reading Room, Blind Brook Public School, Port Chester Public Schools, Rye Public Schools, Family Services of Westchester, Forever Families through Adoption, NAACP, Westchester County Board of Legislators, Don Bosco Community Center, Hispanic Resource Center, Human Development Services of Westchester Port Chester/Rye Brook Rotary Club, Port Chester Police Department, Rye Police Department, Rye Brook Police Department, Port Chester Village Board, Rye Rotary Club, Kiwanis Club Port Chester/Rye Brook, Rye Chamber of Commerce, Port Chester /Rye Brook Chamber of Commerce</td>
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## Priority Area: Access to Care

**Indicator:** Percentage of people in the Greenwich region that indicate that they have put off or postponed getting medical care that they thought they needed. **[2015- Greenwich 13%, Port Chester 22% 2018-Greenwich 19% Port Chester 20%]**

**Indicator:** Percentage of people in the Greenwich region who report having one person or place as their personal doctor or health care provider. **[2015- Greenwich 87%, Port Chester 79% 2018-Greenwich 84% Port Chester 79%]**

**Indicator:** Percentage of people in the Greenwich region who report missing a doctor’s appointment or a visit to a health care provider because they did not have reliable transportation **[2015- Greenwich 4% Port Chester 14%-2018-Greenwich 9% Port Chester 11%]**

**Indicator:** Percent of people in Greater Greenwich reporting discrimination in a medical setting **(2015-N/A, 2018-Fairfield County: 37% Doctor’s office, 30% Hospital/ER, 14% Dentist)**

### Goal:
By February 2022, increase adults who have a regular source of care in the Greenwich & Port Chester area by 2%.

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| Implement initiatives to improve access to coordinated primary and specialty health care | • Determine barriers to accessing primary and specialty care health care providers and develop collaborative strategies to address (hours of operation the number and availability of providers located in Greenwich (Port Chester area) etc.  
• Promote awareness of primary care and specialty care options and how to access  
• Implement initiatives to facilitate coordination of primary care and specialty care  
• Promote awareness of specialty care options and how to access  
• Develop initiatives to address specialty care transportation issues | # initiatives to determine barriers  
# efforts to increase the community’s awareness of available resources  
# initiatives to facilitate coordination  
# providers who accept a broader range of insurance assignment  
# providers who provide sliding scale payment schedule for uninsured  
# providers with more expanded operations (e.g. hours, days) |
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| Identify and mobilize individuals and/or trusted organizations that can assist in navigating and connecting uninsured and underinsured residents to healthcare resources | • Collaborate with partners to identify trusted individuals and/or organizations with connections to uninsured and underinsured residents  
• Increase connection and promote awareness to available resources for uninsured and underinsured residents                                                                 | # additional outreach workers and organizations engaged  
# of uninsured and underinsured residents-engaged in outreach efforts.                                                                                                                                 |
| Improve access to/awareness of about medication/prescription availability | • Determine barriers to care for medication/prescription availability  
• Promote awareness of medication/pharmacy options                                                                                                        | # initiatives to increase awareness about resources  
# Medicare Savings Program (MSP) applications filed  
# Residents who registered with a new Rx plan                                                                                                                                                      |
| Collaborate with partners to improve access to and community awareness about reliable medical transportation | • Determine accessibility issues related to medical transportation options, including public transportation and medical ride programs  
• Continue conversation(s) with transportation organizations in understanding resident concerns about medical transportation  
• Partner with aging-in-place organizations to assist with medical transportation improvements  
• Promote community awareness of transportation options etc.                                                                                     | # medical transportation resources available  
# affordable transportation options  
# Changes in policies and procedures by transportation providers that influence access (Ex: extended hours of operation)  
# initiatives to increase community awareness about transportation resources                                                                         |
### Priority Area: Access to Care, continued

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<th>Outcomes</th>
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| Promote diversity & Inclusion to reduce discrimination and improve access | • Promote CLAS tools in medical community  
• Initiate discussions with healthcare providers to increase awareness of implicit bias  
• Share written information about CLAS and ways to incorporate in medical setting | # of CLAS initiatives  
# attendees  
% increase in providers implementing CLAS  
# of providers who self-report use of CLAS in practice |
Priority Area: Access to Care, continued

### Partner Organizations

**GCHIP/CT:** Greenwich Hospital, Greenwich Department of Health, Greenwich Department of Human Services, Greenwich Hospital Center for Behavioral & Nutritional Health, Greenwich Hospital Outpatient Clinic, Northeast Medical Group, Optimus Healthcare, SNAP Eligibility & Outreach, Silver Hill Hospital, Southwest Regional Mental Health Board (HEALTHY MINDS CT) Greenwich Commission of Aging, Liberation Programs, Neighbor to Neighbor, Pathways, FQHC Wilbur Peck, Family Centers, Laurel House, Inc. River House Adult Day Center; ShopRite; YMCA of Greenwich; YWCA of Greenwich; Boys and Girls Club of Greenwich; Greenwich Emergency Management Operations, The Nathaniel Witherell Rehabilitation and Nursing Center; Global Health Systems Consultants, LLC, The Housing Authority of Greenwich, St. Catherine’s, First Congregational Church, Greenwich Library, Byram Shubert Library, Perrot Memorial Library, Cos Cob Library, Greenwich Private Schools (Brunswick), Greenwich Board of Education, Greenwich Public Schools, Abilis, Child Guidance Center, Communities 4 Action, Get Healthy CT, League of Women Voters of Greenwich, F.S. DuBois Center, DMHAS, Community Answers, Greenwich Department of Parks and Recreation, Kids in Crisis, NAMI Stamford/Greenwich, United Way Greenwich, Greenwich Rotary Club, Greenwich Police Department, Chamber of Commerce.

**CCS/NY:** Greenwich Hospital, Hudson Valley Health (HRHCare Community Health - HRHCare HRHCare), FQHC Open Door Family Medical Center, Port Chester-Rye-Rye Brook EMS, Port Chester Carver Center, Rye YMCA, The Osborn, Rye Brook Seniors, Staying Put in /Rye and Environ's (SPRYE) Port Chester Seniors, Rye Seniors, Westchester Department of Health, Port Chester Housing Authority, All Souls Parish, KTI Synagogue, St. Paul’s, St. Peter’s, Port Chester – Rye Brook Public Library, Rye Reading Room, Blind Brook Public School, Port Chester Public Schools, Rye Public Schools, Family Services of Westchester, Forever Families through Adoption, NAACP, Westchester County Board of Legislators, Don Bosco Community Center, Hispanic Resource Center, Human Development Services of Westchester Port Chester/Rye Brook Rotary Club, Port Chester Police Department, Rye Police Department, Rye Brook Police Department, Port Chester Village Board, Rye Rotary Club, Kiwanis Club Port Chester/Rye Brook, Rye Chamber of Commerce, Port Chester /Rye Brook Chamber of Commerce.
## Priority Area: Behavioral Health

### Indicator: Percentage of people in Greenwich region who indicate that they felt down, depressed or hopeless in the past two weeks. [2015-N/A; 2018-Greenwich-several or more days: 25% Port Chester 27%]

### Indicator: Percentage of people in the Greater Greenwich region who indicate that they receive the emotional and social support they need. [2015-N/A; 2018-Greenwich- 75% Port Chester 70%]

### Indicator: Percentage of people in the Greater Greenwich region who indicate that they were somewhat/mostly/completely anxious yesterday. [2015-23% Greenwich 31% Port Chester; 2018-Greenwich- 27% Port Chester 36%]

### Community partners collaboratively addressing substance misuse issues:

**Indicator:** Percentage of people in the Greater Greenwich region who indicate that they know anyone who has struggled with misuse or addiction to heroin or other opiates such as prescription painkillers at any point during the last three years. [2015-N/A; 2018-Greenwich-one or more people: 22% Port Chester 19%]

**Indicator:** Percentage of people in the Greater Greenwich region who indicate that they have tried using vapor or vape pens, electronic cigarettes or E-cigarettes [2015-Greenwich 11% Port Chester 21%, 2018-16%; 14%]

### Goal:
By February 2022, there will be a 2% increase in adults in the Greater Greenwich region indicating they receive the social-emotional support they need.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Action Steps</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Implement initiatives to reduce stress and promote behavioral health & wellness in the community | • Promote and increase resident awareness and knowledge of community emotional health/wellness resources and social support systems available (mindful meditation, healthy diets, Yoga, spirituality/faith communities)  
• Identify unified messages and materials for dissemination by targeted providers  
• Develop & disseminate strategies to reduce stress by providing education and resources on utilizing coping skills and resiliency techniques | % targeted providers disseminating emotional and wellness resources to patients |
## Priority Area: Behavioral Health, continued

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Action Steps</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Implement initiatives to reduce stress and promote behavioral health & wellness in the community (continued) | • Identify subgroups most impacted by the lack of social-emotional support and target outreach and support strategies tailored to the group  
• Identify and address myths surrounding mental illness and addiction | % of targeted vulnerable groups reached using identified strategies  
Change in perception related to myths supporting stigma |
| Implement initiatives to address depression & anxiety | • Promote awareness and knowledge of services for mental health in the community and how to access (hours of operation, in-town availability, etc.)  
• Increase screening & early intervention throughout the community  
• Collaborate to promote and launch 1 or more peer support options for identified vulnerable population(s)  
• Promote awareness and use/implementation of e-consults / teletherapy  
• Determine strategies for selected populations in need (young adults, older adults, racial/ethnicity/language, etc.) | % targeted providers conducting screenings during patient visits & community events  
% peer support participants indicating satisfaction with peer support option |
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Action Steps</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Support substance use education and prevention efforts in the community | • Leverage existing collaborative to promote awareness of health impacts of vaping and marijuana  
• Focus action steps on supporting the efforts that are underway by other partners responsible for this area  
• Develop collaborative strategies to educate residents and providers on prescription opiates misuse, heroin and fentanyl. Promote education and awareness of available treatment services, including harm reduction and use of Narcan, and how to access  
• Determine strategies for selected populations in need (young adult, ethnicity, etc) | • Decrease in vaping incidents at Greenwich schools as measured by Greenwich Together  
• Increase community participation in take-back days as measured by pounds of medication turned in  
• Increase in attendance at community events as a result of GCHIP / CCS promotional/supportive efforts  
• Increase in number of GCHIP partners who display safe medication disposal cards |
### Partner Organizations

<table>
<thead>
<tr>
<th>Greenwich Boys and Girls Club, Greenwich Hospital, Greenwich Hospital Center for Behavioral &amp; Nutritional Health</th>
<th>Greenwich Hospital Outpatient Clinic</th>
<th>Northeast Medical Group</th>
<th>Optimus Healthcare</th>
<th>SNAP Eligibility &amp; Outreach</th>
<th>Silver Hill Hospital</th>
<th>The Hub</th>
</tr>
</thead>
</table>

### CCS/NY:
- Greenwich Hospital, Hudson Valley Health (HRHCare Community Health - HRHCare HRHCare), FQHC Open Door Family Medical Center, Port Chester-Rye-Rye Brook EMS, Port Chester Carver Center, Rye YMCA, The Osborn, Rye Brook Seniors, Staying Put in /Rye and Environ (SPRYE) Port Chester Seniors, Rye Seniors, Westchester Department of Health, Port Chester Housing Authority, All Souls Parish, KTI Synagogue, St. Paul’s, St. Peter’s, Port Chester – Rye Brook Public Library, Rye Reading Room, Blind Brook Public School, Port Chester Public Schools, Rye Public Schools, Family Services of Westchester, Forever Families through Adoption, NAACP, Westchester County Board of Legislators, Don Bosco Community Center, Hispanic Resource Center, Human Development Services of Westchester Port Chester/Rye Brook Rotary Club, Port Chester Police Department, Rye Police Department, Rye Brook Police Department, Port Chester Village Board, Rye Rotary Club, Kiwanis Club Port Chester/Rye Brook, Rye Chamber of Commerce, Port Chester /Rye Brook Chamber of Commerce
ii. COMMUNITY HEALTH IMPROVEMENT PLAN:
GREENWICH HOSPITAL
## Priority Area: Healthy Lifestyles

### Indicator: Percentage of people in Greater Greenwich region who indicate that they have been told by a doctor or health professional that they have hypertension.

- **[2015-Greenwich 24% Port Chester 26%, 2018-23%; 27%]**

### Indicator: Percentage of people in Greater Greenwich region who indicate that they work out 1 or more days per week

- **[2015-Greenwich 86% Port Chester 77%, 2018-77%; 74%]**

### Indicator: Percentage of people who did not have enough money to buy food that they or their family needed

- **[2015-Greenwich 6% Port Chester 14%, 2018-7%; 11%]**

### Goal: By February 2022, there will be a 2% reduction in CVD risk factors among adults in the Greater Greenwich region

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Action Steps</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Participate in and provide support for the Greenwich Community Health Improvement Partnership (GCHIP) and Council Community Services (CCS) | • Provide in-kind and financial support for Get Healthy CT  
• Co-host collaborative health/wellness events with community partners  
• Fund consultant to facilitate and support GCHIP partnership | # of health/wellness events  
Financial support for consultant  
% of employees screened |
| Provide in-kind and financial support to area organizations | • Provide in-kind and financial resources to organizations to promote healthy lifestyles | $ community benefit |
| Provide programs to improve the health of employees | • Encourage employee involvement in personal health through the Know Your Numbers program for employees  
• Enhance health coaching and other services and programs to employees through livingwellcares program  
• Develop programs relating to chronic disease and smoking/vaping cessation for employees | % of employees screened  
# of employee participants |
### Priority Area: Healthy Lifestyles, continued

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Action Steps</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| **Provide programs to improve the health of employees (continued)** | • Promote opportunities for employees to be physically active  
• Pursue funding for initiatives through grants or philanthropy  
• Track ROI where applicable | # of programs/# of participants  
$ funding secured  
ROI |
| **Implement initiatives to promote a culture of healthy living to improve the health of the community and reduce chronic disease** | • Provide education to promote awareness of risk factors of heart disease, cancer, hypertension, stroke, diabetes  
• Initiate healthy lifestyles programs to prevent and improve self-management for chronic diseases  
• Conduct Speaker’s Bureau Lectures:  
  o Heart disease (CVD)  
  o Stroke/Brain Attack  
  o Diabetes & Pre-Diabetes  
  o Know Your Meds/Med compliance  
  o Cancer Prevention and Screening  
• Collaborate within GH service lines to conduct hospital sponsored health and wellness programs and screening events including:  
  o Heart and Stroke Fair  
  o GH Cancer Survivorship Fair  
  o Support Groups including diabetes, heart, stroke and Better Breathers  
  o Know Your Numbers Free metabolic screenings  
  o Nurse Is In Program  
  o Teddy Bear Clinic  
  o Fresh Start Smoking Cessation Program | # of initiatives for promoting awareness of hypertension/stroke  
# of initiatives for promoting cancer prevention  
# of initiatives for promoting cardiovascular health & wellness programs to reduce CVD disease  
# of initiatives to promoting healthy lifestyles aimed at preventing and managing diabetes  
# of health/wellness screening events  
Evaluation data on satisfaction and utility of events and initiatives  
# speakers bureau lectures  
# hospital sponsored programs  
# community sponsored programs |
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Action Steps</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Implement initiatives to promote a culture of healthy living to improve the health of the community and reduce chronic disease (continued) | • Conduct hospital sponsored programs with collaborating community partners or participate in community sponsored programs including:  
  o Kids in the Kitchen  
  o High School Health Care Careers Programs  
  o Senior TIPS Program  
  o Scouts Medical Explorers Program  
  o Community-based fairs (schools, faith-based)  
  o Community-based/sponsored gardens  
  o Health Extensions  
  o WGCH Radio – Spotlight on Medicine  
  o Library Sponsored Programs  
  o Injury Prevention Programs (Fall Safety, Bike Safety, AARP)  
  • Pursue funding for initiatives through grants or philanthropy  
  • Track ROI where applicable | $ funding secured  
  ROI |
| Promote exercise, physical activity and benefits of quality sleep         | • Collaborate within GH service lines to conduct hospital sponsored health and wellness programs regarding sleep  
  • Enhance Speakers’ Bureau to provide education on  
    o Benefits of Exercise  
    o Benefits of Sleep  
    o Tai Chi  
    o Mindful Meditation  
    o Yoga | # of participants who participated/attended programs  
  Evaluation data on satisfaction of events and initiatives  
  # educational initiatives and programs to promote physical activity/exercise and sleep |
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Action Steps</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Promote a culture of healthy eating   | • Collaborate within GH service lines to conduct hospital sponsored health and wellness programs regarding healthy eating  
  • Provide education & awareness to the community on the benefits of consumption of fresh fruits /vegetables/plant-based diets  
  • Conduct Speaker’s Bureau Lectures to educate residents on healthy eating  
    o Mediterranean Diets  
    o Plant-Based Diets  
    o DASH Diets  
    o Healthy Meal Planning  
    o Reading Food Labels  
    o Eating Healthy on a budget  
  • Pursue funding for initiatives through grants or philanthropy  
  • Track ROI where applicable                                                                 | # of participants who participated/attended programs  
  Evaluation data on satisfaction of events and initiatives  
  # educational initiatives and programs to promote healthy eating  
  $ funding secured  
  ROI                                                                  |
Priority Area: Access to Care

**Indicator:** Percentage of people in the Greenwich region that indicate that they have put off or postponed getting medical care they thought they needed. [2015- Greenwich 13%, Port Chester 22% 2018-Greenwich 19% Port Chester 20%]

**Indicator:** Percentage of people in the Greenwich region who report having one person or place as their personal doctor or health care provider. [2015- Greenwich 87%, Port Chester 79% 2018-Greenwich 84% Port Chester 79%]

**Indicator:** Percentage of people in the Greenwich region who report missing a doctor’s appointment or a visit to a health care provider because they did not have reliable transportation [2015- Greenwich 4% Port Chester 14%-2018-Greenwich 9% Port Chester 11%]

**Indicator:** Percent of people in Greater Greenwich reporting discrimination in a medical setting (2015-N/A, 2018-Fairfield County: 37% Doctor’s office, 30% Hospital/ER, 14% Dentist)

**Indicator:** During the past 12 months, was there any time you needed prescription medicines but didn’t get them because you couldn’t afford it? [2015 Greenwich 4% Port Chester 13%-2018-Greenwich 7% Port Chester 8%]

**Goal:** By February 2022, increase adults who have a regular source of care in the Greenwich & Port Chester area by 2%.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Action Steps</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participate in and provide support for the Greenwich Community Health Improvement Partnership (GCHIP) and Council Community Services (CCS)</td>
<td>• Provide in-kind and financial support for access to care initiatives • Co-host collaborative events with community partners to ensure access to resources • Fund consultant to facilitate and support GCHIP partnership</td>
<td># of events related to access Financial support for consultant</td>
</tr>
<tr>
<td>Provide in-kind and financial support to area organizations</td>
<td>• Provide in-kind and financial resources to organizations to ensure access to care</td>
<td>$ community benefit</td>
</tr>
<tr>
<td>Provide access to services for underserved populations</td>
<td>• Provide free care and Medicaid services • Operate outpatient primary and specialty care clinic services for eligible individuals</td>
<td>$ free care $ Medicaid under reimbursement</td>
</tr>
<tr>
<td>Strategy</td>
<td>Action Steps</td>
<td>Outcomes</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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<td>-------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Provide access to services for underserved populations (continued)      | • Assist eligible individuals in the Greenwich Hospital Outpatient Clinic to enroll in available insurance programs  
• Offer financial assistance information and other information in English and Spanish  
• Identify barriers or gaps in care and develop strategies to increase access  
• Pursue funding for initiatives through grants or philanthropy  
• Track ROI where applicable | # enrolled primary clinic patients  
# specialty clinic patients  
# individuals enrolled in insurance  
$ funding secured  
ROI                                                                                       |
| Promote diversity & inclusion to reduce discrimination and improve access to care | • Conduct Diversity and Inclusion Council initiatives within Greenwich Hospital  
• Conduct Diversity and Inclusion Council initiatives in the Greenwich Hospital community | # of D&I initiatives                                                                                                                                |
| Implement initiatives to improve access to care or knowledge of available resources for individuals living in the Greenwich Hospital service area | • Provide hospital sponsored programs and support community sponsored programs including:  
  o Parish Nurse  
  o Thriving Well with Cancer  
  o Cancer Wellness Series  
  o Nurse Is In  
  o Health Fairs  
  o GH Consumer Librarian | # hospital sponsored programs  
# community sponsored programs  
# participants screened  
# support groups  
# individuals served by grants |
### Priority Area: Access to Care, continued

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Action Steps</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Implement initiatives to improve access to care or knowledge of available resources for individuals living in the Greenwich Hospital service area (continued)</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Collaborate within GH service lines to conduct hospital sponsored programs and screening events to increase access to care including:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Head and Neck</td>
<td></td>
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<td></td>
<td>o Metabolic/BMI Screenings</td>
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<td></td>
<td>o Prostate</td>
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<tr>
<td></td>
<td>• Provide support groups including:</td>
<td></td>
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<tr>
<td></td>
<td>o Stroke</td>
<td>$ funding secured</td>
</tr>
<tr>
<td></td>
<td>o Parkinson’s Disease</td>
<td>ROI</td>
</tr>
<tr>
<td></td>
<td>o MS</td>
<td></td>
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<tr>
<td></td>
<td>o Chronic Pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Parents Exchange</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Prostate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Diabetes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Participate in CT Early Detection and Prevention Program (CEDPP) Grant and Breast Cancer Alliance Grant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Collaborate with community partners to increase awareness of available resources such as FQHCs and Greenwich Hospital Outpatient Clinic for uninsured and underinsured patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pursue funding for initiatives through grants or philanthropy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Track ROI where applicable</td>
<td></td>
</tr>
</tbody>
</table>
## Priority Area: Behavioral Health

### Indicator:
Percentage of people in Greenwich region who indicate that they felt down, depressed or hopeless in the past two weeks. [2015-N/A; 2018-Greenwich—several or more days: 25% Port Chester 27%]

### Indicator:
Percentage of people in the Greater Greenwich region who indicate that they receive the emotional and social support that they need. [2015-N/A; 2018-Greenwich—75% Port Chester 70%]

### Indicator:
Percentage of people in the Greater Greenwich region who indicate that they were somewhat/mostly/completely anxious yesterday. [2015-23% Greenwich 31% Port Chester; 2018-Greenwich—27% Port Chester 36%]

### Community partners collaboratively addressing substance misuse issues:

#### Indicator:
Percentage of people in the Greater Greenwich region who indicate that they know anyone who has struggled with misuse or addiction to heroin or other opiates such as prescription painkillers at any point during the last three years. [2015-N/A; 2018-Greenwich—one or more people: 22% Port Chester 19%]

#### Indicator:
Percentage of people in the Greater Greenwich region who indicate that they have tried using vapor or vape pens, electronic cigarettes or E-cigarettes [2015-Greenwich 11% Port Chester 21%, 2018-16%; 14%]

### Goal:
By February 2022, there will be a 2% increase in adults in the Greater Greenwich region indicating they receive the social-emotional support they need.

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<tr>
<th>Strategy</th>
<th>Action Steps</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Participate in and provide support for the Greenwich Community Health Improvement Partnership (GCHIP) and Council Community Services (CCS) | • Co-host collaborative behavioral health events with community partners  
• Fund consultant to facilitate and support GCHIP partnership | # of behavioral health events  
Financial support for consultant |
<p>| Provide in-kind and financial support to area organizations | • Provide in-kind and financial resources to organizations to promote behavioral health programs and services | $ community benefit |</p>
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Action Steps</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide mental health resources for employees and their families</td>
<td>• Offer resources and programs related to stress management and other mental health issues to employees and their families</td>
<td># of programs offered # of employees participating in programs</td>
</tr>
<tr>
<td>Implement initiatives to promote behavioral health and wellness to reduce stress, anxiety and depression</td>
<td>• Promote and increase awareness and knowledge of Greenwich Hospital behavioral health and wellness resources &lt;br&gt; • Conduct Social Support Programs including: &lt;br&gt; o Stroke Support Group &lt;br&gt; o Parkinson’s Support Group &lt;br&gt; o MS Support Group &lt;br&gt; o Caregiver Café Support &lt;br&gt; o NEXT Cancer Rehab (Nutrition, Exercise, Therapy) &lt;br&gt; o Cancer Counseling &lt;br&gt; o Chronic Pain Support Group &lt;br&gt; o Parents Exchange &lt;br&gt; o Prostate Support Group &lt;br&gt; o Breast Cancer Support &lt;br&gt; o Living With Cancer &lt;br&gt; o Cancer Wellness Program &lt;br&gt; • Conduct Speaker’s Bureau Lectures &lt;br&gt; o Stress Management &amp; Coping &lt;br&gt; o End of Life Care and Support &lt;br&gt; o Addiction Recovery</td>
<td># of social support programs # of speaker’s bureau lectures # of hospital or community sponsored programs</td>
</tr>
</tbody>
</table>
## Priority Area: Behavioral Health, continued

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Action Steps</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Implement initiatives to promote behavioral health and wellness to reduce stress, anxiety and depression (continued) | • Provide programs or support community sponsored programs to reduce stress by providing education and resources on utilizing coping skills and resiliency techniques  
  o Anxiety and Depression Screenings  
  o Tai Chi  
  o Mindful Meditation  
  o Yoga  
  o Pastoral Care Services  
  o Center for Healthy Aging Programs  
  o Clinic Services  
  o Center for Behavioral and Nutritional Health Services  

• Promote and conduct cultural diversity programs to reduce barriers and stigma around behavioral health disorders | # hospital sponsored programs  
# community sponsored programs  
$ funding secured  
ROI |
| Support substance use education and prevention efforts in the community | • Promote awareness of the health impacts of smoking, vaping and marijuana  
  o Fresh Start Smoking Cessation Program  
  o Participate in ACS Great American Smoke Out  
  o Smoking Prevention Programs (Kids in The Kitchen)  
  o Speaker’s Bureau in collaboration with community partners  
  o Support and participate in school based wellness programs and health fairs  
  o Participate in community sponsored programs to promote prevention and reduce substance abuse | # hospital sponsored programs  
# community sponsored programs  
$ funding secured  
ROI |
## Priority Area: Behavioral Health, continued

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Action Steps</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Support substance use education and prevention efforts in the community (continued) | • Support community programs and organizations that focus on substance abuse  
  ○ Mental Health First Aid  
  ○ NAMI (National Alliance for Mental Illness)  
  ○ Medication Drop-off Boxes at Police Stations  
  ○ Speaker Bureau  
  ○ Narcan Training  
  ○ Addiction Recovery Center Services and Support Groups  
    ▪ Alcoholics Anonymous (AA)  
    ▪ Al-Anon  
    ▪ Drugs Anonymous (DA)  
    ▪ LifeRing  
• Pursue funding for initiatives through grants or philanthropy  
• Track ROI where applicable |  |
The Greenwich Hospital Community Health Improvement Plan / Implementation Strategies are comprehensive to address the three areas prioritized through the Community Health Needs Assessment Process. Other areas identified through the Community Health Needs Assessment process will not be specifically addressed as part of this effort by Greenwich Hospital due to resource constraints but are already being addressed through existing services and initiatives, as outlined below.

<table>
<thead>
<tr>
<th>Health Issue</th>
<th>Sample Listing of Existing Programs and Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>Free cancer screenings and / or exams for Breast Cancer, Prostate Cancer, and Head and Neck Cancer; Prostate Cancer education forum, Cancer Counseling and Support Services, Cancer Wellness Education, Support Groups including Post-Treatment Breast Cancer Support Group, Living with Cancer, Thriving with Cancer and the Caregiver Café; Cancer Awareness Campaign, and a Speakers Bureau</td>
</tr>
<tr>
<td>Injury Mortality</td>
<td>AARP Safe-Driving Classes; Chronic Pain Education Forum; CPR and First Aid Programs; Dance programs that promote balance, muscle strengthening, coordination and safe physical activity; and participation in various health fairs</td>
</tr>
</tbody>
</table>
VIII. Community Resources

One goal of the CHNA is to understand the needs of a particular community and the overall challenges they face, to plan for future policies. Community-level challenges can resonate through the needs of the individual, the organization, the neighborhood, or more broadly part of the larger city. Within communities, there exist various resources, including organizations, people, policies, and physical spaces, among others, that elevate the quality of life of a community. As each person has unique needs within their community, what is considered an asset or resource to one may not be for another. Homeless shelters, food pantries, day clinics, financial assistance programs, recreational centers, are all examples of community resources that may be used by different community members. Identifying the resources that are available in the community and that the community actively uses is one important factor of the community health needs assessment, as it can help ensure public awareness of available resources and demonstrate what models work well within that community, and what can be done to fill in the existing gaps.

One method to find these assets is by utilizing the 2-1-1 program by United Way of Connecticut, which is supported by the State of Connecticut and other Connecticut-based United Ways. United Way 2-1-1 is an organization that aims to provide a state-wide resource to educate and connect its residents to services. Dialing 2-1-1 connects you to a specialist who will help you locate local services in the area including utility assistance, food, housing, child care, after school programs, elder care, and crisis intervention among others. Entrance to certain housing shelters for example, can be facilitated by referral from 2-1-1. 2-1-1 also has a continually updated, comprehensive, and searchable online database of 4,100 agencies providing over 40,000 programs. 2-1-1 began as Infoline in 1976 and Connecticut became the first state to use 2-1-1 statewide in 1999. In 2018, a total of 248,890 calls and a total 322,166 requests were made in Connecticut. 2-1-1 is available 24 hours a day every day of the year, with multilingual assistance available.

The following pages include a sample of Community Resources found by navigating the 2-1-1 website. In this example, health resources are organized into six health topics: access to care, food insecurity, healthy lifestyle, housing, mental health, and substance abuse for the Town of Greenwich.

Here are ways to access 2-1-1 CT. A more detailed description of how to access the services may be found in Appendix C.

Dialing from Connecticut: 2-1-1
Dialing from outside of Connecticut: 1-800-203-1234
Website: https://www.211ct.org/
### Community Resources

#### Access to Care
- Cancer Detection
- Community Clinics
- Dental Care
- Disability Related Transportation
- English as a Second Language
- Eye Screening
- Health Screening/Diagnostic Services
- Health Insurance Counseling
- Local Bus Services
- Local Rail Services
- Medicaid
- Medical Appointments
- Transportation
- Medical Expense Assistance
- Medicare
- Senior Ride Programs
- Specialized Treatment Programs
- Veterans

#### Food Insecurity
- Community Action Agencies
- Commodity Supplemental Food Program
- Congregate Meals/Nutrition Sites
- Food Pantries
- Food Stamps/SNAP
- Home Delivered Meals
- Local Officials Offices
- Soup Kitchens
- WIC

#### Healthy Lifestyles
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- Nature Centers/Walks
- Recreational Activities/Sports
- Wellness Programs
- Youth Enrichment Programs

#### Housing
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- Ex-Offender Halfway Houses
- Housing Authorities
- Homeless Drop-In Centers
- Housing Search and Information
- Homeless Shelter
- Runaway/Youth Shelters
- Single Room Occupancy Housing
- Transitional Housing/Shelter

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- Domestic Violence Hotlines
- General Counseling Services
- Home Based Mental Health Services
- Mental Health Evaluation
- Mental Health Related Support Groups
- Psychiatric Disorder Counseling
- Psychiatric Mobile Response Teams
- Suicide Prevention Hotlines
- Talklines/Warmlines
- Therapy Referrals
- Youth Issues Hotlines

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- Drug Use Disorder Support Groups
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- General Assessment for Substance Use Disorder
- Inpatient Drug Detoxification
- Inpatient Medically Assisted Alcohol Detoxification
- Medication Assisted Maintenance Treatment for Substance Use Disorders
- Medication Assisted Maintenance Treatment for Opioid Use Disorders
- Methadone Maintenance
- Opioid Antidote Distribution Programs
- Outpatient Drug Detoxification
- Outpatient Medically Assisted Alcohol Detoxification
- Sober Living Homes
- Substance Abuse Walk in Assessment Center
- Substance Use Disorder Counseling
- Substance Use Disorder Day Treatment
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<td>Town of Greenwich 101 Field Point Road Greenwich, CT 06830 (203) 622-6460</td>
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| Greenwich Hospital, Yale New Haven Health  
5 Perryridge Road  
Greenwich, CT 06830  
(203) 863-3690 | Neighbor to Neighbor  
248 East Putnam Avenue  
Greenwich, CT 06830  
(203) 622-9208 | Meals on Wheels of Greenwich  
89 Maple Avenue  
Greenwich, CT 06830 |
| Town of Greenwich  
299 Greenwich Avenue  
Greenwich, CT 06830  
(203) 862-6700 |  |

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<td><strong>Wellness Programs</strong></td>
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| Audubon Connecticut  
613 Riversville Road  
Greenwich, CT 06831  
(203) 869-5272 | Greenwich Family YMCA  
50 East Putnam Avenue  
Greenwich, CT 06830  
(203) 869-1630 | Greenwich Hospital,  
Yale New Haven Health  
5 Perryridge Road  
Greenwich, CT 06830  
(203) 863-3756 |
| Town of Greenwich  
101 Field Point Road  
Greenwich, CT 06830  
(203) 633-7814 | YWCA Greenwich  
259 East Putnam Avenue  
Greenwich, CT 06830  
(203) 869-6501 |

**Youth Enrichment Programs**

| Banksville Community House  
12 Banksville Road  
Greenwich, CT 06831  
(203) 622-9597 |
| **Boy Scouts of America, Greenwich Council**  
63 Mason Street  
Greenwich, CT 06830  
(203) 869-8424 |
| **Boys and Girls Club of Greenwich**  
4 Horseneck Lane  
Greenwich, CT 06830  
(203) 869-3224 |
| Community Centers, Inc.  
61 East Putnam Avenue  
Greenwich, CT 06830  
(203) 869-1276 |

*2-1-1 United Way Connecticut data is current as of March 12, 2019*
## Domestic Violence Shelters

**YWCA Greenwich**  
259 East Putnam Avenue  
Greenwich, CT 06830  
(203) 622-0003

## Housing Authorities

**Greenwich Housing Authority**  
249 Milbank Avenue  
Greenwich, CT 06830  
(203) 869-1138

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### Adolescent/Youth Counseling

- **Child Guidance Center of Southern Connecticut**  
  81 Holy Hill Lane  
  Greenwich, CT 06830  
  (203) 324-6127

- **Family Centers**  
  20 Bridge Street  
  Greenwich, CT 06830  
  (203) 629-2822

### General Counseling Services

- **Greenwich Hospital, Yale New Haven Health**  
  77 Lafayette Place  
  Greenwich, CT 06830  
  (203) 863-3704

- **Community Centers, Inc.**  
  61 East Putnam Avenue  
  Greenwich, CT 06830  
  (203) 869-1276

- **Jewish Family Services of Greenwich**  
  1 Holly Hill Lane  
  Greenwich, CT 06830  
  (203) 622-1881

### Mental Health Related Support Group

- **Depression and Bipolar Support Alliance, Greenwich**  
  27 Stag Lane  
  Greenwich, CT 06831  
  (203) 661-8282

### Psychiatric Disorder Counseling

- **Child Guidance Center of Southern Connecticut**  
  81 Holy Hill Lane  
  Greenwich, CT 06830  
  (203) 324-6127

- **Greenwich Hospital, Yale New Haven Health**  
  5 Perryridge Road  
  Greenwich, CT 06830  
  (203) 863-3316

- **Wilkins Center**  
  7 Riversville Road  
  Greenwich, CT 06831  
  (203) 531-1909

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<td><strong>Alcohol Use Disorder Support Groups</strong></td>
<td><strong>Opioid Antidote Distribution Programs</strong></td>
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<td>CVS Health 99 Greenwich Avenue Greenwich, CT 06830 (203) 862-9320</td>
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<td>Greenwich Hospital, Yale New Haven Health 5 Perryridge Road Greenwich, CT 06830 (203) 863-4673</td>
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<td>Liberation Programs 50 East Putnam Avenue Greenwich, CT 06830 (203) 851-2077</td>
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2-1-1 United Way Connecticut data is current as of March 12, 2019
Indicators of social progress, economic opportunity, and population well-being in Fairfield County neighborhoods

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
Thank you to our Major Funders

2018 DataHaven Community Wellbeing Survey Funders
The Fairfield County Community Wellbeing Index makes extensive use of the DataHaven Community Wellbeing Survey, which completed live, in-depth interviews with 16,043 randomly-selected adults in Connecticut last year. In addition to the major funders listed above, supporters of the interviews in Fairfield County included local public health departments serving the towns and cities of Stamford, Danbury, Norwalk, Bridgeport, Fairfield, Stratford, Trumbull, Monroe, Easton, Newtown, Bethel, and New Fairfield, as well as the Valley Community Foundation (serving Shelton) and Newtown-Sandy Hook Community Foundation (serving Newtown).

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FAIRFIELD COUNTY

Community Wellbeing Index 2019

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

50 figures, 35 tables, 1 report – here’s a preview of what we learned about Fairfield County

Follow the story and access resources at #CommunityIndex
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DataHaven Community Index & Personal Wellbeing Index

**QUALITY OF LIFE**
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- DataHaven Personal Wellbeing Index

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DataHaven Fairfield County Community Wellbeing Index

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- Nutrition, Physical Activity, & Substance Use
- The Opioid Crisis

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**Figure 4.2** In towns with more surplus money, residents rate neighborhood assets & facilities more highly.

**Figure 4.3** Towns that spend more on their libraries see greater library use.

**Figure 4.4** Voter turnout is high for national & state elections, but much lower in municipal ones.

**Figure 3.1** Residents often see their race as a major reason for discrimination in multiple areas of their lives.

**Figure 3.2** Wealthier towns net more money from property values & spend more money on education.

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What matters more, having a job or having food on your plate?

Can money really buy happiness? Is it really true that if you haven’t got your health, you haven’t got anything?
As federal, state, and local agencies wrestle with one tough budget season after another, these questions matter—a lot.

Understanding what people need across our regions and neighborhoods helps answer these questions.

This report, The Fairfield County Community Wellbeing Index 2019, collects and analyzes over 100 sources of national, state, and local data that pertain to these questions. But we have supplemented that information by conducting live, in-depth interviews with tens of thousands of randomly-selected adults statewide—over 32,000 in 2015 and 2018, including conversations with 10,000 representative adults in Fairfield County. The DataHaven Community Wellbeing Survey (DCWS), believed to be the largest of its type in the United States, produces reliable data about life satisfaction, physical and mental health, neighborhood conditions, economic opportunity, and civic engagement that are not available at the local level from any of the other public data sources we work with. We use the latest data from the 2018 DCWS throughout this report. Data from our 2015 DCWS were also discussed in the 2016 iteration of this report.¹

Working with DataHaven, researchers Jan Wollenberg and Chris Barrington-Leigh of McGill University used this survey data to construct a model that could predict individuals’ levels of life satisfaction.² The model accounted for household income, household size, self-reported physical and mental health, and personal experiences including food security, employment, and neighborhood conditions. Using these variables, Wollenberg and Barrington-Leigh created a life satisfaction score ranging from 0 to 100. Among the key findings:

Addressing food insecurity would be more likely to increase overall life satisfaction than addressing unemployment.

Some might think that, after health, employment matters above all else. Indeed, for adults in the workforce, having employment improved life satisfaction as much as a nearly six-fold increase in household income did, whereas food security equaled only a 4.2-fold increase. However, there are approximately 400,000 food-insecure Connecticut adults, including 80,000 in Fairfield County, compared to about 200,000 Connecticut adults who are unemployed, according to the DataHaven survey.

Money can buy happiness—but only up to a point.

Underscoring the importance of food security, the researchers found that having enough money to consistently buy food for themselves and their families improved adults’ life satisfaction as much as if they quadrupled their household income. Meanwhile, even more Connecticut adults than who are food-insecure—about 680,000, or 19 percent—say they live in neighborhoods with low walkability. The researchers’ analysis of life satisfaction data shows that improving quality of life issues such as walkability, trust in neighbors, and interactions with local government would likely make life better for many residents.

The old saying about health turned out to be somewhat true, but not for the reasons we might expect.

Having excellent rather than poor physical and mental health improved life satisfaction scores by 18 and 26 points, respectively. The sizable effect of improving mental health and the number of adults who face challenges in this area is consistent with other research suggesting that preventing depression would translate into enormous gains in life satisfaction. Meanwhile, a lack of
health insurance had just a modest effect on the entire population. This is not because health insurance is not important—having insurance improved life satisfaction by 4 points on the scale. But in recent years, Connecticut has done a relatively good job making sure that all people can get health insurance, whether through work, state-sponsored insurance, or AccessHealthCT (the state’s insurance marketplace under the Affordable Care Act). Currently, only about 5 percent of adults in Connecticut are uninsured. If uninsurance rates were to rise back to where they were before the Affordable Care Act, the model suggests that the effect on people’s well-being would be quite significant.

What does all this mean for local and state agencies looking to do the best they can with what they have? The survey’s insights—whether at the level of the entire population or a single program—suggest more cost-effective ways to improve the lives of the widest range of people. Increasing families’ incomes across the board would be a costly endeavor. Thus, improving access to nutritious food and health care, strengthening neighborhood assets and walkability, and deepening people’s relationships with different levels of government are both more attainable and, perhaps, more effective.

**About this Community Indicators Program and Community Health Needs Assessment**

*The Fairfield County Community Wellbeing Index 2019* is part of a comprehensive community indicators program that collects, shares, and evaluates quality-of-life data on an ongoing basis at the state, regional, and neighborhood levels. This work builds upon the primary mission of DataHaven, a formal partner of the National Neighborhood Indicators Partnership, and is consistent with our focus since we released our first printed book of social indicator maps nearly 25 years ago in New Haven.

This report was made possible by contributions from more than 100 funders. A list of funders in this region can be found inside the front cover. We have also consulted extensively with other community partners and subject matter experts throughout the state and beyond, and are profoundly grateful for their guidance and support.

**Fairfield County’s Community Foundation**, a core funder of this report, plans to use this new data in several ways. They will use this data to inform their competitive grantmaking aligned with their new strategic plan, and will share the data with donor-advised fundholders seeking to understand changing regional and community needs. Fairfield County’s Community Foundation will also ensure that Fairfield County nonprofits, through their Center for Nonprofit Excellence, analyze the data and use it to inform strategic planning and fundraising efforts.

Because it covers health and several other issues that relate to it,*The Fairfield County Community Wellbeing Index 2019* is also designed to meet requirements for **Community Health Needs Assessments (CHNA)** for Greenwich Hospital, Stamford Hospital, Norwalk Hospital, Danbury Hospital, St. Vincent’s Medical Center, and Bridgeport Hospital individually, as laid out in Internal Revenue Service Form 990 Schedule H and Notice 2011-52. The CHNA also serves local health departments participating in national accreditation processes. Chapter 3 of the *Community Wellbeing Index* is intended to document key health needs in communities served by all hospitals, while using a unified approach to reach the broadest possible audience throughout Fairfield County. To add further context and locally-specific analysis, additional CHNA sections **SEE TABLE** have been created based on the work of a
multi-agency community-hospital coalition existing within each hospital’s primary service area. Whereas the entire county is of interest to every hospital, these additional sections provide further documentation of community needs within each hospital’s geographic area of focus, and outline the processes used by each hospital to develop CHNAs and Community Health Improvement Plans within their primary service areas. Like this report, the additional sections have benefited from input from dozens of local public health experts, and will be found on the individual hospital websites when they are finalized this year.

The topics included in this report have been the subject of other studies, but to our knowledge there has never been a program that has synthesized them into a single report. Following on our 2016 Community Wellbeing Index, we envision that this report will continue to serve as a platform to further the availability of neighborhood-level data and address gaps in disaggregated data related to age, gender, race, ethnicity, national origin, sexual orientation, disability, and other demographic characteristics. Since 2016, we have improved the quality of available data in several ways, including by working diligently to ensure that all persons are represented in the information sources used in the report. Doing so allows the program to highlight areas where the region is and is not doing well, and also lets community leaders find data that are relevant to their interests and see how the work they do across different sectors contributes to the broader whole.

We recognize that most of the potential demographic or neighborhood data breakdowns do not fit within the practical confines of this report. We have published disaggregated data elsewhere on the DataHaven website (ctdatahaven.org), and we plan to release additional regional and statewide publications on health equity and other subject-specific topics in the near future. In 2019, we have also worked with partner organizations to publish separate reports that cover other areas of Connecticut including the Greater Hartford and Greater New Haven regions. We encourage community partners to submit requests for the data that they need, using the instructions on our website: ctdatahaven.org/ask-mark.

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<td>Bridgeport, Easton, Fairfield, Monroe, Trumbull, Stratford</td>
</tr>
<tr>
<td>2019 Valley Community Index separately-produced; CHNA for Griffin Hospital</td>
<td>Shelton, plus other towns in the Lower Naugatuck Valley region</td>
</tr>
</tbody>
</table>
CHAPTER 1

DataHaven Community Index and Personal Wellbeing Index

Gross Domestic Product or Gross Domestic Happiness?
Asking residents about how they are doing on a daily basis is the most democratic approach to evaluating the extent to which a region’s communities are flourishing. Measures of subjective well-being do not presuppose that any given resident needs a set of specific material goods, such as a paycheck of a certain size or a car, in order to be content with life. The greatest hopes and concerns of residents may lie within social aspects such as supportive friendships; access to fresh air, water, parks, and safe streets; or how they generally perceive their lives and their communities.

Traditional economic measures such as gross domestic product—the monetary value of all goods and services produced within the area—often show that Connecticut’s metropolitan regions are among the wealthiest and most productive in the world. However, they do not necessarily account for how that affluence is distributed or how residents experience it. The many processes and policies that lead to social and economic inequalities, and the impacts that these inequalities can have on children and adults over time, are fundamental to understanding our current and future levels of well-being. Countries such as the United Kingdom and New Zealand have already begun to harness the power of a population well-being framework to inform public policy decisions.3, 4

When integrated with other data, measures of well-being also help illuminate the deep connections among financial stress, health, and happiness in a way that economic statistics alone do not. For example, one in nine Fairfield County adults experience food insecurity. Our analysis suggests that reducing food insecurity would lead to a dramatic increase in the overall well-being of Fairfield County. The same data suggest that boosting incomes universally would lead to a much smaller gain.

To summarize and draw connections across these measures, we begin the report by introducing indexes of the region: the DataHaven Community Index and Personal Wellbeing Index. Additionally, a Neighborhood Assets Index is defined later in this report. Each index is a blend of indicators that capture the physical and social environments in which people live in Fairfield County—including measures of community-wide health, infrastructure, education, and economics.

Executive Summary

The DataHaven Community Index incorporates 12 indicators into a single factored score that can be compared across multiple geographies. The indicators range from common economic measures, including poverty and unemployment rates, to educational attainment, life expectancy at birth, and other general measures of quality of life. Fairfield County ranks 15th among 107 large U.S. metropolitan areas, but the relatively high standard of living is divided; the region includes some of the highest- and lowest-scoring areas in our analysis.

Between 2012 and 2017 (the latest year for which these data are available), many Community Index scores improved, due in large part to economic recovery and expansion after the Great Recession. Despite this apparent progress, substantial regional and racial inequalities remain. DataHaven’s Personal Wellbeing Index—consisting of measures of self-reported life satisfaction, happiness, anxiety, and health—also reveals a high degree of inequality by geography, race and ethnicity, and household income level.
## FIG 1.1
Community well-being comes from a number of different factors

### COMPONENTS OF THE DATAHAVEN COMMUNITY INDEX, 2017

<table>
<thead>
<tr>
<th>INDEX COMPONENTS</th>
<th>US</th>
<th>CONNECTICUT</th>
<th>FAIRFIELD COUNTY</th>
<th>BEST</th>
<th>WORST</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPPORTUNITY YOUTH</td>
<td>7%</td>
<td>5%</td>
<td>4%</td>
<td>BRIDGEPORT, NORTH/BLACK ROCK</td>
<td>BRIDGEPORT, CENTRAL 14%</td>
</tr>
<tr>
<td>YOUNG CHILD POVERTY</td>
<td>22%</td>
<td>15%</td>
<td>13%</td>
<td>6 WEALTHIEST FC TOWNS 2%</td>
<td>BRIDGEPORT, EAST END 43%</td>
</tr>
<tr>
<td>UNEMPLOYMENT</td>
<td>7%</td>
<td>7%</td>
<td>8%</td>
<td>6 WEALTHIEST FC TOWNS 5%</td>
<td>BRIDGEPORT, EAST END 17%</td>
</tr>
<tr>
<td>POVERTY</td>
<td>15%</td>
<td>10%</td>
<td>9%</td>
<td>6 WEALTHIEST FC TOWNS 3%</td>
<td>BRIDGEPORT, EAST END 26%</td>
</tr>
<tr>
<td>HIGH SCHOOL GRADUATES</td>
<td>87%</td>
<td>90%</td>
<td>89%</td>
<td>6 WEALTHIEST FC TOWNS 98%</td>
<td>DANBURY, CENTRAL 68%</td>
</tr>
<tr>
<td>PRESCHOOL ENROLLMENT</td>
<td>48%</td>
<td>64%</td>
<td>69%</td>
<td>GREENWICH 84%</td>
<td>DANBURY, CENTRAL 39%</td>
</tr>
<tr>
<td>LIFE EXPECTANCY</td>
<td>79 yrs</td>
<td>80 yrs</td>
<td>82 yrs</td>
<td>6 WEALTHIEST FC TOWNS 84 yrs</td>
<td>BRIDGEPORT, EAST END 76 yrs</td>
</tr>
<tr>
<td>SEVERE HOUSING COST BURDEN</td>
<td>15%</td>
<td>16%</td>
<td>19%</td>
<td>DANBURY, OUTER 14%</td>
<td>BRIDGEPORT, EAST END 33%</td>
</tr>
<tr>
<td>HEALTH INSURANCE</td>
<td>90%</td>
<td>94%</td>
<td>90%</td>
<td>6 WEALTHIEST FC TOWNS 96%</td>
<td>NORWALK, SOUTH/CENTRAL 70%</td>
</tr>
<tr>
<td>WORKERS WITH SHORT COMMUTE</td>
<td>63%</td>
<td>65%</td>
<td>60%</td>
<td>STAMFORD, CENTRAL 67%</td>
<td>6 WEALTHIEST FC TOWNS 51%</td>
</tr>
<tr>
<td>YOUTHFUL LABOR FORCE</td>
<td>26%</td>
<td>24%</td>
<td>24%</td>
<td>STAMFORD, CENTRAL 38%</td>
<td>6 WEALTHIEST FC TOWNS 17%</td>
</tr>
<tr>
<td>MEDIAN HOUSEHOLD INCOME</td>
<td>$58K</td>
<td>$74K</td>
<td>$90K</td>
<td>6 WEALTHIEST FC TOWNS $181K</td>
<td>BRIDGEPORT, EAST END $36K</td>
</tr>
<tr>
<td>COMMUNITY INDEX OVERALL (0–1,000)</td>
<td>594</td>
<td>657</td>
<td>655</td>
<td>6 WEALTHIEST FC TOWNS 772</td>
<td>BRIDGEPORT, EAST END 418</td>
</tr>
</tbody>
</table>

**NOTE:** Please refer to text (Chapter 1) and endnotes (Chapter 5) for definitions of indicators used in this Index.
FIG 1.2

Compared to the US and other metros, well-being is high but varied

COMPOSITE SCORE OF THE DATAHAVEN COMMUNITY INDEX BY TOWN & NEIGHBORHOOD WITH NEARBY METROS, 2017

United States
Springfield, MA
618
Connecticut
Boston, MA
666
Fairfield County
Worcester, MA / CT
649
Providence / Warwick, RI / MA
586

DANBURY, OUTER
676
DANBURY, CENTRAL
486

6 WEALTHIEST FC TOWNS
772

STAMFORD, NORTH
728
GREENWICH
745

Note: Index ranges from 0 (worse) to 1,000 (better).

FIG 1.3

White and Asian residents rank well above Black and Latino residents on well-being measures

COMPONENTS OF THE DATAHAVEN COMMUNITY INDEX BY RACE/ETHNICITY, FAIRFIELD COUNTY, 2017

<table>
<thead>
<tr>
<th></th>
<th>OPPORTUNITY YOUTH</th>
<th>POVERTY</th>
<th>YOUNG CHILD POVERTY</th>
<th>HIGH SCHOOL GRADUATES</th>
<th>HEALTH INSURANCE</th>
<th>SEVERE HOUSING COST BURDEN</th>
<th>LIFE EXPECTANCY</th>
<th>UNEMPLOYMENT</th>
<th>MEDIAN HOUSEHOLD INCOME</th>
<th>YOUTHFUL LABOR FORCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHITE</td>
<td>4%</td>
<td>5%</td>
<td>4%</td>
<td>95%</td>
<td>95%</td>
<td>17%</td>
<td>83 yrs</td>
<td>58%</td>
<td>$108k</td>
<td>20%</td>
</tr>
<tr>
<td>BLACK</td>
<td>12%</td>
<td>17%</td>
<td>27%</td>
<td>85%</td>
<td>88%</td>
<td>31%</td>
<td>78 yrs</td>
<td>59%</td>
<td>$49k</td>
<td>28%</td>
</tr>
<tr>
<td>LATINO</td>
<td>6%</td>
<td>18%</td>
<td>25%</td>
<td>68%</td>
<td>75%</td>
<td>33%</td>
<td>78 yrs</td>
<td>65%</td>
<td>$51k</td>
<td>32%</td>
</tr>
<tr>
<td>ASIAN</td>
<td>N/A</td>
<td>8%</td>
<td>91%</td>
<td>91%</td>
<td>21%</td>
<td>N/A</td>
<td>N/A</td>
<td>59%</td>
<td>$116k</td>
<td>38%</td>
</tr>
</tbody>
</table>
Residents are happier and healthier in places that score high on community well-being...

PERSONAL WELLBEING INDEX VS DATAHAVEN COMMUNITY INDEX

NOTE: Each index is scaled from 0 (worse) to 1,000 (better).
...as well as those with strong neighborhood assets

PERSONAL WELLBEING INDEX VS DATAHAVEN NEIGHBORHOOD ASSETS INDEX
### Table 1A
**DataHaven Community Index**
Scores for Large U.S. Metropolitan Areas and Local Cities, Towns, and Neighborhoods, 2012 and 2017

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Madison, WI</td>
<td>706</td>
<td>631</td>
<td>+12%</td>
</tr>
<tr>
<td>2</td>
<td>Des Moines, IA</td>
<td>691</td>
<td>635</td>
<td>+9%</td>
</tr>
<tr>
<td>3</td>
<td>San Jose, CA</td>
<td>688</td>
<td>595</td>
<td>+18%</td>
</tr>
<tr>
<td>4</td>
<td>Minneapolis-St. Paul, MN</td>
<td>683</td>
<td>607</td>
<td>+13%</td>
</tr>
<tr>
<td>5</td>
<td>Ogden, UT</td>
<td>683</td>
<td>612</td>
<td>+12%</td>
</tr>
<tr>
<td>6</td>
<td>Norwalk, north</td>
<td>678</td>
<td>655</td>
<td>+4%</td>
</tr>
<tr>
<td>7</td>
<td>Danbury, outer</td>
<td>676</td>
<td>622</td>
<td>+9%</td>
</tr>
<tr>
<td>8</td>
<td>Portland, ME</td>
<td>675</td>
<td>590</td>
<td>+14%</td>
</tr>
<tr>
<td>9</td>
<td>Hartford, CT metro area (incl. Middlesex County)</td>
<td>671</td>
<td>604</td>
<td>+11%</td>
</tr>
<tr>
<td>10</td>
<td>Albany, NY</td>
<td>669</td>
<td>606</td>
<td>+10%</td>
</tr>
<tr>
<td>11</td>
<td>Stamford</td>
<td>668</td>
<td>566</td>
<td>+18%</td>
</tr>
<tr>
<td>12</td>
<td>Provo, UT</td>
<td>667</td>
<td>592</td>
<td>+13%</td>
</tr>
<tr>
<td>13</td>
<td>Boston, MA</td>
<td>666</td>
<td>598</td>
<td>+11%</td>
</tr>
<tr>
<td>14</td>
<td>Omaha, NE</td>
<td>665</td>
<td>612</td>
<td>+9%</td>
</tr>
<tr>
<td>15</td>
<td>Grand Rapids, MI</td>
<td>663</td>
<td>557</td>
<td>+19%</td>
</tr>
<tr>
<td>16</td>
<td>Stratford</td>
<td>660</td>
<td>614</td>
<td>+7%</td>
</tr>
<tr>
<td>17</td>
<td>Connecticut (state avg.)</td>
<td>657</td>
<td>593</td>
<td>+11%</td>
</tr>
<tr>
<td>18</td>
<td>San Francisco, CA</td>
<td>656</td>
<td>566</td>
<td>+18%</td>
</tr>
<tr>
<td>19</td>
<td>Salt Lake City, UT</td>
<td>656</td>
<td>574</td>
<td>+14%</td>
</tr>
<tr>
<td>20</td>
<td>Bridgeport-Stamford-Norwalk, CT (Fairfield County)</td>
<td>655</td>
<td>593</td>
<td>+10%</td>
</tr>
<tr>
<td>21</td>
<td>Honolulu, HI</td>
<td>653</td>
<td>580</td>
<td>+13%</td>
</tr>
<tr>
<td>22</td>
<td>Colorado Springs, CO</td>
<td>652</td>
<td>574</td>
<td>+14%</td>
</tr>
<tr>
<td>23</td>
<td>Raleigh, NC</td>
<td>651</td>
<td>586</td>
<td>+11%</td>
</tr>
<tr>
<td>24</td>
<td>Worcester, MA</td>
<td>649</td>
<td>594</td>
<td>+9%</td>
</tr>
<tr>
<td>25</td>
<td>Harrisburg, PA</td>
<td>647</td>
<td>598</td>
<td>+8%</td>
</tr>
<tr>
<td>26</td>
<td>Washington, DC</td>
<td>647</td>
<td>584</td>
<td>+11%</td>
</tr>
<tr>
<td>27</td>
<td>Bridgeport, central</td>
<td>647</td>
<td>587</td>
<td>+10%</td>
</tr>
<tr>
<td>28</td>
<td>Bridgeport, central</td>
<td>647</td>
<td>587</td>
<td>+10%</td>
</tr>
<tr>
<td>29</td>
<td>Bridgeport, East End</td>
<td>644</td>
<td>556</td>
<td>+18%</td>
</tr>
</tbody>
</table>

Connecticut cities, towns, and neighborhood areas

◊ Community Index Score improvement at or above the national average.
Fairfield County Ranks 15th Nationally

The Community Index integrates 12 individual and household indicators into a single factored score ranging from 0 to 1,000. Distilling this information into a single score allows us to make relative comparisons of multiple geographies ranging from the national level to large metropolitan regions to individual neighborhoods within cities. These measures incorporate the latest available Census American Community Survey (ACS) data with life expectancy data from the Centers for Disease Control and Prevention.

With an overall Community Index score of 655, the Bridgeport-Stamford-Norwalk metro area (Fairfield County) ranks 15th among 107 U.S. metropolitan areas with a population of at least 500,000. In Fairfield County as a whole, the average score has improved by 10 percent (62 points) since 2012 as the result of continued economic recovery since the Great Recession. Most Index scores in 2017 are higher as a result of improvements in economic outcomes such as unemployment and the expansion of health insurance coverage. Central Stamford saw the greatest increase—149 points, or 34 percent. Despite ranking the lowest in our analysis of Fairfield County and U.S. metros, the score for Bridgeport’s East End neighborhood increased by 40 percent (119 points) between 2012 and 2017, driven in part by improvements in preschool enrollment (63 percent in 2017, up from 55 percent in 2012) and reductions in the average rates of poverty (26 percent in 2017, down from 35 percent in 2012) and unemployment (17 percent in 2017, down from 23 percent in 2012). It is worth noting that several community-based nonprofits are located in the East End.

While the improvement in Fairfield County’s Community Index score is not itself significant in light of the overall improvement nationwide, it is driven by significant decreases in rates of unemployment and severe housing cost burden, or the share of households spending more than half of their income on housing costs. Despite overall improvement in the latter, severe housing cost burden still affected 19 percent of households in Fairfield County and 33 percent of households in Bridgeport’s East End in 2017. Fairfield County includes areas that, by themselves, would rank among both the highest and lowest scoring regions in the nation. The six wealthiest towns in the county scored 772—more than 60 points higher than the highest-ranking US metro area—while the East End in Bridgeport scored 418—lower than the lowest-ranking metro area. This inequality is largely related to income. Median household income in the six wealthiest towns ($181,155) was five times greater than in the East End ($36,373). As a result, the poverty rate in that neighborhood was nine times greater, and the poverty rate among young children was 17 times greater. However, there are other significant differences, including life expectancy, health insurance coverage, and educational attainment.

Community Index by Race/Ethnicity

To further reveal the extent to which these measures vary across the population, we disaggregated each of the Community Index indicators by four racial/ethnic groups. White and Asian residents are generally more economically advantaged than Black and Latino residents. In 2017, the median income in white and Asian households was well over $100,000 per year compared to $90,000 per year in Fairfield County overall. In Black and Latino households, median income was approximately $50,000 per year. Consequently, poverty rates were more than three times greater for Black and Latino adults than for white adults, and more than six times greater for Black and Latino children compared to white children.

Likewise, 12 percent of Black youth in Fairfield County between 16 and 19 years old were considered “opportunity youth” (or “disconnected youth”)—defined as young adults neither in school nor working—compared to 4 percent of white youth. And the average unemployment rate in Black communities was more than double (14 percent) the rate of white communities (6 percent) in 2017. These young people who become “disconnected” from school and the labor force often find it difficult to reconnect, which may further complicate their ability to pursue higher education or ultimately secure a living-wage job. These outcomes can significantly limit lifetime economic mobility and, in the worst cases, perpetuate intergenerational poverty.
## TABLE 1B
DataHaven Community Index and its components by area and neighborhood
LOCAL DATA VALUES AND SCORES, 2017

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>OPPORTUNITY YOUTH</th>
<th>POVERTY</th>
<th>HIGH SCHOOL GRADUATES</th>
<th>YOUNG CHILD POVERTY</th>
<th>HEALTH INSURANCE COVERAGE</th>
<th>PRE-SCHOOL ENROLLMENT</th>
<th>UNEMPLOYMENT RATE</th>
<th>LIFE EXPECTANCY</th>
<th>SEVERE HOUSING COST BURDEN</th>
<th>YOUTHFUL LABOR FORCE</th>
<th>WORKERS WITH SHORT COMMUTE</th>
<th>MEDIAN HOUSEHOLD INCOME</th>
<th>2017 COMM. INX.</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>7%</td>
<td>15%</td>
<td>87%</td>
<td>22%</td>
<td>90%</td>
<td>48%</td>
<td>7%</td>
<td>78.7</td>
<td>15%</td>
<td>26%</td>
<td>63%</td>
<td>$57,652</td>
<td>594</td>
</tr>
<tr>
<td>CT</td>
<td>5%</td>
<td>10%</td>
<td>90%</td>
<td>15%</td>
<td>94%</td>
<td>64%</td>
<td>7%</td>
<td>80.3</td>
<td>16%</td>
<td>24%</td>
<td>65%</td>
<td>$73,781</td>
<td>657</td>
</tr>
<tr>
<td>FC</td>
<td>4%</td>
<td>9%</td>
<td>89%</td>
<td>13%</td>
<td>90%</td>
<td>69%</td>
<td>8%</td>
<td>81.6</td>
<td>19%</td>
<td>24%</td>
<td>60%</td>
<td>$89,773</td>
<td>655</td>
</tr>
<tr>
<td>6 wealthiest FC towns</td>
<td>2%</td>
<td>3%</td>
<td>98%</td>
<td>2%</td>
<td>96%</td>
<td>82%</td>
<td>5%</td>
<td>84.1</td>
<td>15%</td>
<td>17%</td>
<td>51%</td>
<td>$181,155</td>
<td>772</td>
</tr>
<tr>
<td>All other FC towns</td>
<td>2%</td>
<td>4%</td>
<td>95%</td>
<td>3%</td>
<td>96%</td>
<td>63%</td>
<td>6%</td>
<td>82.1</td>
<td>14%</td>
<td>19%</td>
<td>55%</td>
<td>$107,611</td>
<td>716</td>
</tr>
<tr>
<td>Bridgeport</td>
<td>1%</td>
<td>21%</td>
<td>76%</td>
<td>36%</td>
<td>84%</td>
<td>65%</td>
<td>14%</td>
<td>77.7</td>
<td>28%</td>
<td>30%</td>
<td>60%</td>
<td>$44,841</td>
<td>472</td>
</tr>
<tr>
<td>Danbury</td>
<td>4%</td>
<td>12%</td>
<td>82%</td>
<td>19%</td>
<td>83%</td>
<td>42%</td>
<td>7%</td>
<td>81.4</td>
<td>18%</td>
<td>29%</td>
<td>64%</td>
<td>$68,068</td>
<td>596</td>
</tr>
<tr>
<td>Fairfield</td>
<td>3%</td>
<td>5%</td>
<td>95%</td>
<td>4%</td>
<td>96%</td>
<td>74%</td>
<td>6%</td>
<td>82.2</td>
<td>16%</td>
<td>19%</td>
<td>53%</td>
<td>$127,746</td>
<td>720</td>
</tr>
<tr>
<td>Greenwich</td>
<td>3%</td>
<td>7%</td>
<td>95%</td>
<td>5%</td>
<td>95%</td>
<td>84%</td>
<td>6%</td>
<td>84.0</td>
<td>19%</td>
<td>21%</td>
<td>61%</td>
<td>$138,180</td>
<td>745</td>
</tr>
<tr>
<td>Norwalk</td>
<td>8%</td>
<td>9%</td>
<td>87%</td>
<td>11%</td>
<td>81%</td>
<td>75%</td>
<td>8%</td>
<td>82.6</td>
<td>21%</td>
<td>28%</td>
<td>64%</td>
<td>$81,546</td>
<td>634</td>
</tr>
<tr>
<td>Stamford</td>
<td>4%</td>
<td>9%</td>
<td>89%</td>
<td>8%</td>
<td>87%</td>
<td>63%</td>
<td>7%</td>
<td>81.9</td>
<td>21%</td>
<td>31%</td>
<td>67%</td>
<td>$84,893</td>
<td>668</td>
</tr>
<tr>
<td>Stratford</td>
<td>5%</td>
<td>8%</td>
<td>90%</td>
<td>11%</td>
<td>95%</td>
<td>73%</td>
<td>7%</td>
<td>79.7</td>
<td>20%</td>
<td>24%</td>
<td>61%</td>
<td>$72,757</td>
<td>660</td>
</tr>
</tbody>
</table>

### INDIVIDUAL NEIGHBORHOODS

<table>
<thead>
<tr>
<th>Neighbohood</th>
<th>OPPORTUNITY YOUTH</th>
<th>POVERTY</th>
<th>HIGH SCHOOL GRADUATES</th>
<th>YOUNG CHILD POVERTY</th>
<th>HEALTH INSURANCE COVERAGE</th>
<th>PRE-SCHOOL ENROLLMENT</th>
<th>UNEMPLOYMENT RATE</th>
<th>LIFE EXPECTANCY</th>
<th>SEVERE HOUSING COST BURDEN</th>
<th>YOUTHFUL LABOR FORCE</th>
<th>WORKERS WITH SHORT COMMUTE</th>
<th>MEDIAN HOUSEHOLD INCOME</th>
<th>2017 COMM. INX.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgeport, central</td>
<td>14%</td>
<td>24%</td>
<td>73%</td>
<td>43%</td>
<td>82%</td>
<td>61%</td>
<td>15%</td>
<td>77.0</td>
<td>30%</td>
<td>30%</td>
<td>62%</td>
<td>$46,344</td>
<td>425</td>
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<tr>
<td>Bridgeport, East End</td>
<td>13%</td>
<td>26%</td>
<td>70%</td>
<td>34%</td>
<td>84%</td>
<td>63%</td>
<td>17%</td>
<td>76.0</td>
<td>33%</td>
<td>31%</td>
<td>62%</td>
<td>$36,373</td>
<td>418</td>
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<tr>
<td>Bridgeport, North/ Black Rock</td>
<td>1%</td>
<td>11%</td>
<td>83%</td>
<td>21%</td>
<td>86%</td>
<td>77%</td>
<td>10%</td>
<td>79.7</td>
<td>22%</td>
<td>29%</td>
<td>56%</td>
<td>$66,962</td>
<td>602</td>
</tr>
<tr>
<td>Danbury, central</td>
<td>5%</td>
<td>18%</td>
<td>68%</td>
<td>26%</td>
<td>70%</td>
<td>39%</td>
<td>9%</td>
<td>79.1</td>
<td>23%</td>
<td>34%</td>
<td>67%</td>
<td>$49,965</td>
<td>486</td>
</tr>
<tr>
<td>Danbury, outer</td>
<td>3%</td>
<td>7%</td>
<td>90%</td>
<td>13%</td>
<td>92%</td>
<td>45%</td>
<td>6%</td>
<td>83.1</td>
<td>14%</td>
<td>26%</td>
<td>61%</td>
<td>$86,480</td>
<td>676</td>
</tr>
<tr>
<td>Norwalk, north</td>
<td>9%</td>
<td>6%</td>
<td>91%</td>
<td>4%</td>
<td>85%</td>
<td>76%</td>
<td>7%</td>
<td>83.4</td>
<td>20%</td>
<td>26%</td>
<td>64%</td>
<td>$95,552</td>
<td>678</td>
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<tr>
<td>Norwalk, south/ central</td>
<td>6%</td>
<td>18%</td>
<td>77%</td>
<td>32%</td>
<td>70%</td>
<td>74%</td>
<td>11%</td>
<td>79.3</td>
<td>24%</td>
<td>33%</td>
<td>66%</td>
<td>$60,523</td>
<td>517</td>
</tr>
<tr>
<td>Stamford, central</td>
<td>4%</td>
<td>15%</td>
<td>81%</td>
<td>17%</td>
<td>79%</td>
<td>56%</td>
<td>8%</td>
<td>80.0</td>
<td>24%</td>
<td>38%</td>
<td>67%</td>
<td>$63,307</td>
<td>588</td>
</tr>
<tr>
<td>Stamford, north</td>
<td>3%</td>
<td>5%</td>
<td>94%</td>
<td>3%</td>
<td>92%</td>
<td>69%</td>
<td>7%</td>
<td>83.1</td>
<td>20%</td>
<td>27%</td>
<td>67%</td>
<td>$118,174</td>
<td>728</td>
</tr>
</tbody>
</table>
Chapter 1   DataHaven Community Index and Personal Wellbeing Index

As discussed above, the DataHaven Community Wellbeing Survey’s questions on health, happiness, anxiety, and life satisfaction help us understand how people evaluate and experience their day-to-day life across multiple dimensions. Designed by a panel of local and national survey research experts, these questions are regularly used to evaluate personal well-being. For this report, we integrate the following four items into a Personal Wellbeing Index score from 0 to 1,000:

- How would you rate your overall health?
- Overall, how satisfied are you with your life nowadays?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?

Fairfield County’s score on the Personal Wellbeing Index is slightly better than the state average. However, throughout most of the state and in Fairfield County, personal well-being has worsened slightly since 2015, with the measure of life satisfaction declining the most. In Fairfield County, 69 percent of all adults reported being mostly or completely satisfied with life in 2018, compared to 74 percent in 2015. Further analysis is needed to identify and address this decline in life satisfaction, which has been steepest among adults under 50.

The DataHaven survey also includes questions on topics such as social support, meaning and purpose in life, and having time to enjoy life. The results from these measures are also essential for understanding quality of life, and detailed data may be found on the DataHaven website. However, they are not included in this report’s Personal Wellbeing Index score.

We often find strong correlations between the Community Index, Personal Wellbeing Index, and other community-level outcomes, suggesting that continuing to improve community health and quality of life in Fairfield County requires a comprehensive, multi-sectoral approach. The aspiration of this report is that these data will reveal both assets and opportunities in Fairfield County communities, and provide a starting point for action by community leaders.

DataHaven Index scores
FAIRFIELD COUNTY WITH DEMOGRAPHIC GROUPS

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>COMMUNITY INDEX</th>
<th>PERSONAL WELLBEING INDEX</th>
<th>NEIGHBORHOOD ASSETS INDEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>657</td>
<td>612</td>
<td>556</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>655</td>
<td>662</td>
<td>598</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BY DEMOGRAPHIC WITHIN FAIRFIELD COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Age 18–34</td>
</tr>
<tr>
<td>Age 35–49</td>
</tr>
<tr>
<td>Age 50–64</td>
</tr>
<tr>
<td>Age 65+</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>Black</td>
</tr>
<tr>
<td>Latino</td>
</tr>
<tr>
<td>&lt;$15K</td>
</tr>
<tr>
<td>$15K–$30K</td>
</tr>
<tr>
<td>$30K–$50K</td>
</tr>
<tr>
<td>$50K–$75K</td>
</tr>
<tr>
<td>$75K–$100K</td>
</tr>
<tr>
<td>$100K–$200K</td>
</tr>
<tr>
<td>$200K+</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BY TOWN</th>
<th>COMMUNITY INDEX</th>
<th>PERSONAL WELLBEING INDEX</th>
<th>NEIGHBORHOOD ASSETS INDEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgeport</td>
<td>472</td>
<td>438</td>
<td>259</td>
</tr>
<tr>
<td>Danbury</td>
<td>596</td>
<td>662</td>
<td>522</td>
</tr>
<tr>
<td>Fairfield</td>
<td>720</td>
<td>716</td>
<td>859</td>
</tr>
<tr>
<td>Greenwich</td>
<td>745</td>
<td>792</td>
<td>881</td>
</tr>
<tr>
<td>Norwalk</td>
<td>634</td>
<td>655</td>
<td>563</td>
</tr>
<tr>
<td>Stamford</td>
<td>668</td>
<td>751</td>
<td>602</td>
</tr>
<tr>
<td>Stratford</td>
<td>660</td>
<td>523</td>
<td>460</td>
</tr>
</tbody>
</table>

Note: All indices scaled from 0 (worse) to 1,000 (better).

FAIRFIELD COUNTY’S 19-YEAR DIFFERENCE IN LIFE EXPECTANCY

While Fairfield County’s average life expectancy of 81.6 years is very high, it masks a dramatic difference within the region. Life expectancy in part of Central Bridgeport is just 70.4 years—nearly 19 years lower than that of the neighborhood with the highest life expectancy (89.1 years, in Westport). Town-wide averages range from a maximum of 86.5 years in Weston to a minimum of 77.7 years in Bridgeport, a difference of nine years. SEE CHAPTER 3 FOR MORE DETAILS.
Before we can begin to understand what life is like in Fairfield County, we need to understand who lives here.
Executive Summary
Residents are growing both older and more diverse—diversity is increasingly concentrated in urban areas and highest among residents under 35. Part of this increase in diversity has been driven by a more than doubling of the number of immigrant residents in Fairfield County since 1990.

Compared to the state overall, Fairfield County has a larger share of married couples with children and a smaller share of single adults living alone. In 2017, most housing units in Fairfield County were single-family although housing construction permits issued have shifted toward multi-family buildings in recent years.

By many metrics, Fairfield County is wealthy; however, this wealth is highly concentrated. In 2017, median household income in the six wealthiest towns was more than double that of the county overall and more than four times that of Bridgeport, the lowest in the region. Nearly one-third of Fairfield County adults reported in 2018 that they are just getting by or finding it difficult to manage financially.

In addition to the geographic concentration of wealth, multiple significant wage gaps can be seen when looking at gender, race, and education level. Likely related, at least in part, to this income inequality, Fairfield County’s neighborhoods are growing more segregated as middle-class neighborhoods shrink and neighborhoods at both high-income and low-income extremes grow.

Similar inequality marks homeownership in Fairfield County. With a median home value among the top 2 percent of counties nationwide, homeownership is inaccessible to a large percentage of Black and Latino adults, and housing costs are unsustainable for many, with more than a quarter of Fairfield County renters spending more than half of their income on rental housing.

Jobs are shifting from manufacturing toward service industries, including health care and social assistance. While Fairfield County boasts the highest wages in the state, inflation-adjusted wages actually fell between 2000 and 2017.

Data point to a significant shortage in childcare options for infants and toddlers, but nearly 7-in-10 three- and four-year-olds were enrolled in preschool in Fairfield County in 2017. However, preschool enrollment is considerably higher in Fairfield County’s wealthiest towns. Fairfield County’s K–12 student body is growing more diverse each year; however, Fairfield County’s Black and Latino students face significant challenges, including lower rates of standardized test passing and graduation, and higher rates of chronic absenteeism and school discipline.
**FIG 2.1**
Fairfield County’s older population is projected to continue growing

**POPULATION AND CHANGE BY AGE GROUP, 1990–2035**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0–4</td>
<td>56,857</td>
<td>64,005</td>
<td>53,454</td>
<td>58,404</td>
<td>-6%</td>
<td>+9%</td>
</tr>
<tr>
<td>5–17</td>
<td>130,168</td>
<td>162,208</td>
<td>166,413</td>
<td>151,392</td>
<td>+28%</td>
<td>-9%</td>
</tr>
<tr>
<td>18–34</td>
<td>220,281</td>
<td>179,417</td>
<td>186,652</td>
<td>193,420</td>
<td>-15%</td>
<td>+4%</td>
</tr>
<tr>
<td>35–64</td>
<td>310,171</td>
<td>359,773</td>
<td>380,803</td>
<td>353,103</td>
<td>+23%</td>
<td>-7%</td>
</tr>
<tr>
<td>65–79</td>
<td>85,195</td>
<td>84,123</td>
<td>89,789</td>
<td>100,213</td>
<td>+5%</td>
<td>+12%</td>
</tr>
<tr>
<td>80+</td>
<td>24,873</td>
<td>33,040</td>
<td>39,468</td>
<td>42,892</td>
<td>+59%</td>
<td>+9%</td>
</tr>
<tr>
<td>Total Population</td>
<td>827,645</td>
<td>882,567</td>
<td>916,680</td>
<td>899,424</td>
<td>+11%</td>
<td>-2%</td>
</tr>
</tbody>
</table>
FIG 2.2
Children and younger adults are much more racially diverse
POPULATION BY AGE AND RACE, FAIRFIELD COUNTY, 2010

FIG 2.3
The region is diversifying, some places more than others
NON-WHITE SHARE OF POPULATION, 1990–2017
FIG 2.4

*Immigrants make up a growing share of the region’s population*

**FOREIGN-BORN SHARE OF POPULATION, 1990 AND 2017**

FIG 2.5

*Fairfield County is home to a large immigrant community*

**FOREIGN-BORN SHARE OF POPULATION, 2017**
FIG 2.6
Shares of married-couple households have declined slightly
HOUSEHOLDS BY TYPE, FAIRFIELD COUNTY, 1990–2017

FIG 2.7
Low-income rates are rising, especially among children
LOW-INCOME RATE BY AGE, 2000–2017
FIG 2.8
Fairfield County has wide income disparities
MEDIAN HOUSEHOLD INCOME BY TOWN, 2017

United States
$58K
Connecticut
$74K
Fairfield County
$90K
6 Wealthiest FC Towns
$181K

BETHEL
$97K
STAMFORD
$85K
GREENWICH
$138K
DARIEN
$82K
FAIRFIELD
$128K

BRIDGEPORT
$45K
BROOKFIELD
$113K
BETHEL
$97K
NEWTOWN
$115K
MONROE
$110K
EASTON
$137K
TRUMBULL
$115K
SHELTON
$89K
WILTON
$180K
NEW FAIRFIELD
$104K
DANBURY
$68K
RIDGEFIELD
$151K
REDDING
$130K
WESTON
$220K
WILTON
$180K
NEW CANAAN
$175K
SHERMAN
$114K
FAIRFIELD
$128K

FIG 2.8
Fairfield County has wide income disparities
MEDIAN HOUSEHOLD INCOME BY TOWN, 2017

United States
$58K
Connecticut
$74K
Fairfield County
$90K
6 Wealthiest FC Towns
$181K

BETHEL
$97K
STAMFORD
$85K
GREENWICH
$138K
DARIEN
$82K
FAIRFIELD
$128K

BRIDGEPORT
$45K
BROOKFIELD
$113K
BETHEL
$97K
NEWTOWN
$115K
MONROE
$110K
EASTON
$137K
TRUMBULL
$115K
SHELTON
$89K
WILTON
$180K
NEW FAIRFIELD
$104K
DANBURY
$68K
RIDGEFIELD
$151K
REDDING
$130K
WESTON
$220K
WILTON
$180K
NEW CANAAN
$175K
SHERMAN
$114K
FAIRFIELD
$128K

FIG 2.8
Fairfield County has wide income disparities
MEDIAN HOUSEHOLD INCOME BY TOWN, 2017
Chapter 2  Demographic Change and an Inclusive Economy

FIG 2.9

The highest-earning 5% make 15x more money than the bottom 20%

MEDIAN HOUSEHOLD INCOME BY QUANTILE, FAIRFIELD COUNTY, 2016

FIG 2.10

Fairfield County has a wage gap by both gender and race

MEDIAN INCOME OF FULL-TIME ADULT WORKERS, 2016

FIG 2.11

Fairfield County’s middle class has shrunk drastically

DISTRIBUTION OF POPULATION BY NEIGHBORHOOD INCOME LEVEL, 1980–2017

FIG 2.12

Average incomes have risen, but only in high-income towns

MEDIAN HOUSEHOLD INCOME, 1990–2017 ADJUSTED TO 2017 DOLLARS
FIG 2.13
Fairfield County averages very high housing values, especially near New York City

MEDIAN HOUSING VALUE BY TOWN, 2017
Renters’ cost-burden rates haven’t declined post-Recession

Cost-burden and severe cost-burden rates by tenure, Fairfield County, 2005–2017

The average renter’s income is $7K short of affording a 2BR apartment

Median renter household income and minimum household income to afford 2BR housing, 2017 (with shortfall shown)

Homeownership is still low in Fairfield County’s lower-grade areas

Homeownership rate by historic redlining grade, 2010

High-grade areas in Fairfield County are still predominantly white

White share of population by historic redlining grade, 2010
FIG 2.18
The patterns in 1930s redlining maps are still present today
HOLC REDLINED AREAS OF STAMFORD, DARIEN, AND NEW CANAAN, 1937

HOLC GRADE
- A — BEST
- B — STILL DESIRABLE
- C — DEFINITELY DECLINING
- D — HAZARDOUS
Note: Net inflow defined as number of workers commuting in minus number of workers commuting out. Areas with negative net inflow are those that lose more workers than they gain.
**FIG 2.20**

Fairfield County's manufacturing sector has declined, while health care & social assistance jobs soar

**NUMBER OF JOBS BY SECTOR, FAIRFIELD COUNTY, 2000–2017**

**FIG 2.21**

Fairfield County’s wealthiest school districts are much less diverse than the larger cities

**COUNT OF K–12 STUDENTS BY RACE, PER 100 STUDENTS, 2018–2019**

**FIG 2.22**

Black and special education students are suspended far more often than others

**SHARE OF STUDENTS SUSPENDED OR EXPELLED AT LEAST ONCE, FAIRFIELD COUNTY K–12 DISTRICTS, 2017–2018**
### FIG 2.23

**Fairfield County schools have wide achievement gaps**

*SHARE OF PUBLIC K–12 STUDENTS MEETING ACHIEVEMENT MEASURES*

<table>
<thead>
<tr>
<th>BY GROUP</th>
<th>4-YEAR GRADUATION RATE¹</th>
<th>CHRONIC ABSENTEEISM²</th>
<th>SBAC ENGLISH PROFICIENCY RATE²</th>
</tr>
</thead>
<tbody>
<tr>
<td>NON-WHITE WHITE</td>
<td>82%</td>
<td>11%</td>
<td>38%</td>
</tr>
<tr>
<td>ELL NOT ELL</td>
<td>68%</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td>FRPM NOT FRPM</td>
<td>81%</td>
<td>15%</td>
<td>36%</td>
</tr>
<tr>
<td>SPED NOT SPED</td>
<td>74%</td>
<td>18%</td>
<td>22%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COUNTY VS STATE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FC</td>
<td>91%</td>
<td>9%</td>
<td>61%</td>
</tr>
<tr>
<td>CT</td>
<td>88%</td>
<td>11%</td>
<td>55%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BY DISTRICT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BRIDGEPORT</td>
<td>75%</td>
<td>19%</td>
<td>26%</td>
</tr>
<tr>
<td>DANBURY</td>
<td>78%</td>
<td>7%</td>
<td>46%</td>
</tr>
<tr>
<td>GREENWICH</td>
<td>95%</td>
<td>5%</td>
<td>78%</td>
</tr>
<tr>
<td>NORWALK</td>
<td>93%</td>
<td>11%</td>
<td>48%</td>
</tr>
<tr>
<td>STAMFORD</td>
<td>91%</td>
<td>11%</td>
<td>48%</td>
</tr>
<tr>
<td>6 WEALTHIEST FC TOWNS</td>
<td>98%</td>
<td>6%</td>
<td>83%</td>
</tr>
<tr>
<td>OTHER FC TOWNS</td>
<td>96%</td>
<td>6%</td>
<td>78%</td>
</tr>
</tbody>
</table>

Note on school years: 1. Class of 2017  2. School year 2017–2018

### FIG 2.24

**Six years after graduating high school, only 58% of Fairfield County public school students have a college degree**

*NUMBER AND SHARE OF STUDENTS ENROLLING IN, PERSISTING IN, AND GRADUATING FROM COLLEGE, OF FAIRFIELD COUNTY HIGH SCHOOL GRADUATES*

<table>
<thead>
<tr>
<th>GRADUATE HIGH SCHOOL¹</th>
<th>ENROLL IN COLLEGE W/I 1 YR¹</th>
<th>PERSIST TO 2ND YR¹</th>
<th>EARN DEGREE IN 6 YRS²</th>
</tr>
</thead>
<tbody>
<tr>
<td>9,971</td>
<td>79%</td>
<td>91%</td>
<td>58%</td>
</tr>
<tr>
<td></td>
<td>7,848</td>
<td>7,174</td>
<td>439</td>
</tr>
<tr>
<td></td>
<td>5,175</td>
<td></td>
<td>5,175</td>
</tr>
</tbody>
</table>

Note on school yrs: 1. Class of 2014  2. Class of 2010
**FIG 2.25**

**Fairfield County residents have very different ideas of what young people may experience**

SHARE OF ADULTS RATING AS ALMOST CERTAIN OR VERY LIKELY THAT YOUNG PEOPLE IN THEIR AREA HAVE THE FOLLOWING EXPERIENCES, 2018

<table>
<thead>
<tr>
<th></th>
<th>GRADUATE FROM HIGH SCHOOL</th>
<th>GET A JOB WITH OPPORTUNITIES FOR ADVANCEMENT</th>
<th>GET ARRESTED FOR A FELONY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BY LOCATION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ALL ADULTS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CONNECTICUT</strong></td>
<td>88%</td>
<td>59%</td>
<td>11%</td>
</tr>
<tr>
<td><strong>FAIRFIELD COUNTY</strong></td>
<td>88%</td>
<td>59%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>BRIDGEPORT</strong></td>
<td>62%</td>
<td>40%</td>
<td>34%</td>
</tr>
<tr>
<td><strong>DANBURY</strong></td>
<td>93%</td>
<td>64%</td>
<td>9%</td>
</tr>
<tr>
<td><strong>GREENWICH</strong></td>
<td>96%</td>
<td>75%</td>
<td>4%</td>
</tr>
<tr>
<td><strong>NORWALK</strong></td>
<td>94%</td>
<td>64%</td>
<td>6%</td>
</tr>
<tr>
<td><strong>STAMFORD</strong></td>
<td>94%</td>
<td>64%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>FAIRFIELD COUNTY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BY RACE/ETHNICITY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>WHITE</strong></td>
<td>94%</td>
<td>69%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>BLACK</strong></td>
<td>78%</td>
<td>58%</td>
<td>29%</td>
</tr>
<tr>
<td><strong>LATINO</strong></td>
<td>77%</td>
<td>60%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>FAIRFIELD COUNTY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BY INCOME</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>UNDER $30K</strong></td>
<td>78%</td>
<td>46%</td>
<td>25%</td>
</tr>
<tr>
<td><strong>$30K–$75K</strong></td>
<td>80%</td>
<td>61%</td>
<td>13%</td>
</tr>
<tr>
<td><strong>$75K–$100K</strong></td>
<td>90%</td>
<td>69%</td>
<td>9%</td>
</tr>
<tr>
<td><strong>$100K+</strong></td>
<td>95%</td>
<td>74%</td>
<td>2%</td>
</tr>
</tbody>
</table>

**FIG 2.26**

**White children from low-income homes in Fairfield County can expect greater upward economic mobility than Black children from high-income homes**

PROBABILITY (%) OF REACHING TOP 20% OF HOUSEHOLD INCOMES AS ADULTS BY RACE AND CHILDHOOD HOUSEHOLD INCOME, FAIRFIELD COUNTY

- **Black**
- **Latino**
- **White**

<table>
<thead>
<tr>
<th></th>
<th>Low Childhood Income Level</th>
<th>Middle Childhood Income Level</th>
<th>High Childhood Income Level</th>
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</thead>
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<tr>
<td><strong>Black</strong></td>
<td>5%</td>
<td>9%</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Latino</strong></td>
<td>10%</td>
<td>16%</td>
<td>24%</td>
</tr>
<tr>
<td><strong>White</strong></td>
<td><strong>24%</strong></td>
<td><strong>29%</strong></td>
<td><strong>37%</strong></td>
</tr>
</tbody>
</table>
Chapter 2  Demographic Change and an Inclusive Economy

A Growing Population
Fairfield County is the most populous of Connecticut’s eight counties. The total population of its 23 towns and cities is 947,328, including 219,635 children. Rather than having one large core city, Fairfield County is a polycentric region with its downtowns, waterfront villages, and harbors hugging the winding shoreline of Long Island Sound and clustered along Metro-North Railroad’s New Haven Line, the busiest commuter rail line in the United States. Collectively, its seven largest towns and cities—Bridgeport, Stamford, Norwalk, Danbury, Greenwich, Fairfield, and Stratford—are home to 626,469 residents (66 percent of the regional total), including 138,564 children, with Bridgeport alone being home to 16 percent of the county’s total population.23

National reports tend to define metropolitan areas based on counties, so Fairfield County as a whole is frequently referred to as the Bridgeport-Stamford-Norwalk metropolitan statistical area (MSA). In many cases, it is considered to be a component of the New York City megalopolis (the “Tri State” area) as well, as it is set within the New York City Designated Market Area, the nation’s largest media market, and has a high share of commuters who travel to or come from that region.

The population of every town in the region has grown since 1990. Since 2000, Fairfield County’s population has increased by 7 percent, a faster rate than that of Connecticut overall (up 5.5 percent).24 Stamford led the state in population growth, from 117,083 residents in 2000 to 128,851 residents in 2017—just over a 10 percent increase.

From 1990 to 2015, Fairfield County’s population of young adults ages 18 to 34 declined by 15 percent, or 33,629 people.27 The population of older seniors ages 80 and over increased by 59 percent, or 14,596 people, and the population of children ages 5 to 17 increased by 28 percent, or 36,245 people, making them the fastest-growing age groups during this period; however, middle-aged adults ages 35 to 64 represented the largest segment of growth, increasing by 23 percent, or 70,732 people.28

Looking forward to 2035, Fairfield County’s older population is projected to keep growing as the Baby Boomer generation ages. The region is expected to see an 11 percent increase in the senior population (ages 65 and over)—a more modest growth rate than the projected 20 percent statewide increase.29 The transition of Baby Boomers into the senior age group is projected to contribute to a 7 percent decline in Fairfield County’s middle-aged population.30 The growth of the county’s senior population is expected to be accompanied by a modest increase in young adults, which will help to fuel a 9 percent increase in young children under five years old, or 4,950 young children.31

Fairfield County’s total population is expected to change little between 2015 and 2035: a projected decrease of 2 percent, or 17,256 people.32

Increased Diversity
Between 1990 and 2017, people of color living in Fairfield County increased from 20 percent of the population to 37 percent.33 In 2017, 63 percent of Fairfield County residents were white, 10 percent were Black, 19 percent were Latino, 5 percent were Asian, and 3 percent identified as another race/ethnicity.34 Fairfield County has the largest Latino population of any county in Connecticut and a higher proportion of Latinos than the state overall.35 Combined, the non-white population of the county more than doubled to over 350,000 people between 1990 and 2017.36 Meanwhile, the size of the white population in Fairfield County decreased by about 65,000 between 1990 and 2017—a nearly 10 percent reduction that mirrors statewide trends.37 Population projections estimate all of Fairfield County’s net population growth will be driven by people of color over the next 30 years.38

However, not all municipalities are diversifying at similar rates and magnitudes. During the same time period, the non-white share in Fairfield

An Aging Region
Between 2000 and 2017, the median age in Fairfield County increased from 37.3 to 40.2.24 This increase is in line with Connecticut’s other more urban counties, while the state’s rural counties generally experienced steeper increases. Overall, the median age in Fairfield County is slightly younger than that of the state (40.8), but older than that of the U.S. (37.8).25 The median ages of Fairfield County’s larger cities—Bridgeport (33.8), Stamford (37), Norwalk (39.2), and Danbury (37.6)—are younger than that of the county overall.26

Between 2000 and 2017, the median age in Fairfield County increased from 37.3 to 40.2.24 This increase is in line with Connecticut’s other more urban counties, while the state’s rural counties generally experienced steeper increases. Overall, the median age in Fairfield County is slightly younger than that of the state (40.8), but older than that of the U.S. (37.8).25 The median ages of Fairfield County’s larger cities—Bridgeport (33.8), Stamford (37), Norwalk (39.2), and Danbury (37.6)—are younger than that of the county overall.26
County’s six wealthiest towns increased from 4 percent to 13 percent. The region’s largest cities are far more diverse, and are home to major shares of the county’s non-white populations: currently, 79 percent of Bridgeport residents and 51 percent of Stamford residents are people of color. Two-thirds of the county’s Black residents and half the county’s Latinos live just in these two cities.

Racial and ethnic diversity in Fairfield County is highest among the population under 35, supporting the proposition that the region will continue to diversify over the coming decades. Based on the most recent decennial census figures, from 2010, only 29 percent of middle-aged residents (ages 35 to 64), 19 percent of younger seniors (age 65 to 79), and 10 percent of older seniors (ages 80 and up) in the county’s six wealthiest towns increased from 4 percent to 13 percent. The region’s largest cities are far more diverse, and are home to major shares of the county’s non-white populations: currently, 79 percent of Bridgeport residents and 51 percent of Stamford residents are people of color. Two-thirds of the county’s Black residents and half the county’s Latinos live just in these two cities.

### TABLE 2A

**Population and growth**

**POPULATION IN FAIRFIELD COUNTY AND TOWNS, 2017**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>248,709,873</td>
<td>321,004,407</td>
<td>29%</td>
<td>91</td>
<td>35.3</td>
<td>37.8</td>
<td>2.5</td>
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<tr>
<td>Connecticut</td>
<td>3,287,116</td>
<td>3,594,478</td>
<td>9%</td>
<td>742</td>
<td>37.4</td>
<td>40.8</td>
<td>3.4</td>
</tr>
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<td>Fairfield County</td>
<td>827,645</td>
<td>947,328</td>
<td>14%</td>
<td>1,515</td>
<td>37.3</td>
<td>40.2</td>
<td>2.9</td>
</tr>
<tr>
<td>Bethel</td>
<td>17,541</td>
<td>19,526</td>
<td>11%</td>
<td>1,155</td>
<td>37.1</td>
<td>43.2</td>
<td>6.1</td>
</tr>
<tr>
<td>Bridgeport</td>
<td>141,686</td>
<td>147,586</td>
<td>4%</td>
<td>9,167</td>
<td>31.4</td>
<td>33.8</td>
<td>2.4</td>
</tr>
<tr>
<td>Brookfield</td>
<td>14,113</td>
<td>17,064</td>
<td>21%</td>
<td>862</td>
<td>39.2</td>
<td>43.6</td>
<td>4.4</td>
</tr>
<tr>
<td>Danbury</td>
<td>65,585</td>
<td>84,573</td>
<td>29%</td>
<td>2,018</td>
<td>35.2</td>
<td>37.6</td>
<td>2.4</td>
</tr>
<tr>
<td>Darien</td>
<td>18,196</td>
<td>21,742</td>
<td>19%</td>
<td>1,712</td>
<td>38.0</td>
<td>39.4</td>
<td>1.4</td>
</tr>
<tr>
<td>Easton</td>
<td>6,303</td>
<td>7,607</td>
<td>21%</td>
<td>278</td>
<td>40.4</td>
<td>49.0</td>
<td>8.6</td>
</tr>
<tr>
<td>Fairfield</td>
<td>53,418</td>
<td>61,611</td>
<td>15%</td>
<td>2,061</td>
<td>38.5</td>
<td>41.2</td>
<td>2.7</td>
</tr>
<tr>
<td>Greenwich</td>
<td>58,441</td>
<td>62,782</td>
<td>7%</td>
<td>1,316</td>
<td>40.2</td>
<td>42.6</td>
<td>2.4</td>
</tr>
<tr>
<td>Monroe</td>
<td>16,896</td>
<td>19,766</td>
<td>17%</td>
<td>757</td>
<td>38.1</td>
<td>44.5</td>
<td>6.4</td>
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<tr>
<td>New Canaan</td>
<td>17,864</td>
<td>20,357</td>
<td>14%</td>
<td>917</td>
<td>40.2</td>
<td>43.2</td>
<td>3.0</td>
</tr>
<tr>
<td>New Fairfield</td>
<td>12,911</td>
<td>14,081</td>
<td>9%</td>
<td>691</td>
<td>37.3</td>
<td>45.1</td>
<td>7.8</td>
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<tr>
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<td>20,779</td>
<td>28,030</td>
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<td>486</td>
<td>37.5</td>
<td>45.0</td>
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<tr>
<td>Norwalk</td>
<td>78,331</td>
<td>88,537</td>
<td>13%</td>
<td>3,866</td>
<td>36.6</td>
<td>39.2</td>
<td>2.6</td>
</tr>
<tr>
<td>Redding</td>
<td>7,927</td>
<td>9,274</td>
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<td>294</td>
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<td>Ridgefield</td>
<td>20,919</td>
<td>25,206</td>
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<td>731</td>
<td>39.4</td>
<td>45.1</td>
<td>5.7</td>
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<tr>
<td>Shelton</td>
<td>35,418</td>
<td>41,428</td>
<td>17%</td>
<td>1,349</td>
<td>39.8</td>
<td>46.8</td>
<td>7.0</td>
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<tr>
<td>Sherman</td>
<td>2,809</td>
<td>3,654</td>
<td>30%</td>
<td>167</td>
<td>42.1</td>
<td>48.9</td>
<td>6.8</td>
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<tr>
<td>Stamford</td>
<td>108,056</td>
<td>128,851</td>
<td>19%</td>
<td>3,427</td>
<td>36.4</td>
<td>37.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Stratford</td>
<td>49,389</td>
<td>52,529</td>
<td>6%</td>
<td>3,002</td>
<td>40.3</td>
<td>44.1</td>
<td>3.8</td>
</tr>
<tr>
<td>Trumbull</td>
<td>32,016</td>
<td>36,455</td>
<td>14%</td>
<td>1,571</td>
<td>40.3</td>
<td>43.5</td>
<td>3.2</td>
</tr>
<tr>
<td>Weston</td>
<td>8,648</td>
<td>10,369</td>
<td>20%</td>
<td>524</td>
<td>39.7</td>
<td>45.2</td>
<td>5.5</td>
</tr>
<tr>
<td>Westport</td>
<td>24,410</td>
<td>27,777</td>
<td>14%</td>
<td>1,389</td>
<td>41.4</td>
<td>45.2</td>
<td>3.8</td>
</tr>
<tr>
<td>Wilton</td>
<td>15,989</td>
<td>18,859</td>
<td>17%</td>
<td>696</td>
<td>40.2</td>
<td>43.2</td>
<td>3.0</td>
</tr>
</tbody>
</table>
Fairfield County were people of color; however, 46 percent of children under five, 38 percent of children ages 5 to 17, and 48 percent of young adults (ages 18 to 34) identified as such.42 SEE FIG 2.2

Fairfield County’s diverse population includes a large and growing immigrant community. Between 1990 and 2017, the number of immigrants residing in Fairfield County more than doubled, increasing by 105,023 individuals or 104 percent.43 By 2017, 22 percent of the county’s residents, or 205,984 individuals, were foreign-born, a share higher than any other county in the state and well above the statewide share (14 percent).44 Immigrants from around the world call Fairfield County home, including more than 10,000 people each from Mexico, India, Guatemala, Jamaica, Ecuador, and Brazil.45 SEE FIG 2.4, 2.5

Much of the county’s immigrant population resides in its cities. The four towns with the highest foreign-born shares in the state are all in Fairfield County: immigrants are roughly 30 percent of the populations of Norwalk, Bridgeport, and Danbury, and 35 percent in Stamford.46 Additionally, immigrants made up about a quarter of Greenwich’s population.47 Consider that in 2017, Stamford and Bridgeport accounted for 29 percent of the county’s population and 43 percent of its immigrants.48

In 2017, 46 percent of immigrants living in Fairfield County were naturalized U.S. citizens—slightly below the 50 percent naturalization rate for immigrants statewide.49 While both Connecticut’s and Fairfield County’s largest cities serve as enclaves for immigrant populations, naturalization rates tend to be lower in these urban areas: Danbury, Bridgeport, Stamford, and Norwalk all have naturalization rates below the county average.50 Additionally, urban-dwelling immigrants are more likely to have arrived in the U.S. since 2000.51 Overall, 46 percent of immigrants residing in Fairfield County arrived in 2000 or later, with 15 percent arriving in 2010 or later.52

As of 2017, 22 percent of Connecticut residents ages 5 and older lived in households where English was not the primary language.53 Unsurprisingly, Fairfield County’s comparatively large share of immigrants contributes to a higher share of the population speaking a language other than English at home—29 percent of residents.54 After English and Spanish, Portuguese, Haitian Creole, Italian, Polish, and Chinese are the most common languages, in that order.55 In 2017, 12 percent of Fairfield County residents ages 5 and older struggled with English proficiency, meaning they spoke English less than very well—above the state rate of 8 percent.56 Higher rates of low English proficiency are more common in larger cities like Bridgeport, where 23 percent of the population ages 5 and older report having low English proficiency.57 Understanding the changing needs of Fairfield County’s immigrant communities is

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>TOTAL POPULATION</th>
<th>PERCENT WHITE</th>
<th>PERCENT BLACK</th>
<th>PERCENT LATINO</th>
<th>PERCENT ASIAN</th>
<th>PERCENT OTHER RACE</th>
<th>FOREIGN-BORN POPULATION</th>
<th>PERCENT FOREIGN BORN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>3,594,478</td>
<td>68%</td>
<td>10%</td>
<td>15%</td>
<td>4%</td>
<td>3%</td>
<td>511,893</td>
<td>14%</td>
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<tr>
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<td>947,328</td>
<td>83%</td>
<td>7%</td>
<td>19%</td>
<td>5%</td>
<td>3%</td>
<td>205,984</td>
<td>22%</td>
</tr>
<tr>
<td>Bridgeport</td>
<td>147,586</td>
<td>21%</td>
<td>33%</td>
<td>39%</td>
<td>3%</td>
<td>3%</td>
<td>43,614</td>
<td>30%</td>
</tr>
<tr>
<td>Danbury</td>
<td>84,573</td>
<td>52%</td>
<td>6%</td>
<td>31%</td>
<td>6%</td>
<td>5%</td>
<td>26,076</td>
<td>31%</td>
</tr>
<tr>
<td>Fairfield</td>
<td>61,611</td>
<td>85%</td>
<td>1%</td>
<td>6%</td>
<td>5%</td>
<td>3%</td>
<td>7,522</td>
<td>12%</td>
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<tr>
<td>Greenwich</td>
<td>62,782</td>
<td>74%</td>
<td>3%</td>
<td>13%</td>
<td>8%</td>
<td>3%</td>
<td>14,767</td>
<td>24%</td>
</tr>
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<td>Norwalk</td>
<td>88,537</td>
<td>52%</td>
<td>14%</td>
<td>27%</td>
<td>5%</td>
<td>2%</td>
<td>24,536</td>
<td>28%</td>
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<tr>
<td>Stamford</td>
<td>128,851</td>
<td>49%</td>
<td>14%</td>
<td>27%</td>
<td>8%</td>
<td>2%</td>
<td>44,986</td>
<td>35%</td>
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<tr>
<td>Stratford</td>
<td>52,529</td>
<td>64%</td>
<td>14%</td>
<td>15%</td>
<td>3%</td>
<td>3%</td>
<td>7,847</td>
<td>15%</td>
</tr>
<tr>
<td>6 wealthiest FC towns</td>
<td>124,110</td>
<td>87%</td>
<td>1%</td>
<td>5%</td>
<td>5%</td>
<td>2%</td>
<td>15,571</td>
<td>13%</td>
</tr>
<tr>
<td>Other FC towns</td>
<td>196,749</td>
<td>88%</td>
<td>2%</td>
<td>7%</td>
<td>4%</td>
<td>2%</td>
<td>21,065</td>
<td>11%</td>
</tr>
</tbody>
</table>
critical for local government, nonprofit organizations, resident leaders and philanthropy. Building One Community, a nonprofit in Stamford, will soon release the first-ever Immigrant Community Needs Assessment. Focused on Stamford, this assessment framework could be a model for other communities.

Another aspect of diversity among Fairfield County residents is in sexual orientation and gender identity. A 2016 Gallup poll found that 10 million Americans—4.6 percent—identify as lesbian, gay, bisexual, or transgender (LGBT), an increase of 1.75 million people since 2012. The 2018 DataHaven Community Wellbeing Survey found that 8 percent of adults in Connecticut identify as not being straight, with a similar proportion in Fairfield County. Additionally, 0.7 percent of adults in both Connecticut and Fairfield County identify as transgender. Quantifying diversity in sexual orientation and gender identity is valuable in itself, but it also has important implications for other aspects of well-being, like health. LGBTQ individuals face specific health challenges, discussed in Chapter 3.

### Changing Household Structure

In 2017, Fairfield County had 337,678 total households, representing an 11 percent increase from 1990, or an additional 32,667 households. The share of households headed by married couples has decreased slightly, from 58 percent of the county’s households in 1990 to 53 percent in 2017. Households composed of adults living alone, single adults with children, and groups of unrelated people all showed growth during this period. Compared to the state overall, Fairfield County has a larger share of households comprised of married couples with children (24 percent of Fairfield County households, 19 percent of Connecticut households) and a smaller share of single adults living alone (24 percent in Fairfield County, 28 percent of Connecticut). Fairfield County’s larger cities, particularly Bridgeport, had smaller shares of married-couple households and larger shares of single adult and other non-family households than the region overall—a pattern that holds true in Connecticut’s other large urban areas.

### Table 2C

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>TOTAL HOUSEHOLD COUNT</th>
<th>MARRIED, W/ CHLD. COUNT</th>
<th>MARRIED, NO CHLD. COUNT</th>
<th>MARRIED, W/ CHLD. SHARE</th>
<th>MARRIED, NO CHLD. SHARE</th>
<th>SINGLE, W/ CHLD. COUNT</th>
<th>SINGLE, NO CHLD. COUNT</th>
<th>SINGLE, W/ CHLD. SHARE</th>
<th>LIVING ALONE COUNT</th>
<th>LIVING ALONE SHARE</th>
<th>OTHER HOUSEHOLDS COUNT</th>
<th>OTHER HOUSEHOLDS SHARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>118.8M</td>
<td>22.7M</td>
<td>34.7M</td>
<td>19%</td>
<td>29%</td>
<td>10.8M</td>
<td>9%</td>
<td>28%</td>
<td>32.9M</td>
<td>28%</td>
<td>17.7M</td>
<td>15%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>1.4M</td>
<td>259,868</td>
<td>404,743</td>
<td>19%</td>
<td>30%</td>
<td>116,400</td>
<td>9%</td>
<td>30%</td>
<td>383,275</td>
<td>28%</td>
<td>197,469</td>
<td>15%</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>337,678</td>
<td>82,447</td>
<td>98,728</td>
<td>24%</td>
<td>29%</td>
<td>27,188</td>
<td>8%</td>
<td>24%</td>
<td>82,482</td>
<td>24%</td>
<td>46,833</td>
<td>14%</td>
</tr>
<tr>
<td>Bridgeport</td>
<td>50,341</td>
<td>7,824</td>
<td>9,153</td>
<td>16%</td>
<td>18%</td>
<td>8,065</td>
<td>16%</td>
<td>21%</td>
<td>13,881</td>
<td>28%</td>
<td>11,418</td>
<td>23%</td>
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<tr>
<td>Danbury</td>
<td>29,692</td>
<td>6,124</td>
<td>7,868</td>
<td>21%</td>
<td>27%</td>
<td>2,704</td>
<td>9%</td>
<td>32%</td>
<td>8,062</td>
<td>27%</td>
<td>4,970</td>
<td>17%</td>
</tr>
<tr>
<td>Fairfield</td>
<td>20,365</td>
<td>6,446</td>
<td>6,807</td>
<td>32%</td>
<td>33%</td>
<td>887</td>
<td>4%</td>
<td>9%</td>
<td>4,331</td>
<td>27%</td>
<td>1,894</td>
<td>9%</td>
</tr>
<tr>
<td>Greenwich</td>
<td>22,284</td>
<td>6,582</td>
<td>6,808</td>
<td>30%</td>
<td>31%</td>
<td>1,407</td>
<td>6%</td>
<td>10%</td>
<td>5,328</td>
<td>24%</td>
<td>2,159</td>
<td>10%</td>
</tr>
<tr>
<td>Norwalk</td>
<td>33,385</td>
<td>7,007</td>
<td>9,055</td>
<td>21%</td>
<td>27%</td>
<td>2,839</td>
<td>9%</td>
<td>9%</td>
<td>9,148</td>
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<td>5,336</td>
<td>16%</td>
</tr>
<tr>
<td>Stamford</td>
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<td>10,158</td>
<td>12,673</td>
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<td>3,385</td>
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</tr>
<tr>
<td>Stratford</td>
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<td>1,583</td>
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</tr>
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<td>6 wealthiest FC towns</td>
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<td>33%</td>
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<td>12%</td>
<td>7,076</td>
<td>17%</td>
<td>2,883</td>
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<td>Other FC towns</td>
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<td>4,017</td>
<td>8%</td>
<td>22%</td>
<td>15,207</td>
<td>22%</td>
<td>6,739</td>
<td>10%</td>
</tr>
</tbody>
</table>
Median Income Disparities
Fairfield County households had a median income of $89,773 in 2017—about $16,000 higher than Connecticut and $32,000 higher than the nation. Since 1990, inflation-adjusted median household income has decreased both statewide (3.1%) and in Fairfield County (1.4%). But while the county averages high incomes, income inequality remains a significant issue. Fairfield County had the highest level of income inequality among the 100 largest U.S. metros in 2016. Median household income in the region’s six wealthiest towns was $181,155 in 2017—more than double that of the county as a whole and more than four times that of Bridgeport ($44,841), the lowest in the region. In 2016, the highest-earning 5 percent of households in Fairfield County earned about $486,000—15 times more than the roughly $32,000 earned by the poorest 20 percent of households.

Wage Gaps and Wealth Gaps
While median household income is a useful indicator for analyzing inequality, it is critical to dig deeper into other underlying disparities, including differences in wages and wealth. Consider the wages of Fairfield County’s full-time, year-round workers aged 25 and older in 2016: when disaggregated by sex, men had median earnings of $78,343, compared to $57,437 for women. In other words, Fairfield County’s women earned 73 cents on the men’s dollar—a slightly larger gender wage gap than Connecticut’s overall (77 cents on the dollar).

Looking at full-time, year-round workers by both sex and race/ethnicity yields even starker discrepancies—particularly in Fairfield County, where median earnings for white men and women were high compared to the state overall, but median earnings for people of color were near or below their statewide counterparts. The overall wage gap in Fairfield County in 2016 can be largely attributed to the higher median earnings of white men; the intraracial wage gaps between men and women within the Black and Latino communities are relatively small. Educational attainment also plays a role in the wage gap, but fails to account for it entirely. Statewide, the wage gap between men and women with graduate degrees was wider than within any other level of educational attainment.

This educational attainment/sex wage gap was especially pronounced in Fairfield County, where women with graduate degrees earned only 60 cents on the dollar of men who also had advanced degrees. Taking the analysis one step further, large wage gaps were apparent when disaggregating median earnings by sex, race/ethnicity, and educational attainment. For example, statewide, Latinas with bachelor’s degrees earned over $4,500 less than white men with only high school diplomas; white men with bachelor’s degrees made over $20,000 more than Black women with graduate or professional degrees, and nearly $22,000 more than Latinas with graduate or professional degrees.

Beyond income is wealth, or money, assets, and other financial resources that go beyond one’s current paycheck. The racial wealth gap is a particular concern: nationally, white adults aged 60 to 70 have a median net worth about seven times greater than that of Black adults the same age. Differences in earnings are one important factor, but there are others: for instance, white families overall are about five times more likely than black families to receive the kind of a large inheritance or cash transfer that might be used for the purchase of a home or vehicle, invested in business endeavors, or used toward education costs. Discrimination also results in property devaluation for some Black homeowners; in 2016, the median home value in majority Black neighborhoods in Fairfield County ($142,281) was estimated to be devalued by about 32 percent on average, or $53,840, after accounting for structural characteristics of homes and neighborhood amenities. In Fairfield County, 22 percent of Black and 24 percent of Latino adults report that they have a negative net worth, compared to just 9 percent of white adults.

Income Inequality
Income and wealth are perhaps the most important factors in determining where an individual or family lives, because of choice or the resources available to them. As will be discussed later in this chapter, housing costs differ vastly—not only between municipalities, but also between neighborhoods. While gentrification has become a frequent topic of public debate due to skyrocketing housing costs in desirable parts of “superstar cities” such as New York and San Francisco, recent studies have found that the most common form of contemporary
neighborhood change is the concentration of low-income populations. For example, one such study found that between 2000 and 2016, the low-income population of economically declining areas grew by 44 percent (5,369,000 people) in the 50 largest U.S. metropolitan areas; while Fairfield County was not included in the analysis, the New York City and Hartford metropolitan regions reported similar increases of 49 percent and 44 percent, respectively, in the number of low-income people living in economically declining areas.78

Analyzing population distribution by neighborhood income level paints a picture of the shrinking of the region’s middle class, as increasing numbers of people are living in neighborhoods at the extremes.79 Fairfield County’s middle-class neighborhoods—those where average income is similar to that of the state overall—have progressively shrunk from housing 46 percent of the population in 1980 to only 28 percent in 2017. Meanwhile, the population of affluent neighborhoods increased by 50 percent, and the population in poor neighborhoods more than tripled. While similar shifts happened over the same period statewide, this polarization has been far more severe in Fairfield County. SEE FIG 2.11 / SEE TABLE 2D

These income inequality trends have direct bearing on the well-being of Fairfield County residents. A wealth of research shows that regardless of objective economic growth, communities will not become happier without addressing inequality.80 Income inequality fragments communities by dismantling trust and ties, especially across income lines.81 In regions with higher levels of inequality, people are less likely to belong to social organizations and participate in civic life—all important components of community well-being.82 As discussed throughout this report, the concentration of economically disadvantaged residents in particular neighborhoods has negative impacts on well-being that stem from fewer educational and job opportunities, increased health risks, and limited access to quality community resources.83 Research indicates that areas that are more residentially segregated by race and income have lower levels of economic mobility, defined as the ability of those in the next generation to move up the economic ladder compared to their parents.84 In towns experiencing an increasing concentration of low-income populations, local governments may struggle to distribute public resources in a manner that meets the basic needs of their residents, resulting in overburdened public schools, underfund ed public libraries, and deferred maintenance on important public goods such as parks, roads, and other infrastructure. SEE CHAPTER 4

Further exacerbating income inequality is the fact that median household incomes have increased only in Fairfield County’s higher-income towns.85 Between 1990 and 2017, the six wealthiest towns saw over a 15 percent increase in inflation-adjusted median household income.86 Conversely, the county-wide inflation-adjusted median household income was stagnant during this period, decreasing by around 1 percent—a reflection of the wider state trend.87 The region’s largest cities also experienced a decline, with Danbury and Bridgeport seeing sharp decreases of over 14 percent.88 SEE FIG 2.12

### Growing neighborhood income inequality

<table>
<thead>
<tr>
<th>INCOME BRACKET</th>
<th>DEFINITION BASED ON AVG FAMILY INCOME</th>
<th>POPULATION 1980</th>
<th>POPULATION 2017</th>
<th>CHANGE IN TOTAL POPULATION 1980–2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affluent</td>
<td>1.5x AFI or above</td>
<td>186,103</td>
<td>279,468</td>
<td>▲50%</td>
</tr>
<tr>
<td>High income</td>
<td>1.25 to 1.49x AFI</td>
<td>108,261</td>
<td>133,494</td>
<td>▲23%</td>
</tr>
<tr>
<td>Middle income</td>
<td>0.75 to 1.24x AFI</td>
<td>369,057</td>
<td>262,902</td>
<td>▲29%</td>
</tr>
<tr>
<td>Low income</td>
<td>0.5 to 0.74x AFI</td>
<td>116,945</td>
<td>186,083</td>
<td>▲59%</td>
</tr>
<tr>
<td>Poor</td>
<td>Under 0.5x AFI</td>
<td>26,778</td>
<td>84,425</td>
<td>▲215%</td>
</tr>
</tbody>
</table>

Note: See Fig. 2.11 for a graphic representation of these data.

### Rising Low-Income Rate

Along with growing income inequality, the low-income rate is also on the rise in Fairfield County. “Low-income” denotes individuals living in households with annual incomes of less than twice the federal poverty line, also encompassing those living below the poverty level.89 In 2017, a family of two earning $32,480 or less was considered low-income, as was a family of four earning $49,200 or less.90 Between 2000 and 2017, the share of Fairfield County’s population living in low-income households increased from 17 percent to 21 percent, similar to the statewide increase from 19 percent to 23 percent. Low-income rates in the region’s larger cities are above the county-wide rate, and are much higher than the 8 percent low-income rate in the region’s six wealthiest towns. SEE TABLE 2E
In Fairfield County, the low-income rate among children is both higher and growing faster than for the population as a whole. In 2017, two-thirds of children ages 0 to 17 in Bridgeport lived in low-income households, meaning that in that city alone, nearly 22,000 youth faced severe economic hardship on a daily basis. See Fig 2.7

Financial Security
While this report uses the low-income threshold to identify those living under severe economic hardship, many individuals and families above that line struggle mightily to make ends meet. The ALICE Project (Asset Limited, Income Constrained, Employed), a United Way initiative spanning a number of states including Connecticut, utilizes a “household survival budget” based on the actual costs of basic necessities such as housing, childcare, food, transportation, and health care for different types of households in each county in Connecticut to establish an ALICE income threshold which encompasses households above the poverty line that earn less than the basic cost of living in the county. See Table 2F. The most recent ALICE analysis found that in 2016, 31 percent of Fairfield County’s households qualified as ALICE—along with an additional 8 percent of households below the poverty line. Taken together, 39 percent of households were struggling to satisfy basic needs required to live and work, well above the 21 percent low-income rate for the county defined above.

The 2018 DataHaven Community Wellbeing Survey results revealed many Fairfield County residents face financial stress; 30 percent of adults in the region report that they are just getting by or finding it difficult to manage financially. These rates have changed little since the last time the survey was conducted, in 2015. See Table 2F.

When people are forced to choose among basic needs, such as rent, childcare, transportation to work, or treating a health condition, they are left with no good options—their well-being and their family members’ well-being will ultimately suffer.

### TABLE 2E
Low-income population
Low-income (<200% FPL) population by age group, Fairfield County, 2017

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>ALL AGES, POVERTY STATUS DETERMINED</th>
<th>ALL AGES, LOW-INCOME</th>
<th>ALL AGES, LOW-INCOME RATE</th>
<th>AGES 0–17, POVERTY STATUS DETERMINED</th>
<th>AGES 0–17, LOW-INCOME</th>
<th>AGES 0–17, LOW-INCOME RATE</th>
<th>AGES 0–5, POVERTY STATUS DETERMINED</th>
<th>AGES 0–5, LOW-INCOME</th>
<th>AGES 0–5, LOW-INCOME RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>3,486,033</td>
<td>802,453</td>
<td>23%</td>
<td>752,655</td>
<td>225,715</td>
<td>30%</td>
<td>221,412</td>
<td>72,246</td>
<td>33%</td>
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<tr>
<td>FC</td>
<td>929,135</td>
<td>198,133</td>
<td>21%</td>
<td>216,767</td>
<td>57,196</td>
<td>26%</td>
<td>63,614</td>
<td>18,611</td>
<td>29%</td>
</tr>
<tr>
<td>Bridgeport</td>
<td>142,927</td>
<td>65,303</td>
<td>46%</td>
<td>34,430</td>
<td>21,851</td>
<td>64%</td>
<td>11,784</td>
<td>8,048</td>
<td>68%</td>
</tr>
<tr>
<td>Danbury</td>
<td>81,199</td>
<td>22,115</td>
<td>27%</td>
<td>17,582</td>
<td>6,801</td>
<td>39%</td>
<td>6,304</td>
<td>2,691</td>
<td>43%</td>
</tr>
<tr>
<td>Fairfield</td>
<td>56,847</td>
<td>6,853</td>
<td>12%</td>
<td>14,532</td>
<td>1,503</td>
<td>10%</td>
<td>4,141</td>
<td>342</td>
<td>8%</td>
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<tr>
<td>Greenwich</td>
<td>62,209</td>
<td>9,124</td>
<td>15%</td>
<td>16,071</td>
<td>2,471</td>
<td>15%</td>
<td>5,103</td>
<td>780</td>
<td>15%</td>
</tr>
<tr>
<td>Norwalk</td>
<td>87,963</td>
<td>22,107</td>
<td>25%</td>
<td>18,452</td>
<td>6,690</td>
<td>36%</td>
<td>6,132</td>
<td>2,222</td>
<td>36%</td>
</tr>
<tr>
<td>Stamford</td>
<td>127,945</td>
<td>30,490</td>
<td>24%</td>
<td>25,892</td>
<td>8,087</td>
<td>31%</td>
<td>8,779</td>
<td>2,579</td>
<td>29%</td>
</tr>
<tr>
<td>Stratford</td>
<td>52,067</td>
<td>11,056</td>
<td>21%</td>
<td>9,608</td>
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<td>27%</td>
<td>2,734</td>
<td>550</td>
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<td>36,453</td>
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<td>8,360</td>
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<tr>
<td>Other FC towns</td>
<td>194,494</td>
<td>21,007</td>
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<td>43,747</td>
<td>4,818</td>
<td>11%</td>
<td>10,277</td>
<td>998</td>
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</tr>
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</table>
### TABLE 2F

**Financial insecurity**

**SHARE OF ADULTS, FAIRFIELD COUNTY, 2018**

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>JUST GETTING BY</th>
<th>LESS THAN 2MO SAVINGS</th>
<th>NEGATIVE NET WORTH</th>
<th>FOOD INSECURE</th>
<th>UTILITY SHUTOFF THREAT</th>
<th>TRANSPORTATION INSECURE</th>
<th>NO BANK ACCOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>33%</td>
<td>33%</td>
<td>17%</td>
<td>13%</td>
<td>10%</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>FC</td>
<td>30%</td>
<td>29%</td>
<td>13%</td>
<td>11%</td>
<td>10%</td>
<td>11%</td>
<td>9%</td>
</tr>
</tbody>
</table>

**BY DEMOGRAPHIC WITHIN FAIRFIELD COUNTY**

<table>
<thead>
<tr>
<th>Category</th>
<th>JUST GETTING BY</th>
<th>LESS THAN 2MO SAVINGS</th>
<th>NEGATIVE NET WORTH</th>
<th>FOOD INSECURE</th>
<th>UTILITY SHUTOFF THREAT</th>
<th>TRANSPORTATION INSECURE</th>
<th>NO BANK ACCOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>28%</td>
<td>26%</td>
<td>12%</td>
<td>10%</td>
<td>8%</td>
<td>10%</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>32%</td>
<td>31%</td>
<td>14%</td>
<td>13%</td>
<td>11%</td>
<td>12%</td>
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</tr>
<tr>
<td><strong>Age 18–34</strong></td>
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<td><strong>Age 50–64</strong></td>
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</tr>
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<tr>
<td><strong>Black</strong></td>
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<td>24%</td>
<td>21%</td>
<td>23%</td>
<td>19%</td>
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<tr>
<td><strong>Latino</strong></td>
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<td></td>
</tr>
<tr>
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<td>25%</td>
<td>21%</td>
<td>22%</td>
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<td></td>
</tr>
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<td>61%</td>
<td>32%</td>
<td>29%</td>
<td>20%</td>
<td>26%</td>
<td>18%</td>
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</tr>
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<td>16%</td>
<td>12%</td>
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</tr>
<tr>
<td></td>
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<td>33%</td>
<td>9%</td>
<td>7%</td>
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</tr>
<tr>
<td>$100K–$200K</td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>18%</td>
<td>18%</td>
<td>5%</td>
<td>5%</td>
<td>6%</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>$200K+</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>6%</td>
<td>8%</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
<td>2%</td>
</tr>
</tbody>
</table>

**BY GEOGRAPHY**

<table>
<thead>
<tr>
<th>Location</th>
<th>JUST GETTING BY</th>
<th>LESS THAN 2MO SAVINGS</th>
<th>NEGATIVE NET WORTH</th>
<th>FOOD INSECURE</th>
<th>UTILITY SHUTOFF THREAT</th>
<th>TRANSPORTATION INSECURE</th>
<th>NO BANK ACCOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgeport</td>
<td>52%</td>
<td>48%</td>
<td>30%</td>
<td>28%</td>
<td>23%</td>
<td>23%</td>
<td>21%</td>
</tr>
<tr>
<td>Danbury</td>
<td>31%</td>
<td>32%</td>
<td>14%</td>
<td>11%</td>
<td>5%</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Fairfield</td>
<td>24%</td>
<td>23%</td>
<td>15%</td>
<td>6%</td>
<td>5%</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>Greenwich</td>
<td>20%</td>
<td>23%</td>
<td>7%</td>
<td>7%</td>
<td>6%</td>
<td>9%</td>
<td>6%</td>
</tr>
<tr>
<td>Norwalk</td>
<td>31%</td>
<td>21%</td>
<td>8%</td>
<td>8%</td>
<td>7%</td>
<td>10%</td>
<td>9%</td>
</tr>
<tr>
<td>Stamford</td>
<td>25%</td>
<td>29%</td>
<td>13%</td>
<td>9%</td>
<td>7%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Stratford</td>
<td>40%</td>
<td>34%</td>
<td>15%</td>
<td>20%</td>
<td>20%</td>
<td>14%</td>
<td>9%</td>
</tr>
</tbody>
</table>
“Fairfield County had the highest level of income inequality among the 100 largest U.S. metros.... the highest-earning 5 percent of households earned about $486,000—15 times more than the roughly $32,000 earned by the poorest 20 percent of households”
**HOUSING**

**Housing Stock**

In 2017, 68 percent of Fairfield County households owned the home in which they lived, about the same as statewide.95 The region’s homeownership rate grew slowly but steadily between 1980 and 2010, from 67 to 71 percent.96 But this gain was essentially wiped out from 2010 to 2017, when the rate decreased to 68 percent.97 This recent decline in homeownership, a trend seen across Connecticut and nationally, reflects the massive impact of the 2008 housing crash and subsequent Great Recession.

Statewide and in Fairfield County, denser cities have lower homeownership rates and higher shares of renters than the suburbs.98 Homeownership rates also vary widely by race in Fairfield County: in 2017, 79 percent of white households owned their housing, compared to 41 percent of Black households and 37 percent of Latino households.99 SEE TABLE 2G

In 2017, the majority of housing units in Fairfield County were single-family (65 percent), the same share as the state overall; however, the region’s shifting household structure is affecting the types of housing units being built.100 Units in multi-family residential buildings, traditionally concentrated in urban areas, are increasingly becoming the housing type of choice for young workers, single adults, and other non-traditional households, due to a preference to be nearer to the amenities typical of denser, urban communities; the inability to afford to purchase or maintain a single-family home; or a desire to downsize.

Developers continue to respond to this shift in regional housing demand: 60 percent of housing units built between 2014 and 2017 were in multi-family buildings, compared to just 24 percent built between 2001 and 2004.101 SEE TABLE 2H

**Housing Affordability**

The cost of owning a home in Fairfield County is high, particularly in the cities and towns closest to New York City. The median housing value ranks among the top 2 percent of counties nationwide.102 In 2017, Fairfield County’s median housing value was about $417,800, nearly $150,000 above the

**TABLE 2G**

**Homeownership**

**HOMEOWNERSHIP RATE, TOTAL AND BY RACE OF HOUSEHOLDER, FAIRFIELD COUNTY, 2017**

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>TOTAL HOUSEHOLDS</th>
<th>OWNER OCCUPIED HOUSEHOLDS</th>
<th>HOMEOWNERSHIP RATE</th>
<th>WHITE TOTAL HOUSEHOLDS</th>
<th>WHITE OWNER OCCUPIED HOUSEHOLDS</th>
<th>WHITE HOMEOWNERSHIP RATE</th>
<th>BLACK TOTAL HOUSEHOLDS</th>
<th>BLACK OWNER OCCUPIED HOUSEHOLDS</th>
<th>BLACK HOMEOWNERSHIP RATE</th>
<th>LATINO TOTAL HOUSEHOLDS</th>
<th>LATINO OWNER OCCUPIED HOUSEHOLDS</th>
<th>LATINO HOMEOWNERSHIP RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>118.8M</td>
<td>75.8M</td>
<td>64%</td>
<td>81.3M</td>
<td>58.2M</td>
<td>72%</td>
<td>14.5M</td>
<td>6.1M</td>
<td>42%</td>
<td>15.1M</td>
<td>7M</td>
<td>46%</td>
</tr>
<tr>
<td>CT</td>
<td>1,361,755</td>
<td>906,798</td>
<td>67%</td>
<td>1,000,287</td>
<td>762,221</td>
<td>76%</td>
<td>130,942</td>
<td>51,237</td>
<td>39%</td>
<td>164,460</td>
<td>55,650</td>
<td>34%</td>
</tr>
<tr>
<td>FC</td>
<td>337,678</td>
<td>228,666</td>
<td>68%</td>
<td>232,870</td>
<td>183,366</td>
<td>79%</td>
<td>35,556</td>
<td>14,387</td>
<td>41%</td>
<td>50,998</td>
<td>19,089</td>
<td>37%</td>
</tr>
<tr>
<td>Bridgeport</td>
<td>50,341</td>
<td>21,138</td>
<td>42%</td>
<td>13,519</td>
<td>7,828</td>
<td>58%</td>
<td>17,346</td>
<td>6,868</td>
<td>40%</td>
<td>17,732</td>
<td>5,461</td>
<td>31%</td>
</tr>
<tr>
<td>Danbury</td>
<td>29,692</td>
<td>17,693</td>
<td>60%</td>
<td>18,860</td>
<td>13,325</td>
<td>71%</td>
<td>1,757</td>
<td>746</td>
<td>43%</td>
<td>6,709</td>
<td>2,170</td>
<td>32%</td>
</tr>
<tr>
<td>Fairfield</td>
<td>20,365</td>
<td>16,867</td>
<td>83%</td>
<td>18,282</td>
<td>15,408</td>
<td>84%</td>
<td>260</td>
<td>143</td>
<td>55%</td>
<td>897</td>
<td>635</td>
<td>71%</td>
</tr>
<tr>
<td>Greenwich</td>
<td>22,284</td>
<td>14,874</td>
<td>67%</td>
<td>17,455</td>
<td>12,841</td>
<td>74%</td>
<td>591</td>
<td>125</td>
<td>21%</td>
<td>2,426</td>
<td>816</td>
<td>34%</td>
</tr>
<tr>
<td>Norwalk</td>
<td>33,385</td>
<td>19,885</td>
<td>60%</td>
<td>20,163</td>
<td>14,658</td>
<td>73%</td>
<td>4,803</td>
<td>1,961</td>
<td>41%</td>
<td>6,803</td>
<td>2,261</td>
<td>33%</td>
</tr>
<tr>
<td>Stamford</td>
<td>48,647</td>
<td>28,406</td>
<td>54%</td>
<td>28,897</td>
<td>19,420</td>
<td>68%</td>
<td>6,661</td>
<td>2,044</td>
<td>31%</td>
<td>8,986</td>
<td>2,620</td>
<td>29%</td>
</tr>
<tr>
<td>Stratford</td>
<td>20,179</td>
<td>16,080</td>
<td>80%</td>
<td>14,236</td>
<td>11,935</td>
<td>84%</td>
<td>2,822</td>
<td>1,789</td>
<td>63%</td>
<td>2,540</td>
<td>1,881</td>
<td>74%</td>
</tr>
<tr>
<td>6 wealthiest FC towns</td>
<td>42,080</td>
<td>35,444</td>
<td>84%</td>
<td>38,070</td>
<td>32,567</td>
<td>86%</td>
<td>356</td>
<td>116</td>
<td>33%</td>
<td>1,491</td>
<td>960</td>
<td>64%</td>
</tr>
<tr>
<td>Other FC towns</td>
<td>70,705</td>
<td>60,279</td>
<td>85%</td>
<td>63,788</td>
<td>55,384</td>
<td>87%</td>
<td>960</td>
<td>595</td>
<td>62%</td>
<td>3,414</td>
<td>2,285</td>
<td>67%</td>
</tr>
</tbody>
</table>
statewide median of $270,100; in the county’s six wealthiest towns, the median value was well over $1 million.\textsuperscript{103} White homeowners in Fairfield County have higher median home values—approximately $449,000—while median values for Black and Latino homeowners are less than $275,000.\textsuperscript{104} The drastic differences in housing values between towns in the region mean that many prospective homeowners are limited to more affordable communities, potentially contributing to the region’s neighborhood income inequality. Overall, inflation-adjusted median housing values in the region increased by $39,385, or 10 percent, between 2000 and 2017; the statewide increase during this period was $40,853, or 18 percent.\textsuperscript{105}

In Connecticut in 2017, more than 37,000 mortgages were issued to homebuyers,\textsuperscript{106} 5 percent of which qualified as high-cost. High-cost mortgages have annual percentage rates that exceed by a certain threshold the rate that would be granted to a well-qualified borrower.\textsuperscript{107} These mortgages are more expensive for borrowers, theoretically increasing the risk of default. In Connecticut, the proportion of mortgages qualifying as high-cost held around 1 percent from 2010 to 2012, peaked at 7 percent in 2014, sharply declined, and now appears to be increasing as of 2016. In Fairfield County, just under 4 percent of mortgages in 2017 were high-cost, but the percent of high-cost mortgages varied widely by town, from 15 percent in Bridgeport to less than 0.5 percent in Easton, Greenwich, and New Canaan.\textsuperscript{108}

Historically, Black and Latino homebuyers have received high-cost mortgages more often than white borrowers. In Fairfield County in 2017, just 2 percent of white borrowers received high-cost mortgages, compared to 8 percent of Latino borrowers and 13 percent of Black borrowers. Statewide in the same year, 4 percent of white borrowers, 12 percent of Black borrowers, and 11 percent of Latino borrowers received high-cost mortgages. These loans are often concentrated in areas with more non-white residents. The average high-cost mortgage in Fairfield County in 2017 went to a homebuyer in a census tract where 43 percent of residents were people of color. Non-high-cost mortgages were given in census tracts with 26 percent people of color, on average.\textsuperscript{109} Homebuyers with lower incomes are more likely to receive high-cost mortgages. In Fairfield.

<table>
<thead>
<tr>
<th>Table 2H: Housing units and new housing permits</th>
<th>Housing units per structure (2017) and new housing permits (2001-2017), Fairfield County</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LOCATION</strong></td>
<td><strong>CURRENT HOUSING STOCK</strong></td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL UNITS COUNT</strong></td>
</tr>
<tr>
<td>CT</td>
<td>1.5M</td>
</tr>
<tr>
<td>FC</td>
<td>367.6K</td>
</tr>
<tr>
<td>Bridgeport</td>
<td>58,078</td>
</tr>
<tr>
<td>Danbury</td>
<td>32,219</td>
</tr>
<tr>
<td>Fairfield</td>
<td>21,609</td>
</tr>
<tr>
<td>Greenwich</td>
<td>24,552</td>
</tr>
<tr>
<td>Norwalk</td>
<td>35,237</td>
</tr>
<tr>
<td>Stamford</td>
<td>53,228</td>
</tr>
<tr>
<td>Stratford</td>
<td>21,728</td>
</tr>
<tr>
<td>6 wealthiest FC towns</td>
<td>45,296</td>
</tr>
<tr>
<td>Other FC towns</td>
<td>75,643</td>
</tr>
</tbody>
</table>
County, the median income for high-cost borrowers in 2017 was $82,000, compared to $130,000 for borrowers with non-high cost mortgages. The median loan amount for a high-cost mortgage was $236,500, compared to $360,000 for other mortgages. In both cases, loan amounts are lower than the median home value of $417,800 in Fairfield County, suggesting that more affordable housing is in demand.

Housing affordability is a serious issue in Fairfield County. The 2018 DataHaven Community Wellbeing Survey found that 7 percent of adults did not have enough money for housing or shelter at some point in the preceding year. But nearly 4 in 10 households are either housing cost-burdened (20 percent)—meaning that they spend more than the recommended 30 percent of income on housing—or severely housing cost-burdened (19 percent), meaning more than 50 percent of their income goes toward housing. Renters are generally at heightened risk: 28 percent of renter-occupied households are severely housing cost-burdened, nearly double the 15 percent of owner-occupied households.

The overall housing cost-burden rate peaked in 2010 during the Great Recession and has declined since, and the severe housing cost-burden rate stayed steady before, during, and after the recession. However, renters have seen no such relief in the recovery years. In fact, their situation has gotten worse, with renters’ severe housing cost-burden rate rising from 22 percent in 2005 to 26 percent in 2010 to 28 percent in 2017.

In 2017, the median rent for a two-bedroom housing unit in Fairfield County was $1,522 per month, or $18,264 annually. Based on this, the average renting household in Fairfield County would need to earn $60,880 per year to avoid being cost-burdened—about $6,500 more than the median household income for the county’s renter households. This rent affordability shortfall varies across the county, but is particularly large in Bridgeport ($17,400), Stamford ($13,100), and Danbury ($12,600).

Renters facing this affordability shortfall may also face the possibility of eviction when their wages are not enough to cover rent. The eviction rate (number of evictions per renter-occupied household) in Connecticut between 2001 and 2016 averaged 3.1 percent, peaking at 3.9 percent in 2003. In 2016, the eviction rate in Connecticut was 3.0 percent—or 13,800 households, slightly higher than the national average that year of 2.3 percent. In Fairfield County, 2.6 percent, or approximately 3,000 renter-occupied households, were evicted in 2016. More than half of these formal evictions took place in Bridgeport, where 1,600 or 5.0 percent of renter-occupied households were evicted in 2016.

### TABLE I

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>MEDIAN HOUSING VALUE</th>
<th>NUMBER OF HOUSEHOLDS</th>
<th>SEVERELY COST BURDENED</th>
<th>SEVERE COST-BURDEN RATE</th>
<th>NUMBER OF RENTER HOUSEHOLDS</th>
<th>SEVERELY COST-BURDENED</th>
<th>RENTER SEVERE COST-BURDEN RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>$193,500</td>
<td>118,825,921</td>
<td>17,381,545</td>
<td>15%</td>
<td>42,992,786</td>
<td>10,170,930</td>
<td>24%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>$270,100</td>
<td>1,361,755</td>
<td>223,106</td>
<td>18%</td>
<td>454,957</td>
<td>115,898</td>
<td>26%</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>$417,800</td>
<td>337,678</td>
<td>64,655</td>
<td>19%</td>
<td>109,012</td>
<td>30,371</td>
<td>28%</td>
</tr>
<tr>
<td>Bridgeport</td>
<td>$170,300</td>
<td>50,341</td>
<td>14,325</td>
<td>29%</td>
<td>29,203</td>
<td>10,051</td>
<td>34%</td>
</tr>
<tr>
<td>Danbury</td>
<td>$289,700</td>
<td>29,692</td>
<td>5,307</td>
<td>18%</td>
<td>11,999</td>
<td>3,064</td>
<td>26%</td>
</tr>
<tr>
<td>Fairfield</td>
<td>$597,900</td>
<td>20,365</td>
<td>3,326</td>
<td>16%</td>
<td>3,498</td>
<td>964</td>
<td>28%</td>
</tr>
<tr>
<td>Greenwich</td>
<td>$1,217,500</td>
<td>22,284</td>
<td>4,179</td>
<td>19%</td>
<td>7,410</td>
<td>1,765</td>
<td>24%</td>
</tr>
<tr>
<td>Norwalk</td>
<td>$421,900</td>
<td>33,385</td>
<td>7,061</td>
<td>21%</td>
<td>13,500</td>
<td>3,778</td>
<td>28%</td>
</tr>
<tr>
<td>Stamford</td>
<td>$516,000</td>
<td>48,647</td>
<td>10,439</td>
<td>22%</td>
<td>22,241</td>
<td>5,561</td>
<td>25%</td>
</tr>
<tr>
<td>Stratford</td>
<td>$250,700</td>
<td>20,179</td>
<td>4,014</td>
<td>20%</td>
<td>4,099</td>
<td>1,405</td>
<td>34%</td>
</tr>
<tr>
<td>6 wealthiest FC towns</td>
<td>$1,058,200</td>
<td>42,080</td>
<td>6,386</td>
<td>15%</td>
<td>6,636</td>
<td>1,504</td>
<td>23%</td>
</tr>
</tbody>
</table>
Shelton had the lowest eviction rate, 0.4 percent or 13 households. These rates are derived from the best available nationwide evictions dataset, which is based on court-reported filings and whether an eviction took place as a result. Because not all evictions take place through the legal system, and because these data are based solely on available court records, these rates likely do not capture the true magnitude of evictions.¹¹⁷

Evictions, whether formal or informal, do not affect all families equally. The 2018 DataHaven Community Wellbeing Survey found that 14 percent of white adults, 25 percent of Black adults, and 30 percent of Latino adults in Fairfield County had moved within the past three years; of these adults, who were mostly renters, 7 percent had been evicted.¹¹⁸ Of those renters who were not evicted, about 1 in 10 white adults and 1 in 5 Black and Latino adults said they had moved in part because of rent increases at their previous home, and about 1 in 10 said they moved because their landlord would not fix things. Low-income adults (earning less than $30,000 per year) and adults with children at home were more likely to report feeling unable to afford adequate housing. For children in housing-insecure families, educational and cognitive development outcomes are a concern as they must cope with the stress of increased residential mobility and risk of homelessness.¹¹⁹

Housing Discrimination

“Redlining” is the shorthand used to refer to the practice of rating certain neighborhoods as risky or undesirable for investment for reasons historically rooted in the races, ethnicities, occupations, and income levels of the areas’ residents. In the early 1930s, the federal government established the Home Owners’ Loan Corporation (HOLC) to help fund mortgages for homebuyers. HOLC created maps of cities that rated neighborhoods from A (“Best”) to D (“Hazardous”).¹²⁰ Neighborhoods rated as “hazardous” were shaded red and were subsequently considered to be too risky for mortgage loans or other investments.

Today, the impact of redlining on communities across the country remains apparent. Comparing the neighborhoods targeted for investment decades ago to demographics from 2010,¹¹ we notice comparatively high rates of homeownership in higher-grade areas—65 percent in Fairfield County towns’ A-grade areas compared to 50 percent overall and just 34 percent in D-grade areas. The areas are also racially segregated, and higher-grade areas were predominantly white in 2010. In A-grade areas, 76 percent of residents were white, compared to just 19 percent in D-grade areas.¹²² See Fig. 2.16, 2.17, 2.18

Zoning is perhaps the most common and powerful tool policymakers have at their disposal to encourage the development of more and more affordable housing where it is needed most, but local zoning codes are often used instead to prevent the development of affordable units. At their worst, zoning regulations further perpetuate decades of race- and class-based discrimination. A recent Connecticut Mirror/ProPublica article reveals the extent to which zoning regulations in southwest Connecticut prevent willing developers from building affordable housing despite evident need and demand.¹²³ When they are permitted, these affordable developments are disproportionately located in low-income neighborhoods and communities of color, further reinforcing the region’s social and economic segregation. For example, according to the Connecticut Department of Housing, 20 percent of Bridgeport’s total housing units received some form of government housing assistance in 2018, compared to about 3 percent of units in Westport and about 11 percent of the state’s housing stock overall.¹²⁴

Regional Job and Wage Trends

Since 2000, the number of jobs in Fairfield County has ebbed and flowed in line with the larger economic climate. The total job count fell following the early 2000s recession, fully bounced back by 2008, and sharply decreased following the Great Recession. By 2017, the number of jobs in Fairfield County (429,874) had recovered to match the last peak in 2007 (429,786).¹²⁵ This pattern tracked closely with the statewide trend over the same time period.

While the total number of jobs in Fairfield County in 2017 was almost identical to the number in 2000, they have shifted dramatically toward a service economy. In the early 2000s, about equal numbers of jobs existed in the health care and social assistance, retail trade, and manufacturing sectors. Since then, manufacturing jobs have
plummeted by about a third, and health care jobs have soared to become far and away the largest sector in the region, with around 66,000 employees.126 Home health aides, nurses, and health care managers and executives are among the most common occupations within this sector.127 As Fairfield County’s senior population grows, health care and social assistance workers will likely continue to be in high demand. The Connecticut Department of Labor’s most recent 2016 forecast estimates that statewide, the health care and social assistance sector will grow by an additional 11 percent by 2026.128 Both educational services and accommodation and food services also saw growth from 2000 to 2017, adding about 8,000 and 9,200 jobs respectively.129

### TABLE 2J

**Wage trends by sector**  
**AVERAGE WAGE BY INDUSTRY, FAIRFIELD COUNTY, 2000–2017, IN 2017 DOLLARS**

<table>
<thead>
<tr>
<th>INDUSTRY</th>
<th>WAGE 2017</th>
<th>CHANGE IN WAGE 2000–2017</th>
<th>PERCENT CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>All NAICS Sectors</td>
<td>$86,224</td>
<td>$3,213</td>
<td>3.6%</td>
</tr>
<tr>
<td>Finance and Insurance</td>
<td>$264,986</td>
<td>$37,347</td>
<td>16.4%</td>
</tr>
<tr>
<td>Professional, Scientific, and Technical Services</td>
<td>$125,809</td>
<td>$3,936</td>
<td>3.2%</td>
</tr>
<tr>
<td>Health Care and Social Assistance</td>
<td>$55,427</td>
<td>$797</td>
<td>1.5%</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>$95,036</td>
<td>$1,320</td>
<td>1.4%</td>
</tr>
<tr>
<td>Management of Companies and Enterprises</td>
<td>$198,266</td>
<td>$22,755</td>
<td>13.0%</td>
</tr>
<tr>
<td>Educational Services</td>
<td>$59,419</td>
<td>$805</td>
<td>1.3%</td>
</tr>
<tr>
<td>Wholesale Trade</td>
<td>$127,981</td>
<td>$5,075</td>
<td>4.1%</td>
</tr>
<tr>
<td>Retail Trade</td>
<td>$40,271</td>
<td>$19,486</td>
<td>32.6%</td>
</tr>
<tr>
<td>Information</td>
<td>$113,839</td>
<td>$13,932</td>
<td>13.9%</td>
</tr>
<tr>
<td>Administrative and Support and Waste Management and Remediation Services</td>
<td>$54,921</td>
<td>$3,313</td>
<td>6.4%</td>
</tr>
<tr>
<td>Construction</td>
<td>$70,331</td>
<td>$3,224</td>
<td>4.4%</td>
</tr>
<tr>
<td>Accommodation and Food Services</td>
<td>$25,274</td>
<td>$2,473</td>
<td>11.7%</td>
</tr>
<tr>
<td>Other Services (except Public Administration)</td>
<td>$37,605</td>
<td>$1,417</td>
<td>3.6%</td>
</tr>
<tr>
<td>Public Administration</td>
<td>$69,280</td>
<td>$7,265</td>
<td>13.9%</td>
</tr>
<tr>
<td>Transportation and Warehousing</td>
<td>$59,755</td>
<td>$5,401</td>
<td>9.3%</td>
</tr>
<tr>
<td>Real Estate and Rental and Leasing</td>
<td>$85,481</td>
<td>$13,108</td>
<td>18.1%</td>
</tr>
<tr>
<td>Arts, Entertainment, and Recreation</td>
<td>$39,317</td>
<td>$8,342</td>
<td>17.5%</td>
</tr>
<tr>
<td>Utilities</td>
<td>$115,801</td>
<td>$1,713</td>
<td>1.5%</td>
</tr>
<tr>
<td>Agriculture, Forestry, Fishing and Hunting</td>
<td>$44,345</td>
<td>$1,012</td>
<td>2.3%</td>
</tr>
<tr>
<td>Mining, Quarrying, and Oil and Gas Extraction</td>
<td>$123,941</td>
<td>$77,478</td>
<td>106.8%</td>
</tr>
</tbody>
</table>

### TABLE 2K

**Changing industry footprint**  
**SHARE OF TOTAL PAYROLL BY INDUSTRY, FAIRFIELD COUNTY, 2000–2017**

<table>
<thead>
<tr>
<th>INDUSTRY</th>
<th>PAYROLL</th>
<th>SHARE OF PAYROLL 2000</th>
<th>SHARE OF PAYROLL 2017</th>
<th>CHANGE SHARE OF PAYROLL</th>
</tr>
</thead>
<tbody>
<tr>
<td>All NAICS Sectors</td>
<td>$37,000,000,000</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Finance and Insurance</td>
<td>$9,100,000,000</td>
<td>21.4%</td>
<td>24.6%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Professional, Scientific, and Technical Services</td>
<td>$4,300,000,000</td>
<td>11.2%</td>
<td>11.5%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Health Care and Social Assistance</td>
<td>$3,700,000,000</td>
<td>7.0%</td>
<td>9.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>$3,100,000,000</td>
<td>12.6%</td>
<td>8.4%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Management of Companies and Enterprises</td>
<td>$2,400,000,000</td>
<td>8.5%</td>
<td>6.6%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Educational Services</td>
<td>$2,300,000,000</td>
<td>4.7%</td>
<td>6.1%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Wholesale Trade</td>
<td>$2,100,000,000</td>
<td>5.8%</td>
<td>5.8%</td>
<td>&lt;0.1%</td>
</tr>
<tr>
<td>Retail Trade</td>
<td>$2,000,000,000</td>
<td>8.3%</td>
<td>5.3%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Information</td>
<td>$1,700,000,000</td>
<td>4.1%</td>
<td>4.6%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Administrative and Support and Waste Management and Remediation Services</td>
<td>$1,500,000,000</td>
<td>4.0%</td>
<td>4.2%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Construction</td>
<td>$990,000,000</td>
<td>3.0%</td>
<td>2.7%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Accommodation and Food Services</td>
<td>$820,000,000</td>
<td>1.7%</td>
<td>2.2%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Other Services (except Public Administration)</td>
<td>$720,000,000</td>
<td>1.8%</td>
<td>1.9%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Public Administration</td>
<td>$590,000,000</td>
<td>1.3%</td>
<td>1.6%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Transportation and Warehousing</td>
<td>$540,000,000</td>
<td>1.7%</td>
<td>1.4%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Real Estate and Rental and Leasing</td>
<td>$480,000,000</td>
<td>1.4%</td>
<td>1.3%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Arts, Entertainment, and Recreation</td>
<td>$490,000,000</td>
<td>1.1%</td>
<td>1.3%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Utilities</td>
<td>$150,000,000</td>
<td>0.8%</td>
<td>0.4%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Agriculture, Forestry, Fishing and Hunting</td>
<td>$18,000,000</td>
<td>&lt;0.1%</td>
<td>&lt;0.1%</td>
<td>&lt;0.1%</td>
</tr>
<tr>
<td>Mining, Quarrying, and Oil and Gas Extraction</td>
<td>$5,200,000</td>
<td>&lt;0.1%</td>
<td>&lt;0.1%</td>
<td>&lt;0.1%</td>
</tr>
</tbody>
</table>

SEE FIG 2.20
In 2017, the average wage in Fairfield County was the highest of any county in Connecticut at $86,224—a strong mark, considering that the state average was $66,990. However, while average wages rose statewide by a modest 1.2 percent between 2000 and 2017, Fairfield County experienced a 3.6 percent decline. In the county’s fast-growing service sectors, wages are generally lower, and since 2000 have been largely stagnant or declining. Meanwhile, wages in some high-paying sectors have continued to climb. Of Fairfield County’s leading sectors, only three experienced wage increases of over 10 percent during this period—finance and insurance, information, and management of companies and enterprises—and these sectors already averaged six-figure salaries in 2000. Workers in Fairfield County’s prominent finance and insurance sector earned an average $264,986 in 2017—nearly four times the salary of the average Connecticut worker. SEE TABLE 2J

While finance and insurance accounted for only 8 percent of Fairfield County’s total jobs in 2017, and lost about 1,600 jobs from the year 2000, the sector made up nearly 25 percent of the county’s total payroll (total amount in wages paid to all employees)—an increase of more than 3 percentage points since 2000. The health care and social assistance sector added around 17,000 jobs between 2000 and 2017, and currently accounts for over 15 percent of all jobs in the county. But the sector’s share of payroll is only about 10 percent, which grew slightly slower than that of the finance and insurance sector. Wage growth in the highest-paying industries, coupled with a proliferation of lower-wage jobs in the region, will likely contribute to increased income inequality. SEE TABLE 2K

Transportation and Job Locations

With jobs spread across the county and state, and even beyond state lines, the importance of reliable and affordable transportation cannot be overstated. Fairfield County overall has a net outflow of 17,000 higher-wage workers—those with earnings of at least $40,000 per year—to New York State, meaning that the number of higher-wage workers living in Fairfield County that commute to New York State is greater than the number that commute from locations in New York State to job locations within Fairfield County. While many Fairfield County residents also travel to Other FC towns in Connecticut, Fairfield County has a net inflow of 29,000 higher-wage workers and 8,600 lower-wage workers from other parts of the state. As is the case in other large cities, Stamford experiences a particularly large net inflow of higher-wage workers ($15,000) from Other FC towns each day. Greenwich and Danbury also see large net inflows of higher-wage workers. The issue known as spatial mismatch, in which many workers experience “reverse” commutes to get to lower-paying jobs in outer suburbs, is also important. In particular, Bridgeport has a high concentration of residents with lower-wage jobs, and most travel to surrounding towns for work; this is seen in the net inflow of lower-wage workers in the suburbs of Fairfield ($5,600), Westport ($4,000), and Trumbull ($2,600), combined with the strikingly large net outflow of lower-wage workers seen in Bridgeport ($16,000), the largest outflow in the state. SEE FIG 2.19

Regional commuter rail connections, bus services, and walking or biking provide options for some workers, especially those employed in city centers. However, the vast majority of Fairfield County’s workers rely on a car to reach the greatest number of available jobs within a reasonable commuting distance, as well as necessary services such as shopping and health care. Results from the 2018 DataHaven Community Wellbeing Survey indicate that 10 percent of Fairfield County’s adults do not have access to a car when they need it. In the region, 40 percent of adults who earn less than $15,000 per year and 28 percent who earn between $15,000 and $30,000 report not having access to a car when needed. Adults with limited car access also report much higher levels of underemployment. Additionally, about half of adults who face transportation insecurity report that they have missed a doctor’s appointment in the past year due to lack of reliable transportation. These survey data underscore the importance of alternative local transportation options for low-income adults. SEE TABLE 2L

Lack of car access is far more common for Black residents (25 percent) and Latino residents (20 percent) than among white residents (only 6 percent). As discussed above, the substantial disparity in median household income and family wealth between white households and Black and Latino households in Fairfield County is one important factor in explaining these differences in car access.

Additionally, it is important to consider the potential trade-offs between housing and transportation costs. Adults who seek lower-cost
housing farther from work or services may shoulder a much greater burden of transportation expenses, and have to cope with the many other impacts of longer daily travel times, including those related to employment and health.141

**Underemployment**
Fairfield County’s average unemployment rate from 2013 to 2017 (8 percent) was similar to the statewide and nationwide rates (both 7 percent), though there was significant variation by place and race/ethnicity within the region. SEE FIG 1.3, TABLE 1B

However, a much greater number of residents—particularly within certain population groups—find economic opportunities to be limited.142 The unemployment rate counts people without a job but looking for work; it does not consider part-time workers who would prefer full-time work, nor those who are interested in working but not actively searching for a job. The DataHaven Community Wellbeing Survey captures both of these groups in its underemployment measure.

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>FEEL AREA HAS GOOD OPPORTUNITIES FOR EMPLOYMENT</th>
<th>FEEL YOUTH HAVE OPPORTUNITIES FOR JOB ADVANCEMENT</th>
<th>UNDEREMPLOYED</th>
<th>HAVE ACCESS TO A CAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>50%</td>
<td>59%</td>
<td>16%</td>
<td>88%</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>55%</td>
<td>68%</td>
<td>15%</td>
<td>90%</td>
</tr>
</tbody>
</table>

**BY DEMOGRAPHIC WITHIN FAIRFIELD COUNTY**

<table>
<thead>
<tr>
<th>DEMOGRAPHIC</th>
<th>FEEL AREA HAS GOOD OPPORTUNITIES FOR EMPLOYMENT</th>
<th>FEEL YOUTH HAVE OPPORTUNITIES FOR JOB ADVANCEMENT</th>
<th>UNDEREMPLOYED</th>
<th>HAVE ACCESS TO A CAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>59%</td>
<td>64%</td>
<td>14%</td>
<td>90%</td>
</tr>
<tr>
<td>Female</td>
<td>53%</td>
<td>66%</td>
<td>18%</td>
<td>89%</td>
</tr>
<tr>
<td>Age 18–34</td>
<td>52%</td>
<td>64%</td>
<td>25%</td>
<td>83%</td>
</tr>
<tr>
<td>Age 35–49</td>
<td>54%</td>
<td>67%</td>
<td>12%</td>
<td>92%</td>
</tr>
<tr>
<td>Age 50–64</td>
<td>57%</td>
<td>68%</td>
<td>12%</td>
<td>91%</td>
</tr>
<tr>
<td>Age 65+</td>
<td>61%</td>
<td>67%</td>
<td>9%</td>
<td>89%</td>
</tr>
<tr>
<td>White</td>
<td>62%</td>
<td>69%</td>
<td>12%</td>
<td>84%</td>
</tr>
<tr>
<td>Black</td>
<td>33%</td>
<td>58%</td>
<td>28%</td>
<td>75%</td>
</tr>
<tr>
<td>Latino</td>
<td>47%</td>
<td>80%</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>&lt;$15K</td>
<td>38%</td>
<td>45%</td>
<td>78%</td>
<td>60%</td>
</tr>
<tr>
<td>$15K–$30K</td>
<td>36%</td>
<td>46%</td>
<td>45%</td>
<td>72%</td>
</tr>
<tr>
<td>$30K–$50K</td>
<td>45%</td>
<td>65%</td>
<td>21%</td>
<td>88%</td>
</tr>
<tr>
<td>$50K–$75K</td>
<td>52%</td>
<td>58%</td>
<td>15%</td>
<td>92%</td>
</tr>
<tr>
<td>$75K–$100K</td>
<td>58%</td>
<td>69%</td>
<td>8%</td>
<td>96%</td>
</tr>
<tr>
<td>$100K–$200K</td>
<td>65%</td>
<td>71%</td>
<td>5%</td>
<td>97%</td>
</tr>
<tr>
<td>$200K+</td>
<td>74%</td>
<td>80%</td>
<td>5%</td>
<td>99%</td>
</tr>
</tbody>
</table>

**BY GEOGRAPHY**

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>FEEL AREA HAS GOOD OPPORTUNITIES FOR EMPLOYMENT</th>
<th>FEEL YOUTH HAVE OPPORTUNITIES FOR JOB ADVANCEMENT</th>
<th>UNDEREMPLOYED</th>
<th>HAVE ACCESS TO A CAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgeport</td>
<td>28%</td>
<td>40%</td>
<td>28%</td>
<td>77%</td>
</tr>
<tr>
<td>Danbury</td>
<td>54%</td>
<td>64%</td>
<td>11%</td>
<td>95%</td>
</tr>
<tr>
<td>Fairfield</td>
<td>61%</td>
<td>84%</td>
<td>N/A</td>
<td>95%</td>
</tr>
<tr>
<td>Greenwich</td>
<td>72%</td>
<td>75%</td>
<td>13%</td>
<td>92%</td>
</tr>
<tr>
<td>Norwalk</td>
<td>55%</td>
<td>64%</td>
<td>14%</td>
<td>91%</td>
</tr>
<tr>
<td>Stamford</td>
<td>63%</td>
<td>64%</td>
<td>18%</td>
<td>87%</td>
</tr>
<tr>
<td>Stratford</td>
<td>38%</td>
<td>56%</td>
<td>N/A</td>
<td>87%</td>
</tr>
</tbody>
</table>
In 2018, 15 percent of Fairfield County adults reported being underemployed. This figure was similar to that of the state, and more than double the region’s unemployment rate in that same year. The underemployment rate varied; for example, twice the share of adults in Bridgeport were underemployed (28 percent) as in Greenwich (13 percent). Across Fairfield County, both young adults (25 percent) and Black and Latino residents (28 percent and 20 percent, respectively) face higher rates of underemployment than the county’s population overall. This reality may play a role in the more negative outlook regarding economic opportunities reported by Black and Latino residents. Understandably, Fairfield County residents who have higher incomes are more optimistic about job opportunities in the region.

### EDUCATION

#### Early Childhood

Children’s experiences in their first five years profoundly affect their life outcomes. Their mother’s access to prenatal care, the quality of their living environment, and their social interactions affect their brain development, overall well-being and ability to succeed in school and beyond.

According to a 2017 Connecticut Voices for Children report, the state expanded its funding for childcare services from 2005 to 2016, with the result that 80 percent of four-year-olds in the state were enrolled in preschool, even though the need for care for infants and toddlers still surpassed the available capacity. This Connecticut Voices for Children report notes that community wealth strongly predicts both whether children go to preschool and the level of their later academic performance, suggesting that greater attention should be paid to the economic barriers that prevent many children from accessing high-quality early childhood education.

From 2000 to 2017, the share of children enrolled in preschool in Fairfield County remained unchanged. In 2017, 15,284 children, or 69 percent of the county’s three- and four-year-olds, were enrolled in preschool, including about 3,300 children in preschool classrooms provided by public school districts. As noted in the DataHaven Community Index, preschool enrollment is significantly higher in the six wealthiest Fairfield County towns and in Greenwich than in the county as a whole.

Additionally, childcare providers in Fairfield County have a combined capacity of about 4,980 slots for infants and toddlers, representing only about 16 percent of the region’s children under age 3, and indicating a severe shortage in early childcare options.

According to the United Way ALICE Project, the minimum monthly childcare cost for a young family—a household with two adults, one infant, and one preschooler—is about $1,845 in Fairfield County. In Fairfield County in 2018, the average childcare facility charged about $280 a week to care for infants and toddlers, and about $256 for preschoolers. According to these figures, the young family described above would spend $27,872 per year on childcare.

These high costs have clear implications for the county’s many working families struggling to make ends meet. According to the 2018 DataHaven Community Wellbeing Survey, of adults in the county living with children below kindergarten age, 60 percent report that it is either somewhat or very difficult to find high-quality, affordable childcare. In Fairfield County, childcare is both a great financial burden and a great necessity, as it prepares children for the future and enables parents to work.

#### K–12 and Postsecondary Education

Fairfield County is home to 140,836 public school students from preschool to 12th grade, including 3,430 in pre-kindergarten programs, 94,520 kindergarten and elementary school students, and 42,886 high school students. The county’s public school students are about half (53 percent) white, 27 percent Latino, 11 percent Black, and 9 percent other races. Notably, the student population is far less diverse in Fairfield County’s wealthier districts: 82 percent of students in the districts covering the county’s six wealthiest towns are white, 6 percent are Latino, and fewer than 1 percent of the students are Black. Several of the county’s largest districts are far more diverse: in Bridgeport, Norwalk, Danbury, Stamford, and Stratford, no one racial group constitutes a majority of the students.

Students who take special education classes, who qualify for free or reduced-price meals (FRPM) at school based on family incomes less than 185
percent of the federal poverty line, or who are English language learners (ELL) are considered to be high-needs students; students may have more than one of these designations. In Fairfield County, 14 percent of students have a special education designation, 37 percent of students qualify for FRPM, and 9 percent of students are ELL. While special education students make up similar shares of school districts, the county’s six wealthiest districts serve much smaller shares of ELL students (1 percent of students) than schools in Danbury (26 percent), Bridgeport (18 percent), Norwalk (16 percent), or Stamford (13 percent). Only 3 percent of students in these wealthy towns are FRPM-eligible.

On the state’s major standardized test, the Smarter Balanced Assessment Consortium (SBAC), scores rated as meeting or exceeding grade-level goals are considered passing. Since 2015, students in Fairfield County public school districts have maintained passing rates 5 to 6 percentage points higher than the state’s passing rates in both English/language arts (ELA) and math. In the 2017–18 school year, 61 percent of Fairfield County public school students passed the ELA test, and 53 percent passed in math, above the statewide passing rates of 55 percent and 47 percent, respectively. While Fairfield County’s ELA scores have remained the same in the few years since the state adopted the SBAC, math pass rates have risen steadily from 45 percent in the 2014–15 school year.

Stark disparities in standardized test performance exist throughout Fairfield County. In the 2017–18 school year, white students had more than twice the pass rate (76 percent) of Black students (32 percent), and about twice that of Latino students (39 percent) in ELA; these gaps are even wider in math scores. Gaps of similar magnitude exist between students eligible for FRPM and those ineligible, and are even more severe between students in special education and those not, and ELL versus non-ELL students.

Disparities also muddle the county’s relatively high four-year high school graduation rates. Following the rising statewide trend—from 83 percent of the class of 2011 graduating on time to 88 percent of the class of 2017—the four-year graduation rate for students in Fairfield County increased from 87 percent in 2011 to 91 percent in 2017. Of the class of 2017, 95 percent of white students graduated on time, several percentage points above the rates of Black students (84 percent) and Latino students (81 percent), a pattern mirrored statewide. The gaps are even wider for high-needs students: the four-year high school graduation rate is only 75 percent for special education students, 68 percent for ELL students, and 81 percent for FRPM students in Fairfield County.

In discussing achievement gaps, it is worth noting the role of school segregation and distribution of resources. There are 24 public school districts within Fairfield County, but the majority of Black, Latino, FRPM, and ELL students are concentrated in just a few. The three largest districts—Bridgeport, Stamford, and Danbury—educate a combined 34 percent of the county’s students, but are home to 68 percent of the county’s Black students, 58 percent of Latino students, 62 percent of FRPM-eligible students, and 68 percent of ELL students. Forty-six percent of the county’s Black students go to school in Bridgeport alone. These are also towns that have less money available to spend on students and other resources that can support opportunities for young people.

One way to level the playing field moving into adulthood might be through post-secondary preparatory programs. Many high schools offer college and career readiness (CCR) programs, including Advanced Placement (AP), International Baccalaureate (IB), career education, and other opportunities. In the 2017–18 school year, 78 percent of Fairfield County’s 11th- and 12th-graders—or about 16,500 upperclassmen—were in CCR courses and programs. This varies widely between districts, but not along the wealth lines we often see on other measures—53 percent of Bridgeport’s upperclassmen and 59 percent of those in Danbury took CCR, but those percentages are about the same in the wealthy, higher-spending districts of Wilton (52 percent) and Darien (61 percent).

While four out of five high school graduates in Fairfield County enroll in college within a year, and 91 percent of those students re-enroll for a second consecutive year, only 58 percent of a given Fairfield County high school class have a college degree six years after graduating high school. A 2019 report from Fairfield County’s Community Foundation highlights the importance of post-secondary certificates offered in expanding job sectors at area community colleges.

Adults with high school diplomas or college degrees have more employment options and considerably higher potential earnings, on average,
than those who do not finish high school. In 2017, 11 percent of adults aged 25 and older in the county had less than a high school education, or about 68,000 people. While almost 50 percent of adults in the county have four-year college degrees, attainment rates are not as high in some areas, including central Danbury, south/central Norwalk, and several neighborhoods in Bridgeport, where up to one-third of adults 25 years and older lack a high school diploma.

### Risk Factors for Youth

A major risk factor for students’ academic success is chronic absenteeism, or missing more than 10 percent of the days for which a student is enrolled in a school year. A national study found that over half of chronically-absent kindergarteners became chronically-absent first graders. In the 2017–18 school year, 9 percent of students in Fairfield County were chronically absent from school. Like many other indicators, this differs by race: 6 percent of white students, 15 percent of Black students, 13 percent of Latino students, and 7 percent of students of other races/ethnicities were chronically absent that year. Further, special education students and those eligible for FRPM were more than twice as likely to miss so many days of school as their lower-risk counterparts. Factors that contribute to chronic absenteeism may include individual- and family-level predictors such as asthma and other chronic diseases, poverty, and parent involvement; neighborhood-level issues such as access to transportation and safe routes to school; and school-level factors such as bullying and school maintenance.

### Academic Disadvantages that result from chronic absenteeism are also at play for students who miss class due to in-school or out-of-school suspensions. Students who are suspended or expelled from school are more likely to have negative perceptions of school and to have lower GPAs. Perhaps most gravely, they are also more likely to be involved with the juvenile justice system. Black and Latino students—particularly boys—are expelled or suspended far more frequently than white students, even as early as preschool. Even when the confounding effects of socioeconomic status are controlled for, Black students are still disciplined more frequently than their white counterparts. In Fairfield County public schools, Black students are suspended or expelled at a rate 5 times greater than white students, and special education students are suspended or expelled 2.5 times as often as students who are not in special education.
Adults’ perceptions of what youth in their towns are likely to experience are generally positive, but vary greatly from town to town. For example, in Bridgeport, adults are much less likely to think that a young person in their town will graduate from high school or get a job with opportunities for advancement compared to adults in the state, in the county’s wealthier towns such as Greenwich, and in similarly large cities such as Stamford. Bridgeport residents are also 8 times more likely than Greenwich residents and almost 3.5 times more likely than residents countywide to think that a young person in their neighborhood will get arrested for a felony. In addition to perceptual differences by place within the county, adults also perceive youth experiences differently depending on race. Black and Latino adults in the county are more likely than white adults to think that children in their neighborhood will someday be arrested for a felony. Lastly, wealth correlates with more positive perceptions of young people’s future experiences. For example, 46 percent of adults earning under $30,000 think that their neighborhood youth are very likely to get a job with opportunities for advancement, compared to 74 percent of adults earning $100,000 or more who think the same.176 SEE FIG 2.25

The quality of a child’s education is highly correlated with upward mobility,177 but a person’s economic future is largely dependent upon the circumstances of their youth beyond their control. The place a child grows up, their race, and their family’s income will generally determine whether that child will move up the socioeconomic ladder. Children in Connecticut are slightly more advantaged than children nationwide178—partially due to the state’s overall wealth—but other disparities are evident. White children in Fairfield County, regardless of their family’s income, are more likely than their Black or Latino peers to experience upward economic mobility. Within Fairfield County, the probability that a low-income white child will reach the top 20 percent of households by income (24 percent probability) is almost twice that of a high-income Black child (14 percent probability), and nearly five times that of a low-income Black child (5 percent probability).179 As a result of factors beyond their control, these children are subject to the effects of differential access to quality education, post-secondary and employment opportunities, and wealth-building opportunities. Those with better access tend to have correspondingly better overall health and higher quality of life than people with limited access to those opportunities. SEE FIG 2.26 DH

**TABLE 2N**

**Educational attainment**

**EDUCATIONAL ATTAINMENT, ADULTS AGE 25+, FAIRFIELD COUNTY, 2017**

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>POPULATION AGES 25+</th>
<th>NO HIGH SCHOOL DIPLOMA COUNT</th>
<th>NO HIGH SCHOOL DIPLOMA SHARE</th>
<th>BACHELORS OR HIGHER COUNT</th>
<th>BACHELORS OR HIGHER SHARE</th>
<th>MASTERS OR HIGHER COUNT</th>
<th>MASTERS OR HIGHER SHARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>216,271,644</td>
<td>27,437,114</td>
<td>13%</td>
<td>66,887,603</td>
<td>31%</td>
<td>25,510,535</td>
<td>12%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>2,480,287</td>
<td>242,500</td>
<td>10%</td>
<td>953,199</td>
<td>38%</td>
<td>421,144</td>
<td>17%</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>642,401</td>
<td>68,146</td>
<td>11%</td>
<td>298,496</td>
<td>47%</td>
<td>132,570</td>
<td>21%</td>
</tr>
<tr>
<td>Bridgeport</td>
<td>94,935</td>
<td>23,164</td>
<td>24%</td>
<td>17,148</td>
<td>18%</td>
<td>6,263</td>
<td>7%</td>
</tr>
<tr>
<td>Danbury</td>
<td>57,871</td>
<td>10,474</td>
<td>18%</td>
<td>17,649</td>
<td>31%</td>
<td>7,488</td>
<td>13%</td>
</tr>
<tr>
<td>Fairfield</td>
<td>39,088</td>
<td>1,798</td>
<td>5%</td>
<td>24,780</td>
<td>63%</td>
<td>11,307</td>
<td>28%</td>
</tr>
<tr>
<td>Greenwich</td>
<td>42,698</td>
<td>2,066</td>
<td>5%</td>
<td>27,972</td>
<td>66%</td>
<td>13,918</td>
<td>33%</td>
</tr>
<tr>
<td>Norwalk</td>
<td>62,227</td>
<td>7,881</td>
<td>13%</td>
<td>25,576</td>
<td>41%</td>
<td>10,495</td>
<td>17%</td>
</tr>
<tr>
<td>Stamford</td>
<td>90,915</td>
<td>10,269</td>
<td>11%</td>
<td>43,285</td>
<td>48%</td>
<td>19,498</td>
<td>21%</td>
</tr>
<tr>
<td>Stratford</td>
<td>38,430</td>
<td>3,724</td>
<td>10%</td>
<td>12,837</td>
<td>33%</td>
<td>5,126</td>
<td>13%</td>
</tr>
<tr>
<td>6 wealthiest FC towns</td>
<td>79,385</td>
<td>1,554</td>
<td>2%</td>
<td>62,199</td>
<td>78%</td>
<td>29,697</td>
<td>37%</td>
</tr>
<tr>
<td>Other FC towns</td>
<td>136,454</td>
<td>7,216</td>
<td>5%</td>
<td>67,050</td>
<td>49%</td>
<td>28,838</td>
<td>21%</td>
</tr>
</tbody>
</table>
“Between 1990 and 2017, the number of immigrants residing in Fairfield County more than doubled, increasing by 105,023 individuals or 104 percent.”
As a whole, Fairfield County is a healthy place to call home.
Residents average higher levels of self-reported health than their peers statewide and nationally.

**Executive Summary**

Residents average higher levels of self-reported health than their peers statewide and nationally, and this is reflected in an above-average life expectancy, again when compared to both the state and national levels. However, these impressive measures belie more concerning health patterns for both lower-income and Black and Latino residents. Residents of more marginalized neighborhoods of Fairfield County are less likely to report being in good health; have lower life expectancies, by up to 19 years; shoulder a higher burden of chronic illnesses such as cardiovascular disease and diabetes; have considerably higher rates of infant mortality; and report higher rates of anxiety and depression. One health struggle that is currently borne to a greater extent by white Fairfield County residents is the opioid epidemic. The drug overdose death rate has been higher for white residents than people of color, but death rates are increasing more rapidly among people of color in the past few years.

Disparities also exist in health insurance coverage and preventive care. While only 3 percent of white adults are uninsured, 13 percent of Black adults, 14 percent of Latino adults, and 15 percent of adults with incomes under $30,000 lack health insurance. Residents reported multiple barriers to accessing health care, including being too busy, not feeling their health concerns warranted a trip to the doctor, and the high cost of health care. These barriers may contribute to residents’ reliance on health care delivered in the emergency room: in 2018, nearly a quarter (23 percent) of Fairfield County adults reported going to the emergency room at least once. Greater reliance on the emergency room, measured by those who visited an ER at least three times in the past year, was twice as high among lower-income adults as among those with higher incomes. In addition, geographic discrepancies in the rates at which Fairfield County residents visit hospitals and emergency rooms appear to be growing, with such visit rates increasing faster from 2012 to 2017 in towns with higher chronic disease burdens.

Analysis of all available data did point to some potential improvements over recent years, including lower rates of chronic-disease-related hospitalizations and emergency room visits in some areas, such as diabetes in Stamford and heart disease in Norwalk. One potential cause for these decreases could be area disease prevention programs and strategies. In addition, while opioid-related deaths are still at epidemic levels, the increases year over year have started to slow. DH
“In the 2018 DataHaven Community Wellbeing Survey, one in every four adults in Fairfield County reported knowing someone who has struggled with abuse of or addiction to prescription painkillers, heroin, or other opiates in the past three years.”
FIG 3.1
Life expectancy in Fairfield County is high, but often differs by several years between adjacent neighborhoods

ESTIMATED LIFE EXPECTANCY IN YEARS, 2010–2015
FIG 3.2

Cancers and infant/fetal mortality impact Fairfield County’s lifespans the most

YEARS OF POTENTIAL LIFE LOST BEFORE AGE 75 PER 100,000 RESIDENTS BY CAUSE OF DEATH, 2010–2014

<table>
<thead>
<tr>
<th>General Causes</th>
<th>Years of Potential Life Lost to Age 75 Per 100K Residents</th>
<th>Avg. Years Lost Per Death</th>
<th>Deaths Before Age 75</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant/Fetal Mortality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accident</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homicide</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Liver Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Lower Respiratory Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sepsis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Types</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pancreatic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accident Types</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poisoning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motor Vehicle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DataHaven Fairfield County Community Wellbeing Index
Fig 3.3
Rates of hospitalizations and ED visits vary by geography
Age-adjusted and relative age-adjusted rates, per 10,000 residents, 2015–2017

Chapter 3 Creating a Healthier Region
Preventable hospital visits show large differences across age and gender

CHRONIC DISEASE, ENCOUNTER RATE (PER 10,000 RESIDENTS), 2015–2017

FIG 3.4

DataHaven   Fairfield County Community Wellbeing Index
FIG 3.5
Preventable hospital visits show large differences across age and gender
OTHER HEALTH ISSUES, ENCOUNTER RATE (PER 10,000 RESIDENTS), 2015–2017
Growing inequality in rates of hospital encounters

CHRONIC DISEASE, AGE-ADJUSTED RATE OF HOSPITALIZATIONS AND ED ENCOUNTERS (PER 10,000 RESIDENTS), 2012–2014 TO 2015–2017

FIG 3.6

DataHaven Fairfield County Community Wellbeing Index


BETTER

WORSE

Heart Disease

Diabetes

Hypertension

COPD

Asthma
FIG 3.7
Growing inequality in rates of hospital encounters
OTHER HEALTH ISSUES, AGE-ADJUSTED RATE OF HOSPITALIZATIONS AND ED ENCOUNTERS (PER 10,000 RESIDENTS), 2012–2014 TO 2015–2017
Nearly half of all adults say youth susceptibility to drug and alcohol abuse is a toss-up

**RESIDENTS’ RATING OF LIKELIHOOD THAT YOUTH IN THEIR AREA WILL ABUSE DRUGS OR ALCOHOL, PERCENT OF RESPONDENTS BY RACE AND INCOME, FAIRFIELD COUNTY, 2018**

<table>
<thead>
<tr>
<th>TOTAL</th>
<th>NOT AT ALL LIKELY</th>
<th>NOT VERY LIKELY</th>
<th>A TOSS UP</th>
<th>VERY LIKELY</th>
<th>ALMOST CERTAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONNECTICUT</td>
<td>7%</td>
<td>21%</td>
<td>42%</td>
<td>21%</td>
<td>8%</td>
</tr>
<tr>
<td>FAIRFIELD COUNTY</td>
<td>5%</td>
<td>20%</td>
<td>46%</td>
<td>20%</td>
<td>9%</td>
</tr>
<tr>
<td>BRIDGEPORT</td>
<td>15%</td>
<td>28%</td>
<td>33%</td>
<td>15%</td>
<td>8%</td>
</tr>
<tr>
<td>GREENWICH</td>
<td>3%</td>
<td>16%</td>
<td>45%</td>
<td>26%</td>
<td>11%</td>
</tr>
<tr>
<td>NORWALK</td>
<td>3%</td>
<td>18%</td>
<td>45%</td>
<td>25%</td>
<td>8%</td>
</tr>
<tr>
<td>STAMFORD</td>
<td>2%</td>
<td>22%</td>
<td>43%</td>
<td>25%</td>
<td>8%</td>
</tr>
</tbody>
</table>

**RACE/ETHNICITY**

<table>
<thead>
<tr>
<th>WHITE</th>
<th>NOT AT ALL LIKELY</th>
<th>NOT VERY LIKELY</th>
<th>A TOSS UP</th>
<th>VERY LIKELY</th>
<th>ALMOST CERTAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>18%</td>
<td>51%</td>
<td>19%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>BLACK</td>
<td>10%</td>
<td>28%</td>
<td>30%</td>
<td>20%</td>
<td>12%</td>
</tr>
<tr>
<td>LATINO</td>
<td>11%</td>
<td>32%</td>
<td>30%</td>
<td>19%</td>
<td>8%</td>
</tr>
</tbody>
</table>

**INCOME**

<table>
<thead>
<tr>
<th>UNDER $30K</th>
<th>NOT AT ALL LIKELY</th>
<th>NOT VERY LIKELY</th>
<th>A TOSS UP</th>
<th>VERY LIKELY</th>
<th>ALMOST CERTAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>12%</td>
<td>26%</td>
<td>34%</td>
<td>17%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>$30K–$75K</td>
<td>5%</td>
<td>18%</td>
<td>49%</td>
<td>18%</td>
<td>10%</td>
</tr>
<tr>
<td>$75K–$100K</td>
<td>6%</td>
<td>19%</td>
<td>47%</td>
<td>20%</td>
<td>7%</td>
</tr>
<tr>
<td>$100K+</td>
<td>3%</td>
<td>19%</td>
<td>52%</td>
<td>21%</td>
<td>6%</td>
</tr>
</tbody>
</table>
FIG 3.9

Overdose death rates have skyrocketed over the past few years
AGE-ADJUSTED MONTHLY RATE OF DRUG OVERDOSE DEATHS PER 1 MILLION RESIDENTS, 6 MONTH MOVING AVERAGE, 2012–2018

FIG 3.10

Fentanyl’s steep rise has eclipsed decreasing overdose rates from other drugs
COUNT OF DRUG OVERDOSE DEATHS AT 6-MONTH INTERVALS BY PRESENCE OF FENTANYL, WITH PERCENTAGE OF DEATHS THAT ARE FENTANYL-RELATED, FAIRFIELD COUNTY, 2012–2018
Residents often see their race as major reason for discrimination in multiple areas of their lives

**FIG 3.11**

PERCENT OF ADULTS REPORTING PERCEIVED REASONS FOR THEIR DISCRIMINATION, OF ADULTS CITING A REASON FOR EXPERIENCES OF DISCRIMINATION, FAIRFIELD COUNTY, 2018

<table>
<thead>
<tr>
<th>Reason</th>
<th>Race</th>
<th>Education or Income Level</th>
<th>Some Other Aspect of Physical Appearance</th>
<th>Gender</th>
<th>Age</th>
<th>Health Insurance Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevented from moving</td>
<td>67%</td>
<td>23%</td>
<td>21%</td>
<td>35%</td>
<td>32%</td>
<td>23%</td>
</tr>
<tr>
<td>Unfair police stops</td>
<td>55%</td>
<td>31%</td>
<td>30%</td>
<td>31%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Workplace discrimination</td>
<td>31%</td>
<td>30%</td>
<td>28%</td>
<td>23%</td>
<td>22%</td>
<td>21%</td>
</tr>
<tr>
<td>Unequal access to healthcare</td>
<td>30%</td>
<td>29%</td>
<td>28%</td>
<td>27%</td>
<td>26%</td>
<td>25%</td>
</tr>
</tbody>
</table>

**FIG 3.12**

Black, Latino, and lower-income adults disproportionately experience negative encounters with police

**FIG 3.12**

PERCENT OF FAIRFIELD COUNTY ADULTS REPORTING UNFAIR POLICE STOPS, SEARCHES, OR OTHER MISTREATMENT AND FREQUENCY OF INCIDENTS, BY RACE AND INCOME, 2018

<table>
<thead>
<tr>
<th>Race</th>
<th>At Least One Incident</th>
<th>Multiple Incidents in Past 3 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>Black</td>
<td>20%</td>
<td>16%</td>
</tr>
<tr>
<td>Latino</td>
<td>16%</td>
<td>14%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income</th>
<th>At Least One Incident</th>
<th>Multiple Incidents in Past 3 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$30K</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>$30K–$75K</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>$75K+</td>
<td>3%</td>
<td>2%</td>
</tr>
</tbody>
</table>
As in the nation as a whole, the health of Fairfield County’s residents helps drive their high quality of life and economic vitality. Children and adults who have the resources they need to reach their full health potential face fewer barriers to success in school and in the workforce, and experience fewer health care costs. Over the long term, employers and individual households prefer to establish themselves in areas where they can benefit from this resulting prosperity. Furthermore, any healthy population is going to be stronger, more innovative, and better able to overcome adversity than one facing greater barriers to health.

In the 2018 DataHaven Community Wellbeing Survey, 63 percent of Fairfield County’s adults reported being in very good health—a figure that was above the statewide average (59 percent) and well above the most recent national rate (51 percent). This measure of self-rated health is widely used, as it is one of the most reliable ways to predict a population’s quality of life and lifespan.

Similarly, most Fairfield County residents can expect to live long and healthy lives. The average life expectancy in the county was 81.6 years from 2010 to 2015, well above the national and statewide averages of 78.7 years and 80.3 years, respectively. Life expectancy in Fairfield County is higher than that of all but 4 percent of counties nationwide.

There are many opportunities to improve the region even further by reducing or removing the barriers that prevent all residents from reaching their full health potential. The conditions that shape the health a person experiences throughout their lifespan are known as the social determinants of health.

While the U.S. is financially prosperous overall, its income-related health differences are among the highest of all middle- or high-income nations in the world. Nationally, wealthier residents (i.e., those earning $100,000 or more annually) are nearly half as likely as middle-income residents to rate their health as fair or poor, and the percent of low-income residents who reported not being able to access health care due to the cost was 16 percentage points higher than among wealthy residents. Income-related differences in health are also evident in Fairfield County, where 76 percent of adults earning $100,000 or more per year report being in very good health, compared to 41 percent of adults who earn less than $30,000 per year.

Income and employment status often drive differences in access to healthcare, the likelihood of getting preventive screenings as recommended, the affordability of life-saving medicines, and the ability to purchase other goods and services, including high-quality housing. These differences can compound over generations, as children who grow up in higher-income households are more likely to succeed in school and obtain jobs with greater potential for advancement.

Factors such as racial or gender-based discrimination, sleep deprivation, health literacy, linguistic isolation, family social history, excessive debt, and variations in the quality of the built environment—all of which can underlie income differences—also play a role in disparate health outcomes. Poor health can worsen as these factors interact with each other.

On the other hand, communities may enact policies and provide resources that can improve the health status of all people. These “protective factors” include stable and affordable housing, accessible childcare, reliable transportation options, green spaces and places to exercise, effective public health services, and policies such as paid family leave. Region-wide efforts to align policies, unify monitoring and data collection systems, and address gaps in services can help begin to create conditions in which everyone can achieve their full health potential.

Information collected during the 2019 Community Health Needs Assessment process—including data on life expectancy, adverse conditions, and self-rated health, as well as interviews and focus groups with hundreds of residents and local experts—reveal that concerns around well-being and the social determinants of health vary significantly from neighborhood to neighborhood within Fairfield County. Residents and policymakers can use these local data to further elevate the health and prosperity of Fairfield County.

**Fairfield County’s 19-Year Difference in Life Expectancy**

While Fairfield County’s average life expectancy of 81.6 years is three years longer than the national average, it masks a dramatic difference within the region. In some Bridgeport neighborhoods, life expectancy is as low as 70.4 years—nearly 19
years lower than what it is in the Westport neighborhood with the highest life expectancy in the region (89.1 years). Town-wide averages range from a maximum of 86.5 years in Weston to a minimum of 77.7 years in Bridgeport, a difference of nine years. **SEE FIG 3.1**

Differences within cities and towns are significant. Within Bridgeport, the Black Rock neighborhood’s life expectancy is above the state average of 80.3. Those of the East End, Mill Hill, East Side, Hollow, West End-West Side, and several other Bridgeport neighborhoods are at least four years lower. In Stamford’s West Side and South End, life expectancy is 78.1; in North Stamford and the Westover neighborhood, life expectancy is 7 to 8 years higher, at 86.2 and 85.4, respectively.¹⁸⁷ Large differences in life expectancy are also found within Norwalk, Danbury, Stratford, and Shelton neighborhoods.

These variations in life expectancy can be explained by differences in the rates of premature death within the population—calculated based on the number of years of potential life lost by residents before they reach their 75th birthdays (YPLL-75). In Fairfield County, cancers, fetal and infant mortality, cardiovascular diseases, opioid use disorders, suicides, motor vehicle crashes, and homicides are most prominent among the causes of premature death as measured by YPLL-75. **SEE FIG 3.2**

To illustrate the impact of the differences in the rates of premature death in Fairfield County, consider the 6.5 year difference in life expectancy between Bridgeport and Greenwich. For every 100,000 residents under the age of 75, a total of 6,928 years of potential life were lost due to all premature deaths in Bridgeport each year from 2010 to 2014, compared to 2,667 in Greenwich. Heart disease, one of the leading causes of premature death, cost 1,056 years of life per 100,000 residents in Bridgeport (based on 100 premature deaths each year, with an average age at death of 60) and 293 in Greenwich (16 premature deaths each year, with an average age at death of 65). Homicides, a cause of premature death with some of the greatest disparities by place, race, and gender, led to the loss of 526 years of life per 100,000 residents in Bridgeport (17 premature deaths from homicide each year, with an average age at death of 31), and nearly zero in Greenwich (fewer than one death per year). **SEE TABLE 3A**

**Leading Causes of Death: Cancer, Heart Disease, and Injuries**

Cancers were among the most common causes of premature death in Fairfield County from 2010 to 2014, with lung cancer by far the most common cause of cancer-related premature mortality. Premature death rates from lung cancer in each of Fairfield County’s five largest towns and cities were similar to or below the state average, and Fairfield County residents also experienced lower rates of lung cancer-related encounters at hospitals and emergency departments compared to the state.¹⁸⁸ However, rates of premature mortality due to lung cancer were relatively higher in Stratford and Shelton (371 and 301 years lost per 100,000 residents, respectively).

**TABLE 3A**

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>ALL PREMATURE DEATHS</th>
<th>ALL CANCERS</th>
<th>INFANT AND FETAL DEATH</th>
<th>HEART DISEASE</th>
<th>DRUG-RELATED DEATHS</th>
<th>LUNG CANCER (SUBSET OF CANCER)</th>
<th>SUICIDE</th>
<th>MOTOR VEHICLE ACCIDENTS</th>
<th>HOMICIDE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>5,418</td>
<td>1,284</td>
<td>828</td>
<td>802</td>
<td>451</td>
<td>297</td>
<td>287</td>
<td>259</td>
<td>158</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>4,254</td>
<td>1,047</td>
<td>832</td>
<td>624</td>
<td>294</td>
<td>210</td>
<td>212</td>
<td>189</td>
<td>137</td>
</tr>
<tr>
<td>Bridgeport</td>
<td>6,928</td>
<td>1,233</td>
<td>1,793</td>
<td>1,056</td>
<td>403</td>
<td>266</td>
<td>190</td>
<td>277</td>
<td>526</td>
</tr>
<tr>
<td>Danbury</td>
<td>4,267</td>
<td>1,018</td>
<td>954</td>
<td>680</td>
<td>401</td>
<td>227</td>
<td>211</td>
<td>197</td>
<td>64</td>
</tr>
<tr>
<td>Greenwich</td>
<td>2,687</td>
<td>802</td>
<td>497</td>
<td>293</td>
<td>200</td>
<td>139</td>
<td>210</td>
<td>119</td>
<td>4</td>
</tr>
<tr>
<td>Norwalk</td>
<td>4,718</td>
<td>1,177</td>
<td>1,039</td>
<td>770</td>
<td>220</td>
<td>242</td>
<td>188</td>
<td>251</td>
<td>117</td>
</tr>
<tr>
<td>Stamford</td>
<td>3,775</td>
<td>970</td>
<td>867</td>
<td>529</td>
<td>248</td>
<td>158</td>
<td>211</td>
<td>137</td>
<td>97</td>
</tr>
</tbody>
</table>
Premature deaths due to other types of cancer were, for the most part, not statistically different from statewide averages, but a few notable differences within the county were observed. The rates of premature death due to liver and colorectal cancers in Bridgeport (99 and 106 years lost per 100,000 residents, respectively) were twice that of Greenwich (42 and 56 years lost per 100,000 residents, respectively). Colorectal cancer was also relatively high in Stratford, with 166 years lost per 100,000 residents, higher than the state average of 108 years lost per 100,000 residents (and equivalent to about 2 excess premature deaths among Stratford residents from that type of cancer each year).

Cigarette smoking is one notable risk factor for cancer, causing an estimated 48.5 percent of all deaths from 12 major types of cancer combined. It is a contributing factor in up to 90 percent of lung cancer deaths, as smokers are 15 to 30 times more likely to die of lung cancer than non-smokers, as well as half of bladder cancer deaths. While smoking rates have fallen during the past two decades, they remain relatively high in parts of the region. Obesity, unhealthy diets, alcohol consumption, and physical inactivity are also considered to be significant risk factors for cancer.

Heart disease and other cardiovascular diseases cause one-third of US deaths overall and are also a leading cause of premature death in Fairfield County. From 2010 to 2014, Fairfield County had lower rates of premature mortality due to heart disease compared to the statewide average, but in Bridgeport, the rate was higher than that of the state.

Injury is also a leading cause of death, particularly among younger adults and children. Injuries broadly include deaths from overdoses, motor vehicle crashes, homicides, suicides, and other traumas. From 2010 to 2014, the impact of injuries on premature death rates was similar to that of cancer in most towns, with the highest impact seen in Bridgeport. Since 2014, the opioid crisis has made this category even more significant as a cause of reduced life expectancy. Topics related to the leading causes of death are discussed below in more detail.

**Healthy Birth Outcomes**

A person’s childhood is formative in almost every way, and the health of a child in the first few years of their life strongly determines how healthy they will be as an adult. This path begins while the child is still in the womb—with the health of the child’s mother.

Since the dawn of modern public health, statistics on infant outcomes have been considered one of the most effective indicators of the overall health of a community. Despite rising life expectancy overall due to medical advances, rates of infant mortality in the U.S. remain very high relative to what they are in many other advanced economies. In 2017, France, Spain, Italy, the Czech Republic, South Korea, and Hong Kong had infant mortality rates of between 2.6 and 3.3 deaths per 1,000 live births—about half the U.S. rate of 5.8 deaths per 1,000 live births that year. In 2015, the rate of infant mortality in Fairfield County was 4.8 deaths per 1,000 live births. This was below the state average of 5.6 deaths per 1,000 live births, but is still high by international standards.

County-level averages mask large disparities by race and ethnicity. In Fairfield County in 2015, the infant mortality rate of babies born to Black mothers was 11.9 per 1,000 live births, above the 7.8 per 1,000 rate for babies born to Latina mothers, and 3 times higher than the rate of 3.9 per 1,000 babies born to white mothers. The differences in these rates are similar to those observed statewide. Rates differ by geography as well: in 2015, the infant mortality rate in Bridgeport (10.7 deaths per 1,000 live births) was 3.3 times higher than it was in the remainder of Fairfield County.

The two most significant causes of infant mortality are birth defects and conditions related to preterm birth or low birthweight. Birth defects have many causes, some of which are unknown, but some of the most preventable risk factors may include a lack of folic acid, alcohol use, smoking, obesity, and uncontrolled diabetes. Similarly, the causes of premature birth and low birthweight are complex, but some are related to health inequities such as a lack of adequate prenatal care, poor nutrition, and factors that exacerbate the risk of chronic diseases. As shown elsewhere in this report, the rates at which women face these conditions diverge along socioeconomic, racial, and geographic lines.
The rate of low birthweight babies—defined as the percentage of infants born that weigh fewer than roughly five and a half pounds—has been stable in Fairfield County over the past decade. Our analysis of local area data used five-year periods ending in 2010 and 2015; during both periods, 7.5 percent of babies born in Fairfield County had low birthweights. Statewide, the low birthweight rate fell from 8.0 percent in the 2006–2010 period to 7.8 percent in the 2011–2015 period, though rates differed from town to town.  

The rate of non-adequate prenatal care—meaning that the mother went to fewer than 80 percent of the expected prenatal care visits or did not start the visits until her second trimester—rose from 20.9 percent of 2006–2010 births to 24.4 percent of 2011–2015 births, similar to the trend observed statewide during that time period. In Bridgeport and Stamford, non-adequate prenatal care rates were 33 percent in the 2011–2015 period, translating to annual averages of 700 births in Bridgeport and 600 births in Stamford with non-adequate prenatal care.

### Environmental Threats

While lead—a dangerous neurotoxin—is toxic to everyone, lead poisoning is of particular concern to children under the age of six due to rapid development in early childhood. Health problems related to lead are a constant concern in areas with older housing stock that contain lead paint. As such, regulations that aim to limit children’s exposure have been tightened. Even at relatively low levels, however, lead poisoning can cause behavioral changes and cognitive impairment in children. As of May 2013, the state’s reference level is 5 micrograms of lead per deciliter of blood (μg/dL); a child under six years old with a level higher than that is classified as lead poisoned. In 2016, there were 452 children under six years old in Fairfield County, or 2.1 percent of those tested, who had blood lead concentrations higher than the reference. More than half of these cases were among children living in Bridgeport (261 cases). That city’s rate of lead poisoning has declined slightly, from 6.5 percent of all children tested in 2013 to 4.7 percent in 2016. By comparison, the statewide rate of lead poisoning was 2.7 percent in 2016.

Children are also at increased risk of asthma exacerbations due to environmental factors, including cockroaches, mold, and traffic pollution. Childhood asthma affects children’s quality of life and performance in school, and can be fatal if left untreated. According to the State of Connecticut Department of Public Health’s School-Based Asthma Surveillance Report of 2019, levels of childhood asthma were generally lower in Fairfield County public schools than statewide between 2012 and 2014; however, there are noticeable differences from town to town. Across Connecticut, one in seven children in the public school system had asthma (about 14 percent).
Rates of childhood asthma in most Fairfield County public school districts fell below the statewide average, including in Weston, Sherman, Westport, and Wilton, where the rates were lower than 8 percent. On the other hand, Norwalk, Stamford, Bethel, and Bridgeport had the highest rates among public school districts in Fairfield County. Rates of hospital and emergency room encounters for asthma among children four years old and younger also differ from town to town across the county.\textsuperscript{200} \textit{See Table 3C}

### Table 3C

#### Asthma prevalence by public school district

<table>
<thead>
<tr>
<th>SCHOOL DISTRICT</th>
<th>ASTHMA PREVALENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weston</td>
<td>5.1%</td>
</tr>
<tr>
<td>Sherman</td>
<td>6.9%</td>
</tr>
<tr>
<td>Westport</td>
<td>7.3%</td>
</tr>
<tr>
<td>Wilton</td>
<td>7.7%</td>
</tr>
<tr>
<td>New Canaan</td>
<td>8.1%</td>
</tr>
<tr>
<td>Newtown</td>
<td>8.2%</td>
</tr>
<tr>
<td>Easton</td>
<td>8.6%</td>
</tr>
<tr>
<td>Redding</td>
<td>8.8%</td>
</tr>
<tr>
<td>Greenwich</td>
<td>8.9%</td>
</tr>
<tr>
<td>Darien</td>
<td>10.1%</td>
</tr>
<tr>
<td>Trumbull</td>
<td>10.1%</td>
</tr>
<tr>
<td>Brookfield</td>
<td>10.2%</td>
</tr>
<tr>
<td>Fairfield</td>
<td>10.4%</td>
</tr>
<tr>
<td>Regional District 9</td>
<td>11.3%</td>
</tr>
<tr>
<td>New Fairfield</td>
<td>11.4%</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>12.2%</td>
</tr>
<tr>
<td>Stratford</td>
<td>12.2%</td>
</tr>
<tr>
<td>Shelton</td>
<td>12.4%</td>
</tr>
<tr>
<td>Monroe</td>
<td>12.6%</td>
</tr>
<tr>
<td>Ridgefield</td>
<td>12.7%</td>
</tr>
<tr>
<td>Danbury</td>
<td>13.0%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>14.3%</td>
</tr>
<tr>
<td>Norwalk</td>
<td>14.4%</td>
</tr>
<tr>
<td>Stamford</td>
<td>15.4%</td>
</tr>
<tr>
<td>Bethel</td>
<td>15.8%</td>
</tr>
<tr>
<td>Bridgeport</td>
<td>15.9%</td>
</tr>
</tbody>
</table>

Inadequate Access to Health and Dental Care

Health-related challenges begin with access to healthcare. In 2018, the percentage of uninsured adults in Fairfield County—6 percent—was about the same as that of Connecticut overall (5 percent),\textsuperscript{202} yet there are notable disparities. While only 3 percent of Fairfield County’s white population lacks insurance, the numbers jump to 13 percent for its Black population, 14 percent for Latinos, and 15 percent of adults who earn less than $30,000 per year.\textsuperscript{202}

Having health insurance, however, does not guarantee timely or high-quality medical care. Reasons for foregoing medical care are complex and overlapping, and lower-income residents may disproportionately be faced with the challenge of pursuing medical care in lieu of other basic necessities. In Fairfield County, 13 percent of adults—and about a quarter of those under age 35—lack a medical home, meaning that they do not have any person or place that they consider to be their personal doctor, who they see on an ongoing basis.\textsuperscript{203}

In 2018, 22 percent of Fairfield County adults reported having postponed necessary medical care within the past year, and 9 percent reported having failed to get care altogether.\textsuperscript{204} They cited myriad reasons. More than half of survey respondents who missed or postponed care cited having been too busy with work or other commitments (61 percent), fearing the cost would be too high (54 percent), or not feeling their issues were serious enough (52 percent). Scheduling problems can disrupt care: 31 percent of adults who missed or postponed care could not get an appointment soon enough, and 26 percent could not get to a provider during their open hours. Insurance not paying for treatment was an issue for 32 percent of adults missing or delaying care, and insurance not being accepted was an issue for 20 percent. Additionally, 24 percent of those with disrupted care cited their family caregiving obligations.\textsuperscript{205} \textit{See Table 3E}

Lacking affordable medical care may play a role in residents relying on the emergency room. In 2018, 23 percent of Fairfield County adults reported receiving care in a hospital emergency room at least once.\textsuperscript{206} While only 3 percent of adults...
in Fairfield County did so three or more times during the past year, this figure was more than double among those earning less than $30,000 per year. Lack of transportation, food insecurity, and unstable housing also contribute to frequent use of emergency rooms. In Fairfield County, residents lacking health insurance were about as likely as those with insurance to be frequent users of an emergency room last year, but residents who experienced food or transportation insecurity were substantially more likely to have visited an emergency room than other residents.

Affordability is a challenge for many residents. In 2018, 15 percent of Fairfield County residents earning less than $30,000 per year did not get prescription medicines they needed because they could not afford the medication, compared to 8 percent of residents overall, and 5 percent of residents earning over $100,000 per year. Additionally, 6 percent of adults in Fairfield County said that they altered the way they take their prescription medicines last year because they could not afford to get more of them.

Dental care is also important because oral health affects many other areas of life, including overall well-being and performance at school and in work. Good oral health helps prevent infections, heart disease, stroke, adverse birth outcomes, and other serious conditions, and has other impacts on quality of life. According to the CDC, over 40 percent of US adults experience mouth pain each year, causing many people to miss work for emergency dental care. In Connecticut, about 16 percent of elementary school-age children have untreated tooth decay.

In 2018, 23 percent of Fairfield County adults said they had not been to the dentist in the past year. This rate was substantially higher among younger adults (30 percent), Black and Latino residents (36 percent and 29 percent respectively), and residents earning less than $30,000 per year (39 percent).

Emergency room encounters related to preventable dental conditions are considered an incidence proxy for the lack of timely and adequate oral health care. Seeking acute care at a hospital for a severe tooth infection, for example, may not address the underlying need for preventive dental care. Overall, from 2015 to 2017, Fairfield County had lower rates of emergency room encounters and hospitalizations for preventable dental conditions than the state average. Bridgeport’s rates were higher, especially in the 0–19 age group. While the number of emergency room and hospital encounters for this issue has declined in most towns since 2014, there was a significant disparity by town.

<table>
<thead>
<tr>
<th>Share of Adults</th>
<th>Fairfield County, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO HEALTH INSURANCE</td>
<td>DENTAL CARE</td>
</tr>
<tr>
<td>All adults in the region</td>
<td>6%</td>
</tr>
<tr>
<td>Adults who did not receive care in ER last year</td>
<td>4%</td>
</tr>
<tr>
<td>Adults who used ER 1–2x last year</td>
<td>8%</td>
</tr>
<tr>
<td>Adults who used ER 3x+ last year</td>
<td>8%</td>
</tr>
</tbody>
</table>

Relative risk: Frequent users vs. non-users of ER

<table>
<thead>
<tr>
<th>Relative Risk</th>
<th>Adult Use of ER in Past Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4x</td>
<td>Frequent use of ER</td>
</tr>
<tr>
<td>3.0x</td>
<td>1–2x use of ER</td>
</tr>
<tr>
<td>3.9x</td>
<td>3x+ use of ER</td>
</tr>
<tr>
<td>4.0x</td>
<td>Stayed home due to lack of transport</td>
</tr>
<tr>
<td>9.4x</td>
<td>Threatened with utility shutoff</td>
</tr>
<tr>
<td>3.5x</td>
<td>Physically attacked or threatened</td>
</tr>
<tr>
<td>4.2x</td>
<td>Physical attack or threat</td>
</tr>
</tbody>
</table>

SEE TABLE 3D
Chapter 3  Creating a Healthier Region

Experiences of Discrimination

In 2018, the DataHaven Community Wellbeing Survey included for the first time a sequence of questions about experiences of discrimination (EOD), drawn from a body of scientific work pioneered largely by David Williams of the Harvard School of Public Health. Discrimination is a social stressor that impacts mental and physical health both directly and indirectly, especially within the context of structural, institutional, and cultural racism. In Fairfield County, some adults reported that discrimination affected their ability to get the health care they needed. In 2018, 9 percent of all adults in the region said that, when seeking health care, they had been treated with less respect, or received worse care than others. For these adults, race, health insurance status, and gender were the most commonly reported reasons for discrimination. Most of these adults experienced this issue repeatedly: 57 percent said such incidents had happened multiple times in the past three years.

LGBTQ individuals, as a group, have a higher risk for a variety of conditions, including sexually-transmitted diseases, poor mental health, homelessness, harassment, violence, and social isolation. They also face stigmas, lack of cultural competency in healthcare providers, and exclusionary insurance policies. Transgender people in particular often have difficulty simply accessing care: statewide, only 57 percent of self-identifying transgender participants in the DataHaven Community Wellbeing Survey reported that their primary care provider can provide them with trans-inclusive services, and 44 percent said they had forgone medical care in the past year for fear of harassment or mistreatment. These findings match research done nationally by organizations seeking to understand the concrete ways discrimination and lack of access to resources impair the health of LGBTQ people.

In addition to asking about health care discrimination, the 2018 survey probed residents’ experiences with negative interactions with and unfair stops by police, differential treatment while searching for housing, and unfair treatment when seeking employment or a promotion. Combining the survey items into an experiences-of-discrimination scale suggests a link between discrimination and poor health in Fairfield County. In a future report, we will complete a more rigorous statistical analysis of these data.

### TABLE 3E

<table>
<thead>
<tr>
<th>Barriers to healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHARE OF ADULTS, FAIRFIELD COUNTY, 2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>DIDN’T GET CARE</th>
<th>POSTPONED CARE</th>
<th>NO MEDICAL HOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>9%</td>
<td>23%</td>
<td>12%</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>9%</td>
<td>22%</td>
<td>13%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BY DEMOGRAPHIC WITHIN FAIRFIELD COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Age 18–34</td>
</tr>
<tr>
<td>Age 35–49</td>
</tr>
<tr>
<td>Age 50–64</td>
</tr>
<tr>
<td>Age 65+</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>Black</td>
</tr>
<tr>
<td>Latino</td>
</tr>
<tr>
<td>Under $30K</td>
</tr>
<tr>
<td>$30K-$100K</td>
</tr>
<tr>
<td>$100K+</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BY GEOGRAPHY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgeport</td>
</tr>
<tr>
<td>Danbury</td>
</tr>
<tr>
<td>Fairfield</td>
</tr>
<tr>
<td>Greenwich</td>
</tr>
<tr>
<td>Norwalk</td>
</tr>
<tr>
<td>Stamford</td>
</tr>
<tr>
<td>Stratford</td>
</tr>
</tbody>
</table>

SEE FIG 3.11, 3.12 / SEE TABLE 3F
Adverse Childhood Experiences

According to the Connecticut Department of Public Health, adverse childhood experiences (ACEs) can affect a child’s social, emotional, and cognitive development; their adoption of risky behavior later in life; and their chances of disease and even early death. Three of five adults across the state reported having had at least one ACE—ranging from an incarcerated household member or sexual abuse to the more prevalent household drinking problems, divorced parents, and emotional abuse. Two-thirds of those who had at least one ACE had multiple ACEs.221

In the 2018 DataHaven Community Wellbeing Survey, Fairfield County residents expressed general concerns for youth living in their neighborhoods. Among all the adults in the region, 26 percent thought it was likely that youth would abuse drugs or alcohol, 10 percent thought it was likely that youth would join a gang, and 10 percent felt the same about the chances of youth getting arrested for felonies.222 These data varied by town and neighborhood, however. SEE FIG 2.25, 3.8

Nutrition, Physical Activity, and Substance Use

Attaining and maintaining good health requires not only access to high quality medical services, but also engagement in daily behaviors that promote health. However, broader issues of income, education, employment, and racial and gender discrimination can pose obstacles to living a healthy lifestyle. Being able to afford nutritious food costs money. Taking full advantage of preventive screenings through regular checkups, to say nothing of exercising regularly, takes time. While tobacco use, poor diets, lack of exercise, and substance use—modifiable behavioral risk factors that are sometimes referred to as the “actual” causes of death—are critical to understand, they should be considered in the context of a growing body of literature that documents their connections to poverty, inequality, and other social issues.

Statistical modeling has revealed the extent to which body weight is influenced by neighborhood factors such as access to healthy foods and walking spaces. Social context can also influence health-related behaviors: for example, if you live in a neighborhood where smoking is prevalent, you are more likely to take up smoking yourself. Or, if recreational sports are important to the fabric of your community, you may be more active. The effects of these ecological drivers on children and adolescents can impact the development of obesity later in life.223 Consequently, there is a need to intervene on these pervasive drivers of health risks that also contribute to cancer, depression, diabetes, heart disease, stroke, injury, and other conditions that can reduce life expectancy and quality of life.

In Connecticut, 29 percent of adults have a body mass index that classifies them as obese. Connecticut’s obesity rate has increased dramatically since 1990, when it was estimated to be only 10 percent.224 Between 2015 and 2018, the prevalence of obesity among Fairfield County adults rose from 22 percent to 27 percent—in line

<p>| TABLE 3F | Experiences of discrimination |
| SHARE OF ADULTS HAVING EVER EXPERIENCED DISCRIMINATION, FAIRFIELD COUNTY, 2018 |</p>
<table>
<thead>
<tr>
<th>LOCATION</th>
<th>WORKPLACE</th>
<th>POLICE STOPS</th>
<th>PREVENTED FROM MOVING</th>
<th>RECEIVED POOR SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>27%</td>
<td>11%</td>
<td>4%</td>
<td>10%</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>29%</td>
<td>10%</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td><strong>BY DEMOGRAPHIC WITHIN FAIRFIELD COUNTY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>27%</td>
<td>14%</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Female</td>
<td>29%</td>
<td>5%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Age 18–34</td>
<td>19%</td>
<td>12%</td>
<td>4%</td>
<td>11%</td>
</tr>
<tr>
<td>Age 35–49</td>
<td>32%</td>
<td>11%</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>Age 50–64</td>
<td>37%</td>
<td>9%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Age 65+</td>
<td>23%</td>
<td>5%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>White</td>
<td>26%</td>
<td>7%</td>
<td>2% N/A</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>31%</td>
<td>20%</td>
<td>12% N/A</td>
<td></td>
</tr>
<tr>
<td>Latino</td>
<td>26%</td>
<td>16%</td>
<td>8% N/A</td>
<td></td>
</tr>
<tr>
<td>Under $30K</td>
<td>38%</td>
<td>16%</td>
<td>8% N/A</td>
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</tr>
<tr>
<td>$30K-$75K</td>
<td>28%</td>
<td>10%</td>
<td>6% N/A</td>
<td></td>
</tr>
<tr>
<td>$75K+</td>
<td>27%</td>
<td>7%</td>
<td>3% N/A</td>
<td></td>
</tr>
<tr>
<td><strong>BY GEOGRAPHY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bridgeport</td>
<td>31%</td>
<td>18%</td>
<td>10% N/A</td>
<td></td>
</tr>
<tr>
<td>Danbury</td>
<td>26%</td>
<td>7%</td>
<td>3% N/A</td>
<td></td>
</tr>
<tr>
<td>Fairfield</td>
<td>24%</td>
<td>7%</td>
<td>2% N/A</td>
<td></td>
</tr>
<tr>
<td>Greenwich</td>
<td>22%</td>
<td>6%</td>
<td>4% N/A</td>
<td></td>
</tr>
<tr>
<td>Norwalk</td>
<td>27%</td>
<td>11%</td>
<td>5% N/A</td>
<td></td>
</tr>
<tr>
<td>Stamford</td>
<td>26%</td>
<td>10%</td>
<td>5% 6%</td>
<td></td>
</tr>
<tr>
<td>Stratford</td>
<td>31%</td>
<td>12%</td>
<td>2% N/A</td>
<td></td>
</tr>
</tbody>
</table>
Chapter 3   Creating a Healthier Region

with the trend statewide, where obesity rates rose from 26 percent in 2015 to 29 percent in 2018 according to the DataHaven Community Wellbeing Survey, and from 25 percent in 2015 to 27 percent in 2017 according to the Behavioral Risk Factor Surveillance System. Additionally, while 59 percent of Fairfield County adults report exercising at least three days per week, the share who report that they did not get exercise even once during a typical week increased slightly, from 16 percent to 19 percent, between 2015 and 2018. Childhood obesity is also a major concern, though Connecticut’s estimated 11.9 percent obesity rate among youth ages 10 to 17 is lower than the U.S. rate of 15.8 percent. Local, state, and national rates are calculated based on self-reported or parent- and caregiver-reported height and weight, and likely underestimate the actual obesity rate by a few percentage points.

Despite major reductions in cigarette smoking over the past several decades, there is still room for significant progress. The connection between smoking and cancer is discussed above, and smoking and secondhand smoke have been linked to many other health issues including infant health, asthma, and stroke. Fewer adults smoke cigarettes in Fairfield County (12 percent) than in the state overall (14 percent). The region’s smoking rate remained steady between 2015 and 2018, but is still relatively high among residents earning less

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>VERY GOOD SELF-RATED HEALTH</th>
<th>ANXIETY</th>
<th>DIABETES</th>
<th>CURRENT ASTHMA</th>
<th>OBESITY</th>
<th>HAS HEALTH INSURANCE</th>
<th>DENTAL VISIT PAST YR</th>
<th>DEPRESSION</th>
<th>SMOKING</th>
<th>FOOD INSECURITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>59%</td>
<td>12%</td>
<td>10%</td>
<td>9%</td>
<td>27%</td>
<td>95%</td>
<td>74%</td>
<td>9%</td>
<td>14%</td>
<td>13%</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>63%</td>
<td>12%</td>
<td>9%</td>
<td>27%</td>
<td>94%</td>
<td>78%</td>
<td>8%</td>
<td>12%</td>
<td>11%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BY DEMOGRAPHIC WITHIN FAIRFIELD COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Age 18–34</td>
</tr>
<tr>
<td>Age 35–49</td>
</tr>
<tr>
<td>Age 50–64</td>
</tr>
<tr>
<td>Age 65+</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>Black</td>
</tr>
<tr>
<td>Latino</td>
</tr>
<tr>
<td>Under $30K</td>
</tr>
<tr>
<td>$30K–$100K</td>
</tr>
<tr>
<td>$100K+</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BY GEOGRAPHY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgeport</td>
</tr>
<tr>
<td>Danbury</td>
</tr>
<tr>
<td>Fairfield</td>
</tr>
<tr>
<td>Greenwich</td>
</tr>
<tr>
<td>Norwalk</td>
</tr>
<tr>
<td>Stamford</td>
</tr>
<tr>
<td>Stratford</td>
</tr>
</tbody>
</table>
than $30,000 per year (22 percent) and within certain towns such as Bridgeport (21 percent).\textsuperscript{229} Vaping is becoming more common, particularly among young adults. In 2018, 7 percent of adults in Fairfield County reported using e-cigarettes or vaping more than once a month, close to the statewide rate of 8 percent; among adults age 18 to 34, 37 percent had tried e-cigarettes as of 2018, and 18 percent were currently using them.\textsuperscript{229} See Table 3G

Some in the region struggle with alcohol, marijuana, and opioid use disorders. In 2018, 5 percent of adults reported drinking heavily (more than four drinks in one sitting for women or five drinks for men) at least six times in the past month. Six percent of adults—including 14 percent of those ages 18 to 34—reported using marijuana more than 10 times during any given month.\textsuperscript{231} Drinking too much can dramatically change mood and behavior, and long-term alcohol use can damage organs including the heart and liver, increasing the risk of cancers and other diseases.\textsuperscript{232} Like alcohol, marijuana is associated with depression and anxiety, though it is not yet known whether this is a causal relationship.\textsuperscript{233} The opioid crisis, which has connections to the use of other substances such as alcohol, is covered below.

**The Opioid Crisis**

The opioid crisis has made headlines across the country, with some of the highest overdose death rates occurring in the northeast U.S. In 2016, Connecticut’s drug overdose death rate ranked 11th among all states in the country, and several nearby states—including New Hampshire, Massachusetts, Rhode Island, and Maine—fell within the top 10.\textsuperscript{234} Thousands of Americans die of opioid overdoses each month, including an average of 67 Connecticut residents per month from 2015 to 2018. Between 2015 and 2018, Fairfield County averaged 15 drug overdose deaths per 100,000 residents per year, below the state’s rate of 24.2 per 100,000; filtered for just opiate- and opioid-related deaths, these rates become 13.9 and 22.8, respectively.\textsuperscript{235, 236} See Table 3H, 3I

The full effect of the opioid crisis is not captured in the comprehensive 2010–2014 premature mortality data that we used toward the beginning of this chapter. Over just a few years, the number of deaths in Fairfield County from drug overdoses doubled, from 74 deaths in 2014 to 157 deaths in 2016; this increase was driven mostly by a steep rise in opiate- and opioid-related deaths.\textsuperscript{237} The weight of overdose deaths comes not only from sheer numbers, but also from the epidemic’s reach: the median age for fatal overdoses of Fairfield County residents is 41, about half the county’s average life expectancy.\textsuperscript{238} When ranking major causes of premature death by years of potential life lost prior to age 75 (YPLL-75) in Fairfield County, we estimate that deaths from opioid-related overdoses between 2015 and 2018 would rank 5th highest after cancer, infant and fetal mortality, heart disease, and accidents.\textsuperscript{238} See Fig 3.9, 3.10

The Centers for Disease Control and Prevention characterizes the epidemic as multilayered with three distinct waves.\textsuperscript{240} Prescription opioids were the main drivers of the first wave (1990s); heroin was largely responsible for the rise in 2010; and synthetic opioids, such as fentanyl, have driven the current wave, which began in 2013.\textsuperscript{241}

These patterns hold true in Fairfield County, where the death rate from drug overdoses has mirrored the upward trend seen throughout the state and country—though between 2012 and 2018 it stayed well below the statewide average. Similar also is the skyrocketing prominence of fentanyl; the

---

**Table 3H**

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>ANY SUBSTANCE COUNT</th>
<th>ANY SUBSTANCE RATE</th>
<th>OPIATE/OPIOID COUNT</th>
<th>OPIATE/OPIOID RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>3,423</td>
<td>24.2</td>
<td>3,202</td>
<td>22.8</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>557</td>
<td>15.0</td>
<td>512</td>
<td>13.9</td>
</tr>
</tbody>
</table>

**Table 3I**

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>WHITE COUNT</th>
<th>WHITE RATE</th>
<th>BLACK COUNT</th>
<th>BLACK RATE</th>
<th>LATINO COUNT</th>
<th>LATINO RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>2,673</td>
<td>29.5</td>
<td>296</td>
<td>18.9</td>
<td>393</td>
<td>19.1</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>396</td>
<td>18.8</td>
<td>64</td>
<td>14.1</td>
<td>83</td>
<td>11.5</td>
</tr>
</tbody>
</table>
substance was detected in 17 out of Fairfield County’s 130 overdose deaths (13 percent) in 2012 and 2013, but in 199 of the 294 deaths (68 percent) in 2017 and 2018.242

As is the case elsewhere, men make up much larger shares of Fairfield County drug overdose deaths than women: since 2012, women have never accounted for more than a third of the county’s overdose deaths in a given year. Rates for white residents are higher as well: between 2015 and 2018, white residents’ age-adjusted overdose death rate was 18.8 per 100,000 residents per year, higher than Black residents’ rate of 14.1 or Latinos’ 11.5.243

For every person who dies of an opioid overdose, many more seek treatment, often multiple times. Between the 2014 and 2018 fiscal years, Fairfield County residents were admitted to opioid treatment programs a total of 24,302 times, averaging 4,860 admissions per year, or 513 admissions per 100,000 residents per year. Bridgeport, Danbury, Shelton, Stratford, Bethel, and Brookfield had rates above the county average; the rate in Bridgeport was more than twice as high, at 1,359 admissions per 100,000 residents per year. The majority of these admissions were to programs funded by the state Department of Mental Health and Addiction Services. Though harder to track, people often are admitted to programs multiple times within one year.244

Many residents also seek or receive care for substance use disorders at area hospitals and emergency rooms. Compared to Connecticut as a whole, Fairfield County has lower rates of hospital and emergency room encounters for substance use, a category that includes diagnoses related to use of opioids and other drugs. However, Bridgeport residents experience much higher rates of hospital and emergency room encounters than residents of most Other FC towns, and several towns saw considerable increases in these rates between 2012–2014 and 2015–2017, including Stratford, Danbury, and Brookfield. Across the state, there is a greater burden of drug-related hospital encounters on males than females, as well as on adults ages 20 to 64.245

The reach of the opioid crisis goes beyond just people who have struggled with addiction themselves. In the 2018 DataHaven Community Wellbeing Survey, one in every four adults in Fairfield County reported knowing someone who has struggled with abuse of or addiction to prescription painkillers, heroin, or other opiates in the past three years. Out of those respondents, 37 percent cited a family member struggling with painkillers and opioids, 33 percent cited a close friend, 54 percent cited an acquaintance, and 6 percent said they themselves were dealing with this issue; these numbers include respondents who knew multiple people dealing with addiction.246

One in five Fairfield County adults reported knowing at least one person who died of an opioid overdose. Twenty-two percent of these adults lost a family member to an opioid overdose, 30 percent lost a close friend, and 66 percent lost an acquaintance; again, respondents might have referred to more than one person.247

A 2019 New England Public Policy Center report found that counties with the lowest rates of opioid prescribing are also those with the lowest rates of fatal overdoses.248 Additionally, some research has suggested a relationship between opioid misuse and frequent drinking249 and tobacco use.250 The frequent use of these substances has been associated with higher pain intensity, which may increase the person’s likelihood of developing an opioid dependency. In particular, many studies of alcohol use disorders have established that heavy drinking is a strong predictor of opioid misuse.251 In addition to improving our understanding of addiction and expanding access to prevention and treatment services, strategies to address the opioid crisis may include the promotion of overdose-reversing drugs such as naloxone, improved prescription monitoring, evidence-based pain management, and public education.
Early Onset of Chronic Diseases
According to the U.S. Centers for Disease Control and Prevention (CDC), six out of every ten adults in the U.S. live with a chronic disease, and four out of every ten have two or more concomitant chronic conditions. These conditions include heart disease, cancer, chronic lung disease, chronic kidney disease, stroke, Alzheimer’s, and diabetes. Ninety percent of healthcare expenditures go towards the treatment of chronic and mental health conditions; in 2010, chronic diseases comprised seven of the top ten causes of mortality in the U.S., accounting for over 65 percent of all deaths.

According to the Hospitalization Cost and Utilization Project (HCUP), from 2006 to 2011, emergency department visits for common chronic conditions increased significantly among adults, with the greatest increase observed in adults 85 and over. Disproportionately more clinical visits to physicians’ offices and hospitals occur for patients who are in the oldest age groups and those who are more prone to experiencing chronic diseases.

While chronic diseases are a relatively common experience for older adults, they may develop much earlier in life, sometimes even in childhood. As described above, the data on Fairfield County’s neighborhood life expectancy and premature mortality reveal large disparities in health and well-being within the region. However, mortality data only tell us about people who die; they do not provide a complete picture of the impact of chronic diseases on people’s quality of life throughout youth and middle age. Our analyses of the data collected through the DataHaven Community Wellbeing Survey and of the records of residents’ visits to statewide hospitals and emergency rooms over the past six years create a clearer picture of the full burden of these conditions.

In Fairfield County, chronic diseases such as hypertension, heart disease, diabetes, and chronic lung diseases such as chronic obstructive pulmonary disease (COPD) have consistently ranked among the most common causes for hospitalization and emergency room encounters. Hospital encounter rates in Fairfield County due to these conditions were lower than the statewide averages from 2015 to 2017, and often displayed relatively smaller increases from the 2012–2014 period. However, the region’s towns with a greater burden of chronic disease often saw larger increases in their per capita hospital encounter rates over this six-year period than healthier towns. This suggests that health-related inequalities, as measured by the impact that these conditions have on residents of different towns and demographic groups, may have increased in recent years.

Examining data from hospitals and other sources by age, gender, and race/ethnicity reveals disparities in the extent to which chronic diseases develop early in populations that face greater levels of economic and social adversity. For cardiovascular disease, disparities between Black and white adults are particularly pronounced. A 2010 study found that, nationally, 28 percent of cardiovascular disease deaths among Black adults occurred before age 65, compared to just 13 percent of white adults. Consistent with statewide and national averages, in Fairfield County the greatest burden of hospitalization and emergency department visits from 2015 to 2017 due to heart disease fell on older age groups. However, there were some exceptions to this rule that are likely driven by racial and ethnic disparities. Residents in the 45–74 age range in Bridgeport also experienced particularly high rates of hospital encounters related to heart disease. Compared to the trends observed in Connecticut as a whole, Bridgeport experienced considerable increases in hospital visits for lung disease, diabetes, and asthma, mainly driven by steadily higher rates of these encounters among its residents aged 45 to 74. While available hospital encounter data has limitations when it comes to fully capturing the race/ethnicity of patients, our analysis suggests that middle-aged Black adults are several times more likely than whites of the same age to be hospitalized for cardiovascular disease.

Some trends appear more positive. Compared to Connecticut as a whole, Stamford experienced higher rates of hospital encounters related to heart disease. Compared to the trends observed in Connecticut as a whole, Bridgeport experienced considerably increases in hospital visits for lung disease, diabetes, and asthma, mainly driven by steadily higher rates of these encounters among its residents aged 45 to 74. While available hospital encounter data has limitations when it comes to fully capturing the race/ethnicity of patients, our analysis suggests that middle-aged Black adults are several times more likely than whites of the same age to be hospitalized for cardiovascular disease.

Some trends appear more positive. Compared to Connecticut as a whole, Stamford experienced higher rates of hospital encounters related to hypertension and diabetes during 2012–2014, but lower rates in 2015–2017. Norwalk experienced similar trends regarding heart disease encounters. If sustained over time, these trends show how disease prevention efforts may be promoting health.
### Selected hospital encounters and hospital encounters by age

**RATES OF HOSPITALIZATIONS AND ED VISITS PER 10,000 RESIDENTS PER YEAR, 2015–2017, FAIRFIELD COUNTY**

#### AGE-ADJUSTED RATES OF HOSPITALIZATIONS AND ED VISITS FOR ALL RESIDENTS

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>DEPRESSIVE DISORDER</th>
<th>DIABETES</th>
<th>FALLS</th>
<th>HEART DISEASE</th>
<th>HYPERTENSION</th>
<th>MENTAL DISORDER</th>
<th>SUBSTANCE ABUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>326</td>
<td>639</td>
<td>328</td>
<td>240</td>
<td>1,261</td>
<td>694</td>
<td>178</td>
</tr>
<tr>
<td>FC</td>
<td>203</td>
<td>498</td>
<td>313</td>
<td>206</td>
<td>998</td>
<td>467</td>
<td>113</td>
</tr>
<tr>
<td>Bridgeport</td>
<td>288</td>
<td>1,145</td>
<td>477</td>
<td>367</td>
<td>1,678</td>
<td>743</td>
<td>270</td>
</tr>
<tr>
<td>Danbury</td>
<td>305</td>
<td>641</td>
<td>366</td>
<td>215</td>
<td>1,278</td>
<td>599</td>
<td>118</td>
</tr>
<tr>
<td>Fairfield</td>
<td>156</td>
<td>225</td>
<td>226</td>
<td>155</td>
<td>615</td>
<td>330</td>
<td>65</td>
</tr>
<tr>
<td>Greenwich</td>
<td>160</td>
<td>310</td>
<td>325</td>
<td>149</td>
<td>838</td>
<td>341</td>
<td>51</td>
</tr>
<tr>
<td>Norwalk</td>
<td>141</td>
<td>507</td>
<td>346</td>
<td>231</td>
<td>987</td>
<td>440</td>
<td>107</td>
</tr>
<tr>
<td>Stamford</td>
<td>188</td>
<td>607</td>
<td>278</td>
<td>213</td>
<td>1,155</td>
<td>442</td>
<td>98</td>
</tr>
<tr>
<td>Stratford</td>
<td>233</td>
<td>550</td>
<td>310</td>
<td>252</td>
<td>1,126</td>
<td>513</td>
<td>126</td>
</tr>
<tr>
<td>6 wealthiest FC towns</td>
<td>123</td>
<td>174</td>
<td>224</td>
<td>120</td>
<td>566</td>
<td>300</td>
<td>43</td>
</tr>
<tr>
<td>Other FC towns</td>
<td>203</td>
<td>352</td>
<td>263</td>
<td>186</td>
<td>824</td>
<td>426</td>
<td>87</td>
</tr>
</tbody>
</table>

#### AGE-SPECIFIC RATES OF HOSPITALIZATIONS AND ED VISITS FOR DIABETES AND HEART DISEASE

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>DIABETES</th>
<th>HEART DISEASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
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<td>908</td>
</tr>
<tr>
<td>FC</td>
<td>153</td>
<td>653</td>
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<tr>
<td>Bridgeport</td>
<td>376</td>
<td>1,899</td>
</tr>
<tr>
<td>Danbury</td>
<td>138</td>
<td>818</td>
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<tr>
<td>Fairfield</td>
<td>43</td>
<td>245</td>
</tr>
<tr>
<td>Greenwich</td>
<td>80</td>
<td>343</td>
</tr>
<tr>
<td>Norwalk</td>
<td>811</td>
<td>662</td>
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<tr>
<td>Stamford</td>
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<td>840</td>
</tr>
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<td>Stratford</td>
<td>179</td>
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<tr>
<td>6 wealthiest FC towns</td>
<td>26</td>
<td>142</td>
</tr>
<tr>
<td>Other FC towns</td>
<td>85</td>
<td>384</td>
</tr>
</tbody>
</table>

Note: See Figures 3.4 and 3.5 for additional age- and gender-specific rates
Mental Health

As described in the introduction to this report, reducing the frequency at which residents experience depression or other mental health disorders represents one of the greatest opportunities to improve the overall well-being of Fairfield County. Depression may be rooted within many different social, medical, and environmental factors, including substance use, traumatic experiences, and social isolation. In addition, not only is depression underdiagnosed among racial and ethnic minorities, including Black, Latino, and Asian Americans, but these groups are also less likely to have access to and receive adequate care for depression.261 Depression is a risk factor or cause of many other health problems, including chronic pain, insomnia, and conditions that are exacerbated when patients have difficulty accessing medical care or taking medications according to the instructions of health care providers.262

In the 2018 DataHaven Community Wellbeing Survey, 8 percent of Fairfield County adults reported feeling down, depressed, or hopeless more than half of the days during the past two weeks, and 12 percent reported being anxious most or all of the time—rates that were similar to the statewide average and have changed little since our 2015 survey. Residents with low incomes experienced higher rates of anxiety and depression: among adults earning less than $30,000 per year, 23 percent reported feeling depressed more than half of the days during the past two weeks, and 21 percent reported being bothered by anxiety all or most of the time. Only 3 percent of adults earning over $100,000 per year reported such levels of depression, and 9 percent reported such persistent anxiety.263

Depression and other mental health disorders are significant factors in Fairfield County residents’ decisions to seek or receive care within the state’s hospitals and emergency rooms. Statewide and throughout the region, hospital encounters for mental disorders rose considerably between the 2012–2014 period and the 2015–2017 period, and also increased for depressive disorders. Fairfield County’s rate of hospital encounters for depressive disorders was generally lower than the state average.264 Furthermore, a difference was also observed by gender: in Fairfield County, females experienced higher rates than males across all age groups for depressive and mental disorders. In both the state and Fairfield County, the per capita rates of hospital encounters for suicide and self-harm are highest among the female 0–19 age group—generally two to three times higher than they are for males of the same age group.265 Recent studies have noted a doubling of the suicide rate among women aged 15 to 19 since 2007 in the U.S., compared to a 31 percent increase among men in that same age group.266 On the other hand, young men tend to experience slightly higher rates of hospitalization and injury from homicide and assault compared to women of the same age.267

The above data point to a significant challenge around mental health and well-being in Fairfield County. A series of conversations about mental health held by Fairfield County’s Community Foundation identified barriers to reducing the mental health burden, including low awareness and knowledge, stigma, limited access to care, and the unique needs specific to a variety of sub-groups. Progress has been made in reducing a number of these barriers in recent years across Fairfield County. One example of this is the work of the Newtown-Sandy Hook Community Foundation, Inc., which transitioned its financial support post-Sandy Hook from an immediate focus on living expenses to longer-term support for ongoing psychological healing. Importantly, this longer-term support has not only been tailored to individuals’ needs but has also focused on strengthening ties across and throughout the community as a whole.268, 269

Injuries

Intentional and unintentional injuries, including drug overdoses (covered above), falls, assaults, and suicide, are the leading causes of death in the U.S. for people between the ages of 1 and 44. They also have major consequences on quality of life, as there are 13 hospitalizations and 129 emergency room encounters for every death.270 Injuries—as well as the physical and mental tolls they can take—can have a negative impact on productivity and quality of life. Data on hospital and emergency room encounters help illustrate the extent of this burden within Fairfield County. See Fig 3.3, 3.4, 3.5, 3.6, 3.7

Falls are the most common cause of non-fatal injury in the U.S. and within Fairfield County. Rates of hospital and emergency room encounters are particularly high among older seniors. According to the CDC, one in four adults ages 65 and up will fall each year, and 20 percent of falls will induce a serious injury such as a hip fracture or traumatic
brain injury, which can be debilitating and sometimes life-threatening. Extensive and costly treatment may often be required, with greater burden on older adults for whom costs average $30,000 per fall, making them among the 20 most expensive medical conditions. Fall prevention strategies, physical rehabilitation, and close assessments of risk factors offer effective mechanisms for reducing the burden of these types of encounters. As such, fall encounters offer a lens into access to preventive care, safe housing, and ambulatory processes among older populations. Within Fairfield County, residents in Bridgeport, Danbury, and Norwalk experience higher rates of hospital encounters due to falls. It is important to note that Fairfield County has several aging-in-place nonprofits which help seniors affordably retrofit their homes.

The burden of injuries related to motor vehicle crashes is also considerable. The World Health Organization (WHO) reports that in 2013, among high-income countries, the U.S. experienced the highest rates of road traffic deaths and second highest in crash deaths related to alcohol. Motor vehicle accidents can be prevented through interventions that improve seat belt use, create safer streets for pedestrians and cyclists, and enhance the enforcement of traffic safety laws, especially among youth who are at risk. The rate of road crash-related hospital encounters in Fairfield County is similar to that of the state as a whole, but the burden is drastically higher among Bridgeport residents, and is slightly elevated among Stratford residents. Although most types of hospital and emergency room encounters are far more prevalent among older adults than they are among children and youth, motor vehicle accidents are among the causes that are more likely to affect children and youth (ages 0 to 19) than older adults.

Intentional injuries, such as those related to violence (domestic violence and otherwise) and suicide attempts, are also troubling. Within Fairfield County, Bridgeport was the only town that had rates of hospital encounters related to purposeful injuries that were much higher than the statewide average. The greatest burden of injury due to homicide and assault was seen within the 20–44 age group, although a disproportionately high rate was also seen among youth ages 0 to 19. These disparities were particularly evident in Bridgeport, but were also observed in Danbury, Norwalk, Stamford, and Stratford. Most towns did not experience significant changes in these rates between 2012–2014 and 2015–2017. On the other hand, hospital encounters related to suicide and self-harm decreased during this time period. For suicide and self-harm encounters, the greatest burden was on females ages 0 to 19, and on both men and women ages 20 to 44. The Connecticut Suicide Prevention Plan (PLAN 2020) contains detailed information on suicide and self-harm data and prevention.

**Infectious Diseases**

Sexually transmitted infections (STIs) are a concern in Fairfield County, as throughout the state and nation. Like other infectious organisms, STIs can have long-term implications for health, including reproductive health problems and certain types of cancers. Generally speaking, reported infection rates in Connecticut for chlamydia, which is the most common STI, are nearly double what they were 15 years ago. In both 2011 and 2015, reported chlamydia infection rates in Bridgeport (829 per 100,000 persons in 2015) were between 2.3 and 3.0 times higher than the rates reported statewide or throughout Fairfield County (301 per 100,000 people in 2015). Rates in towns such as Fairfield, Shelton, Westport, and Greenwich are roughly 20 to 30 percent of the statewide average. Gonorrhea infections in Fairfield County have slightly declined over the past two decades. While rates are generally too small to be reportable for smaller towns, reported gonorrhea infection rates in Bridgeport (134 per 100,000 persons in 2015) were still more than twice as high as the statewide average and 3.1 times the county’s average (43 per 100,000 people in 2015). STI prevention is a focus area for many local health departments.

Other infectious diseases are also important to the health of the region. The Connecticut Department of Public Health routinely tracks reports of certain infectious diseases such as influenza, Lyme disease, West Nile virus, and tuberculosis in order to identify trends and help prevent and control outbreaks. These topics have been covered in previous iterations of this report, but were not highlighted by stakeholders and key informants as major community health concerns and thus are not a focus of this year’s report.
Civic Life and Infrastructure

Civic life, defined broadly as the attitudes, activities, and investments that build on the collective resources, skills, expertise, and knowledge of citizens to improve the quality of life in communities, is a powerful dimension of our overall health and well-being.
Executive Summary
This chapter looks at three key components of civic life.

Stewardship of the Public Realm includes how municipalities provide essential services to their residents. In Connecticut, municipal revenue consists primarily of grants and property tax receipts. Reliance on property taxes presents a challenge to Connecticut’s larger cities, which tend to house more tax-exempt properties—including colleges and hospitals—and thus impose a higher tax burden on their residents. In addition, as Connecticut’s property tax rate is the same regardless of income level, it is regressive and therefore results in lower-income households’ taxes consuming a greater share of income. As a result, wealthier towns generate higher tax receipts, which fund higher-quality public resources, including education, which then attract additional wealthy residents. When considering residents’ perceptions of their local governments’ stewardship, 55 percent of Fairfield County adults felt positively about the responsiveness of their local government to the needs of residents, and 78 percent responded positively about the condition of area parks and public recreational facilities. The vast majority of adults report being satisfied with the area where they live. Overall, residents’ wealth influences their perceptions, with higher-income residents reporting greater access to and satisfaction with community resources.

Community Trust and Appreciation: a strong majority of Fairfield County residents reported trusting neighbors, having reliable social support networks, and feeling satisfied with where they live. While most white residents rated the police positively in terms of keeping residents safe, this measure was not as high among minority residents. Minority residents were also more likely to report experiencing unfair or abusive treatment by police multiple times in the past three years.

Participation in Public Life, including volunteering, voting, and using available cultural resources, was more common among higher-income residents and those with more education. In 2018, most Fairfield County adults felt their neighbors were invested in improving their neighborhood and would organize to prevent the closing of a fire station. Since 2015, adults statewide reported a significant increase in their perceived ability to influence local government decision-making, a positive trend seen within Fairfield County as well, and which may be due, at least in part, to a national increase in young voters' political engagement.

Civic life represents all the ways that residents can participate in their communities, and help improve the quality of life for everyone.

IN THIS CHAPTER

→ Wealthier towns in Fairfield County have access to more property tax revenue to fund public resources.

→ Community trust is high but variable—as is participation in public life through voting, volunteering, and advocating for the community.
FIG 4.1

Wealthier towns net more money from property values and spend more money on education

Note: Other than municipal gap, values are given by fiscal year.

- **Municipal Gap/Surplus Per Capita, 2012**
  - $3.6K to $5.1K Surplus
  - $900 to $3.6K Surplus
  - $100 to $900 Surplus
  - $100 Surplus to $100 Gap
  - $300 to $100 Gap
  - $100 to $300 Gap
  - $300 to $1.2K Gap

- **Equalized Net Grand List Per Capita, 2017**
  - $59K to $90K
  - $90K to $232K
  - $232K to $454K
  - $454K to $674K
  - $674K to $735K

- **Total Expenditure Per Daytime Population, 2017**
  - $2.5K to $3.2K
  - $3.2K to $4.7K
  - $4.7K to $5.6K
  - $5.6K to $7.5K
  - $7.5K to $9.4K

- **Education Spending Per Pupil, 2017**
  - $13K to $14K
  - $14K to $17K
  - $17K to $19K
  - $19K to $20K
  - $20K to $22K
FIG 4.2
In towns with more surplus money, residents rate neighborhood assets and facilities more highly
NEIGHBORHOOD ASSETS INDEX VS MUNICIPAL SURPLUS PER CAPITA

FIG 4.3
Towns that spend more on their libraries see greater library use
AVERAGE TOWN PUBLIC LIBRARY VISITS PER CAPITA AND CIRCULATION PER CAPITA VERSUS TOTAL LIBRARY EXPENSES PER CAPITA, 2017–2018
Voter turnout is high for national and state elections, but much lower in municipal ones

PERCENT OF ELIGIBLE VOTERS WHO VOTED IN ELECTIONS, WITH FAIRFIELD COUNTY HIGHEST AND LOWEST TOWN RATES, 2016–2018
INTRODUCTION

Civic life, defined broadly as the attitudes, activities, and investments that build on the collective resources, skills, expertise, and knowledge of citizens to improve the quality of life in communities, is a powerful dimension of our overall health and well-being. We view civic life broadly, encompassing both engagement and trust, as the sum of all efforts that promote the common good within communities. These range from the more recognizable—like informed local voting and volunteering—to the less obvious, such as access to and quality of public resources, design and upkeep of public parks, and residents’ sense of safety in their neighborhoods. Measures of civic life provide insight as to how residents feel about their communities, the ways they choose to get involved, and opportunities for improving life in the cities and towns they share.

As a growing body of research continues to illuminate the strength of the link between civic life and community health and well-being, we are reminded that our connection to and involvement in our communities is inextricably linked to quality of life. Higher levels of civic trust, participation, and engagement are correlated with both more equitable economic outcomes and many positive health outcomes, such as lower mortality rates, improved mental and physical health, and lower crime rates. Based on this body of work, we chose to frame our Civic Life section using three key domains: Stewardship of the Public Realm, Community Trust and Appreciation, and Participation in Public Life.

Fairfield County towns and cities each have a unique sense of community, with varying traditions, public resources, and physical spaces. Each reader should reflect on the dynamics of civic life within their particular community as they read this section, in order to recognize local assets and identify specific ways in which they can strengthen their communities.

STEWARDSHIP OF THE PUBLIC REALM

Investment in Public Resources: Municipal Financial Capacity

Residents rely on their local governments to provide a wide array of resources. While public education, social and health services, public safety, and infrastructure may come to mind as the key municipal responsibilities, local governments offer many additional programs and services—like public libraries and related programming, transportation assistance, and adult education—which underserved or at-risk populations may disproportionately rely on. The fiscal health of local governments directly impacts their ability to invest in such programs and services. These resources are truly a cornerstone of civic life, helping to mitigate socio-economic inequalities, bridging social divides, and ultimately, fostering trust in the responsiveness of government to community needs.

Local government revenue comes from municipal taxes and fees (almost exclusively property tax in Connecticut), as well as state and federal grants. On a per capita basis, Connecticut’s wealthier suburbs—able to draw on stronger tax bases—are the biggest spenders. Between 2002 and 2015, spending in the state’s wealthiest communities increased much faster than spending in the poorest communities. In 2017, Westport spent the most per resident of Fairfield County’s cities and towns at $8,059—over 2.5 times the $3,143 per resident in Danbury, the region’s lowest-spending municipality, and nearly twice the statewide average of $4,084. In some ways, a more telling figure is expenditures per daytime “resident”—that is, the spending done to support the number of people present in a town during the average workday. This helps illustrate the spending towns must do to meet the needs of people who work, but do not live, in that town, such as road maintenance and public safety needs. In municipalities with large inflows of workers, this measure of per-capita spending drops; bigger cities that act as regional job centers are most impacted. It is a fiscal challenge for these urban areas to provide the resources necessary to support a large inflow of workers, while being unable to draw on these workers as an asset to their taxbase. For example, Stamford, the town with the largest net inflow in the county, spends an already low $4,169 per resident, but only $3,217 per daytime population.
Research has confirmed that disparities in towns’ “municipal gap”—the difference between a town’s costs of providing public services and its ability to pay for such services—are driven primarily by differences in revenue-raising capacity. Wealthier municipalities with greater tax-generating ability can afford to fund more high-quality public resources, while fiscally distressed municipalities may experience challenges in meeting the needs of their residents. In some of Fairfield County’s towns with very large tax bases, this municipal gap becomes a surplus, with towns like New Canaan, Darien, and Greenwich taking in thousands more dollars in revenue per resident than they need to spend; meanwhile, Bridgeport operates on a gap of more than $1,000 per resident. There is a strong correlation between the size of a municipality’s equalized net grand list per capita (an estimate of the market value of all taxable property per resident) and overall spending: even when they do not have high tax rates, towns with more taxable wealth are able to spend substantially more money on resources for residents. A number of Fairfield County’s wealthier towns had equalized net grand lists per capita of well over $500,000 in 2017, compared to $150,956 statewide, and only $59,188 in Bridgeport.

Connecticut municipalities’ reliance on property taxes to generate revenue is particularly troublesome for larger cities, many of which are home to a disproportionate number of tax-exempt state-owned and private properties, like hospitals and colleges. For example, nearly 30 percent of Bridgeport’s 2016 total grand list was tax-exempt, compared to between 6 and 10 percent in the region’s towns with the highest equalized net grand lists per capita (Darien, Greenwich, New Canaan, and Westport). While state payment in lieu of taxes (PILOT) grants were designed to partially reimburse municipalities for funds lost due to tax-exempt property, these reimbursements have declined in recent years. A 2017 report estimated that Bridgeport should have received $19.3 million in PILOT reimbursements for tax-exempt hospitals and colleges based on state statutory obligations for the 2015–16 fiscal year, but actually received only $8 million—a more than $11 million shortfall.

Local property taxes play an important role in funding public schools; in Connecticut, 58 percent of all education funding comes from this source. Though spending per student varies widely, even among municipalities with similar populations, the state’s wealthiest suburbs generally spend more per student than its largest cities. Fairfield County’s highest-spending towns overall also tend to spend a comparatively high amount of money per pupil. In 2017, per-pupil spending in Fairfield County was $16,983, similar to the state overall at $16,592. However, Bridgeport, Brookfield, Danbury, and Shelton spent less than $15,000 per pupil, while Darien, Greenwich, New Canaan, Westport, Weston, and Redding spent over $20,000 per pupil.

<table>
<thead>
<tr>
<th>TABLE 4A</th>
<th>Municipal expenditures and financial capacity indicators</th>
<th>INDICATORS BY TOWN, FAIRFIELD COUNTY, FY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOCATION</td>
<td>MUNICIPAL GAP OR SURPLUS PER CAPITA</td>
<td>EXPENDITURE PER DAYTIME POPULATION</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------------------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>Connecticut</td>
<td>N/A</td>
<td>$4,156</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>N/A</td>
<td>$4,967</td>
</tr>
<tr>
<td>Bethel</td>
<td>+$985</td>
<td>$4,161</td>
</tr>
<tr>
<td>Bridgeport</td>
<td>-$1,168</td>
<td>$4,052</td>
</tr>
<tr>
<td>Brookfield</td>
<td>+$658</td>
<td>$3,843</td>
</tr>
<tr>
<td>Danbury</td>
<td>-$198</td>
<td>$2,536</td>
</tr>
<tr>
<td>Darien</td>
<td>+$3,782</td>
<td>$6,523</td>
</tr>
<tr>
<td>Easton</td>
<td>+$1,132</td>
<td>$8,438</td>
</tr>
<tr>
<td>Fairfield</td>
<td>+$885</td>
<td>$4,677</td>
</tr>
<tr>
<td>Greenwich</td>
<td>+$5,110</td>
<td>$5,199</td>
</tr>
<tr>
<td>Monroe</td>
<td>+$210</td>
<td>$5,606</td>
</tr>
<tr>
<td>New Canaan</td>
<td>+$3,703</td>
<td>$7,474</td>
</tr>
<tr>
<td>New Fairfield</td>
<td>+$353</td>
<td>$6,177</td>
</tr>
<tr>
<td>Newtown</td>
<td>+$289</td>
<td>$6,457</td>
</tr>
<tr>
<td>Norwalk</td>
<td>+$318</td>
<td>$3,655</td>
</tr>
<tr>
<td>Redding</td>
<td>+$1,096</td>
<td>$6,745</td>
</tr>
<tr>
<td>Ridgefield</td>
<td>+$1,350</td>
<td>$5,505</td>
</tr>
<tr>
<td>Shelton</td>
<td>+$1,289</td>
<td>$2,731</td>
</tr>
<tr>
<td>Sherman</td>
<td>+$1,385</td>
<td>$5,359</td>
</tr>
<tr>
<td>Stamford</td>
<td>+$643</td>
<td>$3,217</td>
</tr>
<tr>
<td>Stratford</td>
<td>-$299</td>
<td>$4,158</td>
</tr>
<tr>
<td>Trumbull</td>
<td>+$281</td>
<td>$5,140</td>
</tr>
<tr>
<td>Weston</td>
<td>+$1,908</td>
<td>$9,398</td>
</tr>
<tr>
<td>Westport</td>
<td>+$3,622</td>
<td>$6,126</td>
</tr>
<tr>
<td>Wilton</td>
<td>+$1,791</td>
<td>$5,494</td>
</tr>
</tbody>
</table>
Cities and towns with lower property values may be forced to levy higher property taxes to fund public education and other critical municipal programs and services. For example, based on the most updated mill rates for the 2019 fiscal year, the owner of a $200,000 home would pay $1,592 of property taxes in Greenwich, but $7,612 in Bridgeport. A house valued at $200,000 in Bridgeport would have a substantially higher value in Greenwich. Nonetheless, research shows that the property tax has the largest impact on Connecticut households of any state or municipal tax and is indeed regressive, meaning low-income households pay a higher share of their incomes than wealthy households because assessed property value, rather than income level, determines the tax.

**Perceived Access to and Quality of Community Resources**

On the whole, Fairfield County respondents to DataHaven’s 2018 Community Wellbeing Survey indicated general satisfaction with the quality of and access to public resources while acknowledging room for improvement. When asked about the responsiveness of their local government, 55 percent of adults in Fairfield County described it as “excellent” or “good,” 4 percentage points higher than the statewide average. Over half of adults agreed there were safe sidewalks and places to

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>GOVT IS RESPONSIVE</th>
<th>GOOD TO RAISE KIDS</th>
<th>GOOD CONDITION OF PARKS</th>
<th>SAFE SIDEWALKS</th>
<th>SAFE BIKING</th>
<th>REC FACILITIES AVAILABLE</th>
<th>NEIGHBORHOOD ASSETS INDEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>51%</td>
<td>75%</td>
<td>75%</td>
<td>61%</td>
<td>63%</td>
<td>70%</td>
<td>556</td>
</tr>
<tr>
<td>FC</td>
<td>55%</td>
<td>76%</td>
<td>78%</td>
<td>58%</td>
<td>57%</td>
<td>68%</td>
<td>598</td>
</tr>
</tbody>
</table>

**BY DEMOGRAPHIC WITHIN FAIRFIELD COUNTY**

| AGE 18–34 | 48% | 66% | 71% | 68% | 61% | 58% | 543 |
| Age 35–49 | 52% | 72% | 77% | 60% | 57% | 73% | 569 |
| Age 50–64 | 56% | 81% | 79% | 50% | 54% | 58% | 642 |
| Age 65+   | 62% | 84% | 84% | 55% | 56% | 63% | 706 |

| WHITE     | 60% | 83% | 84% | 52% | 57% | 59% | 693 |
| BLACK     | 35% | 49% | 57% | 77% | 53% | 45% | 359 |
| LATINO    | 51% | 63% | 67% | 68% | 54% | 58% | 482 |

| UNDER $30K | 41% | 58% | 63% | 71% | 57% | 59% | 449 |
| $30K–$100K | 52% | 73% | 76% | 63% | 56% | 58% | 560 |
| $100K+     | 62% | 88% | 84% | 50% | 58% | 72% | 725 |

**BY GEOGRAPHY**

| BRIDGEPORT | 31% | 31% | 54% | 78% | 48% | 51% | 259 |
| DANBURY    | 58% | 73% | 70% | 43% | 42% | 57% | 522 |
| FAIRFIELD  | 62% | 94% | 92% | 70% | 69% | 80% | 859 |
| GREENWICH  | 77% | 91% | 91% | 72% | 72% | 79% | 881 |
| NORWALK    | 48% | 72% | 75% | 77% | 66% | 58% | 563 |
| STAMFORD   | 47% | 75% | 77% | 72% | 64% | 71% | 602 |
| STRATFORD  | 33% | 72% | 72% | 76% | 54% | 73% | 460 |
Three-quarters rated the condition of public parks and other public recreational facilities as “excellent” or “good,” roughly on par with the state average. Disaggregating survey results by respondents’ town and income levels reveals that wealthier individuals and residents of wealthier towns report greater access to and satisfaction with goods and services, cultural events, and recreational facilities in their communities.\(^{311}\)  

Food deserts, defined as areas where it is difficult to purchase fresh fruits, vegetables, and other healthful whole foods, typically occur in economically distressed urban areas.\(^{312}\) The low-income people who live in those areas are less likely to have the car access needed to get to grocery stores across the region.\(^{313}\) In 2018, only 54 percent of Bridgeport adults reported good or excellent access to affordable, high-quality fruits and vegetables, contrasted with 83 percent of Greenwich adults.\(^{314}\)

**Highlight: Public Libraries**

Public libraries are invaluable anchor institutions that transcend their traditional role of lending books. While their utilization and functions vary greatly from community to community, they often act as centers for educational programming, incubators for entrepreneurs and ideas, hubs for technology and digital learning, and platforms for civic engagement and arts education and appreciation. Overall, library spending in Fairfield County in the 2017 and 2018 fiscal years averaged $77 per resident—well above the state average of $60.\(^{315}\) However, some towns spent much less, while others exceeded the region’s average spending; Bridgeport spent only $38 per capita, while the region’s six wealthiest towns spent $174.\(^ {316}\)

Towns that spend more on their libraries generally see higher use; in other words, towns with higher total library expenses per capita tend to experience more visits and have higher circulation per capita than lower-spending towns. In 2017 and 2018, Bridgeport’s libraries had 2.7 visits per capita and a circulation per capita of 2.0 items, while Darien’s libraries had 17.6 visits per capita and a circulation per capita of 28.9 items.\(^{317}\)  

As libraries have evolved over the years, the way residents interact with and utilize them is changing; statewide, library circulation per capita has trended downward since the early 2000s, decreasing from an average 8.3 in 2001 and 2002 to 6.8 in 2017 and 2018.\(^{318}\) For lower-income residents—less likely to own an internet-connected device or have wifi access at home—library computers are a critical resource. In 2017 and 2018, Fairfield County’s six wealthiest towns had more public library computers available per 10,000 residents (20.3) than the region overall (14.2); towns like Danbury (9.8) and Shelton (4.4) had fewer.\(^{319}\) Bridgeport has made a strong investment in computers, with 18.3 per 10,000 residents.\(^ {320}\)

**Highlight: Climate Stewardship**

Carbon dioxide and other greenhouse gas emissions, driven by human activity, are increasing global temperatures and thus contributing to issues that have major implications for Connecticut and Fairfield County residents: damage to ecosystems, severe storms, extreme flooding, and more heat waves.\(^ {321}\) One study projects that the average summer temperature high in Stamford in 2050 will be 88.2 degrees, which would be an increase of 4.4 degrees since 2000.\(^ {322}\)

With a substantial shoreline, Fairfield County is particularly vulnerable to sea level rise, coastal storms, and flooding.\(^ {323}\) Estimates suggest Fairfield County’s “100-year flood height”—the level of flooding that statistically has a 1 percent chance of occurring any given year—is 5.8 feet above the high tide line.\(^ {324}\), \(^ {325}\) The region is home to more than 29,000 residents who live in areas six feet or less above the high tide line, meaning their property would be at risk of exposure if a 100-year flood were to occur; an estimate puts the property value in this exposure zone at $9.1 billion.\(^ {326}\) One risk model estimates a 49 percent chance of such a flood in Fairfield County between 2016 and 2050.\(^ {327}\) Coastal management, forward-looking building and zoning codes, and emergency preparedness are important considerations.\(^ {328}\)

Looking at the bigger picture, efforts to address climate change and its symptoms should lead to infrastructure and policy changes that reduce carbon emissions, such as more efficient housing, transportation, and land use. Currently, the estimated annual carbon footprint of each Fairfield County household ranges from roughly 35 metric tons of emissions in the most densely populated central areas of Bridgeport and Stamford to more than 80 metric tons in Darien, Easton, New Canaan, Weston, and Wilton—with Weston, at 88 tons, having the highest rate of any town in the Northeastern U.S.\(^ {329}\)
“Bridgeport spent only $38 per capita on its public libraries, while the region’s six wealthiest towns spent $174 per capita.”
COMMUNITY TRUST AND APPRECIATION

At a fundamental level, civic trust helps to bridge divides and foster cooperation—conditions necessary for both political engagement and economic development. In fact, research has shown strong, positive correlations between regions’ levels of civic trust and economic performance.330, 331 Higher levels of civic trust also lead to healthier and more cohesive communities, encouraging the growth of social organizations—some of which promote equitable access to much-needed local programs and services in education, transportation, community health, and recreation.

Overall, Fairfield County adults report feelings of trust in one another, good relationships with friends and family, and appreciation for the communities in which they live. The 2018 DataHaven Community Wellbeing Survey showed that 86 percent of adults agreed that people in their neighborhood could be trusted, 71 percent usually or always received the social support they need, and 83 percent were satisfied with where they live.332 Fairfield County adults also indicated they felt safe in their communities, as 80 percent rated the job done by police to keep residents safe as excellent or good, and 70 percent felt safe walking in their neighborhoods at night—about the same as statewide rates for both measures.333 However, only 53 percent and 70 percent of Black and Latino adults in the region said local police are doing a good or excellent job, compared to 88 percent of white adults.334 This may stem from these communities’ interactions with the police force: 20 percent of Black adults and 16 percent of Latino adults reported experiencing an unfair stop, search or other incident of mistreatment by the police at least once, compared to only 7 percent of white adults.335 See Fig. 3.12 / See Table 4C

Confidence in civic and nonprofit organizations serving the area is another important aspect of community trust. In recent years, a national debate has arisen regarding the third sector, raising doubts about whether large community organizations and foundations can act as reliable, inclusive, and equitable long-term change agents. Community philanthropy that supports locally driven development, strengthens community capacity and voices, builds on local resources, and holds itself accountable not only produces lasting results but also increases residents’ trust in their community institutions.318

Highlight: Local News Coverage

Local news coverage is a vital tool for encouraging political participation and accountability. A growing body of literature has documented the effect of news coverage on measures of local civic trust and engagement. Areas with fewer local news outlets and declining coverage tend to have lower levels of civic participation and voter turnout.337 Individuals who are more likely to volunteer, vote, and be active in their communities are also more likely than less engaged residents to use and value local news.338 Cities served by newspapers experiencing sharp declines in staffing—as many nationwide have in recent years—see reduced political competition in mayoral elections.339 Additionally, declining local news coverage has been linked to a reduction in community political knowledge and participation, and ongoing research suggests that the closure of a local newspaper may actually increase cost of government due to reduced journalistic scrutiny of deals and spending.340, 341

In recent years, local political news coverage has continued to diminish as the industry’s revenue declines, with well over a thousand local newspapers being shuttered across the U.S. over the last 15 years.342 According to the 2018 Pew Research Center’s Local News Survey, 84 percent of adults living in the Bridgeport-Stamford-Norwalk MSA did not pay for local news during the past year.343 Only 63 percent of adults reported that they follow the local news very or somewhat closely.344

It is important to note that several new nonprofit digital journalism platforms are available in Connecticut. We can get an idea of the demand for local journalism in Fairfield County by looking at data for usage of The Connecticut Mirror, a nonprofit media organization headquartered in Hartford that focuses on public policy and political issues in the state. Between July 2018 and July 2019, CT Mirror recorded nearly 216,000 readers in Fairfield County, a 22 percent increase from the previous year.345
## TABLE 4C
Community trust and appreciation
SHARE OF ADULTS, FAIRFIELD COUNTY, 2018

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>SATISFIED W/ AREA</th>
<th>POLICE APPROVAL</th>
<th>SAFE WALKING AT NIGHT</th>
<th>TRUST NEIGHBORS</th>
<th>POSITIVE ROLE MODELS</th>
<th>RECEIVE SOCIAL SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>82%</td>
<td>78%</td>
<td>70%</td>
<td>85%</td>
<td>78%</td>
<td>71%</td>
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<tr>
<td>Fairfield County</td>
<td>83%</td>
<td>80%</td>
<td>70%</td>
<td>86%</td>
<td>80%</td>
<td>71%</td>
</tr>
</tbody>
</table>

**BY DEMOGRAPHIC WITHIN FAIRFIELD COUNTY**

<table>
<thead>
<tr>
<th>GROUP</th>
<th>SATISFIED W/ AREA</th>
<th>POLICE APPROVAL</th>
<th>SAFE WALKING AT NIGHT</th>
<th>TRUST NEIGHBORS</th>
<th>POSITIVE ROLE MODELS</th>
<th>RECEIVE SOCIAL SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>84%</td>
<td>82%</td>
<td>73%</td>
<td>87%</td>
<td>81%</td>
<td>71%</td>
</tr>
<tr>
<td>Female</td>
<td>83%</td>
<td>79%</td>
<td>87%</td>
<td>85%</td>
<td>79%</td>
<td>71%</td>
</tr>
<tr>
<td>Age 18–34</td>
<td>81%</td>
<td>71%</td>
<td>83%</td>
<td>78%</td>
<td>71%</td>
<td>66%</td>
</tr>
<tr>
<td>Age 35–49</td>
<td>82%</td>
<td>78%</td>
<td>74%</td>
<td>84%</td>
<td>78%</td>
<td>66%</td>
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<tr>
<td>Age 50–64</td>
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<td>84%</td>
<td>74%</td>
<td>90%</td>
<td>84%</td>
<td>72%</td>
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<tr>
<td>Age 65+</td>
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<td>87%</td>
<td>92%</td>
<td>85%</td>
<td>81%</td>
</tr>
<tr>
<td>White</td>
<td>86%</td>
<td>88%</td>
<td>75%</td>
<td>92%</td>
<td>85%</td>
<td>77%</td>
</tr>
<tr>
<td>Black</td>
<td>73%</td>
<td>53%</td>
<td>56%</td>
<td>67%</td>
<td>80%</td>
<td>85%</td>
</tr>
<tr>
<td>Latino</td>
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<td>58%</td>
<td>71%</td>
<td>86%</td>
<td>82%</td>
</tr>
<tr>
<td>&lt;$15K</td>
<td>72%</td>
<td>58%</td>
<td>45%</td>
<td>69%</td>
<td>59%</td>
<td>44%</td>
</tr>
<tr>
<td>$15K-$30K</td>
<td>73%</td>
<td>61%</td>
<td>53%</td>
<td>74%</td>
<td>85%</td>
<td>52%</td>
</tr>
<tr>
<td>$30K-$50K</td>
<td>81%</td>
<td>72%</td>
<td>80%</td>
<td>78%</td>
<td>71%</td>
<td>66%</td>
</tr>
<tr>
<td>$50K-$75K</td>
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<td>78%</td>
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<td>67%</td>
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<td>74%</td>
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<td>93%</td>
<td>85%</td>
<td>77%</td>
</tr>
<tr>
<td>$200K+</td>
<td>90%</td>
<td>93%</td>
<td>85%</td>
<td>97%</td>
<td>93%</td>
<td>84%</td>
</tr>
</tbody>
</table>

**BY GEOGRAPHY**

<table>
<thead>
<tr>
<th>CITY</th>
<th>SATISFIED W/ AREA</th>
<th>POLICE APPROVAL</th>
<th>SAFE WALKING AT NIGHT</th>
<th>TRUST NEIGHBORS</th>
<th>POSITIVE ROLE MODELS</th>
<th>RECEIVE SOCIAL SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgeport</td>
<td>69%</td>
<td>47%</td>
<td>43%</td>
<td>60%</td>
<td>48%</td>
<td>56%</td>
</tr>
<tr>
<td>Danbury</td>
<td>85%</td>
<td>84%</td>
<td>70%</td>
<td>85%</td>
<td>79%</td>
<td>88%</td>
</tr>
<tr>
<td>Fairfield</td>
<td>88%</td>
<td>95%</td>
<td>85%</td>
<td>96%</td>
<td>84%</td>
<td>80%</td>
</tr>
<tr>
<td>Greenwich</td>
<td>92%</td>
<td>90%</td>
<td>76%</td>
<td>95%</td>
<td>89%</td>
<td>77%</td>
</tr>
<tr>
<td>Norwalk</td>
<td>84%</td>
<td>79%</td>
<td>88%</td>
<td>83%</td>
<td>76%</td>
<td>70%</td>
</tr>
<tr>
<td>Stamford</td>
<td>84%</td>
<td>83%</td>
<td>70%</td>
<td>86%</td>
<td>84%</td>
<td>72%</td>
</tr>
<tr>
<td>Stratford</td>
<td>78%</td>
<td>79%</td>
<td>72%</td>
<td>87%</td>
<td>73%</td>
<td>88%</td>
</tr>
</tbody>
</table>
Volunteering
In 2018, just over 40 percent of Fairfield County adults reported having volunteered in the past year, equal to the state level.\textsuperscript{343} However, statewide data reveals that some residents volunteer more than others. As educational attainment and personal income increase, so do rates of volunteering. For example, only 29 percent of adults with a high school degree or less reported volunteering, compared to 48 percent of those with a bachelor’s degree or higher; 27 percent of adults earning less than $30,000 per year volunteered, compared to 54 percent of adults earning over $100,000.\textsuperscript{346}

The DataHaven Community Wellbeing Survey attempts to capture neighborhood engagement beyond formal volunteering; the survey asks about collective efficacy, such as whether people nearby are involved in trying to improve their neighborhood, and how likely it is that they would organize to prevent the closing of a local fire station.\textsuperscript{351} In 2018, 80 percent of Fairfield County adults felt their neighbors were invested in improving the neighbor-hood, while 84 percent believed neighbors would organize to prevent the closing of a fire station.\textsuperscript{352} Though difficult to measure at the local level, “informal

### TABLE 4D

#### Participation in public life

<table>
<thead>
<tr>
<th>SHARE OF ADULTS, FAIRFIELD COUNTY, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LOCATION</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Connecticut</td>
</tr>
<tr>
<td>Fairfield County</td>
</tr>
<tr>
<td><strong>AGE GROUP WITHIN FAIRFIELD COUNTY</strong></td>
</tr>
<tr>
<td>Age 18–34</td>
</tr>
<tr>
<td>Age 35–49</td>
</tr>
<tr>
<td>Age 50–64</td>
</tr>
<tr>
<td>Age 65+</td>
</tr>
<tr>
<td><strong>BY GEOGRAPHY</strong></td>
</tr>
<tr>
<td>Bridgeport</td>
</tr>
<tr>
<td>Stamford</td>
</tr>
</tbody>
</table>
volunteering”—such as supporting family and friends or doing favors for neighbors—is also an important aspect of community life. According to the Corporation for National and Community Service, in 2018, national rates for these activities were 43 percent and 51 percent, respectively.353

Arts and Culture
Community-based arts and cultural resources serve as venues for creativity, innovation, dissent, and dialogue; nurture cultural movements; cultivate public imagination; and drive and inspire authentic civic engagement. From film festivals to theatre groups and museums, these assets provide opportunities for bringing together diverse groups of people and building social capital—both between people and across organizations, like block associations, civic groups, congregations, and political and business groups.354 By providing the physical and experiential space for people to connect, build trust, and cultivate understanding, local arts and cultural resources act as platforms for public dialogue and engagement—critical elements of a healthy democracy.355

Research has shown access to arts and culture fosters stewardship, participation, and civic trust. People who partake in arts and cultural activities were found to be 12 percent more likely to donate money to a local organization, 14 percent more likely to attend local events, and 21 percent more likely to rate local leaders as effective.355 In 2018, 67 percent of Fairfield County adults utilized arts and cultural resources in the area—such as concerts, museums, and cultural events—at least a few times over the past year, similar to the statewide rate.267 As with volunteering, statewide data show that individuals with higher levels of educational attainment and personal income utilize arts and cultural resources more often: 51 percent of adults with a high school degree or less compared to 70 percent with a bachelor’s degree or higher, and 56 percent of individuals earning less than $30,000 per year versus 70 percent of those earning above $100,000.258 Fairfield County’s two nonprofit arts alliances—The Cultural Alliance of Fairfield County and the Cultural Alliance of Western Connecticut—both work to promote the arts and culture sector throughout the region.

Voting
As is the trend nationally, voter turnout in Fairfield County varies by type of election, with greater turnout for higher-office elections. The county’s turnout rate was 77 percent in the 2016 presidential election, 64 percent in the 2018 midterm election, and only 29 percent in the 2017 municipal election.359 These rates were nearly identical to the statewide marks, and significantly higher than national levels. In Fairfield County, turnout for the 2016 presidential election increased only slightly from that in 2012, while turnout for the 2018 midterm election was 11 percentage points higher than for the 2014 midterms.360 Nationally, turnout in the 2018 midterms was the highest in four decades, reversing a trend of declining interest in midterm elections and likely reflecting the tumultuous political landscape following the 2016 presidential election.361 But turnout in local elections has continued to trend downward in both the state and Fairfield County. In the 2007 municipal elections, 35 percent of registered Fairfield County residents cast a ballot—6 percentage points higher than turnout for the 2017 municipal election a decade later.262

Table 4E

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>2018 MIDTERM</th>
<th>2017 MUNICIPAL*</th>
<th>2016 PRESIDENTIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>65%</td>
<td>30%</td>
<td>77%</td>
</tr>
<tr>
<td>Fairfield County</td>
<td>64%</td>
<td>29%</td>
<td>77%</td>
</tr>
<tr>
<td>Bridgeport</td>
<td>43%</td>
<td>10%</td>
<td>56%</td>
</tr>
<tr>
<td>Danbury</td>
<td>58%</td>
<td>N/A</td>
<td>75%</td>
</tr>
<tr>
<td>Fairfield</td>
<td>72%</td>
<td>N/A</td>
<td>79%</td>
</tr>
<tr>
<td>Greenwich</td>
<td>71%</td>
<td>N/A</td>
<td>85%</td>
</tr>
<tr>
<td>Norwalk</td>
<td>61%</td>
<td>29%</td>
<td>78%</td>
</tr>
<tr>
<td>Stamford</td>
<td>63%</td>
<td>27%</td>
<td>79%</td>
</tr>
<tr>
<td>Stratford</td>
<td>50%</td>
<td>N/A</td>
<td>73%</td>
</tr>
<tr>
<td>6 wealthiest FC towns</td>
<td>72%</td>
<td>36%</td>
<td>83%</td>
</tr>
<tr>
<td>Other FC towns</td>
<td>70%</td>
<td>36%</td>
<td>81%</td>
</tr>
</tbody>
</table>

* Unofficial Results: note, only towns holding November municipal elections were included in these rates.
recent major elections, turnout rates were lowest in Bridgeport, at 41 percent in the 2018 midterm, 10 percent in 2017 municipal, and 56 percent in 2016 presidential elections. Turnout for those same elections in Fairfield County’s six wealthiest towns were 72 percent, 36 percent, and 83 percent, respectively.\textsuperscript{363} Low voter turnout is driven by a range of factors, including a lack of basic information on elections, distance to polling stations and hours of operation, inflexible work schedules, limited transportation, and other barriers that disproportionately affect economically distressed communities.

Between 2015 and 2018, Fairfield County adults’ perceived ability to influence local government decision-making increased substantially, a trend also seen statewide. The share of residents believing they had at least a little influence on local government increased by 7 percentage points—from 65 percent to 72 percent for Fairfield County (and from 62 percent to 72 percent statewide).\textsuperscript{364} This jump may reflect the recent surge in political energy and interest across the nation, and particularly among younger voters: voter turnout for adults ages 18 to 29 increased a whopping 79 percent between the 2014 and 2018 midterm elections nationwide.\textsuperscript{365} Similarly, the share of Fairfield County residents ages 18 to 34 who felt they had at least a little influence on local government increased 12 percentage points between 2015 and 2018 to about 74 percent—slightly above the overall county rate.\textsuperscript{366}

\textbf{Highlight: Community Design}

The design of neighborhoods and public spaces impacts residents’ civic health. Cycling, walking, and access to nature and green spaces are all connected to civic trust and participation; urban parks are particularly important, as they promote inclusion and strengthen social networks across diverse groups of people.\textsuperscript{367, 368} Individuals residing in walkable neighborhoods report higher levels of civic trust and participation, while those with access to parks and green space are more likely to trust their neighbors and believe community members are willing to help one another.\textsuperscript{369, 370}

Research has shown that even the presence of a community garden in easy walking distance is associated with increased participation in public life and more informed local voting.\textsuperscript{371} Access to well-maintained green spaces, safe sidewalks, and quality cycling infrastructure are positively associated with many indicators that promote well-being, like increased physical activity, lower levels of stress, stronger social connections, and even reduced mortality.\textsuperscript{372, 373, 374, 375} Investment in well-designed and equitable communities isn’t simply about making neighborhoods more visibly desirable; rather, it’s about using the built environment as a tool to deliver increased well-being to residents.\textsuperscript{366}
“In 2018, 67 percent of Fairfield County adults utilized arts and cultural resources in the area—such as concerts, museums, and cultural events—at least a few times over the past year.”
Behind every number in this document are people, families, and communities that are far more complex than a few summary statistics. Human beings never match all the averages used to describe them.
Data can help us tell stories, but they cannot tell complete stories on their own.

THE 2020 CENSUS

→ “With $10.7 billion dollars in annual federal funding to the state on the line, an accurate count of the people living in Connecticut is crucial.”
Susan Bysiewicz, Lieutenant Governor of Connecticut

→ “The Constitution requires that every ten years, the nation undertakes what is arguably its most essential task: ensuring a fair and valid count of every single one of its now 330 million residents.... The products of these efforts are data sets that characterize our population, create political districts, and enable virtually all other ongoing data collection efforts.”

Conclusion

Connecticut is changing: our population is growing older and more diverse, our neighborhoods are becoming more stratified, our coastline faces rising sea levels. Data help us understand these changes, and increased data literacy brings more people and new approaches into that work. But the undercurrents of inequality and segregation that define much of life in Connecticut are not absolute. Our neighborhoods are always more than just two-dimensional places of either never-ending hardship or trouble-free affluence. Our attempts at presenting a more nuanced view are nowhere near perfect. Any researchers, ourselves included, have blindspots that influence what we prioritize and what we leave out of our analysis.

Data are never truly objective, either. They might help identify patterns and connect bits of information, but every decision that goes into how data are defined, measured, interpreted, and acted upon is subject to the same bias we know exists in our society. In a time of climate change denial, re-politicization of the Census, and fake news—both the accusation used to deflect criticism and the actual, webclick-optimized phenomenon—dry facts are not enough in pushing for a more just, equitable, and sustainable society.

Data are even used in ways that deepen inequality. Mortgage approvals and bail amounts are made by black-box algorithms that their subjects do not even know about. Data tools, such as the Constitutionally-mandated Census count or the geographical demarcation of where you vote and how much your vote matters, can be used to include and support people, or to render them uncounted, unheard, and invisible. The fact that data can be used in these ways shows just how powerful they can be, and why it is important to understand that social prejudice is often reflected in something presented as impartial.

Our hope is that you will help make this document more whole. Critique it. Find its blind spots, take its conclusions in different directions, and use it to think more critically about the world around you. Share an interesting fact you read here with your neighbor, and see how you might both relate to it differently. Fill in the gaps between data points with your stories. Work with neighbors to help ensure a more equitable and complete population count during the 2020 Census.

Above all, not everything important can be measured. Take what is on the pages here and bring it to life and to action. DH
SECTION 1. NOTES ON FIGURES AND TABLES

GENERAL NOTE ON DATAHAVEN COMMUNITY WELLBEING SURVEY
One of the major sources used in this report is the DataHaven Community Wellbeing Survey (CWS). This survey was most recently carried out from March to November 2018, during which 16,000 randomly-selected adults were interviewed, including residents from all 169 towns in Connecticut; the 2015 iteration had a similar sample size and scope. Questions on the CWS are compiled from local, national, and international sources and best practices, and are developed with input from an advisory committee of leading experts in survey research. All reported CWS estimates are weighted in order to accurately represent the underlying adult population within each region, town, or neighborhood. For more information and crosstabs of data, see https://cdatadhaven.org/reports/datahaven-community-wellbeing-survey

GENERAL NOTE ON GEOGRAPHY
Fairfield County is made up of 23 towns: Bethel, Bridgeport, Brookfield, Danbury, Darien, Easton, Fairfield, Greenwich, Monroe, New Canaan, New Fairfield, Newtown, Norwalk, Redding, Ridgefield, Shelton, Sherman, Stamford, Stratford, Trumbull, Weston, Westport, and Wilton. In some parts of this report, we refer to the county’s 6 wealthiest towns in aggregate; these are Darien, New Canaan, Ridgefield, Weston, Westport, and Wilton. In some charts and tables, the county’s larger towns are highlighted, often Bridgeport, Danbury, Fairfield, Greenwich, Norwalk, Stamford, and Stratford, as are the 6 wealthiest towns. The group “other towns” would then be the remaining towns of Bethel, Brookfield, Easton, Monroe, New Fairfield, Newtown, Redding, Shelton, Sherman, and Trumbull.

Analysis of PUMS data throughout the report is done for combinations of public use microdata areas (PUMAs), the smallest geographic unit for which PUMS data is available. Fairfield County is made up of the Connecticut PUMAs with FIPS codes 00100, 00101, 00102, 00103, 00104, and 00105.

Chapter 1

FIG 1.1. COMPONENTS OF THE DATAHAVEN COMMUNITY INDEX, 2017
DataHaven analysis (2019). The 12 indicators used in the Community Index include: (1) Opportunity youth, or the share of people ages 16 to 19 who are neither in school nor working, (2) the unemployment rate, (3) the overall poverty rate, (4) the share of children ages 0 to 5 living in poverty, (5) the share of adults with a high school education or more, (6) the share of people with health insurance, (7) severe housing cost burden, or the share of households paying 50 percent or more of their income towards housing costs, (8) the share of three- and four-year-olds enrolled in preschool, (9) average life expectancy, (10) the share of workers whose commutes are 30 minutes or less, (11) youth labor force, or the share of the population ages 25 to 44, and (12) median household income.

The Community Index assigns each of the 12 component indicators a relative value from 0 to 1,000, where 1,000 is assigned to the best/preferred outcome. In other words, the value is generated relative to the areas with the highest and lowest indicator values. This helps to control for the different distributions of each indicator, but may exaggerate the effect of outliers. Colors indicate how each area ranks relative to other locations in the analysis as better or worse than average. Data tables contain “N/A” where information is not available. In addition to major geographic regions, the larger towns or regions with the best and worst values are displayed to the right of the chart.

Because the data used for these indicators are available at different geographic levels nationwide, local neighborhoods, towns, and regions in Connecticut were compared not just to each other, but to U.S. averages and metropolitan areas. See Fig. 1.2 for details on Metropolitan Areas.

Data are from two main sources: The National Center for Health Statistics, U.S. Small-Area Life Expectancy Estimates Project (USALEEP): Life Expectancy Estimates Files, 2010–2015, and U.S. Census Bureau American Community Survey (ACS) 2012 and 2017 5-year estimates, Tables B01001, Sex by Age; B08303, Travel Time to Work; B14003, Sex by School Enrollment by Type of School by Age for the Population 3 Years and Over; B14005, Sex by School Enrollment by Educational Attainment by Employment Status for the Population 16 to 19 Years; B15001, Sex by Age by Educational Attainment for the Population 18 Years and Over; B17001, Poverty Status in the Past 12 Months by Sex by Age; B18135, Age by Disability Status by Health Insurance Coverage Status; B19001, Household Income in the Past 12 Months (in 2017 Inflation-Adjusted Dollars); B23025, Employment Status for the Population 16 Years and Over; B25070, Gross Rent as a Percentage of Household Income in the Past 12 Months; B25091, Mortgage Status by Selected Monthly Owner Costs as a Percentage of Household Income in the Past 12 Months. ACS tables available at https://factfinder.census.gov. USALEEP data available at https://www.cdc.gov/nchs/nvss/usaLEEP/usaLEEP.html.

Life expectancy is a prediction of the number of years a person born today might expect to live given the mortality rate among all age groups in the area in which they are born. Because of the interrelated nature of health and socioeconomic status, life expectancy can be understood as a measure of health and a measure of social well-being. The latest available data for life expectancy covers the period from 2010 to 2015 and is summarized here as the population-weighted average life expectancy for each geographic area based on the census tracts within that area. See Fig. 3.1 for more granular analysis of life expectancy data.

The Community Index uses Census ACS estimates for health insurance coverage to allow for nationwide comparisons at many geographic levels. Elsewhere in this report, health insurance coverage is reported from Data Haven's Community Wellbeing Survey.

The average (mean) of the 12 scaled indicators represents the area’s Community Index score. Five-year averages for 2008–2012 and 2013–2017 were used because they represent non-overlapping estimate ranges only; the 2013–2017 values are shown in figures. See Table 1A for 2008–2012 Values.

FIG 1.2. COMPOSITE SCORE OF THE DATAHAVEN COMMUNITY INDEX BY AREA, 2017
See Fig. 1.1 for methodology behind the Community Index. Metropolitan areas are defined by the federal Office of Management and Budget. While metropolitan areas from around the country were used in ranking values, only those in New England states with at least 300,000 people, and New York, NY, are displayed here.

Fairfield County’s larger cities’ Census tracts were clustered into neighborhood groups as follows: Bridgeport was broken into Central (tracts 070200, 070300, 070400, 070500, 070600, 070900, 071000, 071100, 071200, 071300, 071400, 071600, 071900, 072000, 072100, 072200, 073000, 073100, 073200, 073300, 073400, 073700, and 257200); East End (tracts 073500, 073600, 073800, 073900, 074000, 074300, and 074400); and Outer (tracts 070100, 072300, 072400, 072500, 072600, 072700, 072800, and 072900). Danbury was broken into Central (tracts 210100, 210200, 210300, 210600, 210701, and 210702) and Outer (tracts 210400, 210500, 210800, 210900, 211000, 211100, 211200, 211300, and 211400). Norwalk was broken into South/Central (tracts 043400, 043700, 044000, 044100, 044400, and 044500).
and North (tracts 042500, 042600, 042700, 042800, 042900, 043000, 043100, 043200, 043300, 043400, 043500, 043600, 043800, 043900, 044200, 044300, and 044600). Stamford was broken into Central (tracts 020100, 021400, 021500, 021700, 021802, 022100, 022200, and 022300) and North (tracts 020200, 020300, 020400, 020500, 020600, 020700, 020800, 020900, 021000, 021100, 021200, 021300, 021600, 021801, 021900, 022000, and 022400). All tracts are within Fairfield County (FIPS code 09001).

FIG 1.3. COMPONENTS OF THE DATAHAVEN COMMUNITY INDEX BY RACE/ETHNICITY, 2017
SEE FIG 1.1 Many American Community Survey subtables are available for individual racial/ethnic groups; these were used to calculate Community Index indicators by race/ethnicity. For indicators not available through American Community Survey tables (severely housing cost burden, and the share of workers with short commutes), additional Data Haven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year public use microdata sample (PUMS) data was conducted. Analysis of PUMS data involves weighting survey responses to reflect overall population demographics. For life expectancy, results are reported as the population-weighted life expectancy for tracts by racial/ethnic group comprising the largest share of population in that tract. Due to low sample sizes, age ranges for preschool enrollment differ between population-level tables and subtables. Since the two are not comparable, that indicator is removed from this Index.


FIG 1.4. DATAHAVEN PERSONAL WELLBEING INDEX VS COMMUNITY INDEX; DATAHAVEN PERSONAL WELLBEING INDEX VS NEIGHBORHOOD ASSETS INDEX
SEE FIG 1.1 FOR COMMUNITY INDEX DETAILS / SEE TABLE 1C FOR PERSONAL WELLBEING INDEX DETAILS The Neighborhood Assets Index is an aggregate of 2018 DataHaven Community Wellbeing Survey participants’ positive ratings on 6 indicators about the area where they live: (1) condition of local parks, (2) quality of the area as a place to raise children, (3) responsiveness of local government, (4) availability of recreation facilities, and the presence of (5) safe places to bike and (6) safe sidewalks and crosswalks. Likert-style responses (e.g. “excellent,” “good,” “fair,” “poor”) were converted to scaled numeric values, averaged, and used for factor analysis to get a single composite score for each location and demographic group. These scores were then scaled to range from 0 (lower ratings of assets) to 1,000 (higher ratings of assets).

SEE TABLE 4B

### Table 1A. DataHaven Community Index Scores for Large U.S. Metropolitan Areas and Local Cities, Towns, and Neighborhoods, 2012 and 2017

<table>
<thead>
<tr>
<th>Area Type</th>
<th>2012 Score</th>
<th>2017 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
<td>850</td>
<td>900</td>
</tr>
<tr>
<td>Town</td>
<td>750</td>
<td>800</td>
</tr>
<tr>
<td>Neighborhood</td>
<td>650</td>
<td>700</td>
</tr>
</tbody>
</table>

### Table 1B. DataHaven Community Index and Its Components by Area and Neighborhood, 2017

<table>
<thead>
<tr>
<th>Component</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment</td>
<td>350</td>
</tr>
<tr>
<td>Safety</td>
<td>250</td>
</tr>
<tr>
<td>Economy</td>
<td>150</td>
</tr>
<tr>
<td>Education</td>
<td>100</td>
</tr>
<tr>
<td>Health</td>
<td>50</td>
</tr>
</tbody>
</table>

### Table 1C. DataHaven Index Scores by Demographic Group and Town, 2017

<table>
<thead>
<tr>
<th>Demographic Group</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>950</td>
</tr>
<tr>
<td>Black</td>
<td>850</td>
</tr>
<tr>
<td>Hispanic</td>
<td>750</td>
</tr>
<tr>
<td>Other</td>
<td>650</td>
</tr>
</tbody>
</table>

### Table 1D. DataHaven Index Scores by Race/Ethnicity, 2017

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Alone</td>
<td>950</td>
</tr>
<tr>
<td>Black or African-American Alone</td>
<td>850</td>
</tr>
<tr>
<td>Hispanic</td>
<td>750</td>
</tr>
<tr>
<td>Asian</td>
<td>650</td>
</tr>
</tbody>
</table>

### Chapter 2

#### FIG 2.1. Population and Change by Age Group, 1990–2035

DataHaven analysis (2019). 1990 and 2000 figures are from the U.S. Census Bureau Decennial Census; for 1990, SF1 Table P11; and for 2000, SF1 Table P12, Sex by Age. 2015 figures are from U.S. Census Bureau American Community Survey 2015 5-year estimates Table B01001. 1990 figures accessible via Census Data API; all other above tables available at [https://factfinder.census.gov](https://factfinder.census.gov). 2035 projected figures are from the Connecticut State Data Center (2017) 2015–2040 Population Projections—Town Level. Available at [https://data.ct.gov/resource/hxn-h2e3k](https://data.ct.gov/resource/hxn-h2e3k).

#### FIG 2.2. Population by Age and Race, 2010

DataHaven analysis (2019) of U.S. Census Bureau Decennial Census SF1 Table P12; and subtables P12B, Sex by Age (Black or African-American Alone); P12H, Sex by Age (Hispanic or Latino); and P12I, Sex by Age (White Alone, not Hispanic or Latino). Available at [https://factfinder.census.gov](https://factfinder.census.gov).


DataHaven analysis (2019). 1990 figures are from U.S. Census Bureau Decennial Census SF1 Tables P1 and P8, accessible via Census Data API. 2017 figures are from U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B03002, Hispanic or Latino Origin by Race. Available at [https://factfinder.census.gov](https://factfinder.census.gov).

#### FIG 2.4. Foreign-Born Share of Population, 1990 and 2017

DataHaven analysis (2019). 1990 figures are from U.S. Census Bureau Decennial Census SF3 Table P42, accessible via Census Data API. 2017 figures are from U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B05001, Nativity and Citizenship Status in the United States. Available at [https://factfinder.census.gov](https://factfinder.census.gov).

#### FIG 2.5. Foreign-Born Share of Population, 2017


#### FIG 2.6. Households by Type, 1990–2017

DataHaven analysis (2019). 1990 and 2000 figures are from the U.S. Census Bureau Decennial Census; for 1990, SF1 Table P16; and for 2000, SF1 Table P18, Household Size, Household Type, and Presence of Own Children. 2010 and 2017 figures are from U.S. Census Bureau American Community Survey 2010 and 2017 5-year estimates Tables...
B11001, Household Type (Including Living Alone); and B11003, Family Type by Presence and Age of Own Children Under 18 Years. 1990 figures accessible via Census Data API; all other above tables available at [factfinder.census.gov](https://factfinder.census.gov).

**FIG 2.7. LOW-INCOME RATE BY AGE, 2000–2017**

DataHaven analysis (2019). 2000 figures are from U.S. Census Bureau Decennial Census SF3 Tables P08, Ratio of Income in 1999 to Poverty Level; and PCT750, Age by Ratio of Income in 1999 to Poverty Level. U.S. Census Bureau American Community Survey 2017 5-year estimates, Tables B17024, Age by Ratio of Income to Poverty Level in the Past 12 Months; and C17002, Ratio of Income to Poverty Level in the Past 12 Months. Available at [factfinder.census.gov](https://factfinder.census.gov). As described in the report text, “low-income” is defined here as individuals living in households whose household income is less than twice (200 percent of) the federal poverty level.

**FIG 2.8. MEDIAN HOUSEHOLD INCOME BY TOWN, 2017**


**FIG 2.9. MEDIAN HOUSEHOLD INCOME BY QUANTILE, 2016**

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2016 5-year public use microdata sample (PUMS) data. Analysis of PUMS data involves weighting survey responses to reflect overall population demographics. Values shown here represent the 20th, 50th (median), 80th, and 95th percentiles of total household incomes.

Analysis of PUMS data is done for combinations of public use microdata areas (PUMAs), the smallest geographic unit for which PUMS data is available. Fairfield County is made up of the Connecticut PUMAs with FIPS codes 00105, 00103, 00102, 00104, 00100, and 00101.

PUMS data accessed via IPUMS. Ruggles et al., 2012–2016 ACS 5-year Census microdata.

**FIG 2.10. MEDIAN INCOME OF FULL-TIME ADULT WORKERS, 2016**

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2016 5-year public use microdata sample (PUMS) data. Analysis of PUMS data involves weighting survey responses to reflect overall population demographics. To ensure comparison between groups, as well as comparison with other related analyses, adults here are filtered to only include those ages 25 and over working full-time. In this and other analyses, we define full-time workers as workers with positive earnings who, over the previous 12 months, were employed at least 35 hours per week. Median income is defined as each group’s median earnings from work, excluding other non-work sources of income. See FIG 2.9 for details on construction of geographies for PUMS analysis.

PUMS data accessed via IPUMS. Ruggles et al., 2012–2016 ACS 5-year Census microdata.

**FIG 2.11. DISTRIBUTION OF POPULATION BY NEIGHBORHOOD INCOME LEVEL, 1980–2017**

DataHaven analysis (2019) 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 the 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. 2017 values are calculated from U.S. Census Bureau American Community Survey 2017 5-year estimates Tables B01003, Total Population; B19101, Family Income in the Past 12 Months (in 2017 Inflation-Adjusted Dollars); and B19127. Available at [factfinder.census.gov](https://factfinder.census.gov). Neighborhood income categories are 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. See TABLE 2D for definitions of income brackets.

**FIG 2.12. MEDIAN HOUSEHOLD INCOME, 1990–2017**


**FIG 2.13. MEDIAN HOUSING VALUE BY TOWN, 2017**

DataHaven analysis (2019). Figure come from U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B25077, Median Value (Dollars). Available at [factfinder.census.gov](https://factfinder.census.gov).


DataHaven analysis (2019). All figures are from U.S. Census Bureau American Community Survey. 2005 values are from Tables B25070 and B25091. 2010 and 2015 figures are from 5-year estimates, Tables B25074, Household Income by Gross Rent as a Percentage of Household Income in the Past 12 Months; and B25091. Available at [factfinder.census.gov](https://factfinder.census.gov).

**FIG 2.15. MEDIAN RENTER HOUSEHOLD INCOME AND MINIMUM HOUSEHOLD INCOME TO AFFORD 2BR HOUSING, 2017**

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year estimates, Tables B25031, Median Gross Rent by Bedrooms; B25042, Tenure by Bedrooms; and B25119, Median Household Income the Past 12 Months (in 2017 Inflation-Adjusted Dollars) by Tenure. Available at [factfinder.census.gov](https://factfinder.census.gov). For comparison, we only studied two-bedroom apartments, both for median rent and median household income. Because some towns have few renters, leading to larger margins of error, values were filtered to only include towns with relatively small margins of error compared to median rent and where at least 20 percent of households were renter-occupied. Rent is considered affordable based on Federal Department of Housing and Urban Development (HUD) guidelines that housing costs total no more than 30 percent of a household’s total income. We calculated the minimum household income needed for the median rent of a two-bedroom apartment to be affordable under this guideline, and consider the shortfall to be the difference between this minimum household income and the median income of a renter household in a two-bedroom apartment. See also HUD, “Defining Housing Affordability,” [https://www.huduser.gov/portal/pdjredge/prd edge-fedat-article-081417.html](https://www.huduser.gov/portal/pdjredge/prd-edge-fedat-article-081417.html).

**FIG 2.16. HOMEOWNERSHIP RATE BY HISTORIC REDLINING GRADE, 2010**

DataHaven analysis (2019). To calculate current demographics data of areas by HOLC grade, we used digitized versions of historical HOLC maps from Mapping Inequality. See reference below and overlaid these shapefiles with shapefiles of current blocks from U.S. Census Bureau TIGER/Line shapefiles, available at [https://www.census.gov/programs-surveys/geography/geographies/mapping-files.html](https://www.census.gov/programs-surveys/geography/geographies/mapping-files.html). We then aggregated 2010 Decennial Census data, the most recent data available at the block level, for each of these graded areas. Homeownership data comes from U.S. Census Bureau 2010 Decennial Census SF1 Table H4, Tenure, available at [factfinder.census.gov](https://factfinder.census.gov). See FIG 2.18 for local recreation of HOLC maps.


**FIG 2.17. WHITE SHARE OF POPULATION BY HISTORIC REDLINING GRADE, 2010**

DataHaven analysis (2019). U.S. Census Bureau 2010 Decennial Census SF1 Table P5, Hispanic or Latino Origin by Race, available at [factfinder.census.gov](https://factfinder.census.gov); and Nelson, et al., Mapping Inequality. White population is defined as non-Hispanic white residents of each area. See FIG 2.16 for spatial analysis methodology; see FIG 2.18 for local recreation of HOLC maps.
FIG 2.18. HOLL ردLineD AREAS, 1937

FIG 2.19. NET INFLOW OF WORKERS BY TOWN AND WAGE, 2015
DataHaven analysis (2019) of U.S. Census Bureau Longitudinal Employer-Household Dynamics Origin-Destination Employment Statistics (LODES) to construct a directional network of workers moving between pairs of towns in the region. LODES data reports the census block in which workers live and the census block in which they are employed, though employer locations are based on the location of payroll and other financial offices, rather than physical place of employment. Presumably, workers work in the same town as the financial office that represents the employer. The analysis includes people who 1) both live and work in Connecticut; 2) live in New York, New Jersey, Rhode Island, Massachusetts, or Connecticut but work in Connecticut; or 3) live in Connecticut but work in New York, New Jersey, Rhode Island, Massachusetts, or Pennsylvania. This should capture most workers with interstate commutes, but may miss small numbers of people working remotely or either living or working in Connecticut. In this analysis, high-wage jobs are those paying more than $3,333 per month, or $39,996 annually, while low-wage jobs are those paying $39,996 or less annually. Block-level LODES files are available at http://leh.ces.census.gov/data.

FIG 2.20. NUMBER OF JOBS BY SECTOR, 2000–2017
DataHaven analysis (2019) of U.S. Census Bureau Quarterly Workforce Indicators, available at http://qwiexplorer.ces.census.gov at the county level. Industries are categorized based on the North American Industry Classification System (NAICS); those shown are sectors in which there were an average of at least 10,000 workers in the region in 2017. Job trends displayed are actually quarterly counts adjusted with the LODESS method to show changes within years while smoothing out sharp fluctuations. In a few cases, quarterly counts were unavailable and thus annual averages were not reported; in these cases, annual values are the mean of that year's available quarters. Numbers shown at each endpoint are their respective years' annual averages, not quarterly counts.

FIG 2.21. COUNT OF K–12 STUDENTS BY RACE, PER 100 STUDENTS, 2010–2019
DataHaven analysis (2019) of 2018–2019 school year enrollment data from the Connecticut State Department of Education, accessed via EdSight at http://edsight.ct.gov. For this and other indicators based on public school districts, regional districts were included as parts of regions to which their sending towns belong; in some cases, these towns also run their own districts for elementary school, but send middle and/or high school students to the regional district. Fairfield County values include Regional School District 9, comprised of high school students from the towns of Easton and Redding.

FIG 2.22. PERCENTAGE OF STUDENTS SUSPENDED OR EXPELLED AT LEAST ONCE, K–12 DISTRICTS, 2017–2018
DataHaven analysis (2019) of 2017–2018 school year discipline data from the Connecticut State Department of Education, accessed via EdSight at http://edsight.ct.gov. Numbers here represent the share of students who have been suspended (in-school or out-of-school) or expelled in the past school year, not deduplicated suspension rates. SEE FIG 2.21 FOR DETAILS ON REGIONAL DISTRICTS

FIG 2.23. SHARE OF PUBLIC K–12 STUDENTS MEETING ACHIEVEMENT MEASURES, 2017–2018
DataHaven analysis (2019) of data from the Connecticut State Department of Education, accessed via EdSight at http://edsight.ct.gov. Graduation rates presented are four-year cohort graduation rates, giving the percentage of students in the graduating class of 2017 who earned a high school diploma alongside the cohort with which they started 9th grade. A student is considered chronically absent if they miss at least 10 percent of the school days for which they were enrolled in a year for any reason; the chronic absenteeism rate is then the percentage of enrolled students who are chronically absent in a year. The Smarter Balanced Assessment Consortium (SBAC) standardized test is the Common Core-aligned test used in Connecticut since 2015 for both English/language arts (ELA) and math. Students are considered to pass a test if they score at meeting or exceeding grade-level goals; proficiency rates here are the share of students taking each test who passed. Chronic absenteeism and SBAC proficiency rates are from the 2017–2018 school year. SEE FIG 2.21 FOR DETAILS ON REGIONAL DISTRICTS

FIG 2.24. NUMBER AND SHARE OF STUDENTS ENROLLING IN, PERSISTING IN, AND GRADUATING FROM COLLEGE
DataHaven analysis (2019) of data from the Connecticut State Department of Education, accessed via EdSight at http://edsight.ct.gov. Enrollment rates are defined as the percentage of students from a given graduating class who enroll in college within one year of graduation. Persistence rates are defined as the percentage of students who, after enrolling in college within one 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 six years of graduating high school, out of the entire high school graduating class. The most recent available data is shown here, which is the high school graduating class of 2014 for graduation, enrollment, and persistence rates, and the class of 2010 for degree attainment rates. SEE FIG 2.21 FOR DETAILS ON REGIONAL DISTRICTS

FIG 2.25. SHARE OF ADULTS RATING AS ALMOST CERTAIN OR VERY LIKELY THAT YOUNG PEOPLE IN THEIR AREA HAVE THE FOLLOWING EXPERIENCES, 2018
DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Indicators show percentage of survey participants who believe the chances of each experience are almost certain or very likely, disaggregated by location, self-reported race/ethnicity, and income. SEE COMMUNITY WELLBEING SURVEY NOTE AT THE START OF THIS SECTION

FIG 2.26. PROBABILITY (%) OF REACHING TOP 20% OF HOUSEHOLD INCOMES AS ADULTS BY RACE AND CHILDHOOD HOUSEHOLD INCOME
DataHaven analysis (2019) of data from Chetty, R., Friedman, J. N., Hendren, N., Jones, M. R., & Porter, S. R. (2018). The Opportunity Atlas: Mapping the Childhood Roots of Social Mobility. Table 5: All Outcomes by County, Race, Gender and Parental Income Percentile. See paper and data at https://opportunitiesights.org/paper/the-opportunity-atlas. Chetty et al. used deidentified Census data to model the upward mobility of people of different demographic groups, based on the percentile of household income of the household in which they grew up. Percentages here represent the share of children of each racial group born between 1978 and 1983 whose childhood household was low-income (at the national 25th percentile), middle-income (50th percentile), or high-income (75th percentile) who then lived in households with incomes in the top 20 percent nationally in 2014 and 2015.

TABLE 2A. POPULATION AND GROWTH, 1990 AND 2017
DataHaven analysis (2019). 1990 population figures are from the U.S. Census Bureau Decennial Census, S1 Table P1, accessible via Census Data API. 2017 population figures are from U.S. Census Bureau American Community Survey 2017 5-year estimate, Table B01003. 2000 median age is from U.S. Census Bureau Decennial Census, S1 Table P13, Median Age by Sex. 2017 median age is from U.S. Census Bureau American Community Survey 2017 5-year estimate, Table B01002, Median Age by Sex. All above tables available at https://factfinder.census.gov. Population density is based on 2017 population (above) and land area calculated from U.S. Census Bureau TIGER/Line shapefiles, available at https://www.census.gov/programs-surveys/geography/geographies/mapping-files.html.

TABLE 2B. CHARACTERISTICS BY RACE AND ORIGIN, 2017
DataHaven analysis (2019). Populations by race and ethnicity are from U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B03002. Foreign-born
population comes from U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B05001. Tables available at https://factfinder.census.gov.

TABLE 2C. HOUSEHOLD STRUCTURE, 2017

TABLE 2D. GROWING NEIGHBORHOOD INCOME INEQUALITY, 2017
SEE NOTE FOR FIG 2.11

TABLE 2E. LOW-INCOME POPULATION, 2017
DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year estimates, Tables B17024; and C17002. Tables available at https://factfinder.census.gov. As described in the report text, “low-income” is defined here as individuals living in households where the household income is less than twice (200 percent of) the federal poverty level.

TABLE 2F. FINANCIAL INSECURITY, 2018
DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. For share “just getting by,” survey participants, when asked how well they were managing financially, responded that they were just getting by, finding it difficult, or finding it very difficult. Less than two months savings is based on participants’ estimate. Negative net worth is based on participants’ estimates of whether they would have money left over were their household to liquidate its assets and major possessions and pay off all debts. Transportation insecurity is defined as the share of participants reporting that at some point in the past 12 months, they could not go somewhere due to lack of reliable transportation. Likewise, food insecurity is defined as the share of participants reporting that at some point in the past 12 months, they were unable to afford to buy food they needed. Utility shutoffs are based on participants who reported having received a utility shutoff warning or completion during the past 12 months. Values are disaggregated by location and self-reported demographic groups. SEE COMMUNITY WELLBEING SURVEY NOTE AT THE BEGINNING OF THIS SECTION

TABLE 2G. HOMEOWNERSHIP, 2017
DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year estimates, Tables B25003, Tenure; B25003B, Tenure (Black or African American Alone Householder); B25003H, Tenure (White Alone, Not Hispanic or Latino Householder); and B25003I, Tenure (Hispanic or Latino Householder). Tables available at https://factfinder.census.gov.

TABLE 2H. HOUSING UNITS AND NEW HOUSING PERMITS
DataHaven analysis (2019). Counts of housing unit types, and shares of all housing units, are from U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B25024, Units in Structure. Available at https://factfinder.census.gov. Data on housing permits from Connecticut Department of Economic and Community Development Export, Housing, and Income Data, available at https://portal.ct.gov/DECD/Content/About_DECD/Research-and-Publications/01_Access-Research/Exports-and-Housing-and-Income-Data. Numbers of permits are averaged over four-year periods to smooth out fluctuations in construction from year to year, for example when a single large building is built.

TABLE 2I. HOUSING COSTS, 2017

TABLE 2J. WAGE TRENDS BY SECTOR, 2000–2017
DataHaven analysis (2019) of U.S. Census Bureau Quarterly Workforce Indicators, available at http://qwiexplorer.ces.census.gov at county level. Average wages are given, and are calculated here as means of total annual payroll over annual average employment by sector. 2000 wages are adjusted for inflation in order to accurately calculate changes in average wages over time. Industries are categorized based on the North American Industry Classification System (NAICS); those shown are sectors in which there were at least 10,000 workers in the region in 2017. SEE FIG 2.20 FOR DETAILS ON GEOGRAPHY

TABLE 2K. CHANGING INDUSTRY FOOTPRINT, 2000–2017
DataHaven analysis (2019) of U.S. Census Bureau Quarterly Workforce Indicators, available at http://qwiexplorer.ces.census.gov at county level. Each share is given as that sector’s divided over the region’s total payroll across all sectors. Numbers of permits are averaged over four-year periods to smooth out fluctuations in construction from year to year, for example when a single large building is built.

TABLE 2L. ECONOMIC OPPORTUNITY, 2018
DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Access to good opportunities for employment is the share of survey participants rating the ability of residents to obtain suitable employment as excellent or good. Youth opportunities for job advancement is the share of participants estimating that it is almost certain or very likely that young people in their area will get a job with opportunity for advancement. Car access is the share of participants saying they very often or fairly often have access to a car when they need it. Underemployment is calculated as the share of participants not working within the past 30 days but wanting to work, plus the share working part-time but preferring full-time work. SEE COMMUNITY WELLBEING SURVEY NOTE AT THE BEGINNING OF THIS SECTION

TABLE 2M. COLLEGE ENROLLMENT, PERSISTENCE, AND COMPLETION
SEE FIG 2.24 / SEE FIG 2.21 FOR DETAILS ON REGIONAL DISTRICTS

TABLE 2N. EDUCATIONAL ATTAINMENT, 2017
Chapter 3

FIG 3.1. ESTIMATED LIFE EXPECTANCY IN YEARS, 2010–2015

FIG 3.2. YEARS OF POTENTIAL LIFE LOST BEFORE AGE 75 PER 100,000 RESIDENTS BY CAUSE OF DEATH, 2010–2014
DataHaven analysis (2019) of data from the Connecticut Department of Public Health. For Years of Potential Life Lost (YPLL), we created annualized YPLL rates (or “Premature Death Rates”) by cause using the 2010–2014 dataset at the 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)*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 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.

FIG 3.3. AGE-ADJUSTED AND RELATIVE AGE-ADJUSTED ENCOUNTER RATES PER 10,000 RESIDENTS, 2015–2017
DataHaven analysis (2019) of CHIME data. 2018. Data about residents’ visits to hospitals and emergency rooms may be used as a tool to examine variations in health and quality of life by geography and within specific populations. Unless otherwise noted, all information from this source is based on a DataHaven analysis of 2012–2014 and 2015–2017 CHIME data provided by the 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 over 10,000,000 Connecticut hospital and emergency department encounters incurred by any residents of any town in Connecticut during the six year period studied. 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. 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 under-reported in some cases. Annualized encounter rates were calculated for the indicator flags assigned within the dataset including Asthma, COPD, Substance Abuse, and many other conditions. Analyses in this document describe data on “all hospital encounters” including inpatient, emergency department (ED), and observation encounters. Annualized encounter rates per 10,000 persons were calculated for the three-year period 2012–2014 and the three-year period 2015–2017 by merging CHIME data with population data. For each geographic area and indicator, our analysis generally included an annualized encounter rate for populations in each of six age strata (0–19, 20–44, 45–64, 65–74, 75–84, and 85+ years), and by gender, as well as a single age-adjusted annualized encounter rate. It is important to note that there is no way to discern the unique number of individuals in any zip code, 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. To better examine encounter rates for asthma, a more appropriate set of age groupings was used (0–4, 5–19, 20–44, 45–64, 65–74, and 75+ years), so age-adjusted rates were not calculated for asthma. Please contact DataHaven for further information.

FIG 3.4. CHRONIC DISEASE, ENCOUNTER RATES PER 10,000 RESIDENTS 2015–2017
SEE FIG 3.3

FIG 3.5. OTHER HEALTH ISSUES, ENCOUNTER RATES PER 10,000 RESIDENTS, 2015–2017
SEE FIG 3.3

SEE FIG 3.3

SEE FIG 3.3

FIG 3.8. RESIDENTS’ RATING OF LIKELIHOOD THAT YOUTH IN THEIR AREA WILL ABUSE DRUGS OR ALCOHOL, BY RACE AND INCOME, 2018
DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Indicators show percentage of survey participants guessing that chances of each experience are of each likelihood shown, disaggregated by location and self-reported race/ethnicity and income. Unlike similar questions where the focus was the percentage of adults estimating each event as almost certain or very likely, on this indicator, we chose to focus instead on participants’ uncertainty, illustrating that the risk of drug and alcohol abuse is a problem seen across demographic groups. SEE FIG 2, 25 FOR OTHER QUESTIONS IN THIS BANK, AND COMMUNITY WELLBEING SURVEY NOTE

FIG 3.9. AGE-ADJUSTED MONTHLY RATE OF DRUG OVERDOSE DEATHS PER 1 MILLION RESIDENTS, 2012–2018
DataHaven analysis (2019) of data from the Connecticut Office of the Chief Medical Examiner, available at https://data.ct.gov/resource/rybz-nyjw. Data is given for each individual to have died in Connecticut of a drug overdose from 2012 to 2018. For this analysis, data was filtered to only include people with a Connecticut town listed as their place of residence at the time of death and with their age on record. Monthly counts by age were used to calculate crude rates of overdose deaths per 1 million residents of each age group. To get age-adjusted rates, crude rates by age group were then weighted with the U.S. Centers for Disease Control and Prevention (CDC) 2000 U.S. Standard Population 18 age group weights available at https://seer.cancer.gov/stdpopulations. The rates shown here are 6-month rolling averages; that is, the rate for any given point shown in the chart represents the age-adjusted overdose death rate for that month averaged with the rates of the five months preceding it.

FIG 3.10. COUNT OF DRUG OVERDOSE DEATHS AT 6-MONTH INTERVALS BY PRESENCE OF FENTANYL, WITH PERCENTAGE OF DEATHS THAT ARE FENTANYL-RELATED, 2012–2018
DataHaven analysis (2019) of data from the Connecticut Office of the Chief Medical Examiner, available at https://data.ct.gov/resource/rybz-nyjw. In data on drug overdose deaths, individuals are marked for several common substances that may be found by the medical examiner, and may also have a more detailed cause of death written out. The categories in the data include heroin, fentanyl, and generic names of several opioids, such as oxycodone and hydromorphone. We used text mining techniques to find additional names of opiates and opioids from the cause of death text in order to fill in cases where those substances were not checked off otherwise, relevant substances didn’t fit into a given category, or where substances were misspelled or abbreviated. In total, more than a dozen substances were included as search terms.
to mark a death as opiate- or opioid-related; these deaths may have involved non-opiates as well. Similarly, cases were marked as fentanyl-related if either checked categories or text fields reported fentanyl or any fentanyl-analogues being found. See also Fig. 3.3

FIG 3.11. PERCENT OF ADULTS REPORTING PERCEIVED REASONS FOR THEIR DISCRIMINATION, OF ADULTS CITING A REASON FOR EXPERIENCES OF DISCRIMINATION, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Survey participants were asked a bank of questions on experiences of discrimination, namely whether at any point in their lives participants had been discriminated against or treated unfairly in each of several settings, including workplace hiring and promotion; police encounters; ability to move into a neighborhood, based on access to renting or buying housing; and quality of health care services. If respondents answered that they had been discriminated against in one of these areas, they were then asked to identify the reasons why they thought this happened; those reasons are included here if at least 20 percent of respondents cited them. Note that respondents were allowed to identify more than one issue. See Community Wellbeing Survey note at the beginning of this section

FIG 3.12. PERCENT OF ADULTS REPORTING UNFAIR POLICE STOPS, SEARCHES, OR OTHER MISTREATMENT AND FREQUENCY OF INCIDENTS, BY RACE AND INCOME, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Survey participants were asked about whether they had ever been unfairly stopped, searched, or otherwise mistreated by police; if so, they were then asked about the frequency of these incidents within the past three years.

See Community Wellbeing Survey note at the beginning of this section

TABLE 3A. PREMATURE DEATH RATES BY GEOGRAPHY, 2010–2014

See Fig. 3.2


DataHaven analysis (2019) of data from the Connecticut Department of Public Health Vital Statistics for the 2006–2010 and 2011–2015 periods, available at https://portal.ct.gov/DPH/Health-Information-Systems--Reporting/Hisrhome/Vital-Statistics-Registration-Reports. Low birthweight is defined as 2,500 grams (roughly 5.5 pounds). Non-adequate prenatal care indicate that the mother attended fewer than 80 percent of expected prenatal care visits, or did not start attended visits until the second trimester. Both the low birthweight rate and non-adequate prenatal care rates are given as a percent of total births for each of the 5-year periods. Percent change in both indicators are given as a percent change in the rate of each.

TABLE 3C. ASTHMA PREVALENCE BY PUBLIC SCHOOL DISTRICT, 2012–2014

DataHaven analysis (2019) of data from the Connecticut Department of Public Health School-Based Asthma Surveillance Report of 2019, available at https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/hems/asthma/pdf/SBASS_2012_2014.pdf?la=en. Asthma prevalence rates for regions are given as the weighted average of districts within the region based on the percent of students enrolled in that district in the 2018–2019 academic year. Very small school districts had suppressed values and were omitted from averages.

TABLE 3D. FREQUENT EMERGENCY ROOM USE AND HEALTH-RELATED SOCIAL NEEDS, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Respondents were asked to self-report the number of times in the past 12 months they visited the emergency room or urgent care clinic. We then looked at other responses provided by those adults to further reveal characteristics about their health and well-being, including whether, in the past 12 months, they chose to forego medical care for any reason; there had been times they were unable to afford food; they had access to a car less than “fairly often” when needed; were threatened with a utility shut-off notice; or whether they self-reported that they had been physically attacked or threatened.

TABLE 3E. BARRIERS TO HEALTHCARE, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Survey participants were asked about their experience of healthcare, whether they had access to it, and the barriers they faced. Respondents were then asked about their health and well-being, including whether, in the past 12 months, they chose to forego medical care for any reason; there had been times they were unable to afford food; they had access to a car less than “fairly often” when needed; were threatened with a utility shut-off notice; or whether they self-reported that they had been physically attacked or threatened.

TABLE 3F. EXPERIENCES OF DISCRIMINATION, 2018

See Fig. 3.11

TABLE 3G. ASTHMA PREVALENCE BY PUBLIC SCHOOL DISTRICT, 2012–2014

DataHaven analysis (2019) of data from the Connecticut Department of Public Health School-Based Asthma Surveillance Report of 2019, available at https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/hems/asthma/pdf/SBASS_2012_2014.pdf?la=en. Asthma prevalence rates for regions are given as the weighted average of districts within the region based on the percent of students enrolled in that district in the 2018–2019 academic year. Very small school districts had suppressed values and were omitted from averages.

TABLE 3H. OVERDOSE DEATHS BY SUBSTANCE, 2015–2018

DataHaven analysis (2019) of data from the Connecticut Office of the Chief Medical Examiner, available at https://data.ct.gov/resource/rybz-nyjw. Shown here are aggregated counts of accidental overdose deaths between 2015 and 2018, with annualized age-adjusted rates over that period. See Fig. 3.9 for details on age-adjustment.

TABLE 3I. OVERDOSE DEATHS BY RACE AND ETHNICITY, 2015–2018

DataHaven analysis (2019) of data from the Connecticut Office of the Chief Medical Examiner, available at https://data.ct.gov/resource/rybz-nyjw. Shown here are aggregated counts of accidental overdose deaths between 2015 and 2018 by race/ethnicity as given in their medical examiner record, with annualized age-adjusted rates over that period. See Fig. 3.9 for details on age-adjustment.

TABLE 3J. SELECTED HOSPITAL ENCOUNTERS AND HOSPITAL ENCOUNTERS BY AGE, 2015–2017

See Fig. 3.3

TABLE 3K. HEALTH RISK FACTORS, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Adult respondents were asked to rate their overall health; report recent levels of depression and anxiety; and report whether they had ever 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 they had seen a dentist in the past 12 months. DataHaven analysis (2019) of data from the Connecticut Department of Public Health Vital Statistics for the 2006–2010 and 2011–2015 periods, available at https://data.ct.gov/Examiner, available at https://data.ct.gov/Examiner. Shown here are aggregated counts of accidental overdose deaths between 2015 and 2018, with annualized age-adjusted rates over that period. See Fig. 3.9 for details on age-adjustment.

FIG 3.13. BARRIERS TO HEALTHCARE, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Survey participants were asked about their experience of healthcare, whether they had access to it, and the barriers they faced. Respondents were then asked about their health and well-being, including whether, in the past 12 months, they chose to forego medical care for any reason; there had been times they were unable to afford food; they had access to a car less than “fairly often” when needed; were threatened with a utility shut-off notice; or whether they self-reported that they had been physically attacked or threatened.

TABLE 3L. SELECTED HOSPITAL ENCOUNTERS AND HOSPITAL ENCOUNTERS BY AGE, 2015–2017

See Fig. 3.3
Library profiles. Similarly, averages of total units circulated and visits are divided by the population given by the State Library profiles.

FIG 4.1. MEASURES OF PER-PERSON MUNICIPAL ASSETS AND SPENDING
Data Haven analysis (2019). Equalized net grand list (ENGL), total expenditures, and education spending data are from the fiscal years 2013–2017 municipal fiscal indicators database from the Connecticut Office of Policy and Management (OPM), available at https://portal.ct.gov/OPM/GP-MUNFINSR/Municipal-Financial-Services/Municipal-Fiscal-Indicators. Each of these values included are for fiscal year 2017. ENGL is divided by 2017 town populations to get per-capita values. Education spending is divided by the number of enrolled public school students in each town; in cases of regional school districts that span more than one town, their pupils were allocated to towns by weighting each town’s population under age 18. OPM’s website gives details on which types of expenditures are included or excluded in calculating education spending. Total expenditures are divided by towns’ daytime population, calculated as a town’s population plus the number of people who work in that town minus the number of residents who leave the town for work; this better captures the financial strains put on towns with large numbers of incoming commuters. Municipal gap/surplus comes from the New England Public Policy Center. Municipal surplus per capita is the difference between a town’s municipal capacity per resident, or the amount of money from tax revenue available to that municipality, and municipal cost per resident, or the amount of money needed to cover the town’s estimated public expenses. Negative values signify a gap in funding available to cover those costs. See Zhao, B., & Weiner, J. (2015). Measuring municipal fiscal disparities in Connecticut. Federal Reserve Bank of Boston, New England Public Policy Center Research Report, 15–1.

FIG 4.2. NEIGHBORHOOD ASSET INDEX VS MUNICIPAL SURPLUS PER CAPITA
Data Haven analysis (2019). See FIG 1.4 FOR DEFINITION OF NEIGHBORHOOD ASSET INDEX / SEE FIG 4.1 FOR DEFINITION OF MUNICIPAL GAP/ SURPLUS. Towns may have a negative surplus (i.e. a gap), in which case they are shown to the left of $0 along the bottom axis. Towns to the right of $0 operate on a surplus, or higher capacity than cost per person.

FIG 4.3. AVERAGE TOWN PUBLIC LIBRARY VISITS PER CAPITA AND CIRCULATION PER CAPITA VS TOTAL LIBRARY EXPENSES PER CAPITA, 2017–2018
Data Haven analysis (2019) of Connecticut State Library Statistical Profiles, available at http://libguides.ctstatelibrary.org/dld/stats. Data for fiscal years 2017 and 2018 were averaged to control for single-year major spending (such as on facility renovations). Expenses per capita is the average of the total expenditure divided by the total population, as given by the State Fiscal Reports, 15–1.

FIG 4.4. PERCENT OF ELIGIBLE VOTERS WHO VOTED IN ELECTIONS, BY REGION AND WITH HIGHEST AND LOWEST TOWN RATES, 2016–2018
Data Haven analysis (2019) of voter turnout data from the Connecticut Secretary of the State, available at https://ctemspublic.pecctg.net. Voter turnout is defined as the percentage of officially registered voters who are documented as having voted. This includes overseas ballots but does not include absentee voters. Note that the years differ in which presidential, midterm, and local elections are held; as such, the most recent data for each type of election was used. As of 2019, this includes the 2018 state elections, including Congressional midterms; 2017 municipal elections, held in most but not all towns; and 2016 national elections, including votes for president. Participants in the 2018 Data Haven Community Wellbeing Survey also answered a question regarding their registration to vote.

TABLE 4A. MUNICIPAL EXPENDITURES AND FINANCIAL CAPACITY INDICATORS, FY2017
See FIG 4.1.

TABLE 4B. PERCEIVED ACCESS TO AND QUALITY OF COMMUNITY RESOURCES, 2018
Data Haven analysis (2019) of questions from the 2018 Data Haven Community Wellbeing Survey. The indicators shown are the unscaled components of the Neighborhood Assets Index. See FIG 1.4 FOR DETAIL ON THE NEIGHBORHOOD ASSETS INDEX / SEE COMMUNITY WELLBEING SURVEY NOTE AT THE BEGINNING OF THIS SECTION.

TABLE 4C. COMMUNITY TRUST AND APPRECIATION, 2018
Data Haven analysis (2019) of questions from the 2018 Data Haven Community Wellbeing Survey. The indicators shown here indicate the percentage of adults in each area who answered affirmatively to the questions shown. Data are disaggregated by geographic area, self-reported age group, and household income. See COMMUNITY WELLBEING SURVEY NOTE AT THE BEGINNING OF THIS SECTION.

TABLE 4D. PARTICIPATION IN PUBLIC LIFE, 2018
Data Haven analysis (2019) of questions from the 2018 Data Haven Community Wellbeing Survey. The indicators shown here indicate the percentage of adults in each area who answered affirmatively to the questions shown. Data are disaggregated by geographic area, self-reported age group, and household income. Due to low sample sizes, only select disaggregations are provided. See COMMUNITY WELLBEING SURVEY NOTE AT THE BEGINNING OF THIS SECTION.

TABLE 4E. RECENT VOTER TURNOUT, 2016–2018
See FIG 4.4.

SECTION 2. TEXT ENDNOTES
5 See Notes for FIG 1.1
6 See Notes for FIG 1.2
7 See Notes for FIG 1.1
8 The Community Index uses Census American Community Survey estimates for health insurance coverage to allow for nationwide comparisons at many geographic levels. Elsewhere in this report, health insurance coverage is reported from Data Haven’s Community Wellbeing Survey.
9 U.S. Census Bureau. American Community Survey 2012 and 2017 5-year estimates, Table B14003, Sex by School Enrollment by Type of School By Age for the Population 3 Years and Over. This and all other Census tables available at https://factfinder.census.gov unless otherwise noted.
10 U.S. Census Bureau. American Community Survey 2012 and 2017 5-year estimates, Table B17001, Poverty Status in the Past 12 Months by Sex by Age.
The six wealthiest towns are Darien, New Canaan, Ridgefield, Weston, Westport, and Wilton. See additional geographic detail in the Table and Figure notes.


16 DataHaven analysis (2019) of data from the National Center for Health Statistics. U.S. Small-Area Life Expectancy Estimates Project (USALEEP): Life Expectancy Estimates Files, 2010–2015. Available at https://www.cdc.gov/nchs/nvss/usaleep/usaleep.html. The tract with the lowest life expectancy (70.4 years) is 09001070900; the tract with the highest (89.1 years) is 09001050100.

17 For life expectancy, results are reported as the population-weighted life expectancy for tracts by the plurality of population by race/ethnicity in that tract.

18 Census data used here references the race of the head of household, which may differ from other members of the household. For purposes of simplicity, “white households” means households with a white head of household.


23 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Table B01001, Sex by Age.

24 SEE NOTES FOR TABLE 2A

25 Ibid.

26 Ibid.

27 SEE NOTES FOR FIG 2.1

28 Ibid.

29 Ibid.

30 Ibid.

31 Ibid.

32 Ibid.

33 SEE NOTES FOR FIG 2.3

34 SEE NOTES FOR TABLE 2B

35 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Table B03002, Hispanic or Latino Origin by Race.

36 SEE NOTES FOR FIG 2.3

37 Ibid.


39 SEE NOTES FOR FIG 2.3

40 Ibid.

41 SEE NOTES FOR FIG 2.2

42 Ibid.

43 SEE NOTES FOR FIG 2.4

44 SEE NOTES FOR FIG 2.5


46 SEE NOTES FOR FIG 2.5

47 Ibid.

48 Ibid.

49 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Table B05001, Nativity and Citizenship Status in the United States.

50 Ibid.

51 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Table B05007, Place of Birth by Year of Entry by Citizenship Status for the Foreign-Born Population.

52 Ibid.

53 DataHaven analysis (2019) of Ruggles et al. American Community Survey 2016 5-year Census microdata. Because of changes the Census Bureau made to classification of languages, including Haitian Creole, values here may not be directly comparable to ACS tables.

54 Ibid.

55 Ibid.

56 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Table B06007, Place of Birth by Language Spoken at Home and Ability to Speak English in the United States.

57 Ibid.

58 Reynolds, D. (2017, January 12). Gallup Poll: A Record Number of Americans Identify as LGBT. Advocate. Retrieved from https://www.advocate.com. While our preference, and what we use elsewhere, is the grouping “lesbian, gay, bisexual, transgender, or queer” (LGBTQ), we follow the language used in sources such as this one.

59 In data from the U.S. Census Bureau and represented here, a household is defined as one or more people who occupy a house, apartment, or other group of rooms with separate living quarters.

60 SEE NOTES FOR FIG 2.8

61 Ibid.

62 Ibid.

63 SEE NOTES FOR TABLE 2C

64 Ibid.

65 SEE NOTES FOR FIG 2.8

66 SEE NOTES FOR FIG 2.12


68 SEE TABLE 1B / SEE NOTES FOR FIG 2.8

69 SEE NOTES FOR FIG 2.9

70 SEE NOTES FOR FIG 2.10

71 Ibid. SEE ALSO FIG 1.3


73 Ibid.

74 Ibid.


77 SEE NOTES FOR TABLE 2F
Chapter 5  Conclusion and Endnotes


79 See Notes for Fig 2.11


85 See Notes for Fig 2.12

86 Ibid.

87 Ibid.

88 Ibid.

89 In 2017, approximately 9 percent of Fairfield County’s population lived below the federal poverty line, slightly below the statewide rate of 10 percent and well below the nationwide rate of 15 percent. U.S. Census Bureau. American Community Survey 2017 5-year estimates, Table C17002, Ratio of Income to Poverty Level in the Past 12 Months.


91 See Notes for Fig 2.7


94 See Notes for Table 2F

95 See Notes for Table 2G


97 Ibid.

98 See Notes for Table 2G

99 Ibid.

100 See Notes for Table 2H

101 Ibid.

102 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Table B25077, Median Value (Dollars).

103 Ibid. See also Notes for Fig 2.13


106 DataHaven analysis (2019) of data from the Federal Financial Institutions Examination Council Home Mortgage Disclosure Act Loan Application Register datasets available at https://www.ffiec.gov/hmda. The subset of loans considered here are for 1- to 4-family homes. These were loans intended for a home purchase, not remodel, with the intent of being occupied by the owner.

107 For first-lien mortgages, the threshold is 1.5 percentage points above the average prime offer rate, or AOR, and for subordinate liens, 3.5 percentage points above AOR.


109 Ibid.

110 Ibid.

111 DataHaven. (2018). DataHaven Community Wellbeing Survey. See Survey Note Intable and Figure Notes


113 See Notes for Fig 2.14

114 Ibid.

115 See Notes for Fig 2.15

116 Ibid.

117 DataHaven analysis (2019) of data from The Eviction Lab at Princeton University, a project directed by Matthew Desmond and designed by Ashley Gromis, Lavar Edmonds, James Hendrickson, Katie Krywukulski, Lillian Leung, and Adam Porton. The Eviction Lab is funded by the JPB, Gates, and Ford Foundations as well as the Chan Zuckerberg Initiative. More information is found at evictionlab.org.

118 DataHaven. (2018). DataHaven Community Wellbeing Survey. See Survey Note Intable and Figure Notes The DCWS asked adults about their experience with their last apartment, whereas the Eviction Lab data referenced above summarizes court-reported filings by address. These rates are therefore not directly comparable, but are provided to supplement our understanding of formal and informal evictions in the region.


121 Because the HOLC maps use very small geographical units, 2010 data was used because it is available at correspondingly small geographies.

122 See Notes for Fig 2.16 and 2.17


125 SEE NOTES FOR FIG 2.20

126 Ibid.


129 SEE NOTES FOR FIG 2.20

130 SEE NOTES FOR TABLE 2J

131 Ibid.

132 Ibid.

133 Ibid.

134 SEE NOTES FOR FIG 2.20

135 SEE NOTES FOR TABLE 2K

136 SEE NOTES FOR FIG 2.19

137 SEE NOTES FOR TABLE 2L

138 Ibid.

139 Ibid.

140 Ibid.


142 SEE NOTES FOR TABLE 2L

143 Ibid.

144 Ibid.

145 Ibid.


148 DataHaven analysis (2019) of data from the 2-1-1 Child Care Annual Capacity, Availability and Enrollment Survey. Available at https://www.211childcare.org/reports/annual-survey-2018


151 DataHaven. (2018). DataHaven Community Wellbeing Survey. SEE SURVEY NOTE IN TABLE AND FIGURE NOTES


153 SEE NOTES FOR FIG 2.21


155 Ibid.

156 Ibid.


158 Ibid.


162 SEE NOTES FOR FIG 2.24


165 SEE NOTES FOR TABLE 2N


167 SEE NOTES FOR FIG 2.23


173 SEE NOTES FOR FIG 2.22 See also Rocque, M. (2010).

175 Rocque, M. (2010).

176 SEE NOTES FOR FIG 2.25


179 SEE NOTES FOR FIG 2.26

180 DataHaven. (2018). DataHaven Community Wellbeing Survey. See survey note in table and figure notes


183 SEE NOTES FOR FIG 3.1


186 SEE NOTES FOR TABLE 3G

187 SEE NOTES FOR FIG 3.1

188 SEE NOTES FOR FIG 3.2, 3.3 AND TABLE 3A.


191 Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. (2019). Division for Heart Disease and Stroke Prevention at a glance. Available at https://www.cdc.gov/chronicdisease/resources/publications/aag/heart-disease-stroke.htm


193 See notes for tables 3A and 3B Local data on the overall impact of fetal and infant deaths are included above, in the section on premature mortality.

194 Ibid.


197 Ibid.


200 See notes for Fig 3.4

201 See notes for table 3G

202 Ibid.

203 See notes for table 3E

204 Ibid.

205 DataHaven. (2018). DataHaven Community Wellbeing Survey. See survey note in table and figure notes

206 See notes for table 3D

207 Ibid.

208 Ibid.

209 DataHaven. (2018). DataHaven Community Wellbeing Survey. See survey note in table and figure notes

210 Ibid.


213 DataHaven. (2018). DataHaven Community Wellbeing Survey. See survey note in table and figure notes


216 See notes for table 3F and fig 3.11


219 DataHaven. (2018). DataHaven Community Wellbeing Survey. See survey note in table and figure notes


222 See Notes for Fig 2.25


229 DataHaven. (2018). DataHaven Community Wellbeing Survey. See survey note in Table and Figure Notes

230 Ibid.

231 Ibid.


235 See Notes for Fig 3.9, 3.10, and Table 3H

236 Ibid.

237 See Notes for Fig 3.9 and Table 3A

238 Ibid.

239 Ibid.


241 Ibid.

242 See notes for Fig 3.10.

243 See notes for Table 3l.

244 DataHaven analysis (2019) of data from the Connecticut Department of Mental Health and Addiction Services. (2019). Opioid related treatment admissions by town in Department of Mental Health and Addiction Services programs. Available at https://data.ct.gov/resource/4pv7-jx8n

245 See Notes for Fig 3.3, 3.4, 3.5, 3.6, and 3.7.

246 DataHaven. (2018). DataHaven Community Wellbeing Survey. See survey note in Table and Figure Notes

247 Ibid.


257 See Notes for Fig 3.4, 3.5, 3.6, and 3.7


259 See Notes for Fig 3.4 and 3.5

260 See Notes for Fig 3.6 and 3.7


263 DataHaven. (2018). DataHaven Community Wellbeing Survey. See survey note in Table and Figure Notes

264 See Notes for Fig 3.4, 3.5, 3.6, and 3.7

265 See Notes for Fig 3.4 and 3.5
267 See notes for Fig. 3.4 and 3.5


275 Ibid.

276 See notes for Fig. 3.4 and 3.5


278 DataHaven analysis (2019) of Connecticut Department of Public Health, STD statistics in Connecticut. Available at https://portal.ct.gov/DPH/Infectious-Diseases/STD/STD-Statistics-in-Connecticut, Rates were not calculated if fewer than 20 cases were reported.


286 Adapted from the Center for Active Design’s Four Key Civic Life Outcomes framework. Retrieved from https://centerforactivedesign.org/assembly


290 See notes for Fig 4.1

291 Ibid.


294 See notes for Fig 4.1

295 Ibid.


297 Ibid. See also notes for Fig 4.1


304 See notes for Fig 4.1

305 Ibid.

Because Long Island Sound is so important to the region, collaborative efforts to further improve the Sound are critical, such as the Long Island Sound Stewardship Fund and Sustainable Connecticut.


332 SEE NOTES FOR TABLE 4C

333 Ibid.

334 Ibid.

335 Ibid. SEE ALSO NOTES FOR FIG 3.12


344 Ibid.


349 SEE NOTES FOR TABLE 4D

350 Ibid.


352 DataHaven. (2018). DataHaven Community Wellbeing Survey. SEE SURVEY NOTE IN TABLE AND FIGURE NOTES


357 Ibid.

358 Ibid.

359 Ibid.

360 Ibid.

361 Ibid.

362 Ibid.

363 Ibid.

364 Ibid.

365 Ibid.

366 Ibid.

367 Ibid.

368 Ibid.

369 Ibid.

370 Ibid.

371 Ibid.

372 Ibid.

373 Ibid.

374 Ibid.

375 Ibid.

376 Ibid.

377 Ibid.

378 Ibid.

379 Ibid.

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381 Ibid.

382 Ibid.

383 Ibid.

384 Ibid.

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387 Ibid.

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412 Ibid.

413 Ibid.

414 Ibid.

415 Ibid.

416 Ibid.

417 Ibid.

418 Ibid.

419 Ibid.

420 Ibid.

421 Ibid.

422 Ibid.

423 Ibid.

424 Ibid.

425 Ibid.

426 Ibid.

427 Ibid.

428 Ibid.


357 SEE NOTES FOR TABLE 4D

358 Ibid.

359 SEE NOTES FOR FIG 4.4

360 Ibid.


362 SEE NOTES FOR FIG 4.4

363 Ibid.


Ships on the water, South Norwalk, CT. Photo credit: Nelson J. Flowers
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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.

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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.

Additional information related to this report is posted on our websites. Follow the story and access resources at #CommunityIndex
Greenwich Community Health Improvement Partnership

Providers
Greenwich Boys and Girls Club
Greenwich Hospital
Greenwich Department of Health
Greenwich Department of Human Services
Greenwich Public Schools
Greenwich Library
Optimus Healthcare
SNAP Eligibility & Outreach
Silver Hill Hospital
The Hub (formerly Southwest Regional Mental Health Board)
Brunswick School
Greenwich Commission of Aging
Liberation Programs
Neighbor to Neighbor
Pathways
Communities 4 Action
FQHC Wilbur Peck
Family Centers
Laurel House, Inc.
River House Adult Day Center
ShopRite
YMCA of Greenwich
YWCA of Greenwich
Greenwich Emergency Management Operations
The Nathaniel Witherell Rehabilitation and Nursing Center
Global Health Systems Consultants, LLC

Housing
The Housing Authority of Greenwich

Faith Based
St. Catherine’s
First Congregational Church
Libraries
Greenwich Library System
  Byram Shubert Library
  Perrot Memorial Library
  Cos Cob Library

Community
Greenwich Rotary Club
Greenwich Police Department
Greenwich Chamber of Commerce

Schools
Greenwich Private Schools
Greenwich Board of Education
Greenwich Public Schools

Advocacy Groups
Abilis
Child Guidance Center
Get Healthy CT
League of Women Voters of Greenwich

State Agencies
F.S. DuBois Center, DMHAS

Social Services
Community Answers
Greenwich Department of Parks and Recreation
Kids in Crisis
NAMI Stamford/Greenwich
United Way Greenwich
Council of Community Services (NY) Partners

Providers
Greenwich Hospital
Hudson Valley Health (HRHCare Community Health - HRHCare HRHCare)
FQHC Open Door Family Medical Center
Port Chester-Rye-Rye Brook EMS
Port Chester Carver Center
Rye YMCA
The Osborn
Rye Brook Seniors
Staying Put in /Rye and Environs (SPRYE)
Port Chester Seniors
Rye Seniors

Health Departments
Westchester Department of Health

Housing
Port Chester Housing Authority

Faith Based
All Souls Parish
KTI Synagogue
St. Paul’s
St. Peter’s

Libraries
Port Chester – Rye Brook Public Library
Rye Reading Room

Schools
Blind Brook Public School
Port Chester Public Schools
Rye Public Schools
Advocacy Groups
Family Services of Westchester
Forever Families through Adoption
NAACP

State Agencies
Westchester County Board of Legislators

Social Services
Don Bosco Community Center
Hispanic Resource Center
Human Development Services of Westchester
Port Chester Cares
Caritas

Community
Port Chester/Rye Brook Rotary Club
Port Chester Police Department
Rye Police Department
Rye Brook Police Department
Port Chester Village Board
Rye Rotary Club
Kiwanis Club Port Chester/Rye Brook
Rye Chamber of Commerce
Port Chester/Rye Brook Chamber of Commerce
APPENDIX C: HOW TO SEARCH FOR A SERVICE USING THE 2-1-1 DATABASE

1. Visit https://www.211ct.org/ if you are looking for a particular service, and want to be connected.
2. If you know the particular service you are looking for, type in the service or need (e.g. “food”, “clothing”, “financial assistance”) in the search box. A variety of items will auto-suggest for you to choose from if you want.

3. If you are unsure of what you are looking for, there is a selection of menus you can choose from, to narrow down what services you might want.
4. Click a category based on your specific need.

Listed Categories: Basic Needs, Children and Families, Crisis, Food, Health Care, Housing, Income, Legal Assistance, Mental Health, Older Adults, Re-Entry, Substance Use Disorder, Transportation, Utility Assistance, Volunteer, Youth

5. Example: Children and Families category. You can click on a sub-category best fitting your needs. We will select “SNAP” under the Child Nutrition Programs for this example.
6. This is the results list that shows up once clicking “SNAP”, under the Child Nutritions Program subcategory. Relevant organizations are listed as red flags on the map. You can use the “Show Advanced Filters” option to narrow down an organization closest or most relevant to you.

7. Once you have found a service of your liking, you can click on the program name or on the More Details button from any of the resource cards on the left-hand side to view its location and description.
8. Scroll down for detailed information on the service such as contact, location, documents required, and more.

9. You can call 2-1-1 during the search process to be connected with a specialist who can guide you to find the service fitted to your needs.

**How to Access the Services by Phone**

To access 2-1-1’s telephone-based services, you can dial 2-1-1 within Connecticut, or 1-800-203-1234 outside Connecticut, 24/7. A Contact Specialist will try to connect you to a service fitted to your needs.