

Race, Place, and Health: A comparative review of health data on African American males in Bridgeport, Connecticut

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Project Background

This report helps develop a baseline of information about a variety of barriers that may prevent African-American men in Bridgeport and other Connecticut cities from achieving their full health potential. When these barriers involve system-wide, avoidable and unjust social and economic policies that create unequal access to opportunity, they are often known as “**health inequities**.”

To gather these data, the Aspen Institute has engaged DataHaven, a New Haven-based nonprofit organization whose mission is to help improve access to and use of public information within local communities in Southern Connecticut. DataHaven is a partner of the National Neighborhood Indicators Partnership, a collaborative national effort by the Urban Institute and approximately 40 local partners who further the development and use of neighborhood information systems in local policymaking and community building. Further information on the data in this report is available from DataHaven.

Approach to Data Collection

Federal and State data sources, such as the U.S. Census Bureau or State Department of Education, can provide a rich source of information about African-American men at a local level. Despite the very large amount of available data, it is often difficult to obtain and is not always collected or reported by age, gender, race, ethnicity or cultural group, which can limit its usability to local communities.

In order to help contextualize the information that is available on African-American men, we looked at the State’s urban centers as a whole as well as the regional context surrounding Bridgeport. In each case we used the most recent and/or most accurate public data available.

Sources consulted include:

- Demographic and economic data on population size, age, race, household structure, and social characteristics. Unless otherwise noted, the most recent 5-Year U.S. Census Bureau American Community Survey estimates are used for all socioeconomic indicators, such as income by age group, while 2010 Decennial Census data are used for all population indicators, such as total population by age group. We also consulted data from various State agencies.
- Health care utilization and access patterns, including hospitalization, insurance data, disease incidence, and other measures of health issues and access. These are mostly from the Connecticut Department of Public Health and the Greater Bridgeport Community Health Needs Assessment, a recent publication from a regional and citywide health coalition.
- Data on the criminal justice system and residents’ exposure to this system.
- Other local data on the neighborhoods where young African Americans are most likely to live, in order to help evaluate environmental conditions and to provide location context for Aspen Institute partners working in Bridgeport or other Connecticut cities.

Community Profile: Demographic and Socioeconomic Data

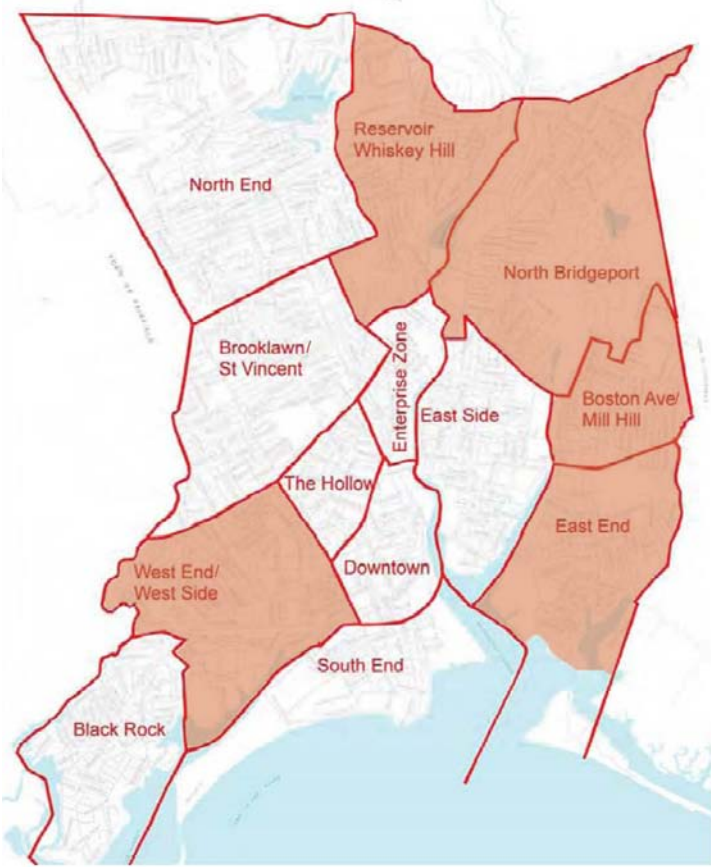
Given the large amount of available data on each topic, we could not include the full range of information within this report due to space and time limitations. A summary of key data points follows.

Place Matters: Profile of Bridgeport Neighborhoods where African-American men live

*“We know that a child’s life expectancy is predicted more by his ZIP code than his genetic code.”
RWJF President and CEO Risa Lavizzo-Mourey, MD¹*

Neighborhoods play a critical role in health. In particular, neighborhoods have been shown to have a deeply-ingrained association with life expectancy. In many cities, life expectancy can differ by 20 or more years from one neighborhood to the next. This is because access to life-enhancing resources such as jobs, transportation, fresh air, quality foods, housing, places to exercise, and good schools, and an individual’s risk of injury from crime victimization or from a traffic crash, are partly determined by place.

In addition to our citywide analyses throughout this document, we looked at the neighborhoods where African-American men are most likely to be living. The five neighborhoods highlighted in red on the map below – Boston Ave/Mill Hill, East End, North Bridgeport, Reservoir Whiskey Hill, and West End – are those where the proportion of African Americans is significantly greater than that of the city (35%). We grouped these five areas into a category that we will call “**Predominantly African-American neighborhoods**” allowing them to be compared with “**Other Bridgeport neighborhoods**” or with the Greater Bridgeport area as a whole. Although this analysis is fairly simple, we believe that it allows a better understanding of the neighborhoods where African-American men are most likely to live than that provided by a simple look at citywide or regional statistics.²



Neighborhoods Map | Source BfJ Planning
Higher concentration of African-Americans than city

The “Predominantly African-American neighborhoods” are home to 41% of the citywide number of men of all races over age 25, but are home to 58% of all African-American men of that age.

Twenty-seven percent of all African-American men over age 25 living within the Bridgeport-Stamford metropolitan statistical area, which extends from Greater Bridgeport south to Greenwich and north to Danbury, live within these five neighborhoods.

The highest concentrations of African-Americans are in the East End and Reservoir Whiskey Hill, where approximately 55% of residents identify as Black or African-American alone. North End and Black Rock are the only two city neighborhoods where the proportion of African-American residents is significantly smaller than the citywide average, although even in those two areas, one out of five residents identifies as Black or African-American.

Demographic Profile

The tables below provide basic demographic profiles of the geographies included within this report, including the “Predominantly African-American Neighborhoods” identified in the section above.

In some cases, demographic differences are more pronounced by geography than they are by race (Table 1). For instance, roughly 4 in 10 African-American families with children are headed by a married couple, and 6 in 10 are headed by a single parent. Husband-wife families comprise the majority of families with their own children living at home in Connecticut (70%) and within most Bridgeport neighborhoods (51%), but in the city’s predominantly African-American neighborhoods, they are the minority (42%).

Table 1. Population, Households, and Families (2010 Census)

	Connecticut	Bridgeport-Stamford Metro Area	City of Bridgeport Total	Predominantly African-Am. N’borhoods	Other Bridgeport N’borhoods
Total Population	3,574,097	916,829	144,229	60,668	83,561
African-Am. Population and as a % of Total	362,296 10%	99,317 11%	49,842 35%	26,893 44%	22,949 27%
Total Households	1,371,087	335,545	51,255	21,126	30,129
Non-Family Households: Male householder living alone	157,923	33,783	6,707	2,688	4,019
African-Am. Male living alone	15,061	3,634	1,955	1,061	894
Total Families with own children <18 yrs	410,990	113,425	16,505	7,366	9,139
% w/ Husband & Wife	70%	76%	47%	42%	51%
% headed by Female, no husband present	24%	19%	44%	49%	40%
% headed by Male, no wife present	6%	5%	9%	9%	9%
African-Am. Families with own children <18 yrs	46,302	12,821	6,511	3,485	3,026
% w/Husband & Wife	39%	42%	37%	35%	40%
% headed by Female, no husband present	53%	51%	54%	56%	52%
% headed by Male, no wife present	8%	7%	8%	9%	8%

African-Americans are significantly less likely to own their home (Table 2).

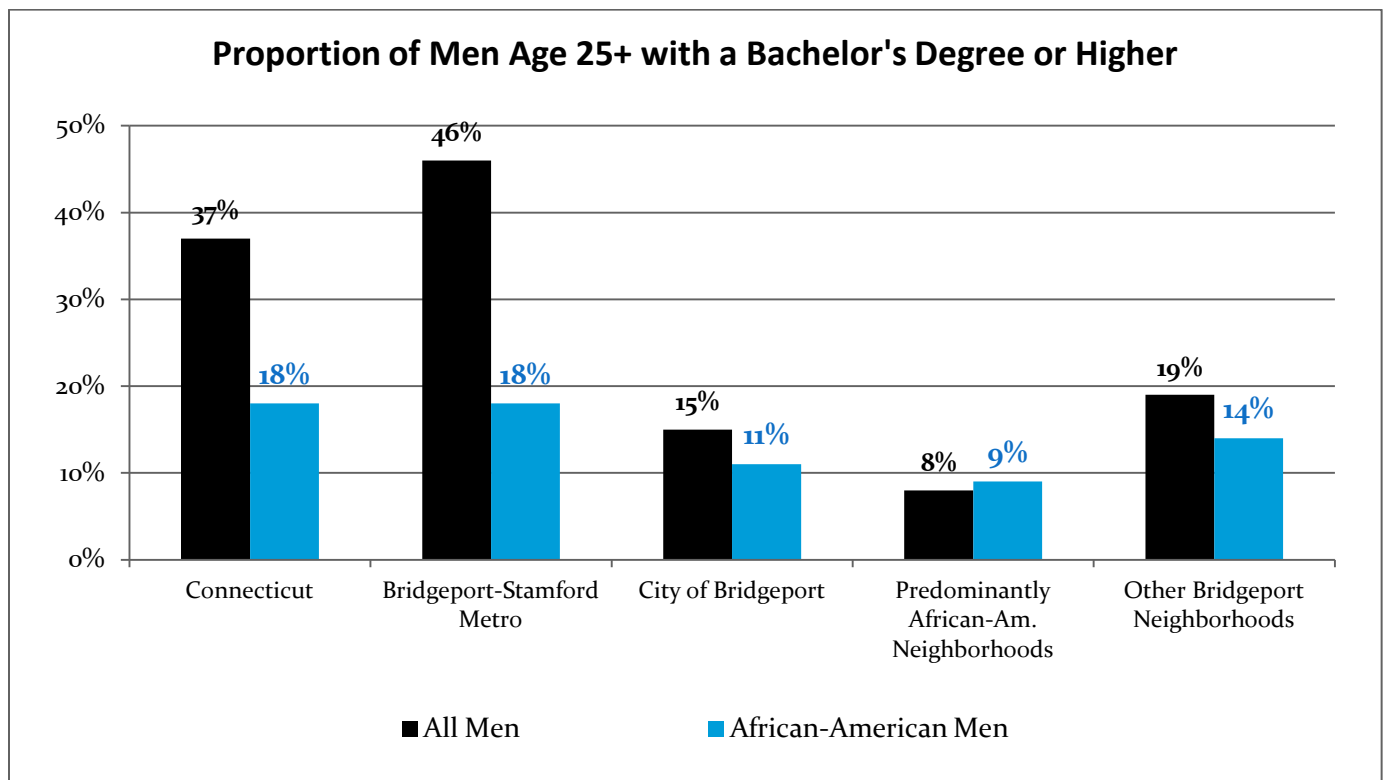
Table 2. Homeownership Rate (2010 Census)

	Connecticut	Bridgeport-Stamford Metro Area	City of Bridgeport Total	Predominantly African-Am. N’borhoods	Other Bridgeport N’borhoods
Percent of all units that are owner-occupied	67%	69%	43%	41%	44%
Percent of all units w/ African-American householders that are owner-occupied	40%	42%	40%	41%	38%

Table 3 shows the levels of education that have been attained by men age 25 or older within each of our profiled areas. Within the Bridgeport-Stamford metropolitan area as a whole, 18% of African-American men and 46% of all men possess a Bachelor's Degree or higher. However, in the City of Bridgeport, only 11% of African-American men and 15% of all men have a Bachelor's Degree. Educational attainment is lower within Bridgeport's predominantly African-American neighborhoods. Of the 7,087 men in these neighborhoods, 652 (9%) are estimated to have a Bachelor's Degree or above, and 1,827 (26%) have no high school degree or equivalent. This is of interest because a large share of new job postings in the Bridgeport area require applicants to have completed a Bachelor's Degree or higher.

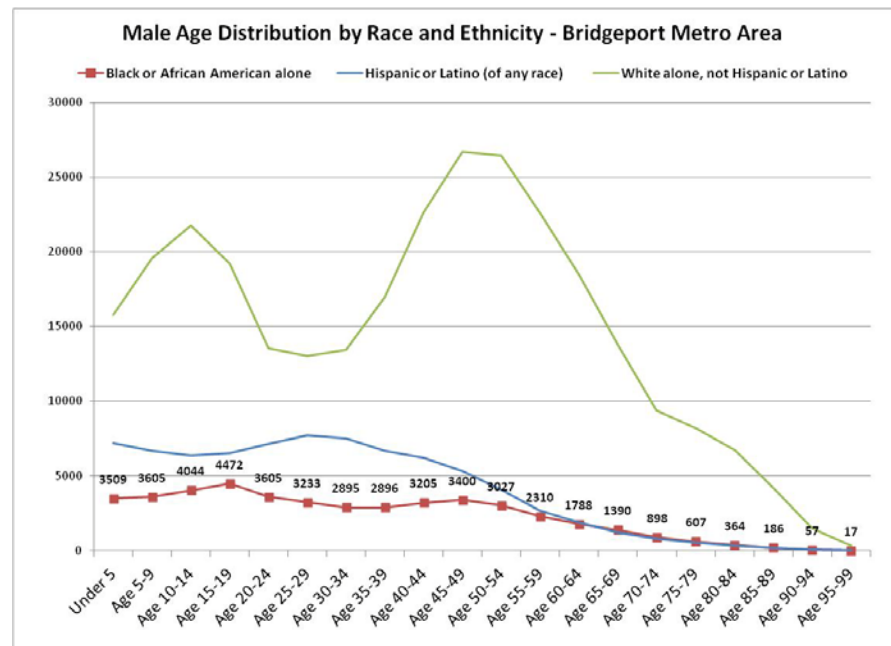
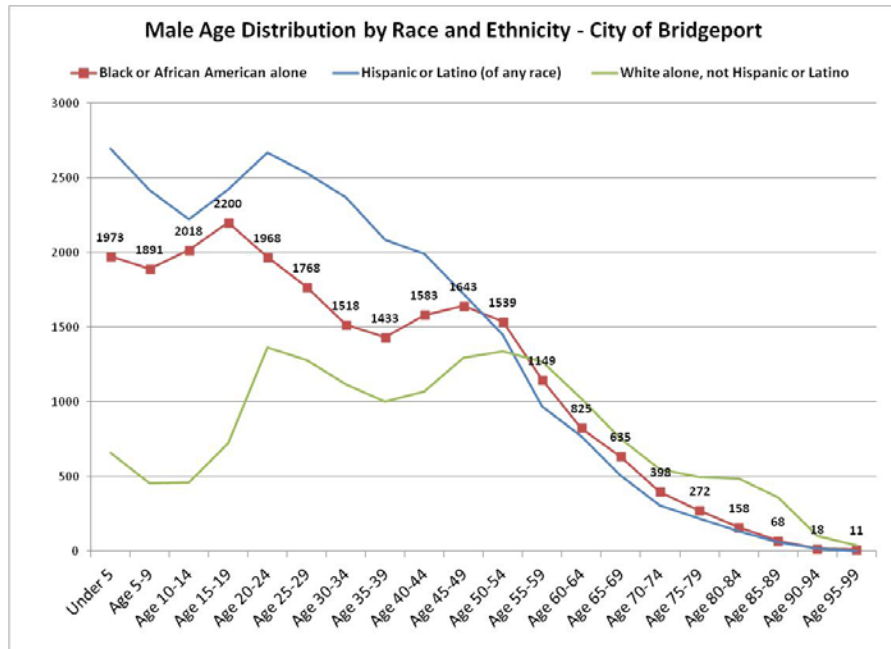
Table 3. Educational Attainment of Men Age 25+ (2011 5Y American Community Survey)

	Connecticut	Bridgeport-Stamford Metro Area	City of Bridgeport Total	Predominantly African-Am. N'borhoods	Other Bridgeport N'borhoods
Number of Men Age 25+	1,144,612	289,883	41,024	16,787	24,237
African-Am. Men 25+	96,077	25,846	12,239	7,087	5,152
Proportion of Men with no high school degree	12%	12%	28%	32%	26%
Number and Proportion of African-Am. Men with no high school degree	18,410 19%	5,292 21%	2,825 23%	1,827 26%	998 19%
Proportion of Men with a Bachelor's Degree or higher	37%	46%	15%	8%	19%
Number and Proportion of African-Am. Men with a Bachelor's Deg or higher	17,349 18%	4,649 18%	1,393 11%	652 9%	741 14%



Age Distribution of Men by Race and Ethnicity

The graphs below show the number of men, by age group, in the City of Bridgeport and the Bridgeport-Stamford metropolitan area, respectively, as of the 2010 Census. African-American (shown in red) and Latino (shown in blue) men in the area are concentrated within the City.



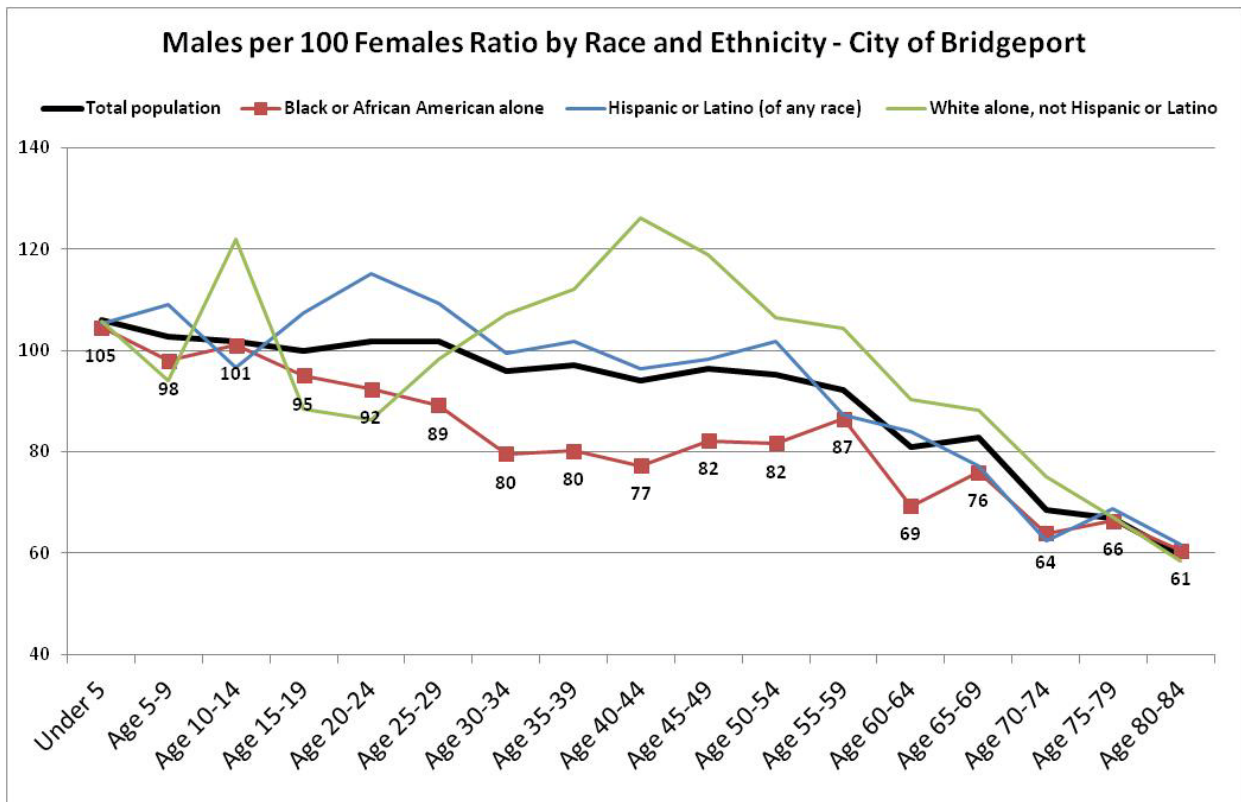
Taken together, these graphs illustrate that young adults of color in the metropolitan region are particularly concentrated within the City of Bridgeport. For example, the City is home to 56% of the African-American male children under the age of 5 living in the entire metropolitan region (1,973 in the City, out of 3,509 in the region), even though it is home to just 4% of the area’s non-minority children under age 5 (660 out of 15,765). Research shows that this type of racial residential isolation can predict increased risks of poor health, higher crime, limited access to employment, and other negative outcomes.

Ratio of Men to Women and the Incarceration Rate

The graph below shows demographic data from the City of Bridgeport, but this time as a ratio comparing the size of the male population to the size of the female population. A ratio of 100 males to 100 females is a numerical balance. For the population as a whole, the ratio stays near 100 (see black line) until beginning to slowly decline when people approach age 60, reflecting shorter life expectancies among men. However, for African Americans, the ratio declines much more quickly, meaning that there are far fewer African American men living in Bridgeport relative to the number of women living there. Overall ratios across all ages are presented in Table 4.

Table 4. Number of Males per 100 Females (2010 Census)

	Connecticut	Bridgeport-Stamford Metro Area	City of Bridgeport Total	Predominantly African-Am. N'borhoods	Other Bridgeport N'borhoods
Total Population	95	95	94	93	95
African-American Population	91	85	86	85	87

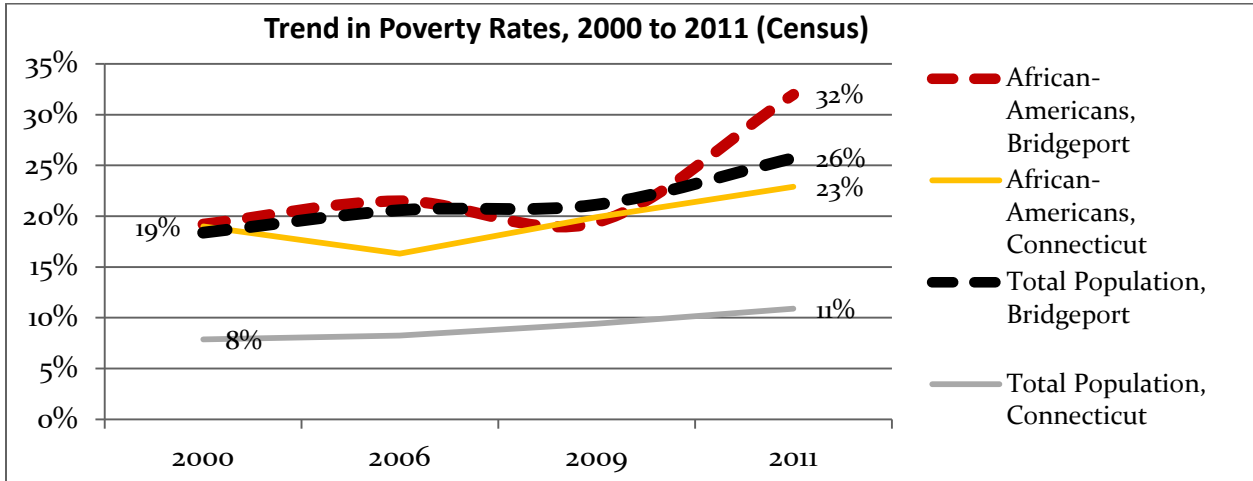


This divergence may be explained in part by a high incarceration rate, as residents of Bridgeport who go to prison are typically counted as living in another town. In 2008, 5.4% of African-American men living in Connecticut were incarcerated in a prison or jail, versus just 0.4% of White non-Hispanic men.³ Rates are significantly higher among young men and high school dropouts. Nationally, 10% of all Black men in their thirties are currently incarcerated.⁴ As of 2008, there were 2,195 Bridgeport residents incarcerated in Connecticut prisons – more than from any other municipality except Hartford and New Haven. By comparison, there were 86 incarcerated residents from Fairfield, Easton, and Trumbull combined.⁵

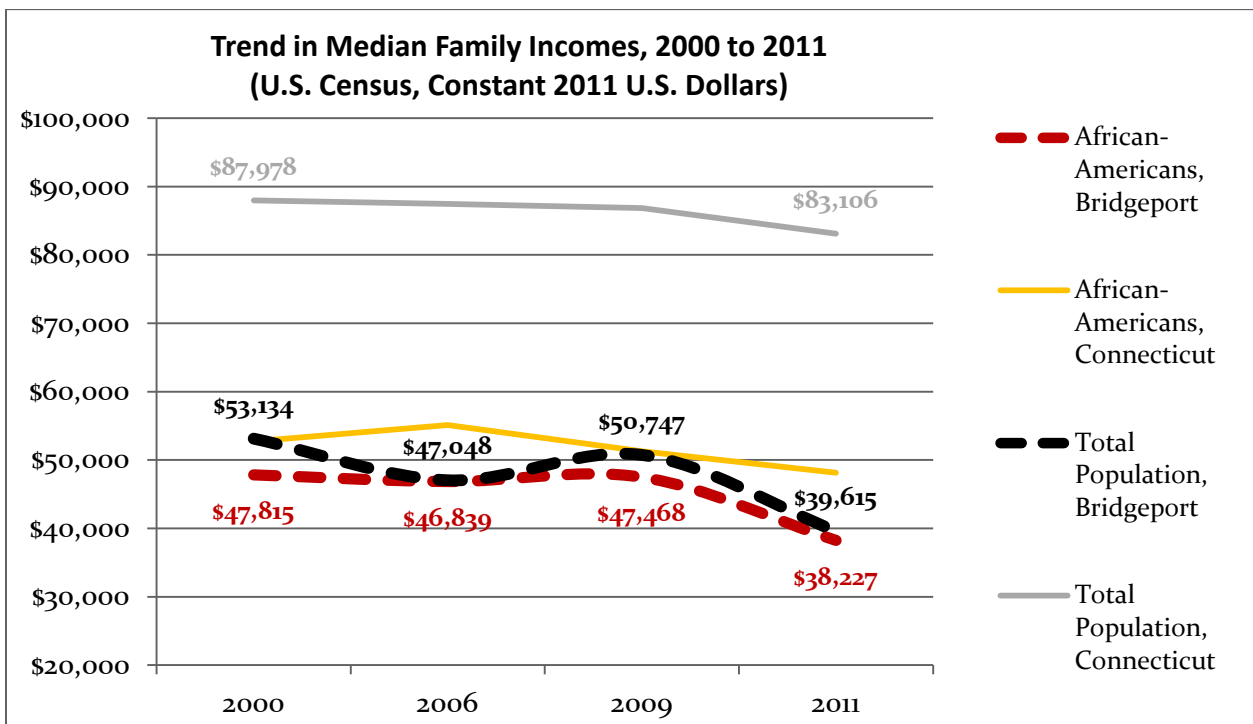
Access to Life-Sustaining Economic Resources among African-American Men

Access to Income

Residents living below the poverty line often face significant daily stress, such as uncertainty about where to find food or housing. Although poverty rates have been elevated among African-Americans for decades, it has increased significantly since the beginning of the Great Recession in 2008-2009.



The figure below shows the trend in inflation-adjusted incomes for typical families within the City of Bridgeport and in Connecticut as a whole. In 2011, the typical African-American family in Bridgeport had 20% less income than they did in 2000, a drop from \$47,815 per year in 2000 to \$38,227 per year in 2011. During the same time period, median family incomes in the State as a whole declined by 6% (to \$83,106), and among non-Hispanic White families, they declined by less than 1% (from \$95,916 to \$95,109).



Looking at the years from 2006 through 2010, the last period for which comprehensive data by demographic group are available, poverty rates among men in Bridgeport (20% of all men living below the poverty line) were significantly higher than those within the metropolitan area (7%). The poverty rates were just 3% among White, non-Hispanic men in the metropolitan area. On the whole, poverty rates in predominantly African-American neighborhoods were as high as those in the rest of the city, and much higher than those found in surrounding suburban towns. Among African-American men in Bridgeport, poverty rates from 2006 through 2010 were highest among children (32%), followed by young adults (15%), older adults (13%) and senior citizens (10%) but in all cases, rates are significantly elevated over those of the regional population as a whole.

Table 5. Poverty Rates Among Men (2010 5Y American Community Survey)⁶

	Connecticut	Bridgeport-Stamford Metro Area	City of Bridgeport Total	Predominantly African-Am. N'borhoods	Other Bridgeport N'borhoods
Total Population, Male	8%	7%	20% (13,057)	20%	19%
African-Am., Male	26%	18%	20% (4,582)	19%	22%
Hispanic/Latino, Male	22%	17%	24% (5,931)	n/a	n/a
White Non-Hispanic, Male	5%	3%	12% (2,043)	n/a	n/a
Age 0-18, Male	13%	9%	30% (5,779)	30%	30%
African-Am. 0-18, Male	26%	28%	32% (2,558)	29%	35%
Age 18-34, Male	11%	11%	20% (3,613)	18%	21%
African-Am. 18-34, Male	18%	15%	15% (877)	11%	19%
Age 35-64, Male	6%	5%	13% (2,970)	15%	11%
African-Am. 35-64, Male	13%	12%	13% (1,000)	15%	12%
Age 65+, Male	5%	4%	12% (695)	15%	9%
African-Am. 65+, Male	9%	9%	10% (147)	13%	5%

Note: Within the City of Bridgeport column, numbers in parentheses represent the total number of men in poverty.

The official poverty measure is based on income, not assets. It has been criticized as being outdated, as the current threshold does not accurately reflect costs of living – single persons making more than \$11,490 per year, or households of three persons making more than \$19,530 per year, are not considered to be living in poverty. Though the total number of residents living in poverty is important for planning access to social services and insurance, there are often at least as many residents who have incomes that place them “near poverty,” and who are also unable to provide for their families without using social assistance.

Access to High School and College Degrees

High school and college degrees are a key predictor of lifetime income, as well as risk of exposure to the criminal justice system. For instance, nationally in 2009, individuals with no high school diploma earned just \$19,500 per year on average.⁷ Black men who dropped out of high school in recent decades have been 11 times more likely to be incarcerated than Black men who attended at least one year of college.⁸

Information on the current educational attainment rates of the population age 25 or older as a whole are shown in the above section on demographics. Census data show that African-American residents within Bridgeport are at least four times less likely than residents in the remainder of the metropolitan area to have a four-year college degree, and more than twice as likely to not have any high school degree.

The following tables illustrate the issue of unequal access to quality education for children growing up within Bridgeport. At most schools, women appear to outperform men by a significant degree.

Graduation and College Completion Data by Selected High School

Bridgeport is similar to other predominantly low-income urban school districts nationally in the sense that fewer than one in ten students currently entering high school is likely to receive any type of college certificate or degree by the time they are 25 years old. To illustrate, of those who entered Harding High School in Bridgeport, only 45% graduated within four years, compared to 83% statewide. Of those who did graduate, only 10% received a degree or credential within six years (see graphic below).

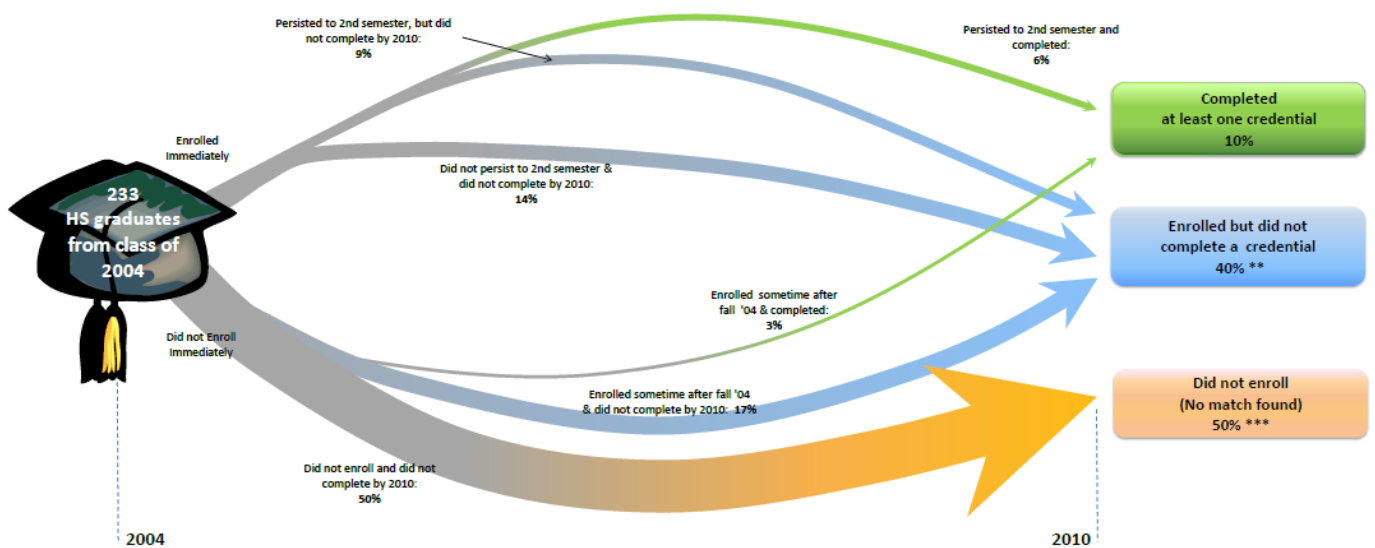
Table 6. Enrollment, High School and College Graduation Rates by Bridgeport Area High School

Key: M = Men, F = Women, AA = African-American, W = White

High School	Number of African-Am. men enrolled in 12 th grade (2011)	Non-White Percentage of enrolled 12 th graders (2011)	4-Year Cohort Graduation Rates from High School (2011)	High school grads who completed a college degree or credential within 6 years (2010)
All schools, State of Connecticut	N/A	33%	83% Total 80% M, 86% F // 71% AA , 89% W	41%
Bridgeport: Bassick High	43	97%	61% Total 58% M, 64% F // 66% AA , 69% W	7%
Bridgeport: Central High	72	91%	74% Total 66% M, 82% F // 79% AA , 69% W	28%
Bridgeport: Harding High	84	98%	45% Total 37% M, 53% F // 54% AA , 75% W	10% (see chart below)
Fairfield: Warde	5	27%	94% Total	57%
Trumbull	19	18%	98% Total	58%
Stratford	30	57%	89% Total	24%

Note: High school enrollment and Cohort Graduation Rates are published by the State Department of Education.⁹ College persistence data is tracked based on how many graduates within the Class of 2004 received any degree or credential by 2010, and is available from the State Board of Regents P-20 Council.¹⁰

Graphic from P-20 Council: Pathways to college for graduates of Harding High School¹¹



Enrollment and Graduation Rates from Selected Area Colleges

The following table shows some of the available data on local colleges and universities, from the National Center for Educational Statistics Integrated Postsecondary Education Data System (IPEDS).¹² Significant disparities between women and men, and between African-American students and students of other backgrounds, are evident in these enrollment and degree attainment rates. One of the limitations to the data set is that the race and ethnicity of students is not known in every case.

Table 7. Enrollment and Graduation Rates by Race at Bridgeport Area Colleges¹³

Key: M = Men, F = Women, AA = African-American, W = White

Institution	Undergraduate Enrollment: 2011, Unduplicated 12-Mos	Graduation Rates within 150% of normal time to completion: 2011	Degrees Awarded, 2011 Note: Only most common degrees awarded are shown
University of Bridgeport	Total: 3,076 962 M, 2,114 F 1,098 AA, 854 W	Total: 28% 26% M, 30% F 18% AA, 36% W	Bachelor's Degree 116 M, 249 F // 109 AA, 128 W Master's Degree 465 M, 426 F // 32 AA, 272 W
Sacred Heart University (Fairfield)	Total: 4,860 1,914 M, 2,948 F 225 AA, 3,356 W	Total: 68% 63% M, 71% F 57% AA, 68% W	Bachelor's Degree 337 M, 531 F // 25 AA, 756 W Master's Degree 172 M, 426 F // 17 AA, 510 W
Housatonic Comm. College (Bridgeport)	Total: 9,008 3,359 M, 5,649 F 1,840 AA, 2,618 W	Total: 9% 8% M, 10% F 6% AA, 10% W	Associate's Degree 189 M, 302 F // 107 AA, 224 W
Southern CT State Univ (New Haven)	Total: 9,983 3,918 M, 6,065 F 1,349 AA, 6,827 W	Total: 44% 40% M, 46% F 40% AA, 44% W	Bachelor's Degree 487 M, 1,094 F // 180 AA, 1,163 W Master's Degree 181 M, 524 F // 46 AA, 559 W

Data on college persistence show that many students who enter college must take remedial coursework, and often must do so without receiving college credit.¹⁴ For instance, of the 252 graduates of Harding High School in Bridgeport in 2010, State data shows that 63 enrolled within the State's Community College system. Of these, 56 were recommended for "developmental" (remedial, no-credit) courses based on the Accuplacer Placement Exam, and only one student tested at "College Level." Of the 433 graduates of Central High School, 100 of the 117 who enrolled in Community Colleges were recommended for developmental coursework and only five tested at "College Level." An additional 21 graduates of Central enrolled in the CT State University system, of whom 19 were recommended either for remedial or developmental coursework.

Graduates of suburban schools surrounding Bridgeport who enroll within State universities are far more likely to be placed at "College Level" when they begin college – meaning they have a significant head start, both in time and often money, towards obtaining a college degree.

Access to Transportation

Transportation is a major barrier to the accessibility of jobs and health care. Within the City of Bridgeport, African-Americans are more than three times less likely to have access to a vehicle than residents of the metropolitan area as a whole. African-American men living in Bridgeport are more reliant on public transportation and have slightly longer commute times to work than non-minority residents.

Spatial mismatch between jobs and neighborhoods is one way to analyze this issue. The impact of spatial mismatch on African-Americans is described in a primer on the subject by Keith Ihlanfeldt:

“The cost of searching for jobs in the suburbs or commuting to these jobs may be high for central-city blacks for three reasons. First, lower-skilled black workers have little knowledge of suburban job openings, because they rely on informal rather formal methods of job search. Consulting with friends and neighbors and making direct applications without referrals are used often, while methods that would better inform blacks of suburban jobs, such as responding to classified advertisements in local newspapers or registering with a local employment agency, are seldom employed. Second, these workers rely heavily on public transit to make the journey to work and this mode of travel does a poor job in meeting the needs of reverse-commuters. The basic problem is that suburban jobs are highly dispersed and most are not located within walking distance of a suburban transit stop. Finally, the search costs of blacks are increased because they encounter greater labor-market discrimination in the suburbs. The prejudices of white employers, white employees, and white customers all act to decrease the hiring rates of blacks in the suburbs, forcing them to make more applications for each of the job offers that they receive.”¹⁵

Whereas in previous generations many men would have been able to work in nearby urban factories or businesses, today, the vast majority of jobs are located in the suburbs, and nearly three-quarters of Black men living in Bridgeport now face commutes to other towns throughout the metropolitan area. Many jobs are not accessible without a car, yet 26% of African-American households in the City of Bridgeport have no vehicle available.

Although transit stops exist throughout Bridgeport, and rush-hour service frequency is similar to US averages, for residents living in the “core” cities of Bridgeport and Stamford, only 36% of jobs in the broader Bridgeport-Stamford metro area are reachable via transit in 90 minutes.¹⁶ This means that many residents within Bridgeport are unable to access a large share of total regional job openings.

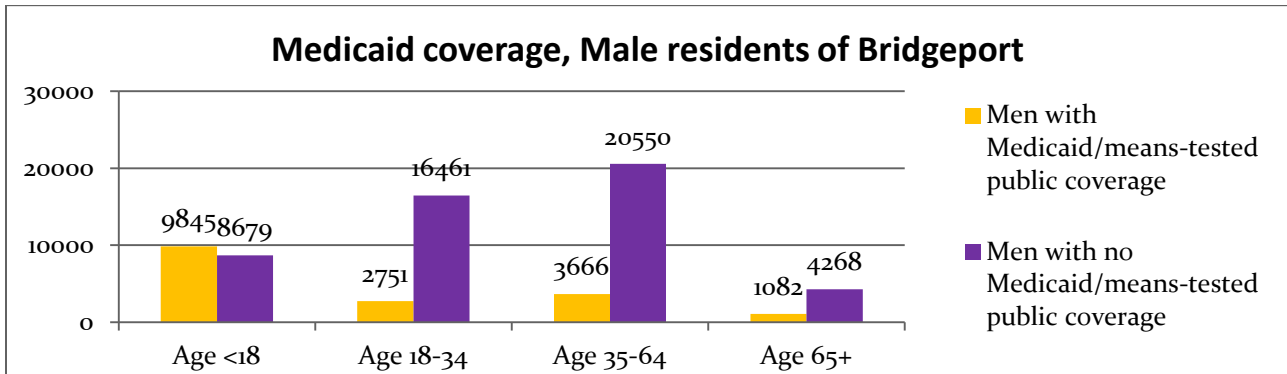
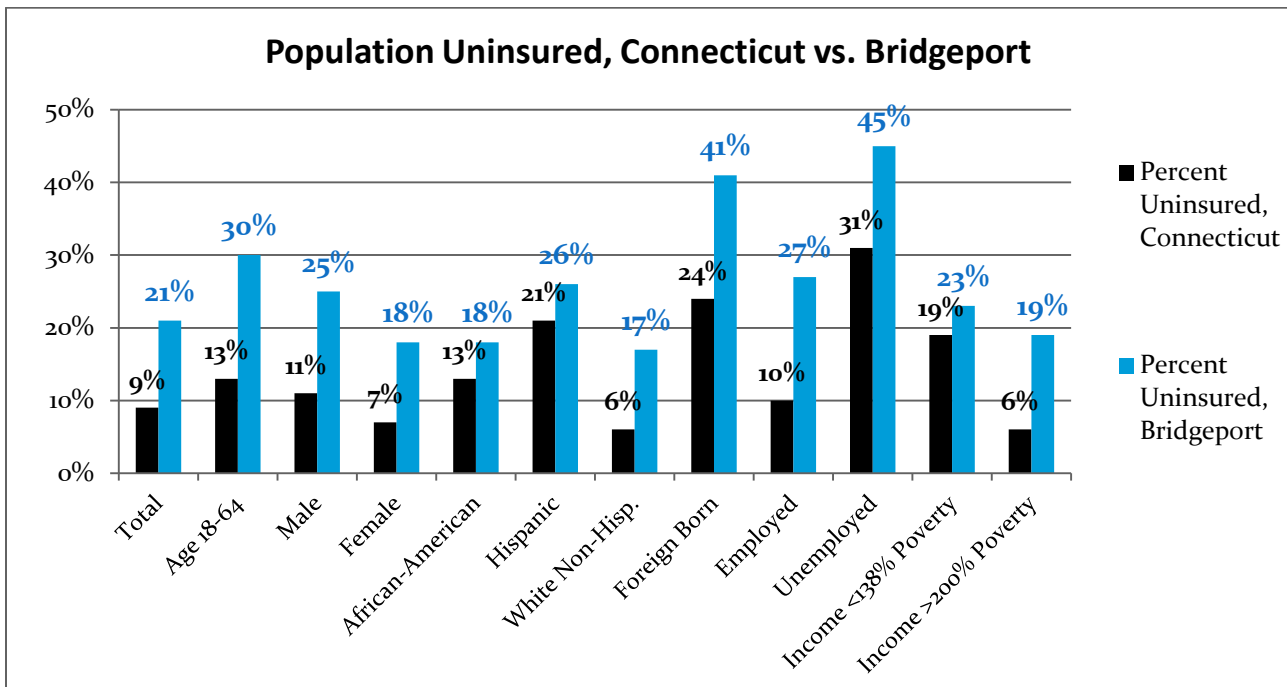
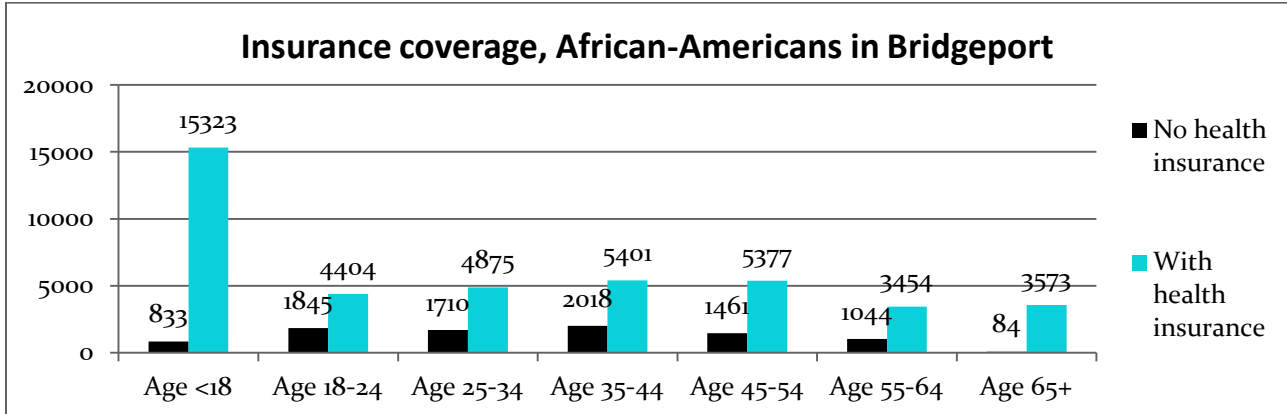
Among Bridgeport residents, only 27% of African-American men who work have jobs that are located within Bridgeport. African-American men appear to have better access to local jobs in the nearby cities of Hartford and New Haven: in them, 42% and 49% of African-American male workers, respectively, have jobs that are located in the same city where they live.

Table 8. Selected Transportation Characteristics (2010 5Y American Community Survey)

	Connecticut	Bridgeport-Stamford Metro Area	City of Bridgeport Total	Predominant ly African-Am. N’borhoods	Other Bridgeport N’borhoods
Average Commute Time in minutes¹⁷					
All Male workers	25.6	29.4	27.0	25.0	28.3
African-Am. Male Workers	25.2	27.6	28.6	~27	~29
Means of Transportation to Work					
Car: All workers	87%	81%	80%		
Car: African-Am.	79%	76%	75%		
Public transit: All workers	4%	9%	12%		
Public transit: African-Am.	12%	16%	19%		
Zero Vehicles Available					
All householders	9%	8%	22%		
African-Am. householders	22%	23%	26%		

Access to Care: Health Insurance and Health Care

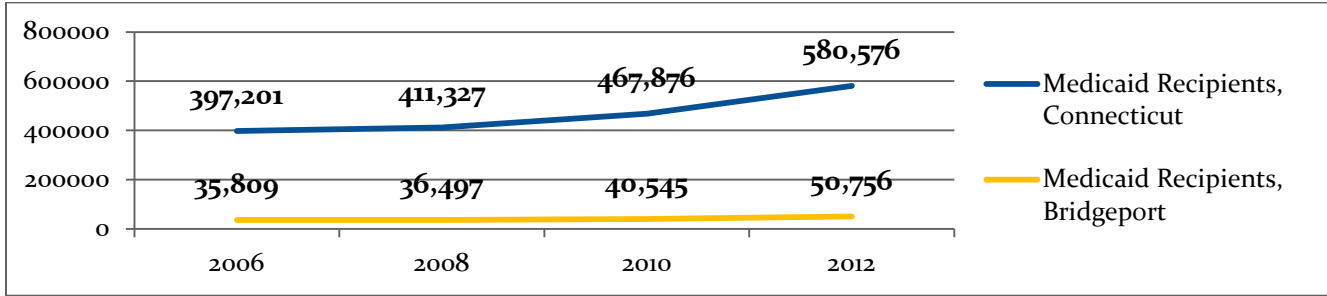
The Census Bureau's American Community Survey collects data on health insurance as of 2009, so the types of detailed tables by race used in the 2010 5Y American Community Survey are not yet available for smaller geographic areas. However, a number of data sets are available for the City of Bridgeport using American Community Survey data collected from 2009 to 2011 (2011 three-year ACS). Examples follow.



Access to care is a major concern in Connecticut cities, particularly among minority residents. For example, from 2006-2008, 18% of African-American men and 18.8% of Hispanic men said they could not visit a doctor in the past year because of cost. This figure was 6.5% among White men statewide.¹⁸ Also, 37.5% of Black men reported having no dental checkup in the past two years, versus 20.3% of White men.

Predicted Increase in Medicaid Access and Insurance Rates among Low-Income Residents

The number of Medicaid recipients in Connecticut and Bridgeport has grown in recent years, according to DSS, rising 46% and 42%, respectively since 2006. On a per capita basis, residents of Bridgeport are currently more than two times more likely to be receiving Medicaid than residents Statewide.



Considering the most current data on men living in Bridgeport who are either in poverty or “near poverty,” and the current Medicaid coverage rate, it stands to reason that a large proportion of male residents who are eligible for Medicaid are not currently enrolled.

The Medicaid expansion, enabled in the Affordable Care Act (ACA), is predicted to significantly increase the number of low-income residents who are eligible for Medicaid or insurance subsidies. According to the most recent (2011 one-year) American Community Survey estimates, Connecticut is home to 304,186 nonelderly African American residents, of whom 34,841 are uninsured. Of those who are uninsured, 56% have an income under the 138% of the Federal Poverty Level that makes them eligible for Medicaid.¹⁹

Based on the available data for the City of Bridgeport for the same year, there are 28,604 adults age 18-64 who have incomes below 138% of the Federal Poverty Level. Of these, an estimated 9,873 (35%) have no health insurance coverage at all, while 13,240 (46%) have Medicaid or other means-tested public coverage.²⁰ American Community Survey estimates of health insurance by poverty status are not yet available by race/ethnicity or gender.

Other Access Issues

As shown in one of the charts above, residents who are employed are much more likely to have health insurance than residents who are unemployed. Residents who work in full-time, year-round jobs, or jobs that require higher skill levels, are also significantly more likely to have health insurance coverage than those who work in part-time or lower-paying jobs. Additionally, residents who recently moved to the United States have more difficulty obtaining health insurance for various reasons.

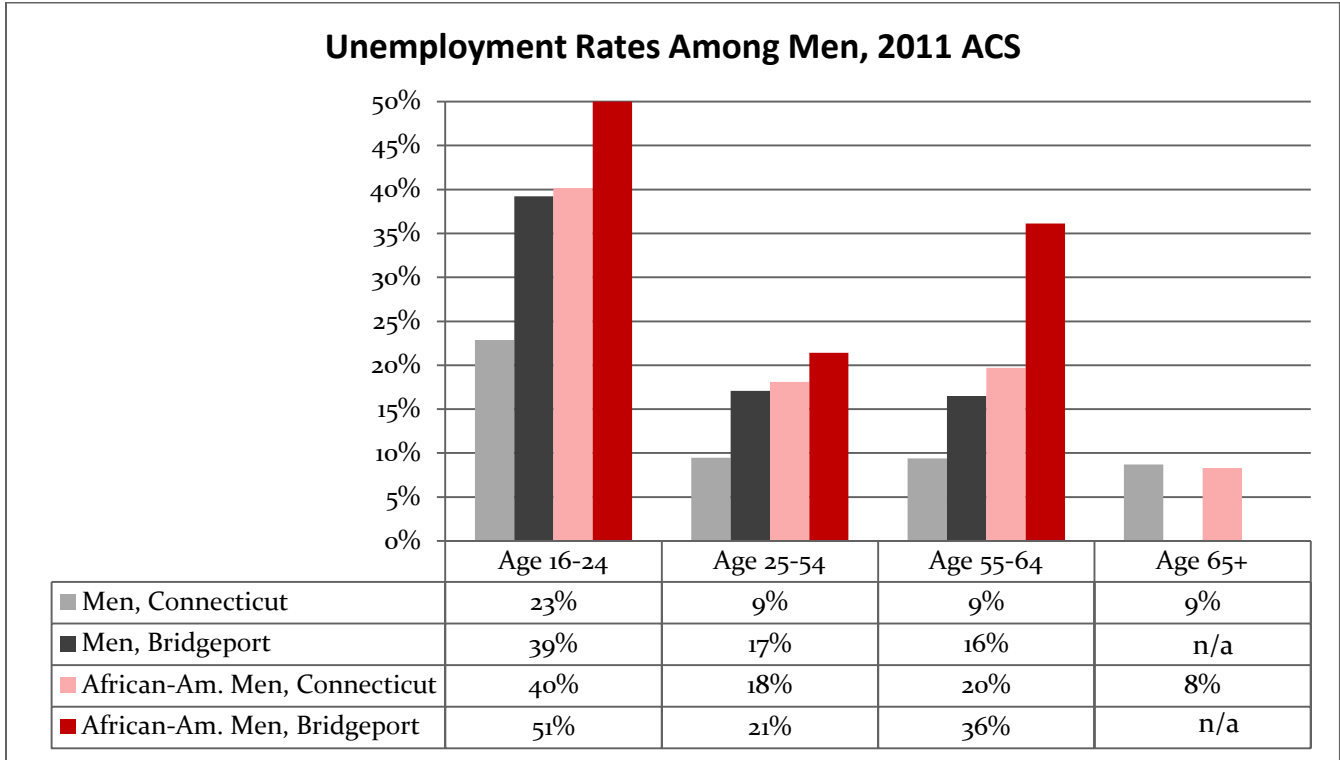
Respondents to the Bridgeport Community Health Needs Assessment Survey were asked about the issue of access to health care in more depth. As detailed in subsequent sections, this survey was a large-scale convenience sample conducted throughout the Greater Bridgeport area, including five immediately surrounding towns, and was designed to be representative of the population as a whole, but with a

particular focus on the City of Bridgeport.²¹ In particular, 61% of the respondents who lacked insurance in 2012 indicated that cost of care was a barrier to accessing health care. African-American and Hispanic residents surveyed were much more likely than Whites to cite lack of transportation, discrimination and unfriendliness of staff, and language issues (in the case of Hispanic residents) as barriers to care. Among Bridgeport residents as a whole, the most frequently cited barriers to health care were long waits for appointments (30%), cost of care (25%), lack of health insurance (21%), lack of evening or weekend hours (21%), lack of transportation (20%), and discrimination or unfriendliness of staff (9%). 76% of Bridgeport residents said they had some difficulty accessing care.

Access to Jobs: Unemployment Rates

A significant proportion of African-American men in Bridgeport lack access to suitable employment, a factor that can negatively impact their overall health, economic wellbeing, and access to health insurance coverage. To illustrate, of the roughly 2,000 African-American men age 55 to 64 in Bridgeport, only 1,500 are in the labor force, and of those, only 2 out of 3 are employed. By comparison, more than 9 out of 10 White non-Hispanic men in the labor force in that age group are employed.

According to the 2011 one-year American Community Survey (ACS), the official unemployment rates among African-American men are typically twice as high as the unemployment rates among all men in Connecticut. For example, while 9% of men age 25 to 54 were unemployed in Connecticut in 2011, 18% of African-American men in Connecticut were unemployed. Unemployment rates are higher among young men, and generally are much higher in the City of Bridgeport than in surrounding suburban areas.



The official unemployment rate does not include people who have given up looking for work or who are not eligible to work for some other reason (e.g., being a full-time student). The poor employment market leads some men to drop out of the workforce entirely, which means that they are not included within the

calculation. The official unemployment rate also does not consider “underemployment,” a situation in which many adults are currently working in part-time jobs even though they would prefer to work full-time. “Underemployment” rates tend to be much higher than unemployment rates – for example, as of April 2013, the official rates at the national level were 13.9% and 7.5%, respectively.²²

Unemployment has been shown to have a negative impact on health, causing decreases in life expectancy and in mental health status. This seems to be particularly true of long-term unemployment (the condition of being unable to find work for 6 months or more), which at a national level is much higher among older adults (those over 55) and among African-Americans.

Currently, the 7,605 unemployed men in Bridgeport are about 50% more likely to be in poverty than the 112,364 unemployed men in the State of Connecticut as a whole, which is one indication that long-term joblessness is a contributor to financial stress among adult men. Within Bridgeport in 2011, the poverty rate among unemployed men age 16 and over (31%) is estimated to be about 3.5 times higher than the poverty rate among employed men age 16 and over (9%). In Bridgeport, poverty rates among men who are not in the labor force or who have given up looking for work altogether are similar to poverty rates among the unemployed (about 1 in 3).²³

Health Data on African-American Men in Bridgeport

About the Health Data

In order to analyze health data on African-American males in Bridgeport and other Connecticut cities, we consulted the latest available data from the Connecticut Health Data Scan (a project of the Connecticut Commission for Health Equity), other data from the State Department of Public Health, and data collected by the Greater Bridgeport Community Health Needs Assessment, involving interviews with 1,302 regional residents and over 200 focus group participants, and published in April 2013.²⁴

In Connecticut, public health data are often analyzed on the basis of aggregate Health Reference Group (HRG) geography due to small sample sizes within each of the 169 municipalities in the State. Even in larger towns like Bridgeport, sufficient data are not available to produce estimates for all indicators and population groups. The recency of health data is an issue. The most updated health data available by district is typically about five years old, and data on national sites such as State Health Facts is also only available for 2006-2008. Due to resource limitations at the Connecticut Department of Public Health, technical assistance has not been available to allow researchers to create more recent estimates for small geographic areas. Despite the limitations, the available health data allows us to illustrate how health disparities are closely related to disparities in income, race and ethnicity within Connecticut’s urban areas.

In the following tables and charts, “Urban Centers” is a Health Reference Group consisting of the State’s three largest city centers: Bridgeport, Hartford, and New Haven. “Wealthy Suburbs” is an aggregate of 27 wealthy towns including high-income areas near Bridgeport such as Darien, Easton, Fairfield, Trumbull, and Woodbridge. We chose these areas in order to illustrate the disparities between men in urban centers and men in more typical, middle-class and upper-middle-class parts of the State.

Life Expectancy, Premature Death, and Hospitalization Rates

As of 2007, life expectancy at birth in Connecticut was estimated to be 80.4 years for Whites, 77.3 years for African-Americans, 83.9 years for Latinos, and 92.4 years for Asian-Americans. Life expectancy was 77.7 for males, and 82.4 years for females.²⁵ Life expectancy calculations are based on current mortality rates. A more common method to understand the relative risk of premature mortality is to analyze the age-adjusted mortality rates (AAMR) for individuals under age 75. The following data from the Health Data Scan show that Bridgeport residents are significantly more likely to experience premature mortality:

Table 9. Age-Adjusted Mortality Rate, Under Age 75, Per 100,000 (2005-2008)

Indicator	Connecticut	Urban Centers	Wealthy Suburbs	Bridgeport city
Total, all persons	289	446	178	425
Black, Not Hispanic	497	574	248	n/a
White, Not Hispanics	280	453	185	n/a
Hispanic (any race)	248	286	122	n/a

Table 10 shows statewide disparities in hospitalization rates, for all conditions except birth, by age group.

Table 10. Age-Specific Hospitalization Rate per 100,000 CT Residents (2007)²⁶

Age Group	African-Americans	Whites	Disparity Ratio
Age 15-24	4,128	2,521	1.6 times more likely
Age 25-44	8,587	4,894	1.8 times more likely
Age 45-64	17,007	8,867	1.9 times more likely

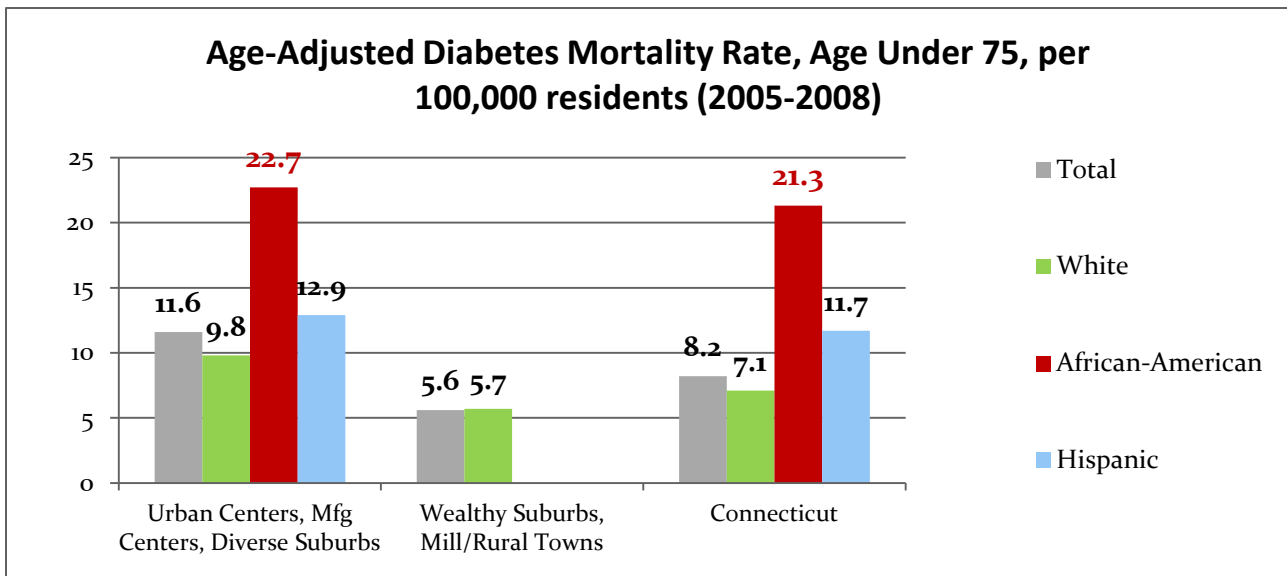
Among the 15-24 age group, the largest differences in hospitalization rates by race and ethnicity were for respiratory disease (with African-Americans that age 2.8 times more likely to be hospitalized than Whites), diabetes mellitus (2.4 times more likely), and injury (1.9 times more likely). Among the 25-44 age group, the largest differences were for infectious disease (African-Americans 3.1 times more likely to be hospitalized than Whites), respiratory disease (2.7 times more likely), and endocrine and metabolic disorders including diabetes (2.7 times more likely). Differences for the 45-64 age group are presented in Table 11, showing large differences by race in the hospitalization rate across most conditions.

Table 11. Connecticut Resident Hospitalizations for ages 45-64 by Race/Ethnicity (2007) – Number and Rate per 100,000

By Diagnostic Group (ICD-9)	White Non-Hispanic		Black Non-Hispanic	
	Number	Rate	Number	Rate
Infectious & parasitic diseases (001-139)	1,966	250	622	852
Malignant neoplasms (140-208)	4,371	555	571	782
Benign neoplasms (210-229)	1,352	172	311	426
Endocrine, nutritional, metabolic, immun. disorders (240-279)	3,071	390	836	1,145
Diabetes mellitus (250)	983	125	417	571
Psychotic conditions ex alc/rug psychoses (290,293-299)	4,222	536	672	920
Mental disorders (290-319)	6,657	846	1,024	1,402
Diseases of the nervous system & sense organs (320-389)	1,313	167	246	337
Diseases of the respiratory system (460-519)	5,424	689	1,122	1,536
Diseases of the digestive system (520-579)	8,756	1,112	1,409	1,929
Diseases of the genitourinary system (580-629)	3,852	489	609	834
Injury & poisoning (800-999)	6,262	795	1,030	1,410
All Discharges, Age 45-64	69,815	8,867	12,423	17,007

Diabetes

Diabetes and diabetes-related conditions are a disproportionately large driver of Connecticut’s racial disparities in health. The age-adjusted diabetes mortality rate among African-Americans in Connecticut is three times higher than the rate among Whites. In addition to Urban Centers and Wealthy Suburbs described above, the particular analysis below incorporates other Health Reference Groups in order to create two “groups” of towns –one for larger urban areas (including Urban Centers like Bridgeport), and one for wealthier suburbs and more rural areas.



Obesity and Overweight

In the 2012 Bridgeport community health assessment survey, which covered Bridgeport plus immediately surrounding towns, African American respondents were more likely to report being obese based on their self-reported height and weight. 37% of non-Hispanic Black respondents in the area are considered obese, compared to 24% of non-Hispanic White respondents. The barriers to healthy nutrition and weight management that lead to obesity begin in elementary school or earlier. Based on available data including the recent Bridgeport health needs assessment, we estimate that childhood obesity rates within Bridgeport are generally twice the statewide average. The most recent analysis of data that allows for comparison of state and local areas, below, shows that wealthy suburbs have much lower obesity rates:

Table 12. Percentage of Adults 18+ who are Obese (2004-2007) ²⁷

Indicator	Connecticut	Urban Centers	Wealthy Suburbs	Bridgeport city
Total, all persons	20%	25%	13%	28%
Black, Not Hispanic	32%	34%	n/a	33%
White, Not Hispanic	20%	20%	14%	23%
Hispanic (any race)	23%	28%	n/a	34%

Physical Activity and Leisure Time Activity

In the 2012 Bridgeport CARES health survey, which covered Bridgeport plus immediately surrounding towns, African American respondents were more likely to report having no leisure time physical activity. Although 24% of the survey sample said they had no leisure time physical activity in the last month, the figure ranged from 18% in wealthy suburbs to 37% in the City of Bridgeport. The health assessment

(which also involved focus groups) found that all participants believed physical activity was important, but that challenges to being active included lack of time and the presence of community infrastructure that did not encourage physical activity, such as streets with no sidewalks and safety concerns in urban parks. The most recent analysis of statewide survey data on physical activity is presented below.

Table 13. Percentage of Adults 18+ with No Physical Activity (2004-2007)²⁸

Indicator	Connecticut	Urban Centers	Wealthy Suburbs	Bridgeport city
Total, all persons	6%	14%	5%	15%
Black, Not Hispanic	12%	17%	n/a	18%
White, Not Hispanic	6%	10%	5%	10%
Hispanic (any race)	15%	17%	n/a	18%

Asthma

Asthma rates are elevated among African-Americans and within the State's urban centers. According to the Connecticut Department of Public Health's (CTDPH's) comprehensive new report on Asthma, African-American children are about twice as likely to have asthma as White children (18.9% versus 9.9%).²⁹ The CTDPH report concludes that to improve asthma outcomes, we must improve neighborhood environmental quality and reduce the stresses that are associated with racial residential segregation, particularly for African-American residents and lower-income children.

Table 14a. Percentage of Adults Ever Told They Had Asthma (2000-2003)

	Connecticut	Urban Centers	Wealthy Suburbs	Bridgeport
Percentage of Adults Ever Told They Had Asthma (2000-2003)				
Total, all persons	12%	15%	10%	15%
Black, Not Hispanic	14%	14%	n/a	n/a
White, Not Hispanic	12%	16%	12%	n/a
Hispanic (any race)	14%	15%	n/a	n/a

Table 14b. Self-Reported Current Asthma Prevalence Among Adults³⁰ (2010)

All adults	CT: 9.2% Total, 8.5% among Whites, 15.4% among African-Americans
All adults, by gender	CT: 6.8% among Men, 11.3% among Women

Current Smoking Prevalence

As of 2011, current rates of smoking in Connecticut as a whole are estimated to be 17% among all White non-Hispanics, and 21% among all African-Americans. Men (19%) are more likely to be current smokers than women (15%).³¹

A recent large-scale wellbeing and health survey conducted in the nearby metropolitan area of Greater New Haven found similar rates of smoking as Connecticut (e.g., 18% among White men, 28% among all African-American men). However, it found that smoking rates in lower-income, higher-stress city neighborhoods were 2-4 times higher than smoking rates in wealthier city neighborhoods and suburbs. The survey found that 11% of men reporting a household income of \$50,000 per year or more currently smoked, versus 31% of those reporting a household income of less than \$50,000.³²

Local data and Federal government (BRFSS survey) estimates from Bridgeport also suggest that smoking rates in low-income neighborhoods are significantly higher than the statewide averages. Using aggregate, age-adjusted 2004-2007 data, smoking rates in the Urban Centers (Hartford, Bridgeport, and New Haven)

were estimated at 22% among all adults, male and female, including 24% of all African-American adults. Smoking rates among all adults in the Wealthy Suburbs (see definitions above) were estimated at 11%.³³

Although data specifically for men in Bridgeport is not available, based on a review of available data sets, it is likely that current smoking rates among African-American men in Bridgeport are at least 25% and possibly as high as 35% - a rate two to three times the average found in surrounding suburbs.

Mental Health

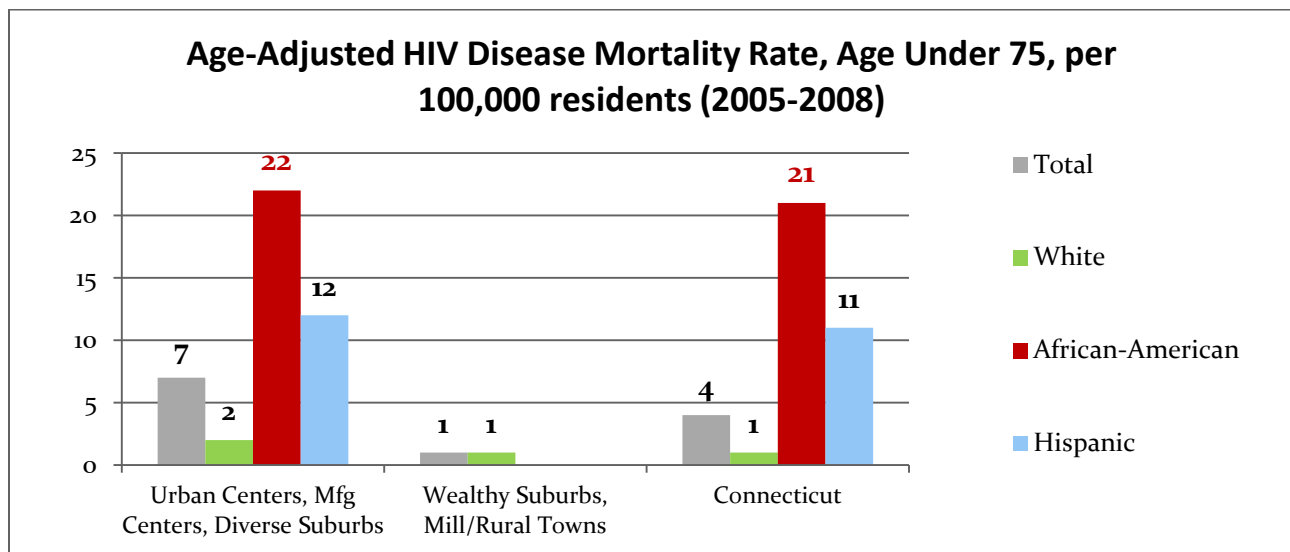
Residents of Bridgeport are significantly more likely to use mental health and substance abuse services, and to report poor mental health, than their counterparts in wealthier sections of Connecticut. The data below are drawn from the Connecticut Community Health Data Scan unless otherwise indicated.

Table 15. Mental Health Indicators

Indicator	Connecticut	Urban Centers	Wealthy Suburbs	Bridgeport city
Behavioral Health Emergency Room Visit Rates by Resident Town, Adults Age 18+ (2007)				
Rate per 1,000	28.7	59.4	11.6	46.9
Persons Receiving Publicly-Supported Mental Health or Substance Abuse Services (2006-07)				
Rate per 1,000	28.3	58.0	9.7	40.3
Percentage of Adults Age 18+ With Poor Mental Health (2004-07)				
Total	8.2	9.6	6.4	10.4
African-American	9.0	9.8	n/a	n/a
White, Not Hispanic	8.2	8.4	6.8	n/a

HIV/AIDS

Data on HIV mortality and prevalence are limited mostly to Statewide estimates. Neighborhood-level AIDS/HIV prevalence often can not be reliably estimated due to privacy concerns. However, it is clear that new diagnoses, and AIDS mortality, are greatly elevated among African-Americans, as shown in the chart below, as well as within urban centers. Prevention strategies to reach lower-income minority men are critical: In 2010, the rate of AIDS diagnoses per 100,000 residents in Connecticut was **51 for African-Americans**, 39 for Hispanics, and **6 for White non-Hispanics**.³⁴



For persons with HIV/AIDS, access to care is an issue. Of Connecticut residents who were enrolled in the AIDS Drug Assistance Program (ADAP) in 2011, an estimated 63% were uninsured, a rate similar to the national average.³⁵ In Connecticut, about one-third of clients in ADAP are African-American, and 72% are men, of whom about two thirds are age 45 and above. If other barriers to insurance access can be addressed, the rate of insurance coverage within this group may rise due to Medicaid expansion, and because the Affordable Care Act has improved options for individuals with pre-existing conditions.

Injury and Community Safety

For young African-American men, death by assault is one of the leading causes of death in Connecticut's urban centers. In many Connecticut cities, nearly 100% of homicide victims are African-American or Hispanic men, with the vast majority killed in public spaces (streets, sidewalks) using a handgun. This topic has been extensively covered in other reports. In Connecticut, the age-adjusted homicide rates (of both men and women age under 75) between 2005 and 2008 were **16 per 100,000 among African-Americans**, and 6 per 100,000 among Hispanics, but only **1 per 100,000 among White non-Hispanics**.

Community safety is an important health issue far beyond the absolute numbers of victims of firearm violence each year. For every homicide in Connecticut, we estimate there are 5-10 non-fatal shootings of individuals, as well as 30 or more situations in which bullets are fired at people, typically in a public place. The level of community trauma caused by gun violence, typically concentrated within small geographic areas where narcotics are sold illegally, places immense stress on neighborhoods and individuals, leading to mental health problems, fear of leaving the house to get exercise or take walks, especially at night, fewer chances to interact with neighbors, and a hampered desire to invest in one's local community.

Age-adjusted mortality rates from all unintentional or accidental injuries, falls, and motor vehicle crashes in Connecticut's urban centers among African-American residents of all ages (about 25-30 per 100,000) are not significantly different from the rates among White or Hispanic residents.

General Health Improvement Needs

The Greater Bridgeport Community Health Needs Assessment recently completed surveys and focus groups which asked residents, health providers, and policymakers what could be done to improve health. A brief summary of the common "health needs" that emerged from these conversations follows here:

- Marketing of existing community services (information, service hours)
- Education on how to navigate the health "system" in particular
- Support services for vulnerable populations (support for young adults who have no activities, support for seniors who are isolated, outreach to diverse populations and immigrants)
- Mental health services (counseling across all age groups, parenting education)
- Enhanced environment (more sidewalks, biking facilities, safer streets, less fast food)
- Prevention focus (programs within the community to educate about health prevention)
- Improved collaboration between hospitals and community-based care
- Community-based and faith-based health initiatives
- Enhanced public involvement and education of elected officials
- Improvements to the economy, including transportation, affordable housing, workforce initiatives, and redevelopment of polluted sites

Conclusion

The barriers to good health that lead to disparities in wellbeing between African-Americans and Whites consist of a collection of identifiable factors that can influence each individual's risk of adverse health. These factors, or social inequities, include those related to race and gender, such as discrimination and isolation in highly-segregated neighborhoods, but also differences in neighborhood quality or safety, annual income, employment history, disability status, previous criminal record, education level, and variations in intergenerational wealth and personal assets. In some cases, individuals may possess multiple overlapping factors that place them in higher risk categories.

For a variety of historical reasons, the "health opportunity gap" between African-Americans and other residents has been a major concern for decades, and persists today. The Health Disparities project has calculated relative risks on the basis of excess adverse health events faced by African-Americans in Connecticut compared to White Non-Hispanic residents over the years 2000 through 2004.³⁶ Assigning Whites a "relative risk" of 1.0, African-Americans as a whole had a higher relative risk of annual mortality (RR=1.2X), translating to 376 excess deaths of African-Americans every year. Of these 376 excess deaths, 74 were related to HIV/AIDS (RR=14.9X), 70 to Heart Disease (RR=1.2X), 56 to Cancer (RR=1.1X), 49 to Diabetes (RR=2.5X), and 38 to Homicide (RR=10.4X). Similarly, African-Americans were much more likely to be hospitalized each year, particularly for Diabetes (RR=3.8X) and Asthma (RR=3.7X).

These disparities should be of great concern not just within the African-American community or among health care providers, but also among policymakers across the entire State. In order to maintain its competitiveness in a global economy, Connecticut must work harder to ensure that all citizens have the potential to attain the highest possible health outcomes. Poor health outcomes in and of themselves may be barriers to educational success and the ability to hold a good job or fully participate in civic life.

With these considerations in mind, we offer the following avenues toward health improvement:

1. Many African-American men in Bridgeport face severe economic hardship. In its worst form, extreme poverty and unemployment can lead to poor mental health and cripple an individual's ability to focus on their own long-term health needs. Therefore, policy topics such as employment, education, housing, transportation, neighborhood social and environmental quality, and other issues must be understood first and foremost within their public health context. It is unlikely that the health status of Bridgeport and Connecticut's other urban areas can be dramatically improved without making measurable annual progress in these related policy areas.
2. Many adverse health conditions, such as those related to obesity, are preventable in most cases. Others require additional interventions, such as improved mental health services or counseling, before they can be addressed. This report makes clear the importance of strengthening health care access, and health insurance coverage, in Bridgeport's African-American neighborhoods.
3. Leaders in Greater Bridgeport must take a place-based approach to reducing health disparities, particularly given the high degree of income inequality, racial segregation and disinvestment in some urban neighborhoods. These can include targeting employment and neighborhood investment to the most disadvantaged areas, promoting mixed-income housing, and training health care professionals to view patients "as a whole person," recognizing that there are multiple social factors which limit health care access and create barriers to achieving optimal health status.

Endnotes and References

- ¹ Lavizzo-Mourey, R. (2012). Why Health, Poverty, and Community Development Are Inseparable. Accessed at <http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/09/why-health--poverty--and-community-development-are-inseparable.html>, May 2013.
- ² The specific Census Tracts used to calculate indicators for predominantly African-American neighborhoods are 2010 Tracts 703, 706, 709, 710, 711, 712, 728, 729, 730, 731, 732, 733, 734, 737, 743, and 744. Data from tracts were aggregated into a total figure that represents neighborhoods with the greatest concentration of African-American residents. This figure closely approximates the neighborhood boundaries shown on the map; actual neighborhood boundaries may shift over time and definitions can vary.
- ³ The Kaiser Family Foundation, statehealthfacts.org. 2008 is the most recent year of data available from the U.S. Bureau of Justice Statistics, via their 2010 National Prisoner Statistics report.
- ⁴ The Sentencing Project (2010), "Racial Disparity." Accessed at <http://www.sentencingproject.org/template/page.cfm?id=122>, May 2013.
- ⁵ CT Office of Legislative Research (2008). Town of Residence of Incarcerated Inmates. Accessed at <http://www.cga.ct.gov/2008/rpt/2008-R-0228.htm>, May 2013.
- ⁶ This indicator is calculated by DataHaven based on 2010 5-Year American Community Survey SF4 tables by race. The complete dataset for African-American men was not available for a handful of smaller Census Tracts within Bridgeport, so the neighborhood values should be treated as an approximation.
- ⁷ Alliance for Excellent Education (2011). The High Cost of High School Dropouts: What the Nation Pays for Inadequate High Schools. Accessed at <http://www.all4ed.org/files/HighCost.pdf>, February 2013.
- ⁸ Forman, J. (2011), "The black poor, black elites, and America's prisons." Yale Law School Faculty Scholarship Series Paper 3853. Accessed at http://digitalcommons.law.yale.edu/fss_papers/3853, January 2013.
- ⁹ State Department of Education (2013). CEDaR Website, Research Reports. Accessed at http://sdeportal.ct.gov/Cedar/WEB/ct_report/CedarHome.aspx?, May 2013. Reporting high school graduation rates using the Cohort Graduation Rate method is required by the "No Child Left Behind Act" (NCLB) and by the National Governors Association. In previous years, graduation rates could only be estimated from cumulative dropout data and aggregate graduation data. The old method of calculating graduation rates did not require tracking individual students through high school. The new graduation rate method calculation, shown in this report, tracks a group of students from their initial entrance into ninth grade through to graduation with student-level data from a longitudinal data set.
- ¹⁰ Hosch, B. and Kiehne, J. (2011). Postsecondary enrollment and completion patterns of students from Connecticut public high schools: An analysis of data from the National Student Clearinghouse. Hartford: Connecticut Board of Regents for Higher Education.
- ¹¹ Connecticut P-20 Council (2011). "Connecticut College and Career Readiness Toolkit Supplemental Data: Harding High School." Accessed at <http://www.ct.edu/files/pdfs/p20/015%20Bridgeport%20-%20Harding.pdf>, May 2013.
- ¹² National Center for Education Statistics, IPEDS Data Center (2013). Institution look-up tables, accessed at <http://nces.ed.gov/ipeds/datacenter/SnapshotX.aspx>, May 2013.
- ¹³ Similar disparities are found at other institutions that are popular among local high school graduates. For example, at Fairfield University, UCONN-Storrs, UCONN-Waterbury, and Norwalk Community College, the total "on-time" graduation rates are 82%, 82%, 51%, and 10%, respectively. For African-Americans they are reported to be 55%, 64%, 37%, and 4%, respectively. At UCONN-Storrs, African-Americans comprise 5% of Bachelor's, 6% of Master's, and 4% of Doctoral Degree recipients.
- ¹⁴ Connecticut P-20 Council (2011). "Connecticut College and Career Readiness Toolkit Supplemental Data" for selected Bridgeport-area high schools. Accessed at <http://www.ct.edu/files/pdfs/p20/015%20Bridgeport%20-%20Harding.pdf>, <http://www.ct.edu/files/pdfs/p20/144%20Trumbull.pdf>, and other URLs by individual high school, May 2013.

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- ¹⁵ Ihlanfeldt, K. (2006). A primer on spatial mismatch within urban labor markets, in: R. J. Arnott and D. P. Mcmillen (Eds) *A Companion to Urban Economics*, pp. 404-417.
- ¹⁶ Brookings Institution (2011). *Missed Opportunity: Transit and Jobs in Metropolitan America*, Bridgeport-Stamford profile. Accessed at <http://www.brookings.edu/~media/series/jobs%20and%20transit/bridgeportct.pdf>, May 2013.
- ¹⁷ This indicator is calculated by DataHaven based on 2010 5-Year American Community Survey SF4 tables by race. The complete dataset for African-American men was not available for a handful of smaller Census Tracts within Bridgeport, so the neighborhood values should be treated as an approximation.
- ¹⁸ State Health Facts (2013). Accessed at <http://kff.org/disparities-policy/state-indicator/no-doctor-visit-in-past-year-due-to-cost-2/?state=CT>, May 2013.
- ¹⁹ Kaiser Family Foundation (2013). *Impact of the Medicaid Expansion for Low-Income Communities of Color Across States*. Accessed at <http://kff.org/medicaid/report/impact-of-the-medicaid-expansion-for-low-income-communities-of-color-across-states/>, May 2013.
- ²⁰ U.S. Census Bureau (2011). *American Community Survey one-year estimates for 2011*, table B27016.
- ²¹ Bridgeport Community Health Needs Assessment (2013).
- ²² Bureau of Labor Statistics (2013). *Alternative Measures of Labor Utilization*. Accessed at <http://www.bls.gov/news.release/empsit.t15.htm>, May 2013.
- ²³ U.S. Census Bureau (2011). *American Community Survey one-year estimates for 2011*, table B17005.
- ²⁴ Connecticut Community Health Data Scan (2011). The Data Scan is published by the Connecticut Health Foundation and Connecticut Commission on Health Equity (CCHE). It is currently being made available through the Connecticut Data Collaborative, and hosted on the DataHaven / CTData Knowledge Center at http://ctdatahaven.org/know/index.php/Connecticut_Community_Health_Data_Scan. Detailed notes on the source data and their limitations are available for most indicators. Many Health Data Scan indicators are drawn from the CDC Behavioral Health Risk Factor Surveillance Survey (BRFSS).
- ²⁵ State Health Facts (2013). Accessed at <http://kff.org/other/state-indicator/life-expectancy-by-re/?state=CT>, May 2013. Data are from the Centers for Disease Control and Prevention, with calculations from the American Human Development Index.
- ²⁶ Connecticut Community Health Data Scan (2011).
- ²⁷ Connecticut Community Health Data Scan (2011).
- ²⁸ Connecticut Community Health Data Scan (2011).
- ²⁹ Connecticut Department of Public Health (2012). *The Burden of Asthma in Connecticut: 2012 Surveillance Report*.
- ³⁰ State Health Facts (2013). Accessed at <http://kff.org/other/state-indicator/asthma-prevalence-by-re/?state=CT>, May 2013. Data are from BRFSS.
- ³¹ State Health Facts (2013). Accessed at <http://kff.org/other/state-indicator/smoking-adults-by-raceethnicity/>, May 2013. Smoking prevalence data are from BRFSS.
- ³² DataHaven and Siena College Research Institute (2013). *Greater New Haven Community Wellbeing Survey*. Accessed at <http://www.ctdatahaven.org/wellbeingsurvey>. The Wellbeing Survey is the largest survey of its kind ever completed in the Greater New Haven Region, involving interviews with 1,307 randomly selected residents via cell phone and landline telephone in September and October 2012. The survey was conducted by DataHaven on behalf of a large group of community institutions and funders.
- ³³ Connecticut Community Health Data Scan (2011).
- ³⁴ State Health Facts (2013). Accessed at <http://kff.org/hiv/aids/state-indicator/aids-diagnosis-rate-by-re/>, May 2013. Data on AIDS diagnoses by Race and Ethnicity were obtained through a special data request from CDC's Division of HIV/AIDS Prevention, Surveillance and Epidemiology.

³⁵ State Health Facts (2013). Accessed at <http://kff.org/hiv/aids/state-indicator/adap-clients-by-insurance-status/>, May 2013. Data are from the National ADAP Monitoring Project.

³⁶ Stratton, Alison, Margaret M. Hynes, and Ava N. Nepaul (2009). The 2009 Connecticut Health Disparities Report. Hartford, CT: Connecticut Department of Public Health.