



Connecticut

Commission on Health Equity

2nd Annual Report September 2011



Presented to the
Connecticut General Assembly

Prepared by Dr. Raja Staggers for the
CT Commission on Health Equity



**“It is my aspiration that health finally will
be seen not as a blessing to be wished
for, but as a human right to be fought for”**

— United Nations Secretary-General Kofe Annan



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Table of Contents

Acknowledgments	4
Letter from the Executive Director.....	6
Executive Summary.....	8
Introduction.....	11
Update on Health Disparities in Connecticut.....	18
Connecticut Best Practice Model to Achieve Health Equity	18
Report on 2010-2011 Objectives/Activities	25
2011-2012 Action Plan.....	25
Conclusions	30

This report is dedicated our friend and colleague the late Commissioner Dr. Janet Williams.

Acknowledgement

The Board and the Executive Director of the Connecticut Commission on Health Equity would like to acknowledge the Connecticut General Assembly and Governor Dannel P. Malloy for continuing to make health disparities a priority in the State. We particularly thank Senator Toni N. Harp for leading the effort to establish the Commission on Health Equity and for her continued support. We also acknowledge the support of the Office of Health Care Advocate for providing administrative assistance. We are especially grateful to the Connecticut Health Foundation for selecting the Commission on Health Equity as the host site for the Community Health Data Scan, so that we might continue to make state health data available to the public. We also thank the Connecticut Hospital Association and Office of Health Care Advocate for funding the development of the Commission on Health Equity Brochure and the Hispanic Health Council for offering space to hold the 2011 Strategic Planning Retreat.



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Letter from the Executive Director

Dear Friends:

The Connecticut Commission on Health Equity was signed into legislation by the Connecticut General Assembly in 2008. Tasked with developing strategies and solutions to eliminate health disparities in Connecticut, the Commission on Health Equity has begun to establish some of the preliminary infrastructure needed to reach its mandate. Since the release of the first annual report in 2010, the Executive Board has hired a fulltime Health Equity Director (Executive Director) to dedicate all efforts to the goals and objectives set by the legislation and the Board of the Commission on Health Equity.

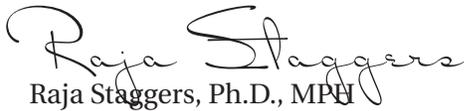
This year, we launched a website; developed outreach materials; held four public forums; publicly supported universal health care access through the SUSTINET Legislation; and proposed legislative language on the implementation of culturally and linguistically appropriate standards in healthcare settings. Further, staff and commissioners have dedicated substantial time to present to a number of groups and organizations and to participate in numerous activities, events, and meetings to heighten awareness of the need for health equity in Connecticut. We have worked in collaboration with the Connecticut Hospital Association to join in its Health Disparities Roundtable featuring the world-renowned surgeon, Dr. Benjamin Carson. We also co-sponsored a Health Equity Meeting with the CT. Association of the Directors of Health in Hartford, in conjunction with the 2011 National Association of County and City Health Officials conference.



As we continue our efforts to achieve health parity, the Board and Executive Director will focus on building the infrastructure of the Connecticut Commission on Health Equity to achieve long-term sustainability. Of utmost importance is to develop sustaining strategies that will ensure that health equity becomes a reality. A primary objective is to secure the resources necessary to build an effective best practice model for Connecticut that is replicable for other states. The research supports a model that merges data collection, work with the public, legislative and policy solutions, and resource allocations. Such a model has the capacity to influence policy makers, healthcare organizations and local activities around the state and perhaps the nation. Data demonstrates the importance of alleviating health disparities to minimize health care cost, to maximize human potential and societal contributions, and to acknowledge health as a human right.

Over the past year, the national stage has made strides to address health disparities and health equity. The Commission on Health Equity will align its goals and objectives with national platforms, adjusting for concerns specific to Connecticut, and continue to work with state agencies and other entities. The national and state budget concerns require the Commission on Health Equity to work even more diligently with the public and state agencies to address gaps in care and services for vulnerable populations. However, the conditions in which people are born, grow, live, and age must be influenced by both public and private policies — thus, there is little question about the work set out before us.

Sincerely,


Raja Stagers, Ph.D., MPH



Executive Summary

in health status based on race ethnicity, gender, and linguistic ability, thereby improving the quality of health for all of Connecticut's residents. Further, CHE exists to systematically review and collect State-level data (quantitative and qualitative) on health disparities, to work with state agencies, and other entities in Connecticut to make systemic changes to enhance the health of disenfranchised groups. Our primary focuses are to:

- Serve as a repository for health equity information in Connecticut
- Enhance state agency and legislative understanding of social determinants of health
- Engage the public in conversations on health disparities and health inequities
- Support or propose legislation and policies to improve the health of vulnerable populations

The key health priorities adopted by CHE reflect areas where Connecticut exceeds the national average in prevalence, morbidity, or mortality and or health concerns where racial ethnic minorities far exceed disparities compared to majority groups in Connecticut. Hence, CHE tracks and monitors these core health equity indicators and areas of needed improvement in Connecticut:

- **HIV/AIDS**
- **CANCER**
- **DIABETES**
- **ASTHMA**
- **LOW BIRTH WEIGHT**
- **CARDIO VASCULAR DISEASE**

During the 2010-2011 Legislative Session, CHE completed the following activities:

- Tracked and monitored health related bills
- Proposed legislative language to support the implementation of culturally and linguistically appropriate standards in healthcare settings
- Conducted Public Forums in Hartford, Bridgeport, New Haven, and Waterbury
- Adopted the CT DataScan
- Collected and reviewed data on health disparities in CT

Our focus for the 2011-2012 Legislative Session will include:

- Work with state agencies to develop health equity plans
- Support legislation on US DHHS Office of Minority Health *Culturally and Linguistically Appropriate Standards in Medical Care and Treatment*
- Raise statewide awareness of health as a Human Right
- Increase CHE access to data sources to monitor health disparities
- Offer educational opportunities on health equity to State Legislature and Connecticut State Agencies
- Diversify CHE funding streams
- Recognize Community Health Initiatives that improve health equity
- Convene practitioners and public health professionals to discuss issues of health equity

Recommendations:

- Connecticut should adopt legislation to support culturally and linguistically appropriate standards in healthcare settings.
- Connecticut should require the implementation of policies and practices to establish accountable for health equity.
- Connecticut should require state agencies to have policies that encourage health equity.
- Connecticut should allocate funding for language interpreters in healthcare settings.
- The Health Exchange Board should have representation from the Connecticut Commission on Health Equity to represent racial, ethnic, and gender populations that experience health disparities.



Introduction

According to the Urban Institute’s 2009 report, “Estimating the Cost of Racial and Ethnic Health Disparities,” it was projected that health disparities will cost the U.S. health care system \$23.9 billion dollars.¹ While Medicare will spend an additional \$15.6 million, private insurers will incur \$5.1 million in costs due to health disparities.² The same report estimated that over the ten year period from 2009-2018, the total cost of disparities will exceed \$300 billion.³ Similarly, the Agency for Healthcare Research and Quality, in the National Summary Report, 2003, noted the personal and social costs of neglecting to eliminate health disparities. The report acknowledged that, “ the personal cost of disparities can lead to significant morbidity, disability, and lost productivity at the individual level.”⁴ Furthermore, societal neglect has the potential for far reaching costs that are avoidable by addressing opportunities to eliminate health disparities (National Healthcare Disparities Report, 2003).

One of few commissions nationally, the presence of the Commission on Health Equity demonstrates Connecticut’s foresight and leadership in tackling issues of health disparities and health equity. In establishing the Connecticut Commission on Health Equity, the Connecticut General Assembly asserted that the elimination of health disparities is a priority of the State. The persistence of health disparities in Connecticut is evident in state-level health outcomes compared to national levels but even more apparent is the comparison among racial and ethnic minorities to Caucasian populations in Connecticut and between and among wealthy and poorer counties and cities. Connecticut is one of the most densely populated states with about 84% of the population living in Hartford, Bridgeport, and New Haven Counties.⁵ Nationally, Connecticut has one of the highest per capita income rates, a reputation of high health insurance coverage in adults, compared to other states, and some of the most highly educated residents in the country.^{6,7} Since 2000, there has been a steady increase in the racial ethnic diversity of residents. As of 2009, the Latino population was 11.6%; African-Americans/Blacks 9.1%, and Asian/Pacific Islanders 3.3% of Connecticut Residents.⁸

The urban centers of Connecticut, Hartford, Bridgeport, Waterbury and New Haven, fair amongst the worst in the nation in terms of health outcomes for HIV/AIDS, violence, asthma, and diabetes.

1 Waidman, T. 2009. Estimating the Cost of Racial and Ethnic Health Disparities. The Urban Institute.

2 Ibid.

3 Ibid.

4 Agency for Healthcare Research and Quality. 2003. National Healthcare Disparities Report. p. 5. U.S. Department of Health and Human Services. <http://www.ahrq.gov/qual/nhdr03/nhdrsum03.htm>

5 U.S. Census Bureau, Population Division. March 2010. Table 1. Annual Estimates of the Resident Population for Counties of Connecticut: April 1, 2000 to July 1, 2009 (CO-EST2009-01-09)

6 U.S Department of Commerce. 2007. Health Insurance Coverage Status, Percent Uninsured by State, 2007. Economic and Statistics Administration. U.S. Census Bureau. http://www.census.gov/did/www/sahie/data/2007/files/AllRacebyAge_2007_State.pdf

7 U.S. Census Bureau, Census 2000 Summary File 3, Matrices P18, P19, P21, P22, P24, P36, P37, P39, P42, PCT8, PCT16, PCT17, and PCT19

8 Source: U.S. Census Bureau, 2005-2009 American Community Survey, Connecticut.

Compared to Whites, Connecticut's African Americans, Hispanics and Native Americans are more likely to live in poverty. These residents are oftentimes more vulnerable to adverse health due to high rates of unemployment or underemployment, low education levels, poor housing, and unlimited access to medical homes.⁹ The urban centers of Connecticut, Hartford, Bridgeport, Waterbury and New Haven, fair amongst the worst in the nation in terms of health outcomes for HIV/AIDS, violence, asthma, and diabetes.^{10 11 12} Further, within the State, the differences between racial-ethnic groups and at the intersections of race, gender, and class suggest significant health inequities. Racial ethnic minorities in Connecticut are more likely to die from heart disease and cancer, at higher rates, than their Caucasian counterparts.^{13 14}

Beginning in 2009, the CHE Data Committee reviewed several state and federal data sources to determine how poverty and other social determinants affect the health of African Americans, Hispanics, Asians, and Native Americans. Accordingly, twice as many African Americans (18.4%) and Hispanics (29.1%) report having no health insurance compared to Whites (9%).¹⁵ Further rates for hospitalizations for ambulatory care services and emergency visits are twice as high for African Americans and Hispanics than Caucasians.¹⁶

The committee also identified six health priority areas that CHE would observe and monitor. The main health concerns identified by CHE were HIV/AIDS, Diabetes, Cancer, Low Birth Weight, Cardiovascular Disease, and Asthma. These health areas include conditions for which Connecticut rates higher than the national average or conditions demonstrating extreme disparities across racial-ethnic, gender, and class groups. Collectively, these health priorities demonstrate a significant financial burden to Connecticut as well as to individuals and families due to hospitalizations and related mortality. Identifying the root causes of these health priority areas and barriers to health equity would greatly improve the lives of Connecticut residents and the productivity of the State.

Connecticut ranks 7th in the nation, of people living with AIDS.

1. HIV/AIDS

In 2007, there were over 10,700 people living with HIV/AIDS in Connecticut.¹⁷ HIV/AIDS rates are disproportionate across racial ethnic groups. Rates of HIV infection are nearly thirty times greater in African Americans and Hispanics than Caucasians. Thirty-four percent of those infected were White; 29% were African American/Black, 36% were Hispanic; and 1% other racial-ethnic minorities.¹⁸ Rates in African Americans and Hispanics are alarming relative

9 Comprehensive HIV Planning Consortium. Connecticut Comprehensive HIV Care and Prevention Plan, 2009-2012.

10 Ibid.

11 Connecticut Asthma Advisory Council Plan Revision Workgroups, A Collaborative Effort for Addressing Asthma in CT: CT Statewide Asthma Plan 2009-2014. State of CT Department of Public Health, Asthma Program, Hartford, CT 2009.

12 The Connecticut Diabetes Prevention and Control Plan, 2007-2012. State of CT Department of Public Health, Hartford, CT 2009.

13 The Burden of Cardiovascular Disease in Connecticut. 2006 Surveillance Report. Dec. 2006. State of CT Department of Public Health, Hartford, CT.

14 Kaiser Family Foundation. Statehealthfacts.org. Connecticut: Age-Adjusted Cancer Incidence Rate Per 100,000 Population by Race/Ethnicity, 2007. <http://www.statehealthfacts.org/profileind.jsp?ind=66&cat=2&rgn=8>

15 U.S Department of Commerce. 2007. Health Insurance Coverage Status, Percent Uninsured by State, 2007. Economic and Statistics Administration, U.S. Census Bureau.

16 Connecticut Voices for Children. Ambulatory Care Utilization by Children Enrolled in Husky A in 2005, Feb. 2007. <http://www.ctkidslink.org/publications/h07ambulatorycare05.pdf>.

17 Connecticut HIV Planning Consortium, 2009. Connecticut Comprehensive HIV Care Plan 2009-2012.

18 Ibid.

to the total make-up of both groups, only about, 20% of the population of Connecticut.¹⁹

Connecticut ranks 7th in the nation, of people living with AIDS. The Connecticut rates of HIV/AIDS are slightly higher than national averages for most groups.²⁰ Nationally, the rate of HIV/AIDS in women is 26% compared to 36% in Connecticut. The infection rate in African Americans / Blacks is 47% nationally compared to 25.8% in Connecticut (or 1,093 per 100,000).²¹ Nationally, the rate of infection in Hispanics is 18%. In Connecticut, the infection rate in Hispanics is 41.4% (or 897 per 100,000).²²

The primary modes of transmission of HIV/AIDS in Connecticut are through drug use or sexual contact. Half of the cases have been associated with sharing infected drug equipment.²³ Although HIV/AIDS affects individuals in most cities and towns in Connecticut, almost half of the cases are in Hartford, New Haven, and Bridgeport.

People Living with HIV/AIDS (PLWHA) experience issues linked to health status.²⁴ Poverty often correlates with HIV/AIDS status in Connecticut such that people face barriers to accessing health care, safe housing, and educational information to prevent infection.²⁵

2. DIABETES

In 2010, nearly 7% of the adult population of Connecticut was diabetic.²⁶ Approximately every six out of 100 adults in Connecticut is a diabetic, and every 17.2 deaths out of 100,000 is due to diabetic related complications.²⁷ Still, there are approximately 70,000 adults in Connecticut with undiagnosed diabetes.²⁸ Diabetes correlates with racial-ethnic identity and socio-economic class. African-Americans / Blacks have significantly higher rates of diabetes than Whites and Hispanics. Additionally, mortality from diabetes is three times greater in African and Hispanics than Caucasians.²⁹ The risk of mortality from diabetes in Black men and women is 2.4 and 2.9 times greater than their White counterparts, respectively.³⁰ Although the risk of mortality in Hispanic males is not significantly different than Whites, the rates in Latinas is double that of their White counterparts.³¹

3. LOW BIRTH WEIGHT

Persistent disparities in low birth weight (LBW) have been a public health concern in Connecticut. Low birth weight, very low birth weight, pre-term birth, and neo-natal survival are perinatal indicators but moreover strong indicators of a population's health

19 Ibid.

20 Ibid

21 Ibid

22 Ibid

23 Ibid

24 Ibid

25 Ibid.

26 Kaiser Family Foundation. Statehealthfacts.org Connecticut: Diabetes. <http://www.statehealthfacts.org/profileind.jsp?ind=70&cat=2&rgn=8>

27 Ibid.

28 The Connecticut Diabetes Prevention and Control Plan, 2007-2012. State of CT Department of Public Health, Asthma Program, Hartford, CT 2009.

29 Kaiser Family Foundation. Statehealthfacts.org. Connecticut: Numbers of Diabetic Deaths per 100,000 Population by Race/Ethnicity. 2007. <http://www.statehealthfacts.org/profileind.jsp?ind=76&cat=2&rgn=8>

30 Op cit.

31 Ibid.

status (Office of Disease Prevention and Health Promotion, 2007). Although Connecticut does not fair much differently than national averages, racial ethnic disparities in low birth weight are significant.³² Low birth weight (LBW), less than 2,500 grams, and very low birth weight, less than 1,500 grams, at the time of birth can occur within the normal period of gestation, about 27 weeks.³³ Most of the cases in Connecticut are pre-term births. LBW among African American/ Black women has persisted at more than double the rate of White women.³⁴ Rates in Hispanic women are also slightly elevated.³⁵ However, pre-term births in African American/ Black women remain significantly greater than other groups. Further, the cost of LBW is exorbitant. With over 2,700 hospitalizations for LBW babies, hospital charges were nearly \$195 million.³⁶ The average length of hospital stay for LBW cases approached 16 days compared to the normal 2.5 days, which costs nearly \$70,000.³⁷

4. CARDIO VASCULAR DISEASE

Mortality rates for cardio vascular disease (CVD) including heart attack and stroke varied across race-ethnicity. African Americans/ Blacks experienced significantly higher deaths from CVD in Connecticut.³⁸ Hispanic mortality rates from CVD were significantly less than CVD in Whites.³⁹ Coronary heart disease (CHD) death rates also differ by race, ethnicity, and gender. Deaths from CHD were also significantly higher in African Americans/ Blacks. In Hispanics, mortality was lower than in Whites. White women experienced significantly higher mortality rates of CHD compared to their Hispanic counterparts. As in other Cardiovascular diseases, mortality in stroke varies by race ethnicity and gender⁴⁰.

5. ASTHMA

Connecticut's asthma rates exceed that of the national average and rates are steadily increasing. There were a reported 248,000 adults (or 9.3%) and 86,000 children (10.5%) with asthma.⁴¹ Asthmatic conditions were reportedly greater in women and male children.⁴² Rates were also significantly greater among African Americans / Blacks and Hispanics. Although asthma may be managed through medical treatment and prevention, Connecticut has extremely high hospitalizations due to asthma.⁴³ According to 2005 data, there were approximately 4,500 asthma related hospitalizations.⁴⁴ The rates in women were 38% and 37% in children less than 9 years.⁴⁵ Asthma hospitalizations were also three times greater in African Americans / Blacks and Hispanics compared to Whites. Geographical region also affected rates of asthma morbidity and mortality. Residents of Connecticut's major cities, Hartford, New Haven,

32 Connecticut Department of Public Health. Epidemiology Unit. Low Birth Weight in Connecticut: Fact Sheet. Winter, 2009

33 Davis, L., Stone, C., & Morin, J. 2009. Low Birth Weight Outcomes and Disparities in Connecticut: A Strategic Plan for the Family Health Section, Department of Public Health. Connecticut State Department of Public Health, February, 2009.

34 Ibid.

35 Ibid.

36 Ibid.

37 Ibid.

38 The Burden of Cardiovascular Disease in Connecticut. 2006 Surveillance Report. Dec. 2006. State of CT Department of Public Health, Hartford, CT.

39 Ibid.

40 Ibid.

41 Connecticut Asthma Advisory Council Plan Revision Workgroups, A Collaborative Effort for Addressing Asthma in CT: CT Statewide Asthma Plan 2009-2014. State of CT Department of Public Health, Asthma Program, Hartford, CT 2009.

42 Ibid.

43 Ibid.

44 Ibid.

45 Ibid.

Waterbury, Bridgeport, and Stamford were three times more likely to present for emergency care due to asthma and twice as likely to die from asthma compared to Whites.⁴⁶

6. CANCER

Cancer is the second leading cause of death in Connecticut.⁴⁷ The burden of disease is greatest among low-income and racial-ethnic groups even when health coverage is available.⁴⁸ The incidence of cancer in African American/Blacks and Hispanics in Connecticut is 488.2 and 450.9 per 100,000, respectively compared to the national incident rates of 471.1 and 350.1 per 100,000.⁴⁹ Lung, colorectal, female breast, and prostate cancers account for more than half of new cancer cases.⁵⁰ Although cancer rates from lung, colorectal, and breast cancer are relatively equal among African Americans and Whites (Hispanics have the least mortality), African Americans are more likely to succumb to these diseases.⁵¹

Reshaping Our Work

As CHE continues to track and monitor health outcomes in key areas, it is acknowledged that the health status of racial and ethnic minorities are indicators of other social factors including poverty, educational level, inadequate or insufficient housing, and region. A long-term approach to eliminating these health disparities requires addressing the social conditions in which these disparities exist. Hence, although CHE monitors and tracks these health concerns, CHE will focus much effort in identifying and addressing the social determinants of health and the culturally competent means of promoting health in an effort to endorse system changes that aggravate these disparities.

To affect health status, it is critical that CHE's work address systems (political, legislative, etc.) that influence health disparities. Health research demonstrates that educated people are healthier and people who live in safe neighborhoods with access to healthy foods are better off. Whereas neighborhoods without grocery stores and limited transportation to such stores carry a greater burden of obesity and related health concerns. Addressing system change will certainly yield health parity.

⁴⁶ Ibid.

⁴⁷ Connecticut Cancer Partnership. Connecticut Cancer Plan, 2009-2013.

⁴⁸ Ibid.

⁴⁹ Kaiser Family Foundation. Statehealthfacts.org. Connecticut: Age-Adjusted Cancer Incidence Rate per 100,00 Population by Race/Ethnicity, 2007.

⁵⁰ Ibid.

⁵¹ Ibid.



Guiding Concepts

Health Equity and Social Determinants of Health

In 2011-2012, CHE will recommit to focusing on the social determinants of health, those socially driven conditions that affect how people experience health, including how and if people are educated, where people live, work, and play, access to quality food and places to exercise, and respectable health care. Social determinants that affect individuals derive from larger social structures influenced by policy: distribution of money, power, and resources at global, national and local levels. The social determinants of health drive health inequities.

If equity is the ability of various social groups (racial, economic, regional, gender, etc.) to experience similar outcomes across various factors, health inequity is the inability for groups to secure similar health. In addition to experiencing social inequities due to race-ethnicity, gender, or linguistic ability, populations vulnerable to health disparities also lack political and economic power. Hence, the effective elimination of health disparities requires a model that aims to do more than solve one specific inequity, but that addresses systemic concerns through legislation and policies.

CHE acknowledges that the six adopted health priorities, do not exist in isolation, but are socially determined by poverty, limited education, poor housing, ineffective or limited medical care, and limited access to health enhancing resources (i.e. grocery stores). Further, as we track and monitor the progress of these health areas, CHE focuses on addressing structural issues that lead to these disparities. There is national and global acknowledgement that improvement to health disparities relies on structural changes. In establishing the Commission on the Social Determinants of Health (CSDH) in 2005, the World Health Organization recommended that the elimination of health disparities might consider: (1) improvement to daily living conditions, (2) addressing the distribution of wealth, power, and resources, and (3) measuring and understanding the impact of the problem and the impact of remedying the problem. Connecticut has adapted a similar approach to the elimination of health disparities through exploring policy solutions, legislation, state level data, public engagement, and resource allocation. CHE acknowledges this framework as a best practice model for Connecticut to achieve health parity.

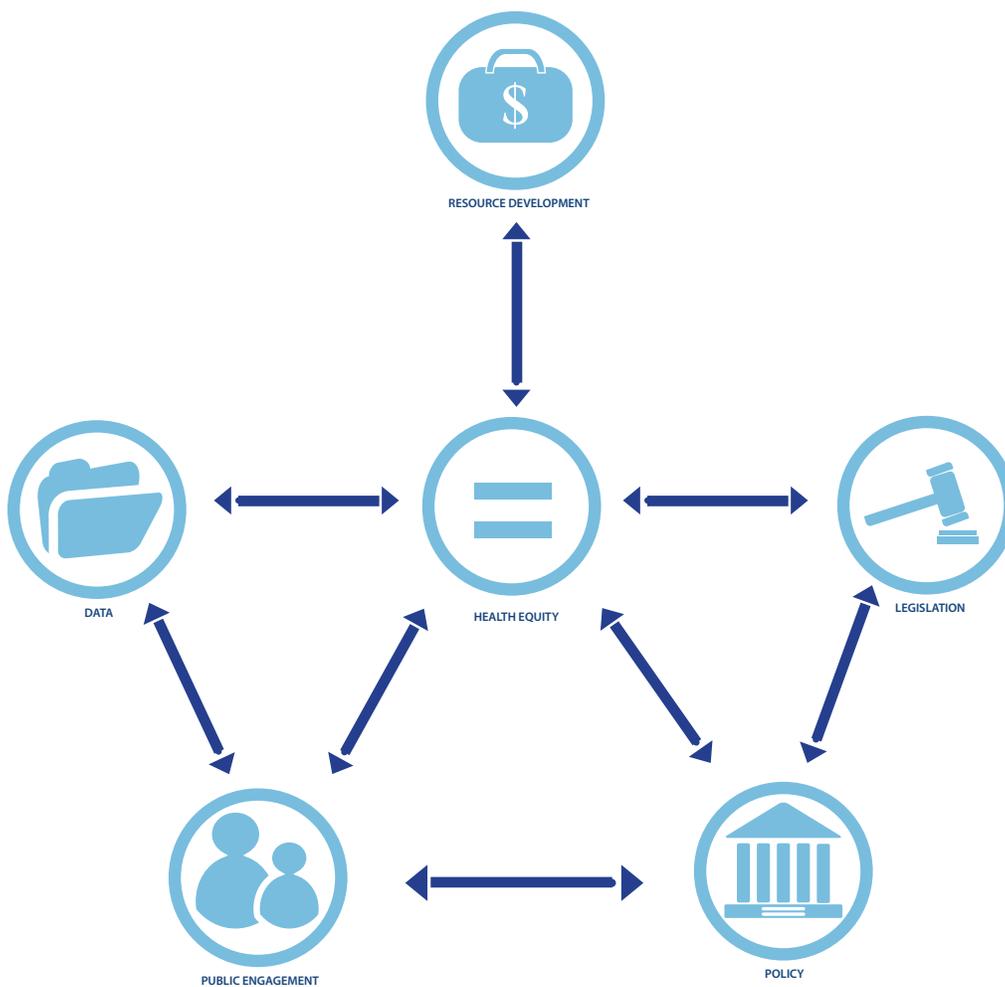
Connecticut's Best Practice Model

For the Elimination of Health Disparities

One of few states in the nation to have a Commission designed to establish metrics to eliminate health disparities, Connecticut is a leader, in tackling the hard issue, of achieving health equity. Further, Connecticut acknowledges that to make an impact on health disparities requires legislation and policy solutions. CHE offers a strong model, and perhaps a best practice model to affect change in health outcomes in vulnerable populations.

Below, Exhibit 1. demonstrates how the committee structure of CHE will achieve health parity. The model emphasizes the six core committees or components of CHE: Data (Committee), Policy (Committee), Public Engagement (Public Voice Committee), Legislation (Committee) and Resource Development (Committee). The model suggests that the collective impact of the component parts will lead to health equity. Following the model from left to the right the data and public engagement components are bi-directional (affecting one another). CHE collects annual data from several state resources to monitor and track health trends. CHE also shares this data with the public and collects qualitative data, from the public via public engagement activities, to understand overcome health disparities. CHE's policy solutions are influenced by state data and other data sources that we collect and review. If we take the important example of childhood obesity, as indicated in First Lady Michelle Obama's Childhood Obesity Prevention Campaign, district wide trends that suggest high rates of childhood obesity that correlate with limited access to healthy foods or grocery stores are indicative of health policy solutions that might incorporate the State Departments of Transportation and Children and Families. Addressing the ability of residents to access health enhancing foods through local transportation, combined with other efforts (i.e. education, economics, etc.) can affect obesity rates through improvements to diet and fitness. Further, legislation is a critical component to the health equity matrix. Legislation offers the muscle needed to ensure policy implementation and establishes accountability for the improvement of population health. Finally, CHE is committed to exploring statewide and national resources to further our work and to support the work of Connecticut initiatives that aim to improve health outcomes.

EXHIBIT 1. CONCEPTUAL MODEL FOR THE ELIMINATION OF HEALTH DISPARITIES





What We Did:

Report on 2010-2011 Objectives/Activities

SIX HEALTH PRIORITY AREAS

In 2011, CHE has adopted the approach of using the six health priority areas (HIV/AIDS, Infant Mortality/Low Birth Weight, Diabetes, Asthma, Cardiovascular Disease, and Cancer) to guide legislative action. The CHE Legislative Committee tracked and monitored bills relating to these health areas. Additionally, CHE decided that a stronger approach to achieve the goal of the elimination of health disparities is to address larger systems. CHE redefined the use of these health priority areas as health indicators. Further CHE began to raise awareness of local health concerns and factors that create barriers to communities achieving optimal health. Under this approach, during the 2010-2011 Legislative Session, CHE offered testimony in support of SUSTINET. CHE also proposed legislation that derives from National CLAS Standards to offer Language Access Services and Culturally Competent Care to Limited English Speakers in Connecticut through Proposed HB 5608, “An Act Concerning the Implementation of Culturally and Linguistically Appropriate Standards in Health Care Settings”.

COMMITTEE WORK



I. PUBLIC VOICE COMMITTEE

Goal: Work with the public to understand the core regional health concerns and the multiple social factors that aggravate health disparities

Objectives:

- Host 3-4 public forums to engage communities in discussion around health disparities
- Increase public knowledge of CHE

- Create a public voice advisory board to inform CHE on an ongoing basis of local health concerns

2010-2011 Accomplishments:

- Conducted four public forums in Bridgeport, Hartford, New Haven, and Waterbury.
- Recruited two members of the public to sit on the Public Voice Committee
- Launched CHE website
- Developed CHE outreach and promotional material



II. POLICY COMMITTEE

Goal: To affect policies and regulations to establish health equity for Connecticut’s most vulnerable populations.

Objectives:

- To promote policies and regulations to ensure health equity for vulnerable populations.
- To work with state agencies to develop policies that improve health equity across Connecticut

2010-2011 Accomplishments:

- Met with higher level State Officials to discuss strategies to incorporate Connecticut agencies in discussions of health equity
- Developed internal operational policies



III. LEGISLATIVE COMMITTEE

Goal: To ensure that Connecticut’s policies and regulations create health equity for vulnerable populations.

Objectives:

- To analyze existing and potential legislation that affects health equity for vulnerable populations
- To recommend to the Commission legislative language that promotes health equity.

2010-2011 Accomplishments:

- Legislative testimony to support SUSTINET
- Proposed legislative language to support the implementation of culturally and linguistically appropriate standards in healthcare settings



IV. DATA COMMITTEE

Goal: To assess and measure the clinical and social determinants of health in vulnerable populations

Objectives:

- Review epidemiological and other data sources to follow trends in disease by race ethnicity, gender, and linguistic ability.
- Identify diverse data sources in Connecticut that measure health disparities.
- Create multiple partnerships with academic institutions and other state entities that collect and measure health disparities data.

2010-2011 Accomplishments:

- Adopted the CT DataScan to collect, track, and monitor state health disparities.



V. RESOURCE DEVELOPMENT COMMITTEE

Goal: Create a sustainability plan for the Commission on Health Equity

Objectives:

- Create a diverse budget that includes legislative, private, and public support
- Identify funding streams for CHE

2010-2011 Accomplishments:

- Partnered with DPH in the Community Capacity Building Grant
- Partnered with the Connecticut Office of Health Reform and Innovation, Lt. Governor's Office, DPH, and DSS on the National Academy for State Health Policy Grant for Technical Assistance



Looking Forward What Will Do:

Plan of Action 2011-2012

I. Develop Health Equity Plans With Connecticut State Agencies.

CHE will support state agencies in the development of health equity plans. Health Equity Plans will highlight each agencies policies around ensuring that: A) the health of vulnerable populations are not adversely affected by an agency's work, B) decision-makers implement policies to consider the impact of an agency's work on the health of vulnerable populations, and 3) decision-makers have a clear indication of the correlation between an agency's work (social determinants) and health. CHE will develop minimum guidelines for state health equity plans and offer educational sessions and workshops on health equity and health disparities and writing and implementing health equity plans.

II. Legislate Outreach And Education.

CHE will offer more information at the legislative level on the social determinants of health and health equity. In addition to offering foundational understanding of health disparities, CHE will share specific regional concerns, and findings from public forums and community conversations with decision-makers.

III. Track And Monitor Legislation.

CHE will continue its work of tracking and monitoring Connecticut legislation that impacts vulnerable populations. CHE will track and monitor bills that relate to the six health priority areas: HIV/AIDS, infant mortality, diabetes, asthma, cardiovascular disease, and cancer. CHE will recommit to focusing on the social determinants of health. We will continue to advance legislation on the implementation of culturally and linguistically appropriate services in healthcare and advocate for equitable health care through language access services and cultural competent care.

IV. Identify Health Equity Data Sources.

CHE data committee will identify additional sources of data used in Connecticut that measure health disparities. CHE will continue to expand the utility of CT Data Scan to include other measures of health disparities and to quantify population groups accurately to measure differences in health status.

V. Convene Health Practitioners And Public Health Professionals.

CHE will hold a mini conference in May 2012 that will bring together Health Practitioners and Public Health professionals to discuss health disparities in Connecticut. The conference will recognize ongoing challenges of practitioners and public health agents and highlight the available resources in Connecticut for addressing the elimination of health disparities.

VI. Public voice Advisory Committee.

CHE will establish a Public Voice Advisory Sub Committee, a sub committee of the Public Voice Committee. This group will consist of members of the public across Connecticut concerned about health issues in their communities. They will assist CHE in understanding the nature of health concerns at the community level and support public forums and community outreach efforts.

VII. Technical Assistance And Training.

As part of the long-term sustainability plan, CHE will seek technical assistance and training opportunities. The Resource Development Committee will identify several federal and private grant opportunities that will help sustain the work of CHE and to help support community health initiatives.

VIII. Raise Statewide Awareness Of Health As A Human Right.

CHE will continue to host public forums throughout the state to understand the health concerns of local residents and continue to share this information with State Legislature.

IX. Acknowledge Community Health Initiatives.

CHE will host an awards ceremony in April 2012 to acknowledge community health initiatives that affect the lives of disenfranchised populations in Connecticut.

In Our Own Voice:

Findings from CHE Public Forums

Between April and May 2011, CHE conducted regional public forums in New Haven, Bridgeport, Hartford, and Waterbury. The regions selected demonstrated high rates of health disparities in racial and ethnic groups. The purpose of the forums was to speak to local residents and practitioners to understand specific regional concerns and critical issues that affect Connecticut residents. Each forum occurred in public spaces with the exception of Waterbury, held at New Opportunities, Inc., a local non-profit. The majority of participants were healthcare providers or those who work directly with disenfranchised populations. The forums included a brief showing of the segment “Place Matters” from the documentary film, “Unnatural Causes.” Using a protocol developed out of the CHE – Public Voice Committee, several questions guided the discussion of health disparities. The findings of the Public Forums were summarized and listed under seven categories:

Faces of Health Disparities - describes participant understanding of what segment of the population experiences the most adverse health outcomes;

Factors Related to Health Disparities - highlights those social and personal concerns that relate to poor health outcomes in individuals, families, and communities;

Environmental Concerns - addresses those factors in the home and community that are known to lead to poor health outcomes in residents;

Health Insurance and Healthcare - acknowledges the health gaps of residents;

Racial and Ethnic Disparities - specifies differential outcomes in health or concerns that lead to differential health in populations;

Engaging Decision-makers - identifies information that decision-makers might consider to affect legislation and policy decisions that support vulnerable populations; and

Solutions - provide ideas and strategies that might be useful in closing the gap in health disparities.

All findings reflect the thoughts and ideas of participants that attended each forum. The findings are summarized below.

I. FACES OF HEALTH DISPARITIES

- Low-income minorities
- Residents of low-income neighborhoods
- Newly unemployed
- Young parents
- Elderly
- Ex-offenders
- Homeless
- Rural area residents

II. FACTORS RELATED TO HEALTH DISPARITIES

- Lack of jobs/lack of good paying jobs
- Focus on the medical model rather than prevention
- Not enough affordable quality housing
- Gun violence
- Well intentioned programs and services, however, the policies make it difficult for individuals and families to make healthy choices and to do healthy things
- People are provided too much information about health – it makes it difficult for them to process – for example, increased anxiety about what to eat
- Jobs for people with a high school diploma require more travel
- School systems are poorly equipped to prepare students
- Teenage pregnancy
- Stress – causes of stress (chronic, prolonged, internalized stress)
- Disrupted family structure (female-headed households) among African Americans and Latinos
- Economics, wealth distribution, and poverty
- Distribution of health resources and services (including providers)
- Racism

III. ENVIRONMENTAL CONCERNS: WHAT IS AFFECTING THE HEALTH OF RESIDENTS?

- Housing / neighborhoods located in close proximity to Brownfields
- Crowded housing
- Old homes and lead paint
- Asthma and lead poisoning
- Lack of supermarkets
- Gun violence

IV. HEALTH INSURANCE AND HEALTHCARE: WHAT ARE THE NEEDS?

- Limitations in access to specialty care
- Providers do not take Medicaid
- Uninsured and newly unemployed do not qualify for husky or Medicaid
- Healthcare delivery system requires restructuring
- Funding issues in urban hospitals detracts from care
- Need to take the profit out of healthcare
- Address health literacy, health education, and health-advocacy.
- Increase the number of health providers
- There is a high need for psychiatric care in urban centers
- Many detoxification services are closed or at capacity
- Medical transportation is often limited
- Limited needle exchange programs

V. RACIAL AND ETHNIC DISPARITIES: WHAT EXPERIENCES DO PEOPLE HAVE IN CARE AND TREATMENT?

- Minorities do not receive similar prenatal health care
- Health services are not evenly accessible or available in certain areas
- Breastfeeding occurs in lower rates in racial and ethnic groups
- Minority men often enter care late
- The system of care caters to women and children
- Language barriers persist in health care
- Ongoing mistrust in medical providers
- Patients do not see health professionals that look like them

VI. ENGAGING STATE OFFICIALS: WHAT DO PEOPLE WANT STATE OFFICIALS TO KNOW?

- It is hard for elected officials to grasp health disparities
- Lack of understanding of the repercussions of decision-making (such as SUSTINET, zoning changes, and the absence of supermarkets)
- Legislation might focus on increasing funding in certain areas,
- Need to improve housing and increase opportunities for homeownership
- Address policy issues and expand resources that improve access to healthy foods
- Establish expectations for negative industries to support the surrounding community
- State officials need to come together
- The legislature needs the courage to tackle the issue – fear of touching sensitive issues
- Failure to use existing resources to address concerns
- Educate decision makers – particularly legislators and people in the health care system

VII. SOLUTIONS: HOW DO WE RESOLVE ISSUES OF HEALTH DISPARITIES?

- Change the culture re-examine priorities to create and support health
- Incorporate youth
- Develop community gardens
- Restore hope and the belief that people can make changes
- Establish outreach programs to reach people (consider transportation)
- Turn abandoned factories into useful green spaces
- Address greed, competition, fraud, misuse and overuse of services for personal gain
- Offer additional resources to cities
- Increase understanding of individual power, address hopelessness, neglect, power
- Address system ingrained racism
- Move conversation on health and health disparities into public schools
- Community empowerment strategies
- Provide activities that encourage relationships and conversations as well as opportunities to engage in problem solving (for example, how to sustain a soccer league in communities)
- Address racism – examine and acknowledge policies and make changes
- Undo racism through education – deconstruct the construct
- Educate and involve communities themselves
- Include information in major institutions such as schools including colleges
- Involve health care and public health professionals and the legal justice system



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