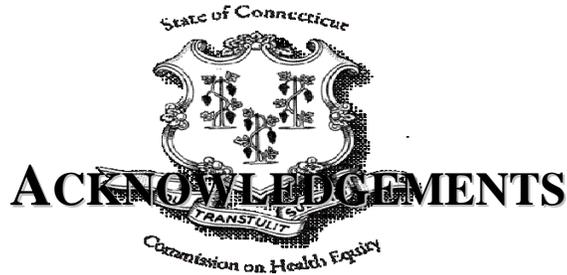


**STATE OF CONNECTICUT
COMMISSION ON HEALTH EQUITY
FIRST ANNUAL REPORT**



SEPTEMBER 1, 2010



A report like this does not come about without the commitment and dedication of a host of individuals. Without the vision of the Connecticut General Assembly and Governor M. Jodi Rell, Public Act No. 08-171: *An Act Establishing a Commission on Health Equity* could never have assembled the extraordinary cadre of individuals who serve as Commissioners.

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COMMISSIONER TORY WESTBROOK
COMMISSIONER JANET WILLIAMS
COMMISSIONER MICHAEL WILLIAMS

*EXECUTIVE COMMITTEE MEMBERS

** EX-OFFICIO MEMBER

Nor could we have worked so collaboratively to build a baseline for the Plan of Action in the report without the help of the Commissioners of the State of Connecticut:

DEPARTMENT OF CHILDREN AND FAMILIES
DEPARTMENT OF CORRECTIONS
DEPARTMENT OF DEVELOPMENTAL SERVICES
DEPARTMENT OF EDUCATION
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
DEPARTMENT OF PUBLIC HEALTH
DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF TRANSPORTATION

We wish to send a very special note of appreciation to the extraordinary staff of the **Office of the Healthcare Advocate** for their support and responsiveness to our needs throughout this period.

Letter from the Chair

The commissioners of the CT. Commission on Health Equity wish to thank Governor M. Jodi Rell and members of the General Assembly for the passage of PA 08-171, which supports the elimination of health disparities and inequities in health status of Connecticut's residents based on race, ethnicity, and linguistic ability, thus improving the quality of health for all. We would also like to acknowledge those organizations and residents in Connecticut who have attended our meetings and provided valuable feedback for the work we have begun, and better yet – for the work we intend to accomplish. Most importantly, we would like to recognize those adults and families—African Americans, Hispanics, Asian Americans, Native Americans and others who are disenfranchised from access to quality health services and care.

Through the support of the CT. Health Foundation, we are pleased to have developed this report which is intended to be an action-oriented document that provides evidence of productive, collaborative efforts and accomplishments underway, thereby, creating a model for this state, and others that will effectively reduce/eliminate health disparities and inequities. In order to begin the development of a systemic approach to eliminate health disparities in Connecticut, we have expanded our work to: include reviews of state agency policies to assess the extent to which they perceive their policies, procedures and resources meet that objective; to acquire public testimony of residents' perceptions of evidence of healthcare disparities; to review raised bills to assess their potential impact on the elimination of health disparities/inequities on state residents; through evidence-based research, capture accurate evidence of key factors and best practices associated with health disparities impacting racial, ethnic, gender, cultural and linguistic differences; and, to acquire sufficient resources to award support to innovative/creative community-based initiatives committed to the elimination of health disparities/inequities.

Sustainable partnerships with the Commission will be maintained and grow as we connect with federal, state and local entities to assure support of integrated approaches to build upon Connecticut's model of a statewide coordinated healthcare plan to eliminate health disparities and inequities in our state.

Sincerely,



Marie M. Spivey, Ed.D, RN, MPA
Chair, CT. Commission on Health Equity

EXECUTIVE SUMMARY

INTRODUCTION

In 2008, the General Assembly of Connecticut approved and Governor M. Jodi Rell signed into law Public Act No. 08-171: *An Act Establishing a Commission on Health Equity*. It was predicated on three important assumptions. First, high quality health care is a human right and a priority of the State of Connecticut. Second, state-based research and experience reveal that Connecticut residents face barriers to high quality health based on racial, ethnic, national origin, and linguistic ability. Third, such barriers should be addressed through the collection, analysis, and reporting of information that identifies causes and leads to the development and implementation of policy solutions that both address health disparities and improve the health of Connecticut citizens. The twenty-eight members of the Commission represent all departments of the Executive Branch of the State of Connecticut, University of Connecticut, Yale University, Black and Hispanic Caucuses of the General Assembly, key community and legislative groups representing African Americans, Hispanics, Asians, and Native Americans, and members of the public representing disenfranchised populations.

In 2009, the Commission on Health Equity (Commission) developed a timeline for its work that would result in a 2010 Annual Report with recommendations from the Commission to the Governor, General Assembly, and the public. Embedded in the report would be a detailed plan that would guide the work of the Commission in subsequent years. Driving that work would be the objectives established by each of several Committees — Policy, Legislative, Public Voice, Data, and Resource Development. Each Committee was chaired by appointees of the Chair of the Commission and comprised of members of the Commission.

The Committees worked for nearly two years with key members of community agencies, academic partners from Yale University and the University of Connecticut, legislators, policy leaders, and representatives of local and state government agencies. The work of these Committees was conducted with little to no staff support so that hundreds of hours of volunteer time were committed to reach completion of the full Committee reports found in the Annual

Report. In part, these reports represent initial examination of the complex health system in Connecticut. However, the findings for each Committee were salient enough to provide insight regarding the development of targeted plans for the forthcoming fiscal year. Commensurate with the implementation of all plans will be an energetic effort in resource development to advance the work of the Commission and its recommendations. While many states are struggling with the implementation of their Plans of Action, this Commission, under the direction of the Chair, has already actively begun to seek legislative and private support for this important work. The overarching and implied goal of the work of the Commission is to become a *model state* in its design for collaborative efforts to reduce and eliminate health disparities/inequities among its most vulnerable populations. The result of this work will evolve into a highly effective public health system committed to the delivery of health care equity to its most vulnerable Connecticut residents, thereby improving the quality of health for all.

KEY FINDINGS

Data collected by the Committees of the Commission revealed strong evidence that:

- (1) For most of Connecticut's vulnerable populations -- racial and ethnic minorities, in particular—health disparities do exist. The Commission approved the recommendations of the Data Committee identifying cancer, cardiovascular disease, HIV/AIDS, infant mortality/low birth weight, diabetes and asthma as the most salient health issues requiring urgent efforts to improve racial and ethnic health equity.
- (2) The Policy Committee found that while state agencies seek to work more closely together in addressing these issues, strengthened support from effective policies and regulations are needed; and, enhanced and consistent outcome indicators and measures are required in order to better demonstrate the potential for reducing health disparities and inequities.
- (3) The Public Voice Committee found that consumers, community leaders, faith-based organizations and health institutions need to strengthen collaborations for information-sharing, cultural competency education, workforce development and policies and procedures for health promotion/disease prevention.

(4) To be successful, there is much more that needs to be learned about how health disparities affect vulnerable adults and families, how health inequity interferes with the State's cost containment efforts, and how the State will prepare for the implementation of National Health Care Reform mandates. The partnership of the state resources with its universities, hospitals, community health centers, community groups and state agencies working with the Governor and the Connecticut General Assembly is critical and will require private and public sources of support.

CONCLUSIONS

Connecticut, like its sister states in Massachusetts, Washington, Minnesota, California, and New Mexico is involved in the process of developing and promoting state action plans to address health disparities among its most vulnerable populations. Many of the plans in place focus on the need for better, more informative data that will help design and direct effective services, and track the success of such practices. The plan delineated in this report will promote in Connecticut, stronger linkages between and among state agencies, academic and health care institutions, and community-based organizations to increase resources for evidence-based research in order to gain a better understanding of the antecedents of health disparities and the interventions that work best for all state residents. Explicit in the recommendations and oversight by the Commission on Health Equity is the commitment to collaboratively create steps to: convene interactive lines of communication among state agencies to share strategies of their work to eliminate health disparities and inequities; increase public information and patient/provider training on culturally and linguistically competent health services; promote concerted efforts to develop a more racially and ethnically diverse healthcare workforce among health professions; and, to ensure that services are delivered in a high quality, competent manner to all culturally and linguistically diverse residents.

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INTRODUCTION

In 2008, the General Assembly of Connecticut approved and Governor M. Jodi Rell signed into law Public Act No. 08-171: *An Act Establishing a Commission on Health Equity*. It was predicated on three important assumptions. First, high quality health care is a human right and a priority of the State of Connecticut. Second, state-based research and experience reveal that Connecticut residents face barriers to high quality health based on racial, ethnic, national origin, and linguistic ability. Third, such barriers should be addressed through the collection, analysis, and reporting of information that identifies causes and leads to the development and implementation of policy solutions that both address health disparities and improve the health of Connecticut citizens.ⁱ Membership of the Commission represents departments of the Executive Branch of the State of Connecticut, University of Connecticut, Yale University, Black and Hispanic Caucuses of the General Assembly, key community and legislative groups representing African Americans, Hispanics, Asians, and Native Americans, and members of the public in support of disenfranchised populations.

In 2009, the Commission on Health Equity (Commission) developed a timeline for its work that would result in a 2010 annual report with recommendations from the Commission to the Governor, General Assembly, and the public. Embedded in the report would be a detailed plan that would guide the work of the Commission in subsequent years. Driving that work would be the objectives of several Committees of the Commission — Policy, Legislative, Public Voice, Data, and Resource Development. Each Committee was chaired by appointees of the Chair of the Commission and comprised of members of the Commission.

This annual report delineates the efforts of all the Committees under the direction of the Chair and Executive Committee. Each Committee examined new and existing data, analyzed and interpreted those data vis-à-vis national and state trends in those areas, and reported to the Commission with recommendations and plans for the forthcoming 2010-2011 fiscal period. This report not only substantiates the premise for Public Act No. 08-171, it also corroborates national research and policy analyses on the issues surrounding health disparities.

DEFINING HEALTH CARE DISPARITY/HEALTH EQUITY

There are a number of definitions of health disparity and health equity, but perhaps the clearest definitions for this report come from the U.S. Department of Health and Human Services. The Agency for Healthcare Research and Quality of the U.S. Department of Health and Human Services defines disparity in health as “the condition or fact of being unequal, as in age, rank, or degree.”ⁱⁱ Differences in health care for different populations may be the result of a number of causes. At the individual level, a patient may receive different treatment because of differences in the disease process, personal choice, insurance coverage, language barriers, race, ethnicity, gender or a host of socioeconomic conditions such as poverty, homelessness, disability, and old age. While it may not be possible to delineate the cause or causes of treatment differences, how individuals and groups of individuals are provided treatment can be documented to determine disparities.”

When health disparities are defined, such as those documented in this report, they are usually the result of what the Institute of Medicine calls, “inequality in quality.”ⁱⁱⁱ Equity, it states, “is the provision of health care of equal quality based solely on need and clinical factors.”^{iv} Implicit in this definition is that access is the key to the elimination of health disparities.

In Connecticut, data reveal that those most likely to have little or no access to quality health care are largely African American, Hispanics, Asian American/Pacific Islanders and Native Americans. However, race and ethnicity are not the only determinants of inequity or disparities in health. The creation of the Connecticut Health Equity Index^v effort is based on research pointing to the importance of gender, employment status, poverty, homelessness, disability, language, and sexual orientation as important indicators of poor health outcomes. Social factors, when combined with racial and ethnic minority status, can result in reduced access to quality health care and disparities in health outcomes when compared to those who do not share these characteristics.

WHY IS HEALTH EQUITY IMPORTANT

In the past several decades, there has been growing concern about the poor health outcomes of minority populations. In 2002, Congress asked the Institute of Medicine “to assess the quality and extent of racial and ethnic differences in the quality of health care received by patients, not attributable to known factors such as access to care, ability to pay, or insurance coverage..[and to] evaluate potential sources of these disparities, including the role of bias, discrimination, and stereotyping at the provider, patient, institutional, and health system levels...^{vi}”

The research literature examined for the report of the Institute of Medicine revealed several examples of evidence substantiating racial and ethnic differences in diagnosis, treatment and care. The racial and ethnic differences in cardiovascular care provided the strongest evidence of disparities.^{vii viii ix x xi} At least one researcher found that the differences in treatment between minorities and Caucasians were not the result of the severity of the disease or overuse by Caucasians. In fact, treatments such as coronary revascularization more often resulted in the death of African Americans than Caucasians.^{xii} Other studies revealed similar kinds of disparities.

African Americans with HIV infection were less likely than non-minorities to receive antiretroviral treatment.^{xiii} Prophylaxis for pneumocystic pneumonia and protease inhibitors were also inequitably provided to African Americans with HIV^{xiv}. Despite access to care, differences in the quality of care for African Americans with HIV have been associated with a poorer survival rates.^{xv xvi} Yet other studies of diseases revealed disparities in diabetes care, end stage renal and kidney transplantation, pediatric care, maternal and child health, mental health, rehabilitative and nursing home care for minority populations.^{xvii}

The final report to Congress summarized their findings in five key areas:

- “Racial and ethnic disparities in health care do exist. Even when there is adequate insurance and income and when age and the severity of the disease are taken into account, death among minorities from cancer, heart disease and diabetes outpace Caucasians.

- Social and behavioral studies reveal that these differences occur to some degree because of economic inequities and racial and ethnic discrimination.
- The health system as a whole contributes to racial and ethnic disparities.
- Patient and provider interaction contribute to racial and ethnic disparities.
- While minority patients are more likely than Caucasian patient to refuse services, minority patient refusal rates do not fully explain health care disparities.”

In addition to the empirical reality of racial and ethnic disparities in health care, there has also been a looming concern regarding the cost of inaction in this area. The United States spends over \$2.2 trillion in health care.^{xviii} A study, Commissioned by the Joint Center for Political and Economic Studies through Johns Hopkins University and the University of Maryland revealed that more than 30% of the direct medical costs (out-of-pocket and third party payments) of African Americans, Hispanics, and Asian Americans were additional costs burdens because of health inequities. This means \$230 billion over three years of the study alone. When indirect costs (productivity lost due to illness and losses from premature death) of inequities are added, the sum, according to this study is \$1.24 trillion^{xix}-- more than the gross domestic product of India, the world’s 12th largest economy. In its conclusions, the authors stated,

“The large numbers of premature deaths represents a substantial loss of human potential, loss of talent and productivity that might otherwise have contributed to the betterment of society. By exacting a substantial burden on the economy, health inequalities visit further suffering on society.”

The studies of racial and ethnic disparities in disease and the social determinants of disease combined with the studies of the economic impact of failure to address these health disparities have forced a national debate on health care reform that is yet to be fully realized at the state level. Connecticut as other states will have to address implementation issues on such Health Care Reform items as:

- Collecting and reporting data by race and ethnicity and language.
- Expanding cultural competency education among providers, evaluating changes, monitoring revisions in care plans to improve outcomes and deinstitutionalize racism.

- Providing support for research on the causes of health disparities and racial and ethnic differences, and develop strategies to provide equal quality services in the overall health care system.
- Establishing a wide array of policy priorities to reduce health disparities, including medical home models and community-based intervention strategies.
- Addressing disparities in health insurance reform such as in Medicaid expansion.
- Removing barriers to quality health care access, such as in workplace wellness programs.
- Improving quality in health care through such efforts as a national quality improvement priorities and strategies effort.
- Evaluating effective cost containment efforts, such as different payment mechanisms in public programs.
- Addressing the social determinants of health.

In order to understand how the National Health Care Reform Bill will ultimately affect the potentially unique circumstances of different communities in different states, Connecticut and a number of states have launched commissions on health disparity/health equity. Massachusetts, Washington State, Ohio, Minnesota, New Mexico, and California are among the growing number of states eager to examine their potential to insure health equity for racial and ethnic minorities in their states.

OBJECTIVES/ACTIVITIES OF THE CONNECTICUT COMMISSION ON HEALTH EQUITY

The current twenty-eight members of the Commission on Health Equity began the task of formulating a state plan of action on racial and ethnic health disparities through the creation of several committees: Policy, Legislative, Public Voice, Data, and Resource Development. The tasks for all the committees was to first explore existing data and information for each of their designated areas, analyze those efforts, and make recommendations for a statewide plan of action. Each Committee was chaired by a member of the Commission with other Commissioners serving as members of the Committee. The objectives and activities for each of Committees were defined as follows:

POLICY COMMITTEE

Chairs: Jeanette DeJesus and Marie Spivey

OBJECTIVE:

To determine whether state policies, procedures, activities and resource allocations dedicated to the elimination of health status disparities have the potential to improve the quality of health for all.

ACTIVITIES:

- **Conduct surveys of all state agencies whose purview is relevant to the elimination of health disparities.**
- **Review Department of Public Health's health disparities performance measures.**
- **Develop recommendations toward a Plan of Action from findings.**

PUBLIC VOICE COMMITTEE

Chairs: Kelsone Ettienne-Modeste and Janet Williams

OBJECTIVE:

To gather preliminary understanding of the perceptions of health disparities among medically underserved and socioeconomically deprived racial and ethnic minorities in the State of Connecticut.

ACTIVITIES:

- **Conduct public hearings, and interview and receive testimony regarding issues of health disparity and inequities in treatments.**
- **Review findings and develop a plan for coalition-building and partnership between populations experiencing racial, ethnic, cultural, and/or linguistic disparities in health care and State Agencies providing services.**
- **Develop recommendations toward a Plan of Action from findings.**

DATA COMMITTEE

Chairs: Paul Cleary and Greg Stanton

OBJECTIVE:

To determine from existing state data the key disease, illness, and/or injury areas of greatest need in addressing racial and ethnic health disparities.

ACTIVITIES:

- Collect and analyze government and other data regarding the health status of state residents based on race, ethnicity, national origin, and linguistic ability.
- Prioritize those health areas of greatest health need for state residents based on race, ethnicity, national origin, and linguistic ability.
- Develop recommendations toward a Plan of Action from findings.

LEGISLATIVE COMMITTEE

Chairs: Sharon Mierzwa and Natasha Pierre

OBJECTIVE:

To promote effective legislation on health equity that is based on policy analysis of state data and information, as well as analyses of the impact of current legislation and proposed legislation.

ACTIVITIES:

- Review and comment to the Commission on any proposed state legislation and regulation that may affect the health of racial and ethnic minorities in Connecticut.
- Draft and recommend legislation, regulations and other policies designed to address health disparities in Connecticut to the Commission for approval.
- Develop recommendations toward a Plan of Action for implementation of a full legislative agenda.

RESOURCE DEVELOPMENT COMMITTEE

Chairs: Anne Ferris and [To be Announced]

OBJECTIVE:

To sustain the work of the Commission in addressing racial and ethnic health disparities in the State of Connecticut.

ACTIVITIES:

- Explore “best practice” health disparities activities in other states.
- Examine federal, state, and private sector support for the work of the Commission in research, data collection, public education and communication, and policy development.
- Develop a long-term sustainability plan that achieves the goals of the Commission and improves health equity for citizens of Connecticut.

Each of the Chairs of these Committees worked for nearly two years with key members of the Commission, community agencies, academic partners from Yale University and the University of Connecticut, legislators, policy leaders, and representatives of local and state government agencies. The work of these Committees was conducted with little to no staff

support so that hundreds of hours of volunteer time were committed to the completion of the full reports. In part, these reports represent initial examination of a complex health system in Connecticut. However, the findings for each Committee were salient enough to provide insight regarding the development of targeted plans for the forthcoming fiscal year. Commensurate with the implementation of all the plans will be an energetic effort in fund and resource development to fulfill the intention of the Committees' reports. While many states are struggling with the implementation of their Plans of Action, this Commission, under the direction of the Chair, has already actively begun to seek legislative and private support of this important work. The overarching and implied goal of the work of the Commission is to become a model state for the reduction in health disparities among its most vulnerable populations and the building of a highly effective equitable system of health care.

KEY FINDINGS

The work of the Commission through its Committee structure revealed strong evidence that (1) Connecticut does experience health disparities among its most vulnerable populations—racial and ethnic minorities in particular; (2) state agencies seek to become partners in addressing these issues through support from effective policies and regulations, as well as resources; (3) patients, community leaders, faith-based organizations, institutions of higher education, and health institutions need to strengthen collaborations for information, cultural competency training, and policy promotion; and, (4) much more needs to be learned about how health disparities affects vulnerable adults and families, how it interferes with the State's cost containment efforts, and how it will prepare itself for the implementation of the National Health Care Reform mandates.

The face of health disparity in Connecticut

Connecticut is the third smallest state in the nation comprised of 169 separate and politically autonomous towns with a very loosely constructed no county structure. Yet, it is also one the most densely populated states with the cities of Bridgeport, New Haven, and Hartford accounting for 84% of the population. Because it is such a small state, its differences are cogent. On the one hand, Connecticut maintains its quaint New England village characteristics while attaining one of the highest per capita income rates, the best adult insurance coverage, the most

highly educated residents in the country; and, overall good health.^{xx} Its proximity to the wealth of New York City and Boston along with its once highly visible standing as the insurance capital of the world and home to universities such as Yale, the University of Connecticut and Wesleyan is striking when compared to the poverty, homelessness, unemployment, and poor health of a disproportionately high number of its population.

Since 2000 there has been a steady rise in the racial and ethnic diversity of Connecticut. As of 2007, Hispanics in the state comprise 11.5% of the population, African Americans, 9.3%, and Asians 3.4%--numbers that represent an average of a 25% increase since 2000. Compared with Caucasians, Connecticut's African Americans, Hispanics, and Native Americans are three to four times more likely to live in poverty.^{xxi} These residents tend to be unemployed or underemployed, undereducated or dropouts from high school, poorly housed, poorly linked to medical homes, and dying from heart disease, cancer, and cerebrovascular disease at a higher rate than the state's Caucasian population.^{xxii}

Beginning in 2009 the 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. Their analysis revealed that although Caucasians are healthier than African American or Hispanic populations, binge drinking among Caucasians is two times higher among African Americans. However, Committee members caution that these differences were flattened after age 54 in all populations.

Committee members also found that health insurance coverage has a direct impact on a number of health indicators. Twice as many African Americans (18.4%) and more than three times as many Hispanics (29.1%) report having no health insurance compared to Caucasians (9%). The implication is that African Americans and Hispanics do not have consistent medical homes. However, one possible explanation for the low rates of health insurance coverage or lack of primary care is that the rates of hospitalization for ambulatory care of sensitive conditions (ACSC) and emergency room visits are twice as high for African Americans and Hispanics as for Caucasians. Ironically though, Caucasians and African Americans almost equally report having a regular source of medical care (87.5% and 80.7%, respectively). Given the apparent lack of insurance or a primary care, almost twice as many African Americans and Hispanics

report being in fair or poor health compared to Caucasians. The rates of very low and low birth weight babies are between one and a half and two times as high among Hispanic and African Americans as Caucasians.

The Committee found that Connecticut residents regardless of race or ethnicity surpassed or met the standards set out in *Healthy People 2010* for preventive health indicators for breast cancer (mammogram), cervical cancer (Pap smear) and colorectal cancer (sigmoidoscopy/colonoscopy and blood stool test). Testing rates are all comparatively equal among African Americans, Hispanics, Asian, and Caucasian (83%, 88.5%, 45.9% and 28.9%, respectively). Even mortality rates for lung, colorectal, and breast cancer are all comparatively equal among these populations with Hispanic rates 25% to 50% lower than African American and Caucasian. However, the Committee did find that mortality rates due to prostate cancer in African Americans are more than twice that of Caucasians or Hispanics. One possible explanation is that the PSA screening test data are not available for African Americans and labeling for Hispanics could be reduced by those who define themselves as Caucasian. Although it is known that the link between prevention and mortality is strong, without data the Committee could not surmise if there could be a connection between prevention and mortality for this group.

In addition, the Committee reported that the mortality rate from diabetes in African Americans and Hispanics is consistently over time almost three times the rate in Caucasians. Mortality from HIV infection in African Americans and Hispanics is between 20 and 30 times higher, respectively, than among Caucasians. This represents an alarming doubling of HIV/AIDS mortality in this population between 2001 and 2005. It appears that those areas in which early detection and preventive screening are either not done or are not documented may have some impact on understanding the rates of mortality in African Americans and Hispanics. Because the Institute of Medicine consistently has seen the problems of race and ethnic designation in data, one component of the Health Care Reform bill calls for the capture of race, ethnicity, language and health literacy proficiency as a minimal requirement of patient data collection.

In the examination of behavioral risk factors for mortality, the Committee found that suicide rates for Caucasians is twice as high as it is for African Americans and almost 25% higher than it is for Hispanics. Yet, the homicide rate among African Americans is over 10 times higher and in Hispanics almost 5 times higher than in Caucasians. There is evidence that the health of African Americans in the urban centers of Bridgeport, New Haven, and Hartford (individually or in aggregate of HRG1) is worse than the health of African Americans in non-urban areas. Generally, African Americans in the wealthy suburbs, in mill towns, and in rural areas report better health than those living in urban centers. Unfortunately, race data is not stratified by area for most of the preventative indicators or for the mortality causes.

The Data Committee determined their recommendations for the Commission on Health Equity using the following criteria:

1. “The prevalence in the entire population or subgroup (e.g. racial or ethnic).
2. The impact of the condition or process in terms of morbidity and/or mortality.
3. Racial or ethnic disparity.
4. The cost of untreated or inappropriately treated cases.
5. Prompt attention will avoid a much larger problem later.
6. The extent to which factors affecting disparities can be changed (e.g. easier to change school programs than environmental factors).
7. Opportunities for intervention (e.g. existing coalitions, community support, available funding, political.”

The following indicators were approved by the Commission on Health Equity as of November 17, 2009:

HIV/AIDS: The relative risks for mortality and *ever tested* are of key concern. The availability of the federally-funded Yale Center for Interdisciplinary Research on AIDS (CIRA) as a key resource in its statewide program to improve testing and treatment rates are among the reasons for selecting HIV/AIDS.

Infant mortality/low birth weight: Probably no indicator indicates health disparities in the United States more than infant mortality. Low birth weight is the most important risk factor for infant mortality. A potential disadvantage is that infant mortality rates and birth weight are notoriously difficult to improve, but the Commission is determine to address this important area.

Diabetes: It is estimated that the disease and its effects will only get worse for communities of color without effective intervention. Additionally, all communities of color - African American, Hispanic, Native American, and Asian American are at increased risk. Addressing diabetes will also affect risk factors for other chronic conditions like heart disease. Diabetes touches multiple health care and public health systems and there are several existing diabetes efforts with which the Commission will collaborate. Among them are the University of Connecticut Center for Eliminating Disparities among Hispanics and the diabetes clinical research area at Yale University School of Medicine and Yale University School of Nursing.

Asthma: The asthma prevalence and hospitalization rates, as well as the relative ease of treating asthma substantiate that more and better work can be done in this area. There is a coalition of genetics, clinical, and public health researchers focusing on this issue in Connecticut and so it should be possible to link research and clinical expertise to effective practice.

Cardiovascular Disease: Its effects are greatest among racial and ethnic minorities in this state and extensive research work through the University of Connecticut and Yale University can link evidence to more effective prevention practices.

Cancer: Prevention of cancers through early screening and detection is one of the purviews of Connecticut's system of Federally Qualified Community Health Centers. Linking behavioral research with practice can improve utilization of early screening procedures.

The Commission also accepted the recommendations of the Data Committee to collaborate with the Department of Public Health on *Healthy People 2020*. The Commission will serve as a catalyst, collaborator, and advisor to the State of Connecticut in the development of the State's *Healthy People 2020 Plan* (HP2020) as it relates to eliminating racial, ethnic and gender disparities.

State agencies seek to become partners in addressing these issues through support from effective policies and regulations, as well as resources and support

To effectively implement a statewide plan that reduces the chronic diseases prioritized by the Commission and builds health equity for African Americans, Hispanics, Asian Americans and Native Americans, the Policy Committee recognized the importance of Connecticut's Executive Branch. Their assessment of the Departments of Developmental Services, Public

Health, Education, Mental Health and Addiction Services, Children and Families, Social Services, Corrections and Transportation revealed several important findings.

First, state agencies collect a considerable amount of data to meet local, state, and federal reporting mandates. Perhaps the most critically important department in data collection is Public Health. In order to research and evaluate changes in morbidity and mortality rates in each of the areas proposed by the Commission, sound surveillance data is important. According to an assessment conducted by the Policy Committee, the Department of Public Health completed a report in 2009 on Connecticut health disparities.^{xxiii} Both the Policy and Data Committees indicated that the report produced an effective depiction of incidence and prevalence for a wide array of acute and chronic illnesses, diseases, injuries, and behavioral health risks. The report also defines issues related to insurance coverage and accessibility of health care services to consumers, as well as some early insights regarding social determinants of health such as socioeconomic indicators, education and housing status. However, both the Policy and Data Committees found inconsistencies in data collection and reporting methods throughout the departments that may serve as barriers to empirical understanding of the impact of health disparities on racial and ethnic minority populations and to tracking progress of community and patient interventions to address health equity.

The Department of Social Services also collects important data on vulnerable families through the HealthFirst Connecticut and Healthy Kids Initiatives. This data is used to compare plans for vulnerable children and families in Connecticut and across the country. These data can be informative, especially when combined with DSS's traditional collection of health plan descriptive information such as cost of care, administrative performance, authorizations, denials, appeals and hearing, and access and utilization along with data on the patient perceptions of service satisfaction. While these data are collected for populations participating in specific programs, they need to be analyzed and aggregated in any way that might be helpful to the tracking of changes in health disparities and inequities. At a minimum rudimentary evaluation of changes in health and social services outcomes for these populations would be helpful. However, these evaluations can only serve as a stepping stone to more rigorous population studies.

The Department of Mental Health and Addiction Services is also a potential resource for health related data. However, general population-based behavioral health and substance abuse disparities data is not available. Instead, DMHAS has a number of initiatives designed to reduce health disparities among the clients it targets. Again, these data can be helpful in determining methodologies for evaluating client-base community interventions. Client-related information is also available in the Departments of Developmental Services and Corrections that can also provide insight regarding successful intervention methods for specific target populations. The remaining Departments—Education, Children and Families, and Transportation — also collect client-based data connected with specific interventions and initiatives to address health disparities and socioeconomic disparities that can lead to poor health. Data from the Departments of Labor and Housing are to be acquired during this next period of the Commission’s work.

The common perception of all these departments is that their data are inconsistent – one from the other - and not population-based. However, this appears to be a problem in many states addressing health disparities. Initiatives and interventions supported by state legislators, federal and private grants tailor how data is collected and reported. It is not until recently that funders mandated public dissemination of client and patient-based data findings. However, Connecticut’s department data is useful in the area of health disparities for several important reasons. First, interventions and initiatives are an opportunity for academic communities to understand effects on communities, clients, and patients—sometimes providers as well. These data can be helpful in the design of rigorous population-based research. Second, the results of empirical research and the findings in the plethora of reports mandated in all these departments can be helpful to all departments. Departments revealed an interest in sharing their data and reports with other departments and using information to examine internal strategic planning for programs and services and to explore collaborative opportunities with each other, and with academic institutions, community agencies, etc. Third, a clearinghouse of data and reports from departments and from others who use department data for research and evaluation could be a useful public information tool for policy leaders, providers, community agencies, and civic organizations. Finally, access to the analysis and review of these data can provide extensive

opportunities for new directions in regulations and policies—particularly in light of the National Health Care Reform Bill.

Patients, community leaders, faith-based organizations and health institutions need to strengthen collaborations for information, cultural competency training, and policy promotion.

Through assessment of focus groups, hearings, and other community feedback, the Public Voice Committee of the Commission defined the importance of civic engagement and public education of providers, clients/patients, and residents as a key component of reducing health disparities and ensuring health equity. Review of the data from public forums revealed the following:

1. Disparities in socioeconomic status are prevalent across all towns, cities, and villages of Connecticut.
2. Clients/patients report that the health care system is fragmented and contains little in the way of useful, culturally and linguistically appropriate information about health rights, eligibility to services, and opportunities to access high quality health care. Increased communications across racial and ethnic minorities in towns, cities, and villages would create public awareness and increase opportunities for communities and municipalities to build strategies that would address disparities at a local level.
3. Local and state governments should play a major role in encouraging collaborations across state departments, community agencies, health services, etc. that would result in effective policies and regulations that would meet the needs of those affected by disparate treatment in health and social services.
4. Health directors in local communities can be key facilitators of interdisciplinary approaches to reduction in health disparities.
5. While collaborations and public communication are important to health equity for vulnerable populations, local health agencies acknowledge that human resources and financial support are key obstacles to progress.

Behavioral research indicates that with diseases such as HIV/AIDS, cardiovascular disease, and some cancers culturally and linguistically appropriate public education can reduce the incidence of illness among the target population, by increasing utilization of health and

welfare system for patients and their families.^{xxiv} Public and patient education has been demonstrated to reduce those behaviors that are linked to chronic illness, such as sun screening education to prevent skin cancer,^{xxv} increased condom use to reduce HIV infection among heterosexual and homosexual partners,^{xxvi} and language- appropriate interpreters for physician/patient interaction on regimens for antiretrovirals.^{xxvii}

In addressing the social determinants of health the Annie E. Casey Foundation has supported a number of Connecticut-based civic engagement efforts that empower vulnerable populations to learn about and advocate for better housing, schools, and health services. And, finally, the work of Connecticut's Community Health Centers is based on prevention-oriented patient education in multiple languages. Federal reports reveal that Community Health Centers or Federally Qualified Community Health Centers are effective, replicable models of prevention-oriented care that is greatly accessed by neighborhood adults and families because of its commitment to public education, patient engagement, and neighborhood based high quality services. In fact, Community Health Centers have been strongly supported by Congress and are strongly supported in the National Health Reform Bill as important entrées to health equity for vulnerable populations.

Improving the quality of health care delivery through provider education is an important avenue to health equity. Yet, the Public Voice Committee also found that while a number of state and local agencies conduct cultural competence training of providers, it is considered to be conducted inconsistently and for too short a duration. While there are striking efforts on the part of the Department of Higher Education and Labor to increase the number of culturally appropriate providers and practitioners in the community, there continues to be a dearth of culturally competent physicians, physician's assistants, nurse practitioners, social workers and counselors. Recent efforts on the part of the state's workforce development efforts – particularly in the north central region of the state – through grant funded initiatives, educational programs have been designed and implemented to improve the academic skills and clinical/workforce competencies of low-wage, diverse frontline adult workers interested in advanced credentials in the healthcare career pipeline.

Finally, the Public Voice Committee analyses revealed that there are few, if any, grassroots education campaigns directed at vulnerable populations who should be seeking quality culturally appropriate services. When asked if they are knowledgeable about where to access information on good health care services, most Hispanic clients/patients (especially those with language limitations) living with HIV/AIDS from Bridgeport, New Haven, and Hartford indicated that they are not knowledgeable.^{xxviii} When asked if they had “medical homes,” most client/patients pointed to the social service program they were involved in and not a physician or medical facility.^{xxix} There appear to be very few statewide community-based media or web-driven campaign to increase knowledge or information in the state.

Much more needs to be learned about how health disparities affect vulnerable adults and families

The work of the Data, Public Voice, and Policy Committees of the Commission reveal two important facts. First, there are indeed resources in this state from which to develop a system of care that is equitable to African Americans, Hispanics, Asian Americans, and Native Americans. It is true that those resources are often inconsistent and largely incomplete. However, the State Executive Branch of government has overwhelmingly expressed an interest in examining information and data in a way that provides both health indicators and social determinants of disease, illness and injury. Academic institutions are interested in exploring partnerships with state agencies and workforce development agencies to further understand the health circumstances of the state’s most vulnerable population. These kinds of partnerships should provide information for public education and provider training, and should offer legislators and policy leaders insight regarding new health laws and regulations. It is also anticipated that such partnerships will help to provide information on cost containment issues in quality and equitable health care.

The Resources Committee has taken a step in the direction of expanding knowledge in a way that affects practice and policy. It has successfully completed the process of compiling a cadre of qualified candidates for the position of a Health Equity Director. To date, the Commission has carried out its tasks through the voluntary efforts of its Commissioners in the various Committees. Other than limited resources for translation of meeting minutes and

mailings through the efforts of the Office of the Health Advocate, few staff resources have been applied to the Commission on Health Equity. With a Health Equity Director on board, the Commission can begin the process of fulfilling its work plan.

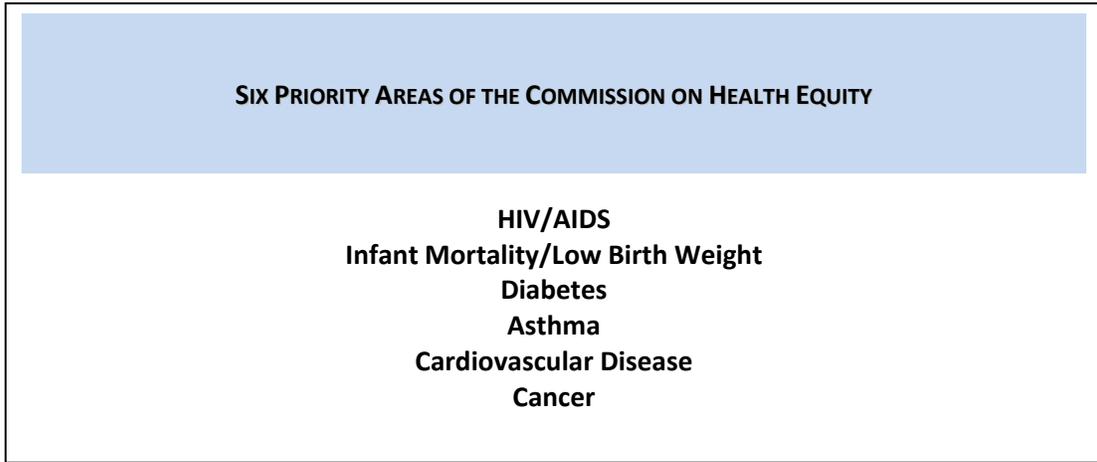
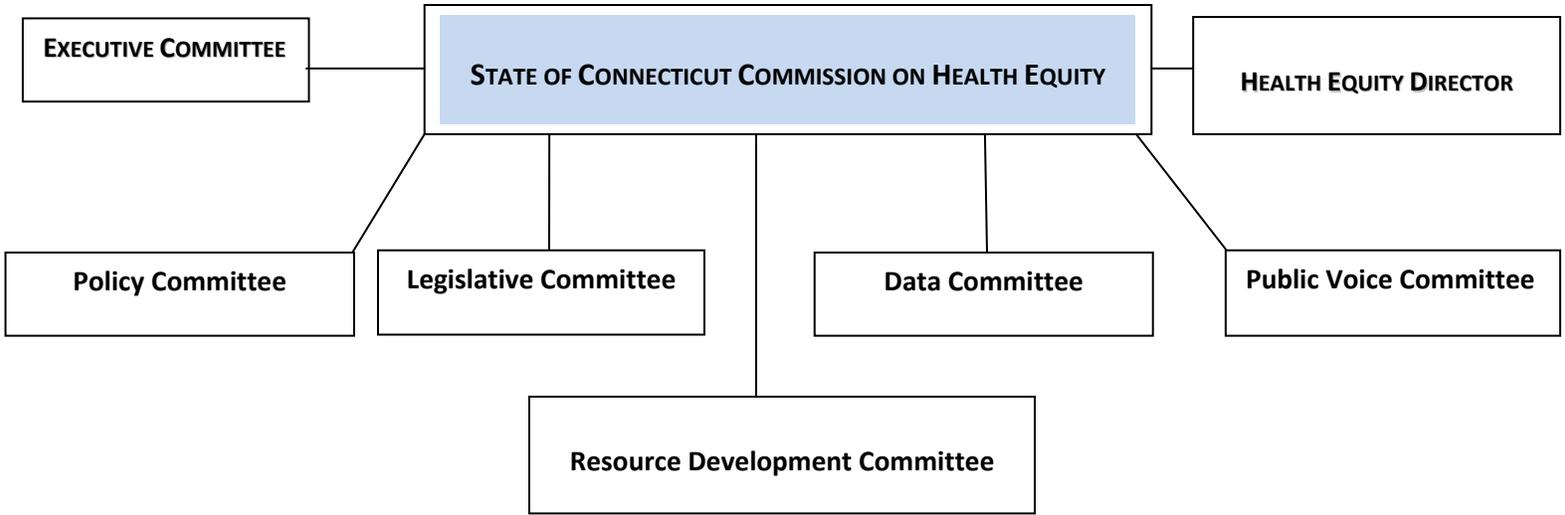
The Legislative Committee will initiate its work prior to the start of the new state Legislative session. With potential staff support, its work will be to be cognizant of the implication of the impact on the elimination of health disparities and inequitable services that proposed bills imply, and to recommend to the Commission legislative testimony and/or language to ensure effective results.

The work of the Committees is fundamental to the understanding of the depth and scope of the issues facing the Commission. Now that these issues have been incorporated into a Plan of Action for the following year, the Legislative Committee will be valuable in helping to define legislative language that can build health equity in the State of Connecticut.

2010-2011 PLAN OF ACTION FOR CONNECTICUT

The Plan of Action for Connecticut's Health Disparity/Health Equity approach is premised on the six priority areas adopted by the Commission. Chart 1 below illustrates how the organization would devote its goals and objectives to address the empirical, services, educational, resources, policy and legislative aspects associated with these priority areas. The Commission is now in the process of hiring a Health Equity Director who will work closely with the Commission and its Committees to coordinate and fully implement the Plan of Action for the first year. In addition, the Director will work closely with the Commission to review and promote legislative language; policies and regulations that support the priority areas. Finally, the Director will commit a significant portion of his/her time in coordinating grant writing opportunities and development efforts to ensure long-term sustainability of the Commission on Health Equity and its Plan of Action.

CHART 1: ORGANIZATIONAL STRUCTURE



PUBLIC VOICE COMMITTEE

GOAL: INCREASE ACCESS TO QUALITY HEALTH CARE FOR VULNERABLE POPULATIONS

OBJECTIVES:

- ✚ To increase knowledge and public action to reduce health disparities and increase health equity in the six priority areas.
- ✚ To ensure a high quality culturally competence health care delivery system.
- ✚ To engage policy leaders, researchers, providers and others in creating health equity.

ACTIVITIES:

1. Increase membership of Committee to include representatives of vulnerable populations.
2. Work with the Department of Public Health, Social Services, and others to design and implement public education campaign on health issues in the six priority areas that include discussion of social determinants. Focus on Bridgeport, New Haven, and Hartford and on selected rural communities.
3. Use the Department of Mental Health and Addiction Services model of cultural competence training for health care providers, policy leaders, staff of agency in a carefully designed methodology that includes evaluation of knowledge gained, attitudes changed, and behavioral intentions pronounced.
4. Conduct statewide media information releases on departmental and research findings related to health equity issues.
5. Connect with Community Health Centers to expand the potential for client/patient and provider education in the six priority areas.

EXPECTED OUTCOMES BY THE NEXT FISCAL YEAR:

- ❖ Tested curricula with evaluation components will be designed and implemented in at least three sites with at least three different target groups in a cross section of the public including client/patients, providers, students in health care training, policy leaders, etc.
- ❖ Tracking system to analyze progress of public information and community engagement.
- ❖ Methodology for the dissemination of health equity information and data through the public and the media.
- ❖ At least three community-level public information sessions will be conducted and evaluated for effectiveness.

DATA COMMITTEE

GOAL: EMPIRICALLY SUBSTANTIATE REDUCTIONS IN HEALTH DISPARITY AND GROWTH IN HEALTH EQUITY.

OBJECTIVES:

- ✚ To increase knowledge regarding clinical and social determinants of the health of vulnerable populations in the six priority areas.

ACTIVITIES:

1. Create a partnership between Yale and the University of Connecticut and the commissioners and staff of State of Connecticut Departments to share data, reports, and other documents that may help devise research questions that can be answered from existing or additional data collection.
2. Examine the feasibility of applying for at least one grant that enhances knowledge in at least one priority area.
3. Include Public Voice Committee Chair in meetings to ensure that these and other data are reviewed from a public information and community education perspective.

EXPECTED OUTCOMES BY THE NEXT FISCAL YEAR:

- ❖ Regular exchanges of academic and departmental data will result in clearer definition of research questions.
- ❖ Regular exchanges of academic and departmental data will result in better strategies for services and data collection of vulnerable populations.
- ❖ The Public Voice Committee will use at least five information sources from academic and departmental exchanges to design public information dissemination materials.

POLICY COMMITTEE

GOAL: STATE OF CONNECTICUT POLICIES AND REGULATIONS WILL CREATE HEALTH EQUITY FOR THE STATES MOST VULNERABLE POPULATIONS.

OBJECTIVES:

- ✚ To promote policies and regulations that ensures health equity for vulnerable populations.

ACTIVITIES:

1. Work closely with State Departments, the Public Health Committee of the Legislature, and other members of the Legislative body to ensure that policies and regulations are supported or changed as new data and information reveal ways to create health equity for African Americans, Hispanics, Asian Americans, Native Americans and other vulnerable population in Connecticut.
2. Provide the State General Assembly with policy briefings as new data from local and national health disparity research and policy efforts emerge.
3. Collaborate with the Departments of Public Health and Social Services and the General Assembly on implementing the National Health Care Reform Bill in a manner that is responsive to racial and ethnic health equity.

EXPECTED OUTCOMES BY THE NEXT FISCAL YEAR:

- ❖ At least two policy briefings on emerging issues in health disparity research.
- ❖ Early empirical evidence that changes policies that affect health disparities in at least one of the six priority areas.

RESOURCE DEVELOPMENT COMMITTEE

GOAL: CREATE A SUSTAINABILITY PLAN FOR THE OFFICE OF THE COMMISSION ON HEALTH EQUITY

OBJECTIVES:

- ✚ To develop a diverse budget that includes legislative, private and public support.

ACTIVITIES:

1. Design a business plan that includes operational costs and support for community initiatives committed to the elimination of health disparities.
2. Develop partnerships with academic institutions for research, and private/public support for specific initiatives to eliminate health disparities.

EXPECTED OUTCOMES BY THE NEXT FISCAL YEAR:

- ❖ To have in place a fully operational, sustainable plan to support the efforts of the Commission.

LEGISLATIVE COMMITTEE

GOAL: STATE OF CONNECTICUT POLICIES AND REGULATIONS WILL CREATE HEALTH EQUITY FOR THE STATES MOST VULNERABLE POPULATIONS.

OBJECTIVES:

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

ACTIVITIES:

1. Work closely with the Legislature and other members of the Legislative body to ensure that legislation supports the goals and objectives of the Commission.
2. Provide the State General Assembly with legislative briefings as new data from local and national health disparities research and policy emerge.
3. Collaborate with Governor and State General Assembly to create language supporting implementation of the National Health Care Reform Bill.

EXPECTED OUTCOMES BY THE NEXT FISCAL YEAR:

- ❖ At least two legislative briefings on emerging issues in health disparity research and policies.
- ❖ Early empirical evidence that new legislative language can affect health disparities in at least one of the six priority areas.

CONCLUSIONS

This report demonstrates that the Commission on Health Equity has conducted extensive work in characterizing health disparity in the State of Connecticut. Using existing data and research efforts, it has concluded that African Americans, Hispanics, Asian Americans, and Native Americans are at greatest risk for poor health access and poor health outcomes. While the Connecticut health delivery system admits to having to adjust delivery of more culturally competent health services, it is clear that high quality services do exist. The disjuncture is between the most vulnerable populations who need it and their inability—through lack of information, discrimination, cultural and linguistic barriers that create fear and distrust, insufficient insurance or no insurance coverage—to access it.

The Plan of Action brings together representatives of those vulnerable populations, researchers, policy leaders, community agencies, health systems, and state and local agencies who deliver services and conduct data surveillance. Through the Commission and its work with all these sectors of Connecticut society, six priority areas have been chosen for the design of a Plan of Action. In 2010-2011 fiscal year, this plan reflects early implementation strategies with benchmarks for expected outcomes that are intended to build upon subsequent year's work.

In light of the National Health Care Reform Bill, Connecticut and many other states are launching rigorous approaches to reduce racial and ethnic health disparities and establish for states high quality care that reaches all sectors of the population. In addition to reducing health disparities, the Connecticut Action Plan seeks to enjoy the added benefits of cost containment.

“Usually we think of change as coming with costs, that doing something will cost more than doing what we are accustomed to doing. But in the case of health inequalities, doing nothing has a cost we should not continue to bear.”

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