Draft Report
CHE Data Group
September 11, 2009

Data Group Goals

Of the 10 Commission on Health Equity (CHE) mandates, specified in Public Act No. 08-171, Commission members recommended that the Data Group should focus on four:

- Collect and analyze data relevant to the mission of the Commission -- including on metrics, best practice, and promising models/initiatives – to inform its arguments, recommendations, and call for action.

- Review and comment on the Department of Public Health's health disparities performance Measures.

- Explore other successful programs in other sectors and states, and pilot and provide grants for new creative programs that may diminish or contribute to the elimination of health disparities in the state and culturally appropriate health education demonstration projects, for which the commission may apply for, accept and expand public and private funding.

- Have the authority to collect and analyze government and other data regarding the health status of state inhabitants based on race, ethnicity, national origin and linguistic ability, including access, services and outcomes in private and public health care institutions within the state, including, but not limited to, the data queried through the Connecticut Health Information Network.

The Data Group decided to focus initially on the first two goals listed above.

Activities to date

In addition to participating in Commission meetings and Retreats, Data Group members have met in person and via conference calls on several occasions. In person meetings were held in New Haven on June 15th and July 20th with some members calling into each of these meetings. Conference calls were held on June 22nd , August 6th and September 11th.

During these meetings and calls, Data Group members discussed the goals to focus on, proposed data group activities, the process by which the Data Group should prioritize commission foci, and ways of working with other state entities on issues related to health equity. For example, on their most recent call, they had a discussion with Robert Trestman regarding the availability of data on individuals in the corrections system. Similarly the group has explored how to develop better data regarding children and persons with behavioral health issues.

Data Review and Summary

The Data Group reviewed several potential sources of state and federal data on health disparities to identify sources of information on health disparities in Connecticut. Twelve reports were reviewed and were summarized based on health indicators (Table 1). Ten of these reports contained Connecticut-specific health data.

Table 1. Health Disparities Reports Data Summary

	CT Health Data Scan	2009 CT Hth Disparities Report	Common-wealth	Kaiser	Kaiser Wmn's Health CT	NAACP 2007	ACSC CT	Hispanic Health Council	NCI State Cancer Profile	CDC US Cancer Stats (USCS)	CT Hlth Fndtn Racial and Ethnic Panel Report
CT State Specific Detail	yes	yes	no	yes	yes	yes	yes	yes	yes	yes	
Disparity							Prevent-able hosp. data from CT Office of Health Care Access 2008				
Health Status											
fair/poor health	x, 1		x, 9		x, 21	x, 3					
limited activity	x, 1				x, 21	x, 3					
chronic condition or disability			x, 10								
chronic condition or disability by FPL			x, 10								x
life expectancy			x, 11								
obesity	x, 1	x, 5	x, 10		x, 21			x			
smoking	x, 1	x, 5	x, 9		x, 21						x
diabetes	x, 1	x, 5	x, 12		x, 21	x, 3, 15		x			
cardiovascular disease			x, 11			x, 15					
cancer incidence			x, 9, 13			x, 13				x, 13	x
HIV/AIDS incidence		x, 5	x, 14	x	x, 14						
HIV/AIDS prevalence								x			
asthma (all ages)			x, 9								
asthma (adult/adolescent)	x, 1		x, 9			x, 15					
asthma (pediatric)						x, 3		x			
asthma (adult - ever told)	x, 1										
frequent mental distress	x, 1		x, 15		x, 21						
serious psychological distress					x, 22	x, 3					
low birthweight (live babies)	x, 5	x, 5			x, 9	x, 2					
prematurity						x, 2					
seat belt use	x, 1										
binge drinking	x, 1										
Mortality											
infant mortality	x, 6	x, 5	x	x							
cardiovascular/heart disease mortality	x, 8	x, 5	x, 9								
cancer incidence and mortality	x, 8	x, 5	x		x, 13				x, 13		
asthma mortality			x, 9								x
diabetes mortality	x, 8	x, 5		x				x			
HIV mortality	x, 8	x, 5									x
Access to and Utiliatization of Health Care											
no doctor			x, 10		x, 21	x, 15					
regular source of care	x, 1		x, 10			x ,15					
no routine checkup in past 2yrs	x, 1				x, 21						
go without needed care			x, 10			x, 15					
forgo dental care	x, 1	x, 28	x, 10		x, 21			x			
pediatric dental care		x, 5									
forgo prescription meds			x, 10								
angioplasty rate			x, 11								
no mammogram in past 2yrs	x, 1	x, 5			x, 21						
no Pap smear in last 3yrs	x, 1	x, 5			x, 21						
late/no prenatal care	x, 3	x, 5			x, 24	x, 3		x			
cancer screenings (Pap, Mammo, PSA, Colonoscopy)	x, 1	x, 5				x					
HIV (ever tested)	x, 1										
flu vaccine	x, 1										
ED visits	x, 7										
asthma hospitalizations		x, 5, 8 ,11									
diabetes hospitalizations		x, 5									
Health Insurance Coverage											
lack insurance	x, 1	x, 5	x, 16	x	x, 23	x		x			
no insurance by education level			x, 10								

continuous insurance			x, 10								
insurance by citizenship			x, 11								
Quality of Care											
physician perspective of QOC			x, 11								
heart attack mortality rates			x, 11								
Medicare quality ranking by state			x, 11								
mortality rate due to hospital complications			x, 17								
post-op complications			x, 17								
youth restraints in psychiatric hospitals			x, 11								
physical restraints in nursing homes			x, 17								
length of time to appointment date			x, 10								
leave ER/ED without treatment			x, 17								
timeliness of emergent procedures			x, 17								
rates of preventive screenings/procedures	x, 1		x, 18, 11, 17								
pneumococcal vaccination	x, 1		x, 17								
pediatric dental care			x, 18								
prenatal care			x, 17								
treatment for depression			x, 17								
recommended hospital care for pneumonia			x, 17								
recommended hospital care for heart failure			x, 17								
ER/ED use for regular care			x, 19			x, 15					
ACSC/100,000	x, 4		x, 20			x, 26	x				
Social Determinants											
living in poverty	x, 8	x, 8	x, 9	x	x, 25	x, 27					
median household income			x, 8		x, 25						
education level		x, 8	x, 8								
no high school diploma		x, 8			x, 25						
college graduate	x, 8	x, 8									
woman in female head of household home w/ children	x, 8				x, 25						
birth data by education level	x, 5, 8										

Source Key

1 - BRFSS '99-'03; 2 - CDC NSCH 2004; 3 - DPH Vital Statistics; 4 - CT Office of Healthcare Access and US Census; 5 – DPH; 6 - DPH CT Resident Deaths '03; 7 - CHIME Database, CHA; 8 - US Census; 9 - CDC National Center for Health Statistics 2006; 10 - The Commonwealth Fund 2006; 11 – publication; 12 - NIH 2005; 13 – SEER database; 14 - CDC HIV/AIDS Surveillance Report 2006; 15 - BRFSS 2005; 16 - National Center for Health Statistics 2004; 17 - AHRQ National Healthcare Disparities Report 2006; 18 - AHRQ National Healthcare Disparities Report 2005; 19 - The Commonwealth Fund Biennial Health Insurance Survey 2005; 20 - The Commonwealth Fund National Scorecard 2006; 21 - BRFSS 2004-2006; 22 - SAMHSA 2004-2007; 23 - Current Population Survey 2004-2006; 24 - CDC National Center for Health Statistics 2007; 25 - CPS 2004-2006; 26 - CT Office of Health Care Access 2005; 27 - UConn Center for Population Research; 28 - BRFSS 2008

After reviewing the data in Table 1, the Data Group decided that two of the best available sources for information on health disparities in Connecticut are the Connecticut Health Foundation's Health Data Scan and the 2009 Connecticut Health Disparities Report. Summaries of these reports are presented in Table 2 and Table 3, respectively.

Table 2. Health Indicator Summary of information in the Connecticut Health Foundation's Community Health Data Scan of Connecticut

		CT			Across Areas		
Table #	**Description**	**WR**	**BR/WR**	**HR/WR**	**BHigh/BLow**	**Area**	**Notes**
44	Seat Belt Use	89.20	0.95	0.99	1.18	Bridge/NH	
54	Obesity	15.90	1.94	1.36	1.36	NH/HRG4-6	
57	No Phys Activity	20.30	1.72	2.00	1.46	HRG2/HRG4-6	
61	Binge Drinking	17.50	0.51	0.83	1.58	Hartford/HRG3	
63	Smoking	21.30	0.98	0.97	1.54	Bridge/HRG3	
64	No Health Insurance	9.00	2.04	3.23	3.21	Bridge/HRG4-6	
65	Reg Source Med Care	87.50	0.92	0.80	1.20	HRG4-6/HRG2	
67	Dental Visit	81.70	0.81	0.81	1.13	Hart;NH/HRG2	
76	Mammogram	83.00	0.95	0.98	1.05*	HRG1/HRG2	* very small sample size
77	Pap Smear	88.50	0.97	0.91	1.13	NH/Hartford	
78	Colonoscopy	45.90	1.00	0.90	na	na	only HRG1 recorded
79	Blood Stool	28.90	0.92	0.82	na	na	only HRG1 recorded
80	PSA test	60.20	na	na	na	na	only White data available
81	HIV (ever tested)	43.50	1.41	1.19	1.14	Hartford/HRG3	
84	Flu shot (age 50-64)	39.50	0.87	1.30	na	na	only HRG1 recorded
85	Flu shot (age 65+)	70.50	0.83	0.94	na	na	data not stratified by HRG
86	Pneumonia shot (65+)	61.60	0.62	0.75	na	na	data not stratified by HRG
92	Hosp./100,000 for ACSC	1191	2.01	1.75	1.83	HRG1/HRG6	
94	ED visits/1000	329.40	2.05	1.94	1.90	HRG1/HRG4	
97	Fair or Poor Health	10.10	1.80	2.80	1.70	NH/HRG4-6	
99	Poor Mental Health	8.10	1.14	1.27	2.24	HRG3/HRG4-6	
101	Asthma (ever told)	12.40	1.12	1.14	2.81	NH/Bridge	
106	Low/Very Low Birth Wt.	7.60	2.14	1.36	1.91	HRG1/HRG6	
113	Mortality/100,000***						
	All Causes	750.30	1.36	0.89			
	All Cancers	187.60	1.27	0.72			**HRG** Key**
	- Lung Ca	50.90	1.13	0.52			1 - Urban Centers (Bridgeport, Hartford, New Haven)
	- Colorectal Ca	18.80	1.45	0.72			2 - Manufacturing Centers
	- Breast Ca	28.60	1.18	0.65			3 - Diverse Suburbs
	- Prostate Ca	20.00	2.36	1.00			4 - Wealthy Suburbs
	Cardiovascular	275.70	1.33	0.83			5 - Mill Towns
	Diabetes	16.60	2.80	1.80			6 - Rural Towns
	HIV	1.00	30.90	20.40			
	Pneumonia	21.00	1.00	0.94			
	Accidental Injury	32.00	1.10	1.00			
	Motor Vehicle Deaths	5.30	0.87	0.85			
	Suicide	8.80	0.55	0.70			
	Homicide	1.30	10.85	4.62			

** HRG – Health Reference Group

*** Mortality data was not stratified by HRG

Notes for Table 2

- Primary sources of the data include: CT DPH BRFSS Survey Data, 1999-2003; CDC BRFSS web site; (www.cdc.gov/brfss); CT DPH; ; the Connecticut Office of Health Care Access (OHCA); CHIME Database, CHA

- Demographic data came the 2000 U.S. Census 2000
- CT calculations are ratios
    - WR = White Rate
    - BR/WR = ratio of the Black Rate to the White Rate
    - HR/WR = ratio of the Hispanic Rate to the White Rate
- Across HRGs (Health Reference Groups)
    - We identified the areas with the highest and lowest Black Rate for each health indicator listed
    - Calculation is the ratio of highest rate : lowest rate (i.e. Table 64 – more than 3 times as many Blacks in Bridgeport report not having health insurance as do Blacks in the aggregate of HRG4 – HRG6 (Wealthy Suburbs, Mill Towns, and Rural Towns, respectively))
- HRG Key represents how the cities and towns in CT were clustered into "like" areas based on total population, property value, number of single female-headed households, percentage of minorities, population density, percentage of population with college degree over age 25, and percent living below the federal poverty level.

Summary of the Connecticut Health Foundation's Health Data Scan

In general, these health indicators show that the White population in CT is healthier than the Black and Hispanic populations. The only clear difference in this statement is where binge drinking is involved. Here, binge drinking in Whites is reported twice as much as in Blacks, however it should be noted that when the binge drinking data are stratified by age, a clear difference in the rates can only be seen up to age 54, where rates among Whites, Blacks and Hispanics essentially equalize at much lower rates.

Health insurance coverage definitely impacts other health indicators. Twice as many Blacks (18.4%) and more than three times as many Hispanics (29.1%) report having no health insurance as compared to Whites (9%). Most likely related to low rates of health insurance coverage (i.e., lack of primary care) are the rates of hospitalization for ambulatory care of sensitive conditions (ACSC) and ER visits where rates for Blacks and Hispanics are double that of Whites. Ironically though, Whites and Blacks almost equally report having a regular source of medical care (87.5% and 80.7%, respectively). Almost twice as many Blacks and Hispanics report being in fair or poor health compared to Whites. And the rates of very low/low birth weight babies are between one and a half and two times as high in Hispanic and Black populations (respectively) as in White.

With regards to preventative health indicators for breast cancer (mammogram), cervical cancer (Pap smear) and colorectal cancer (sigmoidoscopy/colonoscopy and blood stool test), testing rates were all comparatively equal across all three races (83%, 88.5%, 45.9% and 28.9%, respectively, for Whites). These rates either surpassed or were slightly under the *Healthy People 2010* target rates for these measures.

Mortality rates due to cancer (lung, colorectal, breast) are all comparatively equal between Whites and Blacks and are between 25-50% lower in Hispanics. The mortality rate due to prostate cancer in Blacks, however, is more than twice that of Whites and Hispanics. Because PSA test data was not available for Blacks and Hispanics, it is difficult to surmise if there could be a connection between prevention and mortality for this group. The mortality rate due to diabetes in Blacks is almost three times the rate in Whites. The mortality rate due to HIV infection in Blacks and Hispanics is between 20 and 30 times higher, respectively, than the mortality rate in Whites. The suicide rate for Whites is twice as high as it is for Blacks and almost 25% higher than it is for Hispanics. The homicide rate in Blacks was over 10 times higher and in Hispanics almost 5 times higher than in Whites.

When observing the Black data as it is stratified by geographic area, there are some clear conclusions that can be drawn. The health of Blacks in the Urban Centers (Bridgeport, New Haven, or Hartford individually or the aggregate of HRG1) is worse than the health of Blacks in non-urban areas. Generally, Blacks in the Wealthy Suburbs, Mill Towns, and Rural Town report better health than in the Urban Centers. Unfortunately the race data was not stratified by area for most of the preventative indicators or for the mortality causes, however it should be noted that the mortality rate of Blacks to Whites was over 115% higher in all areas (not included in the spreadsheet).

Table 3. Health Indicator Summary of the 2009 Connecticut Health Disparities Report

			CT			
Table/Fig #	**Source**	**Description**	**WR**	**BR/WR**	**HR/WR**	**Notes**
		Health Indicator				
F19	x, 5	physical inactivity	--	--	--	not stratified by race
F16	x, 5	obesity	--	--	--	not stratified by race
F15	x, 5	smoking	--	--	--	not stratified by race
F6	x, 5	diabetes	5.3	2.4	2.2	
F17	x, 5	cardiovascular disease (hypertension)	23.1	1.5	1.1	
T22	x, 5	HIV/AIDS incidence	11.0	6.7	7.5	
T31	x, 5	low birthweight (live babies)	6.7	1.9	1.3	
		Mortality/100,000				
T29	x, 5	infant mortality	3.9	3.3	1.7	
T8	x, 5	cardiovascular/heart disease mortality	198.6	1.2	0.7	heart disease mortality only
T14	x, 5	cancer incidence and mortality	180.6	1.1	0.6	
T11	x, 5	diabetes mortality	15.8	2.5	1.5	
T23	x, 5	HIV/AIDS mortality	1.8	14.9	9.8	
T17	x, 5	suicide	8.2	0.5	0.7	
T19	x, 5	homicide	1.2	10.3	4.6	
		Access to and Use of Health Care				
T33	x, 5	pediatric dental care - % needing treatment	9.1	2.2	2.3	
NA	x, 28	dental care in last year	82.7	0.9	0.8	
F12	x, 5	no mammogram in past 2yrs	--	--	--	not stratified by race
F13	x, 5	no Pap smear in last 3yrs	--	--	--	not stratified by race
T30	x, 5	late/no prenatal care	7.8	2.8	3.0	
F14	x, 5	cancer screenings (Pap, Mammogram, PSA, Colonoscopy)	--	--	--	not stratified by race
T34	x, 5, 8 ,11	asthma hospitalizations/100,000	84.5	3.7	3.9	
T35	x, 8, 11	pediatric asthma ED Visits/100,000	32.7	4.6	5.2	
T12	x, 5	diabetes hospitalizations/100,000	94.5	3.8	2.3	
		Health Insurance Coverage				
F47	x, 5	lack insurance	6.5	2.7	5.4	
		Social Determinants				
T6	x, 8	living in poverty (FPL)	5.3	3.6	4.7	
T5	x, 8	no high school diploma	13.7	1.9	3.0	
T5	x, 8	college graduate	33.5	0.4	0.3	

Summary of the 2009 Connecticut Health Disparities Report

Most of the indicators on the 2009 Connecticut Health Disparities Report show similar rates to the rates indicated on the Health Data Scan. A major difference, however, is the difference in HIV mortality of Blacks and Hispanics between the two reports. The Health Data Scan reports the mortality rates for Blacks and Hispanics were over 30 and 20 times higher, respectively, than the White mortality rate. The Health Disparities Report shows the Black and Hispanic mortality rates were nearly 15 and 10 times higher, respectively, than the White mortality rate.

There are a couple of important issues to note regarding the Health Disparities Report. The issues surround the fact that smoking, obesity, and cancer screening (by race) rates are not observed in the report. All three of these indicators were key issues discussed in HealthyPeople 2010 and are expected to play a similar role in HealthyPeople 2020.

Possible criteria for prioritizing foci

The Data Group has been discussing the process by which possible criteria should be chosen in order to prioritize our focus on specific health indicators. A number of criteria have discussed including:

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. Urgency; e.g., is this a problem for which 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 interest/will)

Contingent on discussion with CHE members, we plan to first circulate data and possible foci to data group members and ask them to rank order their preferences for foci (of pilot intervention demonstration projects), circulate group rankings and reach a consensus regarding top three areas through group discussion. Then we would circulate the criteria, data, and proposed high priority areas, to Commission members for discussion and potential voting. Once a consensus was reached regarding several high priority areas, in terms of need, we would develop a process for soliciting community input regarding support, approach, and preferred strategy for addressing different areas.

Recommendation for CHE to collaborate with DPH on HP2020

The Data Group recommends that CHE should be 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. Rather than duplicate other efforts to describe disparities, we could take a leadership role in guiding agencies and organizations to systematically prioritize, reduce and eliminate disparities. Given its creation by a public act and its charge, CHE is uniquely positioned to monitor the State's success eliminating racial, ethnic and gender disparities. There may be federal funds for HP2020 planning, and it might be easier to get federal funds for evaluating interventions that address targeted objectives identified in the HP2020 plan.