

PATHWAYS TO EQUAL HEALTH:
Eliminating Racial and Ethnic Health Disparities in Connecticut

Recommendations of the Connecticut Health Foundation's
Policy Panel on Racial and Ethnic Health Disparities

March 2005

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The recommendations in this March 2005 report were made independently by members of the Policy Panel on Racial and Ethnic Health Disparities and were not influenced by the opinions or positions of the Connecticut Health Foundation Board of Directors.

Letter from Sanford Cloud, Jr., Policy Panel Chair

Great medical advances have significantly improved the length and quality of life for Americans, but a great many of our fellow residents have not experienced improved health outcomes.

In fact, if you are an African American, Latino, Native American or Asian, among other historically underrepresented populations, you are at a much greater risk of suffering from poor health outcomes — even when insurance coverage and income are taken into consideration.

What's more, these health disparities affect more than the victims of unequal care. They also impact our well being as a society and add enormous and unnecessary burdens to a health care system that faces sky-rocketing costs year after year.

I accepted the position as Chair of the Connecticut Health Foundation's Policy Panel on Racial and Ethnic Health Disparities to help find solutions to this problem. With our distinguished group of panelists — leaders in the public, private and nonprofit sectors — we have spent the better part of a year studying the issues and learning from the residents of our communities, as well as national and local experts.

Together with community groups and advocates, we hope to use the following recommendations as a blueprint to rid Connecticut of unjust racial and ethnic health disparities.

I wish to thank the incredibly talented, gifted and experienced members of the Policy Panel who gave their time and expertise to this project. They are not only proud residents of our state, but also recognize the great need for a community declaration to change the unequal health status across the racial and ethnic divide. I thank the numerous women, men and organizations that provided invaluable information that aided the Panel in forming and making its recommendations. Finally, the Policy Panel joins me in thanking the Board of Directors of the Connecticut Health Foundation (CHF) for its visionary leadership in identifying and addressing racial and ethnic health disparities and the Foundation's staff for its exceptional guidance and support.

One of the important lessons we have learned through our intensive year of study and listening to people from across the great State of Connecticut is that we have all we need, in terms of talent and experience, to fully and completely eliminate health disparities if we, as a community, have the will to do so.

On behalf of my fellow Panel members, I urge the leaders of our state's institutions and communities to pay close attention to the issues raised in this report and implement these bold, yet pragmatic and workable solutions as quickly as possible.

Letter from Leo Canty, Chair, Connecticut Health Foundation Board of Directors

Shortly after the Connecticut Health Foundation (CHF) was formed in July of 1999, we conducted focus group surveys of ordinary residents and talked to many decisionmakers throughout the state about the most pressing public health problems in Connecticut. Time after time, both health experts and the public indicated that unequal health outcomes based on race and/or ethnicity — also known as racial and ethnic health disparities — are a major public health problem in urban, suburban, and rural areas of the state.

The Board of Directors and staff of the Foundation selected racial and ethnic health disparities as one of its three program priority areas, along with oral health and children's mental health. To date, CHF has dedicated more than \$4.8 million in grants to programs and organizations committed to reducing these disparities throughout the state.

Aside from grantmaking, the Foundation also seeks to change systemic and institutional policies that perpetuate health disparities. In December of 2003, the Foundation created an independent Policy Panel of community, business, nonprofit and government leaders to study racial and ethnic health disparities in Connecticut, and develop pragmatic policy recommendations designed to address these inequities.

After a year of hard work — including educational briefings, three public hearings, and hours of thoughtful deliberations — I am delighted to report that the Policy Panel on Racial and Ethnic Health Disparities, under the leadership of its Chair, Sanford Cloud, Jr., has released a series of 14 recommendations to reduce health disparities in the areas of social and environmental factors, data collection, language barriers, and workforce diversity.

On behalf of my colleagues on CHF's Board of Directors, we would like to thank the Policy Panel for its efforts in identifying problems, heightening awareness and working on ways to address this wide-reaching, often overlooked public health problem. By bringing different experiences and perspectives to Policy Panel discussions, each member of this distinguished group made a significant contribution to the development of recommendations that could change the political landscape around racial and ethnic health disparities today, tomorrow, and well into the future.

Throughout 2005 and beyond, the Foundation is committed to incorporating Policy Panel recommendations into our racial and ethnic health disparities strategic plan. We will channel resources into priority recommendations through grantmaking, technical assistance, and public policy research in an effort to create statewide momentum that will move Connecticut along a path toward eliminating racial and ethnic health disparities.

EXECUTIVE SUMMARY

RECOMMENDATIONS AT A GLANCE

“Of all the forms of inequality,
injustice in health care is the
most shocking and inhumane.”

Dr. Martin Luther King, Jr.



Executive Summary

The 2002 Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, sounded the alarm nationally: There are unequivocal health disparities among racial and ethnic communities, even when factors like income, insurance, and access to health care are considered. In short, people of color are subject to unequal treatment in the nation's health care system.

In December 2003, the Connecticut Health Foundation (CHF) created a 12-member Panel of state leaders from the public, private, and nonprofit sectors to study unequal health outcomes among racial and ethnic communities in Connecticut, and develop sound policy recommendations for both the public and private sectors.



Over the last year, the Panel has investigated how scientific and health research organizations collect data and inform the public about health disparities, and how residents from various racial and ethnic communities experience the health care system first-hand.

The Panel has gathered information and developed its recommendations by:

- **Reviewing and analyzing** pertinent documentation from various national and local sources.
- **Holding public hearings** in Bridgeport (June 8), Willimantic (July 14) and Hartford (September 14), where invited experts and members of the community provided testimony.
- **Meeting regularly to review** the collected information and discuss policy options.

After evaluating much of the data, the Policy Panel decided to focus its attention and recommendations in four areas — Social and Environmental Factors, Data Collection, Language Barriers, and Workforce Diversity.

It was determined that within these areas of focus, the Panel could provide practical recommendations to policymakers, non-profit organizations and private institutions in order to deal more effectively with this problem throughout the state.

The Panel is now releasing its findings and policy recommendations to the public.

Recommendations at a Glance

SOCIAL AND ENVIRONMENTAL FACTORS

1. The State of Connecticut should allocate no less than \$2.12 million of Connecticut's State Tobacco Settlement funds to specifically support evidence-based, culturally and linguistically competent health promotion programs that respond to the health needs of underserved racial and ethnic populations.
2. The Connecticut Department of Transportation-owned bus service (Connecticut Transit) should retrofit all vehicles with diesel particulate filters or replace them with new vehicles equipped with exhaust emission control technologies.
3. The State of Connecticut should guarantee reasonable and adequate health coverage to ensure primary and preventive care for all Connecticut residents who are uninsured or underinsured.

DATA COLLECTION

1. The State of Connecticut should fully fund a coordinating body to oversee and provide leadership in monitoring the state's progress in eliminating racial and ethnic health disparities.
2. The State of Connecticut should develop a uniform data collection and management system by 2010 that coordinates all health data on racial and ethnic populations across all state agencies.
3. The Connecticut Department of Public Health should collect and integrate racial and ethnic health data into all of its statewide planning efforts and publish a biennial report on key findings from data collected on the health status of racial and ethnic populations.
4. The State of Connecticut should make health data collected by all state agencies available to the public upon request and provide that information at either no charge or for a nominal fee.
5. The Connecticut Office of Health Care Access and the Connecticut Department of Public Health should require health care organizations, including providers and payers, to collect data on each patient's primary language in health records and information systems, and post signage in the languages of the patients they serve.

LANGUAGE BARRIERS

1. The Connecticut Department of Social Services should allow reimbursement for interpretation services under the Medicaid program to maximize federal matching funds.
2. The Connecticut Department of Public Health should establish a certification program for all medical interpreters to ensure cultural competence and quality service.
3. The Health Systems Regulations Bureau of the Connecticut Department of Public Health should establish a system for monitoring and enforcing the law regarding linguistic access in acute care hospitals (Public Act No. 00-119) and publish a report on its findings for public and legislative review.

WORKFORCE DIVERSITY

1. The Connecticut Department of Public Health should (a) collect and track data on the race and ethnicity of all licensed medical professionals and issue an annual report on the diversity of the health care workforce in the state and (b) require all health care professionals to participate in cultural and linguistic competence continuing education programs through licensure requirements.
2. The Connecticut Department of Public Health should match all available federal dollars allocated to the national loan forgiveness program each year; target these funds to attract a greater number of historically underrepresented students to the health professions; and promote the loan forgiveness program broadly and effectively.
3. The Connecticut Department of Higher Education should require public and independent educational institutions offering health professional programs to create strategic plans that include specific goals, standards, policies and accountability mechanisms that ensure institutional diversity and cultural competence.

As part of these plans, these institutions should:

- Demonstrate how they recruit, retain and graduate students from historically underrepresented populations and report on their performance annually.
- Base admission decisions on a comprehensive review of each applicant (balancing the consideration of quantitative and qualitative data) and include representatives from historically underrepresented communities on admission committees.

“The conditions in which many clinical encounters take place — characterized by high time pressure, cognitive complexity, and pressures for cost containment — may enhance the likelihood that these processes will result in care poorly matched to minority patients’ needs. Minorities may experience a range of other barriers to accessing care, even when insured at the same level as whites, including barriers of language, geography, and cultural familiarity. Further, financial and institutional arrangements of health systems, as well as the legal, regulatory, and policy environment in which they operate, may have disparate and negative effects on minorities’ ability to attain quality care.”

*Unequal Treatment:
Confronting Racial and Ethnic Health Disparities in Health Care*



Introduction

Nothing conveys the serious, often tragic impact of racial and ethnic health disparities in Connecticut better than the voices of real people. The Policy Panel on Racial and Ethnic Health Disparities conducted three public hearings in 2004 in which both experts and ordinary resident told heart-wrenching stories that put a human face on this significant social and public health problem.

On September 14, 2004, Bloomfield resident Pauline Johnson spoke emotionally about her ailing, immigrant mother, a former state employee who has adequate health insurance:

“I’m very upset because my Mom has given her life to taking care of all nationalities. And when it came time, after working so hard, with the medical coverage she had, I still have to fight to get proper care (for her). And it starts at the top where the policies are being made, because the color of your skin tells people what you can pay before they even know who you are and where you’re coming from.... We appreciate the medical profession and we will work with them, but just don’t write us off.”

Mary Scully, a nurse with Khmer Health Advocates, Inc., who has worked with Cambodian immigrants for the last 24 years, also told stories of suffering during her testimony in Bridgeport on June 8th. In one example, a stroke victim was deemed ineligible for disability because his neurologist thought he could work. While the man's vital signs were fine, the doctor didn't realize that the man didn't know his full name, where he lived, the names of his children, or how to dress himself. This doctor didn't know because he couldn't communicate with his patient.

“Every day in Connecticut people are denied access to care because they don't speak English,” she said. “Access to care means much more than being able to get through the doors of a clinic or a doctor's office. It means being able to communicate with your health care provider and knowing that your health care provider understands your health history.... Lack of access causes suffering, disabilities and at times death. It causes great hardship for families and it takes a great toll on society.”



BUT WHAT EXACTLY ARE RACIAL AND ETHNIC HEALTH DISPARITIES?

Racial and ethnic health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups. In Connecticut, as in the majority of the United States, data shows that those communities disproportionately impacted by health disparities include African Americans, Latinos, Native Americans and some Asian communities.

This means that these communities receive a lower quality of health care than the majority white population, even when such factors as a patient's insurance status and income are equal. The sources of these disparities are complex, involving both historical and current social conditions – ranging from lingering racism and language/cultural barriers to environmental injustice and a health care system that is slow to change, despite the efforts of well-intentioned people.

The fact is disparities in health among racial and ethnic populations may be the most critical yet least understood health problem in Connecticut. And this lack of appropriate care for so many residents comes at a staggering personal and financial cost.

Data from the Centers for Disease Control and Prevention (CDC), which tabulates years of potential life lost before the age of 75, reveal a disturbing pattern.

In Connecticut, from 1999 to 2001, African Americans lost 11,028 years of potential life and Latinos lost 6,806 years of potential life, compared to the white population, which lost 5,687 years of potential life.¹

These findings rank Connecticut 33rd in the nation, behind Georgia, Louisiana, and South Carolina.²

A recent national report substantiates these great losses. It goes on to say:

“Medical advances averted 176,633 deaths, but equalizing the mortality rates of whites and African Americans would have averted 886,202 deaths. Achieving equity may do more for health than perfecting the technology of care.”³

If we think about these losses in a broader context, racial and ethnic health disparities not only cut down lives prematurely, but also threaten to burden communities with needless personal and economic trauma that stifles the chance for growth. And when we realize that the health and well being of our nation is at the core of our national security, the potential loss of life even jeopardizes America's strength.

The result is clear: there are two health care systems in this country — one for whites and another for underrepresented racial and ethnic populations.

Powerful data

In addition to extensive public testimony from area experts and members of the community, the Policy Panel has collected a significant amount of data from various sources — including the U.S. Department of Health and Human Services — documenting the extent of racial and ethnic health disparities. The report *Unequal Treatment*, published in 2002 by the Institute of Medicine of the National Academies, in particular, addressed the issue fully and galvanized attention among policymakers, health care professionals and community activists.

The following data suggest the catastrophic outcomes of health disparities both nationally and in Connecticut:

- **Life expectancy varies by race/ethnicity:** In 2002, life expectancy was 68.8 years for African American men; 75.1 years for white men; 75.6 years for African American women; and 80.3 years for white women.⁴ Median age at death in Connecticut in 1998 was 68 years for African Americans; 62 years for Latinos; and 79 years for whites.⁵

- **Infant mortality:** The average infant mortality rate for African American infants was more than triple the rate for white infants between 1998 and 2000 (13.5 deaths per 1,000 live births compared to 4.7 deaths per 1,000 live births).⁶

- **Diabetes:** Latinos are nearly twice as likely to die from diabetes as whites. In Connecticut, the age adjusted death rate per 100,000 for diabetes: 30.5 for African Americans, 15.9 for Latinos, 18 for Native Americans, and 12.6 for whites. Since mortality varies across age groups, the age adjusted death rate statistically standardizes this variation when calculating overall death rates.⁷

- **Cancer death rate:** The death rate for all cancers is 30 percent higher among African Americans than among whites. In Connecticut, the death rate for all cancers per 100,000 population is 199.2 for African Americans and 159.0 for whites.⁸

- **AIDS case rate:** The AIDS case rate for African Americans or Latino adults/adolescents per 100,000 population was much higher than that of whites in 2003. The case rate (per 100,000 population) was 107.8 cases for Latinos; 71.8 cases for African Americans; and 11.4 cases for whites.⁹

Perhaps most frustrating is the fact that racial and ethnic health disparities exist even among people within the same system of care and managed care plans. In a 5 percent sample of more than 1.2 million Medicare claims in a Health Care Finance Administration (renamed Centers for Medicare & Medicaid Services) database, African Americans were found less likely than whites to receive 23 of 32 services, and the disparities were found even when patients were insured by both Medicare and Medicaid, minimizing the confounding of race with financial barriers to care.¹⁰

THE SEARCH FOR SOLUTIONS

Eliminating racial and ethnic health disparities is a central challenge for our society — one that can be addressed over time through practical action, based on a comprehensive, multi-level strategy.

Until action is taken, however, no one will ever know how productive the people of our state can be — when all of our human potential can be realized. While the issue is complex and difficult, there are solutions that, if implemented, could help to eliminate racial and ethnic health disparities and improve the lives of countless millions.

It is time for the people of Connecticut to develop the will to act.

“Tell me someone’s race. Tell me their income. Tell me whether they smoke. The answers to those three questions will tell me more about their longevity and health status than any other questions I could possibly ask. There’s no genetic blood test that would have anything like that for predictive value.”

Donald M Berwick, Pediatrician and former member of President Bill Clinton’s Commission on Health Care Quality.¹¹



Recommendations and Rationales

Social and Environmental Factors

Many factors in society affect people's health. Education, gainful employment, adequate housing, access to quality health care, vibrant communities, and clean air have a profound impact on the health and well being of people and their communities. When any or all of these factors are lacking, health can be seriously jeopardized.

The poor and disenfranchised suffer the most from health disparities caused by social and environmental factors, but they are not alone. Research clearly shows that people of color — from all rungs of the economic ladder — also are vulnerable. To reverse this long-standing trend, the people and government of Connecticut must commit themselves to addressing social and environmental factors that influence racial and ethnic health disparities, including a personal and systemic commitment to end racism and discrimination.



Because social and environmental influences on health are complex and difficult to address, the Policy Panel decided to concentrate its recommendations in three core categories — health promotion, environmental health and access to health care.

Health promotion and education programs provide people and communities with the tools they need to improve health and well being.

Equipped with sound information and skills, communities can encourage changes in behavior, and help support laws and policies that contribute to good health.

All people have a right to breathe clean air.

Pollution and other toxins contribute to health problems ranging from asthma and other bronchial conditions to certain forms of cancer. Pollution even has an impact on mental health, according to The National Institute of Environmental Health Sciences website (www.niehs.nih.gov). Although air pollution is a chronic statewide problem, it disproportionately affects large urban communities where pollution is the worst. It is no coincidence that these communities

include large numbers of African Americans and Latinos. According to the American Lung Association website, the asthma prevalence rate in 2002 among African Americans was almost 38 percent higher than the rate among whites (www.lungsusa.org).

People need access to quality health care regardless of income or social status.

Without access to basic health care, many people don't get the health care they need when they really need it. Over the long term, this pattern of delay can result in poor health outcomes and often raises costs, because patients require more serious treatment options later.

Once in the health care system, people from diverse populations deserve culturally and linguistically competent care, especially those that have been under- or inappropriately served in the past.

SOCIAL AND ENVIRONMENTAL FACTORS
<p>Recommendation: The State of Connecticut should allocate no less than \$2.12 million of Connecticut’s State Tobacco Settlement funds to specifically support evidence-based, culturally and linguistically competent health promotion programs that respond to the health needs of underserved racial and ethnic populations.</p>
<p>Rationale: State Tobacco Settlement Fund dollars can be reallocated to health promotion programs, which are known to prevent disease, improve health choices, and help reduce racial and ethnic health disparities.</p>

Over the years, the federal government has been the largest source of funding for health promotion programs to help prevent disease. These programs provide information and resources that raise awareness and encourage sound health choices. As the nation and state face increasing budget deficits, however, Connecticut must find additional sources to pay for programs.

Possibly the greatest opportunity — and the largest source of funding to help residents choose positive health behaviors — is the State Tobacco Industry Settlement Agreement, which created the State Tobacco Settlement Fund in Connecticut and many other states.

This resource brings \$3.6 billion to Connecticut over a 25-year period.¹²

The CDC created state guidelines for spending settlement funds on comprehensive tobacco prevention programs. It recommends that Connecticut should allocate between \$21.2 million and \$53.9 million a year for tobacco-related health programs.¹³ Currently, the state deposits all settlement funds into the General Fund and spends approximately \$500,000 per year on tobacco prevention, ranking Connecticut 45th in the United States, according to 2005 data.¹⁴

Fiscal 2005 State Funding for Tobacco Prevention

State	CDC Annual Funding Recommendation (in millions)	FY 2005 Annual Funding (in millions)	National Ranking
Maine	\$14.2	\$11.19 - \$25.35	1
Delaware	9.3	8.63 - 18.46	2
Mississippi	20.0	18.79 - 46.8	3
Connecticut	21.2 - 53.9	0.5	45

Source: Tobacco Free Kids. FY2005 Rankings of State Funding for Tobacco Prevention. www.tobaccofreekids.org

The state should reallocate at least 10 percent of the CDC's suggested tobacco settlement budget guideline, or no less than \$2.12 million annually, to fund comprehensive health promotion programs

(not limited to tobacco cessation or prevention) that are culturally and linguistically competent and target racial and ethnic health disparities.

Recommendation:

The Connecticut Department of Transportation owned bus service (Connecticut Transit) should retrofit all vehicles with diesel particulate filters or replace them with new vehicles equipped with exhaust emission control technologies.

Rationale:

Reducing environmental triggers, like diesel fuel, will help reduce the alarming incidence of asthma.

According to the U.S. Environmental Protection Agency (EPA), heavy-duty trucks and buses, or diesel engines, emit about 33 percent of nitrogen oxides and about 25 percent of particulate matter emissions from mobile sources, both of which contribute to serious public health problems throughout the country.¹⁵

A number of studies show that the substances in diesel exhaust are likely to cause lung cancer, aggravate respiratory and cardiovascular disease, and exacerbate respiratory illnesses like asthma. According to one report, "even very short-term exposures can cause coughing and wheezing episodes, chest pain and reduce lung function."¹⁶

The entire State of Connecticut has been designated a "severe or serious ozone non-attainment area." This means ozone levels are well above federal standards. What's more, the EPA has designated two Connecticut Metropolitan

Statistical Areas — Hartford and New London-Norwich — as two of the top ten areas in the nation for being at risk of exceeding the ozone standard between 2007 to 2030.¹⁷

To address this problem, a federal regulation called the "Control of Air Pollution from New Motor Vehicles: Heavy-Duty Engine and Vehicle Standards and Highway Diesel Fuel Sulfur Control Requirements" was established.¹⁸

According to this regulation, beginning with model year 2007, all heavy-duty trucks and buses (like the Connecticut Transit bus service) must be equipped with exhaust emission control technologies that filter out 90 percent to 95 percent of particulate matter. Also, after July 1, 2006, all supplied or distributed diesel fuel must be ultra-low sulfur diesel fuel, which will decrease particulate matter by 5 percent to 20 percent.¹⁹

The problem: this regulation does not cover heavy-duty vehicles that are older than model year 2007. Since buses can last between 12 and 14 years, the regulation will not have much of an impact if most of the Connecticut Transit buses are older.²⁰

Connecticut Transit currently operates 395 buses and has agreed to retrofit buses that are less than 6 years old with particulate matter filters, thereby affecting 175 buses but excluding 220 buses that are more than 6 years old. Since it costs about \$6,000 to retrofit each of the older buses, the total cost to the state would equal about \$1.3 million.²¹

<p>Recommendation: The State of Connecticut should guarantee reasonable and adequate health coverage to ensure primary and preventive care for all Connecticut residents who are uninsured or underinsured.</p>
<p>Rationale: Improving access to health coverage is one way to reduce racial and ethnic health disparities.</p>

While expanded access to health coverage does not guarantee better health outcomes, expanded access will increase the chance for more people to utilize health care services.

Without adequate health coverage, Connecticut’s uninsured — 318,300 people, or 9.4 percent of the state’s population (of whom about half are African American or Latino) — have little if any access to proper health care other than already overburdened emergency room (ER) services.²²

Expanding access also will reduce the staggering personal and financial costs associated with loss of life and productivity.

The CDC tabulates years of potential life lost before age 75 by race and ethnicity. In Connecticut, the CDC reports that from 1999 to 2001, African Americans lost 11,028 years of potential life, and Latinos lost 6,806 years of potential life, compared to the white population, which lost 5,687

years of potential life, ranking Connecticut 33rd in the nation, behind Georgia, Louisiana, and South Carolina.²³

And everyone pays the price for the lack of health insurance through uncompensated care — taxpayers, the health care system (providers and payers) and the uninsured.

Based on the 2003 rate of the uninsured, Connecticut loses \$584 million each year in reduced life expectancy and \$1.164 billion in combined shorter lives and increased illness.²⁴

According to a 2002 Connecticut Center for Economic Analysis report, the uninsured receive an estimated \$1.16 billion in care. Of that total, the uninsured pay \$312 million out of pocket; non-health insurance programs like Workers’ Compensation pay \$439.2 million; and hospitals, clinics and physicians absorb \$404.5 million.²⁵

Data Collection

Developing effective public health policy depends on good data. Reliable data helps public health officials answer key questions: What is the extent of the state’s public health problems? Who is suffering the most? And what programs are most effective? Clearly, a coordinating body is needed to both collect and analyze data with a uniform system of data collection to shed light on racial and ethnic health disparities.

Because of the state’s inadequate data collection system, however, there is no coordinating state body that can regularly examine the health disparities of underrepresented racial and ethnic populations.

As a result, the 1999 Multicultural Health Report, which used 1997 data, is still the only comprehensive source on racial and ethnic health disparities in the state. With no additional data collection or analysis, policymakers must evaluate programs in 2005 with information that is nearly ten years old.

When we find that African Americans in Connecticut have a 30 percent higher risk of dying at any time relative to whites,²⁶ the problem of racial and ethnic health disparities begs for solutions — solutions that only can be developed and targeted with accurate data.

According to the IOM report, *Eliminating Health Disparities: Measurement and Data Needs*, “Improving and broadening the collection of racial and ethnic data are critical to fulfilling core goals of the U.S. health system. While such efforts will pose significant challenges and entail real costs, ignoring this important need may ultimately be more costly than definitively solving the problem.”²⁷

The current lack of such data in Connecticut creates complications for health departments and the statewide health infrastructure, making it very difficult to grasp the extent of the problem, justify expenditures and forge successful, targeted programs.



DATA COLLECTION
<p>Recommendation: The State of Connecticut should fully fund a coordinating body to oversee and provide leadership in monitoring the state’s progress in eliminating racial and ethnic health disparities.</p>
<p>Rationale: A coordinating body would provide the necessary oversight to monitor and measure progress in eliminating racial and ethnic health disparities.</p>

Eliminating racial and ethnic health disparities in Connecticut can only be achieved with strong state leadership. To provide this leadership, the state must be able to consistently measure the impact and effectiveness of existing programs designed to bridge the disparities gap. The ability to monitor progress centrally will enable Connecticut to achieve attainable results in eliminating health disparities.

The state should either reestablish the Office of Minority Health (OMH) to oversee this effort, or create a new organization that will coordinate data collection and analysis among all state agencies. Previously funded at about \$180,000 per year (including a director, administrative assistant, and epidemiologist),²⁸ the OMH was designed to help state agencies and local communities collaborate in eliminating differences in disease, disability, and death rates among racial and ethnic populations.

Its mandate was to monitor the health status of racial and ethnic populations, assess the effectiveness of state programs, identify resource needs, and disseminate key findings.

A coordinating body, whether it’s the OMH or a new organization, must be funded over the long term and should support the work of the Multicultural Health Advisory Commission, which was created by the Connecticut General Assembly in 2001 to eliminate the health disparities caused by economic, racial or social status.

The coordinating body should use data to develop and implement comprehensive health strategies that target specific disparities suffered disproportionately by certain racial and ethnic populations.

Moreover, it should measure Connecticut’s goals and guidelines against those of Healthy People 2010, which were developed by the U.S. Department of Health and Human Services to help states improve the health status of residents, including the elimination of racial and ethnic health disparities.

Recommendation:

The State of Connecticut should develop a uniform data collection and management system by 2010 that coordinates all health data on racial and ethnic populations across all state agencies.

Rationale:

With a centralized data collection system, the state can gather and coordinate all pertinent data for agencies serving historically underrepresented racial and ethnic populations.

Policymakers cannot accurately track and monitor a program’s effectiveness in reducing racial and ethnic health disparities without effective data collection and information management systems. It’s also impossible to determine where the state’s resources are best spent.

According to a National Research Council report, “Without accurate information on the racial and ethnic characteristics of populations served, public health efforts and associated resources are likely to be poorly targeted and may miss large segments of the populations most in need. Poorly managed chronic conditions or undiag-

nosed disease can result in more severe disease, worse outcomes, and higher health costs.”²⁹

The costs involved in changing reporting and computer systems are significant. However, other states, like Hawaii and Washington, have reallocated and/or added resources to develop and implement surveys, as well as update information technology systems over time to create a more effective system.³⁰

Connecticut should take note: states that have improved their data collection systems have added costs into their operating budgets each year.

Recommendation:

The Connecticut Department of Public Health should collect and integrate racial and ethnic health data into all of its statewide planning efforts and publish a biennial report on key findings from data collected on the health status of underrepresented racial and ethnic populations.

Rationale:

With a central source of data on racial and ethnic health disparities, the state and health care advocates could target solutions more effectively.

The lack of viable health data on racial and ethnic populations is a glaring deficiency.

Even when there is a law on the books to collect health data, the results are incomplete without the

inclusion of racial and ethnic information. A case in point is An Act Concerning Access to Data by the Department of Public Health (Public Act No. 02-65),³¹ which requires the Connecticut Department of Public Health (DPH) to collect a

range of data on everything from hospital discharges to home health care agency client encounters and services. But it does not require the collection of data on racial and ethnic populations.

monitor health and identify problems, every year since 1968.³² As a result, Hawaii publishes annual reports on the general demographics, income, health insurance, and health conditions of the state’s population.

While Connecticut falters with a lack of clarity on these key issues, other states have been collecting data successfully. The Hawaii Department of Health, for example, has conducted the Hawaii Health Survey, a household survey designed to

Officials at DPH should review existing data collection procedures and systems in other states, and develop a comprehensive mechanism to collect racial and ethnic data in Connecticut.

Recommendation:

The State of Connecticut should make health data collected by all state agencies available to the public upon request and provide that information at either no charge or for a nominal fee.

Rationale:

The public has a right to access data on racial and ethnic health disparities and programs designed to eliminate them.

The availability of data is the fuel that generates pragmatic strategic plans to overcome racial and ethnic health disparities at the national, state and local levels.

for Connecticut.³³ The state of Georgia established methods, standards, and procedures for integrating data among offices in its Division of Public Health. Its data protocol requires all branches under the division to access the centralized data repository, which currently includes hospital discharge data, cancer registry, and vital statistics data.

Access to accurate data is essential if we are to understand the nature and extent of health disparities, identify health patterns and trends, and gain insights into how different populations of people are affected and determine what steps must be taken.

The Health Information Factory Project did not incur any costs other than reallocating key staff, and the public can access the data through an online user interface at no charge.

Theoretically, state agencies have access to their own databases, but local communities — neighborhood and/or faith-based groups, for example — often do not.

By making access to state data, either free or at a greatly reduced rate, state agencies would provide a valuable service to local communities in developing and implementing comprehensive strategies, programs and services.

In 1998, Georgia developed a “Health Information Factory Project,” which could serve as a model

Recommendation:

The Connecticut Office of Health Care Access and the Connecticut Department of Public Health should require health care organizations, including providers and payers, to collect data on each patient's primary language in health records and information systems, and post signage in the languages of the patients they serve.

Rationale:

The more accurate the patient data collected from providers, the better both payers and providers can understand and meet the language and cultural needs of their clients and patients.

Language data also helps to improve provider-patient relationships, which would reduce health risks due to miscommunication.

Even the use of multi-lingual signage creates a welcoming environment, reduces confusion and increases the chance of a satisfactory encounter between provider and patient. Such signage also should be required to inform patients of their rights to free interpretation services.

What's more, insurers and other payers who collect data are able to monitor the quality of care and evaluate the effectiveness of disease management programs specific to racial and ethnic populations.



Language Barriers

In many cases, adequate interpretation services can be the difference between a correct diagnosis or a continuing health problem. In some cases, it can be the difference between life and death.

A man who did not speak English recently suffered from an accident at work, according to Mary Scully, who testified during the public hearing in Bridgeport. A doctor saw him without an interpreter and decided that he had suffered no injury. In fact, this man suffered from a traumatic brain injury and sustained serious memory and concentration problems.

Scully of Khmer Health Advocates, an organization helping 18,000 Southeast Asians living in Connecticut, also noted that “64 percent of these adults say they need interpreters to communicate with their doctors, yet 61 percent say they see a doctor without an interpreter. The vast majority of people who use an interpreter are using a family member or a friend, people who are not trained interpreters.”

For these immigrants and so many others in Connecticut, language barriers compromise the delivery of adequate care and jeopardize the safety of the patient because information is not exchanged properly, patient instructions are not understood, and decisionmaking is not shared.

As a result, patients with limited English proficiency all too often are forced to wait for substantial periods of time, find their own interpreters (who often are not qualified), or make repeated visits to the provider’s office until an interpreter is available.

Without adequate interpretation services, therefore, many Connecticut residents with limited English proficiency are at a significantly higher risk of misdiagnosis and mistreatment, which incur a significantly greater cost to our health care system.

It’s a given that clear patient-provider communication is essential for good health. It’s also the right of every Connecticut resident whose primary language is not English to have access to appropriate interpretation services. In fact, providing access to these services is a requirement for states under the equal access provisions of Title VI of the Civil Rights Act of 1964. Violations of this statute can lead to lawsuits.

LANGUAGE BARRIERS
<p>Recommendation: The Connecticut Department of Social Services should allow reimbursement for interpretation services under the Medicaid program to maximize federal matching funds.</p>
<p>Rationale: Providing interpretation services will reduce the number of misdiagnoses and related costs, while increasing access to health care for people with limited English proficiency.</p>

The lack of readily available interpretation services comes at a high cost based on widespread misdiagnosis and mistreatment. The provision of such services will not only guarantee the rights of non-English speaking residents to essential services, but also reduce escalating costs over the long term.

Perhaps most important, the federal government will match every dollar the state spends on the Medicaid program. Yet Connecticut has decided not to include language interpretation services as an allowable Medicaid expense. If this expense was allowed, the state could take full advantage of these matching funds.

The lack of interpretation services affect a significant portion of the state's population. More than 7 percent of Connecticut residents speak English "less than very well," representing almost 235,000 people.³⁴

According to October 2004 Medicaid data, 8.78 percent of adults and children enrolled in the Medicaid program in Connecticut speak a language other than English at home — 26,754 out of 304,846 total enrollees.³⁵ Between 34 percent and 46.5 percent of residents from key urban areas — Stamford, Danbury, Bridgeport and Hartford — speak a language other than English at home.³⁶

Costs for adequate interpretation services are relatively low. A recent report from the U.S. Office of Management and Budget estimates that language services only would add approximately \$4.04 to the average cost of a health care visit (only 0.5 percent above the average \$856 cost per visit).³⁷

State costs for interpretation services vary widely. Hawaii spends about \$144,000 annually on interpreter services for approximately 2,570 visits, at approximately \$56 per visit.³⁸ In New Hampshire, the state spent \$4,692 on interpreters in 2002, and \$3,675 in 2001.³⁹

Recommendation:

The Connecticut Department of Public Health should establish a certification program for all medical interpreters to ensure cultural competence and quality service.

Rationale:

A medical interpreter certification program would ensure a high level of cultural as well as lingual competence to improve the vital provider-patient relationship.

Medical interpreters, who participate in cultural and linguistic competency training, help to improve access and ensure quality health care services.

Interpreters also need to be fully trained and knowledgeable in the cultural background of clients in order to ensure quality health care services.

A study conducted by the Center for the Advancement of Urban Children determined that many errors by such untrained interpreters had clinical consequences.⁴⁰ When a 7-year-old girl visited the doctor with an ear infection, an ad hoc interpreter instructed the mother to put three teaspoons of antibiotics in the child’s ears three times a day, rather than instructing her to take the medicine orally, as prescribed.

The Washington State Department of Health and Social Services may be a useful model. Starting in 1991, the department began to certify medical and social service interpreters and agreed to not only provide (and pay for) interpreters but also ensure the quality of the provided services.⁴¹ The state of Washington developed and currently administers a standardized test for interpreters for a nominal fee.

Understanding medical terms and conditions in various languages is one aspect of medical interpretation services.

The administrative cost of creating this medical interpreter certification program was approximately \$180,000 over the first two years.⁴² In future years, licensing and examination fees will defray administrative costs.

Some health and social service providers try to bridge the language gap by encouraging clients to provide their own interpreters — usually a family member or friend — as an alternative to qualified bilingual employees or interpreters. These untrained “interpreters” usually don’t understand the medical concepts and terminology they’re being asked to interpret or translate.

Recommendation:

The Health Systems Regulations Bureau of the Connecticut Department of Public Health should establish a system for monitoring and enforcing the law regarding linguistic access in acute care hospitals (Public Act No. 00-119) and publish a report on its findings for public and legislative review.

Rationale:

Monitoring Public Act No. 00-119 will help reduce misdiagnosis and improve treatment compliance.

Acute care hospitals must provide interpreter services to non-English speaking patients, according to Connecticut law (An Act Concerning Linguistic Access in Acute Care Hospitals, Public Act No. 00-119).⁴³ Hospitals that violate Public Act No. 00-119 also may be in violation of Title VI of the Federal Civil Rights Act.

Public hearing testimony confirms that there is no systematic method of collecting or analyzing information surrounding linguistic access in acute care hospitals.

Since current data suggest that people of limited English proficiency tend to go to hospital emergency rooms and clinics to receive care, the enforcement of Public Act No. 00-119 will potentially reduce misdiagnosis, improve treatment compliance and outcomes, and thereby improve overall health.

Massachusetts, a leader in providing language services in clinical health settings, recently passed legislation to mandate quality interpretation services in acute care hospital emergency rooms, including acute emergency psychiatric services.⁴⁴ The Massachusetts Attorney General's Office is authorized to monitor and enforce the law.

Workforce Diversity

The lack of diversity among the health care workforce in the nation as a whole, and in Connecticut in particular, has a substantial, negative impact on the level of trust and the quality of care for racial and ethnic communities.

“The consequences of underrepresentation of minorities in the health care workforce are significant,” says Charles Huntington, Associate Director of the Connecticut Area Health Education Center. “First is the lack of cultural sensitivity and cultural and linguistic competence among the health care workforce. And it’s not just that minorities embody cultural sensitivity and cultural and linguistic competence in the care they provide, but their presence in the health care workforce will, in fact, bring greater cultural sensitivity to the overall workforce.”

While African Americans, Latinos and Native Americans make up more than

25 percent of the U.S. population, they represent less than 9 percent of nurses, 6 percent of physicians, and 5 percent of dentists.⁴⁵ Connecticut’s health care workforce reflects similar deficiencies.

Ironically, racial and ethnic minorities constitute the largest untapped reservoir of future health care providers. Addressing shortages in the nursing, pharmacy, and allied health workforce would require intense recruitment from these communities. This can be accomplished by increasing educational opportunities in the health professions and tracking progress to reduce current gaps.

The challenges are formidable but the actions we take today will make a difference tomorrow, resulting in more competent treatment and greater access to quality care for racial and ethnic populations.

WORKFORCE DIVERSITY

Recommendation:

The Connecticut Department of Public Health should (a) collect and track data on the race and ethnicity of all licensed medical professionals and issue an annual report on the diversity of the health care workforce in the state and (b) require all health care professionals to participate in cultural and linguistic competence continuing education programs through licensure requirements.

Rationale:

Connecticut’s health care workforce should be culturally and linguistically competent and reflect the state’s racial and ethnic composition.

Collecting data helps to identify trends and patterns of migration and access gaps in the state. It also helps policymakers and other health care leaders to understand the nature and extent of the issue, and where to focus attention.

According to the 2000 Census, the percentages of historically underrepresented health care providers in Connecticut vary widely from the corresponding racial and ethnic populations, which, combined, make up nearly 18 percent of the state.⁴⁶

African Americans represent 9.1 percent of the Connecticut population, but only 2.2 percent of the state's physicians, according to American Medical Association data.⁴⁷ Latinos represent 9.4 percent of the Connecticut population, but only 2.4 percent of the state's physicians.⁴⁸

Recent national studies demonstrate the importance of increasing the diversity and cultural competence of the health professions:

- Physicians from historically underrepresented populations are more likely to treat patients of color, which improves problems of access.⁴⁹
- A survey found that 69 percent of African American, 45 percent of Latino, and 35 percent of Asian/Pacific Islander dental students intended to practice in underserved communities after graduation.⁵⁰

- Psychologists from historically underrepresented populations are more likely to practice in racial and ethnic communities.⁵¹

- Patients from racial and ethnic communities are more satisfied with the care they receive from historically underrepresented professionals.⁵²

In addition, all health professionals, regardless of their background, need on-going education so that they can work effectively with cultural and linguistically diverse populations.

The purpose of continuing education is to protect the public by ensuring that health care professionals have formal opportunities to update their knowledge and skills, and learn from one another through networking.

Through continuing education in cultural and linguistic competence, these professionals can work more effectively in cross-cultural settings and with people who are culturally and linguistically different from themselves.

Requiring a certain number of hours in cultural and linguistic competence continuing education may improve provider-patient communication, increase patient compliance with medical and health promotion advice, and decrease the incidence of medical error.

Recommendation:

The Connecticut Department of Public Health should match all available federal dollars allocated to the national loan forgiveness program each year; target these funds to attract a greater number of historically underrepresented students to the health professions; and promote the loan forgiveness program broadly and effectively.

Rationale:

Loan forgiveness programs may be the only chance for some students to attend college and go on to health care professions. The Department of Public Health also should be required to match the federal dollars allocated to Connecticut so that our students can receive the most financial aid possible.

Currently the federal government allocates \$294,500 to Connecticut for the federal loan forgiveness program, but the state spends only \$122,620 in matching funds leaving thousands of federal dollars unused.⁵³ The department should promote the program sufficiently to use all the matching funds it is eligible to receive.

The reasons are clear:

- An active loan forgiveness program can encourage many more students from historically underrepresented populations to pursue health professions.
- Because of high costs, many students from historically underrepresented populations do not have the chance to attend college, since most of these undergraduates come from low-income families.

- Tuition and fees at dental schools increased by 84.6 percent from academic year 1991-92 to academic year 1997-98, with the largest increase occurring in public sector schools (94.5 percent).⁵⁴
- Sources of grant aid have decreased. Pell Grants, for example, covered 84 percent of the costs of attending a four-year public college in 1976, but only 39 percent in 2000.⁵⁵ At the same time, higher education is increasing awards based on merit, rather than need; at private institutions grants for middle-income students have exceeded grants for low-income students.⁵⁶

Recommendation:

The Connecticut Department of Higher Education should require public and independent educational institutions offering health professional programs to create strategic plans that include specific goals, standards, policies and accountability mechanisms that ensure institutional diversity and cultural competence. As part of these plans, these institutions should:

- Demonstrate how they recruit, retain and graduate students from historically underrepresented populations and report on their performance annually.
- Base admission decisions on a comprehensive review of each applicant (balancing the consideration of quantitative and qualitative data) and include representatives from historically underrepresented communities on admission committees.

Rationale:

With a focused approach to recruiting and retaining students from historically underrepresented populations, the state's educational institutions can diversify the health care workforce more rapidly.

Many studies show that increasing the size and diversity of the health care workforce has a positive impact on society as a whole, and on underserved communities in particular. As we have noted, greater diversity among health professionals is associated with improved access to care, greater patient choice and satisfaction, and better provider-patient communication.⁵⁷ Yet, Connecticut continues to lag behind other states in increasing the diversity of its health care workforce. While there have been modest gains in the number of health professionals from the African American and Latino communities, the rate of growth is slower than the growth of those populations.

Changing the racial and ethnic makeup of the health care workforce is a complex and difficult task. Progress to improve representation from underserved communities has been slow for several reasons, including inadequate pre-

professional education; the high cost of tuition; institutional policies and environments, such as inflexible admission policies; few, if any, mentors; and the lack of faculty from historically underrepresented communities.⁵⁸

One solution is to demand greater accountability for how educational institutions attract, retain and graduate members of underrepresented populations. In times of limited resources, it is vital that higher education institutions develop a comprehensive strategic plan to diversify both the student body and teaching staff.

The Connecticut Department of Higher Education (DHE) should require institutions to develop clear and practical plans that will encourage students from historically underrepresented communities to pursue careers in health care and significantly increase their numbers among faculties.



*top row, from left to right, Carrie Saxon Perry, Georgina I. Lucas, Gregory B. Butler,
bottom row, from left to right, Sanford Cloud, Jr., James Griffin, Jeannette B. DeJesús*

Members of the Policy Panel

Sanford Cloud, Jr., Chair

From 1994 to 2004, he served as President of The National Conference for Community and Justice (NCCJ), the first African American to lead the NCCJ since its founding. Earlier, Cloud, an attorney, served as a Connecticut State Senator and a senior executive at Aetna Life & Casualty Company.

Tina Brown-Stevenson

Tina Brown-Stevenson, a certified managed care executive, is the business head of Aetna Integrated Informatics, which is devoted to researching and developing sophisticated clinical and financial information products and services.



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Larry M. Gold

Gregory B. Butler, J.D.

Gregory B. Butler is Senior Vice President, Secretary and General Counsel of the Northeast Utilities system (NU). Earlier in his career, he served as a senior attorney with the United States Department of Justice and an associate counsel to the Minority Leader for the New York State Assembly.

David G. Carter, Sr., Ph.D.

David George Carter is President of Eastern Connecticut State University (ECSU). Before assuming Eastern's presidency in 1988, Carter was the Associate Vice President for Academic Affairs, Associate Dean in the School of Education, and Professor of Educational Administration at the University of Connecticut.

Jeannette B. DeJesús, M.P.A., M.S.W.

Jeannette DeJesús is the Executive Director of the Hispanic Health Council, a 25-year-old Hartford-based organization committed to improving the health and social well being of Puerto Rican/Latinos and other underserved communities through community-based research, direct service, training, and advocacy.

Larry M. Gold

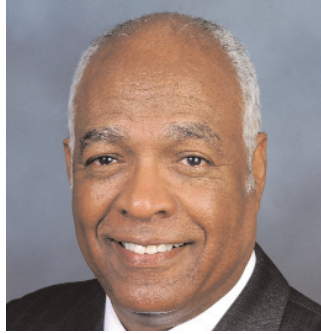
Larry Gold is President and Chief Executive Officer of the Connecticut Children's Medical Center, a position he has held since 1997. Prior to coming to Hartford, Gold was the Administrator of Children's Hospital of Illinois.

James Griffin

James Griffin, a longtime community activist, is the President of the Greater Waterbury branch of the NAACP and the immediate Past President of the Connecticut State Conference of NAACP branches.



Dannel P. Malloy



Curtis L. Patton



Ramón Rojano

Georgina I. Lucas, M.S.W.

Georgina Lucas is Deputy Director of the Robert Wood Johnson Clinical Scholars Program at the Yale University School of Medicine. Previously, Lucas served as a management consultant to nonprofit executives and was the founding Director of the Center for Innovative Practice at the Smith College Graduate School for Social Work, in Northampton, Mass.

Dannel P. Malloy

Dannel P. Malloy is serving his third term as the Mayor of Stamford. He also serves the U.S. Conference of Mayors as a Trustee, Vice Chair of the Mayors and Public Schools Task Force, and Co-Chair of the Small Business/Partner America Task Force.

Curtis L. Patton, Ph.D.

Curtis Patton is a Professor and Director of the Division of Global Health at the Yale University School of Public Health. He also is a faculty member of Yale's Division of Epidemiology of Microbial Diseases.

Carrie Saxon Perry

Carrie Saxon Perry served as Mayor of Hartford from 1987 to 1993. Currently, she is the Chairperson for the Hartford Black History Project, an exhibit of Hartford's African American community from the late 19th to the 20th century.

Ramón Rojano, M.D., M.P.H.

Ramón Rojano is the Director of the Hartford Department of Human Services, as well as an Adjunct Professor of Community Medicine at the University of Connecticut.



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BRIDGEPORT PUBLIC HEARING – JUNE 8, 2004

Moderator

Gwen Taylor-Edwards, *News12 Connecticut*

Introductions

Barbara Edinberg, *Bridgeport Child Advocacy Coalition*

Expert Testimony

Conrado Bárzaga, *Southwestern AHEC, Sacred Heart University*

Sharon Lewis, *Connecticut Coalition for Environmental Justice*

Mary Scully, *Khmer Health Advocates, Inc.*

Public Testimony

Mary Alice Cook

Rick Cruz, *Bridgeport Community Health Center*

Barbara Edinberg, *Bridgeport Child Advocacy Coalition*

Meredith Ferraro, *Southwestern AHEC, Sacred Heart University*

Ralph Ford, Jr., *Connecticut Department of Mental Health and Addiction Services*

Philip Greiner, *Fairfield University*

Frances Haynes, *Connecticut Department of Mental Health and Addiction Services*

Tom Hill, *Bridgeport Community Health Center*

Frances Newby, *Southwest Community Health Center*

Marilyn Ondrasik, *Bridgeport Child Advocacy Coalition*

Mariano Ortíz, *Connecticut Department of Mental Health and Addiction Services*

Janet Srinivasan, *Southwest Community Health Center*

Kathy Yacavone, *Southwest Community Health Center*

WILLIMANTIC PUBLIC HEARING – JULY 14, 2004

Moderator

John Robert Allen, *North End Agents*

Introductions

Katherine Fowler, *Windham Regional Community Council*

Michael Paulhus, *Town of Windham*

Walter Pawelkiewicz, *Connecticut General Assembly*

Jane Metzler Potz, *Windham Regional Community Council*

Edith Prague, *Connecticut General Assembly*

Expert Testimony

David I. Gregorio, *University of Connecticut*

Rafael Pérez-Escamilla, *University of Connecticut*

Public Testimony

Irving Buchbinder, *Community Health Services*

Catina Colón-Owen

Adrienne Marks, *Willimantic WIC Program*

Bill Powers, *Windham High School*

Arvind Shaw, *Generations Family Health Center*

HARTFORD PUBLIC HEARING – SEPTEMBER 14, 2004

Moderator

Rick Hancock, *Fox 61 News*

Introductions

Dennis Coley, *Connecticut Department of Children and Families*

Duncan Harris, *Alpha Phi Alpha Fraternity, Inc.*

The Rev. Barbara Headly, *Faith Congregational Church*

Gil Martínez, *Hispanic Professional Network*

Expert Testimony

Charles Huntington, *Connecticut AHEC*

Mary Lyon, *Connecticut Hospital Association*

Lloyd Mueller, *Connecticut Department of Public Health*

Alondra Nelson, *Yale University*

Public Testimony

José Arce, *Connecticut Coalition for Environmental Justice*

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- 57 *Ibid.*, pp. 29-33.
- 58 *Ibid.*, pp. 6-15



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