I. Executive Summary

Executive Summary

Ranking 5th among states in life expectancy at 80.9 years compared to a U.S. average of 78.5, the health status of Connecticut's 3.5 million people is better than most states. However, indices of average status on which such comparisons rely conceal disturbingly large disparities in both the health status and healthcare delivered to lower income residents in general and lower income people of color more specifically. The fact that different groups experience different burdens of disease and risk of premature death requires stressing that many of these disparities are the social and economic consequences of inequality and discrimination, and importantly, are largely preventable.

An extensive examination of evidence leads to the conclusion that Access Health CT's core mission to improve the health of the people of Connecticut by reducing the population without health insurance, and increasing access to and utilization of health and medical services, cannot be achieved without addressing the substantial health disparities between the state's racial/ethnic and income groups, its cities, and within cities, across neighborhoods. This conclusion follows directly from a consideration of Access Health CT's mission:

- Reducing the uninsured population is not possible without targeting the subpopulations with the largest groups of uninsured. Only 5.9% of Connecticut's population is uninsured, but this relatively small number hides significant disparities among race/ethnic groups and across space
    - Hispanics in Connecticut are almost 4 times more likely to be uninsured than Non-Hispanic Whites; Blacks are 3 times more likely than Whites. Blacks and Hispanics have also lost health insurance coverage at a greater rate during the pandemic
    - While most Connecticut neighborhoods cluster in a range with 2% to 6% uninsured residents, many neighborhoods across the state have 20% or more uninsured residents, several exceed 30%
    - Invariably, the latter neighborhoods are disproportionately composed of Hispanics or Blacks as are the cities and towns where the neighborhoods are located

- Both objective data and self-reports from Connecticut consumers reveal large disparities in access to health and medical services that are driven by social determinants of health (SDoH) such as income, education, and housing, each highly correlated with the spatial and group differences mentioned above
    - About 1-in-11 Connecticut neighborhoods are both food and medical deserts where a dearth of supermarkets selling fresh and healthy food options and a lack of medical facilities interact with other SDoH to undermine healthy choices and health outcomes
    - African American, Hispanic, and lower to moderate income respondents to surveys are significantly more likely to report barriers to medical services and healthy lifestyle choices that are based on lack of access to relevant resources

- This research uncovered how consumer experiences within the healthcare delivery system often exacerbate the impact of other SDoH and cause underutilization of the healthcare delivery system. Particularly, there are three key areas of experience that provide barriers to the healthcare delivery system:
    - Not all insurance plans are accepted or treated equally
    - For consumers, the cost of healthcare is unmanageable
    - Poor patient/provider relations exist

What is a Health Disparity?

We adopt the definition of health disparity suggested by the U.S. Department of Health and Human Services. A health disparity is:

"a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic-status, gender, age, or mental health; cognitive, sensory, or physical disability; social orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

This Report summarizes a data-grounded project designed to identify the needs and opportunities of many communities in Connecticut to allow Access Health CT to build a strategic framework that brings together appropriate public, private and non-profit

sector entities in support of developing new products, services and delivery methods that can address health disparities and make meaningful differences in people's lives. The project was completed in three parts.

- **Part 1:** a review of third-party public data to identify and quantify health and health-related issues, morbidity and mortality causes, and their relationship to demographic and socioeconomic status
- **Part 2:** solicitation of collective feedback from Connecticut stakeholders to understand perceptions of health disparities along with perceptions of Access Health CT for potential partnership opportunities and product, service and support ideas
- **Part 3:** distribution of a consumer survey designed to understand Connecticut residents' views on health and health-related topics along with interests and desires to engage with health-related products, services and supports

The Drivers of Health Disparity

Health disparities are easily visible as differences among race/ethnic groups, but the drivers of those disparities (their root causes) stem from a complex and interrelated set of individual, health system, societal, and environmental factors including poverty, poor educational attainment, inadequate housing, unsafe working conditions, and inadequate access to insurance and health care. They are thus reflections of the persistent inequities that exist in society.

- Large differences in life expectancy across Connecticut towns (and within towns, across neighborhoods) are driven by gross racial and ethnic differences in poverty, education, and access to health care
    - The highest life expectancy, a neighborhood of Westport with an 89.1-year life expectancy, is 91% White; by contrast, a neighborhood in Northeast Hartford with a life expectancy 68.9 years is 94% Black and Hispanic
    - In the Westport neighborhood, 8 of 10 adults graduated college, in the Northeast Hartford neighborhood, less than 1 of 10; the Westport neighborhood's poverty rate is 4 in 100, the Northeast Hartford neighborhood's, 44 in 100

- Many health disparities are linked to differences in insurance coverage and associated differential access to a regular health care provider. In Connecticut:
    - 18% of Hispanics and 11% of Blacks were uninsured during 2018, compared to only 8% of Whites
    - More than 1-in-4 Hispanic adults had no personal doctor in 2017. Among White adults, it was just over 1-in-10
    - Hispanic adults were more than twice as likely as Whites to report cost as the reason they did not see a doctor during the previous 12 months

- Barriers to accessing healthcare are very pervasive, and residents who are experiencing barriers often experience multiple challenges rather than a single isolated problem. Across the board, the following groups are more likely to experience barriers to getting healthcare:
    - Low socioeconomic status (SES) residents
        - Residents below 400% of the federal poverty level (FPL) are more likely to experience barriers to healthcare compared to people who are above this threshold. Findings are similar for household income (HHI). Only when HHI exceeds $50,000–$75,000 do barriers start disappearing
    - Residents insured through Medicaid, Husky, or a non-traditional plan
        - These residents are more likely to experience multiple barriers, especially finding a provider who takes their insurance, getting an appointment when needed, and barriers related to cost or insurance in general. They are more likely than others to distrust or fear going to the doctor
    - Residents who are in poorer health
        - People who are in poorer health and/or have a serious health condition are more likely to experience multiple barriers
    - Black residents
        - These residents are especially likely to experience various barriers, especially those related to cost and insurance coverage, getting an appointment when needed, and finding a doctor who accepts their insurance
    - Women
        - Women experience some barriers to a greater degree, and this could be interrelated with other characteristics such as SES
    - Having other SDoH risk factors
        - People who think they are at a health disadvantage, because something in their

world or reality is impossible or hard to change, actually are at a disadvantage—they are disproportionately likely to face barriers. This supports the idea that health inequity is partly grounded in the reality that we are held back because of the world that we live in and emphasizes the importance of system-level changes to close the gap in health equity

While these findings indicate relationships between SDoH and various challenges that may have implications for health outcomes, the fact that such relationships exist does not necessarily mean that these factors are drivers of health inequity or that Access Health CT needs address these challenges to meaningfully reduce health disparities. We must consider other root causes.

Because the uninsured are less likely to seek preventive care, diseases go untreated until at an acute stage or they require emergency care. Consequently, the burden of disease and consequences of poor disease management negatively impact health outcomes. Reducing these disparities is important not only from a health equity standpoint, but also from an economic perspective.

- That lack of health insurance and inadequate preventive care causes delayed treatment is consistent with the fact that for several diseases such as cancer and cardiovascular disease, although Whites have the highest prevalence, Blacks have the highest hospitalization and mortality rates
- A recent study at Yale Medical School found that expansion of health insurance through Medicaid lowered the average rate of diagnosis of breast cancer in women largely because lower income women with insurance more readily sought health services earlier. The effects were largest among African American women
- Largely due to emergency room use, the excess hospital cost of Black residents is over $384 million and that of Hispanics over $121 million compared with non-Hispanic White residents

Lessons from COVID-19 in Connecticut

- Connecticut's COVID-19 disease and mortality burdens differ considerably from national trends, and the differences convey the socioeconomic determinants of contracting the disease versus the medical and age-related factors determining who dies
- Although Black and Hispanic residents are disproportionately at risk of contracting the disease, Whites are more likely to die once they have the disease
  - The White percent of COVID-19 cases is only about half their population share.
  - Whites with COVID-19 have died at more than twice the rate of their population proportion among those with the disease
  - Hispanics with COVID-19 have died at less than half their population proportion among those with the disease
  - Blacks with COVID-19 die at about a 15% higher rate than their population proportion among those with the disease
- SES factors appear most significant in determining who contracts the disease
- Who is more likely to die once infected is determined more by health and medical factors such as age and preexisting medical conditions associated with severe COVID-19 cases. The relevant medical conditions are highly correlated with race and ethnicity.

Implications and Recommendations to Access Health CT

The research shows there are five key areas of focus and recommended actions for Access Health CT as the organization builds out its strategic framework for addressing health disparities in Connecticut.

1. **Address systemic causes of health inequity: healthcare cannot be an observer of issues or continue to suggest that health inequity is sustained by broader social forces alone.**

Much of the discussion on health disparities addresses individual socioeconomic and behavioral determinants. Yet, health inequities are not a product of such characteristics alone. Our research shows that vulnerable groups feel that the healthcare system shuts them out and hinders their engagement in various ways. It is clear that consumer experiences *within the healthcare delivery system* exacerbate the impact of other SDoH and play a powerful role in perpetuating unequal health outcomes.

Implementing solutions at the system level will be critical for meaningful advances in health equity

and reducing root causes of consumer healthcare avoidance. Solutions should include efforts to:

- Reduce cost of care
  - This was consumers' top suggestion for improving healthcare in their community
  - This was also a high priority for stakeholders interviewed
- Improve insurance coverage
  - Health insurance is a way to pay for care but is not the only means of accessing care. It is not enough to be insured. The type and quality of coverage matters, and Access Health CT is well-positioned to advocate for improvements or the creation of new products and services in this area
- Improve quality of patient-provider interactions
- Increase the number of providers and choices available to people; reduce disparities in insurance acceptance by providers
- Improve ability to get timely care
- Improve health and health insurance literacy

2. To improve patient-provider interactions, we must address implicit bias in healthcare and recognize how providers may be unwittingly contributing to inequities.

Strategies should aim to reduce the impact of bias rather than eliminate it entirely. Examples include:

- Efforts to make care more patient-centered—getting physicians to see each patient as an individual and fostering a team approach to patient care
- Bias training and cultural competency training that can help providers to become better attuned to implicit biases and develop skills to address them
- Foster an organizational climate that is truly committed to equity—this has been found to be more effective at reducing bias than formal diversity curricula
- Encourage diversity in physicians and organizational leaders

3. Take proactive measures to get people to engage with care

People benefit from both intrinsic and extrinsic rewards to take interest in their health and well-being and to get and stay on any form of care path. However, they also need someone to reach out to bring them into the system first before they can get on this path. Once they are in, helping them understand more about themselves and their health is critical and providing guidance along the way to keep them focused and on a plan. Supporting the work of Community Health Workers or Care Coordinators as "super navigators" is an area to explore further.

4. Assess current work around Data and Information centralization to see how Access Health CT can help

True integration of care to support the whole person requires information sharing. For the commissions, organizations or providers that support underserved communities, there are limitations to how data is shared or a lack of data sharing. For example, many struggle with the costs of Electronic Patient Record (EPR) systems or are unable to access these types of systems. All of this creates barriers for patients. As the State of Connecticut is working to centralize data, make data more accessible or enhance reporting to better support whole person health, Access Health CT should assess this work in progress in these areas to understand how the data Access Health CT has can support or enhance these efforts.

5. Access Health CT brand perception is neutral to positive

With a lack of trust for public and private institutions growing among consumers, yet Access Health CT brand perception being neutral or positive, Access Health CT has the opportunity to take on the role of building trust and relationships, and represents an opportunity to expand its current role to better help those in need.

These initial recommendations encompass six areas that will guide development of more specific new products, services and supports forthcoming in the next phase of the project.