COMMUNITY HEALTH DATA SCAN FOR CONNECTICUT
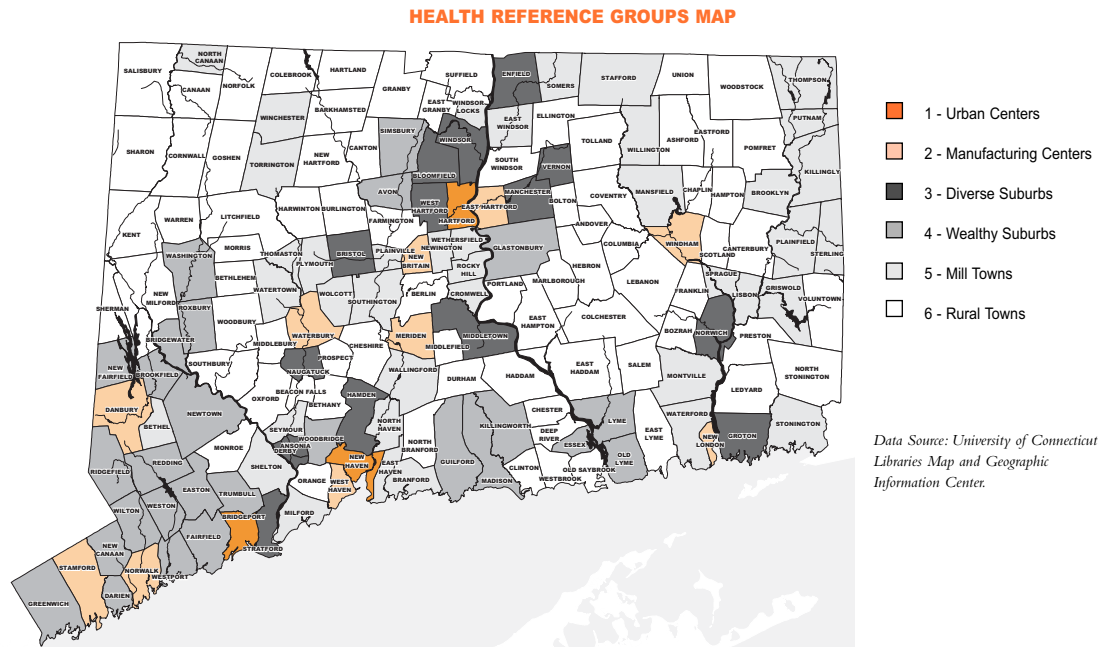
EXECUTIVE SUMMARY

WHAT IS THE COMMUNITY HEALTH DATA SCAN FOR CONNECTICUT?

The *Community Health Data Scan for Connecticut* was developed by the Connecticut Health Foundation (CHF) for several purposes: to assist the foundation in setting priorities for funding programs and policy studies; to help citizens better understand a range of key health risk, health care and health outcome issues; and to provide state policy-makers and community leaders with information that can be used in developing sound public policy. Using federal, state and nongovernmental sources, the *Data Scan* reports quantitative data on the social characteristics, health and well-being of Connecticut's residents. Racial and ethnic health disparities are a main concern investigated in the *Data Scan*.

LOOKING AT CONNECTICUT THROUGH HEALTH REFERENCE GROUPS

The *Data Scan* uses a principal methodology of Health Reference Groups (HRGs) to report data. For this document, Connecticut's communities were divided into six HRGs, somewhat like the nine Educational Reference Groups used by the Connecticut Department of Education. Because HRGs are based on socio-demographic similarity, they do not correspond to regional breakdowns such as counties, Health Districts or Uniform Service Regions. The six HRGs are: (1) Urban Centers; (2) Manufacturing Centers; (3) Diverse Suburbs; (4) Wealthy Suburbs; (5) Mill Towns; and (6) Rural Towns.

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The HRGs are statistically derived groups of cities and towns to assist in examining community health. They are highly predictive of health risk and health outcome. In addition, they provide a means of avoiding the "broad brush" approach to health disparities that treats all Asian, black, Hispanic, and white residents the same, regardless of the types of communities in which they live. HRGs allow the examination of health disparities within different types of communities.

HEALTH REFERENCE GROUPS MAP

- 1 - Urban Centers
- 2 - Manufacturing Centers
- 3 - Diverse Suburbs
- 4 - Wealthy Suburbs
- 5 - Mill Towns
- 6 - Rural Towns

Data Source: University of Connecticut Libraries Map and Geographic Information Center.

A brief description of each HRG category and its historical background follows:

Urban Centers

The three Urban Centers (Bridgeport, Hartford and New Haven) are traditional large population centers. Their communities became more diverse throughout the 20th century with the in-migration of blacks and, later, Hispanics. Post-World War II suburbanization and deindustrialization, however, helped create large concentrations of poor black and Hispanic populations within these Urban Centers.

Manufacturing Centers

The 10 Manufacturing Centers were the most successful mill towns of the early 1800s. As the white population became better educated, manufacturing labor demand in the 20th century was met through the in-migration of black and Hispanic workers. These cities and their populations have experienced suburbanization and deindustrialization; they have less diverse economic bases than those of the Urban Centers.

Diverse Suburbs

The 15 Diverse Suburbs may be thought of as a set of relatively dense, medium-sized towns with diverse populations. They are located close enough to large population clusters that they have benefited by becoming suburban communities. The Diverse Suburbs are similar in the age of their housing stock, density, population size, and population diversity.

Wealthy Suburbs

The 27 Wealthy Suburbs were largely untouched by industrialization and retained their rural character well into the 1900s. Improvements in transportation, increasing incomes and federal government policies all contributed to their suburbanization after World War II.

Mill Towns

The 39 Mill Towns are generally the smaller, earliest mill towns. Their slow growth in the 1900s meant they never experienced large black or Hispanic in-migration. Thus, these towns face many of the same problems of entrenched poverty as the Manufacturing Centers, but they are not as large, and their populations are predominately white.

Rural Towns

The 75 Rural Towns were largely untouched by industrialization, suburbanization or deindustrialization and generally retained a traditional New England landscape. For various reasons (e.g., distance and lack of transportation infrastructure) they have escaped large-scale suburbanization, although many have seen the development of low-density, high-end housing by wealthy in-migrants.

CONNECTICUT'S POPULATION IS CHANGING

Discussions of health priorities must factor in population changes. Projecting over the next 25 years, Connecticut's population will increase between 2000 and 2025 and then remain stable through 2030. The total change between 2000 and 2030 is projected at 8.3 percent.

The population will change also in composition. Projections show that there will be virtually no growth in the "white race" population through 2025 (+2.5 percent). The "black race" population is expected to increase by more than 50 percent, the "Hispanic ethnicity" population by 99 percent and the "Asian race" population by 113 percent.

The Hispanic population is currently the youngest group (74 percent are under 35), followed by the black race population (59 percent), the Asian race population (55 percent) and the white race population (41 percent).

FACTORS FOR MORBIDITY AND MORTALITY

A context for examining health data is research-based knowledge of major risk factors for leading causes of morbidity and mortality. Some of these factors are disease agents, others are behavioral and still others are environmental. Among the numerous morbidity and mortality risk factors analyzed here are: smoking; diet and exercise [e.g., behaviors likely to increase the risks of diabetes and cardio-vascular disease]; alcohol abuse; exposure to environmental toxins; exposure to violence [e.g., child endangerment, street violence]; sexual behavior [e.g., incidence of sexually transmitted diseases and teen pregnancy]; and travel safety [e.g., motor vehicle crashes, and bicycle helmet and seat belt use].

The report also considers issues of health care access and health care quality, examining areas such as: availability of care; health insurance status; availability of safety net programs; health care quality disparities; the use of and over-reliance on hospital emergency departments; linguistic isolation; the role of screenings and vaccinations in promoting health; nursing home and home health care quality; and hospital performance measures.

A SYSTEMS VIEW

Health-related behaviors can be understood only in their relevant contexts — including health care and health promotion access, utilization and quality; peer group and cultural norms; and the physical environment — as well as by examining both assets and barriers to good health. The report's findings and recommendations locate problems at all levels of the "system": federal, state, community, health provider, corporate, family, peer group, and individual. Each level may require work for the health outcome to change.

As an example: Focusing on diabetes may require changes in how primary care clinicians counsel patients about issues of obesity, diet and exercise. It also may require changes in how parents understand and implement their responsibilities regarding their children's diets and exercise habits. Changes may be required in community-specific cultural norms about diet and exercise. Programs should be pursued to increase public knowledge about healthy food choices and to decrease the marketability of unhealthy diets. The state may need to expand its capacity to collect population-based data on children and youth in local school districts to make better estimates on the extent of their in-school and out-of-school activities and risk behaviors. School bus and school lunch policies may have to change, as may transportation policy, so that more opportunities are available for safe walking and biking.

To tackle significant health problems, a systems view will require supporting investigations and action in each part of the causal chain.

RECOMMENDATIONS IN BRIEF

The *Data Scan* suggests six focus areas to improve the health of the people of Connecticut by: increasing access to and quality of care; promoting disease prevention, wellness and management of chronic health problems; and encouraging improvement of health outcomes and wise use of resources.

1. **Focus on the health reference groups, and racial/ethnic groups in greatest need.** The three Urban and 10 Manufacturing centers in Connecticut need the greatest health promoting investments. Within these communities, black/African American and Puerto Rican Hispanic residents may be in greatest need.

2. **Focus on diabetes and other conditions in the metabolic syndrome.** Risk factors for diabetes and related conditions — called the metabolic syndrome — are increasing nationwide and are prevalent in Connecticut in all populations, especially in the black/African American population. To address the problem, public policy solutions must be developed and prevention-focused support given to organizations that serve youth and adults.

3. **Focus on ensuring a medical home for all Connecticut residents.** Overuse of emergency department (ED) care and hospital admissions could be avoided if every Connecticut resident had, and used, a primary care "medical home." Reducing avoidable ED and hospital utilization will require a whole systems approach focused on increasing access to and comfort with the language and cultural surroundings of the medical home; using the medical home to discuss issues of chronic disease and issues of child and youth safety; and promoting adherence to medical regimens prescribed in the primary care setting.

4. **Focus on the binge drinking and smoking culture.** Smoking and binge drinking are major contributors to many health problems and premature mortality. The youth and young adult white population is especially at risk for smoking and binge drinking, and these behaviors may spread to immigrant populations as they acculturate. Methods of changing the culture of chronic and binge drinking and smoking could include: increasing the level of information about the signs and consequences of alcohol abuse and tobacco use; supporting wider limitations on use and abuse; and strengthening the enforcement of existing limitations.

5. **Focus on youth risks and opportunities.** Major youth health risks include sexually transmitted diseases, teen pregnancy, lack of use of seat belts and bicycle helmets, and child abuse. There is a need for broad initiatives on child and youth risk taking and safety, focused especially on the Urban and Manufacturing centers, and with black and Hispanic children and youth, who are most at risk regarding a variety of safety and risk issues. Some of these problems could be addressed through focused initiatives by out-of-school programs for youth.

6. **Improve the community health data system.** The community health data system could be improved in many areas to provide data where none currently exists and to make community-specific data more easily available to the public. Issues that need to be addressed include: data access, including the need for web-based query systems to customize community health data for data consumers; data delays; need for greater community health mapping capability; community health observations; increasing detail in race and ethnicity categories and providing residents with multiple race options in the health data gathering context; health care quality indices; improving mental health data; out-of-school data; and documentation about the data.

For a copy of the full report, please contact CHF at 860.224.2200, ext. 33, or databriefing@cthealth.org.

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