

Data to Promote Health Equity for Children and Families in Connecticut

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This analysis offers a survey of state-level race/ethnicity data available for indicators of children's and families' health and access to health care and services. We have included data indicators for parents/caregivers because parents' health is closely associated with the health and wellbeing of their children. This overview considers data collected through national and state efforts such as the various census tools and state and federal reporting requirements. It notes, but does not examine, private/proprietary information and is not comprehensive as a result. The goal of this effort was to examine how advocates, policy makers, and implementers define and track progress towards health equity for children in Connecticut and to recommend pathways to making this data more actionable and publicly accessible.

What is health equity and why is data on race/ethnicity important?

Health equity means that everyone—regardless of race/ethnicity,* income, disability status or other characteristics—has the opportunity to be as healthy as possible.¹ In Connecticut, as well as in the United States as a whole, population averages obscure serious health concerns for minority populations, particularly for Black and Latino Americans.^{2,3} Opportunities vary dramatically for people of different races/ethnicities in Connecticut, and the opportunity to grow up as healthy as possible is no exception.

Connecticut is highly segregated by both income and race/ethnicity.⁴ To name just a few disparities, the state's Black and Latino residents are more likely than White residents to be uninsured, to be employed in low-wage jobs, to die before reaching adulthood, and to report being in poor health.^{5,6} Each of these factors impacts an individual's ability to avoid preventable illness, seek care when needed, or achieve a sense of wellbeing. Importantly, these gaps are not experienced in the same way or to the same degree by all communities. Identifying and evaluating solutions to health disparities necessitates knowledge of which communities experience gaps in health care access and outcomes, in which areas of health these gaps exist, and whether the gaps are growing or narrowing.

Seminal studies in the United Kingdom and around the world have identified social determinants of health as the underlying causes of health inequity.^{7,8,9,10} A review of 175 studies of patients in the United States found that racial disparities in health persisted even when controlling for health coverage, chronic illness, income, and a myriad of other factors.¹¹ Similarly, disparities persist within Connecticut's HUSKY (Medicaid and Children's Health Insurance Program) population

* The term "race/ethnicity" is used throughout because many data sources use both terms, sometimes to differentiate Latino heritage from identifying as Black, White, or Asian. Since all of these categories are culturally determined and subjective, we refer to race/ethnicity as one concept.

despite uniform insurance coverage and similar income levels.^{12,13} Attention to racial/ethnic health disparities highlights the impact of social determinants of health. These social determinants include the impact of systemic racism on the health of individuals due to the stress of experiencing daily racism, the implicit and explicit racism of providers and insurers, and the lower socioeconomic status that is often the result of racist policies and historical oppression.^{14,15}

Like many issues related to health outcomes, the intertwined nature of social determinants of health makes tracking progress difficult. Race/ethnicity is an imperfect proxy of other factors such as income or culture, but is the best available indicator of an individual's exposure to racism. While race and poverty are highly correlated in the U.S. and in Connecticut, specifically, these facets of an individual's lived experience impact health in different ways.¹⁶ As one researcher notes, "[race] precisely captures the social classification of people in a race-conscious society such as the United States. The race noted on a health form is the same race noted by a sales clerk, a police officer, or a judge, and this racial classification has a profound impact on daily life experience in this country."¹⁷

The term "health equity" has become popular in Connecticut's discourse about health policy, and many ongoing efforts (e.g., patient centered medical homes) aim to impact the social determinants of health that can narrow disparities while improving overall population health. Reports on health equity in Connecticut calling for better data with which to track disparities date to at least 2005, and this data is a focus of the Healthy People 2020 efforts.^{18,19} Yet, the ability to track health disparities remains elusive. Tracking disparities highlights preventable disease and disproportionate disease burden and is key to both evaluating the effectiveness of our health and social service systems and identifying areas that require further investment. Recent census data indicate that disparities in health insurance coverage in Connecticut have decreased since the Affordable Care Act (ACA) took effect, though they remain significant.²⁰ This progress may be reversed as the ACA is threatened and the state continues to cut social and health service in response to its ongoing fiscal crisis.²¹ For example, the most recent state budget will result in over 13,000 parents/caregivers losing their public health insurance. In this situation, it is critical to understand how changes to state policies impact communities with needs that are masked in state averages. Such masking of experiences is common in Connecticut and is particularly apparent in certain aspects of health, such as infant mortality for which the state's White infants have the lowest mortality rates in the country while our Latino infants have one of the highest.²²

Without data disaggregated by race/ethnicity it is impossible to identify these disparities or to assess the adequacy of networks and systems to adapt to the state's changing demographics and create equitable health opportunities for all of Connecticut's citizens. For example, while only 4.9 percent of people in Connecticut lacked health insurance in 2016, 12 percent of the state's Latino residents lacked insurance.²³ The gap between Latino and White residents without insurance shrank from 11.8 percent to 9.4 percent from 2015 to 2016. Overall rates of insured residents improved slowly while disparities between Latino and White residents decreased at a

faster pace; suggesting that Latino residents were reached by enrollment efforts. This is just one example of how data can be used to track progress towards health equity and identify programs that are successful at decreasing disparities.

Defining what we mean by “health equity” and how we measure progress towards this goal is crucial to the process of eliminating disparities. Unless race/ethnicity data is integrated broadly into evaluations of our health systems, our focus will remain limited to “moving the needle” on specific indicators rather than the ultimate goal of equity in the opportunity to be as healthy as possible.

Summary of findings: Is adequate data on health disparities available in Connecticut?

Through health systems and health service providers, an enormous amount of data is collected, and many of these data sets include race/ethnicity. Some clear and useful data on race/ethnicity and associated health gaps is available, as detailed in the appendix and discussed below. However, much of the race/ethnicity data that is collected is unpublished.

Language data and detailed racial/ethnic data (beyond the most common categories of Black, White, Latino, and Asian) are scarce. Language data can be crucial in identifying disparities in access and barriers to quality care for some communities. However, language data in Connecticut is so scarce that it was not included in this discussion.

What follows is an overview of race/ethnicity data from the largest and most commonly used data sets that include indicators of health for children and families at the state level. The appendix includes additional sources and added detail.

Census Data

American Community Survey data available at the state level and for some municipalities includes race/ethnicity indicators that can be viewed across responses. The survey includes questions about health insurance coverage and socio-economic factors that can impact health.

The National Survey on Children’s Health was administered in 2016 after a 4-year gap. The data from the 2016 survey was recently released and includes state-level data on children’s physical and mental health and well-being. The usefulness of this data for Connecticut depends on the sample sizes of subgroups (some national surveys result in data sets for which sub-groups are too small to be viewed at the state level).²⁴

Connecticut’s Department of Public Health publishes a report on the Behavioral Risk Factors Surveillance System (BRFSS) and summary data from the Youth Risk Behavior Survey. The data is also available online and includes information about health-related behaviors, which can be viewed by race/ethnicity. These surveys also record gender identity and sexual orientation,

which is crucial to tracking disparities for the LGBTQ community and is rare in other available sources.

State Data Collected at the National Level

State agencies report to federal agencies on a variety of metrics tied to the quality of services and to the distribution of federal funding. For example, the Department of Public Health reports on various environmental and infectious disease indicators and the state's HUSKY program participates in many of the Medicaid voluntary reporting projects. Unfortunately, only broad state-wide comparisons or rankings and population-wide data are made public. The data used to reach these aggregate figures and rankings is not publicly available, though it is likely that these analyses could be altered to include race/ethnicity data. One exception is the Agency for Healthcare Research and Quality (AHRQ), which offers limited state-level quality indicators, some of which are disaggregated by race/ethnicity. These include patient-reported quality of care indicators.

Other data reported to federal agencies — on topics such as lead poisoning, asthma, unmet need for children's Medicaid-funded services, and quality of care indicators — are not shared in a way that allows us to track disparities. As a result, it is not possible to use these sources to analyze the effectiveness of policy changes in making progress towards health equity. On the other hand, the large quantity of existing reports and occasional inclusion of race/ethnicity data suggest that small changes could offer a rich source of information on health disparities.

State Agency Data and Data Portals

Several recent efforts have resulted in state data portals that allow Connecticut's residents, health systems stakeholders, and policymakers to more easily access data. These portals include measures on hospital and provider costs and quality, the health of Connecticut's population, and specific efforts to improve health in Connecticut.

All-payer claims database (APCD): This relatively new database includes data for 522,100 members of commercial plans from 2012-16 and aims to ultimately include 50% of the state's commercially insured population.²⁵ Given the limited scope of the data set, it is not representative of the state's population and therefore difficult to draw conclusions from unless comparison data from other networks becomes available. In addition, very little of the data can be viewed by race/ethnicity. However, it does offer some indicators by health reference groups, which link towns based on similar characteristics with the goal of elucidating health disparities.²⁶ Efforts to expand this database to include data from public insurers and improve robustness were included in the FY18-19 budget implementer bill.²⁷

MONAHRQ: This resource (the name is a trademark, not an acronym) aims to allow consumers to compare quality indicators across hospitals, nursing homes, or physicians. The usefulness of the data for consumers and researchers will depend on populating more fields. At present, many

searches return no results and race/ethnicity data is very limited. This site was launched in 2017 and may become more robust in time.

State Innovation Model (SIM) Data Dashboard: This project is also quite recent and incorporates data from census tools, Consumer Assessment of Healthcare Providers and Systems (CAHPS), and HUSKY and will soon include APCD data. This dashboard provides access to summary tables and some race/ethnicity data. However, unless it is possible to disaggregate all indicators by insurance type as well as demographic characteristics, the usefulness of the data may be limited due to the limitations of the APCD noted above. In the current iteration, users can view data for each indicator by one variable at a time. The FY18-19 state budget bill includes provisions to create an Office of Health Strategy overseeing both the Health Information Technology Officer and State Innovation Model. This change suggests the possibility of future integration and improvements.

Open Data Portal CT: This portal offers access to discrete data sets generated by state agencies, some of which include race/ethnicity data. For those interested in specific topic areas, some data sets include historic data and allow for analysis of trends in disparities over time. Integrating these data sets across agencies and/or with claims data would provide for a more robust and holistic analysis of health disparities. This project is run by the Chief Data Officer and was generated as part of efforts to improve transparency. However, the portal includes limited data from some agencies, perhaps resulting from a combination of lack of compulsory submission of certain data and concerns about privacy.

State Agency Reports to Federal and State Entities

The state's departments of Social Services (DSS), Children and Families (DCF), Public Health (DPH), Mental Health and Addiction Services (DMHAS), and Developmental Services (DDS) all report to federal and state entities on the progress of various efforts. Of these, the Department of Public Health regularly publishes indicators disaggregated by racial/ethnic category.

In 2016, Beacon Health Options conducted research on equity in behavioral health services for HUSKY enrollees and recommended adopting metrics that include racial/ethnic categories.²⁸ Recent reports to the Behavioral Health Partnership Oversight Council and other bodies show the adoption of this recommendation in the past year.

For health-related data from other agencies, including other aspects of the HUSKY program, race/ethnicity data is sparse. This includes the Children's Report Card, which discusses the importance of disparities, but offers little disaggregated data.

Local or Municipal Data

DataHaven publishes information on municipalities and neighborhoods in Connecticut, particularly through its Community Welfare Survey. The CT Data Collaborative publishes town profiles and data on various indicators of social, mental, and physical wellbeing. Local school

districts, municipal governments, and departments of health occasionally publish information, but in a more limited and inconsistent manner.

Other Sources of Data

Private and proprietary data is likely to include robust race/ethnicity indicators. Examples include medical records, ChimeData collected and utilized by Connecticut hospitals, data collected by self-insured or private insurers, and provider report cards established and distributed through each of the Administrative Services Organizations serving Medicaid participants.

Additional data, some from sources that are not publicly available, is presented in testimony at legislative hearings and in reports to various health committees. A brief survey of these sources found very little data disaggregated by race/ethnicity despite many references to racial/ethnic and income disparities.

Reports by the Offices of the Healthcare Advocate and the Office of the Child Advocate provide context and occasionally include quantitative information by race/ethnicity. These reports are not intended to be comprehensive, but do indicate rates of complaint and usage of certain health services as well as case studies.

Finally, some researchers and advocates publish information on the state's health systems and services. Before ending in 2016, the independent HUSKY Performance Monitoring project obtained individual-level data on HUSKY enrollees and published many reports analyzing this data.²⁹ Academic researchers at Connecticut universities and non-governmental organizations have also published analyses of data supplied by various state agencies and projects.

Discussion

Connecticut is a leader in reforming public health insurance and promoting public health goals such as medical homes and improved access to oral health.^{30,31} Perhaps more importantly, stakeholders in the state have acknowledged the deep disparities between residents of color and White residents for over a decade.³² While some strides have been made towards analyzing health disparity trends in the state, access to accurate and actionable race/ethnicity gap data remains uneven. As a result, the effectiveness of various innovations to promote health equity is unclear.

Achieving health equity requires that all of Connecticut's residents have access to services, systems, and environments that promote health. The HUSKY programs provide a uniquely illuminating lens for examining progress on health equity for several reasons: (1) Medicaid is well-positioned to address both health and social needs.³³ (2) The HUSKY population is uniformly lower-income, roughly accounting for any conflation of income disparities with those associated with race/ethnicity. (3) In Connecticut, HUSKY disproportionately affects people of color,³⁴ ensuring that disparities are not masked due to small population size. Furthermore, Connecticut's HUSKY program consciously aims to address social determinants of health

through efforts such as the patient-centered medical home (PCMH) approach and more recent efforts to connect patients to social services through support from community health workers and a value-based payment model.^{35,36} As a result, comparing health access and outcome measures for HUSKY enrollees to rates for the state’s commercially insured and uninsured populations can highlight where innovation in HUSKY and protections specific to Medicaid (such as Early and Periodic Screening Diagnostic and Treatment benefits) are/are not effective at narrowing health disparities.

Data on nativity and language were even more limited than race/ethnicity in the data sets surveyed here. Barriers to health care are an increasing concern for families with immigrant members, but the logistical and ethical complexities of collecting high-quality nativity data are beyond the scope of this paper and, particularly for small minority groups, may be better addressed through qualitative research and outreach conducted by these communities. This is not to say that the lack of data should result in a lack of action—where race/ethnicity data renders gaps in health coverage evident, additional research is needed to parse the barriers to care. These barriers may be tied to a family’s immigration status, primary language, or other social or cultural factors that will not be clear from racial/ethnic identity alone. Improved collection of primary language data could identify the degree to which language contributes to barriers to health for specific subsets of various racial/ethnic populations, including Connecticut’s small, but growing population of immigrants from Southeast Asia and the Middle East. Similarly, data on immigration status or nativity could illuminate the degree to which access to care is limited in families with at least one foreign-born family member. Particularly in the current political climate, fear of contact with government systems may be a concern even when a family lacks undocumented members.

Finally, many social determinants of health are clustered geographically—residents of some neighborhoods have more or less access to healthy food, safe environments, exposure to lead and other pollutants, and other environmental and structural determinants of health.^{37,38} Connecticut is small, but diverse and heavily segregated both economically and by race/ethnicity.³⁹ Resources vary widely between towns and concentrated populations of smaller minorities may have unmet needs that are lost in race/ethnicity data but highlighted by geographic disparities at the town or neighborhood level. In combination with race/ethnicity data, geographic data—whether by neighborhood, school district, congressional district, or health reference group methodology—can render analyses of health disparities more actionable and enable the state to target resources where they are most needed.

Recommendations

While Connecticut has made some progress in decreasing health disparities and has invested in strategies to achieve health equity, the available data is inadequate to evaluate progress. Yet, this data is already collected and stored by state agencies. As noted above and detailed in the appendix, this state collects an enormous amount of data and many of these data sets include or

could be linked to race/ethnicity indicators. We have a long way to go before we can adequately analyze Connecticut's progress towards health equity, but this goal is absolutely attainable.

The recommendations that follow acknowledge the realities, costs, and imperfections of race/ethnicity data collection. Recognizing the state's current fiscal crisis and recent rollback of services to low-income families, these suggestions range from low/no-cost immediate shifts to longer term goals that could be included under systems change efforts, such as the Office of Health Strategy. While the current state context requires particular attention to costs, it does not preclude long-term thinking.

Short-Term Recommendations:

1. **Establish reporting guidelines:** Reports produced by government agencies should consistently include accurate race/ethnicity data and adhere to principles of clarity. For example, reports noting a percentage change from one year to the next should include the total population and the percent of the population impacted—not just the percent change.⁴⁰ Many reports presented to oversight bodies and the legislature lack trend data and do not consistently include race/ethnicity.

Existing oversight bodies—like the Council on Medical Assistance Program Oversight (MAPOC), Behavioral Health Partnership Oversight Council (BHPOC), or the Health Innovation Steering Committee (HISC)—regularly receive reports from the Departments of Social Services (DSS), Children and Families (DCF), Public Health (DPH), Developmental Services (DDS), and Mental Health and Addiction Services (DMHAS) and could establish standards for these reports that include: (a) disaggregating indicators by race/ethnicity; (b) providing trend data, when available, over a 5-year period, and (c) including total counts as well as rate/percentage for clarity and usefulness. The practical use of race/ethnicity data that is already available would be greatly improved should reporting agencies release tables in addition to summary statistics. Since these tables are produced in order to write the reports, this should not add significant time or cost. In fact, improvements in how data is shared could reduce inquiries by email, phone, or FOIA.

2. **Improve the accuracy of race/ethnicity data:** Reliance on self-reported race/ethnicity categories can improve the quality of the data collected.⁴¹ Incorporating guidelines on race/ethnicity data collection into ongoing training for providers, outreach workers, and certified enrollment counselors would improve the accuracy of available race/ethnicity indicators.
3. **Increase timeliness:** Many of Connecticut's agencies share limited data publicly and regularly (though generally without race/ethnicity indicators). Still, data sets are often 5 years old or more (see DPH.ct.gov). Routinely collected data sets should be released and shared in accessible formats no more than 18 months after collection has ended. This will enable

policymakers, practitioners, advocates, and concerned citizens to track the impact of policy changes and to act quickly to correct policies or regulations that are not working as intended. The state’s rapidly evolving health care policy necessitates the use of recent data to analyze the impact of changes before these changes are scaled up, repealed, or altered.

Medium to Long-Term Recommendation:

1. **Data integration:** As has been suggested in more than one analysis over many years, the state needs more holistic and actionable data on health and social determinants of health in order to work towards health equity.⁴² Systems changes can integrate race/ethnicity data collected within agencies and improve the utilization of data collected across state agencies. Advocates and researchers at a recent meeting noted the difficulty of aggregating data from local health departments or individual schools and of linking data from one agency to that collected by another.⁴³ Structural changes, such as the proposed Office of Health Strategy and its oversight of the Health Information Exchange and State Innovation Model offer the opportunity to advance cross-agency data integration in Connecticut and, as a result, enable more consistent evaluation and reporting of health disparities. Any evaluation of the impact of integrating social services with primary care would be enhanced dramatically by the ability to analyze services across agencies. More broadly, linking data sets consistently would improve the state’s ability to understand the impact of changes to health systems, insurance coverage, and social services on various populations and to target interventions appropriately. Systems and data integration has proven successful in other locations, including Alleghany County, Pennsylvania which has developed a “data warehouse” integrating health and social services data.^{44,45} The Office of Health Strategy is well positioned to guide this process.
2. **A robust public data portal.** Integrated data would improve reporting and decision making within agencies, but public access to data is also vital. As noted above, several data portal projects are operated in the state at present; unfortunately, each project is fragmented or not yet fully realized. Ideally, a robust data portal would allow for analyses along multiple factors—for example, whether or not disparities by race/ethnicity differ by age group or geographic location. While patient privacy concerns require the suppression of small results, more robust data sets combining multiple years of data will return results that adhere to privacy regulations while providing clearer information about which of Connecticut’s residents experience disparities in which areas.

The SIM Data Dashboard offers one opportunity to incorporate data on many issue areas, should it be expanded beyond claims data and/or assimilated with one or more of the state’s other data sharing projects. As noted above, while claims data does not tend to include race/ethnicity indicators, this information could be integrated by matching claims data with enrollment or vital statistics data, whenever possible. A team at UCONN has developed software geared towards creating and matching unique IDs across data sets, which could

facilitate this process and alleviate privacy concerns.⁴⁶In the long term, inclusion of quality and outcomes data from hospitals and providers, data from the State Department of Education, and data on public health screenings and social services would provide a holistic picture of the state's health disparities and their causes and allow for informed evaluation of policies.

3. ***Reconsider race/ethnicity and disparity categories.*** A broader conversation about how we collect and use data about individuals of varying identities is warranted. The above recommendations do not address the barriers to care faced by transgender youth, disabled individuals, or sub-groups within the commonly collected race/ethnicity categories (for example, first and second generation immigrants from Southeast Asian former conflict zones whose experiences differ from the aggregate “Asian” experience). Connecticut's small population suggests that small communities' needs may be better assessed through local qualitative analyses since quantitative research that considers many categories may not sample enough individuals from each community to ensure privacy or enable robust analyses. However, this does not mean that more detailed data should not be collected. Over time, as populations grow or multiple years of data are combined, this information can inform policy evaluation and change. Systems changes and the integration of health and social services should include ongoing input from the affected communities. In conversation with stakeholders, the state should standardize collection of primary language and detailed race/ethnicity data in order to better understand and address health disparities within and among identity groups. These discussions may require some time, but this goal is attainable with minimal resources and could begin within a relatively short timeline.

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Appendix: Survey of Race/Ethnicity Indicators in Publicly Available Connecticut Health Data with Relevance for Children and Families

Please note that while the data surveyed here is publicly available at some level, not all indicators are published and most data sets that include race/ethnicity data lack complex analyses of disparities. Further, very little raw data is available. Data is primarily published in reports and, as a result, is limited in scope.

| | Publications/ organizations | Health disparity indicators | | | | | What type of health data? | | | Category of services | | | Where to find? (Note: All CT Agencies are in process of updating their websites; links may be broken as a result) | Latest year available | Notes |
|---|---|---|----------|----------|-----------|--------|---------------------------|--------|----------|-------------------------|--------|--|--|--|---|
| | | Race/ ethnicity | Language | Nativity | Geography | Income | Outcomes | Access | Coverage | Medical/vital | Dental | Behavioral/ Mental | | | |
| Non- governmental and Academic Sources | DataHaven | Y | N | Y | Y | Y | Y | Y | Y | Y | Y | Y | www.ctdatahaven.org | 2016 | Some data available only for specific towns |
| | Urban Institute | Y | Y | Y | Y | Y | Y | Y | Y | Y | N | N | https://www.urban.org/research | 2016 | Issue-specific research |
| | Kaiser Center for Children and Families (CCF) Georgetown | Y | N | N | N | N | Y | Y | Y | Y | Y | Y | https://www.kff.org/statedata/?state=ct | 2016 | Analyses of data collected at national and state level |
| | America's Health Rankings | N | N | N | Y | N | N | Y | Y | N | N | N | https://ccf.georgetown.edu/ | 2017 | Analyses of data collected at national and state level |
| | Catalyst Center at Boston University | https://www.americashealthrankings.org/explore/2015-annual-report/measure/Overall/state/CT | Y | N | N | N | Y | Y | Y | Y | Y | Y | https://www.americashealthrankings.org/explore/2015-annual-report/measure/Overall/state/CT | 2014 | Analyses of data collected at national and state level |
| | CT Data Collaborative | Y | Y | N | N | Y | Y | Y | Y | Y | Y | Y | http://chartbook.cahpp.org/statedata | 2016 | Analyses of data collected at national and state level |
| | Kids Count | Y | N | N | Y | Y | Y | Y | Y | Y | N | Y | ctdata.org | 2016 | Simplified access to data collected at national and state level |
| | UCONN Health and Health Disparities Institute | Y | Y | N | N | Y | Y | Y | Y | Y | Y | Y | http://datacenter.kidscount.org | 2015 | Analyses of data collected at national and state level |
| | The Child Health and Development Institute of Connecticut | Y | TBD | TBD | Y | TBD | N | Y | Y | N | N | N | http://www.publichealth.uconn.edu/research.html and https://health.uconn.edu/health-disparities/ | 2007 | Research projects are at varying stages and have a variety of focuses, including health insurance literacy, prevention, etc. |
| | Community Health Centers | Y | N | N | Y | N | N | Y | N | Y | Y | Y | www.chdi.org | 2017 | Reports and recommendations on evidence-based practices with a focus on behavioral health and early childhood |
| | Connecticut Health Foundation | Y | Y | N | Y | N | Y | Y | Y | Y | Y | Y | https://bphc.hrsa.gov/uds/datacenter.aspx?year=2016&state=CT | 2016 | Limited reporting of specific quality and outcome indicators. Only outcomes and total patients are disaggregated by race/ethnicity. |
| Government Agencies and Census Projects | Substance Abuse and Mental Health Services Administration | Y | N | N | N | Y | Y | N | N | N | Y | https://www.cthealth.org/ | 2017 | Reports, infographics, and policy briefs on a variety of health topics | |
| | HUSKY reporting to state government | Y | N | N | Y | Y | N | Y | Y | Y | Y | https://www.samhsa.gov/data/sites/default/files/Connecticut-2016.pdf | 2016 | Race/ethnicity data limited to % of population | |
| | Federal database: Medicaid and Statistical Information System (MSIS) | Y | N | N | N | N | N | N | Y | N | N | N | https://www.medicaid.gov/medicaid/benefits/epsdt/index.html | 2016 | Lists 0 as dual race and 0 Hispanic only suggesting limitations |
| | Sample state data reported to federal agency: Report on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits | N | N | N | N | N | N | Y | Y | N | Y | Y | https://www.medicaid.gov/medicaid/benefits/epsdt/index.html | 2016 | |
| | Sample federal Medicaid report: Quality of care core measure reports | N | N | N | N | N | N | Y | NA | Y | Y | Y | https://www.medicaid.gov/medicaid/quality-of-care/downloads/child-core-sets-brief.pdf | 2015 | Summary data only |
| | DPH reporting to state government | Y | N | N | Y | Y | Y | Y | Y | Y | Y | Y | http://www.ct.gov/dph/site/default.asp_MONAHRQ | 2016 | |
| | Sample report for Department of Public Health (DPH): diabetes report | Y | N | N | Y | N | Y | Y | N | Y | N | N | http://www.ct.gov/dph/lib/dph/hems/diabetes/ct_diabetes_stats_2016_8apr2016_final2.pdf | 2016 | |
| | All-Payer Claims Database (APCD) | Limited Only Hispanic/ Other | N | N | Y | N | N | Y | Y | Y | N | Y | https://www.analyzehealthct.com/index.html | 2015 | Currently limited in population |
| | MONAHRQ @ | Y | N | N | Y | N | Y | Y | N | Y (cost and quality) | TBD | Y | http://ctmonahrq.ct.gov/ | 2015 | Recent release; many fields are blank or lack comparison data |
| | Federally Qualified Health Centers (FQHC) | Y | Y | N | Y | Y | Y | Y | Y | Y | Y | Y | https://bphc.hrsa.gov/uds/datacenter.aspx?q=d&year=2013 | 2016 | Some data on availability of service providers is public |
| | Pregnancy Risk Assessment Monitoring System (PRAMS) | NA | | | | | | | | | | | https://www.cdc.gov/prams/pramstat/index.html | 2011 | CT is listed as participating, but data is unavailable |
| | State Innovation Model (SIM) reports and data dashboard | some | N | N | Y | N | Y | Y | Y | Y | Y | Y | http://www.publichealth.uconn.edu/sim_dash.html | 2015 | Recent release; many fields are blank |
| | Behavioral Health Partnership Oversight Council (BHPOC) reports | some | N | N | N | N | Y | Y | N | N | N | Y | https://www.ct.gov/ph/BHPOC/ | 2017 | |
| | National notifiable diseases surveillance | Y | N | N | Y | N | N | N | N | Y | N | N | https://www.cdc.gov/ndss/ | 2015 | Reports of incidence only |
| | Consumer Assessment of Healthcare Providers and Servers (CAHPS)/Agency for Healthcare Research and Quality (AHRQ) | Y | N | N | N | Y | N | Y | Y | Y | N | N | https://www.ahrq.gov/cahps/index.html | 2015 | Summary data only |
| | Centers for Disease Control and Prevention (CDC) databases | Y | N | N | N | N | Y | N | N | Y | N | N | https://www.sortablestats.cdc.gov/#/detail | 2015 | |
| | Children's report card | N | N | N | N | N | Y | Y | Y | Y | N | Y | https://www.ct.gov/kid/rba/results.asp | 2015 | Discusses race/ethnicity, but does not disaggregate |
| Department of Mental Health and Addiction Services (DMHAS) | Y | N | N | Y | N | Y | Y | N | N | N | Y | http://www.ct.gov/dmhas/site/default.asp | 2016 | | |
| Department of Children and Families (DCF) CT Open Data Portal | Y | N | N | Y | N | N | Y | Y | Y | N | Y | http://www.portal.ct.gov/DCF/Data-Connect/Data-Connect-Homepage/DCF-Data-Reports https://data.ct.gov/ | 2016 | Children's behavioral health data is disaggregated; other DCF reporting varies | |
| Census Tools | CT School Health Survey/Youth Risk Behavior Survey | Y | N | N | N | N | N | N | N | Y | N | Y | http://www.ct.gov/dph/cwp/viaw.asp?a=3132&q=388104&dphNav_GID=1832%20_OR https://www.cdc.gov/healthyouth/data/yrbps/participation.htm | 2015 | |
| | CT Behavioral Risk Factor Surveillance System (BRFSS) | Y | N | N | limited | Y | Y | Y | N | Y | Y | Y | http://www.ct.gov/dph/lib/dph/hisr/pdf/brfss2015_ct_report.pdf | 2015 | Data is available at a municipal level for one urban region in CT and another in CT/MA |
| | American Community Survey (ACS)/Census | Y | Y | P | Y/N | Y | N | N | Y | N | N | N | https://www.census.gov/progr/ams-surveys/acs/ | 2016 | |
| | National Survey of Children's Health | Y | Y | N | N | N | Y | Y | Y | Y | Y | Y | http://childhealthdata.org/browse/survey | 2016 | |
| Additional state government reports | Office of the Child Advocate | NA | | | | | | | | | | | http://www.ct.gov/oca/lib/oca/FINAL ANNUAL REPORT 2016.pdf | 2016 | Report on activities including child deaths |
| | Office of Fiscal Analysis | NA | | | | | | | | | | | https://www.ct.gov/ofa/ | 2017-19 | Budget analyses and spending trends |
| | Offices of the Healthcare Advocate | NA | | | | | | | | | | | http://www.ct.gov/oha/lib/oha/oha_2016_annual_report.pdf | 2015 | Report on annual call volumes by type |

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