COMMISSION ON RACIAL EQUITY IN PUBLIC HEALTH

CONNECTICUT GENERAL ASSEMBLY

Co-Chairs: Claudio Gualtieri, Undersecretary for Health and Human Services &
Ayesha Clarke, Interim Executive Director, Health Equity Solutions

January 2023 Report to the Connecticut General Assembly's Public Health and Appropriations Committees

Table of Contents

[1]Per charge in Section 4 of PA 21-35

[2]December 2022 Minutes are not attached, as they need to be approved by the Commission at the next meeting, scheduled for February 2023.

[3]Presented at the December 12, 2022 Commission meeting

Activities of the Commission

Staffing

During the summer, the Executive Director hired an Associate Commission Analyst and Commission Analyst I. The analyst positions were envisioned to assist with analyzing policy, drafting policy recommendations, strategic planning, writing Commission reports and materials, monitoring legislation related to or involving the Commission, and other duties needed to fulfil the Commission's charge. The Associate Commission Analyst, Muna Abbas, and Commission Analyst I, Gretchen Marin, started on September 30, 2022. The Commission was allotted three personnel, including the executive director, in its FY22/23 budget and is therefore considered fully staffed at this time.

Bylaws

Pursuant to our enabling act, PA 21-35, Commission staff have drafted bylaws in accordance with Sec. 2(i)(6) which will be put to the Commission body for review and adoption. The bylaws provide a clear governance structure, outline duties and responsibilities of the Commission, and detail the membership and operations surrounding our work.

Subcommittee & Focus Area Updates

Focus on Metrics

In summer and early fall, the subcommittees focused on recommending disparity metrics for the Commission to track and report to the General Assembly. The executive director did a crosswalk of the member-recommended metrics and the metrics and data categories listed in statute. She refined the list to reflect both the statutory charge and recommendations of the commission members. Subcommittees discussed the refined metric list and advised on potential sources of data including state agencies, census data, and validated surveys conducted by non-governmental agencies. In addition to the metric work, subcommittees discussed policy related to their focus areas and heard from content experts.

Restructuring

The team collectively restructured the Commission's subcommittees following the late October full Commission meeting. The new organizational structure better reflects the clusters of subject matters outlined in statute, alongside the experience and expertise of our Commission Members.

Prior to the subcommittee restructuring, the subcommittees were: 1) Criminal Justice; 2) Public Health, Health Outcomes and Health Living; 3) Structural Racism in Laws, Regulation, State Business & Hiring; and 4) Zoning.

The restructured subcommittees and their members are:

Health and Wellbeing

- Senator Mary Abrams[4]
- Representative Johnathan Steinberg[5]
- Deputy Commissioner Heather Aaron
- Tiffany Donelson
- Laura Morris
- Melissa Santos

Housing, Environment, and Communities

- Kyle Abercrombie
- Carline Charmelus
- Marina Marmolejo
- Monica Rams
- Annie Decker

Education and Economic Security

- Representative Hilda Santiago
- Steven Hernández
- Astread Ferron-Poole
- John Frassinelli
- Diana Reyes

Criminal Justice

- Representative Travis Simms
- District Administrator Eulalia Garcia
- Leonard Jahad
- Kenyatta Muzzani
- Kean Zimmerman

[4]The Public Health Committee Senate Chair will be Senator Saud Anwar as of January 4th, 2023. The current House Chair and Member of the Commission is Senator Mary Abrams.
[5]The Public Health Committee House Chair will be Representative McCarthy Vahey as of January 4, 2023. The current House Chair and Member of the Commission is Representative Johnathan Steinberg.

Subcommittee meetings are facilitated by commission staff and provide an opportunity for members to hear from content experts, discuss policy proposals, and share knowledge. Each subcommittee met approximately every two weeks leading up to session. The focus in November and December was on mission-relevant policy proposals in preparation for the 2023 legislative session. The staff and members identified key stakeholders in our focus areas and held meetings with them to discuss the scope of their work and priorities in the space of racial equity.

As we approach our inaugural legislative session as a staffed commission, the subcommittees have reflected on legislative proposals put forward in their respective focus areas and discussed how they may impact racial and ethnic disparities in Connecticut – directly, or indirectly.

In addition to the four newly formed subcommittees, the Commission will be designing a plan for consistently engaging community and has delegated the Structural Racism in State Government work to the staff. The community engagement and structural racism work is crosscutting, as community input will inform all focus areas and the structural racism charge applies to all state agencies.

Community Engagement

It is essential that the Commission engages with members of the community impacted by racial disparities. While we analyze and prioritize policy recommendations as a Commission body, we will build a feedback loop to share information with and gather input and feedback from communities that are disproportionately impacted by racism. The Commission, guided by our Community Engagement Advisors, will be developing a plan to build this infrastructure. Early planning includes a vision for hosting community conversations in partnership with community-based organizations around policy ideas and implementation. Having a feedback loop within our operations will ensure that our decision-making processes elevate and include the voices of those most impacted.

Commission members who will be our Community Engagement Advisors are as follows:

- Ayesha Clarke
- Chavon Hamilton-Burgess
- Tammy Hendricks
- Leonard Jahad

Structural Racism in State Government

Through sec. 4 of PA 21-35, the Commission is charged with examining structural racism, which includes determining best practices and recommendations to eliminate racial disparities within state agencies. The

previous Structural Racism subcommittee discussed state hiring, contracting and procurement, as well as ideas for mapping or inventorying state agency equity efforts. Commission staff have picked up this work, as the subcommittee restructure sunsetted this subcommittee and the charge is a cross agency and cross branch effort. Outcomes, recommendations, and proposals from this work will be put to the full Commission for feedback.

In our early stages of exploring this work, we have looked in particular at state hiring practices, and mechanisms to diversify the state workforce to better reflect the state's population. In addition, we have had discussions with individual state agencies to determine what efforts they have undertaken to address structural racism which may exist within their operations. These discussions have included hiring, contracting and procurement, and practices related to services the agencies provide.

Diversification of State Employees Across Position Levels

Commission staff have been meeting with researchers and content experts on how to best improve recruitment and retention practices across government. We have met with UConn's School of Public Policy and the Office of State Comptroller and reviewed their work and data collection which they gathered for the Taskforce to Study the State Workforce and Retiring Employees set up by the legislature in 2021. The Taskforce delivered their recommendations in 2022. Recommendations relevant to the Commission's charge include reporting on employee racial, ethnic, and gender demographics by agency, position type, and earnings to assess inequities and set targets for improvement; establishing a position of a Chief Diversity, Equity, and Inclusion (DEI) Officer who would oversee agency reporting and improvement planning; and the creation of an Equity Advisory Committee, which would, along with the Chief DEI Officer, monitor the activities of state agencies and their efforts to reach diversity goals.

The former Structural Racism subcommittee reviewed and provided feedback on these recommendations at the October 20th Commission meeting. The staff are continuing conversations with stakeholders and government offices to assess the recommendations and larger state hiring policy landscape.

Broader Factfinding Efforts

Staff are also in conversation with the Commission on Human Rights and Opportunities on the state's disparity study and with agencies such as the Department of Children and Families to gain an insight into how equity work is being operationalized in their respective departments. As we delve deeper into an assessment of individual state agencies and form a better understanding of present successes and opportunities for improvement, we hope to identify best practices and encourage agencies to incorporate them into their operations, tailored to their individual needs.

Commission Meetings

July 25th, 2022 – Regular Meeting

The Commission held a business meeting to hear the newly hired executive director's plan for meeting with members and stakeholders, hiring staff, and strategic planning. Subcommittees offered updates on their efforts thus far and the co-chairs announced a transition in leadership. Dr. Tekisha Everette was resigning from her position as Executive Director of Health Equity Solutions to pursue another opportunity, and then Deputy Director Ayesha Clarke would assume the role of Interim Executive Director of Health Equity Solutions and the Co-Chair of the Commission.

October 20th, 2022 – Regular Meeting

The Commission held its first in-person meeting in October, focused on metrics. Mark Abraham, Executive Director of DataHaven, presented on health and social drivers of health disparities. Scott Gaul, Chief Data Officer at the Office of Policy and Management, spoke briefly about his role in assisting the Commission with identifying appropriate sources and processes for accessing state agency data. Dr. William Clark, Principal at Eli Patrick & Co., provided a brief presentation on the importance of data. Following the presentations, the Public Health, Criminal Justice, and Zoning subcommittees broke into groups to review, affirm, and amend the metric selections in their respective topic areas. Abraham and Gaul were resources for these three subcommittees as they affirmed or amended their metric selections. Dr. Clark facilitated the Structural Racism subcommittee's review of a set of state hiring policy recommendations. Subcommittees were provided a list of all metrics, allowing the Commission to view the metrics holistically. The Commission collected feedback through electronic forms for all subcommittees. Director Goodwin explained the next steps for the staff would include further refining the metrics list based on the members' feedback and developing a data collection and reporting plan.

December 12th, 2022 – Regular Meeting

The Commission heard data collection and reporting updates and a review of subcommittee reorganization from the executive director. Associate Commission Analyst, Muna Abbas, presented an overview of legislative and policy proposals expected to come up in the 2023 session. Proposals were grouped by subcommittee focus area, to the extent possible, as some proposals straddle focus areas. Members discussed topics the Commission may want to focus its efforts on and the Commission's role in reviewing legislation and making recommendations.

Strategic Plan Update

Director Goodwin met with commission members and stakeholders during the summer and asked each their view of the priorities, challenges, and opportunities for advancing racial equity in public health in Connecticut. Racial/ethnic/language data, workforce shortages and diversity, and community-informed policy were common themes, though members provided a large range of feedback across sectors. The Commission has used these conversations to inform our work thus far, and will continue to discuss priorities and opportunities throughout our work.

The main components of the strategic plan shall be 1) a disparity data reporting plan, 2) a community engagement strategy, 3) long-term visioning, and 4) short-term goals and subsequent plans for executing those goals.

The Commission has made significant headway on the disparity data section of the plan and is assembling an initial data report, which will be released in 2023. In May 2023, the Commission will host a data walk in the Legislative Office Building and Capitol to further disseminate and discuss the data snapshots with the General Assembly, stakeholders, and the public.

The staff, co-chairs, and community engagement advisors will develop a plan for consistently engaging community on our focus areas, including plans for conducting community conversations. The Commission plans to pick up long-term visioning and short-term goal setting following the 2023 legislative session, in order to allot the necessary staff and member time to a deliberate process.

Attachments

The following materials are attached to the end of this report:

- July 25th, 2022 – Regular Meeting Minutes
- October 20th, 2022 – Regular Meeting Minutes
- 2023 Commission Meeting Schedule
- Comments from the Commission to the National Academies Study Committee
- Mission-Relevant Legislative Landscape Slide Deck

Racial Equity in Public Health Commission

Executive Director: Pareesa Charmchi Goodwin
Co-Chair: Claudio Gualtieri, OPM Undersecretary for Health and Human Services
Co-Chair: Dr. Tekisha Dwan Everette, Executive Director, Health Equity Solution

Regular Commission Meeting Minutes

Monday, July 25th
9:00 AM-10:00 AM
Via Teams

Members Present: Co-Chair Claudio Gualtieri, Co-Chair Tekisha Everette, Talitha Coggins for Astread Ferron Poole, Carline Charmelus, Chavon Hamilton, Heather Aaron, Hilda Santiago, Chlo-Anne Bobrowski for John Frassinelli, Annie Decker for Katie Dykes, Kean Zimmerman, Tina Hyde for Kim Martone, Kyle Abercrombie, Leonard Jahad, Melissa Santos, Steven Hernandez, Tammy Hendricks, Vanessa Dorantes

Guest Present: Executive Director for the Commission Pareesa Charmchi Goodwin

Members Absent: Craig Burns, Diana Reyes, Jonathan Steinberg, Kenyatta Muzzani, Marina Marmolejo, Mary Daughtery Abrams, Tiffany Donelson, Travis Simms

Opening remarks from the Co-Chairs

Everette called the meeting to order at 9:04 AM. Attendance was taken as members signed onto Teams, so roll call was not taken. Gualtieri noted that Acting Executive Director Kim Martone would now represent OHS on the Commission.

Public Comment

Dorantes spoke about the newly established 988 crisis hotline that replaced the ten digit, nationwide suicide hotline number. She noted a recent article in the Chicago Tribune titled "Mistrust Hinders Mental Health Line". The article indicated there are some communities of color that are leery of this new hotline/system. She stated the Commission could play a critical role in highlighting parity between mental and physical health; enlisting credible messengers in disseminating information about mental health resources; and thinking about a 9-1-1/law enforcement response in cases of mental health emergencies. Everette and Gualtieri voiced appreciation for her remarks and noted that these immediate action steps align with the Commission's goals and legislation (HB 5001/SB 1, SB 2) passed this year. Dorantes provided the link to the article.

Meeting Minutes Approval

A motion was made by Abercrombie and seconded by Charmelus to approve meeting minutes from the Commission's Fourth Regular Meeting that was held on May 23rd. The motion passed unanimously on a voice vote.

Updates from the Executive Director

Charmchi Goodwin provided the following updates on her first month in the role of Executive Director:

- The statutorily required, biannual report on commission activity was submitted to the Appropriations and Public Health Committees on June 29th. The report covered commission activities occurring between January 2022 and June 2022, along with updates on the strategic planning effort and subcommittee reports.
- Meetings with commission members and stakeholders to discuss their efforts thus far and vision for the commission have occurred and continue to be ongoing.
- Strategic planning will begin later this summer/early fall. The plan will include both long-term visioning and immediate action items.
- Job postings for an Executive Assistant and Commission Analyst will be shared on various websites (LinkedIn Idealist, Government Jobs, etc.) and circulated among commission members. If they know individuals interested in these roles, they should encourage them to apply.

There were no questions for the Executive Director.

Subcommittee Updates

Criminal Justice

Since the May 23 Commission on Racial Equity in Public Health (CREPH) meeting, the Criminal Justice Subcommittee ("the subcommittee") met three times.

First, on June 9, Dr. Danielle Cooper and Erika Nowakowski from The University of New Haven Tow Youth Justice Institute ("Tow") provided an overview of the Juvenile Justice Policy Oversight Committee (JJPOC), which was established by Public Act 14-217. The JJPOC, which receives staff support from Tow, oversees continued reform of and improvements to the juvenile justice system. Included among its charges is analyzing disproportionate minority contact across the juvenile justice system. Updates to JJPOC's 2019 strategic plan includes the goal of reducing racial and ethnic disparities in Connecticut's juvenile justice system. JJPOC includes the Racial and Ethnic Disparities Work Group (RED Work Group), which is co-chaired by Dr. Derrick Gordon and Hector Glynn. The RED Work Group produces recommendations annually and carries out analysis throughout the year as part of the JJPOC. More broadly, the JJPOC produces a wide array of racial and ethnic disparity data analyses as well as recommendations addressing disparity in the juvenile justice system. As the CREPH sets up its work, the JJPOC will be an important partner. Dr. Cooper and Ms. Nowakowski indicated a strong willingness to support the CREPH's work involving juvenile justice.

Second, on June 23, staff from the YWCA Hartford Region delivered a presentation regarding *An Act Requiring the Development of a Plan Concerning the Delivery of Health Care and Mental Health Care Services to Inmates of Correctional Institutions* (Public Act 22-133). A coalition of organizations and individuals worked on the effort, which involved the introduction of the above legislation during the 2022 session of the Connecticut General Assembly. The public act requires the Department of Correction commissioner to release, by February 1, 2023, to the Public Health Committee a report containing a plan regarding health care service delivery to people housed in correctional institutions. The report covers mental health, substance use disorder, and dental care services and will, pursuant to the statutes, follow several guidelines and contain recommendations. The plan likely will contain analysis, recommendations, and other content that will be informative to the CREPH's ongoing and future work.

Third, on July 7, staff from the Office of Policy and Management Criminal Justice Policy and Planning Division (OPM CJPPD) delivered a presentation to the subcommittee containing an update on the Equity Dashboard, a JJPOC project that was recommended by IOYouth Task Force. The dashboard will use juvenile justice administrative and publicly available data to monitor and compare system involvement for youth of different races and ethnicities. Within the JJPOC, the dashboard will inform the RED Work Group's efforts to inform ongoing system improvements. OPM CJPPD staff updated the subcommittee on the dashboard design and technical implementation. While OPM is expected to host the dashboard on

its website, the technical implementation is a collaborative effort among the Connecticut Judicial Branch, which administers most parts of the juvenile justice and therefore manages most of the data, and the OPM Data and Policy Analytics Unit. Moreover, the JJPOC is coordinating the ongoing implementation work on the dashboard. When the dashboard is completed, it will provide valuable analysis and information to the CREPH.

The subcommittee expects to receive one more presentation – from The Transitions Clinic, a primary care clinic for individuals recently released from prison and jail who are living with chronic health conditions as well as substance use disorder — that is in the process of being scheduled.

The subcommittee expects to concentrate its remaining work on developing:

(1) A summary of the subcommittee's meetings and presentations,

(2) A list of data sources and publications involving disparities in the juvenile and criminal justice systems discussed within the subcommittee, and

(3) Recommendations of priorities to include in the CREPH's strategic plan.

Public Health

The Public Health Subcommittee has determined their metrics. The first metric they plan to research further is access, both financial and logistical. They plan to hear from Access Health, OHS, DSS and Community Health Network of CT on this topic in the coming months.

Structural Racism in State Hiring

The Structural Racism in State Hiring Subcommittee will be meeting soon. One of their immediate focuses is to engage with DAS as they undertake a new equity study.

Zoning

The Zoning Subcommittee has been meeting regularly and inviting guest presenters to learn more about their efforts in the housing and zoning fields. They recently met with the CT Housing Finance Authority, will be meeting with Desegregate CT at their next meeting, and plan to meet with the COGS and a UConn Professor focused on environmental health later this summer.

Updates from the Co-Chairs

Everette shared that she is departing Health Equity Solutions (HES)for another job opportunity out of state. She thanked members for their service and commitment to the Commission. HES Deputy Director Ayesha Clarke will be stepping in as the co-chair.

Good of the Order

There was no Good of the Order.

Next Steps & Adjournment

Everette adjourned the meeting at 9:39 AM.

Racial Equity in Public Health Commission

Executive Director: Pareesa Charmchi Goodwin
Co-Chair: Claudio Gualtieri, Undersecretary for Health and Human Services, OPM
Co-Chair: Ayesha Clarke, Interim Executive Director, Health Equity Solutions

Regular Commission Meeting Minutes

Thursday, October 20th, 2022
4:00 PM-5:30 PM
165 Capitol Avenue, Hartford

Members Present: Co-Chair Ayesha Clarke, Co-Chair Claudio Gualtieri, Melissa Santos, Hilda Santiago, Heather Aaron, Jodi Hill-Lilly (for Vanessa Dorantes, DCF), Astread Ferron-Poole, Kyle Abercrombie, John Frassinelli, Marina Marmolejo, Laura Morris, Eulalia Garcia (for Craig Burns, DOC), Annie Decker (for Katie Dykes, DEEP), Leonard Jahad, Tiffany Donelson, Steven Hernández

Guest Presenters & Commission Staff Present: Mark Abraham, Dr. William Clark, Scott Gaul, Pareesa Charmchi Goodwin, Muna Abbas, Gretchen Marin

Members Absent: Chavon Hamilton-Burgess, Kenyatta Muzzani, Carline Charmelus, Mary Daughtery Abrams, Jonathan Steinberg, Travis Simms, Kean Zimmerman, Diana Reyes, Tammy Hendricks

Opening Remarks from the Co-Chairs
Gualtieri called the meeting to order at 4:18 PM and welcomed Commission members and the public.

Meeting Minutes Approval
Approval of the July meeting minutes was tabled for the next meeting.

Public Comments
Gabriel Fallas from UNITE US discussed the importance of perspective on strategy, with a focus on data. He recommends the Commission keep the following in mind as they move forward with their mission: How are health and healthcare tracked? How is "disparity" being defined? Importance of socioeconomic and non-socioeconomic data. Establishment of data reporting measurements. Health outcomes can be measured. Recommends use of CDC data, specifically "Healthy Days" and other CDC data.

Introductions

New Commission Members
Laura Morris- Office of Health Strategy
Ayesha Clarke- Interim Executive Director, Equity Solutions and CREPH Co-chair

Eulalia Garcia- District Administrator, DOC. DA Garcia will be taking the place of Dr. Craig Burns as he transitions roles.

New Commission Staff

Pareesa Charmchi Goodwin introduces two new staff members:

- Muna Abbas-Associate Commission Analyst
- Gretchen Marin-Commission Analyst

Guest Presentations

Charmchi Goodwin introduced presenters and guests:

- Mark Abraham, Executive Director of DataHaven presented on equity-focused data in CT.
- Scott Gaul, Chief Data Officer, OPM was in attendance to offer his expertise on type of data collected by the state and how to collect it.
- Dr. William Clark, Consultant & Principal at Eli Patrick & Co. designed the interactive metrics and recommendations assessment tool for use at today's meeting.

Mark Abraham- DataHaven

DataHaven is a non-profit with 30-year history of public service to CT. Data they make available comes from federal, state, and local sources. DataHaven has conducted thousands of structured interviews with randomly selected adults in CT.

Abraham presented on the importance of the disaggregation of data. Disaggregating data helps to contextualize the data. Discussed how the disaggregation of data can paint a very different, and more accurate, picture.

Dr. William Clark

Introduced an interactive metric tool designed to help the subcommittees refine their goals and narrow down the metrics they will use to measure these goals. Clark explained that data is simply a tool used to tell a story. Take complex data sets. What story are you telling? Who are you telling the story to? Why are you doing it? What's the bottom line?

Subcommittee Breakout Rooms

The Commission members separated into their subcommittee groups to discuss, affirm, or make further recommendation to metrics the Commission will regularly report. The Structural Racism subcommittee instead reviewed and discussed a set of proposals regarding state hiring practices, in service of the Commission's duties described in Section 4 of Public Act 21-35. Dr. Clark facilitated the Structural Racism subcommittee conversation.

Abraham, Gaul, Clarke, Gualtieri, and Charmchi Goodwin floated from subcommittee to subcommittee to lend their expertise.

Good of the Order

There were no comments from members.

Next Steps
CREPH staff will synthesize the subcommittee responses and reflections and share it with the membership and the public. CREPH Co-Chairs and Executive Director will schedule the next meeting and circulate the date and information with the membership and the public.

Adjournment
Gualtieri adjourned the meeting at 5:35 PM.

Full Commission Meeting

COMMISSION ON RACIAL EQUITY IN PUBLIC HEALTH

DECEMBER 12, 2022 | LEGISLATIVE OFFICE BUILDING

Organizational Overview

Sub-committees

- **Regular meetings**
- **Presentations from stakeholders**
- **Knowledge sharing**
- **Policy analysis**

Legislative Landscape 2023

JANUARY 4, 2023 – JUNE 7, 2023

Health and Wellbeing

- Sustainable reimbursement of community health workers
- Doula certification and reimbursement
- Expanding Husky for immigrants, regardless of age and status
- Strengthening protections around medical debt
- Licensing for dental therapists and removing unnecessary barriers to the field
- Strengthening workforce pipelines and addressing healthcare worker shortages
- Increasing services covered by Medicaid
- Healthcare affordability

Housing, Environment, and Communities

- Continued efforts to review and reform 8-30g
- Transit oriented communities
- Fair share housing
- Environmental justice considerations in permit applications
- Tenant's rights and protections
- Home energy labelling – affordability for home buyers
- Disclosure of ownership of real property
- Housing for aging communities and formerly incarcerated individuals

Criminal Justice

- Prosecutorial accountability
- Eliminating deceptive interrogation practices by police
- Bail bond reform
- Raising the minimum age of juvenile court jurisdiction
- Alternatives to arrest
- Enhancing youth re-entry into society practices
- Measures to tackle community violence interruption and intervention

Education and Economic Security

- Investment, availability, and affordability of early childcare
- Facilitation for creation of home family childcare homes
- Child tax credit rebate
- Fair work week schedules
- Paid sick leave
- Tackling high school expulsion and suspension rates
- Indoor air quality in schools
- Teacher recruitment, retention, and mentoring
- Reforming school assessments

Structural Racism and Civil Rights

- Adoption of state workforce and retiring employees taskforce recommendations to diversify hiring in the state work force
- Monitoring the implementation of race, ethnicity, and language (REL) data collection
- Early voting bill

Questions and Comments

COMMISSION ON RACIAL EQUITY IN PUBLIC HEALTH

CONNECTICUT GENERAL ASSEMBLY

Co-Chairs: Claudio Gualtieri, Undersecretary for Health and Human Services & Ayesha Clarke, Interim Executive Director, Health Equity Solutions

2023 Full Commission Meeting Schedule

4th Mondays of Even Months*
12:30 PM – 1:30 PM

Legislative Office Building, 300 Capitol Ave, Hartford, CT 06106
Ground Floor Hearing Room, 1D (Subject to Change)

February 27th
April 24th
June 26th
August 28th
October 23rd
December 18th *

(one week earlier due to Holiday)

COMMISSION ON RACIAL EQUITY IN PUBLIC HEALTH

CONNECTICUT GENERAL ASSEMBLY

September 30, 2022

Dear National Academies Study Committee,

The Commission on Racial Equity in Public Health, a newly formed Commission within the Connecticut General Assembly (Section 2, Public Act 21-35), applauds the National Academies efforts to analyze federal policies and make recommendations to further racial and ethnic health equity. The Commission is charged with providing analysis and recommendations regarding policies to advance racial equity in public health, including the social drivers of health (e.g., education, housing, environmental justice, criminal justice, etc.). I am writing in my capacity as Executive Director of the Commission to offer recommendations on two areas we believe would have a positive impact and are ripe for further action: data and workforce.

Data:

Disaggregated race, ethnicity, and language data is essential to 1) identifying and tracking disparities and 2) informing policy and programmatic priorities and solutions to address inequities.

Section 11 of Public Act 21-35 calls for state agencies and health providers participating in the State-wide Health Information Exchange to collect racial, ethnic, and language (REL) data in a manner which allows for aggregation and disaggregation, greater specificity, self-identification, selection of multiple races and/or ethnicities, a write-in option, and a refusal option. These new, more granular and informative state-level standards must also link or roll-up to the Office of Management and Budget (OMB) racial and ethnic categories. Linking state and federal racial and

ethnic categories are necessary for public health research and assistance program enrollment and reporting. But this comes with challenges. One such challenge is how to reflect racial/ethnic data of people who identify as multiple races and/or ethnicities, as this does not align with the OMB minimum categories.

Federal guidance regarding the alignment of more granular state-level categories would benefit the implementation and accuracy of REL data by states and other programmatically involved systems. Additionally, an examination of and discussion about updating federal categories to allow more specificity and selection of multiple races/ethnicities could benefit REL data efforts nationally. However, even if the OMB categories were expanded, it is likely states would benefit from the ability to create their own additional categories as state demographics vary and categories need to be informed by sample size.

Workforce Development:

Section 5 of Public Act 21-35 calls for the study of recruitment and retention of a racially and ethnically diverse health care workforce. The Connecticut Department of Public Health and Office of Policy and Management co-chaired the working group tasked with studying the issue and making recommendations to the legislature. The report, attached to this letter, provides 1) an overview of the importance of a racially diverse and representative workforce among healthcare staff and decision-makers within the health system, 2) commentary on the financial barriers to diversifying the healthcare workforce mainly related to education expenses and debt, and 3) recommendations for diversifying the healthcare workforce and delivering culturally and linguistically appropriate care. The recommendations in the report focus on the nursing workforce and community health workers (CHWs).

<u>Nurses:</u>

Nurses have expertise and involvement across all health settings and the nurse-patient relationship is key for addressing the needs of the patient as nurses have a high-level of patient interaction. Economic barriers to education and training are a key factor to mediate in creating a representative

workforce. The recommendations outline strategies to eliminate or mediate education cost barriers and strategies to recruit prospective nursing students from cities with a high Social Vulnerability Index score.

Community Health Workers:

Community Health Worker (CHW) is an umbrella term for frontline public health workers who are often members of and have shared experiences, language, and culture with the communities they serve. The CHW recommendations center around further integration of community health workers in health settings and sustainable financing.

Please refer to the attached report for more information on the CHW and nursing recommendations.

Oral Health Workforce:

In addition to the important focus on nurses and CHWs, we would like to raise attention to the developing dental therapy (DT) workforce and opportunity to expand access and culturally and linguistically appropriate dental care. Dental therapists (DTs) are analogous to physician assistants in the oral health field. They are licensed providers that can work in traditional or alternative settings to deliver routine preventive care and treatment. This profession was forged by community leaders to address chronic dentist shortages and develop consistent access to trusted oral health providers. DT in the United States is currently debated and authorized on State or Tribal levels. There are growing inconsistencies in state definitions that could complicate and hinder DT workforce development. Experts have drafted model legislative language and rules, which should inform future state policies and any potential Federal action on this issue.

Federal funding for oral health workforce development would allow various states and communities to begin or scale up education and employment of DTs or deploy other strategies to develop and retain an adequate workforce. Congress established a grant program, Section 340G-1 of the Public Health Service Act, to fund oral health workforce initiatives in 2010. Unfortunately, Congress continues to include appropriations language which prohibits funding to this program.

We recommend Congress eliminate this funding ban. The oral health workforce grants program would allow areas of the country with dental provider shortages the funding and opportunity to implement workforce strategies that advance access and equity.

Thank you for the opportunity to comment. Please do not hesitate to contact the Commission with any questions. We welcome any further communication.

/s/Pareesa Charmchi Goodwin
Pareesa Charmchi Goodwin, MPH
Executive Director

Pareesa.CharmchiGoodwin@cga.ct.gov

February 1st, 2022

Report of the Working Group Studying
the Development and Implementation of a Recruitment and Retention Program for
Health Care Workers People of Color in Connecticut

TO: Chairs and Ranking members of the Public Health Committee, Senator Abrams and Representative Steinberg; Senator Hwang, Senator Somers, and Representative Petit; and Distinguished Members of the Public Health Committee

FROM: Commissioner Manisha Juthani, MD
Co-Chairs Heather Aaron, Deputy Commissioner and Claudio Gualtieri, Undersecretary

In accordance with **Section 5** of **Public Act 21-35**, we hereby submit to the Public Health Committee the report and recommendations of the working group tasked with studying the development and implementation of a recruitment and retention program for health care workers in the state who are people of color. The working group hopes the committee will give these recommendations strong consideration as a basis for legislation in the 2022 Legislative Session.

c: Michael Jefferson, Clerk of the Senate
Frederick Jortner, Clerk of the House
Office of Legislative Research
Legislative Library
State Library

TABLE OF CONTENTS

Introduction to Public Act 21-35

In 2021, the Legislature enacted Public Act (PA) 21-35, *An Act Equalizing Comprehensive Access to Mental, Behavioral and Physical Health Care in Response to The Pandemic,* with bipartisan support. The overarching goals of PA 21-35 are to equalize comprehensive access to mental, behavioral, and physical health care in response to the pandemic. Section 5 of the Act established a working group that was charged with studying the development and implementation of a recruitment and retention program for health care workers in the state who are people of color. The Department of Public Health was tasked with leading the study with a report due to the Legislature's Public Health Committee by February 1, 2022.

Also created in PA 21-35, under Section 2, was the Commission on Racial Equity in Public Health. The legislation prescribed seven focus areas for the commission to study and then biannually report on to the Legislature:

- Structural racism in the state's laws and regulations impacting public health, where "structural racism" means a system that structures opportunity and assigns value in a way that disproportionally and negatively impacts Black, Indigenous, Latino or Asian people or other people of color.
- Racial disparities in the state's criminal justice system and its impact on the health and well-being of individuals and families, including overall health outcomes and rates of depression, suicide, substance use disorder and chronic disease.
- Racial disparities in access to the resources necessary for healthy living, including, but not limited to, access to adequate fresh food and physical activity, public safety, and the decrease of pollution in communities.
- Racial disparities in health outcomes.
- The impact of zoning restrictions on the creation of housing disparities and such disparities' impact on public health.
- Racial disparities in state hiring and contracting processes.
- Any suggestions to reduce the impact of the public health crisis of racism within the vulnerable populations.

After the Commission's first meeting, it was evident that their areas of expertise intersected with the working group's assignment: To develop a plan to eliminate work silos and collectively address the issues around recruiting and retaining people of color in the healthcare workforce. Members of the working group included a cross-section of stakeholders, hospitals and other health care institutions, health professional associations, workforce experts, consumer advocates, state agency representatives and policy leaders (Representative Jonathan Steinberg, Senator Mary Abrams, Representative Hilda Santiago, and Representative Travis Simms). A full list of participants can be found at the end of the report.

This report represents a collective effort of individuals from the Commission, working group, and public and private sector stakeholders to share new methods and ideas surrounding the recruitment and retention of healthcare workers of color. Working together has ensured that a broad swath of expertise and experience has been present to vet and consider what is contained in this report.

Diversity in Context

Diversity in the Workplace

The lack of a representative workforce in our state stems from inequitable education, social, institutional, and economic policies imbedded in our daily lives and have permeated into the delivery of care, disproportionately impacting people of color. This report is the product of a great collaboration, reflecting the participation of many community sectors and organizations that have been leaders in the effort to diversify the health care workforce. We are determined to deliver recommendations that will lay the foundation for significant change.

To diversify the workforce, institutions and leaders must look at the barriers that inhibit people of color from being represented within health care and beyond. A 2019 Kaiser Family Foundation (KFF) survey indicated that, of the 18.9 million people working in various health care professions and settings, 60% were white and 40% were People of Color.[1] When broken down further, 16% were Black, 13% were Hispanic and 7% were Asian. While at face value this seems like a fine distribution, it is misleading because of the type of jobs within the workforce held by people of color are disproportionately lower paying. According to this survey, Black and Hispanic health care workers made up a relatively larger proportion of Aides and Personal Care Workers, as well making up a large share of Home Health Care Aides.

According to the U.S. Census Bureau, Connecticut has an estimated 72,255 Registered nurses (RN) and licensed practical nurses (LPN) working in the various health settings throughout the state. Of this workforce, approximately, 56,142 are white, 7,092 are Black, 3,454 are Latinx, 3,357 are Asian, 907 are multiracial, 137 are Pacific Islander, 104 are American Indians and 1,062 are of other racial backgrounds not listed. This means that in CT, 78% of Registered Nurses and License Practical nurses are white, while about 22% are People of Color.[2] We believe that the COVID-19 pandemic may have decreased the totals due to combat fatigue which may have deepened the equity divide.

Diversity in Decision Making in the Workplace

The lack of People of Color in decision-making roles in health care increases community distrust with the health care system and highlights the need for community targeted health equity initiatives. A 2020 poll by KFF suggests that most Black People have low levels of trust in the health care system and how the system would care for them. According to a KFF survey in partnership with ESPN's The Undefeated, seven of ten Black People say the health care system treats people unfairly based on race, a notable increase from 56%, when a similar question was asked in a 1999 poll. In 1999, about 4 out of 10 People of Color stated that they thought the health care system treated people unfairly based on race, while in 2020, 7 out of 10 Black People felt the same exact way. The results demonstrate that the level of community distrust in communities of color is significant.[3]

[1] Artiga, S., Rae, M., Pham, O., Hamel, L., & Munana, C. (2020, November 11). COVID-19 Risks and Impacts Among Health Care Workers by Race/Ethnicity. (Accessed here)

[2] Proto, M. B. (2019, April). CTS Statewide Nursing Supply Report—CCNW. Insights into Connecticut Nursing and Health care Workforce. (Accessed here)

[3] Washington, J. (2020, October 13). New poll shows Black Americans put far less trust in doctors and hospitals than white people. (Access here)

Diversity in Physician Care

In terms of healthcare-related outcomes, diversity of physician care has demonstrated considerable benefits at the community level and also on the national landscape. Racial and ethnic minority health care clinicians are significantly more likely than their white peers to serve minority and medically underserved communities, thereby helping to improve problems of limited minority access to care. Additionally, minority patients were four times more likely than white patients to receive health care from nonwhite physicians. Medically indigent patients were also between 1.4 and 2.6 times more likely to receive care from minority physicians than were more affluent patients. Minority physicians' patients were more likely to report being in poor health, with more acute complaints, more chronic conditions, and greater functional limitation.[4]

Research cited from the Journal of American Medicine on the impact of physicians of color in the community discussed that relative to non-minority communities, minority neighborhoods tend to face shortages of physicians; yet physicians of color are disproportionately more likely to serve in these communities. Over half of the patients seen by Black and Hispanic physicians, on average, were members of these clinicians' racial or ethnic group. Within these pairings, racial and ethnic minority patients are generally more satisfied with the care that they receive from minority physicians. For example, Hispanic patients who received care from Hispanic physicians did not rate their doctors as significantly better than Hispanic patients with non-Hispanic health care clinicians, but patients with an ethnically concordant provider were more likely to be satisfied with their overall health care. Patients in race- and ethnic-concordant relationships, however, rated their visits as significantly more participatory than patients in race- and ethnic-discordant relationships.[5]

Additionally, a study conducted at Stanford University and the University of California found that Black men who received a health screening from a Black doctor received better care than those who received care from a white doctor. With a Black doctor, the men were 56% more likely to take a flu shot, 47% more likely to agree to a diabetes screening, and 72% more likely to agree to a cholesterol screening. [6]

Diversity Equity and Inclusion, Not Quotas

The Bloomberg Law article further states that "DEI (diversity, equity and inclusion) efforts are designed to increase the breadth of perspectives in the health care workforce by expanding opportunities for underrepresented groups." The work group strongly concurs with the importance of "the development and promotion of equitable systems and initiatives to make sure historically underrepresented populations feel welcome, and have equal access to career development opportunities."[7] It is important to note that efforts to make meaningful and substantive improvements to the number of underrepresented employees in the health care workforce should not encompass adopting quotas. Instead of targeting a fixed and/or mandated percentage of individuals in certain roles by a certain date based upon race or ethnicity, we recommend efforts geared towards setting people of color up for success at all stages of the process (educating, recruiting, training, developing, and retaining) to increase diversity.

It is not just a numbers game. We want to ensure that people are offered the adequate resources and opportunities, beginning from youth, to excel in the classroom, workforce, and community. We

[4] Moy E, Bartman BA. Physician race and care of minority and medically indigent patients. JAMA. 1995 May 17;273(19):1515-20. PMID: 7739078.

[5] (Cooper-Patrick L, Gallo JJ, Gonzales JJ, et al. Race, Gender, and Partnership in the Patient-Physician Relationship. *JAMA.* 1999;282(6):583–589. doi:10.1001/jama.282.6.583

[6] Diversity in Healthcare: How Increased Representation & CLAS Impacts Communities & Improves Care (edumed.org)

[7] W*orkplace diversity-getting it right with goals, not quotas*. news.bloomberglaw.com. (2020, November 10). (Accessed here).

recommend efforts also be geared towards removing barriers to career progression for certified nurse aides and licensed practical nurses through opportunities such as internships, scholarships, and mentorship programs.

Diversity in Language-Based Communications

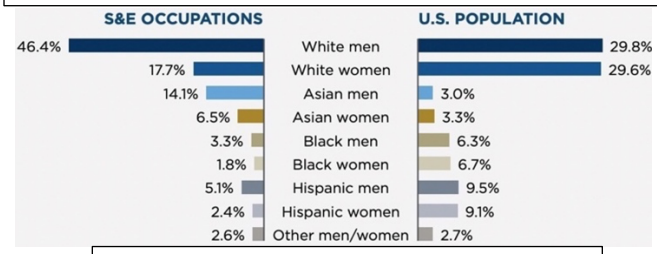
Health profession disciplines are grappling with the impact of major demographic changes in the United States population, including a rapid increase in the proportions of Americans who are nonwhite, who speak primary languages other than English, and who hold a diverse range of cultural values and beliefs regarding health and health care. According to a 2015 public health report, having a language-concordant physician was associated with better patient self-reported physical functioning, psychological well-being, health perceptions, and lower pain.[8]

Nearly one in five Spanish-speaking U.S. residents delayed or refused needed medical care because of language barriers. [9] Nearly 2 in 5 Latinos, 27 percent of Asian Americans, 23 percent of Black People, and 16 percent of whites reported communication problems with their doctor. Nearly half of Asian Americans and Pacific Islanders have problems with availability of mental health services because of limited English proficiency and lack of providers who have appropriate language skills. Minority physicians display better process-of-care behaviors with minority patients than nonminority clinicians.[10]

Diversity in the Sciences & Funding

The current rate of people of color employed in science-based occupations, shown in the following chart, is far below that of white people nationally.

Rates of employment in Science-Based Occupations



(2019 American Community Survey)

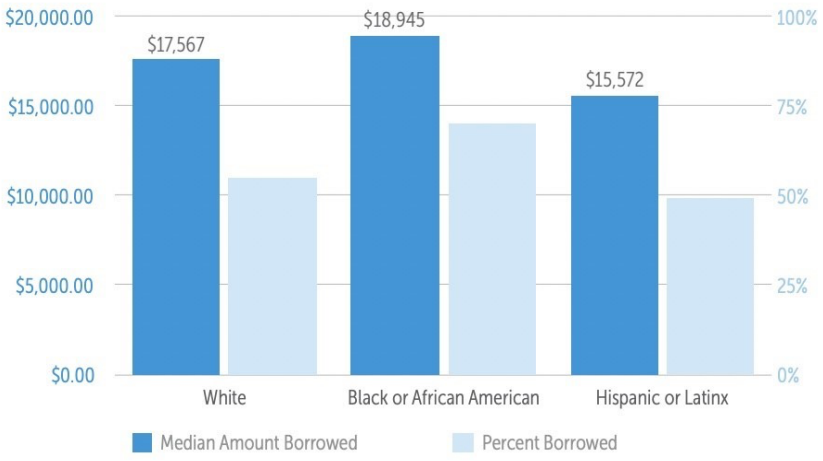
[8] Jih, J., Vittinghoff, E., & Fernandez, A. (2015). Patient-physician language concordance and use of preventive care services among limited English proficient Latinos and Asians. *Public health reports (Washington, D.C. : 1974)*, *130*(2), 134–142. https://doi.org/10.1177/003335491513000206

[9] National Academies of Sciences, Engineering, and Medicine; National Academy of Medicine; Committee on the Future of Nursing 2020–2030; Flaubert JL, Le Menestrel S, Williams DR, et al., editors. The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity. Washington (DC): National Academies Press (US); 2021 May 11. Summary

[10] Collins KS, Hughes DL, Doty MM, Ives BL, Edwards JN, Tenney, K. (1999) Diverse communities, common concerns: Assessing health care quality for minority Americans: findings from the Commonwealth Fund 2001 health care quality survey.

A key aspect behind this disparity is the financial ability to support attendance in these programs. The following chart shows the average amount of postsecondary student aid borrowed, by racial and ethnic group.

Postsecondary Student Aid Borrowed By Race/Ethnicity



[11]

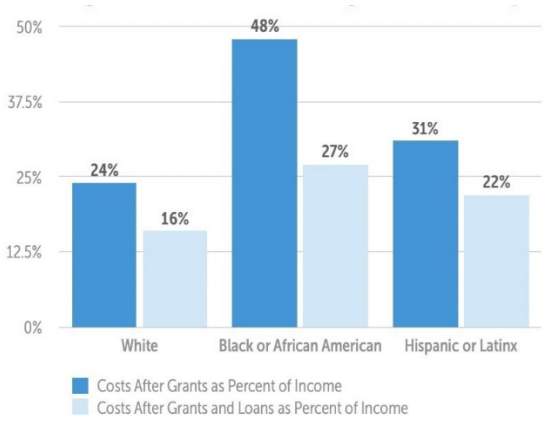
U.S. Department of Education, National Center for Education Statistics (2016)

College costs take up an average of 63 percent of Black Peoples' household income, controlled for the type and price of institutions they choose. For Hispanic families, their college costs make up 53 percent of their household income. Whereas for white families, college costs make up about 44 percent of their household income. As a result, minority households are forced to spend a far larger portion of their total income on postsecondary education. For example, Black households come to the table with lower incomes to pay for college, and so we see that they are more likely to rely on loans at higher rates per the U.S. Department of Education, National Center for Education Statistics, which reports that 70 percent of Black families take out student loans. In other words, Black students are 26 percent more likely than white students (55 percent of whom borrow) to take out student loans.[10]

[11] Anderson, John MM, and Gilda Barabino. "Making Visible the Invisible." *The Committee on Equal Opportunities in Science and Engineering*, National Science Foundation, 13 Feb. 2019, https://www.nsf.gov/od/oia/activities/ceose/reports/2019-2020-ceose-biennial-report-508.pdf.

[10] The Institute of College Access and Success, "Impact of House and Senate Budget Proposals to Freeze The Maximum Pell Grant for 10 Years: Making College Even Less Affordable", (Washington D.C., 2015), accessed May 18, 2015, http://ticas.org/blog/impacthouse-and-senate-budget-proposals-freeze-maximum-pell-grant-10-years-making-college-even

Percentage of Income Towards Post-Secondary Education



U.S. Department of Education, National Center for Education Statistics (2016)

Even with student loans, which are paid back with interest, Black and Hispanic families still must dedicate a larger percentage of their income to college than white households. Further, Black families make up more of the cost of college with loan debt than other families. Even after subtracting all grants and loans, Black and Hispanic families dedicate 22 and 27 percent of their income, respectively, compared to only 16 percent for white families.[11]

Diversity in Nursing Staffing

After reviewing data underlining the urgency to increase the nursing workforce, it was clear that action on nursing recruitment needed to be a priority for both the primary care and behavioral health care arenas. However, we must focus on sustainable recruitment and recognize the need to change the community of care for nursing professionals of color. Structural barriers to people of color in the health care workforce are driven by socioeconomic and implicit bias that causes emotional distress and distrust among employees and the patients they serve. The following narrative will focus on the nursing profession specifically because of the shortage of LPN's and RN's, a shortage that has become progressively more impactful as the pandemic has continued. By using subtle impressions of concern for their performance, nurses of color are often questioned and addressed in a manner that indirectly suggests that they are delivering inferior care without the negative assessment being explicitly stated. This in certain work environments evokes a constant concern to justify the work that they are doing, which can create an unhealthy and hostile working environment.

Diversify the Nursing Workforce

Nurses are instrumental and serve as key contributors to making progress towards health equity in the U.S. "Nurses from diverse racial, ethnic and socioeconomic backgrounds are more likely to work with diverse, underserved communities and provide culturally tailored care."[12] Using a person-centered approach, which focuses on embracing personal choice and autonomy, nurses have the capability to provide personalized care by collaborating with patient and other care teams to address physical, mental, and social needs of the patient. This personal approach reduces the anxiety and distrust that a patient may have during their health care experience. Further, when this approach is utilized by a nurse

[11] 2 Young Invincibles calculations, The College Board, "Trends in College Pricing", Table 2a, http://trends.collegeboard.org/college-pricing/figures-tables/tuition-fees-roomboard-time-1974-75-2014-15-selected-years, accessed May 12, 2015.

[12] Wakefield, M. K., Williams, D. R., Le Menstrele, S., & Flaubert, J. L. (2021). *The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity.* Washington (DC): National Academies Press (U.S.).

of color when treating a patient of color a rapport can be made, thus enabling the patient to enter into a community of familiarity with their health care team(s).

This approach would enable health care teams to meet the needs of these vulnerable communities, respect their beliefs and values, promote anti-discriminatory care, and bring attention to such issues as race, ethnicity, gender, sexual identity, religion, age, socioeconomic status, and differing ability status, thus providing culturally competent and sensitive care. Person-centered care focuses not only on the individual but also on families and caregivers, as well as prevention and health promotion. Integrating person-centered care that improves patient health literacy is necessary to ensure patient empowerment and engagement and maximize health outcomes. Health literacy ensures that "patients know what they must do after all health care encounters to self-manage their health." [15]

Diversity Training in Cultural Humility

In the recruitment and retention of health care workers of color, it is important that racial equity and diversity trainings occur. These trainings should focus on helping these workers develop and adopt cultural humility in their work. "Cultural humility" is defined as flexibility; awareness of bias; a lifelong, learning-oriented approach to working with diversity; and a recognition of the role of power in health care interactions.[13] This humility allows nurses to participate in more respectful partnerships with the patients. Without this, a nurse will not recognize how their implicit bias can negatively impact patient interactions and health outcomes through the quality of care they give. These trainings must follow the sometimes-specific needs that are unique to patients of color and overcome the cultural and linguistic barriers that cause disparities in care. "When nurses are educated and empowered to act at multiple levels it helps to reduce the effects of structural inequities generated by the health care system."[14]

Short-Term Recommendations for Nursing Recruitment & Retention

The recommendations provided cover a cross-section of agency expertise and purview. Therefore, implementation will require ongoing collaboration across multiple state entities, legislators, stakeholders, and community partners. The following recommendations are made with respect to diversifying the nursing workforce:

a) Online Associate Degree in Nursing (ADN) programs have the infrastructure and capacity to educate Licensed Practical Nurses (LPN) quickly and cost-effectively, offering an affordable option to proprietary programs. However, there is also a need to modernize outdated LPN education regulations to align with nursing education in other states, such as New Jersey. By offering an LPN certification option for nursing students who complete one year of an accredited program, students could then function as LPNs, earning higher wages and potentially working fewer hours, and employers could onboard them and benefit from their employment. In addition, this could assist nursing students who may not be able to complete their RN education for some reason.

b) Attract students into nursing by relieving their financial burden.

c) Market, recruit, and prepare a diverse candidate pool for in-demand roles and practice settings. Tuition repayment programs may be offered to work in high-need areas over time, usually 2-3 years, to improve retention and reduce the cost to employers associated with staff attrition.

[15]Hook, J. N., Davis, D., Owen, J., & DeBlaere, C. (2017). *Cultural humility: Engaging diverse identities in therapy.* American Psychological Association. https://doi.org/10.1037/0000037-000

[14] Wakefield, M. K., Williams, D. R., Le Menstrele, S., & Flaubert, J. L. (2021). The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity. Washington (DC): National Academies Press (U.S.).

d) Deliberate focus on the top ten Social Vulnerability Index (SVI) cities and high school students in these communities. Develop an intense monthly program on career building for nurses. Work with high schools in high SVI communities to develop credit programs that can be used to accelerate completion of nursing programs. The students should complete all coursework in theory in high school as extra credit and, upon graduation, begin clinical rotations. The high school would develop memoranda of understanding (MOU) with nursing schools, with the state sharing responsibility for tuition reimbursement with the nurse's employer. The resulting educational cost savings to the nurse would act as a strong impetus to recruitment and retention.

e) There is an opportunity to apply for additional Centers for Disease funding (CDC) announced in November 2021. The grant will extend $240 Million to Expand Public Health Workforce by Creating Pipeline Program for 13,000 Community Health Workers and Paraprofessionals from Underserved Communities.

f) Adopt the Social Determinants of Learning framework used by Chamberlin University School of Nursing.

g) Encourage adoption of evidence-based Chamberlain University framework initiatives to bridge social barriers to learning by:[15]

    a. Focusing on holistic student admissions processes that evaluate factors beyond standardized test scores and grade point average (GPA), two factors that have shown to contribute to bias and discrimination.

    b. Adopting practices using personalized and data-driven approaches to assess student potential and outcomes.

    c. Emphasizing student success and mindfulness through personalized learning approaches, which encourage strong student outcomes. Pre-licensure Bachelor of Science in Nursing graduates experienced nearly a 13% increase in the National Council of Examination for Registered Nurses pass rates from 2016 to 2020, and in 2020 the rates were above the national average.

    d. Prioritizing mental health. Racial and ethnic minority students often battle with feelings of discomfort, unbelonging, anxiety, and overall stress. To support student psychological health and manage stressors that can be a barrier to student progress, Chamberlain's pre-licensure BSN program integrated an eight-week program to aid students through these feelings. More than 60 percent of participating students reported a reduction in stress levels.

h) Incorporate evidence-based strategies from Frontier Nursing University:
    a. Frontier Nursing University, located in Versailles, Kentucky, has taken a similar approach and tripled its student of color population from 9 percent to 28 percent in the last decade through its Diversity Impact Program.

[15] Davis, C. (2021, September 24). Chamberlain University launches framework to increase diversity in nursing. Health Leaders Media. (Accessed here)

b. This has provided more instances of shared racial identity between healthcare providers and patients. Frontier representatives attended conferences such as the National Black Nurses Association and the National Association of Hispanic Nurses to ensure the inclusion or admission of students from diverse backgrounds and rural and underserved areas.

c. Frontier is not only focused on admitting diverse talent, but also providing them the necessary resources—such as mentoring, tutoring, and scholarships for students of color—to sustain them throughout the process and ensure they were able to successfully graduate.

Diversity with Community Health Workers

Strengthen Professional Pathways for Community Health Workers: Build a Comprehensive Community Health Workforce that is Part of an Integrated Care Delivery Team

A community health worker (CHW) is a frontline public health worker, who has a trusted relationship with members of a community and has a unique understanding of the experiences, language, culture, and socioeconomic needs of the community they serve.[16] A CHW serves as an intermediary between individuals, communities, and health and social services to enhance access to care, improve the quality and cultural responsiveness of service delivery, and tackle social determinants of health.[17] A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of culturally appropriate services such as: outreach and engagement; education, coaching, and informal counseling; social support; advocacy; care coordination, basic screenings and assessments; and research and evaluation.[18]

A recent examination, conducted for the New England Comparative Effectiveness Public Advisory Council, covered a plethora of studies, and focused on why community health workers are effective.[19] Of 32 studies that reported positive outcomes from CHW interventions, one of the key themes was CHWs sharing a background with patients. Of the successful interventions, 66% ensured that CHWs shared race or ethnicity characteristics with patients.[20]

The fact that CHWs are reflective of the communities they serve means they are effective at building trust with families. Trust-building is a critical component of their success. Most community health workers in Connecticut and nationally are people of color, particularly Black and Hispanic women. In 2012, Southwestern AHEC, Inc. surveyed 97 employers of CHWs in Connecticut and found that the majority of CHWs surveyed were Hispanic (60.5%), followed by non-Hispanic white (18.6%), and non-Hispanic Black (16.3%).[21] In another 2012 survey conducted by the same organization, a large portion of Connecticut community health workers identified working with specific populations including Hispanic People (23.3%)

[16] Community Health Workers Association of Connecticut and Connecticut Public Health Association definition. (Accessed here).
[17] *Id.*
[18] *Id.*
[19] Becker, A. (2019, March). *Understanding community health workers: Who they are and why they matter for Connecticut.* Connecticut Health Foundation. (Accessed here).
[20] *Id*.
[21] Alvisurez, J., Clopper, B., Felix, C., Gibson, C., & Harpe, J. (2012). *Community health workers: Connecticut.* Southwestern AHEC, Inc. swahec_survey_report_06172013.pdf (ct.gov)

and Black People (20.9%).[22] Additionally, 23.3% of CHWs targeted immigrants and 9.3% targeted migrant workers.[23]

In addition to their ethnic and racial diversity, CHWs are uniquely positioned to provide services because they can be rapidly trained and deployed in high-need areas.[24] But, without a cohesive and unified approach to the community health workforce, career pathways and economic opportunities within and beyond the profession will remain limited and fragmented. In Connecticut, there are over 180 community health workers who hold a CHW certification through the CT Department of Public Health (DPH). Certification, however, is not a requirement under Connecticut statutes to provide CHW duties. Therefore, many individuals throughout the state perform the duties of a CHW without the official certification through DPH.

To add to the complexity of the current landscape, CHWs are referred to by many different job titles in Connecticut. These include: outreach workers, patient navigators, peer advocates, family support workers, and community messengers. They are also employed by various organizations ranging from hospital systems and nonprofits to community-based organizations. Hospitals need patient navigators and CHWs to help manage complex cases, especially involving pregnant women who may require additional health services outside of maternity care such as mental health or intimate partner violence support. The disparate approach to CHWs creates a challenge in identifying and tracking all the individuals doing this work. Opportunities are also limited to clearly establish a CHW role with sustainable funding sources. Furthermore, the patchwork and grant-based approach to hiring and training can result in burnout and undermine long-term success or career development.

Short Term Recommendations for Community Health Workers

a) Use CHW grant program created and funded in the Budget Implementer (PA 21-2, Sections 36 and 37, June Special Session) to effectively integrate CHWs into the care delivery team and strengthen linkages with clinical provider organizations.

b) Provide information to CHWs on the profession, certification, continuing education requirements (CEUs) and courses available to help ensure CHWs are trained and appropriately certified through DPH. This will help build a strong foundation for sustainable payment models in the future.

c) Provide training and capacity building for CHWs, employers, champions, and community members.

d) Identify networking and professional development opportunities.

Diversity in Cross-Cutting Investments to Diversify the Health Care Workforce

Student Loan Repayment

Lengthy and often costly academic programs can be a barrier for individuals with fewer financial means to enter a health care field or pursue advanced education for higher level positions in the health care sector. To help address this barrier, the Budget Implementer (Public Act 21-2, June Special Session)

[22] *Id*.
[23] *Id*.
[24] Morgan, John and Vasan, Aditi. Community Health Worker Interventions: New Evidence of Effectiveness in Reducing Hospitalizations. University of Pennsylvania Leonard Davis Institute of Health Economics. July 25, 2020. (Accessed here).

allocated $1,000,000 over the biennium ($500,000 per fiscal year) to reinstate a student loan repayment in Connecticut.

That program, which is under development, will provide financial relief to health care providers serving patients in federally designated health care shortage areas. The benefits of this program are two-fold—first, the loan repayment program can make academic preparation for health care careers more financially feasible for historically underrepresented students of color and retain providers in underserved areas; and second, patients in high SVI communities will have better access to health care services when and where they need it.

Since enactment of the Budget Implementer, the federal Health Resources and Services Administration (HRSA) announced an enhanced and expanded grant program to support state student loan repayment programs. The purpose of this program is to make grants to states to assist them in operating their own state educational loan repayment programs for primary care providers working in Health Professional Shortage Areas within their state. The exact amount of the award that CT may receive cannot be determined in advance but would likely range from a minimum of $200,000 to a capped maximum of $1.0 million a year for four years (September 1, 2022, through August 31, 2026).

To maximize the impact of our student loan repayment and address the shortage of health care providers in both primary and behavioral health care, it is recommended that:

Short Term Recommendations for Cross-Cutting Strategies

a) The Department of Public Health (DPH) should apply for the HRSA grant program in the Spring 2022 and braid federal funding to enhance the state's loan repayment option.

b) Consideration of further investment of ARPA funds to expand the student loan repayment and expand access to behavioral health clinicians is encouraged.

c) Request and track race and ethnicity information in student loan applications as an optional field to ensure equitable distribution.

Federally Qualified Health Centers (FQHC)[25]

A federally qualified health center (FQHC) strives to help meet the needs of an underserved area or population. The FQHC provides primary outpatient services and opportunities for employment for the community, often while working to meet community initiatives. These services target health disparities and work to empower underserved areas with high-quality patient care.

An FQHC qualifies for enhanced reimbursement from the Health Resources and Services Administration (HRSA) under the Medicare and Medicaid programs. As a nonprofit and tax-exempt organization, an FQHC can receive grants from the government, the private sector, as well as private donations. Any patient care center can apply to become an FQHC if the health center meets specific requirements to receive funds from HRSA.

FQHC Requirements

HRSA supports addressing areas of need by providing funding to FQHCs to treat geographically isolated, economically, or medically vulnerable populations. To qualify as an FQHC, specific requirements must be met, which include: serving an underserved area or population; providing

[25] Research regarding FQHCs was taken from the Health Resources & Services Administration (HRSA) website. (Accessed here).

care on a sliding fee scale based on ability to pay; operating under a governing board of directors that includes patients; completing annual reporting requirements; providing holistic health and social services; having an ongoing quality assurance program; and not be concurrently approved as a rural health clinic. [26]

FQHC Services

FQHCs provide comprehensive services with a team-based approach to provide holistic patient care. Services are typically provided on site in an outpatient clinic and can include preventative health care, dental, mental health, and substance abuse treatment. If services are not available on site, they must have a connection to coordinate care with another provider. These may be for needs such as transportation services for patient care and specialty care or visiting nursing services for homebound patients in an area where there is a shortage of home health agencies.

The provision of FQHC services cannot occur in an inpatient or outpatient hospital or a facility that precludes FQHC visits.

FQHC Serving the Underserved

An FQHC strives to ensure underserved populations and areas are receiving holistic healthcare by working to address social determinants of health. The Affordable Care Act (ACA) has resulted in more patients being insured in the populations that many FQHCs serve. This has enabled many federally qualified health centers to grow their capacity. There are 10 FQHCs in Connecticut, listed below:

Health Center	**Year FQHC Status Received**
Cornell Scott Hill Health Center	1968
Community Health Services, Inc.	1989
Fair Haven Community Health Center, Inc.	1980
Southwest Community Health Center, Inc.	1976
StayWell Health Center, Inc.	1994
Community Health Center, Inc.	1989
Bridgeport Community Health Center, Inc. (Now known as Optimus Health Care, Inc.)	1990
Charter Oak Health Center, Inc.	1979

[27] Research regarding FQHCs was taken from the Health Resources & Services Administration (HRSA) website. (Accessed here).

Generations Family Health Center	1992
East Hartford Community Healthcare, Inc.	2002

Benefits of the FQHC

FQHCs are affordable: open to everyone, with sliding scale fees based on income and family size; appropriate: offering primary health, oral and mental health/substance abuse services, and preventive health care, as well as supportive services such as translation, transportation, case management, health education, and social services; accessible: providing services that include primary and preventive care, outreach, and dental care; such services must be available to all residents of their service areas to help ensure access to care and continuity of care; accountable: a community board, most of whose members are patients of the health center, is the governing body; and acceptable: meeting customer service expectations.[28]

Long Term Recommendations - Proposed for Request for Proposal (RFP)

a. Work with FQHCs to develop a matrix for an intentional push for diversity, equity and inclusion among providers working in their facilities.

b. Explore the opportunity to pilot a potential expansion of FQHC's hours of operations (evenings, weekends, 24/7) to improved health care access and expand clinical placement opportunities. An FQHC located in a high SVI community often serves as the primary care provider in that same community. Data has identified that when the FQHCs are not open, community residents turn to the hospital emergency room for care. The emergency room's primary responsibility is to serve patients having urgent care needs who may require hospital level care. Through expanded FQHC operating hours (up to 24 hours a day) the burden on hospital emergency rooms and inpatient resources could be reduced. FQHCs do not currently have mandated hours of operation.

c. Investigate the feasibility of nursing school rotation opportunities at the FQHCs during evening/night shifts to allow for low-income students to have an opportunity to complete a residency for their RN program.

d. Expand the FQHC's behavioral health services to pediatric and adolescent patients.

e. Explore opportunities to expand FQHCs and staff them with health care workers of color that are culturally sensitive to the community.

f. Consider tuition grant payment for health care students in LPN and RN course tracks with an obligation to work within the FQHC for 3 to 5 years.

[28] Research regarding FQHCs was taken from the Health Resources & Services Administration (HRSA) website. (Accessed here).

Summary

The committee has listened to the large cross section of stakeholders in developing short-term and long-term recommendations to address the recruitment and retention for people of color in health professional jobs in Connecticut. The data demonstrates the barriers that result in a lack of diversity because of micro and macro racism and the systemic implicit bias in our health care institutions' employment practices and the lack of viable opportunities for low-income families. We appreciate the legislature's interest in addressing these issues, and we look forward to continued support in your review of these recommendations.

Appendix

Community Members' Testimonies Taken by the DPH Equity Team in January 2022

Nurse Testimony

A CT-based RN, Claudine A., argued that the distrust is reflective on both the provider and patient sides but is confident that with more RNs of color in decision-making roles, many of the issues can be addressed. Claudine reported that as a Black nurse, she faced a lot of challenges when she chose to enter the health care field. However, she did not realize that she would be questioned on her knowledge and tested by both her colleagues and patients as often as she is.

Often, though she is knowledgeable about her patients and the care she can deliver within her scope of practice, she often faces scrutiny when administering medications and making care recommendations. She finds that she spends more time justifying her rationale to her patients and colleagues while her white counterparts with comparable experience are welcomed with open arms. As much as these interactions sadden her, she recognizes the value she brings to her work. Claudine stated, "For every 6 patients and colleagues that question me, I know and see that the other 6 patients and colleagues are excited to have an African American in their health care team. I plan on starting an APRN program as soon as my son is in kindergarten."

When asked why she chooses to stay in a field where she is not represented in upper management or in decision-making settings, she stated, "I will be a decision maker and I will make room for people who look like me. My children need to see that if Mommy can be an APRN or a Chief Nursing Officer, there is no table they cannot sit at. The only limit they will have will be the ones they place on themselves, not those placed on because of racial bias."

Patient Testimony

Victoria stated, "It is important to note that, without cultural competency and sensitivity, nurses may contribute to structural inequities in how they facilitate or hamper access to quality health care services since they are frequently the first point of contact for many individuals who need care. For example, when my family and I first immigrated to the U.S. from Ghana, West Africa, we faced cultural issues within the U.S. health system. My elementary school nurse at the time served as our primary care provider. This was due to our lack of insurance and other immigration factors. She would make a point of weighing my siblings and I every morning, to ensure that we were eating and meeting 'milestones' she never explained.

The school nurse questioned whether we were drinking our milk. When asked, the answer was a resounding No; she would get extremely frustrated, and one day she decided to confront my parents because of what she assumed was their 'inability to provide their children adequate sources of nutrition.' After all, without milk, we were not going to grow up to be big and strong. This created a moment of confusion to my parents for various and frankly obvious reasons.

Firstly, we were being fed nutritious meals. In fact, during that time, my father had dietary restrictions and as a precautionary and prevention measure, my mom modified his diet in a fashion that allowed all of us to eat the same foods and reduce our risk for having the same health problems as him. And secondly, coming from Ghana West Africa, it was not a cultural norm for us to drink milk. In fact, to this day, it is rare to find a gallon of whole milk in any supermarket. So, milk would have never been our diet, let alone be our beverage of choice.

Further, during our experimentation of American food, we all quickly found out what our lactose thresholds were. Nonetheless, my parents were angry, and they were justified. A nurse insinuated that they were not taking care of their children, and further, not only did she fail to refer to the lactose

sensitivity, but she failed to recognize that other cultures exist outside of the U.S. due to her implicit bias. It took years for my parents to find a health care provider that would see us as whole people with a diverse background, but we eventually found one who possessed the cultural humility to guide us through our health care experience."

A Local Health District Director's Testimony

What are some trends you have seen during your tenure as local health Director that you have identified that impact the barriers that CT residents face when accessing health care?

(D) reported that she noticed that over her years at various health departments, there is a need for health and policy reforms that are community specific. However, it is important to recognize that though these reforms are needed, communities who have often been neglected are hesitant to trust people who are outside of their community and lack the experience to have their best interests at heart. Sometimes making multiple touchpoints is necessary to glean information that may not be expressed in data about community struggles.

What are some ways in which your health departments were able to address these issues?

(D) emphasized the importance of community partnerships and community outreach efforts. Vulnerable populations are already at a socioeconomic status disadvantage, so it is important to meet them where they are. Recognizing this allows her team to understand that promoting health initiatives requires "boots on the ground" that reflects the community and can deliver information and resources in a manner that is easily understandable and accessible. Also, it is important to identify community outreach centers, agencies, libraries, churches, and congregation areas that those without access to technological services (i.e., Internet, phone services) can access to receive information in a digestible format. During the COVID-19 vaccine rollout, (D's) health department was able to educate, empower and encourage her communities to get vaccinated through the trusted partners and trusted messengers in the communities. Vaccine clinics that were hosted by trusted partners of the community showed higher vaccination rates than those without intervention by the health department and trusted messengers.

Trusted messengers place a key role in keeping vulnerable communities in touch with the latest initiatives that impact their lives. How can CT DPH form partnerships with these messengers and community health workers to promote health equity?

According to (D), community health workers and trusted messengers will often know more about the communities they serve than local health departments. The way in which the CT DPH can continue to form these partnerships is to develop opportunities for people of color to be invited to decision-making opportunities. If policies are established for communities of color by those who don't reflect the communities they serve, health inequities will continue to exist. Social and cultural behaviors specific to those communities that may be the solution to low vaccination rates, for example, would never be addressed. It is crucial that community health workers, trusted messengers, and public health officials, not only reflect the communities they serve, but are also supported by the CT DPH. This will inspire the communities to seek opportunities that allows them to be their self-advocates. Ultimately, you cannot expect people to advocate for themselves without illustrating that they will have the support and guidance to pursue it.

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- Senator Mary Abrams, Senate Chairperson of the Public Health Committee
- Representative Hilda Santiago, Black and Puerto Rican Caucus Member
- Representative Travis Simms, Black and Puerto Rican Caucus Member
- Tiffany Donelson, President and CEO - CT Health Foundation
- John Frassinelli, Division Director for the Bureau of Health, Nutrition, Family Services and Adult Education - State Department of Education
- Victoria Veltri, Executive Director - Office of Health Strategy
- Laura Morris, Director of Consumer Engagement - Office of Health Strategy
- Mary Kate Mason, Legislative Liaison - Department of Mental Health and Addiction Services
- Anthony Barrett, Workforce Development Specialist - Department of Economic and Community Development
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- Tammy Hendricks, Director of Health Equity - Access Health CT
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- Bernie Park, Governors' Workforce Council /Career Pathways in Healthcare Subcommittee
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