UNDERSTANDING RACIAL INEQUITIES THROUGH DATA

Data Report, May 2023

Commission on Racial Equity in Public Health
Connecticut General Assembly

COMMISSION ON RACIAL EQUITY IN PUBLIC HEALTH

CONNECTICUT GENERAL ASSEMBLY

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

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In 2021, the Connecticut General Assembly declared racism a public health crisis and acknowledged that disparities in health outcomes are largely the result of race-based inequities.[1] The Commission on Racial Equity in Public Health was established to examine these inequities and to inform policies to achieve health equity.

Pursuant to Section 3 of Public Act 21-35 (PA 21-35), the Commission has issued this report on health, education, economic security, and criminal justice system involvement data by race and ethnicity. The Commission will issue subsequent reports on additional metrics and updated data periodically.

Terminology: Disparity, Inequity, and Race

PA 21-35 instructs the Commission to present racial/ethnic disparity measurements, and accordingly disparity is the term most used in this report. Disparity refers to a difference. Inequity, more specifically, is a disparity caused by a social injustice. While disparities outlined in this report are caused or modified by social injustices, the term inequity is used sparingly and only when referring to a policy or practice that contributed to a disparity.

Race is a social construct, as evidenced by the National Institutes of Health's Human Genome Project. There is no evidence of genetic variation based on the racial categories our society recognizes. Racial categorization has historically been used to establish social hierarchies. Differences in treatment based on these racial categories is commonly referred to as racial discrimination or racism. Racism rather than

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[1] Public Act 21-35: https://www.cga.ct.gov/2021/act/Pa/pdf/2021PA-00035-R00SB-00001-PA.PDF

"race" is the cause of racial inequities. Misconceptions about race being biological have been used to justify the marginalization of certain groups and to falsely explain differences in health outcomes.[2,3]

Public Health & Social Determinants of Health

Charles-Edward Amory Winslow, an American bacteriologist who created Yale's Department of Public Health, now Yale School of Public Health, defined public health as "the science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health; organizing these benefits in such fashion as to enable every citizen to realize his birthright of health and longevity."[4] To date, this is the standard definition of public health.

In modern times, public health practitioners have come to understand the "social machinery," which shapes health outcomes as the social determinants of health (SDOH). SDOH are defined by the Centers for Disease Control (CDC) and the World Health Organization (WHO) as "nonmedical factors that influence health outcomes," specifically, "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."[5,6]

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[2] National Institutes of Health, National Human Genome Research Institute, https://www.genome.gov/genetics-glossary/Race

[3] Gannon, M. "Race is a Social Construct, Scientists Argue: Racial Categories are Weak Proxies for Genetic Diversity and Need to be Phased Out", *Scientific American* , February 5, 2016. https://www.scientificamerican.com/article/race-is-a-social-construct-scientists-argue/

[4] Steve Kemper, "A Public Health Giant: C-E.A. Winslow, Who Launched Public Health at Yale a Century Ago, Still Influential Today," YaleNews, November 18, 2021, https://news.yale.edu/2015/06/02/public-health-giant-c-ea-winslow-who-launched-public-health-yale-century-ago-still-influe.

[5] "Social Determinants of Health at CDC." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, December 8, 2022. https://www.cdc.gov/about/sdoh/index.html.

[6] "Social Determinants of Health," World Health Organization (World Health Organization), accessed April 30, 2023, https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

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Section 1: Demographics and Economic Security

The Connecticut demographics, poverty rates, and median household income data are from the U.S. Census Bureau's American Communities Survey (ACS)- 5-year Estimates. Commission staff worked with the Health Statistics and Surveillance Section of the Connecticut Department of Public Health (CT DPH) to provide the food insecurity and housing insecurity data in this section.

Racial/Ethnic Category Labels Used in Tables and Figures Throughout the Report:
White = White alone, not Hispanic or Latino/a
Black = Black alone, not Hispanic or Latino/a
AI/AN = American Indian and Alaska Native alone, not Hispanic or Latino/a
Asian = Asian alone, not Hispanic or Latino/a
NH/PI = Native Hawaiian and Other Pacific Islander alone, not Hispanic or Latino/a
Other = Some other race alone, not Hispanic or Latino/a
Multiracial = Two or more races, not Hispanic or Latino/a
Hispanic = Hispanic or Latino/a origin (of any race)

1.1 Connecticut Demographics

Table 1.1 Connecticut Demographics

Connecticut by Race/Ethnicity (2021)	
Race/Ethnicity	**%**
White	64.9%
Black	10.0%
AI/AN	0.2
Asian	4.6
NH/PI	<0.1*
Other	0.5
Multiracial	2.9
Hispanic	16.9%

* 761 respondents identified as NH/PI. ACS statistical analysis rounds the NH/PI population to 0.0%. We display the data as <0.1% to indicate there is a NH/PI population in CT.

Figure 1.1 Connecticut Demographics
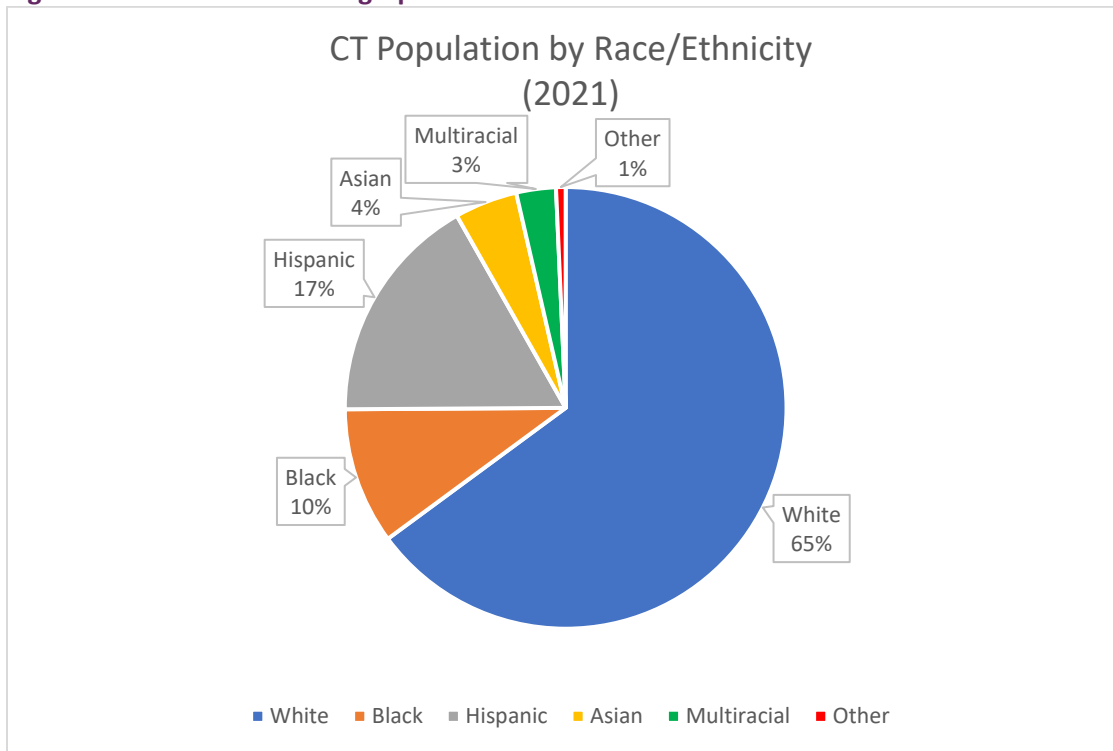
Source: U.S. Census Bureau, 2021 ACS 5-Year Estimates
*American Indian/Alaska Native and Native Hawaiian/Pacific Islander are categorized as other in this chart.
**Chart shows percentages rounded to whole numbers.

1.2 Poverty Rates

Poverty is generally understood to be an economic measure which impacts a person's ability to provide for basic needs, such as food and shelter. However, the official measure of poverty is defined by the income thresholds set by the U.S. Census Bureau. These thresholds vary according to family size and may be adjusted from year to year. To illustrate, the threshold for a single person to be categorized as living below the poverty level is approximately $13,000-14,000, depending on whether the person is over or under the age of 65; for a family of four, the threshold is $27,740. The per household and per child poverty thresholds can be found in the appendix.

Table 1.2 and Figure 1.2 show that Hispanic and Black residents of the state experience poverty rates of 21.4% and 17.3%, respectively, and fewer than 10% of White and Asian residents live in poverty.

According to the U.S. Department of Health and Human Services, "individuals who experience childhood poverty are more likely to experience poverty into adulthood, which contributes to generational cycles of poverty."[7] Poverty and generational wealth are interconnected. The wealth a family accrues through generations of financial stability, educational attainment, marriage, and ownership of homes and/or

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[7] "Poverty," Poverty - Healthy People 2030 (U.S. Department of Health and Human Services), accessed April 30, 2023, https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty#cit25.

business enterprises shapes the opportunities afforded to their future generations.[8] The legacy of exploitation of Black and other minoritized people, particularly through chattel slavery, set the course for substantial income inequality along racial lines.

Table 1.2 Poverty Rates in Connecticut

Poverty in Connecticut	
Race	% Below Poverty
White	6.1%
Black	17.3%
AI/AN	20.7%
Asian	8.7%
NH/PI	27.3%
Other	24.7%
Multiracial	13.5%
Hispanic	21.4%

Source: 2021 U.S. Census American Communities Survey, 5-year Estimates

Figure 1.2 Poverty Rates in Connecticut
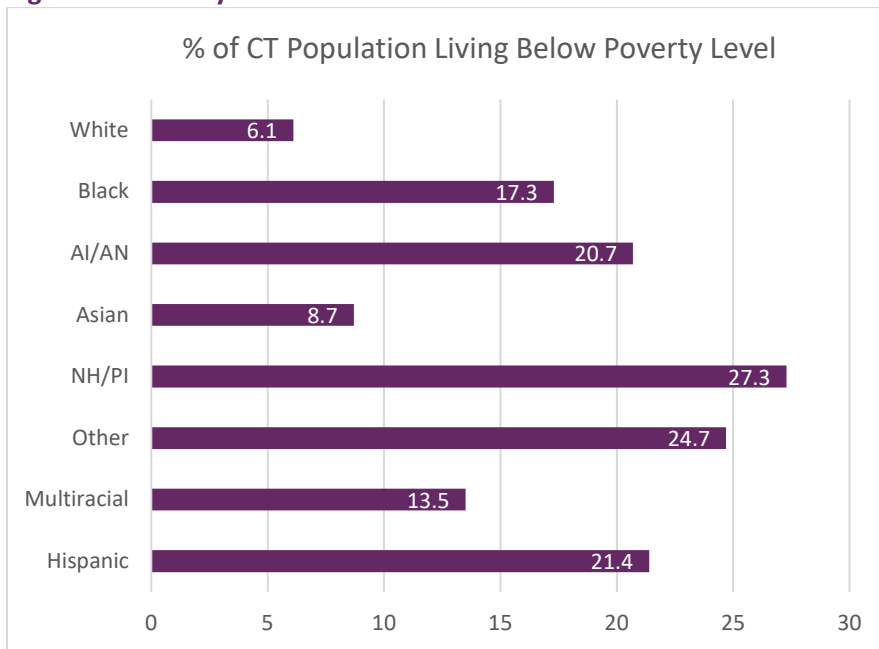
Source: 2021 U.S. Census American Communities Survey, 5-year Estimates

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[8] Fabian T Pfeffer and Alexandra Killewald, "Generations of Advantage. Multigenerational Correlations in Family Wealth," *Social Forces* 96, no. 4 (2017): pp. 1411-1442, https://doi.org/10.1093/sf/sox086.

1.3 Median Income

Median Household Income is a commonly used indicator of financial health and economic stability. Although this measure fails to provide insight into generational wealth, it offers an awareness of the different economic opportunities afforded to different races and ethnicities.

In Connecticut, the median incomes of Black and Hispanic households are $54,325 and $50,912, respectively. Meanwhile, at $108,485, the median income for Asian households is roughly double that. White households have the second highest median income at $95,246.

These disparities reflect the ways in which Black and Hispanic residents experience the impacts of the historical and systemic barriers discussed in this report. Families with lower incomes are often hindered by limited housing opportunities and disproportionately reside in poor areas with underfunded and under-resourced school districts. Money facilitates opportunities to live in healthy homes and neighborhoods with well-resourced schools, leading to improved employment options and overall health.

It is important to note that higher education plays a significant role in dictating future employment prospects, but it is not the sole driver of income disparity. Significant racial income gaps persist among college-educated people and within the same profession. Sociologists have attributed income disparities to multiple factors including workforce experience, occupation, and discrimination.[9,10]

Table 1.3 Median Income in Connecticut

Median Household Income in Connecticut (2016-2021)	
Race	**Median Income (Dollars)**
White	95,246
Black	54,325
AI/AN	43,750
Asian	108,485
NH/PI	25,534
Other	44,836
Multiracial	66,899
Hispanic	50,912

Source: 2021 U.S. Census American Communities Survey, 5-year Estimates

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[9] Patten, Eileen, "Racial, gender wage gaps persist in the U.S. despite some progress," Pew Research Center (Pew Research Center, July 1, 2016), https://www.pewresearch.org/short-reads/2016/07/01/racial-gender-wage-gaps-persist-in-u-s-despite-some-progress/#:~:text=Large%20racial%20and%20gender%20wage,83%25%20as%20much%20as%20men.

[10] Heywood, John S., and Daniel Parent. "Performance Pay and the White-Black Wage Gap." *Journal of Labor Economics* 30, no. 2 (2012): 249–90. https://doi.org/10.1086/663355.

Figure 1.3 Median Household Income in Connecticut

Median Household Income in CT (2016-2021)
(Red Dash Line indicates CT median income across all groups= $83,572)
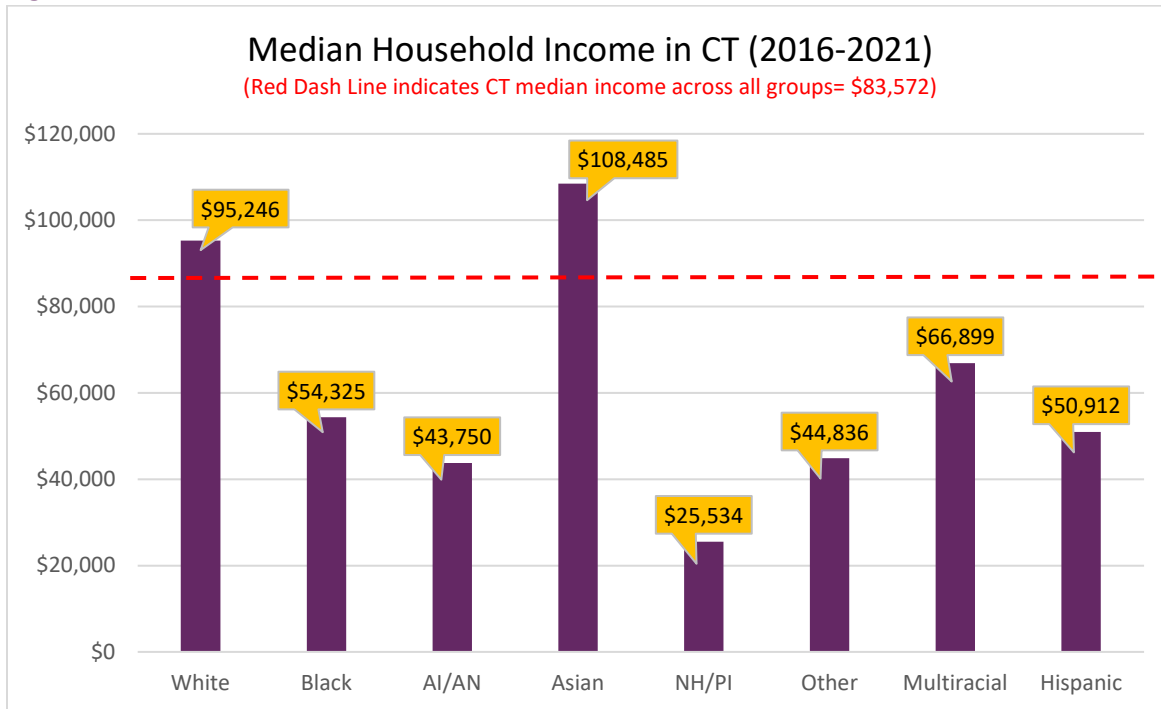
Source: 2021 U.S. Census American Communities Survey, 5-year Estimates

1.4 Food Insecurity

Nutrition is key to health. Nutritious foods help with brain function, energy and activity levels, weight, endocrine function, mood, and a host of other important bodily functions. However, access to nutritious food is greatly influenced by racism and income.

Close to 10% of Black households, and 16% of Hispanic households are food insecure. For White households, that number drops to 6%. Limited income is an obvious contributor to food insecurity, and is heavily influenced by inflation, rising costs of food, fuel, and rent.[11]

Those with limited incomes often live in areas designated as "food deserts." Food deserts are defined by the USDA as areas that "feature large proportions of households with low incomes, inadequate access to transportation, and a limited number of food retailers providing fresh produce and healthy groceries for affordable prices."[12] The USDA determined that food deserts are more likely to exist in areas where larger percentages of people of color reside – a relic of residential segregation and redlining.

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[11] Susan Dunne, "Food Insecurity Is Rising in Connecticut: 'Their Income Can't Get Them Enough Food'," Hartford Courant (Hartford Courant, December 3, 2022), https://www.courant.com/2022/12/03/food-insecurity-is-rising-in-connecticut-their-income-cant-get-them-enough-food/.

[12] "Characteristics and Influential Factors of Food Deserts" (United States Department of Agriculture), accessed April 30, 2023, https://www.ers.usda.gov/webdocs/publications/45014/30940_err140.pdf.

Families living in food deserts often resort to shopping at small, local stores which carry mostly processed foods and very little fresh produce. Additionally, fresh produce is typically priced higher than processed foods, making affordability another barrier.

Table 1.4 Food Insecurity

Food Insecurity in Connecticut		
Indicator Description: Among all adults, the proportion who "always" or "usually" felt worried or stressed about having enough money to buy nutritious meals.		
Race/Ethnicity	**%**	**95% CI**
Non-Hispanic White	5.8	(4.3-7.3)
Non-Hispanic Black	9.8	(4.9-14.6)
Hispanic	15.8	(11.3-20.4)

Source: 2021 Connecticut Behavioral Risk Factor Surveillance System (BRFSS), July-Dec

Figure 1.4 Food Insecurity
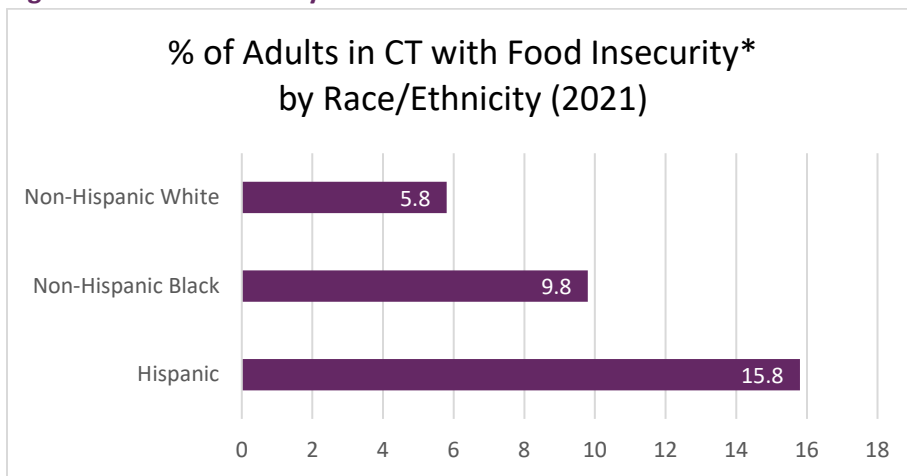
Source: 2021 Connecticut Behavioral Risk Factor Surveillance System (BRFSS), July-Dec.
*Food insecurity is defined as the proportion of adults "who 'always' or 'usually' felt worried or stressed about having enough money to buy nutritious meals."

1.5 Housing Insecurity

As discussed in the *Poverty* and *Median Income* sections of this report, housing, income, and wealth, are influenced by structural and institutional racism. Historical policies and practices such as residential segregation have disadvantaged people of color.[13]

People of color are more likely to be "cost burdened," meaning they spend more than 30% of their household income on housing.[14] Hispanic households are almost three times as likely to be housing insecure compared to White households, and Black households are almost two and a half times more likely to be housing insecure than White households.

Table 1.5 Housing Insecurity

Housing Insecurity in Connecticut		
Indicator Description: Among all adults, the proportion who "always" or "usually" felt worried or stressed about having enough money to pay for housing.		
Race/Ethnicity	**%**	**95% CI**
Non-Hispanic White	9.6	(7.8-11.4)
Non-Hispanic Black	12.0	(7.2-16.9)
Hispanic	28.2	(22.3-34.0)
Non-Hispanic Other*	10.8	(5.0-16.5)
*Estimates with limited validity due to high CV, 20.0% < CV < 30.0%; caution should be exercised when interpreting these estimates.		

Source: 2021 Connecticut Behavioral Risk Factor Surveillance System (BRFSS), July-Dec

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[13] Zinzi D. Bailey, Justin M. Feldman, and Mary T. Bassett, "How Structural Racism Works — Racist Policies as a Root Cause of U.S. Racial Health Inequities," *New England Journal of Medicine* 384, no. 8 (2021): pp. 768-773, https://doi.org/10.1056/nejmms2025396.

[14] Molly Cromwell, "Renters More Likely than Homeowners to Spend More than 30% of Income on Housing in Almost All Counties," Census.gov (U.S. Census Bureau, December 8, 2022), https://www.census.gov/library/stories/2022/12/housing-costs-burden.html.

Figure 1.5 Housing Insecurity

% of Adults in CT with Housing Insecurity*
by Race/Ethnicity (2021)

Race/Ethnicity	Value
Non-Hispanic White	9.6
Non-Hispanic Black	12.0
Hispanic	28.2
Non-Hispanic Other	10.8
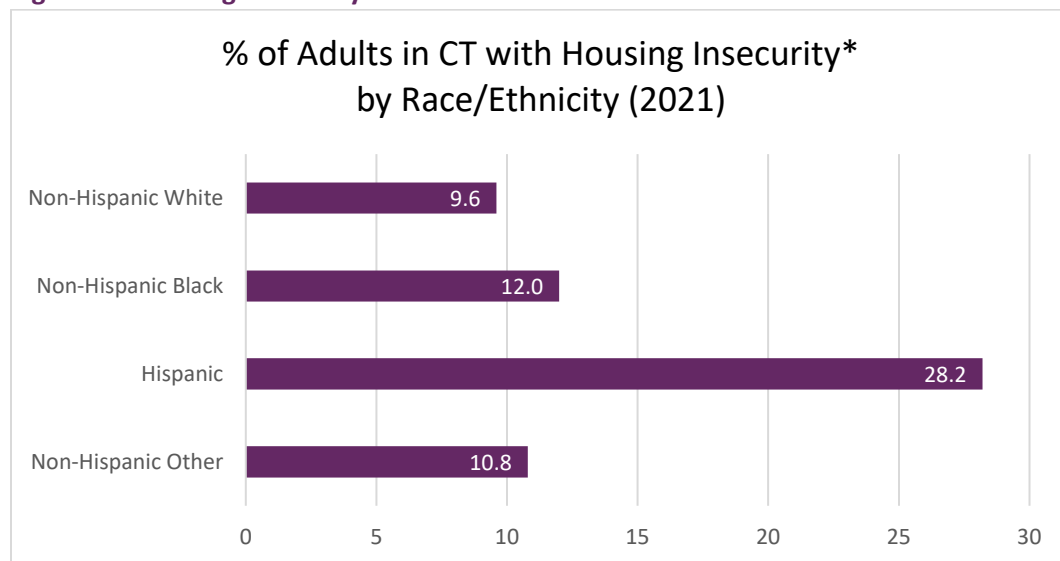
Source: 2021 Connecticut Behavioral Risk Factor Surveillance System (BRFSS), July-Dec
*Housing insecurity is defined as the proportion of adults "who 'always' or 'usually' felt worried or stressed about having enough money to pay for housing."

Section 2: Health Insurance

Commission staff compiled health coverage data using the U.S. Census Bureau's American Communities Survey.

Insurance coverage is an essential component to accessing care.[15] In addition, the quality and affordability of coverage impacts the choice of providers, and treatment and service options available to them. This data only reflects the portions of residents by race/ethnicity (Table 2.1) and by citizenship status (Table 2.2) who are insured or uninsured, regardless of quality of coverage. It is important to note that non-citizens, non-White people, lower income people, and younger people are undercounted in census data,[16,17] Undercounting can happen when there is a hesitancy to respond to the Census, lack of familiarity with the Census, and/or the absence of a stable address to respond accordingly. Conversely, residents who have multiple addresses (or children in college living away from home) may receive multiple Census response notices and may mistakenly respond multiple times and therefore be overcounted. Residents with multiple addresses are disproportionately wealthier than average, and are more likely to be White and ages 50 or older.[18]

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[15] Elements of Access to Health Care. Content last reviewed June 2018. Agency for Healthcare Research and Quality, Rockville, MD. Accessed April 30, 2023.
https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/access/elements.html.
[16] Jennifer Van Hook et al., "Uncertainty about the Size of the Unauthorized Foreign-Born Population in the United States," *Demography* 58, no. 6 (2021): pp. 2315-2336, https://doi.org/10.1215/00703370-9491801.
[17] D'Vera Cohn and Jeffrey S. Passel, "Key Facts about the Quality of the 2020 Census," Pew Research Center (Pew Research Center, June 8, 2022), https://www.pewresearch.org/short-reads/2022/06/08/key-facts-about-the-quality-of-the-2020-census/.
[18] Ibid.

Most Connecticut residents have health insurance coverage, but there are racial/ethnic and citizenship-based disparities. Residents rely on employer-sponsored benefits, social programs, and/or other financial means to acquire coverage. Some residents fall into a coverage gap, meaning they do not have access to affordable coverage, and they earn too much to qualify for state insurance. There are other reasons for lacking coverage, including recent moves or employer changes, re-entry into society from incarceration, or undocumented status.

2.1 Insured & Uninsured

Table 2.1 Percentages of Connecticut Residents Insured & Uninsured by Race/Ethnicity

Race and Hispanic or Latino Origin	Percent Insured		Percent Uninsured	
	Estimate	Margin of Error	Estimate	Margin of Error
White	96.9%	±0.1	3.1%	±0.1
Black	93.6%	±0.5	6.4%	±0.5
AI/AN	88.6%	±4.0	11.4%	±4.0
Asian	94.8%	±0.5	5.2%	±0.5
NH/PI	94.6%	±5.7	5.4%	±5.7
Other	82.6%	±1.1	17.4%	±1.1
Multiracial	92.3%	±0.8	7.7%	±0.8
Hispanic	87.5%	±0.5	12.5%	±0.5

Source: 2021 U.S. Census American Communities Survey, 5-year Estimates

Figure 2.1 Percentages of Insured & Uninsured in Connecticut by Race/Ethnicity
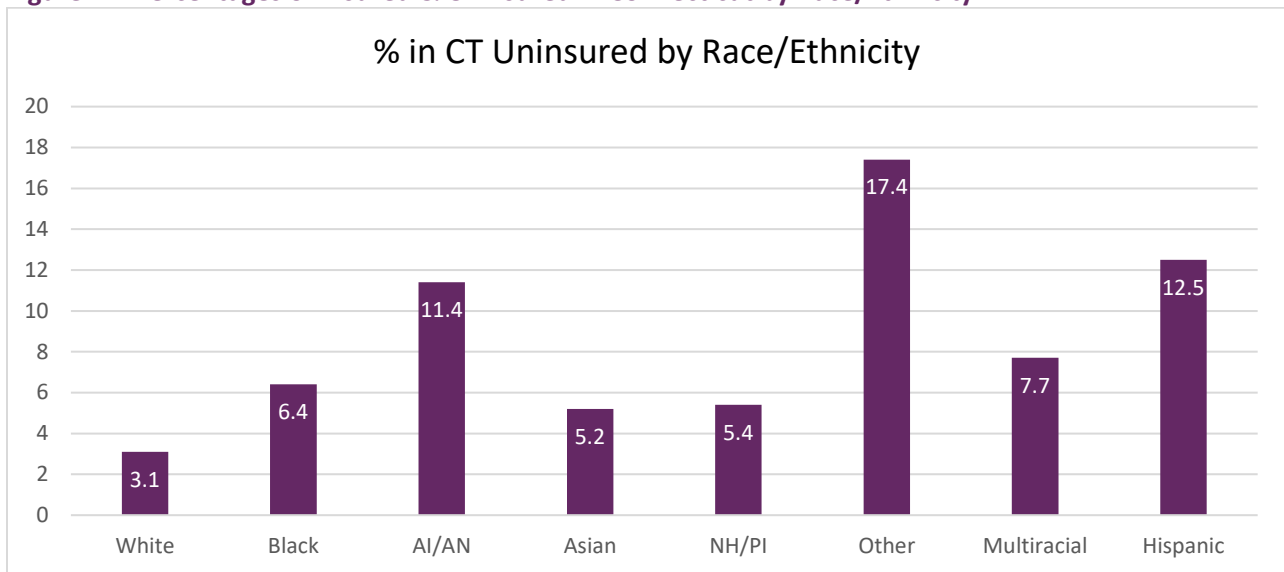
Source: 2021 U.S. Census American Communities Survey, 5-year Estimates

2.2 Insured by Citizenship Status

Native Born: Native born citizen refers to any person born in the United States or a United States territory, as well as those born abroad to at least one parent who is a U.S. citizen.[19]

Foreign Born: Includes any person who is not a U.S. citizen at birth, and they fall into two categories:

    Naturalized: Naturalized refers to foreign born citizens who were granted lawful permanent residency after meeting the requirements established by Congress in the Immigration and Nationality Act.[20]

    Non-citizen: Non-citizens include lawful permanent residents (green card holders), temporary migrants (such as foreign students or people on temporary work visas), humanitarian migrants (such as refugees and asylees), and unauthorized migrants (undocumented immigrants).[21]

Health insurance options differ for non-citizens based on their employment, income, and immigration status. Many income-qualified non-citizens, including lawful permanent residents, are subject to a 5-year waiting period before they can receive Medicaid or Children's Health Insurance Program (CHIP) coverage. Refugees and asylees are not subject to the 5-year waiting period.[22] Additionally, there is a refugee medical assistance program.[23]

The foreign-born non-citizen population is markedly more likely to be uninsured than native born or naturalized citizens. This data does not differentiate undocumented immigrants from other non-citizens. There is a state Medicaid-look-alike program for undocumented children ages 12 and under, and people who are pregnant or in the postpartum period. Additionally, currently enrolled minors will be allowed to retain coverage through age 18. Acquiring coverage remains difficult for adults or those over the current program's age threshold.[24] Undocumented immigrants face specific barriers to acquiring private insurance as they are not permitted to purchase on the health insurance exchange and other private health insurance applications may require a social security number or proof of legal residence.[25]

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[19] "American Community Survey and Puerto Rico Community Survey 2020 Subject Definitions" (U.S. Census Bureau), accessed April 30, 2023, https://www2.census.gov/programs-surveys/acs/tech_docs/subject_definitions/2020_ACSSubjectDefinitions.pdf.

[20] "Citizenship and Naturalization," USCIS (U.S. Citizenship and Immigration Services, July 5, 2020), https://www.uscis.gov/citizenship/learn-about-citizenship/citizenship-and-naturalization.

[21] "American Community Survey and Puerto Rico Community Survey 2020 Subject Definitions" (U.S. Census Bureau).

[22] "Health Coverage for Lawfully Present Immigrants," HealthCare.gov, accessed May 1, 2023, https://www.healthcare.gov/immigrants/lawfully-present-immigrants/.

[23] 54 FR 5480, Feb. 3, 1989

[24] Proposed House Bill 6616 would increase the age threshold for income-eligible undocumented immigrants.

[25] "Marketplace Eligibility," KFF, August 6, 2020, https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/can-i-buy-a-plan-in-the-marketplace-if-i-dont-have-a-green-card/.

Table 2.2 Percentage of Insured in Connecticut by Citizenship Status

% Insured by Nativity & Citizenship	Estimate	Margin of Error	Percentage
Total:	3,556,794	±635	
Native Born:	3,026,047	±6,864	
With health insurance coverage	2,929,061	±7,555	96.8%
With private health insurance	2,179,448	±12,629	72.0%
With public coverage	1,125,307	±9,579	37.2%
No health insurance coverage	96,986	±3,798	3.2%
Foreign Born:	530,747	±6,845	
Naturalized:	286,368	±5,488	
With health insurance coverage	269,979	±5,021	94.3%
With private health insurance	197,460	±4,375	69.0%
With public coverage	109,196	±3,219	38.1%
No health insurance coverage	16,389	±1,363	3.1%
Noncitizen:	244,379	±5,225	
With health insurance coverage	171,602	±4,438	70.2%
With private health insurance	128,954	±3,842	52.8%
With public coverage	51,641	±2,391	21.1%
No health insurance coverage	72,777	±3,188	13.7%

Source: 2021 U.S. Census American Communities Survey, 5-year Estimates

Figure 2.2 Percentage of Insured in Connecticut by Citizenship Status
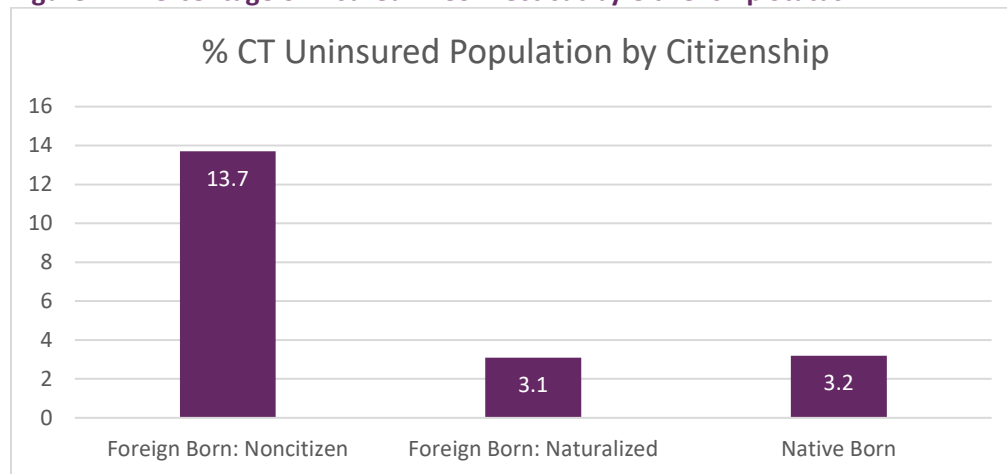
Source: 2021 U.S. Census American Communities Survey, 5-year Estimates

Section 3: Health Outcomes and Receipt of Services

Commission staff worked with the Health Statistics and Surveillance Section of the Connecticut Department of Public Health (CT DPH) to provide the health outcomes data in this section.

3.1 Adult Asthma

Asthma, a disease of the lungs which leads to constricted airways and restricts breathing, disproportionately affects adults and children of color. It is caused by environmental triggers which include exposure to vermin in substandard housing and air pollution caused by proximity to heavily trafficked highways, incinerators, and sewage treatment plants, among others. Economic inequality and permitting of affecting facilities disproportionately in low-income communities of color fuel asthma rate disparities. Black and Hispanic adults in Connecticut are five times more likely to require hospitalization compared to White residents in this state.[26] Hospitalization not only affects health; it impacts the ability to work and earn wages and can lead to medical debt.

Table 3.1 Adult Asthma

% Adults in Connecticut Who Currently Have Asthma, 2021		
Race/Ethnicity	**%**	**95% CI**
Non-Hispanic White	9.6	(8.5-10.7)
Non-Hispanic Black	14.6	(10.7-18.6)
Hispanic	13.6	(11.0, 16.1)
Non-Hispanic Other	7.5*	(4.7-10.4)
†Estimates may be of limited validity due to a high coefficient of variation (CV), 15.0% ≤ CV ≤20.0%		

Source: CT DPH, 2021 CT BRFSS Summary Tables, *www.ct.gov/DPH/BRFSS*

Figure 3.1 Adult Asthma
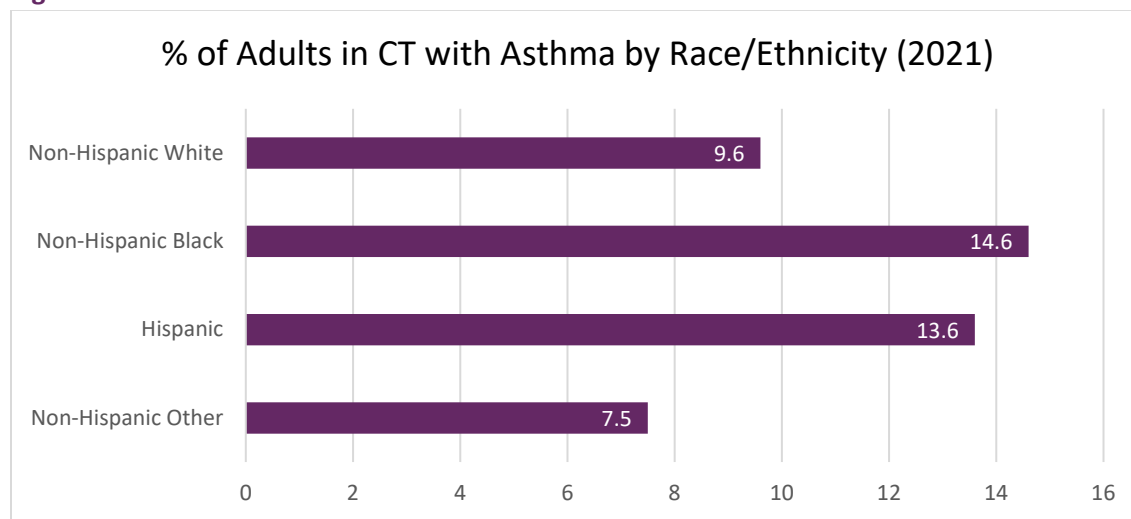
Source: CT DPH, 2021 CT BRFSS Summary Tables, *www.ct.gov/DPH/BRFSS*

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[26] "Health Disparities in Connecticut: Asthma" (Connecticut Health Foundation, 2020), https://www.cthealth.org/wp-content/uploads/2020/08/Health-disparities-fact-sheet-asthma.pdf.

3.2 Child Asthma

Children of color disproportionately suffer from asthma, with almost twice as many Black and Hispanic children carrying a diagnosis compared to White children. Hispanic and Black children are three and five times more likely, respectively, than White children to require hospitalization for asthma symptoms[27] even though it is the most preventable hospitalization condition.[28]

Children suffering from chronic asthma are often restricted from fully participating in sports and other activities, hindering their relationship-building opportunities with peers. In addition, asthma contributes to missed school days which can present challenges with academic performance.[29]

Table 3.2 Child Asthma

Because of small counts in single-year estimates, 3-year Rolling Averages are calculated for better validity.		
Current Asthma Prevalence Among Connecticut Children (0-17 years old), 3-year Rolling Averages, 2019-2021		
Demographic Characteristics	**2018-2020**	
	%	95% Confidence Interval
Overall	**9.9**	**(8.6-11.2)**
	n=68,200	
Gender		
Male	10.7	(8.7-12.7)
Female	9.1	(7.3-10.9)
Race/Ethnicity		
Non-Hispanic White	7.6	(5.9-9.1)
Non-Hispanic Black	11.3[†]	(7.3-15.2)
Hispanic	13.8	(10.5-17.1)
Non-Hispanic Other	~10.*	
[†]Estimates may be of limited validity due to a high coefficient of variation (CV), 15.0% ≤ CV ≤20.0%. *Estimates rounded to the nearest 5% with limited validity due to a high CV, 20.0% < CV ≤30.0%; caution should be taken when interpreting these estimates.*		

Source: CT DPH, Asthma Statistics, Child Current Rolling Average, *https://portal.ct.gov/DPH/Health-Education-Management--Surveillance/Asthma/Asthma-Statistics*

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[27] Ibid.

[28] "Facilities and Services Plan 2018 Supplement" (Connecticut Office of Health Strategy, April 1, 2019), https://portal.ct.gov/-/media/OHS/HSP/Facilities-and-Services-Plan-2018.pdf.

[29] "Childhood Asthma," Mayo Clinic (Mayo Foundation for Medical Education and Research, April 5, 2023), https://www.mayoclinic.org/diseases-conditions/childhood-asthma/symptoms-causes/syc-20351507.

Figure 3.2 Child Asthma

% of Children in CT Who Currently Have Asthma by Race/Ethnicity (2018-2020)
(Red Line Indicates CT Average of 9.9%)

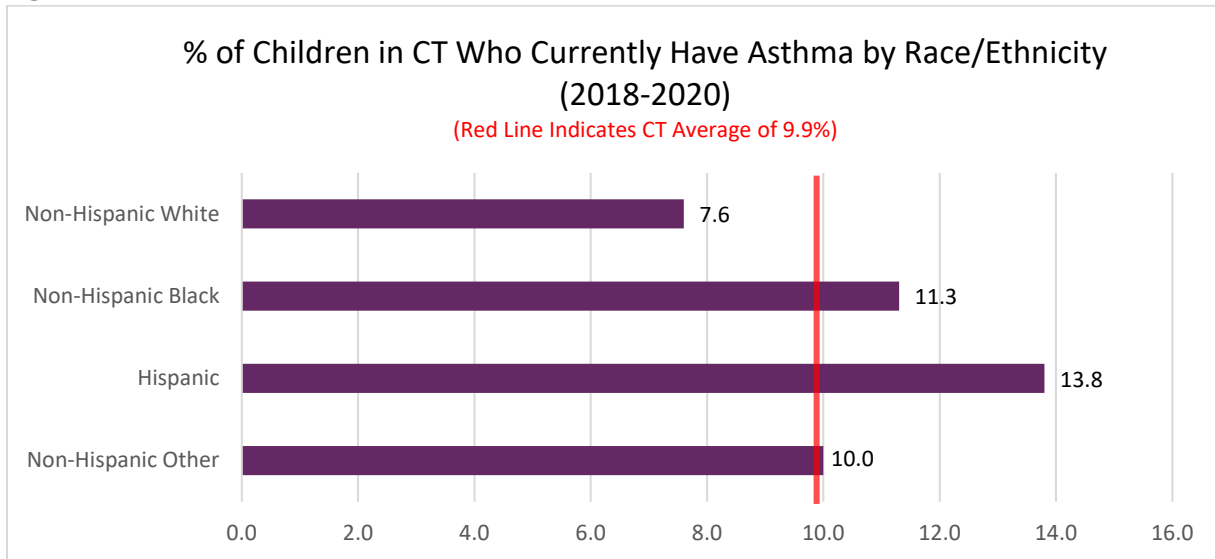| Race/Ethnicity	Value
Non-Hispanic White	7.6
Non-Hispanic Black	11.3
Hispanic	13.8
Non-Hispanic Other	10.0

Source: CT DPH, Asthma Statistics, Child Current Rolling Average, *https://portal.ct.gov/DPH/Health-Education-Management--Surveillance/Asthma/Asthma-Statistics*

3.3 Prenatal Care

Data shows that White people in Connecticut receive early prenatal care at rates higher than pregnant people of other races and ethnicities. Hispanic (non-Puerto Rican) and Black people have the lowest rates of receiving early prenatal care, at 75.9% and 78.0%, respectively.

Prenatal care is essential to a healthy pregnancy and baby. Appointments, testing, and imagery in the early weeks of pregnancy can screen for dangers or complications to the baby and mother, and reduce the risks of preterm birth and maternal mortality.[30] The first trimester of a pregnancy (up to 13 weeks) is particularly important, as medical professionals assess the social, economic, mental, and physical needs, of the pregnant person while monitoring the development of the fetus.[31]

The availability and types of insurance, combined with cost, and proximity to providers, influence the racial and ethnic disparities some people face when seeking early prenatal care.[32] Given how important the early weeks of pregnancy are, expectant pregnant people are encouraged by medical professionals to initiate prenatal care promptly and maintain regularly scheduled appointments. This can be costly and

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[30] Bryant, Allison S., Ayaba Worjoloh, Aaron B. Caughey, and A. Eugene Washington. "Racial/Ethnic Disparities in Obstetric Outcomes and Care: Prevalence and Determinants." *American Journal of Obstetrics and Gynecology* 202, no. 4 (2010): 335–43. https://doi.org/10.1016/j.ajog.2009.10.864.

[31] "Increase the Proportion of Pregnant Women Who Receive Early and Adequate Prenatal Care - Mich-08," U.S. Department of Health and Human Services, accessed April 30, 2023, https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/increase-proportion-pregnant-women-who-receive-early-and-adequate-prenatal-care-mich-08.

[32] Tiffany Green, "What Drives Racial and Ethnic Disparities in Prenatal Care for Expectant Mothers?," Scholars Strategy Network, February 1, 2019, https://scholars.org/contribution/what-drives-racial-and-ethnic-disparities-prenatal-care-expectant-mothers.

take away valuable time from work for people who are employed in hourly wage-based and/or less stable jobs which are disproportionately filled by Black and Hispanic women.

Table 3.3 CT Resident Early Prenatal Care by Mother's Race and Ethnicity, 2017-2021 (provisional)

CT Resident Early Prenatal Care (PNC)[a] by Mother's Race and Ethnicity, 2017-2021 (provisional)			
Race/Ethnicity	**Count of Pregnant Women Receiving Early PNC**	**Count of Pregnant Women Delivering Live Births[c]**	**Early PNC Rate (%)[b]**
White (Non-Hispanic)	80,518	90,944	88.5
Black (Non-Hispanic)	16,175	20,734	78.0
Asian (Non-Hispanic)	9,027	10,672	84.6
American Indian/Alaskan Native (Non-Hispanic)	123	155	s
Two or More Races (Non-Hispanic)	2,797	3,459	80.9
Puerto Rican	16,894	20,209	83.6
Other Hispanic	17,940	23,648	75.9
Unknown	398	506	s
All Races and Ethnicities	143,872	170,327	84.5
[a] Early PNC is defined as PNC initiation during the first 13 weeks of pregnancy.			
[b] Early PNC rates are suppressed (s) for RSE >30% due to poor statistical reliability.			
[c] Counts of women with unknown dates of PNC initiation are excluded from tabulations.			

Source: Connecticut Department of Public Health Office of Vital Records and Surveillance Analysis and Reporting Unit, Births Registry vDEC8_2022

Figure 3.3 CT Resident Early Prenatal Care by Mother's Race and Ethnicity, 2017-2021 (provisional)
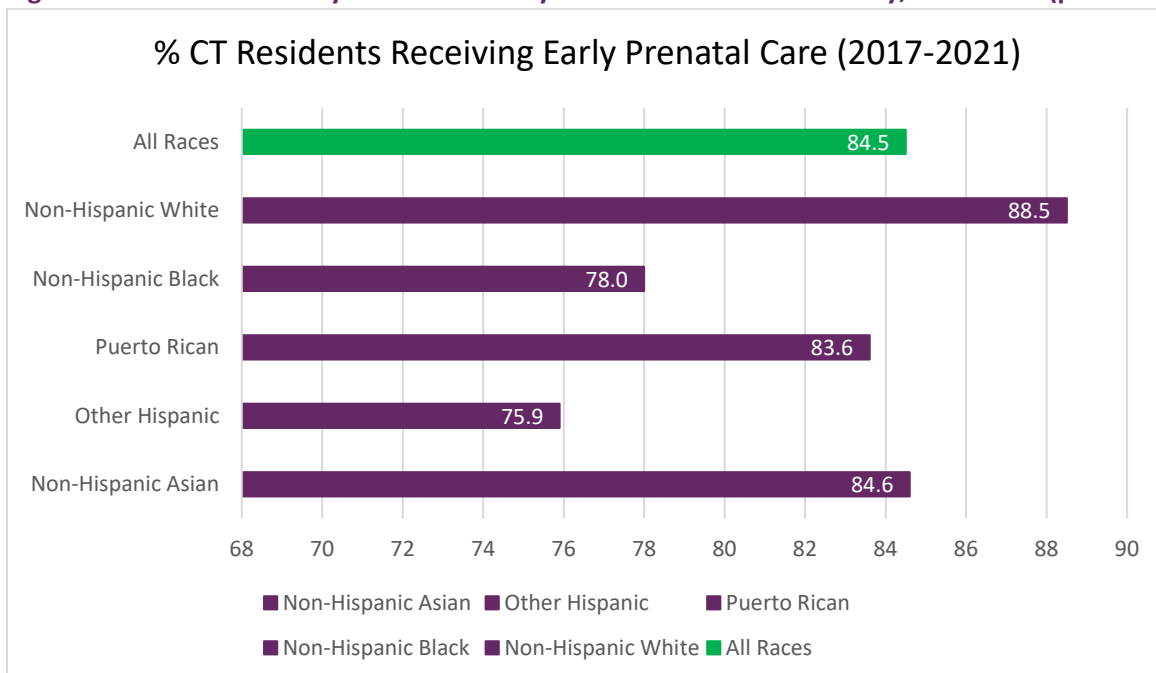
Source: Connecticut Department of Public Health Office of Vital Records and Surveillance Analysis and Reporting Unit, Births Registry vDEC8_2022*, A narrative summary of state rates of Early Prenatal Care trends over time and disparities by race/ethnicity current through 2018 is available on pages 14-15: https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/Vital-Statistics/Registration-Reports/Reports/2018_CT_Registration_Report_rev.pdf.*

3.4 Pregnancy-Associated Deaths

Pregnancy-associated deaths occur during or within one year of pregnancy, but are not necessarily causally related to pregnancy.[33] Pregnancy-related deaths are a subset of pregnancy-associated deaths that *are* causally related to pregnancy or its management. Forty percent (40%) of pregnancy-associated deaths which occurred between 2015 and 2020 were determined by the Connecticut Maternal Mortality Review (MMR) Committee to be pregnancy-related. The Connecticut MMR determined 60% of these pregnancy-related deaths were preventable.[34]

Hispanic and Black people are more than two and three times more likely, respectively, to suffer a pregnancy-associated death. Many factors experienced by people of color, and Black people especially, lead to these deaths. These factors include underlying health conditions, implicit bias, and social drivers of health, such as housing and food insecurity.[35]

Table 3.4 Pregnancy-Associated Deaths

Race/Ethnicity of Pregnancy-associated Deaths in CT (2015-2020)			
Race/Ethnicity	**Number of Deaths**	**Percent**	**Rate per 100,000**
White*	35	43.75	2.64
Black*	21	26.25	10.40
Hispanic	19	23.75	6.21
Other	5	6.25	-
Total	**80**	**100**	-
Black & White include only those who did not identify as Hispanic or Latina/o			

Source: Issue Brief: Pregnancy-Associated Deaths in Connecticut: Data from Connecticut Maternal Mortality Review Committee, 2015-2020

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[33] Issue Brief: Pregnancy-Associated Deaths in Connecticut: Data from Connecticut Maternal Mortality Review Committee, 2015-2020.

[34] Ibid.

[35] "Working Together to Reduce Black Maternal Mortality," Centers for Disease Control and Prevention (Centers for Disease Control and Prevention, April 3, 2023), https://www.cdc.gov/healthequity/features/maternal-mortality/index.html.

Figure 3.4 Pregnancy-Associated Deaths

Pregnancy-Associated Deaths in CT
by Race/Ethnicity (2015-2020)
Rate per 100,000 Live Births

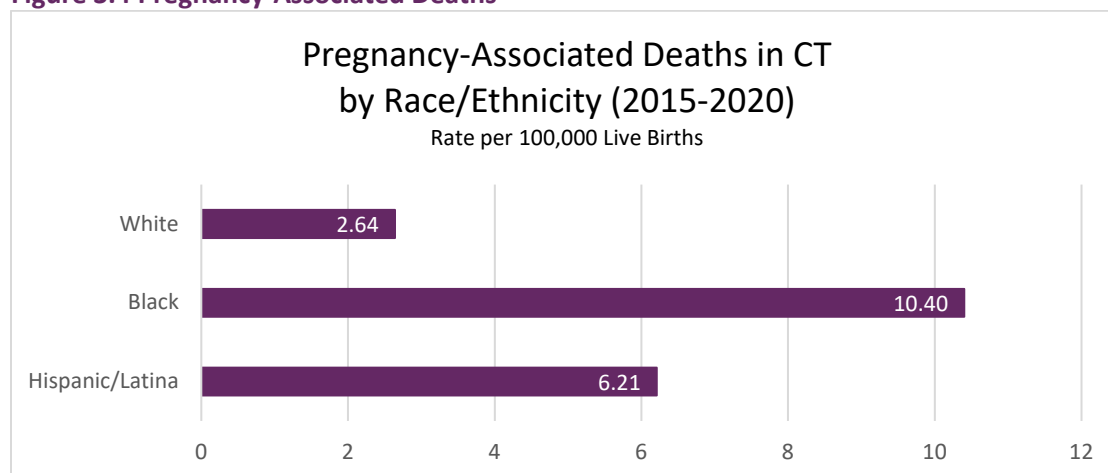Source: Issue Brief: Pregnancy-Associated Deaths in Connecticut: Data from Connecticut Maternal Mortality Review Committee (MMR), 2015-2020

3.5 Infant Mortality

Infant mortality is defined as "deaths that occur among children less than one year of age."[36] There are significant infant mortality disparities among racial/ethnic groups, with Black and Puerto Rican families experiencing a disproportionate burden of mortality. The infant mortality rate for Puerto Rican infants is more than double the infant mortality rate for White and Asian infants. Black infants experience the highest infant mortality rate at 9.4 deaths per 100,000 live births, which is more than twice the state average.

These inequities are influenced by several factors ranging from access to medical care (both before and during pregnancy), environmental stressors, and unconscious bias by medical providers which influences their perceptions of people of color and their medical decisions. Although higher socioeconomic status, good health insurance, and access to medical care can alleviate barriers to care for many racial and ethnic groups, this does not always correspond with better results for Black births. National data shows that "the richest Black women have infant mortality rates at above the same level as the poorest White women."[37]

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[36] Connecticut Department of Public Health Office of Vital Records and Surveillance Analysis and Reporting Unit, Deaths Registry vDEC8_2022, *A narrative summary of state Infant Mortality Rate Trends over time and disparities by race/ethnicity current through 2018 is available on pages 12-13:* https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/Vital-Statistics/Registration-Reports/Reports/2018_CT_Registration_Report_rev.pdf.
[37] Sarah Kliff, Claire Cain Miller, and Larry Buchanan, "Childbirth Is Deadlier for Black Families Even When They're Rich, Expansive Study Finds," The New York Times (February 12, 2023), https://www.nytimes.com/interactive/2023/02/12/upshot/child-maternal-mortality-rich-poor.html.

Table 3.5 CT Resident Infant Mortality Rates by Infant's Race and Ethnicity, 2017-2021 (provisional)

CT Resident Infant Deaths, Live Births, and IMR by Infant's Race and Ethnicity, 2017-2021 (provisional)			
Race/Ethnicity	**# of Infant Deaths**	**# of Live Births**	**Infant Mortality Rate (IMR, per 1,000)[b]**
White (Non-Hispanic)	280	92,186	3.0
Black (Non-Hispanic)	198	21,382	9.4
Asian (Non-Hispanic)	31	10,802	2.9
American Indian/Alaskan Native (Non-Hispanic)	0	159	s
Two or More Races (Non-Hispanic)	6	3,525	s
Puerto Rican	138	20,702	6.7
Other Hispanic	102	24,064	4.2
Unknown	23	566	s
All Races and Ethnicities	778	173,386	4.5
[a] Annual Infant Deaths are reported using the information provided in the death record only.			
[b] Infant Mortality Rates are suppressed (s) for 0-10 events (RSE >30%) due to poor statistical reliability.			

Source: Connecticut Department of Public Health Office of Vital Records and Surveillance Analysis and Reporting Unit, Deaths Registry vDEC8_2022
Note: Race/ethnicity in these data reflects maternal (birthing persons) race/ethnicity.

Figure 3.5 CT Resident Infant Mortality Rates by Infant's Race and Ethnicity, 2017-2021 (provisional)

Infant Mortality* in CT Per 1,000 Live Births (2017-2021)
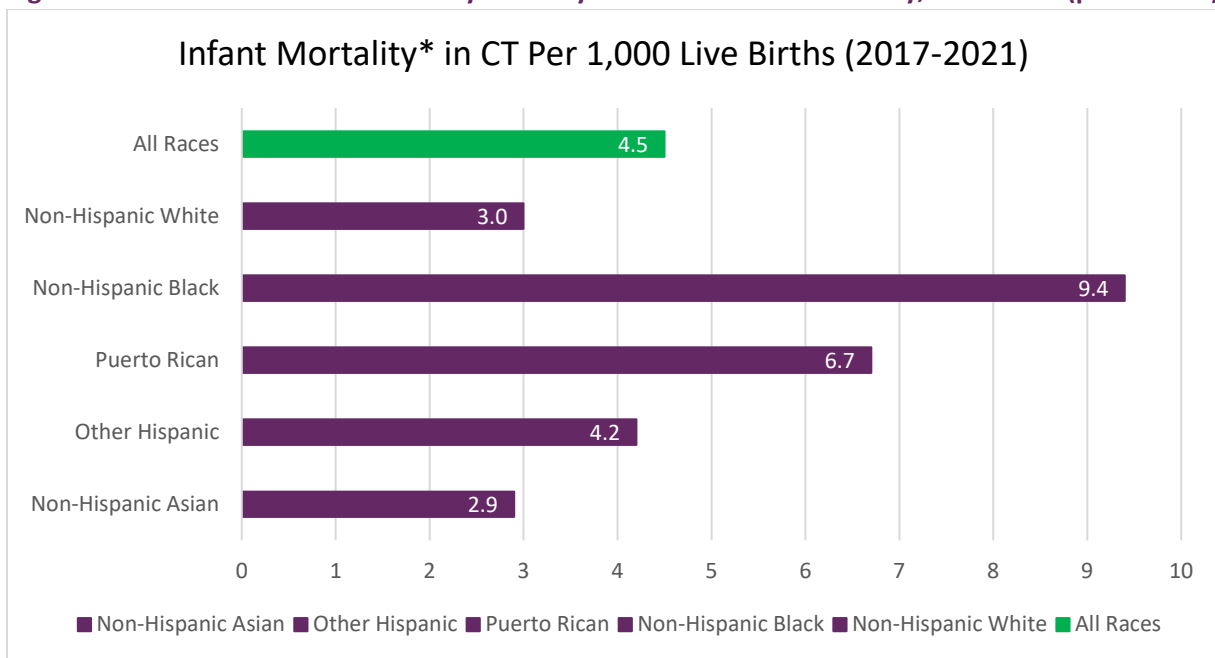
Source: Connecticut Department of Public Health Office of Vital Records and Surveillance Analysis and Reporting Unit, Deaths Registry vDEC8_2022
Note: Race/ethnicity in these data reflects maternal (birthing persons) race/ethnicity.

3.6 Depression

Disparities exist in rates of adults with a diagnosed depressive disorder. Almost 20% of White adults are diagnosed with a depressive disorder with Hispanic adults not very far behind at 17.7%. However, just under 12% of Black adults have a diagnosed depressive disorder.

These numbers only reflect those with a *diagnosed* depressive disorder. It is important to note that mental health disorders are underdiagnosed among people of color, skewing the data. Several factors contribute to underdiagnosis including, but not limited to, inequitable access to care, stigma, and provider bias.

Access to mental health clinicians is essential to receiving a diagnosis and treatment. It is determined by health insurance coverage and quality, geographic proximity to providers, and ability to cover out-of-pocket costs and attend appointments, typically scheduled during the workday.

Stigma is another contributor to underdiagnosis. In many communities, and particularly in some communities of color, mental health conditions are viewed as a source of shame or a weakness in terms of how a person views themself and others. Stigma prevents individuals from seeking professional help.

Provider bias, which can be conscious and unconscious, along with a lack of cultural humility, contribute to the underdiagnosis, misdiagnosis, and/or inadequate treatment options for Black people and other people of color.[38,39]

Table 3.6 Depression

% Adults in Connecticut with a Depressive Disorder, 2021		
Race/Ethnicity	**%**	**95% CI**
Non-Hispanic White	19.9	(18.4-21.4)
Non-Hispanic Black	11.7	(8.4-15.0)
Hispanic	17.7	(14.8-20.6)
Non-Hispanic Other	10.2*	(7.1-13.3)
Estimates with CVs greater than 15.0% and less than or equal to 20.0% may be of limited validity.		

Source: CT DPH, 2021 CT BRFSS Summary Tables, *www.ct.gov/DPH/BRFSS*

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[38] "African Americans," NAMI: National Alliance on Mental Illness, accessed April 30, 2023, https://nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Black-African-American.

[39] "Racial Disparities in Diagnosis and Treatment of Major Depression," Blue Cross Blue Shield, 2022, https://www.bcbs.com/the-health-of-america/reports/racial-disparities-diagnosis-and-treatment-of-major-depression.

Figure 3.6 Depression

% CT Adults with a Depressive Disorder by Race/Ethnicity (2021)

Race/Ethnicity	Value
Non-Hispanic White	19.9
Non-Hispanic Black	11.7
Hispanic	17.7
Non-Hispanic Other	10.2
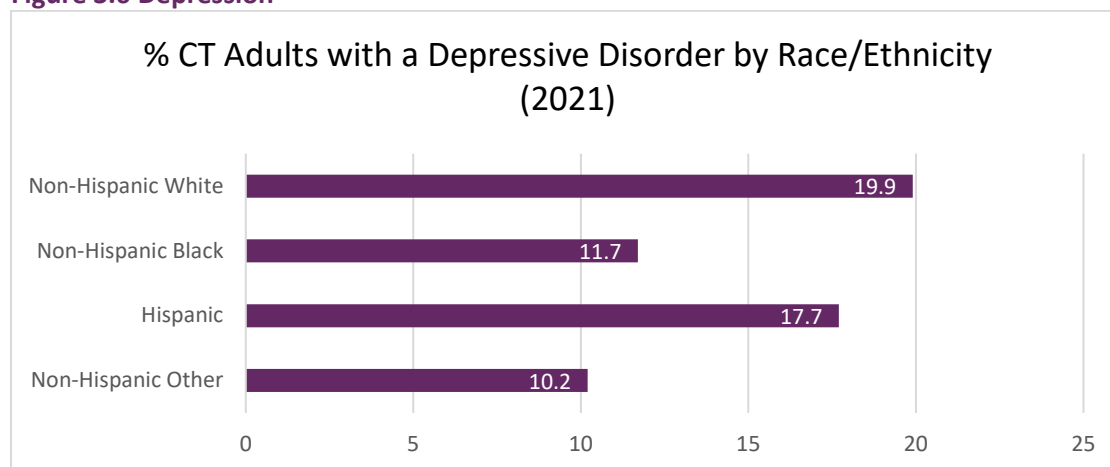
Source: CT DPH, 2021 CT BRFSS Summary Tables, *www.ct.gov/DPH/BRFSS*

3.7 Lead Poisoning

Lead poisoning is a condition that results from exposure to lead, a naturally occurring but toxic metal. The primary source of lead exposure comes from paint used in homes built prior to 1978 when the use of lead was outlawed. Prior to that time, lead was commonly used in homes in paint and water pipes. Lead can also be found in the soil surrounding these homes.[40] Most lead poisoning in children comes from the ingestion of lead-based paint chips and dust, and drinking contaminated water from lead pipes.

Young children are particularly susceptible to lead poisoning given that, relative to adults, they absorb larger amounts of this metal into their small and rapidly developing bodies.[41] Lead poisoning can have detrimental effects on a child's health and development and result in problems with hearing, speech, learning, and behavior. It can also result in slowed growth and development, brain damage, and damage to the central nervous system.[42] In the most extreme cases, lead poisoning can result in death.[43]

Throughout the country, it has been found that low-income populations and people of color are disproportionately affected by lead poisoning. The same pattern exists in Connecticut where the data shows that the White population has the lowest rates of lead poisoning, whereas people of color are two to three times more likely to suffer from the condition.

Connecticut's history of redlining has concentrated people of color into high-poverty areas where old, poorly maintained buildings provide the majority of available affordable housing. In addition, much of this housing is found in areas designated as food deserts due to the difficulty in accessing fresh, nutritious

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[40] "About Lead," CT.gov (Connecticut Department of Public Health), accessed April 30, 2023, https://portal.ct.gov/DPH/Environmental-Health/Lead-Poisoning-Prevention-and-Control/About-Lead.
[41] "Lead Poisoning," World Health Organization, August 31, 2022, https://www.who.int/news-room/fact-sheets/detail/lead-poisoning-and-health.
[42] "Health Effects of Lead Exposure," Centers for Disease Control and Prevention, September 2, 2022, https://www.cdc.gov/nceh/lead/prevention/health-effects.htm.
[43] "Lead Poisoning," World Health Organization, August 31, 2022

food. According to the World Health Organization (WHO) "undernourished children are more susceptible to lead because their bodies absorb more lead if other nutrients, such as calcium or iron, are lacking."[44]
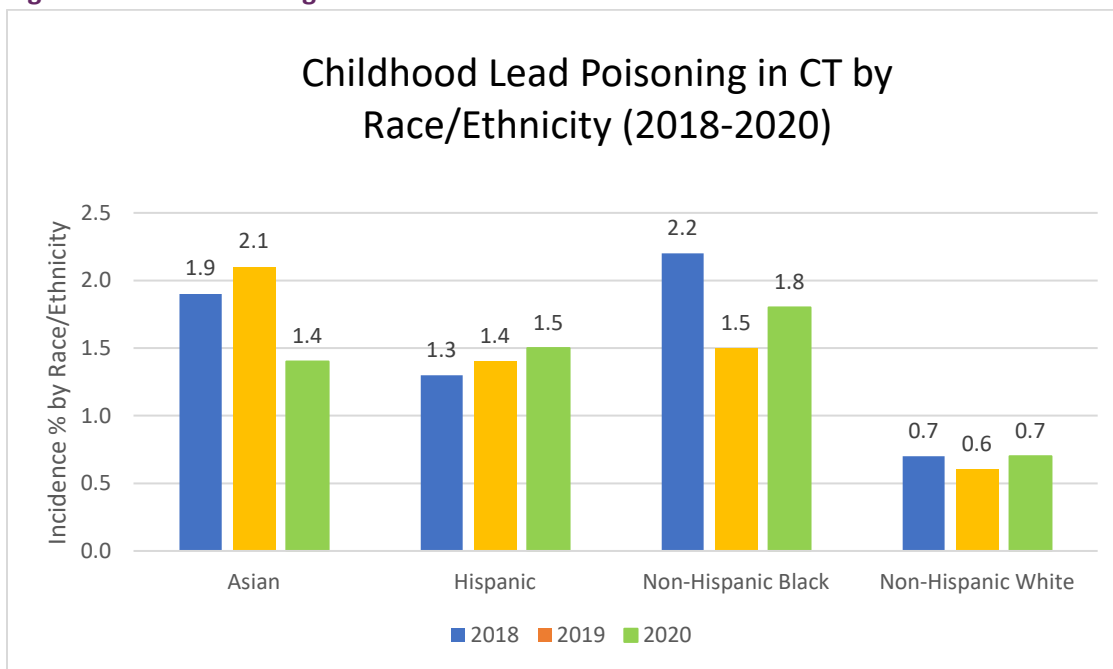
Table 3.7 Lead Poisoning

Incidence Percentage by Race/Ethnicity and Year			
Race/Ethnicity	**2020**	**2019**	**2018**
Asian	1.4	2.1	1.9
Hispanic	1.5	1.4	1.3
Non-Hispanic Black	1.8	1.5	2.2
Non-Hispanic White	0.7	0.6	0.7
The incidence rate of Non-Hispanic Black people, Non-Hispanic Asian people and Hispanic people was 1.8%, 1.4%, and 1.5% as compared to 0.7% among Non-Hispanic White people. This translates into significant elevated risks of by at least two-fold for all groups as compared to Non-Hispanic White people.			
Although the disparity remains, the relative risk has decreased for the Black and Asian population from 3.3 and 2.8 in 2018 to 2.6 and 2, respectively, in 2020. The risk for the Hispanic population increased from 2 to 2.2 from 2018 to 2020. The reduction in new cases among the Black population correlates with prevention efforts utilizing media campaigns funded by the CDC starting in 2015. It also shows increased prevention efforts are needed toward Hispanic populations.			

Source: CT DPH- Executive Summary: Childhood Lead Poisoning Surveillance Report, *https://portal.ct.gov/-/media/DPH/EHDW/Executive-Summary-of-CT--2020-Childhood-Lead-Poisoning-Surveillance-Report-and-prev-data-tables.pdf*

Figure 3.7 Lead Poisoning

Source: CT DPH- Executive Summary: Childhood Lead Poisoning Surveillance Report, *https://portal.ct.gov/-/media/DPH/EHDW/Executive-Summary-of-CT--2020-Childhood-Lead-Poisoning-Surveillance-Report-and-prev-data-tables.pdf*

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[44] Ibid.

3.8 High Blood Pressure

Research notably from the American Heart Association, American Journal of Medicine, and National Institutes of Health, has found that Black adults suffer from hypertension at disproportionately higher rates than any other group. This has been reflected in national data. State-level data provided by CT DPH affirms that non-Hispanic Black adults have the highest rates of high blood pressure in the state.

In 2020, research published by the American Heart Association found "lifetime discrimination may increase the risk of hypertension in African Americans."[45] Moreover, according to the American Journal of Medicine, increased risk of hypertension leads to higher stroke and heart disease mortality rates, along with "a 320% greater rate of hypertension-related end-stage renal disease than seen in the general population."[46]

Table 3.8 High Blood Pressure

% Adults in Connecticut Ever Been Told They Have High Blood Pressure, 2021		
Race/Ethnicity	**%**	**95% CI**
Non-Hispanic White	33.4	(31.7-35.0)
Non-Hispanic Black	41.9	(36.3-47.5)
Hispanic	22.6	(19.2-25.9)
Non-Hispanic Other Race	21.6	(16.6-26.6)

Source: CT DPH, 2021 CT BRFSS Summary Tables, *www.ct.gov/DPH/BRFSS*

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[45] Forde, A. T., Sims, M., Muntner, P., Lewis, T., Onwuka, A., Moore, K., and Diez Roux, A.V. "Discrimination and Hypertension Risk Among African Americans in the Jackson Heart Study." *American Heart Association: Hypertension*. September 2020, Volume 76 (3), 715-723.

[46] Bosworth, H.B., Dudley, T. Olsen, M.K., Voils, C.I., Powers, B. Goldstein, M.K, and Oddone, E.Z. "Racial Differences in Blood Pressure Control: Potential Explanatory Factors." *The American Journal of Medicine*, January 2006, Volume 119(1), P70.E9-70.E15.

Figure 3.8 High Blood Pressure

% of CT Adults Ever Told They Have
High Blood Pressure by Race/Ethnicity (2021)

Non-Hispanic White — 33.4
Non-Hispanic Black — 41.9
Hispanic — 22.6
Non-Hispanic Other Race — 21.6
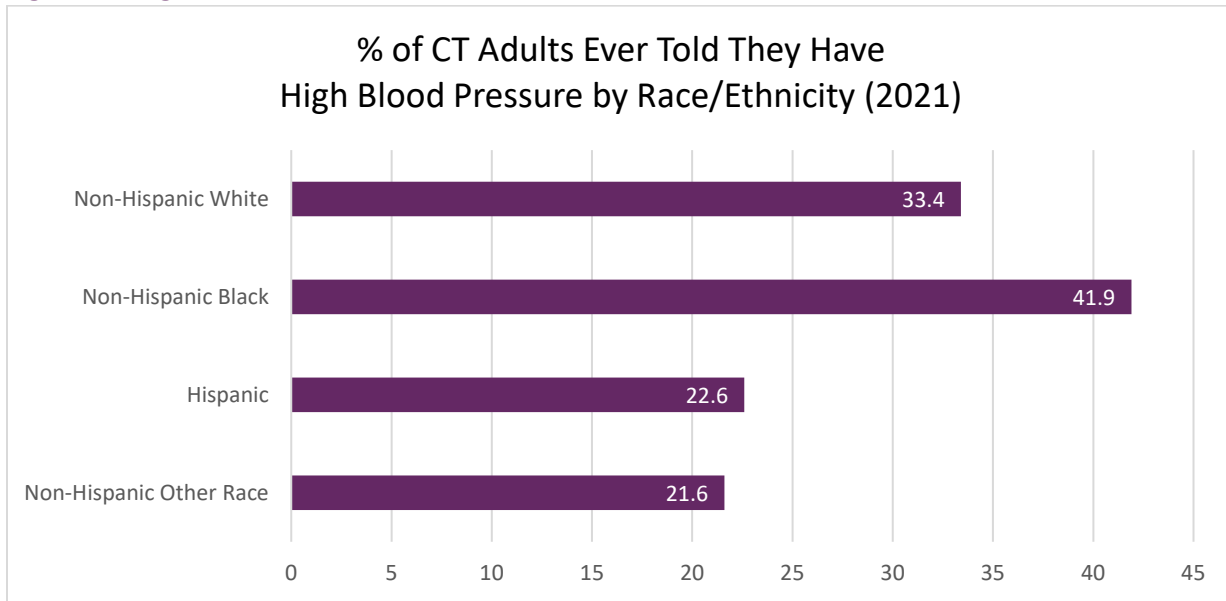
Source: CT DPH, 2021 CT BRFSS Summary Tables, *www.ct.gov/DPH/BRFSS*

3.9 Diabetes

Blood sugar, or glucose, is the main source of energy in the body. The body processes glucose by way of a hormone called insulin. Diabetes is a chronic condition in which the body is not able to produce or use insulin effectively which results in elevated glucose levels in the blood. This disease can cause a variety of health problems which include, but are not limited to, kidney disease, nerve problems, vision loss, and skin problems such as bacterial and fungal infections.[47] Agencies such as the Center for Disease Control and Prevention (CDC) and National Institutes of Health (NIH), among others, have indicated demographic disparities in diabetes prevalence. According to the CDC, "some racial and ethnic minority groups and groups with lower socioeconomic status have historically higher rates of illness and death from diabetes than White people."[48] The NIH has noted that these disparities have widened over the last few decades.

According to data provided by CT DPH, 16.2% of Black residents in Connecticut have been diagnosed with diabetes at some point in their lives, whereas that number drops to 10.2% for White residents. An October 2020 report by CT DPH stated that Black residents have the highest diabetes-related age-adjusted mortality rates and years of potential life lost in the state.[49]

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[47] "Statistics about Diabetes," Statistics About Diabetes | ADA, July 28, 2022, https://diabetes.org/about-us/statistics/about-diabetes.

[48] "Advancing Health Equity," Centers for Disease Control and Prevention, April 4, 2023, https://www.cdc.gov/diabetes/health-equity/index.html.

[49] Poulin, S. M. (2020). Connecticut Diabetes Statistics Report, 2020. Hartford, CT: Connecticut Department of Public Health. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/hems/diabetes/Connecticut-Diabetes-Statistics-Report-Oct-2020.pdf.

There are three main factors which medical professionals agree contribute to a diabetes diagnosis: being overweight, eating unhealthy food, and living a sedentary life.[50] These seemingly simple behaviors are difficult to change when a person cannot afford nutritious foods, or does not have access to fresh, unprocessed foods due to living in a food desert. In addition, lacking open green spaces and/or working long hours, makes it challenging to lead an active lifestyle.

Table 3.9 Diabetes

% Adults in Connecticut Ever Been Told They Have Diabetes		
Race/Ethnicity	**%**	**95% CI**
Non-Hispanic White	10.2	(9.2-11.3)
Non-Hispanic Black	16.2	(11.9-20.6)
Hispanic	9.6	(7.4-11.8)
Non-Hispanic Other	11.8*	(7.6, 16.0)
Estimates with CVs greater than 15.0% and less than or equal to 20.0% may be of limited validity.		

Source: CT DPH, 2021 CT BRFSS Summary Tables, *www.ct.gov/DPH/BRFSS*

Figure 3.9 Diabetes

% of CT Adults Ever With Diabetes (2021)
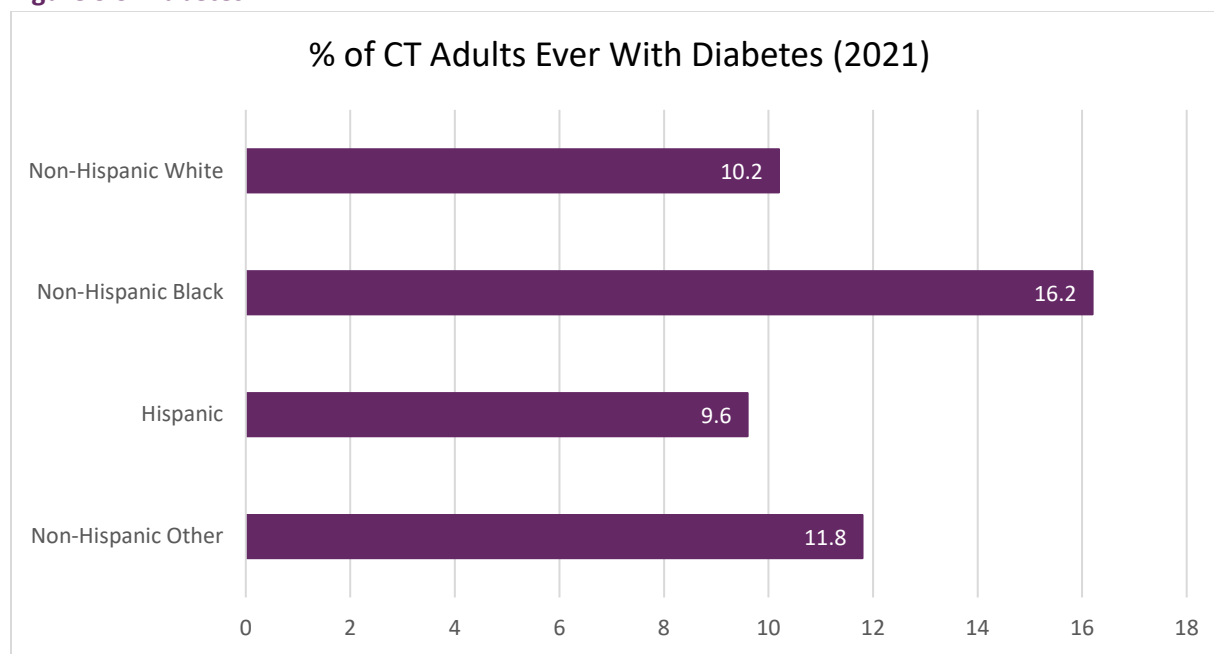
Source: CT DPH, 2021 CT BRFSS Summary Tables, *www.ct.gov/DPH/BRFSS*

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[50] "Symptoms & Causes of Diabetes - NIDDK," National Institute of Diabetes and Digestive and Kidney Diseases (U.S. Department of Health and Human Services), accessed April 30, 2023, https://www.niddk.nih.gov/health-information/diabetes/overview/symptoms-causes.

3.10 Cancers

This section reviews incidence counts and age-adjusted rates for breast, colorectal, and prostate cancer (diagnosis period 2015-2019). As per the *Cancer in Connecticut* 2019 report by CT DPH, the incidence rate is "the number of new cancer cases in a given population per year and is expressed per 100,000 population at risk. Incidence rates are usually age-adjusted which accounts for differences in the age distributions in different populations or in a population over time."[51]

Cancer incidence rates are disproportionately high for Black people. One exception is breast cancer, for which the incidence rate in Connecticut is highest for White women. According to an article in the *New England Journal of Medicine*, White women have a higher incidence rate of breast cancer, but they also have a higher survival rate than Black women. These differences are largely attributed to a lack of access to screening.[52]

For Black people, cancers are often diagnosed at more advanced stages.[53,54] Inequities in education, housing, income, insurance coverage, and transportation contribute to the racial disparities in cancer incidence and mortality rates.[55] Routine screening impacts the stage at which cancer will be detected and therefore the development of cancer and the mortality rates.

3.10a Breast Cancer

Table 3.10a Breast Cancer

Breast Cancer Counts for Connecticut Women (2015-2019)			
Race/Ethnicity	Cases 2015-2019	Average Cases per Year	Rate per 100,000 Women
Non-Hispanic White	13,291	2,658	145.5
Non-Hispanic Black	1,399	280	132.2
Hispanic	1,395	275	123.8

Source: CT DPH-Connecticut Tumor Registry, *Note: Incidence rates are age-adjusted to the 2000 U.S. Standard Population.*

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[51] Swett, K., Gonsalves, L., and Mueller, L.M. 2019. Cancer in Connecticut. Hartford, CT: Connecticut Department of Public Health. Health and Surveillance Section, Connecticut Tumor Registry. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/Tumor-Registry/pdf/CancerInConnecticut2019.pdf.

[52] Ismail Jatoi, Hyuna Sung, and Ahmedin Jemal, "The Emergence of the Racial Disparity in U.S. Breast-Cancer Mortality," *New England Journal of Medicine* 386, no. 25 (2022): pp. 2349-2352, https://doi.org/10.1056/nejmp2200244.

[53] American Cancer Society. Cancer Facts & Figures for African American/Black People 2022-2024. Atlanta: American Cancer Society, 2022. https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-facts-and-figures-for-african-americans/2022-2024-cff-aa.pdf

[54] Tong, M., Hill, L., and Artiga, S. 2022. "Racial Disparities in Cancer Outcomes, Screening, and Treatment," KFF. https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-cancer-outcomes-screening-and-treatment/

[55] John M. Carethers, "Racial and Ethnic Disparities in Colorectal Cancer Incidence and Mortality," *Advances in Cancer Research*, 2021, pp. 197-229, https://doi.org/10.1016/bs.acr.2021.02.007.

Figure 3.10a Breast Cancer

Breast Cancer Rates for Women in CT (2015-2019)
(Rates are age-adjusted per 100,000)

Race/Ethnicity	Rate
Non-Hispanic White	145.5
Non-Hispanic Black	132.2
Hispanic	123.8
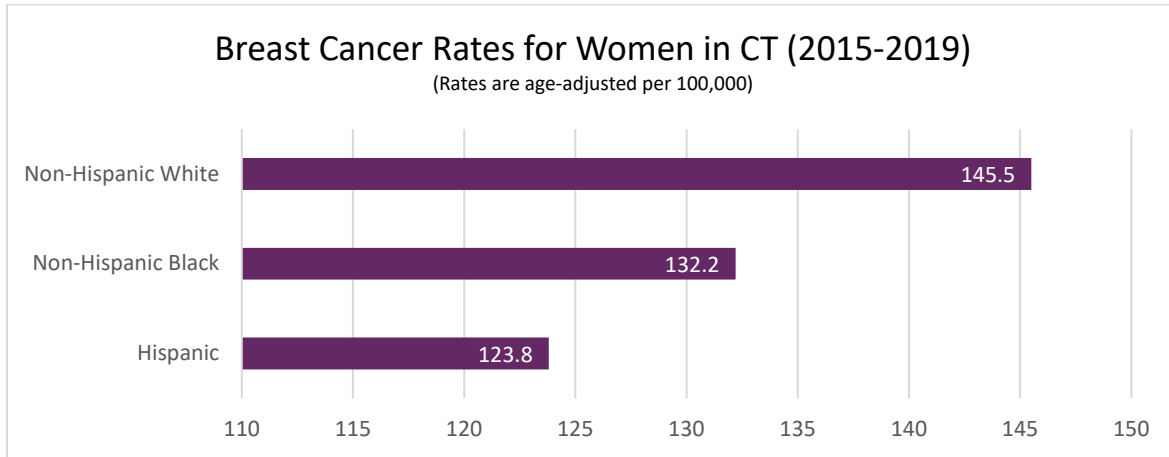
Source: DPH-Connecticut Tumor Registry

3.10b Colorectal Cancer

I. Colorectal Cancer in Women

Table 3.10b(I)

Colorectal Cancer Counts for Women in CT (2015-2019)			
Race/Ethnicity	**Cases 2015-2019**	**Average Cases per Year**	**Rate per 100,000 Women**
Non-Hispanic White	3,006	601	29.2
Non-Hispanic Black	371	74	35.5
Hispanic	316	63	29.7

Source: DPH-Connecticut Tumor Registry, *Note: Incidence rates are age-adjusted to the 2000 U.S. Standard Population.*

Figure 3.10b(I)

Colorectal Cancer Rates for Women in CT (2015-2019)
(Rates are age-adjusted per 100,000)

Race/Ethnicity	Rate
Non-Hispanic White	29.2
Non-Hispanic Black	35.5
Hispanic	29.7
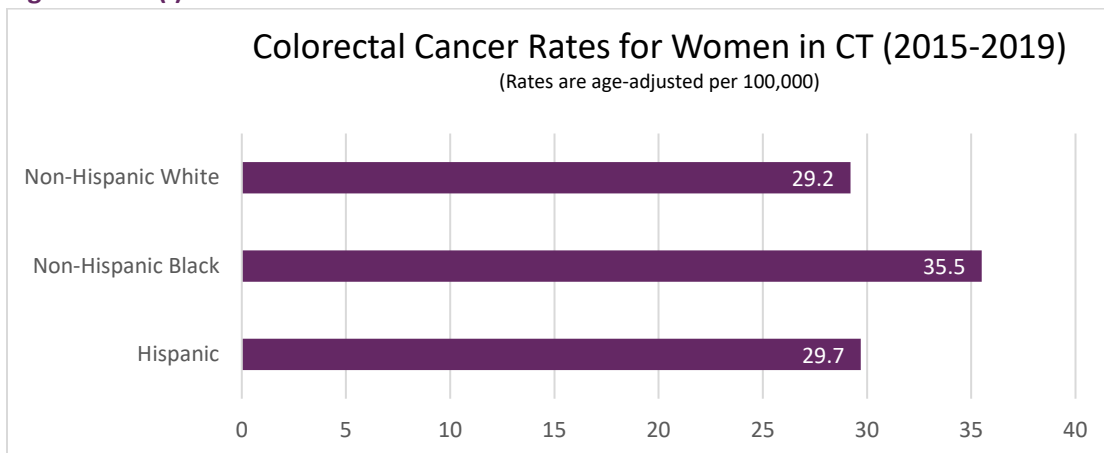
Source: DPH-Connecticut Tumor Registry

II. Colorectal Cancer in Men

Table 3.10b(II)

Colorectal Cancer Counts for Men in Connecticut (2015-2019)			
Race/Ethnicity	Cases 2015-2019	Average Cases per Year	Rate per 100,000 Men
Non-Hispanic White	3,225	645	39.2
Non-Hispanic Black	355	71	45.0
Hispanic	389	78	45.7

Source: DPH-Connecticut Tumor Registry, *Note: Incidence rates are age-adjusted to the 2000 U.S. Standard Population.*

Figure 3.10b(II)
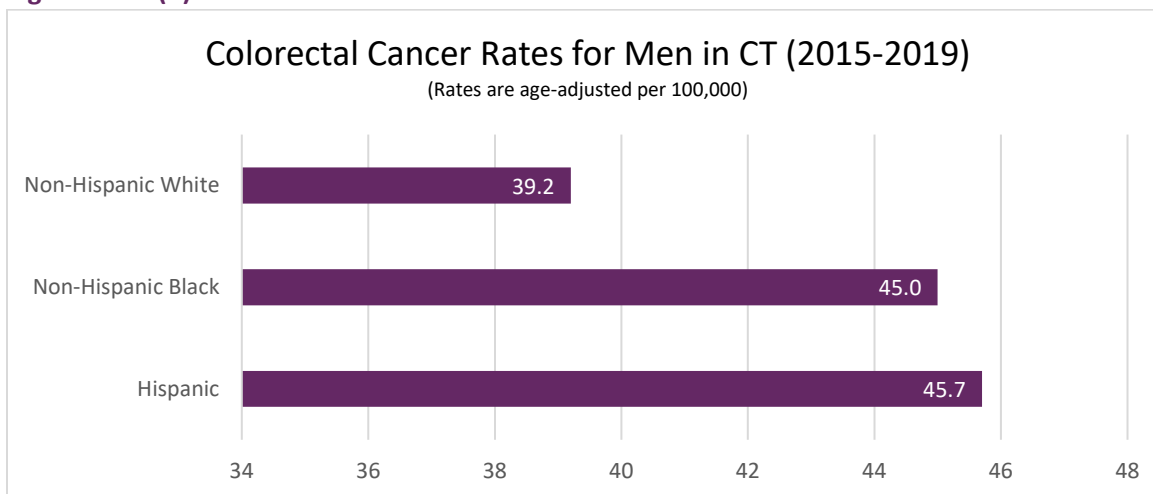
Source: DPH-Connecticut Tumor Registry

3.10c Prostate Cancer

Table 3.10c Prostate Cancer in Men

Prostate Cancer Counts Among Men in Connecticut (2015-2019)			
Race/Ethnicity	Cases 2015-2019	Average Cases per Year	Rate per 100,000 Men
Non-Hispanic White	11,144	2,229	118.5
Non-Hispanic Black	1,575	315	189.3
Hispanic	933	187	113.2

Source: DPH-Connecticut Tumor Registry, *Note: Incidence rates are age-adjusted to the 2000 U.S. Standard Population.*

Figure 3.10c Prostate Cancer in Men

Prostate Cancer Rates Among Men in CT (2015-2019)
(Rates are age-adjusted per 100,000)

Group	Rate
Non-Hispanic White	118.5
Non-Hispanic Black	189.3
Hispanic	113.2
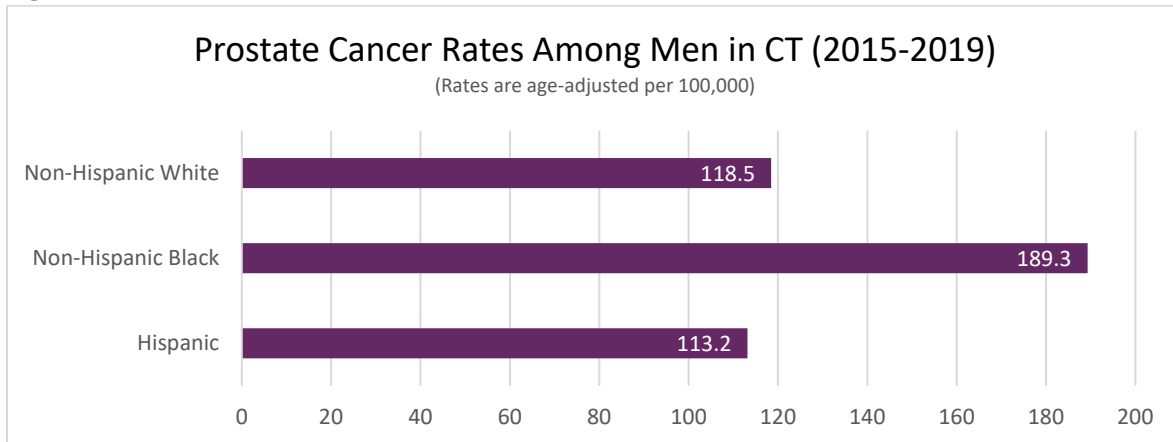
Source: DPH-Connecticut Tumor Registry

3.11 Life Expectancy

The Centers for Disease Control hosts an interactive map[56] of life expectancy data by census tract on its website. This data visualization gallery is a collaborative project between the National Center for Health Statistics (NCHS), the National Association for Public Health Statistics and Information Systems (NAPHSIS), and the Robert Wood Johnson Foundation.   Figure 3.11a is a visual of life expectancy estimates in Connecticut by census tract for the period of 2010-2015.
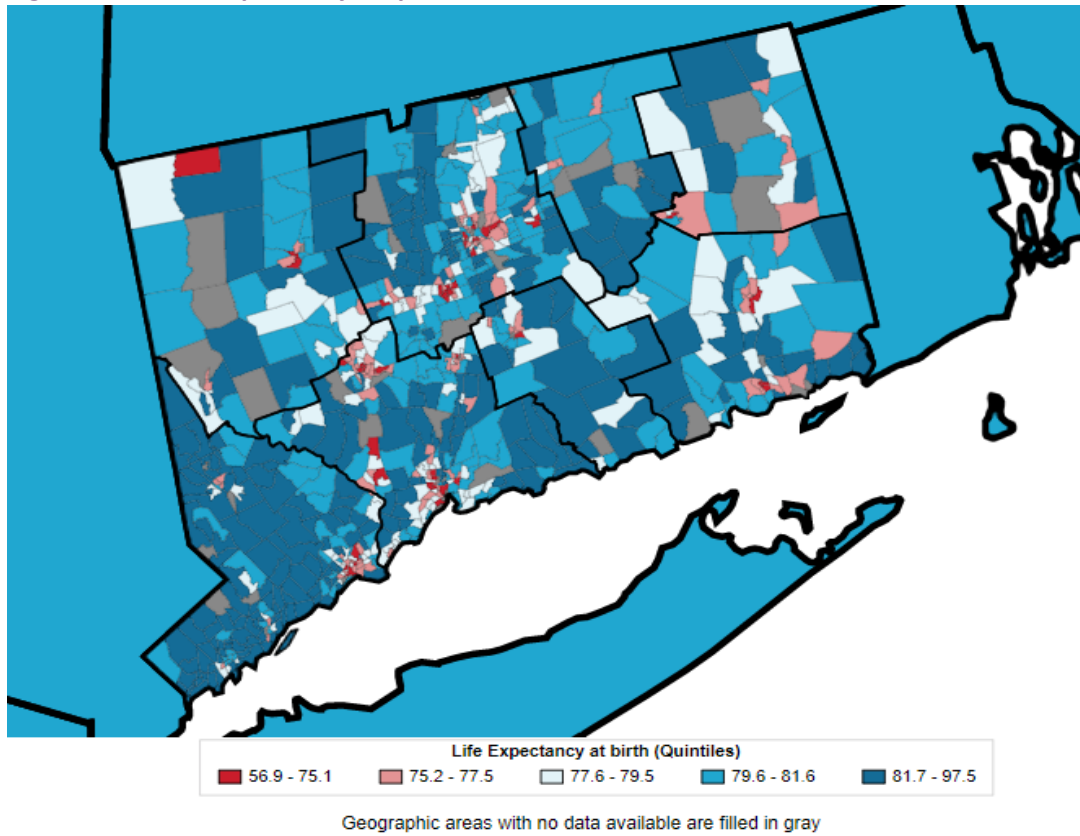
According to the National Vital Statistics System, "life expectancy tells us the average number of years of life a person who has attained a given age can expect to live. Life expectancy estimates from the National Center for Health Statistics provide a reliable snapshot of population health and mortality in the United States."[57] Dark red on the map (Figure 3.11a) indicates tracts with the lowest life expectancy (56.9 to 75.1 years) and dark blue parts of the map indicate the highest life expectancy (81.7 to 97.5 years). In Connecticut, most of the census tracts with the lowest life expectancy are urban areas whose populations are predominately comprised of low-income people of color. Tracts with the highest life expectancy are in suburban areas whose populations are disproportionately wealthy and White.

Hartford and New Haven are the two counties whose census tracts show the greatest disparities in life expectancy, though similar disparities along racial lines exist in all of Connecticut's counties. Within Hartford County, the cities of Hartford, New Britain, and Bristol have census tracts with the lowest life expectancies at 68.9, 71.5, and 73.0 years, respectively. In contrast, Avon, Glastonbury, and West Hartford, have tracts with life expectancies of 88.1, 87.4, and 86.2 years, respectively. The life expectancy within Hartford County ranges by 19 years. The racial disparities become clear when reviewing the racial composition of census tracts (see Tables 3.11a and 3.11b).

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[56] "Life Expectancy Data Viz," Centers for Disease Control and Prevention (Centers for Disease Control and Prevention, March 9, 2020), https://www.cdc.gov/nchs/data-visualization/life-expectancy/.
[57] Ibid

Figure 3.11a Life Expectancy Map

Life Expectancy at birth (Quintiles)

| 56.9 - 75.1 | 75.2 - 77.5 | 77.6 - 79.5 | 79.6 - 81.6 | 81.7 - 97.5 |

Geographic areas with no data available are filled in gray

Source: Centers for Disease Control, https://www.cdc.gov/nchs/data-visualization/life-expectancy/

Table 3.11a Hartford County- Racial Demographics & Life Expectancy

Racial Demographics (2020 DEC Redistricting Data) & Life Expectancy (2010-2015 CDC Data)				
				% of State Population
White				72.0%
Black				10.8%
Hispanic				16.9%
% of Town/City Population shaded below only if the population for that specific demographic is 5 percentage points overrepresented or underrepresented in comparison to the total state demographic population – i.e. if the percentage of White is greater than 77%, it is shaded in green; less than 67% is shaded in red.				
Hartford County				
City/Town	**Census Tract #**	**Life Expectancy in Years**	**% of Town/City Population***	**Overrepresented or Underrepresented**
Avon	4622.02	88.1		
White			70.45%	

Black				2.51%	Underrepresented
Hispanic				4.07%	Underrepresented
Bristol	4061	73.0			
White				52.9%	Underrepresented
Black				9.5%	
Hispanic				31.2%	Overrepresented
Glastonbury	5205.01	87.4			
White				84.9%	Overrepresented
Black				0.8%	Underrepresented
Hispanic				4.2%	Underrepresented
Hartford	5012	68.9			
White				1.8%	Underrepresented
Black				61.6%	Overrepresented
Hispanic				33.4%	Overrepresented
New Britain	4171	71.5			
White				22.8%	Underrepresented
Black				15.5%	
Hispanic				56.3%	Overrepresented
West Hartford	4970	86.2			
White				83.8%	Overrepresented
Black				2.5%	Underrepresented
Hispanic				5.5%	Underrepresented

The same pattern is evident in New Haven County where certain tracts within the cities of Waterbury, New Haven, and Meriden have life expectancies of 69.8, 71.7, and 73.1 years, respectively. In contrast, those living in specific census tracts located in Middlebury, Guilford, and Branford have life expectancies of 85.4, 84.8, and 82.4 years, respectively. Here, there is a life expectancy difference of 12-16 years between the two groups of tracts.

**Table 3.11b New Haven County- Racial Demographics & Life Expectancy**

Racial Demographics (2020 DEC Redistricting Data) & Life Expectancy (2010-2015 CDC Data)				
				% of State Population
White				72.0%
Black				10.8%
Hispanic				16.9%
% of Town/City Population shaded below only if the population for that specific demographic is 5 percentage points overrepresented or underrepresented in comparison to the total state demographic population – i.e. if the percentage of White is greater than 77%, it is shaded in green; less than 67% is shaded in red.				

New Haven County				
City/Town	**Census Tract #**	**Life Expectancy in Years**	**% of Town/City Population**	**Overrepresented or Underrepresented**
Branford	1846	82.4		
White			92.2%	Overrepresented
Black			0.3%	Underrepresented
Hispanic			3.9%	Underrepresented
Guilford	1902	84.8		
White			86.6%	Overrepresented
Black			1.0%	Underrepresented
Hispanic			4.8%	Underrepresented
Meriden	1702	73.1		
White			21.8%	Underrepresented
Black			14.8%	
Hispanic			60.3%	Overrepresented
Middlebury	3442	85.4		
White			84.5%	Overrepresented
Black			1.2%	Underrepresented
Hispanic			4.0%	Underrepresented
New Haven	1415	71.7		
White			4.2%	Underrepresented
Black			72.0%	Overrepresented
Hispanic			19.1%	
Waterbury	3501	69.8		
White			18.3%	Underrepresented
Black			17.1%	Overrepresented
Hispanic			58.8%	Overrepresented

Tables 3.11a and 3.11b illustrate how large disparities exist in life expectancy between census tracts, including those located in the same county and sometimes the same city. This becomes particularly important when we examine Connecticut's history of redlining. When we look at a redlined map of Hartford and West Hartford from 1937, we find that life expectancy rates in areas which historically excluded people of color are longer.

Figure 3.11b 1937 Hartford and West Hartford "Redlining" Map & Two Current Census Tracts
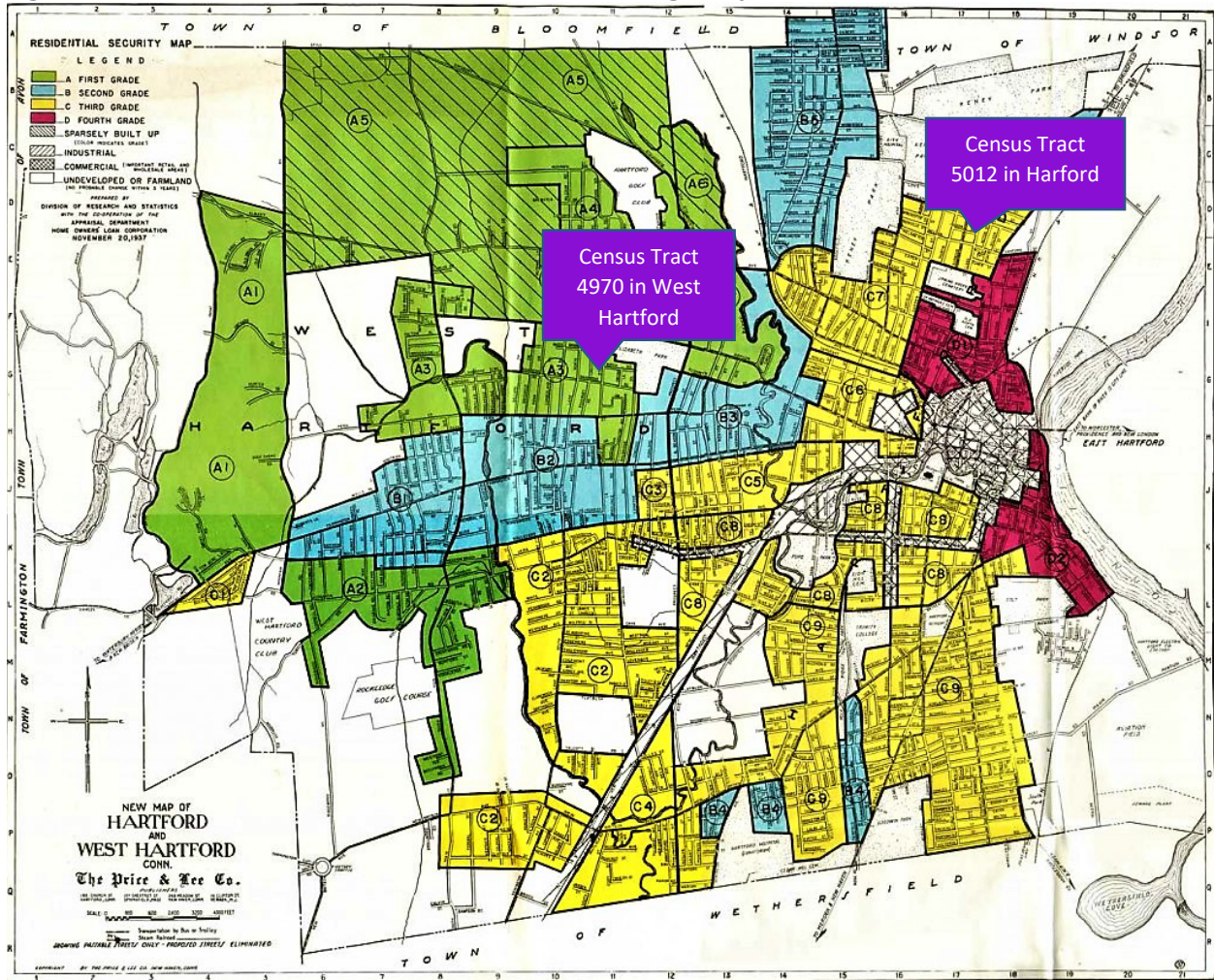
Source: Home Owner's Loan Corporation (HOLC) residential security map of Hartford area in 1937. Records of the Federal Home Loan Bank Board, National Archives, II, College Park, Maryland
*Current Census Tract labels added by Gretchen Marin, MA

The map in Figure 3.11b was created by the Home Owner's Loan Corporation in 1937 to assess the "trend of desirability" in residential areas in an effort to combat foreclosures. These maps were used by banks to determine the level of risk associated with providing residential mortgages in areas within Connecticut and throughout the country. The racial and socioeconomic makeup of a neighborhood was used to evaluate whether a mortgage in the area would be deemed a worthwhile investment.[58] The neighborhoods were color coded and graded: A (green) was categorized as the most desirable; B (blue) as desirable; C (yellow) as less desirable; and finally, D (red) as the least desirable. Most areas with Black residents were systematically graded D (red). This signaled that areas with Black residents were not desirable - causing the property values to plummet and stifling homeownership and lending in these neighborhoods.[59]

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[58] McGann, S., "The Effects of 'Redlining' on the Hartford Metropolitan Region," Connecticut History, March 18, 2014, https://connecticuthistory.org/the-effects-of-redlining-on-the-hartford-metropolitan-region/.
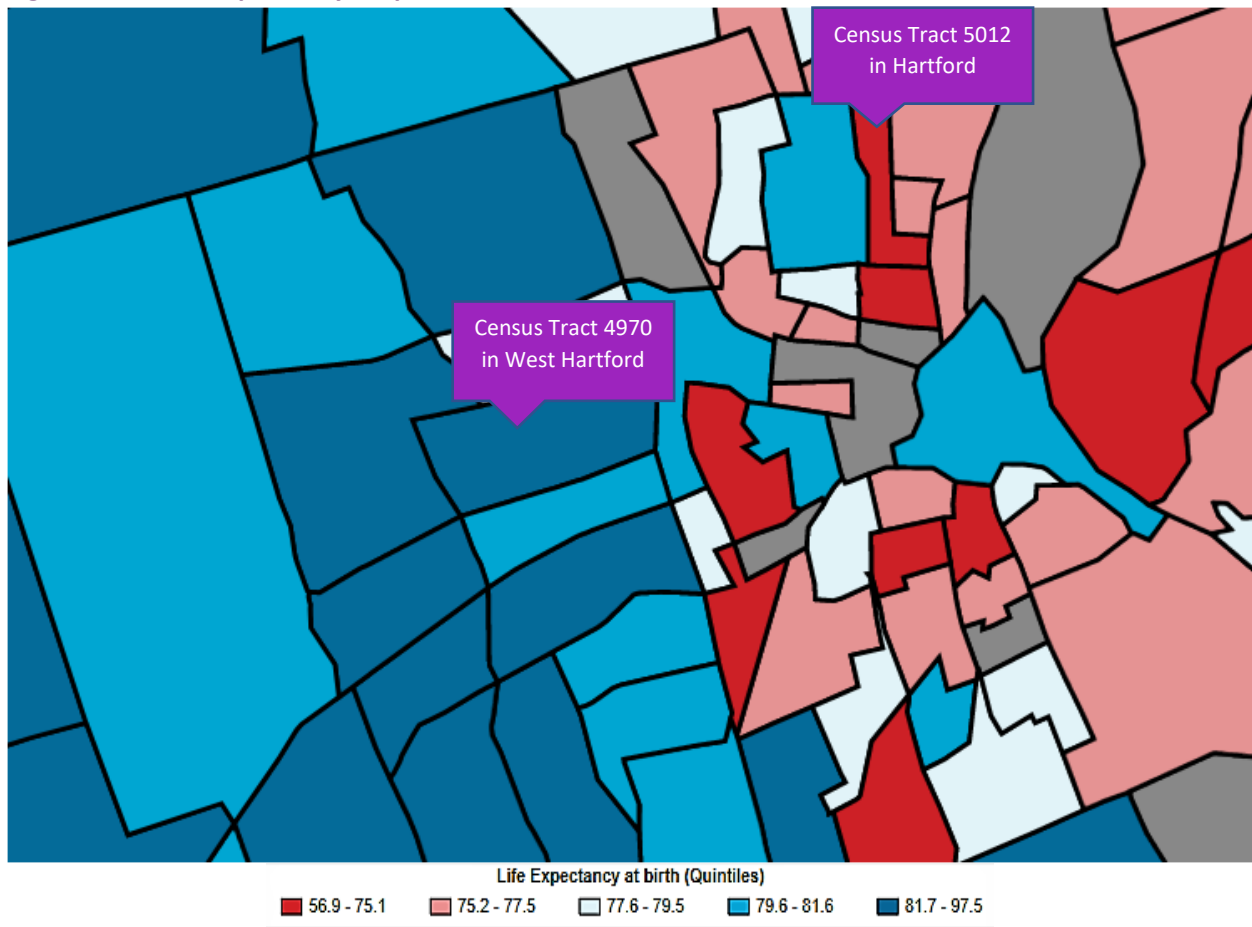[59] Jackson, C. "What is Redlining," *The New York Times,* Aug. 17, 2021, https://www.nytimes.com/2021/08/17/realestate/what-is-redlining.html

When comparing a redlined map of Hartford alongside a U.S. Census Bureau Life Expectancy map, it is apparent that census tracts which were redlined in 1937 have the lowest life expectancies in the state. Today, residents of the green and blue sections of the redlined map are predominantly White and have longer life expectancies than the residents of the red and yellow sections which are predominantly Black and have shorter life expectancies. These maps show how census tracts became a proxy for race on a community level.

In an example of community level disparities, two census tracts – one in Hartford and one in West Hartford – show dramatic differences. Residents in census tract 5012 in Hartford have an average life expectancy of 68.9 years with 1.8% of the residents being White. In contrast, residents in census tract 4970, located in West Hartford, have an average life expectancy of 86.2 years with 83.5% of its residents being White. Although these two census tracts are less than five miles apart, the difference in life expectancy is 17.3 years.

The data shows how Connecticut's history of redlining is reflected in the racial and ethnic composition of communities throughout the state today. Despite the passage of the Fair Housing Act in 1968, which was designed to end the practice of redlining, communities in Connecticut remain racially segregated.

Figure 3.11c Life Expectancy Map & Two Current Census Tracts

Life Expectancy at birth (Quintiles)

■ 56.9 - 75.1	■ 75.2 - 77.5	□ 77.6 - 79.5	■ 79.6 - 81.6	■ 81.7 - 97.5

Geographic areas with no data available are filled in gray

Source: Centers for Disease Control, https://www.cdc.gov/nchs/data-visualization/life-expectancy/
*Current Census Tract labels added by Gretchen Marin, MA

Section 4: Education Performance & Discipline

Commission staff worked with the Connecticut State Department of Education to prepare the school performance and discipline data in this section. For clarity, the figures below represent four of the seven racial/ethnic categories listed in the tables.

4.1 KEI Rates

The Kindergarten Entrance Inventory (KEI) is a teacher rating whereby student behaviors and skills are rated by specific indicators in six domains: language skills, literacy skills, numeracy skills, physical/motor skills, creative/aesthetic skills, and personal/social skills.

Students are divided into 3 categories indicating the level of support needed: 1 (substantial support), 2 (some support), or 3 (minimal support).

The charts and figures below show the percentage of students requiring minimal instructional support (Level 3) in each of the six areas for the past five years.

In each of the six Kindergarten Entrance Inventory (KEI) measures, Black and Hispanic children consistently score lower than their White and Asian counterparts. English language learners face particular challenges that impact their scores.[60] Socioeconomic status (SES) is also a main contributor to these disparities. SES has a strong relationship to race/ethnicity (explained more fully in the *Poverty* and *Median Income* sections of this report).[61]

4.1a Language Skills

The first domain listed in the inventory is language skills. There are six indicators under this domain:
1) Participates in conversations.
2) Retells information from a story read to him/her.
3) Follows simple verbal two-step directions.
4) Speaks using sentences of at least five words.
5) Communicates feelings and needs.
6) Listens attentively to a speaker.

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[60] Michael J. Strambler, Clare W. Irwin, Joanna L. Meyer, and George A. Coleman. "Assessing Kindergarten Entry Skills in Connecticut: The Kindergarten Entrance Inventory, 2010-2013," Partnership for Early Education Research, April 2018. https://medicine.yale.edu/psychiatry/peer/publications/peer%20brief_kindergarten%20entry%20skills%20in%20connecticut_332364_284_31376_v1.pdf

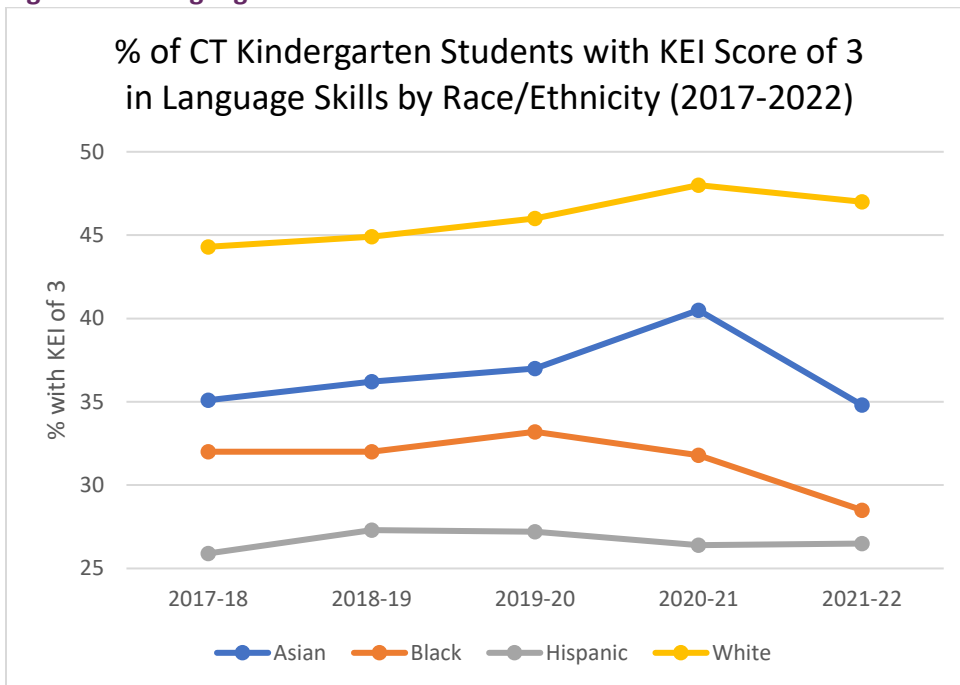[61] Ibid.

Table 4.1a Language Skills

Race/Ethnicity	2017-18	2018-19	2019-20	2020-21	2021-22
AI/AN	33.8%	36.0%	40.8%	29.7%	30.3%
Asian	35.1%	36.2%	37.0%	40.5%	34.8%
Black	32.0%	32.0%	33.2%	31.8%	28.5%
Hispanic	25.9%	27.3%	27.2%	26.4%	26.5%
NH/PI	39.6%	36.0%	21.4%	20.0%	50.0%
Multiracial	40.7%	40.1%	40.2%	42.1%	41.3%
White	44.3%	44.9%	46.0%	48.0%	47.0%

Source: Connecticut State Department of Education

Figure 4.1a Language Skills

Source: Connecticut State Department of Education

4.1b Literacy Skills

The second domain listed in the inventory is literacy skills. There are seven indicators under this domain:

1) Holds a book and turns pages from front to the back.
2) Understands that print conveys meaning.
3) Explores books independently.

4) Recognizes printed letters, especially in his/her name and familiar printed words.
5) Matches/connects letters and sounds.
6) Identifies some initial sounds.
7) Demonstrates emergent writing.

Table 4.1b Literacy Skills

Race/Ethnicity	2017-18	2018-19	2019-20	2020-21	2021-22
AI/AN	36.3%	31.5%	23.7%	18.9%	30.3%
Asian	43.5%	44.5%	47.5%	46.3%	43.2%
Black	30.6%	31.2%	32.8%	29.2%	27.0%
Hispanic	23.5%	25.3%	25.4%	21.9%	22.5%
NH/PI	33.3%	40.0%	17.9%	28.6%	40.9%
Multiracial	40.5%	38.5%	38.7%	40.1%	39.6%
White	42.8%	43.0%	45.6%	45.4%	45.0%

Source: Connecticut State Department of Education

Figure 4.1b Literacy Skills

% of CT Kindergarten Students with KEI Score of 3 in Literacy Skills by Race/Ethnicity (2017-2022)
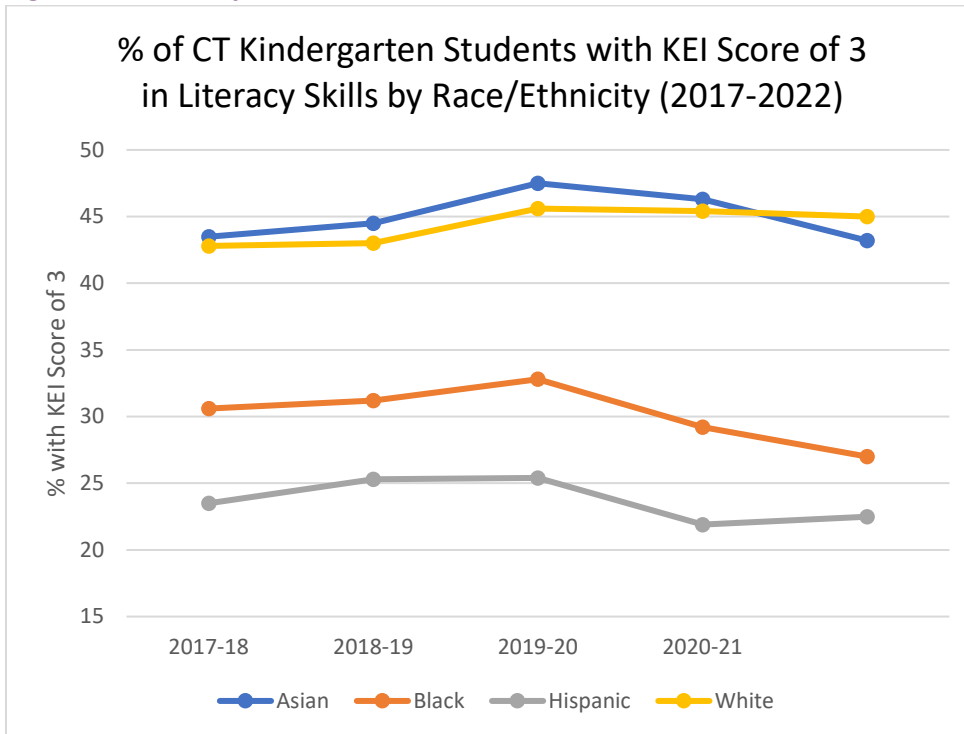
Source: Connecticut State Department of Education

4.1c Numeracy Skills

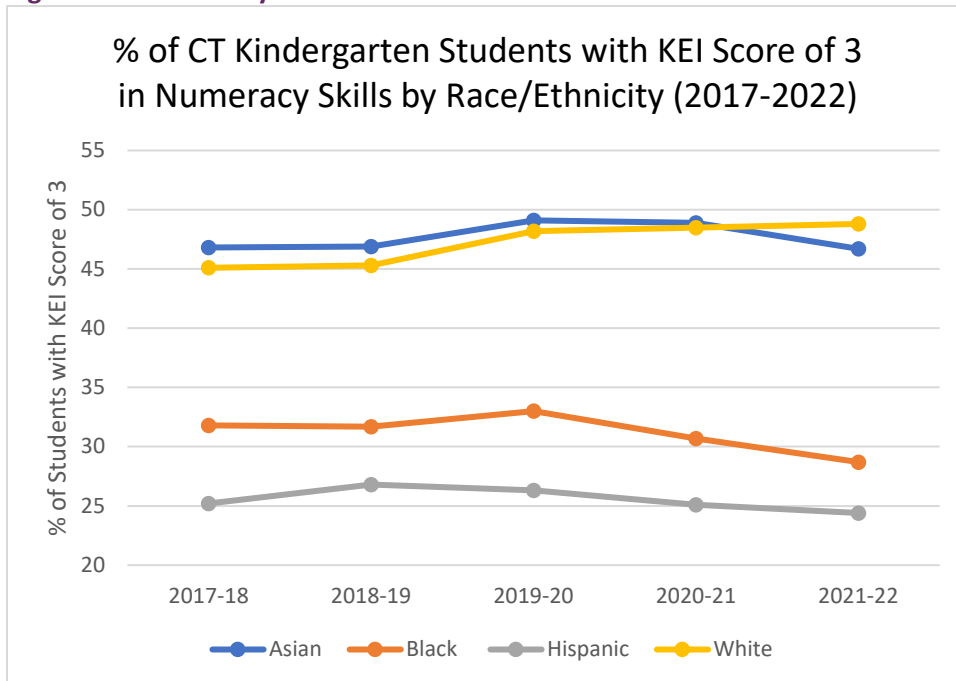The third domain listed in the inventory is numeracy skills. This domain is defined by seven indicators:
1) Counts to 10.
2) Demonstrates 1-to-1 correspondence while counting (e.g., touches objects as he/she counts).
3) Measures objects using a variety of everyday items.
4) Identifies simple shapes (e.g., circles, squares, rectangles, and triangles).
5) Identifies patterns.
6) Sorts and groups objects by size, shape, function (use), or other attributes.
7) Understands sequence of events (e.g., before, after, yesterday, today, or tomorrow).

Table 4.1c Numeracy Skills

Race/Ethnicity	2017-18	2018-19	2019-20	2020-21	2021-22
AI/AN	31.3%	29.2%	31.6%	29.7%	33.3%
Asian	46.8%	46.9%	49.1%	48.9%	46.7%
Black	31.8%	31.7%	33.0%	30.7%	28.7%
Hispanic	25.2%	26.8%	26.3%	25.1%	24.4%
NH/PI	35.4%	40.0%	21.4%	31.4%	40.9%
Multiracial	41.6%	40.2%	41.2%	43.3%	42.4%
White	45.1%	45.3%	48.2%	48.5%	48.8%

Source: Connecticut State Department of Education

Figure 4.1c Numeracy Skills

Source: Connecticut State Department of Education

4.1d Physical Skills

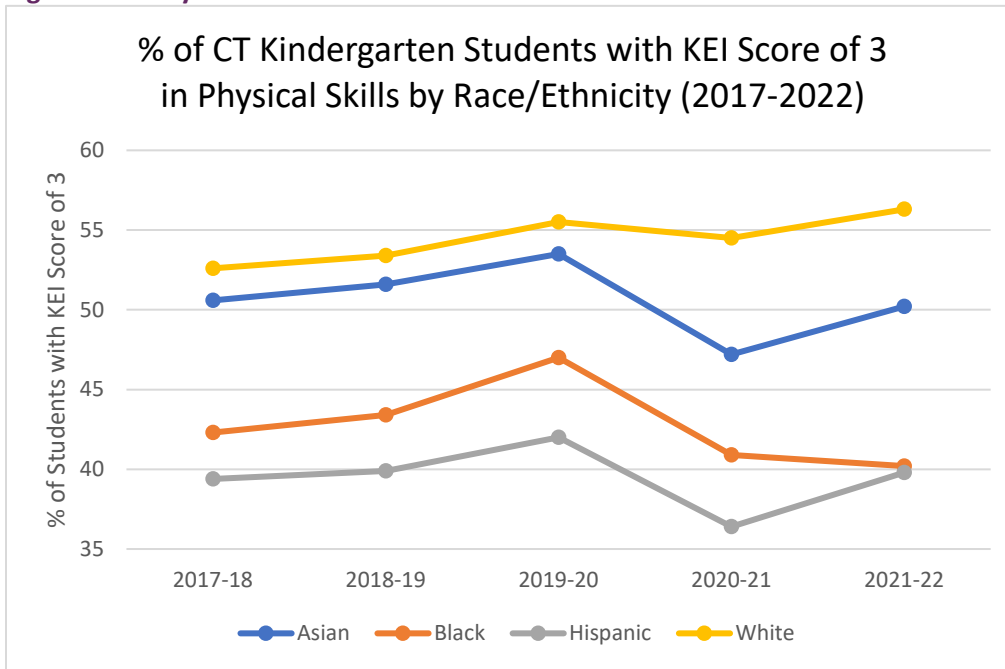The fourth domain listed in the inventory is physical/motor skills. This domain is defined by four indicators:
1) Runs, jumps, or balances.
2) Kicks or throws a ball, climbs stairs, or dances.
3) Writes or draws using writing instruments (e.g., markers, chalk, pencils, etc.).
4) Performs tasks, such as completing puzzles, stringing beads, or cutting with scissors.

Table 4.1d Physical Skills

Race/Ethnicity	2017-18	2018-19	2019-20	2020-21	2021-22
AI/AN	45.0%	46.1%	59.2%	40.5%	46.5%
Asian	50.6%	51.6%	53.5%	47.2%	50.2%
Black	42.3%	43.4%	47.0%	40.9%	40.2%
Hispanic	39.4%	39.9%	42.0%	36.4%	39.8%
NH/PI	41.7%	56.0%	42.9%	31.4%	61.4%
Multiracial	50.7%	49.2%	49.2%	48.6%	51.8%
White	52.6%	53.4%	55.5%	54.5%	56.3%

Source: Connecticut State Department of Education

Figure 4.1d Physical Skills

% of CT Kindergarten Students with KEI Score of 3 in Physical Skills by Race/Ethnicity (2017-2022)

Source: Connecticut State Department of Education

4.1e Creative Skills

The fifth domain listed in the inventory is creative/aesthetic skills. This domain has been defined by three indicators:
1) Draws, paints, sculpts, or builds to represent experiences.
2) Participates in pretend play.
3) Enjoys or participates in musical experiences (e.g., singing, clapping, drumming, or dancing).

Table 4.1e Creative Skills

Race/Ethnicity	2017-18	2018-19	2019-20	2020-21	2021-22
AI/AN	43.8%	38.2%	51.3%	35.1%	44.4%
Asian	50.1%	51.7%	54.1%	49.6%	49.0%
Black	40.9%	42.6%	42.4%	37.9%	38.5%
Hispanic	38.3%	38.5%	39.7%	35.0%	38.2%
NH/PI	43.8%	56.0%	39.3%	31.4%	52.3%
Multiracial	49.5%	49.7%	48.0%	47.9%	50.2%
White	53.8%	54.9%	56.4%	55.0%	56.6%

Source: Connecticut State Department of Education

Figure 4.1e Creative Skills

% of CT Kindergarten Students with KEI Score of 3 in Creative Skills by Race/Ethnicity (2017-2022)
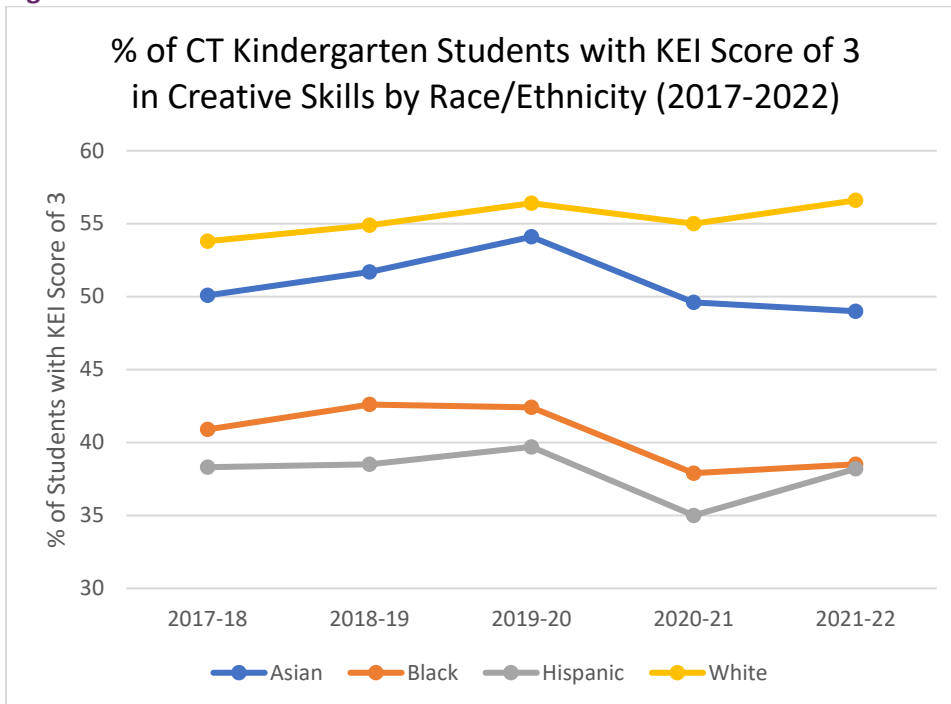
Source: Connecticut State Department of Education

4.1f Personal Skills

The sixth and final domain listed in the inventory is personal/social skills. This domain has been defined by five indicators:
1) Engages in self-selected activities.
2) Interacts with peers to play or work cooperatively.
3) Uses words to express own feelings or to identify conflicts.
4) Seeks peer or adult help to resolve a conflict.
5) Follows classroom routines.

Table 4.1f Personal Skills

Race/Ethnicity	2017-18	2018-19	2019-20	2020-21	2021-22
AI/AN	30.0%	33.7%	39.5%	37.8%	35.4%
Asian	41.4%	42.4%	42.1%	42.0%	38.3%
Black	32.0%	32.7%	34.1%	32.6%	29.9%
Hispanic	30.3%	31.5%	31.4%	30.5%	30.4%
NH/PI	43.8%	44.0%	21.4%	25.7%	54.5%
Multiracial	40.7%	39.2%	39.8%	43.5%	42.9%
White	45.7%	46.3%	47.3%	49.2%	48.1%

Source: Connecticut State Department of Education

Figure 4.1f Personal Skills
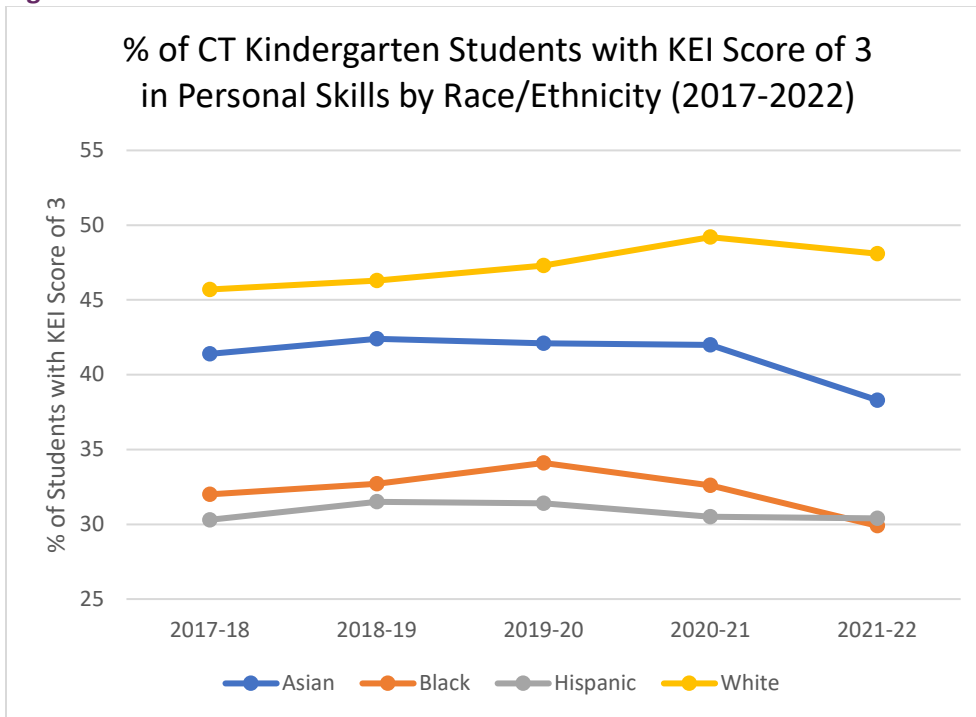
Source: Connecticut State Department of Education

4.2 Third Grade English Language Arts Proficiency

Note:
In 2019-20, all statewide academic assessments were cancelled due to the COVID-19 pandemic.
In 2020-21, school learning models changed throughout the school year and many students learned remotely for a significant part of the year. In light of these significant variations, the 2020-21 results are reported separately with specialized considerations and analyses by the State Department of Education.[62] Therefore, the 2019-2020 and 2020-2021 academic years were omitted from the chart and graph below.

Similar to the KEI measures, Black and Hispanic children have consistently scored less than their White and Asian classmates. Scores on the English Language Arts assessment for third grade Black and Hispanic students are nearly identical to each other, ranging from roughly 26.5% to 35.5%, whose writing is considered, at a minimum, "adequate".[63] Although White students score slightly higher than Asian students, both groups score about twice as high as Black and Hispanic students ranging between 62% to 73.4%. Racial segregation and concentrated poverty, which impacts both school resources and challenges faced by families, are associated with lower test scores.[64]

Table 4.2 Third Grade English Language Arts Proficiency

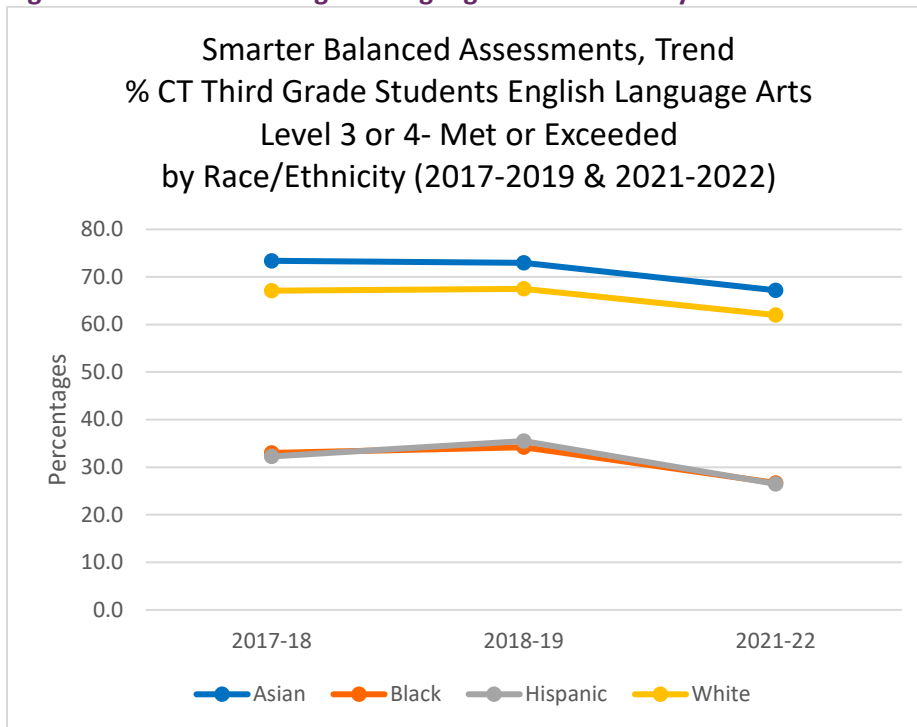| Smarter Balanced Assessments, Trend % Connecticut Third Grade Students English Language Arts, Level 3 or 4 (Met or Exceeded)			
Race/Ethnicity	**2017-18**	**2018-19**	**2021-22**
AI/AN	50.0	*	36.0
Asian	73.4	73.0	67.2
Black	33.0	34.2	26.7
Hispanic	32.3	35.5	26.5
NH/PI	45.7	*	37.9
Multiracial	58.4	58.4	54.2
White	67.1	67.5	62.0

Source: EdSight, *https://public-edsight.ct.gov/performance/smarter-balanced-achievement-participation?language=en_US*

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[62] "Statewide Summative Assessment Results 2020-21," CT.gov (State Department of Education), accessed April 30, 2023, https://portal.ct.gov/SDE/Student-Assessment/Main-Assessment/Statewide-Summative-Assessment-Results-2020-21.

[63] "English Language Arts," Smarter Content Explorer, accessed April 30, 2023, https://contentexplorer.smarterbalanced.org/target/e-g3-c2-t7.

[64] Katharine Bradbury, "Racial and Socioeconomic Test-Score Gaps in New England Metropolitan Areas: State School Aid and Poverty Segregation," Education Resources Information Center (New England Public Policy Center, February 2021), https://files.eric.ed.gov/fulltext/ED615013.pdf.

Figure 4.2 Third Grade English Language Arts Proficiency

Smarter Balanced Assessments, Trend
% CT Third Grade Students English Language Arts
Level 3 or 4- Met or Exceeded
by Race/Ethnicity (2017-2019 & 2021-2022)

Source: EdSight, *https://public-edsight.ct.gov/performance/smarter-balanced-achievement-participation?language=en_US*

4.3 Chronic Absenteeism

The data on chronic absenteeism mimics the data from the third grade English Language Arts assessments. Data for Black and Hispanic students closely mirror each other, as does data for White and Asian students (with some deviation during the 2020-21 school year due to COVID-19).

The rates for chronic absenteeism are at least twice as high for Black and Hispanic students with that gap widening following the declaration of COVID-19 as a public health emergency. In the years following this declaration, chronic absenteeism increased for all groups but there was a sharp increase for Black and Hispanic students.

The data provided includes all grade levels, K-12. The State Department of Education has conducted its own research to provide insight and explanations as to why students are chronically absent. They divide their findings into four categories: myths and misperceptions about attendance; barriers to attendance; aversion to school, and disengagement from school.[65] In addition, the causes of absenteeism are likely different for a child in elementary school versus a youth in high school. For example, an elementary student is more likely to miss school due to increased exposure to respiratory illnesses and reduced

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[65] Connecticut State Department of Education, Reducing Chronic Absence in Connecticut's Schools: A Prevention and Intervention Guide for Schools and Districts, 2014, https://portal.ct.gov/SDE/Publications/Reducing-Chronic-Absence-in-Connecticuts-Schools/Why-are-students-chronically-absent

immunity, parent choice to keep child home due to mild illness, episodic asthma, or dental pain. Alternatively, a high school student may be more prone to disengage from school due to lack of access to health care, mental health challenges, employment, or to provide childcare for younger siblings.
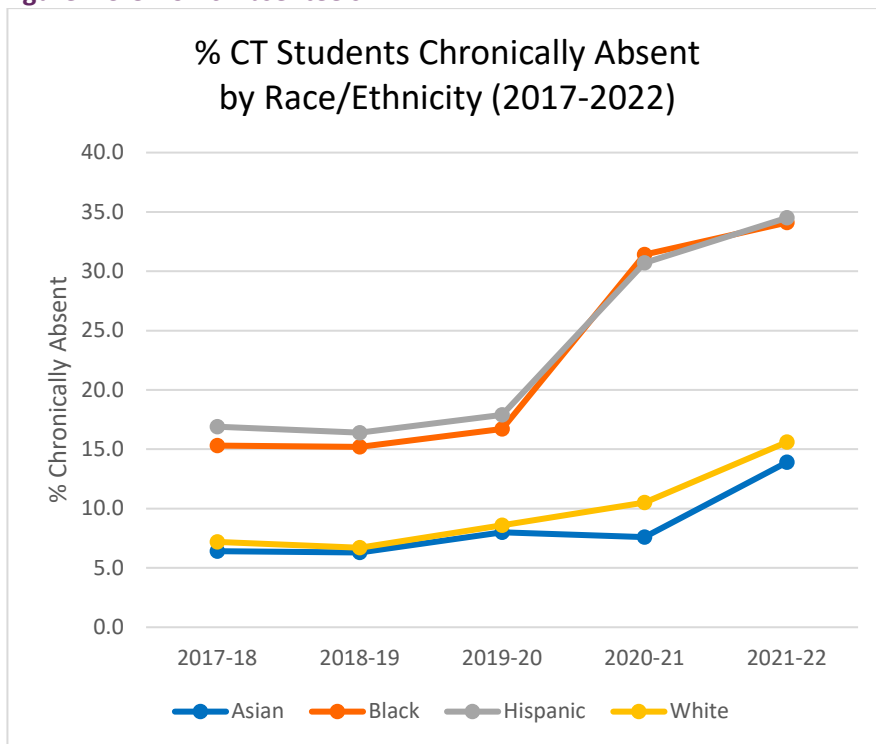
Table 4.3 Chronic Absenteeism

Note: A student is chronically absent if they miss ten percent or greater of the total number of days enrolled in the school year for any reason. Pre-Kindergarten students are excluded from this calculation.

% Connecticut Students Who Are Chronically Absent					
Race/Ethnicity	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**
AI/AN	13.9	12.0	15.0	28.4	29.9
Asian	6.4	6.3	8.0	7.6	13.9
Black	15.3	15.2	16.7	31.4	34.1
Hispanic	16.9	16.4	17.9	30.7	34.5
NH/PI	12.7	9.9	14.8	20.6	23.6
Multiracial	10.0	10.0	12.1	19.4	23.8
White	7.2	6.7	8.6	10.5	15.6

Source: EdSight, *https://public-edsight.ct.gov/students/chronic-absenteeism?language=en_US*

Figure 4.3 Chronic Absenteeism

Source: EdSight, *https://public-edsight.ct.gov/students/chronic-absenteeism?language=en_US*

4.4 Suspension Rates

Notes regarding the COVID-19 pandemic:

- In the 2019-20 school year, in-person classes were cancelled in mid-March; all districts switched to fully remote instruction for the remainder of the school year.
- In the 2020-21 school year, students attended school in-person to varying degrees; some learned fully/mostly remotely for the entire school year.
- Due to the large period of remote instruction in the 2019-20 school year and varying degrees of in-person schooling in 2020-21, we have not included these years in the chart below.

The graph for suspension rate data looks differently from the previous education data charts, but the common trend is consistent. As displayed, White and Asian students have significantly lower suspension rates than their Hispanic and Black counterparts. The rate for Asian students is the lowest, hovering at roughly 2% or below. The rate for White students hovers around 4% which is about twice the rate of Asian students. The rate for Hispanic students ranges from 8-10% which is significantly higher than that of Asian and White students. Black students have the highest suspension rate of all groups ranging from about 12-14%. There is a significant disparity between the suspension rates for Black and White students with Black students being suspended 2 to 3 times more often than White students. The greatest disparity is seen between Black and Asian students with the suspension rates for Black students being about 6 to 7 times higher than that of Asian students.

There are many contributing factors as to why racial disparities in suspension rates exist. Students may be suspended for defiant, disrespectful, or disruptive behavior. The interpretation of observed behavior using these terms can be subjective and misinterpreted across cultures. Additionally, many young people experience disconnection between the school environment and their daily lived experience, including stressors from outside the classroom (food or housing instability and/or other community, family, or personal issues).

Factors that affect behavior and can support positive, pro-social behaviors of students in school include, but are not limited to:

- Constructive strategies to teach and support students, and respond to behavioral concerns in a similar manner to academic concerns (i.e., increasing instruction and support when the issues occur).
- Review and analysis of disaggregated discipline data and root causes.
- Implementation of the Multi-Tiered Systems of Support – a comprehensive systems approach to prevent and address challenging behaviors, designed by the State Department of Education.[66]
- Policies that provide for alternative discipline practices instead of exclusionary discipline.
- Classroom and school connectedness, and relationships with adults.
- Coordination of services between schools and community agencies to meet students' non-academic and behavioral needs.
- Consistent communication of schoolwide expectations.

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[66] Connecticut State Department of Education. "Leveraging Multi-Tiered Systems of Support (MTSS) to Enhance Educational Leadership," Access May 11, 2023, https://portal.ct.gov/-/media/SDE/Social-Emotional-Learning/MTSS_Leadership.pdf

- Calm, safe, and restorative learning environments with positive, proactive, and predictable classroom management strategies.
- Student, family, and community partnerships that can promote empathy, foster collaboration, and reap the strengths of our diverse and multicultural state.
- Identification and timely treatment for social, behavioral, mental, and physical health issues.
- School-based services to address specialized and individual needs for multilingual learners and students with disabilities.

Table 4.4 Suspension Rates

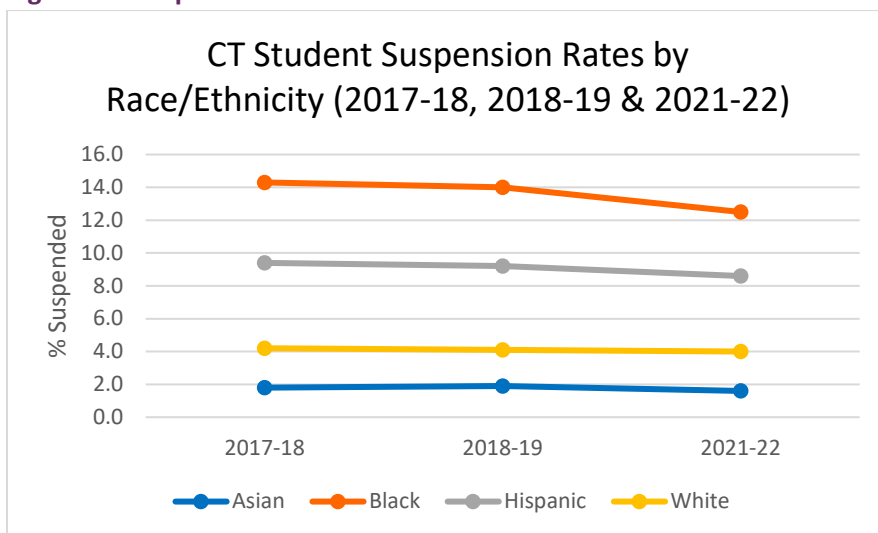| Suspension Rates					
Race/Ethnicity	2017-18	2018-19	2019-20	2020-21	2021-22
AI/AN	8.4	8.3	6.6	1.8	8.5
Asian	1.8	1.9	1.1	0.4	1.6
Black	14.3	14.0	10.3	2.1	12.5
Hispanic	9.4	9.2	6.9	1.5	8.6
NH/PI	5.8	5.7	5.3	1.4	8.5
Multiracial	7.0	7.0	4.9	1.9	7.0
White	4.2	4.1	2.9	1.3	4.0

[1]Suspension Rate equals the number of students reported with at least one suspension (in-school or out-of-school) or expulsion in ED166 Student Disciplinary Offense Data Collection divided by the unduplicated student enrollment count for the school or district across the October, January (until 2016) and June PSIS Collections for the given school year.

When a filter, or student group, is selected, the Suspension Rate equals the number of students in that student group reported with at least one suspension (in-school or out-of-school) or expulsion in ED166 Student Disciplinary Offense Data Collection divided by the unduplicated student enrollment count for that particular student group.

This report excludes students in prekindergarten.

Source: EdSight, *https://public-edsight.ct.gov/students/suspension-rates?language=en_US*

Figure 4.4 Suspension Rates

CT Student Suspension Rates by Race/Ethnicity (2017-18, 2018-19 & 2021-22)

Source: EdSight, *https://public-edsight.ct.gov/students/suspension-rates?language=en_US*

4.5 Four-Year High-School Graduation Rates

Note: The Four-Year Graduation Rate is the percentage of students who received a standard high school diploma within four years, including early and summer graduates from the cohort.

The education measures we have examined so far come to a head with this measure. KEI scores, Third Grade English Language Arts scores, chronic absenteeism rates, and suspension rates all inform high school graduation rates. The same pattern we have seen with White and Asian students, and Black and Hispanic students, following similar trajectories, is also evident in graduation rates. By the time students get into high school, issues affecting their educational performance discussed earlier culminate and often worsen. In addition, chronic absenteeism combined with possible lost learning time due to out-of-school suspensions may cause students to fall farther behind. Despite these challenges, there are encouraging trends for Black and Hispanic students emerging in the realm of education. Graduation rates have increased across all racial and ethnic groups over the past decade, and the disparity has decreased (see Figure 4.2b).

Multiple Connecticut school districts have employed various strategies to successfully increase high school graduation rates and narrow disparities. Examples of these solutions include access to proactive career coaches, school-based health services, social support services (by way of full-time social workers and guidance counselors, bilingual social workers, and external partnerships), education credit recovery and extended day support programs, free summer school, family engagement, and student-informed initiatives.[67]

Table 4.5a Four-Year High-School Graduation Rates

% Who Graduate Within Four Years				
Race/Ethnicity	**2017-18**	**2018-19**	**2019-20**	**2020-21**
Asian	95.7	95.9	95.5	96.3
Black	80.2	79.8	80.8	81.6
NH/PI	100.0	94.0	85.4	100.0
Hispanic	78.8	80.2	80.7	82.3
AI/AN	85.3	92.4	88.7	91.3
Multiracial	87.7	88.4	90.8	89.3
White	93.3	93.3	93.6	94.0

Source: EdSight, *https://public-edsight.ct.gov/performance/four-year-graduation-rates?language=en_US*

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[67] Connecticut State Department of Education. " Improving High School Graduation Rates: Insights from Four Connecticut Districts," May 2022, https://portal.ct.gov/-/media/SDE/Press-Room/Graduation-Rate-Insights_2018-19_May-2020.pdf

Figure 4.5a Four-Year High School Graduation Rates
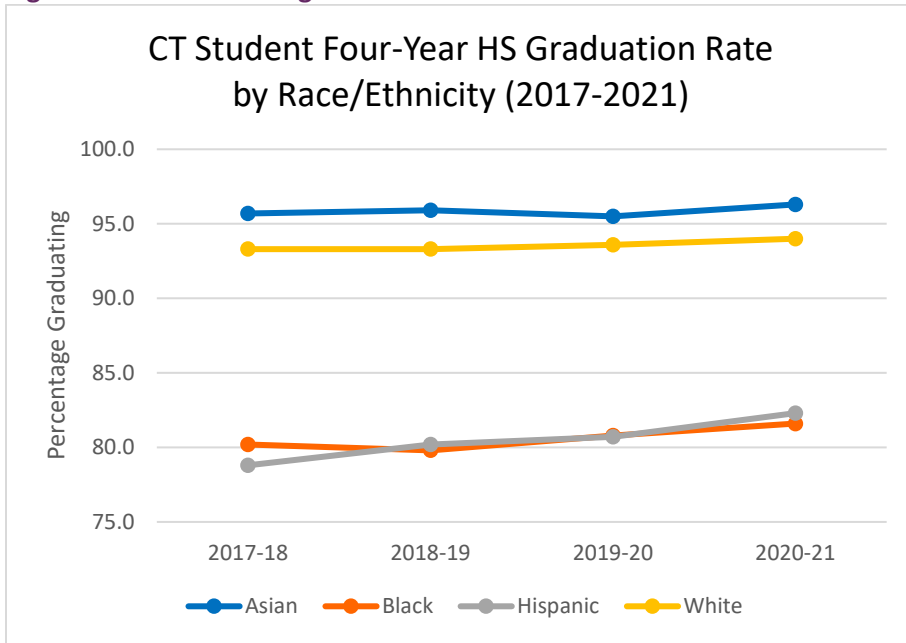
CT Student Four-Year HS Graduation Rate
by Race/Ethnicity (2017-2021)

Source: EdSight, *https://public-edsight.ct.gov/performance/four-year-graduation-rates?language=en_US*

Table 4.5b Percentage of Students Who Graduate Within Four Years

% Who Graduate Within Four Years	
Race/Ethnicity	**2010-11**
Asian	92.2
Black	71.2
Hispanic	64.2
AI/AN	72.5
White	89.4

Note: The NH/PI and Multiracial categories were not used by the State Department of Education in 2010-11.

Figure 4.5b Percentage of Students Who Graduate Within Four Years

CT Student Four-Year HS Graduation Rate by Race/Ethnicity (2010-2021)
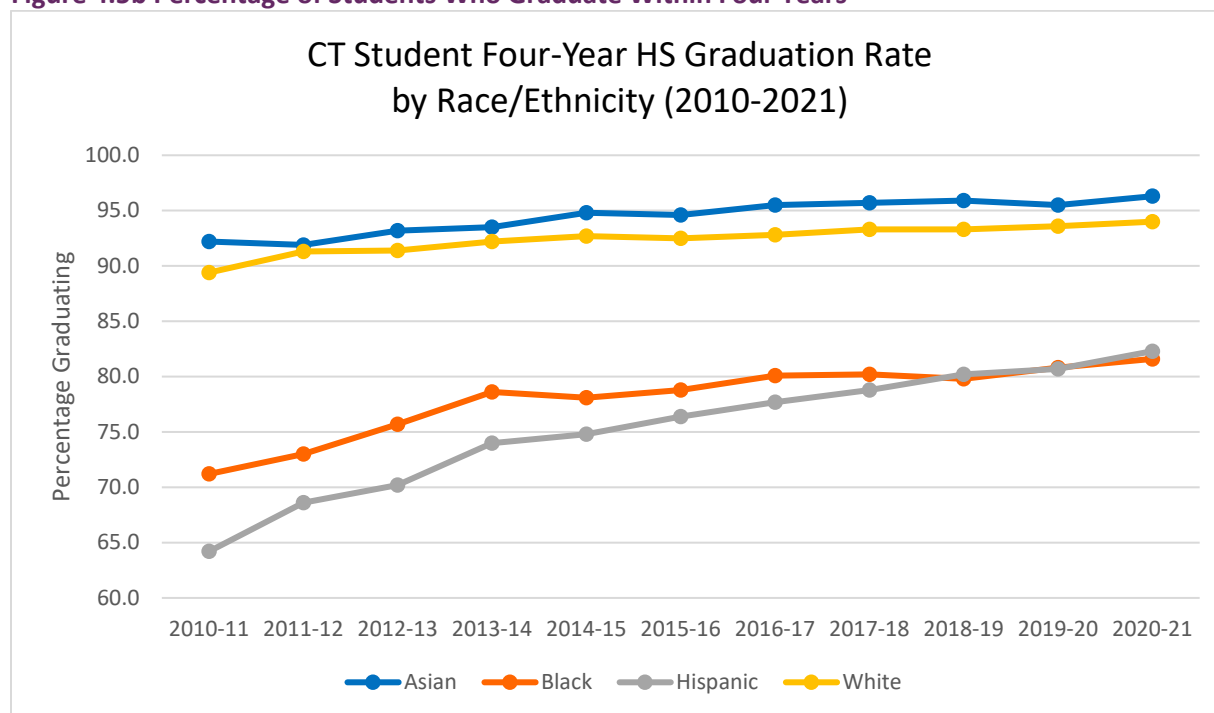
4.6 College Enrollment, Persistence, & Graduation Rates

The State Department of Education collects data on cohorts of high school graduates as it pertains to their post high school educational pursuits. They collect and report the percentages of students who:

- Enroll in college following their high school graduation (Enrolled First Year)
- Return to college for their second year (Persistence Rate)
- Graduate from college within four years (4-Year Graduation Rate)
- Graduate from college within six years (6-Year Graduation Rate)

The data shows that Asian and White high school graduates have high rates of college enrollment and completion. Hispanic graduates consistently have the lowest enrollment and completion rates followed by Black graduates. For each measure, there are clear disparities in post-secondary enrollment and completion. There are many factors that contribute to these disparities including higher education cost, Free Application for Federal Student Aid (FAFSA) completion, and family history of postsecondary participation.[68,69]

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[68] Connecticut State Department of Education. "Statewide FAFSA Completion Report 2020-21," September 2021, https://portal.ct.gov/-/media/SDE/Performance/Professional-Learning/Connecticut_FAFSA_Completion_Summary_Spring2021.pdf

[69] Reber, S and Smith, E. "College Enrollment Disparities," *Center on Children and Families at Brookings*, January 2023, https://www.brookings.edu/wp-content/uploads/2023/02/20230123_CCF_CollegeEnrollment_FINAL2.pdf

Table 4.6 College Enrollment, Persistence, & Graduation Rates

2016 CT High School Graduates- College Enrollment, Persistence, & Graduation Rates				
Race/Ethnicity	Enrolled First Year	Persistence Rate	4-Year Graduation Rate	6-Year Graduation Rate
Asian	85.7%	95.2%	52.2%	69.3%
Black	64.2%	79.4%	17.1%	27.1%
NH/PI	71.4%	80.0%	21.4%	32.1%
Hispanic	57.9%	77.1%	17.0%	25.0%
AI/AN	62.0%	85.3%	24.8%	30.6%
Multiracial	64.2%	87.4%	29.0%	40.3%
White	77.2%	91.9%	46.6%	59.4%

Source: Edsight, *https://public-edsight.ct.gov/Performance/College-Enrollment-Dashboard/College-Enrollment-Export?language=en_US*

Section 5: Criminal Justice

While 10% of Connecticut's residents are Black, 43% of the incarcerated population is Black – a greater than four-fold overrepresentation. Hispanic people are also overrepresented in the incarcerated population – while 17% of the population is Hispanic, they account for 28% of incarcerated individuals. Nationwide data shows similar trends with Black people overwhelmingly overrepresented in correctional facilities. Data from the U.S. Department of Justice shows that although there has been a significant drop in incarceration rates for Black residents, large disparities still exist. As of 2020, for every 100,000 Black residents, 938 were incarcerated. In contrast, for every 100,000 White residents, 183 were incarcerated.[70]

There are numerous reasons as to why there is a steep disparity in the racial makeup of those incarcerated in comparison to demographic data. Poverty increases the risk of both committing offenses and the risk of being arrested. Due to structural factors previously outlined in this report, Black and Hispanic people are disproportionately likely to be low-income and to live in under-resourced communities. Additionally, racial bias impacts decision-making within the criminal justice system at multiple touch points such as police stops and sentencing.[71]
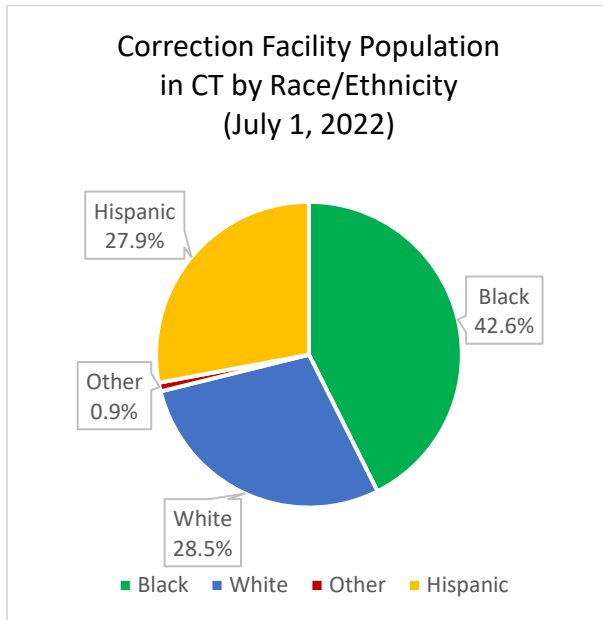
The repercussions of incarceration continue long after release, with formerly incarcerated individuals facing barriers such as finding housing, employment opportunities, and struggling generally with

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[70] Ann E Carson, "Prisoners in 2020 – Statistical Tables" (U.S. Department of Justice, Bureau of Justice Statistics, December 2021), https://bjs.ojp.gov/content/pub/pdf/p20st.pdf.

[71] Elizabeth Hinton, LeShae Henderson, and Cindy Reed, "An Unjust Burden: The Disparate Treatment of Black Americans in the Criminal Justice System," Vera Institute, May 2018.
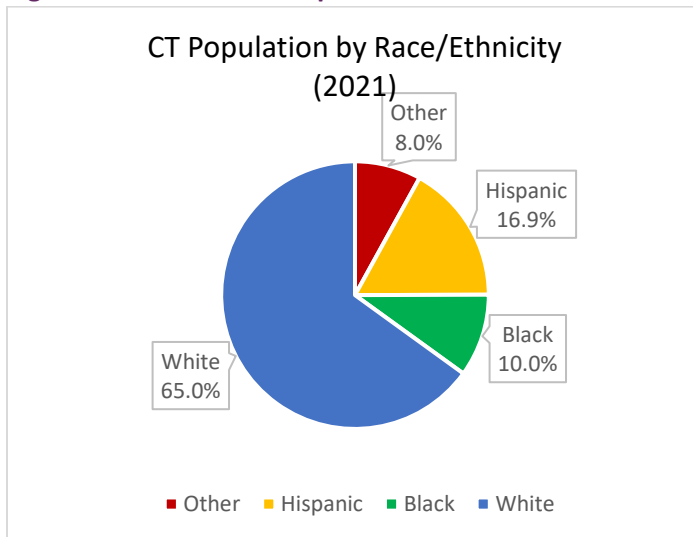
reintegration into society.[72] The instability of getting back to "normal" life has ultimately led to adverse health outcomes.[73]

Figure 5.1 Connecticut Correction Facility Population

Correction Facility Population
in CT by Race/Ethnicity
(July 1, 2022)

Hispanic 27.9%
Black 42.6%
Other 0.9%
White 28.5%

■ Black ■ White ■ Other ■ Hispanic

Source: Connecticut Department of Correction (DOC), Monthly Statistics, July 1, 2022, https://portal.ct.gov/-/media/DOC/Pdf/MonthlyStat/Stat07012022.pdf

Figure 5.2 Connecticut Population

CT Population by Race/Ethnicity
(2021)

Other 8.0%
Hispanic 16.9%
Black 10.0%
White 65.0%

■ Other ■ Hispanic ■ Black ■ White

Source: U.S. Census Bureau, 2021 ACS 5-Year Estimates
*Asian residents account for 5% of the CT population. They are included in the "Other" category in this chart for purposes of comparison to the incarcerated population chart.

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[72] Ashley Nellis, "The Color of Justice: Racial and Ethnic Disparity in State Prisons," The Sentencing Project, October 13, 2021, https://www.sentencingproject.org/reports/the-color-of-justice-racial-and-ethnic-disparity-in-state-prisons-the-sentencing-project/.

[73] "Incarceration Is A Health Threat. Why Isn't It Monitored Like One?", Health Affairs Blog, October 19, 2021. DOI: 10.1377/hblog20211014.242754

APPENDIX

Poverty Thresholds for 2021 by Size of Family and Number of Related Children Under 18 Years

(In USD)

Size of family unit	Weighted average thresholds	Related children under 18 years								
		None	One	Two	Three	Four	Five	Six	Seven	Eight or more
One person (unrelated individual):	13,788									
Under 65 years...	14,097	14,097								
65 years and over.	12,996	12,996								
Two people: Householder under 65 years....	17,529 18,231	18,145	18,677							
Householder 65 years and over......	16,400	16,379	18,606							
Three people.......	21,559	21,196	21,811	21,831						
Four people.........	27,740	27,949	28,406	27,479	27,575					
Five people.........	32,865	33,705	34,195	33,148	32,338	31,843				
Six people...........	37,161	38,767	38,921	38,119	37,350	36,207	35,529			
Seven people......	42,156	44,606	44,885	43,925	43,255	42,009	40,554	38,958		
Eight people..............	47,093	49,888	50,329	49,423	48,629	47,503	46,073	44,585	44,207	
Nine people or more.	56,325	60,012	60,303	59,501	58,828	57,722	56,201	54,826	54,485	52,386

Source: U.S. Census Bureau, 2022.
Note: The source of the weighted average thresholds is the 2022 Current Population Survey Annual Social and Economic Supplement (CPS ASEC).