THE CT REPORT CARD

ON **HEALTH EQUITY** AMONG BOYS AND MEN OF COLOR

DECEMBER 2018

UCONN HEALTH

HEALTH DISPARITIES INSTITUTE

ABOUT UCONN HDI

UConn established the Health Disparities Institute in 2011 as part of the Bioscience Connecticut initiative to enhance research and the delivery of care to minority and underserved populations in the state. Bioscience Connecticut is a package of state investments in UConn Health and other health care entities in the region introduced by Governor Dannel P. Malloy to bolster the state's health care and biomedical research capacities while creating thousands of jobs.

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MISSION

The UConn Health Disparities Institute is committed to producing evidence-for-action and the implementation of strategies designed to eliminate health disparities and advance health equity among Connecticut's minority and medically underserved populations.

APPROACHES

We will achieve our mission by taking the following approaches:

- Applying a population health lens and focusing on root causes of CT's most pressing health disparities.

- Incubating, accelerating, and collaborating on high risk/reward transdisciplinary research.

- Amplifying existing and stimulating new community and multi-sectoral engagement.

- Leveraging arts-based methods to center youth and community voice.

- Tracking and monitoring health outcomes.

- Translating evidence into meaningful action.

WHAT IS HEALTH EQUITY

Health equity means that everyone has a fair and just opportunity to be their healthiest, regardless of individual or population based groups of race, ethnicity, gender, income, sexual orientation, where you live, or other social conditions that shift, change, or impact, health outcomes.

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INTRODUCTION AND OVERVIEW

Boys and Men of Color include the following census-defined populations:

- American Indians/Alaska Natives (AIAN)
- Asians
- Black/African Americans (Black/AA)
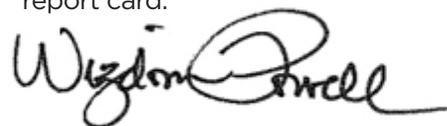- Hispanics/Latinos
- Native Hawaiians/Pacific Islanders (NHPI)

Boys and men of color (BMoC) have considerable untapped potential for contributing to Connecticut's economic growth, vitality, competitiveness, and social innovations. Unleashing the full potential of Connecticut's BMoC requires a focus on advancing health equity, or fair and just opportunities to be healthy. Like their U.S. counterparts, BMoC in Connecticut have some of the most disparate health outcomes due in large measure to social determinants, broader social factors operating where they live, play, pray, get educated, and receive healthcare. Poor health outcomes in BMoC are preventable and modifiable if they are tracked and monitored.[1]

Research confirms that we can prevent poor health outcomes in BMoC through clinical, community, and policy level interventions. Yet, it is difficult to design effective multilevel interventions to eliminate disparities and achieve health equity in the lives of BMoC without adequate data. What gets measured gets done. The UConn Health Disparities Institute has developed the first Connecticut Report Card on Health Equity among BMoC to monitor key health outcomes across nine multisector indicators of health and well-being, life expectancy and mortality rates. Communities represented in this report are referenced using the following census designations: American Indians/Alaska Natives (AIAN), Asians, Black/African Americans (B/AA), Hispanics/Latinos (H/L), Native Hawaiians/Pacific Islanders (NHPI), and non-Hispanic White

Social determinants of health include factors operating where individuals live, work, play, pray, and get educated.[2,3] Like:

- Economic and social conditions
- Neighborhood conditions
- Available resources and supports
- Quality of schooling
- Cleanliness of air, food, and water

(NH White). This report card arrives at a time when our nation is in the midst of one of the most significant demographic transitions. In fact, it is estimated that people of color will be the majority of America's working class by 2032.[4] Advancing health equity in boys and men of color is critical to ensuring that our nation and state has full capacity to compete in the global marketplace. The production of this report card furthers the achievement of our legislative mandate to reduce health disparities among CT's medically underserved populations. This inaugural report card serves as a resource for key policy decision-makers, program evaluators, advocates, researchers, funders, service providers, and community members. The report card can be leveraged in statewide and local strategic planning initiatives aimed at reducing health disparities, improving healthcare quality, and transforming service delivery models to improve the health of boys and men. This report card takes an initial step towards capturing data for a segment of CT's population at heightened risk for health disparities. Future iterations of this report card will expand data capture for BMoC and other groups in CT impacted by health disparities (i.e., women and girls of color). We believe that it will be particularly useful as the state mounts strategies to establish whole-person centered health systems, improve population health, and promote more equitable access to healthcare. We are especially grateful for the support we received from Orlando Velazco and Commissioner Raul Pino of the CT Department of Public Health. We look forward to working with other health equity leaders across the state on future iterations of this report card.

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Director, Health Disparities Institute

EXECUTIVE SUMMARY

This Executive Summary provides an overview of some of the key report card findings. The 2018 CT Report Card on Health Equity Among Boys and Men of Color (BMoC) is divided into the following 9 sections:

- Demographics
- Income, Education, Employment and Transportation
- Housing
- Safety and Incarceration
- Fatherhood
- Health Insurance, Preventative Health Screenings and Cancer Disparities
- Behavioral Health
- Life Expectancy
- Mortality

METHODOLOGY

The CT Report Card on Health Equity Among BMoC uses national and state-level data to compare indicators disaggregated by race/ethnicity (R/E), gender, and age. Several public data sources were utilized including the CT Department of Public Health mortality data, US census data, and CDC data (full list in Appendix: Data Sources). Within each indicator, we report the health disparity rate (HD) defined in this report as how many more times individuals in a R/E group experience a more harmful outcome than those in the R/E reference group. In most cases, the reference group is the R/E group with the best health outcome. For example, a rate of 1 means that the comparison group and the reference group exhibit equal rates for the health equity indicator (no Health Disparities - no HDs). Similarly, a rate of 1.5 (or higher) means that the comparison groups exhibit a rate that is one and a half times (or more) larger than the reference group: we consider them moderate HDs. We mark such HDs as "1.5x vs W", to show for example the actual

KEY TO HD DESIGNATION IN CHARTS AND GRAPHS

S = severe HD

M = moderate HD

size of HDs compared to the White reference group. Lastly, a rate of 2 or more means that the reference group exhibits a rate that is at least twice that of the reference group (severe HDs). We also report HDs in mortality rates defined as excess deaths or how many more men from a R/E comparison group died than those in the reference group (non-Hispanic White men, commonly). This rate represents actual deaths that could have been prevented if equal mortality rates were realized for men across R/E groups. Excess deaths were computed by reverting to equal mortality rates (assuming that the groups with higher mortality experienced the same mortality outcome as the reference group or the group with the lowest mortality within each age group). In most cases, we used raw percentages and counts to classify the data and raw percentages and rates to make direct comparisons. When raw data needed to be processed, we estimated rates (per 100, or percentages, or per 1,000 e.g.) for each R/E group by referencing them to the population totals for each group, to obtain comparable rates. We computed rates by dividing raw counts (numerator, e.g. confined CT males in each R/E group, multiplied by 1,000) by the R/E population totals (denominator, e.g. total CT residents in each R/E group).

The most recent mortality data was from 2014. Therefore, we report 2014 data for other health equity indicators except where these data were unavailable. In many instances, reliable state-level data were available for Black/AA, Hispanic/Latino, and non-Hispanic White boys and men. Data for AIAN, NHPI, and Asian boys and men were more limited. The limited availability of data for these subpopulations of BMoC illuminates a critical knowledge gap for the State of CT. Producing this report card takes an important step towards raising awareness about the pressing need for disaggregated data in these population groups.

DEMOGRAPHICS

According to the US census, BMoC comprise over 30% of the CT population. Compared to non-Hispanic White males, the Black/AA and Hispanic/Latino male population decreases as age increases. Overall, there is a difference in self-rated health status by R/E and geographic areas in CT. In residential areas where there is a higher percentage of racial and ethnic minorities, male residents report poorer self-rated health status.

INCOME, EDUCATION, AND EMPLOYMENT, AND TRANSPORTATION

Economically secure and better educated boys and men have the greatest opportunity for better health and well-being.[5] In 2014, twice as many CT residents than US residents earned salaries greater than $200,000. Black/AA and Hispanic/Latino men in CT earned roughly half of non-Hispanic White men's total earnings. Between 2006 and 2010, 34% of men between the ages of 18 to 24 in the U.S. reported a high school diploma as their highest level of educational attainment. Of those men, 47%

were ANs, followed by AIs (38%), Black/AAs (36%), and Hispanic/Latinos (35%). For the same national population of 18 to 24 year old men, 7% obtained a college degree. Yet, Asian (16%) and non-Hispanic White (8%) men obtained college degrees at rates above the national average.

Twice as many non-Hispanic White than Black/AA and Hispanic/Latino 3rd graders achieved the Connecticut Mastery Test (CMT) mathematics goal. Half of Black/AA men and Hispanic/Latino men in CT hold a high school diploma compared to non-Hispanic White men.

The national unemployment rate among men for 2017 was 4.4%.[6] Unemployment data at the national level disaggregated by R/E, gender, and age are presented in the report card from 2010–2015. These data detect variation in unemployment rates across R/E and age groups. Unemployment in the US is highest among Black/AAs (8.1%), AIANs (7.8%), Hispanic/Latinos (7.5 %), and NHPIs (5.4%). Among 16–19 year-olds, unemployment in the nation is highest among Black/AA (42%) and lowest among non-Hispanic White men (26%). In the 20–24 age group, unemployment is highest among Asian (33%) and Black/AA (27%) men and lowest among non-Hispanic White men. From 2010–2015, the national average of unemployment among men during prime working years (between the ages of 25–54) was 7%. In this same age group, 23% of Asian men in the U.S. are unemployed—three times the national average. Thirteen percent of 25–54 year-old Black/AA and AIAN men in the U.S. are unemployed—two times the national average. Among individuals 55 and older, average unemployment from 2010–2015 was 6% and was highest among Asian men (21%) and lowest among non-Hispanic White men. In 2016, men of color in CT were unemployed at twice the rate of non-Hispanic White men.

HOUSING

Linkages between housing stability and health equity are well-established.[7] In this report card, we present data on home ownership and homelessness. In many cases, data disaggregated by R/E, age, and gender were unavailable at the national and state levels. Therefore, we present homeownership and homelessness data for the total CT population in the report card. Here, we also provide a brief overview of national-level data on homelessness.

Among all CT residents, home ownership rates among non-Hispanic Whites are double that of Black/AAs and Hispanic/Latinos. As of December 2017, approximately 554,000 people in America are homeless. Roughly 61% of individuals experiencing homelessness are men.[8] There are also R/E differences in homelessness and sheltered status at the national level. For example, most individuals experiencing homelessness during 2017 were non-Hispanic White (47.1%) followed by Black/AAs (40.6%). However, more Black/AAs experiencing homelessness reported staying in emergency shelters or transitional housing.[8] CT is one of two states (Utah is the other) with homelessness rates below the national average.[9] However, 3,383 people in CT were homeless as of January 2017. In January 2018, close to five times as many AIAN, Hispanic/Latino, and Black/AA CT residents were homeless, compared to their non-Hispanic White counterparts.

SAFETY & INCARCERATION

Nationally, 1.1% of all males were in custody (in prisons or jails) as of 2011. From 2007 to 2011, nearly 7 times more Black/AA males than non-Hispanic White males in the nation were in custody. During this time period, 1.7 times more Hispanic/Latino males than non-Hispanic White males in the nation were in custody.

In CT, Black/AAs are nine times more likely than non-Hispanic White residents to be both victims and perpetrators of murder. In 2016, more Black/AA boys in CT reported being threatened or injured with a weapon on school property (11.3%) than Hispanic/Latino (7.5%) or non-Hispanic White boys (6.9%). Over nine times more Black/AA men and four times more Hispanic/Latino men than non-Hispanic White men were incarcerated in 2016. The juvenile justice population in CT mirrors that of the adult prison population. Six times more Hispanic/Latino and 10 times more Black/AA than non-Hispanic White boys were admitted to one of CT's two detention centers.

FATHERHOOD

Fatherhood presents a unique window of opportunity for health promotion among boys and men. State level reports affirm that fathers in CT are highly involved and place significant importance on fulfilling their parental roles. However, fathers in CT also report persistent structural barriers to engagement including: finding employment, gaining support groups, trust in services, being able to see their children more often, and job training and education attainment.

HEALTH INSURANCE, PREVENTATIVE HEALTH SCREENINGS, AND CANCER DISPARITIES

Equitable access to health insurance and timely preventative healthcare are essential to advancing health equity for BMoC. Across the nation and in our state, BMoC are more likely to be disconnected from formal health systems.[10] At the national level, 49% of men between the ages of 18 to 34, were covered by either private or public insurance. Within this age group, nearly 40% of Hispanic/Latino men and 41% of AIAN were covered by health insurance.

From 2011 to 2015, over 30% of Hispanic/ Latino men and over 16% of Black/AA men in CT on average were uninsured. During the same time period, an average of nearly 9% of non-Hispanic White men were uninsured.

In CT, twice as many AIAN and NHPI men did not receive a routine/annual health checkup, compared to Black/AA men. Fewer Hispanic/ Latino and Asian men had up-to-date blood pressure screenings than non-Hispanic White and Black/AA men. In 2016, only 14% of Hispanic/Latino and non-Hispanic White boys were tested for HIV. This rate is nearly three times below the Healthy People 2020 goal for both adolescents and adults aged 15–44 years. In 2017, nearly two times more Black/AA and Hispanic/Latino men than non-Hispanic White men were tested for HIV. During 2011 to 2015,nearly two or more times Black/AA, non-Hispanic White,and Hispanic/Latino men were diagnosed with colon and lung cancers than Asian and NHPI only men. In the same time period, more than three times as many Black/AA, non-Hispanic White, and Hispanic/ Latino men had prostate cancer compared to Asian and NHPI men. Approximately 1.6 times as many Black/AA men were diagnosed with prostate cancer compared to non-Hispanic White men. Over two and a half times as many Hispanic/Latino men, approximately two times as many Asian and NHPIs, and one and a half times as many Black/AA men had liver cancer compared to non-Hispanic White men.

BEHAVIORAL HEALTH

Behavioral health typically refers to the interconnection of mental health and substance (i.e., alcohol, drugs, inhalants, and tobacco) abuse. We report data on Depression (Major Depressive Disorders, Dysthymia, and Minor Depression), suicide deaths, suicide attempts and ideation, substance use (cigarette use and binge drinking), and drug-related deaths. In some cases, disaggregated data were not available for both boys and men.

Boys and men in our nation and in CT are less likely than women and girls to report depression. Yet, they also have higher rates of suicide completion and drug-related deaths.[11,12,13] Compared to Hispanic/Latino and non-Hispanic White men, Black/AA men in CT were less likely to be told by a health care professional that they have a depressive disorder. More than three times more non-Hispanic White men compared to Black/AA men have died due to reported suicides in CT. One in four AIANs and NHPIs report struggling with suicide ideation or attempting suicide during 2015. Similarly, 1 in every 10 Hispanic/Latino and Black/AA boys report struggling with suicide ideation or attempts. Approximately, 5% of non-Hispanic White boys and 3% of Asian boys report thinking about committing suicide.

Trauma exposure, and risk for trauma, as measured by the Adverse Childhood Experiences (ACEs) is associated with health and social problems, such as substance abuse across the life-course.[14] In 2017, 1.6 times more Black/ AA children and 1.4 times more Hispanic/Latino children, compared to non-Hispanic White children experienced at least 1 childhood adverse experiences. Data disaggregated by R/E and gender is not currently available.

> **CT Health Disparities Due to Any of the Top 5 Leading And Preventable Causes of Death in 2014**
> 1. 176 Black/African American Men Lives
> 2. 133 Non-Hispanic White Men Lives
> 3. 10 Hispanic/Latino Men Lives

Nationally, 1.5 million more students used e-cigarettes in 2018 than in 2017.[15,16] The use of vaping devices has heightened concerns among US Surgeon General, Jerome Adams because of its strong association with the use of other tobacco products. Nationally, older students, Hispanics/Latinos, and non-Hispanic Whites are more likely to use e-cigarettes than younger students and Black/AAs.[17]

In 2015, twice as many non-Hispanic White and Hispanic/Latino high school students used e-cigarettes or vaping products than Black/AA high school students. In 2017, twice as many non-Hispanic White and 1.6 times as many Hispanic/Latino high school students used e-cigarettes or vaping products than Black/AA students. These data are not disaggregated by R/E and gender.

In 2016, Asian and Black/AA men had the highest rates of cigarette smoking. Binge drinking among Hispanic/Latino men and non-Hispanic White men were 2 and 1.5 times higher than among Black/AA men. A higher percentage of non-Hispanic White boys smoked cigarettes in 2016 compared to Hispanic/Latino and Black/AA boys. From 2010 to 2015, there was an increased trend in drug-related deaths among males in CT. Compared to men from all other R/E groups in CT, 7 times more non-Hispanic White men, and 6 times more Black/AA men died from drug-related incidents, such as opioid overdoses, In one year.

LIFE EXPECTANCY AND MORTALITY

We report data on life expectancy, mortality rates, and excess death disparities by R/E across age groups. In 2014, Black/AA men lived 4.2 fewer years than non-Hispanic White men. During the same time period, Hispanic/Latino men lived a half year longer than non-Hispanic White men. The five leading causes of death among CT men in 2014 were, 1) Major Cardiovascular Disease; 2) Diseases of the Heart; 3) Malignant Neoplasms (Cancer); 4) Ischemic Heart Disease; 5) Trachea, bronchus & Lung Cancer. For every 1,000 men in CT, there were approximately 8 men who passed away from one of the top five leading causes of death in 2014. Overall, Black/AA men had the highest number of excess deaths from the combined top five leading causes compared

to White men (181 lives lost), followed by Hispanic/Latino men (13 lives lost).

Three times more Black/AA men than non-Hispanic White men between the ages of 20–34 died from the combined top five leading causes of death. Similarly, nearly twice as many 35 to 44 year-old Black/AA men than non-Hispanic White men died from the combined top five leading causes of death. Across all ages, more Black/AA men passed away prematurely than non-Hispanic White men from major cardiovascular diseases. Thirty-three Black/AA men died prematurely due to diseases of the heart—a range across various age groups of 1.5 to nearly 5 times more than non-Hispanic White men. During 2014, nineteen excess deaths from ischemic heart disease occurred among non-Hispanic White in the following age groups: 20–34, 35–44, and 65–74.

More than 16 excess deaths from malignant neoplasms (cancer) among Black/AAs occurred in 2014. Black/AA men between the ages of 20–34, 35–44, and 65–74 died 1.5 times more from malignant neoplasms than non-Hispanic White men. Death rates from cancer of the trachea, bronchus and lung among Black/AA men in CT were two to three times higher than those observed among non-Hispanic White men. Data from 2014 indicates that 26 Black/AA men and 8 Hispanic/Latino men died prematurely in CT from these cancers.

REPORT CARD LIMITATIONS

While the report card provides a baseline for developing, monitoring, and tracking health equity indicators, we also note the following limitations. This report presents raw numbers as either percentages, counts per 1,000, or per 100,000 without indications of significant differences (i.e. p values). We did not conduct significance testing because many outcomes were entire population estimates, and others were only available as aggregate numbers.

The CT DPH mortality tables use different age groupings than the CT Census table, so we recoded the population of men numbers extracted from the census data (non-Hispanic White, Black/AA and Hispanic/Latino) to match the CT DPH mortality categories (e.g. 35–39 year old and 39–44 year old age groups were grouped into 35–44 year old age group).

Individual underlying causes of death are not mutually exclusive, as the same person could be counted in more than one mortality statistic.

We recognize that our report card focuses primarily on cis gender males (males whose personal identity and gender corresponds with their birth sex). Therefore, we are limited in the conclusions that can be drawn from this report card about transgender males who are at heightened risk for health disparities (i.e., behavioral health and HIV) and face significant barriers to achieving health equity.[18] National and state-level data for this subpopulation of males is scarce and where present is not disaggregated by age or race/ethnicity. As such data becomes available, we will include it in future iterations of this report card.

RECOMMENDATIONS

Eliminating disparities and advancing health equity among BMoC and other medically underserved populations in CT requires changes in the policies we design, health care we deliver, and the research infrastructures we build. Following is a sample list of recommendations stemming from this report card:

Policy

1. Protect achievement and build on advancements of the ACA including Medicaid expansion, coverage of pre-existing conditions, access to the Essential Health Benefits

   • It is critical that we leverage existing and future policy opportunities to create equitable access to quality health care. For example, since the expansion of Medicaid,

there has been an unprecedented uptick in insurance coverage attainment among childless, low income men.[19,20] Protecting this policy intervention could reduce critical health insurance barriers for men (and boys) in CT.

2. Support CT's Second Chance Society Reintegration Program with upstream interventions aimed at reducing the school to prison pipeline and incarceration disparity

   • A significant number of BMoC in CT are currently or have been involved with the criminal justice system. Interventions that improve reintegration among justice-involved citizens, as well as, reduce the likelihood of becoming involved with criminal justice systems could have significant positive health (e.g., behavioral health) impacts.

3. Support statewide efforts to increase the quality, availability, and analysis of disaggregated data

   • There is a notable gap and time-lag in the availability of quality data that is disaggregated by race/ethnicity, gender, and age. Such data is essential to designing clinical and community interventions for BMoC that are developmentally and culturally appropriate.

4. Devote resources to improve the coordination of and reduce gaps in data sharing

   • Data sharing across systems could improve timely receipt of and referral to appropriate clinical and community services among BMoC.

System/Administrative

1. Fortify statewide infrastructure for clinical-community integration

   • Non-medical factors (e.g., individual finances, transportation access, and education attainment) are important drivers of health outcomes in BMoC. Addressing such factors requires collaboration between clinicians and community workers. Though traditional

clinical practices are important, BMoC are less likely to seek care from these venues.[21,22]

2. Fund culturally and linguistically appropriate Community Health Workers models to eliminate navigation and utilization barriers to clinical and community health services

   • The CT State Innovation Model in the Office of Health Strategy has developed evidence-based recommendations for legislative consideration.

3. Establish off-peak hours for primary care practices (e.g., evenings and weekends)

   • BMoC have competing financial priorities and other normative barriers to seeking care. Offering clinic hours on evenings and weekends may increase uptake of timely preventive screenings

4. Provide and evaluate ongoing implicit bias training for healthcare providers and staff

   • Mistrust of health systems and providers is a significant barrier to healthcare use among BMoC. Often, this mistrust is rooted in a recognition of historical abuses by health systems and in present-day experiences with racism. Training that focuses on providing greater clarity of how implicit biases impact clinical decision making and patient experiences could increase healthcare utilization.

5. Improve the integration of primary and behavioral health services

   • Providing one-stop shop for primary care and behavioral health services may timely detection of substance abuse, addiction, and suicide risk.

6. Introduce well-male visits earlier in the life-course

   • Boys and men lack consistent early-life socialization around the use of health systems. Establishing a culture of preventive health during early childhood and adolescence could offset health disparities among BMoC later in the life-course.

7. Implement trauma-informed clinical care

   • A significant number of BMoC have undetected psychological wounds associated with trauma exposure that impact physical and mental health. Clinical care that recognizes and address trauma could improve related patient health outcomes (e.g., cardiovascular disease and diabetes).

Research

1. Support research that employs innovative methods/strategies designed to center and amplify the voices of BMoC

   • Advancing health equity among BMoC will require moving beyond usual strategies towards uncommon solutions. Research that leverages technology and the arts, as well as, established community-based participatory methods could increase interest and engagement among BMoC.

2. Establish public-private partnerships focused on supporting health equity research and innovation

   • Cross and multi-sectoral solutions are needed to address the broad factors impacting the health of BMoC in CT. Public-private partnerships could address the fragmentation of research efforts created by decreasing federal funding.

3. Develop pipeline programs designed to increase the number of BMoC in research-intensive academic medical institutions

   • The declining presence of racial/ethnic minority men in academic medicine represents a significant workforce gap. Increasing access to academic and clinical medicine careers would create more economic security for BMOC and improve the diversification of CT's healthcare workforce.

3. Develop pipeline programs designed to increase the number of BMoC in research-intensive academic medical institutions

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Community

1. Increase knowledge and awareness among CT's BMoC and their families about risks and opportunities for improving health outcomes

   - There is a pressing need for community-based dissemination of knowledge about behavioral health, trauma, and preventive screening among BMoC. Integrating health information into primary and secondary school curriculums and developing social media campaigns could improve knowledge acquisition especially in younger boys and men.

2. Meet BMoC where they are in the places they frequently congregate

   - BMoC are less likely to seek help from formal health systems and providers. Engaging men and delivering preventive screening in spaces like barbershops, community centers, and places of worship are strategies that could improve early detection and chronic disease control.

3. Recruit and train R/E minority men to serve as Community Health Workers (CHWs)

   - CHWs are an important component of advancing health equity in CT's communities. CT recently established law "An Act Concerning Community Health Workers", which could lead to a statewide certification program and the use of taxpayer dollars to fund the services provided by CHWs. Focusing on recruiting and training more R/E minority men could address unemployment in this population and improve outreach to BMoC who are disconnected from formal health systems.

HEALTH EQUITY INDICATORS

Indicator	Definition	Measure(s)	Source
Income	Individual annual earnings	Annual Earnings, 2013-2014	The American Human Development Index
Education	The number of years of formal education	Percentage earned Bachelor's Degree, 2016; Percentage earned High School Diploma, 2016;	US Census & American Community Survey
	Obtaining the 3rd Grade CT Mastery Testing Goal	Reached CMT "Goal" for reading comprehension and mathematics	State of Connecticut, data.ct.gov
Employment	Unemployment: not having a job, actively looking for work in the 4 weeks, and currently available for work	Unemployment, 2016	US Census & American Community Survey
Transportation	Individual means of getting to and from work/home	Commuting or journey to work, 2016	US Census & American Community Survey
Housing	Homelessness is defined as "lacking a regular nighttime residence or having a primary nighttime residence that is a temporary shelter or other place of designated for sleeping."	Home ownership, 2012–2016 Homelessness, 2018	PolicyMap Connecticut Coalition to End Homelessness Health Disparities Institute
Safety	Boys threatened or injured on school property	Percentage of boys threatened or injured with a weapon on school property, 2016;	CDC's Youth Risk Behavior Surveillance System
	Rate of adult victims of murder	Rate per 1,000 residents of murder victim, 2013–2017; rate per 1,000 residents of murder offender, 2013-2017	CT Office of Policy and Management (OPM)
	Rate of adult perpetrators of murder and violent crimes (aggravated assault, robbery, and rape)	Rate per 1,000 residents of violent crimes by offender, 2013-2017	CT Office of Policy and Management (OPM)
Incarceration	Individuals in prison	Percent of R/E group in prison; Population of males in prison per 1,000 residents	CT Department of Correction RISE
	Individuals in juvenile justice system	Admission into detention centers per 10,000 youth younger than 18 y.o.	Bureau of Justice Statistics
Fatherhood	Number of fathers enrolled in fatherhood programs	Fathers enrolled in a statewide CT program, 2006–2007/ population distribution	CT Department of Social Services
Health Insurance	Number of individuals without health insurance coverage	Percent of men uninsured	CT Census. gov

Preventative Health Screenings	Individuals who have not received a health checkup	Percent of men who have not received health checkup, 2016	BRFSS America's Health Rankings
	Individuals who received cholesterol screening	Percent of men who had a cholesterol screening, 2017	
	Individuals who received a blood pressure screening	Percent of residents who had a blood pressure screening in the past 12 months, 2017	
	Individuals who were tested for HIV	Percent of boys who were tested for HIV; Percent of men who have ever had a HIV screening	
Cancer Disparities	Cancer diagnoses		National Cancer Institute
Behavioral Health	The interconnection of mental health and substance (i.e., alcohol, drugs, inhalants, and tobacco) abuse. We report data on Depression (Major Depressive Disorders, Dysthymia, and Minor Depression), suicide deaths, suicide attempts and ideation, substance use (cigarette use and binge drinking), and drug-related deaths	Percent of whether a doctor, nurse, or other health professional ever told you that you had: major depressive disorder, dysthymia, or minor depression, 2016	BRFSS
		Rate of suicide deaths per 10,000 residents, 2012-2018	CT DPH Vital Records
		Percent of suicide attempts and ideation among 9 to 12th grade and 15 to 25y.o., 2015	CDC's Youth Risk Behavior Surveillance System
		Percent of boys who smoked greater than 20 cigarettes/day in past 30 days, 2016	CDC's Youth Risk Behavior Surveillance System
		Percent of reported binge drinking in past 30 days, 2016	CDC's Youth Risk Behavior Surveillance System
		Drug-related death; unintended drug-related deaths per 100,000, 2015	Office of the Chief Medical Examiner. Health and Human Services.
Life Expectancy	Number of years an individual is expected to live	Average life expectancy, 2013-2014	Measure of America Social Security Administration
Mortality	Number of deaths due to the top five leading causes of death: Cardiovascular diseases; diseases of the heart; malignant neoplasm; ischemic heart disease; trachea, bronchus & lung cancer; unintended injuries	By age group, the rate of deaths per 1,000 residents, 2014	CT DPH Vital Records
	Excess deaths	Excess deaths per 1,000, 2014	

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4. Bureau of Labor Statistics, U.S. Department of Labor, Labor Force Statistic from the Current Population on the Internet at https://www.bls.gov/cps/cps_htgm.htm#unemployed
5. RISE for Boys and Men of Color, 2017, Research Data Center on the Internet at http://www.risebmoc.org/data-center
6. Gibson, M., Petticrew, M., Bambra, C., Sowden, A. J., Wright, K. E., & Whitehead, M. (2011). Housing and health inequalities: a synthesis of systematic reviews of interventions aimed at different pathways linking housing and health. Health & place, 17(1), 175-184.
7. Office of Community Planning and Development, U.S. Department of Housing and Urban Development, *The 2017 Annual Homeless Assessment Report (AHAR) to Congress*, on the internet at https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf
8. Benedict, K. (2018). Estimating the Number of Homeless in America. *The DataFace, LLC*. 21 Jan 2018 http://thedataface.com/2018/01/public-health/american-homelessness
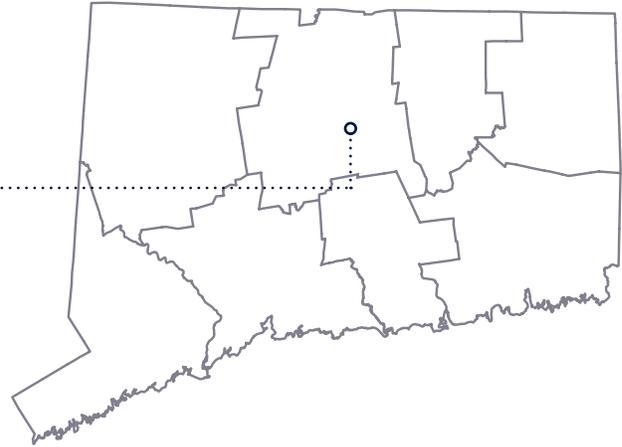
DEMOGRAPHICS

MALES BY RACE/ETHNICITY IN CT, 2016

In 2016, the CT population was 3,588,683 (48.5% males and 51.5% females) people. Thirty percent of males in CT were boys and men of color, and in Hartford, over 80% of males were boys and men of color.

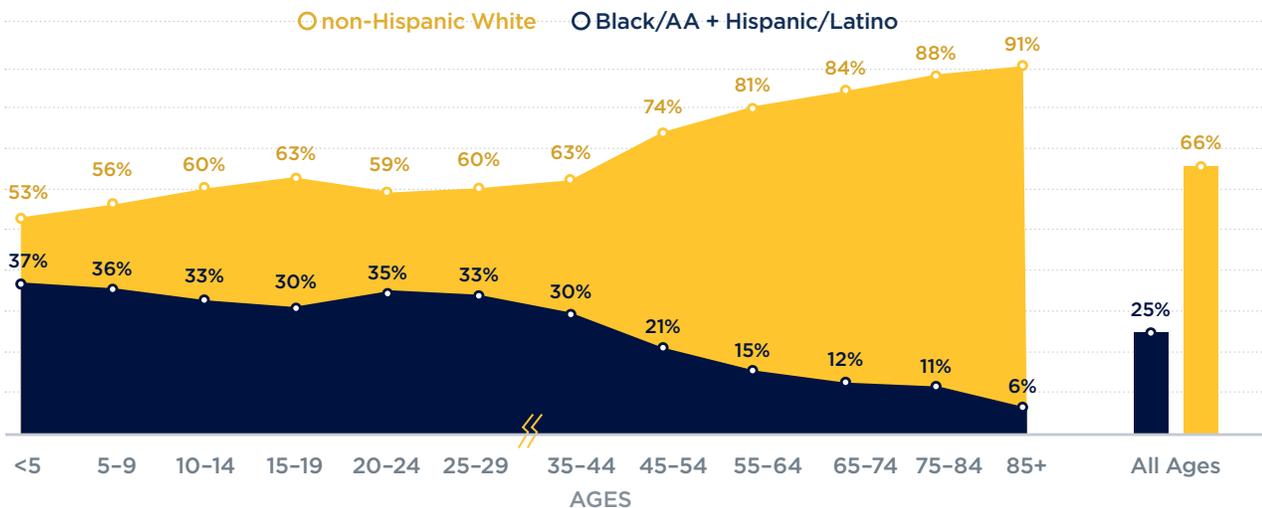**CT**

10% B/AA NH   16% H/L   70% NH White   4% Asian   .3% AIAN   .03% NAPI

HARTFORD

35% B/AA NH   44% H/L   16% NH White   3% Asian   .4% AIAN   0.0% NAPI

Notes: B/AA: non-Hispanic Black/African American; H/L: Hispanic/Latino; NH White: non-Hispanic White; Asian: Asian; AIAN: American Indian or Alaskan Native; NHPI: Native Hawaiian or Other Pacific Islander only. The population defined designation is based off of the Census Bureau.

PERCENTAGE OF NON-HISPANIC WHITE MEN & BOYS AND BLACK/AA OR HISPANIC/LATINO MEN & BOYS IN CT, BY AGE

○ non-Hispanic White   ○ Black/AA + Hispanic/Latino

AGES	non-Hispanic White	Black/AA + Hispanic/Latino
<5	53%	37%
5–9	56%	36%
10–14	60%	33%
15–19	63%	30%
20–24	59%	35%
25–29	60%	33%
35–44	63%	30%
45–54	74%	21%
55–64	81%	15%
65–74	84%	12%
75–84	88%	11%
85+	91%	6%
All Ages	66%	25%

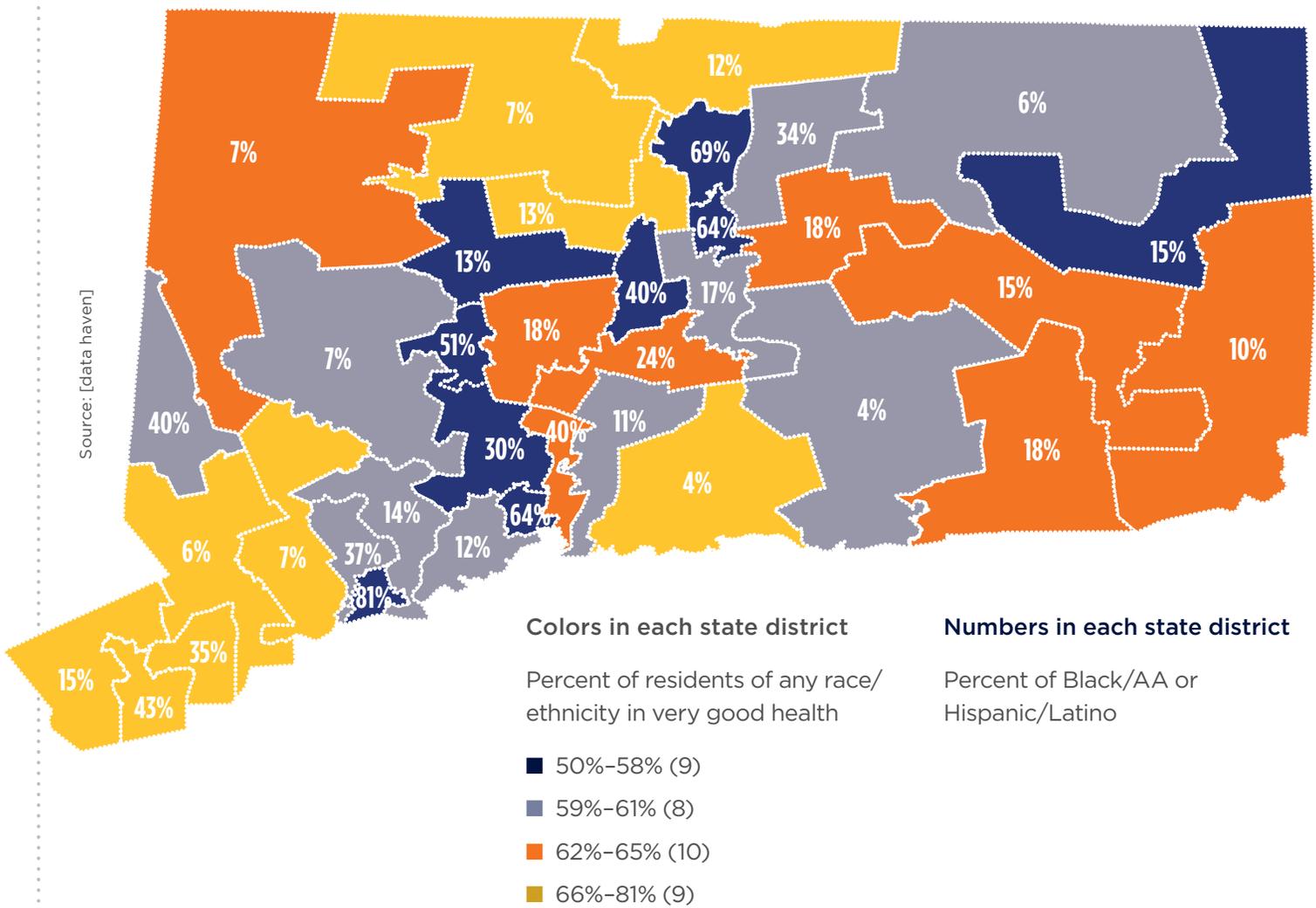2014 • Source: US Census https://www.census.gov/

While 25% of the total population of CT's men were B/AAs or Hispanic/Latinos and 69% were non-Hispanic Whites, the proportions of these groups between the ages of 25–29 were relatively similar.

The graph excludes Asian, American Indian or Alaskan Native, or Native Hawaiian or Other Pacific Islander.

RACIAL/ETHNIC RESIDENTIAL COMPOSITION AND SELF-RATED HEALTH STATUS IN CT REGIONS

The map below displays the percentage Black/AAs or Hispanic/Latinos by the percent of residents of combined R/E in very good health, across CT state districts.

The 9 blue districts have the fewest residents reporting very good health (<58%), while the 8 orange districts have between 62% and 65% of residents report very good health. The 10 light purple districts have 59%–62% residents with good health, and the 9 yellow districts are those with >68% residents reporting very good health. Data comes from the US Census (data source: [6]) and the DataHaven[7] Community Wellbeing Survey (data source: [9]), freely downloadable.

Source: [data haven]

Colors in each state district

Percent of residents of any race/ethnicity in very good health

- ■ 50%–58% (9)
- ■ 59%–61% (8)
- ■ 62%–65% (10)
- ■ 66%–81% (9)

Numbers in each state district

Percent of Black/AA or Hispanic/Latino

Spatial models reveal a significant relationship between **higher** percent minority residents and **lower** percent of residents reporting very good health, across CT state districts.

Senate districts with more minorities have fewer residents reporting very good health.

# INCOME, EDUCATION, EMPLOYMENT AND TRANSPORTATION

CT MEN'S MEDIAN EARNINGS, 2013-2014

Black/AA men's median earnings were 55% of what non-Hispanic White men earned. While, Hispanic/Latino men's median earnings were 45% of non-Hispanic White men's.

50k

28k

23k

NON-HISPANIC WHITE MEN

BLACK/AA MEN
(1.8x vs. W)

HISPANIC/LATINO MEN
(2.2x vs. W)
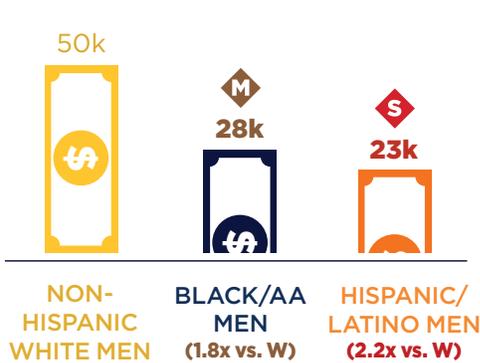
SALARIES GREATER THAN $200,000/YEAR

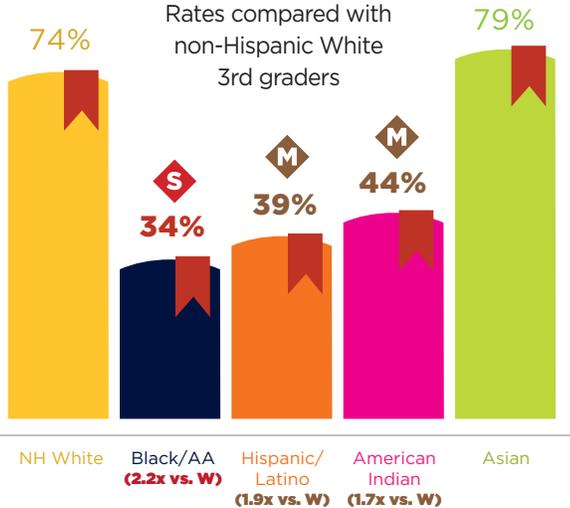Overall, CT has nearly twice as many residents earning >200k a year than in the US as a whole.

4.0%

2.1%

U.S.A.

CONNECTICUT
(1.9x vs. USA)
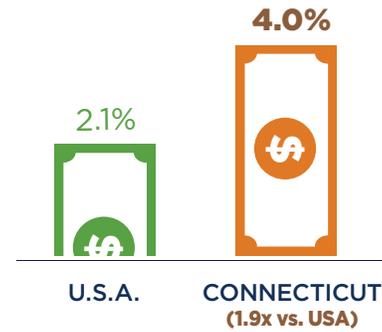
READING AND MATH PROFICIENCY AMONG CT BOYS

STATEWIDE CMT 3RD GRADE MATHEMATICS BY RACE/ETHNICITY
Rates compared with non-Hispanic White 3rd graders

74%

34%

39%

44%

79%

NH White

Black/AA
(2.2x vs. W)

Hispanic/Latino
(1.9x vs. W)

American Indian
(1.7x vs. W)

Asian

Twice as many non-Hispanic White than Black/AA and Hispanic/Latino 3rd graders achieved the Connecticut Mastery Test (CMT) mathematics goal.

STATEWIDE CMT 3RD GRADE READING BY RACE/ETHNICITY
Rates compared with non-Hispanic White 3rd graders
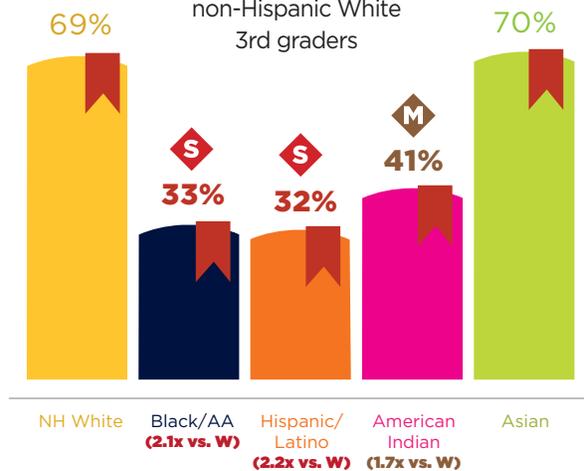
69%

33%

32%

41%

70%

NH White

Black/AA
(2.1x vs. W)

Hispanic/Latino
(2.2x vs. W)

American Indian
(1.7x vs. W)

Asian

Twice as many non-Hispanic White 3rd graders achieved the reading Connecticut Mastery Test (CMT) goal in 2013 than either Black/AA and Hispanic/Latino children. (data source: [15])

EDUCATION LEVELS OF CT MEN

Between 2006 and 2010, 34% of men between the ages of 18 to 24 in the U.S. reported a high school diploma as their highest level of educational attainment. Of t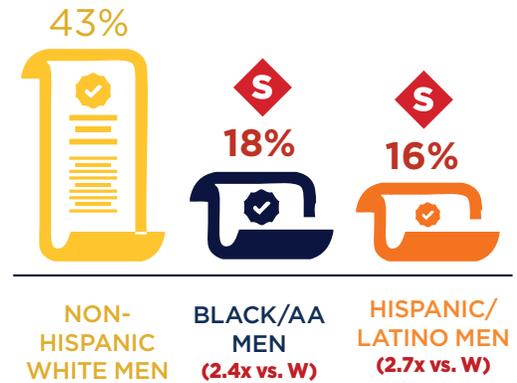hose men, 47% were ANs, followed by AIs(38%), Black/AAs (36%), and Hispanic/Latinos (35%). For the same national population of 18 to 24 year old men, 7% obtained a college degree. Yet, Asian (16%) and non-Hispanic White (8%) men obtained college degrees at rates above the national average.
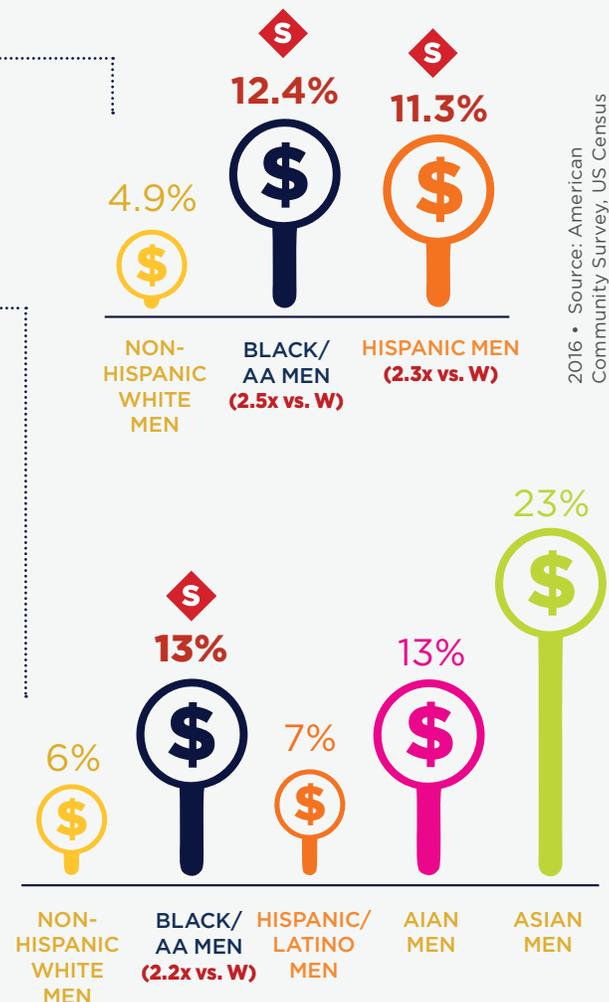
CT MEN WITH A HIGH SCHOOL DIPLOMA

94%
NON-HISPANIC WHITE MEN

84%
BLACK/AA MEN
(1.1x vs. W)

71%
HISPANIC MEN
(1.3x vs. W)
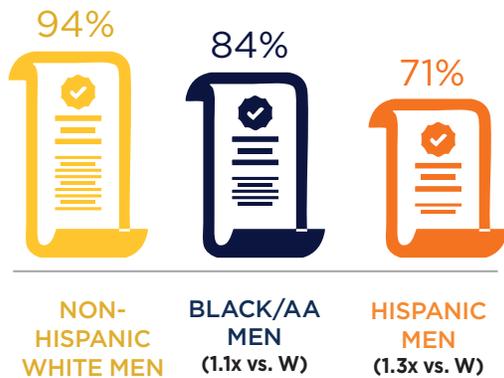
CT MEN WITH BACHELOR'S DEGREE

43%
NON-HISPANIC WHITE MEN

18%
BLACK/AA MEN
(2.4x vs. W)

16%
HISPANIC/ LATINO MEN
(2.7x vs. W)

UNEMPLOYED MEN IN CT, 2016

More than twice the percentage of Black/AA men and Hispanic men were unemployed compared to non-Hispanic White men.

EMPLOYMENT STATUS MALES 25–54 BY RACE & ETHNICITY, U.S. (2010–2015)

The national unemployment rate among men for 2017 was 4.4%.[3] Unemployment in the US are highest among Black/AA (8.1%), AIANs (7.8%), Black/AA (7.5 %), and NH/PI (5.4%). Among 16–19, unemployment in the nation is highest among Black/AA (42%) and lowest among non-Hispanic White men (26%). In the 20–24 age group, unemployment is highest among Asian (33%) and Black/AA (27%) men and lowest among non-Hispanic White men. From 2010–2015, the national average of unemployment among men during prime working years (between the ages of 25–54) is 7%. In this same age group, 23% of Asian men in the U.S. are unemployed—three times the national average. Thirteen percent of Black/AA and AIAN men in the U.S. are unemployed—two times the national average. Among individuals 55 and older, average unemployment from 2010–2015 was 6% and was highest among Asian men (21%) and lowest among non-Hispanic White men.

4.9%
NON-HISPANIC WHITE MEN

12.4%
BLACK/ AA MEN
(2.5x vs. W)

11.3%
HISPANIC MEN
(2.3x vs. W)

6%
NON-HISPANIC WHITE MEN

13%
BLACK/ AA MEN
(2.2x vs. W)

7%
HISPANIC/ LATINO MEN

13%
AIAN MEN

23%
ASIAN MEN

TRANSPORTATION IN CT, 2016

The percentages of CT residents over age 16 who drive to work are similar between R/E groups. However, 1.8 times as many Hispanic/Latinos in CT carpool, compared non-Hispanic White. Approximately 3.3 times as many Black/AA and 1.7 as many Hispanic/Latino residents use public transportation than non-Hispanic White residents. (data source: [2])

CT WORKERS 16 YEARS AND OLDER BY MEANS OF TRANSPORTATION TO WORK

	DRIVE			CARPOOL			PUBLIC TRANSPORTATION	
NH White	Black/AA	Hispanic/Latino	NH White	Black/AA	Hispanic/Latino	NH White	Black/AA	Hispanic/Latino
88.6%	78.0%	80.0%	7.6%	9.0%	14.0%	3.8%	13.0%	6.0%
					1.8x vs. W		3.3x vs. W	1.7x vs. W
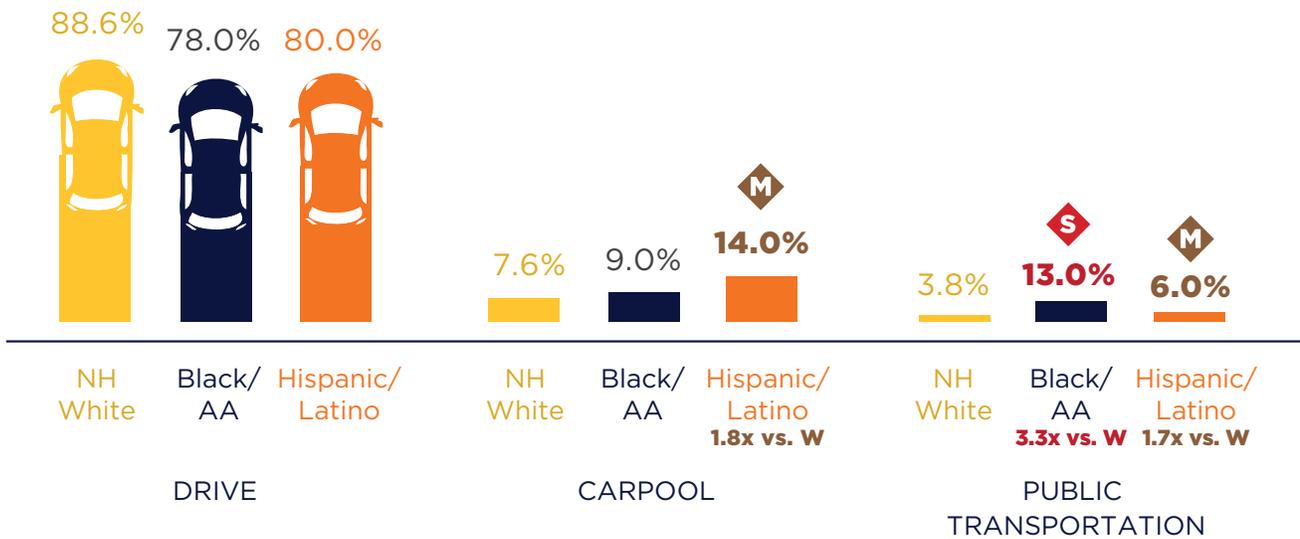
2017 • Source: Census (CT)

HOUSING

HOME OWNERSHIP

Home ownership in CT is 3% higher than the US average, yet the distribution of homeownership varies by race/ ethnicity group. For every one home a Black/AA or Hispanic/Latino resident owns, home ownership is double among non-Hispanic White residents.
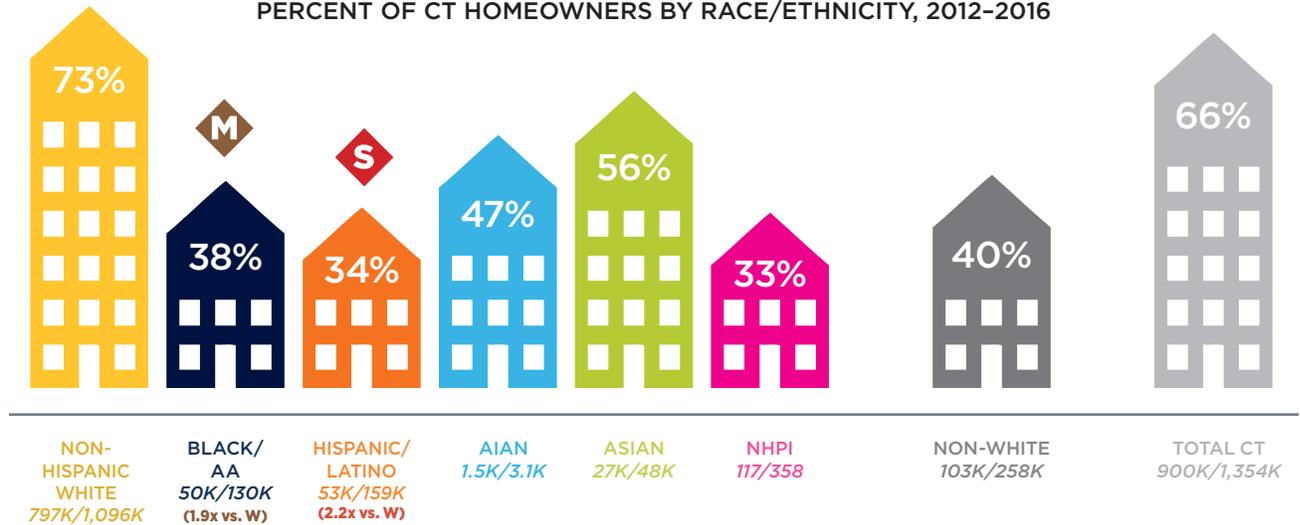
PERCENT OF CT HOMEOWNERS BY RACE/ETHNICITY, 2012–2016

73%	38% **M**	34% **S**	47%	56%	33%	40%	66%

| NON-HISPANIC WHITE *797K/1,096K* | BLACK/AA *50K/130K* (1.9x vs. W) | HISPANIC/LATINO *53K/159K* (2.2x vs. W) | AIAN *1.5K/3.1K* | ASIAN *27K/48K* | NHPI *117/358* | NON-WHITE *103K/258K* | TOTAL CT *900K/1,354K* |

Note: Home ownership data disaggregated by race/ethnicity and gender is not available for CT.
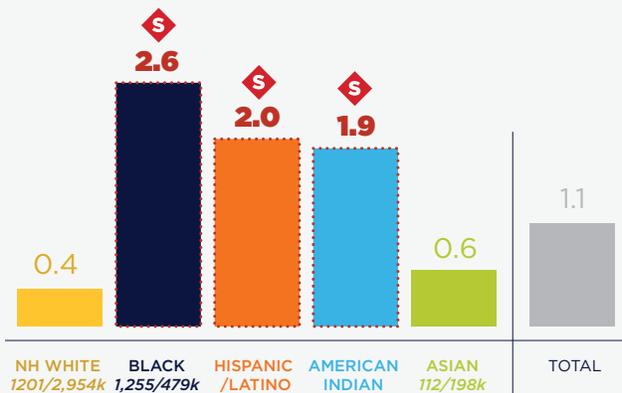
HOMELESSNESS

Nearly five times as many AI, Hispanic/Latino, and Black/AA CT residents were homeless, compared to non-Hispanic White counterparts, in January 2018.

Data on homelessness that are disaggregated by race/ethnicity and gender is not available for CT. However, of the homeless males enrolled in CT's Rapid Rehousing program from 2013 to 2015, there were nearly four times more Black/AA males (and 1.6 more Hispanic/Latino males) than non-Hispanic White males. (data source: [19])

RACIAL/ETHNIC DISPARITIES IN HOMELESSNESS IN CT
(HOMELESS POPULATION CT, PER 1,000 RESIDENTS • N = 3,383)

NH WHITE *1201/2,954k*	BLACK *1,255/479k* **S**	HISPANIC/LATINO **S**	AMERICAN INDIAN **S**	ASIAN *112/198k*	TOTAL
0.4	2.6	2.0	1.9	0.6	1.1

Hispanic/Latino and race categories are not mutually exclusive

RAPID REHOUSING HOMELESS POPULATION CT
(PER 10,000 RESIDENTS • N = 287 • MALE+FEMALE: 1,171)
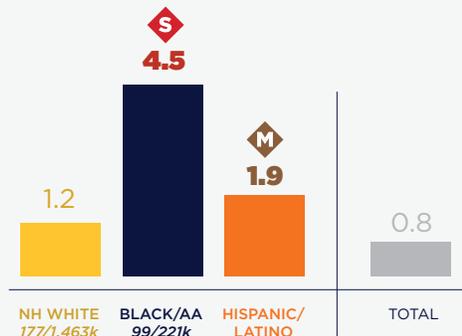
NH WHITE *177/1.463k*	BLACK/AA *99/221k* **S**	HISPANIC/LATINO **M**	TOTAL
1.2	4.5	1.9	0.8

Hispanic/Latino and race categories are not mutually exclusive

SAFETY & INCARCERATION

WEAPONS

PERCENTAGE OF CT BOYS THREATENED OR INJURED WITH A WEAPON ON SCHOOL PROPERTY (PAST 12M) ....

More Black/AA boys were threatened or injured with a weapon on school property (11.3%) than Hispanic/Latino (7.5%) or non-Hispanic White (non-Hispanic) boys (6.9%) in 2016. According to the Youth Risk Behavior Surveillance System (YRBSS)   (by a weapon such as a gun, knife, or club, one or more times during the 12 months before the survey, CDC20.
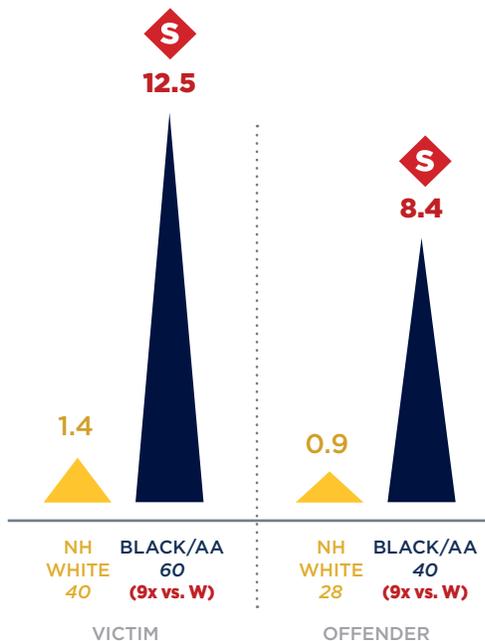
8%
11%
7%

HISPANIC/ LATINO BOYS
(1.1x vs. W)

BLACK/ AA BOYS
(1.6x vs. W)

NON- HISPANIC WHITE BOYS
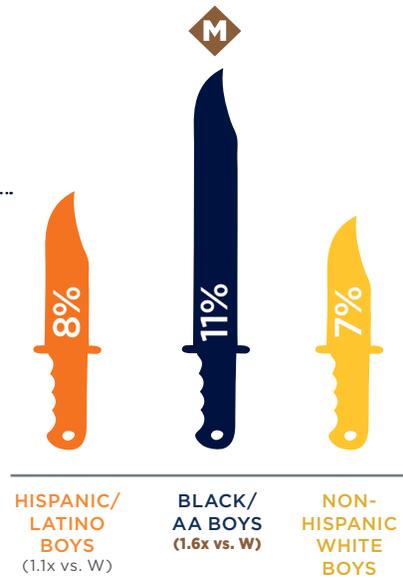
MURDERS

Black/AA residents are nine times more likely than non-Hispanic White residents to be both a victim and a perpetrator of murder in CT (data source: [12]). Most of the murder victims and offenders are males (80% and 90%, respectively).

MURDER VICTIM & OFFENDER, BY RACE (NON-HISPANIC WHITE & BLACK/AA) (PER 100,000 RESIDENTS)

S
12.5

S
8.4

1.4

0.9

NH WHITE *40*	BLACK/AA *60* **(9x vs. W)**	NH WHITE *28*	BLACK/AA *40* **(9x vs. W)**
VICTIM		OFFENDER	

VIOLENT CRIMES

according to the CT OPM Criminal Justice Policy & Planning Division (data source: [12]) Black/AA residents are more likely than non-Hispanic White residents to be perpetrators of a violent crime. Most offenders were males (97%, 85%, and 76%, respectively by crime category).

VIOLENT CRIMES, BY OFFENDER RACE (NON-HISPANIC WHITE & BLACK/AA)

S
22.52

S
10.7

S
8.6

4.67

1.8

4.0

BLACK/AA **(4.8x vs. W)**	NH WHITE	BLACK/AA **(5.8x vs. W)**	NH WHITE	BLACK/AA **(2.1x vs. W)**	NH WHITE
AGGRAVATED ASSAULT/10K		ROBBERY/10K		RAPE/100K	
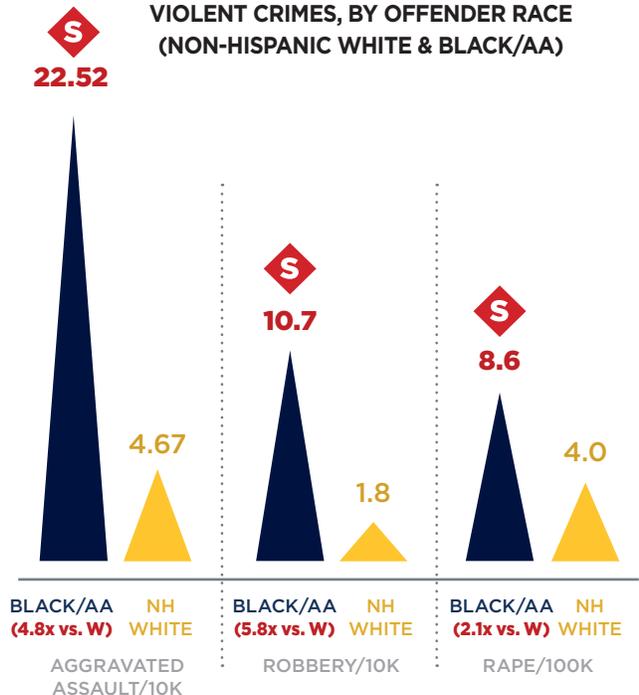
RACIAL & ETHNIC DISTRIBUTION OF MALES IN PRISON IN CT (PER 1,000)

13,550 males and 982 females were confined in CT prisons in 2016[26]. While Black/AA males make up 10.7% of the CT population, they make up 30.3% of the prison population. Similarly, Hispanics are 16% of CT residents, but make up 26.4% of males in prison.
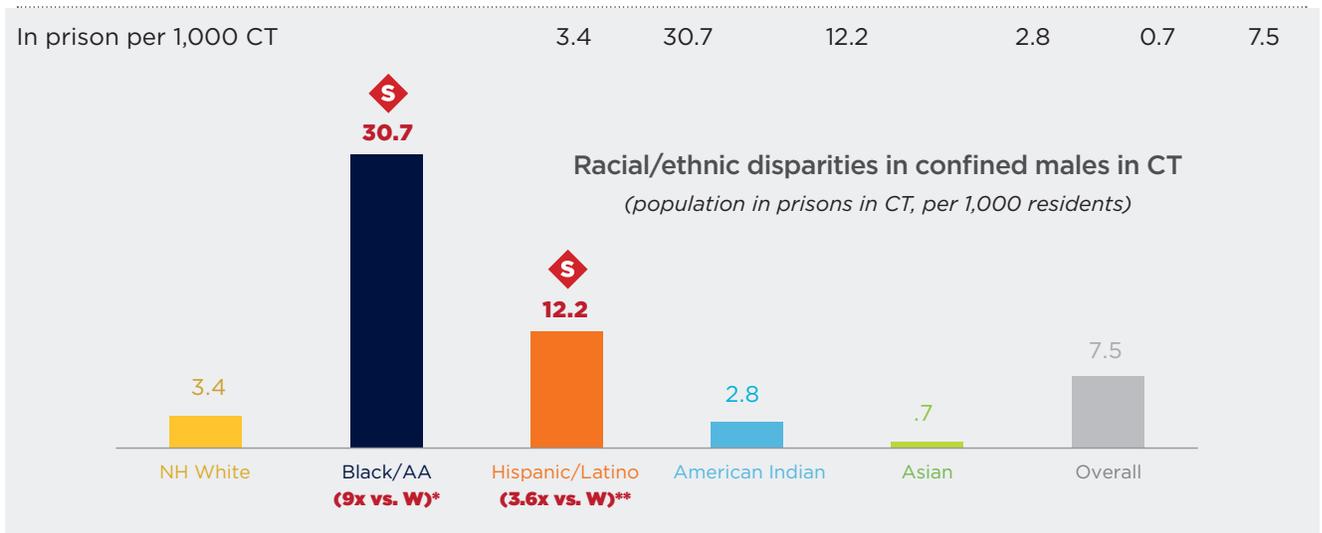
	NH White	Black /AA	Hispanic /Latino	Am. Indian	Asian	TOTAL
Percent R/E of CT population	67.5%	10.7%	16.0%	0.6%	5.1%	-
Males in prison	4,108	5,774	3,571	32	65	13,550
R/E group's % of all males in CT prisons	30.3%	42.6%	26.4%	0.2%	0.5%	-
In prison per 1,000 CT	3.4	30.7	12.2	2.8	0.7	7.5

Racial/ethnic disparities in confined males in CT
(population in prisons in CT, per 1,000 residents)

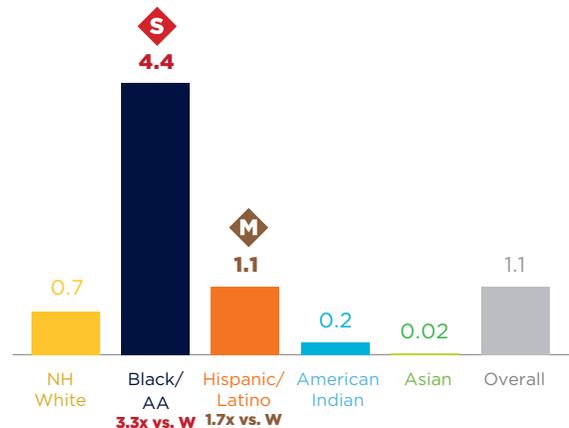| NH White	Black/AA (9x vs. W)*	Hispanic/Latino (3.6x vs. W)**	American Indian	Asian	Overall
3.4	30.7	12.2	2.8	.7	7.5

* Nine times more Black/AA than non-Hispanic White residents males were in CT prisons in 2016, relative to their population: 30.7 per 1,000 Black/AA males vs. 3.4 per 1,000 non-Hispanic White males. ** Nearly four times more Hispanic/Latino residents were imprisoned in CT than non-Hispanic White residents: 30.7 per 1,000 Black/AA males vs. 3.4 per 1,000 non-Hispanic White males[25].

Data after 2018 will exhibit men only population following a legislative mandate.

NATIONAL POPULATION OF MALES IN CUSTODY (IN PRISONS OR JAILS)

Nationally, 1.1% of all males were in custody (in prisons or jails) as of 2011. In the U.S., nearly 7 times more Black/AA males were in custody in the 2007 to 2011 period than White males, and 1.7 more Hispanic/Latino males than White males were in custody.

NH White	Black/ AA 3.3x vs. W	Hispanic/ Latino 1.7x vs. W	American Indian	Asian	Overall
0.7	4.4	1.1	0.2	0.02	1.1

2016 • Source: CT Department of Correction and US Census

Over the last eight years, nearly four times more Hispanic/Latino residents were imprisoned in CT than non-Hispanic White residents (3.7, eight year average), and nearly 9 times more Black/AA residents were imprisoned than non-Hispanic White residents (8.6, eight years average).[27]

Racial/ethnic rate comparisons of the composition of the CT prison population
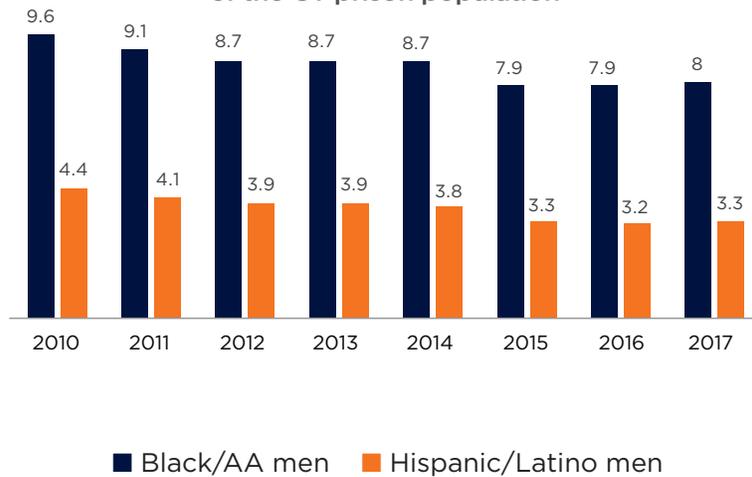
Year	Black/AA men	Hispanic/Latino men
2010	9.6	4.4
2011	9.1	4.1
2012	8.7	3.9
2013	8.7	3.9
2014	8.7	3.8
2015	7.9	3.3
2016	7.9	3.2
2017	8	3.3

■ Black/AA men ■ Hispanic/Latino men

JUVENILE JUSTICE POPULATION

In 2016, ten times more Black/AA than non-Hispanic White juveniles were admitted to juvenile detention centers in CT. During this same period, six times more Hispanic/Latino than non-Hispanic Whites were admitted. Like the adult prison population, juvenile detention center detainees are predominately male.

ADMISSION TO JUVENILE DETENTION CENTERS IN CT (PER 10,000 JUVENILES)

	NH White	Black/AA	Hispanic/Latino	Overall
Rate	6	56 Ⓢ	33 Ⓢ	14
	208	439	351	775
		(10x vs. W)	(5.9x vs. W)	
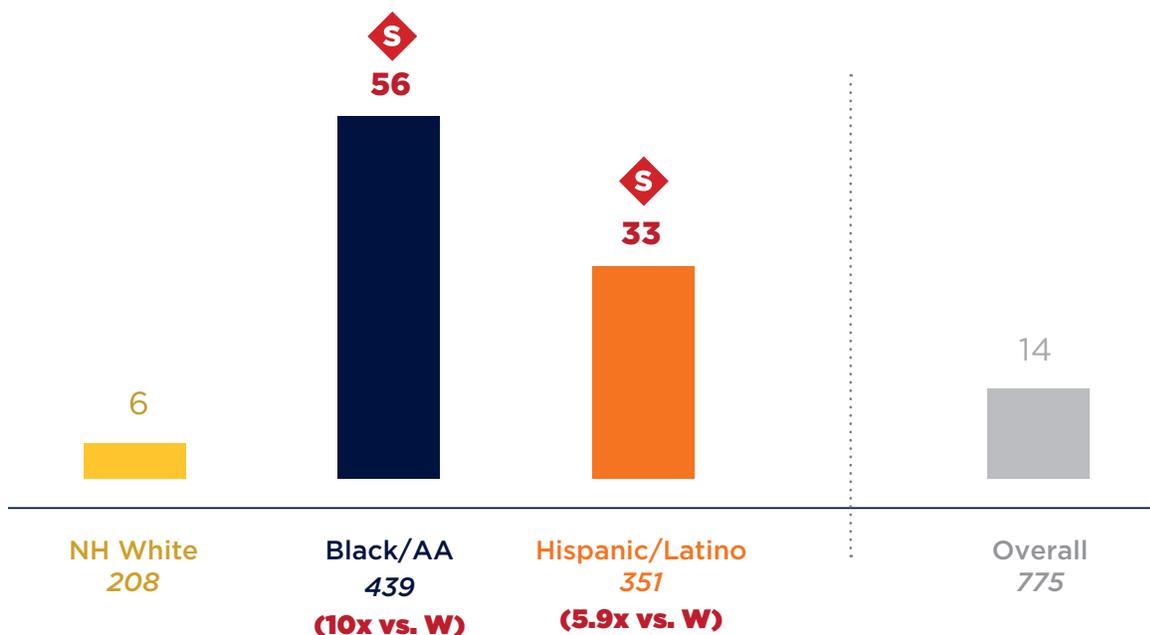
GAPS IN FATHERHOOD SUPPORT

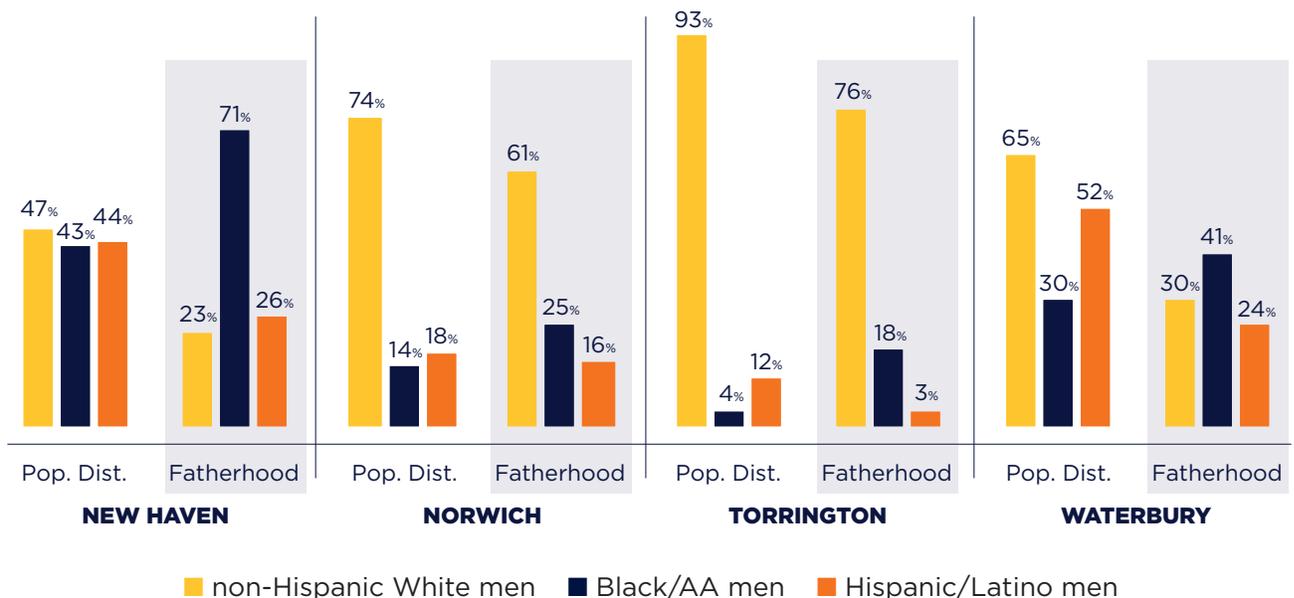## FATHERHOOD AND HEALTH

The science is still evolving and we have very little population level data about fathers and their relationships with their children. However, there is compelling evidence affirming that fathers play a critical role in the health and development of their children.[28,29,30] Infancy is an especially important window for healthy child development when fathers bond with their children.[31] For example, when fathers shower infants with high levels of affection (responding to their cries and playing together), these infants display more signs of secure attachment.[32] Children with more secure father attachment may be at lower risk for developing depressive symptoms during adolescence.[33] Fathers continue to play critical roles in the healthy development and educational outcomes of their children as they grow. For example, fathers make positive contributions to children's high academic achievement. Fathers also serve as important models for managing or

regulating emotions and behavior.[34] Caring fathers also produce more confident and emotionally secure children.[35] Yet, fathers are rarely supported by policy interventions in carrying out these kinds of expressive and caring roles.

To be clear, we lack consistent and progressive family leave policies for fathers and mothers in our nation. However, most child welfare policies emphasize the economic contributions that fathers make. Such policy-related barriers to father involvement are even more pronounced for young, low-income, and racial/ethnic minority fathers who also have to overcome narratives about 'responsible fatherhood' that can be tinged with implicit bias. While these economic contributions are important, there also needs to be an equal emphasis placed on the contributions fathers make to the social and emotional development of their children. Focusing on removing policy barriers to caring fatherhood practices is a critical strategy in advancing health equity among boys and men of color in CT.

FATHERS ENROLLED IN "PROMOTING RESPONSIBLE FATHERHOOD"

Fathers enrolled in a statewide "fatherhood" program in four CT cities enrolled more Black/AA fathers and fewer non-Hispanic White and Hispanic/Latino fathers than are represented in the CT population.

Source: CT Dept. of Social Services
2006-2007

Legend: non-Hispanic White men | Black/AA men | Hispanic/Latino men

NEW HAVEN — Pop. Dist.: 47%, 43%, 44% | Fatherhood: 23%, 71%, 26%
NORWICH — Pop. Dist.: 74%, 14%, 18% | Fatherhood: 61%, 25%, 16%
TORRINGTON — Pop. Dist.: 93%, 4%, 12% | Fatherhood: 76%, 18%, 3%
WATERBURY — Pop. Dist.: 65%, 30%, 52% | Fatherhood: 30%, 41%, 24%

GAPS IN FATHERHOOD SUPPORT

Participants (n=523) in the 'Promoting Responsible Fatherhood' asked for assistance with:

1 Finding a job or finding a better paying job (84.9%)

2 Skills to become a better parent (63.7%)

3 "Getting on the right track" (54.7%)

4 Talking with others in the same situation (45.9%)

5 Getting to see their children more often (41.0%)

6 Additional education or training (40.0%)

7 Child support payments or debts (36.9%)

HEALTH INSURANCE, PREVENTATIVE HEALTH CARE USE, & CHRONIC DISEASE

HEALTH INSURANCE COVERAGE

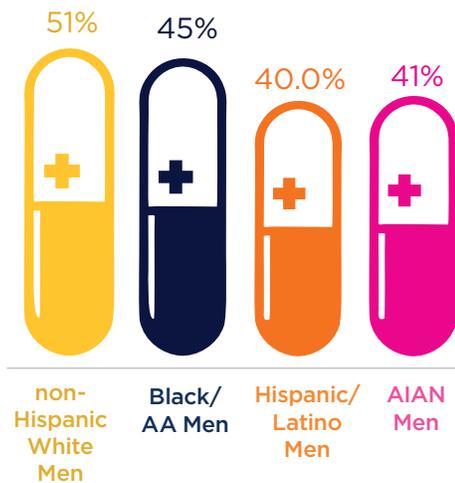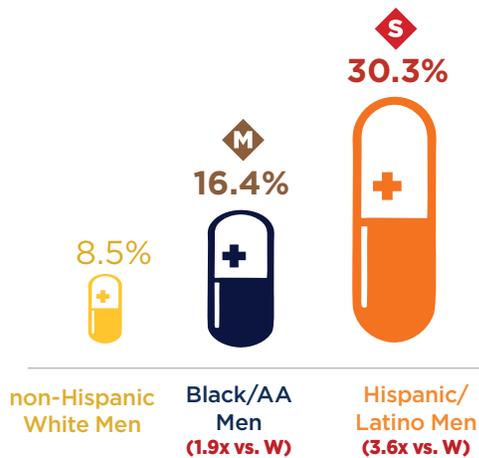### PERCENT UNINSURED IN CT, MEN > 18 YEARS

3.6 times more Hispanic/Latino men and 1.9 times more Black/AA men were uninsured, compared to non-Hispanic White men in CT.

More men (10.8%) than women (6.5%) in CT were uninsured (CT Census, 5 year estimates).

2011-15 • Source: https://factfinder.census.gov

8.5% non-Hispanic White Men

M **16.4%** Black/AA Men (1.9x vs. W)

S **30.3%** Hispanic/Latino Men (3.6x vs. W)

HEALTH INSURANCE COVERAGE, MEN 18–34 YEARS, U.S. 2011-2013

Health insurance coverage data shows that between the ages of 18 to 34, 49% of men were coved by either private or public insurance. Nearly 40% of Hispanic/Latino men and 41% of AIAN were covered by health insurance.

2018 • Source: RISE BMOC

51% non-Hispanic White Men

45% Black/AA Men

40.0% Hispanic/Latino Men

41% AIAN Men

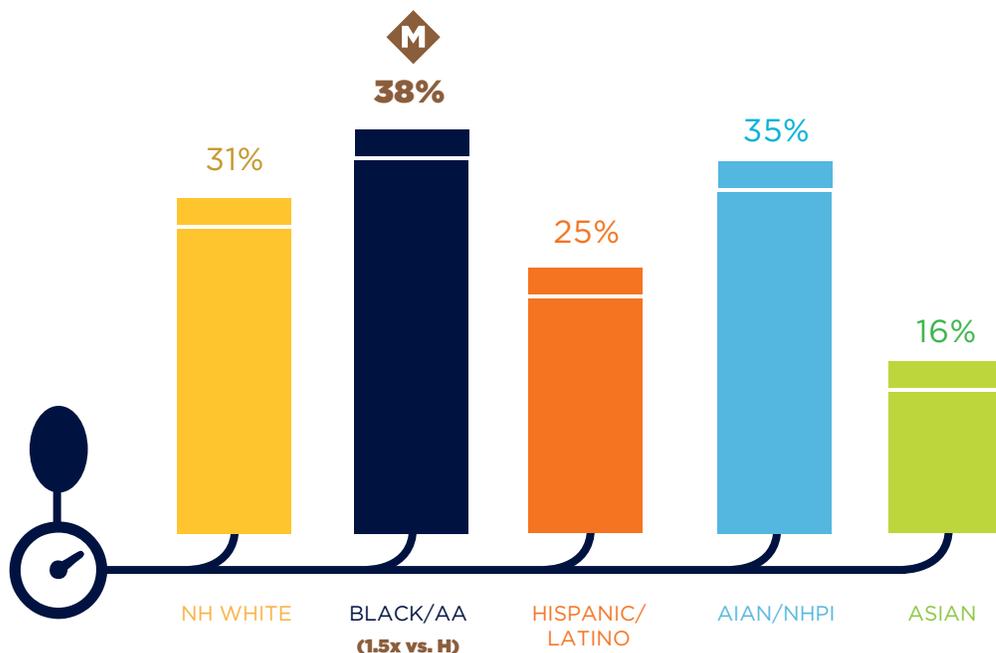### CT MEN WHO HAVE NOT RECEIVED A HEALTH CHECKUP IN THE PAST YEAR

1.9 times more AIAN or NHPI men have not had a health checkup in the year before in 2016, compared to Black/AA males (data source 7: BRFSS, CDC).[9]

2016 • Source: BRFSS, CDC

NH White	Black/AA	Hispanic/Latino	AIAN or NHPI	Asian
23% 3,681	20% 251	30% 428	**M** 38% 29 (1.9x vs. W)	33% 23
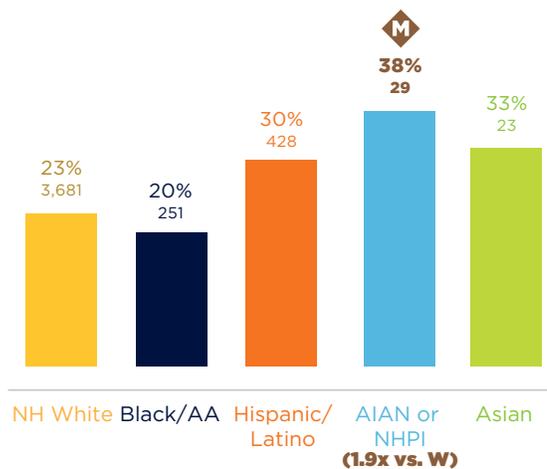
BLOOD PRESSURE SCREENINGS

CT RESIDENTS WHO HAD A BLOOD PRESSURE SCREENING IN THE PAST 12 MONTHS

NH WHITE	BLACK/AA	HISPANIC/ LATINO	AIAN/NHPI	ASIAN
31%	**38%** (M)	25%	35%	16%
	(1.5x vs. H)			

2017 • Source: BRFSSAmerica's Health Rankings
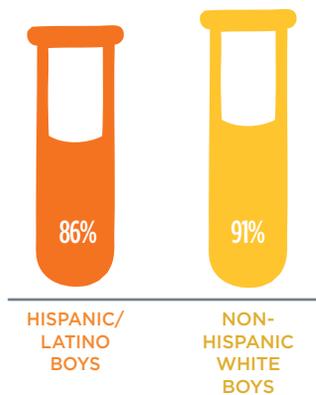
1.5 fewer Hispanics screening for high blood pressure in 2017, compared to Black/AA residents (in 2017). (data source: [7])

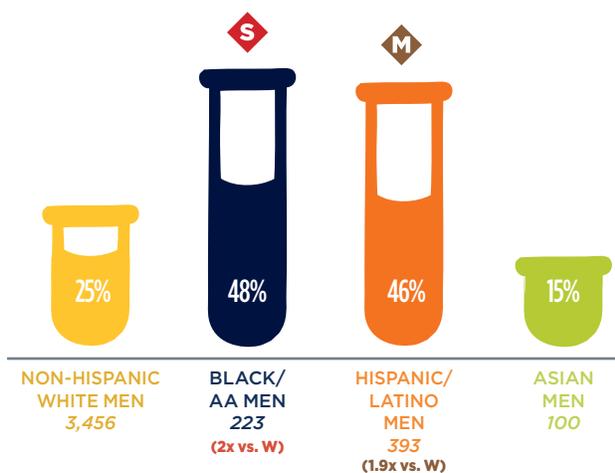# HUMAN IMMUNODEFICIENCY VIRUS (HIV) SCREENING

PERCENT OF CT BOYS NEVER TESTED FOR HUMAN IMMUNODEFICIENCY VIRUS (HIV)

HISPANIC/ LATINO BOYS	NON- HISPANIC WHITE BOYS
86%	91%

Three times more NH White (91%) and Hispanic/ Latino boys (86%) reported never being tested for HIV, in 2016, compared to the Healthy People 2020 goal of 26.4%.[24]

CT MEN WHO HAVE EVER TESTED FOR HUMAN IMMUNODEFICIENCY VIRUS (HIV)

| NON-HISPANIC WHITE MEN 3,456	BLACK/ AA MEN 223 (2x vs. W)	HISPANIC/ LATINO MEN 393 (1.9x vs. W)	ASIAN MEN 100
25%	48% (S)	46% (M)	15%

2017 • Source: BRFSS, CDC

Approximately 50% fewer non-Hispanic White males in CT ever tested for HIV in 2017, compared to Black/AA or Hispanic/Latino men. (data source: [21])

CHOLESTEROL SCREENING

CT RESIDENTS WHO HAD A CHOLESTEROL SCREENING IN THE PAST 12 MONTHS

87% NH White

80% Black AA

70% Hispanic or Latino

86% AI/AN

84% Asian
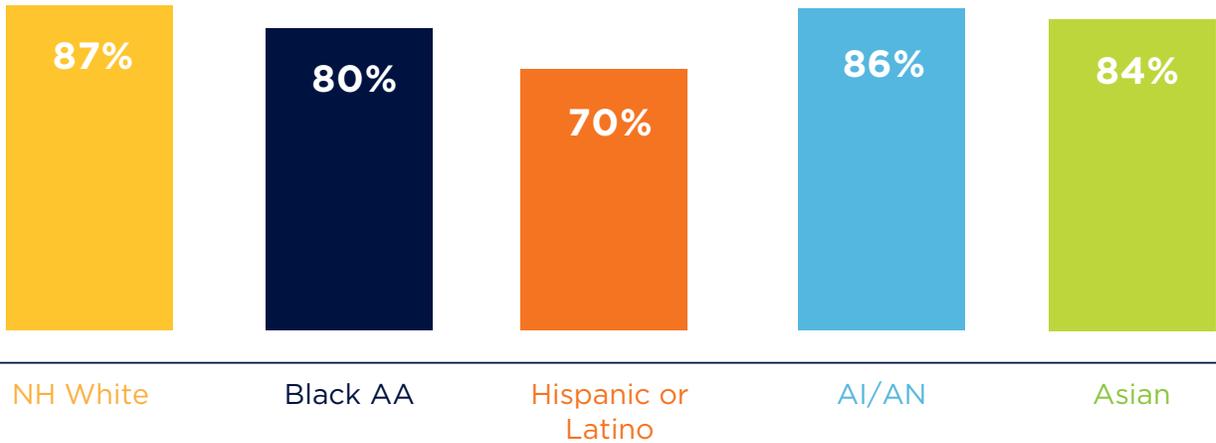
The majority of CT residents had a cholesterol screening in 2017, with similar rates by race/ethnicity (> 70%, data source: [7])

COLON AND LUNG CANCERS AMONG CT MALES

(per 100,000 residents)

Two or more times as many Black/AA, Non-Hispanic White, and Hispanic Latino men were diagnosed with colon and lung cancers than Asian and Pacific Islander men (Asian/ PI). Black/AA men had 1.2 times as many incidences of colon cancer than non-Hispanic White men.

COLON AND RECTUM

NH WHITE MEN
42

M
BLACK/AA MEN
50
1.5x vs W

S
HISPANIC/LATINO
48
2.6x vs W

M
ASIAN OR NHPI
23
1.9x vs W

TRACHEA, BRONCHUS & LUNG CANCER

S
NH WHITE MEN
69
2.3x vs Asian/PI

S
BLACK/AA MEN
71
2.4x vs Asian/NHPI

S
HISPANIC/LATINO
62
2.0x vs Asian/PI

ASIAN OR NHPI
30

PROSTATE AND LIVER CANCERS AMONG CT MALES

(Prostate per 10,000 residents & Liver per 100,000 residents)
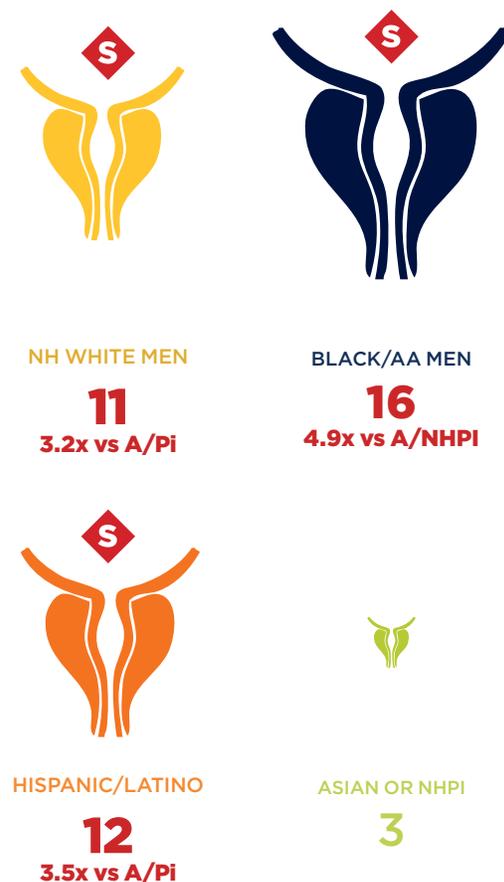
More than three times as many Black/AA, non-Hispanic White, and Hispanic/Latino men had prostate cancer compared to Asian and Pacific Islander men. Approximately 1.6 times as many Black/AA men were diagnosed with prostate cancer compared to non-Hispanic White men. Over two and a half times as many Hispanic/Latino men, approximately two times as many Asian and PI men, and one and a half times as many Black/AA men had liver cancer compared to non-Hispanic White men.

In 2003, 1.8 times as many Black/AA men were diagnosed with liver cancer than non-Hispanic White men and 1.5 times as many Black/AA men were diagnosed with prostate cancer than non-Hispanic White men.

LIVER BILE DUCT

NH WHITE MEN
11

BLACK/AA MEN
16
1.5x vs W

HIOSPANIC/LATINO
29
2.6x vs W

ASIAN OR NHPI
20
1.9x vs W

PROSTATE

NH WHITE MEN
11
3.2x vs A/Pi

BLACK/AA MEN
16
4.9x vs A/NHPI

HISPANIC/LATINO
12
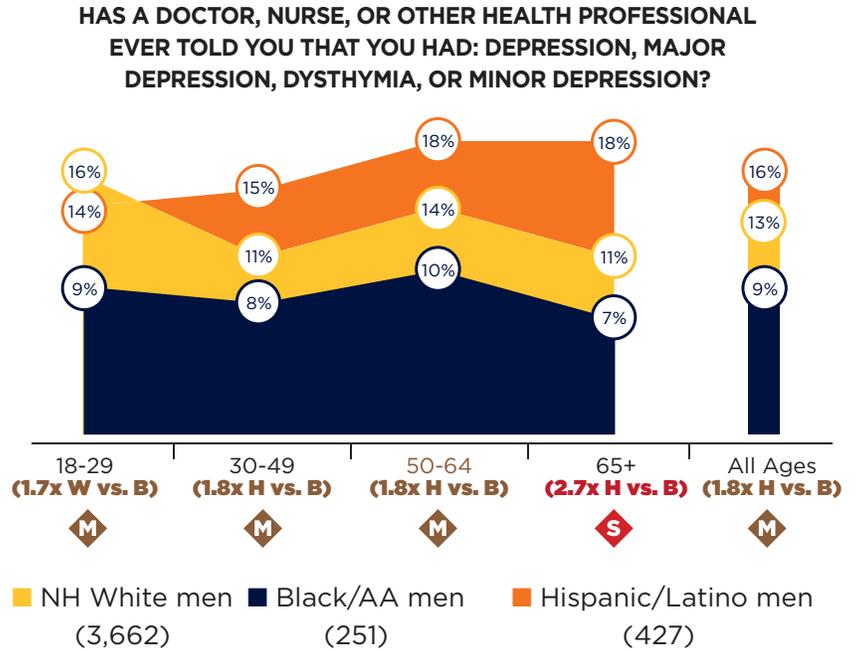**3.5x vs A/Pi**

ASIAN OR NHPI
3

2011–2015 • Source: NCI
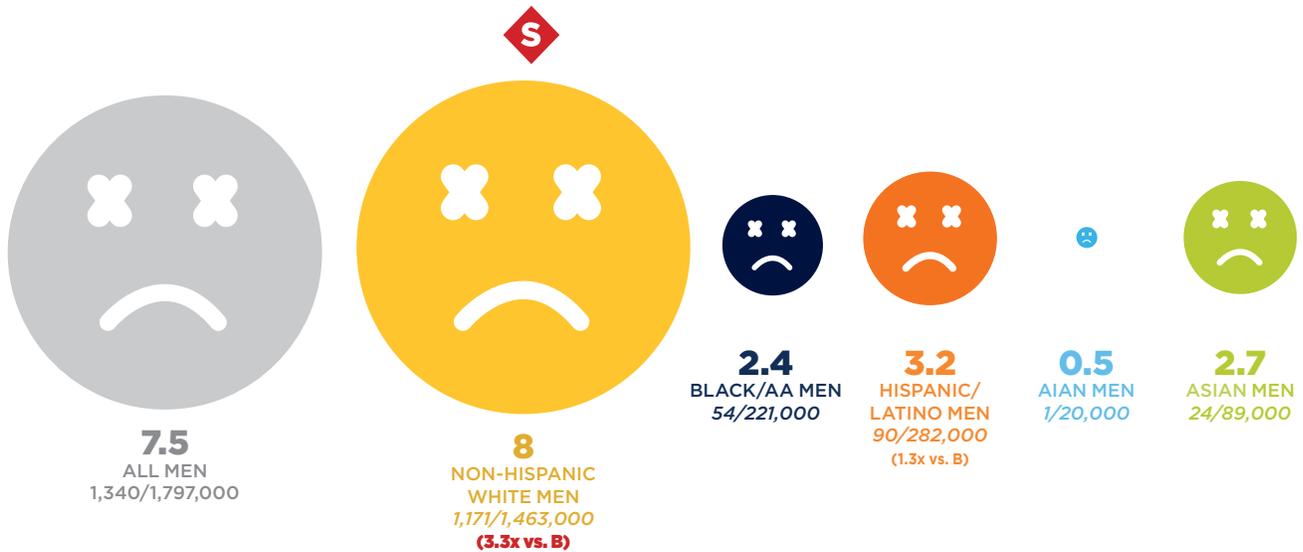
BEHAVIORAL HEALTH

DEPRESSION AMONG MEN

More non-Hispanic White and Hispanic/Latino men had a depressive disorder than Black/AA men. Nearly twice as many 18–29 year old Hispanic/Latino in the same age group men had a depressive disorder than young Black/AA men. Nearly three times as many older (65 years and older) Hispanic or Latino males reporting having a depressive disorder than Black/AA men in this same age group.

HAS A DOCTOR, NURSE, OR OTHER HEALTH PROFESSIONAL EVER TOLD YOU THAT YOU HAD: DEPRESSION, MAJOR DEPRESSION, DYSTHYMIA, OR MINOR DEPRESSION?

| 18-29 **(1.7x W vs. B)** | 30-49 **(1.8x H vs. B)** | 50-64 **(1.8x H vs. B)** | 65+ **(2.7x H vs. B)** | All Ages **(1.8x H vs. B)** |

2016 • Source: BRFSS

■ NH White men (3,662) ■ Black/AA men (251) ■ Hispanic/Latino men (427)

SUICIDE DEATHS AMONG CT MEN

Racial/ethnic disparities in suicide (per 10,000 residents)

7.5
ALL MEN
1,340/1,797,000

8
NON-HISPANIC
WHITE MEN
1,171/1,463,000
(3.3x vs. B)

2.4
BLACK/AA MEN
54/221,000

3.2
HISPANIC/
LATINO MEN
90/282,000
(1.3x vs. B)

0.5
AIAN MEN
1/20,000

2.7
ASIAN MEN
24/89,000

2012–2018 • Source: CT DPH

According to data from the CT DPH, more than three times more non-Hispanic White males than Black/AA males die of suicide in CT. (data source: [1])

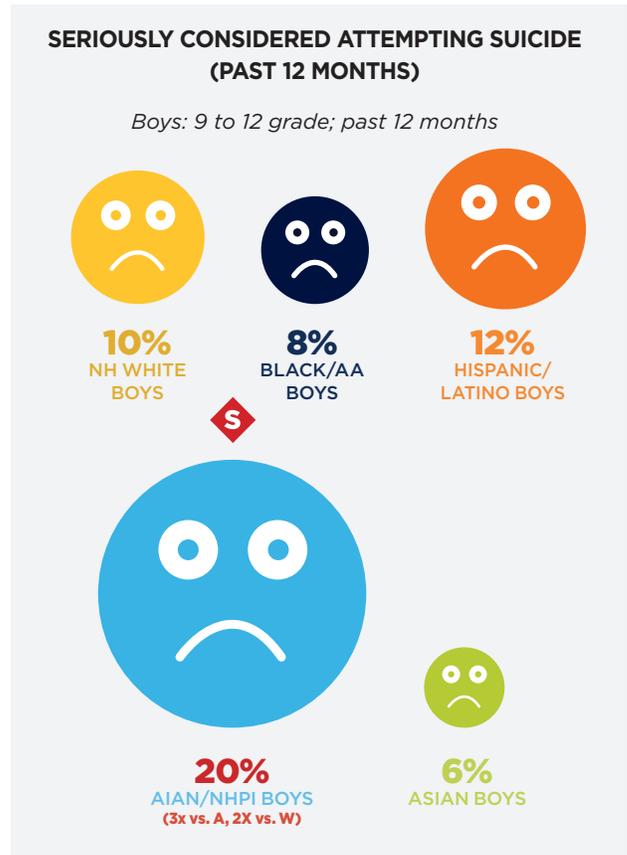# CT SUICIDE ATTEMPTS AND IDEATION AMONG CT BOYS AND YOUNG MEN

Nationally, suicide is the second leading cause of deaths among American Indians/Alaska Native 10–24 years old youth (AIAN).[25] Suicides among 15–25 years old young men in CT are 3 times more prevalent in Whites than Hispanic/Latinos, 14 White young men died in excess in 2014 comparatively.

More than three times more AIAN/NHPI boys in CT seriously considered suicide in the past 12 months than Asian boys (two times more than non-Hispanic White boys).

Note that suicide is the second leading cause of death in young AIAN (American Indian or Alaskan Native, non-Hispanic) men (in each 10–14, 15–24, 25–34 year old groups).[27]

CT reported numbers were too small[23], so we report on estimates[36] from the raw data.

The estimated percentage of boys attempting suicide in 2015 in CT (10.4%) was more than six times larger than the 2020 Healthy People target of 1.7%. The percent of AIAN/NHPI boys who attempted suicide (26%) was 8 times larger than Asian boys (3%) and 5 times larger than non-Hispanic White boys (5%).

SERIOUSLY CONSIDERED ATTEMPTING SUICIDE (PAST 12 MONTHS)

Boys: 9 to 12 grade; past 12 months

10%
NH WHITE BOYS

8%
BLACK/AA BOYS

12%
HISPANIC/LATINO BOYS

20%
AIAN/NHPI BOYS
(3x vs. A, 2X vs. W)

6%
ASIAN BOYS

ATTEMPTED SUICIDE   (1 OR >; PAST 12M)

26%
AIAN/NHPI BOYS
(8x vs. A, 5X VS.. W)

5%
NH WHITE BOYS

8%
BLACK/AA BOYS

10%
HISPANIC/LATINO BOYS

3%
ASIAN BOYS

2015 • Source: CDC YRBS estimates

SUICIDES
(15–25 YEARS OLD; PER 100,000)

.12
(3x vs. H)
W: 14 vs. H
W: 28 vs. B

0

.04

W: 3 vs. B
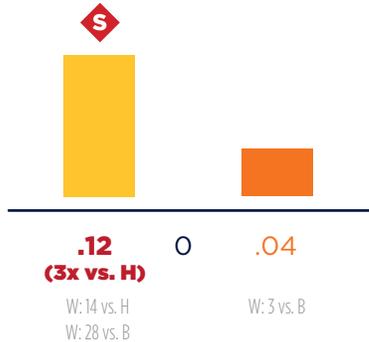
■ = NH White boys   ■ = Hispanic or Latino boys

2014 • Source: CT DPH

SUICIDE DEATHS AMONG CT BOYS

1 means: same rate per 1,000 in Black/AA or Hispanic/
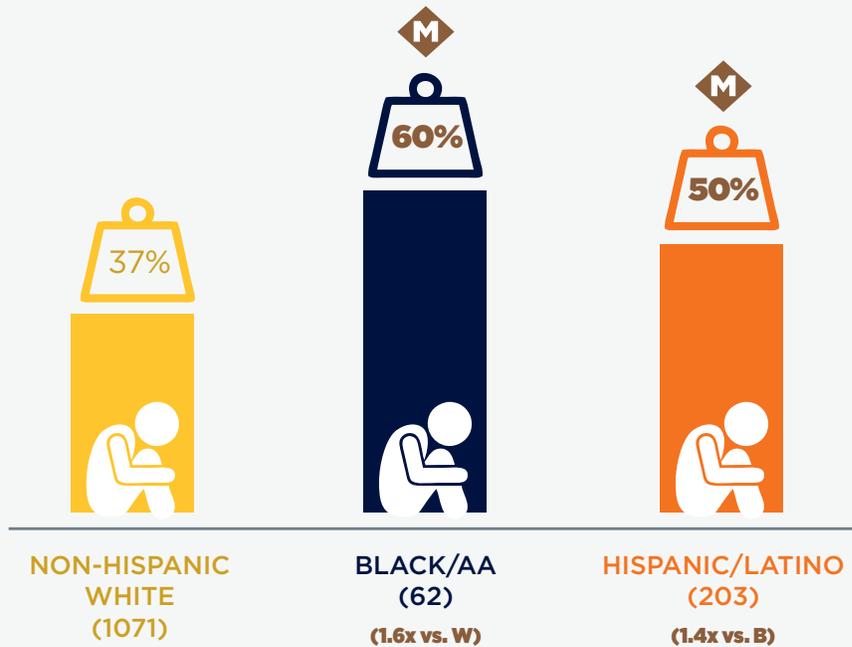Latino men, compared to non-Hispanic White men.

Excess deaths: W=Excess non-Hispanic White Deaths,
B=Excess Black/AA Deaths, or H=Excess Hispanic/
Latino Deaths

"vs. H" = the group has worse outcomes than Hispanic/
Latino men

The CT DPH mortality data for 2014 reports 273 males (of any age) who died by suicide. Three times more young non-Hispanic White men (15–25 years olds, 0.12 suicides per 1,000) died by suicide than Hispanic/Latino men (0.04/1,000); no Black/AA men 15–25 years old were recorded to have died by suicide that year. Nationally, 3.6 times more men than women died of suicide in 2014.[37] If one compares suicide deaths to Black/AA young men deaths (0), all 28 non-Hispanic White and all 3 Hispanic/Latino young men deaths can be deemed 'excess' or 'unnecessary' deaths.

ADVERSE CHILDHOOD EXPERIENCES IN CT
(percent of 0–17 year old children who experienced one or more)

37%

60%

50%

**NON-HISPANIC
WHITE
(1071)**

**BLACK/AA
(62)**
(1.6x vs. W)

**HISPANIC/LATINO
(203)**
(1.4x vs. B)

In 2017, 1.6 times more Black/AA children and 1.4 times more Hispanic/Latino children, compared to non-Hispanic White children experienced at least 1 childhood adverse experiences, which are associated with health and social problems across the life-course. The disaggregated data by gender is not reported.
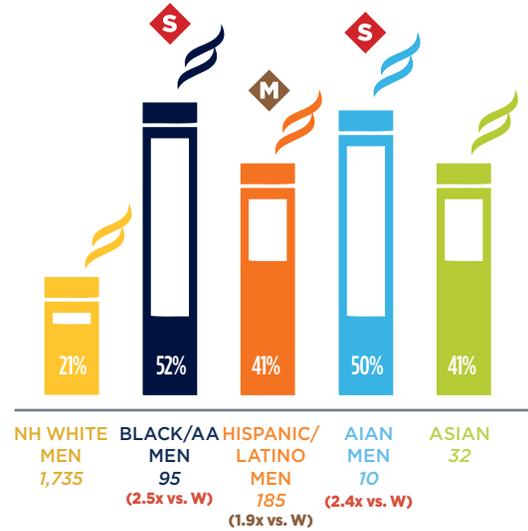
SUBSTANCE USE

9TH–12TH GRADE BOYS WHO CURRENTLY SMOKE CIGARETTES (>20 CIGATERRES/DAY, PAST 30 DAYS)

8.4% — HISPANIC/ LATINO BOYS

8.6% — BLACK/ AA BOYS

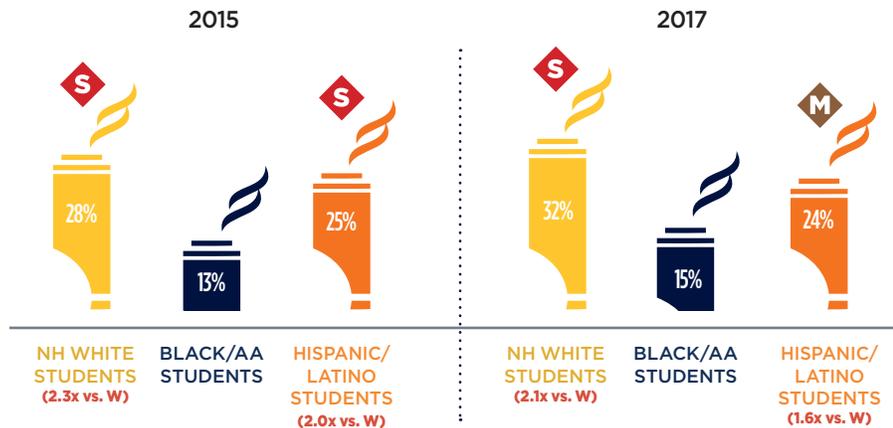**10.7%** — NH WHITE BOYS (1.3x vs. H)
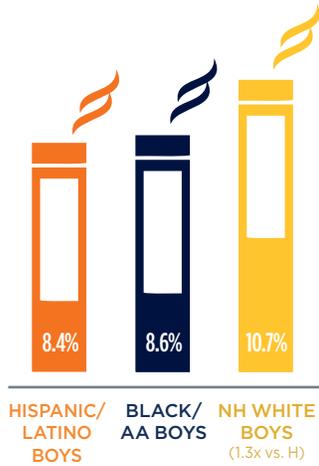
In 2016, more non-Hispanic White boys (10.7%) in CT smoked cigarettes on at least 1 day during the past 30 days than Black/AA (8.6%) or Hispanic/Latino boys (8.4%).

CT MEN WHO SMOKE CIGARETTES (EVERY DAY OR SOME DAYS)

21% — NH WHITE MEN *1,735*

52% — BLACK/AA MEN *95* (2.5x vs. W)

41% — HISPANIC/ LATINO MEN *185* (1.9x vs. W)

50% — AIAN MEN *10* (2.4x vs. W)

41% — ASIAN *32*

In 2016, nearly twice as many Hispanic/Latino males smoked than non-Hispanic White males. During this same period, more than twice as many Black/AA and AIAN men than non-Hispanic White males smoked.

CT HIGH SCHOOL STUDENTS WHO EVER USED E-CIGARETTES OR VAPING PRODUCTS

2015

28% — NH WHITE STUDENTS (2.3x vs. W)

13% — BLACK/AA STUDENTS

25% — HISPANIC/ LATINO STUDENTS (2.0x vs. W)

2017

32% — NH WHITE STUDENTS (2.1x vs. W)

15% — BLACK/AA STUDENTS

24% — HISPANIC/ LATINO STUDENTS (1.6x vs. W)

In 2015, twice as many non-Hispanic White high school students and Hispanic/ Latino high school students used e-cigarettes or vaping products than Black/AA high school students. In 2017, twice as many non-Hispanic White high school students and 1.6 times as many Hispanic/Latino students used e-cigarettes or vaping products than Black/AA students. R/E data is not disaggregated by gender.
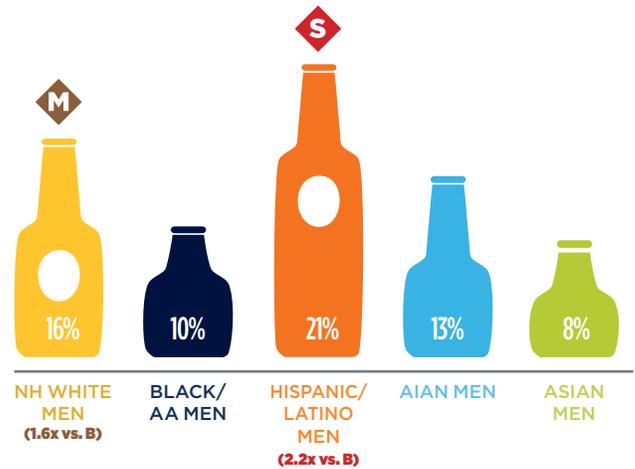
CT BOYS WHO REPORTED CURRENT BINGE DRINKING (IN THE PAST 30 DAYS)

12.0%
HISPANIC/
LATINO
BOYS

16.7%
NH WHITE
BOYS
(1.4x vs. H)
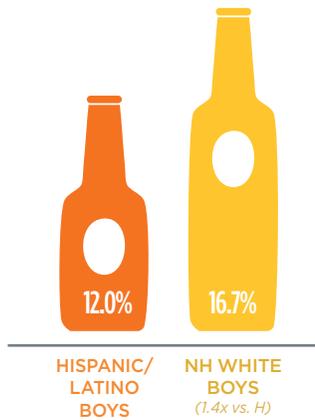
In 2016, more non-Hispanic White boys (16.7%) reported binge drinking (consuming five or more drinks in a row, in a couple of hours, on at least 1 day) than Hispanic/Latino boys (12.0%). (data source: [8])

CT MEN WHO REPORTED BINGE DRINKING (IN THE PAST 30 DAYS)

16%
NH WHITE
MEN
(1.6x vs. B)

10%
BLACK/
AA MEN

21%
HISPANIC/
LATINO
MEN
(2.2x vs. B)
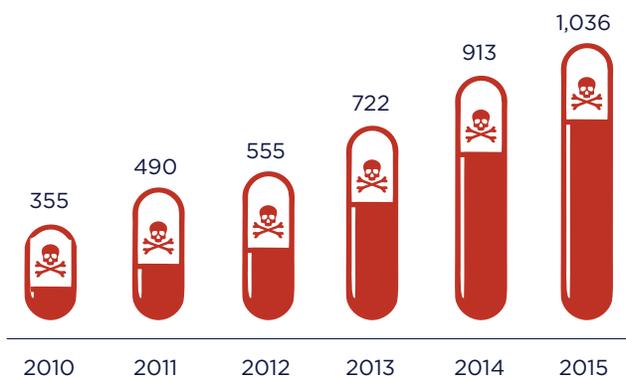
13%
AIAN MEN

8%
ASIAN
MEN

In 2016, nearly twice as many Hispanic/Latino men and 1.6 times more non-Hispanic White men reported binge drinking (once or more in the past 30 days) than Black/AA men. (data source: [7])

DRUG-RELATED DEATHS

UNINTENDED DRUG-RELATED MALE DEATHS IN CT (PER 100,000)

355
2010

490
2011

555
2012

722
2013

913
2014

1,036
2015

The number of unintended male deaths caused by drugs (mainly opioids) tripled in the past 5 years.[37]

UNINTENDED DRUG-RELATED DEATHS IN CT FOR BLACK/AA, NON-HISPANIC WHITE, AND MALES OF OTHER RACES (PER 100,000)

16   16   4
2012
(4x W vs. O)
(4x B vs. O)

51   41   7
2017
(7x W vs. O)
(6x B vs. O)

3.1x increase
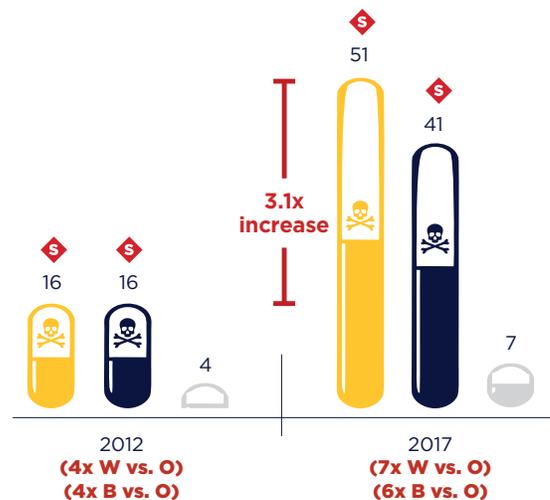
Data for Hispanic/Latino males:
0.1 (2012); 0.3(2017)

■ NH White men   ■ Black/AA men
■ AIAN/NHPI/Asian and 2 or more races

7 times more non-Hispanic White males, and 6 times more Black/AA males, than males of other racial/ethnic groups, died of drug-related accidents (opioids primarily).[37]

LIFE EXPECTANCY

LIFE EXPECTANCY OF CT MEN (IN YEARS)

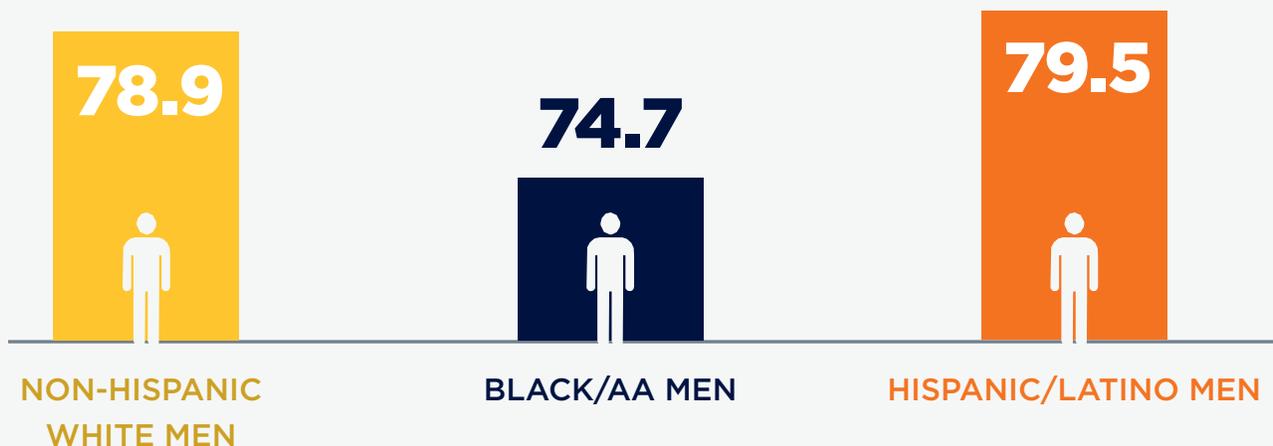Men average (2013–2014): 78.6

78.9

74.7

79.5

NON-HISPANIC WHITE MEN

BLACK/AA MEN

HISPANIC/LATINO MEN

Black/AA men lived 4.2 fewer years compared to non-Hispanic White men, and Hispanic/Latino men lived about half a year longer than non-Hispanic White men.

MORTALITY

MORTALITY OF CT MEN IN 2014, BY RACE/ETHNICITY

- ■ Solid = Total number
- ☐ Outline = Per 1,000

■ ■ ■ = Died of Leading Causes
■ ■ ■ = Died of Other Causes

445 / .4
11,792 / 9.8

166 / .9
892 / 5

236 / .9
608 / 2.2

non-Hispanic White
1,200,235
(68% of all CT men)

Black/AA
178,068
(10% of all CT men)

Hispanic/Latino
270,794
(15% of all CT men)
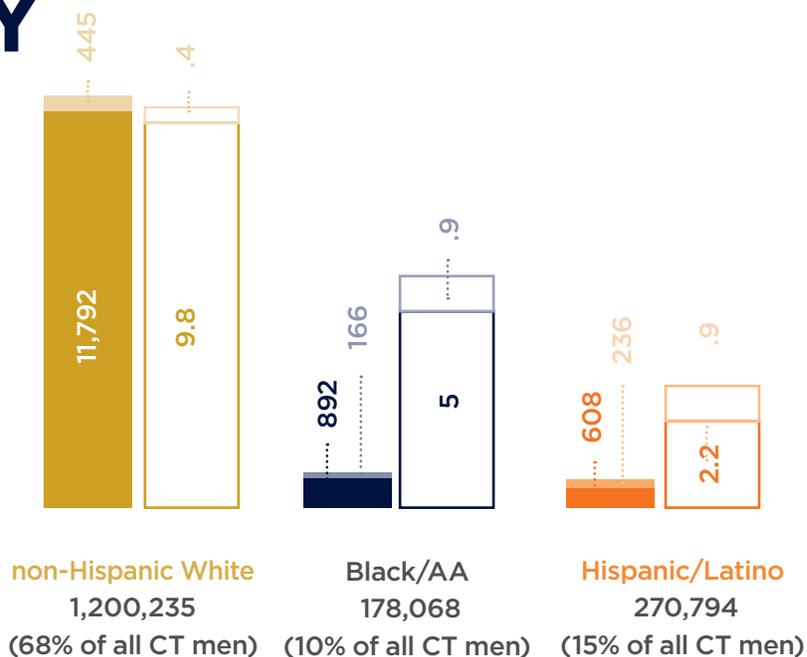
Most men died of one of the top 5 leading causes of death in the U.S. (regardless of age), therefore a more detailed breakdown by cause of death is warranted.

The number of deaths by 1,000 residents in CT by race/ethnicity seem to indicate more non-Hispanic White men died than Black/AA or Hispanic/Latino, at least in terms of the deaths aggregated across all age groups[2].

FIVE LEADING CAUSES OF DEATH IN 2014 (PER 1,000 MEN)

#1
Major cardiovascular diseases
4,028 (2.3)

#2
Diseases of heart
3,301 (1.9)

#3
Malignant neoplasms
3,372 (1.9)

#4
Ischemic heart disease
1,958 (1.1)

#5
Trachea, bronchus & lung cancer
816 (0.5)

SUM OF FIVE LEADING CAUSES . . . . 13,475 . . . . (7.7)
ACCIDENTAL INJURIES . . . . 980 . . . . (0.5)

TOTAL . . . . .14,455 . . . . (8.2)
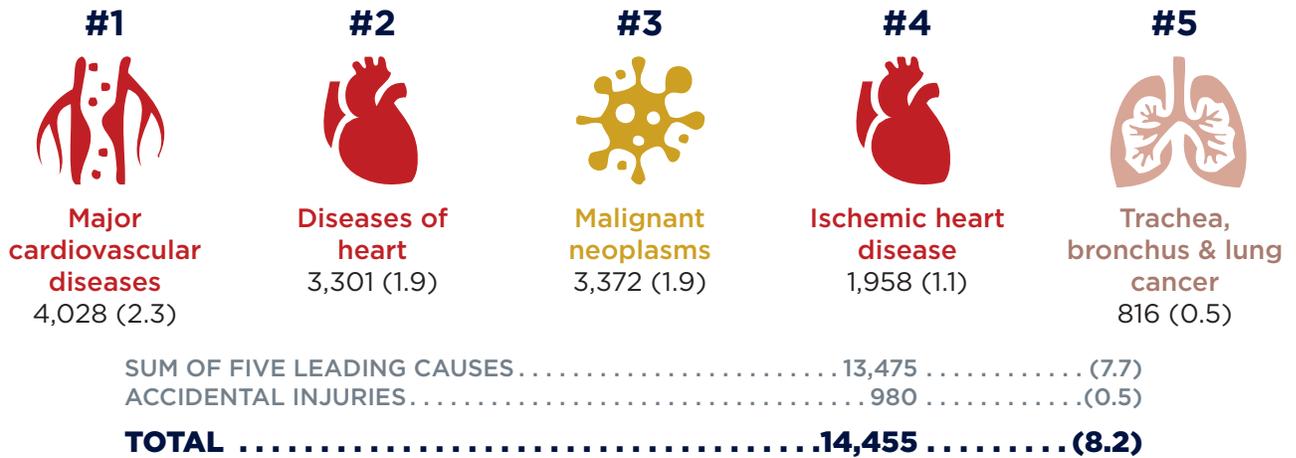
There were 8.2 deaths for every 1,000 men in CT in 2014.

Almost all of these deaths were due to the five leading causes of death depicted above and accidental injuries (0.5/1,000).

We report further on the five leading medical causes of death in order to gauge potential health disparities (HDs).

Note: Total number of deaths among CT men in 2014 (all racial/ethnic groups): 14,685; 980 deaths were due to unintentional injuries, which were not among the five leading causes of deaths for men.

INTERPRETATION AID FOR MORTALITY GRAPHS

All mortality comparisons are made primarily between men of color and non-Hispanic White men, but mortality rates (per 1,000) are shown separately for: non-Hispanic White men, Black/AA men and Hispanic/Latino men—in each age group. Disparities are shown when rates, i.e. the ratios of deaths (Black/AA vs. non-Hispanic White, e.g.), exceed 1.5, meaning more than 1.5 Black/AA men died compared to non-Hispanic White men, for example.

The disparities are marked as the group doing worse vs the group doing better, e.g. W vs. H
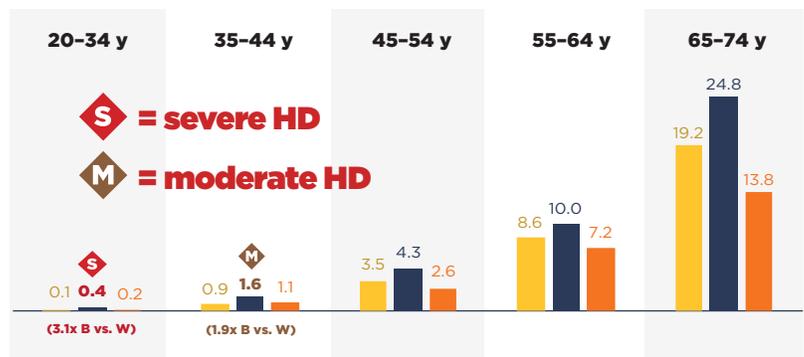
means non-Hispanic White men vs. Hispanic/Latino men disparity rate, if non-Hispanic White men fare worse then Hispanic/Latino men.

While health disparities (HDs) are not apparent for men overall, there seem to be evident racial/ethnic (R/E) differences within certain age groups. For example, there were 67 excess deaths among 55-64 years old Black/AA men, or 1.5 more Black/AA men died within this age group than the reference non-Hispanic White men group (comparatively, i.e. as deaths per 1,000 residents).

per 1,000 | ■ = White men ■ = Black men ■ = Hispanic men

MORTALITY DUE TO TOP FIVE LEADING CAUSES

Deaths due to any of the 5 leading causes

Three times more Black/AA men aged 20–34 died in 2014 than NH White men as a result of any of the five leading medical causes of death, or specifically, 13 excess deaths occurred that could have potentially been prevented). Similarly, nearly twice (1.9x) as many 35–44 year old Black/AA men died than NH White men (or 18 excess deaths).

20-34 y	35-44 y	45-54 y	55-64 y	65-74 y

S = severe HD
M = moderate HD

20-34 y: 0.1 **0.4** 0.2 (3.1x B vs. W)
35-44 y: 0.9 **1.6** 1.1 (1.9x B vs. W)
45-54 y: 3.5 4.3 2.6
55-64 y: 8.6 10.0 7.2
65-74 y: 19.2 24.8 13.8

	20–34 y	35–44 y	45–54 y	55–64 y	65–74 y

LEADING CAUSE OF MORTALITY

Deaths due to major cardiovascular diseases

There are severe HDs in mortality due to major cardiovascular diseases between Black/AA and NH White men, among age groups 20–34 (3.1x HD), 35–44 (2.0x HD), 45–54 (1.7x HD), and 75–84 (1.5x HD).

20–34 y: 0.1 / **0.2** (S) / 0.1 — (3.1x B vs. W)
35–44 y: 0.3 / **0.5** (S) / 0.4 — (2.0x B vs. W)
45–54 y: 0.9 / **1.6** (M) / 0.9 — (1.7x B vs. W)
55–64 y: 2.3 / 3.3 / 1.8
65–74 y: 4.7 / **5.6** (M) / 3.8 — (1.5x B vs. W)

SECOND CAUSE OF MORTALITY

Deaths due to diseases of heart

Severe HDs in deaths due to diseases of heart are observable between Black/AA and NH White men in the age groups: 20-34 years old (4.8x HD), 35-44 years old (1.9x HD), 45-54 years old (1.5x HD), and 75-84 years old (1.5x HD; 33 excess Black/AA men deaths).

20–34 y: 0.0 / **0.2** (S) / 0.0 — (4.8x B vs. W)
35–44 y: 0.2 / **0.5** (M) / 0.3 — (1.9x B vs. W)
45–54 y: 0.8 / **1.2** (M) / 0.6 — (1.5x B vs. W)
55–64 y: 2.0 / 2.3 / 1.4
65–74 y: 3.9 / **4.3** (M) / 3.1 — (1.5x B vs. W)

THIRD CAUSE OF MORTALITY

Deaths due to malignant neoplasms

There are severe HDs between Black/AA and NHWhite men in three age groups, with 30 combined excess deaths among Black/AA men and 16 excess deaths that occurred among NH White men aged 75-84 years old (compared to Hispanic/Latino men).

20–34 y: 0.0 / **0.1** (M) / **0.1** (M) — (1.5x B vs. W) (1.5x H vs. W)
35–44 y: 0.2 / **0.3** (M) / 0.2 — (1.7x B vs. W)
45–54 y: 1.0 / 0.8 / 0.7
55–64 y: 2.5 / 3.1 / 2.5
65–74 y: 6.3 / **9.3** (M) / 4.5 — (1.5x B vs. W)

FOURTH CAUSE OF MORTALITY

Deaths due to ischemic heart disease

Several NH White and Black/AA men deaths could have been potentially prevented when we compare them to Hispanic men of the same age groups: 31 White deaths among 35–84 year olds; 9 Black deaths among 35–84 year olds (numbers for 75–84 olds not shown in graph).

20–34 y: **0.01** (S) / **0.05** (M) / 0.0 — (1.8x B vs. W) (2.0x W vs. H)
35–44 y: **0.14** (M) / **0.25** (S) / 0.07 — (1.7x W vs. H) (3.3x B vs. H)
45–54 y: 0.5 / 0.5 / 0.3
55–64 y: 1.2 / 1.1 / 0.9
65–74 y: **2.5** (M) / **2.5** (M) / 1.4 — (1.7x W vs. H) (1.7x B vs. H)

FIFTH CAUSE OF MORTALITY

Deaths due to trachea, bronchus & lung cancer

There are excess deaths in NH White men compared to Black/AA (or Hispanic/Latino) men: 3 (5) among 45-54 year olds; 7 (3) among 55-64 year olds. There were 13 (65-74 olds) and 3 (75-84 olds) excess Black/AA men deaths, compared to NHWhite men.
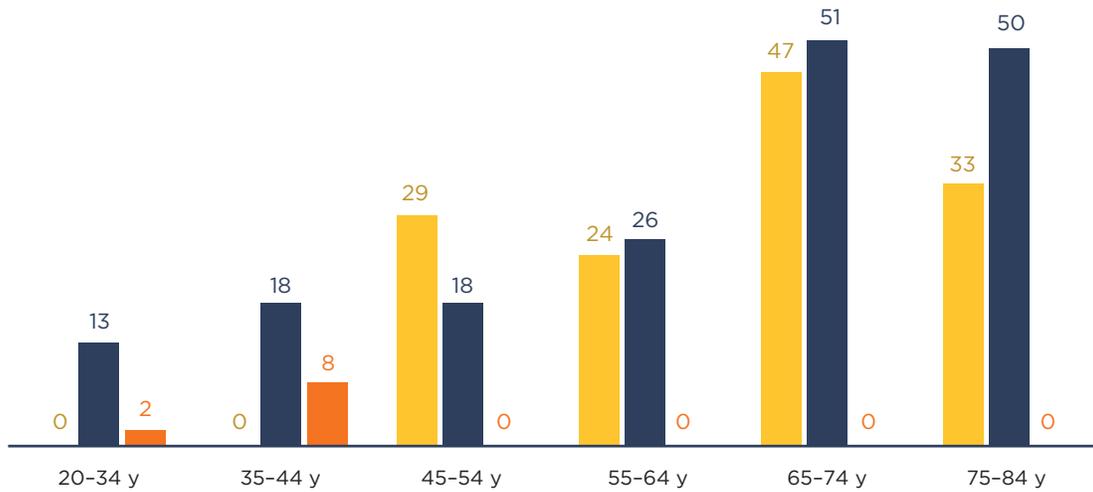
Too few data for <35 years men

45–54 y: **0.3** (S) / 0.1 / 0.1 — (2.0x W vs. B) (2.5x W vs. H)
55–64 y: **0.7** (S) / 0.3 / 0.5 — (2.5x W vs. B)
55–64 y: 1.8 / **3.2** (M) / 1.1 — (1.8x B vs. W)
65–74 y: 3.2 / **3.9** (M) / 1.4 — (1.8x B vs. W)

SIXTH LEADING CAUSE OF MORTALITY

Mortality in men due to unintended injuries

More non-Hispanic White men than Black/AA and Hispanic/Latino men died due to accidental injuries and among 55-64 year olds, 1.9 as many Black/AA than NH White died due to unintended deaths.

20–34 y: **1.0** (S) / 0.5 / 0.4 — (2.0x W vs. B) (2.5x W vs. H)
35–44 y: **0.8** (M) / 0.6 / 0.7 — (1.5x W vs. B)
45–54 y: **0.7** (S) / 0.3 / 0.8 — (2.2x W vs. H)
55–64 y: 0.5 / 0.5 / 0.5
65–74 y: **0.5** (S) / **0.9** (M) / 0.2 — (1.9x B vs. W) (2.1x W vs. H)

EXCESS CT MEN DEATHS DUE TO THE FIVE LEADING CAUSES (PER 1,000)

Age group	NH White men	Black/AA men	Hispanic/Latino men
20–34 y	0	13	2
35–44 y	0	18	8
45–54 y	29	18	0
55–64 y	24	26	0
65–74 y	47	51	0
75–84 y	33	50	0

Total: ■ NH White men - 133   ■ Black/AA men - 176   ■ Hispanic/Latino men - 10

Note: Excess deaths were computed by reverting (counterfactually) to equity, i.e. assuming that the groups with higher mortality enjoyed the outcome of the reference group, the group with the lowest mortality within each age group (marked with 0 excess deaths). The data shows that 176 Black men and 10 Hispanic men died prematurely in 2014 in CT, when compared to White men. However, 133 White men died before their time too, when compared to Hispanic men.

NEXT STEPS

To advance health equity among BMoC in CT over the next several years, the Health Disparities Institute has the following plans.

LONG TERM GOAL:

Enhance health equity research, training, and innovation

Strategies:

Design and seed innovative interventions and research focused on neighborhoods, behavioral health, and trauma

Support and train health equity research leaders from academic institutions across the state

LONG TERM GOAL:

Deepen community engagement and cultivate cross-sector collaborations

Strategies:

Promote authentic dialogue & foster trust building through our #BraveNewSpaces initiatives

Create opportunities for community-centered joint learning & knowledge exchange via a statewide convening on health equity among BMoC

Expand the activities of the CT Multi-Sector Alliance for Health Equity among Boys and Men of Color to include the cultivation of public-private partnerships

LONG TERM GOAL:

Support policy action and systems change

Strategies:

Create policy advocacy tools and disseminate best practices models for clinical-community integration

Translate scientific evidence about health equity and disparities among BMoC into policy briefs

LONG TERM GOAL:

Change public and scientific narratives

Strategies:

Leverage the arts to change narratives, bridge empathy gaps, and inspire systems change through our year-long *Visualizing Health Equity among Boys and Men of Color initiatives*

Update and produce annual health equity report cards for BMoC and other medically underserved populations

Use Big Data analytics and GIS tools (e.g., PolicyMap) to map local, state, and national data on health and well-being indicators

APPENDIX: DATA SOURCES

The CT BMoC report card includes the most recent publicly available data from several public sources:

1. CT Department of Public Health (DPH) 2014 Vital Records data[2], most recent full data available when the report was initiated (2015 has been released since).
2. US Census data – the American Community Survey 2016 1-Year Estimates[3]
3. Measure of America - Social Science Research Council. (life expectancy, 2014)[6]
4. Social Security Administration – life expectancy (overall, 2014)[38]
5. CT branch of NAACP (National Association for the Advancement of Colored People), cancer rates in 2003)[39]
6. CT DataHaven, race/ethnicity data by senate districts from US Census.[7]
7. CDC's Behavioral Risk Factor Surveillance System (BRFSS).[9]
8. CDC's Youth Risk Behavior Surveillance System (YRBSS, 9–12 grades, 2016)[24]; Black youth data not reported for several behaviors due to small numbers (<100).
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RACE & ETHNICITY CODING IN THE MAIN DATASETS

US Census[A]	NH White	B/AA	AIAN	Asian	NHPI	Hispanic[C]
CDC	NH White	B/AA	AIAN	-	Asian or Other Pacific Islander	Hispanic
CT DPH[B]	White	Black	-	-	-	Hispanic

Note: B/AA: Black or African American; American Indian or Alaska Native; NHPI: Native Hawaiian or Other Pacific Islander; [A] the CDC and YRBS classification of racial/ ethnic categories are identical, [B] CT DPH only disaggregated data by three racial/ ethnic categories. Individuals in the AIAN, A, & NHPI racial/ ethnic groups were grouped into an "Other" category, [C] Residents in each race category can also choose Hispanic or Non Hispanic.

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