

PART III

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OTHER VULNERABLE POPULATIONS

In this section of the report, health and data collection issues of other vulnerable populations are briefly addressed. These are social groups who are “impoverished and disenfranchised, or those who are subject to discrimination, intolerance, subordination, and stigma” (Flaskerud et al. 2002; Peternej-Taylor 2005). For a variety of reasons, these people may find it difficult to receive or afford appropriate health information or health care, or to make their own health care decisions. Consistent, integrated, or easily accessible health information for these groups is often limited or difficult to find. This section provides a brief discussion of selected health concerns of these populations.

RURAL HEALTH

Although Connecticut is a densely-populated state, “rural” areas are very much a part of the state’s geography. In 2004, sixty-five out of Connecticut’s 169 towns were designated rural (Holt, Wexler and Farnam 2006, 3). The racial and ethnic composition of the rural areas in Connecticut tends to be overwhelmingly White (96.6%) and non-Hispanic (98%) compared to urban areas or to the state overall (Holt, Wexler and Farnam 2006, 7; Connecticut State Office of Rural Health [ORH] 2001, 20).

Recent rural health reports have noted important issues affecting our rural residents: 1) an aging rural population which will require more intensive health care services; 2) the coordination of and access to transportation to healthcare providers or facilities; 3) the effects of seasonal work (e.g. tourism, agriculture) on family economies and health care access; 4) the level of education and type of employment options for rural residents; 5) travel time to work and health care facilities; and 6) the small but growing proportion of rural racial and ethnic minority residents (ORH 2001; Holt, Wexler, and Farnam 2006; New England Rural Health RoundTable 2007). Echoing national concerns for rural populations, providers in Connecticut also note how difficult it is to provide chronic disease management, oral health, and mental health services to rural populations, and especially to low-income residents (Agency for Healthcare Research and Quality (AHRQ) 2008). Finally, health care providers are often unwilling or unable to accept insurance reimbursement levels, which is a significant barrier to health care for rural residents (Holt, Wexler, and Farnam 2006).

AGE AND HEALTH

Different age groups have different health needs and concerns. The health and social needs for *young children* include good nutrition, good oral health practices, healthy indoor and outdoor environments, and quality education. Major public health concerns of a younger population include poor nutrition/food choices and physical inactivity, which can lead to childhood obesity, lead poisoning, asthma, and risk of injury in both the home and outdoors. *Adolescents and young adults* must manage health issues such as motor vehicle use, violence, substance use, sexual behavior, and tobacco use. They must also learn to balance social factors such as their family, peer groups, school, and community expectations (CDC 2008i). In Connecticut, Hispanics or Latinos are overall a younger population than the White population. Hispanics or Latinos are especially overrepresented in the 0–19 age group, and underrepresented in the 65 and over age group relative to the state’s White population. This population distribution will shape health intervention programming at the local and state levels.

Connecticut has one of the country’s oldest populations: The Connecticut State Data Center projects that by 2030, the median age in Connecticut will be 41.5, while the national median age will be 39 (Connecticut State Data Center n.d.). The median ages among our state’s racial and ethnic groups also will increase by 2030, and aging in our rural areas will be dramatic, which will lead to increasing demand for transportation and health care services at (University Communications 2007). Health concerns for *older adults* center around prevention efforts, managing chronic conditions, healthy lifestyle behaviors, and using early detection practices (e.g., screening for cancer, diabetes, and depression) (CDC 2008j; U.S. DHHS 2002, 2007c). In 2005, 66.3% people in the state’s oldest age cohort (85+) report having a disability, compared with 12.9% of the general population (Center for Personal Assistance Services 2008). In addition, many racial and ethnic minority elders are uninsured or underinsured for their conditions, may have limited English proficiency, and are more likely than White elders to live in poverty (CDC and Merck 2007, 3). Elders living in poverty may be less likely or less able to access health care services and other support services (U.S. DHHS 2002, 2007c).

SEXUAL AND GENDER MINORITIES

Sexual and gender minorities (e.g., lesbian, gay, bisexual and transgender [LGBT] persons) are as diverse as the rest of the population and are parts of our neighborhoods, families and social fabric (See Appendices IV and VII). In 2000, *Healthy People 2010* recognized sexual and gender minorities as populations who experience health disparities (U.S. DHHS 2000a). Yet nine years after the publication of that report, there is a dearth of systematic collection and reporting of data on LGBT populations—nationally and at the state level (excepting HIV/AIDS and sexually transmitted infection and disease risk among men who have sex with men) (Blank, Asencio and Descartes in press; Gay and Lesbian Medical Association [GLMA] and LGBT Health Experts 2001, 19). In addition to the lack of systematic data collection with these populations, each of these subgroups may have health issues that affect one group much more than the others. For example, with certain health risks, the gay male population may have a different risk level than the lesbian population, or the transgendered population may be more likely to have an elevated risk for a certain health concern as compared to the other subpopulations and the general population (Blank, Asencio and Descartes in press). Also, the transsexual population and intersexual population that have undergone surgical sex reassignment may have additional health concerns and consequences that are not necessarily shared by others embedded in the larger category of sexual and gender minorities. Thus, any discussion of the data should take into account data limitations as well as the commonalities and differences among these populations in terms of a particular health disparity.

Among the LGBT population, discrimination, harassment, and family, community and peer pressures or violence can lead to serious physical and mental health concerns. In addition, the health care system uses “heteronormative standards that may or may not be appropriate or useful for ensuring the health of [LGBT] people and their families” (Blank, Asencio and Descartes in press). LGBT people who also belong to racial or ethnic minorities face special vulnerabilities based on the combination of these identities (GLMA and LGBT Health Experts 2001, 19).

Within the LGBT community, individuals are at risk for not only HIV/AIDS but other health conditions as well. The emerging literature suggests higher rates of breast cancer, hepatitis B and influenza (GLMA and LGBT Health Experts, 2001, 19). Additional health issues include post-traumatic stress syndrome, mental health and suicide issues as well as

provider ignorance and misconduct (Dean et al. 2000, 111–125). While this is not an exhaustive list, it points to the ongoing need to record and monitor health disparities within this population.

There are also health issues that affect or are more salient to LGBT persons at different points in their life span or throughout their life span. LGBT *teens* often have to deal with issues of their family or social network dissolution and reformulation (sometimes due to their coming out process), running away or leaving school early, and the challenges of urban life, including poverty and possible involvement in prostitution. LGBT *homeless* teens have many similar issues to their heterosexual homeless teen counterparts, but may more frequently be “victims of parental physical abuse, substance abusers, and have both mental and general physical health problems” (Cochran et al. 2002, 773). In the case of the aging gay male population and the “graying of HIV/AIDS,” Medicare/Medicaid reimbursements for services may be problematic, as well as early aging due to the disease and its long-term treatments (Engel 2008). Additionally, older LGBT individuals may suffer from social isolation, depression, and internalization of the heterosexism of the majority society (Blank, Asencio and Descartes in press).

PERSONS WITH DISABILITIES

Everyone will have some kind of disabling condition at some point in his or her life. Indeed, it is often said that, “it is not whether, but when, not so much which one, but how many, and in what combination.”

—Zola (1993, 18, emphasis in original)

According to Census 2000, about 50 million people in the United States have some kind of long-lasting health condition or disability (U.S. Census Bureau 2003c). This number represents 19.3% of the 257.2 million people who were aged 5 and older in the civilian non-institutionalized population—or nearly one person in five (U.S. Census Bureau 2003c). In 2007 in Connecticut, 12.8% of the population aged 5 or older in the civilian non-institutionalized population had a disability, with a prevalence ranging from 5.3% ages 5 to 15 years old, to 47.6% of people aged 75 and older (Rehabilitation Research and Training Center on Disability Demographics and Statistics [StatsRRTC] 2007a, 3). Both nationally and in Connecticut, people with disabilities had lower educational attainment levels and employment rates, and higher poverty rates than people

without disabilities (StatsRRTC 2007a, 2007b). In 2006, prevalence rates of disability for non-institutionalized people ages 21–64 years in Connecticut were: 13.3% among Blacks or African Americans, 15.6% of Native Americans, 10.4% of Whites, and 5.7% of Asians. This database did not analyze data for Hispanics or Latinos for 2006 (StatsRRTC 2007a, 20).

Federal legislation and policies have created more than 67 definitions of “disability” (Drum et al. 2005, 31; Caruk et al. 2007, 3; StatsRRTC 2007b). Therefore, disability statistics vary widely depending on definitions, data collection instruments, and purposes of data collection. Moreover, the idea that “health” and “disability” are mutually exclusive terms may cloud health care provision and data collection.

People with disabilities are more likely than the general population to experience early deaths, chronic conditions, high rates of oral disease, and higher rates of diabetes (Drum et al. 2005, 36). People with disabilities also have relatively fewer preventive and routine health screenings and services (i.e., blood pressure and cholesterol screening, mammography, and counseling about alcohol and substance abuse, diet and eating habits, exercise, and smoking cessation) (Drum et al. 2005, 36–37; National Center on Birth Defects and Developmental Disabilities [NCBDDD] 2001). People with disabilities also confront systemic barriers to treatments such as: provider ignorance or insensitivity, equipment inaccessibility, transportation difficulties, cost of health care and programs, and lack of health information in alternative print, plain language, or sign language (Drum et al. 2005, 37–38; NCBDDD 2001).

IMMIGRANTS AND REFUGEES

IMMIGRANTS

Immigrants and persons with limited English proficiency (LEP) often have difficulty getting appropriate medical interpreter services and culturally competent health care, which often leads these groups to defer health care services (Capps et al. 2005). In addition, immigrants have many diverse economic, political, health and social needs. For example, one of the largest and growing subgroups in Connecticut’s Asian population is South Asians from India (U.S. Census Bureau 2005a, 2008a.). Many people in this population are highly-educated, English-speaking professionals, well-trained for jobs in high-paying job sectors and have higher per capita/household incomes than the White population in the state (Narayan 2004; Capps et al. 2005).

In sharp contrast are Asian refugees from Vietnam, Thailand, Cambodia, and Laos, including Hmong populations. Beginning in the mid-1970s, these populations were resettled in Connecticut and in the U.S., and resettlement and secondary migration continues to this day. Many of these people suffered years of flight from their homelands, living in refugee camps and enduring torture, degradation, malnutrition, and social and familial collapse (U.S. DHHS 2006a). Their health issues stem from little or no primary, dental, or mental health care during years of extremely traumatic experiences, and from culture shock and linguistic isolation in their new country.

Nationally, immigration statistics show that “Latin American and Caribbean immigrants account for over half of all immigrants (52%), and Mexico alone accounts for almost a third” (Capps et al. 2005:6). However, Connecticut’s immigrant population is not overwhelmingly dominated by one subgroup or ancestry. Our immigrant population is made up of 22% Asian; 22% Latin American, 14% Caribbean, and 5% African immigrants (Capps et al. 2005:7). Connecticut’s largest immigrant population is from Europe (38%), reflecting earlier waves of immigration, but this is an older and aging population compared to the newer immigrants. Poland and Jamaica are the most common countries of birth for immigrants in Connecticut, at 8% and 7% respectively in 2004 (Capps et al. 2005, 7). Increasing numbers of people have immigrated from Mexico and Central America (10%) and South America (12%), but the largest Hispanic or Latino ethnic subpopulation in Connecticut remains Puerto Ricans, who are U.S. citizens (Capps et al. 2005, 7).

Immigrants in particular may suffer health problems due to lack of access to health care. Cultural and linguistic factors, relatively lower education and income levels, and location and availability of health care providers affect the health status of immigrants. In addition, insurance coverage may be too expensive, too complicated to decipher, or simply unavailable to immigrants in their jobs (Capps et al. 2005).

REFUGEES

The term “*refugee*” refers to persons “who [are] outside his or her country of nationality who [are] unable or unwilling to return to that country because of persecution or a well-founded fear of persecution. Persecution or the fear thereof must be based on the alien's race, religion, nationality, membership in a particular social group, or political opinion” (U.S. Department of Homeland Security 2007). Refugees represent a small

portion of the overall immigrant population, and are usually folded into the latter for purposes of census surveys. In the U.S., the majority of refugees are coming from the following countries: Somalia, Liberia, Sudan, Ethiopia, Afghanistan, Iran, Iraq, Former USSR, Cuba, Laos, Myanmar, and Vietnam (Immigration and Refugee Services of America 2006). Connecticut received about 380 people in federal fiscal year 2008 (Connecticut Department of Social Services 2008).

Refugees have unique personal history issues (war, torture, trauma, history of living in refugee camps), health concerns (certain diseases), culture shock, and linguistic difficulties (linguistic isolation, resettlement without others from same nation/region, lack of interpreters for uncommon languages or dialects) possibly not faced as often by other immigrants. Refugee populations suffer from high rates of tuberculosis, parasitic diseases, dental problems, and post-traumatic stress disorder diagnoses due to war, torture, displacement, and culture shock (Lobato, Mohamed, and Hadler 2007; U.S. DHHS 2006a).

LIMITED ENGLISH PROFICIENCY (LEP) POPULATIONS

One source estimates that 90 million people in the U.S. have trouble understanding basic health information (National Library of Medicine 2004). People who do not speak, read or write English well will very often have limited or inconsistent access to healthcare and lowered health status. Medical histories, symptoms, diagnoses, treatment regimens, and illness belief systems are more likely to be misunderstood or incompletely described when there is language discordance between patients and health care providers (Smedley, Stith, and Nelson 2003). Increased patient mistrust or refusal of care, missed medication or office appointments, and reliance on emergency room services may result without proper interpretation, translation, and comprehension of medical information (Smedley, Stith and Nelson 2003; Hispanic Health Council 2006, 31). In 2005, about 22% of Connecticut doctors reported that they felt unprepared to treat patients with limited English proficiency (Hispanic Health Council 2006, 31–32).

In the last few decades, the federal government has repeatedly supported the use of linguistically appropriate social services, including health care. Institutions that receive federal funding must comply with the language access provisions of Title VI of the Civil Rights Act of 1964 (U.S. DHHS 2001, 1, 8–11; Meyers 2007, 19). The “culturally and linguistically appropriate services (CLAS) standards” are designed to provide meaningful

access to health services (U.S. DHHS 2001). The only standards that are *mandated* are those that deal with the language needs of clients, such as competent and available interpreter and translation services, and the translation of health-related materials into commonly-used languages found in a service area (U.S. DHHS 2001, 8–11).

While most people in Connecticut’s LEP population speak Spanish, there are other persons who come from small language populations (i.e., Mexican indigenous languages, African ethnic dialects, Asian ethnic dialects) that may make it difficult to find qualified medical interpreters. Although hospitals and medical professionals frequently respond to the needs of LEP populations, there is a need for greater emphasis on better linguistic services (Connecticut Health Foundation 2006). Hospital and agency employees, telephone interpreter services, community volunteers, licensed on-site medical interpreters, and multilingual picture cards in binders have all been used to help alleviate the problems of translation in medical settings (U.S. DHHS n.d.).

HOMELESS PERSONS

It has been estimated that 2.5 to 3.5 million people now experience homelessness each year in the United States (Donohoe 2004, see Appendix IV for definitions). In 2001, the Reaching Home Campaign estimated that about 33,000 individuals experience homelessness in Connecticut every year (Connecticut Coalition to End Homelessness [CCEH] et al. 2007, 4). In Connecticut between January 1, 2008 and March 31, 2008, there were 8,337 people experiencing homelessness who were recorded by 13 communities that use the state Homeless Management Information System [HMIS] (CCEH 2008a). A point-in-time survey on January 30, 2008 estimated that 3,444 households experienced homelessness that night (CCEH et al. 2008, 3–4). The 2008 samples show that Connecticut’s homeless persons show that 38% are White, 30% Black, and 25% Latino/a (CCEH 2008a). 87% of adults in sheltered families were females, while single homeless people, sheltered or unsheltered, tended to be male (about 72%–73%) (CCEH et al. 2008, 24).

Rates and severity of disease among homeless populations occur differentially depending on where one lives—whether on the streets, in shelters, or in supportive housing (McLaughlin, Glasser and Maljanian 2002; Glasser and McLaughlin 2006; Hwang 2001, 230). Homeless persons tend to die earlier than the general population, suffer disproportionately from chronic and infectious diseases, and develop health

disabilities at younger ages than the general population (Donohoe 2004; Hwang 200, 230). In Connecticut, the most reported conditions among a 2002 health survey of homeless persons were: drug abuse, depression, alcohol abuse, chronic back problems, severe headaches, chronic allergies, trouble seeing, mental health issues, toothaches, and physical disability (McLaughlin, Glasser and Maljanian 2002, 63). In general, homeless persons also suffer from skin and foot problems related to living on the street, walking long distances and standing with inadequate shoes (Hwang 2001, 230). In addition, regular maintenance of personal hygiene and access to washing machines that could get rid of pests, insects, and vermin may be difficult or expensive (HCH Clinicians' Network 2005). Finally, homeless persons experience violence (e.g., assault and rape), sexual and reproductive health issues, and unintentional injuries (e.g., being struck by a vehicle, accidental drug or alcohol overdoses, or exposure to the elements) more often than the general population (Hwang 2001, 230–1).

