

Prepared by the Center for Community  
Engagement and Health Equity

# Connecticut Catchment Area Profile

## Welcome

We deliver the highest quality patient-centered care, achieve breakthrough discoveries, and train the future leaders in cancer science and medicine, serving our state-wide Connecticut catchment area. Yale Cancer Center is Connecticut's only National Cancer Institute-designated comprehensive cancer center, with more than 300 cancer researchers on faculty and \$87 million in cancer research funding. Smilow Cancer Hospital brings together both inpatient and outpatient care in one hospital and is the largest provider of cancer care in the state. Smilow reaches patients across Connecticut through its 16 Care Centers and treats nearly one-half of the patients diagnosed with cancer each year.

This catchment profile provides a brief overview of our catchment area, the structural and social determinants of health in our state, and our cancer burden and priorities. Connecticut is a microcosm of the United States, having a similar demographic composition as the US overall. However, Connecticut is a patchwork of many unique communities and extreme disparities exist between and within these communities. Connecticut is ranked second in the nation for income inequality. The percentage of people living in poverty in several cities is more than double the state's average. There is significant residential segregation. And the cancer burden is not shared equally across our communities.

The Center for Community Engagement and Health Equity (CEHE), within Smilow Cancer Hospital and Yale Cancer Center, builds on a longstanding commitment to high-quality, expert, and patient-centered cancer care, screening, and prevention across the state of Connecticut. The Center is dedicated to ensuring cancer health equity and improving outcomes, with an emphasis on traditionally underserved communities. The Center leverages a wide range of approaches to community-engaged research, community outreach, education, policy & advocacy, and access to clinical care.

We hope this Catchment Area Profile will aid in the advancement of catchment-focused and health equity research across the cancer control continuum.



**Marcella Nunez-Smith, MD, MHS**  
Associate Cancer Center Director for  
Community Outreach and Engagement  
at Yale Cancer Center; Chief Health Equity  
Officer at Smilow Cancer Hospital.

Associate Dean for Health Equity  
Research, C.N.H. Long Professor of  
Internal Medicine, Founding Director  
of the Equity Research and Innovation  
Center (ERIC), and Director for the Center  
for Research Engagement (CRE) at Yale  
School of Medicine.

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## Introduction

### Purpose of this report

#### Profile description

This report serves as a reference guide describing our catchment area characteristics, our cancer epidemiology and priorities, and the social determinants of cancer burden across the cancer control continuum for our catchment area. The catchment area for the Yale Cancer Center is the entire state of Connecticut.

#### Audience

These data are intended to reach a broad audience of cancer stakeholders. We provide these data to Yale Cancer Center and Smilow Cancer Hospital scientists and clinicians conducting basic, clinical and translational, and population and community research to catalyze catchment focused research. We provide these data to community-based organizations and partners across Connecticut to inform their work on behalf of Connecticut communities. We hope these data can help bridge partnerships

between patients, communities, scientists, and providers to achieve equitable care delivery and research across the cancer care continuum.

We are building a data visualization resource that will be accessible to cancer scientists and to community stakeholders and will integrate multi-level, multi-source data streams to provide comprehensive, timely catchment data to inform research, health, and social care across the cancer control continuum. We aim to ensure this dashboard includes high-quality race, ethnicity, and language data; risk factor data at all levels of ecology (e.g., genetic, behavioral, environmental); and focuses on structural and social determinants of health. The dashboard will leverage Geographic Information Systems to map high disease burden “hotspots” and low screening rates “coldspots” for catchment.

## Glossary and Important Concepts

<p><b>Catchment Area</b></p>	<p>Yale Cancer Center (YCC) catchment area is the entire state of CT. NCI requires YCC to focus on research relevant to our catchment area. Catchment area needs are generated based on CT data and input from CT community members to ensure their needs and priorities are considered when generating new research. This can include CT-specific cancer health disparities, cancer sites of high incidence/mortality in CT, environmental exposures in CT, behavioral risk factors in CT, or other issues.</p>
<p><b>Catchment- Focused Research</b></p>	<p>Research that specifically addresses the cancer burden, risk factors, incidence, morbidity, mortality, and inequities within the catchment area. Research that addresses cancers that are of particular interest to communities within CT is also important.</p>
<p><b>Cancer Health Disparities</b></p>	<p>NCI defines cancer health disparities as differences in the incidence, prevalence, mortality, and burden of cancer and related adverse health conditions that exist among specific population groups in the U.S.</p>
<p><b>Health Disparity Populations</b></p>	<p>NIH defined health disparity populations include:</p> <ul style="list-style-type: none"> <li>· American Indians/Alaska Natives</li> <li>· Asian Americans</li> <li>· Blacks/African Americans</li> <li>· Hispanics/Latinx</li> <li>· Native Hawaiians and other Pacific Islanders</li> <li>· Sexual and gender minorities</li> <li>· Socioeconomically disadvantaged populations</li> <li>· Underserved rural populations</li> </ul> <p>In CT, we have higher rates of residents aged 40+, 50+, 60+ years, a higher percentage of immigrants, and higher rates of language isolation as compared to the U.S.</p>
<p><b>Health Equity</b></p>	<p>Health equity, according to the Robert Wood Johnson Foundation, means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.</p>
<p><b>Structural Racism/ Discrimination</b></p>	<p>Macro-level conditions (e.g., residential segregation, institutional policies) that limit opportunities, resources, power, and well-being of individuals and populations based on race/ethnicity. This contributes to poorer health outcomes for marginalized populations. For example, neighborhood segregation, a widely studied form of structural racism, has been shown to directly influence racial disparities in health outcomes.</p>
<p><b>Community Engagement</b></p>	<p>The process of working collaboratively with geographic (e.g., New Haven) and non-geographic (e.g., African American breast cancer survivors) communities to address issues affecting the well-being of that group. Community engagement can take many forms, and partners can include organized groups, agencies, institutions, or individuals. The goal is bidirectional, equitable community partnerships to increase trust and impact.</p>

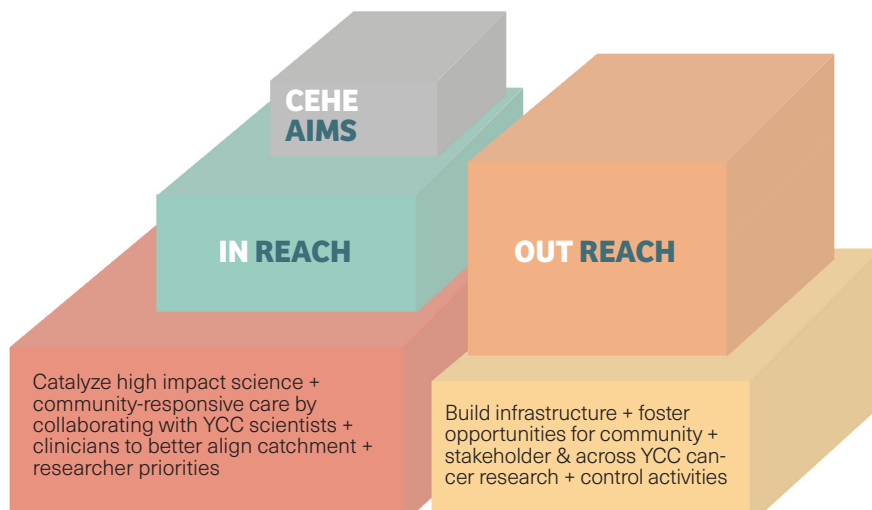
# Center for Community Engagement and Health Equity

The Center for Community Engagement and Health Equity within Smilow Cancer Hospital and Yale Cancer Center was established with the mission to bridge partnerships between patients, communities, scientists, and providers and use data-driven approaches to achieve equitable care delivery and research across the cancer care continuum.

The Center for Community Engagement and Health Equity has two aims. Aim 1 is to catalyze high impact science and community-responsive care by collaborating with YCC scientists and clinicians to better align catchment and researcher priorities. Subaims include: a) routinely assess and disseminate data on catchment area cancer burden, disparities and community-articulated cancer needs to YCC members and researchers; b) develop infrastructure and norms to facilitate

researcher knowledge of and engagement with catchment communities to generate innovative and catchment-relevant research and programs; and c) collaborate across YCC to strengthen clinical trial infrastructure by focusing on knowledge generation and interventions that support catchment engagement and health equity.

Aim 2 is to build infrastructure and foster opportunities for community and stakeholder engagement across YCC cancer research and control activities. Subaims include: a) build signature programs that support community and stakeholder engagement in the planning, implementation, and evaluation of cancer research across YCC; and b) identify opportunities for community engagement and inclusion of community perspectives in YCC community education, professional development, and dissemination activities.



## Yale Cancer Center Catchment Area

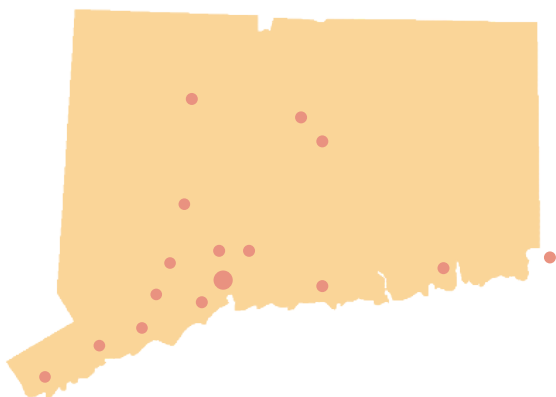
The Yale Cancer Center catchment area is the entire state of Connecticut. This catchment area was defined by senior leadership, as patients from all eight counties of Connecticut receive care at Smilow Cancer Hospital and our Care Centers throughout Connecticut.

Connecticut is the third smallest state by area, but the fourth most densely populated state in the US. It ranks 29th for population size. It has the highest per capita personal income, but household **income inequality is second highest** among US states. While the percentage of persons living in poverty in Connecticut is similar to that of the US, many Connecticut cities have more than double the state's percentage of people living in poverty. And while its overall racial and ethnic composition is similar to the US, Connecticut has many cities for which NIH-defined health disparity

populations represent the majority of residents (see Social and Structural Risk Factors Affecting Connecticut Communities section). Connecticut also has one of the **fastest aging populations** in the US.

### Catchment Assets

Connecticut is a vibrant and diverse state with many community strengths and assets. Connecticut residents have high levels of trust for local health officials, with 90% of residents reporting a great or fair amount of trust in these institutions. Most residents (81%) report being satisfied with the city or area where they live. More than 40% of residents volunteered in their communities in the past year, and almost one-third say they often use arts and cultural resources in their area. Nearly three-quarters of adults agree that children in their town have the positive role models they need.<sup>10</sup>



**Smilow Care Center Locations**

## Yale Cancer Center Catchment Area

Connecticut has many exciting community initiatives and partnerships, as well as many local organizations with a cancer-focused mission. Connecticut's community-based organizations have expertise in identifying, understanding, and addressing community needs. They work in partnership with communities and researchers to deliver culturally appropriate, evidence-based services, and information to community residents.

Connecticut is home to a significant number of non-profit organizations dedicated to providing tangible and emotional support to cancer patients

and families and to funding cancer research. Connecticut has a long history of connecting residents with unmet needs to community resources through the 2-1-1 program—a free, multi-lingual information and referral service that connects people to essential health and human services 24 hours a day, seven days a week. Connecticut was a model state in developing this system in 1976 and expanded its use statewide in 1999. Through the support of the State of Connecticut, the United Way maintains the 2-1-1 service with a database of over 4,000 agencies providing over 40,000 programs.

### Spotlight on Community-Academic Partnerships

The Center for Community Engagement and Health Equity partners with the Community Alliance for Research and Engagement (CARE) to deliver the Community Research Fellowship Program, which embeds community residents within Yale Cancer Center research teams for 9-month placements to provide community perspectives and consult on cancer research projects. CARE provides training and support for academic and community partners on community engaged research and community based participatory research. Three of our nine 2021 Fellows are featured here. This program expanded to twenty fellows in 2022. It has extended to Bridgeport residents for 2023 and Hartford residents for 2024.



**James Rawlins**

*"We have a chance now to really partner with researchers as they develop great agendas that can improve health outcomes. It's really important when the opportunity is there, as a community partner, to be engaged as much as possible."*



**Sean Reeves**

*"My mom recently passed away from cancer, battled for 20 years, it made me interested in learning more about the research and development of treatments."*



**Victoria Dancy**

*"Community Based Research is very important because it allows the community's voice to be heard. It is really about making sure the community is at the table, their voices are being heard."*



# Yale Cancer Center Catchment Area

## Priority Cancers

YCC priority cancers were selected based on the epidemiology of cancer throughout the State of Connecticut, including incidence, mortality, and disparities. Additionally, we considered which cancers are on the rise and have higher incidence, mortality, or disparities compared to the US overall.<sup>1-4</sup>

YCC works toward the elimination of all cancer types. We prioritize our science, and its translation to patient care, for cancers that are most consequential for our communities. YCC has identified **four priority cancer** types: 1) **breast** cancer, 2) **hepatocellular** (liver) cancer, 3) **lung** cancer, and 4) **prostate** cancer. Breast, lung, and prostate cancer are among the most prevalent in Connecticut and are characterized by racial/ethnic disparities in mortality. The incidence of hepatocellular (liver) cancer has increased, and diagnoses are disproportionately occurring in underserved, minoritized populations in Connecticut.

We have also identified four cross-cutting themes of interest and concern in our catchment area: 1) **obesity**, 2) **tobacco use**, 3) **brain metastases**, and 4) **cancer occurring in individuals 18 to 49 years of age**. These areas require more research

to better serve catchment populations. Obesity and tobacco use impact cancer treatment and outcomes for patients with established disease. Brain metastases has become an increasing problem in the era of improved cancer treatment for extra-CNS disease and has an impact on cancer outcomes. Cancer arising in individuals 18 to 49 years of age is significant to outcomes because of the somewhat unique biologic features of such cancers and the impact on psychosocial outcomes.

## Timely Cancer Screening

**Colorectal** (20% diagnosed at late stage in CT)

**Lung** (almost 1/2 diagnosed at late stage in CT)

## Selected Connecticut Health Risk Factors

- Smoking
- Binge drinking
- No physical activity
- No daily vegetable consumption
- Not current on cancer screening recommendations

## Connecticut Populations at Higher Risk

**Non-Hispanic Black** (men have highest incidence & mortality, women have highest mortality, higher health risk factors)

# Yale Cancer Center Catchment Area

## CT Populations at Higher Risk Cont.

**Hispanic** (higher incidence for all site cancers than US Hispanics, higher health risk factors than non-Hispanics)

**<\$35K** (Connecticut has higher percentage of unemployed than US, higher health risk factors than ≥\$35K)

**Uninsured** (higher health risk factors than insured)

**<HS education** (higher health risk factors than ≥HS education)

## Special Connecticut Populations

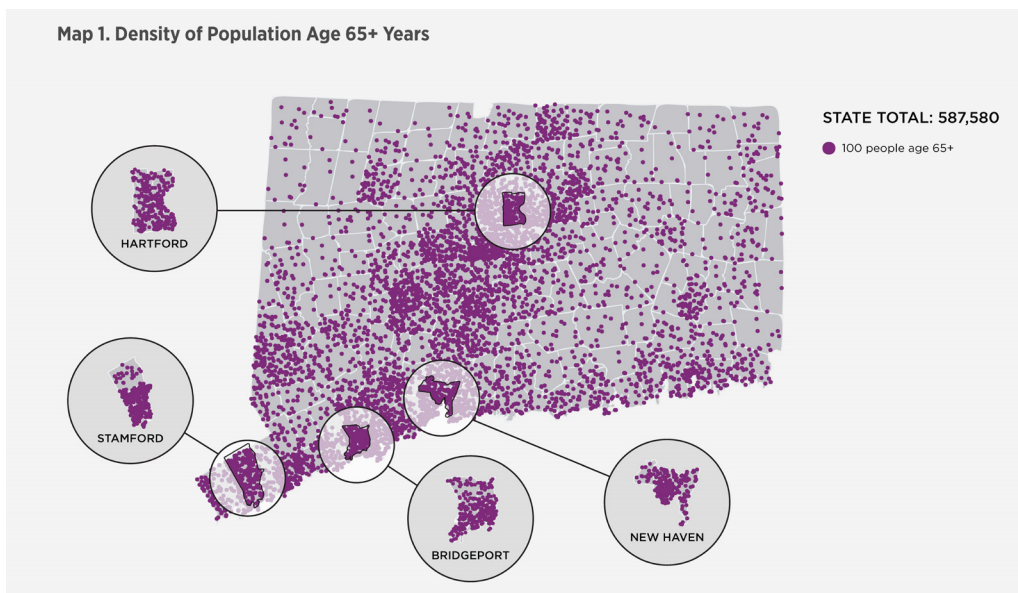
**Immigrants** (higher percentage than US average, higher rates of language isolation than US)

**Elderly** (higher rates of 40+, 50+ and 65+ than US)

## Spotlight on Aging

Connecticut is the 7th oldest state in the nation; 23% of the state's total population is aged 60 or older.

Connecticut's older adult population is the most racially and ethnically diverse in New England, with 17.5% of residents 65 or older being people of color. Significant income disparities exist among Connecticut residents 65 years and older. Further, 62% have been diagnosed with four or more chronic health conditions.<sup>5</sup>



2021 Connecticut Health Aging Data Report

# Social and Structural Risk Factors Affecting Connecticut Communities

## Social and Structural Risk Factors Affecting Connecticut Communities

Connecticut is geographically separated into urban, rural, and suburban areas, with people with different racial, ethnic, and socioeconomic backgrounds across these regions.

The Five Connecticut<sup>6</sup> is a classification system that places individual towns into one of five categories—Wealthy, Suburban, Rural, Urban Periphery, and Urban Core. This reflects the marginalization of specific communities and is based on the median household income, population density, and poverty rate of each town using 2010 Census data. The estimates for any individual town in Connecticut will be similar to other towns within its category.

Towns by Five Connecticut Grouping

GROUP	TOWNS
Urban Core	Bridgeport, Hartford, New Britain, New Haven, New London, Waterbury
Urban Periphery	Ansonia, Bloomfield, Branford, Bristol, Danbury, Derby, East Hartford, East Haven, Enfield, Groton, Hamden, Manchester, Meriden, Middletown, Milford, Naugatuck, Newington, Norwalk, Norwich, Plainville, Rocky Hill, Stamford, Stratford, Torrington, Vernon, West Hartford, West Haven, Wethersfield, Windham, Windsor Locks
Suburban	Avon, Barkhamsted, Berlin, Bethany, Bethel, Bolton, Bridgewater, Brookfield, Burlington, Canton, Cheshire, Chester, Clinton, Colchester, Columbia, Cromwell, Durham, East Granby, East Hampton, Ellington, Essex, Fairfield, Farmington, Glastonbury, Granby, Guilford, Haddam, Hebron, Killingworth, Lyme, Madison, Marlborough, Middletown, Middletfield, Monroe, New Fairfield, New Hartford, Newtown, North Branford, North Haven, Old Lyme, Old Saybrook, Orange, Oxford, Prospect, Riddings, Robury, Salem, Shelton, Sherman, Simsbury, Somers, South Windsor, Southbury, Southington, Suffield, Tolland, Trumbull, Wallingford, Watertown, Westbrook, Windsor, Wolcott, Woodbury
Rural	Andover, Ashford, Beacon Falls, Bethlehem, Bozrah, Brooklyn, Canaan, Canterbury, Chaplin, Colebrook, Cornwall, Coventry, Deep River, East Haddam, East Lyme, East Windsor, Eastford, Franklin, Goshen, Griswold, Hampton, Hartland, Harwinton, Kent, Killingly, Lebanon, Ledyard, Lisbon, Litchfield, Mansfield, Meriden, Morris, New Milford, Norfolk, North Canaan, North Stonington, Plainfield, Plymouth, Pomfret, Portland, Preston, Putnam, Salisbury, Scotland, Seymour, Sharon, Sprague, Stafford, Sterling, Stonington, Thomaston, Thompson, Union, Voluntown, Warren, Washington, Waterford, Willington, Winchester, Woodstock
Wealthy	Darien, Easton, Greenwich, New Canaan, Ridgefield, Weston, Westport, Wilton, Woodbridge

Image from DataHaven

## The Five Connecticut

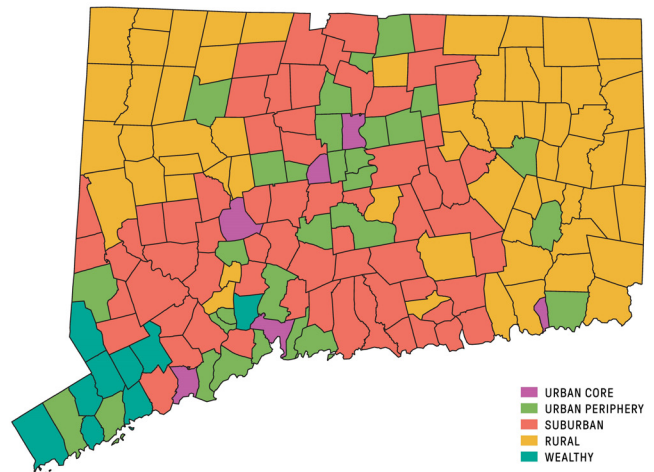


Image from DataHaven

## Children born in wealthy towns can expect to live six years longer than children born in Connecticut's cities

LIFE EXPECTANCY (YEARS), BY FIVE CONNECTICUTS GROUP, 2015

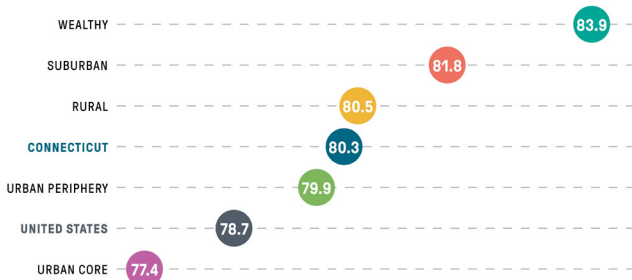


Image from DataHaven

This spatial segregation of populations across CT is related to life expectancy—children born in wealthy towns can expect to live six years longer than those living in Urban Core. Within these Urban Cores, which are primarily representative of Connecticut cities, Black and Latinx populations are over-represented.<sup>7</sup> This economic and racial segregation is rooted in racist redlining policies that are still affecting communities today.<sup>8</sup>

## Social and Structural Risk Factors Affecting Connecticut Communities

### Structurally marginalized populations in Connecticut cities

Connecticut cities compared with Connecticut overall comprise a greater proportion of Black and Latinx people and people living in poverty<sup>9</sup>

	% People living in poverty	% Black or African American	% Latinx or Hispanic
US	10.5	13.4	18.5
Connecticut	10.0	12.2	16.9
Bridgeport	21.8	35.1	40.8
Hartford	28.1	37.7	44.3
New Britain	21.7	12.8	43.3
New Haven	26.5	32.6	31.2
New London	24.5	15.0	33.4
Waterbury	23.4	21.7	37.4

The following section outlines findings from an analysis of data from the 2018 DataHaven Community Wellbeing Survey (CWS) administered across a representative sample of people living in Connecticut.<sup>10</sup> The CWS was most recently carried out from March to November 2018, during which 16,000 randomly-selected adults were interviewed, including residents from all 169 towns in Connecticut. The questions on the CWS are compiled from local, national, and international sources and best practices, and are developed with input from an advisory committee of leading experts in survey research. All reported survey estimates are weighted in order to accurately represent the underlying adult population within each region, town, or neighborhood. For more information and crosstabs of data, see <https://ctdatahaven.org/reports/datahavencommunity-wellbeing-survey>.

Using data from this survey, we outline some key social and structural determinants of health affecting our Connecticut communities, such as educational attainment, housing, and issues with transportation.

# Social and Structural Risk Factors Affecting Connecticut Communities

## Educational attainment

Connecticut, as compared with the US, has a greater proportion of people with a bachelor’s degree. However, this level of education is not equal between various racial/ethnic groups.

- Racial and ethnic minority groups, as compared to White populations, are less likely to have attained a bachelor’s degree.
- Those who speak another language other than English, as compared with those who speak only English at home, are also less likely to have attained a bachelor’s degree.

EDUCATIONAL ATTAINMENT FOR ADULTS (AGES 25+), CONNECTICUT, 2018

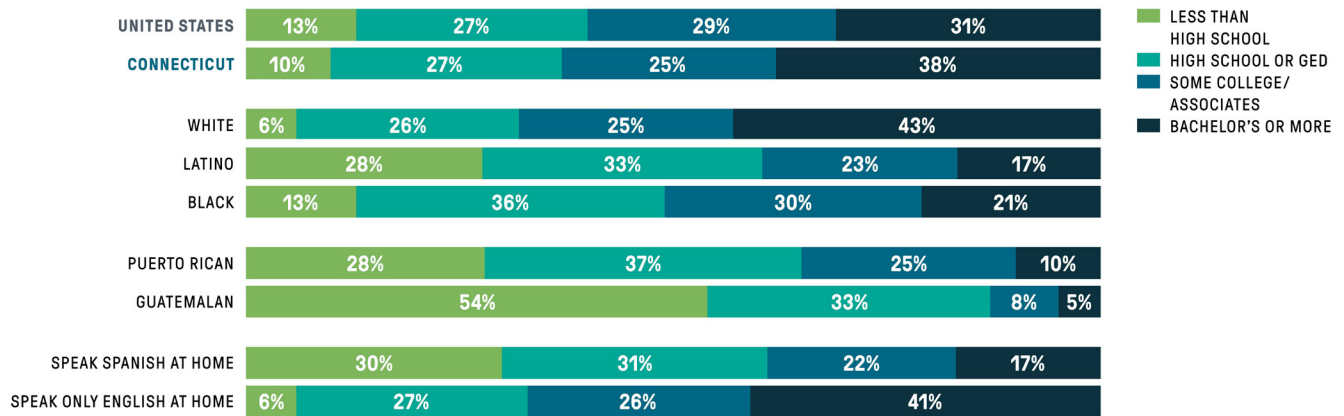


Image from DataHaven

## Housing security and eviction

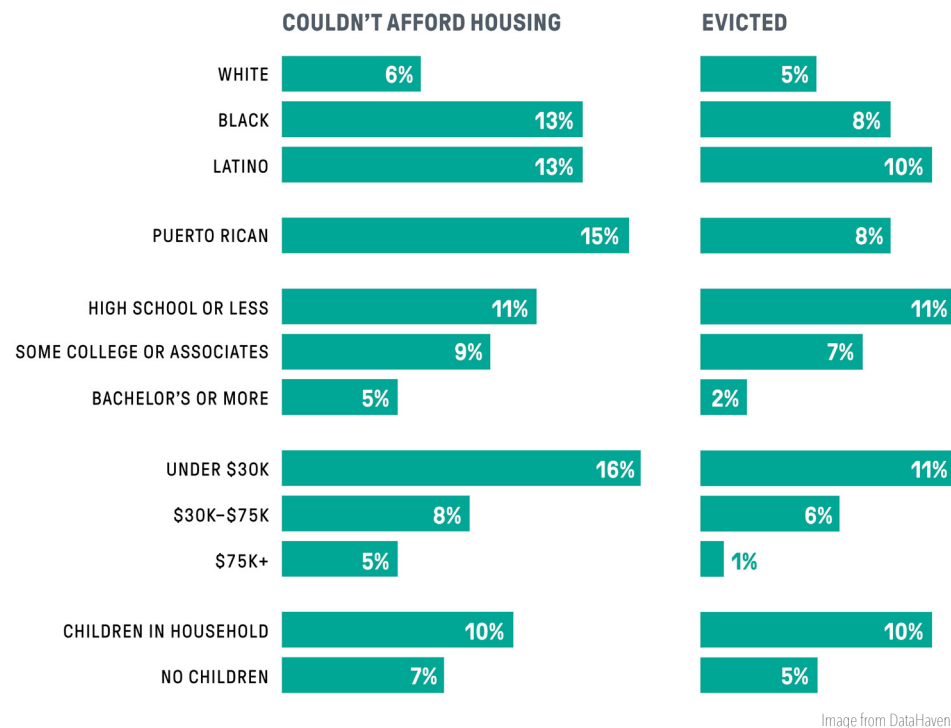
For the Survey, respondents were asked about housing security and history of eviction. Respondents were asked whether in the past 12 months, they had enough money to provide adequate shelter or housing for themselves or their families.

A subsample of respondents were asked about their history of eviction, defined as when a landlord forces one to move against their will. Only respondents who did not own a home, previously rented a home, and reported moving residences since 2016 received this question regarding eviction. Respondents were asked whether they or a person they were staying with was evicted from the home they moved from.

# Social and Structural Risk Factors Affecting Connecticut Communities

## Housing insecurity affects low-income and non-white groups most

COULDN'T AFFORD HOUSING: SHARE OF ADULTS; EVICTED: SHARE OF RENTERS WHO MOVED IN PAST THREE YEARS; CONNECTICUT, 2018



Black and Latinx adults as compared with White adults were more likely to report housing insecurity, i.e. they could not afford housing.

Among individuals who did not own a home, previously rented a home, or reported residential mobility since 2016, adults who are racial/ethnic minorities, who did not make a living wage, have a high school education or less, and have children were more likely to have a landlord evict them.

# Social and Structural Risk Factors Affecting Connecticut Communities

## Food security

Survey respondents of the 2018 CWS were asked whether at some point in the past 12 months, they were unable to afford to buy food they needed.

### Food insecurity disproportionately affects low-income and non-white adults

SHARE OF ADULTS WHO SAID THEY COULD NOT AFFORD FOOD AT SOME POINT IN THE PAST YEAR, CONNECTICUT, 2018

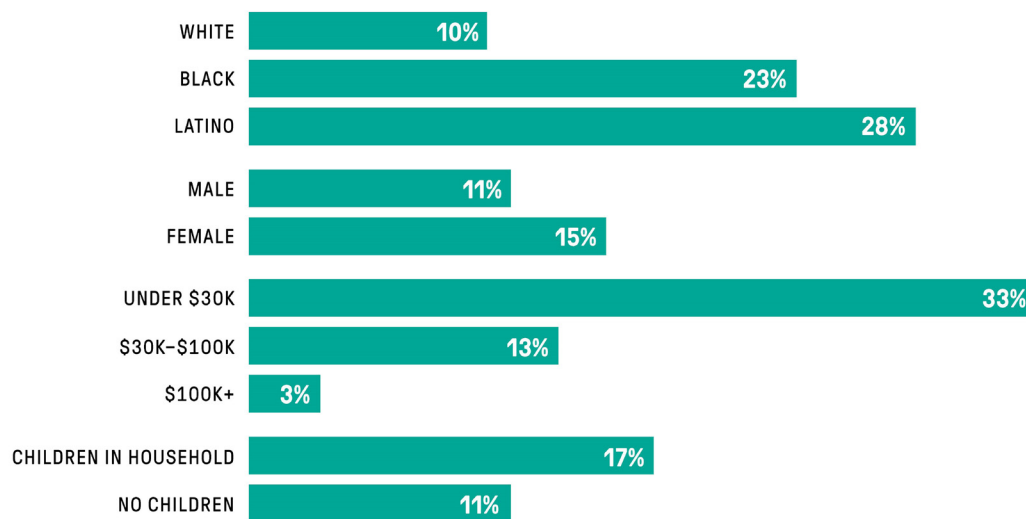


Image from DataHaven

Black and Latinx adults, as compared with White populations, were more likely to report they could not afford food at some point in the past year.

Adults who did not earn a living wage were more likely to report food insecurity in the past year. Thirty-three percent of those who earn under \$30,000 reported food insecurity in the past year. Adults in households with children were also more likely to report food insecurity in the past year.

## Social and Structural Risk Factors Affecting Connecticut Communities

### Limited English proficiency and linguistic isolation

Using data from the American Community Survey, DataHaven found that 5 percent of households in Connecticut overall report that no inhabitant speaks English “very well,” with more than 20 percent of the households where Spanish or an Asian or Pacific Island language is spoken reporting limited English proficiency. In urban areas, the prevalence is higher, but those households are more likely to be co-located near community members and health care providers who speak the same language. In Connecticut’s rural areas, 31 percent of households where Asian or Pacific Island languages are spoken report limited English proficiency where no inhabitant speaks English “very well”, and those residents may not live near others who speak the same language, suggesting linguistic isolation.

### Transportation security (Data not shown)

88% of all adults say they often have access to a car when they need it. But this varies by age (83% of young adults, 91% of middle-age adults, 88% of seniors), race/ethnicity (91% of white and 77% of Black/African-American and Latinx adults).

12% of adults stayed home at least once in the past year due to lack of transportation.

- Transportation insecurity ranged from 37% among low-income adults to 3% among high-income adults.
- Among those without access to reliable transportation, 38% say they had to miss doctor’s appointments or could not visit a health care provider because they had no transportation.<sup>11</sup>



# Social and Structural Risk Factors Affecting Connecticut Communities

## Smoking

Respondents were asked to estimate the number of cigarettes they smoked. Those who estimated having smoked at least 100 cigarettes in their entire lives were then asked whether they smoked every day, some days, or not at all. Smoking prevalence for the entire population was then extrapolated from these two survey items.

### Smoking rates are elevated among adults with low income and low educational attainment

SHARE OF ADULTS WHO CURRENTLY SMOKE, CONNECTICUT, 2018

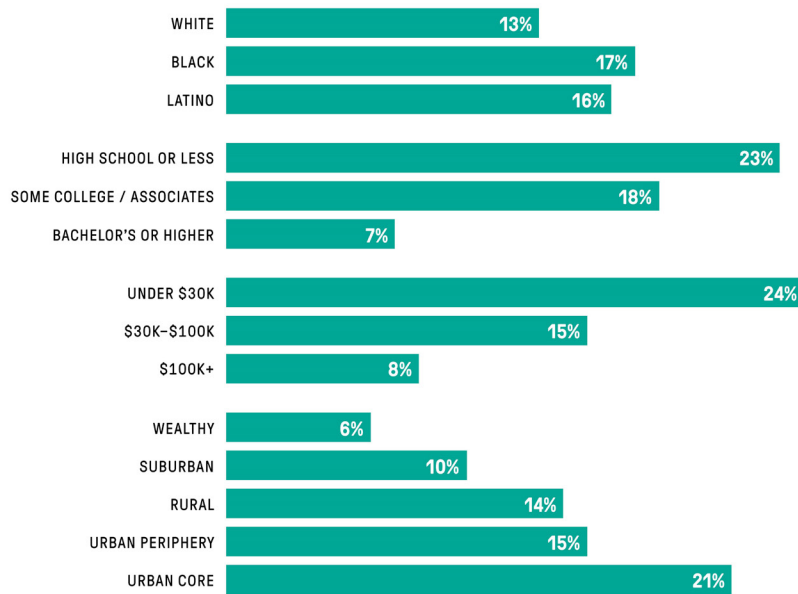


Image from DataHaven

Smoking prevalence was higher among Black and Latinx adults as compared with White adults; among those whose educational attainment was high school or less as compared with those who have attained some college education or above; and among those who live in the urban core as compared with those who live in other Connecticut regions.

Smoking prevalence was lowest in wealthy Connecticut regions, among those with a higher income, and among those who attained a higher level of education.

# Social and Structural Risk Factors Affecting Connecticut Communities

## Obesity and diabetes

In the 2018 Community Wellbeing Survey, participants reported their height and weight, from which their body mass index (BMI) was calculated; obesity in adults is defined as a BMI of 30 or higher. Adult respondents were asked to report whether they had ever been told by a doctor or medical professional that they had diabetes.

### Rates of obesity, diabetes, and stroke, by group

CONNECTICUT, † 2018, ‡ 2010–2014 AGE-ADJUSTED RATE

GROUP	OBESITY, ADULTS 18+ †	OBESITY, ADULTS 50+ †	DIABETES, ADULTS 18+ †	DIABETES, ADULTS 50+ †
Total	29%	30%	10%	16%
White	28%	28%	10%	15%
Black	35%	40%	14%	27%
Latino	36%	41%	9%	24%
Under \$30K	36%	36%	16%	28%
\$30K–\$100K	31%	32%	10%	16%
\$100K+	25%	27%	5%	9%
Wealthy	17%	21%	5%	5%
Suburban	25%	27%	13%	13%
Rural	29%	31%	15%	15%
Urban Periphery	30%	31%	11%	19%
Urban Core	37%	39%	12%	23%

Image from DataHaven

Prevalence of obesity was higher among Black and Latinx adults as compared with White adults; higher among those living with lower income compared with those with higher income; higher among those who live in the urban core as compared with those who live in other Connecticut regions.

Prevalence of diabetes was higher among Black and Latinx adults aged 50+ compared with White adults; higher among those living with lower income compared with higher income; higher among those who live in the urban core aged 50+ compared with those who live in other Connecticut regions.

# Social and Structural Risk Factors Affecting Connecticut Communities

## Access to health care

The following is a snapshot of issues that Connecticut residents face to obtain accessible and high-quality health care. The information comes from analysis of US Census Bureau and DataHaven surveys. Participants were asked several questions about their ability to access health care and prescribed medications and their experience with discrimination in the health care setting.

## Insurance

DataHaven analyzed U.S. Census Bureau American Community Survey 2018 5-year estimates to examine prevalence of health insurance coverage in different groups. They examined health insurance status stratified by age and by race/ethnicity.

SHARE OF UNINSURED POPULATION BY AGE AND RACE/ETHNICITY GROUPS, CONNECTICUT, 2018

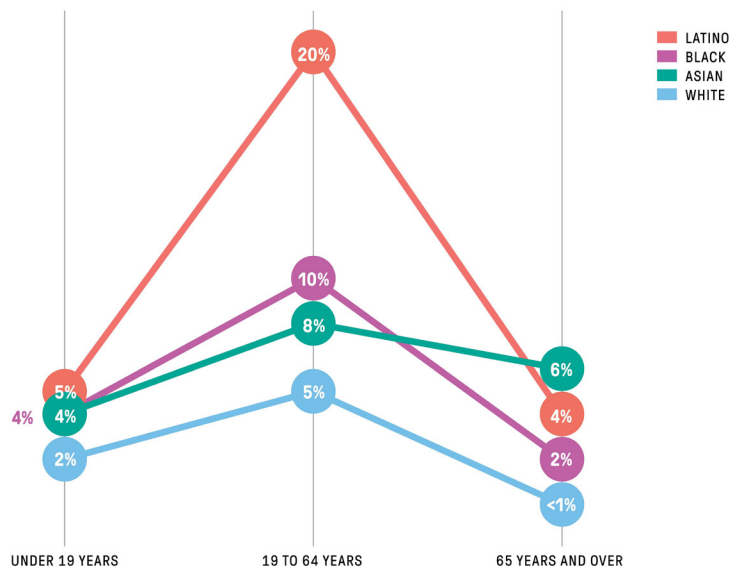


Image from DataHaven

Of the uninsured population, a greater proportion are 19 to 64 years old; within each age group, race and ethnicity minorities are more likely to be uninsured. The largest proportion of uninsured adults 19 to 64 years old are Latinx.

# Social and Structural Risk Factors Affecting Connecticut Communities

## Reasons for going without health care

Participants were asked whether at any point in the previous 12 months they postponed or did not receive health care they needed.

- 16% of Latinx participants said they delayed or went without the health care they needed
- 16% of low-income participants said they delayed or went without the health care they needed

Among participants who went without/postponed health care they needed, they were asked the reasons why.

- More than half of Latinx participants reported they postponed/missed care because they were too busy (55%) and that health care was too costly (57%)

## Reasons given for going without health care

CONNECTICUT, 2018

GROUP	WENT WITHOUT HEALTH CARE (SHARE OF ALL ADULTS)	REASONS GIVEN FOR MISSING CARE (SHARE OF ADULTS WHO DIDN'T GET CARE)					
		TOO BUSY	TOO COSTLY	CAREGIVING	NOT SERIOUS ENOUGH	INSURANCE NOT ACCEPTED	INSURANCE WON'T PAY
Total	9%	53%	50%	22%	47%	18%	30%
Ages 18–34	13%	65%	57%	23%	57%	23%	30%
Ages 35–49	11%	53%	49%	28%	44%	16%	29%
Ages 50–64	8%	49%	51%	16%	43%	16%	34%
Ages 65+	5%	35%	28%	21%	41%	11%	22%
White	8%	55%	49%	23%	49%	17%	31%
Black	10%	48%	51%	17%	40%	14%	29%
Latino	16%	55%	57%	28%	46%	28%	36%
Under \$30K	16%	47%	49%	24%	41%	25%	32%
\$30K–\$100K	9%	55%	56%	23%	47%	15%	32%
\$100K+	5%	64%	42%	18%	56%	15%	24%
No children	8%	51%	50%	15%	47%	16%	31%
Children at home	11%	59%	48%	33%	48%	20%	30%

Image from DataHaven

# Social and Structural Risk Factors Affecting Connecticut Communities

## Access to prescription medications ("Pharmacoequity")

In the 2018 DataHaven Community Wellbeing Survey, survey respondents were asked whether in the past 12 months there was any time they needed prescription medicines but did not get them because they could not afford them, and whether they altered the way they took prescriptions, because they could not afford to get more. People who are unable to afford their medicines may split their pills or skip doses so that they have access to these medicines over a longer period of time..

### Adults reporting altering or skipping prescriptions CONNECTICUT, 2018

GROUP	COULD NOT AFFORD PRESCRIPTION IN PAST YEAR	ALTERED PRESCRIPTION IN PAST YEAR
Total	9%	7%
Female	10%	7%
Male	7%	6%
White	8%	6%
Black	11%	6%
Latino	18%	17%
Ages 18–34	12%	8%
Ages 35–49	10%	7%
Ages 50–64	9%	8%
Ages 65+	4%	3%
Under \$30K	15%	11%
\$30K–\$100K	10%	8%
\$100K+	5%	2%
High school or less	12%	11%
Some college or Associates	10%	8%
Bachelor's or higher	6%	4%

Image from DataHaven

- 18% of Latinx population reported being unable to afford their prescriptions in the past year;
- 15% of adults who earn under \$30K reported being unable to afford their prescriptions in the past year

# Social and Structural Risk Factors Affecting Connecticut Communities

## Experiences of discrimination

For the 2018 Community Wellbeing Survey, survey participants were asked questions on their experiences of discrimination when receiving health care services. If respondents answered that they had been discriminated against, they were then asked to identify the reasons why they thought this happened. Respondents were allowed to identify more than one issue.

In 2018, 10% adults experienced some form of discrimination while accessing health care within the past three years (Data not presented).

- Latinx adults were the most likely to report discrimination while accessing health care (17%), followed by Black adults (14%), compared to just 9% of White adults.
- Lower-income adults also reported discrimination more frequently than higher-income adults, and younger adults more often than older adults.

Of all adults who had ever experienced discrimination while trying to access health care, 61% said it had happened multiple times in the past three years (Data not presented).

- The most commonly cited reason—mentioned by 26% of all respondents who

gave a reason for discrimination—was health insurance status (Data not presented).

- Nearly 7% of Black adults in Connecticut said race played a part. Black and Latinx adults were at least nine times as likely as white adults to report racial discrimination in accessing health care.
- Four times as many women as men cited gender as a factor.

### Race and insurance status are among the reasons for perceived discrimination in accessing health care

SHARE OF ADULTS, CONNECTICUT, 2018, EXPERIENCING DISCRIMINATION IN ACCESSING HEALTH CARE BASED ON THEIR...

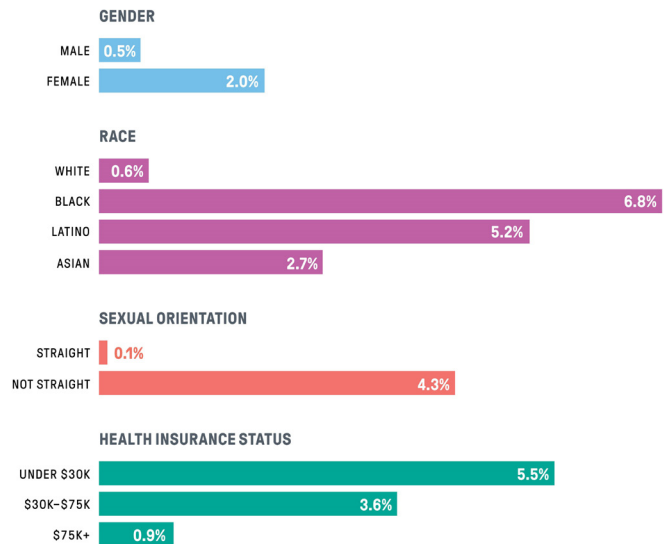
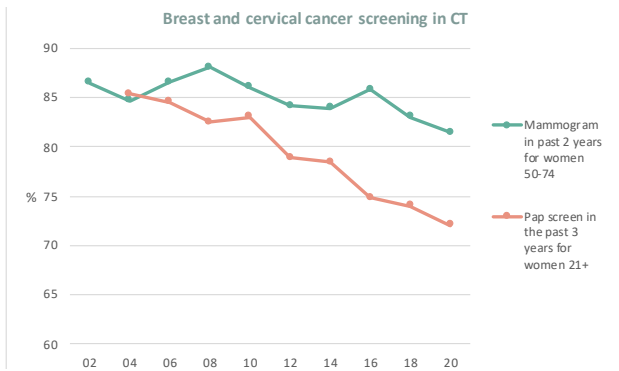


Image from DataHaven

# Timely Cancer Screening

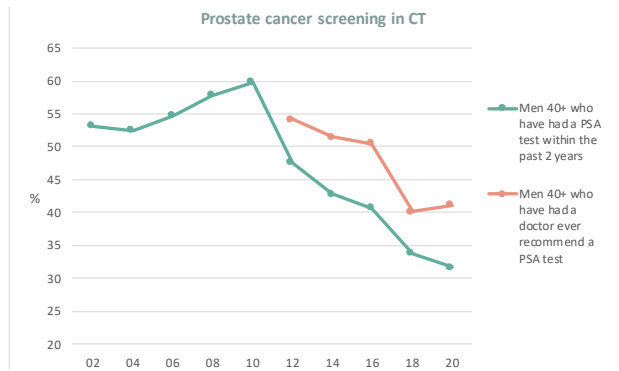
## Screening Rates

### Breast and Cervical



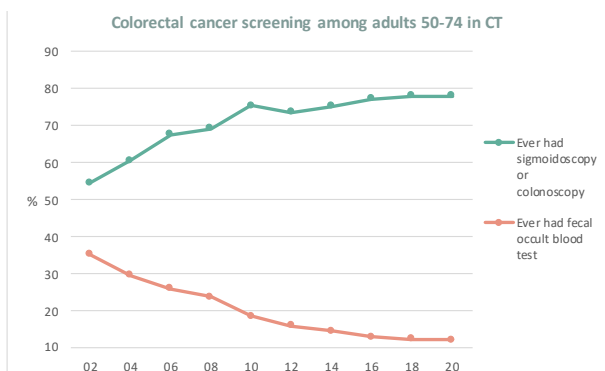
The percentage of women in CT between 50–74 years who received a mammogram within the past 2 years has incrementally decreased over the past two decades, from ~86% in 2002 to 82% in 2020. The percentage of women over 21 who received a Pap screen within the past 3 years has decreased dramatically from ~85% in 2004 to 72% in 2020.

### Prostate



Although between 2002 and 2010 there was a small increase in CT men over 40 who have had a Prostate-Specific Antigen (PSA) test within the past 2 years, from 2010 to 2020, this percentage has decreased to as low as 32%. The percentage of men over 40 who have had a doctor ever recommend a PSA test decreased from ~55% in 2012 to 40% in 2020.

### Colorectal



Between 2002–2020, the percentage of CT adults between 50–74 years who have had a sigmoidoscopy or colonoscopy screening has increased from 55% in 2002 to ~79% in 2020; the percentage of adults over 50 who have had a fecal occult blood test decreased, from ~35% in 2002 to 13% in 2020.

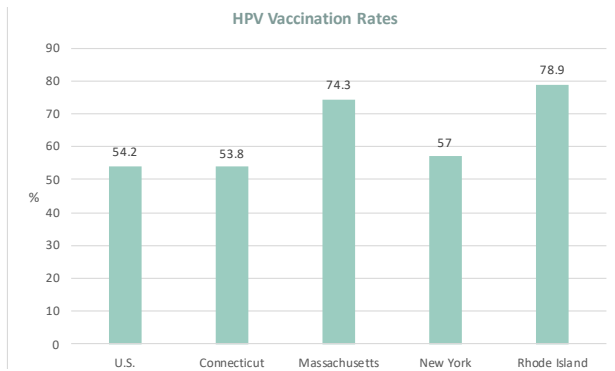
\*In 2020, the BRFSS question regarding sigmoidoscopy/colonoscopy included the addition of virtual colonoscopy.

# Prevention: HPV vaccination

Percentage of adolescents ages 13-17 who have received all recommended doses of the human papillomavirus (HPV) vaccine. Detailed race/ethnicity data are unavailable for our catchment area.<sup>12</sup>

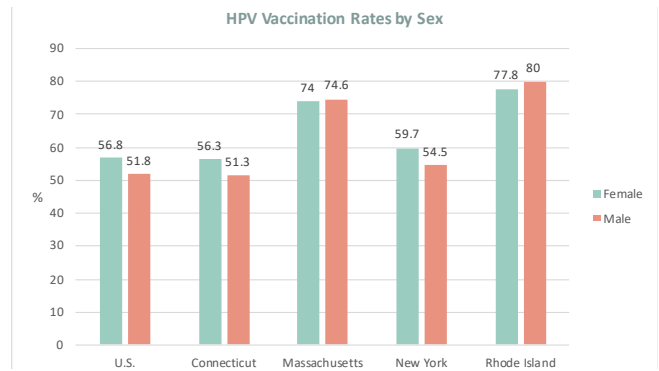
## Vaccination Rates

### Overall



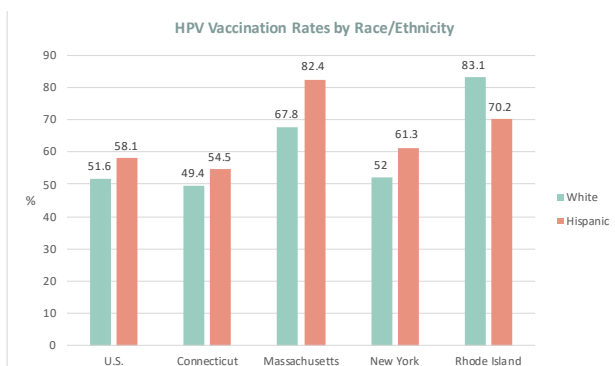
The HPV vaccine rate among adolescents ages 13 to 17 in CT (53.8%) is similar to that of the national average (54.2%). Compared to neighboring states such as Rhode Island, whose HPV vaccination rate is 78.9%, CT's rate is much lower.

### By Sex



When split by sex, the HPV vaccine rate among adolescents 13–17 in CT is still similar to that of the national average. HPV vaccination rates for both males and females in CT still trails neighboring states such as Massachusetts and Rhode Island.

### By Race/Ethnicity



HPV vaccination rates for both White and Hispanic residents in CT are slightly lower than the national average, and much lower than those of Rhode Island and Massachusetts.<sup>1</sup>(pg. 8)



# Cancer Statistics in Connecticut

All cancer statistics reported here are available through the CDC U.S. Cancer Statistics Data Visualizations Tool.<sup>13</sup> This database provides age-adjusted and crude incidence and mortality rates per 100,000 people. Available at the national, state, and county level, data can be stratified by age group, sex, and race. Raw case and death counts are not available through this tool. Rates have been suppressed when the numbers of cases or deaths used to compute rates are small, as those rates tend to have poor reliability.

## Age-adjusted Rates by Sex: CT Compared to US, 2014-2018

### Incidence rate per 100,000 (Male)

Cancer Site/Type	CT	US
All Cancer Sites Combined	499.5	487.9
Prostate	114.4	106.4
Lung and Bronchus	62.8	65.8
Urinary Bladder	41.7	34
Colon and Rectum	39.6	43.5
Non-Hodgkin Lymphoma	25.3	23.1
Oral Cavity and Pharynx	18	18.1
Leukemias	17.4	18.1
Liver and Intrahepatic Bile Duct	12.6	13.1
Thyroid	9.2	7.3
Myeloma	9.1	8.6
Brain and Other Nervous System	8.1	7.6
Larynx	5.6	5.4
Hodgkin Lymphoma	3.9	3

For males, the age-adjusted incidence rate of all cancer sites combined per 100,000 in the U.S. is 487.9, and in CT is 499.5.

### Mortality rate per 100,000 (Male)

Cancer Site/Type	CT	US
All Cancer Sites Combined	167.5	185.6
Lung and Bronchus	38	46.9
Prostate	17.8	19
Colon and Rectum	12.6	16.3
Liver and Intrahepatic Bile Duct	8.5	9.7
Leukemias	7.7	8.4
Urinary Bladder	7.7	7.4
Non-Hodgkin Lymphoma	7	7
Brain and Other Nervous System	5.7	5.4
Myeloma	3.7	4.1
Oral Cavity and Pharynx	2.9	3.9
Larynx	1.4	1.7
Thyroid	0.5	0.5
Hodgkin Lymphoma	0.4	0.4

In males, the age-adjusted mortality rate per 100,000 in the U.S. is 185.6, and in CT is 167.5.

### Incidence rate per 100,000 (Female)

Cancer Site/Type	CT	US
All Cancer Sites Combined	443.6	423
Female Breast	140.2	126.9
Lung and Bronchus	54.2	50.8
Colon and Rectum	31.1	33.4
Thyroid	25.6	20.7
Non-Hodgkin Lymphoma	17.2	15.9
Leukemias	11.3	11
Urinary Bladder	11.2	8.5
Oral Cavity and Pharynx	7.2	6.5
Brain and Other Nervous System	5.8	5.5
Myeloma	5.6	5.7
Liver and Intrahepatic Bile Duct	3.9	4.7
Hodgkin Lymphoma	2.6	2.3
Larynx	1.4	1.2

CT, when compared to the greater U.S., has similar cancer incidence rates for both females and males when adjusted for age. The age-adjusted incidence rate of all cancer sites combined per 100,000 for females in the U.S. is 423, and in CT is marginally higher at 443.6.

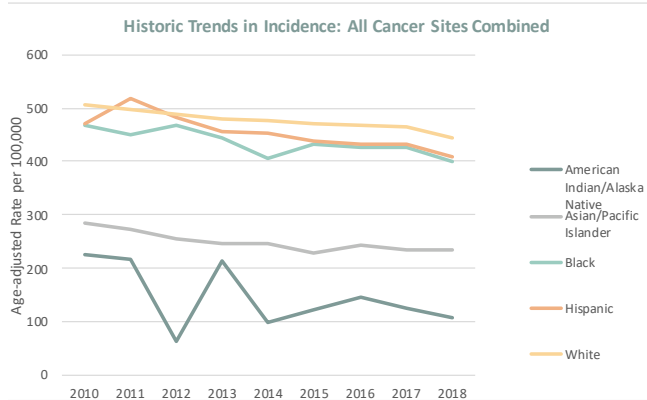
### Mortality rate per 100,000 (Female)

Cancer Site/Type	CT	US
All Cancer Sites Combined	122.9	133.6
Lung and Bronchus	29.6	32
Female Breast	17.4	20.1
Colon and Rectum	9.1	11.5
Leukemias	4.7	4.7
Non-Hodgkin Lymphoma	3.9	4.1
Brain and Other Nervous System	3.5	3.6
Liver and Intrahepatic Bile Duct	3.4	4
Myeloma	2.3	2.6
Urinary Bladder	2.2	2.1
Oral Cavity and Pharynx	0.9	1.3
Thyroid	0.4	0.5
Larynx	0.3	0.4
Hodgkin Lymphoma	0.1	0.2

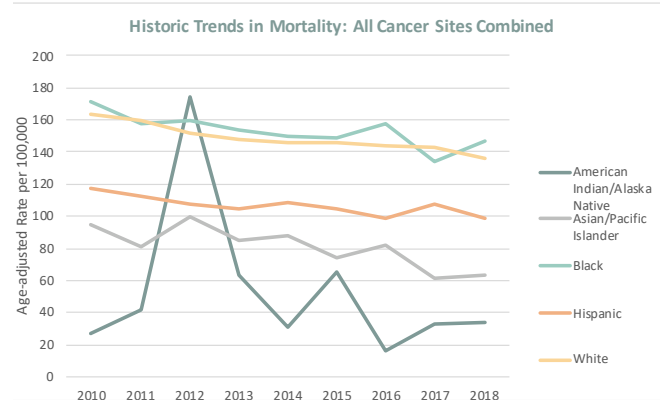
Furthermore, the age-adjusted mortality rate for both males and females in CT is lower than the national average. The mortality rate for females in the U.S. per 100,000 is 133.6, whereas in CT is 122.9.

# Incidence and Mortality by Race and Sex in Connecticut

## All Cancers Combined Includes all CDC defined cancer sites

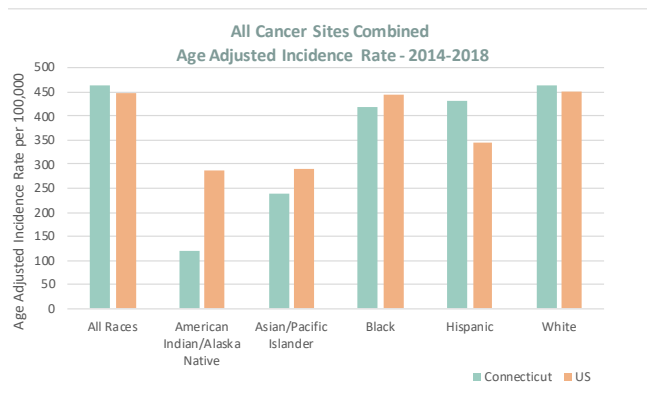


The incidence rate for all cancer sites combined has seen a net decrease across all racial groups from 2010 to 2018.

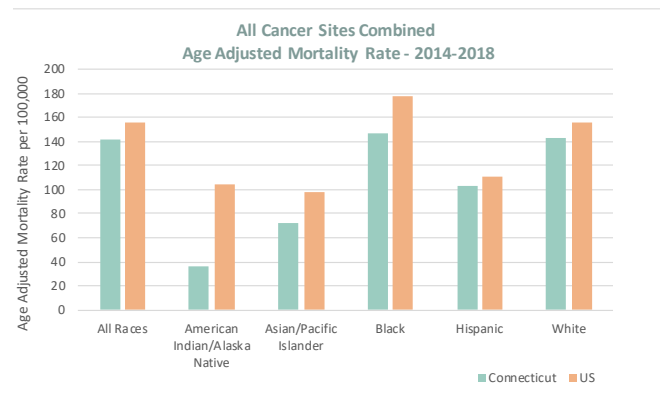


Mortality rates for all cancer sites combined has decreased across all racial groups between 2010–2018, with the exception of American Indian/Alaska Native individuals, which saw a peak in 2012, before returning close to the same level in 2018 as it was in 2010. In 2018, Black people had the highest mortality rate for all cancer sites combined when compared with all other racial groups.

## Age-Adjusted Incidence and Mortality Rates in CT versus US: Race/Ethnicity



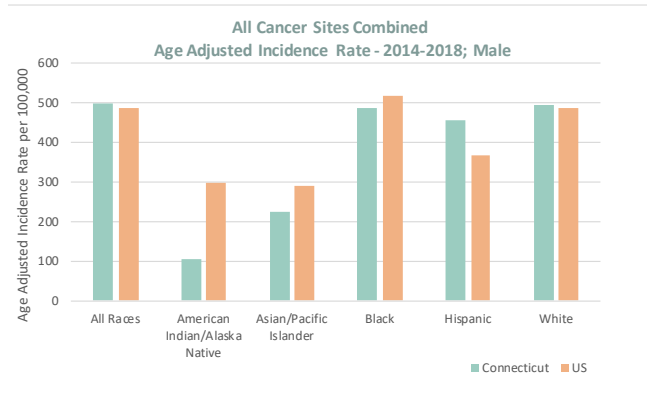
Incidence rates for all cancers combined are higher for Hispanic and White residents in CT compared to the overall U.S.



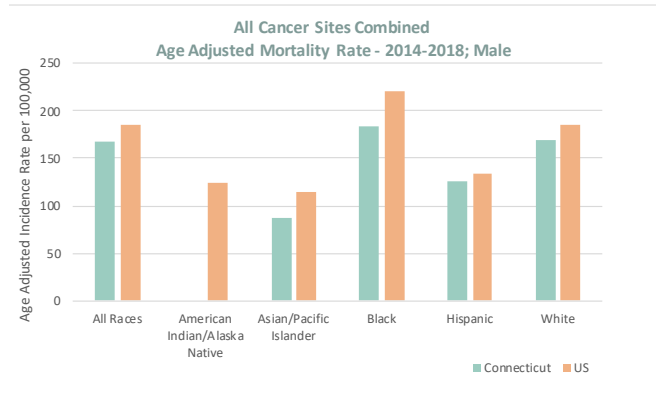
Mortality rates for all cancers combined are lower for all race and ethnicity groups in CT compared to the national rates.

# Incidence and Mortality by Race and Sex in Connecticut

## All Cancers Combined Incidence and Mortality Rates: Male

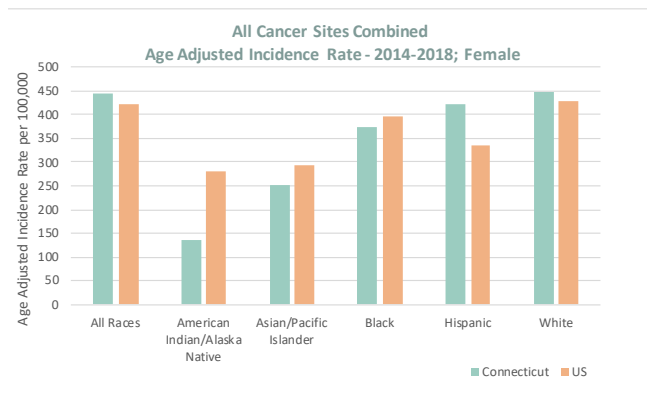


The largest disparity in incidence rates for all cancers combined for men can be seen in Hispanic residents. Their incidence rates are higher in CT than in the U.S. White males in CT have slightly higher rates compared to the national rate.

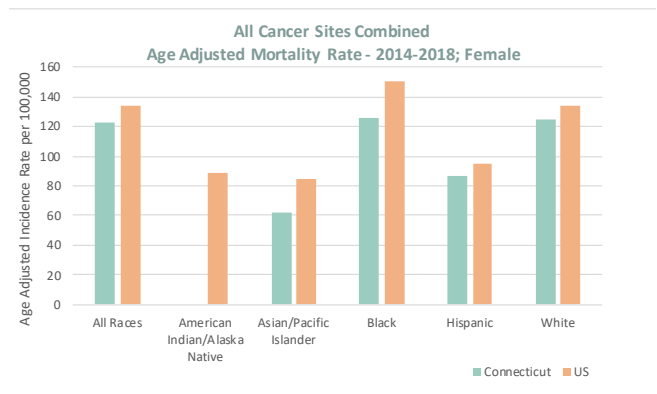


Mortality rates for all cancers combined are lower for all race and ethnicity groups among men in CT compared to the national rates. Data in CT are unavailable for American Indian/Alaska Native residents due to small numbers.

## Incidence and Mortality Rates: Female



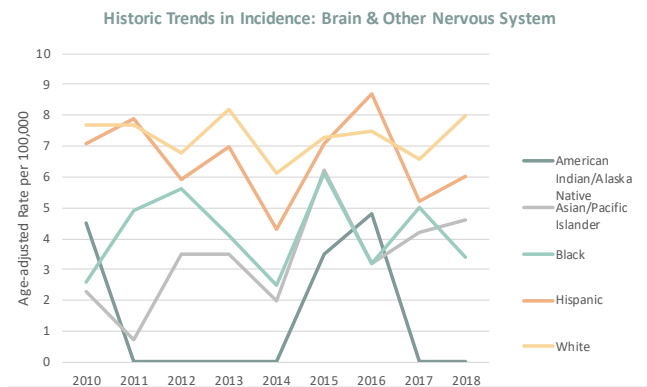
Hispanic and White female CT residents have higher incidence rates for all cancers combined compared to the U.S.



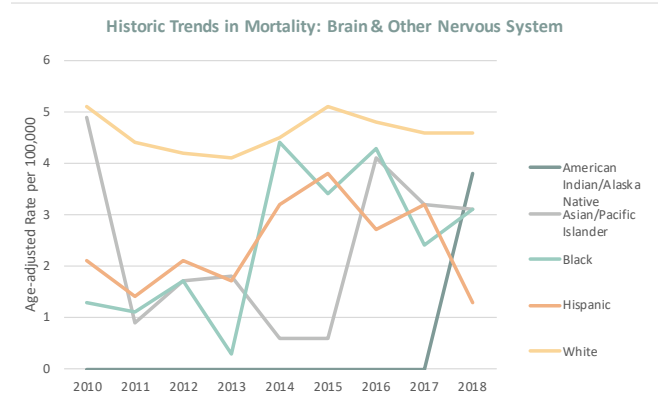
Similar to the male residents, female residents of CT have lower mortality rates for all cancers combined in all race/ethnicity groups than in the nation as a whole.

# Incidence and Mortality by Race and Sex in Connecticut

## Brain and Other Nervous System

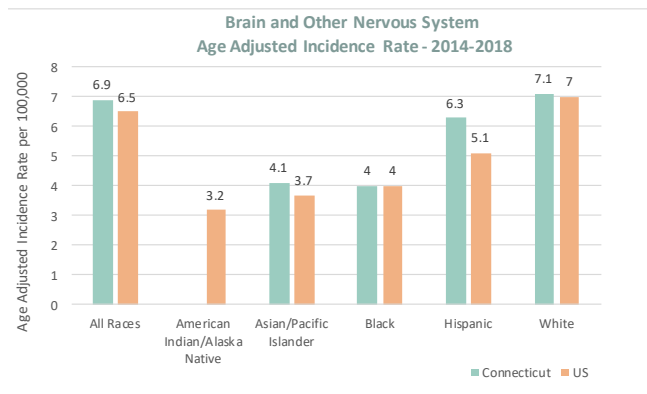


The incidence rate of brain and other nervous system cancers has seen no notable change across races between 2010 and 2018. All incidence rates fall below 10 per 100,000.

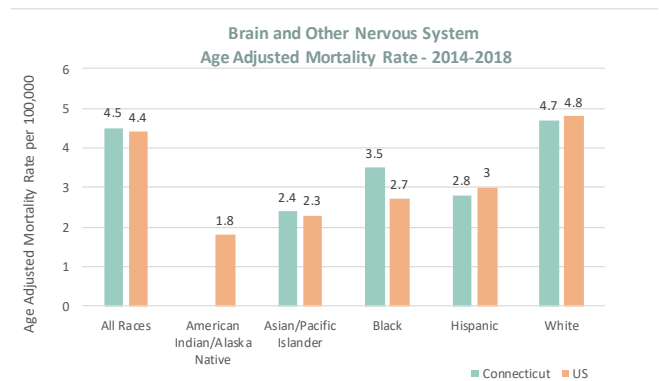


The mortality rate of brain & other nervous system cancers across all racial categories fall under 5 per 100,000 in 2018.

## Age-Adjusted Incidence and Mortality Rates in CT versus US: Race/Ethnicity



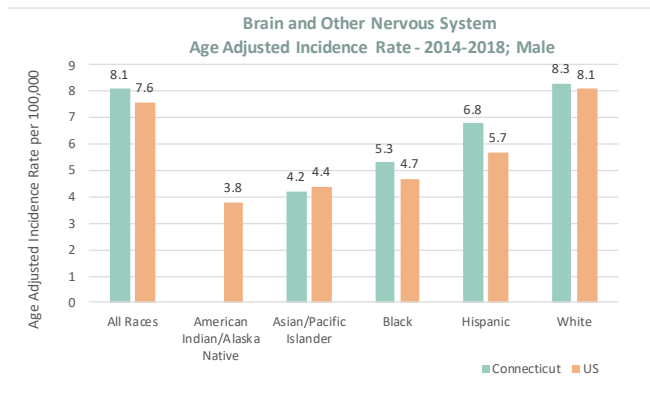
The age-adjusted incidence rate for brain and other nervous system cancers is greater in CT than the national average. Of particular note, the age-adjusted incidence rate for Hispanic CT residents (6.3 per 100,000) is much greater than the national average (5.1 per 100,000).



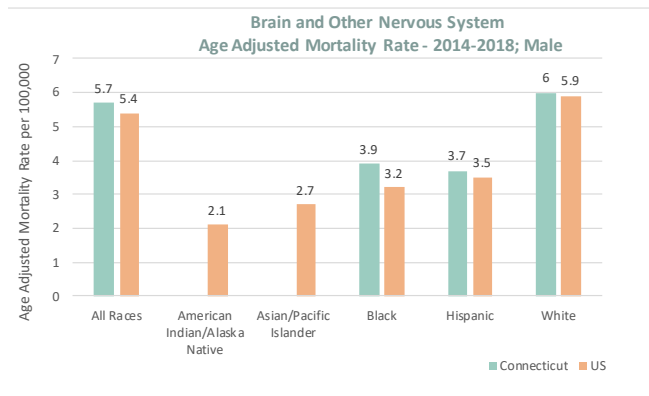
The age-adjusted mortality rate for brain and other nervous system cancers is greater in CT than the rest of the U.S. Of particular note, the mortality rate for Black CT residents (3.5 per 100,000) is much greater than for Black Americans (2.7 per 100,000).

# Incidence and Mortality by Race and Sex in Connecticut

## Brain and Other Nervous System Incidence and Mortality Rates: Male

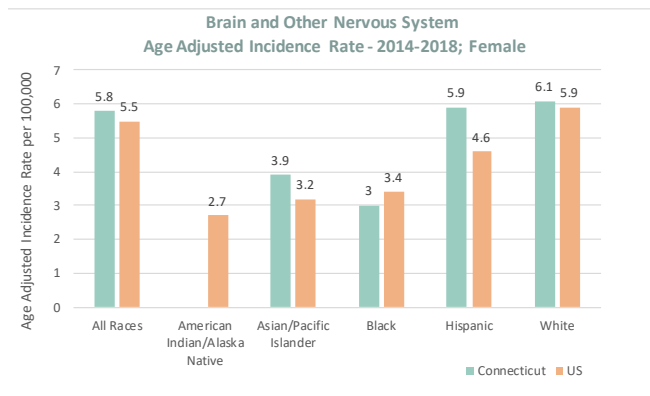


The age-adjusted incidence rate for brain and other nervous system cancers in males is greater in CT than the U.S. That rate is greater for Hispanic and Black CT residents than in the U.S.

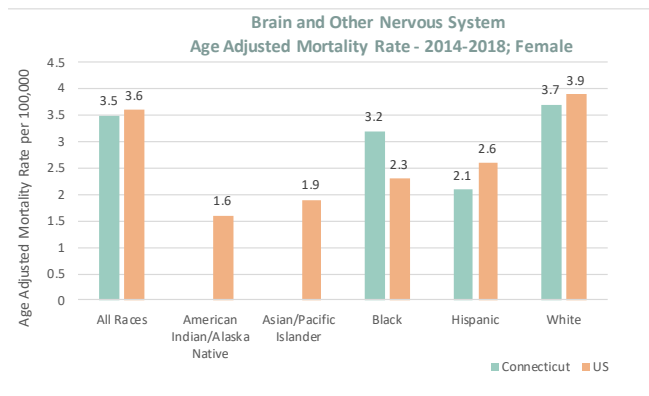


The age-adjusted mortality rate for brain and other nervous system cancers in males is greater in CT than the U.S. That rate is greater for Hispanic and Black CT residents than in the U.S.

## Incidence and Mortality Rates: Female



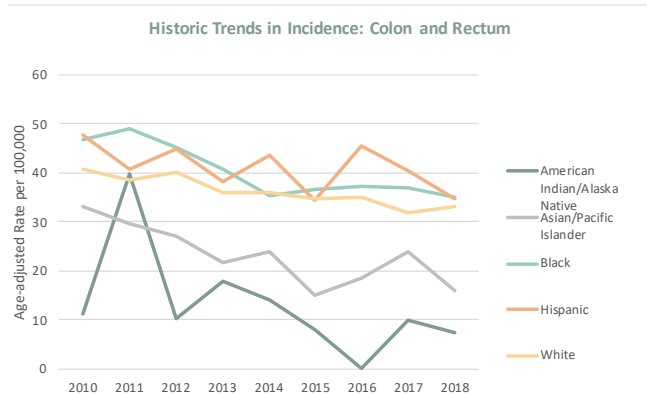
The age-adjusted incidence rate for brain and other nervous system cancers in females is greater in CT than the U.S. That rate is greater for Hispanic CT residents than for the U.S. Hispanic population.



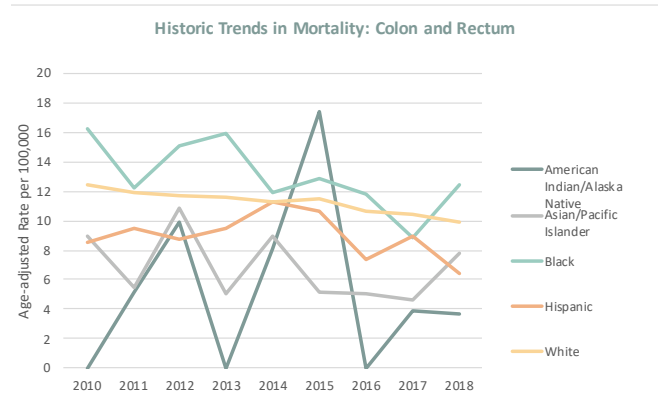
The age-adjusted mortality rate for brain and other nervous system cancers in females is lower in CT than the U.S. That rate is greater for Black CT residents than for the U.S. Black population.

# Incidence and Mortality by Race and Sex in Connecticut

## Colon and Rectum

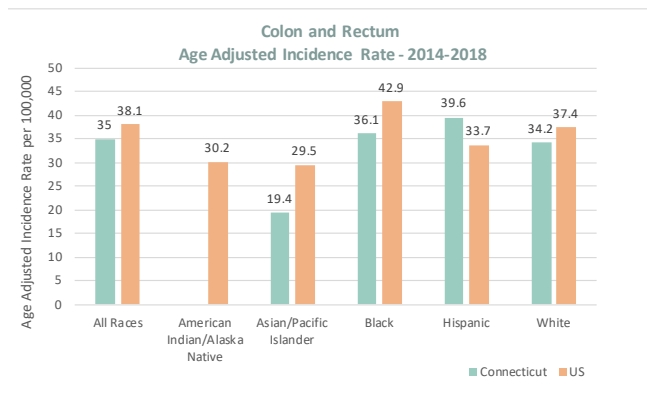


The colon and rectum cancer incidence rate has decreased across all racial categories between 2010 and 2018.

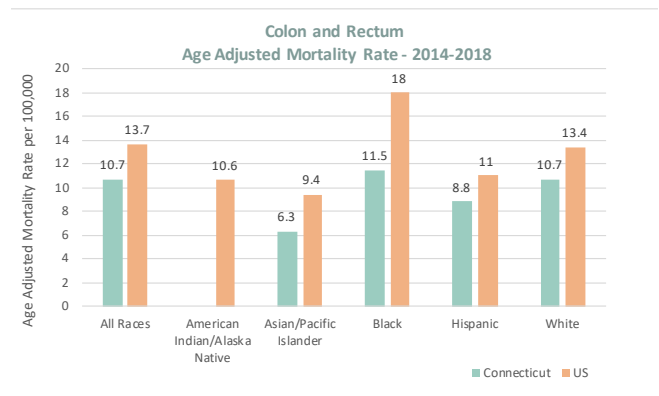


The mortality rate of colon and rectum cancer has decreased across all racial categories, with the exception of American Indian/Alaska Native CT residents, which has had a marginal net increase between 2010 and 2018.

## Age-Adjusted Incidence and Mortality Rates in CT versus US: Race/Ethnicity



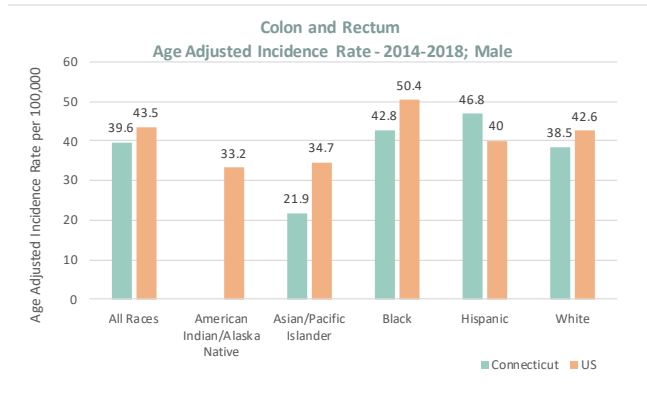
Although colon and rectum cancer age-adjusted incidence rates are lower when disaggregated by sex in CT compared to the national average, when disaggregated by race, data reveals that in reality, the incidence rate among Hispanic CT residents is greater in CT (39.6%) than in the rest of the U.S. (33.7%).



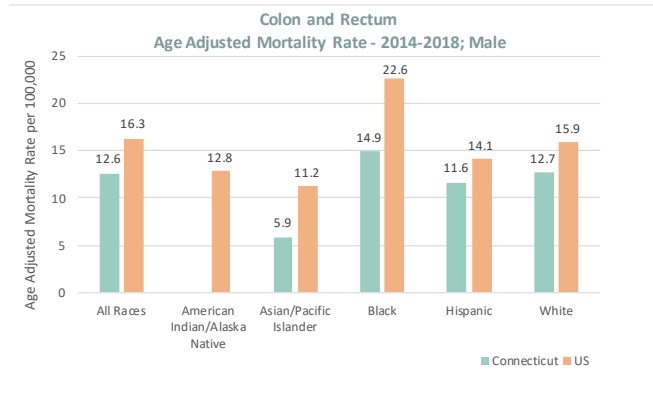
Moreover, the colon and rectum cancer age-adjusted mortality rate is greatest for Black CT residents, and within the greater U.S. compared to all other races.

# Incidence and Mortality by Race and Sex in Connecticut

## Colon and Rectum Incidence and Mortality Rates: Male

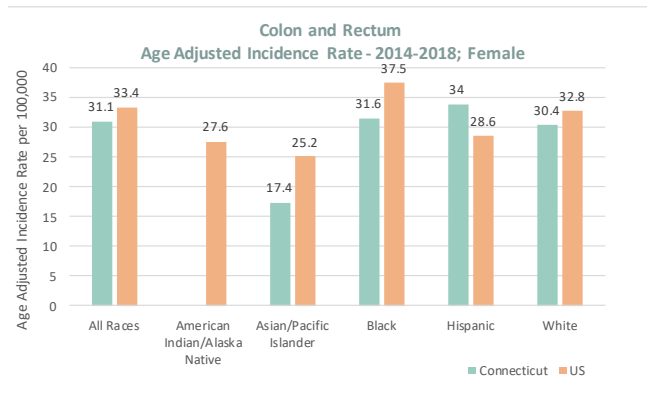


Hispanic men have the highest age-adjusted incidence rate of colon and rectum cancer in CT (46.8 per 100,000), and higher than the U.S. Hispanic average (40 per 100,000). Black men have the second highest incidence rate in CT (42.8 per 100,000).

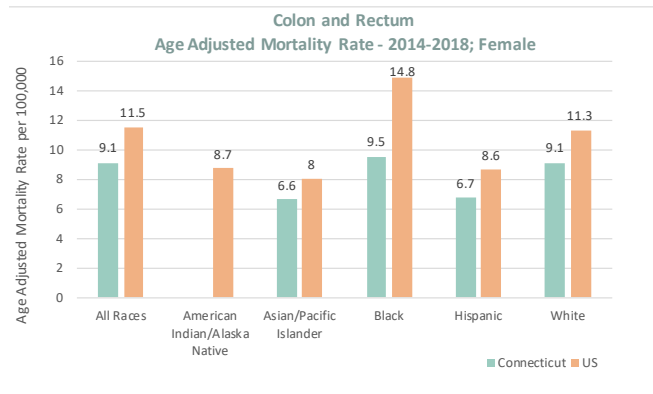


Black men have the highest age-adjusted mortality rate of colon and rectum cancer in CT (14.9 per 100,000) and nationally (22.6 per 100,000).

## Incidence and Mortality Rates: Female



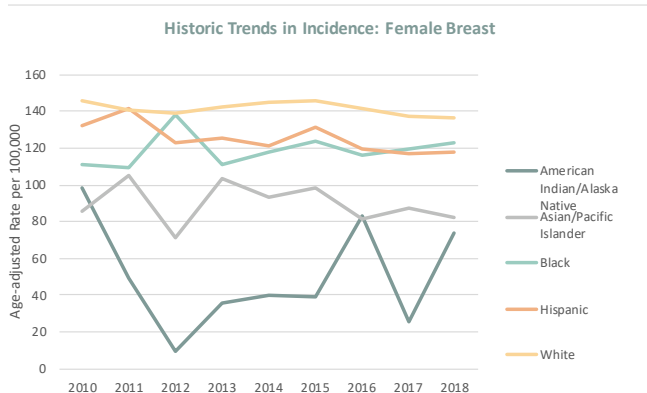
Hispanic women have the highest age-adjusted incidence rate of colon and rectum cancer in CT (34 per 100,000), which is higher than the incidence rate of Hispanic women in the U.S. (28.6 per 100,000).



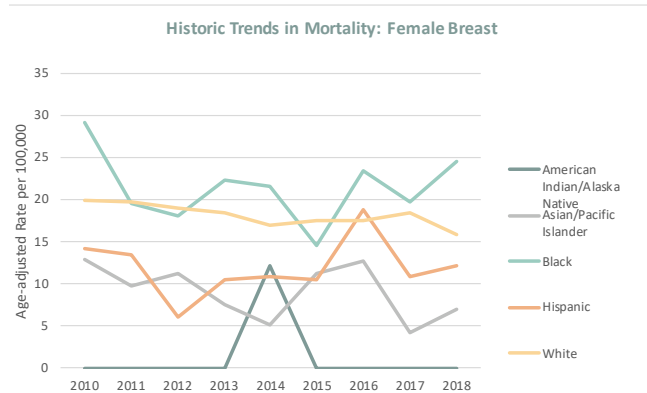
Black women have the highest age-adjusted mortality rate of colon and rectum cancer in CT (9.5 per 100,000) and nationally (14.8 per 100,000).

# Incidence and Mortality by Race and Sex in Connecticut

## Female Breast

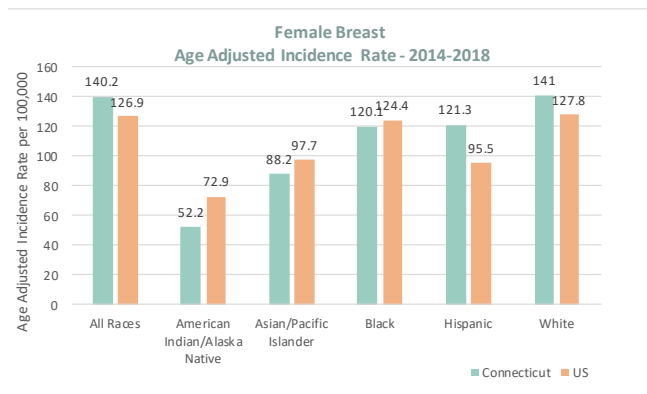


The incidence rate of female breast cancer has remained steady between 2010 and 2018. There are slight decreases within Hispanic and Asian/Pacific Islander female CT residents, and an increase within Black female CT residents.

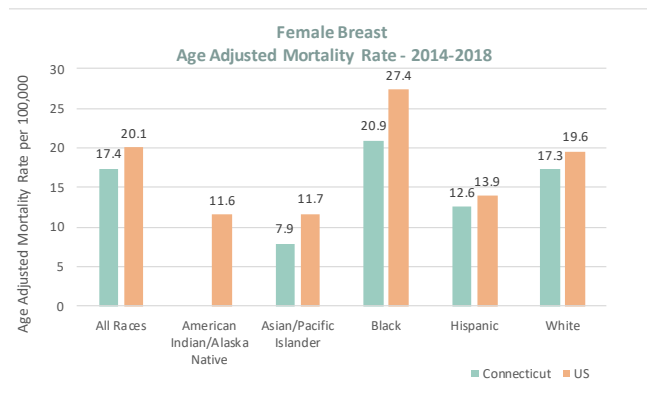


Female breast cancer mortality rates have decreased between 2010 and 2018 across all racial categories. Still, Black women continue to have the highest mortality rate compared with all other racial categories.

## Age-Adjusted Incidence and Mortality Rates in CT versus US: Race/Ethnicity



The overall age-adjusted incidence rate of breast cancer is greater in CT (140.2 per 100,000) than the national average (126.9 per 100,000). Particularly, the incidence rate for female Hispanic CT residents (121.3) is much greater than the national average (95.5).

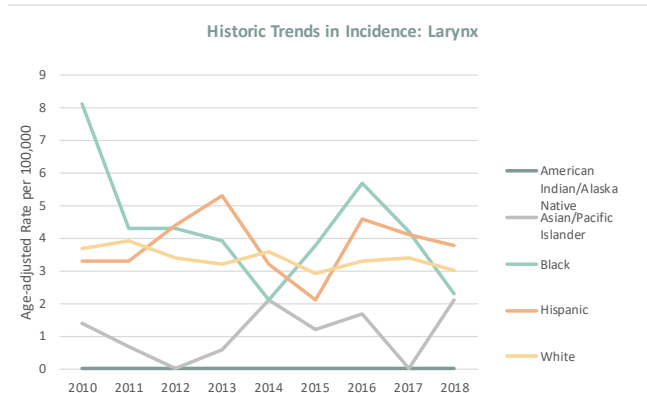


The age-adjusted mortality rate of breast cancer is greater among Black women in both the state (20.9 per 100,000) and nationally (27.4 per 100,000) when compared to all other races.

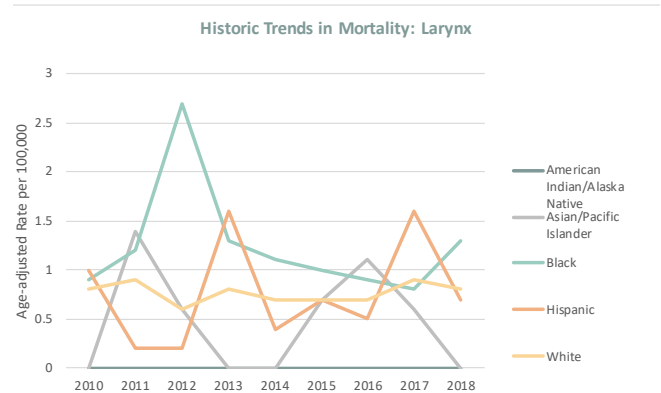


# Incidence and Mortality by Race and Sex in Connecticut

## Head and Neck Larynx

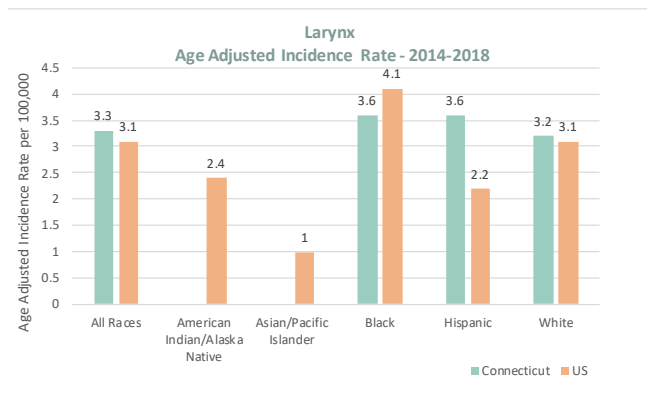


The incidence rate of larynx cancers has remained steady across all racial categories between 2010 and 2018, with the exception of the rate for Black CT residents, which saw a net decrease. In 2018, Hispanic CT residents had the highest incidence rate among all racial categories.

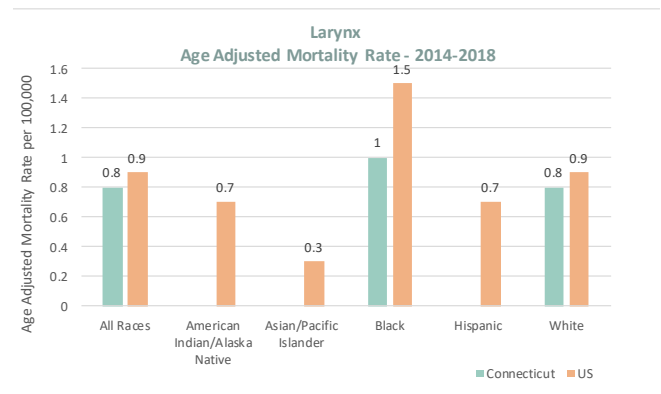


The mortality rate for larynx cancer has remained steady across all racial categories between 2010 and 2018, all lying below 3 per 100,000.

## Age-Adjusted Incidence and Mortality Rates in CT versus US: Race/Ethnicity



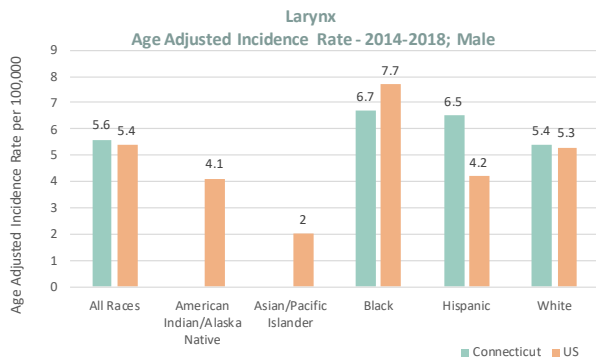
The age-adjusted incidence rate of larynx cancer is greater in CT (3.3 per 100,000) than the U.S. (3.1 per 100,000). Of particular note, the rate for Hispanic CT residents (3.6 per 100,000) is much higher than the rate for the Hispanic U.S. population. (2.2 per 100,000). Black and Hispanic racial groups had the highest incidence rate in CT.



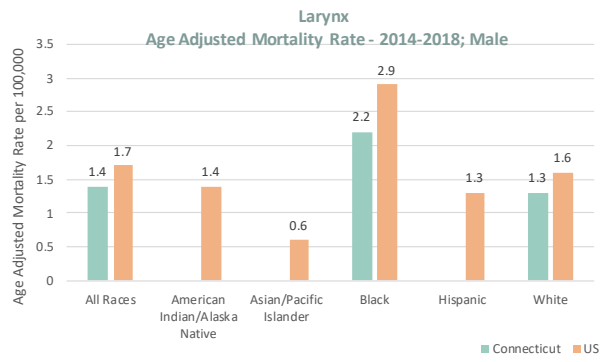
The age-adjusted mortality rate for larynx cancer is greatest among Black people in the U.S. (1.5 per 100,000) compared to every other racial category.

# Incidence and Mortality by Race and Sex in Connecticut

## Head and Neck: Larynx Incidence and Mortality Rates: Male

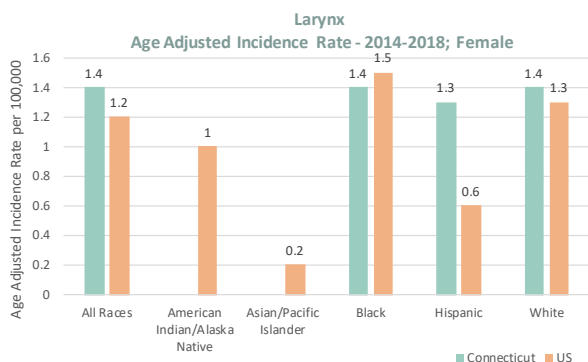


The age-adjusted incidence rate for larynx cancer in males is greater in CT than the U.S. Black people had the highest incidence rate of larynx cancer in the U.S. across all racial groups (7.7 per 100,000). The incidence rate of larynx cancer for Hispanic CT residents (6.5 per 100,000) is much higher than the incidence rate for the Hispanic U.S. population (4.2 per 100,000).

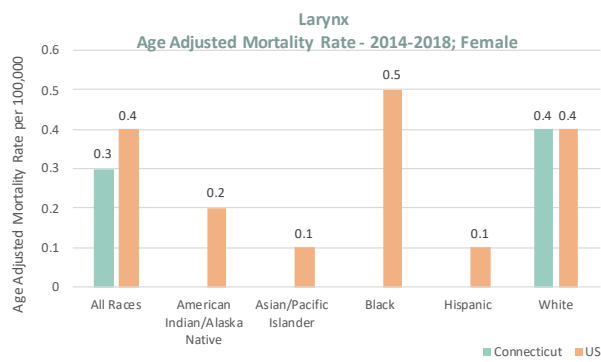


The age-adjusted mortality rate for larynx cancer in males is greatest among Black individuals in both CT (2.2 per 100,000) and the U.S. (2.9 per 100,000).

## Incidence and Mortality Rates: Female



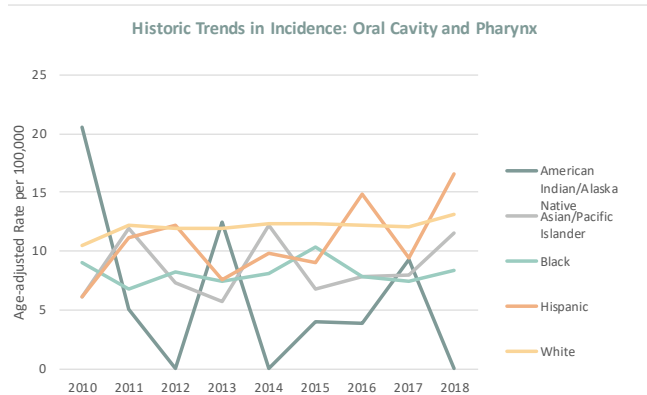
The age-adjusted incidence rate for larynx cancer in females was greater in CT than in the U.S. Moreover, the incidence rate for larynx cancer in Hispanic females was greater in CT (1.3 per 100,000) than the rest of the U.S. (0.6 per 100,000).



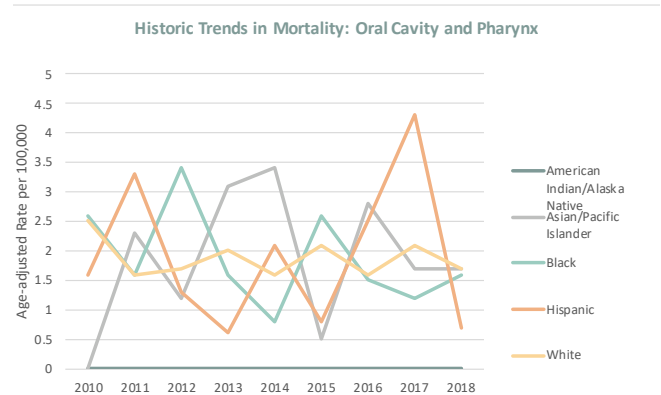
The age-adjusted mortality rate for larynx cancer in females is greatest among Black individuals in the U.S. (0.5 per 100,000).

# Incidence and Mortality by Race and Sex in Connecticut

## Head and Neck Oral Cavity and Pharynx

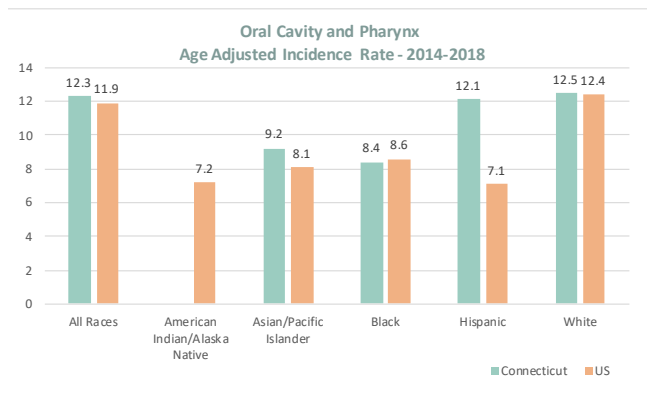


The incidence rate of oral cavity and pharynx cancers between 2010 and 2018 have relatively increased across all racial categories, with the exception of American Indian/Alaska Native and Black CT residents. In 2018, Hispanic CT residents had the highest incidence rate across all racial categories.

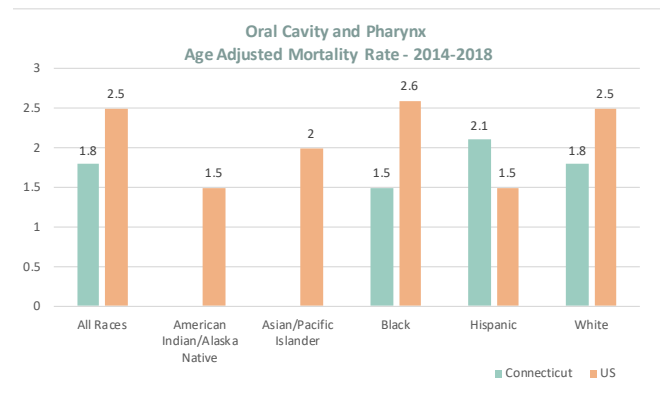


The mortality rates of oral cavity and pharynx cancers all fell below 5 per 100,000 across all racial categories.

## Age-Adjusted Incidence and Mortality Rates in CT versus US: Race/Ethnicity



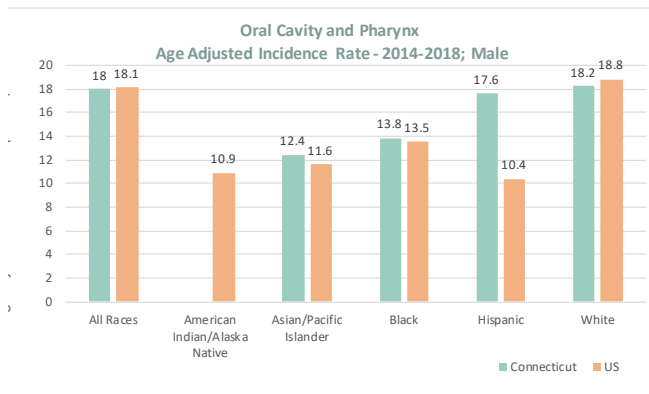
The age-adjusted incidence rate for oral cavity and pharynx cancer is greater in CT (12.3 per 100,000) than in the U.S. (11.9 per 100,000). The incidence rate is much greater for Hispanic CT residents (12.1 per 100,000) than for the U.S. Hispanic population (7.1 per 100,000). The incidence rate is much greater for Asian/Pacific Islander CT residents (9.2 per 100,000) than in the U.S. (8.6 per 100,000).



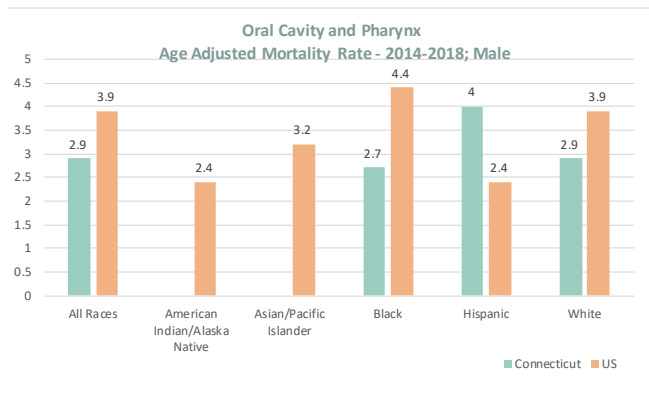
The age-adjusted mortality rate of oral cavity and pharynx cancer is greatest among the Black population in the U.S. (2.6 per 100,000) and Hispanic CT residents (2.1 per 100,000).

# Incidence and Mortality by Race and Sex in Connecticut

## Head and Neck: Oral Cavity and Pharynx Incidence and Mortality Rates: Male

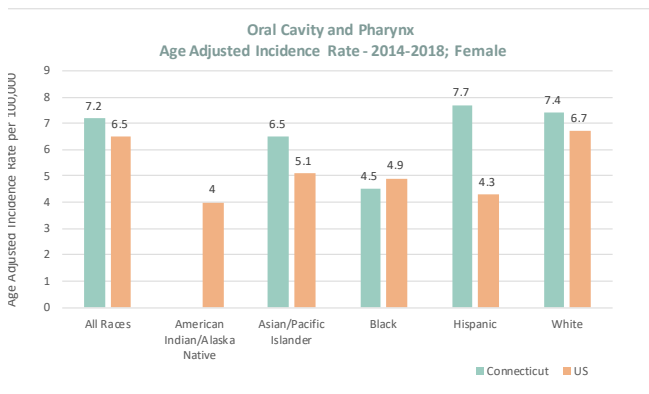


The age-adjusted incidence rate of oral cavity and pharynx cancer was greater in Hispanic (17.6 per 100,000), Asian (12.4 per 100,000) and Black males (13.8 per 100,000) in CT compared with the rest of the U.S.

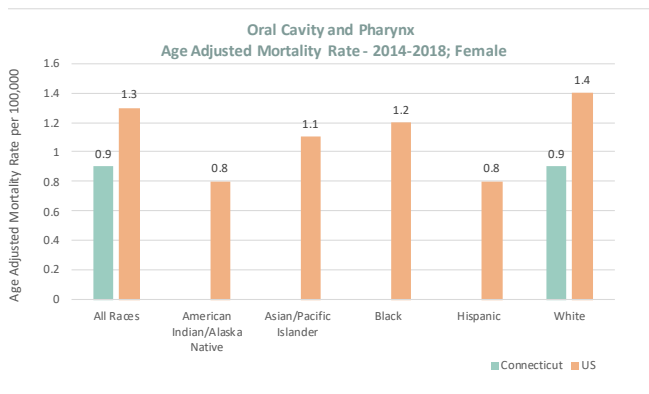


The age-adjusted mortality rate of oral cavity and pharynx cancer in males is greatest among Black individuals (4.4 per 100,000) compared against all other racial groups. In CT, the incidence rate for Hispanic males (4 per 100,000) was much greater than the rate for Hispanic males in the U.S. (2.4 per 100,000).

## Incidence and Mortality Rates: Female



The age-adjusted incidence rate of oral cavity and pharynx cancer in females was greater in CT (7.2 per 100,000) than in the U.S. (6.5 per 100,000). The incidence rate was much greater in CT among Asian/Pacific Islanders (6.5 per 100,000) and Hispanics (7.7 per 100,000) when compared to Asian/Pacific Islander and Hispanic in the U.S.

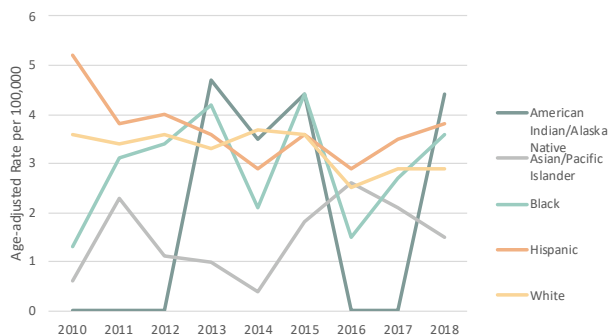


The age-adjusted mortality rate of oral cavity and pharynx cancer in females is lower in CT (0.9 per 100,000) than in the U.S. (1.3 per 100,000).

# Incidence and Mortality by Race and Sex in Connecticut

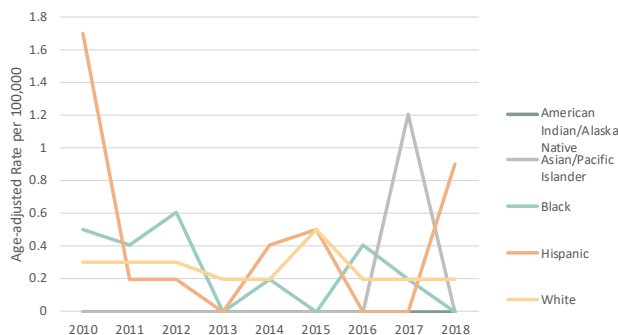
## Heme Malignancies Hodgkin Lymphoma

Historic Trends in Incidence: Hodgkin Lymphoma



The incidence rate of Hodgkin Lymphoma fell below 5 per 100,000 in 2018 across all racial categories. In 2018, American Indian/Alaska Native CT residents had the highest incidence rate across all racial categories.

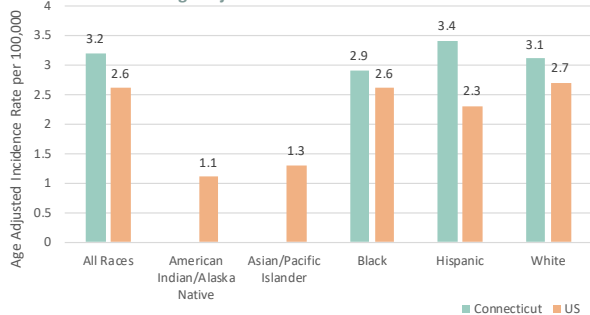
Historic Trends in Mortality: Hodgkin Lymphoma



The mortality rate of Hodgkin Lymphoma has remained steady between 2010 and 2018 across all racial categories. In 2018, all mortality rates fell below 1 per 100,000 across racial categories.

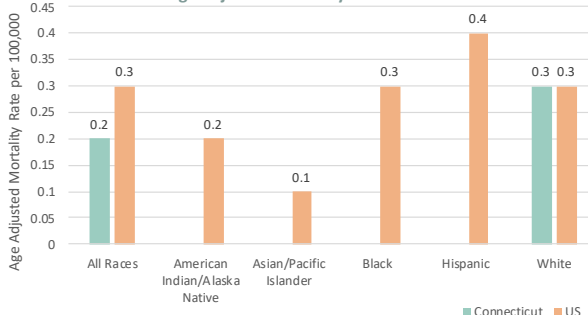
## Age-Adjusted Incidence and Mortality Rates in CT versus US: Race/Ethnicity

Hodgkin Lymphoma  
Age Adjusted Incidence Rate - 2014-2018



The age-adjusted incidence rate of Hodgkin Lymphoma is higher in CT (3.2 per 100,000) than in the U.S. (2.6 per 100,000). Moreover, it is higher across all racial groups in CT. Hispanic CT residents have the highest incidence rate (3.4 per 100,000).

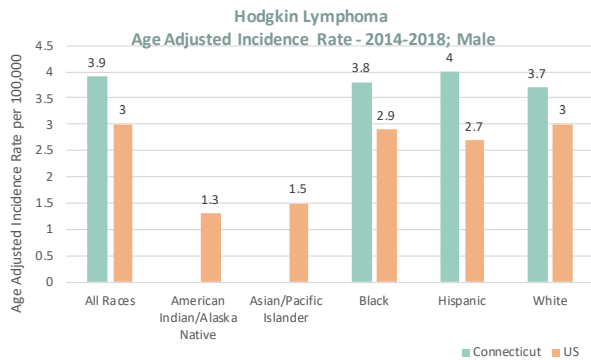
Hodgkin Lymphoma  
Age Adjusted Mortality Rate - 2014-2018



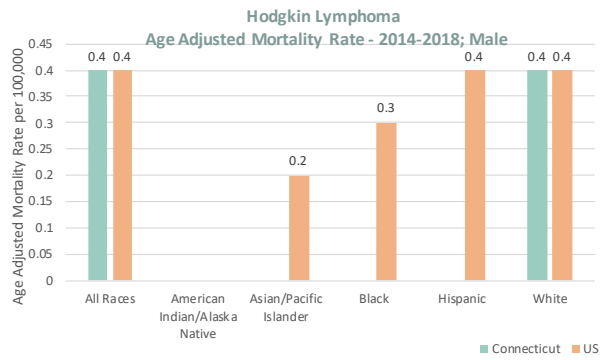
The age-adjusted mortality rate of Hodgkin Lymphoma is lower in CT (0.2 per 100,000) than in the U.S. (0.3 per 100,000).

# Incidence and Mortality by Race and Sex in Connecticut

## Heme Malignancies: Hodgkin Lymphoma Incidence and Mortality Rates: Male

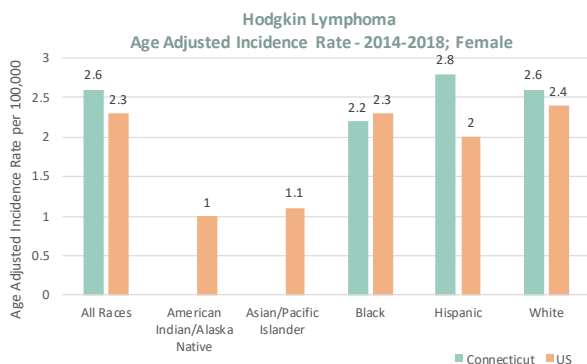


The age-adjusted incidence rate of Hodgkin Lymphoma in males is greater in CT (3.9 per 100,000) than in the U.S. (3 per 100,000). The incidence rate is greatest among Hispanic CT male residents (4 per 100,000) and Black male CT residents (3.8 per 100,000).

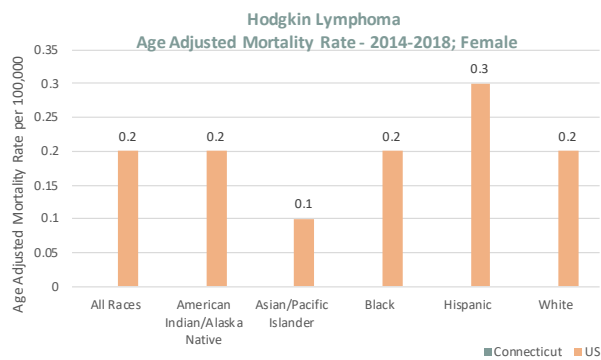


The age-adjusted mortality rate of Hodgkin Lymphoma in males is the same in CT and in the U.S. (0.4 per 100,000).

## Incidence and Mortality Rates: Female



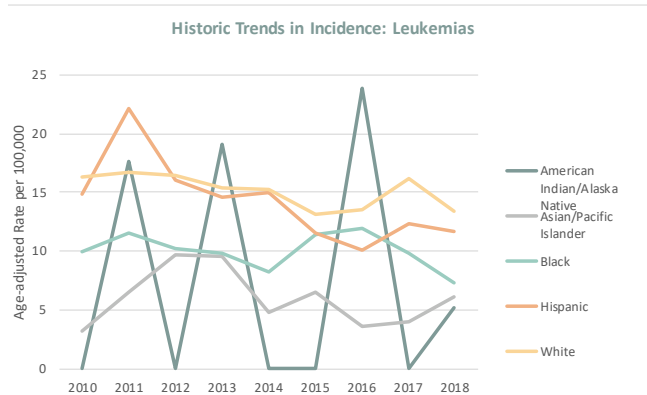
The age-adjusted incidence rate of Hodgkin Lymphoma for females is greater in CT (2.6 per 100,000) than in the U.S. (2.3 per 100,000). The rate is greatest for Hispanic women in CT (2.8 per 100,000) among all racial groups.



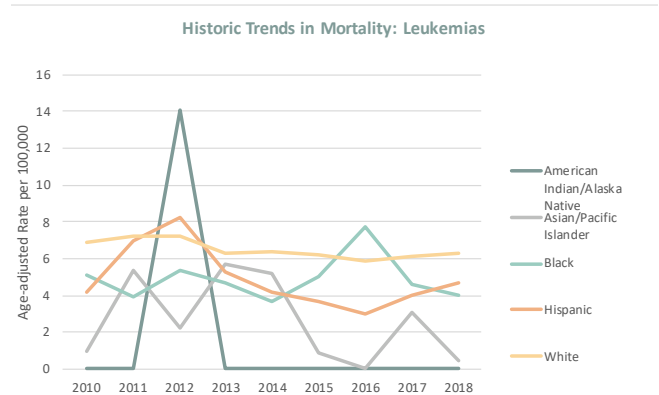
There is no data on the age-adjusted mortality rate of Hodgkin Lymphoma in females in the state of CT. The mortality rate for females in the U.S. is 0.2 per 100,000.

# Incidence and Mortality by Race and Sex in Connecticut

## Heme Malignancies Leukemias

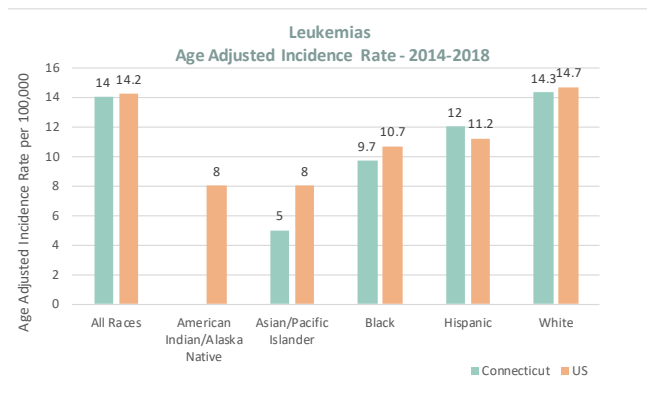


The incidence rate of leukemias decreased among Black and Hispanic CT residents between 2010 and 2018.

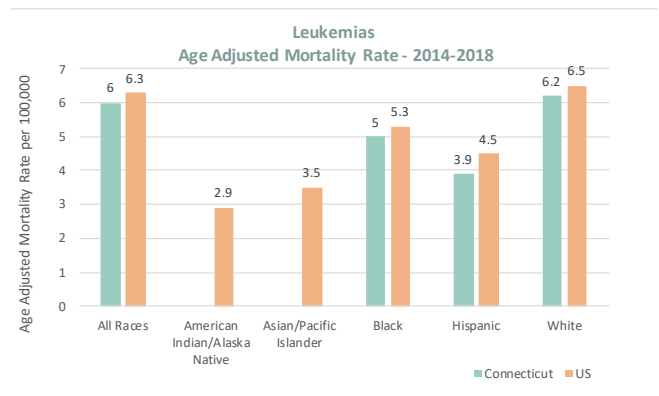


The mortality rate for leukemias fell below 8 per 100,000 across all racial categories.

## Age-Adjusted Incidence and Mortality Rates in CT versus US: Race/Ethnicity



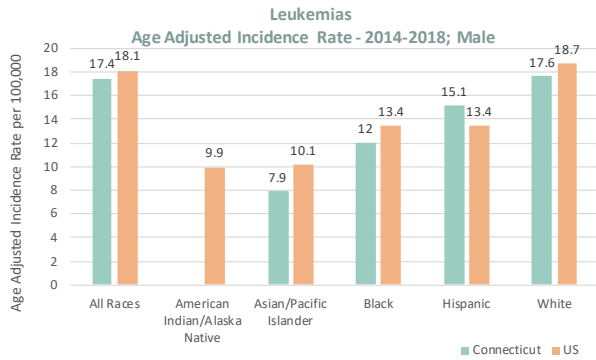
The age-adjusted incidence rate of leukemias is greater in the U.S. (14.2 per 100,000) than in CT (14 per 100,000). However, that rate is greater among Hispanic individuals in CT (12 per 100,000) than among Hispanic individuals in the U.S. (11.2 per 100,000).



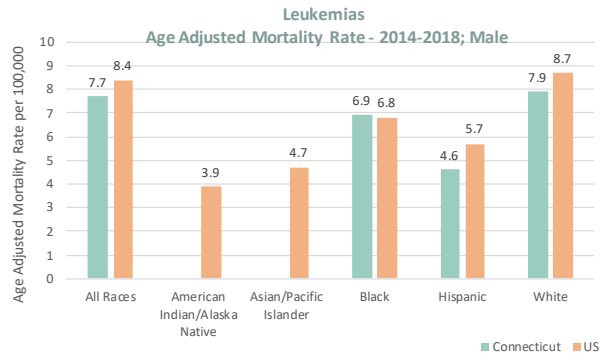
The age-adjusted mortality rate for leukemias is greater in the U.S. (6.3 per 100,000) than in CT (6 per 100,000).

# Incidence and Mortality by Race and Sex in Connecticut

## Heme Malignancies: Leukemias Incidence and Mortality Rates: Male

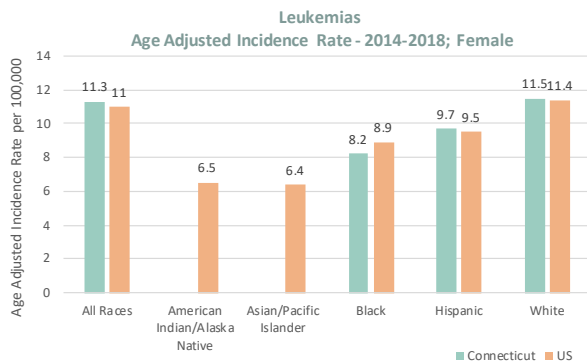


The age-adjusted incidence rate of leukemias in males is greater in the U.S. (18.1 per 100,000) than in CT (17.4 per 100,000). However, the incidence rate in Hispanic males is greater in CT (15.1 per 100,000) than in the rest of the U.S. (13.4 per 100,000).

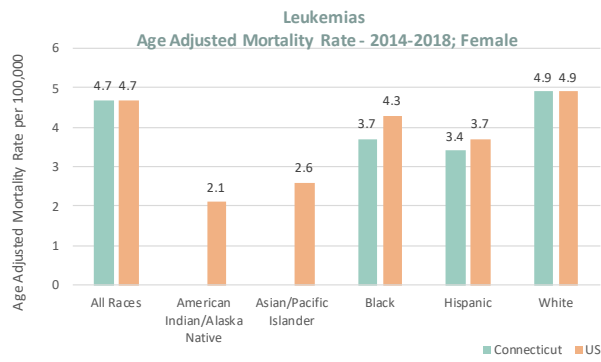


The age-adjusted mortality rate of leukemias in males is lower in CT (7.7 per 100,000) than in the U.S. (8.4 per 100,000). However, that rate is slightly greater in Black males in CT (6.9 per 100,000) than for Black males in the U.S. (6.8 per 100,000).

## Incidence and Mortality Rates: Female



The age-adjusted incidence rate of leukemias in females is greater in CT (11.3 per 100,000) than in the U.S. (11 per 100,000). Moreover, the incidence rate among Hispanic women in CT (9.7 per 100,000) is greater than that of Hispanic women in the U.S. (9.5 per 100,000).

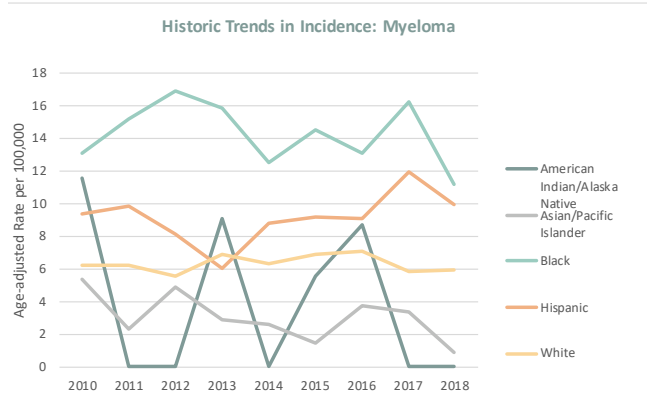


The age-adjusted mortality rate of leukemias in females is equal in CT and in the U.S. (4.7 per 100,000).

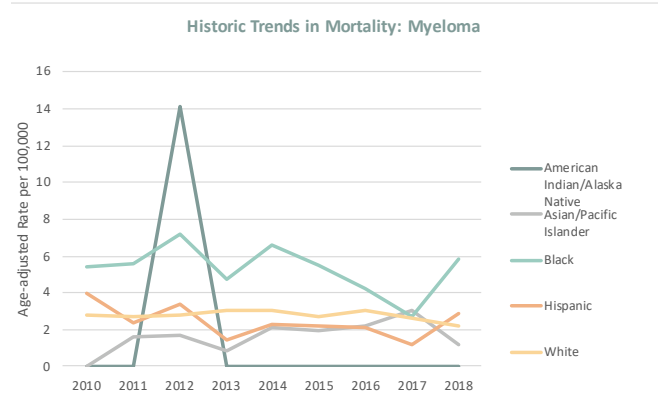


# Incidence and Mortality by Race and Sex in Connecticut

## Heme Malignancies Myeloma

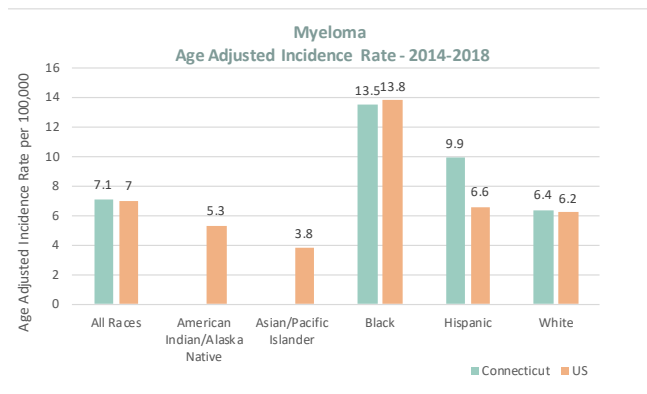


Black people had the highest incidence rate of myeloma across all racial categories between 2010 and 2018.

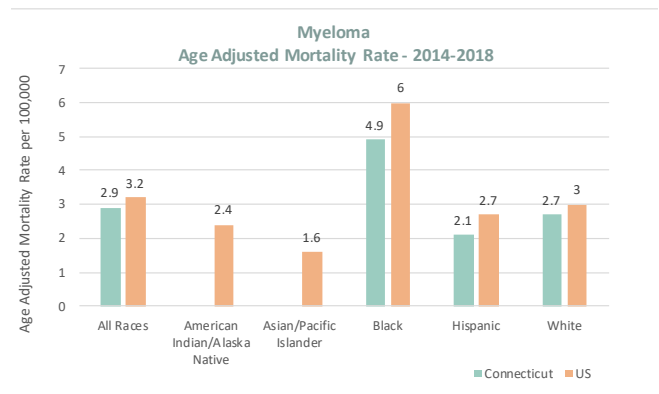


The mortality rate of myeloma has remained steady between 2010 and 2018 across all racial categories. In 2018, Black people had the highest mortality rate of Myeloma across all racial categories.

## Age-Adjusted Incidence and Mortality Rates in CT versus US: Race/Ethnicity



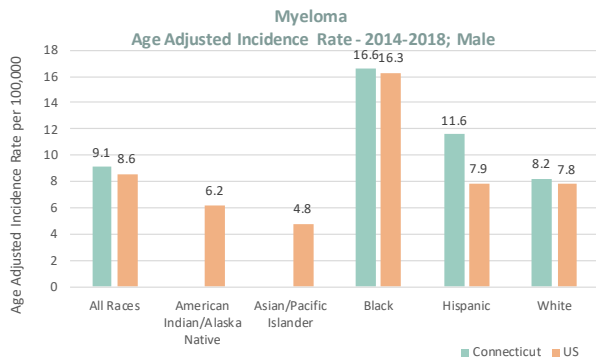
The age-adjusted incidence rate for myeloma is slightly greater in CT (7.1 per 100,000) than in the U.S. (7 per 100,000). It is greatest among Black individuals in both CT (13.5 per 100,000) and the U.S. (13.8 per 100,000). And it is greater among Hispanic individuals in CT (9.9 per 100,000) than for Hispanic individuals in the U.S. (6.6 per 100,000).



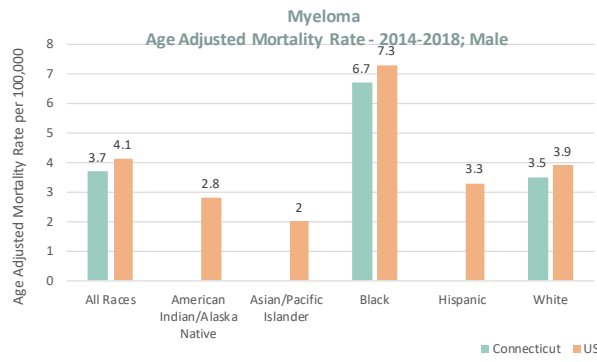
The age-adjusted mortality rate of myeloma is lower in CT (2.9 per 100,000) than in the U.S. (3.2 per 100,000). Among all racial groups, Black individuals had the highest mortality rate in both CT (4.9 per 100,000) and the U.S. (6 per 100,000).

# Incidence and Mortality by Race and Sex in Connecticut

## Heme Malignancies: Myeloma Incidence and Mortality Rates: Male

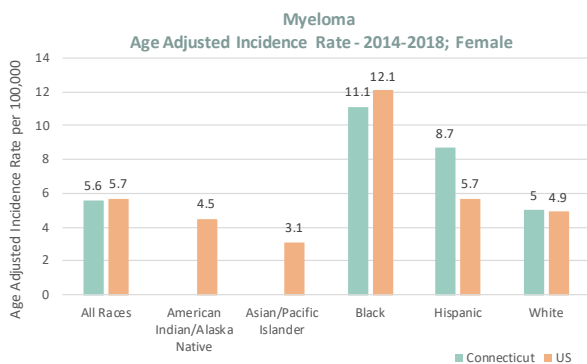


The age-adjusted incidence rate of myeloma in males is greater in CT (9.1 per 100,000) than in the U.S. (8.6 per 100,000). Moreover, Black males had the highest rate among all racial groups in both CT (16.6 per 100,000) and the U.S. (16.3 per 100,000). The incidence rate is much greater for Hispanic males in CT (11.6 per 100,000) than for those in the U.S. (7.9 per 100,000).

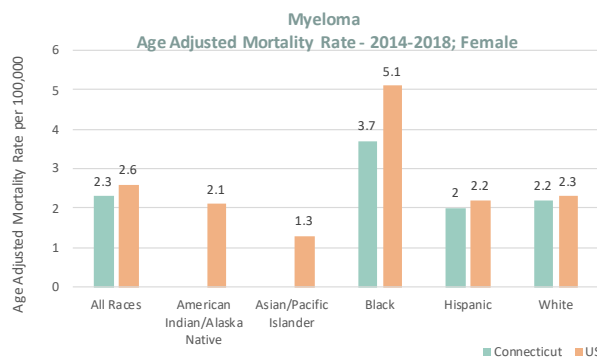


The age-adjusted mortality rate of myeloma in males is greatest among Black males in both CT (6.7 per 100,000) and the U.S. (7.3 per 100,000).

## Incidence and Mortality Rates: Female



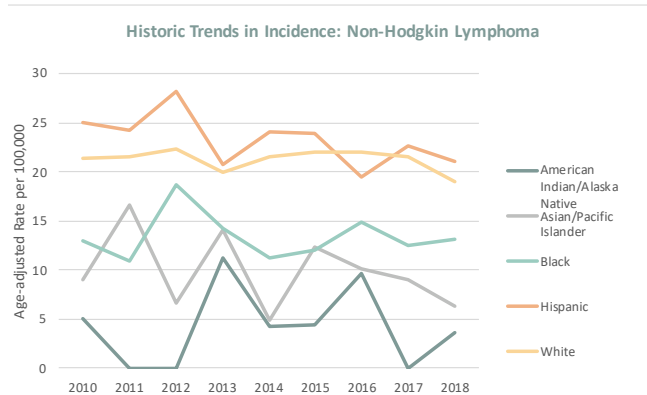
The age-adjusted incidence rate of myeloma in females is greatest among Black women in CT (11.1 per 100,000) and the U.S. (12.1 per 100,000). The incidence rate is greater for Hispanic women in CT (8.7 per 100,000) than for Hispanic women in the U.S. (5.7 per 100,000).



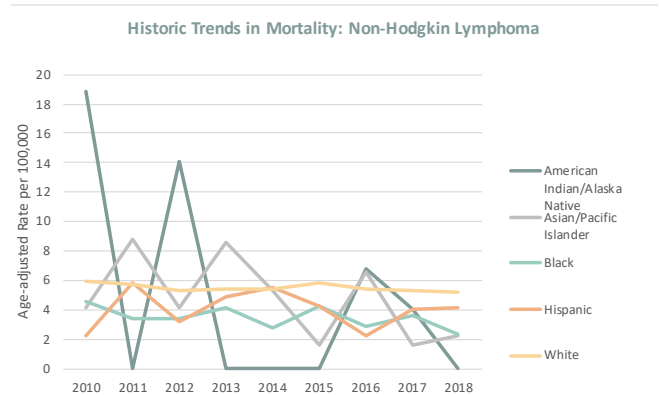
The age-adjusted mortality rate of myeloma in females is greatest among Black women in both CT (3.7 per 100,000) and the U.S. (5.1 per 100,000).

# Incidence and Mortality by Race and Sex in Connecticut

## Heme Malignancies Non-Hodgkin Lymphoma

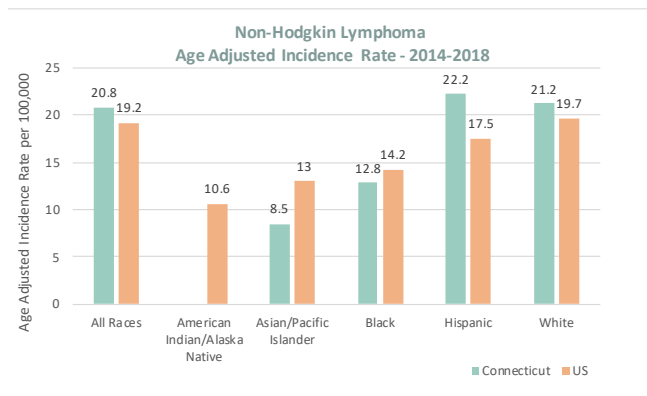


The incidence rate of non-Hodgkin lymphoma has decreased among White, Asian/Pacific Islander, and Hispanic residents, and remained constant among Black and American Indian/Alaska native residents. In 2018, Hispanic residents had the highest incidence rate among all racial categories.

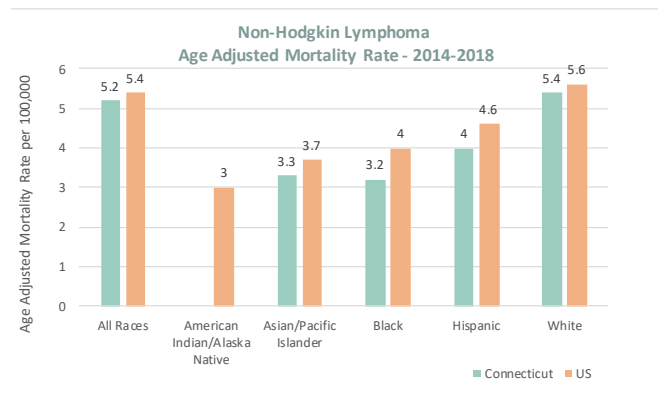


The mortality rate for non-Hodgkin lymphoma has remained steady across all racial categories between 2010 and 2018, with the exception of American Indian/Alaska Native residents, which saw a large decrease in mortality rate. In 2018, mortality rates fell below 6 per 100,000 across all racial categories.

## Age-Adjusted Incidence and Mortality Rates in CT versus US: Race/Ethnicity



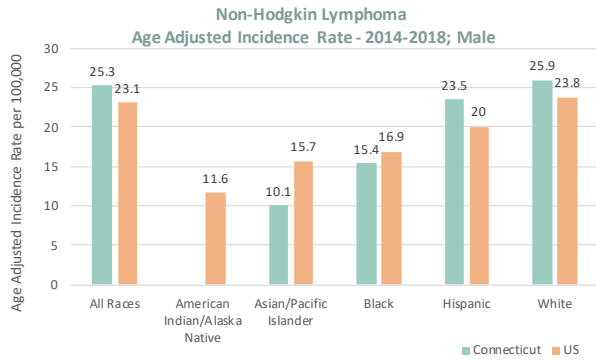
The age-adjusted incidence rate of non-Hodgkin lymphoma is greater in CT (20.8 per 100,000) than in the U.S. (19.2 per 100,000). Additionally, Hispanic CT residents had a higher incidence rate (22.2 per 100,000) compared to the U.S. Hispanic population (17.5 per 100,000).



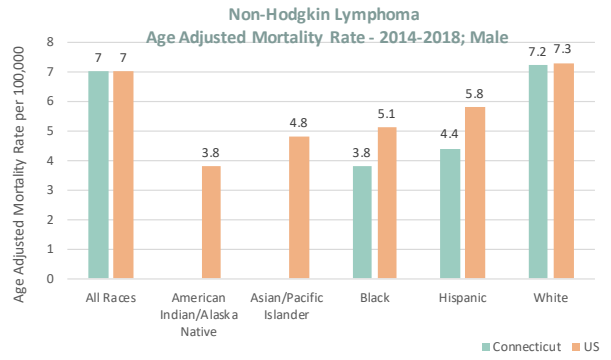
The age-adjusted mortality rate of non-Hodgkin lymphoma is lower in CT (5.2 per 100,000) than in the U.S. (5.4 per 100,000).

# Incidence and Mortality by Race and Sex in Connecticut

## Heme Malignancies: Non-Hodgkin Lymphoma Incidence and Mortality Rates: Male

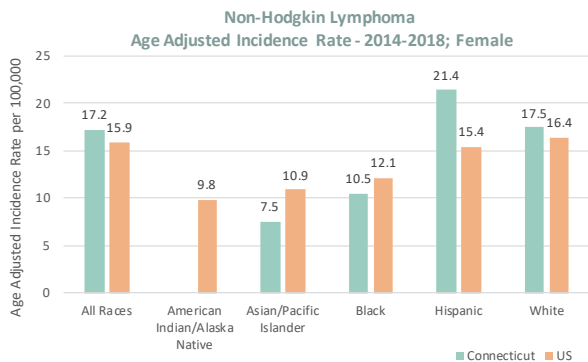


The age-adjusted incidence rate of non-Hodgkin lymphoma is greater in CT (25.3 per 100,000) than in the U.S. (23.1 per 100,000). Moreover, the incidence rate is greater among Hispanic males in CT (23.5 per 100,000) than for Hispanic males in the U.S. (20 per 100,000).

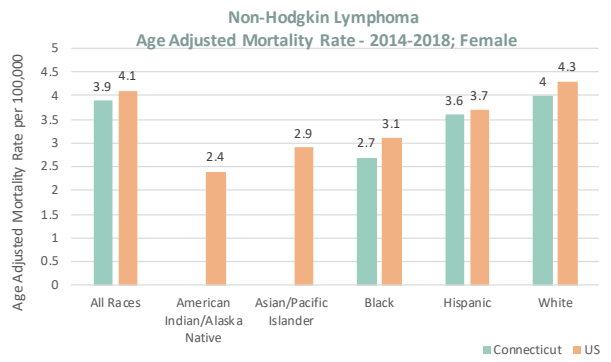


The age-adjusted mortality rate of non-Hodgkin lymphoma is the same for males in CT and in the U.S. (7 per 100,000).

## Incidence and Mortality Rates: Female



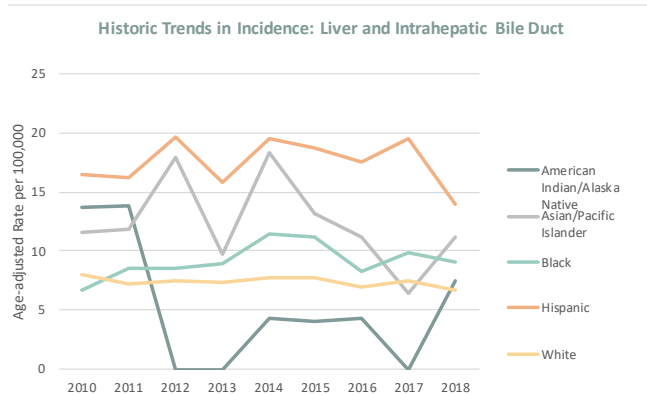
The age-adjusted incidence rate of non-Hodgkin lymphoma in females is greater in CT (17.2 per 100,000) than in the U.S. (15.9 per 100,000). Hispanic females in CT had a higher incidence rate (21.4 per 100,000) than Hispanic females in the U.S. (15.4 per 100,000), or any other racial group in CT.



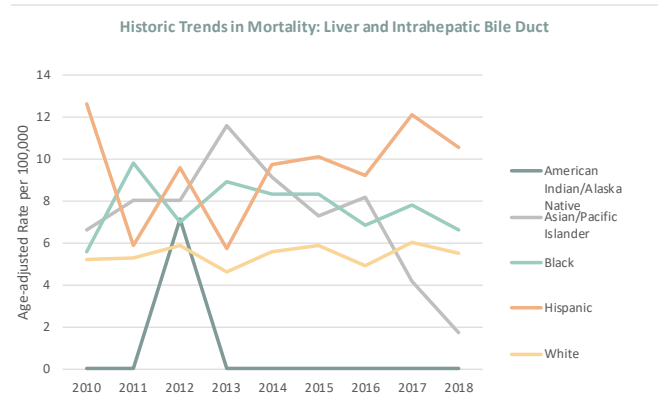
The age-adjusted mortality rate of non-Hodgkin lymphoma is lower for females in CT (3.9 per 100,000) than for females in the U.S. (4.1 per 100,000).

# Incidence and Mortality by Race and Sex in Connecticut

## Liver and Intrahepatic Bile Duct

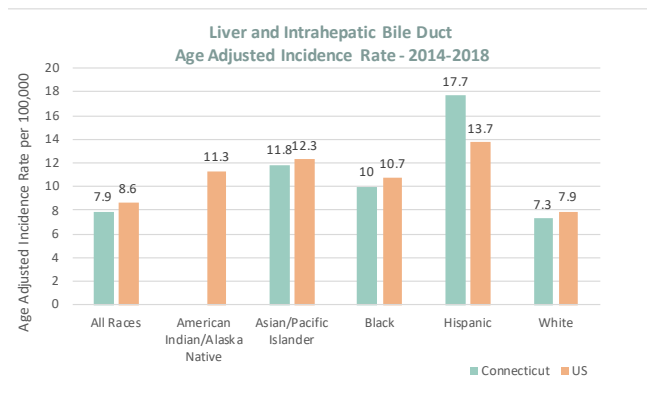


The incidence rate of liver and intrahepatic bile duct cancers has remained relatively stable between 2010 and 2018 across all racial categories.

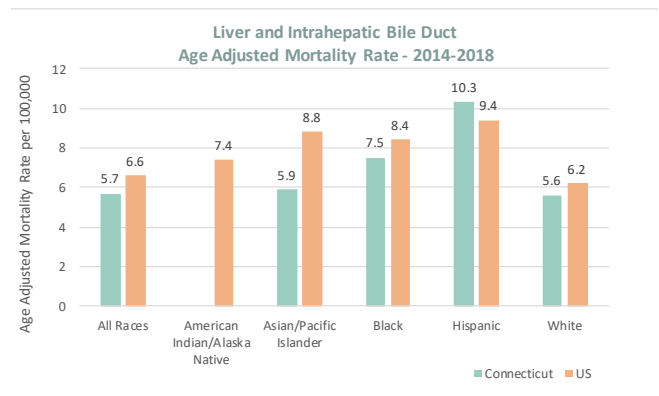


The mortality rate of liver and intrahepatic bile duct cancers has remained relatively stable between 2010 and 2018 across all racial categories.

## Age-Adjusted Incidence and Mortality Rates in CT versus US: Race/Ethnicity



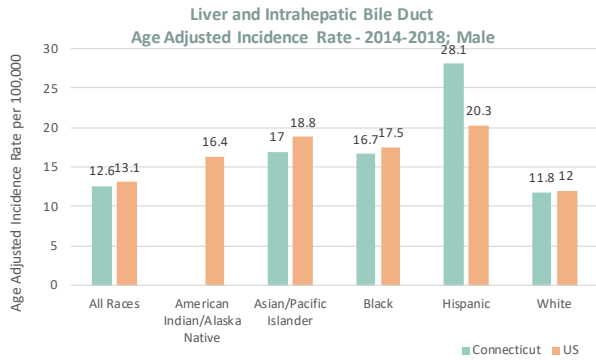
The age-adjusted incidence rate for liver and intrahepatic bile duct cancers is greatest among Hispanics in CT (17.7 per 100,000) and in the U.S. (13.7 per 100,000) compared to all other racial groups.



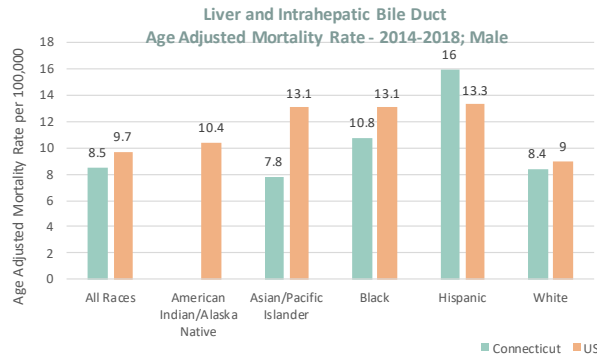
The age-adjusted mortality rate for liver and intrahepatic bile duct cancer is lower in CT (5.7 per 100,000) than in the U.S. (6.6 per 100,000). However, the mortality rate is greater among Hispanic CT residents (10.3 per 100,000) than among the U.S. Hispanic population (9.4 per 100,000). Hispanic individuals have the highest mortality rate across the state and country compared to all other racial groups.

# Incidence and Mortality by Race and Sex in Connecticut

## Liver and Intrahepatic Bile Duct Incidence and Mortality Rates: Male

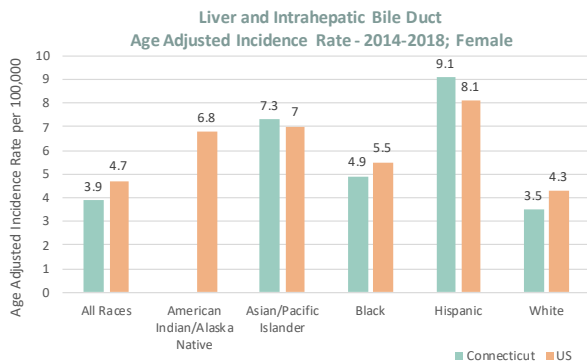


The age-adjusted incidence rate for liver and intrahepatic bile duct cancer in males is lower in CT (12.6 per 100,000) than in the U.S. (13.1 per 100,000). The incidence rate is greater among Hispanic males in CT (28.1 per 100,000) than in the U.S. (20.3 per 100,000).

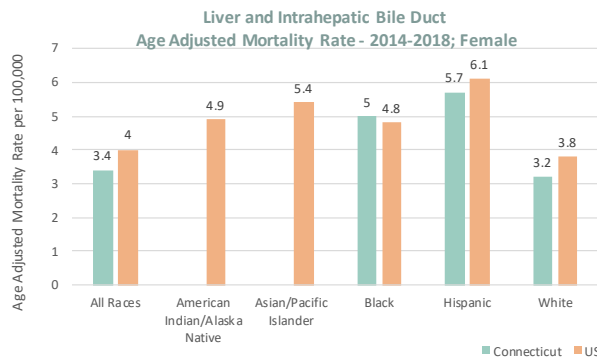


The age-adjusted mortality rate for liver and intrahepatic bile duct cancer in males is lower in CT (8.5 per 100,000) than in the U.S. (9.7 per 100,000). However, the mortality rate is greater among Hispanic males in CT (16 per 100,000) than in the U.S. (13.3 per 100,000). Hispanic males have the highest mortality rate across the state and country compared to all other racial groups.

## Incidence and Mortality Rates: Female



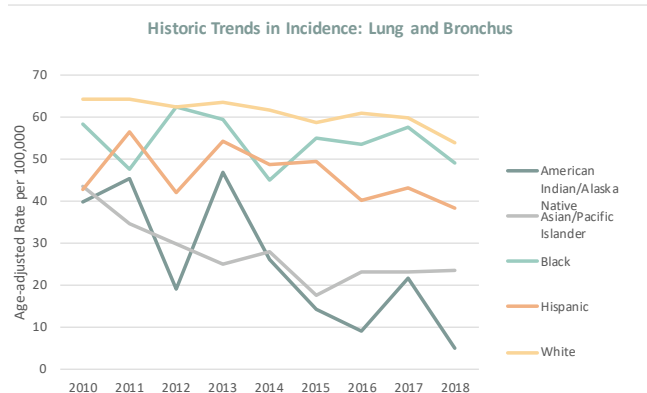
The age-adjusted incidence rate for liver and intrahepatic bile duct cancer in females is lower in CT (3.9 per 100,000) than in the U.S. (4.7 per 100,000). The incidence rate is greater among Hispanic females in CT (9.1 per 100,000) than in the U.S. (8.1 per 100,000).



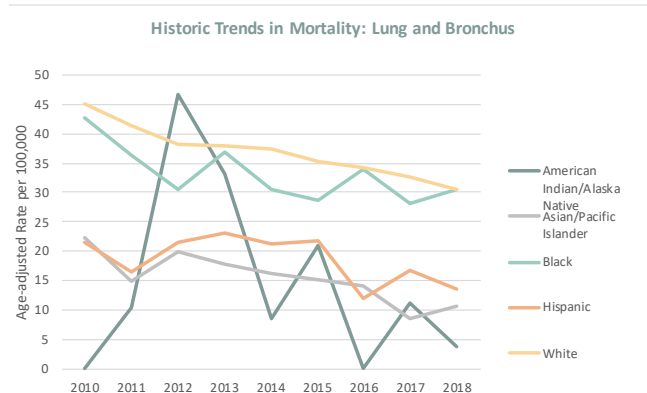
The age-adjusted mortality rate for liver and intrahepatic bile duct cancer in females is lower in CT (3.4 per 100,000) than in the U.S. (4 per 100,000). Hispanic females have the highest mortality rate across CT (5.7 per 100,000) and the U.S. (6.1 per 100,000) compared to all other racial groups.

# Incidence and Mortality by Race and Sex in Connecticut

## Lung and Bronchus

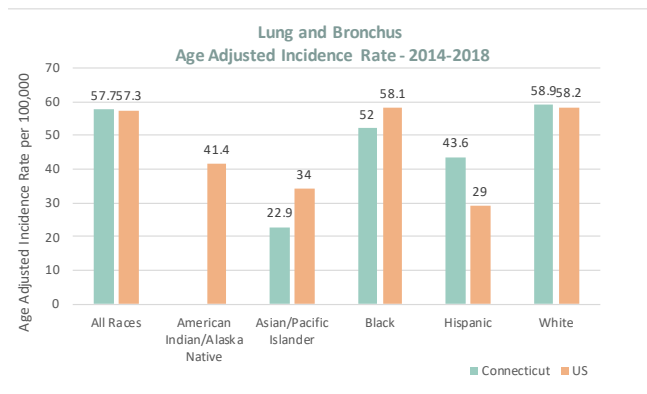


The incidence rate of lung and bronchus cancers has decreased between 2010 and 2018 across all racial categories.

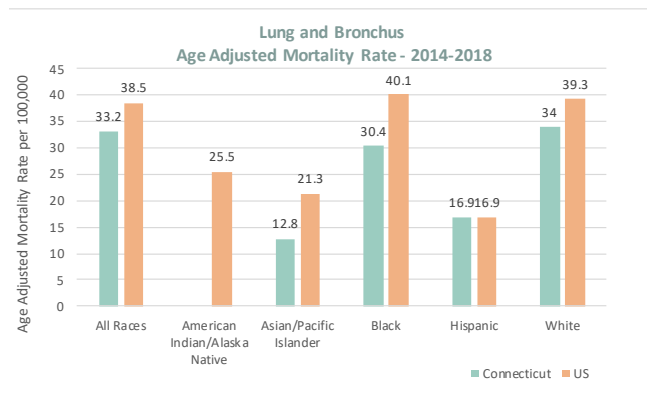


The mortality rate of long and bronchus cancer has decreased across all racial categories, with the exception of American Indian/Alaska Native, which has had a marginal net increase between 2010 and 2018.

## Age-Adjusted Incidence and Mortality Rates in CT versus US: Race/Ethnicity



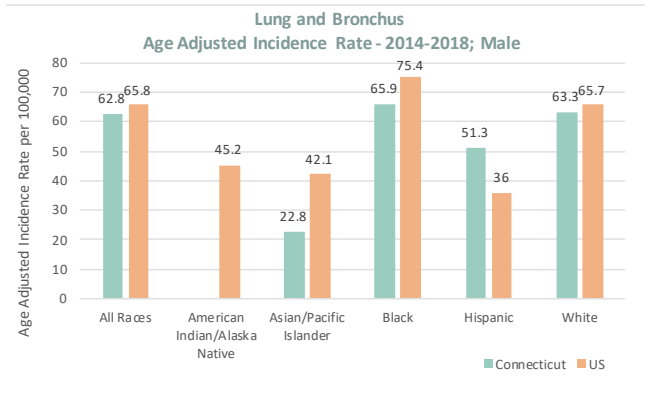
When lung and bronchus cancer age-adjusted incidence rate is split by race, data reveals that the incidence rate in CT (57.7%) is greater than that of the national average (57.3%). Of particular note, the incidence rate of Hispanic CT residents is 43.6%, compared to the U.S. average of 29%.



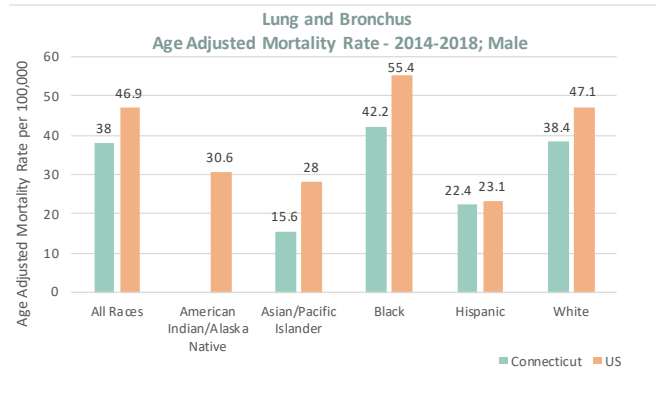
When lung and bronchus cancer age-adjusted mortality rate is split by race, the incidence rate in CT is lower than that of the national average. The mortality rate of Hispanic CT residents is relatively equal to the average for the U.S. Hispanic population.

# Incidence and Mortality by Race and Sex in Connecticut

## Lung and Bronchus Incidence and Mortality Rates: Male

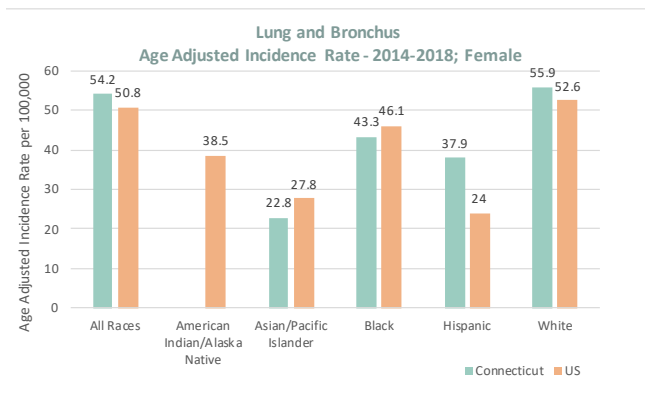


Black men have the highest age-adjusted incidence rate of lung cancer in CT (65.9 per 100,000). Hispanic men have a much higher incidence rate in CT (51.3 per 100,000) than the national Hispanic average (36 per 100,000).

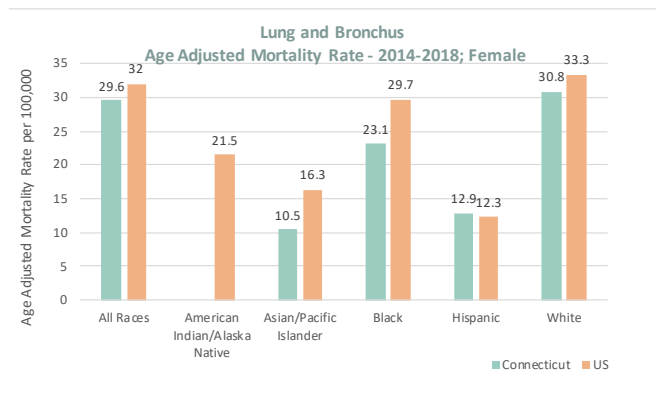


Black men have the highest age-adjusted mortality rate of lung and bronchus cancer in CT (42.2 per 100,000) and nationally (55.4 per 100,000).

## Incidence and Mortality Rates: Female



Hispanic women in CT have a much higher age-adjusted incidence rate of lung and bronchus cancer (37.9 per 100,000) than Hispanic women in the U.S. (24 per 100,000).

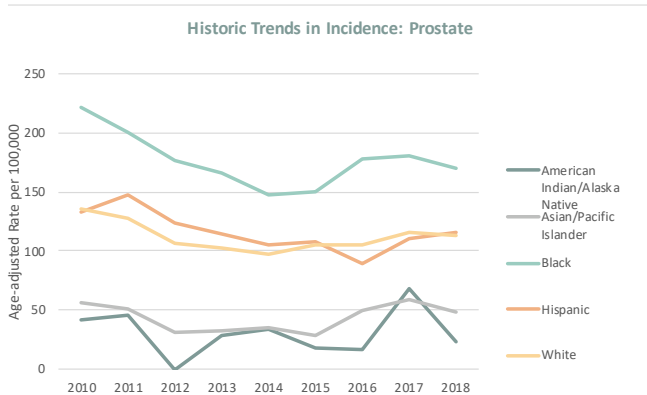


Hispanic women in CT have a slightly higher age-adjusted mortality rate of lung and bronchus cancer (12.9 per 100,000) than Hispanic women in the U.S. (12.3 per 100,000).

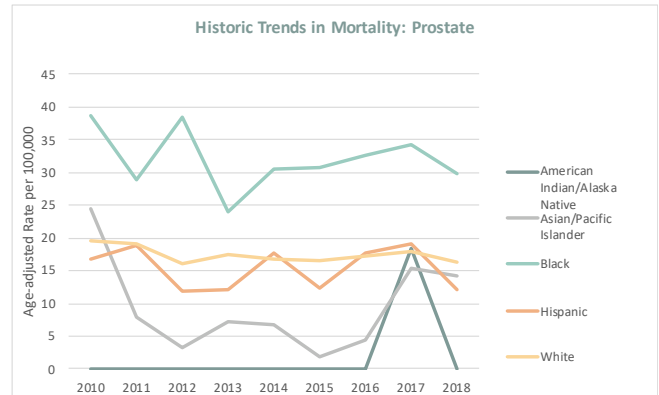


# Incidence and Mortality by Race and Sex in Connecticut

## Prostate

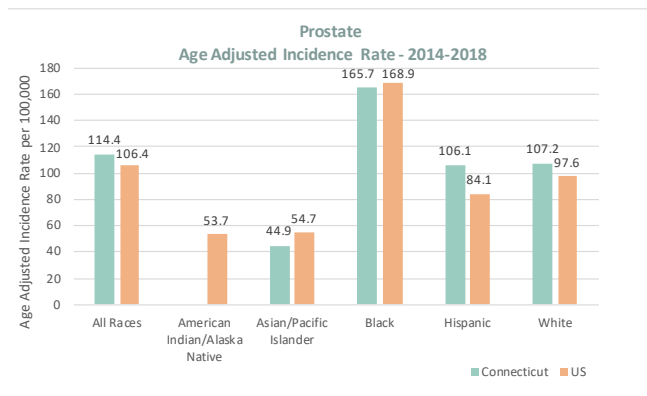


The incidence rate of prostate cancer has decreased across all racial categories between 2010 and 2018. Black men have the highest incidence rate across all racial categories.

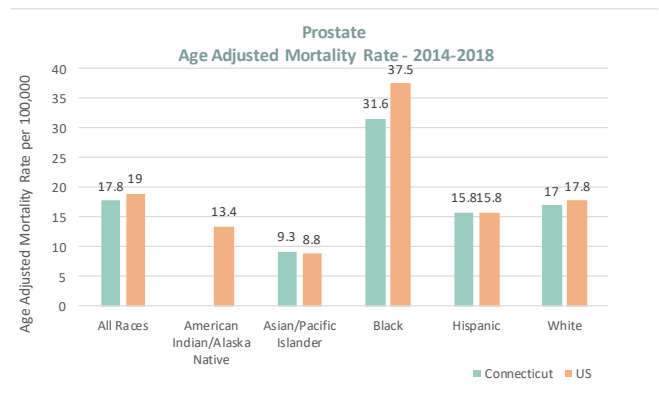


The mortality rate of prostate cancer has decreased across all racial categories between 2010 and 2018. Black men have the highest mortality rate among all racial categories.

## Age-Adjusted Incidence and Mortality Rates in CT versus US: Race/Ethnicity



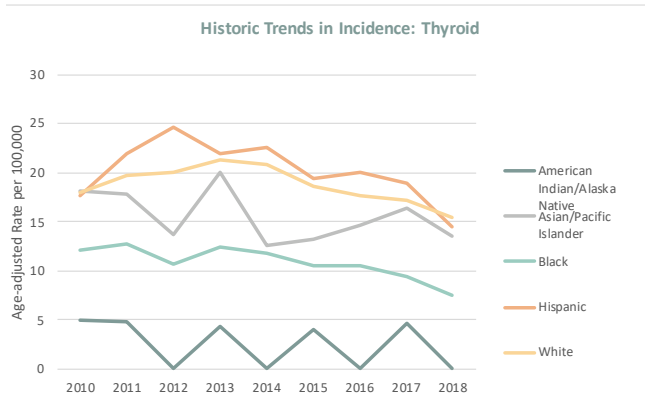
The age-adjusted incidence rate of prostate cancer is greater in CT than the national average. Black men have the highest incidence rate compared to all other races on the state and national level. The incidence rate for Hispanic CT residents is greater than the incidence rate for the U.S. Hispanic population.



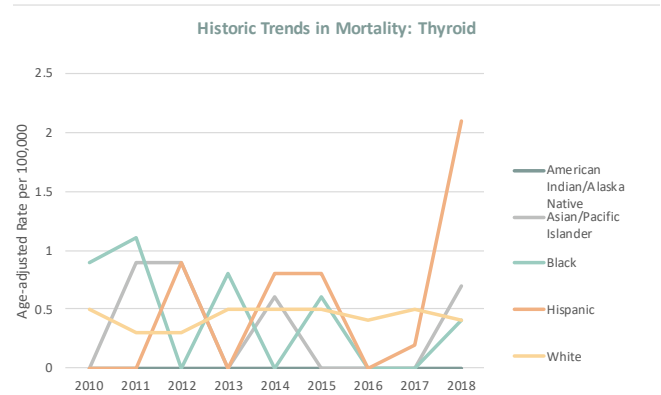
The age-adjusted mortality rate of prostate cancer is lower in CT (17.8 per 100,000) than in the U.S. (19 per 100,000). Black men have the highest age-adjusted prostate cancer mortality rate in CT (31.6 per 100,000) and in the U.S. (37.5 per 100,000).

# Incidence and Mortality by Race and Sex in Connecticut

## Thyroid

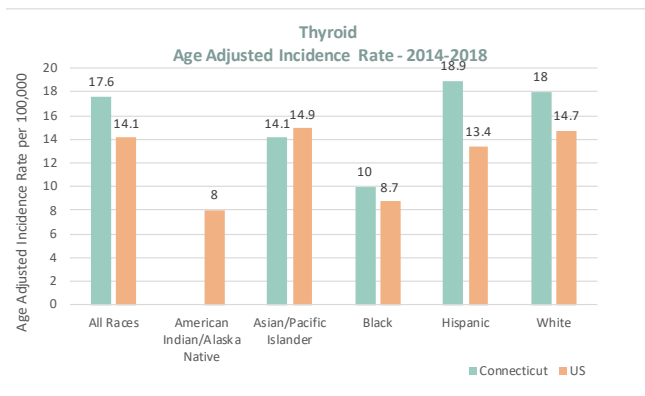


The incidence rate of thyroid cancers has decreased across all racial categories between 2010 and 2018.

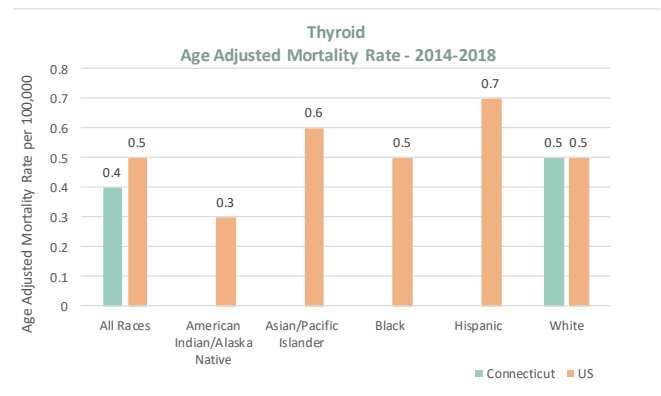


The mortality rate of thyroid cancers has remained steady between 2010 and 2018 across all racial categories. Hispanic people have the highest mortality rate across all racial categories in 2018, at roughly 2.1 per 100,000.

## Age-Adjusted Incidence and Mortality Rates in CT versus US: Race/Ethnicity



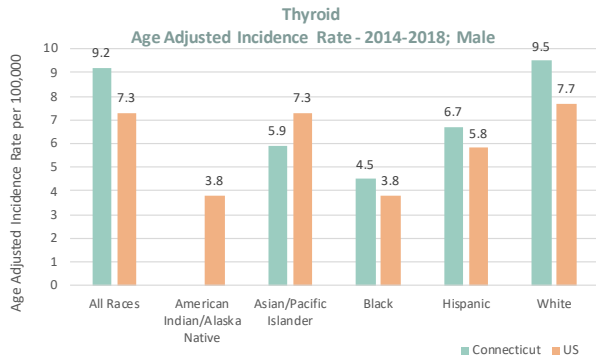
The age-adjusted incidence rate for thyroid cancer is greater in CT (17.6 per 100,000) than in the U.S. (14.1 per 100,000). It is highest among Hispanic CT residents (18.9 per 100,000) compared to all other racial groups and is higher than the incidence rate of the U.S. Hispanic population (13.4 per 100,000). The incidence rate is greater for Black people in CT (10 per 100,000) than in the U.S. (8.7 per 100,000).



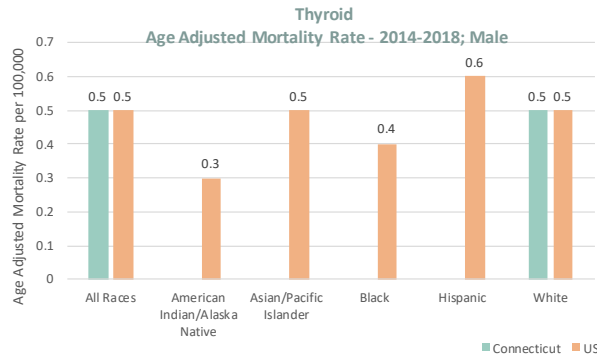
The age-adjusted mortality rate for thyroid cancer is lower in CT (0.4 per 100,000) than in the U.S. (0.5 per 100,000). In the U.S., Hispanic individuals had the highest mortality rate (0.7 per 100,000) compared to all other racial groups, followed by Asian/Pacific Islander individuals (0.6 per 100,000).

# Incidence and Mortality by Race and Sex in Connecticut

## Thyroid Incidence and Mortality Rates: Male

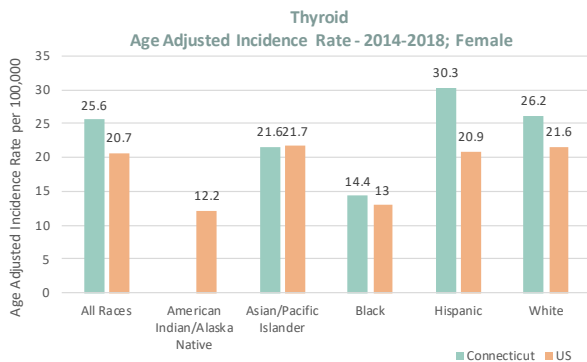


The age-adjusted incidence rate of thyroid cancer in males is greater in CT (9.2 per 100,000) than in the U.S. (7.3 per 100,000). Moreover, Hispanic males in CT had a higher incidence rate (6.7 per 100,000) than Hispanic males in the U.S. (5.8 per 100,000). Black males in CT also had a higher incidence rate (4.5 per 100,000) than Black males in the U.S. (3.8 per 100,000).

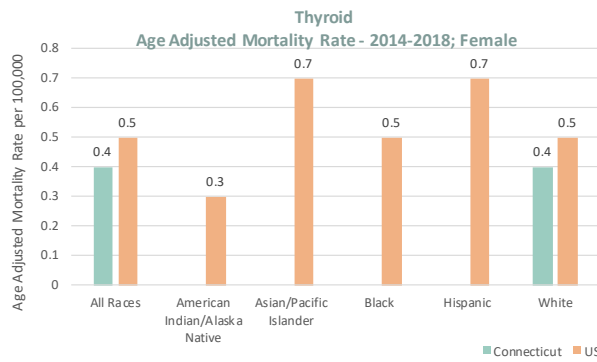


The age-adjusted mortality rate of thyroid cancer in males was equal in both CT and the U.S. (0.5 per 100,000). Hispanic males in the U.S. had the highest mortality rate compared to all other racial groups (0.6 per 100,000).

## Incidence and Mortality Rates: Female



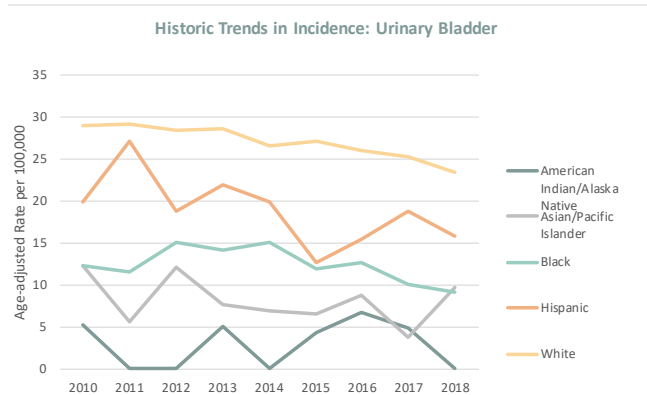
The age-adjusted incidence rate of thyroid cancer in females is greater in CT (25.6 per 100,000) than in the U.S. (20.7 per 100,000). Hispanic females in CT had a higher rate (30.3 per 100,000) than in the U.S. (20.9 per 100,000) and the highest rate compared to all other racial groups in CT. Black females in CT had a higher incidence rate (14.4 per 100,000) than in the U.S. (13 per 100,000).



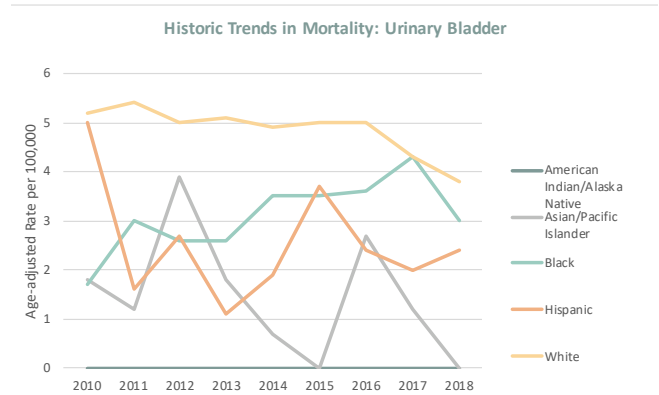
The age-adjusted mortality rate of thyroid cancer in females is greater in the U.S. (0.5 per 100,000) than in CT (0.4 per 100,000). Asian/Pacific Islanders and Hispanics had the highest mortality rate (0.7 per 100,000) compared to all other racial groups in the U.S.

# Incidence and Mortality by Race and Sex in Connecticut

## Urinary Bladder

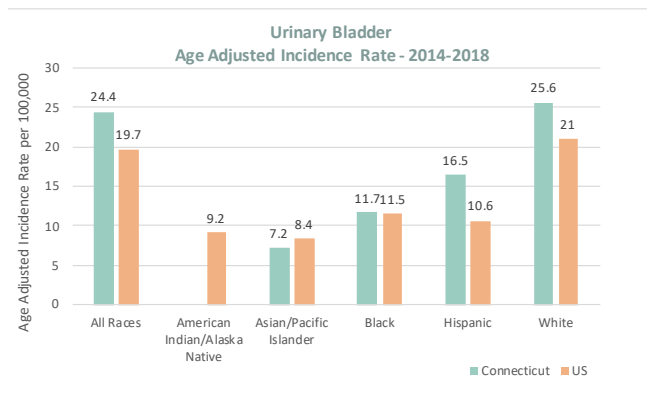


The incidence rate of urinary bladder cancer has decreased among all racial categories between 2010 and 2018.

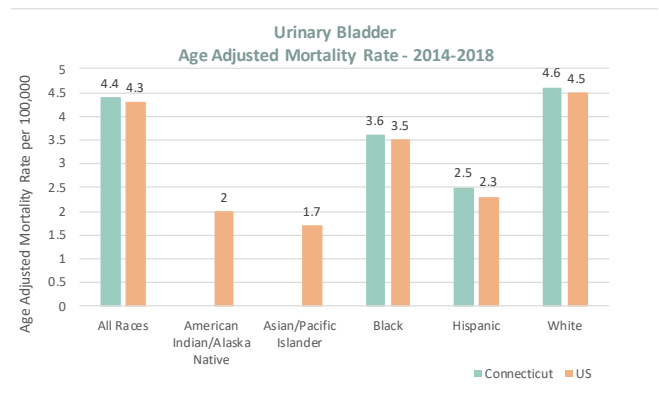


The mortality rate of urinary bladder cancers has remained steady among all racial categories between 2010 and 2018. In 2018, all mortality rates fell below 4 per 100,000.

## Age-Adjusted Incidence and Mortality Rates in CT versus US: Race/Ethnicity



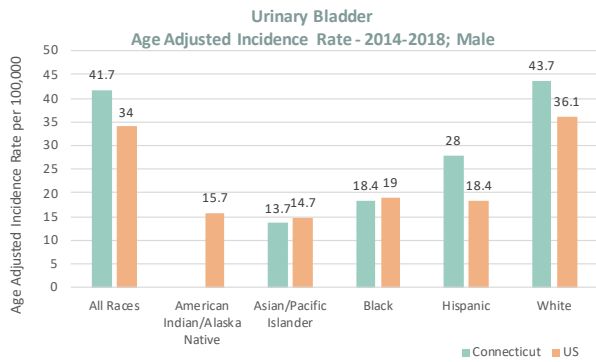
The age-adjusted incidence rate of urinary bladder cancer is greater in CT (24.4 per 100,000) than in the U.S. (19.7 per 100,000). The incidence rate is higher among Hispanic CT residents (16.5 per 100,000) and Black CT residents (11.7 per 100,000) compared to the Hispanic (10.6 per 100,000) and Black population (11.5 per 100,000) in the U.S.



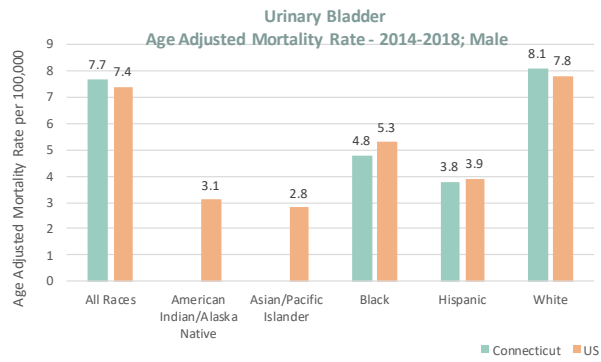
The age-adjusted mortality rate for urinary bladder cancer is greater in CT (4.4 per 100,000) than in the U.S. (4.3 per 100,000). The mortality rate is greater for Black people in CT (3.6 per 100,000) than for Black people in the U.S. (3.5 per 100,000). The mortality rate is greater for Hispanic CT residents (2.5 per 100,000) than for the U.S. Hispanic population (2.3 per 100,000).

# Incidence and Mortality by Race and Sex in Connecticut

## Urinary Bladder Incidence and Mortality Rates: Male

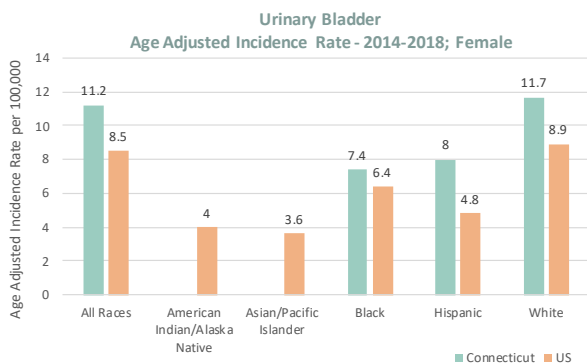


The age-adjusted incidence rate of urinary bladder cancer in males is greater in CT (41.7 per 100,000) than in the U.S. (34 per 100,000). Additionally, the incidence rate is greater among Hispanic males in CT (28 per 100,000) than in the U.S. (18.4 per 100,000).

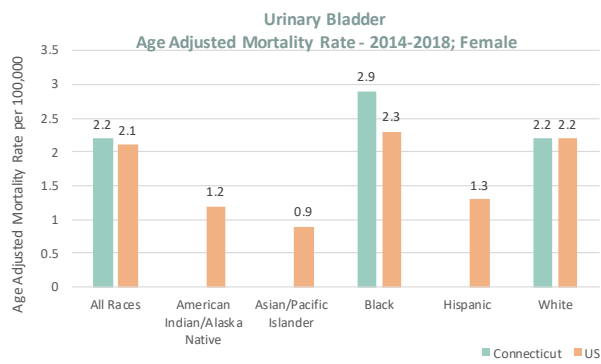


The age-adjusted mortality rate of urinary bladder cancer in males is greater in CT (7.7 per 100,000) than in the U.S. (7.4 per 100,000).

## Incidence and Mortality Rates: Female



The age-adjusted incidence rate of urinary bladder cancer in females is greater in CT (11.2 per 100,000) than in the U.S. (8.5 per 100,000). The incidence rate is greater among Hispanic females in CT (8 per 100,000) than in the U.S. (4.8 per 100,000). The incidence rate is greater among Black females in CT (7.4 per 100,000) than in the U.S. (6.4 per 100,000).



The age-adjusted mortality rate of urinary bladder cancer in females is greater in CT (2.2 per 100,000) than in the U.S. (2.1 per 100,000). Additionally, Black females had the highest mortality rate compared to all other racial groups in both CT (2.9 per 100,000) and in the U.S. (2.3 per 100,000).

## Center for Community Engagement and Health Equity

The Center for Community Engagement and Health Equity's mission is to bridge partnerships between patients, communities, scientists, and providers and use data-driven approaches to achieve equitable care delivery and research across the cancer care continuum. We offer professional development, tools, and services to support this mission. If you would like more information about how to get involved, please contact [Jessica.Lewis@yale.edu](mailto:Jessica.Lewis@yale.edu).

YaleNewHavenHealth  
Smilow Cancer Hospital

Yale CANCER  
CENTER  
A Comprehensive Cancer Center Designated  
by the National Cancer Institute

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