HEALTH
EQUITY
SOLUTIONS

Testimony Supporting S.B. No. 1: An Act Equalizing Comprehensive Access to Mental, Behavioral and Physical Health Care in Response to the Pandemic

Tekisha Dwan Everette, PhD
Public Health Committee
March 17, 2021

Dear Senator Abrams, Representative Steinberg, and esteemed members of the Public Health Committee,

My name is Tekisha Dwan Everette and I am testifying today in my role as the Executive Director of Health Equity Solutions (HES). Health Equity Solutions is a nonprofit organization with a statewide focus on promoting policies, programs, and practices that result in equitable health care access, delivery, and outcomes for all people in Connecticut. Our vision is for every Connecticut resident to attain optimal health regardless of race, ethnicity, or socioeconomic status.

HES strongly supports S.B. 1: An Act Equalizing Comprehensive Access to Mental, Behavioral and Physical Health Care in Response to the Pandemic and, in particular, the sections that **declare racism a public health crisis; define the doula profession; standardize race, ethnicity, and language data; and strengthen the state's community benefit regulations**. Each of these provisions has the potential to advance health equity in our state and all are timely and needed responses to the pandemic's exacerbation of already wide disparities experienced by Connecticut residents.

Systemic racism is the root cause of health inequities and, in turn, the longstanding and widespread burden of death and disease that predates and will outlast the deep inequities experienced by Black, Indigenous, Latinx, and other people of color during this pandemic. Due to structural racism and its resultant outcomes, Black, Indigenous, Latinx, and other people of color in Connecticut are more likely to live in densely populated neighborhoods, work wage-based jobs, have less wealth, and suffer from chronic health conditions such as asthma and diabetes.[1, 2, 3] These longstanding injustices have resulted in a disproportionate toll of the social, physical, and economic hardships of the pandemic, including COVID-19 death and disease, falling on people of color.

---

[1] DataHaven. *Towards Health Equity in Connecticut*. Retrieved from https://ctdatahaven.org/sites/ctdatahaven/files/DataHaven%20Health%20Equity%20Connecticut%20061820.pdf

[2] Centers for Disease Control and Prevention, *African American Health Creating equal opportunities for health.* Retrieved from https://www.cdc.gov/vitalsigns/aahealth/index.html#:~:text=The%20death%20rate%20for%20African%20Americans%20decreased%2025%25%20from%201999,high%20blood%20pressure%20than%20whites.

[3] John Hopkins Center for Health Equity, *The State of Black America*. Retrieved from https://soba.iamempowered.com/sites/soba.iamempowered.com/files/Johns%20Hopkins%20Report%20PDF%20Download%20SOBA%202020.pdf

Sections 6 & 7: Declaring racism a public health crisis

A declaration that racism is a public health crisis is a commitment to intentionally anti-racist policymaking. Racism is ingrained in our policies, processes, and ways of being. This declaration and the actions that immediately follow are the first steps in dismantling the racism in our systems and engaging in the long-term process of embedding anti-racism in governance in Connecticut.

In response to the public outcry against racist violence and the unjust toll of the pandemic, HES has worked with partners across the state since June to call on all levels of government to declare racism a public health crisis and take steps to dismantle it. 20 Connecticut municipalities and the Mashantucket Pequot Tribal Nation have joined over 180 local, county, and state governments across the U.S. in making this declaration. We urge the Connecticut General Assembly to recognize racism as the public health crisis it is and create structural and procedural changes to embed health equity into government decision-making processes.

Preventable death and disease continue to disproportionately impact people of color because of our collective failure to address the consequences of systemic racism. **We must acknowledge the problem AND address it.**

HES respectfully recommends the following to further embed an equity lens in governance:

1. Establish a staffed commission in the executive branch to create and maintain a health equity in all policies (HEiAP)[4] approach and to convene a council to develop and implement a comprehensive, cross-sectoral strategic plan to eliminate health disparities and inequities and to improve the efficiency, cost-effectiveness, and collaborative work of state government. Health in All Policies approaches in at least five other states have increased the prominence of health equity as a policy concern.[5] Centering equity in the approach can strengthen this. A transformational approach to community engagement[6] would ensure policy recommendations meet the needs of people experiencing inequities. Any work to address systemic racism should require meaningful community participation from diverse racial, ethnic, sexual orientation, gender identity, and disability status groups who experience inequities in health. In our testimony below on the community benefit provisions of S.B. 1, we include recommended language for defining "meaningful participation."
2. Make resources available for racial and ethnic impact assessments to be completed on any proposed bill. Dedicated staff would make this a robust and meaningful part of the legislative process.
3. Review and make recommendations to embed equity in existing policies and practices overseen by the Connecticut General Assembly.
4. Adjust Section 15 to analyze **disparities** in the distribution of resources during the pandemic and make recommendations to remedy these. Consider, for example, disparities in enrollment in

---

[4] For information about Health in All Policies approaches in other states and localities, see the American Public Health Association: https://www.apha.org/topics-and-issues/health-in-all-policies

[5] Hall R. & Jacobson P. (2018) "Examining Whether the Health-In-All-Policies Approach Promotes Health Equity." *Health Affairs*. Doi: https://doi.org/10.1377/hlthaff.2017.1292

[6] Curren R., Nelson, J., Marsh, D.S., Noor, S., Liu, N. "Racial Equity Action Plans, A How-to Manual.": Haas Institute for a Fair and Inclusive Society, University of California, Berkeley, 2016.

Medicaid, SNAP, unemployment benefits, business and housing loans, vaccine doses, federal funding across sectors, and so on.

Section 10: Defining the doula profession

HES strongly supports defining the doula profession and the study to determine whether the Department of Public Health should establish a state certification process for doulas.

A doula is a birthing professional who provides physical and emotional support to an individual who is pregnant, in labor, or who has recently given birth. Doulas empower pregnant people to have safe and informed birthing experiences by providing comfort, care, and safety before, during, and after birth. Doulas can specialize in areas such as postpartum, fertility, adoption, end-of-life, and bereavement, and have a variety of evidence-based skillsets to support the birthing person, newborn, and family. Increasing equitable access to doula care services, particularly in minoritized communities, has been shown to improve outcomes for both mothers and newborns.[7,8,9]

Safety is critically important, especially for Black and Latino families and infants of color who experience disproportionately high rates of complications, morbidity, and mortality related to birth. Among high-income countries, the United States consistently faces the worst rate of pregnancy/childbirth-related deaths.[10] Black women are more than three times as likely to die during or related to pregnancy than white women, regardless of socioeconomic status.[11] In Connecticut, the maternal mortality rate is rising at an alarming pace and the maternal mortality rate for Black women is 48.0, compared to 14.8 for white women.[12] Doulas and the care they provide can mitigate these disparities.

Studies have shown that doula care improves health outcomes for both birthing adults and babies. For example, doula care is associated with lower rates of postpartum depression and of costly interventions like cesarean births, while increasing the likelihood of a shorter labor, a spontaneous vaginal birth,

---

[7] Strauss N, Giessler K, McAllister E. How Doula Care Can Advance the Goals of the Affordable Care Act: A Snapshot From New York City. J Perinat Educ 2015;24(1):8-15.

[8] Thomas MP, Ammann G, Brazier E, Noyes P, Maybank A. Doula Services Within a Healthy Start Program: Increasing Access for an Underserved Population. Matern Child Health J 2017;21(Suppl 1):59-64.

[9] Kozhimannil KB, Vogelsang CA, Hardeman RR, Prasad S. Disrupting the Pathways of Social Determinants of Health: Doula Support during Pregnancy and Childbirth. J Am Board Fam Med 2016;29(3):308-17. 21.

[10] UNICEF Data. Monitoring the situation of women and Children. Available at: https://data.unicef.org/topic/maternalhealth/maternal-mortality/

[11] Center for Disease Control and Prevention. Pregnancy-Related Deaths. Retrieved from: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm

[12] America's Health Rankings. Available at: https://www.americashealthrankings.org/explore/health-of-women-andchildren/measure/maternal_mortality_a/population/maternal_mortality_a_black/state/CT

higher Apgar[13] scores for babies, and positive childbirth experiences.[14] Patients who have had a doula have reported feeling valued and having had a voice in consequential childbirth decisions.[15, 16]

HES believes that moving towards more equitable access to doulas starts by defining the doula profession and respectfully recommends that lines 204-207 reflect that "doula" means a trained, nonmedical professional who provides physical, emotional, and informational support to a pregnant person before, during, and after birth, in person or virtually.

Section 17: Standardizing the collection of race, ethnicity, and language data

HES strongly supports standardizing the collection of race, ethnicity, and language data by the state. Race, ethnicity, and language (REL) data is a critical component of evaluating disparities health outcomes and promoting equity. We cannot claim to be addressing inequities in health if we are not measuring disparities to hold ourselves accountable. By consistently collecting and publishing health data broken down by race, ethnicity, and primary language the state can recognize and work to address how, where, and for whom disparities occur.

Why is REL data collection important, especially now? The collection, processing, analyzing, and sharing of REL data is critical to identifying disparities, applying for funding, directing resources and planning, as well as targeting and evaluating interventions and services. As has been made abundantly clear in recent months, race, ethnicity, and age data are necessary during a pandemic to ensure that resources are targeted to the hardest hit communities. ***Without REL data, decisionmakers are drawn to one-size-fits-most solutions, which are likely to exacerbate the racial inequities that are deeply ingrained in our status quo***. Health inequities are rooted in structural inequality that has privileged some individuals and communities and disenfranchised others.

REL data provides us with the information we need to intentionally address systemic racism. For example, recently released COVID-19 vaccination data[17] highlights enormous disparities in vaccine administration in Connecticut. Even when assessing vaccine distribution by race and age to account for the higher proportion of older adults who are white, Black residents of our state are both disproportionately unvaccinated and disproportionately likely to suffer serious illness and death from COVID-19.[18] A targeted and culturally sensitive approach could ameliorate this inequity. Having this data

---

[13] Apgar stands for "Appearance, Pulse, Grimace, Activity, and Respiration," and is used to evaluate a newborn's health. See: https://kidshealth.org/en/parents/apgar.html

[14] Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health (2016). Retrieved from https://www.nationalpartnership.org/our-work/resources/health-care/maternity/overdue-medicaid-and-privateinsurance-coverage-of-doula-care-to-strengthen-maternal-and-infant-health-issue-brief.pdf

[15] Gruber, K. J., Cupito, S. H., & Dobson, C. F. (2013). Impact of doulas on healthy birth outcomes. The Journal of perinatal education, 22(1), 49–58. https://doi.org/10.1891/1058-1243.22.1.49

[16] Hofmeyr GJ, Nikodem VC, Wolman WL, Chalmers BE, Kramer T. Companionship to modify the clinical birth environment: effects on progress and perceptions of labour, and breastfeeding. Br J Obstet Gynaecol. 1991 Aug;98(8):756-64. doi: 10.1111/j.1471-0528.1991.tb13479.x. PMID: 1911582.

[17] CT Department of Public Health Immunization Program. *COVID-19 Vaccine Distribution in Connecticut—Update for 2/25/2021*. Retrieved from: https://data.ct.gov/stories/s/CoVP-COVID-Vaccine-Distribution-Data/bhcd-4mnv/

[18] Connecticut Open Data. *Connecticut Daily COVID-19 Update for 3/15/2021*. Retrieved from https://data.ct.gov/stories/s/q5as-kyim

allows the state to evaluate whether or not efforts to promote equity in vaccine allocation are successful and to course correct as necessary.

While a preponderance of scientific research concludes that race has no biological value, its relevance to the lived experiences of individuals in our society makes REL data a necessary tool in efforts to dismantle systemic racism. Efforts to standardize and collect this data are not new, though this issue has seen a resurgence in interest as we grapple with increased awareness of systemic inequities and calls for anti-racist policymaking.[19]

A recent report found that the five Connecticut state agencies examined by the research team each collected a different set of race and ethnicity categories.[20] If the state collected data in a standardized manner, cross-sector efforts to identify and address inequities would be more efficient and meaningful. Further, this would enhance the state's ability to match data sets so that information on a person's racial and ethnic identity can be collected once and then matched with data collected for other purposes and used, in keeping with the strict privacy protections already in place in our state, to advance health equity, evaluate our progress towards this goal, and course correct as necessary. Consider, for example, how importing REL data into COVID-19 case reporting and contact tracing efforts could have simplified one administrative hurdle to tracking equity during the pandemic and shortened the contact tracing questionnaire.

Leveraging categories for REL data collection that were research and field-tested under Connecticut's State Innovation Model Community and Clinical Integration Program (CCIP), as proposed in S.B. 1, will lead to a standard set of categories that reflect the identities of Connecticut's population. These categories were collected by participating entities in the CCIP project and research on the categories was presented to the Office of Health Strategy in late 2018.[21] Since these categories have been tested by health providers in Connecticut, we know that collection of them is feasible. The CCIP categories offer a subset of options for each of the standard, large, race and ethnicity categories. For example, using the CCIP categories an individual could identify themselves as Arab, European, Portuguese, or Middle Eastern/Northern African rather than only having the option to identify as white or skip the question. The categories collected in the CCIP roll up to the Office of Management and Budget categories utilized in some federal reporting so that there is no need for complex data consolidation for reporting. In other words, these categories are specific enough to increase the likelihood of Connecticut residents seeing their identities reflected in the categories and completing the race and ethnicity section of a form without adding administrative complexity.

Stringent guidelines are in place for the utilization of health data in our state.[22] Specifically, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), protects health data. Further, state data management regulations suppress reporting any category with very small numbers to avoid unintentionally exposing the information of one individual or family unit. Finally, should there be any

---

[19] Siegel, Karen. 2018. *Data to Promote Health Equity for Children and Families in Connecticut*. Connecticut Voices for Children. New Haven, CT. Retrieved from: https://ctvoices.org/wp-content/uploads/2018/02/Data-for-Health-Equity-FINAL.pdf

[20] Health Equity Data Analytics. 2020. Policy Recommendations Report: September 2020. Retrieved from: https://portal.ct.gov/-/media/OHS/docs/HEDA-Recommendations_-Sept2020.pdf

[21] Health Equity Solutions. 2018. Recommendations for Granular Race & Ethnicity Data Collection. Presented to State Innovation Model Program Staff on November 2, 2018. Report available upon request.

[22] See the Office of the Attorney General's Privacy and Data Security Department: https://portal.ct.gov/AG/Departments/Privacy/The-Privacy-and-Data-Security-Department

risk of this data being misused, organizations such as HES and our partners would immediately raise concerns with the responsible entity. **The reality is that REL data is already routinely collected and kept private by health care providers and state agencies**. This proposal simply standardizes how these existing processes are carried out so that the data can more effectively be used to promote equity at the population level.

Without uniform, consistently collected and reported data on race, ethnicity, and primary language data it is impossible to effectively and fairly allocate state resources or to track progress in resolving disparities in health and well-being. Clear guidance on data collection now has the potential to facilitate intentionally antiracist policies, processes, and actions in the near term and well into the future.

Section 18: Strengthening Connecticut's community benefit requirements

HES strongly supports these efforts to strengthen Connecticut's community benefit program requirements. Tying community benefit spending to needs identified by communities in community health needs assessments (CHNAs) is a promising strategy for advancing health equity. This strategy aligns community investments with initiatives that address underlying barriers to health. Greater community benefit program spending has been associated with lower hospital readmission rates,[23] which can lead to tangible reductions in health care costs and signify improved health.

Over 14 states (including: OR, CA, ID, MA, WA, RI, IL, NV, PA, TX, UT, MD, ME, and VT) have passed laws outlining community benefit spending requirements and/or reporting standards that go beyond the federal IRS standards. Connecticut has an opportunity to learn from the experiences of other states and leverage community benefit programs as a tool to advance equity.

The community benefit program was designed as a required accountability mechanism for nonprofit hospitals to contribute to the wellbeing of their communities in lieu of their contributions to state and federal income and property taxes that would otherwise fund local resources and the education system.[24] Since triannual CHNAs are already a federally required process and recognized as a tool for health equity [25, 26, 27] ***linking these existing programs adds accountability without adding burden***. In other words, this proposal ties community benefit to data on and input already gathered from the hospital's community.

Currently, the largest share of community benefit dollars is spent on financial community benefits, with these dollars going directly back to the hospital to make up for the costs of care provided to un- and

---

[23] Chaiyachati, K. H., Qi, M., & Werner, R. M. (2020). Nonprofit hospital community benefit spending and readmission rates. Population health management, 23(1), 85-91.

[24] Rubin DB, Singh SR, Young GJ. Tax-exempt hospitals and community benefit: new directions in policy and practice. Annu Rev Public Health. 2015;36:545–57.

[25] Ainsworth D, Diaz H, Schmidtlein MC. Getting more for your money: designing community needs assessments to build collaboration and capacity in hospital system community benefit work. Health Promot Pract. 2013;14(6):868–75.

[26] Cain CL, Orionzi D, O'Brien M, Trahan L. The power of community voices for enhancing community health needs assessments. Health Promot Pract. 2016;18(3):437–43.

[27] Mathews AL, Coyle BS, Deegan MM. Building community while comply-ing with the Affordable Care Act in the Lehigh Valley of Pennsylvania. Prog Community Health Partnersh. 2015;9(1):101–12.

under-insured people.[28] Examples of spending on non-financial community benefits include lead abatement, supportive housing, legal aid, community health advocacy, and coalition building.[29]

Community benefit spending, as reported on the IRS 990 Form H, has decreased across the country since the enactment of the Affordable Care Act (ACA). Much of this reduction in community benefit spending reflects higher insurance coverage rates following the passage of the ACA and a corresponding decrease in the need for subsidized and free healthcare. However, community benefit spending in other areas has not increased to make up for this reduction.[30]

The range of spending on non-financial community benefits among Connecticut hospitals is meant to depend, in part, on the social, economic, and health needs of the population served by each hospital. Developing a unique spending floor requirement based on previous trends in spending, priorities identified in the CHNA, and each hospital's financial performance provides a minimum threshold that is tailored and responsive to a hospital's individual circumstances. This approach increases transparency and is calibrated to avoid any undo burden on our hospitals. For example, this process accounts for hospitals' proportion of uninsured patients, which has been linked to lower community health improvement spending.[31]

Effectively, **S.B. 1 proposes aligning existing processes for a more coordinated, impactful, and community-responsive approach that recognizes and further supports hospitals in serving as "anchor institutions" that work to help address costly health inequities in their communities.**[32]

The pandemic and related disproportionate rates of COVID-19 infection and death experienced by Black, Indigenous, and Latino communities have demonstrated the need for and value of local resources to maintain health in times of vulnerability.[33,34] Setting aside a minimum amount of community benefit dollars to address health disparities and social determinants of health ensures that nonprofit hospitals' reinvestments stay local and help to support needed community resources. As it stands, Connecticut sees a robust level of investment via community benefit spending programs. ***These proposed changes***

---

[28] *FY 2018 tax returns from Connecticut nonprofit hospitals*

[29] Catholic Health Association. (2020). *Community Benefit Categories and Definitions*. https://www.chausa.org/docs/default-source/community-benefit/guide-for-planning-2020/cb_guide-for-planning_2020_categories_and_definitions.pdf?sfvrsn=0

[30] Genevieve Kanter et al., *Association of State Medicaid Expansion with Hospital Community Benefit Spending*, JAMA NETWORK OPEN (May 29, 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766544.

[31] Geri Cramer et al., *The Progress of U.S. Hospitals in Addressing Community Health Needs*, 107 AM. J. PUB. HEALTH 2 (2017), 255-261.

[32] Economic Studies at BROOKINGS. *Hospitals as Community Hubs: Integrating Community Benefit Spending, Community Health Needs Assessment, and Community Health Improvement.* Retrieved from https://www.brookings.edu/wp-content/uploads/2016/07/Rosenbaum-PDF-Layout-FINAL-1.pdf

[33] Putterman, A. (2020, April 8). Black and Latino residents hit particularly hard by COVID-19 in Connecticut, as experts fear disparities will widen. *Hartford Courant*. https://www.courant.com/coronavirus/hc-news-coronavirus-covid-19-racial-disparities-0407-20200408-jsrg2au2fnab5fbxhpu4ioqmb4-story.html

[34] Hatcher SM, Agnew-Brune C, Anderson M, et al. COVID-19 Among American Indian and Alaska Native Persons — 23 States, January 31–July 3, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1166–1169. DOI: http://dx.doi.org/10.15585/mmwr.mm6934e1

strengthen clarity and create a reporting system so that the impact of these programs can be better understood. At present, it can be challenging to parse the human impact of these programs because of the IRS-focused reporting structure.

Clear and detailed information through standardized reporting requirements improves nonprofit hospitals' accountability to the communities they serve and better highlights their investments in them. Currently, the IRS defines community benefit spending categories; however, the federal guidance is ambiguous.[35] As a result, it is difficult to compare community benefit programs across hospitals, fully understand which programs and partners were included, or identify hospitals' work to support community health. The proposed reporting standards for CHNAs and community benefit programs are critical for improving transparency and targeting disparities unique to each hospital's service area.

HES respectfully recommends the following:

- **Define "meaningful participation"** to set a standard for soliciting community input and engagement for CHNAs and community benefit programs. The IRS offers a sweeping description of "Input Representing the Broad Interests of the Community,"[36] leaving the program without a common or measurable definition of how communities are engaged to participate in these processes. Clarifying this element will ensure these processes are comparable across hospitals. Suggested possible definition:
    - *"Meaningful participation" means that (1) residents of a hospital's community, defined pursuant to Section XX, shall have an appropriate opportunity to participate in decisions about that hospital's CHNA practices and implementation strategy (2) such participation adequately represents and reflects all subcommunities served by the hospital, including those populations facing the greatest health disparities relative to the community as a whole considering race, ethnicity, language, disability status, sexual orientation, and gender identities; (3) the public's participation shall influence the hospital's CHNA and implementation strategy; and (4) the hospital conducting the CHNA shall seek out and facilitate the participation of those potentially affected by its community benefits spending.*
- **Specify demographic data reporting requirements** to include population-level data already collected by hospitals on demographic factors associated with health disparities, including race, ethnicity, primary language, disability status, sexual orientation, and gender identity. This data can serve as basis for partnership and collaboration with community-based organizations skilled and engaged in addressing social determinants of health through culturally and linguistically appropriate approaches.[37]
- **Solicit public feedback via an annual public comment period** on the OHS summary and analysis of community benefits program reports. This ensures an opportunity for communities and stakeholders to provide input and serves as an accountability and transparency mechanism to respond to stakeholder recommendations whether or not they are adopted. In other words, this is a relatively simple way of creating a sustained feedback loop among hospitals, the Office of Health Strategy, and consumers.

---

[35] Health Affairs. *Modifying Hospital Community Benefit Tax Policy: Easing Regulation, Advancing Population Health.* Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20161201.057691/full/

[36] IRS. *Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3).* Retrieved from https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

[37] Carroll-Scott, A., Henson, R. M., Kolker, J., & Purtle, J. (2017). The role of nonprofit hospitals in identifying and addressing health inequities in cities. *Health Affairs*, *36*(6), 1102-1109

Stronger community benefit standards can help to elevate opportunities for all Connecticut residents to attain their optimal health. The spending floor, reporting standards, and our suggested changes promote fairness and transparency. They also promote health equity by encouraging upstream investments to alleviate social and economic inequities (e.g. housing and food insecurity, uninsurance) that drive disparate health outcomes (e.g. maternal mortality, diabetes, life expectancy) for Black, Indigenous, Latino, Asian, and other people of color in our state.

Additional Sections of SB 1

Section 4: HES strongly supports efforts to learn collectively from the disparate impact of the COVID-19 pandemic and respectfully suggests this study include an analysis of the distribution of federal funding, particularly to health care providers who serve disproportionate numbers of low-income households and people of color.

Section 11 & 12: HES supports requiring implicit bias training for hospital staff interacting with pregnant or postpartum individuals (though cultural humility training—an approach to ongoing learning and questions of biases is preferred) as well as studying racial disparities in maternal mortality and morbidity.

Section 33: By meeting children where they are, school-based health centers remove barriers to medical, oral, and behavioral health care. These sites help children focus on school by addressing distractions such as dental pain, asthma, and behavioral health needs. Further, because Black, Indigenous, and other children of color are more likely to both lack access to a regular source of medical care and to suffer from chronic health problems, school-based health centers are an important tool in promoting health equity.[38] HES strongly supports expanding services of existing school-based health centers and establishing new school-based health centers.

Thank you for the opportunity to testify in support of S.B. 1. I can be reached with any questions at teverette@hesct.org or 860.937.6610.

---

[38] Knopf et al. (2016). "School-Based Health Centers to Advance Health Equity A Community Guide Systematic Review." Am J Prev Med 2016;51(1):114–126. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/27320215