Oral Health System: Pandemic Response Working Group
Virtual Meeting
March 17, 2021
4:00-5:30 pm ET

Group Memory

Convenor:
Michael Monopoli, Vice President, Grants Strategy
CareQuest Institute for Oral Health

Facilitator:
Patrick Finnerty, Strategic Advisor
CareQuest Institute for Oral Health

Content Manager:
Sara Oaklander, Interaction Institute for Social Change

Table of Contents

I. Participants

A. Pandemic Response Workgroup

The following Pandemic Response Workgroup participants were present at the meeting.

Name	Organization
Pamela Alston, DDS	President, National Dental Association
Eme Augustini	Executive Director, National Association of Dental Plans
Ann Battrell, MDSH	Chief Executive Officer, American Dental Hygienist Association
Gregory Chavez	Chief Executive Officer, Dental Trade Alliance
Manuel A. Cordero, DDS, CPH, MAGD	Executive Director & Chief Executive Officer, Hispanic Dental Association
Terri Dolan, DDS, MPH	President-Elect, Santa Fe Group
Chelsea Fosse, DMD, MPH	Senior Health Policy Analyst, American Dental Association Health Policy Institute
Jane Grover, DDS, MPH	Director, Council on Advocacy for Access and Prevention, American Dental Association
Hazel Harper, DDS, MPH	Past President, National Dental Association
Lavette Henderson	Executive Director, National Dental Association
Ifetayo Johnson, MA	Executive Director, Oral Health Progress and Equity Network
Sarah Miller, MPA	Director of Philanthropy and Foundation Operations, Dental Trade Alliance
Myechia Minter-Jordan, MD, MBA	President and CEO, CareQuest Institute for Oral Health
Mike Monopoli, DMD, MPH, MS	VP, Grants Strategy, CareQuest Institute for Oral Health
Alan Morgan, MPA	Chief Executive Officer, National Rural Health Association
Colin Reusch	Senior Advisor, Oral Health Policy, Dental Access Project Community Catalyst
RADM Tim Ricks, DMD, MPH, FICD	Chief Professional Officer, USPHS, OHCC, IHS
Tonia Socha-Mower, MBA, EdD	Executive Director, American Association of Dental Boards
Emily Stewart	Executive Director, Community Catalyst
Robert Zena, DMD	President, American Association of Dental Boards

The following Pandemic Response Workgroup participants were unable to attend today's meeting.

Name	Organization
Vanetta Abdellatif, MPH	President and CEO, Arcora Foundation
Stacy Bohlen, CEO	CEO, National Indian Health Board
Latisha Canty, RDH, MS	President-Elect, National Dental Hygienist Association
Edwin A. del Valle-Sepulveda, DMD, JD	President, Hispanic Dental Association
Susan Flores	Senior Policy Coordinator, California Pan-Ethnic Health Network
Mitch Goldman, JD, MBA	Executive Committee, Association of Dental Services Organizations, and CEO, Mid-Atlantic Dental Partners
Steve Kess, MBA	VP, Global Professional Relations, Henry Schein
Casey Long	Public Health Project Associate, National Indian Health Board
Diane Oakes, MSW, MPH	Chief Mission Officer, Delta Dental of Washington

Marko Vujicic, PhD	Chief Economist and VP, American Dental Association
Barbie Vartanian	Executive Director, Project Accessible Oral Health
Christine Wood	Executive Director, Association of State and Territorial Dental Directors
Vicki Young, PhD	COO, South Carolina PHCA and member of National Association of Community Health Clinics

B. Strategic Advisors and Staff

- Marcia Brand, PhD, former Deputy Administrator, Health Resources and Services Administration
- Patrick Finnerty, former Medicaid Director for the Commonwealth of Virginia
- Dora Hughes, MD, MPH, Associate Research Professor, GWU Milken Institute School of Public Health and former Counselor for Science and Public Health, Department of Health and Human Services
- Marianne Hughes, former Executive Director, Interaction Institute for Social Change
- Kristin LaRoche, Vice President, Public Relations, CareQuest Institute for Oral Health
- Laurie Norris, JD, former Senior Policy Advisor for Oral Health, Centers for Medicare & Medicaid Services
- Al Yee, MD, MPH, Senior Advisor to Community Catalyst Dental Access Project and leader in health care, public health, and philanthropy
- Brenda Cocuzzo, Executive Assistant, CareQuest Institute for Oral Health
- Hannah Cardosi, Administrative Coordinator, CareQuest Institute for Oral Health

Cara V. James, PhD, CEO, Grantmakers in Health, was also present as today's guest speaker.

II. Start-Ups

A. Welcome

Mike Monopoli welcomed everyone to the meeting and thanked everyone for being here today. A lot has happened since we met last time, as always. Today we have a mix of good and bad news.

- Vaccinations are stepping up - 2-3 million people per day are getting vaccinated. However, vaccine hesitancy is still an issue.
- Former President Trump has recommended the vaccine and taken it, which is good.
- Disparities are continuing as relates to equitable access and distribution of the vaccine.
- The Ad Council will do a national campaign about COVID vaccinations…and states are doing their own outreach, as well.
- The PREP Act has been modified – we'll talk about that later in the meeting, as well as passage of the COVID-19 relief act.

B. Purpose of the Effort in 2021 and of Today's Meeting

Pat Finnerty also welcomed everyone and introduced Dr. Pamela Alston, President, National Dental Association who is joining today for the first time.

The purpose of today's meeting is to build awareness of and commitment to health equity and racial justice as we move the work of the Pandemic Response Workgroup forward

C. Desired Outcomes

Pat reviewed the desired outcomes.
By the end of the meeting, the group is expected to have:

- An opportunity to welcome a new team participant
- An update on COVID 19: American Rescue Plan Act of 2021, vaccine rollout, dental teams' involvement, and issues concerning the virus variants
- An update on the on-going distribution and response to the PRW statement
- A shared understanding of what we mean by health equity in the oral health context and how we can measure progress toward our equity goals, in our organizations, and in the field
- An awareness of one organization's approach to implementing a health equity framework
- An opportunity to share how our organizations are tackling these issues and what we can learn from each other

D. Updates on Pandemic Response Workgroup Statement

Dr. Michael Monopoli presented.
The collective action letter, urging federal and state policymakers to take action allowing dentists and dental hygienists to participate as vaccinators, has had a good sign-on. Some groups are working through the process – we're continuing with rolling sign-on's to encourage additional support. It went to federal agencies, governors, and all chiefs of staff around the two areas addressed in the letter.

Kristen added:
A press release was issued and got some pick-up in dental trades. The announcement that dentists were going to be included in the PREP Act happened around the same time as when we sent out the press release which took some of the wind out of our sails. Next steps are to discuss how to engage the total oral health workforce, including dental hygienists, in the vaccination process

Pat thanked the workgroup members and staff who contributed to getting the letter out.

III. COVID-19 Updates

Marcia Brand presented and emphasized that this is an evolving body of work so changes may already have happened since last night!

A. COVID-19 Health Equity Taskforce

- Created by Presidential Executive Order on January 21, 2021
- Part of a government-wide effort to identify and eliminate health and social disparities that result in higher rates of exposure, illness, hospitalization and death related to COVID-19
- Twelve individuals serve as non-federal members; chaired by Marcella Nunez-Smith, MD, MHS
- An additional six federal agencies are represented (USDA, DoE, HHS, HUD, DOJ, DOL), reflecting this as a government-wide effort.
- First meeting – February 26, 2021; welcoming remarks, swearing in, presentations

Data Challenges and Opportunities: Presentations Made at the First Task Force Meeting

- **Nancy Krieger, Ph.D.**, Professor of Social Epidemiology, Harvard T.H. Chan School of Public Health - **COVID-19, Health Inequities, Data Gaps + Solutions**
    - COVID inequities in 1) exposure due to working and living conditions, 2) risk of dying, if infected, due to pre-existing social, economic and health inequities, 3) vaccine rollouts and access and institutional mistrust, 4) data for action to change these terrible facts.
    - Need better data to inform actions; recommendations for use of ZIP code data, educational and occupational data, US Census Household Pulse survey data, create real-time public roster of new social data CDC is adding for COVID-19.
- **Daniel Dawes, JD**, Associate Professor, Executive Director, Satcher Health Leadership Institute, Morehouse School of Medicine – **Health Data Transformation**
    - Recommendations – 1) provide resources to the CDC to assemble and publish comprehensive COVID outcomes and vaccine data, 2) compile a registry in primary care practice to identify and track patients with detailed demographic, social and medical history, 3) create metrics for success and/or failure in vaccination efforts, 4) mandate requirements for granular race and ethnicity data fields, 5) establish a national standardization of categories of race/ethnicity data fields and other identifying information.

Follow the Taskforce's Work

HHS.gov Office of Minority Health
https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=100h

B. American Rescue Plan Act of 2021

This is a huge bill with government-wide impact. Today we are highlighting the public health-related provisions. Folks from ASTHO did a great job creating a summary.

Key Public Health Appropriations and Provisions (ASTHO, 3/11/21)

- Vaccines and Therapeutics
- Testing, Tracing and Mitigation
- Public Health Workforce
- Public Health Investments
- Mental Health and Substance Use Disorder
- State and Local Recovery Funds
- Unemployment Insurance
- Medicaid Provisions

Overview: Public Health Workforce

- **Local and State Health Departments** have lost 23% of their workforce since 2008; a quarter of the workforce is eligible for retirement.
- **$7.66 billion**, to remain available until expended, to **establish, expand, and sustain a public health workforce**, including by making awards to state, local, and territorial public health departments. Specifically, funds can be used for:
  - Costs related to recruiting, hiring, and training individuals to serve as case investigators, contact tracers, social support specialists, community health workers, public health nurses, disease intervention specialists, epidemiologists, program managers, laboratory personnel, informaticians, communication and policy experts, and other related positions.
- **$100 million**, to remain available until expended, for the **Medical Reserve Corps.** This is managed by assistant secretary of preparedness and response and includes vaccination clinics.

Overview: Public Health Investments

Much of this is being managed by HRSA.

- **$7.6 billion**, to remain available until expended, for **community health centers** for vaccine related activities, COVID-19 mitigation activities, establishing and sustaining the necessary workforce to perform COVID-19 related activities, and conducting community outreach and education related activities.
  - Support for HRSA and CDC to 950 health centers serving high proportions of low-income and minority patients, provide services to rural/frontier populations, operate Tribal/Urban Indian Health Programs, and/or utilize vans to deliver services.
- **$800 million**, to remain available until expended, for the **National Health Service Corps**.
- **$200 million**, to remain available until expended, for the **Nurse Corps**.
- **$330 million**, to remain available until Sept. 30, 2023, for **Teaching Health Centers that operate Graduate Medical Education**.

There is an additional $120m in mental health resources for health care providers and another $100m for training behavioral health workforce providers.

C. COVID-19 Vaccination Rollout and Issues, Role of Dental Teams, Virus Variants

Dr. Mike Monopoli presented…

- Code maintenance committee of the ADA met in March and passed a motion for seven COVID administration fees. They're being put into effect more quickly than usual.
- While it's good news that dentists and dental students can administer vaccines, and the PREP Act creates immunity from liability as long as there is no negligence involved.
- There is a lot of funding in the Rescue Act to promote the ability of community health centers to be involved in outreach and advancement of equity.
- We can provide support for inclusion of dental teams
- However, half of the dental work force was left out…dental hygienists, so there is more work to be done there

Anne Battrell commented.
We were delighted that oral health was included in expanding the PREP Act to cover more types of providers; however dental hygienists and therapists were not included. We quickly wrote to Jack Hermann in the Office of the Assistant Secretary for Preparedness and Response and he has promised to advance it. We're fairly confident that hygienists will eventually be included and any advocacy efforts you can provide will be greatly appreciated.

D. Questions, Comments, Additional Updates

The Hispanic Dental Association is in full support of this effort to include dental hygienists as vaccinators.

Q. Is this only for federal action or is there state action that can be taken?
A. *Yes, governors have capacity to do emergency regulations to expand the role of the oral health workforce; 14 states have taken this action already*

Q. Is Marcia aware of activities that AAPHD may start moving on with all this funding around public health?
A. Marcia responded that she hasn't heard anything but will check into it. AAPHD has a COVID website that includes resources and might be a place to watch for additional information.
https://aaphd.memberclicks.net/covid-19-resources

Q. Now that the dentists are authorized as vaccinators, many members of the NDA are in the process of volunteering in different states. As they sign up to volunteer, some of the community centers were requesting that the dentists be licensed in that particular state where they are looking to volunteer. Does anyone know if this is a general requirement, across all states, or if there is something that could mitigate this requirement?

A. The State of Florida has specific laws about this to allow folks licensed elsewhere to be eligible and protected but I am not aware of a national regulation.
A. Your license in one state does not cross over to another… even in an emergency unless there is specific language to cover that. The federal is for "licensed dentists" and it's state by state.
A. When FEMA approached our members about volunteering, they provided complete coverage for the equipment. So if it's through a federally mandated program it is allowed. Otherwise, it's state by state.
A. Mike offered to further research this and share the information that is gathered.

IV. Health Equity and Racial Justice in the Time of COVID and Beyond

A. Understanding Health Disparities and Opportunities to Advance Health Equity

Cara V. James, PhD, President and CEO, Grantmakers in Health, presented. Her slides can be found in the appendix.

A few key takeaways from Dr. James' talking points

- Health inequities are costing us a lot of money, and this will continue to increase if we don't address these issues.
- And the moral argument has not worked thus far so we need to find another way.
- Inequities start at birth and persist throughout life.
- There is a lot of diversity within our populations, and there is data missing for some populations because it is not available (e.g., Native American, Alaskan Natives)
- This is national data; and where you live matters. If we had more time to drill down, you would see how that is the case. For example, the darker a county in Maryland, the greater the disparities.
- National health care disparities – quality of care has improved for everyone but the disparities have remained – so quality improvement is not sufficient.
- Non-Hispanic whites are not always the group performing the best. e.g., there are higher rates of suicide among non-Hispanic whites.

Regarding what it takes to achieve health equity

- What does it take to achieve health equity? I suggest 8 things: (1) making health equity a priority; (2) strengthening the role of leadership; (3) engaging communities through humble inquiry; (4) supporting data infrastructure and analysis; (5) tackling tough issues; (6) making health equity part of standard operating procedures; (7) creating program and policy sustainability; and (8) developing a robust pipeline.
- We don't get there by treating everyone the same but rather by giving everyone what they need to achieve that highest level of health.
- There is a sense that the attention is on this issue now; however, maintaining that attention is critical.
- With regard to advancing health equity, start by understanding the existing disparities and best to pick something and get started.

- https://www.gih.org/from-the-president/enough-is-enough-it-is-time-to-get-serious-about-eliminating-racial-disparities/

V. Health Equity and Racial Justice: An Organizational Approach

A. Presentation: Dr. Myechia Minter-Jordan

What I realize about this work is that it is work that must be done with intention. We are looking internally at ourselves to see how we're living out this commitment within our organization.

Action we've taken across our organization

- Developed a data driven Diversity, Equity and Inclusion (DEI) plan in 2020 to establish aspirational goals
- Took action to meet our goals….
    - Introduced a new DEI index in the employee engagement survey to measure our corporate competency
    - Launched new inclusion training for all employees in November 2020
    - Established partnerships with external professional associations to promote our upcoming job recruitment with talent from diverse backgrounds and offer external development opportunities to our employees.
    - Developed dashboards to evaluate the impact of DEI initiatives
    - Implemented new applicant sourcing approaches and recruitment techniques (diverse candidate slates and diverse interview panels) to widen the net to reach more diverse talent. It's not just where we recruit and post, but who is doing the interviewing. Attending to internal biases is critical.

We still have work to do

- Engaging in the development of a contractor/supplier diversity initiative
- We are continuing the learning with quarterly conversations on DEI topics to inspire actions and behaviors to drive an inclusive culture where everyone belongs
- Design and invest in talent development programs to prepare employees for growth opportunities

Actions specific to our grantmaking

- We instituted a non-mandatory demographics section to all of our grant proposals that requests information about all Board and Staff related to race/ethnicity, gender, sexual orientation, and disability status. This year we will establish a baseline and set DEI goals for our grants portfolio in 2022 and onward.
- In all grant applications we explicitly ask them to speak to how they are applying a health and/or racial equity lens when considering who is impacted by their work and whose voices they are strengthening. This process was informed by our evaluation consultant, Community Science.

    - To pair with the application, we built a scoring rubric for all grant applications that explicitly focuses on the degree to which health and/or racial equity is intentionally demonstrated in the proposal.
- Internally we have set a proportion of our grantmaking budget aside in 2021 specifically to pursue investments in underrepresented voices in our grantmaking portfolio that are representative of communities such as black and indigenous communities of color, immigrant communities, the disability community, and veterans.
    - In addition to sharing our grants strategy through new philanthropic channels, we are proactively reaching out to organizations who serve and/or partner with the communities above, leveraging connections of our grantees, OPEN, and consultants. We have introductory calls with all new organizations to establish a relationship and explore potential partnership opportunities.
- There are many more initiatives going on, including work at the board level.

B. Small Groups

Pat invited the participants to breakout in small groups and discuss:

- What are your key takeaways from Cara's and Myechia's presentations?
- Share the equity approach your organization is implementing, including your aspirations to deepen that work.
- How will you measure progress?

Group One

Report Out:

- Thank you to Cara for her excellent presentation
- Health inequities not felt the same by all populations
- Opportunities for education in our professional communities; helping folks reach their aha moments
- Importance of this being a movement not just a moment in time
- Talked about the Diverse Dental Society and the importance of collaboration
- Dr. Jane Grover shared how the ADA is doing health equity training for staff and CAAP is putting together a health equity resolution and educational materials

Notes:

What are your key takeaways from Cara's and Myechia's presentations?

- Cara provided excellent background and evidence to fuel and propel the conversation.
- Health inequities are not felt the same by all populations.
- There's so much work to be done to break down the institutionalized injustices.
- Significant growth opportunities for our professional communities: There's significant need for education, but not everyone is ready to be educated. We need to get folks to the "aha" moment.
- Will this be a fleeting focus? How horrific that would be. How do we not allow this to be just a moment, but a movement?

- The need for uniform data collection. The need for external audiences to be brought in to make sure we're measuring what's important.

Share the equity approach your organization is implementing, including your aspirations to deepen that work.

- Diverse Dental Society! It was conceived the week before the pandemic was declared. There's a level of trust that took effort and time to build among these organizations; took time to listen, collaborate, ask hard questions, apologize for what you don't know.
- We need to start asking these tough questions of each other. For example, why aren't there more educational opportunities for the dental profession around public health, social injustice, etc.
- Income-based barriers are a huge driver of some of these inequities, too. There's so much in our health care system that is not working; let's get to work on this.
- ADA: Conducting health equity training for staff, for leadership. The Council on Advocacy for Access and Prevention is submitting a resolution to the ADA House of Delegates on health equity. Doing more educational webinars.

<u>Group Two</u>

Report Out:

- Also appreciate the valuable presentations
- Dental boards want to explore systemic racism in the dental profession and explore regulations, how they might address disparities
- Could there be courses on racism and disparities in dental education
- Patient must be patient of record for teledentistry – is that exclusive?
- Importance of addressing dental trauma within health equity work
- What can be done about pipeline to dental schools?
- Measurement is a difficult question. For any individual organization, it's a lifelong commitment that involves personal and organizational change. Metrics may not fully capture progress in a complex system and aspirational goals. Want to see long-term goals that shift toward justice and equity and then somehow distill them to shorter-term goals.

Notes:

What are your key takeaways from Cara's and Myechia's presentations?

- Very timely presentation because on March 30 ADA will have health equity webinar and the data could be added to the session

Share the equity approach your organization is implementing, including your aspirations to deepen that work.

- At national meeting of dentists and dental boards, would like to invite expert speakers to talk about systemic racism in the dental profession. Explore connection to how regulations are written. How can regulations be changed to address disparities?

- There is coursework dentists must take for infection control and other topics. Could there be other courses for racism and disparities?
- Telehealth requirements that visit be a patient of record, but could that exclude those who need care or who had been excluded from the delivery system previously – something to discuss
- Training on unconscious bias was mentioned by several
- OPEN has established a team/group on equity to make sure every presentation they give, every group they are part of, etc. can be viewed through equity lens
- Importance of dental trauma in health equity is something to consider
- Mapping the oral health system where we have leverage points to make a difference -- OPEN
- We are doing an equity audit of our own organization – OPEN (An equity audit can be a beginning point to then measure progress later)
- Developing Board and individual staff goals related to DEI
- Produced an oral health equity tool considering who is involved and engaged in a conversation
- What can be done about pipeline to dental schools? Recent data shows little progress on race and ethnic diversity in dentists/dental provider community.

How will you measure progress?

- An equity audit can be a beginning point to then measure progress later
- Measurement is a difficult question. For any individual organization, it's a lifelong commitment that involves personal and organizational change. Metrics may not fully capture progress in a complex system and aspirational goals. Want to see long-term goals that shift toward justice and equity and then somehow distill them to shorter-term goals.

Group Three

Report Out:

- Our orgs are committed to this journey
- There is a practical need for additional resources regarding how we can move forward – how do we assist one another
- Data did not surprise anyone; considerable interest in Dr. James' discussion of what it will take.

Notes:

- Ann Battrell: commitment and buy in is there, need assistance and resources to get started.
- Tonia: having a summit in the fall on systemic racism and role of dental boards
- Lavette: equity is core to NDA's mission; focusing on educational pipeline
- *Colin Reusch shared:* Here's the link to our oral health policy equity tool, which is focused on helping oral health advocates engage more meaningfully with communities and include them in policy agenda setting

processes: https://www.communitycatalyst.org/initiatives-and-issues/initiatives/dental-access-project/oral-health-policy-equity-tool We are also actively incorporating health equity and racial justice into our strategic planning process - as part of that, we have been interviewing peer organizations who have taken on concerted anti-racism work to learn from them

VI. Next Steps and Close

Pat thanked everyone and reminded folks that the next meeting is April 21. We'll turn our attention at that time to setting up the working teams.

VII. Appendix: Dr. Cara James Presentation: Understanding Health Disparities and Opportunities to Advance Health Equity

Attached.

Understanding Health Disparities and Opportunities to Advance Health Equity

Cara V. James, PhD
President and CEO
Grantmakers In Health
March 17, 2021

An Introduction to Grantmakers In Health

Mission – To foster communication and collaboration among grantmakers and others, and to help strengthen the grantmaking community's knowledge, skills, and effectiveness.

Vision – Better health through better philanthropy

Grantmakers In Health is comprised of nearly 240 funding partners (i.e., foundations, corporate giving programs, and philanthropy serving organizations) in 38 states and the District of Columbia, whose focus area ranges from local to international.

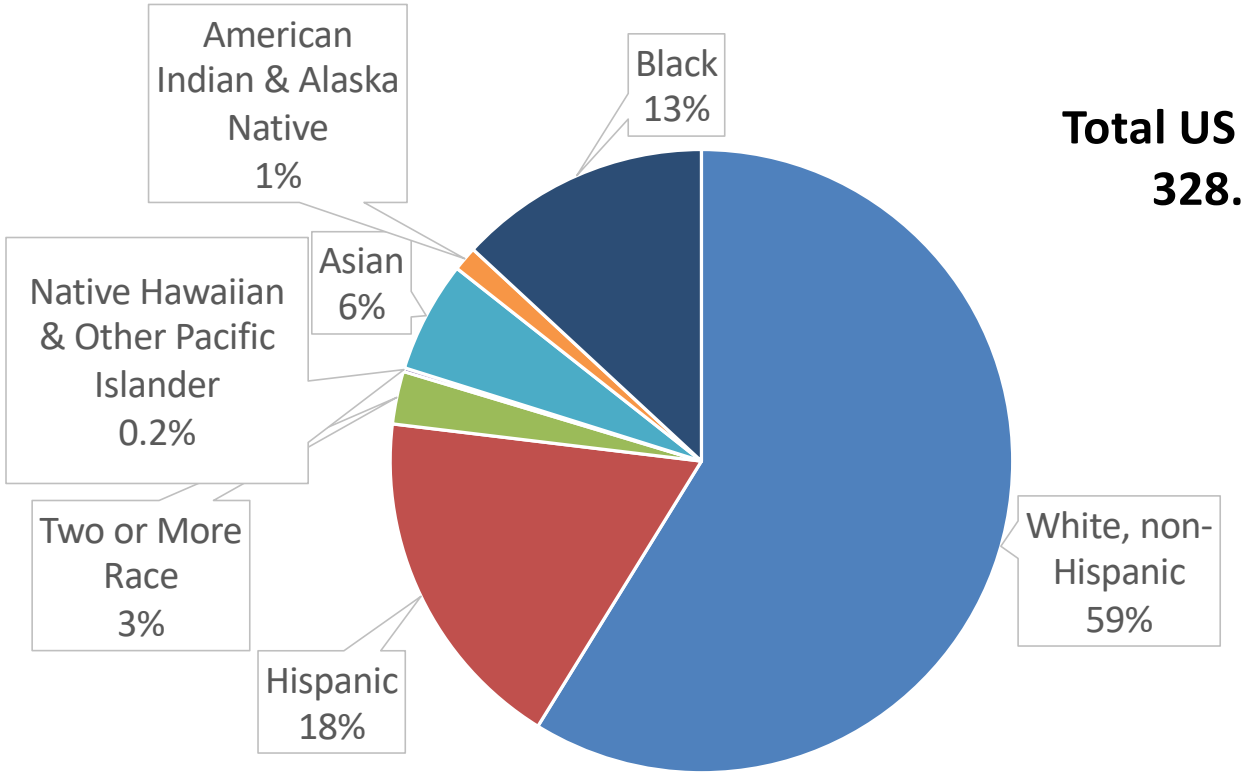
Our work is organized into 12 areas:

- Access
- Advocacy Strategies
- Behavioral Health
- Children and Families
- Governance and Operations
- Health Equity
- Health Eating & Active Living
- Integrative Health
- Older Adults
- Oral Health
- Population Health
- Quality

Types of Health Disparities

- Racial and Ethnic
- Sex
- Socioeconomic Status
- Disability
- Geographic
- Sexual Orientation and Gender Status

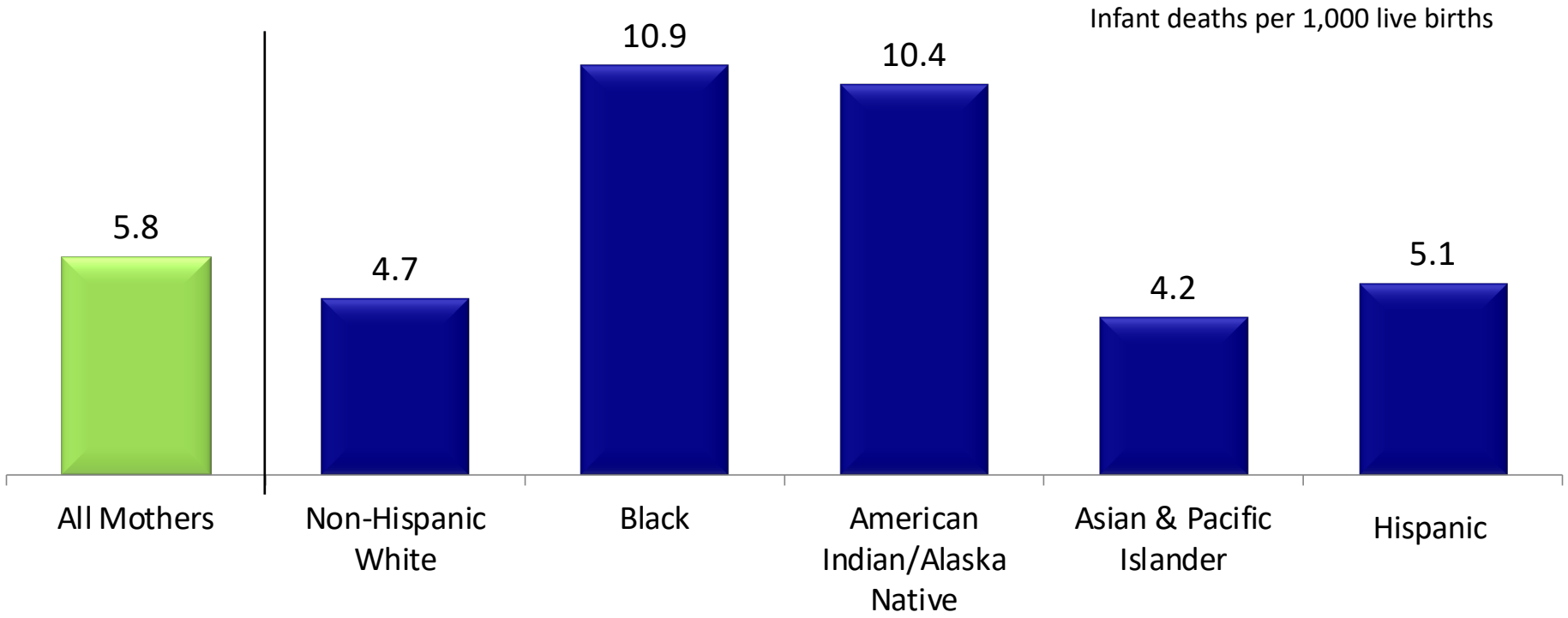
United States Population by Race and Ethnicity, 2019



Total US Population = 328.2 million

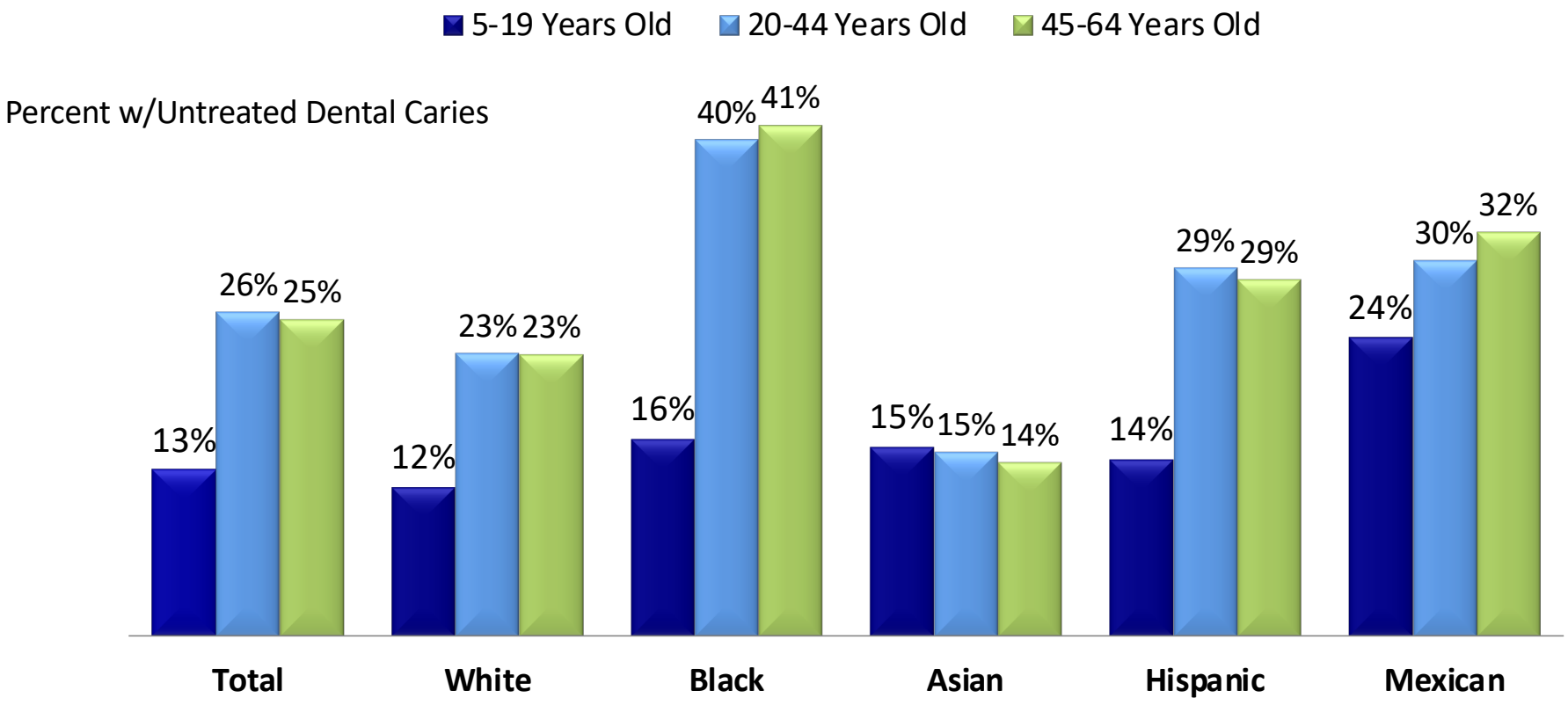
SOURCE: Quick Facts, United States. US Census Bureau. https://www.census.gov/quickfacts/fact/table/US/EDU685218

Infant Mortality by Race and Ethnicity, 2017



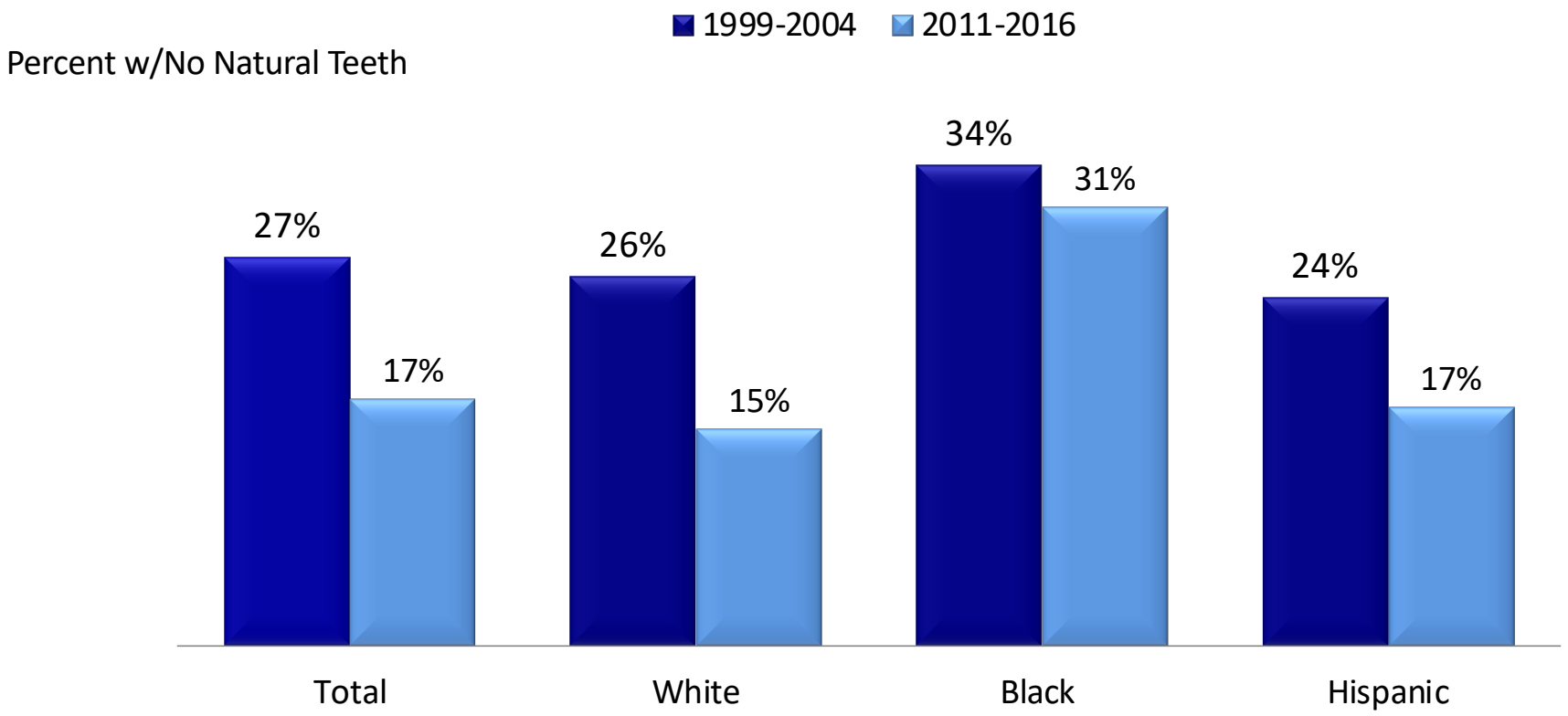
SOURCE: Table 2. Infant, neonatal, postneonatal, fetal, and perinatal mortality rates, by detailed race and Hispanic origin of mother: United States, selected years 1983–2017. *Health, United States, 2018*. Centers for Disease Control and Prevention

Untreated Dental Caries among the Nonelderly by Race and Ethnicity and Age, 2015-2018



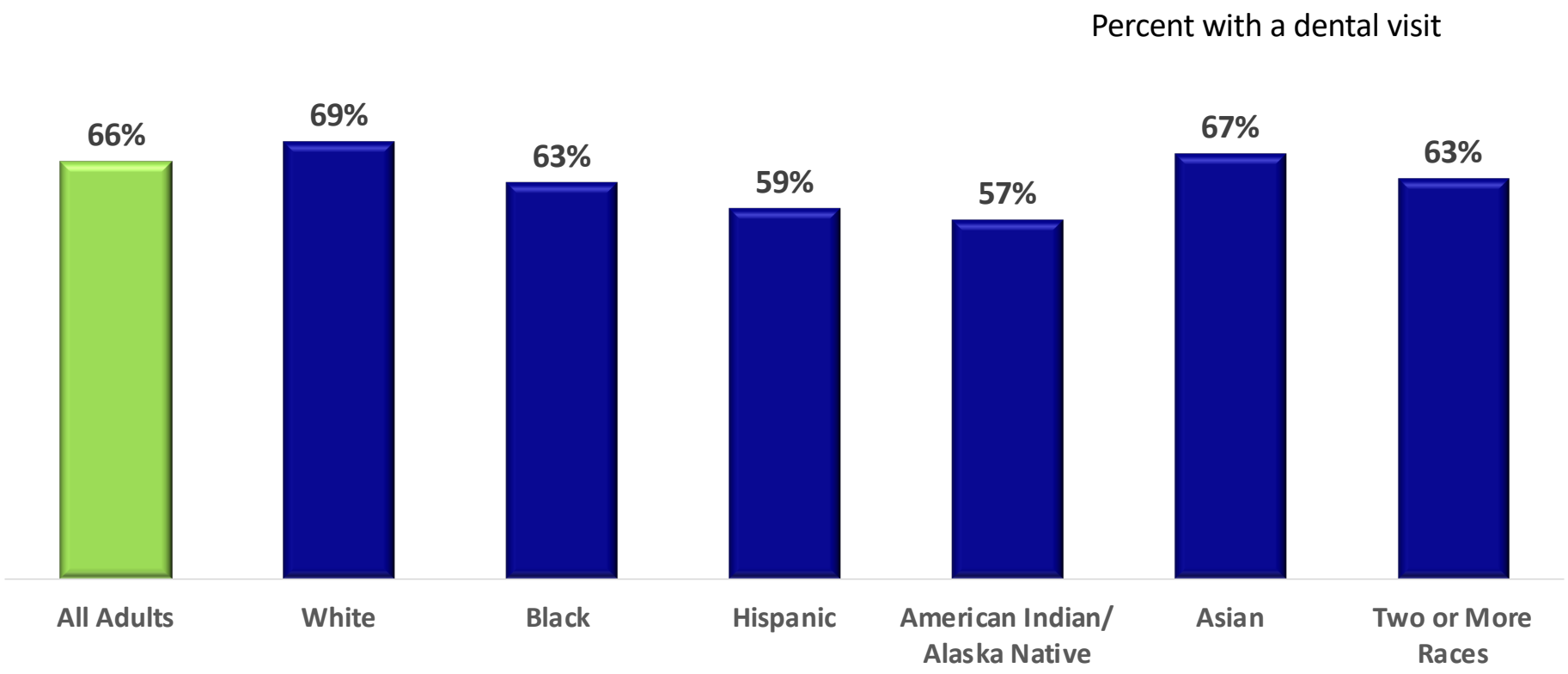
SOURCE: Centers for Disease Control and Prevention. Health, *United States, 2019*. https://www.cdc.gov/nchs/data/hus/2019/028-508.pdf

Percent of Older Adults with No Natural Teeth by Race and Ethnicity



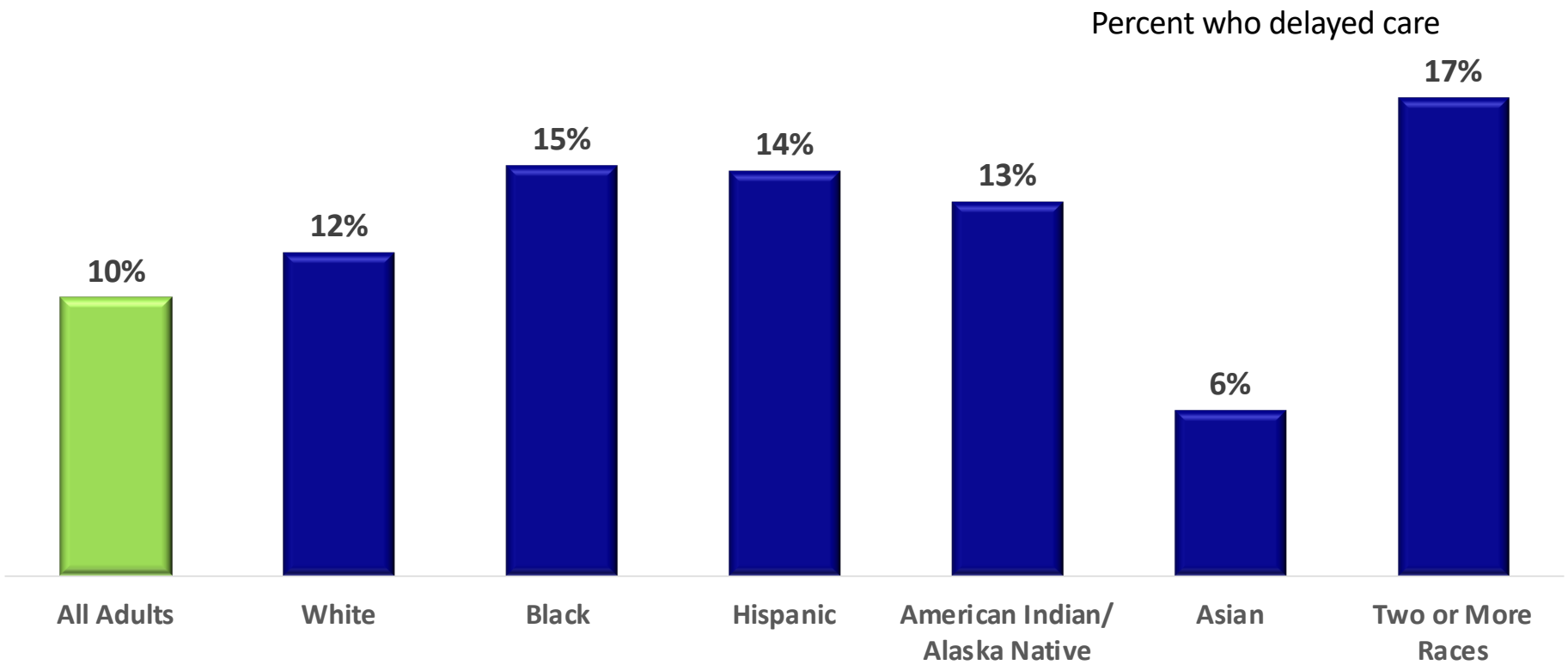
SOURCE: Oral Health Surveillance Report, 2019

Past Year Dental Visit among Nonelderly Adults by Race & Ethnicity, 2018



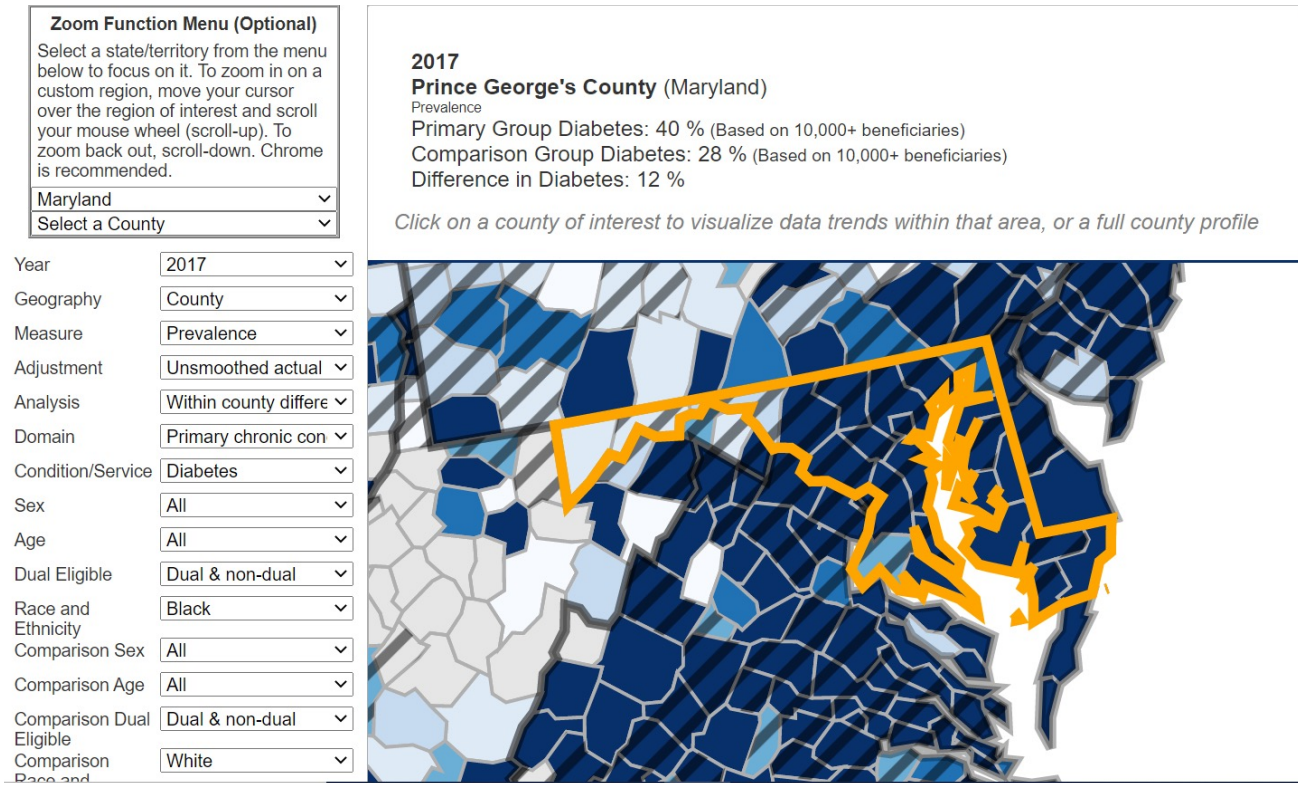
SOURCE: Centers for Disease Control and Prevention. Health, *United States, 2019*. https://www.cdc.gov/nchs/data/hus/2019/028-508.pdf

Delayed Needed Dental Care Due to Cost among the Nonelderly by Race & Ethnicity, 2018



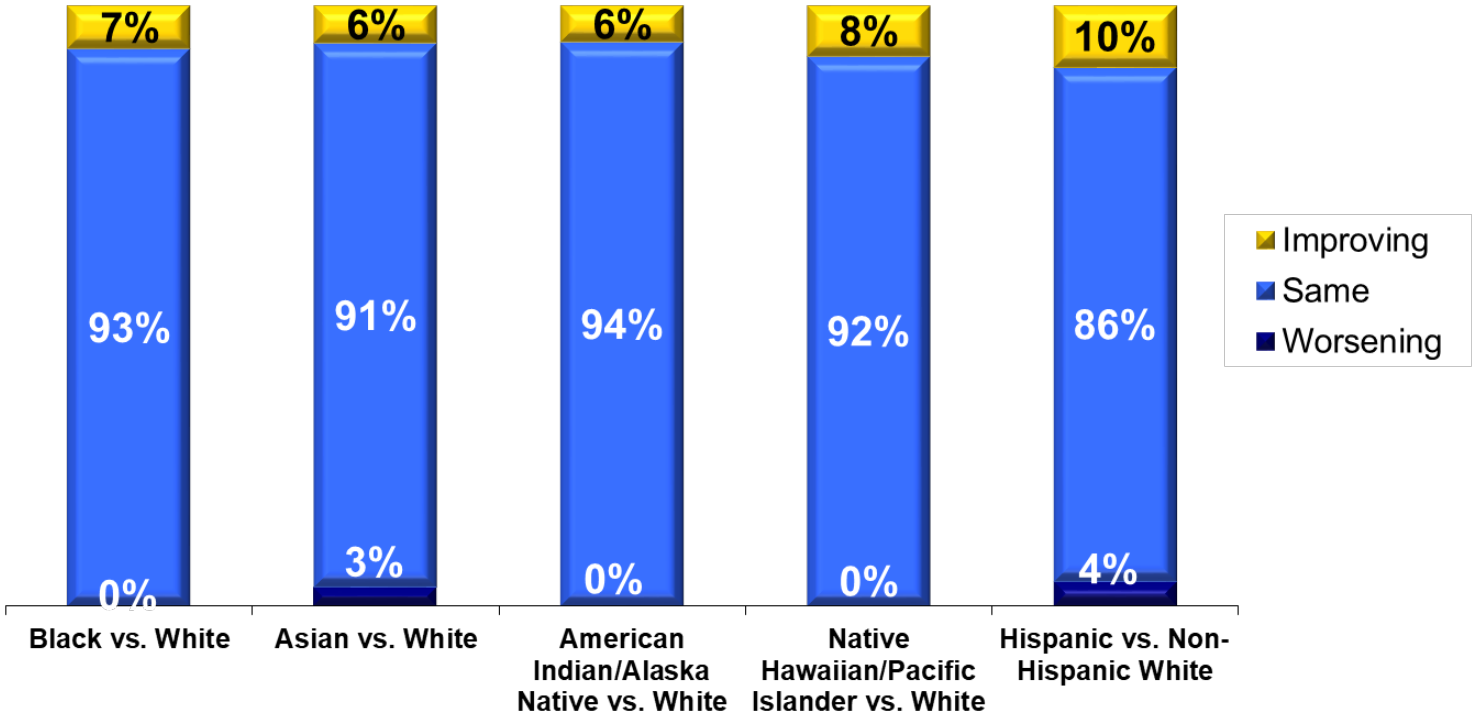
SOURCE: Centers for Disease Control and Prevention. Health, *United States, 2019*. https://www.cdc.gov/nchs/data/hus/2019/028-508.pdf

Black-White Medicare Diabetes Disparities by County, 2017



SOURCE: Centers for Medicare & Medicaid Services. Mapping Medicare Disparities (MMD) Tool. https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Mapping-Medicare-Disparities

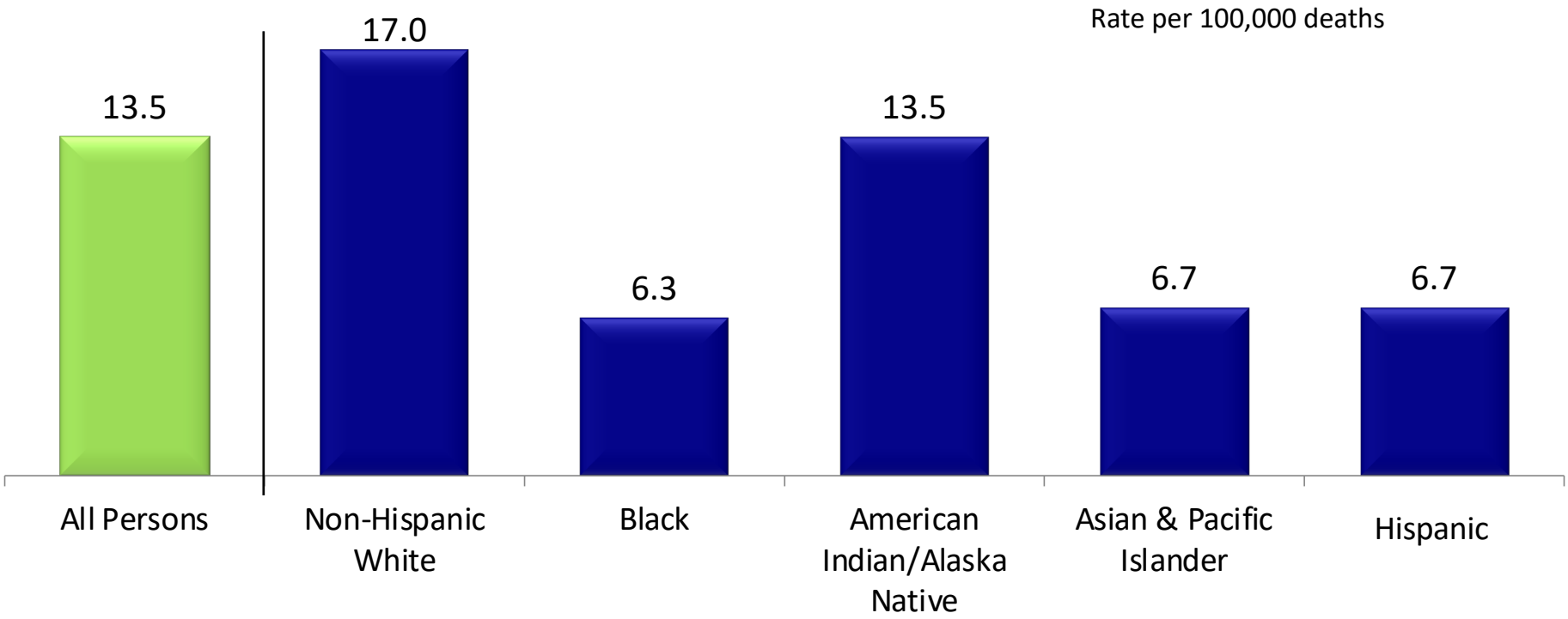
Changes in Quality of Care Disparities Over Time: Summary by Race and Ethnicity, 2000 through 2013-2017



NOTES: "Improving" means disparity is becoming smaller over time; "worsening" means disparity becoming larger over time. Data on all measures are not available for all groups. Totals may not add to 100% due to rounding.

SOURCE: 2018 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality; September 2019. AHRQ Pub. No. 19-0070-EF.

Suicide by Race and Ethnicity, 2016



SOURCE: Table 17. Age-adjusted death rates for selected causes of death, by sex, race, and Hispanic origin: United States, selected years 1950–2016. *Health, United States, 2017*. Centers for Disease Control and Prevention

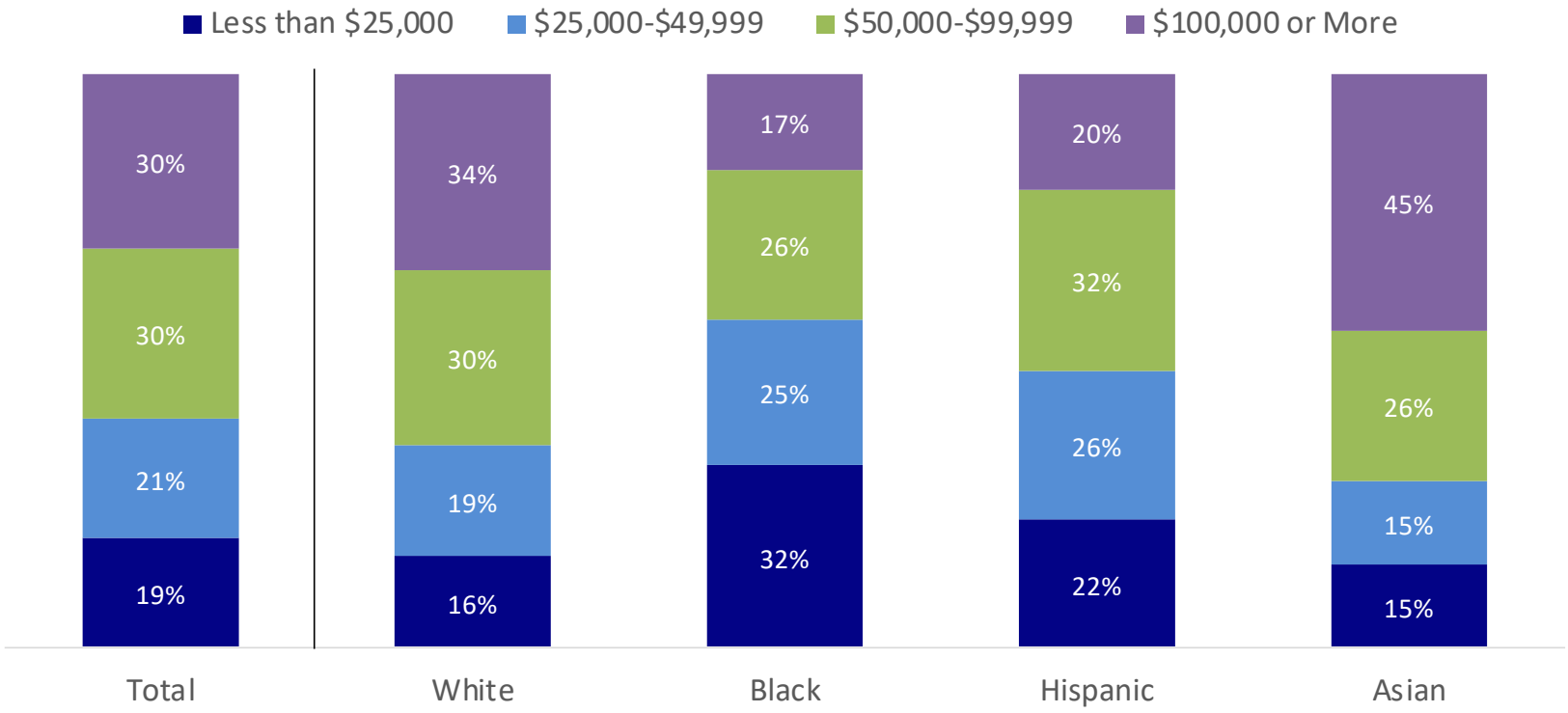
Drivers of Health Disparities

Healthy People Social Determinants of Health

- **Economic Stability**
  - Poverty
  - Employment
  - Food Security
  - Housing Stability
- **Education**
  - High School Graduation
  - Enrollment in Higher Education
  - Language and Literacy
  - Early Childhood Education & Development
- **Social and Community Context**
  - Social Cohesion
  - Civic Participation
  - Discrimination
  - Incarceration
- **Health and Health Care**
  - Access to Health Care
  - Access to Primary Care
  - Health Literacy
- **Neighborhood and Built Environment**
  - Access to Healthy Foods
  - Quality of Housing
  - Crime and Violence
  - Environmental Conditions

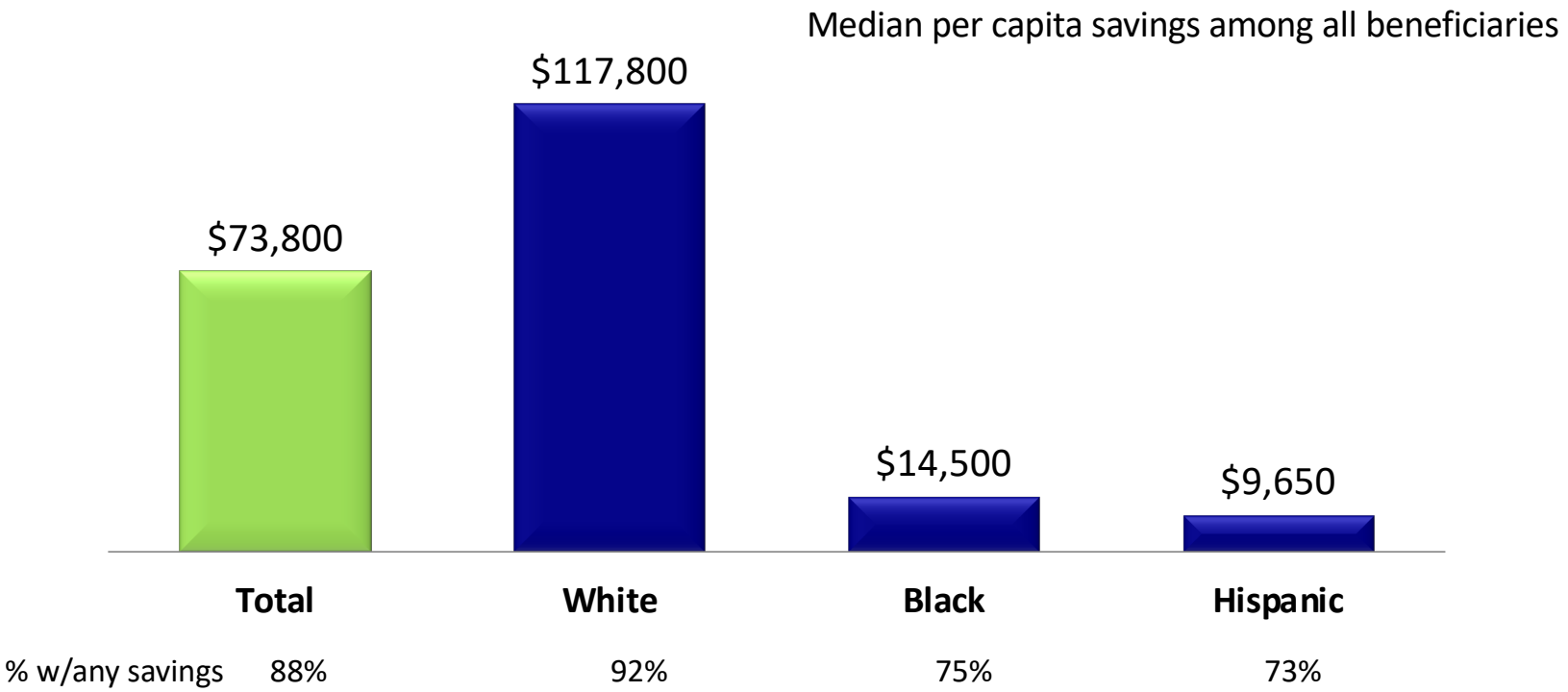
SOURCE: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health#two

Household Income Distribution by Race and Ethnicity, 2018



SOURCE: Income and Poverty in the United States: 2018. United States Census Bureau.
https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-266.pdf

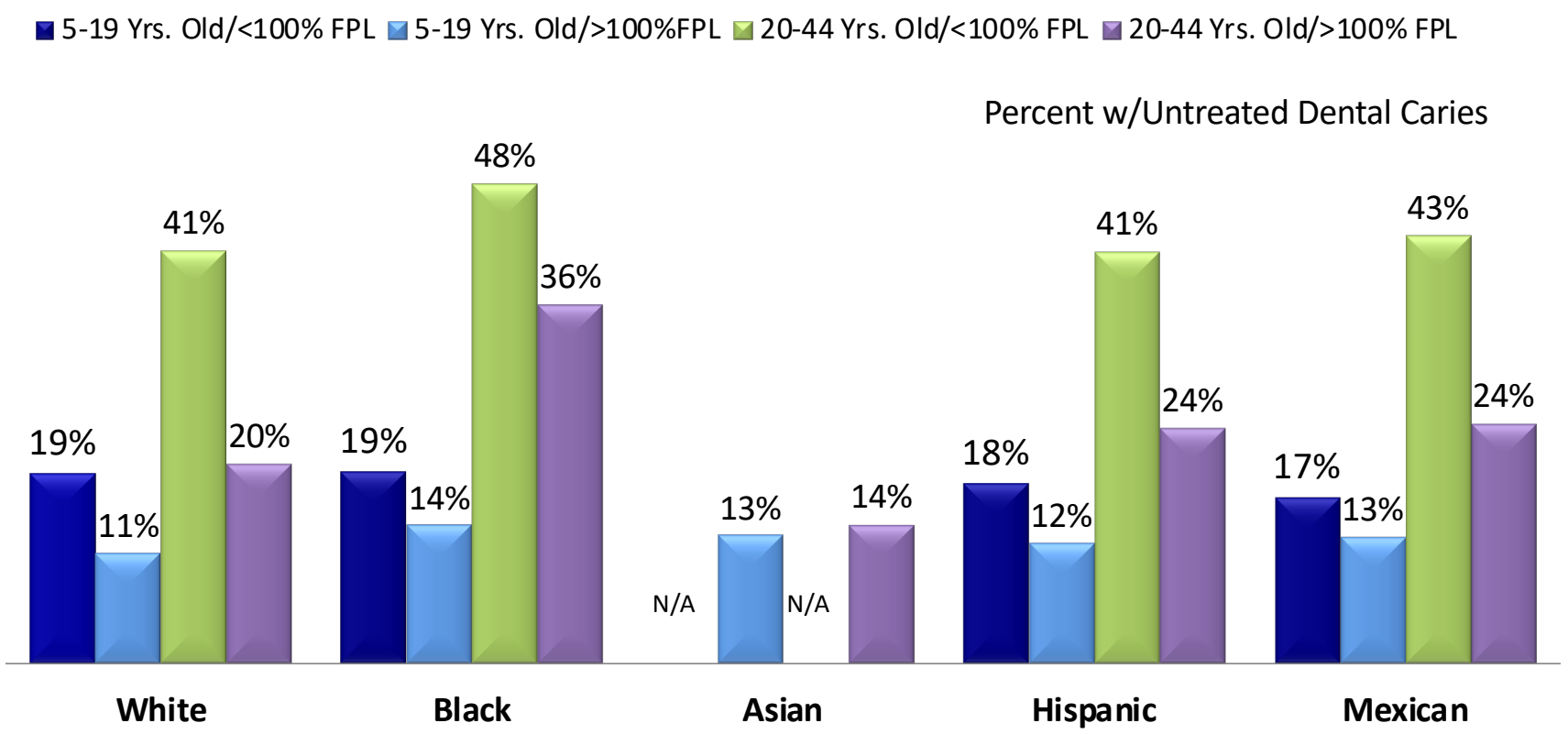
Median Per Capita Savings among Medicare Beneficiaries by Race and Ethnicity, 2019



	Total	White	Black	Hispanic
% w/any savings	88%	92%	75%	73%

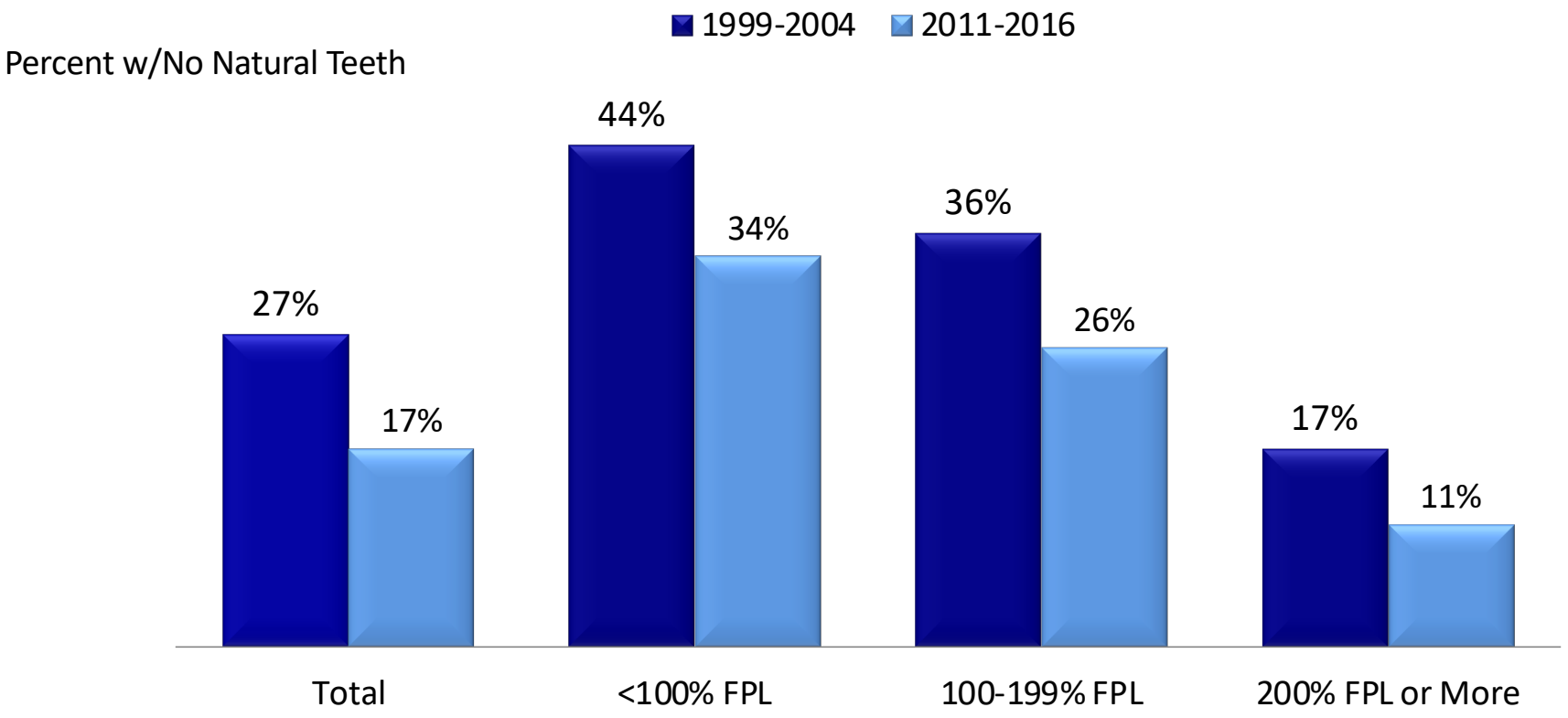
SOURCE: Kaiser Family Foundation, "Medicare Beneficiaries' Financial Security Before the Coronavirus Pandemic". April 2020.

Untreated Dental Caries by Age, Income, and Race and Ethnicity, 2015-2018



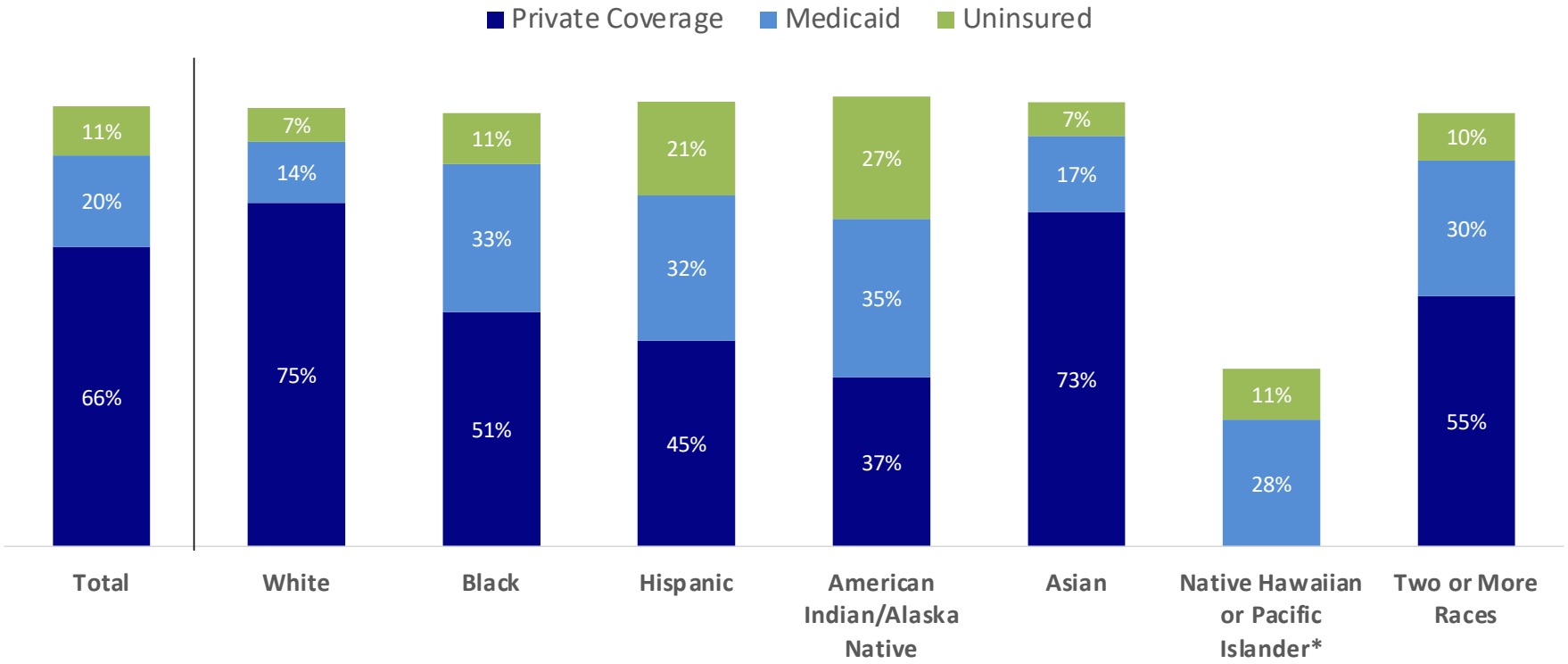
SOURCE: Centers for Disease Control and Prevention. Health, *United States, 2019*. https://www.cdc.gov/nchs/data/hus/2019/028-508.pdf

Percent of Older Adults with No Natural Teeth by Income



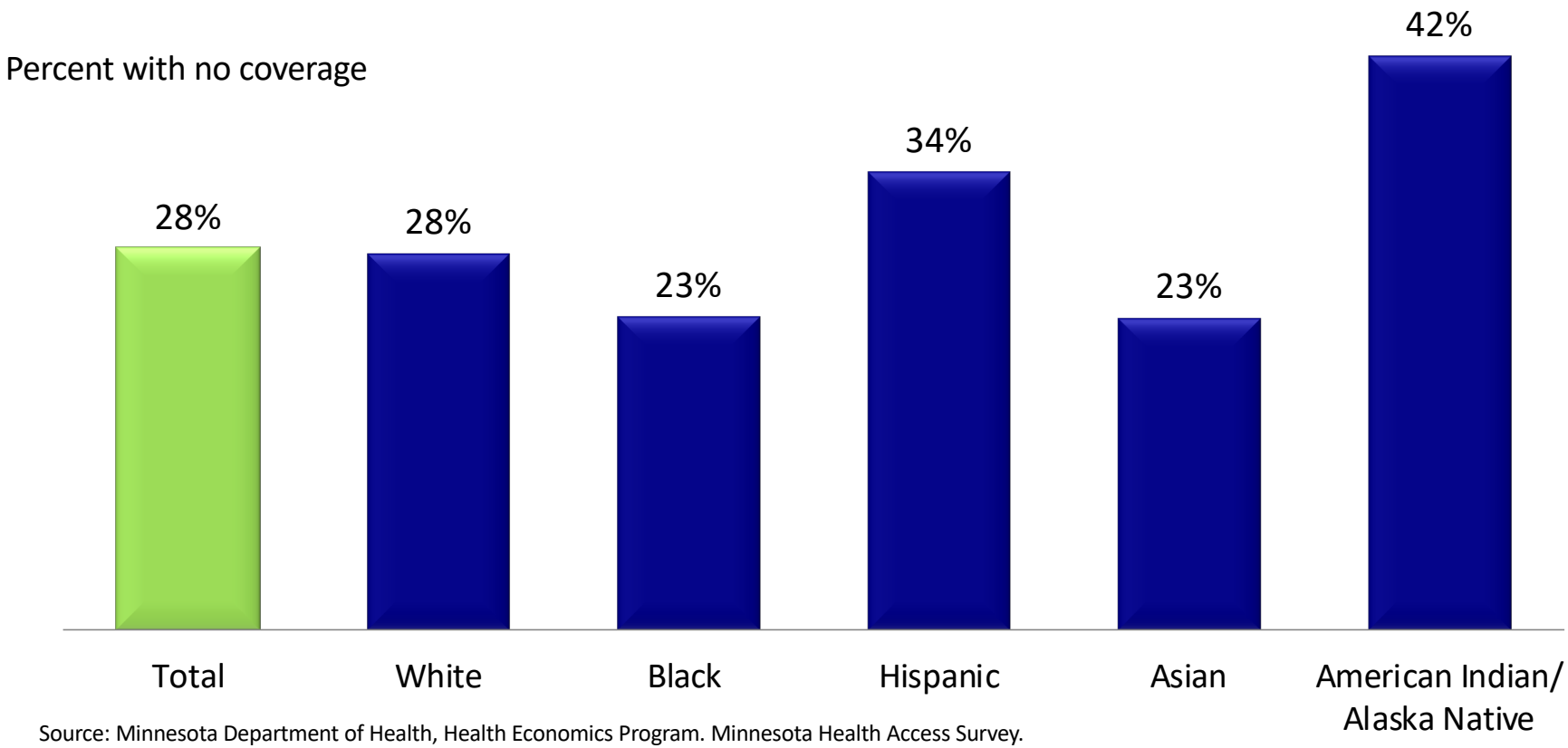
SOURCE: Oral Health Surveillance Report, 2019

Health Coverage Distribution of Nonelderly Adults by Race and Ethnicity, 2017



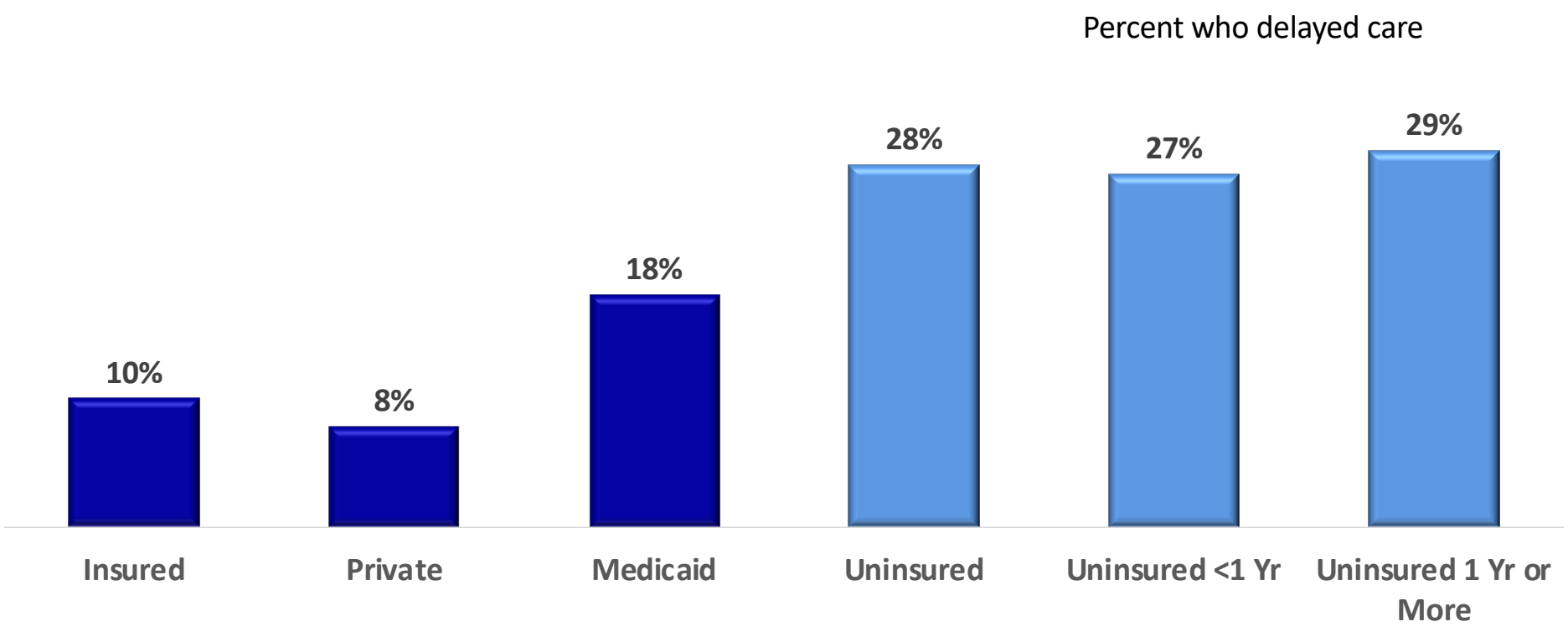
NOTE: * Estimates not reported because they were deemed unreliable
SOURCE: Tables 45-47. Health insurance coverage among persons under age 65, by selected characteristics: United States, selected years 1984–2017. Health, United States, 2018. Centers for Disease Control and Prevention.

No Dental Coverage in Minnesota by Race & Ethnicity, 2017



Source: Minnesota Department of Health, Health Economics Program. Minnesota Health Access Survey.

Delayed Needed Dental Care Due to Cost among the Nonelderly by Coverage, 2018



SOURCE: Centers for Disease Control and Prevention. Health, *United States, 2019*. https://www.cdc.gov/nchs/data/hus/2019/028-508.pdf

GRANT MAKERS IN HEALTH

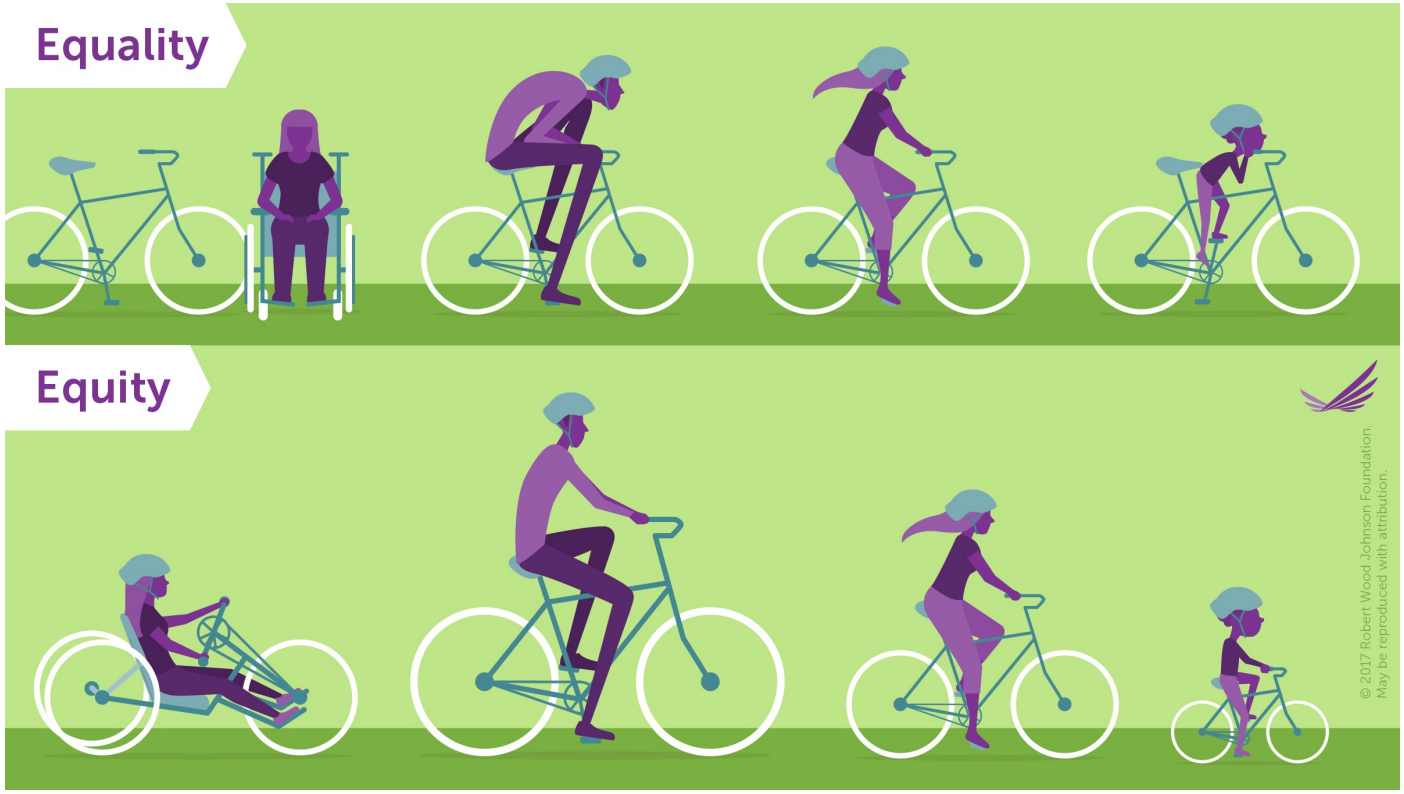
What It Takes to Achieve Health Equity

What is Health Equity?

- Healthy People 2020 defines health equity as the "attainment of the highest level of health for all people.“

- For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups. (RWJF, 2017)

Health Equity vs. Equality



SOURCE: Robert Wood Johnson Foundation. https://www.rwjf.org/en/library/infographics/visualizing-health-equity.html#/download.

What Does It Take to Achieve Health Equity?

1. Making health equity a priority
2. Strengthening the role of leadership
3. Engaging communities through humble inquiry
4. Supporting data infrastructure and analysis
5. Tackling the tough issues
6. Making health equity part of standard operating procedures
7. Creating program and policy sustainability
8. Developing a robust pipeline

SOURCE: https://www.gih.org/from-the-president/enough-is-enough-it-is-time-to-get-serious-about-eliminating-racial-disparities/

Addressing Health Disparities at All Levels

Division of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion. (2011). Social Ecological Model. Retrieved March 17, 2015. From http://www.cdc.gov/cancer/crccp/sem.htm.

Healthy People 2030 Oral Conditions Objectives

- **General**
  - Adults w/active or untreated tooth decay
  - Early detection of oral and pharyngeal cancers
  - Use of oral health system
- **Adolescents**
  - Children & adolescents w/lifetime tooth decay
  - Children & adolescents w/active or untreated tooth decay
- **Health Care Access and Quality**
  - People w/dental insurance
  - Dental care when needed
- **Health Policy**
  - Water systems have recommended fluoride
- **Nutrition and Healthy Eating**
  - Consumption of added sugar, ages 2 and up
- **Older Adults**
  - Untreated root surface decay
  - No natural teeth
  - Moderate & severe periodontitis
- **Preventive Care**
  - Preventive visit for low-income youth
  - Sealants on molars for children and adolescents
- **Public Health Infrastructure**
  - States w/oral and craniofacial health surveillance system

SOURCE: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health#two

Applying an Equity Lens to Program and Policy Development

1. **What are the existing disparities in this area?**
   - What are the causes of those disparities, and how will this policy improve or worsen these disparities?
2. **How might this change affect the availability of treatment and services for different communities?**
   - Think about availability, accessibility, continuity of care, care coordination, quality, and efficiency.
   - Can you make adjustments to reduce barriers to care and improve quality for vulnerable populations?
3. **How might this change impact the willingness or ability of providers to treat patients?**
   - Think about the numbers, skills mix, distribution, turnover, working conditions, incentives and disincentives for providers offering needed services, and what is needed to effectively meet your policy objectives.
   - How might you change the policy to address workforce barriers?

SOURCE: Adapted from Rural-Proofing for Health: Guidelines, and based in part on the World Health Organizations Health System Framework and Building Blocks. https://health-e.org.za/wp-content/uploads/2015/02/2015-01-13-RHAP-Rural-Proofing-Guideline-A4-Email-1.pdf

Applying an Equity Lens to Program and Policy Development

4. **What will be the impact on the ability to collect, analyze and report data necessary to monitor and evaluate the impact of the policy?**
   - Does the policy include support for the data infrastructure needed to know whether improvements are being made? What are the reporting requirements for the policy?
5. **What resources are needed to implement the policy, and do those needs differ by community or population?**
   - Think about economies of scale. In rural areas where volume levels are differ, care may be more expensive. Similarly for providers who see more Medicaid patients, their reimbursement rates will be lower for the same service.
   - How does the policy or budget account for the variability in resources needed to implement the policy?
6. **How have you engaged the communities you seek to help with this policy?**
   - Think about who represented those communities and whether you heard multiple perspectives.
   - Will their voices be incorporated into the monitoring process?

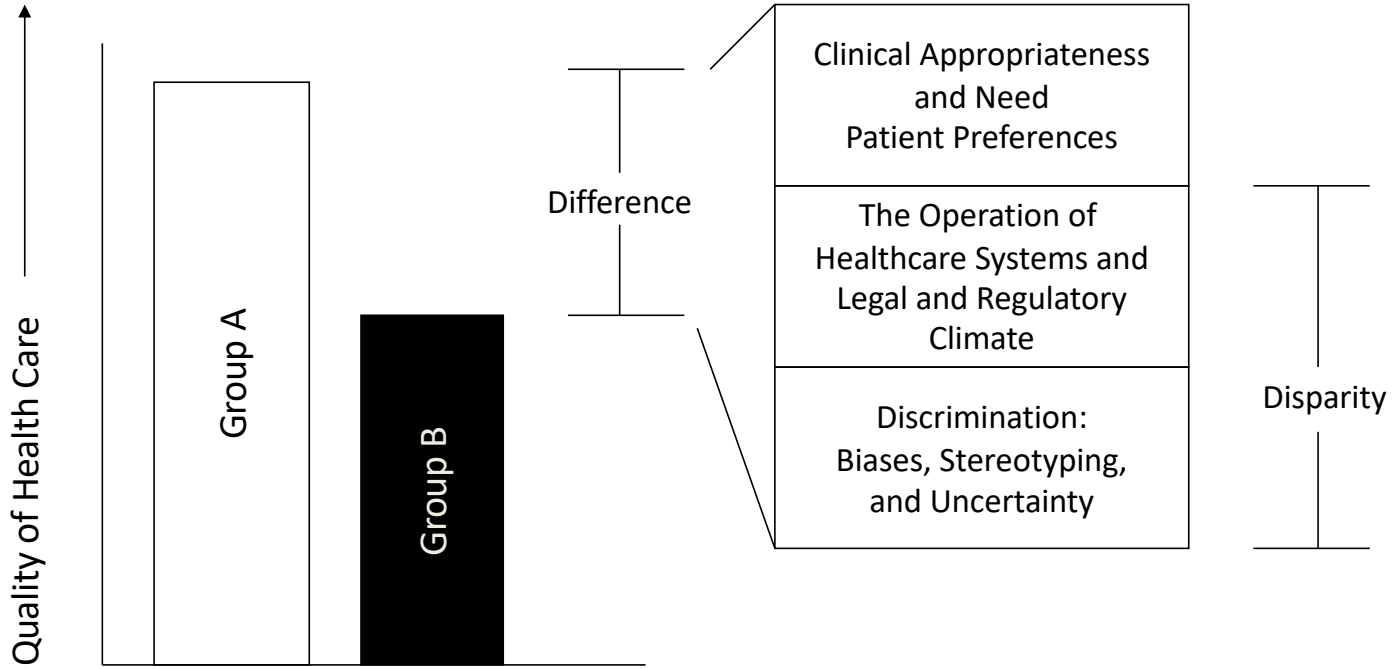
GRANT MAKERS IN HEALTH

Thank you!

Visit us at www.gih.org
president@gih.org

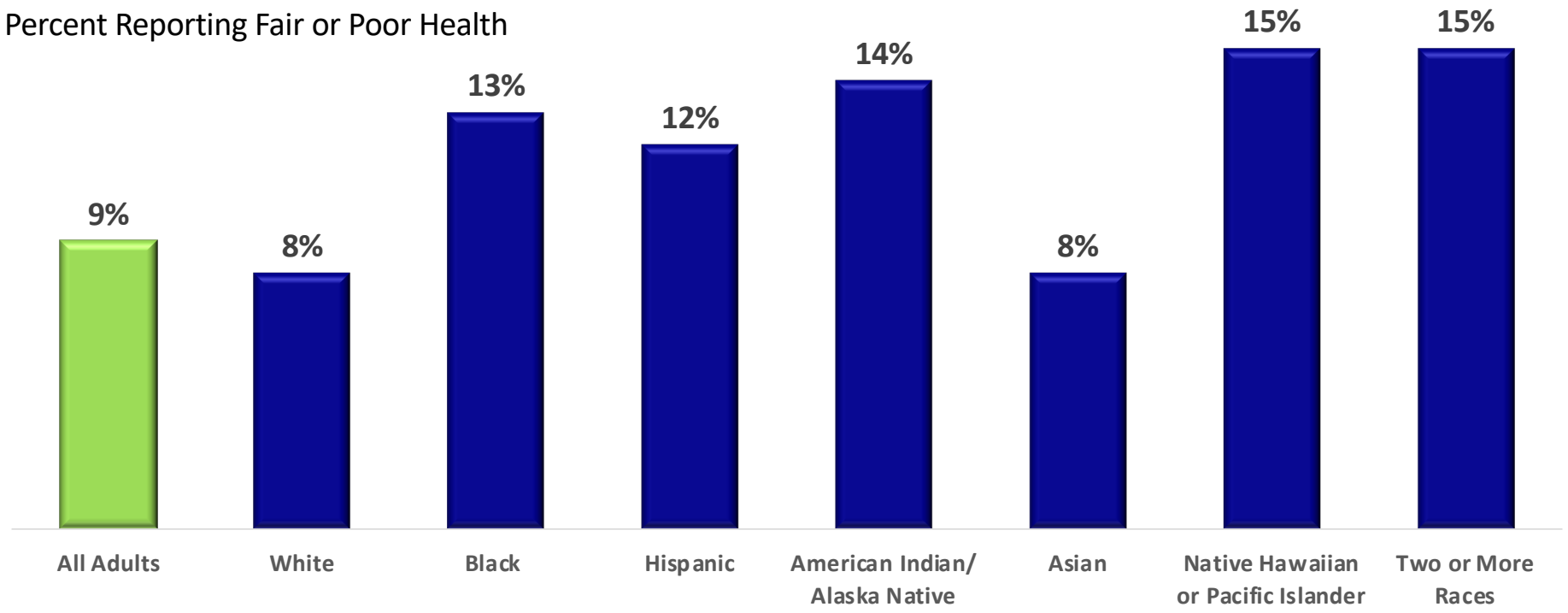
Appendix

What Are Health Disparities?



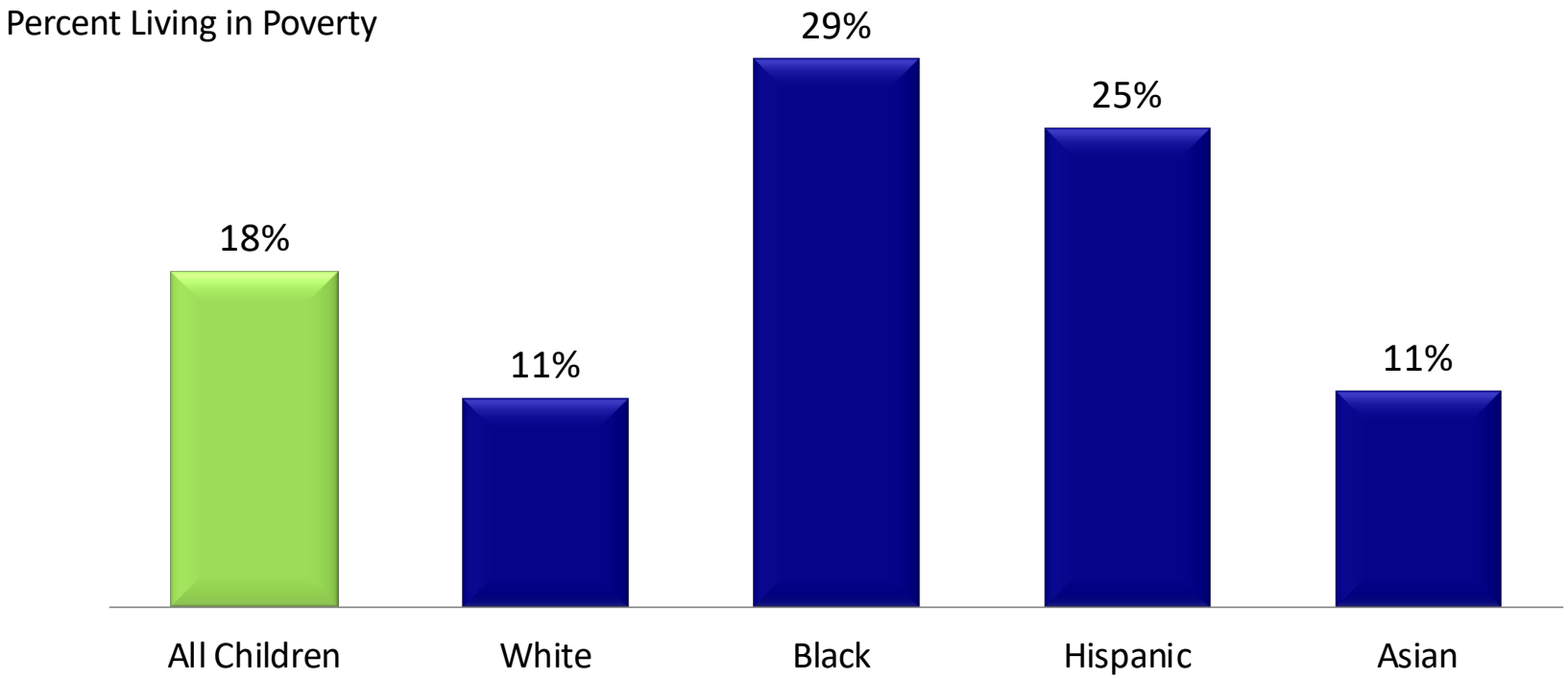
SOURCE: Figure 1. Differences, Disparities, and Discrimination: Populations with Equal Access to Healthcare. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, Summary*. Brian Smedley, Adrianne Stith, and Alan Nelson, Eds. Washington, DC. Institute of Medicine, 2002.

Fair or Poor Health Status Among Adults by Race & Ethnicity, 2017



SOURCE: Table 16. Respondent-assessed fair-poor health status, by selected characteristics: United States, selected years 1991–2017. Health, United States, 2018. Centers for Disease Control and Prevention.

Children in Poverty by Race & Ethnicity, 2017



NOTE: FPL for a Family of 3 = $20,420; FPL for a Family of 4 = $24,600
SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2018..

Other Languages Spoken at Home in the United States

- More than 62 million people speak a language other than English at home
- More than 25 million (41%) of those who speak another language at home speak English less than "very well" (LEP)
- Top 10 Languages in US other than English:

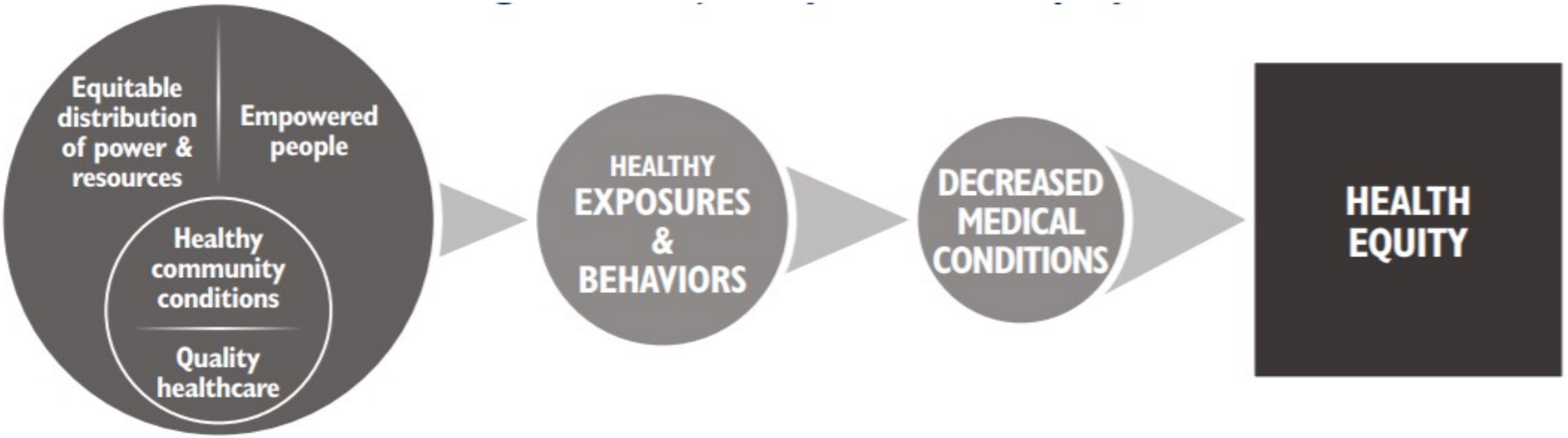
1.	Spanish	38.7 million	6.	Korean	1.1 million
2.	Chinese	3.1 million	7.	Arabic	1.0 million
3.	Tagalog	1.7 million	8.	German	1.0 million
4.	Vietnamese	1.5 million	9.	Russian	0.90 million
5.	French	1.3 million	10.	French Creole	0.79 million

SOURCE: *Detailed Languages Spoken at Home and Ability to Speak English for the Population 5 Years and Over for United States: 2011-2015.* U.S. Census Bureau.

Take Home Messages Regarding Health Disparities

1. Disparities exist in health status, access to care, quality of care, and health outcomes, there is still much we don't know, due to a lack of data.
2. Regardless of how they fair in the aggregate, all racial groups have problems.
3. Racial groups are not monolithic, and health differs within racial groups.
4. Cost of not addressing disparities is large and apt to get worse, as the population changes.
5. Many factors aside from race impact health and health care.
6. A myriad of efforts are underway to address disparities, but we still have a long way to go to eliminate disparities.

Prevention Institute's Trajectory for Health Equity



SOURCE: https://www.preventioninstitute.org/publications/measuring-what-works-achieve-health-equity-metrics-determinants-health

Health Equity Measurement Resources

1. National Quality Forum - Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity. https://www.qualityforum.org/Disparities_Project.aspx

2. Prevention Institute - Measuring What Works to Achieve Health Equity: Metrics for the Determinants of Health. https://www.preventioninstitute.org/publications/measuring-what-works-achieve-health-equity-metrics-determinants-health

3. Agniel, D., Martino, S.C., Burkhart, Q. *et al.* Incentivizing Excellent Care to At-Risk Groups with a Health Equity Summary Score. *J GEN INTERN MED* (2019). https://doi.org/10.1007/s11606-019-05473-x

Health Equity Data Resources

1. Health, US – Centers for Disease Control and Prevention
   https://www.cdc.gov/nchs/hus/index.htm

2. National Healthcare Quality & Disparities Report – Agency for Healthcare Research and Quality
   https://www.ahrq.gov/research/findings/nhqrdr/index.html

3. Mapping Medicare Disparities Tool – Centers for Medicare & Medicaid Services
   go.cms.gov/omh

4. Census data – US Census Bureau
   www.data.census.gov

5. State Health Facts – Kaiser Family Foundation
   https://www.kff.org/statedata/

6. County Health Rankings – University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation
   https://www.countyhealthrankings.org/