U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Minority Health
Office of the Assistant Secretary for Health, Region III

Region III Meeting:
"Bridging Health Equity Across State Lines and Communities"
August 2, 2017
Philadelphia, Pennsylvania

Record of the Proceedings

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Meeting Report

The U.S. Department of Health & Human Services (HHS), Office of Minority Health (OMH), Office of the Assistant Secretary for Health (OASH)-Region III convened the "Bridging Health Equity Across State Lines and Communities" meeting on August 2, 2017. The proceedings were held at Thomas Jefferson University, Alumni Hall, in Philadelphia, Pennsylvania.

The purpose of the meeting was to explore a collaborative strategy to achieve health equity across state lines and communities in Region III: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia. To achieve this goal, diverse input would be collected from policymakers, public health professionals, clinicians, and other subject-matter experts on reducing health disparities among minority populations.

The following objectives were established for the meeting: (1) identify the most recent health disparity data and programmatic barriers in addressing key health disparities across Region III; (2) discuss the impact of federal and state policies on preventing health disparities in minority and vulnerable populations; and (3) determine concrete action steps that are needed to advance health equity initiatives across state lines and communities in Region III.

Several presentations would be made over the course of the meeting to assist the State Offices of Minority Health (SOMHs) in identifying and reaching consensus on conducting a health equity collaborative project throughout Region III.

- Overviews by federal agencies of ongoing activities to advance health equity at the regional, state, and local level: HHS/OMH Headquarters, Centers for Medicare & Medicaid Services (CMS), and Health Resources and Services Administration (HRSA).
- An overview by the Mid-Atlantic Regional Health Equity Council (i.e., RHEC III) of ongoing activities to advance health equity at the regional level.
- Overviews by the SOMHs of ongoing activities to advance health equity in each of the six Region III states:
- An overview of ongoing activities by an academic partner in Region III, Thomas Jefferson University (TJU), to advance health equity.

Welcome and Opening Remarks

Alexandria (Alexis) Skoufalos, EdD
Associate Dean for Strategic Development
Executive Director, Center for Population Health Innovation
Jefferson College of Population Health
Thomas Jefferson University

Dr. Skoufalos welcomed the participants to the Region III meeting, "Bridging Health Equity Across State Lines and Communities." She was honored that the meeting was being held at the TJU campus in Philadelphia. She emphasized that the current HHS/OASH-Region III and TJU partnership serves as an excellent model of collaboration between public health and academia.

Dr. Skoufalos noted that a detailed presentation would be made during the meeting to describe the ongoing activities of the TJU Jefferson College of Population Health (JCPH) to address health equity, health disparities, and social determinants of health (SDOH) in Region III. In the interim, however, she provided a brief background on TJU/JCPH.

TJU is a leading academic health center that was founded in Philadelphia in 1824. JCPH was established in 2008 to explore the policies and forces that define the health and well-being of populations. JCPH's mission is "to prepare leaders with a global vision to examine the social determinants of health and to evaluate, develop, and implement health policies and systems that will improve the health of populations and thereby enhance the quality of life."

Dr. Skoufalos reported that she is aware of OMH's major goal to end health disparities in all 10 HHS regions. To support this effort in Region III, she hoped that the meeting would result in TJU/JCPH leveraging its existing partnership with HHS/OASH-Region III to establish strong collaborations with the SOMHs in all six Region III states and the Mid-Atlantic RHEC.

Dalton Paxman, PhD
Regional Health Administrator
U.S. Department of Health & Human Services
Office of the Assistant Secretary for Health, Region III

Dr. Paxman joined Dr. Skoufalos in welcoming the participants to the meeting. He explained that the leadership role of HHS/OASH-Region III is to strengthen the public health infrastructure, implement priority health objectives, and provide resources to support these efforts throughout the region.

Dr. Paxman thanked the Region III SOMHs and the Mid-Atlantic RHEC Co-Chairs for taking time to attend the meeting and contribute their expertise. He was particularly pleased that the overarching objective of the meeting to develop a dynamic network to bridge health equity across Region III would reflect full representation at the state level (participation by all six Region III SOMHs) and the regional level (participation by the Mid-Atlantic RHEC Co-Chairs).

Dr. Paxman announced that he would serve as the "Day 2 Facilitator" of the meeting. In this role, he would lead a series of discussions to assist the Region III SOMHs and the RHEC III Co-Chairs in achieving the key meeting objective. He concluded his opening remarks by commending Mr. Daniel Bones Gallardo, the Regional Minority Health Consultant/Health Equity Team Lead, and the entire HHS/OASH-Region III staff for their leadership. Their outstanding

efforts in planning, organizing, and convening the meeting would play a critical role in allowing the SOMHs to develop and implement a collaborative project to bridge health equity across state lines and communities in Region III.

Pamela Kania, MS
Acting Regional Director, Region III
Office of Intergovernmental and External Affairs
U.S. Department of Health & Human Services

Ms. Kania informed the participants that HHS is an extremely large federal agency with a budget of approximately $1 trillion to administer more than 100 programs across its operating divisions. All HHS programs have a common goal to protect the health of Americans, improve their well-being, and provide essential human services, particularly for people who are least able to help themselves. Of the entire U.S. population, 1 in every 13 Americans currently receives health services from an HHS-funded entity.

To navigate through HHS's complex organizational structure, a Regional Director is assigned to each of the 10 regions to collaborate directly with state, local, and tribal entities. As the Acting Regional Director of Region III, Ms. Kania was interested in obtaining feedback from the SOMHs and the Mid-Atlantic RHEC Co-Chairs on identifying a collaborative project that could be conducted to bridge health equity across state lines and communities in Region III. Similar to her colleagues, she also thanked Mr. Gallardo and the entire HHS/OASH-Region III staff for their excellent leadership in guiding and navigating the efforts of the SOMHs in this important initiative.

Mary Ann Cooney, MPH, MS
Chief, Health Systems Transformation
Association of State and Territorial Health Officials (ASTHO)

Ms. Cooney served as the Facilitator of the Region III meeting and welcomed the participants. She began her opening remarks by describing the rationale for the strong partnership between ASTHO and HHS. ASTHO is a national nonprofit organization that represents over 100,000 public health professionals who are employed by public health agencies in the United States, District of Columbia, and U.S. territories. ASTHO formulates and influences sound public health policy and ensures excellence in state-based public health practice.

ASTHO's two primary functions are to (1) track, evaluate, and advise its members on the establishment and impact of public or private health policies and (2) provide guidance and technical assistance (TA) on improving the nation's health. ASTHO's vision is "healthy people thriving in a nation free of preventable illness and injury." ASTHO's mission is to "transform public health within states and territories to help members dramatically improve health and wellness."

Ms. Cooney announced that in addition to the traditional focus areas on public health prevention and population health improvement ASTHO assists the state health officials under 3 areas: capacity building, policy, advocacy, and leadership. Also, recently Ms. Cooney and another state health official have considered the importance of non-traditional factors into public health interventions, such as "love," "caring," and "compassion." We know that building community caring is just one way to help build social connections to assure well-being. During the meeting, Ms. Cooney asked that the SOMHs apply their "love" and "passion" as state health officials in

the development of a new collaborative health equity project that could be implemented and sustained in Region III over time. Ms. Cooney encouraged the participants to use the meeting as an opportunity to make bold and creative suggestions on new and innovative health equity partners to engage at federal, regional, state, local, and community levels. She also invited the participants to visit and utilize the ASTHO website as a resource (http://www.astho.org).

Keynote Address: Advancing Health Equity Through Community, State, and Federal Collaboration

Carol Jimenez, JD
Acting Director, Office of Minority Health
U.S. Department of Health & Human Services

HHS released a landmark publication in 1982, the *Report of the Secretary's Task Force on Black and Minority Health* (i.e., the Heckler Report). The publication documented the existence of health disparities in racial/ethnic minorities in the United States and characterized these disparities as "an affront both to our ideals and to the ongoing genius of American medicine."

OMH was established in 1986 as one of the most significant outcomes of the Heckler Report. The document included a compelling conclusion: "Despite the unprecedented explosion in scientific knowledge and the phenomenal capacity of medicine to diagnose, treat, and cure disease, Blacks, Hispanics, Native American Indians and those of Asian/Pacific Islander Heritage have not benefited fully or equitably from the fruits of science or from those systems responsible for translating and using health sciences technology."

The mission of OMH is "to improve the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities." OMH's primary functions focus on five key areas: awareness; data; partnerships and networks; policies, programs, and practices; and research, demonstrations, and evaluation.

OMH's strategic priorities are three-fold: (1) support initiatives and programs that provide access to quality health care; (2) lead the implementation of the HHS Action Plan to Reduce Racial and Ethnic Health Disparities; and (3) coordinate the National Partnership for Action to End Health Disparities (NPA) and the National Stakeholder Strategy for Achieving Health Equity. To achieve its strategic priorities, OMH focuses on translating core minority health and health disparities programs into strategic activities and policies at federal, state, tribal, territorial, and local levels. OMH also extensively collaborates with multiple federal partners to address minority health issues.

The NPA defines health equity as "the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." The Healthy People 2020 Initiative defines SDOH as "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." Additional information on these two important definitions is available at http://www.npa-rhec.org/health-equity-what-does-it-mean-to-you.

The mission of the NPA is "to increase the effectiveness of programs that target the elimination of health disparities through the coordination of partners, leaders, and stakeholders committed to action and by bringing attention to the social determinants of health." The four principles that guide the NPA's targeted actions are a community-driven, partnership-based, multi-level/multi-sector, and SDOH approach.

NPA's implementation structure engages stakeholders at all levels to facilitate actual progress toward achieving health equity. The four components of the NPA infrastructure include the Federal Interagency Health Equity Team (FIHET), RHECs in all 10 HHS regions, SOMHs, and national partners.

In terms of the SOMHs, Regional Minority Health Consultants provide leadership for OMH at the regional level. Most notably, regional meetings are convened to promote collaboration and leverage resources. Bimonthly calls are held and projects are conducted to publicize the important activities of the SOMHs. For example, Maryland and Virginia are the two successful grant recipients in Region III that were awarded funding under the 2015-2010 State Partnership Initiative to Address Health Disparities. SOMHs also were awarded grants under the State Partnership Programs to Improve Minority Health in 2010-2013 and 2013-2015. Moreover, the SOMHs collect important data for the *State and Territorial Health Disparities Survey and Report*.

In terms of the RHECs, these public/private coalitions are comprised of regional stakeholders who are dedicated to addressing health equity at the local level. Each RHEC determines its individual regional priorities and initiatives. The RHECs are supported by OMH and ensure that their priorities are aligned with those of HHS and OMH. The 10 RHECs represent the same geographic regions as the 10 HHS regions. In addition to the 10 RHECs, three crosscutting workgroups also were established: American Indian/Alaska Native (AI/AN) NPA Caucus, Cross-RHEC Community Health Worker (CHW) Coalition, and Cross-RHEC Oral Health Workgroup. The Mid-Atlantic RHEC represents the six Region III states.

OMH published the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care in April 2013 (www.thinkculturalhealth.hhs.gov). The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to implement and provide culturally and linguistically appropriate services. OMH also developed five CLAS E-Learning Programs as additional resources for various audiences. With the exception of *promotores de salud*, all of these programs offer continuing education credits.

- *A Physician's Practical Guide to Culturally Competent Care*
- Culturally Competent Nursing Care
- *Cultural Competency Curriculum for Disaster Preparedness and Crisis Response*
- Cultural Competency Program for Oral Health Professionals
- Cultural Competency for *Promotores De Salud*

Examples of OMH's grant programs include Communities for a Healthier Nation Initiative, National Workforce Diversity Pipeline Program, Partnerships to Achieve Health Equity, Communities Addressing Childhood Trauma, Re-Entry Community Linkages Program, and Minority Youth Violence Prevention Programs I and II.

The OMH Resource Center (OMHRC) is the nation's largest repository of information on the health of minority populations in the United States and its territories. The OMHRC provides a wide range of services, including literature and funding searches, recent data/statistics, capacity building, consumer materials, TA, e-newsletters, and social media expertise. The OMHRC is available from Monday through Friday, 9:00 a.m.-5:00 p.m. EST, by telephone (301-251-1797; 800-444-6472) or email (info@minorityhealth.hhs.gov).

HHS ensures that multiple opportunities are available for community input on its health equity activities. Most notably, planning efforts are underway for Healthy People 2030. The new set of 10-year national objectives will be designed to improve the health of all Americans. This initiative will focus on establishing a framework, vision, mission, and overarching goals as well as identifying new objectives. The multi-year process for Healthy People 2030 will include input from subject-matters experts, organizations, and members of the public. The content on SDOH will be updated as well. HHS is holding public meetings and accepting written comments on Healthy People 2030 through September 29, 2017 (https://www.healthypeople.gov/2020/About-Healthy-People/Development-Healthy-People-2030/Public-Comment).

The HHS Strategic Plan (2018-2022) will be available for public comment after September 11, 2017. HHS and all other federal agencies update their strategic plans every four years. The new HHS Strategic Plan will outline the goals and objectives that direct the vision and activities of the department to address national health issues. The strategic plan is a living document that tracks the accomplishments of HHS over time.

Ms. Jimenez concluded her keynote address by thanking several individuals for their ongoing support to end health disparities in Region III: Mr. Gallardo, Ms. Kania, the SOMHs, and the RHEC III members. She also thanked Ms. Stacey Williams, the HHS Regional Operations Officer, for her leadership in planning and organizing the meeting.

The participants thanked Ms. Jimenez for taking time from her busy schedule to join the meeting via video conference and present a comprehensive overview of HHS/OMH's ongoing efforts to advance health equity through community, state, and federal collaboration. Several participants noted that HHS/OMH's research, publications, and other resources would be particularly helpful to the SOMHs in designing a new collaborative health equity project for Region III.

Starting on the Same Page: A Review of Equity, Disparity, and the Social Determinants of Health

Rosemary Frasso, PhD, MSc, CPH
Director of Public Health
College of Population Health
Thomas Jefferson University

Dr. Frasso presented an overview of equity, disparity, and SDOH to guide the discussions of the SOMHs in developing a collaborative health equity project in Region III. The ability to achieve and maintain good health is a complex matter. Most notably, the differences in health between groups can be unfair, unjust, unclear, underappreciated, or simply avoidable.

The difference between "equality" and "equity" is subtle, but significant. With equality, for example, three people would have the same three stools to reach the same three apples (or the

same assistance for all people). With equity, three different people would have three adjusted stools to reach the same apples (or different assistance to people based on their needs).

Health equity is defined as "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." Health inequality is defined as "the difference in health status or in the distribution of health determinants between different population groups." Some health inequalities are unavoidable, while others are avoidable.

A health disparity is "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage." Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on multiple factors: race or ethnicity, religion, socioeconomic status (SES), gender/gender identity, sexual orientation, age, mental health status, geographic location, cognitive/sensory/physical disability, or other characteristics historically linked to discrimination or exclusion.

A health care disparity relates to "differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of interventions. These differences include the role of bias, discrimination, and stereotyping at individual provider/patient, institutional, and health system levels."

Examples of health and health care disparities are described as follows. Data collected by the Centers for Disease Control and Prevention (CDC) showed health disparities in asthma prevalence in the United States in 2015. By age, the asthma prevalence was 8.4% in children and 7.6% in adults. By gender, the asthma prevalence was 9.1% in females and 6.5% in males. By race/ethnicity, the asthma prevalence was 10.3% in Blacks, 7.8% in Whites, and 6.6% in Hispanics.

The 2008 Esnaola, *et al.* study and the 2010 Cykert, *et al.* study analyzed data on the use of surgical resection of localized, non-small cell lung cancer among 2,506 White and 550 Black patients. After controlling for SES, comorbidities, and tumor factors, the studies concluded that Black patients (44.7%) were less likely to undergo resection than White patients (63.4%).

The 2015 U.S. Transgender Survey reported that transgender people encounter high levels of mistreatment when seeking health care. Of transgender people who presented to a health care provider, 33% reported at least one negative experience (e.g., verbal harassment or refusal of treatment). Of all transgender people who responded to the survey, 23% reported not seeking necessary health care services in the prior year due to fears of being mistreated. The 2016 Herman, *et al.* study showed that the vast majority of states have existing laws for sex discrimination protections only. At this time, only a small number of states have passed laws with clear gender identity/sexual orientation protections or sex/sexual orientation protections.

During her keynote address to the Harvard School of Public Health graduating class of 2014, Melody Goodman, PhD, of Washington University, emphasized that "your zip code is a better predictor of your health than your genetic code." Her statement was evidenced in the 2013 publication, *Community-Generated Recommendations Regarding the Urban Nutrition and Tobacco Environments: A Photo-Elicitation Study in Philadelphia*. The photographs in the study documented the large number of tobacco outlets in the city and the contradiction between cigarette smoke at a health-promoting farmer's market.

Other studies have reported that Blacks, Hispanics, and Asians are most likely to live in areas with high levels of air pollution than Whites. The prevalence of inadequate housing, as defined by moderate to severe deficiencies in plumbing, heating, and electricity, was found to be highest for Blacks (9%), Hispanics (7.8%), and American Indians (7.5%) than for Asians (4.6%) and Whites (4.1%). The 2005 Hood study, "Dwelling Disparities: How Poor Housing Leads to Poor Health," also documented health disparities based on geographic location.

The factors that impact an individual's health are summarized below.

- Social and economic factors (40%)
    - Education
    - Employment
    - Income
    - Family and social support
    - Community safety
- Health behaviors (30%)
    - Tobacco use
    - Diet
    - Exercise
    - Alcohol and drug use
    - Sexual activity
- Health care (20%)
    - Access to care
    - Quality of care
- Physical environment (10%)
    - Air
    - Water
    - Housing
    - Transportation

Health care from providers competes with the realities of communities. The 2016 Berkowitz, *et al.* study showed that patients with unmet needs (e.g., affordable health care, food, and utilities) are more likely to report depression, asthma, diabetes, frequent use of emergency departments (EDs), and frequently missed clinic appointments. The 2015 Purnell study, *What It's Worth*, included a compelling quote from communities: "If you want to lower my blood pressure, help me pay my electric bill."

SDOH is comprised of multiple elements that all affect health: neighborhood and the built environment, health and health care, social and community factors, education, and economic stability. The key drivers of SDOH are at the institutional level (laws and policies; workplaces, and hospital settings); social level (racism, education access, and poverty); and environmental level (air quality, housing, and food safety).

The complexities related to SDOH have been featured in numerous media publications, including *Time*, *Newsweek*, and *The New Yorker*. TJU/JCPH has launched several qualitative studies in Region III to address SDOH. In terms of healthy food, the Philadelphia Department of Public Health conducted a supermarket study with urban shoppers who were responsible for feeding their children. The supermarket study did not implement traditional methods to obtain data from participants, such as focus groups, surveys, or interviews that rely on reflections by the community. Instead, these methods were replaced with walking interviews that allowed the

asset mapping team to connect with community members during their experiences with community resources.

The advantages of the walking interview approach included several logistical benefits. Equipment was readily accessible. The "desensitized" public did not notice the asset mapping team in the supermarkets. The recall bias was eliminated. Data were collected in real-time. The strategy allowed for nimble questioning. However, the challenges with the walking interview approach included a noisy environment, the need to move equipment, a "walking and talking" setting, a social desirability bias, and reactivity. If required, permission was obtained from store managers to conduct the study in their supermarkets. Both the interviewer and the participant wore microphones and recorders.

The interviewers were surprised by one key outcome of the supermarket study. Most participants selected frozen foods as their "healthy food." The participants explained that insecticides are routinely sprayed near fresh fruits and vegetables for pest control.

In terms of housing, collaborations were established to shed light on the lived experience. Dr. Frasso partnered with Willie Baronet, a Dallas artist, to conduct a new project, "Cardboard Commentary: A Qualitative Analysis of the Signs from America's Streets." Mr. Baronet has been collecting signs from homeless and poor people on the streets across the United States for 20 years. His goal is to use art to raise awareness of homelessness and poverty. Dr. Frasso presented several photographs of the signs that were included in the project and the engagement of TJU/JCPH students in this initiative.

In terms of neighborhood, several urban community gardening clubs have been formed in Philadelphia. However, numerous gardeners have expressed concerns regarding soil safety, particularly in the context of high lead levels in soil.

DISCUSSION: OVERVIEW OF EQUITY, DISPARITY, AND SDOH

Dr. Frasso provided additional details on TJU/JCPH's ongoing health equity activities in response to specific questions by the participants. The discussion focused on the following topics.

- The schedule of the Cardboard Commentary art exhibit, particularly its return to jurisdictions in Region III other than Philadelphia.
- Effective strategies to encourage young students to pursue a career in public health.
- Health disparities/health equity activities that are specifically targeted to people 60 years of age and older.
- The extent to which Dr. Frasso's TJU/JCPH colleagues were receptive to her mixed-methods qualitative research.
- TJU/JCPH's plans to share its mixed-methods qualitative research design for replication by other universities.

Overview of the HRSA Bureau of Health Workforce (BHW) Programs

Camille Soondar
Regional Supervisor, Region III
Division of Regional Operations, Bureau of Health Workforce
Health Resources and Services Administration
U.S. Department of Health & Human Services

Ms. Soondar presented an overview of the HRSA/BHW Programs. BHW's approach is to make a positive and sustained impact on health care delivery for underserved communities with its three core components of education, training, and service. The "education" component focuses on scholarships, loans, and loan repayment. The "training" component focuses on health professions training. The "service" component focuses on graduate medical education.

Ms. Soondar presented an organizational chart to illustrate the BHW infrastructure. The mission of BHW is to "improve the health of underserved and vulnerable populations by strengthening the health workforce and connecting skilled professionals to communities in need." BHW fulfills its mission by focusing on three key priorities.

- Prepare a workforce that increases the number of diverse, culturally competent primary care providers who represent various disciplines.
- Improve workforce distribution throughout the nation, particularly in underserved, rural, and tribal areas.
- Advance modern health care by implementing changes in health professions training that are responsive to the evolving needs of the health care system.

The roles, responsibilities, and functions of the BHW divisions are described as follows. The Division of Regional Operations (DRO) is located in each of HRSA's 10 regional offices: (https://nhsc.hrsa.gov/sits/index.html; https://nhsc.hrsa.gov/downloads/sitereference.pdf).

DRO conducts numerous activities to support BHW.

- Conducts National Health Service Corps (NHSC) site visits and provides TA to NHSC sites
- Oversees NHSC site applications and recertification reviews
- Recruits and retains participants
- Places scholars at NHSC-approved sites
- Builds partnerships and collaborations with local, state, national, and federal stakeholders

The Division of Nursing and Public Health (DNPH) (https://bhw.hrsa.gov/grants) supports BHW by (1) overseeing nursing grants and cooperative agreements to promote nursing education and practice and (2) overseeing Public Health Workforce and Development grants and cooperative agreements to increase the number, quality, and ability of individuals in the public health workforce to meet national, state, and local health care needs. Ms. Soondar presented organizational charts to illustrate the portfolio of programs and activities that are administered by the DNPH Nursing Education and Practice Branch and the Advanced Nursing Education Branch.

The Division of Health Careers and Financial Support (DHCFS) supports BHW through programs that provide education and training opportunities to individuals from disadvantaged backgrounds. The goals of these programs are to increase access to care for underserved populations and increase opportunities for minority patients to receive care from practitioners who share a common race, ethnicity, or language.

As of fiscal year (FY) 2016, NURSE Corps participants served in both urban areas (83%) and rural areas (17%). The 1,697 NURSE Corps participants collectively provide services to over 1.7 million patients at 1,080 Critical Shortage Facilities. Of all NURSE Corps participants, approximately 80% work in Health Professional Shortage Areas with scores greater than 14.

Minorities represent approximately 29.7% of the NURSE Corps field strength and more than 40% of the NURSE Corps pipeline. African American nurses represent 12.2% of the national nursing workforce, but 16% of the NURSE Corps workforce. African American, AI/AN, and Hispanic NURSE Corps participants also surpass national averages for nursing faculty. Among scholars, 25.8% are African American, 12% are Hispanic, 8.5% are Asian/Pacific Islander, and 1.7% are AI/AN.

Ms. Soondar presented an organizational chart to illustrate the DHCFS branches. Additional information on these programs is available at:
https://bhw.hrsa.gov/grants
https://bhw.hrsa.gov/loansscholarships/schoolbasedloans
https://bhw.hrsa.gov/loansscholarships/nursecorps.

The Division of National Health Service Corps supports BHW by providing scholarship and loan repayment programs to help underserved communities recruit and retain primary health care providers (https://bhw.hrsa.gov/loansscholarships/nhsc). NHSC Scholarship Programs provide scholarships for primary care medical and dental providers-in-training. NHSC Loan Repayment Programs provide loan repayment for primary care medical, dental, and mental/behavioral health clinicians.

The National Center for Health Workforce Analysis supports BHW by conducting research in two key areas: (1) examining issues that impact the supply, demand, distribution, and education of the nation's health workforce; and (2) providing policymakers with necessary information to make decisions (https://bhw.hrsa.gov/national-center-health-workforce-analysis).

In addition to these programs, BHW also developed several resources to improve health care delivery to underserved communities. The BHW Health Workforce Connector is a free online recruitment resource for all NHSC-approved sites to post medical, dental, and mental/ behavioral health job vacancies (https://connector.hrsa.gov).

HRSA Advisory Councils were established to provide ongoing guidance on HRSA's health professions policies and programs. HRSA accepts nominations for members on a continuous basis as vacancies become available. Nominations can be submitted to the Advisory Council Operations Team at HWAdvisoryCouncilFRN@hrsa.gov. The five HRSA Advisory Councils are listed below.

- Advisory Committee on Interdisciplinary, Community-Based Linkages
- Advisory Committee on Training in Primary Care Medicine and Dentistry
- Council on Graduate Medical Education

- National Advisory Council on Nursing Education and Practice
- National Advisory Council on the National Health Service Corps

DISCUSSION: HHS REGIONAL AGENCY UPDATES
The participants commended CMS for establishing a priority in its Health Equity Plan to increase access to health care services among people with LEP.

Ms. Soondar provided additional details on the current health equity activities conducted by HRSA in response to specific questions by the participants. The discussion focused on the following topics.

- The need for close collaboration between HRSA and the SOMHs to further increase the diversity of the health care workforce in Region III.
- Potential strategies for the Region III states to use HRSA's federal programs (e.g., the NHSC Scholarship and Loan Repayment Programs and the Division of Health Careers and Financial Support Programs) as models to develop similar programs at the state level, particularly to increase the reach of these initiatives to Historically Black Colleges and Universities (HBCUs).

In response to Dr. Luta's request for clarification, Ms. Soondar explained that graduates of international medical/dental schools who migrate to the United States are not eligible for NHSC scholarships or loan repayment. These benefits are limited to graduates of medical/dental schools in the United States.

Update by the Mid-Atlantic Regional Health Equity Council

Jenné Johns, Mid-Atlantic RHEC Co-Chair
Director of Health Equity
AmeriHealth Caritas

Seneca Bock, Mid-Atlantic RHEC Co-Chair
Founder and Chief Strategist
Community Capacity Builders, LLC

Ms. Johns and Ms. Bock presented an update on the Mid-Atlantic RHEC. The Mid-Atlantic RHEC is one of 10 RHECs in the United States that was formed in 2011 to implement the NPA. The mission of the Mid-Atlantic RHEC is to inform and strengthen programs, policies, practices, and services that contribute to achieving better health for all people in Region III: Delaware, Maryland, Pennsylvania, Virginia, West Virginia, and the District of Columbia. The Mid-Atlantic RHEC coordinates these efforts with the SOMHs to eliminate health disparities, address the National CLAS Standards and SDOH, and stimulate communities to empower themselves.

The 20 members who serve on the Mid-Atlantic RHEC are affiliated with a diverse group of organizations and entities, including state health departments, hospital systems/health care organizations, academic institutions, private foundations, community-based organizations, faith-based organizations, and businesses. The Mid-Atlantic RHEC is conducting several activities in support of its three priority areas.

- To “increase awareness of the significance of health disparities,” health equity profiles are being published and disseminated. Collaborations are being established with regional stakeholders to provide education about health insurance provisions under the ACA.
- To “improve cultural and linguistic competency,” regional practitioners from multiple sectors are being educated on cultural competency and unconscious bias. Access to information is being increased to support adoption of culturally competent practices.
- To “address pipeline workforce development for people of color,” leaders are being convened to increase the health care pipeline for minority students. Youth education and leadership are being enhanced through training on heath equity, SDOH, mentoring, and practicum experiences.

The Mid-Atlantic RHEC conducts its activities with two committees and one workgroup. The goal of the Awareness Committee is to increase awareness of health equity, the significance of health disparities, and their impact in Region III. The committee also is charged with identifying key stakeholders for collaboration on health equity-related activities. The committee has oversight of the Annual Health Equity Hero Award and the rollout of activities for Annual Health Equity Day on April 5.

The goal of the Cultural Competency Committee is to improve cultural and linguistic competency and utilization of the National CLAS Standards. The committee administers surveys to assess awareness and implementation in this area and identify regional goals. The committee created a cultural competency database of hospitals and Federally Qualified Health Centers. To date, 43 respondents have completed the most recent survey that was administered in October 2016. The survey findings will be released later in 2017 and will be used to develop training and identify resources.

The goal of the Ad Hoc HBCU Workgroup is to explore strategies for collaboration in promoting the training of African Americans in health professions. The workgroup hosts the biannual HBCU Professions Summit. The most recent event was held at Howard University in 2015. The workgroup aims to achieve several objectives to achieve its goal. Assistance is provided to facilitate building sustainable cross-collaboration health professions programs, including focus areas for emerging leaders and the youth development pipeline.

Support is provided to emerging leaders and the youth development pipeline. Awareness is raised regarding pathways that lead from health and hard sciences to public health, nursing, and future innovation. Awareness is raised regarding new and emerging employment opportunities, particularly those in the health care field. Strategies are explored to increase collaborative relationships within the HHS infrastructure that are consistent with new priorities.

The Mid-Atlantic RHEC was pleased to host a Community Dialogue on December 9, 2016 at Norfolk State University in Virginia. The participants made a number of thoughtful and helpful recommendations for the Mid-Atlantic RHEC to consider. Collaborations with faith-based organizations (FBOs) should be strengthened because churches play an integral role in communities. Other important equity issues should be addressed, such as rural health issues, transportation, housing, homelessness, obesity, diabetes, cardiovascular disease (CVD), and veteran’s health.

Additional resources should be posted on the Mid-Atlantic RHEC website, particularly on culturally appropriate programs for African Americans, communities of color, persons with

disabilities, and the LGBTQIA population (lesbian, gay, bisexual, transgender, questioning, intersex, and allies). Training and TA should be provided on developing tools for these underserved populations. More emphasis should be placed on the root of problems related to disparities, such as SDOH and structural issues (e.g., housing, pain management, and substance use disorder). A stronger focus should be directed to system-level changes.

Overall, the Mid-Atlantic RHEC is considering a number of key issues for Region III to achieve the NPA goal ending health disparities. Funding efforts that address SDOH will be supported. Cross-collaboration will be expanded in Region III among the Mid-Atlantic RHEC, HHS/OMH, and the SOMHs. Transparency will be enhanced to establish new partnerships to advance health equity. For example, the Mid-Atlantic RHEC's ongoing initiatives related to health literacy and the National CLAS Standards will be integrated.

The Mid-Atlantic RHEC will expand its reach by exploring collaborative opportunities with NPA's existing partners, such as the AI/AN NPA Caucus, to improve access to educational opportunities, training, and TA. Collaborative relationships will be established and promoted with underserved communities and special populations, such as tribal communities. Strategies will be developed to maintain the momentum on health equity under the current Administration. Partnerships will be created with HBCUs and other colleges/universities to develop and sustain a strong youth workforce pipeline.

DISCUSSION: MID-ATLANTIC RHEC UPDATE

The participants were impressed by the excellent portfolio of activities that the Mid-Atlantic RHEC has developed to improve health equity in Region III. However, several participants highlighted other potential partners that the Mid-Atlantic RHEC should consider engaging in its ongoing efforts to achieve the NPA goal of ending health disparities. The discussion focused on the following topics.

- The increasingly important role of payers in addressing health disparities in their respective target communities.
- The ongoing development of a health literacy project by an insurance company due to survey results that showed the critical importance of this topic throughout Region III.
- The need for the Mid-Atlantic RHEC to expand its membership to include representation by the payer community.
- The need for the Mid-Atlantic RHEC to engage the grassroots voice. For example, a project on community-developed/-driven strategies is being piloted in Philadelphia County to better address health needs at the local neighborhood level.

Ms. Johns responded to some of the issues raised during the discussion. In addition to serving as the co-chair, she also represents the payer community on the Mid-Atlantic RHEC in her position as the Director of Health Equity at AmeriHealth Caritas. Based on her experience, she acknowledged the reluctance of payers to establish partnerships with other organizations due to the confidential nature of their data. During the upcoming call for new members, however, she made a commitment to ensure that payers would continue to be represented on the Mid-Atlantic RHEC.

Prior to the break, Mr. Gallardo thanked the participants for their informative feedback on potential collaborative opportunities between the Mid-Atlantic RHEC and grassroots/community-based initiatives. He emphasized the importance of this input because one of the major

outcomes of the meeting would be to build a strong network of health equity resources in Region III.

Region III SOMH Update: DISTRICT OF COLUMBIA

C. Anneta Arno, PhD, MPH
Director, Office of Health Equity
District of Columbia Department of Health (DCDOH)

The vision of DCDOH is "to be the healthiest city in America." The mission statement of DCDOH is to "promote health, wellness, and equity across DC and protect the safety of residents, visitors, and those doing business in our nation's Capital."

DCDOH has a three-pronged role as a role model, regulator, and convener/collaborator. DCDOH established five strategic priorities to guide its activities: (1) promote a culture of health and wellness; (2) address SDOH; (3) strengthen public/private partnerships; (4) close the gap between clinical medicine and public health; and (5) implement a data-driven outcome approach to program and policy development.

DCDOH collects, analyzes, and maintains a wealth of data to track and monitor the health status and health disparities of the DC population in several areas. Of the 10 leading causes of death that DCDOH reported for the entire DC population in 2015, heart disease and cancer collectively accounted for slightly over 60% of mortality.

By race/ethnicity, DCDOH observed disparities across some of the 10 leading causes of death in DC between non-Hispanic Whites versus non-Hispanic Blacks and Hispanics. Blacks also accounted for the highest infant mortality rates, based on the race of the mother, that DCDOH reported from 2005-2014. Dr. Arno presented a chart to illustrate the differences in life expectancy at birth, based on place of residence, between DC Wards 1 through 8 in 2010 and 2015. Wards 2 and 3, with predominantly White populations, had significantly higher life expectancy rates than the other wards.

DCDOH collected data in 2014 from its Behavioral Risk Factor Surveillance System (BRFSS) to determine differences in SDOH and health outcomes. By employment status, 19.3% of unemployed DC residents self-reported "fair" or "poor" health compared to 5.9% of employed DC residents. By insurance status, the percentages of DC residents without any type of health coverage were 8.8% among Blacks and 3.5% among Whites. The percentages of Blacks without health insurance and those who were unemployed (excluding homemakers, students, retirees, or people with disabilities) were statistically significant.

The 2014 DC BRFSS dataset showed dramatic differences in health outcomes by education in four categories: no high school diploma, high school diploma, some college, and college graduate. Of DC residents with no high school diploma, the diabetes rate was 22.4% and the asthma rate was 20.9%. Of DC residents who were college graduates, the diabetes rate was 4% and the asthma rate was 8.1%. The differences in diabetes and asthma rates between the two educational groups in DC were statistically significant.

Statistically significant outcomes also were observed in health behaviors among the four educational categories. Of DC residents with no high school diploma, 40.4% smoked daily and

44.1% did not engage in any physical activity. Of DC residents who were college graduates, 14.2% smoked daily and 9.5% did not engage in any physical activity.

Similar to other parts of the country, DC also is being affected by the national opioid epidemic. Of 3,201 people in DC who had opioid-related hospital encounters from January 1, 2017 to July 24, 2017, the 45-64 age group accounted for the vast majority of acute opioid poisoning, non-acute opioid problems, suspected acute opioid poisoning, or suspected overdose as the chief complaint. By gender, males overwhelmingly accounted for opioid-related hospital encounters over the same time period. By geographic location, Wards 5 and 8 have accounted for the majority of 2,466 opioid-related hospital encounters reported in 2017 to date.

By age, people 55 years of age and older accounted for the highest percentage of opioid overdose deaths reported in DC in 2016 (45%) and exceeded the percentage of opioid overdose deaths in the same age group in the U.S. population (19%). By race, Blacks accounted for the highest percentage of opioid overdose deaths reported in DC in 2016 (84%) and exceeded the percentage of opioid overdose deaths in the same racial group in the U.S. population (8%). DCDOH has purchased Naloxone kits to help communities reverse opioid overdoses and save lives.

Dr. Arno presented a series of map to from the recently released **DC Health Systems Plan, 2017**, which show some of the unique challenges that the District currently faces. After a decade of multimillion dollar investments in primary care throughout the city, there are challenges with local underutilization, and continued overutilization of emergency room services. Many residents continue to travel long distances to access services, seemingly unaware and/or unwilling to use services closer to home. Plans are underway to promote improved health literacy with emphasis on preventive services promotion, and the appropriate utilization of health insurance benefits -- seeking the right care, and the right time, in the right place.

The mission of the DCDOH Office of Health Equity (OHE) is to “address the root cause of health disparities, beyond health care and health behaviors, by supporting projects, policies, and research that will enable every resident to achieve their optimal level of health.” OHE achieves is mission by informing, educating, and empowering people about health issues and facilitating multi-sector partnerships to identify and solve community health problems related to SDOH.

OHE has designed a comprehensive strategy and framework to monitor the results of its activities. The overarching goal of the framework is to improve the context for equitable opportunities for health in DC. The framework also describes specific activities that will be conducted to support three priority strategies: build multi-sector collaborations, leverage community-based participatory research, and demonstrate health equity practice.

OHE is institutionalizing health equity practice by collecting and publishing baseline health equity data in DC, releasing the 2017 *Health Equity Report* in the near future, establishing the Commission on Health Equity in June 2017, and forming collaborations throughout the DCDOH administration. Dr. Arno concluded her update by highlighting preliminary data that will be released in the 2017 *Health Equity Report*.

- Life expectancy at birth by DC ward from 2010-2014.
- The percentage of DC adults 25 years of age and older with less than a high school diploma who are living in poverty and the percentage of DC youth 18-24 years of age with less than a high school diploma. The data show that college graduates can expect

to live five years longer than individuals who did not complete high school. The data further show that educational attainment among adults is linked to their children's heath, including their educational attainment, beginning early in life and beyond.
- Unemployment rates in DC by ward and age (e.g., people 16 years of age and older). The data show that in addition to providing a paycheck, a good job also fosters independence, promotes discipline, and contributes to the health of the community. The 18.2% of DC residents who live in poverty is higher than the U.S. average of 15.5%.
- The percentage of DC residents in poverty in the total DC population and by ward.
- The percentage of households on public assistance/SNAP in the total DC population and by ward.
- The percentage of households that spend over 35% of their income on housing in the total DC population and by ward.

Region III SOMH Update: MARYLAND

Shalewa Noel-Thomas, PhD, MPH
Director, Office of Minority Health and Health Disparities (OMHHD)
Maryland Department of Health (MDOH)

OMHHD was established in 2004 by statute to address minority health disparities in Maryland. The mission of OMHHD is to "address SDOH and eliminate health disparities by leveraging MDOH's resources, providing heath equity consultation, impacting external communications, guiding policy decisions, and influencing strategic direction on behalf of the Secretary of Health."

The vision of OMHHD is to "achieve health equity where all individuals and communities have the opportunity and access to achieve and maintain good health." OMHHD's FY2017 budget includes approximately $1.6 million in general funds and $200,000 in federal funds. Dr. Noel-Thomas presented organizational charts for both MDOH and OMHHD.

OMHHD utilizes a framework for health equity that works upstream and includes both socioecological and medical models. OMHHD adopted the Healthy People 2020 definition of SDOH: "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."

PolicyLink released data in 2012 that showed American communities often are segregated by race and income. Low-income communities or those of color frequently have the worst community conditions and the highest level of several health problems. Dr. Noel-Thomas presented two photographs of urban communities in Maryland to illustrate differences in the life expectancies of 79 years of age in the more affluent neighborhood versus 70 years of age in the low-income neighborhood. Health disparities also have been reported in rural areas. The 18 rural jurisdictions in the state of Maryland have limited access to health care providers, lack of transportation, high rates of chronic disease, and reduced access to emergency care.

OMHHD collects, analyzes, and maintains a rich dataset to identify, quantify, and locate health disparities, identify their causes, plan interventions, and track progress. The cost of minority health disparities in Maryland is between $1 to $2 billion per year in direct medical costs. In 2011 alone, excess charges between Black/White hospitalization disparities in Maryland were

$814 million. Based on 2014 estimates, the racial/ethnic breakdown of the Maryland minority population was Blacks (64%), Hispanics (20%), and Asians (13%).

Health uninsured rates reported in 2013 decreased in all racial/ethnic groups in 2015 in Maryland. However, health uninsured rates in 2015 among Whites (3%) were still significantly lower than those reported for races characterized as "other" (31%), Hispanics (24%), and American Indians (11%). Disparities also have been reported in education, income, and unemployment rates in Maryland. Based on 2011-2013 and 2015 datasets, 26% of Blacks and 43% of Whites had household incomes of over $100,000 per year; 7.9% of Blacks and 4.2% of Whites were unemployed; and 25.1% of Blacks and 36.8% of Whites were college graduates.

Based on the number of deaths reported in 2012-2014 and the number of ED visits reported in 2014 per 100,000 people in Maryland, Blacks had higher rates than Whites in all of the following chronic diseases: heart mortality, cancer mortality, diabetes, hypertension, and asthma. Geographic disparities also were observed in ED visits by jurisdiction. Of all racial/ethnic groups, Blacks accounted for the highest rates of low birth weight and infant mortality in Maryland in 2010-2014. Of all racial/ethnic groups, Blacks accounted for the highest prevalence of diagnosed diabetes in Maryland in 2011-2013 in three age groups: 18-44, 45-64, and 65 years and older. Assault (homicide) rates have decreased in all races from 2005-2014, but the Black:White ratio has increased from 7 in 2005 to 7.29 in 2014.

The U.S. Surgeon General has identified several concrete action steps to close gaps in disparities. The cultural and communication competence of health care providers should be increased. Gaps in health insurance rates should be closed. Care coordination and quality of care should be enhanced. Data should be used to identify populations at greatest risk. Collaborations should be established with communities to implement policies and programs that address the highest priority needs. Coordination, collaboration, and opportunities to engage community leaders and members in prevention should be improved. SDOH and health behaviors should be addressed.

MDOH is continuing to implement diverse programs and initiatives to address its current priorities and areas of focus: the opioid epidemic; Medicare Contract and Health Care Delivery Model; organizational integration and development; population health improvement with a focus on chronic diseases, opioids, and infant mortality; and rural health care delivery.

MDOH is utilizing three legislative mandates to guide its programs and activities. The "Health in all Policies" framework is designed to analyze and make recommendations on incorporating health conditions into decision-making across state agencies. The University of Maryland Center for Health Equity serves as the lead for this effort. The Health Occupations Board (HOB) addresses racial/ethnic disparities by increasing the cultural and linguistic sensitivity among health professionals who are regulated under the HOB. The Maryland Interagency Council on Homelessness improves the emergency services network for homeless people by partnering with local stakeholders to create a comprehensive assessment and discharge planning process that is used at intake and discharge from medical facilities or jails.

The goal of the Minority Outreach and Technical Assistance Program (MOTAP) is to empower communities to improve health outcomes of racial/ethnic minorities through community engagement, partnerships, outreach and education, TA, and a focus on SDOH. MOTAP identified the following priority disease areas of significance that affect minority populations and impact health disparities in the state of Maryland: tobacco, birth outcomes, HIV/AIDS, health

insurance and health care access issues, CVD, cancer, diabetes, obesity, and asthma. MOTAP grant recipients are required to select and target interventions to up to two of these priority areas based on needs in their individual jurisdictions.

MOTAP was redesigned in FY2017 to drive outcomes. Data reporting standards were improved with the availability of a program narrative and data reporting tool. The MOTAP evaluation methodology was strengthened with specific, measurable, achievable, relevant, and timely (SMART) objectives, performance measures, and outcomes. TA for MOTAP grant recipients was increased. Dr. Noel-Thomas presented an example of a performance monitoring report card for a MOTAP grant recipient.

The St. Mary's County Health Department conducts an asthma control and management program for rural communities. The goal of this initiative is to apply evidence-based public health practice of home-based, multi-trigger, multi-component interventions with an environmental focus on children and adolescents (2-18 years of age) with asthma. The interventions include home visits by CHWs. The objectives of the program are five-fold:

- Reduce home exposure to indoor asthma triggers for children and adolescents (2 to 18 years of age) with asthma.
- Provide asthma education within the home setting for families of children with asthma.
- Promote utilization of written asthma action plans.
- Promote smoking cessation for people living in homes occupied by a child with asthma.
- Decrease ED visits, hospitalizations, missed school days, and courses of oral steroids due to asthma.

MDOH is a recipient of a federal grant, "Educating Minorities of Benefits Received After Consumer Enrollment" (EMBRACE). The goal of the initiative is to increase the number and percentage of populations that are appropriately utilizing primary care services. EMBRACE includes five key objectives to achieve the overarching goal.

- Decrease the percentage of people without health insurance in the target zip codes.
- Decrease the rate per 100,000 population in target zip codes of ED visits with a primary diagnosis that is a prevention quality indicator (PQI) condition.
- Decrease the rate per 100,000 population in target zip codes of hospital admissions with a primary diagnosis that is a PQI condition.
- Decrease the percentage of people enrolled in Medicaid who have not had at least one primary care visit in the target zip codes, particularly among high utilizers of ED and admission care.

EMBRACE was designed with strategies at multiple levels to achieve the five key objectives. CHWs will be deployed to communities to educate individuals on the benefits of health insurance enrollment and resources for Medicaid and exchange plans. Hospitals will identify individuals without insurance who have a high number of ED visits or hospital admissions. These people will be linked to enrollment support systems, such as connector entities, exchange navigators, or EMBRACE-funded community-based organizations (CBOs) and CHWs.

MDOH has made tremendous progress in its EMBRACE activities from quarters one to three in year 2 of the project period: from 54 to 120 educational sessions; from 295 to 852 attendees at

educational sessions; from 911 to 2,368 informational materials distributed; from 210 to 562 one-on-one sessions; from 62 to 164 referrals to insurance enrollment; and from 81 to 238 referrals to primary care.

MDOH conducts numerous initiatives to advance health equity in the state of Maryland. Training on the National CLAS Standards is offered to local health departments (LHDs) and MDOH public health service staff. MDOH will implement a CLAS toolkit in three LHDs by December 31, 2017 and also will offer CLAS train-the-trainer programs to three LHDs by March 31, 2018. MDOH's other objective will be to increase the proportion of its internal workforce with proficiency in describing the social, structural, cultural, and system-based factors that contribute to health inequities.

MDOH provides a forum for the exchange of information on its priorities as well as best and promising practices to advance health equity in Maryland. These events include holding the Annual Health Equity Conference, launching activities in support of National Minority Health Month, facilitating community conversations, and convening panel discussions. MDOH will host the 2017 Annual Health Equity Conference on December 7, 2017.

The OMHHD Health Equity Internship Program was established with a goal of improving the heath equity core competency of the emerging public health workforce in Maryland using Kolb's experiential learning model. OMHHD internship opportunities support the goal of the Workforce Development and Training Initiative to build the capacity of the public health workforce to effectively advance health equity. OMHHD has made a strong commitment to provide interns with a meaningful learning experience.

MDOH created a strategic plan and timeline, that began in July 2017, to improve CHW workforce development. Collaborations will be established with relevant stakeholders and legislators to develop recommendations that will lead to training and oversight of CHWs in the future, including practical and cost-effective strategies and guidance on potential legislative and regulatory changes for this effort. MDOH expects to complete the activities for this initiative by December 1, 2017, such as conducting research, engaging stakeholders, administering a survey to CHWs in Maryland, analyzing the survey data, convening a stakeholder meeting, obtaining feedback from stakeholders, and drafting, revising, and finalizing a CHW workforce development report.

MDOH's influence and consultation include its membership on multiple committees and workgroups; its role as a senior advisor to the Maryland Secretary for Health; and its membership on the Maryland Children's Cabinet for resource allocation decisions, strategic planning, and policy decisions. MDOH also has oversight of the review and approval of grant applications.

Overall, MDOH is continuing to address key challenges in the areas of funding, state-funded positions, leadership priorities, organizational realignment, staff resistance to TA, consultation, training, silos and fragmentation, and a desire to maintain the "status quo," but with an expectation of different result.

Region III SOMH Update: WEST VIRGINIA

Bruce Adkins, MS, PA
Director, Office of Community Health Systems and Health Promotion
West Virginia Department of Health and Human Resources (WVDHHR)

Based on 2016 data, the population in West Virginia is 93% White and 3% Black. West Virginia is the only state that is entirely within the Appalachian Region. In 2016, 84 counties in the state qualified for a "distressed" status based on low per capita income and high rates of poverty and unemployment, while 116 counties qualified for "at risk" status. Most of these counties lie within the economically distressed coal fields of Eastern Kentucky, Southeastern Ohio, Northeastern Tennessee, Western Virginia, and Southwestern West Virginia.

West Virginia is the third most rural state in the country. Of all residents, 51% live in rural settings. The median age of West Virginia residents of 42.2 years is the fourth oldest in the nation. The 18.2% of the population that is elderly is the third oldest in the country. Of all U.S. states, West Virginia ranks 42nd for high school diploma attainment, 50th for college degree attainment, 48th for per capita income, and 49th for median household income. Other demographics of West Virginia compared to other states include the highest disabled rate (18.9%), the lowest life expectancy, and the lowest rate of labor force participation.

West Virginia is ranked first in the nation for three major adult risk factor indicators. The prevalence in West Virginia is 27.3% for current smoking, 9.4% for smokeless tobacco use, and 35.1% for obesity. The U.S. prevalence for these risk factor indicators is 18.1% for current smoking, 3.7% for smokeless tobacco use, and 28.3% for obesity. West Virginia also is ranked first in the nation for overall mortality (e.g., cancer, chronic lower respiratory disease, and diabetes); age-adjusted mortality (e.g., all accidents and drug overdose); and behavioral health problems (e.g., severe mental illness, poor mental health days/inability to function, prescriptions for controlled substances, and drug-induced deaths).

WVDHHR collects, analyzes, and maintains an extensive amount of data to determine racial/ethnic health disparities in West Virginia. Based on 2012-2014 data among adults 18-64 years of age in West Virginia, multiracial non-Hispanics (31.6%), Hispanics (28%), and Blacks (27.6%) had the highest prevalence of no health care coverage. Multiracial non-Hispanics (38%), Hispanics (32%), and others/non-Hispanics (31%) had the highest prevalence of current smoking. Blacks (40.9%), Hispanics (37.1%), and Whites (34.7%) had the highest prevalence of obesity.

Blacks (19.1%), others/non-Hispanics (15.9%), and multiracial non-Hispanics (13.6%) had the highest prevalence of diabetes. Others/non-Hispanics (18.9%), Whites (14.3%), and Blacks (13.3%) had the highest prevalence of CVD. Whites (13.7%), multiracial non-Hispanics (11.4%), and Hispanics (8.2%) had the highest prevalence of cancer. Others/non-Hispanics (18.3%), Hispanics (13.8%), and multiracial non-Hispanics (12.2%) had the highest prevalence of chronic obstructive pulmonary disease (COPD).

Based on 2014 data, adults with less than a high school education in West Virginia had the highest prevalence of all but one risk factor: no health care coverage, smoking, diabetes, CVD, cancer, and COPD. However, adults with a high school diploma or GED in West Virginia had the highest prevalence of obesity. Based on 2014 data, adults with annual household incomes less than $15,000 had the highest prevalence of smoking and COPD. Adults with annual

household incomes between $15,000 and $24,999 had the highest prevalence of no health care coverage, obesity, and diabetes. Adults with annual household incomes between $25,000 and $34,999 had the highest prevalence of cancer.

Similar to other parts of the country, West Virginia also has a significant opioid overdose epidemic. The *Charleston Gazette-Mail* reported on its investigation in December 2016 that found drug wholesalers shipped over 780 million doses of opiate painkillers to West Virginia from 2007-2012. The rate of overdose deaths of 41.5 deaths per 100,000 people in West Virginia is the highest rate in the nation. Mr. Adkins presented a series of maps to illustrate the drug overdose deaths by county in West Virginia.

WVDHHR's statutory requirement is to provide a supportive and enabling public health system, but an ambitious goal has been established to improve health, enhance quality, and reduce costs. WVDHHR has identified the following multi-level strategy to achieve this goal: the "Health in All Policies" framework, innovative patient-centered care in communities, traditional clinical approaches, data systems and analytics, and value-based care.

WVDHHR is aware that important issues need to be considered to achieve its goal. In terms of education, awareness is lacking on primary and secondary prevention methods, community-based and/or primary care programs and services, and health issues that are unique to specific populations. In terms of communication, system services and payment structures should be communicated at macro, mezzo, and micro levels to address cultural customs, personal beliefs, and linguistic differences. In terms of transportation, the lack of transportation plays a critical role in whether many West Virginia residents will visit a hospital ED or primary care practice.

In terms of cultural awareness, communities in West Virginia distrust medical professionals and health care systems due to historical bioresearch projects and ethical dilemmas, such as the Tuskegee Syphilis Study and the production of the HeLa cell line with cancer cells submitted by Henrietta Lacks. Moreover, the Appalachian culture is fatalistic and practices "natural medicine" based on customs that are derived from ancient cultures.

In terms of local interventions, WVDHHR is collaborating with the Health Innovation Collaborative to reduce the rates of obesity, tobacco usage, and substance use disorder. The use of electronic health records is being increased to allow population health demographics to be quantified. Partnerships are being established with institutions of higher learning to recruit and retain diverse professionals in health care settings. In terms of a reduction in disparities, emphasis is being placed on linking quality and equity, creating a culture of equity, diagnosing the disparity, designing the activity, securing endorsement, and implementing change.

WVDHHR is placing a strong focus on adverse childhood experiences (ACEs). An ACE is a traumatic, unhappy, unpleasant, and/or hurtful event that occurred to a child before 18 years of age and is recalled by the individual as an adult. ACEs often are referred to as "toxic stress" or "childhood trauma." An ACE is defined as surviving one of the following categories of abuse, neglect, or loss prior to 18 years of age:

- Emotional abuse by a parent
- Physical abuse by a parent
- Sexual abuse by anyone
- Emotional neglect
- Physical neglect

- Loss of a parent
- Growing up with an alcohol and/or drug abuser in the household
- Living with a family member with mental illness
- Experiencing the incarceration of a household member

Multiple health problems are associated with ACES, including:

- Alcoholism/alcohol abuse
- COPD
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease
- Risk for intimate partner violence
- Liver disease
- Multiple sexual partners
- Sexually transmitted diseases
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy

Based on 2014 data, the prevalence of the top five ACEs among West Virginia adults was substance abuse (28.8%), separation/divorce (26.6%), verbal abuse (22.7%), mental illness (17%), and domestic violence (16.1). The West Virginia data are comparable to CDC's data that found an association between multiple ACEs and fair/poor health, current smoking, binge drinking, obesity, COPD, depression, and disability. These findings serve as a foundation for the prevention of chronic diseases and unhealthy behaviors based on modification or avoidance of ACEs.

Region III Community Update: DELAWARE

Noël Sincere Duckworth
Healthy Neighborhoods Program Manager
Delaware Center for Health Innovation (DCHI)

Ms. Duckworth joined the meeting via video conference to describe community-based activities that are underway in Delaware to advance health equity. DCHI is a non-profit organization that guides the implementation of the Delaware State Health Care Innovation Plan. Health care outcome and patient experiences are average in Delaware compared to other states. The Delaware population is relatively unhealthy overall. Delaware is ranked the 31st healthiest state in the nation, but has the third highest health care expenditures per capita by state. Delaware's total health care expenditures of $75 billion in 2009 are projected to dramatically increase to $170 billion in 2020.

Ms. Duckworth presented a series of photographs to illustrate efforts that are underway to promote health care transformation in Delaware, such as the Healthy Living and Chronic Disease Task Force and Wilmington Wellness Day. The community partners in these initiatives include Sussex County Health Coalition, Wilmington/Claymont Healthy Neighborhood Council, and Dover/Smyrna Stakeholders Planning Council and Task Forces. The health care transformation activities include:

- Establishing a foundation to leverage opportunities
- Eliminating silos
- Building local, multi-sector councils to focus on equity and community engagement
- Communicating at multiple levels
- Convening and coalescing rather than duplicating or competing
- Translating data to be easily understood by communities
- Planning and testing innovation to achieve a shared goal in a collaborative manner
- Ensuring that the councils remain engaged and informed

Ms. Duckworth presented an organizational chart to illustrate the role and responsibilities of DCHI, its community partners, committees, and subcommittees. For example, the Healthy Neighborhoods initiative targets four critical health priorities to improve the overall health and well-being of all Delaware residents: healthy lifestyles, maternal and child health, mental health and addiction, and chronic disease prevention and management.

DCHI is attempting to improve equity in Delaware based on the five conditions of collective impact: a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone support. Equity activities are being designed based on the following guiding principles:

- Engage the voices of those who are most affected to establish an agenda.
- Allocate resources to those whose involvement is a financial burden.
- Analyze data to determine the “root cause” of the disparity, such as government or institutional policies or practices that create barriers to safe, affordable, and healthy housing.
- Carefully consider the disaggregation of data to reveal disparities.
- Compensate for data gaps by applying the experiences of members of the most impacted groups.
- Communicate and deliver messaging that disrupts rather than normalizes persistent inequities.
- Ensure the credibility of staff with communities that are most affected by inequities.

DCHI’s methodology to achieve equity includes process observation, trauma-informed techniques, participatory facilitation, establishment and implementation of core values, consensus decision-making, the “Getting to Outcomes” approach, and asset mapping. The guiding principles of this methodology include a community focus, equity, respect, collective impact, accountability, and dedication.

The Strategic Planning Task Force is conducting resource and needs assessments by reviewing data, creating an inventory of available resources, and mapping existing assets. The task force also is identifying opportunities to align strategic criteria; researching and proposing evidence-based strategies; determining high-priority and feasible approaches; and evaluating

strategies for their state and local content as well as for their political, philosophical, and practical considerations.

Region III SOMH Update: DELAWARE

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Division of Public Health
Delaware Department of Health and Social Services (DDHSS)

DDHSS collects, analyzes, and maintains a rich dataset to determine health disparities in Delaware. By race/ethnicity, Whites in Delaware account for the highest rates of pneumococcal, pediatric, and influenza vaccination as well as depression. Blacks in Delaware account for the highest rates of HIV, obesity, diabetes, and hypertension. Hispanics in Delaware account for the highest uninsured rates.

The five-year averages of infant mortality rates decreased in all races from 1998-2009. In 2009, however, the infant mortality rate in Blacks (15.6 per 1,000 births) was still significantly higher than the rates in Whites (5.7 per 1,000 births) and all other races (8.3 per 1,000 births). In addition to birth outcomes, Delaware also has reported tremendous health disparities in other areas.

Based on 2005-2015 national, state, and local data, Black women 15-19 years of age in the United States, Delaware, and Kent, New Castle, and Sussex Counties accounted for higher five-year teen birth rates than Whites. White women 15-19 years of age accounted for higher five-year teen birth rates than Blacks in Wilmington only. The five-year age-adjusted HIV mortality rate in Delaware in 2010-2014 was 15.1 per 100,000 population in Blacks and 1.2 per 100,000 population in Whites.

The five-year age-adjusted hypertension mortality rate in Delaware in 2000-2014 was 7.4 per 100,000 population in Blacks and 4.2 per 100,000 population in Whites. The five-year age-adjusted diabetes mortality rate in Delaware in 2000-2014 was 39.5 per 100,000 population in Blacks and 16.7 per 100,000 population in Whites. Whites accounted for significantly higher five-year age-adjusted drug-induced mortality rates than Blacks in Delaware in 2000-2014.

Violence among young Black men 15-24 years of age is disproportionately higher than in other racial/ethnic groups. Wilmington is the fourth most violent city in the United States. The same high trend of violence in this population has been observed in 2017 to date. More Millennials died from gun violence than substance abuse, suicides, and accidents than any other cause with the exception of motor vehicle accidents. Each death has changed two lives forever. Lifetime incarceration of a young person beginning at 20 years of age might cost up to $2 million.

DDHSS developed and released the *Health Equity Guide for Public Health Practitioners and Partners*. In its 1988 publication, the *Future of Public Health*, the Institute of Medicine emphasized that “public health is what we, as a society, do collectively to assure the conditions in which all people can be healthy.”

Region III SOMH Update: PENNSYLVANIA

David Saunders, MEd
Director, Office of Health Equity
Pennsylvania Department of Health (PDOH)

Minority populations account for over 3 million of the12.8 million people living in Pennsylvania. The poverty rates are disproportionately higher in Hispanics (29%) and Blacks (25%) compared to Whites (9%). Based on 2013 data, Blacks also accounted for significantly higher cancer rates. Compared to Whites, Blacks and Hispanics accounted for higher rates of hospital discharges of young asthma patients, infant mortality, low birth weight, and teen pregnancy.

PDOH is attacking the disparity problem in Pennsylvania from multiple angles. With its external intersectoral approach, PDOH is providing leadership for Public Health 3.0 Echo events in Pennsylvania. Public Health 3.0 is a national movement that calls for business leaders, community leaders, state lawmakers, and federal policymakers to boldly expand public health to address all aspects of promoting health and well-being. These factors include economic development, education, transportation, food, environment, housing, and safe neighborhoods just to name a few.

To increase life expectancy and address chronic disease PDOH will build capacity and develop local leadership. To provide TA, PDOH will host TA calls, widely disseminate best practices, and promote the "livehealthypa" website. To sustain efforts, PDOH will acquire funding, develop and distribute quarterly reports, and host biannual meetings.

PDOH replicated the FIHET to establish the Pennsylvania Interagency Health Equity Team (PIHET) with 14 agencies that convene monthly meetings. The PIHET's accomplishments to date include the selection of short- and long-term goals; completion of the *School Resource Guide*; creation of a data-sharing approach; and the development of collaborative opportunities.

With its internal approach through the National CLAS Standards, PDOH has obtained direct guidance from the Pennsylvania Secretary of Health, established a task force, conducted assessments, and provided training. PDOH will continue to identify and implement solutions to address key challenges. For example, interns will be recruited to address the lack of staff. Political support will be leveraged to address the lack of funding.

In 2018, the *Health Equity Report* will be released to address the lack of awareness regarding this issue.

Region III SOMH Update: VIRGINIA

Karen Reed, MA
Director, Division of Multicultural Health and Community Engagement
Office of Minority Health and Health Equity (OMHHE)
Virginia Department of Health (VDOH)

Ms. Reed reported that similar to the other Region III SOMHs, VDOH/OMHHE also is continuing to address longstanding disparities and a growing opioid epidemic in the state of Virginia. Instead of presenting data on these disparities, however, her update focused on VDOH's

programs and activities that are having an impact on reducing health, geographic, and educational disparities in Virginia.

VDOH established a mission to "protect the health and promote the well-being of all people in Virginia" and a vision to "become the healthiest state in the nation" (http://www.vdh.virginia.gov). To fulfill its mission and achieve its vision, VDOH developed a plan for the well-being of Virginia residents, created and implemented a strategic plan, and adopted a population health focus to guide its activities.

VDOH's plan for well-being includes a system of health care, a strong start for children, preventive actions, and healthy, connected communities. VDOH's programs and projects are based on the following determinants of equity:

- Affordable, safe, and quality housing
- Access to parks and natural resources
- Equity in county practices
- Access to affordable and healthy local food
- Equitable law and justice system
- Community and public safety
- Access to safe and efficient transportation
- Access to health and human services
- Healthy built and natural environments
- Quality education
- Family wage jobs and job training
- Early childhood development
- Economic development
- Strong and vibrant neighborhoods

VDOH/OMHHE established a vision of "health equity for all Virginians" and a mission to "identify health inequities and their root causes and promote equitable opportunities to be healthy" (http://www.vdh.virginia.gov/health-equity). VDOH adopted the CDC framework, "Paving the Road to Health Equity," to provide an opportunity for all people to be as healthy as possible. The four components of the framework include programs (successful health equity strategies); measurement (data practices to support the advancement of health equity); policy (laws, regulations, and rules to improve population health); and infrastructure (organizational structures and functions that support health equity).

VDOH created the Virginia Health Opportunity Index (HOI) based on a compilation of data from multiple sources: health disparity data, Virginia language needs assessment data, Health Professional Shortage Areas data, and Medically Underserved Areas data. The HOI is based on the concept of "health matters, place matters." VDOH uses the HOI to help communities understand the factors that determine health and improve health outcomes for all residents. The HOI data are mapped, organized, and visually displayed with dashboards.

The HOI identifies areas and populations in Virginia that are most vulnerable to adverse health outcomes based on SDOH and also ranks neighborhoods in Virginia based on available opportunities for residents to live long and healthy lives. The HOI allows VDOH to direct resources to specific causes of poor health in disadvantaged neighborhoods.

The SDOH that predict diverse health outcomes are grouped into four profiles of the HOI. The Community Environmental Profile focuses on air quality, population churning, population density, and walkability. The Economic Opportunity Profile focuses on employment access, income inequality, and job participation. The Consumer Opportunity Profile focuses on affordability, education, food accessibility, and material deprivation. The Wellness Disparity Profile focuses on access to care and segregation.

The VDOH data portal allows users to map several SDOH indicators by locality, such as children in poverty, the overall population in poverty, unemployment, uninsured children, the overall uninsured population, and voter turnout. Ms. Reed presented a map to illustrate HOI outcomes by census tract. Additional information on the HOI is available at: (http://www.vdh.virginia.gov/health-equity/division-of-social-epidemiology).

VDOH/OMHHE sponsors several community engagement programs. VDOH/OMHHE used its HHS/OMH grant award in 2015 to develop and implement the Danville Youth Health Equity Leadership Institute (YHELI). The three semesters of Danville YHELI began in the summer of 2016 and ended in the spring of 2017. Danville YHELI was launched as an innovative best practice program with a goal to improve public health by addressing racial, ethnic, and socioeconomic disparities in educational attainment and also by implementing effective public health practice models. The overarching objective of Danville YHELI was to "provide leadership and critical thinking skills to help students navigate high school and life's journey."

A full-time program manager and a part-time OMHHE specialist administered Danville YHELI. The curriculum covered topics and activities in three major categories: academic and life skills, community leadership, and advocacy; mentorship and enrichment visits; and life goals, visioning, and empowerment. Ms. Reed presented a series of photographs and slides to illustrate the participation of Danville YHELI students in numerous activities, the success of and learning opportunities provided by the program, and positive feedback from the students.

The Virginia Partners in Prayer and Prevention (P3) was established with a goal to increase population health by providing a variety of resources and strategies to help educate, transform health outcomes, and improve the well-being of people in all congregations and communities in Virginia. Virginia P3 also supports the Virginia Congregations for Million Hearts to ensure that existing and new congregations remain engaged in their efforts to provide education and promote health. Ms. Reed presented a series of photographs to illustrate the activities of these congregations.

The *CLAS Plan and Implementation Guide* was developed to serve as a resource for health impact assessments and the "Health in All Policies" framework. The Population Health Workgroup provides orientation and training sessions to all VDOH staff. VDOH's multicultural resources to increase access to health services in Virginia include the implementation of National CLAS Standards for the LEP population as well as education and training on the unique health care considerations of multicultural communities. Additional information on VDOH/OMHHE's community engagement programs is available at: (http://www.vdh.virginia.gov/health-equity/division-of-multicultural-health-and-community-engagement).

DISCUSSION: REGION III SOMH UPDATES

The participants commended the SOMHs for their leadership in their respective states to conduct activities that are designed to close gaps in disparities and make further progress on

achieving health equity in Region III. The participants made several suggestions for the SOMHs to consider during their deliberations on the following day to identify and reach consensus on conducting a health equity collaborative project throughout Region III.

- West Virginia's experiences and lessons learned should be compiled and disseminated to the other Region III states to better address health disparities in rural areas. This information will be particularly helpful for the 18 rural jurisdictions in the state of Maryland.
- Maryland was commended on its extensive community outreach, such as the Rural Health Asthma Management Program and the CHW workforce development initiative. However, several participants noted that longstanding barriers have persisted in terms of Maryland and DC developing a meaningful partnership. Although the HIV staff conducts multiple health equity projects in DC, Dr. Arno was aware of problems related to establishing external collaborations with Maryland. She made a commitment to meet with the entire DCDOH/OHE staff to explore new collaborative opportunities in this regard.
- The participants were encouraged to visit the Mid-Atlantic RHEC website (http://region3.npa-rhec.org). Based on the recommendations that stakeholders proposed to the Mid-Atlantic RHEC during the Community Dialogue in December 2016, stronger efforts should be made in Region III to outreach to, connect with, and engage CBOs, FBOs, and grassroots organizations. These entities are actually conducting health equity projects in their local communities to improve the health of their residents.
- Honest and candid discussions should be held on specific action steps that OMH is taking to address the lack of support for health equity in Region III and whether OMH's partnership with the SOMHs is equitable. The SOMHs should begin exploring these issues during their deliberations on the following day.
- Innovative and creative strategies should be developed and implemented to provide more support to grassroots organizations. For example, a dedicated funding stream could be created to assist grassroots organizations in achieving their goals. A portion of these funds could be used to support SOMHs to build the capacity of these grassroots partners.
- All six Region III states should develop and maintain a "core" set of health equity elements to better utilize and leverage limited resources.
    - Build and retain strong partnerships at multiple levels.
    - Create a dynamic website with up-to-date news on emerging health equity activities, projects, and funding opportunities.
    - Extensively involve the community-at-large, including CBOs, FBOs, and grassroots organizations, in state-level health equity activities.
    - Provide ongoing funding, TA, and other support to CHWs. For example, the ability of CHWs to translate materials and serve as interpreters in communities can serve as a tremendous resource to SOMHs and other staff in state/local health departments.

Mr. Gallardo provided additional information on the OMHRC in response to questions by the participants on the availability of free e-learning training sessions and other resources. The OMHRC is the nation's largest repository of minority health research, literature, and referrals for marginalized communities. The OMHRC provides a wide range of services at no charge, including literature and funding searches, recent data/statistics, capacity building, consumer materials, TA, grant writing assistance, and social media expertise. The participants were

encouraged to subscribe to the e-newsletter at info@minorityhealth.hhs.gov to receive up-to-date information from the OMHRC.

Ms. Cooney agreed with the comments by the SOMHs on the need to mobilize communities to reduce and eliminate barriers to funding. Most notably, empowered communities can advocate on behalf of state and federal agencies to overcome funding-related problems. For example, community advocacy played an instrumental role in incorporating capacity building funding into the TANF Program. The SOMHs should explore the possibility of leveraging this new partnership in their respective states.

Ms. Cooney confirmed that ASTHO would welcome the opportunity to serve as a facilitator or convener in strengthening cross-agency relationships at federal, state, and local community levels to further advance health equity in Region III. She thanked the participants for their excellent input on day one of the meeting.

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Attachment 2: Glossary of Acronyms

Acronym	Definition
ACA	Affordable Care Act
ACEs	Adverse Childhood Experiences
AI/AN	American Indian/Alaska Native
ASTHO	Association of State and Territorial Health Officials
BHW	Bureau of Health Workforce
BRFSS	Behavioral Risk Factor Surveillance System
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBOs	Community-Based Organizations
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CLAS	Culturally and Linguistically Appropriate Services
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular Disease
DCDOH	District of Columbia Department of Health
DCHI	Delaware Center for Innovation
DDHSS	Delaware Department of Health and Social Services
DHCFS	Division of Health Careers and Financial Support
DNPH	Division of Nursing and Public Health
DOL	U.S. Department of Labor
DRO	Division of Regional Operations
EDs	Emergency Departments
EMBRACE	Educating Minorities of Benefits Received After Consumer Enrollment
FBOs	Faith-Based Organizations
FIHET	Federal Interagency Health Team
FOAs	Funding Opportunity Announcements
FY	Fiscal Year
HBCUs	Historically Black Colleges and Universities
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HOB	Health Occupations Board

Acronym	Definition
HOI	Health Opportunity Index
HRSA	Health Resources and Services Administration
HUD	U.S. Department of Housing and Urban Development
LEP	Limited English Proficiency
LGBTQIA	Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Allies
LHDs	Local Health Departments
MCOs	Managed Care Organizations
MDOH	Maryland Department of Health
MMD	Mapping Medicare Disparities
MOTAP	Minority Outreach and Technical Assistance Program
NAWB	National Association of Workforce Boards
NHSC	National Health Service Corps
NPA	National Partnership for Action to End Health Disparities
NPC	National Prevention Council
OASH	Office of the Assistant Secretary for Health
OHE	Office of Health Equity
OMH	Office of Minority Health
OMHHD	Office of Minority Health and Health Disparities
OMHHE	Office of Minority Health and Health Equity
OMHRC	Office of Minority Health Resource Center
P3	Partners in Prayer and Prevention
PDOH	Pennsylvania Department of Health
PIHET	Pennsylvania Interagency Health Team
PQI	Prevention Quality Indicator
RHEC	Regional Health Equity Council
ROI	Return on Investment
SDOH	Social Determinants of Health
SES	Socioeconomic Status
SMART	Specific, Measurable, Achievable, Relevant, and Timely
SNAP	Supplemental Nutrition Assistance Program
SOMHs	State Offices of Minority Health
TA	Technical Assistance
TANF	Temporary Assistance for Needy Families
TJU/JCPH	Thomas Jefferson University, Jefferson College of Public Health
VDOH	Virginia Department of Health
WDBs	Workforce Development Boards
WVDHHR	West Virginia Department of Health and Human Resources
YHELI	Youth Health Equity Leadership Institute