December 18, 2020

The Honorable Mike DeWine
Governor of Ohio
Riffe Center, 30th Floor
77 South High Street
Columbus, Ohio 43215

Re: Response to the Ohio COVID-19 Minority Health Strike Force and Ohio's Executive Response

Dear Governor DeWine:

The COVID-19 pandemic has undeniably exposed health disparities faced by people of color in Ohio. On August 13, 2020, your office simultaneously released the COVID-19 Ohio Minority Health Strike Force (MHSF) Blueprint and Ohio's Executive Response: A Plan of Action to Advance Equity (Executive Response). Ohio Consumers for Health Coverage (OCHC) writes today to complement certain elements of the MHSF Blueprint and Executive Response, offer suggestions related to some, and raise concerns about others.

OCHC is a coalition of over 20 organizations, both statewide and local, that has worked since 2007 to unite the consumer voice with the goal of achieving affordable, high quality health care for all. Its organizational membership is diverse, representing both those with illness and those in good health, both insured and uninsured, those with resources, and those of limited means. In 2020, one of OCHC's highest priorities has been to advocate for integrating health equity considerations into policymaking.

MHSF's Systemic Approach and the Governor's Commitments Are Encouraging.

OCHC is encouraged by the MHSF approach in advocating for a comprehensive and systemic approach to advancing health equity for people of color in Ohio. By offering recommendations not only in health care and public health, but also in areas that impact the social, economic, and physical environments, the MHSF has focused attention on some of the "causes of the causes"

of health inequity. The MHSF Blueprint provides a transfusion of energy on racial health disparities, a persistent problem which OCHC and many other coalitions, organizations, and agencies have called out for the great harm it causes many (arguably all) Ohioans.

The Executive Response, published simultaneously with the MHSF Blueprint, indicates the commitment of the Governor's office within its sphere of influence to "direct and lasting change to eliminate racism, oppression, and inequity…." The Executive Response offers initial action steps to which it aspires, including high level pledges of Ohio agencies' steps for increasing equity. First and foremost, the Executive Response commits to creating the Governor's Equity Advisory Board to advise the Executive Branch on taking actions recommended by the MHSF. OCHC supports this action, recognizing its potential to catalyze sustained change.

Overall, OCHC endorses and champions the implementation of the MHSF Blueprint. OCHC commends the MHSF and the Governor's office for the considerable effort they have brought to this important topic. In the sections below, OCHC describes provisions of the MHSF Blueprint and Executive Response it supports, as well those provisions that cause concern. OCHC concerns are in the following areas:

1. **Transparency and Accountability:** First and foremost, OCHC cautions that this effort must be exceedingly transparent and accountable if it is to succeed in changing the current state of racial health disparity. Without that additional commitment, Ohio will not succeed in building confidence in institutions that have failed Black and brown Ohioans. Specifically, rather than the annual reporting suggested by the MHSF, OCHC contends that there should be monthly or bi-monthly updates on progress on specific MHSF recommendations and an established avenue for regular community participation.
2. **Diverse participation**: The Equity Advisory Board must include a variety of perspectives of Black Ohioans whose participation is supported by funding and resources to remove barriers to engagement.
3. **Recognize the problem**: Recognizing racism as a public health crisis is essential.
4. **Build trust**: Improving the health of Black Ohioans in particular requires authentic commitment to taking the steps necessary to build trust where the good cause for mistrust has been embedded in healthcare for generations. This effort must begin with diversifying the healthcare workforce, increasing access to health care, and insisting that healthcare providers act to recognize and act to eliminate their implicit biases.
5. **Social drivers of health**: Acting on the social determinants of health, increase access to high quality early childhood education; identify non-punitive solutions to chronic absenteeism; and bridge the digital divide with cultural awareness to rural and urban barriers and without increasing health disparities.
6. **Data**: Commit to data collection and transparency; oversample Asian and African subpopulations when collecting data; collect essential demographic information to better understand the breadth of patient experience.

OCHC has attached to this letter a more-detailed memo describing each of these concerns, offering specific recommendations, and identifying several upcoming opportunities to act.

OCHC may also be of assistance in identifying consumers and consumer groups to bring their essential perspective to the State's efforts. OCHC members have relationships with individuals who could bring important perspectives to the Equity Advisory Board as members or as engaged consumers. Further, OCHC members have expertise in the particular needs of various Ohio populations, including senior citizens, children, low-income people, blue collar and service industry workers, individuals with Multiple Sclerosis, LGBT Ohioans, and more. The issues of health equity in general, and racial health equity in particular, is integral to our work. Our goal is to raise these issues and advance systemic improvements that increase health equity and decrease racial health disparities.

Conclusion

OCHC is committed to the hard work of achieving racial health equity. We appreciate the opportunity to provide input at this stage of the process and welcome the opportunity to discuss any of the matters raised in this letter at greater length. OCHC is hopeful that the promise of the MHSF Blueprint may be realized and sees the recent appointment of Ohio Health Opportunity Advisor Jamie Carmichael as an important step. It is incumbent upon the state government to take up the mantle, and not allow the MHSF Blueprint to be cast aside or become bogged down.

Please do not hesitate to reach out. Our offer of collaboration is genuine and heartfelt.

Sincerely,

Darold Johnson

Darold Johnson, Co-Chair
Ohio Consumers for Health Coverage

Marie B. Curry

Marie B. Curry, Co-Chair
Ohio Consumers for Health Coverage

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Columbus, OH 43215

MEMORANDUM

To: The Honorable Mike DeWine
Governor, State of Ohio
cc: Ms. Jamie Carmichael, Ohio Health Opportunity Advisor
cc: Director Angela Dawson, Ohio Commission on Minority Health

From: Ohio Consumer for Health Coverage
Darold Johnson, Co-Chair
Marie B. Curry, Co-Chair

Date: December 17, 2020

Re: Response to the Ohio COVID-19 Minority Health Strike Force and Ohio's Executive Response: A Plan of Action to Advance Equity

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I. Executive Summary

The COVID-19 pandemic has undeniably exposed health disparities faced by people of color in Ohio. On August 13, 2020, your office simultaneously released the COVID-19 Ohio Minority Health Strike Force (MHSF) Blueprint and Ohio's Executive Response: A Plan of Action to Advance Equity (Executive Response). Ohio Consumers for Health Coverage (OCHC) writes today to complement certain elements of the MHSF Blueprint and Executive Response, offer suggestions related to some, and raise concerns about others.

OCHC is a coalition of over 20 organizations, both statewide and local, that has worked since 2007 to unite the consumer voice with the goal of achieving affordable, high quality health care for all. Its organizational membership is diverse, representing both those with illness and those in good health, both insured and uninsured, those with resources, and those of limited means. In 2020, one of OCHC's highest priorities has been to advocate for integrating health equity considerations into policymaking.

II. MHSF's Systemic Approach and the Governor's Commitments Are Encouraging.

OCHC is encouraged by the MHSF approach in advocating for a comprehensive and systemic approach to advancing health equity for people of color in Ohio. By offering recommendations not only in health care and public health, but also in areas that impact the social, economic, and physical environments, the MHSF has focused attention on some of the "causes of the causes" of health inequity. The MHSF Blueprint provides a transfusion of energy on racial health disparities, a persistent problem which OCHC and many other coalitions, organizations, and agencies have called out for the great harm it causes many (arguably all) Ohioans.

The Executive Response, published simultaneously with the MHSF Blueprint, indicates the commitment of the Governor's office within its sphere of influence to "direct and lasting change to eliminate racism, oppression, and inequity…." The Executive Response offers initial action steps to which it aspires, including high level pledges of Ohio agencies' steps for increasing equity. First and foremost, the Executive Response commits to creating the Governor's Equity Advisory Board to advise the Executive Branch on taking actions recommended by the MHSF. OCHC supports this action, recognizing its potential to catalyze sustained change.

Overall, OCHC endorses and champions the implementation of the MHSF Blueprint. OCHC commends the MHSF and the Governor's office for the considerable effort they have brought to this important topic. In the sections below, OCHC describes provisions of the MHSF Blueprint and Executive Response it supports, as well those provisions that cause concern. OCHC concerns are in the following areas:

1. **Transparency and Accountability:** Rather than the annual reporting suggested by the MHSF, OCHC contends that there should be monthly or bi-monthly updates on progress on specific MHSF recommendations and an established avenue for regular community participation.
2. **Diverse participation**: The Equity Advisory Board must include a variety of perspectives of Black Ohioans whose participation is supported by funding and resources to remove barriers to engagement.
3. **Recognize the problem**: Recognizing racism as a public health crisis is essential.

4. **Build trust**: Improving the health of Black Ohioans in particular requires authentic commitment to taking the steps necessary to build trust where the good cause for mistrust has been embedded in healthcare for generations. This effort must begin with diversifying the healthcare workforce, increasing access to health care, and insisting that healthcare providers act to recognize and act to eliminate their implicit biases.
5. **Social drivers of health**: Acting on the social determinants of health, increase access to high quality early childhood education; identify non-punitive solutions to chronic absenteeism; and bridge the digital divide with cultural awareness to rural and urban barriers and without increasing health disparities.
6. **Data**: Commit to data collection and transparency; oversample Asian and African subpopulations when collecting data; collect essential demographic information to better understand the breadth of patient experience.

OCHC welcomes the opportunity to discuss any of these concerns at greater length. OCHC members have relationships with individuals who could bring important perspectives to the Equity Advisory Board as members or as engaged consumers. Further, OCHC members have expertise in the particular needs of various Ohio populations, including senior citizens, children, low-income people, blue collar and service industry workers, individuals with Multiple Sclerosis, LGBT Ohioans, and more. The issues of health equity in general, and racial health equity in particular, is integral to our work. Our goal is to raise these issues and advance systemic improvements that increase health equity and decrease racial health disparities.

III. OCHC Has Concerns About Implementation of MHSF Recommendations.

OCHC is encouraged by the Governor's commitments, but we recognize that the Executive Response may lack details as such details are left to the Equity Advisory Board to articulate as part of its work. However, due to the lack of details by the Executive Response, OCHC members have concerns about some of the specifics of implementation. In the remainder of this letter, OCHC will communicate those concerns, in addition to offering support and insights on other aspects of both the MHSF Blueprint and the Executive Response.

A. Annual Reporting of Progress is Not Sufficient to Work Toward Lasting Change.

OCHC believes it is important to highlight one serious and significant shortcoming of the MHSF Blueprint that must be revised if meaningful progress is to be made on health equity. In Recommendation 33, the MHSF proposes that Ohio should "[i]mplement the blueprint and interim report and monitor success." To be clear, OCHC supports the MHSF recommendation to implement the blueprint and the interim report. The problem lies in the MHSF's recommendation that actions should be tracked and reported *annually*. OCHC emphatically contends that annual reporting is inadequate to the task of bringing about real and lasting change. Without a transparent, consistent, and obvious undertaking of this work, the effort is more likely to fizzle and fade. The community energy and input needed for success requires constant attention. To undertake this effort without rigorous dedication to continuous assessment and observable outcomes will undermine confidence in the state's commitment.

Notably, Commitment 8 of the Executive Response includes some provision for creation of a public-facing dashboard dedicated to tracking progress and promoting transparency and trust. This language does begin to respond to the gap OCHC raises here. As Ohio has done with its coronavirus.ohio.gov website, it should also provide data in an accessible format that describes the breadth and depth of racial health disparities, as well as the milestones, timelines, and progress for MHSF recommendations.

OCHC recommends much more frequent reporting, perhaps monthly or bi-monthly updates on progress on specific MHSF recommendations, and an established avenue for regular community participation.

B. The composition of the Equity Advisory Board must include Black Ohioans with a variety of demographic characteristics and lived experience.

In order to build trust and community understanding, the voices of people of color must be an integral part of the Equity Advisory Board. Appointment of Board members must include people of color from a range of socioeconomic backgrounds, as well as community organizers, researchers who have studied racial health disparities, and business and religious leaders who

are active in communities of color. Moreover, the Executive Office, in creating the Equity Advisory Board, must keep front of mind that individuals' identities are complex, not solely defined by a single racial category. By recognizing that people may also be old or young; male, female, or non-binary; disabled or able-bodied; LGBTQ+; refugees; or any of a multitude of other significant defining characteristics. In keeping with this effort, the Governor's office must acknowledge the burden that accompanies participation with or on the Equity Advisory Board. For stretched families, essential employees, and others, they are willing to participate but feel their concerns are invisible when their barriers to participation are apparently ignored. Again, to build trust by showing respect, consideration to scheduling, transportation, childcare, and other barriers is foundational.

OCHC recommends that the people of color, and Black Ohioans in particular, be named in sufficient numbers to bring a range of voices to the Equity Advisory Board and be sufficiently supported in their appointment that they are able to participate in an ongoing and meaningful way, potentially including transportation, childcare, remote participation, and scheduling consideration.

C. Dismantling Racism to Advance Health Equity (Rec. 1-7)

1. Recommendation 1: Acknowledge Racism as a Public Health Crisis.

The MHSF endorses seven essential recommendations under the objective of dismantling racism to advance health equity. The MHSF's number one recommendation, to "acknowledge racism as a public health crisis and commit to swift action to dismantle racism...," provides the foundation for all that follows. OCHC also appreciates that the Executive Response accepts that racism is having an adverse impact on the health of Black and brown Ohioans. this. Recognizing this link forms the basis of understanding that the poor health and early death of Black Ohioans is directly linked to a long history of past and present institutional (and individual) racism. Honoring this reality, which Black people live with day in and day out, begins the arduous effort to break down Black people's well-founded distrust of institutions of government in general and healthcare in particular.

For decades, researchers have reported that the Black community reports significantly higher levels of distrust of government and the largely white medical establishment. The factors that have fed Black mistrust are as numerous as the systems they have lived with throughout their lives, and, to the extent the scars of trauma are inherited, throughout the lives of the generations that came before. Medical experimentation, forced sterilization (past and present), the dearth of Black and brown doctors, unequal access to health insurance, and persistent racial disparities in diagnosis and treatment are just some of the bricks in the wall that separates Black Ohioans from health equity. Additional barriers to health equity that spring from outside of the medical realm, but are no less relevant to health, are poverty, exclusionary zoning, discriminatory banking practices, unconstitutional school-funding formulas, less qualified teachers, and criminal justice practices. Without acknowledgment of these wrongs, rooted in racism, efforts to engender trust are destined to fail.

Acknowledgement, moreover, is a beginning, and the next steps must quickly follow. Without essential changes to the institutions themselves as are offered at a very high level from agency directors in the Executive Response, declaring racism a public health crisis will do nothing to alleviate the burden of racism on Ohioans. The exigent conditions warrant a commitment of resources to changing structures that perpetuate racism. Until the Executive Office takes action, provides updates, and treats this problem as an emergency, progress will be neither meaningful nor sustained. As just one example, the MHSF offers specific direction, calling for a “thorough review of internal and external policies and procedures,” to identify foci of institutional change. If the Equity Advisory Board accepts this charge at the depth and breadth recommended by the MHSF, with transparency and community input, and the work of the Equity Advisory Board is embraced, then meaningful change in response to the declaration may be realized.

OCHC recommends that all Executive agencies (1) recognize the urgency of the public health crisis wrought by racism and prioritize immediate action, (2) affirmatively support the efforts of the Equity Advisory Board’s review all policies and procedures, and (3) explicitly, with metrics that can be measured, incorporate changes to their policies and procedures necessitated by the review.

2. Recommendation 2: Apply a health equity lens to policy.

The second recommendation, to "apply a health equity lens to policy" also has the potential to rebuild trust between Black Ohioans and government rule-makers. The Executive Branch of government in Ohio has the opportunity to take immediate steps to implement a "health and equity in all policies" approach in all it does. Indeed, many of the commitments described in the Executive Response seem to pledge just that.

Ohio is fortunate to have a public health association that has been advocating for a health and equity perspective in policymaking for the last several years.[1] The Ohio Public Health Association has worked with other stakeholders to develop a tool for Executive agencies to use to take the action MHSF recommends. This "Analytical Tool for Consideration of the Impact of Proposed Rule on the Determinants of Health," calls on agencies to consider the likelihood, severity, magnitude, and distribution of impacts on health determinants including income, housing, education, environment, and transportation. OCHC is attaching the tool to this document and encourages the Governor to implement its use by all Ohio agencies. OPHA, a member of OCHC, is available to meet with the Ohio Equity Advisory Task Force, once formed, and to provide agency leaders with training on use of the tool.

OCHC recommends that all Executive agencies create a structure, including identification of who will be charged with responsibility, to (1) institute protocols to embed a "health and equity in all policies" lens into their current policy-making process, including decisions made regarding the implementation of policies and (2) undertake an audit of existing policies to identify and change policies that result in inequities manifested by racially disparate health outcomes.

[1] OPHA also championed the introduction in the 132nd General Assembly of SB 302 by Senator Charleta Tavares, calling for a "Health and Equity in All Policies Initiative." https://www.legislature.ohio.gov/legislation/legislation-summary?id=GA132-SB-302 (accessed Nov. 23, 2020).

3. Recommendation 4, 5: Develop community trust and learn to identify and correct implicit biases.

In its fourth and fifth recommendations, the MHSF explicitly raised the need to develop trust and learn cultural humility. The Executive Response also lifts up these goals in commitments 1 and 3. OCHC welcomes the focus on the need to build trust, and, through implicit bias training, teach cultural humility and cultural awareness. However, these efforts will do yet more damage if executed at a superficial level. OCHC raises three points relative to these goals.

First, the Executive response must include recognition of the legitimate bases on which Black Ohioans harbor distrust for institutions, whether health care, criminal justice, education, social services, or a myriad of others. Racism, in the form of institutional structure, is the genesis of the disproportionate burden of poverty, poor housing, early death, incarceration, and other negative outcomes borne by Black Ohioans. Redlining, the impact of which continues to this day, provides just one historical example of a significant contributor to the lack of wealth held by Black families. Lack of resources to purchase homes, pay for college, choose private school education for children, and manage a financial setback can all be traced to government actions that deprived Black people from enjoying the dividends afforded White people. Absent such an acknowledgment, the toxic stress of being Black will not subside.

Second, in order to build trust and community understanding, the voices of people of color must be part of the planning and implementation phases of any process. In addition, leaders must reach out and ask for input, perhaps at health town halls in communities of color where government employees with authority and resources are present to respond to issues raised. Both these and other efforts must also include explicit recognition of intersectionality (e.g., lesbian Black women, Latinx seniors, low-income Black minimum-wage workers, parents who arrived as refugees). When “influential leaders” from or serving the Black community, for example, are invited to the table, as is recommended, those who set the table must think expansively to ensure that one or two invited leaders are not expected to speak to the lived experience of all those whose voices are needed. Inclusion must be “both/and” -- influential leaders and individual members of Black and brown communities.

Third, individual implicit bias training is necessary but NOT sufficient. It does not give participants the tools and practice they need to interrupt their unconscious brain from imposing a stereotype on what they see and hear. For "public and private entities to build and develop trust [in] partnership with communities of color through authentic engagement," as the MHSF's fourth recommendation describes at 4(5), those entities must go beyond implicit bias training.[2] They must undertake the greater commitment to teach people how not only to notice the bias in their thoughts but also to pivot away from conclusions based on generations of racist assumptions that are so ingrained they are considered incontrovertible.[3]

To realize the MHSF recommendation to build community trust, OCHC recommends that Black Ohioans with a variety of backgrounds and lived experience be an integral part of planning and implementing changes to reduce racial health disparities. In addition, OCHC recommends that the Executive Office undertake a sustained effort to require public and encourage private entities to create conditions to recognize, interrupt, and correct implicit racial bias.

[2] Undertaking an effort to improve health literacy, as described in MHSF recommendation 4, in the business community will bring its own special challenges. Businesses often seem unaware of the impact of historical trauma and current inequity on the performance of their workforce. Without this understanding, businesses will continue to struggle to hire and keep competent employees in a tight job market like Ohio was experiencing prior to the current public health emergency. In contrast, with business and government engaging authentically with communities of color, Ohio businesses may find increased success in hiring and retaining a more diverse workforce.

[3] Consider the recent study indicating that, after analyzing 1.8 million hospital births in Florida from 1992 to 2015, researchers found that when black newborns are cared for by black doctors, significantly fewer of them die than when they are cared for by white doctors. Black babies are less likely to die when cared for by black doctors, US study finds. BMJ 2020;370:m3315. doi: https://doi.org/10.1136/bmj.m3315 (Published 21 August 2020). Taking for granted that doctors caring for newborns all intend and are highly motivated to treat black and white babies the same, this study suggests that something other than intent, something like implicit bias, may be implicated. See *Just Medicine: A Cure for Racial Inequality in American Health Care*, by Dayna Bowen Matthew, NYU Press, 2015, JSTOR, www.jstor.org/stable/j.ctt15zc6c8.1. Accessed 10 Dec. 2020.

D. Health and Health Care (Rec. 8-13)

Under the broad topic of health and health care, the MHSF proffers six recommendations, four related to reducing discrimination and increasing workforce diversity, and two related to increasing access to health care. The Executive Response includes Commitments 2, 3, and 4, which also address reducing discrimination and increasing diversity among state employees. OCHC is supportive of all six of these recommendations and will limit its comments to a few areas of concern.

1. Recommendation 9: Internal Reviews of Patient Outcomes by Race and Other Factors.

In Recommendation 9, the MHSF advises state government leadership to "work with and consider requiring" internal reviews of healthcare provider organizations' policies and practices as a tool to mitigate health disparities. This process mirrors the similar undertaking by Ohio agencies recommended by OCHC in reference to MHSF recommendation 2. To create the criteria for such an internal review, OCHC again sees the need for input from patients with a variety of demographic characteristics and lived experiences. As an example of why this is essential, consider that implementation of a complaint or whistleblower hotline will be effective only if people of color participate in developing and implementing the complaint or whistleblower process. With a diverse group engaged in developing this process, and healthcare providers sincere in the effort, this is another opportunity to repair trust broken built on current implicit bias and generational trauma.

Health systems may be able to use an existing process to bring together patients and families who are experiencing these disparate health outcomes. Health systems can use as a starting point the focus groups it convenes to undertake their triennial Community Health Needs Assessment (CHNA). In many cases, the breadth of experience may need to be enhanced. Moreover, trusted individuals must be tapped as facilitators to encourage honest input. OCHC is aware of one non-profit health system that is using a focus group originally convened for its CHNA to gather ongoing input as the health system attempts changes to address institutional racism. Health systems also have excellent opportunities to use their required community benefit dollars to take concerted action to respond to the "causes of causes" of racial health disparities. Community benefit dollars should be

directed to make meaningful and measurable impact in reducing implicit bias in healthcare, discussed earlier. Perhaps in collaboration with other community partners, these dollars can also be used ameliorate housing and food instability,

Taking this recommendation a step further, the State is in an opportune position to require health systems to use their community benefit dollars to increase health equity. Requiring broad participation by Black and brown consumers in both the needs assessment and the implementation plan is one important step. Mandating that a higher percentage of community benefit dollars be devoted to action items to reduce health inequity is a second. The role that healthcare institutions have played historically, and into the 21st century, in the disregard of Black humanity, is well documented, from medical experimentation to forced sterilization. The return of healthcare dollars to Black and brown communities is but a small step in correcting that wrong.

There is an additional practice built into some aspects of healthcare that obscures health inequity and must be examined and corrected. The elements of race built into algorithms used for diagnosis and treatment decisions must be recognized for what they are: tools to perpetuate invisible institutional racism. One example of this inexcusable problem is the diagnosis of kidney disease, and subsequent decision regarding whether a patient is eligible for a kidney transplant based on factors that explicitly include race.[4] The medical community is beginning to see this practice for what it is.[5] Ohio agencies can advance correction of this practice.

OCHC recommends that Ohio agencies through a coordinated effort (1) establish best practices for healthcare providers to incorporate the voices of people of color in their review and revision of internal policies and procedures; (2) require that non-profit hospitals use community benefit dollars in explicit and measurable actions to reduce

[4] Vyas, D., Eisenstein, L., Jones, D. Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms. N Engl J Med 2020; 383:874-882 (August 27, 2020). DOI: 10.1056/NEJMms2004740.
[5] Norris KC, Eneanya ND, Boulware LE. Removal of Race From Estimates of Kidney Function: First, Do No Harm. JAMA. Published online December 02, 2020. doi:10.1001/jama.2020.23373. Accessed 9 Dec 2020.

health inequity; and (3) identify opportunities to identify and change medical decision-making algorithms that incorporate an often-hidden racial factor.[6]

2. Recommendation 10: Increase health provider competence in providing trauma-informed healthcare.

In Recommendation 10, the MHSF identifies the need for trauma-informed health care. As one step to increase provider competence in this area, ***OCHC urges state government to use its areas of influence to embed in health care screening both children and adults for Adverse Childhood Experiences (ACEs).*** The value of making this standard of care is found in the interventions that are then used to respond to the unhealthy outcomes associated with high ACE scores. In learning how to ask about ACEs, practitioners create the opportunity to gain understanding (i.e., practicing cultural awareness and cultural humility) about the conditions under which their patients' poor health developed and tailor interventions to causes rather than symptoms.

3. Recommendation 12, 13: Increase access to health care.

The MHSF offers two recommendations to increase access to health care, first, to bolster health insurance enrollment support, and second, to integrate behavioral health into primary care. Neither is alluded to in the Executive Response. However, these two recommendations are critically important, particularly in light of the current public health and economic emergencies Ohioans face. The number of Ohioans on Medicaid has grown during the current public health emergency. In this context, OCHC is concerned about the mismatch between the rising Medicaid enrollment and the even higher number of Ohioans who are newly unemployed. Many more people are apparently unemployed than are enrolling in Medicaid, potentially leaving many people uninsured. One possible way the state could bolster health insurance enrollment support is by embedding in the unemployment application process questions that trigger a preliminary assessment of whether the applicant is eligible for essential health benefits like Medicaid, CHIP (to cover dependent children, for example) or health insurance through the ACA

[6] Ohio governmental agencies and entities, for example, Department of Medicaid, Department of Insurance, Department of Health, and the State Medical Board, may be in the best position to uncover and unwind these default decisions.

Marketplace. These benefits are a life raft for families and individuals who are facing health risks (and hunger).

OCHC also remains a vigilant voice for consumers in protecting Medicaid benefits and eligibility. The current "maintenance of effort" requirement tied to the Federal CARES Act provides some present protection. Nevertheless, Medicaid benefits, including additional services like dental and vision, will be under pressure with falling state revenue. Under the current circumstances of people losing jobs and their employer-based insurance coverage, it is more important than ever for policy makers to remain committed to ensuring access to robust Medicaid coverage. Anything short of that is likely to exacerbate racial health disparities. Moreover, the lack of assured stability in the Medicaid program further points to the overarching need for guaranteed comprehensive health insurance coverage for all Ohioans, independent of employment status.

Regarding the integration of mental health and primary care, the evidence for this approach is well-established. Given the heightened stigma of mental illness in Black communities, the need for culturally sensitive opportunities to access mental health services is necessary in order to increase take-up. Integrating mental health and primary care is one such opportunity. OCHC is also supportive of state agency collaborations, like those suggested by the MHSF, to break down barriers and create additional opportunities for Black patients to access mental health services.

OCHC recommends embedding in Ohio's unemployment application process a path to health insurance, either through Medicaid, CHIP, or the ACA Marketplace. OCHC recommends the additional services (aka "optional services") continue to be available to individuals and families who rely on Medicaid for their health insurance. Finally, OCHC fully supports integration of mental health services into the provision of primary care.

E. Social and Economic Environment

1. Recommendations 14 &16: Identify health metrics to measure health impact of increased access to both early childhood intervention and higher education.

As the health impact of our social and economic environment is becoming better understood, the range of creative and effective interventions grows. The MHSF focuses first on education, advocating for improved access to high-quality education by strengthening early childhood education and building pathways to higher education, both undeniably worthy goals. ***In recognizing the link between education and health, the state must identify appropriate health indicators to measure progress on these recommendations.***

2. **Recommendation 15: As school districts identify students struggling with chronic absenteeism and develop action plans, they must include parents of students of color to identify with accuracy and cultural humility the barriers and potential solutions and should use school-based health clinics to respond to health issues that are at the root of absences.**

In Recommendation 15, the MHSF identifies the need to ensure "K-12 chronic absenteeism efforts meet the needs of children of color." Especially significant during this period of disrupted learning, schools must be diligently anti-racist in how its students are counted as "present" or "absent." Schools should be slow to affix the label of "chronic absenteeism" because it may reduce a child's future opportunities. "Absences" should be investigated to determine the cause. If a student lacks access to technology to take advantage of remote online learning, then the student needs an alternative way to be present and participate in learning. Ohio cannot solve the challenges manifested by student absences unless it brings parents in communities of color to the conversation about the barriers their children face in accessing education, rather than imposing sanctions and penalties.

Chronic absenteeism is often a by-product of health issues, or lack of childcare. When examining this problem, the Equity Advisory Board should take the opportunity to increase student access to school-based health clinics. Children would benefit from automatic determination of eligibility for Medicaid and wraparound services like primary care visits, dental care, immunizations, and behavioral healthcare. These health clinics should service the children in the surrounding community.

OCHC recommends that the Equity Advisory Board, in taking steps to implement this recommendation, ensure that parents of students struggling with absenteeism be "at the table," either as members of the Equity Advisory Board, or as individuals knowledgeable about the problem providing input to the Equity Advisory Board. Moreover, the State should do all it can to increase access to health care through expansion of school-based health clinics.

3. Addition Recommendations in Social and Economic Domains

With respect to the remaining areas covered by the MHSF under social and economic environment, OCHC briefly comments on two specific areas. First, regarding the recommendations related to reducing poverty and increasing investment and employment, these efforts require long-term sustained change, beyond a 2- or 4-year window. The Governor's Equity Advisory Board should set this agenda and identify interim, e.g., two-year benchmarks to show progress. The Governor must then invest resources in that agenda. Second, regarding the Recommendation 20, the charge to develop "a health and criminal justice partnership" is a demand to examine the harmful militarism of police, bias in the judiciary, bail reform, and parity in sentencing. In addition, this partnership should focus on public health, mental health, and access to health care, as these matters interface with criminal justice. ***There are many additional points OCHC could, and would welcome the opportunity to, share on these and other social and economic recommendations as the Equity Advisory Board takes up these recommendations.***

F. Physical Environment

Within the context of the health impact of the physical environment, the MHSF has offered recommendations related to housing, transportation, and technology. Each of these areas are foundational for health equity. Solutions depend on creative thinking. OCHC will focus its comments on the third of these, technology, and incorporate by reference the comments of Summit Coalition on Community Health Improvement (SCCHI) on housing and transportation.

1. **Recommendation 27: In bridging the digital divide, Ohio must commit to infrastructure in both rural and urban communities, while ensuring that increased racial health disparities are not an unintended consequence of expanded access to health care through telehealth.**

The digital divide is a gaping chasm on the edge of which both urban and rural Ohioans are crouched. The lack of digital infrastructure in our communities, both rural and urban, coupled with inadequate technology in people's homes, leaves students unable to learn remotely and patients unable to obtain health care through telehealth. The State must assure broadband access in unserved and underserved communities across the state. Beyond broadband access, the State must take steps to remove related barriers, like insufficient minutes, lack of video technology, and technology illiteracy. Ohio must not allow the leap in technological solutions to leave behind Ohioans with limited resources.

Moreover, the pandemic-related infrastructure funds provided to enable low-income residents to obtain internet services -- an intended benefit -- potentially set a trap for those very residents. This much-needed support puts families at risk for accumulating arrearages to internet providers after the government support for internet ends. As the state channels money to meet the need for broadband, it must hold companies accountable for ensuring that the onus is not put on individual purchasers to "opt out" of non-essential digital services when any subsidy ends. It is these hidden tactics that create disparate impacts that the Equity Advisory Board should affirmatively squelch.

In addition, OCHC cautions that in its enthusiasm to bridge the digital divide, the State does not lose sight of the need for in-person contact, particularly for patients. Given the deep disparities in health outcomes by race, Ohio must be cautious about over-use of telehealth. There is no reason to think that the implicit bias in the provision of health care (described earlier) will disappear because telehealth is now a more-viable option for health care providers. At times, an in-office interaction is essential for proper diagnosis and monitoring.

For these reasons, OCHC recommends that the Executive office take steps to protect Ohioans as broadband consumers and as patients, while expanding access to

broadband services and providing avenues for telehealth, which are both essential for equity.

2. The need for environmental justice must be recognized.

OCHC calls attention to one additional area related to the physical environment that is not explicitly referenced in either the MHSF Blueprint or the Executive Response - the issue of environmental justice. Environmentally harmful land use is much more prevalent in neighborhoods where people of color and low-income people reside. This reality contributes to the health disparities those residents experience. Through several existing initiatives, the Governor has acknowledged the need to rectify, to some extent, the racial and economic disparities in who bears the heaviest burdens of environmental toxins like lead in paint and water, contaminated drinking water, and air pollution. ***OCHC recommends that efforts to advance environmental justice be folded into the work of the Equity Advisory Board to enhance transparency and accountability for progress.***

G. Data, Implementation, and Accountability

1. Recommendations 28 & 32: Ohio must require and facilitate oversampling of subpopulations and data collection on race, ethnicity, language, and country of origin.

At the beginning of this letter, OCHC identified Recommendation 33 as the MHSF recommendation of greatest concern and advocated for transparency and accountability well in excess of the MHSF-recommended annual report. OCHC also already noted the MHSF recommendations describing public access to data and creation of accessible dashboards, because they are an essential part of the same effort. Juxtaposed with these concerns are two recommendations that OCHC commends - Recommendations 28 & 32. OCHC is a strong proponent of oversampling to understand what is happening in smaller populations, such as Asian and African subpopulations. Absent oversampling, data are insufficient to disaggregate by subgroups, masking disparities that demand attention. Similarly, without data on race, ethnicity, language, country of origin, and other demographic characteristics, the disparities that persist remain unacceptably invisible.

In order to collect meaningful data, the State will have to invest funding to hire and train data collectors who will be able to build trust in Black and brown communities. Without trust, including assurances about privacy, people will not be confident in sharing their personal health information. This effort, like every effort undertaken to improve health equity, presents an opportunity to be intentional about correcting past breaches of trust.

OCHC recommends that the Executive office ensure widespread data collection that includes the oversampling of relevant racial and ethnic subpopulations as well as the collection of, especially, race and ethnicity.

IV. Opportunities

The MHSF Blueprint presents many avenues to improve the lives and health of Ohioans. OCHC mentions just a few noteworthy and timely opportunities.

A. Equity Advisory Board; The Biennial Budget

Your recent appointment of a Chief Health Opportunity Advisor to advance the recommendations of the Minority Health Strike Force is a welcome first step. OCHC anticipates that the creation of the Equity Advisory Board will occur in short order. Moreover, you have the opportunity to show your commitment to prioritizing the implementation of MHSF blueprint in your biennial budget proposal, by not only funding the creation of the Equity Advisory Board, but also targeting resources to the intentional implementation of the MHSF Blueprint.

B. The Capitol Budget

The Capital Budget also provides the State with an excellent opportunity to establish a long-term commitment to public participation in assuring broadband access in unserved and underserved communities across the state. Where private companies hesitate to serve, the state should step in and provide the service.

C. Implicit Bias - Kirwan Institute

Ohio is fortunate to have significant expertise on recognizing and ameliorating implicit bias at the Kirwan Institute for the Study of Race and Ethnicity, located at The Ohio State University. This remarkable local resource may be instrumental in leading Ohio through implementation of MHSF recommendations related to implicit bias

D. Trust-building

Building an environment of trust will take time, commitment, and authenticity. Many Black and brown Ohioans will not be inclined to embrace efforts to gain their trust. Nor will they assume best intentions. The history of racist policies and practices has left a wound that will not be easily healed. Actions undertaken to improve trust must be explicit -- Black and brown Ohioans must know the steps the State is undertaking to build trust.

E. Identify roles and responsibilities

Finally, a critical step will be identifying who will do the hard work. For purposes of accountability and transparency, the State must identify roles and responsibilities for achieving the promise of the MHSF Blueprint.

V. Conclusion

OCHC is committed to the hard work of achieving racial health equity. We appreciate the opportunity to provide input at this stage of the process and would be glad to discuss any of the matters raised in this letter at greater length. OCHC may also be of assistance in identifying consumers and consumer groups to bring their essential perspective to the State's efforts. OCHC is hopeful that the promise of the MHSF Blueprint may be realized. It is incumbent upon the state government to take up the mantle, and not allow the MHSF Blueprint to be cast aside or become bogged down. Please do not hesitate to reach out. Our offer of collaboration is genuine and heartfelt.

Attachment:
Analytical Tool for Consideration of the Impact of Proposed Rule on the Determinants of Health

FINAL DRAFT– FINAL DRAFT
Ohio Public Health Association (OPHA)
Health and Equity in All Policies (HEiAP) Committee -Analytical Tool to assess impact of proposed legislation and rules on the determinants of health
JCARR Version

Analytical Tool for Consideration of the Impact of Proposed Rule on the Determinants of Health

Purpose: To qualify, quantify, and provide transparency for impact of the proposed rule on the health equity of all Ohioans and to evaluate the health impacts, including the determinants of health and their indirect impact on health.

Definitions for the Purposes of this Tool:

Health – The state of a person's physical, mental, and social well-being; is not limited to the absence of disease or infirmity

Determinants of Health – The range of personal, social, economic, and environmental factors that influence health status; includes, but not limited to, income, education, family, housing, food security, environment, community, and transportation

Health Equity – Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally. This requires addressing historical and contemporary injustices and removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, access to transportation, safe environments and health care.

General Information:

- Agency, Board, or Commission proposing the rule
- Rule/Package Title (general description of the rules' substantive content)
- Rule Number(s)
- Rule Type (New, Amended, No Change, or Rescinded)

Summary of the Proposed Rule: Please briefly describe the draft rule in plain language. *Include the key provisions of the rule as well as any proposed amendments.*

Background:

- What problem is this rule trying to address?
- How does the rule address this problem?

Regulatory Intent and Development of the Rule:

- Identify the geographical area(s) impacted by the rule
- Identify the specific population(s) targeted by the rule
- How will the Agency measure the effects of this rule on health outcomes?

- Please list the community/consumer and health-based stakeholders included by the Agency in the development or initial review of the draft rule
- What input was provided by the stakeholders, and how did that input affect the draft rule being proposed by the Agency?
- What scientific and health-related data was used to develop the rule or the measurable outcomes of the rule? How does this data support the rule being proposed?
- Please describe the Agency's plan for implementation of the rule, including any measures to ensure that the rule is applied consistently and predictably for the regulated community

Impact to Health Questions:

- Does this rule directly impact the health of Ohioans? If so, how?
- How does this rule impact the determinants of health and indirectly impact the health of Ohioans?
- Describe the beneficial or adverse impact the proposed rule would have on different groups based on demographics (including infancy and throughout the lifespan, gender, race, ethnicity, sexual orientation, geographical location, disability status).

Please make sure to cite all of your sources.

Answer these questions as to the likelihood, severity, magnitude and distribution of health and health-related impact. See Appendix A for guidance.

See Appendix B for guidance on Impact to Determinants of Health.

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Appendix A. Rating Importance of Health Effects

Likelihood	***How certain is it that the rule will effect health determinants or outcomes?***
Unlikely/Implausible	Logically implausible effect; substantial evidence against mechanism of effect
Possible	Logically plausible effect with limited or uncertain supporting evidence
Likely	Logically plausible effect with substantial and consistent supporting evidence and substantial uncertainties
Very Likely/Certain	Adequate evidence for a causal and generalizable effect
Severity	***How important is the effect with regards to human function, well-being, or longevity, considering the affected community's current ability to manage the health effects?***
Low	Acute, short-term effects with limited and reversible effects on function, well-being, or livelihood that are tolerable or entirely manageable, within the capacity of the health system
Medium	Acute, chronic, or permanent effects that substantially affect function, well-being, or livelihood but are largely manageable within the capacity of the health system OR Acute, short-term effects on function, well-being, or livelihood that are not manageable within the capacity of the health system
High	Acute, chronic, or permanent effects that are potentially disabling or life-threatening, regardless of health system manageability OR Effects that impair the development of children or harm future generations
Magnitude	***How much will health outcomes change as a result of the rule (i.e., what is the expected change in the population frequency of the symptoms, disease, illness, injury, disability, or mortality)?***
Limited	A change of less than one-tenth of 1% in the population frequency of a health endpoint
Moderate	A change of between 0.1% and 1% in the population frequency of a health endpoint
Substantial	A change in greater than 1% in the population frequency of a health endpoint
Distribution	***Will the effects, whether adverse or beneficial, be distributed equitably across populations? Will the rule reverse or undo baseline or historical inequities?***
Disproportionate Harms	The rule will result in disproportionate adverse effects to populations defined by demographics, culture, or geography
Disproportionate Benefits	The rule will result in disproportionate beneficial effects to populations defined by demographics, culture, or geography

Restorative Equity Effects	The rule will reverse or undo existing or historical inequitable health-relevant conditions or health disparities

Appendix B. Guidance on Impact to Determinants of Health

In describing the beneficial or detrimental impact that the proposed rule will have on health, please consider the impact on the determinants of health. The determinants of health include, but are not limited to, the following:

- *Income*: Effect on employment/income level, security of employment, the portion of the population living in relative or absolute poverty, and/or income inequality
- *Family*: Effect on quality and proximity of childcare services, and/or quality, access, or capacity of schools for children
- *Housing*: Effect on housing affordability, adequacy or housing supply, quality or safety of housing, and/or racial/ethnic/income segregation of housing
- *Food Security and Nutrition*: Effect on the supply or cost of food, food safety, and/or access to and affordability of healthy food resources
- *Education*: Effect on early childhood years, primary and secondary education and lifelong learning leading to trade school, college, employment earning a living wage, and/or military
- *Environment*: Effect on the level of hazardous chemical/biological pollutants in outdoor air, soil, and drinking water, and/or the risk and response to fire hazards, natural disasters, spills of hazardous materials, etc.
- *Community*: Effect on the quality and proximity of goods and services, educational resources, health services, financial institutions, and parks/public spaces
- *Transportation*: Effect on traffic volume or vehicle speeds, and/or availability and proximity of public transportation