Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

PUBLIC HEALTH COUNCIL

January 20, 2021

Please standby – the meeting will begin shortly

Today's presentation is available on the mass.gov/dph website under "Upcoming Events" by clicking on the January 20 Public Health Council listing

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Local public health nurses assist with vaccinations

Milton

Northampton

Melrose

When can I get a COVID-19 vaccine in MA?

PHASE ONE

In order of priority

- Clinical and non-clinical healthcare workers doing direct and COVID-facing care
- Long term care facilities, rest homes and assisted living facilities
- First responders (EMS, Fire, Police)
- Congregate care settings (including corrections and shelters)
- Home-based healthcare workers
- Healthcare workers doing non-COVID-facing care

December - February

PHASE TWO

In order of priority

- Individuals with 2+ comorbidities (high risk for COVID-19 complications), individuals age 75+, and residents and staff of public and private low income and affordable senior housing
- Early education and K-12 workers, transit, grocery, utility, food and agriculture, sanitation, public works and public health workers
- Adults 65+
- Individuals with one comorbidity

February - April

PHASE THREE

Vaccine available to general public

April - June

Estimated timeframes

For more information on vaccine distribution visit **Mass.gov/COVIDvaccine**

Mass.gov

Search Mass.gov SEARCH

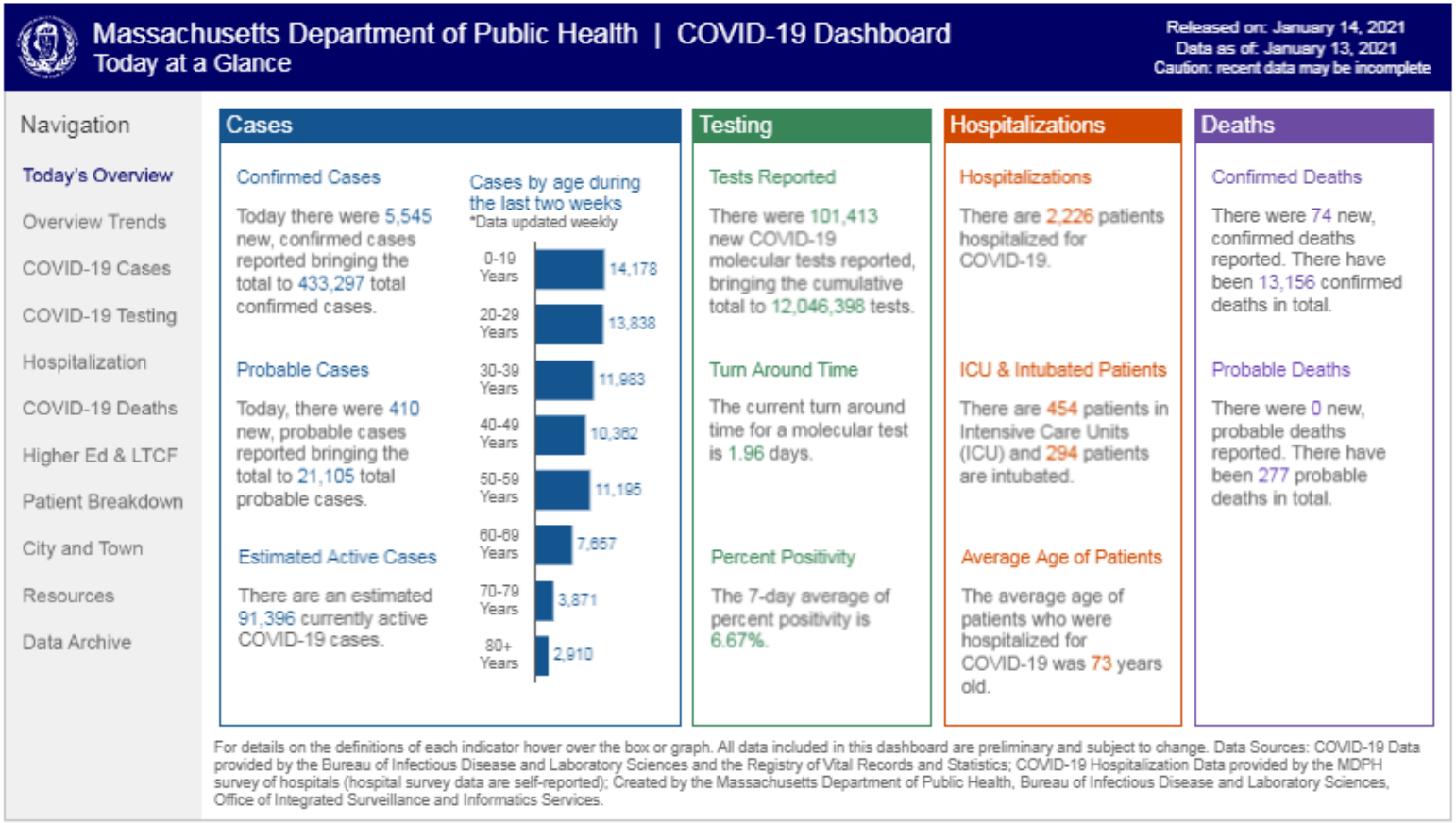
COVID-19 Vaccine in Massachusetts

Massachusetts is preparing for the safe, equitable, and effective delivery of an FDA-approved COVID-19 vaccine. Learn about the approach and when you can expect to get vaccinated.

WHEN CAN I GET THE VACCINE?

www.mass.gov/covidvaccine

COVID-19 Interactive Data Dashboard



www.mass.gov/CovidData

Determination of Need:

New England Surgery Center, LLC Request for Proposed Substantial Change in Service

Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

Final Promulgation of Amendments to 105 CMR 700.000 Implementation of M.G.L. c. 94C

Public Health Council
January 20, 2021

Lauren B. Nelson, Esq.
Director of Policy and Regulatory Affairs
Bureau of Health Professions Licensure

Summary of Regulation

105 CMR 700.000, *Implementation of M.G.L. c. 94C*:

- Sets forth consistent standards for the safety, security and storage of controlled substances;
- Outlines Drug Control Program (DCP) requirements for practitioners and facilities to receive a Massachusetts Controlled Substances Registration (MCSR); and
- Manages oversight of the Massachusetts Prescription Awareness Tool (MassPAT) through the Prescription Monitoring Program (PMP).

Flu Vaccine Administration

Prior to November 18, 2020, 105 CMR 700.003(H) allowed the Commissioner to expand flu vaccine administration by authorizing DPH licensed or certified health care professionals or medical or nursing students to possess and administer vaccine for the prevention of a pandemic, novel, or seasonal influenza virus, after determining there are insufficient health care professionals available for timely vaccine administration, and issuing an order authorizing such administration.

- November 2, 2020 – The Commissioner made such a determination and issued such an order under this regulation for paramedics, medical students and nursing students to administer influenza vaccine.

COVID-19 Vaccine Administration

On November 18, 2020, the Public Health Council approved an emergency amendment to 105 CMR 700.003(H) to provide greater access to COVID-19 vaccine by authorizing possession and administration by DPH licensed or certified health care professionals or qualified medical or nursing students to designated vaccines for the prevention of a pandemic, novel or other vaccine-preventable disease, rather than only influenza.

- Link to Current Order and Guidance under the Emergency Amendment: Order of the Commissioner of Public Health Allowing Certain Individuals to Administer Influenza and COVID-19 Vaccines | Mass.gov

Summary of Comments

During the Public Comment period, 21 comments were received from students and programs for licensure as Physician Assistants:

- Commenters, including PHC members, expressed support for Pharmacy students' and PA students' capability and training to provide vaccine administration.
- Professors at PA Programs outlined the length and rigor of programs to prepare PAs to work in health care facilities, with at least 4 hours of injection training, including indications, contra-indications, and risks of injections and immunizations.
- Students noted that PA Programs are spread widely across Massachusetts, expanding access to vaccines in western MA if added to the pool of vaccinators.
- The Massachusetts Association of Physician Assistants implored DPH, at a time when residents must have access to fast, effective vaccinations, to recognize that PA students possess skills and experience equivalent to Nurse Practitioners.

Summary of Amendments – Post-Comment

The proposed post-comment emergency amendments expand access to vaccine further by authorizing possession and administration by a larger pool of individuals from which the Commissioner may designate vaccinators

- including ***any student of a program for licensure as a health care professional.***

Together, the Emergency Regulation and these proposed amendments allow the commissioner to expand access to designated vaccines AND designated vaccinators.

Regulation Changes (Post-Comment):
Students of Programs for Licensure of Health Care Professionals

- **Bold blue = new language**
- ~~Red strikethrough~~ = deleted language
- Regular text = existing language
- **Bold green = changes post comment**

(H) Notwithstanding any other Department regulation, a health care professional duly licensed or certified by the Department, or a ~~**medical or nursing**~~ student duly enrolled in an approved or accredited program for licensure **as a health care professional** and acting in accordance with the policies of that program, may possess and administer **any** vaccine **designated by the Commissioner** for the prevention of a pandemic, novel**,** or ~~seasonal influenza virus~~**other vaccine-preventable disease,** provided the Commissioner determines that there are or will be insufficient health care professionals available for timely vaccine administration and issues an order authorizing such administration.

(1) To the extent authorized by 105 CMR 700.003(H), a health care professional duly licensed or certified by the Department, or a ~~**medical or nursing**~~ student duly enrolled in an approved or accredited program for licensure **as a health care professional** and acting in accordance with the policies of that program, may administer vaccine if:

Next Steps

It is respectfully requested that the Public Health Council vote to approve the post-comment emergency amendments to the regulation, 105 CMR 700.000, for final promulgation.

Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

Thank you for the opportunity to present this information today.

For more information regarding Drug Control, including the Prescription Monitoring Program, please find the relevant statutory language and the full current regulation here:

https://www.mass.gov/doc/105-cmr-700-implementation-of-mgl-c94c/download

Please direct any questions to:

David E. Johnson, Director

Drug Control Program

Bureau of Health Professions Licensure

dcp.dph@mass.gov

617-983-6700

Massachusetts Department of Public Health

150 YEARS OF ADVANCING PUBLIC HEALTH

DPH HEALTH EQUITY DASHBOARD:
RACE AND HISPANIC ETHNICITY 2020

JANUARY 2021 PUBLIC HEALTH COUNCIL MEETING

HEALTH EQUITY DASHBOARDS

History & Purpose

- Disparities in health outcomes are linked with socioeconomic status, race/ethnicity, gender, sexual orientation, immigration, history, and other social characteristics
- Development of Health Equity Dashboards via Population Health Information Tool (PHIT) to highlight persistent disparities part of ISA with EHS
- These data are consolidated from previously existing DPH reports and we encourage viewers to supplement their knowledge by following links to the sources provided throughout the report
- These Health Equity Dashboards aim to:
  - Improve access to data by ***populations*** rather than by health outcome
  - Give the viewer an introductory level understanding to existing disparities for each population and provide actionable data

RACE & HISPANIC ETHNICITY DASHBOARD

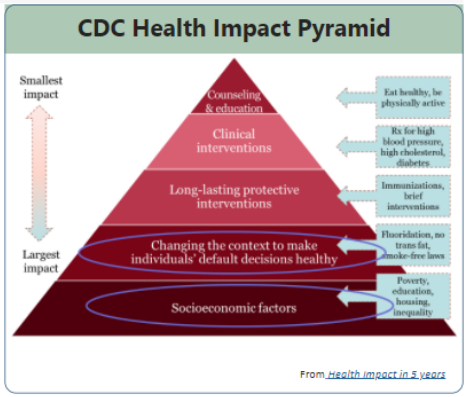
Overview & Structure

- Communities of Color is the first to be developed in the Health Equity Dashboard series
- The Dashboard highlights the impact of race and ethnicity on the health of MA residents
  - This initial version focuses on the 1997 Office of Management and Budget (OMB) standards Race and Ethnicity categories and Hispanic origin
- The Race and Hispanic Ethnicity Dashboard provides health outcome data from across DPH in a centralized location
  - Data are consolidated from previously existing reports published by DPH
- Supporting materials including key terms, references, technical notes on data collection are also provided

Examples of Supporting Materials

Key Terms

What is health equality? Everyone is given the same health intervention without consideration of underlying needs.
What are health disparities? Disparities are significant differences in health outcomes between populations.
What are health inequities? Inequities are the unjust distribution of resources and power between populations which manifests in disparities.
What is health equity? Everyone has what they need to attain their highest level of health.

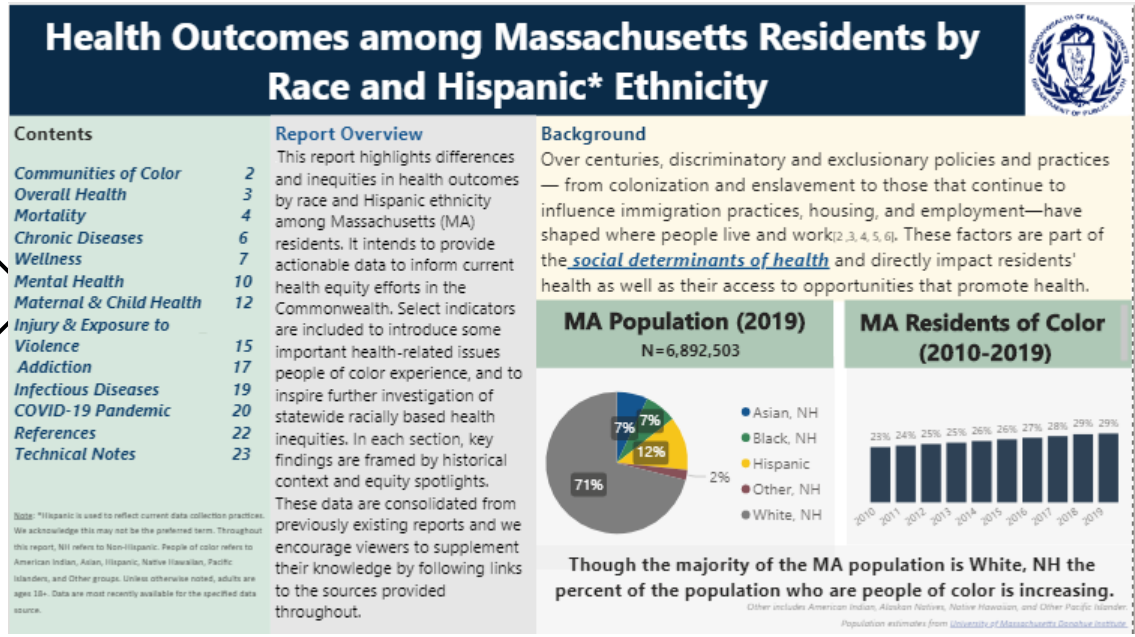


- Organized by 9 Health Outcomes plus a section on the ongoing COVID-19 pandemic

- Health Outcomes and Indicators selected for this version were guided by the [2017 State Health Assessment]
  - We gathered equity metrics found in numerous published DPH data reports in one location with the goal of providing actionable data to inform current health equity efforts

Health Outcomes

Title Page



Health Outcomes among Massachusetts Residents by Race and Hispanic* Ethnicity

Contents

Note: *Hispanic is used to reflect current data collection practices. We acknowledge this may not be the preferred term. Throughout this report, NH refers to Non-Hispanic. People of color refers to American Indian, Asian, Hispanic, Native Hawaiian, Pacific Islanders, and Other groups. Unless otherwise noted, adults are ages 18+. Data are most recently available for the specified data source.

Report Overview

This report highlights differences and inequities in health outcomes by race and Hispanic ethnicity among Massachusetts (MA) residents. It intends to provide actionable data to inform current health equity efforts in the Commonwealth. Select indicators are included to introduce some important health-related issues people of color experience, and to inspire further investigation of statewide racially based health inequities. In each section, key findings are framed by historical context and equity spotlights. These data are consolidated from previously existing reports and we encourage viewers to supplement their knowledge by following links to the sources provided throughout.

Background

Over centuries, discriminatory and exclusionary policies and practices — from colonization and enslavement to those that continue to influence immigration practices, housing, and employment—have shaped where people live and work[2,3,4,5,6]. These factors are part of the *social determinants of health* and directly impact residents' health as well as their access to opportunities that promote health.

MA Population (2019)
N=6,892,503

MA Residents of Color (2010-2019)

Though the majority of the MA population is White, NH the percent of the population who are people of color is increasing.

Other includes American Indian, Alaskan Natives, Native Hawaiian, and Other Pacific Islander
Population estimates from University of Massachusetts Donahue Institute

- Each outcome features 2-3 indicators by available race/ethnicity data
- Focus is on recent data (2014-present) that is publicly available

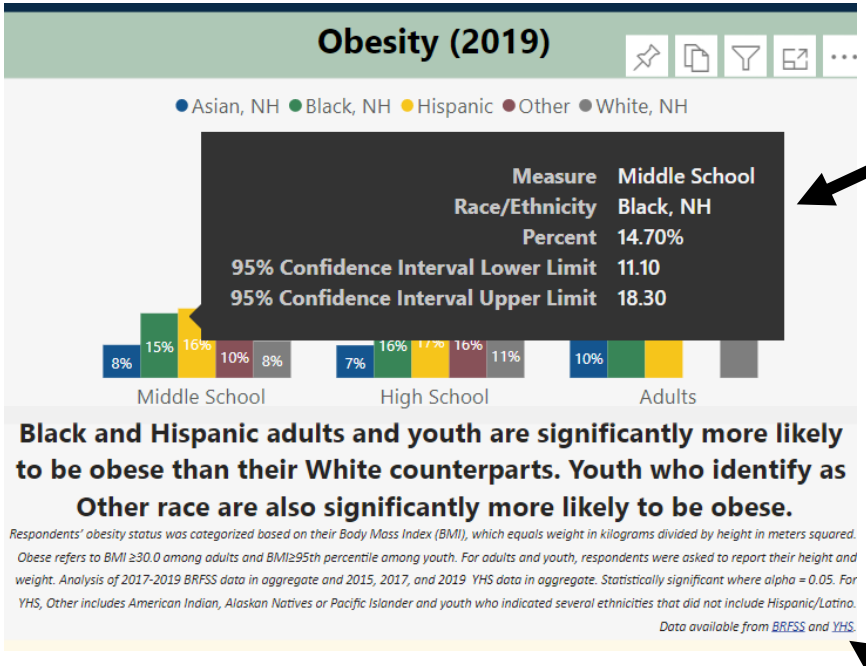
Health Outcome Topic	Data Indicators Included
Overall Health	Adults Reporting Fair or Poor Health
Mortality	Premature Mortality, Leading Causes of Death, All Cancers Mortality, Prostate Cancer Mortality, Breast Cancer Mortality
Chronic Diseases	Incidence of All Cancers, ED Visits for Diabetes, Asthma Hospitalizations
Wellness	Physical Activity, Adequate Fruit & Vegetable Consumption, Obesity, Current Smoking & Successful Quitting, Flu Vaccinations, Hepatitis B Vaccinations, Recent Dental Visits
Mental Health	Suicide Rates, Youth Suicide Attempts, Youth Depression Symptoms, Adult Depression Diagnoses, Postpartum Depressive Symptoms
Maternal & Child Health	Overweight during Pregnancy & Gestational Diabetes Mellitus, Adequate Prenatal Care, Severe Maternal Morbidity, Infant Mortality Rate, Preterm Births, Children with Lead Poisoning,
Injury & Exposure to Violence	Youth Bullied at School, Work Related Hospitalizations, Homicide Rates, Firearm Death Rates
Addiction	Heavy Drinking, Opioid-Related Overdose Fatalities, Referral & Enrollment in Intervention Programs for Infants with Neonatal Abstinence Syndrome, Enrollment in Addiction Services
Infectious Diseases	Tuberculosis Cases, Infectious Syphilis Cases, HIV Diagnoses
COVID-19 Pandemic	COVID-10 Cases, Hospitalizations, and Deaths

RACE & HISPANIC ETHNICITY DASHBOARD

Key Features

Example of Features from Content Pages

- Interactive format is available that provides links to data sources and additional information (e.g. confidence intervals)
  - Additional functionality to be added



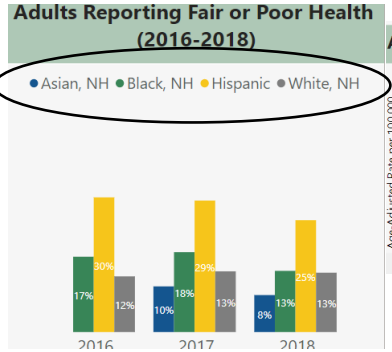
Interactive "hover" that shows more detailed data (i.e. confidence intervals)

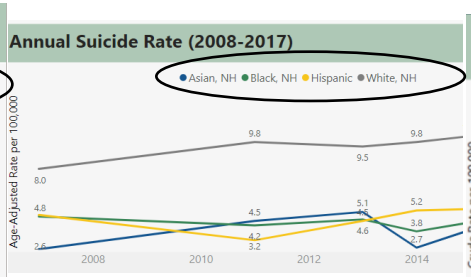
Links to data source/further information

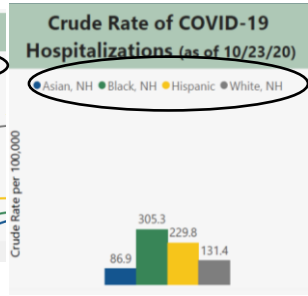
- Consistent color scheme for easier visual navigation throughout
- Data findings are framed by historical context
  - Historical context provides narrative overviews of important events and policies that have had an impact on social determinants of health

Example of Features from Content Pages

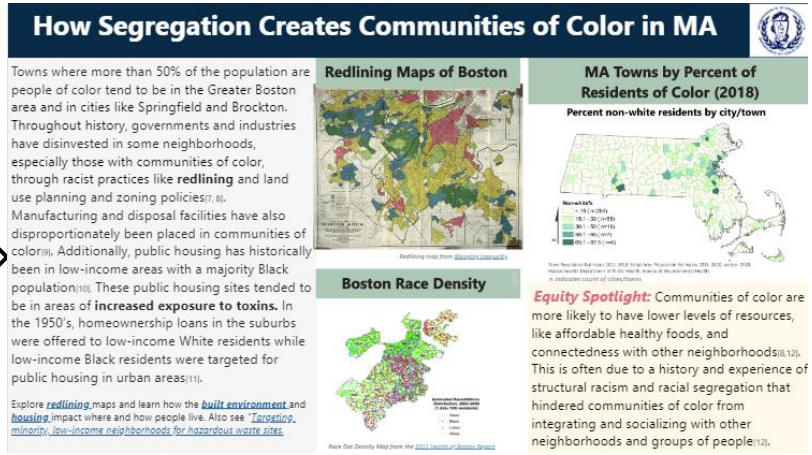
Consistent color scheme for groups across graphs





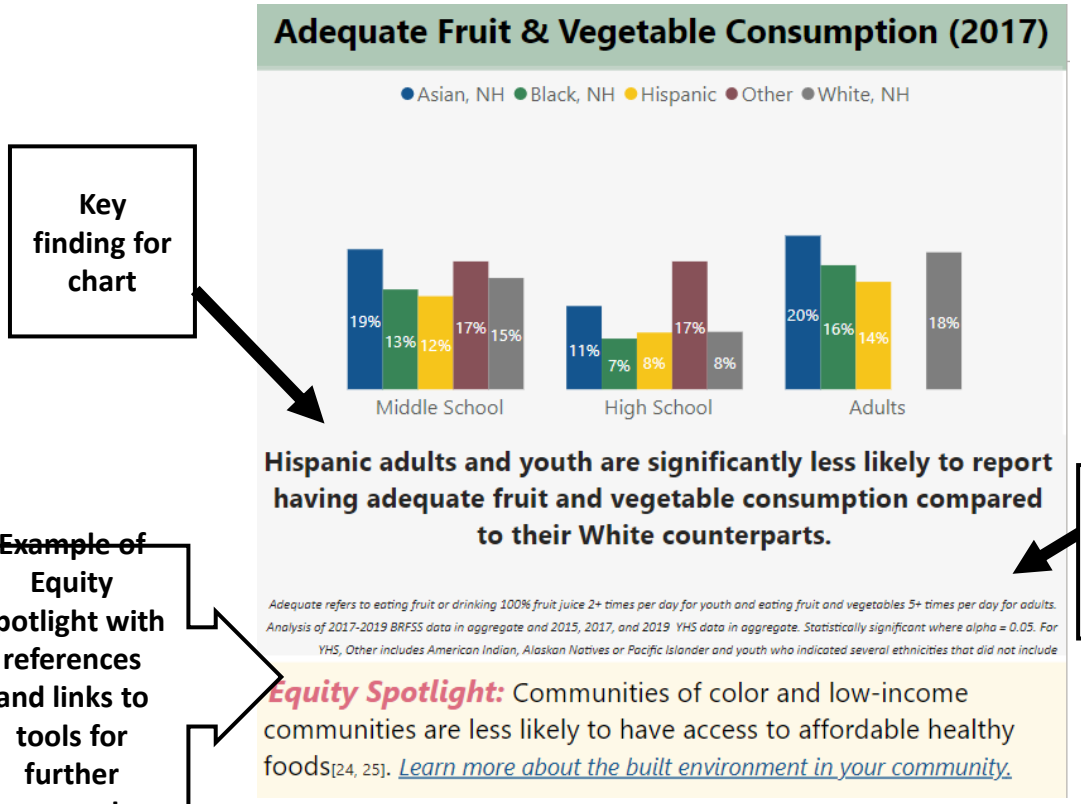


Example of Historical Context



Example of Features from Content Pages

- Key findings from each chart aids in data interpretation
  - Relevant data notes are provided for each source
- Equity Spotlights are found throughout the dashboard
  - These short texts are meant to draw attention to systemic and structural inequality that serve as driving factors or impediments to good health

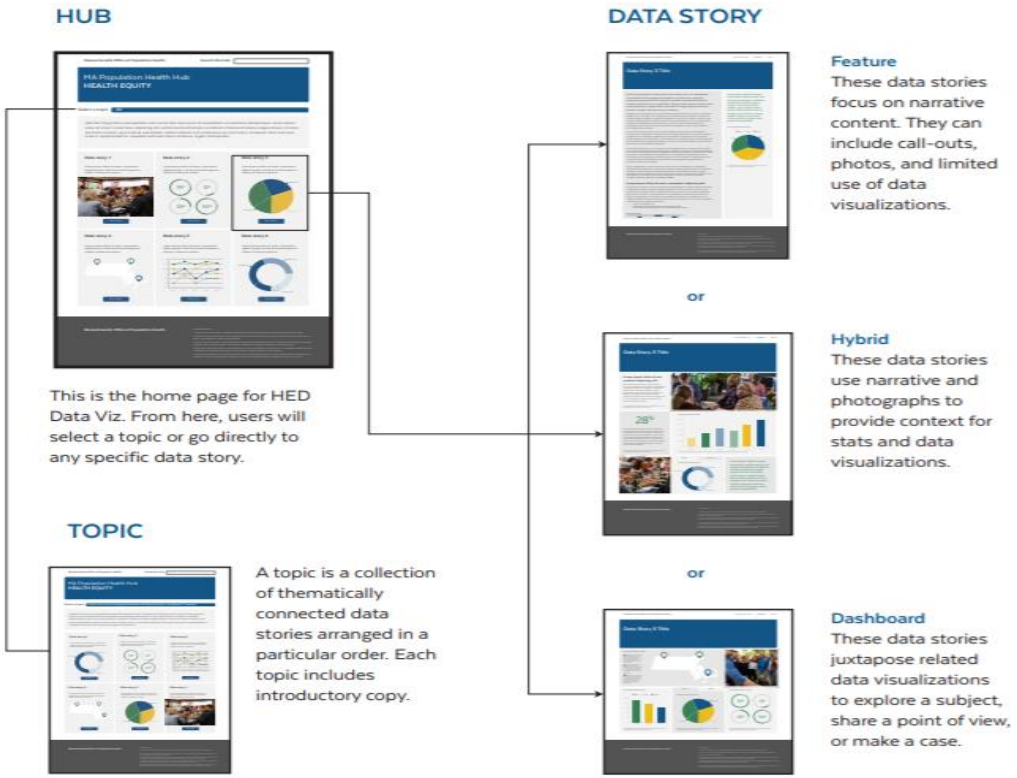


RACE & HISPANIC ETHNICITY DASHBOARD

Next Steps

- This website will be a mobile friendly access point for data disaggregated by race/ethnicity via the PHIT website.
- OPH is currently engaging with a vendor to help create a centralized website for the Health Equity Dashboards
  - The website will allow for further interactivity, mobile-friendly navigation and search features so viewers can find population/topics of interest easily

Draft Layout



Future Work: More In-depth Dashboard for Communities of Color (Q2 2021 and Beyond)

- This initial Race and Hispanic Ethnicity Dashboard is a brief overview of Communities of Color
- We are working on expanding this Dashboard by:
  - Adding more health indicators
  - Using detailed ethnicity data (e.g. indicators that are available by countries of origin)
  - Updating COVID-19 data
  - Incorporation of additional and interactive maps
  - Adding indicators that feature intersectionality populations (e.g. health indicators by race and gender)

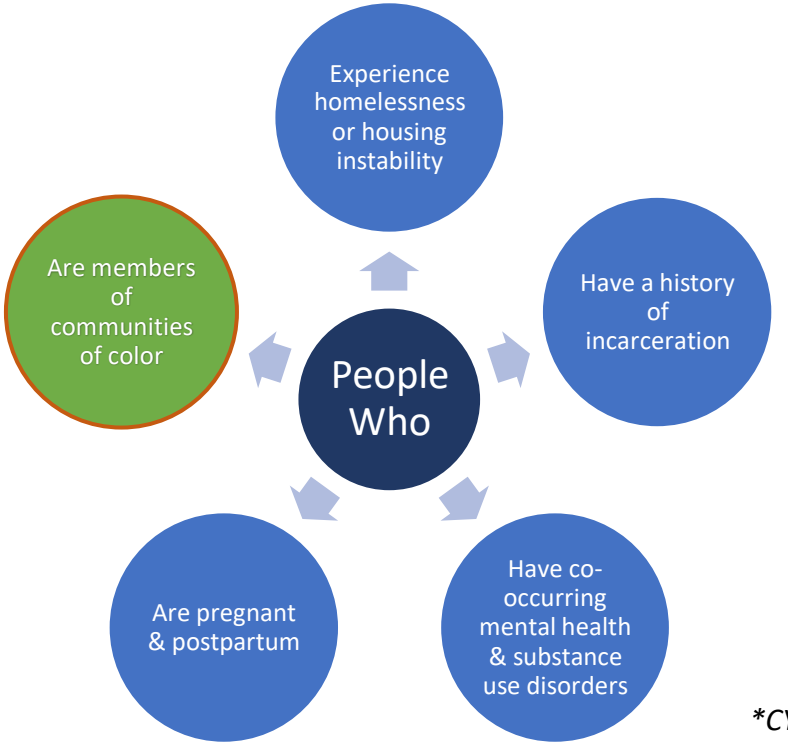
HEALTH EQUITY DASHBOARDS

Next Steps

Future Work: Additional Health Equity Dashboards (Q2 2021 and Beyond)

- Additional Dashboards on the other Commissioner identified priority populations will be created
- Additional visual representations of additional analytics to indicate statistically significant differences

*Commissioner Priority Populations**



**CY 20*

APPENDIX

Full Race & Hispanic Ethnicity Dashboard

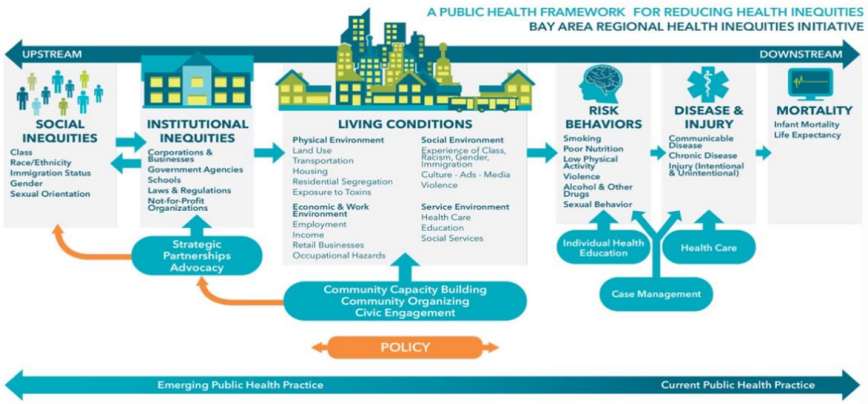
Part of Landing Page/Hub

ADDITIONAL BACKGROUND ON HEALTH EQUITY

This section is intended to provide some foundational knowledge to the health equity topics covered in this report. We encourage readers to consult the resources/references throughout the report for more extensive understanding of specific public health topics.

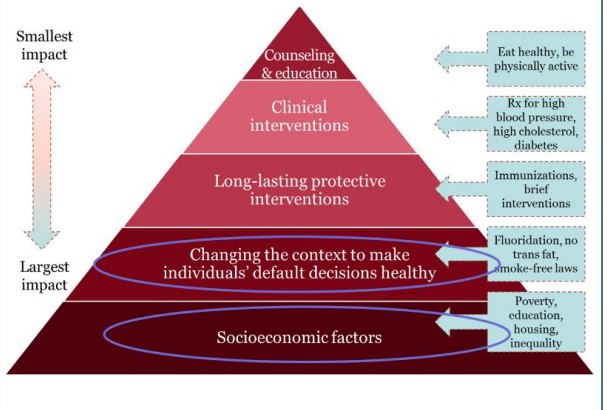
The mission of the Massachusetts Department of Public Health is to prevent illness, injury, and premature death, to assure access to high quality public health and health care services, and to promote wellness and **health equity** for all people in the Commonwealth. **Disparities in health** outcomes are linked with socioeconomic status, race/ethnicity, gender, sexual orientation, immigration, history, and other social characteristics[1]. Understanding how the social, geographic and economic factors shape health is necessary to identify areas for intervention and meet the needs of Massachusetts residents. *Adapted from the 2017 Massachusetts State Health Assessment*

Public Health Framework for Reducing Inequities



Framework from *Bay Area Regional Health Inequities Initiative*

CDC Health Impact Pyramid



From *Health Impact in 5 years*

Key Terms

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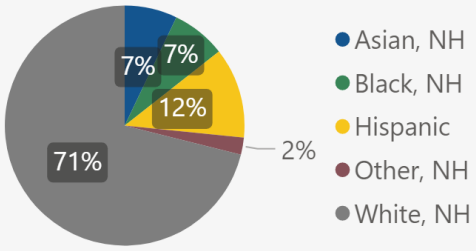
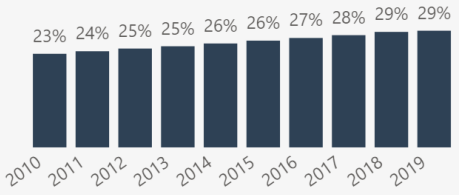


MA Residents of Color (2010-2019)



Though the majority of the MA population is White, NH the percent of the population who are people of color is increasing.

Other includes American Indian, Alaskan Natives, Native Hawaiian, and Other Pacific Islander.

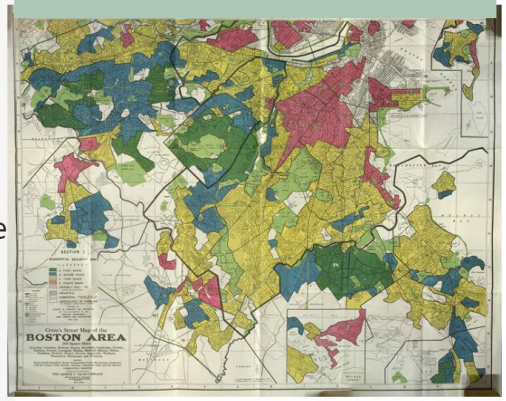
Population estimates from University of Massachusetts Donahue Institute

How Segregation Creates Communities of Color in MA

Towns where more than 50% of the population are people of color tend to be in the Greater Boston area and in cities like Springfield and Brockton. Throughout history, governments and industries have disinvested in some neighborhoods, especially those with communities of color, through racist practices like **redlining** and land use planning and zoning policies[7, 8]. Manufacturing and disposal facilities have also disproportionately been placed in communities of color[9]. Additionally, public housing has historically been in low-income areas with a majority Black population[10]. These public housing sites tended to be in areas of **increased exposure to toxins.** In the 1950's, homeownership loans in the suburbs were offered to low-income White residents while low-income Black residents were targeted for public housing in urban areas[11].

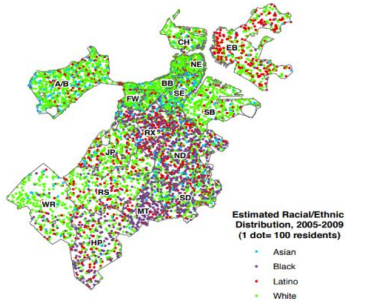
Explore ***redlining*** maps and learn how the ***built environment*** and ***housing*** impact where and how people live. Also see "*Targeting minority, low-income neighborhoods for hazardous waste sites.*

Redlining Maps of Boston



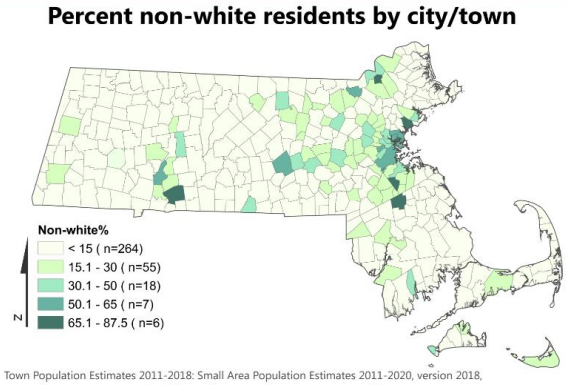
Redlining map from Mapping Inequality

Boston Race Density (2011)



Race Dot Density Map from the 2011 Health of Boston Report

MA Towns by Percent of Residents of Color (2018)



Town Population Estimates 2011-2018: Small Area Population Estimates 2011-2020, version 2018, Massachusetts Department of Public Health, Bureau of Environmental Health;
n indicates count of cities/towns

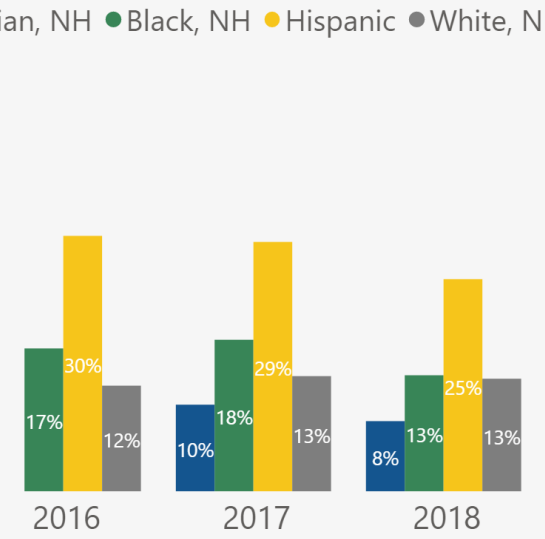
Equity Spotlight: Communities of color are more likely to have lower levels of resources, like affordable healthy foods, and connectedness with other neighborhoods[8,12]. This is often due to a history and experience of structural racism and racial segregation that hindered communities of color from integrating and socializing with other neighborhoods and groups of people[12].

Overall Health Indicators

Individuals and communities that have experienced poverty, racism, discrimination, and racial segregation may also face **trauma** as a result. **Historical trauma** is "multi-generational trauma experienced by a specific cultural group." Historical trauma can impact people living in families that have previously experienced severe trauma, war, genocide, poverty, and/or discrimination[13]. This lived historical experience can continue to burden future generations and be compounded with the trauma from the ongoing experience of racism today. Trauma can result in post-traumatic stress disorder and increased stress. Chronic stress increases the risk of developing chronic diseases including **cardiovascular disease, diabetes, and hypertension**[14, 15, 16]. *Learn more about your community's social environment.*

Equity Spotlight: Sometimes common race and ethnicity groupings can mask important differences in the experiences of subgroups. For example, Asian Americans and Native Hawaiians and Other Pacific Islanders are often shown as one category. Some subgroups within this category have very high average incomes which can mask others in the group that have extremely low incomes[17, 18, 19, 20]. These variations are often a reflection of the different pathways and circumstances of how groups entered the USA. *Learn more about how income and employment impact your experience and health.*

Adults Reporting Fair or Poor Health (2016-2018)



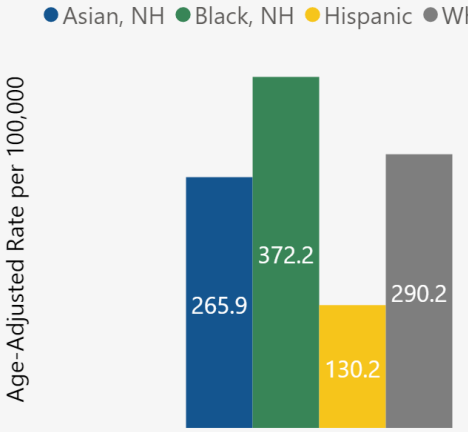
Black and Hispanic adults report worse overall health than White adults.

In 2016, data were insufficient for the Asian, NH group.

Data available from BRFSS

Mortality

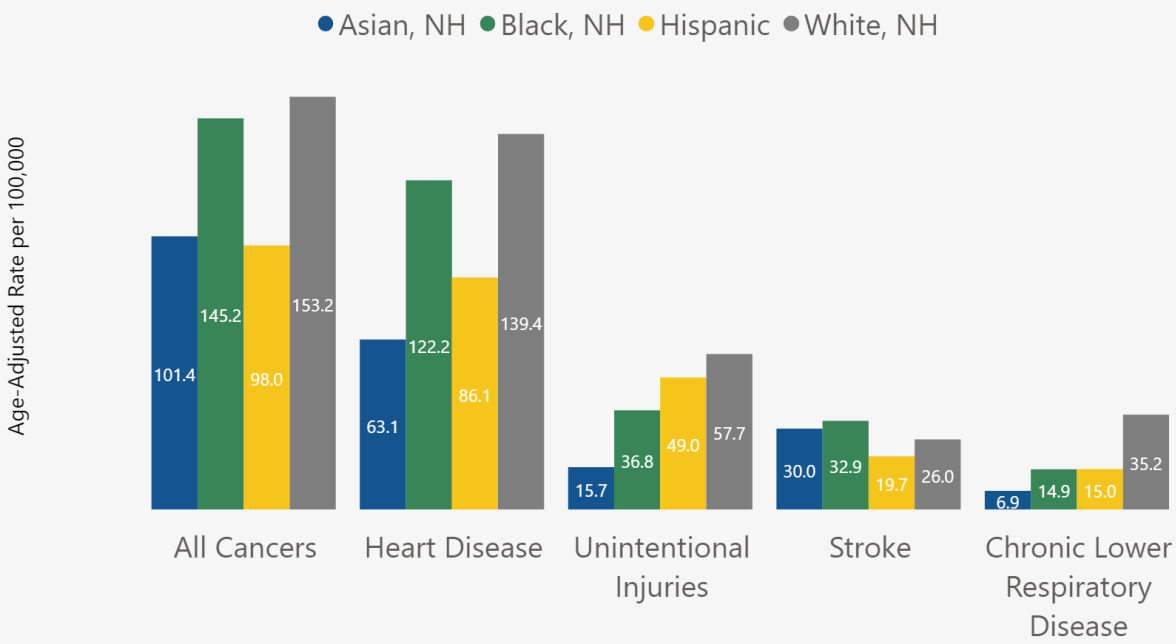
Premature Mortality Rate (2017)



Premature mortality measures unfulfilled life expectancy and is based on anticipated life expectancy at birth. Black residents have a Premature Mortality Rate (PMR) 1.3 times greater than White residents.

Premature Mortality Rate is defined as deaths that occur before the age of 75 years per 100,000 age-adjusted to the 2000 US standard population under 75 years of age.

Leading Causes of Death (2017)



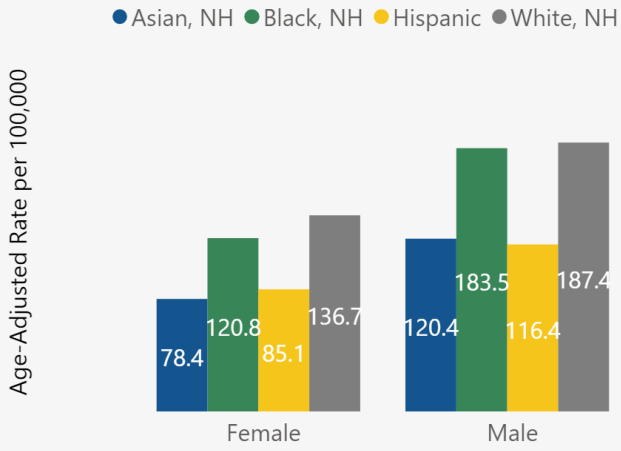
Cancer and heart disease are the leading causes of death for all MA residents. Black and Asian residents are more likely to die due to stroke than White residents.

Unintentional injuries includes motor vehicle-related deaths, poisonings, falls, fires, and drownings that were not intended to occur. Deaths are for all age groups.

For more information on PMR and Leading Causes of Death please see the Death Data via the Registry of Vital Records and Statistics..

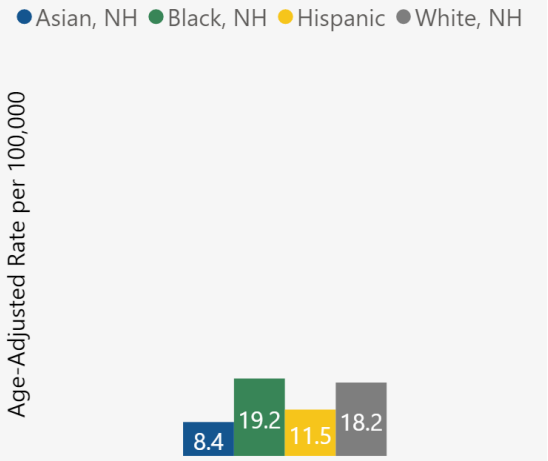
Cancer Mortality (2013 through 2017)

All Cancers (2017)



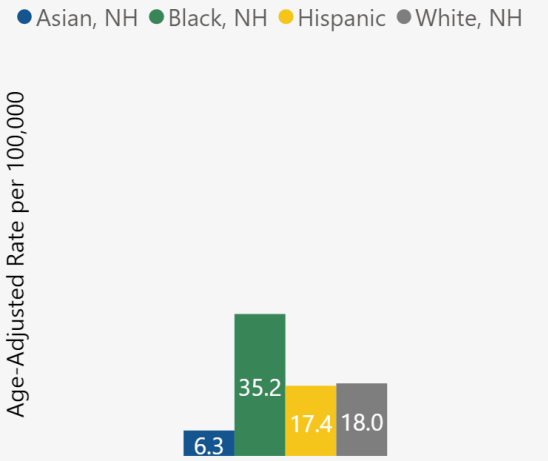
White females had significantly higher mortality rates for all cancers compared to Black females. Both were significantly elevated compared to Asian and Hispanic females. All cancer mortality rates for White and Black males were comparable but significantly elevated compared to Asian and Hispanic males.

Breast Cancer (2017)



Breast cancer mortality rates were significantly elevated for Black and White females compared to Asian (over 2 times higher) and Hispanic females (about 1.5 times higher).

Prostate Cancer (2017)



Prostate mortality was significantly elevated among Black, males compared to White, Asian, and Hispanic males. The prostate cancer mortality rate was 2 times higher for Black males than White males.

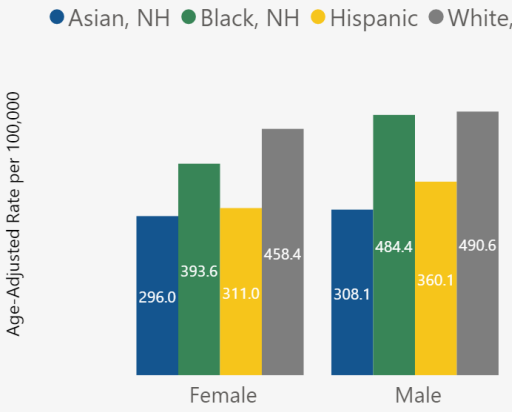
Mortality rates are an analysis of 2013-2017 data in aggregate. Statistically significant where alpha = 0.05. Breast cancer mortality rates are among females only. Age-adjusted rates were calculated using the 2000 U.S. Standard Population.

Based on data released Nov 2020. For more information, see the Massachusetts Cancer Registry online database

Chronic Diseases

Chronic diseases contribute to 56% of mortality in MA. Chronic diseases include cancer, diabetes, chronic lower respiratory disease, stroke and cardiovascular disease. The most predictive risk factors for developing chronic diseases are: poor nutrition, physical inactivity, and tobacco use and exposure. While historically these risk factors were considered dependent on personal choices, we now understand that the **conditions in which people live, learn, work, and play do not offer equal access or opportunity to make this possible**[21, 22, 23, 24, 25, 26]. As a result, some **populations**, including Black and Hispanic/Latinx residents, low-income residents, Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) residents, **experience inequitable health outcomes**. *Learn more about chronic disease data.*

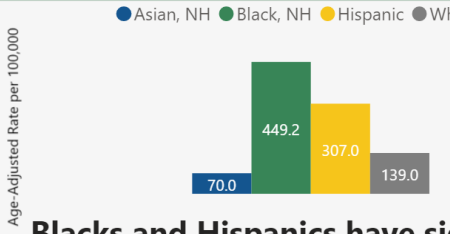
Incidence of All Cancers (2017)



White females have the highest incidence rate for all cancer types combined, significantly higher than other female race/ethnicity groups. Black males and White males have the highest age-adjusted incidence rates of all cancer types combined, significantly higher than Asian or Hispanic males.

Analysis of 2013-2017 data in aggregate. Statistically significant where alpha = 0.05. Age-adjusted rates were calculated using the 2000 U.S. Standard Population. For more information see Cancer Incidence and Mortality in MA

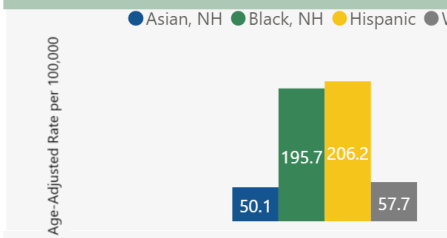
Diabetes ED Visits (2017)



Blacks and Hispanics have significantly higher ED visit rates for diabetes

ED refers to Emergency Department. Analysis of 2016-2017 data in aggregate. Statistically significant where alpha = 0.05. Age-adjusted rates were calculated using the 2010 U.S. Standard Population. Data from the Massachusetts Emergency Visits Discharge Database courtesy of CHIA

Asthma Hospitalizations (2017)

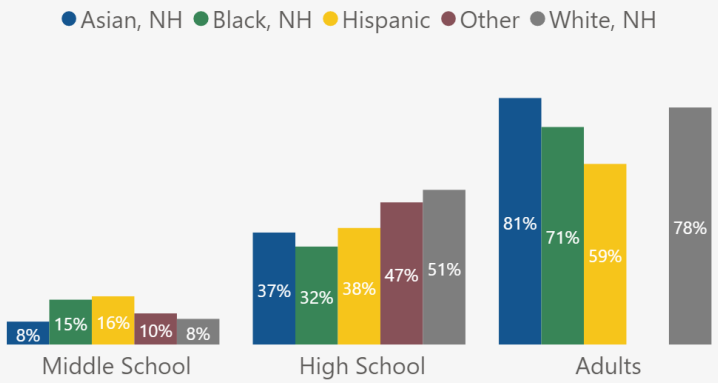


Blacks and Hispanics have significantly higher hospitalization rates for asthma.

Analysis of 2016-2017 data in aggregate.Statistically significant where alpha = 0.05. Age-adjusted rates were calculated using the 2010 U.S. Standard Population. Data from the Massachusetts Hospitalization Discharge Database courtesy of CHIA

Wellness: Exercise & Nutrition

Physical Activity (2018)

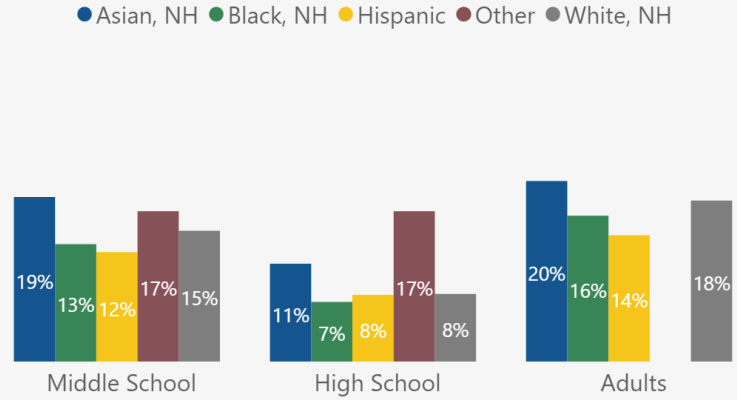


Black and Hispanic adult and youth are significantly less likely to engage in adequate physical activity. Asian youths are also significantly less likely to have adequate physical activity.

Adequate physical activity refers to being physically active for 60 minutes, 5+ days/week. *Analysis of 2017-2019 BRFSS data in aggregate and 2015, 2017, and 2019 YHS data in aggregate. Statistically significant where alpha = 0.05. For YHS, Other includes American Indian, Alaskan Natives or Pacific Islander and youth who indicated several ethnicities that did not include Hispanic/Latino.Data available from BRFSS and YHS..*

Equity Spotlight: Areas of low socioeconomic status and communities of color often have less access to safe and quality parks, green space, and other options for physical activity[21, 22, 23].

Adequate Fruit & Vegetable Consumption (2017)



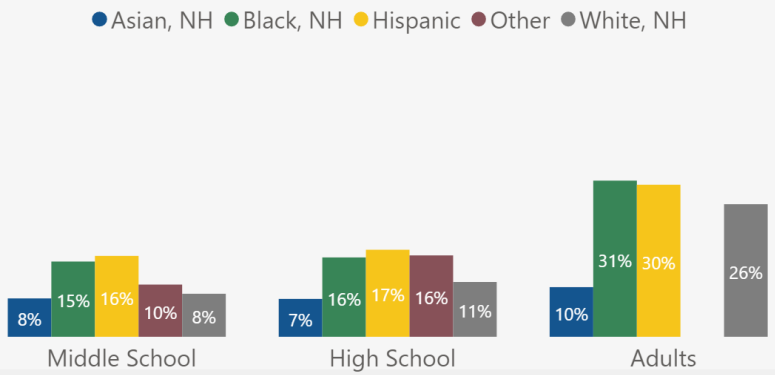
Hispanic adults and youth are significantly less likely to report having adequate fruit and vegetable consumption compared to their White counterparts.

Adequate refers to eating fruit or drinking 100% fruit juice 2+ times per day for youth and eating fruit and vegetables 5+ times per day for adults. Analysis of 2017-2019 BRFSS data in aggregate and 2015, 2017, and 2019 YHS data in aggregate. Statistically significant where alpha = 0.05. For YHS, Other includes American Indian, Alaskan Natives or Pacific Islander and youth who indicated several ethnicities that did not include

Equity Spotlight: Communities of color and low-income communities are less likely to have access to affordable healthy foods[24, 25]. *Learn more about the built environment in your community.*

Wellness: Risk Factors

Obesity (2019)

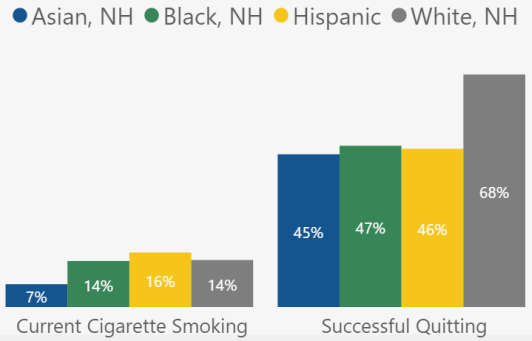


Black and Hispanic adults and youth are significantly more likely to be obese than their White counterparts. Youth who identify as Other race are also significantly more likely to be obese.

Respondents' obesity status was categorized based on their Body Mass Index (BMI), which equals weight in kilograms divided by height in meters squared. Obese refers to BMI ≥30.0 among adults and BMI≥95th percentile among youth. For adults and youth, respondents were asked to report their height and weight. Analysis of 2017-2019 BRFSS data in aggregate and 2015, 2017, and 2019 YHS data in aggregate. Statistically significant where alpha = 0.05. For YHS, Other includes American Indian, Alaskan Natives or Pacific Islander and youth who indicated several ethnicities that did not include Hispanic/Latino. Data available from BRFSS and YHS.

Equity Spotlight: Marketing of junk food, sugary drinks, tobacco, and alcohol more often targets communities of color. Retail density and access to these items is also higher in these communities[27, 28, 29, 30, 31]. *Learn more about the built environment in your community*

Current Smoking & Successful Quitting (2018)



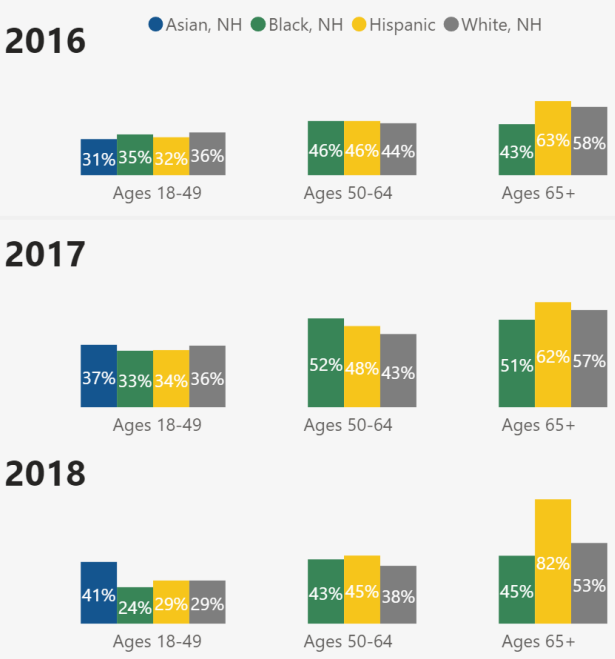
While people of color smoke at similar or lower rates than Whites, they are also significantly less likely to successfully quit. In particular, Asian adults have significantly lower smoking rates compared to Whites but have significantly lower rates of successful quitting.

Analysis of 2016-2017 data in aggregate. Statistically significant where alpha = 0.05. Data available from BRFSS

Equity Spotlight: People of color are less likely to receive quitting advice from a healthcare professional, and are less likely to be prescribed evidence-based cessation treatments, such as nicotine-replacement therapy (NRT), compared to Whites[32, 33].

Wellness: Preventive Care

Flu Vaccinations by Age Group (2016-2018)



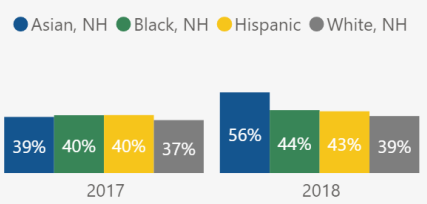
For adults 65 and older, Black adults are the least likely to report receiving a flu vaccine.

From 2016 to 2018 Hispanic adults over 65 report the highest rates of flu vaccinations compared to other groups.

From 2017 to 2018, flu vaccinations declined for almost all groups.

Data were insufficient for the Asian, NH group aged 50 and older for 2016-2018. Data available from BRFSS

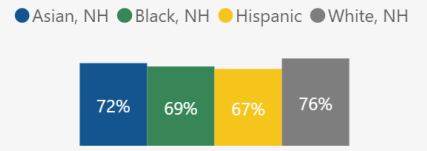
Hepatitis B Vaccine (2017-2018)



White adults are least likely to have received all 3 doses of the Hepatitis B vaccine.

Data available from BRFSS

Recent Dental Visit (2018)



Black and Hispanic adults are least likely to have a dental visit in the past year.

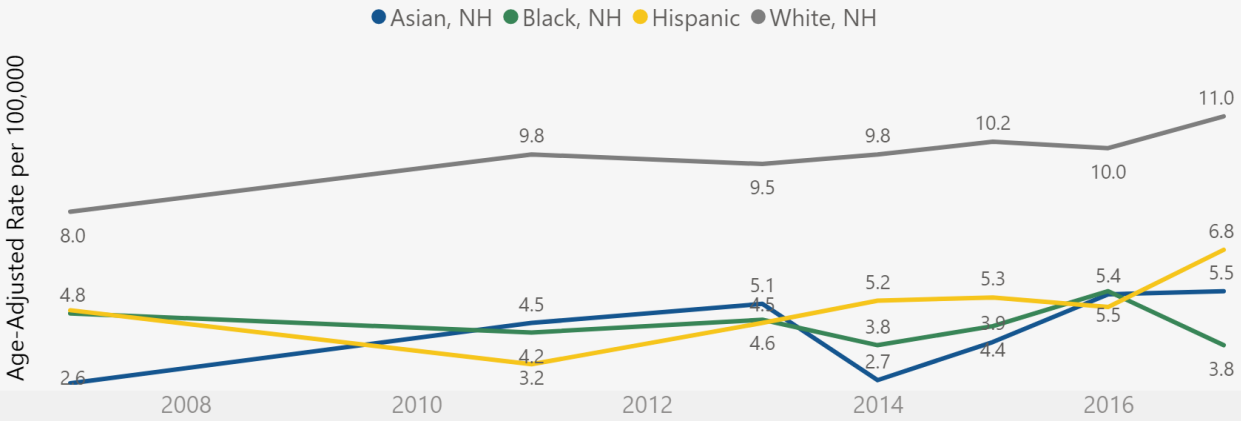
Data available from BRFSS

Equity Spotlight: Income levels and health insurance benefits directly impact health by determining people's access to medical care[34, 35]. Communities of color are more likely to face discrimination in hiring practices and make up a substantial portion of the working poor[36]. This leads to more people of color in lower-paying and part-time jobs with fewer benefits, adding barriers to accessing crucial preventive care. *Learn more about how employment impacts access to resources and health.*

Mental Health: Suicide

Deaths of despair have been on the rise, especially among middle-aged White, NH men with a high-school education or less. These ***deaths of despair*** are drug related, alcohol induced, and/or suicides. Researchers hypothesize that the trend has been **driven by changing economic and social conditions**; this demographic group tends to maintain the expectation of inter-generational economic stability, but has experienced increased poverty, loss of job opportunities, and the deterioration of social and economic support systems[37].

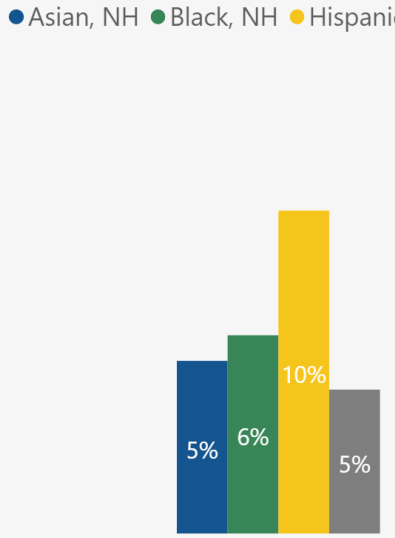
Annual Suicide Rate (2008-2017)



Suicide death rates are higher for White residents than other race/ethnicity groups.

For further information on Annual Suicide Rates in MA see the Death Data from the Registry of Vital Records and Statistics..

Youth Suicide Attempts (2017)

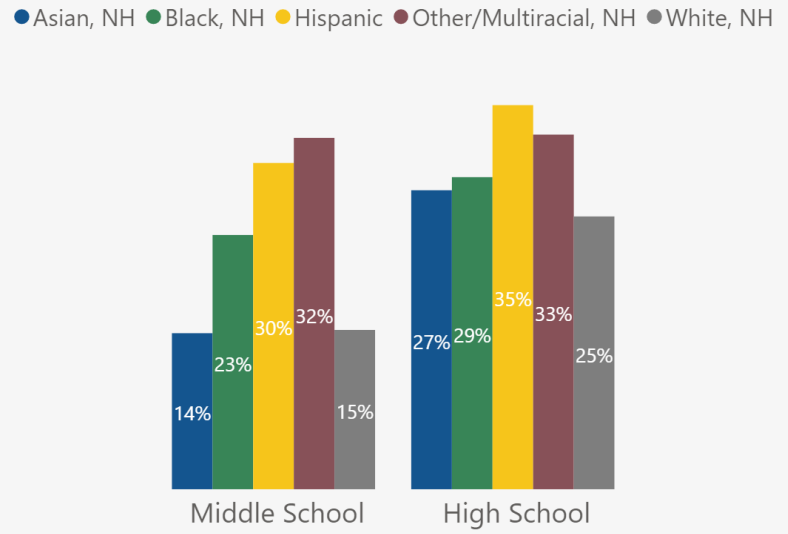


Among high school students, Hispanic youth are significantly more likely to report attempting suicide than Whites.

Suicide attempt data only available for high school students. Analysis of 2017 and 2019 YHS data in aggregate. Statistically significant where alpha = 0.05. Other includes American Indian, Alaskan Natives or Pacific Islander and youth who indicated several ethnicities that did not include Hispanic/Latino.Youth indicators from YHS. For more information see the Suicides and Suicidal Ideation in MA

Mental Health: Depression

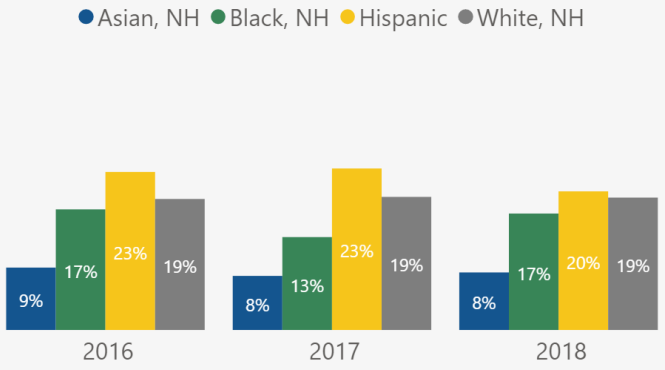
Youth Depression Symptoms (2017)



Students of color are more likely to report poor mental health than White students. Hispanic and Other/Multiracial students reported the highest rates of feeling sad or hopeless for 2 or more weeks.

Other includes American Indian, Alaskan Natives or Pacific Islander and youth who indicated several ethnicities that did not include Hispanic/Latino. Youth indicators from YHS.

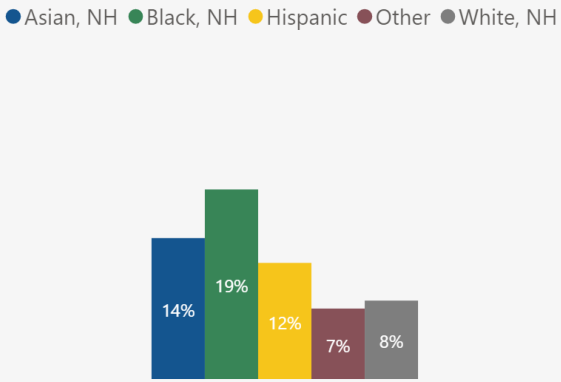
Depression Diagnoses (2016-2018)



Hispanic adults consistently report higher depression diagnoses.

Data available from BRFSS

Postpartum Depressive Symptoms (2018)

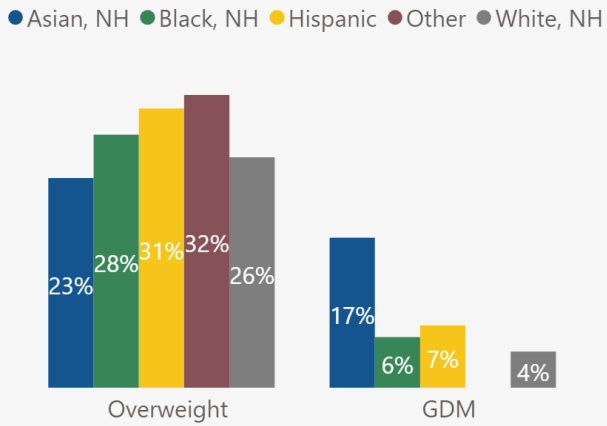


Postpartum people of color are more likely to experience postpartum depressive symptoms than White parents. Black parents are the most likely group to experience these symptoms.

Other includes those who identified as Other or American Indian races. Postpartum depression data from PRAMS. .

Maternal and Child Health

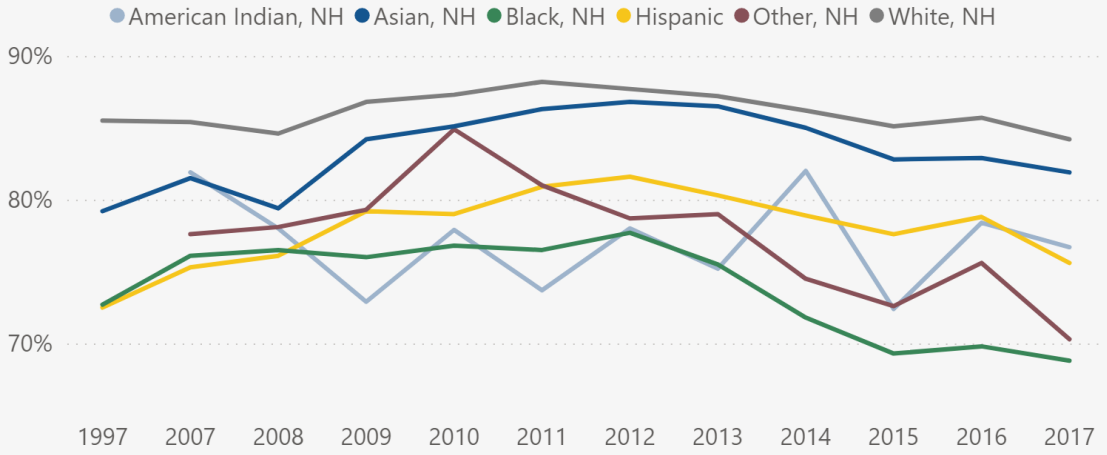
Pregnancy Risk Factors (2018)



More Black and Hispanic pregnant people reported overweight BMI, and Asian pregnant people were almost twice as likely than other groups to report Gestational Diabetes (GDM).

Overweight refers to BMI ≥25.0 to <30.0. . Other includes those who identified as Other and American Indian races. Unknown is not included in Other. GDM Data were insufficient for the Other group in 2018. Pregnancy indicators from PRAMS.

Adequate Prenatal Care (1997-2017)



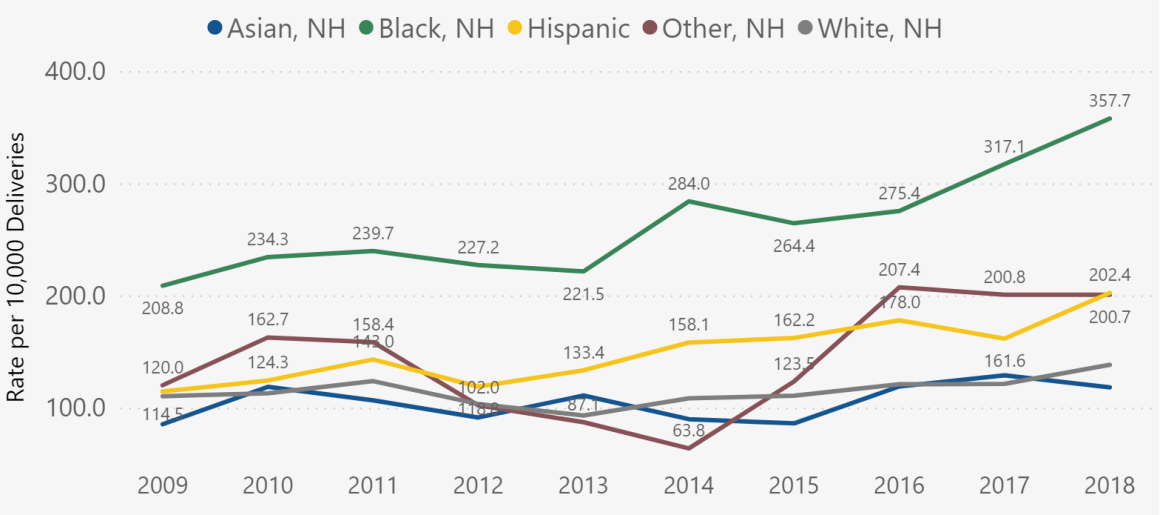
Overall from 2014 to 2017, the percentage of births to parents who received adequate prenatal care (APC) decreased from 83% to 81%. Pregnant people of color are less likely to have APC than White people. Since 2012, Black pregnant people have been the least likely to have APC.

Adequate prenatal care is based on Adequacy of Prenatal Care Utilization (APNCU) Index. Data from the Birth Data Reports via the Registry of Vital Records and Statistics.

Equity Spotlight: Women are more likely to work in part-time jobs which often have lower wages and less access to benefits such as health care[38]. *Learn more about how employment impacts your health.*

Maternal and Child Health

Severe Maternal Morbidity (2009-2018)



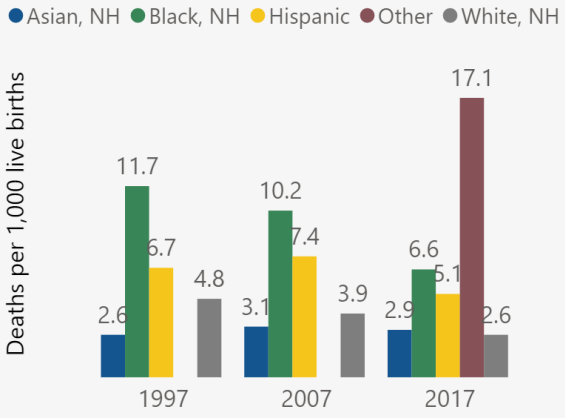
Since 2009, Black pregnant and postpartum people have consistently had the highest rates of SMM. In 2018, Black pregnant and postpartum people were almost three times as likely to have SMM than White pregnant and postpartum people. Hispanic and pregnant and postpartum people in the Other race group were 1.5 times as likely to have SMM.

SMM 21 shown (including blood transfusions). SMM identified using International Classification of Diseases (ICD) diagnosis and procedure codes. Other includes those who identified as Other, American Indian races, unknown, refused, and missing. For more information on SMM please see the Maternal Mortality and Morbidity Initiative via the Pregnancy, Infancy and Early Childhood Division.

Severe maternal morbidity (SMM) occurs when unexpected outcomes of labor and delivery have significant short- or long-term consequences to a woman's health[39]. Maternal mortality rates and SMM have significantly increased over the last two decades in the United States[40, 41] and trends in MA indicate similar increases[42]. However, **SMM is 50 to 100 times more common than maternal death and racial/ethnic disparities in SMM exist**. Nationally, Black pregnant and postpartum people have the highest proportion of SMM, and a 70% greater risk of SMM[43]. The consequences of increasing SMM prevalence, in addition to health effects to postpartum people, include higher medical costs and longer hospital stays[42]. Recognizing and tracking SMM by race/ethnicity along with developing and carrying out interventions to improve the quality of maternal care, are essential to addressing racial/ethnic inequities in SMM.

Maternal and Child Health

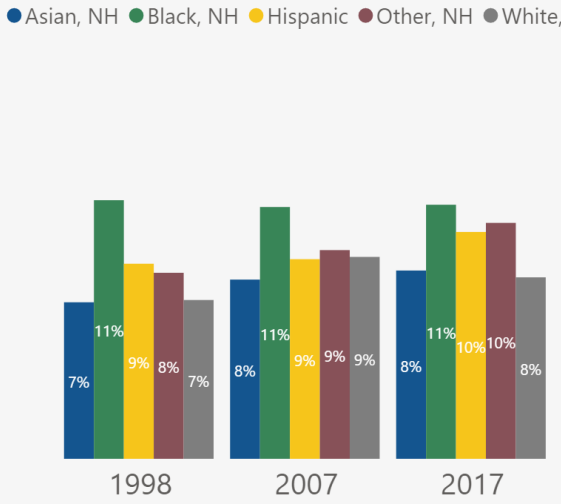
Infant Mortality Rate (1997, 2007, 2017)



Despite MA having the lowest overall infant mortality rate (IMR) in the US, Black IMR in 2017 is still greater than White IMR was in 1997. Black IMR (6.6) is 2.5 times higher than White IMR (2.6).

Other category (includes those who identified as Other or American Indian races) not shown due to suppressed rates. Data from the Death Data Reports via the Registry of Vital Records and Statistics..

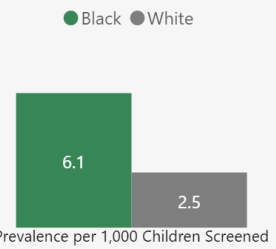
Preterm Births (1998, 2007, 2017)



Since 1997 preterm births have occurred more frequently among Black parents, Hispanic parents, and parents in the Other race group.

Preterm birth refers to births occurring at less than 37 weeks of gestation. Other includes those who identified as Other or American Indian races. Data from the Birth Data Reports via the Registry of Vital Records and Statistics

Children with Lead Poisoning (2015)



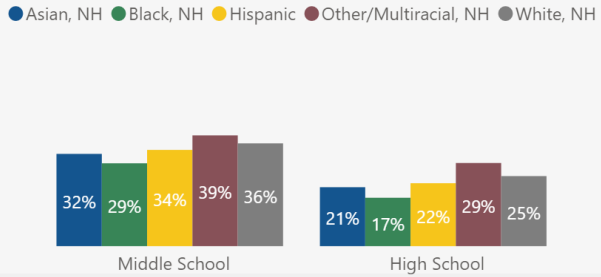
Black children are almost 2.5 times more likely to have lead poisoning than White children.

Blood lead levels ≥10 µg/dL are considered poisoned. Race/ethnicity shown is based on maternal race/ethnicity. Data from the Childhood Lead Exposure Data Brief

Equity Spotlight: **Public housing** and **older housing stock** have historically been located in low-income areas with a majority Black population[11]. Public housing sites tend to be in historically less desirable locations with increased **exposure to toxins** such as lead[44]. *Learn more about how housing impacts health here.*

Injury and Exposure to Violence

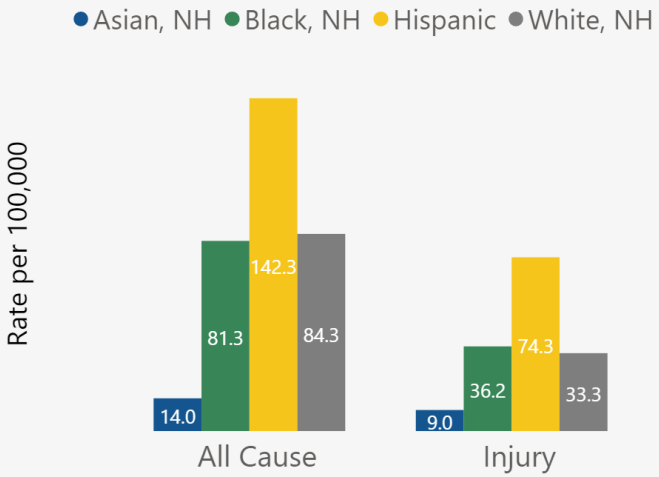
Youth Bullied at School (2017)



Youth who identify as Other/Multi-Racial and White youth were significantly more likely than other groups to report having been bullied at school in the past year. However, for middle school students some differences were not significant. Differences between Other/Multi-Racial and White middle school students were not significant. White middle school students reported significantly more experiences being bullied than Black middle school students alone.
Black high school students were significantly less likely to report being bullied than their counterparts.

Analysis of 2009, 2011, 2013, 2015, and 2017 YHS data in aggregate. Statistically significant where alpha = 0.05. Other includes American Indian, Alaskan Natives or Pacific Islander and youth who indicated several ethnicities that did not include Hispanic/Latino. Youth indicators from YHS.

Work Related Hospitalizations among those Aged 16-24 Years (2014)



Hispanic youth and young adults are more likely to be hospitalized for work-related hospitalizations overall (all cause) and for injury associated causes.

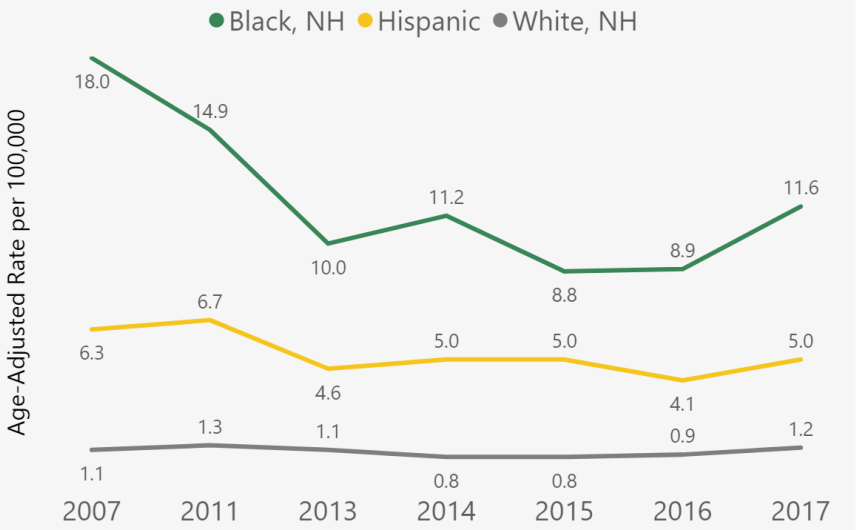
Analysis of 2008 to 2014 data in aggregate. Hospitalization population sizes are estimated from the American Community Survey Annual file 2008-2014. Hospitalization data courtesy of CHIA

Equity Spotlight: Immigrants and communities of color are more likely to be employed in jobs with a high risk for injuries[45, 46, 47, 48]. Additionally, low-wage workers are often also disproportionately exposed to health-impairing work conditions and have more limited access to preventive care. *Explore why occupational segregation, the uneven distribution of racial, ethnic, and gender groups across occupations[49], happens by visiting the employment report for your community.*

Injury and Exposure to Violence

Violence disproportionately affects communities that have a history of experiencing **structural racism** and facing social **policies that perpetuate inequality** such as discriminatory housing and lending policies, environmental policy and disenfranchisement.

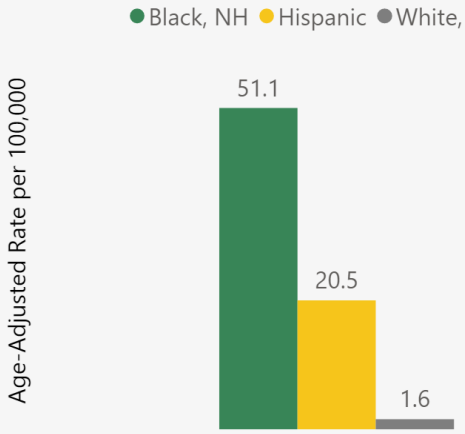
Annual Homicide Rate (2007-2017)



Black residents have consistently experienced the highest homicide rates. In 2017, Black and Hispanic residents had homicide rates 10 times (11.6) and 4 times (5.0) higher than White residents.

In 2013, Asian, NH had a rate of 1.1 homicide deaths per 100,000. For all other years, there were insufficient data for this group. For more information on Annual Homicide Rates in MA see the Death Data via the Registry of Vital Records and Statistics.

Firearm Death Rate: Males Aged 15-24 (2015)

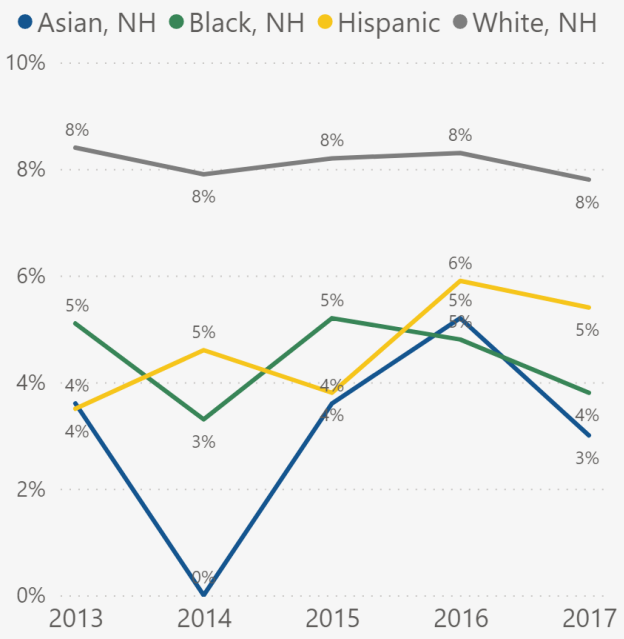


Firearm death rates are 32 times higher for young Black men and 13 times higher for young Hispanic men than their White counterparts.

Analysis of 2011 to 2015 data in aggregate. Population sizes from Missouri Census Data Center (2018), Population Estimates by Age [Massachusetts 2016]; and the National Center for Health Statistics in collaboration with the U.S. Census Bureau and the U.S. Census Bureau American Community Survey 2011-2015 5-year estimates. Data were insufficient for the Asian, NH group. Data provided by MAVDRS.

Addiction

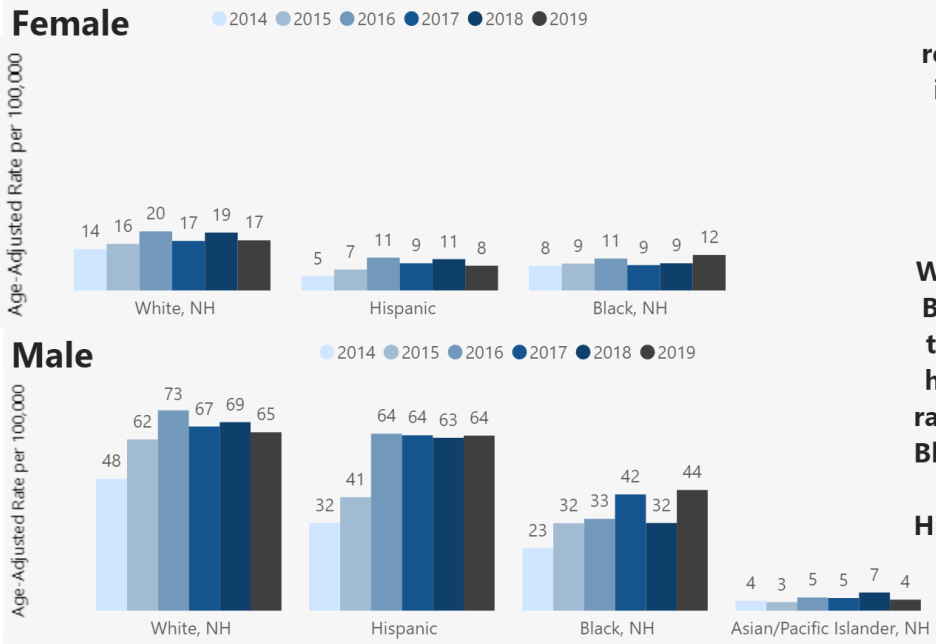
Heavy Drinking (2013-2017)



White adults report the highest rates of heavy drinking.

Data available from BRFSS

Opioid-Related Overdose Death Rates (2014-2019)



Overall fatal opioid-related overdoses have increased since 2014. Hispanic and Black female residents experienced a larger increase than their White counterparts. For Black female residents, the death rate was the highest in 2019. Death rates continue to rise for Black male residents and remain high among Hispanic male residents.

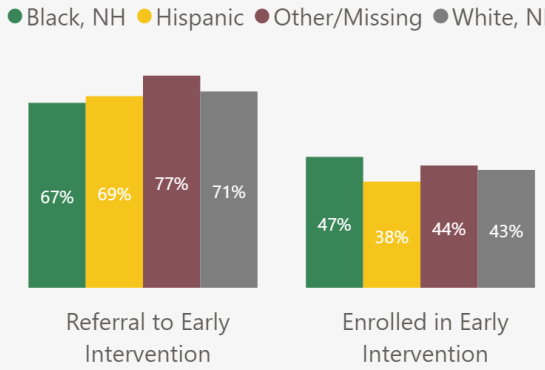
Data were insufficient for Asian, NH females.

For more information see Opioid-related Overdose Deaths among MA Residents

Equity Spotlight: Interventions to address the opioid epidemic have been successful in disrupting the rise in overdose deaths overall. However, breaking down the data by race/ethnicity clearly shows the need to tailor interventions to ensure that Black and Hispanic residents also benefit.

Addiction: Intervention & Treatment Services

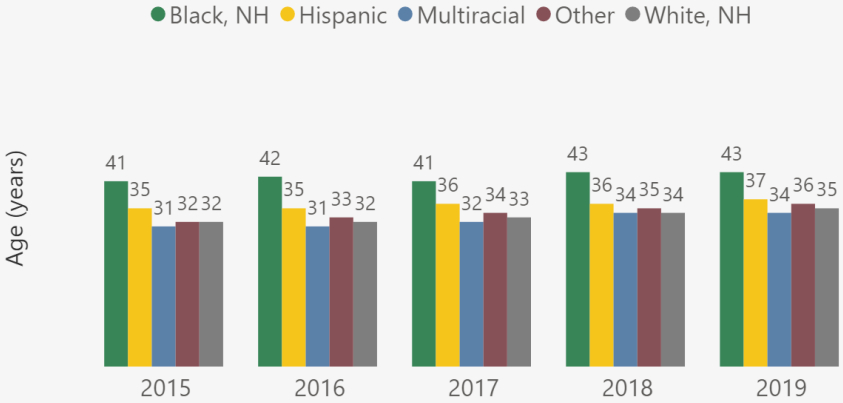
Referral & Enrollment in Early Intervention Programs among Infants Diagnosed with Neonatal Abstinence Syndrome (2017)



All infants diagnosed with Neonatal Abstinence Syndrome (NAS) in MA are eligible to receive 1 year of Early Intervention services. **Overall, referral rates to Early Intervention programs for infants with NAS are higher than enrollment rates within 1 year of birth. Infants who are Hispanic and those with Other/Missing race had the largest difference between referral and enrollment.**

Data were insufficient for the Asian/Pacific Islander and American/Alaska Native groups. Data available from the PELL. For more information see the Neonatal Abstinence Syndrome Dashboard

Median Age at First Enrollment* for Addiction Treatment (2015-2019)



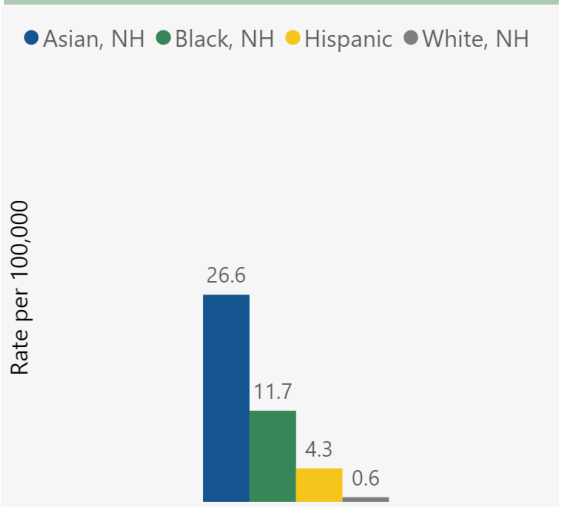
Early access to addiction treatment can reduce the risk of developing associated health problems and improve the likelihood of successful treatment.

Black patients first access treatment in programs* approximately 5 years later in their lifetimes when compared to other groups.

**Enrollments into addiction treatment programs licensed and/or contracted with the Bureau of Addiction Services. Other includes those who identified as Other, Asian, Native Hawaiian/Pacific Islander, or Native American/Alaskan Native. Multiracial are those who indicated more than one race. Data is from the Bureau of Substance Addiction Services (BSAS), including provider-submitted data as of October 9, 2020. For more information see BSAS Substance Addiction Treatment Data*

Infectious Diseases

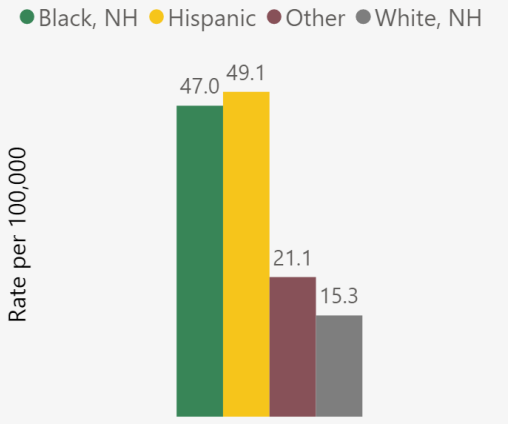
Tuberculosis Cases (2018)



Compared with White residents, the relative risk for being diagnosed with TB in 2018 is 44 times higher among Asian, 20 times higher among Black, and 7 times higher among Hispanic residents.

TB data are extracted from MAVEN and incidence rates were calculated using the 2010 U.S. Census For more information see TB Reports.

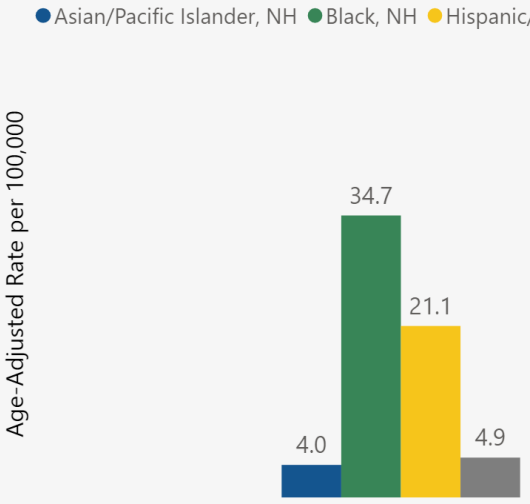
Infectious Syphilis Cases (2018)



Infectious syphilis case rates for Black residents and for Hispanic residents are more than 3 times that of White residents

Infectious syphilis is defined as primary, secondary and early latent stages of syphilis. . Due to small counts cases with races other than white or black they were collapsed into Other category. *Data reflect confirmed and probable cases and are current as of 4/5/2019 and are subject to change. Syphilis data are extracted from MAVEN. Cases with unknown race/ethnicity were excluded. For more information see STD Surveillance Report.*

HIV Diagnoses (2017)



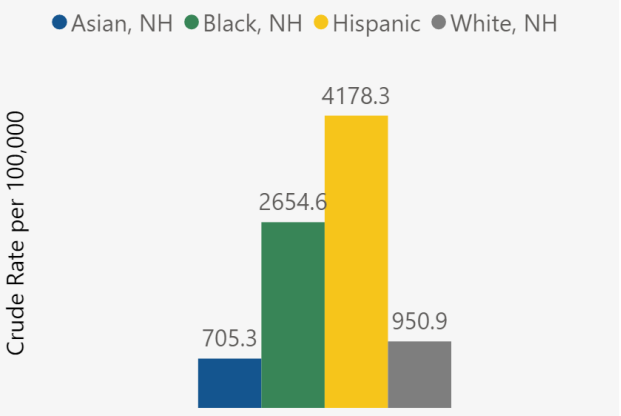
HIV diagnosis rates for Black residents and for Hispanic residents are 7 times and 4 times that of White residents.

Analysis of 2015-2017 data in aggregate. Denominators for rate calculations are Vintage 2017 Bridged-Race Postcensal Estimates (release date: June 2018), produced by the U.S. Census Bureau, Population Estimates Program in collaboration with National Center for Health Statistics. All rates are age-adjusted using the 2000 US standard population.

For more information see HIV/AIDS Epidemiologic Profile,

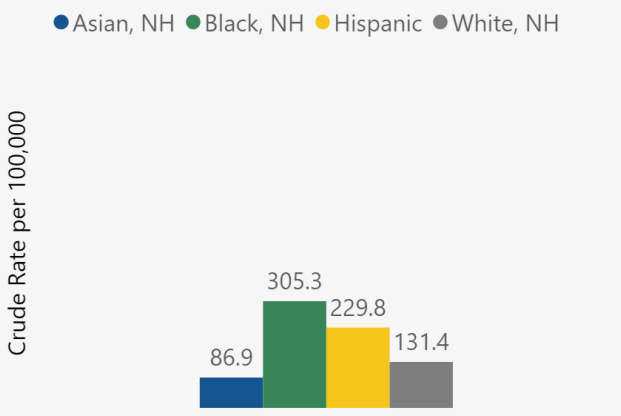
COVID-19 PANDEMIC

Crude Rate of COVID-19 Cases (as of 10/23/20)



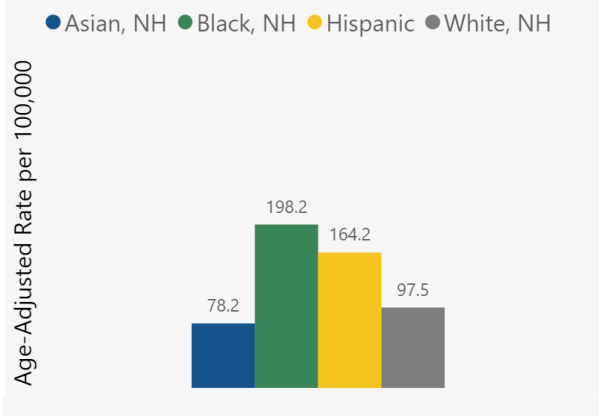
Black and Hispanic residents have the highest case rates, almost 3 times and 4 times higher than White residents.

Crude Rate of COVID-19 Hospitalizations (as of 10/23/20)



Black and Hispanic residents have hospitalization rates, 2.3 times and 1.7 times higher than White residents.

Rate of COVID-19 Deaths (as of 10/23/20)

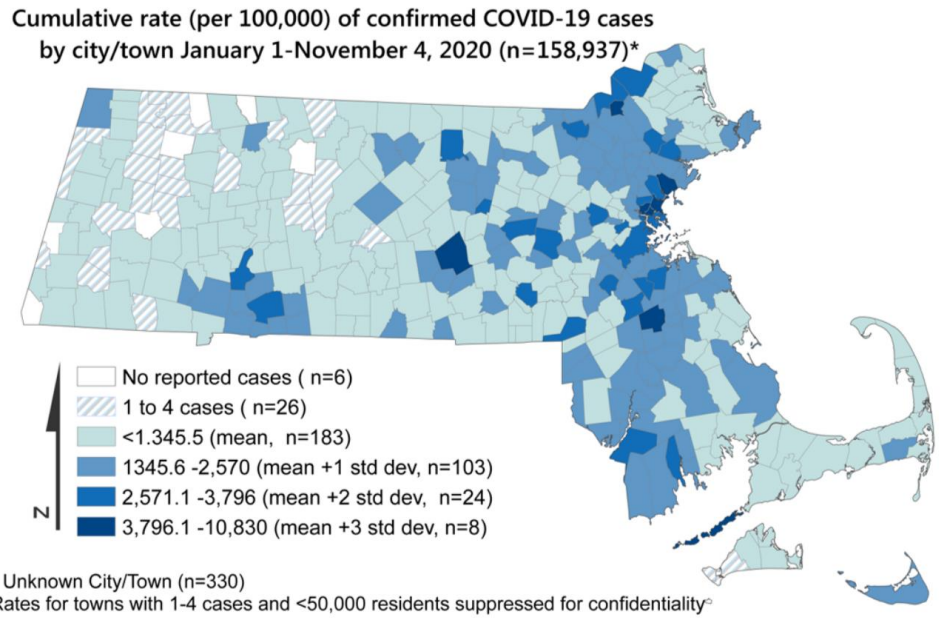


Black and Hispanic residents have the highest death rates.

COVID-19 data as of 10/23/20. COVID-19 data and analytics will be updated as the pandemic continues. Age-adjusted death rates are used for comparisons among race groups given differences in the underlying age distribution of the MA population by race, and differences in COVID-19 death trends by age. Calculated rates per 100,000 population using denominators estimated by the University of Massachusetts Donahue Institute using a modified Hamilton-Perry model (Strate S, et al. Small Area Population Estimates for 2011 through 2020, report published Oct 2016.) Daily updates are found on the COVID-19 Dashboard and more information disparities among case, hospitalization, and death rates can be found at the COVID-19 Health Equity Advisory Group page.

Equity Spotlight: Hispanic and Black residents are bearing a higher burden of COVID-19 cases, hospitalizations, and deaths relative to their population in MA. Workers of color are likely at higher risk of exposure at work due to occupational segregation[50].

COVID-19 IN COMMUNITIES OF COLOR



City/Town	Cumulative Case Rate as of 11/04/20	Percent of Residents who are People of Color
Chelsea	10,829.8	80%
Lawrence	7,263.9	87%
Everett	5,733.8	61%
Lynn	5,703.5	66%
Revere	5,561.7	52%
Brockton	5,533.9	68%
Worcester	3,806.3	51%
Lowell	3,702.8	55%
Middleton	3,634.0	12%
Framingham	3,586.9	36%

Data Sources: COVID-19 data provided by the Bureau of Infectious Diseases and Laboratory Sciences; Maps provided by the Office of Population Health; Town population Estimates 2011-2018 Small Area Population Estimates, version 2018; Massachusetts Department of Public Health, Bureau of Environmental Health

COVID-19 data as of 11/04/20. Calculated rates per 100,000 population using denominators estimated by the University of Massachusetts Donahue Institute using a modified Hamilton-Perry model (Strate S, et al. Small Area Population Estimates for 2011 through 2020, report published Oct 2016.) Town level updates are found weekly in the COVID-19 Weekly Public Report and more information disparities among case, hospitalization, and death rates can be found at the COVID-19 Health Equity Advisory Group page.

Equity Spotlight: Communities with the highest case rates are primarily in high density population areas and where the majority of residents are people of color.

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Technical Notes

Indicator selection

This report gathered equity metrics found throughout DPH published data reports in one common location. When choosing the indicators to feature in this dashboard, we focused on publicly available data and the State Health Assessment (SHA) priority indicators. In some instances proxy measures were used if race/ethnicity data were limited (e.g. Hepatitis B Vaccinations Rates in place of Viral Hepatitis Prevalence Rates). Only indicators that had sufficient data for breakdowns by race/ethnicity were included.

Time-frame for Data Shown

In all cases, the most recent data for each indicator are incorporated. For some topics (e.g. hospitalizations for various causes), only older data are available by race/ethnicity. However, the goal of this dashboard is to capture the current experiences of this priority population. As such, the years of data presented are different for each chart; we opted for the most recent data available over using the same (older) year across all indicators in the report.

Race/Ethnicity Group Definition and Data Collection

This report presents race/ethnicity data as it is collected and defined by each source. DPH complies with the the Federal Office of Management and Budget (OMB) Standards and have adapted the recommendations to capture this information. We acknowledge that the race/ethnicity breakdowns presented here may not reflect each group's preferred terms. We recognize that race groups are not monolithic. Grouping into larger categories (e.g. Asian) and grouping Hispanic separately (e.g. Black and Hispanic is not a category in this report) is problematic and may not fully capture the experiences specific groups have. Data on language and disability status are not reflected in this version of the report but we plan to include these in future versions. Detailed information on the specific race/ethnicity group definitions and data collection practices can be found using the links to data sources provided for each chart. The DPH Race/Ethnicity/Language Data Standards Guide provides information on current department wide minimum compliance for collecting, defining, and reporting this information.

Data Suppression

For some charts, race/ethnicity groups may not be shown. This varies by data source and reflects insufficient sample size to support reliable estimates or suppression to protect residents privacy. For more information on the DPH suppression guidelines, please see the Department of Public Health Confidentiality Procedures.

Current Analysis

Unless otherwise noted, the differences between race/ethnicity groups in this report are based on descriptive observations (i.e. estimates are higher or lower than others) and key findings for the data shown in charts do not represent statistically significant differences. Any language that indicates statistical significance is taken directly from reports that have performed these analyses separately from this dashboard. For more information on how analyses were performed and definitions for significance, please see the data source notes provided for each chart.

Future Plans

This initial report focuses on communities of color. Additional dashboards on the other priority populations will be created. We also plan to expand dashboard contents including adding more indicators, updating data currently included, and incorporating intersectionality of populations (e.g. data by race/ethnicity and sexual orientation/gender identity). Visual representations of statistical significance and additional analytics to compare differences between groups will also be incorporated.

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