CONNECTICUT DENTAL HEALTH PARTNERSHIP

the dental plan for HUSKY Health

ORAL HEALTH EQUITY REPORT

STATUS AND ACTION

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I. Executive Summary

In order to effectuate the Connecticut Dental Health Partnership's (CTDHP) mission of enabling all HUSKY Health members to achieve and maintain good oral health, CTDHP is committed to ensuring that access and availability of oral health services are fairly distributed across the CT Medicaid population. CTDHP is committed to develop data driven strategies to address population specific needs to reduce barriers to accessing and utilizing oral health services.

The Connecticut Dental Health Partnership has prioritized developing its Oral Health Equity Plan, a contract deliverable, during state fiscal year 2021. Significant effort went into ensuring CTDHP listened to multiple voices during the process, both internally and externally to CTDHP. CTDHP's Health Equity Officer convened three separate workgroups to support the effort, meeting collectively seventeen times throughout the year. The groups were comprised of two internal teams at CTDHP, one a cross section of employees from different work units and the second an executive leadership team focused on reducing risks and barriers to the work. A third workgroup was comprised of community partners and stakeholders to receive feedback and solicit intervention ideas. Additionally, CTDHP completed its first member survey to identify barriers to care directly from HUSKY Health members. A total of 3,957 HUSKY Health members responded to the survey to provide their insights into the dental program.

CTDHP reviewed utilization data over a two-year period to examine what disparities may existing among race, ethnicity and age lenses.

The review found the largest disparity in dental non-utilization is primarily aged based, with adults disproportionally under and non-utilizing dental services as compared to children. And, the disparity is also geography based with sixty percent off all non-utilizers concentrated to 25 towns/cities in the state.

Identified as the "High Impact 25" throughout this document, the demography of the towns and cities reflect socioeconomic disparities, characterized by below or lowest average income, high poverty rates, and high social vulnerability factors.

CTDHP reports a robust HUSKY Health dental provider network, exceeding network adequacy standards. Focusing on the High Impact 25 enables us to look at which areas to prioritize recruitment of dental providers.

Network Analysis in the High Impact 25 found 2,054 general dentists who see adults and children and 483 pediatric specific dentists in these towns. The total membership (from the review period analyzed) to dentist ratio is 1 dentist per every 223 members. However, there are wide variances in dentist to member ratios.

Incorporating voices of the member through a member-based survey illuminated several areas to focus our efforts. Members overwhelmingly reported that COVID-19 impacted their dental service delivery over the past twelve months.

The barriers consistently identified by survey respondents were:
1) Challenges in finding quality dentists that accepted HUSKY for adults;
2) Locating dental offices that had more convenient hours like evenings and weekends;
3) For Spanish speakers finding a dentist that spoke Spanish; and,
4) Limitations in the adult benefit resulting in the member either paying for non-covered services or not engaging in care due to inability to pay for non-covered services.

Over the next two years CTDHP is committed to prioritizing actions to improve utilization overall and with particular focus in the High Impact 25 Towns/Cities. The following strategies have been identified and are proposed in the action plans in the document:

1) ***Develop new member engagement messaging and campaigns to promote oral health, finding a consistent dentist to engage in care over time, and using CTDHP member services to assist members in locating a dentist and setting appointments.***
2) ***Revise and update the Husky Health Dental Benefits grids and benefits related information on the CTDHP website to be user friendly and to promote a better understanding of member benefits.***
3) ***Develop robust communication channels, both online and traditional, to members, with emphasis on channel development in the High Impact 25 towns/cities.***
4) ***Improve our CTDHP web-based provider search tool to aid members in locating a dentist.***
5) ***Prioritize trusted-person model, high touch community outreach in the High Impact 25 Towns/Cities by our Dental Health Care Specialists with 90% of community-based outreach focused in the High Impact 25 and targeted to specific outreach types.***
6) ***Prioritize provider recruitment in 5 Towns/Cities with the highest member to dentist ratios.***

Additionally, CTDHP will focus its efforts in meeting the 15 National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. This will be accomplished by:

1) ***Workforce development via required and ongoing training, employee assessment of cultural competency, and broadening new employee recruitment tactics beyond traditional recruitment sites to increase the diversity of candidate pools.***
2) ***Promotion of the Community Health Worker (CHW) profession via implementation of a CHW internship program at CTDHP.***
3) ***Implementation of CLAS and Americans with Disability Act quality assurance processes applied to all member facing content and design for print and online communications.***
4) ***Partner with sister ASO's, community-based organizations, and direct to member feedback opportunities to continuously learn and understand the oral health services needs and barriers from HUSKY Health Members and incorporate our learnings in strategy planning and intervention design.***
5) ***Develop reporting measures and processes to inform of CTDHP's efforts and outcomes to the Department, advisory workgroups, and oversight committees.***

Finally, improvements in reducing the disparity between adults and children would benefit from policy changes enacted by the Department of Social Services to improve the HUSKY Health dental provider landscape for adults. Recommendations include:

1) ***Increase adult provider fees to market competitive rates to incent more providers to join the network and increase HUSKY panel sizes for existing dental providers. This will enable the Department to increase its FMAP rate on adult dental services.***
2) ***Enhance the medical necessity and prior authorization processes to enable providers to efficiently determine if adult members need cleanings more than once annually to increase adult preventative utilization.***
3) ***Reward quality providers through a value-based payment methodology.***
4) ***Enable the Department to study the network and administrative implications to assigning dental providers to members upon joining the Husky Health program to reduce member barriers to finding and locating a dentist.***
5) ***Leverage the Department's research/university partners (e.g. UCONN Schools of Public Health, Dentistry, Social Work) to conduct ongoing analysis on oral health disparities to ensure independence and proper research rigor.***

II. CTDHP Health Equity Definitions

Developing a common language and standard definitions was among the first actions CTDHP undertook to ensure we were identifying and speaking to the same problems and opportunities. The following definitions have been embraced and endorsed by CTDHP and are used throughout this document. Definitions of Health Disparities, Health Equity, and Health Inequity were developed and modified from the Center for Disease Control and Prevention's "Attaining Health Equity" found at https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/overview/healthequity.htm

CTDHP Commitment to Oral Health Equity

In order to effectuate CTDHP's mission of enabling all HUSKY Health members to achieve and maintain good oral health, CTDHP is committed to ensuring that access and availability of oral health services are fairly distributed across the CT Medicaid population. Achieving oral health equity requires us to develop data driven strategies to address population specific needs to reduce barriers in accessing and utilizing oral health services.

Health Disparities

Health disparity is a quality that separates a group from a reference point on a particular measure of health that is expressed in terms of rate, proportion, mean, or some other quantitative measure.

Health Equity

Health equity is the fair distribution of health determinants, outcomes, and resources within and between the segments of the population, regardless of social standing.

Health Inequity

Health inequities are the difference in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, live, work, and age.

Geographic Accessibility

Geographic accessibility is the proximity to dental providers for members as measured by distance or alternatively expressed as driving time. Geographic accessibility metrics are measured based on the percentage of members within a population for whom a certain count of primary care dentists, and separately specialists, are available within a certain distance from each member's home. Common standards for geographic accessibility are 90% of members with at least 1 primary care dentist within 20 miles, 90% of members with at least one specialist within 30 miles, etc. CTDHP standards are set to exceed those measures in areas where sufficient dental practitioners exist to meet a stricter outcome.

Dental Provider Capacity

Capacity is the ability of the network's dental providers to treat both their existing patients of record and new patients referred to them. Currently, CTDHP does not espouse primary care dentist "assignment" as an effective mechanism for managing dentist's patient panel size. We do believe in reinforcing – through provider and member education – the concept of maintaining a family dental home. The dental home concept is further reinforced through plan design and programmatic incentives that encourage members to identify and stay with a usual source of dental care. By utilizing analytic

models that forecast network capacity at varying geographic levels (statewide, county, town, zip code) CTDHP is able to focus on recruiting those specific dental offices needed to balance the capacity of the network and in turn make dental care accessible to members so that they can easily establish and maintain a dental home. This approach will ultimately reduce the amount of urgent dental care presented, which in turn further extends the capacity of the network to serve members on a regular, preventive, basis.

Dental Provider Appointment Availability

Availability, like capacity, is a function of the network's dental providers to provide timely appointments and services to their existing patients of record or new patients referred to them. CTDHP utilizes a variety of communications methodologies and encourages dentists to keep us informed when they must close their office to new patients or when they are able to take on new patients. This information is recorded and updated in real time and made accessible in our web-based provider locator and Member Services tools. This ensures that members are being referred to providers with whom they can make an appointment and who are most appropriate to address that member's specific needs.

Geographic Access, Capacity and Appointment Availability

There is a positive correlation between expanded geographic access, capacity and appointment availability. As the number of participating provider's increases, each individual dentist and each service location is under less pressure to serve as large of a patient population as they were under less extensive networks. This enables those providers and offices to expand their individual capacity and make appointments more readily available to their historic patients and new patients alike.

CTDHP also conducts periodic "secret shopper" surveys of all participating providers in order to measure their individual compliance with contract requirements regarding new patient appointment availability, routine recall appointment availability and urgent care appointment availability. Providers that fail to meet the appointment availability standards are immediately placed on "do not refer" status until such time as they complete and satisfy an individual corrective action plan relevant to their appointment availability compliance.

Accessibility, capacity and availability data is combined with detailed capability and preference data for each provider or office location. Capability and preference data is gathered through the enrollment process and through periodic provider surveys. This data ranges from indicators of the geography of a dentist's patient panel catchment area (i.e. within a zip code, town or radius of their location) to preferences on minimum and maximum patient ages that they are comfortable treating, as well as over 30 different special care dentistry indicators for physical, intellectual and other disabilities, treating pregnant women, sedation services and others.

III. Moving into Action: Addressing Oral Health Disparities Action Plan SFY 22-23

Solutions to reducing the disparity between adults and children utilization with emphasis in the High Impact 25 requires tactical, strategic, and policy changes. The action plan focuses on four overarching objectives to reduce the disparity:

1. **Fostering behavior change to enhance member motivation to go to the dentist regularly.**
2. **Reducing barriers for members to locate and engage with dental providers.**
3. **Creating opportunities for members to be informed of and understand their plan benefits.**
4. **Enabling the oral health ecosystem to provide quality oral health services to adults.**

The action plans identified in the following sections focus on meeting those objectives via policy considerations, internal actions to meet CLAS standards, community-based outreach in the High Impact 25, Member Engagement initiatives, and Provider Engagement Priorities.

A. Policy Considerations

Consideration	Rationale
Increase adult provider fees to market competitive rates	The last rate increase for adult providers was in 2007. Increasing adult rates would incentivize existing providers to open panels to HUSKY Health members and increase net new providers to the network.
Enhance the medical necessity and prior authorizations processes to enable providers to efficiently determine adult members who need cleanings more than once annually to increase adult preventative utilization.	Overwhelmingly member survey responses categorized in the "Limited Benefit" requested twice annual cleanings. Twice annual cleanings for members determined to be clinically appropriate would increase preventative utilization and increase member's exposure to dental providers to identify any treatment needs more frequently. This is particularly true for members with certain medical diagnosis and prescribed medications. (Examples include diabetes, heart related diseases, autoimmune diseases) Systematizing, via MMIS, changes that will auto-accept more than annual cleanings based on the presence of members medical diagnosis codes and or prescription drugs would reduce provider burden in the prior authorization processes and increase member preventative utilization.
Implementing a value-based payment program to reward high quality providers.	Rewarding quality care and outcomes rather the quantity of care can foster competitiveness in the oral health ecosystem to meet quality metrics, create further accountability among providers for the overall oral health of their patients and enable the department to further medical-dental integration aims.

	Quality measure designs can focus on structural, process, and outcome measures that align with reducing member barriers to care including requiring practices to be open evenings and weekends and maintain open panels.
Study the administrative implications to assigning dental providers to HUSKY Health Members at enrollment.	Member survey responses consistently identified the difficulty in finding a provider. Assigning providers at the onset of enrollment would work to reduce the barrier. It can also support panel management in a value-based payment program. There are considerable operational and fiscal implications that need to be studied to consider this change.
Leverage the Department's research/university partners (e.g. UCONN Schools of Public Health, Dentistry, Social Work) to conduct ongoing analysis on oral health disparities to ensure independence and proper research rigor.	Maximizing the department's ability to leverage state agency/university cooperative agreements would enable ongoing independent analysis of oral health disparities to inform CTDHP and the Department of the need to update and create new programmatic and policy strategies.

B. National Culturally and Linguistically Appropriate Services (CLAS) Action Plan

Currently, CTDHP has met four, partially met four, and has not met seven0 of the CLAS Standards. CTDHP will engage in several projects throughout the next two fiscal years to improve on and meet applicable CLAS Standards.

Actions are identified below:

Action and Objective		Project Lead and Responsible Work Units	Attributed CLAS Standard #	Timeline of Completion
1.	Include Oral Health Equity statement to CTDHP Mission and Values Statements.	Health Equity Officer, Communications Specialist	2	Q1 SFY 22
2.	Incorporate CTDHP's commitment to oral health equity and CLAS Standards to all new education materials, in office signage, e-mail taglines, and all public facing communications.	Health Equity Officer, Communications Specialist	2	Q1 SFY 22
3.	Develop Standard Onboarding Cultural Competency Training. 100% of all new CTDHP staff receive cultural and linguistic competency training.	Health Equity Officer, All Work Units	2	Q3 SFY 22
4.	Target recruitment for new hires beyond traditional recruitment sites. Include a health equity, commitment to diversity statement in all new hire documents and job descriptions.	Health Equity Officer, All Hiring Managers	3	Q1 SFY 22
5.	Design and Implement Community Health Worker internship program.	Health Equity Officer, CC&O DHCS Manager	13	Q1 SFY 22
6..	Develop CLAS and ADA review quality check process to all new and existing member communications development workflow for both English and Spanish. 100% of materials undergo CLAS and ADA quality review.	Health Equity Officer, Communications Specialist	4	Q1 SFY 22
7.	As part of CTDHP web redevelopment, promote use of language assistance services, ensure ADA compliance. SFY 22 develop baseline click rate - set targets for the years thereafter.	Communications Specialist, Health Equity Officer	6 & 8	Q4 SFY 22
8.	Develop one stand-alone collateral document that highlights the availability of translation services in the ACA approved 15 languages for outreach purposes. Document to be used in community-based outreach efforts. Distribute to 500 Community Partners.	Communications Specialist, Health Equity Officer	6 & 8	Q2 SFY 22

9.	Develop procedures to access American Sign Language and spoken language interpreters - laminate “easy to grab” resources and publish on internal web-based Intranet for all staff access. 100% of staff are aware of internal procedures on providing language assistance to HUSKY Health members.	Health Equity Officer, All Work Units	7	Q2 SFY 22
10.	Conduct annual review of standard operating procedures for cultural competency. 100% completion of existing materials.	Health Equity Officer, All Managers	9	Q2 SFY 23
11.	Conduct Internal annual (anonymous) CLAS Assessment Survey Tool with oral health equity specific questions and workforce climate as it relates to diversity and inclusion. Complete analysis to develop baseline scoring. Conduct yearly thereafter. 95% completion rate by all CTDHP staff. Targets set post baseline survey.	Health Equity Officer, All Work Units	10	Q3 SFY 22 Q3 SFY 23
12.	Enhance the reporting of linguistic services provided, utilization disparities, internal CLAS survey tool outcomes, health equity plan and outcomes on CTDHP internal web-based intranet for staff access.	Director of Care Coordination and Outreach, Health Equity Officer	10	Q4 SFY 22 (Ongoing thereafter)
13.	Conduct yearly member and community organization survey to assess cultural and linguistic oral health needs of the Husky Health population.	Director of Care Coordination and Outreach, Health Equity Officer, Executive Team	12	Q4 SFY 22 Q4 SFY 23
14.	Review utilization disparities data yearly, at the start of the state fiscal year to determine if intervention and program design changes are needed.	Director of Care Coordination and Outreach, Health Equity Officer, Executive Team	12	Q2 SFY 22 Q3 SFY 22
15.	Partner with sister ASO’s who have established consumer/member forums to understand members’ oral health service needs and barriers to incorporate into outreach planning.	Health Equity Officer	13	Q1 SFY 22 ongoing thereafter
16.	Continue to organize and lead CTDHP’s Oral Health Equity External Workgroup to receive feedback on intervention design and execution to reduce oral health disparities.	Health Equity Officer, Executive Team	13	Implemented Ongoing Maintenance and Operations
17.	Review existing processes for Grievance and Appeals to determine if there are additional areas to provide materials in languages other than English and Spanish.	Health Equity Officer, Grievance and Appeals Manager	14	Q2 SFY 22

18.	Report CTDHP's Efforts and outcomes on CLAS and Health Equity Plan to DPAC, MAPOC, and other stakeholder groups.	Health Equity Officer, Executive Team	15	Q3 SFY 22 Q3 SFY 23
19.	Continue to participate along with other ASO's in DSS's Health Equity Workgroup to present efforts and results.	Health Equity Officer, Executive Team	15	Ongoing

C. Community-Based Outreach in the High Impact 25 Action Plan

The High Impact 25 Towns/Cities represent 60% of all non-utilizers in the review period. CTDHP's Care Coordination and Outreach Team, comprised of 7 Dental Health Care Specialists (DHCS) assigned to regions in Connecticut will prioritize intensive, community-based outreach in the High Impact 25 during state fiscal year 22 and quarter 1 of SFY 23. Their efforts will work towards increasing utilization in the High Impact 25 by 2% by the end of State Fiscal Year 2023. Roughly 90% of their outreach efforts will be in the High Impact 25 areas in their regions:

High Impact 25	
Bloomfield	Naugatuck
Bridgeport	New Britain
Bristol	New Haven
Danbury	New London
East Hartford	Norwalk
East Haven	Norwich
Enfield	Shelton
Hamden	Stamford
Hartford	Torrington
Manchester	Wallingford
Meriden	Waterbury
Middletown	West Haven
Milford	

CTDHP will continue engaging in the trusted-person model, engaging with community partners to become champions of oral health and versed in CTDHP services, including care coordination and other member services that HUSKY members can access for support.

Dental Health Care Specialists will be assigned to the High Impact 25 towns/cities within their regions and work to develop an "oral health outreach profile" to work with organization types with the objectives to train staff on Husky Dental Plan & CTDHP services, develop referral pathway for care coordination, work to develop and support the creation of oral health assessment as part of intake and care management processes. DHCS will also offer direct to member training on oral health and work with members to understand barriers and needs to accessing dental services. Tactically, DHCS will be accountable to a set monthly outreach activity count to monitor effort.

The following Outreach Locations will be identified by DHCS for prioritized outreach efforts in the High Impact 25:

- Homeless Shelters
- Public Housing – Resident Services Coordinators
- American Job Centers/Career Centers
- Area Agencies on Aging
- City/Town Human Services Departments & Municipal Agents
- Grocery Stores with Nutritionist Services
- Local Health Departments
- Food Pantries
- Health Focused Organizations (YMCA's, YWCA's)
- Faith Communities
- Neighborhood Revitalization Zone Committees/Groups
- WIC Clinics
- Community Action Agencies

The team will also work to build awareness of the HUSKY dental plan benefits and CTDHP services through local based free communication methods (interviews, press releases, letters to the editor), ad buys, poster placement, and local street level billboards. These will include:

- Local Cable Channels – interviews and local ad buy
- Local Radio Stations – interviews and local ad buy
- Local Thrift Shops – poster placement
- Markets/Bodegas near public housing – poster placement
- Local Transit – ad buy

D. Member Engagement Priorities

CTDHP will work to enhance their existing direct to member engagement efforts and add new member engagement channels and campaigns with focus in the High Impact 25 Towns/Cities. This includes developing new content and messaging intended to inform members of their dental benefit, how CTDHP services can help them locate a dentist, and use creative and positive messaging to go to the dentist. The following engagement channels will be enhanced or developed:

Channel	Targets	Objective
Automated Calls	All Adults who have not had a dental visit in 12 months. Repeat on call failure to members living in High Impact 25.	Inform of benefit, CTDHP services, remind importance of annual visit.
Text		
Letter (upon call/text fails)		
Facebook, Twitter, Instagram, Google Ad Buys	High Impact 25	Delivery of topical messages, reminders, and inform of CTDHP member services.
Radio, Cable, local newspapers, street level billboard ad buys	High Impact 25	Member campaign focused on oral health and CTDHP services.
Member Newsletters	All HUSKY Members with email addresses	Topic oriented messages, oral health information, promotion of CTDHP member services.
Community Partner Newsletter	All Community Partners	
Updated CTDHP Website	All HUSKY members	Enhance member experience through Improvements to provider locator tools, community partner portal, user friendly benefit grid and instructions on how to access CTDHP services.

E. Provider Engagement Priorities

CTDHP's provider network team continuously works to solicit new providers to the HUSKY Health dental network. Focused efforts will be on the areas identified in the High Impact 25 to recruit new provider practices including: Naugatuck, East Haven, Milford, Naugatuck, and West Haven. The greatest dependency on recruitment of new providers is the current adult fee schedule.

In 2020, CTDHP piloted engaging dental providers and their staff to participate in Cross Cultural and Diversity Inclusiveness Training provided by the Hispanic Health Council. Given the participation from one large dental service organization, CTDHP will work to offer continued cultural competency training to providers.

Additionally, in 2016 CTDHP and the Connecticut State Dental Association collaborated on developing provider educational materials on providing language assistance services to comply with section 1557 of the Patient Protection and Affordable Care Act. CTDHP will continue to provide collateral educational material to existing and new providers to ensure compliance.

IV. Health Equity Data Analysis: Oral Health Disparities

Utilization of dental service rates was used as the primary measure to understand the HUSKY Health population- what groups are or aren't accessing oral health treatment services to determine where disparities may exist.

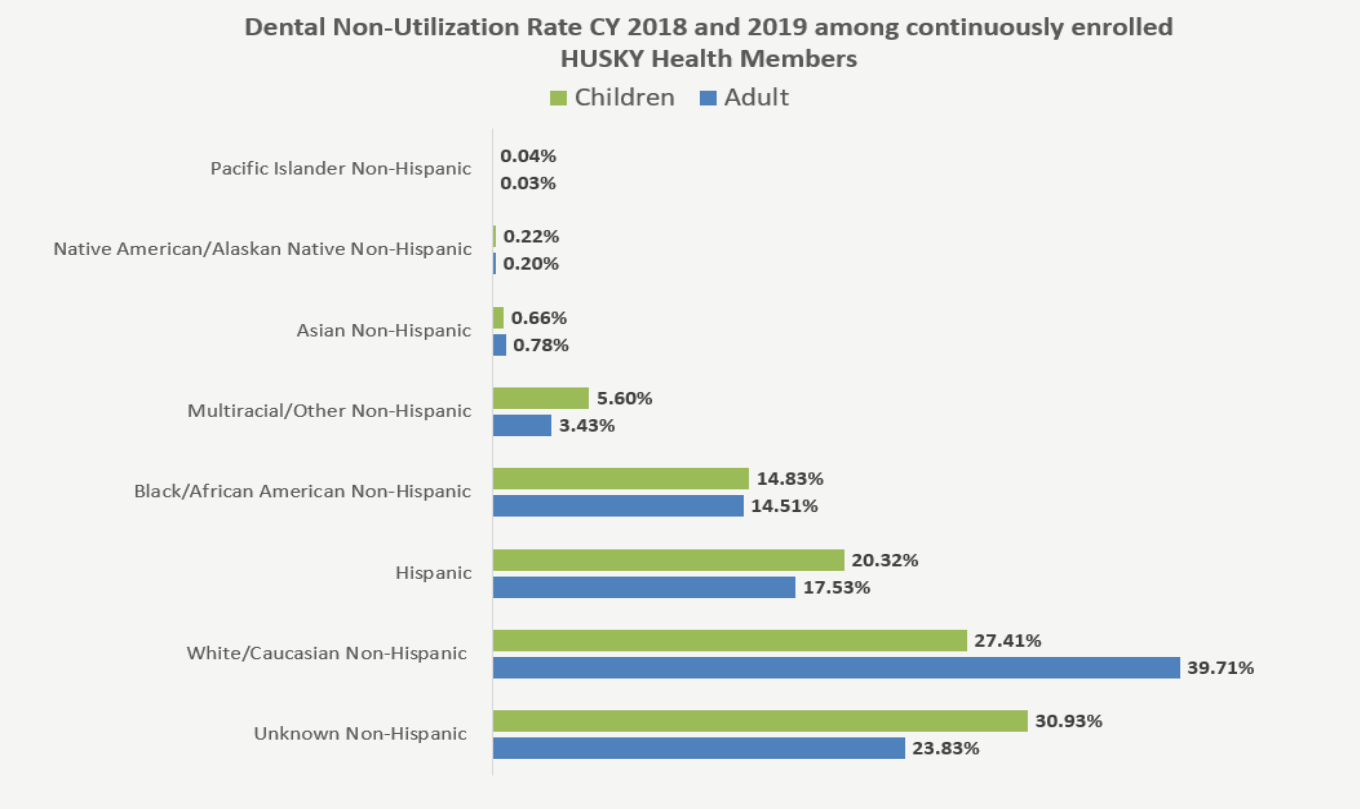
Any dental claim, preventative or treatment services, were calculated between calendar years 2018 and 2019 among HUSKY Health Members who were continuously enrolled or actively eligible in the HUSKY/Medicaid program in the same time period. All medical coverage groups were included. Rates were analyzed by age groups (children from 0 to 21, Adults 21 and over) and by race and ethnicity. Race and ethnicity definitions are pre-determined from member self-report on Medicaid eligibility forms.

Non-Utilization is defined as any member who had no dental utilization in the 2018 and 2019 calendar years. Of the 527, 457 HUSKY Health members, 177,348 had no dental utilization or 33% of total population in the review period. Adults had significantly higher non-utilization rates (143,446) than children (33,882). Adults represented 81% of the non-utilizers.

The total review size was 527,457 members with race and ethnicity breakouts below:

Race/Ethnicity	Raw Count	%
White/Caucasian Non-Hispanic	169,378	32.1%
Unknown Non-Hispanic	135,713	25.7%
Hispanic*	116,739	22.1%
Black/African American Non-Hispanic	77,017	14.6%
Multiracial Non-Hispanic	23,736	4.5%
Asian Non-Hispanic	3,706	0.7%
Native American / Alaskan Native Non-Hispanic	988	0.2%
Pacific Islander Non-Hispanic	180	0.0%
Total	527,457	100%
Racial Break Out of Hispanic Members		
Race	**Raw Count**	**%**
Unknown Hispanic	70,459	60.4%
White/Caucasian Hispanic	37,022	31.7%
Black/African American Hispanic	5,930	5.1%
Multiracial Hispanic	2,687	2.3%
Native American / Alaskan Native Hispanic	473	0.4%
Asian Hispanic	108	0.1%
Pacific Islander Hispanic	60	0.1%
Total	116,739	100%

The highest non-utilization rate for adults was among the White/Caucasian Non-Hispanic population. The highest non-utilization rate for children was among the Unknown Non-Hispanic population. Examining the proportion of non-utilizers to the total population and its racial and ethnic break out there does not appear to be a large variance in any race or ethnicity to identify a substantive disparity.



Break out of non-utilization rates by age and race/ethnicity are as follows:

Total Non-Utilization (Adults and Children)		
Race/Ethnicity	**Total Population**	**% Non-Utilizers**
White/Caucasian Non-Hispanic	66,248	37.35%
Unknown Non-Hispanic	44,658	25.18%
Hispanic	32,035	18.06%
Black/African American Non-Hispanic	25,833	14.57%
Multiracial Non-Hispanic	6,812	3.84%
Asian Non-Hispanic	1,341	0.76%
Native American / Alaskan Native Non-Hispanic	360	0.20%
Pacific Islander Non-Hispanic	61	0.03%
Total	177,348	

Non-Utilization -Adults		
Race/Ethnicity	**Total Population**	**% Non-Utilizers**
White/Caucasian Non-Hispanic	56,962	39.71%
Unknown Non-Hispanic	34,1748	23.83%
Hispanic	25,149	17.53%
Black/African American Non-Hispanic	20,807	14.51%
Multiracial Non-Hispanic	4,916	3.43%
Asian Non-Hispanic	1,119	0.78%
Native American / Alaskan Native Non-Hispanic	286	0.20%
Pacific Islander Non-Hispanic	49	0.03%
Total	143,446	

Non-Utilization –Children		
Race/Ethnicity	**Total Population**	**% Non-Utilizers**
Unknown Non-Hispanic	10,480	30.93%
White/Caucasian Non-Hispanic	9,286	27.41%
Hispanic	6,886	20.32%
Black/African American Non-Hispanic	5,026	14.83%
Multiracial Non-Hispanic	1,896	5.60%
Asian Non-Hispanic	222	0.66%
Native American / Alaskan Native Non-Hispanic	74	0.22%
Pacific Islander Non-Hispanic	12	0.04%
Total	33,882	

Key Takeaways:

1) Adults had significantly higher non-utilization rates (143,446) than children (33,882). Adults represented 81% of the non-utilizers.
2) White/Caucasian and Unknown Non-Hispanic adults and children represent the largest percentage of non-utilizers compared to any other population.
3) Non-utilization rates were proportional to the race/ethnicity population groups in the sample size, indicating a lack of meaningful disparities existing across racial/ethnic groups.

A. Themes in the Data - Geographical Analysis

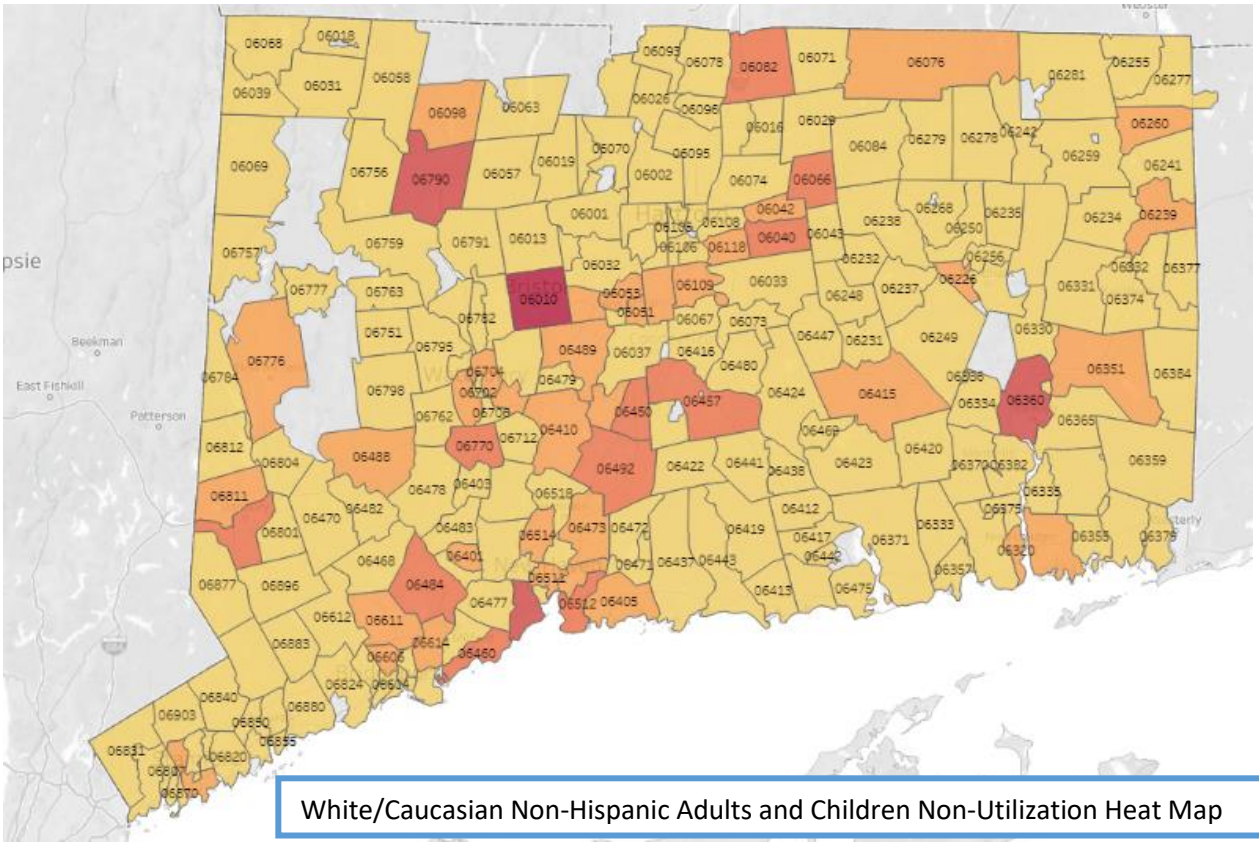
Non-Utilization alone does not tell the full story of oral health disparities among the HUSKY Health population. Applying a geographical analysis enabled CTDHP to identify “hot spots” or areas of concentrated populations that can illuminate disparity types other than age-based or racial/ethnic disparities.

Zip code assignments were made to the total non-utilizing population and organized by age and race/ethnicity definitions. Member zip codes were identified from the DSS Medicaid eligibility information.

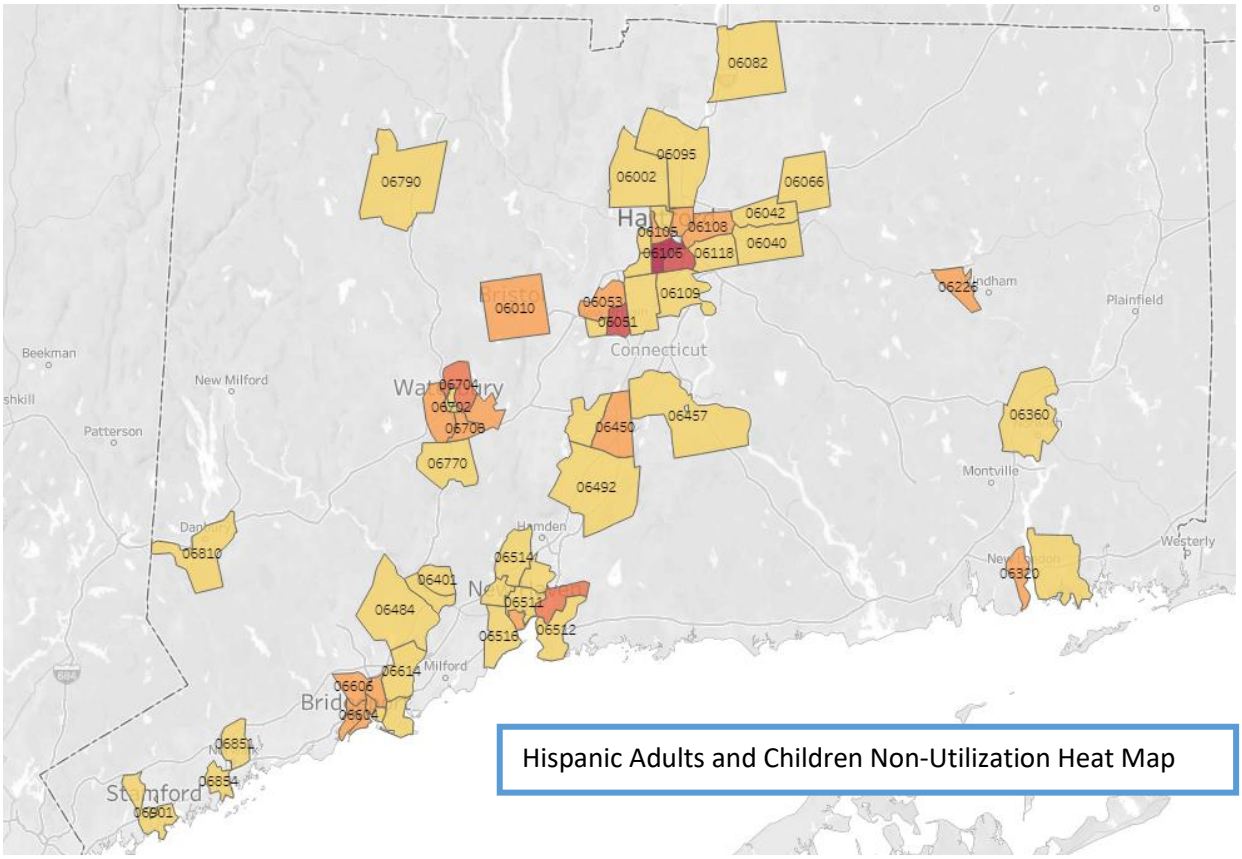
Largely, zip code analysis by race/ethnicity reflects the demography and racial segregation in the state. White/Caucasian Non-Hispanic Children and Adults were far more disparate across the state and less concentrated in geography than their Black/African American and Hispanic counterparts.

Despite this, there were areas that reflected higher concentration of non-utilization across multiple racial and ethnic populations. 60% or 105,939 of the non-utilizers were concentrated to 25 towns/cities in Connecticut. CTDHP has identified these town/cities as the “High Impact 25”, given the greatest opportunity to impact member’s non-utilization due to the volume concentration.

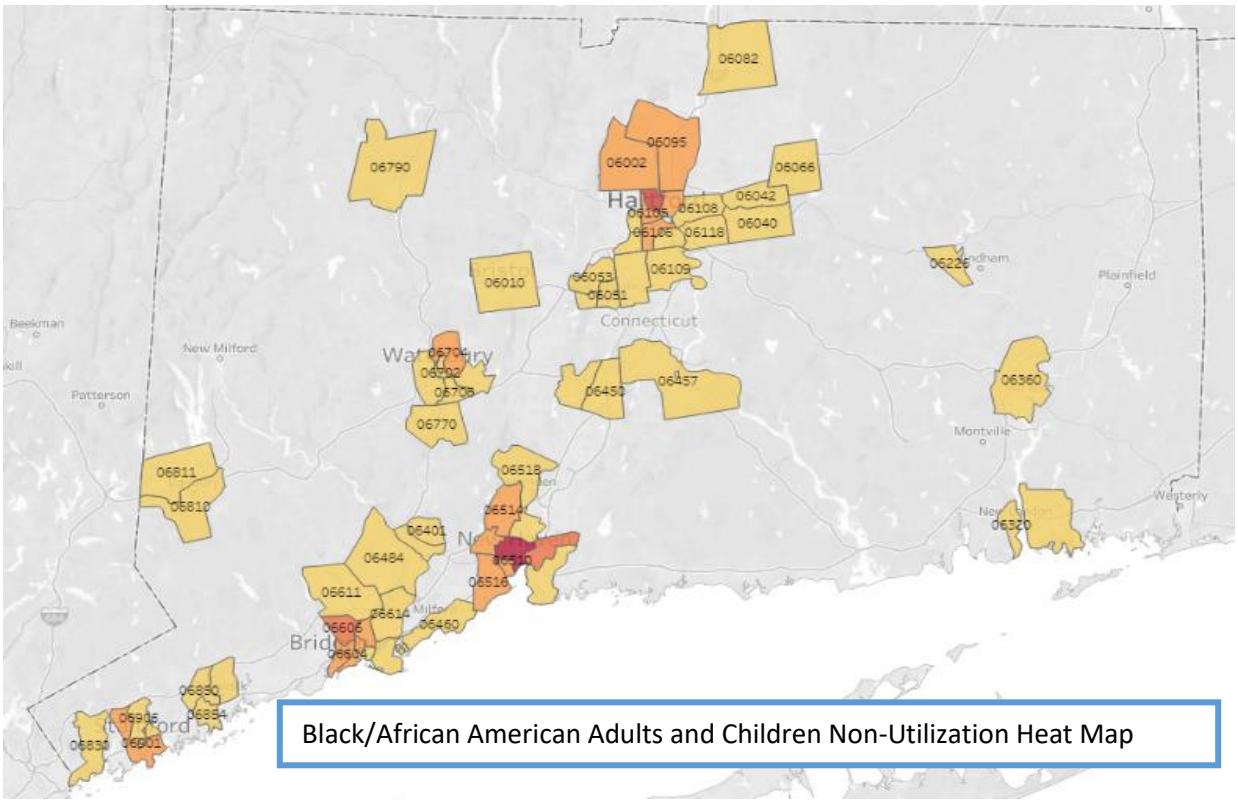
Below illustrates the geographical spread versus concentration by race/ethnicity type:



White/Caucasian Non-Hispanic Adults and Children Non-Utilization Heat Map



Hispanic Adults and Children Non-Utilization Heat Map



Black/African American Adults and Children Non-Utilization Heat Map

against existing demographic data sets identify a geographical socioeconomic disparity. The "High Impact 25" have below or lowest average income, high poverty, and have been identified among the most socially vulnerable towns/cities to withstand environmental or man-made hazards on the community. *(Connecticut United Way, "ALICE in Connecticut: A Financial Hardship Study" 2020, UCONN Center for Population Research, "The Changing Demographics of Connecticut-1999-2000 Part 2: The Five Connecticut's" May 2004, CDC/ATSDR Social Vulnerability Index 2018 Database Connecticut. https://www.atsdr.cdc.gov/placeandhealth/svi/data_documentation_download.html accessed April 2021)*

It is without question the geographical disparities of the High Impact 25 are rooted in economic and social inequities. Core differences in the quality of life and wellbeing are represented in the High Impact

25 as compared to other towns and regions within the state. This most starkly identified metric to exemplify the disparity is life expectancy. The life expectancy in Connecticut's urban core is 77.4 years, in the urban periphery is 79.9 while in Connecticut's wealthy areas it is 83.9 and overall in Connecticut is 80.3. Work completed by DataHaven notes, "Children born in the wealthy towns can expect to live six years longer than children born in Connecticut's cities". *(Davila, Kelly, Abraham, M., Seaberry, C. "Towards*

Health Equity in Connecticut: The Role of Social Inequality and the Impact of COVID-19" June 2020)

25 Towns/Cities with Highest Impact Opportunity

- 25 Towns/Cities represent 60% of the total non-utilizing population of adults and children across all races/ethnicities.
- Opportunity to impact 105,939 white/Caucasian Non-Hispanic, Unknown Non-Hispanic, Hispanic, and Black/African American Non-Hispanic populations. (Break Outs below)

Population	Total Population Non-Utilizers Size	High Impact 25 Non-Utilizers Population Size
White/Caucasian Non-Hispanic	66,428	28,582
Unknown Non-Hispanic	44,658	28,912
Hispanic	32,035	26,522
Black/African American Non-Hispanic	25,833	21,923

Given the geographic concentration of Hispanic and Black/African American Non-Hispanic there is over representation in the High Impact 25. Given the lack of concentration for White/Caucasian Non-Hispanic and Unknown Non-Hispanic there is under representation in the High Impact 25.

High Impact 25	
Bloomfield	Naugatuck
Bridgeport	New Britain
Bristol	New Haven
Danbury	New London
East Hartford	Norwalk
East Haven	Norwich
Enfield	Shelton
Hamden	Stamford
Hartford	Torrington
Manchester	Wallingford
Meriden	Waterbury
Middletown	West Haven
Milford	

High Impact 25 – Characteristics against Established Data Sets

CDC's Social Vulnerability Index (SVI) SVI is defined by CDC is the "potential negative effects on communities caused by external stresses on human health".

- **23 of the 25 on the Top 50 of CT's SVI list.** (Hamden and Norwich are excluded)
- SVI is currently being used to target geographies to reduce health disparities in COVID-19 Vaccine distribution.

The Five Connecticuts groupings help illuminate the socio-economic characterizations of the High Impact Towns/Cities:

- **17 of the 25** are identified as **Urban Periphery**. Urban periphery is characterized by "below average income, average poverty, and high population density".
- **6 of the 25** are identified as **Urban Core** (Bridgeport, Hartford, New Britain, New Haven, New London, Waterbury). Urban Core is characterized by "lowest income, highest poverty, and highest population density". Per The Five Connecticuts report there are 7 urban core s in 2000s.
- **2 of the 25** are identified as **Suburban** (Shelton and Wallingford**)**. Suburban is characterized by " above average income, low poverty, and moderate population density."

United Way's ALICE Report identify the number of households that are Asset Limited, Income Constrained, Employed. These households are earning above the Federal Poverty Level, but below a basic cost of living threshold. The ALICE Report helps to identify the percentage of households within each town/city at both the ALICE levels and Federal Poverty Line to illuminate the magnitude households struggling to meet their basic needs.

- The range of percentage of households meeting both ALICE and FPL within the High Impact 25 are at the lowest 26% of households to 69% of households within the town/city experiencing ALICE and FPL.
- **The median percentage is 41% of households within the town/city experiencing ALICE and FPL.**

Key Takeaways:

1) Zip code analysis largely reflects the demographic composition of the state.
2) There are 25 Towns/Cities that have high concentration of non-utilizers- 60% of the reviewed sample.
3) The "High Impact 25" represent a socioeconomic disparity in their demographic composition highlighted by below or lowest average income, average or high poverty, and socially vulnerable to withstand negative effective on the community.

Understanding root causes that influence non-utilization is key to developing the appropriate interventions to improve the disparity. The availability of HUSKY Health dental providers within the High Impact Area can illuminate if the provider network is a cause of the disparity e.g. members in the High Impact 25 do not have dental providers to access, therefore utilization is low.

CTDHP reports annually to the Department of Social Services the geographical accessibility of providers to members to determine network adequacy. This includes the average distance in miles from zip codes to closest provider at the zip code level and county level.

At the statewide level the current access breakdown is as follows:

- 100% of Adult HUSKY Members have access to a provider within 20 miles.
- 99.8% of Adult HUSKY Members have access to a provider within 10 miles.
- **96.5% of Adult HUSKY Member have access to a provider within 5 miles.**
- **97.2% of Child HUSKY Members have access to provider within 5 miles.**

Listed below are the number of general dentists and practices within the High Impact 25 Towns/Cities. This list is inclusive of Federally Qualified Health Centers, Private Practices, and Dental Service Organizations of June 22, 2021. Additionally, ratio analysis was conducted of how many total members from the review sample (continuously enrolled Husky adults and children) per dentists in the town/cities. While overall there is 1 dentist to 223 members and is aligned with network adequacy standards, there are considerable variances by town/city. Naugatuck, East Haven, Bloomfield, Milford, and West Haven have the highest members to dentist ratios. It is important to note that while member to dentist ratio analysis is town/city specific, members can and often locate their dental provider outside the town/cities in which they live.

High Impact Town/City	Number of General Dentists that see Adults and Children	Number of General Dentists that see Children Only	Ratio of general dentists that see adults and children to members (Total Continuously Enrolled Husky Members Adults/Children in Review Period)
Bloomfield	7	29	1: 1429
Bridgeport	142	22	1: 327
Bristol	134	9	1:116
Danbury	68	25	1:182
East Hartford	19	33	1:750
East Haven	9	7	1:1931
Enfield	120	27	1:41
Hamden	55	12	1:384
Hartford	213	16	1:272
Manchester	108	33	1:119
Meriden	62	8	1:249
Middletown	53	12	1:173
Milford	5	13	1:1429
Naugatuck	1	1	1:5883
New Britain	148	15	1:185
New Haven	179	8	1:295
New London	116	1	1:108
Norwalk	121	37	1:98
Norwich	17	10	1:683
Shelton	7	26	1:590
Stamford	123	40	1:121
Torrington	85	15	1:104
Wallingford	23	6	1:265
Waterbury	222	66	1:169
West Haven	17	12	1:1232
Totals	2054	483	1:223

Key Takeaways:

1) The HUSKY Health dental provider network exceeds network adequacy standards.
2) There are a total of 2,054 general dentists who see adults and patients and 483 pediatric specific dentists in the High Impact 25.
3) The total membership to dentist ratio is 1 dentist per every 223 members.
4) However, there are wide variances in dentist to member ratios from the review period. Example: Naugatuck has 1 dentist per every 5883 members while Enfield has 1 dentist to every 41 members.
5) Provide network development has the opportunity to prioritize Naugatuck, East Haven, Milford, Naugatuck, and West Haven.

B. Themes in the Data- Member Survey Analysis

CTDHP sought to understand barriers to accessing dental services and root causes of non-utilization by surveying members directly. The intent of the survey was to understand where oral health services fit in the importance of Husky Health Members lives for themselves and their children, understand what would make it easier to go to the dentist regularly, and what if any reasons a member did not go to the dentist in the past 12 months. The survey was rooted in aspects of social determinants of health with the assumption that social barriers may exist to accessing oral health services.

Members were sent electronic surveys via email on April 30th 2021 in both English and Spanish. A total of 237,222 English Speaking Members with emails and 25,927 Spanish speaking members with email were sent links to the survey. The survey was closed for data analysis collection on May 20th 2021.

The survey had a total of 13 questions which focused on the individual's response and if they had children, response to any barriers to services for their children. Questions contained multiple choice answers, but also commentary by the member to hone in on any specific issues or barriers. Qualitative, free form responses were coded into 28 common themes to identify meaningful responses.

In the survey, 605 members requested communication from CTDHP to further communicate concerns. This was accomplished via 150 reply emails, 239 members received outbound calls by the CTDHP Member Center, and 45 members received outbound calls by the Dental Health Care Specialists for members reporting complex concerns in navigating the oral health system. As of print, 8 members were actively engaged in care coordination with the Care Coordination and Outreach Team.

Response rates are identified below:

Member Survey Responses				
	Total Emails Sent	**Total Responses**	**Response Rate**	**Total Completion Rate of Survey**
English Survey	237,222	3,400	1.4%	72%
Spanish Survey	25,927	557	2.1%	75%

Of the respondents who answered survey demographic questions, the breakdown of respondent characteristics are as follows:

Member Survey Responses				
	Gender	**Age**	**Race**	**Ethnicity**
English Survey	69% Female 27% Male 2% Prefer Not to Say 0.4% Transgender 0.3% Non-Binary 0.1% Gender Neutral 0.1% None of Listed Genders Apply	33% Ages 56-64 27% Ages 46-55 24% Ages 31-45 7% Ages 22-30 6% 65 and Over 2% Prefer Not to Say 1% 21 and Under	70% White/Caucasian 13% Prefer Not to Say 7.63% African American 5% Multi-Racial 3% Asian .60% Native American .18% Pacific Islander	76% Non-Hispanic 12% Hispanic 12% Prefer Not to Say
Spanish Survey	82% Female 15% Male 2% Prefer Not to Say .1% Gender Neutral .25% Transgender .25% Non-Binary	43% Ages 31-41 25% Ages 46-55 14% Ages 22-30 4% 65 and Over 2% 21 and Under 1% Prefer Not to Say	50% Prefer Not to Say 27% White/Caucasian 11% Multi-Racial 6% Native American 2% African American	98% Hispanic 2% Prefer Not to Say
Combined	**71% Female** **26% Male** **2% Prefer Not to Say** **<1% Transgender** **<1% Non-Binary** **<1% Gender Neutral** **<1% None of Listed Genders Apply**	**30% Ages 56-64** **26% Ages 31-45** **25% Ages 46-55** **9% 65 and Over** **7% Ages 22-30** **2% Prefer Not to Say** **1% 21 and under**	**66% White/Caucasian** **17% Prefer Not to Say** **7% African American** **6% Multi-Racial** **2% Asian** **1% Native American** **<1% Pacific Islander**	**65% Not Hispanic** **24% Hispanic** **11% Prefer Not to Say**

Respondents (both English and Spanish Speaking) came from 166 towns/cities in CT. The largest volumes of responses came from Bridgeport, Stamford, Norwalk, and New Haven. Break out of responses is below:

Number of Survey Respondents	Towns/Cities				
100 or more	Bridgeport Stamford	Norwalk	New Haven		
50-99	Hartford Waterbury Danbury	Meriden West Haven New Britain	Milford (Other-Did Not Specify)	Manchester Stratford	Bristol Hamden
49-25	East Hartford Middletown Norwich Fairfield	Wallingford West Hartford Greenwich Enfield	East Haven New Milford New London Branford	Torrington Groton Naugatuck Vernon	Southington Monroe Shelton Seymour
24-10	Windsor Glastonbury Guilford Plainville Ansonia Bethel Farmington Southbury Trumbull Windham Putnam	Brookfield Bloomfield Cheshire Ridgefield Waterford Simsbury Coventry Killingly Newtown Derby Westbrook	East Haddam East Lyme Stonington Berlin East Windsor Madison Canton Colchester Rocky Hill Westport Wolcott	Windsor Locks Clinton Granby S. Windsor Wethersfield Winchester Cromwell North Haven Old Saybrook	Plainfield Stafford Watertown Wilton Darien Haddam Montville New Canaan New Fairfield North Branford
9 or Less	Easton Griswold Ledyard Oxford Plymouth Portland Kent Tolland Avon Brooklyn Ellington Essex Litchfield Suffield Thompson Warren	Willington Woodbury Ashford Burlington Canaan Deep River Harwinton Mansfield Marlborough New Hartford Prospect Redding Weston Woodbridge Beacon Falls	East Hampton Hebron Lebanon Middlefield Sherman Thomaston Bethlehem East Granby Hampton Lisbon Middlebury N. Stonington Preston Sprague Sterling	Washington Woodstock Bolton Bridgewater Canterbury Chester Columbia Durham Killingworth Morris N. Canaan Old Lyme Salisbury Sharon Somers	Barkhamsted Cornwall Hartland Lyme Orange Salem Scotland Union Voluntown Chaplin Eastford Franklin Norfolk Pomfret Roxbury

Responses to "thinking about all that is going on in your life, how important is if for YOU to see a dentist regularly? (For example, seeing your dentist for a routine cleaning, treatment as directed by your dentist)"

83% of respondents noted it was "very important" for them to see the dentist regularly and 96% of respondents noted it was "very important" for their children to see a dentist regularly.

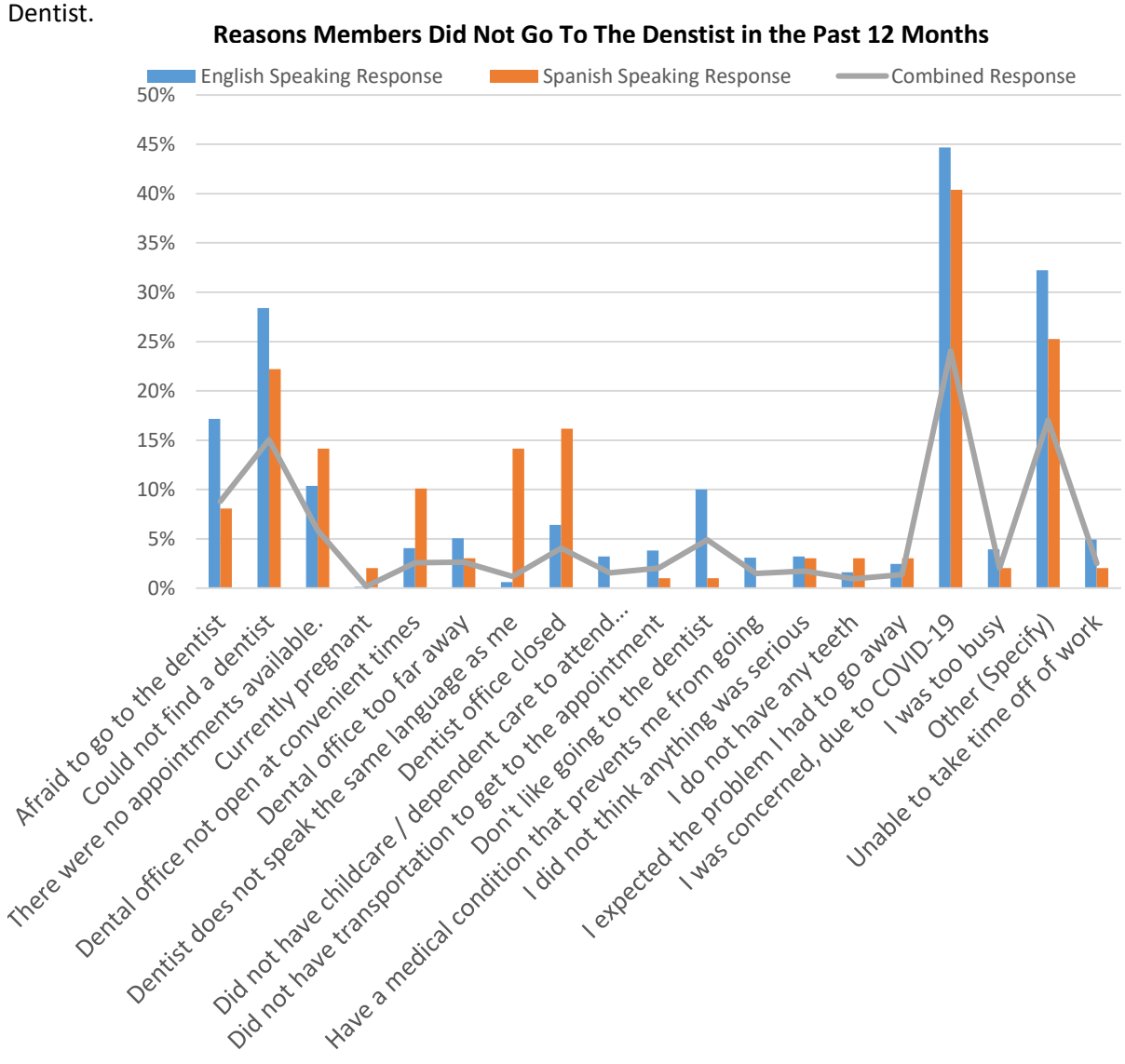
Recognizing that valuing going to the dentist regularly does not always correlate with the behavior of actually going, we asked *"what would help making going to the dentist regularly become either "very important"* or "somewhat important" in a free text comment. Comments were coded and tagged based on thematic results. There were 134 English survey responses and 8 Spanish survey responses. The Top 5 categorized responses are as follows:

English "Other" Responses- Top 5 Response Categories		
Response Category	**%**	**Sample Responses**
"Neutral" Response	19%	"Nothing in Particular" "Not Sure" "I can't think of anything offhand. Maybe free mouthwash or toothpaste"
Provider-Quality Issues	**13%**	"LESS PAIN and dentists who are competent" "Better HUSKY dentists" "It would be become substantial[y] more important if Husky had more Dentist[s] to pick from in the Network. The Dentist in my area to pick from are horrible, the reviews from previous patients are like nightmares"
Other Priorities	**9%**	"Nothing. [I] only go when there is pain." "If I had an obvious issue with my dental health" "If I had more time" "I don't know. There are other things that take priority"
COVID-19 Pandemic	**8%**	"Once my family is fully vaccinated we can all return to our regular appts" "The end of the pandemic" "Covid is under control"
Lack of Awareness of Dental Benefit	**7%**	"If I knew it was covered under my insurance. If I knew which dentist I could go to" "If you covered the costs to have my teeth done" "If I had insurance"
Provider-Hard to Find	**7%**	"The ease of finding a Dr. that takes patients" "Having a dentist that stays with the practice so I don't have to find a different one" "Having better dentist choices and knowing what [is] on my dental plan."
Benefit Limitations-Dentures	**7%**	"Not having to wait 7 years to renew dentures that no longer fit correctly." "Being able to get dentures adjusted to fit properly/get new ones" "Issues with dentures"

There were eight Spanish speaking responses of which 3 of the 8 were categorized as "Provider-Hard to Find" indicating challenges in finding a dental provider. Translated examples are:

Spanish "Other" Responses to ***"What would help making going to the dentist regularly become either "important" or "very important"***- Top 5 Response Categories		
Response Category	**%**	**Sample Responses (Translated to English)**
Provider-Hard to Find	37%	"More dentist available so I don't have to wait so long to get an appointment" "Being able to find another dentist as my previous one doesn't see me anymore"
Provider-Quality	25%	"Have other options of quality dentist that are sensitive to people like myself that have sensitive gums" "Finding a good quality dentist"
Provider- Language Barrier	13%	"Have dentist that speak my language"

Responses to Adults/Children Dental Care Utilization in the Past 12 Months In the last year, 92% of respondents and 87% of their children needed or wanted dental care. However, 70% of respondents and 83% of respondent's children went to the dentist. Both English and Spanish speaking survey respondents had the same top 3 reasons to not go: 1) I was concerned, due to COVID-19 2) Other 3) Could Not Find a Dentist.



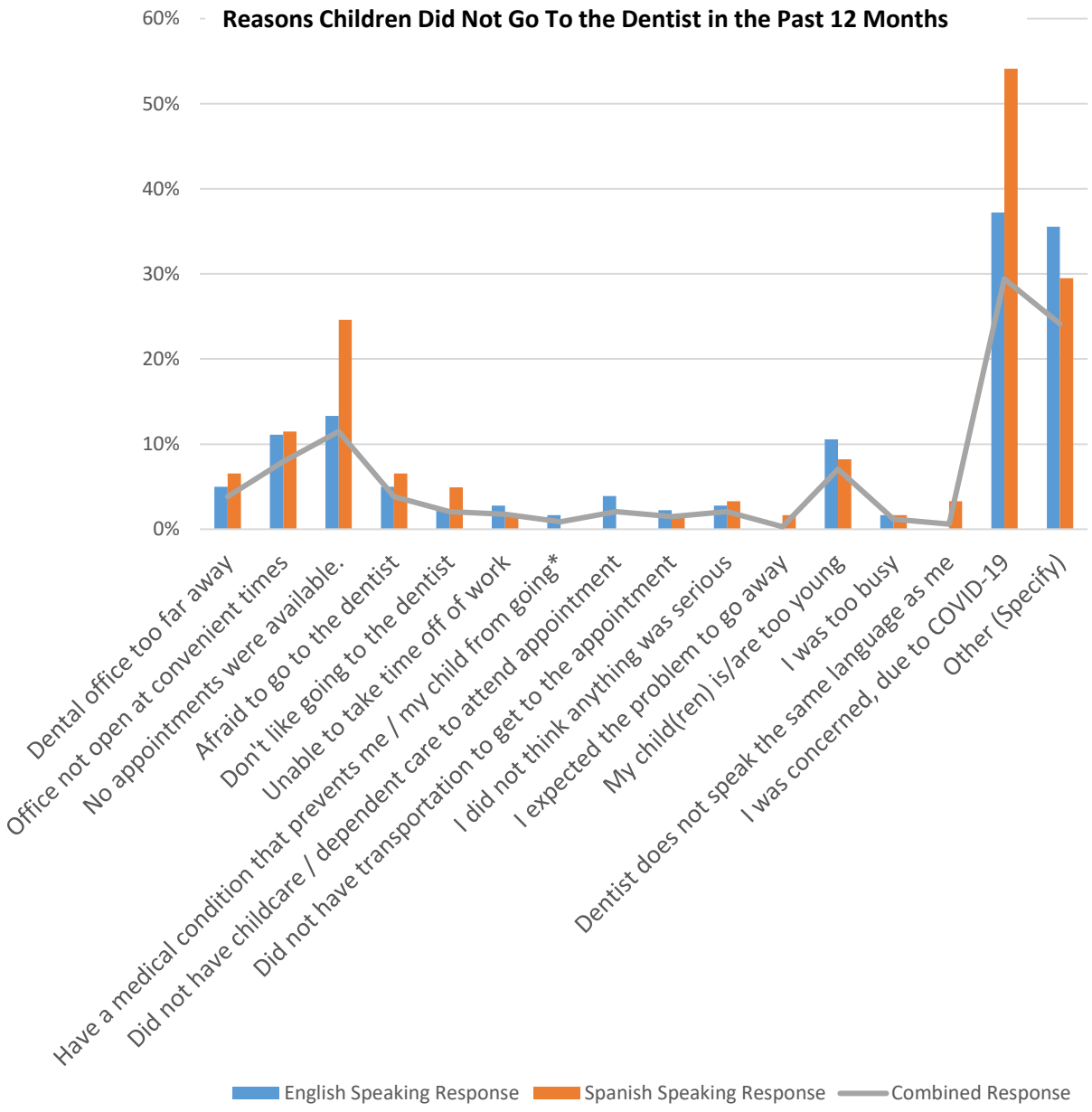
There were 261 (32%) English speaking respondents and 25 (25%) of Spanish speaking respondents who answered "Other" in response to reasons they did not go to the dentist in the past twelve months. Responses were categorized by theme, with the following top 5 responses identified:

English "Other" Adult Responses to Reasons Why Member Did Not Go to Dentist - Top 5 Response Categories		
Response Category	**%**	**Sample Responses**
Provider- Hard to Find	25%	"I had to pay out of pocket. The kids have a place to go to locally and it is covered by insurance but the adults can't find reputable, well run practice so I end up paying out of pocket." "Difficulty finding Husky A for adults" "When I called dentists listed on the website, I was told that they no longer participate"
Benefits- Costs	18%	"Insurance doesn't cover what I need done to my teeth and it's too expensive." "I need dental care beyond simple preventative care and Husky D makes that impossible" "I also need periodontal work husky doesn't provide or cover the expense. Without teeth who will hire you? Tooth loss affects your health in other areas of the body."
Lack of Awareness of Benefit	16%	"I don't know how to get dental care through husky" "I don't think I have insurance. Too expensive" "Unclear about what services are covered"
Provider-Quality Issues	13%	"Last visit wasn't very good. The cleaning was horrible" "Husky dentists are very shady. Trying to make you do work on your teeth that you don't need" "Not satisfied with the quality of Husky dentists"
COVID 19-Closure	5%	"Most dentists were not seeing patients during the pandemic" "List just opened up" "They were closed due to COVID and then I had surgery"

Spanish "Other" Adult Responses to Reasons Why Member Did Not Go to Dentist - Top 5 Response Categories		
Response Category	**%**	**Sample Responses (Translated to English)**
Lack of Awareness of Benefit	24%	"I'm not sure if my medical plan includes dental" "I don't think I have dental benefits"
COVID-19-Safety	24%	"The dental office wasn't seeing patients due to COVID" "I had to get a COVID test" "Dental office closed because of COVID"
Provider-Hard to Find	12%	"There aren't a lot of dentists in HUSKY" "Dentist now only sees children, hard to find one that sees adults"
Provider-Quality Issues	12%	"The service the dentist in my area provide is very poor. They treat people in the HUSKY plan differently" "The dental office called my wife for an appointment, but when she went to the office, they told her they were short staffed and couldn't see her"

		"I would like to find a good quality dentist since I already went through a very bad experience with one"
Other Priorities	8%	"I recently went through a surgery for my left knee and now in physical therapy" "I have medical conditions such as diabetes, heart problems and cancer"
Benefits-Costs	8%	"Unfortunately, I can't afford to pay for the extra cost of dental services" "Financial reasons, can't pay dental cost"

The reasons children did not go to the dentist are slightly different than adult responses, although COVID-19 remains a continuous theme throughout the survey responses. Among both English and Spanish Speakers, the top reasons were 1) Concern due to COVID-19 2) Other (further breakout below) and 3) Could Not Schedule an Appointment. No Appointments Were Available. *Of note, the Spanish speaking survey inadvertently omitted the response "Have a medical condition that prevents me/my child from going". This omission skews the data in terms of identifying the responses. CTDHP will make every effort to include in the next iterations of the member survey.*



There were 64 (34%) English speaking respondents and 18 (30%) of Spanish speaking respondents who answered "Other" in response to reasons why their children did not go to the dentist in the past twelve months. The responses were categorized by theme, with the following top 5 responses identified. For the English survey respondents, the largest response (27%) were free form comment noting they did not have children or was not applicable. Listed below are the following categories and responses:

English "Other" Responses to Reasons Why Member's Child/ Children Did Not Go to Dentist - Top 5 Response Categories		
Response Category	**%**	**Sample Responses**
Provider-Hard to Find	27%	"The dentist we had that would work with my son (special needs) passed away…difficulty finding one now." "Looking for a family dentist that not only participates with husky a but also husky c" "No one in my town is accepting Husky right now"
COVID-19 Closures & Safety	22%	"The pandemic closed our dental office" "Office was closed"
Positive Comment	8%	"Already went for cleaning" "They are all up to date with their dentist"
Other Priorities	**6%**	"Too many activities from school" "Caregiving for my dad and kids not in school, plus working" "Due to sports/school, and then also COVID, he is not able to go to the dentist"
Benefits- Limited Coverage for Braces	**3%**	"My child needs braces and there is no coverage" "Don't have money to pay for my son [to] have braces"
Accessibility Issues	**3%**	"No help in getting my special needs daughter to a special needs dentist. Issues is not transportation but her special need" "Chronic medical conditions greatly affect my mobility"

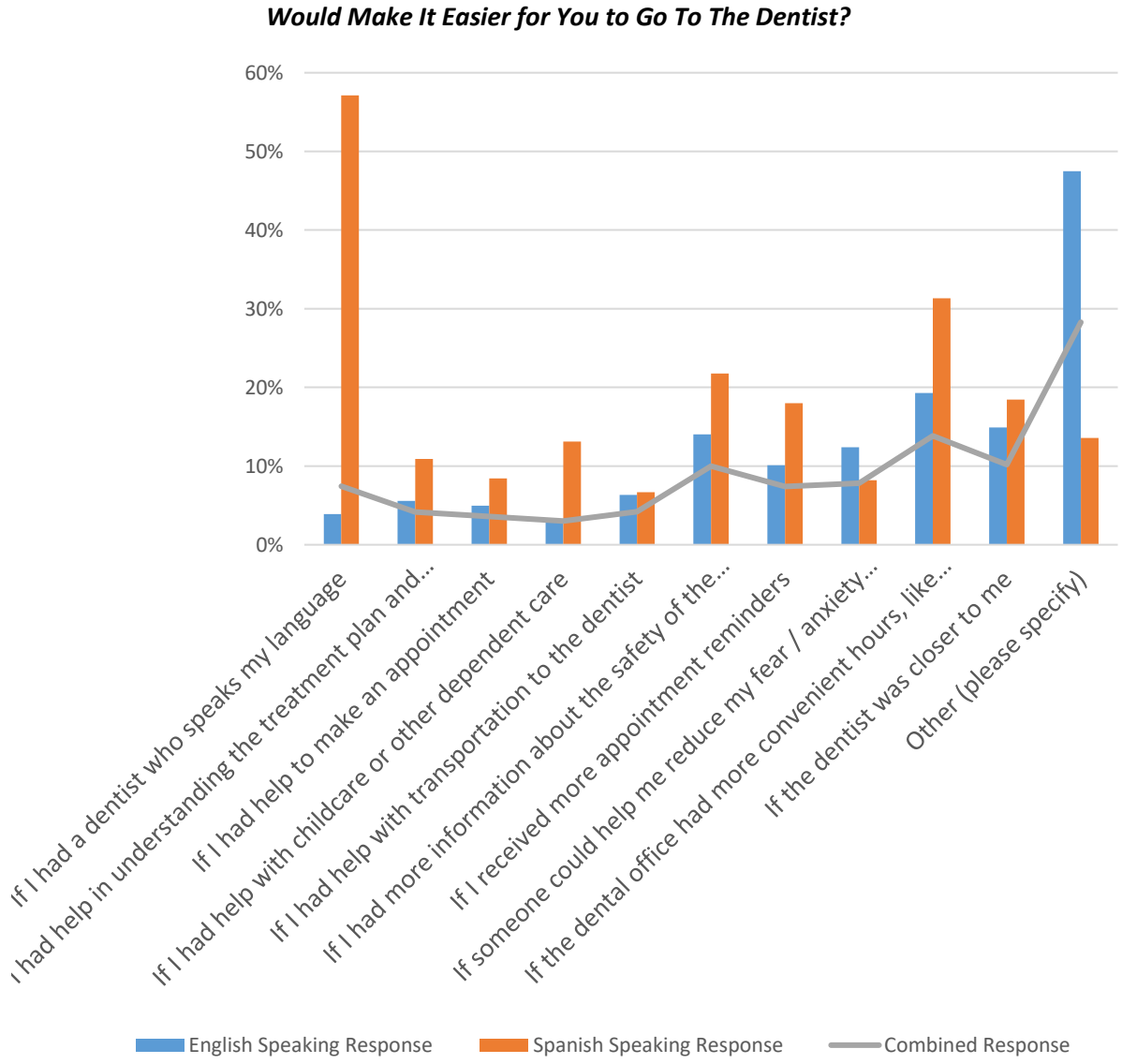
*CTDHP Dental Health Care Specialist assigned to survey response for follow up

Spanish "Other" Responses to Reasons Why Member's Child/ Children Did Not Go to Dentist - Top 5 Response Categories		
Response Category	**%**	**Sample Responses**
COVID-19	28%	"No dentist was available due to COVID -19" "The dentist was only seeing emergencies"
Children Too Young	17%	"My child is still a baby" "I have a baby"
Lack of awareness of Benefits	11%	"I don't think I have dental benefits"
Provider- Office Closure	11%	"The office was closed" "The office closed and have to look for another one"
Provider- Office Hours	6%	"The office hours are the same as my work hours"
Provider- Appointment Availability	6%	"They barely have appointments available for a cleaning. For example, I can call now and only be able to get an appointment 6 months from now"

Responses to "what would make it easier for you to go to the dentist"

Based on responses there is a slight divergence between the English and Spanish Speaking respondents in the top categories. Spanish speaker's top responses were 1) If I had dentist who speaks my language 2) If the dental office had more convenient hours and 3) If I had more information about the safety of dental offices regarding COVID-19. English speaker's top responses were 1) Other (see below for breakout) 2) If the dental office had more convenient hours like evenings or weekends and 3) If the dentist was closer to me.

The break out of structured responses is as follows:



There were 1,327 (47%) English speaking respondents and 61 (13.56%) of Spanish speaking respondents who answered "Other" in response to what would make it easier for you to go to the dentist.

English "Other" Responses to What Would Make It Easier for You to go to the Dentist		
Response Category	**%**	**Sample Responses**
Provider-Hard to Find	20%	"If more Dentist would accept Husky Adult insurance" "The online CTDHP SEARCH to find a participating dentist was not very helpful because most participating dentists only provide for children or persons under 21. It was difficult to find a new patient participating dentist for an Adult…."
Provider-Quality Issues	13%	"Finding a dentist that accepts husky that actually cares" "If more providers who accepted husky were trustworthy and experienced" "Not enough dentists except husky. The ones that did were either far from me or didn't make me feel comfortable"
Positive Statement	12%	"Having the dental plan is great" "No problem, we love our dentist" "I have no issues getting to the dentist with the husky options available to me" "Knowing the cost is covered. This is the first dental insurance I've ever had. Always paid out of pocket before"
Benefit-Limited Coverage	11%	"If I had money to pay for it, CT coverage doesn't cover enough of what is needed to properly treat patients, just cavities and extractions…It just not right dental care is important as regular health care" "I would like the dental coverage to pay for all dental work including 2 cleanings per year" "If the gap between what my dentists recommends and what husky insurance will pay for the shortened or at least explain to me that would be best.
Benefit-Costs	5%	"the main problem was the bill" "If Husky will pay more procedures that I am not able to pay" "If it was more affordable"

Spanish "Other" Responses to What Would Make It Easier for You to go to the Dentist		
Response Category	**%**	**Sample Responses**
Benefits-Limited	27.87%	"To have the HUSKY plan include more dental work such as, deep cleanings" "To have better coverage for treatments where a specialist is needed" "To expand your benefits that will include a cleaning for adults every six months not just once a year"
Provider-Quality	22.95%	"For the dental office staff and dentist to be more courteous and show that they want to help the patient and not treat me differently because I have HUSKY insurance" "To have an honest dentist that isn't just focused on performing additional dental procedures to get more money from HUSKY" "To have the dentist clearly explain and make sure I understand the treatment plan"
Provider-Hard to Find	14.75%	"To have more options of providers in my area and to cover more dental benefits" "Finding a dentist that accepts the plan for adults" "To have a dentist that has appointments available for adults"
Lack of awareness of Benefits	6.56%	"To understand what my dental plan covers every year" "I haven't used the dental benefits; I don't even know what they are" "If HUSKY had dental benefits"
Benefits-Costs	4.92%	"If I could afford to pay the additional cost at the dentist" "If I had help to pay for additional cost at the dentist'' "If dental procedures weren't so expensive"

Responses to "Is there anything else you would like to tell us about the HUSKY Health and the Connecticut Dental Health Partnership?"

Member were able to leave free form comments about their dental plan, dental services, and CTDHP in general. There were 1,781 English speaking responses, given time limitations and resources 1,440 were randomly selected to be tagged and categorized. 213 Spanish speaking responses, all answers were tagged. Answers were tagged by thematic category. Highlighted below are the top 5 categories in English and Spanish:

English Responses to "Anything else you would like to tell us about HUSKY Health and the CTDHP?"		
Response Category	**%**	**Sample Responses**
Limited Benefit	22%	"I think Husky should allow cleanings 2 times a year. A lot can happen in a year" "Due to the fact that Husky has a cap their dental payments to $1000 I now have to be selective on the dental work I have done as I don't have the funds to cover out of network costs" "Yes, we need more than just seeing the dentist for annual checkup. More services to be allowed for the older generation. Deep cleaning should be covered. When you need partials, the criteria is very high."
Provider-Hard to Find	13%	"I can't find a dentist to see my husband and me" "If more dental offices actually took the Husky insurance. The reason I didn't go to a dentist is because all the ones I tried either don't take Husky at all or don't take Husky for those over the age of 18 (I am 35). Update the list of dental providers that take Husky on the website would help too." "I think all dentists should require and take husky. It's hard to find dentists that take husky"
Positive Comment	10%	"No, it's an excellent plan for me and I very pleased with the all-around service" "This is the first time in my life that I needed dental help. The Husky experience has been amazing and gave me such confidence that my teeth were very well taken care of. Thank you" "I am deeply grateful for the help and services offered through HUSKY and CTDHP- I have had a lot of dental issues over the past couple of years, and I have received excellent help, with little or no issues at all- both from the dentist and Husky- Your services are the absolute best, THANK YOU!!!"
Provider-Quality	8%	"I'm disappointed at the quality of dental services for adults. On the other hand, I am impressed by the quality of health care services and dental services offered to my child" "Many of the participating dentists do not offer good quality services. I've been unhappy with many of the dentists work." "I know my dental care has suffered due to lack of quality care. It's nerve wracking enough to go to dentist- please don't align with dentists whose reviews rate them horribly…How can you expect people to trust that care and want to go"
Lack of Awareness of Benefits	4%	"I am going to have to look into it again. I thought I had zero coverage except for emergencies like getting a tooth pulled." "I didn't even know this existed. I'm going to seek more information now"

Spanish Responses to "Anything else you would like to tell us about HUSKY Health and the CTDHP?"		
Response Category	**%**	**Sample Responses**
Benefits-Limited	28.17%	"If the plan could cover crowns and other procedures that would help maintain our natural teeth, and not only leave us with the option of needing to have the tooth extracted instead." "That you would provide more economic aid for dental health needs to the poor older adult population. Sometimes, we do not smile because we're missing a tooth and we cannot afford to pay for it because it is very expensive." "The points system for children's braces is very high and inconvenient for the poor parents who want to be able to do the best for our children's dental needs that are not cosmetic. It would be helpful if the point system is lowered, even if we pay a percentage of the cost, but at least to be able to have an option to fix our children's teeth.
Positive Comment	24.88%	"I like this HUSKY insurance. I am very pleased to have a health insurance where I can take care of my medical needs, like my physical and dental needs. Thank you, Husky." "I am very satisfied and understand that at this time the state is making great efforts to keep us with our health insurance. God bless you all always." "We are in a difficult time, but thanks for always worrying about our family and our children so much. Thank you, HUSKY health."
Lack of awareness of Benefits	7.04%	"Does HUSKY only cover cleanings?" "What type of coverage do we have with dental? You need to inform us better of what our coverage is and we need to have better access to the information." "I don't understand much about the limit per year, but I have problems with my gums and nobody can tell me what it is and that has caused me dental problems. The year just started and I apparently already reached the spending limit."
Provider-Quality	5.63%	"The HUSKY plan is a blessing to me, but the dentists who work for you make us wait 2 hours and do a bad cleaning in10 minutes, but they go ahead and charge you as if they have done an excellent job." "That I would like the dental insurance to be accepted at more dental clinics and for those dentists to do good work with their patients. The doctors of these clinics seem to charge more money and treat the husky patients poorly and some don't even want to take in HUSKY members." "The people who have HUSKY health are treated differently. It's been more than two years that I can't go to the dentist because the dentists in my area are not professionals."
Provider-Hard to Find	4.69%	"I would like to know if there are any dentists close to my area. My child and I would like a cleaning and a dental exam because we really need it. It's hard to find an office that speaks Spanish and I would like to speak in Spanish because I do not understand English, thanks."

		"I have a hard time finding good dentists who accept this insurance and if there is one, I have to wait a long time for an appointment because they are very few of them. They usually do not give the care that should be given because they get paid very little and they do a fast and not so well job." "There should be access to members of available dental offices by area. It is very difficult to get a dentist that accepts the plan and some don't take new patients."

Key Takeaways:

1) Members and their children report going routinely to the dentist as very important.
2) Dental closure during the height of the COVID-19 pandemic and safety concerns relative to seeing the dentist were predominant barrier to services.
3) Members identified alternative hours (weekends, evenings) as a way to make it easier to go the dentist.
4) Spanish speaking members identified having a provider that speaks their own language as a way to make it easier to go the dentist.
5) Overwhelmingly, finding a quality provider that accepts adult HUSKY Health patients was a key challenge for both English and Spanish speaking respondents. Variations on the theme of "hard to find" providers included challenges using provider location tools, dentists that members currently use and have established trust do not take HUSKY insurance, and challenges finding dentists in their location.
6) Members also identify costs, particularly for adults, as a barrier to services. Articulated in predominantly two ways, members are challenged by paying for non-covered services or certain services should either be covered by HUSKY without prior authorization or covered in general. Namely twice annual cleanings for adults, root canals, implants, deep cleaning, mouth guards and changes to denture refit and replace policies. Specific to children, braces coverage was highlighted.
7) Members have a lack of awareness of having HUSKY Health dental insurance, knowing the plan benefits, and how to utilize the benefit.

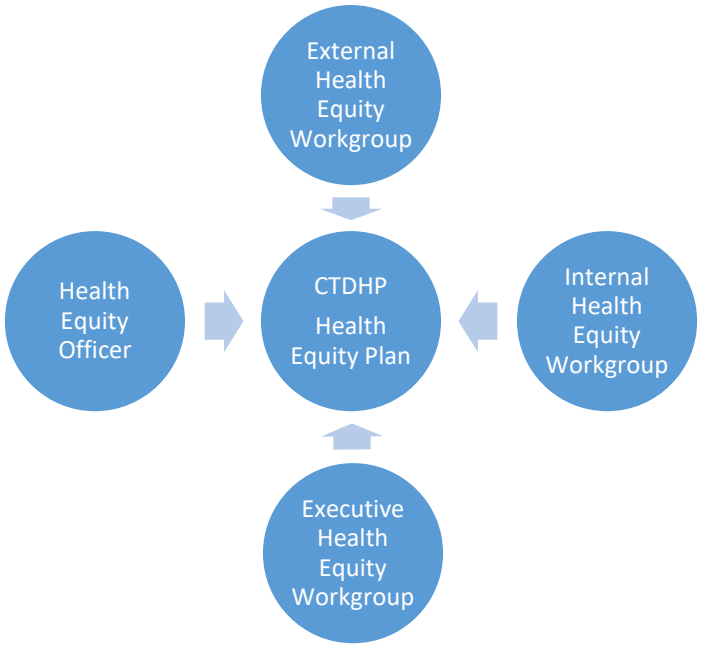
Exhibit I: CTDHP Efforts to Develop the Oral Health Equity Plan

CTDHP is committed to ensuring that access and availability of oral health services are fairly distributed across the CT Medicaid population. Achieving oral health equity requires us to develop internal and external partnerships committed to pursuing and addressing our oral health equity goals and social determinants of health factors to care that arise within our member population. The establishments of three health equity workgroups, led by CTDHP's Health Equity Officer, were essential to leverage strengths of each partner and apply them strategically to make lasting progress on issues related to member oral health care needs and barriers to care. The workgroups were engaged throughout the Health Equity Planning process were particularly focused on creating solutions that aligned to CTDHP's work and ensure our goals are meaningful and actionable. These workgroups will continue to build upon transparency and accountability within our Oral Health Equity work to build trust, demonstrate integrity and strengthen our relationships.

Goals included;

- Improve our chances of making meaningful changes in community conditions by gaining community members' trust in a broad-based coalition of partners.
- Increase understanding of a community's needs and assets.
- Improve internal policies and processes.
- Share or develop the necessary resources for action and problem solving.
- Minimize duplication of effort and services.
- Recruit participants from diverse backgrounds and with diverse experiences.
- Promote community-wide change through the use of multiple approaches proposed by representatives from different sectors of the community.

CTDHP Workgroup Structure:



The workgroup composition is as follows:

CTDHP Internal Workgroup	
Goals	• Support execution of the internal assessments including CLAS standards. • Provide edits, feedback, and thought partnership on the Healthy Equity Plan with particular focus on action plans to reduce disparities and gaps internally and externally. • Transition from a planning workgroup in 2021 to an implementation workgroup 2022-2023 to provide support to reduce barriers encountered during implementation, and own tasks of the plan.
Composition	• Representation from all CTDHP work units regardless of role • Internal Workgroup members: o Call Center/Member Services: Paulette Sapp o Grievance and Appeals: Magdalena Carter + Christine Boisvert o Provider Relations: Norma Listro o Care Coordination and Outreach: DHCS Elaine Spinato + Sandra Sapere
Meeting Structure	• Internal Workgroup kicked off on 12.9.20 and has met 7 times since. o Monthly general meeting o Breakout groups as needed based on the work to be supported
Outputs	The Internal Workgroup supported efforts on: • CTDHP's Health Equity and Oral Health Equity Definitions o Review/Feedback • Organizational Assesment of Cultural Linguistic Appropriate Services (CLAS) o Departmental gaps & action plan • Social Determinants of Health (SDOH) Member Survey o Survey questions & execution • High Impact 25 o Tactics to increase member dental utilization rates

CTDHP Executive Workgroup	
Goals	• Receive status updates on planning processes including barriers, risks, and problems. • Mitigate barriers, risks, and problems. • Provide thought partnership and feedback on both process and plan.

Composition	• Representation from CTDHP executive team
	• Executive Workgroup members:
	  ○ President & CEO BeneCare: Lee Serota
	  ○ Director Operations: Paul Lanza
	  ○ Director Care Coordination and Outreach: Kate Parker-Reilly
	  ○ Director Community Engagement: Marty Milkovic

Meeting Structure	The Governance Executive Group kicked off on 12.16.20 and has met 5 times since. • Monthly general meeting • Breakout groups as needed based on the work to be supported
Outputs	The Governance Executive Group supported efforts on: • Executive Group Approval/Endorsement to Adopt Center for Disease Control (CDC) Health Disparities, Health Equity & Health Inequity Definitions. • Oral Health Equity Workgroups: Review/Feedback/Approval of Oral Health Equity Workgroup Compositions • CLAS Action Plan Recommendations: Review/Feedback/Implementation/Approval • CT Dental Workforce racial and ethnic data: Review/Feedback/Approval • Member Survey: Content/Review/Implementation/Execution • Utilization Data Analysis – High Impact 25: Review/Feedback/Implementation/Approval

CTDHP External Workgroup	
Goals	• Support execution of the external assessments including member survey and community-based organization survey. • Provide edits, feedback, and thought partnership on the health equity data analysis, CLAS assessment outcomes. • Identify interventions and actions to reduce disparities • Transition from a planning workgroup in 2021 to an implementation workgroup 2022-2023 to provide support to reduce barriers encountered during implementation, and own tasks of the plan. • Build/foster external partnerships that support CLAS and Health Equity work.

Composition	• No more than ten members from organizations that serve HUSKY Health member communities.
	• Community Champions - identified by the DHCS
	• Organizations that work with Community Health Workers
	• Members:
	  ○ Awilda Maldonado- CTDHP Health Equity Officer
	  ○ Christy Georgeoulis- Institute for Communities
	  ○ Kari Cifarellie-MOMS Partnership Program
	  ○ Heloise Nana- City of Stamford, Stamford Library
	  ○ Pareesa Charmchi Goodwin-CT Oral Health Initiative, Inc.
	  ○ Hope Mitchell-Williams-CT Dept. of Social Services
	  ○ Dr. Donna Balaski- CT Dept. of Social Services
	  ○ Dr. Darnell Young- Elm Family Dental
	  ○ Lee Serota- BeneCare Dental Plans
	  ○ Paul Lanza- CTDHP
	  ○ Marty Milkovic- CTDHP
	  ○ Kate Parker-Reilly-CTDHP

Meeting Structure	• External Workgroup kicked off on 3.12.21 and has met 2 times since. ○ Every other month meeting cycle
Outputs	• CTDHP's Health Equity and Oral Health Equity Definitions Review/Feedback • CLAS Action Plan Recommendations Review/Feedback • CT Dental Workforce racial and ethnic data Review/Feedback • Social Determinants of Health Member Survey Review/Feedback • Utilization Data Analysis – High Impact 25 Review/Feedback on methodology/tactics on improving member utilization rates

Exhibit II: CLAS Standards-Current State at CTDHP

A key tool to help asses CTDHP's year-long effort to develop a Health Equity Plan (HEP) are the National Standards for Culturally and Linguistically appropriate Services (CLAS). The CLAS Standards are comprised of 15 Standards that provide a blueprint for community-based organizations and health care organizations to implement culturally and linguistically appropriate services that assist in the advancement of health equity, improved quality and help eliminate health care disparities. The CLAS standards represent a path to correcting current inequities in the provision of healthcare services and to making those services more responsive to the needs of individuals of all cultural and linguistic backgrounds. Although the standards are meant to be inclusive of all cultures, they are designed to address in particular the needs of racial, ethnic, and linguistic population groups that may experience unequal access to healthcare services. The findings of the CLAS assessment allows CTDHP to prioritize approaches to meeting these needs. The information we draw to define these needs will come from existing data we collect through surveys and other surveillance methods, as well as data collected by outside organizations.

Initial Outcomes of Organizational CLAS Standards Assessment Method

As one of its first actions the CTDHP external oral health equity work group completed the internal self-evaluation tool that aligns with the CLAS standards. The toolkit, adapted from the Connecting to Care Health Equity Toolkit, a part of the federally-funded Connecting to Care initiative, supports a critical reflection of CTDHP efforts to date and provides insight into areas in need of improvement to meet the CLAS standards. The assessment asks the respondent to determine if CTDHP has Met, Partially Met, or Not Met each statement provided.

The results of the assessment, and definitions of met, partially met, or not met are identified below:

Standard Not Met	No work is in progress or established as "standard work". Work plan and project needs to be designed, developed, and implemented.
Standard Partially Met	Considered a "work in progress" evidenced by work plans of project efforts underway, or is standard work but in place informally and needs documented processes.
Standard Met	Considered "standard work" evidenced by well documented processes, regular review and updating, and engrained into workforce via communications channels and general understanding of the work on a day-to-day basis.

Cultural Competence Survey Results	
Not Met	The organization has a Health Equity Plan (HEP) (i.e., cultural competency plan, etc.).
	Employees of the organization reflect the diversity within the community.
	The program supports/provides employees training on how to work with sign and spoken language interpreters.
	The program has conducted a survey among its clients to determine if the program and its employees are perceived as being inclusive of diverse populations.
	CTDHP Program services are designed and evaluated with direct input from client populations and representatives in their support systems.
	Organizational programs conduct outreach efforts appropriate for the populations in the service area and engages diverse populations for meaningful participation in services offered (e.g., advisory board, peer support program).
	The organization reflects its commitment to cultural and linguistic competence in all policy and practice documents including its mission statement, strategic plan, and budgeting practices.
Partially Met	The program has a process in place for assessing the cultural competencies of employees and a mechanism to support and monitor continuous professional development.
	The organization has implemented the use of evidence-based practices or best practice guidelines appropriate for the populations served (and you can identify the source of the guidelines).
	The organization is responsive (removes barriers) to the variety of social, educational, economic, and other stressors that populations may experience as barriers to achieving desired program outcomes.
	The organization communicates its progress in implementing and sustaining cultural and linguistic competencies to all stakeholders, constituents, and the general public.
Met	A process is in place for ensuring language competence of employees who identify themselves as bi - or multilingual and provide interpretation and/or translations services on behalf of the organization.
	The program has a process to ensure informational and educational materials are culturally appealing and easy to understand by the populations served.
	The organization collects client outcome data and monitors outcomes by demographics characteristics to ensure equitable access to, and delivery of services (e.g., completion rates by race, met treatment plan goals by sex).
	The program has a process in place to access (internally and externally) spoken and sign language interpretation (spoken and sign) and translations (written) services.