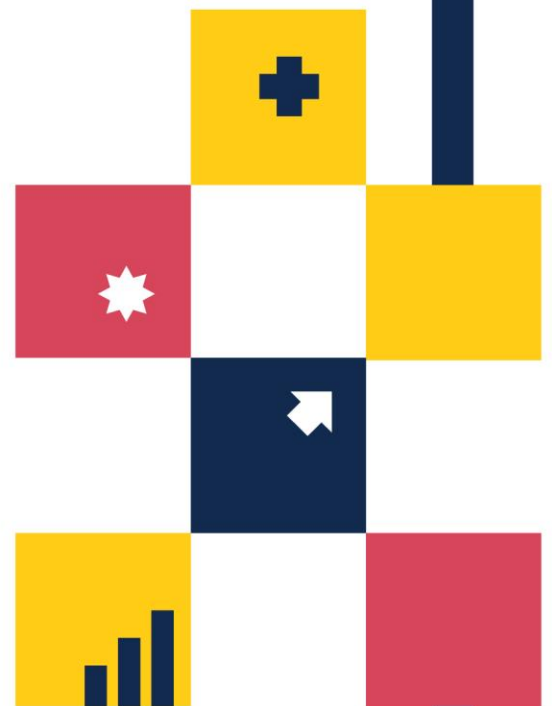


# HB 309/SB 565

## HEALTH DISPARITIES LEGISLATIVE REPORT



December 2021

**Maryland Department of Health**  
Dennis Schrader, Secretary of Health

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## Table of Contents

Executive Summary	3
Introduction	4
Background	5
Definitions of Health Equity and Health Disparity	5
Maryland Demographics	6
Selected Examples of Racial/Ethnic Health Disparities in Maryland	6
Recent Health Equity Work in Maryland	8
Approach	9
Findings	10
Recommendations	13
Limitations	16
Appendix A	18
HB 309/SB 565 Public Health - Data - Race and Ethnicity Information Gathering	
Appendix B	24
List of Programs Submitted	
Appendix C	29
Executive Memorandum Sent to MDH Units	
Appendix D	30
Data Collection Tool Provided to Respondents	

### Acknowledgment

The Office of Minority Health and Health Disparities (OMHHD) and the Maryland Health Care Commission (MHCC) thank the individuals that took the time to respond to the questionnaire. The valuable information provided by more than 150 individuals made this report possible. Although OMHHD and MHCC tried to develop a short questionnaire, we recognize that many respondents took considerable time to provide a thorough response.

## Executive Summary

Health disparities and health inequities refer to differences in health outcomes that have their origin in some form of injustice: racism, discrimination, exclusion, or in social, economic and/or environmental disadvantages. Health disparities are seen in the areas of death rates, health care utilization rates, disease frequency and severity, risk factor prevalence, and access to health care. In Maryland these disparities are largest for health care utilization, birth outcomes, and certain death rates.

Health disparities have as their root causes adverse social determinants of health. According to the U.S. Department of Health and Human Services (DHHS) social determinants of health (SDOH) are defined as factors that affect an individual's wide range of health, life outcomes, and risks based on several environmental factors including where they live, were born, religion etc. Over the past several years various legislative initiatives have been established in Maryland to address health disparities. These include the establishment of the Office of Minority Health and Health Disparities (OMHHD) in Maryland Department of Health (MDH) in 2004, the creation of the Health Enterprise Zone program in 2012, and the Health Equity Resource Community Program and the Maryland Health Equity Commission established by legislation in 2021.

In 2021, HB309 and SB565 called for a renewed focus on the collection of race and ethnicity data to support the State's ability to address health disparities. Section 2 of the legislation requires the OMHHD, in coordination with the Maryland Health Care Commission (MHCC) and the MDH, to submit to the General Assembly a plan that reflects the State's current goals and implementations to eliminate minority health disparities. As a first step to respond to the new legislation, the OMHHD, MDH, and MHCC collaborated to develop and administer a questionnaire to obtain descriptive information on all MDH programs that directly or indirectly address the needs of Maryland's vulnerable populations. Over 150 MDH respondents submitted information on 405 program activities covering a wide range of medical conditions and health concerns. Program information was organized into a uniform and concise format with the intent to establish a statewide resource that could be accessed by MDH Units, consumers, and other stakeholders. It became clear early on that much more work was needed to capture useful program performance data to support a meaningful and searchable database. Staff continue to work towards building that comprehensive MDH program catalogue, but this report provides the following four basic recommendations from lessons learned.

1. Invest in the infrastructure for standardized Race/Ethnicity data collection across all MDH Units,
2. Identify tools for measuring social determinants of health (SDOH) to inform health equity work across the state,
3. Require the collection of race and ethnicity data through the health boards' licensure application and renewal process and invest in the infrastructure to ensure data sharing, and
4. Work closely with the newly established Health Equity Commission to inform this work going forward.

## Introduction

This report contains the initial Maryland Department of Health (MDH) response to the following legislative expectations from

SB565/HB309 (Sections 2 and 3 of the bill).

Specifically:

1. That, on or before December 31, 2021, the Maryland Office of Minority Health and Health Disparities shall (OMHHD), in coordination with the Maryland Health Care Commission (MHCC) and the (MDH), submit to the General Assembly a plan that reflects the State's current goals and implementations to eliminate minority health disparities.
2. That, on or before January 1, 2022, the OMHHD shall, in coordination with the MHCC and the MDH, establish, submit to the General Assembly, and implement a plan for: (1) improving the collection of health data that includes race and ethnicity information in the State; (2) ensuring that the Office has access to up-to-date health data that includes race and ethnicity information; (3) to the extent authorized under federal and State privacy laws, posting health data that includes race and ethnicity information on the Office's website; and (4) updating the data on the Office's website at least once every 6 months.

This report focuses primarily on establishing an inventory of currently implemented MDH programs that have either the stated goal of or the indirect effect of reducing health disparities in Maryland. The manpower resources required to meet the legislative expectations stated above in six months simply were not available in the face of continued staff time involvement in ongoing COVID-19 response to an evolving and yet to be controlled pandemic.

Regarding a plan for elimination of minority health disparities, a similar charge with a due date of December 1, 2023, has been given to the newly established Maryland Commission on Health Equity. Comprehensive planning for health disparity elimination requires sufficient time to involve the relevant stakeholders, and sufficient funding to be able to deliver the required interventions and could not be completed by December 31, 2021. MDH intends to drive this comprehensive planning process through the Maryland Commission on Health Equity along the timeline specified in its establishing legislation. This will allow the plan to fully address the Social Determinants of Health in a Health in All Policies approach across all executive cabinet agencies. Doing this as a single planning process will avoid the production of duplicative, redundant, or inconsistent multiple plans.

Developing an achievable and well thought out plan takes time and input from all stakeholders; therefore, it is best suited to be done under the direction of the Maryland Commission on Health Equity. That being said, the main issues requiring resolution to achieve better, and more complete racial/ethnic data collection and reporting include:

1. Improving the format and completeness of racial data collection at the point of client contact for healthcare providers, hospitals, health insurers, health professions boards, etc. And one limitation is that clients can always opt out of responding.
2. Assuring that MDH and external partner data systems collect and store race/ethnic data according to the OMB Directive No. 15<sup>1</sup> guidelines as a minimum. This could require some significant re-tooling of legacy data systems.
3. Improving the approaches to race/ethnic data analysis and reporting done by the custodians of our various health outcome data systems.
4. Streamlining data sharing agreement processes, or providing secure web-access portals, so that data can be analyzed outside of the original custodian organizations.
5. Obtaining social determinant of health data sets and developing approaches to merging those social determinant data with our existing health outcome data to assess the contributions of adverse social determinants to adverse health outcomes, and to estimate the potential benefit of various interventions to correct adverse social determinants.
6. Full staffing of OMHHD to enable the Office to perform the data assembly, analysis and report writing function required for a six-month cycle of data updates on its website.

These data improvement goals are also assigned to the Maryland Commission on Health Equity, and its prescribed Data Advisory Committee. Working with the new Data Office in MDH, that committee will be examining the methods for constructing the Health Equity Data Set that merges social determinant data with health outcome data. It will also address questions of where to house the data in an integrated fashion among MHCC, HSCRC, CRISP, and MD-THINK. The work of the Maryland Commission on Health Equity, and its prescribed Data Advisory Committee is the natural place to execute the data improvement aims of SB565/HB309.

Therefore, this report primarily focuses on presenting the inventory of MDH programs and implementations that have either the stated goal of or the indirect effect of reducing health disparities in Maryland. It also contains comments and recommendations regarding steps for improving data collection, analysis, and reporting.

## **Background**

For the purpose of this report, the term “Units” is used to describe all organizations within the Department of Health (MDH) even though the official title may include bureau, commission, department, division, or office.

### **Definitions of Health Equity and Health Disparity**

The U.S. Federal Government’s Health and Human Services program “Healthy People” defines health equity as

“... the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address

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<sup>1</sup> See for example <https://wonder.cdc.gov/wonder/help/populations/bridged-race/directive15.html>

avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”

Healthy People defines a health disparity as

“... a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”<sup>2</sup>

While the term “health disparities” is often used or interpreted to reflect differences between racial or ethnic groups, this definition shows that disparities can exist across many other dimensions as well, such as gender, sexual orientation, age, disability status, socioeconomic status, and geographic location. Efforts to reduce health disparities focus on designated priority populations, including people of color, low-income populations, women, children/adolescents, elder, individuals with special needs, and individuals living in rural and inner-city areas. These groups are often not mutually exclusive and intersect in various ways.

### **Maryland Demographics**

According to the U.S. Census, the total population estimate for the state of Maryland in 2019 was 6,045,680. About 15.9% of the population are adults 65 years old or above.

Regarding proportion of population that is racial/ethnic minority:

- 50.0% of the population is Non-Hispanic (NH) White, therefore
- 50.0% of the population is racial or ethnic minority
- 10.6% of the population is Hispanic or Latino
- 2.9% of the population is multi-racial. Of the 97/1% reporting only one race<sup>3</sup>
- 58.5% are White
- 31/1% are Black or African American
  
- 0.6% are American Indian or Alaska Native (note that multiracial status is very common in this group, so the proportion with some ancestry in this group will be larger)
- 6.7% are Asian
- 0.1% are Native Hawaiian or Other Pacific Islander (note that multiracial status is very common in this group, so the proportion with some ancestry in this group will be larger)

### **Selected Examples of Racial/Ethnic Health Disparities in Maryland**

**Death rate disparities.** For some leading causes of death, Maryland has seen improvement in some Black vs. White disparities, but they have not been eliminated.

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<sup>2</sup>Healthy People 2030 Questions & Answers | Health.Gov. <https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2030/questions-answers#q9>. Accessed 8 Dec. 2021.

<sup>3</sup> U.S. Census Bureau QuickFacts: Maryland. <https://www.census.gov/quickfacts/MD>. Accessed 8 Dec. 2021.

Compared to Non-Hispanic Whites, the death rates for Non-Hispanic Blacks are:<sup>4,5</sup>

- 1.1 times as high for deaths from all causes
- 1.1 times as high for heart disease
- 1.0 times as high for cancer
- 1.3 times as high for stroke
- 1.9 times as high for diabetes
- 12.3 times as high for HIV
- 14.4 times as high for homicide

**Utilization rate disparities** tend to be some of our largest.

For example, the rates of ED visit comparing Non-Hispanic Blacks to Non-Hispanic Whites are:<sup>6,7</sup>

- 2.9 times as high for Asthma
- 3.0 times as high for Diabetes
- 3.6 times as high for High Blood Pressure

Disparities in deaths and utilization stem in part from **disparities in the frequency of diseases**. For example, in the prevalence of Diabetes, NH Black prevalence is 66% higher than NH White prevalence, while NH Asians and Hispanics are 21% and 17% higher, respectively.<sup>8</sup>

**Health insurance disparities** are a driver of disparities in disease frequency and disease severity. The rate uninsured, compared to Non-Hispanic Whites, is<sup>9</sup>

- 7.1 times as high for Hispanics (regardless of race)
- 1.9 times as high for Blacks (regardless of Hispanic ethnicity)
- 1.9 times as high for Asians (regardless of Hispanic ethnicity)
- 2.5 times as high for American Indians/Alaska Natives (regardless of Hispanic ethnicity)
- 3.6 times as high for Native Hawaiians/Other Pacific Islanders (regardless of Hispanic ethnicity)

Disease frequency and severity are **products of social factors**. For example, income is a strong determinant of health. For diabetes prevalence, higher income means lower diabetes prevalence for both NH Blacks and NH Whites. However, at every level of income, NH Black prevalence is higher. In addition, the gap between Blacks and Whites is larger at higher

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<sup>4</sup> "Maryland Department of Health Reports." *Maryland.Gov Enterprise Agency Template*, <https://health.maryland.gov/vsa/Pages/default.aspx>. Accessed 8 Dec. 2021.

<sup>5</sup> Neall et al. - *Maryland Department of Health Vital Statistics Adm.Pdf*. <https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2019Annual.pdf>. Accessed 8 Dec. 2021.

<sup>6</sup> "Maryland Department of Health Reports." *Maryland.Gov Enterprise Agency Template*, <https://health.maryland.gov/vsa/Pages/default.aspx>. Accessed 8 Dec. 2021.

<sup>7</sup> "Pages - SHIP Lite Home." *Maryland.Gov Enterprise Agency Template*, <https://health.maryland.gov/pophealth/Pages/default.aspx>. Accessed 8 Dec. 2021.

<sup>8</sup> *Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Center for Disease Control and Prevention, [2019].*

<sup>9</sup> *Census - Table Results*. <https://data.census.gov/cedsci/table?q=Health%20insurance%20rates&g=0400000US24&tid=ACSST5Y2019.S2701>. Accessed 15 Dec. 2021.

incomes: somehow, increasing income protects Whites better than it protects Blacks for this outcome. Finally, NH Blacks are 2.7 times as likely to be in the sickest and lowest income group, and 40% less likely to be in the healthiest and highest income group.<sup>10,11,12</sup>

*Because American Indians are only 1% or less of the Maryland population, some of our data systems are unable to produce reliable data for that group.*

Below are some infant outcomes disparity data<sup>13</sup>

Compared to Non-Hispanic Whites, infant mortality rates are

- 2.3 times as high for NH Blacks
- 1.4 times as high for Hispanics
- similar to NH Whites for NH Asians
- similar to NH Whites recently for NH American Indians (was higher previously)

Compared to Non-Hispanic Whites, low birth weight rates are

- 1.9 times as high for NH Blacks
- 1.1 times as high for Hispanics
- 1.3 times as high for NH Asians
- 1.2 times as high for NH American Indians

Compared to Non-Hispanic Whites, rates of late or no prenatal care are

- 2.0 times as high for NH Blacks
- 2.6 times as high for Hispanics
- slightly less than NH Whites for NH Asians
- 1.4 times as high for NH American Indians

### Recent Work in Health Equity in Maryland

- Health equity emphasis in the Cigarette Restitution Fund legislation:
  - Establishment of the Minority Outreach & Technical Assistance Program (MOTA)
  - Establishment of local cancer and tobacco coalitions with a minority focus
- Legislation in the 2004 Maryland General Assembly session that established the Office of Minority Health and Health Disparities (MHHD) in the MDH
- The Maryland Health Improvement and Disparities Reduction Act of 2012 which:
  - Established the successful four-year Health Enterprise Zone Program
  - Required a variety of health equity data collection and reporting enhancements from MHCC, HSCRC, hospitals, health insurers, and institutions of higher education in the health professions

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<sup>10</sup> Maryland Diabetes Action Plan, Figures 19, 20 on pages 26, 27

<sup>11</sup> "Pages - Diabetes Action Plan." *Maryland.Gov Enterprise Agency Template*, <https://health.maryland.gov/phpa/ccdpc/Pages/default.aspx>. Accessed 8 Dec. 2021.

<sup>12</sup> *Diabetes Action Plan June 1 2020.Pdf*. <https://health.maryland.gov/phpa/ccdpc/Documents/Diabetes%20Action%20Plan%20documents/Diabetes%20Action%20Plan%20June%201%202020.pdf>. Accessed 8 Dec. 2021.

<sup>13</sup> "----." *Maryland.Gov Enterprise Agency Template*, <https://health.maryland.gov/vsa/Pages/default.aspx>. Accessed 8 Dec. 2021.

- Legislation from the 2021 Maryland General Assembly session:
  - HB 463 / SB 172 Maryland Health Equity Resource Act which enables a process to designate and fund “Health Equity Resource Communities” that are like the previous Health Enterprise Zones.
  - HB 78 / SB 52 (The Shirley Nathan-Pulliam Health Equity Act of 2021) which established the Maryland Health Equity Commission to promote a health in all policies approach to health equity, develop a statewide health equity data set, produce analysis from those data, and to develop a statewide health equity plan.
  - **HB 309/SB 565 Public Health – Data – Race and Ethnicity Information** requiring the State to collect data pertaining to current disparity reducing policies and implementations, and to develop a goal-oriented plan addressing these health disparities by the end of the 2021 calendar year. It is this task that is taken on by the OMHHD, MHCC, and MDH.

## Approach

In June 2021, OMHHD and MHCC created a draft questionnaire, the Vulnerable Populations Questionnaire (VPQ), for the collection of data on all MDH programs that provide services to vulnerable populations. The survey was distributed broadly to all MDH Units to shift the mindset of program managers to view the goal of reducing health disparities as a fundamental component of all programs that serve to improve the lives of vulnerable populations. An off the shelf survey tool was identified to accommodate the immediacy of this data collection effort. MDH Units were provided two methods to electronically submit responses and a hardcopy of the questionnaire was also made available to permit coordination of data submission within Units. The VPQ was fielded tested with three Units including MHCC’s Center for Quality Measurement and Reporting, OMHHD, and the Maryland Primary Care Program. Input from the field test was used to further refine the questions. Prior to the release of the VPQ, Secretary Schrader sent a communication requiring the participation of all MDH organizational units due to the importance of the project. Throughout the survey period, staff were available to answer questions about the questionnaire.

To increase the response rate and facilitate the accuracy and completeness of responses, MHCC initiated calls to programs that did not meet the established deadline. Individual conference calls were held with Units with multiple programs and technical assistance was provided to all Units upon request. Despite staff efforts, a limited number of Units did not respond to staff outreach. The questionnaire and official communications that were sent to the MDH organizational Units are included in the Appendices.

When analyzing the data, staff had to review the websites of several programs to glean more information. At times, internet searches had to be used to learn more about submitted programs. Some programs were very descriptive in the information they provided while others were not as detailed. All information received was archived as it came; however, to ensure accuracy in reporting the findings for this report, staff removed duplications from calculations.

## Findings

Responses were received from over 150 respondents identifying 405 programs that attempt to address vulnerable populations in Maryland. For the purposes of this report, programs were organized by jurisdiction and whether a reported program aligns with the Statewide Integrated Health Improvement Strategy (SIHIS). In 2019, the State collaborated with the Center for Medicare and Medicaid Innovation (CMMI) to establish the SIHIS.<sup>14</sup>

### What is SIHIS

The State of Maryland and the Centers for Medicare & Medicaid Services (CMS) have executed a memorandum of understanding to create a **SIHIS**. SIHIS is an extension of the Total Cost of Care (TCOC) Agreement and is intended to focus statewide efforts on transforming health care delivery across the State, reducing healthcare disparities, and improving population health. Maryland’s SIHIS efforts span three domains. CMS will be measuring Maryland’s progress towards these goals between 2021-2026.

Domain Area	Statewide Goal(s)
<b>Domain 1 – Hospital Quality</b> Establish enhanced hospital quality targets that build on historical performance targets to drive continued improvement in care quality.	<ul style="list-style-type: none"> <li>● Reduce avoidable admissions</li> <li>● Improve Readmission Rates by Reducing Within-Hospital Disparities</li> </ul>
<b>Domain 2 – Care Transformation Across the System.</b> Expand care coordination activities and value-based payment models that incentivize better outcomes.	<ul style="list-style-type: none"> <li>● Increase the amount of Medicare TCOC or number of Medicare beneficiaries under Care Transformation Initiatives (CTIs), Care Redesign Program, or successor payment models</li> <li>● Improve care coordination for patients with chronic conditions</li> </ul>
<b>Domain 3 • Domain 3 “Total Population Health” – A statewide approach to improve health outcomes for Marylanders in three health priority areas:</b>	
<b>Domain 3 – “Diabetes”</b>	<ul style="list-style-type: none"> <li>● Reduce the mean BMI for adult Maryland residents</li> </ul>
<b>Domain 3 – “Opioid Use Disorder”</b>	<ul style="list-style-type: none"> <li>● Improve overdose mortality</li> </ul>
<b>Domain 3 – “Maternal and Child Health”</b>	<ul style="list-style-type: none"> <li>● Reduce severe maternal morbidity rate</li> <li>● Decrease asthma-related emergency department visit rates for ages 2-17</li> </ul>

Additional consideration was given to programs that prioritize cardiovascular disease, cancer, and mental/behavioral health as the aforementioned are also top reasons for morbidity and

<sup>14</sup> *SIHIS Proposal - CMMI Submission 12142020.Pdf*. <https://hsrc.maryland.gov/Documents/Modernization/SIHIS%20Proposal%20-%20CMMI%20Submission%2012142020.pdf>. Accessed 8 Dec. 2021.

mortality. Approximately 16% (65/405) of programs explicitly targeted the SIHIS domain goals. Another 21% (84/405) of programs reported addressing cardiovascular disease, cancer, and mental/behavioral health. The remaining roughly 75% (304/405) of programs had goals and objectives categorized as “Other” by this report. Several conditions were collapsed into “Other” included sexual health, other chronic diseases, physical disability, communicable diseases, and substance use disorder broadly. It is important to note that condition groupings are not mutually exclusive. As such, about 12% (50/405) of programs had more than one condition focus.

Respondents identified which jurisdictions were served by each program choosing from a list of each Maryland county, “All Counties” or “Other” with a write in option. About one third (134/405) of programs stated they provide services to all counties. Below, Table 1 demonstrates the number of total programs by county, which includes both programs that are implemented statewide and programs that only serve certain counties. Table 2 exhibits just the number of programs that serve each county specifically. For example, Allegany County residents have access to services from 144 MDH statewide implemented programs of which 10 programs are unique to Allegany.

**Table 1**

<b>Number of Total Programs by County*†</b>		
<b>Allegany: 144</b>	<b>Charles: 159</b>	<b>Prince George’s: 159</b>
<b>Anne Arundel: 164</b>	<b>Dorchester: 159</b>	<b>Queen Anne’s: 170</b>
<b>Baltimore: 173</b>	<b>Frederick: 170</b>	<b>St. Mary’s: 148</b>
<b>Baltimore City: 198</b>	<b>Garrett: 145</b>	<b>Somerset: 171</b>
<b>Calvert: 143</b>	<b>Harford: 169</b>	<b>Talbot: 145</b>
<b>Caroline: 153</b>	<b>Howard: 186</b>	<b>Washington: 168</b>
<b>Carroll: 172</b>	<b>Kent: 156</b>	<b>Wicomico: 179</b>
<b>Cecil: 181</b>	<b>Montgomery: 165</b>	<b>Worcester: 164</b>

\*County totals in Table 1 may differ from totals in Table 3 as the data in Table 3 are not mutually exclusive

†Total includes programs implemented statewide and programs that operate solely in specific counties

**Table 2**

<b>Number of Programs by County</b>		
<b>Allegany: 10</b>	<b>Charles: 25</b>	<b>Prince George’s: 25</b>
<b>Anne Arundel: 30</b>	<b>Dorchester: 25</b>	<b>Queen Anne’s: 36</b>
<b>Baltimore: 39</b>	<b>Frederick: 36</b>	<b>St. Mary’s: 14</b>
<b>Baltimore City: 64</b>	<b>Garrett: 11</b>	<b>Somerset: 37</b>
<b>Calvert: 9</b>	<b>Harford: 35</b>	<b>Talbot: 11</b>
<b>Caroline: 19</b>	<b>Howard: 52</b>	<b>Washington: 34</b>
<b>Carroll: 38</b>	<b>Kent: 22</b>	<b>Wicomico: 45</b>
<b>Cecil: 47</b>	<b>Montgomery: 31</b>	<b>Worcester: 30</b>

Three programs reported jurisdiction as “other” and stated that either anyone can sign-up online for their services or that anyone born in the state of Maryland regardless of current residency can receive services. Roughly 16% of programs (63/405) support more than one county. Five percent (22/405) did not provide an answer.

Program responses were organized to juxtapose jurisdiction of each program with conditions of focus as reported by respondents. Programs that indicated they served all counties were added to the county specific totals within each condition grouping. Three programs are categorized as “other.” A total of 23 programs did not provide an answer. The numeric breakdown of programs within each specific county and stratified by condition focus is as follows:

**Table 3**

Number of SIHIS Related Programs Reported by County								
	Programs related to SIHIS Goals				Non-SIHIS Programs			
	Opioid Overdose	Severe Maternal Morbidity	Diabetes	Childhood Asthma	Cancer	Cardio-vascular Disease	Mental/ Behavioral Health	Other
Allegany	8	6	7	1	5	1	23	96
Anne Arundel	11	6	6	1	6	1	23	113
Baltimore	11	8	8	3	7	2	25	119
Baltimore City	11	9	8	4	7	2	25	143
Calvert	8	7	7	1	6	2	23	94
Caroline	8	9	7	1	7	2	25	99
Carroll	11	9	8	1	5	3	28	118
Cecil	11	4	9	1	7	2	31	127
Charles	8	6	10	3	6	4	26	110
Dorchester	9	7	8	3	6	1	27	108
Frederick	9	8	11	4	7	3	31	114
Garrett	9	5	7	1	5	3	22	95
Harford	11	8	8	3	6	2	24	116
Howard	14	6	7	1	6	2	34	125
Kent	8	6	6	1	6	1	26	106
Montgomery	8	8	9	1	7	2	27	112
Prince George’s	8	8	10	3	6	1	26	108
Queen Anne’s	11	6	6	1	6	2	29	115
St. Mary’s	9	7	9	2	6	3	24	98
Somerset	9	9	8	1	6	2	28	119
Talbot	8	6	6	1	5	1	24	96
Washington	8	7	8	1	5	2	29	115
Wicomico	9	8	8	3	6	2	34	124
Worcester	9	6	10	1	5	3	26	111

Respondents were queried regarding 11 variables that their programs may be currently collecting. These variables were: age, broadband wi-fi access, disability, ethnicity, gender identity, history of Incarceration, nationality, race, sexual orientation, socio-economic status, veteran status, and other. Respondents had the option to write in variables not offered to be categorized as “other.” Examples of “other” variables were sex assigned at birth, level of education, language, and history of homelessness. Of 405 programs, roughly three-fourths (304/405) collect either race, ethnicity, or both. Approximately 15% (59/405) of programs did not provide an answer. Table 4 delineates the number of programs by county that collect either race or ethnicity variables to assess reach and impact on vulnerable populations.

**Table 4**

Number of Programs Collecting Race/Ethnicity Data by County		
<b>Allegany: 76</b>	<b>Charles: 84</b>	<b>Prince George’s: 86</b>
<b>Anne Arundel: 96</b>	<b>Dorchester: 88</b>	<b>Queen Anne’s: 98</b>
<b>Baltimore: 103</b>	<b>Frederick: 96</b>	<b>St. Mary’s: 77</b>
<b>Baltimore City: 132</b>	<b>Garrett: 74</b>	<b>Somerset: 96</b>
<b>Calvert: 75</b>	<b>Harford: 98</b>	<b>Talbot: 75</b>
<b>Caroline: 82</b>	<b>Howard: 118</b>	<b>Washington: 94</b>
<b>Carroll: 99</b>	<b>Kent: 86</b>	<b>Wicomico: 108</b>
<b>Cecil: 109</b>	<b>Montgomery: 94</b>	<b>Worcester: 89</b>

Respondents state they collect demographic data using various methods which include existing databases, during program enrollment, medical claims, focus groups, and more. Written in responses included examples of home visits, invoices, and in-clinic data gathering as collection methods. When asked who uses program data and with whom is the data shared, respondents reported a wide range of answers such as: various MDH staff, local health department staff, national partners, providers, vendors, and some data is public facing. In this initial data gathering effort the question of “how the data is used” was not asked.

Respondents were requested to provide estimated values for each program budget for fiscal year 2021 and any projected budget for fiscal year 2022 regardless of funding source. A total of 384 programs reported estimates that ranged from no budget to upwards of 970 million dollars. Approximately five percent of programs (21/405) did not provide a response. Of the 405 programs, 65% (263/405) programs reported that they received federal funding for their programs, while 26% (106/405) reported not receiving federal funding. With future iterations of the project, the questionnaire could request respondents to explain the proportion of funding received.

**Recommendations**

The timeline and scope of the initial data collection period makes it very challenging to generate a comprehensive catalogue of programs that serve minority and vulnerable

populations in Maryland, not to mention the effectiveness of those programs and activities. The infrastructure simply does not exist. This report summarizes the information gathered through the VPQ from MDH programs and is designed to enhance our understanding of current programs and services and to inform future analysis of the Department's efforts to promote health equity. Over a six-month period, the MHCC and OMHHD developed and administered the VPQ to facilitate broad participation among MDH Units including local health departments. As discussed previously, our focus was on all programs that directly or indirectly address health disparities. It is important going forward that we have that resource to measure and monitor our performance and to share up to date information with consumers and stakeholders.

The results of the questionnaire highlighted several areas in which MDH could improve upon current operations to better measure and respond to health disparities within vulnerable populations. The recommendations developed through this program review are listed below:

1. Invest in the infrastructure for standardized data collection on race and ethnicity
2. Investigate tools for measuring social determinants of health (SDOH) that affect health outcomes
3. Implement the infrastructure for collection and sharing of race and ethnicity data through the health boards' licensure application and renewal process
4. Collaborate with the newly established Health Equity Commission

**Recommendation 1. Invest in establishing the infrastructure for standardized data collection**

*Communication*

This project underscores a need for an effective MDH wide communication plan for future work. Administration of the VPQ (i.e., the data collection tool) entailed extensive delays associated with the inability to identify appropriate contacts and clearly defined roles among program staff to support data collection for this project. Numerous emails and phone calls were required to solicit information and to increase survey participation and response rates. Communication within MDH units when collaboration among program staff was required to gather data was most challenging. The survey was designed to engage all units that touch the lives of vulnerable populations, but much time was spent educating some Units on their role in promoting health equity even though it may not be specifically stated in their charge. This project and the catalogue of programs developed over the past few months, can serve as a foundation for understanding and measuring our progress in reducing health disparities in Maryland and where there are high performing programs or gaps in services.

*Standardized Data Collection*

A standardized electronic data collection tool is needed to help MDH Units gather race and ethnicity data to better identify and target populations in need and to develop performance metrics for addressing health disparities. The VPQ revealed how limited our data collection and reporting infrastructure is currently when it comes to promoting health equity. The VPQ results provide insight on where the challenges are and a baseline for moving forward.

### *Catalogue/Inventory MDH Programs that Promote Health Equity*

An annual review of program performance data would require the establishment and maintenance of an inventory for programs that target vulnerable populations in Maryland. This inventory could serve as an electronic resource document for consumers, advocates, and other stakeholders interested in understanding what programs exist and where they are located. A few offices mentioned that having this project annually would “allow them time to prepare their responses each year.” An annual collection of this information would allow implementation of lessons learned from this project. With appropriate time frames and the knowledge gained from this initial exercise, the process for collecting data could be refined and automated to minimize the reporting burden on staff.

### *Make Health Equity a Fundamental Goal of All MDH Programs*

During the initial planning of this project, Units were encouraged to think broadly about the services they provide and how those programs reach various populations. This is an important first step as the state begins to consider and incorporate health equity into all programs. Health equity defined earlier as - “the attainment of the highest level of health for all people” should be the underlying focus of all MDH programs rather than the exclusive responsibility of the OMHHD. Achieving the concept of health equity requires extensive coordination and collaboration. There is an abundance of programs that target specific communities across the state, for example diabetes self-management, cancer screening programs, childhood lead, etc., across the state. Programs without specific participant requirements can look to programs that have those specific requirements as a model to see where they may have greater impact in their communities. Unit leaders, where possible, should seek to leverage connections of existing programs to establish greater reach within underserved communities. For example, there is evidence that programs that use members of a community to reach others within that community garner positive outcomes; but there were only a handful of programs that explicitly spoke to the use of community health workers. Likewise, to achieve health equity programmatically, some Units may need to consider investing and allocating funds for hiring staff dedicated specifically to work on health disparities and health equity activities.

### *Establish Limited and Measurable Performance Goals*

The VPQ results identified an array of program activities across MDH. Leadership should set measurable goals for each program to monitor performance and to share results with consumers and stakeholders. Program results should be compiled at least annually and made available to the public on the state’s website - such as the OMHHD, MDH, and the MHCC websites.

### **Recommendation 2. Investigate tools for measuring social determinants of health**

According to the U.S. Department of Health and Human Services (DHHS) social determinants of health (SDOH) are defined as factors that affect an individual’s wide range of health, life outcomes, and risks based on several environmental factors including where they live, were born, religion etc. There are several tools available for measuring social determinants of health. Working across state agencies to understand what tools are under consideration or currently

being used is important to building a comprehensive and effective strategy to promote health equity.

**Recommendation 3. Incorporate race/ethnicity data into health care occupational licensing and renewal process and share the information with the OMHHD and other relevant state agencies**

During this initial phase of this project, the staff reached out to the health occupational boards to solicit their participation in the survey and to address their questions and concerns. Board representatives explained that they voluntarily collect demographic information at the time of licensure and that the infrastructure is not in place for distributing that data with other state agencies. Studies show that individuals tend to be responsive and compliant to treatment from health care professionals who are perceived to be like them. One way health care occupational boards can support health equity is to help inform our understanding of the demographic make-up of healthcare professionals practicing in Maryland. Gathering race and ethnicity data once at the time of initial licensure is the most effective way to measure the diversity of the health care workforce.

**Recommendation 4. Collaborate with the new Health Equity Commission**

The Shirley Nathan Pulliam Health Equity Act of 2021 created a new commission to promote health equity. The charge of the new commission is:

“[T]he commission will work to align public and private stakeholder policies and advise on matters concerning racial, ethnic, cultural and socioeconomic health disparities. Two subcommittees will inform the commission’s work: the data advisory committee, which will make recommendations on data collection, needs and quality assurance through Maryland’s health information exchange, CRISP; and the health equity policy committee, which will advise on implementing a statewide health equity framework”

As discussed earlier in this report, the resources and expertise associated with the new Health Equity Commission should guide and/or inform the work outlined in HB309 and SB565.

**Limitations**

The complexity of MDH’s organizational structure presented some challenges. As mentioned previously, communication among and within Units to identify the appropriate points of contact was at times difficult and led to multiple extensions of time to submit data. The MHCC staff reached out to non-responsive Units several times to increase the survey response rate and several extensions and allowances were allotted to submit data. These delays in data submission led to delays in cleaning, reformatting, and analyzing the data. To increase compliance, data was accepted well into October 2021.

In cleaning the data, various instances of duplication were identified that are described by the following:

- A sub-office within an organizational Unit submitted additional or partial data regarding a program that had previously been submitted.  
A respondent used multiple methods for submitting data.
- Multiple individuals within a Unit submitted information on the same program.
- Individuals submitted information for a program then returned after the initial deadline to add more information for the same program, thus generating a different submission.

How programs are implemented and funded across the state presented unique complexities in terms of how each program should be counted.

- For example, several Units argued that they supported broad programs that covered multiple jurisdictions or multiple state Units.
- The function of some Units is solely to provide support to other Units, so that reporting Unit did not have any unique programs within house.
- Some programs have been discontinued.
- Some Units did not believe they had any programs that served vulnerable populations.

Other significant limitations arose due to the surveying platform used to disseminate the questionnaire. Staff recognized that some Units may want to complete a single questionnaire that described multiple programs as opposed to opening a new questionnaire every time; therefore, staff created two unique data collection links. One link allowed respondents to answer the questionnaire for just one activity/program/service while the other allowed for the submission of multiple activities/programs/services in one sitting. Despite this added flexibility, a few MDH programs and some local health departments continued to have difficulties submitting their data through the survey application, so staff created a manual process that required MHCC staff to enter the information gathered into the database.

Finally, it should be noted again that the information reported in the findings is based on self-reported data. Some Units provided very detailed information on their program(s) while others did not. The OMHHD nor MHCC can speak to the reliability or validity of the information submitted. Despite the subjective nature of self-reported data, the team worked diligently to categorize and synthesize information presented in the findings.

**Appendix A**

HB 309/SB 565 Public Health - Data - Race and Ethnicity Information Gathering

LAWRENCE J. HOGAN, JR., Governor

Ch. 762

Chapter 762

**(Senate Bill 565)**

AN ACT concerning

**Public Health – Data – Race and Ethnicity Information**

FOR the purpose of altering a certain provision of law requiring the Maryland Office of Minority Health and Health Disparities to collaborate with the Maryland Health Care Commission to publish and provide a certain report card to require the Office to also collaborate with certain health occupations boards; requiring the report card to include the racial and ethnic composition of all individuals who hold a certain license or certificate, rather than only physicians; requiring the report card to include a comparison of certain information; requiring the Office to respond to certain requests within a certain period of time to the extent authorized under certain laws; requiring the Director of the Office to meet with certain representatives at least annually to examine the collection of certain data and identify certain changes; requiring certain health occupations boards to include a certain option on a certain form and to encourage an applicant to provide certain information; requiring the Office, in coordination with the Maryland Health Care Commission and the Maryland Department of Health, to establish, submit to the General Assembly, and implement a certain plan on or before a certain date; requiring the Office, in coordination with the Commission and the Maryland Department of Health, to submit to the General Assembly a certain plan on or before a certain date; and generally relating to public health data and race and ethnicity information.

BY repealing and reenacting, with amendments,

Article – Health – General  
Section 20–1004 and 20–1005  
Annotated Code of Maryland  
(2019 Replacement Volume and 2020 Supplement)

BY adding to

Article – Health Occupations  
Section 1–225  
Annotated Code of Maryland  
(2014 Replacement Volume and 2020 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,  
That the Laws of Maryland read as follows:

**Article – Health – General**

20–1004.

The Office shall:

- (1) Be an advocate for the improvement of minority health care by working with the Department on its own, or in partnership with other public and private entities to establish appropriate forums, programs, or initiatives designed to educate the public regarding minority health and health disparities issues, with an emphasis on preventive health and healthy lifestyles;
- (2) Assist the Secretary in identifying, coordinating, and establishing priorities for programs, services, and resources that the State should provide for minority health and health disparities issues;
- (3) Collect, classify, and analyze relevant research information and data collected or compiled by:
  - (i) The Department;
  - (ii) The Department in collaboration with others; and
  - (iii) Other public and private entities;
- (4) Research innovative methods and obtain resources to improve existing data systems to ensure that the health information that is collected includes specific race and ethnicity identifiers;
- (5) Serve as a clearinghouse and resource library for information about minority health and health disparities data, strategies, services, and programs that address minority health and health disparities issues;
- (6) Develop a strategic plan to improve public services and programs targeting minorities;
- (7) Obtain funding and, contingent upon funding, provide grants to community-based organizations and historically black colleges and universities to conduct special research, demonstration, and evaluation projects for targeted at-risk racial and ethnic minority populations and to support ongoing community-based programs that are designed to reduce or eliminate racial and ethnic health disparities in the State;
- (8) Develop criteria for the awarding of grants for programs that are designed to improve minority health care;
- (9) Review existing laws and regulations to ensure that they facilitate the provision of adequate health care to the minorities of this State;
- (10) Recommend to the Secretary any additions or changes to existing laws and regulations designed to facilitate the adequate provision of health care to minorities in this State;

- (11) Identify and review health promotion and disease prevention strategies relating to the leading health causes of death and disability among minority populations;
- (12) Develop and implement model public and private partnerships in racial and ethnic minority communities for health awareness campaigns and to improve the access, acceptability, and use of public health services;
- (13) Develop recommendations for the most effective means of providing outreach to racial and ethnic minority communities throughout the State to ensure their maximum participation in publicly funded health benefits programs;
- (14) Develop a statewide plan for increasing the number of racial and ethnic minority health care professionals which includes recommendations for the financing mechanisms and recruitment strategies necessary to carry out the plan;
- (15) Work collaboratively with universities and colleges of medicine, nursing, pharmacy, dentistry, social work, public health, and allied health in this State and other health care professional training programs to develop courses with cultural competency, sensitivity, and health literacy, that are designed to address the problem of racial and ethnic disparities in health care access, utilization, treatment decisions, quality, and outcomes;
- (16) Work collaboratively with the Maryland Health Care Disparities Initiative, the Morgan–Hopkins Center for Health Disparities Solutions, the University of Maryland Disparity Project, the Monumental City Medical Society, faculty and researchers at historically black colleges and universities, and other existing alliances or plans, to reduce or eliminate racial and ethnic disparities in the State;
- (17) Seek to establish a statewide alliance with community–based agencies and organizations, historically black colleges and universities, health care facilities, health care provider organizations, managed care organizations, and pharmaceutical manufacturers to promote the objectives of the Office;
- (18) Evaluate multicultural or racial and ethnic minority health programs in other states to assess their efficacy and potential for replication in this State and make recommendations regarding the adoption of such programs, as appropriate;
- (19) Apply for and accept any grant of money from the federal government, private foundations, or other sources which may be available for programs related to minority health and health disparities;
- (20) Serve as the designated State agency for receipt of federal funds specifically designated for minority health and health disparities programs;

(21) Work collaboratively with the Governor’s Office of Small, Minority, and Women Business Affairs as the Office determines necessary; [and]

(22) In collaboration with the Maryland Health Care Commission **AND THE HEALTH OCCUPATIONS BOARDS ESTABLISHED UNDER THE HEALTH OCCUPATIONS ARTICLE**, publish annually on the Department’s website and provide in writing on request a “Health Care Disparities Policy Report Card” that includes:

(i) An analysis of racial and ethnic variations in insurance coverage for low-income, nonelderly individuals;

(ii) The racial and ethnic composition of the [physician population] **INDIVIDUALS WHO HOLD A LICENSE OR CERTIFICATE ISSUED BY A HEALTH OCCUPATIONS BOARD ESTABLISHED UNDER THE HEALTH OCCUPATIONS ARTICLE** compared to the racial and ethnic composition of the State’s population; and

(iii) The racial and ethnic disparities in morbidity and mortality rates for cardiovascular disease, cancer, diabetes, HIV/AIDS, infant mortality, asthma, and other diseases identified by the Maryland Health Care Commission; **AND**

**(IV) A COMPARISON OF THE INFORMATION INCLUDED UNDER ITEMS (I) AND (II) OF THIS PARAGRAPH WITH PREVIOUSLY PUBLISHED “HEALTH CARE DISPARITIES POLICY REPORT CARDS” INCLUDING THE SAME INFORMATION; AND**

**(23) TO THE EXTENT AUTHORIZED UNDER FEDERAL AND STATE PRIVACY LAWS, RESPOND TO REQUESTS FOR HEALTH DATA THAT INCLUDES RACE AND ETHNICITY INFORMATION WITHIN 30 DAYS AFTER RECEIPT OF THE REQUEST.**

20–1005.

Subject to the limitations of any law that governs the activities of other units of the Executive Branch of State government, the Director shall:

(1) Promote health and the prevention of disease among members of minority groups;

(2) Distribute grants from available federal and special funds to community-based health groups to be used to promote health and the prevention of disease among members of minority groups; [and]

(3) Fund projects which are innovative, culturally sensitive, and specific in their approach toward reduction of the incidence and severity of those diseases or conditions which are responsible for excess morbidity and mortality in minority populations; **AND**

**(4) MEET WITH REPRESENTATIVES FROM THE MARYLAND HEALTH CARE COMMISSION AND THE DEPARTMENT AT LEAST ANNUALLY TO:**

**(I) EXAMINE THE COLLECTION OF HEALTH DATA THAT INCLUDES RACE AND ETHNICITY INFORMATION IN THE STATE; AND**

**(II) IDENTIFY ANY CHANGES FOR IMPROVING THE HEALTH DATA THAT INCLUDES RACE AND ETHNICITY INFORMATION THAT IS ACCESSIBLE BY THE OFFICE.**

**Article – Health Occupations**

**1-225.**

**EACH HEALTH OCCUPATIONS BOARD AUTHORIZED TO ISSUE A LICENSE OR CERTIFICATE UNDER THIS ARTICLE SHALL:**

**(1) INCLUDE ON THE FORM FOR AN APPLICATION FOR THE LICENSE OR CERTIFICATE OR A LICENSE OR CERTIFICATE RENEWAL AN OPTION FOR THE APPLICANT TO PROVIDE THE APPLICANT’S RACE AND ETHNICITY INFORMATION; AND**

**(2) ENCOURAGE AN APPLICANT TO PROVIDE RACE AND ETHNICITY INFORMATION ON THE APPLICATION.**

SECTION 2. AND BE IT FURTHER ENACTED, That, on or before January 1, 2022, the Maryland Office of Minority Health and Health Disparities shall, in coordination with the Maryland Health Care Commission and the Maryland Department of Health, establish, submit to the General Assembly, in accordance with § 2-1257 of the State Government Article, and implement a plan for:

(1) improving the collection of health data that includes race and ethnicity information in the State;

(2) ensuring that the Office has access to up-to-date health data that includes race and ethnicity information;

(3) to the extent authorized under federal and State privacy laws, posting health data that includes race and ethnicity information on the Office’s website; and

(4) updating the data on the Office’s website at least once every 6 months.

*SECTION 3. AND BE IT FURTHER ENACTED, That, on or before December 31, 2021, the Maryland Office of Minority Health and Health Disparities shall, in coordination*

with the Maryland Health Care Commission and the Maryland Department of Health, submit to the General Assembly, in accordance with § 2-1257 of the State Government Article, a plan that reflects the State's current goals and implementations to eliminate minority health disparities.

SECTION ~~3~~ 4. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2021.

**Enacted under Article II, § 17(c) of the Maryland Constitution, May 30, 2021.**

## Appendix B

### List of Programs Submitted

A.F. Whitsitt Center  
ACCESS Harm Reduction Grant  
Acute Care Coordination Unit (ACCU)  
Administrative Care Coordination (ACC) and Supplemental Administrative Care Coordination (S-ACC)  
Administrative Care Coordination Unit (ACCU)\*  
Administrative Care Coordination/Ombudsman Program\*  
Admission to the hospital  
Adolescent and Reproductive Health  
Adult Day Care Grants  
Adult Dental Clinic\*  
Adult Dental Pilot Program  
Adult Evaluation and Referral Service  
Adult Evaluation and Review Service (AERS)\*  
Adult Evaluation and Review Service (AERS)/CFC  
Adult Evaluation Services  
Adult Immunizations Program  
Adult Public Guardianship  
Adult Services  
Adult Services Coordination  
Alive! Maryland Training and Capacity Building  
Assessments and Nurse Monitoring Program  
Assistance in Community Integration Services (ACIS) Case Management  
Autism Waiver  
Babies Born Healthy Program\*  
Back to School Immunization Program  
Baltimore, Virtual Supermarket  
Baltimore Infants and Toddlers  
Bay Restoration Fund Grant  
Behavioral Health Court Liaison at District Court  
Behavioral Health Navigation  
Behavioral Health Programs  
Behavioral Risk Factor Surveillance System  
Best Beginnings  
Birth Defects Reporting and Information System (BDRIS)  
Birth to Five  
Board of Acupuncture  
Board of Dietetic Practice  
Board of Environmental Health Specialists  
Board of Examiners for Audiologists, Hearing Aid Dispensers & Speech-Language Pathologists  
Board of Examiners of Psychologists  
Board of Morticians and Funeral Directors  
Board of Occupational Therapy Practice  
Board of Optometry  
Board of Physical Therapy Examiners  
Board of Physicians  
Board of Podiatric Medical Examiners  
Board of Social Work Examiners  
Brain Injury Waiver  
Breast and Cervical Cancer Diagnosis and Treatment Program  
Breast, Cervical and Colorectal Programs  
Bystander Intervention (TurnAround)  
Call 211, Press 1 Awareness Campaign  
Cancer Prevention  
Cancer Program (BCCP, CRC, CRF-CPEST)  
Cancer Screening Program  
Capitol Bonds  
Care Coordination Services\*  
Care for Kids  
Cecil Addiction Treatment Coordination Hotline (CATCH)  
Center for Tobacco Prevention and Control (CTPC) Statewide Programs  
Child Fatality Review (CFR) program\*  
Child Health Program  
Child/Adolescent Services Coordination  
Childhood Immunizations  
Childhood Lead Poisoning Prevention and Environmental Case Management Program  
Childhood Obesity in the Dental Setting program  
Children's Health Insurance Program (CHIP)  
Children's Medical Services Program  
Cigarette Restitution Fund (CRF) Cancer Prevention, Education, Screening and Treatment (CRF-CPEST) Program  
Cigarette Restitution Fund (CRF) Tobacco Local Public Health Programs  
Cigarette Restitution Fund (CRF) Tobacco Prevention and Cessation Program  
Collaborative Care Model (CoCM) Pilot Program  
Communicable Disease and Epidemiology STD/HIV Program  
Communicable Disease Program HIV and TB case management  
Communicable Disease Program\*  
Communicable Diseases Surveillance Program  
Community Asthma Program  
Community Engagement Program (Health Equity & Outreach Team)  
Community First Choice & Community Personal Assistance Services  
Community First Choice\*  
Community Health Facilities Grant Program  
Community Health Resources Commission (CHRC) Grant Proposals

Community Health Worker (CHW) Improving Health and Resilience Program  
 Community Health Worker (CHW) Program  
 Community Pathways Waiver  
 Community Personal Assistance Program  
 Community Personal Assistance Services\*  
 Community Supports Waiver  
 Comprehensive Cancer Control Program  
 Comprehensive Quality Improvement in Primary Care (CQI) project  
 Congregate Meals  
 Connecting For Success  
 Construction Workers & Substance Use Disorders Awareness Campaign  
 Contact Tracing  
 Continuum of Care (CoC) Housing Program  
 Coordination of Community Services Program\*  
 COVID Messaging to Nursing Home Staff Awareness Campaign  
 COVID-19 Community Vaccination Program  
 COVID-19 Long-Term Care Partnership Program  
 Creating Protective Environments (BSU)  
 Crisis Intervention Training (CIT) for Law Enforcement\*  
 Crisis Response Services (CRS)  
 Dangers of Fentanyl Awareness Campaign  
 Dental Clinic  
 Dental Program\*  
 Dental Sealant Program  
 Detention Center, Recovery Preparation and Re-entry Coordination Services  
 Developmental Disabilities Coordination of Community Services (CCS)\*  
 Diabetes Prevention Program (DPP) Capacity Building project  
 Diabetes Self-Management Education and Supports (DSMES) Capacity Building project  
 Diabetes Self-Management Education and Supports (DSMES) Umbrella project  
 Disability Health Inclusion Program  
 Division of Vital Records  
 Drug Court  
 Driving Under the Influence (DUI)/Drug Court Treatment Coordination at District Court  
 Durable Medical Equipment, Durable Medical Supplies, Oxygen (DME/DMS/OXY)  
 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)  
 Early Care Program  
 Early Screening, Decision Making, Assessment, Referral, and Treatment (E-SMART)  
 Emergency Preparedness Program  
 Engaging Male Students Social Marketing (UMES)  
 Epidemiology and Laboratory Capacity (ELC)  
 Community Health Worker (CHW) Project\*  
 Evidence Based Health Promotions

Family Caregivers  
 Family Options Program  
 Family Planning Program  
 Family Planning/Sexually Transmitted Infection (STI) Program, Queen Anne's County  
 Family Supports Waiver  
 Federal Grant Funds for Mobile Methadone  
 Federally Qualified Health Centers (FQHC) Grant Program  
 Fetal and Infant Mortality Review (FIMR) Program\*  
 Foreign Born Outreach Coordination Program  
 Good Samaritan Law Awareness Campaign  
 Harm Reduction Program  
 Harm Reduction/Syringe Services Program  
 Harmony Harm Reduction Services  
 HBCU Behavioral Health Student Workforce Expansion Program  
 Healing Session Mental Health Resources  
 Health and Human Services  
 Health Equity Program\*  
 Health Planning and Epidemiology  
 Health Promotion Program  
 HealthChoice Diabetes Prevention Program  
 Healthiest Maryland Businesses (HMB) Program  
 Healthy Families\*  
 Healthy Homes for Healthy Kids  
 Healthy Montgomery  
 HIV Case Management (F763N)  
 HIV Integrated Prevention and Health Services Program  
 HIV Oral Health Referral program  
 HIV Prevention Program (F765N)  
 HIV Program & Case Management Services  
 HIV Programs  
 HIV Testing in Behavioral Health Settings  
 HIV/Sexually Transmitted Infection (STI) Prevention Program  
 Home and Community Based Options Waiver\*  
 Home and Community Based Services  
 Home and Community Options Waiver  
 Home Delivered Meals  
 Home Health Program  
 Home Visiting Services (HVS) Pilot  
 Hospital Uncompensated Care Policy  
 How to Administer Naloxone Awareness Campaign  
 Hub and Spoke Program\*  
 Human Rabies Prevention Control Program  
 Immunization Program\*  
 Improved Food Access Initiatives  
 Increased Community Supports  
 Intermediate Care Facility for Individuals with Intellectual Disabilities  
 It's Your Business Bystander Intervention (BSU)  
 Kent On the Move Initiative  
 Kids Like Us Program  
 Know Your Risk Awareness Campaign

Law Enforcement Assisted Diversion Program  
 Lead and Asthma Program  
 Lead Poisoning Prevention Program\*  
 Legal Resource Center at the University of Maryland  
 Baltimore, Francis King Carey School of Law and  
 Maryland Smoke-Free Living  
 Living Well! Take Charge of Your Health: Chronic  
 Disease Self Management (CDSMP)  
 Local Health Department (LHD) Funding for  
 Substance Use Disorder Programs  
 Local Health Improvement Coalition  
 Local Health Improvement Coalitions (LHIC)/Local  
 Health Department (LHD) Diabetes Grant  
 Local Prevention Program  
 Lower Shore Friends (Wellness and Recovery  
 Center)  
 Maryland Access Point  
 Maryland Breast and Cervical Cancer Program  
 (BCCP)  
 Maryland Cancer Fund  
 Maryland Children's Health Insurance Program  
 (MCHP)  
 Maryland Children's Health Program (MCHP)\*  
 Maryland Children's Health Program/Medical  
 Assistance (MCHP/MA)\*  
 Maryland Coalition Against Sexual Assault  
 (MCASA)  
 Maryland Colorectal Cancer Control Program  
 (MCRCCP)  
 Maryland Community Criminal Justice Treatment  
 Program (MCCJTP)\*  
 Maryland Conrad 30 (J-1 Visa Waiver) Program  
 Maryland Early Hearing Detection and Intervention  
 Program  
 Maryland Family Planning Program  
 Maryland Health and Lifestyle Training (HALT)  
 Diabetes Program  
 Maryland HealthChoice Program  
 Maryland Kids in Safety Seats  
 Maryland Medicaid Fee-for-Service Pharmacy  
 Program  
 Maryland Optimal Adolescent Health Program  
 (MOAHP)  
 Maryland Primary Care Program (MDPCP)  
 Maryland State Loan Repayment Program  
 Maryland Violence and Injury Prevention Program  
 Maryland's National Center on Physical Activity and  
 Disability (NCHPAD) inclusive Community  
 Implementation Process (NiCIP) Project  
 Maternal and Child Health Funding  
 Maternal and Infant Care (M&I) Home Visiting  
 Programs  
 Maternal Opioid Misuse (MOM) Model  
 Maternity Partnership Program  
 Medicaid Non-Emergency Transportation Program  
 Medicaid Program  
 Medicaid Provider Services (MPS)  
 Medical Adult Day Care  
 Medical Assistance Transportation Program\*  
 Medical Day Care Waiver  
 Mental Health Patient Outreach  
 Mental Health Services  
 Migrant Health Program\*  
 Minority Health Programs  
 Minority Outreach and Technical Assistance Program  
 (MOTA)  
 Minority Youth Outreach Program  
 Mobile Integrated Community Health (MICH)\*  
 Mobilizing for Action through Planning and  
 Partnerships (MAPP) Framework Community Health  
 Assessment  
 Model Waiver  
 Modified Interim Value-Based Payment (MIVBP)  
 Diabetes Prevention Program (DPP)\*  
 Money Follows the Person  
 Montgomery Cares  
 Non-Emergency Medical Transportation (NEMT)\*  
 Nursing Facility Services  
 Office of Antimicrobial Resistance and Healthcare  
 Associated Infection Response  
 Office of Chief Medical Examiner  
 Operation Courage Awareness Campaign  
 Opioid Misuse Prevention Program (OMPP)  
 Opioid Operational Command Center (OOC)  
 Grants Program  
 Oral Disease and Injury Prevention program (ODIP)  
 Outpatient Behavioral Health  
 Outreach to Survivors of Overdose (OSO)  
 Overdose Response Prevention (ORP) Program  
 Overdose Survivors Expansion Program  
 Pedestrian Safety, Bike Helmet Fittings and  
 Distribution & Passenger Safety, Car Seat Assistance  
 Program (CSAP)  
 Peer Recovery Support Program  
 Personal Responsibility Education Program (PREP)  
 Potomac Center Programs  
 Preceptor Tax Credit Program  
 Prenatal Breastfeeding Support Training for Health  
 Care Practitioners  
 Pre-Exposure Prophylaxis (PrEP) Program, Cecil  
 County  
 Prevent T2 Diabetes Prevention Program\*  
 Prevention, Recovery, and Interventions Designed for  
 Equity (PRIDE) in Health  
 Primary Care COVID-19 Vaccine Program  
 Primary Care Office  
 Private Duty Nursing via Rare and Expensive Case  
 Management (REM)  
 Problem Gambling Awareness Campaign  
 Program 2 and Lead Case Management  
 Program of All-Inclusive Care for the Elderly  
 (PACE)

Project Linkage, Pre-Trial Screening for Public Defender Clients  
 Projects for Assistance in Transition from Homelessness (PATH)  
 Projects Under CDC Grant (CDC-RFA-OT21-2103)  
 Psychiatric Rehabilitation Program  
 Psychogeriatric Services Coordination Program  
 Quality Improvement Project  
 Rabies Program  
 Racial Disparities Task Force  
 Recruitment Outreach Unit Initiatives  
 Refugee Health Program  
 Refugee Health Screening Services  
 Regional Institute for Children and Adolescents (RICA) Baltimore Psychiatric Residential Treatment Center with public Special Education School  
 Regional Partnership Catalyst Program  
 Reproductive Health Program\*  
 Reproductive Health/Family Planning Program  
 Residential Treatment Center (RTC) and Day Program  
 Readmission Reduction Incentives Program (RRIP)  
 Within-hospital Disparity Measure  
 Rural Communities Opioid Response Program Implementation Grant  
 Ryan White Part A  
 Ryan White Part B  
 Safe Routes to School (SRTS) Program  
 School Based Health Program  
 School Based Health Services\*  
 School-Based Wellness Centers  
 Screening, Diagnosing, and Treating Behavioral Health Disorders Amongst Marylanders with Limited English Proficiency  
 Secure Evaluation and Therapeutic Treatment (SETT) Program  
 Secure Transport and Investigation Unit  
 Self Monitoring Blood Pressure Project  
 Senior Care Program  
 Senior Centers  
 Senior Companion Program  
 Senior Health Information Program (SHIP)/Senior Medicare Patrol Senior (SMP)  
 Senior Prescription Drug Assistance Program  
 Sexual Health and Wellness Program  
 Sexual Health in Recovery (SHIR)\*  
 Sexual Risk Avoidance Education Program (SRAE)  
 Sexual Transmitted Disease Testing Programs  
 Sexual Violence Prevention and Intervention Services Project  
 Sick Cell Disease Long Term Follow up Program  
 Sobriety Treatment and Recovery Teams (START) Program  
 Social Marketing Outreach to Support PrEP Uptake  
 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)\*

SPOT Van Mobile Clinic Program  
 State Billing Rates  
 State Care Coordination\*  
 State Health Improvement Process (SHIP) Newsletter  
 State Loan Repayment Program  
 State Office of Rural Health Program  
 Statewide Integrated Health Improvement Strategy  
 Staying Alive Program  
 Sexually Transmitted Infection (STI) Clinic, Cecil County  
 Strengthening Fathers Program  
 Subsidy Housing Program  
 Substance Abuse Prevention Services  
 Substance Abuse Treatment Outcomes Partnership (STOP) Grant Funding\*  
 Substance Use Disorder Screening for Temporary Cash Assistance Consumers at Social Services  
 Substance Use Screening/Referrals for Temporary Cash Assistance Recipients at DSS  
 Substance Use Treatment at Detention Center  
 Surveillance and Quality Improvement  
 Syringe Services Program  
 Syringe Support Program  
 Taking Off Pounds Sensibly (TOPS) program  
 Talk to Your Doctor Awareness Campaign  
 Targeted Case Management to Adults  
 The Breast, Cervical, and Colorectal Cancer Screening Program  
 The Maryland Family Planning Program (MFPP)  
 The Maryland Maternal, Infant, and Early Childhood Home Visiting Program  
 The Maryland Tobacco Quitline  
 The Newborn Screening and Critical Congenital Heart Disease Follow-up Program  
 Thrive by Three Fund  
 Title V Systems Development Grants  
 Title V Maternal and Child Health Services Block Grant Program  
 Tobacco Free Baltimore  
 Tobacco Program  
 Tobacco Use Prevention, Cessation and Enforcement Services  
 Training, Education, Advocacy for LatinX (TEAL)  
 Transgender Response Team  
 Transportation Assistance Program  
 Tri-County Alliance for the Homeless Program  
 Tuberculosis Control and Prevention\*  
 Tuberculosis Program  
 Tuberculosis Program and Clinic  
 U Choose Program  
 Vaccines for Children (VFC)\*  
 Vaccines for Children and Adult Immunization Program  
 Vital Records, Birth and Death Certificates\*  
 Vocational Adjustment Services  
 Walk Maryland Day

Western Maryland Hospital Center (WMHC)  
Worcester Wellness Weigh  
Workforce Development/Employment Coaching  
Youth Suicide Prevention Program

Youth Services and Advocacy Program

\*Titles with an asterisk denote programs that have been reported by two or more MDH Units.

## Appendix C

### Executive Memorandum Sent to MDH Units



Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

**CONFIDENTIAL &  
SUBJECT TO EXECUTIVE PRIVILEGE**

**EXECUTIVE MEMORANDUM**

To: MDH Deputy Secretaries and Executive Directors, Boards & Commissions  
From: Dennis R. Schrader, Secretary  
Subject: HB 309/SB 565 Public Health - Data - Race and Ethnicity Information Gathering  
Date: July 8, 2021

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The Maryland General Assembly passed the **HB 309/SB 565 Public Health - Data - Race and Ethnicity Information** requiring the State to collect data pertaining to current disparity reducing policies and implementations, and to develop a goal-oriented plan addressing these health disparities by the end of the 2021 calendar year. It is this task that is taken on by the Office of Minority Health and Health Disparities (OMHHD), the Maryland Health Care Commission (MHCC), and MDH.

To collect this information, an electronic survey has been developed and a survey link will be sent out to the major organizations of MDH. This information is not only critical to fulfill the MDH requirement of reporting but also to identify gaps in service where attention and resources must be focused. Further information may need to be collected via interview if necessary.

It is critical that this information is not only provided by you, the leaders of MDH but that it is done in a timely manner, allowing for consolidation, analysis, and follow up if need be. Therefore, all surveys must be completed by July 30th, 2021 at 4 P.M.

I recommend that you preview the survey to help you advise your staff on the information that will be required. You can access the survey by clicking on the link below.  
<https://www.surveymonkey.com/r/QBSKL6X>

Thank you for your cooperation in this effort to protect Maryland's minority populations. If you have any questions, please reach out to Noel Brathwaite [noel.brathwaite@maryland.gov](mailto:noel.brathwaite@maryland.gov) or Ben Steffen [ben.steffen@maryland.gov](mailto:ben.steffen@maryland.gov) for more information.

## Appendix D

### Data Collection Tool Provided to Respondents

**This document is a replica of the online questionnaire that can be used for collaborating your responses within your Unit.**

### **Vulnerable Populations Questionnaire for all MDH Programs**

**HB 309/SB 565 Public Health - Data - Race and Ethnicity Information**, requires the Office of Minority Health and Health Disparities (OMHHD) in coordination with the Maryland Department of Health (MDH) and the Maryland Health Care Commission (MHCC) to develop and submit a report to the General Assembly by December 31, 2021, that reflects the State’s current and future goals and implementations to eliminate health disparities. This questionnaire seeks to collect information from each MDH organizational unit regarding current goals and existing implementations to reduce health disparities in support of this new legislative requirement. You are receiving this questionnaire because your unit has been identified as providing a program (e.g., activity/project/service) related to vulnerable populations. We ask that you carefully read through the following 20-25 questions and **submit your completed questionnaire by Tuesday August 31, 2021, at 4 p.m.** Additionally, we ask that this questionnaire be distributed to the heads of any Office, Bureau, or Division within your organizational unit that may be able to better answer the following questions.

#### **Notes**

- *A separate questionnaire is required for each program (e.g., activity/project/service).*
- *If you have multiple programs, we recommend you contact us to provide a unique link that will accommodate the submission of multiple entries in one sitting.*
- *The system will automatically save your responses each time you click the “Next” button.*
- *You may be contacted to gather additional or clarifying information following the submission of this questionnaire.*

Should you have questions or concerns please contact:

**Diana Estefania Estrada Alamo, Program Manager, MHCC**

[diana.estradaalamo1@maryland.gov](mailto:diana.estradaalamo1@maryland.gov)

410-764-3834

**Mariama Gondo, Chief, MHCC**

[mariama.gondo1@maryland.gov](mailto:mariama.gondo1@maryland.gov)

410-764-337

**\*Indicates a required question.**

## Section One: Organizational Unit Name and Contact

1. MDH Organizational Unit Name:\*

Choose an item.

2. Office/Bureau/Division Name: \*

Click or tap here to enter text.

3. Primary Follow-up Contact\*

Name: Click or tap here to enter text.

Title: Click or tap here to enter text.

Email Address: Click or tap here to enter text.

Phone Number: Click or tap here to enter text.

4. Alternate Follow-up Contact

Name: Click or tap here to enter text.

Title: Click or tap here to enter text.

Email Address: Click or tap here to enter text.

Phone Number: Click or tap here to enter text.

5. Do you have more than one program (e.g., activity/project/service) that deals with vulnerable populations or health disparities?

Click or tap here to enter text.

6. If yes, how many?

Click or tap here to enter text.

## Section Two: Program (e.g., Activity/Project/Service) Description

7. What is the title of the program that serves vulnerable populations including racial and ethnic minorities?

Click or tap here to enter text.

8. Provide a brief summary of the program including primary goals and objectives.\*

*Note: You will have the opportunity to upload supplemental documents at the end of this section. If providing a large document, please specify the page number(s) we should review.*

Click or tap here to enter text.

9. What is the program's inception date? If a program is planned for the future, please provide the proposed start date.

Use the calendar tool below to choose the desired date. You can toggle from year to year and month to month as needed. If the exact month is unknown use January and if the

exact day is unknown the first day (01).

Click or tap to enter a date.

10. List the total annual funding level for fiscal year 2021 and any projected budget for fiscal year 2022. (All sources e.g., state, federal, other)

Click or tap here to enter text.

11. Did the program receive federal funding for fiscal year 2021? (Choose one)

Yes

No

12. What is the program’s statutory authority/legislative mandate? (If any; check all that apply)

<input type="checkbox"/> Legislative Mandate	<input type="checkbox"/> Statutory Authority	<input type="checkbox"/> Federal Requirement
<input type="checkbox"/> Judicial Requirement	<input type="checkbox"/> Recommended by MDH	<input type="checkbox"/> Unknown

13. List specific legislative mandate or statutory authority citation. (If available)

Click or tap here to enter text.

14. Does the program collect any of the following variables to assess the reach and impact on vulnerable populations? (Check all that apply)

<input type="checkbox"/> Age	<input type="checkbox"/> Broadband wifi access	<input type="checkbox"/> Disability
<input type="checkbox"/> Ethnicity	<input type="checkbox"/> Gender identity	<input type="checkbox"/> History of incarceration
<input type="checkbox"/> Nationality	<input type="checkbox"/> Race	<input type="checkbox"/> Sexual orientation
<input type="checkbox"/> Socio-economic status	<input type="checkbox"/> Veteran status	<input type="checkbox"/> Other (please specify):

*You identified that your program is collecting one of the variables related to vulnerable populations. Please answer the next two questions describing the data that is collected. Feel free to upload a data dictionary to supplement answers to these questions. You can upload that information using the upload feature in question 22.*

15. How is the data collected? (Check all that apply)

<input type="checkbox"/> During program enrollment	<input type="checkbox"/> Existing (in-house) database	<input type="checkbox"/> Focus group
<input type="checkbox"/> Medical claims/records	<input type="checkbox"/> Online survey	<input type="checkbox"/> Paper survey
<input type="checkbox"/> Phone interview	<input type="checkbox"/> Web scraping/online analytics	<input type="checkbox"/> Other (please specify):

16. Who uses this data and with whom is it shared?

[Click or tap here to enter text.](#)

17. Please summarize the performance of your program. Include any information or statistics that address the effectiveness of the program (objectives, number of participants served, custom metrics, etc.).

*Note: If you prefer to upload an existing document, please use Question 22 below.*

[Click or tap here to enter text.](#)

18. Which jurisdiction(s) does the program serve? (Check all that apply)

<input type="checkbox"/> All counties	<input type="checkbox"/> Allegany	<input type="checkbox"/> Anne Arundel	<input type="checkbox"/> Baltimore	<input type="checkbox"/> Baltimore City
<input type="checkbox"/> Calvert	<input type="checkbox"/> Caroline	<input type="checkbox"/> Carroll	<input type="checkbox"/> Cecil	<input type="checkbox"/> Charles
<input type="checkbox"/> Dorchester	<input type="checkbox"/> Frederick	<input type="checkbox"/> Garrett	<input type="checkbox"/> Harford	<input type="checkbox"/> Howard
<input type="checkbox"/> Kent	<input type="checkbox"/> Montgomery	<input type="checkbox"/> Prince George's	<input type="checkbox"/> Queen Anne's	<input type="checkbox"/> Somerset
<input type="checkbox"/> St. Mary's	<input type="checkbox"/> Talbot	<input type="checkbox"/> Washington	<input type="checkbox"/> Wicomico	<input type="checkbox"/> Worcester
<input type="checkbox"/> Other (please specify):				

19. Is outreach similar across jurisdictions? If not, please explain.

[Click or tap here to enter text.](#)

20. How do program outcomes compare to Statewide rates by demographic categories such as race and ethnicity? In other words, are program participants better off than non-participants?

[Click or tap here to enter text.](#)

21. Add hyperlinks to any internal or external evaluations, assessments, legislative studies, or audits of the program. (If any)

Click or tap here to enter text.

22. Upload additional information. (If any)

### **Section Three: Additional Questions**

23. Identify ongoing monitoring and evaluation efforts regarding health disparities (e.g., consumer surveys, equity of reach and equity of impact performance metrics, program reviews, other formal program evaluations and efforts, etc.)

Click or tap here to enter text.

24. Describe any remaining gaps, services, or other ideas the department/office/bureau has on reaching vulnerable populations.

Click or tap here to enter text.

25. Is there anything else you would like to add?

Click or tap here to enter text.

**For official submission of your responses, please enter the online application by using this link: <https://www.surveymonkey.com/r/QBSKL6X>**

**Contact Diana or Mariama if you have additional questions or need assistance. Thank you!**



**MARYLAND**  
**Health Care**  
**Commission**

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Baltimore, MD 21215

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[mhcc.maryland.gov](http://mhcc.maryland.gov)