Maryland Commission on Health Equity

2022 ANNUAL REPORT

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Glossary

Acronym	Exansion
CBO	Community Based Organization
DAC	Data Advisory Committee
HEPA	Health Equity Policy Assessment
HEPC	Health Equity Policy Committee
HIAP	Health in All Policies
HLA	Health Lens Analysis
HOP	Health Opportunities Program
HSCRC	Health Services Cost Review Commission
LHD	Local Health Department
MCHE	Maryland Commission on Health Equity
MFHN	Maryland Faith Health Network
SDOH	Social Determinants of Health
SDW	Study Design Workgroup
SMW	Small Workgroup
VoC	Voices of the Community
YPLL	Years of Productive Life Lost

Message from the Chair

Collaborating to advance health equity in Maryland's public-health and healthcare systems is imperative to provide an opportunity for all Marylanders to achieve their highest level of health and well being. The Maryland Commission on Health Equity (MCHE) was established by the Shirley Nathan-Pulliam Health Equity Act of 2021 in furtherance of this goal. In its first year of operation, the Commission has convened a coalition of state and local-government partners to collaborate on ideas and initiatives to develop a comprehensive health equity plan for Maryland that will address the social determinants of health and promote health equity for all Maryland communities.

This document is the first Annual Report for the MCHE. The report summarizes the progress that was made in year one and outlines the work that remains in the years to come. The report demonstrates the enthusiasm and energy the Commission has seen from participating state and local agencies, subject-matter experts, and other members contributing their time and effort to the shared mission of health equity. While each independent agency aims to tackle inequities through its own influence and mandate, the Commission sees the opportunity for greater impact through collaboration and coordinated effort.

The MCHE has been organized into two subcommittees: the Data Advisory Committee, which will make recommendations on state health equity data needs and reporting; and the Health Equity Policy Committee, which will develop a Health Equity Framework to promote the establishment of systems and programs to address health disparities.

This report summarizes the efforts of these committees and the progress they have made over the past year.

The Commission is dedicated to making tangible progress toward reducing health disparities in Maryland through inter-agency collaboration and alignment. We look forward to building on the work we have done in year one to move towards a more just and equitable Maryland.

Sincerely,

Steven R. Schuh
Chair, Maryland Commission on Health Equity

Overview of the Maryland Commission on Health Equity

The Shirley Nathan-Pulliam Health Equity Act of 2021[1] established the Maryland Commission on Health Equity (MCHE). The mandate outlined in the legislation requires the MCHE to advise on issues of racial, ethnic, cultural, and socioeconomic health disparities, develop a comprehensive health equity plan to address the social determinants of health, and set goals for achieving health equity in alignment with other statewide planning activities.

To achieve these goals, two subcommittees were created under the MCHE: the Data Advisory Committee (DAC) and the Health Equity Policy Committee (HEPC). The DAC is statutorily required and will make recommendations on data collection, needs, reporting, evaluation, and visualization. Additionally, the DAC is charged with developing, maintaining, and utilizing a Health Equity Data Set defined by and approved by the MCHE. The HEPC will advise the MCHE on employing a Health Equity Framework, a public health model for reducing inequities in health outcomes.

Since October 1, 2021, the membership of the MCHE was impaneled with representatives of all relevant state agencies named in the legislation. A full roster outlining departmental representatives can be found in Appendix I. Additionally, Bylaws governing MCHE operations were created and adopted by the members of the MCHE (see Appendix II).

The MCHE has met on five occasions since it was first established. MCHE meetings have included briefings from both the chairs of the HEPC and the DAC. The meetings also featured updates from representatives of the Community Health Resource Commission, who provided briefings on the work of the Health Equity Resource Communities initiative, and from representatives of the state's Statewide Integrated Health Improvement Strategy initiative to help ensure that MCHE efforts align with Maryland's population-health priorities. Larger MCHE meetings also include special presentations from leaders in the health equity space.

To view meeting agendas, minutes and presentation materials, please visit: https://health.maryland.gov/mche/Pages/default.aspx.

[1] The Shirley Nathan–Pulliam Health Equity Act of 2021. https://mgaleg.maryland.gov/2021RS/Chapters_noln/CH_750_sb0052e.pdf

Data Advisory Committee Update

Understanding data on health inequities and current disparities in Maryland is a key initial step in advancing health equity. In the spring of 2022, the DAC began meeting to develop a plan for fulfilling its mandate, as outlined in the Shirley Nathan-Pulliam Health Equity Act. To organize its efforts, the DAC established a Charter to ensure clarity in understanding and alignment of purpose.

Mission of the Data Advisory Committee (DAC)

Pursuant to the legislation, the DAC is required to define the parameters for a Health Equity Data Set to be maintained by Maryland's health information exchange, including indicators for:

I. Social and Economic Conditions;

II. Environmental Conditions;

III. Health Status;

IV. Behaviors;

V. Health Care, and

VI. Priority Health Outcomes for Monitoring Health Equity for Racial and Ethnic Minority Populations in the State.

Additionally, the DAC is charged with advising the MCHE with:

- making recommendations on the training of healthcare providers to promote consistent and proper collection of data on race/ethnicity and language spoken, and
- identifying measures for monitoring and advancing health equity in Maryland.

DAC Membership

A complete list of DAC members can be found in Appendix III.

DAC Membership Responsibilities

DAC members are expected to meet at least quarterly or as needed and are required to:

- Attend subcommittee meetings and calls;
- Provide policy and public health perspective;
- Review draft reports and documents;
- Issue periodic reports and recommendations to the full commission;
- Review and reassess the adequacy of the DAC Charter annually and recommend any proposed changes, and
- Perform other appropriate responsibilities, as assigned.

The DAC seeks to reach recommendations through consensus as much as possible. The approach includes but is not limited to:

- Active participation and deliberation among participants;
- Consideration of all ideas and points of view;
- Resolution of differences through open discussion, and
- Identification of areas of agreement and disagreement.

Current Status

In furtherance of its mission, a small workgroup (SMW) focused on study methods was developed with key members of the DAC. This group was convened to review and assess technical details related to the Health Equity Data Set. The SMW has made substantial progress in identifying and planning key activities and tasks that need to be undertaken in order to fulfill the charge to the DAC.

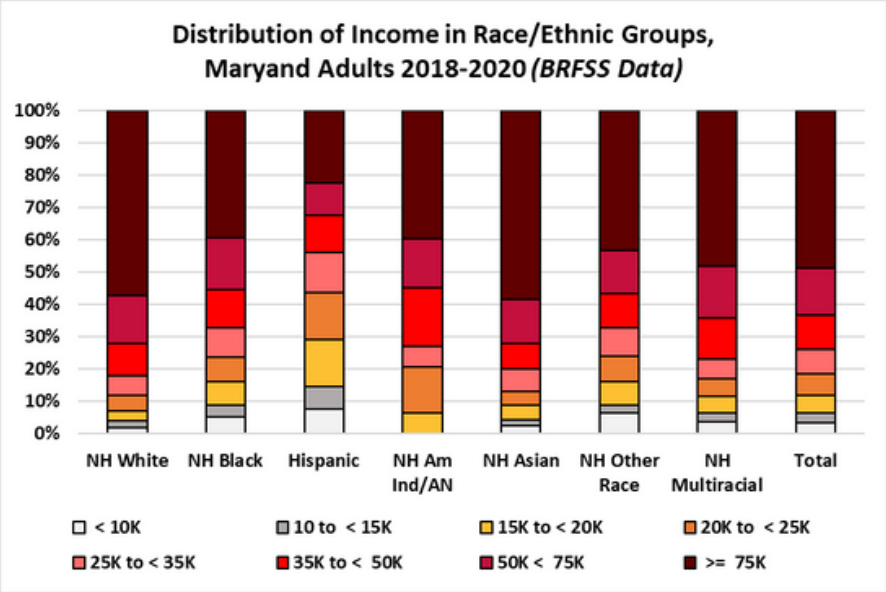
Based on the legislative requirements and deliverables required of the MCHE, the members of the SMW (and the DAC, by extension) continue to consider a set of questions to guide the development and maintenance of the Health Equity Data Set. These questions are related to determining the adverse social factors that cause disparities in health outcomes, including:

1. Which adverse social determinants have the strongest effect on poor health in Maryland?
2. Which adverse social determinants are most common in Maryland?
3. Based on the above, which adverse social determinants generate the most “poor health” in Maryland?

4. Which places in Maryland have the most adverse social determinants (for targeting intervention programs)?

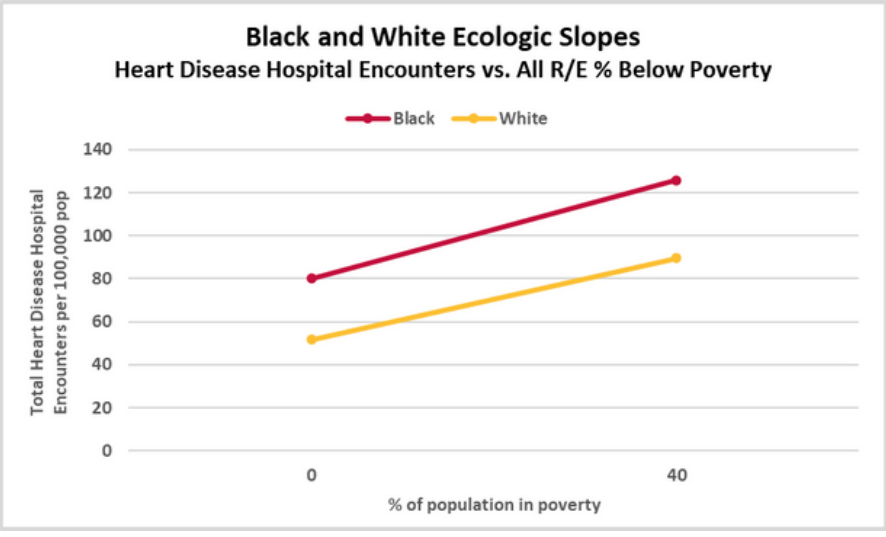
Figure 1, below, illustrates an example of descriptive charts of social determinants of health that the DAC will produce.

Figure 1. Distribution of Income in Race/Ethnic Groups for all Maryland Adults (2018–2020)



While the example above shows statewide data, analogous charts for individual jurisdictions will also be produced as the DAC continues its analytical work. These charts will also be created for the other nine legislatively defined social factors, for which available variables and data have been identified. The DAC intends to also produce reports on the health impacts of social determinants, including charts similar to Figure 2, below.

Figure 2. Total Heart-Disease-Related Hospital Encounters per 100,000 Population, by Percent of Population Below the Federal Poverty Line by Maryland Jurisdiction and Race

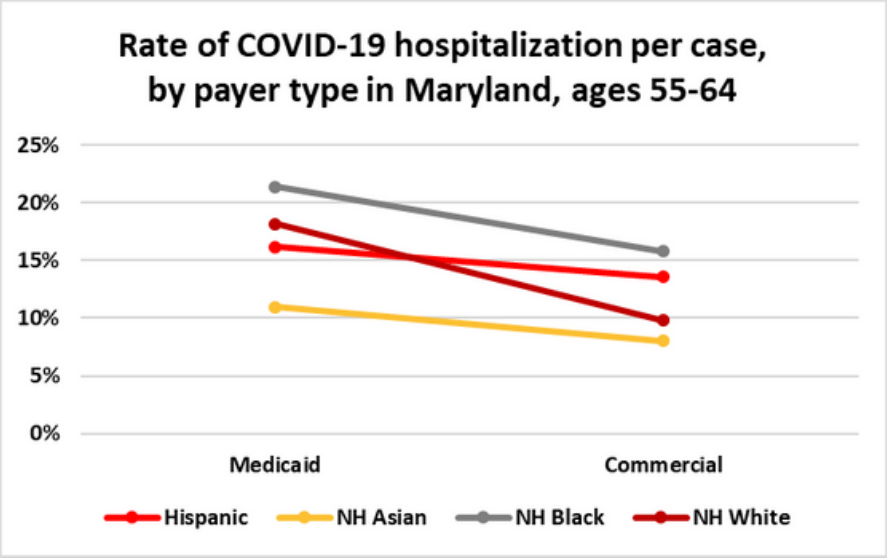


The chart in Figure 2 represents the relationship between levels of a social factor (poverty) and levels of health outcomes (heart disease-related hospital encounters). In this example, we see that for both Black Marylanders and white Marylanders, as the percentage of poverty in a location increases, the hospital encounter rate for heart disease also increases. Additionally, we see that at every level of poverty, the Black hospital-encounter rate exceeds the white rate. This indicates that poverty explains some, but not all, of the racial difference in the outcome. This type of analysis will be performed to compare racial/ethnic-specific rates of social factors and health outcomes for all racial/ethnic groups where the analysis can be validly produced. This analysis will be completed initially for 10 social-factor variables and six selected health outcomes:

1. Diabetes death rate;
2. Asthma-related emergency department visit rate;
3. Low birth weight rate;
4. Opioid overdose death rate;
5. Health uninsurance rate, and
6. Years of productive life lost (YPLL).

Eventually, the goal of the DAC is to create person-level data sets with variables on social factors and health outcomes. An example of this analysis is the following chart, which was able to be done on person-level data in the COVID-19 database comparing the cumulative rate of COVID-19 hospital admission per COVID-19 cases between Medicaid-insured and commercially insured (a proxy of poverty vs. non-poverty).

Figure 3. Comparison of Medicaid-Insured and Commercially Insured COVID-19 Hospital Admissions per COVID-19 Case



This analysis shows there is a difference between the COVID-19 hospitalization rates for individuals between the ages of 55 and 64 when comparing Medicaid to commercial insurance. For all groups, hospitalizations per case are better for commercial insurance than for Medicaid. There is a greater degree of benefit of commercial insurance for non-Hispanic whites than for the racial/ethnic minority population. Further analysis should explore why commercial insurance and corresponding non-poverty protect white Marylanders more than minority populations.

The SMW initially identified three potential database models to analyze health outcomes by social factors including:

1. Ecologic data set at the ZIP-code level, county level, or something in between. This produces a ZIP-code-level or county-level analysis of the relationship statewide.

2. Imputed person-level data: ZIP-code-level or county-level social factor data are imputed into person-level data sets of health outcomes. Person-level analysis is possible with this model within-county and even within-ZIP-code relationships. However, there is risk of exposure misclassification.

3. Actual person-level, social-factor data linked to person-level health outcome data. This permits person-level analysis of within-country and within-ZIP relationships, with less misclassification. However, the assembly of such a data set is very time- and labor-intensive.

Within the DAC, a separate workgroup was formed to more closely examine the specifics of analyzing health outcomes by social factors. This workgroup is referred to as the Study Design Workgroup (SDW). Due to the uncertainty of available funding to resource questions two and three, the SMW and the SDW has recommended that database model #1, which involves the identification and use of existing data sources for an ecological analysis at the jurisdictional level, as the most-efficient and cost-effective way to move the project forward initially, in order to meet the reporting deadline of December 1, 2023. Developmental work toward the eventual implementation of model #3 will also be pursued as funding resources for this effort are identified. The SDW is also identifying and assessing key questions that need to be answered including the following:

1. What data sets are readily available to use?
2. What types of Data Use Agreements are needed?
3. Where should the analytic workforce reside (MD THINK, etc.)?
4. What should be the size of the analytic workforce?
5. What qualifications are needed for the data analysts?

The DAC, SMW, and SDW all continue to work to fulfill the charge to the DAC. Status updates on progress are provided periodically to MCHE leadership, the Health Equity Policy Subcommittee, and to the DAC sub-workgroups. The DAC is on track to fulfill its charge and to support the MCHE to fulfill its legislative mandate.

Health Equity Policy Committee Update

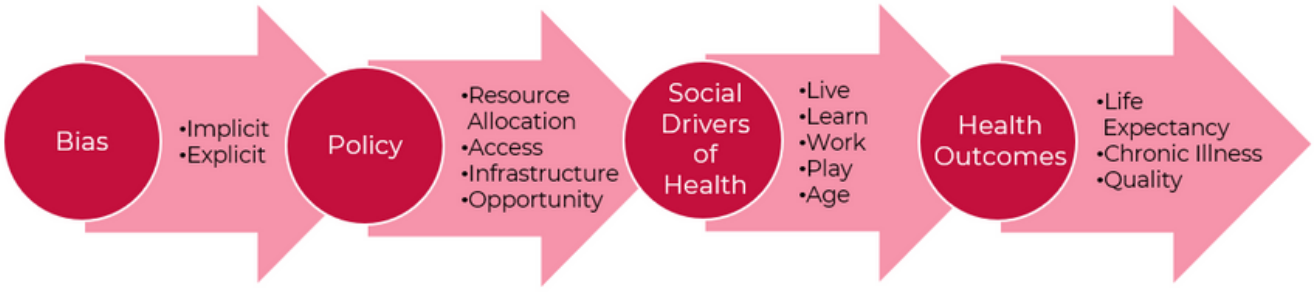
The HEPC is charged with advising the MCHE on employing a Health Equity Framework, which is a public-health planning model to reduce inequities in health outcomes. In managing that responsibility, the HEPC determined that three workgroups should be convened to focus on various aspects of operationalizing the legislation, including policy, voices of the community, and best practices. A summary of the work of these groups, critical considerations, and goals for future examination are provided below.

Workgroup 1: Policy

Although health disparities and health inequities have long existed, public acknowledgment and support for addressing disparities holistically has been gaining momentum over the past several years. Making progress on Maryland's equity goals requires not only consideration of the outcomes driven by and incentivized in policy, but also an awareness of and consideration of equity through the policymaking and policy-decision process.

Up to 80 percent of health outcomes are influenced by non-clinical factors, such as access to nutritious food, reliable transportation, quality housing, and financial stability. In other words, most of our health is driven by factors that happen outside of the doctor's office or by factors unrelated to direct care.[2] In fact, our health is increasingly determined more by the ZIP code we live in than by the doctor we see. These conditions – where people live, learn, work, and play – affect a wide range of health and quality-of-life risks and outcomes. Figure 4, below, demonstrates how upstream causes (bias, policy) lead to downstream health effects.

Figure 4. Upstream Impacts of Health Effects



[2] Robert Wood Johnson Foundation, 2019. https://www.rwjf.org/en/library/research/2019/02/medicaid-s-role-in-addressing-social-determinants-of-health.html

Each state agency has a role to play and can influence various social driver domains, as seen in Figure 5 below, which was presented in the Maryland Health in All Policies Guide for Implementation.

Figure 5. Social Determinants of Health

To neutralize bias and to enhance awareness of social determinants of health, policy- and decision-makers must apply a health equity lens. This requires strategies focused on three key factors: intention, awareness, and data. A health equity policy assessment (HEPA) enhances decision-making processes and minimizes unintended consequences by leveraging all three of these factors. The HEPA is a tool used to guide an entity through a Health Lens Analysis (HLA), through which health and other agencies work together to create mutually beneficial goals.

The five steps of an HLA are to:

1. Engage other sectors;
2. Gather evidence;
3. Generate policy recommendations;
4. Navigate the decision-making process, and
5. Evaluate effectiveness.

The HEPA consists of five questions (see Appendix IV) intended to facilitate thoughtful and intentional policy- and decision-making, while centering on equity and building a culture around health equity. The HEPA tool is intended to foster dialogue on how equity is considered in both process and outcomes by illuminating blind spots and by avoiding unintended consequences along the policy-development continuum.

To ensure effective and focused implementation of an HLA using the HEPA, we would propose utilizing a case study as an example of how the tool would work. The workgroup selected housing as one of the social determinants of health to explore, based on prior research and the knowledge and experiences of workgroup members. There is strong evidence characterizing the relationship between housing and health outcomes. Housing stability, quality, safety, and affordability all affect health outcomes, as do physical and social characteristics of neighborhoods.2 Additionally, there are many factors connected directly or indirectly to housing and correlated with the social determinants of health (e.g., access to affordable and quality housing or accessibility of public transit relative to where individuals reside). A listing of planned measures and data sources is provided in Appendix V.

Workgroup 2: Voices of the Community

The Shirley Nathan–Pulliam Health Equity Act of 2021 emphasized that community perspectives and insights would be essential to informing the approach to health equity within the State of Maryland. As such, the HEPC created a workgroup focused on identifying and infusing community perspectives into the work of the larger committee – the Voices of the Community (VoC).

The VoC Workgroup utilized two strategies for incorporating community voices into the final report that will be provided in December 2023. The first is gaining knowledge of communities by utilizing both new and existing data sources from community forums (e.g., focus groups or town hall meetings) and community surveys. This strategy will be implemented next year.

The second strategy is the development of personas, which are tools that seek to derive insights using community profiles. The VoC workgroup worked between February 2022 and August 2022 to examine the perspectives of different communities and needs using person-based reporting. This type of reporting brings insight based on the real-life experiences of community members that have been disenfranchised or underserved in Maryland. The design concept took individuals that exemplify various community members that the VoC Subcommittee believes are most impacted by health inequities in Maryland and created a story around their experience, fears, goals, and needs. These stories aimed to help the VoC Subcommittee identify overarching themes that have the most potential to be impacted by policy related to health equity.

The VoC Workgroup began this exercise by putting together empathy maps for different types of community members (for example, an older, retired, chronically ill, Black American that is on a fixed income). An empathy map is a collaborative visualization tool that articulates information about a particular individual or group of stakeholders (referred to as a “persona”).

Each empathy map laid out the persona's daily tasks, feelings, pains, and goals to lay the foundation of his or her daily experiences and needs. The empathy maps created the context for current medical and social structures to provide vision into the gaps between what communities are experiencing and what is needed to overcome systemic inequities.

The VoC Workgroup identified two key emerging possibilities for engagement with communities directly, with policy impacts that can support requested activities.

1. **Verify persona details through community engagement**: Support funding to allow for direct community engagement to verify the persona-development activities, including interviews with Community-Based Organizations (CBOs) and Local Health Departments (LHDs) and analysis of Maryland Department of Health engagement data. Through direct interaction with community members, CBOs, and LHDs, the VoC Workgroup can validate the community representative's assumptions of gaps that have the greatest impact on individuals facing inequity and provide clarity into policy recommendations that target those specific gaps.

2. **Partner with existing state initiatives to determine feasibility of a broad, community-navigator concept**: An overarching theme from the empathy maps created by the VoC Workgroup was that communities experiencing inequities can benefit from key individuals who are culturally competent and can help community members navigate their physical-, mental-, and spiritual-health landscapes. Personas commonly identified that it is hard to navigate "the system" alone, especially when facing inequity in social structures, digital literacy, and education. The Maryland Faith Health Network (MFHN), which was created by the health advocacy organization, Health Care for All, developed a health-/community-navigator concept in 2015. The goal of this model is to connect hospital administrators to a "safe leader" in congregations, CBOs, or other trusted organizations in an effort to promote guided navigation through the healthcare system and social-. assistance programs. The MFHN was successful in that it demonstrated that a concept such as this could keep individuals out of the hospital and even reduce the number of return visits.

Based on the response to this initial submission, the VoC Workgroup will continue to develop community personas and to incorporate community voice through the most-feasible mechanisms available. Information shared through the Best Practice Workgroup provided other potential models (such as examples from Washington and Massachusetts) that could be used to further assess health inequities at the community level. These approaches could be used to supplement a coordinated strategy to implement the recommendations made in a 2015 report issued by the Health Services Cost Review Commission's (HSCRC) Consumer-Standing Advisory Committee.

Workgroup 3: Best Practices

The Best Practices Workgroup was tasked with the responsibility of creating a Health Equity Framework, as mandated by the Shirley Nathan–Pulliam Health Equity Act of 2021. This workgroup focused its efforts on research into the health equity strategies being implemented in California, Illinois, Massachusetts, North Carolina, Texas, and Washington. Of these, North Carolina and California offer examples of Medicaid 1115 waivers. California, Massachusetts, and Washington have varying approaches for creating and implementing innovative strategic plans that address both underlying and related racism issues and the social determinants of health as the drivers for disparate treatments and health outcomes. (A narrative of key aspects for each of these three states is included as Appendix VI.) The next research phase should include a comprehensive environmental scan of policies, strategies, and programs currently in place, or planned, for the Maryland Department of Health and LHDs, as well as all other State agencies and divisions.

Throughout its research and analysis, the Best Practices Workgroup observed the historical impacts of racism on our healthcare systems, primarily within "communities of color, people with lower socioeconomic status, and individuals with disabilities, who are more likely to experience poor health outcomes as a consequence of their social determinants of health."

To reduce health disparities, the workgroup identified the following as key components for Maryland's Health Equity Framework:

1. *Committed leadership* – Committed leadership with the assurance of adequate resources (financial and human) and an administrative structure to support effective coordination across all state agencies are critical to success. Washington State has created an Office of Equity that coordinates a government-wide, health equity agenda and provides consulting services and resources to other departments. Maryland could create a Sub-Cabinet Commission on health equity to serve a similar purpose.

2. *Innovation in health payment systems* – A Medicaid Waiver program, such as North Carolina's Healthy Opportunities Program (HOP), and other innovative models being piloted in other states could be explored in Maryland.

3. *Standardization of data across all departments* – At a minimum, government agencies should be required to implement the data-reporting standards outlined in the CMS Framework for Health Equity. Adoption of this framework will standardize data on "race, ethnicity, language, gender identity, sex, sexual orientation, disability status, and SDOH."

4. *Framework operational transparency* – Maryland could create a publicly accessible, interactive, data dashboard to measure progress toward promoting more-equitable health outcomes, ensure accountability, and provide the tools to encourage community engagement and to build public confidence. Innovative models include the California Healthy Communities and Data Indicator Project, which incorporates 9 SDOH-related domains. Massachusetts is addressing the challenges of health inequities with the Racial Equity Data Road Map, and Connecticut is also assessing the promising models. Another promising resource is the HOPE Initiative, which tracks social determinants of health and health outcomes by race, ethnicity, and socioeconomic status.

5. *Comprehensive health equity analyses* – Data insights should be incorporated into legislation and resource allocation. Such insights could include:
    - Implementation of Health in All Policies (HIAP)
    - Development of Departmental budgets, and
    - All proposed legislation (see Policy Workgroup).

6. *Support of cultural competency and literacy* – Policymakers can promote health equity by promoting training for the healthcare workforce and by leveraging the resources of the Horowitz Center on Health Literacy's Consumer Health Information Hub to increase Marylanders' health literacy levels.

The Best Practice Workgroup is near completion of its work in identifying and analyzing models for health equity. The Workgroup will continue to scan for any additional or emerging models and/or practices that may prove useful to the final framework recommendations.

Health Equity Policy Subcommittee Summary

HEPC Members and Contributors are listed in Appendix VII. Collectively, the members of the HEPC see the interrelatedness across all the workgroups and see the work moving forward with these two fundamental aspects already established by the current findings and discussion:

1. The success of any health equity framework requires collaboration across all state agencies in a formalized structure to house the framework and with established resources and regulations to govern it.

2. Data of multiple types and at multiple levels are key for the work. A data system that comports with a health equity framework should be independently funded to assure that the data and analyses needed to document inequities and to monitor change are available and sustainable. As with the framework, data should be comprehensive and multi-faceted and should be assessed on a regular basis to keep pace.

It is essential that whatever Health Equity Framework is finally established, it should be viewed as a living document that reflects: (a) ongoing analysis of Maryland's progress on its vision and mission; (b) the most-current and -comprehensive data; (c) analysis of the best practices and models being carried out in Maryland and in other states; and (d) the voice and input of Maryland residents, specifically those impacted by the history of racism and other exclusionary practices that help produced the inequities we see today.

Looking Forward

In the next year, the MCHE will continue to convene to implement policies and recommendations from both supporting subcommittees. The DAC will work toward fulfilling its legislative mandate of producing a Health Equity Data Set, and the HEPC will present a Health Equity Framework for adoption. These concurrent efforts will support the MCHE's mission for improving health outcomes for all Marylanders.

Appendices

I. Membership Roster
II. Organizational Policies
III. DAC Leadership and Membership

Name	Affiliation/Email Address
Baur, Cynthia	University of Maryland
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DeShields, Tracey	Maryland Hospital Association
Dougherty, Geoff	Health Services Cost Review Commission
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Eckert, Katie	Maryland Hospital Association
Fries, Anja	CRISP
Hill-Golden, Sherita	Johns Hopkins Medical System
Martin, Mark	MDH, Office of Minority Health and Health Disparities

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Peralta, Ligia	ligiaperalta@gmail.com
Van Sluytman, Laurens	Morgan State University

IV. Health Equity Assessment Tool (Key Questions)

1. What is the policy under consideration?
    - What are the desired results and outcomes? How would the proposed policy change existing racial and other inequities? How does the proposed policy address historic or contemporary inequities?
2. What are the racial and other equity impacts of this particular decision?
    - Who is most impacted (neighborhoods, regions, racial/ethnic groups, income groups)?
3. Who will benefit from or be burdened by the particular decision?
    - Are there potential negative impacts or unintended consequences? Are there strategies to mitigate the unintended consequences?
4. Have affected community members or leaders been engaged in the development or vetting of the proposal?
    - What has your engagement process told you about the factors that produce or perpetuate racial inequity related to this proposal? What has your engagement process told you about how the proposed policy will be perceived by affected groups?

5. Can the policy be successfully implemented and evaluated for impact?
    - Is there adequate funding, required community/stakeholder engagement, mechanisms for accountability, data collection, and reporting to track progress? (Data collection can include a combination of quantitative and qualitative data gathered from screening, public health data, hospital data, public agencies and other formal sources.)

Abbreviated assessment tool for "quick turnaround decisions" (3 questions):

1. What are the racial equity impacts of this particular decision?
2. Who will benefit from or be burdened by the particular decision?
3. Are there strategies to mitigate the unintended consequences?

V. Measures and Sources of Data (Housing)

Domain	Subdomain	Measure	Source
Well-Being of Places	Healthy communities index	US News and World Report Healthiest Communities Rankings	US News & World Report Healthiest Communities Rankings
		County health rankings and roadmaps ranking	County health rankings and roadmaps rankings

Environment & Infrastructure	Neighborhood characteristics	Net migration: % change in population in a 10-year period, accounting for births and deaths	University of Wisconsin Madison Applied Population Lab
		% of population living within a 10-minute walk of green space	ParkServe(R), The Trust for Public Land
		Theil Index measuring racial segregation (scored 0-1, with 0 being LEAST diverse)	Census
		Distressed Communities Index (0- 100)	Economic Innovation Group
		Area Deprivation Index (0-10)	Health Innovation Program
	Built environment	Presence of lead levels above safe limits in drinking water (0 = no presence, 1= presence)	EPA
		Walkability index	US Environmental Protection Agency (EPA)
Food & Agriculture	Food availability	% of population with low food access, defined as living beyond 1 mile (urban) or 10 miles (rural) of supermarket	USDA Food Security Survey, Feeding America
Housing	Infrastructure & capacity	One-day sheltered homeless rate (# per 10,000)	Census/ACS
		30-day placement rate into permanent supportive housing	HUD

	Quality	% of households with one or more of these housing conditions in 2010: lacked complete plumbing, lacked complete kitchen, paid 30 percent or more of income for owner costs or rent, or had more than one person per room	US Department of Housing and Urban Development
	Use/ Affordability	% of households paying 30% or more of their income for housing	US Department of Housing and Urban Development Comprehensive Housing Affordability Strategy (CHAS) data
		H+T affordability index (housing + transportation) (0%-100%)	Center for Neighborhood Technology
Public Safety	Perceptions of public safety	% of adults who feel safe walking on their street after dark	Gallup Crime Survey

Source:
https://insight.livestories.com/s/v2/win-measures/2fda874f-6683-49bd-adb2-22f6f3c5a718/

VI. Health Equity Preliminary Comparison of State Frameworks

The Best Practices Work Group (BPWG) of the Policy Advisory Committee of the Maryland Commission on Health Equity was asked to research effective health equity models in other states. As a result, the BPWG undertook an initial analysis of health equity initiatives in three states (California, Massachusetts and Washington). The goal of their efforts, as with Maryland, is to ensure that all residents have "equal opportunities for optimal health, mental health and well being." Included below are what have been identified to date as key elements that could inform the development of Maryland's Health Equity Framework. Relevant sections of the CMS Framework for Health Equity are also cited below.

The health equity plans for each state have been developed over a period of years and some, like Massachusetts, have taken on increased urgency in light of the impact of disparities that have been highlighted by COVID-19. This document is not intended to be a complete analysis of any one plan. Rather, it is a first look at elements that Maryland could or should consider as it moves forward.

To further inform the process, it would be advisable to conduct a full environmental scan of all current and proposed health equity-related efforts in Maryland, particularly those in the public sector. This would support the effective leveraging of successful endeavors while reducing expensive duplicative efforts.

Additional research should also include related models in other states such as Pennsylvania. The PA Rural Health Model bears similarities to Maryland's own unique Total Cost of Care Model that could prove useful. Additional information can be found in the Discovery Article – Addressing Health Equity in rural Pennsylvania; Office of Health Equity, The State of Health Equity in Pennsylvania.

VII. HEPC Members and Contributors

The following individuals are members or contributors to the HEPC: Betsy Baker, Michelle Boulden-Hammond, Meenakshi Brewster, Michelle Briggs Blanc, Orville Browne, Dimitri Cavathas, Sandra Conner, Daryl Gaskin, Leeshe Grimes, Danielle Haskin, Gabriela Lemus, Djinge Lindsay, Michael Planz, Eleanor Preston, Donald Shell, Brian Sims, Kim Sydnor, Toni Thompson-Chittams, Hoai-An Truong.