Office of Minority Health and Health Disparities Annual Report 2024

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Maryland Department of Health

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Executive Summary

The Office of Minority Health and Health Disparities (MHHD) within the Maryland Department of Health (MDH) was established by statute in 2004 (Health-General § 20-1001-1007). The statute sets forth 22 areas of focus and responsibility for the office.
The mission of MHHD is to:

- Address social determinants of health, reduce health disparities and advance health equity by leveraging the resources of the Maryland Department of Health;
- Collect, compile, and analyze race and ethnicity data to improve health outcomes;
- Foster robust community public/private partnerships to advance health equity advocacy and education.
- Guide policy, practice, and program decisions within MDH, and influence the overall strategic direction of the Department on behalf of the Secretary of Health.

Additional legislation in 2021 added (1) participation on the Maryland Commission on Health Equity, (2) responsibility for creating and maintaining a list of implicit bias training courses for licensed health care providers, and (3) the creation of a healthcare disparities report card to MHHD's portfolio of responsibilities.

Health Equity Data

Data presented in this report shows that Maryland's investments in minority health improvement and minority health disparity reduction are bearing some fruit, particularly in the areas of mortality disparities for several leading causes of death. These results also show that for other areas, such as preventable health care utilization and HIV/AIDS, large disparities remain.

MHHD Collaboratives and Initiatives

- MHHD launched a Health Equity Liaisons Collaborative within the Maryland Department of Health committed to integrating health equity principles throughout the work of the department.
- MHHD supported the Maryland Commission on Health Equity's two committees - the Data Advisory Committee and Health Equity Policy Committee - until the MCHE's reorganization in October 2004 at which time the MHHD Director was appointed to serve as a member of the Commission.
- MHHD finalized a state health equity framework building upon the work of the MCHE Health Equity Policy Committee. The framework is a public health framework through which policymakers and stakeholders in the public and private sectors can use collaborative approaches to improve health outcomes and reduce health inequities in the State by incorporating health considerations into decision making and policy.
- MHHD guides MDH in implementing health impact assessments and related frameworks and toolkits across the department to support building the agency's health equity capacity.

- MHHD provides advice and guidance to MDH colleagues, community, faith-based and academic partners; and healthcare associations and organizations on reducing disparities and addressing social determinants of health statewide.
- MHHD develops and circulates within MDH a health equity newsletter that aims to inform employees about the latest news, research, and policy developments related to achieving health equity.
- MHHD continues to offer extensive support to the Root Causes of Health Initiative (RoCHI), which is an equity-focused quality improvement project being implemented by the Prevention and Health Promotion Administration (PHPA) within MDH. The project seeks to determine the "equity of reach" and "equity of impact" for various PHPA programs. Some programs have good equity of reach and impact, and other programs have a mismatch of reach and/or unequal impact.
- MHHD continues to identify and approve implicit bias training programs that healthcare providers must complete to satisfy the requirements of the Health Occupations Article registration or renewal process. MHHD has listed 20 approved training courses for this purpose on its website.

MHHD Grant Programs at a Glance

In FY 2024 MHHD administered over $4M in grant funding to 41 community-based and faith-based organizations, academic institutions, and local health departments.

- Minority Outreach and Technical Assistance (MOTA) Program
    - $509,999 to 12 grantees reaching 32,930 individuals.
- Social Determinants of Health (SDOH) Program
    - $2,170,000 to 21 grantees reaching 102,608 individuals.
- Epidemiology and Laboratory Capacity (ELC) Program (CDC COVID funds)
    - $1,764,000 to 8 grantees reaching 14,301 individuals.

MHHD Communications and Social Media Outreach

In 2024 MHHD increased its reach through utilizing communications channels such as social media, a department-wide quarterly newsletter, and collaborations with other MDH units collectively reaching tens of thousands of Marylanders.

MHHD Legislative Review

In 2024 MHHD centered principles of fairness and justice when analyzing legislative bills assigned to the office for review during the Maryland General Assembly's 90-day legislative session. MHHD emphasized highlighting and addressing the structural barriers and systemic inequalities that often hinder access to and quality of care for marginalized and underserved populations in key areas where legislative action can advance health equity.

MHHD Student Training Programs

In 2024 MHHD hosted two interns through the Public Health Workforce Development Internship Program. The interns worked on a variety of projects such as data analysis, grant administration, grantee communications, and social media planning. MHHD also hosted one resident from the University of Maryland School of Medicine residency program in General Preventive Medicine and Public Health for a practicum rotation. The resident worked on equity data analysis, and learned the MHHD approach to grant award making, grantee performance management, and review of legislation.

MHHD Annual Conference

On December 10, 2024, MHHD celebrated its 20th Anniversary Health Equity Conference at Morgan State University in Baltimore. The theme was “Making Progress, More to Do.” The conference focused on health equity issues and solutions related to education; income, wealth building and medical debt; housing; workforce training and support; the needs of our aging communities; the environment; transportation; public safety; immigrant, women, rural, LGBTQIA+, veterans and disability health care needs and also included a focus on the collection, reporting and analysis of health disparities data as well as faith-based solutions. The conference highlighted successful approaches to achieving optimal health and wellness for unserved and underserved communities and understanding the impact that upstream social determinants can have on health outcomes. Former Maryland State Senator Shirley Nathan-Pulliam was in attendance and received a Lifetime Achievement Award from the office.

I. Background

The Office of Minority Health and Health Disparities (MHHD) within the Maryland Department of Health (MDH) was established in statute in 2004 (Health General §§§20-1001-1007). The statute sets forth 22 areas of focus and responsibility for the office.

The mission of the Office of Minority Health and Health Disparities (MHHD) is to:

- Address social determinants of health, reduce health disparities and advance health equity by leveraging the resources of the Maryland Department of Health.
- Collect, compile, and analyze race and ethnicity data to improve health outcomes.
- Foster community public/private partnerships for health equity advocacy and education.
- Guide policy, practice, and program decisions within MDH, and influence the overall strategic direction of the Department on behalf of the Secretary of Health.

MHHD's vision is to achieve health equity where all individuals and communities in Maryland have a fair and just opportunity to attain their optimal health regardless of race, ethnicity, sexual orientation, gender identity, or socioeconomic status

Key activities include:

- Collection and publication of race and ethnicity data through a "health care disparities policy report card", responding to data requests, and serving as a resource for information on effective data collection
- Advocating to improve minority health outcomes by establishing educational forums, programs (including grants to community-based organizations), and health awareness campaigns
- Identifying and reviewing health promotion and disease prevention strategies related to high mortality and morbidity rates among marginalized and underserved communities
- Fostering public/private partnerships
- Assisting the Secretary of Health in setting health equity priorities, advising on policies affecting the delivery of equitable health, and creating of a health equity strategic framework to address social determinants of health

Additional legislation in 2021 added (1) participation on the Maryland Commission on Health Equity, (2) responsibility to create and maintain a list of implicit bias training courses for licensed health care providers, and (3) the creation of a healthcare disparities report card to MHHD's portfolio of responsibilities.

In July 2023, Camille Blake Fall began her tenure as the fifth Director of MHHD. At that time, the office was half-staffed with 50% of its positions vacant due to employee departures. Since arriving Director Blake Fall has been able to fill the following positions: (1) Program Manager, (2) Fiscal Manager, (3) Minority Outreach and Technical Assistance Grant Manager, (4) Epidemiology and Laboratory Capacity Grant Manager, and (5) Social Determinants of Health Grant Manager. Director Blake Fall also hired a Special Assistant for Programs and Policy, a position she created to support the communications and policy needs of the office. Finally, MHHD recently executed a contract with a grant writer to offer free, open-to-the-public grant writing technical assistance workshops in 2025 tailored to

the needs and capacity building objectives of community-based organizations.

II. Health Disparities Progress and Success

The data presented below show that Maryland's investments in minority health improvement and minority health disparity reduction are bearing some fruit, particularly in the areas of mortality disparities for several leading causes of death. These results also show that for other areas, such as preventable health care utilization, HIV/AIDS, and infant mortality, large disparities remain. Efforts must continue to complete the work of eliminating minority health disparities in Maryland. Given the apparent slowing of the rate of improvement in both non-Hispanic (NH) Black and NH White health for some conditions, regaining momentum toward improvement will require one or more of the following actions:

- Application of new effective interventions
- Increasing the effectiveness of existing interventions
- Increasing the reach and scale of currently delivered effective interventions
- Finding ways to better reach the hard-to-reach populations that likely represent the highest risk for poor health and may not be being reached currently

According to the 2020 U.S. Census, the Maryland population was 6,177,224 in 2020. Of this, 48.7% were single race Whites who were not Hispanic or Latino (https://www.census.gov/library/stories/state-by-state/maryland-population-change-between-census-decade.html). This means that 51.3% of Maryland's population reported some ancestry from a racial or ethnic minority group (a group other than NH White) in 2020, making Maryland a "majority minority" state. Population estimates as of July 1, 2023, put this minority percentage at 52.7%. This characteristic of our population makes minority health and minority health disparities crucial to the overall health of Maryland. An example of this minority impact on the State's health is that before the insurance expansion under the Affordable Care Act, about two-thirds of Maryland's non-elderly uninsured were members of racial or ethnic minority groups. Another example is that between 48% and 68% of hospital utilization for asthma, diabetes, and hypertension are attributable to the Black or African American population in Maryland.

The population size of individual racial/ethnic groups in Maryland is a complex combination of those who are single race, multi-race, Hispanic or Latino, or not Hispanic or Latino members of a particular racial group. Table 1 below provides the population counts for these various categories from the 2020 census:

Table 1. Detailed Race/Ethnic Breakdown of Maryland Population as of 2020 Census

Number of Persons	White	Black	Am Ind / Alask Nat	Asian	Nat Hawaiian / Other Pac Isle	Some Other Race
Not Hispanic or Latino						
Race alone	2,913,782	1,795,027	12,055	417,962	2,575	35,314
Race in combination	229,268	127,246	73,244	73,979	6,749	54,245
Alone or in combination	3,143,050	1,922,273	85,299	491,941	9,324	89,559
Hispanic or Latino						
Race alone	94,092	25,445	19,790	2,982	672	375,627
Race in combination	184,716	29,735	23,561	7,250	1,444	194,993
Alone or in combination	278,808	55,180	43,351	10,232	2,116	570,620
Regardless of His or Lat						
Race alone	3,007,874	1,820,472	31,845	420,944	3,247	410,941
Race in combination	413,984	156,981	96,805	81,229	8,193	249,238
Alone or in combination	3,421,858	1,977,453	128,650	502,173	11,440	660,179

Percent of MD Total Pop	White	Black	Am Ind / Alask Nat	Asian	Nat Hawaiian / Other Pac Isle	Some Other Race
Not Hispanic or Latino						
Race alone	47.2%	29.1%	0.2%	6.8%	0.04%	0.57%
Race in combination	3.7%	2.1%	1.2%	1.2%	0.11%	0.88%
Alone or in combination	50.9%	31.1%	1.4%	8.0%	0.15%	1.45%
Hispanic or Latino						
Race alone	1.5%	0.4%	0.3%	0.0%	0.01%	6.08%
Race in combination	3.0%	0.5%	0.4%	0.1%	0.02%	3.16%
Alone or in combination	4.5%	0.9%	0.7%	0.2%	0.03%	9.24%
Regardless of His or Lat						
Race alone	48.7%	29.5%	0.5%	6.8%	0.05%	6.65%
Race in combination	6.7%	2.5%	1.6%	1.3%	0.13%	4.03%
Alone or in combination	55.4%	32.0%	2.1%	8.1%	0.19%	10.69%

MHHD continues to monitor racial and ethnic health disparities in Maryland and finds that while disparities continue, progress toward elimination of some disparities has been made. This progress is apparent in Non Hispanic Black (B) vs. Non Hispanic White (W) disparities in death rates from some of the most common causes of death. This is illustrated in Table 2 on p. 10 below, which shows 1999, 2009, 2019 and 2022 mortality rates and disparities for some of the leading causes of death (from Vital Statistics Administration annual reports) and rates of change over two 10-year intervals, from 1999 to 2009 and from 2009 to 2019, (pre COVID) and 2019 to 2022 (COVID era). Several other leading causes of death do not typically demonstrate Black vs. White disparities, including chronic lower respiratory disease, Alzheimer's disease, and influenza/pneumonia.

Changes over the entire 23-year period (1999 – 2022) were:
(Gap is the NH Black minus NH White difference and is the best disparity metric for population health impact):

Heart Disease age-adjusted death rate per 100,000
population NH Black trend 42.2% reduction
NH White trend 36.1% reduction
B-W gap 66.5% reduction

Cancer age-adjusted death rate per 100,000 population
NH Black trend 40.0% reduction
NH White trend 31.2% reduction
B-W gap 74.9% reduction

Stroke age-adjusted death rate per 100,000 population
NH Black trend 28.3% reduction
NH White trend 30.1% reduction
B-W gap 15.7% reduction

Diabetes age-adjusted death rate per 100,000 population
NH Black trend 39.8% reduction
NH White trend 17.2% reduction
B-W gap 54.9% reduction

HIV/AIDS (*2022 race-specific age-adjusted rates were not published by VSA***)**

Infant Mortality (infant deaths per 1000 live births)
NH Black trend 29.9%
reduction
NH White trend 39.2% reduction
B-W gap 25.0% reduction

Over the entire period, the NH Black to NH White death rate disparity expressed as the gap (rate subtraction) improved by 75% for cancer, by 67% for heart disease, by 55% for diabetes, and by 16% for stroke. The infant mortality disparity declined by 25%.

The rates of mortality improvement for both NH Blacks and NH Whites remained robust in the second 10-year period for heart disease, cancer, HIV, and infant mortality. Improvement slowed for diabetes, and for stroke improvement reversed to worsening (for both groups).

Table 2: Age-adjusted Deaths per 100,000 Population (except infant mortality)

	1999	99 to 09 % change	2009	09 to 19 % change	2019	19 to 22 % change	2022	99 to 22 % change
Heart Disease								
NH Black	**310.5**	-22.54%	**240.5**	-21.95%	**187.7**	-4.42%	**179.4**	-42.22%
NH White	**247.6**	-23.63%	**189.1**	-15.65%	**159.5**	-0.75%	**158.3**	-36.07%
Ratio	***1.25***	*7.00%*	***1.27***	*-34.95%*	***1.18***	*-24.61%*	***1.13***	*-47.53%*
Gap	***62.9***	*-18.28%*	***51.4***	*-45.14%*	***28.2***	*-25.18%*	***21.1***	*-66.45%*
Cancer								
NH Black	**254.6**	-23.53%	**194.7**	-17.46%	**160.7**	-4.85%	**152.9**	-39.95%
NH White	**203.7**	-11.39%	**180.5**	-17.95%	**148.1**	-5.40%	**140.1**	-31.22%
Ratio	***1.25***	*-68.52%*	***1.08***	*8.14%*	***1.09***	*7.39%*	***1.09***	*-63.44%*
Gap	***50.9***	*-72.10%*	***14.2***	*-11.27%*	***12.6***	*1.59%*	***12.8***	*-74.85%*
Stroke								
NH Black	**78.7**	-37.99%	**48.8**	6.97%	**52.2**	8.05%	**56.4**	-28.34%
NH White	**58.2**	-33.16%	**38.9**	2.31%	**39.8**	2.26%	**40.7**	-30.07%
Ratio	***1.35***	*-27.75%*	***1.25***	*22.42%*	***1.31***	*23.81%*	***1.39***	*9.52%*
Gap	***20.5***	*-51.71%*	***9.9***	*25.25%*	***12.4***	*26.61%*	***15.7***	*-23.41%*
Diabetes								
NH Black	**58.1**	-40.62%	**34.5**	-7.25%	**32.0**	9.38%	**35.0**	-39.76%
NH White	**23.3**	-24.89%	**17.5**	-4.00%	**16.8**	14.88%	**19.3**	-17.17%
Ratio	***2.49***	*-34.96%*	***1.97***	*-6.86%*	***1.90***	*-10.09%*	***1.81***	*-45.53%*
Gap	***34.8***	*-51.15%*	***17.0***	*-10.59%*	***15.2***	*3.29%*	***15.7***	*-54.89%*
HIV/AIDS								
NH Black	**33.8**	-47.34%	**17.8**	-58.43%	**7.4**	N/A	**NP**	N/A
NH White	**2.0**	-45.00%	**1.1**	-45.45%	**0.6**	N/A	**NP**	N/A
Ratio	***16.90***	*-4.52%*	***16.18***	*-25.35%*	***12.33***	*N/A*	*N/A*	*N/A*
Gap	*31.8*	*-47.48%*	***16.7***	*-59.28%*	***6.8***	*N/A*	*N/A*	*N/A*
Infant Mortality (infant deaths per 1000 live births)								
NH Black	**14.7**	-7.48%	**13.6**	-31.62%	**9.3**	10.75%	**10.3**	-29.93%
NH White	**5.1**	-13.73%	**4.4**	-6.82%	**4.1**	-24.39%	**3.1**	-39.22%
Ratio	***2.88***	*11.08%*	***3.09***	*-39.34%*	***2.27***	*83.13%*	***3.32***	*23.39%*
Gap	***9.6***	*-4.17%*	***9.2***	*-43.48%*	***5.2***	*38.46%*	***7.2***	*-25.00%*

Yellow highlight = an increase in the race-specific rate, or in the disparity metric, in the interval

NP *means not published* ***N/A*** *means not applicable (data for computation not published)*

Still comparing the two 10-year periods, disparity reduction (using the trend in the gap) accelerated for heart disease and infant mortality. It continued briskly for HIV, slowed for diabetes and cancer, and reversed to worsening for stroke.

The interval 2019 to 2022 is highly influenced by the health care and societal effects of COVID-19. Several rates and disparity metrics show worsening. It remains to be seen whether these patterns will resolve, or if they represent a new normal.

Slowing in the rate of improvement in prevalence of tobacco use, and the recent increases in obesity and diabetes prevalence, as well as the natural tendency for the results of any level of effort to eventually stabilize at an equilibrium point (diminishing marginal returns), may account for the slowing of progress in recent periods for some conditions.

In time periods where NH White improvement exceeds NH Black improvement, disparities increase even as NH Black health improves. Innovations tend to produce this effect, as they are often adopted sooner in more advantaged populations.

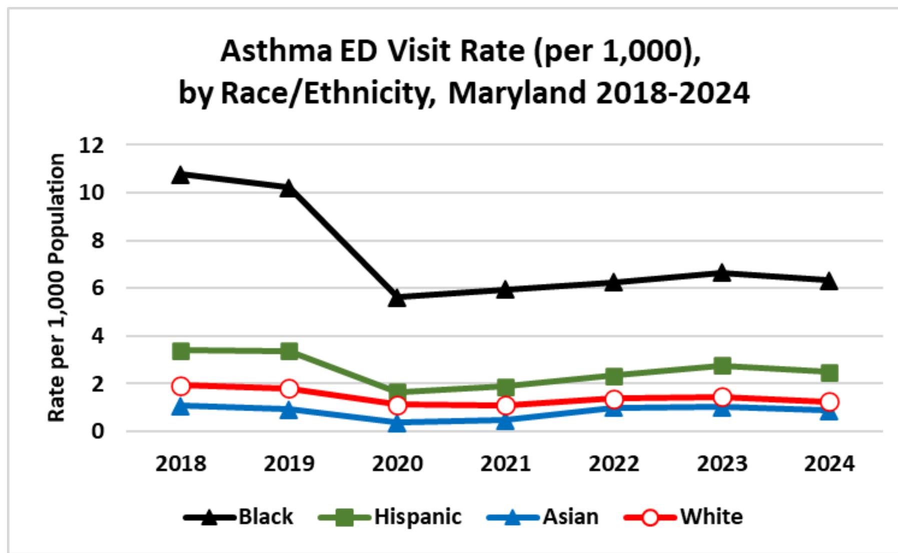
Slowing rates of health disparity reduction may also reflect a declining benefit from health care system interventions, as most of the benefits of that approach may have already been realized. Remaining disparities could be more related to disparities in the social determinants of health. Progress will require a focus on these social determinants and a health in all policies approach.

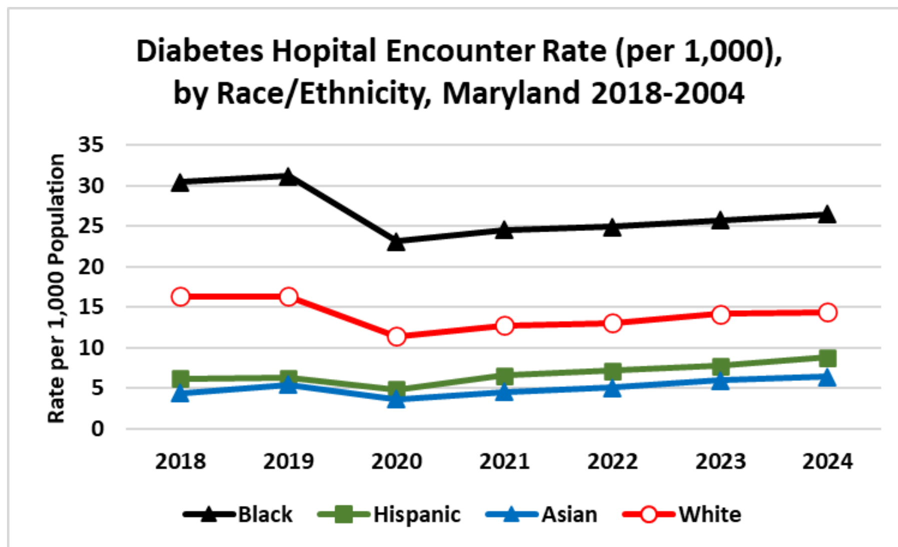
Large disparities persist in rates of preventable healthcare utilization, although some progress has been made in this area. This is shown in Figures 1 to 3 on p. 12 below, which displays the 2018 to 2024 trends in three utilization metrics from the Chesapeake Regional Information System for our Patients (CRISP) Health Equity Explorer, Disparity Index report. (*Due the small American Indian population in Maryland, data in this format is not statistically stable for that group and is not presented.)*

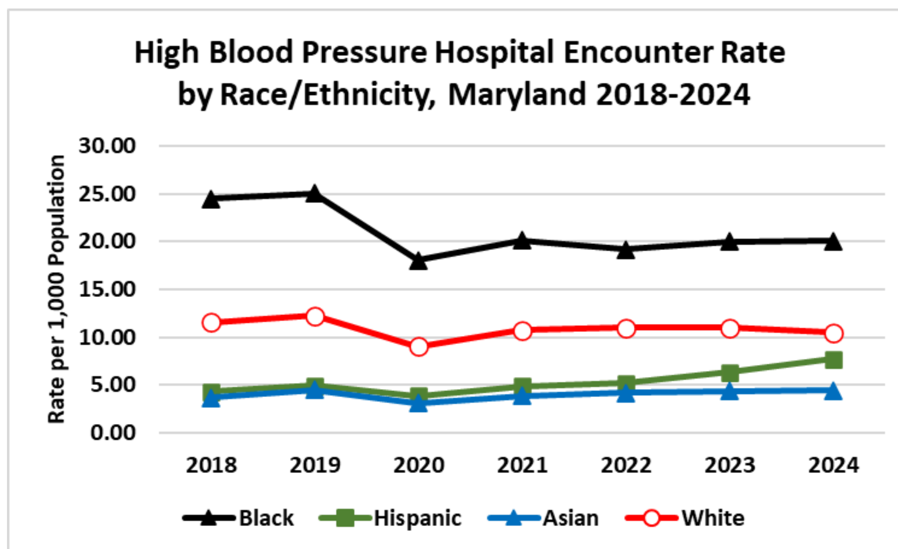
Within individual years, Black utilization rates for asthma, diabetes, and high blood pressure have been two to five times as high as White rates. **This means that 46% to 68% of this utilization is occurring in the Black population, and that 50% to 80% the Black utilization for these conditions would not occur if the Black rate was lowered to match the White rate.**

Hispanic rates were slightly higher than White rates for Asthma ED visits, but not for the Diabetes and High Blood Pressure hospital encounter rates. Asian rates were lower than White rates.

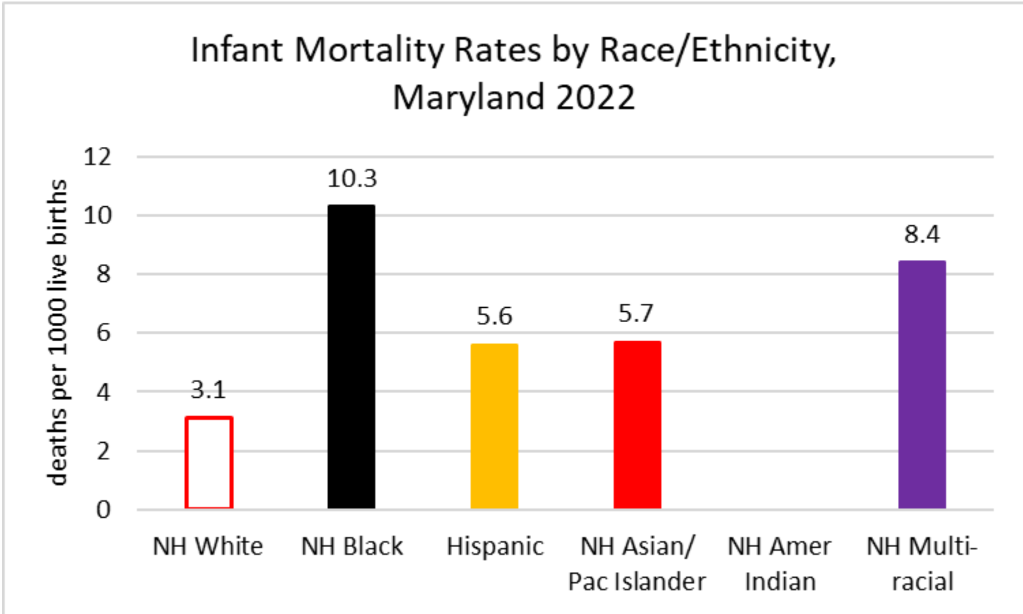
Figures 1-3. Selected Health Care Utilization rates per 1,000 in Maryland 2018-2024





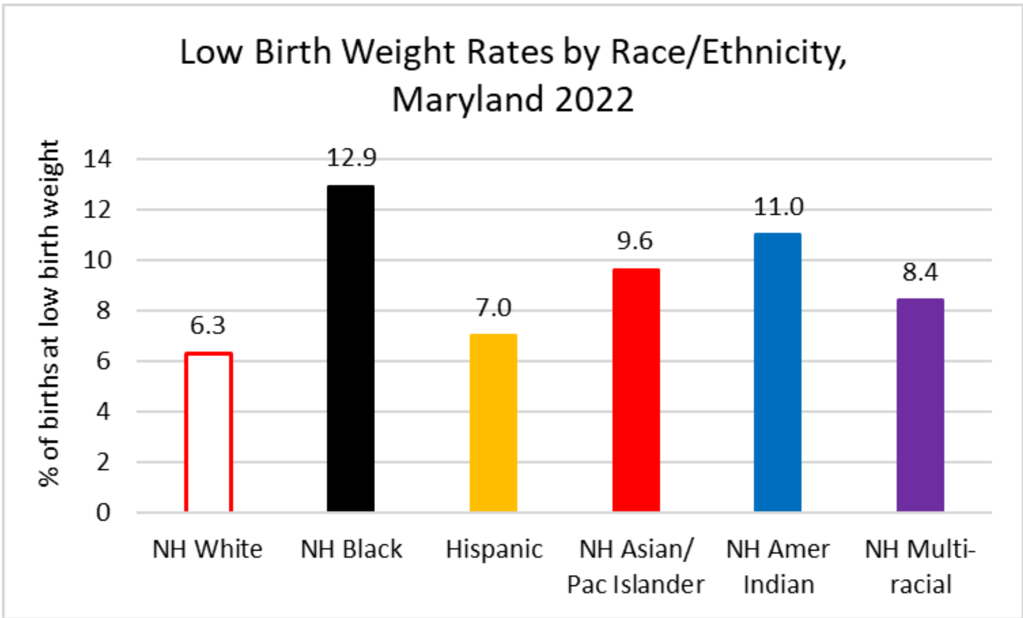


Additional examples of health disparities in Maryland are shown below *(first 3 charts from 2022 Maryland Vital Statistics Annual Report, last 3 charts from 2022 Maryland BRFSS).*



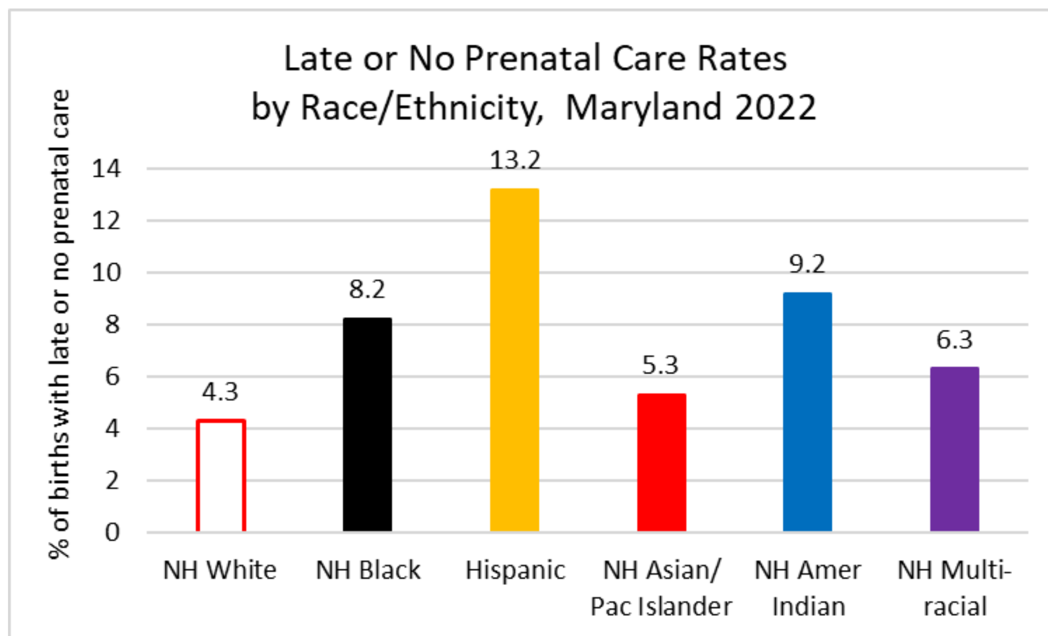
In 2022, compared to the Non-Hispanic White rate, the infant mortality rate was:

- 3.3 times as high for Non-Hispanic Blacks or African Americans.
- 1.8 times as high for Hispanics or Latinos.
- 1.8 times as high for Non-Hispanic Asians or Pacific Islanders.
- 2.7 times as high for Non-Hispanic Multi-racial persons.



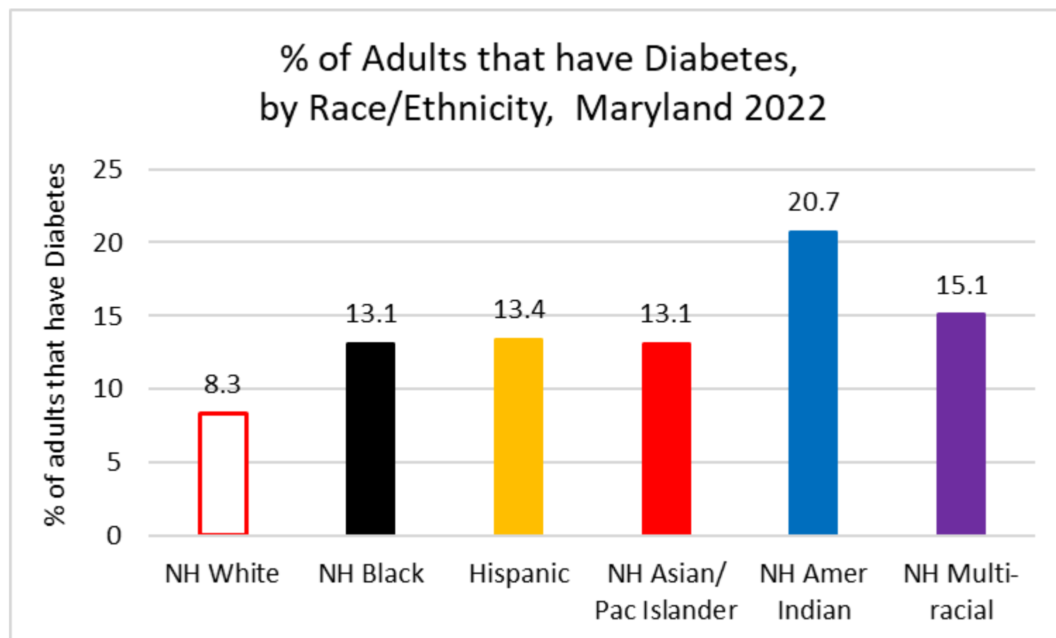
In 2022, compared to the Non-Hispanic White rate, the low birth weight rate was:

- 2.1 times a high for Non-Hispanic Blacks or African Americans.
- 1.1 times as high for Hispanics or Latinos.
- 1.5 times as high for Non-Hispanic Asians or Pacific Islanders.
- 1.8 times as high for Non-Hispanic American Indians or Alaska Natives.
- 1.3 times as high for Non-Hispanic Multi-racial persons.



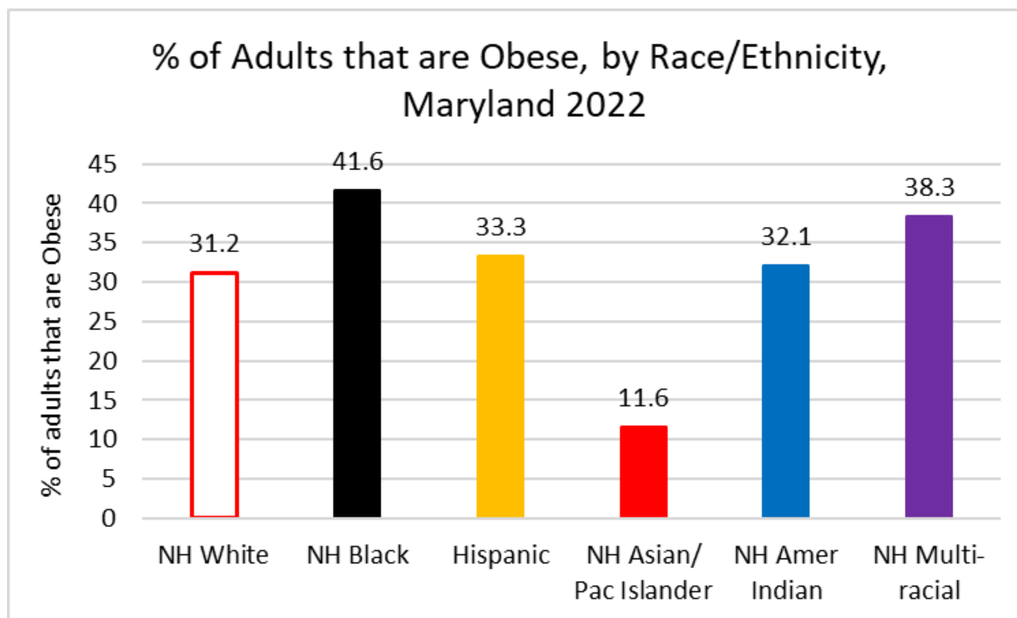
In 2022, compared to the Non-Hispanic White rate, the late or no prenatal care rate was:

- 1.9 times a high for Non-Hispanic Blacks or African Americans.
- 3.1 times as high for Hispanics or Latinos.
- 1.2 times as high for Non-Hispanic Asians or Pacific Islanders.
- 2.1 times as high for Non-Hispanic American Indians or Alaska Natives.
- 1.5 times as high for Non-Hispanic Multi-racial persons.



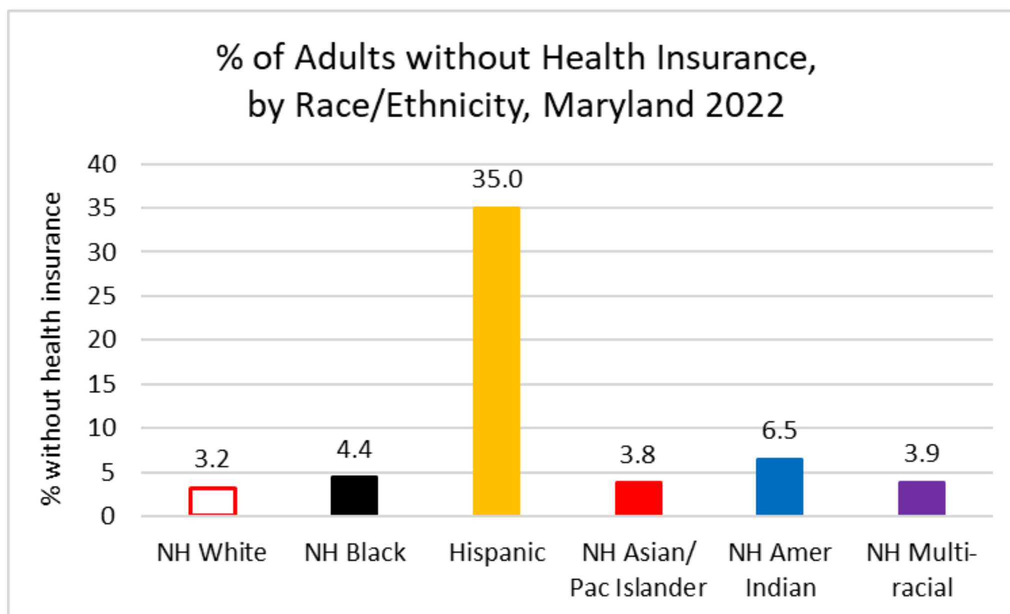
In 2022, compared to the Non-Hispanic White rate, diabetes prevalence rate was:

- 1.6 times a high for Non-Hispanic Blacks or African Americans.
- 1.6 times as high for Hispanics or Latinos.
- 1.6 times as high for Non-Hispanic Asians or Pacific Islanders.
- 2.5 times as high for Non-Hispanic American Indians or Alaska Natives.
- 1.8 times as high for Non-Hispanic Multi-racial persons.



In 2022, compared to the Non-Hispanic White rate, the obesity prevalence rate was:

- 1.3 times a high for Non-Hispanic Blacks or African Americans.
- 1.1 times as high for Hispanics or Latinos.
- 0.4 times as high for Non-Hispanic Asians or Pacific Islanders.
- 1.0 times as high for Non-Hispanic American Indians or Alaska Natives.
- 1.2 times as high for Non-Hispanic Multi-racial persons.



In 2022, compared to the Non-Hispanic White rate, the health uninsurance rate was:

- 1.4 times a high for Non-Hispanic Blacks or African Americans.
- 11.0 times as high for Hispanics or Latinos.
- 1.2 times as high for Non-Hispanic Asians or Pacific Islanders.
- 2.0 times as high for Non-Hispanic American Indians or Alaska Natives.
- 1.2 times as high for Non-Hispanic Multi-racial persons.

III. MHHD Consultations and Collaborations

A. Maryland Commission on Health Equity and AHEAD Model

The Maryland Commission on Health Equity (MCHE) was established by the Shirley Nathan-Pulliam Health Equity Act of 2021. The legislation charged the Commission with five main tasks:

1. Develop a Health Equity Framework
2. Convene a Data Advisory Committee (DAC) to define the parameters of a health equity data set to be maintained by the state-designated health information exchange.
3. Examine the impact of specified social factors on the health of the residents of Maryland and report those results in its annual report.
4. Provide recommendations for improving health equity.
5. Establish a state plan for achieving health equity in alignment with other Statewide planning activities in coordination with the State's Health and Human Services, Housing, Transportation, Education, Environment, Community Development, and Labor systems.

MHHD collaborated with CRISP and the DAC to execute the data collection and analysis efforts required to produce the data published in the MCHE's 2023 report.

In 2024, the charge of MCHE was amended with the introduction of House Bill 1333 (HB1333). HB1333 was introduced to broaden the scope of the MCHE and align it with the governance requirements of the Centers for Medicare and Medicaid Innovation's All-Payer Health Equity Approaches and Development (AHEAD) Model.

HB1333 alters the purpose, duties, and membership composition of the MCHE. The purpose of MCHE has expanded to include developing a statewide health equity plan and providing direct advice to the State's independent health regulatory commissions.

HB1333 requires the MCHE, using a health equity framework, to develop and monitor a "statewide health equity plan" as required by the Center for Medicare and Medicaid Innovation. In support of this requirement, MHHD provided significant contributions to the final version of the Health Equity Framework that built upon the efforts of the inaugural commission.

HB1333 mandates include the following:

1. MCHE must coordinate with the MDH and the Health Services Cost Review Commission (HSCRC) when establishing an advisory committee
2. Repeals the requirement that the Governor designate the MCHE chair
3. Expands the purpose of MCHE and alters its duties and membership
4. Alters reporting requirements

The MCHE serves as the model governance structure required under AHEAD and informs all model activities. Per HB1333, the MHHD Director is named to serve as an MCHE member.

B. Root Causes of Health Initiative

The Root Causes of Health Initiative (RoCHI) is an equity-focused quality improvement project being implemented by the Prevention and Health Promotion Administration (PHPA) within MDH with intensive data consultation from the data staff of MHHD.

This national initiative is a co-venture of the Institute for Healthcare Improvement and the National Association of Chronic Disease Directors. Each year, cohorts of about four states each participate in a training process to learn and implement a quality improvement process based on theory of change and the Plan-Do-Study-Act cycle approach to quality improvement. PHPA and MHHD staff participated in this training in the Spring of 2022 and implemented the approach with our initial cohort of five PHPA programs in the Summer and Fall of 2022. A second cohort of five PHPA programs completed the process in FY 2024.

The MDH implementation of the RoCHI process focuses on assessing the “equity of reach” and “equity of impact” of PHPA programs that have an individual-level participation component.

- **Equity of reach** assesses whether the actual race/ethnic distribution of the program participants matches the expected race/ethnic distribution of the program participants. This is a comparison of the racial composition of the program to the racial composition of the population in need.
    - Actual distributions are obtained from the program performance data
    - Expected distributions are obtained from one of three possible distributions, depending on which is the most appropriate for the program:
        - Race/ethnic distribution of the eligible population
        - Race/ethnic distribution of the population that has the disease being addressed.
        - Race/ethnic distribution of the population experiencing complications or preventable health care utilization due to the disease.
- **Equity of impact** assesses whether the “success rate” (achievement of some program health goal, target, or milestone by individual participants) is the same or roughly similar among the different race/ethnic groups participating in the program.

The five PHPA programs that participated in the FY 2024 cohort, and the results of the assessment, are listed below.

Lead Home Visiting Program

This program in the Environmental Health Bureau seeks to enroll children identified with high blood lead levels to provide home visiting to assess and remediate sources of lead exposure. The program is implemented as a Health Services Initiative (HSI) in the Maryland Children’s Health Program (MCHP). The following two charts describe the equity of reach and equity of Impact (in this case, of successful program completion) for 2021 (the latest year with complete data).

Figure 1. All Participating Home Visiting (HV) Jurisdictions*:

Racial/Ethnic Distribution of Children Expected to be Eligible for HV Program vs. Racial/Ethnic Distribution of Children Actually Offered and Enrolled in HV Program in 2021

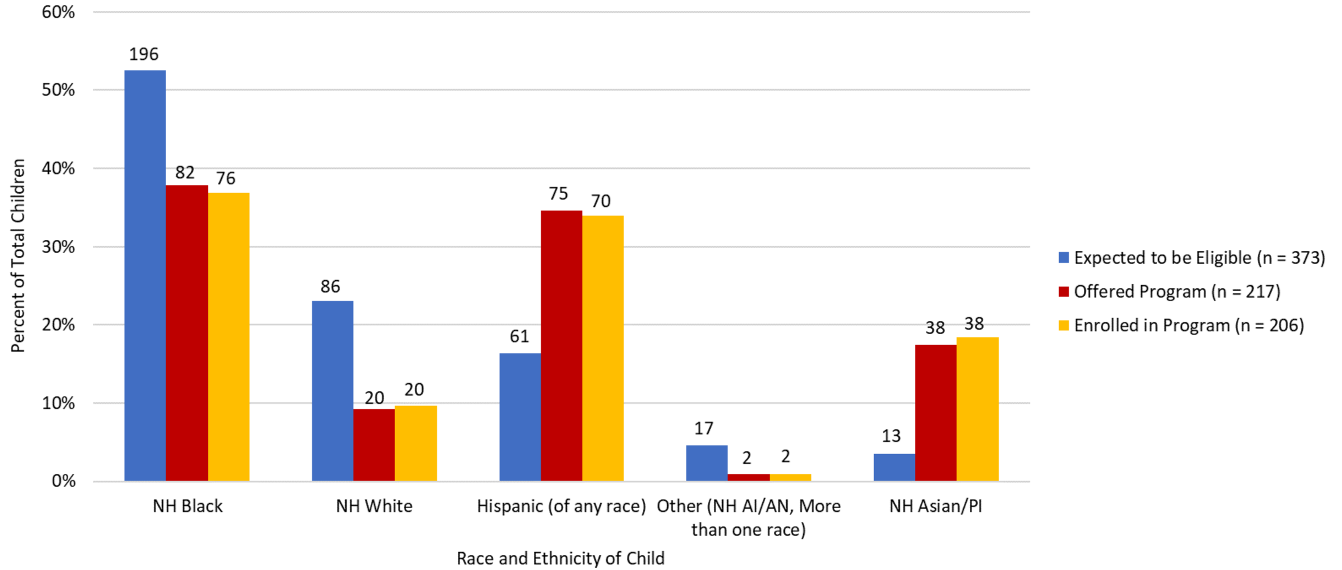
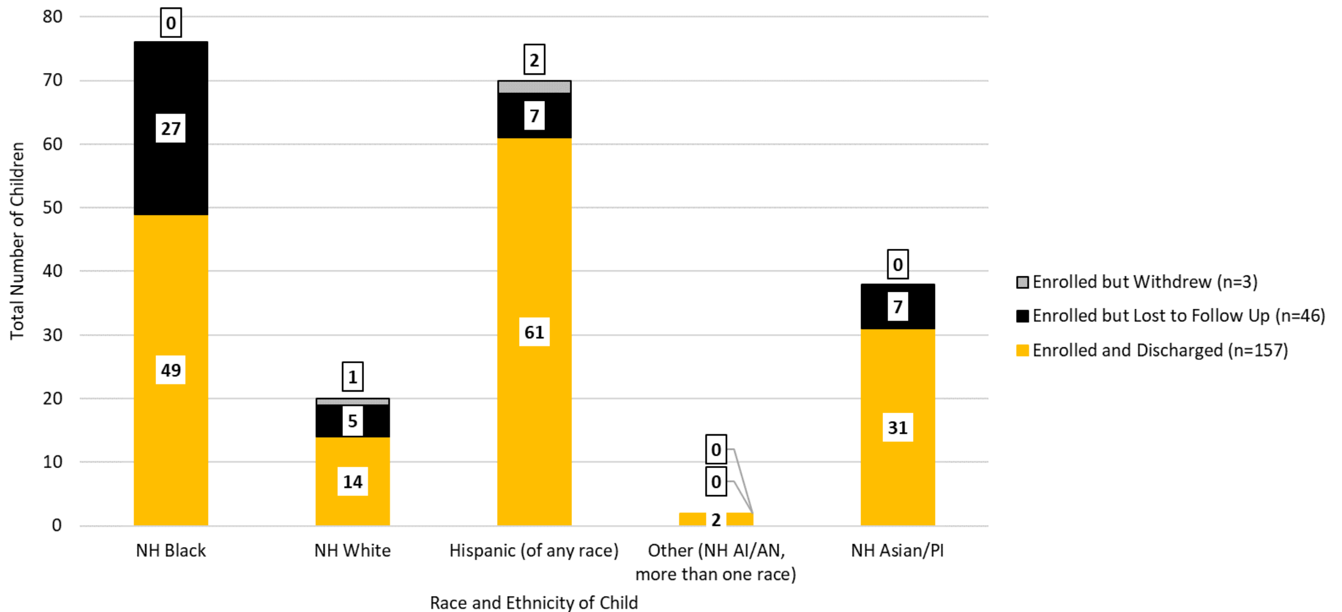


Figure 2. All Participating Home Visiting (HV) Jurisdictions*:

Racial/Ethnic Distribution of Enrolled Children and their Outcomes in 2021



*Participating Jurisdictions in 2021: Baltimore County, Baltimore City, Charles County, Dorchester County, Frederick County, Harford County, Prince George's County, St. Mary's County, Wicomico County

The findings for equity of reach were

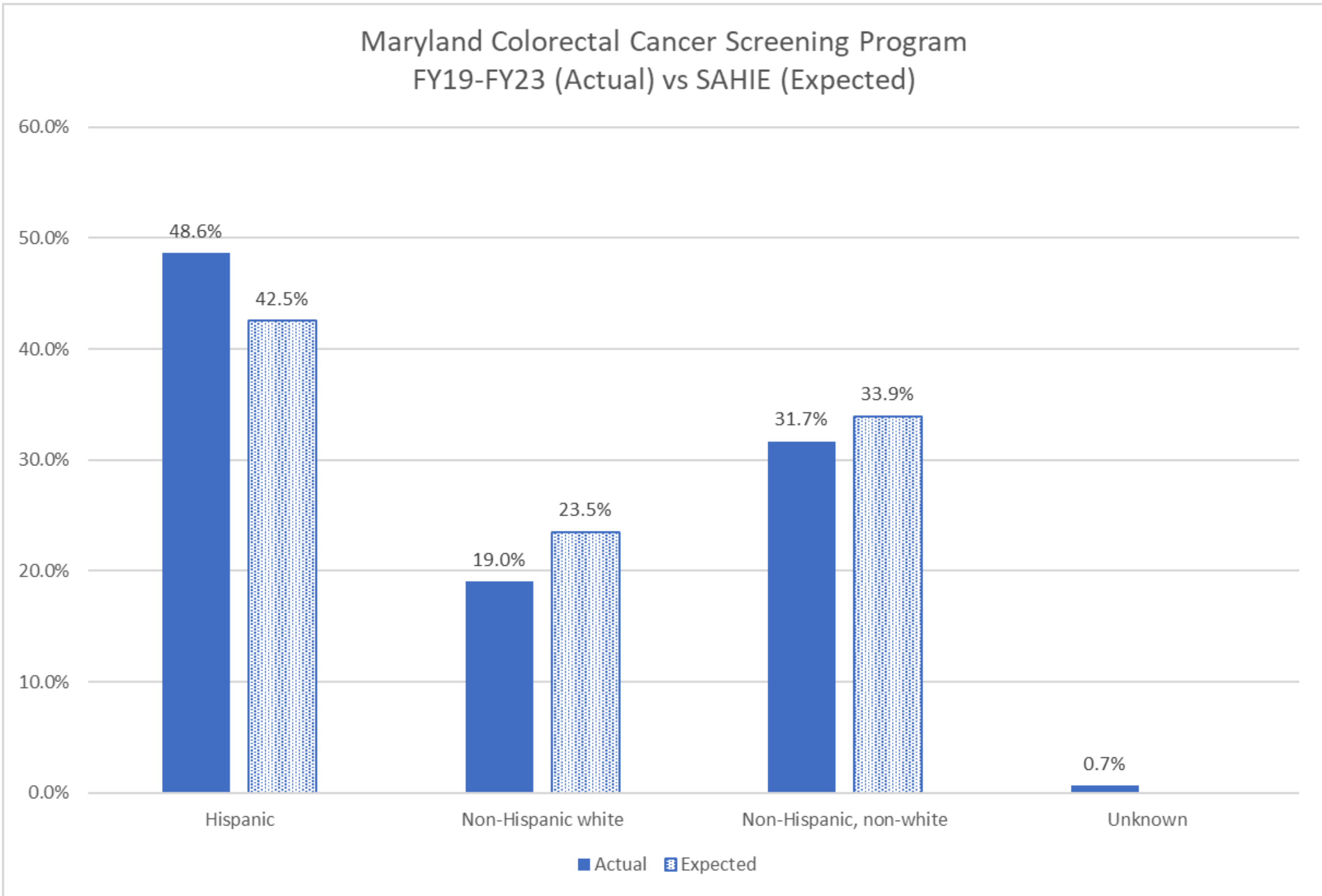
- Most children offered the program are enrolled
- Actual Hispanic and NH Asian numbers exceed what is expected for offer and enrollment
- Actual NH Black, NH White, and other NH race numbers were below what was expected

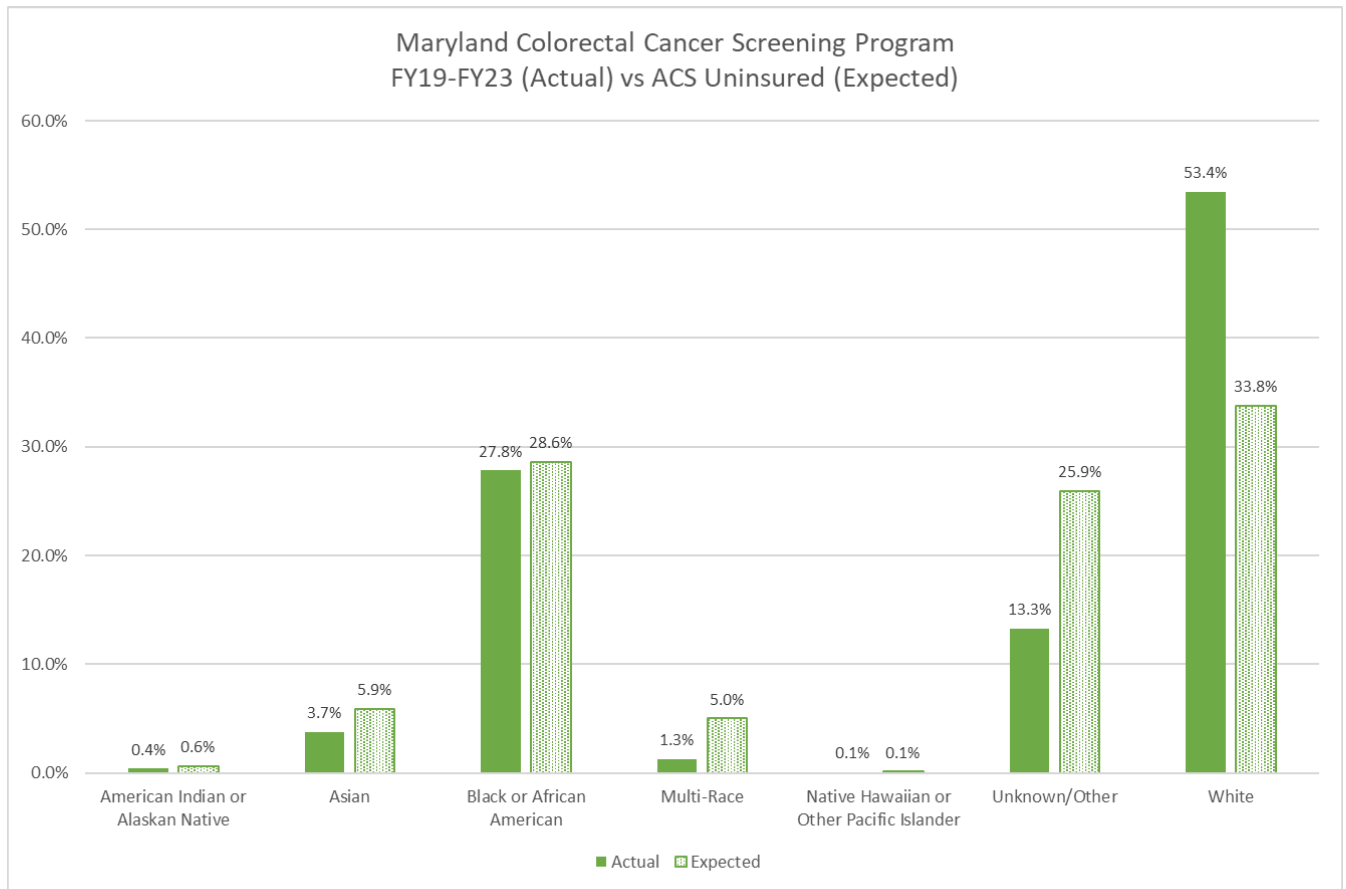
The findings for equity of impact were

- Most enrolled children, regardless of race/ethnicity, successfully completed the program
- The completion rate was lowest for NH Black children
- NH Black children make up more than half of those children enrolled but lost to follow up

Colorectal Cancer Screening Program

The colorectal cancer screening program within Maryland's Cancer Prevention, Education, Screening, and Treatment (CPEST) Program provides screening and treatment services to Maryland residents at or below 250% of the federal poverty level, are uninsured or underinsured, and 45-74 years of age. Charts comparing ethnic and racial distributions of program participants to the ethnic and racial distributions of the population meeting these eligibility criteria are shown below.





Findings regarding the ethnic and racial equity of reach were

- Actual Hispanic enrollment was slightly above the expected value
- Actual White enrollment was above the expected value
- Actual Black enrollment was comparable to the expected value
- Actual enrollment for the remaining minority races was below the expected values

Early Hearing Detection and Intervention Program

The Early Hearing Detection and Intervention Program reviews 60,000 to 70,000 newborn hearing screenings each year and works to assure that those who did not pass the screening are appropriately referred to additional diagnostic and treatment services. The program found that the screening data submitted by hospitals is often incomplete regarding baby names and demographics. The program focused their project on improving data quality by developing a data linkage system with Vital Statistics Administration birth certificate records. The program was able to achieve 98% matching in the data linkage process for the 2022 data. This improvement to data quality will allow the program to proceed with equity of follow up analysis going forward.

Influenza Prevention Activities Program

The Influenza Prevention Activities Program within the Infectious Disease Epidemiology and Outbreak Response Bureau monitors influenza immunization rates and influenza hospitalization rates. The program performed an intricate analysis comparing racial/ethnic distributions of the Maryland population (the expected values with the racial/ethnic distributions of influenza immunizations, and influenza hospitalizations, across five age groups. The findings of this analysis can be summarized as follows.

- The age-specific race/ethic distribution of influenza immunizations match the age-specific race/ethnic distribution of the Maryland population
- This indicates that immunization rates by age group are similar among all racial /ethnic groups
- The Non-Hispanic Black population made up a disproportionately high share of influenza hospitalizations for all age groups under 65+

This indicates that the Non-Hispanic Black population is at higher risk for influenza hospitalization despite equal rates of influenza immunization. This could be due to less access to health care, more of the health conditions that predispose to worse influenza outcomes, and/or greater exposure to adverse social determinants of health. Resolving these issues, as well as promoting even higher uptake of influenza immunization in the Black population, could reduce this influenza hospitalization disparity.

Infectious Disease Prevention and Health Services Bureau

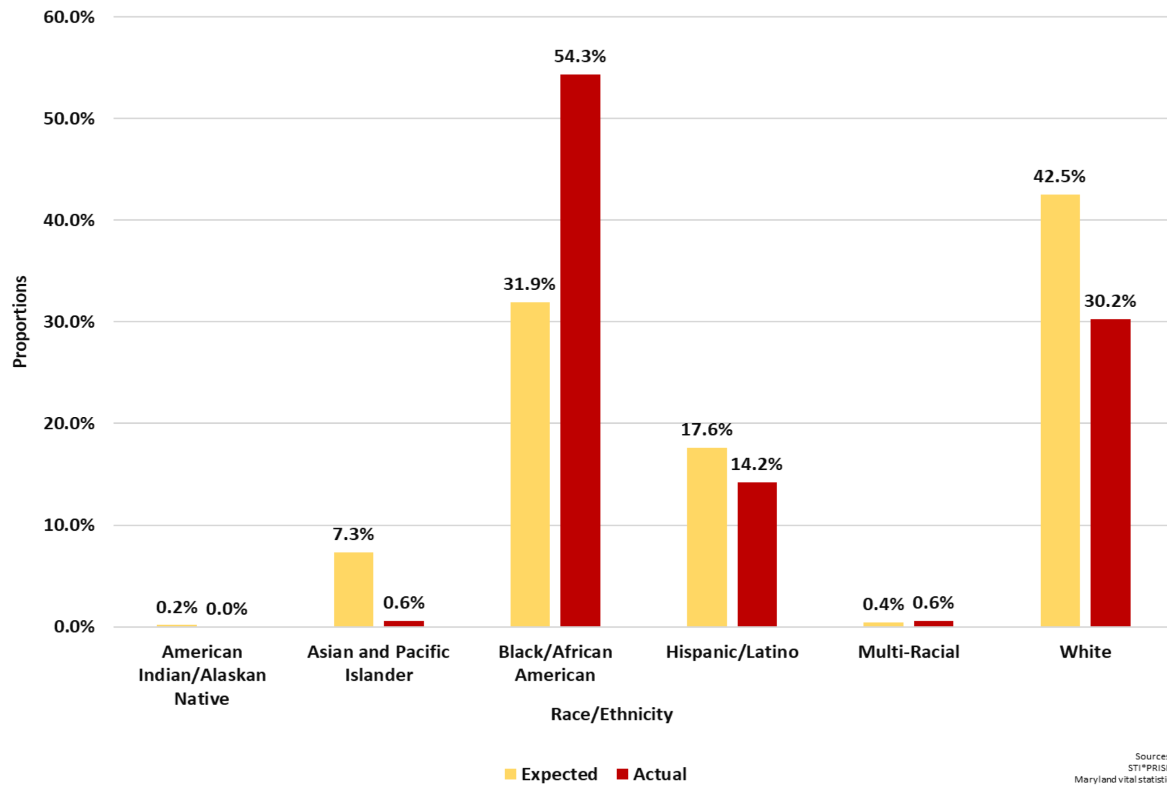
The Center for Sexually-Transmitted Infections Prevention in the Infectious Disease Prevention and Health Services Bureau examined how racial/ethnic distributions of congenital syphilis cases and new syphilis case among people of childbearing capacity compared to racial/ethnic distributions of births and people of childbearing capacity, respectively. The findings are shown in the two charts on page 18.

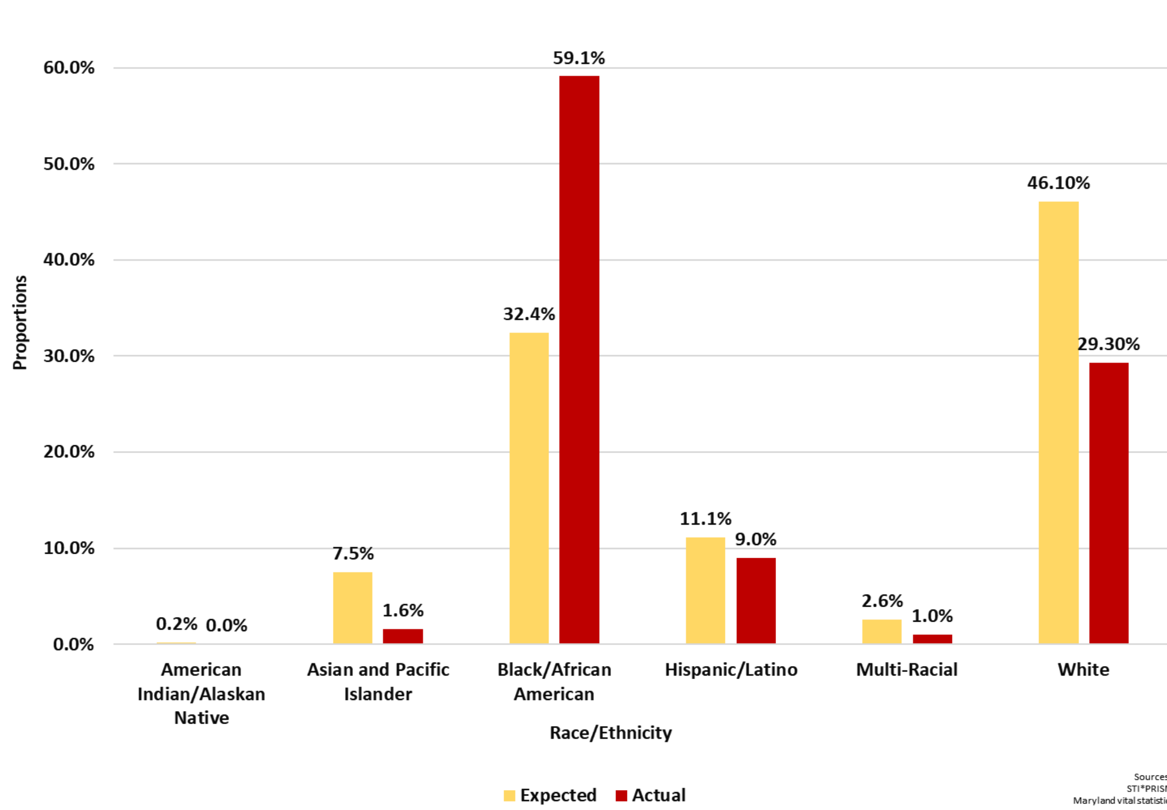
Regarding congenital syphilis (top panel on page 18):

- **Black/African Americans were 32% of persons delivering babies, yet were of 54.3% of CS cases**
- Whites made up 42.5% of persons delivering babies, while accounting for only 30.2% of CS cases
- Hispanic/Latinos were 17.6% of persons giving birth, but were 14.2% of CS cases
- Asian and Pacific Islanders were 7.3% of persons delivering babies, and were 0.6% of CS cases

Regarding new syphilis cases in persons of childbearing capacity (lower panel on page 18):

- **Black/African Americans were 32.4% of people of childbearing age capacity, but were 59.1% of acquired syphilis cases in people of childbearing capacity**
- Whites were 46.1% of people of childbearing capacity, but only 29.3% of acquired syphilis cases
- Hispanics/Latinos were 11.1% of people of childbearing capacity and 9% of acquired syphilis cases in people of childbearing capacity.


Expected and Actual Proportions of Congenital Syphilis Cases by Birth Parent's Race/Ethnicity, 2016-2020, Maryland
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Proportions
0.2%
0.0%
7.3%
0.6%
31.9%
54.3%
17.6%
14.2%
0.4%
0.6%
42.5%
30.2%
American Indian/Alaskan Native
Asian and Pacific Islander
Black/African American
Hispanic/Latino
Multi-Racial
White
Race/Ethnicity
Expected
Actual
Sources:
STI*PRISM
Maryland vital statistics


Expected and Actual Proportions of Acquired Syphilis Cases Among People of Childbearing Capacity by Race/Ethnicity, 2016-2020, Maryland
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Proportions
0.2%
0.0%
7.5%
1.6%
32.4%
59.1%
11.1%
9.0%
2.6%
1.0%
46.10%
29.30%
American Indian/Alaskan Native
Asian and Pacific Islander
Black/African American
Hispanic/Latino
Multi-Racial
White
Race/Ethnicity
Expected
Actual
Sources:
STI*PRISM
Maryland vital statistics

C. Health Professional Implicit Bias Training

Program Overview and Purpose

The MHHD Cultural and Linguistic Health Care Professional Competency Program ensures compliance with Maryland General Assembly HB 28 (2021), a statute that requires all licensed healthcare providers to complete implicit bias training to renew their licenses by attesting to completing an evidence-based course on implicit bias. To remain compliant, healthcare providers have three options:

1. **Select a course on ACCME's website**.
2. **Complete one of the twenty courses listed on MHHD's webpage**.
3. **Complete a course recognized by one of the twenty health occupations boards**.

Board Guidance and Compliance

MHHD has worked proactively with leaders from State Health Occupations Boards to ensure that they recognize implicit bias courses that meet the requirements of HB 28. MHHD emphasizes that, given the diversity of healthcare professions, it is the responsibility of each board to determine which courses are most relevant to their specific profession and the populations they serve. This ensures that training is tailored to the unique needs of each healthcare provider and their patients.

Course Selection

MHHD conducts research to identify courses that comply with HB 28. The goal is to select courses that are not only evidence-based but also practical, rigorous, and accessible to all providers without undue financial or time barriers. MHHD ensures that the courses selected address implicit bias, but they do not review or approve courses related to broader topics like diversity, oppression, cultural competence, or racism, as these are not included in the scope of implicit bias training.

Collaboration and Health Equity Initiatives

While healthcare providers are increasingly aware of the importance of implicit bias training, many are also integrating health equity initiatives into their broader work. For example, Springfield Hospital has developed a Health Equity Committee that focuses on addressing language barriers for patients with limited English proficiency (LEP) and improving care for patients with diverse gender identities.
MHHD encourages healthcare providers to expand these initiatives and offers support for exploring collaborations on health equity projects. These may include programs for addressing LEP concerns, gender identity issues, or other disparities that impact patient care.

D. Underrepresented Behavioral Health Professionals Workgroup

Maryland General Assembly House Bill 97 (2022) established the Workgroup on Black, Latino, Asian American Pacific Islander, and Other Underrepresented Behavioral Health Professionals (UBHP). The Workgroup includes representatives from Black Colleges and Universities; hospital networks that primarily serve Black, Latino, or Asian American Pacific Islander communities; behavioral health professionals; individuals who provide social services in the State; and representatives of organizations, networks, or associations of behavioral health professionals that are composed of or primarily work to represent and support Black, Latino, or Asian American Pacific Islander communities, or other underrepresented behavioral health professionals.

The legislation tasked the workgroup with the following responsibilities:

1. Identify and examine the shortage of behavioral health professionals in the State who are from Black, Latino, Asian American, Pacific Islander, or other underrepresented backgrounds in the behavioral health profession.
2. Evaluate and provide recommendations on incentives or other methods to increase:
    a. Students from Black, Latino, Asian American, Pacific Islander, or other underrepresented backgrounds in the behavioral health profession who study at an institution of higher education in the state to become behavioral health professionals; and
    a. Behavioral health professionals from Black, Latino, Asian American, Pacific Islander, or other underrepresented backgrounds in the behavioral health profession who provide behavioral health services in the State, particularly in underserved communities.

In 2024, the Workgroup submitted interim recommendations to be refined in 2025. The Workgroup highlights the following key recommendations (this list represents a sample of recommendations):

1. Equitably distributing resources to institutions of higher education that serve Black, Latino, Asian American and Pacific Islander students to provide more opportunities to educate, provide research opportunities for, and fund underrepresented students interested in behavioral health professions.
2. Establishing pathways for international professionals in the United States to validate credentials they have from abroad instead of requiring them to establish their education and credentials from scratch.
3. Establishing a fund or process (via professional boards possibly) by which licensing and supervision fees are decreased or waived.
4. Targeting exposure and recruitment from elementary school into college.
5. Establishing a career-progression ladder that allows potential professionals to see their path/future.
6. Offering loan forgiveness for underrepresented professionals who accept positions serving other underrepresented people groups.
7. Creating incentive programs to fund relocation.
8. Establishing a people-of-color leadership program.

MHHD Director, Camille Blake Fall co-chairs the Workgroup alongside Laura Torres, the Director of Primary Behavioral Health/Early Intervention at the Behavioral Health Administration. MHHD and BHA staff also provide administrative support to the Workgroup.

E. Health Equity Liaisons Collaborative

In 2024, MHHD created the Health Equity Liaisons Collaborative (HELC) within MDH. The HELC, composed of MDH employees, is an internal collaborative focused on identifying opportunities to advance and embed health equity principles and practices throughout the department in support of the Department's mission of reducing health care disparities and improving access to clinical services for all underserved Marylanders. The Health Equity Liaisons provide guidance, information, and direction to help foster a broader understanding of the racial, social, structural, and systemic factors that can impact health outcomes with a focus on communities of color, gender-diverse people, people with disabilities, rural communities, and other priority populations. HELC members also support the MDH legislative bill review process during the Maryland General Assembly's 90-day legislative session by serving as health equity subject matter experts working alongside the MDH legislative liaisons charged with bill review.

A key, early initiative within the HELC is to create a single definition of health equity for use across all of MDH. The HELC is working to achieve this through a review and analysis of federal, non-profit, health care-focused foundations, and internal definitions of health equity. The HELC also reviews external sources, such as peer-reviewed articles on health in all policies and racial impact assessments, to inform its actions.

F. Other MHHD Consultations and Collaborations

Collaborations with the MDH Prevention and Health Promotion Administration

Health Equity Initiatives
MHHD data staff serve on the following PHPA health equity groups:

- Cancer and Chronic Disease Bureau
    - CCDB Health Equity Steering Committee: (4 meetings in CY 2024)
    - CCDB Data to Action Committee: (16 meetings in CY 2024)

Diabetes Program
MHHD data staff serve on the following diabetes-related groups:

- Diabetes Action Committee: (7 meetings in CY 2024)

Maternal and Child Health Bureau

MHHD data staff serve on the following groups within the Maternal and Child Health Bureau:

- Maryland Maternal Health Improvement Task Force (2 meetings in CY 2024)
- Maternal Mortality Review Stakeholder Group (1 meeting in CY 2024)
- Morbidity and Mortality Quality Review Committee (2 meetings in CY 2024)

Examples of Collaborations Outside of MDH

- In the fall of 2023, MHHD applied for and was accepted into a National Academy for State Health Policy (NASHP) data learning laboratory and joined three other states for a 6-month deep dive into health equity data analytics (7 meetings in CY 2024). During the lab, participants shared information and learned about best practices related to collecting and analyzing health equity data as essential tools for identifying and addressing health disparities.

- MHHD MOTA program administrator, Lindsay Lotter, serves as a member of the Maryland State Advisory Council on Health and Wellness and a member of the diabetes subcommittee. The role of the council is to advise MDH on promoting a healthy lifestyle for all Marylanders and to offer targeted support in the topic areas of arthritis, diabetes, heart disease and stroke, and physical fitness through bimonthly committee meetings. The 34 member council is composed of state employees, various organizational representatives, and members of the public. MHHD representation on the council is without term limits as one of 6 designated seats detailed by the founding legislation as a voting member. Following appointment to the council, the MHHD Program Administrator has attended 3 council meetings and 3 committee meetings and is contributing to the development of an updated diabetes workplan and social media strategy for the prevention and mitigation of diabetes and associated adverse health effects.

- During Fiscal Year 2024, MHHD Director Camille Blake Fall, offered guidance and expertise on reducing health disparities and advancing health equity as a member of the following commissions, committees, and workgroups and in partnership with the following community-based organizations:
    - ☐ Maryland Commission on Health Equity
    - ☐ Maryland Commission on Public Health
    - ☐ Maryland Opioid Restitution Fund Advisory Workgroup
    - ☐ Maryland Equitable Justice Collaborative
    - ☐ Maryland Health Equity Resource Communities (HERC) Advisory Committee
    - ☐ Maryland Health Services Cost Review Commission (HSCRC) Health Equity Workgroup
    - ☐ Maryland Board of Physicians Workgroup to Study Licensure of Foreign-Trained Physicians
    - ☐ MDH Workforce Data Clearinghouse Strategic Planning Workshop
    - ☐ MDH Trauma-Informed Care Plan Committee
    - ☐ MDH "Building a Healthier Maryland" State Health Assessment and State Health Improvement Plan
    - ☐ West Baltimore Renaissance Foundation Board
    - ☐ Baltimore City Local Health Improvement Coalition
    - ☐ Government Alliance on Race and Equity
    - ☐ Jubilee Association of Maryland
    - ☐ Black Mental Health Alliance
    - ☐ Open My Heart Foundation
    - ☐ Maryland Health Care for All
    - ☐ Community Coalition for Lifelong Health and Wellness
    - ☐ Johns Hopkins University Bloomberg School of Public Health
    - ☐ Maryland Hospital Association
    - ☐ Morgan State University
    - ☐ University of Maryland Medical System

IV. MHHD Grant Programs

In FY 2024 MHHD administered over $4M in grant funding to 41 community-based and faith-based organizations, academic institutions, and local health departments. The grant funds were distributed to the following three programs: Minority Outreach and Technical Assistance Program (MOTA), Enhancing Epidemiology and Laboratory Capacity for COVID-19 (ELC) Program, and Social Determinants of Health (SDOH) Program.

- Minority Outreach and Technical Assistance (MOTA) Program
    - $509,999 to 12 grantees reaching 32,930 individuals.
- Social Determinants of Health (SDOH) Program
    - $2,170,000 to 21 grantees reaching 102,608 individuals.
- Epidemiology and Laboratory Capacity (ELC) Program (CDC COVID funds)
    - $1,764,000 to 8 grantees reaching 14,301 individuals.

Details of performance for the FY 2024 grant programs are provided in the tables that follow.

In the third quarter of CY 2024 (first quarter of FY 2025), MHHD implemented mandatory grantees' quarterly meetings to provide the grantees with grant management support and technical assistance. The first grantees' quarterly meeting was held on September 16, 2024, and there were over 50 participants. In addition, on September 23, 2024, a fiscal grant management workshop was held to provide the grantees with technical assistance with the fiscal requirements of their grants.

MHHD program still will conduct site visits at least once per year to monitor the implementation of the grant programs and identify gaps in services. Upon completion of any site visit, a grantee receives a summary report of the visit.

Grant Writing Workshop

In 2024, MHHD initiated a process to hire a contractor who will support MHHD by conducting grant writing workshops to provide technical assistance to community-based organizations and by researching, writing, and submitting grant proposals to secure funding for MHHD's programs and growth. The contractor will collaborate closely with MHHD staff to ensure that proposals align with the office's goals and strategic priorities. In this way, MHHD continues to implement best practices and strengthen relationships with the community-based organizations and local health departments to improve health equity for Marylanders.

A. Minority Outreach and Technical Assistance (MOTA) Program

Introduction

The purpose of the Minority Outreach and Technical Assistance (MOTA) program is to improve the health outcomes of racial and ethnic minority communities through community engagement, partnerships, outreach, technical assistance, targeted case management, and ongoing intervention for individuals with self-identified needs. To qualify for funding, MOTA programs must focus on one of the following targeted health challenges and key areas: pregnancy and birth outcomes, mental health, cardiovascular disease, obesity, pre-diabetes and diabetes, diabetes self-management, cancer, and asthma. In FY 2023, the Office of Minority Health and Health Disparities (MHHD), through a competitive Request for Applications (RFA) process, funded 15 community-based organizations of the 31 organizations that applied. In FY24, 12 of the 15 currently funded programs successfully submitted Continuation Grant Applications for continued funding and programmatic support. Below is the annual data reported by the 12 grantees during the FY 24 grant cycle.

Program Data from FY 2024 MOTA Funded Grantees/Partners

Grantee	Jurisdiction	Award Amount	Health Focus Area	Individuals Reached (number of encounters)	Intervention (number of individuals enrolled)
Program Totals		**$509,999**		**32,930**	**3,396**
Aaron's Place, Inc.	Caroline	$24,999	Diabetes/Obesity	5,023	301
American Diversity Group	Montgomery	$50,000	Diabetes/Obesity	1,008	59
Eastern Shore Wellness Solutions, Inc.	Dorchester	$50,000	Diabetes/Diabetes Self-Management Program (DSMP)	1,781	73
Greater New Hope Church and Ministries	Caroline	$30,000	Obesity	1,579	75
Healthlincs, Inc.	Montgomery	$50,000	Prediabetes/ Diabetes	559	8
Healthy Harford	Harford	$50,000	Diabetes	5,176	2,218
Holy Cross Health	Montgomery	$50,000	Prediabetes/ Diabetes	2,632	184
Hope Connections for Cancer Support	Prince George's	$50,000	Cancer	1,654	40
Jolly Dream Foundation, Inc.	Charles	$25,000	Diabetes/Obesity	2,703	284
Lifestyles of Maryland, Inc.	Charles	$50,000	Mental Health	6,916	105
Minority Outreach Coalition of St. Mary's County	St. Mary's	$30,000	Prediabetes/ Diabetes	3,899	49
United Way of Central MD*	Baltimore City	$50,000	Pregnancy/Birth Outcomes	0	0

*unable to spend award, due to staff turnover; no funding disbursed

B. Social Determinants of Health (SDOH) Program

Introduction

The Social Determinants of Health (SDOH) program aims to reduce health inequity among Maryland's racial and ethnic minorities by providing community-based interventions to address those social determinants of health (SDOH) by reducing health inequity. Examples of SDOH to be addressed are as follows:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Health Language and literacy skills

The SDOH objectives are organized into five place-based domains:

1. Economic stability
2. Education access,
3. Health care access and quality
4. Neighborhood, built environment
5. Social and community context

SDOH content is also interwoven throughout other programs funded by MHHD. SDOH objectives highlight the significance of upstream factors, typically outside health care delivery, necessary to reduce health disparities and maintain healthy communities and populations. SDOH objectives are aligned with several state strategies and priorities to improve value-based healthcare delivery and health outcomes.

Program Data from FY 2024 SDOH Funded Grantees

Grantees	Juris- diction	Award Amount	Health Focus Area	Individuals Reached (number of encounters)	Intervention (number of individuals enrolled)
Program Totals		**$2,170,000**		**102,608**	**60,160**
AACF- Asian American Center of Frederick	Frederick	$90,000	Food and Nutrition	13,020	8686
Aaron's Place	Caroline	$90,000	Food and Nutrition	4593	4593
Baltimore Medical Systems, Inc	Baltimore City	$90,000	Food and Nutrition	1020	466
Calvert County Health Department	Calvert	$90,000	Food and Nutrition	6219	620
Cecil County Health Department	Cecil	$90,000	Obesity	1387	1339
Community Engagement and Consultation, Inc.	Prince George's	$90,000	Workforce readiness/ retention	4687	3255
Eastern Shore Wellness Solutions, Inc	Dorchester	$90,000	Obesity	1746	945
Frederick Health Hospice	Frederick	$90,000	Language Services, Grief Supt	2637	2211
Greater New Hope Church & Ministries	Caroline	$90,000	Health Education	975	975
HeartSmiles	Baltimore City	200,000	Workforce Development	5418	2293
ICCI- Institute for Creative Community Initiatives	Prince George's	$90,000	Workforce readiness/ retention	541	497
KEYS Empowers, Inc.	Balt City Balt Co Prince G	$200,000	Violence reduction	19,124	615

MOC- Minority Outreach Coalition	Charles County	$90,000	Health Education	3384	2498
LASOS -Linking All So Others Succeed, Inc.	Harford County	$90,000	Obesity	2421	1972
Leading by Feeding	Baltimore City Baltimore Co Prince George's Eastern Shore, Anne Arundel	$150,000	Food and Nutrition	20,167	18,041
Lifestyles of Maryland, Inc.	Charles and Calvert	$90,000	Housing instability	2363	1674
Organization of Hispanic/Latin Americans of Anne Arundel	Annapolis	$90,000	Health Education & Referrals	3464	2374
OMT-Office Management & Technology, Inc.	Baltimore City, Baltimore Co	$90,000	Food and Nutrition	1888	1817
The Bridge of Edgewood Corp	Harford	$90,000	Health Education	1841	1443
University of Maryland Eastern Shore (UMES)	Somerset	$90,000	Obesity	2085	1132
Vibrant Health & Wellness Foundation, Inc.	Prince George's	$90,000	Type 2 Diabetes	3628	2714

C. Epidemiology and Laboratory Capacity (ELC) Program (CDC COVID funds)

As part of Maryland's strategy for enhancing Epidemiology and Laboratory Capacity for COVID-19, MHHD grantees funded through this federal grant provide community-based services including outreach and education and additional COVID-related support. Services were provided by eight grantees in eight Maryland jurisdictions in FY24.

Program Data from FY 24 ELC- CHW/ CTCBS Funded Grantees/Partners

Enhancing Epidemiology and Laboratory Capacity for COVID-19 Through Community-Based Strategies					
Grantee	**Jurisdiction**	**Award Amount**	**Health Focus Area**	**Individuals Reached (number of encounters)**	**Intervention (number of individuals enrolled)**
Program Totals		**$1,764,000**		**28,382**	**11,330**
Leading by Feeding	Baltimore City/ Baltimore County/ Anne Arundel County/Eastern Shore	$200,000	COVID-19	10,237	7,743
Career Haven	Prince George's County	$150,000	COVID-19	7,905	930
Diamonds on the Rise, Inc.	Baltimore City and Baltimore County	$250,000	COVID-19	756	279
Total Lifestyle Change / Healing Our Village of Maryland, Inc. Baltimore County	Baltimore County	$475,000	COVID-19	3,900	200
Organization of Hispanic/Latin Americans of Anne Arundel	Anne Arundel County	$250,000	COVID-19	2,744	1,488
Keys Empowers, Inc.	Baltimore City and Baltimore County	$249,000	COVID-19	420	61
Calvert County Health Department	Calvert County	$90,000	COVID-19	2,009	218
Greater New Hope Church and Ministries	Caroline County (and surrounding Counties)	$100,000	COVID-19	411	411

Example of an MHHD Grant in Action:

On December 2nd, 2023, the MHHD Program Administrator for the ELC grant, Saroje Portious, attended the HBCU College Fair as a representative of the Office and in support of ELC grantee, KEYS Empowers Inc. (KEYS). KEYS takes immense pride in empowering youth and providing them with the resources necessary to succeed.

This College Fair aimed to connect aspiring students of color to colleges and universities of interest, empowering them to imagine bright futures through continued educational achievement. KEYS Empowers Inc. offers valuable resources and services that align with MHHD's mission, including:

1. **Community-Based Health Strategies**: Promoting equitable access to health and educational resources and addressing disparities in underserved populations.

2. **Career Pathways in Public Health**: Encouraging youth and students to pursue studies in all fields including health-related fields.

3. **Education and Awareness**: Providing critical information on health equity and ways to contribute to reducing disparities through education and advocacy.

As a partner, this is an example of how MHHD remains committed to strengthening its relationships with CBOs, educational institutions, and public health initiatives to continue addressing health disparities and ensuring that underserved and disadvantaged communities, particularly communities of color, have the resources needed to succeed and thrive.

V. MHHD Communications and Social Media Outreach

In 2024 MHHD increased its reach through utilizing communications channels such as social media, a department wide quarterly newsletter, and collaborations with other MDH units. Collectively reaching tens of thousands of Marylanders, the below described communications efforts expand the reach of MHHD within MDH and across the state.

1. Social Media

    a. Continues to recognize the multiple heritage days and months celebrated by the state including Juneteenth, National Hispanic Heritage Month, Health Literacy Month, and more.

    b. MHHD utilizes our social media to raise awareness of current events affecting health equity including sharing releases from other MDH units and new federal releases.

2. Quarterly Newsletter

    a. The MHHD Quarterly Newsletter is released once per season. Each newsletter features recent/upcoming events or news related to health equity.

    b. Newsletters are sent to all MDH employees (6,000+).

3. Collaborations with other MDH units

    a. MHHD collaborated with various MDH units and organizations such as the Behavioral Health Administration, Prevention and Health Promotion Administration, the Office of Suicide Prevention, and the Black Mental Health Alliance to create content raising awareness for Black History Month, National Minority Mental Health Awareness Month, National Public Health Week, and more.

VI. MHHD Legislative Review

Advancing Health Equity through Legislative Action

MHHD is committed to advancing health equity through the legislative process. Our role is to review bills assigned to us by the MDH Office of Governmental Affairs and identify opportunities to enhance policies to address social determinants of health, reduce health disparities and advance health equity for all underserved and underresourced populations. We strive to ensure that policies do not inadvertently create barriers for marginalized communities and that they actively work toward reducing disparities in healthcare quality, access, and outcomes.

Key Areas of Focus:

Equity: We assess how proposed legislation may impact marginalized groups, particularly those who are often underserved or overlooked. We advocate for policies that actively reduce health disparities and promote fairness.

Language Access: Language barriers can significantly affect a community's ability to access and navigate healthcare and healthcare systems. We advocate for policies that ensure individuals with limited English proficiency can fully engage with healthcare providers and services.

Cultural Competence: Cultural competence is essential for reducing disparities. We work to ensure that bills consider cultural differences in care and make provisions for training healthcare professionals in cultural awareness.

Budget Impacts: We closely monitor how legislative actions may affect our budget, particularly if policies result in reduced funding for services aimed at supporting vulnerable communities. We advocate for sustainable funding that supports health equity goals. Through our work, we raise awareness of the challenges faced by vulnerable communities in accessing healthcare and advocate for policies that remove barriers and improve the healthcare experience for all individuals.

Additionally, prior to the start of the 2024 Maryland General Assembly legislative session, MHHD proposed the idea of implementing a health equity analysis as part of the agency's legislative bill review process. Beginning with the 2025 legislative session, MDH's Office of Governmental Affairs has formalized a process within the department requiring all legislative liaisons to conduct an equity analysis on bills reviewed and provide an assessment of the potential positive or adverse impacts of a particular bill on underserved populations.

VII. MHHD Student Training Programs

In the Summer of 2024, MHHD participated in hosting two interns through the Public Health Workforce Development Internship Program. This paid program accepts applications from Undergraduate, Graduate students, and recent graduates for 10-week internships throughout the year. Supervised by our Epidemiologist, Program Administrator, and Special Assistant; the interns worked on a variety of projects such as data analysis, grant administration, grantee communications, and social media planning.

MHHD serves as an elective practicum rotation site for physicians in their third year of specialty training in the General Preventive Medicine and Public Health residency program of the Department of Epidemiology and Public Health in the University of Maryland School of Medicine (at University of Maryland, Baltimore). Rotations are two to three months duration. One resident chose to rotate at MHHD in CY 2024. Residents learn the MHHD principles of health equity data analysis and assist with data analysis projects. They also learn about the MHHD grant program management approach (including RFA development, application review and award decisions, and post award grantee performance management), and learn about the public health legislative process and how MHHD reviews certain equity-related legislation.

MHHD is excited to continue supporting early career public health professionals in 2025 through fellowships, resident training, and the Public Health Workforce Development Internship program.

VIII. MHHD Annual Conference

MHHD celebrated its 20th Anniversary Health Equity Conference on December 10, 2024, at Morgan State University in Baltimore. The theme was “Making Progress, More to Do.” MHHD partnered with the Maryland Department of Aging, Maryland Latin America Youth Center, CASA, Inc., Hagerstown Area Religious Council, and Interfaith Works to host the event. The conference kicked off at 8:00 a.m. with registration and a continental breakfast. The morning plenary session included welcome and opening remarks delivered by state leaders, a fireside chat on behavioral health, a data presentation, a presentation of health equity champion awards, and a musical performance. In the afternoon, there were three topic tracks with nine breakout sessions: Track 1: Social Equity for Health Equity, Track 2: Financing Equitable Healthcare in Maryland, and Track 3: Advancing Equity for Special Populations.

Opening the conference, MHHD Director, Camille Blake Fall, delivered welcome remarks followed by a video greeting from Maryland Governor Wes Moore. Thereafter, opening remarks were delivered by Maryland Lieutenant Governor Aruna Miller, and Secretaries Laura Herrera Scott, Maryland Department of Health; Carmel Roques, Maryland Department of Aging; and Anthony Woods, Maryland Department of Veterans and Military Families. The theme of their remarks focused on the need to continue promoting health equity and improving health outcomes for all Marylanders. Following remarks, Rachel Talley, Chief Medical Officer for MDH, Behavioral Health Administration, led a behavioral health fireside chat with Secretaries Roques and Woods and MDH Deputy Secretary Alyssa Lord. Afterward, Katyayani Bhide, MDH Chief Data Officer, offered a presentation on health disparities, data collection, analysis, and reporting. The presentation highlighted the importance of utilizing data to understand and address the unique health needs of Marylanders.

MHHD also awarded the Calvert County Health Department and Baltimore City community-based organization, Heartsmiles, with the 2024 Health Equity Award for their outstanding public health efforts to improve the lives of Marylanders. Additionally, former Maryland State Senator Shirley Nathan-Pulliam attended the conference and was presented with a Health Equity Lifetime Achievement Award. To close the morning, the renowned Morgan State University Choir, led by Dr. Eric Conway, performed several musical selections.

The afternoon consisted of three tracks with nine breakout sessions.

- Track 1: Social Equity for Health Equity,
- Track 2: Financing Equitable Healthcare in Maryland, and
- Track 3: Advancing Equity for Special Populations.

During the conference, participants had the opportunity to network and receive health information and giveaways from the following 12 exhibitors:

- Latin American Youth Centers (LAYC)
- Maryland Department on Aging (MDOA)
- CASA, Inc.
- MDH, Office of Population Health Improvement (OPHI)

- Asian American Center of Frederick (AACF)
- Community Engagement and Consultation Group (CECG), Inc.
- My Life Foundation, Inc.
- The Center for LGBTQ Health Equity at Chase Brexton Health Care
- Taking Effective Action (TEA), Inc.
- Diamond On The Rise
- Moveable Feast, Inc.
- Maryland Health Connection

The conference was an incredible success and well-attended with over 300 attendees.

IX. Director's Note: Making Progress, More to Do

2024 was a banner year for MHHD as the office celebrated its 20th anniversary. And the MHHD annual health equity conference theme, "Making Progress, More to Do," highlighted the inflection point at which the work of the office finds itself. Now, more than ever, the goals of reducing disparities and advancing health equity are top of mind objectives across the entire healthcare delivery ecosystem. This is something to celebrate as we have long understood how structural and systemic inequities, racism and discrimination, and persistent adverse social conditions, contribute to poor health outcomes for marginalized, underserved, and underresourced communities. MHHD is excited to be in partnership with many statewide organizations and institutions focused on addressing these challenges and finding solutions. And this is where "the rubber hits the road." Not only must we continue to take action within our spheres of influence, but we must also unify behind a strategic direction, the most expedient path forward, to achieve our desired outcomes of supporting and maintaining healthy communities across Maryland.

As an approach to carrying out its mission, MHHD is inspired by the American Medical Association's (AMA) health equity strategy, entitled *Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity*. The strategy offers a multi-pronged process to embed racial justice and advance equity that is adaptable for implementation across the whole of healthcare. In general terms, the AMA's five-point plan includes:

1. Embedding racial and social justice in an organization's culture, systems, polices and practices
2. Building alliances and sharing power with historically marginalized and disadvantaged healthcare practitioners and community partners
3. Ensuring equitable structures and opportunities in innovations
4. Pushing upstream to address all social determinants of health and root causes of inequities
5. Fostering pathways for truth, racial healing and transformation

The AMA's approach is holistic by design to ensure that all aspects of care are identified and reformed as needed, from the patient to the provider to the academic and place-based communities in which patients and providers exist and beyond. The approach also seeks to address the historical and societal impact and legacy of past and present inequities to help spur innovative solutions that can optimize access to the highest quality care.

This year, MHHD's annual health equity conference; its establishment of a first-ever, department-wide Health Equity Liaisons Collaborative; its student training program; its work finalizing a statewide health equity framework; its efforts leading an underrepresented behavioral health professionals workgroup; its ongoing analysis of health disparities data and funding for dozens of local organizations; its capacity-building initiatives for community-based organizations; its advocacy and support of the MDH Office of Governmental Affairs' health equity assessment process; its continued efforts to promote implicit bias training for healthcare practitioners; its local, community-based partnerships; and the introduction, development, and dissemination of an MHHD quarterly newsletter reflect tremendous progress made. And yet, so much more work remains.

What I noted last year bears repeating - advancing health equity is the long game. Change doesn't happen overnight. But how long is too long? I think it's fair to say that it's been long enough. So we have our work before us, and the wind at our back. And collaborating together, we can absolutely create the levers of change necessary to achieve our shared goal of equitable, accessible health and wellness for all.

In solidarity,

Camille Blake Fall, Director
Office of Minority Health and Health Disparities