Office of Minority Health and Health Disparities

Annual Report FY 2023

March 1, 2024

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Executive Summary

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 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 (MDH);
- 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.

There are currently 22 areas of focus to direct MHHD activities in this section of statute.

In addition to the requirements in the MHHD statute, legislation passed in 2021 added focus areas for MHHD's work including:

- HB 78 (2021)-- Public Health - Maryland Commission on Health Equity (The Shirley Nathan-Pulliam Equity Act 2021)
- HB 309 (2021) -- Public Health - Data - Race and Ethnicity Information
- HB 28 (2021) -- Public Health - Implicit Bias Training and the Office of Minority Health and Health Disparities

Health Equity Data

Data presented in this report 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.

MHHD Collaborations and Initiatives

- MHHD provides significant staffing support to the Maryland Commission on Health Equity (MCHE) and produced the data materials presented in the 2023 MCHE Annual Report.
- MHHD provides 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.
- Pursuant to Chapter 744 (HB 28) of 2021, MHHD identifies and approves implicit bias training programs that an individual may complete to satisfy the requirements of the Health Occupations Article (that applicants for license renewal complete, one time, an implicit bias training course). MHHD has listed 18 approved training courses for this purpose on its website.

- MHHD has an ongoing collaboration with the Community Health Resources Commission (CHRC) in their ongoing implementation of the Health Equity Resource Communities (HERC) program. The HERC program is part of the Maryland Health Equity Resource Act approved by the Maryland General Assembly in 2021 and will provide approximately $42 million in new grant funding to reduce health disparities and improve health outcomes in underserved communities.

MHHD Grant Programs

- Minority Outreach and Technical Assistance (MOTA) Program
    - $660,000 to 15 grantees reaching 35,605 individuals
- Social Determinants of Health (SDOH) Program
    - $3,000,000 to 28 grantees reaching 253,309 individuals
- Epidemiology and Laboratory Capacity (ELC) Program (CDC COVID funds)
    - $1,441,000 to 11 grantees reaching 38,216 individuals
- Sickle Cell Program (jointly with the Office of Genetics)
    - Assisted with completion of the required Sickle Cell Report, assisted with development of grantmaking documents for an award in FY 2024.

MHHD Annual Conference

On December 13, 2023, MHHD hosted a community conversation entitled, "Accelerating Health Equity: Driving Change Together" focused on surfacing challenges currently facing communities post-COVID-19. The session brought together a multi-disciplinary group of leaders working in their communities to discuss issues related to childhood poverty, behavioral health, chronic disease, women's health, immigrant services and quality public school education and brainstorm innovative approaches to accelerating health equity post-pandemic.

MHHD Plans for FY 2024

Advancing health equity is the long game as change doesn't happen overnight. But if we join together - government, philanthropy, academia, business – and remain vigilant and relentless in our pursuit of "fairness and justice for all," the possibilities are endless. MHHD looks forward to continuing to work with our internal and external colleagues and collaborators and deeply appreciates your partnership.

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 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 (MDH);
- 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.

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 identify or socioeconomic status

There are currently 22 areas of focus to direct MHHD activities in this section of statute.

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), 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 Health Secretary in setting health equity priorities and advise on policies affecting the delivery of equitable health care and the creation of a strategic plan to address social determinants of health

In addition to the requirements in the MHHD statute, legislation passed in 2021 added focus areas for MHHD’s work including:

- HB 78 (2021) -- Public Health - Maryland Commission on Health Equity (The Shirley Nathan-Pulliam Equity Act 2021)
- HB 309 (2021) -- Public Health - Data - Race and Ethnicity Information
- HB 28 (2021) -- Public Health - Implicit Bias Training and the Office of Minority Health and Health Disparities

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 2, 2023, put this minority percentage at 51.7%. 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 NH Black (B) vs. NH White (W) disparities in death rates from some of the most common causes of death. This is illustrated in Table 2 on p. 9 below, which shows 1999, 2009, 2019 and 2021 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 2021 (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 22-year period (1999 – 2021) 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	39.3% reduction
NH White trend	34.3% reduction
B-W gap	59.1% reduction

Cancer age-adjusted death rate per 100,000 population

NH Black trend	39.2% reduction
NH White trend	32.5% reduction
B-W gap	66.2% reduction

Stroke age-adjusted death rate per 100,000 population

NH Black trend	21.6% reduction
NH White trend	29.4% reduction
B-W gap	0.5% reduction

Diabetes age-adjusted death rate per 100,000 population

NH Black trend	37.7% reduction
NH White trend	21.9% reduction
B-W gap	48.3% reduction

HIV/AIDS (*2021 race-specific age-adjusted rates were not published by VSA***)**

Infant Mortality (infant deaths per 1000 live births)

NH Black trend	33.3% reduction
NH White trend	27.5% reduction
B-W gap	36.5% reduction

Over the entire period, the NH Black to NH White death rate disparity expressed as the gap (rate subtraction) improved by 66% for cancer, by 59% for heart disease, by 48% for diabetes, but no change for stroke. The infant mortality disparity declined by 36%.

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 21 % change	2021	99 to 21 % change
Heart Disease								
NH Black	**310.5**	-22.54%	**240.5**	-21.95%	**187.7**	0.37%	**188.4**	-39.32%
NH White	**247.6**	-23.63%	**189.1**	-15.65%	**159.5**	2.01%	**162.7**	-34.29%
Ratio	***1.25***	*7.00%*	***1.27***	*-34.95%*	***1.18***	*-10.66%*	***1.16***	-37.82%
Gap	***62.9***	*-18.28%*	***51.4***	*-45.14%*	***28.2***	*-8.87%*	***25.7***	-59.14%
Cancer								
NH Black	**254.6**	-22.47%	**197.4**	-18.59%	**160.7**	-3.73%	**154.7**	-39.24%
NH White	**203.7**	-11.39%	**180.5**	-17.95%	**148.1**	-7.16%	**137.5**	-32.50%
Ratio	***1.25***	*-62.53%*	***1.09***	*-9.13%*	***1.09***	*47.03%*	***1.13***	-49.94%
Gap	***50.9***	*-66.80%*	***16.9***	*-25.44%*	***12.6***	*36.51%*	***17.2***	-66.21%
Stroke								
NH Black	**78.7**	-37.99%	**48.8**	6.97%	**52.2**	18.20%	**61.7**	-21.60%
NH White	**58.2**	-33.16%	**38.9**	2.31%	**39.8**	3.27%	**41.1**	-29.38%
Ratio	***1.35***	*-27.75%*	***1.25***	*22.42%*	***1.31***	*60.87%*	***1.50***	42.30%
Gap	***20.5***	*-51.71%*	***9.9***	*25.25%*	***12.4***	*66.13%*	***20.6***	0.49%
Diabetes								
NH Black	**58.1**	-40.62%	**34.5**	-7.25%	**32.0**	13.13%	**36.2**	-37.69%
NH White	**23.3**	-24.89%	**17.5**	-4.00%	**16.8**	8.33%	**18.2**	-21.89%
Ratio	***2.49***	*-34.96%*	***1.97***	*-6.86%*	***1.90***	*9.31%*	***1.99***	-33.78%
Gap	***34.8***	*-51.15%*	***17.0***	*-10.59%*	***15.2***	*18.42%*	***18.0***	-48.28%
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**	5.38%	**9.8**	-33.33%
NH White	**5.1**	-13.73%	**4.4**	-6.82%	**4.1**	-9.76%	**3.7**	-27.45%
Ratio	***2.88***	*11.08%*	***3.09***	*-39.34%*	***2.27***	*29.99%*	***2.65***	-12.42%
Gap	***9.6***	*-4.17%*	***9.2***	*-43.48%*	***5.2***	*17.31%*	***6.1***	-36.46%

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 2021 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.

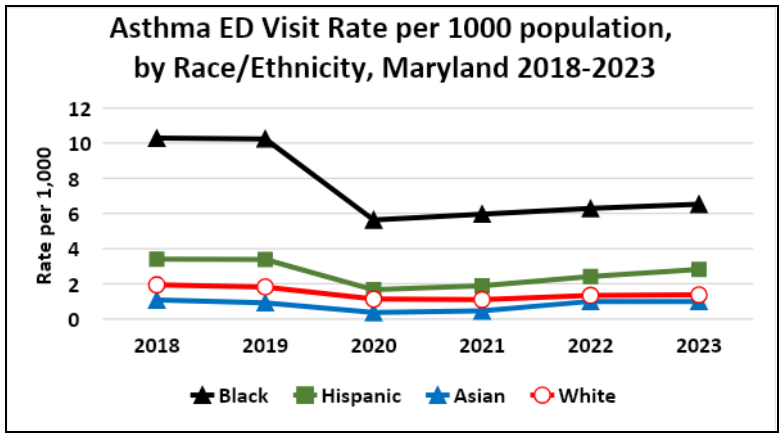
Slowing rates of health disparity reduction may also reflect a declining benefit from health care system interventions, as most of the benefits of that approach may have already been realized. Remaining disparities could be more related to disparities in the social determinants of health. Progress will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

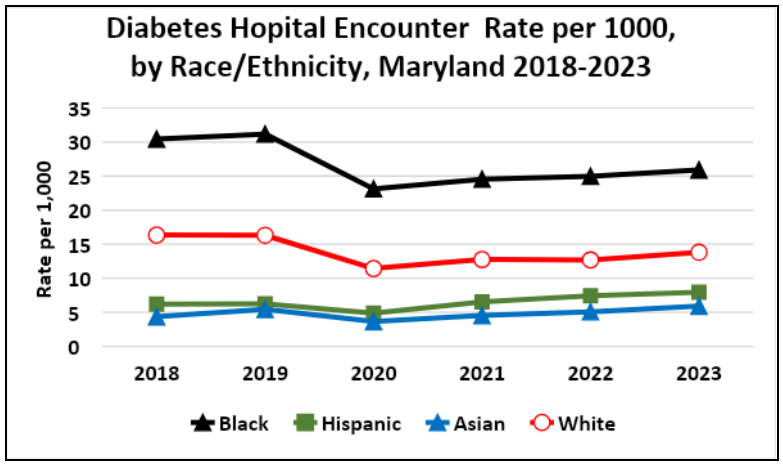
Large disparities persist in rates of preventable healthcare utilization, although some progress has been made in this area. This is shown in Figures 1 to 3 on p. 12 below, which displays the 2018 to 2023 trends in three utilization metrics from the CRISP Health Equity Explorer, Disparity Index report. (*Due the small American Indian population in Maryland, data in this format is not statistically stable for that group and is not presented.)*

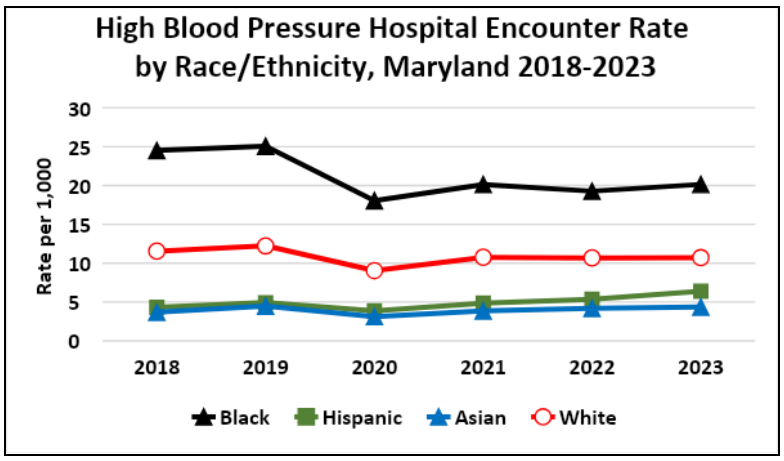
Within individual years, Black utilization rates for asthma, diabetes, and high blood pressure have been two to five times as high as White rates. **This means that 46% to 68% of this utilization is occurring in the Black population, and that 50% to 80% the Black utilization for these conditions would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

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

Figures 1-3. Selected Health Care Utilization rates per 1,000 in Maryland 2018-2023







III. MHHD Consultations and Collaborations

A. Maryland Commission on Health Equity

The Maryland Commission on Health Equity (MCHE) was established by the Shirley Nathan-Pulliam Health Equity Act of 2021 (Ch 750, SB 52 of 2021 Maryland General Assembly). The legislation charges 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 due 12/1/2023
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 provides staff support to the Health Equity Policy Committee in its efforts to develop a Health Equity Framework for Maryland (item #1 above). That framework is expected to be completed by the Summer of 2024, as collection of public input for the framework is being completed.

The MHHD Director serves as the Chair of the Data Advisory Committee (DAC). The MHHD epidemiologist serves on the DAC (item #2 above).

The MHHD epidemiologist, along with CRISP and the DAC, assembled the county-level data for the initial data analysis included in the 2023 report.

MHHD data staff conducted the analysis and produced the initial draft of the data section of the 2023 report.

The 2023 report contains race/ethnic by jurisdiction rates of five social factors (potential causes), five health outcomes (effects), and health uninsurance (both cause and effect).

MHHD data staff also conducted analysis of the relationship between social factor potential causes and the health outcomes (not included in the report due to space limitations).

Figure 4 below is an example of the kind of data included in the 2023 MCHE Annual Report. It shows the median household income for each racial/ethnic group in each jurisdiction (where those results were reportable) in 2020. Some key findings are:

- Compared to Whites, income for Blacks and Hispanics is generally lower.
- Compared to Whites, income for Asians is generally similar or higher.
- Compared to Whites, income for American Indians/Alaska Natives is lower in some places and higher in other places.
- There is a lot of geographic variability in median household income for each racial/ethnic group.

Figure 4. Median Household Income by Race/Ethnicity and Jurisdiction, Maryland 2020

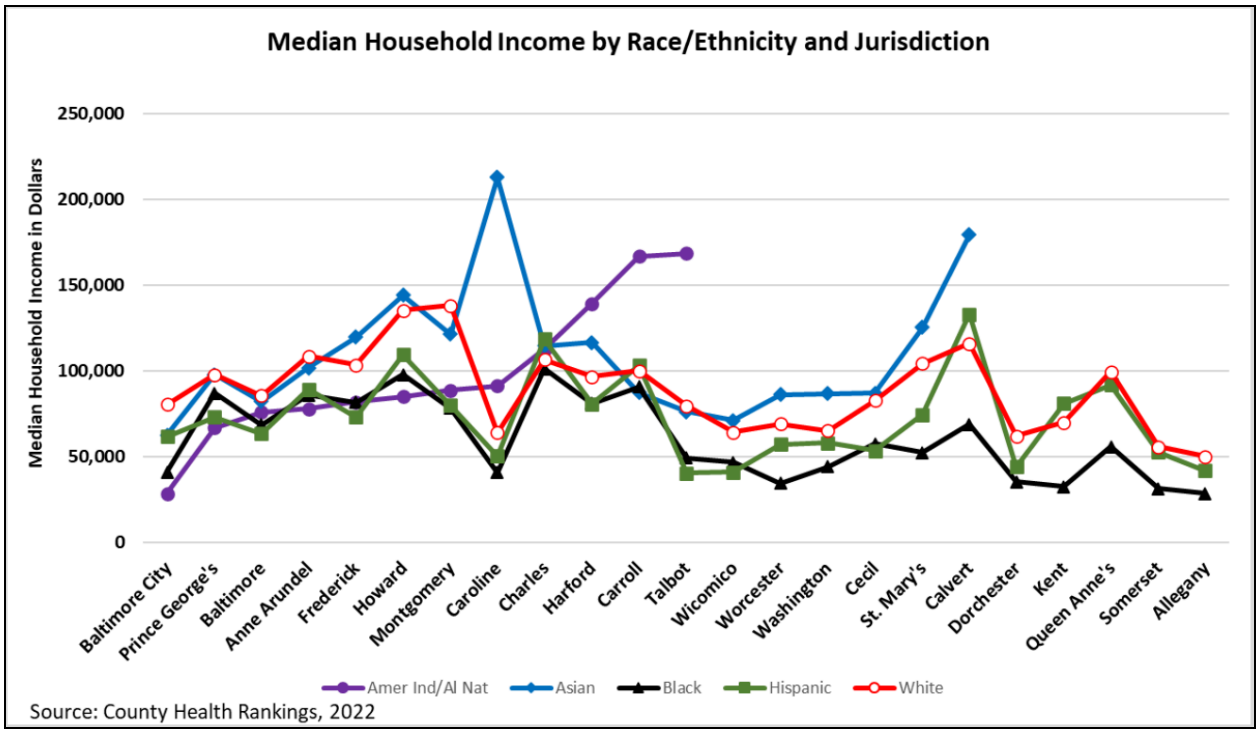
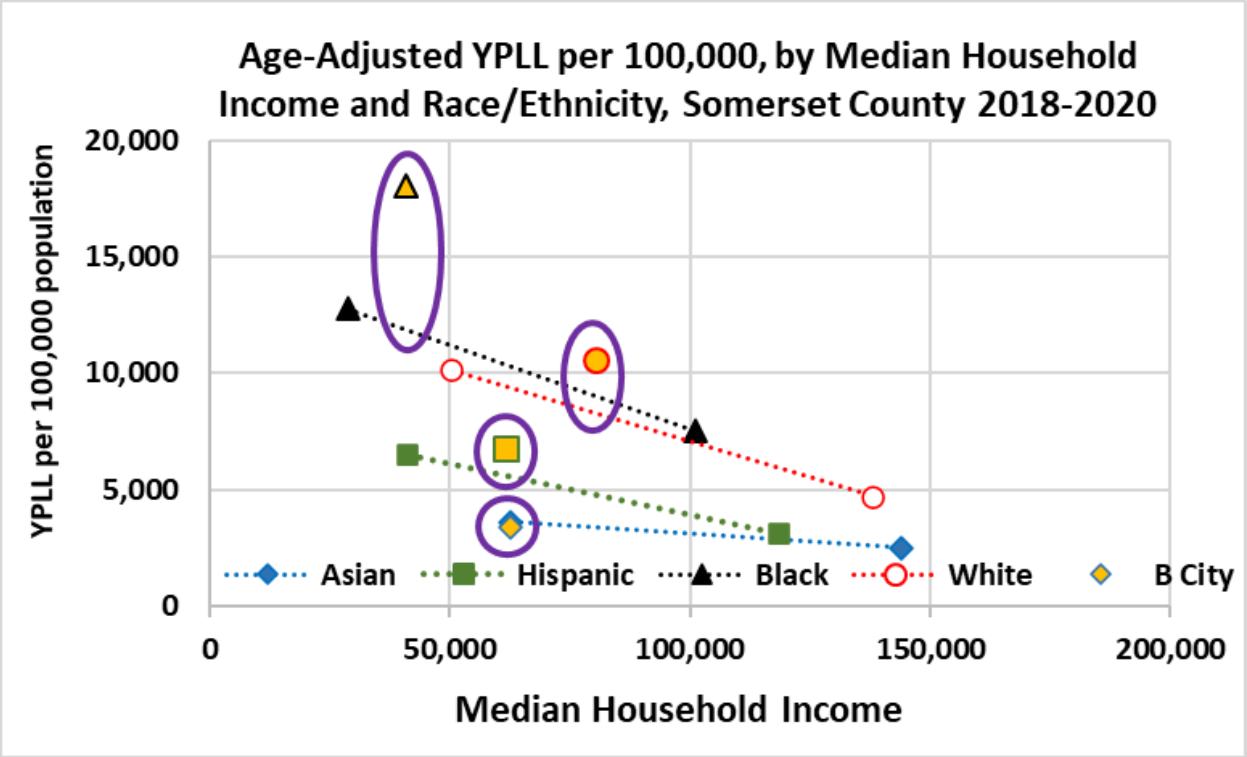


Figure 5 below is an example of the kind of analysis that could not be included in the 2023 MCHE Annual Report.

- YPLL is Years of Potential Life Lost: the sum of years before age 75 lost for each death that occurs before age 75. This correlates to life expectancy: deaths at young age increase YPLL and decrease life expectancy.
- Dotted lines are the relationship of income to YPLL Statewide (based on the data from the jurisdictions) for each race/ethnic group.
- The lines also indicate the range of income and the range of YPLL for each group.
- Circled dots are the Baltimore City values.
- **These data were not included because there would have been <u>840</u> of these charts.**

Figure 5. Baltimore City Levels Compared to Underlying Statewide Relationships, Age-adjusted YPLL by Median Household Income, Maryland, 2018-2020.



Some key findings are:

- The American Indian/Alaska Native population is too small to report results for YPLL.
- Baltimore City is in the low quarter of income for Blacks, Hispanics, and Asians.
- Baltimore City is in the low-middle quarter of income for Whites.
- Baltimore City's Asian YPLL rate is where we would expect based on its income.
- Baltimore City's Hispanic and White YPLL rates are higher than expected from income.
- Baltimore City's Black YPLL rate is <u>substantially higher</u> than expected based on income.

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.

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.
    - 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 Fall 2022 cohort, and the results of the assessment, are listed below.

Asthma Home Visiting Program

This program in the Environmental Health Bureau seeks to enroll children with frequent ED visits for asthma to provide home visiting to assess and remediate environmental triggers, and to promote disease self-management at home. Black ED visit rates in Maryland are generally 3 to 3.5 times as high as White rates. Other race/ethnic groups have lower ED visit rates for asthma than Whites. As a result, **the focus of the analysis for this program was to assure sufficient actual Black enrollment compared to Black proportion of asthma ED visits** (the expected value for the enrollment proportion). **For all 10 jurisdictions participating in the program, actual Black enrollment proportions matched or exceeded the Black proportion of asthma ED visits** (the expected enrollment proportion). The Black proportions of ED visits

ranged from 30% to 90% depending on the jurisdiction, and the Black proportion of actual program enrollment ranged from 45% to 100% depending on the jurisdiction.

Maryland Tobacco Quitline

The Maryland Tobacco Quitline provides telephone smoking cessation support and nicotine replacement products to Maryland Residents. In this case, the analysis was to compare the race/ethnic proportion of current smokers to the race/ethnic proportion of quitline users. Results are shown in the table below:

	Asian	Black	Hispanic	White
% of smokers	5.9%	32.9%	4.7%	57.0%
% of quitline users	0.7%	45.6%	2.8%	47.4%

- Blacks use the quitline at 39% more than their fraction of current smokers.
- Hispanics use the quitline at 40% less than their fraction of current smokers.
- Whites use the quitline at 17% less than their fraction of current smokers.
- Asians use the quitline at only 12% of their fraction of current smokers. This may in part be due to referral of non-English speaking Asians to a national quitline where interpretation for languages other than English or Spanish is available.

Lower quitline use among Asians and Whites may also be due to the higher incomes in those two race/ethnic groups, which may enable them to have more access to smoking cessation services outside of the quitline.

An analysis of the equity of impact for the Tobacco Quitline was performed, comparing the race/ethnic specific rates of several measures of success. The results are shown in the table below:

	All other R/E	Black	Hispanic	White
7-day quit	55.0%	44.3%	34.5%	37.1%
30-day quit	45.0%	36.9%	31.0%	31.6%
25% smoking reduction	65.0%	65.7%	50.0%	67.2%
50% smoking reduction	50.0%	41.0%	35.7%	48.1%
Use of nicotine replacement	89.5%	86.0%	88.0%	87.1%
Satisfaction with quitline	98.3%	95.8%	96.2%	92.8%

Race/ethnic minority success rates were similar to or higher than White rates for most measures, the exceptions being some cases of the smoking reduction measures.

HIV Testing Program

The HIV testing program considered two risk factors in combination: race/ethnicity and type of exposure behavior. This produced nine R/E by exposure behavior groups. For those groups, the group's proportion of new HIV infections was compared to the group's proportion of testing for individual jurisdictions. Ideally, the group most at risk for HIV (indicated by highest new infection rate) would be the group that is most likely to be tested. In one jurisdiction, there was a mismatch of testing to risk as shown in the table below:

	Proportion of new Infections	**Proportion of testing**
NH Black, Male to Male Sexual Contact	9.1%	1.7%
Hispanic, Male to Male Sexual Contact	9.1%	1.7%
NH White, Male to Male Sexual Contact	18.2%	9.1%
NH Black, Intravenous Drug Use	14.5%	0.0%
Hispanic, Intravenous Drug Use	0.0%	0.0%
NH White, Intravenous Drug Use	9.1%	0.8%
NH Black, Heterosexual Contact	21.8%	20.7%
Hispanic, Heterosexual Contact	18.2%	15.7%
NH White, Heterosexual Contact	0.0%	38.8%

Racial/ethnic minority populations with the risk factors of male-to-male sexual contact or intravenous drug use were a much larger share of new infections than their share of the testing in the program. Non-Hispanic Whites without these risk factors had a 35.8% share of the testing but a 0% share of the new infections, while Black intravenous drug users had a 14.5% share of the new infections but a 0% share of the testing in the program.

This kind of imbalance is not unexpected for this kind of voluntary participation program, where a service is made available, and individuals choose to participate in the screening or not. In such cases, it is not unusual for the more affluent and health aware portions of the population (the "worried well") to have high participation in such screening programs, despite often having lower risk. The higher risk portion of the population may lack awareness or may have other barriers to participation in the service.

The challenge upon finding a result of this type is to identify the barriers to participation by the high-risk groups (awareness, motivation, or access) and to work to resolve those barriers.

Breast and Cervical Cancer Program

Maryland's Breast and Cervical Cancer Screening Program (BCCP) provides breast and cervical cancer screening, diagnosis, and patient navigation services to Maryland women. Eligibility criteria include:

- Maryland resident
- 40-64 years old for breast cancer screening
- 21-64 years old for cervical cancer screening
- Have a household income at or below 250% of federal poverty guidelines.
- Have no health insurance or health insurance that does not completely pay for needed services.
- Have health insurance but have not been able to get screened or get needed follow-up testing.

CDC, the program funder, provides estimates of the eligible population that meets these criteria (poverty threshold and uninsured/underinsured) disaggregated by race/ethnic group. These estimates were used to generate the expected racial/ethnic distribution of program participants, which was compared to the actual racial/ethnic distribution of program participants:

	All other R/E	**NH Black**	**Hispanic**	**NH White**
Expected eligible	7.8%	29.2%	40.8%	22.4.%
Actual enrollment	4.6%	17.8%	66.8%	10.8%

Hispanics were 66.8% of the enrolled population while being 40.8% of the estimated eligible population (and 11.5% of the Maryland population). Other groups had lower proportions of the enrolled population compared to their proportions of the estimated eligible population. In particular, the Non-Hispanic Black population was estimated to be 29.2% of the eligible population but was only 17.8% of the enrolled population.

The Hispanic population in Maryland has the highest rates of health uninsurance of any other race/ethnic group, by a wide margin. This unexpectedly high rate of Hispanic participation (with resulting lower than expected participation of other groups) might not be undesirable if in fact the poor and un/under-insured members of the other race/ethnic groups are finding other ways to access these services.

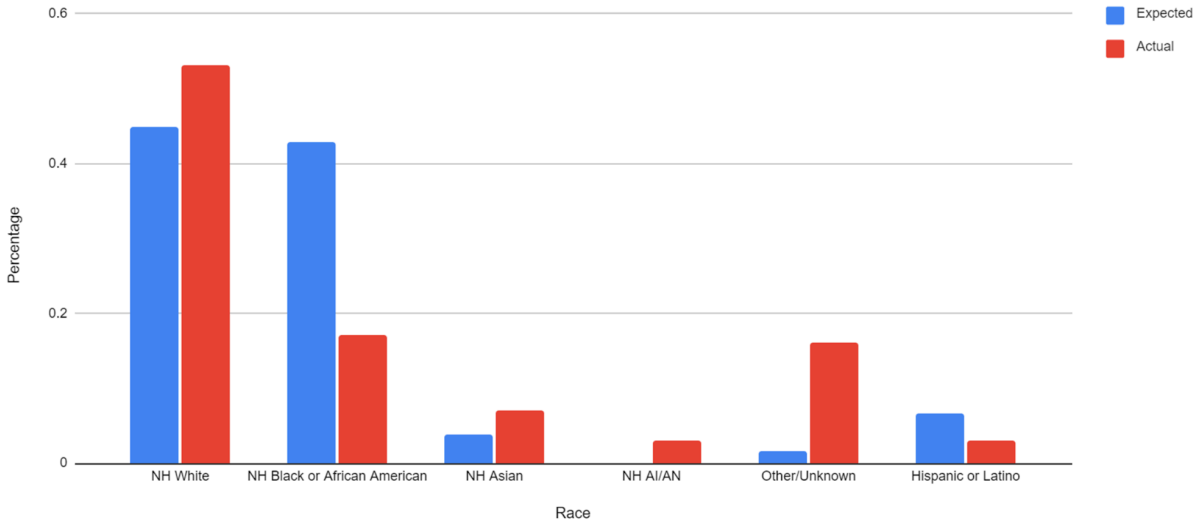
So, the next refinement of this analysis would be to assess rates of utilization of these screening services overall in these race/ethnic groups (regardless of being in or out of this program). If there is no disparity in service utilization, then the finding here of higher-than-expected Hispanic utilization of this service might be necessary to prevent a disparity. If there is a disparity in service use, especially for the Black population, then the goal would be to enhance Black participation in this program, without sacrificing the high levels of Hispanic participation.

Maternal Mortality Review Team

The MDH Maternal Mortality Review Team is a group of clinical and public health experts and community representatives from across the State. Since 2001, case reviews have been conducted to investigate all deaths of Maryland resident individuals during pregnancy or up to one year after the conclusion of pregnancy from any cause and to identify opportunities to prevent future deaths.

In this analysis, the assessment was to determine if the racial/ethnic makeup of the MMRT Team is proportional to the racial/ethnic distribution of maternal mortality events (pregnancy-associated deaths or PAD) in Maryland.

Figure 1 - Expected (PAD) vs. Actual MMRT Distribution



Non-Hispanic Blacks are represented on the MMRT at less than half of the expected proportion based on pregnancy-associated deaths. It may be that Blacks are also underrepresented in the expert workforce from which the members of the MMRT must be drawn. Efforts to increase Black recruitment to the MMRT and to increase Black representation in the relevant workforce need to be undertaken.

C. Health Professional Implicit Bias Training

Chapter 744 (HB 28) of 2021 required MHHD and Health Occupations Boards to identify and approve implicit bias training programs that an individual may complete to satisfy the requirements of the Health Occupations Article (that applicants for license renewal complete, one time, an implicit bias training course). It also required MHHD to provide a list of training programs so approved on request.

In response, MHHD undertook the following activities:

- Developed the administrative processes for HB 28 - This included data review, analysis, regulatory assessments, and meeting with subject matter experts in the areas of implicit bias data, DEI, human resources, and health care providers.
- Created all aspects of the constituent webpage including design, layout, copy and content.
- Monitored and analyzed evidence-based content in the healthcare marketplace to ensure statutory compliance.
- Attended health occupations boards meetings.
- Responded to constituent inquiries sent via email.
- Responded to constituent inquiries via the IQ system.
- Posted approved implicit bias training programs for this purpose to the MHHD website: https://health.maryland.gov/mhhd/Pages/Implicit-Bias-Resources.aspx

The website currently contains 18 approved training programs.

There are over 400,000 licensees between the 20 boards, all with different renewal schedules and requirements.

For example, the Maryland Board of Physicians has a two-year renewal interval and renews the top half of the alphabet (A-L) on or before September 30 of even numbered years and renews the remainder (M-Z) on or before September 30 of odd numbered years. Thus, most Maryland physicians (other than those newly licensed who have not yet processed a renewal) should have taken an implicit bias training course as of the end of 2023.

It is likely that most licenses should have taken an implicit bias training course by the end of 2023, except for any professions that have renewal cycles longer than 3 years.

D. Health Equity Resource Communities Work with CHRC

MHHD has an ongoing collaboration with the Community Health Resources Commission (CHRC) in their ongoing implementation of the Health Equity Resource Communities (HERC) program. This program is the next evolution of the previously successful Health Enterprise Zone (HEZ) program, which MHHD had helped to design.

The HERC program is part of the Maryland Health Equity Resource Act approved by the Maryland General Assembly in 2021. The program will provide approximately $42 million in new grant funding to reduce health disparities and improve health outcomes in underserved communities. The HERC grant program builds on the prior Pathways to Health Equity grant program established two years ago, also under the Maryland Health Equity Resource Act.

The act also established the Health Equity Resource Community Advisory Committee to provide guidance to the CHRC in implementation of the Act. The MHHD Director serves on the Health Equity Resource Community Advisory Committee.

E. Other MHHD Consultations and Collaborations

1. Collaborations with the Prevention and Health Promotion Administration of MDH

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

- PHPA Health Equity Workgroup: (one meeting in FY 2023)
- Cancer and Chronic Disease Bureau Health Equity Workgroup: (one meeting in CY 2023)
    - CCDB Health Equity Steering Committee: (six meetings in CY 2023)
    - CCDB Data to Action Committee: (nine meetings in CY 2023)

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

- Diabetes Committee: (two meetings in FY 2023)
- Diabetes Quality Task Force: (five meetings in FY 2023)
- Diabetes Dashboard Development group: (35 in FY 2023)

And participated in other diabetes meetings: (three in FY 2023)

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 (five meetings in FY 2023)
- Maternal Mortality Review Stakeholder Group (five meetings in FY 2023)
- Morbidity and Mortality Quality Review Committee (three meetings in FY 2023)

And participated in other meetings on maternal morbidity and mortality (four in FY 2023).

Tobacco Program: (two meetings in FY 2023)

2. Collaborations with other MDH colleagues and partners

- **PHS Data Modernization Workgroup**: (four meetings in FY 2023)
- **Medicaid:** SDOH webinar presentation preparation: (four meetings in FY 2023)
- **Maryland Primary Care Program:** (four meetings in FY 2023)
- **COVID data consultations to external contractor:** (11 meetings in FY 2023)
- **Legislative liaison review with OGA:** (10 meeting in first quarter of CY 2023)

IV. MHHD Grant Programs

A. 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, preventive intervention strategies, and technical assistance. MOTA programs are required to focus on one of the following key areas: Pregnancy/birth outcomes, cardiovascular disease, diabetes, obesity, 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. Below is the annual data reported by the 15 grantees during the FY 23 grant cycle.

Program Data from FY 2023 MOTA Funded Grantees/Partners

Grantee/Partner	Jurisdiction	Funding Amount	Health Focus Area	# Of Minorities Reached (Total cumulative number of Encounters	Intervention (cumulative number of individuals enrolled in the program)
Program Totals		**$659,541**		**35,605**	**1,460**
Aaron's Place, Inc.	Caroline	$24,999	Obesity/Diabetes	3,116	316
American Diversity Group	Montgomery	$50,000	Obesity/Diabetes	1,752	43
Eastern Shore Wellness Solutions, Inc.	Dorchester	$50,000	Diabetes/Diabetes Self-Management Program (DSMP)	4,578	47
Esperanza Center (Catholic Charities)	Baltimore City	$50,000	Diabetes Self-Management Program (DSMP)	193	48
Holy Cross Health	Montgomery	$50,000	Prediabetes	3,974	186
Healthy Harford	Harford	$49,542	Diabetes	3,176	The program did not have an intervention component
Healthlincs, Inc.	Montgomery	$50,000	Prediabetes/Diabetes	519	12
Lifestyles of Maryland, Inc.	Charles	$50,000	Pre-diabetes	5,329	323

Maintaining Active Citizens, Inc.	Wicomico	$50,000	Diabetes Self-management (DSMP)	3,017	112
Minority Outreach Coalition	St. Mary's	$30,000	Pre-diabetes	2,877	26
Jolly Dream Foundation, Inc.	Prince George's	$25,000	Obesity/Diabetes	2,089	29
Leading by Feeding	Anne Arundel County	$50,000	Mental Health	687	105
Greater New Hope Church and Ministries	Caroline	$30,000	Obesity/Diabetes	2,014	152
United Way of Central Maryland	Baltimore City	$50,000	Pregnancy and Birth Outcomes	131	38
Hope Connections for Cancer Support	Prince George's County	$50,000	Breast Cancer	2,153	23

B. Social Determinants of Health 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: economic stability, education access, health care access and quality, quality, neighborhood, built environment, and 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 2023 SDOH Funded Grantees/Partners

Grantee or Partner	Jurisdiction	Funding Amount	Health Focus Area	# Of Minorities Reached (number of encounters)	Number of persons enrolled in program
Program Totals		**$3,010,210**		**253,309**	**12,031**
AACF- Asian American Center of Frederick	Frederick	$90,000	Food and Nutrition	7667	1185
Aaron's Place	Caroline	$75,000	Food and Nutrition	4729	598
AWPLI- Access to Wholistic and Productive Living, Inc.	Prince George's	$100,000	Training and Education	4126	25
AZIZA PE&CE	Baltimore City, Baltimore Co Prince George's	$200,000	Violence reduction	3491	168
Backyard Basecamp	Baltimore City	$99,000	Exercise Education	1555	122
Baltimore Medical System	Baltimore City	$100,000	Food and Nutrition	1779	136
Baltimore Safe Haven	Baltimore City	$100,000	Access to Housing	3556	36
Community Engagement and Consultation, Inc.	Prince George's	$100,000	Workforce readiness/ retention	5898	271
Frederick Health Hospice	Frederick County	$99,580	Language Services, Greif Support	2596	159
Greater New Hope	Caroline	$100,000	Health Education	1891	116
Horizon Goodwill Industries	Washington	$100,000	Access to Housing	2715	234
Inner County Outreach	Harford	$47,742	Food and Nutrition, Exercise Education	778	62
ICCI- Institute for Creative Community Initiatives	Prince George's	$150,000	Workforce readiness/ retention	2279	228

Institute for Public Health Innovation	Prince George's	$99,800	Food and Nutrition	21,266	*N/A*
KEYS Empowers, Inc.	Baltimore City Baltimore Co Prince George's	$200,000	Violence reduction	24,703	600
Leading by Feeding	Baltimore City Baltimore Co Prince George's Eastern Shore, Anne Arundel	$200,000	Food and Nutrition	97,380	2,988
Luminis Health	Prince George's	$100,000	Food and Nutrition	6,646	214
MAC, Inc.	Wicomico	$94,088	Food and Nutrition, Exercise Education	15,616	48
Mary's Center	Prince George's	$100,000	Nutrition Education	1503	201
Meritus Health	Washington County	$100,000	Food and Nutrition	9397	1807
MOC- Minority Outreach Coalition	Charles County	$30,000	Health Education	2651	4
OHLA- Organization of Hispanic/Latin Americans of Anne Arundel	Annapolis	$100,000	Health Education & Referrals	11,871	1306
OMT-Office Management & Technology, Inc.	Baltimore City, Baltimore Co	$50,000	Food and Nutrition	2433	208
PPHUF-Plantation Park Heights Urban Farm	Baltimore City	$75,000	Food and Nutrition	5735	*N/A*
Resolve Inc.	Baltimore City, Montogomery & Washington	$100,000	Food and Nutrition	4617	915
The Bridge of Edgewood Corp	Harford County	$100,000	Health Education	2193	165
T.I.M.E Organization	Baltimore City, Montogomery & Washington	$200,000	Mental Health	616	182
Vibrant Health & Wellness Foundation, Inc.	Prince George's	$100,000	Type 2 Diabetes	3622	53

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

Introduction

MHHD conducts a component of the CDC's Enhancing Epidemiology and Laboratory Capacity (ELC) program for COVID-19. Grantees funded through this MHHD program provide community-based services including outreach and education, quarantine and isolation, and other COVID-response-related support. Grantees funded through this RFA provide community-based services including outreach, education, and additional COVID-related support. Services were provided by 11 grantees in 8 Maryland jurisdictions in FY 2023.

Program Data from FY 23 ELC- CHW/ CTCBS Funded Grantees/Partners

Enhancing Epidemiology and Laboratory Capacity for COVID-19					
Grantee/ Partner	**Jurisdiction**	**Funding Amount**	**Health Focus Area**	**# of Minorities who received at least one service**	**# of events, and Total attendees at events**
Program Totals		**$1,441,000**		**38,216**	**770** **29,108**
Eastern Shore Wellness Solutions, Inc.	Dorchester	$182,000	COVID-19	1,779	36 1,342
Hepatitis B Initiative of Washington	Prince George's	$200,000	COVID-19	2,046	254 7,881
Lifestyles of Maryland, Inc.	Charles	$199,000	COVID-19	5,086	188 4,793
Harford County Health Department	Harford	$150,000	COVID-19	245	15 523
African Women Cancer Awareness Association	Montgomery	$150,000	COVID-19	20,791	22 1978
Access to Wholistic and Productive Living Inc.	Prince George's	$100,000	COVID-19	1,855	27 4,965
The Institute for Creative Community Initiative	Prince George's	$80,000	COVID-19	1,290	129 1,169

Community Health Education and Research, Corp.	Prince George's and Montgomery	$80,000	COVID-19	1,021	28 784
Linking All So Others Succeed	Harford	$100,000	COVID-19	2,858	28 2,547
Healthlincs, Inc.	Anne Arundel, Baltimore City, Howard, Prince George's, and Montgomery	100,000	COVID-19	386	15 520
Central Maryland Area Health Education Center	Baltimore City	$100,000	COVID-19	859	28 2606

D. Sickle Cell Program

MHHD is the fiscal steward of funding to support the Maryland Statewide Steering Committee on Sickle Cell Disease.

The Committee is (and has been) staffed by the Office of Genetics and People with Special Health Care Needs (OGPSHCN), who also manages the newborn screening program and is where MDH expertise in Sickle Cell Disease resides).

MHHD worked with OGPSHCN and the Committee to develop a workplan and grant award to utilize the sickle cell funding for patient care services beginning in FY 2024.

MHHD is working with OGPSHCN and the Committee on hiring a full-time employee to manage the grants process (application, awards, grant management) process for the sickle cell funding.

MHHD worked with OGPSHCN and the Committee to make funds available to hire a temporary contractor to produce the Sickle Cell report required by Acts of 2022 Ch 279 (HB 1188).

V. MHHD Annual Conference

In 2023, MHHD continued to expand its engagement in reaching a diverse network of partners within and external to MDH in support of the office's charge to collaboratively work to reduce health disparities by hosting a community conversation entitled, "Accelerating Health Equity: Driving Change Together." The session brought together a multi-disciplinary group of leaders working in their communities to address issues facing communities post-COVID-19 and tackle challenges related to childhood poverty, behavioral health, chronic disease, women's health, immigrant services and quality public school education. The day-long convening was facilitated by Camille Blake Fall, MHHD Director, and Kelly Umana, Senior Specialist, Health Equity Monitoring & Evaluation, Maryland Latinos Unidos and welcomed over 100 attendees.

VI. Future Direction of MHHD

As MHHD looks to advance health equity in 2024 and beyond, we know that radical transformation of our institutional systems and structures is a must. Despite concerted efforts, our current approaches have not moved the needle on improving overall health or health outcomes nearly fast enough, so we must commit ourselves to doing things differently. We must take an "all of the above approach" to eliminating disparities for all Marylanders regardless of race, ethnicity, sexual orientation, disability, gender identity or socioeconomic status. And while MHHD's path to advancing change will continue to be multi-pronged, our "North Star" remains unwavering – working to ensure that every person in the state is empowered and enabled to access all the resources and opportunities necessary to achieve the best possible physical, emotional, and social well-being.

We are clear that underpinning this critical work, and key to its success, is a threshold mandate to identify and address racism and all the related "isms" that plague our societies. We know that racism and discrimination lead to disparate treatment and that disparate treatment leads to disparate outcomes across the entire social, civic, and economic spectrum. While government programs like Medicaid, Medicare, and the Maryland Health Benefit Exchange cannot fully solve social and economic inequities, the health care system has an important role to play in identifying and addressing social determinants of health and health-related social needs as part of whole person care.

To achieve these goals, we must, first and foremost, center and empower community leaders to guide us toward the change we seek rather than the other way around. It will not just be a matter of shared decision-making power or inviting community voices "to the table" but a whole cloth dismantling of the table so that we might rebuild it in the image of community. We must also set our sights on and follow the lead of those embedded and most proximate to the challenges faced by the unserved, underserved, and marginalized.

Additionally, we understand that to eliminate the health disparities gap we must commit to improving the chronic health conditions and mortality/morbidity rates of people of color more

quickly than we improve the chronic health conditions and mortality/morbidity rates of the white population without compromising on the provision of high-quality health care for all. And we must dedicate ourselves to removing barriers to access through the robust implementation of cultural competency practices, and language access, anti-racism and implicit bias training, all of which can serve as tools to begin to identify and, ultimately, neutralize the root causes of discrimination and inequity.

Advancing health equity is the long game. Change doesn't happen overnight. But we must join together – government, philanthropy, academia, business – and remain vigilant and relentless in our pursuit of "fairness and justice for all." As the well-trodden proverb reminds us, "If you want to go fast, go alone; if you want to go far, go together."

MHHD looks forward to continuing to work with our internal and external colleagues and collaborators "to go far" in eliminating disparities and deeply appreciates your partnership.

Onward!

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