



BUILDING A HEALTHIER MARYLAND

STATE HEALTH IMPROVEMENT PLAN



2026 Update
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Executive Summary

The 2024-2029 State Health Improvement Plan (SHIP) is a five-year plan that provides a framework for Maryland Department of Health (MDH) programs, sister state agencies, partner associations, community-based organizations, and health systems in Maryland to address five priority health areas. These priority health areas were identified through a systemic analysis of primary and secondary data as part of the [State Health Assessment \(SHA\)](#). The SHIP offers a shared language and vision to inform decision-making, prioritize activities, and allocate resources where they are most needed to ultimately improve health outcomes in Maryland.

The SHIP supports state and local community health improvement by:

- Providing state and jurisdictional data to support and monitor progress for Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs), and strategic planning.
- Providing a menu of suggested strategies to address statewide health priorities for agencies and local partners to use for action.
- Serving as a point of reference and offering core data, objectives, and strategies for grants and program proposals.
- Helping organizations promote policy, systems, and environmental change.

The five priority areas and the corresponding goals and objectives are presented in the following tables. Each objective includes a menu of suggested strategies that can be used by state and local partners to drive towards collective impact.

State Health Improvement Plan Priorities



Chronic Disease



Access to Care



Behavioral Health



Women's Health



Violence

State Health Improvement Plan (SHIP) Priorities, Goals, Objectives

Priority Area: Chronic Disease	
Goals	Objectives
Goal 1: Enhance primary prevention of chronic disease	<p>Objective 1.1.1: Prevent increases in household food insecurity in Maryland, maintaining the rate at 16.4% for 2027 and decreasing the rate to 15% in 2036.</p> <p>Objective 1.1.2: By 2029, decrease the percentage of adults reporting no physical activity or exercise other than their regular job in the past 30 days from 22.7% to 21.6%.</p>
Goal 2: Enhance screening, treatment, and care for chronic illness	<p>Objective 1.2.1: Increase the percentage of Maryland adults ages 45–75 years who receive one or more of the recommended colorectal cancer screening tests, per 2021 U.S. Preventive Services Task Force (USPSTF) guidelines, from 49.3% to 50.7% by 2027 and 54.6% by 2036.</p> <p>Objective 1.2.2: By 2029, increase the percentage of high-risk populations receiving lung cancer screenings from 16.8% to 17.6%.</p> <p>Objective 1.2.3: Reduce the rate of emergency room (ED) visits for asthma among all children aged 2 to 17 years old from a 2023 baseline rate of 7.8 per 1,000 to a rate of 5.3 per 1,000 by 2029; and reduce the rate of ED visits for asthma among all non-Hispanic and Hispanic Black children aged 2 to 17 years old from a 2023 baseline rate of 14.6 per 1,000 to a rate of 6.9 per 1,000 by 2029.</p> <p>Objective 1.2.4: Reduce the percentage of patients ages 18–75 years with type 1 or type 2 diabetes with poor glycemic control (most recent hemoglobin A1c > 9.0%) from 67.8% to 65.8% by 2027 and to 60.3% by 2036.</p> <p>Objective 1.2.5: By 2029, decrease the proportion of adults 18–85 years of age who have a diagnosis of hypertension from 35.8% to 27.3%.</p>

Priority Area: Access to Care	
Goals	Objectives
Goal 1: Enhance care delivery models to meet the needs of different populations	<p>Objective 2.1.1: By 2029, increase the proportion of statewide behavioral health outpatient service recipients who receive services via telehealth from 59.1% to 67%.</p> <p>Objective 2.1.2: By 2029, increase the total percentage of students enrolled in School Based Health Centers from 35% to 70% at that school.</p>
Goal 2: Recruit and retain high quality healthcare and public health workforce	<p>Objective 2.2.1: By 2029, reduce the average wait time for primary care first appointment.</p>
Goal 3: Reduce barriers to care	<p>Objective 2.3.1: By 2029, reduce the total proportion of individuals not covered by private or public health insurance from 7% to 5.5%.</p>

State Health Improvement Plan (SHIP) Priorities, Goals, Objectives

Priority Area: Women's Health	
Goal	Objectives
<p>Goal 1: Improve maternal health outcomes through improved maternal care before, during, and after pregnancy</p>	<p><u>Objective 3.1.1: By 2029, reduce the rate of preterm births from 10.7% to 9.4%.</u></p> <p><u>Objective 3.1.2: By 2029, reduce the infant mortality rate from 6.5 per 1,000 live births to 5.2 per 1,000 live births.</u></p> <p><u>Objective 3.1.3: By 2029, reduce the percentage of babies born with low birth weight from 8.5%.</u></p> <p><u>Objective 3.1.4: By 2029, reduce unintended pregnancy rate from 42% to 36.5%, with a focus on addressing health disparities.</u></p> <p><u>Objective 3.1.5: By 2029, increase the percentage of deliveries in which individuals were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care.</u></p> <p><u>Objective 3.1.6: By 2029, reduce the total maternal mortality rate from 21.3 to 17.2 per 100,000 live births, and for Black women from 31.4 to 19.2 per 100,000 live births.</u></p> <p><u>Objective 3.1.7: By 2029, increase the percentage of pregnant women who receive prenatal care beginning in the first trimester from 78.1% to 82%.</u></p>
<p>Goal 2: Increase breast and cervical cancer prevention, screening, and care</p>	<p><u>Objective 3.2.1: By 2029, increase the number of women indicated to have a breast cancer screening who receiving a breast cancer screening for which one is indicated from 78.3% to 82.2%.</u></p> <p><u>Objective 3.2.2: By 2029, increase youth HPV vaccine coverage rates to reach the following targets:</u></p> <ul style="list-style-type: none"> • Girls age 13-17 years who are up to date on HPV vaccination to 73.1% (2023 Baseline: 70.2%) • Boys age 13-17 years who are up to date on HPV vaccination to 67.5% (2023 Baseline: 64.3%) <p><u>Objective 3.2.3: By 2029, increase the proportion of females who receive a cervical cancer screening based on the most recent guidelines from 51.4% to 79.2%.</u></p>

State Health Improvement Plan (SHIP) Priorities, Goals, Objectives

Priority Area: Violence	
Goal	Objectives
Goal 1: Reduce firearm-related suicides, homicides, and injuries	<p><u>Objective 4.1.1: By 2029, reduce the age-adjusted rate of firearm-related suicides from 4.8 to 2 per 100,000.</u></p> <p><u>Objective 4.1.2: By 2029, reduce the age-adjusted rate of firearm-related homicides from 8.4 to 6.6 per 100,000.</u></p>
Goal 2: Reduce the rates of, and harms associated with intimate partner and sexual violence (IPV/SV).	<p><u>Objective 4.2.1: By 2029, reduce emergency department visits related to intimate partner violence (IPV).</u></p>

Priority Area: Behavioral Health	
Goal	Objectives
Goal 1: Expand access to, and utilization of, behavioral health services	<p><u>Objective 5.1.1: Increase the percentage of patients discharged from hospitalization for mental illness who receive follow-up care within seven days of discharge from 38.0% to 38.5% by 2027 and to 40.5% by 2036. Increase the percentage of patients discharged from hospitalization for mental illness who receive follow-up care within 30-days of discharge from 64.3% to 64.8% by 2027 and 66.8% by 2036.</u></p> <p><u>Objective 5.1.2: By 2029, reduce the rate of suicides from 9.9 per 100,000 to 9.1 per 100,000.</u></p> <p><u>Objective 5.1.3: Increase the number of youth substance use treatment providers by 2% each year.</u></p> <p><u>Objective 5.1.4: By 2029, increase utilization of public behavioral health services by 4%.</u></p>
Goal 2: Reduce disparities in mental health outcomes.	<p><u>Objective 5.2.1: By 2029, reduce the percentage of students who felt sad or hopeless most days for more than 2 weeks in the past 12 months from 42% for all students, and from 64.6% for LGBTQ students.</u></p> <p><u>Objective 5.2.2: By 2029, increase availability of affordable housing from 46.1% as a way to improve health outcomes, including mental health.</u></p>
Goal 3: Reduce overdose and the negative health outcomes associated with substance use.	<p><u>Objective 5.3.1: By 2029, reduce the number of opioid-related overdose deaths by 20%.</u></p>



Background

The Building a Healthier Maryland (BAHM) initiative presents the 2026 update to the 2024 State Health Improvement Plan (SHIP). The SHIP identifies Maryland's health priorities and presents associated goals and objectives to improve health outcomes. The SHIP is intentionally rooted in community input. It builds on population health data, community feedback gathered throughout Maryland, as well as community-informed priorities identified from the local Community Health Assessment (CHAs) and Community Health Improvement Plan (CHIPs). Additional input from local health departments (LHDs), state agencies, health care organizations, and community partners informed the framing and structure of the SHIP.

Ultimately, the SHIP reflects the lived experiences and priorities of communities throughout Maryland. It facilitates collective impact across sectors by engaging communities, aligning partners, and using health indicator data to monitor progress. Implementation of the SHIP involves Maryland Department of Health (MDH) programs, sister state agencies, partner associations, community-based organizations, and health systems working together to ultimately benefit all Marylanders.

The SHIP is a living document that evolves as health priorities, data sources, and best practices change. First published in September 2024, this updated version aligns with and supports implementation of the Population Health Accountability Plan (formerly the State Health Equity Plan). The Population Health Accountability Plan is required for Maryland's participation in the

[Achieving Healthcare Efficiency through Accountable Design \(AHEAD\) Model](#), from the Centers for Medicare and Medicaid Services. While the SHIP sets a broad foundation for health improvement, the Population Health Accountability Plan drives targeted actions that contribute to SHIP implementation. Both plans drive towards improved health outcomes for Marylanders.

The 2026 revised SHIP includes updated objectives and an expanded menu of evidence-based strategies and MDH subject matter expert-recommended strategies. Objectives were updated for several reasons, including to align with the Population Health Accountability Plan and other MDH programmatic plans and to reflect changes in data sources or calculations for certain metrics. Any changes to objectives are noted under that objective. The evidence-based strategies that were added to the SHIP were identified through an extensive literature review and vetted by subject matter experts at MDH.



Development of the State Health Improvement Plan

Development of this State Health Improvement Plan (SHIP) was guided by the State Health Assessment (SHA). The SHA synthesizes primary and secondary data to provide a comprehensive picture of health in Maryland.

The SHA includes:

- Statewide health and demographic data.
- A broad array of population-level metrics, including socioeconomic indicators that affect health outcomes
- Findings from a statewide administered community input survey capturing Marylanders' perspectives on the most pressing needs in their communities.

In developing the SHIP, community health assessments conducted by local jurisdictions were reviewed. This input helped ensure that state priorities reflect local conditions and community-identified needs. The SHIP builds on the SHA by establishing statewide priorities, goals and SMART (specific, measurable, attainable, realistic, timebound) objectives. Local health departments and local health improvement coalitions use the SHIP as a guiding framework when developing Community Health Improvement Plans (CHIPs); this promotes alignment between state and local health improvement efforts.

Methods

The SHIP is a long-term systematic plan that addresses issues identified through the SHA. Development of this plan utilized a participatory, community-driven approach guided by the Mobilization for Action through Planning and Partnerships 2.0 (MAPP) process. While the MDH facilitated the development of the SHIP, it was a collaborative effort that involved state agencies, local health departments, local health improvement coalitions, and community based organizations. This inclusive approach ensures the SHIP is truly community-owned and reflects a diversity of voices and perspectives.

A Building a Healthier Maryland (BAHM) Steering Committee was convened to develop goals, objectives and strategies for the 2024-2029 SHIP cycle. In 2025, an extensive literature review was conducted to identify additional evidence-based strategies and subject matter expert recommendations to support progress towards each SHIP objective. These additions expand the menu of strategies that community-based organizations, local and state agencies, healthcare partners, and community advocates can use to guide action. All cited literature can be found in [Appendix IV](#).



Development of the State Health Improvement Plan

Steering Committee and Workgroups

MDH convened a series of Steering Committee meetings from December 2023 through March 2024. Members reviewed primary and secondary data from the SHA, identified state health priorities, and crafted goals, objectives and strategies.

During these meetings, the Steering Committee members:

- Reviewed and discussed the primary and secondary data from the SHA
- Discussed the importance of health equity and how that may be addressed in the SHIP
- Conducted a root cause analysis on eight identified health issues of concern
- Came to consensus on the five health priority areas

Following the selection of the five health priority areas, a workgroup was created for each health priority. The workgroups met over the next few months to solidify goals for their priority areas, objectives and strategies that could be employed to achieve those goals, and metrics that should be tracked to monitor progress.

For a more detailed explanation of the Steering Committee and Workgroup meeting process, see [Appendix III](#).

Health Equity

When selecting the top five health priority areas for the SHIP, health equity was suggested as a stand-alone priority. However, based on the data review and conversations about the root cause analyses, it was clear that all health priorities must address health equity if true progress was to be made. Ultimately, rather than silo health equity in its own category, all five of the selected health priority areas incorporated within every priority area to achieve progress.

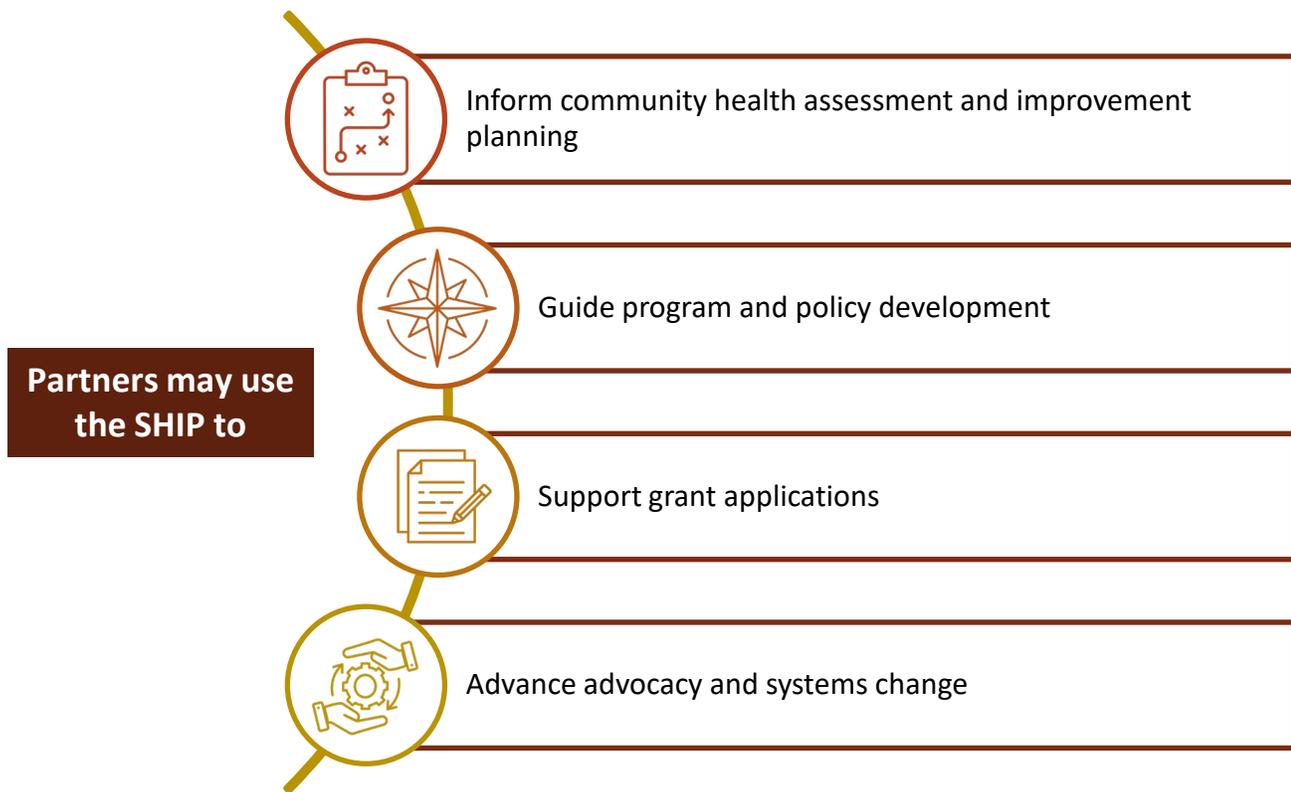
As a result, each priority incorporates health equity into the goals, objectives and strategies. When necessary, priority populations are elevated through targeted objectives and strategies. This approach underscores the need to work with a diversity of implementation partners with expertise and strong ties to those priority populations.



How to use the State Health Improvement Plan (SHIP)

The SHIP defines Maryland’s five health priority areas and presents a plan to address and improve health outcomes in those areas, with health equity at the center of our approach. Each health priority area has goals and objectives, along with suggested evidence-based strategies and metrics to track progress.

The SHIP is designed to be adaptable to local needs while supporting statewide alignment. Successful implementation of the SHIP requires the involvement of a diverse range of partners, including those beyond the traditional scope of governmental public health and could include those working at state, regional, county, city, neighborhood, and other local levels.





How to use the State Health Improvement Plan (SHIP)

Support community health assessment and improvement planning

Local health departments (LHDs) and local health improvement coalitions (LHICs) lead community health improvement by conducting CHAs, sometimes referred to as Community Health Needs Assessments (CHNAs) and Community Health Improvement Plans (CHIPs). The SHA and SHIP can inform this process by providing statewide data, priorities, and evidence-based strategies. Local partners are encouraged to adopt or adapt relevant SHIP priorities, objectives, strategies, and data when developing CHIPs and local action plans.

Inform the development of programs, community action plans, and policies at the state, local, and neighborhood level

Organizations may reference the SHIP specific and measurable objectives and the menu of strategies when developing or expanding policies, programs and action plans (e.g., the AHEAD Population Health Accountability Plans) that address priority areas. Because the SHIP strategies reflect evidence-based approaches and promising practices, they provide a strong foundation for implementation.

Support grant proposal development

The SHIP can strengthen grant proposals by demonstrating alignment with statewide priorities and data-informed needs. In addition, local decision-makers and funders can further support alignment with statewide priorities by encouraging prospective grant applicants to reference the SHIP when developing proposals.

Offer a framework for advocacy groups and organizations

A key strength of the SHA and SHIP is their community-driven approach. Community input gathered during the assessment process provides essential context for quantitative data and was critical in shaping the SHIP's priority areas, goals, and objectives. Advocacy groups and organizations can use the SHIP to advance policy, systems, and environmental change. The strategies included are broad and adaptable, allowing for implementation across a variety of settings.

Ultimately, the SHIP supports collective action by providing a shared framework that organizations, agencies, and decision-makers can use to inform and align policy development.



State Health Improvement Plan: 5 Health Priority Areas



Chronic Disease



Access to Care



Women's Health



Violence



Behavioral Health





State Health Improvement Plan Strategy Classifications

Each SHIP objective includes suggested strategies to support implementation. Strategies include evidence-based practices (with citations) and Maryland Department of Health subject matter experts' recommendations. To further support implementation and alignment across sectors, strategies are categorized using the classifications below, which help readers select strategies that fit their organization's role, capacity, and community context. These classifications describe the primary focus, approach, or level at which a strategy is intended to operate.



Health Equity Strategy: A strategy that aims to ensure everyone has a fair and just opportunity to attain the highest level of health.



Social Determinants of Health Strategy: A strategy that addresses non-medical factors – such as housing, food access, education, transportation, and employment – that influence health outcomes.



Policy and Systems Level Strategy: A strategy that changes policies, organizational practices, or systems to achieve sustainable, population-level impact.



Local Health Improvement Coalition (LHIC) Aligned Strategy: A strategy that aligns with or is implemented through local health improvement coalitions.



Place-Based Strategy: A strategy that focuses on collaboration within a specific geographic area (e.g., a neighborhood, city, county, or region) and is tailored to the local context, assets, and needs of that community to improve health outcomes.



Cross-Sector Collaboration Strategy: A strategy that intentionally engages partners from multiple sectors, such as public health, healthcare, education, housing, transportation, community organizations, and business, to coordinate efforts, share resources, and address complex health challenges that no single sector can solve alone.



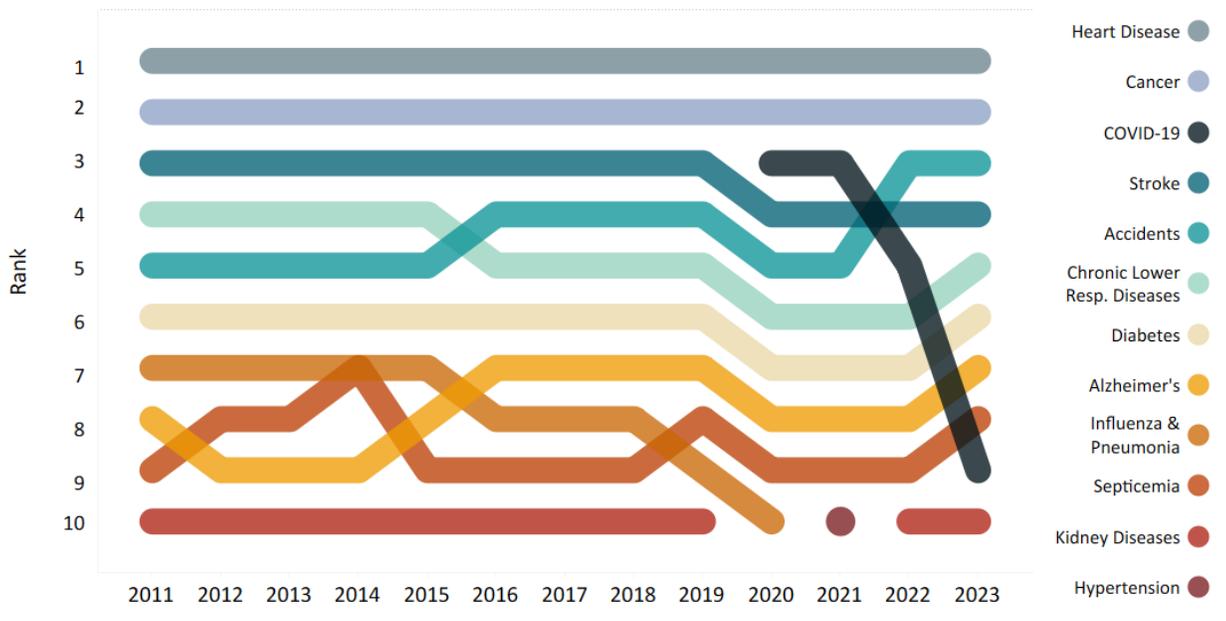
Chronic Disease

Despite advances in screening, diagnosis, and treatment over the years, chronic disease remains the leading cause of death in Maryland, with heart disease (#1) and cancer (#2) as the top two leading causes of death for over a decade. Diabetes (#6 in 2023) has also persistently been among the top causes of death for Maryland residents.

Many factors contribute to persistently high mortality rates from chronic disease, including but not limited to unequal access to healthy food, built environment barriers (such as lack of spaces for physical activity), lack of access to accessible and affordable healthcare, insufficient insurance coverage for screening and prevention, and a breakdown in linkage to post-diagnosis care.

In addition to the state-level metrics that point to chronic disease as a health priority area, chronic disease was the fourth most common health issue of concern selected in the Community Input Survey. Many respondents wrote about how chronic disease continues to impact their communities - and highlighted the importance of access to healthy food and physical activity as protective factors.

Top 10 Leading Causes of Death Among Maryland Residents, 2011-2023





Priority Area 1:

Chronic Disease Planning Workgroup Members

Reena Rambharat – Lead

Howard County Local Health Improvement Coalition

Della Leister

Baltimore County Local Health Improvement Coalition

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Wicomico Local Health Improvement Coalition



Priority Area 1: Chronic Disease Goals

Goal 1: Enhance primary prevention of chronic disease

Goal 2: Enhance screening, treatment and care for chronic illness

“Chronic Diseases are prevalent in [my community]. Heart disease and Cancer are running neck in neck. High blood pressure and diabetes are a close second. Usually by the time an individual goes to a doctor, it is to late. We need early detection and intervention.”

**Community Input Survey
Respondent, Kent County**

“Chronic Disease - Minority populations are the highest at-risk populations as many are uninsured/underinsured. It is important that we continue to provide access to healthcare for all and to provide free health screenings or health events to the community.”

Community Input Survey Respondent



Priority Area 1: Chronic Disease

Goals, Objectives, Strategies

Goal 1: Enhance primary prevention of chronic disease

Objective 1.1.1 (Shared measure with AHEAD Population Health Accountability Plan):

Prevent increases in household food insecurity in Maryland, maintaining the rate at 16.4% for 2027 and decreasing the rate to 15% in 2036.

Data Source, Baseline Year: Behavioral Risk Factor Surveillance System, 2023

Target: Aligned with AHEAD Population Health Accountability Plan targets

Update Note: Objective 1.1.1 in the 2024 SHIP was originally stated as: “By 2029, lower the percentage of households experiencing food insecurity due to resource limitations from 9.5% to 8.3%.” This objective was updated to align with the 2025 AHEAD Population Health Accountability Plan food insecurity measure, which uses a different data source from the original measure (the USDA Household Food Security in the United States Report Series).

1.1.1 Suggested Strategies	Type of Strategy
Increase Maryland Woman, Infants, and Child (WIC) Program participation and enrollment to allow more families access to nutritious food benefits (e.g., fruits and vegetables). ^{1,2,3}	
Increase participation in the Supplemental Nutrition Assistance Program (SNAP) among eligible populations through outreach, education, and policy changes to facilitate enrollment. ^{4,5}	
Increase awareness and use of home-delivered meal programs and medically tailored meal programs through case managers or community health workers. ^{6,7,8}	
Enhance access to home-delivered and congregate meal services for older adults. ⁹	
Support expanded access to no cost school meals for all students. ⁹	
Increase access to healthy foods through expanding food pantries, community gardens, Community Supported Agriculture, and farmers markets. ^{10,11,12}	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 1: Chronic Disease

Goals, Objectives, Strategies

Goal 1: Enhance primary prevention of chronic disease

Objective 1.1.2: By 2030, decrease the percentage of adults reporting no physical activity or exercise other than their regular job in the past 30 days from 22.7% to 21.6%.

Data Source, Baseline Year: Behavioral Risk Factor Surveillance System, 2023

Target: 5% change, aligned with the 2026-2030 Maryland Comprehensive Cancer Control Plan

Update Note: Objective 1.1.2 baseline and target have been updated to align with the 2026-2030 Maryland Comprehensive Cancer Control Plan.

1.1.2 Suggested Strategies	Type of Strategy
Promote free and low-cost community wellness and fitness classes through targeted communications, partnerships with local organizations, and the utilization of public spaces. ^{13,14,15}	
Promote and increase movement-promoting community programs which increase social support for fitness, such as walking groups, buddy systems, and group fitness activities. ^{13,14,15}	
Engage communities in enhancing the safety and accessibility of community spaces through improvements to the built environment. Built environment improvements may include enhancing pedestrian and bicycle systems or improving the infrastructure of parks, trails, and greenway. ^{13,14,15}	
Create community-wide campaigns to increase physical activity by engaging multiple sectors of the community, for example through education across community sectors, community health fairs, work site risk factor screening, and promoting activity in the community. Most effective campaigns involve multiple components, such as risk-factor screening and health education. ⁹ The CDC Active People, Healthy Nation campaign includes resources on how different sectors can engage in increasing physical activity.	
Promote the Move Your Way campaign in communities. This resource provides tools, videos, fact sheets, and tips to make physical activity easier. ¹⁶	
Introduce individually-adapted health behavior change programs which help participants incorporate activity into their daily routines through goal-setting, building social support, structured problem-solving, and self-reward. ⁹	
Implement home-based exercise interventions for adults aged 65 and older. ⁹	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 1: Chronic Disease

Goals, Objectives, Strategies

Goal 1: Enhance primary prevention of chronic disease

1.1.2 Suggested Strategies	Type of Strategy
Promote digital health and telephone interventions to increase healthy eating and physical activity in worksites and community settings, and for adults 55 years and older. ⁹ These interventions use websites, mobile apps, texts, emails, or calls to facilitate professional coaching, client goal setting and self-monitoring, and education. Interventions may include social support through online forums, apps that gamifying fitness, or computer-generated feedback providing tailored information.	
Strengthen community promotion of physical activity through signage, worksite policies, social support, infrastructure improvements, state agency partnerships, and joint-use agreements to allow for use of safe facilities (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	
Develop and/or implement transportation and community plans that promote walking and other methods of active transport (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	
Incorporate strategies to reduce sedentary time across various settings (e.g., workplaces, schools, homes) by promoting movement breaks, standing desks, active meeting options, and encouraging limiting prolonged screen time (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 1: Chronic Disease

Goals, Objectives, Strategies

Goal 2: Enhance screening, treatment, and care for chronic illness

Objective 1.2.1 (Shared measure with AHEAD Population Health Accountability Plan):

Increase the percentage of Maryland adults ages 45–75 years who receive one or more of the recommended colorectal cancer screening tests, per 2021 U.S. Preventive Services Task Force (USPSTF) guidelines, from 49.3% to 50.7% by 2027 and 54.6% by 2036 .

Data Source, Baseline Year: All-Payer Claims Database (APCD), 2023

Target: Aligned with AHEAD Population Health Accountability Plan targets

Update Note: Objective 1.2.1 in the 2024 SHIP was originally stated as: “By 2029, increase the percentage of adults ages 45-75 who reported receiving one or more of the recommended colorectal cancer screening tests within the recommended time interval from 71.8% to 75.3%.” This objective was updated to align with the 2025 AHEAD Population Health Accountability Plan colorectal cancer screening measure, which uses a different data source from the original measure (the Behavioral Risk Factor Surveillance System (BRFSS)).

1.2.1 Suggested Strategies	Type of Strategy
Mitigate structural barriers (such as cost, transportation and other issues) to cancer screening through interventions such as reducing client out-of-pocket costs, modifying hours to meet client needs, offering services in residential communities or worksites with mobile vans, offering transportation, or connecting with patient navigators. ^{17,18,19}	 
Enhance access to targeted, culturally, and linguistically sensitive cancer and prevention care resources. ^{20,21,22}	 
Increase the use of patient navigation services. ⁹ This includes encouraging payers to reimburse for patient navigation, including navigation conducted by community health workers. This also includes encouraging health systems to build processes to bill for services already approved by the Centers for Medicare and Medicaid (CMS) so that they may staff patient navigators (subject matter expert recommendation, MDH Center for Cancer Prevention and Control).	
Engage community health workers to increase colorectal cancer screening, particularly in underserved communities and for men. ⁹	
Educate family members around the importance of sharing personal and family health history with relatives. Educate the public on the relationship between family history, inherited genetic variants, cancer risk, and the importance of genetic counseling prior to genetic testing (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 1: Chronic Disease

Goals, Objectives, Strategies

Goal 2: Enhance screening, treatment, and care for chronic illness

1.2.1 Suggested Strategies	Type of Strategy
Develop and deliver culturally competent education on colorectal cancer risk and treatment, such as delivering education in trusted community spaces like churches. Evidence supports these strategies for specifically improving screening rates for Black populations. ²³	 
Promote non-invasive screening for patients at average risk, especially in areas with long colonoscopy wait times (subject matter expert recommendation, MDH Center for Cancer Prevention and Control).	
Encourage one-on-one patient education on eligibility for and benefits of colorectal cancer screening. ⁹ Discuss all screening options. Prompt and prepare patients to complete the entire continuum of care from consult to screening to diagnosis to treatment, as needed (subject matter expert recommendation, MDH Center for Cancer Prevention and Control).	
Refer low-income uninsured and underinsured individuals to the Cigarette Restitution Fund-Cancer Prevention, Education, Screening, and Treatment Program (CRF-CPEST) (subject matter expert recommendation, MDH Center for Cancer Prevention and Control).	
Implement media campaigns, such as videos and printed materials (such as brochures and newsletter), to inform and motivate people to be screened for cancer. ⁹ Leverage social media to address fear of, disgust of, and machismo against colorectal cancer screening (subject matter expert recommendation, MDH Center for Cancer Prevention and Control).	
Implement provider reminder and recall systems for patients who are due or overdue for colorectal cancer screening. Increase the use of client reminders through phone calls (including automated messages), texts, letters, or emails. ⁹ Evidence supports these strategies for specifically improving screening rates for Black populations. ⁹ Configure the electronic health record to automate these alerts. Discuss all screening options, including stool-based testing (subject matter expert recommendation, MDH Center for Cancer Prevention and Control).	
Educate clinicians about the importance of, indications for, and availability of screening procedures at their clinic. ²³	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 1: Chronic Disease

Goals, Objectives, Strategies

Goal 2: Enhance screening, treatment, and care for chronic illness

1.2.1 Suggested Strategies	Type of Strategy
Work through professional medical associations/organizations and schools of medicine, nursing, and dentistry to build health care provider cultural and linguistic competency and understanding of health disparities and unintentional bias (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	
Provide continuing education opportunities for health care providers in cancer prevention and early detection guidelines. Utilize web-based methods, health care provider meetings and conferences, seminars, grand rounds, and/or other opportunities (subject matter expert recommendation, MDH Center for Cancer Prevention and Control).	
Maintain or increase public health funding for cancer screening, diagnosis, and treatment for low-income and uninsured Marylanders (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	
Plan and develop standard operating procedures to maintain cancer prevention and control activities during a state of emergency to ensure timely cancer screening, diagnosis, and treatment (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	
Encourage patient navigation professionals to join and support the Maryland Patient Navigation Network (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	
Leverage technology and innovative practice models, such as telemedicine and visiting consultants, to improve patient access and better connect primary care and other health care providers to cancer specialists (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 1: Chronic Disease

Goals, Objectives, Strategies

Goal 2: Enhance screening, treatment, and care for chronic illness

Objective 1.2.2: By 2030, increase the percentage of high-risk populations receiving lung cancer screenings from 16.8% to 17.6%.

Data Source, Baseline Year: American Lung Association's "State of Lung Cancer" report, 2024 using 2022 BRFSS source data

Target: 5% increase, aligned with the 2026-2030 Maryland Comprehensive Cancer Control Plan

Update Note: Objective 1.2.2 in the 2024 SHIP was originally stated as: "By 2029, increase the percentage of high-risk populations receiving lung cancer screenings from 2.9% to 4.5%". This objective was revised due to a change in methodology used by the American Lung Association's State of Lung Cancer report. Screening rates are now calculated using 2022 BRFSS data and updated USPSTF eligibility criteria. The revised objective reflects this methodological change and aligns with the 2026-2030 Maryland Comprehensive Cancer Control Plan.

1.2.2 Suggested Strategies	Type of Strategy
Mitigate structural barriers (such as cost, transportation and other issues) to cancer screening through interventions such as reducing client out-of-pocket costs, modifying hours to meet client needs, offering services in residential communities or worksites with mobile vans, offering transportation, or connecting with patient navigators. ^{17,18,19}	 
Enhance access to targeted, culturally, and linguistically sensitive cancer and prevention care resources. ^{20,21,22}	
Increase the use of patient navigation services. ²⁴ This may include encouraging payers to reimburse for patient navigation, including navigation conducted by community health workers, and encouraging health systems to build processes to bill for services already approved by the Centers for Medicare and Medicaid (subject matter expert recommendation, MDH Center for Cancer Prevention and Control).	
Engage community health workers to educate the public about lung cancer screening. ^{25,26}	
Educate family members around the importance of sharing personal and family health history with relatives. Educate the public on the relationship between family history, inherited genetic variants, cancer risk, and the importance of genetic counseling prior to genetic testing (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 1: Chronic Disease

Goals, Objectives, Strategies

Goal 2: Enhance screening, treatment, and care for chronic illness

1.2.2 Suggested Strategies	Type of Strategy
Provide continuing education opportunities for health care providers in cancer prevention and early detection guidelines. Utilize web-based methods, health care provider meetings and conferences, seminars, grand rounds, and/or other opportunities (written communication, MDH Center for Cancer Prevention and Control,).	
Refer tobacco users to the Maryland Tobacco Quitline and to their providers for lung cancer assessment for screening (subject matter expert recommendation, MDH Center for Cancer Prevention and Control).	
Implement patient shared decision-making protocols which help patients to understand the risks and benefits of screening. ^{27,28}	
Produce and promote educational materials on lung cancer screening which destigmatize lung cancer and smoking and describe the benefits of early detection. Educational materials may include educational videos or digital awareness campaigns. ^{29,30}	
Increase access to and knowledge of low-cost lung cancer screening. ^{28,31,32,33} If available, refer low-income uninsured and underinsured individuals to the Cigarette Restitution Fund-Cancer Prevention, Education, Screening, and Treatment Program (CRF-CPEST) if lung services are available in the county of residence (subject matter expert recommendation, MDH Center for Cancer Prevention and Control).	
Educate providers about the importance of lung cancer screening and screening insurance coverage available to clients to increase appropriate referrals. ^{31,34,35}	
Develop education and outreach tools based on known risk factors for lung cancer to emphasize populations at risk (e.g., populations living in areas with higher radon exposure with smoke or second-hand smoke exposure, certain occupations) as well as recognized disparities. ^{36,37,38}	
Educate healthcare providers to routinely include lung cancer screening information and counseling for patients who report a history of smoking tobacco and/or cannabis. ³⁹	
Maintain or increase public health funding for cancer screening, diagnosis, and treatment for low-income and uninsured Marylanders (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	



Health Equity Strategy



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Priority Area 1: Chronic Disease

Goals, Objectives, Strategies

Goal 2: Enhance screening, treatment, and care for chronic illness

1.2.2 Suggested Strategies	Type of Strategy
Plan and develop standard operating procedures to maintain cancer prevention and control activities during a state of emergency to ensure timely cancer screening, diagnosis, and treatment (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	
Encourage patient navigation professionals to join and support the Maryland Patient Navigation Network (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	
Leverage technology and innovative practice models, such as telemedicine and visiting consultants, to improve patient access and better connect primary care and other health care providers to cancer specialists (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	



Health Equity Strategy



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Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 1: Chronic Disease

Goals, Objectives, Strategies

Goal 2: Enhance screening, treatment, and care for chronic illness

Objective 1.2.3: Reduce the rate of emergency room (ED) visits for asthma among all children aged 2 to 17 years old from a 2023 baseline rate of 7.8 per 1,000 to a rate of 5.3 per 1,000 by 2029; and reduce the rate of ED visits for asthma among all non-Hispanic and Hispanic Black children aged 2 to 17 years old from a 2023 baseline rate of 14.6 per 1,000 to a rate of 6.9 per 1,000 by 2029.

Data Source, Baseline Year: Maryland Health Services Cost Review Commission (HSCRC, annual data received by the Environmental Health Bureau), 2023

Target: Statewide Integrated Health Improvement Strategy (SIHIS)

Objective Update: Objective 1.2.3 in the 2024 SHIP was originally stated as: “By 2026, reduce the rate of emergency room visits for asthma among children from 7.8 per 1,000 to 5.3 per 1,000, and for Black children from 19 per 1,000 to 9 per 1,000.” This objective was revised due to a change in methodology used to identify asthma-related ED visits from annual HSCRC data received by MDH’s Environmental Health Bureau. New baseline rates and targets were calculated to reflect the changes in methodology. This objective continues to reflect a 53% reduction, as originally captured in [Maryland’s 2018 Statewide Integrated Health Improvement Strategy \(SIHIS\)](#), in ED visits for Black children.

1.2.3 Suggested Strategies	Type of Strategy
Develop culturally appropriate education materials for parents covering topics like vaping, secondhand smoke, peak flow meters, medication self-administration for children, inhaler storage, and questions for healthcare providers. ^{40,41,42}	
Conduct home visits to identify asthma triggers present in the home environment combined with multicomponent interventions to address the triggers through education and connections with social services. ^{43,44}	
Implement family and school-based asthma educational interventions, including the use of asthma action plans for all children with diagnosed asthma. ^{45,46,47}	
Increase care coordination across the health care system and community services through engaging community health workers, creating patient-centered medical homes, and other interventions. ⁴⁸	
Educate parents about the availability of tobacco cessation counseling and promote participation. ⁴⁸	



Health Equity Strategy



Social Determinants of Health Strategy



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Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 1: Chronic Disease

Goals, Objectives, Strategies

Goal 2: Enhance screening, treatment, and care for chronic illness

1.2.3 Suggested Strategies	Type of Strategy
Implement coordinated school programs for addressing asthma that include school health services, education, physical education and activity, healthy school environment, and community integration. ⁴⁸	
Promote the creation of school-based health centers to improve asthma case management and medication adherence. ⁴⁹	
Implement and maintain multi-disciplinary strategies such as the Boston Children’s Community Asthma Initiative (CAI) in which nurses and community health workers (CHWs) provide community-based asthma case management and home visits among Black and/or Hispanic children. ^{50,51,52}	
Incorporate age-appropriate education for children on asthma self-management into routine asthma care. ⁵³	
Implement environmental policies to reduce asthma triggers, such as smoke-free policies and facilitating clean diesel school buses. ^{48,49}	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 1: Chronic Disease

Goals, Objectives, Strategies

Goal 2: Enhance screening, treatment, and care for chronic illness

Objective 1.2.4 (Aligned with AHEAD Population Health Accountability Plan): : Reduce the percentage of patients ages 18–75 years with type 1 or type 2 diabetes with poor glycemic control (most recent hemoglobin A1c > 9.0%) from 67.8% to 65.8% by 2027 and to 60.3% by 2036.

Data Source, Baseline Year: All-Payer Claims Database (APCD), 2023

Target: Aligned with AHEAD Population Health Accountability Plan targets

Objective Update: Objective 1.2.4 in the 2024 SHIP was originally stated as: “Objective 1.2.4: By 2029, reduce the proportion of adults with diabetes who have an A1c value above 9% from 33.9% to 11.6%.” This objective was updated to align with the 2025 AHEAD Population Health Accountability Plan A1c control measure, which uses a different data source from the original measure (National Committee for Quality Assurance (NCQA)).

1.2.4 Suggested Strategies	Type of Strategy
Enhance disease management and early intervention for diabetes and heart disease, such as lifestyle therapy through dietitians or exercise psychologists, or wearable trackers and mobile apps which promote lifestyle self-management. ^{54,55,56}	
Increase cultural competency of, and participation in, evidence-based chronic disease self-management classes (e.g., local health department Living Well Chronic Disease Self-Management Programs ; Diabetes Self Management, Education, and Support Programs (DSMES)). ^{54,56,57,58}	
Enhance coordination among healthcare providers, specialists, and support services to ensure comprehensive care for individuals with diabetes or heart disease. Care coordination activities may include hiring care coordinators to consult with care teams and connect patients to resources, implement regular communication protocols with other physicians and the patient, and working to identify gaps in the patient’s care plan. ^{59,60,61}	
Raise awareness about prediabetes, individual risk and how to modify risk for developing diabetes, such as through communications campaigns (e.g., the MDH Prediabetes Communication Campaign), self-administered surveys (e.g., “ Know Your Risk ” survey), and other awareness mechanisms. ⁶²	
Engage community health workers in interventions to help provide education, offer social support, and refer patients to services that address health concerns and social determinants of health.	
Increase engagement of community health workers to promote linkages between health care delivery systems and community resources for diverse populations of adults with diabetes. ^{63,64,65}	



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LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 1: Chronic Disease

Goals, Objectives, Strategies

Goal 2: Enhance screening, treatment, and care for chronic illness

1.2.4 Suggested Strategies	Type of Strategy
Encourage participation in diabetes peer-support interventions, especially for patients with low support or poor health literacy. ^{66,67,68}	
Promote team-based care practices which integrate the patient, their primary care provider, and other professionals involved in their care to facilitate care coordination, encourage evidence-based practices, establish structured follow-up, and engage patients in their care plan. ⁹	
Promote participation in chronic disease management programs which may educate patients, provide health coaching, and develop skills for self-management under the guidance of a multidisciplinary care team. ⁴⁹	
Deliver intensive lifestyle interventions for patients with type 2 diabetes including ongoing counseling, coaching, or individualized guidance for a period of more than 6 months. ⁹	
Promote and increase access to dietician-delivered nutrition therapy for people with diabetes. ^{69,70}	
Encourage the use of mobile phone applications that are integrated with health systems to promote diabetes self-management. These applications allow patients to enter data and receive direct feedback from care professionals or automated systems. ⁹	
Incorporate obesity and pre-diabetes screening during routine dental visits, followed by referrals to lifestyle change programs if warranted. ⁹	
Promote tobacco and cannabis cessation counseling and increase awareness that exercise can help reduce withdrawal symptoms, weight gain and improve lung function (subject matter expert recommendation, MDH Center for Tobacco Prevention and Control).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 1: Chronic Disease

Goals, Objectives, Strategies

Goal 2: Enhance screening, treatment, and care for chronic illness

Objective 1.2.5: By 2029, decrease the proportion of adults 18–85 years of age who have a diagnosis of hypertension from 35.8% to 27.3%.

Data Source, Baseline Year: Behavioral Risk Factor Surveillance System (BRFSS), 2023

Target: Set based on the State with the lowest rate of diagnosed hypertension (Colorado and Utah).

Objective Update: Objective 1.2.5 in the 2024 SHIP was originally stated as: “By 2029, increase the proportion of adults 18–85 years of age who have a diagnosis of hypertension and whose blood pressure was adequately controlled to 18.9%”. The data for the original indicator are not readily available; therefore, the objective was adjusted to address the prevalence of diagnosed hypertension, for which data are consistently available.

1.2.5 Suggested Strategies	Type of Strategy
Enhance disease management and early intervention for diabetes and heart disease, such as lifestyle therapy through dietitians or exercise psychologists, or wearable trackers and mobile apps which promote lifestyle self-management. ^{54,71,72}	
Increase cultural competency of, and participation in, evidence-based chronic disease self-management classes (e.g., local health department Living Well Chronic Disease Self-Management Programs ; Diabetes Self Management, Education, and Support Programs (DSMES)). ^{73,74,75}	
Enhance coordination among healthcare providers, specialists, and support services to ensure comprehensive care for individuals with diabetes or heart disease. Care coordination activities may include hiring care coordinators to consult with care teams and connect patients to resources, implement regular communication protocols with other physicians and the patient, and working to identify gaps in the patient’s care plan. ^{76,77,78}	
Engage community health workers in interventions to help provide education, offer social support, and refer patients to services that address health concerns and social determinants of health. Effective programs have included the Health Hearts Ambassador Program , Community Outreach and Cardiovascular Health (COACH) Trial , and Salud para su Corazón . ^{50,79}	



Health Equity Strategy



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LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 1: Chronic Disease

Goals, Objectives, Strategies

Goal 2: Enhance screening, treatment, and care for chronic illness

1.2.5 Suggested Strategies	Type of Strategy
Promote team-based care practices which integrate the patient, their primary care provider, and other professionals involved in their care to facilitate care coordination, encourage evidence-based practices, establish structured follow-up, and engage patients in their care plan. ⁹	
Increase the use of telemedicine interventions for blood pressure control, especially interventions that last more than 6 months. ⁴⁹	
Introduce and increase the use of interventions (e.g. tailored pharmacy-based interventions, mHealth) to improve medication adherence ⁹	
Promote and expand the use of self-measured blood pressure monitoring interventions, including interactive digital interventions for blood pressure self-management, and implementation of text messaging interventions, such as automated reminders, to promote medication adherence. ^{9,80,81,82,83,84}	
Implement health coaching programs for patients. ^{80,83}	
Introduce interactive digital interventions for blood pressure self-management. ⁹	
Support healthcare providers and patient navigators in integrating culturally tailored tobacco cessation into hypertension management plans, emphasizing how quitting can lower blood pressure and reduce the risk of heart attack and stroke (subject matter expert recommendation, MDH Office of Oral Health).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



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Place-Based Strategy



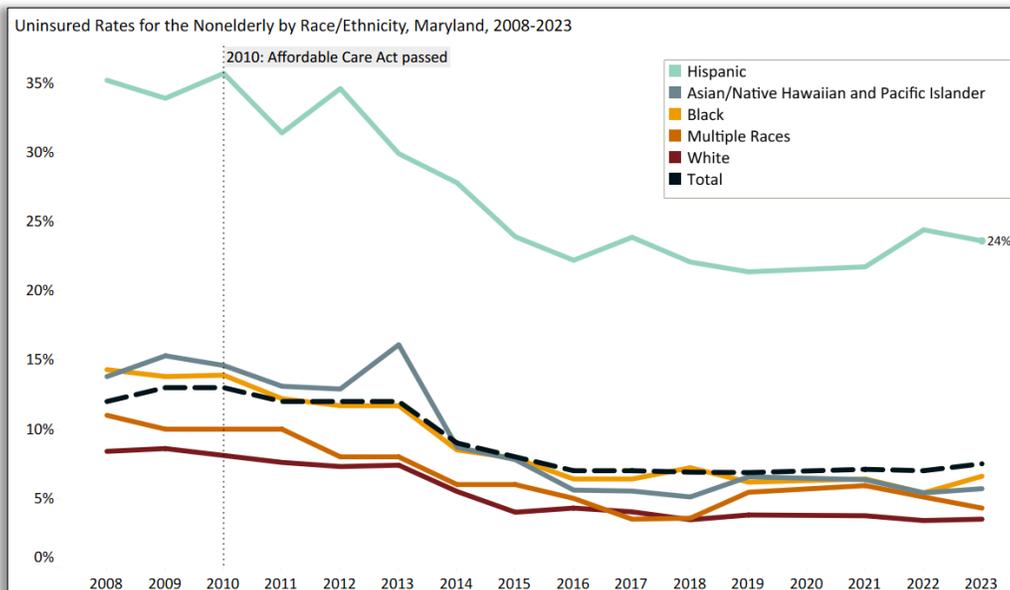
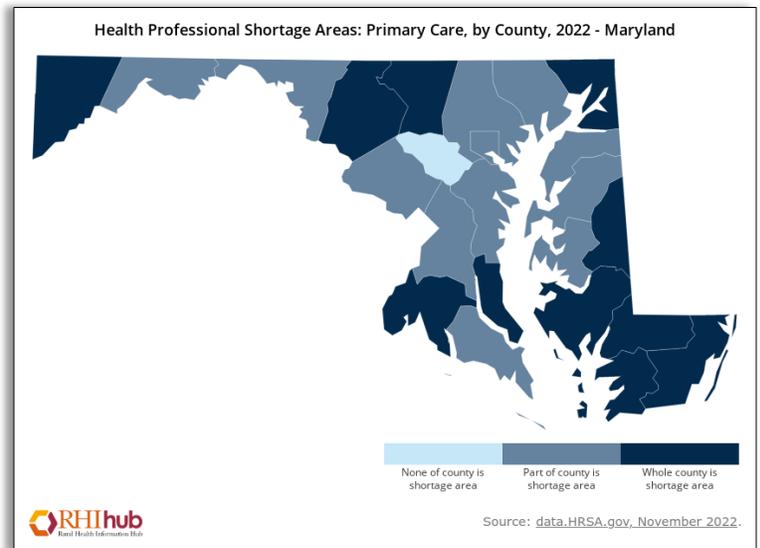
Cross-Sector Collaboration Strategy



Access to Care

Evidence-based prevention, necessary screening tests, life-saving medication, and innovative treatment are useless if they can't be accessed by the people who need them. Access to quality, appropriate and affordable healthcare remains an issue across the United States, and Maryland is no exception.

In Maryland, some of the barriers include a healthcare professional shortage, both for primary and specialty care (particularly in more rural areas), lack of health insurance (particularly for Maryland's Hispanic population), and a need for improved health literacy. The need for improved healthcare access was highlighted by community members, who selected access to affordable healthcare as the most frequent response to the question "what are the most important things that make a community healthy?".





Priority Area 2:

Access to Care Planning Workgroup Members

Nicole Morris - Lead

Mid Shore Health Improvement Coalition

Earl Stoner

Washington County Health Department

Danielle Weber

Somerset County Health Department

Jacqueline Wells

St. Mary's County Local Health Improvement Coalition

Dr. Nilesh Kalyanaraman

MDH Deputy Secretary for Public Health Services

Ryan Moran

MDH Deputy Secretary for Health Care Financing

Meghan McClelland

Maryland Hospital Association

Erin Roth

MD Dept of Labor

Stuart Campbell

MD Dept of Housing and Community Development

Sec. Carmel Roques

MD Dept of Aging

Tiffany Erbelding

MD Dept of Aging

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Cecil County Community Health Advisory Committee

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Wicomico Local Health Improvement Coalition



Priority Area 2: Access to Care

Goals

Goal 1: Enhance care delivery models to meet the needs of different populations

Goal 2: Recruit and retain high quality healthcare and public health workforce

Goal 3: Reduce barriers to care

Community Input
Survey Respondent,
Baltimore County

“Access to health care, in a City with world-renowned health care facilities, is expensive and difficult. Too many primary care providers are shifting to concierge medicine, which marginalizes out people of lower income. Primary care should be readily accessible and low cost--that is critical to prevention; this is how early detection happens.”

“La barrera del lenguaje y al no tener seguro médico incrementa las enfermedades crónicas porque es difícil el acceso a proveedores de salud”

“The language barrier and not having health insurance increases chronic illnesses because it is difficult to access health care providers.”

Community Input
Survey Respondent



Priority Area 2: Access to Care

Goals, Objectives, Strategies



Goal 1: Enhance care delivery models to meet the needs of different populations

Objective 2.1.1: By 2029, increase the proportion of statewide behavioral health outpatient service recipients who receive services via telehealth from 59.1% to 67%.

Data Source, Baseline Year: Medicaid, 2023

Target: Highest rate in Maryland in the past 5 years

2.1.1 Suggested Strategies	Type of Strategy
Provide technical support and training to healthcare providers to support care delivery via telehealth in underserved areas, such as rural areas, in Maryland. ^{85,86}	
Increase consumer awareness of available educational support on how to use telehealth and digital technology. ^{85,86}	
Coordinate with external agencies to identify additional data on targeted care delivery models (subject matter expert recommendation, BAHM Access to Care Planning Workgroup).	
Provide interactive assistance for providers to support clinician engagement with technology. ^{87,88}	
Implement strategies that reduce technological and privacy barriers to tele-mental health, such as providing private rooms with internet access in local libraries. ⁸⁷	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 2: Access to Care

Goals, Objectives, Strategies

Goal 1: Enhance care delivery models to meet the needs of different populations

Objective 2.1.2: By 2029, increase the total percentage of students enrolled in School Based Health Centers from 35% to 70% at that school.

Data Source, Baseline Year: [Maryland School Based Health Center Program, 2023](#)

Target: Based on guidance from the School Based Health Alliance

2.1.2 Suggested Strategies	Type of Strategy
Create new, sustainable school-based health centers (SBHCs) in schools that serve high-need, under-resourced communities. ^{89,90}	
Investigate key drivers of successful enrollment methodologies and provide targeted assistance to support implementation of best practices across SBHCs. ⁹¹	
Increase the number of schools whose students and families are served by a nearby SBHC (subject matter expert recommendation, BAHM Access to Care Planning Workgroup).	 
Implement accountability measures to drive enrollment increases, including ongoing education, quality improvement planning, and structured quality assurance visits (subject matter expert recommendation, MDH School-Based Health Center Program).	
Strengthen connections between the SBHC and the host school community by increasing visibility and engagement—such as having SBHC clinical staff attend back-to-school nights, hosting open houses, and integrating SBHC consent forms into standard back-to-school registration materials. This includes, where allowable, implementing an opt-out consent process to streamline enrollment and maximize access to services. ^{93,94,95}	



Health Equity Strategy



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Place-Based Strategy



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Priority Area 2: Access to Care

Goals, Objectives, Strategies



Goal 2: Recruit and retain high quality healthcare and public health workforce

Objective 2.2.1: By 2029, reduce the average wait time for primary care first appointment.

Data Source, Baseline Year: Medicaid, CAHPS Survey, 2023

Target: Directional target

2.2.1 Suggested Strategies	Type of Strategy
Recruit a workforce that reflects Maryland’s diversity. ^{96,97}	 
Provide incentives to current students and providers to enter and remain in under-resourced specialties and regions. ^{98,99}	 
Promote the adoption of mental health resources and tools for providers to prevent burnout. ^{100,101,102}	
Expand and promote registered apprenticeship opportunities. ¹⁰³	
Explore and implement solutions to expand transportation services, especially in rural areas. ^{104,105}	 
Facilitate learning collaboratives to share best practices regarding transportation (subject matter expert recommendation, BAHM Access to Care Planning Workgroup).	
Provide open-access scheduling for patients. ^{65,66}	
Promote the use of primary care teams to increase practice efficiency. ⁶⁵	
Increase implementation of telemedicine in primary care. ^{67,68}	



Health Equity Strategy



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Place-Based Strategy



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Priority Area 2: Access to Care

Goals, Objectives, Strategies

Goal 3: Reduce barriers to care

Objective 2.3.1: By 2029, reduce the total proportion of individuals not covered by private or public health insurance from 7% to 5.5%.

Data Source, Baseline Year: U.S. Census Bureau, American Community Survey, 2022

Target: Developed with Maryland Health Benefit Exchange

2.3.1 Suggested Strategies	Type of Strategy
Increase availability of health navigators providing information and guidance about insurance coverage to various populations in targeted communities and in multiple languages. ^{106,107}	
Increase availability of community-based case managers offering health insurance information and application support. ¹⁰⁸	
Increase awareness of insurance availability through mass media campaigns or targeted campaigns at community-based locations. ¹⁰⁹	
Increase the adoption of a plain language checklist by state and local government agencies. ^{110,111,112,113}	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Women's Health

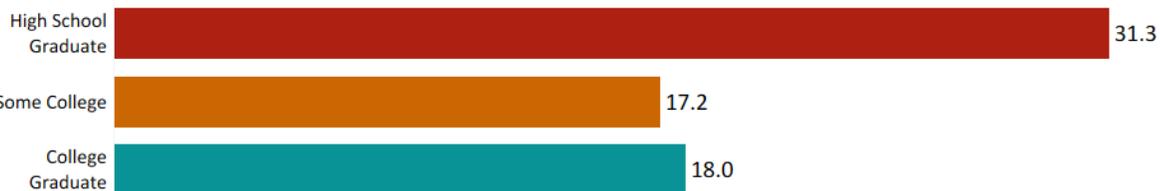
While the overall maternal mortality rate in Maryland (23.7 per 100,000 in 2022) is lower than the US average, our state is no exception to the national trend in stark maternal mortality disparities between White and Black women. Recent data shows that Black women experience maternal mortality at a rate that is 60% higher than White women. To best address maternal mortality, it is vital that the SHIP work to not only improve maternal care throughout the entire cycle of pregnancy and postpartum but also take a targeted approach to reducing the disparities in maternal outcomes.

As women's health extends beyond just maternal health, the Women's Health priority area will also work to improve prevention, screening and care coordination for breast and cervical cancer. Rates of women in Maryland receiving mammograms in the past two years (81.3%) and women receiving pap smears in the past three years (79.8%) are in line with the national average; however, Maryland has a higher breast cancer incidence rate (128.6 per 100,000) than the national rate.

When the community was asked "are you concerned about the health and wellbeing of any particular populations in your community?," the fourth most common response was "women," with over 60% of respondents indicating that they had concerns about maternal health outcomes and the health of women of color.

Maternal Mortality by Characteristics, Maryland, 2019-2023

Educational Attainment



Race





Priority Area 3:

Women's Health Planning Workgroup Members

Shelley Argabrite- Lead

Garrett County Local Health Improvement Coalition

Dr. Elizabeth Kromm

MDH Prevention and Health Promotion Administration

Malcolm Furgol

Coalition for a Healthier Frederick County

Ronya Nassar

Harford County Health Department

Jackie Ward

Worcester County Health Planning Advisory Council/Local Health Improvement Coalition

Jean Marie Kelley

Cecil County Community Health Advisory Committee

Kimberly Stinchcomb

Prince George's Healthcare Action Coalition



Priority Area 3: Women's Health

Goals

Goal 1: Improve maternal health outcomes through improved maternal care before, during and after pregnancy

Goal 2: Increase breast and cervical cancer prevention, screening and care

“Black women are not surviving childbirth and have less access to healthcare and services for their families.”

**Community Input Survey
Respondent, Baltimore County**

“Women are not treated fairly; we cannot even make all of our own, private decisions about our own bodies' care.”

**Community Input Survey
Respondent, Prince George's
County**



Priority Area 3: Women’s Health

Goals, Objectives, Strategies



Goal 1: Improve maternal health outcomes through improved maternal care before, during, and after pregnancy

Objective 3.1.1. By 2029, reduce the rate of preterm births from 10.7% to 9.4%.

Data Source, Baseline Year: Maryland Department of Health Vital Statistics Administration, 2021

Target: Healthy People 2030 Target

3.1.1 Suggested Strategies	Type of Strategy
Expand the use of risk assessment models and tools to identify women at risk for preterm birth. Connect at risk patients to preventive services.. ^{114,115,116,117,118}	
Promote tobacco cessation among pregnant women, including pharmacological interventions. ^{119,120}	
Promote cessation of other substance use, including marijuana, among pregnant women and women who are planning to become pregnant. ^{121,122,123,124}	
Expand the reach of newborn and early child home visiting programs and focus outreach efforts towards at-risk, first-time parents. ^{125, 126,127, 128, 129}	
Increase access to prenatal care services including screening, health promotion, and health interventions. ¹³⁰	
Reduce low-risk cesarean deliveries and non-medically indicated delivery before 39 weeks, through clinical leadership, education, and quality improvement initiatives. ¹³⁰	
Introduce smoke-free policies for indoor areas. ⁴⁹	
Expand group prenatal care services, especially for Black women. ⁴⁹	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



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Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women's Health

Goals, Objectives, Strategies



Goal 1: Improve maternal health outcomes through improved maternal care before, during, and after pregnancy

3.1.1 Suggested Strategies	Type of Strategy
Implement midwife-led continuity models of care. ¹²⁵	
Promote adequate nutrition for pregnant women including the appropriate use of vitamins and supplements, especially for women with limited access to nutritious foods. ¹²⁴	
Expand prenatal and postpartum care services to include routine tobacco and cannabis screening, counseling, and cessation support, while also engaging partners in tobacco and cannabis cessation and prevention efforts. ¹²³	
Ensure that there are strong, accessible community-based supports for high-risk pregnant women through perinatal care coordination programs in each local health department (subject matter expert recommendations, MDH Maternal Child Health Bureau). ¹³²	



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LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women's Health

Goals, Objectives, Strategies



Goal 1: Improve maternal health outcomes through improved maternal care before, during, and after pregnancy

Objective 3.1.2: By 2029, reduce the infant mortality rate from 6.5 per 1,000 live births to 5.2 per 1,000 live births.

Data Source, Baseline Year: Maryland Department of Health Vital Statistics Administration, 2022

Target: Developed with the MDH Maternal and Child Health Bureau

3.1.2 Suggested Strategies	Type of Strategy
Expand the use of preterm birth risk prevention and risk stratification models and other tools to identify women at risk for preterm birth and offer access to preventive services. ^{114,115,116,117,118}	
Promote tobacco cessation among pregnant women, including pharmacological interventions. ^{119,120}	
Promote cessation of other substance use, including marijuana, among pregnant women and women who are planning to become pregnant. ^{115,116,117,118}	
Expand the reach of early child home visiting programs and focus outreach efforts towards at-risk, first-time parents. ^{121,122,123,124}	
Increase the health insurance coverage, particularly through Medicaid, among Black pregnant women. ^{134,135,136,137}	
Increase the availability of and promote the use of doulas and other community-based birth workers, particularly among Black women. ^{137,138}	
Reduce low-risk cesarean deliveries and non-medically indicated delivery before 39 weeks, through clinical leadership, education, and quality improvement initiatives. ¹³⁰	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women's Health

Goals, Objectives, Strategies



Goal 1: Improve maternal health outcomes through improved maternal care before, during, and after pregnancy

3.1.2 Suggested Strategies	Type of Strategy
Increase the availability of prenatal education programs. ^{140,141}	
Implement education campaigns on ways to reduce Sudden Infant Death Syndrome, including messaging and education on safe sleep practices. ¹⁴²	
Promote participation in Nurse-Family Partnerships . ⁴⁹	
Ensure that there are strong, accessible community-based supports for high-risk pregnant and postpartum women through perinatal care coordination programs in each local health department (subject matter expert recommendation, MDH Maternal Child Health Bureau).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women's Health

Goals, Objectives, Strategies

Goal 1: Improve maternal health outcomes through improved maternal care before, during, and after pregnancy

Objective 3.1.3: By 2029, reduce the percentage of babies born with low birth weight from 8.5%.

Data Source, Baseline Year: Maryland Department of Health Vital Statistics Administration, 2020

Target: Directional target

3.1.3 Suggested Strategies	Type of Strategy
Expand the use of preterm birth risk prevention and risk stratification models and other tools to identify women at risk for preterm birth and offer access to preventive services. ^{114,115,116,117,118}	
Promote tobacco cessation among pregnant women, including pharmacological interventions. ^{119,120}	
Promote cessation of other substance use, including marijuana, among pregnant women and women who are planning to become pregnant. ^{115,116,117,118}	
Expand the reach of early child home visiting programs and focus outreach efforts towards at-risk, first-time parents. ^{121,122,123,124}	
Expand group prenatal care services, especially for Black women. ⁴⁹	
Increase the availability of and promote the use of doulas, particularly among Black women. ^{134,135}	
Reduce low-risk cesarean deliveries and non-medically indicated delivery before 39 weeks, through clinical leadership, education, and quality improvement initiatives. ¹³⁰	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women's Health

Goals, Objectives, Strategies



Goal 1: Improve maternal health outcomes through improved maternal care before, during, and after pregnancy

3.1.3 Suggested Strategies	Type of Strategy
Increase participation in WIC for prenatal individuals. ¹⁴⁵	
Promote home visiting, clinical services, and pregnancy counseling for pregnant adolescents. ¹⁴⁶	
Identify and address health-related social needs for pregnant women, including food and housing insecurity. ^{147,148}	
Increase the rate of pregnant women who receive regular dental care to reduce risks linked to preterm birth and low birth weight (subject matter expert recommendation, MDH Office of Oral Health).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women’s Health

Goals, Objectives, Strategies



Goal 1: Improve maternal health outcomes through improved maternal care before, during, and after pregnancy

Objective 3.1.4 (Targeted Health Disparity Objective): By 2029, reduce unintended pregnancy rate from 42% to 36.5%, with a focus on addressing health disparities.

Data Source, Baseline Year: Maryland Pregnancy Risk Assessment Monitoring System, 2020

Target: [Healthy People 2030](#)

3.1.4 Suggested Strategies	Type of Strategy
Introduce emergency contraception to non-clinical sites at universities and colleges through methods such as vending machines, self-service kiosks, trained peer health educators, and local pharmacy partnerships. ^{149,150}	 
Expand access to contraception and client-centered contraceptive counseling at Maryland Family Planning Program (MFPP) sites, primary care settings, colleges, and universities. ^{151,152}	 
Conduct a statewide needs assessment for adolescent sexual and reproductive health to understand the gaps and strengths in Maryland (subject matter expert recommendation, BAHM Women’s Health Planning Workgroup).	 
Increase access to quality family planning services, including contraceptive services, pregnancy testing and counseling, and preconception health services. ¹⁵³	
Establish multi-component interventions combining education and contraceptive promotion for adolescents. ^{154,155}	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women’s Health

Goals, Objectives, Strategies



Goal 1: Improve maternal health outcomes through improved maternal care before, during, and after pregnancy

Objective 3.1.5: By 2029, increase the percentage of deliveries in which individuals were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care.

Data Source: Medicaid

Target: Directional target

Data Source Consideration: This objective relies on data from the Medicaid Healthcare Effectiveness Data and Information Set (HEDIS). Currently, this data is not reported consistently and the ability to report on progress using this measure is limited.

3.1.5 Suggested Strategies	Type of Strategy
Evaluate what programs and screenings are currently provided to identify gaps in care coordination (subject matter expert recommendation, BAHM Women’s Health Planning Workgroup).	
Increase postpartum depression screening and referral to treatment. ^{156,157}	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women’s Health

Goals, Objectives, Strategies



Goal 1: Improve maternal health outcomes through improved maternal care before, during, and after pregnancy

Objective 3.1.6 (Targeted Health Disparity Objective): By 2029, reduce the total maternal mortality rate from 21.3 to 17.2 per 100,000 live births, and for Black women from 31.4 to 19.2 per 100,000 live births.

Data Source, Baseline Year: MDH Maternal Child Health Bureau, 2022

Target: Developed with the MDH Maternal and Child Health Bureau

Objective Update: Objective 3.1.6 in the 2024 SHIP was originally stated as: “By 2029, reduce the total maternal mortality rate from 21.7 to 17.2 per 100,000 live births, and for Black women from 30.7 to 19.2 per 100,000 live births.” The data source for this objective has changed from the Maryland Department of Health Vital Statistics Administration to the Maryland Department of Health Maternal Child Health Bureau (MCHB) to align with data presented on the [MDH Women’s Health Dashboard](#).

3.1.6 Suggested Strategies	Type of Strategy
Increase access to prenatal care and the number of Medicaid recipients receiving prenatal care. ^{158,159,160}	
Increase utilization of <u>WIC</u> among women that qualify. ¹⁶¹	
Promote social determinants screenings and intervention prior to delivery to link women to basic needs, such as housing, food, and transportation. ^{162,163}	
Fully implement the <u>Alliance for Innovation on Maternal Health (AIM) Patient Safety Bundles</u> to address maternal/postpartum hemorrhage and hypertension among providers and birthing hospitals. ^{164,165}	
Expand group-based prenatal care, specifically for Black pregnant women. ^{166,167}	
Increase access to midwives, doulas, and other birth worker models across the state. ^{168,169,170}	
Establish holistic perinatal care targeted for Black pregnant women. ^{171,172}	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women's Health

Goals, Objectives, Strategies



Goal 1: Improve maternal health outcomes through improved maternal care before, during, and after pregnancy

3.1.6 Suggested Strategies	Type of Strategy
Increase the number of healthcare providers receiving implicit bias training. ^{173,174}	 
Increase use of low-dose aspirin to prevent preeclampsia in people who are more than 12 weeks pregnant and are at high risk for preeclampsia. ¹⁷⁵	
Implement screening for hypertensive disorders during pregnancy. ¹⁶⁸	
Strengthen and support the implementation of recommendations to prevent maternal deaths, utilizing the existing Maternal Mortality Review (MMR) program and the Maternal Mortality Review Stakeholder Group. ¹⁷⁶	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women's Health

Goals, Objectives, Strategies



Goal 1: Improve maternal health outcomes through improved maternal care before, during, and after pregnancy

Objective 3.1.7: By 2029, increase the percentage of pregnant women who receive prenatal care beginning in the first trimester from 78.1% to 82%.

Data Source, Baseline Year: Maryland Department of Health Vital Statistics Administration, 2021

Target: Developed with the MDH Maternal and Child Health Bureau

3.1.7 Suggested Strategies	Type of Strategy
Increase access to prenatal care and the number of Medicaid recipients receiving prenatal care. ^{151,152,153}	
Increase utilization of <u>WIC</u> among women that qualify. ¹⁵⁴	
Promote social determinants screenings and intervention prior to delivery to link women to basic needs, such as housing, food, and transportation. ^{162,163}	
Expand group-based prenatal care, specifically for Black pregnant women. ^{166,167}	
Increase access to doulas and midwives across the state. ^{168,169,170}	
Establish holistic perinatal care targeted for Black pregnant women. ^{171,172}	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women's Health

Goals, Objectives, Strategies



Goal 1: Improve maternal health outcomes through improved maternal care before, during, and after pregnancy

3.1.7 Suggested Strategies	Type of Strategy
Increase the number of healthcare providers receiving implicit bias training. ^{172,173}	 
Expand the use of mobile reproductive health clinics. ¹⁷⁴	
Increase the availability of virtual visits for prenatal care. ¹⁷⁵	
Increase the availability of culturally-aware prenatal care, including providing prenatal care and educational materials in a variety of languages. ^{111,112}	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women’s Health

Goals, Objectives, Strategies



Goal 2: Increase breast and cervical cancer prevention, screening, and care

Objective 3.2.1: By 2030, increase the number of women receiving a breast cancer screening for whom one is indicated from 78.3% to 82.2%.

Data Source, Baseline Year: Behavioral Risk Factor Surveillance Survey (BRFSS), 2022

Target: Aligned with the 2026-2030 Maryland Comprehensive Cancer Control Plan

Objective Update: Objective 3.2.1 in the 2024 SHIP was originally stated as: “By 2029, increase the number of women receiving a breast cancer screening for which one is indicated from 83.2% to 87%.” The original data were determined to be inaccurate; therefore, the baseline and target were updated to reflect the correct data.

3.2.1 Suggested Strategies	Type of Strategy
Provide patient education around prevention services covered by health insurance options and low-cost or no-cost screening programs. ^{179,180}	 
Promote and strengthen the services provided by Maryland Breast and Cervical Cancer Programs to address current health disparities in breast cancer (subject matter expert recommendation, BAHM Women’s Health Workgroup).	 
Increase care coordination across the healthcare delivery system for women with abnormal cancer screenings. ^{76,181,182}	 
Increase the use of patient navigation services. ¹⁷⁶ This may include encouraging payers to reimburse for patient navigation, including navigation conducted by community health workers, and encouraging health systems to build processes to bill for services already approved by the Centers for Medicare and Medicaid (subject matter expert recommendation, MDH Center for Cancer Prevention and Control).	
Engage community health workers to promote breast cancer screenings, particularly in underserved communities. ⁹	 
Educate family members around the importance of sharing personal and family health history with relatives. Educate the public on the relationship between family history, inherited genetic variants, cancer risk, and the importance of genetic counseling prior to genetic testing (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women's Health

Goals, Objectives, Strategies



Goal 2: Increase breast and cervical cancer prevention, screening, and care

3.2.1 Suggested Strategies	Type of Strategy
Increase the use of multi-component interventions that include two or more intervention approaches (e.g., increasing community demand, increasing access, and increasing provider delivery of screening services). ¹⁸³	
Increase the use of patient reminders through phone messages (including automated texts), letters, or emails. ¹¹²	
Encourage one-on-one patient education on eligibility for and benefits of breast cancer screening. ⁹ Encourage patients to request breast cancer risk assessment from their providers to determine if at increased risk and when to start screening. Encourage providers to conduct breast cancer risk assessments for their patients to determine if at increased risk and when to start screening. ¹⁷⁶ Prompt and prepare patients to complete the entire continuum of care from screening to diagnosis to treatment, as needed. ¹⁸⁴	
Expand group education on the indications for, benefits of, and ways to overcome barriers to screening. ⁹	
Reduce patient out-of-pocket costs by reducing co-pays and extra clinic visits. Refer low-income uninsured and underinsured individuals to the Maryland Breast and Cervical Cancer Program (subject matter expert recommendation, MDH Center for Cancer Prevention and Control).	
Reduce structural barriers (non-economic burdens) to cancer screening through interventions such as modifying hours to meet patient needs; offering services in residential communities or worksites with mobile vans; offering scheduling assistance, transportation, translation, or patient navigation; and limiting number of clinic visits. ⁹	
Implement small media campaigns, such as videos and printed materials, to inform and motivate people to be screened for cancer. ⁹ Leverage social media to spread awareness about cancer screening.	
Implement provider reminder and recall systems for patients who are due or overdue for breast cancer screening. ⁹ Configure the electronic health record to automate these alerts. ¹⁷⁶	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women’s Health

Goals, Objectives, Strategies



Goal 2: Increase breast and cervical cancer prevention, screening, and care

3.2.1 Suggested Strategies	Type of Strategy
Implement provider assessment and feedback ⁹ to evaluate their performance referring patients for screening or delivering screening to patients.	
Adapt screening practices and education to patient’s cultural and linguistic needs. ⁴⁹ This could be accomplished through engagement with community health workers, community-based workshops, faith-based interventions, and culturally tailored educational materials.	
Enhance the use of community-based organizations to address disparities, including through partnerships among healthcare providers, community organizations, and outreach programs. ¹⁸⁵	
Promote mobile screening units to reach underserved areas. ¹⁷²	
Provide continuing education opportunities for health care providers in cancer prevention and early detection guidelines. Utilize web-based methods, health care provider meetings and conferences, seminars, grand rounds, and/or other opportunities (subject matter expert recommended strategy, MDH Center for Cancer Prevention and Control).	
Maintain or increase public health funding for cancer screening, diagnosis, and treatment for low-income and uninsured Marylanders (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	
Plan and develop standard operating procedures to maintain cancer prevention and control activities during a state of emergency to ensure timely cancer screening, diagnosis, and treatment (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	
Encourage patient navigation professionals to join and support the Maryland Patient Navigation Network (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	
Leverage technology and innovative practice models, such as telemedicine and visiting consultants, to improve patient access and better connect primary care and other health care providers to cancer specialists (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women’s Health

Goals, Objectives, Strategies



Goal 2: Increase breast and cervical cancer prevention, screening, and care

- Objective 3.2.2:** By 2030, increase youth HPV vaccine coverage rates to reach the following targets:
- Girls age 13-17 years who are up to date on HPV vaccination to 73.1% (2023 Baseline: 70.2%)
 - Boys age 13-17 years who are up to date on HPV vaccination to 67.5% (2023 Baseline: 64.3%)

Data Source, Baseline Year: National Immunization Survey-Teen, 2022

Target: Aligned with the 2026-2030 Maryland Comprehensive Cancer Control Plan

Objective Update: Objective 3.2.2 in the 2024 SHIP was originally stated as: “By 2029, increase the proportion of adolescents ages 13-17 who are up to date on HPV vaccine from 72% to 80%”.

3.2.2 Suggested Strategies	Type of Strategy
Educate health care providers, particularly pediatricians, on the importance of making a strong and timely HPV vaccination recommendation for children as young as age 9 years and encourage discussion of HPV vaccination during well child checks. ^{186,187}	
Implement home visitation programs to assess patients’ vaccination status, discuss the importance of recommended vaccinations, and either provide vaccinations to clients in their homes or refer them to other vaccination sites and services. ⁹	
Reduce patient out-of-pocket costs (economic burdens) by reducing extra clinic visits and utilizing the <u>Vaccines for Children (VFC) Program</u> and/or <u>340B Drug Pricing Program</u> when appropriate. ^{188,189}	
Increase the use of client reminders through phone messages (including texts), letters, or emails. ⁹ Configure the electronic health record to automate these alerts. ¹⁸⁵	
Implement provider assessment and feedback to evaluate their performance when offering or delivering HPV vaccination to patients. ¹⁹⁰	
Implement standing orders to administer HPV vaccination. ¹⁹¹	
Promote enrollment in school-based health centers. ^{192,193}	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women’s Health

Goals, Objectives, Strategies



Goal 2: Increase breast and cervical cancer prevention, screening, and care

3.2.2 Suggested Strategies	Type of Strategy
Establish multi-component client-based interventions to increase HPV vaccination, including patient education and provider recommendations. ⁴⁹	
Implement community-based interventions such as education campaigns, ⁴⁹ navigation support, provider referrals, and vaccine provision in trusted community spaces.	
Increase awareness of HPV infection as a cancer risk factor among Marylanders (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	
Bundle administration of HPV and Tdap vaccines at the same visit. ¹⁹⁴	
Leverage social media to promote HPV vaccination and correct misinformation. ^{195,196}	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women’s Health

Goals, Objectives, Strategies



Goal 2: Increase breast and cervical cancer prevention, screening, and care

Objective 3.2.3: By 2030, increase the proportion of females who receive a cervical cancer screening based on the most recent guidelines from 51.4% to 79.2%.

Data Source, Baseline Year: Maryland Behavioral Risk Factor Surveillance System (BRFSS), 2022

Target: Aligns with the 2026-2030 Maryland Comprehensive Cancer Control Plan.

Objective Update: Objective 3.2.3 in the 2024 SHIP was originally stated as: “By 2029, increase the proportion of females who receive a cervical cancer screening based on the most recent guidelines from 79.3% to 82.5%.” The Behavioral Risk Factor Surveillance System survey updated the question related to cervical cancer screening, resulting in a change in the data. The updated objective aligns with the 2026-2030 Maryland Comprehensive Cancer Control Plan.

3.2.3 Suggested Strategies	Type of Strategy
Promote and strengthen the services provided by Maryland Breast and Cervical Cancer Programs to address current health disparities in cervical cancer (subject matter expert recommendation, BAHM Women’s Health Planning Workgroup).	
Increase care coordination across the healthcare delivery system for women with abnormal cancer screenings. ^{197,198}	
Increase the use of patient navigation services. ¹⁸² This may include encouraging payers to reimburse for patient navigation, including navigation conducted by community health workers, and encouraging health systems to build processes to bill for services already approved by the Centers for Medicare and Medicaid (subject matter expert recommendation, MDH Center for Cancer Prevention and Control).	
Engage community health workers to increase screenings, particularly in underserved communities. ⁹	
Increase the use of patient reminders through phone messages (including automated texts), letters, or emails. Implement provider reminder and recall systems for patients who are due or overdue for cervical cancer screening. ⁹ Configure the electronic health record to automate these alerts.	
Educate family members around the importance of sharing personal and family health history with relatives. Educate the public on the relationship between family history, inherited genetic variants, cancer risk, and the importance of genetic counseling prior to genetic testing (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 3: Women's Health

Goals, Objectives, Strategies



Goal 2: Increase breast and cervical cancer prevention, screening, and care

3.2.3 Suggested Strategies	Type of Strategy
Encourage one-on-one client education on eligibility for and benefits of cervical cancer screening. ⁹ Prompt and prepare patients to complete the entire continuum of care from screening to diagnosis to treatment, as needed.	
Implement small media campaigns, such as videos and printed materials, to inform and motivate people to be screened for cancer. ⁹ Leverage social media to spread awareness about cancer screening.	
Implement provider assessment and feedback ⁹ to evaluate performance referring patients to screening or delivering screening to patients.	
Provide continuing education opportunities for health care providers in cancer prevention and early detection guidelines. Utilize web-based methods, health care provider meetings and conferences, seminars, grand rounds, and/or other opportunities (subject matter expert recommendation, MDH Center for Cancer Prevention and Control).	
Implement evidence-based programs designed to increase cervical cancer screening and awareness in underserved populations as described by the National Institutes of Health, such as A Su Salud en Acción and Faith Moves Mountains . ¹⁹⁹	
Maintain or increase public health funding for cancer screening, diagnosis, and treatment for low-income and uninsured Marylanders (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	
Plan and develop standard operating procedures to maintain cancer prevention and control activities during a state of emergency to ensure timely cancer screening, diagnosis, and treatment (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	
Encourage patient navigation professionals to join and support the Maryland Patient Navigation Network (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	
Leverage technology and innovative practice models, such as telemedicine and visiting consultants, to improve patient access and better connect primary care and other health care providers to cancer specialists (subject matter expert recommendation, 2026-2030 Maryland Comprehensive Cancer Control Plan).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy

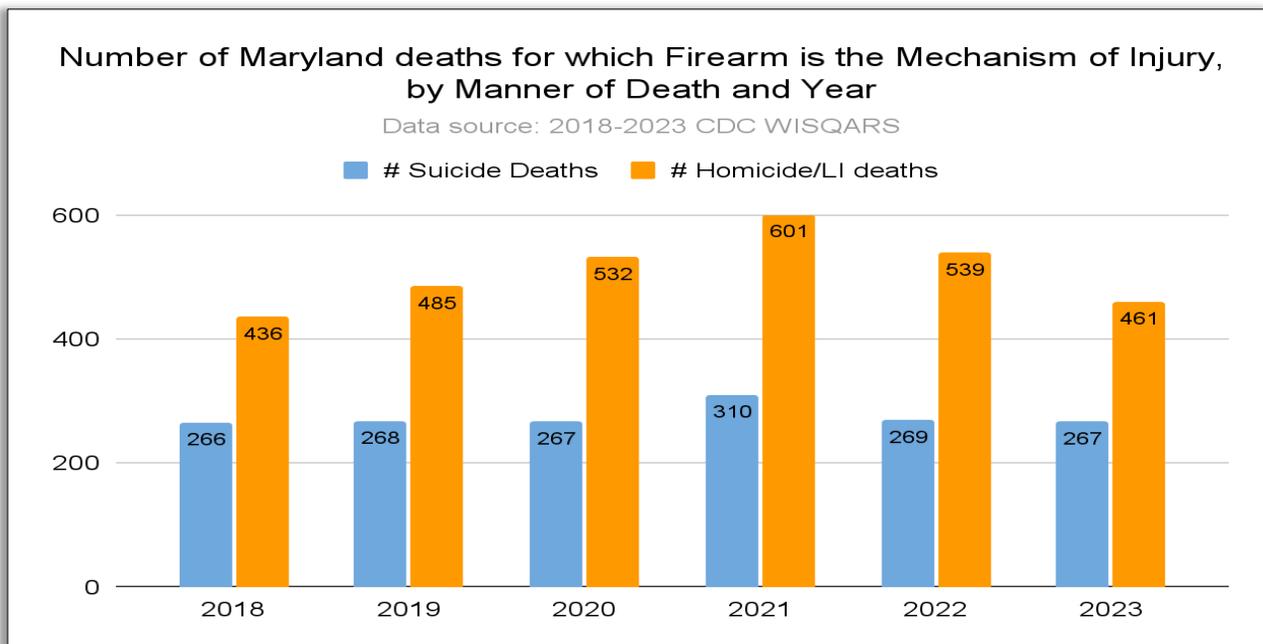


Violence

Maryland's violent crime rate (444.8 per 100,000) is 24% higher than the national average (358.2 per 100,000). A large component of this issue, and a topic that was selected as the fifth most important factor impacting the health and wellbeing of Maryland, is gun violence. Firearms are the mechanism of use for over 80% of homicides and over 40% of suicides in Maryland.

Many factors contribute to the increasing rates of gun violence, including ease of access to guns, poverty, lack of safe spaces and opportunities for youth, racism and lack of community investment. However, the recent recognition of gun violence as a public health concern is a promising development, allowing for a more holistic approach to the issue.

In addition to firearm related homicide, suicide and injury, the need to address intimate partner (IPV) and sexual violence (SV) was identified as a goal for this priority area. While objectives and strategies to reduce gun violence can certainly positively impact rates of IPV and IPV related fatalities, additional attention should be paid to enhancing IPV related screening and data collection as a way to better understand the nature and scope of the issue.





Priority Area 4:

Violence Planning Workgroup Members

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Mary Beth Haller

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Dr. Nilesh Kalyanaraman

MDH PHS Deputy Secretary

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Mindi Garrett

Healthy Anne Arundel Coalition

Jackie Ward

Worcester County Health Planning Advisory Council/Local Health Improvement Coalition



Priority Area 4: Violence

Goals

Goal 1: Reduce firearm-related suicides, homicides, and injuries

Goal 2: Reduce the rates of, and harms associated, with intimate partner and sexual violence (IPV/SV)

“I work in Baltimore City Public Schools. I see on a weekly basis the effect that gun violence has on ALL of our communities. That we must manage our daily lives with the expectation that being on the street INHERENTLY risks gunshot and death is a profound daily stressor and insidious threat to our health and wellbeing. This year alone, to date, there have been **THREE** gunshot episodes immediately on my campus or within shooting distance of my campus. How am I (a mental healthcare provider) and the other adults I work with supposed to support our students if we cannot simply establish safety for us and them, let alone begin to make progress on their health and education goals when we fear for our lives by simply going to work, school, or walking home.”

Community Input Survey
Respondent,
Baltimore City

“Being able to walk safely around your neighborhood is something many of us take for granted, but it's not available to those living in isolated areas or in crime ridden areas.”

Community Input Survey Respondent



Priority Area 4: Violence

Goals, Objectives, Strategies

Goal 1: Reduce firearm-related suicides, homicides, and injuries

Objective 4.1.1: By 2029, reduce the age-adjusted rate of firearm-related suicides from 4.8 to 2 per 100,000.

Data Source, Baseline Year: Vital Statistics Administration (VSA), 2022

Target: Current lowest rate, New Jersey

Objective Update: Objective 4.1.1 in the 2024 SHIP was originally stated as: “By 2029, reduce the age-adjusted rate of firearm-related suicides from 4.8 to 2 per 100,000.” The data source for this objective was changed from the CDC Web-based Injury Statistics Query and Reporting System (CDC WISQARS) to the Maryland Violence Death Reporting System (MVDRS) to align with data presented on the [MDH Firearm Violence Data Dashboard](#).

4.1.1 Suggested Strategies	Type of Strategy
Use available data to identify populations and communities disproportionately impacted by suicide using firearms, such as older adults, veterans, people in the construction industry, and rural areas to inform prevention and intervention policies and programs. ^{200,201}	
Strengthen and implement policies, programs, and partnerships that limit firearm access and promote lethal means safety among individuals at high risk for suicide, including consistent and robust implementation of Extreme Risk Protective Orders (ERPO) and access to safe and secure gun storage options (subject matter expert recommendation, MDH Center for Firearm Violence Prevention and Intervention).	
Increase awareness, resources, skills, and partnerships on the connection between suicide and firearms access, including gatekeeper training in key sectors (schools, employers, veterans’ organizations) and establishing and enhancing the use of trauma-informed crisis intervention teams (subject matter expert recommendation, MDH Center for Firearm Violence Prevention and Intervention).	
Expand education and access to trauma-informed mental health care within communities and among populations disproportionately impacted by suicide, including the utilization of therapeutic approaches designed to reduce suicidality and related factors and conducting safety planning with individuals expressing suicidal ideation (subject matter expert recommendation, MDH Center for Firearm Violence Prevention and Intervention).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 4: Violence

Goals, Objectives, Strategies

Goal 1: Reduce firearm-related suicides, homicides, and injuries

Objective 4.1.2: By 2029, reduce the age-adjusted rate of firearm-related homicides from 8.4 to 6.6 per 100,000.

Data Source, Baseline Year: Vital Statistics Administration (VSA), 2022

Target: Current US rate

Objective Update: Objective 4.1.2 in the 2024 SHIP was originally stated as: “By 2029, reduce the age-adjusted rate of firearm-related homicides from 10.3 to 6.6 per 100,000.” The data source for this objective was changed from the CDC Web-based Injury Statistics Query and Reporting System (CDC WISQARS) to the Maryland Violence Death Reporting System (MVDRS) to align with data presented on the [MDH Firearm Violence Data Dashboard](#).

4.1.2 Suggested Strategies	Type of Strategy
Use available data to identify populations and communities disproportionately impacted by firearm homicide to inform prevention and intervention policies and programs (subject matter expert recommendation, MDH Center for Firearm Violence Prevention and Intervention).	
Strengthen and implement evidence-informed policies to keep individuals prohibited from possessing and purchasing firearms from accessing them, including firearm surrender processes for domestic abusers and extreme risk laws (subject matter expert recommendation, MDH Center for Firearm Violence Prevention and Intervention).	
Introduce, enhance, and promote community violence intervention initiatives, such as street outreach or interruption models, focused deterrence or group violence intervention, and hospital violence intervention programs (subject matter expert recommendation, MDH Center for Firearm Violence Prevention and Intervention).	
Engage with individuals that have been impacted by gun violence to identify community-informed strategies that address root causes of gun violence, including neighborhood revitalization and green spacing, trauma and mental health supports, and food and housing assistance programs (subject matter expert recommendation, MDH Center for Firearm Violence Prevention and Intervention).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 4: Violence

Goals, Objectives, Strategies

Goal 2: Reduce the rates of, and harms associated with intimate partner and sexual violence (IPV/SV)

Objective 4.2.1: By 2029, reduce emergency department visits related to intimate partner violence (IPV)

Data Source: Health Services Cost Review Commission (HSCRC)

Objective Note: This objective relies on data from the HSCRC. Currently, this data is not reported consistently and the ability to report on progress using this measure is limited. This measure has limitations and efforts will continue to identify comprehensive and appropriate indicators to measure rates of intimate partner violence.

4.2.1 Suggested Strategies	Type of Strategy
Engage men and boys as partners in reducing intimate partner and sexual violence (IPV/SV) through communications campaigns and mentorship programs around healthy relationships, respect, and consent. ^{202,203}	
Expand awareness of and access to IPV and SV programs that provide legal support, advocacy, counseling, emergency shelter, and wraparound services (such as education, employment, job training, housing, day care) for those disclosing IPV and SV. ^{204,205}	 
Establish consistent screening and referral protocols for pregnant and postpartum people in health care settings and home visiting programs. ^{198,206,207}	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy

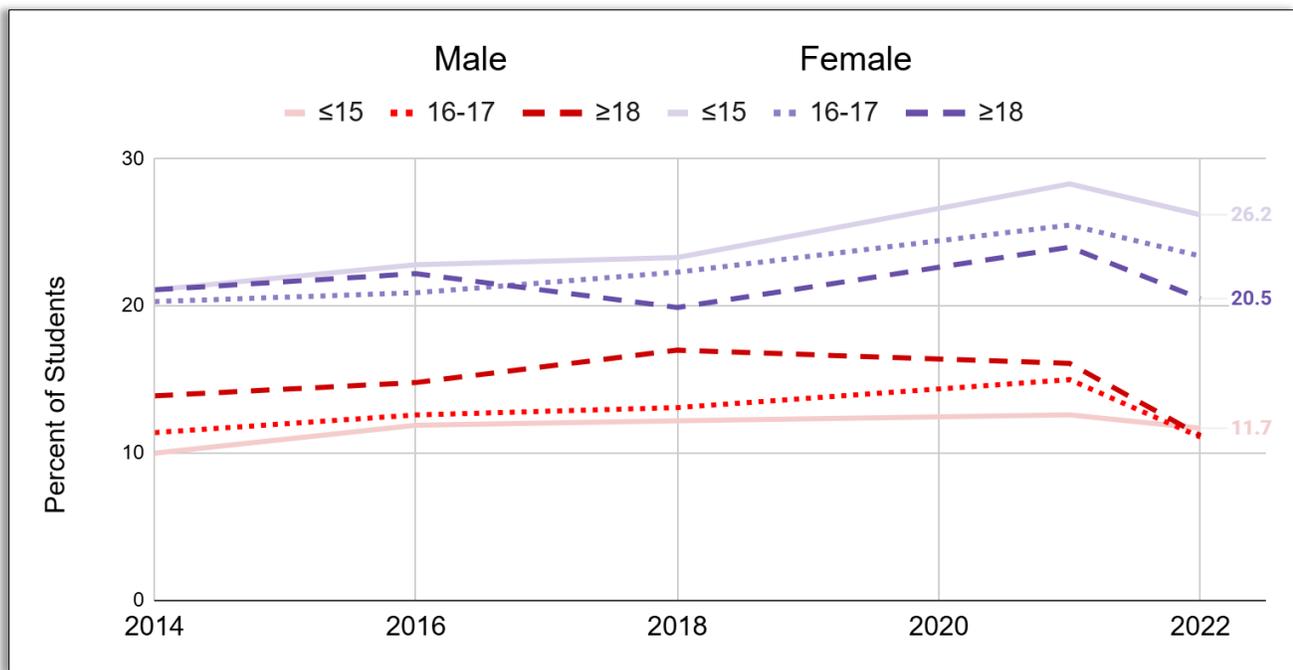


Behavioral Health

When asked the question “what are the most important factors impacting the health and wellbeing of your community”, the most common answer provided by respondents was “Mental Health”. It is clear that mental health, and behavioral health more broadly, is a topic of great importance and concern and was a clear choice for inclusion as one of the state’s health priority areas. Rates of suicidal ideation among youth has risen in recent years, particularly among females.

The root cause analysis for this topic included the identification of barriers such as ongoing stigma around accessing mental health services, language and cultural barriers in treatment, a need for enhanced coordination of care and wraparound services, affordability and accessibility of treatment, and poverty.

High School Students Who Seriously Considered Attempted Suicide by Age and Sex, Maryland, 2014 - 2022





Priority Area 5:

Behavioral Health Planning Workgroup Members

Malcolm Furgol - Lead

Coalition for a Healthier Frederick County

Shelley Argabrite

Garrett County Local Health Improvement Coalition

Alyssa Lord

MDH Deputy Secretary for Behavioral Health Administration

Meghan McClelland

Maryland Hospital Association

Mary Gable

MD State Dept of Education

Mindi Garrett

Healthy Anne Arundel Coalition

Jackie Ward

Worcester County Health Planning Advisory Council/ Local Health Improvement Coalition

Daniel Coulter

Cecil County Health Department

Elise Bowman

Baltimore City Local Health Improvement Coalition



Priority Area 5: Behavioral Health

Goals

Goal 1: Expand access to, and utilization of, behavioral health services

Goal 2: Reduce disparities in mental health outcomes

Goal 3: Reduce overdose and the negative health outcomes associated with substance use

“Mental health I think is one of the most important health issues to address - it can have such a detrimental impact on individuals' ability to survive and thrive. And when struggling with your mental health, you're less able to handle a shock or acute stressors, as you are already experiencing chronic stressors.”

Community Input Survey
Respondent,
Anne Arundel County

“The opioid epidemic hard hit the entire country. Our small county in the state of Maryland is no different. We try to create awareness with county driven initiatives, but we still report staggering numbers of overdoses and death. Our loved ones are dying. If we can not change the "shame on you" stigma then we will continue to bury them.”

Community Input
Survey Respondent



Priority Area 5: Behavioral Health

Goals, Objectives, Strategies



Goal 1: Expand access to, and utilization of, behavioral health services

Objective 5.1.1 (aligned with AHEAD Population Health Accountability Plan):

Increase the percentage of patients discharged from hospitalization for mental illness who receive follow-up care within seven days of discharge from 38.0% to 38.5% by 2027 and to 40.5% by 2036.

Increase the percentage of patients discharged from hospitalization for mental illness who receive follow-up care within 30-days of discharge from 64.3% to 64.8% by 2027 and 66.8% by 2036.

Data Source, Baseline Year: All-Payer Claims Database (APCD), 2023

Target: Aligned with AHEAD Population Health Accountability Plan

Objective Update: Objective 5.1.1 in the 2024 SHIP was originally stated as: “By 2029, reduce the rate of emergency department visits for mental health conditions from 4,510 per 100,000.” This objective was updated to align with the 2025 AHEAD Population Health Accountability Plan, which uses a different measure with a focus on follow-up after hospitalization rather than emergency room visits for mental health conditions.

5.1.1 Suggested Strategies	Type of Strategy
Implement community-based Critical Time Intervention (CTI) programs to support vulnerable populations through periods of transition. ²⁰⁸	
Utilize multifaceted and multimodal interventions post-discharge with a focus on in-person mental health interventions. ²⁰⁹	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 5: Behavioral Health

Goals, Objectives, Strategies

Goal 1: Expand access to, and utilization of, behavioral health services

Objective 5.1.2: By 2029, reduce the rate of suicides from 9.9 per 100,000 to 9.1 per 100,000.

Data Source, Baseline Year: Maryland Department of Health, Vital Statistics Administration, 2021

Target: 2014 Maryland SHIP target

5.1.2 Suggested Strategies	Type of Strategy
Partner with support service organizations to increase awareness and referrals to crisis care services. ²¹⁰	 
Increase access to walk-in urgent care and Behavioral Health Crisis Stabilization Centers. ^{203,211}	
Increase mobile crisis response and stabilization access and utilization. ^{212,213}	
Increase awareness and utilization of the 988 Suicide and Crisis Lifeline and ensure that 988 lines are adequately funded, staffed, and trained for increased volume. See the 988 Toolkit to support raising awareness. ²¹⁴	 
Expand the utilization of Maryland’s “Ask the Question” campaign to identify Service Members, Veterans, and their Families to ensure appropriate resource connection within this priority population (subject matter expert recommendation, MDH Behavioral Health Administration).	
Increase community knowledge around lethal means safety strategies for firearms, sharp objects, and medications in communities across the State (subject matter expert recommendation, MDH Behavioral Health Administration).	
Expand the utilization of the Maryland Action Plan to Prevent Suicide (MAPS) across Maryland school communities (subject matter expert recommendation, MDH Behavioral Health Administration).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 5: Behavioral Health

Goals, Objectives, Strategies

Goal 1: Expand access to, and utilization of, behavioral health services

Objective 5.1.3: Increase the number of youth substance use treatment providers by 2% each year.

Data Source, Baseline Year: Maryland Public Behavioral Health System, 2023

Target: Aligned with Maryland Managing for Results target

5.1.3 Suggested Strategies	Type of Strategy
Utilize findings from gap analyses and needs assessments to inform where service delivery is needed and the types of services (inpatient, outpatient, community settings) to be deployed (subject matter expert recommendation, BAHM Behavioral Health Planning Workgroup).	
Enhance partnerships with local and state health departments, local behavioral health authorities, local addictions authorities, trade associations, large provider groups, and core service agencies to identify strategic provider collaborations to bring services online based on identified needs. ²¹⁵	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 5: Behavioral Health

Goals, Objectives, Strategies

Goal 1: Expand access to, and utilization of, behavioral health services

Objective 5.1.4: By 2029, increase utilization of public behavioral health services by 4%.

Data Source, Baseline Year: Maryland Public Behavioral Health System, 2023

Target: Developed in conjunction with MDH Behavioral Health Administration.

5.1.4 Suggested Strategies	Type of Strategy
Improve public knowledge of behavioral health conditions, needs and resources for support and treatment. ^{216,217}	
Reduce stigma around behavioral health treatment through multimedia public awareness campaigns (public service announcements, posters, social media). ²¹⁸	
Increase behavioral health providers that can accept insurance. ^{219,220}	
Increase access and use of telehealth for behavioral healthcare services in accordance with the <u>Preserve Telehealth Act</u> . ^{221,222}	
Increase access to Peer Recovery services, including community treatment outreach and Recovery Community Centers that can facilitate warm handoffs to community treatment providers across the state (subject matter expert recommendation, MDH Behavioral Health Administration).	
Increase access to Infectious Disease Prevention Services that serve people who use drugs and offer referrals to formal treatment programs across the state (subject matter expert recommendation, MDH Behavioral Health Administration).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 5: Behavioral Health

Goals, Objectives, Strategies

Goal 2: Reduce disparities in mental health outcomes

Objective 5.2.1: By 2029, reduce the percentage of students who felt sad or hopeless most days for more than 2 weeks in the past 12 months from 42% for all students, and from 64.6% for LGBTQ students.

Data Source, Baseline Year: Youth Risk Behavior Survey, 2021

Target: Directional target

5.2.1 Suggested Strategies	Type of Strategy
Increase the use of evidence-informed primary prevention factors (e.g., CDC What Works In Schools) that contribute to improved mental health for youth, such as creating safe and supportive environments for LGBTQ+ youth. ^{223,224,225}	
Provide student-led support programs such as Gay-Straight Alliance (GSA) in schools that support community building and provide a positive support space for LGBTQ+ youth (subject matter expert recommendation, MDH Behavioral Health Administration).	
Expand the utilization of the Maryland Action Plan to Prevent Suicide (MAPS) across Maryland’s school communities (subject matter expert recommendation, MDH Behavioral Health Administration).	
Screen adolescents 12-18 years old for major depressive disorder (MDD). ²²⁶	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 5: Behavioral Health

Goals, Objectives, Strategies

Goal 2: Reduce disparities in mental health outcomes

Objective 5.2.2 (Targeted Health Disparity Objective): By 2029, increase availability of affordable housing from 46.1% as a way to improve health outcomes, including mental health.

Data Source, Baseline Year: Maryland Department of Planning, 2019

Target: Directional target

5.2.2 Suggested Strategies	Type of Strategy
Expand the availability of permanent supportive housing and the services that community organizations provide to include continuum of care rental assistance and permanent supportive housing. ²²⁷	 
Work to establish permanent supportive housing providers in underserved jurisdictions (subject matter expert recommendation, BAHM Behavioral Health Planning Workgroup).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Priority Area 5: Behavioral Health

Goals, Objectives, Strategies



Goal 3: Reduce overdose and the negative health outcomes associated with substance use

Objective 5.3.1: By 2029, reduce the number of opioid-related overdose deaths by 20%.

Data source: Maryland Department of Health, Vital Statistics Administration, 2022

Target: Developed in conjunction with MDH Behavioral Health Administration

5.3.1 Suggested Strategies	Type of Strategy
Increase naloxone distribution. ^{228,229}	
Increase access to drug-checking services. ^{230,231}	
Increase low-barrier medication for opioid use disorder (MOUD). ^{232,233}	
Promote use of <u>Screening, Brief Intervention, and Referral to Treatment (SBIRT)</u> . ²³⁴	
Promote evidence-based alternatives to pain management and reduce inappropriate prescribing of opiates. ^{235,236}	
Educate the public on the purpose and benefit of substance use strategies (i.e. harm reduction, recovery-oriented programs, recovery houses). ^{237,238,239}	
Educate the public on overdose response including naloxone administration (subject matter expert recommendation, MDH Behavioral Health Administration).	
Expand opioid-associated disease prevention and outreach programs (subject matter expert recommendation, MDH Behavioral Health Administration).	
Educate the public on potential drug interactions - especially between cannabis, alcohol, cocaine and opiates (subject matter expert recommendation, BAHM Behavioral Health Workgroup).	
Promote the adoption and use of Trauma Informed Care practices and approaches across SUD treatment and recovery programs (subject matter expert recommendation, MDH Behavioral Health Administration).	
Educate the public on recent or current substance adulteration trends utilizing MDH's <u>Rapid Analysis of Drugs (RAD)</u> program (subject matter expert recommendation, MDH Behavioral Health Administration).	



Health Equity Strategy



Social Determinants of Health Strategy



Policy and Systems Level Strategy



LHIC Aligned Strategy



Place-Based Strategy



Cross-Sector Collaboration Strategy



Next Steps

Following publication of the SHIP in 2024, the *Building a Healthier Maryland* initiative moved to implementation. In order to address the goals and objectives included in the SHIP, the BAHM team facilitates the following:

Annual Steering Committee meetings: After the implementation Kick Off, the Steering Committee will meet annually to review progress, share lessons learned and collaboratively update the SHIP, as needed.

Monthly Workgroup and Sub Workgroup meetings: Each priority area will have an implementation workgroup that facilitates and guides progress towards that priority's goals and objectives. As much as possible, this work will leverage existing groups (e.g., Committees, Task Forces, etc.) in order to build off of in progress SHIP-related work. As needed, additional sub workgroups will be formed to address and implement specific strategies. Members of the planning workgroups will be encouraged to continue their participation in implementation workgroups, and additional partners will also be invited to join.

The SHIP is a living document. As the implementation phase progresses, the BAHM team will ensure the plan is responsive to suggested alterations or additions. Together, we look forward to Building a Healthier Maryland!



Resources and Assets



Public Health Systems Assessment

An integral part of the creation and ultimate implementation of the SHIP is having a comprehensive understanding of the resources and assets available in the state of Maryland for the delivery of public health services. In order to accomplish this, a Public Health Systems Assessment was conducted. The purpose of this assessment was two-fold:

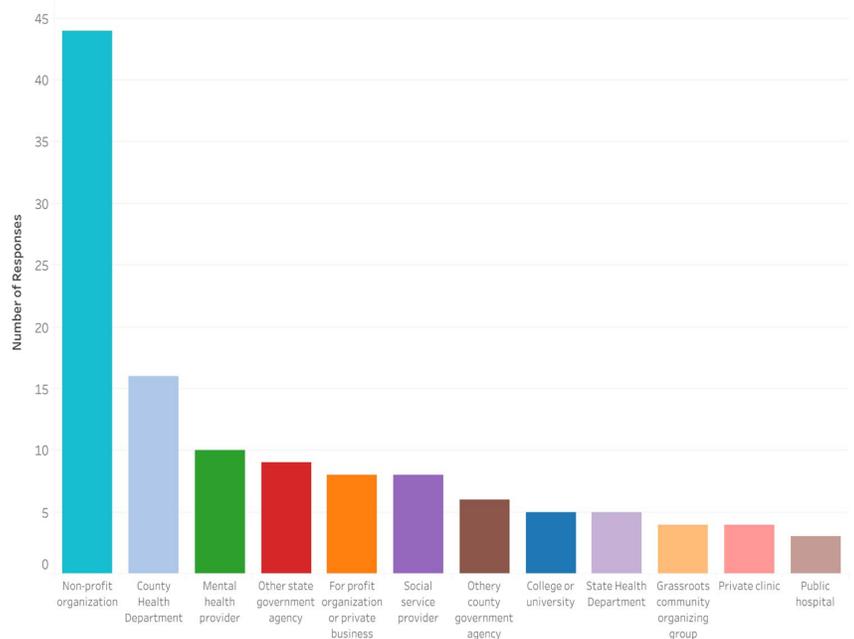
- Better understand the public health services provided and the populations served, the health concerns that they address, and what community-building activities are occurring across the state in order to identify strengths and gaps
- Compile a directory of resources we can tap into for the implementation of our plan's strategies

The assessment instrument was adapted from the MAPP 2.0 Community Partner Assessment. BAHM partners were asked to complete one survey on behalf of their organizations, and distribute the survey to other external partners they work with.

As of May 2024, The BAHM team has received 109 responses; the survey will remain open for the duration of the SHIP process so that organizations can be continuously added to the directory.

The majority of responses are from non-profit organizations (n=44, 40%), however local health departments, colleges and universities, other state agencies and medical clinics are also represented.

Which of the following best describe(s) your organization? (n=109)

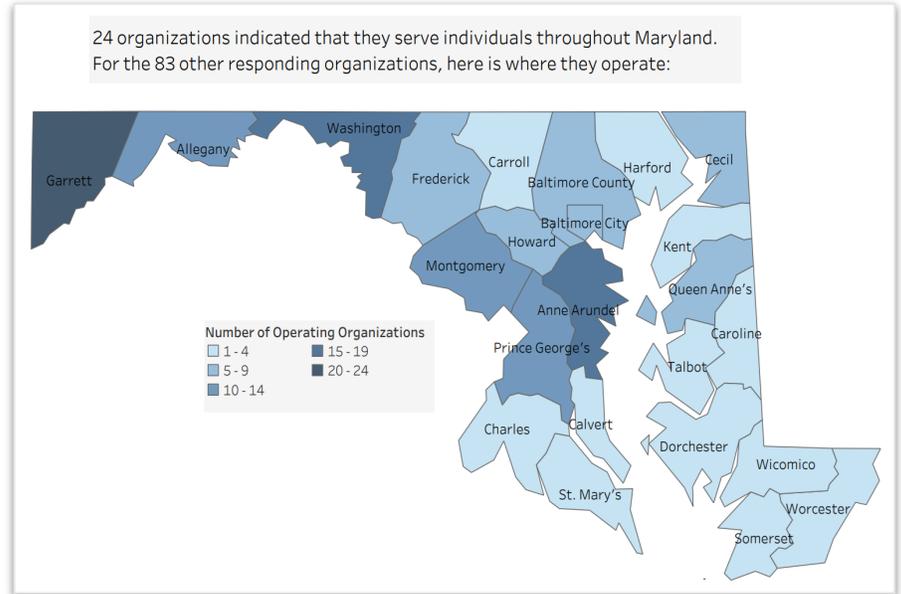


Public Health Systems Assessment

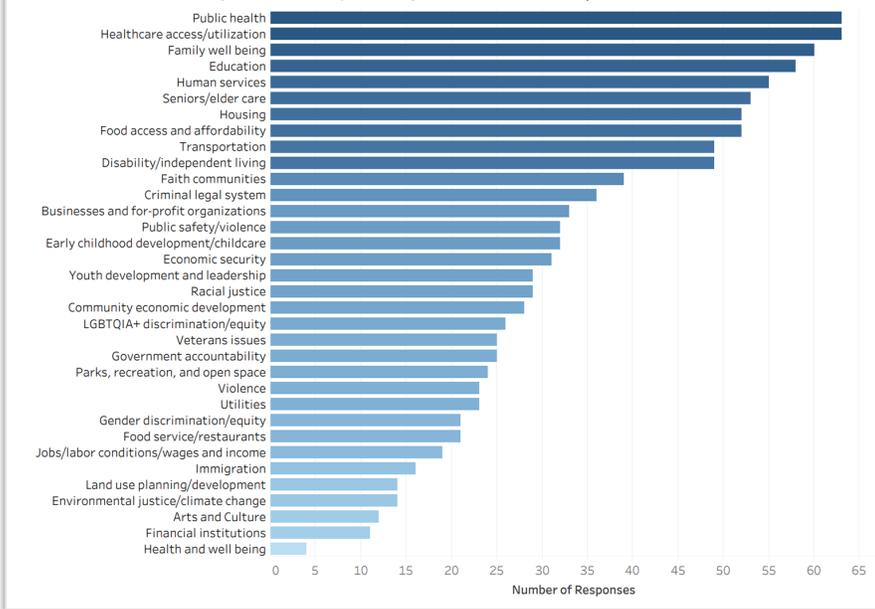
In accordance with the MAPP 2.0 instrument, the BAHM Public Health Systems Assessment asked organizations to provide information on the demographics and characteristics of their clients served, their organizations' area of focus, organizational capacity and strengths, community engagement practices, policy and advocacy practices and data and evaluation practices.

Of the responses received to date, 24 operate across the entire state of Maryland. The remaining 85 are spread throughout the state, with at least one organization being present in each of the 24 jurisdictions.

Ongoing efforts will be made to identify and include additional organizations from jurisdictions with fewer responses.



Which of the following areas does your organization work on/with?



Note: This question was "mark all that apply".

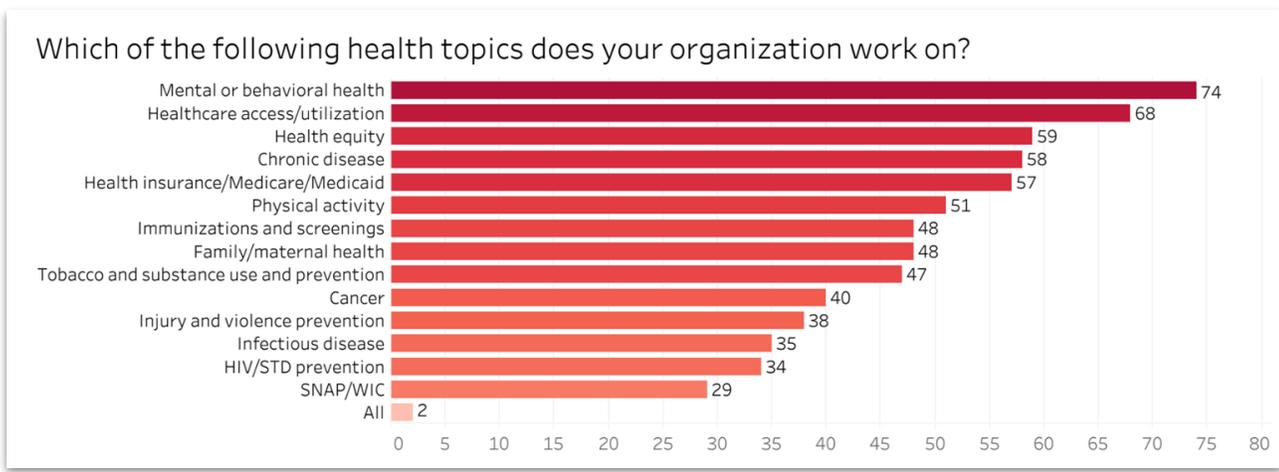
The majority of the responding organizations work in the public health space (n=65, 60%). Additionally, there is organizational representation across many of the health priority areas, identified strategies and priority populations including:

- Healthcare access/utilization - 63 responses
- Seniors/elder care - 53 responses
- Housing - 52 responses
- Food access - 52 responses
- Public safety/violence - 32 responses
- Youth development/leadership - 29 responses
- Racial Justice - 29 responses
- Parks and recreation - 24 responses

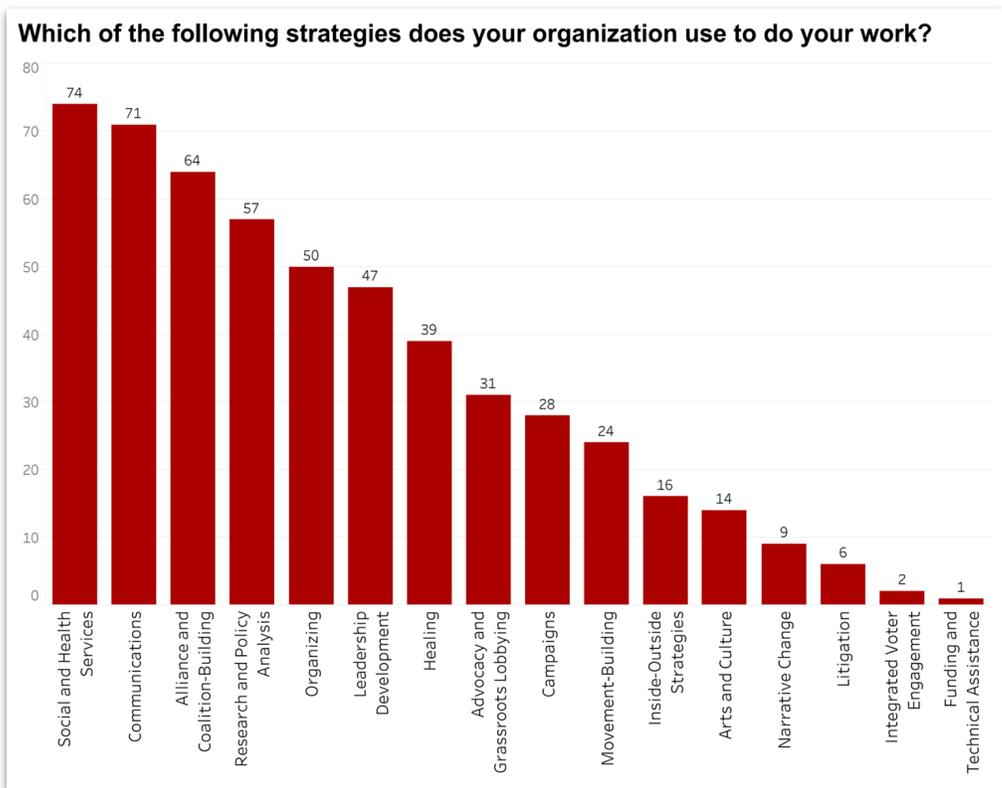
Public Health Systems Assessment

In addition to organizational focus, many of the responding organizations work on the health topics that are in alignment with our state’s health priority areas, including chronic disease, health care access and behavioral health.

The responding organizations employ a wide variety of strategies and services in order to meet the needs of the individuals they serve. The vast majority of organizations provide basic social and health services (n=74, 68%), however in addition, 64 (59%) organizations said they engage in alliance and coalition building, 57 (52%) reported conducting research and policy analysis and 47 (43%) reported that they provide leadership development.



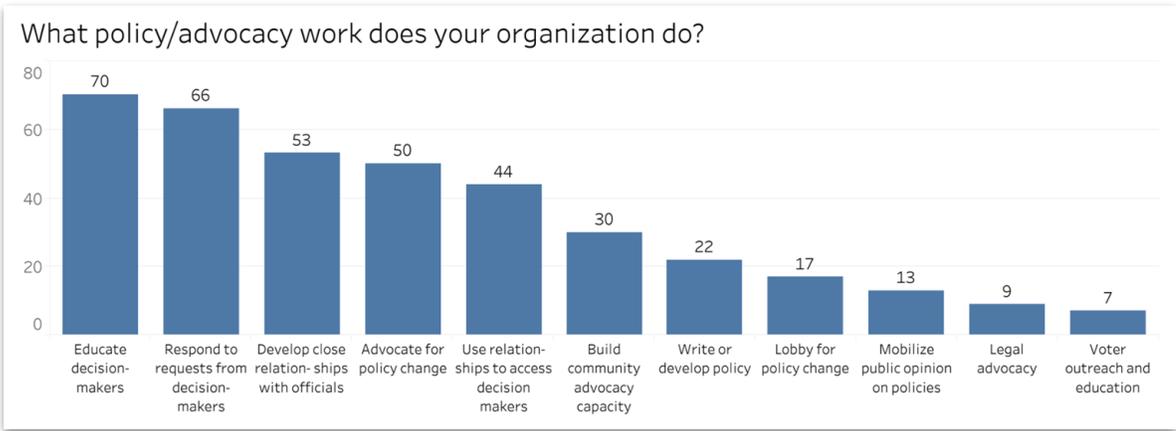
Note: These questions were “mark all that apply”.



Public Health Systems Assessment

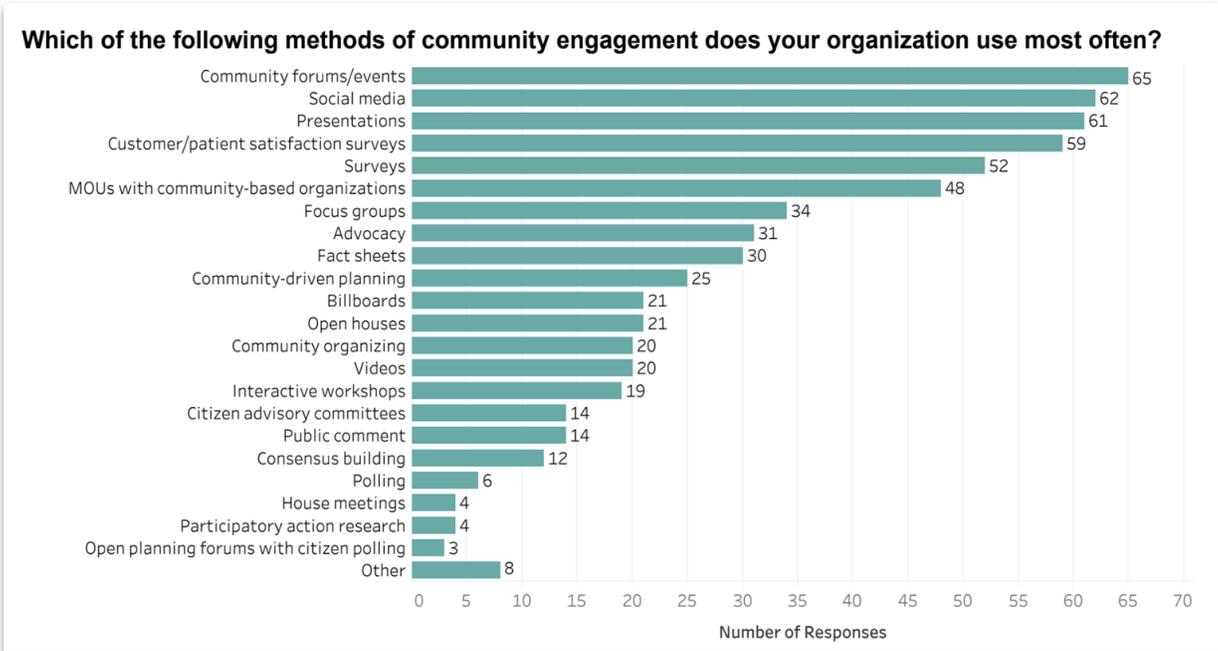
As policy and systems changes will play a major role in the implementation of the SHIP resulting in permanent change, organizations were asked to define what types of policy and advocacy work they do.

Almost all respondent organizations participate in some soft of policy work, with the majority conducting education with and responding to questions from decision-makers.



Note: These questions were "mark all that apply".

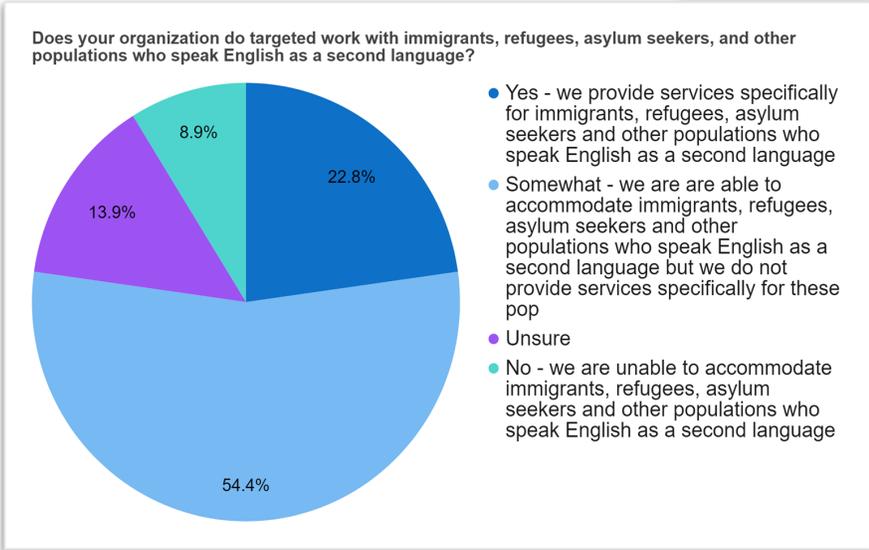
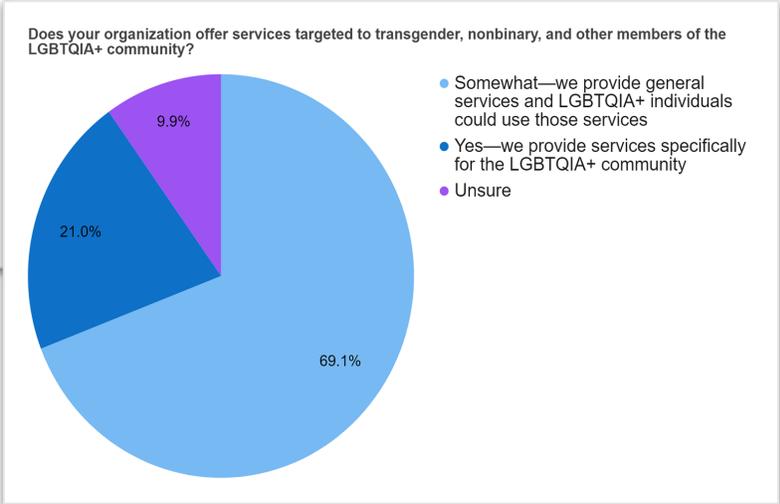
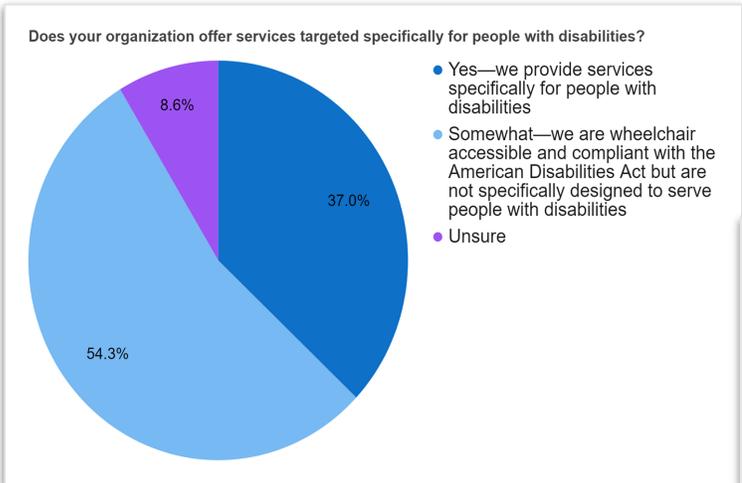
Because the SHIP is a community-driven plan, engagement with the community and community building will be vital to the success of the plan. To this end, organizations were asked to identify the types of community engagement activities they participate in. The most common type was engagement with community forums or events (n=65, 60%), but many organizations also employ social media strategies, presentations to the public and community surveys as a way to gauge satisfaction and gather feedback.



Public Health Systems Assessment

Addressing health equity was an essential element of consideration when selecting objectives and strategies for the SHIP. In order to ensure that implementation of targeted activities reach the appropriate populations, BAHM must be able to link with organizations working with those populations.

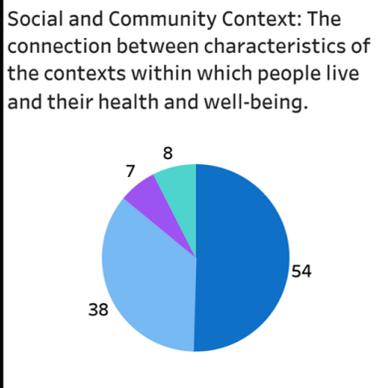
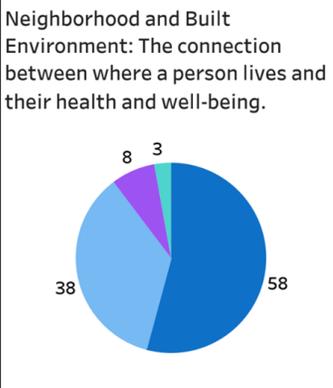
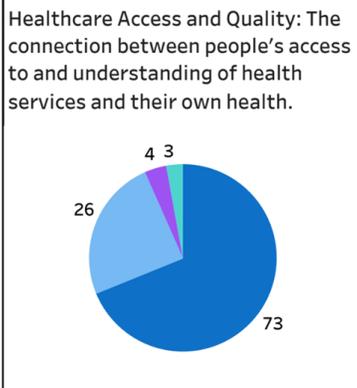
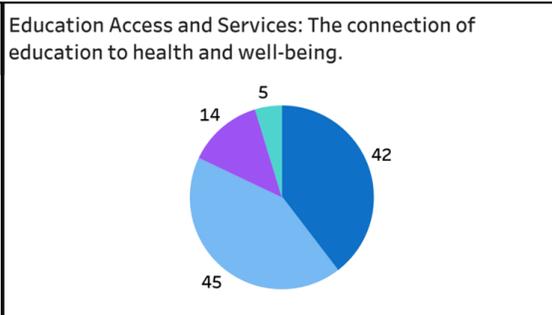
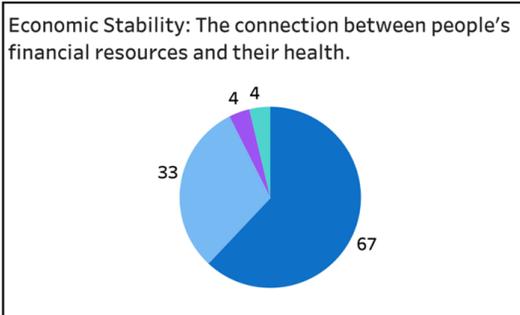
Based on responses, BAHM has access to organizations who, in addition to serving the general population, do targeted work with all of the priority populations identified in the SHIP. This includes expertise on working with racial and ethnic minorities, immigrants and people who speak English as a second language, older adults, the LGBTQ+ community, and individuals with disabilities.



Public Health Systems Assessment

How much does your organization focus on each of these topics?

■ A lot ■ A little ■ Not at all ■ Unsure



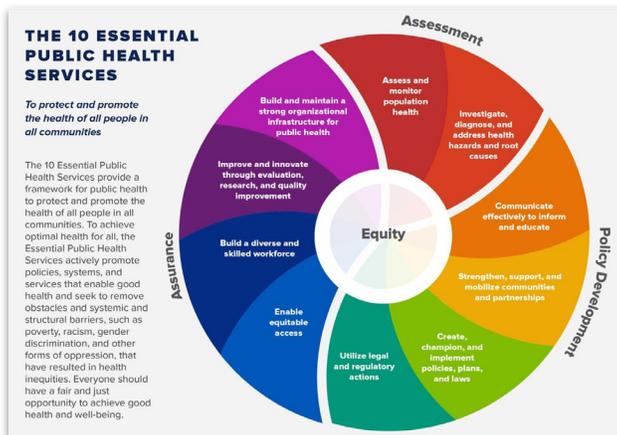
In addition to considerations of health equity, when crafting the objectives and strategies, the BAHM steering committee made sure to consider social determinants of health, defined as “the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.” The social determinants of health are generally grouped into five domains: economic stability, education access and services, healthcare access and quality, neighborhood and built environment, and social and community context.

In order to best address factors in each of these five domains, BAHM will need partner organizations who conduct work across the spectrum of the social determinants of health. The above pie charts demonstrate that BAHM has access to at least 40 organizations to tap into for each of these vital areas.

Public Health Systems Assessment

Finally, of primary importance is the need to work with organizations that address the 10 essential public health services, the framework for public health to protect and promote the health of all people in all communities.

Based on current responses, all ten essential public health services are well represented across responding organizations. Over 80% of organizations report that they conduct activities that strengthen, support, and mobilize communities and partnerships to improve health (#4 above) and communicate effectively to inform and educate people about health, factors that influence it, and how to improve it (#3 above). The public health service with the least amount of representation is “utilize legal and regulatory actions designed to improve and protect the public’s health” (#6 above), with only 24% of organizations reporting providing this service. As we recruit more partner organizations, a concerted effort will be made to include more organizations who provide this service.



As Maryland’s State Health Improvement Plan moves into the implementation phase, it will be vital to have access to community programs across the state that provide a broad range of services, serve diverse populations, and employ a multitude of different strategies. Based on current responses to the Public Health Systems Assessment, the BAHM team will have many resources to tap into and have potential partner organizations who work not only on the SHIP’s health priority areas, but also with many of the priority populations identified. In addition, BAHM will have access to organizations that work to address the five domains of social determinants of health and across the ten essential public health services.



Public Health Systems Assessment

2024 Public Health Systems Assessment: Full List of Respondent Organizations

Local Health Departments	Hospital/Medical Clinic/FQHC
Allegany County Health Department	August Rose Health Center
Anne Arundel Co Mental Health Agency	Canopy Family Care
Baltimore County Department of Health	Garrett Regional Medical Center
Carroll County Health Department	H&G Elite Wellness, LLC
Carroll County Health Department, Local Behavioral Health Authority and Bureau of Prevention, Wellness and Recovery	Johns Hopkins Howard County Medical Center
Cecil County Health Department	Luminis Health
Charles County Department of Health	Meritus Medical Center
Frederick County Health Department	Mountain Laurel Medical Center
Garrett County Health Department	Muslim Community Center DBA MCC Medical Clinic
Howard County Health Department	Premier Spine and Sports Medicine
Kent County Health Department	Tri-State Community Health Center
Montgomery County Public Health Services	UPMC Western Maryland
Prince George's County Health Department	West Cecil Health Center
Somerset County Health Department	College/University
St. Mary's County Health Department	Coppin State University
Washington County Health Department	Johns Hopkins Bloomberg School of Public Health
State Health Department	The Hilltop Institute at the University of Maryland, Baltimore County
MDH Center for Cancer Prevention and Control, Comprehensive Cancer Control Program	University of Maryland Extension
Office of Population Health Improvement, Maryland Department of Health	University of Maryland, School of Social Work
Maryland Primary Care Program	Library
Other Local Government Agency	Ruth Enlow Library of Garrett County
Anne Arundel County Department of Aging and Disabilities	Non-Profit Organization
Anne Arundel County Mental health Agency Inc	Accessible Resources for Independence, Inc. (ARI)
Anne Arundel Department of Aging and Disabilities	Addiction Recovery, Inc DBA Hope House Treatment Centers
Baltimore County Department of Aging	AHEC West
Garrett County Dept. of Technology & Communications	Allegany County Human Resources Development Commission
Garrett County Government	Anne Arundel County Mental Health Agency
Washington County Board of Education	Appalachian Parent Association, Inc
Washington County Department of Social Services	Assn of Community Services of Howard Co

Public Health Systems Assessment

2024 Public Health Systems Assessment: Full List of Respondent Organizations To Date

Non-Profit Organization Continued
Autism Society of Maryland
Baltimore Safe Haven
Centro De Apoyo Familiar
Chesapeake Regional Information System for our Patients (CRISP)
Chinese Culture and Community Service Center, Inc. (CCACC)
Circle of Rights Inc.
Community Free Clinic, Inc.
Deep Creek Lake Lions Club
Food & Friends, Inc.
Fort Ritchie Community Center Corporation
Garrett County Area Agency on Aging at Garrett County Community Action Committee, Inc
Garrett County Community Action (Senior Health & Fitness Club)
Garrett County Community Action/Garrett Transit Service
Horizon Foundation of Howard County
Hospice of Garrett County, Inc.
Job Opportunities Task Force
Maryland Children's Alliance, Inc.
Maryland Rural Health Association
Mid Shore Health Improvement Coalition
Mountain Laurel Medical Center
Muslim Community Center DBA MCC Medical Clinic
Parish Nursing Network of the Tri-State Region
People Encouraging People Inc.
Primary Care Coalition of Montgomery County, Maryland
Proyecto Salud Clinic
Reach of Washington County
Robert W Johnson Community Center
Serenity Sistas Inc
Smart Public Health Consulting (SPHC) & SPHC Foundation

Non-Profit Organization Continued
The Community Ecology Institute
The Coordinating Center
The Hilltop Institute at the University of Maryland, Baltimore County
UPMC Western Maryland
Voices of Hope, Inc.
Western Maryland Allied Health Education Center
Grassroots Community Organizing Group/Organization
Child and Adolescent Health Work Group
Horizon Foundation of Howard County
Muslim Community Center DBA MCC Medical Clinic
NAACP Howard County Branch
Smart Public Health Consulting (SPHC) & SPHC Foundation
Social Service Provider
Autism Society of Maryland
Maryland Living Well Center of Excellence, a Division of MAC, Inc. AAA
Mountain Laurel Medical Center
Muslim Community Center DBA MCC Medical Clinic
People Encouraging People Inc.
The Partnership Development Group, Inc.
Mental Health Provider
Aspire Wellness Center, Inc
August Rose Health Center
Canopy Family Care
Connected Communities For Behavioral Wellness
I-Matter, LLC
Mountain Laurel Medical Center
Muslim Community Center DBA MCC Medical Clinic
People Encouraging People Inc.
The Mental Health Center of Western Maryland Inc.

Public Health Systems Assessment

2024 Public Health Systems Assessment: Full List of Respondent Organizations To Date

Foundation/Philanthropy
Horizon Foundation of Howard County
Smart Public Health Consulting (SPHC) & SPHC Foundation
For Profit Organization/Private Business
Aspire Wellness Center, Inc
Beach to Peak Yoga
Canopy Family Care
Elevate Recovery Centers, LLC
Hub City Nutrition
Jazzercise Oakland MD of Simon Pearce Outlet
Smart Public Health Consulting (SPHC) & SPHC Foundation
Tereance Moore Consulting
The Partnership Development Group, Inc.
Unraveling Obesity Inc
Faith Based Organizations
Muslim Community Center DBA MCC Medical Clinic
Parish Nursing Network of the Tri-State Region



Appendices

Appendix I: Steering Committee Members

Local Health Departments	Kisha Davis	Health Officer	Montgomery County HD
	Earl Stoner	Health Officer	Washington County HD
	Danielle Weber	Health Officer	Somerset County HD
	Mary Beth Haller	Interim Health Commissioner	Baltimore City HD
Local Health Improvement Coalitions (LHIC)	Reena Rambharat	LHIC Lead	Howard County LHIC
	Della Leister	Deputy Health Officer and LHIC POC	Baltimore County LHIC
	Jacqueline Wells	Director of Community Engagement and Policy	St. Mary's County LHIC
	Shelley Argabrite	Health Strategist & Director of the Population Health, Innovation & Informatics Unit	Garrett County LHIC
Maryland Department of Health (MDH)	Nilesh Kalyanaraman	MDH PHS Deputy Secretary	PHS Deputy Secretary
	Ryan Moran	MDH Health Care Financing Deputy Secretary	Health Care Financing
	Alyssa Lord	MDH BHA Deputy Secretary	Behavioral Health Administration
	Camille Blake Fall	Director, Office of Minority Health and Health Disparities	Office of Minority Health and Health Disparities
	Elizabeth Kromm	Director, MDH Prevention and Health Promotion Administration	Prevention and Health Promotion Administration
Non-Profit & Other Community Organizations	Nora Hoban	Chief Executive Officer	Mid-Atlantic Association of Community Health Centers
	Meghan McClelland	Chief Operating Officer & Senior Vice President	Maryland Hospital Association
	Jonathan Dayton	Executive Director	Maryland Rural Health Association
	Gene M. Ransom III	Chief Executive Officer	Maryland State Medical Society (MedChi)
Other State Agencies	Erin Roth	Assistant Secretary	MD Dept of Labor
	Stuart Campbell		MD Dept of Housing and Community Development
	Heather Zenone	Assistant Secretary for Policy	MD Dept of Human Services
	Carmel Roques	Secretary	MD Dept of Aging
	Tiffany Callander Eberling		MD Dept of Aging
	Lyn Farrow	Director of External Affairs	MD Dept of Transportation
	Mary Gable	Assistant State Superintendent of Student Support, Academic Enrichment, & Educational Policy	MD State Dept of Education
	Suzanne Dorsey	Deputy Secretary	MD Dept of the Environment
	Aneca Atkinson	Assistant Secretary of Environmental Justice	MD Dept of the Environment

Appendix I: Steering Committee Members - LHIC Partners

Local Health Improvement Coalition Name	Representative Name	Representative Position
Coalition for a Healthier Frederick County	Malcolm Furgol	Executive Director
Harford County Health Department	Ronya Nassar	Director of Population Health / Public Information Officer
Healthy Anne Arundel Coalition	Mindi Garrett	Health Policy Analyst
Mid Shore Health Improvement Coalition	Nicole Morris	Director
Montgomery County LHIC	Christopher Rogers	Acting Chief
Healthy Washington County	Danielle Stahl	Co-chair for HWC and Program Manager
Partnerships for a Healthier Charles County	Amber Starn	Epidemiologist and Director
Calvert Health	Mary Golway	Director of Education & Training and Community Wellness
Allegany County Health Planning Coalition	Melissa Nething	Health Planner
Worcester County Health Planning Advisory Council / Local Health Improvement Coalition	Jackie Ward	Health Planner III
Cecil County Community Health Advisory Committee	Jean-Marie Kelly	Director of Policy, Planning & Assessment
Baltimore City Local Health Improvement Coalition	Elise Bowman	
The Partnership for a Healthier Carroll County	Maggie Kunz	Health Planner
Prince George's Healthcare Action Coalition	Kimberly Stinchcomb	
Healthy Somerset	Andra J. Taylor	Director of Planning, Prevention and Communication
Wicomico Local Health Improvement Coalition	Tammy Griffin	

Appendix II: Steering Committee Charter

Purpose

The Maryland State Health Improvement Plan (SHIP) Steering Committee provides oversight and guidance for the revision and implementation of an updated State Health Assessment (SHA) and SHIP. The SHIP Steering Committee consists of partners from various and diverse sectors across the state.

The Steering Committee's main purpose is to identify state health improvement priorities as indicated by a systematic state health assessment and to champion and oversee the implementation of data-informed and evidence-based initiatives that address the priorities and enhance the well-being of all residents in Maryland.

Primary Functions & Activities

- Provide input during all phases of the State Health Assessment (SHA) and the State Health Improvement Plan (SHIP)
 - Review and provide input on SHA data
 - Prioritize issues for action
 - Identify metrics associated with each priority that can demonstrate progress, be used as Total Cost of Care population health measures, be used for local health department priority setting, and be incorporated into the performance management system
- Review and approve final SHA, SHIP and other work products (i.e., documents, assessment tools)
- Oversee and monitor the implementation of the SHIP strategies and goals; direct changes as needed
- Identify opportunities to partner and build on existing efforts
- Advocate for SHA and SHIP activities in their respective agencies and organizations and across the state
- Meet at least annually and attend SHIP events
- Discuss, revise and approve the SHIP, annually

Benefits of Participation

- Improved organizational and community coordination and collaboration
- Increased knowledge of public health and interconnectedness of activities
- Strengthened partnerships within state and local public health systems
- Identified strengths and weaknesses to address in quality improvement efforts
- Benchmarks for public health practice improvements

Benefits of Participation

- Improved organizational and community coordination and collaboration
- Increased knowledge of public health and interconnectedness of activities
- Strengthened partnerships within state and local public health systems
- Identified strengths and weaknesses to address in quality improvement efforts
- Benchmarks for public health practice improvements

Member Time Commitment, Meeting Frequency and Process

- Membership will be maintained for the duration of the State Health Improvement Plan, which is a five-year plan.
- In the first 6 months of standing up the Steering Committee, the members shall meet at least five (5) times with additional meetings as needed for the completion of the State Health Assessment and the development of the State Health Improvement Plan, and after that at least two times per year for the duration of the Plan.
- Decisions will be based either on consensus or by majority vote of the members present at a meeting

Participants

- The Steering Committee will be chaired by the Maryland Department of Health Deputy Secretary for Public Health Services.
- Steering Committee membership may consist of the [representatives](#) of partner organizations from various and diverse sectors across the state.

Appendix III: Detailed Steering Committee Process

Steering Committee Meeting #1 - December 4th, 2023

In the fall of 2023, MDH convened the first Building a Healthier Maryland Steering Committee meeting. At this meeting, Steering Committee members were introduced to the SHA and SHIP processes and were provided with an overview of the Building a Healthier Maryland mission. In addition, as a way to begin laying the foundation for the future decisions that needed to be made, a comprehensive data review was conducted. The BAHM team provided an overview of both the qualitative and quantitative data from the Community Input Survey as well as the secondary data from the SHA. Special attention was paid to providing disaggregated data wherever possible and highlighting metrics with stark health disparities.

Steering Committee Meeting #2 - December 15th, 2023

In order to continue underscoring the importance of prioritizing health equity in the development of our SHIP, the Director of MDH’s Office of Minority Health and Health Disparities was invited to kick off the second Steering Committee meeting. This conversation, in addition to the data review conducted in the first meeting, laid the groundwork for the Steering Committee’s first task - the group was divided into four breakout rooms, with each room discussing two questions:

- ★ What are the most important issues affecting the health and wellbeing of your communities?
- ★ Are you concerned about the health and wellbeing of any particular populations in your community?

From those discussions, each room was asked to identify their top four health concerns, which were as follows:

Room 1	Room 2	Room 3	Room 4
<ul style="list-style-type: none">● Community Safety● Access to Care and Workforce● Substance Use● Chronic Disease	<ul style="list-style-type: none">● Nutrition/Food Security● Physical Activity● Lack of Equity● Substance Use Disorder	<ul style="list-style-type: none">● Access to Care● Chronic Disease● Air, Land and Water Pollution● Env health metrics	<ul style="list-style-type: none">● Chronic Disease● Income Inequality● Technical Literacy Access● Economy/Living Wages

Appendix III: Detailed Steering Committee Process

Steering Committee Meeting #3 - January 8th, 2024

During the third meeting, the Steering Committee was tasked with conducting a root cause analysis on eight of the major health concerns that were identified from the previous meeting's discussions:

- ★ Violence and crime are issues in Maryland
- ★ Inadequate and inconsistent access to health care in Maryland
- ★ Persistently high rates of substance use in Maryland
- ★ Challenges with aging in place in Maryland
- ★ Obesity and related comorbidities are increasing in Maryland residents
- ★ Disparities in reproductive health outcomes in Maryland
- ★ Certain populations in Maryland are disproportionately affected by pollution
- ★ People who live in poverty in Maryland have worse health outcomes

The group once again broke out into four rooms, each room conducting an analysis on two topics. Robust discussions were held and common themes were identified across rooms, including poverty, food and nutrition access, racism and systemic discrimination and structural barriers to accessing high quality affordable health care. Identifying common themes and upstream factors to each health issue allowed the steering committee to gain a more holistic view of the factors impacting the health of Maryland's residents.

Steering Committee Meeting #4 - January 22nd, 2024

The fourth meeting began with an overview and breakdown of LHIC priorities, shared as way to ensure alignment of objectives and strategies moving forward. Then, taking into account those LHIC priorities, along with all primary and secondary data and the discussion held during the second and third meeting, the Steering Committee came to a consensus on the SHIP's top 5 Health Priority Areas:

- ★ Chronic Disease
- ★ Access to Care
- ★ Behavioral Health
- ★ Women's Health
- ★ Violence

Workgroups and Next Steps

Following the selection of the 5 Health Priority Areas, a workgroup was created for each health priority. Steering committee members were invited to join as many of the workgroups as they wished, and each workgroup had an identified Steering Committee lead as well as an MDH liaison to provide logistical support. The workgroups met over the course of the next few months to solidify goals for their priority areas, as well as objectives and strategies that could be employed to achieve those goals, and metrics that should be tracked in order to see progress.

In addition, workgroups discussed potential partners and resources that could be utilized during implementation. As the SHIP moved from the planning phase into the implementation phase, workgroups will continue to meet and efforts will be made to connect with and include these additional potential partners wherever possible.

Appendix IV: Citations

- 1 Insolera N, Cohen A, Wolfson JA. SNAP and WIC Participation During Childhood and Food Security in Adulthood, 1984–2019. <https://doi.org/10.2105/AJPH.2022.306967>. doi:10.2105/AJPH.2022.306967
- 2 Metallinos-Katsaras E, Gorman KS, Wilde P, Kallio J. A Longitudinal Study of WIC Participation on Household Food Insecurity. *Maternal and Child Health Journal*. 2010;15(5):627-633. doi:<https://doi.org/10.1007/s10995-010-0616-5>
- 3 Arteaga I, Heflin C, Gable S. The impact of aging out of WIC on food security in households with children. *Children and Youth Services Review*. 2016;69:82-96. doi:<https://doi.org/10.1016/j.childyouth.2016.07.015>
- 4 Wang M, Levi R, Seligman H. New SNAP Eligibility in California Associated With Improved Food Security and Health. *Prev Chronic Dis*. 2021;18:E28. doi:10.5888/pcd18.200587
- 5 Kaiser L, Chaidez V, Algert S, et al. Food Resource Management Education With SNAP Participation Improves Food Security. *Journal of Nutrition Education and Behavior*. 2015;47(4):374-378.e1. doi:10.1016/j.jneb.2015.01.012
- 6 Zhu H, An R. Impact of home-delivered meal programs on diet and nutrition among older adults: a review. *Nutr Health*. 2013;22(2):89-103. doi:10.1177/0260106014537146
- 7 Seligman HK, Berkowitz SA. Aligning Programs and Policies to Support Food Security and Public Health Goals in the United States. *Annu Rev Public Health*. 2019;40:319-337. doi:10.1146/annurev-publhealth-040218-044132
- 8 Loopstra R. Interventions to address household food insecurity in high-income countries. *Proceedings of the Nutrition Society*. 2018;77(3):270-281. doi:10.1017/S002966511800006X
- 9 CPSTF. Recommended by the Community Preventive Services Task Force. <https://www.thecommunityguide.org/media/pdf/cpstf-finding-lists/CPSTF-All-Findings-508.pdf>
- 10 Bazerghi C, McKay FH, Dunn M. The Role of Food Banks in Addressing Food Insecurity: A Systematic Review. *J Community Health*. 2016;41(4):732-740. doi:10.1007/s10900-015-0147-5
- 11 Eicher-Miller HA. A review of the food security, diet and health outcomes of food pantry clients and the potential for their improvement through food pantry interventions in the United States. *Physiology & Behavior*. 2020;220:112871. doi:10.1016/j.physbeh.2020.112871
- 12 Leonard T, Andrews D, Pruitt SL. Impact of changes in the frequency of food pantry utilization on client food security and well-being. *Applied Economic Perspectives and Policy*. 2022;44(2):1049-1067. doi:10.1002/aep.13166
- 13 Bantham A, Taverno Ross SE, Sebastião E, Hall G. Overcoming barriers to physical activity in underserved populations. *Progress in Cardiovascular Diseases*. 2020;64(1). doi:<https://doi.org/10.1016/j.pcad.2020.11.002>
- 14 Springer AE, Castro V, Ruiz F, et al. Interweaving Adult Fitness Classes Into Community Settings Via Stronger Austin's Community Partnership Model. *Family & Community Health*. 2022;45(2):125-135. doi:<https://doi.org/10.1097/fch.0000000000000321>
- 15 Milton K, Cavill N, Chalkley A, et al. Eight Investments That Work for Physical Activity. *Journal of Physical Activity and Health*. 2021;18(6):1-6. doi:<https://doi.org/10.1123/jpah.2021-0112>
- 16 Olscamp K, Pompano L, Piercy KL, et al. Understanding the Impact of Move Your Way Campaign Exposure on Key Physical Activity Outcomes – Results from a Multi-site Pilot Evaluation. *J Healthy Eat Act Living*. 2(3):113-125.
- 17 Barrington WE, DeGross A, Melillo S, et al. Patient navigator reported patient barriers and delivered activities in two large federally-funded cancer screening programs. *Prev Med*. 2019;129S:105858. doi:10.1016/j.ypmed.2019.105858
- 18 Leach KM, Granzow ME, Popalis ML, Stoltzfus KC, Moss JL. Promoting colorectal cancer screening: A scoping review of screening interventions and resources. *Preventive Medicine*. 2021;147:106517. doi:<https://doi.org/10.1016/j.ypmed.2021.106517>
- 19 Doubeni CA, Selby K, Gupta S. Framework and Strategies to Eliminate Disparities in Colorectal Cancer Screening Outcomes. *Annual Review of Medicine*. 2021;72(1):383-398. doi:<https://doi.org/10.1146/annurev-med-051619-035840>
- 20 Lucas T, Thompson HS, Blessman J, et al. Effects of culturally targeted message framing on colorectal cancer screening among African Americans. *Health Psychology*. 2021;40(5):305-315. doi:<https://doi.org/10.1037/hea0001073>
- 21 Briant KJ, Sanchez JI, Ibarra G, et al. Using a Culturally Tailored Intervention to Increase Colorectal Cancer Knowledge and Screening among Hispanics in a Rural Community. *Cancer Epidemiology, Biomarkers & Prevention*. 2018;27(11):1283-1288. doi:<https://doi.org/10.1158/1055-9965.epi-17-1092>
- 22 Culturally Tailored Navigator Intervention Program for Colorectal Cancer Screening | Evidence-Based Cancer Control Programs (EBCCP). ebccp.cancercontrol.cancer.gov. <https://ebccp.cancercontrol.cancer.gov/programDetails.do?programId=1493683>
- 23 Ward SH, Lin K, Meyer B, et al. Increasing Colorectal Cancer Screening among African Americans, Linking Risk Perception to Interventions Targeting Patients, Communities and Clinicians. *J Natl Med Assoc*. 2008;100(6):748-758. doi:10.1016/s0027-9684(15)31356-0
- 24 Healthy People 2030. Establishing Effective Patient Navigation Programs in Oncology: Proceedings of a Workshop - | odphp.health.gov. 2018. Accessed March 19, 2025. <https://odphp.health.gov/healthypeople/tools-action/browse-evidence-based-resources/establishing-effective-patient-navigation-programs-oncology-proceedings-workshop>
- 25 Williams LB, Looney SW, Joshua T, McCall A, Tinggen MS. Promoting Community Awareness of Lung Cancer Screening Among Disparate Populations: Results of the cancer-Community Awareness Access Research and Education Project. *Cancer Nursing*. 2021;44(2):89. doi:10.1097/NCC.0000000000000748

Appendix IV: Citations

- 26 Williams LB, Shelton BJ, Gomez ML, Al-Mrayat YD, Studts JL. Using Implementation Science to Disseminate a Lung Cancer Screening Education Intervention Through Community Health Workers. *J Community Health*. 2021;46(1):165-173. doi:10.1007/s10900-020-00864-2
- 27 Lowenstein LM, Deyter GMR, Nishi S, Wang T, Volk RJ. Shared decision-making conversations and smoking cessation interventions: critical components of low-dose CT lung cancer screening programs. *Transl Lung Cancer Res*. 2018;7(3):254-271. doi:10.21037/tlcr.2018.05.10
- 28 Van Hal G, Diab Garcia P. Lung cancer screening: targeting the hard to reach—a review. *Transl Lung Cancer Res*. 2021;10(5):2309-2322. doi:10.21037/tlcr-20-525
- 29 Dodd RH, Sharman AR, McGregor D, et al. Education messages and strategies to inform the public, potential screening candidates and healthcare providers about lung cancer screening: A systematic review. *Preventive Medicine*. 2023;169:107459. doi:10.1016/j.ypmed.2023.107459
- 30 Jessup DL, Iv MG, Daye D, et al. Implementation of Digital Awareness Strategies to Engage Patients and Providers in a Lung Cancer Screening Program: Retrospective Study. *Journal of Medical Internet Research*. 2018;20(2):e8932. doi:10.2196/jmir.8932
- 31 Dodd RH, Sharman AR, McGregor D, et al. Education messages and strategies to inform the public, potential screening candidates and healthcare providers about lung cancer screening: A systematic review. *Preventive Medicine*. 2023;169:107459. doi:10.1016/j.ypmed.2023.107459
- 32 Jonnalagadda S, Bergamo C, Lin JJ, et al. Beliefs and attitudes about lung cancer screening among smokers. *Lung Cancer*. 2012;77(3):526-531. doi:10.1016/j.lungcan.2012.05.095
- 33 Pegues JN, Isenberg EE, Fendrick AM. The Cost to Breathe: Eliminating Cost Sharing Associated with Lung Cancer Screening. *Annals of the American Thoracic Society*. Published online May 31, 2024. doi:10.1513/AnnalsATS.202401-064VP
- 34 Akhtar A, Sosa E, Castro S, et al. A Lung Cancer Screening Education Program Impacts both Referral Rates and Provider and Medical Assistant Knowledge at Two Federally Qualified Health Centers. *Clinical Lung Cancer*. 2022;23(4):356-363. doi:10.1016/j.clcc.2021.12.002
- 35 Olazagasti C, Seetharamu N, Kohn N, Steiger D. Implementing physician education to increase lung cancer screening uptake. *Lung Cancer Manag*. 11(2):LMT55. doi:10.2217/lmt-2022-0008
- 36 Tsosie U, Anderson N, Woo N, et al. Understanding determinants of lung cancer preventive care in at-risk urban American Indians and Alaska Natives: A mixed-methods study. *Preventive Medicine Reports*. 2024;45:102822. doi:https://doi.org/10.1016/j.pmedr.2024.102822
- 37 Raman V, Yong V, Erkmen CP, Tong BC. Social Disparities in Lung Cancer Risk and Screening. *Thorac Surg Clin*. 2022 Feb;32(1):23-31. doi: 10.1016/j.thorsurg.2021.09.011. PMID: 34801192
- 38 Senthil P, Kuhan S, Potter AL, Jeffrey Yang CF. Update on Lung Cancer Screening Guideline. *Thorac Surg Clin*. 2023 Nov;33(4):323-331. doi: 10.1016/j.thorsurg.2023.04.002. Epub 2023 May 31. PMID: 37806735.
- 39 Olazagasti C, Seetharamu N, Kohn N, Steiger D. Implementing physician education to increase lung cancer screening uptake. *Lung Cancer Manag*. 2023 Apr 25;11(2):LMT55. doi: 10.2217/lmt-2022-0008. PMID: 37122495; PMCID: PMC10135441.
- 40 McCallum GB, Morris PS, Brown N, Chang AB. Culture-specific programs for children and adults from minority groups who have asthma. *Cochrane Database of Systematic Reviews*. 2017;(8). doi:https://doi.org/10.1002/14651858.cd006580.pub5
- 41 Liu M, Chung JE, Robinson B, Taylor L, Andrew RA, Li J. A home visit program for low-income African American children with asthma: Caregivers' perception of asthma triggers and a gap in action. *Journal of Pediatric Nursing*. 2022;67:e79-e84. doi:https://doi.org/10.1016/j.pedn.2022.09.006
- 42 Zheang M, Rodriguez E, Alvarado C, Correa R, Kahlor LA, Matsui EC. Exploring low-income African American and Latinx caregiver perspectives on asthma control in their children and reactions to messaging materials. *J Asthma*. 2022;59(6):1269-1275. doi:10.1080/02770903.2021.1903918
- 43 Marshall ET, Guo J, Flood E, Sandel MT, Sadof MD, Zotter JM. Home Visits for Children With Asthma Reduce Medicaid Costs. *Preventing Chronic Disease*. 2020;17. doi:https://doi.org/10.5888/pcd17.190288
- 44 Gill I, Shah A, Lee EK, et al. Community Interventions for Childhood Asthma ED Visits and Hospitalizations: A Systematic Review. *Pediatrics*. 2022;150(4):e2021054825. doi:https://doi.org/10.1542/peds.2021-054825
- 45 Ng JSK, Chau JPC, Chan AWK, Lui JKC, Cheng JWCH. A nurse-led web-based home asthma education program for children and their families: A randomized controlled trial. *Journal of Pediatric Nursing*. 2021;59:158-163. doi:https://doi.org/10.1016/j.pedn.2021.04.014
- 46 Eakin MN, Zaeh S, Eckmann T, et al. Effectiveness of a Home- and School-Based Asthma Educational Program for Head Start Children With Asthma: A Randomized Clinical Trial. *JAMA Pediatrics*. 2020;174(12). doi:https://doi.org/10.1001/jamapediatrics.2020.3375
- 47 Coffman, J. M., Cabana, M. D., Halpin, H. A., & Yelin, E. H. (2008). Effects of asthma education on children's use of acute care services: a meta-analysis. *Pediatrics*, 121(3), 575–586. https://doi.org/10.1542/peds.2007-0113
- 48 CDC. EXHALE: Strategies to Help People with Asthma Breathe Easier. CDC National Asthma Control Program. October 1, 2024. Accessed March 19, 2025. https://www.cdc.gov/national-asthma-control-program/php/exhale/index.html

Appendix IV: Citations

- 49 WWFH. Recommended by What Works for Health. <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies>
- 50 Woods ER. Community Asthma Initiative to Improve Health Outcomes and Reduce Disparities Among Children with Asthma. *MMWR Suppl.* 2016;65. doi:10.15585/mmwr.su6501a4
- 51 Bhaumik U, Sommer SJ, Giller-Leinwohl J, et al. Boston children's hospital community asthma initiative: Five-year cost analyses of a home visiting program. *J Asthma.* 2017;54(2):134-142. doi:10.1080/02770903.2016.1201837
- 52 Sommer SJ, Queenin LM, Nethersole S, et al. Children's hospital Boston community Asthma initiative: partnerships and outcomes advance policy change. *Prog Community Health Partnersh.* 2011;5(3):327-335. doi:10.1353/cpr.2011.0044
- 53 Wolf FM, Guevara JP, Grum CM, Clark NM, Cates CJ. Educational interventions for asthma in children. *Cochrane Database Syst Rev.* 2003;(1):CD000326. doi:10.1002/14651858.CD000326
- 54 Handelsman Y, Butler J, Bakris GL, et al. Early intervention and intensive management of patients with diabetes, cardiorenal, and metabolic diseases. *Journal of Diabetes and its Complications.* 2023;37(2):108389. doi:10.1016/j.jdiacomp.2022.108389
- 55 Herman WH, Ye W, Griffin SJ, et al. Early Detection and Treatment of Type 2 Diabetes Reduce Cardiovascular Morbidity and Mortality: A Simulation of the Results of the Anglo-Danish-Dutch Study of Intensive Treatment in People With Screen-Detected Diabetes in Primary Care (ADDITION-Europe). *Diabetes Care.* 2015;38(8):1449-1455. doi:<https://doi.org/10.2337/dc14-2459>
- 56 The Importance of Regular Diabetes Screening & Early Detection. Metro Group of Hospitals. Published November 14, 2024. <https://www.metrohospitals.com/blog/the-importance-of-regular-diabetes-screening-early-detection/>
- 57 Batalha APDB, Ponciano IC, Chaves G, Felício DC, Britto RR, da Silva LP. Behavior change interventions in patients with type 2 diabetes: a systematic review of the effects on self-management and A1c. *Journal of Diabetes & Metabolic Disorders.* 2021;20(2). doi:<https://doi.org/10.1007/s40200-021-00846-8>
- 58 Okeyo HM, Biddle MJ, Williams LB. Impact of Diabetes Self-Management Education on A1C Levels Among Black/African Americans: A Systematic Review. *The Science of Diabetes Self-Management and Care.* 2023;50(1). doi:<https://doi.org/10.1177/26350106231213400>
- 59 Northwood M, Shah AQ, Abeygunawardena C, Garnett A, Schumacher C. Care Coordination of Older Adults With Diabetes: A Scoping Review. *Canadian Journal of Diabetes.* 2023;47(3):272-286. doi:10.1016/j.cjcd.2022.11.004
- 60 Mikhael EM, Hassali MA, Hussain SA. Effectiveness of diabetes self-management educational programs for type 2 diabetes mellitus patients in middle east countries: A systematic review. *Diabetes, Metabolic Syndrome and Obesity: Targets and Therapy.* 2020;13(13):117-138. doi:<https://doi.org/10.2147/dmso.s232958>
- 61 Miller-Rosales C, Rodriguez HP. Interdisciplinary primary care team expertise and diabetes care management. *The Journal of the American Board of Family Medicine.* 2021;34(1):151-161. doi:<https://doi.org/10.3122/jabfm.2021.01.200187>
- 62 Smith ML, Zhong L, Lee S, Towne Jr SD, Ory MG, Towne SDJ. Effectiveness and economic impact of a diabetes education program among adults with type 2 diabetes in South Texas. *BioMed Central Public Health.* 2021;21(1):1-12. doi:<https://doi.org/10.1186/s12889-021-11632-9>
- 63 Marsh Z, Nguyen Y, Teegala Y, Cotter VT. Diabetes management among underserved older adults through telemedicine and community health workers. *Journal of the American Association of Nurse Practitioners.* 2022;34(1):26. doi:10.1097/JXX.0000000000000595
- 64 Coleman CM, Bossick AS, Zhou Y, et al. Introduction of a community health worker diabetes coach improved glycemic control in an urban primary care clinic. *Preventive Medicine Reports.* 2021;21:101267. doi:10.1016/j.pmedr.2020.101267
- 65 Blecker S, Paul MM, Jones S, et al. A Project ECHO and Community Health Worker Intervention for Patients with Diabetes. *The American Journal of Medicine.* 2022;135(5):e95-e103. doi:10.1016/j.amjmed.2021.12.002
- 66 Patil SJ, Ruppert T, Koopman RJ, et al. Peer Support Interventions for Adults With Diabetes: A Meta-Analysis of Hemoglobin A1c Outcomes. *Ann Fam Med.* 2016;14(6):540-551. doi:10.1370/afm.1982
- 67 Piette JD, Resnicow K, Choi H, Heisler M. A Diabetes Peer Support Intervention That Improved Glycemic Control: Mediators and Moderators of Intervention Effectiveness. *Chronic Illn.* 2013;9(4):10.1177/1742395313476522. doi:10.1177/1742395313476522
- 68 Heisler M, Dyer WT, Finertie H, et al. Using Peer Support to Aid in Prevention and Treatment in Prediabetes (UPSTART): Results of a pragmatic randomized controlled trial. *Am J Prev Med.* 2023;65(2):239-250. doi:10.1016/j.amepre.2023.02.015
- 69 Nitta A, Imai S, Kajiyama S, et al. Impactort Study. *Nutrients.* 2022;14(14):2865. doi:10.3390/nu14142865
- 70 Dudzik JM, Senkus KE, Evert AB, et al. The effectiveness of medical nutrition therapy provided by a dietitian in adults with prediabetes: a systematic review and meta-analysis. *The American Journal of Clinical Nutrition.* 2023;118(5):892-910. doi:10.1016/j.ajcnut.2023.08.022
- 71 Choudhry NK, Kronish IM, Vongpatanasin W, et al. Medication adherence and blood pressure control: A scientific statement from the american heart association. *Hypertension.* 2021;79(1). doi:<https://doi.org/10.1161/hyp.000000000000203>
- 72 Parati G. Current challenges for hypertension management: From better hypertension diagnosis to improved patients' adherence and blood pressure control. *International Journal of Cardiology.* 2021;331(1):262-269. doi:<https://doi.org/10.1016/j.ijcard.2021.01.070>

Appendix IV: Citations

- 72 Parati G. Current challenges for hypertension management: From better hypertension diagnosis to improved patients' adherence and blood pressure control. *International Journal of Cardiology*. 2021;331(1):262-269. doi:<https://doi.org/10.1016/j.ijcard.2021.01.070>
- 73 Shah MK, Wyatt LC, Gibbs-Tewary C, Zanowiak JM, Mammen S, Islam N. A Culturally Adapted, Telehealth, Community Health Worker Intervention on Blood Pressure Control among South Asian Immigrants with Type II Diabetes: Results from the DREAM Atlanta Intervention. *Journal of General Internal Medicine*. Published online October 16, 2023. doi:<https://doi.org/10.1007/s11606-023-08443-6>
- 74 Paczkowska A, Hoffmann K, Kus K, et al. Impact of patient knowledge on hypertension treatment adherence and efficacy: A single-centre study in Poland. *International Journal of Medical Sciences*. 2021;18(3):852-860. doi:<https://doi.org/10.7150/ijms.48139>
- 75 Eck C. Efficacy of Hypertension Self-Management Classes Among Patients at a Federally Qualified Health Center. *Preventing Chronic Disease*. 2021;18. doi:<https://doi.org/10.5888/pcd18.200628>
- 76 Elliott MN, Adams JL, Klein DJ, et al. Patient-Reported Care Coordination is Associated with Better Performance on Clinical Care Measures. *J GEN INTERN MED*. 2021;36(12):3665-3671. doi:10.1007/s11606-021-07122-8
- 77 Persell SD, Petito LC, Anthony L, et al. Prospective Cohort Study of Remote Patient Monitoring with and without Care Coordination for Hypertension in Primary Care. *Applied Clinical Informatics*. 2023;14:428-438. doi:10.1055/a-2057-7277
- 78 Galic A, Tyranska-Fobke A, Kuich A, Zapasnik A, Robakowska M. Analysis of the Effectiveness of Coordinated Care in the Management of Pharmacotherapy of Patients with Hypertension and Comorbidities in Primary Care—Preliminary Reports. *Healthcare*. 2024;12(11):1146. doi:10.3390/healthcare12111146
- 79 Balcázar H, Alvarado M, Cantu F, Pedregon V, Fulwood R. A promotora de salud model for addressing cardiovascular disease risk factors in the US-Mexico border region. *Prev Chronic Dis*. 2009;6(1):A02.
- 80 Mills KT, Obst KM, Shen W, et al. Comparative Effectiveness of Implementation Strategies for Blood Pressure Control in Hypertensive Patients: A Systematic Review and Meta-analysis. *Ann Intern Med*. 2018;168(2):110-120. doi:10.7326/M17-1805
- 81 Abdalla M, Bolen SD, Brettler J, et al. Implementation Strategies to Improve Blood Pressure Control in the United States: A Scientific Statement From the American Heart Association and American Medical Association. *Hypertension*. 2023;80(10). doi:10.1161/HYP.000000000000232
- 82 *Journal of Hypertension*. Accessed March 19, 2025. https://journals.lww.com/jhypertension/abstract/2019/02000/supporting_self_management_for_people_with.4.aspx
- 83 Meng F, Jiang Y, Yu P, et al. Effect of health coaching on blood pressure control and behavioral modification among patients with hypertension: A systematic review and meta-analysis of randomized controlled trials. *Int J Nurs Stud*. 2023;138:104406. doi:10.1016/j.ijnurstu.2022.104406
- 84 Patel S, Jacobus-Kantor L, Marshall L, et al. Mobilizing Your Medications: An Automated Medication Reminder Application for Mobile Phones and Hypertension Medication Adherence in a High-Risk Urban Population. *J Diabetes Sci Technol*. 2013;7(3):630-639.
- 85 Traube DE, Cederbaum JA, Taylor A, Naish L, Rau A. Telehealth Training and Provider Experience of Delivering Behavioral Health Services. *The Journal of Behavioral Health Services & Research*. 2020;48(1):93-102. doi:<https://doi.org/10.1007/s11414-020-09718-0>
- 86 OUP accepted manuscript. *Health and Social Work*. Published online 2021. doi:<https://doi.org/10.1093/hsw/hlab036>
- 87 Appleton R, Barnett P, Vera San Juan N, et al. Implementation strategies for telemental health: a systematic review. *BMC Health Services Research*. 2023;23(1):78. doi:10.1186/s12913-022-08993-1
- 88 Fleddermann K, Chwastiak L, Fortier A, et al. Levels of Telehealth Use, Perceived Usefulness, and Ease of Use in Behavioral Healthcare Organizations After the COVID-19 Pandemic. *J Behav Health Serv Res*. 2025;52(1):48-63. doi:10.1007/s11414-024-09902-6
- 89 Jones VC, Spin P, Connor K, Cheng TL, Johnson SB. Are “No” and “No Thanks” the Same for School-based Health Center Enrollment?. *Health Behavior and Policy Review*. 2019;6(1):101-106. doi:<https://doi.org/10.14485/hbpr.6.1.9>
- 90 Kohm A, Rich. *Sustaining School Based Health Centers.*; 2019. https://www.chapinhall.org/wp-content/uploads/SBHC_Brief.pdf
- 91 Katz E. *Realizing the Potential of School-Based Health Centers: A Research Brief and Implementation Guide.*; 2020. <https://nysbha.org/wp-content/uploads/2020/10/Harvard-sbhc-briefs.pdf>
- 92 Thomas KE. *Qualitative Case Study Analysis: Increasing the Utilization Services for a School-Based Health Center From the Perspective of Teachers and School Administrators.* Ohiolink.edu. Published 2024. Accessed January 7, 2026. https://etd.ohiolink.edu/acprod/odb_etd/etd/r/1501/10?clear=10&p10_accession_num=dayton1713730224780588
- 93 Sprigg SM, Wolgin F, Chubinski J, Keller K. School-Based Health Centers: A Funder's View Of Effective Grant Making. *Health Aff (Millwood)*. 2017;36(4):768-772. doi:10.1377/hlthaff.2016.1234
- 94 Cutuli JJ. School-based health centers as a context to engage and serve communities. *Current Opinion in Pediatrics*. 2022;34(1):14. doi:10.1097/MOP.0000000000001086
- 95 Johnson V, Ellis RS, Hutcherson V. Evaluating a Strategy for Implementation and Sustainability of School-Based Health Centers in 3 Disparate Communities. *J Sch Health*. 2020;90(4):286-294. doi:10.1111/josh.12875

Appendix IV: Citations

- 95 Johnson V, Ellis RS, Hutcherson V. Evaluating a Strategy for Implementation and Sustainability of School-Based Health Centers in 3 Disparate Communities. *J Sch Health*. 2020;90(4):286-294. doi:10.1111/josh.12875
- 96 Why the Lack of Diverse Physicians Matters – Third Way. www.thirdway.org. <https://www.thirdway.org/blog/why-the-lack-of-diverse-physicians-matters>
- 97 Rosen AK, Beilstein-Wedel E, Shwartz M, Davila H, Gurewich D. Racial and Ethnic and Rural Variations in Access to Primary Care for Veterans Following the MISSION Act. *JAMA Health Forum*. 2024;5(6):e241568. doi:<https://doi.org/10.1001/jamahealthforum.2024.1568>
- 98 Swami M, Scott A. Impact of rural workforce incentives on access to GP services in underserved areas: Evidence from a natural experiment. *Social Science & Medicine*. 2021;281:114045. doi:<https://doi.org/10.1016/j.socscimed.2021.114045>
- 99 Yee CA, Barr K, Minegishi T, Frakt A, Pizer SD. Provider supply and access to primary care. *Health Economics*. 2022;31(7):1296-1316. doi:<https://doi.org/10.1002/hec.4482>
- 100 Oakman T, Smith-Ramakrishnan V. Physician Burnout Will Burn All of Us. The Century Foundation. Published October 25, 2023. <https://tcf.org/content/report/physician-burnout-will-burn-all-of-us/>
- 101 Incredible (Terrible) Shrinking Physician Supply. [Pnhp.org](http://pnhp.org). Published 2025. Accessed January 7, 2026. <https://pnhp.org/news/incredible-terrible-shrinking-physician-supply/>
- 102 Razai MS, Kooner P, Majeed A. Strategies and interventions to improve healthcare professionals' well-being and reduce burnout. *Journal of Primary Care & Community Health*. 2023;14(1). doi:<https://doi.org/10.1177/21501319231178641>
- 103 Helper S, Noonan R, Nicholson JR, Langdon D. The Benefits and Costs of Apprenticeships: A Business Perspective. US Department of Commerce; 2016. <https://eric.ed.gov/?id=ED572260>
- 104 Smith LB, Yang Z, Golberstein E, Huckfeldt P, Mehrotra A, Neprash HT. The effect of a public transportation expansion on no-show appointments. *Health Services Research*. 2021;57(3). doi:<https://doi.org/10.1111/1475-6773.13899>
- 105 Nwagbara UI, Hlongwana KW, Chima SC. Mapping evidence on the factors contributing to long waiting times and interventions to reduce waiting times within primary health care facilities in South Africa: A scoping review. *PLoS ONE*. 2024;19(8):e0299253-e0299253. doi:<https://doi.org/10.1371/journal.pone.0299253>
- 106 Natale-Pereira A, Enard KR, Nevarez L, Jones LA. The Role of Patient Navigators in Eliminating Health Disparities. *Cancer*. 2011;117(15 0):3543-3552. doi:10.1002/cncr.26264
- 107 Ercia A, Le N, Wu R. Health insurance enrollment strategies during the Affordable Care Act (ACA): a scoping review on what worked and for whom. *Archives of Public Health*. 2021;79(1):129. doi:10.1186/s13690-021-00645-w
- 108 Jia L, Yuan B, Huang F, Lu Y, Garner P, Meng Q. Strategies for expanding health insurance coverage in vulnerable populations. *Cochrane Database Syst Rev*. 2014;2014(11):CD008194. doi:10.1002/14651858.CD008194.pub3
- 109 Meng Q, Yuan B, Jia L, et al. Expanding health insurance coverage in vulnerable groups: a systematic review of options. *Health Policy and Planning*. 2011;26(2):93-104. doi:10.1093/heapol/czq038
- 110 Politi MC, Kaphingst KA, Liu J, et al. A Randomized Trial Examining Three Strategies for Supporting Health Insurance Decisions among the Uninsured. Published online October 1, 2016. doi:<https://doi.org/10.1177/0272989x15578635>
- 111 How To Boost Health Insurance Enrollment: Three Practical Steps That Merit Bipartisan Support. Forefront Group. Published online August 17, 2020. doi:<https://doi.org/10.1377/forefront.20200814.107187>
- 112 Smith C. The power of plain language in health care marketing. | Aquent. Aquent. Published October 31, 2024. Accessed January 7, 2026. <https://aquentalent.com/blog/the-power-of-plain-language-in-health-care-marketing>
- 113 Kakar R, Combs RM, Hoepf Young M, Ali N, Muvuka B. Health Insurance Literacy Perceptions and the Needs of a Working-Class Community. *HLRP: Health Literacy Research and Practice*. 2022;6(2). doi:<https://doi.org/10.3928/24748307-20220309-01>
- 114 Gravett MG, Menon R, Tribe RM, et al. Assessment of current biomarkers and interventions to identify and treat women at risk of preterm birth. *Front Med*. 2024;11. doi:10.3389/fmed.2024.1414428
- 115 Branch DW, VanBuren JM, Porter TF, et al. Prediction and Prevention of Preterm Birth: A Prospective, Randomized Intervention Trial. *American Journal of Perinatology*. 2021;40(10):1071-1080. doi:<https://doi.org/10.1055/s-0041-1732339>
- 116 Lisa Be Shields, Weymouth C, Bramer KL, et al. Risk assessment of preterm birth through identification and stratification of pregnancies using a real-time scoring algorithm. *Sage Open Medicine*. 2021;9:205031212098672-205031212098672. doi:<https://doi.org/10.1177/2050312120986729>
- 117 Preventing preterm births: analysis of trends and potential reductions with interventions in 39 countries with very high human development index. *The Lancet*. 2013;381(9862):223-234. doi:[https://doi.org/10.1016/S0140-6736\(12\)61856-X](https://doi.org/10.1016/S0140-6736(12)61856-X)
- 118 Cunningham SD, Lewis JB, Shebl FM, et al. Group Prenatal Care Reduces Risk of Preterm Birth and Low Birth Weight: A Matched Cohort Study. *Journal of Women's Health*. 2019;28(1):17-22. doi:<https://doi.org/10.1089/jwh.2017.6817>
- 119 Zhu K, Shelton J, Li C, et al. Association between maternal cigarette smoking cessation and risk of preterm birth in Western New York. *Paediatric and Perinatal Epidemiology*. 2024;38(4):316-326. doi:<https://doi.org/10.1111/ppe.13075>

Appendix IV: Citations

- 120 Delcroix MH, Delcroix-Gomez C, Marquet P, Gauthier T, Thomas D, Aubard Y. Active or passive maternal smoking increases the risk of low birth weight or preterm delivery: Benefits of cessation and tobacco control policies. *Tobacco Induced Diseases*. 2023;21(72). doi:<https://doi.org/10.18332/tid/156854>
- 121 Klebanoff MA, Wilkins DG, Keim SA. Marijuana Use during Pregnancy and Preterm Birth: A Prospective Cohort Study. *American Journal of Perinatology*. 2020;38(S 01):e146-e154. doi:<https://doi.org/10.1055/s-0040-1708802>
- 122 Baía I, Domingues RMSM. The effects of cannabis use during pregnancy on low birth weight and preterm birth: a systematic review and meta-analysis. *American Journal of Perinatology*. Published online July 28, 2022. doi:<https://doi.org/10.1055/a-1911-3326>
- 123 Ragsdale AS, Noor Al-Hammadi, Loux TM, Bass S, Keller JM, Chavan NR. Perinatal substance use disorder: examining the impact on adverse pregnancy outcomes. *European journal of obstetrics & gynecology and reproductive biology X*. 2024;22:100308-100308. doi:<https://doi.org/10.1016/j.eurox.2024.100308>
- 124 DeJong KN, Choby B, Valent AM. IX Strategies for Prevention or Treatment of Tobacco and Cannabis Use Disorder. *Clinical Obstetrics & Gynecology*. 2022; Publish Ahead of Print. doi:<https://doi.org/10.1097/grf.0000000000000688>
- 125 McConnell MA, Rokicki S, Ayers S, et al. Effect of an Intensive Nurse Home Visiting Program on Adverse Birth Outcomes in a Medicaid-Eligible Population: A Randomized Clinical Trial. *JAMA*. 2022;328(1):27-37. doi:10.1001/jama.2022.9703
- 126 Goyal NK, Hall ES, Meinzen-Derr JK, et al. Dosage Effect of Prenatal Home Visiting on Pregnancy Outcomes in At-Risk, First-Time Mothers. *Pediatrics*. 2013;132(Suppl 2):S118-S125. doi:10.1542/peds.2013-1021J
- 127 Moniz MH, Low LK, Stout MJ. Intensive Nurse Home Visiting Program and Adverse Birth Outcomes. *JAMA*. 2022;328(1):23-24. doi:<https://doi.org/10.1001/jama.2022.9162>
- 128 Cristian Meghea, Raffo JE, X Y, et al. Community Health Worker Home Visiting, Birth Outcomes, Maternal Care, and Disparities Among Birthing Individuals With Medicaid Insurance. *JAMA Pediatrics*. 2023;177(9):939-939. doi:<https://doi.org/10.1001/jamapediatrics.2023.2310>
- 129 The Effects of Home Visiting on Prenatal Health, Birth Outcomes, and Health Care Use in the First Year of Life: Final Implementation and Impact Findings from the Mother and Infant Home Visiting Program Evaluation-Strong Start. *Acf.gov*. Published September 22, 2024. <https://acf.gov/opre/report/effects-home-visiting-prenatal-health-birth-outcomes-and-health-care-use-first-year>
- 130 Shapiro-Mendoza CK. CDC Grand Rounds: Public Health Strategies to Prevent Preterm Birth. *MMWR Morb Mortal Wkly Rep*. 2016;65. doi:10.15585/mmwr.mm6532a4
- 131 Medley N, Vogel JP, Care A, Alfirevic Z. Interventions during pregnancy to prevent preterm birth: an overview of Cochrane systematic reviews. *Cochrane Database of Systematic Reviews*. 2018;(11). doi:10.1002/14651858.CD012505.pub2
- 132 USPSTF. Recommendation | United States Preventive Services Taskforce. www.uspreventiveservicestaskforce.org. Published 2021. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions>
- 133 ACOG Releases New Recommendations Cannabis Use Pregnancy Lactation. *Acog.org*. Published 2025. <https://www.acog.org/news/news-releases/2025/09/acog-releases-new-recommendations-cannabis-use-pregnancy-lactation>
- 134 Kim HJ, Min KB, Jung YJ, Min JY. Disparities in infant mortality by payment source for delivery in the United States. *Preventive Medicine*. 2021;145:106361. doi:10.1016/j.ypmed.2020.106361
- 135 Morriss Jr. FH. Increased Risk of Death among Uninsured Neonates. *Health Services Research*. 2013;48(4):1232-1255. doi:10.1111/1475-6773.12042
- 136 Brown Speights JS, Goldfarb SS, Wells BA, Beitsch L, Levine RS, Rust G. State-Level Progress in Reducing the Black–White Infant Mortality Gap, United States, 1999–2013. *Am J Public Health*. 2017;107(5):775-782. doi:10.2105/AJPH.2017.303689
- 137 Hone T, Gonçalves J, Seferidi P, et al. Progress towards universal health coverage and inequalities in infant mortality: an analysis of 4.1 million births from 60 low-income and middle-income countries between 2000 and 2019. *The Lancet Global Health*. 2024;12(5):e744-e755. doi:10.1016/S2214-109X(24)00040-8
- 138 Thomas MP, Ammann G, Brazier E, Noyes P, Maybank A. Doula Services Within a Healthy Start Program: Increasing Access for an Underserved Population. *Matern Child Health J*. 2017;21(Suppl 1):59-64. doi:10.1007/s10995-017-2402-0
- 139 Sobczak A, Taylor L, Solomon S, et al. The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review. *Cureus*. 15(5):e39451. doi:10.7759/cureus.39451
- 140 Using Education to Improve Birth Outcomes in Georgia. *Office of Disease Prevention and Health Promotion*. Accessed March 19, 2025. <https://odphp.health.gov/news/201905/using-education-improve-birth-outcomes-georgia>
- 141 Bellazaire A, Skinner E. Preventing Infant and Maternal Mortality: State Policy Options. *National Council of State Legislatures*; 2019. Accessed March 19, 2025. <https://www.ncsl.org/health/preventing-infant-and-maternal-mortality-state-policy-options>
- 142 Healthy People 2030. Safe to Sleep. Accessed March 19, 2025. <https://odphp.health.gov/healthypeople/tools-action/browse-evidence-based-resources/safe-sleep>
- 143 Alvarado G, Schultz D, Malika N, Reed N. United States Doula Programs and Their Outcomes: A Scoping Review to Inform State-Level Policies. *Women’s Health Issues*. 2024;34(4):350-360. doi:10.1016/j.whi.2024.03.001

Appendix IV: Citations

- 144 Sobczak A, Taylor L, Solomon S, et al. The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review. *Cureus*. 15(5):e39451. doi:10.7759/cureus.39451
- 145 Caulfield LE, Bennett WL, Gross SM, et al. Maternal and Child Outcomes Associated With the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Published online 2022. Accessed March 21, 2025. <https://europepmc.org/article/nbk/nbk579797>
- 146 Brunton G, Thomas H. The effectiveness of public health strategies to reduce or prevent the incidence of low birth weight in infants born to adolescents: a systematic review. In: Database of Abstracts of Reviews of Effects (DARE): Quality-Assessed Reviews [Internet]. Centre for Reviews and Dissemination (UK); 2001. Accessed March 20, 2025. <https://www.ncbi.nlm.nih.gov/books/NBK68595/>
- 147 de Freitas Rocha AR, de Souza de Morais N, Azevedo FM, de Castro Morais D, Priore SE. Maternal food insecurity increases the risk of low birth weight babies: Systematic review and meta-analysis. *Acta Paediatr*. 2024;113(10):2180-2188. doi:10.1111/apa.17327
- 148 DiTosto JD, Holder K, Soyemi E, Beestrums M, Yee LM. Housing instability and adverse perinatal outcomes: a systematic review. *Am J Obstet Gynecol MFM*. 2021;3(6):100477. doi:10.1016/j.ajogmf.2021.100477
- 149 Stein RA, Deverakonda AN, Katz A, Schmidt EO. Emergency Contraception: Access and Challenges at Times of Uncertainty. *American Journal of Therapeutics*. 2022;29(5):e553. doi:10.1097/MJT.0000000000001560
- 150 Atkins K, Kennedy CE, Yeh PT, Narasimhan M. Over-the-counter provision of emergency contraceptive pills: a systematic review. Published online March 1, 2022. doi:10.1136/bmjopen-2021-054122
- 151 Nelson HD, Cantor A, Jungbauer RM, et al. Effectiveness and Harms of Contraceptive Counseling and Provision Interventions for Women. *Annals of Internal Medicine*. Published online May 24, 2022. doi:10.7326/M21-4380
- 152 Hale N, Dehlendorf C, Smith MG, Stapleton J, McCartt P, Khoury AJ. Contraceptive counseling, method satisfaction, and planned method continuation among women in the U.S. southeast. *Contraception*. 2024;132:110365. doi:10.1016/j.contraception.2024.110365
- 153 Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs - Healthy People 2030 | odphp.health.gov. Accessed March 19, 2025. <https://odphp.health.gov/healthypeople/tools-action/browse-evidence-based-resources/providing-quality-family-planning-services-recommendations-cdc-and-us-office-population-affairs>.
- 154 Oringanje C, Meremikwu MM, Eko H, Esu E, Meremikwu A, Ehiri JE. Interventions for preventing unintended pregnancies among adolescents. *Cochrane Database Syst Rev*. 2016;2(2):CD005215. doi:10.1002/14651858.CD005215.pub3
- 155 Multi-component interventions to prevent teen pregnancy | County Health Rankings & Roadmaps. October 31, 2023. Accessed March 19, 2025. <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/multi-component-interventions-to-prevent-teen-pregnancy>
- 156 Perinatal Depression: Preventive Interventions - Healthy People 2030 | odphp.health.gov. Accessed January 16, 2026. <https://odphp.health.gov/healthypeople/tools-action/browse-evidence-based-resources/perinatal-depression-preventive-interventions>
- 157 Depression and Suicide Risk in Adults: Screening - Healthy People 2030 | odphp.health.gov. Accessed January 16, 2026. <https://odphp.health.gov/healthypeople/tools-action/browse-evidence-based-resources/depression-and-suicide-risk-adults-screening>
- 158 General (OSG) O of the S. STRATEGIES AND ACTIONS: IMPROVING MATERNAL HEALTH AND REDUCING MATERNAL MORTALITY AND MORBIDITY. In: The Surgeon General's Call to Action to Improve Maternal Health [Internet]. US Department of Health and Human Services; 2020. Accessed January 16, 2026. <https://www.ncbi.nlm.nih.gov/books/NBK568218/>
- 159 CDC. Preventing Pregnancy-Related Deaths. *Maternal Mortality Prevention*. May 21, 2025. Accessed January 16, 2026. <https://www.cdc.gov/maternal-mortality/preventing-pregnancy-related-deaths/index.html>
- 160 Howell EA. Reducing Disparities in Severe Maternal Morbidity and Mortality. *Clin Obstet Gynecol*. 2018;61(2):387-399. doi:10.1097/GRF.0000000000000349
- 161 Caulfield LE, Bennett WL, Gross SM, et al. Discussion. In: Maternal and Child Outcomes Associated With the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) [Internet]. Agency for Healthcare Research and Quality (US); 2022. Accessed January 16, 2026. <https://www.ncbi.nlm.nih.gov/books/NBK579790/>
- 162 Dagher RK, Linares DE. A Critical Review on the Complex Interplay between Social Determinants of Health and Maternal and Infant Mortality. *Children*. 2022;9(3):394. doi:10.3390/children9030394
- 163 Screening and Referral for Social Determinants of Health: Maternity Patient and Health Care Team Perspectives | *Health Equity*. Accessed January 16, 2026. <https://www.liebertpub.com/doi/full/10.1089/heap.2022.0020>
- 164 Vogel JP, Nguyen PY, Ramson J, et al. Effectiveness of care bundles for prevention and treatment of postpartum hemorrhage: a systematic review. *American Journal of Obstetrics and Gynecology*. 2024;231(1):67-91. doi:10.1016/j.ajog.2024.01.012
- 165 Chang OH, Levy B, Lytle H, et al. Implementation of the Alliance for Innovation on Maternal Health Program to Reduce Maternal Mortality in Malawi. *Obstetrics & Gynecology*. 2019;133(3):507. doi:10.1097/AOG.0000000000003108

Appendix IV: Citations

- 166 Marton J, Smith JC, Heberlein EC, Laboy A, Britt J, Crockett AH. Group Prenatal Care and Emergency Room Utilization. *Med Care Res Rev.* 2022;79(5):687-700. doi:10.1177/10775587211059938
- 167 Martens N, Crone MR, Hindori-Mohangoo A, et al. Group Care in the first 1000 days: implementation and process evaluation of contextually adapted antenatal and postnatal group care targeting diverse vulnerable populations in high-, middle- and low-resource settings. *Implement Sci Commun.* 2022;3:125. doi:10.1186/s43058-022-00370-7
- 168 Falconi AM, Bromfield SG, Tang T, et al. Doula care across the maternity care continuum and impact on maternal health: Evaluation of doula programs across three states using propensity score matching. *eClinicalMedicine.* 2022;50. doi:10.1016/j.eclinm.2022.101531
- 169 Knocke K, Chappel A, Sugar S, Lew ND, Sommers BD. Doula Care and Maternal Health: An Evidence Review.
- 170 Doula Support and Pregnancy-Related Complications and Death Among Childbearing Women in the United States: A Scoping Review - Crawford - 2024 - *Journal of Midwifery & Women's Health* - Wiley Online Library. Accessed January 16, 2026. <https://onlinelibrary.wiley.com/doi/10.1111/jmwh.13543>
- 171 Alhalel J, Patterson L, Francone NO, et al. Addressing racial disparities in perinatal care for African American/Black individuals in the Chicago community health setting: a qualitative study. *BMC Pregnancy Childbirth.* 2022;22(1):771. doi:10.1186/s12884-022-05100-4
- 172 Craft-Blacksheare M, Kahn P. Midwives' and Other Perinatal Health Workers' Perceptions of the Black Maternal Mortality Crisis in the United States. *Journal of Midwifery & Women's Health.* 2023;68(1):62-70. doi:10.1111/jmwh.13433
- 173 How Implicit Bias Contributes to Racial Disparities in Maternal Morbidity and Mortality in the United States | *Journal of Women's Health.* Accessed January 16, 2026. <https://www.liebertpub.com/doi/full/10.1089/jwh.2020.8874>
- 174 Mobile reproductive health clinics | County Health Rankings & Roadmaps. www.countyhealthrankings.org. Published June 12, 2018. <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/mobile-reproductive-health-clinics>
- 175 Wu KK, Lopez C, Nichols M. Virtual Visits in Prenatal Care: An Integrative Review. *Journal of Midwifery & Women's Health.* 2021;67(1). doi:<https://doi.org/10.1111/jmwh.13284>
- 176 Montalmant KE, Ettinger AK. The Racial Disparities in Maternal Mortality and Impact of Structural Racism and Implicit Racial Bias on Pregnant Black Women: A Review of the Literature. *J Racial and Ethnic Health Disparities.* 2024;11(6):3658-3677. doi:10.1007/s40615-023-01816-x
- 177 USPSTF. Recommended by USPSTF. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>
- 178 Office of the Surgeon. STRATEGIES AND ACTIONS: IMPROVING MATERNAL HEALTH AND REDUCING MATERNAL MORTALITY AND MORBIDITY. In: *The Surgeon General's Call to Action to Improve Maternal Health.* US Department of Health and Human Services; 2020. Accessed March 21, 2025. <https://www.ncbi.nlm.nih.gov/books/NBK568218/>
- 179 Noman S, Shahar HK, Abdul Rahman H, Ismail S, Abdulwahid Al-Jaberi M, Azzani M. The Effectiveness of Educational Interventions on Breast Cancer Screening Uptake, Knowledge, and Beliefs among Women: A Systematic Review. *International Journal of Environmental Research and Public Health.* 2021;18(1):263. doi:10.3390/ijerph18010263
- 180 Levano W, Miller JW, Leonard B, et al. Public Education and Targeted Outreach to Underserved Women Through the National Breast and Cervical Cancer Early Detection Program. *Cancer.* 2014;120(0 16):2591-2596. doi:10.1002/cncr.28819
- 181 Chan RJ, Milch VE, Crawford-Williams F, et al. Patient navigation across the cancer care continuum: An overview of systematic reviews and emerging literature. *CA: A Cancer Journal for Clinicians.* 2023;73(6):565-589. doi:10.3322/caac.21788
- 182 Healthy People 2030. Establishing Effective Patient Navigation Programs in Oncology: Proceedings of a Workshop - | odphp.health.gov. 2018. Accessed March 19, 2025. <https://odphp.health.gov/healthypeople/tools-action/browse-evidence-based-resources/establishing-effective-patient-navigation-programs-oncology-proceedings-workshop>
- 183 Breast Cancer Screening: Multicomponent | *The Community Guide.* December 17, 2025. Accessed January 20, 2026. <https://www.thecommunityguide.org/findings/cancer-screening-multicomponent-interventions-breast-cancer.html>
- 184 NCCN Guidelines for Patients: Breast Cancer Screening and Diagnosis. *Breast Cancer Screening and Diagnosis.* Published online 2025.
- 185 Nayyar S, Chakole S, Taksande AB, Prasad R, Munjewar PK, Wanjari MB. From Awareness to Action: A Review of Efforts to Reduce Disparities in Breast Cancer Screening. *Cureus.* 2023;15(6):e40674. doi:10.7759/cureus.40674
- 186 Wu CF, Highfield L, Swint JM, Lairson DR. Provider-Based HPV Vaccine Promotion Interventions: A Meta-analysis. *Pediatrics.* 2023;151(5):e2022058029. doi:10.1542/peds.2022-058029
- 187 Oh NL, Biddell CB, Rhodes BE, Brewer NT. Provider communication and HPV vaccine uptake: A meta-analysis and systematic review. *Preventive Medicine.* 2021;148:106554. doi:10.1016/j.ypmed.2021.106554
- 188 Pages - vaccines-for-children-program. Maryland.gov Enterprise Agency Template. Accessed January 20, 2026. <https://health.maryland.gov/phpa/OIDEOR/IMMUN/Pages/default.aspx>

Appendix IV: Citations

- 189 340B Drug Pricing Program | HRSA. Accessed January 20, 2026. <https://www.hrsa.gov/opa>
- 190 Vaccination: Provider Assessment/ Feedback | The Community Guide. May 14, 2025. Accessed January 20, 2026. <https://www.thecommunityguide.org/findings/vaccination-programs-provider-assessment-and-feedback.html>
- 191 Vaccination: Standing Orders | The Community Guide. May 14, 2025. Accessed January 20, 2026. <https://www.thecommunityguide.org/findings/vaccination-programs-standing-orders.html>
- 192 The Community Guide. SDOH: School-Based Health Centers. February 20, 2025. Accessed March 19, 2025. <https://www.thecommunityguide.org/findings/social-determinants-health-school-based-health-centers.html>
- 193 Hansen CE, Okoloko E, Ogunbajo A, North A, Nicolai LM. Acceptability of School-Based Health Centers for Human Papillomavirus Vaccination Visits: A Mixed-Methods Study. *J Sch Health*. 2017;87(9):705-714. doi:10.1111/josh.12540
- 194 Zhu Y, Wu CF, Giuliano AR, Fernandez ME, Ortiz AP, Cazaban CG, Li R, Deshmukh AA, Sonawane K. Tdap-HPV vaccination bundling in the USA: Trends, predictors, and implications for vaccine series completion. *Prev Med*. 2022 Nov;164:107218. doi: 10.1016/j.ypmed.2022.107218. Epub 2022 Aug 23. PMID: 36007751; PMCID: PMC9691592.
- 195 Social Media Toolkit on Cervical Health. November 22, 2022. Accessed January 20, 2026. <https://www.ashasexualhealth.org/cervical-health-toolkit/>
- 196 HPV Awareness Campaign - Cancer Control TAP. October 11, 2023. Accessed January 20, 2026. <https://cancercontroltap.org/news/hpv-awareness-campaign/>
- 197 Chan RJ, Milch VE, Crawford-Williams F, et al. Patient navigation across the cancer care continuum: An overview of systematic reviews and emerging literature. *CA: A Cancer Journal for Clinicians*. 2023;73(6):565-589. doi:10.3322/caac.21788
- 198 Fuzzell LN, Perkins RB, Christy SM, Lake PW, Vadaparampil ST. Cervical cancer screening in the United States: Challenges and potential solutions for underscreened groups. *Preventive Medicine*. 2021;144:106400. doi:10.1016/j.ypmed.2020.106400
- 199 Cervical Cancer Screening Evidence-Based Programs Listing | Evidence-Based Cancer Control Programs (EBCCP). Accessed March 19, 2025. <https://ebccp.cancercontrol.cancer.gov/topicPrograms.do?topicId=102264&choice=default>
- 200 Goldstein EV, Prater LC, Wickizer TM. Preventing Adolescent and Young Adult Suicide: Do States With Greater Mental Health Treatment Capacity Have Lower Suicide Rates? *Journal of Adolescent Health*. 2022;70(1):83-90. doi:10.1016/j.jadohealth.2021.06.020
- 201 Price JH, Khubchandani J. Firearm Suicides in the Elderly: A Narrative Review and Call for Action. *J Community Health*. 2021;46(5):1050-1058. doi:10.1007/s10900-021-00964-7
- 202 Graham LM, Embry V, Young BR, et al. Evaluations of Prevention Programs for Sexual, Dating, and Intimate Partner Violence for Boys and Men: A Systematic Review. *Trauma, Violence, & Abuse*. 2021;22(3):439-465. doi:10.1177/1524838019851158
- 203 Wong JS, Bouchard J, Lee C. The Effectiveness of College Dating Violence Prevention Programs: A Meta-Analysis. *Trauma, Violence, & Abuse*. 2023;24(2):684-701. doi:10.1177/15248380211036058
- 204 Wright EN, Anderson J, Phillips K, Miyamoto S. Help-Seeking and Barriers to Care in Intimate Partner Sexual Violence: A Systematic Review. *Trauma, Violence, & Abuse*. 2022;23(5):1510-1528. doi:10.1177/1524838021998305
- 205 Intimate Partner Violence Prevention Resource for Action. https://www.cdc.gov/violenceprevention/pdf/ipv-prevention-resource_508.pdf
- 206 Sabri B, Tharmarajah S, Njie-Carr VPS, et al. Safety Planning With Marginalized Survivors of Intimate Partner Violence: Challenges of Conducting Safety Planning Intervention Research With Marginalized Women. *Trauma, Violence, & Abuse*. 2022;23(5):1728-1751. doi:10.1177/15248380211013136
- 207 Catherine NLA, MacMillan H, Jack S, et al. Effects of nurse-home visiting on intimate partner violence and maternal income, mental health and self-efficacy by 24 months postpartum: a randomised controlled trial (British Columbia Healthy Connections Project). Published online January 1, 2025. doi:10.1136/bmjopen-2023-083147
- 208 Critical Time Intervention | CTI Model | Critical Time Intervention. Accessed January 20, 2026. <https://www.criticaltime.org/cti-model/>
- 209 Dhaliwal JS, Dang AK. Reducing Hospital Readmissions. In: *StatPearls*. StatPearls Publishing; 2025. Accessed January 20, 2026. <http://www.ncbi.nlm.nih.gov/books/NBK606114/>
- 210 Hoge MA, Vanderploeg J, Paris M, Lang JM, Olezeski C. Emergency Department Use by Children and Youth with Mental Health Conditions: A Health Equity Agenda. *Community Ment Health J*. 2022;58(7):1225-1239. doi:10.1007/s10597-022-00937-7
- 211 Burns A, Vest JR, Menachemi N, et al. Availability of behavioral health crisis care and associated changes in emergency department utilization. *Health Services Research*. 2025;60(2):e14368. doi:10.1111/1475-6773.14368
- 212 Vacher C, Ho N, Skinner A, et al. Reducing mental health emergency visits: population-level strategies from participatory modelling. *BMC Psychiatry*. 2024;24(1):627. doi:10.1186/s12888-024-06066-7
- Vakkalanka JP, Neuhaus RA, Harland KK, Clemens L, Himadi E, Lee S. Mobile Crisis Outreach and Emergency Department Utilization: A Propensity Score-matched Analysis. *West J Emerg Med*. 2021;22(5):1086-1094. doi:10.5811/westjem.2021.6.52276

Appendix IV: Citations

- 214 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care. <https://library.samhsa.gov/sites/default/files/national-guidelines-crisis-care-pep24-01-037.pdf>
- 215 Henderson JL, Chaim G, Brownlie EB. Collaborating with community-based services to promote evidence-based practice: Process description of a national initiative to improve services for youth with mental health and substance use problems. *Psychological Services*. 2017;14(3):361-372. doi:10.1037/ser0000145
- 216 Lindow JC, Hughes JL, South C, et al. The Youth Aware of Mental Health (YAM) Intervention: Impact on Help-Seeking, Mental Health Knowledge, and Stigma in US Adolescents. *J Adolesc Health*. 2020;67(1):101-107. doi:10.1016/j.jadohealth.2020.01.006
- 217 Xu Z, Huang F, Kösters M, et al. Effectiveness of interventions to promote help-seeking for mental health problems: systematic review and meta-analysis. *Psychological Medicine*. 2018;48(16):2658-2667. doi:10.1017/S0033291718001265
- 218 Walsh DAB, Foster JLH. A Call to Action. A Critical Review of Mental Health Related Anti-stigma Campaigns. *Front Public Health*. 2021;8. doi:10.3389/fpubh.2020.569539
- 219 Rodgers CRR, Flores MW, Bassey O, Augenblick JM, Cook BL. Racial/Ethnic Disparity Trends in Children's Mental Health Care Access and Expenditures From 2010 to 2017: Disparities Remain Despite Sweeping Policy Reform. *J Am Acad Child Adolesc Psychiatry*. 2022;61(7):915-925. doi:10.1016/j.jaac.2021.09.420
- 220 Lu W, Todhunter-Reid A, Mitsdarffer ML, Muñoz-Laboy M, Yoon AS, Xu L. Barriers and Facilitators for Mental Health Service Use Among Racial/Ethnic Minority Adolescents: A Systematic Review of Literature. *Front Public Health*. 2021;9. doi:10.3389/fpubh.2021.641605
- 221 Appleton R, Williams J, Juan NVS, et al. Implementation, Adoption, and Perceptions of Telemental Health During the COVID-19 Pandemic: Systematic Review. *Journal of Medical Internet Research*. 2021;23(12):e31746. doi:10.2196/31746
- 222 Mulvaney-Day N, Dean D, Miller K, Camacho-Cook J. Trends in Use of Telehealth for Behavioral Health Care During the COVID-19 Pandemic: Considerations for Payers and Employers. *Am J Health Promot*. 2022;36(7):1237-1241. doi:10.1177/08901171221112488e
- 223 CDC. CDC Data Show Improvements in Youth Mental Health but Need for Safer and More Supportive Schools. CDC Newsroom. August 19, 2025. Accessed January 20, 2026. <https://www.cdc.gov/media/releases/2024/p0806-youth-mental-health.html>
- 224 Podiya JK, Navaneetham J, Bholra P. Influences of school climate on emotional health and academic achievement of school-going adolescents in India: a systematic review. *BMC Public Health*. 2025;25(1):54. doi:10.1186/s12889-024-21268-0
- 225 Leurent B, Dodd M, Allen E, Viner R, Scott S, Bonell C. Is positive school climate associated with better adolescent mental health? Longitudinal study of young people in England. *SSM Ment Health*. 2021;1:None. doi:10.1016/j.ssmmh.2021.100033
- 226 Viswanathan M, Wallace IF, Cook Middleton J, et al. Screening for depression and suicide risk in children and adolescents: updated evidence report and systematic review for the US Preventive Services Task Force. *JAMA*. Published online October 11, 2022.
- 227 Peng Y, Hahn RA, Finnie RKC, et al. Permanent Supportive Housing with Housing First to Reduce Homelessness and Promote Health among Homeless Populations with Disability: A Community Guide Systematic Review. *J Public Health Manag Pract*. 2020;26(5):404-411. doi:10.1097/PHH.0000000000001219
- 228 Nielsen S, Scott N, Tidhar T, Quiroga M del M, Lenton S, Dietze P. The cost and impact of distributing naloxone to people who are prescribed opioids to prevent opioid-related deaths: findings from a modelling study. *Addiction*. 2022;117(4):1009-1019. doi:10.1111/add.15727
- 229 Tabatabai M, Cooper RL, Wilus DM, et al. The Effect of Naloxone Access Laws on Fatal Synthetic Opioid Overdose Fatality Rates. *Sage Journals*. Published online January 10, 2023. doi:10.1177/21501319221147246
- 230 Kennedy MC, Dong H, Tobias S, et al. Fentanyl Concentration in Drug Checking Samples and Risk of Overdose Death in Vancouver, Canada. *American Journal of Preventive Medicine*. 2024;66(1):10-17. doi:10.1016/j.amepre.2023.08.016
- 231 Swartz JA, Lieberman M, Jimenez AD, et al. Current attitudes toward drug checking services and a comparison of expected with actual drugs present in street drug samples collected from opioid users. *Harm Reduct J*. 2023;20(1):87. doi:10.1186/s12954-023-00821-x

Appendix IV: Citations

- 232 Chhatwal J, Mueller PP, Chen Q, et al. Estimated Reductions in Opioid Overdose Deaths With Sustainment of Public Health Interventions in 4 US States. *JAMA Netw Open*. 2023;6(6):e2314925. doi:10.1001/jamanetworkopen.2023.14925
- 233 Scheidell JD, Townsend TN, Zhou Q, et al. Reducing overdose deaths among persons with opioid use disorder in connecticut. *Harm Reduct J*. 2024;21(1):103. doi:10.1186/s12954-024-01026-6
- 234 Hawk KF, Vaca FE, D’Onofrio G. Reducing Fatal Opioid Overdose: Prevention, Treatment and Harm Reduction Strategies. *Yale J Biol Med*. 2015;88(3):235-245.
- 235 Alexander GC, Ballreich J, Mansour O, Dowdy DW. Effect of reductions in opioid prescribing on opioid use disorder and fatal overdose in the United States: a dynamic Markov model. *Addiction*. 2022;117(4):969-976. doi:10.1111/add.15698
- 236 Hobelmann JG, Huhn AS. Comprehensive pain management as a frontline treatment to address the opioid crisis. *Brain and Behavior*. 2021;11(11):e2369. doi:10.1002/brb3.2369
- 237 Overdose Prevention and Response Toolkit | SAMHSA Library. Accessed January 20, 2026. <https://library.samhsa.gov/product/overdose-prevention-response-toolkit/pep23-03-00-001>
- 238 Waye KM, Yedinak JL, Koziol J, Marshall BDL. Action-focused, plain language communication for overdose prevention: A qualitative analysis of Rhode Island’s overdose surveillance and information dashboard. *International Journal of Drug Policy*. 2018;62:86-93. doi:10.1016/j.drugpo.2018.08.010
- 239 Carroll J, Green T, Noonan R. Evidence-Based Strategies for Preventing Opioid Overdose: What’s Working in the United States. Centers for Disease Control and Prevention. Published online 2018.