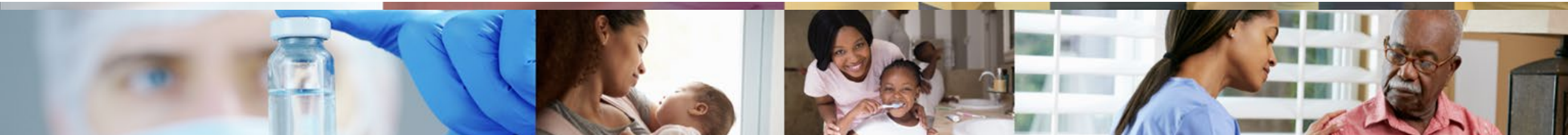
Maryland
DEPARTMENT OF HEALTH

Infectious Disease Prevention and Health Services Bureau

Flip the Script: Integrating Sexual Health

June 12, 2025



FLIP THE SCRIPT:
Integrating Sexual Health

Peter DeMartino, Director

Infectious Disease Prevention and Health Services Bureau

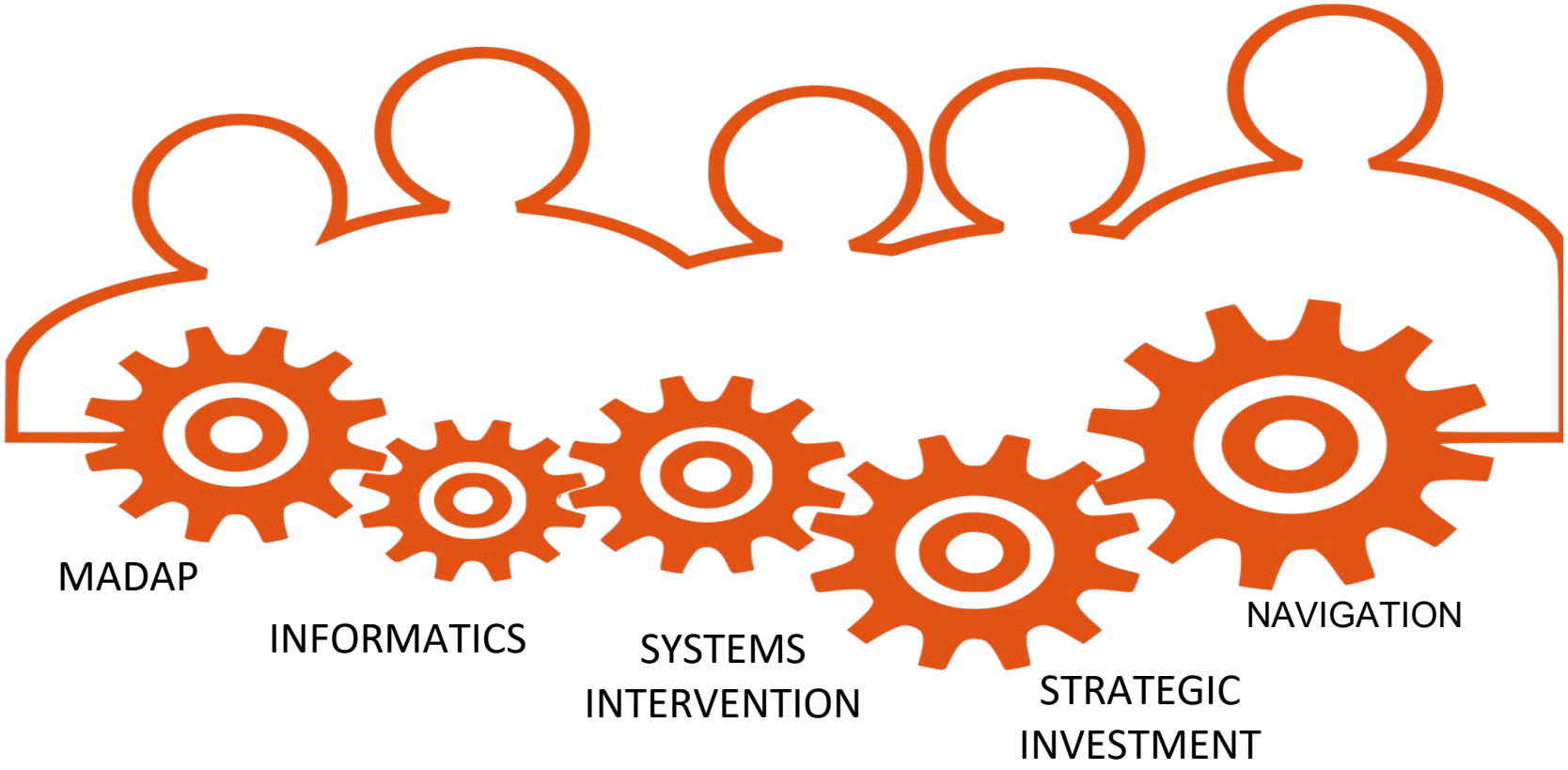
Maryland Department of Health

9:30 am

Fulfilling the MISSoN

IDPHSB Commitment Statement

Our Commitment as a Bureau is to partner with communities to achieve health equity for all Marylanders. Our priority is to advance social and racial justice, and we are committed to undoing racism within our public health systems. It is our responsibility to serve Marylanders without any bias or discrimination and ensure open access to services and resources.



HIV Diagnoses by Year, Maryland

Rate Ratios

Display Data As
Line Chart

Jurisdiction(s)
Maryland

Measure
No. HIV Diagnoses

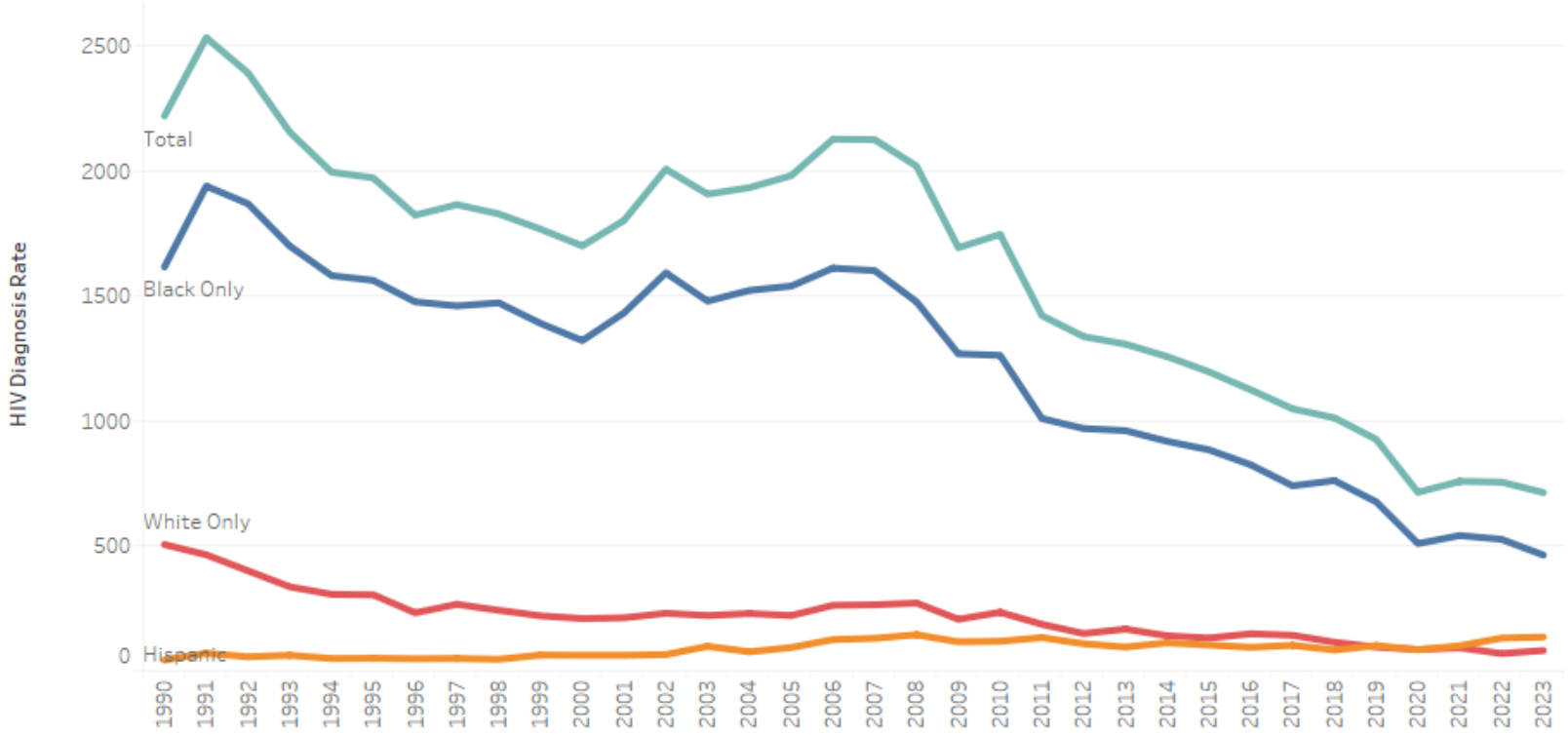
Demographic Groups
Multiple values

Year Range
1990 to 2023
and Null values

- Black Only
- Hispanic
- White Only
- Total

Data-Driven; Heart-Led

No. HIV Diagnoses, 1990 to 2023



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Integrated Plan Framework

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Integrated Plan: Key Themes

Connecting people and services - Many of the recommended goals and activities offered by community members dealt with bringing people to HIV diagnosis, treatment, prevention, and/or response services or bringing HIV diagnosis, treatment, prevention, and/or response services to people.

Education - Community members consistently advocated for better education for service consumers and their families, service providers, and the general public.

Community engagement - Community members expressed a strong desire to have more agency in their relationship with service providers, researchers, and planners so that the services, activities, and goals reflected in the 5-year integrated plan meaningfully reflect the needs and desires of affected communities.

Identifying and addressing system barriers - Ensuring legal, regulatory, and policy barriers do not hinder the effectiveness of the integrated plan and learning from best practices in overcoming these barriers was a major consideration.

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Cross-Pillar Goals

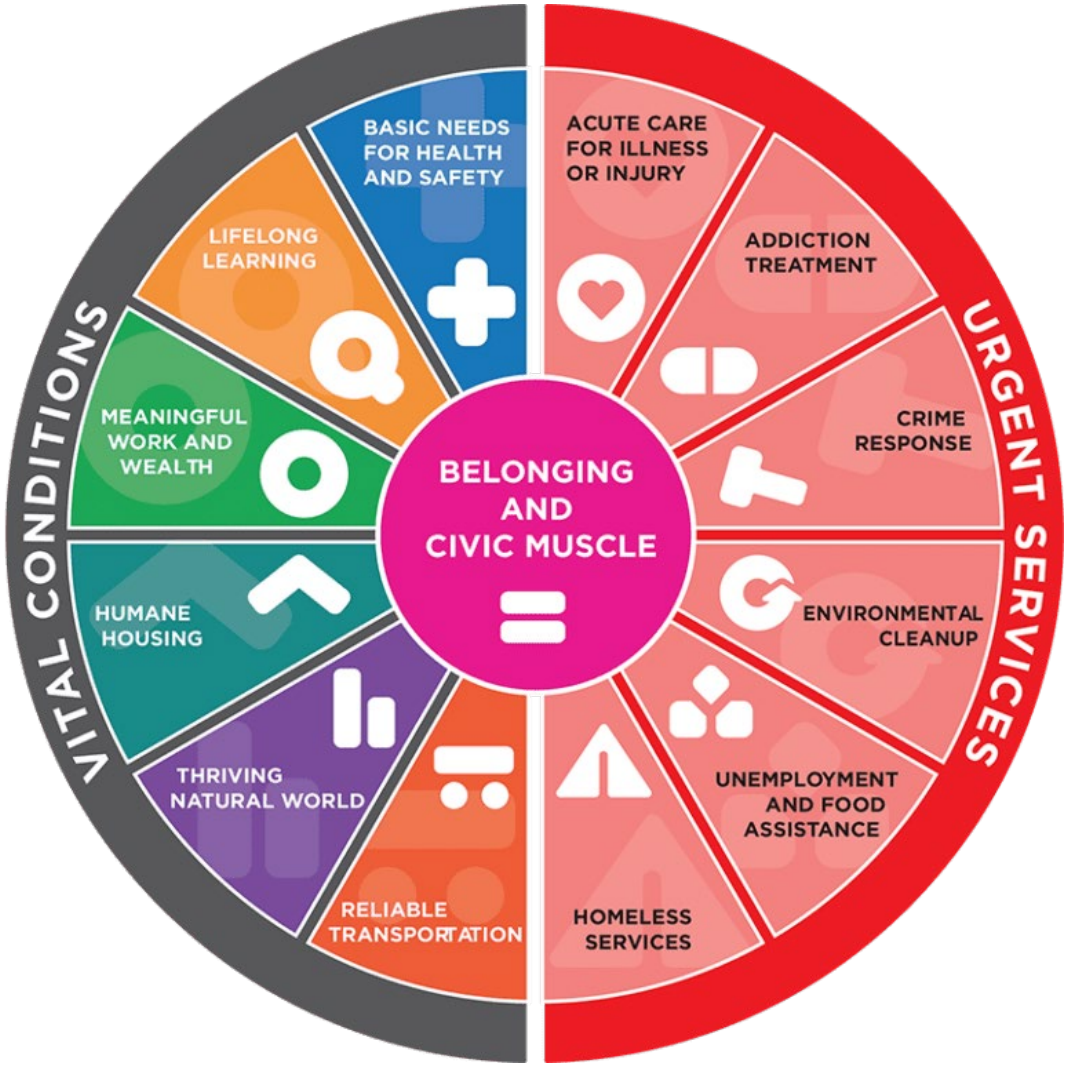
1. Increase **community awareness** and knowledge of sexual and drug user health issues, prevention strategies, testing recommendations, treatment options, and service availability
2. Increase **knowledge** among **health care and social service providers** of sexual and drug user health issues, prevention strategies, testing recommendations, treatment options, and service availability
3. Increase the **capacity** of **health care and social service providers and systems to integrate** sexual health and harm reduction services into all health care and social service settings
4. Increase **community availability and accessibility** of sexual health and harm reduction services

Cross-Pillar Goals

5. **Reduce barriers** to accessing sexual health and harm reduction services and achieving health outcomes
6. Increase the **diversity of funded** agencies and staff providing sexual health and harm reduction services
7. Increase the **capacity** of providers to provide **high-quality, equitable, culturally sensitive** sexual health and harm reduction services that meet the needs of individuals and communities disproportionately impacted by HIV in Maryland.
8. Ensure that **surveillance, evaluation, and research are community-focused** and include meaningful involvement of persons with HIV and members of impacted communities at all stages (I.e., design, data collection, analysis, reporting, utilization, and dissemination).

Operationalizing the Plan

Realigning Public Health Response



https://health.gov/our-work/national-health-initiatives/equitable-long-term-recovery-and-resilience

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Flip the Script: Integrating Sexual Health

AGENDA	June 12, 2025	
8:30 AM	**Breakfast**	
9:30 AM	**Welcome** **Peter DeMartino, Director** Infectious Disease Prevention and Health Services Bureau Maryland Department of Health	
10:00 AM - NOON	**Integrating Sexual Health: A conversation with partners who do not receive direct funding for integration of sexual health services on the work they do, their reasons for sharing in our goals, and their perspectives on how health departments can better support their work.**	
	Session	**Presenter**
10:00 AM	Community Organizing: Maryland Coalition on HIV and Aging	**Dorcas Baker, MCOHA**
10:15 AM	Academic Partners: The Center for Urban Equity	**Dr. Christopher Chauncey Watson** Center for Urban Health Equity Morgan State University
10:30 AM	Faith-Based Efforts: In His Image International Ministry	**Dr. Lisa Conners** In His Image International Ministry, Inc
10:45 AM	Filling a Niche: Private Practice	**Dr. Jamaal Hailey**
11:00 AM	Integrated Access: HealthPort	**Dimitri Cavathas, CEO,** HealthPort
11:15 AM	Building Something New: Serenity Health Center	**Dr. Raj Sonani/Pavan Ramakrishnaiah** Serenity Health Center
11:30 AM	**Conversation with presenters**	
12:00 PM	**Lunch**	
12:30 PM	Public Private Partnerships	**Angelique Griffin** Gilead Sciences, Government Affairs
1:00 PM - 3:00 PM	**Bureau Realignment Updates**	
1:30 PM	Case Statement Overview	**Aaron Davis, Division Manager** Community Mobilization
2:00 PM	HPG Transition	**Peter DeMartino**
2:30 PM	**Wrap Up**	

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FLIP THE SCRIPT:
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Integrating Sexual Health: A conversation with partners who do not receive direct funding for integration of sexual health services on the work they do, their reasons for sharing in our goals, and their perspectives on how health departments can better support their work.

10:00 am - Noon

FLIP THE SCRIPT:
Integrating Sexual Health

Dorcas Baker, MCOHA

10:00 am

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Maryland Coalition on HIV and Aging (MCOHA)

Vision

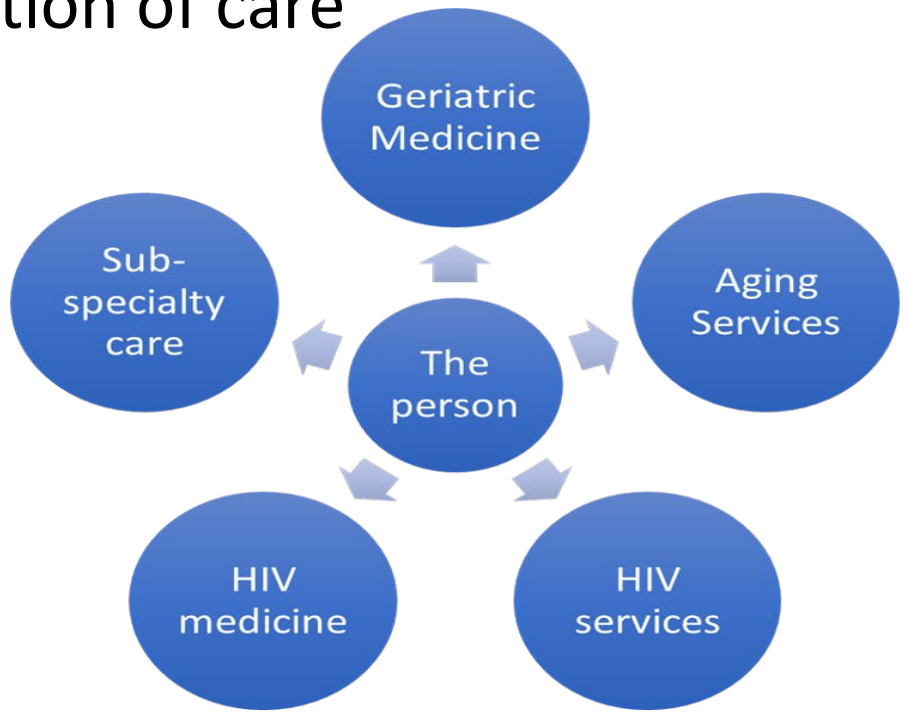
*to improve the quality of life and overall health outcomes for persons aging and thriving with HIV

Mission

*to identify, address, and advocate for the emerging and long-standing needs of persons who are aging with HIV

Our Beginning

- Started as the HIV and Aging Long Term Care Workgroup in 2018
- Reached out to service providers in HIV care on all levels initially to discuss integration of care



Where Are We Now?
Creating a net that works

- Expanded our reach to Aging services and resources
  - Maryland Dept. on Aging and Baltimore County Dept. of Aging, Baltimore City Division of Aging and CARE Services
- Continuing to expand our reach to include community based organizations in and outside of Maryland
  - The Reunion Project
- Maryland HIV and Aging Summit
  - MCOHA members volunteered in Longevity Ready Maryland Dept. of Aging workgroups (very challenging)
- HIV and Aging Policy
  - Decriminalization Act in Maryland repealed (representation from MCOHA), now called the Carlton R. Smith Act effective October 1st

Where Are We Now? Cont'd

- Sexual health still matters
  - Need to educate primary care providers how to include sexual health as a discussion during routine visit
  - Older adults still diagnosed late
  - PEP and PrEP still an option

Where Are We Going?

- **Adapting our practices to include aging assessments in HIV and primary care settings using the 5M's of Geriatrics (NO FUNDING)**

- Partnering with the HIV and Aging Task Force: a standing work group of the Greater Baltimore HIV Health Services Planning Council

Where Are We Going cont'd

Age Friendly Public Health 6Cs Framework

- **Creating and leading policy change** through awareness and advocacy
- **Connecting and convening** multiple sectors to identify language barriers and opportunities for collaboration
- **Coordinating** existing supports to identify gaps and increase access to services
- **Collecting and analyzing data to develop needed interventions**
- **Communicating** research findings and best practices (including care coordination models)
- **Complementing** and supplementing existing supports and services
  - https://www.tfah.org/initiatives/age-friendly-public-health/

Dorcas Baker, RN, BSN, ACRN, CDP
Regional Coordinator
JHU Partner Mid Atlantic AETC
Center for Infectious Disease and Nursing Innovation
Johns Hopkins University
School of Nursing
dbaker4@jhu.edu

FLIP THE SCRIPT:
Integrating Sexual Health

Dr. Christopher Chauncey Watson

Center for Urban Health Equity

Morgan State University

10:15 am

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FLIP THE SCRIPT:
Integrating Sexual Health

Dr. Lisa Connors

In His Image International Ministry, Inc.

10:30 am

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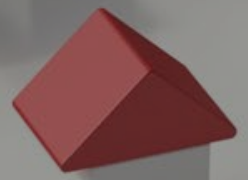
RESTORE in Our Community



Flip the Script: Integrating Sexual Health

Presented by Dr. Lisa Connors, LCPC, LPC, NCC, MAC

June 12, 2025

In His Image international Ministry, Inc.

What We Do: Ministry in Action

Education

Coaching

Counseling

Outreach

Spiritual Support

Whole-Person Health

Our Reality: What We See

Unhoused and Poverty

Issues of MH, Addiction, Suicide

Employment Issues [reentry]

Loss & Grief

……Failed & Flawed Systems

How We Do Our Work

- Radical Hospitality
- Reaching In and Out
- Restoration
- Reconciliation

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How State and Local Health Departments Can Partner With Us

Faith communities are trusted, present, and powerful. With the right support, we can amplify your public health efforts:

- **Respect and Fund Faith-Based Models:**
  Recognize our capacity to reach marginalized populations with compassion and credibility.
- **Offer Training and Resources:**
  Equip clergy and lay leaders with accurate, stigma-free information on HIV, STIs, and viral hepatitis.
- **Integrate Faith Partners Into Planning:**
  Invite us to planning tables — we are your allies in prevention, treatment, and care.
- **Support Mental Health & Grief Ministries:**
  Help us strengthen our response to trauma, addiction, and spiritual distress in tandem with clinical care.
- **Reduce Bureaucratic Barriers:**
  Simplify contracts and applications for grassroots and faith-based organizations that may not have large administrative teams.

RESTORE…

A Faith-Based Approach to Health, Healing, and Wholeness

R – Reconcile people to God, to themselves, and to one another
E – Educate with truth and compassion
S – Serve the most vulnerable
T – Treat the whole person
O – Offer Hope without judgment
R – Restore Dignity through relationship and support
E – Engage Communities in healing work


Questions?

FLIP THE SCRIPT:
Integrating Sexual Health

Dimitrios Cavathas, LCSW-C

CEO

HealthPort

11:00 am

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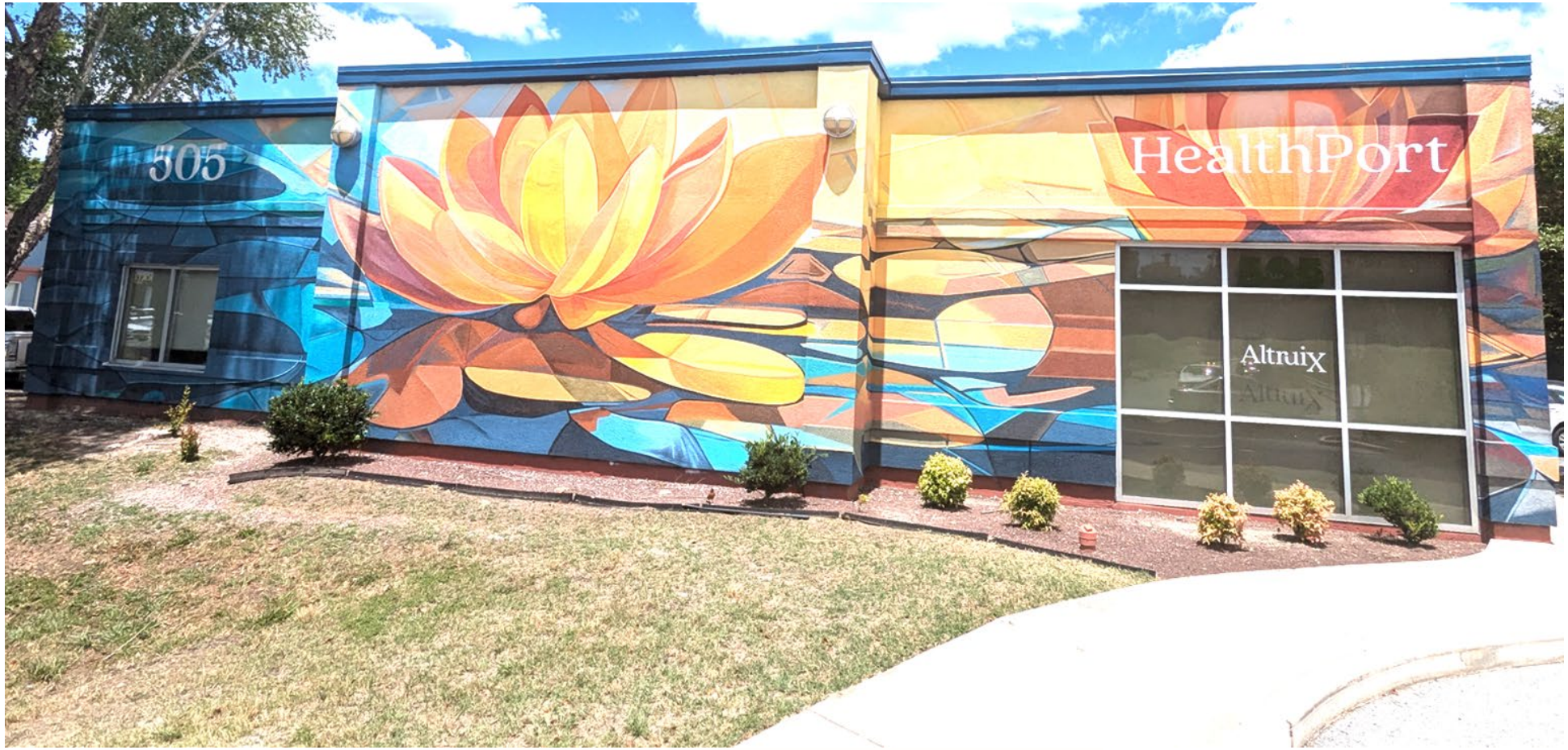


HealthPort

The Social Determinants of Health Model of Care

Flip the Script: Integrating Sexual Health Conference 6-12-2025

HealthPort is a Certified Community Behavioral Health Clinic, a $22 million rural safety net health and housing provider with 193 staff

Our target population includes those with behavioral health issues and citizens impacted by the social determinants of health as a result of poverty, disability & trauma

Accredited by the Commission on Accreditation of Rehabilitation Facilities

Integrated Outpatient Mental Health and Addictions Health Clinic with Same Day Access

Integrated Primary Care Practice with On Site Pharmacy, Population Health Services, and In the Field Lab Draws

Supported Employment & Psychosocial & Residential Rehabilitation Programs and Community Integration & Housing

Assertive Community Treatment with Integrated Mobile Primary Care Practitioner

Weekend Team Provides Support & Services, Crisis Stabilization & On Call Response Team, & Residential Crisis Beds

Ownership of 58 properties: 32 permanent supportive housing lease properties and 105 supervised opportunities in the community.

Two HUD properties with an additional 30 housing opportunities for seniors.

SDOH Research with the University of Maryland School of Social Work

SDOH Interventions Include 83 Vehicles for Staff, Housing First Approach, and Food Is Medicine Program

HP2030
HEALTHY PEOPLE 2030
CHAMPION

OASH | Office of Disease Prevention and Health Promotion

#HP2030

SAMHSA

Substance Abuse and Mental Health Services Administration

CCBHCs Provide Nine Core Services Directly or Through Formal Partnerships

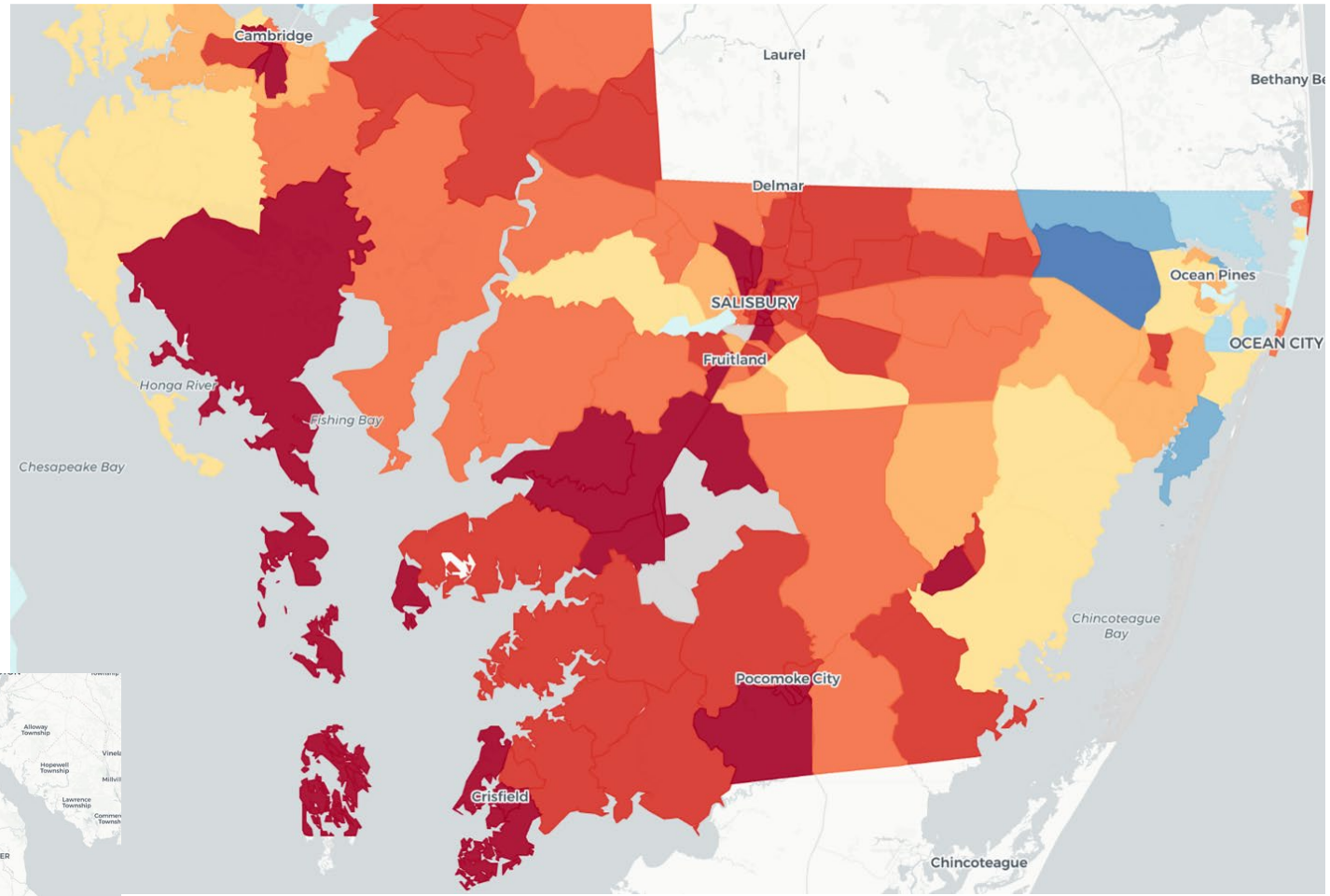
- Crisis Services
- Outpatient Mental Health & Substance Use Services
- Screening, Diagnosis & Risk Assessment
- Person- & Family-Centered Treatment Planning
- Psychiatric Rehabilitation Services
- Community-Based Mental Health Care for Veterans
- Outpatient Primary Care Screening & Monitoring
- Peer, Family Support & Counselor Services
- Targeted Case Management

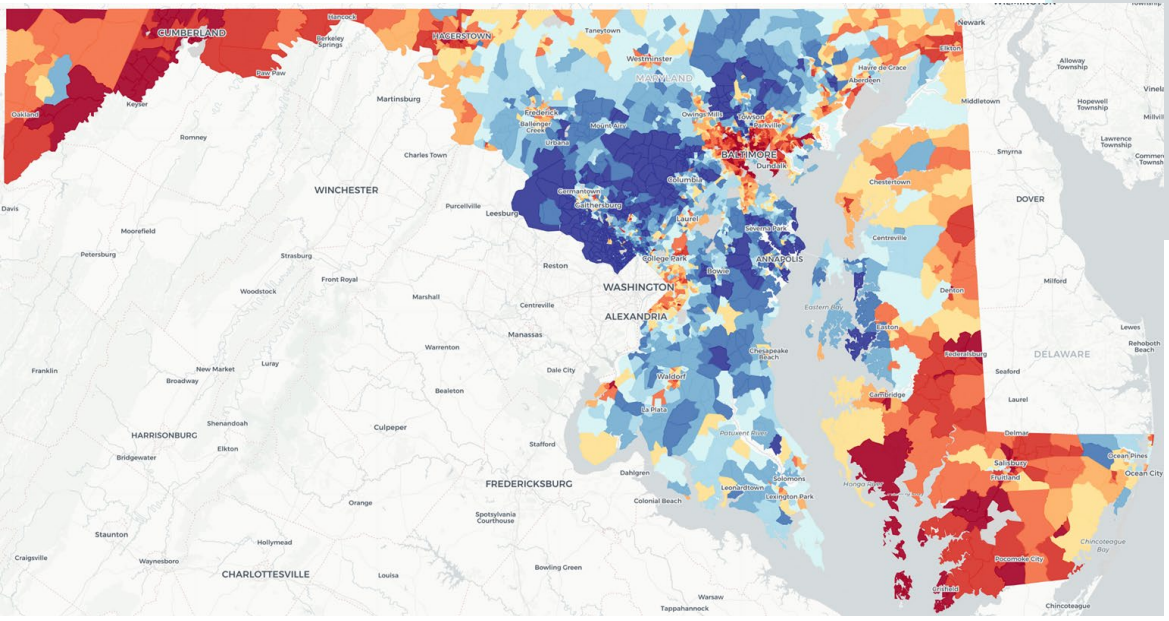
Why This Approach is So Important: Area Deprivation Index (ADI)

ADI scores from within this state alone are ranked from lowest to highest, then divided into deciles (1–10).

least disadvantaged block groups – most disadvantaged block groups

1 2 3 4 5 6 7 8 9 10





Represents rankings of neighborhoods by socioeconomic disadvantage which includes factors for the theoretical domains of income, education, employment, and housing quality. It can be used to inform health delivery and policy, especially for the most disadvantaged neighborhood groups.

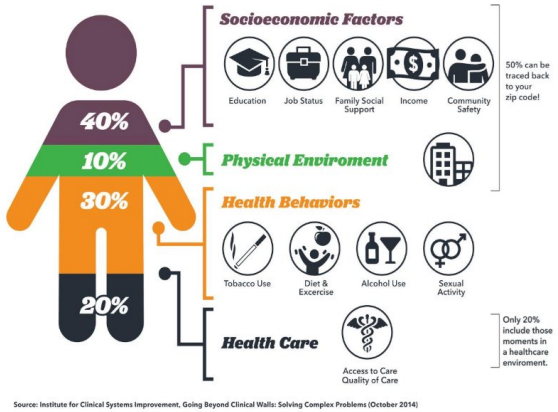
The HealthPort Integrated Model

People

Distance

Social Determinants of Health - Rural

-Higher poverty
-Higher rates of trauma
-Lower levels of education
-Fewer jobs available
-Less infrastructure
-Fewer Hospitals
-Higher levels of uninsured people
-Higher rates of smoking, dangerous drinking behaviors and children born into single parent homes



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

The 13 Dimensions of the SDOH EBP	Housing
Mental Health Care	Primary Care
Adherence to Medications	Substance Use Care
Employment / Education	Populations Health Management
Transportation	Financial Management/Income
Psychiatric Nutrition / Food Security	Community Integration
Access to Flexible Funding	Crisis Stabilization

Clinic Has an Integrated Outpatient Primary Care and Behavioral Health Care Provision with an Onsite Pharmacy, Bidirectional Medicated Assisted Treatment, and Direct Lab Work Capture with Population Health Home Services and Care Coordination with Same Day Access

Integration of 14 Full Time Registered Nurses in Assertive Community Treatment (ACT) Teams and Psychosocial Rehabilitation & Residential Programs (PRP) Directly Connected with the Integrated Clinic. This includes a full time dedicated Primary Care Nurse Practitioner for ACT

Food Is Medicine Integration with ACT and PRP Provided by Food Service in a Commercial Kitchen and Food Delivery Driver

Fleet of 83 Vehicles to Provide Transportation to Any and All Desired Appointments and Destinations to Serve the Social Determinants of Health (SDOH). Weekend Team on Friday, Saturday, & Sunday Provide Supports & Social Activities

The Use of over 100 Medherent Machines and Additional 500 Medication Packaged Services to Monitor Adherence to Medication and Reduce Medication Errors

Supervised and Permanent Supportive Housing Network Supporting Over 200 Persons in the Community backed up by an 8 Bed Residential Crisis Bed Program & 24 hours crisis response program.

The Problem With Medication Management

(1) up to 60% of individuals with SMI do not take their psychiatric or somatic medications as prescribed,

(2) individuals with SMI have poorer clinical outcomes and experience high rates of hospitalizations, and

(3) individuals with SMI experience worse care in somatic care settings such as hospitals and out-patient medical services .

These factors lead to lower quality-adjusted life years and life expectancy of 25 years less than the general population.

Complex populations, such as those with service mental illness, frequently have difficulty following their medication regimens for a variety of reasons often leading to health demise and preventable use of higher levels of care.

Adherence rates of 80% in out-patient settings is considered sufficient for improved health or reduction in symptoms of somatic and psychiatric conditions; individuals with SMI tend to have adherence rates of 50-70%.

Poor adherence is generally not due to a reluctance to take medications, but rather because of the complex multi-drug regimens that people with co-morbid conditions are prescribed, inability to afford medications, and lack of consistent access to pharmacies and medical providers.

In one study, persons with SMI on average, experienced 3 or more chronic health conditions and were taking 22 medications—often with different and competing regimens.

Medication non-adherence is responsible for up to 10% of all health care costs, up to 40% of nursing home admissions, & around 125,000 deaths every year.

Improved Medication Adherence

Clients who use Medherent show 90% or higher medication adherence rates and have 25% fewer emergency room visits. The improvements in adherence translate into 40% fewer dollars spent on hospital bills and up to 7.6 fewer staff hours spent each month on managing medications.

https://altruix.com/medherent-medication-adherence-technology/

Better Outcomes, Lower Costs Remote Medication Monitoring with MedherentTM. Altruix. (2023, October 10). https://altruix.com/medherent-whitepaper/

12 CHEMICALS AND ADDITIVES CONSUMED IN AMERICA THAT ARE BANNED IN OTHER COUNTRIES

Chemical/Ingredient | Used For | Countries Banned In | Possible/Claimed Side Effects

POTASSIUM BROMATE

A strong oxidizing agent used to strengthen dough and give it an appealing white color.

Other names: Bromic acid, potassium salt

Hormel | weis (Kaiser Rolls) | GOYA (Dough for Turnover Pastries)

- Dough
- Bread
- Cookies
- Pizza
- Chips
- Breaded patties
- Cake

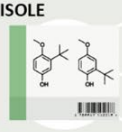
In 1999, the International Agency on Research for Cancer declared it a possible human carcinogen.

United Kingdom, Canada, Brazil, European Union, Argentina, China, India, South Korea, Sri Lanka, Peru, Nigeria

Warning label required in California

BUTYLATED HYDROXYANISOLE (BHA) AND BUTYLATED HYDROXY-TOLUENE (BHT)

Man-made antioxidant used as a preservative.



Kellogg's | Nestlé | NABISCO

- Food
- Food packaging
- Animal feed
- Cosmetics
- Rubber
- Petroleum products
- Medicine

The National Toxicology Program classified BHA as "reasonably anticipated to be a carcinogen."

United Kingdom, European Union, Japan, Australia, Canada, New Zealand

BROMINATED VEGETABLE OIL (BVO)

Mixture of plant-derived triglycerides that contains bromine. Used to keep flavors from separating in citrus soft drinks. It is also used as a flame retardant in plastics and furniture.

Mtn Dew

- Citrus-flavored soft drinks

Bromine has been found to irritate skin and mucous membranes. Excessive long-term use can cause headache, memory loss, and impaired coordination.

European Union, Japan, India

RACTOPAMINE

Feed additive used to promote leanness in animals.

Plainville Farms | Jennie-O

- Pork
- Cattle
- Poultry

Serious adverse effects in animals (death, high stress, lameness, broken limbs, hyperactivity). May affect the cardiovascular system in humans.

Banned in 160 countries (including European Union, Taiwan, mainland China, and Russia)

BRILLIANT BLUE FCF (BLUE 1)

Synthetic compound used to color foods and other products.

Jolly Rancher | M&M's

- Cotton candy
- Canned processed peas
- Sports drinks
- Ice pops
- Children's medications
- Soaps
- Shampoos

Allergic reactions

Austria, Belgium, Denmark, France, Germany, Greece, Italy, Norway, Spain, Sweden, Switzerland

RED 40

Dye made from petroleum used as a food coloring.

Swedish Fish | Kool-Aid | RED VINES

- Candy
- Sports drinks
- Popsicles

Implicated in allergies and worsening behavior in children with ADHD

Denmark, Belgium, France, Germany, Switzerland, Sweden, Austria, Norway, Finland

European Union requires a warning label

YELLOW 5 & 6

Synthetic lemon yellow dye used as food coloring.

Peeps | JELL-O | Hostess

- Ice cream
- Popsicles
- Instant puddings
- Cake mixes
- Soft drinks
- Chips

The EU warning label reads, "May have an adverse effect on activity and attention in children."

Norway, Finland, and Austria

European Union requires a warning label

AZODICARBONAMIDE (ADA)

Chemical substance used as a whitening agent and dough conditioner.

ARNOLD | Jimmy Dean | Pillsbury

- Foamed plastics (like yoga mats)
- Cereal
- Breads
- Some fast-food chain bread products

The World Health Organization has linked it to asthma, and the Center for Science in the Public Interest has cited potential cancer risk, especially in high doses.

European Union

RBST/ARTIFICIAL GROWTH HORMONE

Hormone produced by cows' pituitary glands in small quantities. It has been synthesized artificially and used to increase milk production.

General Mills | LAND O LAKES

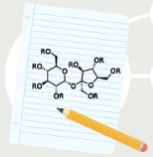
- Dairy milk
- Cheese
- Yogurt
- Ice cream

Possible link to increased risk of cancer; adverse health effects and suffering in cows, including more frequent need for antibiotics, which may promote growth of antibiotic-resistant bacteria.

Canada, European Union, Australia, New Zealand, Japan

OLESTRA/OLEAN®

Fat substitute used to lower calories of otherwise high-fat foods. It was widely used in the 1990s but has since lost popularity.



Pringles | Lay's

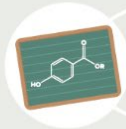
- Chips
- Crackers
- Salad dressings
- Frozen yogurts

May cause gastrointestinal distress and prevent the absorption of key fat-soluble nutrients and carotenoids

Canada, European Union

PARABENS

A class of preservatives used in cosmetics and pharmaceuticals. They inhibit mold and bacteria growth.



Cetaphil | OLAY | COVERGIRL

- Makeup
- Skincare
- Hair products

The European Commission on Endocrine Disruption has found evidence of endocrine disruption, especially in babies. They may disrupt sex hormones and act as a very weak estrogen.

Isopropyl- and isobutylparaben banned by European Union; 5 parabens banned by ASEAN (10 Southeast Asian countries)

"PINK SLIME"

Meat byproduct used to "bulk up" meat products. It is created from scraps and trimmings that have been processed and cleaned with ammonia.

Tyson

- Meat products
- Ground meat
- Fast food

Bans are due to the use of ammonia. However, ammonia is responsible for killing harmful bacteria.

Canada, European Union

The Food Industry Was Built on Surviving Nuclear War. Ultra Processed Food has created an epidemic of chronic disease like obesity, diabetes, & heart disease. Our modern food environment has broken down and the food supply heavily relies on additives to retain shelf life of food rather than food as medicine.

This has created a whole host of downstream problems.

Toxins to Stay Away From:

Trans Fats
Sodium Nitrite
Monosodium Glutamate (MSG)
Artificial Food Coloring
High Fructose Corn Syrup
Aspartame
Sodium Benzoate
Sulfites
Sugar
Seed Oils

HOTLOGIC® Breakroom 8 - Food Warming Appliance
hotlogic.com

https://www.oliverquality.com/product/speedseal-cx/

"If you are confused about what to eat and want to learn how to be in right relationship to your body, nature, and food, read this book!" —MARK HYMAN, MD, author of *FOOD*

EAT LIKE A HUMAN

NOURISHING FOODS AND ANCIENT WAYS OF COOKING TO REVOLUTIONIZE YOUR HEALTH

DR. BILL SCHINDLER

Breathe Better
Eat Better
Sleep Better

The Nudge Approach:

Early Evidence Suggests This Approach Is Making a Difference

How Can We Stay Healthy?

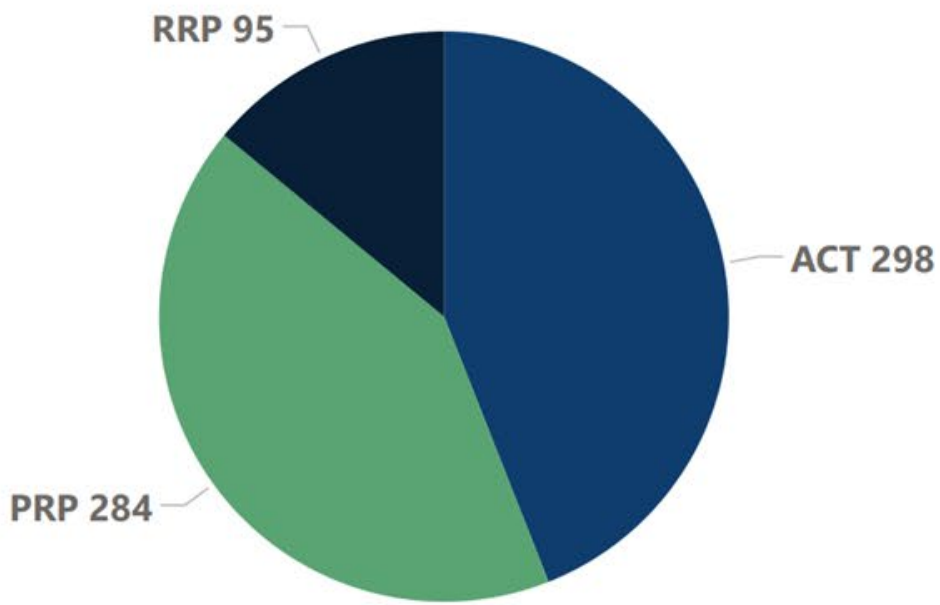
- Eat Real Whole Food
- Conduct Daily Natural Movement Focused on Building Muscle
- Sleep Well
- Breathe Properly
- Reduce Stress
- Be Social
- Drink Water

How Do We Know The Model is Working?

HealthPort

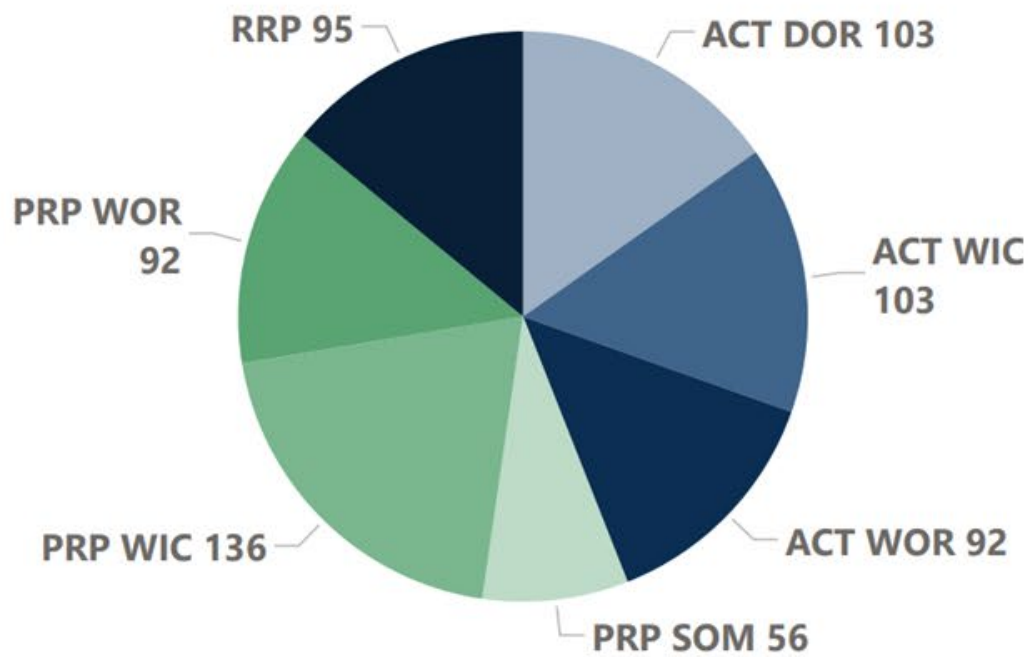
Program Distribution

Number of Consumers



Team Distribution

Number of Consumers

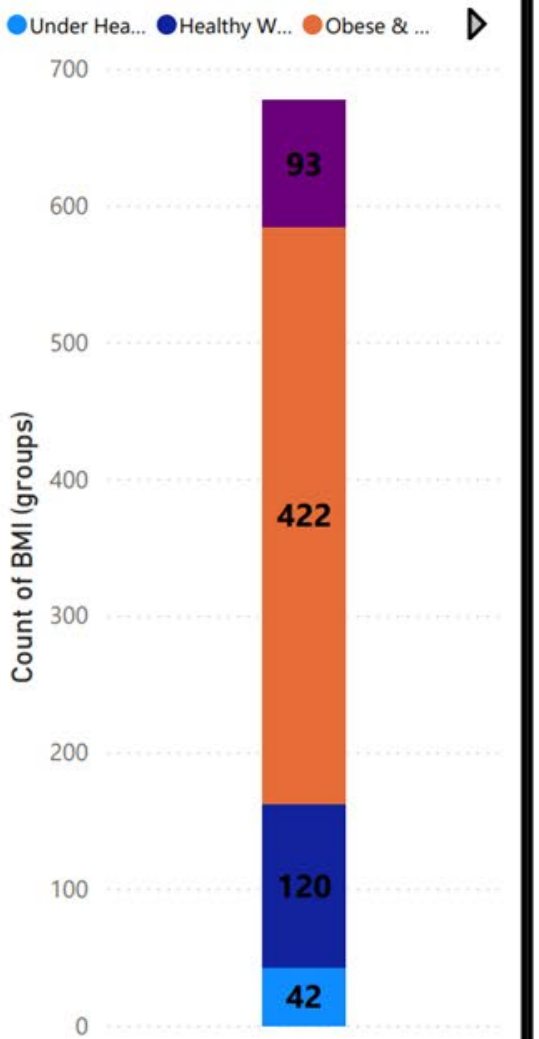


POPULATION HEALTH MANAGEMENT

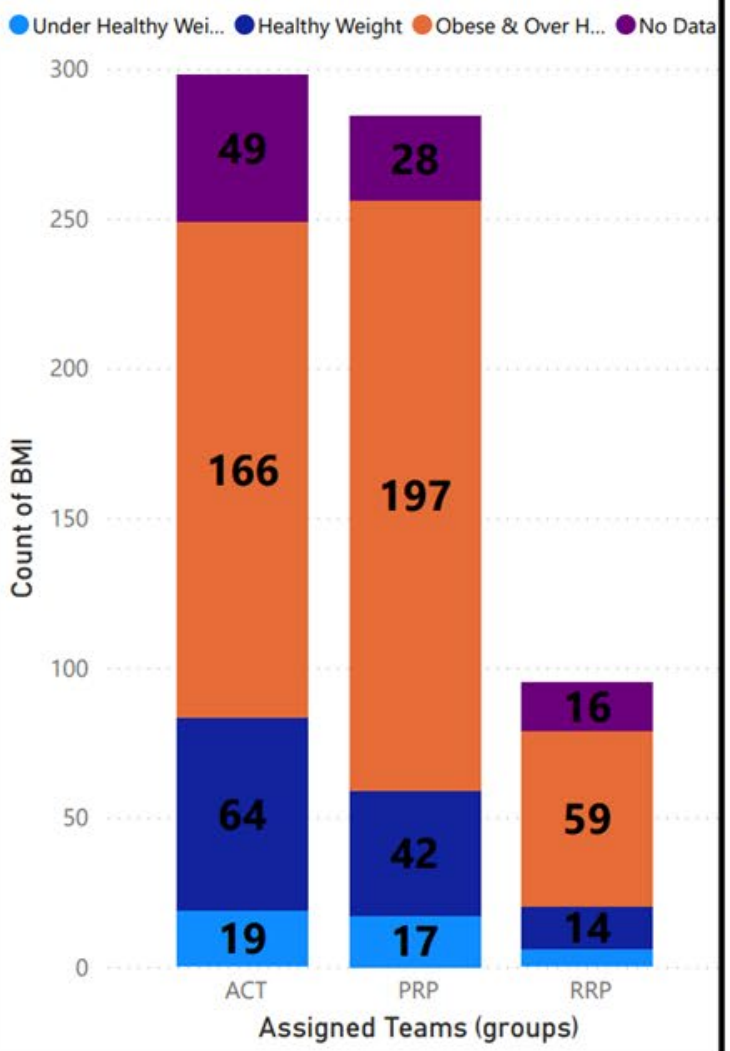
The percentage of clients with Healthy BMIs, Blood Pressure under 140/90, A1C under 5.7, and PHQ-9 scores ≤9 will increase to match Maryland rates.

BMI Goal:<66% Obese/Overweight

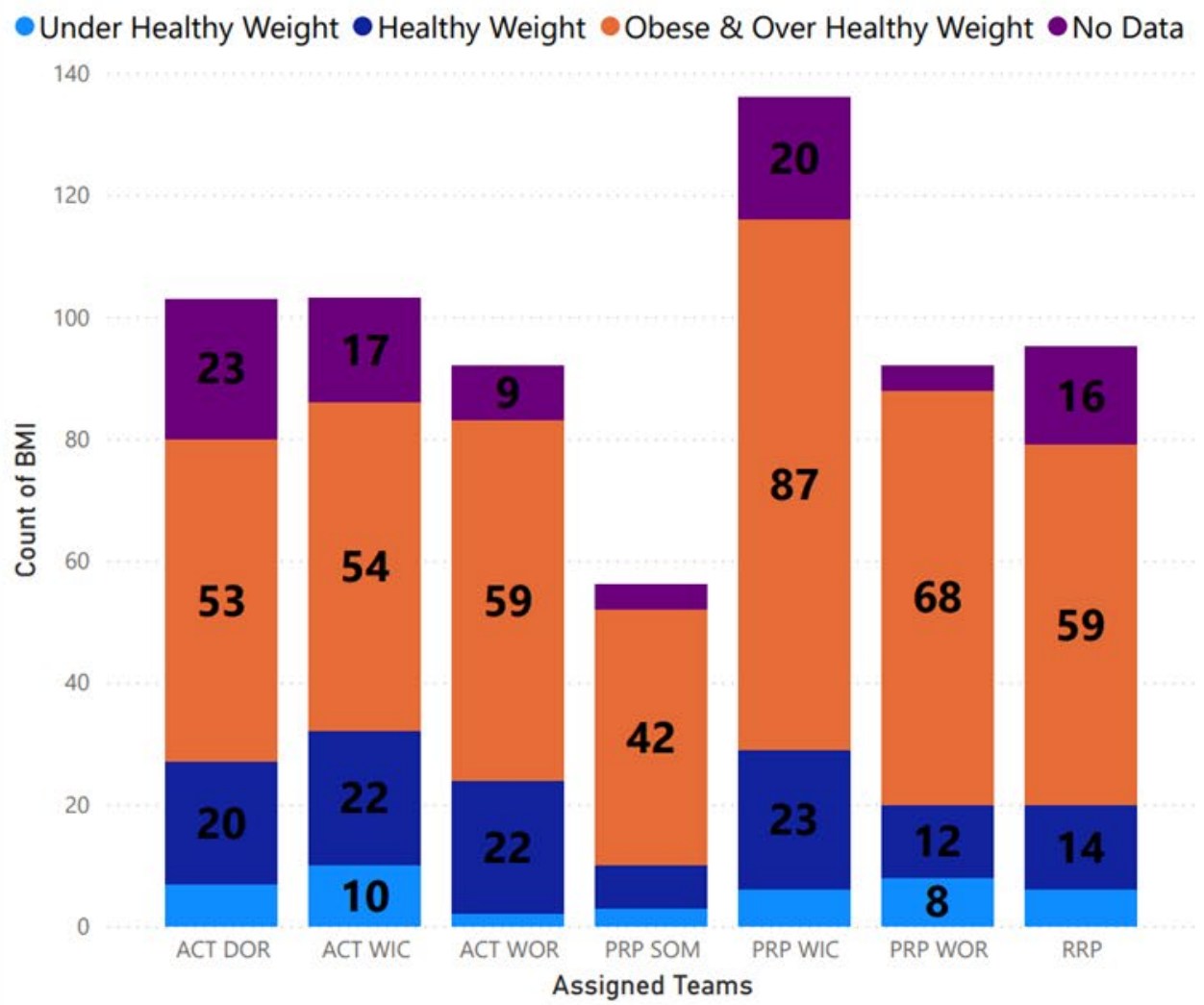
BMI Categories



BMI Categories



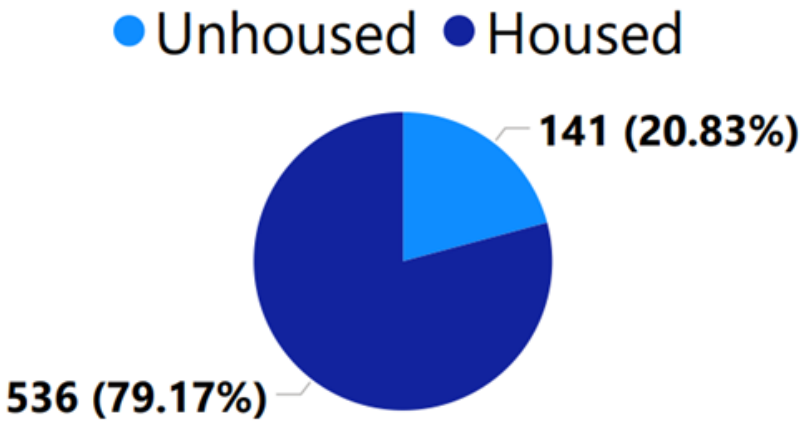
BMI Categories



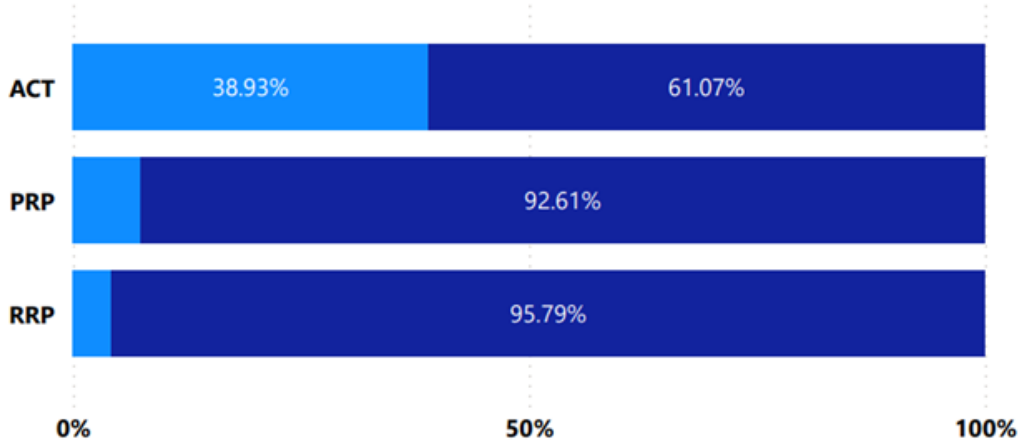
HOUSING

At any given time, 90% of clients will be housed through the use of organizational housing services and access to subsidized housing.

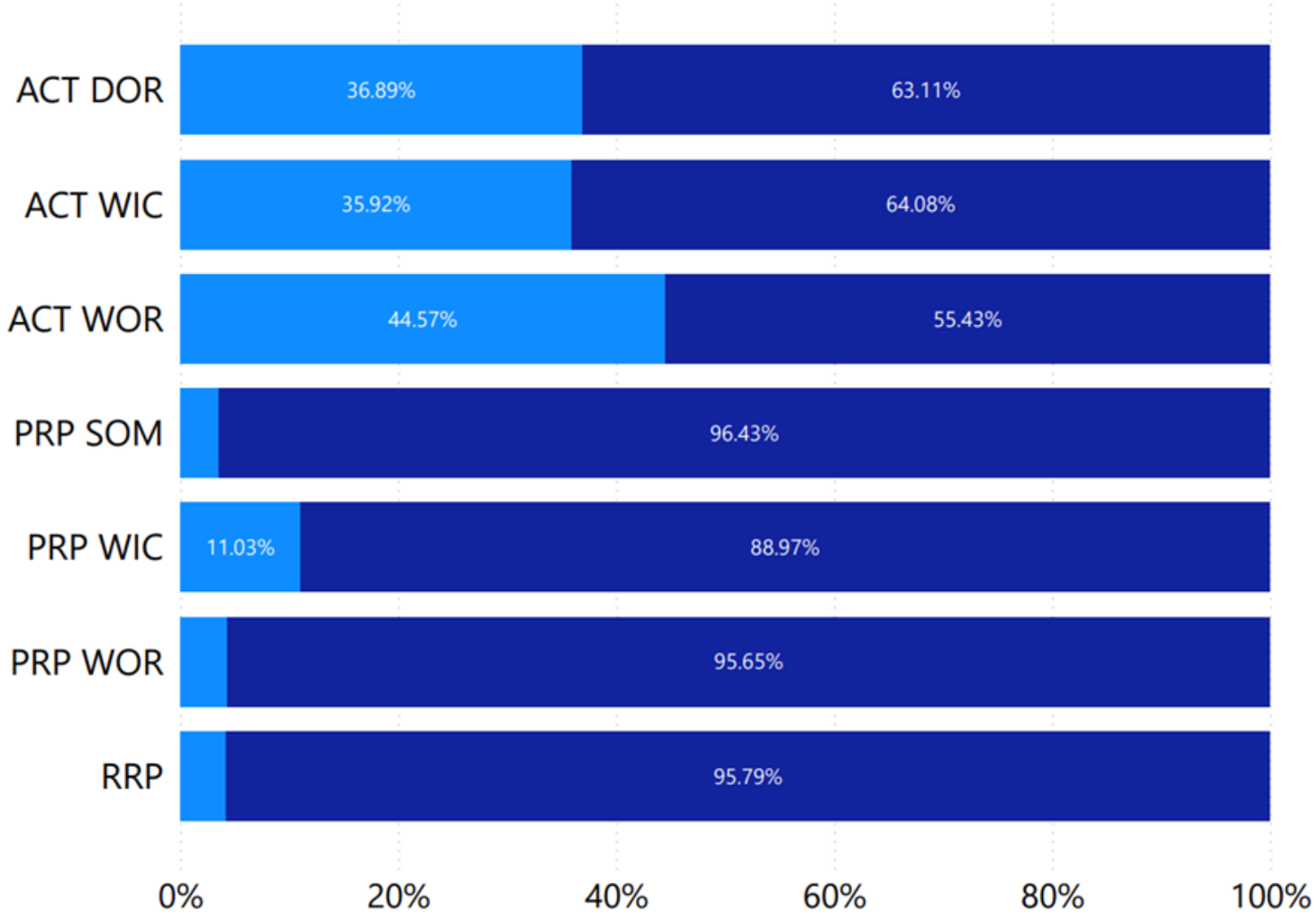
TOTAL HealthPort



Housing Status by Program



Housing Status by Program



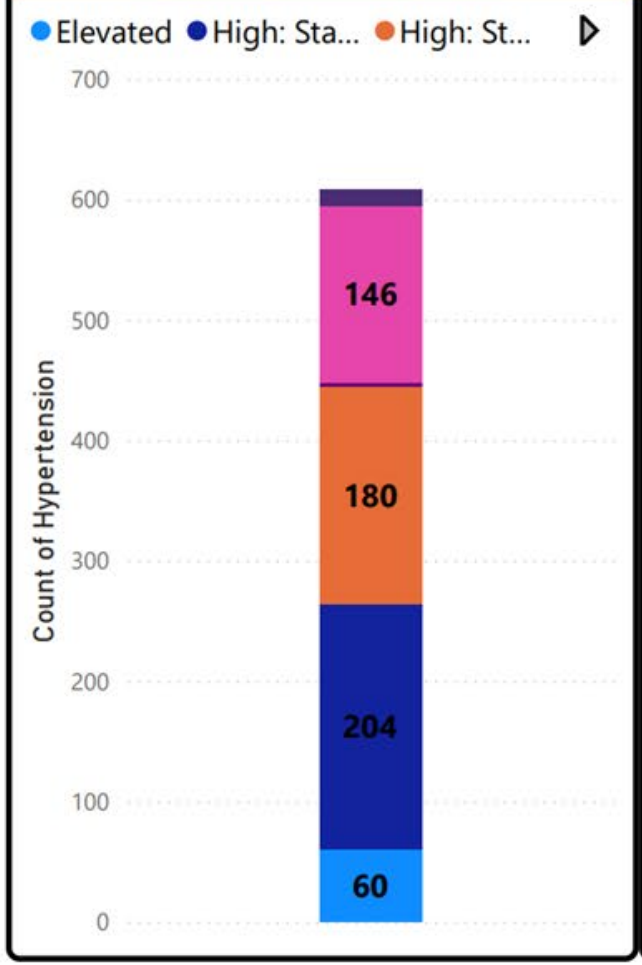
POPULATION HEALTH MANAGEMENT

The percentage of clients with Healthy BMIs, Blood Pressure under 140/90, A1C under 5.7, and PHQ-9 scores ≤9 will increase to match Maryland rates.

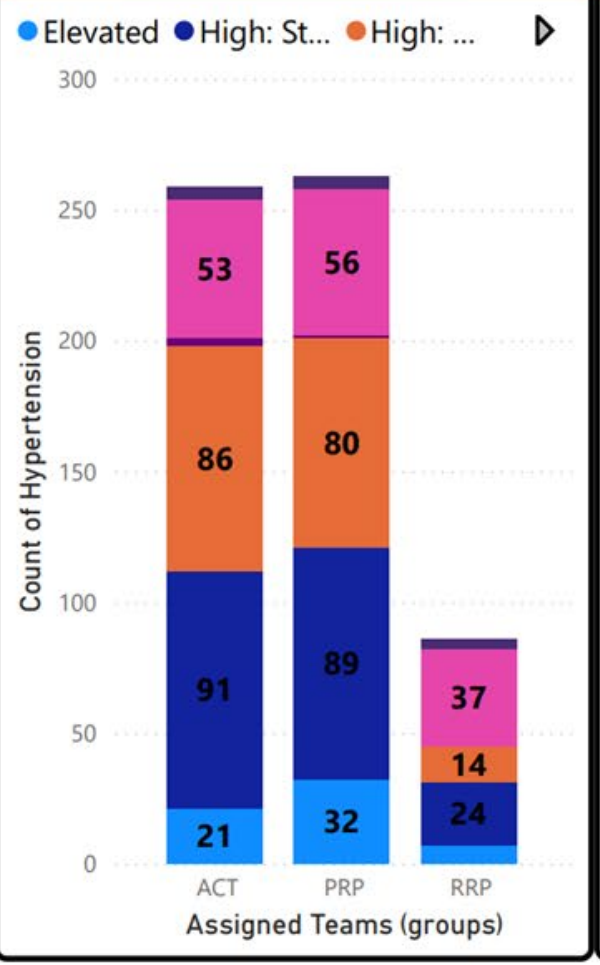
BP Goal:<40% Ever Told Hypertensive

National Average 18+: <47.7% Hypertensive

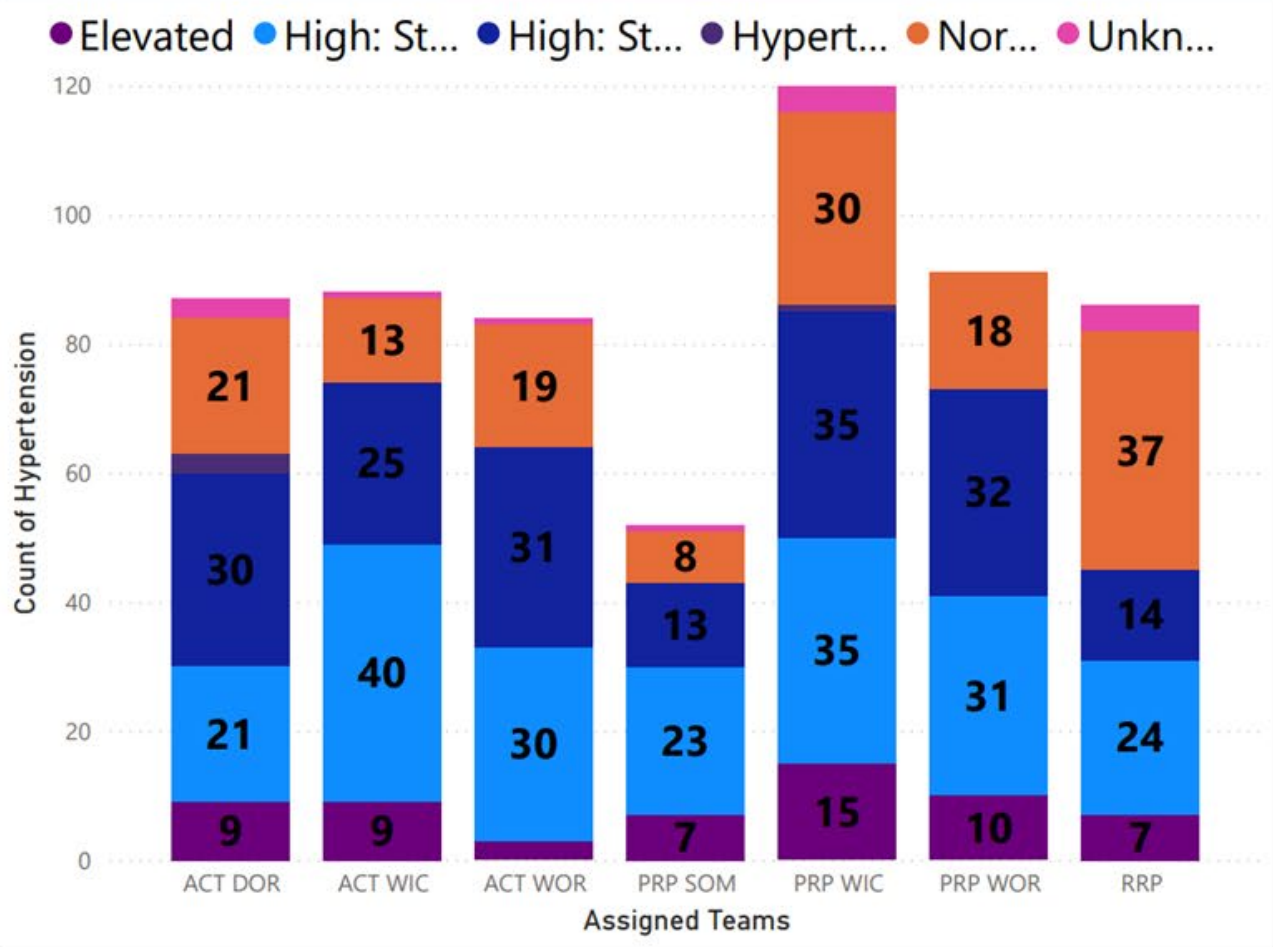
Blood Pressure



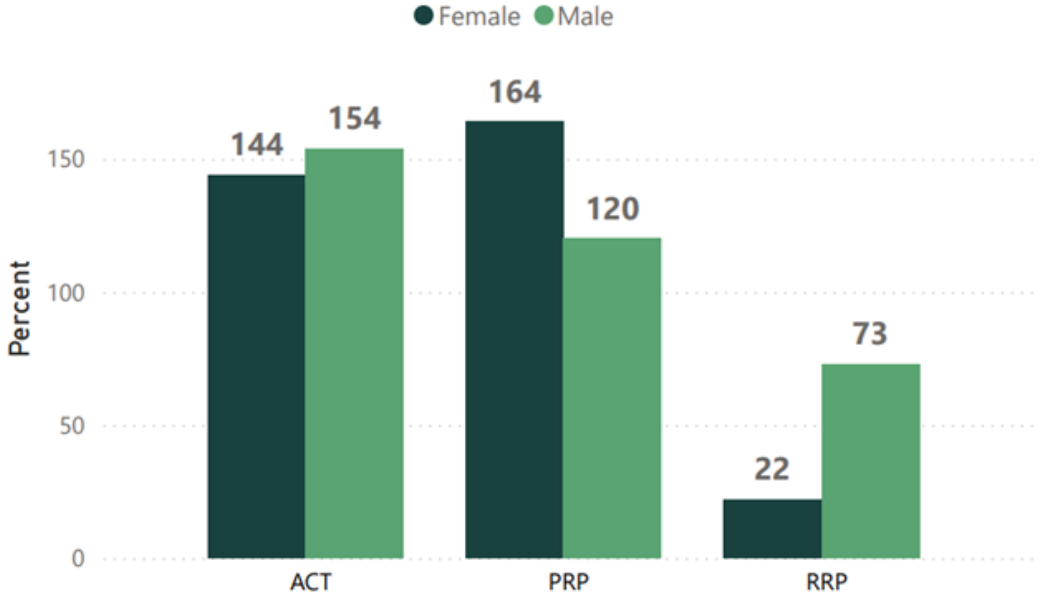
Blood Pressure



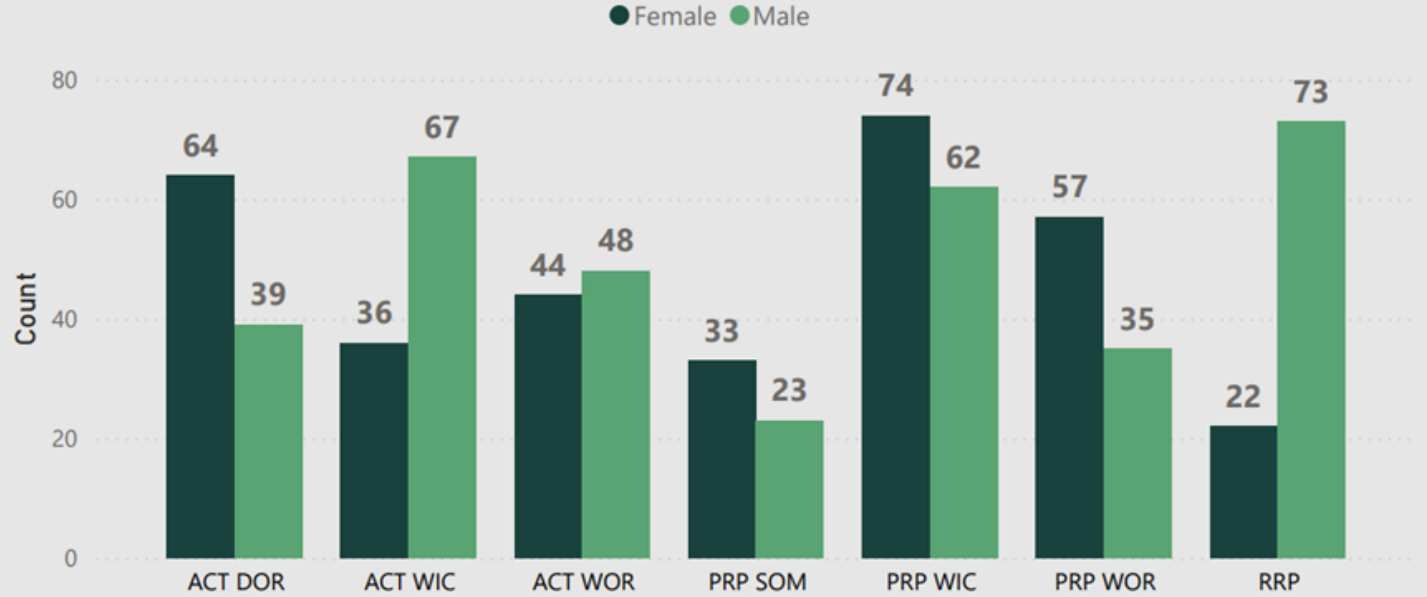
Blood Pressure



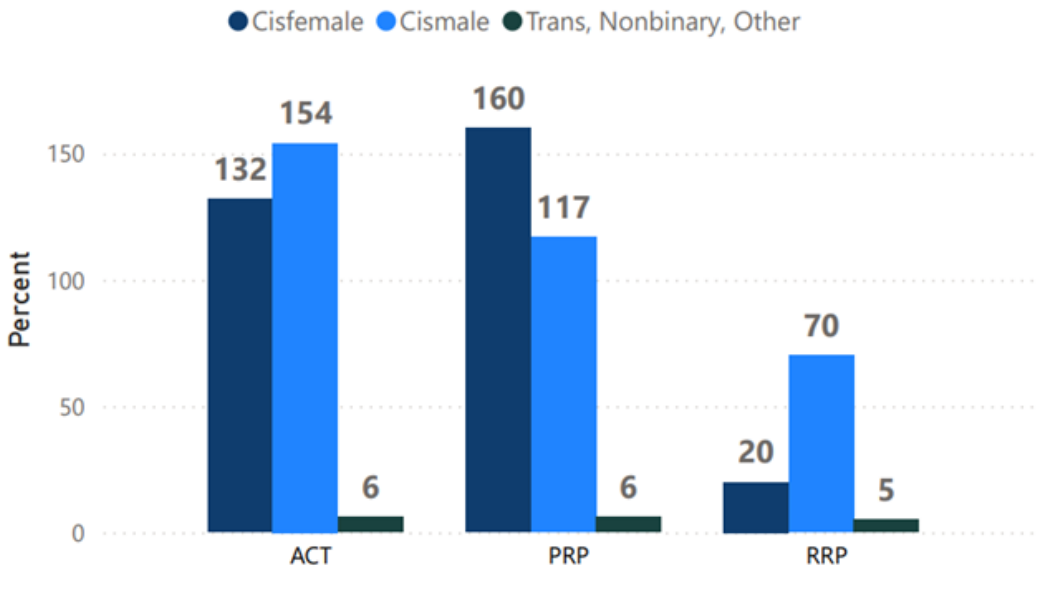
Distribution by Sex



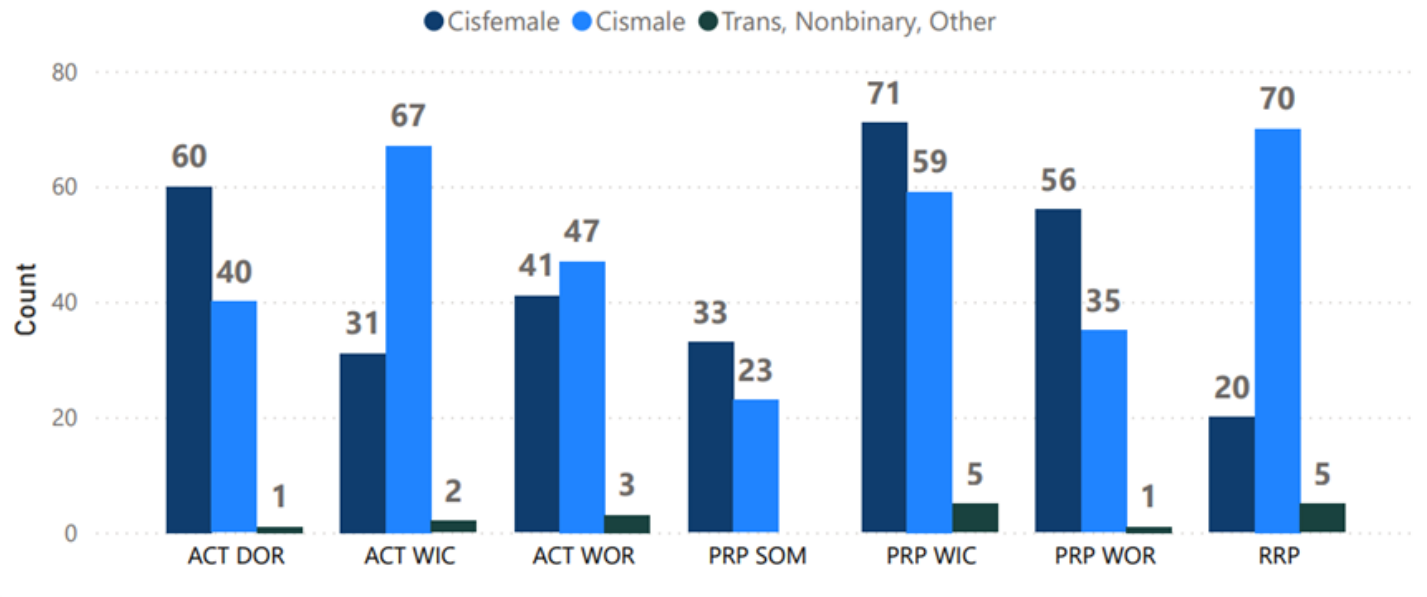
Distribution by Sex



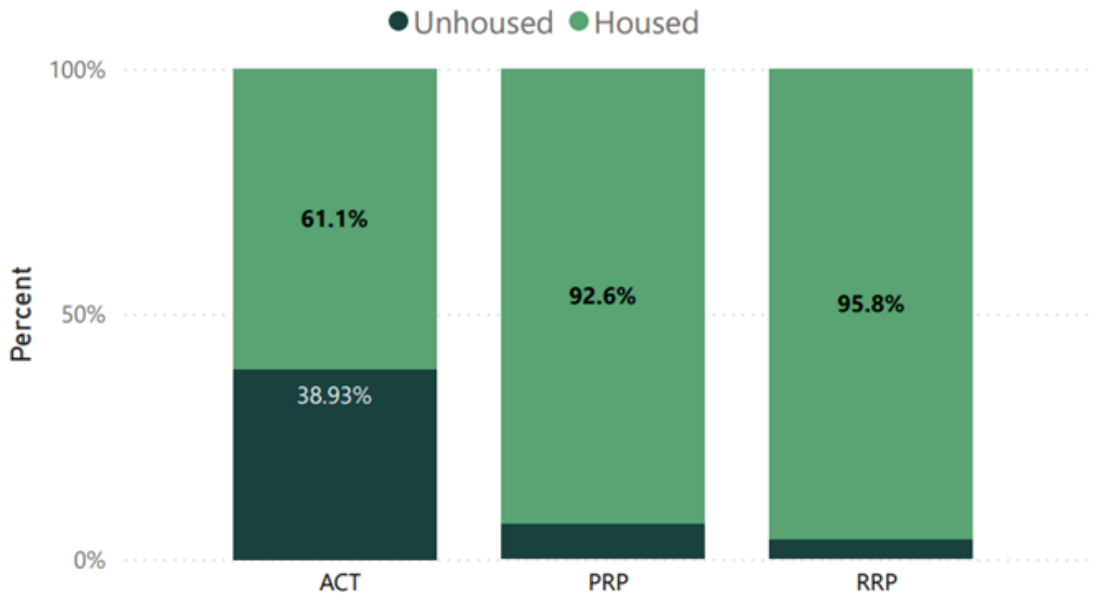
Distribution by Gender



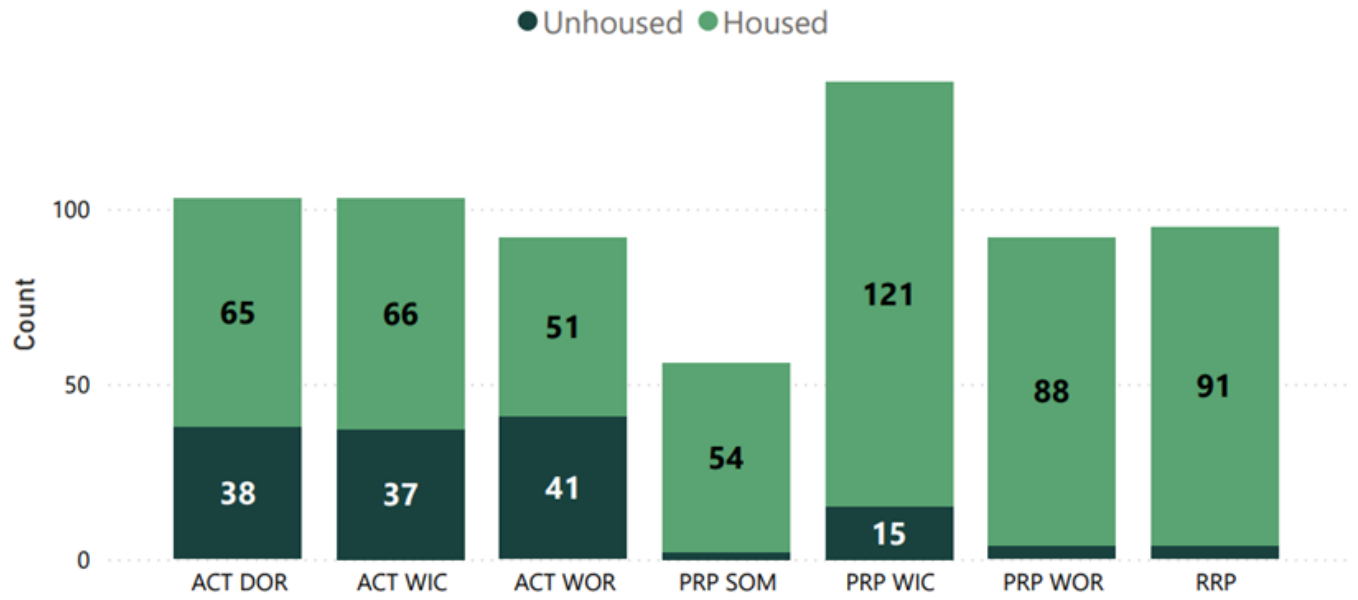
Distribution by Gender



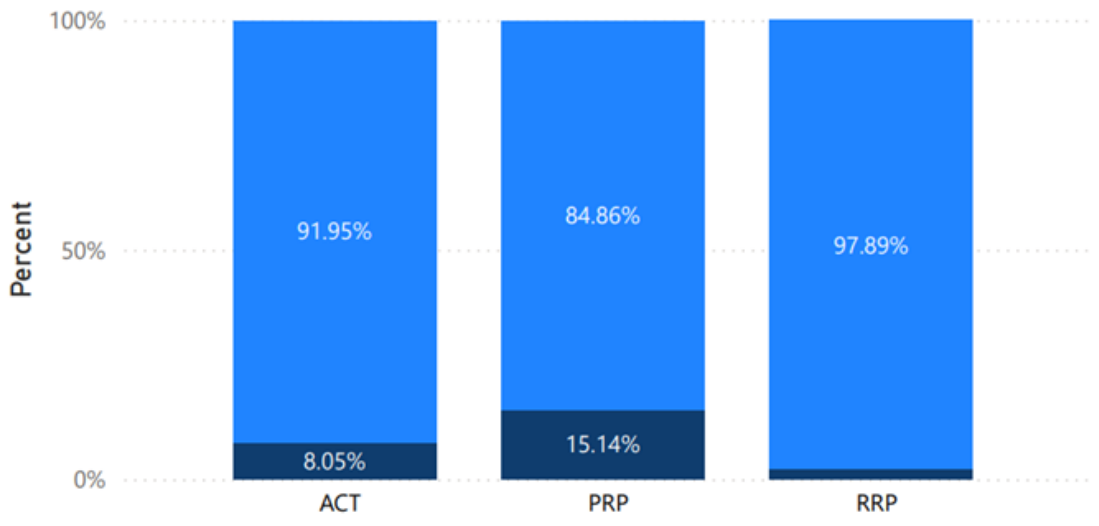
Housing Status Percentage



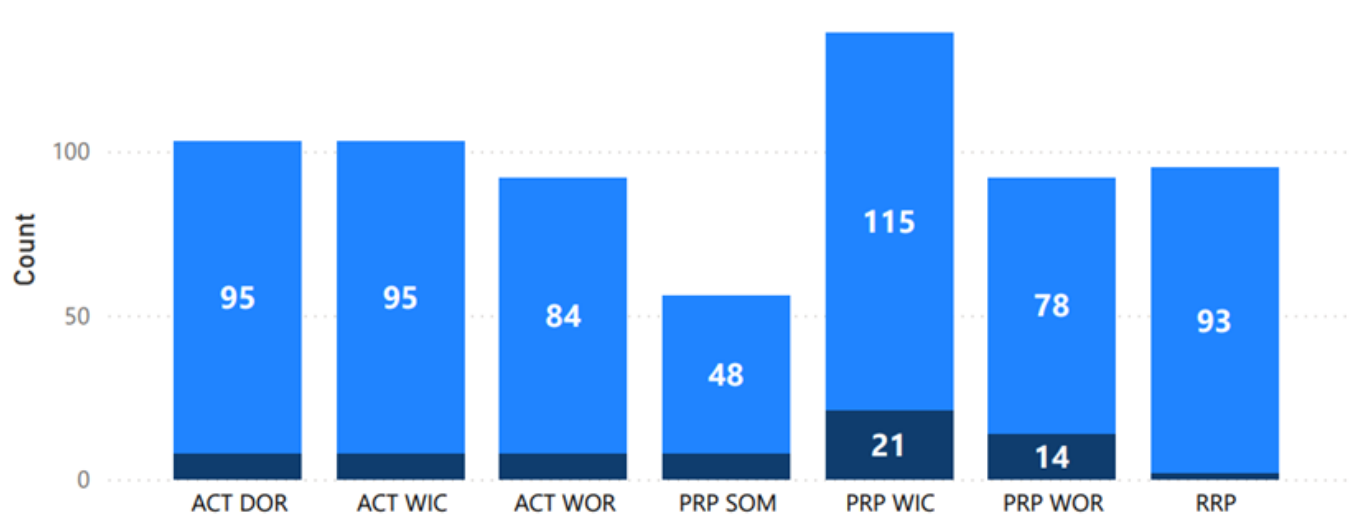
Housing Status Count



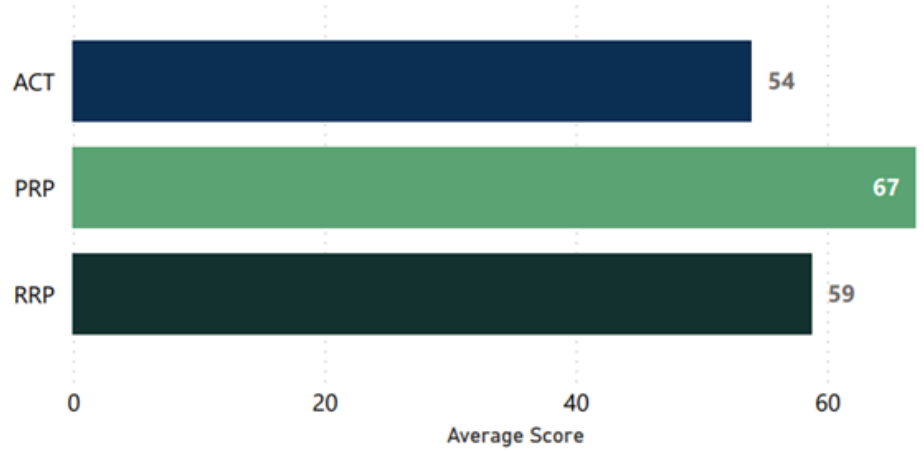
Employment Percentage



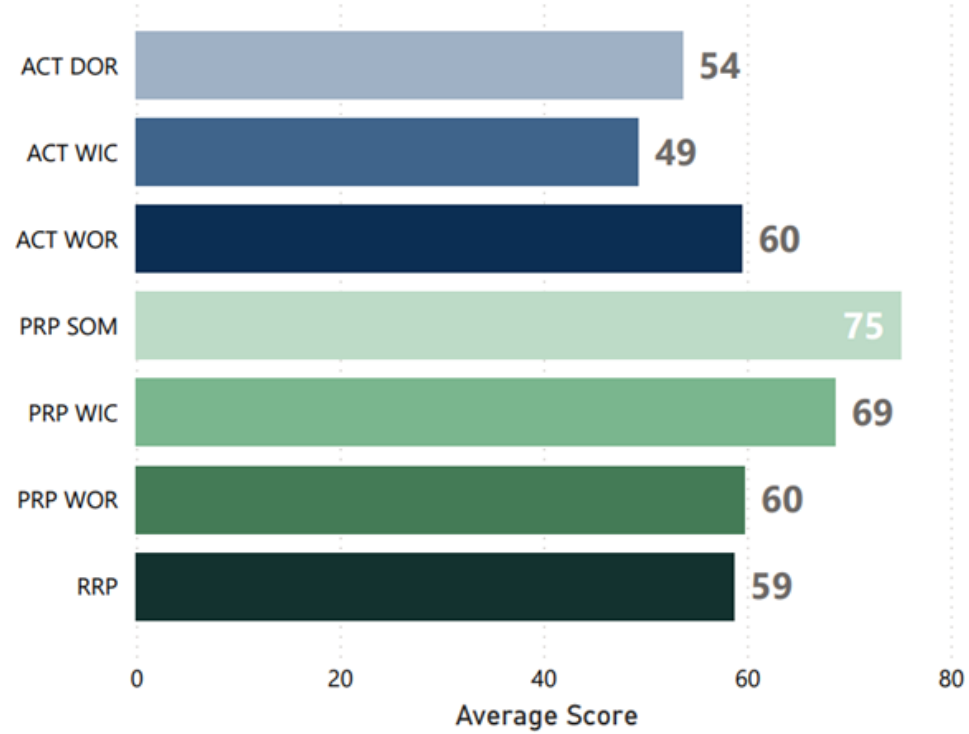
Employment Count



Average DLA-20

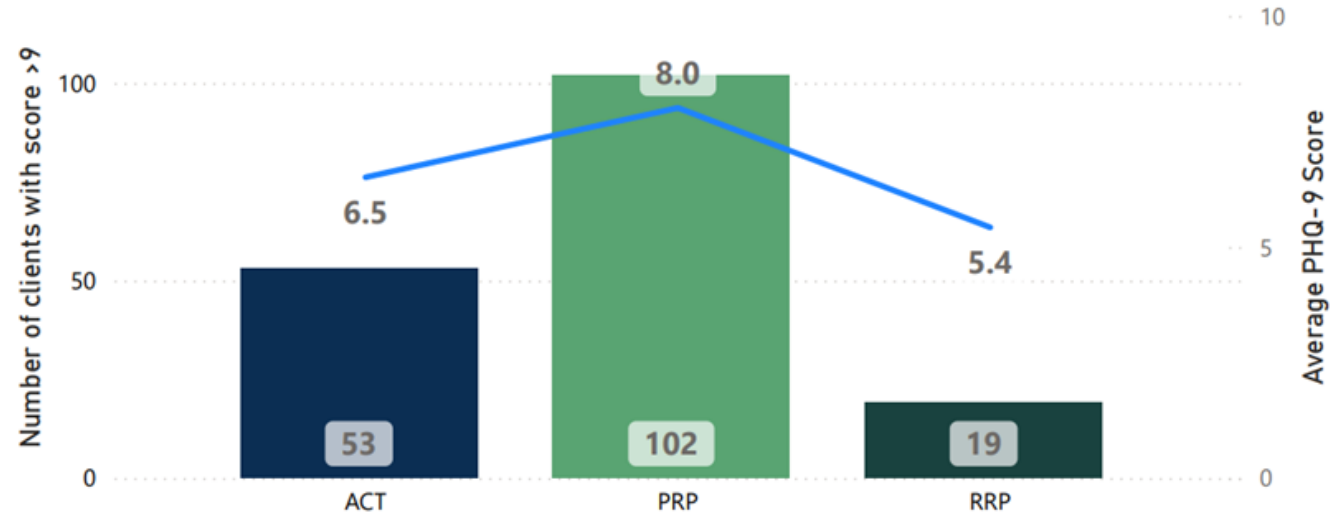


Average DLA-20



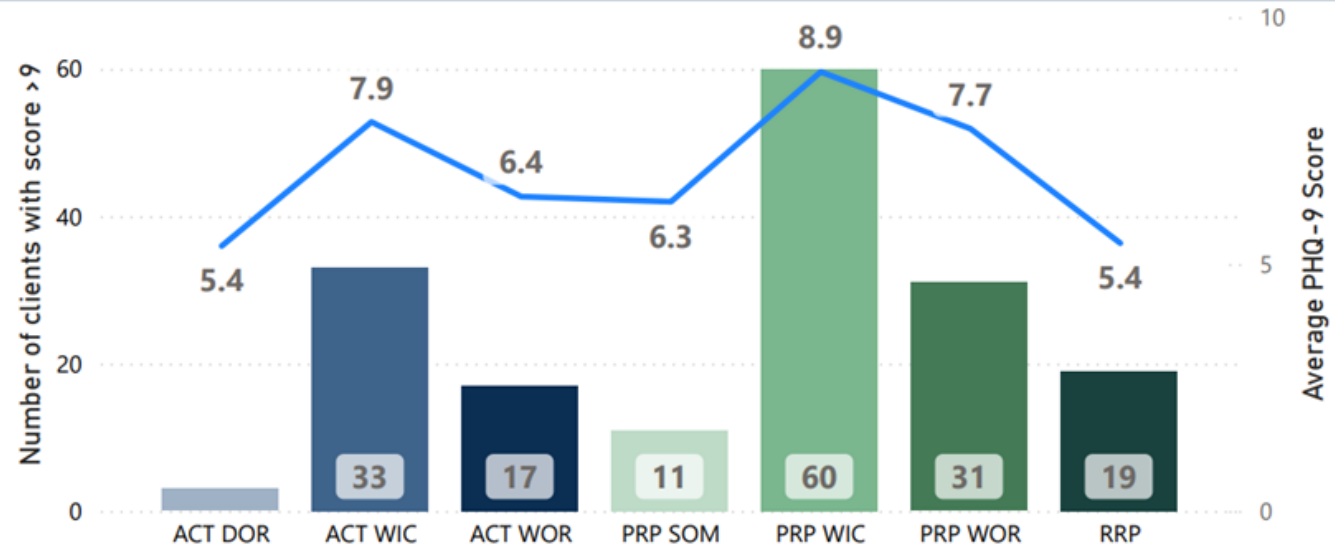
PHQ-9 Scores

Number of Clients with PHQ-9 Scores >9 and Average PHQ-9 Scores

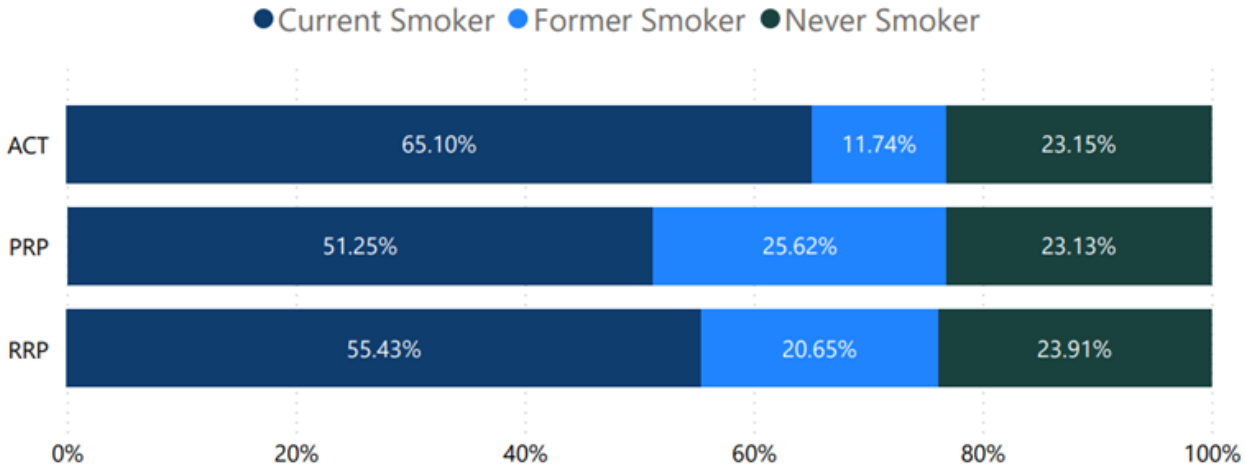


PHQ-9 Scores

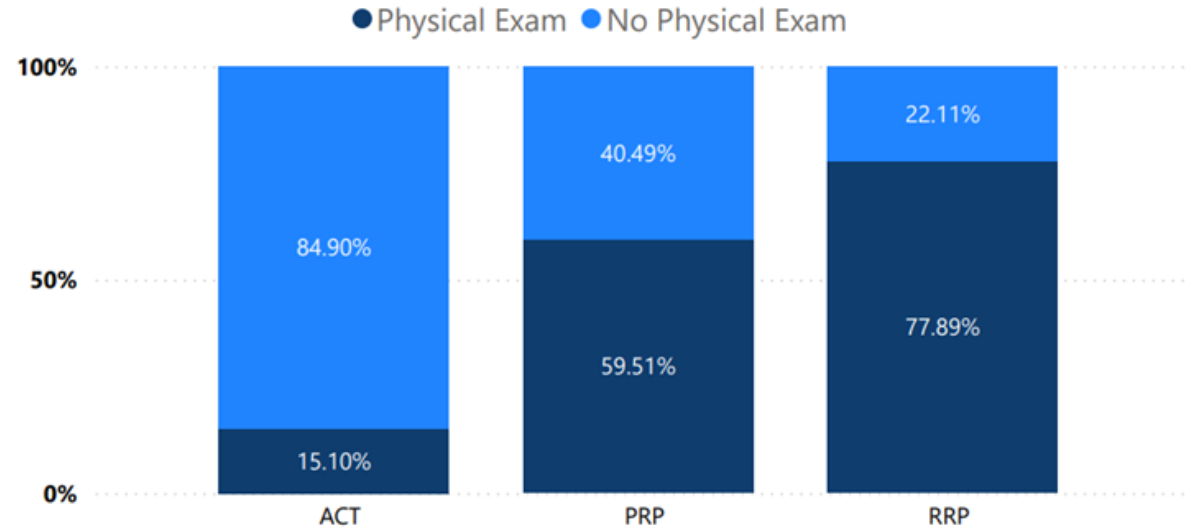
Number of Clients with PHQ-9 Scores >9 and Average PHQ-9 Scores



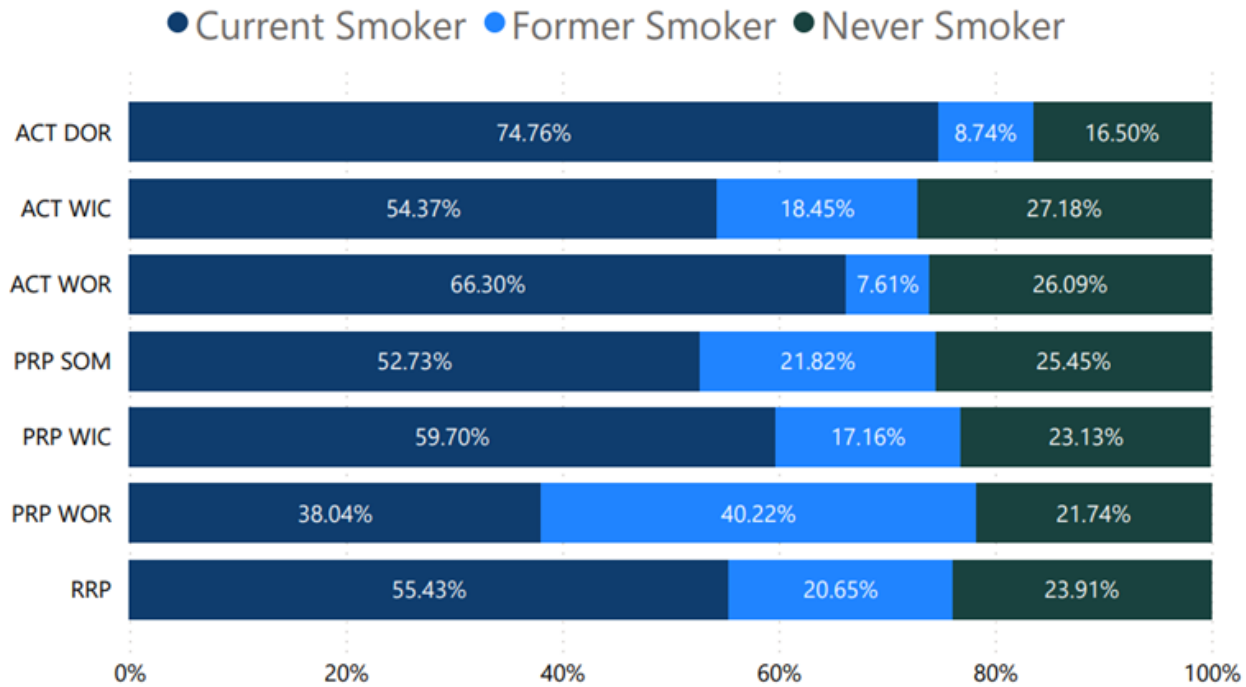
Smoking Status



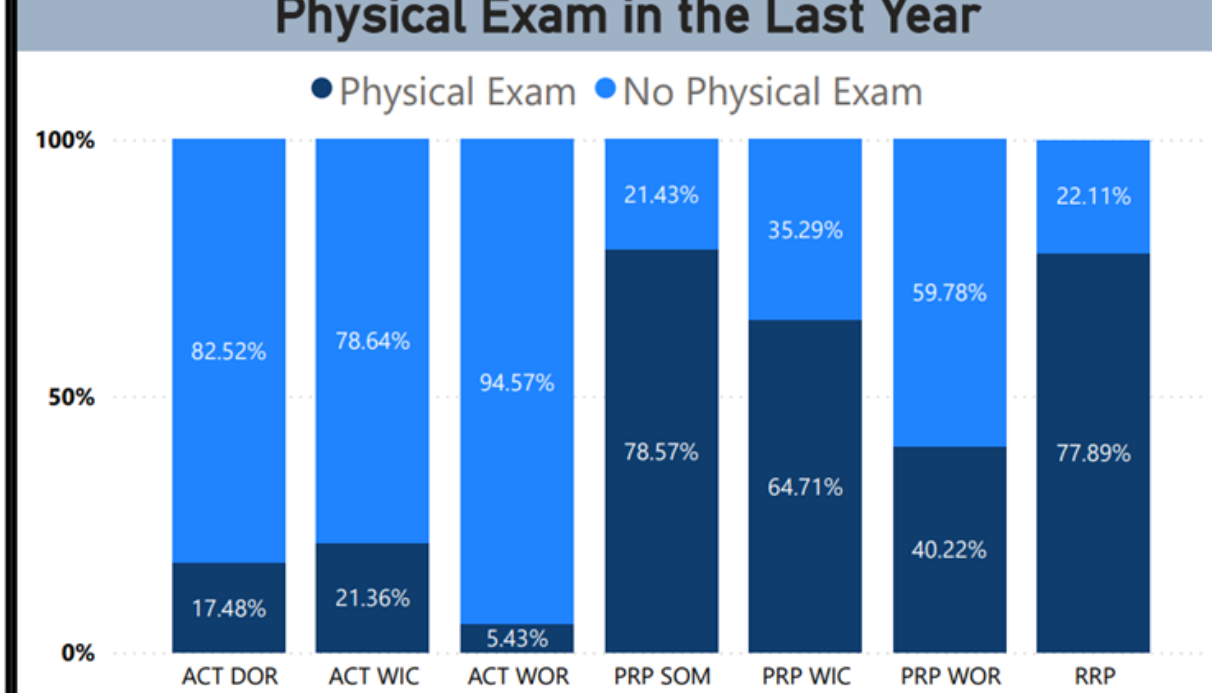
Physical Exam in the last year

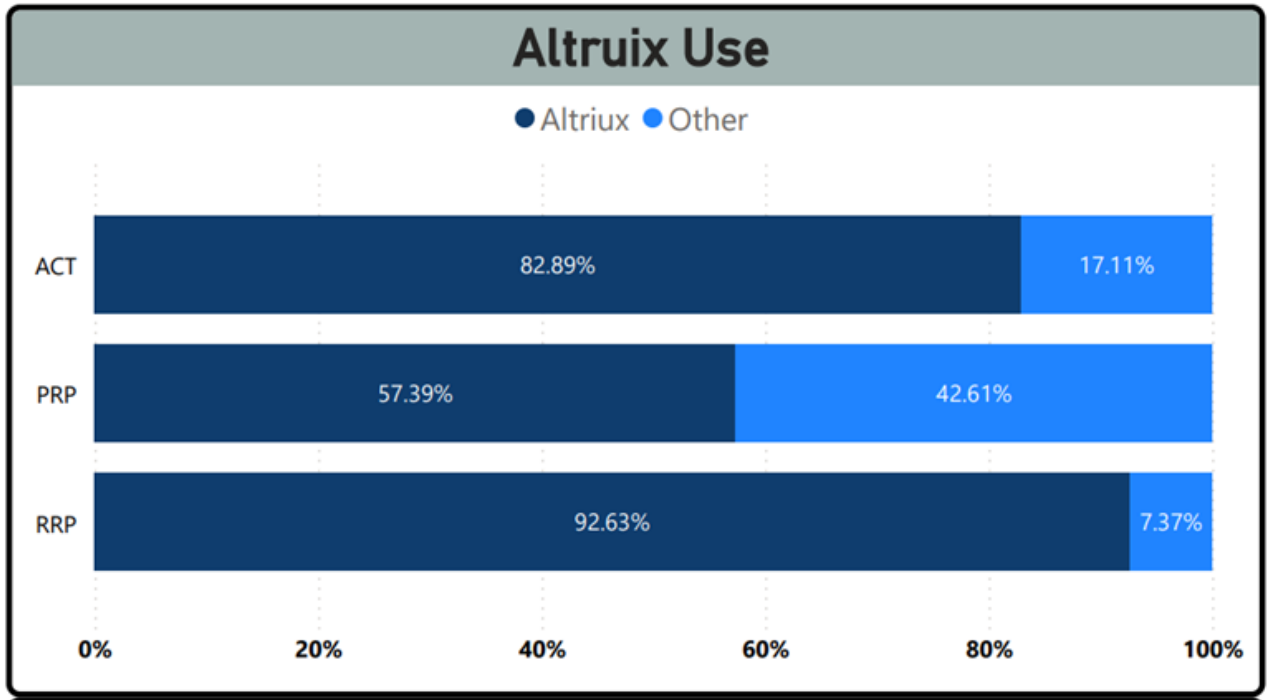


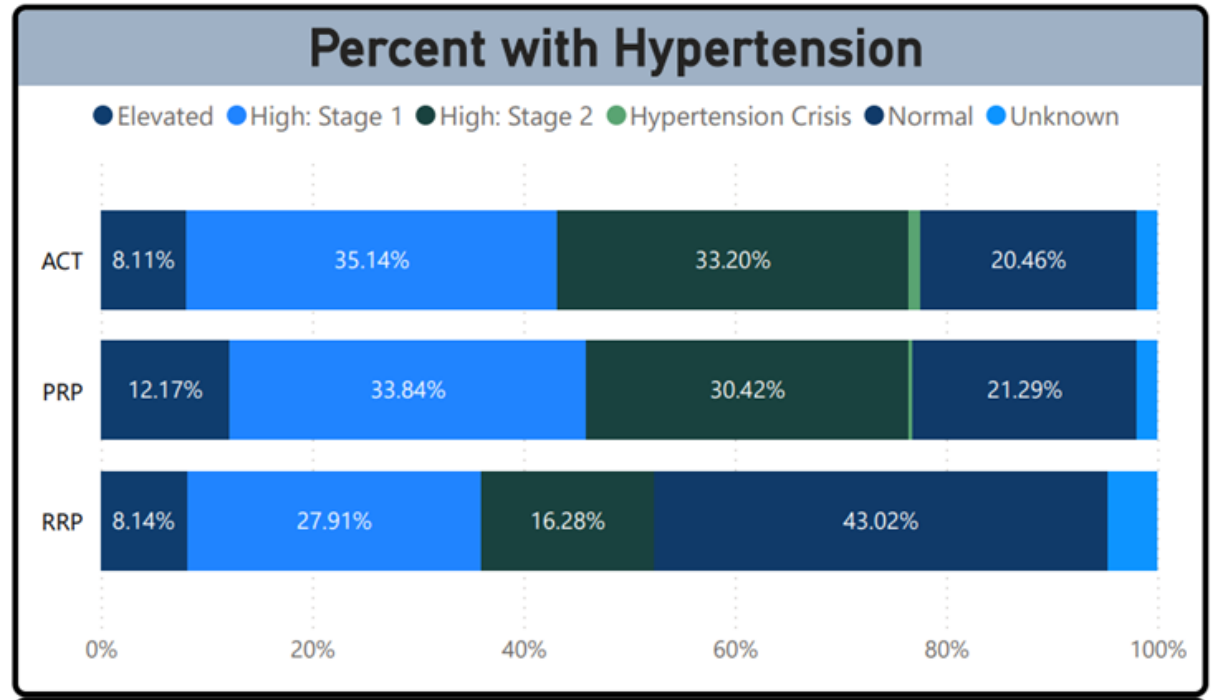
Smoking Status

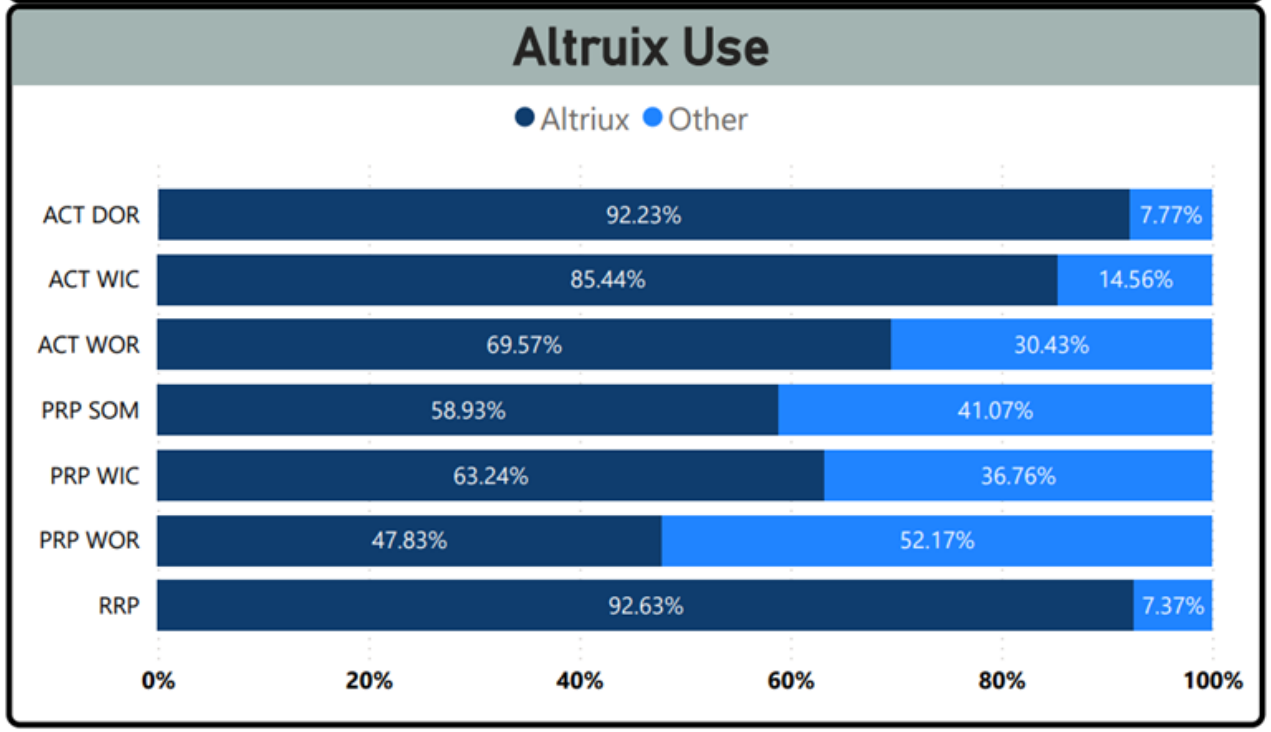


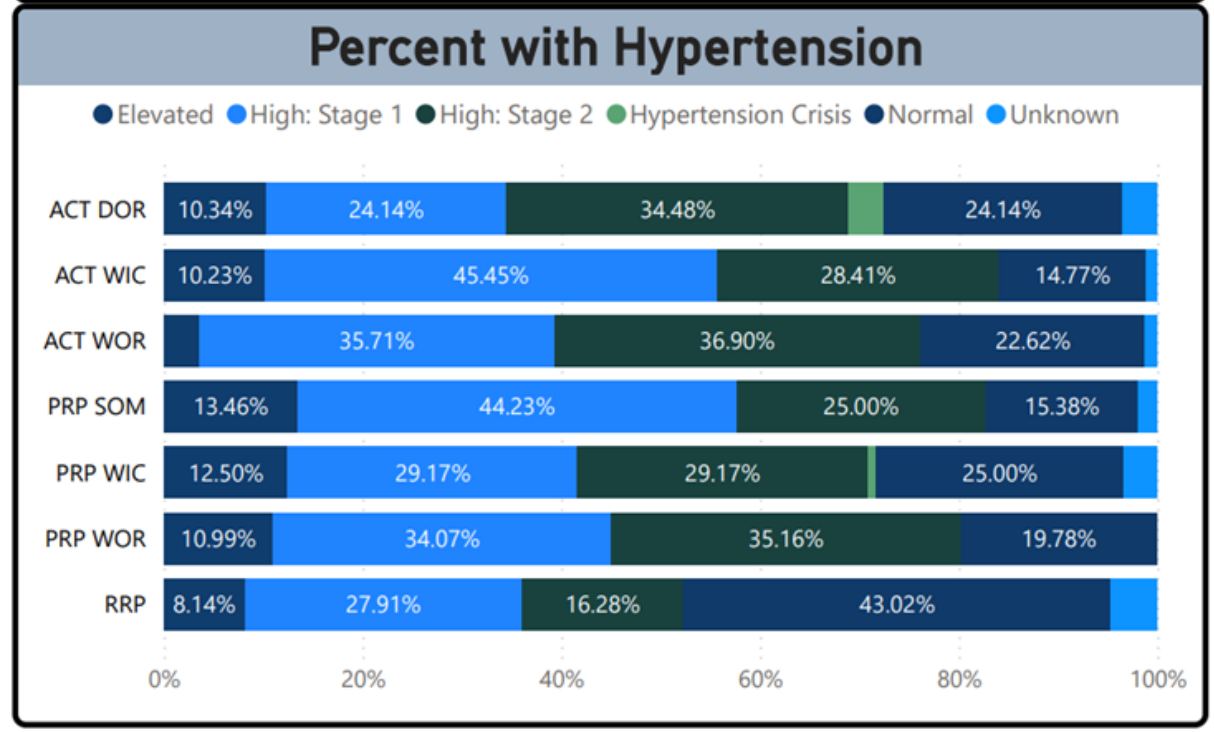
Physical Exam in the Last Year



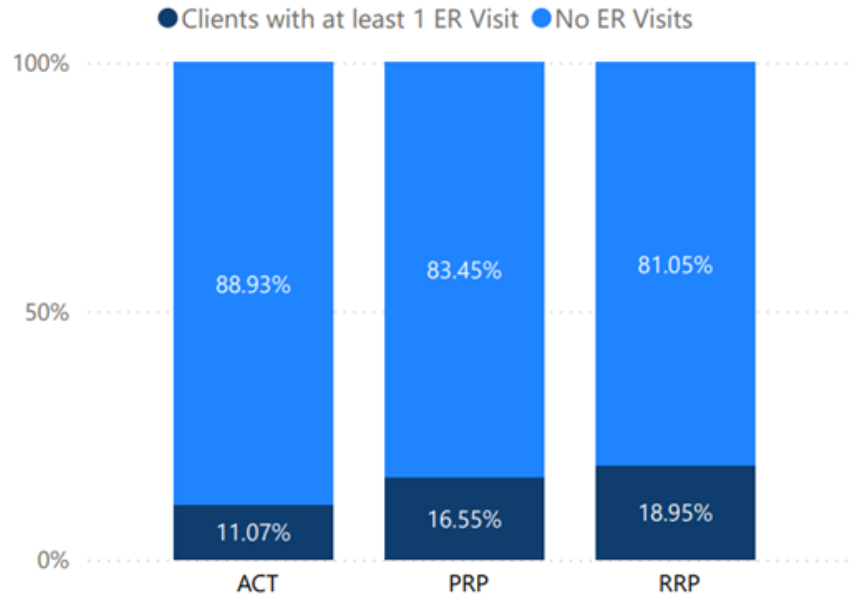

Altruix Use
Altriux
Other
ACT
PRP
RRP
82.89%
17.11%
57.39%
42.61%
92.63%
7.37%
0%
20%
40%
60%
80%
100%


Percent with Hypertension
Elevated
High: Stage 1
High: Stage 2
Hypertension Crisis
Normal
Unknown
ACT
PRP
RRP
8.11%
35.14%
33.20%
20.46%
12.17%
33.84%
30.42%
21.29%
8.14%
27.91%
16.28%
43.02%
0%
20%
40%
60%
80%
100%


Altruix Use
Altriux
Other
ACT DOR
ACT WIC
ACT WOR
PRP SOM
PRP WIC
PRP WOR
RRP
92.23%
7.77%
85.44%
14.56%
69.57%
30.43%
58.93%
41.07%
63.24%
36.76%
47.83%
52.17%
92.63%
7.37%
0%
20%
40%
60%
80%
100%


Percent with Hypertension
Elevated
High: Stage 1
High: Stage 2
Hypertension Crisis
Normal
Unknown
ACT DOR
ACT WIC
ACT WOR
PRP SOM
PRP WIC
PRP WOR
RRP
10.34%
24.14%
34.48%
24.14%
10.23%
45.45%
28.41%
14.77%
35.71%
36.90%
22.62%
13.46%
44.23%
25.00%
15.38%
12.50%
29.17%
29.17%
25.00%
10.99%
34.07%
35.16%
19.78%
8.14%
27.91%
16.28%
43.02%
0%
20%
40%
60%
80%
100%

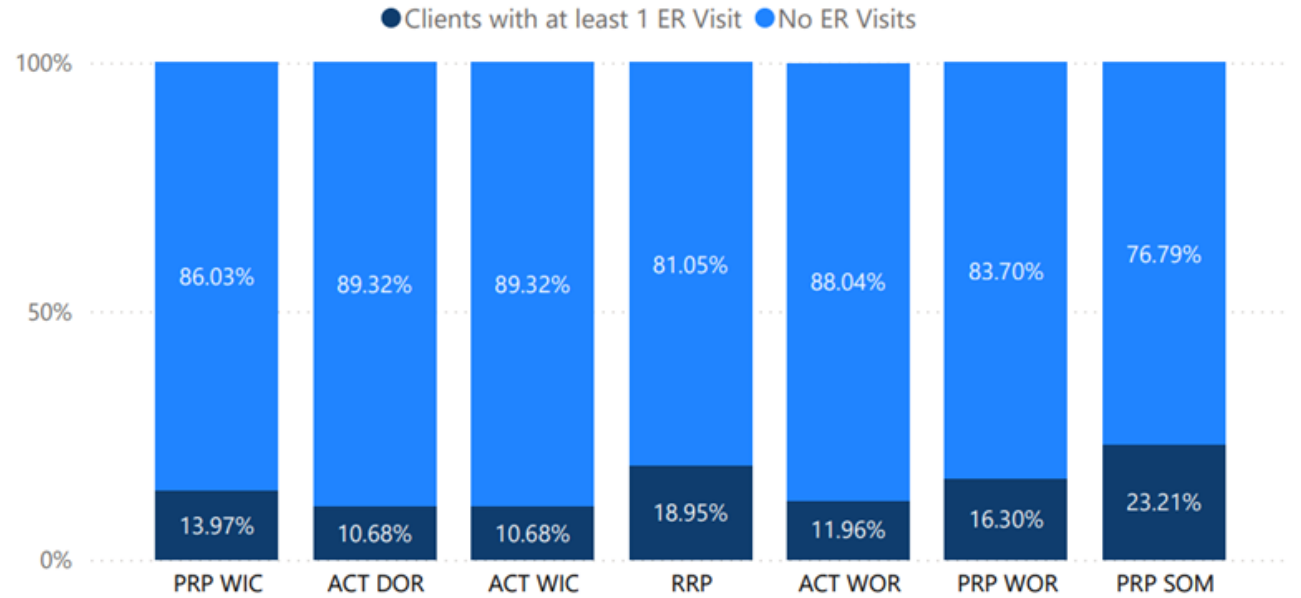
% of Clients with at least 1 ER Visit



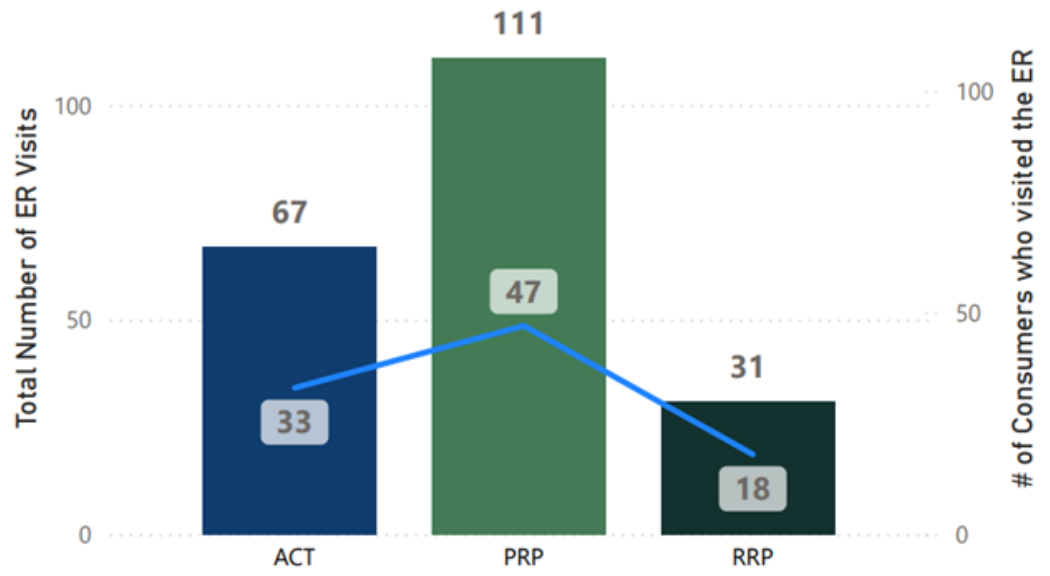
ER Visits

ER Visit Range:
ACT 0-6
PRP 0-8
RRP 0-5

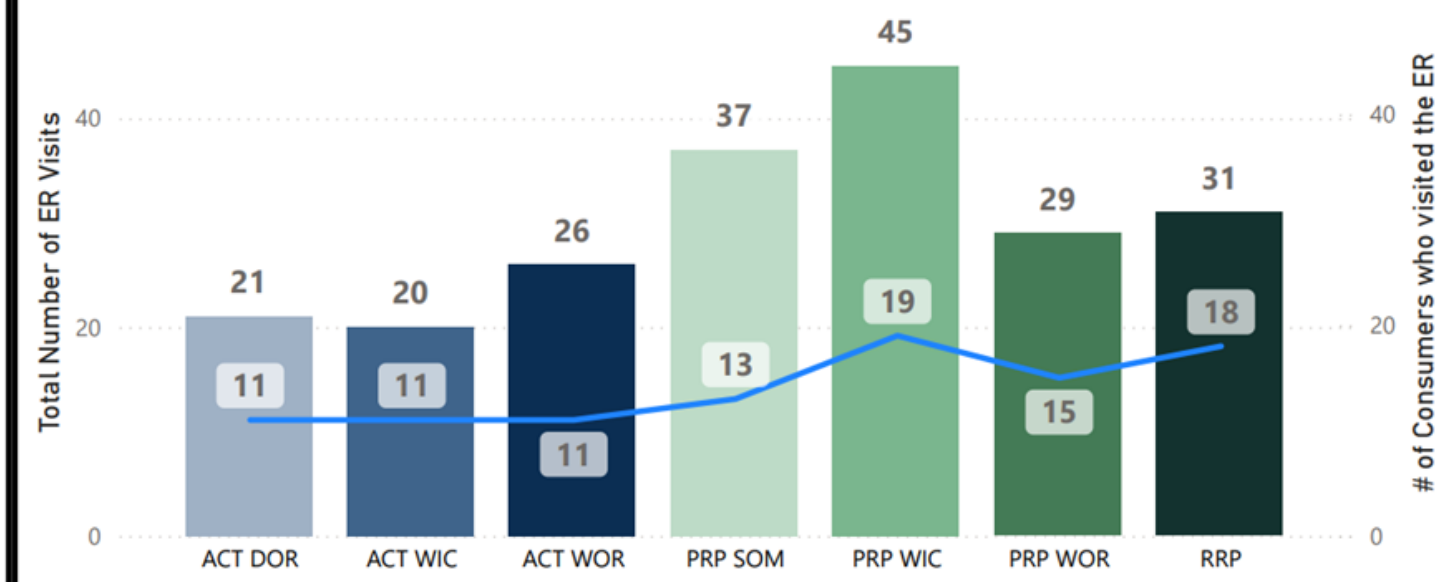
% of Clients with at least 1 ER Visit



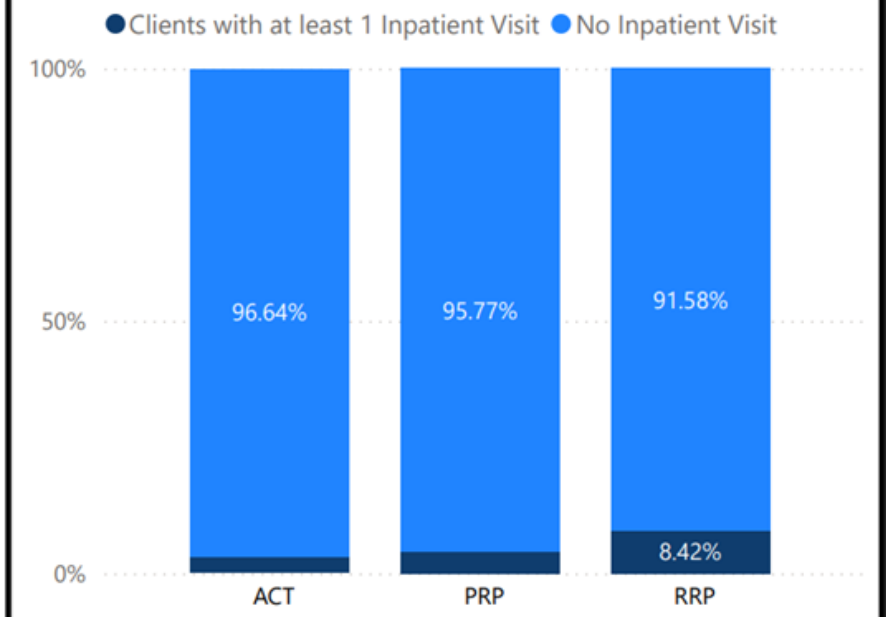
Total ER Visits | # of Clients with at least 1 ER Visit



Total ER Visits | # of Clients with at least 1 ER Visit



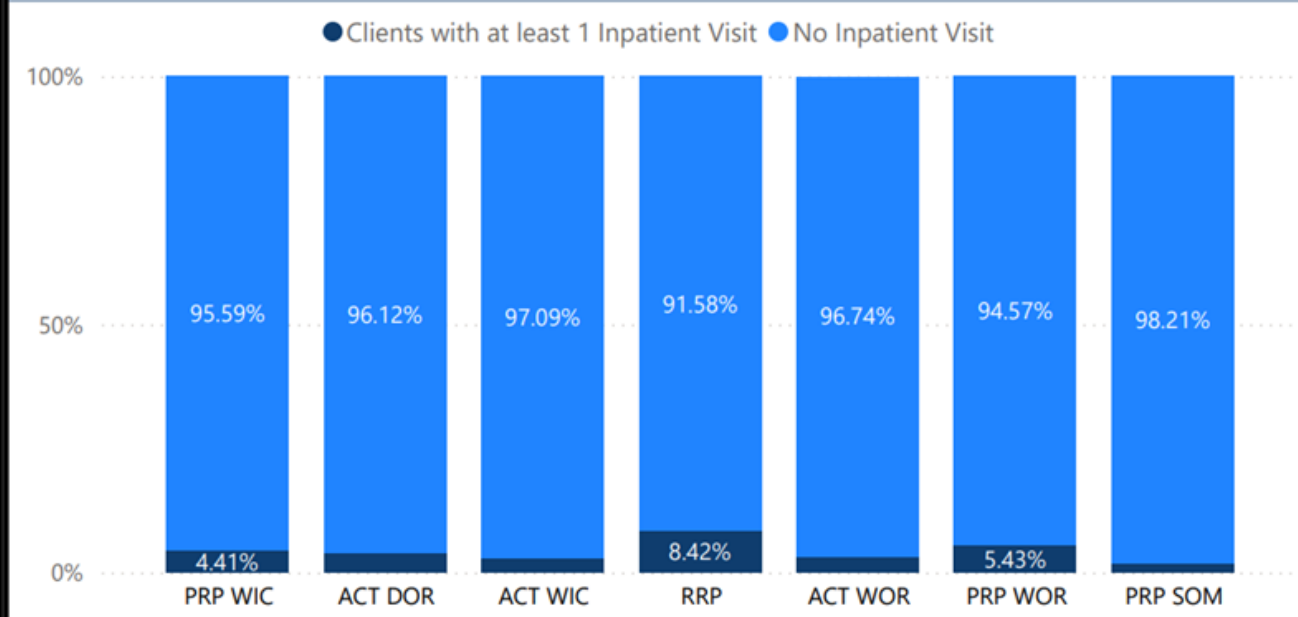
% of Clients with at least 1 Inpatient Visit



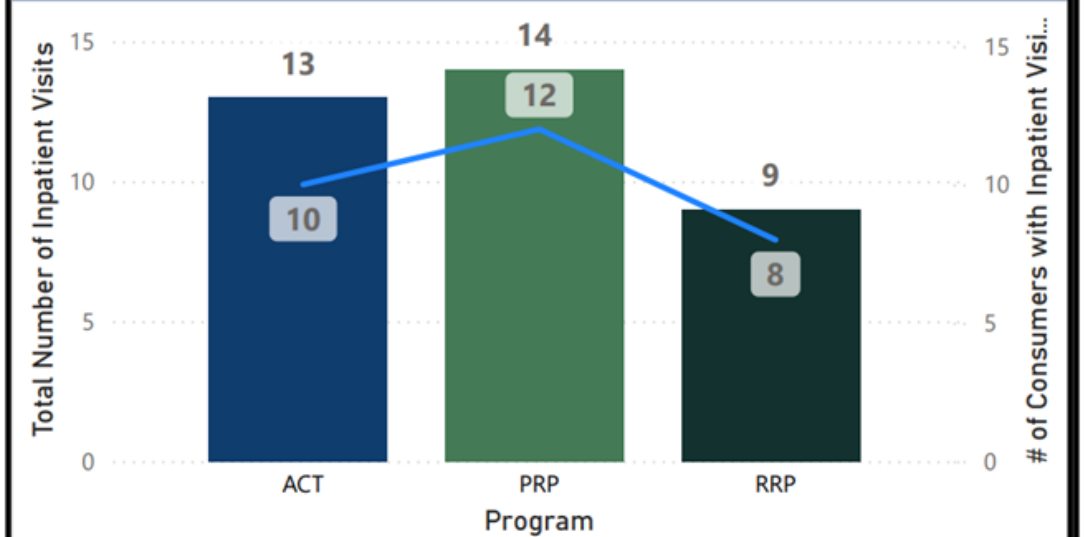
Inpatient Visits

Inpatient Visit Range:
ACT 0-2
PRP 0-2
RRP 0-2

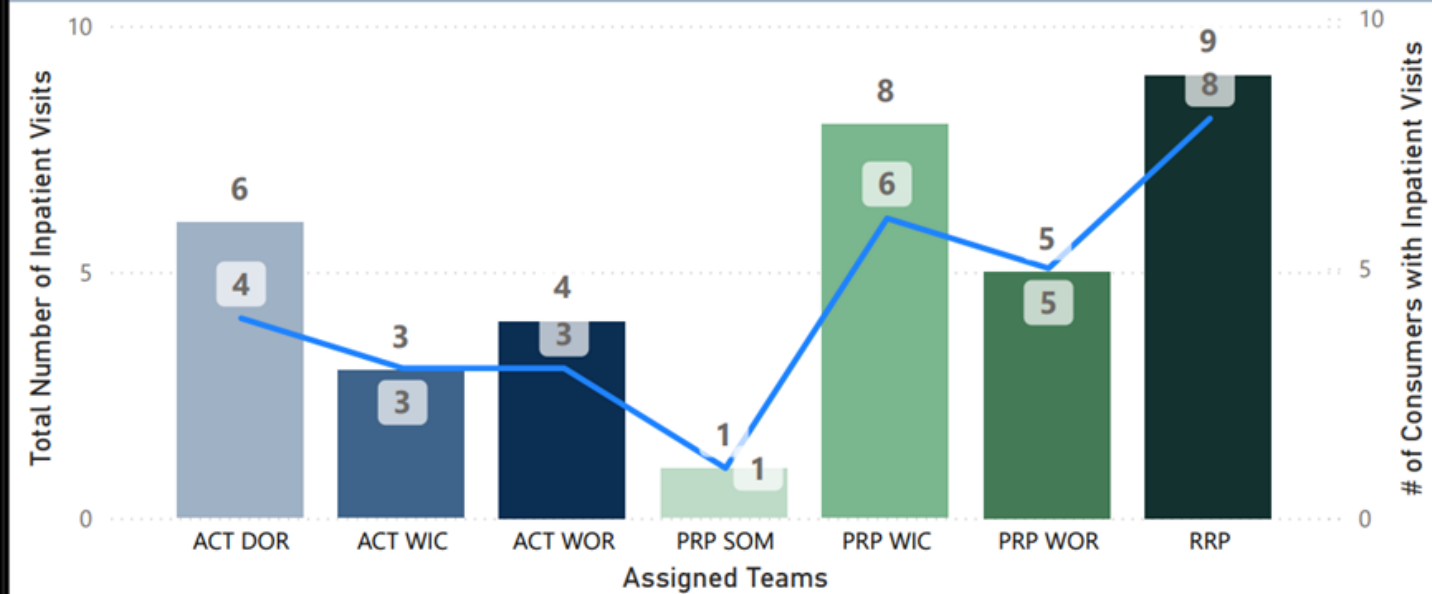
% of Clients with at least 1 Inpatient Visit



Total Inpatient Visits |
| # of Clients with at least 1 Inpatient Visit



Total Inpatient Visits | # of Clients with at least 1 Inpatient Visit



Pre/Post Analysis - Summary

The analysis is based on admissions before and after the enrollment date.
Please select a Program to populate the reports.

Program Name
All Community Program CCBHC (412)

Chronic Conditions
All Patients

Chronic Condition Operator
(•) AND
( ) OR

Most Recent Payer Group
All

Visit Type
All

N/A

N/A

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	576	527	464	359

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	154	100	26.7%	17.4%	-9.4%
3 Months	227	169	43.1%	32.1%	-11.0%
6 Months	259	215	55.8%	46.3%	-9.5%
12 Months	244	221	68.0%	61.6%	-6.4%

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	263	167	4.6	2.9	-1.7
3 Months	582	431	11.0	8.2	-2.9
6 Months	874	706	18.8	15.2	-3.6
12 Months	1,162	976	32.4	27.2	-5.2

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	197	$1,397,819	$424,996	$9,077	$4,250	($4,827)
3 Months	281	$2,866,089	$1,116,699	$12,626	$6,608	($6,018)
6 Months	312	$3,418,635	$2,069,187	$13,199	$9,624	($3,575)
12 Months	285	$4,402,130	$2,508,314	$18,042	$11,350	($6,692)

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	263	167	$1,397,819	$424,996	$5,315	$2,545	($2,770)
3 Months	582	431	$2,866,089	$1,116,699	$4,925	$2,591	($2,334)
6 Months	874	706	$3,418,635	$2,069,187	$3,911	$2,931	($981)
12 Months	1,162	976	$4,402,130	$2,508,314	$3,788	$2,570	($1,218)

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	197	$1,397,819	$424,996	$9,077	$4,250	($4,827)
3 Months	281	$2,866,089	$1,116,699	$12,626	$6,608	($6,018)
6 Months	312	$3,418,635	$2,069,187	$13,199	$9,624	($3,575)
12 Months	285	$4,402,130	$2,508,314	$18,042	$11,350	($6,692)

Pre/Post Analysis - Summary

The analysis is based on admissions before and after the enrollment date.
Please select a Program to populate the reports.

Program Name
PRP Only CCBHC (412)

Chronic Conditions
All Patients

Chronic Condition Operator
(•) AND
( ) OR

N/A

Most Recent Payer Group
All

Visit Type
All

N/A

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	243	229	216	196

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	49	39	20.2%	16.0%	-4.1%
3 Months	88	71	38.4%	31.0%	-7.4%
6 Months	119	107	55.1%	49.5%	-5.6%
12 Months	132	132	67.3%	67.3%	0.0%

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	74	60	3.0	2.5	-0.6
3 Months	200	147	8.7	6.4	-2.3
6 Months	372	309	17.2	14.3	-2.9
12 Months	632	590	32.2	30.1	-2.1

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	69	$213,981	$225,087	$4,367	$5,771	$1,404
3 Months	117	$1,148,178	$353,652	$13,047	$4,981	($8,066)
6 Months	150	$1,505,597	$758,570	$12,652	$7,089	($5,563)
12 Months	159	$2,114,677	$1,396,579	$16,020	$10,580	($5,440)

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	74	60	$213,981	$225,087	$2,892	$3,751	$860
3 Months	200	147	$1,148,178	$353,652	$5,741	$2,406	($3,335)
6 Months	372	309	$1,505,597	$758,570	$4,047	$2,455	($1,592)
12 Months	632	590	$2,114,677	$1,396,579	$3,346	$2,367	($979)

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	69	$213,981	$225,087	$4,367	$5,771	$1,404
3 Months	117	$1,148,178	$353,652	$13,047	$4,981	($8,066)
6 Months	150	$1,505,597	$758,570	$12,652	$7,089	($5,563)
12 Months	159	$2,114,677	$1,396,579	$16,020	$10,580	($5,440)

Pre/Post Analysis - Summary

The analysis is based on admissions before and after the enrollment date.
Please select a Program to populate the reports.

Program Name
RRP Only (412)

Chronic Conditions
All Patients

Chronic Condition Operator
(•) AND
( ) OR

N/A

Most Recent Payer Group
All

Visit Type
All

N/A

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	85	82	75	63

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	10	9	11.8%	10.6%	-1.2%
3 Months	22	16	26.8%	19.5%	-7.3%
6 Months	31	24	41.3%	32.0%	-9.3%
12 Months	35	29	55.6%	46.0%	-9.5%

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	14	11	1.6	1.3	-0.4
3 Months	51	33	6.2	4.0	-2.2
6 Months	98	65	13.1	8.7	-4.4
12 Months	143	77	22.7	12.2	-10.5

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	15	$177,208	$17,573	$17,721	$1,953	($15,768)
3 Months	30	$303,529	$80,632	$13,797	$5,040	($8,757)
6 Months	36	$460,387	$323,208	$14,851	$13,467	($1,384)

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	14	11	$177,208	$17,573	$12,658	$1,598	($11,060)
3 Months	51	33	$303,529	$80,632	$5,952	$2,443	($3,508)
6 Months	98	65	$460,387	$323,208	$4,698	$4,972	$275

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	15	$177,208	$17,573	$17,721	$1,953	($15,768)
3 Months	30	$303,529	$80,632	$13,797	$5,040	($8,757)
6 Months	36	$460,387	$323,208	$14,851	$13,467	($1,384)
12 Months	40	$780,077	$335,029	$22,288	$11,553	($10,735)

Pre/Post Analysis - Summary

The analysis is based on admissions before and after the enrollment date.
Please select a Program to populate the reports.

Program Name
ACT Only CCBHC (412)

Chronic Conditions
All Patients

N/A

N/A

Chronic Condition Operator
(●) AND
( ) OR

Most Recent Payer Group
All

Visit Type
All

Total Number of Members on Panel that could contribute to analysis

	1 Month	3 Months	6 Months	12 Months
Total Number of Patients in Panel that could contribute to analysis	243	211	170	97

Percent of Members on the Panel with 1 or more Visits

Time Period	Total Number of Patients with a visit - Pre	Total Number of Patients with a visit - Post	Total Number of Patients with a visit - Pre %	Total Number of Patients with a visit - Post %	Change in Number of Patients
1 Month	94	50	38.7%	20.6%	-18.1%
3 Months	115	80	54.5%	37.9%	-16.6%
6 Months	107	82	62.9%	48.2%	-14.7%
12 Months	75	57	77.3%	58.8%	-18.6%

Rate of Visits per 10 Members

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Rate of Visits per 10 patients - Pre	Rate of Visits per 10 patients - Post	Visits Rate change
1 Month	172	94	7.1	3.9	-3.2
3 Months	327	248	15.5	11.8	-3.7
6 Months	399	326	23.5	19.2	-4.3
12 Months	374	298	38.6	30.7	-7.8

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	110	$1,004,539	$180,752	$10,687	$3,615	($7,072)
3 Months	131	$1,402,192	$673,667	$12,193	$8,421	($3,772)
6 Months	124	$1,440,092	$977,690	$13,459	$11,923	($1,536)
12 Months	83	$1,475,752	$760,420	$19,677	$13,341	($6,336)

Average Charge per Visit

Time Period	Total Number of Visits - Pre	Total Number of Visits - Post	Total charges - Pre	Total charges - Post	Average Charge per visit - Pre	Average Charge per visit - Post	Total Charges per Visit change
1 Month	172	94	$1,004,539	$180,752	$5,840	$1,923	($3,917)
3 Months	327	248	$1,402,192	$673,667	$4,288	$2,716	($1,572)
6 Months	399	326	$1,440,092	$977,690	$3,609	$2,999	($610)
12 Months	374	298	$1,475,752	$760,420	$3,946	$2,552	($1,394)

Average Charge per Member

Time Period	Total Number of Patients with at least 1 visit pre or post	Total charges - Pre	Total charges - Post	Average Charge per patient - Pre	Average Charge per patient - Post	Total Charges per Patients change
1 Month	110	$1,004,539	$180,752	$10,687	$3,615	($7,072)
3 Months	131	$1,402,192	$673,667	$12,193	$8,421	($3,772)
6 Months	124	$1,440,092	$977,690	$13,459	$11,923	($1,536)
12 Months	83	$1,475,752	$760,420	$19,677	$13,341	($6,336)

Client	Gender	Age	Medicare Status	Dual Status	ADI	HCC Tier	Prediction Score Month Change	Status	HEART	PQI-Like Events	≥4 ED Visits Super Utilizer	Prediction Score Percentile	Prediction Score	Claim Payment Amount
1	Female	67	Aged without ESRD	Yes	70	Complex			Yes	5	Yes	Top 1st Percentile	24.32%	$139,666.35
2	Male	72	Aged without ESRD	Yes	null	Tier 4			No	1	Yes	Between 2nd and 5th Percentile	8.28%	$54,972.47
3	Female	64	Disabled without ESRD	Yes	null	Complex			No	4	Yes	Between 2nd and 5th Percentile	5.35%	$15,712.04
4	Male	62	Disabled without ESRD	No	87	Tier 4			Yes	0	No	Between 2nd and 5th Percentile	3.86%	$75,985.99
5	Female	92	Aged without ESRD	Yes	62	Complex			Yes	2	No	Between 2nd and 5th Percentile	3.58%	$26,424.08
6	Female	73	Aged without ESRD	Yes	48	Tier 4			No	1	No	Between 2nd and 5th Percentile	3.56%	$183,448.89
7	Female	73	Aged without ESRD	Yes	52	Complex			Yes	2	No	Between 2nd and 5th Percentile	2.88%	$12,313.90
8	Male	37	Disabled without ESRD	Yes	50	Tier 2			No	0	Yes	Between 6th and 10th Percentile	2.87%	$40,241.87
9	Male	69	Aged without ESRD	Yes	73	Complex			Yes	0	No	Between 6th and 10th Percentile	2.77%	$27,321.56
10	Male	57	Disabled without ESRD	No	62	Complex			Yes	0	No	Between 6th and 10th Percentile	2.48%	$20,391.98
11	Male	68	Aged without ESRD	Yes	73	Complex			Yes	1	No	Between 6th and 10th Percentile	2.44%	$31,604.69
12	Female	78	Aged without ESRD	Yes	58	Complex			Yes	0	No	Between 6th and 10th Percentile	1.84%	$255,181.54
13	Male	64	Disabled without ESRD	Yes	88	Complex			Yes	0	No	Between 6th and 10th Percentile	1.77%	$42,892.81
14	Male	54	Disabled without ESRD	No	60	Complex			Yes	0	No	Between 6th and 10th Percentile	1.70%	$137,557.50
15	Male	31	Disabled without ESRD	Yes	null	Tier 2			No	1	Yes	Between 6th and 10th Percentile	1.55%	$13,900.63
16	Female	78	Aged without ESRD	Yes	76	Tier 4			Yes	0	No	Between 11th and 20th Percentile	1.38%	$4,511.32
17	Female	59	Disabled without ESRD	Yes	83	Tier 3			No	0	Yes	Between 11th and 20th Percentile	1.37%	$12,931.91
18	Male	59	Disabled without ESRD	Yes	48	Tier 4			No	1	Yes	Between 11th and 20th Percentile	1.36%	$10,052.93
19	Female	63	Disabled without ESRD	Yes	68	Tier 4			Yes	0	No	Between 11th and 20th Percentile	1.30%	$127,670.85
20	Male	87	Aged without ESRD	No	73	Complex			Yes	0	No	Between 11th and 20th Percentile	1.27%	$1,788.78
21	Male	66	Aged without ESRD	No	73	Tier 4			Yes	0	No	Between 11th and 20th Percentile	1.15%	$35,024.35
22	Female	43	Disabled without ESRD	Yes	53	Tier 1			No	0	Yes	Between 11th and 20th Percentile	1.08%	$24,695.23
23	Female	58	Disabled without ESRD	Yes	74	Tier 3			No	0	No	Between 11th and 20th Percentile	1.04%	$2,585.09
24	Female	80	Aged without ESRD	Yes	81	Tier 4			Yes	0	No	Between 11th and 20th Percentile	1.03%	$6,144.64
25	Male	65	Disabled without ESRD	No	73	Tier 3			No	0	No	Between 11th and 20th Percentile	0.98%	$12,140.07
26	Male	37	Disabled without ESRD	Yes	87	Tier 1			No	4	Yes	Between 11th and 20th Percentile	0.78%	$2,702.08
27	Male	72	Aged without ESRD	Yes	71	Tier 2			No	0	No	Between 11th and 20th Percentile	0.78%	$4,043.03
28	Male	71	Aged without ESRD	Yes	null	Complex			No	0	No	Between 11th and 20th Percentile	0.77%	$25,059.39
29	Male	71	Aged without ESRD	Yes	73	Complex	Decreased		Yes	0	No	Between 11th and 20th Percentile	0.74%	$10,015.44
30	Male	73	Aged without ESRD	No	73	Tier 1			No	0	No	Between 11th and 20th Percentile	0.73%	$2,636.04
31	Male	67	Aged without ESRD	Yes	62	Tier 4			Yes	0	No	Between 11th and 20th Percentile	0.73%	$17,337.42
32	Male	66	Aged without ESRD	No	null	Tier 2			No	0	No	Between 21st and 100th Percentile	0.72%	$20,514.87
33	Male	65	Disabled without ESRD	Yes	65	Tier 4			Yes	0	No	Between 21st and 100th Percentile	0.71%	$5,113.27
34	Female	76	Aged without ESRD	Yes	86	Tier 3			No	1	No	Between 21st and 100th Percentile	0.70%	$11,270.22
35	Male	57	Disabled without ESRD	Yes	62	Tier 2			No	1	Yes	Between 21st and 100th Percentile	0.67%	$30,275.82
36	Male	62	Disabled without ESRD	Yes	67	Tier 4			Yes	0	No	Between 21st and 100th Percentile	0.67%	$1,579.05
37	Female	70	Aged without ESRD	No	74	Tier 3			No	0	No	Between 21st and 100th Percentile	0.66%	$1,904.31
38	Male	79	Aged without ESRD	Yes	57	Tier 3			No	0	No	Between 21st and 100th Percentile	0.65%	$19,275.79
39	Female	60	Disabled without ESRD	Yes	83	Tier 2			No	0	No	Between 21st and 100th Percentile	0.65%	$28,083.57
40	Male	69	Aged without ESRD	Yes	77	Complex	Increased		Yes	0	No	Between 21st and 100th Percentile	0.64%	$32,471.19
41	Male	42	Disabled without ESRD	Yes	67	Tier 2			No	0	No	Between 21st and 100th Percentile	0.63%	$8,625.30
42	Male	62	Disabled without ESRD	Yes	62	Tier 4			Yes	0	No	Between 21st and 100th Percentile	0.60%	$8,626.18
43	Female	40	Disabled without ESRD	Yes	48	Complex			No	0	No	Between 21st and 100th Percentile	0.59%	$3,579.05
44	Male	68	Aged without ESRD	Yes	null	Tier 4			No	0	No	Between 21st and 100th Percentile	0.58%	$38,762.18
45	Female	72	Aged without ESRD	No	62	Tier 2	Increased		No	0	No	Between 21st and 100th Percentile	0.56%	$6,554.00
46	Male	57	Disabled without ESRD	Yes	66	Complex			Yes	0	Yes	Between 21st and 100th Percentile	0.56%	$16,687.49
47	Female	47	Disabled without ESRD	Yes	39	Tier 3			No	0	No	Between 21st and 100th Percentile	0.54%	$2,160.26
48	Female	70	Aged without ESRD	Yes	73	Tier 3			No	0	No	Between 21st and 100th Percentile	0.52%	$1,025.73
49	Male	68	Aged without ESRD	No	60	Tier 3			No	1	No	Between 21st and 100th Percentile	0.50%	$9,175.72
50	Female	61	Disabled without ESRD	Yes	77	Tier 3			No	0	No	Between 21st and 100th Percentile	0.49%	$4,011.66
51	Female	54	Disabled without ESRD	Yes	69	Tier 4			Yes	0	No	Between 21st and 100th Percentile	0.46%	$1,081.62
52	Male	59	Disabled without ESRD	No	63	Tier 4			Yes	0	No	Between 21st and 100th Percentile	0.46%	$14,886.28
53	Female	67	Aged without ESRD	Yes	69	Tier 4			Yes	0	No	Between 21st and 100th Percentile	0.46%	$2,618.50
54	Male	68	Aged without ESRD	Yes	73	Tier 2			No	0	No	Between 21st and 100th Percentile	0.44%	$1,550.95
55	Male	65	Not enrolled in Medicare A or B this month	Yes	83	Tier 4			Yes	0	No	Between 21st and 100th Percentile	0.42%	$3,312.64

Demographics

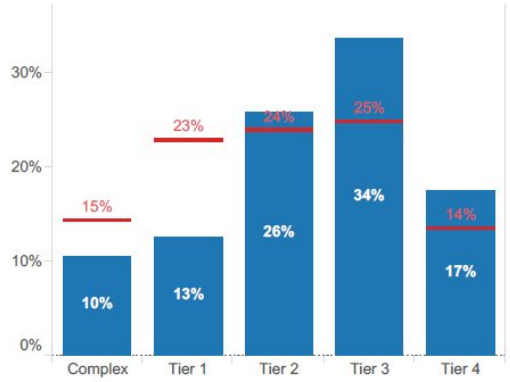
Claims available through 4/30/2025.

CCLF data after 1/31/2025 is considered incomplete due to lag.

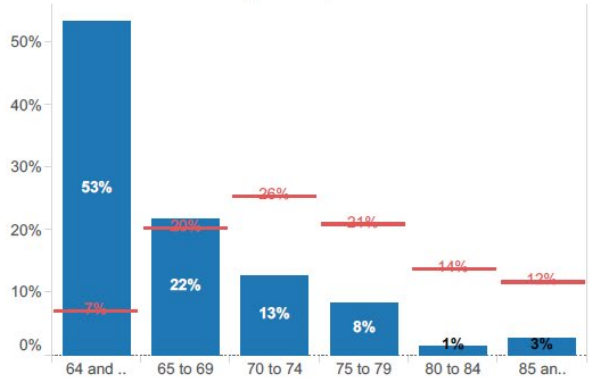
Practice: Lower Shore Clinic, Inc. (T1MD0913)
CTO: No CTO (NO_CTO)

State - Comparison
State - MDPCP

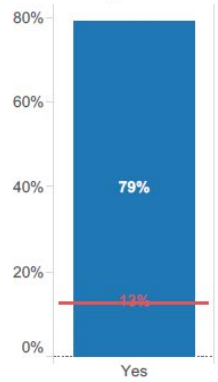
HCC Tier



Age Group

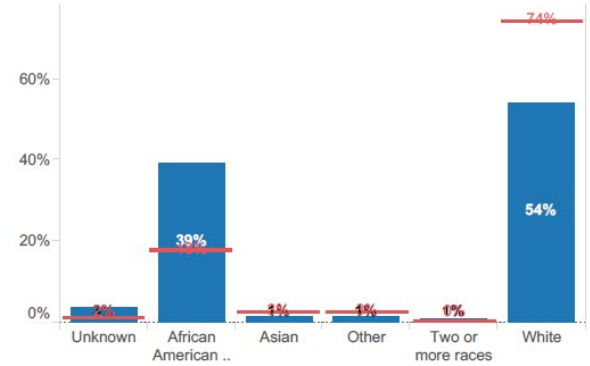


Dual Eligibles

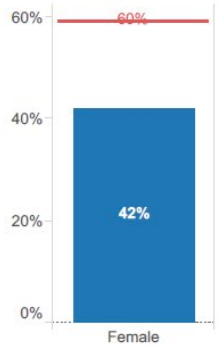


Average HCC Score by HCC Tier

Race



Gender



1. *All distributions shown are given as a percentage of the total practice beneficiary count.*
2. *State benchmarks for HCC Tier and Average HCC Score by HCC Tier will be populated only for State - MDPCP and MDPCP FQHC.*
3. *State numbers are based on latest 12 months time period.*

Legend: Red percentages indicate the average for the selected State - Comparison

Chronic Condition Report

Practice: Lower Shore Clinic, Inc. (T1MD0913)
CTO: No CTO (NO_CTO)

Claims available through 4/30/2025.

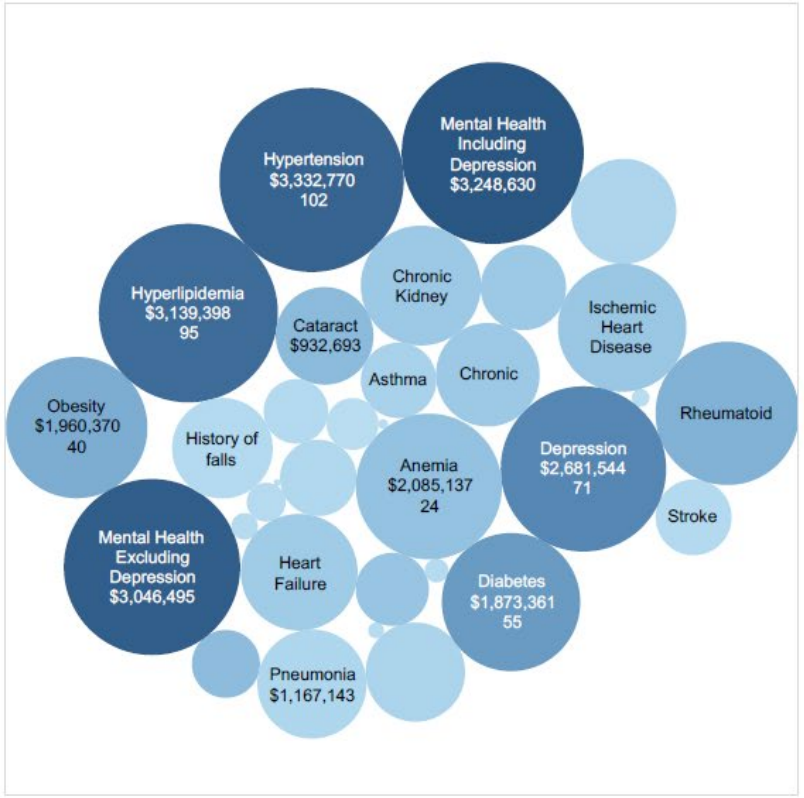
CCLF data after 1/31/2025 is considered incomplete due to lag.

State - Comparison
State - MDPCP

Service Start Month
May 2022

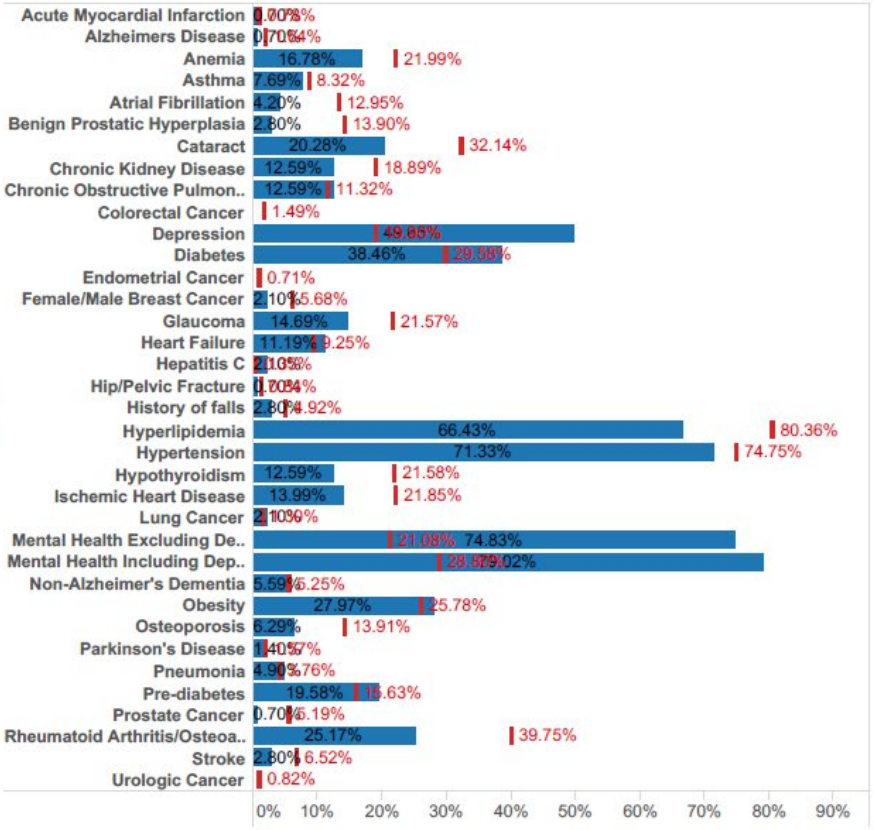
Service End Month
January 2025

Total Payments by CCW Category



Bubble size represents Total Claim Payment Amount and Color represents Beneficiary Count

CCW Category Distribution



Legend: Red indicates the percentage for the selected State - Comparison

CCW Category Summary

	Practice				State - MDPCP			
CCW Category	Beneficiary Count	Claim Count	Claim Payment Am..	Claim Paid Per Me..	Beneficiary Count	Claim Count	Claim Payment Am..	Claim Paid Per Me..
Acute Myocardial Infarction	1	397	$262,102	$262,102	2,714	421,975	$249,758,478	$92,026
Alzheimers Disease	1	27	$8,617	$8,617	5,713	662,311	$252,202,838	$44,145
Anemia	24	4,443	$2,085,137	$86,881	76,490	10,324,028	$4,498,343,006	$58,810
Asthma	11	1,805	$556,693	$50,608	28,928	3,753,214	$1,312,264,648	$45,363
Atrial Fibrillation	6	1,238	$570,276	$95,046	45,051	5,908,718	$2,491,065,213	$55,294
Benign Prostatic Hyperplasia	4	853	$405,330	$101,333	48,333	4,970,645	$1,796,669,393	$37,173
Cataract	29	2,965	$932,693	$32,162	111,785	10,409,254	$3,085,636,542	$27,603
Chronic Kidney Disease	18	2,873	$1,409,314	$78,295	65,698	8,072,088	$3,161,727,213	$48,125
Chronic Obstructive Pulmonar..	18	2,327	$1,050,115	$58,340	39,365	5,202,505	$2,154,478,925	$54,731
Colorectal Cancer					5,176	667,923	$320,377,697	$61,897
Depression	71	8,714	$2,681,544	$37,768	65,712	8,524,660	$3,202,452,153	$48,735
Diabetes	55	5,547	$1,873,361	$34,061	102,856	10,906,086	$3,812,202,760	$37,063
Endometrial Cancer					2,486	321,217	$136,021,411	$54,715
Female/Male Breast Cancer	3	338	$53,846	$17,949	19,757	2,336,051	$831,145,769	$42,068
Glaucoma	21	1,779	$521,598	$24,838	75,013	7,457,508	$2,267,178,899	$30,224
Heart Failure	16	2,587	$1,332,023	$83,251	32,156	4,883,439	$2,317,993,693	$72,086
Hepatitis C	3	444	$146,657	$48,886	1,213	153,803	$73,694,482	$60,754
Hip/Pelvic Fracture	1	51	$4,011	$4,011	2,936	455,031	$244,182,873	$83,169
History of falls	4	1,318	$989,442	$247,360	17,104	2,805,207	$1,347,294,707	$78,771
Hyperlipidemia	95	10,129	$3,139,398	$33,046	279,465	25,766,265	$8,319,339,034	$29,769
Hypertension	102	10,919	$3,332,770	$32,674	259,935	24,612,179	$8,313,653,601	$31,984
Hypothyroidism	18	2,299	$712,782	$39,599	75,059	7,959,148	$2,656,453,979	$35,392
Ischemic Heart Disease	20	3,243	$1,612,226	$80,611	75,976	9,180,823	$3,642,054,303	$47,937
Lung Cancer	3	288	$67,615	$22,538	4,536	707,104	$418,770,689	$92,322
Mental Health Excluding Depr..	107	10,870	$3,046,495	$28,472	73,315	8,949,305	$3,199,132,206	$43,635
Mental Health Including Depre..	113	11,604	$3,248,630	$28,749	100,163	11,884,352	$4,255,873,713	$42,489
Non-Alzheimer's Dementia	8	1,681	$1,080,259	$135,032	18,266	2,448,369	$1,109,331,513	$60,732
Obesity	40	5,414	$1,960,370	$49,009	89,636	9,637,124	$3,383,039,182	$37,742
Osteoporosis	9	1,891	$964,625	$107,181	48,380	5,468,180	$1,810,118,681	$37,415
Parkinson's Disease	2	184	$23,730	$11,865	5,458	796,459	$292,354,932	$53,564
Pneumonia	7	1,837	$1,167,143	$166,735	13,084	2,204,732	$1,168,162,993	$89,282
Pre-diabetes	28	2,205	$450,331	$16,083	54,358	4,871,466	$1,434,249,317	$26,385
Prostate Cancer	1	90	$29,521	$29,521	18,059	1,858,687	$706,032,336	$39,096

HealthPort Logic Model

Dimensions of the Social Determinants of Health Model of Care	HealthPort Interventions	Goals and Outcome Measures
Housing	Residential Rehabilitation Program Psychiatric Rehabilitation Housing Stability Services Supportive Housing	At any given time, 90% of clients will be housed through the use of organizational housing services and access to subsidized housing.
Primary Care	Primary Care Screening and Intervention	The average number of abnormal values in client comprehensive metabolic panel results will decrease by 25%.
Mental Health Care	Outpatient Mental Health Treatment	The percentage of clients with low suicide risk measured by Columbia Suicide Severity Risk Scale will increase to 90%
Substance Use Care	Substance Use Treatment	Overall problematic substance use as measured by the single question screener will decrease to 20%.
Medication Adherence	Medherent Devices Multidose Strip Packaging	Medication adherence rates for clients using the Medherent Device will increase to 95%. The percentage of clients utilizing multidose strip packaging will increase to 90%.
Population Health Management	Health Promotion and Management	The percentage of clients with Healthy BMIs, Blood Pressure under 140/90, A1C under 9, and PHQ-9 scores ≤10 will increase to match Maryland rates.
Employment	Vocational Training Supported Employment	Employment rates of clients in competitive or supported employment will increase to 25%.
Financial Management	Representative Payee Services	For individuals enrolled in organizational representative payee services, 95% of all bills will be paid on time.
Transportation	Transportation Services Agency Vehicle Fleet	100% percent of clients will have access to transportation.
Community Integration	Psychiatric Rehabilitation Day Program	The percentage of clients who report they are lonely during treatment planning will decrease to under 25%.
Food Security	Food is Medicine	Each program will serve an average of 2 meals a day per client, 7 days a week.
Crisis Stabilization	Residential Crisis Services (RCS) Crisis Response System	Clients staying at RCS will not utilize the emergency department or inpatient hospitalization for psychiatric diagnosis during RCS stay and 30 days post-discharge.
Flexible Funding	Member Assistance Loans Charitable Care	100% of member assistance loans and charitable care will remove barriers related to client social determinants of health needs.

Results Monthly Pre-Post analysis of enrolled individuals will show trending decrease of hospital utilization and cost according to health information exchange reporting tools.

University of Maryland School of Social Work

HIV, STI, Viral Hepatitis, and Other Disease and Conditions are Targeted through our Population Health Management Program Using Integrated Registered Nurses in our Programs Connected into our Primary Care Practice.

Health Departments Support Our Work By:

- Understanding Our Unique Position to Make an Impact
- Provide Special Funding for Initiatives such as Harm Reduction Vending Machines and Targeted Disease Interventions to High-Risk Population
- Coordinate with the Local Behavioral Health Authority to Provide Additional Supports and Inform BH Providers of Initiatives They May Not Be Attuned
- Health Departments Can Be the Connection to the Larger Health System and Their Leaders
- Most BH Providers Do Not Provide Primary Care so Health Departments Can Provide Support In This Area
- 57% of super-utilizers (top 10% of spenders) had a mental health or substance use disorder.
- Support the Implementation of the CCBHC Model in Maryland

Thank You!

Dimitrios Cavathas, LCSW-C

CEO

HealthPort

dcavathas@healthport.org

www.healthport.org

FLIP THE SCRIPT:
Integrating Sexual Health

Dr. Raj Sonani/ Pavan Ramakrishnaiah

Serenity Health Center

11:15 am

Maryland
DEPARTMENT OF HEALTH

SERENITY HEALTH CENTER

STI & HIV PREVENTION AND AFTER CARE PROPOSAL

PRESENTATION TO MARYLAND DEPARTMENT OF HEALTH

06/12/2025

Serenity Health Center(SHC) Overview

About

SHC is a nonprofit healthcare provider operating under FQHC guidelines. FQHC application submitted; approval expected imminently.

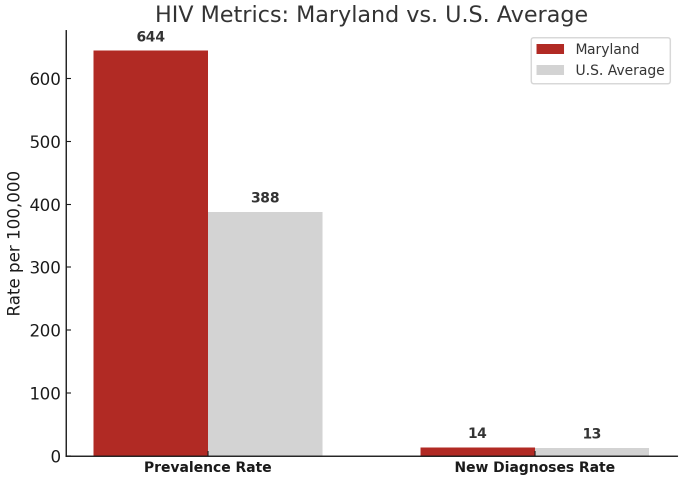
Offers integrated care, including primary care, behavioral health, and care coordination services.

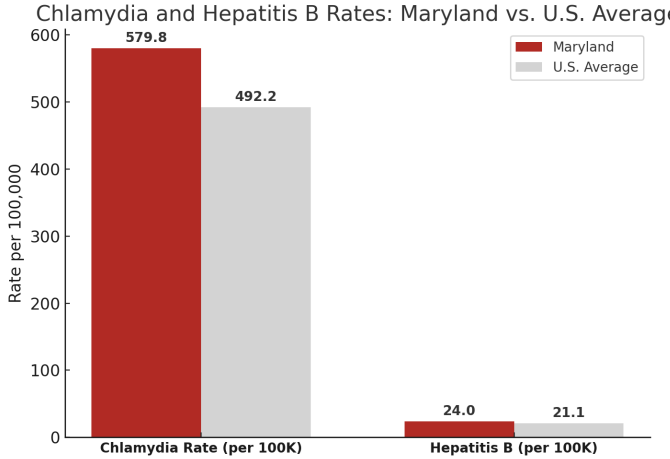
Mission

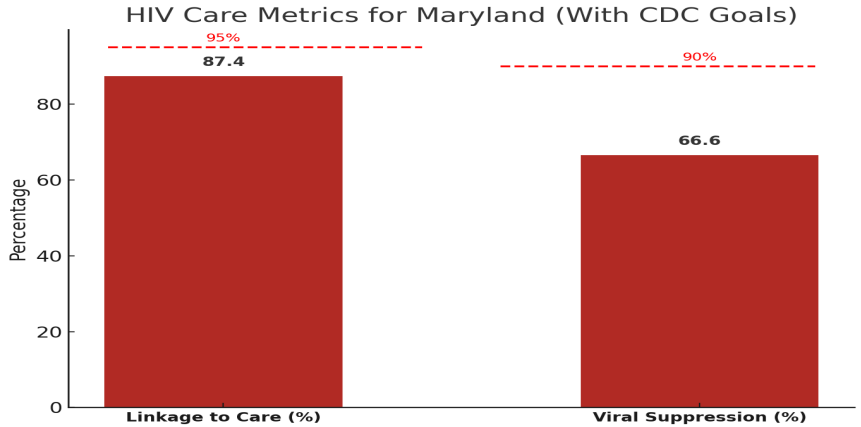
To close care gaps for underserved populations in Carroll County and surrounding areas.

We focus on fair healthcare and outreach for all uninsured patients and communities including Hispanic, Black, LGBTQ+

Key Public Health Indicators: Maryland and National Benchmarks







Health Access Challenges

Provider & Facility Shortages

- Shortage of Primary care access
- Higher ratio of provider-to-patient threshold
- Lack onsite HIV/STI testing, PrEP education, specialty referrals
- Delayed prevention, detection, and treatment

Social Determinants of Risk

- HIV Stigma and Ignorance
- Uninsured population and Poverty (higher among Black & Latino residents)
- Transportation gaps in rural/low-income areas

Care and Current Initiatives

- Establish an FQHC to provide Primary care and care for Uninsured people.
- Conduct STI testing in Specialty clinic setting.
  - Patients on biologic therapies are more susceptible to **infections**, which can include **sexually transmitted infections (STIs).**
  - Clinical guidelines (e.g., CDC STI Treatment Guidelines) emphasize that **immunocompromised individuals require more frequent STI screening**, suggesting elevated risk (cdc.gov)
- Collaborating with the County Health Department
- Offer Free PrEP Services: Partnerships

Care and Current Initiatives

- HIV/STI Testing & Education: Distribute self-test kits and partner notification cards
- Linkage & Retention Support: Hire part-time case managers to achieve ≥95% care linkage within 30 days
- Data & Quality Monitoring
  - Use a centralized EHR system to track HIV care continuum metrics monthly
  - Submit quarterly reports to the state to assess progress and refine strategies
- Social Media Education Campaign to Combat Stigma and Misinformation
- Enhanced Care Services Offering:
  - Expedited Partner Therapy (EPT)
  - Medication Therapy Management (MTM)
  - Medication Adherence Support

Support Requested from Maryland Department of Health (MDH)

Access to State Laboratory Services

- For confirmatory testing, diagnostic follow-up, and integration with referral pathways.

Educational Materials

- Bilingual (English/Spanish) brochures, posters, and digital content on HIV/STI prevention, PrEP eligibility, and safe-sex practices.

Program Supplies

- Provision of male and female condoms, HIV/STI test kits, and any other in-kind materials available under public health initiatives.

Community Event Participation

- Opportunities to join state- or county-led health fairs, outreach events, or testing campaigns for greater exposure and community engagement.

Data source and weblinks

https://health.maryland.gov/phpa/OIDEOR/CHSE/SiteAssets/Pages/statistics/HIV_Annual_Report_2023.pdf

CDC HIV Surveillance Report, 2022 (Vol. 34):

https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-34/index.html

https://health.maryland.gov/phpa/OIDEOR/CHSE/pages/hiv-ahead.aspx

https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html

https://www.cdc.gov/std/statistics/2022/default.htm

https://health.maryland.gov/phpa/OIDPCS/CSTIP/Pages/std-data-statistics.aspx

https://www.cdc.gov/std/prevention/screeningreccs.htm

https://health.gov/healthypeople/objectives-and-data/browse-objectives/sexually-transmitted-infections

https://health.maryland.gov/phpa/OIDPCS/VHPC/Documents/2022-MD-Viral-Hepatitis-Epi-Profile.pdf

https://www.cdc.gov/hepatitis/statistics/index.htm

Q&A

FLIP THE SCRIPT:
Integrating Sexual Health

Conversation with Presenters

Travis Brown
Acting Division Manager, Provider Engagement, Center for Navigation

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FLIP THE SCRIPT:
Integrating Sexual Health

Angelique Griffin
Gilead Sciences, Government Affairs

12:30 pm

Gilead's FOCUS Program Helps Zero In on Early HIV Detection

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FLIP THE SCRIPT:
Integrating Sexual Health

Peter DeMartino, Director

Infectious Disease Prevention and Health Services Bureau

Maryland Department of Health

1:00 pm


and now a word
from our sponsors


AND THE TONE WILL BE DIFFERENT

Cross Pillar Goal

1. Community Awareness	1. Community Awareness	1. Provider Knowledge
2. Provider Knowledge	5. Reduce Barriers	2. Systems Capacity
3. Systems Capacity	8. Data	7. Responsiveness (cultural capacity)
5. Reduce Barriers		4. Community Availability and Accessibility
5. Diversity of Agencies		
8. Data		

We provide community engagement and funding to support an active safety-net for acute and limited interventions and systems change

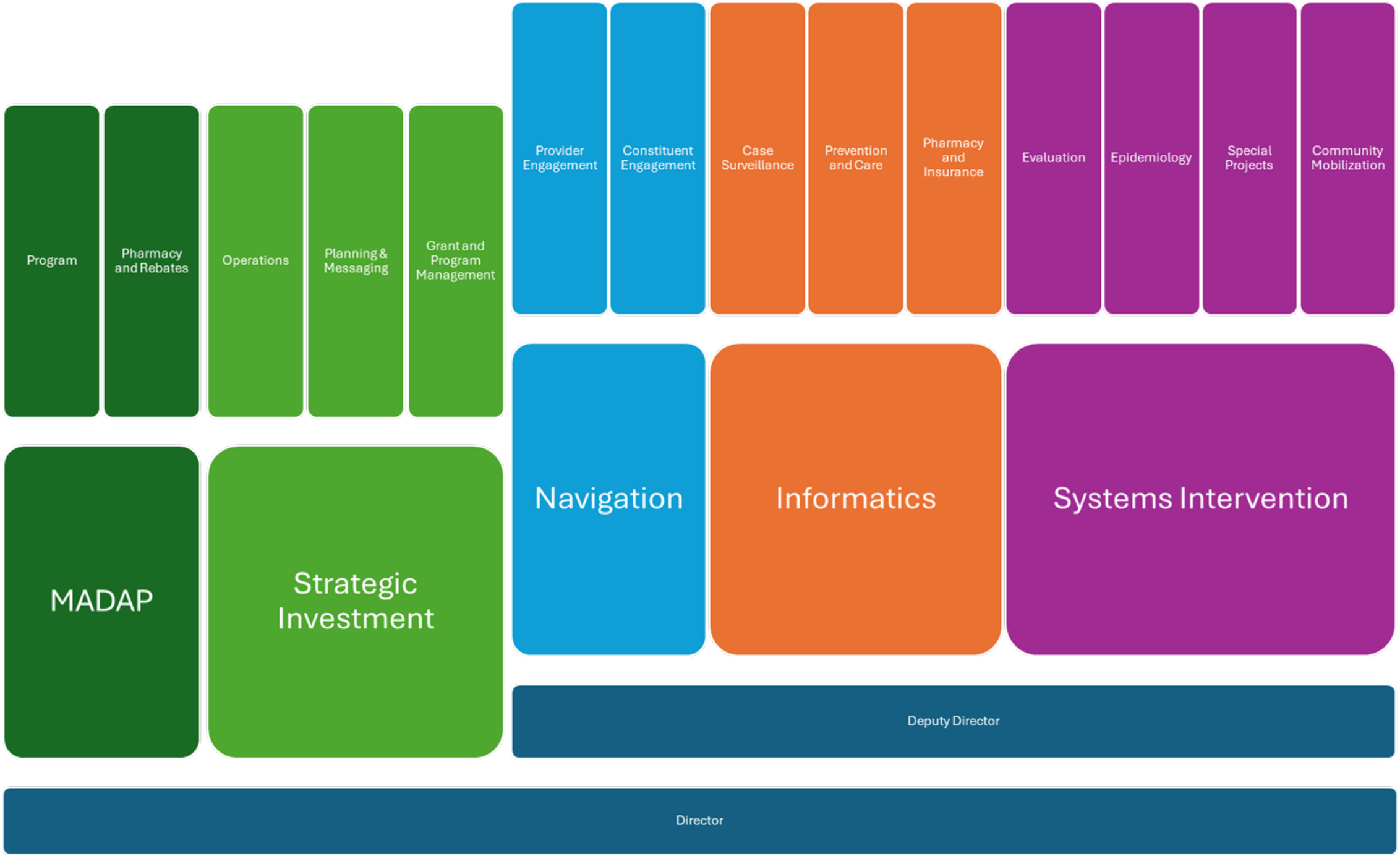
We provide health-incident, data-driven, constituent services that promote on-going wellness and continued engagement in the existing healthcare system

We ensure that payers and systems are responsive to the needs of populations made vulnerable and we provide planning, monitoring, and evaluation to inform capacity building and focused actions for improvements

Learn

See

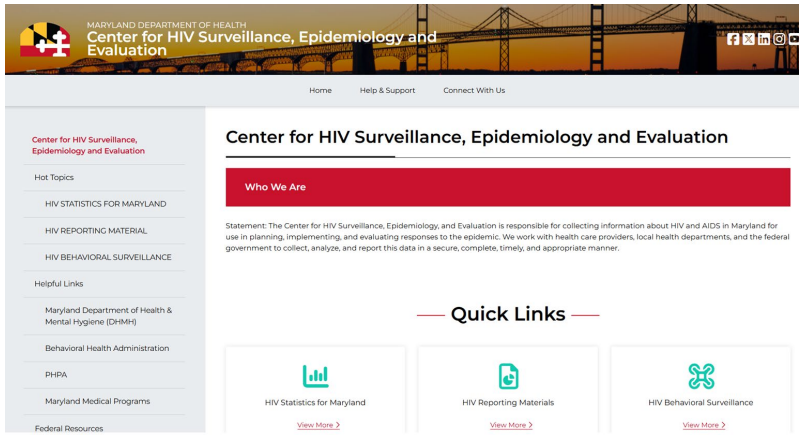
Amplify

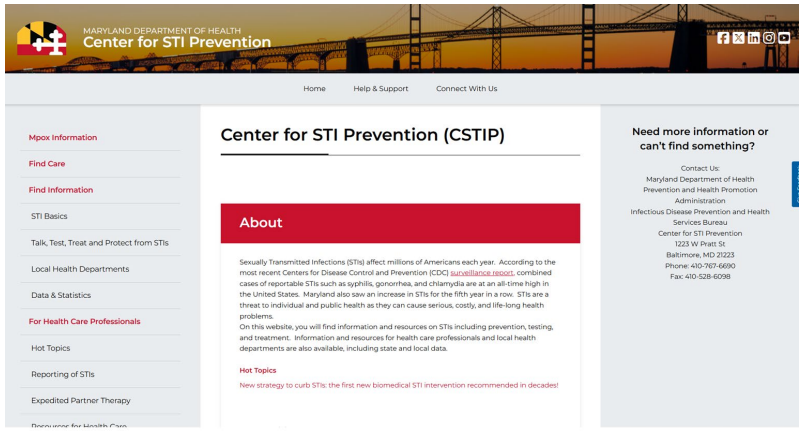

Program
Pharmacy and Rebates
Operations
Planning & Messaging
Grant and Program Management
Provider Engagement
Constituent Engagement
Case Surveillance
Prevention and Care
Pharmacy and Insurance
Evaluation
Epidemiology
Special Projects
Community Mobilization
MADAP
Strategic Investment
Navigation
Informatics
Systems Intervention
Deputy Director
Director

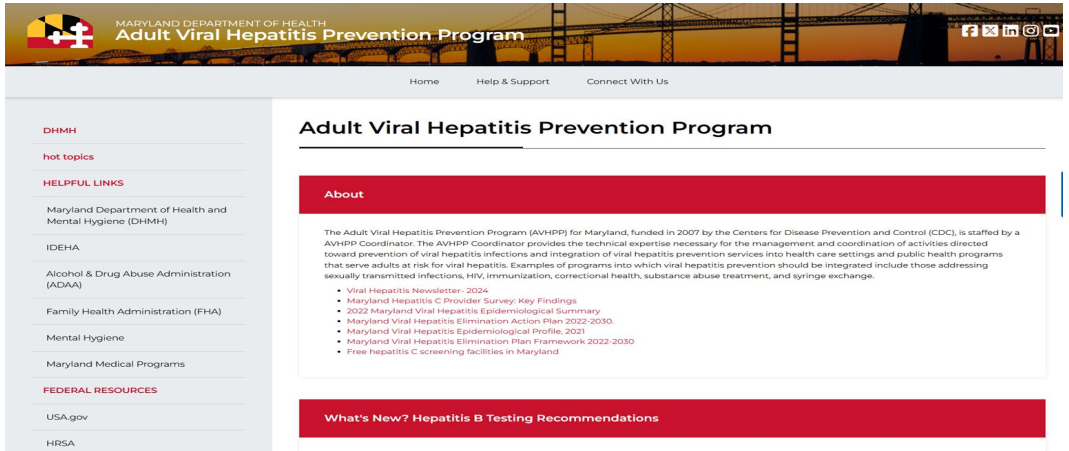
IDPHSB Website Transformation

Our website used to be a bit complicated.

- Every Center had a separate page.
- Many hadn't been updated in 5+ years.
- "Bonus pages" were hidden like Easter eggs, making information hard to find.



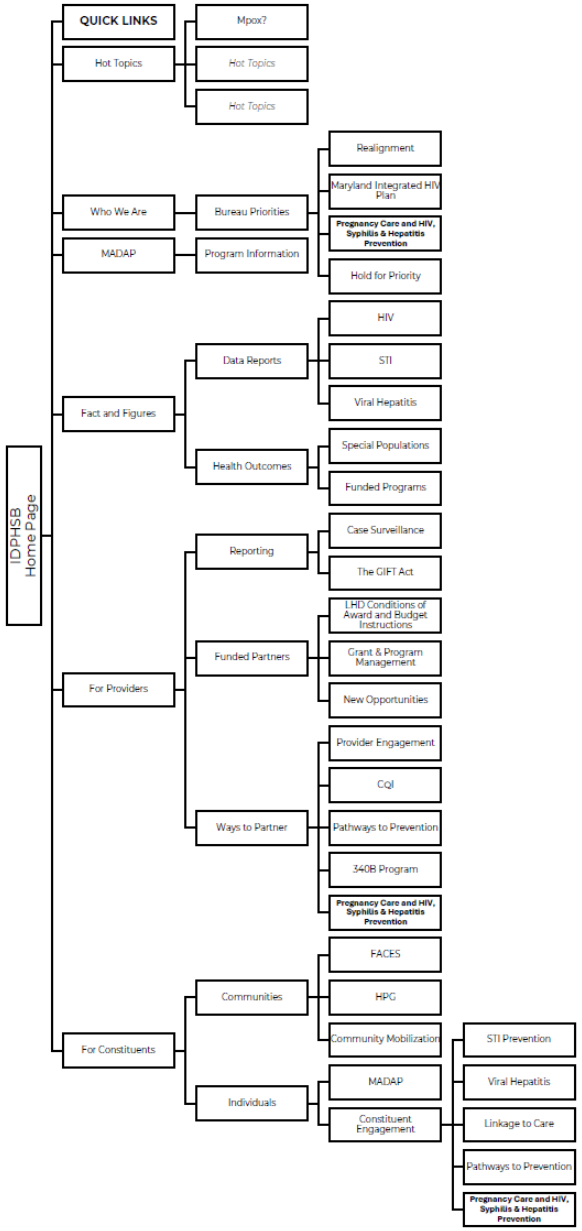




IDPHSB Website Transformation

We merged everything and now all content is now under the IDPHSB banner

IDPHSB Website Transformation



Now that everything is in one place, we're reorganizing the site navigation.

We're creating clear paths for:

- Providers
- Constituents
- Funded Partners

No more guessing where to go!

Whether you're looking for MADAP program information, reporting data, forms, or details on our 340B Partner program, it's all going to make sense.

Scan with your phone to visit our website

340B Expansion

340B Drug Pricing Program

The Maryland Department of Health is offering eligible providers of sexual health services in Maryland the opportunity to participate in the federal Sexually Transmitted Disease Title 318 340B Drug Pricing Program. This program enables covered entities to purchase outpatient drugs at significantly discounted prices from pharmaceutical manufacturers, helping providers enhance their resources to better serve their patients and communities.

For more information, visit Ways to Partner

Updates to nPEP Access

Pathways to Prevention

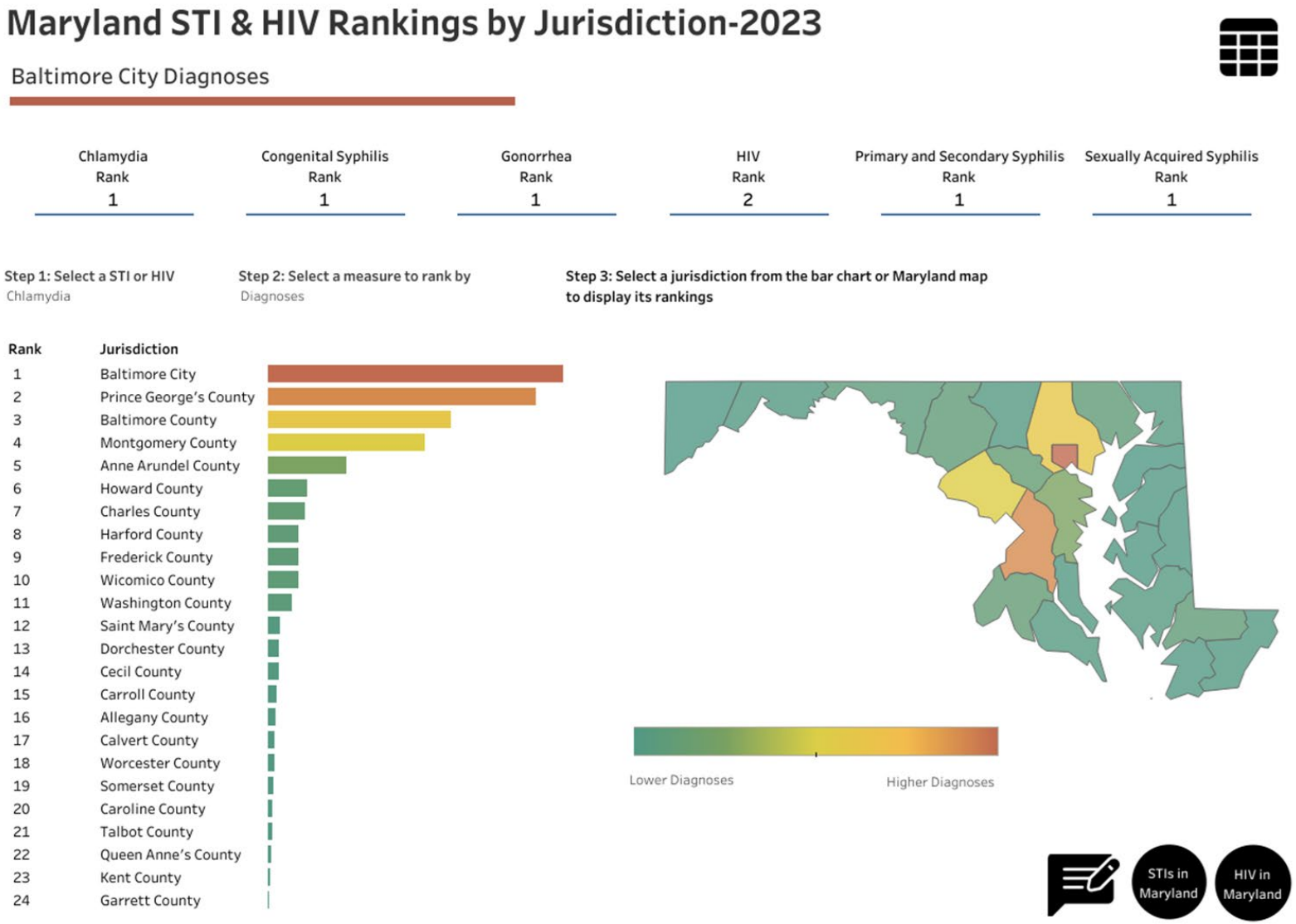
The Non-occupational Post Exposure Prophylaxis (nPEP) Standing Order Program in Maryland allows licensed pharmacists to dispense nPEP under certain circumstances. The Maryland Department of Health is responsible for administering the program, including:

- Adopting regulations for the program
- Addressing the needs of specific populations, such as pediatric patients and victims of sexual assault
- Establishing guidelines for program training

The nPEP Standing Order Program is established by House Bill 0127 and will be effective October 1, 2024.

For more information, visit Pathways to Prevention

Integrated Data Products



HIV Reporting Updates

- An electronic version of the MDH 1140 Morbidity Reporting Form in REDCap is available to report cases of HIV, AIDS, Perinatal HIV Exposures, and/or persons who are pregnant and HIV-positive to the Department.
  - Incoming reports will be reviewed by HIV Surveillance Unit staff and the results of these investigations will be documented in NBS.
  - Individual cases which require additional follow-up will be initiated through the regular partner services workflows with NBS.

Location: https://redcap.link/MDH1140

Instructions: https://health.maryland.gov/phpa/IDPHSB/Pages/reporting-material.aspx

Shortened Website Data Links

HIV Data

http://bit.ly/mdhivstats

STI Data

http://ethemd.co/mdstistats

Hepatitis Data

https://ethemd.co/mdhep

Mpox Data

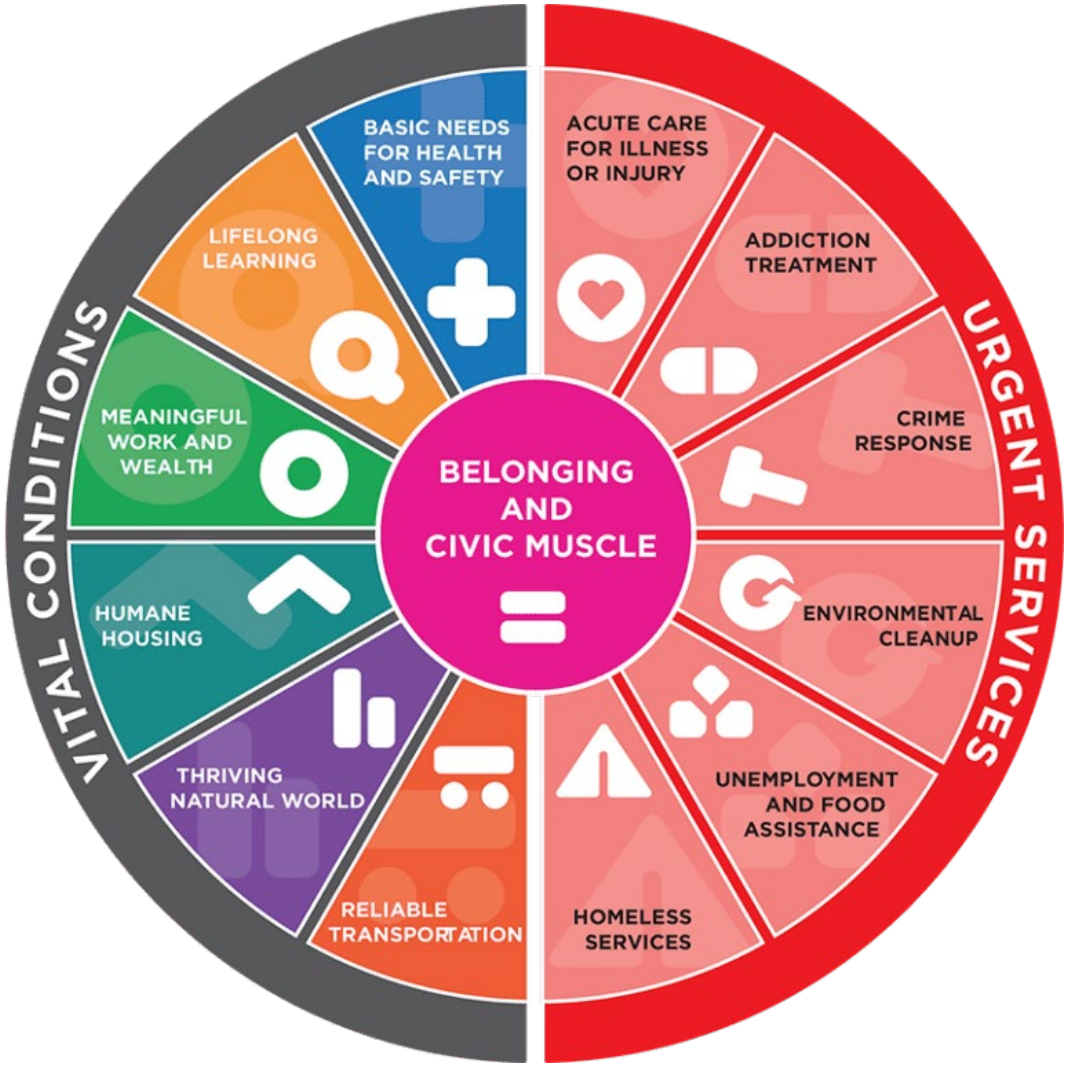
https://ethemd.co/mpoxdb

Request Additional Data

mdh.hivdatarequest@maryland.gov

Operationalizing the Plan

Realigning Public Health Response



https://health.gov/our-work/national-health-initiatives/equitable-long-term-recovery-and-resilience

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FLIP THE SCRIPT:
Integrating Sexual Health

Aaron Davis, MPH

Community Mobilization Division Manager

Center for Systems Intervention

1:30 pm

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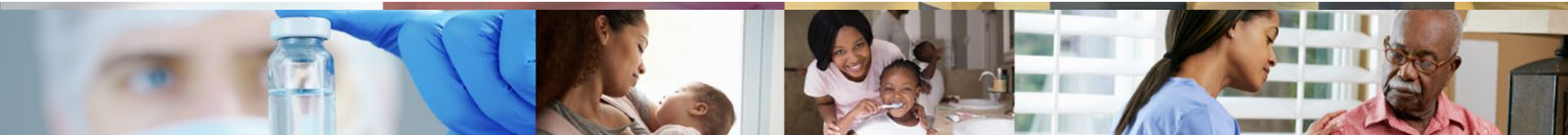
Case Statements as Tools for Priority Setting and Community Mobilization

Aaron Davis, MPH
Community Mobilization Division Manager
Center for Systems Intervention

June 12, 2025



Mission, Strategy, Vision, and Shared Values

Mission: The mission of the Prevention and Health Promotion Administration is to protect, promote and improve the health and well-being of all Marylanders.

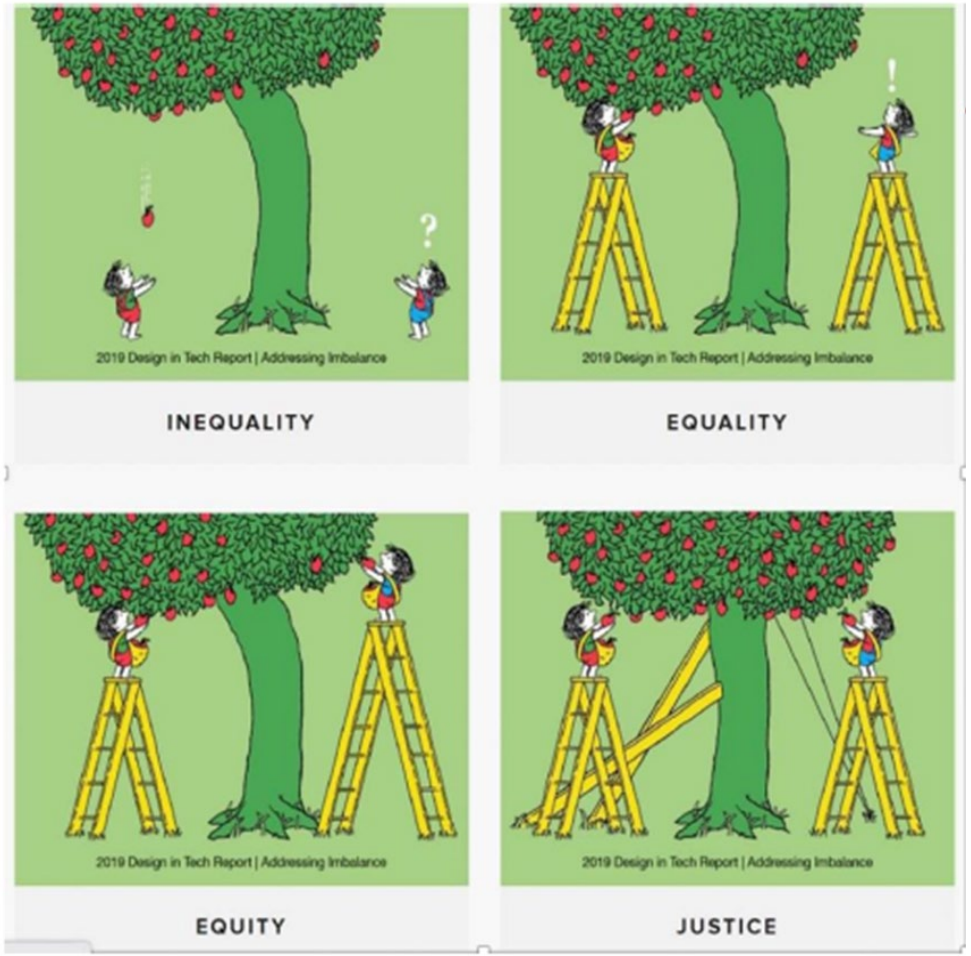
Strategy: PHPA seeks to achieve its mission through: 1) investing in sustainable community-based prevention and intervention efforts through collaborations with strategic public and private partners; 2) promoting health equity by focusing on priority populations; and 3) strengthening the public health workforce.

Vision: The Prevention and Health Promotion Administration envisions a future in which all Marylanders have equitable opportunities to live, thrive, and be healthy.

Shared Values:

- **Respect and Equity:** PHPA recognizes and encourages creativity, differences of opinions, collaboration of ideas, and diversity of all staff, partners and stakeholders
- **Inclusion:** PHPA seeks to honor the participation, leadership, expertise, and lived experiences arising from our communities and other sources, to identify health challenges and develop lasting solutions.
- **Integrity:** PHPA is committed to transparency, timeliness, dependability, and quality customer service.
- **Environmental Stewardship:** PHPA recognizes that health and the environment are intricately intertwined, and seeks to promote sustainable practices that safeguard public health, mitigate the spread of disease, and create thriving communities for all.

IDPHSB COMMITMENT STATEMENT



Our Commitment as a Bureau is to partner with communities to achieve health equity for all Marylanders. Our priority is to advance social and racial justice and we are committed to undoing racism within our public health systems. It is our responsibility to serve Marylanders without any bias or discrimination and ensure open access to services and resources.

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IDPHSB Values

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Objectives

Define community mobilization and its role in public health

Describe the process for developing case statements

Describe how case statements are used in broader priority setting exercises in the Bureau

Definition – Community Engagement

Community Engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations, to address issues affecting the wellbeing of those people.

Source: Agency for Toxic Substances and Disease Registry

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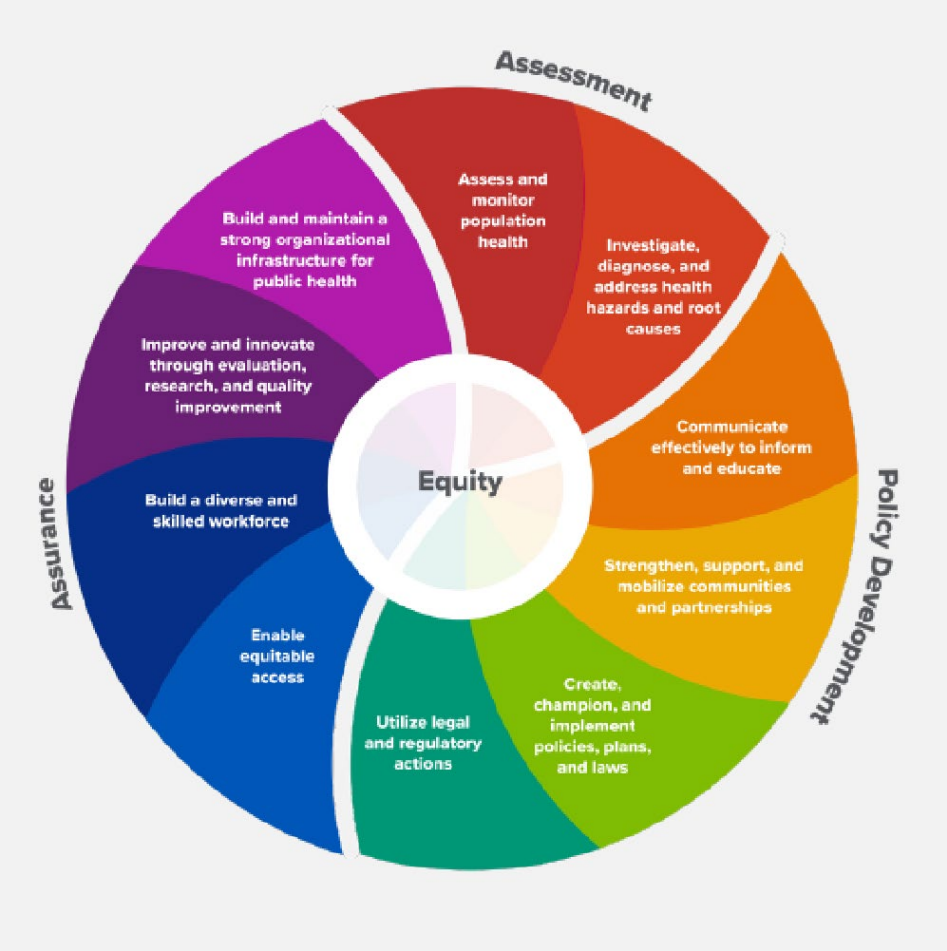
Definition: Community Mobilization

Community Mobilization is a capacity building process through which community members, groups or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own or stimulated by others.

https://www.thecompassforsbc.org/project-examples/all-together-now-community-mobilization-hivaids

The 10 Essential Public Health Services



To protect and promote the health of all people in all communities

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve equity, the Essential Public Health Services actively promote policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities. Such barriers include poverty, racism, gender discrimination, ableism, and other forms of oppression. Everyone should have a fair and just opportunity to achieve optimal health and well-being.

Source: Public Health Accreditation Board
https://phaboard.org

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Essential Public Health Service #4

Strengthen, support, and mobilize communities and partnerships to improve health

This Service includes:	
Convening and facilitating multisector partnerships and coalitions that include sectors that influence health (e.g., planning, transportation, housing, education, etc.)	**Authentically engaging with community members** and organizations to develop public health solutions.
Fostering and building genuine, strengths-based relationships with a diverse group of partners that reflect the community and the population.	**Learning from and supporting existing community partnerships** and contributing public health expertise.

Source: Public Health Accreditation Board
https://phaboard.org

Community Mobilization Division Mission

To strengthen and build opportunities to improve health outcomes for Marylanders vulnerable to HIV, STIs and viral hepatitis through collaboration across multiple public health sectors to empower communities to be healthy and thrive. Linking the rich knowledge of lived experience with science and data, Community Mobilization works with community, industry, policy, and other stakeholders to develop effective, meaningful public health responses.

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Meet the Team

Essential Job Functions

- Leadership Development
- Systems Change
- Grantmaking
- Community Organizing & Education
- Organizational and Community Group Development

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What is a Case Statement?

In the context of public health, a "case statement" serves to articulate the need for support for a particular public health initiative. It is a document that persuasively outlines the problem, the proposed solution, and the anticipated impact.

Key Components of a Public Health Case Statement:

- Defining the Public Health Challenge
- Presenting the Proposed Approach
- Highlighting the Anticipated Results
- Demonstrating the Importance of Support

Purpose:

- Secure funding from grants, foundations, or donors.
- Build support among policymakers and community leaders.
- Raise public awareness about important health issues.
- Communicate the value of public health programs and initiatives.

Source: Google Gemini

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Case Statement Step 1 – Identifying Challenges

CHALLENGE – What barrier are you trying to address?

LEARNING – How did you become aware of the specific challenge?

- Quantitative data?
- Community and stakeholder feedback?

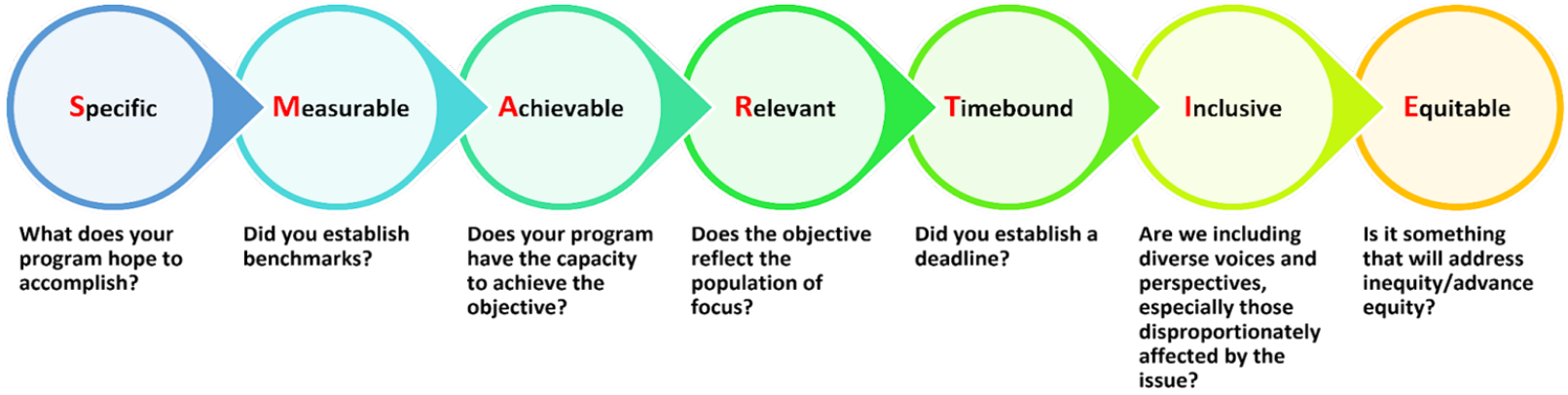
PILLAR – How does the barrier connect to one of the 4 pillars of the Integrated Plan framework?

KEY INFORMANTS – Who are your key stakeholders in the planning phase of case statements and/or could be responsible for addressing the public health challenge?

RAMIFICATIONS – What will happen if the challenge is not address?

Case Statement Step 2 – Developing Intervention Goals and Objectives

OBJECTIVE – What initiative are you planning?



VISION AND VALUE – What are the benefits of the proposal?

- Improved health outcomes?
- Learning and knowledge building?
- Improved coordination, cooperation and/or collaboration?
- Enhanced efficiency or increased productivity?
- Improved program delivery?
- Improved ability to market services?
- Others?

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Case Statement Step 3 – Aligning Intervention Outcomes with Potential Funding

Funder Alignment – Who are the traditional/non-traditional funders whose values align with case statement goals?

Grants Availability – What are the funding opportunities to support project implementation?

Resource Needs – What are the material/non-material resource needs for project implementation (i.e. personnel, technology, promotion, training, etc)?

No-Cost Solutions – What are the implementation methods and resources that can address the public health challenge with little to no cost?

Case Statement Step 4 – Write the Case Statement

THE IRREFUTABLE CASE – What is the need?

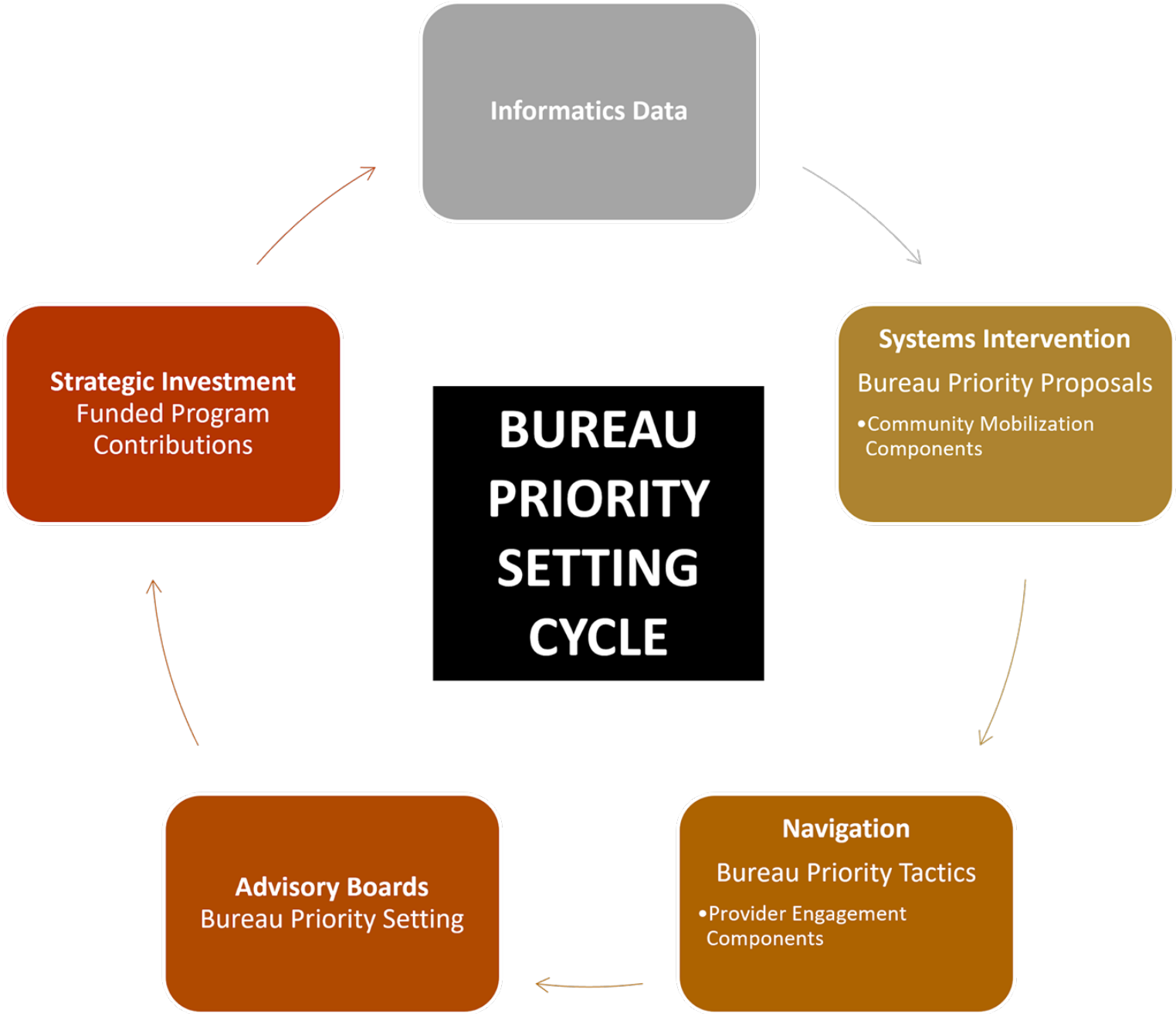
OUR UNIQUE POSITION - How is the Bureau positioned to meet the identified need?

WAVING THE FLAG – Describe the Bureau's history and how it reinforces the urgency of the need?

MAKING IT HAPPEN – What resources are required to address the need?

- Funding?
- Coalitions?
- Policy Change?

SUMMARY – Make your closing argument



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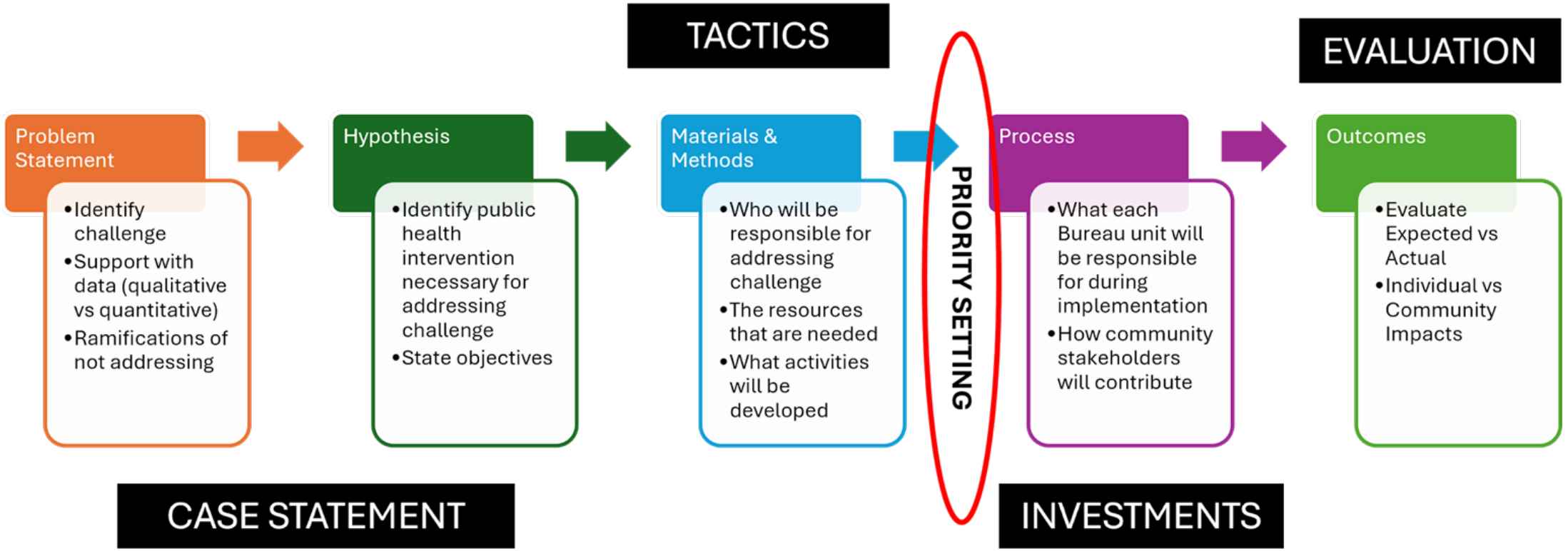
Bureau Priority Setting with Case Statements



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Case Statements – Topics for Initial Priority Consideration

- Increasing viral suppression among foreign-born Marylanders
- Improved infectious disease prevention education methods
- Foreign-born Marylanders and late-stage HIV diagnoses
- Congenital syphilis and perinatal HIV prevention
- Status-neutral housing as treatment and prevention
- Infectious disease prevention through health insurance access for women of color

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Aaron Davis, MPH

Manager, Community Mobilization Division Manager

email: aaron.davis@maryland.gov

cell: (443) 469-1694

FLIP THE SCRIPT:
Integrating Sexual Health

Peter DeMartino, Director

Infectious Disease Prevention and Health Services Bureau

Maryland Department of Health

2:00 pm

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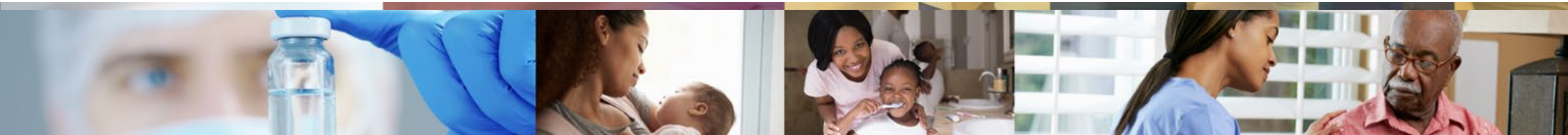
Infectious Disease Prevention and Health Services Bureau

Maryland HPG Transitional Engagement and Realignment Meeting



Transitional Engagement and Realignment Meeting

So Far…

- Integrated Plan and Bureau Realignment
- Success and engagement in planning meetings beyond current HPG membership
- Lack of transparency on decision making
- Multiple advisory bodies
- Potential for impact and coordination of subgroups

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Preliminary Vision

how the work of the existing HIV planning group will be incorporated and expanded, and how STI and hepatitis efforts will be formally integrated

Objectives

- planning for a syndemic future
- emphasize integration
- support equity
- sustain engagement
- improve outcomes
- transparent decision making

Benefits

- support Integrated Plan and Bureau Realignment
- reduce siloing
- more efficient use of resources
- better service integration
- more comprehensive response to community needs

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New Structure: Considerations

- **Membership:** How will members be selected? Ensure diverse representation, including people with lived experience across all three conditions.
- **Leadership:** How will leadership (e.g., co-chairs, steering committee) be chosen? What are their roles and responsibilities?
- **Decision-Making Processes:** How will decisions be made? (e.g., consensus, defined voting rules).
- **Accountability Mechanisms:** How will the group be accountable to the community and its funders? (e.g., regular reporting, public meetings, feedback channels).
- **Workgroups/Committees:** Consider thematic workgroups that address specific aspects of the syndemic (e.g., prevention, testing & linkage to care, policy, data).

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Notes from HPG - Structure

- History of Transition starting with the Community Planning Group, the RACS and other bodies
- Will Local Health Departments be required (anyone receiving funding required to participate?)
- Will there be subgroups for HIV, STI, hepatitis?
- Who is the Transition Team?
  - Current HPG members will select the Transition Team
  - Current HPG members may serve on the Transition Team
- It sounds like you are describing a nonprofit Board
- Creation of Committees with work being done but decisions coming back to the Board
- Be the "managing partner" coordinating activities and holding specific summits/learning sessions with accountability to report out progress to those bodies
- Engagement will need to responsive and provide for both traditional and nontraditional meeting styles and engagement practices - not everyone likes a very structured meeting
- Define our outcomes and define what we are working toward
- The voting body will set the priorities, communicate them through listening sessions, and build new priorities on feedback from communities

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Notes from HPG - Goals

- **Provide a holistic health approach instead of being HIV specific**
- Create a pipeline for local groups and feedback to the board
- Create a feeder system for personnel and core participation
- The group will need to develop gatekeeper relationships with communities and other partners
- Focus on "opening the lens" and identify resources and capacity that already exists in communities
- Create a dashboard and transparency on progress toward those goals
- Focus on a limited number of objectives, projects, and outcomes to make meaningful, measurable change
- Establish a concrete feedback loop - we thought we were doing something - how did we do?
- Establish more ways to work together - identify resources and create ways to share them statewide
- Acknowledge the role of primary care and respond to missed opportunities
- Develop a systems way of addressing the business models that work and create support that speaks that language
- Address real opportunities to reach populations who may have been neglected - Black Women/Hetrosexual Men

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Notes from HPG - Realities

- Funding is uncertain
- Smaller communities are less likely to participate
- Local Health Departments have limitations to be the only partner
- Also recognize the limitations of community capacity and provide meaningful tools to help expand existing capacity
- Be realistic about what can be funded and what needs to be done by partners
- Develop a culture of service integration - change the way we do business with measured outcomes and realistic goals
- Sponsor and support networks of multisector stakeholders to share resources

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Timeline

1. June 12 meeting (This one)
2. Meeting of current HPG
    a. Dissolution of current HPG and establishment of new body
    b. Identify Transition Team with key priorities

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Transition Team

1. Continue to communicate change
2. Promote opportunity for membership
3. Prepare governance documents
4. Select members
5. Plan for first meeting in October 2025

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https://www.cognitoforms.com/MDH3/StateOfMarylandHIVPlanningGroupTransitionApplication

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STATE OF MARYLAND HIV PLANNING GROUP TRANSITION APPLICATION

Exciting news! The Maryland HIV Planning Group (HPG) is forming a Transition Team to help create a new advisory board. This board will go beyond HIV, building stronger partnerships with the Infectious Disease Prevention and Health Services Bureau at the Maryland Department of Health.

The Transition Team will:

- Define membership, leadership, and governance
- Build accountability and committee structures
- Work through July, August & September 2025
- Commitment: 6 hours/month

SCAN TO APPLY

APPLY TO JOIN THE TEAM!

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THANK YOU
FOR ALL YOU DO
TO MAKE THE LIVES OF
MARYLANDERS BETTER

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