Maryland
DEPARTMENT OF HEALTH

Office of Minority Health and Health Disparities Advisory Committee 2021 Report

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Executive Summary

The mission of Maryland's Office of Minority Health and Health Disparities (OMHHD) is to address the social determinants of health by leveraging the Department's expertise, resources, and influence. The OMHHD Advisory Committee was formed to support the work of the OMHHD and this subcommittee is part of the larger advisory effort. The OMHHD Advisory Committee's 2021 report considered the two seminal developments this year: the COVID-19 pandemic and the re-emergence of social justice and equity into the national and local discourse. Because of the presence of the newly established Shirley Nathan Pulliam Health Equity Commission, the Advisory Committee felt it most relevant to highlight the efforts undertaken with regard to framing health equity and present these within the Executive Summary. Below are the focus areas proposed:

- ***Wealth and capital as sources of inequity***: Solutions to health inequity are often linked to income and employment. However, this approach is very reductionist. Wealth is a more encompassing framework and touches upon many sectors and policies (housing policies, financing practices, economic development) that have considerable influence on health equity with multi-generational effects.

- ***Spatial and technological as sustainers of inequity***: The inequitable geographic distribution of resources (e.g., adequate transportation, affordable, health food, quality health services) is clear across multiple social determinants of health (SDOH) and health outcomes and needs to be part of strategic responses. Overcoming place through use of technology alone cannot be an effective strategy as access to and affordability of the technology have the same placed-based inequitable distribution.

- ***Historical trauma as producer of inequity***: Achieving the goal of health equity in the State of Maryland will require a look backward at the policies and practices of the State of Maryland and its localities, especially in the area of criminal justice, to understand the harm, alter policies and practices that produced it, and make effective change for moving towards equity.

- **Intersectionality and Equity in All Policies as strategies for equity**: To strategically address health equity will require review of siloed policies and existing approaches that fail to take into account the whole. Wholistic/systems-thinking needs to be the standard for governmental operations in achieving equity.

The Advisory Committee's findings and excerpted policy recommendations are offered below:

- **Identify and Effectively Address Racism and Racial Implicit Bias**. Public health and health care professionals must name racism as a determinant of health and recognize their own racial implicit bias through effective education and training.
- **Conduct Racial Equity Policy Assessment**. Maryland Department of Health (MDH) should conduct a department-wide Racial Equity Policy Assessment to explicitly acknowledge and address racially discriminatory policies that are currently in place that are responsible for the existence and perpetuate health inequities.
- **Adopt a Health in All Policies Approach**. The Maryland Commission on Health Equity recently convened and allows for a cross-agency and multi-agency approach. This Commission should

capitalize on this convening to implement a health in all approach. The MDH Secretary should support the Governor in encouraging and facilitating a Health in All Policies approach.

- **Implement Health Equity Impact Assessment.** MDH should implement the universal application of a Health Equity Impact Assessment (HEIA) tool in all state health equity activities. The MDH Secretary should also support the Governor in encouraging HEIA across all of state government.
- **Build Medicaid MCO Capacity to Address Health Equity**. Given MDH's role in providing health coverage to over one million people in Maryland through the Medicaid program, it could better ensure its contracted MCOs have the capacity and flexible financing to address health equity and to ensure its MCOs are working with health care providers, community-based organizations, social service providers, and residents to address social determinants of health.
- **Improve data collection and reporting**. MDH should develop a process to assess the degree to which the recommendations and legislative expectations listed in Appendix A have been or are being implemented.

Conclusion

This report is not definitive but hopefully will be informative and thought provoking. Recognizing the depth and breadth of the SDOH and operating toward equity will require multi-level thinking and assessment (conception to implementation), multi-sector collaborations, and meaningful community voice and engagement. Institutionalized and sustainable practices that root equity in all will be the path to Maryland's achievement of its equity goals. The almost post-COVID moment is an opportune time for moving towards health equity in Maryland and is a moment that should not be lost. Shifting from framework to action is what the Advisory Committee recommends so that we are not expending more energy than needed in conceptualizing rather than in operationalizing for equity.

Report of the Office of Minority Health and Health Disparities Advisory Committee
December 2021

I. Introduction

The vision of Maryland's Office of Minority Health and Health Disparities (OMHHD) is to achieve health equity where all individuals and communities have the opportunity to achieve and maintain good health. Its mission is to address the social determinants of health and eliminate health disparities by leveraging the Department's resources, providing health equity consultation, impacting external communications, guiding policy decisions and influencing strategic direction on behalf of the Secretary of Health. The OMHHD Advisory Committee was formed to support the work of the OMHHD and crafted statement to inform its work as conceived by the group.

The OMHHD Advisory Committee's 2021 report considered two seminal developments this year: the COVID-19 pandemic and the re-emergence of social justice and equity into the national and local discourse. These are distinct yet intertwined forces that have shaped, and will continue to shape, the health and well-being of residents moving into next year and beyond. Recognizing these twin towers of influence, the MHHD Advisory Committee has determined that this year's report should focus on these two things, to provide a path forward from the COVID era and beyond. This report describes the impact of COVID-19 on communities of color in Maryland, followed by a health equity framework to guide the creation of OMHHD policies and practices. The report concludes with a series of policy recommendations.

II. The Impact of COVID-19 on Communities of Color in Maryland

The COVID-19 pandemic in the Spring of 2020 very quickly demonstrated worse outcomes for racial/ethnic minority populations. These outcome gaps received substantial media and political attention, which also drew attention to health equity more generally.

The reality of COVID health inequities is that they did not start with COVID and will not end once we have reached the end of the pandemic and gained control over the virus. Rather, the COVID related inequities stem from long-standing social inequities that were present before COVID and will continue after COVID. These inequities have impacted COVID outcomes in the following ways:

- COVID Exposure Risk:
  - Higher risk of acquiring COVID outside of the home, due to higher rates of employment in essential services that are public facing and can't be done remotely (which correlate with lower paying jobs and the inequitable association of poverty with race).
  - Higher risk of spreading COVID within the home, due to larger household size and denser living arrangements, which make isolation within the home to protect housemates more difficult.
- Presence of Co-Morbidities
  - Higher minority comorbidity rates that drive more severe disease once one is infected. Relevant comorbidities that could worsen COVID outcomes. Relevant comorbidities include cardiovascular disease, high blood pressure, diabetes, obesity, and lung disease.

With these drivers of increased risk of infection and of severe disease in place, large disparities in case rates, admission rates, and death rates were seen early in the pandemic. These have become smaller as the response has evolved but the impact of the inequity was felt.

For example, case rate ratios comparing Blacks to Whites were 3 to 1 for several age groups during the Spring of 2020. By the surge of Winter 2020-21, these ratios ranged from no difference to at most 1.5 to 1. However, the smaller ratios were largely due to unexpectedly high White rates. Both Black rates and White rates have been higher than Asian rates in all peaks during and since Winter 2020-21.

Hispanic disparities were even larger initially, with Hispanic to Non-Hispanic case rate ratios of as high as 11 to 1 for some ages in the Spring of 2020. That had fallen to ratios under 2 to 1 by the surge of Winter 2020-21, and now case rates for Hispanics are the same as or lower than Non-Hispanic rates.

There were early disparities in vaccine uptake, which are inevitable when certain communities experience discrimination and marginalization. Marginalized communities have more barriers to adoption of anything new. However, with targeted minority outreach of messaging and vaccine delivery, including the work of the Vaccine Equity Task Force, vaccine uptake disparities, for the primary series, when analyzed within age groups, have now been resolved in almost all cases. Hispanics have equal or higher vaccination rates by age group compared to Non-Hispanics. Black vaccine uptake matches White vaccine uptake except for a small Black lag for ages 25-44 and a small Black advantage for ages 45-64. Asians have higher vaccine uptake than Blacks or Whites.

Vaccine uptake is lower at younger ages, and minority populations are younger than the White population. So examined with all ages combined, minorities other than Asians are somewhat less vaccinated. Consequently, there should be a push to get young adults to be vaccinated, regardless of race or ethnic group.

To some extent, the currently small racial/ethnic disparities in COVID outcomes and vaccine uptake are driven by less than desired vaccine uptake and COVID outcomes among the younger White population. MDH observes similar racial disparities that, for the young, also do not achieve the desired levels. Equal yet suboptimal outcomes suboptimal, while perhaps not being a disparity, is not equity.

While progress has been made in diminishing some of the COVID-related disparities, these gaps may reappear in the rollout of boosters and any other additional COVID mitigation strategies. The structures and processes that have helped to attenuate the vaccine uptake disparities will need to be continued and enhanced.

While the analysis shows a diminishing gap, additional data and analyses are needed that examine the spatial distribution of inequities related to COVID, health outcomes, and the SDOH that are known to exist. Identifying and resolving the root social causes of COVID disparities and health inequities more generally with a place-based lens will be important to controlling the COVID pandemic and to health equity beyond the pandemic.

III. Health Equity Framework

In fulfilling the Committee's mission, a Health Equity subcommittee was formed with the primary focus of drafting a health equity framework (guidance) tailored to the State of Maryland and its Department

of Health to facilitate the creation of policies and practices that are in alignment with OMHHD's stated vision.

The current report represents the ongoing work continued from the prior year focused on providing a more detailed description and examples of health equity and how it manifests itself in various domains. The report is mindful of the COVID-19 pandemic and its dominance in the work and interests of OMHHD and the State of Maryland. The pandemic has only served to shine a very bright light, and a confirmation, that health and the systemic resources and structures needed to both create and sustain health lack equitable distribution. Data consistently evidenced that Black, Latino, rural and other underserved communities bore a disproportionate burden of the COVID pandemic even as the State activated a fairly massive response. Housing, transportation, employment, income, food access and other localized resources, educational opportunity, vaccine and general health care access all took a toll that the State of Maryland will need to assess and effectively respond to for many years to come.

Within this context, the expanded examination of health equity proposed by the committee should be a useful tool in where to look as its work, and the work of the newly formed Shirly Nathan Pulliam Health Equity Commission undertakes its work.

Definitions of Health Equity

According to the World Health Organization:

> *Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. "Health equity" or "equity in health" implies that ideally everyone should have a fair opportunity to attain their full* health potential and that no one should be disadvantaged from achieving this potential.[1]

It probably does not need to be said, at this juncture, that the discussion of health equity, and the proliferation of frameworks by organizations across many sectors, dominate current thinking and writing. It is not the intent of this group to create the exhaustive roster (literature review) as frameworks share very common and core elements based on the WHO definition of equity and the framework of social determinants of health (SDOH) that outline the interrelationships among the structural conditions that influence health outcomes and noting the inequitable distribution that center on the confluence of race/ethnicity, space, and wealth.

The sub-committee selected, as a point of reference, the definition of equity utilized Robert Wood Johnson, Foundation (RWJ), one of the largest philanthropic supporters of health and health equity, which is the following:

> *"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[2]"*

Borrowing from an unpublished work on "A new vision for health equity" by Dr. Lawrence Brown, author of the "Black Butterfly: The Harmful Politics of Race and Space in America," the subcommittee is offering an adapted version of the definition that has resulted in identifying five core areas that merit

[1] https://www.who.int/topics/health_equity/en/

[2] https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html

attention and attendant action in redressing inequities and building towards equity in Maryland. Like all other equity discussions, it builds on the social determinants of health which are, according to the Department of Health and Humans Services in its Healthy People 2020 initiative, conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The domains highlighted here are not meant to be exhaustive but to highlight issues that have typically not been well addressed and to expand the thinking about equity in these areas that hopefully will be explored and factored into planning undertaken by the State's Health Equity Commission.

Wealth and Capital Equity

Solutions to health inequity are often linked to economic conditions. The common response is providing opportunity for education and employment with the expectation that better education leads to better employment which should yield greater income. Greater income provides greater access to health insurance and health services, ability to access more positive health behaviors, and diminished stress. However, this approach is very reductionist and may lead to policy and programmatic solutions that have limited utility. This approach also ignores the cumulative effects of economic disadvantage and over emphasizes current access to income. Health inequity is not caused solely by income levels, poverty, or employment; wealth and capital are the real drivers of health inequities.

Wealth is lasting; capital helps build wealth. In the "Wealth Building Framework"[3] developed by The Aspen Institute Community Strategy Group and Wealthworks describes wealth as the reservoir of all assets that can contribute to the well-being of people, places or economies.

Workforce development is not the whole answer. Interventions must address wealth and capital. An example: The practice of redlining practices, housing lending practices, and criteria for assessing housing values. Historically, local policies and business practices have created desirable and undesirable places where people can live (rent or purchase housing). These practices have resulted in either blocking individuals (generally racial/ethnic minority groups) from be being able to purchase homes and then assessment practices have kept home values considerably lower helping to feed the wealth gap and preventing intergenerational transmission of wealth. If we fail to measure wealth, and only measure income and occupation, we lose sight of a significant contributor to inequity that long and enduring effects. Research in the creation of better wealth indices is underway (see Appendix B). Work in examining the policies and practices, and the decision-making processes that accompany those decisions should be a focal interest in future plans for creating equitable environments.

Spatial and Technological Equity

According to Wikipedia, spatial inequities are defined as "unequal amounts of qualities or resources and services depending on the area or location, such as medical or welfare."[4] When this term is considered in the contact of health inequities, there are many factors to be considered. Geographic considerations are extremely important with regard to rural, urban or suburban locations and the many varying factors that play a role in where we as individuals live, work, play and pray. It is important to consider the

[3] https://www.aspeninstitute.org/wp-content/uploads/files/content/images/csg/AES%20Day%20Two%20WB%20handout%20FINAL.pdf
[4] https://en.wikipedia.org/wiki/Spatial_inequality

inequitable geographic distribution of resources that impact the social determinants of health. Just a few of the many possible examples of this are provided below.

> **Transportation** is central to access of resources that are linked to the SDOH. The inequity exists in general lack of public transportation in rural areas and in disconnected public transportation routes in urban areas. Transportation influences employment opportunity, access to health care, and access to resources not localized. This is especially problematic where small business and local enterprises have been absorbed into larger national franchises.
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> **Food insecurity** is a significant challenge in Maryland in many communities. The issue is not only lack of income to purchase food, but the lack of access to localized affordable healthy food choices referred to as food deserts. Not only are there food deserts, there are Food Swamps - areas where an abundance of fast food, junk food outlets, convenience stores, and liquor stores outnumber healthy food options). This is inequity is avoidable and mutable. The policies, practices, and decision-makers who develop, implement and manage planning have the ability to change the environment for food access in the communities most harmed by these spaces.
>
> **Technology** runs society. The inability to have access to, have the understanding of, how to effectively use, and how to effectively protect oneself from technology is essential. Currently, efforts to build technological infrastructure have become front and center. How this technology is equitably distributed will require thinking and enacting programs beyond broadband connect. It will also need to factor affordability and technology training. It should be fundamentally linked to early education, understanding that to navigate websites, even the most advanced, requires a level of literacy that may be lacking due to systemic educational under-funding and under-resourcing.

Historical Context and Trauma

To achieve health equity for all Marylanders, historical context and trauma must be considered, and there must be an understanding that different groups have different histories and traumatic experiences. Although trauma can be seen as a common theme, each group's unique identities and experiences, as well as responses must be acknowledged. These differences should not be ignored or diminished, nor should one group's trauma be compared to another (i.e. no one group's trauma is worse than another's).

As we look at groups such as African Americans, Indigenous people, and LGBTQ people, we find that they have similar traumatic experiences. For example, African Americans were traumatized from a historical context as well as now by slavery, discrimination, racism, and failed health practices/experiments, e.g., Tuskegee Syphilis Experiment. The Indigenous peoples' traumatic experiences from a historical context can be seen in events such as the holocaust, genocide and the outcomes of them, e.g., segregation, colonization, the taking of land, suppression of language and religion. In addition to the aforementioned traumatic experiences, LGBTQ people also experience, rejection physical assault, harassment, discrimination, and hostility. All three groups have been experiencing trauma from crime and violence.

Traumatic experiences are not only found in the past; but the impact of trauma nests itself and influences health behaviors and outcomes to this day. Examples of this can be seen in the refusal of marginalized community members to get the Covid 19 Vaccination shot or wear a mask due to distrust

of government and the medical system. Until addressed and dealt with the trauma does not go away and can be triggered by an experience that resembles the original trauma. This is but one example, there are many to be considered.

Creating the balance between acknowledging and responding to historical trauma is not an easy task but achieving the goal of health equity in the State of Maryland will require a look backward at the policies and practices of the State of Maryland and it localities, especially in the area of criminal justice, to understand the harm, alter policies and practices that produce it, and make effective change.

Intersectionality

Most individuals are a confluence of multiple and overlapping identities and affiliations (e.g. race, gender, sexual identity, intellectual ability/disability, and place of residence). In similar fashion, many people have multiple interrelated health issues, significantly driven by social determinants of health (chronic disease, mental health challenges, substance use disorders). The categorical way in which many health-based programs provide resources and services fail to respect the multiple identities and multiple health issues. Siloed programming may work well for a bureaucratic efficiency but are less useful in practice. Drug treatment programs, chronic disease management, and wellness programs that are offered often miss and cannot serve the needs of those facing multiple issues and falling under designated categories. Evaluation of the cost effectiveness (or ineffectiveness) of these siloed programs needs to be a consistent part of the analysis undertaken in continuing to fund existing programs and creating new ones in the areas where the State and local governments have influence in the interest of achieving equity. A culture of equity in all environments that recognizes race, ethnicity, gender, sexual identity, language, history, locality - in essence which respects the person, should be an aspiration of programs designed to deliver health and wellness. In doing so, what may be considered are the following:

- Language and interventions should be person-centered, not focused on labels.
- Focus should be on the causes of inequities, not just the effects of 'symptoms.'
- Public funding decisions and priorities need to be changed to address the larger issues and not create siloed programs or funding streams.
- Examples: Funding and programs narrowly focused on opioid abuse and not all substance abuse.

Equity in All Policies

Equity in all policies is much like intersectionality but at a structural level. Health equity and the social determinants of health require a systems approach. Failure to see the dominoes and interconnectivity of things will stunt movement toward equity despite best intentions and generous spending. The list below are considerations for implementing a systemic approach to equity:

1. The "Health in All" approach to policy making should be structured in such a way that it is a necessity not a possibility. Establishing the criteria and tools for policy analysis are essential for this to be put into practice.
2. The efforts of the State have to be seen and developed in the context of the non-state stakeholders (public/private) as the social determinants of health are influenced by the multiple stakeholders. The State's leadership role in leveraging for health equity is critical. All voices have to be heard and well-represented.

3. Health equity goes deep. The success of health equity will require mechanisms to look beyond policies and written practices but to examine closely implementation and decision-making. Unconscious bias is a powerful influence and so mechanisms to mitigate against personal decision-making in key areas (financing, agenda setting, hiring) need to be in place.

Barriers, Approaches, and Solutions

The sub-committee has noted a few challenge areas that bear mentioning explicitly as places where an equity agenda can be undermined. They are as follows:

a. Equity requires stability and sustainability. To create lasting change, there needs to be consistency in interventions, policy changes, and funding priorities.
    i. Frequent leadership changes in government leadership (Governor, Secretaries, et.) lead to frequently changing priorities and interventions.
    ii. When funding and policy priorities change, programs and interventions change. "The money leads the work" instead of the need and evidence leading the funding.
    iii. Lack of long-term investment makes it difficult (if not impossible) to create lasting change. Society-wide/public health issues rarely change overnight; time is needed to make lasting change.
    iv. Principles and values must drive the work, not specific individuals. Principles and values must be embedded in the culture and mission of the public sector that work continues despite leadership changes.
b. Additional harmful policies and practices must be identified and discontinued. Facilitative practices must be identified and strengthened.
c. Opportunities for Maryland government to use its influence (more) for the greater good. There should be an intentional process of evaluating, considering, and responding to inequities.
    i. Placed-based strategies by private corporations and business practices driven solely (or primarily) by profit need to be addressed. Government has a role in this, especially in Maryland where the government is a large driver of business.
    ii. Government must also examine its partnerships and collaborations. Do certain favored institutions receive more contracts and support from the government than other institutions?

IV. Health Equity Policy Recommendations

Promoting health equity assures that conditions for optimal health are available for all people that includes health and health care and addresses the social determinants of health like employment, income, housing, transportation, childcare, and education. Using policy levers to advance health equity puts Maryland at the forefront of states seeking to reverse historical health disparities.

Maryland made great strides in 2022 to pass legislation to promote health equity for all Marylanders. First, the Shirley Nathan-Pulliam Health Equity Act of 2021 (SB-52/HB 78) seeks to align public and private policy and to elevate health equity across the state. It establishes the Maryland Commission on Health Equity, a multi-agency committee, committed to making recommendations on data collection and developing a statewide health equity framework. Second, the Maryland legislature passed the

Maryland Health Equity Resource Act (SB172/HB463) which allocates $59 million to address health inequities across the state. The law immediately makes $14 million available for Pathways to Health Equity Grants and later the establishment of Health Equity Resource Communities both administered by the Community Health Equity Resources Commission and assisted by an Advisory Committee. Third, SB05/HB28 requires the Office of Minority Health and Health Disparities to develop a program to identify and approve evidenced-based implicit bias training programs for health care providers in Maryland.

Within this policy context, the state still has additional opportunity to use policy levers to address health equity across the state, including:

- **Identifying and Effectively Addressing Racism and Racial Implicit Bias**. Public health and health care professionals must name racism as a determinant of health and recognize their own racial implicit bias through effective education and training. While SB05 was an important first step, but Maryland can do more by requiring implicit bias training for all health care providers in Maryland.

- **Racial Equity Policy Assessment**. MDH should conduct a department-wide Racial Equity Policy Assessment to explicitly acknowledge and address racially discriminatory policies that are currently in place that are responsible for the existence and perpetuate health inequities. Many of our current health policies create inadequate coverage, access, and quality of care for communities of color and should be lifted-up for reconsideration and adaptation. But this analysis should be extended to all policies that contribute to or impact health and the social determinants of health.

- **Adopt a Health in All Policies Approach**. The Maryland Commission on Health Equity recently convened and allows for a cross-agency and multi-agency approach. MDH has the opportunity to further advance the Commission's work by making this a truly intersectional collaboration by engaging a more diverse arrangement of stakeholders (including the private sector, funders/philanthropy, community members of color, and advocates). Most importantly, communities of color most disproportionately impacted should have a meaningful opportunity to participate. MDH can also think about how to make permanent and structural changes about how agencies coordinate and make decisions about policy changes with a health and equity lens front and center. The MDH Secretary should also support the Governor in encouraging and facilitating a Health in All Policies approach.

- **Health Equity Impact Assessment.** Implement the universal application of a Health Equity Impact Assessment (HEIA) tool in all state health equity activities to identify their individual and collective impacts and challenges. The use of HEIAs in the Maryland Department of Health (MDH) can lead to the identification of equity-oriented impacts on programs, planning and policy. The MDH will require the infrastructure and capacity for measuring and evaluating the impacts of health equity mitigation strategies on their intended programs and associated priority populations. The universal implementation of HEIA utilization are recommended to ensure a more robust and effective health equity impact assessment at predetermined intervals. The MDH Secretary should also support the Governor in encouraging HEIA across all of state government.

- **Build Medicaid MCO Capacity to Address Health Equity**. Given MDH's role in providing health coverage to over one million people in Maryland through the Medicaid program, it could better ensure its contracted MCOs that have the capacity and flexible financing to address health equity and to ensure its MCOs are working with health care providers, community-based organizations, social service providers, and residents to address social determinants of health. One way to do so is to incorporate health equity into existing MCO pay for performance and quality improvement programs. Also, through the annual MCO contract renewal process, MDH can utilize the RFP process and contracts terms that require the following:

    - Requiring MCO Submission of Reports Related to Health Equity Activities - plans describing policies and procedures related to identifying, addressing, and tracking employment, food security, and housing instability, conditions that contribute to health inequities.

    - Require each department within a MCO to form a Health Equity Action Team (HEAT) responsible for the department's internal and external health equity goals;

    - Designate certain health equity related tasks and/or benchmarks (like diabetes treatment outcomes) to be linked to a portion of the MCO performance withhold wherein MDH withholds a portion of a MCO's monthly Capitation Payments to incentivize quality, health outcomes, value-based payments, and health equity.

- **Improve data collection and reporting**. MDH should develop a process to assess the degree to which the recommendations and legislative expectations listed in Appendix A have been or are being implemented.

Conclusion

As earlier noted, this is not definitive but hopefully it will be informative and thought provoking. Recognizing the depth and breadth of the SDOH and operating toward equity will require multi-level thinking and assessment (conception to implementation), multi-sector collaborations, and meaningful community voice and engagement. Institutionalized and sustainable practices that root equity in all will be the path to Maryland's achievement of its equity goals. The almost post-COVID moment is an opportune time for moving towards health equity in Maryland and is a moment that should not be lost.

Moving from framework to action is what the Advisory Committee recommends so that we are not expending more energy than needed in conceptualizing rather than in operationalizing for equity.

Appendix A: Previous Data Recommendations and Expectations

Recommendations from the 2012 Maryland Health Disparities Collaborative

Recommendation 1: Adopt the approach of OMB Directive 15 as the overarching shell for Race, Ethnic and Language data collection.

Recommendation 2: In addition to race and ethnicity, collect data on English proficiency and preferred language for healthcare. Use the questions in the HHS new data collection guidelines.

Recommendation 3: In the future, add to the OMB approach collection of relevant subcategories of the primary racial and Hispanic ethnic groups.

Recommendation 4: The current set of health outcome, healthcare process, and patient experience measures in the HSCRC and MHCC data systems are reasonable for an initial analysis of these outcomes by race, ethnicity and eventually, language.

Recommendation 5: Compare the results of this analysis within and across groups of race, Hispanic ethnicity, and language to identify disparities in these outcome, process, and patient experience measures.

Recommendation 6: Where possible, analyses of quality, process, and outcome variables disaggregated by race, ethnicity, and primary language should include variables that reflect social determinants of health such as patient education level, occupation, and/or zip code of residence (or discharge destination).

Recommendation 7: The current outcome, process, and patient experience measures are publicly reported on the MHCC, HSCRC, and Maryland Hospital Association websites. These same measures when analyzed by race, ethnicity, and language should also be publicly reported on the same websites.

Recommendation 8: The current outcome, process, and patient experience measures are benchmarked on a national and state-level. The same measures when analyzed by race, ethnicity, and language should also be benchmarked on a national and state-level through such reports as the AHRQ National HealthCare Quality and National Healthcare Disparities Reports, the MDH Office of Minority Health and Health Disparities, and Maryland SHIP data.

Data expectations from the Maryland Health Improvement and Disparity Reduction Act of 2012

The Commission [MHCC] shall:

(i) Establish and implement a system to comparatively evaluate the quality of care and performance of categories of health benefit plans as determined by the Commission on an objective basis; and

(ii) Annually publish the summary findings of the evaluation.

(3) The system, where appropriate, shall:

(ii) [On or before October 1, 2007, to the extent feasible, incorporate racial and ethnic variations] ESTABLISH AND INCORPORATE A STANDARD SET OF MEASURES REGARDING RACIAL AND ETHNIC VARIATIONS IN QUALITY AND OUTCOMES; AND

(III) INCLUDE INFOR-MATION ON THE ACTIONS TAKEN BY CARRIERS TO TRACK AND REDUCE HEALTH DISPARITIES, INCLUDING WHETHER THE HEALTH BENEFIT PLAN PROVIDES CULTURALLY APPROPRIATE EDUCATIONAL MATERIALS FOR ITS MEMBERS.

Each nonprofit hospital shall submit an annual community benefit report to the Health Services Cost Review Commission detailing the community benefits provided by the hospital during the preceding year.

(VII) A DESCRIPTION OF THE HOSPITAL'S EFFORTS TO TRACK AND REDUCE HEALTH DISPARITIES IN THE COMMUNITY THAT THE HOSPITAL SERVES, IN THE FORM SET BY THE DEPARTMENT BY REGULATION.

20–904.

(A) ON OR BEFORE DECEMBER 1 OF EACH YEAR, EACH INSTITUTION OF HIGHER EDUCATION IN THE STATE THAT INCLUDES IN THE CURRICULUM COURSES OFFERS A PROGRAM NECESSARY FOR THE LICENSING OF HEALTH CARE PROFESSIONALS IN THE STATE SHALL REPORT TO THE GOVERNOR AND, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY ON THE ACTIONS TAKEN BY THE INSTITUTION TO REDUCE HEALTH DISPARITIES.

(B) THE DEPARTMENT SECRETARY MAY SET STANDARDS FOR THE FORM OF THE REPORT REQUIRED UNDER THIS SECTION.

SECTION 3. AND BE IT FURTHER ENACTED, That the Health Services Cost Review Commission and the Maryland Health Care Commission shall:

(1) Study the feasibility of including racial and ethnic performance data tracking in quality incentive programs;

(2) In coordination with the evaluation of the Maryland Patient Centered Medical Home, develop recommendations for criteria and standards to measure the impact of the Maryland Patient Centered Medical Home on eliminating disparities in health care outcomes;

(2) (3) Report to the General Assembly on or before January 1, 2013, data by race and ethnicity in quality incentive programs where feasible and recommendations for criteria and standards to measure the impact of the Maryland Patient Centered Medical Home on eliminating disparities in health care outcomes; and

(3) (4) Submit a report on or before January 1, 2013, to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly that explains when data cannot be reported by race and ethnicity and describes any necessary changes to overcome those limitations.

The Maryland Health Quality and Cost Council shall:

(i) Convene a workgroup to examine appropriate standards for cultural and linguistic competency for medical and behavioral health treatment and

the feasibility and desirability of incorporating these standards into reporting by health care providers and tiering of reimbursement rates by payors; and

(ii) Assess the feasibility of and develop recommendations for criteria and standards establishing multicultural health care equity and assessment programs for the Maryland Patient Centered Medical Home program and other health care settings; and

(iii) Recommend criteria for health care providers in the State to receive continuing education in multicultural health care, including cultural competency and health literacy training.

Data expectations in the Shirley Nathan–Pulliam Health Equity Act of 2021

SB 52: Maryland Commission on Health Equity (The Shirley Nathan–Pulliam Health Equity Act of 2021)

(G) (1) THE STATE DESIGNATED EXCHANGE SHALL:

(I) PARTICIPATE IN THE ADVISORY COMMITTEE ESTABLISHED UNDER § 13–4206(A)(1) OF THIS ARTICLE; AND

(II) MAINTAIN A DATA SET FOR THE MARYLAND COMMISSION ON HEALTH EQUITY AND PROVIDE DATA FROM THE DATA SET CONSISTENT WITH THE PARAMETERS DEFINED BY THE ADVISORY COMMITTEE.

(2) IF APPROVED BY THE MARYLAND COMMISSION ON HEALTH EQUITY, THE STATE DESIGNATED EXCHANGE MAY USE THE DATA SET MAINTAINED UNDER PARAGRAPH (1) OF THIS SUBSECTION TO IMPROVE HEALTH OUTCOMES FOR 8 PATIENTS.

THE COMMISSION SHALL, IN COORDINATION WITH THE STATE DESIGNATED HEALTH INFORMATION EXCHANGE, ESTABLISH AN ADVISORY COMMITTEE TO MAKE RECOMMENDATIONS ON DATA COLLECTION, NEEDS, QUALITY, REPORTING, EVALUATION, AND VISUALIZATION FOR THE COMMISSION TO CARRY OUT THE PURPOSES OF THIS SUBTITLE.

(2) THE ADVISORY COMMITTEE SHALL INCLUDE REPRESENTATIVES FROM THE STATE DESIGNATED HEALTH INFORMATION EXCHANGE.

(3) THE ADVISORY COMMITTEE SHALL DEFINE THE PARAMETERS OF A HEALTH EQUITY DATA SET TO BE MAINTAINED BY THE STATE DESIGNATED HEALTH INFORMATION EXCHANGE, INCLUDING INDICATORS FOR:

(I) SOCIAL AND ECONOMIC CONDITIONS;

(II) ENVIRONMENTAL CONDITIONS;

(III) HEALTH STATUS;

(IV) BEHAVIORS;

(V) HEALTH CARE; AND

(VI) PRIORITY HEALTH OUTCOMES FOR MONITORING HEALTH EQUITY FOR RACIAL AND ETHNIC MINORITY POPULATIONS IN THE STATE.

(4) THE DATA SET FOR WHICH PARAMETERS ARE DEFINED UNDER PARAGRAPH (3) OF THIS SUBSECTION SHALL INCLUDE DATA FROM:

(I) HEALTH CARE FACILITIES THAT REPORT TO THE HEALTH SERVICES COST REVIEW COMMISSION;

(II) HEALTH CARE PAYERS THAT REPORT TO THE MARYLAND HEALTH CARE COMMISSION; AND

(III) ANY OTHER DATA SOURCE THE ADVISORY COMMITTEE 1 DETERMINES NECESSARY.

Appendix B – Health Equity Resources

American Medical Association
The American Medical Association Plan to Embed Racial Justice and Advance Health Equity
https://www.ama-assn.org/system/files/2021-05/ama-equity-strategic-plan.pdf
Journal publication: Race, Racism and the Policy of 21st Century Medicine

American Public Health Association
Policy Briefs and Fact Sheets on Health Equity
The American Public Health Association: Advancing Health Equity
https://www.apha.org/-/media/Files/PDF/factsheets/Advancing_Health_Equity.ashx

Association of State and Territorial Health Officials (ASTHO)
The State of Health in All Policies Report
https://www.astho.org/HiAP/State-of-HiAP-Report/

Boston Public Health Commission
Racial Justice and Health Equity Framework
Boston Racial Justice and Health Equity Framework
The Guide to Advance Racial Justice and Health Equity

Centers for Disease Control and Prevention (CDC)
A Practitioner's Guide for Advancing Health Equity

National Academy for State Health Policy
Resources for States to Address Health Equity

NACCHO (National Association of County and City Health Officials)
NACCHO Online Course: Roots of Health Inequity

The Robert Wood Johnson Culture of Health Action Framework
https://www.rwjf.org/en/cultureofhealth.html/en/cultureofhealth.html

Practice and Measurement: Journal Publications
Health Equity Framework: A Science and Justice-Based Model for Researcher and Practitioners
ETR (non-profit organization). ETR - Equity webpage

Health Equity Measurement Framework

Appendix C – Advisory Committee Members and MDH OMHHD Staff

Chair: Brian Smedley, PhD
Co Chair: Kim Sydnor, PhD
MHHD Director: Noel Brathwaite, PhD

Members and Staff

Denise Barnes
Barbara Brookmyer, MD
Sedonna Brown
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Darrell Gaskin
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Sandy Washington
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