May 2, 2024 | 2:00 – 5:00 PM EDT
Baltimore County Department of Health (Hybrid) | 6401 York Rd, Baltimore, MD 21212

Google Meet joining info

Video call link: https://meet.google.com/whc-wzpa-osc
Or dial: (US) +1 314-474-3289 PIN: 228 226 804#
More phone numbers: https://tel.meet/whc-wzpa-osc?pin=9675008149300

Agenda

I. Call to Order

II. Adoption of the Agenda

III. April Minutes Review and Approval

IV. Commission Updates
   a. Southern Maryland Public Listening Session & LHD Site Visit (St. Mary's County)
   b. Progress Report and Look Ahead
   c. HB 1333-2024 and timeline changes
   d. Upcoming LHD Site Visits and Regional Public Listening Sessions

V. Presentation: MDH Office of Minority Health and Health Disparities (MHHD), MDH Population Health Transformation Advisory Committee, & 2023 MHHD Annual Report Findings
   Camille Blake Fall, JD
   Director, Office of Minority Health and Health Disparities
   Maryland Department of Health

VI. Presentation: Collaboration Between Public Health and Healthcare Delivery
   Chelsea Cipriano
   Managing Director of the Common Health Coalition

VII. Break

VIII. Discussion: Vision for Maryland's Public Health System

IX. Workgroup Updates
   a. Workforce
   b. Governance and Organizational Capabilities
   c. Data and Information Technology
   d. Funding

e. Communications and Public Engagement

X. Announcements
   a. Western Maryland Public Listening Session at Washington County on May 23, 2024. Details to be confirmed and published.

XI. Adjournment
   a. Next meeting: June 6, 2024, 2:00 – 5:00 PM EDT, at Baltimore County LHD with a virtual option

Thursday, April 4, 2024 | 2:00 PM - 5:00 PM
Baltimore County Dept of Health | Virtual

Meeting Minutes

Commissioners present in person or virtually:
Meenakshi Brewster
Boris Lushniak
Oluwatosin Olateju
Fran Phillips
Nicole Rochester
Maura Rossman
Michelle Spencer
Allen Twigg
Jean Drummond
Nilesh Kalyanaraman
Camille Blake Fall

Not present:
Heather Bagnall
Ariana Kelly
Christopher Brandt
Alysa Lord

I. **Call To Order**
   a. Presiding Co-Chair Oluwatosin Olateju called meeting to order at 2:15 PM
   b. Agenda was summarized and a brief overview of the Commission on Public Health (CoPH) was given
   c. Public comments are encouraged via email: md.coph@maryland.gov
   d. Roll call, quorum met

II. **Adoption of the Agenda**
   a. Agenda approval moved by Nicole Rochester, seconded by Nilesh Kalyanaraman

III. **Minutes Review and Approval**
   a. Motion to approve by Meenakshi Brewster, seconded by Michelle Spencer

IV. **Special Guests**
   a. Shane Hatchett
   b. Dr. Joshua M. Sharfstein

V. **Presentation: Overview of Health Services Cost Review Commission (HSCRC)**

Dr. Joshua M. Sharfstein, Chairman, HSCRC, Vice Dean for Public Health Practice and Community Engagement, Johns Hopkins Bloomberg School of Public Health Presenter introduced by Boris Lushniak.

a. History
    i. Since 1977, the HSCRC has set all-payer rates for all of Maryland's private, acute care hospitals. This system guarantees that:
        1. All payers pay a fair share of hospital financing.
        2. Payers do not negotiate charges with hospitals.
        3. Uncompensated Care is funded equitably via a rate adjustment for all payers.
        4. Charges within each hospital are the same for all payers.

b. Overview
    i. What is global hospital budgeting?
        1. Rather than let volumes control revenue, HSCRC sets an annual revenue target (GBR) that each hospital must meet.
            a. This approach removes incentives for hospitals to increase revenue by growing volume under fee for services systems.
    ii. How does the HSCRC incentivize innovative models of care?
        1. A Care Transformation Initiative (CTI) is any initiative undertaken by a hospital or group of hospitals to reduce the total cost of care (TCOC) of a defined population. CTI have three components:
            a. A clinical intervention
            b. A population definition
            c. A target price.
    iii. How does the HSCRC support population health?
        1. Fees assessed by the HSCRC help to fund important healthcare infrastructure that advances the entire healthcare system.
    iv. How does the HSCRC work towards health equity?
        1. HSCRC addresses health equity through the following initiatives:
            a. Statewide Integrated Health Improvement Strategy
            b. Hospital Quality Programs
            c. Special Funding Programs
            d. Data and Hospital Reporting
            e. Financial Assistance and UCC Funding
            f. State Agency Collaboration
            g. Internal Diversity Taskforce
    v. What is AHEAD?

1. Vision: Empower all Marylanders to achieve health and well being
2. Model is a state total cost of care (TCOC) model designed to
    a. Ensure high value care.
    b. Improve access to care.
    c. Promote health equity.

vi. What are opportunities for convergence between the Maryland Model and public health?
1. Data and analytics
    a. CRISP tools applied at geographic level to support public health.
    b. Examples: falls, asthma, diabetes
2. Discrete population health initiatives
    a. Example: Multi-visit patients, asthma home visits
3. System level engagement
    a. State health equity plan.
    b. Structure of state primary care model
4. Alignment of public health system to state health outcomes.

c. J. Drummond: Thought around utilizing health equity plans to drive action not just reporting it?
    i. J. Sharfstein: suggested state having direction on equity and everything aligning to it.
d. M. Brewster: Regional population health hub and how they will collaborate with other established infrastructure?
    i. Still on developing phase and models not fully built out yet but is important to note that the hub might lean towards patient populations sense instead of geographical population sense.
    ii. There are things that might make sense to be done regionally than on county level.
e. F.Philips: Talked about instances hospitals and public health can work together to better improve health
    i. Proposed that public health should think about how they can structurally embed themselves in the planning and implementation phase of projects.
f. J. Drummond: Suggested that community health workers should be utilized because they speak the language better.
g. J. Sharfstein: Health department innovatively working with hospitals to seek to address specific issues. We need to start showing up on each other's door.

h. O. Tosin: Commented on health departments taking up issues like diabetes and opioid overdose and looking at how they can work together with hospitals to address it.
i. N. Rochester: Sometimes measures used to diagnose most times don't reflect where the outcomes is coming from.
j. J. Drummond: Measures not always telling the full story.
k. B. Lushniak: Commented on making sure that healthcare and public health are same room together figuring out how to address issues.
l. Dushanka: Are there opportunities to align the primary aim of AHEAD and public health.

VI. **Old Business**
   a. M. Brewster: Five regional site visits with regional public listening sessions
      i. St. Mary's County (SoMD): April 16th
      ii. Washington County (Western MD)
      iii. Montgomery County (Central MD)
      iv. Howard County (Central MD)
      v. Talbot County (Eastern Shore)

VII. **New Business**
   a. B.Lushniak: House bill 133. Gives us an extension to get final report ready by October 1, 2025. December 1, 2024, Interim report

VIII. **Workgroup Updates**
O. Tosin introduced the speakers: Questions we should be thinking about for surveys, key informant interviews, and focus groups.
   a. Communications and Public Engagement
      i. Public health agencies
         1. Maryland Department of Health
         2. Local Health Departments
         3. Roles to include
            a. Communications & Marketing Staff
            b. If there are none, determine who contributes to communications and marketing related work at the health department.
         4. Questions
            a. What sources do you get your information from when preparing public facing health communications?
            b. Include a range of places that staff would find health information (ie. Health department website, CDC website, etc.)
            c. What communication tools and/or channels do you have available to reach audiences?

i. Include a list of social media tools and communications channels with any 'other' option where staff could input additional tools/channels not listed

d. Do you have staff formally trained in communications?

e. Do you have dedicated staff solely focused on any of the following areas?

i. Include a list of the following: social media, web design, health education materials, community engagement, and marketing.

ii. Public

1. Do you have reliable internet access that you can use to access digital health information resources?
2. Other than talking with your healthcare provider, where would you most likely go to find health-related information?
    a. Include a range of places where people find health information (ie. Social Media, Health department website, friends and family, etc.)
3. When reading health information, how important do you find the following qualities?
    a. Include a range of options to see what qualities are important (ie. is it evidence-based, do others find it important, that it is CDC approved, etc.)
4. Do you have any social media accounts? Please check all that apply.
    a. Include a range of options to choose from and include an 'other' field for open answers.
5. Do you know whether your health department has social media accounts?
    a. Include responses such as 'yes, and I follow it', 'yes, but I do not follow it', and 'No, I don't know"
6. Would you get your health information from the health department? Why or why not?
7. Where (or who) else do you trust to get your information from? What makes you consider these sources as trustworthy?
8. How would you prefer to engage with the health department?

a. Include a range of options (text message alerts, website, social media, etc.) and an ‘other’ field for open answers.

9. Have you engaged with the health department in the past? Why or why not?
    a. Include a yes or no option and a place to include free text.

b. <u>Data and Information Technology</u>
    i. Resources at our Disposal
        1. Indiana Surveys
        2. CDC Surveys
        3. NACCHO Evaluations
        4. MDH PHS Resources
        5. HOT-FIT Tool*
        6. Surveys*
        7. PHII Self-Assessment Tools
    ii. Targets: Leadership, Frontline Data users (epidemiologists and data analysts), and Technologists (Database administrators etc.) and State agencies (MDH, DoIT, etc.) and all local health departments.
    iii. Humans
        1. I fulfill data requests as part of my job responsibilities?
        2. I share data or create data-related content as part of my job?
        3. I want to or need to use data for analysis as part of my job but I am unable to do so.
        4. What are the barriers keeping you from using data for Access issues or lack of access analysis in your job?
    iv. Organizational
        1. Does your LHD have access to all the data which would be useful to your jurisdiction?
        2. Identify data categories your LHD finds useful and would like to access/obtain
        3. Are there existing barriers to accessing/obtaining the data you have identified as useful for you LHD?
        4. Does your LHD leverage basic data analytics in using data/information?
        5. Do you use data visualization dashboards to display data?
    v. Technological
        1. What is your biggest IT challenge?
        2. How would you describe your cybersecurity preparedness?
        3. Would you have an interest in migrating to a centralized data system?

4. What IT equipment's needs or updates do you need to modernize your systems
5. Do you have an IT strategy?
6. What are your top 5 IT needs by priority?
7. What are your data entry, sharing and reporting concerns or needs?

vi. Next steps
1. Monthly breakout sessions to identify objectives/KPIs
2. Survey Design Subcommittee
3. Draft survey questions
4. Finalize survey and targets
5. Conduct assessments
6. Analyze data
7. Draft assessment findings
8. Draft recommendations

c. Funding

i. Potential survey questions
1. What traditional public health funding sources (CDC, SAMHSA, EPA, CHRC, etc.) have grants or other resources that are currently underutilized or not being utilized by public health agencies in Maryland?
   a. Can you give specific examples of funding sources that are not being used to their maximum extent?
2. Do you know of any non-traditional funding sources (private grant organizations, schools of public health endowments, or other funders) that can be used for Maryland's public health efforts at either the state (MDH/MDE/DHR/MSDE) or local levels (local health departments, EMS, or other community organizations)?
   a. Please give specific examples of sources and the funds they have available.
3. Questions for Whom?
   a. MDH and MDE staff
   b. LHD staff
   c. Philanthropic organizations in Maryland
   d. Schools of Public Health in Maryland

d. Governance and Organizational Capabilities

i. Sources for key informant interview
1. Maryland Health Care Commission*
2. Health Services Cost Review Commission*
3. Maryland Community Health Resources Commission*
4. MD Department of Budget and Management*

5. MD Department of General Services*
6. MD Department of Disabilities*
7. CRISP (state-designated health data utility)*
8. MDH Secretary of Health
9. MDH Deputy Secretary of Health Care Financing and Medicaid Director, etc.

ii. Survey Questions
1. For selected County Executives and Chairs of County Commissions/Councils
   a. View of local health department as state agency or a local agency
   b. Involvement in the selection and/or evaluation of county health officers
   c. Familiarity with the laws and procedures pertaining to the local boards of health
2. For selected health system population health executives
   a. Frequency and nature of engagement with local health officers in jurisdictions where your system operates
   b. View of governmental public health roles and responsibilities compared and contrasted to health system population health roles and responsibilities
3. For selected public, community, business, and academic voices
   a. How varying organization of local health departments affects potential partnerships
   b. Leaders or organizations in your community that are trusted sources of health information
4. Articles Discussed
   a. The water of system change
   b. Public health 3.0 and beyond: Incorporating systemic racism

e. <u>Workforce</u>

i. The Workforce workgroup will be using NACCHO Profile data and 2024 PHWINS data to put together a full picture of the Maryland Workforce

ii. The de Beaumont Foundation is working with contacts at NACCHO to access the data, we hope this will happen by early summer

iii. The de Beaumont Foundation is deploying PH WINS in September of this year and will be working with local contacts to push and monitor the survey

1. The de Beaumont team will check with the Research, Evaluation, and Learning team to see if it is possible to share the instrument ahead of deployment time to increase the quality of responses

iv. The de Beaumont team will be working closely with Ruth and Vanessa to prep all staff members (talking points, one-pagers, optional webinars, accurate time requirements, etc.)

1. This will be a place of increased workgroup involvement to encourage participation, do some message testing, and send reminders to their colleagues

v. Parallel to data collection, the de Beaumont Foundation, the workgroup, and the interns will create table shells for a draft report. While the data will not be available until January 2025, once cleaned, we will simply plug and play. The results will be the basis of the recommendations the working group will put forth into the larger commission report

vi. M. Brewster: Will the survey include non-LHD workforce like MDE, etc that is also paramount to what LHDs do

1. Extra addition will be outside PHWINS survey. More like Maryland supplement. Will still be deployed same time

IX. **Announcements**

a. Next Meeting: May 2, 2024 (2-5pm) at Baltimore County Dept of Health with virtual option

b. Upcoming Southern Maryland Regional Public Listening Session, April 16, 2024, 5:15PM at St. Mary's County Government Center

i. Been published via press release, social media, through our partner networks, and the 3 health departments in southern Maryland.

X. **Adjourn**

a. Motion to adjourn by N. Rochester, M. Spencer seconded – Unanimously approved

b. Meeting ended at 4:42pm

Camille Blake Fall, JD

Director, Office of Minority Health and Health Disparities

Maryland Department of Health

Central Maryland

Communication & Public Engagement Workgroup

Camille Blake Fall is the Director of the MDH, Office of Minority Health and Health Disparities. Camille brings to the role more than 20 years of government service leading policy, programmatic, and legislative advocacy efforts in healthcare and an unwavering commitment to improving communities, advancing equity and driving transformational change.

In a prior role, Camille spent 17 years as an attorney at the U.S. Department of Health and Human Services, Office of the General Counsel (OGC), Centers for Medicare & Medicaid Services (CMS) Division. In addition to providing legal, legislative, regulatory and communication services for several grant and public benefits programs, Camille served as lead legal counsel advising CMS' Division of Tribal Affairs and the CMS Tribal Technical Advisory Group on policies affecting American Indian and Alaskan Native communities to ensure access to culturally competent healthcare in Indian Country. Camille also functioned as lead attorney and subject matter expert on Emergency Medical Treatment and Labor Act (EMTALA) implementation and the related obligations on Medicare-participating acute care hospitals. As one of the department's chief EMTALA experts, Camille represented the agency at various healthcare conferences and trainings nationwide.

Chelsea Cipriano, MPH
Managing Director of the Common Health Coalition

Chelsea Cipriano, MPH serves as Managing Director of the Common Health Coalition. Prior to this role, she served as Executive Director of Government Affairs and Deputy Public Information Officer (for the COVID, mpox responses) for the New York City Department of Health and Mental Hygiene. Chelsea also served within the NYC Mayor's Office - first as a Senior Health Policy Advisor and then as Deputy Chief of Staff for the Office of Management and Budget. She has held additional roles in public health at multiple levels of government, including with the US Centers for Disease Control and Prevention and the US Department of Health and Human Services.

Office of Minority Health and Health Disparities & AHEAD Population Health Transformation Advisory Committee Overview

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

May 2, 2024

MHHD Statute

The office was established in statute in 2004 (Health-General § 20-1001-1007).

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

Key activities include:

- Collection and publication of race and ethnicity data through a "health care disparities policy report card," respond to data requests, and serve as a resource for information on effective data collection
- Advocate to improve minority health outcomes by establishing educational forums, programs (including grants to community-based organizations), and health awareness campaigns
- Identify and review health promotion and disease prevention strategies related to high mortality and morbidity rates among marginalized and underserved communities
- Foster public/private partnerships
- Assist Health Secretary in setting health equity priorities and advise on policies affecting the delivery of equitable health care and the creation of a strategic plan to address social determinants of health

Mission and Vision

Mission

The mission of the Office of Minority Health and Health Disparities (MHHD) is to address social determinants of health, reduce health disparities and advance health equity by leveraging the resources of the Maryland Department of Health (MDH); collect, compile and analyze race and ethnicity data to improve health outcomes; foster robust community public/private partnerships to advance health equity advocacy and education; guide policy, practice, and program decisions within MDH, and influence the overall strategic direction the department on behalf of the Secretary of Health.

Vision

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

MHHD Today – Leveraging MHHD Resources to Amplify Impact

Recent/Current Data Initiatives

The National Academy for State Health Policy's (NASHP) Learning Lab: Healthy People, Health States – Addressing Health Disparities

- MHHD leads the Maryland cohort in this multi-state technical assistance opportunity that supports states in data-driven policymaking approaches to address health disparities.

Maryland Commission on Health Equity (MCHE)

- Provides data support to MCHE Policy Committee tasked with developing a Health Equity Framework
- The MHHD Director serves as the Chair of the MCHE Data Advisory Committee (DAC) & MHHD epidemiologist sits on DAC
- 2023 report (initial draft and data analysis provided by MHHD staff) contains race/ethnic by jurisdiction rates of five social factors (potential causes), five health outcomes (effects), and health uninsurance (both cause and effect)

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Data Initiatives Cont.

Root Causes of Health Initiative Quality Assurance Initiative (RoCHI)

- MHHD provides data support for this program within the Public Health Services Administration
  - The RoCHI project is a co-venture of the Institute for Healthcare Improvement and the National Association of Chronic Disease Directors.
  - Purpose of the initiative is to assess the racial/ethnic equity of reach and equity of impact of various public health programs within MDH.

Grant Programs

Minority Outreach and Technical Assistance Program (MOTA)

- Improve the health outcomes of racial and ethnic minority communities through community engagement, partnerships, outreach, preventive intervention strategies, and technical assistance.

Social Determinants of Health Program (SDOH)

- Reduce health inequity among Maryland's racial and ethnic minorities by providing community-based interventions to address social determinants of health (SDOH).

Epidemiology and Laboratory Capacity (ELC) - COVID Program

- Provides community-based services including outreach, education, and other COVID-response-related support. (Funded by CDC)

Sickle Cell Program

- Fiscal steward of funding to support the Maryland Statewide Steering Committee on Sickle Cell Disease

Upcoming MHHD Activities

In order to better meet the requirements of MHHD laid out in statute, MHHD has focused on these areas:

- Collecting and disseminating up-to-date race and ethnicity disparities data, responding to data requests, and serving as a resource for information on effective data collection
  - This includes engagement with MHCE and their data efforts
- Engaging in a department-wide health equity inventory of MDH's current health equity portfolio for the purpose of identifying ongoing health equity initiatives, programs, policies and practices embedded throughout the agency.
- Developing and promoting internal and external practices to address structural racism and reduce the impact of the social determinants of health on communities, including understanding the most effective means of providing outreach to communities
- Strengthening community capacity by partnering with Community Health Workers and community-based organizations
- Identifying effective and feasible systems-level interventions that can help reduce health disparities

Improving Coordination on Current Activities

Aligning the work of MHHD into the priorities of MDH

- Provide funding opportunities to community partners through grants
- Support the department's legislative and policy development effort, including in the areas of population health, Medicaid engagement, behavioral health system of care
- Collaborate with and advise MDH colleagues on health equity/disparities initiatives
- Serve as a resource for cultural competency training, including implicit bias training, language access training, and programmatic technical assistance
- Expand and deepen partnerships with local health departments, healthcare and community-based organizations to identify and address health equity challenges at the grassroots level

Areas of Future Focus

MHHD is beginning to address the areas under the statute that require further development and alignment with current work

Including:

- Creation of a state plan to increase the number of racial and ethnic minority healthcare professionals in the state
    - MHHD Director is involved with various commissions on Maryland's healthcare workforce
- Partnership opportunities that include research grants to HBCUs
- Identify federal and private funds to enhance work
- Serve as central MDH office receiving federal funds specified for health disparities

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Improving Coordination on Current Activities

Aligning the work of MHHD into the priorities of MDH

- Provide funding opportunities to community partners through grants
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Future of MHHD

Driving MDH Health Equity Objectives:

1. Collaborate with MDH colleagues and external partners to develop a health equity framework
2. Designate equity officers in MDH administrations
3. Build the agency's capacity to understand and embed anti-racism equity practices into MDH's operations (i.e. systems design, vendor and provider contracts), budgets, internal and external communications, workforce development) through training and opportunities for accountability

Population Health Transformation Advisory Committee

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

Elizabeth Kromm, Director, Prevention and Health Promotion Administration, MDH

Meetings held on February 5, 2024 and March 4, 2024

P-TAC Members

Chairs

- Camille Blake Fall, (Maryland Dept. of Health)
- Elizabeth Kromm, Ph.D., M.Sc. (Maryland Department of Health)

Members

- Andrea Brown (Black Mental Health Alliance)
- Ashyrra C. Dotson (Eastern Shore Wellness Solutions)
- Claudia Wilson Randall (Community Development Network of Maryland)
- Delegate Heather Bagnall (House of Delegates, District 33C)
- Farzaneh (Fazi) Sabi, M.D. (Kaiser Permanente Mid-Atlantic States)
- Geoff Dougherty, Ph.D., MPH (Health Services Cost Review Commission)
- Heather Kirby (Frederick Health)
- Heather Zenone (Maryland Department of Human Services)
- Jenna Crawley (Maryland Department of Aging)
- Jimmie Slade (Community Ministry of Prince George's County)
- Joseph Winn (Maryland Managed Care Organization Association)
- Kesha Baptiste-Roberts, Ph.D. (Morgan State University)
- Kisha Davis, M.D., MPH, FAAFP (Maryland Association of County Health Officers Representative, Chief Health Officer, Montgomery County)
- Mary Gable (Maryland State Department of Education)
- Nikki Highsmith Vernick, MPA (Horizon Foundation)
- Suzanne Schlattman, MPH, MSW (HealthCare for All)

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Advisory Committees

Population Health Transformation Advisory Committee (P-TAC)	Primary Care Transformation Advisory Committee (PCP-TAC)	Healthcare Transformation Advisory Committee (H-TAC)
• Advise the State on the approach to equity-centered population health improvement.	• Advise the State on the approach to equity-centered population health improvement through access to robust, value-based primary care.	• Advise the State on continued transformation of Maryland's healthcare delivery system, including all-payer cost growth targets.

160 applicants.

Clinicians, public health experts, consumers, academic institutions, hospitals, and payers.

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Goals of the Advisory Committee

P-TAC will support the development Maryland's application to the AHEAD Model:

a. Identify critical elements of existing strategies, plans and mandates to serve as a foundation for a statewide population health and health equity plan.
b. Assess the current landscape of funding sources and identify opportunities to better align investments across sectors to advance population health and health equity goals.
c. Advise on development of population health and health equity measure set and identify need for new methods/models to measure collective impact of interventions targeting population health improvement and health-related social needs.
d. Advise on approaches to local and/or regional oversight to coordinate efforts that build community capacity to advance population health and health equity goals.

Application due date: March 18, 2024 at 3pm

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Vision

Equity and Excellence in Maryland's Health Care Delivery System that Improves the Health of All

- Community
- Primary Care
- Specialty Care
- Hospital Care
- Post Acute Care
- Palliative Care
- End of Life Care

Equity, Community, & Population Health

Statewide Quality and Equity Targets

- CMS Core Statewide Measures (at least one measure from five core domains)
  - Population Health
  - Prevention and Wellness
  - Chronic Conditions
  - Behavioral Health
  - Health Care Quality and Utilization
- CMS Optional Statewide Measures (at least one of domains)
  - Maternal Health Outcomes
  - Prevention Measure
- Measures selected and targets reflected in State Agreement (July 2025)
- Health Equity Plan informs selection of measures and annual updates report performance on these targets to CMS and describe progress towards meeting targets

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Statewide Health Equity Plan

- Template to be provided by CMS
  - Identify disparities and population health focus
  - Set measurable goals to reduce disparities and improve population health, including optimizing performance on population health and quality measures and primary care investment targets
  - Identify evidence-based strategies to advance towards goals
  - Inform plans for allocating resources to support progress towards goals
  - Develop processes to involve a wide range of stakeholders in State HEP implementation
- Established by end of the Pre-Implementation Period (12/31/25)
- Annual reports to CMS update progress

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Hospital Health Equity Plan

- Developed by participant hospitals to detail observed disparities and identify approaches/resources they will use to advance equitable outcomes with their patient population
- Hospitals will use a CMS Template, begin PY 1 (2026)
- Hospitals submit short annual reports on progress
- State evaluates based on CMS guidance and alignment with statewide Health Equity Plan
- States collect annual updates and include as required component to CMS

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Enhanced Demographic Data Collection

- Hospitals and Participating Primary Care Practices will be required to collect and report standardized self-reported patient demographic data to CMS
- Demographic Data used to monitor impact on disparities and patient outcomes

Health Related Social Needs Screening and Referral

- Hospitals and participating Primary Care Practices required
  - Screen patients for health-related social needs related to food, housing and transportation
  - Make referrals or take other responsive actions
- These requirements recognize, support and seek to accelerate efforts many states are using to identify HRSNs and in some cases fund HRSN services

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P-TAC Summary of Comments

Topic	Comment
Health Equity Definition	Individual and community focus, going beyond clinical focus
	Process and outcomes focused
	Data and need to address subsets of populations (age, chronic condition, ethnicity, neighborhood vs. zip codes; hidden communities with different access points)
	Need to explicit about racial inequalities

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P-TAC Summary of Comments

Topic	Comment
Maryland's Foundation for AHEAD	Community engagement: Communities know what they need; importance of getting community input; Lived experience should be valued in process as much as technical expertise; Accountability for outcomes articulated by the community; building community capacity and funding; equitable role for community organizations
	Accountability: Lack of meaningful progress on some goals; measurement and financial accountability
	Funding: Grants pale in comparison to health care funding; community investments not sufficient; leveraging all funding, including payers
	Intersectionality: Need for creativity in addressing health disparities and community development

P-TAC Summary of Comments

Topic	Comment
Maryland's Foundation for AHEAD (continued)	Focus: Community input into priorities; focus on a few priorities that are appropriately resourced
	Duplication and Collaboration: Opportunity to share what resources are available to reduce duplication of specific hospital initiatives and consideration for systems, regional or local approaches
	Operational and technical considerations: Need for more granular data, potential of technology and innovation to improve access; leverage existing tools; workforce investments; align equity plans with industry standards

P-TAC Summary of Comments

Topic	Comment
Equity	Opportunity for Maryland to think outside the health care box in this new model
	Missing opportunities to align and connect strategies
	Need to think differently and drive innovation and disruption.
Accountability	Need shared accountability for end result
	Investing a lot, but not coordinated and not producing results. Need to align funding and funding and activities to achieve results.
Funding Upstream	Funding upstream and think differently about funding
	Think comprehensively about funding sources beyond. Health care budget. Payer foundations potential source. Consider waivers for funding.
	Transportation and access to healthy foods are known needs. But. we hear we can't do anything about that.

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P-TAC Summary of Comments

Topic	Comment
Trust	Trust is essential to making change happen
	People that don’t understand the process often feel left out. Importance of training.
Value of Lived Experience	Value to going outside normal “health” circles
	CBOs can serve as a bridge to the rest of the community. Important to reach voices that are potentially unorganized.
	Leveraging existing community organizations and coalition. Funding to support on the ground efforts to engage communities.
	Importance of philanthropy to sustainability and community engagement
Importance of how the table is set and by whom	Important to be clear on who is convening and establishing co-equal power dynamic

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Relationship of Funding and Needs	Need a direct connection between needs and funding response and need to track resources
	Resource allocation often goes to where we think progress can be made quickly. Need to figure out how to make progress in harder areas.
Data and Measurement	We have data. We know problems, but. don't know solutions.
	Need to give time to measure trends and see improvements
	Only measure at patient level. Need measures that address equity at structural level.
	We have data on minority health. We have maps, start there. We don't need new measures.

Implications for Public Health Policy Development

In order to accelerate health equity and maximize impact, what factors matter most (and in what order)?

- Improved access to care? Care coordination?
- Workforce development and training?
- Time or timing?
- Funding?
- Social, environmental or political dynamics?
- Vision shared across multiple sectors (public, private, academic, philanthropic) with a demonstrable commitment?

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Thank you.

Happy to take questions.

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