MARYLAND COMMISSION ON PUBLIC HEALTH

November 07, 2024
2:00 PM – 5:00 PM EST

Prince George's County Government Building (Hybrid)
In-person: 1801 McCormick Dr (Rm 140), Upper Marlboro, MD 20774
Online: https://meet.google.com/whc-wzpa-osc
or dial: (US) + 1 314 474-3289 Pin: 228 226804#
More phone numbers: https://tel.meet/whc-wzpa-osc?pin=9675008149300

AGENDA

I. Call to Order

II. Adoption of the Agenda

III. October 03 Minutes Review and Approval

VI. Guest Presentation: Dr. Roderick King, Sr. Vice President and Chief Equity, Diversity, and Inclusion Officer at University of Maryland Medical System

VII. Guest Presentation: State Health Improvement Plan by Dr. Katherine Feldman, Chief Performance Officer, Maryland Department of Health

VIII. Short Recess

IX. Commission Updates

a. Site visits and listening sessions

b. Interim report timeline and assessment update

X. Commission Discussion and Reflection

XI. Announcements

a. Special meeting: November 20, 2024, 10:00 AM – 12:00 noon *virtual only*

b. Next *regular* monthly meeting: Thursday, December 05, 2024, 2:00 – 5:00 PM at Prince George's County Government Building with virtual option

c. Other deadlines/announcements

2025 meeting dates: Jan. 23; Feb. 20; Mar. 13; Apr. 03; May 01; Jun. 05; Jul. 10; Aug. 21; Sep. 11 *(calendar invites sent)*

XII. Adjournment

MARYLAND COMMISSION ON PUBLIC HEALTH

Welcome

November 07, 2024

This meeting will be recorded and posted on the Commission's public website.

MARYLAND COMMISSION ON PUBLIC HEALTH

Roll Call

Commissioners: please say present when your name is called.

Workgroup members: please post your name and workgroup in the chat box or on the sign-in sheet.

MARYLAND
COMMISSION
ON PUBLIC HEALTH

Adoption of Agenda

Commissioners: Please signify your voice vote by saying "aye" or "nay" when the vote is called.

MARYLAND
COMMISSION
ON PUBLIC HEALTH

Approval of Oct. 03 Minutes

Commissioners: Please signify your voice vote by saying "aye" or "nay" when the vote is called.

MARYLAND COMMISSION ON PUBLIC HEALTH

Guest Speaker

Roderick King, MD, MPH

Sr. Vice President & Chief Diversity, Equity and Inclusion Officer at University of Maryland Medical System

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Equity, Diversity and Inclusion

A Cornerstone in our Cultural Evolution

November 7, 2024

Equity, Diversity and Inclusion Shared Services

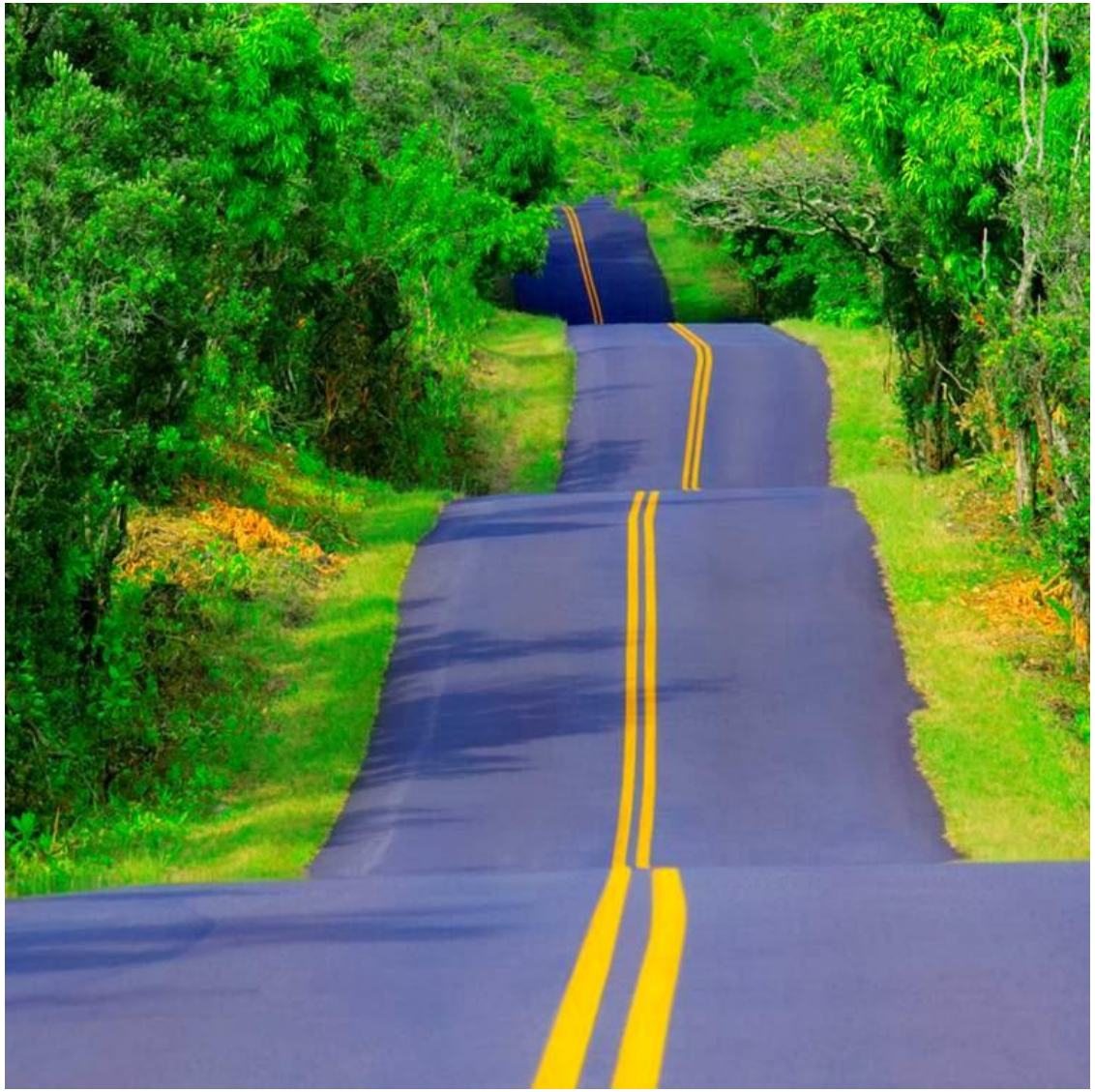
Roderick K. King, MD, MPH

SVP, Chief Equity, Diversity and Inclusion Officer

Overview

- *Participants will understand the history and evolution of the UMMS EDI Roadmap-*
  - *Focus: Equity In Patient Care*
- *Overview of the UMMS Health Equity Transformation work*
- *Where are we going with all of this?*
- *Why have we not made progress on Health Equity in 20 years?*
- *Partnering with Public Health: A Key to Our Success*

UMMS EDI Journey



Our EDI History -

2019 November

Mohan Suntha, MD, MBA is appointed President and CEO of the University of Maryland Medical System. Among other things he expressed his vision for the system to adopt a fully equitable and inclusive culture

2020 June

George Floyd's murder served to accelerate the pace of Dr. Suntha's desired culture changes, and as such he identified 4 work streams that would define our work in the EDI arena. He then gathered a group of executives from across the system and asked them to assemble teams who would deliver a plan of action for each work stream in 30 days.

2020 July

The work streams presented their final plans and budgets to Dr. Suntha

2020 August

Dr. Suntha communicates those plans to all internal stakeholder groups

2020 November

EDI budget is approved by UMMS board of directors as part of the amended (due to COVID-19 pandemic) FY'21 budget

2021 April

Dr. Roderick King, MD, MPH named as UMMS first ever Chief Equity Diversity and Inclusion Officer

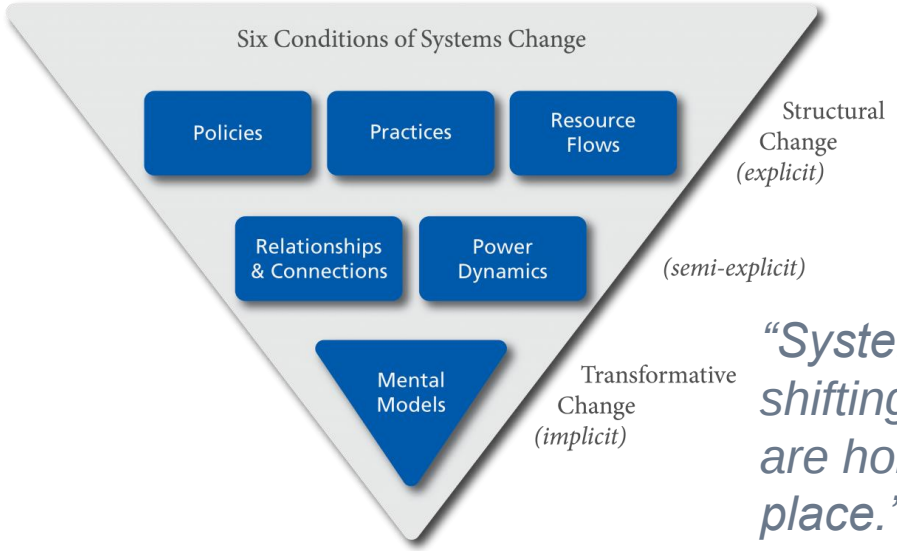
2024 March

Tiffany Wiggins, MD, MPH named as the UMMS Chief Health Equity Officer

The Difference in our Approach… SYSTEM(S) TRANSFORMATION

Advancing Equity in Patient Care by Systems Transformation

Sustainable, Comprehensive (“Equity Lens”)



“Systems change is about shifting the conditions that are holding the problem in place.”

Social Innovation Generation (SIG) / FSG

From “The Water of Systems Change” by Kania, Kramer and Senge, June 2018

UMMS Equity, Diversity, and Inclusion (EDI)
Shared Services

- EDI Shared Services provides **leadership and works collaboratively with Member Organizations to execute strategies** that advance optimal health and wellbeing for all. We envision a system of care in which all people touched by UMMS – patients, families, team members, and community partners – can **thrive**.

- Our work, powered by a data and analytics engine, spans four functional areas:

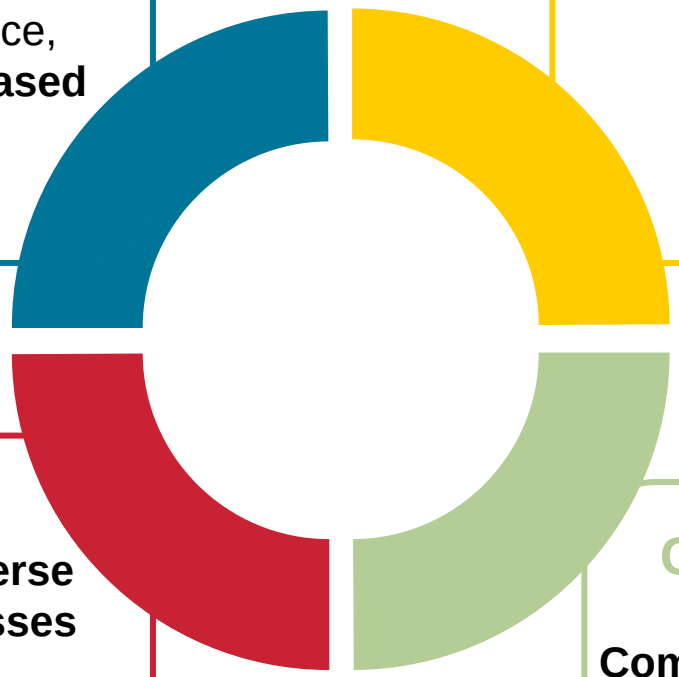
EDI Functional Areas

Equity in Patient Care

Identify and implement procedural and clinical changes that will reduce, and eventually **eliminate, race-based health care disparities**

Diversity & Inclusion in our Workforce

Develop programs that **foster a sense of belonging** and ensure optimized **access to career advancement opportunities** that support our current and future workforce



External Partners

Expand our partnerships with **diverse suppliers and inclusive businesses** as a means to strengthen and empower our health system, business partners and the communities we serve

Community Health Impact

Community Health
Community Needs Assessment & Community Benefits

Community Impact Investments
invest resources to address Social Drivers of Health (SDOH) disproportionately impacted communities

UMMS Equity, Diversity, and Inclusion Steering

CEO Sponsor: Mohan Suntha, MD

Executive Chair: Roderick King, MD

Workforce Diversity & Inclusion

- Tammy Saunaitis– SVP/Chief Human Resources Officer
- Andy Lawrence- VP Team Member Development

External Partners

- Richelle Webb-Dixon - SVP/Chief Administrative Officer
- Patrick Vizzard- VP Supply Chain Management
- Garry Tuggle- Director Enterprise DIV and Inclusion Supply

Equity in Patient Care

- Tiffany Wiggins, MD, MPH – VP/Chief Health Equity Officer

Community Investments

- Kristin Jones Bryce-SVP/Chief External Affairs Officer
- Chuck Tildon - VP External Affairs
- Senior Director, Community Health- EDI Shared Services

Metrics and Reporting

- Warren D'Souza – VP/Chief Innovation Officer
- Joel Klein – SVP/Chief Information

EDI Functional Areas

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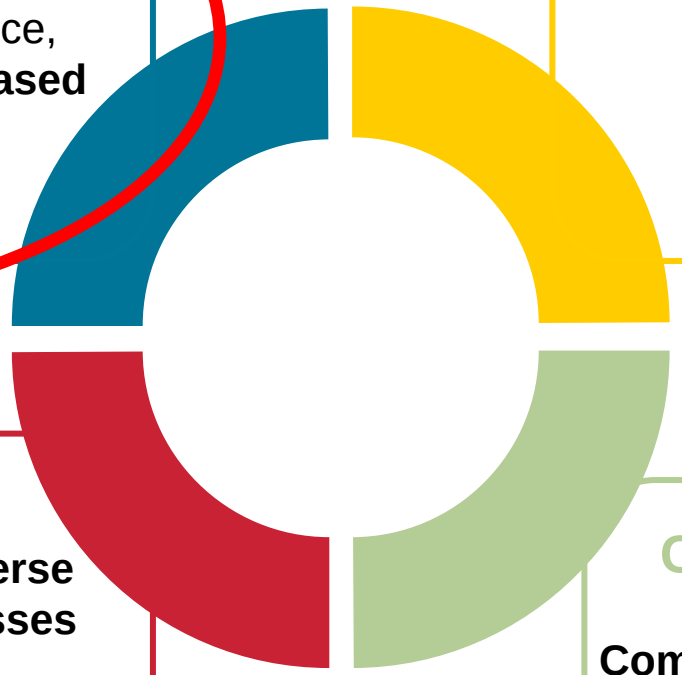

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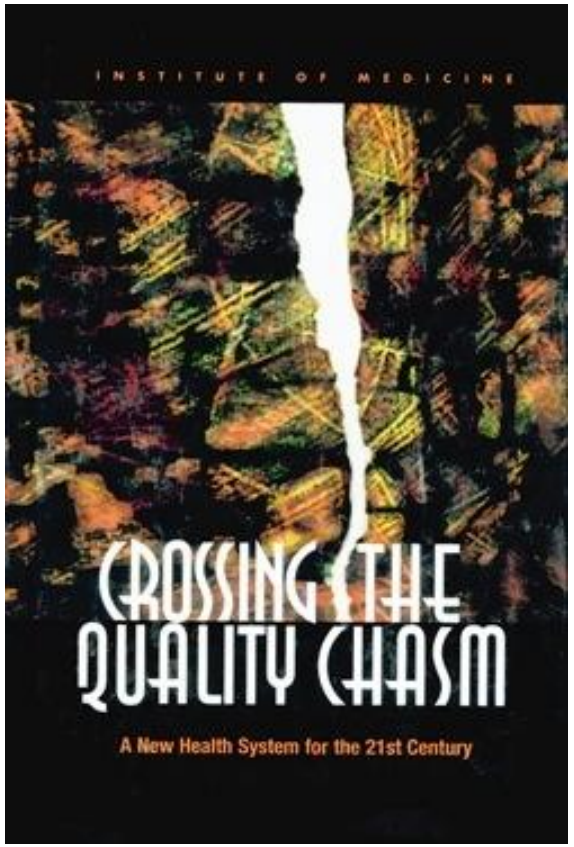
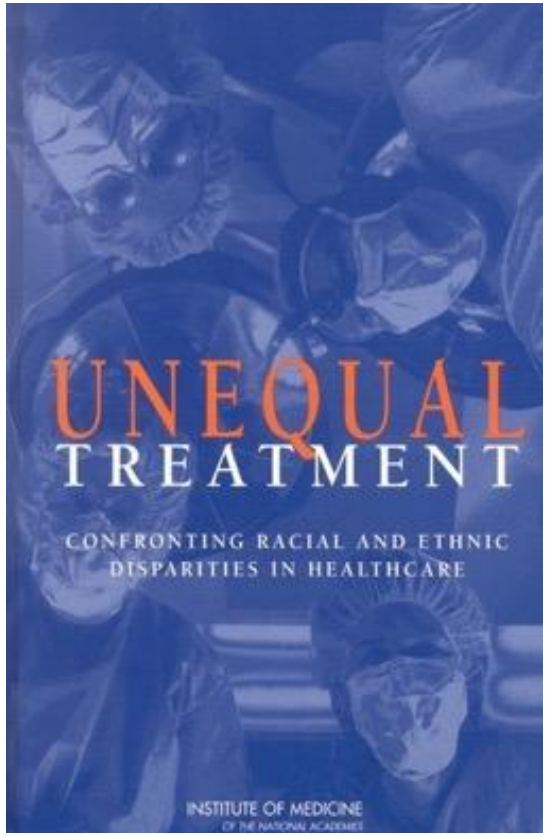
Equity in Patient Care

Quality Care is Equitable Care



Committee on Quality of Health Care in America. Institute of Medicine, ***2001***

- **Safe**
- **Effective**
- **Patient-centered**
- **Timely**
- **Efficient**
- **Equitable**



Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Institute of Medicine, ***2003***

Race Based Clinical Algorithms and Technology

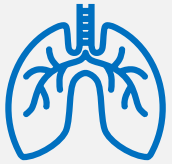
Race-Based Clinical Algorithms (RBCAs) and Decision-Making Tools

Background and National Activity

UMMS Areas of Focus

Estimated Glomerular Filtration Rate (eGFR) algorithm

Vaginal Birth After Cesarean (VBAC) calculator



Pulmonary Function Tests (PFTs), Pulse Oximetry

- In recent years, professional medical societies, clinicians, and scholars have highlighted the (mis)use of race in clinical algorithms and decision-making tools (“algorithms”)

- Concern regarding these algorithms stems from a recognition that race correction/adjustment:
  - Uses race as a biological proxy rather than a social construct
  - Is historically based on methodologically flawed, and often scientifically racist “evidence”
  - Can exacerbate the underlying health inequities we seek to combat

- Their use in all areas of medicine must be explored to advance equity across the entire healthcare landscape

Sources:

New England Journal of Medicine (2020) – Hidden in Plain Sight– Reconsidering the Use of Race Correction in Clinical Algorithms
KFF (2021) – Use of Clinical Diagnosis and Decision Making: Overview and Implications
Health Affairs (2023) - Promoting Equity in Clinical Decision Making: Dismantling Race-Based Medicine
AMA (2022) – Call Race-Based Algorithms What They are: Sources of Harm
AAP (2022) – Eliminating Race-Based Medicine

Equity in Patient Care

Race-Based Clinical Algorithms
UMMS in the News

New health equity execs strive to shape the future, confront the past

modernhealthcare.com/providers/health-equity-executives-inequalities-disparities-umms-allegheny-health

Kara Hartnett

December 11, 2022

Modern Healthcare

NEWS | DIGITAL HEALTH | INSIGHTS | DATA/LISTS | OP-ED | AWARDS | EVENTS

Home › Transformation

May 19, 2022 06:00 AM

How removing race-based guidance can benefit patients and clinical practice

MARI DEVEREAUX KARA HARTNETT

The Washington Post

Democracy Dies in Darkness

University of Maryland Medical System drops race-based algorithm officials say harms Black patients

By Ovetta Wiggins

November 17, 2021 at 2:48 p.m. EST

BECKER'S HOSPITAL REVIEW

Infection Control | Patient Safety & Outcomes | ...cutive Moves | Transaction & Valuation | HR | Capi | ...ordination | Legal & Regulatory | Compensation | P

U of Maryland Medicine eliminates race as birthing decision factor

Cailey Gleeson (Twitter) - Wednesday, May 4th, 2022

Waiting time adjustment approved for kidney transplant candidates affected by race-based calculation

Jan 5, 2023 | Equity, Kidney/pancreas, News, Patient

Transplant programs to begin contacting patients in 2023

UMMC Leads Nation in Kidney Transplants Among African-Americans

University of Maryland Medical Center's longstanding national prominence in organ transplantation has been further elevated with its recent status as the leading center in the United States for performing kidney transplants in African-Americans.

Data from the United Network for Organ Sharing shows UMMC performed more kidney transplants in African-Americans in 2014 than

*** "..14,000 Black kidney transplant candidates…moved up the priority list…"**

AP*: "A biased test key thoughts of Black people from getting a kidney transplant, It's finally changing",* April 1, 2024

Race-Based Clinical Algorithms and Decision-Making Tools

Pulse Oximetry

People with darker skin are 32% more likely to have pulse oximeter readings overestimate oxygen levels, report says

By Jacqueline Howard, CNN

6 minute read · Published 5:45 PM EDT, Wed March 20, 2024

March 2024:
UMMS, Epic, and the Federation of American Scientists publish **study on pulse oximetry bias** involving national sample **(~13K patients)**

Black Patients 32% More Likely Than White Patients to Experience Occult Hypoxemia, Which May Result in Delayed Care

March 20, 2024

Dual Team Study

Team A: Sam Butler, MD • Joe Deckert, PhD • Zach Dezman, MD • Roderick King, MD, MPH

Team B: Jackie Gerhart, MD • Neil Sandberg • Joel Klein, MD • Joseph Wright, MD, MPH • Grace Wickerson

Key Findings

- Non-Hispanic Black patients are 32% more likely to have occult hypoxemia, which is an overestimation of a patient's blood gas by a pulse oximeter that can lead to delayed recognition of low oxygen levels than non-Hispanic White patients.
- Non-Hispanic Black patients are 39% more likely than non-Hispanic White patients to see a difference of 15 percentage points or more between their blood gas (SaO2) and pulse oximeter (SpO2) readings.

Ongoing pulse oximetry bias contributes to inequities in clinical decision-making, outcomes, and costs

- Melanin affects light absorption in estimation of oxygen saturation via pulse oximetry
- FDA approved original pulse oximeter in 1980, when racial diversity requirements in clinical trials did not exist
- Subsequent technology has had limited testing/calibration on diverse skin tones, resulting in inaccurate readings for "darkly pigmented" people

Sources:

Combatting Racism in Medical Innovation
Pulse Oximeter Outcome Disparity - Epic Research
CNN Pulse Oximeter Coverage
Oximeters used to be designed for equity, what happened?

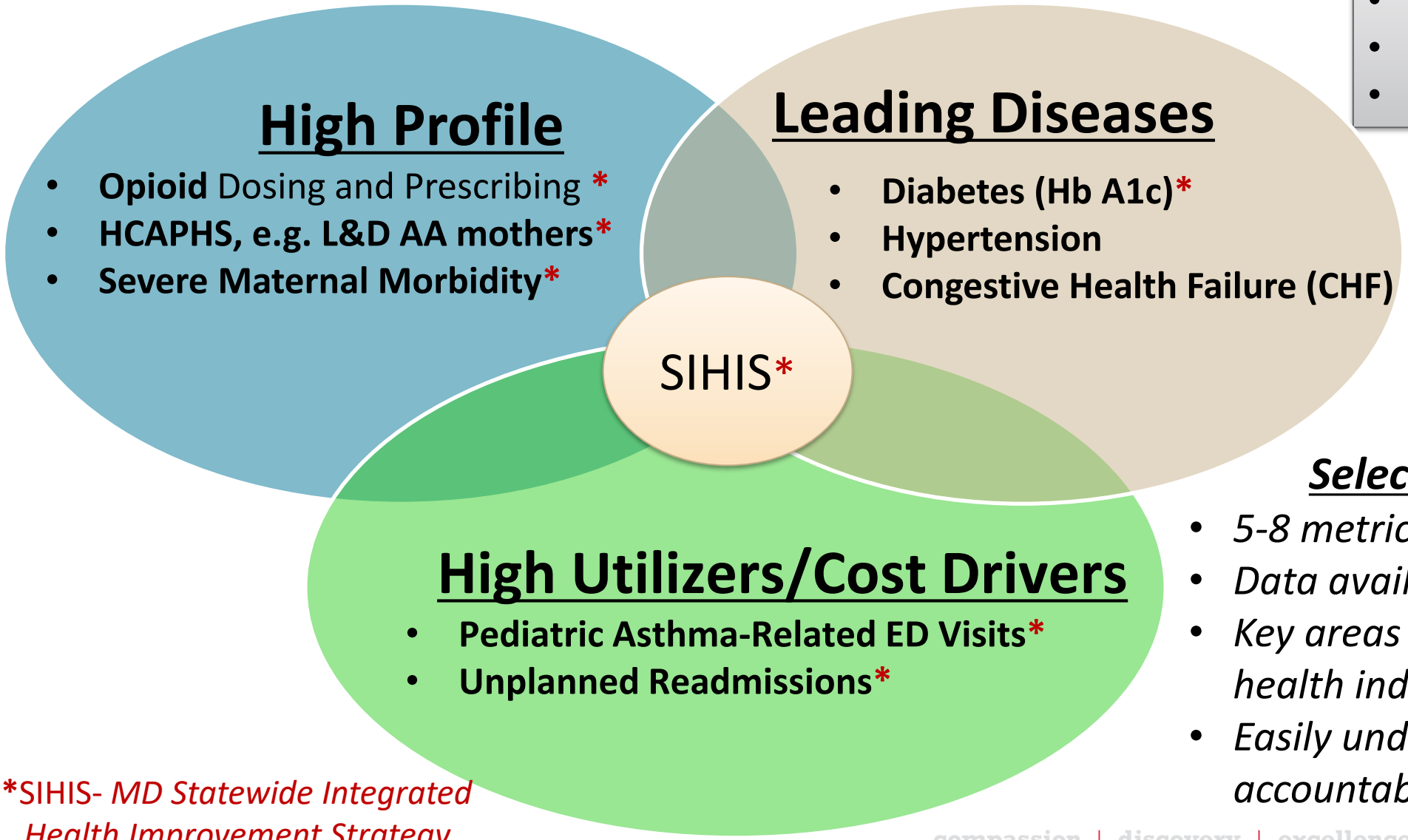
Health Equity Transformation

- Addressing Health Disparities via Systems Change

Using Data to Drive Action: Equity in Patient Care, Metrics and Analytics

UMMS Equity in Patient Care ("EPC") metrics

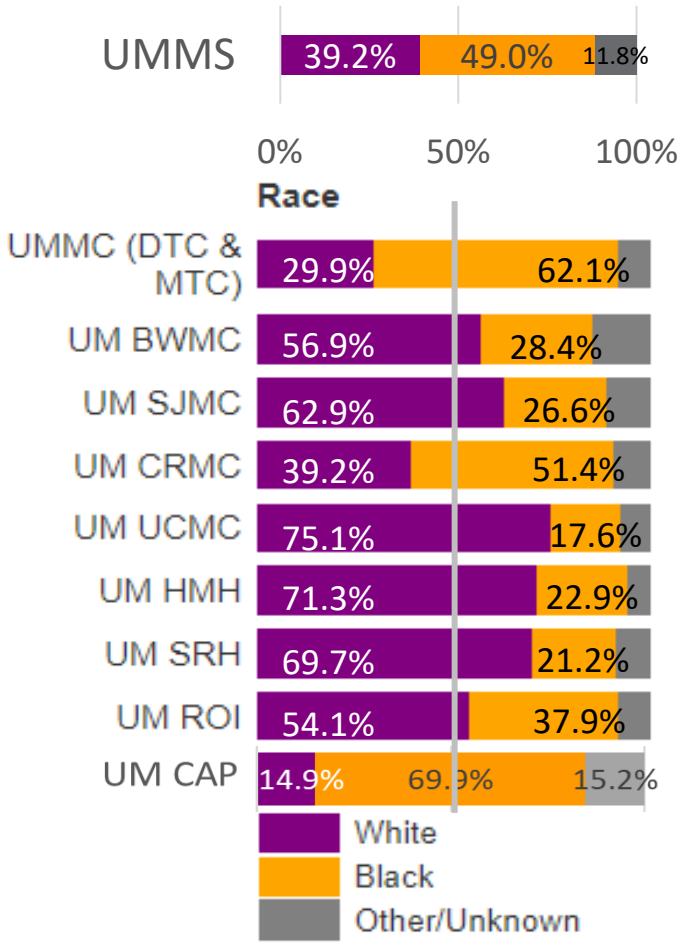
Goals:
- Reduce disparities
- Reduce cost
- Population health impact

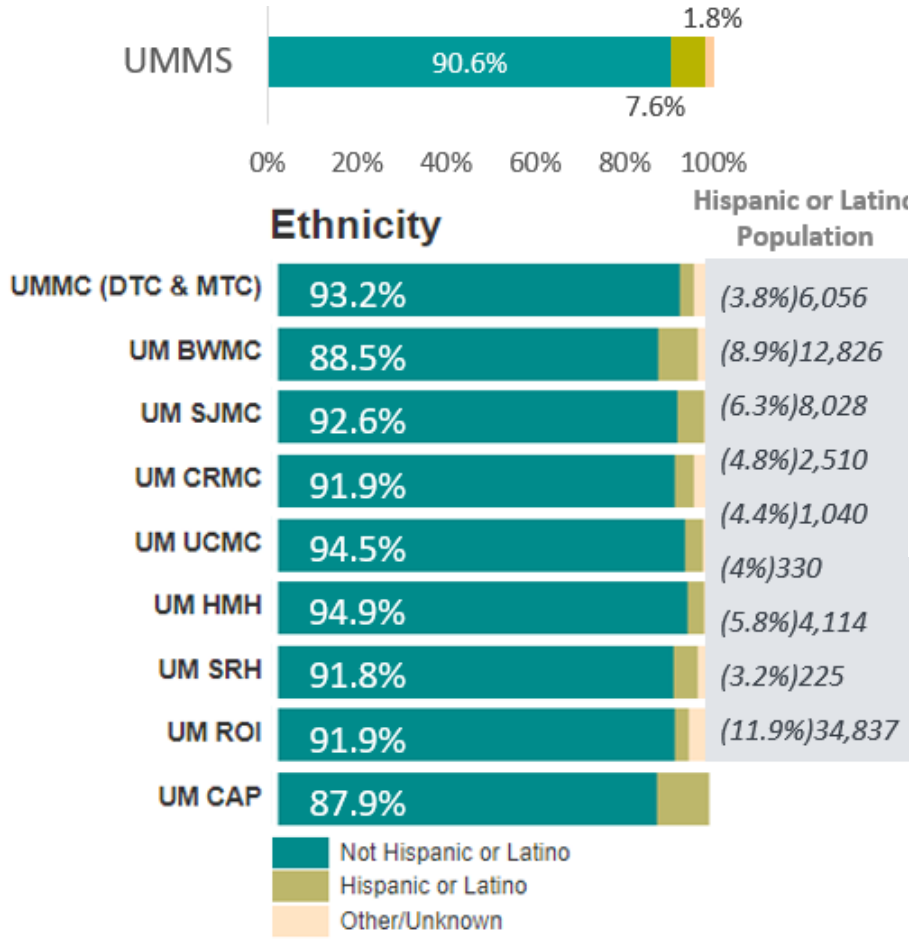


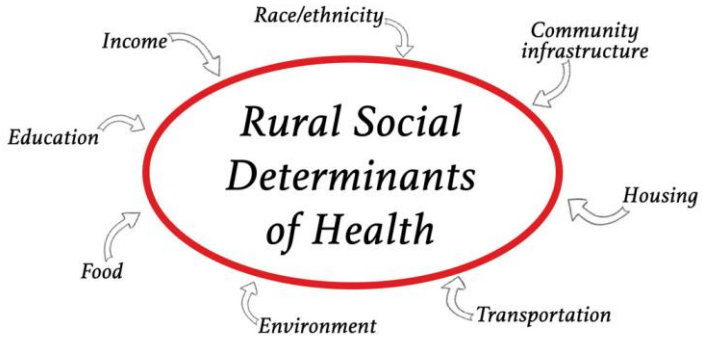
Selection Criteria:
- *5-8 metrics, proxy for others*
- *Data availability*
- *Key areas (visibility, leading health indicators, cost drivers)*
- *Easily understood (public accountability)*

SIHIS- *MD Statewide Integrated Health Improvement Strategy*

Diversity of our Patient Population







Rural Health Disparities

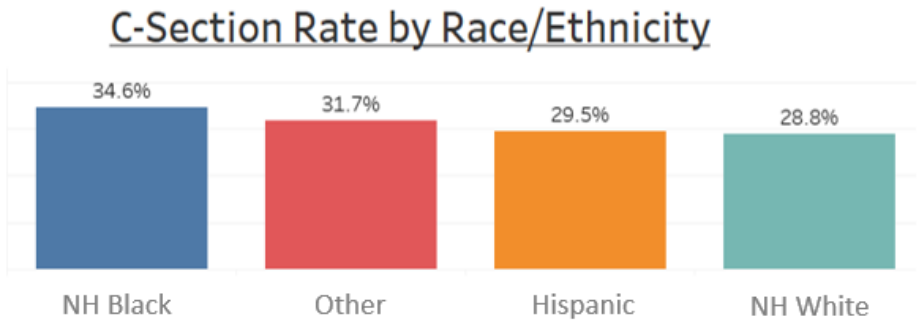
*Patients who had at least one ED or IP encounter between CY2016 and CY2020 inclusive (in Epic).

Other/Unknown includes Missing, Unknown, Other, Asian, American Indian or Alaskan Native, Two or More Races, Native Hawaiian or Other Pacific Islander, Declined to Answer

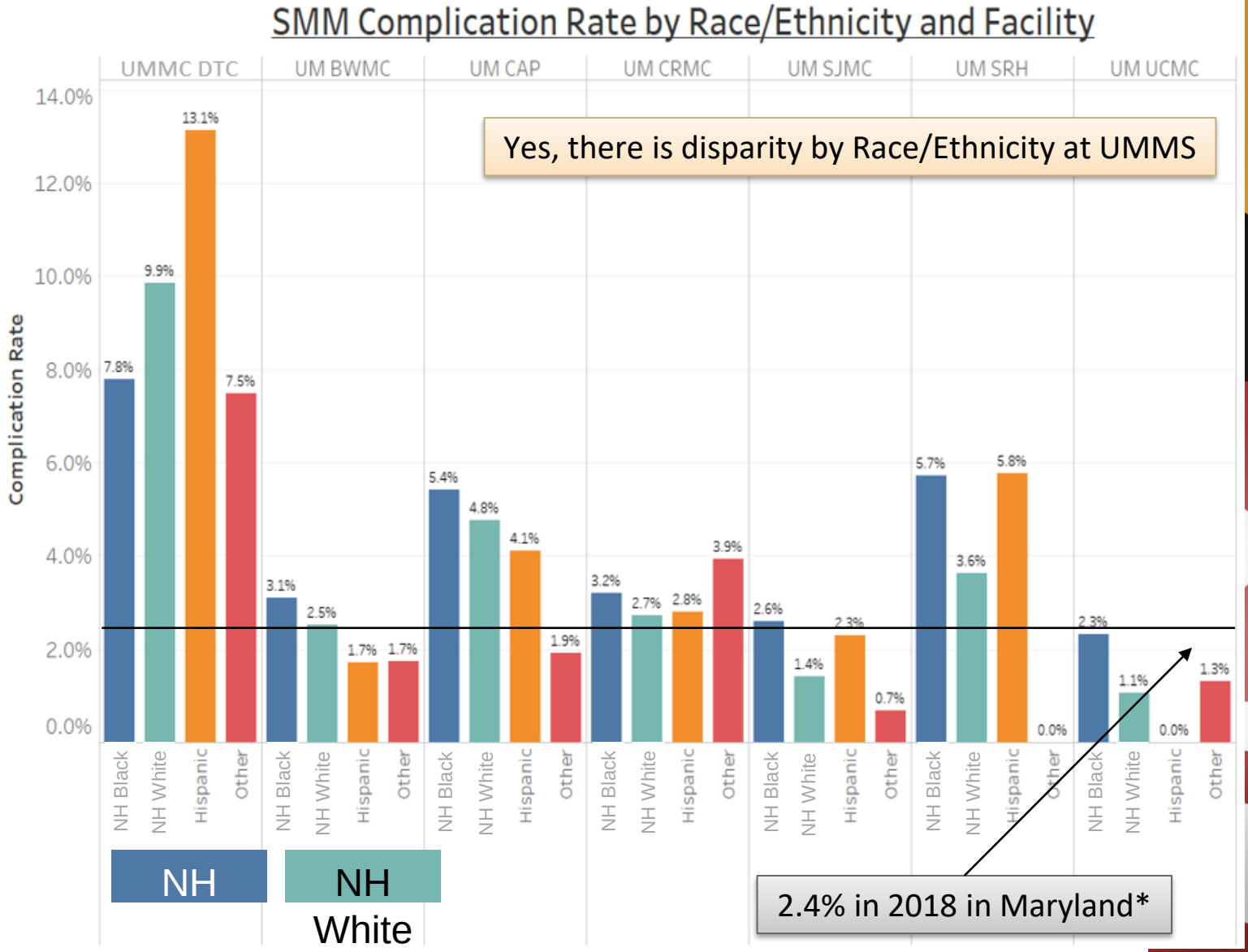
EPC Example: Severe Maternal Morbidity (SMM)

UMMS Status

- Most member hospital had **higher rates of SMM in NH Black patients** vs NH White patients in CY2021
  - UMMC DTC has the highest SMM rates for all races/ethnicities



- Over the last 3+ years at UMMS, NH Black women deliver by C-Section at 6% higher rate than NH White women (34.6% vs 28.8%)

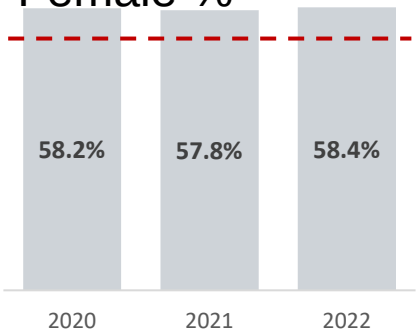


*From SIHIS proposal

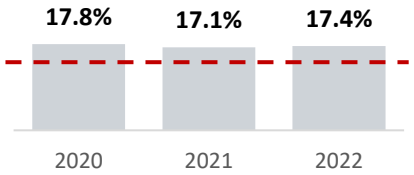
Rural Health Analysis at UM SRH

Demographics of Patients* at UM SRH

Female %



Black or African American %



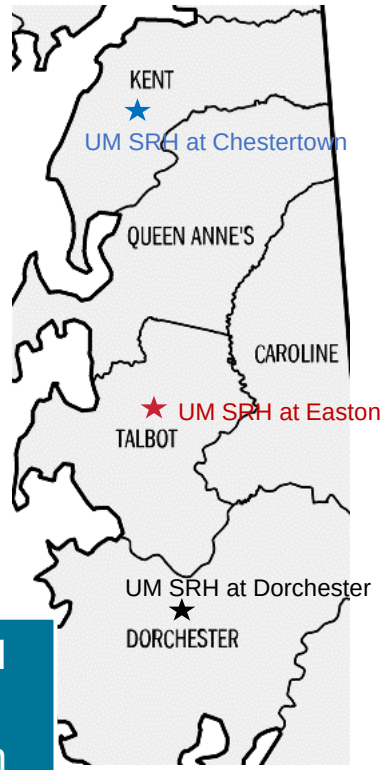
Patients with hospital encounters

Demographics in Kent & Talbot County**

**https://www.census.gov/quickfacts/fact/table/MD/SEX255221

	Kent & Talbot County
Male	47.9%
Female	52.1%
White	82.6%
Black or African American	13.2%
Others	4.2%

Where Kent and Talbot within legislatively designated rural counties



Patient population at UM SRH has similar characteristics of Kent/Talbot County population

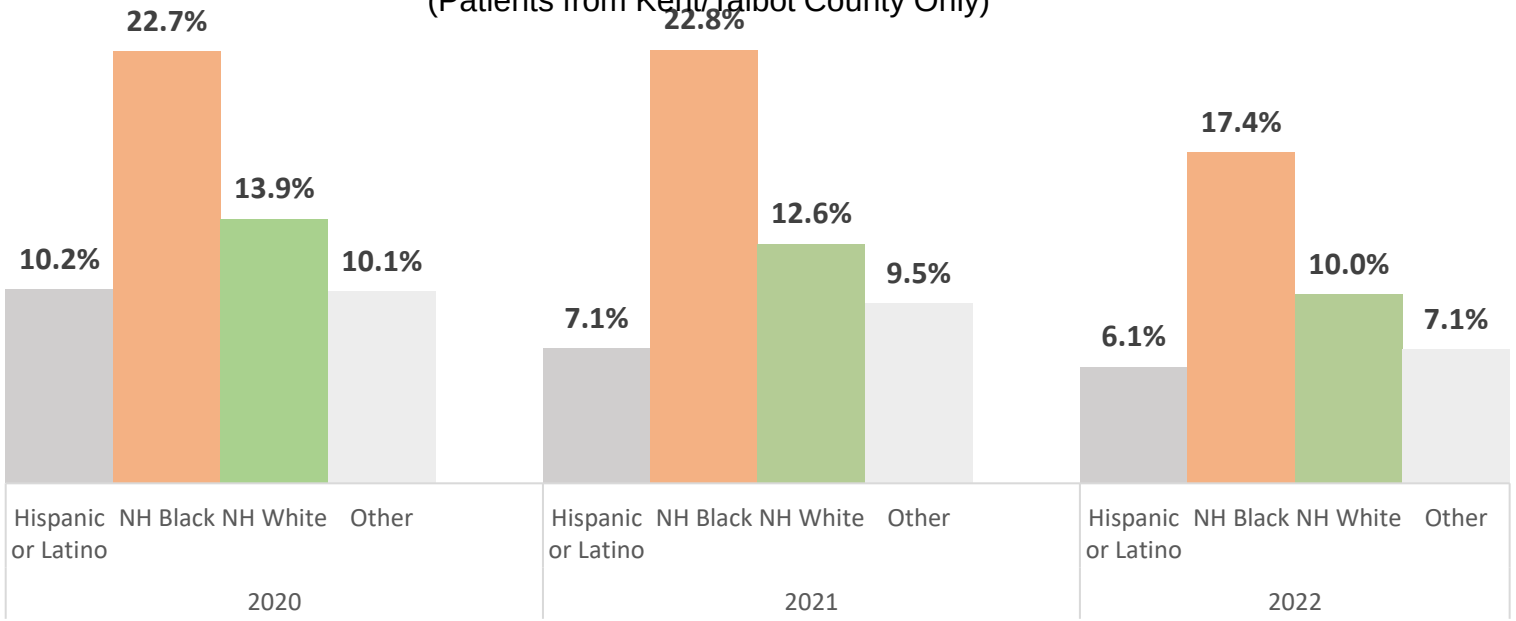
Prevalence of Diabetes by Area at

- ~35% patients came from Kent/Talbot County
- Higher prevalence of Diabetes for

unty

Prevalence of Diabetes by Race/Ethnicity at UM SRH

(Patients from Kent/Talbot County Only)



Higher prevalence of Diabetes in NH Black population from Kent/Talbot County than NH White population

Equity in Patient Care – Diabetes & Prediabetes

EDI Landing Page | Diabetes/Prediabetes Home P... | Diabetes/Prediabetes Overview | HbA1c Testing Access

Diagnosed Diabetes & Prediabetes Prevalence in Adults Treated at UMMS Member Organizations

Facility: (All) Year: (All) Treated adult patients per year with: At least one encounter with Diabetes diagnosis

Background

According to Maryland Dept of Health, 500k (10.5% of 4.7M) adult Marylanders have Diabetes, and **only 160k out of 1.6M (3.4% out of 34%) of adult Marylanders with Prediabetes are aware of their Prediabetes status.**
Racial and ethnic disparities exist in Diabetes and Prediabetes diagnosis. Research has found that Asian, Hispanic and Black Americans are at increased risk for diabetes at lower weights and younger ages than White Americans.

Population Demographics and HbA1c Testing at member organization

1 Overview of Diagnosed Diabetes

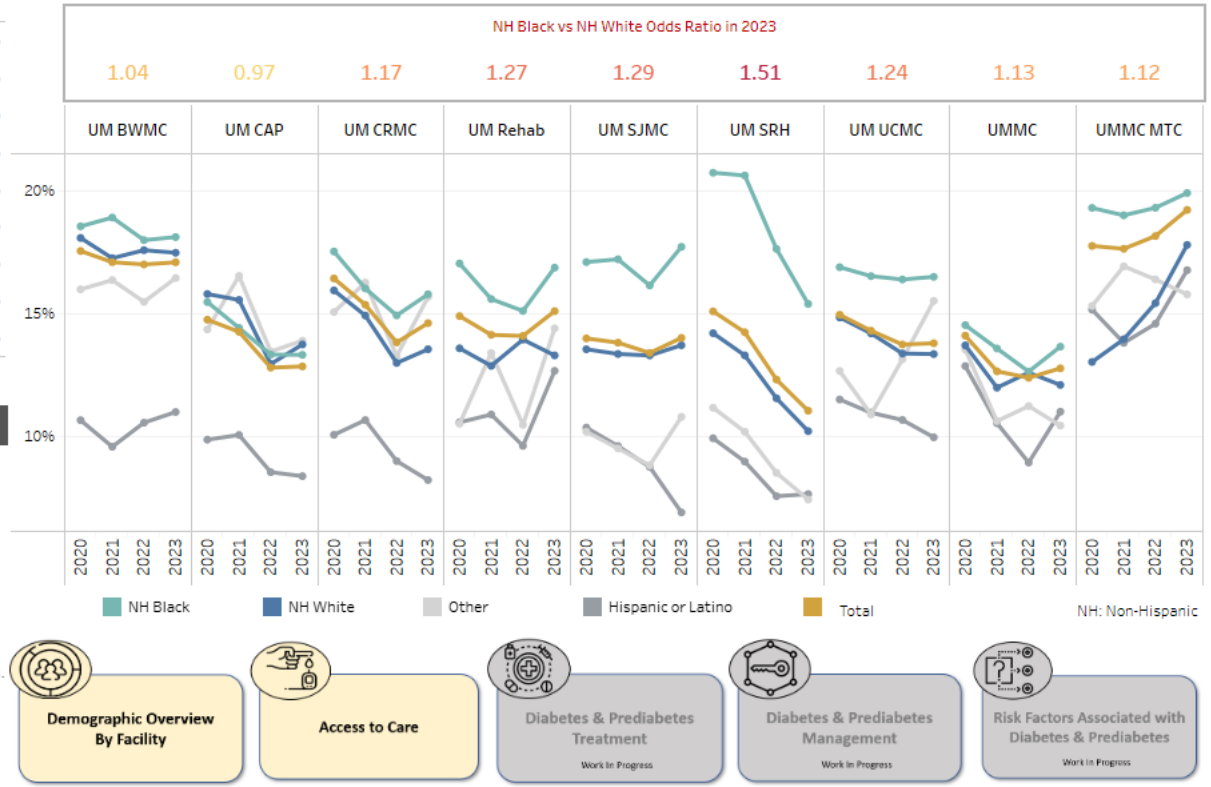
Diabetes Prevalence and Patient Counts by Facility

	2020	2021	2022	2023
UMMC MTC	17.8%	17.6%	18.2%	19.2%
UM BWMC	17.6%	17.1%	17.0%	17.1%
UM Rehab	14.9%	14.1%	14.1%	15.1%
UM CRMC	16.4%	15.4%	13.8%	14.6%
UM SJMC	14.0%	13.8%	13.4%	14.0%
UM UCMC	15.0%	14.3%	13.7%	13.8%
UM CAP	14.8%	14.3%	12.8%	12.9%
UMMC	14.1%	12.7%	12.4%	12.8%
UM SRH	15.1%	14.2%	12.3%	11.1%

10.5% of adult Marylanders have Diabetes.
34% of adult Marylanders have Prediabetes, but only 3.4% of adult Marylanders have diagnosed Prediabetes.

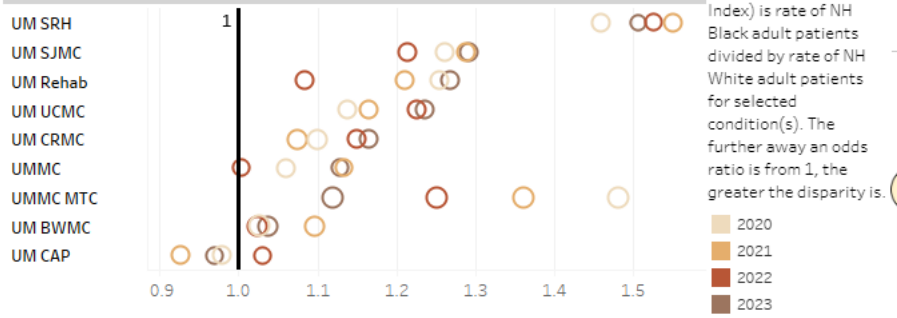
2 Presence of Racial Disparity

Diabetes Prevalence by Race/Ethnicity



3 Magnitude of Racial Disparity Over Time

NH Black vs NH White Odds Ratio of Diabetes Prevalence



Odds ratio (Disparity Index) is rate of NH Black adult patients divided by rate of NH White adult patients for selected condition(s). The further away an odds ratio is from 1, the greater the disparity is.

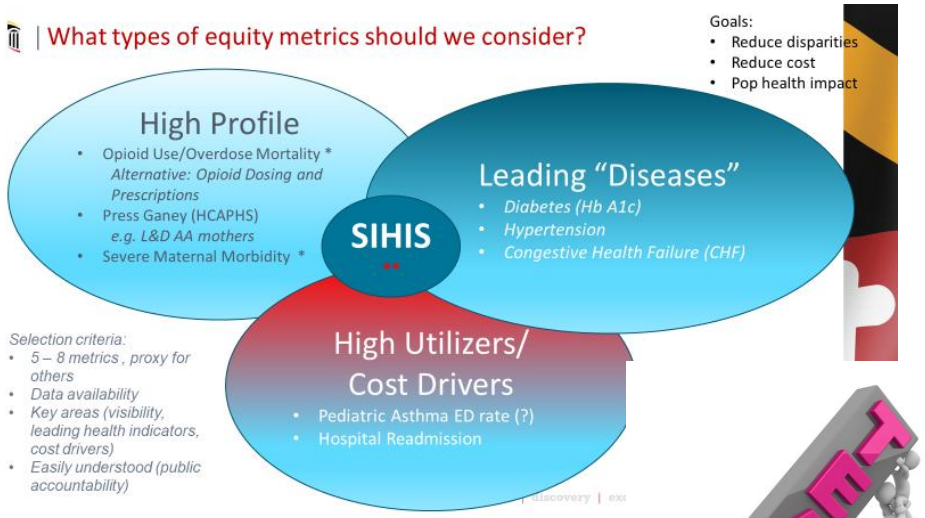
Demographic Overview By Facility | Access to Care | Diabetes & Prediabetes Treatment (Work In Progress) | Diabetes & Prediabetes Management (Work In Progress) | Risk Factors Associated with Diabetes & Prediabetes (Work In Progress)

1 Overview of diagnosed Diabetes across member organization over time → 2 Racial disparity across member organization over time → 3 Magnitude of racial disparity across member organization over time

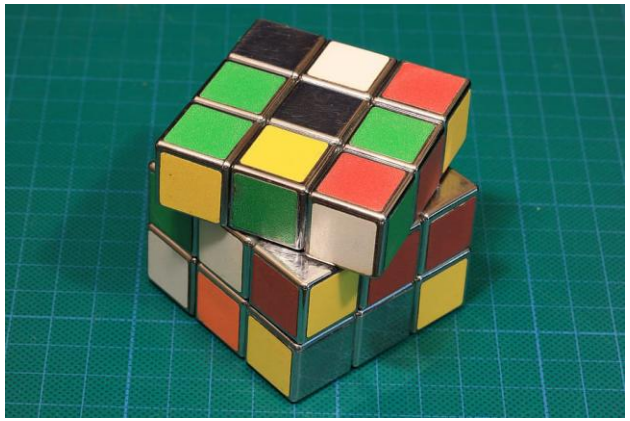
compassion | discovery | excellence | diversity | integrity

UMMS Member Organization EPC Metric Selections

EPC Metrics	Member- Org
Severe Maternal Morbidity (SMM)	BWMC Capital Region Saint Joseph DTC
Pediatric Asthma-Related ED Visits	MTC Upper Chesapeake
Unplanned Readmissions	Saint Joseph Shore Regional DTC
Diabetes/HgbA1C	Charles Regional Shore Regional UM Rehab



"UMMS 90 Day Health Equity Challenge"



R.A.C.E. For Equity - Partner

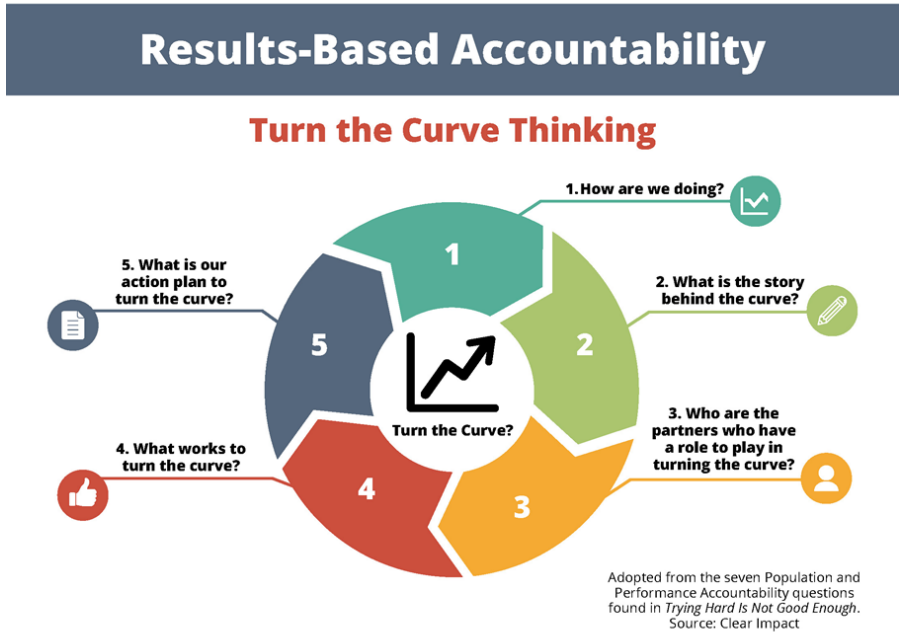
Deitre Epps

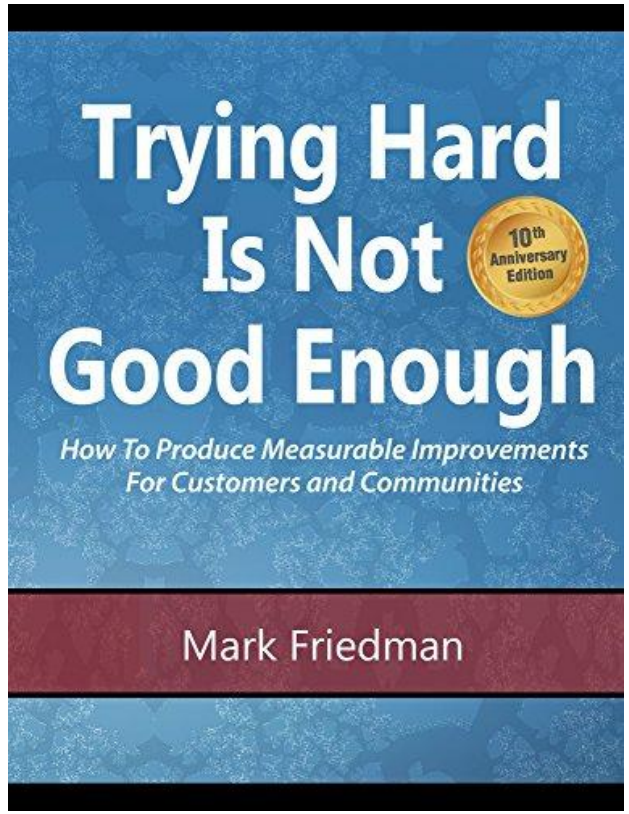
CEO & Founder

RACE for Equity

30

Turn the Curve Thinking™

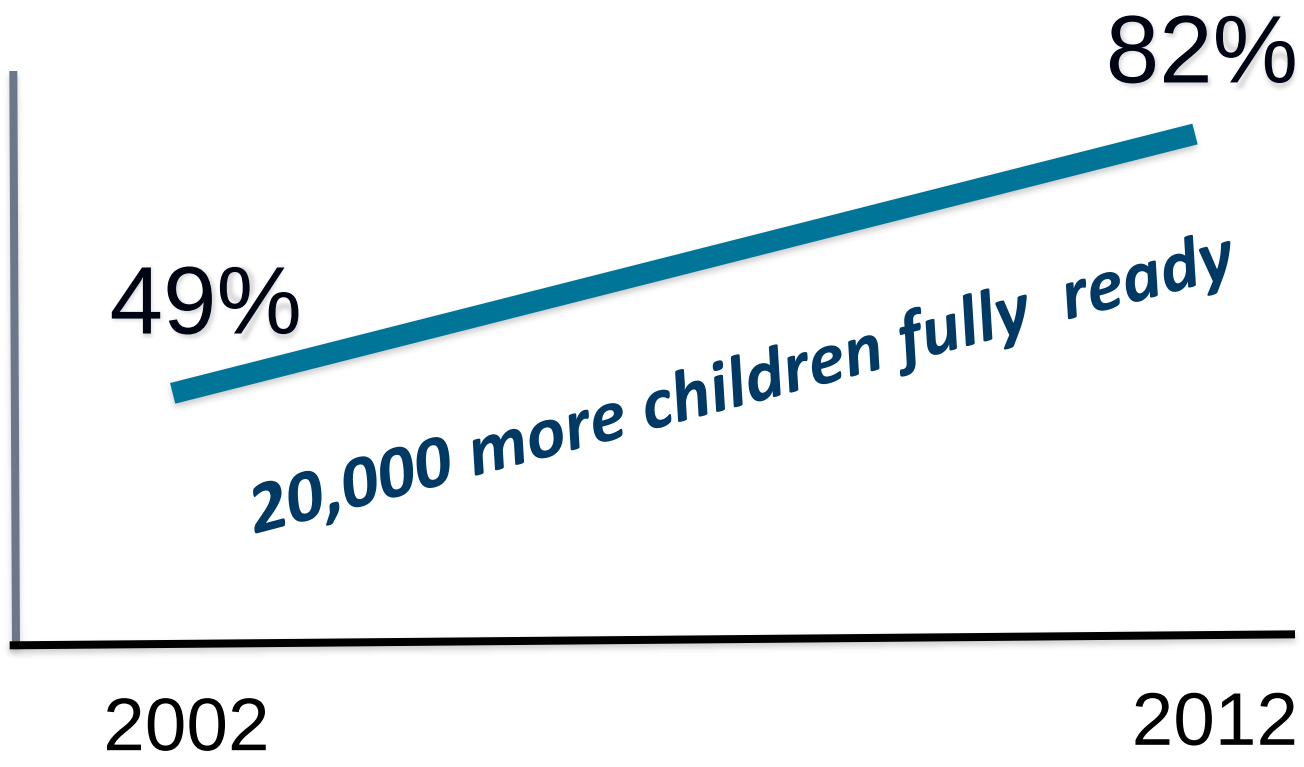




Materials from or adapted from Fiscal Policy Studies Institute, Santa Fe, New Mexico (www.resultsaccountability.com & www.raguide.org)

and Trying Hard is Not Good Enough, by Mark Friedman (Trafford 2005)

Percent of Children in Maryland Entering School Fully Ready



Babies Born Healthy-
Leadership in Action Program

Baltimore, MD, United States

Result: **Babies Born Healthy** (2006-08)

(A.E.C.F. Leadership in Action Program)

- Indicators: *Pre-Term Delivery, Infant Mortality, Low Birth Weight*
- Institutionalize (2008-09) in Baltimore City Health Department and rebranded as ***B'more for Health Babies***
- Infant Mortality decreased by 40% (2009-2012) and black/white disparity decreased by more than 50% *
- Teen birth rate has dropped by 44% **

B'more for Healthy Babies
Every baby counts on you

** Abell Foundation, "B'more for Health Babies: The Story Behind the Data", Feb, 2023*
*** Johns Hopkins Center for Communication Programs, "B'more for Healthy Babies Initiative Leads to Lowest Infant Mortality Rate on Record in Baltimore City", October 2016*

UMMS Health Equity Plan Development

How are we doing?

Why?

Help?

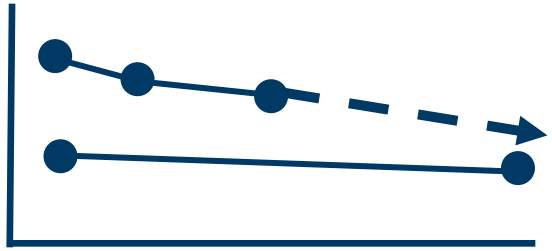
Options?

Propose to do?

Turn-the-Curve Thinking™: Talk to Action

Result: Healthy Diabetics with a HcA1C less than 5

Indicator
Baseline



Story behind the baseline

Partners *(with a role to play in turning the curve)*

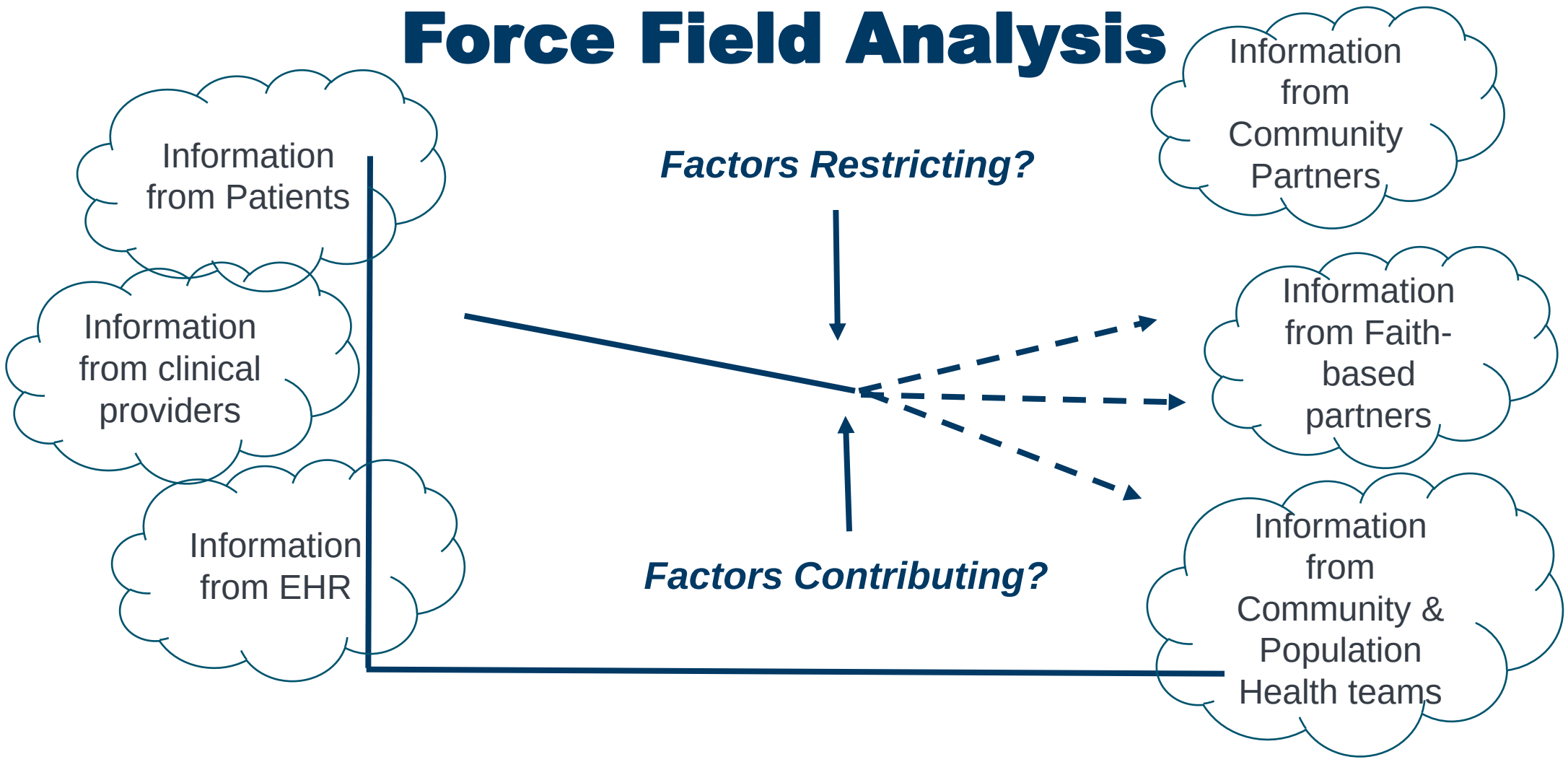
What Works

Strategic Action Plan (with Budget)

Mem Org KPI's:

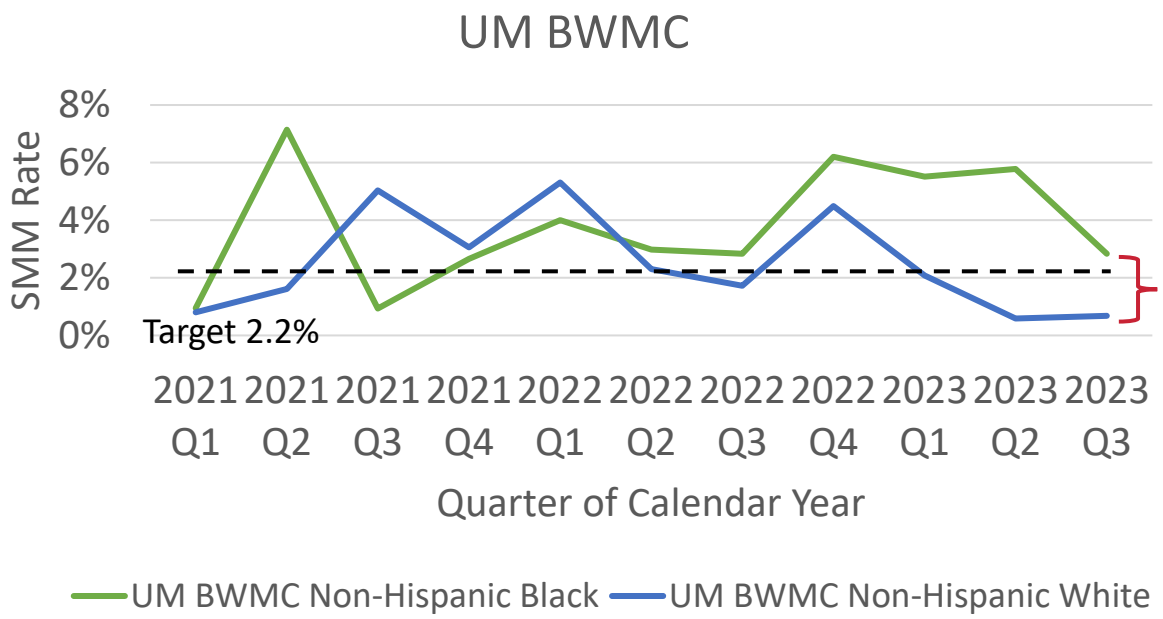
- *How much?*
- *How well did you do it?*
- *Is anyone better off?*

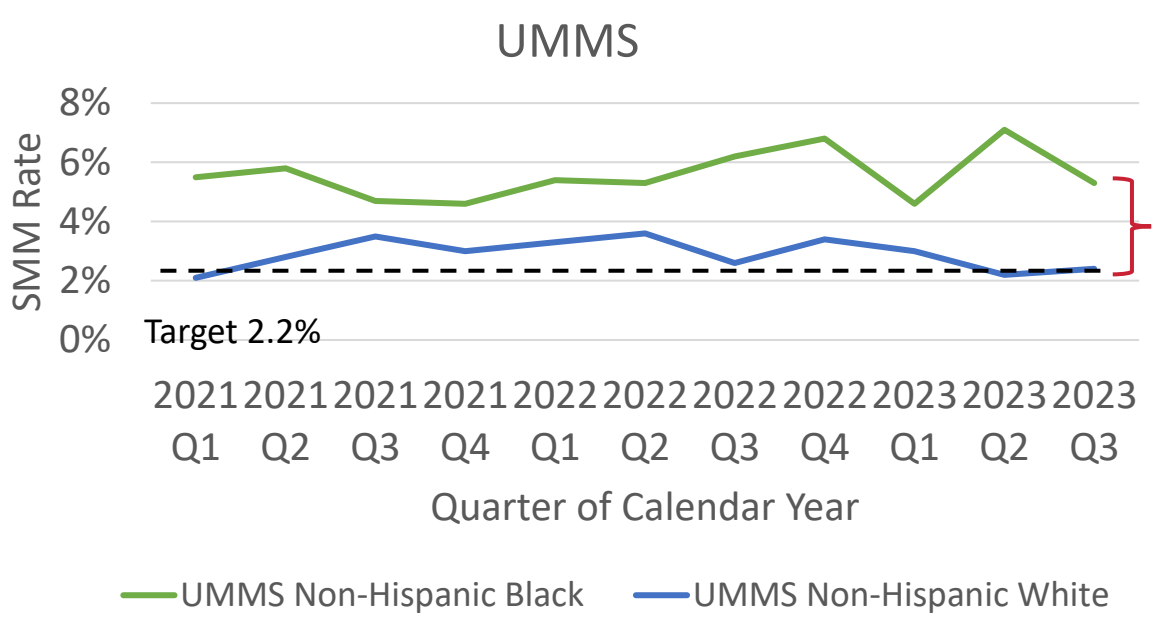
Health Disparity Root Cause Analysis



Health Equity in Maternal Morbidity – UM Baltimore Washington Medical Center

Severe Maternal Morbidity (SMM) Events Rate among Deliveries





- Severe Maternal Morbidity (SMM) identified by CDC 21 indicators*
- The goal of MD Statewide Integrated Health Improvement Strategy (SIHIS) is to reduce the SMM rate to 2.2% by 2023**
  - In 2018, the Maryland state SMM rate was 2.4%

Goal

- **Reduce the SMM rate**
- **Close the gap by Race/Ethnicity**

*https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/severe-morbidity-ICD.htm
**https://hscrc.maryland.gov/Pages/Statewide-Integrated-Health-Improvement-Strategy-.aspx

36

Health Equity Metric

Severe Maternal Morbidity

ROOT CAUSES TO ADD

01 **Factor # 1**

Short description

02 **Factor # 2**

Short description

03 **Factor # 3**

Short description

04 **Factor # 4**

Short description

05 **Factor # 5**

Short description

Immediate Action

Strategies to start now or continue.

- XXX

Short-Term

Strategies to begin within the next 6-8 months.

- XXX

Long-Term

Strategies to begin after at least a year.

- XXXX

Health Equity Action Plan Completion

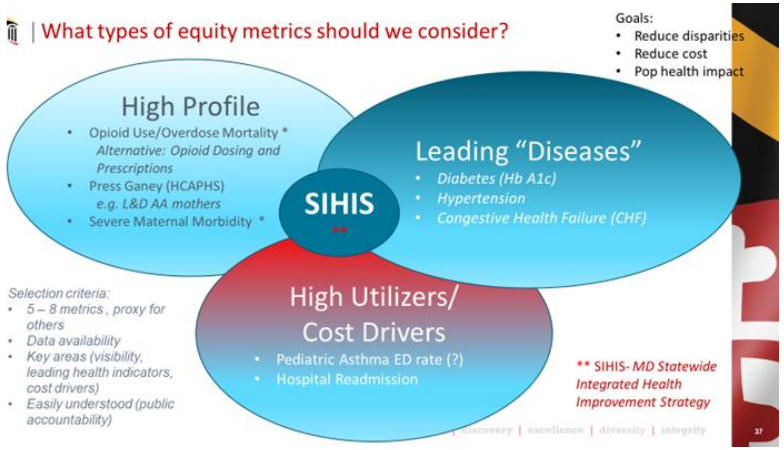
Strategy development

- **Select performance metrics**
  - Establish key performance indicators (KPIs)*
  - Use KPIs to track progress and evaluate future outcomes/impact

How much did we do?	How well did we do it?	Is anyone better off?
# patients served	% common measures	# and % of patients within control
# activities	% activity-specific measures	

* Race for Equity to provide technical assistance with KPI development.

Health Equity Challenge Milestone event: March 2024



EPC Metrics	Member Org
Severe Maternal Morbidity (SMM)	BWMC Capital Region Medical Center St. Joseph Medical Center
Pediatric Asthma-Related ED Visits	UMMC Upper Chesapeake
Unplanned Readmissions	Shore Regional
Diabetes/HbA1C	Charles Regional UM Rehab

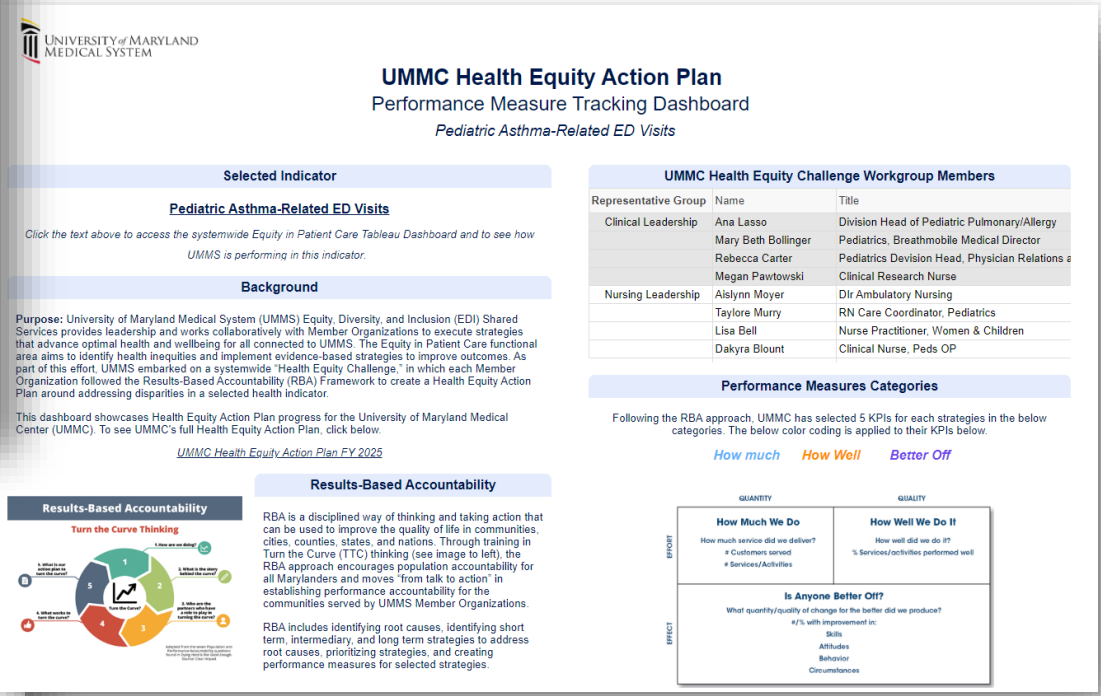
Milestone Event
March 8th, 2024

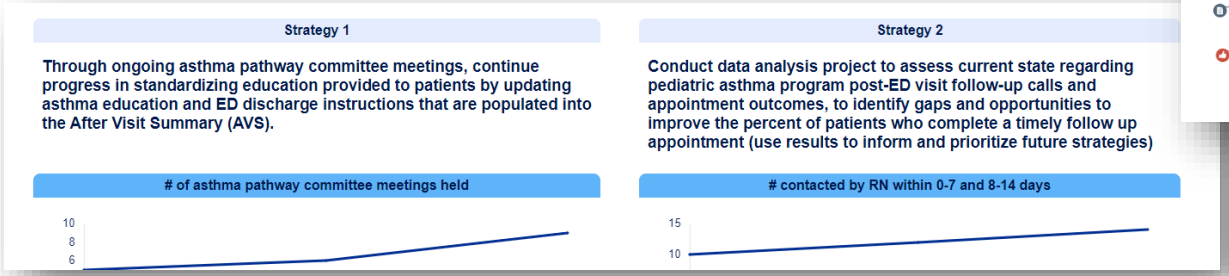
Team Members " Owning the Work "

UMMS "Health Equity Transformation"

Monitoring and Accountability

- Progress will be monitored via Smartsheet dashboards to support systemwide shared learning and accountability
- Dashboards can also portray efforts for internal/external stakeholders (e.g., workgroups, boards, CMS, TJC, etc.)





Equity in Patient Care – Accreditation and Regulatory Environment

Leadership Chapter (LD.04.03.08)

The Joint Commission

Reducing health care disparities for our patients is a quality and safety priority

- EP 1: Designate a health equity leader.
- EP 2: Assess health-related social needs and provide information about community resources and support services.
- EP 3: Identify health care disparities through quality and safety data stratification (using the sociodemographic characteristics of the patient and organization).
- EP 4: Develop a written action plan with strategies to address at least one health care disparity.
- EP 5: Demonstrate actionable response to unmet goal(s) in the written plan.
- EP 6: At least annually, inform key stakeholders, including leaders, licensed practitioners, and staff, about progress to reduce identified health care disparities.

July 1, 2023
NEW
National Patient Safety Goal

https://innovation.cms.gov/strategic-direction

CMS.gov
Centers for Medicare & Medicaid Services

Health Equity Attestation Rule, July 2023

https://www.cms.gov/about-cms/agency-information/omh/health-equity-programs/cms-framework-for-health-equity

How do you Ensure the Change Will Last?

- *Institutionalizing the Change*

UMMS Equity, Diversity and Inclusion Committee

Purpose:

The Medical System is committed to equity in care delivery, diversity in its workforce, expanded opportunities for minority-owned businesses, and meaningful investments in local communities. ***The Equity, Diversity, and Inclusion Committee (the "Committee") will provide oversight of diversity, equity, and inclusion initiatives across the Medical System, and will assist the Board of Directors in promoting a culture of diversity, equity, and inclusion.*** *To that end, the Committee will provide oversight of the Medical System's work to promote equity in patient care, diversity in its workforce, community investments to address social determinants of health, and external partnerships, including partnerships with diverse suppliers and inclusive businesses (collectively, the ED&I workstreams).*

Karen Price-Ward, Chair	
Elisa Basnight, Esq.	Michelle Lipkowitz
Wanda Draper	Cassie Motz
Thomas Scott	Judge Alex Williams
Ex-Officios	Staff Lead
Mohan Suntha, MD	Roderick King, MD

UMMS Equity, Diversity, and Inclusion (EDI) Shared Services

- EDI Shared Services provides **leadership and works collaboratively with Member Organizations to execute strategies** that advance optimal health and wellbeing for all. We envision a system of care in which all people touched by UMMS – patients, families, team members, and community partners – can **thrive**.

- Our work, powered by a data and analytics engine, spans four functional areas:

UMMS Equity Diversity and Inclusion Roadmap and Strategic Plan 2.0

2024 UMMS Equity Diversity and Inclusion Results Based Strategic Plan

Shaping the National Policy Discussion – Pay for Health Equity

UMMS Finance

UMMS EDI

BRG

MENU | BOSTON GLOBE TODAY | METRO | SPORTS | BUSINESS | POLITICS | OPINION | HEALTH

State's largest insurer to start paying providers to address health care disparities

Blue Cross Blue Shield of Massachusetts has found vast disparities along racial lines in cancer screenings, maternal outcomes, rates of adolescent well visits, and other measures.

By Jessica Bartlett Globe Staff, Updated December 15, 2022, 11:00 a.m.

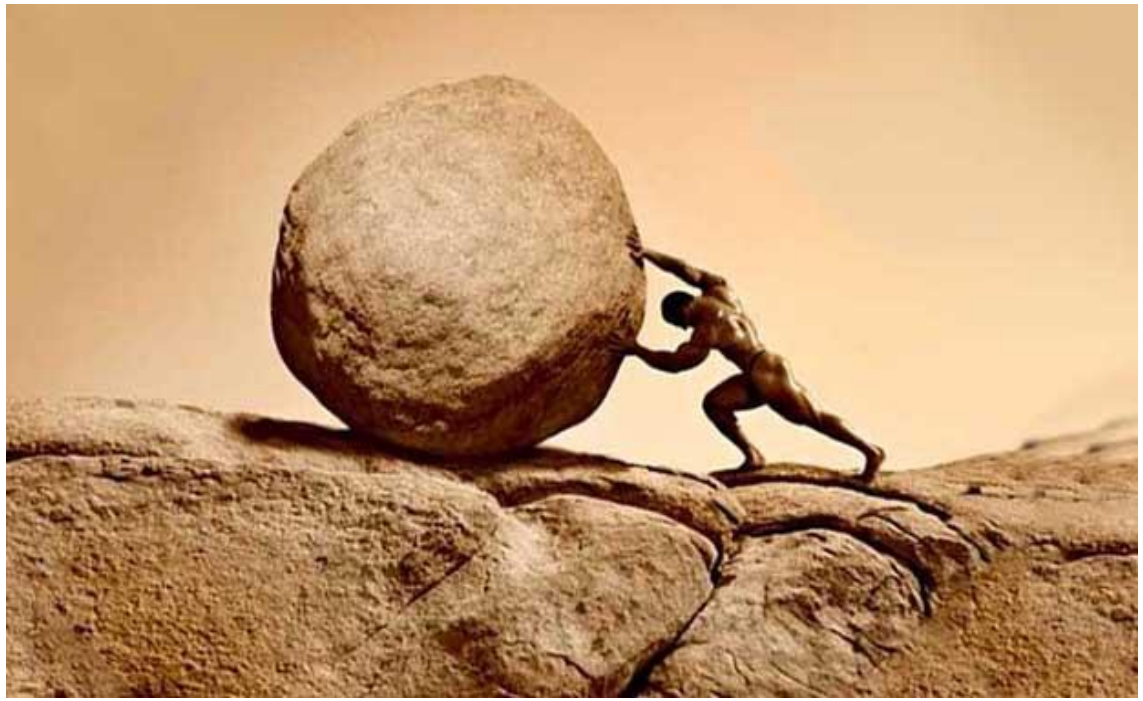
Maryland
DEPARTMENT OF HEALTH

Summary of the Maryland AHEAD Model State Agreement

October 2024

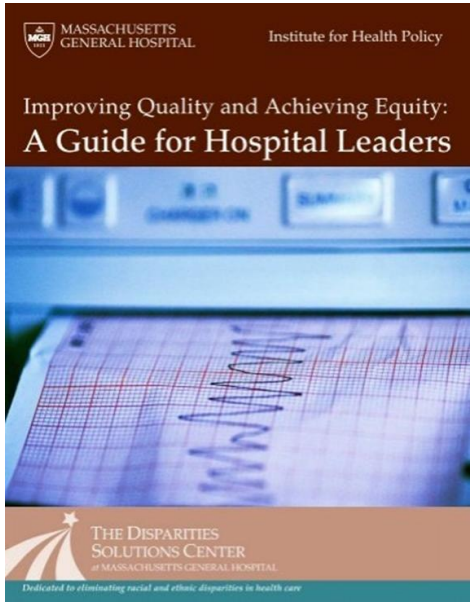
“Hidden Hurdles” in Addressing Health Inequalities

Why has it been so hard to improve health inequalities?



Lessons from the Field…

THE DISPARITIES SOLUTIONS CENTER
One Goal – High Quality Care for All
MGH 1811



Challenges in Addressing Health Inequalities

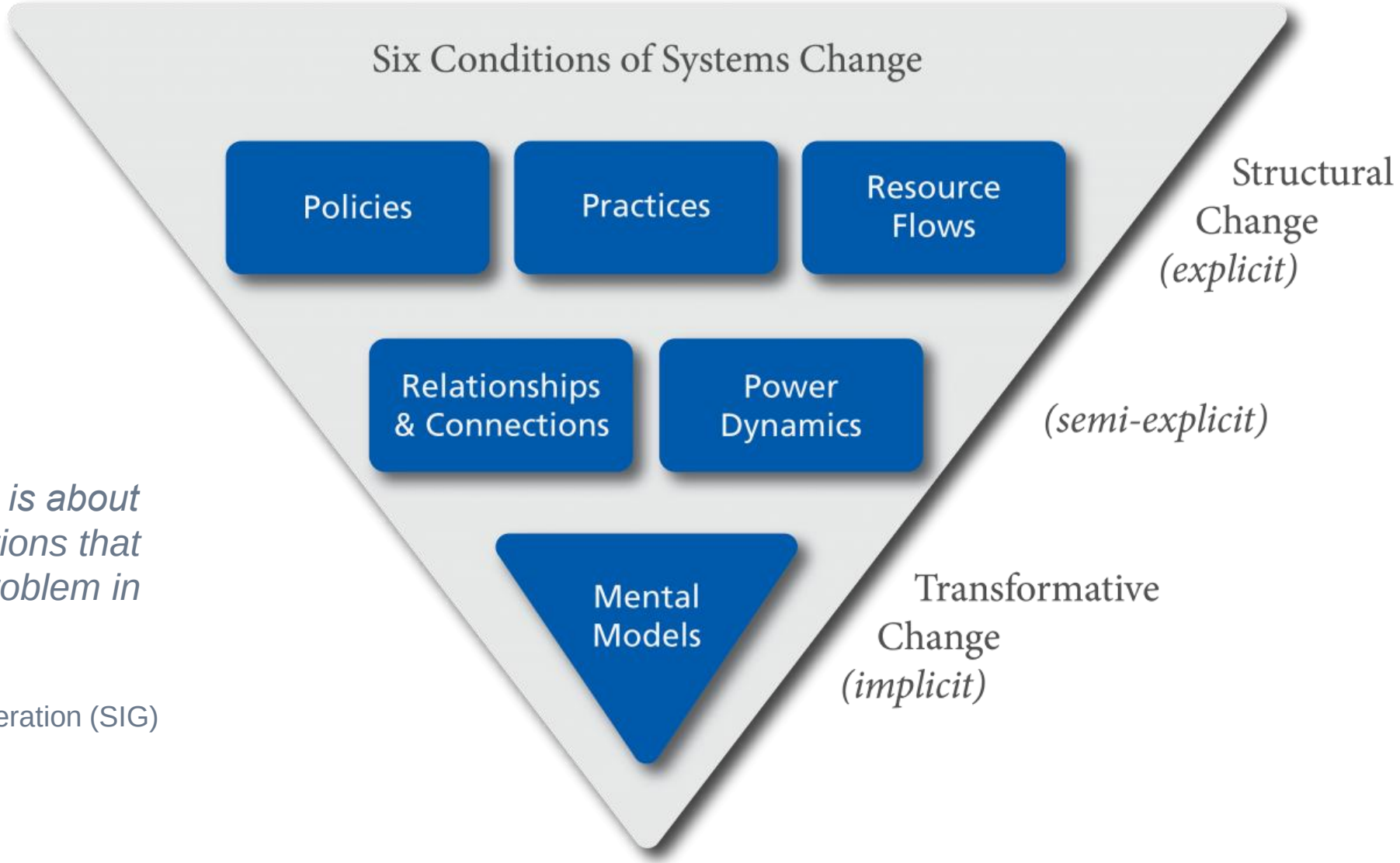
5 Reasons

- **Effective improvements in health disparities requires "System Change"**
- **We develop strategies and tactics in Health Equity based on "assumptions"**
- **We don't really know the "root causes" of specific health disparities**
  - Use of data to drive action (strategies TIED to root causes)
  - Lack a framework to guide the work consistently (e.g. *Results Based Accountability*[1] *or Kotter's Leading Change*[2])
  - Embrace variability of root causes based on variations in location

  (Embracing the Complexity of Health Inequalities)
- Not all the key partners are at the table
- Measuring our progress on impacting disparities- "Is Anyone Better Off?"

1. *"Trying Hard is Not Good Enough", Mark Friedman, 2005*
2. *"Leading Change", John Kotter, HBR press, 2012*

This work requires “System Change”



“Systems change is about shifting the conditions that are holding the problem in place.”

Social Innovation Generation (SIG) / FSG

From “The Water of Systems Change” by Kania, Kramer and Senge, June 2018

Mental Models:

Deeply ingrained assumptions, generalizations, or even pictures or images that influence how we understand the world and how we take action.

Peter Senge, *The Fifth Discipline*

WHY IS THIS IMPORTANT….

Mental Models

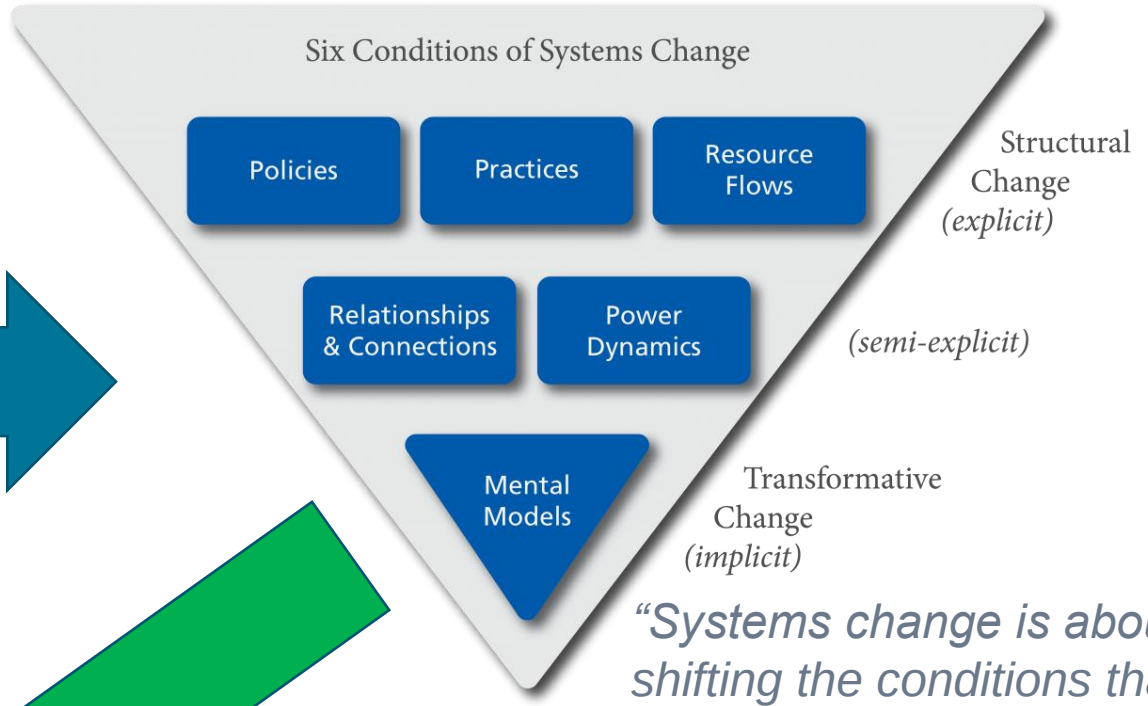
Drive Assumptions

“Sways” root causes identified

Strategies and Actions

The Difference in our Approach…

Sustainable, Comprehensive ("Equity Lens")



"Systems change is about shifting the conditions that are holding the problem in place."

Social Innovation Generation (SIG) / FSG

From "The Water of Systems Change" by Kania, Kramer and Senge, June 2018

Opportunities for Healthcare – Public Health Partnerships

Being at the "Decision Making Table"

- *Public health leaders serving on the Board of Directors of Hospitals*
- *Public Health partners participating in the "Turn the Curve" work of hospitals*

Serving as the "Gateway to the Community"

- *Leveraging Community Health Workers and Health Department outreach to access hard to reach communities*

Leveraging Innovative Outreach Initiatives to provide access to care

- *Innovative CHW outreach programs*
- *Mobile Health Units*
- *Recovery experts*

Opportunities for Healthcare – Public Health Partnerships

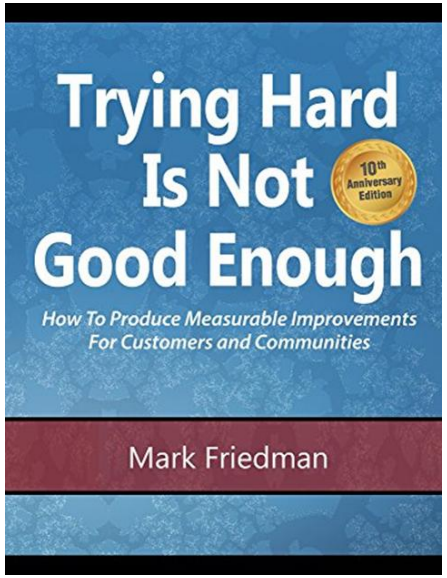
Access to Population Health Data

- *Assisting in integrating healthcare data with population health data to better understand our patients and identify "Hot Spots"*

Workforce Development

- *Primary Care Providers Education and Training*
- *Community Health Workers/Navigators*
- *Others*

Results-Based Accountability



Population Accountability

Focus on well-being of
WHOLE POPULATIONS

All people in a geographic region

For Communities: Cities – Counties – States - Nations

Performance Accountability

Focus on well-being of
CLIENT POPULATIONS

People who receive services directly from your organization

For Programs – Agencies – and Service Systems

Trying Hard is Not Good Enough, Mark Friedman

Why Distinguish Population from Performance Accountability?

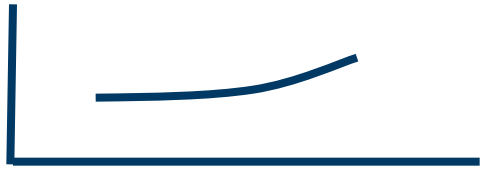
MEASURABLE RESULTS **FOR CLIENTS AND COMMUNITIES**

END

MEANS

Result: Health Mothers in Maryland

Population Accountability



1. Doing the right things?

Community-Wide Strategy/Partners

Performance Accountability

2. Doing those things right?

Program Performance Measures (baselines)

Individual results } **END**

MEASURABLE RESULTS **FOR CLIENTS AND COMMUNITIES**

MARYLAND
COMMISSION
ON PUBLIC HEALTH

Commission Updates

Shane Hatchett, Sarah Borah,
and Dushanka Kleinman

Timeline & General Updates

2024				2025		
	Nov-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Meeting Date, Chair	*07 Nov, Meena*	*20 Nov, Boris*	*05 Dec, Tosin*	*23 Jan, Meena*	*20 Feb, Boris*	*13 Mar, Tosin*
Focus	Discuss interim report this mtg & visioning	Adopt interim report	Deep dive into Funding; finalize vision & review	Infrastructure and Policy	Deep dives into (1)Workforce and (2) Data & IT	Recommendations: Gov. and Org Cap.; Comms & Public Eng.; Funding
Assessment	• KI interviews underway • Focus group guide, membership finalized	• KI interviews wrap up • Focus groups launch • Org survey design	• Final KI Interviews • Analysis of public input • Org survey out	• Surveys and assessments wrap up activities • Analysis underway *(except PH WINS)*	• Surveys and assessments completed (except PH WINS)	• Review completed of existing data sources, PH WINS avail
System Engagement	• Dr. Roderick King, UMMS; Dr. Katherine Feldman, MDH • Preliminary listening session/site visit themes • KI interviews continue	• Focus groups begin soon with system partners • Submit final interim report (1 Dec)	• **Speaker TBD** • Focus groups continue • Org survey & outreach • Final interim report submitted (1 Dec); follow up w/officials as needed	• Policy Panel: (pend. - NPHL, NACCHO, & similar) • Org survey due 21/Jan	• No speakers (preserve time)	• No speakers (preserve time)
Public Engagement	• Begin summarize public comments • Public/Comm Eng. Survey released	• Issue press release and social media campaign highlighting CoPH • New website launch	• Public/Comm Eng. Survey closes EOY (est.) • Issue press release and social media campaign highlighting CoPH work	• Press release on progress to-date	• Press release on progress to-date	• Press release on progress to-date

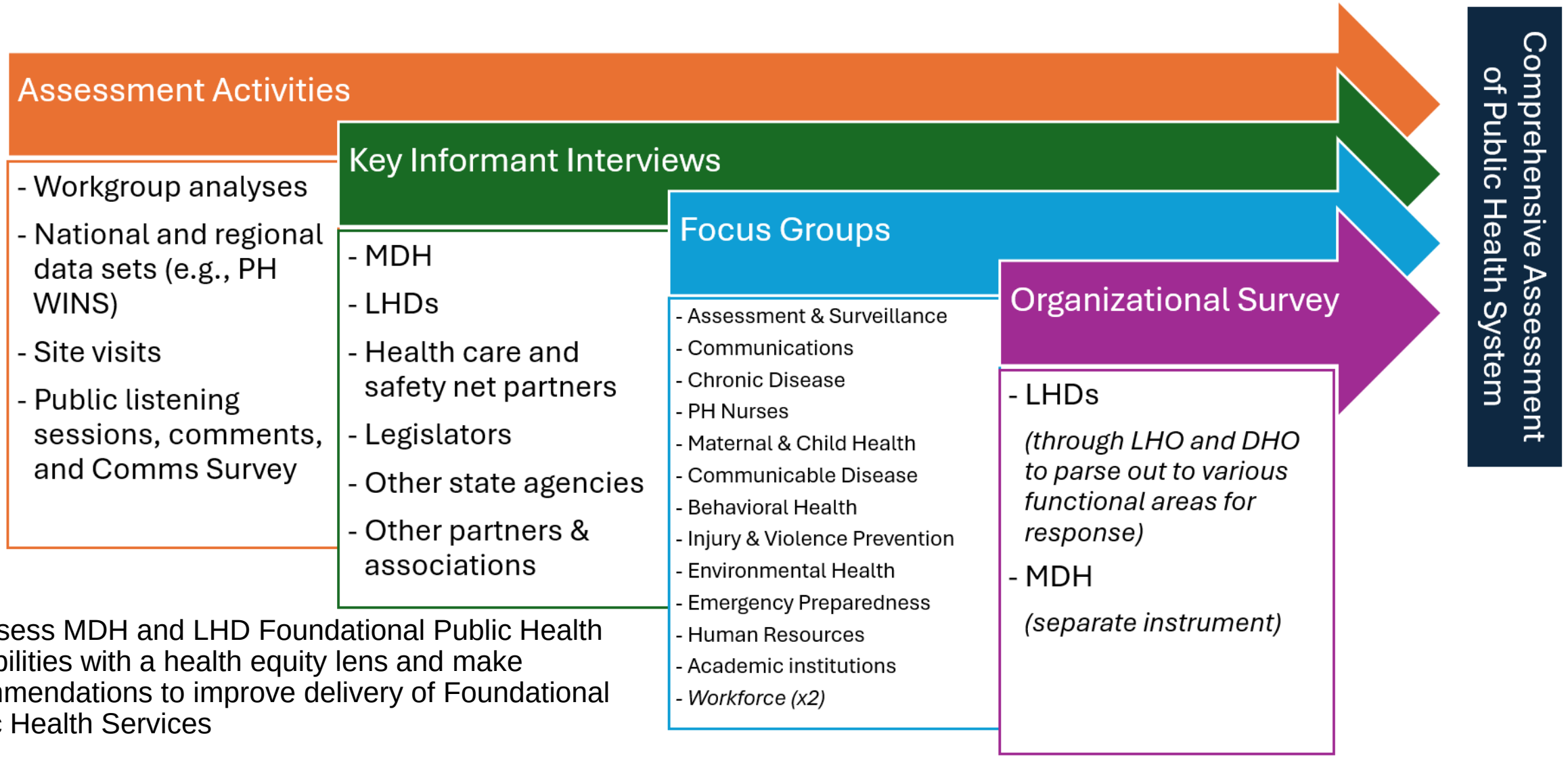
~~Final~~ 2024 Interim Report

- Brief report on activities; approx. 20 pages
- Highlighting connection to other state efforts
- Timeline:
  - Currently integrating Workgroup feedback
  - Nov. 14 to 19 – Commissioner review period
  - Nov. 20 – Special virtual meeting (10:00 am)
  - Dec. 1 - Submit Final Interim Report on or before this date

Public Engagement

- Listening sessions (6 sessions)
- Public comment form (23 submissions)
- Voicemail (1 received)
- Communications/Public Engagement Survey (151 submissions)
- Site visits
  - Discussion informed the assessment design, areas of inquiry
  - Notes shared with WGs to analyze

Assessment Framework



To assess MDH and LHD Foundational Public Health Capabilities with a health equity lens and make recommendations to improve delivery of Foundational Public Health Services

Assessment Update

- Focus groups (14) being finalized , *(draft)* guide developed
  - Focus groups will begin soon
- Interviews going well (47 completed)
  - LHO/DHO, state partners, and external partners
  - Follow-up form to collect additional thoughts if needed
- Organizational survey development next focus area

MARYLAND
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Break

November 07, 2024

The Commission has temporarily recessed and will reconvene soon. Recording will continue.

MARYLAND COMMISSION ON PUBLIC HEALTH

Guest Speaker

Katherine Feldman, DVM, MPH

Chief Performance Officer at Maryland Department of Health, Office of the Deputy Secretary for Public Health Services

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Building a Healthier Maryland

State Health Assessment & State Health Improvement Planning

Katherine Feldman, DVM, MPH

November 7, 2024

Presentation to the Commission on Public Health

Agenda

- Public health accreditation and major Plans
- *Building a Healthier Maryland*
- The 2024 State Health Assessment (SHA) and State Health Improvement Plan (SHIP)
  - SHIP metrics
  - SHIP alignment with AHEAD
- Where to find the SHA and the SHIP

Public Health Accreditation & Major Plans

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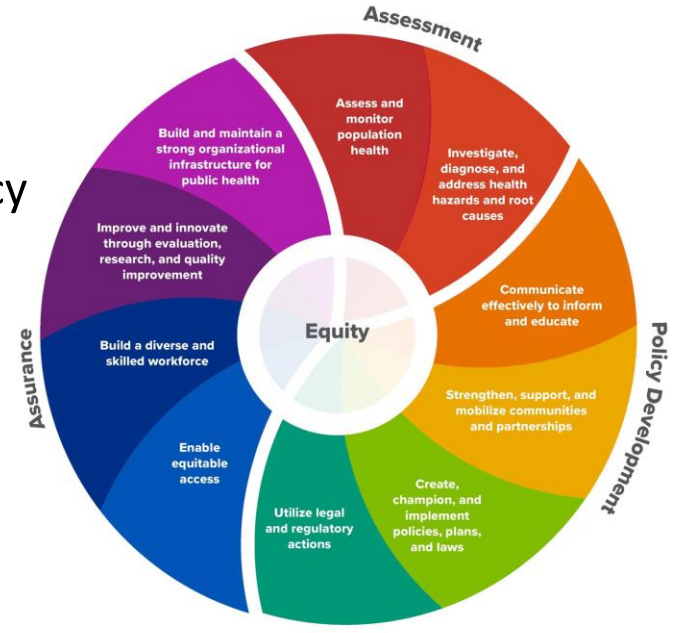
Accreditation by the Public Health Accreditation Board (PHAB)

Accreditation assesses a health department's capacity to carry out the 10 Essential Public Health Services and the Foundational Public Health Capabilities. Accredited health departments are recognized for meeting national public health standards.



Purpose

- Demonstrates accountability and transparency
- Builds credibility and trust
- Improves quality and performance
- Identifies areas for improvement

MDH Accreditation Status

- MDH initially accredited in 2017
- Re-accreditation application in process
- Anticipate PHAB determination in December

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What are the SHA and the SHIP?

- The SHA and SHIP provide a structured framework to improve community health and address disparities
  - Identify critical population health issues
  - Facilitate the strategic allocation of resources
- Collaboration with diversity of partners ensures that the SHIP is community owned

State Health Assessment (SHA)

Systematic approach to collecting, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve the public's health.

State Health Improvement Plan (SHIP)

Long-term systematic plan to address issues identified in the SHA. Describes how the state health department, the public health system and the communities it serves will work together to improve the health of the population.

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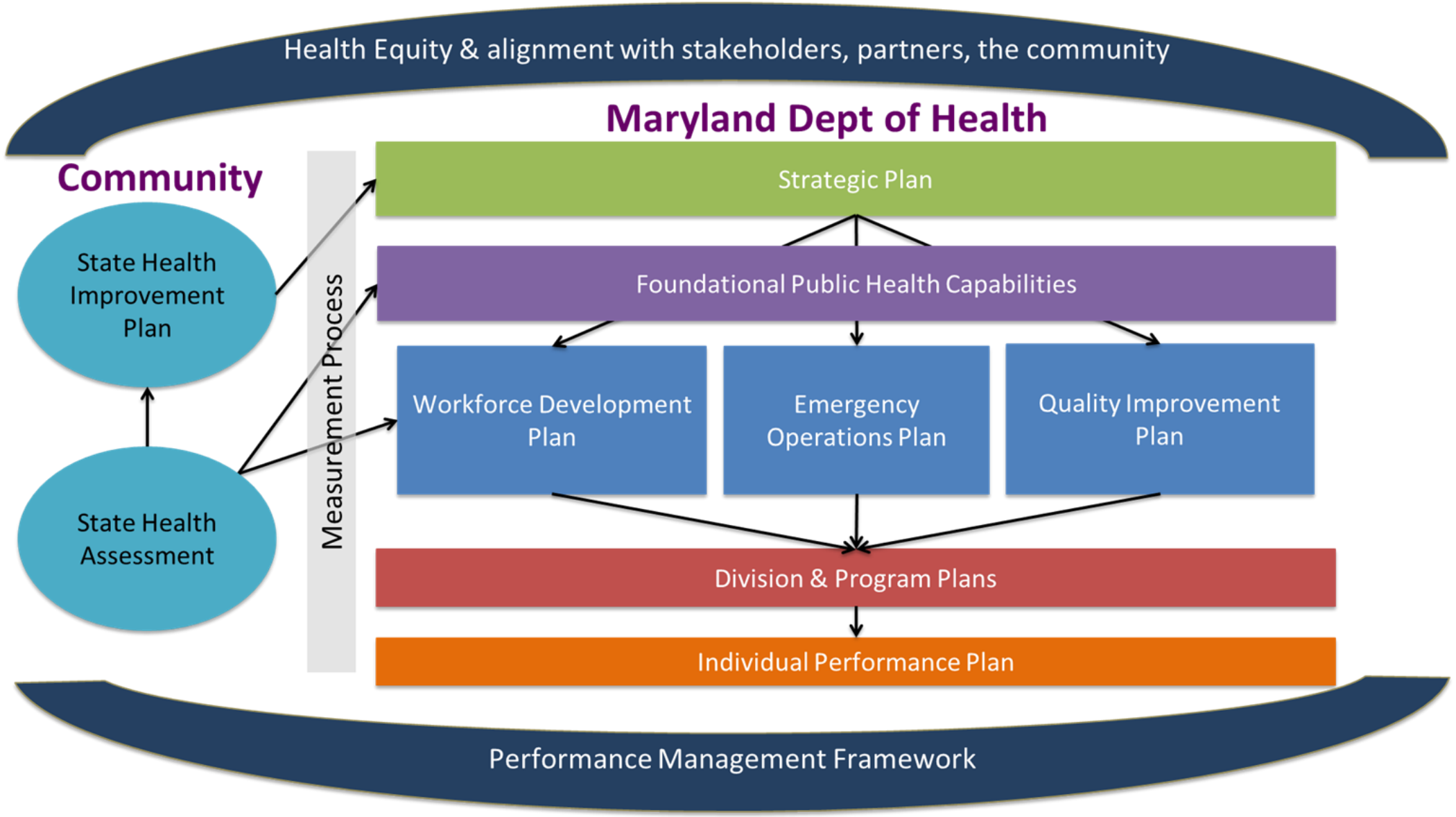

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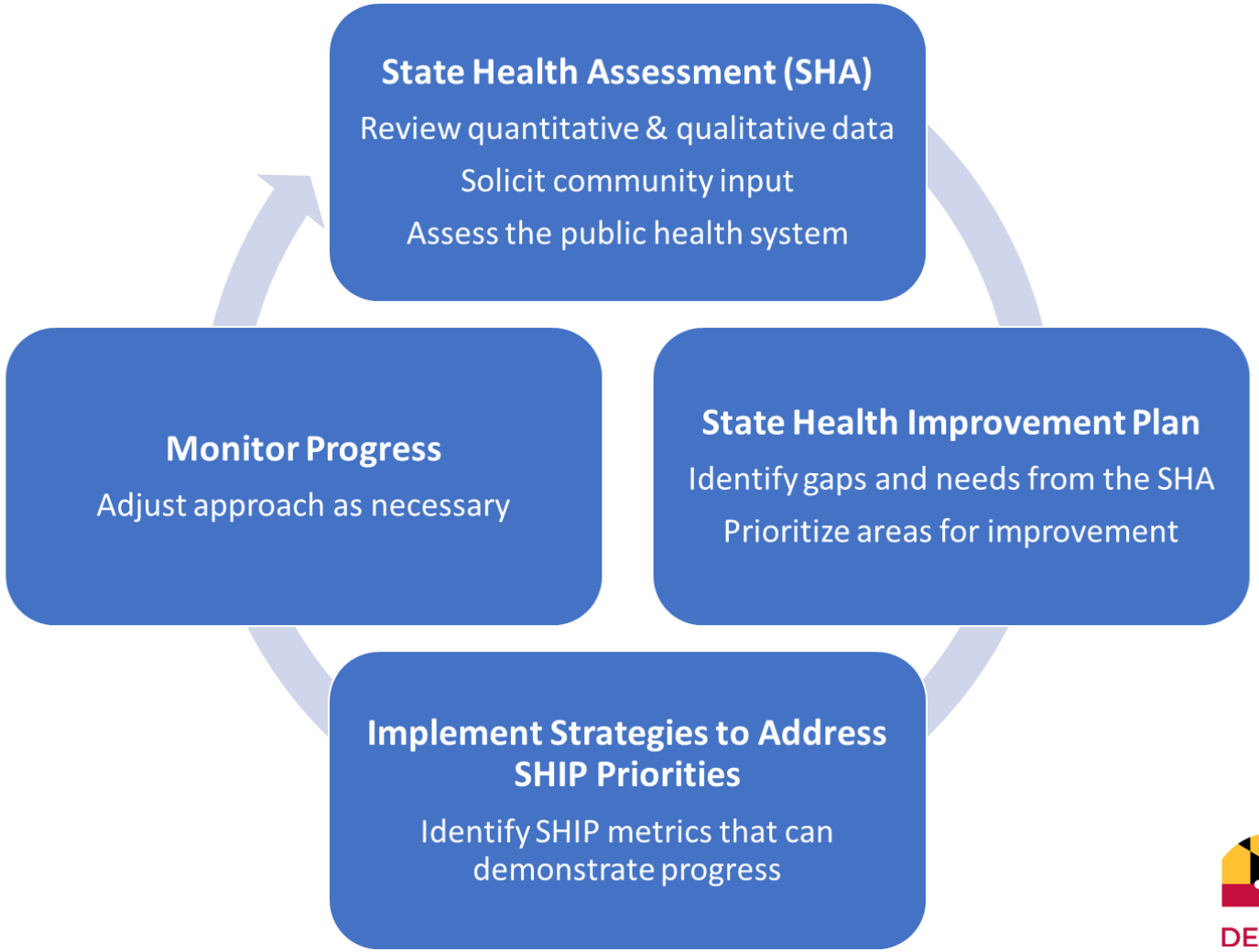
SHA / SHIP Cycle



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Building a Healthier Maryland

Maryland
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MDH Team - *Building a Healthier Maryland*

<table>
<tr>
<td rowspan="4">Coordination & Support

Pam Tenemaza 

Katherine Feldman 

Jessi Rettberg 

ASTHO Partners:
Erima Fobbs
Melissa Touma
Marta McMillion
Sara Bell</td>
<td>State Health Assessment and Health Improvement Planning</td>
<td>Sarah Linden    
Alex Goode

Brandon Blouse

Marcia Pearlowitz</td>
</tr>
<tr>
<td>Strategic Plan</td>
<td>Stephanie Ajuzie  </td>
</tr>
<tr>
<td>Quality Improvement</td>
<td>Andrew Ellis 

Hana Bekele  </td>
</tr>
<tr>
<td>Workforce Development</td>
<td>Vanessa Lamers 

Nyrobi Tyson  </td>
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BAHM Steering Committee

Maryland Department of Health ● Nilesh Kalyanaraman**, Deputy Secretary for Public Health Services ● Ryan Moran, Deputy Secretary for Health Care Financing ● Alyssa Lord, Deputy Secretary for Behavioral Health Administration ● Camille Blake Fall, Director, Office of Minority Health and Health Disparities ● Elizabeth Kromm, Director, Prevention and Health Promotion Administration	**Local Health Departments** ● Kisha Davis, Montgomery County Health Officer ● Earl Stoner, Washington County Health Officer ● Danielle Weber, Somerset County Health Officer ● Mary Beth Haller, Baltimore City Interim Health Commissioner	**Local Health Improvement Coalitions** ● Reena Rambharat, Howard Co. Director ● Della Leister, Baltimore Co. Deputy Health Officer ● Jacqueline Wells, St. Mary's Director of Community Engagement and Policy ● Shelley Argabrite, Garrett County Health Strategist & Director Population Health, Innovation & Informatics Unit
Maryland Department of Labor ● Erin Roth, Assistant Secretary	**Maryland Department of Housing and Community Development** ● Jacob Day, Secretary	**Maryland Dept of Human Services** ● Rafael López, Secretary
Maryland Department of Aging ● Carmel Roques, Secretary	**Maryland Department of Transportation** ● Lyn Farrow, Director of External Affairs	**Maryland State Dept of Education** ● Mary Gable, Asst State Superintendent
Maryland Department of Environment ● Suzanne Dorsey, Deputy Secretary	**Mid-Atlantic Association of Community Health Centers** ● Nora Hoban, Chief Executive Officer	**Maryland Hospital Association** ● Meghan McClelland, Chief Operating Officer & Senior Vice President
Maryland Rural Health Association ● Jonathan Dayton, Executive Director	**Maryland State Medical Society (MedChi)** ● Gene M. Ransom III, Chief Executive Officer	

**Chair of the Steering Committee

Maryland DEPARTMENT OF HEALTH

Steering Committee Member Roles & Responsibilities

Purpose: Identify state health improvement priorities as indicated by a systematic state health assessment and to champion and oversee the implementation of data-informed and evidence-based initiatives that address the priorities and enhance the well-being of all residents in Maryland

- Review and provide input on state health assessment data
- Prioritize issues for action
- Identify metrics associated with each priority to demonstrate progress
- Review and approve final SHA, SHIP and other work products
- Oversee and monitor the implementation of the SHIP strategies and goals
- Advocate for SHA and SHIP activities and identify opportunities to partner
- Meet at least annually and attend SHIP events
- Discuss, revise and approve the SHIP, annually

Steering Committee Charter

Community Survey

Purpose: Solicit input from the community to understand the most pressing health issues and affected populations

- Categorical and open-ended questions
- In English, Spanish, Chinese, Korean and Creole
- Multiple distribution channels
  - Via MDH and LHD social media and other communications channels
  - MDH and LHD public health programs push to partners and their networks
  - Steering Committee members asked to push to their membership and partners

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Public Health System Assessment

Purpose: Survey focuses on assessing organizations, the services they provide, the communities they serve, and their interest in participating in ***Building a Healthier Maryland*** activities

- Categorical and open-ended questions; ~20 minutes to complete
- Modeled after a national standard (MAPP 2.0 Community Status Assessment)
- Intended for organizations that could influence BAHM priorities
- Organization types include (not limited to): Government, Coalitions, Community Services, Business & Industry, Health Care, Education, Faith Based Organizations

Components:

- Information about the organization
- Characteristics of the populations served by the organization
- Accountability structure
- Organizational capacities, strategies, and policies
- What data are collected and if data are shareable
- Practices used to engage with the community
- Involvement with policy, advocacy and communications

2024 State Health Assessment (SHA) (Excerpts)

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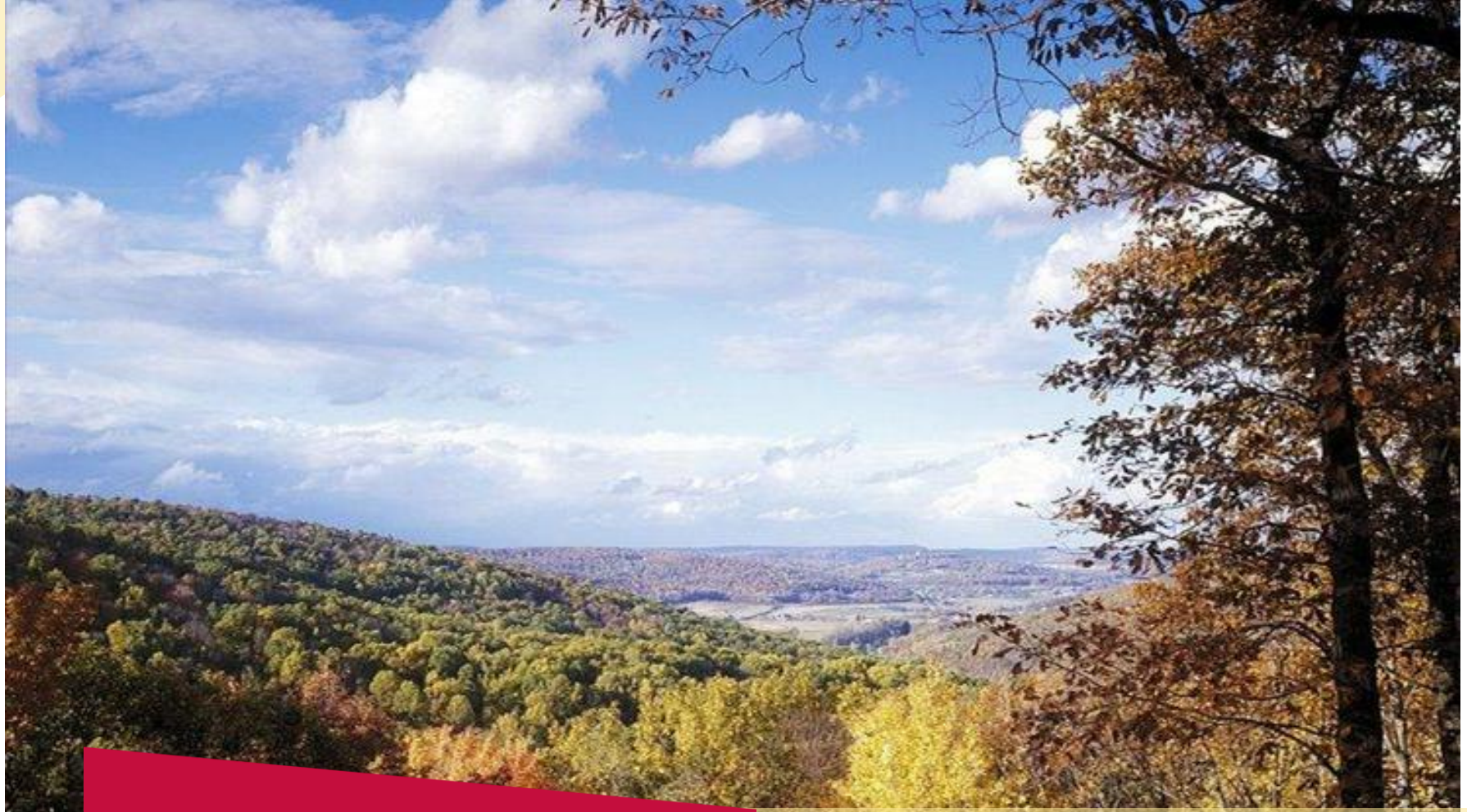


BUILDING A HEALTHIER MARYLAND

STATE HEALTH ASSESSMENT

2024

Maryland
DEPARTMENT OF HEALTH

Public Health Services Administration

201 West Preston Street
5th Floor
Baltimore, Maryland 21201
410-767-6500
Toll Free 1-877-463-3464

Methods - State Health Assessment

This SHA is a compilation of primary and secondary data and also includes a summary of local health priorities in Maryland. Both quantitative and qualitative data are included to provide the most robust snapshot of the health status of Maryland.

Primary Data Collection

Input from Maryland residents was collected via a community input survey, which included the opportunity for participants to select their most pressing health concerns from lists as well as for them to provide additional context via open-ended, qualitative questions.

Local Health Priorities

An environmental scan was conducted to ascertain local health priorities in Maryland's 24 local jurisdictions. Websites of local health departments and/or local health improvement coalitions (as available) were searched and priorities set during 2020-2023 were captured and summarized.

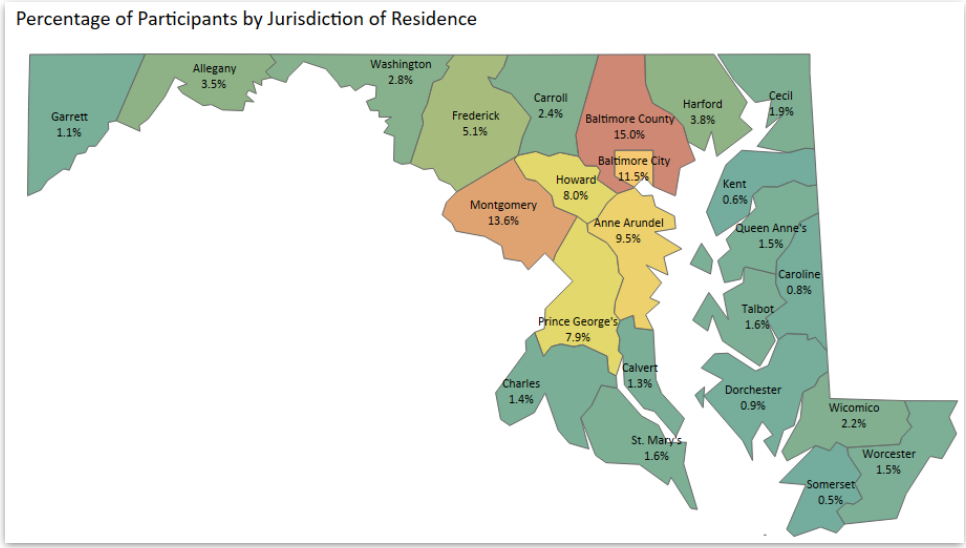
Secondary Data Review

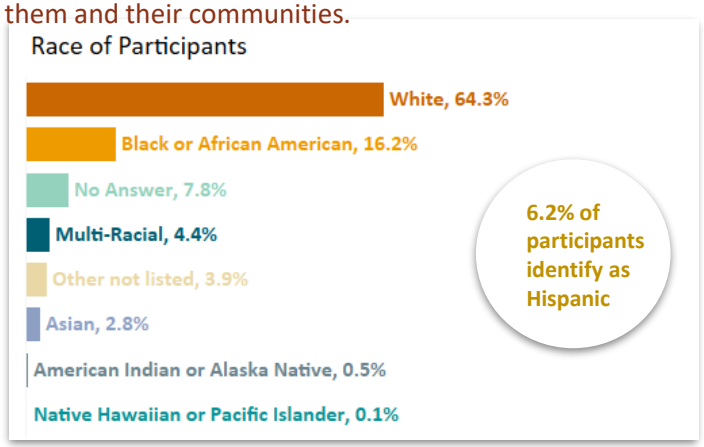
Health indicators that were considered for inclusion were identified by reviewing publications and websites of federal, state, and local government agencies, non-profit organizations, published literature, and the existing SHIP measures (from 2014).

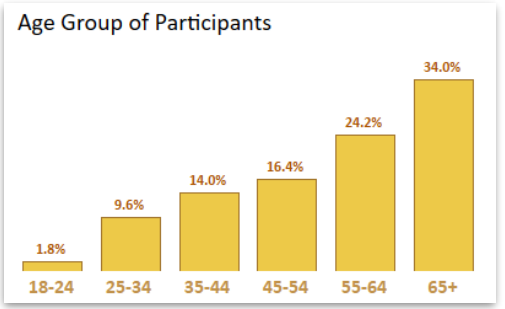
- ★ Initially, over 120 indicators were considered for inclusion
  - 96 indicators were ultimately included, given data availability and utility constraints
- ★ The granularity of available data varies widely
  - Some indicators can only be assessed at the state level and are primarily intended to be contextual
  - Other indicators can be stratified by subpopulations (e.g., race/ethnicity, gender, age, socioeconomic status, and geographic location)

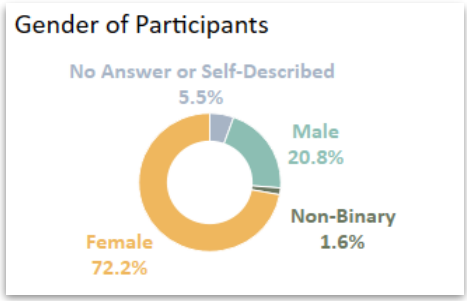
Primary Data Collection: Community Input Survey

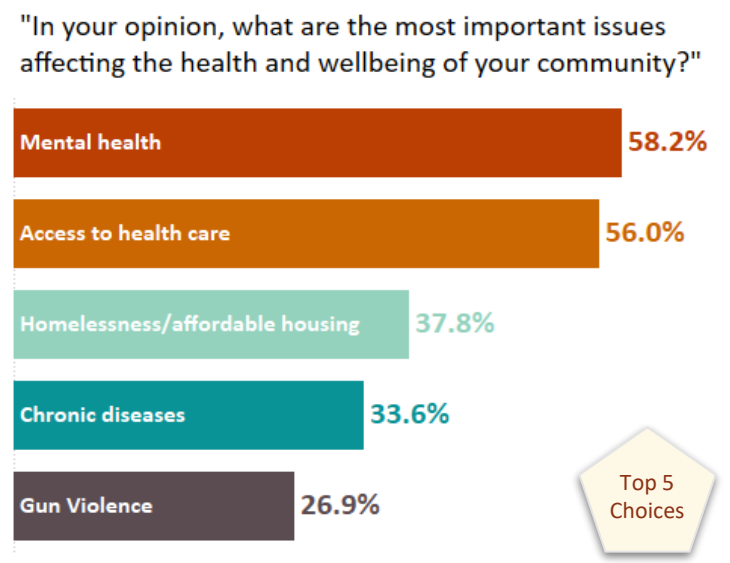
- In November 2023, the Maryland Department of Health (MDH) launched a community input survey to solicit input from Maryland residents at least 18 years old regarding what they consider to be the most pressing health issues in Maryland. Invitations to complete the survey were posted to MDH social media pages, promoted in a press release and shared broadly by partners. The survey was offered in English, Spanish, Haitian Creole, Korean and Chinese.
- As of January 8, 2024, there were **4,535** responses. Participants provided basic demographic information (illustrated on this page) and described the health issues that are most important to them and their communities.





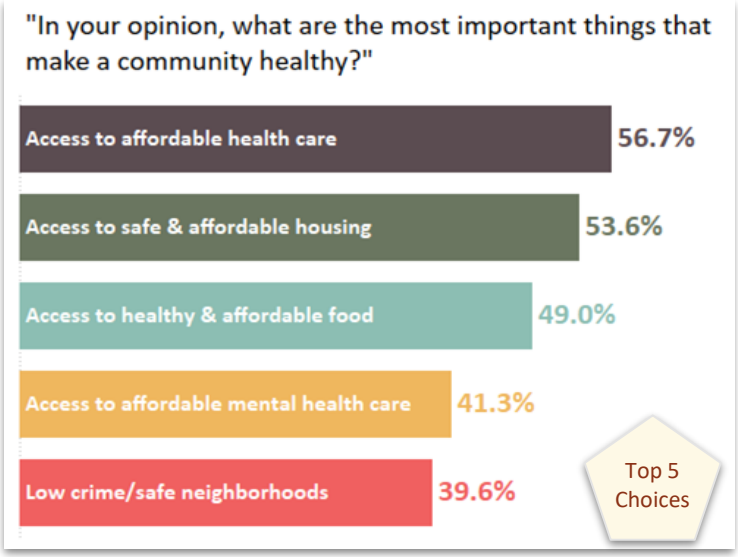


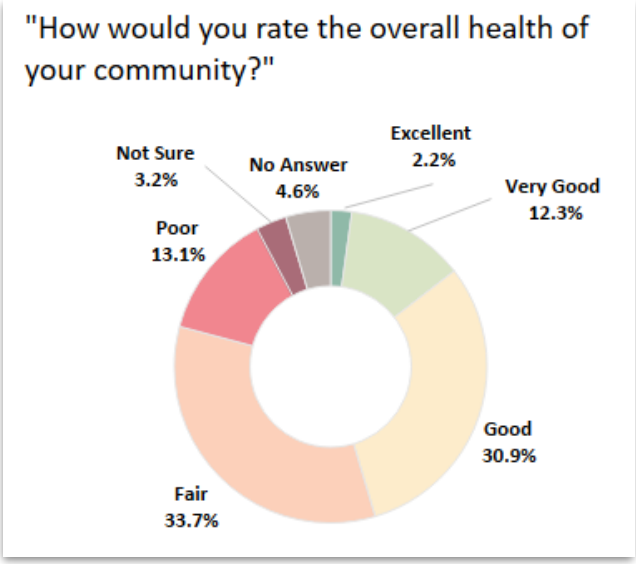




Participants were asked what issues and factors affect the health of their community. They were told they could define their "community" however they choose - examples may include neighborhood, town, city, county, or state.

- The number one important issue selected was "mental health", over **58%** of participants selected it followed closely by "access to health care" at 56%.
- **Over half** of participants selected "access to affordable health care" and "access to safe & affordable housing". Access to healthy food and affordable mental health care were also important followed by "low crime/safe neighborhoods".
- About **Two thirds** of participants reported that the health of their community was "Fair" or "Good"





See Appendix II for the full survey

In addition to the multi-select questions, participants were given the opportunity to expand on their responses with open ended follow up questions. In their explanations for why they selected the top health concerns they did, participants highlighted the interconnected nature of the health issues - "**Most of these issues tie together. Whether it starts with opioid abuse or if it starts with access to healthcare all these that I have chosen tie in together because one issue leads to the next**." Participants stressed the importance of looking holistically at a community's health.

Many participants wrote about their perceptions of the ongoing mental health crisis. They generally felt is was attributable to multiple things, including poverty, COVID-19, rising isolation, and poor physical health. Additionally, they felt it was greatly exacerbated by lack of access to quality mental health care. Aside from mental health, the issue discussed the most was housing and economic stability, with many participants noting that the cost of living continues to rise, without a sufficient parallel rise in wages.

"I chose mental health as one of my choices because a person's mental health affects every aspect of their life. If a person is suffering a mental health issue it ultimately affects education, employment, substance use, homelessness, etc. and the ability to seek help."

"We just really need to do more than just cry 'Mental Health Awareness.' The more we become aware of the issue, the MUCH, MUCH, MORE WE NEED TO DO ABOUT IT!"

"My son has special needs and finding pediatric therapists (speech, OT, PT) has been SUCH a challenge. There are some great practitioners, but they don't take health insurance! And the places that do, are 35+ min away and we can't afford the gas or time to go to those places 1-2x/week."

"Some people may not care about good schools, some may not care about religion. EVERYONE cares about having a roof over their head, food on their plate, and money to pay the bills."

"Poverty kills."

"High quality health care should be a right, not a privilege."

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

"Due to the high cost of living, many Marylanders are finding it difficult to meet their most basic needs, food, shelter, which impacts health since many will not eat nutritional foods (leads to chronic diseases), will not take medications, due to high costs, and impacts stress & mental health which increases risks of chronic health conditions. Many Marylanders are too poor to financially accommodate adequate healthcare or too rich to access Medicaid."

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

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

"Gun violence creates a sense of overwhelming lack of control and inability to maintain basic safety. I worry about going to the grocery store and sending my children to school. I avoid large gatherings like fairs and concerts because of how common mass shootings have become. We need common sense gun laws like in the UK and Australia."

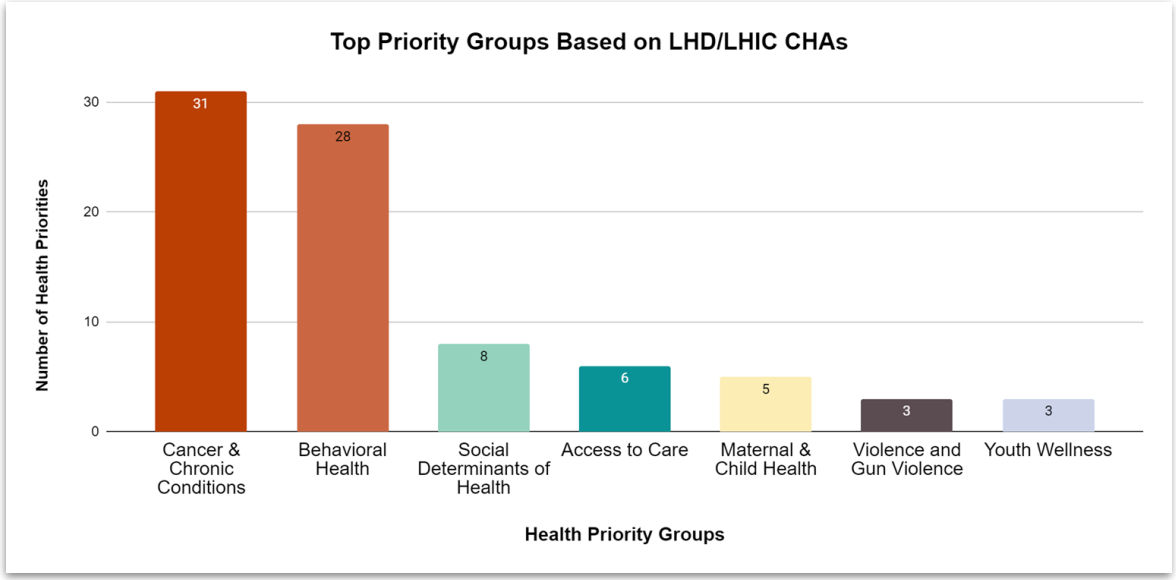
Local Health Priorities

Background and Methods

MDH conducted an environmental scan of community health assessments (CHA) conducted by Local Health Departments (LHDs) and Local Health Improvement Coalitions (LHICs) in Maryland. The aim was to capture and summarize the health priorities identified in the assessments, categorizing them into one of 15 key thematic areas (Cancer & Chronic Conditions, Behavioral Health, Social Determinants of Health, Access to Care, Maternal & Child Health, Violence & Gun Violence, Youth Wellness, Environmental Health, Health Disparities, Health Education, Health Equity, Health Promotion, Infectious Disease, Neurological Health and Oral Health). All CHAs published between 2020 and 2023 were included in this analysis.

Results

- 92 health priorities were identified from 22 of Maryland's 24 local jurisdictions
- Seven of the 15 health priority thematic areas were represented by three or more priorities:
  - Cancer & Chronic Conditions (n=31, 33.7%)
  - Behavioral Health (n=28, 30.4%)
  - Social Determinants of Health (n=8, 8.7%)
  - Access to Care (n=6, 6.5%)
  - Maternal & Child Health (n=5, 5.4%)
  - Violence & Gun Violence (n=3, 3.3%)
  - Youth Wellness (n=3, 3.3%)

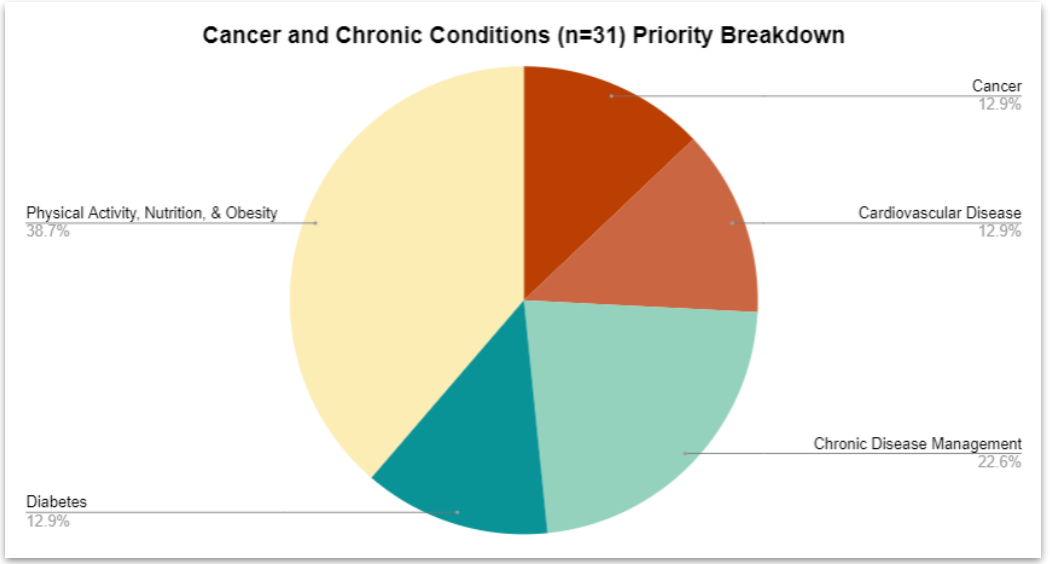


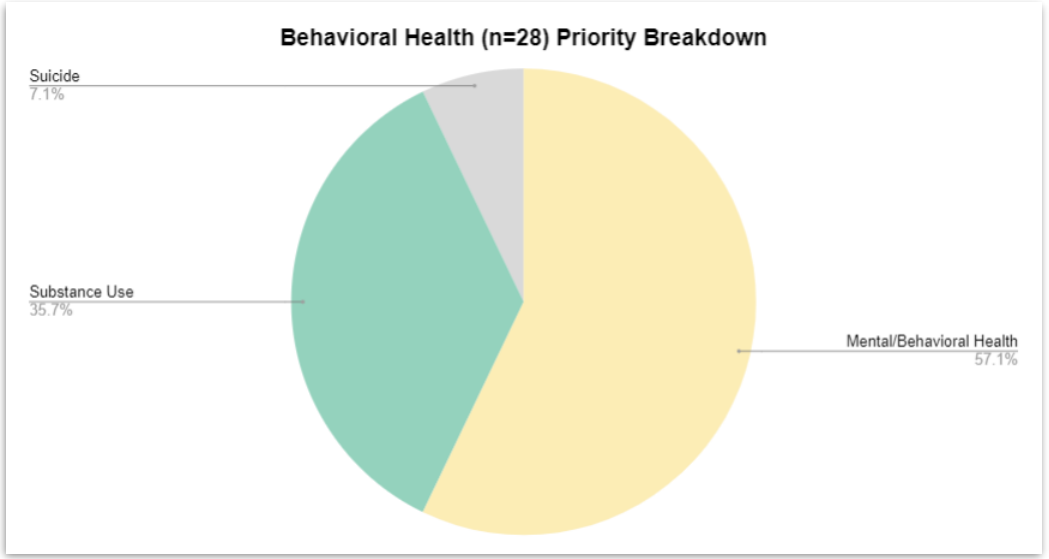
The vast majority of local health priorities were captured in the Cancer & Chronic Conditions and Behavioral Health thematic areas. Given the large number of priorities captured in those thematic areas, the groupings were disaggregated in order to understand the contributing priorities. Within the Cancer & Chronic Conditions grouping, a total of 31 priorities were identified:

- Physical Activity, Nutrition and Obesity (n=12, 38.7 %)
- Chronic Disease Management (n= 7, 22.6%)
- Cancer (n=4, 12.9%)
- Cardiovascular Disease (n=4, 12.9%)
- Diabetes (n=4, 12.9%)

In the Behavioral Health category, a total of 28 priorities were identified, including:

- Mental/Behavioral Health (n= 16, 57.1%)
- Substance Use (n= 10, 35.7%)
- Suicide (n= 2, 7.1%)





See Appendix III for the complete frequency tables

Secondary Data Review

Secondary Data Review: County Health Rankings Model

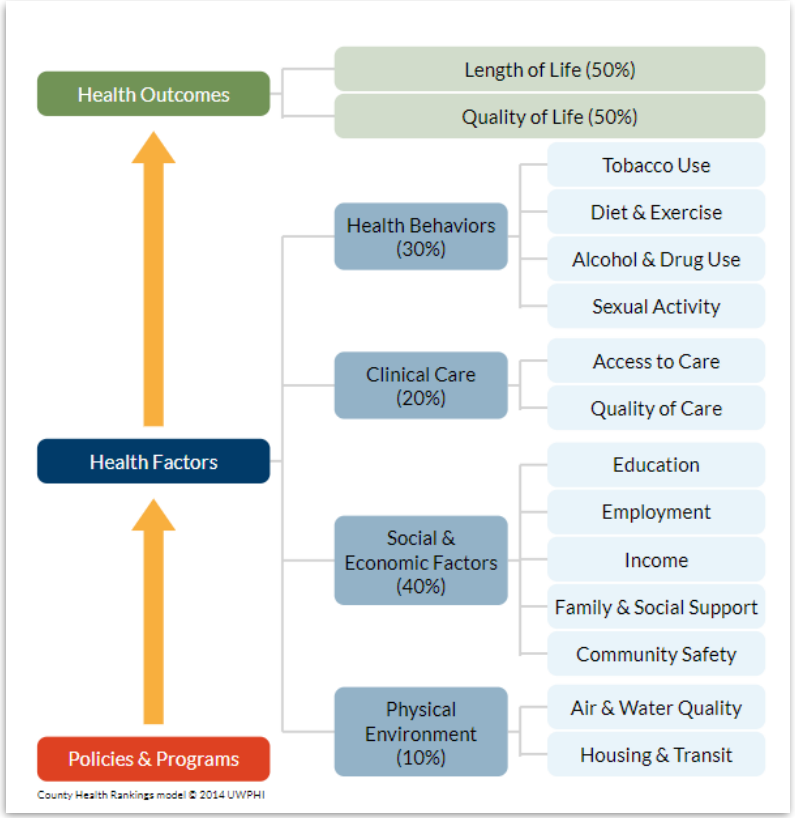
The County Health Rankings Model (CHRM) was used to organize the health indicators for the Maryland SHA. Variations of CHRM are recommended in public health accreditation guidance. CHRM categorizes indicators by:

Health Factors

- ★ *Health Behaviors*: Health-related practices that can improve or damage the health of individuals or community members (e.g., tobacco use, diet and exercise, sexual activity)
- ★ *Clinical Care*: Metrics relating to the direct medical treatment or testing of patients (e.g., access to care, quality of care)
- ★ *Social and Economic Factors*: Conditions that impact the availability of health choices within communities (e.g., education, community safety, employment)
- ★ *Physical Environment*: The healthiness of the physical world around us (e.g., air quality, water quality, transportation access)

Health Outcomes

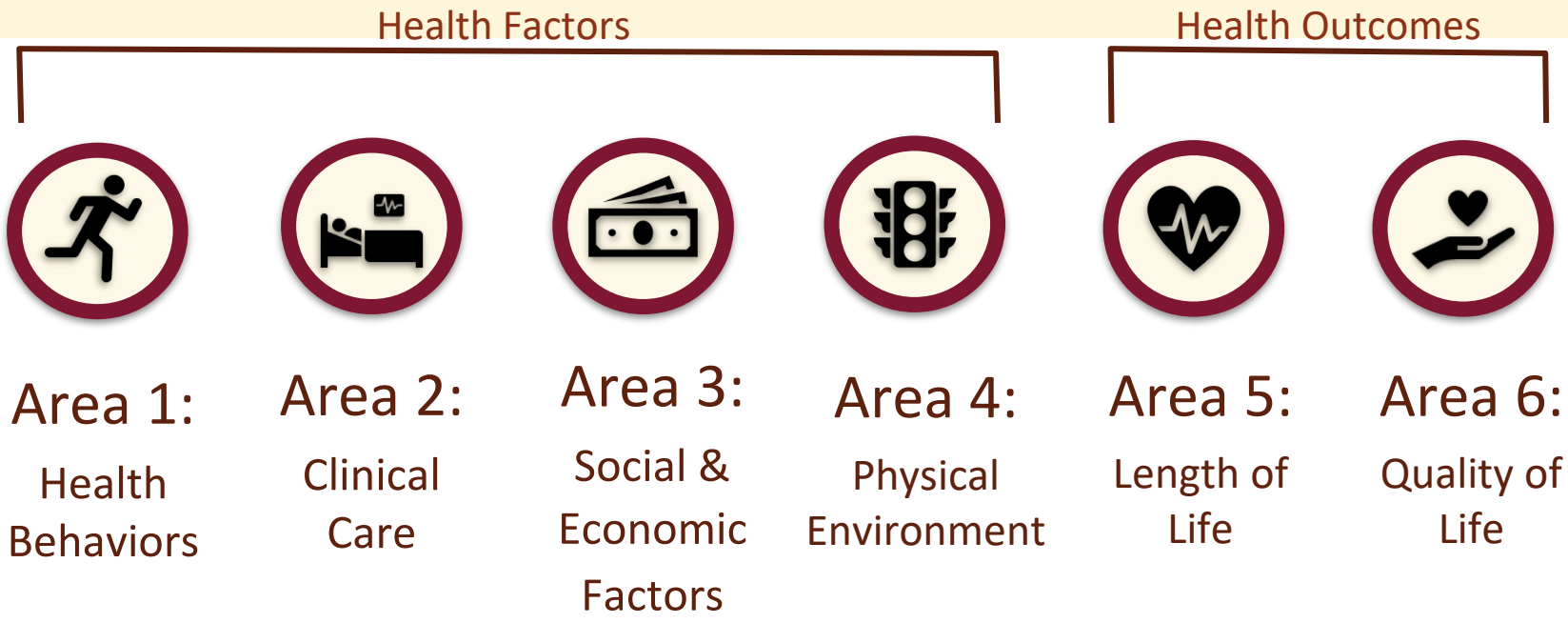
- ★ *Length of Life*: How long people live and their causes of death
- ★ *Quality of Life*: The burden of disease in communities and the perceptions of the communities' health (e.g., disease incidence, Emergency Department utilization, self-reported health status)



*CHRM does not include a category for population characteristics, the SHA includes this as a category

Focus Areas

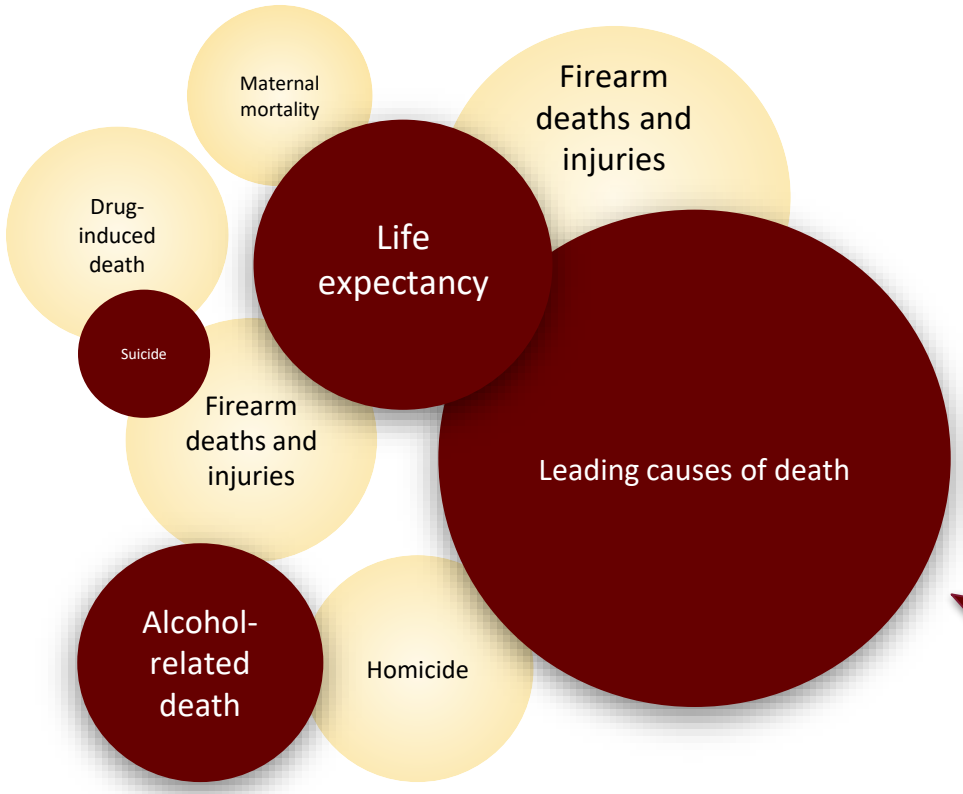
Based on the CHRM, health indicators are presented in six focus areas:



For each focus area, the assessment provides baseline data, factors that impact health, and details on populations that experience poorer health outcomes.

Area 5: Length of Life

This focus area addresses:



"Every time you turn on the news someone else has been killed by gun violence."

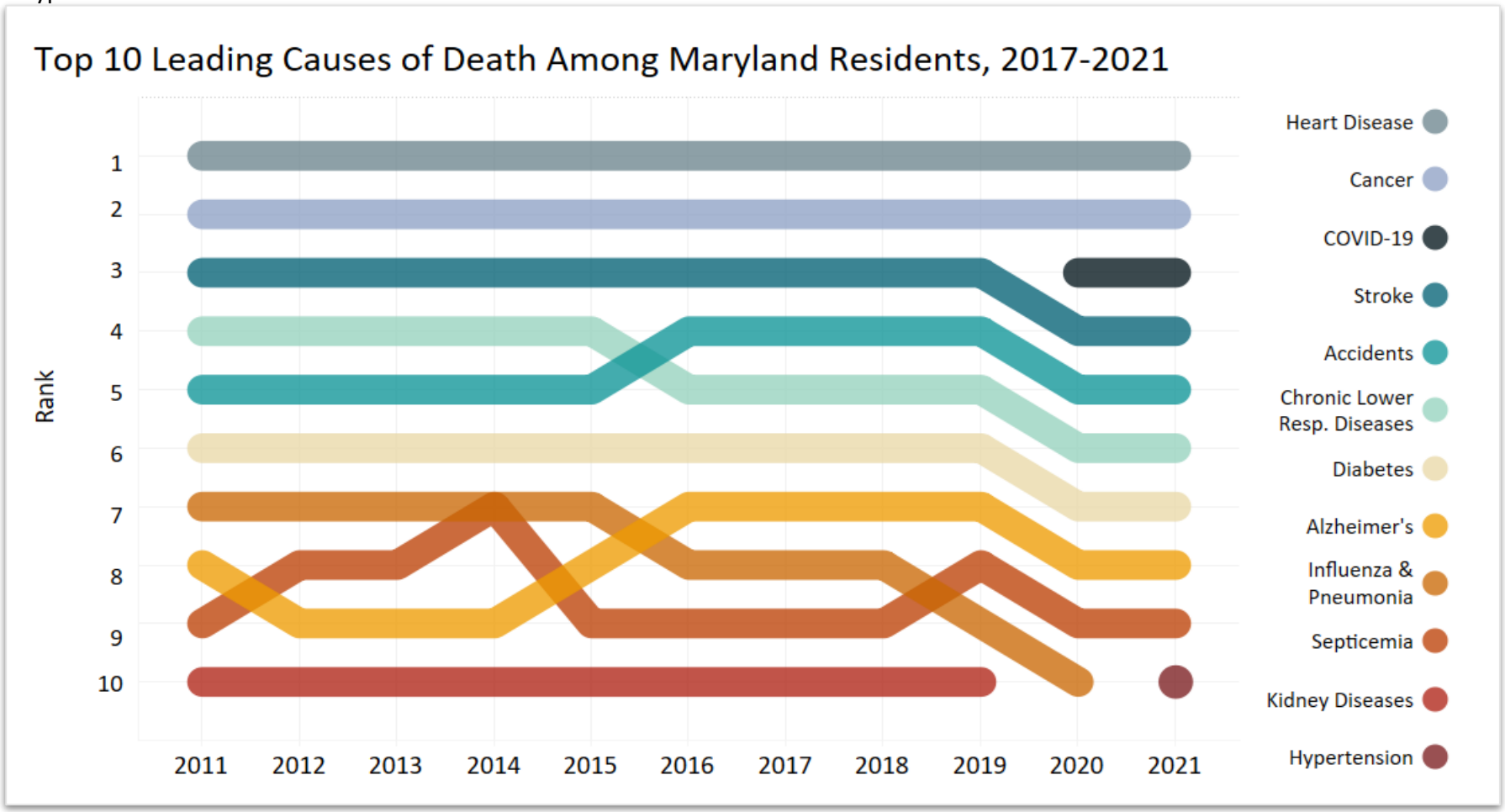
"Maternal morbidity and mortality in Baltimore is worse than the rate in some 3rd world countries. A leading cause of discrimination where Black women are not heard or taken seriously for issues they report."

"Gun violence is a catastrophe not just to those directly affected but to families and entire communities -- I would prefer the term gun deaths because gun suicides outnumber gun homicides."

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

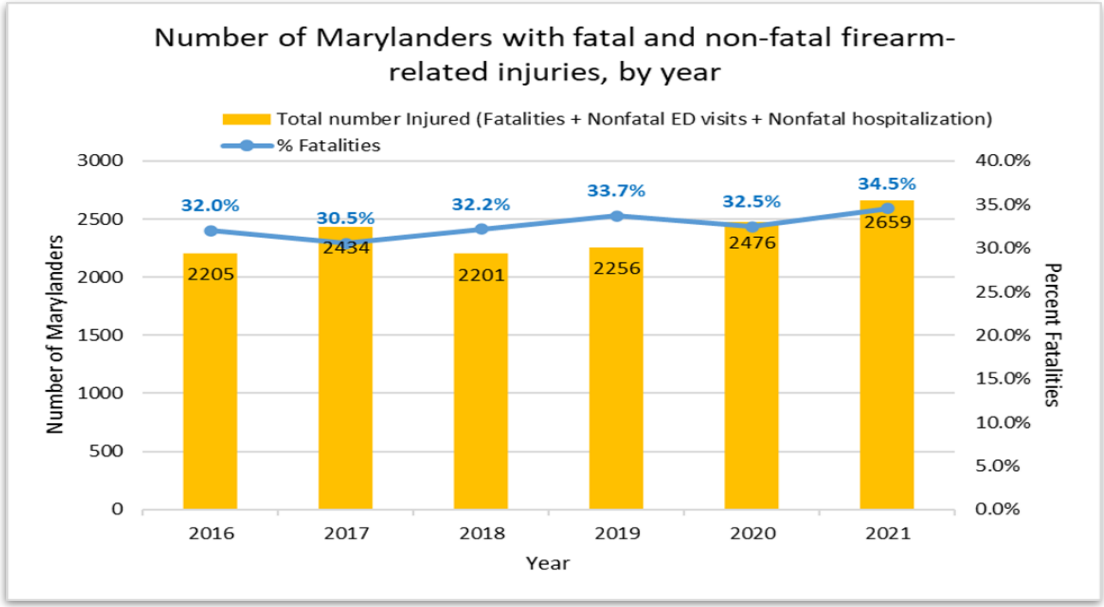
Leading Causes of Death

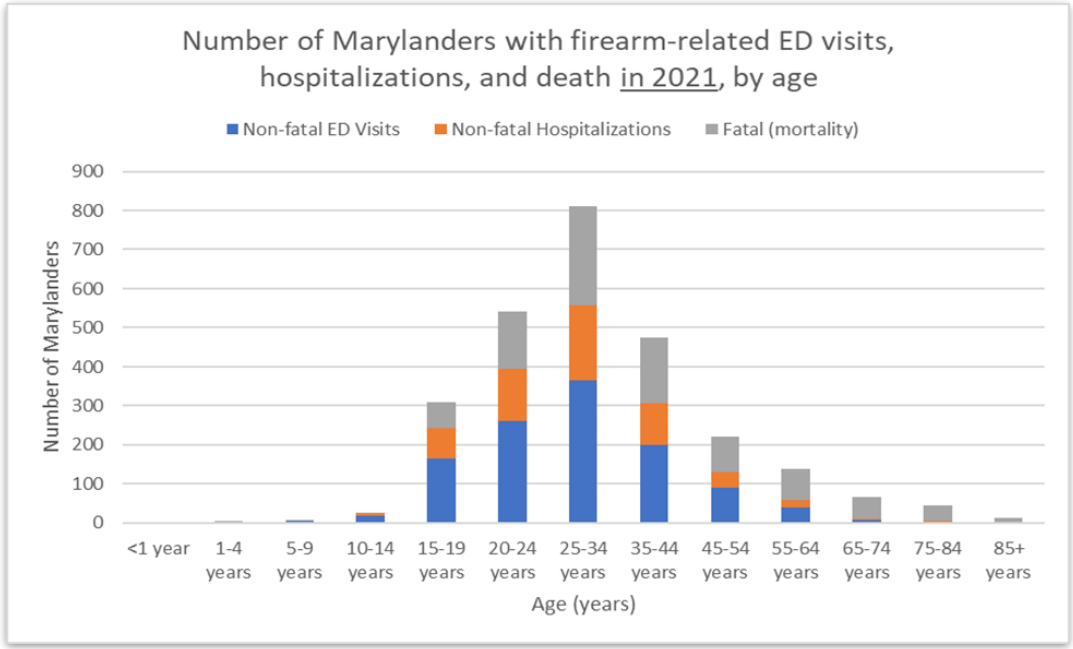
Heart disease and cancer have been the two leading causes of death in the United States since 1938. Although most of the leading causes of death in Maryland are related to chronic disease, the COVID-19 pandemic serves as a reminder that infectious diseases remain a latent threat to public health. In 2021, flu/pneumonia was bumped out of the top 10 and replaced by hypertension.



Firearm Deaths and Injuries

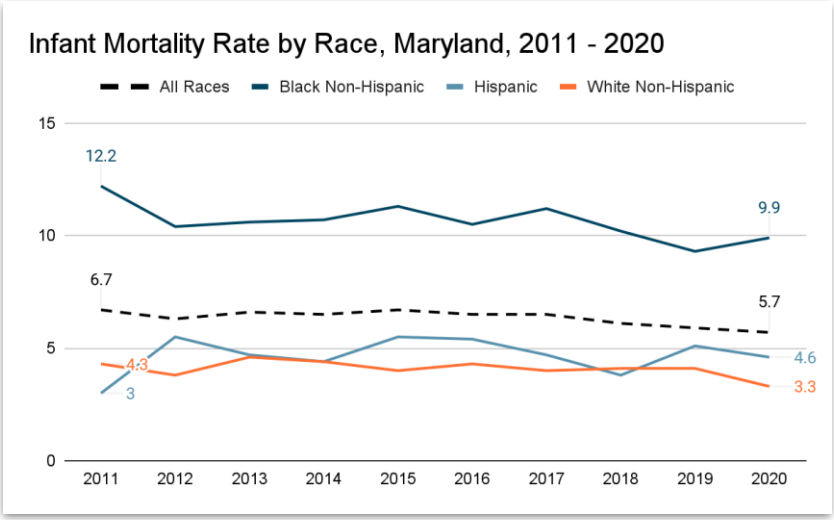
For every firearm fatality in Maryland, there are roughly two additional firearm-related injuries. In 2021, over 2600 people were injured by a firearm, with 34% experiencing fatal injuries. This proportion has been relatively stable over the past several years even as the total number of injuries has increased.





Firearm-related ED Visits

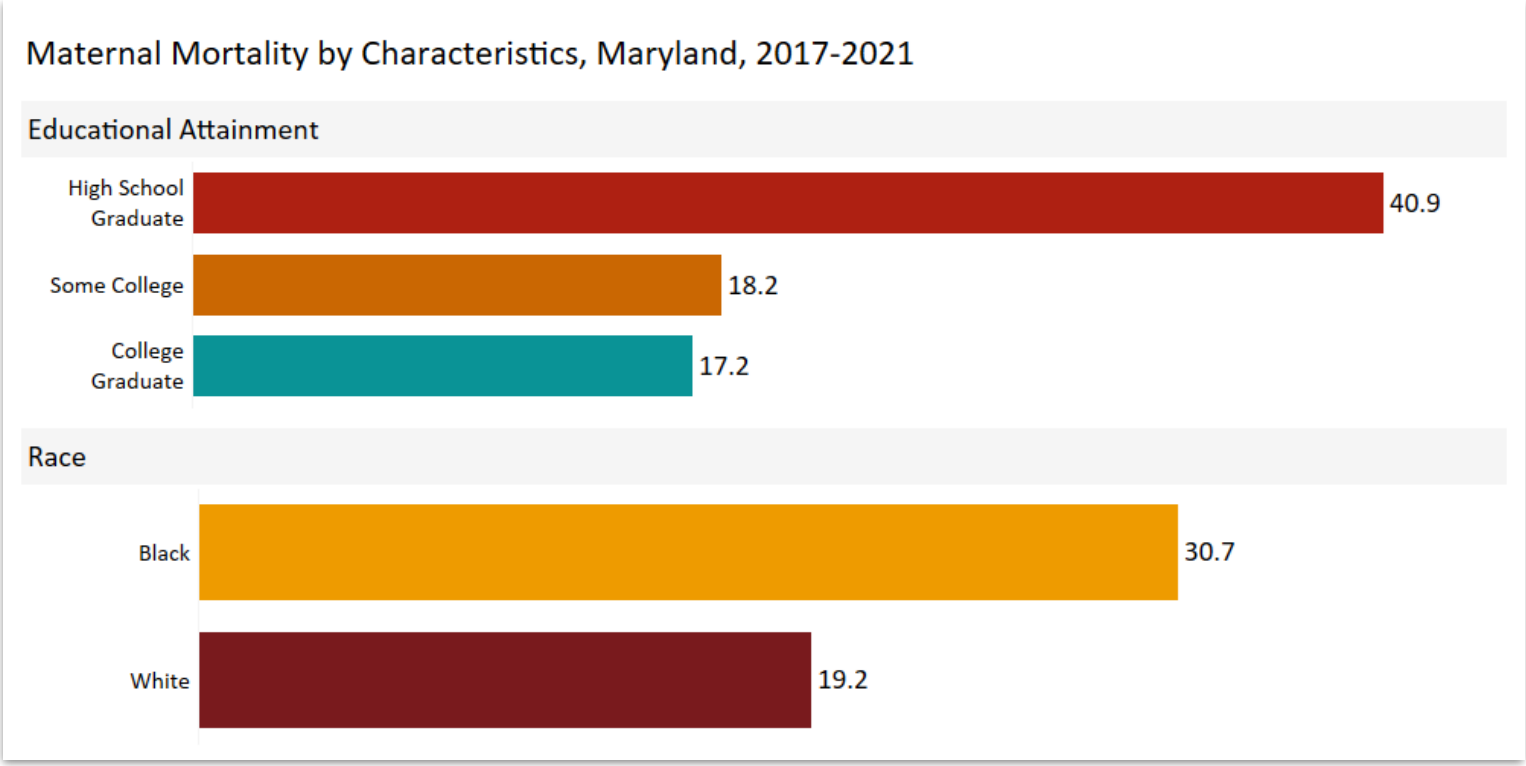
The bulk of firearm related injuries and fatalities occur among individuals in their 20s and 30s. However, the proportion of injuries resulting in death increases steadily with age. 85% of injured individuals over the age of 65 succumbed to their injuries, compared to 28% for individuals ages 15 to 34.



Infant and Maternal Mortality

Progress towards reducing infant mortality has been modest and uneven in the past decade. The mortality rate for Black infants remains three times higher than that of white infants in Maryland, a disparity that has not improved from 2011.

When stratified by education and race, the maternal mortality rate is much higher among women with only a high school diploma. Rates are also 60% higher for Black women than for white women.



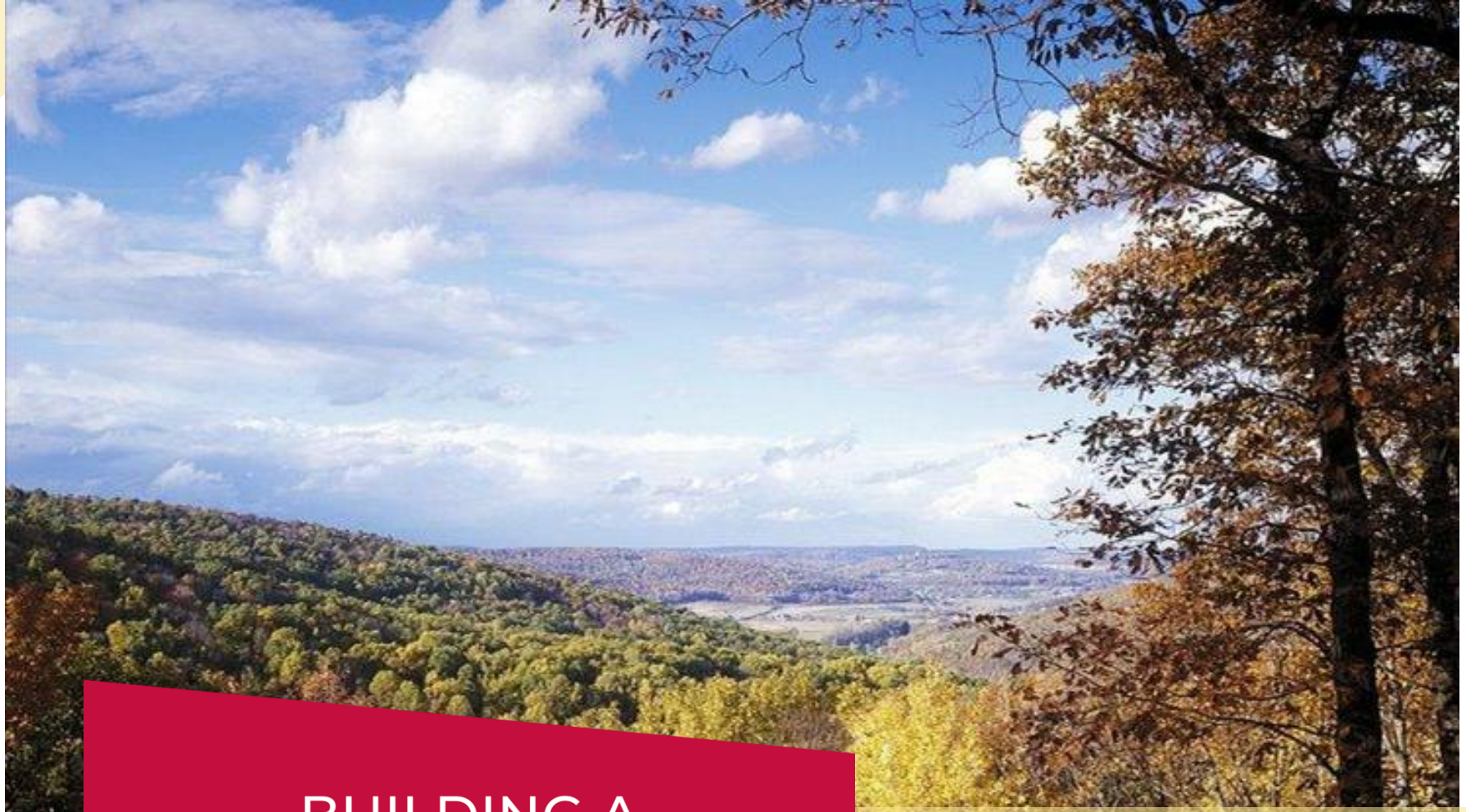
Area 5: Health Indicators

Measure**	MD*	US	Source(s)
Life Expectancy at Birth (years) §	78.2	76.1	CDC (2021); MD VSA (2021)
Accidental Death Rate	45.6	64.7	CDC WONDER (2021)
Motor Vehicle Mortality Rate	10.5	13.8	CDC WONDER (2021)
Alcohol-related Mortality Rate	9.0	14.4	CDC WONDER (2021)
Drug-Induced Mortality Rate §	42.8	32.4	CDC (2021); CDC (2021);
Homicide Rate	12.2	8.2	CDC WONDER (2021)
Suicide Rate §	9.7	14.1	CDC WONDER (2021)
Unintentional Poisoning Mortality Rate	16.7	31.0	CDC WONDER (2021)
Fall-Related Mortality Rate Among Adults Aged 65+ §	83.7	78.0	CDC (2021)
Deaths Before Age 75 from Preventable Causes	214.0	231.9	Commonwealth Fund (2021)

*Measures where Maryland is worse than the national value are indicated in red
**All rates are age-adjusted deaths per 100,000 unless otherwise specified
§ 2014 SHIP metric

2024 State Health Improvement Plan (SHIP) (Excerpts)

Maryland
DEPARTMENT OF HEALTH



BUILDING A HEALTHIER MARYLAND

STATE HEALTH IMPROVEMENT PLAN

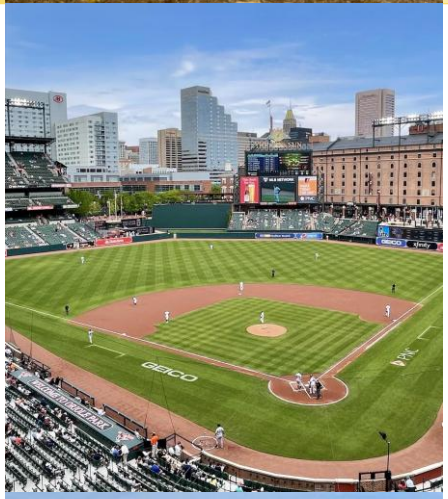
2024

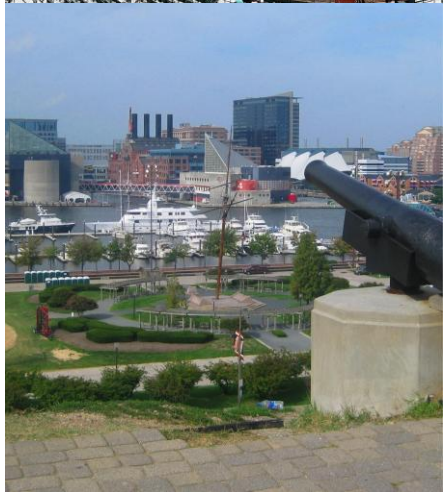
Maryland
DEPARTMENT OF HEALTH

Public Health Services Administration

201 West Preston Street
5th Floor
Baltimore, Maryland 21201
410-767-6500
Toll Free 1-877-463-3464

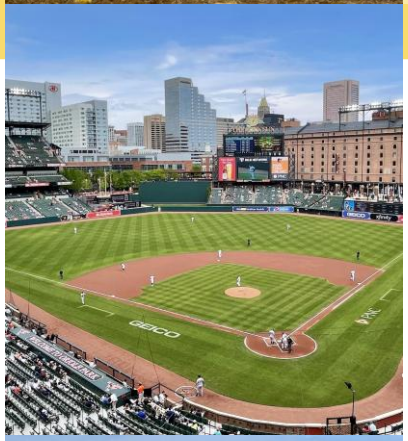
September 10, 2024





State Health Improvement Plan:
5 Health Priority Areas

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

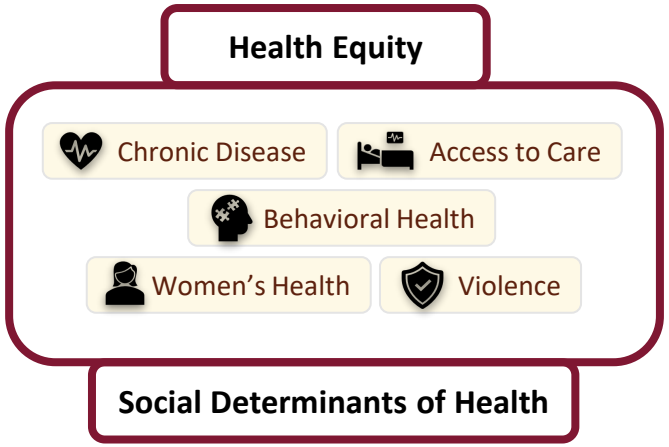


State Health Improvement Plan:
A Note About Health Equity

At the outset of the SHIP process, the BAHM team aimed to ensure the inclusion and elevation of populations experiencing disparities in their health outcomes. Throughout the selection and analysis of the SHA data, the BAHM team disaggregated by race, ethnicity, age, sex and/or geographic location wherever possible. Then, when selecting the appropriate data to present to the Steering Committee during the initial meeting, the team provided data points that highlighted disparate outcomes.

During the second meeting, when the Steering Committee members engaged in discussions around top health issues of concern, whether it was maternal mortality among Black women or the uninsured rates among Hispanic residents, the desire to address equity was raised in every breakout room. These sentiments were echoed in the root cause analyses conducted during the third meeting, with issues such as racism, sexism and structural discrimination being highlighted as root causes impacting all eight health issues.

When selecting the top 5 health priority areas for the SHIP, it was initially suggested that health equity be a priority in and of itself. However, based on the data review and the conversations around the root cause analyses, it was clear that all health priorities must address health equity if true progress is to be made. Ultimately, rather than silo health equity in its own category, all five of the selected health priority areas incorporate health equity into the goals, objectives and strategies. When necessary, priority populations are elevated through targeted objectives and strategies. This approach underscores the need to work with a diversity of implementation partners with expertise and strong ties to those priority populations.



State Health Improvement Plan:

Icon Guide

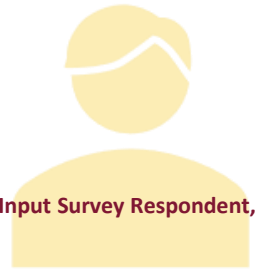
Health Equity Strategy	
Social Determinants of Health Strategy	
Policy and Systems Level Strategy	
Local Health Improvement Coalition Aligned Strategy	
Health Disparity Objective	

Priority Area 1: Chronic Disease

Goal 1: Enhance primary prevention of chronic disease

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

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



Community Input Survey Respondent, Kent County

Priority Area 1: Chronic Disease

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

Target: Developed with MDH Environmental Health Bureau.

OBJECTIVE 1.2.3: By 2026, reduce the rate of emergency room visits for asthma among children from 7.8 per 1,000 to 5.3 per 1,000, and for Black children from 19 per 1,000 to 9 per 1,000.	
Strategy: Develop culturally appropriate education materials for parents covering topics like vaping, secondhand smoke, peak flow meters, self-administration for children, inhaler storage, and questions for healthcare providers.	
Strategy: Conduct home visits to identify and address asthma triggers present in the home environment.	
Strategy: Implement asthma action plans for all students with diagnosed asthma, including a parent education plan distributed through schools.	

Data Source: Maryland Health Services Cost Review Commission, 2019

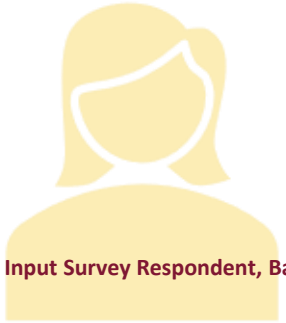
Targeted Health Disparity Objective

Priority Area 2: Access to Care

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

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

Goal 3: Reduce barriers to care



Community Input Survey Respondent, Baltimore County

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

Priority Area 3: Women's Health

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

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

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

Community Input Survey Respondent, Prince George's County

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

Community Input Survey Respondent, Baltimore County

Priority Area 4: Violence

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

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

Community Input Survey Respondent, Baltimore City

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

Priority Area 5: Behavioral Health

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

Goal 2: Reduce disparities in mental health outcomes

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

Community Input Survey Respondent, Anne Arundel County

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

SHIP Metrics

Maryland
DEPARTMENT OF HEALTH

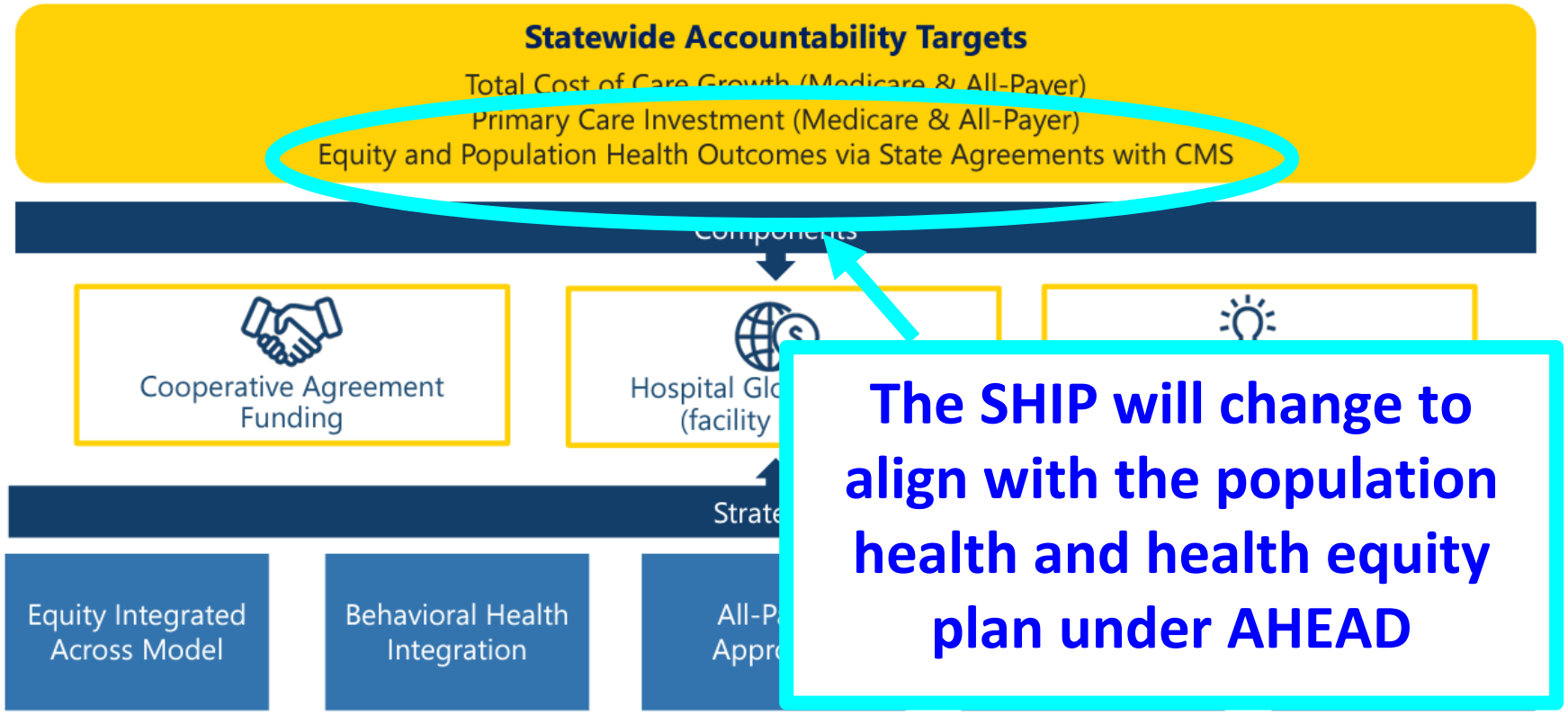
2024 SHIP Metrics*

1.1.1	Households Experiencing Food Insecurity	3.1.6	Maternal Mortality Rate
1.1.2	Adults Reporting No Physical Activity	3.1.7	Prenatal Care in First Trimester
1.2.1	Colorectal Cancer Screening	3.2.1	Breast Cancer Screening
1.2.2	Lung Cancer Screening Among High Risk Individuals	3.2.2	Adolescents with Up-to-Date HPV Vaccination
1.2.3	Asthma-Related ED Visits Among Children	3.2.3	Cervical Cancer Screening
1.2.4	Diabetics with A1c Value over 9% Among Medicaid	4.1.1	Firearm-Related Suicide Rate
1.2.5	Controlled Blood Pressure Among Individuals with Hypertension	4.1.2	Firearm-Related Homicide Rate
2.1.1	Telehealth Utilization Among PBHS recipients	4.2.1	IPV-Related ED Visits
2.1.2	School-Based Health Center Enrollment	5.1.1	Mental Health-Related ED Visits
2.2.1	Average Wait Time for Primary Care First Appt	5.1.2	Suicide Rate
2.3.1	Uninsurance Rate	5.1.3	Number of Youth SUD Treatment Providers
3.1.1	Pre-Term Birth Rate	5.1.4	PBHS Utilization Rate
3.1.2	Infant Mortality Rate	5.2.1	Students Feeling Sad or Hopeless
3.1.3	Babies with Low Birth Weight	5.2.2	Affordable Housing
3.1.4	Unintended Pregnancy Rate	5.3.1	Opioid Fatality Rate
3.1.5	Postpartum Depression Screening	5.3.2	Addictions-Related ED Visits

***SHIP metrics may change to align with AHEAD**

SHIP Alignment with AHEAD

The States Advancing All-Payer Health Equity Approaches and Development, or the AHEAD Model, is a flexible framework designed to improve health outcomes across multiple states.



The SHIP will change to align with the population health and health equity plan under AHEAD

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Thank you!

Katherine.feldman@maryland.gov

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Where to Find the SHA and the SHIP

MARYLAND
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Commission Reflection & Discussion

MARYLAND
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ON PUBLIC HEALTH

Announcements & General Updates

November 07, 2024

MARYLAND COMMISSION ON PUBLIC HEALTH

Adjourned

November 07, 2024

The next Commission meeting is November 20 (virtual only).

Our next regular meeting is December 05 (hybrid).