SCHOOL OF
PUBLIC HEALTH
CENTER FOR HEALTH EQUITY

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January 17, 2019

The Honorable Larry Hogan, Governor
State House
100 State Circle
Annapolis, Maryland 21401

The Honorable Thomas V. Miller, Jr.   The Honorable Michael E. Busch
President   Speaker
Senate of Maryland   Maryland House of Delegates
State House H-107   State House H-101
Annapolis, MD 21401   Annapolis, MD 21401

RE: Report required by State Government Article 5-112 (MSAR #5566)

Gentlemen,

In accordance with paragraph 2-1246 of the State Government Article, University of Maryland School of
    Public Health, Center for Health Equity Workgroup on Health in all Policies respectfully submits
    the January 31, 2019 report.

The University of Maryland School of Public Health, Center for Health Equity Workgroup on Health in
All Policies (SB340) Act became effective June 1, 2017, and will end on June 30, 2019.

We want to take this opportunity to thank the members of the Workgroup for their cooperation and
commitment.

Sincerely,

Stephen B. Thomas, Ph.D.
Professor, Department of Health
Services Administration
Director, Maryland Center for Health Equity
4200 Valley Drive, Suite 3302 SPH, Bldg. 255
College Park, MD 20742

cc: Sarah Albert Department of Legislative Services (5copies)
cc: Chair Senate Education, Health, and Environmental Affairs Committee (1 copy)
cc: Chair House Health and Government Operation Committee (1 copy)

2017's SENATE BILL 340 / HOUSE BILL 1225:

UNIVERSITY OF MARYLAND SCHOOL OF PUBLIC HEALTH, CENTER FOR HEALTH EQUITY

WORKGROUP ON HEALTH IN ALL POLICIES

JANUARY 2019 REPORT

Executive Summary
2017's Senate Bill 340 / House Bill 1225
Health in All Policies Workgroup
January 2019 Report

2017's SB340/HB1225 Legislation
Senate Bill 340 (SB340) and House Bill 1225 (HB1225) requires a workgroup of State and non-state agency representatives to work with the Health in All Policies (HiAP) framework to examine the health of Maryland residents and ways for "State and local government to collaborate to implement policies that will positively impact the health of residents of the state" (SB340 p. 2 (b)).

Recommendations
The Workgroup respectfully submits the following recommendations:

1. The workgroup recommends that a Health in All Policies Council be established, consisting of a wide variety of stakeholders. The Workgroup recommends a process that will assist the Health in All Policies Council in choosing or developing a Maryland Health in All Policies Framework

2. The Workgroup recommends that a Health in All Policies Toolkit be developed based on the outline created by the Workgroup.

3. The Workgroup recommends that the new Health in All Policies council develop an optional addendum for the Maryland procurement process.

4. The Workgroup recommends that the Process to Facilitate Data Sharing within a Health in All Policies Framework be made available for use by State agencies and that a task force within the Health in All Policies Council be responsible for implementing and evaluating the Process to Facilitate Data Sharing within a Health in All Policies Framework in State agencies.

Workgroup Process
The Workgroup met monthly to research and further develop the recommendations presented to the 2018 Maryland General Assembly. Four teams were formed to devote specific attention to four of the 2018 recommendations. Through individual team discussion, the Workgroup developed a list of recommendations and supporting documents.

Next Steps
The Workgroup will continue to develop its recommendations until the Workgroup ends in June 2019. The Workgroup will submit a Final Report with Recommendations to the Maryland General Assembly in June 2019.

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SENATE BILL 340 / HOUSE BILL 1225:
UNIVERSITY OF MARYLAND SCHOOL OF PUBLIC HEALTH,
CENTER FOR HEALTH EQUITY –
WORKGROUP ON HEALTH IN ALL POLICIES

2017's SENATE BILL 340 / HOUSE BILL 1225

Senate Bill 340 (SB 340) and House Bill 1225 (HB 1225) from the 2017 session titled: "University of Maryland School of Public Health, Center for Health Equity – Workgroup on Health in All Policies," presented to the Maryland General Assembly by Senator Shirley Nathan-Pulliam and Delegate Robbyn Lewis passed the Senate and House on third read in March 2017. Maryland Governor Lawrence Hogan signed the bill into law on May 4, 2017.

"This bill requires the University of Maryland School of Public Health's Maryland Center for Health Equity (M-CHE), in consultation with the Department of Health and Mental Hygiene (DHMH), to convene a workgroup to study and make recommendations to units of State and local government on laws and policies that will positively impact the health of residents in the State. The workgroup must use a "Health in All Policies framework" to (1) examine and make recommendations regarding how health considerations may be incorporated into decision making; (2) foster collaboration among State and local governments and develop laws and policies to improve health and reduce health inequities; and (3) make recommendations on how such laws and policies may be implemented. (2017's SB340 Fiscal and Policy Note, p. 1)

Workgroup Task

The Workgroup is tasked to examine the health of Maryland residents and develop ways for units of State and local government to collaborate using a Health in All Policies framework. The Workgroup was tasked to examine the impact of the following factors on the health of Maryland residents:
1) Access to safe and affordable housing;
2) Educational attainment;
3) Opportunities for employment;
4) Economic stability;
5) Inclusion, diversity and equity in the workplace;
6) Barriers to career success and promotion in the workplace;
7) Access to transportation and mobility;
8) Social justice;
9) Environmental factors; and
10) Public Safety

(2017's SB 340 Legislation pp. 2-3)

January 2018 Report Recommendations

The Health in All Policies Workgroup presented a report to the Maryland General Assembly on January 31, 2018 which included five recommendations from the Workgroup based on work the Workgroup conducted in 2017. The Workgroup recommended:

1) A Health in All Policies framework be developed and a Health in All Policies Council be created.
2) A toolkit with a reference guide be developed.
3) Funding announcements encourage applicants to include a Health in All Policies framework in their funding proposals.
4) A process to provide guidance to state and county agencies to facilitate data sharing between and within agencies be developed.
5) Maryland localities consult the Health in All Policies Toolkit and Reference Guide during the Comprehensive Planning and Zoning regulations development process.

RECOMMENDATIONS

The 2017 SB340/HB1225 Health in All Policies workgroup legislation requires a report of the Workgroup's recommendations on or before January 31, 2019.

The following recommendations are presented in accordance with the reporting requirement. They reflect and correspond to the recommendation number as reported in our January 2018 report.

1. **The Workgroup recommends that a Health in All Policies Council be established, consisting of a wide variety of stakeholders. The Workgroup recommends a process that will assist the Health in All Policies Council in developing a Maryland Health in All Policies Framework.**

This recommendation addresses the Workgroup's first 2017 recommendation, that "A Health in All Policies framework be developed and a Health in All Policies Council be created."

The workgroup recommends that a Health in All Policies Council consisting of a wide variety of stakeholders, including state government, community-based organizations, advocacy individuals, and public health and health equity experts be established to help implement and coordinate the statewide Health in All Policies program and activities. The individuals could be identified as "Health in All Policies Champions."

The Workgroup recommends that the Centers for Disease Control and Prevention's Policy Process guide the Council in developing or adapting a Maryland Health in All Policies Framework. The Framework will guide state agencies and other organizations to include health considerations in all policies and programs. This Framework may include prevention

and early intervention strategies as well as statements of principles designed for each agency and organization.

2. **The Workgroup recommends that a Health in All Policies Toolkit be developed based on the outline created by the Workgroup.**

This recommendation addresses the Workgroup's second 2017 recommendation that "A toolkit with a reference guide be developed."

The Health in All Policies toolkit should be developed to help state agencies, legislators, and policy directors understand what is Health in All Policies and how to implement Health in All Policies principals and strategies into their operations.

3. **The Workgroup recommends that the new Health in All Policies Council develop an optional addendum for the Maryland procurement process.**

This recommendation addresses the Workgroup's third 2017 recommendation that "Funding announcements encourage applicants to include a Health in All Policies framework in their funding proposals."

The workgroup recommends that the new Health in All Policies Council develop an optional addendum designed to collect information on efforts made by applicants responding to requests for proposals or other state procurement opportunities to consider broad health implications when making operational, supply, workforce, and other business decisions.

4. **The Workgroup recommends that the Process to Facilitate Data Sharing within a Health in All Policies Framework be made available for use by State agencies and that a task force within the Health in All Policies Council be responsible for implementing and evaluating the Process to Facilitate Data Sharing within a Health in All Policies Framework in State agencies.**

This recommendation addresses the Workgroup's fourth 2017 recommendation that "A process to provide guidance to state and county agencies to facilitate data sharing between and within agencies be developed."

The workgroup created a document delineating a Process to Facilitate Data Sharing within a Health in All Policies Framework and recommends that this document be published for public viewing and for use by State agencies. This data sharing process document takes into consideration efficiency, effectiveness, and the implications of making decisions in order to improve population health and health equity.

The workgroup recommends that a task force be created to implement, troubleshoot, and evaluate the Process to Facilitate Data Sharing within a Health in All Policies Framework in state agencies. This task force may be a subcommittee of the Health in All Policies Council. Members of the task force should be familiar with data sharing in their work.

WORKGROUP PROCESS

The 2017's SB340/HB1225 Workgroup met monthly to discuss work-plans, collaborate, and create recommendations. Conference calls were held between the monthly meetings to maintain communication and assist members. The Workgroup was on recess during the months of February, March, and August.

The workgroup formed four different teams, each dedicated to one of the recommendations from 2017. The four teams were:
1) **Team C** – focused on creating a Health in All Policies Council and developing a Maryland Health in All Policies framework.
2) **Team T** – focused on creating a toolkit with a reference guide.
3) **Team F** – focused on creating funding announcements that encourage applicants to include a Health in All Policies framework in their funding proposals.
4) **Team D** – focused on developing a process to provide guidance to state and county agencies to facilitate data sharing between and within agencies.

The Workgroup's fifth and final recommendation from 2017, that "Maryland localities consult the Health in All Policies Toolkit and Reference Guide during the Comprehensive Planning and Zoning regulations development process" has not yet been addressed by the Workgroup. The Workgroup plans to further develop this recommendation during 2019.

The monthly meetings allowed the teams to work together to develop their final product and receive feedback on their progress from other members of the workgroup. Each team has created a document and recommendations that will guide the workgroup's future actions (see Appendix).

Content experts presented at several workgroup meetings. These presentations provided detailed information on specific topics relevant to the workgroup's recommendations. Clifford Mitchell, MS, MD, MPH of the Environmental Health Bureau in the Maryland Department of Health presented on the Maryland Environmental Public Health Tracking system. In a later meeting, Kristi Pier, MHS, MCHES and Caroline Green, MPH of the Center for Chronic Disease Prevention and Control in the Maryland Department of Health presented on the Healthiest Maryland Businesses program. Jamie Tomaszewski, Chief of Procurement, and Robert Gleason, Senior Procurement Executive of the Maryland Department of Budget and Management presented on the Maryland Procurement Process.

See the Appendix for team workplans and meeting agendas.

Team C

Team C worked on the Workgroup's recommendation that a Health in All Policies framework be developed and a Health in All Policies Council be created.

Team C developed guidance and a potential structure for the Health in All Policies Council. This structure includes a vision that shall guide the Health in All Policies Council, the potential purpose and duties of the Health in All Policies Council, an explanation of who may be the most

effective members of this Health in All Policies Council, and a potential framework that the Health in All Policies Council could adapt to guide its efforts.

Team C reviewed multiple prominent Health in All Policies Frameworks to inform their recommendation for a future Health in All Policies Council. Team C identified the Centers for Disease Control and Prevention's Policy Process,[1] to guide the Council on their choice or creation of a Framework. This is presented in Team C's Health in All Policies Framework and Council Structure in Appendix I of the document. Potential frameworks for the Council's consideration, that Team C discussed, are also identified in this report (in the appendix) to allow a future Health in All Policies Council to decide which framework it believes best suits its purpose. See Appendix I for Team C's Health in All Policies Framework and Council Structure.

Team T

Team T worked on the Workgroup's recommendation that a toolkit with a reference guide be developed.

Team T gathered ideas for their toolkit by researching and reviewing existing state Health in All Policies toolkits. Specifically, Team T reviewed the Health in All Policies toolkit from California[2] and Tennessee.[3] Reviewing these toolkits helped Team T determine elements that are typically included in a Health in All Policies toolkit.

Team T sent a survey to the Workgroup to gain a better understanding of the expectations members have for the toolkit as well as identify some of the best-practices regarding toolkits currently in use in a variety of State agencies.

Team T combined the knowledge gained from reviewing other state's Health in All Policies toolkits with the survey results to create an outline for the Maryland Health in All Policies Toolkit. See Appendix II for Team T's Maryland Health in All Policies Toolkit Outline.

Team F

Team F worked on the workgroup's recommendation that funding announcements encourage applicants to include a Health in All Policies framework in their funding proposals.

Team F consulted with Jamie Tomaszewski, Chief of Procurement and Robert Gleason, Senior Procurement Officer at the Maryland Department of Budget and Management and leaders of the Healthiest Maryland Businesses program to learn how a Health in All Policies approach could have a place in the procurement process while maintaining competition.

Team F created a worksheet that can be used as an optional addendum in the State procurement process. The optional worksheet is designed to collect information on efforts by applicants for

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[1] Centers for Disease Control and Prevention. Overview of CDC's Policy Process. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2012
https://www.cdc.gov/policy/analysis/process/index.html.
[2] http://www.phi.org/resources/?resource=hiapguide.
[3] https://www.nashville.gov/Portals/0/SiteContent/Health/PDFs/NashVitality/HealthyToolkit.pdf.

state procurement opportunities to consider health in making operational, business, supply, workforce, and other decisions. See Appendix III for Team F's optional procurement document.

Team D

Team D worked on the Workgroup's recommendation that a process to provide guidance to state and county agencies to facilitate data sharing between and within agencies be developed.

Team D considered members' experience, other individual's experience, advice, opinions, and expert advice when determining the data sharing challenges that would need to be addressed by a process to facilitate data sharing. Team D developed a process to facilitate data sharing that takes into accounts for efficiency, effectiveness, and the implications of making decisions in order to improve population health and health equity. Team D wanted to ensure that whenever a new project, program, or policy is being developed, health considerations, environmental impacts, and potential outcomes are considered during their formulation.

Team D created a seven-step Process to Facilitate Data Sharing within a Health in All Policies Framework. The Process was collaboratively created by Team D and then sent to a select Focus Group for review and refinement. This Focus Group consisted of members within the Workgroup as well as individuals and state mandated advisory councils (including the Commission for Environmental Justice and Sustainable Communities [CEJSC] and Children's Environmental Health and Protection Advisory Council [CEHPAC]). The Focus Group members provided expertise and/or engage in data sharing and its barriers in their daily work.

This seven-step Process to Facilitate Data Sharing within a Health in All Policies Framework is explained in the Team D Data Sharing Process Document in Appendix IV.

NEXT STEPS

The 2017's SB340/HB1225 legislation requires the Workgroup to continue through June 30, 2019. The Workgroup will submit its final report and recommendations to the Maryland General Assembly in June 2019.

The Workgroup will continue to hold monthly in-person meetings and monthly team conference calls through June 2019.

The Workgroup will continue to develop its recommendations from the 2018 and the 2019 reports.

The Workgroup will work to further develop a structure for a Health in All Policies Council.

The Maryland Health in All Policies Toolkit will be fully developed by June 2019.

The Workgroup plans to conduct a pilot data sharing activity, utilizing the Process to Facilitate Data Sharing within a Health in All Policies Framework.

APPENDIX

Appendix I: Team C Health in All Policies Frameworks and Council Structure

EXECUTIVE SUMMARY

The Centers for Disease Control and Prevention's Policy Process[4] was identified to assist the Council in the development of a Health in All Policies Framework recommended for consideration to guide state agencies and other organizations to include health considerations in all policies and programs. The Workgroup has also identified four possible Frameworks that the Council may find more suitable. These Frameworks can be found in the appendices.

A Health in All Policies Council should be formed and include representation from state agencies; local and community-based organizations; community members; and not limited to any other individual with experience and interest in the HiAP process.

HIAP COUNCIL

The Workgroup discussed and decided that not only senior-level individuals be included in the HiAP Council composition but also representatives that have an understanding of the populations and communities that HiAP activities will affect. These could be individuals of any organizational or community representation that will serve as the "Health in All Policies Champion"

As defined in the Health in All Policies: A Guide for State and Local Governments report:
> A champion is someone with key relationships, high visibility, or organizational influence (such as a county supervisor, mayor, governor, agency director, or well-known community leader), who uses their power to promote a Health in All Policies approach and enlist the support of other important players. Champions need not be involved in the day-to-day operations of the effort but should be kept informed and engaged as advisors and navigators.

Health in All Policies Council Vision:
The Health in All Policies Council will commit to health and health equity as a priority by adopting the principles of Health in All Policies and acting on the social determinants of health to alleviate the challenges and inequity/experienced due to lack of resources and access to:
> (i) access to safe and affordable housing;
> (ii) educational attainment;
> (iii) opportunities for employment;
> (iv) economic stability;
> (v) inclusion, diversity, and equity in the workplace;
> (vi) barriers to career success and promotion in the workplace;

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[4] https://www.cdc.gov/policy/analysis/process/index.html

(vii) access to transportation and mobility;
(viii) social justice; and
(ix) access to comprehensive health insurance and health care.

Health in All Policies Council Purpose and Duties (draft):
Implement and coordinate the Maryland Health in All Policies (HiAP) Program and activities.

a. Embed an approach to health equity in the culture and policy of Department / Organization portfolios
b. Establish shared integrated goals for collaboration
c. Build platform to address the social determinants of health in a systematic manner
d. Advise and operationalize the HiAP Report and recommendations
e. Repository of HiAP best practices – model policies and vision statements
f. Work with toolkit team to determine who will be developing these model practices
g. Agenda and goal setting for practical application (how to implement it)
h. Council will develop the metrics and targets.
i. Host an annual meeting where people will report out. Vetting schedule. Not only a report out but target communities to report out to. Feedback loop.
j. Involving LHO to report out on how the communities are being affected

Council Representation:

Council members should be:
- A tactical and strategic selection of council members
- Able to think creatively about the representation
- Look at the workgroup representation as a start
- Senior level and non-management persons

Council seats should include:
- All state agencies listed in original workgroup legislation
- Elected officials
- CHWs representing urban and rural – foot soldiers
- Community level individuals representing the populations being served (2)
- Community advocate
- Transportation
- Energy
- Food justice
- Faith-based
- Public Safety
- Housing
- Epidemiologist

FRAMEWORK RECOMMENDATION
The Workgroup recommends that the Centers for Disease Control and Prevention Policy Process be used by the HiAP Council to assist in the identification of a Health in All Policies Framework. Additionally, the Workgroup has provided four possible frameworks for consideration in the appendices.

The Centers for Disease Control and Prevention have developed a Policy Process as it recognizes policy as an effective way to improve the health of populations through a variety of avenues and understands that often the domains of the policy cycle overlap or occur out of order.
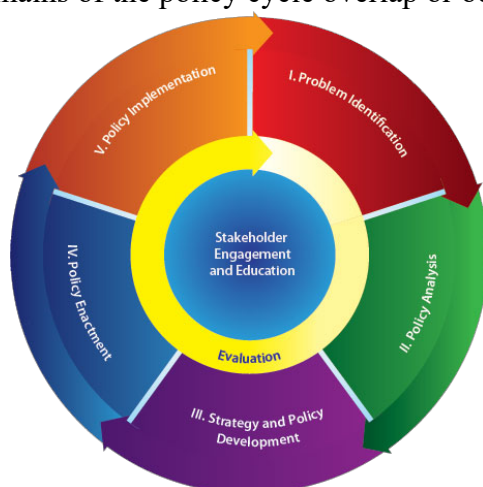
The following provides a summary of the five domains to the CDC's Policy Process[6].

I. Problem Identification: Clarify and frame the problem or issue in terms of the effect on population health.

- Collect, summarize, and interpret information relevant to a problem or issue (e.g., nature of the problem, causes of the problem)

- Define the characteristics (e.g., frequency, severity, scope, economic and budgetary impacts) of the problem or issue

- Identify gaps in the data

- Frame the problem or issue in a way that lends itself to potential policy solutions

II. Policy Analysis: Identify different policy options to address the problem/issue and use quantitative and qualitative methods to evaluate and the policy options to determine the most effective, efficient, and feasible option.

- Research and identify policy options

- Describe: a) how the policy will impact morbidity and mortality (health impact), b) the costs to implement the policy and how the costs compare with the benefits (economic and

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[6] Centers for Disease Control and Prevention. Overview of CDC's Policy Process. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2012
https://www.cdc.gov/policy/analysis/process/index.html

budgetary impacts) and c) the political and operational factors associated with adoption and implementation (feasibility)

- Assess and prioritize policy options

III. Strategy and Policy Development: Identify the strategy for getting the policy adopted and how the policy will operate.
- Identify how the policy will operate and what is needed for policy enactment and implementation (e.g., understand jurisdictional context and identify information and capacity needs)

- Define strategy for engaging stakeholders and policy actors

- Draft the policy (law, regulation, procedures, actions, etc.)

IV. Policy Enactment: Follow internal or external procedures for getting policy enacted or passed
- Enact law, regulation, procedure, administrative action, incentive, or voluntary practice

V. Policy Implementation: Translate the enacted policy into action, monitor uptake, and ensure full implementation.
- Translate policy into operational practice and define implementation standards

- Implement regulations, guidelines, recommendations, directives and organizational policies

- Identify indicators and metrics to evaluate implementation and impact of the policy

- Coordinate resources and build capacity of personnel to implement policy

- Assess implementation and ensure compliance with policy

- Support post-implementation sustainability of policy

The following are **overarching domains** that should be considered as appropriate through all domains.
- Stakeholder Engagement and Education: Identify and connect with decision-makers, partners, those affected by the policy, and the general public.
  - Identify key stakeholders, including supporters and opponents (e.g., community members, decision-makers, nonprofit, and for-profit agencies)

  - Assess relevant characteristics (e.g., knowledge, attitudes, needs)

  - Implement communication strategies and deliver relevant messages and materials

  - Solicit input and gather feedback

- Evaluation: Formally assess the appropriate steps of the policy cycle, including the impact and outcomes of the policy.
  - Define evaluation needs, purpose, and intended uses and users

○ Conduct evaluation of prioritized evaluation questions (e.g., was the problem defined in a way that prioritized action, how were stakeholders engaged, is the policy being implemented as intended, what is the impact of the policy)
○ Disseminate evaluation results and facilitate use

Optional Framework Appendices

Alternative Frameworks for Council Consideration
1. Nine Questions to Guide Development and Implementation of Health in All Policies[7]
2. Health in All Policies: A Guide for State and Local Government[8]
3. ASTHO: Health in All Policies – A Framework for State Health Leadership[9]
4. Frieden T. A Framework for Public Health Action: The Health Impact Period[10]

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[7] Evelyne De Leeuw, Dorothee Peters; Nine questions to guide development and implementation of Health in All Policies, Health Promotion International, Volume 30, Issue 4, 1 December 2015, Pages 987–997, https://doi.org/10.1093/heapro/dau034

[8] http://www.phi.org/resources/?resource=hiapguide

[9] http://www.astho.org/HiAP/Framework/

[10] A framework for public health action: the health impact pyramid. Am J Public Health. 2010;100(4):590-5.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/

Appendix II: Team T Toolkit Outline

I.   Foreward
    a. Letter from Senator Shirley Nathan-Pulliam
II. Executive Summary
    a. Provide brief Health in All Policies (HiAP) context
III. Maryland Workgroup on Health in All Policies (2017's SB340/HB1225)
    a. History: who, why, when, etc.
    b. "Mandate" to do this work
IV. Background
    a. Define HiAP
        i. "Language of the Law"
    b. Explain key elements of HiAP
    c. "Why" HiAP is needed
    d. Multi-Agency efforts
        i. Maryland Department of Health
        ii. University of Maryland
        iii. Other SB340-mandated agencies
V.   Purpose of the Toolkit
    a. Why it is being created
    b. What is included
    c. Who is the audience
        i. State government
        ii. Agency secretaries
        iii. Legislators
        iv. Policy Directors
        v. Institutions of Higher Education
VI. "Healthy Community"
    a. Social determinants of health
    b. Social inequities
    c. Identify common conditions related to the above determinants and inequities
        i. Diabetes
        ii. Asthma
        iii. Food insecurity
    d. "Be Healthy Maryland"
    e. Vignettes or personalized examples to demonstrate health disparity
VII. Best Practices and Resources
    a. Evaluation, Assessment, and Monitoring
    b. Guidelines and Solutions/Outcomes
        i. Evidence-based practices
        ii. Theory-based concepts
        iii. Highlight initiatives that have worked
            1. Maryland statewide
            2. Maryland countywide
            3. Other states

c. HiAP Checklist
    i. Diversity/inclusion
    ii. Help to avoid unintended consequences
    iii. "Food for Thought" or ideas to consider
d. Impact Review for Diverse Populations
e. Resources and Links

Appendix III: Team F Optional Procurement Document

The State of Maryland is committed to improving the lives of its citizens through policies and departmental efforts that support the prevention of disease and the promotion of wellness. One strategy that has been identified to achieve this goal is integrating the concept of Health in All Policies (HiAP) into the decision-making, planning and purchasing processes across all sectors of the government.

The Association of State and Territorial Health Officials (ASTHO) defines HiAP "as a collaborative approach that integrates and articulates health considerations into policymaking across sectors, and all levels, to improve the health of all communities and people." As purchasing agents of the State of Maryland, agencies are allowed to use information on an applicant's strategies that improves health and health equity to make determinations on funding awards. This optional worksheet may permit applicants to receive additional credit in the procurement scoring process based upon their articulated business practices and decision-making that support HiAP.

The Health in All Policies Council has developed a Framework and Toolkit to serve as a guide for organizations seeking to do business with the state. The Framework is based on the U.S. Centers for Disease Control and Prevention's Policy Process Framework which was developed as part of the National Prevention Strategy in 2014 and can be updated and adapted by the HiAP Council to suit the needs of the state of Maryland. It outlines the main policy steps at which HiAP principles can be engaged, while the Toolkit can be used to develop employee training, engage in strategic planning, and enact steps that can directly and/or indirectly lead to positive health outcomes for their workers, customers, Maryland residents, and the general population as a whole. The Framework and Toolkit can be accessed HERE.

We also encourage this addendum to include a table for vendors to fill out that includes questions for the organization, examples of potential ways to answer the question, and potential criteria considered in assessing whether a HiAP framework is employed by the organization bidding on a project:

To Vendor: Please complete the following table so that we can better understand your practices as they relate to health impact.

THESE QUESTIONS SHOULD BE DRIVEN BY THE FRAMEWORK ADOPTED BY THE COUNCIL, BASED ON THE CDC POLICY PROCESS FRAMEWORK IT COULD INCLUDE TRANSPORTATION, ENERGY, FOOD JUSTICE, FAITH-BASED, PUBLIC SAFETY, HOUSING, OR OTHER RELEVANT ACTIVITIES THAT INFLUENCE HEALTH

1) Does your organization take health impacts into consideration when making decisions about purchasing goods or services?	Examples: 1) the organization purchases goods from LEED certified organizations, so we are assured that sustainable practices are used.	Yes/No If yes, please describe
2) Does your organization facilitate employee wellness?	Examples: 1) The organization provides paid leave so individuals can address health issues, 2) The organization provides exercise facilities and healthy food in vending machines, etc.	Yes/No If yes, please describe
3) Does your organization consider the effects of pollution and traffic on health by allowing telework agreements, encouraging use of public transit, etc.	Examples: 1) Subsidize public transportation costs for employees, 2) facilitate carpooling, 3) allow telework, etc.	
4) Does your organization encourage active living among workers and community members?	Examples: 1) hosting or sponsoring activities that contribute to health and wellness, 2) ensuring streets are clean and walkable during construction projects, etc.	

This is not an exhaustive list, is not final, and principles will be developed by the HiAP Council

In addition to your feedback, please answer the following questions:

1) Is an optional addendum helpful to incentivize reporting and activity?
2) Can an optional addendum be used in providing additional points to a vendor?
3) We had envisioned this would be used in competitive bids (i.e. larger RFPs), but is there a mechanism to encourage low-bid contractors or non-competitive contracts (i.e.. interagency agreements) to report on this information?
4) Would it be possible to require RFPs over a certain amount of money ($100,000+) fill out the addendum, or does it need to be completed by all vendors regardless of award amount over $50,000?
5) If you don't recommend this approach, how would you build in the fundamental idea of incentivizing contractors to engage in health-related activities into procurement opportunities?

Appendix IV: Team D Data Sharing Process Document

Background

In January 2018, the first Maryland Health in All Policies (HiAP) Report was provided to the General Assembly as mandated by 2017's Senate Bill 340 and House Bill 1225. Five initial recommendations identified by the HiAP Workgroup were presented in the report, one of which related to creating a process to facilitate both health and non-health data sharing. Specifically, this recommendation (#4) stated:

"The workgroup recommends that a process to provide guidance to state and county agencies to facilitate data sharing, between and within agencies, be developed to ensure health and non-health data are being shared to support health in all policies. Appropriate, efficient data sharing is crucial in developing policies that best address the needs of residents of the State. The workgroup recommends providing county and state agencies with templates of materials, such as Memorandums of Understanding and Data Use Agreements to support agreements between agencies and provide guidance to agencies about how and why it is important to share data to address health problems. Additionally, the workgroup recommends that initially, this process may focus on publicly available data from population survey sources including, but not limited to, the Maryland Behavioral Risk Factor Surveillance System. The workgroup recommends that the process would begin in 2018 as a pilot data sharing activity within the membership of the SB340 Workgroup."

Introduction

This document presents the recommendation for creating a process to provide guidance to state and county agencies that facilitates data sharing, both health and non-health data between and within agencies, to support health in all policies. A data-sharing pilot was not undertaken at this time, because there was group consensus that larger systemic barriers at the agency level for data sharing must be addressed before any pilot study could yield meaningful new information. In other words, pilot studies are most valuable when conducted within or between agencies that value data sharing and have developed internal support structures and feedback loops to improve related processes.

In fulfilling its charge, the workgroup developed a process to facilitate data sharing that takes into account efficiency, effectiveness, and the implications of making decisions that improve population health and health equity. The workgroup wanted to ensure that whenever a new project, program or policy is being developed, the interests of the affected population(s), as well as human health considerations, environmental impacts and foreseeable outcomes are considered during their formulation. The workgroup considered the need for building support structures and the capacity for data sharing, while at the same time ensuring data protection and security. The process to facilitate the inclusion of community concerns and questions, and data sharing (**Figure 1**), explanation of each step, and questions that agencies should consider at each step of the process are included below. This is followed by recommendations of the workgroup.

Figure 1: Process to Facilitate Data Sharing within a Health in All Policies Framework

Step 1: ESTABLISH HEALTH AND HEALTH EQUITY GOALS

ESTABLISH HEALTH AND HEALTH EQUITY GOALS AND DESIRED OUTCOMES OF YOUR PROJECT/PROGRAM/POLICY

Clarity on the goals/vision will guide the development for why data sharing is important, inform what structures need to be in place, and focus on what data needs to be shared e.g., equity measures, health indicators. etc. As shown in **Figure 1**, always consider the stakeholder and community engagement aspect of any task, project or product under consideration by the agency at every step of the process. While government agencies have some data that can be used to generate ideas about what may be going on in a community, that data must be complemented with local needs, priorities, data, information and input from community members.

In order to bring a health and health equity lens into all policies, agencies must require that a consideration of health impacts be brought into the earliest stages of new project, program or policy formulation. Transportation, housing, health care, employment, environmental quality, environmental hazards, working conditions, education, child care, law enforcement—all of these sectors and others have a role in creating the conditions that enable all people and communities to attain and sustain good health. The connections of new programs or policies to health outcomes need to be explored and evaluated to avoid unintended health consequences.

Project goals should include outcomes to improve health especially for vulnerable populations (health equity model). Look beyond overall health outcomes at how health varies between population groups within a jurisdiction, such as a county or community. Look beyond individual behavior at social and economic conditions, investments and outlooks that impact health. Consistent health goals and messaging should be encouraged across disciplines. Agencies need to know what questions they want to answer before they can determine what data are needed. Agencies must also examine if the data they are collecting can accurately provide public health experts with the data necessary to monitor impacts of toxic exposures or known hazards so that actions can be taken to better protect public health.

Finally, being aware of larger statistical information (such as national data collected by CDC, EPA, USGS, etc.) can help focus data priorities on predominant chronic and acute health risks, as well as ensuring positive environmental impacts.

WHAT ARE OUR GOALS?
- ✓ What health indicators and health equity factors should drive what data sources we use? (*Develop performance indicators. Helpful resource may be an epidemiologist.*)

WHAT ARE THE ISSUES? (Look at Health Indicators)
- ✓ What are the stakeholders' health, environmental, equity challenges in their communities?
- ✓ What are the known public health indicators that may be affected by your project, program or policy?
- ✓ Does your data collection adequately provide for scientifically valid public health monitoring? Is it based on a scientifically valid sample? Does it provide the necessary details for needed monitoring such as annual data and data based on zip codes?
- ✓ What populations or demographics will be affected by your project, policy or program?

✓ What is the condition and type of environmental media impacted by your project, program, or policy?
✓ How can these data be shared without violating privacy?

WHO ARE THE STAKEHOLDERS IMPACTED BY YOUR PROJECT?

✓ Who will be affected by the proposed solution, and will different groups be affected differently?

WILL THE DATA SHARING PROCESS REDUCE INEQUITIES? *In order to address social disparities, promote a health equity framework for data sharing.*

✓ Are there subpopulations where inequities have existed in the past?
✓ Are there new or existing population groups that have not been accounted for?
✓ What data are necessary to tease out those inequities?
✓ Is the data collected regularly (e.g., annually, biannually, etc.) in order to assess changes and new unforeseen inputs?
✓ What impact will the data-sharing process have on subgroups, vulnerable or under-resourced groups and communities of a population, and on specific geographic regions?

HOW AND WHEN WILL THE INFORMATION BE USED?

Please think thoroughly through this question.

Step 2: REINFORCE NEED FOR DATA SHARING

REINFORCE THE NEED FOR DATA SHARING BETWEEN AND WITHIN AGENCIES

Buy-in from staff within and across agencies that data sharing will lead to better public health and environmental outcomes, as well as improved agency operations, is essential to the success of data sharing efforts. This can only happen when leadership within and between agencies reinforce and communicate the needs, goals, and co-benefits of a data-sharing culture. Leaders must understand and be able to communicate to staff the answers to the following questions:

- ✓ Why do we need data sharing?
- ✓ What are our goals? *(Project goals should include outcomes to improve health, especially for vulnerable populations [health equity model]. Look not only at overall health outcomes but also at how health varies between population groups within a jurisdiction, such as a county. Look at individual behavior, as well as at social and economic conditions that impact health. Consistent health goals and messaging should be encouraged across disciplines. Agencies need to know what questions they want to answer before they can determine what data are needed.)*
- ✓ How will data sharing help reduce redundancy, save money, and increase effectiveness, especially in cases where multiple partners need the same information? *(For example, transportation agencies could consider broadening the scope of their data collection efforts to include assessment of transportation access to health clinics, parks, and other health-promoting sites.)*
- ✓ Will the benefits of sharing of these data outweigh the risks to privacy that follow from sharing?
- ✓ How will data sharing improve our environment, services and government efficiency?
- ✓ Will sharing data and aligning other processes simplify determining eligibility and enrollment in social and health services?
- ✓ Will data sharing establish a collaborative approach to improving population health?
- ✓ Will data sharing *e*ncourage cross-sectional partnering to address social determinants of health? (*It is important to recognize the relationship between health in all policies and health equity.*)
- ✓ How will the agencies (or other entities) involved ensure that the privacy of individuals is protected?

Step 3: BUILD SUPPORTING STRUCTURES AND PROCESSES

**ASSESS CURRENT DATA- SHARING PROCESSES (*What is the current Data- Sharing process?)*
Being aware of larger statistical information (such as national data collected by CDC, EPA, USGS, etc.) can help focus data priorities on predominant chronic and acute health risks, as well as ensuring positive environmental impacts. There are other models if data sharing is needed relative to programs and strategic processes that address health equity. Given health care transformation, there are a lot of new data sharing and integration processes that will come into play. A discussion of how those new processes can assist with the HiAP goals is important and should be considered.

For example, health equity is an important aspect of the new Total Cost of Care (TCOC) All-Payer model. This model needs to be assessed for how the TCOC and new health transformation goals will affect recommendations. Social determinants of health is a major aspect of this model implementation for data sharing and will require cross sector work. The effort around data sharing is much of what the HiAP is about.

BUILD SUPPORTING STRUCTURES AND PROCESSES FOR DATA SHARING
Institutionalizing supportive structures for data sharing is critical to make data sharing possible within or across agencies. One way to accomplish this is to create an administrative, communication and accountability framework within and across institutions to ensure data sharing and related issues are routinely discussed and tracked. Creating a multidisciplinary data-sharing taskforce responsible for implementing this administrative and accountability framework within the organization, as well as for leading overall implementation of the action plan and reporting to the highest organizational levels, will ensure success.

Developing or adopting specific templates, such as data sharing agreements, can also provide supportive structures for sharing data. Further developing state data centers and clearinghouses, websites for data sharing, or other mechanisms to provide easy data access can also help break down silos and provide supportive structures. Lastly, capacity building within and across organizations is paramount to fostering an ongoing data-sharing culture.

At the same time that these larger within and cross-agency structures are being institutionalized, a smaller-scale process must also be institutionalized whereby positive health impact and health equity, along with positive environmental impact considerations, are brought into any project, program or policy formulation process. It is worth stating that data sharing can also highlight applications needing to be addressed in data collection (e.g., data gaps and/or missing data necessary to monitor health impacts, etc.).

WHAT TYPE OF DATA-SHARING AGREEMENT IS NEEDED (FORMAL? STRUCTURED?)?
Develop a template of Memorandums of Understanding [MOU] and Data Use Agreements (by Legal team and Institutional Review Board [IRB]). Focus on Publicly available data (e.g., CDC's Environmental Health Tracking Network).

ARE RELEVANT QUANTITATIVE AND QUALITATIVE DATA AVAILABLE AND ACCESSIBLE?
- ✓ What is our inventory of data?
  Expand the inventory of data (by key groupings - free data, right to know…. Risk data, mapping data) obtained by various agencies including but not limited to:

  - *State Agencies and Commissions*
    - *Maryland Department of Health*
    - *Maryland Health Care Commission*
    - *Maryland Health Services Cost Review Commission*
    - *Maryland Department of Agriculture*
    - *Maryland Department of Environment*
    - *Maryland Department of Natural Resources*
    - *Maryland State Department of Education*
    - *Maryland Department of Transportation*
    - *Maryland Department of Planning*
    - *etc.*

  - *National Data*
    - *CMS (U.S. Centers for Medicare &Medicaid Services)*
    - *EPA (U.S. Environmental Protection Agency)*
    - *CDC (U.S. Centers for Disease Control and Prevention)*
    - *NIH (U.S. National Institutes of Health)*
    - *NIEHS (National Institute of Environmental Health Sciences)*
    - *U.S. Census Bureau*
    - *USGS (U.S. Geological Survey)*
    - *etc.*

  - *Other State and County Data:*
    - *Education*
    - *Transportation*
    - *Environmental*
    - *Housing*
    - *Maryland Behavioral Risk Factor Surveillance*
    - *Planning*
    - *Zoning*
    - *Other infrastructure data as appropriate*

Step 4: CREATE ACTION PLAN FOR DATA SHARING

CREATE AN ACTION PLAN FOR DATA SHARING
With data selected, developing the action plan can have objectives that focus on the data stewards, templates and examples will facilitate sharing, the qualities of the data sources/sets and incorporate what the limitations and conditions are for those data and if proxies can be found or rules and protections set up for those data. Data selection will also determine what resources (funding, expertise, training, staff, technology) are needed to make the sharing happen prior to actually sharing the data.

Once health and health equity goals have been established, an action plan can be developed to identify strategies and next steps for making key datasets available within and across agencies. Action plans should identify specific deliverables and timeframes for addressing data priorities, and any staff responsible for those efforts. Action plans should also consider barriers or other institutional obstacles to data sharing, particularly handling HIPAA, confidential or personally identifiable information.

IS IT POSSIBLE TO IMPLEMENT THE PROPOSED SOLUTION?
Begin strategic planning and prioritization. Examine feasibility of strategies for data sharing.
> Feasibility: *In some ways, feasibility is a combination of many of these criteria. Often it is a proxy for resources, jurisdiction, and support from decision-makers.* Feasibility must encompass the costs of action but must also include an analysis of the costs of inaction for vulnerable populations.

WHAT RESOURCES ARE AVAILABLE TO YOU?
- ✓ Will state-level or county-level data be sufficient? (*The needed levels may differ depending on how the data will be used*).
- ✓ What steps have partner agencies taken to impart health, equity, and sustainability knowledge to their staff?
- ✓ Are resources available for primary data collection, such as surveys, interviews or focus groups?

DOES THE PROPOSED DATA-SHARING PROCESS REQUIRE ACTION AT THE STATE LEVEL, OR IS THERE ALSO A ROLE FOR LOCAL (OR FEDERAL) JURISDICTIONS?
- ✓ Who has the authority to take action—including regulation, guidance, funding, and convening?

Step 5: REVIEW THE TERMS AND CONDITIONS FOR DATA SHARING

REVIEW THE TERMS AND CONDITIONS FOR DATA SHARING
One of the greatest priorities is to safeguard data: to ensure the privacy of individuals, to protect confidentiality, and preserve the value of proprietary data. Once you have an action plan and know what health-related and/or environmental data are needed for your project, you can determine which datasets require safeguards. Agencies should employ 'need to know' principles, meaning that, when sharing both internally between departments and externally with other organizations, individuals should only have access to certain data if they need it to do their job, and only relevant staff should have access to the data. Important questions to consider during this process include:

- ✓ Does the data-sharing process safeguard the privacy of consumers and protect confidential and proprietary data?
- ✓ Will the data be secure?
- ✓ What information needs to be shared?
- ✓ Who requires access to the shared personal data?
- ✓ How are individuals made aware of the information sharing? (*Consider what to tell the individuals concerned.)*
- ✓ Is their consent needed?
- ✓ Do they have an opportunity to object? How do you take account of their objections?
- ✓ How do you ensure the individual's rights are respected?
- ✓ What risk to the individual and/or the organization does the data sharing pose?
- ✓ When should it be shared?
- ✓ How should it be shared?
- ✓ What are the barriers to data sharing?
- ✓ Are the data accurate? (*Cross reference across federal, county and local study as a rule.*)

Step 6: EVALUATION

EVALUATE DATA SHARING OUTCOMES

A process of continuous evaluation, improvement, and adaptive management on data sharing and incorporating a health lens into policy or programs should be established. This continuous improvement process will help identify remaining institutional barriers and data needs/gaps.

Consideration must be given to analysis and resources necessary for next steps. Once the data is being shared, is there capacity for interpretation, identifying trends and patterns, will there be guidance or recommendations, and how will your agency communicate and collaborate to address what is discovered through data sharing? How will this be done with community input?

How will results be used–will there be changes and improvements based on evaluation findings?

This is an area where pilot studies can be developed to address identified needs and feedback loops established to answer such questions as:

WHAT WORKS AND WHAT DOES NOT WORK?
- ✓ Has participation led to increased trust among impacted stakeholder communities, partner organizations and agencies?
- ✓ Has participation led to a perceived or measurable increase in collaboration across sectors?
- ✓ How do partner agencies see the relationship between health, equity, sustainability, and their own agency objectives?
- ✓ Systems change. Will the proposed solution lead to the institutionalization of Health in All Policies efforts or embed health into decision-making?

HOW WILL FINDINGS BE DISSEMINATED?
- ✓ Will the findings be shared with the public? (*Community Advisory Board or other supported community based entity consisting of impacted or reasonably potentially impacted members.*)
- ✓ How can community members help you interpret the data?

STEP 7: BUILD CAPACITY FOR DATA SHARING

Creating dedicated budgets and positions as well as implementing training and mentoring programs (both ongoing and for new hires) will build the resource and knowledge base for data sharing. Other tools for building capacity, like implementing adaptive management or continuous improvement methods and leadership development programs, will build and sustain a data sharing culture.

HOW DO WE ALIGN PROGRAMS AND RESOURCES WITH ORGANIZATIONAL COMMITMENT TO DATA SHARING AND HEALTH EQUITY?
>   *Example: Department of Budget Management will give funding preference to agencies with data- sharing agreements.*

HAVE HEALTH, EQUITY, AND SUSTAINABILITY CRITERIA BEEN INCORPORATED INTO FUNDING OR PROGRAM EVALUATION CRITERIA OF PARTNERS OUTSIDE PUBLIC HEALTH?

HOW HAVE HEALTH, EQUITY, AND SUSTAINABILITY EXPLICITLY BEEN INCORPORATED INTO GOVERNMENT GUIDANCE OR POLICY DOCUMENTS?
- ✓ Have there been legislative actions to support use of a health and equity lens in decision-making?

HOW CAN WE TRAIN OR SUPPORT HEALTH PROFESSIONALS IN ACQUIRING SKILLS FOR DATA MANAGEMENT AND SHARING? (*provide technical assistance*).
- ✓ Continue to reinforce the HiAP Framework for data sharing and relationship between HiAP and health equity.
- ✓ Build knowledge and capabilities across the health care system to support transitions of care and continuity of service.
- ✓ Engage populations that experience health inequities in the assessment process.

WHAT OTHER USES OF TECHNOLOGY ARE AVAILABLE THAT FACILITATE DATA SHARING?
>   (*Include online applications, document imaging, electronic recordkeeping, enhanced record retrieval, and call centers.*)

RECOMMENDATIONS FOR DATA SHARING:

- **Create a task force responsible for implementing and evaluating the above health data sharing framework in State agencies.** This could be a workgroup within the proposed HiAP Council or Commission. Its members should include stakeholders and impacted community members as well as those with expertise in IT (Information Technology), ethics, study design, data security, data use agreements, and epidemiology.

<u>**Recommendations for the Taskforce:**</u> *Specific to facilitating data sharing between and within agencies:*
- Choose a policy pilot project to test how successfully the proposed approach is incorporating health considerations into decision-making and policy direction.
- Assess data collected by various agencies. Expand the data clearinghouse and make data more readily available to various agencies.
- Scan the data that is being collected to look for areas of overlap, and to see if there are ways of collecting data more efficiently and effectively.
- The Health in All Policies Taskforce should spearhead the development of data access initiatives and identify ways to piggyback data collection efforts across agencies.
- Incorporate human health metrics into program and policy implementation.
- Use equity-focused measures. Require stratification by variables that are already being collected (race, ethnicity, gender, age, zip code, census tract). Consider additional stratification variables including, (status as an environmental justice or traditionally underserved community, sexual orientation, gender identify, disability, low income subsidy, and language).
- The Taskforce should address the security and privacy surrounding the transmission or accessing of data and establish common rules for its security and privacy.
- Recommendation of what health indicators (asthma, obesity, etc.) and health equity (income, education, proximity to pollution, or environmental degradation, etc.) factors should be the priorities for MD's Health in All Policies.
- Develop an accessible and transparent template of MOU and Data Use Agreements.

RESOURCES ON THE BENEFITS OF DATA SHARING:

Disclaimer: Please note that these are not recommendations, simply items reviewed by the workgroup during the creation of this document.

GUIDE: NIH Data Sharing Policy and Implementation Guidance
National Institutes of Health Office of Extramural Research. (2003). *NIH Data Sharing Policy and Implementation Guidance*. Retrieved from
https://grants.nih.gov/grants/policy/data_sharing/data_sharing_guidance.htm#goals
> This guidance provides the National Institutes of Health (NIH) policy statement on data sharing and additional information on the implementation of this policy.

ARTICLE: The Hilltop Institute - Overcoming Interagency Data Sharing Barriers
Idala, D.A., Somerville, M.H., Spicer, L.A., Boddie-Willis, C.L., John, J.L., and Roddy, T. (2011). Overcoming Interagency Data-Sharing Barriers: Lessons from the Maryland Kids First Act. *The Hilltop Institute*. Retrieved from
https://www.scribd.com/document/287534159/Maryland-Data-Sharing-Brief

ARTICLE: Maryland builds cross-department cloud for data sharing
By Sara Friedman, Sep 28, 2017
Friedman, S. (2017). Maryland builds cross-department cloud for data sharing. GCN. Retrieved from https://gen.com/articles/2017/09/28/maryland-cross-department-cloud.aspx

ARTICLE: State's $200M MD THINK program to bring data analytics to social services
By Stephen Babcock, Mar. 10, 2017
https://technical.ly/baltimore/2017/03/10/hogan-md-think-social-services-data/
> MD THINK allows employees to only view data specific to their needs. The goal is to be able to share information among various agency silos, but put it into through a "highly segregated" platform with security controls to limit the amount of sharing of unnecessary details. The platform was initially conceived to include health benefits data from the Department of Health as well, but the work has been scaled back to the two agencies with similar datasets.

REPORT: Counting a Diverse Nation: Disaggregating Data on Race and Ethnicity to Advance a Culture of Health, Babcock, S. (2017). State's $200M MD THINK program to bring data analytics to social services. *Technical.ly Baltimore*. Retrieved from https://technical.ly/baltimore/2017/03/10/hogan-md-think-social-services-data/

Rubin, V., Ngo, D., Ross, A., Butler, D., and Balaram, N. (2018). Counting a Diverse Nation: Disaggregating Data on Race and Ethnicity to Advance a Culture of Health. *PolicyLink*. Retrieved from
http://www.policylink.org/sites/default/files/Counting_a_Diverse_Nation_08_15_18.pdf

EXAMPLE of DATA RESOURCE:

Maryland Department of Health – Environmental Public Health Tracking Program
https://phpa.health.maryland.gov/oehfp/eh/tracking/Pages/home.aspx

Maryland Environmental Public Health Tracking Program is a gateway to environmental and health data resources. On this tracking site, you can create data Tables and Maps or view a Gallery of different health topics in Maryland.

COUNTY AND STATE AGENCY TEMPLATES:
Websites for data sharing agreements.

Disclaimer: Please note that these are not recommendations, simply items reviewed by the workgroup during the creation of this document.

Centers for Medicare and Medicaid Services. (2018). *Sample Interagency Data-Sharing Agreement*. Retrieved from
https://www.cdc.gov/cancer/ncccp/doc/sampleinteragencydatasharingagreement.doc

Maryland Governor's Workforce Development Board. (2016).
WIOA Memoranda of Understanding & Resource Sharing Agreements. Retrieved from
http://www.dllr.maryland.gov/employment/mpi/mpi9-16.pdf

The Council of Large Public Housing Authorities
https://nche.ed.gov/downloads/forum/clpha-data-template.pdf

Data Sharing: Creating Agreements In support of community-academic partnerships
By Paige Backlund Jarquín, MPH
Colorado Clinical and Translational Sciences Institute & Rocky Mountain Prevention Research Center
Retrieved from http://www.ucdenver.edu/research/CCTSI/community-engagement/resources/Documents/DataSharingCreatingAgreements.pdf

The Wage Record Interchange System (WRIS)
https://www.doleta.gov/performance/pfdocs/WRIS_Data_Share_Agree_Amended_Febr_17_2011.pdf

Elements of a data sharing agreement
https://uwaterloo.ca/research/office-research-ethics/research-human-participants/pre-submission-and-training/human-research-guidelines-and-policies-alphabetical-list/data-sharing-or-transfer-agreements-what-are-they-and-when/elements-data-sharing-agreement-example

Industry
GlaxoSmithKline, LLC
https://study329.org/wp-content/uploads/2015/08/DATA-SHARING-AGREEMENT.pdf

Appendix V: Team C Work Plan

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**University of Maryland School of Public Health, Center for Health Equity –
Workgroup on Health in All Policies Act of 2017 (SB 340)**

Team C 2018 Work-Plan

Team C has been tasked with following up on the following recommendation, made by the Health in All Policies Workgroup in the report submitted to the Maryland General Assembly on January 30, 2018:

> **A Health in All Policies Framework be developed and a Health in All Policies Council be created.**
>
> A Health in All Policies Framework should be developed to guide state agencies and other organizations to include health considerations in all policies and programs. This Framework may include prevention and early intervention strategies and statements of principles designed for each agency or organization.
>
> The workgroup recommends that a Health in All Policies Council consisting of senior-level individuals be established to help implement and coordinate the statewide Health in All Policies program and activities. The individuals could be identified as "Health in All Policies Champions."

Procedure: To facilitate the project, Team C members should work independently and in collaboration with their team members both during conference calls and in-person meetings.

Activities:
- Research Maryland Interagency Committees
- Define structure of the Health in All Policies Council
- Delineate the roles and responsibilities of the Heath in All Policies Council
- Determine the feasibility of a Health in All Policies Council
- Refine the language in documents describing the Health in All Policies Council

Appendix VI: Team T Work Plan

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**University of Maryland School of Public Health, Center for Health Equity –
Workgroup on Health in All Policies Act of 2017 (SB 340)**

Team T 2018 Work-Plan

Team T has been tasked with following up on the following recommendation, made by the Health in All Policies Workgroup in the report submitted to the Maryland General Assembly on January 30, 2018:

A toolkit with a reference guide be developed.

The workgroup recommends that a toolkit with a reference guide be developed for use by state agencies and other organizations. To be most beneficial, a toolkit with a reference guide may include, but not be limited to, Health in All Policies definitions, best practices, outlines, training resources, and strategies to address social determinants of health. A toolkit with a reference guide may be used broadly by state agencies and organizations as well as in staff training for state agencies and by licensure boards to engage licensees in Health in All Policies.

During 2018 and 2019, the workgroup will identify partners (academic institutions, technology firms, etc.) and request their participation in the design of the toolkit. The organization responsible for toolkit maintenance will be determined after the toolkit is developed and distributed.

Procedure: To facilitate the project, Team T members should work independently and in collaboration with their team members both during conference calls and in-person meetings.

Activities:
- Review examples of toolkits
- Identify and engage partners
- Define structure of toolkit and reference guide
- Delineate contents of toolkit and reference guide
- Create toolkit and reference guide

Appendix VII: Team F Work Plan

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**University of Maryland School of Public Health, Center for Health Equity –
Workgroup on Health in All Policies Act of 2017 (SB 340)**

Team F 2018 Work-Plan

Team F has been tasked with following up on the following recommendation, made by the Health in All Policies Workgroup in the report submitted to the Maryland General Assembly on January 30, 2018:

> **Funding announcements encourage applicants to include a Health in All Policies framework in their funding proposals.**
>
> The workgroup will evaluate the merits and feasibility of how a Health in All Policies framework can be embedded in funding proposals, including procurement and competitive grants. The goals, objectives, and procedures utilized in the Maryland Small Business Preference Program and Small Business Reserve Program will be researched. The workgroup will be mindful of Federal and State law.

Procedure: To facilitate the project, Team F members should work independently and in collaboration with their team members both during conference calls and in-person meetings.

Activities:
- Review the Maryland Small Business Preference Program and Small Business Reserve Program
- Review relevant Federal and State law
- Examine relevant processes already in place
- Create language for funding announcements that encourage applicants to include a Health in All Policies framework in their funding proposals
- Analyze the feasibility of funding announcements that encourage applicants to include a Health in All Policies framework in their funding proposals

Appendix VIII: Team D Work Plan

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**University of Maryland School of Public Health, Center for Health Equity –
Workgroup on Health in All Policies Act of 2017 (SB 340)**

Team D 2018 Work-Plan

Team D has been tasked with following up on the following recommendation, made by the Health in All Policies Workgroup in the report submitted to the Maryland General Assembly on January 30, 2018:

> **A process to provide guidance to state and county agencies to facilitate data sharing between and within agencies be developed.**
>
> The workgroup recommends that a process to provide guidance to state and county agencies to facilitate data sharing between and within agencies be developed to ensure health and non-health data sharing are being shared to support health in all policies. Appropriate, efficient data sharing is crucial in developing policies that best address the needs of residents of the State. The workgroup recommends providing county and state agencies with templates of materials such as Memorandums of Understanding and Data Use Agreements to support agreements between agencies and provide guidance to agencies about how and why it is important to share data to address health problems. Additionally, the workgroup recommends that initially, this process may focus on publicly available data from population survey sources including, but not limited to, the Maryland Behavioral Risk Factor Surveillance System.
>
> The workgroup recommends that the process would begin in 2018 as a pilot data sharing activity within the membership of the SB340 Workgroup.

Procedure: To facilitate the project, Team D members should work independently and in collaboration with their team members both during conference calls and in-person meetings.

Activities:
- Review Environmental Public Health Tracking Network Portal
- Identify possible data sources, such as the Maryland Behavioral Risk Factor Surveillance System
- Delineate a process for data sharing
- Identify agencies/members to be involved in pilot data sharing activity
- Initiate pilot data sharing activity

Appendix IX: April 12, 2018 Meeting Agenda

UNIVERSITY OF MARYLAND
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**University of Maryland School of Public Health, Center for Health Equity –
Workgroup on Health in All Policies Act of 2017 (SB 340/HB 1225)**

Date & Time: Thursday, April 12, 2018 from 1:00 PM to 3:00 PM
Location: Maryland Department of the Environment, 1800 Washington Blvd, Baltimore, MD 21230

Agenda

1:00 PM	**Welcome & Introductions**
1:15 PM	**Team Breakout Sessions**
1:50 PM	**Team Report-Outs (5 minutes per team)**
2:15 PM	**MDH EPHT Presentation**
2:50 PM	**Q & A**
3:00 PM	**Adjourn**

Appendix X: May 24, 2018 Meeting Agenda

UNIVERSITY OF
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University of Maryland School of Public Health, Center for Health Equity
Workgroup on Health in All Policies Act of 2017 (SB 340/HB 1225)

Date & Time: Thursday, May 24, 2018 from 1:00 PM to 3:00 PM
Location: Wilson H Elkins Building, Chancellor's Board Room, 3300 Metzerott Rd, Adelphi MD, 20783

AGENDA

1:00 PM   **Welcome & Introductions**

1:20 PM   **Content Expert Presentation**
Maryland Department of Health
Healthiest Maryland Businesses
        Kristi Pier, MHS, MCHES
        Director, Center for Chronic Disease Prevention and Control
        Caroline Green, MPH
        Community Programs Coordinator, Center for Chronic Disease Prevention
        and Control

1:45 PM   **Q & A**

2:00 PM   **Break**

2:15 PM   **Content Expert Presentation**
Department of Budget and Management
        Jamie Tomaszewski
        Chief of Procurement

2:40 PM   **Q & A**

2:55 PM   **Wrap-Up**

3:00 PM   **Adjourn**

Note: Parking is Free and Available

Appendix XI: June 28, 2018 Meeting Agenda

UNIVERSITY OF
MARYLAND
SCHOOL OF PUBLIC HEALTH
CENTER FOR HEALTH EQUITY

3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

**University of Maryland School of Public Health, Center for Health Equity –
Workgroup on Health in All Policies Act of 2017 (SB 340/HB 1225)**

Date & Time: Thursday, June 28, 2018 from 1:00 PM to 3:00 PM
Location: Wilson H Elkins Building, Chancellor's Board Room, 3300 Metzerott Rd, Adelphi MD, 20783

Agenda

1:00 PM	**Welcome**
1:15 PM	**Team Breakout Sessions**
	• Team C & Team F work together
	• Team D & Team T work together
2:15 PM	**Break**
2:30 PM	**Team Report-Outs** (15 minutes per team)
3:00 PM	**Adjourn**

Note: Parking is free and available.

Appendix XII: July 26, 2018 Meeting Agenda

UNIVERSITY OF
MARYLAND
SCHOOL OF PUBLIC HEALTH
CENTER FOR HEALTH EQUITY

3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

**University of Maryland School of Public Health, Center for Health Equity –
Workgroup on Health in All Policies Act of 2017 (SB 340/HB 1225)**

Date & Time: Thursday, July 26, 2018 from 1:00 PM to 3:00 PM
Location: Wilson H Elkins Building, Chancellor's Board Room, 3300 Metzerott Rd, Adelphi
MD, 20783

Agenda

1:00 PM	**Welcome**
1:15 PM	**Team Breakout Sessions**
	• Team C & Team F work together
	• Team D & Team T work together
2:15 PM	**Break**
2:30 PM	**Team Report-Outs** (15 minutes per team)
3:00 PM	**Adjourn**

Notes: Parking is free and available; there will not be a call in option available for this meeting.

Appendix XIII: September 27, 2018 Meeting Agenda

UNIVERSITY OF
MARYLAND
SCHOOL OF PUBLIC HEALTH
CENTER FOR HEALTH EQUITY

3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

**University of Maryland School of Public Health, Center for Health Equity –
Workgroup on Health in All Policies Act of 2017 (SB 340/HB 1225)**

Date & Time: Thursday, September 27, 2018 from 1:00 PM to 3:00 PM
Location: Wilson H Elkins Building, Chancellor's Board Room, 3300 Metzerott Rd, Adelphi
MD, 20783

Agenda

1:00 PM	**Welcome**
1:15 PM	**Team Breakout Sessions**
2:00 PM	**Break**
2:15 PM	**Team Report-Outs and Discussion**
3:00 PM	**Adjourn**

Notes: Parking is free and available; there will not be a call in option available for this meeting.

Appendix XIV: October 24, 2018 Meeting Agenda

UNIVERSITY OF
MARYLAND
SCHOOL OF PUBLIC HEALTH
CENTER FOR HEALTH EQUITY

3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

**University of Maryland School of Public Health, Center for Health Equity –
Workgroup on Health in All Policies Act of 2017 (SB 340/ HB1225)**

Date & Time: Thursday, October 25, 2018 from 1:00 PM to 3:00 PM
Location: Wilson H Elkins Building, Atrium, 3300 Metzerott Rd, Adelphi MD, 20783

Agenda

1:00 PM	**Welcome**
1:15 PM	**Team Breakout Sessions**
2:15 PM	**Break**
2:30 PM	**Team Report-Outs**
3:00 PM	**Adjourn**

Notes: Parking is free and available; there will not be a call in option available for this meeting.

Appendix XV: November 30, 2018 Meeting Agenda

UNIVERSITY OF
MARYLAND
SCHOOL OF PUBLIC HEALTH
CENTER FOR HEALTH EQUITY

3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

University of Maryland School of Public Health, Center for Health Equity –
Workgroup on Health in All Policies Act of 2017 (SB 340/HB 1225)

Date & Time: Friday, November 30, 2018 from 1:00 PM to 3:00 PM
Location: Harry Hughes Suite, Maryland Department of Transportation, 7201 Corporate Center Dr., Hanover, MD 21076

Agenda

1:00 PM	**Welcome**
1:15 PM	**Team Breakout Sessions**
2:15 PM	**Break**
2:30 PM	**Team Report-Outs**
3:00 PM	**Adjourn**

Notes: Parking is free and available; there will not be a call in option available for this meeting.

Appendix XVI: December 13, 2018 Meeting Agenda

UNIVERSITY OF
MARYLAND

SCHOOL OF PUBLIC HEALTH
CENTER FOR HEALTH EQUITY

3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

**University of Maryland School of Public Health, Center for Health Equity –
Workgroup on Health in All Policies Act of 2017 (SB 340/HB1225)**

Date & Time: Thursday, December 13, 2018 from 1:00 PM to 3:00 PM
Conference Call: +1-415-655-0002; **Access Code**: 738 535 911

Agenda

1:00 PM	**Welcome**
1:15 PM	**Review January 2019 draft report**
2:30 PM	**Discuss Next Steps**
3:00 PM	**Adjourn**

Appendix XVI: January 17, 2019 Meeting Agenda

UNIVERSITY OF
MARYLAND

SCHOOL OF PUBLIC HEALTH
CENTER FOR HEALTH EQUITY

3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

**University of Maryland School of Public Health, Center for Health Equity –
Workgroup on Health in All Policies Act of 2017 (SB 340/HB1225)**

Date & Time: Thursday January 17, 2019 from 1:00 PM to 3:00 PM
Location: James Senate Office Building, Neall Conference Room, 2nd Floor: 11 Bladen St., Annapolis, MD 21401

Agenda

1:00 PM	**Welcome & Introductions**
1:15 PM	**Final Discussion of SB340/HB1225 January 31, 2019 Report**
1:45 PM	**Voting and Acceptance for Distribution of the Report to the Maryland General Assembly**
2:00 PM	**Break**
2:15 PM	**Next Steps**

2:15 PM   **Next Steps**
In February and March, the Workgroup will have monthly team conference
     calls.
The Workgroup will focus on the opportunity to pilot the Data Sharing
     Process, the HiAP Toolkit, and the optional procurement document
     among member organizations of the Workgroup.
The Workgroup will continue to design the organizational structure of the
     Health in All Policies Council.
The in-person meeting will be held on Thursday April 25, 2019.

3:00 PM   **Adjourn**

Appendix XVII: Workgroup Members

UNIVERSITY OF MARYLAND
SCHOOL OF PUBLIC HEALTH
CENTER FOR HEALTH EQUITY

3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
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University of Maryland School of Public Health, Center for Health Equity
Workgroup on Health in All Policies Act of 2017 (SB 340)

	Name	Title	Organization	Team
1.	Senator Shirley Nathan-Pulliam	Senator	Maryland State Senate	
2.	Delegate Robbyn Lewis	Delegate	Maryland House of Delegates	
3.	Holly Arnold	Deputy Director, Planning and Programming	Maryland Transit Administration	F
4.	Cheryl Austein Casnoff, MPH	Senior Fellow	NORC at the University of Chicago	
5.	Cynthia Baur	Director, Horowitz Center for Health Literacy	School of Public Health, UMD	T
6.	Sharon Baucom	Chief Medical Director	Department of Public Safety and Correctional Services	T
7.	Noel Brathwaite	Director, Minority Health and Health Disparities	Maryland Department of Health	
8.	Veronika Carella	MD CEHC Legislative Director	Maryland Children's Environmental Health Coalition	D
9.	Jonathan Coplin	Executive Assistant to Deputy Secretary	Maryland Department of Transportation	F
10.	Monica Davis	Public Service Scholar	Maryland Department of Health	D
11.	Cheryl De Pinto, MD, MPH, FAAP	Medical Director, Office Population Health Improvement	Maryland Department of Health	T
12.	Jan Desper Peters	Executive Director	Black Mental Health Alliance	C
13.	Emily Dow, Ph.D	Assistant Secretary, Academic Affairs	Maryland Higher Education Commission	F
14.	Jennifer Eastman	Director, Community Living Policies	Maryland Department of Disabilities	F
15.	Jon Enriquez, Ph.D.	Director, Research, and Policy Analysis	Maryland Higher Education Commission	T
16.	Farah Farahati, Ph.D	Lecturer/Senior Health Economist	School of Public Health, UMD	F
17.	Rachael Faulkner	Director of Research and Policy Development	Public Policy Partners	F

18.	Lauren Gilwee	New Americans Initiative Coordinator	Maryland Department of Labor, Licensing, and Regulation, Division of Workforce Development and Adult Learning	T
19.	Kimberly Hiner, MPH	Program Administrator, Minority Health and Health Disparities	Maryland Department of Health	C
20.	Laura Howard	Senior Program Manager, Community Benefit	Kaiser Permanente	C
21.	Kimberly Jones	Director, Office of Government Affairs and Communications	Maryland Department of Health	F
22.	Karen Koski-Miller	Director of Social Work	Department of Public Safety and Correctional Services	T
23.	Andrea Lasker	Special Assistant for Policy and Program Development	Department of Public Works & Transportation Prince George's County Government	T
24.	Glenda Lindsey, Dr. P.H., M.S., R.D.N., L.D.	Nutritionist, Public Health Consultant	Maryland Academy of Nutrition and Dietetics	T
25.	Mark Luckner	Executive Director	Maryland Community of Health Resources Commission	F
26.	Ruth Maiorana	Executive Director	Maryland Association of County Health Officers	T
27.	David Marcozzi, MD, MHS-CL, FACEP	Associate Professor Director of Population Health, Department of Emergency Medicine	University of Maryland at Baltimore	D
28.	Deborah Nelson	Section Chief, Specialist	Maryland State Department of Education, School Safety and Climate, School Psychological Services	C
29.	Adeline Ntatin, MPH, MBIM, MA	Director, Community Development	Aetna Better Health of Maryland	D
30.	Devon Payne-Sturges Dr.P.H.	Assistant Professor, Maryland Institute for Applied Environmental Health	School of Public Health, UMD	D

31.	Keshia Pollack Porter, Ph.D., M.P.H.	Professor, Director, Institute for Health and Social Policy, Department of Health Policy and Management	Johns Hopkins Bloomberg School of Public Health	T
32.	Wesley Queen	Legacy Leadership Institute Coordinator, Health Services Administration, Center for Health Equity, Senior Staff for the HiAP Workgroup	School of Public Health, UMD	
33.	Steven Ragsdale, MSL	Healthcare Management & Cultural Competency Consultant	Consultant	C
34.	Dylan Roby, Ph.D	Associate Professor, Department of Health Services Administration	School of Public Health, UMD	F
35.	Dourakine Rosarion	Special Assistant, Director's Office	Maryland Association of County Health Officers	T
36.	Matthew Rowe	Assistant Director, Water and Science Administration	Maryland Department of the Environment	D
37.	Kathy Ruben	Executive Director	Consumer Health First	D
38.	Darlene Saunders	Special Projects Manager, Health & Wellness Division	Prince George's County Health Department	T
39.	Nicholette Smith-Bligen	Acting FIA Executive Director	Maryland Department of Human Resources	D
40.	Matthew Teffeau	Director, Government Relations	Maryland Department of Agriculture	C
41.	Stephen Thomas, Ph.D	Director, Center for Health Equity	School of Public Health, UMD	
42.	Tamara Toles O'Laughlin	Executive Director of Maryland Environmental Health Network	Maryland Environmental Health Network	C
43.	Caroline Varney-Alvarado	Special Assistant	Department of Housing and Community Development	C
44.	Jennifer Witten	Director of Government Relations	Maryland Hospital Association	D
45.	Elaine Zammett	Chief Staff	Office Senator Shirley Nathan-Pulliam	C
46.	Noel Brathwaite, Ph.D, MSPH	Director	Office of Minority Health and Health Disparities	C