Maryland
DEPARTMENT OF HEALTH

Maryland Commission on Health Equity 2023 Annual Report

DECEMBER 2023

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MESSAGE FROM THE CHAIR

All Marylanders deserve equitable opportunities to achieve their highest level of health. We know that there are differences in health outcomes depending on race, geography, and disability. Collectively, we can do more to eliminate these disparities. Recognizing the need to employ an all-government approach to pursuing health equity, the Maryland General Assembly passed the Shirley Nathan Pulliam Health Equity Act of 2021, which established the Maryland Commission on Health Equity. The Commission includes 26 representatives from relevant state agencies and the Maryland General Assembly. The Commission is charged with identifying a Health Equity Dataset to identify where disparities exist across state governments, and with employing a Health Equity Framework to eliminate disparities.

I am grateful for the Maryland General Assembly's foresight in passing the legislation that created the Maryland Commission on Health Equity, and I have been honored to serve as the Acting Chair since December 2022. The Commission has two supporting subcommittees to help operationalize its goals, and I am proud of the progress that has occurred this year. The Data Advisory Committee has been diligently working to identify key indicators to measure the status of health disparities statewide, and the Health Equity Policy Committee is close to identifying a Health Equity Framework for the larger Commission to consider adopting.

As we wrap up 2023, I will be stepping aside as Acting Chair of the MCHE, as Governor Moore has named Dr. Nilesh Kalyanaraman, Deputy Secretary for Public Health Services at the Maryland Department of Health, as Chair of the Commission. The Commission is energized to continue its mission over the next year, and they will begin work in the Winter of 2023 to survey all state departments to understand each agency's respective equity-related initiatives. With the full support of the Moore-Miller Administration and their commitment to "leave no Marylander behind," I am confident that the Maryland Commission on Health Equity will continue making substantial progress under Dr. Kalyanaraman's leadership. I look forward to continuing partnering with the Commission to eliminate health disparities across the state.

Sincerely,

Courtney McFadden, MPH
Acting Chair, Maryland Commission on Health Equity
Maryland Department of Health

OVERVIEW

Health equity is defined by the Centers for Disease Control and Prevention (CDC) as a state in which all people have a fair and just opportunity to achieve their highest level of health. To achieve health equity, systems should be designed to address historical and contemporary injustices; overcome economic, social, and other obstacles to health care; and eliminate health disparities.[1]

Recognizing the need for an all-government approach to address health equity, the Maryland General Assembly passed the Shirley Nathan-Pulliam Health Equity Act of 2021. This Act established the Maryland Commission on Health Equity (MCHE), which is charged with advising state officials on issues of racial, ethnic, cultural, and socioeconomic health disparities, developing a comprehensive health equity plan to address the social determinants of health, and setting goals for achieving health equity in alignment with other statewide planning activities.

To achieve the goals of the MCHE two committees were formed. The Data Advisory Committee (DAC) is statutorily required and is responsible for making recommendations on data collection, needs, reporting, evaluation, and visualization. Outlined in statute, Chesapeake Regional Information System for our Patients (CRISP), the state's Health Information Exchange (HIE), shall be leveraged to maintain the Health Equity Dataset.

The second committee, the Health Equity Policy Committee (HEPC), was established as an advisory group to the MCHE on developing and employing a Health Equity Framework, a public health planning model, for reducing health outcome disparities.

The MCHE includes representatives from 23 state agencies, the Maryland Association for County Health Officials (MACHO), and the Maryland General Assembly, and is chaired by an appointee of the Governor. A full roster outlining the departments represented can be found in Appendix I. The full commission meets quarterly and will have met four times by the end of calendar year 2023, with the supporting subcommittees meeting monthly. The format of the MCHE includes administrative updates with briefings from the respective sub-committees and questions and discussion from Commission members and attendees. The meeting minutes for meetings held in 2023 can be found in Appendix II.

[1]https://www.cdc.gov/healthequity/index.html#:~:text=Health%20equity%20is%20the%20state,their%20highest%20level%20of%20health.

SUPPORTING HEALTH EQUITY INITIATIVES

In addition to the MCHE, the State of Maryland is pursuing and implementing multiple equity-related initiatives. To align efforts statewide, the MCHE provides an opportunity for other state agencies and departments within the Maryland Department of Health (MDH) to report on initiatives for awareness, as well as to identify opportunities for collaboration. A list of supporting equity-related work can be found in Appendix III.

Health Equity Policy Committee (HEPC) Update 2023

The HEPC is charged with advising the MCHE on selecting a Health Equity Framework to employ statewide. The Health Equity Framework will be used to identify and eliminate the structural and historical health inequalities, and through implementation, is intended to support better health outcomes for Marylanders.

The HEPC has three supporting subcommittees: 1. Policy; 2. Community Inclusion; and 3. Health Equity Frameworks Review. The full HEPC met nine times in the calendar year 2023. Below are the meeting dates:

- Feb 16th
- March 23rd
- May 23rd
- June 27th
- July 25th
- August 22nd
- Sept 25th
- Oct 24th
- Nov 28th

The information below highlights the continued work of these subcommittees and provides the fundamental elements of the Health Equity Framework that will be delivered to the MCHE by March of next year.

GROUNDING THE FRAMEWORK

The HEPC leveraged subject-matter expertise, as well as reviewed literature, to identify **fundamental tenets** to guide the development of the Health Equity Framework. The tenets are identified below.

Driving Factor
Recognizing Maryland's history of structural racism and its impact on the health of the population.

Planned Outcome
Elimination of racial and other inequities to achieve a healthier Maryland.

Approach
Data-driven, community-informed, intersectional, policy-centered, community-empowered, inter-agency coordinated, technologically and informationally current.

Principles
Grounded in social and structural determinants of health, community and culturally responsive, transparent, embedded in the fabric of state operations.

In addition to the fundamental tenets, the HEPC identified critical elements that could be considered to support the successful implementation of the Health Equity Framework, including:

- A coordinating and monitoring unit with a direct report to the Governor's Office.
- Publicly available data dashboard with equity indicators that promote action and continuous quality improvement.
- Engagement strategies that support early and meaningful feedback and input from all stakeholders, including individuals and community organizations.
- An expectation of "Health in All Policies" (HIAP), along with requirements for agency HIAP implementation and reporting.
- A state budget appropriation for health equity analysis with public reporting.

DRAFTING THE MARYLAND HEALTH EQUITY FRAMEWORK MODEL

The Health Equity Frameworks Review Subcommittee reviewed existing frameworks from the Centers for Medicare and Medicaid Services (CMS), California, Massachusetts, and Washington. Based on the Subcommittee's assessment, they found the Massachusetts model as the best model to guide the development of Maryland's Health Equity Framework.

The Subcommittee reviewed the Massachusetts model to identify which core strategies resonated with the Health Equity Framework envisioned for Maryland. Four essential strategies emerged:

1. **Accountability**: Oversight with clear implementation and performance metrics.
2. **Research and data**: Appropriate metrics for outcomes and intervening measures.
3. **Community connectedness**: Assuring relationships and input with stakeholders outside of state government – institutions, organizations, corporations, and people.
4. **Coordination**: State agency-level to include an interagency council.

The HEPC also emphasized the need for resources, specifically dedicated funding for data collection and data system maintenance, and the need to partner with Medicaid to support health-related initiatives.

COMPLETING THE FRAMEWORK

To complete the work, the Committee has developed the following plan of action:

1) Complete Transportation Health Policy Analysis utilizing a health policy toolkit.
2) Assess community perspectives on health equity frameworks from Maryland residents and organizations sampled from regions across the state.
3) Assess existing equity-related programs, policies, and activities within each Maryland State agency (Including digital survey and Point of Contact structured interviews).
4) Draft and finalize recommended Maryland Health Equity Action Framework.

The final Health Equity Framework will include specified outcomes that align with the Health Equity Dataset identified by the DAC. The proposed Health Equity Framework will also include recommended actions and an implementation plan that addresses the necessary infrastructure and processes that will be needed for sustainability.

The broad timeline proposed for the above-listed items is as follows:

DATA ADVISORY COMMITTEE (DAC) UPDATE 2023

Legislative Data Analysis Request

The DAC is a statutorily mandated function of the MCHE. The charge of the DAC is to coordinate with Maryland's state-designated HIE, CRISP, to make recommendations on data collection, needs, quality, reporting, evaluation, and visualization to support the work of the MCHE. Additionally, the DAC shall identify a Health Equity Dataset, which are the indicators that will be used to measure health equity over time. The dataset shall be maintained by CRISP.

A comparison and crosswalk of the data elements requested by various sections of the legislation and the data elements collected and analyzed to date in this report is shown in the table below.

Table 1. Data Crosswalk

Table 1. Data Crosswalk			
Framework Indicators (pages 9-10 of the bill)	**Indicators for the 2023 report (page 13 of the bill)**	**Indicator types for the Dataset (pages 11-12 of the bill)**	**Available Indicators to date, included in this report**
Housing	Housing	Social	
Education	Education	Social	% of adults without High School Diploma or General Education Development (GED)
Employment	Employment	Economic	% Unemployed
Economic Stability	Socio-economic	Economic	Median Household Income % of Children in Poverty
Workplace Diversity Equity and Inclusion (DEI)	Workplace DEI	Economic	
Workplace Barriers	Workplace Barriers	Economic	
Transportation	Transportation	Social	
Social Justice		Social	
Environmental Factors	Environmental Factors	Environmental	
Public Safety & Justice System	Violence	Social	
Food Insecurity		Social	% on Supplemental Nutrition Assistance Program (SNAP) Benefits
	Homelessness	Social	
	Medically Underserved Communities	Health Care	% without Health Insurance
		Behaviors	Drug Overdose Death Rate

Table 1. Data Crosswalk			
		Health Status Priority Indicators	Years of Potential Life Lost Diabetes Death Rate Avoidable Admission Rate Low Birth Weight Rate Drug Overdose Death Rate

Data Advisory Committee Process

The DAC was assembled to consist of health equity experts in both data and policy from state government, academia, and community-based organizations. The DAC provides advice and guidance to the MCHE, MDH, and the HIE on data collection methods, items of data for inclusion in the Health Equity Dataset and analytic approaches to be applied to the Health Equity Dataset.

The DAC has held meetings on the following dates:

- February 8, 2022
- May 18, 2022
- July 12, 2022
- November 2, 2022
- February 7, 2023
- May 16, 2023

The DAC reviewed presentations by MDH and CRISP staff regarding data that were available and analytic approaches for the required 2023 data report, and regarding long-term plans for assembling a more comprehensive person-level data set combining social factor data with health outcome data.

The DAC agreed to the analytic plan of this report, which is the analysis of race/ethnic-specific, county-level data to determine associations between social factors and health outcomes. This was recognized as an initial exploratory step, to be followed by a more comprehensive analysis in a person-level dataset that has not been assembled.

To execute this approach, MDH and CRISP identified a small group of data experts within their organizations who could identify data, assemble data, and identify a data analytics plan. Small working groups of these data experts met bi-weekly to identify and execute the action steps of the process.

DATA METHODS

Race/Ethnic-Specific County-Level Analysis Approach

As a result of limitations in the availability of data analysis staff and dedicated funding for this effort, the scope of this initial data exploration due in 2023 needed to be limited to an analysis of readily available data. Person-level data, the optimal way to approach answering this association question, were not available for this report. This resulted in a geographic-level data (counties, ZIP codes, or census tracts) approach.

Because of an interest in performing this analysis separately in the major racial/ethnic groups defined in Federal Office of Management and Budget (OMB) Directive 15 (White, Black or African American, Asian, American Indian or Alaska Native , and Native Hawaiian or Other Pacific Islander groupings for race, and Hispanic or Latino vs. not Hispanic or Latino for ethnicity), it was decided to pursue a race/ethnic-specific analysis of jurisdiction-level data from available sources. Race/ethnic-specific data for smaller geographic areas were not readily available. Insufficient data were available for jurisdiction-level analysis of the Native Hawaiian or Other Pacific Islander population of Maryland.

The data for 11 items (five social factors, five health outcomes, and the health uninsurance rate [which functions as both a social factor and as a health outcome]) are presented in the sections that follow.

Also presented are summary findings of correlation analysis performed on pairs of these factors. Thirty-five such analyses were done (data permitting) for each race/ethnic group using six social factors and six health outcomes (6 x 6 = 36, minus the unnecessary pairing of health uninsurance with itself).

Social Determinants of Health (SDOH) and Health Outcome Variables Selected for Analysis

The DAC and data analysts at MDH and CRISP selected the six social factors and six health outcomes for this initial associative analysis of how social factors impact health outcomes in Maryland. The criteria for selecting these factors were as follows:

- Race/ethnic-specific data could be provided for the social factor or the health outcome.
- The social factors were generally known to or expected to have an impact on health outcomes.
- The health outcomes were important areas of health disparities.
- The health outcomes, where possible, were related to the outcomes tracked in Maryland's Statewide Integrated Health Improvement Strategy (SIHIS).

Not all the social factors enumerated in the legislation had readily available data that is race/ethnic-specific at the jurisdiction level, and so not all the 11 enumerated social factors are represented in this initial analysis. Race/ethnic-specific data were generally not readily available for geographic areas smaller than jurisdictions. Race/ethnic agnostic analysis of social factors at the level of ZIP codes and census tracts could be pursued in the future from existing data. Race/ethnic-specific analysis at the level of ZIP codes and census tracts would require the assembly of a comprehensive person-level data set.

In most cases, multiple years of data were pooled together (standard practice for American Community Survey, America's Health Rankings, and County Health Rankings) to create more stable data in the small population groups (small race/ethnic groups in small jurisdictions). Even so, there are instances where data were too statistically unreliable to be reportable, leaving missing data in our analysis.

The six social factors and the six health outcomes, along with their data sources and the years of data used, are listed in the next section. The rate of health uninsurance is used both as a social factor to predict health outcomes, and as a health outcome because it occupies a middle position in a series of steps linking social factors to many other health outcomes.

Data Sources and Years of Data for the Analysis

Race-specific jurisdiction-level values or rates for the following variables were analyzed:

Social Factors

Median household income (the income that half of households are above, and half are below)

- Source/Years: County Health Rankings 2022, using Small Area Income and Poverty Estimates 2020

Percent of children < age 18 in poverty

- Source/Years: County Health Rankings 2022, using Small Area Income and Poverty Estimates 2020

Unemployment rate

- Source/Years: American Community Survey Data 2016-2020

Percent of adults 25+ without a high school diploma or GED

- Source/Years: American Community Survey Data 2016-2020

Percent of households on SNAP benefits

- Source/Years: American Community Survey Data 2016-2020

Percent of people without health insurance

- Source/Years: American Community Survey Data 2016-2020

Health Outcomes

Age-adjusted Years of Potential Life Lost (YPLL) (Years before age 75 lost for deaths younger than 75)

- Source/Years: County Health Rankings 2022, using National Center for Health Statistics mortality files 2018-2020

Age-adjusted diabetes death rate

- Source/Years: CDC WONDER underlying cause of death files, online data query tool, 2011-2020

Unadjusted avoidable admission rate (multiple causes), using the AHRQ PQI-90 measure.

- Source/Years: PQI-90 measure from HSCRC/CRISP data 2016-2020

Percent of babies born at low birth weight

- Source/Years: County Health Rankings 2022, using National Center for Health Statistics natality files 2014-2020

Unadjusted drug overdose death rate

- Source/Years: County Health Rankings 2022, using National Center for Health Statistics mortality files 2018-2020

Percent of people without health insurance

- Source/Years: American Community Survey Data 2016-2020

Data Limitations

Limitations of Geographic-Level Correlation Analysis

Correlation analysis of geographic-level data using average rates for places (jurisdictions in this case) is a coarser approach to analysis than person-level data analysis (if it were available). As a result, the associations of social factors with health outcomes may be underestimated compared to what analysis would reveal in person-level data.

Correlation geographic-level analysis also often mixes data on health outcomes from one data source with data on social factors from a different data source. It is possible

that the people experiencing an adverse social factor may not be the same people who are experiencing the adverse health outcome. This may occasionally result in correlation analysis showing relationships that differ from the actual relationships in the population.

Statistical Variability for Small Groups or Places

Data may have a lot of imprecision (large margins of error) in populations of small size, such as small racial/ethnic groups, or small jurisdictions, and especially small racial/ethnic groups in small jurisdictions. This is particularly true for data that comes from sampling a small part of the population and then extrapolating to the whole population.

Data that come from the entire population, such as death data and hospital utilization data, don't have the sampling variation issue of sample data, but can still exhibit a lot of year-to-year variation for small populations.

These two kinds of data instability especially affect Maryland's smaller racial/ethnic populations: Hispanics, Asians, American Indians/Alaska Natives, and Native Hawaiians/Other Pacific Islanders. The approach of pooling multiple years of data is an attempt to reduce these data instability and data reportability issues.

Data Limitations of Specific Data Sources

Vital Statistics death data typically show lower-than-expected death rates for Hispanics, Asian/Pacific Islanders, and American Indians/Alaska Natives. This may be a result of inaccurate recording of race/ethnicity on death certificates for these groups. An additional factor for groups where a high proportion of foreign-born is the return to their birthplace with aging or the development of illness. This selective emigration of a less healthy portion of those populations will cause the death rates to be lower than would be the case without that emigration.

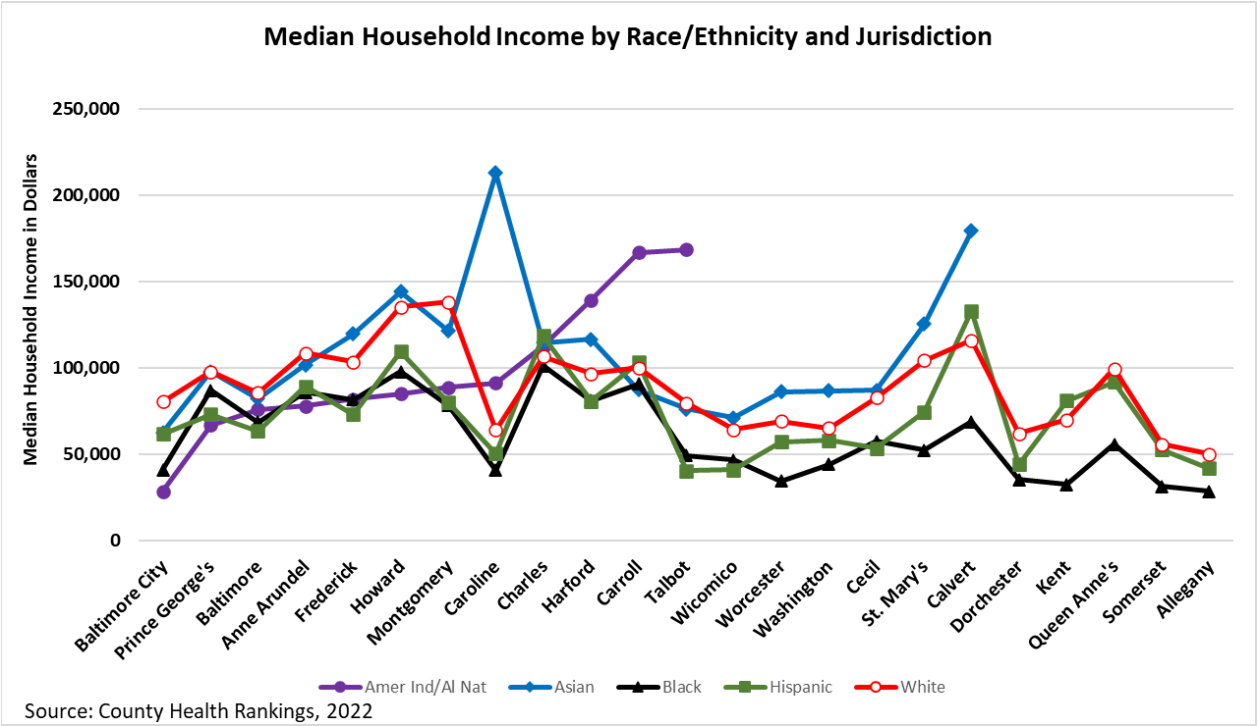
American Community Survey Data is data collected annually from a sample of the US population by the US Census Bureau. Because of the margin of error issues in survey data, there can be a lot of uncertainty about the values produced by the survey for small groups (small racial/ethnic groups, or small jurisdictions, and especially small racial/ethnic groups in small jurisdictions).

Race/Ethnic by Jurisdiction Levels of Selected Social Factors

Median Household Income

Median Household Income is the income level in dollars that divides the group in half, meaning half of the households in the group have a household income below the median value, and half of the households in the group have an income above the median value.

Figure 1. Median Household Income by Race/Ethnicity in Maryland



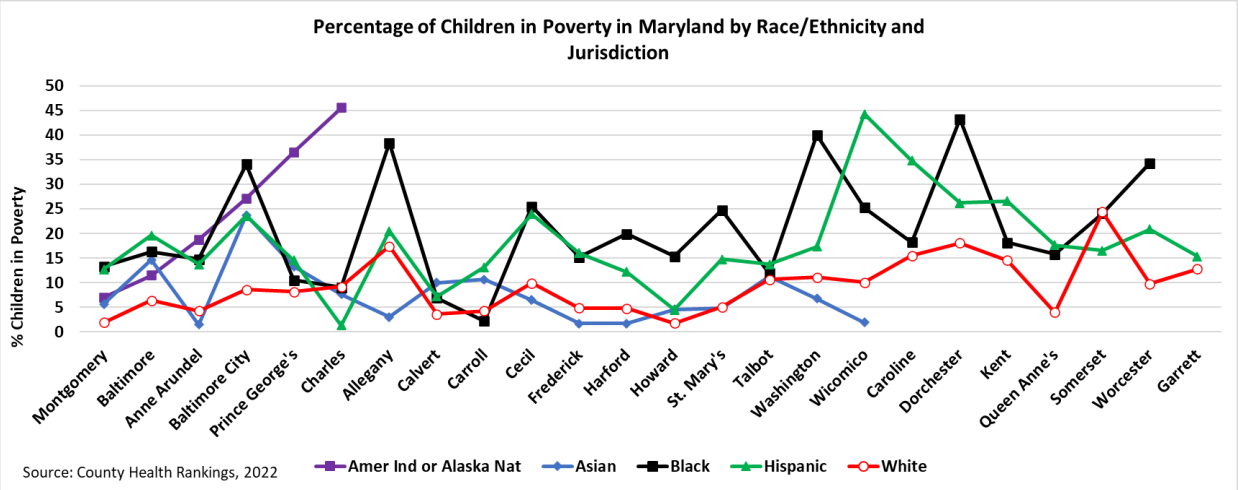
Source: County Health Rankings, 2022

Key Findings:

- Compared to Whites, income for Blacks and Hispanics is generally lower.
- Compared to Whites, income for Asians is generally similar or higher.
- Compared to Whites, income for American Indians/Alaska Natives is lower in some places and higher in other places.
- There is a lot of geographic variability in median household income for each racial/ethnic group.
- The lowest income is seen for **Blacks in Allegany County ($28,676)** and the highest income is seen for **Asians in Caroline County ($212,857).**
- **For American Indians or Alaska Natives**, the lowest income is seen in **Baltimore City ($28,750)** and the highest income is seen in **Talbot County ($168,542).**
- **For Asians**, the lowest income is seen in **Baltimore City ($62,667)** and the highest income is seen in **Caroline County ($212,857).**
- **For Blacks**, the lowest income is seen in **Allegany County ($28,676)** and the highest income is seen in **Charles County ($101,269).**
- **For Hispanics**, the lowest income is seen in **Talbot County ($40,513),** and the highest income is seen in **Calvert County ($133,047).**
- **For Whites,** the lowest income is seen in **Allegany County ($50,288)** and the highest income is seen in **Montgomery County ($138,044).**

Child Poverty

Figure 2. Percentage of Children in Poverty by Race/Ethnicity in Maryland

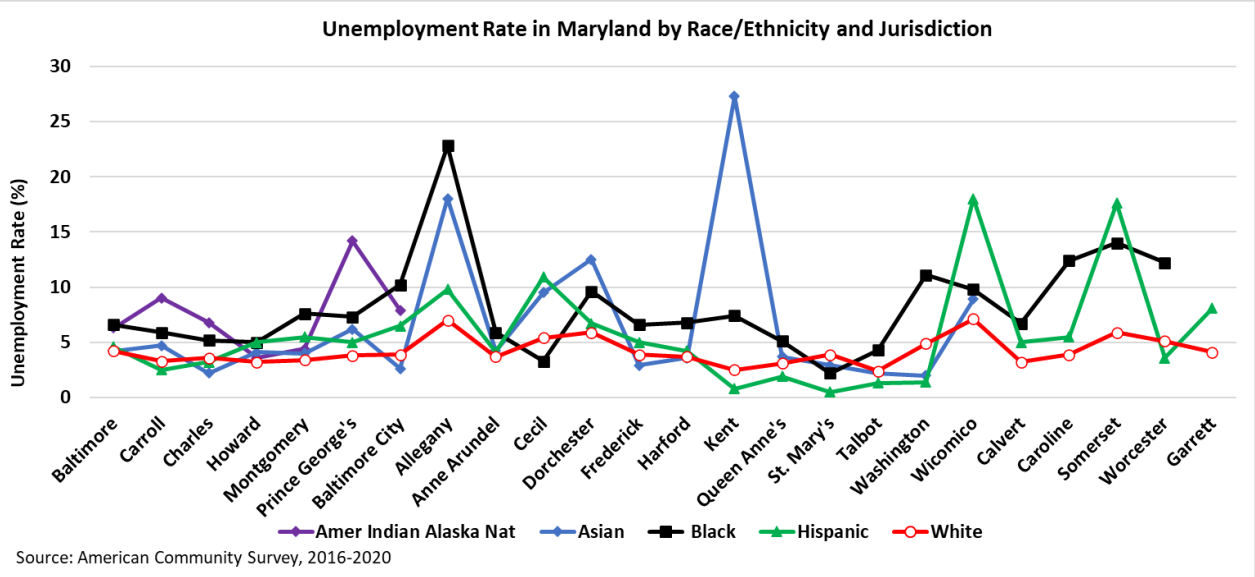


Key Findings:

- Compared to Whites, child poverty for Blacks, Hispanics, and American Indians or Alaska Natives is generally higher.
- Compared to Whites, child poverty for Asians is generally similar, with some exceptions in both directions.
- There is a lot of geographic variability in child poverty for each racial/ethnic group. The variability is greater for Blacks, Hispanics, and American Indians or Alaska Natives.
- The lowest percentage of child poverty is seen for **Hispanics in Charles County (1.36%)** and the highest percentage is seen for **American Indians or Alaska Natives in Charles County (45.53%).**
- **For American Indians or Alaska Natives**, the lowest rate of child poverty is seen in **Montgomery County (7.00%)** and the highest rate is seen in **Charles County (45.53%).**
- **For Asians**, the lowest rate of child poverty is seen in **Anne Arundel County (1.49%)** and the highest rate is seen in **Baltimore City (23.73%).**
- **For Blacks**, the lowest rate of child poverty is seen in **Carroll County (2.24%)** and the highest rate is seen in **Dorchester County (43.23%).**
- **For Hispanics**, the lowest rate of child poverty is seen in **Charles County (1.36%),** and the highest rate is seen in **Wicomico County (44.31%).**
- **For Whites,** the lowest rate of child poverty is seen in **Howard County (1.79%),** and the highest rate is seen in **Somerset County (24.37%).**

Unemployment Rate

Figure 3. Unemployment Rate by Race/Ethnicity and Jurisdiction in Maryland



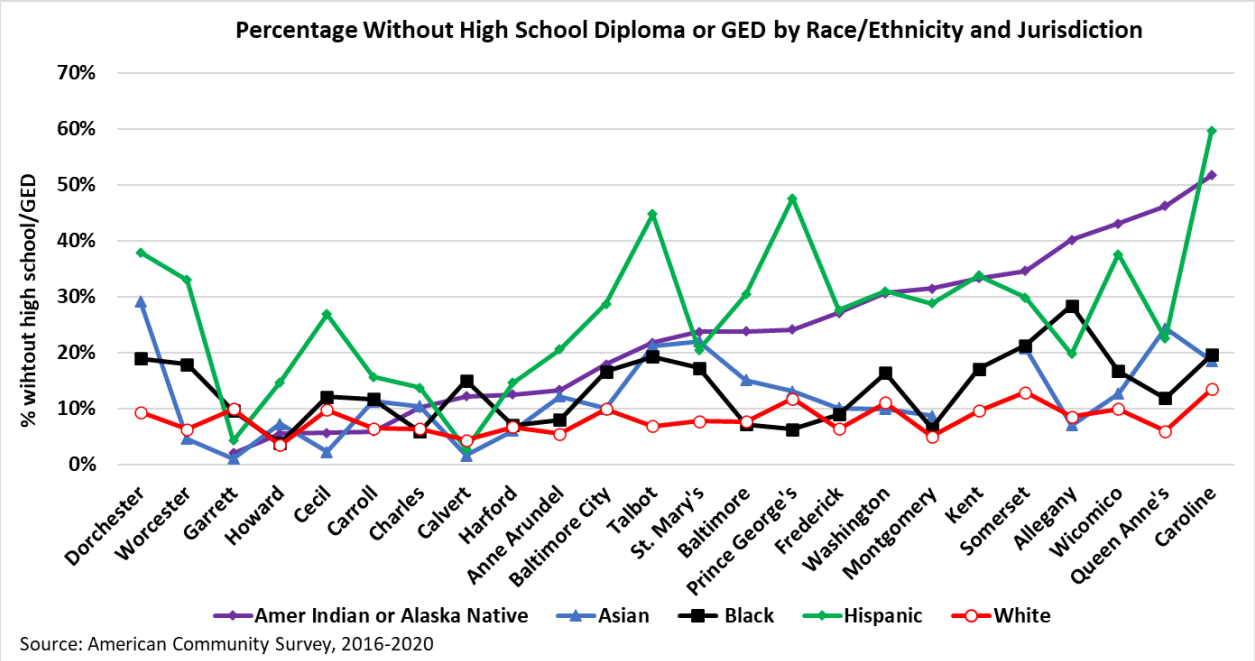
Source: American Community Survey, 2016-2020

Key Findings:

- Compared to Whites, unemployment for Blacks and American Indians or Alaska Natives is generally higher.
- Compared to Whites, unemployment for Hispanics and Asians is similar in some places and higher in others.
- There is a lot of geographic variability in unemployment for non-White racial/ethnic groups.
- The lowest percentage of unemployment is seen for **Hispanics in St. Mary's County (0.5%)** and the highest percentage is seen for **Asians in Kent County (27.3%).**
- **For American Indians or Alaska Natives**, the lowest rate of unemployment is seen in **Howard County (3.6%)** and the highest rate is seen in **Prince George's County (14.2%).**
- **For Asians**, the lowest rate of unemployment is seen in **Charles County (2.2%),** and the highest rate is seen in **Kent County (27.3%).**
- **For Blacks**, the lowest rate of unemployment is seen in **St. Mary's County (2.2%),** and the highest rate is seen in **Allegany County (22.8%).**
- **For Hispanics**, the lowest rate of unemployment is seen in **St. Mary's County (0.5%),** and the highest rate is seen in **Wicomico County (18.0%).**
- **For Whites,** the lowest rate of unemployment is seen in **Talbot County (2.4%),** and the highest rate is seen in **Wicomico County (7.1%).**

Percent without High School Diploma or GED

Figure 4. Percentage Without High School Diploma by Race/Ethnicity in Maryland



Source: American Community Survey, 2016-2020

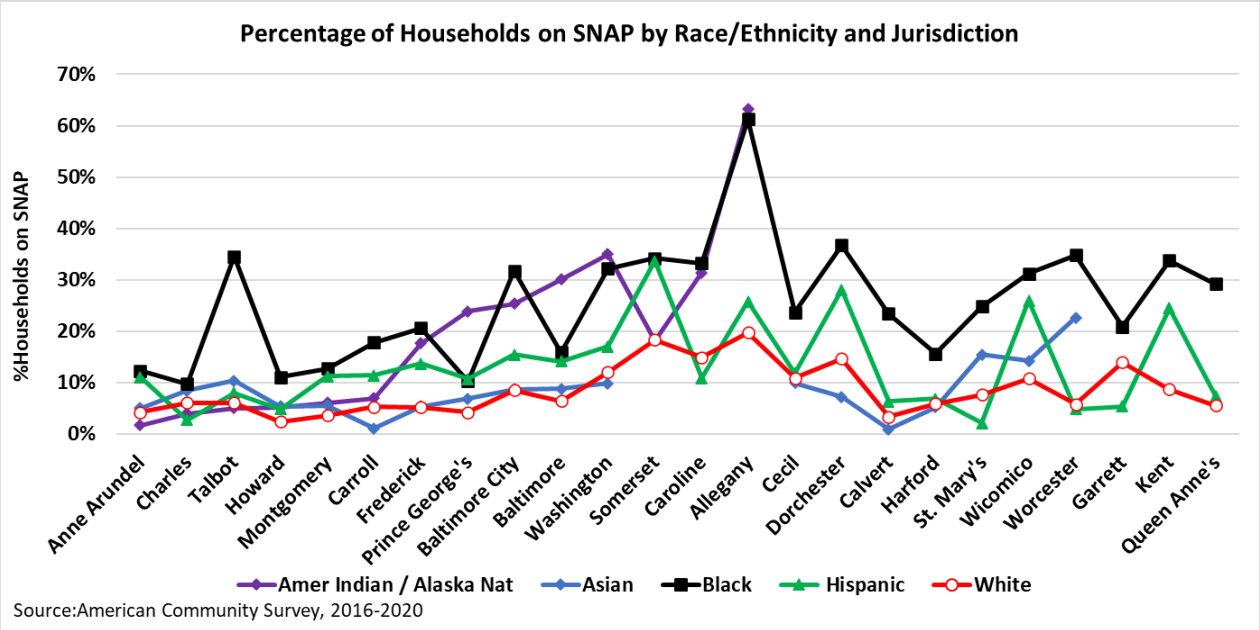
Key Findings:

- Compared to Whites, no High School Diploma/GED for Blacks, Hispanics and American Indians or Alaska Natives is generally higher.
- Compared to Whites, no High School Diploma/GED for Asians is similar in some places and higher in others.
- There is a lot of geographic variability in no High School Diploma/GED for non-White racial/ethnic groups.
- The lowest percentage of no High School Diploma/GED is seen for **Asians in Garrett County (1.1%)** and the highest percentage is seen for **Hispanics in Caroline County (59.6%).**
- **For American Indians or Alaska Natives**, the lowest rate of no High School Diploma/GED is seen in **Garrett County (2.0%),** and the highest rate is seen in **Caroline County (51.7%).**
- **For Asians**, the lowest rate of no High School Diploma/GED is seen in **Garrett County (1.1%),** and the highest rate is seen in **Dorchester County (29.2%).**
- **For Blacks**, the lowest rate of no High School Diploma/GED is seen in **Howard County (3.8%),** and the highest rate is seen in **Allegany County (28.4%).**
- **For Hispanics**, the lowest rate of no High School Diploma/GED is seen in **Calvert County (2.8%),** and the highest rate is seen in **Caroline County (59.6%).**

- **For Whites,** the lowest rate of no High School Diploma/GED is seen in **Howard County (3.5%),** and the highest rate is seen in **Caroline County (13.5%).**

Percent of Households Receiving SNAP Benefits

Figure 5. Percentage of Households on SNAP by Race/Ethnicity and Jurisdiction



Source:American Community Survey, 2016-2020

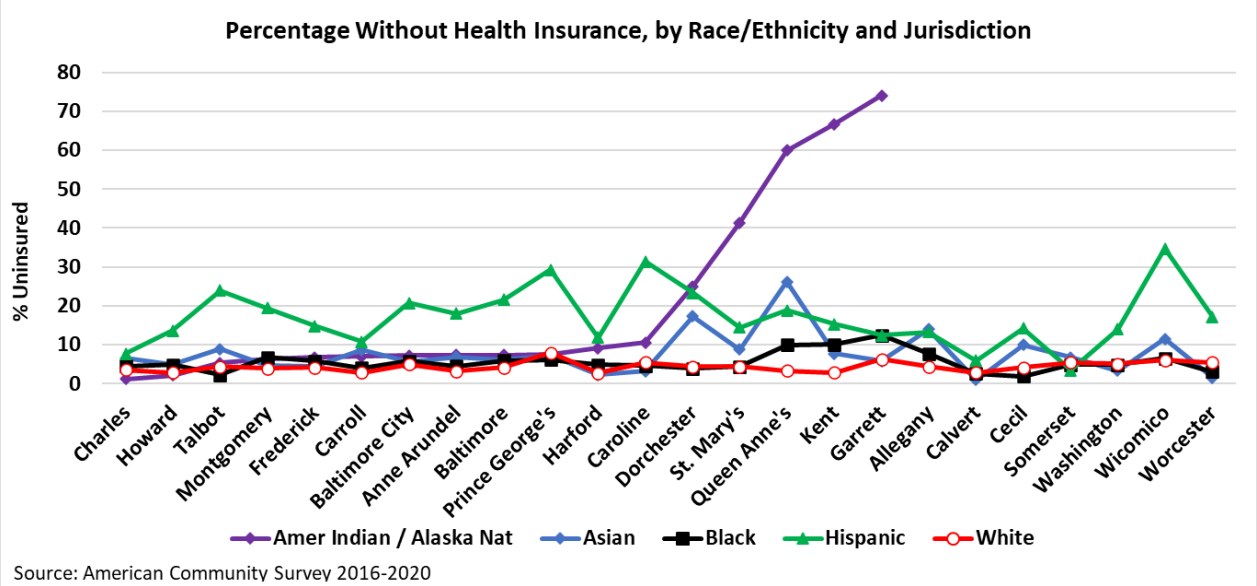
Key Findings:

- Compared to Whites, the % receiving SNAP for Blacks is generally higher.
- Compared to Whites, the % receiving SNAP for Asians is generally similar but is higher in a few jurisdictions.
- Compared to Whites, the % receiving SNAP for Hispanics and for American Indians or Alaska Natives is sometimes similar and sometimes higher.
- There is a lot of geographic variability in % receiving SNAP for non-White racial/ethnic groups.
- The lowest percentage receiving SNAP is seen for **Asians in Calvert County (0.9%)** and the highest percentage is seen for **American Indians or Alaska Natives in Allegany County (63.2%).**
- **For American Indians or Alaska Natives**, the lowest % receiving SNAP is seen **in Anne Arundel County (1.7%)** and the highest rate is seen in **Allegany County (63.2%).**
- **For Asians**, the lowest % receiving SNAP is seen in **Calvert County (0.9%),** and the highest rate is seen in **Worcester County (22.6%).**
- **For Blacks**, the lowest % receiving SNAP is seen in **Charles County (9.8%),** and the highest rate is seen in **Allegany County (61.3%).**

- **For Hispanics**, the lowest % receiving SNAP is seen in **St. Mary's County (2.2%),** and the highest rate is seen in **Somerset County (33.7%).**
- **For Whites,** the lowest rate of % receiving SNAP is seen in **Howard County (2.4%),** and the highest rate is seen in **Allegany County (19.8%).**

Percent Without Health Insurance

Figure 6. Percentage Without Health Insurance in Maryland



Source: American Community Survey 2016-2020

Key Findings:

- Compared to Whites, % without health insurance for Hispanics is generally higher.
- Compared to Whites, % without health insurance for Asians, Blacks, and American Indians or Alaska Natives is similar in some places, and higher in others.
- There is a lot of geographic variability in % without health insurance for Asians, Hispanics, and American Indians or Alaska Natives.
- The lowest percentage without health insurance is seen for **Asians in Calvert County (0.9%)** and the highest percentage is seen for **American Indians or Alaska Natives in Garrett (74.0%).**
- **For American Indians or Alaska Natives**, the lowest % without health insurance is seen in **Charles County (1.2%),** and the highest rate is seen in **Garrett County (74.0%).**
- **For Asians**, the lowest % without health insurance is seen in **Calvert County (0.9%),** and the highest rate is seen in **Queen Anne's County (26.2%).**

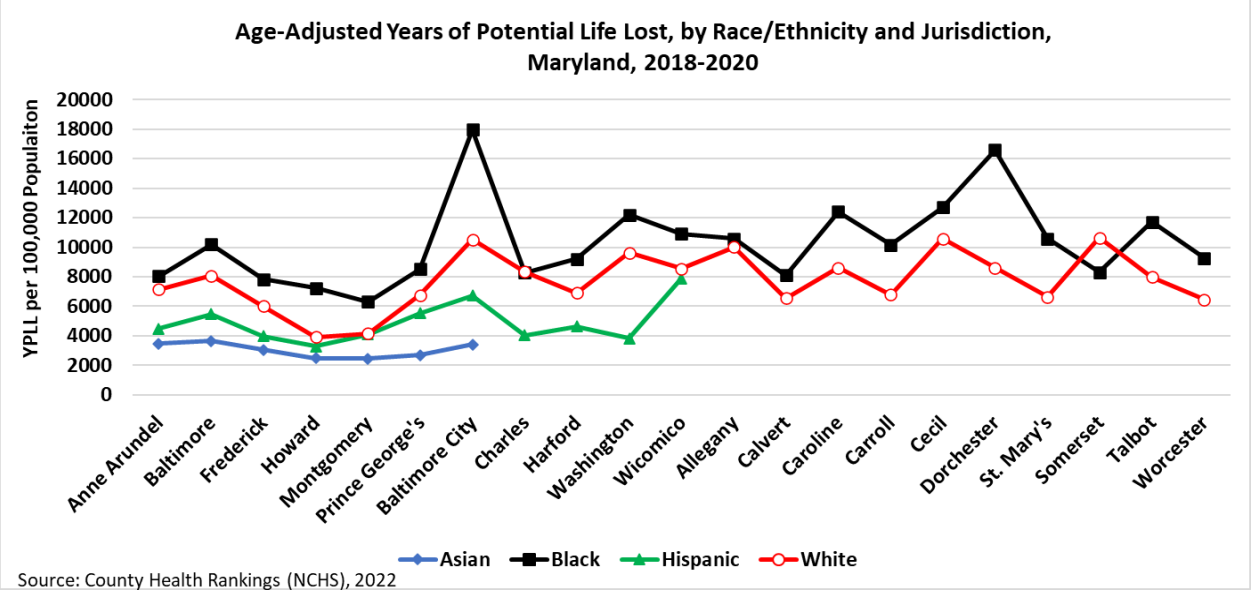
- **For Blacks**, the lowest % without health insurance is seen in **Cecil County (1.9%),** and the highest rate is seen in **Garrett County (12.4%).**
- **For Hispanics**, the lowest % without health insurance is seen in **Somerset County (3.4%)** and the highest rate is seen in **Wicomico County (34.7%).**
- **For Whites,** the lowest % without health insurance is seen in **Harford County (2.7%),** and the highest rate is seen in **Prince George's County (7.9%).**

Race/Ethnic by Jurisdiction Levels of Selected Health Outcomes

Age-adjusted Years of Potential Life Lost

Years of Potential Life Lost (YPLL) is the sum of all the years between age 75 and the age at death that are lost for all deaths that happen before age 75. For example, one infant death at one month of age would contribute 75 lost years to the YPLL count. This makes YPLL the opposite of life expectancy: more years of life expectancy is the desirable outcome, while fewer years of potential life lost is the desirable outcome. For this analysis, the YPLL is age-adjusted (to fairly compare racial/ethnic groups that have different age patterns) and shown as a rate per 100,000 people in the population.

Figure 7. Age-Adjusted Years of Potential Life Lost in Maryland



Source: County Health Rankings (NCHS), 2022

Key Findings:

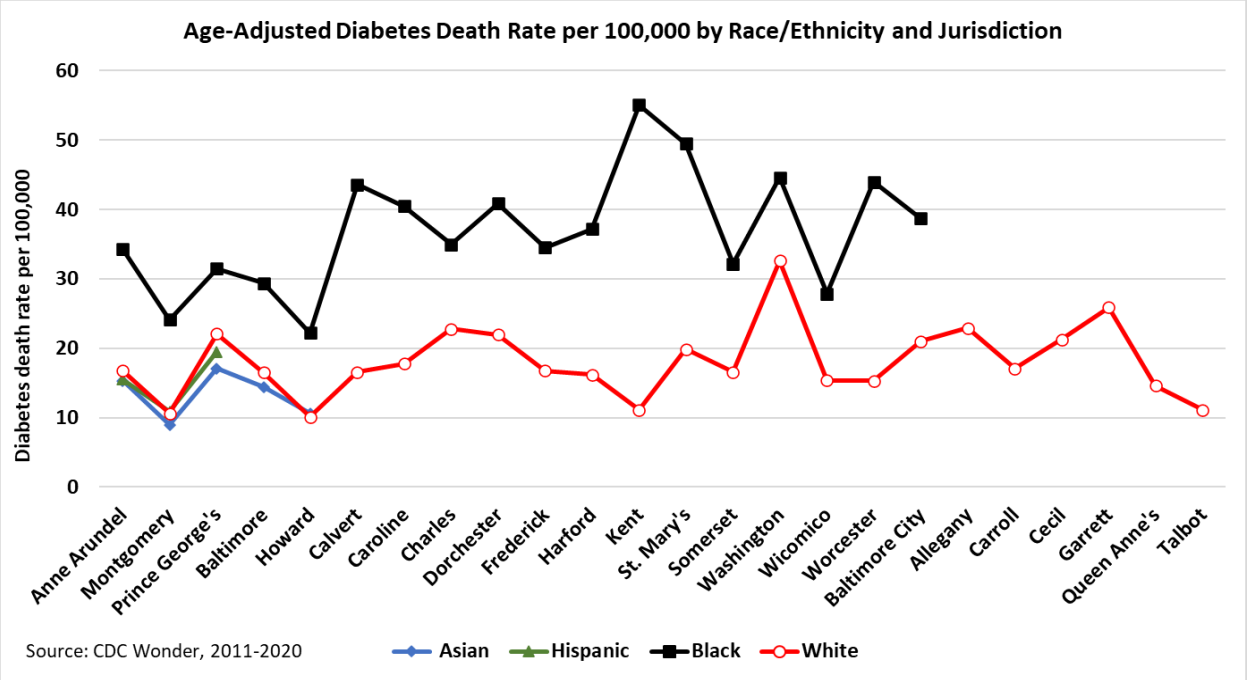
- Compared to Whites, the YPLL rate for Blacks is generally higher.
- Compared to Whites, the YPLL rate for Asians and Hispanics is generally lower. This may be due to some underestimation factors for death rates that are seen in groups with many foreign-born people.

- The data were not reported for American Indians or Alaska Natives.
- There is a lot of geographic variability in the YPLL rate for Blacks, Hispanics, and Whites.
- The lowest YPLL rate is seen for **Asians in Montgomery County (2,459)** and the highest rate is seen for **Blacks in Baltimore City (17,967).**
- **For Asians**, the lowest YPLL rate is seen in **Montgomery County (2.459),** and the highest rate is seen in **Baltimore County (3,659).**

- **For Blacks**, the lowest YPLL rate is seen in **Montgomery County (6,321),** and the highest rate is seen in **Baltimore City (17,967).**
- **For Hispanics**, the lowest YPLL rate is seen in **Howard County (3,290),** and the highest rate is seen in **Wicomico County (7,882).**
- **For Whites,** the lowest YPLL rate is seen in **Howard County (3,913),** and the highest rate is seen in **Somerset County (10,651).**

Age-Adjusted Diabetes Death Rate

Figure 8. Age-Adjusted Diabetes Death Rate in Maryland



Key Findings:

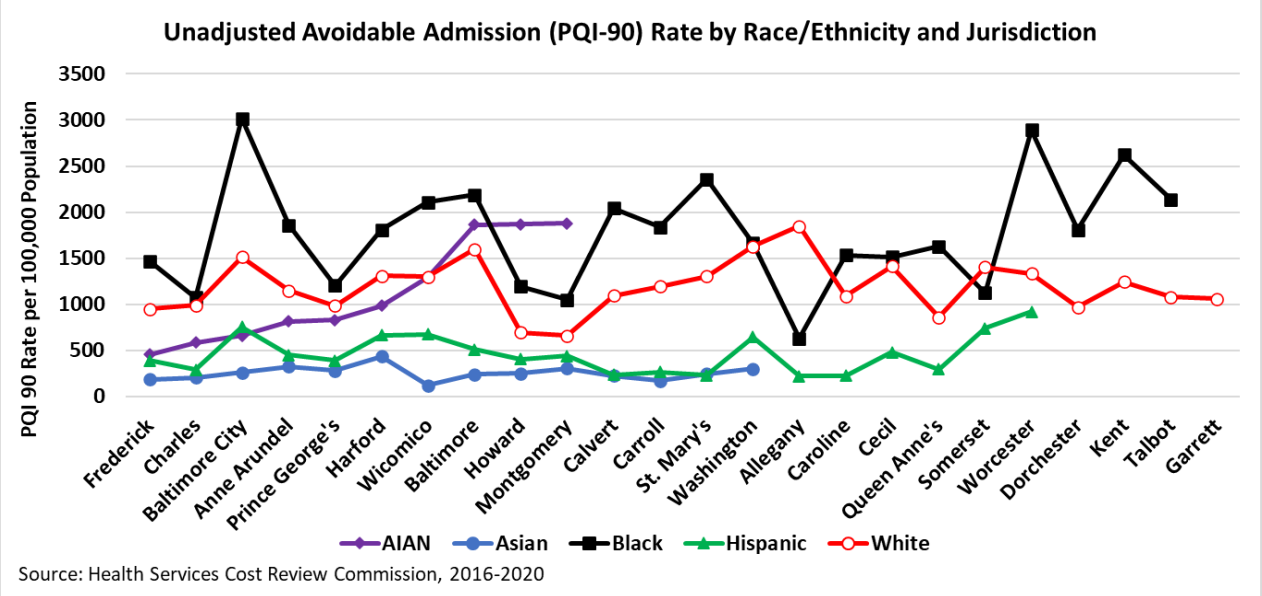
- Compared to Whites, the diabetes death rate for Blacks is higher, sometimes substantially so.
- Compared to Whites, the diabetes death rate for Asians and Hispanics is generally similar. This may be due to some underestimation factors for death rates that are seen in groups with many foreign-born people.

- The data were not reportable for American Indians or Alaska Natives.
- There is a lot of geographic variability in the diabetes death rates for each of the groups.
- The lowest diabetes death rate is seen for **Asians in Montgomery County (9.0)** and the highest rate is seen for **Blacks in Kent County (55.1).**
- **For Asians**, the lowest diabetes death rate is seen in **Montgomery County (9.0)** and the highest rate is seen in **Prince George's County (17.1).**
- **For Blacks**, the lowest diabetes death rate is seen in **Howard County (22.2)** and the highest rate is seen in **Kent County (55.1).**
- **For Hispanics**, the lowest diabetes death rate is seen in **Montgomery County (10.9)** and the highest rate is seen in **Prince George's County (19.5).**
- **For Whites,** the lowest diabetes death rate is seen in **Howard County (10.1)** and the highest rate is seen in **Washington County (32.6).**

Unadjusted Avoidable Admission Rate (PQI-90)

Avoidable admissions are hospital admissions for reasons that should be preventable with the delivery of primary care. Such reasons are referred to as Ambulatory Care Sensitive Conditions (ACSCs), which the Agency for Healthcare Research and Quality (AHRQ) also uses as their Prevention Quality Indicators (PQIs). PQI-90 is a composite indicator that combines all the other PQIs together.

Figure 9. Unadjusted Avoidable Admissions in Maryland



Source: Health Services Cost Review Commission, 2016-2020

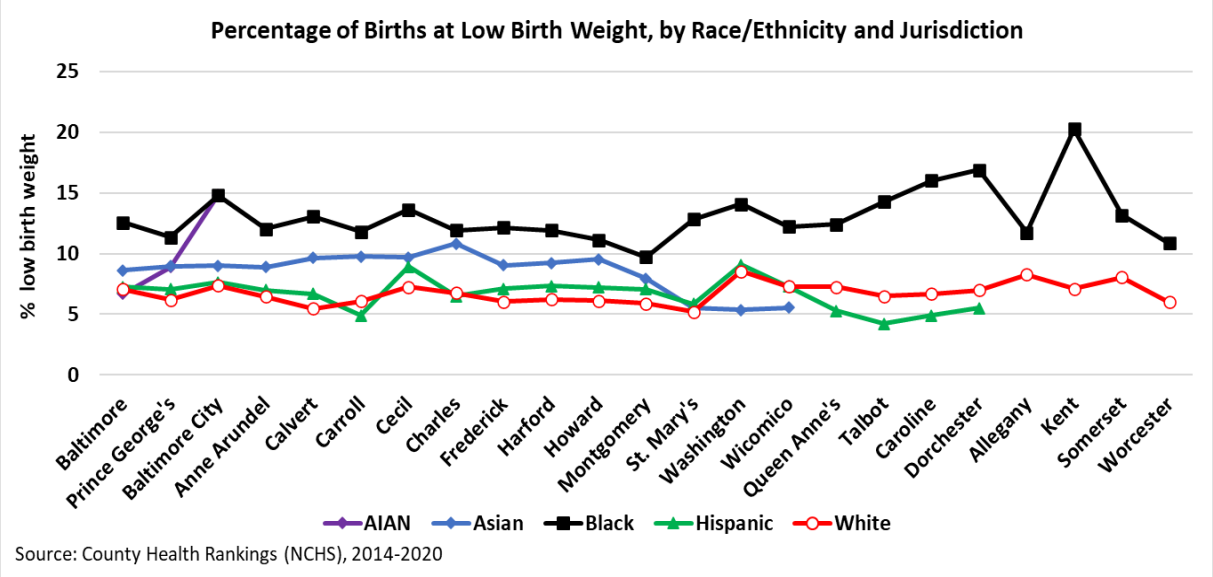
Key Findings:

- Compared to Whites, the avoidable admission rate for Blacks is higher, sometimes substantially.

- Compared to Whites, the avoidable admission rate for Asians and Hispanics is generally lower. This may be due to the lack of age-adjustment, and/or due to lower utilization in populations with higher rates of health uninsurance (reflecting a cost barrier, rather than better health).
- Compared to Whites, the rate for American Indians or Alaska Natives is mixed
- There is a lot of geographic variability in the avoidable admission rates for all groups.
- The lowest avoidable admission rate is seen for **Asians in Wicomico County (121)** and the highest rate is seen for **Blacks in Baltimore City (3,016).**
- **For American Indians or Alaska Natives**, the lowest avoidable admission rate is seen in **Frederick County (455)**, and the highest rate is seen in **Montgomery County (1,881).**
- **For Asians**, the lowest avoidable admission rate is seen in **Wicomico County (121)**, and the highest rate is seen in **Harford County (435).**
- **For Blacks**, the lowest avoidable admission rate is seen in **Allegany County (633),** and the highest rate is seen in **Baltimore City (3,016).**
- **For Hispanics**, the lowest avoidable admission rate is seen in **Allegany County (222),** and the highest rate is seen in **Worcester County (918).**
- **For Whites,** the lowest avoidable admission rate is seen in **Montgomery County (661)** and the highest rate is seen in **Allegany County (1,851).**

Low Birth Weight Rate

Figure 10. Low Birth Weight Rate in Maryland



The low birth weight (LBW) rate is the percentage of all live births that have a weight of less than 2500 grams (5 pounds 8 ounces). LBW is caused by premature birth, or

slower than normal growth during the pregnancy in either full-term or premature infants.

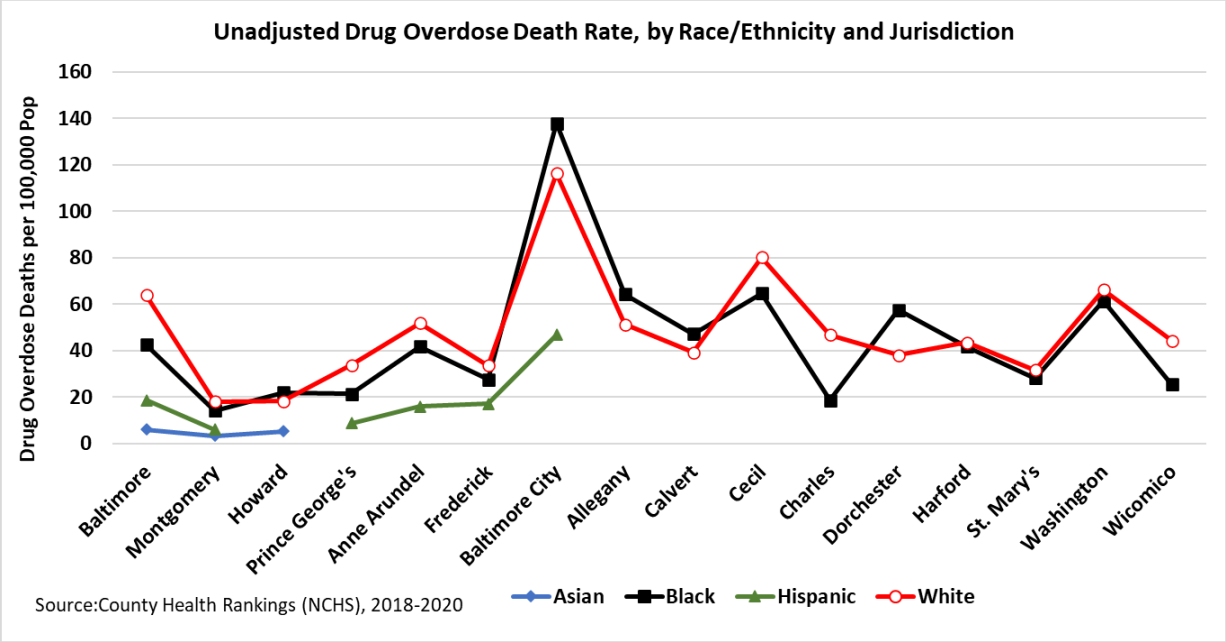
Key Findings:

- Compared to Whites, the % low birth weight for Blacks is higher, sometimes substantially so.
- Compared to Whites, the % low birth weight for American Indians or Alaska Natives is mixed.
- Compared to Whites, the % low birth weight for Asians is generally higher.
- Compared to Whites, the % low birth weight for Hispanics is generally similar.
- There is a lot of geographic variability in the % low birth weight for Asians, Blacks, and American Indians or Alaska Natives.
- The lowest percentage of low birth weight is seen for **Hispanics in Talbot County (4.2%)** and the highest percentage is seen for **Blacks in Kent County (20.3%).**
- **For American Indians or Alaska Natives**, the lowest % low birth weight is seen in Baltimore **County (6.7%)** and the highest rate is seen in **Baltimore City (14.9%).**
- **For Asians**, the lowest % of low birth weight is seen in **Washington County (5.4%)** and the highest rate is seen in **Charles County (10.8%).**
- **For Blacks**, the lowest % low birth weight is seen in **Montgomery County (9.7%)** and the highest rate is seen in **Kent County (20.3%).**
- **For Hispanics**, the lowest % of low birth weight is seen in **Talbot County (4.2%)** and the highest rate is seen in **Wicomico County (9.1%).**
- **For Whites,** the lowest % low birth weight is seen in **St. Mary's County (5.2%)** and the highest rate is seen in **Washington County (8.5%).**

Unadjusted Drug Overdose Death Rate

This is the rate per 100,000 population of accidental deaths due to overdose from drugs of all types. In this analysis, not adjusted for age, differences between Whites and other groups may be underestimated. Geographic differences within groups are not underestimated.

Figure 11. Unadjusted Drug Overdose Death Rate in Maryland



Key Findings:

- Compared to Whites, the drug overdose death rate for Blacks is similar.
- Compared to Whites, the drug overdose death rate for Asians and Hispanics is generally lower.
- Data for American Indians or Alaska Natives was not reported by the source.
- There is a lot of geographic variability in the rates for Blacks, Whites and Hispanics.
- The lowest drug overdose death rate is seen for **Asians in Montgomery County (3)** and the highest rate is seen for **Blacks in Baltimore City (138).**
- **For Asians**, the lowest drug overdose death rate is seen in **Montgomery County (3)** and the highest rate is seen in **Baltimore County (6).**
- **For Blacks**, the lowest drug overdose death rate is seen in **Montgomery County (14)** and the highest rate is seen in **Baltimore City (138).**
- **For Hispanics**, the lowest drug overdose death rate is seen in **Montgomery County (6)** and the highest rate is seen in **Baltimore City (47).**
- **For Whites, the lowest avoidable admission rate is seen in Montgomery and Howard Counties (18) and the highest rate is seen in Baltimore City (116).**

Next Steps for Health Equity Data Analysis

Following the initial data analysis included in this report, the DAC and members of the MCHE intend to continue its mission for developing a Health Equity Dataset as outlined in the statute by identifying the most critical health equity elements, aligning standards, and empowering state agencies with the tools needed to regularly produce disaggregated data. The Health Equity Dataset will assist the MCHE with monitoring health outcomes over time. A work plan providing more specific action steps will be developed in the coming months to guide these activities.

LOOKING FORWARD

In the next year, the MCHE will continue to convene to advance its mission of understanding key indicators of health outcomes and to employ a Health Equity Framework to reduce health disparities across state government. To better understand equity initiatives within each agency, the State Agency Engagement Survey will be conducted beginning in the fall of 2023. Data will be used to understand strengths and opportunities within each department's infrastructure to ensure that the Commission fully understands where disparities exist and to ensure the Health Equity Framework can be implemented with fidelity.

For the MCHE to achieve its mission, dedicated resources are needed to support the coordination and administration of the commission, as well as resources to provide data management and analysis of the Health Equity Dataset. MDH will work toward identifying funding sources to support the Commission's efforts, which may include leveraging federal grant dollars or public/private partnerships.

Lastly, the MCHE will continue to seek opportunities to harmonize its work with other broad statewide efforts to advance health equity. One area for collaboration is the State Health Assessment and State Health Improvement Plan which identify the state's health priorities, strategies to address these priorities, and measures to track progress. Another opportunity is the State's interest in the newly released AHEAD (States Advancing All-Payer Health Equity Approaches and Development) model by CMS which encourages a state level multi sector approach to improving population health and health equity, in addition to its focus on total cost of care and primary care investment.

The MCHE remains engaged and committed to advancing its work in the next year. Together, the MCHE believes that the State of Maryland can be a leader in eliminating health disparities, improving health outcomes, and driving health equity for Marylanders.

APPENDIX I: Departments Represented

Aging
Agriculture
Budget and Management
Commerce
Public Safety & Corrections
Disabilities
Education
Environment
General Services
Housing and Community Development
Human Services
Insurance Administration
Information Technology
Juvenile Services
Labor
Natural Resources
Planning
State Police
Transportation
Veterans Affairs
Maryland Department of Health • Public Health Services • Behavioral Health Administration
Insurance Commissioner
Maryland Association of County Health Officers (MACHO)
Senate
House of Delegates

APPENDIX II: Commission Meeting Minutes

Shirley Nathan-Pulliam Health Equity Act of 2021 | Maryland Commission on Health Equity (MCHE)

February 24, 2023, 1 p.m.-3 p.m.

I. Welcome and Introductions

Ms. Courtney McFadden, Acting Director of MDH Prevention and Health Promotion Administration (PHPA)and Acting MCHE Chair (appointed in December 2022) accompanied by Cydney Hamilton, PHPA Health Equity Coordinator; Sharmin Hossain, Director of Data Initiatives and Research Center for Applied Analytics; Wendeline Frederic, PHPA Health Policy Analyst

II. Special Presentation: PHPA Root Causes of Health Initiative

Ms. Courtney McFadden, Acting MCHE Chair; Dr. David Mann, Office of Minority Health and Health Disparities

A. PHPA Overview
    a. Mission and Vision of PHPA- protecting, promoting, and improving the health of Marylanders through partnership with local, state and federal agencies, and community organizations.
    b. PHPA organized within the Public Health Services Administration (PHS) Programs offered include but not limited to:
        i. WIC
        ii. Ryan White
        iii. Family Planning

B. Root Causes of Health Initiative (RoCHI) Overview
RoCHI is a learning collaborative facilitated by the Institute for Healthcare Improvement for the National Association for Chronic Disease Directors; Maryland was one of four states to participate.
    a. Aim Statement: Implement a quality improvement process that will systematically assess the operational equity of PHPA programs or services with the long-term goal of advancing health equity in the state.
    b. Operational Equity includes:
        i. Collecting and analyzing reporting data with specific reference disadvantaged groups
        ii. Workforce diversity and cultural and linguistic competency in the workforce
        iii. Program equity which encompasses equity of reach and equity of impact
            1. Equity of reach considers if the distribution of program participants matches the expected distribution based on who's eligible and who's disproportionately at risk.
            2. Equity of Impact considers if the benefit of the program being received is the same across the different groups by focusing on the success variables (groups with more barriers are likely to have lower success rates)
    c. Equity Action Lab included 5 programs (Maternal Mortality Review, Asthma Home Visiting Program, HIV Surveillance, Breast and Cervical Cancer, Tobacco)

that assessed program participant data to help improve operational equity; examples provider of data analysis for each program.

d. Data analysis provided an opportunity for programs to determine where they can make improvements in program reach and services.

III. Data Advisory Committee Update
Dr. Mark Martin, Director, Office of Minority Health and Health Disparities, MDH
Dr. David Mann, Office of Minority Health and Health Disparities, MDH

a. DAC has been working to develop a health equity data subset to meet legislative requirements; thus far they have:
   i. Created small workgroups to deal with some of the technical details that have emerged from the health equity data set.
   ii. Held weekly health equity data set meetings with CRISP, MDMH data office, HSCRC, and others.
   iii. Facilitated communication with project leads from other data health equity projects to determine areas of alignment to achieve synergy.
b. DACs approach to building the health equity data set and performing the analysis for the 2023 report include:
   i. Having two database tracks - an ecological track and a person- level data track
      1. Ecologic data set at the zip code level or county level
         a. Limitations of an ecological data set: may tend to underestimate differences between racial and ethnic groups.
      2. Person-level data set that represents the long-term future of the work and linked to person-level health outcome data.
         a. To gain more robust person- level data DAC may seek data from state agencies.
   ii. DAC is currently reviewing 11 current variables with 6 potential health outcomes for the ecological track.
c. The data analysis will seek to answer the following questions:
   i. Which adverse social determinants are most common in the State? How does the distribution look in different jurisdictions?
   ii. Which adverse social determinants have the strongest effect on poor health in the State?
   iii. Which places in the State have the most adverse social determinants?
   iv. How do we understand the relationship between adverse social factors and health outcomes?
d. Potential Health Outcomes to consider in the future (person-level data): diabetes death rate, asthma ED visit rate, low birth weight rate, years of potential life lost, opioid OD death rate, and health uninsurance rate.

IV. Health Equity Policy Committee Update
Dr. Kim Sydnor, Dean, College of Community Health and Policy, Morgan State University

a. The policy committee highlighted the 4 critical components of a health equity framework:
   i. Collaboration across all state agencies is an essential effort.
   ii. Formalized structure to house the framework.
   iii. Established resources to fund the framework.
   iv. Regulations to help govern the implementation.
b. Additional components to consider:
   i. Ensure data system is in alignment with health equity framework and a sustainable pathway to supporting data and analytics.

ii. Health equity framework should be viewed as a living document to adapt to changes as necessary and ensure it is holding up in alignment with mission and vision.
    1. Emphasize the importance of community voice to ensure we hear, understand, and learn from people on the ground.
iii. An analysis of what other states is doing in the health equity arena.

c. Next steps include:
    i. Get periodic updates from work groups which include the Best Practice Group, Policy Analysis Group, Voices Community Input Group
    ii. Case study to apply the health equity policy assessment to housing to see how the tool would be used and areas for improvement.

V. Closing and Wrap Up
Ms. Courtney McFadden, Acting MCHE Chair

a. Next meeting scheduled for May, expect dates soon.
b. Consider developing an approval process from the Commission for the draft of the report due at the end of the year.

Shirley Nathan-Pulliam Health Equity Act of 2021 | Maryland Commission on Health Equity (MCHE)

May 17, 2023, 10 a.m. - 12 p.m.

I. Welcome and Introductions

Ms. Courtney McFadden, Deputy Director, MDH Prevention and Health Promotion Administration (PHPA) and Interim MCHE Chair accompanied by Cydney Hamilton, PHPA Health Equity Coordinator; Sharmin Hossain, Director of Data Initiatives and Research Center for Applied Analytics; Wendeline Frederic, PHPA Health Policy Analyst

II. Opening Remarks from Secretary of Health Laura Hererra Scott, MD, MPH

A. The Moore Administration places a large emphasis on "leaving no Marylander behind", this cannot be done unless we are advancing health equity in the State.
B. Goal of the Department include:
    a. Supporting the Commission's efforts in advancing health equity.
    b. Completing a deep dive on all our data systems to understand "where we're capturing the information and where we're not, where we can impute race, recognizing that that has its own limitations, and where we can't."
    c. Identifying areas where we are not doing the necessary work so people can then start working to address the gaps that we see in our own delivery system.

III. Data Advisory Committee (DAC) Update

Dr. Mark Martin, Director, Office of Minority Health and Health Disparities, MDH

A. Legislative obligation of the DAC is to define the parameters of a health equity data set that is to be maintained by Maryland's Health Information Exchange

Data Visualizations for the Key Questions Presentation **by Dr. David Mann, Epidemiology, Office of Minority Health and Health Disparities, MDH**

A. The State-designated health information exchange, CRISP, is required to maintain a data set for MCHE and provide data consistent with the parameters and recommendations from the advisory committee.
B. The purpose of the Commission is to employ a health equity framework and examine the impact of 11 specified factors (housing, employment, education, economic stability, DEI in the workplace, barriers to career success, transportation/mobility, environmental factors, public safety, food insecurity) on the health of Marylanders.
C. Research questions for the data set to answer include:
    a. Which adverse social determinants are most common in Maryland?
    b. Which adverse social determinants have the strongest effect on poor health?
    c. Based on the above, which adverse social determinants generate the most "poor health"?
    d. Which places in Maryland have the most adverse social determinants?
D. December 2023 Report questions include:
    a. Which racial/ethnic groups have the higher rate of adverse social factors?
        i. Statewide Income Distribution (2018-2020) by R&E displayed the following poverty levels: Hispanic 44%, Non-Hispanic (NH) Black 23%,

NH American Indian 20%, NH Asian American 13%, NH White 11%

ii. Educational attainment (2018-2020) by R&E: Hispanic pop. had the highest rate of not graduating high school (44%), NH American Indian had the second highest (12%), NH Black (9%) NH White (7%)

1. There are likely other factors beyond just educational attainment differences that are driving differences in income levels for the Black population. Examples include quality of education, discriminatory hiring processes etc.

b. What is the health difference between adverse and adequate levels of social factors?

i. Differences in Diabetes diagnosis (2019-2021)- data displayed a gradual decrease in diabetes as income gets higher, general prevalence of diabetes higher in NH Black pop. compared to NH white pop.

1. Dooley Diagram is used to display diabetes prevalence among R&E groups while also looking at factors such as age, education, and income.
2. Age adjusted diagram for diabetes prevalence has a constant gradient over time.

E. DAC goals include:

a. Long-term goal- Build out a person-level data set.
b. 2023 Report goal- Complete an ecological analysis of county-level data.

IV. Health Equity Policy Committee Update

Dr. Kim Sydnor, Dean, College of Community Health and Policy, Morgan State University

A. HEPC plays an advisory role to MCHE and is responsible for employing a health equity framework (still in the developmental phase) and using a public health model for reducing health inequities in Maryland to improve health outcomes overall. Workgroups developed to complete these tasks include:

a. Policy Workgroup- tasked with identifying a usable policy analysis tool. "Health in all policy" emphasis to ensure analysis of policies that are not health specific, but impact health equity.
b. Community Voices Workgroup- developed to ensure that any health equity framework for the state of Maryland captures community voices and includes input from residents of the State.
c. Best Practices Workgroup- looked at existing health equity frameworks and best/ emerging practices from other states and organizations to determine what might be a good fit for Maryland.

B. HEPC Updates

a. HEPC is creating a case application for the health equity policy analysis tool utilizing Housing and Transportation
as examples to be available for the Commission to review at the next session

i. Opportunity for state agencies to see how the tool may be relevant to the work that they do as well.

b. HEPC will provide a scope of work for the environmental scan to gather information to understand what health equity work is already happening in Maryland.

C. Deliverables for 2023 Report
    a. Full case analysis and recommendations for usage of the health equity analysis tool
    b. Updated inventory of health equity best practices
    c. Summary findings from the Environmental Scan and Community Voices data gathering.
    d. Health Equity Framework implementation plan

V. MCHE Annual Report Update

A. The Shirley Nathan-Pulliam Health Equity Act of 2021 established MCHE. The primary role of MCHE per legislation is to advise, develop, and set goals to improve health equity.
B. For more information on specific report requirements: https://mgaleg.maryland.gov/2021RS/Chapters_noln/CH_750_sb0052e.pdf

VI. Closing and Wrap Up

- Rebecca Flora, Secretary of Planning (MDP) manages the state data center and is willing to assist in providing data for data analysis; emphasis on looking at the connectivity of social factors and their impact on health.
- Dr. David Mann: consider the role of social equity "can we get the social equity in place to make the health equity happen?"

Shirley Nathan-Pulliam Health Equity Act of 2021 | Maryland Commission on Health Equity (MCHE)

August 9, 2023, 9 a.m. - 11 a.m.

I. Welcome and Introductions

Ms. Courtney McFadden, Deputy Director of MDH Prevention and Health Promotion Administration (PHPA) and Interim MCHE Chair (appointed in December 2022) accompanied by **Cydney Hamilton**, PHPA Health Equity Coordinator; **Sharmin Hossain**, Director of Data Initiatives and Research Center for Applied Analytics; **Wendeline Frederic,** PHPA Health Policy Analyst

II. Opening Remarks from Deputy Secretary Nilesh Kalyanaraman, MD

Dr. Nilesh Kalyanaraman, Deputy Secretary for Public Health Services, MDH

MCHE Tasks for Agencies

A. It is imperative to implement collaboration among agencies and put our resources together to make groundbreaking changes in how our agencies work, policies, processes, etc. to improve health equity in Maryland. Actionable items of the Commission include identifying and employing a Health Equity Framework for agencies to collaboratively implement policies.
B. State agency engagement will begin in November. State agencies will be contacted individually to assess existing initiatives, programs, data collection practices etc. By March 2024, the Commission will begin to facilitate critical data discussions with state agencies to help develop a robust health equity data set while protecting privacy. Encourage state agencies to utilize the health outcome data for decision-making and goal setting, incorporating changes in real-time.
C. Develop state health equity plan by December 2024

III. Data Advisory Committee (DAC) Update

Dr. David Mann, Epidemiologist, Office of Minority Health and Health Disparities, MDH

Legislative Expectations of the MCHE

A. MCHE is tasked with examining the impact of 11 social factors; a data set will be necessary to allow us to understand the relationship between these factors and the health of Marylanders (see bill for full list of requirements). To meet the legislative requirements within the limited timeframe, the DAC identified 6 social factors with county-level data that they could pair with 6 health outcomes to analyze and get race-specific county-level outcomes.
B. Analysis Examples
    a. Years of Potential Life Lost by Median Income analysis, 2018-2020 (county level by race)- data demonstrated as median income age increased YYPL decreased. NOTE: Income gap existed among races despite similar negative slope trend
        i. American Indian pop. analysis unreportable by all data suppression and statistical stability rules because of the small pop. size
        ii. Data reported included: 7 counties for Asian pop.; 11 counties for Hispanic pop.; 21 counties for both Black and White pop.

b. Maryland Mortality Rate by Median Household Incomes, 2011-2015- after accounting for income the county-level rates for the White and Black pop. superimposed leading one to think most differences may be attributed to the socioeconomic gradient among the racial groups.
c. MD Percent Low Birth Weight by Median Household Incomes, 2011-2015- low birth weight outcomes worse in low-income households; however, a large vertical gap exists between White and Black pop.
    i. After adjusting for income, the gap still exists and possibly represents the impact of having to experience racism and the chronic stress and trauma it produces (i.e., heart disease, diabetes, stroke)
d. Ratio of All-Cause Age-Adjusted Mortality Rate to Benchmark, 2011-2015- The lowest rates were among Black and White pop. in Montgomery and Howard counties
    i. Confirms there are no biological explanations for racial differences, and it is more a product of socially engineered structures.

C. Direction of data collection after the 2023 Report
a. Decide between a person-level data set of social factor predictors and health outcomes OR sub-county geographic data sets if the plan is to complete the analysis in subgroups of race/ethnicity.
b. Census tract-level data not ideal for race/ethnic-specific analysis
c. May be necessary to create uniquely targeted data collection system to fill gaps for populations that under-represented in the standard data systems (i.e., migrant populations)

IV. Health Equity Policy Committee Update

Dr. Kim Sydnor, Dean, College of Community Health and Policy, Morgan State University

A. The committee is broken down into 3 work areas: policy, community voices, and best practices framework.
a. Policy workgroup has undertaken application of the Health Policy Analysis toolkit examining housing and plans to complete a transportation analysis in the next few months.
    i. Health Policy Analysis Toolkit assesses both cultural and programs as it is important to understand the environment in which these policies and decisions are being made.
b. Community Voices (Engagement) segment of the Committee will continue with personae development- creating profiles in many ways to typify Maryland residents in a consumer-based perspective to understand health equity needs.
    i. Will enrich profiles through interviews and focus group sessions.
    ii. Data gathering to be conducted with select local stakeholders across the State.
c. Best Practices has reviewed existing frameworks across the country (state level and organization level) and has identified one framework that would seem a good base model for Maryland (State of Massachusetts)
    i. Review of the models included in the December 2022 report along with recommendations to the Commission.

ii. The group does not want to ignore what is already being done in health equity nor do they want a framework that is not adaptable to the State.

B. Health Equity Framework
   a. The framework will include both a process and outcome perspective.
      i. The outcomes being proposed will be the final 6 indicators identified by the DAC to assure alignment and consistency in key metrics.
      ii. Additional indicators can be added such as CMS elements once the framework has been vetted and refined by the Commission.

C. Health Equity Framework Fundamentals
   a. Driving Factor: keeping racial Inequity at the center and recognizing Maryland's history of structural racism and its impact on the health of the population
   b. Planned Outcome: Elimination of racial inequities and improve health outcomes.
   c. Approach: data-driven, policy centered, community engaged (power at the table); inter-agency coordinated, technologically and informationally current
      i. As technology advances a system that acknowledges those changes and advancements is necessary.
   d. Principles: grounded in social determinants of health, community and culturally responsive, transparent, embedded in the fabric of State operations
      i. Health is not an isolated event therefore agencies have a large role to play in health outcomes.
   e. Anchoring the Framework will include:
      i. A coordinating and monitoring unit with direct report to the Governor's Office
      ii. Publicly available data dashboard with equity indicators
      iii. Mechanism for public reporting and input
      iv. "Health in All Policy" implementation and reporting for agencies (including completion of survey)
      v. State budget health equity analysis with public reporting

V. MCHE Annual Report Update
Ms. Courtney McFadden, Acting MCHE Chair

The 2023 report is due to MGA December 1, 2023. HEPC and DAC are currently working on finalizing drafts. Commission review period will be 9/15-9/22. Internal deadline of 10/2 for OGA review.

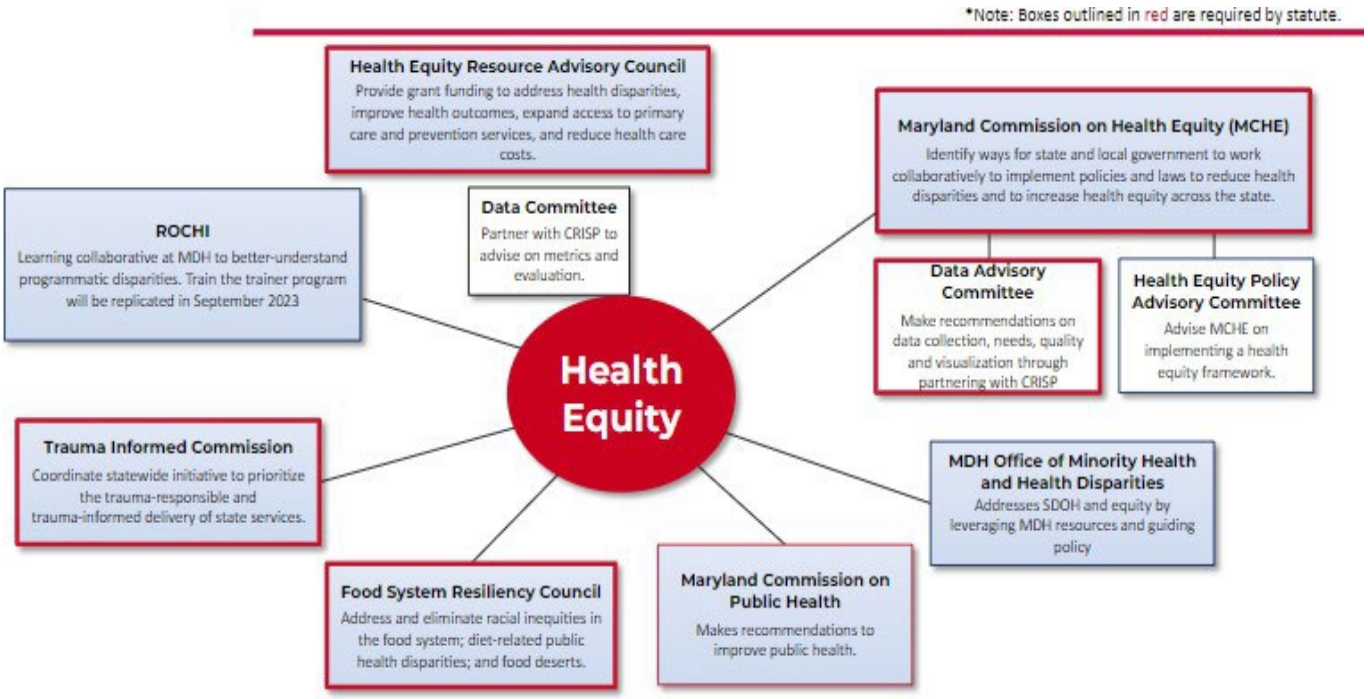
VI. Closing and Wrap Up
Ms. Courtney McFadden, Acting MCHE Chair

a. Next meeting scheduled for December 20, 2023 (in person)
b. State agencies will begin to receive surveys via email before the next MCHE meeting.

Additional Announcements: Dr. Mark Martin departed from his role as the director of the Office of Minority Health and Health Disparities and DAC Chair. **Camille Blake Fall** will serve as the new director of the Office of Minority Health and Health Disparities and DAC Chair.

APPENDIX III: Supporting Equity Initiatives

Health Equity Initiatives



APPENDIX IV: Additional Data Tables

Table 2. Median Income

Median Income By Jurisdiction/Race/Ethnicity					
Jurisdiction	**AI/AN**	**Asian**	**Black**	**Hispanic**	**White**
Allegany			28,676	41,957	50,288
Anne Arundel	78,125	101,972	86,040	89,458	108,749
Baltimore City	28,750	62,667	41,005	61,866	80,455
Baltimore Co.	76,131	82,138	68,627	63,633	85,610
Calvert		179,327	68,920	133,047	115,910
Caroline	91,477	212,857	40,952	50,603	64,008
Carroll	166,667	87,232	90,795	103,256	100,026
Cecil		87,167	57,472	53,636	82,955
Charles	112,589	114,557	101,269	118,438	106,539
Dorchester			35,516	44,356	62,204
Frederick	81,992	119,644	81,734	73,122	103,544
Harford	139,286	116,490	81,200	80,754	96,861
Howard	84,961	144,109	97,920	109,427	135,229
Kent			32,622	81,250	70,043
Montgomery	88,828	121,323	78,246	79,981	138,044
Prince George's	66,959	97,784	87,078	73,275	97,981
Queen Anne's			55,940	91,985	99,705
St. Mary's		125,287	52,612	74,500	104,273
Somerset			31,559	52,750	55,870
Talbot	168,542	76,222	49,280	40,513	79,846
Washington		86,705	44,147	58,162	65,167
Wicomico		71,231	46,768	41,263	64,336
Worcester		86,186	34,595	57,256	69,264

Table 3. Percentage of Children in Poverty

Percentage of Children in Poverty By Jurisdiction/Race/Ethnicity					
Jurisdiction	**AI/AN**	**Asian**	**Black**	**Hispanic**	**White**
Allegany		3.0	38.4	20.48	17.45
Anne Arundel	18.75	1.49	14.77	13.75	4.28
Baltimore County	11.44	14.63	16.31	19.65	6.37
Baltimore City	27.09	23.73	34.10	23.59	8.58
Calvert		10.02	6.92	7.19	3.62
Caroline			18.22	34.84	15.48
Carroll		10.66	2.24	13.18	4.31
Cecil		6.48	25.51	23.98	9.92
Charles	45.53	7.63	9.06	1.36	9.19
Dorchester			43.23	26.23	18.07
Frederick		1.71	15.24	16.06	4.88
Garrett				15.38	12.78
Harford		1.70	19.94	12.24	4.77
Howard		4.59	15.38	4.51	1.79
Kent			18.16	26.56	14.55
Montgomery	7.00	5.66	13.29	12.75	1.92
Prince George's	36.51	13.32	10.52	14.58	8.14
Queen Anne's			15.79	17.63	3.99
Somerset			24.09	16.54	24.37
St. Mary's		4.90	24.78	14.76	5.07
Talbot		11.21	11.90	13.75	10.67
Washington		6.77	40.00	17.36	11.14
Wicomico		1.92	25.28	44.31	10.07
Worcester			34.31	20.85	9.80

Table 4. Unemployment Rate

Unemployment Rate By Jurisdiction/Race/Ethnicity					
Jurisdiction	**AI/AN**	**Asian**	**Black**	**Hispanic**	**White**
Allegany		18.0	22.8	9.8	7.0
Anne Arundel		4.2	5.9	4.1	3.7
Baltimore	6.3	4.2	6.6	4.6	4.2
Baltimore City	7.9	2.6	10.2	6.5	3.9
Calvert			6.7	5.0	3.2
Caroline			12.4	5.5	3.9
Carroll	9.0	4.7	5.9	2.5	3.3
Cecil		9.5	3.3	10.9	5.4
Charles	6.8	2.2	5.2	3.2	3.6
Dorchester		12.5	9.6	6.7	5.9
Frederick		2.9	6.6	5.0	3.9
Garrett				8.1	4.1
Harford		3.6	6.8	4.2	3.7
Howard	3.6	4.1	5.0	5.0	3.2
Kent		27.3	7.4	0.8	2.5
Montgomery	4.4	4.0	7.6	5.5	3.4
Prince George's	14.2	6.2	7.3	5.0	3.8
Queen Anne's		3.7	5.1	1.9	3.1
Somerset			14.0	17.6	5.9
St. Mary's		2.9	2.2	0.5	3.9
Talbot		2.2	4.3	1.3	2.4
Washington		2.0	11.1	1.4	4.9
Wicomico		8.9	9.8	18.0	7.1
Worcester			12.2	3.6	5.1

Table 5. Percentage without High School Degree

Percentage without High School Degree By Jurisdiction/Race/Ethnicity					
Jurisdiction	**AI/AN**	**Asian**	**Black**	**Hispanic**	**White**
Allegany	40.2	7.0	28.4	19.8	8.6
Anne Arundel	13.3	12.2	8.0	20.6	5.5
Baltimore	23.8	15.1	7.2	30.4	7.7
Baltimore City	17.9	10.0	16.6	28.7	9.9
Calvert	12.2	1.6	15.0	2.8	4.4
Caroline	51.7	18.6	19.6	59.6	13.5
Carroll	5.9	11.3	11.7	15.7	6.5
Cecil	5.7	2.3	12.1	26.9	9.8
Charles	10.2	10.4	5.9	13.7	6.4
Dorchester		29.2	19.0	37.9	9.4
Frederick	27.1	10.1	9.0	27.6	6.4
Garrett	2.0	1.1	9.6	4.3	9.9
Harford	12.5	6.1	7.0	14.6	6.7
Howard	5.5	7.3	3.8	14.7	3.5
Kent	33.3		17.1	33.8	9.6
Montgomery	31.5	8.7	6.5	28.8	5.0
Prince George's	24.1	13.1	6.3	47.6	11.8
Queen Anne's	46.2	24.4	11.9	22.5	6.0
Somerset	34.6	20.8	21.3	29.9	12.9
St. Mary's	23.7	22.0	17.3	20.5	7.8
Talbot	21.8	21.2	19.3	44.8	6.9
Washington	30.7	9.9	16.4	31.0	11.1
Wicomico	43.1	12.7	16.7	37.6	9.9
Worcester		4.9	17.9	33.0	6.3

Table 6. Percentage without Health Insurance

Percentage Without Health Insurance By Jurisdiction/Race/Ethnicity					
Jurisdiction	**AI/AN**	**Asian**	**Black**	**Hispanic**	**White**
Allegany		14.0	7.7	13.3	4.4
Anne Arundel	7.3	6.9	4.5	18.0	3.2
Baltimore	7.4	6.0	5.9	21.6	4.2
Baltimore City	7.2	5.6	5.8	20.7	5.0
Calvert		0.9	2.6	5.9	2.9
Caroline	10.6	3.2	4.6	31.4	5.4
Carroll	7.0	8.6	4.0	10.8	2.9
Cecil		10.0	1.9	14.2	4.2
Charles	1.2	6.5	4.5	7.7	3.6
Dorchester	25.0	17.3	3.9	23.3	4.4
Frederick	6.8	4.5	5.8	14.8	4.2
Garrett	74.0	5.8	12.4	12.5	6.3
Harford	9.1	2.2	4.9	11.9	2.7
Howard	2.1	4.8	4.8	13.6	2.9
Kent	66.7	7.7	10.1	15.3	2.8
Montgomery	6.3	4.6	6.8	19.4	3.9
Prince George's	7.5	7.2	6.2	29.3	7.9
Queen Anne's	60.0	26.2	10.0	18.9	3.3
Somerset		6.8	4.9	3.4	5.5
St. Mary's	41.3	8.8	4.4	14.5	4.4
Talbot	5.3	8.9	2.3	23.9	4.4
Washington		3.3	4.8	14.0	5.1
Wicomico		11.5	6.5	34.7	6.1
Worcester		1.6	3.1	17.2	5.4

Table 7. Potential Years in Life Lost

Potential Years in Life Lost By Jurisdiction/Race/Ethnicity				
Jurisdiction	**Asian**	**Black**	**Hispanic**	**White**
Allegany		10598		10018
Anne Arundel	3477	8060	4496	7135
Baltimore	3659	10202	5484	8062
Baltimore City	3403	17967	6736	10524
Calvert		8107		6555
Caroline		12404		8625
Carroll		10177		6777
Cecil		12701		10570
Charles		8296	4052	8348
Dorchester		16580		8612
Frederick	3049	7824	3974	6026
Garrett				
Harford		9213	4638	6923
Howard	2487	7248	3290	3913
Kent				
Montgomery	2459	6321	4115	4152
Prince George's	2707	8538	5547	6748
Queen Anne's				
Somerset		8322		10651
St. Mary's		10594		6654
Talbot		11713		7983
Washington		12197	3824	9633
Wicomico		10903	7882	8543
Worcester		9282		6466

Table 8. Age-Adjusted Diabetes Death Rate

Age-Adjusted Diabetes Death Rate By Jurisdiction/Race/Ethnicity				
Jurisdiction	**Asian**	**Black**	**Hispanic**	**White**
Allegany				22.9
Anne Arundel	15.3	34.3	15.5	16.8
Baltimore	14.4	29.4		16.5
Baltimore City		38.7		21.0
Calvert		43.6		16.6
Caroline		40.5		17.9
Carroll				17.1
Cecil				21.3
Charles		35.0		22.8
Dorchester		40.9		22.0
Frederick		34.5		16.8
Garrett				25.9
Harford		37.2		16.2
Howard	10.6	22.2		10.1
Kent		55.1		11.1
Montgomery	9.0	24.1	10.9	10.6
Prince George's	17.1	31.5	19.5	22.1
Queen Anne's				14.6
Somerset		32.2		16.6
St. Mary's		49.5		19.9
Talbot				11.1
Washington		44.6		32.6
Wicomico		27.9		15.4
Worcester		44.0		15.3

Table 9. Unadjusted Avoidable Admission Rate (PQIs)

Unadjusted Avoidable Admission Rate By Jurisdiction/Race/Ethnicity					
Jurisdiction	**AI/AN**	**Asian**	**Black**	**Hispanic**	**White**
Allegany			633	222	1851
Anne Arundel	814	325	1859	450	1148
Baltimore	1864	243	2187	512	1600
Baltimore City	659	260	3016	757	1514
Calvert		227	2044	236	1093
Caroline			1536	226	1090
Carroll		172	1841	266	1195
Cecil			1514	479	1413
Charles	587	209	1074	291	989
Dorchester			1811		970
Frederick	455	187	1467	389	949
Garrett					1061
Harford	988	435	435	668	1308
Howard	1871	250	250	404	693
Kent			2622		1244
Montgomery	1881	307	1053	444	661
Prince George's	828	281	1207	393	984
Queen Anne's			1627	299	858
Somerset			1123	742	1404
St. Mary's		245	2356	230	1306
Talbot			2137		1081
Washington		304	1666	647	1630
Wicomico	1290	121	2108	675	1298
Worcester			2894	918	1337

Table 10. Low Birth Rate

Low Birth Rate By Jurisdiction/Race/Ethnicity					
Jurisdiction	**AI/AN**	**Asian**	**Black**	**Hispanic**	**White**
Allegany			11.7		8.3
Anne Arundel		8.9	12.0	7.0	6.4
Baltimore	6.7	8.6	12.6	7.3	7.1
Baltimore City	14.9	9.0	14.8	7.6	7.3
Calvert		9.7	13.0	6.7	5.5
Caroline			16.0	4.9	6.7
Carroll		9.8	11.8	4.9	6.1
Cecil		9.7	13.6	8.9	7.3
Charles		10.8	11.9	6.5	6.8
Dorchester			16.9	5.5	7.0
Frederick		9.0	12.2	7.1	6.0
Garrett					
Harford		9.2	11.9	7.3	6.2
Howard		9.5	11.1	7.2	6.1
Kent			20.3		7.1
Montgomery		7.9	9.7	7.1	5.9
Prince George's	8.9	9.0	11.3	7.1	6.2
Queen Anne's			12.4	5.3	7.3
Somerset			13.2		8.1
St. Mary's		5.5	12.8	5.9	5.2
Talbot			14.3	4.2	6.5
Washington		5.4	14.1	9.1	8.5
Wicomico		5.6	12.2	7.3	7.3
Worcester			10.9		6.0

Table 11. Unadjusted Drug Overdose Death Rate

Unadjusted Drug Overdose Death Rate By Jurisdiction/Race/Ethnicity				
Jurisdiction	**Asian**	**Black**	**Hispanic**	**White**
Allegany		64		51
Anne Arundel		42	16	52
Baltimore	6	42	19	64
Baltimore City		138	47	116
Calvert		47		39
Caroline				
Carroll				
Cecil		65		80
Charles		19		47
Dorchester		58		38
Frederick		28	17	34
Garrett				
Harford		42		44
Howard	5	22		18
Kent				
Montgomery	3	14	6	18
Prince George's		21	9	34
Queen Anne's				
Somerset				
St. Mary's		28		32
Talbot				
Washington		61		66
Wicomico		25		44
Worcester				