MARYLAND PLAN TO ELIMINATE MINORITY HEALTH DISPARITIES

Plan of Action 2010 – 2014

March 2010

Maryland Department of Health and Mental Hygiene
Office of Minority Health and Health Disparities

A Healthier Future For All Marylanders

John M. Colmers
Secretary

Carlessia A. Hussein, RN, DrPH
Director

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

June, 2010

Dear Maryland Public Health Partners,

The Department of Health and Mental Hygiene is pleased to present the *Maryland Plan to Eliminate Minority Health Disparities, Plan of Action 2010 – 2014*. This document, published by the Maryland Office of Minority Health and Health Disparities (MHHD), is the second statewide Plan devoted to minority health in Maryland. The *Plan of Action* provides specific action steps to be implemented within the next 5 years, in collaboration with potential stakeholders, in order to continue Maryland's momentum in the elimination of health disparities.

The Maryland Health Disparities Initiative, established in 2004 and directed by Dr. Carlessia A. Hussein, maintains a vision for the organization and delivery of health care services in a manner designed to eliminate health disparities among the state's racial and ethnic populations.

Building on the findings from the first *Maryland Plan to Eliminate Minority Health Disparities* (2006), MHHD has engaged over 2,500 stakeholders from around the state through in-person meetings, electronic communications, and personal discussions in preparation for this *Plan of Action*. In addition to local partner engagement within the state, MHHD has joined with our federal partners at the U.S. Department of Health and Human Services, Office of Minority Health in the drafting of a plan for the National Partnership for Action to End Health Disparities. Most importantly are the valuable contributions by the members of the Maryland Health Disparities collaborative who provided guidance and expert consultation throughout the *Plan of Action* process.

The Patient Protection and Affordable Care Act (H.R. 3950), recently enacted by President Obama and Congress, is focused on addressing the health care needs of all Americans, including several provisions that specifically address the needs of underserved communities. With this new opportunity and renewed focus, the Department of Health and Mental Hygiene, in partnership with the Maryland Office of Minority Health and Health Disparities, our local public health partners, community advocates, colleagues, and friends, is committed to the continuation of our efforts to improve the health of minorities living in our state. Federal health care reform legislation and the measures Maryland takes in implementing health care reform have the potential to transform health care delivery services. Any five- year plan, including this disparities plan, must be flexible to incorporate changes in coverage and delivery systems and to evaluate impact of these changes upon all communities, with special attention to racial and ethnic minorities. The MHHD is committed to monitoring the effects of reform and to changing this Plan of Action as necessary to accommodate systems needs and changes. Please take the measures advanced by the MHHD as you continue your work in eliminating minority health disparities in Maryland.

Sincerely,

John M. Colmers
Secretary

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
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June, 2010

Dear Colleagues,

The Maryland Office of Minority Health and Health Disparities, within the Department of Health and Mental Hygiene, is pleased to present the *Maryland Plan to Eliminate Minority Health Disparities, Plan of Action 2010 – 2014*. It is with great appreciation that we thank the following individuals and groups for their expertise, time, and commitment to improve the health of all Maryland citizens:

- The Maryland State Legislature, and Delegate Shirley Nathan-Pulliam and Senator Nathanial Exum who championed legislation in the 2004 legislative session to establish the Office of Minority Health and Health Disparities.

- Maryland Health Disparities Collaborative Co-Chairs; John M. Colmers, Secretary of the Maryland Department of Health and Mental Hygiene and Ms. Donna Jacobs, Senior Vice President of Government and Regulatory Affairs, University of Maryland Medical System.

- The Maryland Health Disparities Collaborative participants who attended planning meetings, communicated through electronic means to offer their thoughts, comments, and feedback during the drafting and refinement process of the Plan. We would also like to acknowledge the other organizations and groups who participated in the public review and comment periods of the *Plan of Action*. Please see section G for a listing of contributing organizations and groups.

- The Department of Health and Mental Hygiene staff and leadership for their continued support of and commitment to the reduction of health disparities in Maryland.

- The team members of the Office of Minority Health and Health Disparities who contributed greatly to the production of this *Plan of Action*.

The Maryland Office of Minority Health and Health Disparities is grateful to all of our partners, colleagues and friends for your tireless dedication to improving the health of minorities in Maryland. As we continue to address the disparities that still exist, I believe that the recent passage of health care reform will improve all Marylander's quality and access to health care.

Sincerely,

Carlessia A. Hussein

Carlessia A. Hussein, RN, DrPH
Director

Maryland Department of Health and Mental Hygiene
Office of Minority Health and Health Disparities

Maryland Plan to Eliminate Minority Health Disparities
Plan of Action 2010 – 2014

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A. EXECUTIVE SUMMARY

The Maryland Office of Minority Health and Health Disparities (MHHD) published the first Maryland Plan to Eliminate Minority Health Disparities in December of 2006 (located at *www.dhmh.maryland.gov/hd/planelimdisp.html*). The first Plan provides a general overview of health disparities in the state and nation. The Plan presents challenges, recommendations, and strategies to eliminate minority health disparities in Maryland.

The second Plan, the *Maryland Plan to Eliminate Minority Health Disparities, Plan of Action for 2010 - 2014*, provides specific action steps to be implemented within the next 5 years to continue Maryland's momentum in the elimination of health disparities. Key sections of the Plan of Action include:

Minority Health Disparities in Maryland – Presents the current state of racial and ethnic health disparities in Maryland, including current data, charts, graphs, and accompanying discussion.

The 2004 – 2010 Health Disparities Plan & Progress – Offers a detailed description of actions and activities that MHHD has put forth, since the publication of the first Plan in 2006, including accomplishments and progress in the areas of racial and ethnic data collection; collaborations and outreach; information and resource support; workforce diversity and cultural competency; health department assessment and systems change; legislative activity; MHHD-funded grant and pilot projects; and publications and presentations.

Revising the Plan for 2010 – 2014 – Discusses the strategy used to revise and create a *Plan of Action* for the State. Primary strategies included the review of findings from the first Plan and subsequent activities and progress, and collaboration with the U.S. Department of Health and Human Services, Office of Minority Health (HHS OMH) in their development of a "Blueprint for Action" set forth by the National Partnership for Action to End Health Disparities. Key to the review of the *Plan of Action* at the state and local level was the participation of the Maryland Health Disparities Collaborative, a statewide advisory group, as well as a call for public comment.

The Action Plan – Presents a collection of specific *Objectives, Action Steps, Possible Stakeholders,* and *Measures* to address health disparities in the state. The Action Plan's main objectives include:

Objective 1: AWARENESS – Increase awareness of the significance of health disparities, their impact on the state and local communities, and the actions necessary to improve health outcomes for Maryland's racial and ethnic minority populations.

Objective 2: LEADERSHIP – Strengthen and broaden leadership for addressing health disparities at all levels.

Objective 3: HEALTH AND HEALTH SYSTEM EXPERIENCE – Improve health and health care outcomes for racial and ethnic minorities and underserved populations and communities.

Objective 4: CULTURAL AND LINGUISTIC COMPETENCY – Improve cultural and linguistic competency.

Objective 5: RESEARCH AND EVALUATION – Improve coordination and use of research and evaluation outcomes.

The Implementation Strategy - Provides the roadmap that MHHD will use to focus the implementation efforts of each action step. The strategy includes the following steps: Form an Action Team for each of the five Plan objectives; Develop an Action Plan for the Team; Present the Action Step to the stakeholder; Finalize the Action Step; and Begin Action Step Implementation.

B. MINORITY HEALTH DISPARITIES IN MARYLAND

A *health disparity* is a difference in the burden of illness, injury, disability, or mortality experienced between one population group and another. A *healthcare disparity* is defined as racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.

A detailed literature and historical overview of health disparities is presented in the 2006 Plan. The following section is an update of the most current data on minority health and health disparities in the state.

I. Minority Population in Maryland

- Maryland is a state where the combined racial and ethnic minority population is approaching the Non-Hispanic White population. The 2008 estimated Maryland population is 41.6% minority, up by 0.3 percentage points from 2007 (41.3%).

- Eight of Maryland's 24 jurisdictions have minority populations over 30%. More than 20% of the population on the Eastern Shore is minority.

Table 1. Maryland Population, July 1, 2008 by Race and Ethnicity

Race	All Ethnicity		Non-Hispanic		Hispanic	
White	3,611,787	64.1%	3,287,740	58.4%	324,047	5.8%
Non-White	2,021,810	35.9%	1,970,027	35.0%	51,783	0.9%
Black	*1,692,495*	*30.0%*				
Asian/Pac Isle	*305,847*	*5.4%*				
American Indian	*23,468*	*0.4%*				
MD Total	5,633,597	100.0%	5,257,767	93.3%	375,830	6.7%

Source: Maryland Vital Statistics Annual Report 2008

In the sections which follow Table 2, some reporting is limited to comparisons of the Black or African American population to the White population. Where data are not presented for American Indians, Asians and Pacific Islanders, or Hispanics/Latinos, this is because either

- The data have small numbers for these populations, generating statistically unstable estimates;
- The data have large numbers of persons who are missing race or ethnicity information. This creates a large potential for error in estimating the smaller racial and ethnic groups; or
- The data have other technical limitations (misclassification, issues of outmigration, etc.) where the estimates generated are likely to not reflect the true disease burden in these smaller populations.

Table 2. Minority Population by Jurisdiction, Maryland 2008

REGION AND POLITICAL SUBDIVISION	TOTAL	Non-Hispanic White	Minority Population	Percent Minority	% Black or African American	% Asian or Pacific Islander	% American Indian or Alaska Native	Percent Hispanic or Latino
MARYLAND	**5,633,597**	**3,287,740**	**2,345,857**	**41.6%**	**30.0%**	**5.4%**	**0.4%**	**6.7%**
NORTHWEST AREA	**473,041**	**402,006**	**71,035**	**15.0%**	**8.7%**	**2.5%**	**0.3%**	**3.9%**
GARRET	29,698	29,112	586	2.0%	1.0%	0.2%	0.1%	0.7%
ALLEGANY	72,238	66,037	6,201	8.6%	6.8%	0.7%	0.2%	1.1%
WASHINGTON	145,384	124,464	20,920	14.4%	10.2%	1.5%	0.2%	2.7%
FREDERICK	225,721	182,393	43,328	19.2%	9.4%	3.9%	0.3%	6.0%
BALTIMORE METRO AREA	**2,620,026**	**1,645,145**	**974,881**	**37.2%**	**29.8%**	**4.2%**	**0.4%**	**3.4%**
BALTIMORE CITY	636,919	197,880	439,039	68.9%	64.3%	2.2%	0.4%	2.7%
BALTIMORE COUNTY	785,618	525,404	260,214	33.1%	25.6%	4.5%	0.4%	3.1%
ANNE ARUNDEL	512,790	390,325	122,465	23.9%	15.9%	3.5%	0.4%	4.5%
CARROLL	169,353	155,850	13,503	8.0%	4.2%	1.8%	0.2%	1.9%
HOWARD	274,995	178,249	96,746	35.2%	18.0%	12.4%	0.3%	5.0%
HARFORD	240,351	197,437	42,914	17.9%	12.8%	2.4%	0.3%	2.7%
NATIONAL CAPITAL AREA	**1,771,532**	**666,982**	**1,104,550**	**62.3%**	**40.3%**	**9.6%**	**0.5%**	**13.9%**
MONTGOMERY	950,680	519,847	430,833	45.3%	17.5%	14.2%	0.5%	14.8%
PRINCE GEORGE'S	820,852	147,135	673,717	82.1%	66.7%	4.3%	0.6%	12.8%
SOUTHERN AREA	**331,040**	**226,699**	**104,341**	**31.5%**	**25.7%**	**2.4%**	**0.6%**	**3.2%**
CALVERT	88,698	71,782	16,916	19.1%	14.8%	1.6%	0.4%	2.5%
CHARLES	140,764	74,573	66,191	47.0%	39.9%	2.8%	0.8%	3.9%
SAINT MARY'S	101,578	80,344	21,234	20.9%	15.4%	2.4%	0.4%	2.9%
EASTERN SHORE AREA	**437,958**	**346,908**	**91,050**	**20.8%**	**16.8%**	**1.2%**	**0.3%**	**2.9%**
CECIL	99,926	90,121	9,805	9.8%	6.1%	1.1%	0.4%	2.4%
KENT	20,151	16,061	4,090	20.3%	16.1%	0.8%	0.2%	3.6%
QUEEN ANNE'S	47,091	41,561	5,530	11.7%	8.4%	1.2%	0.2%	2.1%
CAROLINE	33,138	26,447	6,691	20.2%	14.6%	0.8%	0.6%	4.8%
TALBOT	36,215	29,670	6,545	18.1%	14.1%	1.0%	0.2%	3.2%
DORCHESTER	31,998	22,074	9,924	31.0%	27.9%	1.0%	0.2%	2.2%
WICOMICO	94,046	66,394	27,652	29.4%	24.3%	1.8%	0.2%	3.4%
SOMERSET	26,119	14,288	11,831	45.3%	42.1%	0.9%	0.4%	2.4%
WORCESTER	49,274	40,292	8,982	18.2%	14.8%	1.0%	0.2%	2.4%

Source: Maryland Vital Statistics Annual Report 2008

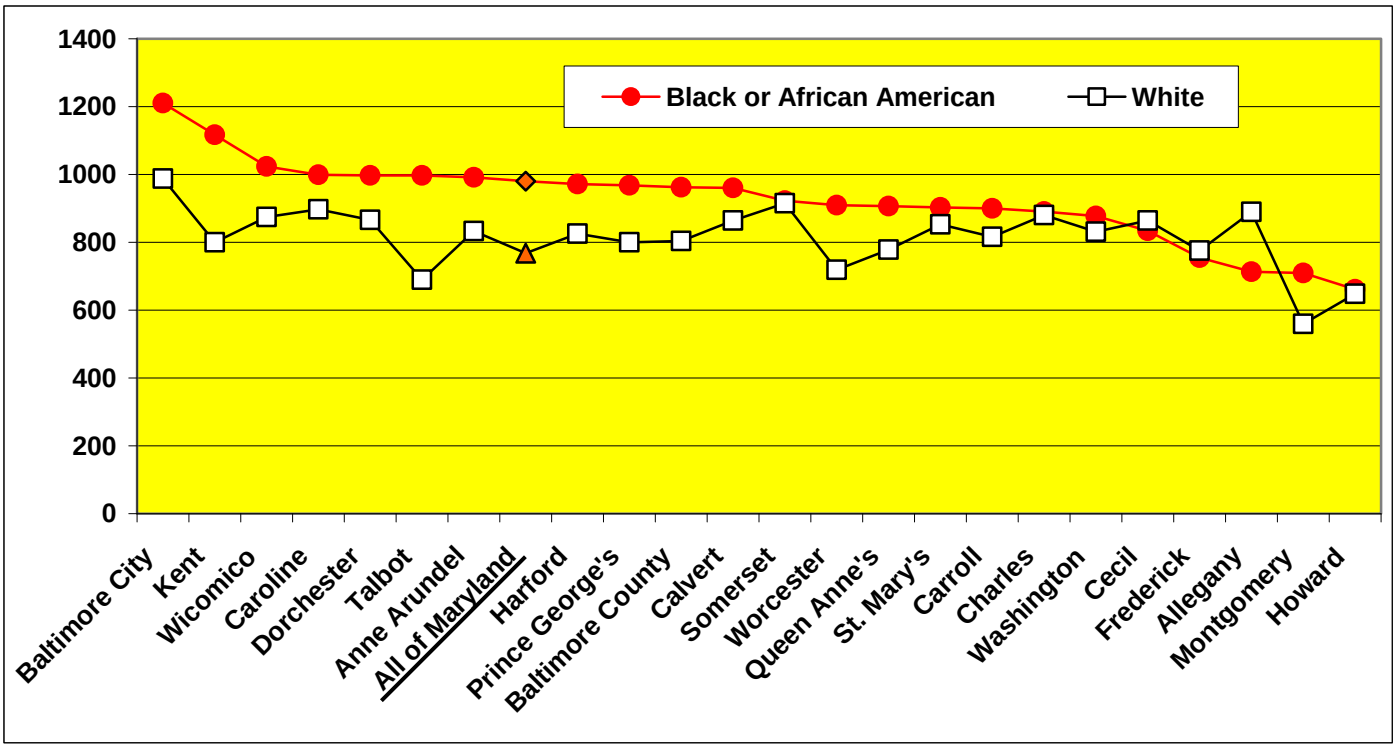
II. Geographic Distribution of Mortality Disparities

Figure 1 displays mortality data for Blacks or African Americans and Whites for 2004 to 2006 combined, and shows that for this period, Black or African American death rates exceed White death rates in 20 of the 23 Maryland jurisdictions where the age-adjusted rates could be calculated.

While Baltimore City has the highest mortality rates for both Blacks or African Americans and Whites, the disparity in mortality, expressed as the difference between the rates, is larger in some other jurisdictions than it is in Baltimore City. Also apparent is a sizeable geographic difference in mortality rates within each racial group: mortality ranges from below 700 deaths per 100,000 to above 1,200 for Blacks or African Americans; and ranges from below 600 to nearly 1,000 deaths per 100,000 for Whites.

The mortality disparity by jurisdiction could not be calculated for other minority groups.

Figure 1. Age-Adjusted All-Cause Mortality (rate per 100,000) by Black or White Race and Jurisdiction, Maryland 2004- 2006 Pooled

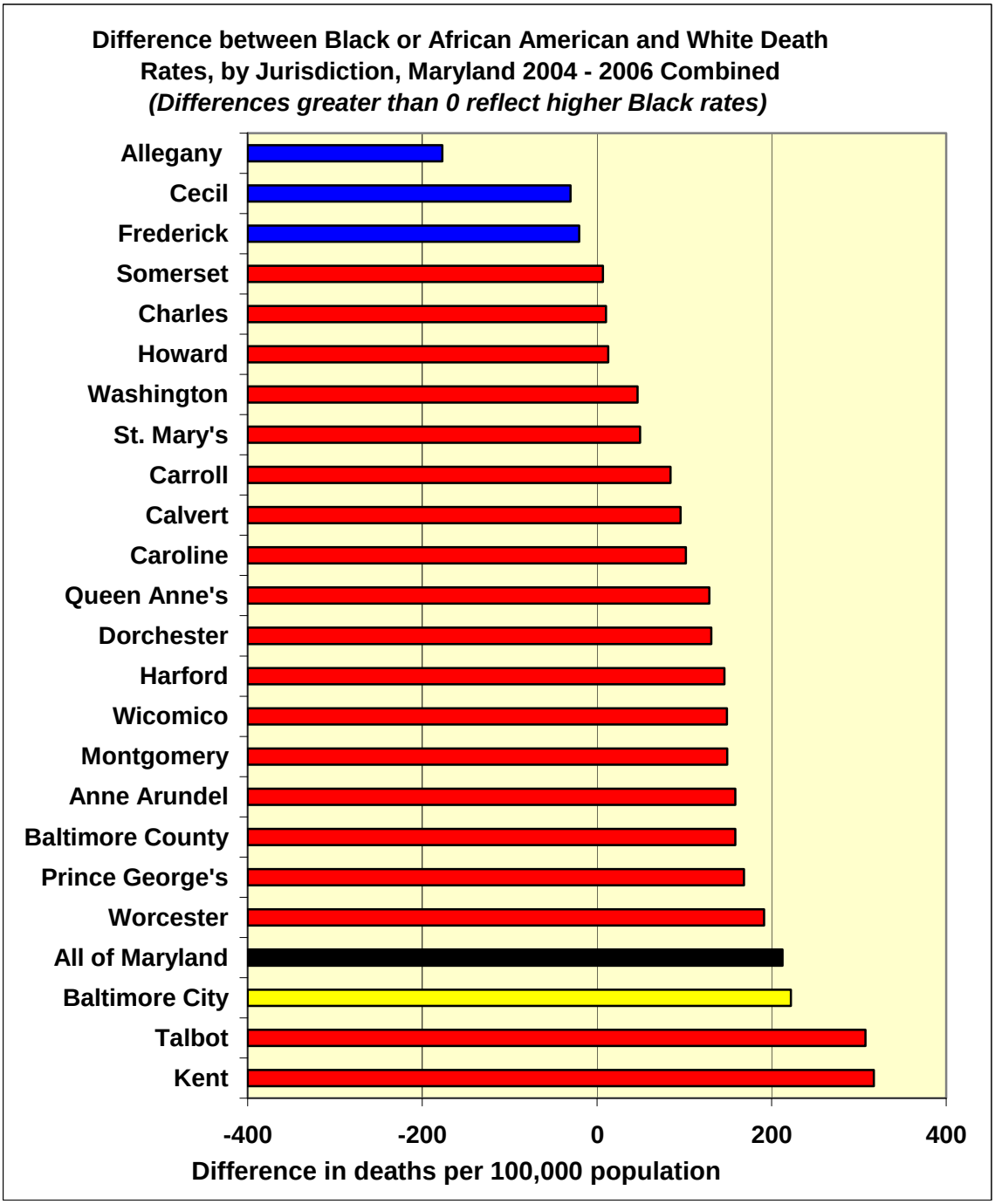


Age-adjusted death rates for Blacks could not be calculated for Garrett County

Source: CDC Wonder Mortality Data 2004-2006

Figure 2 displays the mortality disparity by jurisdiction (the difference between the Black or African American mortality rate and the White mortality rate) combining 2004 to 2006. During this period, the White death rate exceeded the Black or African American rate in three jurisdictions. In the 20 other jurisdictions where rates could be calculated, the Black or African American death rate exceeded the White rate.

Figure 2 Black vs. White Death Rate Differences, by Jurisdiction, 2004-2006



Source: CDC Wonder Mortality data 2004-2006

III. Detailed Maryland Population Distribution by Jurisdiction for Each Racial and Ethnic Minority Group

a. American Indian or Alaska Native

In 2008, American Indians or Alaska Natives represented 0.42% of Maryland's overall population, and between 0.08% and 0.82% depending on jurisdiction, as reported in the Maryland Vital Statistics Annual Report, 2008 [1] (see comments on next page). These data indicate that most of this population lives in the Baltimore Metro and National Capital areas.

Table 1. American Indian or Alaska Native population of Maryland by Jurisdiction, 2008

	All races	American Indian	% of jurisdiction that is Am-Indian	% of Maryland Am-Indian Pop that lives in the Jurisdiction
MARYLAND	5,633,597	23,468	0.42%	100.00%
NORTHWEST AREA	**473,041**	**1,203**	**0.25%**	**5.13%**
GARRETT	29,698	24	0.08%	0.10%
ALLEGANY	72,238	138	0.19%	0.59%
WASHINGTON	145,384	313	0.22%	1.33%
FREDERICK	225,721	728	0.32%	3.10%
BALTIMORE METRO AREA	**2,620,026**	**9,627**	**0.37%**	**41.02%**
BALTIMORE CITY	636,919	2,708	0.43%	11.54%
BALTIMORE COUNTY	785,618	2,953	0.38%	12.58%
ANNE ARUNDEL	512,790	2,051	0.40%	8.74%
CARROLL	169,353	410	0.24%	1.75%
HOWARD	274,995	851	0.31%	3.63%
HARFORD	240,351	654	0.27%	2.79%
NATIONAL CAPITAL AREA	**1,771,532**	**9,496**	**0.54%**	**40.46%**
MONTGOMERY	950,680	4,823	0.51%	20.55%
PRINCE GEORGE'S	820,852	4,673	0.57%	19.91%
SOUTHERN AREA	**331,040**	**1,868**	**0.56%**	**7.96%**
CALVERT	88,698	314	0.35%	1.34%
CHARLES	140,764	1,154	0.82%	4.92%
ST MARY'S	101,578	400	0.39%	1.70%
EASTERN SHORE AREA	**437,958**	**1,274**	**0.29%**	**5.43%**
CECIL	99,926	350	0.35%	1.49%
KENT	20,151	37	0.18%	0.16%
QUEEN ANNE'S	47,091	102	0.22%	0.43%
CAROLINE	33,138	200	0.60%	0.85%
TALBOT	36,215	71	0.20%	0.30%
DORCHESTER	31,998	76	0.24%	0.32%
WICOMICO	94,046	230	0.24%	0.98%
SOMERSET	26,119	108	0.41%	0.46%
WORCESTER	49,274	100	0.20%	0.43%

Source: Maryland Vital Statistics Annual Report 2008 [1]

1. *Underestimation of the American Indian or Alaska Native Population in some reports*

The preceding table based on the Maryland Vital Statistics Annual Report uses the bridged-race estimation technique of the National Center for Health Statistics [2]. This method is also used for population denominators in mortality data from CDC Wonder [3]. This method distributes persons indicating more than one race into single racial groups, to create race estimates that are compatible with other data systems that do not allow more than one race as a response. Bridged-race estimates produce race estimates that add up to exactly 100% of the population.

For the American Indian and Alaska Native population in Maryland, the frequency of reporting more than one race is very high. This means that bridged-race estimation markedly underestimates the number of persons in Maryland who report some American Indian or Alaska Native racial heritage. The Census Bureau provides estimates of persons who report a race either as their only race, or in combination with other races, in a category called "(the specified race) alone or in combination."

Examining data from the 2000 Census [4] and from the 2005 American Community Survey [5], we can estimate the degree to which various racial groups in Maryland report multi-racial heritage. In these years, the percentage of Marylanders reporting a particular race "alone or in combination" who reported only that one race was 98% for Whites, 97% for Blacks or African Americans, and 88% to 90% for Asians or Pacific Islanders, and 39% for American Indians or Alaska Natives. This means that 61% of the American Indian or Alaska Native population gave a multi-racial response.

Further examining data from the 2000 Census [4] and from the 2005 American Community Survey [5], we can determine how closely the bridged-race estimates published in the Maryland Vital Statistics Annual Reports match the "alone or in combination" estimates furnished by the Census Bureau. In both years, for Maryland, the bridged-race estimates were within 3% to 4% of the "alone or in combination" estimates for Whites, Blacks or African Americans, and Asians or Pacific Islanders. For American Indians and Alaska Natives in Maryland, the bridged-race estimates represented 48% to 50% of their "alone or in combination" estimates.

Therefore, of the four racial groups commonly reported in Maryland data, only American Indians and Alaska Natives show a meaningful difference between their bridged-race estimates and their "alone or in combination" estimates. For this racial group, the population numbers in Table 1 above should be multiplied by a factor of two in order to approximate the number of persons in Maryland reporting American Indian or Alaska Native "alone or in combination". Thus, it can be estimated that in Maryland in 2008, there were about 47,000 persons who would consider themselves to have some American Indian or Alaska Native heritage.

b. Asian or Pacific Islander

In 2008, Asians or Pacific Islanders represented 5.43% of Maryland's overall population, and between 0.24% and 14.22% depending on jurisdiction, as reported in the Maryland Vital Statistics Annual Report, 2008 [1]. These data indicate that most of this population lives in the National Capital Area (where Montgomery County has nearly half of this population), with the Baltimore Metro Area second.

Table 2. Asian or Pacific Islander population of Maryland by Jurisdiction, 2008

	All races	Asian/PI	% of jurisdiction that is Asian/PI	% of Maryland Asian/PI Pop that lives in the Jurisdiction
MARYLAND	**5,633,597**	**305,847**	**5.43%**	**100.00%**
NORTHWEST AREA	**473,041**	**11,595**	**2.45%**	**3.79%**
GARRETT	29,698	72	0.24%	0.02%
ALLEGANY	72,238	520	0.72%	0.17%
WASHINGTON	145,384	2,221	1.53%	0.73%
FREDERICK	225,721	8,782	3.89%	2.87%
BALTIMORE METRO AREA	**2,620,026**	**110,494**	**4.22%**	**36.13%**
BALTIMORE CITY	636,919	14,115	2.22%	4.62%
BALTIMORE COUNTY	785,618	35,505	4.52%	11.61%
ANNE ARUNDEL	512,790	18,029	3.52%	5.89%
CARROLL	169,353	2,987	1.76%	0.98%
HOWARD	274,995	34,105	12.40%	11.15%
HARFORD	240,351	5,753	2.39%	1.88%
NATIONAL CAPITAL AREA	**1,771,532**	**170,644**	**9.63%**	**55.79%**
MONTGOMERY	950,680	135,175	14.22%	44.20%
PRINCE GEORGE'S	820,852	35,469	4.32%	11.60%
SOUTHERN AREA	**331,040**	**7,864**	**2.38%**	**2.57%**
CALVERT	88,698	1,379	1.55%	0.45%
CHARLES	140,764	3,997	2.84%	1.31%
ST MARY'S	101,578	2,488	2.45%	0.81%
EASTERN SHORE AREA	**437,958**	**5,250**	**1.20%**	**1.72%**
CECIL	99,926	1,121	1.12%	0.37%
KENT	20,151	166	0.82%	0.05%
QUEEN ANNE'S	47,091	553	1.17%	0.18%
CAROLINE	33,138	263	0.79%	0.09%
TALBOT	36,215	369	1.02%	0.12%
DORCHESTER	31,998	320	1.00%	0.10%
WICOMICO	94,046	1,729	1.84%	0.57%
SOMERSET	26,119	243	0.93%	0.08%
WORCESTER	49,274	486	0.99%	0.16%

Source: Maryland Vital Statistics Annual Report 2008 [1]

c. ***Hispanic or Latino***

In 2008, Hispanics or Latinos represented 6.67% of Maryland's overall population, and between 0.69% and 14.80% depending on jurisdiction, as reported in the Maryland Vital Statistics Annual Report, 2008 [1]. These data indicate that most of this population lives in the National Capital Area (where Montgomery County has over a third and Prince George's County has over a quarter of this population), with the Baltimore Metro Area second.

Table 3. Hispanic or Latino population of Maryland by Jurisdiction, 2008

	All races	Hispanic	% of jurisdiction that is Hispanic	% of Maryland Hispanic Pop that lives in the Jurisdiction
MARYLAND	**5,633,597**	**375,830**	**6.67%**	**100.00%**
NORTHWEST AREA	**473,041**	**18,541**	**3.92%**	**4.93%**
GARRETT	29,698	205	0.69%	0.05%
ALLEGANY	72,238	770	1.07%	0.20%
WASHINGTON	145,384	3,925	2.70%	1.04%
FREDERICK	225,721	13,641	6.04%	3.63%
BALTIMORE METRO AREA	**2,620,026**	**88,018**	**3.36%**	**23.42%**
BALTIMORE CITY	636,919	17,014	2.67%	4.53%
BALTIMORE COUNTY	785,618	24,528	3.12%	6.53%
ANNE ARUNDEL	512,790	23,037	4.49%	6.13%
CARROLL	169,353	3,194	1.89%	0.85%
HOWARD	274,995	13,659	4.97%	3.63%
HARFORD	240,351	6,586	2.74%	1.75%
NATIONAL CAPITAL AREA	**1,771,352**	**245,982**	**13.89%**	**65.45%**
MONTGOMERY	950,680	140,657	14.80%	37.43%
PRINCE GEORGE'S	820,852	105,325	12.83%	28.02%
SOUTHERN AREA	**331,040**	**10,691**	**3.23%**	**2.84%**
CALVERT	88,698	2,237	2.52%	0.60%
CHARLES	140,764	5,484	3.90%	1.46%
ST MARY'S	101,578	2,970	2.92%	0.79%
EASTERN SHORE AREA	**437,958**	**12,598**	**2.88%**	**3.35%**
CECIL	99,926	2,363	2.36%	0.63%
KENT	20,151	723	3.59%	0.19%
QUEEN ANNE'S	47,091	976	2.07%	0.26%
CAROLINE	33,138	1,608	4.85%	0.43%
TALBOT	36,215	1,155	3.19%	0.31%
DORCHESTER	31,998	712	2.23%	0.19%
WICOMICO	94,046	3,244	3.45%	0.86%
SOMERSET	26,119	625	2.39%	0.17%
WORCESTER	49,274	1,198	2.43%	0.32%

Source: Maryland Vital Statistics Annual Report 2008 [1]

d. Black or African American

In 2008, Blacks or African Americans represented 30.04% of Maryland's overall population, and between 0.96% and 66.66% depending on jurisdiction, as reported in the Maryland Vital Statistics Annual Report, 2008 [1]. These data indicate that most of this population lives in the Baltimore Metro Area (where Baltimore City has almost a quarter of this population), with the National Capital Area second (where Prince George's County has almost a third of this population).

Table 4. Black or African American population of Maryland by Jurisdiction, 2008

	All races	African-Am	% of jurisdiction that is African-Am	% of Maryland African-Am Pop that lives in the Jurisdiction
MARYLAND	**5,633,597**	**1,692,495**	**30.04%**	**100.00%**
NORTHWEST AREA	**473,041**	**41,266**	**8.72%**	**2.44%**
GARRETT	29,698	286	0.96%	0.02%
ALLEGANY	72,238	4,887	6.77%	0.29%
WASHINGTON	145,384	14,764	10.16%	0.87%
FREDERICK	225,721	21,329	9.45%	1.26%
BALTIMORE METRO AREA	**2,620,026**	**779,699**	**29.76%**	**46.07%**
BALTIMORE CITY	636,919	409,800	64.34%	24.21%
BALTIMORE COUNTY	785,618	200,875	25.57%	11.87%
ANNE ARUNDEL	512,790	81,602	15.91%	4.82%
CARROLL	169,353	7,068	4.17%	0.42%
HOWARD	274,995	49,624	18.05%	2.93%
HARFORD	240,351	30,730	12.79%	1.82%
NATIONAL CAPITAL AREA	**1,771,532**	**713,104**	**40.25%**	**42.13%**
MONTGOMERY	950,680	165,899	17.45%	9.80%
PRINCE GEORGE'S	820,852	547,205	66.66%	32.33%
SOUTHERN AREA	**331,040**	**85,016**	**25.68%**	**5.02%**
CALVERT	88,698	13,115	14.79%	0.77%
CHARLES	140,764	56,224	39.94%	3.32%
ST MARY'S	101,578	15,677	15.43%	0.93%
EASTERN SHORE AREA	**437,958**	**73,410**	**16.76%**	**4.34%**
CECIL	99,926	6,111	6.12%	0.36%
KENT	20,151	3,245	16.10%	0.19%
QUEEN ANNE'S	47,091	3,972	8.43%	0.23%
CAROLINE	33,138	4,844	14.62%	0.29%
TALBOT	36,215	5,118	14.13%	0.30%
DORCHESTER	31,998	8,934	27.92%	0.53%
WICOMICO	94,046	22,880	24.33%	1.35%
SOMERSET	26,119	11,009	42.15%	0.65%
WORCESTER	49,274	7,297	14.81%	0.43%

Source: Maryland Vital Statistics Annual Report 2008 [1]

IV. Summary of Health Disparities by Racial/Ethnic Group

a. American Indian or Alaska Native Data

The Vital Statistics Administration of the Maryland Department of Health and Mental Hygiene estimates the American Indian or Alaska Native population of Maryland to have been 23,468 persons in 2008 [1], or 0.4% of the State's population.

About 60% of Maryland's American Indian and Alaska Native population report more than one race on Census Bureau surveys [4], [5]. The Vital Statistics estimate above uses a method designed to generate a population estimate that is compatible with data systems that do not report more than one race. If one considers the Maryland population reporting some American Indian or Alaska Native heritage (reporting that race alone or in combination with other races), in 2008 that estimate is about 47,000 persons, or 0.8% of the state's population.

(The differences between the Vital Statistics estimates and the "alone or in combination" estimates for other racial groups are not larger than 4% of the population of that racial group).

Health disparities for American Indians or Alaska Natives can be demonstrated in Maryland for the following issues:

- Infant mortality for American Indians or Alaska Natives was 1.8 times higher than for Whites for the period 2004 to 2008 combined [6].

- The rate of new cases of End-stage Renal Disease (kidney disease) for American Indians or Alaska Natives was about 3 times higher than for Whites for the period 1991 to 2001 combined [7].

- The percent of pregnant American Indian or Alaska Native women who received late or no prenatal care was about 1.1 times higher than the percent for White women for the period 2004 to 2008 combined [6].

Additional disparities for Maryland's American Indian or Alaska Native population are likely to exist, but are difficult to demonstrate at this time due to limitations in our data systems and the small size of this population.

b. Asian or Pacific Islander Data

The Vital Statistics Administration of the Maryland Department of Health and Mental Hygiene estimates the Asian or Pacific Islander population of Maryland to have been 305,847 persons in 2008 [1], or 5.4% of the state's population.

Health disparities for Asians or Pacific Islanders can be demonstrated in Maryland for the following issues:

- The rate of new cases of End-stage Renal Disease (kidney disease) for Asians or Pacific Islanders was about 1.3 times higher than for Whites at ages 65 or older for the period 1991 to 2001 combined [7].

- The proportion of adults without health insurance was 1.7 times higher for Non-Hispanic Asians or Pacific Islanders than for Non-Hispanic Whites for the period 2004 to 2008 combined [8].

- The proportion of adults unable to afford health care in the prior year was 1.5 times higher for Non-Hispanic Asians or Pacific Islanders than for Non-Hispanic Whites for the period 2004 to 2008 combined [8].

- The percent of pregnant Asian or Pacific Islander women who received late or no prenatal care was about 1.3 times higher than the percent for White women for the period 2004 to 2008 combined [6].

- Non-Hispanic Asians or Pacific Islanders were half as likely as Non-Hispanic Whites to have seen a provider for a mental health problem [9], despite having a similar rate of reporting poor mental health [10].

Additional disparities for Maryland's Asian or Pacific Islander population are likely to exist, but are difficult to demonstrate at this time due to limitations in our data systems and the small size of this population.

*c. **Hispanic or Latino Data***

The Vital Statistics Administration of the Maryland Department of Health and Mental Hygiene estimates the Hispanic or Latino population of Maryland to have been 375,830 persons in 2008 [1], or 6.7% of the State's population.

Health disparities for Hispanics or Latinos can be demonstrated in Maryland for the following issues:

- The rate of new cases of End-stage Renal Disease (kidney disease) for Hispanics or Latinos was about 1.3 times higher than for Non-Hispanic Whites at ages 65 or older for the period 1996 to 2001 combined [7].

- The rate of new cases of HIV for Hispanics or Latinos was about 2.7 times higher than for Non-Hispanic Whites in 2007 [11].

- The rate of new cases of AIDS for Hispanics or Latinos was about 4.0 times higher than for Non-Hispanic Whites in 2007 [11].

- The proportion of adults without health insurance was 4.7 times higher for Hispanics or Latinos than for Non-Hispanic Whites for the period 2004 to 2008 combined [8].

- The proportion of adults unable to afford health care in the prior year was 2.9 times higher for Hispanics or Latinos than for Non-Hispanic Whites for the period 2004 to 2008 combined [8].

- The percent of pregnant Hispanic or Latino women who received late or no prenatal care was about 3.5 times higher than the percent for White women for the period 2004 to 2008 combined [6].

- Hispanics or Latinos were half as likely as Non-Hispanic Whites to have seen a provider for a mental health problem [9], despite having a similar rate of reporting poor mental health [10].

Additional disparities for Maryland's Hispanic or Latino population are likely to exist, but are difficult to demonstrate at this time due to limitations in our data systems and the small size of this population.

d. Black or African American Data

The Vital Statistics Administration of the Maryland Department of Health and Mental Hygiene estimates the Black or African American population of Maryland to have been 1,692,495 persons in 2008 [1], or 30.0% of the State's population.

With this large of a population, health disparities for Blacks or African Americans can be demonstrated in Maryland for a wide variety of issues:

- The age-adjusted death rate from all causes combined was 1.25 times higher for Blacks or African Americans than for Whites in 2008 [1]. For specific causes of death, compared to Whites, the Black or African American death rates were:
    - 1.3 times higher for heart disease
    - 1.2 times higher for cancer
    - 1.2 times higher for stroke
    - 2.1 times higher for diabetes
    - 1.9 times higher for septicemia
    - 2.0 times higher for kidney diseases
    - 5.9 times higher for homicide
    - 15.5 times higher for HIV/AIDS [1]

- Infant mortality for Blacks or African Americans was 2.6 times higher than for Whites for the period 2004 to 2008 combined [6].

- Non-Hispanic Black or African American adults reported higher prevalence of the following compared to Non-Hispanic whites for the period 2004 to 2008 [8]:
    - a diagnosis of diabetes at all adult ages
    - a diagnosis of hypertension (high blood pressure) at all adult ages
    - current cigarette smoking for ages 45 and older.

- The rate of new cases of End-stage Renal Disease (kidney disease) for Blacks or African Americans was about 3.0 times higher than for Whites for the period 1991 to 2001 combined [7].

- The rate of new cases of HIV for Non-Hispanic Blacks or African Americans was about 11 times higher than for Non-Hispanic Whites in 2007 [11].

- The rate of new cases of AIDS for Non-Hispanic Blacks or African Americans was about 13 times higher than for Non-Hispanic Whites in 2007 [11].

- Compared to Whites, in 2006 Black or African American adults had
    - 1.3 times higher prevalence of asthma
    - 4.3 times higher emergency department visit rate for asthma
    - 2.4 times higher hospitalization rate for asthma
    - 2.4 times higher mortality rate for asthma [12].

- The proportion of adults without health insurance was 2.1 times higher for Non-Hispanic Blacks or African Americans than for Non-Hispanic Whites for the period 2004 to 2008 combined [8].

- The proportion of adults unable to afford health care in the prior year was 1.8 times higher for Non-Hispanic Blacks or African Americans than for Non-Hispanic Whites for the period 2004 to 2008 combined [8].

- The percent of pregnant Black or African American women who received late or no prenatal care was about 2.9 times higher than the percent for White women for the period 2004 to 2008 combined [6].

- Non-Hispanic Blacks or African Americans were half as likely as Non-Hispanic Whites to have seen a provider for a mental health problem [9], despite having a greater rate of reporting poor mental health [10].

- MHHD has estimated that the hospital cost of excess Black or African American admissions in Maryland in 2004 was at least $481 million (not including the physician fee component of hospitalization or any emergency department cost prior to the admission) [13].

C. THE 2004 – 2010 HEALTH DISPARITIES PLAN & PROGRESS

I. Focus of the Plan

The first *Maryland Plan to Eliminate Minority Health Disparities* was released in December of 2006. The development of the Plan, two years in the making, was a coordinated effort by the Maryland Office of Minority Health and Health Disparities (MHHD) with the public, health professionals, academia, community health groups, other stakeholders, and the Maryland Department of Health and Mental Hygiene (DHMH). The Plan presented a health disparities discussion, with accompanying data on health disparities in Maryland as well as the nation. Additionally, challenges and solutions to eliminating health disparities, gathered through public comment, were presented.

II. Dissemination of the Plan

The Plan was initially distributed, both in hard copy and electronic format, to over 2,000 community groups, legislators and health advocates. Since the Plan's publication, additional copies have been distributed and downloaded from MHHD's Website (*www.dhmh.maryland.gov/hd/planelimdisp.html*). In addition, a two-page Plan Fact Sheet was developed to serve as a brief overview of the Plan. This summary document is distributed primarily in hard-copy format at various events, exhibits, and other informational activities.

III. Implementation Activities

Since the Plan publication in 2006, MHHD has undertaken numerous activities based upon stakeholder recommendations and has implemented many of the suggested strategies. Some examples include:

- Assisted other DHMH programs with minority health and health disparities issues; developed partnerships with health profession colleges and universities in Maryland toward addressing workforce diversity and cultural competency; and developed disparities data to help local entities target their health disparities elimination efforts.

- Assisted in various DHMH initiatives that impact minority health through participation or staffing the Clean Indoor Air Act; the Sickle Cell Disease Steering Committee; Workgroup on Cultural Competency for Mental Health Professionals; Task Force on Minority Participation in the Environmental Community; and the Maryland Commission for Men's Health.

- Hosted annual statewide health disparities conferences gathering 420 participants in 2007, 415 participants in 2008, and 320 participants in 2009.

- Coordinated and co-hosted, with the Maryland Legislature, the 2008 Summit on "Health Disparities: Impact on Business and Economics" that addressed the cost and quality of care. Held in October 2008, approximately 200 persons attended the summit.

- Documented program accomplishments through the submission of annual reports on House Bill 883, the Health Care Services Disparities Prevention Act and House Bill 86, which established the Maryland Office of Minority health and Health Disparities.

IV. Implementation Results and Progress

All functions and operations of MHHD were dedicated to implementing the recommendations and strategies outlined in the 2006 Plan. Both public and private partners were recruited to assist in this statewide initiative.

a. Statewide Collaborations

• The Maryland Statewide Health Disparities Collaborative (The Collaborative) was established in 2008 and serves as the advisory body to the Maryland Minority Health Disparities Initiative.

• The Collaborative is co-chaired by DHMH Secretary John M. Colmers and Ms. Donna Jacobs, Esq., University of Maryland Medical System. The group met twice to provide input to the National Partnership for Action Plan and to identify key actions for Maryland.

• The Statewide Annual Minority Health Disparities Conference has been held six times, attracting 300 to 400 attendees each year. The conferees identified priority actions for Maryland to address the reduction of minority health disparities.

• African American, Hispanic/Latino, Asian American and Native American roundtable discussions have been held with each group to gather input on the major health challenges faced by their members and to identify actions for solution.

• Town hall meetings were held in six regions of the state to gather input from remote and geographically diverse areas regarding recommendations for improving the health of their communities.

• Collaborated with the Maryland Legislature to convene a summit in 2008 on the relationship between health disparities, economics and business. Approximately 200 individuals participated, including elected officials, business leaders, health providers and health disparities interest groups.

b. HHS, Office of Minority Health – Five-Year Partnership Grant

MHHD received funding for Federal fiscal years 2005-2010 to address reducing health disparities in Maryland. The grant has two focus areas: (1) increase workforce diversity and cultural competency, and (2) promote greater focus on eliminating minority health disparities within the State health department programs.

1. Workforce Diversity and Cultural Competency

• Outreached to over 450 individual stakeholders in the state through technical assistance and local presentations on workforce diversity and cultural competency.

• Participated in a Statewide Commission on the Shortage in the Healthcare Workforce to bring attention to workforce shortage issues that impact health workforce diversification.

•Established baseline data and continued to monitor annual enrollment and graduation rates of minority students in health professions schools in Maryland.

• Established and maintained relationships with the deans and other faculty at 16 health professions schools, administrators at 4 local hospital systems, and the 17 health occupations boards in Maryland; laid foundation for development of a Maryland Health Alliance based on the model of the Sullivan Alliance to Transform America's Health Professions.

• Facilitated two nursing roundtable forums, with 32 attendees representing 9 baccalaureate nursing programs to discuss curriculum enhancement, faculty sharing, pipeline outreach and the pressing need for faculty and clinical placements.

• Facilitated discussions between the HBCU schools of nursing and the Maryland Higher Education Commission (MHEC) regarding improving access to state funds to support students, faculty and infrastructure.

• Met with the Maryland Association of Community Colleges and discussed potential opportunities for collaboration with the state's community colleges on health workforce diversity issues.

• Held meetings with MHEC and the Maryland Independent College and University Association (MICUA) to share strategies for monitoring and promoting the inclusion of cultural competency training in professional education programs.

• Provided technical assistance to MHEC in developing a standardized survey of college and university-based cultural diversity activities in the state.

• Submitted a report to the State Legislature on cultural competency training in Maryland's health professions schools. The report (developed in response to House Bill 942 (2008)) is a compilation and analysis of data reported on cultural competency courses and clinical experiences offered to health professions students at nine Maryland universities. The report was shared with MHEC, MICUA, and the participating health professions schools.

• Collaborated with Sinai, Maryland General and St. Agnes hospitals to develop a cultural competency training module for physicians-in-training.

• Provided technical assistance to Sinai Hospital leadership in conducting an Administrative Grand Rounds discussion on health disparities, using excerpts from the documentary "Unnatural Causes" to illustrate the role of cultural competency in providing safe and effective health care. Serve on the Sinai Hospital Health Disparities Community Advisory Panel.

• Worked with the DHMH Health Occupations Boards to promote cultural competency awareness among the state's health professional licensees. Presented cultural competency concepts to new board members at the DHMH Council of Boards and The Commission new board member trainings; wrote five articles on cultural competency for Board newsletters and websites; and provided information about more than 60 opportunities related to cultural competency training, conferences and technical assistance resources.

• Provided technical assistance to the Maryland Board of Psychologists to develop Board guidelines for continuing education credits in cultural competency.

• Provided health career information to diverse students at four urban middle schools and held a "health careers day" at DHMH for employees' children on "Bring your Child to Work Day."

• Continuously scanned, monitored and disseminated developments in national guidelines and promising practices. Disseminated over 100 publications on the latest research and over 90 funding opportunities related to diversity recruitment and retention practices and culturally and linguistically-responsive care.

2. *Health Department Assessment & Systems Change*

The purpose of the Systems Change initiative is to encourage and assist DHMH programs that address the major health disparities in Maryland to conduct a self-assessment and produce actions plans. The action plans are to identify specific changes in the programs that would measure, report and increase the rate of reductions in health disparities.

• Six DHMH programs completed actions plans. These programs include the HIV/AIDS Administration; Family Health Administration's Center for Maternal and Child Health and Diabetes Prevention and Control Program; the Community Health Administration's Epidemiology and Disease Control Programs; and the Mental Hygiene Administration.

• The Family Health Administration and Mental Hygiene Administration have begun to implement recommendations in their respective action plans.

• Working partnerships were developed with numerous DHMH programs to provide technical assistance and to work collaboratively on reducing health disparities.

Family Health Administration

• Office of Chronic Disease Prevention - MHHD membership on Executive Committee of the Maryland Asthma Control Program and the Statewide Asthma Training Committee. MOTA grantees serve as a resource in Maryland Asthma Control Program community outreach activities.

• Center for Maternal and Child Health - MHHD membership on the Babies Born Healthy Summit planning committee and collaboration with the Maternal and Child Health program on reducing Infant Mortality (MHHD-FHA).

• Office for Genetics and Children with Special Health Care Needs - Joint staffing for the Statewide Steering Committee on Developing Services for Adults with Sickle Cell Disease.

Community Health Administration

• MHHD served on the planning team for the new online network of environmental health data called the Environmental Public Health Tracking Network (EPHTN).

• MHHD participated in the proceedings of the Statewide Taskforce on Minority Participation in the Environmental Community and the Commission on Environmental Justice and Sustainable Communities.

• MHHD provided technical assistance to the Office of Epidemiology & Disease Control Programs in the development of an Action Plan to increase awareness of and treatment for Hepatitis C in minority communities.

HIV/AIDS Administration

- Provided Cultural Competency Training Workshop for the HIV/AIDS Administration leadership staff.

- MHHD provided technical assistance to the Health Communications Division of the HIV/AIDS Administration in its development of an Action Plan for serving minority communities.

Assistant Attorney General's Office in State Health Department

- Provided Cultural Competency Training Workshop to the leadership staff in the DHMH Office of the Attorney General.

Behavioral Health and Disabilities

- MHHD staff members served on the Maryland delegation to the National Policy Summit on the Elimination of Disparities in Mental Health Care, sponsored by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

- Jointly with the Mental Hygiene Administration, staffed the Maryland Workgroup on Cultural Competency and Workforce Development for Mental Health Professionals (House Bill 524 (2007)) and contributed to the final report to the State Legislature.

c. Measuring & Monitoring Health Disparities

- Published the first edition of the Maryland Chartbook of Minority Health and Minority Health Disparities Data in November 2007. The Chartbook includes data on minority health disparities trends and has been distributed to over 1,400 individuals. The second edition of the Chartbook was published in January 2010.

- Presented health disparities data to a variety of Maryland State and Local government entities including committees and subcommittees of the General Assembly, the Legislative Black Caucus, the Maryland Health Officers Public Health Roundtable, and local health departments.

- Prepared health disparities data presentations for each of six annual statewide health disparities conferences; the Maryland Legislative Summit on Health Disparities: Economics, Business and Cost; the Maryland Community Health Resources Commission; and the Statewide Cancer Council Conference.

- Provided annual Highlight Reports that showed changing health disparities trends in the state as a whole and in selected jurisdictions. Analyzed minority infant mortality and minority cardiovascular disease trends in jurisdictions to identify where health disparities resources should be targeted.

- Presented health disparities data at national meetings including the annual American Public Health Association, the National Institute of Health Disparities Conference, and the biannual Diversity RX conferences.

• Partnered with the Maryland Health Care Commission (MHCC) to incorporate racial and ethnic data into their annual healthcare quality reports. Collaborated with MHCC and Mathematica Policy Research in the production of two reports on health disparities in hospitalization rates for Maryland Medicare beneficiaries, in December 2008.

d. ***Health Information and Resource Support***

• The MHHD Website (*www.dhmh.maryland.gov/hd*) provided a listing of funding opportunities and available resources including trainings, fellowships and internships. Additionally, a calendar of events was maintained that listed select local and national minority health events of interest. From 2005-2009, over 1,700,000 hits were received on the website.

• Between January 2007 and December 2009, over 212 different health messages were distributed, by electronic mail, to targeted racial/ethnic contacts throughout the state, totaling over 39,580 email messages. Message content included information on upcoming events, recently released reports and documents, available resources and funding opportunities related to disparities.

• Maintained an Information Clearinghouse on minority health and health disparities reports, materials, and resources. The clearinghouse held over 1,000 readily accessible materials and conducted comprehensive searches of other health disparities-related information.

• Displayed MHHD exhibit at community, state and national events. Select events include: Annual Maryland State Council on Cancer Control Conference, Legislative Black Caucus, Take a Loved One to the Doctor Day, African American Men's Health Conference, National Hispanic Medical Association Meeting, and numerous Community Health Fairs and Events. In addition to formal exhibits, MHHD distributes hard copy health and resource information regularly at meetings and activities.

• Planned and organized six statewide health disparities conferences and one statewide legislative summit. Staff plan and coordinate health disparities conferences, reaching 300-400 participants annually, with timely local and national health disparities research findings, information and resources.

e. ***Health Disparities Reduction Demonstration Pilot Projects***

The Maryland Office of Minority Health and Health Disparities launched a series of demonstration pilot projects to aid state jurisdictions in using best practices to successfully target minority health disparities. These pilot projects began in 2007.

1. Charles County - Through collaboration between the Cigarette Restitution Fund Program (CRFP) and MHHD programs, the Charles County Health Department created a pilot prostate cancer program to increase awareness, increase screening rates, and target the uninsured county residents. The Charles County project educated approximately 2,450 individuals and screened 100 men.

2. Baltimore City - Using a cooperative agreement grant model, MHHD funded the Baltimore City Health Department to implement a Minority Cardiovascular Disease Mortality Reduction Project. The project incorporates a community coalition and lay community health workers and delivers services in the community using a cultural competency strategy. Baltimore City also partnered with the Prince George's County Health Department in developing cardiovascular plans for their respective jurisdictions as well as strategies for the jurisdictions to work collaboratively.

3. Prince Georges County - Using a cooperative agreement grant model, MHHD funded the Prince George's County Health Department to implement a Minority Infant Mortality Reduction Project. The project incorporates a community coalition and lay perinatal navigators and delivers services in the community using a cultural competency strategy. The project also funded renovation of an existing site to offer enhanced clinical services that address determinants of health in the care of at-risk pregnant women.

4. Montgomery County - Using a cooperative agreement grant model, MHHD funded the Montgomery County Health Department to implement a Minority Infant Mortality Reduction Project. The project incorporates a community coalition and lay health promoters and delivers services in the community using the social determinants of health framework.

f. H1N1 (Swine Flu) Statewide Outreach Project

MHHD participated on the DHMH H1N1 Planning Team. The MHHD role was to provide advice on matters that related to reaching all groups in the state population and to ensure that cultural and linguistic competency concerns were addressed. MHHD received funds supported by DHMH through the Centers for Disease Control (CDC) Public Health Emergency Response (PHER) to put in place a H1N1 Community Services Outreach Program in each of the state's 24 jurisdictions. The H1N1 Outreach Program was built on the existing overarching Cigarette Restitution Fund Program's Minority Outreach and Technical Assistance (MOTA) program, whose statewide minority network was created in 2000 using Tobacco Master Settlement funds to reduce tobacco use and cancer among ethnic and racial minorities throughout the state.

• Grants were provided to local health departments, MOTA network providers and local minority organizations to hire, train, and supervise an H1N1 Outreach Worker in each jurisdiction.

• A minority consultant group was contracted to assist in developing an H1N1 Outreach Toolkit, develop a training program, and provide training to the newly hired outreach workers.

• MHHD works with the DHMH Office of Communications to review and comment on H1N1 information materials to ensure cultural competency, health literacy and linguistic competence.

• MHHD monitors data on vaccine delivery to each jurisdiction and data on vaccine recipients to determine whether adequate vaccine supply is being delivered to Maryland's high-minority jurisdictions and whether the immunization rates are comparable to the rates for the non-minority members of the H1N1 priority populations.

g. Minority Outreach & Technical Assistance Program (MOTA)

• For fiscal years 2006-2009, $1.2 million of tobacco settlement funds were distributed annually to 16-18 minority and minority-serving community-based organizations throughout the state to reduce tobacco use and control cancer. Grantees worked with local health departments and minority groups to promote awareness, cancer screening, treatment, and smoking cessation and prevention.

• The number of persons reached at various MOTA-sponsored community events totaled 20,378 for FY06; 209,660 for FY07; 377,030 for FY08; and 480,424 for FY09.

• Technical assistance sessions provided to individuals and community-based groups on cancer/tobacco initiatives via electronic messages, and one-on-one or group sessions numbered 73 for FY06: 126 for FY07; 111 for FY08; and 2,436 for FY09.

• The number of community health fairs and cultural events conducted and/or sponsored by MOTA grantees totaled 24 for FY06; 597 for FY07; 496 for FY08; and 1,542 for FY09.

• MOTA actively engaged minorities to attend the local health departments' community health coalition meetings. Minorities that attended cancer/tobacco community health coalition meetings numbered 133 for FY06; 421 for FY07; 338 for FY08; 433 for FY09.

• Between FY 2007 and FY 2009, 438,716 cancer/tobacco health materials/brochures were distributed within the funded jurisdictions.

• Between FY 2007 and FY 2009, a total of 20,907 tobacco cessation program referrals were made, as well as 15,060 cancer screening referrals.

• Since 2000, Maryland has significantly increased cancer screening rates, particularly for colorectal cancer, and has reduced the gap between African American and White cancer mortality by 50%.

h. Statewide Minority Health Disparities Network

• Established a Minority Health Network electronic database and mail distribution list of approximately 3,000 individuals and organizations from around the state.

• The Minority Health Network database was used to inform groups, individuals and organizations about key health issues, late breaking news and important publications and best practices.

• The primary recipients of the minority health information subsequently distributed this information to their local partners and constituents. In turn, MHHD received regular requests for speaking engagements, health disparities data, and health disparities information booths and exhibits.

i. ***Healthy Check***

• The Healthy Check program is a coordinated health and wellness initiative between DHMH, through the Office of Minority Health and Health Disparities, and the Maryland General Hospital in Baltimore.

• The program offered free health screening and medical services on-site bi-weekly to the nearly 3,500 State employees, who are employed at the State Center Complex at Preston and Howard Streets.

• Healthy Check began in May 2008 and offered a variety of regular screening services, including blood pressure screening, cholesterol screening, glucose screening, and PSA screening. Specialty services including vascular and vision screening, dermatology consultation, mental health and stress management, and nutrition advice were offered on a rotating basis. Additional health and wellness information was made available at each screening event.

• The program served as a resource to help employees, some of whom may not have a regular source of health care, to take charge of their health and improve their quality of life, with the goal of producing a healthier workforce.

• MHHD organized 26 Healthy Check events between May 2008 and July 2009. Over 9,000 employees and visitors attended these events, out of which 1,599 received one or more screening services.

• 98,000 health e-mail reminder messages were disseminated to employees within the State Center Complex between May 2008 and July 2009 for the Healthy Check initiative.

• DHMH has utilized the Healthy Check events to provide employees with information from various administrations through exhibits. Additionally, in June 2009, MHHD assisted the DHMH leadership in coordinating an Employee Appreciation Health and Wellness Event that provided exhibits, health-related demonstrations, health information, and nutrition counseling, relaxation, and exercise opportunities.

j. ***Legislation***

• In 2007, the Maryland General Assembly passed legislation (House Bill 524) establishing a workgroup on cultural competency and workforce development for mental health professionals. In January 2008, the workgroup presented a final report of its findings to the General Assembly with recommendations to promote cultural competency training for mental health professionals and increase the number of foreign-born and foreign-trained mental health professionals in Maryland.

• In 2007, the Maryland General Assembly passed legislation (House Bill 788) allowing health insurers to collect information about an individual's race and ethnicity in order to evaluate quality of care outcomes and performance measures. The bill specifically prohibits health insurers from using racial and ethnic data to deny, limit, or cancel coverage, or affect the health insurance policy in any way.

- In 2007, the Maryland General Assembly passed legislation establishing a Statewide Steering Committee on Services for Adults with Sickle Cell Disease (House Bill 793). In December 2008, the Committee submitted a report to the General Assembly with recommendations to improve the quality of life for adults living with sickle cell disease (SCD), including the development of a statewide patient registry, development of standard protocols for emergency SCD treatment, and increasing education to the public and patients about SCD.

- In 2008, the Maryland General Assembly passed House Bill 942 which required schools of medicine, dentistry, pharmacy, and nursing in Maryland to report on their courses and clinical offerings that address cultural competency, sensitivity, and health literacy. MHHD worked with the health professions schools to develop a reporting format and coordinated the collection of data. All nine schools submitted reports to MHHD and the General Assembly. MHHD conducted an analysis of the reports and submitted a final summary report to the General Assembly in September 2009.

- In 2008, the Maryland General Assembly passed House Bill 905, which required institutions of higher education to evaluate their programs that promote and enhance cultural diversity, and prepare reports to their respective educational governing bodies on the status of the programs. MHHD met with both the Maryland Independent College and University Association (MICUA) and the Maryland Higher Education Commission (MHEC) to discuss the content and format of the reports. MHHD is currently providing technical assistance to MHEC in its development of a standardized reporting tool to be used by institutions of higher education in submitting future House Bill 905 reports on diversity activities.

- During the 2009 legislative session, the Maryland General Assembly passed legislation (House Bill 756) creating a Cultural and Linguistic Health Care Provider Program, which encourages health professional societies to offer training and education to health care providers on cultural competency, linguistic competency, and health literacy.

k. Business Case for Eliminating Health Disparities

Cost of Disparities: Cost of Excess African American Hospital Admissions for Ambulatory Care Sensitive Conditions (ACSC)

• The Maryland Health Care Commission (MHCC), in consultation with the Office of Minority Health and Health Disparities, commissioned an analysis of factors accounting for differences in rates of admission for ambulatory care sensitive conditions (ACSC) in the Maryland fee-for-service Medicare population in 2006.

• ACSCs are conditions where optimal outpatient care can prevent the need for most hospital admissions. The estimated costs of excess African American admissions for Maryland Medicare fee-for-service enrollees age 65 and older, in 2006, are shown below. (Source: http://mhcc.maryland.gov/spotlight/disparities2006.pdf)

Cost of Disparities, Maryland 2006
Cost of Excess African American Admissions
Hospital Component of Hospital Admissions
MHCC analysis of Maryland Medicare data

Primary Diagnosis	Medicare Excess Cost
Congestive Heart Failure	$13 Million
Urinary Tract Infection	$2 Million
Dehydration	$2 Million
Diabetes	$5 Million
Asthma	$1 Million
Hypertension	$1 Million

Does not include Physician component of Hospital Admission
Does not include Emergency Room costs
Does not include Outpatient Care costs

l. Presentations and Publications

• Published two editions of the *Maryland Chartbook of Minority Health and Minority Health Disparities Data* (2007, 2010), *Best Practices in Capacity Building and Disease Management Prevention to Address Minority Health Disparities* (2007), and the *Maryland Plan to Eliminate Minority Health Disparities, preliminary copy* (2006).

• Presented an abstract: Business case for eliminating health disparities: A "cost of disparity" methodology for state health departments, at the 136th American Public Health Association Annual Meeting in San Diego, CA (October 2008).

- Presented information on MOTA at the Urban Health Conference hosted by the Johns Hopkins University in Baltimore (October 2007).

- Produced jurisdictional and racial/ethnic-specific data highlights and newsletters and informal article contributions.

D. REVISING THE PLAN FOR 2010 – 2014

The first *Maryland Plan to Eliminate Minority Health Disparities*, published in 2006, provided a general overview of health disparities in the state and nation. The Plan presented challenges, recommendations and strategies to eliminate minority health disparities in Maryland. Public comment was gathered from over 1,200 citizens by convening meetings with four health disparities planning committees, six town hall gatherings, five racial/ethnic health roundtables (Native Americans, African Americans, Hispanic/Latinos and Asian Americans), and three statewide health disparities conferences. Input was also collected from Minority Outreach and Technical Assistance (MOTA) grantees and through the MHHD Website.

The strategies in the first Plan, and the subsequent activities and progress, were used as a foundation for developing the current *Plan of Action for 2010-2014*. In addition, MHHD collaborated with the U.S. Department of Health and Human Services (HHS), Office of Minority Health in its development of a "Blueprint for Action" set forth by the National Partnership for Action to End Health Disparities. The draft "Blueprint for Action" and its strategies were accepted by Maryland, as the national strategies closely aligned with state priorities to address health disparities.

Maryland's planning steps for the development of the *2010-2014 Plan of Action* include:

- **Maryland Health Disparities Collaborative Meeting:** Held June, 6, 2008 to share with members of the Collaborative, the federal Office of Minority Health's plan to hold Regional Conversations across the nation. The Collaborative identified health disparities priority issues in Maryland to be discussed at the regional meeting which Maryland would attend.

- **HHS Office of Minority Health Regional Conversations for Regions I, II, and III:** Held June 17 – 19, 2008 in Pennsylvania. HHS brought together local, State, Tribal, regional and Federal experts and practitioners from the private and public sectors to lay the foundation for a comprehensive, community-driven, sustained approach across the Nation. Regional Conversations culminated in the 2009 Minority Health Summit sponsored by HHS Office of Minority Health. The results of the Summit will become part of the National Blueprint for Action.

- **Maryland Health Disparities Collaborative Meeting:** Held August 19, 2008 to review objectives and action steps that were identified at the Regional Conversation held in Pennsylvania and to discuss how they could be utilized and adapted in Maryland.

- **HHS Office of Minority Health 2009 Health Disparities Summit:** Held February 26, 2009 to present the draft National Blueprint for Action for consideration by a wide representation of health disparities advocates, affected persons, and state, local and national leaders. Speakers presented best and promising practices for eliminating health disparities, from throughout the nation and territories.

- **Maryland Health Disparities Collaborative Meeting:** Held August 19, 2009 to review activities and progress in Maryland from implementation of the 2006 *Maryland Plan to Eliminate Minority Health Disparities*. The Maryland Health Disparities Collaborative considered progress in the state and the "National Blueprint for Action" and arrived at a consensus to align the Maryland Plan for 2010-2014 with the new national planning process and format. The Collaborative concurred with distributing the next draft of the new Maryland Plan to a wide and diverse list of Marylanders to obtain greater input.

• **MHHD Staff Preparation—Draft #1:** On October 16, 2009, the MHHD staff mailed a draft of strategies, actions and measures to 421 Collaborative members and requested further input. Approximately nine organizations responded, providing 135 comments. This information was incorporated into an updated draft.

• **MHHD Staff Preparation—Draft #2:** On December 1, 2009, the MHHD staff sent an electronic version of a more complete draft Plan to a larger mailing list of 2,500 individuals throughout the state. Hard copies were mailed to those without electronic access. Approximately 23 organizations responded, providing 74 comments. This information was incorporated into the final draft.

• **Final Draft Publication:** MHHD released the *Plan of Action 2010-2014* in early 2010. It will be distributed in electronic and hard-copy format throughout the state.

E. THE ACTION PLAN

Maryland's *Health Disparities Plan of Action 2010-2014* is based upon the national planning efforts of the U.S Department of Health and Human Services, Office of Minority Health and its National Partnership for Action "Blueprint for Action." The objectives and strategies have been adapted for state-level actions. The specific action steps of the Plan were derived from the planning steps listed in Section D, "Revising the Plan." The following provides an overview of the Action Plan objectives with corresponding strategies.

Objective 1. Awareness – Increase awareness of the significance of health disparities, their impact on the state and local communities, and the actions necessary to improve health outcomes for Maryland's racial and ethnic minority populations.
Strategies include: Healthcare Agenda; Partnerships; Media; Communication

Objective 2. Leadership – Strengthen and broaden leadership for addressing health disparities at all levels.
Strategies include: Capacity Building; Funding and Research Priorities; Youth

Objective 3. Health and Health System Experience – Improve health and health care outcomes for racial and ethnic minorities and underserved populations and communities.
Strategies include: Access to Care; Health Communications; At-Risk Children

Objective 4. Cultural and Linguistic Competency – Improve cultural and linguistic competency.
Strategies include: Workforce Training; Diversity; Standards; Interpretation Services

Objective 5. Research and Evaluation – Improve coordination and use of research and evaluation outcomes.
Strategies include: Data; Community-Based Research; Community-Originated Intervention Strategies; Coordination of Research; Knowledge Transfer

Potential Stakeholders have been identified for each Action Step. The following list provides a definition of stakeholders; all stakeholders mentioned are Maryland-based, unless otherwise noted.

Academic Institutions – Institutions of higher education
All Health Advocates – All individuals working in the state of Maryland to improve the health of minorities and support the reduction of health disparities
CBO – Community-based organizations
DHMH – Maryland Department of Health and Mental Hygiene
FBO – Faith-based organizations
FQHC – Federally Qualified Health Centers
Health Advocacy Organizations – Non-governmental organizations that work to promote health and wellness
Health Care Organizations – Hospitals and other healthcare delivery institutions
Health Professional Associations – Groups or associations that support health professionals
LHD – Local Health Departments
MHHD – Maryland Office of Minority Health and Health Disparities within the Maryland Department of Health and Mental Hygiene
MOTA Grantees – Minority Outreach and Technical Assistance Grantees as funded by Maryland's Cigarette Restitution Fund Program
National/Federal Health Disparities Organizations – Organizations and agencies, both governmental and non-governmental, that have a focus on eliminating disparities nationwide
State Agencies – Agencies that reside under the State government of Maryland

Maryland Department of Health and Mental Hygiene
Office of Minority Health and Health Disparities

Maryland Health Disparities Plan of Action, 2010-2014

Objectives, Action Steps, Potential Stakeholders, and Measures

Objective 1: Awareness – Increase awareness of the significance of health disparities, their impact on the state and local communities, and the actions necessary to improve health outcomes for Maryland's racial and ethnic minority populations

Action Steps	Potential Stakeholders	Measures
1.1 Identify and disseminate current information on health disparities to increase knowledge and understanding among Maryland's health organizations, citizens, and policy makers (e.g., definitions, research findings, data, news reports, resources, etc.). †	□ DHMH/MHHD □ LHD □ Academic institutions □ Health Care Organizations □ CBO □ FBO	□ # of distributions specific to health disparities □ # of visits to state health disparities websites □ # of organizations/institutions disseminating information
1.2 Identify effective and feasible systems-level interventions (e.g., policies) that address the reduction of health disparities.	□ DHMH/MHHD □ Academic Institutions □ Health Care Organizations	□ # of interventions identified and disseminated
1.3 Utilize various media outlets to distribute health messages to targeted minority groups, including non-conventional methods (e.g., utilizing media in artistic/creative ways).	□ Media outlets □ DHMH/MHHD □ LHD □ Health Advocacy Organizations □ Health Care Organizations □ Health Professional Associations	□ # of media outlets engaged □ # of media outlets disseminating health disparities information □ # of organizations utilizing media outlets
1.4 Educate media in its role in the dissemination of health promotion and disease prevention messages.	□ Media outlets □ DHMH/MHHD □ CBO	□ # of trainings and technical assistance provided to media outlets □ # of health promotion and disease prevention messages distributed

1.5 Expand the development and dissemination of culturally and linguistically competent strategies for outreach and public health information/media campaigns, including the Internet, television, radio and print media. †	□ Media outlets □ DHMH/MHHD □ LHD □ Health Advocacy Organizations □ Health Care Organizations □ Health Professional Associations	□ # of new culturally and linguistically competent outreach strategies developed □ # of culturally and linguistically competent outreach strategies distributed
1.6 Establish outreach partnerships with trusted community organizations/individuals to distribute health messages (e.g., foreign-trained health professionals, faith leaders, community advocates, health promoters/community health workers).	□ FBO □ Health Professionals □ CBO □ Health Care Organizations □ Health Advocacy Organizations	□ # of new partnerships formed □ # of partner messages distributed □ # of outreach activities
1.7 Promote the use of new communication technologies as additional tools of outreach to youth and other groups (e.g., social networking websites – Twitter and Facebook; cell phones – text and video messaging).	□ Academic institutions □ DHMH/MHHD □ Department of Education	□ # of organizations using a new technology for the first time □ # of Facebook hits, tweets, text and video messages sent, etc.
1.8 Identify opportunities to provide technical assistance to K-12 school systems in the integration of health disparities education into the existing curriculum. †	□ Department of Education □ DHMH/MHHD □ Academic Institutions □ Local School Boards	□ # of technical assistance sessions provided □ # of schools that add health disparities topics into curriculum
1.9 Engage representatives from national/federal health disparities organizations in state disparities projects to share resources.	□ DHMH/MHHD □ National/Federal Organizations □ CBO □ FBO □ Health Care Organizations □ Health Advocacy Organizations	□ # of new partnerships □ # of joint projects

1.10 Identify potential partnerships with organizations reaching similar target populations to increase collaboration and leverage resources (e.g., specific to racial/ethnic group, socio-economic factors, faith, gender, age).	□ CBO □ FBO □ DHMH/MHHD □ State Agencies	□ # of partnerships/meetings formalized
1.11 Create and target health disparities messages and information to be applicable across the life cycle (e.g., youth, teens, adults, elderly).	□ All health advocates	□ # of life cycle specific messages
1.12 Engage non-traditional partners (e.g., agriculture, business sector) in health disparities activities and discussions.	□ All health advocates	□ # of non-traditional partners contacted □ # of actual participants
1.13 Identify, locate, and provide assistance to individuals who lack awareness or experience in navigating the health care system (e.g., newly uninsured/unemployed, immigrants, refugees).	□ All health advocates	□ # of individuals identified □ # of individuals connected with assistance/aid
1.14 Raise community awareness of the importance and necessity of collecting data on race, ethnicity, country of origin, preferred language, and health insurance status in order to monitor and improve the health of minority populations.	□ LHD □ CBO □ DHMH/MHHD	□ # of awareness outreach efforts
1.15 Conduct health disparities presentations at conferences, meetings, and other events.	□ All health advocates	□ # of health disparities presentations
1.16 Submit written communications specific to health disparities and minority health topics (e.g., news editorials, newsletter articles, journal submissions).	□ All health advocates	□ # of written communications
1.17 Support the sharing and dissemination of data, best practices, and achievements in eliminating health disparities (e.g., state disparities conference, e-mail distributions, community meetings).	□ DHMH/MHHD □ Academic □ CBO □ LHD	□ # of items distributed

Objective 2: Leadership and Capacity Building – Strengthen and broaden leadership for addressing health disparities at all levels		
Action Steps	**Potential Stakeholders**	**Measures**
2.1 Collaborate with communities to assess unmet needs of minority populations in the state.	□ Academic Institutions □ LHD □ CBO	□ # of community collaborations □ # of community assessments
2.2 Promote the development of learning opportunities for youth specific to health and health disparities (e.g., internships, fellowships, service projects).	□ Department of Education □ LHD □ CBO □ Academic Institutions □ Health Advocacy Organizations □ Health Care Organizations	□ # of new youth learning opportunities developed □ # of youth participating in activities
2.3 Conduct leadership training/empowerment activities in communities to promote and support development of community leaders (e.g., youth, lay community members, patient navigators/community health workers). †	□ All health advocates	□ # of community leadership and empowerment activities □ # of participants
2.4 Promote the inclusion of cultural competency, health literacy, and language access issues in health provider trainings and continuing education; and disseminate most current research findings and recommendations. †	□ Academic Institutions □ Health Professional Boards □ Health Care Organizations □ Health Professional Associations □ DHMH/MHHD	□ # of new trainings/continuing education sessions (including disseminated information) □ # of health providers receiving new trainings/continuing education sessions
2.5 Encourage and provide technical assistance to all public sectors, including non-traditional health partners, to create action plans to address health disparities.	□ DHMH/MHHD □ LHD □ CBO	□ # of technical assistance sessions provided □ # of new action plans developed

2.6 Increase minority community participation in decision-making roles that impact the health of minority populations and/or influence operational, programmatic and funding priorities (e.g., representation by minorities on boards, committees, commissions, task forces, and other advisory bodies).	□ All health advocates	□ # of minority community members on boards, advisory bodies, and task forces
2.7 Assist local health programs in increasing the minority communities' participation in health-related activities (e.g., health fairs, screening events, community presentations).	□ LHD □ CBO □ DHMH/MHHD □ FBO	□ # of minorities participating in health related activities
2.8 Establish public-private partnerships that foster creative and innovative activities to enhance the health of minority communities.	□ All health advocates	□ # of partnerships formed □ # innovative health enhancement activities
2.9 Provide training and technical assistance to local, community, and faith-based groups to increase organizational capacity and sustainability, which would facilitate their work to identify and access available resources and conduct health disparities activities.	□ DHMH/MHHD □ MOTA Grantees □ CBO □ LHD □ FBO	□ # of technical assistance sessions provided □ # of training sessions provided □ # of local, community, and faith-based groups participating

Objective 3: Health and Health System Experience – Improve health and health care outcomes for racial and ethnic minorities and underserved populations and communities

Action Steps	Potential Stakeholders*	Measures
3.1 Encourage the use of the social determinants of health framework in health disparities interventions, including the development of health policies and prevention strategies.	□ All health advocates	□ # of new interventions/practices utilizing the social determinants of health

3.2 Promote equitable screenings and quality care for marginalized populations (e.g., nursing homes, assisted living, correctional institutions, mental health facilities, individuals with limited English proficiency).	□ Department of Corrections □ Department of Aging □ Health Professionals □ Health Care Organizations □ FQHC □ LHD	□ # of new screenings □ # of persons educated □ # of persons targeted with screening messages
3.3 Educate health providers on Federal requirements regarding interpretation services.	□ DHMH □ Health professionals □ Health professional boards □ Health Care Organizations □ Health Professional Associations	□ # of educational messages distributed to providers
3.4 Explore promising/best practices to reduce transportation and geographic barriers to health care.	□ Department of Transportation □ Health Providers □ LHD □ FQHC	□ # of promising/best practices identified □ # of promising/best practices disseminated
3.5 Promote practices that increase access to health care for working families and families with children (e.g., location, days and hours of services, school-based clinics, and integration of services offered at each facility).	□ Health Providers □ LHD □ FQHC □ Health Care Organizations	□ # of supporting practices adopted
3.6 Establish ways to support the training and reimbursement of community health workers/patient navigators who serve communities in need (e.g., travel to remote and rural parts of the state). †	□ DHMH □ LHD □ State Legislators	□ # of support methods adopted

3.7 Collaborate with multiple stakeholders to promote the establishment and availability of equitable environments, with special emphasis on environments that affect children's health (e.g., grocery store availability, access to fresh foods, healthy homes, safe outdoor areas, zoning laws).	□ All health advocates	□ # of new collaborations
3.8 Explore and suggest methods of fair reimbursement practices for employers, physicians and other health care providers who provide linguistic and other culturally appropriate services (e.g., interpreters, trainings).	□ Health Occupation Boards □ Health Care Organizations □ Health Providers	□ # of methods identified □ # of methods shared
3.9 Identify and promote disease-specific initiatives targeting communities in need.	□ DHMH/MHHD □ Academic Institutions □ Health Care Organizations	□ # of initiatives identified □ # of initiatives distributed
3.10 Establish methods to educate and empower patients and their families to manage diseases that disproportionately affect minority groups.	□ DHMH/MHHD □ Health Providers □ LHD □ FQHC □ Health Care Organizations	□ # of methods established
3.11 Promote the expansion of safety-net providers and their capacity to offer primary health care to minority groups and uninsured and under-insured populations.	□ FQHC □ Medicaid/Medicare □ Academic Institutions □ DHMH	□ # of safety net providers
3.12 Educate employers on the importance of occupational safety and health, specifically industries that employ a large number of minorities and immigrants.	□ Maryland Department of the Environment □ Maryland Department of Labor Licensing and Regulation □ DHMH	□ # of educational messages to employers

3.13 Raise health provider awareness of the use of both conventional and unconventional approaches to healing and wellness. †	□ Health Occupations Boards □ Health Professionals	□ # of awareness/educational messages distributed

Objective 4: Cultural and Linguistic Competency – Improve cultural and linguistic competency		
Action Steps	**Potential Stakeholders***	**Measures**
4.1 Enhance partnerships with Historically Black Colleges and Universities (HBCUs), community colleges, and other institutions of higher education to increase enrollment and graduation of under-represented minorities in the post-secondary health professions pipeline.	□ DHMH/MHHD □ Academic Institutions	□ % increase in enrollment of under-represented minorities in STEM and health professional programs □ % increase of STEM and health professional degrees awarded to under-represented minorities
4.2 Explore reimbursement structure for healthcare employers for needed cultural and linguistic competency training for employees.	□ DHMH/MHHD	□ # of potential reimbursement structures identified □ # of potential reimbursement structures shared
4.3 Provide technical assistance to academic and health care institutions in efforts to increase the cultural competence of health professional students and the clinical and non-clinical workforce. †	□ DHMH/MHHD □ Academic Institutions □ Health Care Organizations □ Health Professional Boards □ Health Professional Associations □ LHD	□ # of technical assistance encounters
4.4 Create opportunities at the state and local level for minority students to gain experience, encouragement and resources to pursue studies in the health field (e.g., internships, volunteer placements, parent education, mentoring and scholarship programs, post-baccalaureate programs).	□ Academic Institutions □ Health Care Organizations □ DHMH/MHHD □ LHD □ Department of Education □ Health Occupations Boards	□ # of new opportunities created □ # of participants

4.5 Provide technical assistance for the enhancement of K-12 health education and science curriculum to include health disparities information and the exploration of health career opportunities, with parental involvement. †	□ DHMH/MHHD □ Department of Education □ Local School Boards □ PTA	□ # of schools receiving technical assistance □ # of schools incorporating new information □ # of students reached with the model curriculum
4.6 Provide technical assistance to enhance the professional development of K-12 educators, counselors and administrators through cultural competency training for educating a diverse student population and development of a knowledge base for informing and counseling students about professional health careers and relevant educational pathways. †	□ DHMH/MHHD □ Department of Education □ Local School Boards □ Teachers Unions □ Academic Institutions	□ # of K-12 educators, counselors and administrators participating in cultural competency training □ # of K-12 educators, counselors and administrators participating in training sessions to increase awareness of health careers and educational pathway requirements □ # of school districts with educators, counselors and administrators who have participated in cultural competency and health career trainings
4.7 Provide technical assistance to the health occupations boards in incorporating health disparities, health literacy, and cultural competency training into the continuing education credit requirements for licensure/re-licensure of health professionals.	□ DHMH/MHHD □ Health Occupations Boards □ Academic Institutions	□ # of technical assistance encounters □ # of health occupations boards requiring health disparities, health literacy, and/or cultural competency training for licensure/re-licensure
4.8 Identify and disseminate best practices for establishing standards for cultural competency training of health professionals in the state and a mechanism for evaluating training programs developed by professional organizations in the state.	□ DHMH/MHHD □ Health Occupations Boards □ Academic Institutions	□ # of disseminated best practices for standards and evaluation □ # of training standards implemented □ # of evaluation mechanisms implemented
4.9 Create partnerships with K-12 schools to develop additional health career pipeline programs for diverse students.	□ Department of Education □ Local School Boards □ DHMH/MHHD □ Academic Institutions □ Health Care Organizations	□ # of partnerships created □ # of new school districts participating □ # of new programs formed □ # of students participating

4.10 Develop, implement and evaluate a cultural competency improvement policy, including clear goals, operating procedures, plans and management accountability mechanisms to provide culturally competent services at DHMH and local health departments.	□ DHMH □ LHD	□ # of DHMH offices and LHD offices to develop plan □ # of DHMH offices and LHDs to implement plan □ # of DHMH offices and LHDs to evaluate plan
4.11 Educate and provide technical assistance to all health programs receiving state funds to identify resources for the provision of language assistance services. †	□ DHMH/MHHD □ LHD □ Health Care Organizations □ CBO	□ # of technical assistance encounters □ # of information resources distributed □ # of new language services provided
4.12 Encourage and provide technical assistance to local health departments and community-based organizations to develop and implement strategies for recruitment and retention of a diverse and culturally and linguistically competent staff.	□ DHMH/MHHD □ LHD □ Health Care Organizations □ CBO	□ # of technical assistance encounters □ # of organizations with strategies in place
4.13 Improve outreach and recruitment of foreign-trained health professionals, including the identification of best practices for education and licensure policies and standards, as well as subsidy structures. †	□ Health Occupations Boards □ DHMH/MHHD □ CBO □ Health Advocacy Organizations	□ # of best practices identified □ # of best practices shared □ # of outreach activities
4.14 Explore opportunities to support the expansion of and access to adult education opportunities for members of racial/ethnic minorities seeking a career in health care, including English for speakers of other languages.	□ Department of Labor, Licensing, and Regulations	□ Addition of programs □ Increase in number of program attendees
4.15 Identify and promote strategies to increase the representation of minorities among senior level faculty and administrators at institutions of higher education. †	□ Academic Institutions	□ % increase in minority representation among faculty and administrators

Objective 5: Research and Evaluation – Improve coordination and use of research and evaluation outcomes		
Action Steps	**Potential Stakeholders***	**Measures**
5.1 Support data collection for targeted minority populations and small group populations including promoting the inclusion of racial and ethnic identifiers in data collection systems (e.g., use of BRFSS to reach small group populations). †	□ DHMH/MHHD □ CBO □ FBO □ Academic Institutions	□ # of data reports including small group populations □ # of new data collection systems including racial and ethnic identifiers
5.2 Collaborate to promote the use of health information technology, including CBOs and FBOs (e.g., the use of electronic medical records systems/ health information exchange that will have the capability to gather needed data).	□ Health Care Organizations □ Health Care Providers □ CBO □ FBO □ DHMH	□ # of collaborations formed
5.3 Enhance collaborations with HBCUs and other higher education institutions that reach racial/ethnic minorities, for evaluation, research, and data collection. Support translation and dissemination of work.	□ All health advocates	□ # of collaborations with institutions □ # of research/information dissemination messages
5.4 Partner with national organizations in close proximity to MD/DC/VA to develop demonstration projects and other activities to benefit Maryland (e.g. NIH/CDC projects in the area). †	□ Federal Agencies □ National Organizations □ Academic Institutions □ DHMH//MHHD	□ # of partnerships initiated □ # of projects initiated
5.5 Identify best practices that aim to reduce health disparities and provide technical assistance to communities in tailoring and implementation (e.g., Minority Outreach and Technical Assistance model).	□ DHMH/MHHD □ Academic Institutions □ CBO □ Health Advocacy Organizations	□ # of best practices identified □ # of technical assistance encounters
5. 6 Promote partnerships between academic and research communities and CBOs and FBOs to share in the development, implementation and evaluation of health programs.	□ Academic Institutions □ HBCUs □ CBO □ FBO □ Health Care Organizations	□ # of new partnerships formed

5.7 Promote the use of health impact assessments for a broad range of policy decisions, specifically those that impact on populations with identified health disparities.	□ State Legislators □ Health Professional Boards □ CBO □ FBO □ DHMH/MHHD	□ # of communities using health impact assessments □ # of educational sessions with policy makers, board members, health students and professionals on the theory and the use of health impact assessments.
5.8 Promote the Maryland Department of Health and Mental Hygiene's data collection systems to include race/ethnicity categories, as well as country of origin, preferred language and health insurance. †	□ DHMH/MHHD	□ Inclusion of categories of race/ethnicity, country of origin, preferred language, and health insurance in data collection
5.9 Disseminate current data reports and resources as they become available to state and community stakeholders. †	□ DHMH/MHHD □ Academic Institutions	□ # of data reports distributed

† Action step appears in original 2006 *Maryland Plan to Eliminate Minority Health Disparities*

F. THE IMPLEMENTATION STRATEGY & CONCLUSION

The *Maryland Plan to Eliminate Minority Health Disparities, Plan of Action 2010-2014* is the second Plan publication dedicated to health disparities, published by the Maryland Department of Health and Mental Hygiene. The primary use of the *Plan of Action 2010-2014* is to serve as the engine to drive actions for change. The following steps will be taken:

1. **Form an Action Team for each of the five Plan objectives:**
   a. Identify an DHMH/MHHD staff person to serve as the staff-lead
   b. Seek a Maryland Health Disparities Collaborative Member to serve as Team Chair
   c. Recruit at least two Collaborative Members to serve on the Team
   d. Recruit one DHMH program professional to serve on the Team

2. **Develop an Action Plan for the Team:**
   a. Hold a planning session with the Action Team members
   b. Review and select one to three action steps to implement
   c. Identify one or two lead stakeholders to whom the Action Step will be proposed
   d. Develop a marketing plan to guide the team in promoting the action

3. **Present the Action Step to the stakeholder:**
   a. Develop a succinct presentation with data and best practices
   b. Present a feasible and achievable first-step action
   c. Identify partnership tasks that DHMH/MHHD and other stakeholders can implement
   d. Hold a brainstorming discussion to construct an agreed upon action

4. **Finalize the Action Step:**
   a. Obtain agreement from the stakeholder to take leadership on the action
   b. Obtain agreement from partners regarding specific assistance on the action
   c. Set tentative timelines to begin implementation
   d. Commit agreements in writing
   e. When no agreements are obtained, move to a different stakeholder

5. **Begin Action Step Implementation:**
   a. Follow lead and guidance of the stakeholder
   b. Stakeholder sets timetable and actions to be taken
   c. DHMH/MHHD staff-lead assists by linking needed experts and resources to Team
   d. The Action Team meets periodically to note progress and assist as needed
   e. DHMH/MHHD staff posts matrix of implementation steps and results on website

In conclusion, the Action Plan set forth for Maryland provides guidance and concrete steps that our many health partners can utilize within their organizations and communities. Additionally, provisions in the Patient Protection and Affordable Care Act (H.R. 3950) that address the needs of racial and ethnic minorities, the uninsured, underinsured, underserved, and rural communities, provide promise and encouragement as the Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities works with our state and national partners to continue our momentum forward in the elimination of health disparities in Maryland.

G. HEALTH DISPARITIES COLLABORATIVE & CONTRIBUTING GROUPS

In addition to those individuals, groups and organizations who contributed to the first Plan publication, we would like to acknowledge the following organizations and groups for their commitment and collaboration during the *Plan of Action* process:

Access to Wholistic and Productive Living Institute
Action Langley Park
AFT Healthcare Maryland Local #5197, AFT/AFL-CIO
American Heart Association/ American Stroke Association
Anne Arundel County, Office of Minority Health
Asian American Anti-Smoking Foundation, Inc.
Associated Black Charities
Avanti Strategy Group, LLC
Baltimore American Indian Center
Baltimore American Indian Center, Men's Clinic
Baltimore Medical System Inc.
Baltimore Times
Black Mental Health Alliance for Education and Consultation, Inc.
Brothers United Who Dare to Care, Inc.
Carefirst BlueCross BlueShield
Chase Brexton Health Services
Conexiones, Inc.
Coppin State University, Helene Fuld School of Nursing Community Health Center
Delegate Dan K. Morhaim, MD
Delegate Shirley Nathan-Pulliam
EDJ Associates, Inc.
Esperanza Center
Family Health Administration, Maryland Department of Health and Mental Hygiene
FIRN, Inc. (Providing Resources for the Foreign Born)
Governor's Commission on Asian Pacific American Affairs
Governor's Commission on Hispanic Affairs
Governor’s Commission on Indian Affairs
Governor’s Commission on Middle Eastern American Affairs
Greater Baltimore Urban League
Holy Cross Hospital
Howard County Health Department
Johns Hopkins Parkinson's Disease and Movement Disorders Center
Johns Hopkins School of Medicine
Johns Hopkins Bloomberg School of Public Health
Johns Hopkins Bloomberg School of Public Health, Hopkins Center for Health Disparities Solutions
Johns Hopkins Bloomberg School of Public Health, Center for American Indian Health
Kaiser Permanente
LifeBridge Health, Inc.
Maryland AIDS Administration
Maryland Board of Physicians
Maryland Department of Health and Mental Hygiene, Office of the Secretary
Maryland Department of Health and Mental Hygiene Office of Health Policy and Planning

Maryland Department of Health and Mental Hygiene, Center for Cancer Surveillance and Control
Maryland Department of Health and Mental Hygiene, Maryland Comprehensive Cancer Control Plan
Maryland Department of Health and Mental Hygiene, Vital Statistics Administration
Maryland General Hospital
Maryland Hospital Association
Maryland Mental Hygiene Administration
Maryland NAACP
Maryland Rural Health Association
Maryland State Department of Education
Maryland General Assembly
MayaTech Corporation
MedChi, The Maryland State Medical Society
Mid-Atlantic Association of Community Health Centers
Montgomery County Department of Health and Human Services, Asian American Health Initiative
Montgomery County Department of Health and Human Services, Health Promotion Office
Montgomery County Department of Health and Human Services, Latino Health Initiative
Montgomery County Department of Health and Human Services, Latino Health Initiative & Latino Data Workgroup & Montgomery County Latino Health Steering Committee
Morgan State University, School of Community Health and Policy
National Medical Association - Maryland Chapter
Oasis Behavioral Health, LLC
Prince George's County Health Department
Prince George's County Council, Health, Education and Human Services Committee
Rising Sun Seventh-Day Adventist Church
Sinai Hospital of Baltimore
The Learning Institute for Enrichment and Discovery, Inc. (LIFE & Discovery)
The MayaTech Corporation
The Men’s Center
Through the Kitchen Door International, Inc
Times Community Services, Baltimore Times Foundation
Towson University, Department of Nursing
University of Maryland
University of Maryland, Baltimore, Academic Affairs
University of Maryland, Baltimore, University Student Government Association
University of Maryland Medical System, Government and Regulatory Affairs
University of Maryland School of Medicine, Department of Physical Therapy & Rehabilitation Sciences
University of Maryland, School of Nursing
University of Maryland, School of Pharmacy

H. GLOSSARY, WEBSITES AND REFERENCES

I. Glossary of Health Disparities Terms

Access to Healthcare - The degree to which people are able to obtain care from the healthcare system in a timely manner.

Age-adjustment – Age-adjustment is a method of making a fair comparison between two groups regarding a condition whose impact is vastly different at different ages when the two groups have important differences in their age pattern.

Cultural Competency – A set of congruent behaviors, knowledge, attitudes and policies that come together in a system or organization or among professionals that enables the system or agency or those professionals to work effectively in cross-cultural situations.

Disparity - All differences among populations in measures of health and healthcare.

Health Disparity – A higher burden of illness, injury, disability, or mortality experienced by one population group in relation to a reference group.

Healthcare Disparity – Racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.

Incidence - The rate at which persons without a disease develop the disease.

Minority – A member of the following group: African American, American Indian/Native American, Asian/Pacific Islander, and Hispanic/Latino.

Minority Health Disparities - Differences in the incidence, mortality, and burden of diseases and other adverse health conditions that exist among the historically disenfranchised minority groups in the state.

Mortality rate - The rate of occurrence of death in a defined population during a specified time interval.

Morbidity - The extent of illness, injury, or disability in a defined population.

Prevalence - The proportion of the population that has a disease at a particular time.

Quality of Healthcare - The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Regular Source of Care - A healthcare provider to whom individuals regularly go when they are sick or need medical advice.

Under-Represented Minorities - Racial and ethnic populations that are underrepresented in the health professions relative to their numbers in the general populations.

Vulnerable Populations - Groups that have faced discrimination because of underlying differences in social status. Examples of these groups include individuals with stigmatizing health conditions such as mental illness, recent immigrants and refugees, women and men, and incarcerated populations.

II. Health Disparities Websites

Organization	Web Link
Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services	www.ahrq.gov
The Applied Research Center	www.arc.org
Center to Reduce Cancer Health Disparities, National Cancer Institute	http://crchd.nci.nih.gov/
The Commonwealth Fund	www.cmwf.org
The Cross Cultural Health Care Program	www.xculture.org
Delmarva Foundation	www.delmarvafoundation.org
Diversity Rx	www.diversityrx.org
Division of HIV/AIDS Prevention and Surveillance, Center for Disease Control and Prevention	www.cdc.gov/hiv
Healthy People 2010/2020, U.S. Department of Health and Human Resources	www.healthypeople.gov
The Henry J. Kaiser Family Foundation	www.kff.org
Institute of Medicine	www.iom.edu
Maryland Department of Health and Mental Hygiene	www.dhmh.state.md.us
Maryland Governor's Office of Community Initiatives	http://community.maryland.gov
Maryland Governor's Office for Children	www.ocyf.state.md.us
Maryland Healthcare Commission	http://mhcc.maryland.gov
The National Center for Cultural Competence, Georgetown University	http://nccc.georgetown.edu/index.html
National Center for Health Statistics	www.cdc.gov/nchs/
National Center on Minority Health and Health Disparities, National Institutes of Health	http://ncmhd.nih.gov/
National Minority AIDS Council	www.nmac.org
National Partnership for Action to End Health Disparities, Office of Minority Health, U.S. Department of Health and Human Services	http://minorityhealth.hhs.gov/npa/
Office Minority Health and Health Disparities, Maryland Department of Health and Mental Hygiene	www.dhmh.maryland.gov/hd
Office of Minority Health, U.S. Department of Health and Human Services	www.omhrc.gov
Office of Minority Health, Centers for Disease Control and Prevention	www.cdc.gov/omh
The Prevention Institute	http://www.preventioninstitute.org
The Quality Indicator Project	www.qiproject.org
The Robert Wood Johnson Foundation	www.rwjf.org
Surveillance, Epidemiology, and End Results Program, National Cancer Institute	http://seer.cancer.gov/
U.S. Commission on Civil Rights	www.usccr.gov
U.S. Government – Health Insurance Reform Legislation	www.healthreform.gov
University of Maryland Statewide Health Network	www.mdhealthnetwork.org
Vital Statistics Administration, Maryland Department of Health and Mental Hygiene	http://vsa.maryland.gov/

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For **additional information on *Maryland Plan* documents**, please contact:

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Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 500, Baltimore, MD 21201
Phone: 410-767-7117
Fax: 410-333-5100
Website: www.dhmh.maryland.gov/hd