MARYLAND
Department of Health

MARYLAND DEPARTMENT OF HEALTH

MARYLAND OFFICE OF MINORITY HEALTH AND HEALTH DISPARITIES

2018 ANNUAL REPORT

Health-General Article, § 20-1006
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I. Executive Summary

The Maryland Department of Health (MDH), Office of Minority Health and Health Disparities (hereafter referred to as "MHHD" or the "Office") was established in 2004 by legislation to promote the reduction of health disparities in Maryland. This report provides a summary of MHHD activities and accomplishments during the 2018 calendar year; Minority Outreach and Technical Assistance (MOTA) Program activities by their fiscal year funding and grant cycle, Fiscal Year 2018 (July 1, 2017 - June 30, 2018).

Health Disparities data show that minority health and minority health disparities are critical issues to be addressed for the overall health of Maryland, since our population will be over 50% racial/ethnic minority by 2020. While we see some progress being made toward the elimination of some disparities, much work is still to be done. Lead by the data and best practices, MHHD has targeted its programs and initiatives to emphasize three health conditions that disproportionately impact minorities in Maryland: infant mortality, asthma, and diabetes / prediabetes. Black rates infant mortality are 2.5 to 3 times as high as White rates, and Black emergency department visits rates for asthma and diabetes range from 3 to 4 times as high as White rates.

Some key accomplishments the Office reports for 2018 in the elimination of health disparities in Maryland include:

- The MOTA program provided continuation grant funding to 14 organizations in 12 jurisdictions. MOTA focus areas include infant mortality, diabetes/pre-diabetes, hypertension/cardiovascular disease, cancer (prostate, breast, cervical and colorectal), smoking cessation, health insurance enrollment/case management and obesity.
- Funding was leveraged through collaborations with the Environmental Health Bureau to solicit applications for community-based education and outreach activities utilizing the Environmental Public Health Tracking (EPHT) network portal. Additionally, in collaboration with the Center for HIV/AIDS and Health Services, funded seven organizations to address HIV/AIDS, Hepatitis B and C, and other STDs in minority, medically underserved communities.
- Year three of a five-year award from the U.S. Department of Health and Human Services Office of Minority Health, the Educating Minorities on Benefits Received after Consumer Enrollment (EMBRACE) Initiative was completed. EMBRACE has outperformed the agreed performance measures with the number of educational sessions by 100%, number of attendees at sessions by 117%, number of materials distributed by 100%, number of one-one sessions by 100%, number of referrals for insurance enrollment by 112%, and number of referrals to primary care services by 100%.
- Hosted the 15th Annual Statewide Health Disparities Conference, *Achieving Health Equity and Disparity Reduction: Prevention and Cost Savings Initiatives*, on December 6, 2018 at Martin's West in Baltimore. Approximately 400 attendees participated. The focus of this year's conference aligns with MDH's priorities of reducing health care costs and connecting people to preventive and primary care.

II. Health Disparities Progress and Success

According to the 2010 U.S. Census, 45.3% of Maryland's population reported some ancestry from a racial or ethnic minority group (a group other than non-Hispanic White). Current population estimates as of July 1, 2017 put this minority percentage at 49.1%. This characteristic of our population makes minority health and minority health disparities critical issues to the overall health of Maryland. As one example of this minority impact on the State's health, before the insurance expansion under the Affordable Care Act, about two-thirds of Maryland's non-elderly uninsured were members of racial or ethnic minority groups. Another example is that between half to two-thirds of the ED visits for asthma, diabetes, and hypertension (the ED visits tracked in State Health Improvement Process (SHIP) metrics) are attributable to the Black or African American population in Maryland.

Mortality: MHHD continues to monitor racial and ethnic health disparities in Maryland and finds that disparities continue, but progress toward elimination of some disparities has been made. This progress is most apparent in Black or African American vs. White disparities in death rates from some of the most common causes of death. This is illustrated in the second table below, which shows 2001 and 2016 mortality rates for selected conditions from Vital Statistics Administration annual reports, and rates of change over three 5-year intervals. Changes over the entire 15-year period were (Gap is the Black minus White difference):

Heart Disease age-adjusted death rate per 100,000 population

Black trend	38.5% reduction
White trend	34.5% reduction
B-W gap	54.4% reduction

Cancer age-adjusted death rate per 100,000 population

Black trend	27.8% reduction
White trend	21.9% reduction
B-W gap	52.3% reduction

Stroke age-adjusted death rate per 100,000 population

Black trend	29.4% reduction
White trend	36.6% reduction
B-W gap	5.0% increase (worsening)

Diabetes age-adjusted death rate per 100,000 population

Black trend	40.4% reduction
White trend	33.1% reduction
B-W gap	46.4% reduction

HIV/AIDS age-adjusted death rate per 100,000 population

Black trend	75.2% reduction
White trend	68.4% reduction
B-W gap	75.7% reduction

Infant Mortality (infant deaths per 1000 live births)

NH Black trend	22.8% reduction
NH White trend	17.3% reduction
B-W gap	26.2% reduction

Over the entire period, the Black to White death rate disparity improved by 76% for HIV/AIDS, by just over 50% for heart disease and cancer, by just under 50% for diabetes, and by 26% for infant mortality.

Interestingly, the stroke disparity worsened by 5% despite a 29% improvement in the Black death rate. This is because the White rate improved even faster, widening the gap. This pattern is particularly evident in the table for stroke for 2006 to 2011. The reverse pattern is shown for stoke during 2011-2016 where the disparity gap was reduced by 11% despite an increase in the Black rate. This is because the White rate worsened even more. This illustrates that higher disparity does not always mean worse health, and lower disparity does not always mean better health. One must look at the rates for each group in addition to the disparity metric to get a full and accurate picture of population health.

Also, of interest is the observation that the rates of mortality improvement for both Blacks and Whites appear to be slowing down in the more recent time period for some of these conditions: heart disease, cancer, stroke, and diabetes. In addition, most of the Black infant mortality reduction for 2011 to 2016 occurred between 2001 and 2012, with 2012 to 2016 being essentially constant. Slowing in the rate of improvement in prevalence of tobacco use, and the recent increases in obesity and diabetes, as well as the natural tendency for the results of any level of effort to eventually stabilize at an equilibrium point, may account for this observation.

Age-adjusted Deaths per 100,000 Population

	2001	2001-06 trend	2006-11 trend	2011-16 trend	2016
Heart Disease					
Black	304.7	-18.3%	-19.8%	-4.6%	187.5
White	244.6	-20.5%	-14.3%	-3.9%	160.1
Ratio	1.25	14.0%	-29.3%	-5.0%	1.17
Gap	60.1	-9.3%	-39.4%	-8.7%	27.4
Cancer					
Black	244.2	-13.9%	-9.7%	-7.2%	176.3
White	196.6	-6.6%	-12.2%	-4.8%	153.6
Ratio	1.24	-40.2%	22.9%	-16.9%	1.15
Gap	47.6	-44.1%	7.9%	-20.9%	22.7
Stroke					
Black	69.7	-27.7%	-3.8%	1.4%	49.2
White	57.7	-28.8%	-16.5%	6.7%	36.6
Ratio	1.21	8.8%	83.0%	-16.8%	1.34
Gap	12.0	-22.5%	52.7%	-11.3%	12.6
Diabetes					
Black	52.5	-22.9%	-16.5%	-7.4%	31.3
White	23.6	-25.8%	-2.9%	-7.1%	15.8
Ratio	2.22	7.3%	-24.8%	-0.7%	1.98
Gap	28.9	-20.4%	-27.0%	-7.7%	15.5
HIV/AIDS					
Black	31.9	-23.5%	-52.0%	-32.5%	7.9
White	1.9	-10.5%	-41.2%	-40.0%	0.6
Ratio	16.79	-15.4%	-19.9%	13.7%	13.17
Gap	30.0	-24.3%	-52.9%	-31.8%	7.3
Infant Mortality					
NH Black	13.6	-5.9%	-4.7%	-13.9%	10.5
NH White	5.2	25.0%	-33.8%	0.0%	4.3
Ratio	2.62	-40.0%	89.6%	-21.5%	2.44
Gap	8.4	-25.0%	25.4%	-21.5%	6.2

NH = Non-Hispanic. Red highlight indicates no change or worsening trend.

Where Ratio and Gap trend in different directions, Gap is a better indicator of population health impact

Utilization: Large disparities persist in rates of preventable healthcare utilization. This is illustrated in the first table below, which shows the 2008 and 2016 Black vs. White disparities data from the Maryland State Health Improvement Process website. Because of methodology changes in data collection in the last five years, different years cannot be directly compared to each other and trends should not be calculated. However, within individual years, Non-Hispanic Black ED visits rates for asthma, diabetes, and hypertension (high blood pressure) have been three to four times as high as Non-Hispanic White rates.

(For the conditions presented, Asian and Hispanic rates are the same or lower than White rates, and so there is no disparity. Due the small American Indian population in Maryland, data in this format is not statistically stable for that group and are not presented.)

Age-adjusted Emergency Room Visits per 100,000 Population

	2008	trend*	2016
Asthma ED Visit Rate			
NH Black	1399	*	1386
NH White	323	*	380
Ratio	4.3	*	3.6
Gap	1076	*	1006
Diabetes ED Visit Rate			
NH Black	328.6	*	411.9
NH White	98.5	*	135.2
Ratio	3.3	*	3.0
Gap	230.1	*	276.7
Hypertension ED Visit Rate			
NH Black	402.3	*	607.3
NH White	86.9	*	176.4
Ratio	4.6	*	3.4
Gap	315.4	*	430.9

These results show that Maryland's investments in minority health improvement and minority health disparity reduction are bearing some fruit, particularly in the areas of mortality disparities for heart disease and cancer. These results also show that for other areas, such as infant mortality and preventable health care utilization, large disparities remain. Efforts must continue to complete the work of eliminating minority health disparities in Maryland. Given the apparent slowing of the rate of improvement in both Black and White health for some conditions, regaining momentum toward improvement will require one or more of the following actions:

- Application of new effective interventions
- Increasing the effectiveness of existing interventions
- Increasing the reach and scale of currently delivered interventions

Finding ways to better reach the hard to reach populations that likely represent the highest risk for poor health and may not be being reached currently.

III. Statewide Minority Outreach and Technical Assistance (MOTA) Program

A. Introduction of New MOTA Focus for Fiscal Year 2018

The MOTA Program began in 2001 under the auspices of the Cigarette Restitution Fund Program (CRFP). CRFP was established by Maryland State Legislation and began operations on July 1, 2000 as a major initiative within MDH. MOTA was established to implement the Cigarette Restitution Fund Act's provision requiring outreach and technical assistance to minority communities to ensure their participation in the tobacco and cancer community health coalitions. Minority communities include African Americans/Blacks, Asian and Pacific Islander, Hispanics/Latinos, and American Indians. In 2010, MDH announced the expansion of MOTA beyond tobacco and cancer (2nd leading cause of death in Maryland) to address other racial and ethnic health disparities throughout the State of Maryland. The expanded focus now includes major health disparities that affect racial and ethnic minority communities such as cardiovascular disease (leading cause of death in Maryland), HIV/AIDS, diabetes (6th leading cause of death in Maryland), infant mortality, obesity, and asthma.

For Fiscal Year 2018 (FY 18), MHHD invited all 2017 MOTA grantees to apply for year two continuation grant for the period of July 1, 2017 through June 30, 2018. MHHD developed guidelines to assist the grantees in their continuation application for FY 18 of the grant cycle. The continuation application was used by MHHD to review the FY 17 grantees progress made during the reporting year in planning and conducting project interventions, evaluation the effectiveness of such interventions, and meeting project and program objectives as well as keeping abreast of managerial and other project matters related to the grant as needed. The reports of program progress were carefully considered relative to plans for future funding.

The continuation (year two 2018) application comprised of a year one assessment which included the following:

a) description of any gaps between proposed monthly performance measures and what was achieved during the 2017 grant cycle,
b) description of barriers, challenges, and lessons learned during the 2017 grant cycle and
c) a description of strategies used to resolve any barriers and challenges experienced.

For year 2 (FY 18), the application comprised of:

a) program purpose/strategies and interventions which included a description of any changes from year 1 and providing a rationale for the changes and
b) project goals and objectives, activities/program outcomes and evaluation plans.

Funding remained the same for each grantee and was contingent upon satisfactory progress from FY 17. Funding ranged from $25,000 to $40,000 and focus areas remained the same and they were: *tobacco; birth outcomes; HIV/AIDS; health insurance and healthcare access issue; and chronic diseases such as cardiovascular disease, cancer, diabetes, obesity, and asthma.*

B. MOTA Community Outreach & Public Health Linkages

In FY 18, the MOTA Program awarded a one-year continuation grant to 14 organizations in 12 Maryland jurisdictions (Anne Arundel-one, Baltimore City-one, Baltimore County-two, Dorchester-one, Frederick-one, Harford-one, Howard-one, Kent-one, Montgomery-one, Prince George's-two, St. Mary's-one, and Wicomico-one) targeting African Americans, Asian Americans, Hispanic/Latino Americans, and Native Americans. The funding amount ranged from $25,000 to $40,000. MHHD, through the MOTA Program, increased the following in racial and ethnic minorities and underserved communities:

- Assistance with coordination and navigation of primary and preventive health care services.
- Access to community-based health education.
- Linkage to health insurance enrollment.
- Linkage to primary and preventive care and social services.
- Awareness about MOTA priority health topics.
- Knowledge of the continuum of care for health conditions being addressed.
- Knowledge of prevention, screening, primary care resources for health conditions selected.
- Self-management support through home visiting programs using community health workers, visiting nurses, or other personnel.

In addition, the MOTA grantees demonstrated increased participation and collaboration with their local health departments, partnership and collaboration with other MOTA grantees and community-based organizations, participation in technical assistance, capacity building and program sustainability activities (i.e., workshops, trainings, webinars and conferences). The MOTA grantees partnered and participated in several state public health initiatives during FY 18 to include collaboration with other agencies within MDH such as the Infectious Disease Bureau, Environmental Health Bureau, local health departments, other MOTA partners and other community-based organizations. These partnerships provided the MOTA partners an opportunity to link clients to health services, conduct outreach, educate minority communities in their jurisdictions on available health services, as well as strengthen the referral system between the MOTA Program, local health and service providers.

It has been proven through needs assessment that the lack of involvement of minority community-based organizations capable of providing technical assistance, infrastructure building, health education, awareness, screening, clinical trial, preventive health and resource limitation contributes to elevated medical costs, late diagnosis and higher death rate of minorities. Through the MOTA partners and in collaboration with their local health departments (LHDs), the above impediments continue to improve due to successful development and implementation of outreach activities, education programs, screening and referral for different diseases in high-risk populations in Jurisdictions where disparities are prevalent through data collection and reporting.

C. FY18 Program Outcomes

In FY 18, local MOTA Programs conducted a variety of activities aligned with their focus areas of infant mortality, diabetes/pre-diabetes, hypertension/cardiovascular disease, cancer (prostate, breast, cervical and colorectal), smoking cessation, health insurance enrollment/case management and obesity. Activities included individual or group cohort style (longitudinal) programs, workshops, "baby showers" (educational sessions for women of childbearing age and their spouses), home visiting, cooking and exercise classes, food banks, community gardens, mental health support groups, health fairs and community outreach events to mention a few. Partners infused the concept of the social determinants of health and reducing barriers to health by offering free produce distribution, farmers markets, and community gardens in communities to reduce the burden of living within food desserts and its impact on health outcomes. Several grantees are also following-up with program participants to ascertain linkage to services to which they were referred. Specific to the MOTA focus areas, the following are program outcomes for FY18:

Infant Mortality

- Focus area for three of 15 grantees
- Conducted 13 baby showers (educational sessions for women of child bearing age and their spouses) with 185 attendees. Majority of attendees were African American/Black and Hispanics
- Enrolled 29 women in a home visiting program and followed them through face to face contacts or phone calls at biweekly or weekly intervals until delivery. Women enrolled in the home visiting program were high risk based on well-defined criteria.
- There were 263 in-person or phone call contacts with women enrolled in the home visiting program. 61 % of these contacts were in-person.

Diabetes

- Focus area for 10 of 15 grantees
- There were 122 diabetes workshops conducted with 1427 attendees (a mix of both unique and repeat participants)
- There were 34 group and individual diabetes self-management (DSM) session follow up sessions conducted at 30, 60 and 90-day intervals with a reach of 74 unique individuals
- Twenty-three group and individual chronic disease self-management management (CDSM) follow up sessions conducted at 30, 60 and 90-day intervals with a reach of 42 unique individuals
- Amongst participants in the DSM and CDSM follow-up cohorts, 40 individuals lost weight with an average weight loss of 11.43 pounds. According to the International Journal of Clinical Practice, weight loss in type 2 diabetics has been shown to improve glycemic control, with severe calorie restriction even reversing the progression of T2DM while also improving the quality of life, mobility, physical and sexual function
- The average systolic and diastolic blood pressure reduction among the 12 participants in the CDSM follow-up cohorts who started with elevated blood pressures were 16 mmHg and 10 mmHg respectively. It has been estimated that a 5-mmHg reduction of SBP in the population would result in a 14 percent overall reduction in mortality due to stroke, a nine percent reduction in mortality due to CHD, and a seven percent decrease in all-cause mortality.

Pre-diabetes

- Focus area for two grantees.
- One grantee conducted six cohorts of the Centers for Disease Control and Prevention (CDC) one yearlong Diabetes Prevention Program while the other grantee conducted one cohort of the CDC 6-week Road to Health Intervention.

  Diabetes Prevention Program (DPP)

  - Six cohorts conducted with a total of 131 unique individuals and 1486 instances of reach
  - 156 primary sessions and additional supplemental sessions were conducted as needed
  - Both enrollment and retention rates varied by location. 88 of the enrollees in the program were completers based on the CDC's definition of attendance in at least four sessions of the core phase (1st six months of the intervention) resulting in a retention rate of 67% across all cohorts
  - Average weight loss among completers was 5.5 pounds
  - In addition, 17 outreach activities were also conducted on pre-diabetes education with a reach of 448

  Road to Health Intervention

  - One cohort with 17 participants recruited, all Hispanic
  - Six sessions completed (grantee added on 2 follow up sessions)
  - Target population was Hispanics
  - Fifteen of 17 recruited participants attained weight loss with an average loss of 6.5 pounds
  - Retention rate was approximately 98% and greater than 80% of the participants attended every session

Hypertension/Cardiovascular disease

- Focus area for four of 15 grantees
- 237 workshops with 4764 attendees' instances of reach
- Screenings for blood pressure and BMI were offered and individuals were referred to required services

Obesity

- Focus area for two of 15 grantees
- Conducted 14 adult cooking classes with 142 instances of reach and 80 unique participants. This means 56% of participants came back at least once.
- Five youth cooking classed with 161 instances of reach
- Conducted 52 exercise classes with 249 instances of attendance by 71 unique people. 60% of the participants attended multiple times while 40% attended once

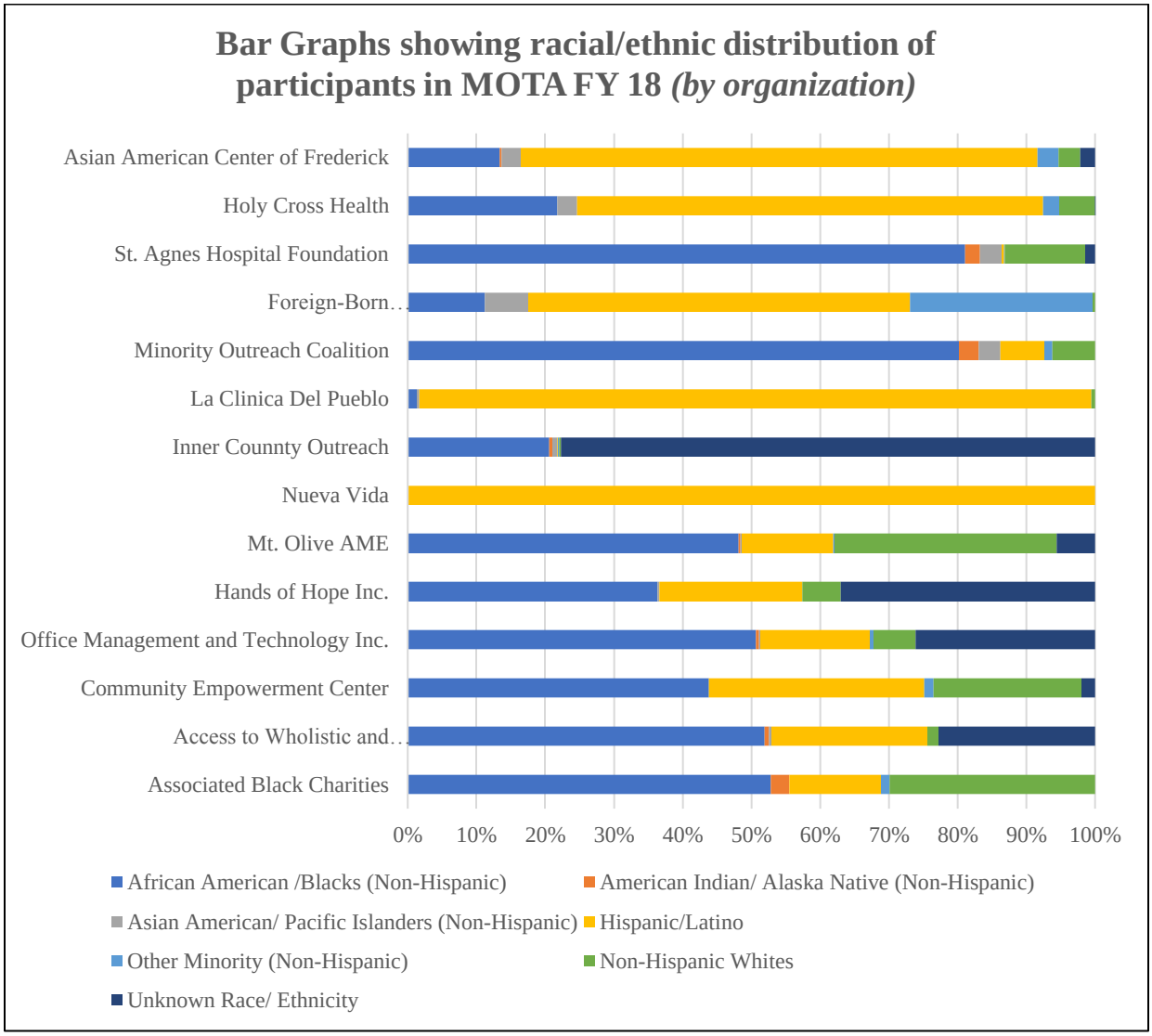
Cancers

- Focus area for two grantees
- Conducted 79 educational sessions or workshops on prostate, breast, cervical and colorectal cancer with 1357 instances of reach

- Three hundred and thirty-two referrals to screenings for prostate, breast, cervical and colorectal cancer were given with 261 screenings completed. A completion rate of 79%.
- Mental health support groups were also conducted with a quality of life assessment completed at intervals for cancer survivors and their care givers

Other Events/Activities (including health fairs, food pantries, community events, community gardens, youth smoking cessation classes, etc.)

- 153 events with 5254 instances of reach
- Case management services for 122 individuals with greater than 140 encounters
- Seven hundred and ninety-seven referrals with 373 linkages to needed services after follow-up
- Eight food pantries serving 31,570 lbs. of food to 1,459 households with 2,769 individuals.



Source: *FY 18 MOTA primary data analysis*

In FY 18, of all participants in MOTA activities, 15% were aged 0-24 years, 37 % were aged in both the 25-44 and 45-64 age categories while 11% were aged 65 and over. Of all these participants, 71% identified as females, 26% as males while 3% identified as other.

D. Individual MOTA Program Highlights

The local MOTA Programs engaged communities and collaborated with other State and community partners through several types of events and activities throughout FY 18. Below are MOTA partner program highlights for FY 18:

- **Anne Arundel County: Hands of Hope**

  The Hands of Hope (HOH)-MOTA Health Legacy Institute's program provided cardiovascular disease educational sessions, a 6-week diabetes education series as well as a six-week nutrition and fitness series with a goal of improving cardiovascular disease and diabetes health outcomes among racial and ethnic minorities in Anne Arundel County. The grantee also sponsored and participated in community health fairs where several health screenings were available alongside other opportunities for education on the health focus area.

  During the second quarter of FY 18, HOH conducted its first fitness nutrition series in Hanover Maryland at Hebron Harmon Elementary School. There were nearly 40 persons educated during those series over the course of six sessions.

  Additionally, during the second quarter HOH co-sponsored the 8th Annual Hispanic Health Festival & Resources held in Severn MD at Heritage Community Church with 150 community members in attendance. Hands of Hope screened 58 persons for prediabetes during the all-day Hispanic Festival. In the third quarter HOH conducted a diabetes series for community citizens that were obese and considered at risk for diabetes and recruited 12 consistent participants in the series. Throughout the series, participants who struggled to maintain a healthy weight, glucose level and body mass index (BMI) were educated on diabetes self-management using the Living Well with Chronic Disease curriculum. The participants were also referred to outside resources as needed and participated in a pre/post measurement of their knowledge about risk factors of obesity and added sugars. Out of the 80 participants who enrolled in the program, 60 improved their knowledge by 80% or greater about the risk factors of obesity and added sugars.

- **Baltimore County: Nueva Vida, Inc.**

  Nueva Vida supported outreach & education programs, successfully navigated clients through the cancer continuum and provided mental health support for breast and cervical cancer survivors. Nueva Vida successfully conducted 66 outreach & education activities including 20 *charlas* (an informal act of talking/presenting; a chat); 21 educational workshops in hospital settings, and 25 outreach activities in the Latino community. "Non-traditional" events occurred in the laundromats, beauty salons/barber shops-*Duran Dominican Hair Salon,* restaurants-*El Parasio Tropical Restaurant* and churches-*Iglesia Sagardo Corazon de Jesus* were effective methods of outreach. Nueva Vida also participated in numerous health fairs such as *Feria Artscape,* provided access to breast,

cervical and colorectal screening for 231 duplicated clients, and supported survivors and caregivers in nine mental health support groups.

Addressing cancer in the Hispanic/Latino community in Baltimore County**,** Quality of Life (QOL) measures (pre-survey) was used to assess baseline data and administered on August 31, 2017. Nueva Vida also administered the SLDS-BC; a 32-item self-administered questionnaire comprised of five domains (social functioning, appearance, physical functioning, communication with medical providers, and spirituality). Scores from 32-224 were recorded with higher scores showing low QOL. A mean pre- score of 82.8 was recorded. Post-Survey scores showed a mean 73.4 indicating a 12.8% increase in QOL.

Nueva Vida has a strong partnership with the Baltimore County Health Department. The MOTA Program Manager and Registered Nurse at the Baltimore County Health Department were in constant contact during the grant year, since Nueva Vida completed all application paperwork from the Health Department for referrals. The Program Manager also attended the State Council Cancer Meeting and the Baltimore County Cancer Coalition Meetings. Nueva Vida was highlighted at the Baltimore County Department of Health in December of 2017. Some of the collaborative activities included the successful navigation and instrumental support provided by the Program Manager such as interpretation along with guidance during medical appointments; obtaining free or inexpensive testing; filling out application for public programs; identifying providers; scheduling appointments; and overall addressing barriers to care together and the assistance of the Maryland Breast and Cervical Cancer Screening Program. The outcomes in this partnership resulted in collaborative efforts for treatment and care among the 14 diagnosed cancer patients.

- **Baltimore County: St. Stephen's Office Management & Technology, Inc. (OMT, Inc.)**

  The OMT-MOTA grantee was funded to provide workshops on diabetes while offering pre-diabetes risk assessment for Hispanics in Baltimore County. The program also provided educational workshops on hypertension which targeted African Americans. In FY 18, OMT sponsored and participated in community outreach events with a focus on diabetes and hypertension prevention education while also providing referrals and follow up for hypertension and diabetes care. In addition, the OMT-MOTA program conducted a pilot program on birth outcomes in collaboration with Chase Brexton to reduce the burden of negative birth outcomes experienced by minority women in Baltimore County. Key accomplishments from the OMT-MOTA program implementation are:
  - Conducted two diabetes prevention educational workshops with 32 Hispanic/Latinos in attendance. All 32 participants completed a diabetes risk assessment test.
  - Conducted two hypertension prevention educational workshops with 40 African Americans in attendance. Thirty-two of those participants increased their knowledge score of 80% or greater on the risks of hypertension after taking the pre and posttest questionnaire.

- Conducted three community outreach events where 45 minorities were screened for hypertension and diabetes. Thirty six of the 45 screened were referred and received hypertension and diabetes care.
- Through the birth outcomes pilot program, 20 expectant mothers were educated through their birth outcomes classes of which 16 were referred for support services and 10 received the support services after follow-up.

- **Dorchester County: Associated Black Charities (ABC)**

  Associated Black Charities (ABC)-MOTA partner developed a program aimed to decrease the number of preventable Emergency Room visits from patients with both diabetes and hypertension. This was done through outreach activities where clients were screened and referred to Diabetes Self-Management (DSM) and Chronic Diabetes Self-Management (CDSM) classes in Dorchester County. On completion of classes, the program provided follow-up group and individualized education and support to interested individuals at 30, 60- and 90-day intervals. ABC also sponsored at least four mobile food pantries at various locations in Dorchester County in collaboration with the MD Food Bank. Below are some of their key accomplishments after the implementation of their proposed MOTA funded program:
  - ABC screened 20 participants for elevated blood pressure during pre and post CDSM 30, 60 and 90-day follow up sessions.
  - Ten CDSM participants were referred for support services and all ten received services after follow-up by a Community Health Worker (CHW).
  - Twenty-five participants were recruited for follow up sessions who were at risk for diabetes and hypertension.
  - ABC sponsored four Mobile Food Pantries to reduce social determinants in food burdened areas in Dorchester County. In addition, they also sponsored and attended 10 community outreach events.

- **Frederick County: Asian American Center of Frederick**

  The Asian American Center of Frederick (AACF) held 13 educational Baby Showers in FY 2018. Typically, there were 6 volunteers at every Baby Shower for 4 hours each with a total of 288 volunteer hours for the Baby Shower events. They also completed 48 hours of monthly outreach promoting AACF activities and events generating a total of 576 volunteer hours annually.

  The Maternal Child Health Team included other Community Health Workers (CHWs) besides our MCH Team Lead and Volunteer Coordinator. Additional CHWs assisted with community outreach and with interpreting at the Baby Showers. Many of the clients are illiterate even in their native language, so assistance is necessary to complete forms, such as intake, HIPAA, pre and post-tests. Interpretation assistance for the guest educational presenter is also necessary. We have Spanish interpretation available at every Baby Shower and if requested ahead of time, provided French, Chinese and Burmese interpretation. The demographics of attendance at the AACF Baby Showers during FY 2018 included 108 Hispanic/Latino, 28 Black/African American, 17 listed N/A, nine Asian/Pacific Islander, seven White, three Mixed, two American Indian, and one Other. Of these, 13 were male, 149 were female 13 listed N/A. and 113 pregnant women. Of the 113 pregnant women, 22 women attended more than one baby shower, 11 attended two

baby showers, four attended three baby showers, five attended four baby showers, two attended five baby showers. The educational topics taught at the showers included, labor and delivery, nutrition and health, postpartum, breastfeeding and new baby care

In addition, AACF developed a Cultural Competence Training and trained staff of the Child Advocacy Center, which included staff from the Maryland State's Attorney's Office, and Victim's Advocates from Frederick County Sheriff's Office. The staff at AACF also presented results of their 2017 Pediatric Asthma Camp to the Community Foundation. Twelve children aged seven-11 in attendance had 19 hospital visits for asthma in the year prior to camp. In the year post camp there had only been seven hospital visits for those 12 children.

Through their CHW School Based Program and collaboration with FCPS (Frederick County Public Schools) AACF offered assistance at multiple school programs as requested. They toured the Career & Technology Center and met with the principal and school counselor to discuss ways they could assist their students. The staff met with FCPS Community Liaisons to discuss collaboration and partnered with Hillcrest Elementary School, Early Childhood Program to promote and host one of their baby showers. As a result of those connections, AACF secured a formal partnership MOU with FCPS.

- **Harford County: Inner County Outreach**
  The Inner County Outreach (ICO)-MOTA grantee implemented an obesity prevention program targeting minority populations in Harford County. The program utilized several healthy cooking and exercise classes as well as exposure to opportunities for maintaining a community garden as strategies for accomplishing this goal. ICO also sponsored and participated in several community events to further increase awareness about obesity and obesity related diseases while also referring and linking individuals to needed support services. Below are some of their key accomplishments in FY 18:
    - Held 12 healthy cooking classes for 75 adults.
    - Conducted five healthy cooking classes for 150 youth.
    - Out of the 150 youth who participated in the 5 healthy cooking classes, 135 increased their knowledge by scoring 80% or greater on the pre and posttest questionnaires administered before and after every healthy cooking class.
    - Hosted 60 exercise classes for 75 participants.
    - Conducted five community garden classes with 150 youth who participated.
    - Organized and hosted seven community events with 1,250 community members in attendance.
    - Referred 50 program participants for support services such as transportation, housing, social services and ascertained 35 received support services after follow up.

- **Howard County: Foreign-Born Information and Referral Network (FIRN)**
  The FIRN-MOTA partner received funding to provide resources needed in navigating the insurance marketplace with the aim of enrolling individuals in health insurance. It provided intensive case management/follow up to ensure individuals received other

needed support (wrap-around) services. In addition, the FIRN program conducted a Diabetes Prevention Program (DPP) for pre-diabetic clients with an aim of preventing diabetes onset. The FIRN-MOTA partner also conducted Minority Health Roundtables which served as a forum for minority individuals living in Howard County to express their concerns about community needs and proffer solutions.

In FY 18 FIRN enrolled 109 Howard County minority residents into health insurance and educated 15 minority residents about diabetes prevention in six education sessions. FIRN provided 138 referrals to 122 minority residents participating in case management with FIRN Community Health Workers.

- **Kent County: Mt. Olive AME Church**

  Mt. Olive AME CATS Team-MOTA grant program targeted African American and Hispanic/Latinos in Kent County with the aim of increasing awareness about risk factors for diabetes through educational sessions. The Grantee screened program participants for both diabetes (blood glucose testing) and pre-diabetes with referrals to the Kent County Health Department for the Diabetes Prevention Program. Other large events for school aged children and youths on nutrition and physical activity were also conducted. Below are highlights of accomplishments for their 2018 MOTA funded program:

  - One of their biggest accomplishments was the unplanned interactions with 100 school children about diet, shopping for nutritional foods and how they can help their parents/aunts/grandparents buy healthy foods.
  - Enrolled 20 African American participants in the Diabetes Prevention Program of which 15 of those completed all 16 sessions.
  - Another accomplishment was being able to provide 10 diabetes seminars for 60 African American and 60 Hispanic/Latino participants.
  - On September 18, 2017 the grantee hosted a Prostate Cancer Forum in which MOTA/CATS team members had the opportunity to discuss the risks of diabetes with the participants and share educational materials while also promoting their Diabetes Prevention Program sessions. 43 participants were recruited and attended a workshop on held on November 4th, Diabetes Prevention Day.
  - Mount Olive AME partnered with Community based organizations to organize a physical activity event to educate 100 children about prediabetes, healthy eating and making healthy behavioral choices through existing events such as Halloween, the Easter Egg Hunt, the Kent County Post Prom event, and the Kent County High School Health Fair.

- **Montgomery County: Holy Cross Hospital**

  Holy Cross Health, Inc.-MOTA Minority Communities Empowerment Project provided several opportunities for education on Cardiovascular Disease and Diabetes for minority individuals residing in Montgomery County through community outreach. The project also provided resources to ensure both the referral and linkage of individuals to services such as Primary Care, Health Insurance Enrollment and other services as needed. Below are key outcomes of their 2018 MOTA funded program:

- As a community collaborative, the Minority Communities Empowerment Project (MCEP) provided culturally competent health education, with links to community resources for low-income, medically underserved, uninsured and underinsured, racial and ethnic communities in Montgomery County. In partnership with MDH, MHHD, MOTA, Holy Cross Health, Community Ministries of Rockville, and Mount Jezreel Baptist Church, the MCEP leveraged its collective abilities to address health disparities and provide a significant presence in its target communities. The MCEP successfully built organizational and community capacity in hard-to-reach, hard-to-teach racial and ethnic communities around cardiovascular disease and diabetes. Their success was a direct result of the ability of Community Health Workers (CHW) to earn the trust of the communities where they live and work. Through the deployment of CHWs, geographically accessible outreach was provided in locations throughout the community including laundromats, churches, barber shops, beauty salons, ethnic grocery stores, health fairs, and community gatherings.
- Coordinated 25 group session one and done community outreach activities on heart disease prevention reaching approximately 625 unduplicated community members- the MCEP coordinated/participated in 42 (168% of goal) group session one and done community outreach activities on heart disease prevention reaching 317 (51% of goal) community members throughout the program year.
- Participated in nine booth/station activities (health fairs) focused on heart health reaching approximately 900 unduplicated community members- the MCEP participated in 17 (188% of goal) booth/station activities (health fairs) focused on heart health prevention reaching approximately 1,020 (113% of goal) unduplicated community members during the program year.
- Coordinated 20 one-to-one face-to-face one-time activities focused on blood pressure awareness and screening, engaging 100 unduplicated community members- the MCEP coordinated 26 (130% of goal) one-to-one face-to-face series activities focused on blood pressure awareness and screening, engaging approximately 129 (129% of goal) unduplicated community members throughout the program year.
- Coordinated 100 one-to-one face-to-face one-time heart health outreach activities.

- **Prince George's County: Access to Wholistic and Productive Living Institute, Inc., (AWPLI)**

  NOTE: The activities described below were completed with MOTA funds during FY18. AWPLI did not receive MOTA funds for FY19. The Prince George's County Health Department continues to ensure continuity of services for all county residents.

  The AWPLI-MOTA Bright Beginnings Continuation Project had an overall goal to reach a broader range of high risk African American and Latino/Hispanic pregnant women living in Prince George's County by providing effective Maternal Child Health (MCH) Care Coordination and community outreach events to educate on pregnancy and birth outcomes. The program also referred and ensured client linkages to services such as Primary Care, WIC and Medicaid. Below are some key accomplishments of their MOTA funded program:

- Access's Bright Beginnings home visiting program had a long history of success in addressing birth outcomes in Prince George's County.
- During this fiscal year, the county did not experience any low birth weight births, fetal deaths or infant deaths.
- Overall, among all their funding streams, they connected 25 women to a medical home for prenatal care. Six of those women were teens who had not begun prenatal care.
- Furthermore, they also helped three women get assistance for domestic violence issues and linked 4 women to mental health services.

- **Prince George's County: La Clinica del Pueblo, Inc. (LCDP)**

  The LCDP-MOTA Tu Salud en Tus Manos (Your Health in Your Hands) project targeted Latinos in Prince George's County through charlas (workshops) with the aim of increasing knowledge and awareness about Diabetes Mellitus, Obesity and Cardiovascular Diseases. The project increased Latino access to needed healthcare services. Another component of Tu Salud en Tus Manos project was to implement a 6-week Road to Health program for pre-diabetic and/or overweight/ obese individuals to aid in weight loss through positive lifestyle changes. Critical accomplishments of this program are listed below:

  - In the second year of the Tu Salud en Tus Manos (Your Health in Your Hands) program, La Clínica del Pueblo surpassed the expected outcomes in each goal and objective established in the original work plan. La Clínica used an effective recruitment strategy that involved key alliances and partnerships, social media (Facebook), flyers, outreach by the Health Promotion Coordinator, and outreach through promotores de salud (health promoters) at the sites of partner organizations and businesses.
  - The first goal was to increase knowledge and awareness in the Latino community about diabetes, obesity, and cardiovascular disease, and increase access to healthcare services through community-based health education workshops. La Clínica reached 211 participants.
  - In Prince George's County through 14 culturally competent small-group workshops, which surpassed the original target of 200 participants, a total of 192 participants increased their knowledge and awareness of chronic disease and chronic disease prevention, as measured through pre/posttests applied during the workshops. La Clínica was able to maximize attendance through their partnership with the City of Hyattsville, which facilitated the recruitment of parents at schools throughout the city.
  - The second goal was to host a community health fair and provide basic health screenings (Body Mass Index and Blood Pressure) for the community. The Health Promotion team hosted a "Día de Muertos" (Day of the Dead) themed Festival and Health Fair on November 5, 2017 at the Langley Park Community Center. This health fair was a huge success, as it was an opportunity to celebrate life, health, and embrace the rich cultural traditions of the Latino community. LCDP was able to bring together traditional arts and crafts with other cultural traditions and integrate them into health promotion activities to create a memorable day. Seventy two people attended and 62 received health screenings (BMI, nutrition

counselling and blood pressure measurements), surpassing our original targets. They also had the five community partners participate, including: the Prince George's County Health Department, Maryland Multicultural Youth Centers, CentroNia, the Mexican Consulate, and Prince George's County Department of Parks and Recreation. The health fair also incorporated in La Clínica's own HIV testing team and women's health team. The festival received praise for its originality and recognized for effectiveness of integrating messages about healthy living while celebrating the richness of Latino culture.

- The third goal was to implement an eight-session chronic disease prevention program utilizing evidence-based intervention to achieve behavior change, with the objective of enrolling 15 pre-diabetic and/or overweight/obese participants. During the course of the grant period, La Clínica enrolled 17 participants in the behavior change program based on the CDC's Road to Health Intervention. Within this group, all 17 participants attended at least four sessions and 15 were able to lose weight and establish lifestyle change goals.
- Another accomplishment for this grant cycle was La Clinica's participation in the End of Year Partnering for Health Equity Conference organized by the Maryland Office of Minority Health and Health Disparities. Dr. Suyanna Barker, Senior Director of Health Equity and Community Action was a keynote speaker and presented on Immigration as a Social Determinant of Health.

- **Saint Mary's County: Minority Outreach Coalition, Inc. (MOC)**

  The MOC-MOTA program had an overarching goal of improving the general health of St. Mary's County residents through educating youth on tobacco and other tobacco product use/ awareness, while also educating minority men on prostate cancers and the need for screening. This was be done through educational workshops and referrals for prostate cancer screening. Key accomplishments of this MOTA funded program in St. Mary's County are listed below:

  - MOC conducted nine tobacco use prevention classes and educated 200 youth, ages 12-18 on the hazards of tobacco use and other emerging tobacco products.
  - Fifty youth, ages 12-18 increased their knowledge by scoring 80% or greater on an administered pre and posttest on the hazards of tobacco use and emerging tobacco products.
  - Another key accomplishment for this grant was that MOC conducted 6 workshops to educate 200 men on prostate cancer, of which 100 were referred for screening. Of the 100 referred, 40 completed the prostate cancer screening after follow up.
  - MOC also sponsored a community Wellness Day Health Fair that had 250 people in attendance.

- **Wicomico County: Community Empowerment Center, Inc. (CEC)**

  During fiscal year 2018 CEC was funded to provide diabetes prevention program targeting minorities in Wicomico County. They were able to educate 15 African Americans on diabetes through education and physical activity to promote a healthy lifestyle and reduce complications of diabetes.

  - With the Hispanic community the CEC staff went out into the community at a local Hispanic restaurant to educate that population within a familiar environment

with hopes of increasing participation for diabetes education. CEC was successful in recruiting 10 Hispanic/Latinos to participate in the Diabetes Prevention Program.

- During National Diabetes month, CEC held a Community Health Fair at the Ward Center with different vendors within the community to promote diabetes education, provide resources where to get care and educated attendees about better food choices for their diet.

IV. Other Grant Funded Programs

A. United States Department of Health and Human Services State Partnership Grant - *Educating Minorities of Benefits Received After Consumer Enrollment (EMBRACE)*

On August 15, 2015, MHHD was awarded a new five-year award from the U.S. Department of Health and Human Services (DHHS) Office of Minority Health that has as its goal increasing rates of health insurance, increasing use of primary care services, and reducing rates of emergency department visits and hospital readmissions in six ZIP Codes (20712, 20737, 20781, 20782, 20783, and 20903) that lie in the northwest part of Prince George's County at the border with Montgomery County and had high rates of health un-insurance prior to implementation of the insurance expansion under the Affordable Care Act.

The grant project years run from August 1 to July 31, which approximates the state fiscal year. Result for the third year of the grant (State FY18):

- The community-based sub-grantee (Mary's Center) that conducts group and individual educational sessions and makes referrals to insurance enrollment and to medical homes, had the following outputs for grant project year 3 (State FY18):

Program Output	**Aug-Oct Year 3 Q1**	**Nov-Jan Year 3 Q2**	**Feb-Apr Year 3 Q3**	**May-Jul Year 3 Q4**	**FY 2018 Total**
Number of educational sessions	25	30	39	36	**130**
Number of attendees at sessions	350	203	246	220	**1019**
Number of informational materials distributed	994	896	664	914	**3468**
Number of one-on-one sessions	279	242	238	235	**994**

Number of referrals for insurance enrollment	77	173	86	80	**416**
Number of referrals to primary care	179	72	74	61	**386**

- Qualitative evaluation is being performed by Morgan State University using focus groups (performed in August - October 2018) and qualitative evaluation (in development to be administer by the end of November in 2018) to assess, among participants in the Mary's Center educational program:
    a) For those without health insurance and eligible for it before the program: how well did the program help them obtain and use insurance
    b) For persons without health insurance and not eligible for insurance: how well did the program help them find free or low-cost (such as sliding fee scale) primary care.
    c) For persons with health insurance, before the program, or without health insurance but obtained it, and did not have a medical home: how well did the program help them connect to a medical home where they could use their insurance for primary care.

The surveys will be conducted on 200 persons during mid-November 2018.

MHHD is beginning to analyze the impact of the program on health uninsurance rates and ED visit and hospital admission rates in the targeted ZIP Codes. Initial results of that outcome analysis should be available next year. The Office successfully submitted a renewal application for this project in May of 2018 and has been funded for FY19.

B. St. Mary's County Asthma Control Program

MHHD partnered with the St. Mary's County Health Department to provide funding and technical assistance to implement an asthma control program (ACP). The ACP utilizes community health workers and community health nurses to outreach and educate children and their families through home-based, multi-trigger, multicomponent interventions with an environmental focus. Adolescents (2-18 years old) diagnosed with asthma and living in St. Mary's County are eligible for the program. Referrals are received through collaboration with community partners such as churches and schools, in addition to a strong presence at community events. To capture at least a 70% minority enrollment into the program, CHWs and nurses focus in the Lexington Park and Great Mills communities in the jurisdiction.

The following are goals of the program with data (from July 1, 2018 - current):

Measurement	**Goal**	**Progress**

# of children enrolled in the Asthma Control Program	20	34
# of children completing the Asthma Control Program	70% of enrolled	4 children; 70%
# of education and outreach events attended	30	68 outreach events attended with 48.5% of events in focus communities
# of community members reached through outreach efforts	700	10,962 community members reached

C. Other Supplemental Funding Collaborations

I. Environmental Health Bureau (EHB) Grant

In FY 18, the Office of Minority Health and Health Disparities (MHHD) in collaboration with the Environmental Health Bureau announced applications for community-based education and outreach activities utilizing the Environmental Public Health Tracking (EPHT) network portal.

Seven MOTA Partners were funded ($5,000 each) to implement education and outreach activities addressing environmental health topics such as (but not limited to) asthma, blood lead poisoning, radon, climate change in local communities. Activities were centered around enhancing the knowledge of the community on these topics utilizing the EPHT portal. Examples of outreach and education activities included:

1. Community education and awareness events that observed asthma awareness month, national health disparities month and other workshops or health fairs that educated people about environmental health topics.
2. Brochures or other materials distributed to a community with follow up and education
3. Cultural and faith-based events that brought awareness to the topic in local communities.

II. HIV/AIDS, Hepatitis B and C, and other STD's Grantees

In FY 2018, MHHD in collaboration with the Center for HIV/AIDS and Health Services solicited applications for community-based education and outreach activities that address HIV/AIDS, Hepatitis B and C, and other STDs in minority, medically underserved communities.

The following community-based organizations applied and received funding to conduct HIV/AIDS, Hepatitis B and C, and other STD outreach and education activities:

ORGANIZATION	PROGRAM DESCRIPTION
Asian American Center of Frederick (AACF) Frederick County	Hepatitis B and C education and screening -HIV, Hepatitis B & C awareness and educational events. -Community outreach events -Conducted about 254 surveys -Testing and referrals for HIV, Hepatitis B & C
Associated Black Charities (ABC) **Dorchester County**	- HIV, STDs, Hepatitis B & C outreach and educational sessions -CHWs trainings on HIV, STDs, Hepatitis B&C -Provisions of health educational materials -Testing and follow-up for HIV, STDs, Hepatitis B&C
Access to Wholistic and Productive Living Institute, Inc. (AWPL) Prince George's County	- Conducted educational awareness campaign programs for HIV and other STDs. - Distributed HIV/AIDS educational materials which were made available in Spanish and English
OMT (Office Management and Technology) Inc. **Baltimore County**	-Conducted education and awareness sessions on HIV, STDs, Hepatitis B and C -Partnered with Chase Brexton Health Systems (CBHS) for community educational events on HIV, Hepatitis and STD awareness days - Educated participants on counseling and testing, provided referrals and follow up via email and as needed
Taking Effect Action (TEA) **Prince George's County**	- Conducted outreach and education for HIV/AIDS, STDs, Hepatitis B and C -Conducted outreach in partnership with churches for HIV/AIDS and STDs awareness. -The grantee used creative arts to convey health awareness information to targeted participants.
Hands of Hope, Inc. **Anne Arundel County**	-Conducted HIV/AIDS, STI, Hepatitis B and C outreach and education. -Conducted health education and awareness events for HIV/AIDS, STDs, Hepatitis B and C. -Provided education on counseling and testing for targeted participants.

LA Clinica Del Pueblo **Prince George's County**	- Conducted community based educational and awareness events for Hispanic/Latino communities on HIV prevention - Provided HIV testing and referrals to care and social support services as needed to targeted participants _Provided provision of HIV/AIDS educational materials (such as pamphlets, condoms and safe sex kits) -Distributed previously developed role model flyers ('Historias de orgullo'/'stories of pride') to targeted participants
Mt Olive A.M.E Church **Kent County**	-Distributed educational materials on Social media (Facebook and Newspaper ads) on HIV, Hepatitis and other STDs during awareness events -Provided HIV/AIDS awareness shirts and informational banners to other Community based organizations in Kent County -Conducted HIV/AIDS outreach and educational events in collaboration with other faith-based organizations.

III. Minority Health Month Community Conversation Supplemental Funding

MHHD sought proposals from FY 18 MOTA partners that outlined a plan to organize and facilitate a community caucus in recognition of Minority Health Month (April) within the partners' funded jurisdiction. The purpose of the caucus was to engage various sectors (local government leaders, legislators, education boards, housing and community development, transportation and mobility, environmental groups, public safety and corrections, agriculture, health care providers and hospital system/federally qualified health centers), and community members to discuss the challenges and possible solutions for addressing the health needs of the community.

MHHD funded seven MOTA partners who applied for the supplemental funding to host events during the month of April in celebration of the National Minority Health Month with the theme, *Partnering for Health Equity*. Highlights of partner's caucus events included:

- **Associated Black Charities (ABC) of Dorchester County** held two community meetings in April. The meetings brought together several stakeholders in Dorchester including community members and varied organizations to discuss the social determinants of health, as well as how they are impacted by equity filters such as social injustice, racism and poverty. The meetings were held at the Eastern Shore State Hospital center, gathering 34 individuals to the first meeting and 22 to the second. A report was created from the meeting findings which were disseminated to MHHD and Dorchester County officials both in the city and county councils.
- **Asian American Center of Frederick (AACF)** hosted a dinner event where different stakeholder from private, public, faith-based organizations as well as community members gathered to discuss and select priorities from the Frederick County Local Health Improvement Plan (LHIP). The event was successful as shown by an attendance of 71 individuals which exceeded their intended attendance by 30 individuals. The event also

featured an AACF resource table where a Community Health Worker highlighted the different programs available at the organization. The findings from the event were shared with the LHIP leaders, Frederick Memorial Hospital, the Frederick Health Department designated contacts who will follow up on the findings from the meeting as well as MHHD. Another outcome from the meeting was the possibility of the development of a minority caucus in Frederick County with shared responsibilities by all partners.

- **Office Management & Technology, Inc (OMT Inc.)** partnered with Chase Brexton Health services, a Federally Qualified Health Center to facilitate a "Community Conversations Lunch & Learn Forum" with their staff. In attendance were 19 health providers who showed an increase in awareness about health disparities while also learning strategies to achieve health equity. OMT Inc. also disseminated a follow up survey to participants of their FY 17 Community Conversations at Medstar Franklin Hospital. Response was received largely from Medstar employees as well as a few community members to find out about what activities they have participated in to improve health equity as well as their current understanding of the concept since the event in 2017. Thirdly, they organized an event with 36 staff and students at Towson State University to provide information on HIV/AIDS.
- **La Clínica Del Pueblo (LCDP)** convened a one-day event with a theme, "Partnering for Health Equity: Strategies, Partnerships and Recommendations for Immigrants' Health in Prince Georges County" in Hyattsville, Maryland. In attendance were 68 stakeholders and leaders from private, governmental, community-based organizations, academia etc. as well as elected officials from the city, county and state levels. The event had two panels on: Mapping health and mental health coverage for immigrants in Prince Georges (PG) County AND Understanding the role of immigration as a social determinant of health. Some major highlights from the event were the need for policy makers to address the high volume of uninsured Latinos in PG County while also considering alternative ways to utilize community resources including the need for culturally competent and bilingual service providers who understand the barriers faced by immigrants. A publicly available report was created and shared with MHHD with recommendations on how to ensure high quality integrated health and mental care for Latino immigrants, how to sustain local initiatives to provide equitable health access for immigrants and how to reorient the health sector towards reducing health inequities as well as next steps. These recommendations were deemed useful not only for PG County but replicable in other immigrant communities.
- **Access to Wholistic and Productive Living Institute** organized "Improving Health Equity through Collaboration Round Table" at the Gladys Spellman Health and Wellness Center in Cheverly Maryland. The event brought together 53 individuals, including community members and leaders from varied organizations, the hospital systems, as well as state and county government officials. The participants discussed the importance of partnership in achieving policy change and improving health equity in the community. The group completed evaluations which rated the event highly and showed an interest in continuing roundtable discussions in the future.
- **Mt. Olive AME Church** organized a youth-led, youth-focused team meeting called Empowering Youth for Health (EYH) in Kent County. The team was conceived when two youths recognized the lack of youth involvement in the discussion of health and challenges affecting the community during a local meeting in 2017. EYH gathered 15

students from the local area who interviewed more than 20 of their peers to ask what they believe to be health challenges in the community, discussed the roles that the youth can play to address these issues, and identified the resources to help their plight. 14 of the 15 participants requested continuation of the team meeting, which the organizers identified as their most impactful result.

- **Hands of Hope Inc.** held a Legacy Lunch & Listen meeting titled "Health L3: The Building Continues" in Anne Arundel County with a focus on Social Determinants of Health (SDH). The mission of the event was to promote and evaluate the county's efforts to improve the health and well-being of its people. Attendees were represented from the community, including faith-based organizations, youth organizations, and governmental agencies. The meeting was divided into 5 groups discussing various SDH such as access to resources/care, social context (community engagement), health care systems (provider availability/quality of care), environment/access to education/housing, power/social context community engagement – voices with coordination by various stakeholders. Attendees identified barriers and strategies to address them.

V. Health Equity Initiatives

A. Health Equity Technical Assistance

MHHD has expanded its efforts in 2018 to offer technical assistance on cultural competency, unconscious bias, linguistic competency, and workforce diversity for state and community leadership teams and frontline staff. In addition to updating online cultural competency resources posted on the MHHD website, MHHD has been engaged in the following activities:

- Conducted presentations addressing social determinants of health, CLAS Standards and implicit bias at events including the University of Maryland Eastern Shore Summit (April 20) and Stevenson University School of Nursing (August 28).
- Conducted 15-minute monthly presentations at MDH new hire orientation to highlight the Office's action plan to achieving health equity, availability of cultural competency training, and introduce terms such as: social determinants of health, culturally and linguistically appropriate services.
- Conduct a 15-minute presentation at the health board orientation, annually to create awareness on the importance of cultural competency, current health disparities data in the state of Maryland, and recommendations to the health boards on steps to motivate their licensees to be more culturally competent.
- Updated PowerPoint presentations and new data trends for the CLAS Standards Tool-Kit available on the MHHD website.
- Updated online suggested trainings on cultural competency offering CEUs for physicians, nurses and other health professionals.
- Created a new list for online-trainings and webinars offering CEUs for healthcare professionals on cultural competency.
- Created an online resource in collaboration with the Prevention and Health Promotion Administration to provide guidance to primary care health professionals on cancer disparities and health equity.

- In collaboration with Behavioral Health System Baltimore, created a 20 min power-point presentation to serve as an online webinar for Peer Support training on health equity.

B. Maryland Interagency Council on Homelessness

The Interagency Council on Homelessness (ICH) was established by SB 796, Chapter 341 (2014) to examine statewide initiatives aimed at ending homelessness throughout the State of Maryland. The MHHD Deputy Director was appointed by the Secretary as the MDH representative on the Interagency Council.

Interagency Council Activities

Homelessness is a critical public health issue that is primarily the result of lack of access to affordable, adequate housing. Safe and affordable housing is one of the primary social determinants of health. Homelessness creates significant health problems and exacerbates existing health issues. Homeless individuals are three to four times more likely to die prematurely than their housed counterparts and experience an average life expectancy as low as 41 years (National Health Care for the Homeless Council, 2011). Racial and ethnic minority groups are more likely to experience homelessness in Maryland. According to the Maryland Department of Housing and Community Development, African Americans account for 59.9% of the homeless population compared to 34.2% non-Hispanic Whites (MD PIT 2017 Analysis by CoC.pdf)

Within the Interagency Council, MHHD leads the efforts of the Health and Homelessness Workgroup. The goal of the Workgroup is to improve the emergency services network for the homeless, by partnering with local stakeholders to create a comprehensive assessment and discharge planning process used at intake and discharge from medical facilities or jails.

The objectives are:

- Assess how the homeless are accessing emergency care and study the manner in which they are being released from hospitals back into the community
- Increase access to proper respite/convalescent care for the homeless statewide.
- Assess exit-planning strategies used by jails and other institutions to determine service and housing gaps.

In FY 18, the Workgroup accomplished the following:

- Conducted quarterly work group meetings
- Attended quarterly ICH meetings
- Continued discussions on Medical Respite programs in Maryland discussing topics such as creating new programs, funding and sustainability.
- Discussed discharge planning policies from hospitals in Maryland with the aim of strengthening policies that limit discharge into homelessness.
- Worked collaboratively with the Department of Public Safety and Correctional Services (DPSCS) to finalize the Re-entry and Exit Planning (REEP) qualitative assessment tool.

- Disseminated the REEP tool was disseminated in jails in 17 of 24 jurisdictions in Maryland with a plan of completing interviews in remaining jails and prisons by the 1st quarter of 2019.
- Developed a preliminary report was developed with findings from the REEP assessment.

The ICH and MHHD are committed to improving the health care delivery process for the homeless population. Achieving this goal will require improving access to safe and affordable housing and social supports for the homeless population. MHHD will continue to employ a multi-sectoral approach to address this complex problem within a health equity framework.

C. Health Equity-Related Legislation

MHHD conducted analyses and recommended positions on legislation introduced during the 2018 legislative session. Specifically, MHHD staff reviewed and provided positions on 26 bills related to the community health worker advisory committee and certification; mortality rates of African American infants and infants in rural areas; social determinants of health in Baltimore City; reconciliation and equity; data collection on race and ethnicity; and others.

I. Health in All Policies Workgroup

On May 4th, 2017, Governor Larry Hogan signed into law the University of Maryland School of Public Health, Center for Health Equity Workgroup on Health in All Policies. Convened by the Maryland Center for Health Equity at the University of Maryland School of Public Health, in consultation with MDH, the Workgroup is to use a "Health in All Policies" framework. A Health in All Policies framework is a public health framework where health considerations that collaboratively improve health outcomes and reduce health inequities drive policy decision-making across the public and private sectors. MHHD holds a seat on the Work Group and provides staff support to the Workgroup.

The Workgroup is tasked with examining the current health status of Maryland citizens, and how State and local governments might collaborate to improve the health of Marylanders. The effect of the following factors on health are to be considered: access to safe and affordable housing; economic stability; educational opportunities; employment prospects; environmental factors; public safety issues; social justice; and workplace factors, such as inclusion, diversity, equity, and barriers to promotion and advancement. The Workgroup will study and make recommendations on how health considerations can be incorporated into decisions by government agencies and entities that interact with them. Moreover, it will recommend how to foster collaboration between State and local governments in devising and implementing laws and policies that improve health and reduce health inequities. An interim report was submitted to the Maryland General Assembly on January 31, 2018. Another interim report will be submitted to the Maryland General Assembly by January 31, 2019 and a final report will be submitted by June 30, 2019.

II. Community Health Worker Bill of 2018

House Bill 0490 / Senate Bill 0163 (Chapter 441) - *Public Health – Community Health Workers – Advisory Committee and Certification* took effect on October 1, 2018. The Committee's primary mandates are the establishment, operation and functioning of the State Community Health Worker Advisory Committee; the setup and implementation of a certification and training process for CHWs in the state; and the establishment of the State Community Health Workers Fund. The Office of Minority Health and Health Disparities holds the staffing role for the Committee. The Committee held its inaugural meeting on October 22, 2018 and will hold meetings bimonthly.

D. Workforce Development

I. Internship/Learning Opportunity Initiative

MHHD offers non-paid learning opportunities to students and professionals interested in health equity-related issues. These opportunities include formal internships and fellowships, informal internships, volunteering, and job shadowing designed to build the skills and competence of the future workforce to address health equity. MHHD has an ongoing relationship with the following academic institutions: Morgan State University's School of Community Health and Policy; University of Maryland School of Medicine; Coppin State School of Social Work; University of South Florida School of Public Health; George Washington University School of Public Health; the University of Maryland Eastern Shore; University of New England; Liberty University, and San Jose University. Additionally, MHHD has taken part in the following internship programs: U.S. Department of Health and Human Services, Office of Minority Health, Youth Health Equity Model of Practice; Kennedy Krieger RISE-UP; Public Health Applications for Student Experience (PHASE); and the Governor's Summer Internship Program.

Projects that 2018 MHHD interns have been engaged in include: Minority Outreach and Technical Assistance program evaluation; opioid overdose messaging in minority communities; chronic disease data analysis; housing and reentry research of the Health and Homelessness Workgroup; community health worker workforce development; health equity policy review; and minority health outreach and program planning.

During 2018, MHHD has hosted 16 students that have represented the following academic programs:

- Two undergraduate social work students from Coppin State University.
- Five medical students from the University of Maryland School of Medicine.
- Four master's degree level internship students from the George Washington University School of Public Health, University of New England, Liberty University, and the University of South Florida.
- One Fellow from the University of Maryland Eastern Shore.
- One doctoral student in public health from Morgan State University.
- Three internship students representing the following programs: U.S. Department of Health and Human Services, Office of Minority Health, Youth Health Equity Model of Practice; Kennedy Krieger RISE-UP; and Public Health Applications for Student Experience (PHASE).

E. Maryland Health Disparities Data

Technical assistance to MOTA grantees regarding program design, data collection, and program evaluation was a major data program function in FY 2018, especially with regard to a new application cycle: developing the RFA reviewing proposals and establishing performance measures for awardees. With the completion of this MOTA process by late summer of 2018, focus on production of data reporting products has resumed. In fall to spring of FY 18 data staff were involved in data analysis and discussions regarding identifying 10 potential top MDH health priorities, from which the final three priority areas of Asthma, Diabetes, and Infant Mortality (and related adverse birth outcomes) were derived.

During FY 2018 MHHD data staff were involved in various data-related activities:

- Worked with the Health Enterprise Zone (HEZ) State Team to present the HEZ model and results to ASTHO at a one-day meeting. MHHD data staff also reviewed and advised on the report from the evaluation subcontractor.
- Developed reporting templates for the MOTA Program and provided data collection/reporting and program design resources, templates and training to the MOTA grantees. Assisted in RFA development and in proposal review for the new application cycle.
- Performed monthly review of the MOTA data reports.
- Served as the Project Director/Principal Investigator for the EMBRACE grant, with executive responsibility for quarterly narrative reports, separate quarterly data reports, and preparation of the yearly renewal application.
- Participated in preparation of a REACH grant proposal, which did not receive funding.
- Provided data analysis and participated in discussions leading to development of the three MDH priority areas of Asthma, Diabetes, and Infant Mortality.
- Provided data support to the development of the MHHD strategic plan
- Participated in and provided data support to the MHCC-led study on Black and rural infant mortality in Maryland mandated by 2018 SB 266
- Acquired access to HSCRC utilization data and began to perform analysis for inclusion in reports on the three priority areas, for a fourth edition of our Chart Book, and for the EMBRACE project evaluation.
- Began trend analysis of Prevalence, Mortality, and Utilization data in the three priority areas of Asthma, Diabetes, and Infant Mortality, to be included in topic-specific reports in these areas to be released in late 2018 or early 2019.

MHHD continues to monitor ethnic and racial health disparities in Maryland and finds that disparities continue, but some progress toward elimination of some disparities is being made (see section II above).

F. Minority Health Month – April 2018

The theme for National Minority Health Month 2018 was *Partnering for Health Equity*. Led by the U.S. Department of Health and Human Services Office of Minority Health (HHS OMH) each year, this national observance joins federal, state, tribal, local and territorial partners across the country in calling for a renewed commitment to eliminate health disparities and achieve health equity.

MHHD chose activities to highlight the theme of *Partnering for Health Equity* to promote the importance of great partnerships at all levels and highlights the vital role of partnerships in reducing health disparities, advancing health equity, and improving the health of people and communities. MHHD hosted the following events during the month of April:

- Chronic Disease Prevention Webinar in collaboration with the Center for Chronic Disease Prevention and Control that presented current data trends in chronic disease disparities, as well as program highlights from a local community-based organization implementing a chronic disease reduction program.
- Building Sustainable Partnerships to Increase Access to Care Panel Discussion featuring three speakers from diverse representation discussing how they work to increase access to care for Maryland communities.
- A 1-Mile Walk for Health, in celebration of National Public Health Week and National Minority Health Month. Approximately 30 individuals participated. Healthy prizes were offered for the top three finishers.
- Health Equity Summit hosted by MHHD & University of Maryland Eastern Shore

G. MHHD Statewide Annual Conference

MHHD hosted its 15th Annual Statewide Health Equity Conference, *Achieving Health Equity and Disparity Reduction: Prevention and Cost Savings Initiatives*, on December 6, 2018 at Martin's West in Baltimore. The event was co-sponsored by the Maryland Behavioral Health Administration, Office of Workforce Development and Training, and the Maryland Center for Health Equity, School of Public Health, University of Maryland.

Approximately 400 people attended the conference. The conference highlighted programs and initiatives that reduce disparities and improve health outcomes in minority communities resulting in reduced health costs and preventable hospital utilization.

Dr. Noel Brathwaite, MHHD Director and Ms. Cheri Wilson, Conference Moderator, provided opening remarks. Senator Shirley Nathan-Pulliam provided greetings and MDH Secretary Robert Neall provided on overview of Maryland's Total Cost of Care All-Payer Model. Dr. Georges Benjamin, Executive Director of the American Public Health Association, delivered the eighth annual address of the Shirley Nathan-Pulliam Health Equity Lecture Series.

A new component of the 2018 Conference was the Health Equity Leadership Awards recognizing an individual and community-based organization that has made a difference in advancing health equity in their communities. The individual awardee was Ms. Ashyrra Dotson, President and CEO of Eastern Shore Wellness Solutions. The community-based organization awardee was the Asian American Center of Frederick.

The conference featured the following sessions: Mobile Integrated Community Health Program; Managed Care Organization Initiatives in Preventable Utilization and Social Determinants; Minority Disparity Reduction Initiatives: Improving Health outcomes in Maryland Department of Health's Priority Focus Areas -- Asthma Prevention and Management, Infant Mortality Prevention, and Prediabetes and Diabetes Prevention and Management; and Return on Investment from High-Utilizer and Social Determinant Interventions: Maryland Success Stories.

H. MHHD Collaborations

During 2018, new collaborative partnerships were established with the Maryland Medicaid program; Managed Care Organizations; Public Health Services and affiliates; and the Behavioral Health Administration; Local Health Departments; Historically Black Colleges and Universities (HBCUs); Towson University; Johns Hopkins University; the University of Maryland College Park; faith-based organizations such as the Maryland Faith Health Network and Adventist Health Care, Center for Health Equity and Wellness; Baltimore Medical System; the Maryland Public Health Association; the Maryland Rural Health Association; the Maryland Mental Health Association; and the National Association for the Advancement of Colored People (NAACP). These partnerships are designed to assist with resources for reaching the three health priorities and the four listed social determinants of health. Early results include participating in conferences, signing of two Memorandum of Understandings, planning for a 2020 HBCU conference and assisting some partners with applying for Community Health Resource Commission grants; and planning an Eastern Shore Southern Maryland leadership initiative.

VI. MHHD Work Plan for 2019

A. MHHD Strategic Plan: 2019

To advance health equity within Maryland and improve health outcomes for all Marylanders regardless of race, ethnicity, gender, social class, sexual orientation, sexual identity or geography, it is imperative that a comprehensive, multi-disciplinary, multi-sectoral, health equity lens is integrated in all the work conducted within MDH. MHHD uses the Triple Aim of Health Equity as the guiding framework for its strategic priorities and goals.

Background: The Maryland Department of Health Office of Minority Health and Health Disparities was established in 2004 by statute, under the Health General Article, Section § 20-1001 to § 20-1007, to address minority health disparities in Maryland.

Mission: To address the social determinants of health and eliminate health disparities by leveraging the Department's resources, providing health equity consultation, impacting external communications, guiding policy decisions and influencing strategic direction on behalf of the Secretary of Health.

Vision: To achieve health equity where all individuals and communities have the opportunity and access to achieve and maintain good health.

Health Equity Framework: This framework is a multi-pronged approach to improve health equity by:

1. Expanding our understanding of what creates health.
2. Implementing a Health in All Policies approach with health equity as the goal.
3. Strengthening the capacity of communities to create their own healthy future.

2019 Strategic Priorities:

Asthma

Goal 1: Provide funding to continue and expand St. Mary's Asthma Program to reduce disparities and improve health outcomes of children and adolescents diagnosed with asthma

Objectives

1. Reduce clinical factors such as Emergency Department (ED) visits, hospital admissions and use of oral steroid in program participants by 45% -50% by end of program period.
2. Reduce social and environmental factors such as days missed from school and house triggers by 60% by end of program period

Goal 2: Collaborate with Medicaid program and Environmental Health Bureau (EHB) partners for preventable utilization reduction among minorities

Objective

1. Monitor how best practices including home visits are been implemented to reduce preventable utilization among Black program participants in nine sites.

Infant Mortality

Goal 1: Reduce adverse infant outcomes in minority populations

Objective

1. Provide a variety of best practices during the project year to improve birth outcomes

Prediabetes

Goal 1: Reduce the incidence of diabetes in Maryland through MOTA efforts

Objective

1. Implement, track and determine outcomes among the cohort of minority pre-diabetics participating in the one-year diabetes prevention program.

B. Federal-State Partnership Grant Project (EMBRACE)

In 2019 MHHD will continue to operate the EMBRACE project in six ZIP Codes primarily in Prince George's County with some extension into Montgomery County (see section IV A above). Mary's Center, the community-based sub-grantee, will continue to hold educational sessions, provide one-on-one counseling, and make referrals to appropriate services, especially

insurance enrollment and linkage to medical homes. Morgan State University will continue to assist in the development of focus groups and surveys for the qualitative evaluation of the program. MHHD will update the social determinant of health data in the Health Equity Profile and will begin to compile the utilization data for the targeted zip codes in 2019.

C. Minority Outreach and Technical Assistance (MOTA)

In FY19, MHHD disseminated the MOTA continuation application and emphasized data collection and outcomes measures of impact of health programs for racial and ethnic minority communities through community engagement, partnerships, outreach, referral, follow up and technical assistance. MOTA applicants were required to focus on one or more areas of the following expanded key areas: birth outcomes, cardiovascular disease, diabetes, obesity, cancer, tobacco use, asthma, HIV/AIDS, lack of health insurance, lack of a medical home, and non-use of a medical home. In an effort to effectively monitor and evaluate tangible outcomes of the MOTA Program in FY18, MHHD developed the workplan below as a guide in achieving the FY19 outcomes.

Activity	**Month**
Development and Dissemination of 2019 MOTA Request for Proposals (RFA)	February-March 2018
2019 MOTA Pre-application Webinar	April 6, 2018
Revision and Finalization of 2019 MOTA Data Reporting Tools	April-May
Monitoring and Evaluation of FY19 MOTA and Collaborative Initiative Reports	July 2018 - July 2019
First Grantee/Partnership Meeting. This includes all MOTA and Collaborative Initiative partners	September 17, 2018
Second Grantee/Partnership meeting	December 18, 2018
MOTA Grantee Site Visits	September 2018 - June 2019
Third Grantee/Partnership Meeting	March 18, 2019
Development and dissemination of 2020 MOTA Request for Proposals (RFA)	February-April 2019
Annual Grantee/Partnership Meeting	June 20 2019
Compilation and Analysis of MOTA Data and Narrative Reports	June 2019
MOTA Annual Reports	July 2019

D. Maryland Health Disparities Data

In 2019 the data program staff will continue to provide programmatic oversight and data/evaluation support for the EMBRACE Project and data/evaluation technical assistance to the MOTA Program. Data program efforts will include:

- Completion of the fourth edition of the Maryland Chartbook of Minority Health and Minority Health Disparities Data
- Completion of topic-specific data reports on Asthma, Diabetes, and Infant Mortality at the statewide level and at the regional or jurisdictional level.
- Executive oversight of the EMBRACE project
- Preliminary analysis of utilization data for EMBRACE project evaluation
- Data monitoring and technical assistance to the MOTA program
- Data support to MDH internal working groups for Asthma, Diabetes, and Infant Mortality
- Participation on and data support to the MHCC-led study on Black and rural infant mortality in Maryland mandated by 2018 SB 266
- Participation in and data support to the MHHD-Medicaid collaboration within MDH

IV. Presentations & Events and Health Equity Resources

A. Key Presentations & Events

- October 30, 2018. Maryland Public Health Association Conference presentations by MHHD Director and MHHD Deputy Director. Dr. Brathwaite presented on public health legislation. Stephanie Slowly presented on implicit bias.
- September 2018. Dr. Brathwaite presented at the Adventist Health Care Seminar
- October 26, 2018. MHHD Director moderated a panel at the NAACP Convention.
- October, annually. MHHD conducts a 15 minutes presentation for New Orientation Health Boards each year. This year the presentation took place on October 15th. The goal of the presentation was to create awareness on the importance of cultural competency, current health disparities data in the state of Maryland, and recommendations to the health boards on steps to motivate their licensees to be more culturally competent.
- August 28, 2018. Stevenson University School of Nursing presentation by Ms. Karen Gutierrez, Senior Program Specialist. Conducted a 45 min presentation on the social determinants of health awareness to undergraduate nursing students.
- April 20, 2018. University of Maryland Eastern Shore Summit April 20th. Stephanie Slowly conducted a 45 min presentation on Implicit Bias, she reviewed micro assaults, and the negative impact of implicit bias.
- Monthly, Wednesdays. MHHD conducts 15 minutes monthly presentations for new hire staff at MDH. The presentation takes place on the first Wednesday of each month. The goal of the presentation is to highlight the office's action plan in achieving health equity, introduce terms such as; social determinants of health, culturally and linguistically appropriate services, and available online trainings on cultural competency.

B. Health Equity Resources

- Health Equity Report 2017. U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Health Equity https://www.hrsa.gov/sites/default/files/hrsa/health-equity/2017-HRSA-health-equity-report.pdf
- 2017 National Healthcare Quality and Disparities Report. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/research/findings/nhqrdr/nhqdr17/index.html
- Association of State and Territorial Health Officials (ASTHO) website, state health equity reports and plans: http://www.astho.org/Programs/Health-Equity/Health-Equity-Reports-by-State-and-Territory/
- American Public Health Association. *Better Health Through Equity: Case Studies in Reframing Public Health Work.* March, 2015 https://www.apha.org/~/media/files/pdf/topics/equity/equity_stories.ashx
- National Academies of Sciences, Engineering, and Medicine. 2017. *Communities in action: Pathways to health equity*. Washington, DC: The National Academies Press. http://nationalacademies.org/hmd/reports/2017/communities-in-action-pathways-to-health-equity.aspx
- Centers for Disease Control and Prevention. *CDC Health Disparities and Inequalities Report — United States, 2013.* MMWR 2013;62(Suppl 3). https://www.cdc.gov/minorityhealth/chdireport.html https://www.cdc.gov/mmwr/pdf/other/su6203.pdf