

Office of Minority Health and Health Disparities
2025 Report

Pursuant to Health-General Article § 20-1006

Maryland Department of Health

March 2026

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Background

The Office of Minority Health and Health Disparities (MHHD) within the Maryland Department of Health (MDH) was established in statute in 2004 (Health General §§§20-1001-1007). The statute sets forth 24 areas of focus and responsibility for the office.

The mission of the Office of Minority Health and Health Disparities (MHHD) is to:

- Address social determinants of health, reduce health disparities and advance health equity by leveraging the resources of the Maryland Department of Health.
- Collect, compile, and analyze race and ethnicity data to improve health outcomes.
- Foster community partnerships for health equity advocacy and education.
- Guide policy, practice, and program decisions within MDH, and influence the overall strategic direction of the Department on behalf of the Secretary of Health.

MHHD's vision is to achieve health equity where all individuals and communities in Maryland have a fair and just opportunity to attain their optimal health regardless of race, ethnicity, sexual orientation, gender identity, or socioeconomic status.

Main activities include:

- Advocating to improve minority health outcomes by establishing educational forums, programs (including grants to community-based organizations), and health awareness campaigns
- Identifying and reviewing health promotion and disease prevention strategies related to high mortality and morbidity rates among marginalized and underserved communities
- Fostering public/private partnerships
- Assisting the Secretary of Health in setting health equity priorities, advising on policies affecting the delivery of equitable health, and creation of a health equity strategic framework to address social determinants of health

Additional legislation in 2021 added (1) participation on the Maryland Commission on Health Equity, (2) responsibility to create and maintain a list of implicit bias training courses for licensed health care providers, and (3) the creation of a healthcare disparities report card to MHHD's portfolio of responsibilities.

I. Health Disparities Data Update

A. New Approach to MDH Health Data Presentation

MDH is actively in the process of developing a centralized Health Indicators Dashboard (HID). This effort is led by MDH's Chief Data Officer. The HID will serve as an interactive self-service data portal with access to health data across various measures, segmented by demographics, and will include measures for monitoring both the State Health Improvement Plan and Population Health Accountability Plan, as well as address other mandated reporting on disparities. The dashboard will meet the various requirements of the Maryland Commission on Health Equity (MCHE) as well as MHHD. MCHE is required by statute to examine several factors that influence the health of Maryland residents. The factors include:

1. Access to safe and affordable housing
2. Educational attainment
3. Opportunities for employment
4. Economic stability
5. Environmental factors
6. Public safety, including the impact of crime, citizen unrest, the criminal justice system, and governmental policies that affect individuals who are in prison or released from prison
7. Food insecurity

The Data Advisory Committee (DAC) of the MCHE reviewed the draft HID between November 2025 and February 2026, provided collective feedback, and aligned the data requirements outlined in statute.

B. Health Disparities Progress

Data presented in this report show that Maryland's investments in minority health improvement and minority health disparity reduction since the creation of MHHD are effective, particularly in the areas of mortality disparities for several leading causes of death. These results also show that for other areas, such as preventable health care utilization and HIV/AIDS, large disparities remain.

According to the 2020 U.S. Census, the Maryland population was 6,177,224 in 2020. Of this, 48.7% were single race Whites who were not Hispanic or Latino (<https://www.census.gov/library/stories/state-by-state/maryland-population-change-between-census-decade.html>). This means that 51.3% of Maryland's population reported some ancestry from a racial or ethnic minority group (a group other than NH White) in 2020, making Maryland a "majority minority" state. **Population estimates as of July 1, 2024, put this minority percentage at 53.6%.** This characteristic of our population makes minority health and minority health disparities crucial to the overall health of Maryland. An example of this minority impact on the State's health is that 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 48% and 68% of hospital utilization for asthma, diabetes, and hypertension are attributable to the Black or African American population in Maryland. The population size of individual racial/ethnic groups in Maryland is a complex combination of those who are single race, multi-race, Hispanic or Latino, or not Hispanic or Latino members of a particular racial group. Table 1 below provides the population counts for these various categories from the 2020 census:

Table 1. Detailed Race/Ethnic Breakdown of Maryland Population as of 2020 Census

Number of Persons	White	Black	Am Ind / Alask Nat	Asian	Nat Hawaiian / Other Pac Isle	Some Other Race
	<i>Not Hispanic or Latino</i>					
Race alone	2,913,782	1,795,027	12,055	417,962	2,575	35,314
Race in combination	229,268	127,246	73,244	73,979	6,749	54,245
Alone or in combination	3,143,050	1,922,273	85,299	491,941	9,324	89,559
<i>Hispanic or Latino</i>						
Race alone	94,092	25,445	19,790	2,982	672	375,627
Race in combination	184,716	29,735	23,561	7,250	1,444	194,993
Alone or in combination	278,808	55,180	43,351	10,232	2,116	570,620
<i>Regardless of His or Lat</i>						
Race alone	3,007,874	1,820,472	31,845	420,944	3,247	410,941
Race in combination	413,984	156,981	96,805	81,229	8,193	249,238
Alone or in combination	3,421,858	1,977,453	128,650	502,173	11,440	660,179

Percent of MD Total Pop	White	Black	Am Ind / Alask Nat	Asian	Nat Hawaiian / Other Pac Isle	Some Other Race
	<i>Not Hispanic or Latino</i>					
Race alone	47.2%	29.1%	0.2%	6.8%	0.04%	0.57%
Race in combination	3.7%	2.1%	1.2%	1.2%	0.11%	0.88%
Alone or in combination	50.9%	31.1%	1.4%	8.0%	0.15%	1.45%
<i>Hispanic or Latino</i>						
Race alone	1.5%	0.4%	0.3%	0.0%	0.01%	6.08%
Race in combination	3.0%	0.5%	0.4%	0.1%	0.02%	3.16%
Alone or in combination	4.5%	0.9%	0.7%	0.2%	0.03%	9.24%
<i>Regardless of His or Lat</i>						
Race alone	48.7%	29.5%	0.5%	6.8%	0.05%	6.65%
Race in combination	6.7%	2.5%	1.6%	1.3%	0.13%	4.03%
Alone or in combination	55.4%	32.0%	2.1%	8.1%	0.19%	10.69%

MHHD continues to monitor racial and ethnic health disparities in Maryland and finds that while disparities continue, progress in reducing some disparities has been made. This progress is apparent in Non-Hispanic Black (B) vs. Non-Hispanic White (W) disparities in death rates from some of the most common causes of death. This is illustrated in Table 2 on p. 5 below, which shows 1999, 2009, 2019 and 2023 mortality rates and disparities for some of the leading causes of death (from Vital Statistics Administration annual reports) and rates of change over two 10-year intervals, from 1999 to 2009 and from 2009 to 2019, (pre COVID) and 2019 to 2023 (COVID era). Several other leading causes of death do not typically demonstrate Black vs. White disparities, including chronic lower respiratory disease, Alzheimer’s disease, and influenza/pneumonia.

Changes over the entire 24-year period (1999 – 2023) were:

(Gap is the NH Black minus NH White difference and is the best disparity metric for population health impact):

Heart Disease age-adjusted death rate per 100,000

NH Black trend	43.0% reduction
NH White trend	38.4% reduction
B-W gap	60.9% reduction

Cancer age-adjusted death rate per 100,000 population

NH Black trend	39.0% reduction
NH White trend	30.2% reduction
B-W gap	74.1% reduction

Stroke age-adjusted death rate per 100,000 population

NH Black trend	32.2% reduction
NH White trend	28.2% reduction
B-W gap	43.4% reduction

Diabetes age-adjusted death rate per 100,000 population

NH Black trend	38.6% reduction
NH White trend	18.0% reduction
B-W gap	52.3% reduction

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

NH Black trend	82.8% reduction
NH White trend	65.0% reduction
B-W gap	84.0% reduction

Infant Mortality (infant deaths per 1000 live births)

NH Black trend	38.8% reduction
NH White trend	27.5% reduction
B-W gap	44.8% reduction

Over the entire period, the NH Black to NH White death rate disparity expressed as the gap (rate subtraction) improved by 74% for cancer, by 61% for heart disease, by 52% for diabetes, and by 43% for stroke. The infant mortality disparity declined by 45%.

The rates of mortality improvement for both NH Blacks and NH Whites remained robust in the second 10-year period for heart disease, cancer, HIV, and infant mortality. Improvement slowed for diabetes, and for stroke improvement reversed to worsening (for both groups).

Table 2: Age-adjusted Deaths per 100,000 Population (except infant mortality)

	1999	99 to 09 % change	2009	09 to 19 % change	2019	19 to 23 % change	2023	99 to 23 % change
Heart Dis								
NH Black	310.5	-22.54%	240.5	-21.95%	187.7	-5.65%	177.1	-42.96%
NH White	247.6	-23.63%	189.1	-15.65%	159.5	-4.39%	152.5	-38.41%
Ratio	1.25	7.00%	1.27	-34.95%	1.18	-8.76%	1.16	-36.50%
Gap	62.9	-18.28%	51.4	-45.14%	28.2	-12.77%	24.6	-60.89%
Cancer								
NH Black	254.6	-23.53%	194.7	-17.46%	160.7	-3.30%	155.4	-38.96%
NH White	203.7	-11.39%	180.5	-17.95%	148.1	-3.98%	142.2	-30.19%
Ratio	1.25	-68.52%	1.08	8.14%	1.09	9.11%	1.09	-62.85%
Gap	50.9	-72.10%	14.2	-11.27%	12.6	4.76%	13.2	-74.07%
Stroke								
NH Black	78.7	-37.99%	48.8	6.97%	52.2	2.30%	53.4	-32.15%
NH White	58.2	-33.16%	38.9	2.31%	39.8	5.03%	41.8	-28.18%
Ratio	1.35	-27.75%	1.25	22.42%	1.31	-10.93%	1.28	-21.21%
Gap	20.5	-51.71%	9.9	25.25%	12.4	-6.45%	11.6	-43.41%
Diabetes								
NH Black	58.1	-40.62%	34.5	-7.25%	32.0	11.56%	35.7	-38.55%
NH White	23.3	-24.89%	17.5	-4.00%	16.8	13.69%	19.1	-18.03%
Ratio	2.49	-34.96%	1.97	-6.86%	1.90	-3.94%	1.87	-41.81%
Gap	34.8	-51.15%	17.0	-10.59%	15.2	9.21%	16.6	-52.30%
HIV/AIDS								
NH Black	33.8	-47.34%	17.8	-58.43%	7.4	-21.62%	5.8	-82.84%
NH White	2.0	-45.00%	1.1	-45.45%	0.6	16.67%	0.7	-65.00%
Ratio	16.90	-4.52%	16.18	-25.35%	12.33	-35.71%	8.29	-54.18%
Gap	31.8	-47.48%	16.7	-59.28%	6.8	-25.00%	5.1	-83.96%
Infant Mortality (infant deaths per 1000 live births)								
NH Black	14.7	-7.48%	13.6	-31.62%	9.3	-3.23%	9.0	-38.78%
NH White	5.1	-13.73%	4.4	-6.82%	4.1	-9.76%	3.7	-27.45%
Ratio	2.88	11.08%	3.09	-39.34%	2.27	12.94%	2.43	-23.90%
Gap	9.6	-4.17%	9.2	-43.48%	5.2	1.92%	5.3	-44.79%

Yellow highlight = an increase in the race-specific rate, or in the disparity metric, in the interval

Still comparing the two 10-year periods, disparity reduction (using the trend in the gap) accelerated for heart disease and infant mortality. It continued briskly for HIV, slowed for diabetes and cancer, and reversed to worsening for stroke.

The interval 2019 to 2023 is highly influenced by the health care and societal effects of COVID-19. Several rates and disparity metrics show worsening. It remains to be seen whether these patterns will resolve, or if they represent a new normal.

Slowing in the rate of improvement in prevalence of tobacco use, and the recent increases in obesity and diabetes prevalence, as well as the natural tendency for the results of any level of effort to eventually stabilize at an equilibrium point (diminishing marginal returns), may account for the slowing of progress in recent periods for some conditions.

In time periods where NH White improvement exceeds NH Black improvement, disparities increase even as NH Black health improves. Innovations tend to produce this effect, as they are often adopted sooner in more advantaged populations.

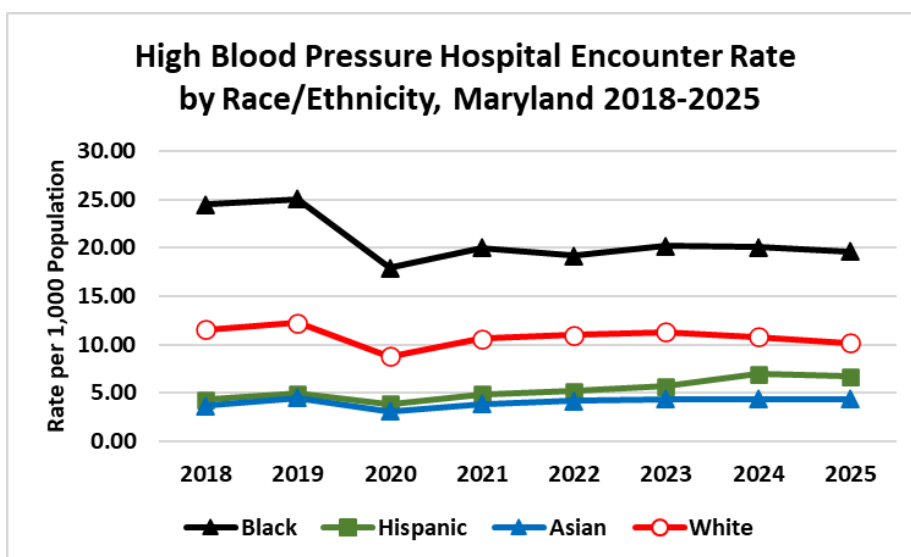
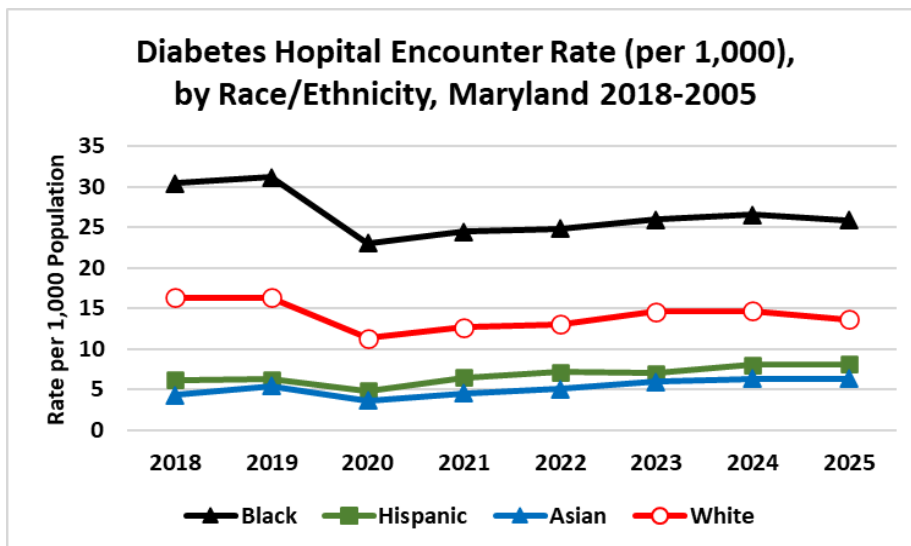
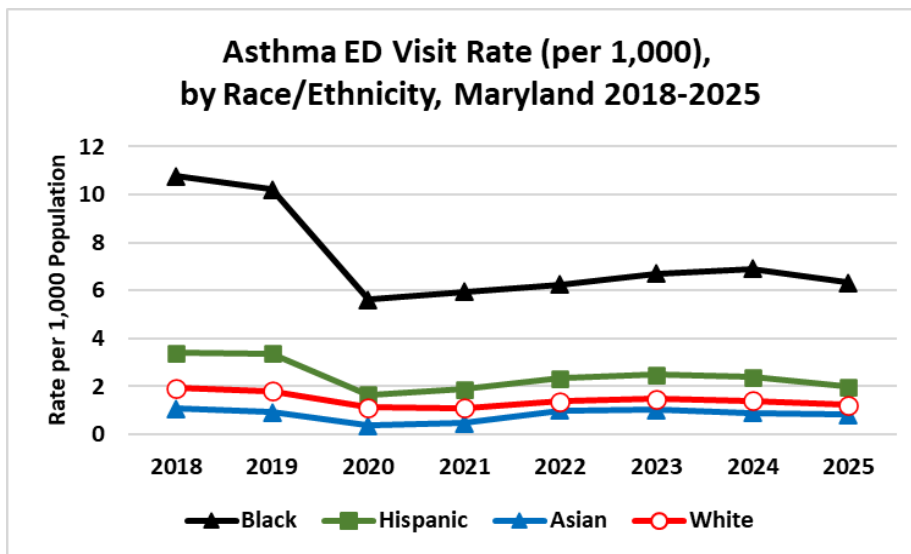
Slowing rates of health disparity reduction may also reflect a declining benefit from health care system interventions, as most of the benefits of that approach may have already been realized. Remaining disparities could be more related to disparities in the social determinants of health. Progress will require a focus on these social determinants and a health in all policies approach.

Large disparities persist in rates of preventable healthcare utilization, although some progress has been made in this area. This is shown in Figures 1 to 3 on p. 7 below, which displays the 2018 to 2025 trends in three utilization metrics from the Chesapeake Regional Information System for our Patients (CRISP) Health Equity Explorer, Disparity Index report. *(Due the small American Indian population in Maryland, data in this format is not statistically stable for that group and is not presented.)*

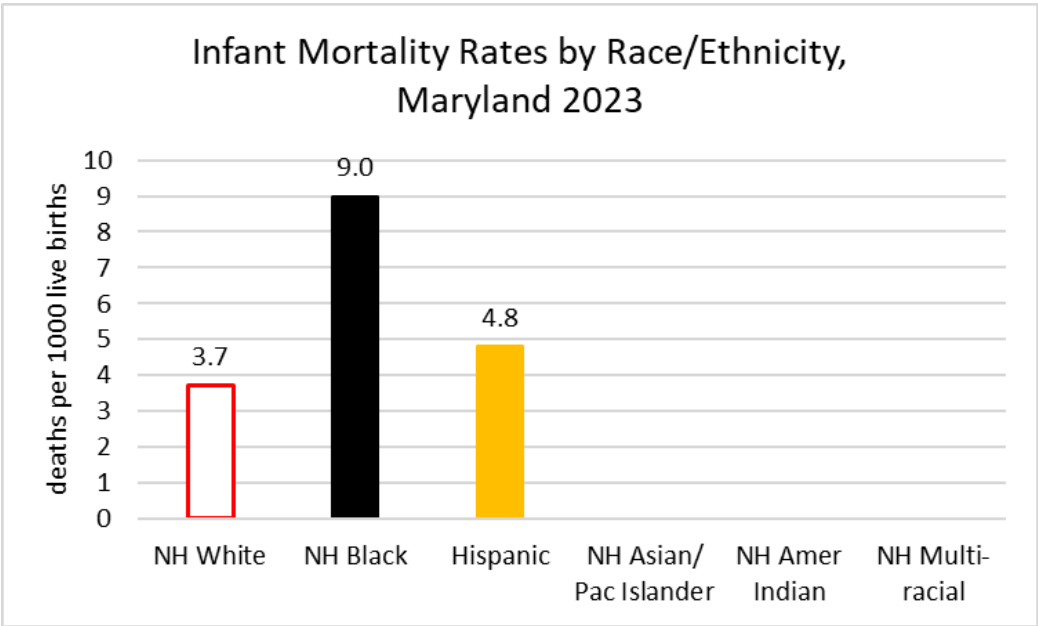
Within individual years, Black utilization rates for asthma, diabetes, and high blood pressure have been two to five times as high as White rates. **This means that 46% to 68% of this utilization is occurring in the Black population, and that 50% to 80% the Black utilization for these conditions would not occur if the Black rate was lowered to match the White rate.**

Hispanic rates were slightly higher than White rates for Asthma ED visits, but not for the Diabetes and High Blood Pressure hospital encounter rates. Asian rates were lower than White rates.

Figures 1-3. Selected Health Care Utilization rates per 1,000 in Maryland 2018-2025

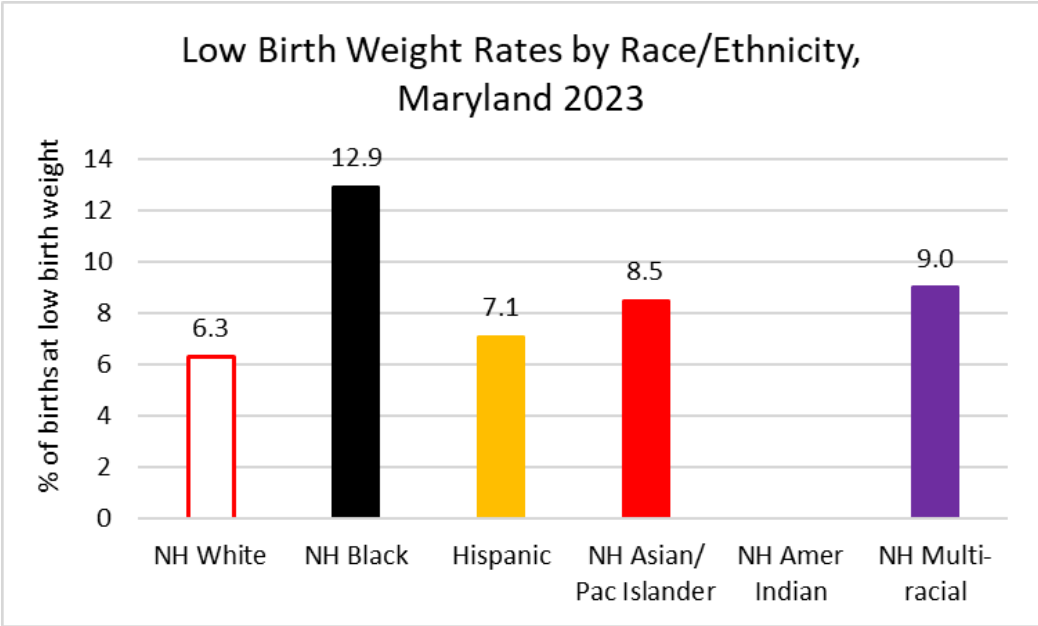


Additional examples of health disparities in Maryland are shown below (*first 3 charts from 2023 Maryland Vital Statistics Annual Report, last 3 charts from 2023 Maryland BRFSS*).



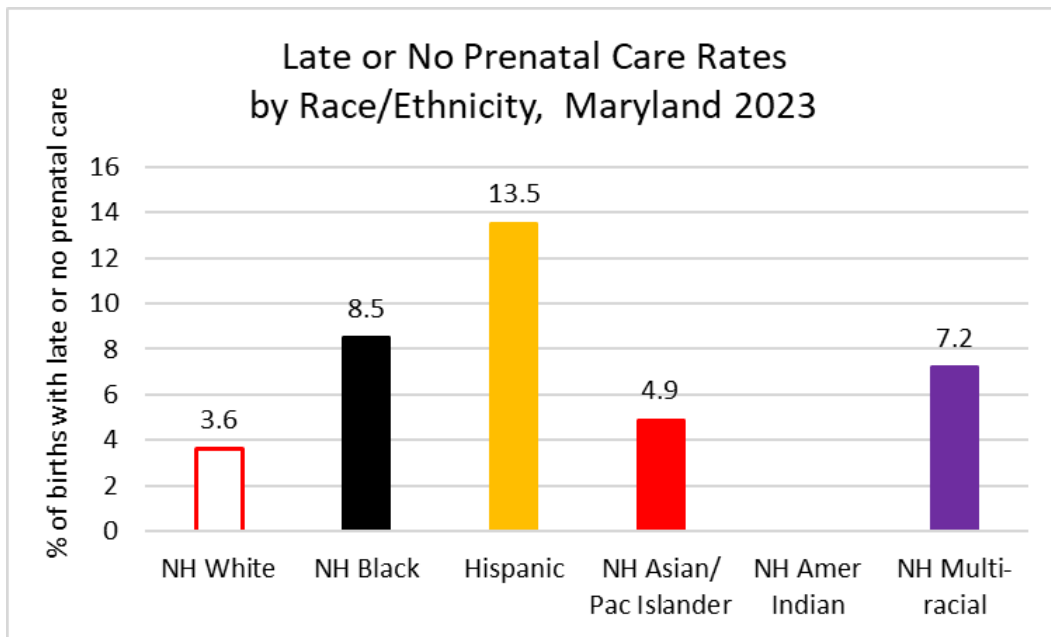
In 2023, compared to the Non-Hispanic White rate, the infant mortality rate was:

- 2.4 times as high for Non-Hispanic Blacks or African Americans.
- 1.3 times as high for Hispanics or Latinos.
- Unpublished for Non-Hispanic Asians or Pacific Islanders, Non-Hispanic American Indians or Alaska Natives, and Non-Hispanic Multi-racial persons.



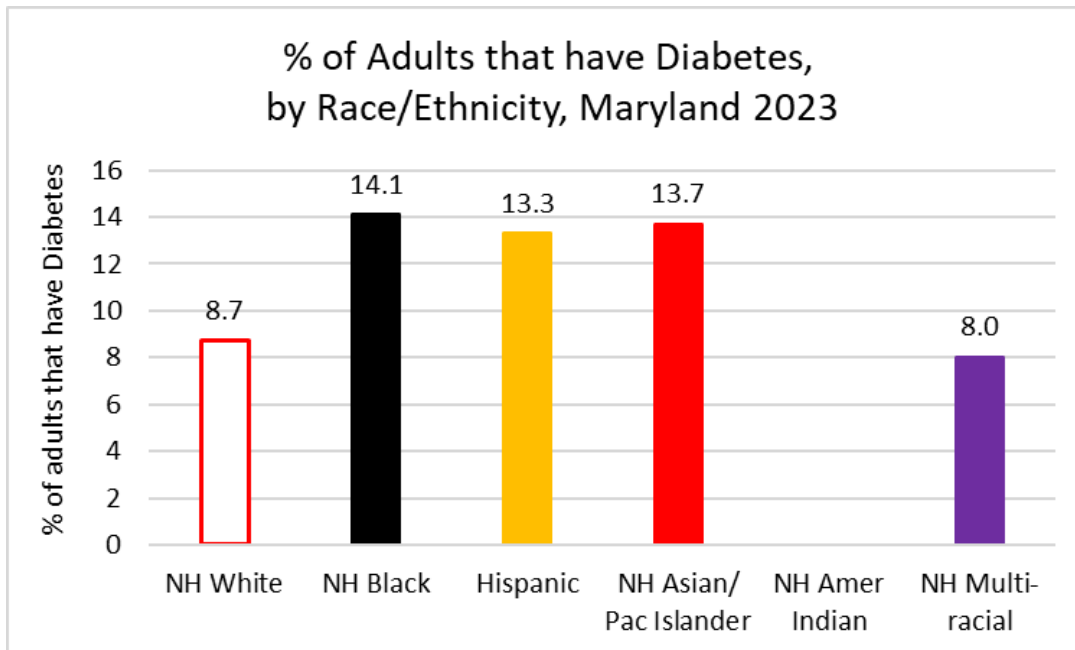
In 2023, compared to the Non-Hispanic White rate, the low-birth-weight rate was:

- 2.0 times as high for Non-Hispanic Blacks or African Americans.
- 1.1 times as high for Hispanics or Latinos.
- 1.3 times as high for Non-Hispanic Asians or Pacific Islanders.
- Unpublished for Non-Hispanic American Indians or Alaska Natives.
- 1.4 times as high for Non-Hispanic Multi-racial persons.



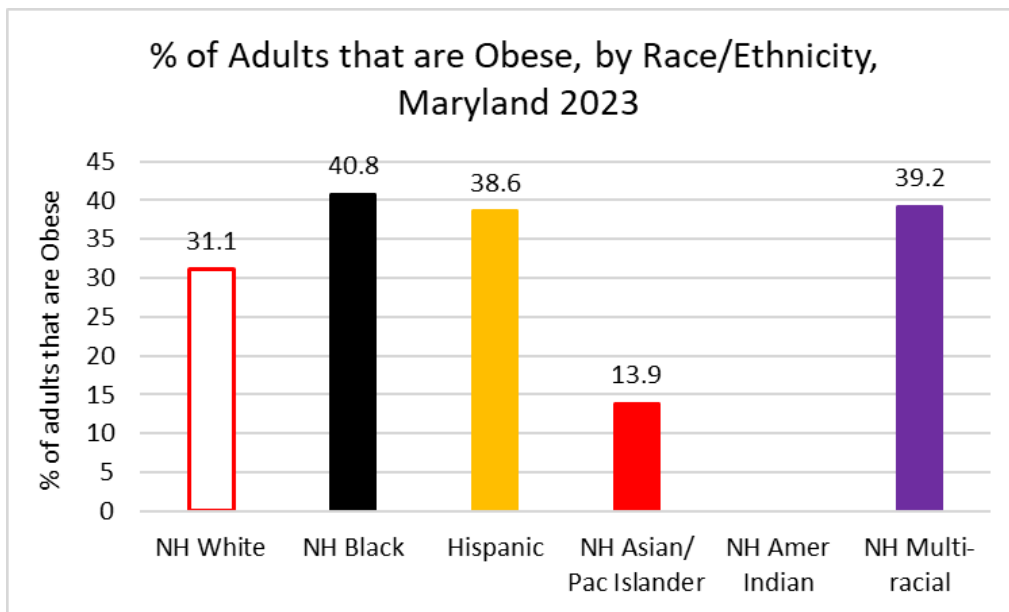
In 2023, compared to the Non-Hispanic White rate, the late or no prenatal care rate was:

- 2.4 times as high for Non-Hispanic Blacks or African Americans.
- 3.8 times as high for Hispanics or Latinos.
- 1.4 times as high for Non-Hispanic Asians or Pacific Islanders.
- Unpublished for Non-Hispanic American Indians or Alaska Natives.
- 2.0 times as high for Non-Hispanic Multi-racial persons.



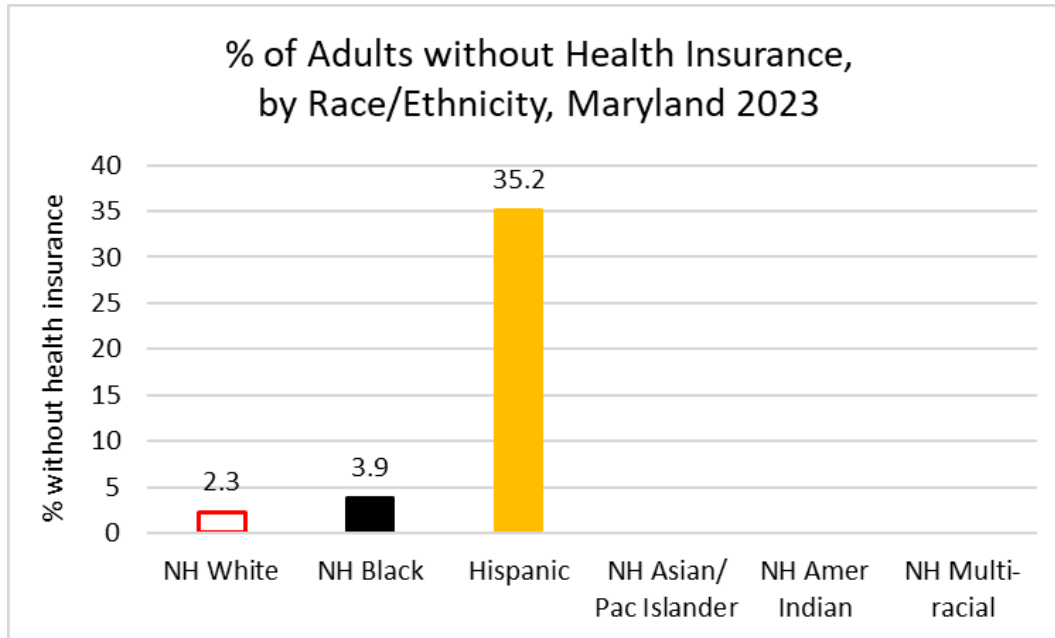
In 2023, compared to the Non-Hispanic White rate, diabetes prevalence rate was:

- 1.6 times as high for Non-Hispanic Blacks or African Americans.
- 1.5 times as high for Hispanics or Latinos.
- 1.6 times as high for Non-Hispanic Asians or Pacific Islanders.
- Unpublished for Non-Hispanic American Indians or Alaska Natives.
- Lower for Non-Hispanic Multi-racial persons.



In 2023, compared to the Non-Hispanic White rate, the obesity prevalence rate was:

- 1.3 times as high for Non-Hispanic Blacks or African Americans.
- 1.2 times as high for Hispanics or Latinos.
- Lower for Non-Hispanic Asians or Pacific Islanders.
- Unpublished for Non-Hispanic American Indians or Alaska Natives.
- 1.3 times as high for Non-Hispanic Multi-racial persons.



In 2023, compared to the Non-Hispanic White rate, the health uninsurance rate was:

- 1.7 times as high for Non-Hispanic Blacks or African Americans.
- 15.3 times as high for Hispanics or Latinos.
- Unpublished for Non-Hispanic Asians or Pacific Islanders.
- Unpublished for Non-Hispanic American Indians or Alaska Natives.
- Unpublished for Non-Hispanic Multi-racial persons.

II. MHHD Grant Programs

In FY 2025 MHHD administered over \$5.4M in grant funding to 43 community-based and faith-based organizations, academic institutions, and local health departments. The grant funds were distributed to the following three programs: Minority Outreach and Technical Assistance Program (MOTA), Enhancing Epidemiology and Laboratory Capacity for COVID-19 (ELC) Program, and Social Determinants of Health (SDOH) Program.

- Minority Outreach and Technical Assistance (MOTA) Program
 - \$1,082,276 to 18 grantees reaching 40,733 individuals
- Social Determinants of Health (SDOH) Program
 - \$2,498,835 to 15 grantees reaching 268,971 individuals.
- Epidemiology and Laboratory Capacity (ELC) Program (CDC COVID funds)
 - \$1,186,356 to 10 grantees reaching 26,547 individuals.

Details of performance for the FY 2025 grant programs are provided in the tables that follow.

MHHD continues to implement mandatory grantees' quarterly meetings to provide grant management support and technical assistance. The grantees meeting were held on the following dates: March 3, 2025, June 2, 2025, August 4, 2025, and November 18, 2025, and there were over 50 participants each date. On August 4, 2025, a fiscal grant management workshop was held to provide the grantees with technical assistance with the fiscal requirements of their grants.

MHHD program conducts site visits at least once per year to monitor the implementation of the grant programs and identify gaps in services. Upon completion of any site visit, a grantee receives a summary report of the visit.

A. Minority Outreach and Technical Assistance (MOTA) Program

Introduction

The purpose of the Minority Outreach and Technical Assistance (MOTA) program is to improve the health outcomes among marginalized and minoritized communities through community engagement, partnerships, outreach, technical assistance, targeted case management, and ongoing intervention for individuals with self-identified needs.

To qualify for funding, MOTA programs must focus on one of the following targeted health challenges and key areas:

- Asthma
- Cancer
- Cardiovascular disease
- Mental health
- Obesity
- Pre-diabetes
- Diabetes self-management
- Pregnancy and birth outcomes

In FY 2025, the Office of Minority Health and Health Disparities (MHHD), through a competitive Request for Applications (RFA) process, **distributed \$1,082,276 to 18 community-based organizations of the 23 organizations that applied. Those 18 organizations reached 40,733 Marylanders across the state.** On the next page is a table of the annual data reported by the 18 grantees during the FY 25 grant cycle. To see a complete list of MOTA grantees with descriptions of their programs, see Appendix I.

Program Data from FY 2025 MOTA Funded Grantees

Grantee	Jurisdiction	Funding Amount	Health Focus Area	Total # of Individuals Reached Out To (whether or not they participated)	Total # of Individuals with Some Level of Program Participation	Total number of Individuals enrolled in multi-step program component
Program Totals		\$1,082,276		40,733	28,392	3221
Aaron’s Place, Inc.	Caroline	\$61,427	Diabetes/ Obesity	5131	5131	420
CASA, Inc.	Montgomery	\$49,232	Cancer	2109	2046	71
Community Ministry of Prince George’s County	Prince George’s	\$75,000	Cancer	7185	3927	106
Eastern Shore Wellness Solutions, Inc.	Dorchester	\$72,000	Diabetes/ Diabetes Self-Management Program (DSMP)	2017	1076	160
EquiHealth Solutions, Inc.	Charles	\$75,000	Pregnancy and Birth Outcomes	568	462	229
Greater New Hope Church and Ministries	Caroline	\$30,000	Obesity	1477	1477	62
Healthlincs, Inc.	Montgomery	\$75,000	Prediabetes / Diabetes	1579	579	80
Holy Cross Health	Montgomery	\$50,000	Prediabetes / Diabetes	3249	2669	129
Hope Connections for Cancer Support	Prince George’s	\$50,000	Cancer	1875	1373	371
Jolly Dream Foundation, Inc.	Charles	\$30,000	Obesity	2366	1294	460

Grantee	Jurisdiction	Funding Amount	Health Focus Area	Total # of Individuals Reached Out To (whether or not they participated)	Total # of Individuals with Some Level of Program Participation	Total number of Individuals enrolled in multi-step program component
Lifestyles of Maryland, Inc.	Charles	\$74,674	Diabetes	1059	723	90
Maryland Association of Nonprofit Organizations, Inc.	Montgomery	\$75,000	Pregnancy/ Birth Outcomes	1066	98	47
Maryland Vietnamese Mutual Association	Montgomery	\$75,000	Cardiovascular disease/ General chronic disease	2084	818	425
Minority Outreach Coalition of St. Mary's County	St. Mary's	\$30,000	Prediabetes / Diabetes	5281	3575	55
My Life Foundation, Inc.	Anne Arundel	\$59,965	Diabetes	1905	1561	219
Taking Effective Action, Inc.	Prince George's	\$75,000	Obesity	554	374	N/A
United Way of Central Maryland	Baltimore City	\$49,978	Pregnancy/ Birth Outcomes	139	120	12
University of Maryland Eastern Shore	Somerset	\$75,000	Mental Health	1089	1089	285

B. Social Determinants of Health (SDOH) Program

Introduction

The Social Determinants of Health (SDOH) program aims to reduce health inequity among Maryland's racial and ethnic minorities by providing community-based interventions to address those social determinants of health (SDOH) by reducing health inequity. Examples of SDOH to be addressed are as follows:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Health language and literacy skills

The SDOH objectives are organized into five place-based domains:

1. Economic stability
2. Educational access
3. Health care access and quality
4. Neighborhood, built environment
5. Social and community context

SDOH content is also interwoven throughout other programs funded by MHHD. SDOH objectives highlight the significance of upstream factors, typically outside health care delivery, necessary to reduce health disparities and maintain healthy communities and populations. SDOH objectives are aligned with several state strategies and priorities to improve value-based healthcare delivery and health outcomes.

In FY 2025 the SDOH program distributed **\$2,498,835 to 15 grantees, reaching 268,971 Marylanders across the state**. A table of their annual reported data is presented on the next page. To see a list of all SDOH grantees with a description of their program, see Appendix II.

Program Data from FY 2025 SDOH Funded Grantees

Grantees	Jurisdiction	Funding Amount	Health Focus Area	Total # of Individuals Reached Out To (whether or not they participated)	Total # of Individuals with Some Level of Program Participation	Total number of individuals enrolled in multi-step program component
Program Totals		\$2,498,835		268,971	52,759	11,164
Community Engagement and Consultation Group	Prince George's	\$200,000	Community Needs and Education	18,391	8015	907
Cecil County Health Department	Cecil	\$122,676	Obesity	2317	2102	47
Chesapeake Multicultural Resource Center	Talbot	\$112,046	Community Needs and Education	3729	1749	870
Care For Your Health Inc	Montgomery	\$199,919	Obesity	1077	1071	200
Chinese Culture and Community Service Center	Montgomery	\$200,000	Obesity	3582	3341	2454
Community Ministry of PG County	Prince George's	\$199,964	Obesity	38,588	14,500	1398
Greater Baden Medical Services Inc	Prince George's	\$193,050	Community Needs and Education	1641	1641	0
Hospice of Frederick	Frederick	\$89,908	Community Needs and Education	2157	1479	123
Harford County Health Department	Harford	\$199,184	Community Needs and Education	1048	522	37
HeartSmiles	Baltimore City	\$200,000	Violence and Reduction	21,249	5227	660

Johns Hopkins University	Baltimore City	\$130,072	Community Needs and Education	13,404	4700	1815
Jolly Dream Foundation	Charles	\$52,250	Community Needs and Education	3573	977	807
KEYS Empowers, Inc.	Baltimore City	\$199,886	Violence and Reduction	151,079	1618	69
Metamorphosis Community Project	Prince George's	\$199,880	Obesity	5637	5275	1619
Movable Feast Inc	Baltimore City	\$200,000	Community Needs and Education	1499	542	158

C. Enhancing Epidemiology and Laboratory Capacity (ELC) for COVID-19 Through Community-Based Strategies Program (CDC Covid Funds)

As part of Maryland’s strategy for enhancing Epidemiology and Laboratory Capacity for COVID-19, MHHD grantees funded through this federal grant provided community-based services including outreach and education and additional COVID-related support. MHHD **distributed \$1,186,356 to ten grantees in FY25. The grantees operated in ten different jurisdictions, reaching 26,547 Marylanders.** To see a full list of ELC grantees with a description of their work, please see Appendix III.

On March 25, 2025, MDH received notification from the Centers for Disease Control and Prevention (CDC) about the termination of the Epidemiology and Laboratory Capacity (ELC) Grant, effective March 24, 2025, with 30 days to close out. The awards supported public health infrastructure, appropriated by Congress in the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020.

Annual program data are shown on the next page for the three quarters of work performed by the ELC grantees.

Program Data from FY 25 ELC- CHW/ CTCBS Funded Grantees

Enhancing Epidemiology and Laboratory Capacity for COVID-19 Through Community-Based Strategies						
Grantee	Jurisdiction	Disbursed Award Amount	Health Focus Area	Total # of Individuals Reached Out To (whether or not they participated)	Total # of Individuals with Some Level of Program Participation	Total number of individuals enrolled in multi-step program component
Program Totals		\$1,186,356		26,547	19,812	9407
Asian American Center of Frederick	Frederick County	\$159,533	COVID-19	3551	1101	581
Calvert County Health Department	Calvert County	\$86,368	COVID-19	2573	2573	126
CASA, Inc., Baltimore City	Baltimore City	\$145,983	COVID-19	2064	1644	893
CASA, Inc., Prince George's County	Prince George's	\$142,597	COVID-19	3059	3058	2372
Diamonds On The Rise, Inc.	Baltimore City and Baltimore County	\$142,335	COVID-19	2349	1455	519
Eastern Shore Wellness Solution	Dorchester	\$124,184	COVID-19	3231	2573	122
EquiHealth Solutions, Inc.	Prince George's and Charles	\$119,326	COVID-19	1427	1260	174
LASOS	Harford	\$74,834	COVID-19	4646	4525	4349
Lifestyles of Maryland Foundation, Inc.	Charles and Calvert	\$139,406	COVID-19	1168	1056	166
Prince George's County Government Health Department	Prince George's	\$51,790	COVID-19	2479	567	105

D. Examples of MHHD Grants in Action

MOTA Program

Eastern Shore Wellness Solutions (ESWS) has significantly improved diabetes and related health outcomes in Dorchester County. This was achieved through their successful community-centered lifestyle adjustment programming and diabetes self-management program.

Dorchester County experiences a disproportionate rate of diabetes compared to the state at large, with even greater health disparities reported among Black residents. ESWS is well-established within the Dorchester community and works diligently to improve overall health and wellness through the promotion of increased physical activity, improved access to screening opportunities, and consumption of healthy and nutritious foods.

During the 2025 fiscal year, ESWS made considerable progress in its targeted health challenge of diabetes and diabetes self-management.

Program Outcomes and Achievements:

- Successfully conducted 22 diabetes self-management education and health promotion sessions, engaging 4 distinct cohorts of Dorchester residents with diabetes and their chosen supporters.
- Demonstrated positive health impacts, with 160 enrolled individuals experiencing a decrease in Body Mass Index (BMI), and 31 of these maintaining weight loss for 180 days post-program completion.
- Achieved significant weight loss for 37 participants, who lost at least 3% of their total body weight by the 90-day program follow-up.
- Facilitated connections for 66 individuals to essential healthcare professionals and/or relevant social support services, enhancing their access to continued care.
- Attended or sponsored 17 community outreach events.

ESWS consistently demonstrates a positive impact on its community members and maintains a profound commitment to understanding and fostering wellness among the individuals it serves. As a MOTA partner, they continue to innovate and collaborate with other organizations to address diabetes in Dorchester County and promote wellness across the state.

SDOH Program

Chesapeake Multicultural Resource Center (ChesMRC)- “Empowering People from Different Cultures to Become Successful and Engaged Members of the Community”- is heading excellent work in our Maryland communities. ChesMRC targets the Limited English Proficiency (LEP) population of Talbot and surrounding counties, ChesMRC works to connect individuals to service providers, assist with immigration cases, enroll families in Medicaid and health insurance plans as Certified Application Counselors, and more. Partnering with key organizations, they effectively support legal residency and citizenship, youth development, language and cultural competency, and community collaboration. ChesMRC provides over 35,000 unique services and continues to be impactful in vulnerable communities.

In FY25, Community Engagement and Consultant Group (CeCg) was recognized for its outstanding work by leveraging the SDOH Workforce Training and Retention Program, an initiative designed to upskill and reskill low-income youth and individuals with limited English proficiency (LEP). The program focuses on eliminating barriers to employment and retention within Prince George's County by providing wraparound support and culturally tailored services.

Grounded in the SDOH domains of Economic Stability, Education Access and Quality, and Social and Community Context, CeCg has been able to make a measurable impact. Under the leadership of Dr. Mwalui and her team, the organization successfully achieved all its FY25 goals.

- Enrolled and supported 917 residents during the grant cycle in industry-aligned workforce training programs by utilizing customized learning pathways tailored to each client's needs, with 92% completing engagement and certification within 12 months.
- Secure employment and on-job paid internships for 80% of program graduates within 60 days post-training, with 90% retention and a 6-month follow-up self-reported.
- Provided coordinated supportive services (e.g., childcare, mental health, housing navigation) to 100% of participants, with at least 80% reporting improved stability in one or more life domains (e.g., housing, health, income) through surveys and testimonies.
- Partner with at least 20 employers to assist with hiring through program career café events, networking events, the Maryland Workforce Exchange platform, the Employ Prince George's initiative, and retention practices, including ongoing professional development with LinkedIn Learning, cultural competency training, and career advancement pathways.
- Establish a Community Workforce Advisory Council, with quarterly feedback loops to co-design training improvements and ensure the community voice informs program evolution.
- Completed 1111 wrap-around services and SDOH assessments with referrals to 48 community services.
- Completed 502 enrollments in the Supplemental Food Assistance Program and provided access to affordable healthcare as a focused area to combat food insecurity and maintain health and well-being while remaining employed.

CeCg continues to evolve and innovate, ensuring its services remain responsive to community needs. Their ability to directly engage with those they serve is a testament to their commitment and effectiveness.

III. MHHD Consultations and Collaborations

A. Maryland Commission on Health Equity and AHEAD Model

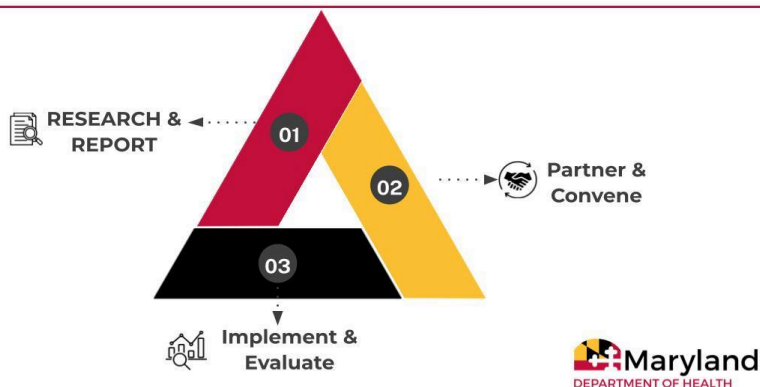
The Maryland Commission on Health Equity (MCHE) was established by the Shirley Nathan-Pulliam Health Equity Act of 2021. In 2024, the charge of MCHE was amended with the introduction of House Bill 1333 (HB1333). The legislation altered the purpose, duties, and membership composition of the MCHE and expanded its responsibilities to fulfill the governance requirements of the Centers for Medicare and Medicaid Innovation’s Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model.

HB1333 requires the MCHE, using a health equity framework, to develop and monitor a “statewide health equity plan” as required by the Center for Medicare and Medicaid Innovation. In support of this requirement, MHHD advised on MCHE’s development of the State Health Equity Framework (SHEF) that built upon the efforts of the inaugural Commission’s Health Equity Policy Subcommittee.

Following the February 2025 MCHE meeting, MCHE members voted to finalize the SHEF (Figure below). The SHEF is a public health framework through which policymakers and stakeholders in the public and private sectors use a collaborative approach to improve health outcomes and reduce health inequities in the State by incorporating health considerations into decision making across sectors and policy areas. To see the full SHEF, refer to the 2025 MCHE report.

Figure - State Health Equity Framework

State Health Equity Framework



MHHD looks forward to continuing its advisory role with the MCHE and supporting the application of the SHEF to fulfill MCHE’s statutory requirements and advance equity throughout the State.

B. Root Causes of Health Initiative

The Root Causes of Health Initiative (RoCHI) is an equity-focused quality improvement project being implemented by the Prevention and Health Promotion Administration (PHPA) within MDH, with intensive data consultation from the data staff of MHHD. The MDH implementation of the RoCHI process focuses on assessing the “equity of reach” and “equity of impact” of PHPA programs that have an individual-level participation component.

Equity of reach assesses whether the actual race/ethnic distribution of the program participants matches the expected race/ethnic distribution of the program participants. This is a comparison of the racial composition of the program to the racial composition of the population in need.

- Actual distributions are obtained from the program performance data
- Expected distributions are obtained from one of three possible distributions, depending on which is the most appropriate for the program:
 - Race/ethnic distribution of the eligible population
 - Race/ethnic distribution of the population that has the disease being addressed.
 - Race/ethnic distribution of the population experiencing complications or preventable health care utilization due to the disease.

Equity of impact assesses whether the “success rate” (achievement of some program health goal, target, or milestone by individual participants) is the same or roughly similar among the different race/ethnic groups participating in the program.

The four PHPA programs that participated in the FY 2025 cohort included programs covering removal from work or school while infectious with a foodborne illness, HIV treatment access, maternal infant and early childhood home visiting, and diabetes prevention. MHHD efforts assist PHPA with more equitably reaching thousands of Marylanders. See Appendix IV for more information on each program.

C. Health Professional Implicit Bias Training

Program Overview and Purpose

The MHHD Cultural and Linguistic Health Care Professional Competency Program ensures compliance with Maryland General Assembly HB 28 (2021), a statute that requires all licensed healthcare providers to complete implicit bias training to renew their licenses by attesting to completing an evidence-based course on implicit bias. To remain compliant, healthcare providers have three options:

1. Select a course on ACCME's website.
2. Complete one of the twenty courses listed on MHHD's webpage.
3. Complete a course recognized by one of the twenty health occupations boards.

Board Guidance and Compliance

MHHD has worked proactively with leaders from State Health Occupations Boards to ensure that they recognize implicit bias courses that meet the requirements of HB 28. MHHD emphasizes that, given the diversity of healthcare professions, it is the responsibility of each board to determine which courses are most relevant to their specific profession and the populations they serve. This ensures that training is tailored to the unique needs of healthcare providers and their patients.

Course Selection

MHHD conducts research to identify courses that comply with HB 28. The goal is to select courses that are not only evidence-based but also practical, rigorous, and accessible to all providers without undue financial or time barriers. MHHD ensures that the courses selected address implicit bias, but they do not review or approve courses related to broader topics like diversity, cultural competence, oppression, or racism, as these are not included in the scope of implicit bias training.

D. Underrepresented Behavioral Health Professionals Workgroup

Maryland General Assembly House Bill 97 (2022) established the Workgroup on Black, Latino, Asian American Pacific Islander, and Other Underrepresented Behavioral Health Professionals (UBHP). The Workgroup, co-chaired by MHHD leadership, includes representatives from Black Colleges and Universities; hospital networks that primarily serve Black, Latino, or Asian American Pacific Islander communities; behavioral health professionals; individuals who provide social services in the State; and representatives of organizations, networks, or associations of behavioral health professionals that are composed of or primarily work to represent and support Black, Latino, or Asian American Pacific Islander communities, or other underrepresented behavioral health professionals.

The legislation tasked the workgroup with the following responsibilities:

1. Identify and examine the shortage of behavioral health professionals in the State who are from Black, Latino, Asian American, Pacific Islander, or other underrepresented backgrounds in the behavioral health profession.
2. Evaluate and provide recommendations on incentives or other methods to increase:
 - Students from Black, Latino, Asian American, Pacific Islander, or other underrepresented backgrounds in the behavioral health profession who study at an institution of higher education in the state to become behavioral health professionals; and
 - Behavioral health professionals from Black, Latino, Asian American, Pacific Islander, or other underrepresented backgrounds in the behavioral health profession who provide behavioral health services in the State, particularly in underserved communities.

In 2025, the Workgroup submitted its final recommendations to the General Assembly. The following are key recommendations (selected from each subgroup) that reflect the most immediate suggested next steps to be explored in the next one to two years:

1. Equitably distributing resources to institutions of higher education that serve Black, Latino, Asian American and Pacific Islander students to provide more opportunities to educate, provide research opportunities for, and fund underrepresented students interested in behavioral health professions.
2. Identify and incentivize mentors who can offer support to new professionals to ensure they understand career pathways and lead to retention in the field.
3. Develop a leadership program focused on professionals of color.
4. Establish pathways for international professionals to validate credentials they have from abroad for use in the United States.
5. Target exposure to and recruitment into behavioral health professions from elementary school through college.
6. Identify and distribute funding to offer loan forgiveness, fund relocation, increase salaries, and decrease or waive licensing and supervision fees.
7. Explore and, if needed, commission research to further substantiate the shortage and needs.

To read the entire report, please visit:

[dlslibrary.state.md.us/publications/Exec/MDH/HB615Ch392\(2023\)_2025.pdf](https://dlslibrary.state.md.us/publications/Exec/MDH/HB615Ch392(2023)_2025.pdf)

E. Other MHHD Consultations and Collaborations

Collaborations with the MDH Prevention and Health Promotion Administration

Rare Diseases Advisory Council

MHHD data staff serve as the MHHD representative on this council

Health Equity Initiatives

MHHD data staff serve on the following PHPA health equity groups:

- Cancer and Chronic Disease Bureau
 - CCDB Health Equity Steering Committee
 - CCDB Data to Action Committee

Diabetes Program

MHHD data staff serve on the following diabetes-related groups:

- Diabetes Action Committee

Maternal and Child Health Bureau

MHHD data staff serve on the following groups within the Maternal and Child Health Bureau:

- Maryland Maternal Health Improvement Task Force
- Maternal Mortality Review Stakeholder Group
- Morbidity and Mortality Quality Review Committee

Collaborations Outside of MDH

Maryland State Advisory Council on Health and Wellness

MHHD MOTA program administrator, Lindsay Lotter, serves as a member of the Maryland State Advisory Council on Health and Wellness and a member of the diabetes subcommittee and legislative workgroup. The role of the council is to advise MDH on promoting a healthy lifestyle for all Marylanders and to offer targeted support in the topic areas of arthritis, diabetes, heart disease and stroke, and physical fitness through bimonthly committee meetings.

The 34-member council is composed of state employees, various organizational representatives, and members of the public. MHHD representation on the council is without term limits as one of 6 designated seats detailed by the founding legislation as a voting member.

Following appointment with the council, the MHHD Program Administrator has attended 8 council meetings and 8 committee meetings and is contributing to the development of an updated diabetes workplan and social media strategy for the prevention and mitigation of diabetes and associated adverse health effects. As a member of the legislative work group, she has attended 6 meetings and contributed to the creation of 3 letters of support on behalf of the workgroup and council at large.

IV. MHHD Community Outreach and Communications

Minority Health Resource Fair - National Minority Health Month

MHHD hosted a Minority Health Resource Fair to celebrate National Minority Health Month and promote the health and well-being of our diverse communities. The event was held on Tuesday, April 8, 2025, from 9:00 a.m. to 2:00 p.m. at the Herbert R. O'Connor State Office Building, located at 201 W. Preston Street. There were over 39 exhibitors on hand to provide important health and wellness information, referrals, and health screenings. Among the exhibitors were community-based organizations (CBOs), local health departments, universities, and government agencies that provided free vaccinations and tests for COVID, Flu, Blood Pressure, Respiratory Syncytial Virus (RSV), Shingles, A1-C, HIV, and Hepatitis C. This was a free event and open to the public. See Appendix VI for a full list of exhibitors.

Grant Writing Workshops

In 2025, MHHD hosted a virtual two-part Grant Writing Workshop with its first session on March 25th from 10:00 a.m. - 1:00 p.m. and the second session on June 11th from 10:00 a.m. - 1:00 p.m. This two-part series focused on how to develop a strong proposal structure, understand how grant funders evaluate your proposal, and strategies to identify funding opportunities. The grant writing workshops provided technical assistance to community-based organizations, universities, and local government agencies. The grant writing workshops were an incredible success and were well attended with over 400 participants. The workshop was free and open to the public. MHHD continues to implement best practices and strengthen relationships with community-based organizations and local health departments to improve health equity for Marylanders.

Social Media and Newsletter

In 2025, MHHD increased its reach through social media and a department-wide quarterly newsletter. Collectively reaching tens of thousands of Marylanders, the below-described communications efforts expand the reach of MHHD within MDH and across the state.

Social Media

- MHHD utilizes Facebook to distribute information on upcoming events, heritage months, affinity days, and more. The MHHD Facebook account currently has 793 followers and is growing. To recognize the multiple heritage days and months celebrated by the state, including Juneteenth, National Hispanic Heritage Month, Health Literacy Month, Native American Heritage Month, and more.
- MHHD utilizes our social media to raise awareness of current events affecting health equity, including sharing releases from other MDH units.

Quarterly Newsletter

- The MHHD Quarterly Newsletter was released once per season, with a target audience of all MDH employees, and featured upcoming events or news related to health equity.
- In 2026, the Office plans to extend its reach for the quarterly newsletter to include our email distribution list of approximately 5,000 subscribers external to MDH.

V. MHHD Student Training Programs

In 2025, MHHD participated in hosting three interns through the Public Health Workforce Development Internship Program, one each in the Spring, Summer, and Fall sessions. This paid program accepts applications from Undergraduate, Graduate students, and recent graduates for 10-week internships throughout the year. Supervised by our Program Administrators and Special Assistant; the interns worked on a variety of projects such as grant administration, grantee communications, and social media planning.

MHHD serves as an elective practicum rotation site for physicians in their third year of specialty training in the General Preventive Medicine and Public Health residency program of the Department of Epidemiology and Public Health in the University of Maryland School of Medicine (at University of Maryland, Baltimore). Rotations are two to three months in duration. Two residents chose to rotate at MHHD in CY 2025. Residents learn the MHHD principles of health equity data analysis and assist with data analysis projects. They also learn about the MHHD grant program management approach (including RFA development, application review, and award decisions, and post-award grantee performance management) and learn about the public health legislative process and how MHHD reviews certain equity-related legislation.

MHHD is excited to continue supporting early-career public health professionals in 2026 through fellowships, resident training, and the Public Health Workforce Development Internship program.

VI. MHHD Annual Conference - Postponed to February 2026

The MHHD Annual Conference was originally scheduled for December 2, 2025, but was postponed due to inclement weather. The conference will take place in early February at Coppin State University and so cannot be reported in detail for this report.

This installment of the conference is configured as a recognition celebration, networking session, and brainstorming/problem solving event for the FY 2025 and 2026 MHHD grantees.

VII. Appendix

Appendix I. MOTA Grantee List

Minority Outreach and Technical Assistance (MOTA) Grantee List With Description:

Aaron's Place:

To improve the health outcomes and reduce the social determinants of health of the racial and ethnic minority communities in Caroline County, Maryland for obesity and diabetes through increased physical activity and improved access to healthy foods.

CASA, Inc.:

To increase awareness of breast cancer risks, preventative measures, and how to access free screenings among Latina immigrant residents in Prince George's County and to facilitate access to screening mammograms for immigrant women in Montgomery County.

Community Ministry of Prince George's County:

To develop and implement a multi-faceted prostate cancer education and health promotion, screening, and supportive care program that improves prostate cancer awareness knowledge, and education which affects mortality and can help address prostate cancer disparities rates in Prince George's County.

Eastern Shore Wellness Solutions, Inc.:

To provide training that will assist the state in reducing the number of preventable Emergency Department (ED) visits among minority diabetic patients in Dorchester County, who participate in Diabetes Self-Management (DSM) education and follow-up by 3% along with increasing the number of DSM training resources available to minority communities through education, outreach, and community events.

EquiHealth Solutions, Inc.:

A comprehensive maternal care program targeting pregnant people of color in Charles County, Maryland, to address alarming disparities in maternal mortality rates. With a focus on education, trust-building between patients and healthcare providers, and increased access to lactation services, the program aims to reduce disparities and improve maternal and infant health outcomes.

Greater New Hope Church and Ministries:

To increase physical activity, improve nutrition education and healthy food choices to reduce obesity outcomes for minorities in the Caroline County Community.

Healthlincs:

Reduce ED visit and hospitalization utilization (and associated costs) of CareLinc Plus participants by at least 15% within the program year and educate participants on prevention & management of diabetes/prediabetes and achieve at least 30% knowledge gain for CareLinc participants within the program year.

Holy Cross Health:

Trained Community Health Workers offer the Road to Health (RTH) diabetes prevention program targeting African American and Latino community members at increased risk of type 2 diabetes, and support participants in establishing weight goals and increasing physical activity to reduce their risk.

Hope Connections for Cancer Support, Inc.:

To combat race-based disparities in cancer outcomes in Prince George's County. We target the four cancers with the most significant disparities for the largest segment of the African American population: breast, colorectal, prostate, and lung cancer.

Jolly Dream Foundation:

To conduct obesity/weight loss exercise classes, line dancing classes, food training classes, track clients' weight and Body Mass Index (BMI), and help them understand how to get the weight off, keep it off, and have fun while doing it at the BRSC Community Outreach Center (BRSC).

Lifestyles of Maryland Foundation, Inc.:

To address the obesity and diabetes illnesses that primarily impact unhoused individuals and those living in substandard housing in Charles County, particularly for minorities. The agency provides additional programming around nutrition education, healthier food access, and providing access to medical care to address those health indicators.

MD Association of Nonprofit Organizations, Inc.:

Advancing maternal health outcomes and resilience for Latinas in Maryland (Project AMOR) is a community-based program designed to improve access to education on the importance of timely prenatal care for pregnant Hispanic/Latina immigrants in Montgomery and Prince George's Counties, Maryland.

MD Vietnamese Mutual Association:

The Healthy Nail Salon Program in Montgomery and Prince George's Counties, Maryland, educates nail salons on the dangers of toxic chemicals and promotes healthier alternatives, fair wages, and labor practices to improve nail technicians' cardiovascular health.

Minority Outreach Coalition of St Mary's County:

To focus on the proposed diabetes and obesity program with workshop class size of 15 for 12 months to create awareness, life-style change, address pre-diabetes among at-risk populations in the county. Ensure all individuals with diabetes get knowledge of care, treatment, and information about how to manage their diabetes or obesity.

My Life Foundation, Inc:

The program serves the Asian American and Pacific Islander (AAPI) population aged 30 and above in specific zip codes in Anne Arundel County to reduce the prevalence of diabetes, prediabetes, and related diseases. It recognizes the often-overlooked unique metabolic risks and diverse needs of Asian American subgroups. By addressing these specific risks, the

program aims to enhance diabetes screening, prevention, and treatment efforts tailored to this population.

Taking Effective Action, Inc.:

The Health Tools for Community Engagement (HTCE) program will train six community health leaders (CHLs) to connect 300 African American Prince George's County residents (18+) with local nutrition and physical activity services and health information. This aims to address chronic conditions like cardiovascular disease and diabetes by combating a lack of knowledge and access to nutritious food and physical activity.

United Way of Central Maryland:

Baby Basics is an evidence-based health literacy program in South Baltimore City that helps pregnant mothers read, understand, and act upon pregnancy information and make informed decisions regarding their nutritional needs during pregnancy, medical care, and overall health.

University of Maryland Eastern Shore:

Aims to address the growing demand for mental health support services in Somerset County through implementing a combination of culturally relevant educational workshops focused on mental health and substance abuse, followed by longitudinal peer support, mentoring groups, and case management follow-up.

Appendix II. SDOH Grantee List

Social Determinants of Health (SDOH) Grantee List With Description:

Care For Youth Health Inc:

This program emphasizes the correct control of cardiovascular risk factors, namely, obesity and its subsequent effects on type 2 diabetes, hypertension, and hypercholesterolemia. Patients receive a weekly supply of fresh fruits and vegetables, and will also be monitored for Weight, Body Mass Index, and Blood Pressure. Fasting blood tests are conducted to check for type 2 diabetes markers.

Cecil County Health Department:

To employ a multi-faceted approach that includes the alignment of programmatic services to address the identified social determinants of health needs, assistance in connecting consumers with the government and community resources, and direct remediation services for obesity through the DPP in Spanish.

Chesapeake Multicultural Resource Center:

Directly addressing social determinants of health in these communities by providing direct language services in Spanish and Haitian Creole, immigration legal services, SNAP benefits, and health insurance navigation.

Chinese Culture and Community Service Center:

Using a comprehensive, culturally tailored service model to improve access to healthcare

and promote healthier lifestyles.

Community Engagement and Consultation Group:

This program utilizes a coordinated supportive service model with comprehensive approaches that include education, vocational training, mentorship, and support services that address mental health and other personal challenges. The aim is to reconnect the youths with education and workforce opportunities that foster environments that support their development and recognize their potential toward career pathways of success and economic stability.

Community Ministry of PG County:

To provide community support that addresses social determinants of health (food assistance, housing assistance, youth mentorship) that are barriers to healthy living, as well as a personalized, SDOH-oriented, weight loss program for the target populations in Prince George's County.

Greater Baden Medical Services Inc:

Utilizing the patient recruitment for SDOH assessments and referrals will be completed based on the patient's insurance status and willingness to engage in the referral process. Based on the need identified by the assessment tool, we will implement a course of treatment.

Harford County Health Department (HCHD):

The HCHD Minority Health Program has three main focuses: hosting educational events, providing care coordination, and connecting with other community organizations in Harford to connect with residents. This type of intervention will build trusting relationships with the residents through outreach, education, and care coordination to provide individuals with services, refer them to programs, or assist them in getting the care they need.

HeartSmiles:

HeartSmiles programs provide space and opportunity for Baltimore's youth to use their voice and real-life experience to solve issues, gain skills, grow their leadership and confidence, and be able to network with supportive adults and goal-oriented peers.

Hospice of Frederick:

Provides grief support through a Spanish-speaking counselor to Hispanic Communities in Frederick County. Additionally, it provides training to school professionals in best practices of culturally sensitive grief support.

Johns Hopkins University (Hopkins Community Connections):

Through routine social needs screening, HCC will work to identify patients and families experiencing food, financial, and transportation insecurity and provide direct resources as part of our overall approach to supporting families by addressing all their identified social needs as a routine part of their child's medical care.

Jolly Dream Foundation:

Continuation and enhancement of the current food distribution, which helps families and children during summer and winter break, as well as the homeless in and around the Western quadrant.

Keys Empowers:

Implementing a holistic violence intervention and prevention program that spans both Baltimore City and Baltimore County, tailored to the unique challenges faced by opportunity-aged youth, KEYS can address the root causes of violence, empower young individuals to make positive choices, and create safer and more resilient communities for all residents in the region.

Metamorphosis Community Project Inc:

Metamorphosis will work with community-serving organizations and community members to reduce health disparities and improve the health, social, and economic outcomes of our target population and communities.

Movable Feast Inc:

This project will serve people who identify as Black, Indigenous, or People of Color, who have at least one nutrition-sensitive chronic illness, and are likely to be experiencing food insecurity.

Appendix III. ELC Grantee List

Enhancing Epidemiology and Laboratory Capacity for COVID-19 Grantee List With Descriptions:

Asian American Center of Frederick:

The program aimed to reduce COVID-19 disparities among socially vulnerable populations in Frederick County, Maryland. The program focused on culturally and linguistically tailored outreach and education, increasing access to COVID-19 vaccination, linking underserved individuals to medical, mental health, and social services, expanding and training a diverse Community Health Worker (CHW) workforce, and building community infrastructure to prepare for future public health emergencies.

CASA, Inc., Baltimore City:

The focus of this project was to reduce health disparities among underserved and minority communities in Baltimore and Central Maryland. Our goal was to increase access to culturally competent and preventive health services for immigrant, Black, Latino/a/e, and low-income residents. CASA worked with their Health and Human Services department to implement services that addressed both immediate and long-term health barriers.

CASA, Inc., Prince George's:

CASA 's Health Team focused on outreach and education to community members about COVID-19 protocols, and vaccination recommendations. Navigate community members to vaccines and testing services and assist those at high risk due to lack of healthcare access.

Resources were provided to community members to eliminate the vaccine barriers that the uninsured face. CASA conducts need assessments with community members to identify health equity gaps and navigate community members to social services to address gaps identified in the needs assessment. CASA's mission is to deliver inclusive, trusted and multicultural healthcare where care is needed, fostering autonomy, and quality of life for all members of our community.

Calvert County Health Department:

Maryland's strategy for enhancing Epidemiology and Laboratory Capacity for COVID-19 in providing education to prevent and control disease by supporting under-resourced and systemically disadvantaged communities with poor social determinants of health. Focusing on promoting health living classes to prevent chronic disease by connecting people with health screenings, CPR and first aid, behavioral health resources, food assistance, housing, financial literacy and providing education for prenatal, and newborn health. The goal was to decrease COVID-19 cases, hospitalizations, and mortality rates among minority populations.

Diamonds On The Rise:

The program focused on improving health, wellness, and emotional development of at-risk and high-risk individuals and families across Baltimore City. The project's primary focus areas include public health education, social-emotional learning, youth mentoring, and resources distribution. The goals are to promote healthy and safe living habits in vulnerable communities, increase access to emotional regulation and mental health education for youth and families, and strengthen community partnerships to enhance outreach and impact.

Eastern Shore Wellness Solution (ESWS):

ESWS' team of Community Health & Outreach Workers (CHWs) performed outreach and education to residents on the looming risk of COVID and its virus variations, RSV, and Influenza along with ensuring that community members have the capacity to actively engage in the testing and vaccination processes while understanding the risks for themselves and their families. ESWS's team conducted ongoing education trainings in-person, one-on-one, and in small group sessions and recruited individuals at community level events and door-to-door outreach exercises for education sessions, testing and vaccination. In addition to providing education and outreach, CHW's worked with community partners to identify social needs and resources for individuals including but not limited to primary care, transportation, housing, behavioral health, access to food, childcare and other support to reduce hesitancy barriers while supporting this marginalized population and connecting them to the needed and desired resources.

EquiHealth Solutions, Inc.:

Addressed critical gaps in vaccination awareness and access among pregnant women and other high-risk populations resided in Prince George's and Charles Counties. Recognizing the disproportionate impact of respiratory illnesses—such as COVID-19, flu, and RSV—on these populations, the project focused on building health literacy, fostering vaccine uptake, and increasing community engagement through a combination of in-person outreach,

educational campaigns, and local partnerships.

LASOS:

The program provided community members with information in multiple languages regarding healthy lifestyles, mental health strategies and support, and Health care.

Lifestyles of Maryland Foundation, Inc.:

The project provided community outreach and education programs to provide greater access to COVID-19 testing, vaccinations, and post COVID support services for unable housed minorities.

Prince George's County Government Health Department:

The program delivered evidence-based, current information on COVID; addressed Social Determinants of Health (SDOH) that prevent vaccination uptake; and ensured that high-risk residents received the current year booster and practice evidence-based COVID prevention behaviors. The project recruited Black, Hispanic and low-income Prince Georgians residing in low-income zip codes: 20712 Brentwood; 20710 Bladensburg; 20783, 20787 Langley Park; and 20737, 20781 East Riverdale. The project assessed residents for SDOH and referred them to SDOH mitigation services and resources; educated residents on COVID symptoms, testing, quarantine and isolation protocols, and vaccination recommendations, and assisted residents to receive the current year COVID vaccine booster.

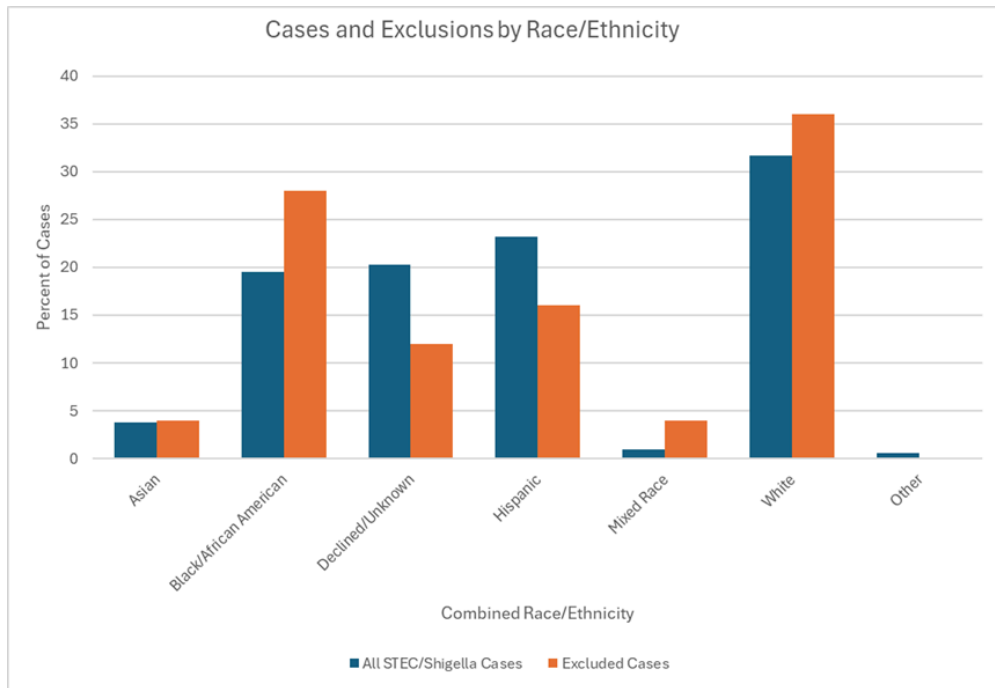
Appendix IV. RoCHI Cohort Data

FoodNet: Foodborne illnesses requiring removal (exclusion) from work or daycare

FoodNet conducts active, population-based surveillance statewide for conditions commonly transmitted through food (including Shigella and STEC). COMAR requires cases in high-risk occupations or situations (foodservice, patientcare, daycare) to be excluded until cleared by the HD via stool testing. Exclusions can create financial strain on cases and their households.

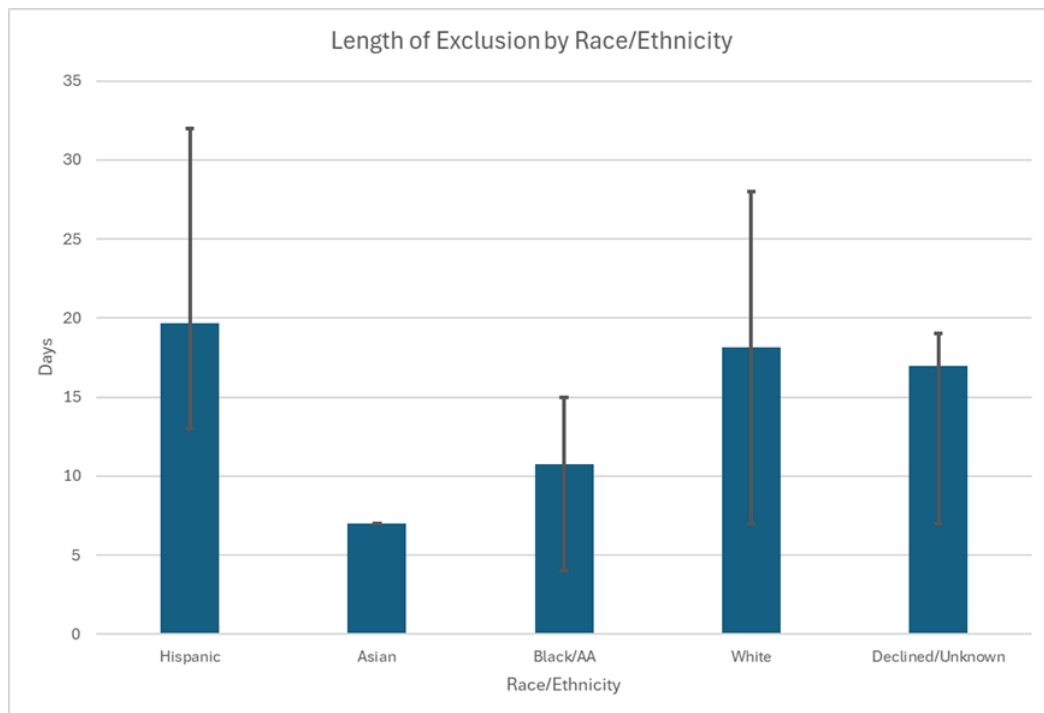
The program sought to examine whether the racial/ethnic distribution of STEC and Shigella cases was similar to the racial/ethnic distribution of people excluded from work or daycare. The program was able to do preliminary analysis of one year of data, which produced the following:

Equity of Exclusion Chart for FoodNet



The program also examined whether there were differences in the length of exclusion by race/ethnicity. Those results are shown below.

Equity of Impact Chart for FoodNet



The first figure above shows that for the Black/African American, White, and mixed-race populations, excluded cases were a slightly higher percentage than their percentage of total cases. This could represent some variability in the measures due to small numbers in single year data, and thus analysis of additional years will be needed to draw any conclusions. It is also possible that different levels of employment in the kinds of jobs that warrant exclusion across different racial/ethnic groups might explain some of the results.

In the second figure above, due to small numbers in single year data, the confidence intervals (or margin of error, shown in the thin lines) are large, and there are no statistically significant differences in any minority length of exclusion compared to the White length of exclusion.

Maryland AIDS Drug Assistance Program (MADAP)

The Maryland AIDS Drug Assistance Program is a Part B Ryan White Program that is Federally funded, State administered, providing medication access for people living with HIV (PLWH).

Eligibility for MADAP requires having an HIV diagnosis, being a Maryland resident, having income less than or equal to 500% of the Federal Poverty Level, and not being eligible for or actively enrolled in Medicaid.

The program examined whether the racial/ethnic distribution of MADAP recipients matched the racial/ethnic distribution of people living with HIV. They also examined whether the benefits of participation (viral suppression rates in this case) were similar across race/ethnic groups.

The MADAP charts presented below are color coded as follows:

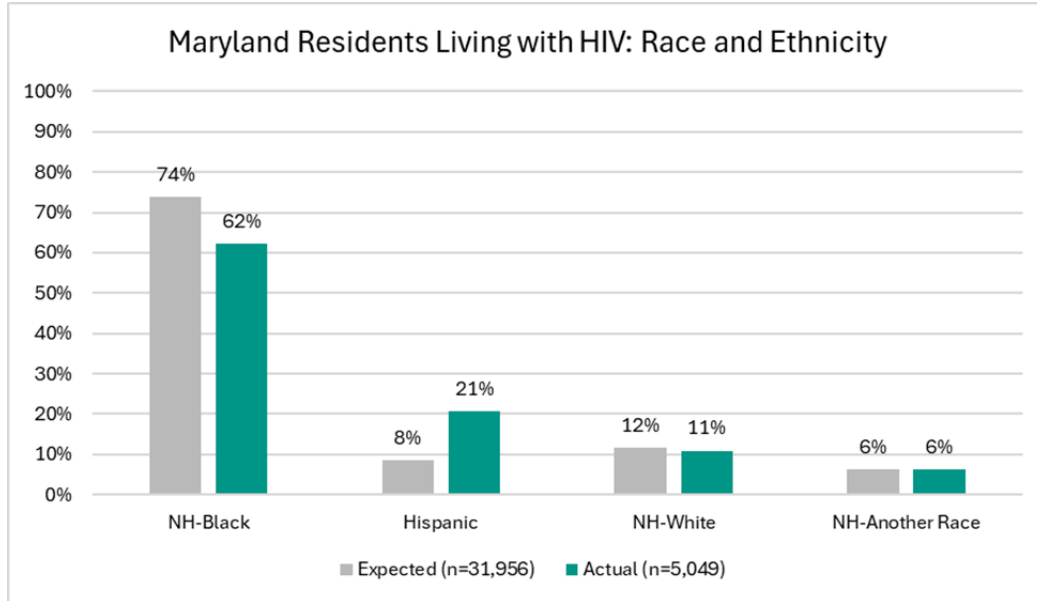
Maryland HIV Surveillance- (Expected) Surveillance Data for People Living with Diagnosed HIV in Maryland, Alive as of December 31, 2023, reported through June 30, 2024.

MADAP Current Clients - (Actual) Engaged in care and receiving MADAP services for the last 13 months (August 1, 2023 - August 31, 2024).

Out of Service MADAP Clients - Out of care and not in receipt of MADAP services for the last 13 months (August 1, 2023 - August 31, 2024).

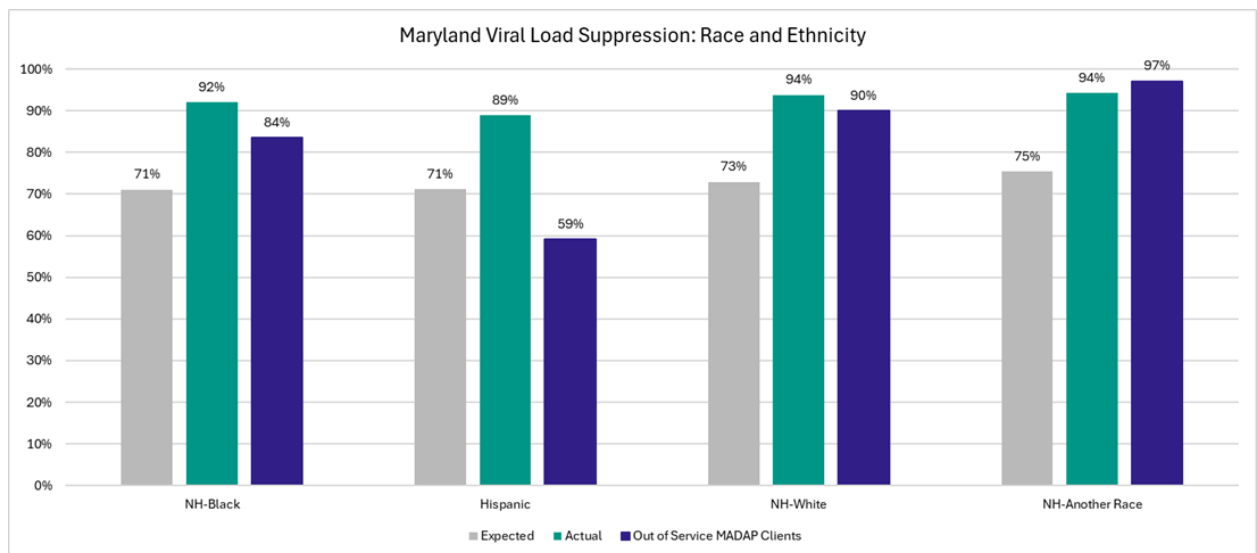
In the first chart on the next page (equity of reach), the proportion of MADAP recipients matched the proportion of HIV cases (the expected proportion) for Non-Hispanic Whites and Non-Hispanic Other Race. The proportion was higher than expected for Hispanics, and lower than expected for the Non-Hispanic Black population. This is likely related to the Black population have access to Medicaid and other insurance for this drug coverage, which is not an option for some members of our Hispanic population.

Equity of Reach Chart for MADAP



In the equity of impact chart below, viral load suppression rates are similar across race/ethnic groups for MADAP participants (teal bars). These rates are higher than the HIV population overall rate (grey bars) and the population that has discontinued MADAP (blue bars). The loss of viral suppression is particularly large for the Hispanic population when MADAP services are lost.

Equity of Impact Chart for MADAP



Maternal Infant and Early Childhood Home Visiting Program (MIECHV)

The Maternal Infant and Early Childhood Home Visiting Program (MIECHV) provides funding to grantees to administer evidence-based home visits to pregnant people and young families. MIECHV priority populations include households with low-income, low education, histories of child abuse and substance use. Home visitors build strong relationships to help families achieve their goals, promote positive parenting, and link them to community resources.

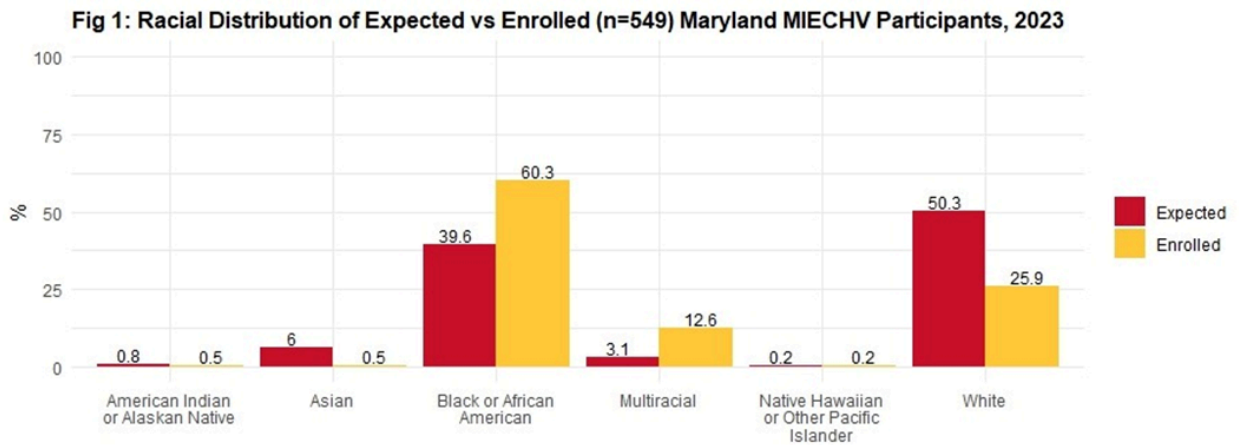
The program compared the race/ethnic distributions of program participants (yellow bars below) to an expected racial ethnic distribution based on preterm births in Maryland (red bars below).

Actual data: 2023 calendar year program data, Maxwell

Inclusion criteria: actively enrolled in 2023, adult caregiver, complete race/ethnicity data

Expected data: Preterm births (<37 weeks gestation) in Maryland in 2023, CDC Wonder

Equity of Reach by Race for MIECHV

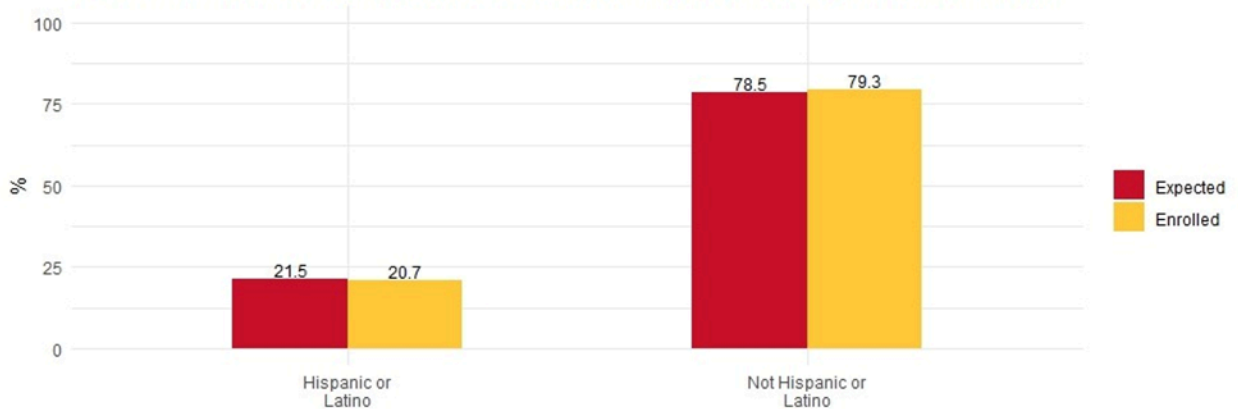


Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2016-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program

(Continued on next page)

Equity of Reach by Hispanic Ethnicity for MIECHV

Fig 2: Ethnic Distribution of Expected vs Enrolled (n=549) Maryland MIECHV Participants, 2023



Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2016-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program

Results for Equity of Reach: American Indian and Alaska Native (AIAN), Asian, and White caregivers are a lower-than-expected percentage of MIECHV participants. Black or African American and multiracial caregivers are a higher-than-expected percentage of participants. Hispanic participation matched expectations.

Results for Equity of Impact (data not shown): Early disengagement from services was a challenge across all racial and ethnic groups, with no clear differences between groups.

Diabetes Prevention Program

The National Diabetes Prevention Program (National DPP) is an affordable, year-long, lifestyle change program for people with prediabetes or at risk of type 2 diabetes. The program is offered by private and public organizations. The goal of the program is to reduce the risk of type 2 diabetes and improve overall health. Topics in the program include healthier eating, ways to incorporate daily physical activity, and improving coping skills.

To participate in the program, a participant must meet these four requirements:

- Be 18 years or older,
- Have a body mass index (BMI) of 25 or higher (23 or higher if the participant is an Asian American person),
- Not be previously diagnosed with type 1 or type 2 diabetes, and
- Not be pregnant.

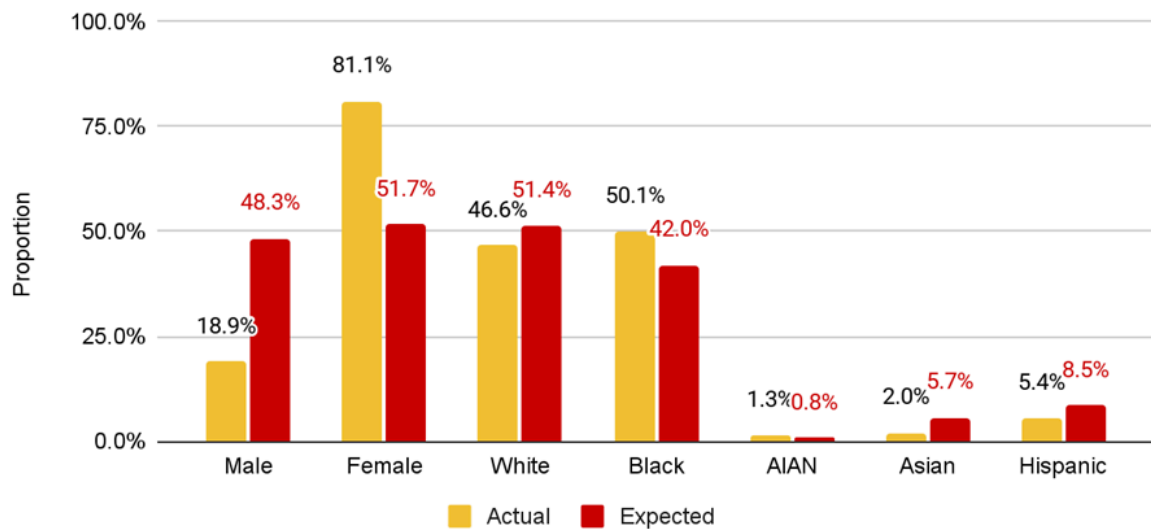
Participants also must meet one (1) of these criteria as well:

- Had a blood test result in the prediabetes range within the past year,
- Be previously diagnosed with gestational diabetes (diabetes during pregnancy), or
- Received a high-risk result (score of 5 or higher) on the Prediabetes Risk Test.

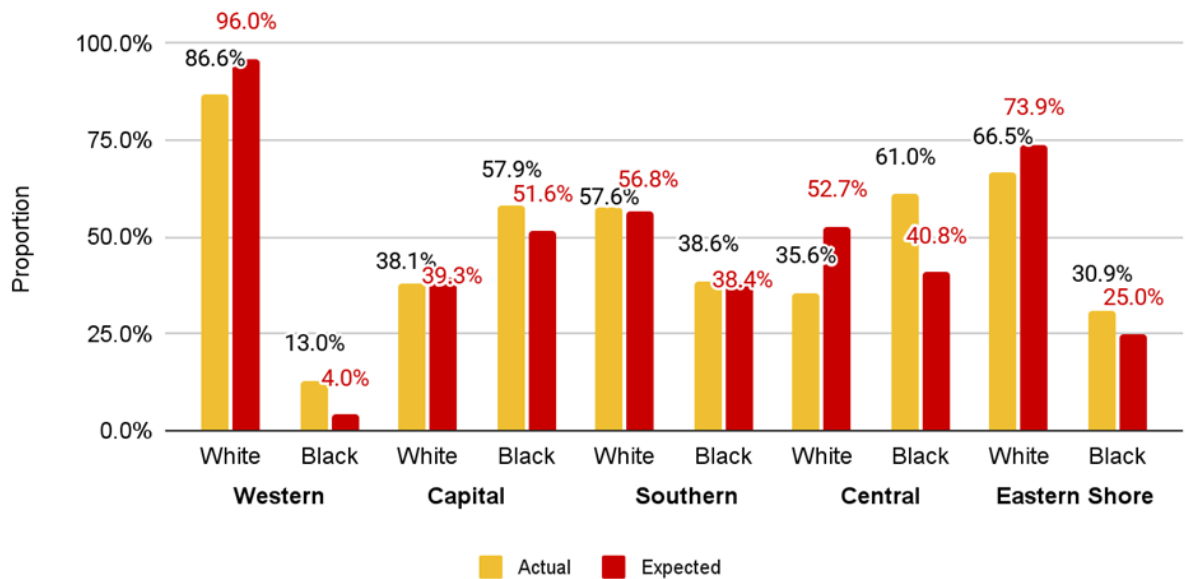
The program sought to compare actual program enrollment data in Maryland (obtained from CDC records) to the prevalence of combined prediabetes and BMI above 25 in Maryland Behavioral Risk Factor Surveillance System data. The program assessed this comparison by sex and by race/ethnicity statewide, and for Black and White races in a regional analysis.

The findings revealed some disparities between expected and actual enrollment. Males were notably underrepresented in the Maryland DPP, comprising only 18.9% of enrollees compared to their BRFSS prevalence of 48.3%. Conversely, females were overrepresented, accounting for 81.1% of enrollees despite representing only 51.7% of the eligible population according to BRFSS. Among racial and ethnic groups, Black/African American participants were overrepresented (50.1% enrolled vs. 42.0% diagnosis), potentially due to high enrollment in urban areas such as Baltimore City and Prince George’s and Montgomery Counties, as can be seen in Figure 2. Hispanic participants were underrepresented (5.4% enrolled vs. 8.5% diagnosis), as were Asians (2.0% enrolled vs. 5.7% diagnosis). Whites were slightly under-enrolled (46.6% enrolled vs. 51.4% diagnosis), and American Indian/Alaska Native enrollment closely matched their diagnosis (1.3% vs. 0.8%).

Racial/Ethnic and Sex Distribution of Expected vs Actual DPP Enrollment Statewide, 2018-2023



Racial Distribution of Expected vs Actual DPP Enrollment by Region, 2018-2023



In the regional analysis, the Black population was somewhat over-represented in most regions. Given that the Black population has the highest disparity in diabetes prevalence, some overrepresentation is necessary to close the gap.

These results highlight both successes and challenges in addressing enrollment equity. The overrepresentation of Black participants is an encouraging finding, suggesting effective outreach in specific regions. However, under-enrollment among other groups, particularly males, Hispanics, and Asians, underscores the need for tailored strategies to engage these populations.

Appendix V. Health Resource Fair Exhibitors

Minority Health Resource Fair Tablers:

1. Asian American Center of Frederick (AACF)
2. Baltimore County Health Department
3. Baltimore City Health Department
4. Baltimore City Health Department (U Choose)
5. Baltimore City Health Department (Office of Public Health Preparedness and Response)
6. CareFirst
7. Care For Your Health, Inc.
8. CASA, Inc. Baltimore City

9. Chase Brexton LGBTQ+ Center
10. Community Diabetes Initiative (CDI)
11. Community Engagement & Consultation Group
12. Greater Baltimore Medical Center
13. Gender Specific Services (GSS), Pregnant and Parenting Women (PPW) Program
14. Harford County Health Department
15. HealthCare Access Maryland (HCAM)
16. Health Equity Resource Communities (HERC)
17. Johns Hopkins Alzheimer & Disease Research Center
18. Johns Hopkins University School of Medicine
19. Latin American Youth Center
20. Leukemia and Lymphoma Society
21. Maryland Department of Aging
22. Maryland Department of Veterans and Military Families
23. Maryland Health Care Commission
24. Maryland Healthy Smiles Dental Program (MDH)
25. Maryland Insurance Administration
26. Maryland Latinos Unidos
27. Maryland Physicians Care
28. MedStar
29. MedStar Family Choice
30. Moveable Feast Inc.
31. My Life Foundation
32. MDH Behavioral Health Administration
33. MDH Cancer and Chronic Diseases
34. MDH, Office of Minority Health and Health Disparities (MHHD)
35. Office of Assessment and Evaluation (OAE), Integrated Maternal Health Services (IMHS) Program
36. Office of Children and Youth with Specific Health Care Needs (OCYSHCN)
37. University of Maryland Medical Center (UMMC)
38. University of Maryland Medical Center (UMMC) - Community Center (CC) Smoking Cessation
39. University of Maryland Medical Center (UMMC) - Community Health Education Center (CHEC)