



Maryland's Ninth Annual Statewide Minority Health Disparities Conference

**Advancing Healthy Public Policy:
The Maryland Health Improvement and Disparities Reduction Initiative**

October 17, 2012
8:00 a.m. to 4:00 p.m.

Conference Proceedings

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PREFACE

The Maryland General Assembly passed legislation establishing the Maryland Office of Minority Health and Health Disparities (MHHD) during the 2004 Legislative Session. MHHD is in statute at the Annotated Code of Maryland in Health General; Title 20 Miscellaneous Health Provision Subtitle 10. MHHD's first conference was held on June 8, 2004 at the University of Maryland Baltimore County in Catonsville, Maryland. The first conference was entitled "Closing The Health Care Divide: Eliminating Disparities for Racial and Ethnic Minorities." The conference was the first statewide event held by MHHD to address the reduction of minority health disparities, in the promotion of quality health equity in Maryland. The conference was attended by 300 academic leaders, federal/state/local governments, minority community leaders, medical societies, public and private practitioners, elected officials, local health department staff, pharmaceutical representatives, residents, students and other stakeholders advocating Health Equity. Then Secretary of Maryland Department of Health and Mental Hygiene, Nelson J. Sabatini wrote, "There is more than enough evidence that health disparities exist. All one has to do is look at the differences between African Americans and Caucasians in infant and maternal mortality rates. The gap between African Americans and Caucasians is even more staggering when looking at HIV data. It is time to stop talking and move forward to eliminate health disparities gap in Maryland."

Over the last nine years, the conferences have been attended by 3,624 health advocates, 493 attended the Ninth Annual Health Disparities Conference held in 2012. The Ninth Annual Conference entitled, "Advancing Health Public Policy: The Maryland Health Improvement and Disparities Reduction Initiative" focused on the State's milestone legislation, the Maryland Health Improvement and Disparities Reduction Act of 2012. This Act, championed by Lt. Governor Anthony Brown drew broad support among elected officials during the 2012 Legislative Session. The legislation is the first for Maryland that seeks to reduce health disparities among Maryland's racial and ethnic groups and geographic areas, improve health care access and health outcomes in underserved communities, and reduce health care costs. Other key aspects of the Act of 2012 include strategies for reducing and eliminating health disparities through the collection and analysis of racial and ethnic data; inclusion of minority communities in health planning and outreach to those communities with health education and health services; cultural and linguistic health competency among service providers; diversity in the health care and public health workforce; access to primary care practitioners; and attention to the social determinants of health. MHHD will play a lead role in implementing the Act, advancing the Office's mission to advocate for policies and programs that reduces the health disparities gap and improves the health of minorities and all Marylanders.

Maryland Office of Minority Health and Health Disparities'
Ninth Annual Health Disparities Conference



Advancing Healthy Public Policy:
**The Maryland Health Improvement
and Disparities Reduction Initiative**



Wednesday, October 17, 2012
Martin's West, Baltimore

Conference Co-Sponsor



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PUBLIC HEALTH
COLLEGE PARK

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Ms. Christine Wiggins	Ms. Monica McCann	Ms. Kimberly Hiner	Ms. Vanessa Jordan
Ms. Alison E. Walker	Ms. Julia Chen		

GUEST PRESENTERS AND SPEAKERS

Dr. Joshua M. Sharfstein	Ms. Wendy Friar	Dr. Norma Poll-Hunter
Dr. Howard K. Koh	Dr. M. Christopher Gibbons	Ms. Carolyn A. Quattrocki
Dr. Carlessia A. Hussein	Ms. Marie Grant	Dr. E. Albert Reece
Delegate Shirley Nathan-Pulliam	Ms. Ellen Langhans	Ms. Alma Roberts
Dr. Jane E. Clark	Ms. Lori Livingston	Mr. Saleem Sayani
Ms. Donna Jacobs, Esq.	Mr. Mark Luckner	Ms. Betsy Simon
	Mr. Rashid Malik	Dr. Brian D. Smedley
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Ms. Paula Blackwell	Dr. Bettye Muwakkil	Dr. Kim Dobson Sydnor
Mr. Eric Brenner	Ms. Debra Perry	Mr. James (Jim) Thomas
Ms. Elizabeth Chung	Mr. Marcos Pesquera	Dr. Stephen Thomas
Mr. E. Keith Colston	Ms. Frances B. Phillips	Ms. Carmi Washington-Flood
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PRESENTERS AND KEYNOTE SPEAKER
SECOND ANNUAL SHIRLEY NATHAN-PULLIAM HEALTH EQUITY
LECTURE



E. Keith Colston, Tuscarora-Lumbee, Administrator,
Maryland Commission on Indian Affairs



Carlessia A. Hussein, RN, DrPH, Director,
Office of Minority Health and Health Disparities,
Maryland Department of Health and Mental Hygiene



Donna Jacobs, Esq, Senior Vice President,
Government and Regulatory Affairs, University of Maryland Medical System:
Conference Moderator



The Honorable Shirley Nathan-Pulliam, House of Delegates,
District 10, Maryland General Assembly



Jane E. Clark, PhD, Professor and Dean, University of
Maryland School of Public Health



Joshua M. Sharfstein, MD, Secretary,
Maryland Department of Health and Mental Hygiene



Howard K. Koh, MD, MPH, Assistant Secretary for Health, U.S.
Department of Health and Human Services,
Second Annual Shirley Nathan-Pulliam Health Equity Lecturer, Keynote



Stephen B. Thomas, PhD, Professor,
Health Services Administration and Director, Maryland Center for Health Equity,
School of Public Health, University of Maryland

Maryland's Ninth Annual Statewide Minority Health Disparities Conference

**Advancing Healthy Public Policy:
The Maryland Health Improvement and Disparities Reduction Initiative**

OPENING REMARKS, GREETINGS & WELCOME

E. Keith Colston, Tuscarora-Lumbee, Administrator, Maryland Commission on Indian Affairs

Mr. Colston delivered an invocation in which he called on the participants, who represented many races and ethnicities, to take advantage of the opportunity to make a difference in their communities.

Carlessia A. Hussein, RN, DrPH, Director, Office of Minority Health and Health Disparities, Maryland Department of Health and Mental Hygiene

Dr. Hussein said the theme of the conference is improving the health of Maryland's minorities and making Maryland a healthier state. The state has two assets in particular propelling it forward in terms of increasing care and managing costs: new legislation and strong leadership. The 2012 Maryland Health Improvement and Disparities Reduction Act (MHIDR) mandates policies and guidelines to measure and address disparities and, importantly, provides funding. Governor Martin O'Malley has speedily enacted state health care reforms in response to the Federal Affordable Care Act (ACA). Lieutenant Governor Anthony Brown's most recent efforts include the creation of Health Enterprise Zones (HEZs) intended to reach those in the poorest and most underserved areas. Maryland Department of Health and Mental Hygiene (DHMH) Secretary Joshua Sharfstein, MD, has worked to improve health statistics in every jurisdiction. Dr. Hussein expressed hope that participants would keep these assets in mind as they considered innovative actions the state can take to make Maryland the healthiest state in the nation.

Donna Jacobs, Esq, Senior Vice President, Government and Regulatory Affairs, University of Maryland Medical System: Conference Moderator

Ms. Jacobs encouraged participants to provide input throughout the conference in person and via Twitter. Maryland is at the forefront of health policy, she said, but continues to face challenges in terms of health disparities among minorities. The Office of Minority Health and Health Disparities (MHHD) has put us on a great trajectory toward improvement, said Ms. Jacobs, but unless we work together, we will not see the results we need. Ms. Jacobs introduced the speakers who would offer the official welcome to participants. (The biographies of all the speakers, as well as the slide presentations from the conference, are available at www.dhmh.maryland.gov/mhhd.)

The Honorable Shirley Nathan-Pulliam, House of Delegates, District 10, Maryland General Assembly

Delegate Nathan-Pulliam welcomed the participants to her district on behalf of the Maryland General Assembly, in which she is serving her 18th year as a delegate. She noted that when she began putting forth legislation to address racial and ethnic disparities, providing statistics about morbidity and mortality rates in Maryland and nationally, no one really listened. She persevered with passion, however, and sought to educate her colleagues. Eventually, her bills began to pass—bills examining cultural sensitivity, cultural competency, and linguistic competency. These bills led to a statewide plan to address disparities. The leadership and foresight of the Assembly created the MHHD, which includes a staff of dedicated public servants of whom she is very proud.

The Assembly created the Minority Health Disparities Subcommittee, which Delegate Nathan-Pulliam chairs. It is among the first of its kind in the United States. Earlier in October, subcommittee members visited the University of Maryland School of Public Health and its Center for Health Equity. Leadership there gave presentations on a common theme: addressing health disparities through cultural and linguistic competency and health literacy to achieve the ultimate goal of health equity. Delegate Nathan-Pulliam said she was in awe to see how far we have come with persistence and passion. Most people never live to see their dreams take shape, she said.

Delegate Nathan-Pulliam said she was also moved to have the Shirley Nathan-Pulliam Health Equity Lecture Series named in her honor. She thanked the inaugural recipient, Stephen B. Thomas, PhD, founding director of the Maryland Center for Health Equity, who gave the first lecture at the 2011 Health Disparities Conference. She also thanked Howard K. Koh, MD, MPH, Assistant Secretary for Health of the U.S. Department of Health and Human Services (HHS), who would deliver the second lecture in the series at this conference.

Delegate Nathan-Pulliam concluded by saying that each of the participants has a dream and a passion to create something that will live on, and she encouraged them not to give up on their dreams. A dream without action is just a dream, she said. A dream with action is a vision come true.

Jane E. Clark, PhD, Professor and Dean, University of Maryland School of Public Health

Dr. Clark said she was honored to take part in the conference and to bring greetings from the School of Public Health, where she had only just taken over as dean. The School of Public Health is proud to sponsor the conference along with the Center for Health Equity. The University of Maryland School of Public Health, launched just 5 years ago, is the only public school of public health in the Mid-Atlantic region, which makes it an affordable option. Dr. Clark emphasized the importance of offering such an option as part of the university's mission as a land grant institution.

Living in Maryland should confer health advantages, said Dr. Clark. The state boasts one of the highest median household incomes in the United States, several top medical schools, and the 10th

lowest rate of smoking. Despite these factors, the state has significant racial and ethnic disparities in health care and health outcomes. For example, Blacks in Maryland have an infant mortality rate three times higher than Whites and a rate of newly diagnosed HIV infections 12 times higher than Whites. In addition, Blacks lack insurance at twice the rate of Whites. Dr. Clark said she would love to reach a point where we did not need to have a conference about health disparities.

Reducing and ultimately eliminating racial and ethnic disparities is a challenge not just for Maryland but for the nation. Working with steadfast and relentless policy leadership from Delegate Nathan-Pulliam and also with Federal government support, Maryland is moving forward and can lead the nation to a better state of health, Dr. Clark concluded.

Joshua M. Sharfstein, MD, Secretary, Maryland Department of Health and Mental Hygiene

Dr. Sharfstein welcomed and thanked the participants for the work they do to make Maryland healthier and address the unacceptable disparities in the state. He said the conference offers lots of opportunities to empower participants and connect them with efforts at the state level to tackle health disparities. He gave special thanks to the MHHD staff, led by Dr. Hussein, for their commitment, skill, and experience. He also thanked Delegate Nathan-Pulliam, noting that the lecture series is only a small part of what she has accomplished. We are lucky to have champions in the legislature like her who ask how we can move health in Maryland forward, said Dr. Sharfstein.

Dr. Sharfstein said part of his job is to explain to different audiences that all is not perfect in Maryland. He describes the state's health outcomes as mediocre. For example, the state ranks in the middle of the nation for life expectancy. By looking at statistics not just by county but by zip code and even neighborhood, is clear that health care is not uniform across any given geographic designation. Some pockets are especially challenging to address, said Dr. Sharfstein.

The Assembly, the Governor, the Lieutenant Governor, and many of the participants together have helped put Maryland in a position to benefit from the ACA. Already, citizens are seeing the benefits—for example, more young adults have access to insurance through their parents' plans, and seniors are better able to afford medications.

A key goal of the ACA is access to affordable care, said Dr. Sharfstein. Within a year, Maryland will launch its own health benefits exchange—the Maryland Health Connection—which links eligible individuals to rapid enrollment in Medicaid and to significant subsidies to purchase insurance. Dr. Sharfstein expects vigorous engagement with community representatives and navigators. As the Website for the exchange evolves, he said, participants can get more information about health care reform and help people get insurance now that it is within arm's reach.

The state also has a major effort underway to address behavioral health issues, including a recent conference on integrating mental health, substance abuse, and somatic care to improve health outcomes. The state saw a 20% decline in drug overdoses from 2009 to 2011 among racial and ethnic minorities, essentially erasing the minority disparity in that measure. The tremendous

improvement, especially involving use of illicit drugs, is an example of the success of targeted police efforts. Maryland is also rebalancing home health care regulations to allow more seniors to age in place. Coalitions of public health providers in the state are working to address health priorities and disparities, said Dr. Sharfstein. He said Maryland needs people like the conference participants to communicate about the underlying causes of poor health.

SECOND ANNUAL SHIRLEY NATHAN-PULLIAM HEALTH EQUITY LECTURE SERIES

Joshua M. Sharfstein, MD, Secretary, Maryland Department of Health and Mental Hygiene

Dr. Sharfstein introduced this year's lecturer, Dr. Howard Koh, pointing out that he first met Dr. Koh during a pediatric fellowship at Boston University in 1999, when Dr. Koh was the Commissioner of Health for the Commonwealth of Massachusetts. Despite Dr. Koh's intimidating position and accomplishments—among other things, he is board-certified in four areas—Dr. Sharfstein found Dr. Koh warm and supportive. The two published two articles together on public health concerns, and Dr. Koh encouraged Dr. Sharfstein to persist in the field of public health. Over the years, the two have remained in touch.

Dr. Koh has been not just a mentor but a role model, and Dr. Sharfstein said he tries to help others in the same way that Dr. Koh has helped him with advice and encouragement. Dr. Sharfstein summarized some of Dr. Koh's accomplishments and responsibilities, noting that Dr. Koh has had a special interest in addressing health disparities throughout his career.

Howard K. Koh, MD, MPH, Assistant Secretary for Health, Department of Health and Human Services

Thanking Dr. Sharfstein for the warm introduction, Dr. Koh said that Maryland is lucky to have a dynamic and brilliant Secretary who demonstrated so much promise early in his career. He thanked conference organizers and participants, noting that he shares their passion for eliminating health disparities and achieving true health equity.

The annual Shirley Nathan-Pulliam Health Equity Lecture honors a true public health hero, said Dr. Koh. He praised her track record of service and leadership and said it was an honor and privilege to recognize a champion in public health.

Dr. Koh said he was also honored to address a room full of visionaries, public servants, and health leaders who are addressing this key issue of our time. He thanked them for their commitment to ensuring that all people reach the highest attainable standard of health. Good health is a gift, he said—both precious and fragile. The phrase “highest attainable standard of health” comes from the World Health Organization (WHO), which further defines “health” as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”

Another champion, Reverend Martin Luther King, Jr., said he wanted every person to enjoy “the sunlight of opportunity.” Unfortunately, said Dr. Koh, we know that is not the case now, because

major, persistent, and pervasive disparities face this country. He cited a number of examples, noting that we know biology accounts for some health disparities, but inequities contribute as well. Reaching a state of health equity is a noble goal that touches on issues of fairness and justice, said Dr. Koh. As Dr. King said, “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

Achieving health equity and eliminating disparities is a moral and social imperative, Dr. Koh noted, and he thanked Delegate Nathan-Pulliam, Dr. Sharfstein, and others for understanding why this conference on health disparities is so important. There are those who are troubled by disparities but question the importance of the issue to the country as a whole. We are a nation of immigrants, said Dr. Koh, and our country is getting more diverse by the minute. As of 2011, according to the Census Bureau, more minority babies than White babies were born in the United States. Our future is increasingly diverse and multicultural, Dr. Koh noted. In 2000, Boston became the first “minority majority” city; now, seven of the 15 most populous U.S. cities, four states, and the District of Columbia have minority majority populations.

As a nation, we are more diverse than ever before, said Dr. Koh, and in public health, we understand that we are all interdependent and interconnected. Our collective health depends on our ability to care for all individuals and to ensure that all reach their highest attainable standard of health.

As the Assistant Secretary for Health, Dr. Koh oversees the Healthy People initiative, which is currently focused on goals for 2020. The health of the individual is almost inseparable from the health of the greater community and the overall health of the nation, he stated. Health equity, therefore, benefits all of us. Dr. Koh again quoted Dr. King, saying, “We may have all come in different ships, but we are in the same boat now.”

Achieving equity is of personal importance to Dr. Koh, the son of Korean immigrant parents who came here searching for the American dream. His parents reminded him how lucky he was to be born in this country, blessed with rights and living in a democracy. They stressed the importance of getting the best education possible and living life with a higher purpose. Dr. Koh was determined to become a doctor and trained in multiple hospitals and in multiple fields.

Like all of his colleagues, Dr. Koh was trained to focus on the biology of disease and viewed health at the level of the individual patient. But over time, he began to see how other dimensions impact health outcomes in ways that an individual practitioner cannot control—factors we now recognize as social determinants of health—racial and ethnic discrimination; poverty; lack of insurance, housing, and transportation; and many more. Dr. Koh quickly saw the need for a broader approach to address health disparities and health equity. He was often called upon to help his parents and grandparents navigate the health care system and wondered what happens to people who do not have a physician in the family to provide such help.

Dr. Koh went on to become the Health Commissioner of Massachusetts and then the first Asian American Assistant Secretary for Health. He leverages his position to work toward ensuring that all people reach the highest attainable standard of health, and he urged other participants to do the same. The 1985 *Report of the Secretary’s Task Force on Black and Minority Health*, by then-

HHS-Secretary Margaret Heckler, highlights the paradox we face: in a country of phenomenal scientific achievements and steady improvements in overall health, we continue to see persistent, significant health disparities among minorities. Since then, many heroic leaders across the country have worked hard to eliminate disparities, but more must be done, and it is time for something new, said Dr. Koh.

First, the ACA, signed in March 2010, is being implemented, and Maryland, led by Dr. Sharfstein, is doing an extraordinary job in that respect, Dr. Koh noted. To aid with implementation, HHS instituted a formal strategy with its Office of Minority Health to get input from community leaders through meetings across the country. In 2011, HHS Secretary Kathleen Sebelius unveiled the first HHS action plan to reduce disparities, which has five goals:

1. Transform health care. The ACA is moving toward this goal by expanding insurance coverage and access to care and enhancing prevention efforts.
2. Strengthen the nation's health and human services infrastructure and workforce. This goal includes increasing both the number and the diversity of workers to improve cultural competence.
3. Advance the health, safety, and well-being of the American people. This goal speaks to the role of public health.
4. Advance scientific knowledge and innovation. To achieve this goal, we must improve data collection about minority health. Without data to illustrate the problem, the implication is that there is no problem.
5. Increase the efficiency, transparency, and accountability of HHS programs.

Now, HHS integrates these goals into everything it does. Healthy People 2020, for example, aims to eliminate health disparities. The National HIV/AIDS Strategy unveiled by President Barack Obama in 2010 sets a goal of eliminating health disparities in HIV detection and treatment by 2015. The ACA required that HHS establish new offices of minority health and health disparities in the Centers for Medicare and Medicaid Services (CMS), the Food and Drug Administration, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention, and the National Center on Minority Health and Health Disparities at the National Institutes of Health. The National Center on Minority Health and Health Disparities will host the 2012 Science of Eliminating Health Disparities Conference later in October.

The ACA will transform health care, said Dr. Koh. In 2006, Massachusetts implemented sweeping health care reform, and now it has the country's lowest rate of uninsured individuals. Disparities are narrowing dramatically there, said Dr. Koh. Beginning in 2014, all states must have health exchanges, and those exchanges will require navigators to help individuals take advantage of the availability of insurance. Systems of care will have to transform as well to reduce disparities.

The ACA led to funding for community health centers that will serve 20 million people, two thirds of whom are racial and ethnic minorities. Recently, HHS announced that it will provide funding to help 800 community health centers become accredited patient-centered medical homes and increase cancer screening. The HHS Office of Minority Health will soon present new

national standards for health care service that reflect the increasing diversity of the population. Also, community health workers, including *promotoras*, are vital to building a culturally competent, team-based approach to care; they can help with behavioral health, mental health, and substance abuse issues as well as physical health concerns. In addition, the first wave of innovation grants for CMS touched on the issue of team-based health care.

The ACA also created the Prevention and Public Health Fund which is being used to tackle disparities and inequities. For the second consecutive year, there has been no racial or ethnic disparity in influenza vaccine coverage for minority kids. Dr. Koh said that achievement is a testament to the work of many people over decades who looked at simple preventive care options like vaccination and saw the entrenched disparities. To reduce disparities among adults, HHS is working with groups such as retail pharmacies to provide vaccine vouchers. To combat childhood obesity, First Lady Michelle Obama launched the Let's Move campaign, and Dr. Koh described what a thrill it was to be part of the kickoff event last year.

Dr. Koh expressed his frustration with the lack of data to support scientific research about minority health, and he noted that we are already seeing changes on this front. For example, more HHS-funded programs are now required to collect data about clients with limited English proficiency. Data standards are being updated to support collection of more granular data on race and ethnicity. The Federal government now has seven subcategories for Asian Americans and four for Pacific Islanders.

To make HHS more accountable and transparent, efforts are underway to include language about disparities in as many funding opportunity announcements as possible. For example, SAMHSA announcements now require applicants to include a disparity impact statement.

In closing, Dr. Koh said he expected that participants would have an exciting day at the conference. All of the topics on the agenda reflect issues with which he has wrestled as a public health official. He quoted Maya Angelou, who said, "Surviving is important. Thriving is elegant." If we help people reach their highest attainable standard of health, they will not just survive but thrive, he said. Finally, Dr. Koh turned again to the words of Dr. King to honor leaders like Delegate Nathan-Pulliam and Dr. Sharfstein who have been willing to take risks and get involved in tough issues: "Everybody can be great... because anybody can serve. You don't have to have a college degree to serve. You don't have to make your subject and verb agree to serve. You only need a heart full of grace, a soul generated by love."

Dr. Stephen Thomas then presented the Shirley Nathan-Pulliam Health Equity Lecture Series award to Dr. Koh with a plaque to honor Dr. Koh's steadfast commitment to the elimination of health disparities and the achievement of health equity for all. Dr. Thomas noted that dedication to public service is at the heart of the award.

PANEL DISCUSSIONS

Panel A: The Maryland Health Improvement & Disparities Reduction Act of 2012: Maryland's Groundbreaking Initiative—Health Enterprise Zones

Conference Moderator: Donna Jacobs, Esq, Senior Vice President, Government and Regulatory Affairs, University of Maryland Medical System

Session Moderator: Benjamin Stutz, Policy Director, State of Maryland Executive Department, Office of the Lieutenant Governor

Mark Luckner, Executive Director, Maryland Community Health Resources Commission

Marie Grant, Director, Governmental Affairs, Maryland Department of Health and Mental Hygiene

E. Albert Reece, MD, PhD, MBA, Vice President for Medical Affairs and Dean of the School of Medicine, University of Maryland

Stephen Thomas, PhD, Professor, Health Services Administration and Director, Maryland Center for Health Equity, School of Public Health, University of Maryland

PANEL A

The Maryland Health Improvement and Disparities Reduction Act of 2012: Maryland's Ground breaking Initiative—Health Enterprise Zones

Conference Moderator: Donna Jacobs, Esq, Senior Vice President, Government and Regulatory Affairs, University of Maryland Medical System

Maryland has always been in the forefront of health care policy, said Ms. Jacobs, as illustrated by the new Health Enterprise Zones (HEZs) established by the 2012 Maryland Health Improvement and Disparities Reduction Act (MHIDR). The legislation was significantly influenced by the recommendations of the Health Disparities Workgroup of the Maryland Health Quality and Cost Council, led by E. Albert Reece, MD, PhD, MBA, Dean of the University of Maryland School of Medicine. The Health Disparities Workgroup brought together experts who discussed the concepts later championed by Secretary Joshua Sharfstein, MD, and Lieutenant Governor Anthony Brown. The MHIDR was the first piece of legislation signed into law by Governor Martin O'Malley in 2012, signifying how important it is, said Ms. Jacobs.

Session Moderator: Benjamin Stutz, Policy Director, State of Maryland Executive Department, Office of the Lieutenant Governor

Mr. Stutz said that Lieutenant Governor Brown is “as passionate as they come” about addressing health disparities and has been working to improve health care in Maryland. Lieutenant Governor Brown has led the state's implementation of the Affordable Care Act (ACA); with each step, he has expressed concern about how the implementation of health reform can help deal with health disparities, which are a major cost driver and a significant problem. Thanks to the efforts of the Maryland Health Quality and Cost Council's Health Disparities Workgroup and the commitment of Governor O'Malley and the Maryland General Assembly, Maryland now will offer \$4 million to communities to address health disparities.

Mark Luckner, Executive Director, Maryland Community Health Resources Commission

The Community Health Resources Commission (CHRC) will oversee the implementation of the HEZs, which have been allotted a total budget of \$4 million per year for 4 years, beginning in fiscal year 2013, to fund up to four HEZs. The Health Disparities Workgroup focused on the largest drivers of health care chronic diseases associated with prominent racial and ethnic disparities in health care and outcomes: asthma, diabetes, and hypertension. The HEZs will enable the state to use public funding as a seed investment to attract partnerships among nonprofit organizations, hospitals, community-based providers, private practitioners, and others.

The HEZs will encourage the use of state resources to reduce racial, ethnic, and geographic health disparities and improve health care access and outcomes in underserved communities, with the ultimate goal of bringing down costs and reducing hospital admissions and readmissions. An HEZ is defined as a contiguous geographic area with documented evidence of health disparities, economic disadvantages, and poor health outcomes. Each HEZ should have a population of at least 5,000 yet be small enough for the funding and incentives to have meaningful and demonstrable impact.

Mr. Luckner described the eligibility requirements, emphasizing that applicants should represent a community-wide collaboration that includes diverse health care providers and builds on the efforts of local health improvement processes. He noted that applications should make a strong case on the basis of community need and also describe intervention strategies that draw on a range of incentives to improve health outcomes.

The HEZs aim to promote health care services in three areas: primary care, behavioral health, and dental care. Mr. Luckner emphasized that the HEZs are focused on types of health care services that will be provided in the HEZ, not on the types of health care practitioners.

The HEZ process was open for public comment in June and July; the results were considered as the request for proposals (RFP) was drafted. The RFP was released in early October, following legislative approval, and the HEZs will be selected from among the applicants by December. On the basis of public comments, the RFP clarified the eligibility criteria, principles of review of the applications, and the potential incentives and benefits available for HEZs. Public forums to discuss the HEZs were held throughout the state in July, August, and September.

Mr. Luckner further described the criteria and data that were used to determine eligibility. He noted that these criteria were selected because most communities have corresponding data (e.g., population figures, Medicaid enrollment, percentage of low-birthweight infants).

Unlike many state programs, applicants are encouraged to draw on a range of available incentives and benefits as they develop their strategies for expanding access. Mr. Luckner said that, ideally, proposals will demonstrate a good balance of incentives. Following release of the RFP, the CHRC held a public conference to respond to questions, and a “frequently asked questions” guidance document was posted on the HEZ public Website, which is accessible via the DHMH Website.

Mr. Luckner described the next steps for applicants. Following a preliminary review of proposals, selected applicants will be asked to give a presentation to the CHRC Board on December 11, and Secretary Sharfstein will make final award decisions by the end of 2012. Proposals will be considered on the basis of a 100-point scale that consists of 13 weighted criteria.

Marie Grant, Director, Governmental Affairs, Maryland Department of Health and Mental Hygiene

Ms. Grant summarized two other provisions of the MHIDR. To promote cultural competency, the MHIDR requires the Maryland Health Care Commission (MHCC) to track efforts by health plans to provide culturally appropriate educational materials for its members. In addition, the Cost Council is convening a workgroup that will recommend criteria for health care providers to receive continuing education in multicultural health care, including cultural competency and health literacy training.

To encourage reporting and analysis of health disparities data, MHCC and the Maryland Health Services Cost Review Commission (HSCRC) will develop and incorporate standard measures on racial and ethnic variations in quality and outcomes and track health insurance carriers' and hospitals' efforts to combat disparities. MHCC will develop recommendations for criteria and standards to measure the impact of the Maryland Patient-Centered Medical Home program on eliminating disparities in health care outcomes. State institutions of higher education that train health care professionals are required to report to the Governor and the General Assembly on their actions aimed at reducing health care disparities.

Ms. Grant encouraged participants to visit the HEZ Website for more information (<http://dhmh.maryland.gov/healthenterprisezones/SitePages/Home.aspx>). Questions can be sent via e-mail to dhmh.hez@maryland.gov.

E. Albert Reece, MD, PhD, MBA, Vice President for Medical Affairs and Dean of the School of Medicine, University of Maryland

Dr. Reece explained that the Cost Council, established by the Governor, took on various initiatives. He chaired the Health Disparities Workgroup, which had the following charge:

The Workgroup shall develop recommendations for best practices, monitoring, and financial incentives for the reduction of disparities in the health care system. These disparities may include:

- Workforce
- Quality of care within an office or hospital setting
- Access to care within a health plan or health care system
- Understanding of care within a health care setting
- Others as determined by the Workgroup

The Workgroup aimed to come up with concrete recommendations that would make a difference. It had broad representation from experts in health disparities, medicine, government, public health, business, academia, state offices, and more. Key stakeholder groups (MedChi, Maryland Nurse Practitioners Association, and CareFirst Blue Cross/Blue Shield) reviewed the recommendations, and their comments were incorporated.

The Workgroup considered three critical factors related to chronic disease: severity, frequency, and health and economic consequences. The Workgroup sought to address the areas of highest disease prevalence and focused on chronic conditions, where 80% of health care dollars are spent. Asthma, cardiovascular disease, and diabetes have the greatest frequency of occurrence, pose a major disease burden, and are associated with the highest rates of disparity. In addition, for each of these diseases, hospital admission data can provide a clear benchmark to assess progress and outcomes.

Poor health outcomes in general—and poor minority health outcomes in particular—result from modifiable health care, community, and individual factors. Identification of these factors may

occur at the national, state, or city level, but remediation almost always takes place in a community setting, said Dr. Reece.

The Workgroup focused on identifying concrete ideas that were feasible and modeled on previous successful efforts. The Workgroup's major recommendation—HEZs—borrowed the construct of economic enterprise zones and will target areas where the prevalence of disease is greatest and the availability of service lowest. In such settings, HEZs seek to fill the service gaps and affect outcomes.

The Workgroup also recommended creating the Maryland Health Innovation Prize, similar to the X Prize, to reward the creation of something innovative and not just a great idea, said Dr. Reece. It also recommended expanding the scope of Maryland's current reimbursement incentives for quality and making them race- and ethnicity-specific. This recommendation seeks to compel systems to track improvements in disparities within the broader context of overall quality improvement and targets quality improvement incentives at reducing disparities. The Workgroup's recommendations became the basis of the MHIDR; the legislature added an emphasis on cultural and linguistic competence and health literacy for the state workforce.

As described by Mr. Luckner, the HEZs can use tax or other economic incentives to encourage broader community involvement—for example, attracting businesses to expand access. Dr. Reece said that HEZs will spur an influx of human and financial resources to expand access to care and improve health outcomes. They should create an extensive and seamless health care delivery system that involves a range of community-based organizations and resources.

As the state moves toward the use of incentive payments based on health outcomes, it is increasingly important to capture racial and ethnic data, said Dr. Reece. The Workgroup's recommendations sought to engage and empower individuals where the greatest disparities exist through incentives, education, outreach, technology, and innovation. Once implemented, said Dr. Reece, they will have an immediate effect on health disparities, improve quality of life, and reduce health care costs. He concluded by saying he was pleased that the recommendations have become part of the law, and now the hard work begins.

Stephen B. Thomas, PhD, Professor, Health Services Administration and Director, Maryland Center for Health Equity, School of Public Health, University of Maryland

Dr. Thomas said Maryland is the only state in the nation with a law to eliminate health disparities. We have a tough road ahead, he noted, and we are on the path forward with the ACA and Governor O'Malley. Dr. Thomas acknowledged the creative leadership of the Workgroup members who cooperated although they are used to competing with one another. The presence of representation from the Governor's office kept the Workgroup members on task, Dr. Thomas noted. He urged participants not to underestimate the significance of the Workgroup's accomplishments or the work ahead.

Just as the Secretary of the U.S. Department of Health and Human Services Margaret Heckler had no idea how much impact her report on minority health would have, the Workgroup did not realize that its recommendations would become law, especially given a contentious General Assembly. Dr. Thomas pointed out that members argued, but Dr. Reece guided them through disagreements to find common ground in the interest of the people of Maryland. The members recognized that health disparities have been around for a long time, and the first step toward addressing them was to collect data to document the problem. The second step was to ask what causes disparity, and researchers have identified poverty, lack of education, lack of access to care, and many other factors. The third step was to identify promising solutions, usually done by academic science centers that conduct studies but walk away from the community once the study is completed.

With the MHIDR, Maryland has made a commitment to take the next step to reduce disparities. These new initiatives will not just look at metrics or gauge the effectiveness of small studies of what works, said Dr. Thomas. They will focus on implementing systems that improve community health.

On the way to a mainstream approach to reducing health disparities, Dr. Thomas said, many lessons have been learned. First, words matter. The previous administration had data on health disparities but tried to change the emphasis by saying that the numbers just represent different health statistics. But, as Dr. Koh said, disparities are not just about differences but about discrimination and injustice, said Dr. Thomas. Such issues can get lost as recommendations make their way into the mainstream, he noted, but the issues of race must remain on the table.

W. E. B. DuBois said, "The problem of the 20th century is the problem of the color-line," and Dr. Thomas said the problem remains in the 21st century. It ripples through time and finds expression in different ways, but racial discrimination is persistent, he stressed. Beyond the Black experience, he noted, for example, how discussions about immigration racialize the experience of Latinos.

While some argue that at the genomic level, humans are all one race, Dr. Thomas pointed out that individuals are still treated differently on the basis of how they look, their accents, and their country of origin—and this treatment affects health. To those who believe we should abandon the concept of race and defer to ethnicity, Dr. Thomas said such a shift would minimize the health impact of racism for populations who are subject to social prejudice because of their skin

color and features. So many efforts to date have not addressed the persistent impact of racism, Dr. Thomas noted. Sophisticated tools are now available to measure the impact of race and racism. Finally, he said, we should not forget the struggles that Delegate Shirley Nathan-Pulliam, Dr. Reece, and others have endured to get us here, to bring these ideas into the mainstream.

Questions and Answers

A participant asked which zip codes or counties qualify as eligible to apply for an HEZ. Mr. Luckner said the HEZs focus on areas with the highest disease burden, then looking upstream to the zip codes and jurisdictions that house those areas. Baltimore City and Prince George's County are among the jurisdictions with the highest disease burden. However, Mr. Luckner stressed the need to avoid focusing discussion on jurisdictions or eligible zip codes. Rather, the purpose of the initiative is to exert a laser-like focus on leveraging limited public resources to galvanize community support and address disparities. Mr. Stutz said there has been no discussion about a specific number of zones, but the funding anticipates awarding two to four applicants HEZ status. The process is a competitive one that seeks to spur collaboration between local governments and community-based organizations.

Dr. Thomas said that the outside-the-box thinking that led to the HEZ recommendation should not be suffocated by the process to implement it. He hoped that those who worked together to create collaborative proposals would continue to work together even if their proposals are not funded. Secretary Sharfstein and others are exploring methods to provide ongoing support for promising collaborations whose proposals are not funded through the HEZ initiative.

A participant said she received pushback for using the term “racism” in the context of health disparities research. Reviewers, publishers, and others are more inclined to use less pejorative terms, such as “diversity” and “racial bias.” She was thrilled that Dr. Thomas mentioned the need to talk about racism, discrimination, and how people are treated when they seek care.

A participant asked how small minority groups or subgroups can ensure they are counted when data are collected. Dr. Reece said the HEZ approach focuses on disease burden, not race. It aims to reduce health disparities across racial and ethnic groups and geographic areas (which include rural areas that have a disparate burden but not necessarily a racial or ethnic minority component). Wherever there is a high disease burden, said Dr. Reece, the recommendations and legislation should be able to identify a target and address concerns. No matter what racial and ethnic group is affected, if they are grouped geographically, they are eligible, said Dr. Reece.

Dr. Thomas added that the Workgroup grappled with such issues. Improving data collection at the subpopulation level will be part of future discourse. Furthermore, certain groups carry the stigma of minority, such as African Americans and Latinos, he said. He pointed to the “mythology of a perfect minority”—for example, the perception that Asians are doing fine. “We have to get to the point where I can tell your story, even though I’m not Asian, so you don’t find yourselves trying simply to get recognized because our data don’t even let you show up,” said Dr. Thomas. Where disparities exist, he said, that is where we should focus.

A participant asked what evaluation mechanisms would be used to determine the potential for HEZs to continue after the grant period ends. Mr. Stutz responded that the legislation requires an evaluation component for every applicant, and the intent is to articulate the need to expand the number of zones throughout the state in the future. Mr. Luckner is among those working on the evaluation component; Mr. Stutz invited participants' thoughts on the matter. Mr. Stutz said he envisions a uniform set of metrics across all zones and an individual set of metrics that each applicant will provide for its own zone. Because each HEZ will focus on different targets, each should have metrics that measure those targets, he added.

Mr. Stutz concluded the discussion by noting that the legislature created the HEZs not to provide a solution to communities but to give them the tools and resources to create programs that change how health care is delivered in their communities. He encouraged participants to think creatively about how to address disparities in their areas.

PANEL DISCUSSIONS

Panel B: The Maryland Health Disparities Collaborative & Workgroups

Moderator: Donna Jacobs, Esq, Senior Vice President, Government and Regulatory Affairs, University of Maryland Medical System

Debra Perry, Chair, Awareness Workgroup; President, AFT Healthcare Maryland Local #5197, AFT/AFL-CIO

Alma Roberts, MPH, FACHE, Chair, Leadership and Capacity Building Workgroup; CEO, Baltimore Healthy Start

Marcella Copes, PhD, RN, Vice Chair, Health and Health System Experience Workgroup; Dean, College of Health Professions, Coppin State University

Ilana Mittman, PhD, MS, CGC, Chair, Cultural and Linguistic Competency Workgroup; Senior Research Associate, The Sullivan Alliance to Transform the Health Professions

Stephen B. Thomas, PhD, Chair, Research and Evaluation (Data) Workgroup; Professor, Health Services Administration and Director, Maryland Center for Health Equity, School of Public Health, University of Maryland

PANEL B

The Maryland Health Disparities Collaborative & Workgroups

Moderator: Donna Jacobs, Esq., Senior Vice President, Government and Regulatory Affairs, University of Maryland Medical System

Ms. Jacobs said the Maryland Health Disparities Collaborative (MHDC) was created in 2008 as an advisory body to the Office of Minority Health and Health Disparities (MHHD); its efforts gathered steam under the direction of MHHD Director Carlessia Hussein, RN, DrPH, beginning in 2011. Ms. Jacobs co-chairs the MHDC with Secretary Joshua Sharfstein, MD. The MHDC established five workgroups to address the objectives laid out in the Maryland Plan to Eliminate Minority Health Disparities. The workgroups are now focusing on providing advice to the Secretary on bringing the vision of the Maryland Health Improvement and Disparities Reduction Act (MHIDR) to fruition. Ms. Jacobs said the collaborative is open to all interested parties, and she invited all the participants to join.

Debra Perry, President, AFT Healthcare Maryland Local #5197, AFT/AFL-CIO

Ms. Perry, chair of the Awareness Workgroup, said her group was asked to provide recommendations about promoting the Health Enterprise Zone (HEZ) application process to community-based organizations. The group began by identifying existing lists and networks of community-based organizations, brainstorming to cast as wide a net as possible. The Workgroup then sent a letter to the organizations (including local health departments, Federally qualified health centers [FQHCs], fraternal and civic organizations, and historically Black colleges and universities, to name a few). The Workgroup created a standard outreach message and template that the organizations could tailor for their own use.

The Awareness Workgroup recommended taking advantage of new and traditional media, teleconferences, webinars, etc. to promote the program. It recommended targeting effective initiatives in areas with high health needs. It also recommended that the review panels for HEZ applications include people with expertise in addressing health disparities and represent the targeted communities.

Asked to provide recommendations on promoting the services provided by the HEZs, the Awareness Workgroup recommended the following:

- Create and test outreach messages to ensure they are pertinent to the community.
- Use multiple channels for marketing and outreach.
- Provide local businesses and community gathering sites with print materials promoting the HEZ.

Alma Roberts, MPH, FACHE, CEO, Baltimore Healthy Start

Ms. Roberts, chair of the Leadership and Capacity Building Workgroup, said she has come to understand the importance of building capacity to help communities address their needs. The group was charged with strengthening and broadening leadership to address health disparities at all levels. Once the MHIDR became law, the group was asked to provide recommendations on establishing a virtual network of community leaders interested in health equity that could be used to make announcements, offer training, and receive input on a wide range of health initiatives (including HEZs). The underlying tenet of the group's recommendation was inclusiveness—specifically, reaching beyond the large organizations working on health disparity issues to the smaller organizations working in communities on a daily basis.

The Leadership and Capacity Building Workgroup recommended including community health leaders and their contacts in the virtual network, such as research organizations and agencies (e.g., FQHCs, local health departments, clinics, and safety net providers). Inclusiveness is key, said Ms. Roberts, who has seen many reform efforts come and go. By way of illustration, she noted that traditional providers were pushed out of Medicaid managed care programs until other providers realized they needed them to care for at-risk populations.

The group further recommended identifying the tools and software used to disseminate information and leveraging them to create and manage virtual networks. To build capacity, efforts are needed that link networks, reduce unnecessary duplication of information, and promote a consistent flow of information that includes feedback. The same network used to promote HEZs and roll out state health care reforms can also help with enrollment in and navigation of the Maryland Health Connection health insurance exchange, said Ms. Roberts.

In addition, the group suggested using other forms of communication and outreach, such as fax and e-mail messages; providing technical assistance to implement promising and evidence-based practices (building the capacity of grassroots organizations and their leadership), and locating funding resources to support applicants not funded under the HEZ initiative, possibly in conjunction with the Maryland Health Equity Learning Committee.

Marcella Copes, PhD, RN, Dean, College of Health Professions, Coppin State University

Dr. Copes, vice chair of the Health and Health System Experience Workgroup, said her group was charged with improving health and health outcomes for racial and ethnic minorities and improving health care in underserved communities. Asked to provide evidence-based options for communities to consider in their HEZ proposals, the group came up with 10 recommendations:

- Set up an interactive Website of evidence-based, promising, and best practices to address chronic disease that can provide communication and learning opportunities for chronic disease programs statewide. (The Website www.dhmmh.maryland.gov/innovations responds to this recommendation.)
- Implement a diabetes prevention campaign (e.g., Small Steps, Big Rewards) to create materials for people at risk for diabetes, using multipronged community outreach.

- Launch a tobacco cessation campaign with advertising campaigns and historical, cultural, and socioeconomic influences targeted to specific groups.
- Promote healthy eating through church-based programs, pastor support, and peer counseling.
- Recruit barbershops to aid in improving hypertension detection and control, helping Black men beat high blood pressure, and controlling cardiovascular disease.
- Assist people released from prison in finding primary care and navigating the health care system.
- Better use hospital emergency departments to test for HIV, hepatitis C virus, and other infectious diseases and conditions and provide assistance and referrals.
- Promote the community health worker movement in Maryland.
- Manage heart failure more effectively through the consistent use of medications, modification of diet, and an exercise and activity program.
- Employ proven effective drug treatment for addiction and combine it with a broad community program in housing, medical care, social rehabilitation, job training, and social support.
- Tackle obesity by increasing the availability of safe places to play and exercise with improved street lighting, infrastructure to make street-crossing safer, and use of traffic-calming approaches; build playgrounds and walking trails; and increase access to healthy foods (eliminating “food deserts”) by developing and supporting farmers’ markets and creating community gardens.

The group identified five successful models of care that improve population health, enhance patient experiences, or reduce costs:

- Bright Beginnings of Maryland
- The Residents Access to a Coalition of Health (REACH)
- S.M.I.L.E. Program (part of the African American Health Program in Montgomery County)
- Diabetes Dining Club (part of the African American Health Program in Montgomery County)
- Community Health Partnership’s Baltimore Community Health Action Team (B-CHAT)

Asked about the format of hospital reporting about health disparities, the group recommended that hospitals report on the racial, ethnic, and language composition of their community benefit service area (CBSA) population. It was also suggested that the Department provide resources to assist with understanding county-level health data by race and ethnicity in Maryland. The group said that metrics used to describe the health of the CBSA population should address the total population and also groups defined by race, ethnicity, and language. Hospitals should assess and report social characteristics of communities that impact health (i.e., social determinants of health). Planning and advisory groups to CBSAs should include representatives of the target communities. Reports should demonstrate that communications among hospitals, patients, and communities conform to accepted standards for cultural, linguistic, and health literacy competency.

Ilana Mittman, PhD, MS, CGC, Senior Research Associate, The Sullivan Alliance to Transform the Health Professions

Dr. Mittman, chair of the Cultural and Linguistic Competency Workgroup, said her group was asked to make recommendations on numerous areas. Regarding the reporting format for institutions of higher education about health disparities, the group recommended consolidating the requirements of two pieces of legislation and updating an existing reporting format developed by MHHD. Regarding HEZs, the group suggested using the list of criteria in the HEZ legislation as a guide for assessing the level of cultural and linguistic competence of HEZ applications and including the criteria as an appendix to the request for proposals (RFP). The criteria should include community engagement, patient-provider communication and language services, workforce diversity and training, managerial and operational supports, care delivery, and data collection. The group also suggested a scoring rubric for evaluating the HEZ applications.

Regarding provider reporting and reimbursement systems, the Cultural and Linguistic Competency Workgroup recommended creating a payment incentive program for providers and incorporating process measures into the performance evaluation. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) supplemental survey items on cultural competence and health literacy could be used as potential outcome measures. The potential benefits of the new data should be weighed against the added cost of administering the cultural competence and health literacy survey items. The group recommended ensuring that eligible participation in an incentive program is structured in a manner that rewards quality improvement efforts and simultaneously addresses health disparities. The group said that if a payment incentive program is not feasible, consideration should be given to developing a provider quality recognition program that could be implemented at different provider levels.

Regarding continuing education for health professionals, the group suggested requiring 6 hours of continuing education on cultural, linguistic, and health literacy competency during each license renewal period. It also addressed verification of such education and the need to ensure that the educational offerings meet health occupation boards' existing approval criteria. The group suggested developing a Department of Health and Mental Hygiene (DHMH)-sponsored training event and maintaining an up-to-date page on the DHMH/MHHD Website dedicated to providing information about upcoming training opportunities. Continuing education would address knowledge, skills, and attitudes.

To evaluate the appropriateness of health plans' consumer information, the group recommended encouraging health benefit plans in Maryland to pursue the National Committee on Quality Assurance (NCQA) "Distinction in Multicultural Health Care" designation or incorporate similar elements of culturally-, linguistically-, and health-literacy-appropriate communication into the health plan evaluation tools and certification processes currently being developed by the Maryland Health Connection and the Maryland Health Care Commission (MHCC). It suggested requiring Maryland health plans to incorporate into their current consumer surveys a standardized subset of supplemental items on cultural competence and health literacy. Again, efforts would be needed to determine if the potential benefits of the new data outweigh the added cost.

Regarding MHHD's Health Primer, Dr. Mittman said the draft has a lot of resources and recommendations but lacks a consensus on teaching and evaluating cultural competence. She added that MHHD is seeking more reviewers and more suggestions for free or low-cost resources on cultural competence and health literacy.

Stephen B. Thomas, PhD, Professor, Health Services Administration and Director, Maryland Center for Health Equity, School of Public Health, University of Maryland

Dr. Thomas, chair of the Research and Evaluation (Data) Workgroup, said that in order to avoid rehashing old debates about data, his group recommended that the MHCC and Maryland Health Services Cost Review Commission (HSCRC) adopt the Federal Office of Management and Budget's definitions for collecting data on race, ethnicity, and language. Doing so will ensure that Maryland data can be compared with national data. Dr. Thomas noted that some believe that race is not a biological but a social construct, so it is not necessary to collect racial data. However, he said, by collecting data, we hold institutions accountable for their policies.

The group also recommended collecting data on English proficiency and the individual's preferred language for health care. Maryland should also collect data on subcategories of racial and ethnic groups.

Regarding the outcomes to be analyzed and methods for analysis, the group said the current data collected using MHCC and HSCRC data systems are reasonable and should be used for initial analysis about race and ethnicity and eventually language disparities. Results of such an analysis could be compared across and within groups to identify disparities, which will help communities create collaborations suitable for HEZs. When possible, analyses should include variables that reflect the social determinants of health. Because current outcome, process, and patient experience measures are publicly reported, the group recommended that these same measures be analyzed according to race, ethnicity, and language and the results publicly reported as well. As with current outcome, process, and patient experience measures, the group recommended establishing benchmarks for data on race, ethnicity, and language. The results can then be used to compare state and Federal efforts, said Dr. Thomas.

Questions and Answers

A participant said the HEZ initiatives focus incentives and benefits on clinical services—medical, dental, and behavioral care; he asked how the model can address the social determinants of health. Ms. Jacobs noted that in addition to the state incentives, there is an open request for innovative proposals, and applicants are encouraged to be creative. Dr. Hussein said the Secretary planned to incorporate the Health Disparities Workgroup recommendations into the RFP and the HEZ guidelines and criteria. The HEZ Website includes the recommendations, and Dr. Hussein encouraged potential applicants to consult the site for details.

Dr. Thomas noted that those who proposed the HEZ initiative and provided recommendations were trying to work outside of the box but still face constraints. The Governor signed the MHIDR into law on the same day it was announced that the state's budget was in freefall, said Dr. Thomas. However, the program got \$4 million in funding on the basis of predicted savings from reducing hospitalizations associated with asthma, hypertension, and diabetes. The HEZ applicants must use hospital-based measures to demonstrate improvement, but how they achieve changes depends on the creativity of the applicants, Dr. Thomas stressed. He added that the Maryland Health Innovation Prize offers the freedom to try new approaches and encourages nontraditional collaborations. The legislation provides some mechanisms to break out of the constraints while staying accountable and measuring specific outcomes.

Delegate Shirley Nathan-Pulliam congratulated all the chairs for their work. She stressed the importance of addressing the clinical component of cultural competence—an area of particular concern to her. She noted that, thanks to a bill she shepherded through the General Assembly in 2006, the MHCC has collected some data on racial and ethnic minorities. It found significant disparities between the percentages of racial and ethnic minorities in Maryland and the percentage of racial and ethnic minority clinicians. For example, 3% of Marylanders are Asian, but 80% of clinicians in Maryland are Asian, which may explain why Asians suffer fewer health disparities than other minorities.

A participant asked whether any discussion has revolved around activating patient populations to take their own measures and collect data (for example, by tracking and relaying their own blood pressure measures on a regular basis). Dr. Thomas applauded the innovative concept. He cautioned that almost all individuals have phones, but not all have smartphones. He added that communities should be introduced to the power of self-monitoring, which can be an intervention in itself.

A participant asked how HIV infection got left out of the legislation, given that health disparities around treatment for HIV/AIDS persist. She noted that with better medications, more people living with HIV/AIDS are avoiding hospitalization, so admission measures would not be applicable. She also raised concerns about hospital upcoding to recoup costs, which may skew measures. Dr. Thomas said that increasingly, we fragment our approach to health care by organ system or condition. This initiative is just a first step, he said, and an opportunity to break out of the current medical model. The HEZ evaluation will hold grantees accountable to a medical model, but they can target families, neighborhoods, and the social determinants of health if they believe it will improve overall health outcomes. Dr. Thomas urged potential applicants not to

fight among themselves but rather to focus on population health. He noted that the Health Disparities Workgroup members fought about what conditions to include and finally settled on those that cost the system a lot and are easy to measure.

A participant asked about the role of mental health in the HEZ initiative. He added that one of the least healthy populations is that impacted by the correctional health system. He said the RFP mentions prevention of re-entry but asked how to prevent entry into the correctional system and how to deal with families of people in prison. Dr. Thomas said the HEZ initiative does not pose any restrictions on whom to address or how. He added that depression is the “unwelcome traveler” for all the other conditions cited by the initiative, and applicants could propose, for example, to address asthma, diabetes, and hypertension by targeting the mental health burden those conditions place on individuals and families.

CONCURRENT INTERACTIVE DISCUSSION SESSIONS

1A: The Art and Science of Effective Collaborations and Community Involvement in Health Disparities Interventions and Policy

Moderator: Wendy Friar, RN, MS, Vice President of Community Health, Holy Cross Hospital

Paula Blackwell, Program Director, Resources for the Foreign Born, Inc.

Elizabeth Chung, MS, Executive Director, Asian American Center of Frederick

Bettye Muwwakkil, PhD, Executive Director, Access to Wholistic and Productive Living Institute, Inc.

Gina Pistulka, PhD, MPH, RN, Chief Nurse Officer, Mary's Center

SESSION 1A

The Art and Science of Effective Collaborations and Community Involvement in Health Disparities Interventions and Policy

Moderator: Wendy Friar, RN, MS, Vice President of Community Health, Holy Cross Hospital

Ms. Friar opened the panel discussion by explaining how Holy Cross Hospital uses collaborations and community involvement to address health disparities issues in Montgomery County. Holy Cross Hospital obtained a grant to set up the Minority Outreach and Technical Assistance (MOTA) program, which illustrates the conference's theme of improving health equity and eliminating disparities. MOTA's specific purpose is to teach community members to develop their own capacities and to inform other organizations about immigration counseling, interpreting, and other critical services. She described MOTA as working virtually around the clock through "ethnic health promoters," local residents who frequently serve the foreign-born at venues such as ethnic grocery stores and all-night laundromats. She invited participants to become involved by attending their local MOTA's Health Disparities Committee meetings.

Summarizing the history of MOTA, Ms. Friar recalled that it originated with funds derived from the 1998 Master Tobacco Settlement Agreement. As those funds were spent, outreach in Maryland filled the void and is largely responsible for the activities discussed in the current conference.

Paula Blackwell, Program Director, Resources for the Foreign Born, Inc.

Resources for the Foreign Born (FIRN) administers the Howard County MOTA program, which serves immigrants from 75 countries and is regarded as central Maryland's key organization for the foreign-born. Its interpreters are fluent in a total of 29 languages. A major challenge they face is that, historically, those who implement the policies affecting the underserved are not, themselves, underserved. FIRN's Local Health Disparities Committee and the Howard County Local Health Improvement Coalition, which is organized by the health department, recommend a number of measures to address this challenge (see presentation for details).

FIRN uses the ethnic diversity in Howard County as a basis for its expertise. FIRN began training local ethnic health promoters and Local Health Disparities Committee members because it recognized cross-cultural proficiency as the core of leadership development. Early on, FIRN saw that shortage of time and the day-to-day demands of life kept many minorities from participating in community governance. Today, the Committee accommodates the needs of members. The Local Health Improvement Coalition, on the other hand, is made up largely of agency heads and others with formal health credentials. The Committee and the Coalition work closely together. One goal is to disaggregate demographic data; for example, important differences exist between African Americans and Africans from the continent.

Howard County is an innovative place, with initiatives that include a ban on smoking in public places and elsewhere. The Committee's own strategy includes a farmers' market to encourage better nutrition (replacing the term "healthy weight," which may have negative connotations) and expanding marketing materials beyond flyers, e.g., via parent-teacher associations and civic

organizations. Other challenges being addressed include lack of transportation and unfamiliarity with healthy food available at farmers' markets and how to prepare it.

Elizabeth Chung, MS, Executive Director, Asian American Center of Frederick

Recalling the statement of Martin Luther King, Jr., “Of all the forms of inequality, injustice in health care is the most shocking and most inhumane,” Ms. Chung itemized 10 different forms of health disparity. One is language and cultural disparities. The Asian American Center of Frederick is largely responsible for developing interpreter services for Frederick County hospitals. A leading goal of the Center is to increase usage of interpreter services. By the end of 2012, the Center hopes to educate 60% of health providers in Frederick County about legal requirements for such services and how to provide them.

Whatever the need being addressed, Ms. Chung encouraged attendees to ask: who benefits (e.g., community, policymakers), who pays, and who makes decisions? For example, over 25% of admissions to Frederick Memorial Hospital in 2010 were for nonemergency needs. However, nonemergency visits have recently declined by 2%.

A resource guide is now available in several languages to describe the many ways to access interpreter and other services in the county. Underscoring the importance of this accomplishment, Ms. Chung noted that Frederick County is one of the state's most conservative counties. Yet the risk of ignoring language and other services to the foreign-born—especially the monetary risk of litigation—counterbalances conservatism. Advocates for non-English speakers recently succeeded in making contact with 60% of the physicians in the county (about 200). Such efforts require collaboration with hospitals, government agencies, health care coalitions, and other like-minded groups. Ms. Chung encouraged attendees to come to the Asian American Center of Frederick's upcoming health fair to learn more.

Bettye Muwwakkil, PhD, Executive Director, Access to Wholistic and Productive Living Institute, Inc.

Dr. Muwwakkil, who founded the Institute, focused her remarks on the African American men's health initiative. African American men experience far worse health than any other racial or ethnic group in the country: their life spans are shorter, especially between the ages of 25 and 54, and in prison, where they are severely overrepresented, they are more likely to suffer from circulatory disease and obesity. The venue for the initiative is the Salvation Army in Hyattsville, MD, which has 400 residents, 75% of whom are recidivists with health problems. If successful, the initiative will improve their level of activity and nutrition. The Institute is seeking to improve policy through needs assessment, health screenings, and train-the-trainer projects.

The African American men's health initiative is a “collective impact initiative,” with a common agenda and shared measurement. To be effective, Dr. Muwwakkil said, it must build trust, ensure continuous communication, and use new technology to achieve interventions. The Institute looked closely at the Salvation Army, and instead of seeking to change past innovations asked what incremental improvements were possible. Of particular importance in the initiative are a

clear administrative structure and a program that introduces the Salvation Army's members to the social determinants of health.

Gina Pistulka, PhD, MPH, RN, Chief Nurse Officer, Mary's Center

Mary's Center maintains many partnerships, integrating health care, education, and social services. In all cases, the Center keeps in mind their partners' legitimately self-interested concerns, some of which are financial. Especially noteworthy partners include Providence Hospital, which provides obstetric and gynecologic services for high risk, underinsured populations; a March of Dimes mobile unit, which originated in the District of Columbia and now serves Prince George's County as well; a youth program in Maryland similar to one the Center started in the District; and health quality information exchange collaboratives in the District, Montgomery County, and Prince George's County.

The Center's work with academic partners—including the National Association of Community Health Centers, Johns Hopkins University, George Washington University, Georgetown University, and Howard University—affords the opportunity to gather and disseminate findings to partners and students. In its advocacy work, the Center partners with La Clinica del Pueblo to promote HIV testing and media campaigns addressing smoking cessation, domestic violence, and infant mortality. The Center succeeded in getting long-term funding from the District City Council to improve HIV screening, especially for Latinos.

Questions and Answers

A participant pointed out that pharmacy companies resist serving undocumented individuals because their programs prohibit it. Dr. Pistulka said Mary's Center faces this problem. She said the District and Montgomery County have resources to provide pharmaceutical assistance; Prince George's County residents often lack resources, so Mary's Center may draw on foundation grants and, sometimes, partners to serve them. Another participant with a similar problem recommended finding a sympathetic individual in a pharmaceutical company (“go old school”), having a nurse call that individual, enticing the pharmaceutical company to attend local events, and taking other creative measures.

On a different subject, Federal action requiring that individuals seeking hospital care be able to communicate in English, Ms. Chung said a similar action by the Frederick County Commission did not have much impact. “You (doctors and the Center) have to do what you have to do,” said Ms. Chung.

CONCURRENT INTERACTIVE DISCUSSION SESSIONS

1B: Student Involvement in Ensuring a Culturally Competent Health Workforce

Moderator: Norma Poll-Hunter, PhD, Director, Human Capital Portfolio,
Association of American Medical Colleges

Kevon-Mark Jackman, Second-Year Doctorate of Public Health, Morgan State
University, Baltimore City, MD

Danielle Scott, Senior, Bachelor of Science in Nursing, Coppin State University,
Baltimore City, MD

Martin Sule, First-Year Master of Science in Nursing, Bowie State University,
Bowie, MD

Shannon Trego, Second-Year Physician Assistant Program, University of
Maryland Eastern Shore, Princess Anne, MD

SESSION 1B

Student Involvement in Ensuring a Culturally Competent Health Workforce

Moderator: Norma Poll-Hunter, PhD, Director, Human Capital Portfolio, Association of American Medical Colleges

Lead Student Panelists:

Kevon-Mark Jackman, Morgan State University

Danielle Scott, Coppin State University

Martin Sule, Bowie State University

Shannon Trego, University of Maryland Eastern Shore

Dr. Poll-Hunter said the goal of the session was to consider students' viewpoints on how to foster a culturally competent workforce and how the state could enable this effort. Following the conference, suggestions will be forwarded to the Office of Minority Health and Health Disparities.

In response to Dr. Poll-Hunter, panelists described why they decided to pursue their current career programs. Mr. Jackman is working toward a doctorate in public health after an advisor at the University of Florida introduced him to epidemiology. Ms. Scott chose nursing because she has always loved science and caring for people. Ms. Trego worked as a private school teacher and ambulance emergency medical technician in Salisbury, MD, and grew to love the medical field; she is studying to become a physician assistant (PA).

All of the students mentioned family members or family health experiences that influenced their decisions to pursue health careers. In response to Dr. Poll-Hunter, about half of the participants in the session said their parents had been a significant influence on their career decisions. Only a few credited teachers or faculty members with similar influence. About half of the participants also said they had had a personal health experience that impassioned them to become a health care provider. Dr. Poll-Hunter noted that personal experiences are often a factor in decisions to become health care providers but it can be a long road to practice and enacting change.

Mr. Jackman said that when he began clinical studies in Miami, FL, he began to see what he had researched in the classroom. He was interested in racial and neighborhood disparities and worked with people who experienced structural disparities that affect individual health.

Dr. Poll-Hunter asked about further influences. Ms. Trego noted that her prior medical experience working in ambulances was a factor in her success in the PA program. Ms. Scott, who served on her school's curriculum committee, commented that the Coppin School of Nursing embodies leadership and professionalism and believes in leadership to shape future nurse leaders. She also credited the dean of Coppin's nursing program with mentoring students. Mr. Jackman said his professors have been very supportive; his mentor in Miami, who conducted HIV research in the Dominican Republic, was a great inspiration, a passionate person who put patient care first.

Dr. Poll-Hunter asked about challenges and the need for constant learning. Ms. Scott said that passion about health disparities and human welfare compels a person to try to do it all—help the homeless, serve pregnant women, treat sick people, etc. It can take some time to narrow the focus.

Ms. Trego said finances are the greatest challenge, and participants strongly agreed. Ms. Trego shared with the audience that she started the program as a single mother and had to continue working to support her family while she continued her higher education goals. Ms. Scott agreed that a health care education program involves a great deal of sacrifice and can impose a huge strain, but there is light at the end of the tunnel and the struggle is worth it. Mr. Jackman said finances were also a struggle for him. Another challenge he faced was learning about a new culture when he began working in Miami. He had to make a conscious decision to either adapt or resist, and it took time to embrace the local cultures and learn the languages.

Dr. Poll-Hunter asked what panel members and participants would recommend to state leadership to ensure a culturally competent health care workforce. Mr. Jackman proposed that state leadership seek out pools of qualified diverse people, including institutions and organizations that employ culturally diverse health professionals. A participant noted that part of the problem is an existing lack of diverse workers and applicants, making it difficult to build a culturally diverse workforce.

Ms. Scott suggested health care workers recognize their own culture and become knowledgeable about the cultures of others whom they serve. Focused cultural education is necessary to avoid passing judgment or making assumptions. For example, doctors might come into Baltimore City without knowing the extent of substance abuse and its impact on communities. Ms. Trego agreed that education is key. She also noted the need for better funding for medical education programs so that financial problems do not prevent students from completing their degrees. Efforts to build cultural competence should begin in high schools and vocational programs.

Mr. Sule, who is in a nurse practitioner master's program, said that his first recommendation to state leadership would be to incorporate culture into programs for educators and instructors. Educators must be involved and understand the roles of different providers (e.g., nurse practitioners, PAs, physicians, nurses).

Dr. Poll-Hunter asked how interprofessional teams can work together to help clients and patients understand cultural competence. Participants suggested a number of points and actions:

- Research cultures to understand their different traditions (e.g., discipline for children, eating habits).
- Make cultural competence a part of the education program, with required courses. The courses should cover not only race and ethnicity but also gender roles and lifestyle choices.
- Value diversity. Appreciation is needed as well as education. Demonstrate value with an open mind about cultural backgrounds and a willingness to fit into a culture.
- Interact with the community. Work on understanding how to communicate effectively.

- Explain concepts that might seem foreign to some cultures. For example, some countries do not have child protective services agencies.
- Know the demographics of the community you are working with.
- Be aware of what resources are available before they are needed.
- Work out relationships with stakeholders before they are needed.
- Understand how community members will react to various situations. For example, in some cultures, individuals are more likely to seek help from the clergy than the police.
- Be aware of the messaging from gestures. A handshake or nod might mean one thing in one culture and something else in another.
- Address cultural issues and questions that arise in the classroom. Students can enhance cultural competence by discussing their own backgrounds and learning from each other. One nursing class watched the movie *Crash*, which addresses cross-culture tensions, and then discussed it.
- Irrespective of culture, treat people as you want to be treated. Try to make friends from all cultures.
- Professional ethics transcend all cultures and professions.
- Apply your beliefs.
- Encourage gatherings of individuals from different cultures. Dinners are a good way to get people together. Some institutions sponsor cultural nights.
- Take the classroom and learning into the community. Apply the concepts of the university to clinical sites.
- Don't neglect the cultures of rural populations and deaf populations. With the deaf, drawing pictures and charades can be used.

Further discussion considered how schools for health professions can change to better develop cultural competence. Students noted frustration that can occur in communications, as with deaf patients. Language differences can present substantial barriers. Americans are notorious for speaking only their own language. Currently, laws require the use of translators to bridge communications gaps.

Students must be taught how to address the needs of patients and how to apply classroom information to real-life situations. Diet is an important part of a culture, and is particularly important in treating diseases such as diabetes and heart disease.

One participant noted that, unfortunately, the world is full of racist individuals, including some health care providers. Prejudices also exist against people who are obese and other groups. Courses in cultural competence should be required. Prejudices against undocumented immigrants must be addressed. Constant dialogue and self-realization is necessary.

A participant emphasized that the concept of cultural competence must reach beyond the educational arena to politics. Those interested in cultural competence must apply political know-how to demand cultural tolerance. For example, some Maryland counties have declared that English is the official language. This is a message of intolerance and should be contested.

A participant noted that the points being made are good ones, but the group is preaching to the choir. Those in the room understand the importance of cultural competence. Minorities are not

adequately represented in the health care professions. It is necessary to educate educators and administrators and address racism and classism. These can be difficult conversations, and educators must feel comfortable and competent with the topics.

A participant observed that when the state spearheads efforts to address cultural competence, administrators are more likely to address the issues. The University of Maryland School of Public Health was suggested as a source of useful programs and training in cultural competence. A clinical social worker added that professional associations also are working on cultural competence. It is important that cultural awareness be incorporated into all courses, not only courses dedicated to culture.

A University of Baltimore student suggested that colleges partner more with each other. The University of Baltimore is a melting pot. Universities also can play a role in high schools and illustrate diversity, which can be as simple as hiring a male school nurse. Diversity can be taught. Another participant suggested students visit other countries and experience other cultures. Dr. Poll-Hunter reminded participants to submit their ideas and suggestions in writing so that they can be reviewed after the conference.

CONCURRENT INTERACTIVE DISCUSSION SESSIONS

1C: Involving Communities in Policy to Address Social Determinants of Health, Structural Racism, and Discrimination

Moderator: Brian D. Smedley, PhD, Vice President and Director, Health Policy Institute, Joint Center for Political and Economic Studies

Marcos Pesquera, RPh, MPH, Executive Director, Center on Health Disparities, Adventist HealthCare, Inc.

Michael Christopher Gibbons, MD, MPH, Assistant Professor, Associate Director, Urban Health Institute, Johns Hopkins University Bloomberg School of Public Health

Kim Dobson Sydnor, PhD, Interim Dean, School of Community Health and Policy, Morgan State University

SESSION 1C

Involving Communities in Policy to Address Social Determinants of Health, Structural Racism, and Discrimination

Moderator: Brian D. Smedley, PhD, Vice President and Director, Health Policy Institute, Joint Center for Political and Economic Studies

Dr. Smedley welcomed a distinguished panel of leaders who have worked for many years to address social, economic, and environmental issues that shape health disparities and inequities. He encouraged participants to provide input and let the Office of Minority Health and Health Disparities (MHHD) know what the participants believe they can do in their own communities to address inequities. The MHHD staff will follow up with participants who provide contact information and to help with coordination of efforts.

Marcos Pesquera, RPh, MPH, Executive Director, Center on Health Disparities, Adventist HealthCare, Inc.

Mr. Pesquera described addressing health disparities from the perspective of a hospital system. First, to understand the needs of the community, organizations gather input from community health needs assessments, community advisory boards that include broad representation, census data, research findings, and other sources to identify the main health care issues and the social determinants of health involved. At his organization, the findings are summarized into a report that forms the basis for a strategic plan for implementation. Mr. Pesquera said his organization integrates implementation into its structure and requires that the Executive Board approve and allocate resources for the strategic plan.

Organizations must acknowledge and address structural racism and discrimination, which can be accomplished by conducting a cultural competence assessment (using tools provided by the Health Resources and Services Administration and interviews with leadership and staff). The assessment yields information about the community and how to address special needs of a population. The findings can form the basis of a strategic plan. Organizations can also evaluate their own quality data, process measures, and strategies along racial and ethnic lines to pinpoint problems. Mr. Pesquera added that board diversity is key.

To raise awareness about disparities, bring providers into the conversation, take them into the communities, and educate them about social determinants of health, Mr. Pesquera suggested. Issues of cultural and linguistic competency can also be addressed through internal policies, education, and services.

Finally, organizations can assume an active role in influencing health care policy. Hospitals and health care systems are routinely involved with various state councils and commissions. Mr. Pesquera said organizations can take those opportunities to raise awareness about efforts to address health disparities and ensure that policies support implementation of such efforts. The Maryland Health Association is a great mechanism for promoting best practices, he noted; the Cost Council and Commission on Health also offer opportunities to educate providers and reach local health departments.

Michael Christopher Gibbons, MD, MPH, Assistant Professor, Associate Director, Urban Health Institute, Johns Hopkins University Bloomberg School of Public Health

Dr. Gibbons said the Urban Health Institute (UHI) conducts a range of activities to address social determinants of health, some more academic, some more community-based. The organization plans a public lecture in November on developing equity-oriented health metrics for city, county, and state governments. It also hosts a series of working group discussions on social determinants of health in Baltimore City that will culminate in a symposium in the spring of 2013. Dr. Gibbons encouraged participants to contact UHI to take part.

Dr. Gibbons focused on the joint effort Building a Healthier East Baltimore, Together, cosponsored by UHI, the community of East Baltimore, and Johns Hopkins University (JHU), whose medical campus is located in East Baltimore. The name of the program signals the intention to work together to build better health, not just dump money into cosmetic changes, said Dr. Gibbons. It aims to establish effective and ongoing working relationships with community partners through a collaborative process.

The program, underway for about 3 years, has brought together about 200 partners; about half come from various JHU departments, and the other half are business leaders, community organizations, individuals, and others. Partners meet weekly (with no pay) and form working groups as needed to discuss openly and with civility what can be done and how to do it. Partners began by reaching consensus on a set of core values that address issues such as engagement, respecting other cultures, and accountability.

The effort began with the standard approach of a population-based health assessment, which, said Dr. Gibbons, assumes that conditions are at their worst and communities have no resources whatsoever. With this approach, even residents find it hard to see any positive aspects or how they can be part of a solution. The program shifted the focus by asking community members to identify problems and solutions, and they identified individuals and businesses that had skills, resources, and the willingness to contribute something. In addition, UHI brought trainers in who trained community members to go out and talk to their neighbors about community assets.

The future looks “amazing,” said Dr. Gibbons. People in East Baltimore are encouraged and believe their efforts could transform their community. The JHU representatives are learning more about the community where they work. With the information gained from building a community asset map, partners can combine skills, services, and resources to build new, sustainable businesses, for example, thus improving health by increasing economic opportunities, and that’s just one idea among many, said Dr. Gibbons.

Kim Dobson Sydnor, PhD, Interim Dean, School of Community Health and Policy, Morgan State University

Dr. Sydnor explained that academic institutions produce research and contribute to policy that affects every aspect of health and the social determinants of health. Community-based participatory research “is a collaborative approach to research that equitably involves all partners

in the research process and recognizes the unique strengths that each brings.” she said. As an example, Dr. Sydnor described a project undertaken by a postdoctorate, Lawrence Brown, PhD, MPA, that addresses a range of issues: You’re the Quarterback.

The idea began when Dr. Brown’s community-based research partner said, “Our men need jobs and health insurance.” He conceived a program using football as a metaphor. Instead of navigators, the program trains “coaches” who hold “training camps” to help residents understand how to use existing community resources to find jobs and get health and education services. The program has a “playbook” of resources. Underlying the program was the goal of using policy and advocacy to address ingrained structural issues that contributed to the current status of community health.

Dr. Brown developed an emerging model of drivers of men’s health. One side of the model includes structural factors—education, criminal background, child support and arrears, job readiness, job training, and drug testing—that affect employability. Dr. Sydnor pointed out that these factors are powerful, and they affect an individual’s trust in the justice, medical, and other systems. In fact, problems paying child support can lead to mental health issues; Dr. Sydnor said some African American men suffer depression because they are unable to afford their child support payments or because they cannot get a job thanks to a criminal past. As a result of these findings, said Dr. Sydnor, efforts are underway to propose legislation about expungement of criminal records and to address the use of child support as “a weapon.”

You’re the Quarterback received just \$10,000 in funding over 2 years, but the program successfully developed community leaders who are actively engaged in addressing policies in their communities. Dr. Brown received a Maryland Award for Service. Dr. Sydnor said Dr. Brown is a model who showed how to use a small amount of money to reach people who may not feel invested in their communities and galvanize them around positive change. “This is how we wed policy and action, begin to address racism, and help people empower themselves,” Dr. Sydnor concluded.

Questions and Answers

Dr. Smedley asked the panelists whether their partnerships brought any surprising players to the table and whether some stakeholders are still left out. Mr. Pesquera said the Office of Minority Health Resource Center approached his organization for training health care providers and communities about caring for African immigrants with HIV. The health care providers were hungry for training, he said, and they contributed to the curriculum as well.

Dr. Sydnor said she was surprised to see how arts programs played a role, such as individual artists who worked with researchers on outreach and messaging, opening up a whole new approach. Artists may not seem like a natural fit for health disparities initiatives, but they have a vested interest in their communities, she added.

Dr. Gibbons said he was surprised by the engagement of JHU leadership, because community health disparities have not been a priority among JHU leaders in the past. Even the president is part of the discussion; he recognizes that collaboration is the direction of health care for the

future, and he is looking to UHI for insight.

Mr. Keith Colston, administrator of the Maryland Commission on Indian Affairs, asked about engagement with Native Americans and offered to get involved in the UHI and other projects. He said Native Americans continue to be left out of minority health improvement efforts. Dr. Gibbons said that UHI has had conversations with local leaders but has no formal projects involving Native Americans. Dr. Smedley said all of the programs would likely contact Mr. Colston to pursue future efforts.

A JHU faculty member said she was interested in making social determinants of health part of the curriculum because so much of population and individual health is affected by them. She asked how to create awareness among medical schools. She also asked where to find resources to help students learn about social determinants of health and how to get students involved in projects addressing social determinants of health when they graduate from medical school. Dr. Gibbons said the JHU used to have one course, Introduction to Community Medicine, that he taught, but since it revamped its medical school curriculum, nothing has taken its place. He said JHU does offer a 1-week intensive course on disparities, and he suggested the participant contact the head of disparities at JHU's medical school as a starting point.

Dr. Sydnor pointed out that the Surgeon General is looking for ways to address disparities, and she is interested in including social determinants of health in medical school curricula and as part of a national framework for health. Mr. Pesquera said that more guidance is forthcoming from MHHD on cultural competence and health literacy, and those works will integrate social determinants of health for medical schools and health care providers. Dr. Smedley suggested contacting the Association of American Medical Colleges.

A social worker asked whether any programs have addressed the impact of transportation access on health disparities. She also asked how schools prepare behavioral health providers to provide culturally sensitive, consistent care. She noted that the stress caused by lack of adequate transportation is significant. She added that there are no outlets or activities for young people in her East Baltimore neighborhood, and police treat groups of young people on the street like criminals. She asked whether any collaborations involve training police departments to treat young people like human beings. She said we must stop trapping young people into believing this is the only way to live and train them how to be healthy.

Dr. Sydnor said many programs are talking with communities about structural issues such as transportation, police attitudes, etc., but there are no answers yet. Training is critical, she noted, and partnering with communities is an opportunity to train and seed the community. Dr. Sydnor also suggested that communities must approach the Department of Transportation and demand better services with their voices and their votes.

Dr. Gibbons agreed with the participant's points and said the district commander of the police department is involved with the UHI joint initiative.

In light of the Health Enterprise Zones initiative, David Mann, MD, PhD, of MHHD, asked what outcomes and measures applicants should consider for evaluating the effect of interventions on

social determinants of health and what timeframes for evaluation should be considered. Dr. Gibbons suggested talking with the community to identify what endpoints are important, then developing metrics to assess them. He said he is judging the success of his work on the East Baltimore project by looking for visible results beyond clinical services.

Dr. Gibbons pointed to the Hispanic Clinic in Community Psychiatry at Johns Hopkins Hospital as an example of reaching out to voiceless communities, such as the undocumented. Transportation is a key barrier, as are the limited hours in which providers see patients. More needs to be done to socialize people to understand what health care is, including the purpose of primary care, the goal of holistic health care, and honoring home remedies, said Dr. Gibbons.

Mr. Pesquera said hospitals can strengthen their relationships with community clinics, for example, by engaging in case management to ensure patients keep appointments. Clinics can provide services on evenings and weekends to meet the community's needs. Mr. Pesquera reminded participants that the Affordable Care Act will not address the needs of the undocumented.

Delegate Shirley Nathan-Pulliam said she appreciated participants raising concerns about police departments and transportation, but she hoped those same participants would find a way to get their community members to City Hall and get them involved politically. We need more minorities playing a part in local and state politics to address these issues, she said.

CONCURRENT SKILL BUILDING WORKSHOPS

2A: Creating a Successful and Competitive Sustainability Plan

Moderator: Carmi Washington Flood, Chief, Faith Based and Community Partnerships, Prevention and Health Promotion Administration, Maryland Department of Health and Mental Hygiene

Eric Brenner, MPA, Director, Maryland Governor's Grants Office

Betsy Simon, MS, CHES, Founding Director, Office for Healthy Aging, Zeta Healthy Aging Partnership, Zeta Center for Healthy and Active Aging

Carolyn A. Quattrocki, JD, Executive Director, Governor's Office of Health Care Reform

WORKSHOP 2A

Creating a Successful and Competitive Sustainability Plan

Moderator: Carmi Washington Flood, Chief, Faith Based and Community Partnerships, Prevention and Health Promotion Administration, Maryland Department of Health and Mental Hygiene

Eric Brenner, MPA, Director, Maryland Governor's Grants Office

The core function of the Governor's Grants Office is to get Federal funds into state agencies. Maryland receives about 507 grants, totaling \$9.3 billion. The best source of relevant information is <http://grants.maryland.gov>, which describes not only Federal and state grants but, most recently, county grants, which include foundation grants. The office does a considerable amount of training for grant recipients, including webinars.

Sustainability addresses the question of what a grant recipient will do to sustain programs once the grant funds are used up. Training stresses three main points, said Mr. Brenner:

- Begin planning from day 1 how to sustain the organization after the grant expires.
- Start in a collaborative mode.
- Engage with employers and community partners.

To illustrate the variability of grant strategies, Mr. Brenner described three recent recipients. One was a successful District nonprofit that distributes free food to seriously ill patients, about three quarters of whom are Medicaid-eligible but pay nothing. The nonprofit relies on volunteers for staffing. Many of its biggest gifts are bequests, and there is no "nickel and diming" of beneficiaries. The second group is South African and began 20 years ago with sizeable grants because of its worldwide acclaim. The group did not need to reach out for grants initially but now is "scrambling" because public interest has moved elsewhere. The South African group failed to engage in networking early on. The third group is a large hospital that draws heavily on insurance, spends a lot of staff time seeking grants and individual contributions, and collaborates extensively with community organizations. Its success depends largely on the hospital's core competency.

The annual report of the Governor's Grants Office tracks every Federal grant that comes into Maryland and demonstrates remarkable stability over the past 10 years. (The spike in funding from the American Reinvestment and Recovery Act was an anomaly; funding dropped this year.) However, there is no guarantee the money will always be there—there is a lot of risk in Federal health care budgets. No matter who wins the Presidential election, it is possible that an across-the-board budget cut of approximately 9% will go into effect on January 2, 2013 (with the exception of a few large programs such as Medicaid, which was exempted from sequestration). In short, no new influx of money should be expected for health care. Maryland is heavily reliant on Federal funds for health care. It will be necessary to be "fairly nimble" over the next few months, said Mr. Brenner.

Betsy D. Simon, M.S., CHES, *Founding Director, Zeta Healthy Aging Partnership (Z-HAP), Zeta Center for Healthy and Active Aging, Baltimore City (corrected 2/3/2013)*

Betsy Simon began her presentation by referencing Mr. Brenner's response to "what a grant recipient will do to sustain programs once the grant funds are used up." She pointed out that she will address and pictorially illustrate how the Zeta Healthy Aging Partnership (Z-HAP) used soft monies and volunteerism to prove sustainability without a significant grant award.

Noting that sustaining programs, partnerships, and even jobs was the topic for this session, Ms. Simon pointed out that not all partnerships are successful, but when they do work, they can save a community, a family, or even a life. Z-HAP is one of many community, school, and faith-based programs developed by Betsy Simon over the years, using the evidence-based Village Model of Care (VMC¹⁹⁹⁵). VMC is a family and community engagement approach to promoting self-empowerment, healthy living and behavioral changes that address disparities among minorities. It has been implemented and evaluated in community-based settings such as Park Heights and throughout Baltimore in school and faith-based settings (1995 to present).

Using her pictorial power point presentation Betsy Simon used the Z-HAP model to illustrate "the strengths and benefits of community partnerships." First and foremost, an appropriate venue is necessary though some previous programs started in a church or even the abandoned storage basement of a City school. The good thing about the start-up for Z-HAP was that an excellent location was available, the newly opened (2009) Zeta Center for Healthy and Active Aging (Zeta Center). This facility was ideal since it is owned by our sponsor, Alpha Zeta Chapter, Myrtle Tyler Faithful Fund, Inc., Zeta Phi Beta Sorority, Inc. The Zeta Center offers a daily array of quality programming including lunch for older adults, 55 and above, Monday through Friday, 8am to 4pm with at least 2 late nights per week. The day to day program management and activities for the Zeta Center are under the leadership of Center Manager Leslie Yancey, BCHD: C.A.R.E.

Simon depicted Z-HAP's journey toward sustainability as follows: 1. Historical basis: officially launched June 2010 as an outgrowth of the very successful Zetas Diabetes Awareness Program (Z-DAP 2009-2010) which actually began in 2006 during Simon's tenure at Coppin State University in partnership with the American Diabetes Association; 2. Needs Assessment: included the use of existing data for the area and direct feed-back from current members of the Zeta Center; 3. Research and Development of Program Design: outcome was the REACH approach (see graphic model on PPP); 4. Trust Building Activities: included meetings with the sorority, Center Manager, Zeta Center members, and potential community partners to share program design, initial plans, evidence-based documentation and our desire to partner building on the existing/on-going work being done in the Southern Park Heights community; 5. Z-HAP Branding: using words, t-shirts and paraphernalia to announce our vision and mission to "REACH for Health Equity in Park Heights" (see design in PPP); 6. Resource Development: initially operations and programming were totally dependent on funds provided by Z-HAP Founder and her husband which led to other soft money donations from sorority members, individuals and mini grants from sources such as Alpha Zeta, LifeBridge Health and P-B Health. In this third year of operation, it is heartening to note that now the Z-HAP members who we

serve have begun to contribute on a monthly basis (ranging from \$10 to \$50); and 7. Sustaining and Growing Participation and Partners: through trust building and evidence-based educational-but-fun activities, program attendance has grown from 7 to 9 members each Friday to 60 to 94 members each Friday with more than 125 in attendance when Saturday activities are offered.

We don't see the Zeta Center as a typical senior center because an environment has been created where the members, ages 55 and over, experience daily self-empowering activities that are void of the crippling effects of ageism. This atmosphere is readily noticed by everyone who visits the Center. This daily programming is under the auspices of C.A.R.E. Center Manager Leslie Yancey who in 2009 agreed to partner with Z-HAP by assigning Fridays, 12noon to 3:00 pm for Simon to offer Z-HAP programming and services. Since then, with the assistance of a trained ZHAP Prep Team and community partners; programming and services have been offered every Friday, 12Noon to 2:30/3:00 pm. Z-HAP, a free service, is advertised and is open to the general public with special encouragement to the families/friends of participants and the general community.

The leading edge experts who are featured speakers/providers each week are made available without charge by our community partners (from 1 partner-the American Diabetes Association, in 2009 to 35 partners in 2012). These partnerships ensure sustainability as much as, sometimes more than, having funds with renewable cycles. In addition to our strategic planning, documentation and solid partnerships, we give back. Our partners help us and we help them with their community outreach efforts such as the ADA "Stop Diabetes Walk," providing a setting for Coppin's Nursing Students with their Professor, to conduct depression screenings, the "Leukemia/Lymphoma Society's "Take Charge of Your Health Navigation Program" and LifeBridge Health's "Community Health Assessment Project".

Finally, the key to sustainability is establishing roots where the needs are and then having the desire and commitment to "see it through" the challenging times until solid ongoing resources can be attained. Always remembering that money is not the only resource...partnerships are crucial.

Carolyn A. Quattrocki, JD, Executive Director, Governor's Office of Health Care Reform

Ms. Quattrocki concentrated on changes in the landscape of health care reform in which nonprofits operate. The Office of Health Care Reform concentrates not only on increasing the numbers of insured individuals but also to improve health. This "incredibly complicated" undertaking will affect everyone. Realizing this, the Office collaborates with the Federal government, state agencies, local jurisdictions, nonprofits, and the private sector.

Ms. Quattrocki contradicted the position taken by many opponents of "Obamacare" who regard it as a top-down imposition of Federal control. The Affordable Care Act (ACA) provides a large set of tools to improve health care but leaves states with considerable discretion as to how they want to implement it, she said. She described the four major "pillars" of the ACA:

- 1) Stronger, nondiscriminatory insurance coverage
- 2) Expanded access to health insurance and health care

- 3) More affordable insurance coverage
- 4) Cost control and quality improvement

In Maryland, a bipartisan executive/legislative coordinating council was created immediately after passage of the ACA. Work groups brought together stakeholders, met frequently, convened public gatherings, and over the course of a year recommended ways to implement the ACA. Ongoing partnerships were recognized as essential for the future. Ms. Quattrocki presented, in numbers, the current challenges and objectives of implementing the ACA in Maryland.

Expanding access to health insurance and health care will be accomplished via the Maryland Health Connection health insurance exchange, which provides Federal health subsidies to purchase insurance for people who earn up to 400% of Federal poverty guidelines, and Medicaid expansion to cover those who earn up to 133% of the Federal poverty level. Ms. Quattrocki presented statistical data that detail the anticipated coverage by the end of the decade through these efforts. Despite these activities, about 350,000 Marylanders will remain uninsured, presenting challenges to community health centers and private providers.

Especially important of the four pillars is more emphasis on cost reduction and quality improvement, e.g., disease prevention, health improvement and reduction in disparities, and new care delivery models. Ms. Quattrocki drew attention to the Office's extensive Website www.healthreform.maryland.gov, which elaborates on current conditions and plans.

Questions and Answers

A participant asked Ms. Quattrocki to compare the Maryland Health Insurance Plan for the medically uninsurable with the Maryland Health Connection. She responded that, in 2014, if everything goes as expected, insurance companies will no longer be able to declare individuals uninsurable, e.g., because of preexisting conditions. In essence, the Maryland Health Insurance Plan will become obsolete. Transition plans are currently under discussion.

A participant asked Ms. Quattrocki whether the ACA envisions making only physicians more cost-effective. She replied that, in fact, all allied health professionals will be affected, including new categories of providers, such as community health workers, who will be responsible for coordinating different health services. Such providers may also take on social work assignments, e.g., compliance. Work force development is another key component of new health care delivery models.

Asked to explain the navigator component, Ms. Quattrocki said the ACA requires that all states reach individuals with no experience with insurance, which requires knowledge of the community, cultural competence, and other skills. The Maryland Health Connection is developing detailed requirements—a “no wrong door” approach—in which navigators will help everyone. The Website referenced earlier links to a navigator site for more details.

Asked how payments to primary care physicians will change under the ACA, Ms. Quattrocki said that the ACA requires that Medicaid funding be increased in one way or another, but the specifics are not yet clear.

In response to participant, Ms. Quattrocki said that undocumented individuals, unfortunately, will not be able to enroll in or purchase policies in the Maryland Health Connection. Government efforts are looking at how to implement a “safety net” for them.

A participant asked what changes are in store for local health departments under the Exchange Bill of 2012. Ms. Quattrocki said that local centers, the major “safety net,” will continue to provide this function but in a different environment. They may train navigators and do other new things, becoming a “one-stop shop.”

A participant said many new residents wonder how to prove disability in a new state where requirements are different than in the state where they previously lived. Ms. Quattrocki said that in 2014, Medicaid will subsume all current disability benefits for those who qualify. As with all aspects of the ACA, details are still being worked out.

CONCURRENT SKILL BUILDING WORKSHOPS

2B: Geographic Information Systems and Mapping: Examples of Targeting Health Disparities Interventions

Moderator: David Mann, MD, PhD, Epidemiologist, Office of Minority Health and Health Disparities

Saleem Sayani, MNCM, PMP, CPHIMS, Chief Information Officer, Office of Information Technology, Maryland Department of Health and Mental Hygiene

Rashid Malik, Certified Oracle DBA, Geographic Information Systems, Prevention and Health Promotion Administration, Maryland Department of Health and Mental Hygiene

Oxiris Barbot, MD, Commissioner of Health, Baltimore City

WORKSHOP 2B

Geographic Information Systems and Mapping: Examples of Targeting Health Disparities Interventions

Moderator: David Mann, MD, PhD, Epidemiologist, Office of Minority Health and Health Disparities

Dr. Mann introduced the session by displaying an example of geographic information system (GIS) mapping—a map that the Office of Minority Health and Health Disparities (MHHD) updates and presents each year showing the state’s racial and ethnic diversity. The map visually depicts the number and percentage of minorities in each county.

Saleem Sayani, MNCM, PMP, CPHIMS, Chief Information Officer, Office of Information Technology, Maryland Department of Health and Mental Hygiene

Mr. Sayani said he previously worked on integrating GIS into the fields of criminal justice and public safety to do predictive modeling and crime analysis. He sought to translate those approaches into public health to identify outbreaks early, deploy resources, and prevent health care crises. The first challenge was centralizing GIS systems, which required a commitment from top leadership. Since he began his work 2 years ago, said Mr. Sayani, his office has forged partnerships beyond the Department of Health and Mental Hygiene (DHMH) to include state and county health officials who have invested in technology.

In keeping with Governor Martin O’Malley’s goal of centralizing systems for efficiency, the DHMH succeeded in centralizing its GIS and offers a number of applications on demand that allow users to tailor the search criteria to create customized data summaries. GIS is not magic, said Mr. Sayani; technology does nothing on its own. Without collecting the right data, even the most capable and sophisticated systems will be subject to the old adage, “garbage in, garbage out.”

Mr. Sayani said he envisions continuing to leverage the existing GIS resources in the state while also learning from industry. While it is sometimes true that the government lags behind the private sector in innovation, Mr. Sayani said Maryland wants to be progressing side-by-side with the private sector.

Rashid Malik, Certified Oracle DBA, Geographic Information Systems, Prevention and Health Promotion Administration, Maryland Department of Health and Mental Hygiene

Mr. Malik said the GIS unit at DHMH began in 2001 with the goal of increasing GIS capacity. The technology is new to everyone on staff, he said, so the unit aims to highlight its potential.

Maintaining data privacy and ensuring data quality are the major limitations to expanding the role of GIS. Sometimes, those issues can be addressed with technological solutions, such as aggregating or masking data. Occasionally, users see the complexity of the solutions as a barrier or a disincentive, but those perceptions are beginning to break down. More users are considering how to use data in new ways. As Mr. Sayani noted, GIS analyses are only as good as the data

available to inform them.

At DHMH, the GIS unit can perform geocoding, which connects places and health events. With geocoding, a user can perform analysis to determine, for example, how many events happened in a given zip code over a given period. Geocoding offers the highest resolution (i.e., granularity) of data, allowing users to get information at the address level. Static mapping, such as the graphic shown by Dr. Mann, displays information in a static fashion. Geospatial analysis applies a combination of analytic techniques to geographic data. Mr. Malik hoped that people would not be discouraged by the complexity of GIS. To help, the GIS unit developed user-friendly applications to customize data and minimize the learning curve.

The HIV mapping application, for example, allows users to look at data down to the sub-county level and to examine racial and ethnic distributions as well. The Health Enterprise Zone (HEZ) application helps users determine their community's eligibility for an HEZ. The Maryland Cancer Prevention, Education, Screening, and Treatment Program Mapper can help identify even small numbers of cases in communities. The asthma mapping application includes 9 years of county-level data. The rabies mapping application has 10 years of data and is easy to use; it can help users see a problem developing over time. Many other applications are available, said Mr. Malik. In the future, the GIS unit will be working on hot-spot analysis and addressing data acquisition issues.

Oxiris Barbot, MD, Commissioner of Health, Baltimore City

Dr. Barbot said the Baltimore City Health Department seeks to use GIS to engage communities, promote health equity, and highlight social determinants of health. Using graphics, she demonstrated the evolution of sharing data, beginning with simple bar charts of average life expectancy by community. Breaking the data down by community allows for comparison with state and national data. It highlights the disparities between communities of higher and lower socioeconomic status. Life expectancy has more to do with social determinants of health where we live, work, and play than with clinical interventions, said Dr. Barbot.

Next, mapping these data allows the viewer to see geographic clusters, and the viewer reflexively considers his or her own neighborhood in relation to the data. Color-coding makes distinctions clear. The map of life expectancy can then be compared with or even layered on top of maps of other factors, such as the number of vacant buildings by neighborhood. Dr. Barbot said she and her staff use these graphics in presentations to communities to illustrate that we cannot have a healthier city unless all of our neighborhoods improve, and we are all invested in improving health outcomes.

Dr. Barbot then displayed a map of avertable deaths—that is, deaths that could have been avoided if all communities in Baltimore City had the same opportunities for good health outcomes. The map depicts the implications of income inequality and maldistribution—something we consider in every context except health, said Dr. Barbot. In Baltimore City, over half of the deaths in some communities are avertable.

Another map shows the number of premature deaths (i.e., before age 75) from cardiovascular

disease, a category that highlights racial disparity in Baltimore City. Dr. Barbot encouraged participants to consider how to present data in a way that engages communities to become partners in addressing underlying social issues affecting health. If these data had not been rendered geographically, said Dr. Barbot, she and her colleagues would not have identified a “heart attack belt” that corresponds with the city’s areas of low socioeconomic status, low education, low life expectancy, and limited transportation. (She added that participants should take into account the visual impact of their presentations, using colors that pop and are easily distinguished from one another.)

Yet another map indicates the number of vacant buildings (data provided by the housing department) combined with the locations of liquor stores (data provided by the liquor board). The map shows a higher density of liquor stores in areas with the most vacant buildings, illustrating how these factors contribute to race-based health disparities. Adding in police data, the viewer can see how homicide rates cluster in those same areas—an issue common throughout the country. In Baltimore City, the areas with the highest density of liquor outlets are also those with the highest density of African American families.

Graphics like these can engage and motivate communities, said Dr. Barbot. She and her colleagues have partnered with Baltimore’s housing department to address zoning codes in an effort to combat the “liquor store effect,” she said. The resulting bill is open for public comment.

David Mann, MD, PhD, Epidemiologist, Office of Minority Health and Health Disparities

Dr. Mann offered some tips on interpreting maps and using GIS:

- Consider what questions you want to answer and whether the data speak to those questions.
- Determine whether the data come from things that can be counted (e.g., births, deaths) or measured (e.g., blood pressure).
- If the data come from counts, do the figures represent raw data (which show the location of the most or least), rate per population (which show better and worse performers), or ratios (which show a comparative proportion)?

By way of example, Dr. Mann showed several maps of asthma metrics. The map of raw counts of asthma admissions showed that the jurisdictions with the largest populations have the highest numbers of asthma admissions. Changing to a map of admission rate per population, Baltimore City, Allegany County, and four counties on the Eastern Shore had the highest rates, revealing a very different picture. Adjusting the rates for age added an additional Eastern Shore county to the second highest rate group.

Dr. Mann recommended that participants look critically at the accuracy and stability of data in small geographic areas. The more granular the data, the less stable the findings. For example, in a graphic showing age-adjusted, all-cause mortality rates, data from one small county show a lot of variation or “wobbling”, while the overall state rate had a more stable trend line. That county would appear similar to the state or much worse than the state depending on which year was displayed on a map, Dr. Mann cautioned. It is important to see whether you have enough data

over small time intervals to draw conclusions; sometimes pooling multiple years of data is required for stability, he noted.

Questions and Answers

A participant said she appreciated Dr. Barbot's vision for making data more compelling communicating the reality of social inequities that contribute to health outcomes. She asked what community organizations can do and what is being done to make data more publicly available. Dr. Barbot said many health departments believe it is their job to crunch the data, and people will come and get it. She said the first step toward breaking down that barrier is to go into communities and talk about the data. Data can be presented beyond Websites, through entities such as *The Baltimore Sun*, to reach more people.

Dr. Barbot said the mayor of Baltimore wants to develop a more robust Website that makes all city data available to citizens. The Health Department plans to contribute, for example, restaurant inspection data. Dr. Barbot and her colleagues are developing partnerships with academics and others to look at new ways to combine and overlay data.

A participant asked how to take history into account when presenting data to communities. She added that some communities seem to be left out of analysis and interpretation because they do not fall into the hot spots. She also referred to the lack of low-income housing in the context of new housing development. Dr. Barbot said the issue of history—how we got here—is complex. She recently got involved with a group working on understanding the history of racial politics in Baltimore. She said a group member presented a map showing redlining in Baltimore City that perfectly reflected her own map of vacant building density. Dr. Barbot said we need more consideration of the various strategies we can use to address the social determinants of health.

In terms of displacement of individuals—a critical question in situations such as housing development on the west side—Dr. Barbot said the Health Department is undertaking a health impact assessment, building capacity, and training community members to do their own assessments and capacity-building. Experts from San Francisco came in to provide such training to community members and to partners in sister agencies.

Mr. Keith Colston of the Maryland Commission on Indian Affairs said he had to go to multiple sites to find data about Native Americans; he asked how the Native American community can help provide more data. Dr. Barbot said that under the Healthy Baltimore 2015 program, the Health Department kicked off a neighborhood health initiative and put out a lot of data. The Health Department made a concerted effort to reach out to many communities, including, for example, the Native American Center in Baltimore City, which is part of a coalition created by the Health Department. Dr. Barbot hopes to create a mechanism for community input from neighborhoods across the city. She said she is open to incorporating information on Native Americans if someone can provide the data.

Dr. Mann said training efforts are underway to ensure that health care providers ask their clients about their race/ethnicity and not simply make assumptions and check a box. It is important to give each person the opportunity to declare his or her race or ethnicity, he said. Also, MHHD

would like to add racial and ethnic data into other systems (e.g., for quality improvement tracking for health insurance systems), so it is necessary that individuals self-identify their race and ethnicity.

A participant asked whether mobile phone applications could be used to collect geographic data from users. Mr. Sayani said the current applications cannot yet collect data from mobile devices because of programmatic—not technological—challenges. Dr. Barbot said the Health Department does not have the capacity to collect data in that manner, but Baltimore is a launch site for the Million Hearts Campaign, which has an application that allows users to assess their own risk of heart disease. The challenge, she said, is how to provide such tools to people who cannot afford smartphones and to those who only have text-messaging capability.

CONCURRENT SKILL BUILDING WORKSHOPS

2C: Exploring New Media: Embracing Social Technologies to Improve Health Outreach

Moderator: Frances B. Phillips, RN, MHA, Deputy Secretary, Public Health Services, Maryland Department of Health and Mental Hygiene

Lori Livingston, Office of Communication Social Media Manager, Maryland Department of Natural Resources

Andy Smith, President, Brothers Who Care, Inc.

Ellen Langhans, MA, healthfinder.gov Program Manager, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services

WORKSHOP 2C

Exploring New Media: Embracing Social Technologies to Improve Health Outreach

*Moderator: Frances B. Phillips, RN, MHA, Deputy Secretary, Public Health Services,
Maryland Department of Health and Mental Hygiene*

*Lori Livingston, Office of Communication Social Media Manager, Maryland Department of
Natural Resources*

Before joining the Maryland Department of Natural Resources (DNR) 2 years ago, Ms. Livingston worked for NASCAR, where she focused on making connections with urban youth. She said that she wears multiple hats for the state and in addition to her work at DNR, she manages social media for the entire state and has been able to use her NASCAR experience. When asked, only a handful of participants indicated that they manage social media for their organizations.

Ms. Livingston emphasized that leadership buy-in is essential for effective use of social media. Maryland has such buy-in from Governor Martin O'Malley and Secretary Joshua Sharfstein, MD. The state provides an excellent list of social media resources. A Google search of social media in Maryland will provide an extensive list of links (<http://www.maryland.gov/pages/socialmedia.aspx>). She recommended that participants check out resources and use them.

The goal of social media is to gain followers and transmit information quickly. Maryland has a hub-and-spoke model for social media, with the state as the hub that has spokes connected to a number of different agencies. Agencies have a presence on multiple sites, including Twitter, Facebook, and Pinterest, and each program has its own account. The state umbrella account supports the agencies and sends relevant information to the various agency accounts.

Success with social media interactions depends in part on developing relationships with other like-minded social programs. Ms. Livingston recommended that programs reach out to others with similar purposes. Social media is not about pushing out information; it is about sharing. Programs can work together to support each other. Organizations with common target populations can establish mutually supportive relationships.

Ms. Livingston noted that the top Twitter accounts are entertainers; many entertainers are willing to share their large audiences with a good cause. For example, race car driver Danica Patrick's grandmother died of chronic obstructive pulmonary disease (COPD), and she has become a spokesperson for the disease. Her Twitter account has more than 600,000 followers. Former football player and current talk show host Michael Strahan also has a family connection with COPD and reaches out through social media. Linking a cause to a celebrity allows an organization to reach a much larger audience than it could on its own.

Andy Smith, President, Brothers United Who Dare to Care, Inc.

Mr. Smith leads Brothers Who Care, a grassroots organization located in Hagerstown, MD. He has been instrumental in broadening the focus of the group from social change for African Americans to encompass multicultural concerns. He edits *Speak Up Community News*, a publication that promotes community culture, health, and self-sufficiency and is distributed in four states. He also manages grant-funded programs to help eliminate minority health disparities and promote health equity, such as the state Minority Outreach and Technical Assistance office in Washington County.

Mr. Smith described himself as a “minimalist” who functions on a low budget. His publication began with door-to-door distribution in Washington County and has extended its reach to four states and Facebook, reaching tens of thousands of readers per month. He emphasized the networking value of Facebook, which allows a post or tag to be distributed to many groups of friends. He has found that using Facebook can save a great deal of money and provide many advantages.

The paper publication has evolved into an e-publication with links to featured events and groups. The organization appreciates the value of using technology to reach out to a broader community. The techniques are simple and inexpensive. Facebook is just one avenue; Brothers Who Care also uses e-mail blasts. Mr. Smith cautioned those using e-mail blasts to blind the recipient lists so they are not pirated by others.

Ellen Langhans, MA, healthfinder.gov Program Manager, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services

Ms. Langhans manages content and access for healthfinder.gov, a Federal Website that provides outreach, decision support, and evaluation to assess return on investment (ROI) and help with overall buy-in. The outreach strategy employs Twitter, Facebook, weekly newsletters, and monthly spotlights in addition to the Website content and e-mail news alerts. It leads to further conversations among users.

The overall mission of healthfinder.gov is to provide accurate, timely, and actionable information to help the public make informed health decisions. It aims to increase consumer understanding of and action on the key principles of healthy living and build consumer confidence that health behavior change is personally attainable. It also aims to build an online presence that supports individuals in attaining healthy living and wellness goals through accountability and encouragement and provide decision support around the preventive services available to users and covered by the Affordable Care Act (ACA).

Consumers are taking charge of their own health care. More and more, people are seeking health information online. Healthfinder.gov wants to provide consumers with credible information they can use. Last year, the Office of Disease Prevention and Health Promotion (ODPHP) developed a strategic plan to implement decision support services that would expand its reach and engagement with the public. The healthfinder.gov Twitter account and Facebook page serve as online communities for supporting the public in setting personal wellness goals and making

appropriate health decisions. Preventive services are evaluated according to their ROI, which is determined by dividing the number of people reached who engaged in decision support by the cost of providing the service. Social media sites represent an online community; they also serve as outreach tools directing people to healthfinder.gov.

Ms. Langhans and her staff calculated that their information about ACA-related preventive services reaches about 11 people per each \$1 spent for information technology. They set the goal of improving that by 45%, to 16 people per \$1 spent and met that goal in February 2012. Evaluation will continue to try to improve the meaningful use of the site and how people are engaging. Engagement was assessed by a number of factors, including ACA-related visits to healthfinder.gov, ACA-related e-mails, ACA-related tweets and re-tweets, ACA-related “likes” and comments on LinkedIn and Facebook, and participants engaging in ACA-related Healthy People Webinars.

Future directions for healthfinder.gov include ongoing outreach, additional Spanish outreach, refreshing the Website with better branding as a prevention/wellness site, enhancing the user experience to spur action, development of mobile applications, content syndication, and updated ROI with more meaningful numbers for reach and engagement.

Questions and Answers

Ms. Livingston asked Ms. Langhans whether ODPHP developed its own analytics package. Ms. Langhans replied that several techniques were used, and a contractor gathered the feedback.

A participant asked whether a future direction for healthfinder.gov would be making multiple languages available on the site. Ms. Langhans said currently Spanish is the only alternative to English and adding languages is expensive. Ms. Livingston commented that foreign language efforts are often criticized if they are not grammatically perfect. The challenge lies in finding talent as well as money. The worst thing is to do something poorly. Translation links are available, but they are not always trustworthy. Mr. Smith agreed, adding that those in the community who want the translations should become involved with providing them. When he uses translations, he adds a caveat to excuse grammatical errors.

A participant reiterated that social media not only disseminate information but also allow people to engage with each other. Ms. Langhans noted that healthfinder.gov has a national health observances calendar on the Website and weekly challenges on Facebook that coincide with the theme for the week. She said that getting people engaged with the content is easier than getting them engaged with each other, but interactions are occurring.

Ms. Livingston said another approach is simply to ask questions. Also, controversial posts tend to provoke conversation. Mr. Smith said he views his efforts as planting seeds. Sometimes they will provoke a conversation.

In response to a comment about the need for Spanish interpreters and translators to be culturally sensitive to the Hispanic community and appreciate that dialects and word meanings sometimes

differ by country, Ms. Langhans said healthfinder.gov uses “neutral” Spanish, but it is difficult to cater to every different need.

Ms. Walker highlighted the importance of health literacy. Even native English speakers might have trouble understanding some health information. Ms. Langhans added that plain, clear language does not mean dumbing down. Technical terms should be defined and phonetic spellings included. Material should be written in short paragraphs and bullet points. Information should be broken down with specifically identified action steps. Ms. Livingston said it can be difficult to limit the use of acronyms in government writings.

A participant asked how to handle controversial issues and offensive comments. Ms. Livingston said this is a challenge of social media. DNR has a comments policy and will delete inappropriate language, but it happens rarely. Those in charge of government social media accounts are comparable to a spokesperson in front of a TV camera. They are the face of an agency and must be trustworthy.

A participant commented that a post on Facebook about the safety of crib bumpers prompted a great deal of useless information but also elicited a very thoughtful comment from a pediatric nurse about why not to use bumpers.

In response to a question about whether consents are necessary to post photographs on social media, Mr. Smith said photos of people in public situations can be used. Ms. Livingston said this is a new world and guidelines are not yet definitive, but the general policy is not to use a picture of someone under age 18 without a signed consent from a parent. Facebook has its own rules, and a photo will be removed if a subject requests it. Ms. Langhans said healthfinder.gov uses only stock photos. Ms. Phillips said that rules about consents are loosening as people become more accustomed to the new ways information is being shared. A Charles County representative asked whether state policies could be shared with local departments, and Ms. Phillips said that was possible. Ms. Livingston added that the state is free with its policies and wants other jurisdictions to use and adapt them.

A participant asked about using a media blast to remind people of appointments and the applicability of Health Insurance Portability and Accountability Act (HIPAA) regulations. Ms. Langhans said healthfinder.gov does not collect personal information. Ms. Livingston said that the questioner should check with the legal department. The answer lies in an “opt-in” policy. Ms. Phillips urged caution and the need to understand a tool before using it. The “reply all” and auto-fill functions can be tricky in mass mailings.

Ms. Livingston said that social media resources are not going away, even though some have been hesitant about using them. Social media has become the way of the world. It is changing the way people communicate. It can be very useful for programs with limited funding. Social media can save time and money and can answer a question once for hundreds of people. The programs provide an opportunity to jump over the press and to provide unmediated, unfiltered information. Reporters get their information from social media. She added that DNR is moving away from press releases. Reporters can get their information from the DNR news page. The opportunities are tremendous but the methods must be thought about and worked out.

A participant noted that the digital divide remains very real in certain communities. It is necessary to work on how to use technologies and have an impact on public health in communities of color. Mr. Smith said he was giving out free computers 12 years ago and asking recipients to donate 10 hours of their time. Because of advancing technology, most phones now have data and people don't need a computer. The challenges of the digital divide have shifted and lessened. Device manufacturers and investors are directing technology to consumers. Ms. Langhans said her office pays attention to trends and statistics, and the use of technology is increasing in different populations. There is not yet a mobile application for healthfinder.gov, but there will be.

Ms. Livingston said African American and Hispanic populations use social media more than Whites. When she was with NASCAR, she found that sometimes the only way to reach urban communities was through their phones. Information spreads in an exponential way and it is not measurable. Mr. Smith cautioned against retiring all of the old methods. When he cut back on delivery points for hard copy of his publication, people asked for it. Methods that worked should not be cast out automatically.

A participant commented that staffing allocation should be relative to the size of a media campaign and asked how many hours should be spent tracking a Facebook page, for example. Ms. Livingston said it depends on the size of the accounts, but it is likely to grow. Also, tools such as aggregators are available. She can do her entire job on her iPhone. There is a learning curve in the beginning, but it becomes second nature. HootSuite, a social media dashboard, can provide analytic information.

Ms. Langhans said the Federal government often works with contractors. She added that it is easy to think of silos when talking about social media, but it is important to keep the overall communications strategy in mind.

Ms. Phillips summarized that the session has produced some tremendous ideas and experiences that can be applied to the purpose of reducing and eliminating health disparities. In 12 months at the next health disparities summit, the growth and dynamism in the field of social media will be apparent.

CONFERENCE WRAP-UP AND EVALUATION

Carlessia A. Hussein, RN, DrPH, Director, Office of Minority Health and Health Disparities, Maryland Department of Health and Mental Hygiene

CONFERENCE WRAP-UP AND EVALUATION

Carlessia A. Hussein, RN, DrPH, director of the Office of Minority Health and Health Disparities, shared her perspective on some of the highlights of the conference:

- The emerging men's health model and You're the Quarterback program presented by Kim Dobson Sydnor, PhD, interim dean of the School of Community Health and Policy at Morgan State University, which demonstrate how community-based participatory research can address real needs, such as jobs and housing
- The use of GIS mapping and graphics by Oxiris Barbot, MD, commissioner of Health for Baltimore City, to make the case for legislation to improve community health in Baltimore by addressing the social determinants of health
- Inspiring comments by Howard K. Koh, MD, MPH, Assistant Secretary for Health of the U.S. Department of Health and Human Services (HHS), about the sunlight of opportunity. (We must take advantage of the opportunity before the sun sets, said Dr. Hussein.)
- News that some HHS agencies are beginning to require grant applicants to include disparity impact statements in their proposals—an approach that Dr. Hussein has promoted in the past and will continue to push in the future

Some of the moderators of the afternoon workshops offered brief summaries. Delegate Shirley Nathan-Pulliam said the conference had been an extraordinary day in terms of the information shared, and she was sure participants were leaving excited about what they can do in their communities. She invited the participants to come to Annapolis for the annual Maryland Black Caucus Workshop, which planned to discuss many of the health care issues raised today. Delegate Nathan-Pulliam said she made sure that cultural and linguistic competency were included in all the health care initiatives recently passed and funded, so she urged participants applying for grants under those initiatives to incorporate cultural and linguistic competency in their proposals.

Delegate Nathan-Pulliam, Dr. Hussein, and Conference Moderator Donna Jacobs, Esq, all offered their thanks to the staff who organized the conference and to the participants.